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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SC WORKERS COMPENSATION COMMISSION

Appellate Panel:
Commissioner Andrea Pope Roche
Commissioner Derrick L. Williams
Commissioner David W. Huffstetler

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SC Court of Appeals

WCC File No. 0906951

Bernard D. Lee,,..... Respondent,

v.

Bondex Inc. and Great American Alliance Insurance Company, ...Appellants.

RECORD ON APPEAL ON BEHALF OF BONDEX INC. & GREAT AMERICAN ALLIANCE INSURANCE COMPANY
Volume II

August 3, 2012

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INDEX

Volume I

1. SCWCC Appellate Panel Order-10/12/11 1
2. Order of the South Carolina Workers Compensation Commission -7/25/11 32
3. Order of Commissioner Avery Wilkerson-12/31/10 33
4. Order of Commissioner Avery Wilkerson-08/31/10 52
5. Consent Order-04/27/10 55
6. Consent Order-12/08/09 57
7. Consent Order-08/28/09 59
8. Form 30 Request for Commission Review-01/12/11 61
9. Form 21-07/09/10 65
10. Form 51-03/17/10 68
11. Form 50-02/15/10 69
12. Form 51-08/31/09 72
13. Form 50-07/30/09 73
14. Appeal Hearing Transcript-05/16/11 76
15. Commissioner Avery Wilkerson's Hearing Transcript-09/07/10 97

Bernard Lee, Direct Examination by Ann Mickle 123

Bernard Lee, Cross Examination by E. Ros Huff Jr. 192

Bernard Lee, Re-direct Examination by Ann Mickle 226

Volume II

Bernard Lee, Re-cross Examination by E. Ros Huff Jr. 233

Bernard Lee, Re-direct Examination by Ann Mickle 234

Lowell Simpkins, Direct Examination by E. Ros Huff Jr. 237

Lowell Simpkins, Cross-Examination by Ann Mickle 247

Lowell Simpkins, Re-direct Examination by E. Ros Huff Jr. 269

Lowell Simpkins, Re-cross Examination by Ann Mickle 274

16. Claimant's letter to Commissioner Wilkerson with enclosed questionnaires of Dr. Carter, Dr. Thomas, Dr. Robinson and Dr. Thesing-09/21/10 279

17. Defendant's letter to Commissioner Wilkerson with enclosed questionnaires of Dr. Westerkam, Dr. Bethea and Dr. Thesing-09/20/10 296

18. SCWCC Hearing Notice-08/26/10 301

19. Employer/Carrier APA Evidence-08/02/10 303

20. Claimant's APA Evidence-07/28/10 535

21. 12A-06/03/09 690

the year before this accident?

A. No, ma'am. I ain't never had no problems with my --

Q. The shoulder is what I'm talking about.

A. -- no -- no problems with my shoulder, none of that. I can't even move my left one now.

Q. All right. Thank you.

Commissioner Wilkerson: Anything else from this witness?

Mr. Huff: Just one (1) quick question, Your Honor.

Commissioner Wilkerson: Sure.

RECROSS-EXAMINATION

By Mr. Huff:

Q. You were asked about the restrictions that was on the questionnaire and it says to the left shoulder, "No lifting, no use of the left shoulder or arm, no overhead work".

A. Yes, sir.

Q. It doesn't make any mention of you having restrictions on the use of your back, does it?

A. I -- I don't -- I don't know. I need to see it.

Q. There you go, right there (indicating).

A. It don't -- it don't say nothing.

Q. It doesn't give any lifting restrictions, does it?

A. It says no lifting.

Q. Left arm only. It doesn't give you any lifting restrictions on the right arm, does it?

A. It says no lifting --

Q. Left shoulder.

A. -- yeah. No lifting with left shoulder. Uh-huh.

Q. It doesn't say -- no -- no limitations or restrictions on the use of your right shoulder or arm, is there, on that document?

A. No, it don't say that. Huh-uh.

Q. And no restrictions or limitations on the use of your lower back, middle back or upper back are there?

A. Huh-uh. It don't say nothing, no, sir.

Mr. Huff: I have nothing further.

FURTHER REDIRECT EXAMINATION

By Ms. Mickle:

Q. And the Commissioner is going to read the records but various doctors -- because I think you've seen five (5) different Orthopedists --

A. Uh-huh.

Q. -- three (3) of them were IME Orthopedists, but various doctors have given various restrictions; is that correct? And I trust that the Commissioner will read the records.

A. Yes, ma'am.

Q. Okay. All right.

Commissioner Wilkerson: Any more questions of this witness?

Mr. Huff: No. No.

Commissioner Wilkerson: Sir, you --

Ms. Mickle: That's the Claimant's case.

Commissioner Wilkerson: -- the Claimant's case, okay. How many do you need to call, Ros?

Mr. Huff: I think I may only need one (1). I'm going to call --

Commissioner Wilkerson: If you want a minute, I need one.

Mr. Huff: -- okay.

Commissioner Wilkerson: We'll go off the record just for a second.

(Off The Record)

Commissioner Wilkerson: Mr. Simpkins, we'll go ahead and put you up here and I'm going to have the Court Reporter swear you in and --

Mr. Simpkins: Okay.

Commissioner Wilkerson: -- watch out that chair -- go ahead, you can sit down. That chair is not the easiest thing to -- we don't put rollers on them because we're afraid they'll roll out that way, so.

Court Reporter: Raise your right hand, please.

whereupon;

LOWELL SIMPKINS, being first duly sworn and cautioned to speak the truth, the whole truth and nothing but the truth, testified as follows:

Court Reporter: Please state your full name for the record.

Witness: Lowell Simpkins.

Court Reporter: Thank you, sir.

Commissioner Wilkerson: Thank you, Mr. Simpkins.

DIRECT EXAMINATION

By Mr. Huff:

Q. Would you spell your last name for the record, please?

A. S-I-M-P-K-I-N-S.

Q. All right. And I'm going to call you Lowell, if that's okay?

A. It is.

Q. Lowell, how old are you?

A. Fifty-one (51).

Q. And where are you employed?

A. Bondex in Trenton, South Carolina.

Q. And how long have you been with Bondex?

A. Two (2) -- over two (2) years.

Q. Okay. And are you a supervisor out there?

A. Yes, I am.

Q. Are you the supervisor that's over Bernard Lee?

A. Yes.

Q. I'm going to hit -- hit some high points and kind of go backwards. We're here today because of a Worker's Comp claim. As a result of the Worker's Comp claim being filed, did you all offer Mr. Lee some light duty?

A. Yes, they did. Yes, sir.

Q. All right. Can you tell me what are some of the light duties that you offered Mr. Lee?

A. Well, he was going to be running the front end. So, to keep him from moving his arm I was to put up the bales for him, open the bales for him and the only thing he was have to do was push the fiber onto the tables. We had three (3) tables, sometimes we run three (3), sometimes we run two (2), sometime we run one (1).

Q. Okay.

A. But I was to open all the bales and all for him, put up all the bales, drive the forklift and everything. Then he said that that was hurting his arm. So, the next night he came in, we had some rolls that had -- the pallets that had -- we put adhesive labels on them. I think it was like nine (9) pallets had to go out. I asked him that night could he take the old labels off and put the new labels on the pallets. He said that night that his arm was hurting or something and that he couldn't do that. So, I informed my Production

Manager, Jay, and, you know -- well, we had him sweeping up but he couldn't -- he said couldn't use nothing but that one (1) hand, and I -- I don't know what came of that. So, eventually Jay just replaced him and brought me some temporary help in.

Q. There is some fiber that we have put in as evidence; if I could see the fiber. Take a look at that.

Commissioner Wilkerson: I'm not throwing it at you; it's just so light.

A. No, sir. No, sir.

Q. Is that the fiber he had to work with?

A. Yeah, this is fiber -- the same fiber we use at the plant, yeah.

Q. All right.

Commissioner Wilkerson: Just leave it there; somebody else might need it.

A. Okay.

Q. Did you assigned Mr. Lee to do this fiber job --

A. Yes.

Q. -- as his supervisor?

A. Yes. To load the tables up out of the bales with this type of fiber, yeah.

Q. Did he ever drive the forklift and bring the bales to the table where he had to work or did you do it?

A. I did it.

Q. When the bales had to have the wire cut off around them, the straps, did you cut it off or did he cut it off.
A. I cut them off.
Q. This fiber here, do you -- when you put it on the conveyor belt, do you have to wet it down?
A. Not this fiber, no.
Q. All right. Did you assign him -- in doing the light duty activities, at any time did you assign him to work with any other type of fiber that required him to wet it down?
A. No. Huh-uh. Because we wasn't running nothing but this type of fiber at that time.
Q. You weren't running any gold fiber?
A. No, not Kermel. Uh-huh.
Q. No other fiber?
A. This is the fiber here (indicating).
Q. Okay. Have you seen Mr. Lee away from Bondex in the community at a car wash?
A. I seen him walking down the highway one day and I seen him at a place on 421.
Q. Is that a car wash?
A. It's a car wash and a little store.
Q. Okay. Thank you. Any doubt in your mind it was Mr. Lee that you saw?

A. No.
Q. If you could tell the Commissioner, on June 2nd, that's the day of this incident --
A. Okay. Uh-huh.
Q. -- you remember June 2nd?
A. Yes.
Q. Were you all putting a hood on the machine?
A. Yes. We was putting the machine back together, yeah.
Q. Were you all using the forklift?
A. Yes, we were.
Q. All right. What -- who was lifting the -- the hood, the forklift or individuals?
A. The forklift, and I was driving the forklift.
Q. Tell the Commissioner what happened and describe what you all do with the lift. He's got some photographs already.
A. Okay. We raised it up -- I raised it up and I had my lead man directing me on how to position the hood because you have to raise up, back out, ease back in to get it over the frame of the machine. What we do is, we sits it over the frame of the machine and then it's got two (2) arms, one (1) on each side, that we move around till we put some bolts about this long (demonstrating) through to tighten -- to hold the hood in place, and then we let it on down.

Q. At any time were the employees that were working that night -- I think one is Tom, one was Al, and one was Bernard Lee --

A. It was them.

Q. -- were they required to lift that hood or did the machine lift the hood up?

A. No, the forklift lift does all the lifting and putting it in place.

Q. To your knowledge, did the hood ever fall off of the forklift?

A. No. It never fell off the forklift.

Q. You were operating the forklift?

A. I was operating the forklift.

Q. Were you the one responsible for raising and lowering the -- the hood?

A. Yes, I was.

Q. Did you or did you not lower the hood onto the lip of the machine?

A. We lowered in place and they wiggles the arms to get them to go into the groove to let the bolts go through.

Q. At any time while you were doing that did you hear any type of scream or yell from Mr. Lee that would indicate that a -- that hood fell on him?

A. No.

Q. Did you hear anybody scream or yell out like they were

hit with the hood?

A. No.

Q. These labels, you were talking about wooden pallets, the labels were on wooden pallets?

A. Yes. We stacked our materials so many rows high on the pallet and they are little square adhesive labels. You just take and pull the old label off and stick the new label on.

Q. Is that something you can do with one (1) arm?

A. Yeah, I'm pretty sure you could, yes.

Q. Would you consider that light duty?

A. Yeah, that's light duty.

Q. All right. Now, these labels, are they like a sticker?

A. Yeah, they're a sticker. They're adhesive. A square adhesive about this big (demonstrating), you just pull it off the backing and stick it on to the rows.

Q. That's what you had him doing?

A. That's what I had him doing.

Q. And he said he couldn't do it?

A. That last night that's what he said he couldn't do.

Q. The fiber that you used, was there any time frame of how much fiber he had to do with -- within a job cycle?

A. No, you just -- because we run by different grams. You just put it on the conveyor belt and the conveyor pulls it into the machine.

Q. How many conveyor belts did he have to load?
A. That night it would have been two (2).
Q. Two. Could he do that one (1) handed, with the right arm?
A. Yes, because I put one (1) bale on the bottom and I stood another bale up -- up top, upright. So, once I broke the bands and took the plastic and all off, the only thing he had to do was just push it on.
Q. And you mentioned some sweeping. What was he sweeping?
A. The floor, sometimes fiber falls on the floor on the sides of the bales and stuff and you sweep that up.
Q. Did you have him doing any sweeping in -- like, in a bathroom, cleaning up the bathrooms or anything?
A. I don't -- that's what he was told he was going to have to do but he never did it.

Mr. Huff: This is an exhibit, Commissioner, it's APA number 1.

Q. Is that your signature at the bottom?
A. Oh, yes. Uh-huh.
Q. Is that your handwriting where it's filled out?
A. Yes, it is.
Q. You filled this document out?
A. Yes. I filled out that night when he came to me and told me he was hurt.
Q. And you signed it?

A. Yes.
Q. It says the employee's name is Bernard Lee. When he came to you did you recognize him as Bernard Lee?
A. Yes, I did.
Q. He didn't have to give you his name did he?
A. No.
Q. You knew it was June 2nd, didn't you?
A. Yes.
Q. You put down 9:25. Is that the time that you filled this out or the time of the accident?
A. That was the time of the accident.
Q. How did you know it was 9:25; did he tell you?
A. Well, we just really guesstimated about the time it was because we had done been to work. We came to work at eight o'clock and it takes us, let's say, a hour, maybe a hour and a half, to get everything back on and the last thing we puts on is the hood.
Q. All right.
A. And he came and told me later that he had hurt his self, just hadn't noticed. So, then I asked him did he want to go to the doctor, I would have to fill out a accident report.
Q. Where it says description of the accident, did you write that down or did he tell you what happened and you wrote it down?

A. I asked him what happened.
Q. And when he told you what happened what did you do?
A. I wrote down exactly what he said.
Q. Okay. Were you all working on number three (3) card machine?
A. It was number two (2) card machine.
Q. This says number three (3).
A. Yeah, because we was in hurry that night and I -- I wrote that up because I -- at the time when he came and told me it was after, like, a break time and we went for break at ten o'clock. So, when I wrote down -- I went on and wrote it up and then I asked him did he want to go to the emergency room and that's when he said yes, he wanted to go.
Q. When you wrote this down, at any time did he indicate to you that a hood that you all were working on that night fell on him between his neck and his shoulder and pinned him against the machine?
A. No, he didn't. No, he didn't.
Q. If he had told you that what would you have done?
A. I would have wrote it down there.
Q. Did you all give him some Goody Powder and Biofreeze?
A. I gave him Biofreeze. We don't have Goody Powders.
Q. Okay. They have a witness here, Tom Harris. Was there also an Al Martin there?

A. Yeah, Al Martin, Tom Harris, and Roosevelt Whitlock; those are the other three (3) employees besides Bernard Lee and myself that was all in the plant that night.

Q. Did Mr. Lee tell you the other gentlemen that you just mentioned, other than Tom Harris, witnessed this or did he just tell you Tom Harris witnessed it?

A. He said he was working next to Tom.

Q. Okay. I have no further questions, and I thank you very much.

A. Okay.

Commissioner Wilkerson: Ms. Mickle?

CROSS-EXAMINATION

By Ms. Mickle:

Q. Mr. Simpson?

A. It's Simpkins.

Q. Simpkins?

A. Yes.

Q. Simpkins.

A. Simpkins, yes.

Q. Okay. All right.

Commissioner Wilkerson: Can you cut that off?

A. Yeah. I'm sorry.

Commissioner Wilkerson: Are you cutting it off or --

A. It's off.

Commissioner Wilkerson: -- yes, sir. Thank you.

A. Uh-huh.

Q. Just a couple of questions in follow up.

A. Uh-huh.

Q. Do you have a criminal record?

A. Who, me?

Q. Yes.

A. I have -- I've got a DUI.

Q. Anything else?

A. An assault charge when I was in high school.

Q. Was that for murder or assault?

A. No --

Q. Just assault?

A. -- just assault.

Q. Okay. Anything else?

A. No.

Q. Okay. Let's talk about some things that are in writing here just to set the background. Were there any problems with the forklift that they were using that night?

A. Later on I had a hydraulic leak on it.

Q. Okay. And tell me about that hydraulic leak because I've got some records on it; why don't you to tell me about it before I show you the records.

A. One (1) of the lines on there had a small hole in it

and it was leaking down -- it would skeet fluid out and it would leak down.

Q. Okay. So, it was shooting fluid out?

A. It was leaking fluid out, not shooting it. It was running right down the hose, straight down.

Q. Okay. And as a result of it leaking the fluid out what would the forklift do?

A. In time it would eventually come down.

Q. When you say that, just to make sure that the record is clear --

A. Uh-huh.

Q. -- forklifts are supposed to lift whatever it's got up --

A. Right.

Q. -- but instead of lifting it up, it would drop down; is that what you're saying?

A. Not drop down. It was -- you -- you could see it like coming down but I had the forklift on. And now, you could put pressure, you know, put on the gas and it would stay up.

Q. Okay. But there was -- you said you could see it coming down; what could you see coming down?

A. The -- the -- the boom but, like I said, I would keep the gas on to -- my foot on the gas to keep the lift directly up in the air.

Q. Okay. And so, do you concede that there were some problems with the forklift or you're denying that there were problems with the forklift?
A. No, it was leaking hydraulic fluid.
Q. Okay.

Commissioner Wilkerson: Was it leaking hydraulic fluid before 9:25 that night or after 9:25 that night?

A. It was after, but I noticed it about 10:00 when we came back from break because I went and got -- we have rags that we use on the job.

Commissioner Wilkerson: Right.

A. I went and got some rags and tied around the hose that was leaking.
Q. When did you do that?
A. After ten o'clock break.
Q. After the ten o'clock break on the 2nd or the 3rd?
A. The -- the 2nd.
Q. Okay. So, after the ten o'clock break on the 2nd, you noticed that the forklift was leaking hydraulic fluid?
A. Yes.
Q. And you tied something around the forklift?
A. Around the hose.
Q. Around the hose so that it wouldn't leak?
A. That it wouldn't -- yeah. So, that way it wouldn't

just get all over the floor.

Q. Okay. So, your testimony is you first noticed it some time at ten o'clock that night?

A. Yeah, after the ten o'clock break, yes.

Q. After the ten o'clock break?

A. Uh-huh.

Q. All right. So, you're not saying that there wasn't a problem before ten o'clock; you're saying that you didn't notice it until ten o'clock break --

Mr. Huff: I'm going to object.

Q. -- or after the 10:00 break?

Mr. Huff: I object to the form of the question --

Ms. Mickle: I'm on cross.

Mr. Huff: -- as to the problem. She has to -- what problem?

Commissioner Wilkerson: We've got to establish the problem first.

Ms. Mickle: Okay.

Commissioner Wilkerson: You have to establish the problem.

Q. Well, you were just saying a leak --

Ms. Mickle: -- he said he noticed a leak --

Commissioner Wilkerson: A leak, that's the problem.

Ms. Mickle: -- that's the problem.

Mr. Huff: If that's it, I have no objection. We're on the same sheet. It's the leak.

Commissioner Wilkerson: Right.

Mr. Huff: And if it's the leak, I have no objection to that.

Q. Okay.

A. Uh-huh.

Q. Because that's what -- you said you tied something around the what?

A. A rag around the -- around the hose.

Q. The hose?

A. Where it was leaking.

Q. And that's on the forklift, right?

A. Yes.

Q. And that's a problem, right? Meaning it's not -- that's not working properly?

A. It's not working properly --

Q. Okay.

A. -- right, you could say that.

Q. Okay. And you first noticed it on the 2nd, after the ten o'clock break --

A. Correct.

Q. -- is that your testimony?

A. Correct.

Q. Your sworn testimony?

A. Correct.
Q. Okay. That doesn't mean the problem wasn't there before --

Mr. Huff: I'm going to object. If -- if -- are we -- is the problem -- is -- is it the leak? I don't want to later on confuse the record.

Commissioner Wilkerson: He's talking about the leak problem.

Ms. Mickle: Yes, that's why I went back and established that --

Mr. Huff: Okay.

Commissioner Wilkerson: Okay. Yes.

Ms. Mickle: -- I went through that.

Commissioner Wilkerson: The problem with the leak.

Mr. Huff: Okay. Thanks.

Q. That doesn't mean, again, that the problem with the leak wasn't there before ten o'clock. Your testimony is you didn't notice it until ten o'clock --
A. I didn't notice it --
Q. -- is that fair?
A. -- until after the ten o'clock break. But if it had been leaking, I'm sitting right here on the forklift, the hose runs right up the side of the frame. If it had been leaking before then I would have seen it

because it -- it starts running down the frame of the forklift.

Commissioner Wilkerson: And let me also ask you a question.

A. Uh-huh.

Commissioner Wilkerson: If it were leaking at nine o'clock --

A. Uh-huh.

Commissioner Wilkerson: -- and it started to come down, you would have given it more gas to keep it -- to stay up, right?

A. Yes, sir.

Commissioner Wilkerson: Okay. Unfortunately, I've run forklifts and I've run tractors and if you -- if you give it the gas it'll keep it up --

A. Yeah.

Commissioner Wilkerson: -- even if there's a problem with the lift.

A. Right.

Commissioner Wilkerson: Okay.

Ms. Mickle: If you give the forklift the gas it keeps --

Commissioner Wilkerson: Yes. It will keep -- it will keep it up. I do that -- I, unfortunately, that's just -- it'll stay up, I promise.

Ms. Mickle: -- Okay.

A. The gas will keep it up.

Q. And -- and so, obviously, there is a discrepancy between your testimony and Mr. Lee's. But these records that we've been given from your employer indicate that -- these are invoices and records of repair of the forklift. Was that -- did that forklift have to be repaired?

A. Yes, it would have to be with the holes in it. Yeah.

Q. It says, repair -- on page 120 of our APA's, repair of mast extension hydraulic cylinders. So, there was something wrong with the hydraulic cylinders on the forklift?

A. I'm not a mechanic --

Q. Are you familiar with this?

A. -- the only thing I could say, I noticed the hose was leaking. Now, I leave at eight o'clock in the morning. I -- I told my supervisor that we was having problems with the forklift. He in turn called in the mechanics to come fix it. They would fix it on first shift; so, I wouldn't know what they fixed on that --

Q. Okay.

A. -- and I didn't look at the records.

Q. Are you familiar with the work -- work records on the forklift at all?

A. No, I haven't seen those.
Q. Okay. So, you didn't order the forklift repair?
A. No, my boss did.
Q. You're the supervisor but --
A. Right.
Q. -- you weren't responsible for that?
A. Right.
Q. You just know that the forklift was repaired at some point?
A. Yeah.
Q. You know that?
A. Yeah, I know it because it was fixed.
Q. Okay. All right. This light duty -- well, first, the -- what is this? It's marked as Defendant's Exhibit Number One; what is this?
A. It's fiber that we used to make the products that we sell at -- that we make at the plant.
Q. Okay. Do you use different kinds of fiber?
A. Oh, yes.
Q. What other kinds of fiber do you use?
A. Polyester, Lomax, Kermel.
Q. Is there something called gold fiber?
A. It's Kermel fiber.
Q. So, Kermel is referred to sometimes as gold fiber?
A. We don't refer to it as that. We --

Q. Do you know what I'm talking about?
A. -- yeah, I know what you're talking about, yes.
Q. Okay. All right. So, somebody has had to refer to it as gold before; so, you do have that in the plant, Kermel?
A. Kermel. Yes, we does.
Q. Okay. All right. Did Mr. Lee use that when he was on light duty?
A. No, we wasn't running the Kermel when he was on light -- when he was on light duty. We was running a polyester type fiber.
Q. Do you have any records to support what you're saying?
A. We can -- yeah, we've got records at the job; I can go back and pull them and see --
Q. Okay. All right.
A. -- what we ran on those days.
Q. Okay. Now, let's go to the accident itself. That night did you see Mr. Lee when he came in, when he reported for duty?
A. Yes. Uh-huh.
Q. Okay. And that night were they supposed to do something with the hood, what we've been referring to as the hood of the card machine?
A. Yes, we had to put it back -- put the machine back together.

Q. Okay. And when you say we, would that have included Mr. Lee?
A. Yes.
Q. Okay. And so, part of his instruction would have been to be working on this hood?
A. Yes.
Q. Okay. With a couple of other gentlemen?
A. Yes.
Q. Who were they?
A. Al Martin, Tom Harris and Roosevelt Whitlock.
Q. Okay. Where is Al Martin today; do you know?
A. No, I don't.
Q. Have you talked to him today?
A. Not today.
Q. Okay. And so, why were they putting the hood there?
A. We were -- they had recrossed -- rewired the dolpher on the machine and some of the workers are strippers. First shift had put most of the machines back together; when we came in we took over from where they had left off. And we were to put the rest of the worker's strippers on and the hood. Then we have to put the apron back together --
Q. Okay.
A. -- and the posts and all the safety guards.
Q. Was Mr. Lee assigned to help put that hood in place?

A. He was up there -- up there to help guide it. And they, like I said, there's two (2) -- there's a arm on each side, they guides it in place, and then they put a long bolt in it to hold it -- to hold it -- the hood up there on the frame.

Q. What's -- when you say, and I'm using your words --

A. Uh-huh.

Q. -- so we won't have any argument here.

A. Uh-huh.

Q. When you say guide it, what's he guiding it with?

A. We have a rope and some of them grab the arm of the -- the frame.

Q. And is he guiding it with his eyes or guiding it with his arms?

A. He should be guiding it with the rope and with his eyes.

Q. Okay. He doesn't have to touch it at all?

A. They wiggle it in place, yes.

Q. Okay. So, now we've got the word guide, now we have the word wiggle it in place?

A. Uh-huh.

Q. So, that's the only touching you're saying he does is to wiggle it in place?

A. Right.

Q. And so, your testimony today is that the forklift

wasn't working at the time of the accident?
A. Yes, it was.
Q. So, I want to be clear.
Commissioner Wilkerson: Wait a minute. I think he said it was working.
Mr. Huff: It was working.
Ms. Mickle: I know.
A. I said yes, it's working.
Q. Oh, yes.
Commissioner Wilkerson: But you said -- you said he testified that it was not working.
Q. Your testimony today -- your testimony --
A. Uh-huh.
Q. -- to this Commissioner, is that at the time of this accident you didn't notice any problems with the forklift?
A. No, not at that time. No, I didn't.
Q. Okay. Your testimony today is that all Mr. Lee had to do was to guide the forklift and wiggle it in place?
A. He wouldn't guide the forklift.
Q. No, guide --
A. I was operating the forklift.
Q. -- guide the hood.
A. Right. He would guide the hood, yeah.
Q. And wiggle it in place?

A. Yes.
Q. And are you saying that he did not have to try to hold the hood at all or lift it at all?
A. No. I was -- the forklift I was operating, we have straps on it to support it, to hang it up in the air to sling it whichever way you want to.
Q. Okay. So, you disagree that the hood was coming down because of the hydraulic system leaking; you disagree with that?
A. I disagree because if it was my other three (3) employees would have got injured also.
Q. And -- well, I don't know about that. And so, you also -- there wouldn't have been no lifting at all involved in that; is that what your statement is?
A. No, because the hood is over five hundred (500) pounds. You wouldn't be able to lift it and -- and put it in there anyway. Because I have all pressure --
Q. Well, if you didn't have --
A. -- with the mast of the forklift holding it up in the air.
Q. -- well, if you didn't have to lift it at all, why have three (3) guys around there?
A. It's to guide it in place.
Q. Why wouldn't you have just one (1) woman there just to kind of, you know, if you -- if you -- if you don't

have to do any --

Mr. Huff: I'm going to object. She's being argumentative.

Ms. Mickle: -- I want to understand this.

Commissioner Wilkerson: I'd say that would be impossible but go ahead and ask him.

Q. Yes, I don't understand this. If you don't have to do any lifting at all, and the forklift does all the work and it's really just guiding it with your eyes, using your words, why do we --

Commissioner Wilkerson: And a rope, he said.

Q. -- and a rope.

Commissioner Wilkerson: And a rope.

Q. And a rope. Why do we need three (3) men?

A. Because of the size of it and you've got -- it's a -- it's a -- it sits on a frame. You've got to have one (1) person --

Q. Oh, okay --

A. -- on each side.

Q. -- I'm sorry, go ahead.

A. You have to have one (1) person on each side and then we have one (1) person mainly just looking, and you've got one (1) man with -- holding the rope on each side. So, when I slings it in place that -- when I get ready -- when they have it in place where they want to,

that's when I lower the -- the frame down into the slots where we've got two (2) arms that fit into the grooves of the frame.

Q. Okay. And is -- did he ever -- is it your testimony that he never complained at the time that they were doing this --

A. No, he --

Q. -- when they were putting the hood on?

A. -- no, he came to me after the ten o'clock break and said I hurt my arm when we was putting the hood up. And that's when I told him then. I asked him then, I said, do you want to go to the emergency room? He said no. He came back to me later on that night and said yes, he does. I said we needed to write it up. That's when I wrote it up and that's when I sent him to University Hospital.

Q. How much time are you saying elapsed, passed, between the time they were putting the hood on and the time he came to you?

A. It was after lunch; so, that's after twelve o'clock break.

Q. And so, I'm asking you, how much time elapsed?

A. About three (3) hours.

Q. So, you're saying that three (3) hours lapsed before you -- you knew, from him, that something happened to

him while he was lifting that forklift --

A. No.

Q. -- I'm sorry, not -- lifting that hood?

A. No. He didn't lift the hood. He came and told me after ten o'clock break. Then he came back after lunch and told me that it was hurting him and he thought he was ready to go to the hospital.

Q. Well, this will clarify. About what time of night do you think that the hood was being lifted, that you described earlier?

A. Between nine 9:00 and 9:30, we had it up in the air; I put it back in place.

Q. So, between 9:00 and 9:30 sometime is when the -- this maneuvering and guiding of the hood would have been done?

A. Yes, ma'am.

Q. Is that fair?

A. Yes, ma'am.

Q. And then you're saying the report would have been around -- after the ten o'clock break?

A. He -- he reported it to me after ten o'clock break.

Mr. Huff: I'm going to have to object, Your Honor. This has just been asked --

Ms. Mickle: The time frames are important.

Commissioner Wilkerson: He's asked and answered

three (3) times.

Mr. Huff: -- I object to that.

Commissioner Wilkerson: He's already asked -- you've already asked it and he's answered three (3) times.

Ms. Mickle: It wasn't clear in my mind because -- and I'll go on to the next question.

Q. Because, if you're saying he didn't report it until after the ten o'clock break --

Commissioner Wilkerson: That's right.

Q. -- this report, the time on this --

Commissioner Wilkerson: Well, he told you why -- he said why that report had 9:25 on it.

Ms. Mickle: -- and it was because of what?

Commissioner Wilkerson: He -- he testified earlier that that's the time he told him he hurt his shoulder; that's what he said earlier in his testimony.

Ms. Mickle: I didn't understand that to be the testimony.

Commissioner Wilkerson: That's what he said.

Ms. Mickle: As a result of this conversation then -- and -- well, I won't go in -- I won't go into it since that's what you say you understand.

Commissioner Wilkerson: It's not -- it's not what

I understood; that's what he testified to.

Ms. Mickle: Okay.

Q. That 9:25 is not the time that the report was made?

A. No.

Q. 9:25 was the time that he said --

A. It was the time that he said he hurt himself.

Q. -- got it. Okay. All right. And with regard to light duty --

A. Uh-huh.

Q. -- do you know why Mr. Lee is no longer at the plant?

A. Because he said he couldn't do the light duty, from what I was explained.

Q. Oh, hold on for a second. Did Mr. Lee tell you that?

A. No.

Q. Okay.

A. My boss told me that --

Q. Okay. I don't want to hear what your boss said.

A. -- okay.

Q. Okay. Have you talked to Ms. Napier about her conversations with Mr. Lee?

A. No.

Q. Okay. Have you seen any of his light -- his out of work slips?

A. No. The only thing I would see was his time card and I would put on there no work, WC, Workman's Comp, and I

turn them back in.

Q. Didn't you advise Mr. Lee in front of his father that because of how he was treated he ought to get a lawyer?

A. No. No.

Q. You deny that?

A. When I -- I haven't seen his father. No. I gave him a ride home one day and I think his father rode back to the job with me but no. Uh-huh. No.

Q. And so, you've never said that either?

A. No.

Q. Have you ever seen his arm swollen? Did he complain to you about the problems with his left arm after the accident?

Mr. Huff: Let me object to the form of the question as being compound.

Q. Did he complain to you about the problems with his arm after the accident?

A. when he came to work the next day.

Q. Okay.

A. He brought the -- well, that wasn't the next day. When he came back to work he brought me a -- a slip from the doctor that say he had light duty. I think he had his arm in -- up. And he kept -- he was saying that it was hurting, he couldn't use that arm. And I read the doctor's excuse saying that he couldn't use that arm.

And that's when I informed him that night that, you know, I was going to put the fiber on the table for him and all this here, and that's what I started doing.

Q. And he continued to try to work light duty --

A. Yeah, he tried to work.

Q. -- after that --

A. Yeah.

Q. -- is that correct?

A. Yes, he did.

Q. And he continued to complain about problems with his left shoulder after that?

A. Yes, he did.

Q. Okay. Now, prior to the incident with the forklift, he had been there for about a year; is that fair?

A. I think he's been there a little over a year, yeah.

Q. Okay. With -- with a staffing company as well as then with Bondex --

A. Right.

Q. -- is that fair?

A. Right.

Q. Okay. Had you ever known of him to complain -- have those complaints to his left arm prior to that time?

A. No.

Q. Okay.

Ms. Mickle: That's all I have at this time, Your

Honor.

Commissioner Wilkerson: Any follow up?

Mr. Huff: Just very on one (1) topic.

REDIRECT EXAMINATION

By Mr. Huff:

Q. As the hood was being lowered down, we talked about Mr. Lee having to guide it and to wiggle it and you made mention of some bolts.

A. Uh-huh.

Q. Did the bolts have to go in some holes?

A. Yes.

Q. What's the purpose of wiggling the hood?

A. The arms would come down and they don't fall directly into the frame.

Q. Okay.

A. You might have to move it around just a little bit for it to get in place and when it gets in place they'll signal to me to drop it on down with the forklift and it goes -- they take the bolts and run them through the holes.

Q. Is the wiggling used to line up the holes?

A. Yeah, it's to line up the holes.

Mr. Huff: Nothing further.

Commissioner Wilkerson: Any follow up?

Ms. Mickle: No.

Commissioner Wilkerson: Thank you, ma'am. Sir, you may step down.

Witness: Okay, thank you.

Commissioner Wilkerson: Throw me my bag back.

Witness: Oh, okay.

Commissioner Wilkerson: Any other witnesses from the Defense?

Mr. Huff: No -- excuse. Commissioner, I -- I made a mistake. I need to call the Claimant back -- I mean, the witness back for one (1) more question.

Commissioner Wilkerson: All right. Come on up. You're still under oath.

Witness: Okay.

Mr. Huff: I'm sorry. And when I do this, I won't need Mr. -- I won't need the other witness.

Commissioner Wilkerson: Okay, that's fine.

Mr. Huff: I had wrote his name down and what I was going to have him do but now I'll just use him and -- and not have to call the other witness.

Commissioner Wilkerson: Okay. That's fine.

Q. While you were sitting outside --

A. Uh-huh.

Q. -- we do that to sequester the witnesses so they don't hear each other's testimony; so, we get truthfulness --

A. Uh-huh.

Q. -- as best we can. Mr. Lee testified that at the time that you all were lifting this hood with the forklift, and the forklift suspending the weight, he said that the forklift --

Ms. Mickle: I've got an objection, Your Honor.

Mr. Huff: -- I'm going to ask a question on his testimony.

Ms. Mickle: But I -- I see where it's going.

Commissioner Wilkerson: Whoa, whoa, whoa, whoa.

Ms. Mickle: There's a -- you cannot pit what's -- is what the evidentiary rule is.

Mr. Huff: I'm not going to pit him.

Ms. Mickle: You cannot pit the testimony of one witness versus another in a cross exam question. Pitting is exactly what he's doing. He's -- he's giving that testimony --

Commissioner Wilkerson: He's not cross examining. This is his direct witness.

Ms. Mickle: -- but you can't pit --

Mr. Huff: I'm not pitting the witness.

Ms. Mickle: -- either way.

Mr. Huff: And I will read something to you.

Commissioner Wilkerson: Hold up.

Mr. Huff: "Irrelevant, immaterial or unduly

repetitious evidence shall be excluded, except in proceedings before the Industrial Commission" which is now 1977, I think, was changed to the Worker's Comp Commission.

Commissioner Wilkerson: That's correct.

Mr. Huff: "The rules of evidence as applied in civil cases in the court of common pleas shall be followed". So, the rules of evidence in this pitting do not apply here, and that's 16 -- 1-23-330 Section 1, page 246 of the 2010 book and I'm not going to pit.

Commissioner Wilkerson: Okay. If -- if --

Mr. Huff: I'm going to ask a question and before you answer the question, he'll rule on it.

Commissioner Wilkerson: -- don't answer until --

Witness: Okay.

Commissioner Wilkerson: -- I tell you yea or nay.

Mr. Huff: Right. Right. Thank you.

Q. Mr. Lee testified that while the forklift was being used to suspend the weight of the hood that it would not lift the hood and was shooting fluid on the floor. My question: At any time while you were doing the running of the forklift did you see any fluid on the floor?

Commissioner Wilkerson: Yes, go ahead. Go ahead,

he can answer that question because I don't think --

Ms. Mickle: Same objection.

Commissioner Wilkerson: -- yes, I understand.

Q. Did you see any fluid on the floor?

Ms. Mickle: I made an objection to the question: Did you see any fluid on the floor?

Commissioner Wilkerson: Right. That -- okay, you don't have any objection to that question.

Ms. Mickle: To that part.

Commissioner Wilkerson: Yes, okay. That's fine. So, did you see any fluid on the floor while lifting the forklift? And that would have been between the -- I know -- too many questions -- between 9:00 and 9:30?

A. No, I didn't.

Commissioner Wilkerson: Okay. Go ahead.

Q. Okay. Did you see any fluid being shot out of the hose so the fluid could fall on the floor?

A. When I noticed after ten o'clock? Yes.

Q. All right.

A. Okay. But not before then.

Q. Okay. All right, thank you. That's all.

Mr. Huff: I don't need Mr. Martin.

Commissioner Wilkerson: Okay. That's fine.

RECROSS EXAMINATION

By Ms. Mickle:

Q. So, after ten o'clock you went back and looked to see if there was fluid on the floor?

A. I could see it running down the frame of the forklift; so, if it's running down the frame it's going to get on the floor.

Commissioner Wilkerson: After ten o'clock?

A. After ten o'clock when I put the --

Commissioner Wilkerson: All right, when you came back from break, did you see any fluid on the floor?

A. -- No.

Commissioner Wilkerson: Okay. After ten o'clock. That was a much simpler question, Ros.

Mr. Huff: I'll let you ask it next time.

Commissioner Wilkerson: You all try to doll them up to get them to answer it the way you want them to answer it. Well, sir, I grew up in Edgefield County --

A. Okay.

Commissioner Wilkerson: -- I understand well.

Ms. Mickle: That's all I have.

Commissioner Wilkerson: Any other witnesses?

Mr. Huff: No, the only other thing that we would

have, Your Honor, is the -- under 42-17-30 and under -- bear with me and I'll just go ahead and quote it for the record -- for the record; it will take me just a second to get to it again.

Commissioner Wilkerson: You're talking about the doctors --

Mr. Huff: Yes, the doctors.

Commissioner Wilkerson: -- or the --

Mr. Huff: You know, the --

Commissioner Wilkerson: -- other -- or Mr. Martin?

Mr. Huff: No, I do not need Mr. Martin.

Commissioner Wilkerson: You do not need the -- Mr. Martin?

Mr. Huff: I do not need him.

Commissioner Wilkerson: Okay.

Mr. Huff: I would just say under 1-23-330, paragraph three (3), we'd like to cross-examine the -- if we can get it done within a two (2) week period and I'll get the deposition as to causation as to the timing of when that tear occurred.

Commissioner Wilkerson: Okay.

Mr. Huff: That's all we have. No other witnesses.

Commissioner Wilkerson: I'm sorry. You may step

down. Do you still have the same objection to that, Ms. Mickle? Have you got the same -- do you have your same objection, 42-17-30, for that?

Ms. Mickle: Are you going to see the lawyers --

Commissioner Wilkerson: Yes.

Ms. Mickle: -- or do you want to --

Commissioner Wilkerson: No, I don't -- I can see the lawyers and we can talk about it then or I -- we can do it on the record. I just want to let you --

Ms. Mickle: The same objection.

Commissioner Wilkerson: -- since -- since --

Ms. Mickle: The same objection.

Commissioner Wilkerson: -- it's not -- okay, same objection.

Ms. Mickle: Without going through --

Commissioner Wilkerson: Yes. Yes, I'm going to see the -- yes, I'm going to see the lawyer when we get through, that's correct. And I will let you all know what I'm going to do at that point in time.

Mr. Huff: Okay.

Commissioner Wilkerson: So, no other witnesses from other side; is that correct?

Ms. Mickle: None.

Commissioner Wilkerson: And this concludes the hearing. Thanks everybody for being here today. And, if I can meet with the Attorneys for a few minutes. Thank you.

(There being no further questions, the hearing concluded at 11:49 A.M.)

STATE OF SOUTH CAROLINA)
)
COUNTY OF RICHLAND)

CERTIFICATE

Be it known that I took the foregoing South Carolina Workers' Compensation Commission Hearing of Bernard D. Lee, vs. Bondex, Incorporated;

That I was then and there a Notary Public in and for the State of South Carolina-At-Large;

That by virtue thereof I was duly authorized to administer an oath;

That the witness was first duly sworn to testify the truth, the whole truth, and nothing but the truth, concerning the matter in controversy aforesaid;

The foregoing transcript of 180 typewritten pages represents a true, accurate and complete transcription of the testimony so given at the time and place aforesaid to the best of my skill and ability;

That I am not related to nor an employee of any of the parties hereto, nor a relative or employee of any attorney or counsel employed by the parties hereto, nor interested in the outcome of this action;

Witness my hand and seal this 10th Day of December, 2010.

Gloria Davis
Notary Public for South Carolina
My Commission Expires 1/22/12

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September 21, 2010

The Honorable Avery Wilkerson
SC Workers' Compensation Commission
P. O. Box 1715
Columbia, South Carolina 29202-1715

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: 0906951

Dear Commissioner Wilkerson:

A re-set hearing in the above referenced case was held on September 7, 2010. At the close of the hearing, you left the record open per the request of attorney Ross Huff to take the deposition of the radiologist who performed the open MRI, Dr. Thesing. In response, I then asked that while the record was open the attorneys be permitted to submit questionnaires to the treaters regarding the causation of Mr. Lee's injuries. The deadline for these submissions was September 21, 2010. We went back on the record to address these issues and I will rely on the Court reporters transcript for our legal positions on these issues.

After the hearing, Mr. Huff's office contacted me with a date for taking Dr. Thesing's deposition within the deadline. I had a conflict with that date and indicated that I could offer other dates. I never heard back. On Thursday of last week, I contacted Mr. Huff's office to confirm our deadline for submission of all evidentiary reports and deposition. I was advised that Mr. Huff sent a causation letter to Dr. Thesing. In response, although not what was agreed upon, I sent one as well. Because we did not agree on a questionnaire to Dr. Thesing, I am officially objecting to either questionnaire being included as a part of the evidentiary record in this case. Enclosed please find the questionnaires we are submitting per the post hearing instructions:

1. Dr. Ty Carter
2. Dr. CharlesThomas
4. Dr. William Robinson
5. Dr. Thesing

Should you need anything further, please do not hesitate to contact me. With kindest personal regards, I remain,

Yours very truly,
MICKLE & BASS, LLC

By: _____
Ann McCrowey Mickle

AMM/emw
Enclosures: questionnaires
cc: E. Ros Huff, Esquire

MICKLE & BASS, LLC.

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Former S. C. Workers' Compensation Commissioner
1996 – 2002

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Reply to: Rock Hill office

September 13, 2010

Dr. Charles B. Thomas
Village Orthopaedic Surgery
535 West Butler Road
Greenville, SC 29607

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: 0906951

Dear Dr. Thomas,

Please be advised that our office represents Bernard Lee as a result of injuries sustained during the course and scope of his employment with Bondex. On June 2, 2009, Mr. Lee and two co-workers were lifting a machine hood when the hood fell onto the left side of Mr. Lee's shoulder and neck. Following the accident Mr. Lee presented to University HealthCare System with pain in the left shoulder.

On June 5, 2009 Mr. Lee presented to Dr. Broder of North Augusta Urgent Care with pain in the left arm/shoulder. Dr. Broder's treatment consisted of continued medications and physical therapy. Mr. Lee's symptoms failed to subside and an MRI of the left shoulder was ordered. On June 26, 2009, Mr. Lee underwent an open MRI of the left shoulder which revealed, "Acromioclavicular joint arthropathy with mild impingement" and "Bicipital tendonitis."

On July 16, 009, the employer sent Mr. Lee for an evaluation with Dr. James Bethea. At that time, Mr. Lee was making complaints of pain in his left shoulder, neck and back. Dr. Bethea's diagnosis consisted of impingement syndrome of the left shoulder and neck and back pain. He provided a cortisone injection to the shoulder, medications and recommended continuing physical therapy.

On August 18, 2009 Mr. Lee presented to Dr. Timothy Shannon with neck, back and left shoulder pain. Dr. Shannon provided an injection to the left shoulder and recommended MRIs of the neck and low back. On October 15, 2009 Dr. Shannon noted, "It is my expert medical

opinion, "most probably and to a reasonable degree of medical certainty" (greater than 50% probability) that Mr. Lee suffers from neck pain, left shoulder pain, and low back pain as a result of his work accident of June 2, 2009."

On October 22, 2009 Mr. Lee presented to your office for an independent medical evaluation. You noted unbearable pain in the neck, lower back and left shoulder and severe impairment of active range of motion. MRIs of the cervical, thoracic and lumbar spines were recommended to rule out a spinal pathology.

On January 25, 2010 Mr. Lee presented to Dr. Ty Carter with pain in his low back, neck, and left shoulder with radiating pain down his arms. Dr. Carter noted, "I feel that the patient mostly has some shoulder and scapular strain issues." As a result, Dr. Carter recommended physical therapy and a return appointment through your office. Dr. Carter released Mr. Lee at maximum medical improvement with regard to the low back and cervical spine.

On May 25, 2010 Mr. Lee returned to Dr. Shannon's office with pain in both upper extremities. Following a physical examination Dr. Shannon recommended electrodiagnostic testing.

On June 10, 2010 Mr. Lee presented to Dr. W. Daniel Westerkam with pain in his shoulder and arm with very limited range of motion. Dr. Westerkam diagnosed myofascial pain and recommended that Mr. Lee not lift over ten pounds with the left arm or lift the left arm over shoulder height.

On September 2, 2010 Mr. Lee underwent an MR arthrogram of the left shoulder. The MR arthrogram revealed a superior labral tear, anterior to posterior without detachment of the labrum.

In order to determine the present status of Mr. Lee's medical treatment and care, please indicate in the below questionnaire your medical opinions relating to his current and future medical needs. (Please check "yes" or "no" and explain if necessary).

1) On October 22, 2009 Mr. Lee presented to my office for an independent medical evaluation.

✓ Yes _____ No

Explanation:_____

2) I have reviewed Mr. Lee's Open MRI of his left shoulder dated June 26, 2009, and the MR arthrogram of the left shoulder dated September 2, 2010 together with my medical records. As a result, I am aware of the following:

a) By history, Mr. Lee has been experiencing left shoulder pain since June 2, 2009.

b) Mr. Lee's June 26, 2009 open MRI of the left shoulder revealed acromioclavicular joint arthropathy with mild impingement and bicipital tendonitis.

d) Mr. Lee continued to experience left shoulder pain following his June 26, 2009 open MRI.

e) Mr. Lee's September 2, 2010 MR arthrogram of the left shoulder revealed a superior labral tear, anterior to posterior without detachment of the labrum.

C

Yes No

Explanation: _____

3) It is my expert medical opinion most probably and to a reasonable degree of medical certainty (greater than 50% probability) that the findings on the September 2, 2010 MRI arthrogram with contrast (a superior labral tear, anterior to posterior without detachment of the labrum) are consistent with Mr. Lee's left shoulder complaints of the last year and the mechanism of his June 2, 2009 work related injury.

C Yes, the left shoulder complaints are causally related to the injury.

_____ No, the left shoulder complaints are NOT causally related to the injury.

Explanation: If no previous treatment for shoulder prior to date of

4) Is an MRI with contrast versus an Open MRI a more detailed/thorough imaging procedure more likely to reveal abnormalities of the shoulder? Then he probably had them this on 6-2-09.

Yes ✓ No

Explanation, if needed: Existing MRI and arthrogram are sufficient.

5) All opinions and boxes checked in this questionnaire are my expert medical opinions, stated most probably and to a reasonable degree of medical certainty (greater than 50% probability), and should be given the same weight as the opinions provided in my dictated notes.

✓ Yes No

Explanation: _____

Dr. Charles B. Thomas Date 9/20/10

Thank you for your assistance in this matter. Should you have any questions, please do not hesitate to contact my office.

Very truly yours,

By: _____
Ann McCrowey Mickle

AMM/emw

Enclosure: referenced medical records

D38997

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Reply to: Rock Hill office

September 13, 2010

[redacted]
Carolina Musculoskeletal Institute
410 University Pwky, Suite 1000
Aiken, SC 29801

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: 0906951

Dear Dr. Carter,

Please be advised that our office represents Bernard Lee as a result of injuries sustained during the course and scope of his employment with Bondex. On June 2, 2009, Mr. Lee and two co-workers were lifting a machine hood when the hood fell onto the left side of Mr. Lee's shoulder and neck. Following the accident Mr. Lee presented to University HealthCare System with pain in the left shoulder.

On June 5, 2009 Mr. Lee presented to Dr. Broder of North Augusta Urgent Care with pain in the left arm/shoulder. Dr. Broder's treatment consisted of continued medications and physical therapy. Mr. Lee's symptoms failed to subside and an MRI of the left shoulder was ordered. On June 26, 2009, Mr. Lee underwent an open MRI of the left shoulder which revealed, "Acromioclavicular joint arthropathy with mild impingement" and "Bicipital tendonitis."

On July 16, 009, the employer sent Mr. Lee for an evaluation with Dr. James Bethea. At that time, Mr. Lee was making complaints of pain in his left shoulder, neck and back. Dr. Bethea's diagnosis consisted of impingement syndrome of the left shoulder and neck and back pain. He provided a cortisone injection to the shoulder, medications and recommended continuing physical therapy.

On August 18, 2009 Mr. Lee presented to Dr. Timothy Shannon with neck, back and left shoulder pain. Dr. Shannon provided an injection to the left shoulder and recommended MRIs of the neck and low back. On October 15, 2009 Dr. Shannon noted, "It is my expert medical

probability) that Mr. Lee suffers from neck pain, left shoulder pain, and low back pain as a result of his work accident of June 2, 2009."

On October 22, 2009 Mr. Lee presented to Dr. Charles Thomas for an independent medical evaluation. Dr. Thomas noted unbearable pain in the neck, lower back and left shoulder and severe impairment of active range of motion. MRIs of the cervical, thoracic and lumbar spines were recommended to rule out a spinal pathology.

On January 25, 2010 Mr. Lee presented to your office with pain in his low back, neck, and left shoulder with radiating pain down his arms. You noted, "I feel that the patient mostly has some shoulder and scapular strain issues." As a result, you recommended physical therapy and a return appointment through Dr. Shannon's office. You released Mr. Lee at maximum medical improvement with regard to the low back and cervical spine.

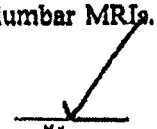
On May 25, 2010 Mr. Lee returned to Dr. Shannon's office with pain in both upper extremities. Following a physical examination Dr. Shannon recommended electrodiagnostic testing.

On June 10, 2010 Mr. Lee presented to Dr. W. Daniel Westerkam with pain in his shoulder and arm with very limited range of motion. Dr. Westerkam diagnosed myofascial pain and recommended that Mr. Lee not lift over ten pounds with the left arm or lift the left arm over shoulder height.

On September 2, 2010 Mr. Lee underwent an MR arthrogram of the left shoulder. The MR arthrogram revealed a superior labral tear, anterior to posterior without detachment of the labrum.

In order to determine the present status of Mr. Lee's medical treatment and care, please indicate in the below questionnaire your medical opinions relating to his current and future medical needs. (Please check "yes" or "no" and explain if necessary).

1) On January 25, 2010 Mr. Lee presented to my office for a follow up regarding his cervical and lumbar MRIs. I noted weakness in the shoulder and diagnosed a scapular strain.



Yes _____ No

Explanation:_____

2) I have reviewed Mr. Lee's Open MRI of his left shoulder dated June 26, 2009, and the MR arthrogram of the left shoulder dated September 2, 2010 together with my medical records. As a result, I am aware of the following:

   a) By history, Mr. Lee has been experiencing left shoulder pain since June 2, 2009.

   b) Mr. Lee's June 26, 2009 open MRI of the left shoulder revealed acromioclavicular joint arthropathy with mild impingement and bicipital tendonitis.

d) Mr. Lee continued to experience left shoulder pain following his June 26, 2009 open MRI.

e) Mr. Lee's September 2, 2010 MR arthrogram of the left shoulder revealed a superior labral tear, anterior to posterior without detachment of the labrum.

✓ Yes _____ No

Explanation:_____

3) It is my expert medical opinion most probably and to a reasonable degree of medical certainty (greater than 50% probability) that the findings on the September 2, 2010 MRI arthrogram with contrast (a superior labral tear, anterior to posterior without detachment of the labrum) are consistent with Mr. Lee's left shoulder complaints of the last year and the mechanism of his June 2, 2009 work related injury.

✓ Yes, the left shoulder complaints are causally related to the injury.

_____ No, the left shoulder complaints are NOT causally related to the injury.

Explanation:_____

4) Is an MRI with contrast versus an Open MRI a more detailed/thorough imaging procedure more likely to reveal abnormalities of the shoulder?

✓ Yes _____ No

Explanation, if needed:_____

5) All opinions and boxes checked in this questionnaire are my expert medical opinions, stated most probably and to a reasonable degree of medical certainty (greater than 50% probability), and should be given the same weight as the opinions provided in my dictated notes.

✓ Yes _____ No

Explanation:_____

Ty Carter MD 7/17/10

Dr. Ty Carter Date

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
2002 – 2008

Associates:
Tyler Bathrick
Gretchen Rogers

COLUMBIA:
1119 BLANDING STREET
2ND FLOOR
COLUMBIA, SC 29201
(803) 929-0029

ROCK HILL:
930 OAKLAND AVENUE
P.O. BOX 10761
ROCK HILL, SC 29731
(803) 980-0083
(803) 328-2526 FAX

MYRTLE BEACH:
1030 44TH AVENUE NORTH
SUITE 102
MYRTLE BEACH, SC 29577
(843) 839-2601
(843) 839-2607 FAX

Reply to: Rock Hill office

September 13, 2010

Via Mail and Facsimile (803-649-2231
Dr. William ~~Robertson~~ Robinson
Margaret J. Weston Medical Center
1211 University Lane,
Aiken, SC 29801

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: 0906951

Dear Dr. Robertson,

Please be advised that our office represents Bernard Lee as a result of injuries sustained during the course and scope of his employment with Bondex. On June 2, 2009, Mr. Lee and two co-workers were lifting a large machine hood when the hood fell onto the left side of Mr. Lee's shoulder and neck. Following the accident Mr. Lee presented to University HealthCare System with pain in the left shoulder.

On June 5, 2009 Mr. Lee presented to Dr. Broder of North Augusta Urgent Care with pain in the left arm/shoulder. Dr. Broder's treatment consisted of continued medications and physical therapy. Mr. Lee's symptoms failed to subside and an MRI of the left shoulder was ordered. On June 26, 2009, Mr. Lee underwent an open MRI of the left shoulder which revealed, "Acromioclavicular joint arthropathy with mild impingement" and "Bicipital tendonitis." The reasons for ordering an open MRI of the left shoulder were unclear as Mr. Lee is not clostrophobic.

On July 16, 009, the employer sent Mr. Lee for an evaluation with Dr. James Bethea. At that time, Mr. Lee was making complaints of pain in his left shoulder, neck and back. Dr. Bethea's diagnosis consisted of impingement syndrome of the left shoulder and neck and back pain. He provided a cortisone injection to the shoulder, medications and recommended continuing physical therapy.

On August 18, 2009 Mr. Lee presented to Dr. Shannon with neck, back and left shoulder pain. Dr. Shannon provided an injection to the left shoulder and recommended MRIs of the neck and low back. On October 15, 2009 Dr. Shannon noted, "It is my expert medical opinion, "most probably and to a reasonable degree of medical certainty" (greater than 50% probability) that Mr. Lee suffers from neck pain, left shoulder pain, and low back pain as a result of his work accident of June 2, 2009."

On October 22, 2009 Mr. Lee presented to Dr. Charles Thomas for an independent medical evaluation. Dr. Thomas noted pain in the neck, lower back and left shoulder and severe impairment of active range of motion. MRIs of the cervical, thoracic and lumbar spines were recommended to rule out a spinal pathology.

On January 25, 2010 Mr. Lee presented to Dr. Ty Carter with pain in his low back, neck, and left shoulder with radiating pain down his arms. Dr. Carter noted, "I feel that the patient mostly has some shoulder and scapular strain issues." As a result, Dr. Carter recommended physical therapy and a return appointment through your office. Dr. Carter released Mr. Lee at maximum medical improvement with regard to the low back and cervical spine.

On May 25, 2010 Mr. Lee returned to Dr. Shannon with pain in both upper extremities. Following a physical examination your recommended electrodiagnostic testing.

On June 10, 2010 Mr. Lee presented to Dr. W. Daniel Westerkam with pain in his shoulder and arm with very limited range of motion. Dr. Westerkam diagnosed myofascial pain and recommended that Mr. Lee not lift over ten pounds with the left arm or lift the left arm over shoulder height.

On September 2, 2010 Mr. Lee underwent an MR arthrogram of the left shoulder. The MR arthrogram revealed a superior labral tear, anterior to posterior without detachment of the labrum.

In order to determine the present status of Mr. Lee's medical treatment and care as well as the causality of his symptoms, please indicate your responses in the below questionnaire. (Please check "yes" or "no" and explain if necessary).

1) On July 20, 2010 Mr. Lee presented to the Margaret J. Weston Medical Center with pain in his left shoulder and neck.

_____ Yes _____ No

Explanation:_____

2) I have reviewed Mr. Lee's Open MRI of his left shoulder dated June 26, 2009, and the MR arthrogram of the left shoulder dated September 2, 2010 together with the information provided above and my medical records. As a result, I am aware of the following:

a) By history, Mr. Lee has been experiencing left shoulder pain since June 2, 2009.

b) Mr. Lee's June 26, 2009 **open** MRI of the left shoulder revealed acromioclavicular joint arthropathy with mild impingement and bicipital tendonitis.

d) Mr. Lee continued to experience left shoulder pain following his June 26, 2009 open MRI.

e) Mr. Lee's September 2, 2010 MR arthrogram of the left shoulder revealed a superior labral tear, anterior to posterior without detachment of the labrum.

✓ Yes _____ No

Explanation: _____

3) It is my expert medical opinion most probably and to a reasonable degree of medical certainty (greater than 50% probability) that the findings on the September 2, 2010 MRI arthrogram with contrast (a superior labral tear, anterior to posterior without detachment of the labrum) are consistent with Mr. Lee's left shoulder complaints of the last year and the mechanism of his June 2, 2009 work related injury.

✓ Yes, the left shoulder complaints are causally related to the injury.

_____ No, the left shoulder complaints are NOT causally related to the injury.

Explanation: Yes medical probability > 50%

4) Is an MRI with contrast versus an Open MRI a more detailed/thorough imaging procedure more likely to reveal abnormalities of the shoulder?

✓ Yes _____ No

Explanation, if needed: _____

5) All opinions and boxes checked in this questionnaire are my expert medical opinions, stated most probably and to a reasonable degree of medical certainty (greater than 50% probability), and should be given the same weight as the opinions provided in my dictated notes.

✓
Yes No

Explanation: _____

Dr. William ~~Robertson~~ Robinson 9/16/10
Date

Thank you for your assistance in this matter. Should you have any questions, please do not hesitate to contact my office.

Very truly yours,

By: _____
Ann McCrowey Mickle

Enclosure: referenced medical records

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
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Associates:
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1039 44TH AVENUE NORTH
SUITE 108
MYRTLE BEACH, SC 29577
(843) 839-2501
(843) 839-2507 FAX

Reply to: Rock Hill office

September 13, 2010

Dr. James A. Thesing
Palmetto Imaging
2997 Sunset Boulevard
West Columbia, South Carolina 29169

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: 0906951
DOB: 4-30-80
SSN: 251-45-2204

Dear Dr. Thesing,

Please be advised that our office represents Bernard Lee as a result of injuries sustained during the course and scope of his employment with Bondex. On June 2, 2009, Mr. Lee and two co-workers were lifting a machine hood when the hood fell onto the left side of Mr. Lee's shoulder and neck. Following the accident Mr. Lee presented to University HealthCare System with pain in the left shoulder.

On June 5, 2009 Mr. Lee presented to Dr. Broder of North Augusta Urgent Care with pain in the left arm/shoulder. Dr. Broder's treatment consisted of continued medications and physical therapy. Mr. Lee's symptoms failed to subside and an **open** MRI of the left shoulder was ordered. On June 26, 2009, Mr. Lee underwent an **open** MRI of the left shoulder which revealed, "Acromioclavicular joint arthropathy with mild impingement" and "Biciptal tendonitis." The reasons for ordering an open MRI of the left shoulder were unclear as Mr. Lee is not clostrophobic.

On July 16, 009, the employer sent Mr. Lee for an evaluation with Dr. James Bethea. At that time, Mr. Lee was making complaints of pain in his left shoulder, neck and back. Dr. Bethea's diagnosis consisted of impingement syndrome of the left shoulder and neck and back pain. He provided a cortisone injection to the shoulder, medications and recommended continuing physical therapy.

On August 18, 2009 Mr. Lee presented to Dr. Shannon with neck, back and left shoulder pain. Dr. Shannon provided an injection to the left shoulder and recommended MRIs of the neck and low back. On October 15, 2009 Dr. Shannon noted, "It is my expert medical opinion, "most probably and to a reasonable degree of medical certainty" (greater than 50% probability) that Mr. Lee suffers from neck pain, left shoulder pain, and low back pain as a result of his work accident of June 2, 2009."

On October 22, 2009 Mr. Lee presented to Dr. Charles Thomas for an independent medical evaluation. Dr. Thomas noted pain in the neck, lower back and left shoulder and severe impairment of active range of motion. MRIs of the cervical, thoracic and lumbar spines were recommended to rule out a spinal pathology.

On January 25, 2010 Mr. Lee presented to Dr. Ty Carter with pain in his low back, neck, and left shoulder with radiating pain down his arms. Dr. Carter noted, "I feel that the patient mostly has some shoulder and scapular strain issues." As a result, Dr. Carter recommended physical therapy ~~and a return appointment through your office.~~ Dr. Carter released Mr. Lee at maximum medical improvement with regard to the low back and cervical spine. → not to the office of Palmetto Imaging

On May 25, 2010 Mr. Lee returned to Dr. Shannon with pain in both upper extremities. ~~Following a physical examination your recommended electrodiagnostic testing.~~ → neither performed a physical exam nor made these recommendations on Mr. Lee

On June 10, 2010 Mr. Lee presented to Dr. W. Daniel Westerkam with pain in his shoulder and arm with very limited range of motion. Dr. Westerkam diagnosed myofascial pain and recommended that Mr. Lee not lift over ten pounds with the left arm or lift the left arm over shoulder height.

On September 2, 2010 Mr. Lee underwent an MR arthrogram of the left shoulder. The MR arthrogram revealed a superior labral tear, anterior to posterior without detachment of the labrum.

At the conclusion of a hearing on September 7, 2010 the Workers' Compensation Commissioner left the record open for medical opinions regarding the tear found in Mr. Lee's MR arthrogram. I would ask that you answer the enclosed questionnaire and return it to my attention along with a statement of your charges. I will forward this questionnaire to the Commissioner upon receipt. Your prompt response is greatly appreciated as the Commissioner has requested that we submit all medical opinions by September 21, 2010.

1) On September 2, 2010 I performed an arthrographic injection and MR arthrogram to Bernard Lee's left shoulder. An MR arthrogram is often referred to as an MRI with contrast. I have not provided any additional medical treatment to Mr. Lee.

X
Yes No

Explanation:_____

_____

2) Is an MRI with contrast versus an Open MRI a more detailed/thorough imaging procedure more likely to reveal abnormalities of the shoulder?

X Yes ____ No

Explanation, if needed: _____

3) On September 13, 2010 the Defendants forwarded a questionnaire to my attention regarding whether or not the tear in Mr. Lee's left shoulder (shown in the MR arthrogram of September 2, 2010) is causally related to Mr. Lee's June 2, 2009 work related injury. I have only provided medical treatment in the form of an arthrographic injection and MR arthrogram. As a result, I will defer to Mr. Lee's treating physicians regarding the **causation** of the tear in Mr. Lee's left shoulder.

X Yes ____ No

Explanation, if needed: _____

4) All opinions and boxes checked in this questionnaire are my expert medical opinions, stated most probably and to a reasonable degree of medical certainty (greater than 50% probability), and should be given the same weight as the opinions provided in my dictated notes.

X Yes ____ No

Explanation: _____

James A. Thesing
Dr. James A. Thesing

9/21/10
Date

second submission

Thank you for your assistance in this matter. Should you have any questions, please do not hesitate to contact my office.

Very truly yours,

By: _____
Ann McCrowey Mickle

Enclosure: referenced medical records

HUFF
LAW FIRM LLC

E. Ros Huff, Jr.
roshuff@colalaw.com

Elizabeth F. Render
erender@colalaw.com

September 20, 2010

Avery B. Wilkerson, Commissioner
S.C. Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202-1715

Re: Bernard Lee v. Southern Felt d/b/a Bondex
WCC File No. 0906951

Dear Commissioner Wilkerson:

At the post hearing conference on September 7, 2010, you agreed to leave the record open until September 21, 2010 for both parties to obtain written opinions (or depositions if needed) from certain physicians. Enclosed are questionnaires from Dr. Daniel Westerkam, Dr. J.F. Bethea and Dr. James A. Thesing.

By copy of this letter to the claimant's attorney, Ann M. Mickle, I am providing her with copies of the completed questionnaires. Ms. Mickle was copied with all questionnaires when they were initially submitted to the physicians. Please let me know if you require anything additional.

Sincerely,

E. Ros Huff, Jr.

ERH/rco

Enclosure

cc: Ann M. Mickle, Esquire

5500.0277

Post Office Box 1935 / 7244 Woodrow Street / Irmo, South Carolina 29063
p: 803.252.2232 / f: 803.252.2231 / www.scinsurancedefense.com

FILE

bcc: Steve Anthony
Janis Napier (via email)

Charles Thomas, MD
September 9, 2010
Page 2

cc: Ann M. Mickle (via email)
Steve Anthony
Janis Napier (via email)

MEDICAL OPINION

Re: Bernard Lee v. Southern Felt d/b/a Bondex
WCC File No. 0906951
Date of Injury: 06/02/09

Based upon treatment/evaluation you provided and upon review of any medical records, can you state to a reasonable degree of medical certainty that the most probably cause (greater than 50%) of the tear in the claimant's left shoulder shown in the MR arthrogram of September 2, 2010 was caused by the event of June 2, 2009?

YES _____ NO ✓

Charles Thomas, MD
W/Daniel Westerkam, MD

9/9/10
Date

5500.0277

cc: Ann M. Mickle (via email)
Steve Anthony
Janis Napier (via email)

MEDICAL OPINION

Re: Bernard Lee v. Southern Felt d/b/a Bendex
WCC File No. 0906951
Date of Injury: 06/02/09

Based upon treatment/evaluation you provided and upon review of any medical records, can you state to a reasonable degree of medical certainty that the most probably cause (greater than 50%) of the tear in the claimant's left shoulder shown in the MR arthrogram of September 2, 2010 was caused by the event of June 2, 2009?

YES _____ NO X

James Bethea, MD

9/15/10
Date

J.F. Bethea MD C60969
Phone 803-806-8198
Fax 803-806-8178
Fed Tax ID 72-1523779

5503.0277

SEP/10/2010/FRI 09:57 AM Huf: aw Firm FAX No. 803-252- '31 P.002
Page:2/2 COLUMBIA ORTHOPAEDIC From:8038068178 SEP-15-2010 16:58 299

cc: Ann M. Mickle (via email)
Steve Anthony
Janis Napier (via email)

MEDICAL OPINION

Re: Bernard Lee v. Southern Felt d/b/a Bondex
WCC File No. 0906951
Date of Injury: 06/02/09

Based upon treatment/evaluation you provided and upon review of any medical records, can you state to a reasonable degree of medical certainty that the most probable cause (greater than 50%) of the tear in the claimant's left shoulder shown in the MR arthrogram of September 2, 2010 was caused by the event of June 2, 2009?

YES _____ NO X

James A. Thesing, DO

9/14/10
Date

5500.0277

cwyatt@colaw.com

From: roshuff@colalaw.com
Sent: Thursday, August 26, 2010 9:11 AM
To: cwyatt@colalaw.com
Subject: FW: RESET HEARING NOTICE 0906951 LEE

From: Boyd, Elaine [mailto:EBoyd@wcc.sc.gov]
Sent: Thursday, August 26, 2010 7:55 AM
To: Ann Mickle; Tyler Bathrick; roshuff@colalaw.com
Cc: ewiedel@mickleandbass.com
Subject: RESET HEARING NOTICE 0906951 LEE

South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

RESET

WCC File #: 0906951
Carrier File #: 09 0602LEE
August 26, 2

NOTICE OF HEARING

BERNARD D LEE v BONDEX INC

Subject:	To determine issues as set forth on Forms 50 and 51.
Date:	September 7, 2010 at 08:30 AM
Location:	South Carolina Workers' Compensation Commission 1333 Main Street, Suite 500
	Columbia, SC 29201

South Carolina Regulations 67-601 through 67-615 govern hearings before the South Carolina Workers' Compensation Commission. The employee must attend when not represented by an attorney or when disfigurement is involved. Corporations must be represented by an attorney, and uninsured employers must attend.

Attorneys must file a Form 58 with proof of service pursuant to Regulation 67-611. Postponements are only granted pursuant to Regulation 67-613. Please visit www.wcc.sc.gov/Commissioners to view Commissioners' Preferences. If you have questions regarding this matter, please contact the office of the undersigned Jurisdictional Commissioner.

Commissioner Avery B. Wilkerson Jr.
803-737-5697, eboyd@wcc.sc.gov

CERTIFICATE OF SERVICE – This is to certify the undersigned has served this notice in the above entitled action upon all parties to this cause by sending a copy hereof by electronic mail or United States mail.

8/26/2010

PHS Date 8/27/10 (AW)

By: Elaine Boyd, SC Workers' Compensation, August 26, 2010

Party	Attorney
Employee: BERNARD D LEE	Ann McCrowey Mickle amickle@mickleandbass.com 803-980-0083
Employee: BERNARD D LEE	Tyler Bathrick tbathrick@mickleandbass.com 803-980-0083
Employer: BONDEX INC Carrier: Great American Alliance Insurance Company	E. Ros Huff, Jr. roshuff@colalaw.com 803-252-2232
Employer: BONDEX INC Carrier: Great American Alliance Insurance Company	Carter Anthony Martling cmartling@allen-kopet.com 803-714-9606

Internal Virus Database is out of date.
Checked by AVG - www.avg.com
Version: 8.5.420 / Virus Database: 270.14.4/2417 - Release Date: 10/06/09 06:50:00

STATE OF SOUTH CAROLINA	)	BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COUNTY OF TRENTON	)	
Bernard Lee,	)	WCC FILE NO. 0906951
Claimant,	)	
vs.	)	NOTICE OF WITNESSES AND WRITTEN REPORT(S)/PHYSICIAN OR OTHER EVIDENCE TO BE INTRODUCED ON BEHALF OF THE EMPLOYER/CARRIER
Southern Felt d/b/a Bondex,	)	
Employer,	)	
and	)	
Great American Alliance Insurance,	)	
Carrier.	)	

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND ANN MICKLE, ESQUIRE, ATTORNEY FOR CLAIMANT:

YOU ARE HEREBY NOTIFIED THAT THE employer/carrier, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330 (1976, as amended), herewith submits the following reports/physicians or other evidence on behalf of the employer/carrier, to wit:

	Medical Provider	Date	Page No.
1	SportsPlus	6/30/09	134
2	Dr. Bethea	7/30/09	135
3	Dr. Charles Thomas	10/22/09	136 – 146
4	Aiken Regional Medical Center	1/25/01 – 9/28/09	147 – 281
5	Medical summary		282 - 289

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the deposition(s) of any of the physicians or other person(s), whose reports are submitted, for the purposes of cross-examination.

YOU ARE FURTHER HEREBY NOTIFIED that a copy of said reports are served on the opposing counsel/party herewith on behalf of the Defendants.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the employer/carrier:

Al Martin
Tom Harrison
Lowell Simpkins
Jay Nicholson
Janis Napier
Nancy Bowers
Claimant's supervisor
Any Other Representative(s) of the Employer/Carrier
The Claimant
Any witness listed by the Claimant

E. Ros Huff, Jr.
HUFF LAW FIRM, LLC
Post Office Box 1935
7244 Woodrow Street
Irmo, South Carolina 29063
(803) 252-2232

Attorneys for Defendant(s)

August 2, 2010

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Prehearing Brief, Notice of Witnesses and medical records have been served upon the following named individuals indicated below by mailing a copy of the same in the United States mail, with sufficient postage affixed thereto and return address clearly marked on August 2, 2010.

Avery Wilkerson
S.C. Workers' Compensation Commission
PO Box 1715
Columbia, South Carolina 29202

Ann Mickle, Esquire
Mickle & Bass, LLC
930 Oakland Avenue
PO Box 10751
Rock Hill, SC 29731

Claire Owens

Claire Owens
Paralegal to E. Ros Huff, Jr.
HUFF LAW FIRM, LLC
Post Office Box 1935
7244 Woodrow Street
Irmo, South Carolina 29063
(803) 252-2232

Attorneys for Defendant(s)

Bernard Lee v. Southern Felt d/b/a Bondex
DEFENDANT'S APA SUBMISSIONS
WCC File No. 0906951

APA	Medical Provider	Date	Page No.
20	SportsPlus	6/30/09	134
21	Dr. Bethea	7/30/09	135
22	Dr. Charles Thomas	10/22/09	136-146
23	Aiken Regional Medical Center	1/25/01-9/28/09	147-281
24	Medical summary		282-289

Exhibits	Description	
A	Photo/Video of job (light duty)	
B	Photo/Video of accident site	

No-Show / Cancelation Record

PATIENT: Lee, Bernard Dx: L shoulder pn. Dr. Brodo

6-30-09	Ns. PB

I did dispense (#60) 500 mg naproxen to be taken one twice a day on food.

I will see him back in about two weeks.

James F. Bethea, M.D.
JFB/prf

N/S

(Next Appointment ~~07/30/09 @ 3:00 p.m.~~)

Cc: Strategic Comp Services
Att: Steve Anthony
P.O. Box 1445
Alpharetta, GA 30009

INDEPENDENT MEDICAL EVALUATION

NAME:	LEE, Bernard
	Mr. Lee is examined voluntarily in my office on 10/22/09 concerning injuries allegedly received to his neck, back, and left shoulder. He was informed that he was being seen solely for the purpose of an Independent Medical Evaluation and was not to be treated or advised in any way. He was asked not to perform motions he found painful on examination.
DATE OF EVALUATION:	October 22, 2009
TIME SCHEDULED:	11:30 AM
TIME BEGUN:	11:25 AM
TIME CONCLUDED:	12:05 PM
REQUESTING PARTY:	Strategic Comp ATTN: Steve Anthony, Field Claim Specialist
TYPE OF IME:	Workman's Compensation
PRESENT AT EXAMINATION:	Myself and the examinee
DATE OF INJURY:	June 2, 2009
RECORDS REVIEWED:	1. Medical Summary and Events of Claim

2. Carolina Musculoskeletal Institute, Dr. Shannon
3. Short Term Disability Form
4. Columbia Orthopaedic Specialists, James Bethea, MD
5. Physical Therapy Progress Notes
6. North Augusta Urgent Care
7. University Open MRI, MRI of the left shoulder
8. University Hospital Dept of Radiology, three views of the left shoulder, 6/3/09

RECORDS NOT REVIEWED BUT KNOWN TO EXIST: None.

AGE: 29 years old

HEIGHT: 6'

WEIGHT: 190 pounds

HAND DOMINANCE: Right hand dominance.

CHIEF COMPLAINT: Neck, back, and left shoulder pain.

HISTORY OF PRESENT ILLNESS: This is a 29 year old black male who was employed by Southern Felt doing business as Bondex Inc. on 6/2/09. He states that on this day a hood weighing 800 pounds fell on him striking him between his left shoulder and his neck.

The following day he presented to University Hospital where left shoulder x-rays were performed and were interpreted as normal except for AC arthrosis. He was instructed to return to work on 6/4/09 and was told to wear a sling for three days.

The following day he presented to North Augusta Urgent Care where the diagnosis was left shoulder pain and he was prescribed physical therapy

and Naprosyn. He was also seen at North Augusta Urgent Care on 6/12/09 by Candice Waters, MD who kept his restrictions in effect.

Subsequent to that, he attended physical therapy. He returned to North Augusta Urgent Care on 6/19/09, 6/26/09, and 7/1/09.

On 7/16/09, he was seen by Dr. Bethea at Columbia Orthopaedic Specialists who opined that his neck and back did not represent serious injury and that he had impingement syndrome of the left shoulder.

He presented to Margaret J. Weston Community Health Center on 8/18/09 complaining of neck, back, and shoulder pain. He was seen by Dr. Al-Soudi and was taken out of work from 8/3/09 to 8/18/09.

Subsequent to that, he was seen at Carolina Musculoskeletal Institute by Dr. Shannon. This apparently represents the last encounter with a healthcare provider he has had.

He states that his pain is getting worse and on a 1-10 scale he rates it on average as a ten. He is on short term disability and is not currently working. He states that his neck, lower back, and left shoulder hurt. Coughing and sneezing exacerbate his symptoms as does breathing.

PAST MEDICAL HISTORY:

Similar or pre-existing conditions – None.

Review of Systems – Positive for hypertension.

Surgeries – Left hand.

Allergies – No known drug allergies.

SOCIAL HISTORY: He smokes, but does not drink.

PREVIOUS WORKER'S COMPENSATION CLAIMS: The left hand injury was a Worker's Comp claim.

PREVIOUS LITIGATION: None.

PREVIOUS SERIOUS INJURIES: None.

PSYCHIATRIC HISTORY: None.

CURRENT MEDICATIONS: Naprosyn.

EDUCATION: He has a high school degree and some college at Aiken Tech.

HOBBIES: Fishing and playing with his daughter.

MARITAL HISTORY: He is single.

PHYSICAL EXAMINATION: Physical examination reveals a 29 year old black male who appears his stated age. He stands 6' tall and weighs 190 pounds. He is right hand dominant.

Examination of the cervical spine shows limited active range of motion with 55 degrees of flexion, 45 degrees of extension, 10 degrees side bending each way, and 20 degrees side rotation. There is no appreciable spasm over the paraspinals or the trapezii. Negative cervical compression test is noted.

The left shoulder shows extreme limitation actively of motion. He refuses to move this more than 5 degrees in any plane. There is slightly positive anterior acromial tenderness. Drop arm test is positive. Impingement test is positive. The rest of the exam is not done due to his refusal to move the shoulder.

Examination of the lumbar spine shows 25 degrees of flexion, 10 degrees of extension, 10 degrees side bending each way, and minus 20 degrees rotation each way. There is no paraspinal spasm over the lumbar spine. Pelvis and scapulae are level. There is no trunk tilt or list.

NEUROLOGIC EXAM

MOTOR - Motor testing is 5/5 in deltoids, biceps, triceps, wrist flexors, wrist extensors, and interossei. Also hip flexors, hip extensors, hamstrings, quadriceps, anterior tib, posterior tib, gastroc soleus, EHL, and peroneals.

REFLEXES – Reflexes are 2+ in biceps, triceps, brachioradialis, knees and ankles bilaterally.

SENSORY – Sensory exam is intact to light touch and proprioception in both upper and lower extremities.

Vascular exam shows palpable pulses in both hands and both feet with no trophic changes.

The claimant left the examining area with no untoward effects or complaints.

IMAGING: None provided.

DIAGNOSIS:
1. Left shoulder pain with normal left shoulder MRI.
2. Neck pain.
3. Low back pain.

PAIN EVALUATION: The examinee completed the patient pain drawing and the pain rating scale. The patient pain drawing is non-anatomic and non-physiologic. The pain rating scale is checked at the highest level.

DISCUSSION AND RATING: The examinee demonstrates severe impairment of range of motion of the left shoulder either on a subjective or an objective basis. He has had a previous negative MRI. At this point, he needs MRIs of his cervical, thoracic, and lumbar spine to rule out significant spinal pathology as his physical exam is equivocal. When we obtain the results of the MRIs of his spine, we will be able to assign permanent impairment rating if any and work restrictions if any.

APPORTIONMENT: Not applicable.

WORK RESTRICTIONS: He is to stay out of work until we get the MRIs of his spine. He does not need to return here, we just need the results of the MRIs.

RECOMMENDED FUTURE MEDICAL TREATMENT: MRIs of the cervical, thoracic, and lumbar spine.

DISCLAIMER: The opinions rendered herein are the opinions of Charles B. Thomas, Jr., M.D. and are to a reasonable degree of medical certainty. This examination has been conducted on the basis of the medical examination and the documentation as provided, with the assumption that the material is true and correct. If more information becomes available at a later date, an additional report may be requested. Such information may or may not change the opinions rendered in this examination. This opinion is based on the clinical assessment, clinical examination and documentation as provided. The opinion does not constitute, per se, recommendation for specific claims or administrative functions to be made or enforced. Occult illnesses not detectable on physical examination or imaging studies provided could exist in this examinee.

Comments are based on specifics provided with this case and should not be generalized to other cases, nor should they be interpreted as criticizing or supporting the providers of medical care.

No "doctor/patient" relationship has been established during this evaluation, and the examinee understands that I am not his/her treating physician.

Charles B. Thomas, M.D.
Fellow, American Academy of Orthopaedic Surgeons
Fellow, American Academy of Disability Evaluating Physicians
CBT/tas

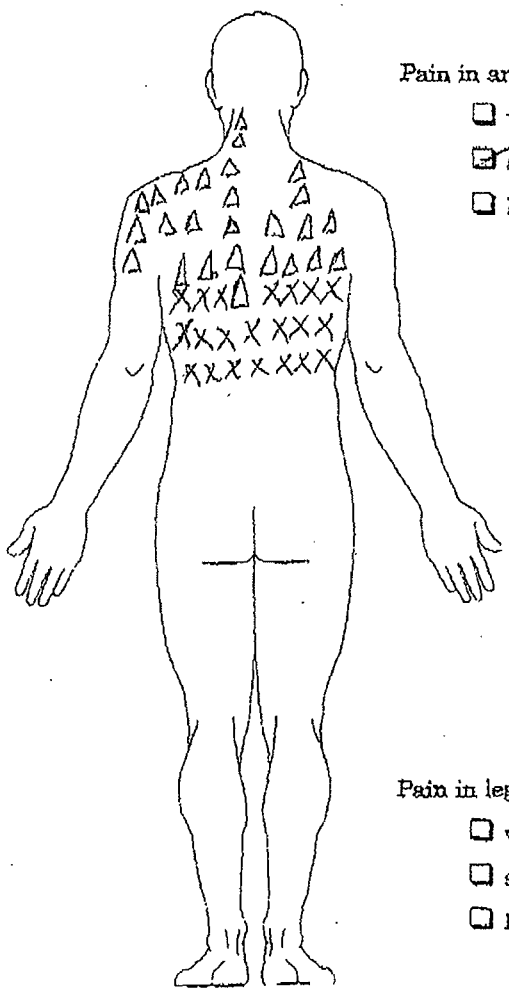
Patient Pain Drawing

Patient name: Bernard Lee Date: 10/22/09

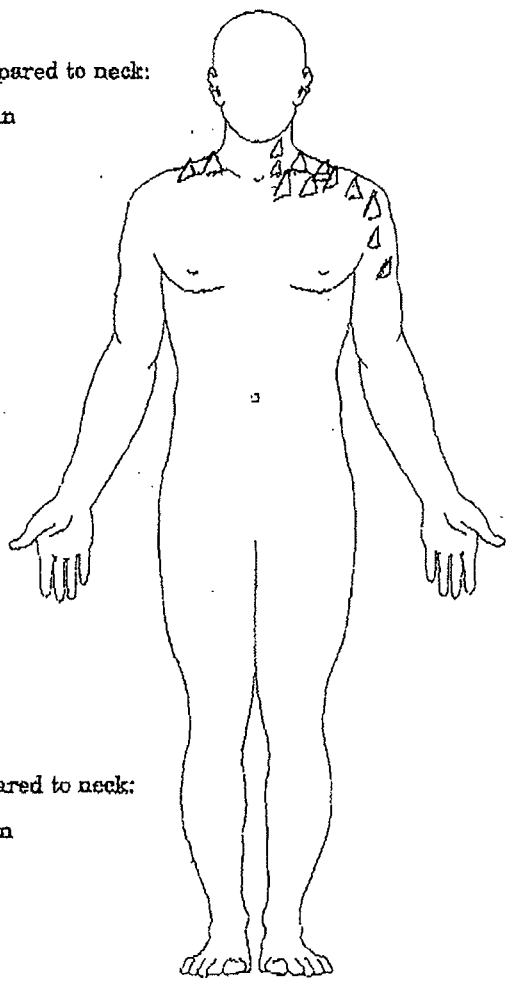
Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas. Just to complete the picture, please draw in your face.

Ache	Numbness	Pins and needles	Burning	Stabbing
ΔΔΔΔΔ	▬▬▬▬▬	OOOOOO	XXXXX	//////

Back



Front



Pain in arm(s) compared to neck:

- ☐ worse than
- ☑ same as
- ☐ less than

Pain in leg(s) compared to neck:

- ☐ worse than
- ☐ same as
- ☐ less than

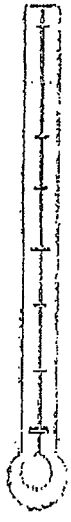
Signature: [signature] Date: 10/22/09

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Pain Rating Scale

Patient name: Bernard Lee Date: 10/22/09

Here is a thermometer with various grades of pain from "no pain at all" at the bottom to the pain is "almost unbearable" at the top. We want you to put a check by the phrase that describes your pain best. Please rate your pain over the last month.



- [x] Pain is almost unbearable
- [ ] Very bad pain
- [ ] Quite bad pain
- [ ] Moderate pain
- [ ] Little pain
- [ ] No pain at all

Signature: Date: 10/22/09

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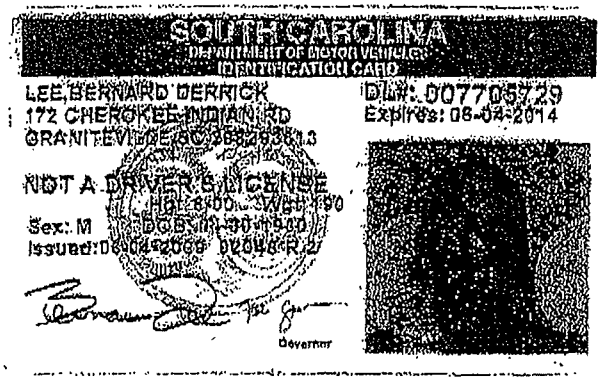
Past Medical History

	N/A	Serious/Significant	Similar Illness/Injury	Multiple, Repetitive Injuries	Comment:
1. Previous medical illnesses	☑	☐	☐	☐	
2. Previous surgical illnesses	☑	☐	☐	☐	
3. Previous vehicular accidents	☑	☐	☐	☐	
4. Previous slips and falls	☑	☐	☐	☐	
5. Previous lifting injuries	☑	☐	☐	☐	
6. Assault related injuries	☑	☐	☐	☐	
7. Direct blows	☑	☐	☐	☐	
8. Other type injuries	☑	☐	☐	☐	
9. Athletic injuries	☑	☐	☐	☐	
10. Previous on-the-job injuries	☑	☐	☐	☐	

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	N/A	Serious/Significant	Similar Illness/Injury	Multiple, Repetitive Injuries	
11. Military injuries	☐	☐	☐	☐	Comment:
12. Previous injuries/complaints at same anatomic area	☑	☐	☐	☐	Comment:
13. Previous chiropractic treatment	☑	☐	☐	☐	Comment:
14. Associated family disabilities	☑	☐	☐	☐	Comment:
15. Current medicines Naproxen	☐	☐	☐	☐	Comment:
16. Allergies	☑	☐	☐	☐	Comment:
17. Habits history	☑	☐	☐	☐	Comment:

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SOUTH CAROLINA
DEPARTMENT OF MOTOR VEHICLES
IDENTIFICATION CARD
LEE,BERNARD DERRICK
172 CHEROKEE INDIAN RD
DL#: 007705729
Expires: 08-04-2014
NOT A DRIVER'S LICENSE
Sex: M
Governor

INITIALS INITIALS

INITIAL ASSESSMENT: Pt'c [illegible] + Level 4
Rt(R) hand limited ROM. C/O(L) knee pain felt new wood pile — [illegible]

TRIAGE NURSE

PRESSOGRAPH

PT NAME: Lee, Bernard Bm 20 | RACE/SEX | AGE | PRESENT MEDICATIONS: Ø

NURSES NOTES:
pt ambulated to room and changed into a gown, history as above [illegible]
Pt p/c c pain medication, wrist splint, + knee immobilizer. pt understands how to take po meds. [illegible] RT wrist splint [illegible]

PMD

TRIAGE CLASS: ☐ EMERGENT ☐ URGENT ☑ NON URGENT
MODE OF ARRIVAL: ☑ AMBULATORY ☐ WHEELCHAIR ☐ CARRIED ☐ STRETCHER ☐ PERSON ACCOMPANIED PATIENT ☐ EMS ☐ POV ☐ PER SELF
BIRTH WEIGHT:
WEIGHT: 173
LMP:
EDC:
G P AB:
CONDITION ON ARRIVAL: ☐ GOOD ☐ FAIR ☐ POOR ☐ CONSCIOUS ☐ UNCONSCIOUS

TIME	T	P	R	BP
[illegible]	98.2	101	20	[illegible]

TRIAGE TIME: [illegible]
TIME IN ROOM: [illegible]
ER RM NO: 4
NURSE'S SIGNATURE:

CRITICAL CARE FLOWSHEET INITIATED ☐

D SMENT:

AUGUSTA DATA INC 12/11/2001 F0000

LABS AND OTHER CHARGES	ORD	INIT
CBC & diff		
CHEM 7		
CMP		
AMYLASE		
LIPASE		
PT/PTT		
TROPONIN		
MYOGLOBIN		
LIVER PANEL		
ALCOHOL		
TYPE + CROSS ___ UNITS		
TYPE & SCREEN		
TYPE & Rh		
BLOOD CULT X ___		
CCUA		
CATHUA		
URINE C & S		
FINGER STICK GLUCOSE		
HCG QUANT.		
URINE DRUG SCR		
EKG's		
ER ABG		
PA/LAT CXR		
P CXR		
C-SPINE		
L-SPINE		
ACUTE ABD		
HEMOCULT		
OLD RECORDS		
OLD ED DICT.		

PULSE OX:
ALLERGIES: NKA
LAST TETANUS: UTD

PHYSICIAN'S ORDERS:
1. (L) knee
2. 23 (R) hand
4.
5. to Xray via WC
6. from Xray via WC
7.
8. knee immobilizer
9. (R) velcro wrist splint
10.
11.
12.
13.
14.
15.
16.
17.
18.
19.
20. 2 Xrays
21.
22.
23.

924.11 923.20 E888 E849.9
93.54 29125RT 29515 LT

DISCHARGE DIAGNOSIS | CODES

(L) knee & (R) hand Contusion

DISCHARGE STATUS
DATE: 12/25/01 TIME: 1507
☐ ROUTINE (HOME) ☐ AMA
☐ ADMIT TO PHYSICIAN
☐ TRANSFERRED TO:
☐ ACCEPTING PHYSICIAN
☐ TRANSFER FORMS COMPLETED RECORDS & PATIENT

EXPIRED
☐ IN E.R. ☐ CORONER'S CASE
☐ DOA ☐ AUTOPSY

CONDITION ON DISCHARGE
☑ STABLE
☐ UNSTABLE
EMERGENCY MEDICAL CONDITION OR PREGNANCY WITH CONTRACTIONS PRESENT.

METHOD OF DISCHARGE
☑ AMBULATORY ☐ AMBULANCE
☐ WHEELCHAIR ☐ STRETCHER
☐ CARRIED ☐ OTHER

ACCOMPANIED BY
☐ SELF ☐ RELATIVE ☐ POLICE
☐ OTHER ☑ FRIEND
EXPLAIN:

METHOD INSTRUCTIONS
☑ VERBAL ☐ WRITTEN
☐ NOT GIVEN (why)
☑ PT. VERBALIZES UNDERSTANDING

NAME OF PHYSICIAN THAT ADMITTED PATIENT: [illegible] TIME MD NOTIFIED PT.
PHYSICIAN'S SIGNATURE: [illegible] DATE: 12/25/01
DISCHARGE NURSE: [illegible] DATE:

URINE PREG ☐ NEGATIVE ☐ POSITIVE ☐ INDETERMINANT

830.09

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED Physician Record

Chief Complaint: Fall

Injury Mech: ☐ Fall # of feet: _____ ☐ Hx from patient: ☐ Hx from other: _____

☐ Pedestrian / Auto ☐ Fire ☐ Explosion ☐ Motorcycle ☐ Helmet ☐ Bicycle ☐ Helmet ☐ Assault ☐ Firearm ☐ Knife

☐ Watercraft ☐ Blunt object _____ ☐ Other _____

☐ MVA ☐ Driver ☐ Passenger ☐ Head-on ☐ Rollover ☐ Rear ☐ Driverside Damage: ☐ Minimal ☐ Moderate ☐ Extensive

☐ Pass side ☐ Ambulated ☐ Ejected ☐ Death at scene

Protection: ☐ Shoul&Lap ☐ Unbelted ☐ Lap only ☐ Shoulder only ☐ Air bag ☐ Car seat ☐ Other: _____

HPI ☐ Unable to obtain History due to: ☐ Time of Last Meal:

20yo NAD BM arrives with Dem to ED via EMS
ED from 20 fall today. Pt arrives arrives
Injuries

Past Medical History: ☑ Neg ☐ Unobtainable ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Angina ☐ Asthma ☐ COPD ☐ CHF ☐ Other: _____

Past Surgical History: ☑ Neg ☐ Unobtainable **Surgeries:** _____

Medications: -0

☐ See ED Front Sheet:

Allergies: _____

Family History: ☑ Neg ☐ Unobtainable ☐ HTN ☐ HD ☐ DM ☐ Cancer ☐ Other: _____

Social History: ☐ Unobtainable Tobacco ☑ No ☐ Yes Amt _____ ETOH ☐ No ☐ Yes Amt _____

☐ Other _____

Review Of Systems: Check ☐ If Neg Check ○ If Pos ☐ Unable to obtain ROS due to: _____ (Comments

Eyes:	☐ Neg/NL	☑	○ Diplopia	☐	○ Blurred	☑	○ Vision chgs	☐	○ Photophobia										
ENT:	☐ Neg/NL	☑	○ Nose bleeds	☐	○ Sore throat	☑	○ Rhinitis	☐	○ Tooth loss										
Cardiac:	☐ Neg/NL	☑	○ Chest pain	☐	○ Palpitation														
Respir:	☐ Neg/NL	☑	○ SOB	☐	○ Cough	☐	○ Hemoptysis												
GI:	☐ Neg/NL	☐	○ Nausea	☐	○ Vomiting	☐	○ Abd pain	☐	○ Diarrhea	☐	○ Melena	☐	○ Hematox						
GU:	☐ Neg/NL	☐	○ Dysuria	☐	○ Frequency	☐	○ Urgency	☐	○ Nocturia										
MS:	☐ Neg/NL	☑	○ Myalgia	☐	○ Joint pain	☑	○ Back pain	☐	○ Neck pain										
Neuro:	☐ Neg/NL	☐	○ Seizures	☐	○ Dizziness	☐	○ Syncope	☐	○ Numbness	☐	○ Weakness								

☐ Other _____

Physical Exam: ☐ Unable to obtain PE due to: _____ Check ☐ If normal Check ○ If abnormal (If not Checked then not applicable.)

Constitutional ☐ Vital Signs Time ____ Pulse ____ RR ____ BP 152/79 Time ____ Glucose ____

General: ☑ All Neg/NL ☐ ○ Mental Status Abn Findings: _____

Eyes: ☑ All Neg/NL ☐ ○ Conjun NL ☐ ○ Lids ☐ ○ PERRL Abn Findings: _____

Head: ☑ All Neg/NL ☐ ○ NL cephalic ☐ ○ Sinuses Abn Findings: _____

ENT: ☑ All Neg/NL ☐ ○ Nose ☐ ○ Throat ☐ ○ Oropharynx ☐ ○ Dentition ☐ ○ Gums ☐ ○ Right TM ☐ ○ Left TM

Abn Findings: _____

Name:

Addressograph

ED Physician Record
Form 10-20040 Revised 9/99
Page 1 of 2

AIKEN REGIONAL MEDICAL CENTERS

302 University Parkway • Aiken, South Carolina 29802

PHYSICAL ASSESSMENT: **TIME PERFORMED** 1248

PULMONARY

Respirations: ☑ even ☑ nonlabored ☐ labored ☐ use of accessory muscles ☐ other*_____

Smoker ☐ Yes ☐ No ☐ Former Smoker

Breath Sounds: ☐ bilateral ☐ clear ☐ labored ☐ diminished ☐ absent* ☐ crackles ☐ wheezes ☐ rhoncii

*describe:_____

Airway: ☐ oral ☐ nasal ☑ self maintained

Cough: ☐ productive ☐ non-productive ☐ Describe secretions:_____

CARDIOVASCULAR

Capillary refill: ☐ brisk ☐ sluggish

Pulses:		RADIAL:	FEMORAL:	PEDAL:	
	Palpable	☐ Rt ☐ Lt	☐ Rt ☐ Lt	☐ Post Tibial	☐ Dorsal
	Doppler	☐ Rt ☐ Lt	☐ Rt ☐ Lt	☐ Rt ☐ Lt	☐ Rt ☐ Lt
	Absent	☐ Rt ☐ Lt	☐ Rt ☐ Lt	☐ Rt ☐ Lt	☐ Rt ☐ Lt

Chest Pain: ☐ No ☐ Yes Describe:_____

Pacemaker: ☐ Yes ☐ No

Edema: ☐ absent ☐ present

NEUROLOGICAL

LOC: ☑ Alert ☐ Oriented ☐ Responds to voice ☐ Responds to pain ☐ Unresponsive

Speech: ☐ Clear ☐ Slurred ☐ Aphasic Other_____

Activity Level: ☐ Sitting/Lying still ☐ Sleeping ☐ Fidgeting ☐ Pacing

Verbal Response: ☑ Speaks calmly ☐ Speaks in phrases ☐ Raises voice ☐ Shouting/Screaming ☐ Whispers/Moans

Facial Expression: ☐ Relaxed ☐ Grimace ☐ Crying ☐ Smiling ☐ Anxious

INTEGUMENTARY

Skin: ☑ warm ☐ dry ☐ cool ☐ pale ☐ clammy ☐ diaphoretic ☐ flushed ☐ mottled ☐ cyanotic ☐ jaundiced ☐ pink

If injury, ☐ unintentional ☐ intentional by:_____ Previous Injury by same person? ☐ Yes ☐ No

Document injury - Description on rear

EENT

☑ Not Applicable

Eyes: ☐ contact lenses ☐ glasses ☐ foreign body ☐ cataracts ☐ mucous membranes moist/dry

☐ injury:_____

Ears/Nose/Throat/Mouth_____

☐ **Dentures** ☐ **Glasses** ☐ **Contacts** ☐ **Disposition**_____

GENITOURINARY

☑ Not Applicable

Urine: ☐ clear ☐ color_____ ☐ cloudy ☐ hematuria ☐ incontinent ☐ other_____

Comments:_____

GASTROINTESTINAL

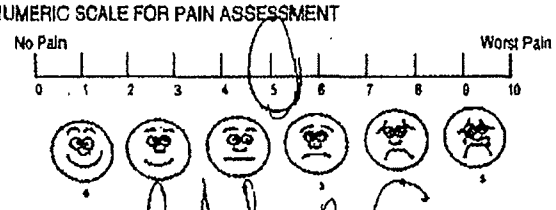
☑ Not Applicable

☐ Nausea ☐ Vomiting Emesis Color_____ ☐ Diarrhea ☐ Constipation

Abdomen: ☐ Soft ☐ Tender ☐ Distended ☐ Stool Present ☐ Color_____

Bowel Sounds: ☐ Present ☐ Absent Comments:_____

NUMERIC SCALE FOR PAIN ASSESSMENT



RN Signature:_____

ADDRESSOGRAPH

E.D. NURSING ASSESSMENT RECORD

630.64 (Rev. 6/00)

10 – 149 –

Aiken Regional Medical Centers

Emergency Services

GENERAL INSTRUCTIONS:

- ☐ Call the next business day and make an appointment to see: _____
  Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: _____ days or less or 5-7 days or less if still ill.
- ☐ Have your blood pressure checked at _____ within _____ days.
- ☐ Return to the Emergency Department after 12:30 p.m. in _____ days for suture removal or re-check.
- ☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.
- ☐ Work / school excuse from 1-25-01 thru 1-26-01.
- ☐ See your company doctor per your company's policy. Light duty until _____.
  (No use of _____ No lifting over _____ lbs.)
- ☐ Ibuprofen 800 mg
  • Splint x 6 weeks.

Your diagnosis was: knee + knee Contusion/Strain

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☑ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

* Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diptheria booster***

Other (on computer)
- ☐ _____
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave If you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X-Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my folowup physician.
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Departme

CLONINGER
Physician

Staff

1-25-01
Date

Patient or Responsible Person

630.06 WHITE - MEDICAL RECORDS C/ – 150 – r PINK - EMERGENCY DEPARTMENT FORM 10-2

AIKEN REGIONAL MEDICAL CENTERS RADIOLOGICAL CONSULTATION

PT NAME: LEE, BERNARD VT: ER SEQ:179
ROOM #: EC4
BILLING#: 0014924575
DOB: 04/30/80
DATE DONE: 01/25/01 XRAY#: 962389
SSN: 251-45-2204 MEDREC#: 177273
SEX: M
REASON:INJURY
REF PHYS: CAMERON MAILE
PRI PHYS: EMERGENCY DEPT

PROCEDURE#1: KNEE 3V LT CPT#1: 73562LT
PROCEDURE#2: CPT#2:
PROCEDURE#3: CPT#3:
.Confidential - if not intended for you, call.....(803) 641 5060.....
Mail Report to :
CAMERON MAILE AIKEN ER , SC

LEFT KNEE:

No evidence of fracture, dislocation, or subluxation.

IMPRESSION:
NORMAL RADIOGRAPHIC ASSESSMENT OF THE LEFT KNEE.

ER 1.

DICTATED BY: G. PAUL FORSYTH, M.D.

DATE DICTATED 01/25/01

PT NAME: LEE, BERNARD
ROOM#: EC4
DATE REQUESTED: 01/25/01
DATE TRANSCRIBED: 01/26/01
TRANSCRIBED BY: BANICKN

G. PAUL FORSYTH, M.D.
PRELIMINARY UNLESS SIGNED

AIKEN REGIONAL MEDICAL CENTERS RADIOLOGICAL CONSULTATION

PT NAME: LEE, BERNARD VT: ER SEQ:180
ROOM #: EC4
BILLING#: 0014924575
DOB: 04/30/80
DATE DONE: 01/25/01 XRAY#: 962389
SSN: 251-45-2204 MEDREC#: 177273
SEX: M
REASON:INJURY
REF PHYS: CAMERON MAILE
PRI PHYS: EMERGENCY DEPT

PROCEDURE#1: HAND 3V RT CPT#1: 73130RT
PROCEDURE#2: CPT#2:
PROCEDURE#3: CPT#3:
.Confidential - if not intended for you, call.....(803) 641 5060.....
Mail Report to :
CAMERON MAILE AIKEN ER , SC

RIGHT HAND:

Plain film assessment of the right hand demonstrates no evidence of fracture, dislocation, or subluxation.

IMPRESSION:
NORMAL RADIOGRAPHIC ASSESSMENT OF THE RIGHT HAND.

DICTATED BY: G. PAUL FORSYTH, M.D.

DATE DICTATED 01/25/01

PT NAME: LEE, BERNARD
ROOM#: EC4
DATE REQUESTED: 01/25/01
DATE TRANSCRIBED: 01/26/01
TRANSCRIBED BY: BANICKN

G. PAUL FORSYTH, M.D.
PRELIMINARY UNLESS SIGNED

Check ☐ if normal Check ○ if abnormal
(If not Checked then not applicable)

302 University Parkway
Aiken, SC 29801

ED Physician Record

Neck: ☑ All Neg/NL ☐ ○ Supple ☐ ○ Palpation ☐ ○ JVD ☐ ○ Trachea ☐ ○ Thyroid
Abn Findings:

Chest: ☑ All Neg/NL ☐ ○ Symmetry ☐ ○ Excursion ☐ ○ Palpation
Abn Findings:

Cardio: ☑ All Neg/NL ☐ ○ Palpation ☐ ○ R & R ☐ ○ Heart sounds
Abn Findings:

Respir: ☑ All Neg/NL ☐ ○ Respir effort ☐ ○ Palpation ☐ ○ Lung sounds
Abn Findings:

Abdom: ☑ All Neg/NL ☐ ○ Palpation ☐ ○ Liver ☐ ○ Spleen ☐ ○ Bowel Sounds
Abn Findings:

MS: ☐ All Neg/NL ☑ ○ Gait ☑ ○ Head ☑ ○ Neck ☐ ○ Spine ☐ ○ Back ☑ ○ Ribs ☑ ○ Pelvis ☑ ○ Digits ☐ ⊘ RUE ☐ ○ LUE ☑ ○ RLE ☐ ⊘ LLE ☑ ○ ROM
Abn Findings: (L)knee - Pain with patellar extension medial joint.

Skin: ☐ All Neg/NL ☐ ○ Temp ☐ ○ Appear ☐ ○ Color ☐ ○ Texture full thickness
Abn Findings: (R)hand - Partial

Neuro: ☐ All Neg/NL ☐ ○ CNS ☐ ○ Sensation ☐ ○ Mus. Strength
Abn Findings: transverse + 2nd MC, ulnar

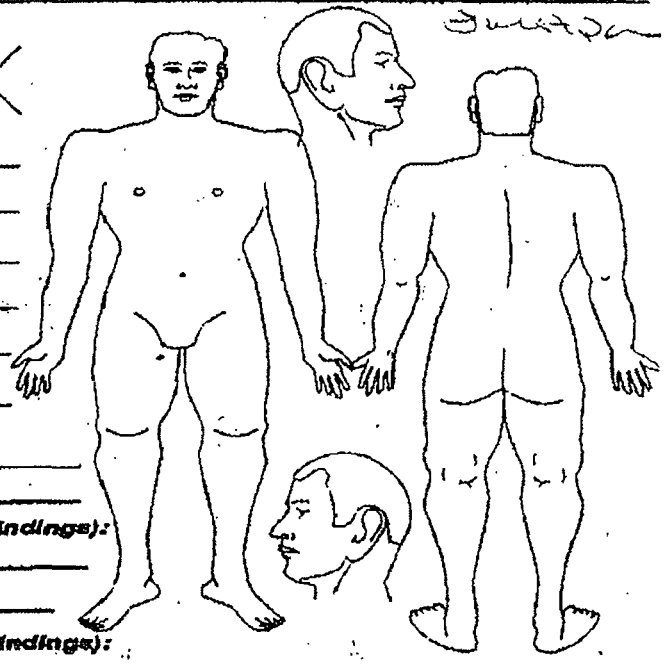
Medical Decision Making and Pos results:

Lab results:

C-spine results:

Other X-ray results: (L)knee Neg
(R)hand Neg

☐ Procedures / Misc:



☐ Laceration/s: (# lac, use diagrams if needed)
☐ Anes Lidocaine/Epi ☐ Anes Lidocaine ☐ Other
☐ All Pos ○ ☐ Wound Anesthetized ○ ☐ Thoroughly Explored ○ ☐ Thoroughly Cleansed
Neg Findings(Lac/s # & findings):

☐ All Neg/NL ☐ ○ Major Vessel injury ☐ ○ Major Tendon injury ☐ ○ Fracture noted ☐ ○ Foreign Body
Pos Findings(Lac/s # & findings):

Consult/s: Referral/s: Ortho

Medications/Rx: Naproxen

Diagnosis: (L)knee & (R)hand Contusion

Disposition: home

Physician Signature: Channing

Time: Date: 1-25-01

Name:
Addressograph

PLACE TOP OF REPORT #3 HERE

HORIZONTAL

PLACE TOP OF REPORT #2 HERE

SOUTH CAROLINA EMERGENCY MEDICINE SPECIALISTS, P.A.

Marc Davis - SC#15906 - DEA BD2084402
C. Staggs - SC#14516 - DEA BS1978355
S. Platte - SC#20087 - DEA BP5052509
L. Simms - PA-C - SC#A566EM

S.Grant - SC#15672 - DEA BG2720793
M. James - SC#14208 - DEA BJ1588384
C. Malle - SC#18899 - DEA BM4528280

C. Lord, PA-C - SC#A512EM
E. Yoh - SC#20098 - DEA BY4915673
D. Weddle - SC#20749 - DEA BW4632508

302 University Pkwy. Aiken, South Carolina 29801 Phone 641-5000

For [illegible] Age

Address Date 1-25-01

℞

Please dispense 30 Medications • NO REFILLS • prefers / does not prefer generic substitute

Dispense as Written M.D. Substitution Permitted M.D.

Form No. 632.02 (5/00)

10-2046

710.12

10-1988

Aiken Regional
MEDICAL CENTERS

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29802

The Health Choice

PATIENT NAME: Lee Bernard Lee DATE OF SERVICE/ADMISSION 01/25/01

CONSENT FOR TREATMENT, GUARANTY OF PAYMENT AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION, AND ASSOCIATED NOTICES AND AUTHORIZATION.

NOTICE TO PATIENT AND ALL SIGNATORIES OF THIS DOCUMENT: By your signature below, each signatory of this document is agreeing to be jointly and severally bound by all of the terms and conditions hereinafter set forth unless otherwise noted. In consideration of the hospital care and treatment to be rendered to Patient by Hospital, the undersigned agree and consent to the following:

1. Consent and Conditions of Admission: The undersigned hereby agrees and gives consent to Hospital for the admission/treatment/testing of Patient. The undersigned hereby consents to any and all hospital care encompassing: X-Ray examination, laboratory procedures, diagnostic procedures, anesthesia and nursing or medical/surgical treatment which Patient's physician, his associates, partners or designees, may deem necessary or advisable under the general and special instructions of the same, during Patient's hospitalization.

2. Medical and Surgical Treatment: The undersigned agrees and understands that all physicians, dentists and or oral surgeons treating Patient are responsible and liable for their own acts or omissions and the Hospital is not responsible or liable for the acts omissions of the aforementioned. The undersigned is aware that the practice of medicine is not an exact science and further state that no guarantee has been made or can be made as to the results of the treatments or examinations i the Hospital.

The undersigned certifies that they have read all of this document, including the reverse side hereof, and that the undersigned is the Patient, or is duly authorized by the Patient or by law, to execute the above Agreement and understands its terms.

All Patients shall receive treatment or service within the hospital's capability and policies. Our hospital is committed to patient's impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care..

3. Assignment of Insurance Benefits and Release of Medical Information: The undersigned hereby assign to Hospital, its successors and assigns, all benefits that may be payable to or on behalf of the Patient under any policy of insurance, (hospitalization, major medical, automobile, workmen's compensation, personal inju benefits available because of liability of a third party, or any other) and authorize Hospital to release specifically requested medical information related to Patient t include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assaults, tests for HIV, ARC and/or AIDS or other infectious diseases necessary for settlement of benefit payment or money payable because of Patient's hospitalization, treatment or injury during this encounter. The undersigned further direct that the payer of any such payment make such payment directly to Hospital. In addition, the undersigned assign to Hospital, its successors and assigns, the proceeds of injury claim resulting from liability to Patient of a third party. Any payments to Hospital under authority of this Assignment shall not exceed the actual charges set forth in Hospital's billing statements issued in connection with Patient's account.

If Patient is eligible for Medicare, the undersigned requests Medicare services and benefits. The undersigned further agree that this Assignment will not be withdrawn or voided at any time until Patient's account is paid in full. The undersigned acknowledge that it is their responsibility to pay Hospital for any charge not covered by insurance. Further, undersigned agree and understand that if the Patient, or his duly authorized representative, requests a private room for the Patient the undersigned is responsible for the entire room difference.

The undersigned hereby authorize any agency or employee of the U.S., any State or Municipal Government to release to the Hospital, its employee, employees and/or its attorney, any and all information concerning governmental programs under which the above named Patient is or may be qualified to receive benefits c and further authorize payment of any and all such benefits direct to Hospital.

The insured whose signature appears in this item one (1), hereby represents to the Hospital that the following insurance policies are the only insurance policies offering coverage to the patient in this matter and hereby assigns to Hospital all benefits payable to or on behalf of Patient thereunder:

Written authorization for HMO/PPO plans: I understand that if my insurance carrier, HMO plan or PPO network requires preauthorization, the Hospital/Provider/Physician is unable to guarantee that my visit will be covered without a written authorization for the services rendered to me or my family members. If the Hospital/Provider/Physician is unable to obtain authorization for my visit, I will be responsible for any unpaid balance. I will be financially responsible for those charges that coincide with any service/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the Hospit accepts no liability for failure to meet any pre/post certification procedures which may be required of me by my coverage carrier. I agree that any such procedu have been or will be properly executed by me.

Primary Insurance Co. [signature]

Patient [signature]

Insured _____

Secondary Insurance Co. _____

Patient _____

Insured _____

Addressograph

PHYSICIAN'S NOT AS EMPLOYEES: I acknowledge that all physicians furnishing services including but not limited to radiologists, pathologists, anesthesiologists, emergency department physicians, consultants and assistants to the physician are not employees of the Hospital. I understand that I may receive separate billing from each of these providers for services rendered.

2. Guaranty of Payment: The undersigned jointly and severally agree to be bound to Hospital for payment and absolutely guarantee payment to Hospital on demand of all charges now or hereafter incurred for goods and services furnished by Hospital to Patient in connection with Patient's treatment and/or stay at Hospital. This is a continuing guarantee of payment on demand of the entire unpaid balance of charges incurred during the period from the date of service or admission above until Patient is discharged and includes guarantee of payment of outpatient charges for services rendered on the date noted above and any follow up outpatient charges. Such charges shall be in accordance with the regular rates and charges of the Hospital in effect at the time of the rendering of the service or the furnishing of the goods for which the charge is incurred.

Should Patient's account be turned over to any attorney for collection or legal proceedings of any kind, the undersigned jointly and severally, absolutely guarantee payment to Hospital of all costs and expenses incurred by Hospital in connection with such collection action and/or legal proceeding, including a reasonable attorney's fee not to exceed fifteen (15) percent of the unpaid balance due.

The undersigned also agrees that any over payments collected in connection with any particular admission or outpatient treatment of Patient may be applied directly to a delinquent account of Patient or any delinquent account for which Patient or any undersigned is legally responsible at the time of collection of the over payment.

Hospital may make a Repayment Agreement with any one or more of the undersigned, which Agreement shall be considered ancillary to and not in lieu of this Agreement and shall not be construed as limiting or modifying the liability of any other signatory to this Agreement.

Patient signatories, Spouse of Patient signatories, Guarantor signatories, and Parent of minor patient signatories are jointly and severally bound by all the terms hereof including liability for payment to Hospital under this Guaranty of Payment agreement.

3. **Assignment of Physician Benefits:** In the event that Patient, in addition to Hospital benefits, is entitled to any physician benefits of any type whatsoever arising out of policy of insurance insuring Patient or any other parties liability to Patient, the undersigned Hereby assign said benefits to any physician rendering care or treatment during the stay associated with this admission or any outpatient visits, to be applied to Patient bill.

5. **Medicare Patient Certification:** The undersigned certify that the information given by the undersigned in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carries any information needed for a Medicare claim related to patient. The undersigned authorize and direct that a copy of this Authorization may be used in place of the original and request payment of authorized benefits be made on behalf of the Patient.

7. **Personal Valuables and Belongings:** The undersigned acknowledge and agree that the Hospital maintains a safe for the safekeeping of valuables. The Hospital shall not be held responsible or liable for the loss or damage to any articles of personal property while Patient is hospitalized unless said articles are deposited with the Hospital in the safe and receipts are issued describing said items. If the patient is unable to sign and in the event no relative is present, the Hospital shall retain possession of valuables and obtain acknowledgement at the first available opportunity.

8. **Cameras and Surveillance Equipment:** Patient has been advised that Aiken Regional Medical Centers uses cameras and other surveillance equipment to monitor patient/employees activities. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment.

9. You have the right to file a grievance regarding concerns with our quality. The agency you may contact is:
Department of Health and Environmental Control (DHEC) Licensing Division
2600 Bull Street
Columbia, South Carolina 29202
803-737-7570

10. Smoking is prohibited except in certain areas. Please discuss any special needs with your physician.

11. I acknowledge that laboratory studies may be performed in the event a health care worker is exposed to my blood or body fluid.

I, the undersigned, state that the information that I have provided Aiken Regional Medical Centers is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by signing it, I am agreeing to it.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
ORIGINAL SIGNATURE ON FILE AT AIKEN REGIONAL MEDICAL CENTERS.

Date / Time

Patient/Parent/Guardian
Relationship to Patient

Witness

Witness

Address

City State Zip

☐ No ID
☐ No Insurance Card
☐ Address Correct on ID

Reason Patient Did Not Sign

☐ Patient was given the option to dispose valuables in safe.

TELEPHONE CONSENT	Patient Name
Witness	Obtained From / Relationship
Witness	Phone # / Date/Time

Aiken Regional
MEDICAL CENTERS
The Health Choice

202 University Parkway, Aiken, SC 29801

MED. REC. NO. 177273

PT NO 15775489	PATIENT NAME LEE , BERNARD D										COUNTY 2
ADDRESS 172 OLD INDIAN CHEROKEE RD											
CITY GRANITEVILLE	STATE SC	ZIP 29829-0000	PHONE 803-663-0560	EXT.	SOCIAL SECURITY NO. 251-45-2204						
AGE 21	DOB 04/30/1980	SEX M	RACE 2	MS S	PREVIOUS NAME			RELIGION BAP	N/S	RM/BED	
ADM DATE 10/07/01	TIME 18:04	SRC EO	PT TYPE T	PRI S	ACCIDENT INFO E 10/07/01 17:30	VOLUNTARY ADM	ORGAN DNR	ISOL	INFANT AGE		
PT EMPLOYER AUGUSTA REGIONAL					TELEPHONE 706-792-7095	EXT	OCCUPATION TRANSPORTATION				
EMPLOYER ADDRESS CIRCLE ST											
CITY AUGUSTA	STATE GA	ZIP 30906-	RETIREMENT DATE								
NEAREST RELATIVE NAME LEE , VIRGINIA											
RLTN B	ADDRESS NA										
CITY CLEARWATER	STATE SC	ZIP 29822-	PHONE 803-593-9792	EXT							
EMERGENCY CONTACT NAME LEE , MARIE											
RLTN N	ADDRESS 172 OLD INDIAN CHEROKEE RD										
CITY GRANITEVILLE	STATE SC	ZIP 29829-	PHONE 803-663-0560	EXT							
GUARANTOR NAME LEE , BERNARD D								RLTN S	SOCIAL SECURITY NUMBER 251-45-2204		
ADDRESS 172 OLD INDIAN CHEROKEE RD									PHONE 803-593-9792		
CITY GRANITEVILLE	STATE SC	ZIP 29829-	OCCUPATION TRANSPORTATION						EXT		
GUARANTOR EMPLOYER AUGUSTA REGIONAL			PHONE 706-792-7095	EXT							
ADDRESS CIRCLE ST											
CITY AUGUSTA	STATE GA	ZIP 30906-								FC B	
INSURANCE NAME 1 BLUE CROSS OUT OF STB	CODE	POLICY # 50251452204	GROUP # 49600	SUBSCRIBER LEE , BERNA S	REL	AUTH #					
INSURANCE NAME 2	CODE	POLICY #	GROUP #	SUBSCRIBER	REL	AUTH #					
INSURANCE NAME 3	CODE	POLICY #	GROUP #	SUBSCRIBER	REL	AUTH #					
ATTENDING PHYSICIAN SCEMS D	ATTENDING # 044198	REF SRC	ADM BY NETTLN	PREV ADM DATE	PREVIOUS FACILITY						
ADM DIAGNOSIS CC/LAC ARM	MED SVC EMX	CODE	ALLERGIES NKDA	SURGERY DATE							
ADMITTING PHYSICIAN SCEMS D	ADMITTING # 044198	AUTHORIZED BY									
PROCEDURE	CLINICAL COMMENT	MODE OF ARRIVAL/ACCOMPANIED BY AMB									
BEL OF MED	ADV DIR	LIVING WILL	LOCATION OF WILL/DIRECTIVE	FAMILY DOCTOR							

FINAL DIAGNOSES (FIRST DIAGNOSIS PRINCIPAL UNLESS NOTED) CODE

PROCEDURES

CONSULTING PHYSICIANS

DRG

LOS

TRANS TO: ACUTE SNF ☐ REHAB ☐ HOSPICE ☐ HOME HEALTH ☐ HOME IV ☐ AGAINST MED ADV ☐ HOME ☐

DISCHARGE DATE	TIME	OTHER

EXPIRED ☐ TIME _____ <48HRS ☐ >48HRS ☐ CORONER ☐ AUTOPSY YES ☐ NO ☐

ATTENDING PHYSICIAN SIGNATURE & DATE

RxLASER, INC. C2488-20051 (714) 986-1559 (2/99)

CHART COPY - DO NOT REMOVE FROM CHART

INITIALS INITIALS

INITIAL ASSESSMENT Cut @ forearm Level 3
on glass ~2cm lac noted c bleeding
controlled ~10min PTA c Dad Brackin

ESSOGRAPH

NAME Brand Lee RACE/SEX BM AGE 21 PRESENT MEDICATIONS none TRIAGE NURSE

NURSE'S NOTES 1824 pt to room #4.
Hx as per MD NT
1905 Tetanus 0.5 ml
in @ deltoid Manley rn

PMD none

TRIAGE CLASS ☐ EMERGENT ☐ URGENT ☐ NON URGENT

MODE OF ARRIVAL ☑ AMBULATORY ☐ WHEELCHAIR ☐ CARRIED ☐ STRETCHER ☐ PERSON ACCOMPANIED PATIENT ☐ EMS ☐ POV ☐ PER SELF

BIRTH WEIGHT

WEIGHT 175#

CONDITION ON ARRIVAL ☑ GOOD ☐ FAIR ☐ POOR ☑ CONSCIOUS ☐ UNCONSCIOUS

LMP

EDC

	TIME	P	R	BP
1st	1808	99	15	120/85

G P AB

TRIAGE TIME 1808

TIME IN ROOM 1824

ER ROOM NO. 4

AUGUSTA DATA STORAGE INC
F0000124128

CRITICAL CARE FLOWSHEET INITIATED ☐

NURSE'S SIGNATURE

DOCTOR'S ASSESSMENT 21 yo m c/o RA
VSS NAD

(R) Forearm 3.5cm lac
Visualized base of wound
Procedure
Betadine/Sterile H2O
Hash c Betadine/Sterile H2O
Anesthetize c 5cc 1% Lido
Irrigate c 500cc NS
Closed c 5-0 nylon 9
PO Rx Abx

881.00 E920.8 E849.9 86.59 12002

DISCHARGE DIAGNOSIS

3.5cm LAC (R) forearm

CODES

LABS AND OTHER CHARGES	ORD	INIT
CBC c diff		
CHEM 7		
CMP		
AMYLASE		
LIPASE		
PT/PTT		
TROPONIN		
MYOGLOBIN		
LIVER PANEL		
ALCOHOL		
TYPE + CROSS UNITS		
TYPE & SCREEN		
TYPE & Rh		
BLOOD CULT X		
CCUA		
CATHUA		
URINE C & S		
FINGER STICK GLUCOSE		
HCG QUANT.		
URINE DRUG SCR		
EKG's		
ER ABG		
PA/LAT CXR		
P CXR		
C-SPINE		
L-SPINE		
ACUTE ABD		
HEMOCULT		
OLD RECORDS		
OLD ED DICT.		

PULSE OX

ALLERGIES NKDA

LAST TETANUS Unsure

PHYSICIAN'S ORDERS

1. Lac tray
2. Betadine
3. Lidocaine
4.
5. Tetanus 0.5cc
6. Lac kit WOS16 AM
7. exp. 19 Jun 03
8. 1905 Manley
9.
10.
11.
12.
13.
14.
15.
16.
17.
18.
19.
20.
21.
22.
23.

DISCHARGE STATUS
DATE 10/7/01 TIME 1910
☑ ROUTINE (HOME) ☐ AMA
☐ ADMIT TO PHYSICIAN
☐ TRANSFERRED TO:
ACCEPTING PHYSICIAN
TRANSFER FORMS COMPLETED RECORDS & PATIENT

EXPIRED
☐ IN E.R. ☐ CORONER'S CASE
☐ DOA ☐ AUTOPSY

CONDITION ON DISCHARGE
☐ STABLE
☐ UNSTABLE
EMERGENCY MEDICAL CONDITION OR PREGNANCY WITH CONTRACTIONS PRESENT.

METHOD OF DISCHARGE
☑ AMBULATORY ☐ AMBULANCE
☐ WHEELCHAIR ☐ STRETCHER
☐ CARRIED ☐ OTHER

ACCOMPANIED BY
☑ SELF ☐ RELATIVE ☐ POLICE
☐ OTHER ☐ FRIEND
EXPLAIN:

METHOD INSTRUCTIONS
☑ VERBAL ☑ WRITTEN
☐ NOT GIVEN (why)
☑ PT VERBALIZES UNDERSTANDING

NAME OF PHYSICIAN THAT ADMITTED PATIENT

TIME MD IN TO SEE PT. 1910

PHYSICIAN'S SIGNATURE

DATE 10/7/01

DISCHARGE NURSE

DATE

URINE PREG ☐ NEGATIVE ☐ POSITIVE ☐ INDETERMINANT

-158-

331

Aiken Regional Medical Centers

Emergency Services

GENERAL INSTRUCTIONS:

☒ Call the next business day and make an appointment to see: PMP

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: 7 days or less or _____ days or less if still ill. or Return to ED

☐ Have your blood pressure checked at _____ within _____ days.

☒ Return to the Emergency Department after 12:30 p.m. in 10 days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☐ Work / school excuse from _____ thru _____.

☐ See your company doctor per your company's policy. Light duty until _____.

(No use of _____ No lifting over _____ lbs.)

☐ _____

_____

_____

Your diagnosis was: 3.5 cm LAC (R) Forearm

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

* Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diptheria booster***
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave If you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X-Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physician.
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physicium for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Department.

_____ *Physician*

_____ *Staff*

10/7/01 *Date*

_____ *Patient or Responsible Person*

630.06 WHITE - MEDICAL RECORDS -159- PINK - EMERGENCY DEPARTMENT FORM 10-2183 3/99

AIKEN REGIONAL MEDICAL CENTERS

302 University Parkway • Aiken, South Carolina 29802

PHYSICAL ASSESSMENT: **TIME PERFORMED** 1800

PULMONARY

Respirations: ☑ even ☑ nonlabored ☐ labored ☐ use of accessory muscles ☐ other* Smoker ☐ Yes ☐ No ☐ Former Smoker

Breath Sounds: ☐ bilateral ☐ clear ☐ labored ☐ diminished ☐ absent* ☐ crackles ☐ wheezes ☐ rhonc

*describe:

Airway: ☐ oral ☐ nasal ☑ self maintained

Cough: ☐ productive ☐ non-productive ☐ Describe secretions:

CARDIOVASCULAR

Capillary refill: ☐ brisk ☐ sluggish

Pulses:

		RADIAL:	FEMORAL:	PEDAL:	
Palpable		☐ Rt ☐ Lt	☐ Rt ☐ Lt	☐ Post Tibial	☐ Dorsal
Doppler		☐ Rt ☐ Lt	☐ Rt ☐ Lt	☐ Rt ☐ Lt	☐ Rt ☐ Lt
Absent		☐ Rt ☐ Lt	☐ Rt ☐ Lt	☐ Rt ☐ Lt	☐ Rt ☐ Lt

Chest Pain: ☑ No ☐ Yes Describe:

Pacemaker: ☐ Yes ☐ No

Edema: ☐ absent ☐ present

NEUROLOGICAL

LOC: ☑ Alert ☑ Oriented ☐ Responds to voice ☐ Responds to pain ☐ Unresponsive

Speech: ☑ Clear ☐ Slurred ☐ Aphasic Other

Activity Level: ☑ Sitting/Lying still ☐ Sleeping ☐ Fidgeting ☐ Pacing

Verbal Response: ☑ Speaks calmly ☐ Speaks in phrases ☐ Raises voice ☐ Shouting/Screaming ☐ Whispers/Moans

Facial Expression: ☑ Relaxed ☐ Grimace ☐ Crying ☐ Smiling ☐ Anxious

INTEGUMENTARY

Skin: ☑ warm ☑ dry ☐ cool ☐ pale ☐ clammy ☐ diaphoretic ☐ flushed ☐ mottled ☐ cyanotic ☐ jaundiced ☐ p

If injury, ☐ unintentional ☐ intentional by: Previous Injury by same person? ☐ Yes ☐ No

Document injury - Description on rear ~5cm lac to (R) fore

EENT

☑ Not Applicable

Eyes: ☐ contact lenses ☐ glasses ☐ foreign body ☐ cataracts ☐ mucous membranes moist/dry ☐ injury:

Ears/Nose/Throat/Mouth

☐ **Dentures** ☐ **Glasses** ☐ **Contacts** ☐ **Disposition**

GENITOURINARY

☑ Not Applicable

Urine: ☐ clear ☐ color ☐ cloudy ☐ hematuria ☐ incontinent ☐ other

Comments:

GASTROINTESTINAL

☑ Not Applicable

☐ Nausea ☐ Vomiting Emesis Color ☐ Diarrhea ☐ Constipation

Abdomen: ☐ Soft ☐ Tender ☐ Distended ☐ Stool Present ☐ Color

Bowel Sounds: ☐ Present ☐ Absent Comments:

NUMERIC SCALE FOR PAIN ASSESSMENT

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain



RN Signature:

ADDRESSOGRAPH

Bernard, Lee

E.D. NURSING ASSESSMENT RECORD

630.64 (Rev. 3/01)

Aiken Regional
MEDICAL CENTERS

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29802

The Health Choice

PATIENT NAME: Bernard Lee DATE OF SERVICE/ADMISSION 10/7/01

CONSENT FOR TREATMENT, GUARANTY OF PAYMENT AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION, AND ASSOCIATED NOTICES AND AUTHORIZATION.

NOTICE TO PATIENT AND ALL SIGNATORIES OF THIS DOCUMENT: By your signature below, each signatory of this document is agreeing to be jointly and severally bound by all of the terms and conditions hereinafter set forth unless otherwise noted. In consideration of the hospital care and treatment to be rendered to Patient by Hospital, the undersigned agree and consent to the following:

1. Consent and Conditions of Admission: The undersigned hereby agrees and gives consent to Hospital for the admission/treatment/testing of Patient. The undersigned hereby consents to any and all hospital care encompassing: X-Ray examination, laboratory procedures, diagnostic procedures, anesthesia and nursing or medical/surgical treatment which Patient's physician, his associates, partners or designees, may deem necessary or advisable under the general and special instructions of the same, during Patient's hospitalization.

2. Medical and Surgical Treatment: The undersigned agrees and understands that all physicians, dentists and or oral surgeons treating Patient are responsible and liable for their own acts or omissions and the Hospital is not responsible or liable for the acts omissions of the aforementioned. The undersigned is aware that the practice of medicine is not an exact science and further state that no guarantee has been made or can be made as to the results of the treatments or examinations the Hospital.

The undersigned certifies that they have read all of this document, including the reverse side hereof, and that the undersigned is the Patient, or is duly authorized by the Patient or by law, to execute the above Agreement and understands its terms.

All Patients shall receive treatment or service within the hospital's capability and policies. Our hospital is committed to patient's impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care..

3. Assignment of Insurance Benefits and Release of Medical Information: The undersigned hereby assign to Hospital, its successors and assigns, all benefits that may be payable to or on behalf of the Patient under any policy of insurance, (hospitalization, major medical, automobile, workmen's compensation, personal injury benefits available because of liability of a third party, or any other) and authorize Hospital to release specifically requested medical information related to Patient include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assaults, tests for HIV, ARC and/or AID or other infectious diseases necessary for settlement of benefit payment or money payable because of Patient's hospitalization, treatment or injury during this encounter. The undersigned further direct that the payer of any such payment make such payment directly to Hospital. In addition, the undersigned assign to Hospital, its successors and assigns, the proceeds of injury claim resulting from liability to Patient of a third party. Any payments to Hospital under authority of this Assignment shall not exceed the actual charges set forth in Hospital's billing statements issued in connection with Patient's account.

If Patient is eligible for Medicare, the undersigned requests Medicare services and benefits. The undersigned further agree that this Assignment will not be withdrawn or voided at any time until Patient's account is paid in full. The undersigned acknowledge that it is their responsibility to pay Hospital for any charg not covered by insurance. Further, undersigned agree and understand that if the Patient, or his duly authorized representative, requests a private room for the Patient the undersigned is responsible for the entire room difference.

The undersigned hereby authorize any agency or employee of the U.S., any State or Municipal Government to release to the Hospital, its employee, employees and/or its attorney, any and all information concerning governmental programs under which the above named Patient is or may be qualified to receive benefits and further authorize payment of any and all such benefits direct to Hospital.

The insured whose signature appears in this item one (1), hereby represents to the Hospital that the following insurance policies are the only insurance policies offering coverage to the patient in this matter and hereby assigns to Hospital all benefits payable to or on behalf of Patient thereunder:

Written authorization for HMO/PPO plans: I understand that if my insurance carrier, HMO plan or PPO network requires preauthorization, the Hospital/Provider/Physician is unable to guarantee that my visit will be covered without a written authorization for the services rendered to me or my family members. If the Hospital/Provider/Physician is unable to obtain authorization for my visit, I will be responsible for any unpaid balance. I will be financially responsible for those charges that coincide with any service/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the Hospit accepts no liability for failure to meet any pre/post certification procedures which may be required of me by my coverage carrier. I agree that any such procedu have been or will be properly executed by me.

Primary Insurance Co. State Benefit Plan

Patient Bernard Lee

Insured

Secondary Insurance Co.

Patient

Insured

Addressograph

PHYSICIANS NOT AS EMPLOYEES: I acknowledge that all physicians furnishing services including but not limited to radiologists, pathologists, anesthesiologists, emergency department physicians, consultants and assistants to the physician are not employees of the Hospital. I understand that I may receive separate billing from each of these providers for services rendered.

. Guaranty of Payment: The undersigned jointly and severally agree to be bound to Hospital for payment and absolutely guarantee payment to Hospital on d of all charges now or hereafter incurred for goods and services furnished by Hospital to Patient in connection with Patient's treatment and/or stay at . This is a continuing guarantee of payment on demand of the entire unpaid balance of charges incurred during the period from the date of service or b on above until Patient is discharged and includes guarantee of payment of outpatient charges for services rendered on the date noted above and any follow-p outpatient charges. Such charges shall be in accordance with the regular rates and charges of the Hospital in effect at the time of the rendering of the service or e furnishing of the goods for which the charge is incurred

hould Patient's account be turned over to any attorney for collection or legal proceedings of any kind, the undersigned jointly and severally absolutely guarantee ayment to Hospital of all costs and expenses incurred by Hospital in connection with such collection action and/or legal proceeding, including a reasonable torney's fee not to exceed fifteen (15) percent of the unpaid balance due.

he undersigned also agrees that any over payments collected in connection with any particular admission or outpatient treatment of Patient may be applied ectly to a delinquent account of Patient or any delinquent account for which Patient or any undersigned is legally responsible at the time of collection of the over ayment.

Hospital may make a Repayment Agreement with any one or more of the undersigned, which Agreement shall be considered ancillary to and not in lieu of this greement and shall not be construed as limiting or modifying the liability of any other signatory to this Agreement

atient signatories, Spouse of Patient signatories, Guarantor signatories, and Parent of minor patient signatories are jointly and severally bound by all the terms ereof including liability for payment to Hospital under this Guaranty of Payment agreement.

. Assignment of Physician Benefits: In the event that Patient, in addition to Hospital benefits, is entitled to any physician benefits of any type whatsoever arising ut of policy of insurance insuring Patient or any other parties liability to Patient, the undersigned hereby assign said benefits to any physician rendering care or eatment during the stay associated with this admission or any outpatient visits, to be applied to Patient bill

. Medicare Patient Certification: The undersigned certify that the information given by the undersigned in applying for payment under Title XVIII of the Social ecurity Act is correct. The undersigned authorize any holder of medical or other information about Patient to release to the Social Security Administration or its ntermediaries or carries any information needed for a Medicare claim related to patient. The undersigned authorize and direct that a copy of this Authorization ay be used in place of the original and request payment of authorized benefits be made on behalf of the Patient.

. Personal Valuables and Belongings: The undersigned acknowledge and agree that the Hospital maintains a safe for the safekeeping of valuables. The Hospital all not be held responsible or liable for the loss or damage to any articles of personal property while Patient is hospitalized unless said articles are deposited with e Hospital in the safe and receipts are issued describing said items. If the patient is unable to sign and in the event no relative is present, the Hospital shall retain ossession of valuables and obtain acknowledgement at the first available opportunity.

. as and Surveillance Equipment: Patient has been advised that Aiken Regional Medical Center uses cameras and other surveillance equipment to monitor at employees activities. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment

. You have the right to file a grievance regarding concerns with our quality. The agency you may contact is:

Department of Health and Environmental Control (DHEC) Licensing Division
2600 Bull Street
Columbia, South Carolina 29202
803/737-7370

0. Smoking is prohibited except in certain areas. Please discuss any special needs with your physician.

1. I acknowledge that laboratory studies may be performed in the event a health care worker is exposed to my blood or body fluid.

the undersigned, state that the information that I have provided Aiken Regional Medical Centers is correct to the best of my knowledge. I acknowledge by my gnature that I have read and received a copy of this statement. I understand that by signing it, I am agreeing to it.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
ORIGINAL SIGNATURE ON FILE AT AIKEN REGIONAL MEDICAL CENTERS.

10/1/01 1807
Date Time

Patient/Parent/Guardian
Relationship to Patient

Witness

Witness

☐ No ID
☐ No Insurance Card
☐ Address Correct on ID

Address

City State Zip

Reason Patient Did Not Sign

☐ Patient was given the option to deposit valuables in safe

TELEPHONE CONSENT

Witness

Patient Name

Obtained From Relationship

Phone # Date/Time

Aiken Regional
MEDICAL CENTERS
The Health Choice

202 University Parkway, Aiken, SC 29801

MED. REC NO. 177273

PT NO 14924575	PATIENT NAME LEE , BERNARD D											COUNTY 2	
ADDRESS 172 OLD INDIAN CHEROKEE RD													
CITY GRANITEVILLE			STATE SC	ZIP 29829-		PHONE 803-593-9792		EXT.		SOCIAL SECURITY NO. 251-45-2204			
AGE 20	DOB 04/30/1980	SEX M	RACE 2	MS S	PREVIOUS NAME				RELIGION BAP	N/S	RM/BED		
ADM DATE 01/25/01	TIME 13:06	SRC EO	PT TYPE T	PRI S	ACCIDENT INFO H	01/25/01 12:59		VOLUNTARY ADM	ORGAN DNR	ISOL	INFANT AGE		
PT EMPLOYER AUGUSTA REGIONAL					TELEPHONE 706-792-7095		EXT	OCCUPATION TRANSPORTATION					
EMPLOYER ADDRESS CIRCLE ST													
CITY AUGUSTA			STATE GA	ZIP 30906-				RETIREMENT DATE					
NEAREST RELATIVE NAME LEE , VIRGINIA													
RLTN B	ADDRESS NA												
CITY CLEARWATER			STATE SC	ZIP 29822-		PHONE 803-593-9792		EXT					
EMERGENCY CONTACT NAME LEE , MARIE													
RLTN N	ADDRESS 172 OLD INDIAN CHEROKEE RD												
CITY GRANITEVILLE			STATE SC	ZIP 29829-		PHONE 803-663-0560		EXT					
GUARANTOR NAME LEE , BERNARD D									RLTN S	SOCIAL SECURITY NUMBER 251-45-2204			
ADDRESS 172 OLD INDIAN CHEROKEE RD										PHONE 803-593-9792			
CITY GRANITEVILLE			STATE SC	ZIP 29829-		OCCUPATION TRANSPORTATION				EXT			
GUARANTOR EMPLOYER AUGUSTA REGIONAL						PHONE 706-792-7095		EXT					
ADDRESS CIRCLE ST													
CITY AUGUSTA			STATE GA	ZIP 30906-								FC F	
INSURANCE NAME 1 PRIVATE PAY		CODE 910	POLICY #		GROUP #		SUBSCRIBER LEE , BERNA		REL S	AUTH #			
INSURANCE NAME 2		CODE	POLICY #		GROUP #		SUBSCRIBER		REL	AUTH #			
INSURANCE NAME 3		CODE	POLICY #		GROUP #		SUBSCRIBER		REL	AUTH #			
ATTENDING PHYSICIAN SCEMS D			ATTENDING # 044198	REF SRC	ADM BY CANNOS	PREV ADM DATE		PREVIOUS FACILITY					
ADM DIAGNOSIS CC: BROKEN HAND RIGHT				MED SVC EMX	CODE	ALLERGIES NKDA						SURGERY DATE	
ADMITTING PHYSICIAN SCEMS D				ADMITTING # 044198	AUTHORIZED BY								
PROCEDURE				CLINICAL COMMENT				MODE OF ARRIVAL/ACCOMPANIED BY CAR/ FRIEND					
REL OF INFO	ADV DIR	LIVING WILL	LOCATION OF WILL/DIRECTIVE			FAMILY DOCTOR							

FINAL DIAGNOSES (FIRST DIAGNOSIS PRINCIPAL UNLESS NOTED) CODE

PROCEDURES

CONSULTING PHYSICIANS

DRG

LOS

TRANS TO:	ACUTE	SNF ☐	REHAB ☐	HOSPICE ☐	HOME HEALTH ☐	HOME IV ☐	AGAINST MED ADV ☐	HOME ☐
DISCHARGE DATE	TIME	OTHER						

EXPIRED ☐ TIME _____ <48HRS ☐ >48HRS ☐ CORONER ☐ AUTOPSY YES ☐ NO ☐

ATTENDING PHYSICIAN SIGNATURE & DATE

RxLASER, INC. C2488-2005 (714) 986-1559 (2/99) CHART COPY - 163 - T REMOVE FROM CHART

Aiken Regional
MEDICAL CENTERS
The Health Choice

202 University Parkway, Aiken, SC 29801

MED. REC. NO. 177273

PT NO: 15812423	PATIENT NAME: LEE , BERNARD D												COUNTY: 2
ADDRESS: 172 OLD INDIAN CHEROKEE RD													
CITY: GRANITEVILLE					STATE: SC	ZIP: 29829-0000	PHONE: 803-663-0560		EXT.		SOCIAL SECURITY NO: 251-45-2204		
AGE: 21	DOB: 04/30/1980	SEX: M	RACE: 2	MS: S	PREVIOUS NAME					RELIGION: BAP	NIS	RM/BED	
ADM DATE: 10/17/01	TIME: 11:06	SRC: EO	PT TYPE: T	PRI: S	ACCIDENT INFO: N	10/17/01 11:00		VOLUNTARY ADM		ORGAN DNR	ISOL	INFANT AGE	
PT EMPLOYER: AUGUSTA REGIONAL						TELEPHONE: 706-792-7073		EXT		OCCUPATION: HST SERVICE			
EMPLOYER ADDRESS: CIRCLE ST													
CITY: AUGUSTA					STATE: GA	ZIP: 30906-				RETIREMENT DATE			
NEAREST RELATIVE NAME: LEE , VIRGINIA													
RLTN: B	ADDRESS: UNK												
CITY: CLEARWATER					STATE: SC	ZIP: 29822-	PHONE: 803-663-1533		EXT				
EMERGENCY CONTACT NAME: LEE , MARIE													
RLTN: N	ADDRESS: 172 OLD INDIAN CHEROKEE RD												
CITY: GRANITEVILLE					STATE: SC	ZIP: 29829-	PHONE: 803-663-0560		EXT				
GUARANTOR NAME: LEE , BERNARD D										RLTN: S	SOCIAL SECURITY NUMBER: 251-45-2204		
ADDRESS: 172 OLD INDIAN CHEROKEE RD											PHONE: 803-663-0560		
CITY: GRANITEVILLE					STATE: SC	ZIP: 29829-	OCCUPATION: HST				EXT		
GUARANTOR EMPLOYER: AUGUSTA REGIONAL						PHONE: 706-792-7073	EXT						
ADDRESS: CIRCLE ST													
CITY: AUGUSTA					STATE: GA	ZIP: 30906-						FC: B	
INSURANCE NAME 1: BLUE CROSS OUT OF ST	CODE: 850	POLICY #: 251452204			GROUP #: 49600		SUBSCRIBER: LEE BERNA S			REL	AUTH #		
INSURANCE NAME 2	CODE	POLICY #			GROUP #		SUBSCRIBER			REL	AUTH #		
INSURANCE NAME 3	CODE	POLICY #			GROUP #		SUBSCRIBER			REL	AUTH #		
ATTENDING PHYSICIAN: WEDDLE DOUGLAS			ATTENDING #: 044644		REF SRC	ADM BY: SHACED		PREV ADM DATE		PREVIOUS FACILITY			
ADM DIAGNOSIS: STITCHES REMOVED			MED SVC: EMR		CODE	ALLERGIES: NKA					SURGERY DATE		
ADMITTING PHYSICIAN: WEDDLE DOUGLAS			ADMITTING #: 044644		AUTHORIZED BY								
PROCEDURE			CLINICAL COMMENT					MODE OF ARRIVAL/ACCOMPANIED BY					
REL OF INFO	ADV DIR	LIVING WILL	LOCATION OF WILL/DIRECTIVE			FAMILY DOCTOR							

FINAL DIAGNOSES (FIRST DIAGNOSIS PRINCIPAL UNLESS NOTED)

CODE



PROCEDURES

CONSULTING PHYSICIANS

DRG

LOS

TRANS TO:	ACUTE	SNF ☐	REHAB ☐	HOSPICE ☐	HOME HEALTH ☐	HOME IV ☐	AGAINST MED ADV ☐	HOME ☐
DISCHARGE DATE	TIME	OTHER						

EXPIRED ☐ TIME _____ <48HRS ☐ >48HRS ☐ CORONER ☐ AUTOPSY YES ☐ NO ☐

ATTENDING PHYSICIAN SIGNATURE & DATE

RxLASER, INC. C2488-2005) (714) 986-1559 (2/99)

CHART COPY - DO NOT REMOVE FROM CHART

TRIAGE ASSESSMENT

LEE ,BERNARD D M 21 / EMR Pt#: 15812423 Page: 1
Atn Dr: WEDDLE DOUGLAS OUTPATIENT Covers Period:
Adm Dt: 10/17/01 ET Isol: Mr#: 177273 10/17/01 00:01 to 10/17/01

Patient Allergies: NKA

TRIAGE NOTE		ORIG DT/TM	RESP PTY	REV DT/TM
TRIAGE NOTE		10/17/01 11:07	SHACED	
	Seen 10/8 ? in ED for lac to rt forearm. here today for removal of su tures. Cresent shaped lac 2inches, well approximated no erythema or s welling.			

COMPLAINT		ORIG DT/TM	RESP PTY	REV DT/TM
TRIAGE DATE	101701			
TRIAGE TIME	1107			

VITAL SIGNS		ORIG DT/TM	RESP PTY	REV DT/TM
TEMPERATURE	097.40			
TEMP (C)	36.33			
TEMP SITE	Oral			
PULSE	87			
PULSE SITE	Radi			
RESP. RATE	18			
BLOOD PRESS	143/69			
WT/KG	79.5454			
WT/LB	175.00			
WT OBTAINED	stated			
PAIN	no			
VITALS DATE	101701			
VITALS TIME	1109			

PT CONDITION		ORIG DT/TM	RESP PTY	REV DT/TM
SKIN COLOR	pink			
SKIN WARM	yes			
SKIN DRY	yes			
ALERT	yes			
ORIENTED	yes			

TRIAGE		ORIG DT/TM	RESP PTY	REV DT/TM
ARRIVAL MODE				
	ambulatory			
	POV			
ACCOMP BY	alone			
CONDITION	good			

GROUP CONTINUED

PERMANENT CHART COPY

TRIAGE ASSESSMENT

LEE ,BERNARD D M 21 / EMR Pt#: 15812423 Page: 2
Atn Dr: WEDDLE DOUGLAS OUTPATIENT Covers Period:
Adm Dt: 10/17/01 ET Isol: Mr#: 177273 10/17/01 00:01 to 10/17/01

Patient Allergies: NKA

TRIAGE		ORIG DT/TM	RESP PTY	REV DT/TM
CONSCIOUSNES	consciou	10/17/01 11:07	SHACED	
TRI CLASS				
	non urgent			
TRAUMA	no			
LAST TETNUS	up to dt			

PAST MED HX		ORIG DT/TM	RESP PTY	REV DT/TM
FAMILY DR				
	none			
PAST SURGERY				
	none			

TRIAGE		ORIG DT/TM	RESP PTY	REV DT/TM
NO TREATMENT	yes			
EXPRESS CARE	yes			
REG/WAIT RM	yes			

ASSESSMT STS		ORIG DT/TM	RESP PTY	REV DT/TM
TRI ASMT STS	C			

****

* SHACED DAVID SHACKFORD RN-ED *

****

END OF REPORT

PERMANENT CHART COPY

Chief Complaint: [illegible] for SK from [illegible] x2 days

HPI:

Current Meds:

☐ See ED nurses notes

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, & ROS Unobtainable due to: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ PMD Renal Disease ☐ Asthma ☐ COPD ☐ CHF

☐ As Above ☐ Other:

Past Surgical History:

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☐ Yes Amt ____ ETOH ☐ No ☐ Yes Amt ____ ☐ Other ____

Review Of Systems: Check ☐ If normal Check ○ If abnormal (If not Checked then not applicable.)

☐ Other ROS Neg

Eyes: ☐ ○ Diplopia ☐ ○ Blurred ☐ ○ Vision chgs ☐ ○ Nose bleeds

ENT: ☐ ○ Rhinitis ☐ ○ Sore throat

Card: ☐ ○ CP ☐ ○ Palpitation

Respir: ☐ ○ SOB ☐ ○ Cough ☐ ○ Hemoptysis

GI: ☐ ○ Nausea ☐ ○ Vomiting ☐ ○ Diarrhea ☐ ○ Abd pain ☐ ○ Melena ☐ ○ Hematochez

GU: ☐ ○ Dysuria ☐ ○ Urgency ☐ ○ Hematuria

MS: ☐ ○ Myalgia ☐ ○ Backpain ☐ ○ Neck pain

Neuro: ☐ ○ Seizures ☐ ○ Dizziness ☐ ○ Syncope ☐ ○ Weakness ☐ ○ Numbness

Endo: ☐ ○ Polyuria ☐ ○ Polydipsia ☐ ○ Hypoglyc ☐ ○ Thyroid Dys

Hem/Lym: ☐ ○ Anemia ☐ ○ Bleeding

☐ For allergies see ED nurses notes

Other ROS

TETANUS STATUS:

ALLERGIES:

Physical Exam:

☐ For vitals see ED nurses notes

Weight	TIME	PULSE OX:	TEMP	P	R	BP
			98			

Check ☐ If normal Check ○ If abnormal

Abn Findings:

General: ☐ ○ Mental Status

Eyes: ☐ ○ Conjun NL ☐ ○ Lids ☐ ○ PERRL

Head: ☐ ○ NL cephalic ☐ ○ Sinuses ☐ ○ Nose

ENT: ☐ ○ Oropharynx ☐ ○ Right TM ☐ ○ Left TM

Neck: ☐ ○ Palpation ☐ ○ Thyroid ☐ ○ Trachea

Chest: ☐ ○ Palpation ☐ ○ Excursion ☐ ○ Symmetry

Cardio: ☐ ○ Heart sounds ☐ ○ R & R

Respir: ☐ ○ Respir effort ☐ ○ Lung sounds

Abdom: ☐ ○ Palpation ☐ ○ Bowel Sounds

MS: ☐ ○ RUE ☐ ○ RLE ☐ ○ Digits

☐ ○ LUE ☐ ○ LLE ☐ ○ Back

☐ ○ Pelvis ☐ ○ Gait

Skin: ☑ ○ Temp ☑ ○ Appear ☑ ○ Color

Neuro: ☑ ○ CNS ☑ ○ Strength ☑ ○ Sensation

well healed arm lac

TEST:	ORD	Initial
CBC W DIFF:		
CHEM 8:		
URINE PREG:		
CCUA:		
CATH UA:		
URINE C&S:		
EKG:		
OLD EKGS:		
TROPONIN:		
PT/PTT:		
FINGER ST GL:		
BLOOD CULT X		
TYPE & SCREEN:		
TYPE CROSS UNITS:		
LIVER PANEL:		
CMP:		
AMYLASE:		
LIPASE:		
HEMOCULT:		
TYPE & RH:		
HCG QUANT:		
URINE DRUG S:		
ALCOHOL:		
ED ABG:		
PA/LAT CXR:		
PCXR:		
C-SPINE:		
L-SPINE:		
ACUTE ABD:		
OLD RECORDS:		
OLD ED Record:		

TIME INITIAL ✓TEST ORDERED

PHYSICIAN'S ORDERS: TIME ORD: TIME COMP Initial

URINE PREG RESULTS:

Saline 1155

Med Decision Making:

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

NAD

CC TIME:

Diff Dx:

Consults:

NAME OF PHYSICIAN THAT ADMITTED PT:

NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

☐ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

DISCHARGE DIAGNOSIS: healing arm lac.

CODES V58.3

Physician Signature: Time MD IN:

ED Encounter Record

Name: Race: Sex: Age:

Addressograph

1581223 21
LEE, BERNARD D M
WESTLE DOUGLAS BAI
4/1 [illegible] /17/01 T EMR
[illegible] B 251-45-2204

Aiken Regional MEDICAL CENTERS

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29802

The Health Choice

PATIENT NAME: Ali Bernard DOB DATE OF SERVICE/ADMISSION 10-17

CONSENT FOR TREATMENT, GUARANTY OF PAYMENT AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION, AND ASSOCIATED NOTICES AND AUTHORIZATION.

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The undersigned certifies that they have read all of this document, including the reverse side hereof, and that the undersigned is the Patient, or is duly authorized by the Patient or by law, to execute the above Agreement and understands its terms.

All Patients shall receive treatment or service within the hospital's capability and policies. Our hospital is committed to patient's impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care.

3. Assignment of Insurance Benefits and Release of Medical Information: The undersigned hereby assign to Hospital, its successors and assigns, all benefits tha may be payable to or on behalf of the Patient under any policy of insurance, (hospitalization, major medical, automobile, workmen's compensation, personal inju benefits available because of liability of a third party, or any other) and authorize Hospital to release specifically requested medical information related to Patient include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assaults, tests for HIV, ARC and/or AIE or other infectious diseases necessary for settlement of benefit payment or money payable because of Patient's hospitalization, treatment or injury during this encounter. The undersigned further direct that the payer of any such payment make such payment directly to Hospital. In addition, the undersigned assign to Hospital, its successors and assigns, the proceeds of injury claim resulting from liability to Patient of a third party. Any payments to Hospital under authority of this Assignment shall not exceed the actual charges set forth in Hospital's billing statements issued in connection with Patient's account.

If Patient is eligible for Medicare, the undersigned requests Medicare services and benefits. The undersigned further agree that this Assignment will not be withdrawn or voided at any time until Patient's account is paid in full. The undersigned acknowledge that it is their responsibility to pay Hospital for any charg not covered by insurance. Further, undersigned agree and understand that if the Patient, or his duly authorized representative, requests a private room for the Patient the undersigned is responsible for the entire room difference.

The undersigned hereby authorize any agency or employee of the U.S., any State or Municipal Government to release to the Hospital, its employee, employees and/or its attorney, any and all information concerning governmental programs under which the above named Patient is or may be qualified to receive benefits and further authorize payment of any and all such benefits direct to Hospital.

The insured whose signature appears in this item one (1), hereby represents to the Hospital that the following insurance policies are the only insurance policies offering coverage to the patient in this matter and hereby assigns to Hospital all benefits payable to or on behalf of Patient thereunder:

Written authorization for HMO/PPO plans: I understand that if my insurance carrier, HMO plan or PPO network requires preauthorization, the Hospital/Provider/Physician is unable to guarantee that my visit will be covered without a written authorization for the services rendered to me or my family members. If the Hospital/Provider/Physician is unable to obtain authorization for my visit, I will be responsible for any unpaid balance. I will be financially responsible for those charges that coincide with any service/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the Hospit accepts no liability for failure to meet any pre/post certification procedures which may be required of me by my coverage carrier. I agree that any such proceedu have been or will be properly executed by me.

Primary Insurance Co. BC out of State

Patient [signature]

Insured

Secondary Insurance Co.

Patient

Insured

Addressograph

PHYSICIANS NOT AS EMPLOYEES: I acknowledge that all physicians furnishing services including but not limited to radiologists, pathologists, anesthesiologists, emergency department physicians, consultants and assistants to the physician are not employees of the Hospital. I understand that I may receive separate billing from each of these providers for services rendered.

4. Guaranty of Payment: The undersigned jointly and severally agree to be bound to Hospital for payment and absolutely guarantee payment to Hospital on demand of all charges now or hereafter incurred for goods and services furnished by Hospital to Patient in connection with Patient's treatment and/or stay at Hospital. This is a continuing guarantee of payment on demand of the entire unpaid balance of charges incurred during the period from the date of service or admission above until Patient is discharged and includes guarantee of payment of outpatient charges for services rendered on the date noted above and any follow-up outpatient charges. Such charges shall be in accordance with the regular rates and charges of the Hospital in effect at the time of the rendering of the service or the furnishing of the goods for which the charge is incurred.

Should Patient's account be turned over to any attorney for collection or legal proceedings of any kind, the undersigned jointly and severally absolutely guarantee payment to Hospital of all costs and expenses incurred by Hospital in connection with such collection action and/or legal proceedings, including a reasonable attorney's fee not to exceed fifteen (15) percent of the unpaid balance due.

The undersigned also agrees that any over payments collected in connection with any particular admission or outpatient treatment of Patient may be applied directly to a delinquent account of Patient or any delinquent account for which Patient or any undersigned is legally responsible at the time of collection of the over payment.

Hospital may make a Repayment Agreement with any one or more of the undersigned, which Agreement shall be considered ancillary to and not in lieu of this Agreement and shall not be construed as limiting or modifying the liability of any other signatory to this Agreement.

Patient signatories, Spouse of Patient signatories, Guarantor signatories, and Parent of minor patient signatories are jointly and severally bound by all the terms hereof including liability for payment to Hospital under this Guaranty of Payment agreement.

5. Assignment of Physician Benefits: In the event that Patient, in addition to Hospital benefits, is entitled to any physician benefits of any type whatsoever arising out of policy of insurance insuring Patient or any other person liability to Patient, the undersigned hereby assigns said benefits to any physician rendering care or treatment during the stay associated with this admission or any outpatient visits, to be applied to Patient bill.

6. Medicare Patient Certification: The undersigned certifies that the information given by the undersigned in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorizes any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for a Medicare claim related to Patient. The undersigned authorizes and directs that a copy of this Authorization may be used in place of the original and requests payment of authorized benefits be made on behalf of the Patient.

7. Personal Valuables and Belongings: The undersigned acknowledges and agrees that the Hospital maintains a safe for the safekeeping of valuables. The Hospital shall not be held responsible or liable for the loss or damage to any article of personal property while Patient is hospitalized unless said articles are deposited with the Hospital in the safe and receipts are issued describing said items. If the patient is unable to sign and in the event no relative is present, the Hospital shall retain possession of valuables and obtain acknowledgement at the first available opportunity.

8. Cameras and Surveillance Equipment: Patient has been advised that Aiken Regional Medical Centers uses cameras and other surveillance equipment to monitor patient/employee activities. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment.

9. You have the right to file a grievance regarding concerns with our quality. The agency to notify/contact is:

Department of Health and Environmental Control (DHEC), Licensing Division
2600 Bull Street
Columbia, South Carolina 29202
803-737-7470

10. Smoking is prohibited except in certain areas. Please discuss any special needs with your physician.

11. I acknowledge that laboratory studies may be performed in the event a health care worker is exposed to my blood or body fluid.

I, the undersigned, state that the information that I have provided Aiken Regional Medical Centers is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by signing it, I am agreeing to it.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
ORIGINAL SIGNATURE ON FILE AT AIKEN REGIONAL MEDICAL CENTERS.

10-17-01 [signature] [signature]
Date Time Patient/Parent/Guardian/Relative/Legal Guardian Witness

Address Witness

☐ No ID
☐ No Insurance Card
☐ Address Correct on ID

City State Zip

Reason Patient Did Not Sign _____ ☐ Patient was given the option to deposit valuables at work.

TELEPHONE CONSENT

Patient Name

Witness

Witness

Obtained From Relationship

Phone # Date/Time

@@1b2838551b287330701b2873'14'681b2873'10'761b287337420

ER D/C ASSESSMENT

LEE ,BERNARD D M 21 / EMR Pt#: 15812423
Atn Dr: WEDDLE DOUGLAS OUTPATIENT
Adm Dt: 10/17/01 ET Isol: Mr#: 177273

Patient Allergies: NKA

@@1B28733742@ER DISCHARGE ORIG DT/TM

DC DATE	101701	10/17/01 12:18	GATESJ
DC TIME	1210		
ACCOMP BY	other		
	self		
DEPART MODE	car		
DSCH VIA	walk		
VALUBL/BELON	rm chckd		
D/C PAIN	n		
DSCH TO HOME	yes		
INSTR GIVEN	yes		
GIVEN TO			
	patient		
VERB UNDERST	yes		

****

* GATESJ JERRY GATES RN-ER

****

==========END OF REPORT==========

@x4

PERMANENT CHART COPY

AIKEN REGIONAL MEDICAL CENTERS

NOTE: THIS FORM MAY BE USED WHEN VITAL SIGNS ARE MORE FREQUENT THAN EVERY FOUR HOURS

DATE	TIME	TEMP	PULSE	RESP	B/P	OUT-PUT			COMMENTS	INITIAL
1/17/01	1135								Amb to R 7 - here for suture removal. Site is	
									redness or erythema	
	1150								EXAM BY DR DAVIS	JB
	1200								SR FOREARM (R) @ S+S	
									INTACT	JB
	1210								PT DC HOME AMB + STABLE.	
									DC INSTRUCT GIVEN	
									VERBALIZED UNDERSTANDING	
									OF DC	JB

INIT.	SIGNATURES	INIT.	SIGNATURES
JB	S. GATES RN	DT	

PATIENT INFORMATION

1581275
LEE, BERNARD J
WEDDLE, DOUGLAS
A/1 /1938 1/17/01 T EMR
B 251-45-2204

SUPPLEMENTAL VITAL SIGNS FLOW SHEET

Aiken Regional Medical Centers

Emergency Services

15812423 21
[illegible] 4/3 [illegible] 1/17/01 I FM
17273 B 251-45-2204

GENERAL INSTRUCTIONS:

- ☐ Call the next business day and make an appointment to see: _____
  Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: _____ days or less or _____ days or less if still ill.
- ☐ Have your blood pressure checked at _____ within _____ days.
- ☐ Return to the Emergency Department after 12:30 p.m. in _____ days for suture removal or re-check.
- ☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.
- ☐ Work / school excuse from _____ thru _____.
- ☐ See your company doctor per your company's policy. Light duty until _____.
  (No use of _____ No lifting over _____ lbs.)
- ☐ _____ Rest as needed

Your diagnosis was:

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

* Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diptheria booster***
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave If you have unanswered questions.)

I have received the instruction sheets indicated above.

I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of m routine and complete care. I will arrange for followup care.

I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occu RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.

Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X-Rays. If cultures were obtained, results wi not be final for 3 or more days.

I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my folowup physicia

The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.

Call your followup physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Departmen

_____ *Physician*

G. GATES RN *Staff*

_____ *Date*

_____ *Patient or Responsible Person*

630.06 WHITE - MEDICAL RECORDS – 172 – IENT PINK - EMERGENCY DEPARTMENT FORM 10-2183 3/9

Aiken Regional
MEDICAL CENTERS
The Health Choice

202 University Parkway, Aiken, SC 29801

MED. REC. NO. 177273

PT NO 101065985	PATIENT NAME LEE, BERNARD D											COUNTY 2	
ADDRESS 172 OLD INDIAN CHEROKEE RD													
CITY GRANITEVILLE			STATE SC	ZIP 29829-0000	PHONE 803-663-0560		EXT.		SOCIAL SECURITY NO. 251-45-2204				
AGE 24	DOB 04/30/1980	SEX M	RACE 2	MS S	PREVIOUS NAME				RELIGION BAP	N/S		RM/BED	
ADM DATE 02/17/05	TIME 14:47	SRC EO	PT TYPE T	PRI X	ACCIDENT INFO H	02/17/05 14:00	VOLUNTARY ADM		ORGAN DNR	ISOL		INFANT AGE	
RT EMPLOYER AUGUSTA					TELEPHONE 706-999-9999		EXT		OCCUPATION EASY GO				
EMPLOYER ADDRESS MIKE PADGET HWY													
CITY AUGUSTA			STATE GA	ZIP 30906-					RETIREMENT DATE				
NEAREST RELATIVE NAME LEE, VIRGINIA													
RLTN B	ADDRESS UNK												
CITY CLEARWATER			STATE SC	ZIP 29822-	PHONE 803-663-7533		EXT						
EMERGENCY CONTACT NAME LEE, MARIE													
RLTN N	ADDRESS 172 OLD INDIAN CHEROKEE RD												
CITY GRANITEVILLE			STATE SC	ZIP 29829-	PHONE 803-663-0560		EXT						
GUARANTOR NAME LEE, BERNARD D									RLTN S	SOCIAL SECURITY NUMBER 251-45-2204			
ADDRESS 172 OLD INDIAN CHEROKEE RD											PHONE 803-663-0560		
CITY GRANITEVILLE			STATE SC	ZIP 29829-	OCCUPATION EASY GO						EXT		
GUARANTOR EMPLOYER AUGUSTA					PHONE 706-999-9999		EXT						
ADDRESS MIKE PADGET HWY													
CITY AUGUSTA			STATE GA	ZIP 30906-								FC	
INSURANCE NAME PRIVATE PAY	CODE 910	POLICY #		GROUP #		SUBSCRIBER LEE, BERNA	REL S	AUTH #					
INSURANCE NAME 2	CODE	POLICY #		GROUP #		SUBSCRIBER	REL	AUTH #					
INSURANCE NAME 3	CODE	POLICY #		GROUP #		SUBSCRIBER	REL	AUTH #					
ATTENDING PHYSICIAN SCEMS D			ATTENDING # 044198	REF SRC	ADM BY MARONB	PREV ADM DATE		PREVIOUS FACILITY					
ADM DIAGNOSIS VAD			MED SVC EMR	CODE	ALLERGIES NKA						SURGERY DATE		
ADMITTING PHYSICIAN SCEMS D			ADMITTING # 044198	AUTHORIZED BY									
PROCEDURE			CLINICAL COMMENT					MODE OF ARRIVAL/ACCOMPANIED BY SLF SELF					
RL OF INFO Y	ADV DIR	LIVING WILL	LOCATION OF WILL/DIRECTIVE		FAMILY DOCTOR								

FINAL DIAGNOSES (FIRST DIAGNOSIS PRINCIPAL UNLESS NOTED)

CODE

787.9
7870

AUGUSTA DATA STORAGE INC.
F0000112412

PROCEDURES

CONSULTING PHYSICIANS

DRG _____

LOS _____

TRANS TO:	ACUTE	SNF ☐	REHAB ☐	HOSPICE ☐	HOME HEALTH ☐	HOME IV ☐	AGAINST MED ADV ☐	HOME ☐
DISCHARGE DATE	TIME	OTHER						
EXPIRED ☐	TIME _____	<48HRS ☐	>48HRS ☐	CORONER ☐	AUTOPSY YES ☐	NO ☐		

ATTENDING PHYSICIAN SIGNATURE & DATE

RxLASER, INC. C2488-20051 (714) 986-1559 (2/99) CHART COPY - 173 - DO NOT REMOVE FROM CHART

Complaint

Chief complaint reported as Vomiting and diarrhea beginning at 0430 today. Emesis x 2-3, diarrhea x 5-7. Pt. alert and well-appearing in triage. No injury present. There is no evidence of abuse and/or neglect

Vital signs

Temperature 98.6 F (37 C). pulse 58 bpm. RR 18. BP 111/ 61 mmHg. Patient's stated weight is 190 lb 0 oz (86 kg 182.6 gm).

Primary Assessment

WNL as evidenced by: Respirations quiet and regular. Skin warm, dry, color within individual normal limits. Alert and oriented to person, place and time. Verbalization clear and understandable. Moves all extremities. Able to stand, walk with steady gait. No change in patient's usual level of functioning.

Pain Initial

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Past Med/Surg Hx

Patient's past medical history includes sinus problems.

Arrival & Vaccine Info

Patient has not received the pneumonia vaccine.

Home Meds

tylenol, last dose 0700;

Triage Info

Patient triaged as non-urgent. After triage patient went to registration, and went to express care. No treatment given in triage.

Allergy History

No known allergies.

©2003, Opus Healthcare Solutions, Inc.

Chief Complaint: V/O — LMHW

HPI: pt c/o N/V/D x 1 day, abd pain, unable to drink PO fluids. Dizziness or weakness

Current Meds: See ED nurses notes

PMD: Ø

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, & ROS Unobtainable due to: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF

☑ As Above ☐ Other:

Past Surgical History: Ø

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☑ No ☐ Yes Amt ETOH ☑ No ☐ Yes Amt ☐ Other

Review Of Systems: (Check ☐ if normal, Check ○ if abnormal, If not Checked then not applicable.)

☑ Other ROS Neg

Eyes:	☐ Diplopia	☐ Blurred	☐ Vision chgs	GU:	☐ Dysuria	☐ Urgency	☐ Hematuria	
ENT:	☐ Rhinitis	☐ Sore throat	☐ Nose bleeds	MS:	☐ Myalgia	☐ Back pain	☐ Neck pain	
Card:	☐ CP	☐ Palpitation		Neuro:	☐ Seizures	☐ Dizziness	☐ Syncope	
Respir:	☐ SOB	☐ Cough	☐ Hemoptysis		☐ Weakness	☐ Numbness		
GI:	☐ Nausea	☐ Vomiting	☐ Diarrhea	Endo:	☐ Polyuria	☐ Hypoglyc	☐ Thyroid Dys	
	☐ Abd pain	☐ Metena	☐ Hematochez	Hem/Lym:	☐ Anemia	☐ Bleeding		

☑ For allergies see ED nurses notes

TETANUS STATUS: Other ROS

ALLERGIES: NKDA

Physical Exam: WEIGHT

TIME	PULSE	OX:	TEMP	P	R	BP
	90	98		18		111/61

☑ For vitals see ED nurses notes

Check ☐ if normal, Check ○ if abnormal

						Abn Findings:
General:	☑	○	Mental Status			
Eyes:	☑	○	Conjun NL	☑ Lids	☑ PERRL	
Head:	☑	○	NL cephalic	☑ Sinuses	☑ Nose	
ENT:	☑	○	Oropharynx	☑ Right TM	☐ Left TM	Mucus
Neck:	☑	○	Palpation	☑ Thyroid	☐ Trachea	
Chest:	☑	○	Palpation	☑ Excurtion	☐ Symmetry	
Cardio:	☑	○	Heart sounds	☑ R & R		
Respir:	☑	○	Respir effort	☑ Lung sounds		
Abdom:	☑	○	Palpation	☑ Bowel Sounds		soft, NT, ND
MS:	☑	○	RUE	☑ RLE	☐ Digits	
	☑	○	LUE	☑ LLE	☐ Back	
	☐	○	Pelvis	☐ Gait		
Skin:	☑	○	Temp	☑ Appear	☑ Color	
Neuro:	☐	○	CNS	☑ Strength	☐ Sensation	

Pt. awake, alert, NAD

TEST:	ORD	Initial	TIME INITIAL ✓TEST ORDERED
CBC W DIFF:			PHYSICIAN'S ORDERS: TIME ORD: TIME COMP Initials
CHEM 8:			
URINE PREG:			→ URINE PREG RESULTS:
CCUA:			
CATH UA:			
URINE C&S:			
EKG:			
OLD EKGS:			
TROPONIN:			
Pt/PTT:			
FINGER ST GL:			WNL Urine
BLOOD CULT X			
TYPE & SCREEN:			Pt Refuses
TYPE CROSS			
UNITS:			
LIVER PANEL:			
CMP:			
AMYLASE:			
LIPASE:			
HEMOCULT:			
TYPE & RH:			
HCG QUANT:			
URINE DRUG S:			
ALCOHOL:			
ED ABG:			
PA/LAT CXR:			
PCXR:			
C-SPINE:			1615
L-SPINE:			
ACUTE ABD:			
OLD RECORDS:			
OLD ED Record:			

Med Decision Making:

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME:

Diff Dx:

Consult/s:

NAME OF PHYSICIAN THAT ADMITTED PT:

NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

☐ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

Name: Race: Sex: Age:

Addressograph

DISCHARGE DIAGNOSIS: ? Acute vomiting / diarrhea

CODES

☑ STABLE

☐ UNSTABLE SEE NOTE

Physician Signature: [illegible] Time MD IN: 1535

101065985

LEE , BERNARD D
DOB: 04/30/1980 24 SX: M EMR
MRN: 177273 ADM/REG DT: 02/17/05
AIKEN REGIONAL MEDICAL CENTER

ED Encounter Record
630.70

10-241

Aiken Regional Medical Centers

Emergency Services

101065985
LEE , BERNARD D
DOB: 04/30/1980 24 SX: M EMR
MRN: 177273 ADM/REG DT: 02/17/05
AIKEN REGIONAL MEDICAL CENTER

GENERAL INSTRUCTIONS:

- ☐ Call the next business day and make an appointment to see: FMC
  Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: _____ days or less or _____ days or less if still ill.
- ☐ Have your blood pressure checked at _____ within _____ days.
- ☐ Return to the Emergency Department after 12:30 p.m. in _____ days for suture removal or re-check.
- ☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.
- ☐ Work / school excuse from 2/16/05 thru 2/18/05.
- ☐ See your company doctor per your company's policy. Light duty until _____.
- (No use of _____ No lifting over _____ lbs.)

1) clear liquids x 24 hours
2) meds as prescribed
3) follow up as above

Your diagnosis was: vomiting, diarrhea

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☑ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☑ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diptheria booster***
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave If you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X_Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physician
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Department.

Physician / Staff _____ Date 2/17/05 Patient or Responsible Person _____

630.06 Rev. 10/02 WHITE - RECORDS CANARY - PATIENT – 176 – EMERGENCY DEPARTMENT GOLDENROD - PATIENT FORM 10-218

AIKEN REGIONAL MEDICAL CENTERS

302 University Parkway • Aiken, South Carolina 29802

TREATMENT AREA Room # 1 Time 15:34 Report to DAVID VIA AMB

ED NURSING ASSESSMENT RECORD

NEUROMUSCULAR

☑ Normal Adult Pattern ☐ Normal Pediatric Pattern

MENTATION ☐ Disoriented ☐ Agitated ☐ Resp to verbal stim ☐ Combative ☐ Unresponsive ☐ Resp to painful stim

PUPILS ☐ Equal ☐ Unequal

Size R____mm L____mm

R ☐ Fixed ☐ Dilated ☐ Non-reactive ☐ Pinpoint ☐ Sluggish

L ☐ Fixed ☐ Dilated ☐ Non-reactive ☐ Pinpoint ☐ Sluggish

Visual Acuity R:_____ L:_____ Both:_____

SENSATIONS

		DECREASED	ABSENT
ARM	R		
ARM	L		
LEG	R		
LEG	L		

ROM

		DECREASED	ABSENT
ARM	R		
ARM	L		
LEG	R		
LEG	L		

CARDIOVASCULAR

☑ Normal Adult Pattern ☐ Normal Pediatric Pattern

HEART ☐ Chest pain Describe:_____

EXTREMITIES ☐ Edema ☐ Obvious deformity _____ Describe:_____

CAP REFILL ☐ < 2 Sec ☐ > 2 Sec

PULSES

		DECREASED	ABSENT
RADIAL	R		
RADIAL	L		
FEMORAL	R		
FEMORAL	L		
PEDAL	R		
PEDAL	L		

RESPIRATORY

Review above information, assess patient, document changes.

☑ Normal Adult Pattern ☐ Normal Pediatric Pattern

☐ Dyspnea ☐ Stridor ☐ Retraction ☐ Nasal Flaring

COUGH ☐ Productive Describe:_____ ☐ Non-Productive

LUNG SOUNDS

	RIGHT	LEFT
Wheezes		
Rales		
Crackles/Course		
Diminished		

CHEST EXPANSION Describe:_____

☐ SYMMETRICAL

☐ ASYMETRICAL

☐ TENDERNESS

GI / NUTRITIONAL STATUS ☐ N/A

☐ Normal Adult Pattern ☐ Normal Pediatric Pattern

ABDOMEN ☐ Firm ☐ Distended: ☐ Tenderness Describe:_____

APPETITE ☐ Fair ☐ Poor ☐ Special Diet at home:_____

STOOL ☐ Diarrhea ☐ Incontinence ☐ Incontinence ☐ Last BM:_____ ☐ Nausea ☐ Vomiting

GU / REPRODUCTIVE ☐ N/A

☑ Normal Adult Pattern ☐ Normal Pediatric Pattern

FEMALE ☐ Vaginal Discharge Color:_____ ☐ Vaginal Bleeding Describe:_____ ☐ Breast Problem ☐ R ☐ L Describe:_____

MALE ☐ Prostate Problem Describe:_____ ☐ Genitalia tenderness / swelling / discharge Describe:_____

VOIDING ☐ Frequency ☐ Urgency ☐ Hematuria ☐ Incontinence ☐ Last Void: ☐ Catheter

INTEGUMENT

☑ Normal Adult Pattern ☐ Normal Pediatric ☐ Laceration ☐ Abrasion ☐ Amputation ☐ Avulsion ☐ Bruising ☐ Burn ☐ Bleeding ☐ Diaphoresis ☐ Abnormal Skin Color ☐ Lesions ☐ Rash

Describe:_____

SENT

Eyes: ☐ Contact Lenses ☐ Glasses ☐ Foreign Body ☐ Cataracts ☐ Mucous Membranes Moist/Dry ☐ Injury:_____

Ear/Nose/Throat/Mouth:_____

Visual Acuity: L_____ R_____

☐ Dentures ☐ Glasses ☐ Contacts ☐ Disposition_____

RN/LPN Signatures:_____

PAIN ASSESSMENT

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

ADDRESSOGRAPH

101065985

LEE , BERNARD D
DOB: 04/30/1980 24 SX: M EMR
MRN: 177273 ADM/REG DT: 02/17/05
AIKEN REGIONAL MEDICAL CENTER

ED NURSING ASSESSMENT RECORD

630.64 (Rev. 8/03)

PROCEDURE / TREATMENTS

TIME	PROCEDURE	COMMENTS	BY WHOM	RESULTS	INITIALS
	☐ NG ☐ OG	Side/Location _____ placement verified by auscultation		Amount	
	Pulse oximeter			O_2 Saturation	
	Peripheral IV Insertion			Character/Amount	
	PEG replacement			Size:	
	Pelvic Exam			Cultures obtained: ☐ Yes ☐ No	
	Ring Removal	Given to:		Skin color/temp. cap. refill _____ sec	
	Side rails up x _____ for patient safety & call bell given			Verbalized understanding	
	Sling			Skin color/temp. cap. refill _____ sec	
	Suture placement	Supplies		Wound edges approximated	
	Tracheostomy/Cricothyrotomy				
	Other				
	Other				
	Wound Care			Verbalized understanding	

PATIENT BELONGINGS CHECKLIST FOR ADMISSIONS OR TRANSFERS

Clothing: ☐ Shirt ☐ Sweater ☐ Coat ☐ Vest ☐ Pants ☐ Underwear ☐ Tie/Scarf ☐ Socks/Hose ☐ Hat/Cap ☐ Gloves ☐ Cutoff PTA/ETC (ED)

Accessories: ☐ Shoes ☐ Purse ☐ Wallet ☐ Keys ☐ Other _____

Jewelry: ☐ Yellow Metal (describe): _____ ☐ Yellow Metal (describe): _____

Miscellaneous: ☐ Home Meds ☐ W/Patient ☐ W/Family ☐ to Pharmacy

☐ Dentures ☐ Upper ☐ Lower ☐ Partial ☐ Glasses ☐ Contact Lenses R / L ☐ Hearing Aid R / L ☐ Walker/Cane

Valuables: ☐ W/Patient ☐ W/Family ☐ Security ☐ Other _____

ADMISSION DISPOSITIONS

Admitting Physician _____

Room # _____ **Time of Admission** _____

VIA ☐ Nurse ☐ Escort ☐ Neg. Agent

Report:

Time: _____

Called to: _____

Portable Monitor: ☐ Yes ☐ No Rhythm: _____

Portable Oxygen: ☐ Yes ☐ No _____ L/M Via _____

Transfer Restraints: ☐ Yes ☐ No

DISPOSITION

DISPOSITION	TYPE	INSTRUCTIONS
	☐ Morgue	☒ See Discharge Instruction Sheet
	☐ LWBS	☒ Verbal/Written Instruction Given To/By:
	☐ AMA	
VIA:	☐ Elopement	☒ Expresses Understanding
☒ Ambulatory	☒ Discharge	☒ Discharged by Physician
☐ Wheelchair	☐ Transfer - See Transfer Record	☐ Instructed not to drive
☐ Stretcher		
☐ Carried		

VS: BP _____ P _____ R _____ T _____ RTS _____ GCS _____

Signature: _____ Time _____

SIGNATURE / TITLE	INITIALS

Medications/Procedure ordered by _____ M.D.

PATIENT MOVES

☐ Unchanged From Initial Assessment _____ Time _____ Int.

☐ Unchanged From Initial Assessment _____ Time _____ Int.

☐ Unchanged From Initial Assessment _____ Time _____ Int.

Assessment changes (time & initials)

AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC

C. Staggs - SC#14516 - DEA BS1978355
S. Platte - SC#20087 - DEA BP5052509
S. Grant - SC#15672 - DEA BG2720793
R. Kogel - SC#24037 - DEA BK8295479
M. James - SC#14208 - DEA BJ1588384
E. Yeh - SC#20098 - DEA BY4915673
D. Weddle - SC#20749 - DEA BW4632508
W. Jackson - SC#23797 - DEA BJ5484225
C. Lavigne, PA-C - SC#A512EM
H. Fountain, PA-C - SC#A770EM
B. Taylor, PA-C - SC#A505EM

302 University Pkwy. Phone 641-5000

101065985

For _____ LEE , BERNARD D Age _____

Address _____ DOB: 04/30/1980 24 SX: M EMR Date 2/17/05
MRN: 177273 ADM/REG DT: 02/17/05
AIKEN REGIONAL MEDICAL CENTER

Rx

Please dispense 1 Medications NO REFILLS prefers / does not prefer generic substitute

_____ M.D. _____ M.D.

Dispense as Written Substitution Permitted

This prescription can be filled next door at

410 University Parkway Suite 2800 **Medical Center Pharmacy** Aiken, South Carolina 29801 (803) 648-2985

M-F 9-6 & SAT 9-12

PLACE TOP OF REPORT #1 HERE

INSTRUCTIONS: To mount first report, pull off the two plastic tabs indicated by the arrows. Position report edges to top and side guide lines, then press the report down over the exposed adhesive.

NOTE: DO NOT OVERLAP REPORTS.

Press lightly to attach temporarily. Press firmly to attach securely and permanently.

ER Discharge

ER Discharge Date/Time: 02/17/2005 16:52. Patient discharged to home. Patient ambulated off the unit, Patient was alone. Transported by private vehicle. Temperature 98.6 F (37 C) orally. Pulse 58 bpm. RR 18. BP 111/ 61 mmHg. Patient is stable. Discharge instructions given to Patient. Medications instructions given to Patient. Patient verbalized understanding. Discharge notes: Rx medication precautions stressed..

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

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AIKEN REGIONAL MEDICAL CENTERS
302 University Parkway
Aiken, SC 29802

PATIENT NAME: [redacted] DATE OF SERVICE/ADMISSION 2-17-05

CONSENT FOR TREATMENT, GUARANTY OF PAYMENT AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION AND ASSOCIATED NOTICES AND AUTHORIZATION.

NOTICE TO PATIENT AND ALL SIGNATORIES OF THIS DOCUMENT: By your signature below, each signatory of this document is agreeing to be jointly and severally bound by all of the terms and conditions hereinafter set forth unless otherwise noted. In consideration of the hospital care and treatment to be rendered to Patient by Hospital, the undersigned agree and consent to the following:

1. Consent and Conditions of Admission: The undersigned hereby agrees and gives consent to Hospital for the admission/treatment/testing of Patient. The undersign hereby consents to any and all hospital care encompassing: X-Ray examination, laboratory procedures, diagnostic procedures, anesthesia and nursing or medical/surgi treatment which Patient's physician, his associates, partners or designees, may deem necessary or advisable under the general and special instructions of the same, duri Patient's hospitalization.

2. Medical and Surgical Treatment: The undersigned agrees and understands that all physicians, dentists and or oral surgeons treating Patient are responsible and liable for their own acts or omissions and the Hospital is not responsible or liable for the acts omissions of the aforementioned. The undersigned is aware that the practice of medicine is not an exact science and further state that no guarantee has been made or can be made as to the results of the treatments or examinations in the Hospital.

The undersigned certifies that they have read all of this document, including the reverse side hereof, and that the undersigned is the Patient, or is duly authorized by th Patient or by law, to execute the above Agreement and understands its terms.

All Patients shall receive treatment or service within the hospital's capability and policies. Our hospital is committed to patient's impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care.

3. Assignment of Insurance Benefits and Release of Medical Information: The undersigned hereby assign to Hospital, its successors and assigns, all benefits that may be payable to or on behalf of the Patient under any policy of insurance, (hospitalization, major medical, automobile, workmen's compensation, personal injury benefits available because of liability of a third party, or any other) and authorize Hospital to release specifically requested medical information related to Patient to include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assaults, tests for HIV, ARC and/or AIDS, or other infectious diseases necessary for settlement of benefit payment or money payable because of Patient's hospitalization, treatment on injury during this encounter. The undersigned further direct that the payer of any such payment make such payment dirtetly to Hospital. In addition, the undersigned assign to Hospital, its success and assigns, the proceeds of injury claim resulting from liability to Patient of a third party. Any payments to Hospital under authority of this Assignment shall not exc the actual charges set forth in Hospital's billing statements issued in connection with Patient's account.

If Patient is eligible for Medicare, the undersigned requests Medicare services and benefits. The undersigned further agree that this Assignment will not be withdrawn voided at any time until Patient's account is paid in full. The undersigned acknowledge that it is their responsibility to pay Hospital for any charges not covered by insurance. Further, undersigned agree and understand that if the Patient, or his duly authorized representative, requests a private room for the Patient the undersigned i responsible for the entire room difference.

The undersigned hereby authorize any agency or employee of the U.S., any State or Municipal Government to release to the Hospital, its employee, employees and/or attorney, any and all information concerning governmental programs under which the above named Patient is or may be qualified to receive benefits due and further authorize payment of any and all such benefits direct to Hospital.

The insured whose signature appears in this item one (1), hereby represents to the Hospital that the following insurance policies are the only insurance policies offerin coverage to the patient in this matter and hereby assigns to Hospital all benefits payable to or on behalf of Patient thereunder:

Written authorization for HMO/PPO plans: I understand that if my insurance carrier, HMO plan or PPO network requires preauthorization, the Hospital/Provider/Physician is unable to guarantee that my visit will be covered without a written authorization for the services rendered to me or my family members the Hospital/Provider/Physician is unable to obtain authorization for my visit, I will be responsible for any unpaid balance. I will be financially responsible for those charges that coincide with any service/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the Hospital accepts no liability for fail to meet any pre/post certification procedures which may be required of me by my coverage carrier. I agree that any such procedures have been or will be properly executed by me.

Primary Insurance Co. Self Pay

Patient [redacted]

Insured [redacted]

Secondary Insurance Co. _____

Patient _____

Insured _____

Addressograph

101065985

LEE , BERNARD D
DOB: 04/30/1980 24 SX: M EMR
MRN: 177273 ADM/REG DT: 02/17/05
AIKEN REGIONAL MEDICAL CENTER

Form 902.02 (Rev 10/04) 10-1983

PHYSICIANS NOT AS EMPLOYEES: I acknowledge that all physicians furnishing services including but not limited to radiologists, pathologists, anesthesiologists, emergency department physicians, consultants and assistants to the physician are not employees of the Hospital. I understand that I may receive separate billing from each of these providers for services rendered.

Guaranty of Payment: The undersigned jointly and severally agree to be bound to Hospital for payment and absolutely guarantee payment to Hospital on demand of all now or hereafter incurred for goods or services furnished by Hospital to Patient in connection with Patient's treatment and/or stay at Hospital. This is a continuing guarantee of payment and shall cover the entire balance of charges incurred during the period from the date of execution above until Patient is discharged and includes payment of patient responsibility charges for services rendered on the date noted above and any follow up outpatient charges. Such charges shall be in accordance with the regular rates and charges of the Hospital in effect at the time of the rendering of the services or the furnishing of the goods for which the charge is incurred.

Should patient's account be turned over to any attorney for collection or legal proceedings of any kind, the undersigned jointly and severally, absolutely guarantee payment to Hospital of all costs and expenses incurred by Hospital in connection with such collection action or legal proceeding, including a reasonable attorney's fee not to exceed fifteen (15) percent of the unpaid balance due.

The undersigned also agrees that any overpayments collected as a result of services rendered to Patient shall be applied directly to the delinquent account of Patient or any delinquent account for which Patient or any undersigned is legally responsible. At the time of collection of the overpayment, Hospital may make a Repayment Agreement with any one or more of the undersigned, which Agreement shall be considered ancillary to and not in lieu of this Agreement and shall not be construed as limiting or modifying the liability of any other signatory to this Agreement.

All Patient Signatories, Spouse of Patient signatories, Guarantor signatories and Parent of minor patient signatories are jointly and severally bound by all the terms hereof including liability for payment to Hospital under this Guaranty of Payment agreement.

Assignment of Physician Benefits: In the event that Patient is/becomes entitled to any physician benefits or any type whatsoever arising out of policy of insurance insuring Patient or any other parties liability to Patient, the undersigned hereby assigns said benefits to any physician rendering care or treatment during the stay associated with this admission or any outpatient visits, to be applied to Patient bill.

Medicare Patient Certification: The undersigned certify that the information given by the undersigned in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for a Medicare claim related to patient. The undersigned authorize and direct that a copy of this Authorization may be used in place of the original and request payment of authorized benefits be made on behalf of the Patient.

Personal Valuables and Belongings: The undersigned acknowledge and agree that the Hospital warrants a safe for the safekeeping of valuables. The Hospital shall not be held responsible or liable for the loss or damage to any articles of personal property while Patient is hospitalized unless said articles are deposited with the Hospital in the safe and receipts are issued describing said items. If the patient is unable to sign and/or the event no relative is present, the Hospital shall retain possession of valuables and obtain acknowledgment at the first available opportunity.

Cameras and Surveillance Equipment: Patient has been advised that Aiken Regional Medical Center uses cameras and other surveillance equipment to monitor employee activities. As a condition of admisson, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment.

9. You have the right to file a grievance regarding concerns with our quality. The agency you may contact is:

Department of Health and Environmental Control (DHEC) Licensing Division
2600 Bull Street
Columbia, South Carolina 29201
803-737-7370

10. Smoking is prohibited except in certain areas. Please discuss any special needs with your physician.

11. I acknowledge that laboratory studies may be performed in the event a health care worker is exposed to my blood or body fluid.

I, the undersigned, state that the information that I have provided Aiken Regional Medical Center is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
ORIGINAL SIGNATURE ON FILE AT AIKEN REGIONAL MEDICAL CENTERS.

2-17-05
Date Time

Patient/Parent/Guardian/POA
Relation if not Patient

Witness

Witness

Address

City State Zip

☐ No ID
☐ No Insurance Card
☐ Address Correct on ID

Reason Patient Did Not Sign _____ ☐ Patient was given the option to deposit valuables in safe.

TELEPHONE CONSENT

Witness

Witness

Patient Name

Obtained From Relationship

Phone # Date Time

Aiken Regional
MEDICAL CENTERS
The Health Choice

202 University Parkway, Aiken, SC 29801

MED. REC. NO. 177273

PT NO: 101265569	PATIENT NAME: LEE , BERNARD D													ADDRESS: 172 OLD INDIAN CHEROKEE RD	COUNTY: 2
CITY: GRANITEVILLE	STATE: SC	ZIP: 29829-0000	PHONE: 803-663-0560	EXT:	SOCIAL SECURITY NO: 251-45-2204										
AGE: 24	DOB: 04/30/1980	SEX: M	RACE: 2	MS: S	PREVIOUS NAME							RELIGION: BAP	NB	RMDED	
ADMDATE: 04/12/05	TIME: 03:25	SRC: EO	PT TYPE: T	PRI: X	ACCIDENT INFO: H 04/11/05 08:00					VOLUNTARY ADM		ORGAN DNR	ISOL	INFANT AGE	
PT EMPLOYER: UNEMPLOYED					TELEPHONE: 706- -		EXT	OCCUPATION: UNEMPLOYED							
EMPLOYER ADDRESS															
CITY: AUGUSTA			STATE: GA	ZIP: 30906-							RETIREMENT DATE				
NEAREST RELATIVE NAME: LEE VIRGINIA															
RLTN: B	ADDRESS: UNK														
CITY: CLEARWATER			STATE: SC	ZIP: 29822-	PHONE: 803-663-1533		EXT								
EMERGENCY CONTACT NAME: LEE MARIE															
RLTN: N	ADDRESS: 172 OLD INDIAN CHEROKEE RD														
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-	PHONE: 803-663-0560		EXT								
GUARANTOR NAME: LEE , BERNARD D											RLTN: S	SOCIAL SECURITY NUMBER: 251-45-2204			
ADDRESS: 172 OLD INDIAN CHEROKEE RD												PHONE: 803-663-0560			
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-	OCCUPATION: UNEMPLOYED							EXT			
GUARANTOR EMPLOYER: UNEMPLOYED					PHONE: 706- -		EXT								
ADDRESS															
CITY: AUGUSTA			STATE: GA	ZIP: 30906-										FC: F	
INSURANCE NAME 1: PRIVATE PAY	CODE: 910	POLICY #		GROUP #			SUBSCRIBER: LEE , BERNARD S		REL	AUTH #					
INSURANCE NAME 2	CODE	POLICY #		GROUP #			SUBSCRIBER		REL	AUTH #					
INSURANCE NAME 3	CODE	POLICY #		GROUP #			SUBSCRIBER		REL	AUTH #					
ATTENDING PHYSICIAN: SCEMS D			ATTENDING #: 044198	REF SRC	ADM BY: HANLIS		PREV ADM DATE		PREVIOUS FACILITY						
ADMDIAGNOSIS: ABD PAIN			MED SVC: EMR	CODE	ALLERGIES: NKA								SURGERY DATE		
ADMITTING PHYSICIAN: SCEMS D			ADMITTING #: 044198	AUTHORIZED BY											
PROCEDURE			CLINICAL COMMENT				MODE OF ARRIVAL/ACCOMPANIED BY: POV								
RLOF INFO: Y	ADV DIR	LIVING WILL	LOCATION OF WILL/DIRECTIVE				FAMILY DOCTOR								

FINAL DIAGNOSES (FIRST DIAGNOSIS PRINCIPAL UNLESS NOTED)

CODE

780.6

AUGUSTA DATA STORAGE, INC.
F0000112412S

PROCEDURES

CONSULTING PHYSICIANS

DRG

LOS

TRANS TO: ACUTE ☐ SNF ☐ REHAB ☐ HOSPICE ☐ HOME HEALTH ☐ HOME IV ☐ AGAINST MED ADV ☐ HOME ☐

DISCHARGE DATE | TIME | OTHER

EXPIRED ☐ TIME _____ <48HRS ☐ >48HRS ☐ CORONER ☐ AUTOPSY YES ☐ NO ☐

ATTENDING PHYSICIAN SIGNATURE & DATE

RxLASER, INC. C2488-20051 (714) 986-1559 (2/99) CHART COPY - DO NOT REMOVE FROM CHART

Chief Complaint: C/o Abd pain x2 days (4)

HPI: Drug / gives, Seems to be worse tonight 0710
5 stabbing, no radiation, no astoc sx

Current Meds:
☐ See ED nurses notes

PMD

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, & ROS Unobtainable due to: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF
☐ As Above ☐ Other: ☐ PMH / PSH

Past Surgical History:

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☐ Yes Amt ETOH ☐ No ☐ Yes Amt ☐ Other

Review Of Systems: (Check ☐ if normal, Check ○ if abnormal, If not Checked then not applicable.)

☐ Other ROS Neg	Eyes:	☐ ○ Diplopia	☐ ○ Blurred	☐ ○ Vision chgs	GU:	☐ ○ Dysuria	☐ ○ Urgency	☐ ○ Hematuria
	ENT:	☐ ○ Rhinitis	☐ ○ Sore throat	☐ ○ Nose bleeds	MS:	☐ ○ Myalgia	☐ ○ Back pain	☐ ○ Neck pain
	Card:	☐ ○ CP	☐ ○ Palpitation		Neuro:	☐ ○ Seizures	☐ ○ Dizziness	☐ ○ Syncope
	Respir:	☐ ○ SOB	☐ ○ Cough	☐ ○ Hemoptysis		☐ ○ Weakness	☐ ○ Numbness	
	GI:	☐ ○ Nausea	☐ ○ Vomiting	☐ ○ Diarrhea	Endo:	☐ ○ Polyuria	☐ ○ Hypoglyc	☐ ○ Thyroid Dys
☐ For allergies see ED nurses notes		☐ ○ Abd pain	☐ ○ Melena	☐ ○ Hematochez	Hem/Lym:	☐ ○ Anemia	☐ ○ Bleeding	

Other ROS

TETANUS STATUS:

ALLERGIES:

Physical Exam: WEIGHT

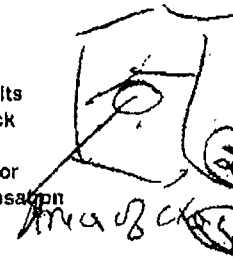
TIME	PULSE	OX:	TEMP	P	R	BP
1000	89	67	98	163	97	

☐ For vitals see ED nurses notes

Check ☐ if normal, Check ○ if abnormal

General:	☐ ○ Mental Status	☐ ○ Lids	☐ ○ PERRL	Abn Findings: VA RK KS
Eyes:	☐ ○ Conjun NL	☐ ○ Sinuses	☐ ○ Nose	
Head:	☐ ○ NL cephalic	☐ ○ Right TM	☐ ○ Left TM	NAD
ENT:	☐ ○ Oropharynx	☐ ○ Thyroid	☐ ○ Trachea	
Neck:	☐ ○ Palpation	☐ ○ Excurtion	☐ ○ Symmetry	
Chest:	☐ ○ Palpation	☐ ○ R & R		
Cardio:	☐ ○ Heart sounds	☐ ○ Lung sounds		
Respir:	☐ ○ Respir effort	☐ ○ Bowel Sounds		
Abdom:	☐ ○ Palpation	☐ ○ RLE	☐ ○ Digits	
MS:	☐ ○ RUE	☐ ○ LLE	☐ ○ Back	
	☐ ○ LUE	☐ ○ Gait		
	☐ ○ Pelvis	☐ ○ Appear	☐ ○ Color	
Skin:	☐ ○ Temp	☐ ○ Strength	☐ ○ Sensation	
Neuro:	☐ ○ CNS			

NAD NOW



TEST: | ORD | Initial | TIME INITIAL / TEST ORDERED

PHYSICIAN'S ORDERS: TIME ORD: TIME COI Initia

TEST:	ORD	Initial
CBC W DIFF:	✓	
CHEM 8:		
URINE PREG:		
CCUA:		
CATH UA:		
URINE C&S:		
EKG:		
OLD EKGS:		
TROPONIN:		
PT/PTT:		
FINGER ST GL:		
BLOOD CULT X		
TYPE & SCREEN:		
TYPE CROSS		
UNITS:		
LIVER PANEL:		
CMP:		
AMYLASE:		
LIPASE:		
HEMOCULT:		
TYPE & RH:		
HCG QUANT:		
URINE DRUG S:		
ALCOHOL:		
ED ABG:		
PA/LAT CXR:		
PCXR:		
C-SPINE:		
L-SPINE:		
ACUTE ABD:		
OLD RECORDS:		
OLD ED Record:		

URINE PREG RESULTS:

HL W/ held

GI Cocktail 30 cc PO

Vitals Q

DLL

Zantac 150mg IV

4050

DLL

Milk of Mag 30 ml PO

Pepcid 20mg PO

0700 tonight

Med Decision Making:

6.2 | 14.1 | 9 | 137 | 107 | 6 | 111 | 3.2 | 31 | 110

LFT's - WNL, Amy = 95 Lip = 22

6a = 9, 3 ☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME:

Diff Dx:

Consult/s:

NAME OF PHYSICIAN THAT ADMITTED PT:

NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

DISCHARGE DIAGNOSIS: Acute Abdominal Pain

☑ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

CODES

STABLE

☐ UNSTABLE SEE NOTE

Name: Race: Sex: Age:

Addressograph

101265569
LEE , BERNARD D
DOB: 04/30/1980 24 SX: M EMR
MRN: 177273 ADM/REG DT: 04/12/05
AIKEN REGIONAL MEDICAL CENTER

Physician Signature: Time MD IN: 0506

ED Encounter Record
630.70

10-24

Aiken Regional Medical Centers

Emergency Services

1012655569
LEE , BERNARD D
DOB: 04/30/1980 24 SX: M EMR
MRN: 177273 ADM/REG DT: 04/12/05
AIKEN REGIONAL MEDICAL CENTER

GENERAL INSTRUCTIONS:

☐ Call the next business day and make an appointment to see: _____

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: _____ days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within _____ days.

☐ Return to the Emergency Department after 12:30 p.m. in _____ days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☑ Work / school excuse from 4/12/05 thru _____ Maybe

☐ See your company doctor per your company's policy. Light duty until _____.

(No use of _____ No lifting over _____ lbs.)

☐ See Dr Lemens (GI Medicine) Return if fever, vomiting with blood, worse abdominal pain

Try Zantac / Tylenol

Your diagnosis was: Abdominal Pain STC

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diptheria booster***
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X_Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physician
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Department.

Physician / Staff

4-12-05
Date

Patient or Responsible Person

630.06 Rev. 10/02 WHITE - RECORDS CANARY - PATIENT – 185 – EMERGENCY DEPARTMENT GOLDENROD - PATIENT FORM 10-2183 3/

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

Patient: LEE, BERNARD D
M.R.#: 177273
Financial #: 101265569
DOB: 04/30/1980 Age: 24yr Sex: M
Location: ER Room/Bed:
Admit Date: 04/12/05
Discharge Date:
Physician: SCEMS D

CLINICAL LABORATORY REPORT

CHEMISTRY

Collected: 04/12/05 @ 05:40 Accn: 12232

Test	Result	Flag	Reference Range	Units
SODIUM	137		135 - 145	meq/l
POTASSIUM	3.2	L	3.5 - 5.5	meq/l
Chloride	104		99 - 111	meq/l
CO2	31		22 - 34	meq/l
GLUCOSE	111		70 - 120	mg/dl
BUN	6	L	7 - 22	mg/dl
CREATININE	1.0		0.5 - 1.2	mg/dl
CALCIUM	9.3		8.7 - 10.2	mg/dl
TOTAL PROTEIN	6.3		6.1 - 8.0	g/dl
ALBUMIN	3.9		3.5 - 4.8	g/dl

Legend
High =H Low = L Critical =C

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JASON FANCEY, M.D.

CLINICAL LABORATORY REPORT

Patient: **LEE, BERNARD D**
M.R.#: 177273
Financial #: 101265569
DOB: 04/30/1980 *Age:* 24yr *Sex:* M
Location: ER *Room/Bed:*
Admit Date: 04/12/05
Discharge Date:
Physician: SCEMS D

CHEMISTRY

Collected: 04/12/05 @ 05:40 Accn: 12232

Test	Result	Flag	Reference Range	Units
BILI TOTAL	0.8		0.1 - 1.2	mg/dl
SGOT	18		0 - 45	U/L
SGPT	24		0 - 40	U/L
ALK PHOS	74		37 - 107	U/L
AMYLASE	95		34 - 122	U/L
LIPASE	22		22 - 51	U/L

Legend
High =H Low = L Critical =C

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
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PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANGEY, M.D.

CLINICAL LABORATORY REPORT

Patient: **LEE, BERNARD D**
M.R.#: 177273
Financial #: 101265569
DOB: 04/30/1980 *Age:* 24yr *Sex:* M
Location: ER *Room/Bed:*
Admit Date: 04/12/05
Discharge Date:
Physician: SCEMS D

HEMATOLOGY

Collected: 04/12/05 @ 05:40 Accn: 12232

Test	Result	Flag	Reference Range	Units
CBC/DIFF				
PLEASE NOTE: CBC REFERENCE RANGES HAVE CHANGED EFFECTIVE 2-17-2005				
WBC X 1000	6.2		3.4 - 10.0	/mm3
RBC X 1000000	4.17	L	4.31 - 5.83	/mm3
HGB	14.1		13.6 - 17.3	g/dl
HCT	41.2		39.7 - 50.4	%
MCV	99	H	80 - 98	fL
MCH	34		27 - 34	pg
MCHC	34		33 - 36	g/dL
RDW	13.0		10.9 - 14.6	%
PLT x 1000	195		140 - 360	/mm3
Automated DIFF			-	
%Segs	64		50 - 70	%
%Lymphs	19	L	20 - 40	%
%Monos	12	H	0 - 8	%
%Eos	5	H	0 - 2	%
%Basos	0		0 - 1	%
Morphology1	RBCs appear normal			

Legend
High =H Low = L Critical =C

Admission Date: 4/12/05
Med. record No.: 177273
Visit No.: 101265569
Attending Phys.: Scems D, MD

ER Discharge Assessment

Patient: Lee, Bernard D
D.O.B.: 4/30/1980, Age: 24
Gender: Male
Location: EMERGENCY ROOM
Room/Bed: I

Scheduled: 4/12/05 00:46 Status: Finished
Performed: 4/13/05 06:39 User: Melissa Moyer,RN,EMER

ER Discharge

ER Discharge Date/Time: 4/13/2005 07:10. Patient discharged to home. Patient is stable.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

cf
B
0430
Acute abd pain
0710

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AIKEN REGIONAL MEDICAL CENTERS

302 University Parkway • Aiken, South Carolina 29802

TREATMENT AREA Room # 5 Time 0430 Report to Jada VIA EMS

ED NURSING ASSESSMENT RECORD

NEUROMUSCULAR

☒ Normal Adult Pattern ☐ Normal Pediatric Pattern

MENTATION ☐ Disoriented ☐ Agitated ☐ Resp to verbal stim ☐ Combative ☐ Unresponsive ☐ Resp to painful stim

PUPILS ☐ Equal ☐ Unequal

Size R____mm L____mm

R ☐ Fixed ☐ Dilated ☐ Non-reactive ☐ Pinpoint ☐ Sluggish

L ☐ Fixed ☐ Dilated ☐ Non-reactive ☐ Pinpoint ☐ Sluggish

Visual Acuity R:_____ L:_____ Both:_____

SENSATIONS		DECREASED	ABSENT
ARM	R		
ARM	L		
LEG	R		
LEG	L		

ROM		DECREASED	ABSENT
ARM	R		
ARM	L		
LEG	R		
LEG	L		

CARDIOVASCULAR

☒ Normal Adult Pattern ☐ Normal Pediatric Pattern

HEART ☐ Chest pain Describe:_____

EXTREMITIES ☐ Edema ☐ Obvious deformity _____ Describe:_____

CAP REFILL ☐ < 2 Sec ☐ > 2 Sec

PULSES		DECREASED	ABSENT
RADIAL	R		
RADIAL	L		
FEMORAL	R		
FEMORAL	L		
PEDAL	R		
PEDAL	L		

RESPIRATORY

Review above information, assess patient, document changes.

☒ Normal Adult Pattern ☐ Normal Pediatric Pattern

☐ Dyspnea ☐ Stridor ☐ Retraction ☐ Nasal Flaring

COUGH ☐ Productive Describe:_____ ☐ Non-Productive

LUNG SOUNDS	RIGHT	LEFT
Wheezes		
Rales		
Crackles/Course		
Diminished		

CHEST EXPANSION ☐ SYMMETRICAL ☐ ASYMETRICAL ☐ TENDERNESS Describe:_____

GI/ NUTRITIONAL STATUS ☐ N/A

☐ Normal Adult Pattern ☐ Normal Pediatric Pattern

ABDOMEN ☐ Firm ☐ Distended: ☐ Tenderness Describe: generalized

APPETITE ☐ Fair ☐ Poor PTSD pain x 1 days ☐ Special Diet at home:_____

STOOL ☐ Diarrhea ☐ Incontinence ☐ Incontinence ☐ Last BM:_____ ☐ Nausea ☐ Vomiting

GU/ REPRODUCTIVE ☐ N/A

☒ Normal Adult Pattern ☐ Normal Pediatric Pattern

FEMALE ☐ Vaginal Discharge Color:_____ ☐ Vaginal Bleeding Describe:_____ ☐ Breast Problem ☐ R ☐ L Describe:_____

MALE ☐ Prostate Problem Describe:_____ ☐ Genitalia tenderness / swelling / discharge Describe:_____

VOIDING ☐ Frequency ☐ Urgency ☐ Hematuria ☐ Incontinence ☐ Last Void: ☐ Catheter

INTEGUMENT

☒ Normal Adult Pattern ☐ Normal Pediatric ☐ Laceration ☐ Abrasion ☐ Amputation ☐ Avulsion ☐ Bruising ☐ Burn ☐ Bleeding ☐ Diaphoresis ☐ Abnormal Skin Color ☐ Lesions ☐ Rash

Describe:_____

EENT

Eyes: ☐ Contact Lenses ☐ Glasses ☐ Foreign Body ☐ Cataracts ☐ Mucous Membranes Moist/Dry ☐ Injury:_____

Ear/Nose/Throat/Mouth:_____

Visual Acuity: L_____ R_____

☐ Dentures ☐ Glasses ☐ Contacts ☐ Disposition_____

RN/LPN Signatures: [signature]

PAIN ASSESSMENT

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

ADDRESSOGRAPH

101265569

LEE , BERNARD D

DOB: 04/30/1960 24 SX: M EMR

MRN: L77273 ADM/REG DT: 04/12/05

AIKEN REGIONAL MEDICAL CENTER

ED NURSING ASSESSMENT RECORD

630.64 (Rev. 3/03) 10-20214

PROCEDURES / INTERVENTIONS

TIME	PROCEDURE	COMMENTS	BY WHOM	RESULTS	INITIALS
	☐ NG ☐ OG	Side/Location placement verified by auscultation		Amount	
	Pulse oximeter			O_2 Saturation	
	Paracentesis/Thoracentesis			Character/Amount	
	REG replacement			Size:	
	Pelvic Exam			Cultures obtained: ☐ Yes ☐ No	
	Ring Removal	Given to:		Skin color/temp. cap. refill _____ sec	
	Side rails up x _____ for patient safety & call bell given			Verbalized understanding	
	Sling			Skin color/temp. cap. refill _____ sec	
	Suture placement	Supplies		Wound edges approximated	
	Tracheostomy/Cricothyrotomy				
	Other				
	Other				
	Wound Care			Verbalized understanding	

BELONGINGS CHECKLIST FOR ADMISSIONS OR TRANSFERS

Clothing: ☐ Shirt ☐ Sweater ☐ Coat ☐ Vest ☐ Pants ☐ Underwear ☐ Tie/Scarf ☐ Socks/Hose ☐ Hat/Cap ☐ Gloves ☑ Cutoff PTA/ETO (ED)

Accessories: ☐ Shoes ☐ Purse ☐ Wallet ☐ Keys ☐ Other _____

Jewelry: ☐ Yellow Metal (describe): _____ ☐ Yellow Metal (describe): _____

Miscellaneous: ☐ Home Meds ☐ W/Patient ☐ W/Family ☐ to Pharmacy

☐ Dentures ☐ Upper ☐ Lower ☐ Partial ☐ Glasses ☐ Contact Lenses R / L ☐ Hearing Aid R / L ☐ Walker/Cane

Valuables: ☐ W/Patient ☐ W/Family ☐ Security ☐ Other _____

ADMISSION INFORMATION

Admitting Physician _____

Room # _____ Time of Admission _____

VIA ☐ Nurse ☐ Escort ☐ Neg. Agent

Report:

Time: _____

Called to: _____

Portable Monitor: ☐ Yes ☐ No Rhythm: _____

Portable Oxygen: ☐ Yes ☐ No _____ L/M Via _____

Transfer Restraints: ☐ Yes ☐ No

DISPOSITION

DISPOSITION	TYPE	INSTRUCTIONS
	☐ Morgue	☒ See Discharge Instruction Sheet
	☐ LWBS	☐ Verbal/Written Instruction Given To/By:
	☐ AMA	
VIA:	☐ Elopement	☐ Expresses Understanding
☐ Ambulatory	☒ Discharge	☐ Discharged by Physician
☐ Wheelchair	☐ Transfer - See Transfer Record	☐ Instructed not to drive
☐ Stretcher		
☐ Carried		

VS: BP _____ P _____ R _____ T _____ RTS _____ GCS _____

Signature: _____ Time 0710

SIGNATURE / TITLE — INITIALS

Medications/Procedure ordered by _____ M.D.

ASSESSMENTS

Review above information, assess patient, document changes

☐ Unchanged From Initial Assessment _____ Time _____ Int.

☐ Unchanged From Initial Assessment _____ Time _____ Int.

☐ Unchanged From Initial Assessment _____ Time _____ Int.

Assessment changes (time & initials)

0430 – pt amb. into unit 5. pt. instructed to [illegible]

0508 – D/C'd on w/c to [illegible] pt. orders noted. lab notified. labs drawn

0620 – awaiting lab results at w/c. waiting for completion

0700 – meds given to pt. up ambulated & D/C'd w/c. D/C instructions given to pt. pt D/C'd

101265569

LEE , BERNARD D

DOB: 04/30/1980 24 SX: M EMR

MRN: 177273 ADM/REG DT: 04/12/05

AIKEN REGIONAL MEDICAL CENTER

AIKEN REGIONAL MEDICAL CENTERS
302 University Parkway
Aiken, SC 29802

PATIENT NAME: Lee, Bernard DATE OF SERVICE/ADMISSION 4/12/05

CONSENT FOR TREATMENT, GUARANTY OF PAYMENT AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION AND ASSOCIATED NOTICES AND AUTHORIZATION.

NOTICE TO PATIENT AND ALL SIGNATORIES OF THIS DOCUMENT: By your signature below, each signatory of this document is agreeing to be jointly and severally bound by all of the terms and conditions hereinafter set forth unless otherwise noted. In consideration of the hospital care and treatment to be rendered to Patient by Hospital, the undersigned agree and consent to the following:

1. Consent and Conditions of Admission: The undersigned hereby agrees and gives consent to Hospital for the admission/treatment/testing of Patient. The undersigned hereby consents to any and all hospital care encompassing: X-Ray examination, laboratory procedures, diagnostic procedures, anesthesia and nursing or medical/surgical treatment which Patient's physician, his associates, partners or designees, may deem necessary or advisable under the general and special instructions of the same, during Patient's hospitalization.

2. Medical and Surgical Treatment: The undersigned agrees and understands that all physicians, dentists and or oral surgeons treating Patient are responsible and liable for their own acts or omissions and the Hospital is not responsible or liable for the acts omissions of the aforementioned. The undersigned is aware that the practice of medicine is not an exact science and further state that no guarantee has been made or can be made as to the results of the treatments or examinations in the Hospital.

The undersigned certifies that they have read all of this document, including the reverse side hereof, and that the undersigned is the Patient, or is duly authorized by the Patient or by law, to execute the above Agreement and understands its terms.

All Patients shall receive treatment or service within the hospital's capability and policies. Our hospital is committed to patient's impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care.

3. Assignment of Insurance Benefits and Release of Medical Information: The undersigned hereby assign to Hospital, its successors and assigns, all benefits that may be payable to or on behalf of the Patient under any policy of insurance, (hospitalization, major medical, automobile, workmen's compensation, personal injury benefits available because of liability of a third party, or any other) and authorize Hospital to release specifically requested medical information related to Patient to include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assaults, tests for HIV, ARC and/or AIDS, or other infectious diseases necessary for settlement of benefit payment or money payable because of Patient's hospitalization, treatment or injury during this encounter. The undersigned further direct that the payer of any such payment make such payment directly to Hospital. In addition, the undersigned assign to Hospital, its successo and assigns, the proceeds of injury claim resulting from liability to Patient of a third party. Any payments to Hospital under authority of this Assignment shall not exce the actual charges set forth in Hospital's billing statements issued in connection with Patient's account.

If Patient is eligible for Medicare, the undersigned requests Medicare services and benefits. The undersigned further agree that this Assignment will not be withdrawn o voided at any time until Patient's account is paid in full. The undersigned acknowledge that it is their responsibility to pay Hospital for any charges not covered by insurance. Further, undersigned agree and understand that if the Patient, or his duly authorized representative, requests a private room for the Patient the undersigned is responsible for the entire room difference.

The undersigned hereby authorize any agency or employee of the U.S., any State or Municipal Government to release to the Hospital, its employee, employees and/or attorney, any and all information concerning governmental programs under which the above named Patient is or may be qualified to receive benefits due and further authorize payment of any and all such benefits direct to Hospital.

The insured whose signature appears in this item one (1), hereby represents to the Hospital that the following insurance policies are the only insurance policies offering coverage to the patient in this matter and hereby assigns to Hospital all benefits payable to or on behalf of Patient thereunder:

Written authorization for HMO/PPO plans: I understand that if my insurance carrier, HMO plan or PPO network requires preauthorization, the Hospital/Provider/Physician is unable to guarantee that my visit will be covered without a written authorization for the services rendered to me or my family members. the Hospital/Provider/Physician is unable to obtain authorization for my visit, I will be responsible for any unpaid balance. I will be financially responsible for those charges that coincide with any service/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the Hospital accepts no liability for fail to meet any pre/post certification procedures which may be required of me by my coverage carrier. I agree that any such procedures have been or will be properly executed by me.

Primary Insurance Co. Self-Pay

Patient [signature]

Insured

Secondary Insurance Co.

Patient

Insured

Addressograph

101265569
LEE , BERNARD D
DOB: 04/30/1980 24 SX: M EMR
MRN: 177273 ADM/REG DT: 04/12/05
AIKEN REGIONAL MEDICAL CENTER

Form 902.02 (Rev 10/04) **10-1983**

PHYSICIANS NOT AS EMPLOYEES: I acknowledge that all physicians furnishing services including but not limited to radiologists, pathologists, anesthesiologists, emergency department physicians, consultants and assistants to the physician are not employees of the Hospital. I understand that I may receive separate billing from each of these providers for services rendered.

4. **Guaranty of Payment:** The undersigned jointly and severally agrees to be bound to Hospital for payment and absolutely guarantees payment to hospital on demand of all [illegible] now or hereafter incurred for goods and services furnished by Hospital to Patient in connection with Patient's treatment and/or stay at Hospital. This is a continuing guarantee of payment on demand of the entire unpaid balance of charges incurred during the period from the date of service of each admission/encounter of Patient is discharged and includes guaranty of payment of outpatient charges for services rendered on the date noted above and any follow-up encounters. Charges such charges shall be in accordance with the regular rates and charges of the Hospital in effect at the time of the rendering of the services or the furnishing of the goods for which the charge is incurred.

Should patient's account be turned over to any attorney for collection or legal proceedings of any kind, the undersigned jointly and severally, absolutely guarantee payment to Hospital of all costs and expenses incurred by Hospital in connection with such collection action and or legal proceedings, including a reasonable attorney's fee not to exceed fifteen (15) percent of the unpaid balance due.

The undersigned also agrees that any over payments collected in connection with any particular admission or outpatient treatment of Patient may be applied directly to a delinquent account of Patient or any delinquent account for which Patient or any undersigned is legally responsible at the time of collection of the over payment. Hospital may make a Repayment Agreement with any one or more of the undersigned, which Agreement shall be considered supplementary to and not in lieu of this Agreement and shall not be construed as limiting or modifying the liability of any other signatory to this Agreement.

Patient signatories, Spouse of Patient signatories, Guarantor signatories and Parent or Guardian signatories are jointly and severally bound by all the terms hereof including liability for payment to Hospital under this Guaranty of Payment Agreement.

5. **Assignment of Physician Benefits:** In the event that Patient, in addition to Hospital services, is entitled to any physician benefits or any type whatsoever arising out of policy of insurance insuring Patient or any other parties liability to Patient, the undersigned hereby assigns said benefits to any physician rendering care or treatment during the stay associated with this admission or any outpatient visits, to be applied to Patient's bill.

6. **Medicare Patient Certification:** The undersigned certify that the information given by the undersigned in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for a Medicare claim related to patient. The undersigned authorize and direct that a copy of this Authorization may be used in place of the original and request payment of authorized benefits be made on behalf of the Patient.

7. **Personal Valuables and Belongings:** The undersigned acknowledge and agree that the Hospital maintains a safe for the safekeeping of valuables. The Hospital shall not be held responsible or liable for the loss or damage to any articles of personal property while Patient is hospitalized unless said articles are deposited with the Hospital in the safe and receipts are issued describing said items. If the patient is unable to sign and in the event no relative is present, the Hospital shall retain possession of valuables and obtain acknowledgement at the first available opportunity.

8. **Cameras and Surveillance Equipment:** Patient has been advised that Aiken Regional Medical Center uses cameras and other surveillance equipment to monitor employee activities. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment.

9. You have the right to file a grievance regarding concerns with our quality. The agency you may contact is:

Department of Health and Environmental Control (DHEC) Licensing Division
2600 Bull Street
Columbia, South Carolina 29202
803-737-7370

10. Smoking is prohibited except in certain areas. Please discuss any special needs with your physician.

11. I acknowledge that laboratory studies may be performed in the event a health care worker is exposed to my blood or body fluid.

I, the undersigned, state that the information that I have provided Aiken Regional Medical Center is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
ORIGINAL SIGNATURE ON FILE AT AIKEN REGIONAL MEDICAL CENTERS

4/12/05 [illegible] Bapp

Date / Time — Patient Parent/Guardian/Responsible Party — Witness

Address — Witness

City — State — Zip

☐ No ID
☐ No Insurance Card
☐ Address Correct on ID

Reason Patient Did Not Sign _____ ☐ Patient was given the option to deposit valuables in safe

TELEPHONE CONSENT	Patient Name
Witness	Obtained From / Relationship
Witness	Phone # / Date Time

Aiken Regional
MEDICAL CENTERS
The Health Choice

202 University Parkway, Aiken, SC 29801

MED. REC. NO. 177273

PT NO 102032224	PATIENT NAME LEE , BERNARD D												PT STS: ET
ADDRESS 172 OLD INDIAN CHEROKEE RD													COUNTY 2
CITY GRANITEVILLE				STATE SC	ZIP 29829-0000	PHONE 803-663-0560		EXT.		SOCIAL SECURITY NO 999-99-9999			
AGE 25	DOB 04/30/1980	SEX M	RACE 2	MS S	PREVIOUS NAME					RELIGION BAP	N/S	RM/BED	
ADMDATE 10/29/05	TIME 03:21	SRC EO	PT TYPE T	PRI X	ACCIDENT INFO H	10/29/05 03:00		VOLUNTARY ADM		ORGAN DNR	ISOL	INFANT AGE	
PT EMPLOYER UNEMPLOYED					TELEPHONE - -		EXT	OCCUPATION UNEMPLOYED					
EMPLOYER ADDRESS													
CITY				STATE	ZIP					RETIREMENT DATE			
NEAREST RELATIVE NAME LEE , VIRGINIA													
RLTN B	ADDRESS UNK												
CITY CLEARWATER				STATE SC	ZIP 29822-	PHONE 803-663-1533		EXT					
EMERGENCY CONTACT NAME LEE , MARIE													
RLTN N	ADDRESS 172 OLD INDIAN CHEROKEE RD												
CITY GRANITEVILLE				STATE SC	ZIP 29829-	PHONE 803-663-0560		EXT					
GUARANTOR NAME LEE , BERNARD D										RLTN S	SOCIAL SECURITY NUMBER 251-45-2204		
ADDRESS 172 OLD INDIAN CHEROKEE RD											PHONE 803-663-0560		
CITY GRANITEVILLE				STATE SC	ZIP 29829-	OCCUPATION UNEMPLOYED					EXT		
GUARANTOR EMPLOYER UNEMPLOYED						PHONE 706-999-9999		EXT					
ADDRESS MIKE PADGET HWY													
CITY AUGUSTA				STATE GA	ZIP 30906-								FC F
INSURANCE NAME PRIVATE PAY		CODE 910	POLICY #		GROUP #			SUBSCRIBER LEE , BERNARD S		REL S	AUTH #		
INSURANCE NAME 2		CODE	POLICY #		GROUP #			SUBSCRIBER		REL	AUTH #		
INSURANCE NAME 3		CODE	POLICY #		GROUP #			SUBSCRIBER		REL	AUTH #		
ATTENDING PHYSICIAN GRANT STEPHEN				ATTENDING # 003848	REF SRC	ADM BY ABBOTA		PREV ADM DATE		PREVIOUS FACILITY			
ADMDIAGNOSIS STABBED IN BACK				MED SVC EMR	CODE	ALLERGIES NKA						SURGERY DATE	
ADMITTING PHYSICIAN GRANT STEPHEN				ADMITTING # 003848	AUTHORIZED BY								
PROCEDURE				CLINICAL COMMENT				MODE OF ARRIVAL/ACCOMPANIED BY POV					
RELEASE Y	ADV DIR	LIVING WILL	LOCATION OF WILL/DIRECTIVE			FAMILY DOCTOR GRANT STEPHEN					003848		

FINAL DIAGNOSES (FIRST DIAGNOSIS PRINCIPAL UNLESS NOTED)

CODE

877.0
E966
E8499

AUGUSTA DATA STORAGE INC.
F0000011241300

86.59
12002

PROCEDURES

CONSULTING PHYSICIANS

DRG _____

LOS _____

TRANS TO: ACUTE ☐ SNF ☐ REHAB ☐ HOSPICE ☐ HOME HEALTH ☐ HOME IV ☐ AGAINST MED ADV ☐ HOME ☐

DISCHARGE DATE | TIME | OTHER

EXPIRED ☐ TIME _____ <48HRS ☐ >48HRS ☐ CORONER ☐ AUTOPSY YES ☐ NO ☐

ATTENDING PHYSICIAN SIGNATURE & DATE

RxLASER, INC. C2408-20051 (714) 986-1559 (2/99) CHART COPY - 194 - NOT REMOVE FROM CHART

Defendant Exhibit

102 052 224

AIKEN REGIONAL MEDICAL HEALTH CENTERS
EMERGENCY PHYSICIAN REPORT

CHIEF COMPLAINT: Stab wounfd back
Patient complains of a laceration on the back. Laceration was caused by a knife approximately 1 hour prior to arrival. The injury allegedly occurred during an altercation.

PATIENT'S ALLERGIES: none
PATIENT'S CURRENT MEDICATIONS: none
REVIEW OF SYSTEMS: General: No mental status change.
Cardiac: No unexpected chest pain.
GI: No significant abdominal pain, no nausea, no vomiting.
Eye: No vision loss.
ENT/Mouth: No tooth loss.
Musculoskeletal: No muscle weakness.
Neuro: No seizure, no paralysis.
Pulmonary: No SOB, no hemoptysis.
Skin: No rash.
PMH: Medical History: negative

PHYSICAL EXAM: Vital Signs: Reviewed Nurse's notes.
PATIENT STATUS: alert and cooperative.
1: linear3 cm laceration of the sacral are. with two smaller 1 cm lacerations laterally. All superficial, clean. There is no foreign body in the wound. No neurovascular deficit related to this injury.

TREATMENT:
1: The affected area was prepped with Betadine. 1% Xylocaine without epinephrine, local block. The laceration was explored to its base. There was no foreign body in the wound. Wound repaired: The skin was closed with 3-0 nylon.

DIAGNOSIS: superficial stab wound x 3 sacral area

DISPOSITION: Patient was discharged home.
Patient was instructed to follow-up with their doctor, and/or the doctor that they were referred to, or return to the Emergency Department if:
Their condition worsens unexpectantly, their condition does not improve as expected, or they develop new symptoms.

S Grant, Sat Oct 29, 2005 04:36 am

AIKEN REGIONAL MEDICAL CENTERS

302 University Parkway • Aiken, South Carolina 29802

TREATMENT AREA Room # _____ Time 0321 Report to Unmuda VIA AMB

ED NURSING ASSESSMENT RECORD

NEUROMUSCULAR

☑ Normal Adult Pattern ☐ Normal Pediatric Pattern

MENTATION ☐ Disoriented ☐ Agitated ☐ Resp to verbal stim
☐ Combative ☐ Unresponsive ☐ Resp to painful stim

PUPILS ☑ Equal ☐ Unequal
Size R____mm L____mm
R ☐ Fixed ☐ Dilated ☐ Non-reactive
☐ Pinpoint ☐ Sluggish
L ☐ Fixed ☐ Dilated ☐ Non-reactive
☐ Pinpoint ☐ Sluggish

ETOH

Visual Acuity R:_____ L:_____ Both:_____

SENSATIONS

		DECREASED	ABSENT
ARM	R		
ARM	L		
LEG	R		
LEG	L		

ROM

		DECREASED	ABSENT
ARM	R		
ARM	L		
LEG	R		
LEG	L		

CARDIOVASCULAR

☑ Normal Adult Pattern ☐ Normal Pediatric Pattern

HEART ☐ Chest pain Describe:_____

EXTREMITIES ☐ Edema ☐ Obvious deformity _____
Describe:_____

CAP REFILL ☐ < 2 Sec ☐ > 2 Sec

PULSES

		DECREASED	ABSENT
RADIAL	R		
RADIAL	L		
FEMORAL	R		
FEMORAL	L		
PEDAL	R		
PEDAL	L		

RESPIRATORY

Review above information, assess patient, document changes.

☑ Normal Adult Pattern ☐ Normal Pediatric Pattern
☐ Dyspnea ☐ Stridor ☐ Retraction ☐ Nasal Flaring

COUGH ☐ Productive Describe:_____
☐ Non-Productive

LUNG SOUNDS

	RIGHT	LEFT
Wheezes		
Rales		
Crackles/Course		
Diminished		

CHEST EXPANSION
SYMMETRICAL
ASYMETRICAL
TENDERNESS

Describe:_____

GI / NUTRITIONAL STATUS

☑ Normal Adult Pattern ☐ Normal Pediatric Pattern

ABDOMEN ☐ Firm ☐ Distended
☐ Tenderness Describe:_____

APPETITE ☑ Fair ☐ Poor
☐ Special Diet at home:_____

STOOL ☑ Diarrhea ☐ Incontinence ☐ Incontinence
☐ Last BM:____ ☐ Nausea ☐ Vomiting

GU / REPRODUCTIVE

☑ Normal Adult Pattern ☐ Normal Pediatric Pattern

FEMALE ☐ Vaginal Discharge Color:_____
☐ Vaginal Bleeding Describe:_____
☐ Breast Problem ☐ R ☐ L Describe:_____

MALE ☐ Prostate Problem Describe:_____
☐ Genitalia tenderness / swelling / discharge
Describe:_____

VOIDING ☐ Frequency ☐ Urgency ☐ Hematuria ☐ Incontinence
☐ Last Void: ☐ Catheter

INTEGUMENT

☐ Normal Adult Pattern ☐ Normal Pediatric ☑ Laceration SS lab
☐ Abrasion ☐ Amputation ☐ Avulsion ☐ Bruising ☐ Burn ☐ Bleeding ☐ Diaphoresis ☐ Abnormal Skin Color ☐ Lesions ☐ Rash
Describe: R Scalp & Superior Lip

EENT

Eyes: ☐ Contact Lenses ☐ Glasses ☐ Foreign Body ☐ Cataracts ☐ Mucous Membranes Moist/Dry
☐ Injury:_____

Ear/Nose/Throat/Mouth:_____

Visual Acuity: L_____ R_____

☐ Dentures ☐ Glasses ☐ Contacts ☐ Disposition_____

RN/LPN Signatures _____

PAIN ASSESSMENT

No Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

ADDRESSOGRAPH

102032224
LEE , BERNARD D
DOB: 04/30/1980 25 SX: M EMR
MRN: 177273 ADM/REG DT: 10/29/05
AIKEN REGIONAL MEDICAL CENTER

ED NURSING ASSESSMENT RECORD

630.64 (Rev. 3/03) 10-20214

TIME	PROCEDURE	COMMENTS	BY WHOM	RESULTS	INITIALS
	☐ NG ☐ OG	Side/Location placement verified by auscultation		Amount	
	Pulse oximeter			O_2 Saturation	
	Peripheral/Thoracentesis			Chemo/Account	
	PEG replacement			Size:	
	Pelvic Exam			Cultures obtained: ☐ Yes ☐ No	
	Ring Removal	Given to:		Skin color/temp. cap. refill _____ sec	
	Side rails up x ____ for patient safety & call bell given			Verbalized understanding	
	Sling			Skin color/temp. cap. refill _____ sec	
	Suture placement	Supplies		Wound edges approximated	
	Tracheostomy/Chest tube				
	Other				
	Other				
	Wound Care			Verbalized understanding	

BELONGINGS CHECKLIST FOR ADMISSIONS OR TRANSFERS

Clothing: ☐ Shirt ☐ Sweater ☐ Coat ☐ Vest ☐ Pants ☐ Underwear ☐ Tie/Scarf ☐ Socks/Hose ☐ Hat/Cap ☐ Gloves ☐ Cutoff PTA/ETC (ED)

Accessories: ☐ Shoes ☐ Purse ☐ Wallet ☐ Keys ☐ Other _____

Jewelry: ☐ Yellow Metal (describe): _____ ☐ Yellow Metal (describe): _____

Miscellaneous: ☐ Home Meds ☐ W/Patient ☐ W/Family ☐ to Pharmacy
☐ Dentures ☐ Upper ☐ Lower ☐ Partial ☐ Glasses ☐ Contact Lenses R / L ☐ Hearing Aid R / L ☐ Walker/Cane

Valuables: ☐ W/Patient ☐ W/Family ☐ Security ☐ Other _____

ADMISSION INFORMATION

Admitting Physician _____

Room # _____ Time of Admission _____

VIA ☐ Nurse ☐ Escort ☐ Neg. Agent

Report:
Time: _____
Called to: _____
Portable Monitor: ☐ Yes ☐ No Rhythm: _____
Portable Oxygen: ☐ Yes ☐ No _____ L/M Via _____
Transfer Restraints: ☐ Yes ☐ No

DISPOSITION

DISPOSITION	TYPE	INSTRUCTIONS
	☐ Morgue	☐ See Discharge Instruction Sheet
	☐ LWBS	☐ Verbal/Written Instruction Given To/By:
	☐ AMA	N/A
VIA:	☐ Elopement	☑ Expresses Understanding
☐ Ambulatory	☑ Discharge	☐ Discharged by Physician
☐ Wheelchair	☐ Transfer - See Transfer Record	☐ Instructed not to drive
☑ Stretcher		
☐ Carried		

VS: BP ____ P ____ R ____ T ____ RTS ____ GCS ____

Signature: _____ Time _____

SIGNATURE / TITLE	INITIALS

Medications/Procedure ordered by _____ M.D.

Progress Notes

☐ Unchanged From Initial Assessment _____ Time _____ Int.
☐ Unchanged From Initial Assessment _____ Time _____ Int.
☐ Unchanged From Initial Assessment _____ Time _____ Int.
Assessment changes (time & initials)

0330 Dressing to wound
0330 X-ray @ R [illegible]
0350 Dressing soaked through, [illegible]
Pressure dressing
applied to [illegible]
back that are cont to
bleed
0420 Dr. Brant @ BS
to [illegible], Pressure
dressing applied to
0500 Dressing dry
intact
Pt sleeping SR1 x 2

102032224
LEE , BERNARD D
DOB: 04/30/1980 25 SX: M EMR
MRN: 177273 ADM/REG DT: 10/29/05
AIKEN REGIONAL MEDICAL CENTER

Aiken Regional Medical Centers

Admission Date: 10/29/05
Med. record No.: 177273
Visit No.: 102032224
Attending Phys.: Grant, S. 003848, MD
Allergies: Not yet reviewed

ER Discharge Assessment

Patient: Lee, Bernard D
D.O.B.: 4/30/1980, Age: 25
Gender: Male
Location: EMERGENCY ROOM
Room/Bed: I

Scheduled: 10/29/05 03:21 User: Amanda Abbot RN
Performed: 10/29/05 05:37 Status: Finished

ER Discharge

0321

ER Discharge Date/Time: 10/29/2005 05:38. Patient discharged to home. Patient discharged via wheelchair, accompanied by relative. Transported by private vehicle. Patient condition is stable. Discharge instructions given to relative. Room checked. No personal belongings found.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family. Comments: pt is still intoxicated. pt d/c'd with cousin to care for pt..

3A
Stab wound X3 + Closure

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Aiken Regional Medical Centers

Emergency Services

102032224
LEE , BERNARD D
DOB: 04/30/1980 25 SX: M EMR
MRN: 177273 ADM/REG DT: 10/29/05
AIKEN REGIONAL MEDICAL CENTER

GENERAL INSTRUCTIONS:

☐ Call the next business day and make an appointment to see: _____

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: _____ days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within _____ days.

☐ Return to the Emergency Department after 12:30 p.m. in _____ days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☐ Work / school excuse from _____ thru _____.

☐ See your company doctor per your company's policy. Light duty until _____.

(No use of _____ No lifting over _____ lbs.)

☐ SUTURES OUT IN 10 DAYS

RETURN IF WORSE

Your diagnosis was:

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions

- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diptheria booster***
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X_Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physician
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Department.

Physician _____ 10/29/05 _____

Staff Date Patient or Responsible Person

630.06 Rev. 10/02 WHITE - RECORDS CANARY - PATIENT GOLDENROD - PATIENT FORM 10-2183 3/

Chief Complaint:

HPI

Current Meds:
☐ See ED nurses notes

PMD

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, & ROS Unobtainable due to: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF
☐ As Above ☐ Other:

Past Surgical History:

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☐ Yes Amt ETOH ☐ No ☐ Yes Amt ☐ Other

Review Of Systems: Check ☐ If normal Check ○ If abnormal *If not Checked then not applicable.)*

☐ Other ROS Neg

Eyes:	☐ ○ Diplopia	☐ ○ Blurred	☐ ○ Vision chgs	*GU:*	☐ ○ Dysuria	☐ ○ Urgency	☐ ○ Hematuria
ENT:	☐ ○ Rhinitis	☐ ○ Sore throat	☐ ○ Nose bleeds	*MS:*	☐ ○ Myalgia	☐ ○ Back pain	☐ ○ Neck pain
Card:	☐ ○ CP	☐ ○ Palpitation		*Neuro:*	☐ ○ Seizures	☐ ○ Dizziness	☐ ○ Syncope
Respir:	☐ ○ SOB	☐ ○ Cough	☐ ○ Hemoptysis		☐ ○ Weakness	☐ ○ Numbness	
GI:	☐ ○ Nausea	☐ ○ Vomiting	☐ ○ Diarrhea	*Endo:*	☐ ○ Polyuria	☐ ○ Hypoglyc	☐ ○ Thyroid Dys
	☐ ○ Abd pain	☐ ○ Melena	☐ ○ Hematochez	*Hem/Lym:*	☐ ○ Anemia	☐ ○ Bleeding	

☐ For allergies see ED nurses notes

Other ROS

TETANUS STATUS:

ALLERGIES:

Physical Exam: WEIGHT | TIME | PULSE | OX: | TEMP | P | R | BP |

☐ For vitals see ED nurses notes

Check ☐ If normal Check ○ If abnormal

					Abn Findings:
General:	☐ ○ Mental Status				
Eyes:	☐ ○ Conjun NL	☐ ○ Lids	☐ ○ PERRL		
Head:	☐ ○ NL cephalic	☐ ○ Sinuses	☐ ○ Nose		
ENT:	☐ ○ Oropharynx	☐ ○ Right TM	☐ ○ Left TM		
Neck:	☐ ○ Palpation	☐ ○ Thyroid	☐ ○ Trachea		
Chest:	☐ ○ Palpation	☐ ○ Excurtion	☐ ○ Symmetry		
Cardio:	☐ ○ Heart sounds	☐ ○ R & R			
Respir:	☐ ○ Respir effort	☐ ○ Lung sounds			
Abdom:	☐ ○ Palpation	☐ ○ Bowel Sounds			
MS:	☐ ○ RUE	☐ ○ RLE	☐ ○ Digits		
	☐ ○ LUE	☐ ○ LLE	☐ ○ Back		
	☐ ○ Pelvis	☐ ○ Gait			
Skin:	☐ ○ Temp	☐ ○ Appear	☐ ○ Color		
Neuro:	☐ ○ CNS	☐ ○ Strength	☐ ○ Sensation		

TEST:	ORD	Initial
CBC W DIFF:		
CHEM 8:		
URINE PREG:		
CCUA:		
CATH UA:		
URINE C&S:		
EKG:		
OLD EKGS:		
TROPONIN:		
PT/PTT:		
FINGER ST GL:		
BLOOD CULT X		
TYPE & SCREEN:		
TYPE CROSS UNITS:		
LIVER PANEL:		
CMP:		
AMYLASE:		
LIPASE:		
HEMOCULT:		
TYPE & RH:		
HCG QUANT:		
URINE DRUG S:		
ALCOHOL:		
ED ABG:		
PA/LAT CXR:		
PCXR:		
C-SPINE:		
L-SPINE:		
ACUTE ABD:		
OLD RECORDS:		
OLD ED Record:		

TIME INITIAL ✓TEST ORDERED

PHYSICIAN'S ORDERS: TIME ORD: TIME COMPL Initials

→ URINE PREG RESULTS:

Med Decision Making:

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME:

Diff Dx:

Consult/s:

NAME OF PHYSICIAN THAT ADMITTED PT:

NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

☐ Encounter only
☐ Dictated only
☐ ~~Temp sheet only~~
☐ Dictated & Encounter
☐ Dictated & Temp sheet

DISCHARGE DIAGNOSIS:

STAB WOUND SACRUM X3
CELLULITE STAB WOUND X2

CODES

☐ STABLE

☐ UNSTABLE SEE NOTE

Physician Signature:

Time MD IN:

Name: Race: Sex: Age:

Addressograph

10203224

LEE , BERNARD D
DOB: 04/30/1980 25 SX: M EMR
MRN: 177273 ADM/REG DT: 10/29/05
AIKEN REGIONAL MEDICAL CENTER

ED Encounter Record
530.70

10-241

AIKEN REGIONAL MEDICAL CENTERS
302 University Parkway
Aiken, SC 29802

PATIENT NAME: Bernard Lee – DATE OF SERVICE/ADMISSION 10/29/05–

CONSENT FOR TREATMENT, GUARANTY OF PAYMENT AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION AND ASSOCIATED NOTICES AND AUTHORIZATION.

NOTICE TO PATIENT AND ALL SIGNATORIES OF THIS DOCUMENT: By your signature below, each signatory of this document is agreeing to be jointly and severally bound by all of the terms and conditions hereinafter set forth unless otherwise noted. In consideration of the hospital care and treatment to be rendered to Patient by Hospital, the undersigned agree and consent to the following:

1. Consent and Conditions of Admission: The undersigned hereby agrees and gives consent to Hospital for the admission/treatment/testing of Patient. The undersigned hereby consents to any and all hospital care encompassing: X-Ray examination, laboratory procedures, diagnostic procedures, anesthesia and nursing or medical/surgical treatment which Patient's physician, his associates, partners or designees, may deem necessary or advisable under the general and special instructions of the same, during Patient's hospitalization.

2. Medical and Surgical Treatment: The undersigned agrees and understands that all physicians, dentists and or oral surgeons treating Patient are responsible and liable for their own acts or omissions and the Hospital is not responsible or liable for the acts omissions of the aforementioned. The undersigned is aware that the practice of medicine is not an exact science and further state that no guarantee has been made or can be made as to the results of the treatments or examinations in the Hospital.

The undersigned certifies that they have read all of this document, including the reverse side hereof, and that the undersigned is the Patient, or is duly authorized by the Patient or by law, to execute the above Agreement and understands its terms.

All Patients shall receive treatment or service within the hospital's capability and policies. Our hospital is committed to patient's impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care.

3. Assignment of Insurance Benefits and Release of Medical Information: The undersigned hereby assign to Hospital, its successors and assigns, all benefits that may be payable to or on behalf of the Patient under any policy of insurance, (hospitalization, major medical, automobile, workmen's compensation, personal injury benefits available because of liability of a third party, or any other) and authorize Hospital to release specifically requested medical information related to Patient to include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assaults, tests for HIV, ARC and/or AIDS, or other infectious diseases necessary for settlement of benefit payment or money payable because of Patient's hospitalization, treatment or injury during this encounter. The undersigned further direct that the payer of any such payment make such payment directly to Hospital. In addition, the undersigned assign to Hospital, its successor and assigns, the proceeds of injury claim resulting from liability to Patient of a third party. Any payments to Hospital under authority of this Assignment shall not exceed the actual charges set forth in Hospital's billing statements issued in connection with Patient's account.

If Patient is eligible for Medicare, the undersigned requests Medicare services and benefits. The undersigned further agree that this Assignment will not be withdrawn or voided at any time until Patient's account is paid in full. The undersigned acknowledge that it is their responsibility to pay Hospital for any charges not covered by insurance. Further, undersigned agree and understand that if the Patient, or his duly authorized representative, requests a private room for the Patient the undersigned is responsible for the entire room difference.

The undersigned hereby authorize any agency or employee of the U.S., any State or Municipal Government to release to the Hospital, its employee, employees and/or i attorney, any and all information concerning governmental programs under which the above named Patient is or may be qualified to receive benefits due and further authorize payment of any and all such benefits direct to Hospital.

The insured whose signature appears in this item one (1), hereby represents to the Hospital that the following insurance policies are the only insurance policies offering coverage to the patient in this matter and hereby assigns to Hospital all benefits payable to or on behalf of Patient thereunder:

Written authorization for HMO/PPO plans: I understand that if my insurance carrier, HMO plan or PPO network requires preauthorization, the Hospital/Provider/Physician is unable to guarantee that my visit will be covered without a written authorization for the services rendered to me or my family members. the Hospital/Provider/Physician is unable to obtain authorization for my visit, I will be responsible for any unpaid balance. I will be financially responsible for those charges that coincide with any service/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the Hospital accepts no liability for failu to meet any pre/post certification procedures which may be required of me by my coverage carrier. I agree that any such procedures have been or will be properly executed by me.

Primary Insurance Co. Private Pay –

Patient X _____

Insured _____

Secondary Insurance Co. _____

Patient _____

Insured _____

Addressograph

102032224

LEE , BERNARD D
DOB: 04/30/1980 25 SX: M EMR
MRN: 177273 ADM/REG DT: 10/29/05
AIKEN REGIONAL MEDICAL CENTER

Form 902.02 (Rev 10/04) 10-1983

PHYSICIANS NOT AS EMPLOYEES: Lakeside Hospital, all employees furnishing services including but not limited to radiologists, anesthesiologists, emergency department physicians, consultants and specialists who perform services are employees of the Hospital. Patient will receive separate billing from each of these providers for services rendered.

4. Guaranty of Payment: The undersigned jointly and severally promise to be bound to Hospital for payment and discharge of Patient's current payment to hospital on demand of all charges or fees of Hospital incurred for goods and services furnished to the Hospital to Patient (whether or not with Patient's agreement) and received at Hospital. This is an affirmative promise to pay upon demand the entire unpaid balance of charges incurred during the period from the date of service rendered to Patient to date Patient is discharged as Hospital patient. Guaranty of payment of outpatient charges for services rendered on the date service is rendered. Hospital charges shall be in accordance with the regular rates and charges of the Hospital in effect at the time of the rendering of the services or the furnishing of the goods for which the charges are incurred.

Should patient's account be turned over to any attorney for collection or legal proceedings are instituted against the undersigned to enforce payment, undersigned promises to pay to Hospital all costs and expenses incurred by Hospital in connection with such collection and/or legal proceedings, including attorney's fees not to exceed fifteen (15) percent of the unpaid balance due.

The undersigned also agrees that any overpayments collected in connection with any insurance, third party, or other reimbursement or collection of Patient's account may be applied directly to a delinquent account of Patient or any delinquent account for which Patient or any undersigned is jointly responsible or for the benefit of either of the overpayment. Hospital may make a Repayment Agreement with any one or more of the undersigned which Agreement shall be considered incorporated herein and made a part of this Agreement and shall not be construed as limiting or modifying the liability of any of the signatory to this Agreement.

Patient signatories, Spouse of Patient signatories, Guarantor signatories, and Parent or Parent guardian signatories are jointly and severally bound by all the terms hereof including liability for payment to Hospital under this Guaranty of Payment agreement.

5. Assignment of Physician Benefits: In the event that Patient, in addition to Hospital benefits, is entitled to any physician benefits or any type whatsoever arising out of policy of insurance insuring Patient or any other parties liability to Patient, the undersigned hereby assigns said benefits to any physicians rendering care or treatment during the stay associated with this admission or any outpatient visits, to be applied to Patient's bill.

6. Medicare Patient Certification: The undersigned certify that the information given in the block signed in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for a Medicare claim related to patient. The undersigned authorize and direct that payment of the Medicare benefits may be made in place of the original and request payment of authorized benefits be made on behalf of the Patient.

7. Personal Valuables and Belongings: The undersigned acknowledges and agrees that the Hospital maintains a valuables safekeeping service for the safekeeping of valuables. The Hospital shall not be held responsible or liable for the loss or damage to any articles of personal property while Patient is hospitalized unless said articles are deposited with the Hospital in the safe and receipts are issued describing said items. If the patient is unable to sign due to severe incapacity, the Hospital will retain possession of valuables and obtain acknowledgment at the first available opportunity.

8. Cameras and Surveillance Equipment: Patient has been advised that Aiken Regional Medical Center uses video monitoring and other surveillance equipment for the purpose of providing security services. As a condition of admission, patient hereby consents to being photographed and monitored by such equipment during the course of his/her stay and agrees not to hold the Hospital liable for any claims arising out of the use of such equipment.

Any questions you may have regarding these services should be directed to:

Department of Health and Human Services
2000 Hall Street
Columbia, South Carolina 29201
(803) 555-1212

9. Surgery is prohibited except in emergencies. Please discuss any special procedures with your physician.

10. Patient understands that [illegible] Medical Center [illegible]

I have read and understand the above paragraphs. I have received a copy of these terms and have had the opportunity to ask questions about them.

10/29/05 — X

A COPY OF THIS SIGNED AUTHORIZATION HAS BEEN PROVIDED TO YOU.
DO NOT SIGN BEFORE YOU HAVE READ THE ENTIRE AUTHORIZATION.

Witness

Witness

Patient

Date

Time

Relationship

Admission Date: 10/29/05
Med. record No.: 177273
Visit No.: 102032224
Attending Phys.: Grant, S. 003848, MD
Allergies: Not yet reviewed

Quick Triage

Patient: Lee, Bernard D
D.O.B.: 4/30/1980, Age: 25
Gender: Male
Location: EMERGENCY ROOM
Room/Bed: I

Scheduled: 10/29/05 03:21 | User: Amanda Abbot RN
Performed: 10/29/05 03:22 | Status: Finished

Quick Triage Info

Patient triaged as emergent. Primary complaint is back pain/injury pt has stab wound to low back. Patient is in pain. Rates pain as 6 on a scale of 0 to 10, with 0 being no pain and 10 being worst pain imaginable. There is no evidence of abuse and/or neglect Treatment given in triage: bleeding control. After triage patient went to ED room 1.

BP 131/60

HR 90

Temp 98.5

Resp 20

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AIKEN REGIONAL MEDICAL CENTERS RADIOLOGICAL CONSULTATION

PT NAME: LEE, BERNARD D VT: ER SEQ: 00021
ROOM #: 1 XRAY#: 962389
BILLING#:102032224 MEDREC#: 177273
DOB: 04/30/1980 REF PHYS: STEPHEN GRANT
DATE DONE: 10/29/05 PRI PHYS: STEPHEN GRANT
SSN: 251452204
SEX: M
TEST REASON: stab wound
COMMENTS:
ADMIT DIAG: STABBED IN BACK
PROCEDURE #1: CHEST 1V CPT#1: 71010
PROCEDURE #2: CPT#2:
PROCEDURE #3: CPT#3:
CONFIDENTIAL - IF NOT INTENDED FOR YOU, PLEASE CALL (803) 641-5060

Job Number:151973 Text Status:checked Text Body:

Job#151973 MR#177273 A0065363

Portable Chest: 10/29/05

History: Stab wound.

Technique: A single view of the chest was obtained.

Findings: The cardiac silhouette and pulmonary vasculature are within normal limits. The lungs are clear. The bony structures are grossly unremarkable. No pneumothorax is identified.

Conclusion:

No acute cardiopulmonary disease.

DATE DICTATED: 10/29/05

PT NAME: LEE, BERNARD D
ROOM#: 1
DATE REQUESTED: 10/29/05 DATE SIGNED: 10-30-05
DATE TRANSCRIBED: 10/29/05 TIME SIGNED: 11:20
TRANSCRIBED BY: YSMOAK

READ BY: ALFONSO GAY, M.D.

ELECTRONICALLY SIGNED BY: ALFONSO GAY, M.D.

Aiken Regional
MEDICAL CENTERS
The Health Choice

202 University Parkway, Aiken, SC 29801

MED. REC. NO. 177273

PT NO: 102075173	PATIENT NAME: LEE, BERNARD D												PT STS: ET
ADDRESS: 172 OLD INDIAN CHEROKEE RD													COUNTY: 2
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-0000		PHONE: 803-663-0560		EXT:			SOCIAL SECURITY NO: 251-45-2204		
AGE: 25	DOB: 04/30/1980	SEX: M	RACE: 2	MS: S	PREVIOUS NAME: BEDLESS;					RELIGION: BAP	N/S	RM/BED	
ADM DATE: 11/09/05	TIME: 09:19	SRC: EO	PT TYPE: T	PRI: X	ACCIDENT INFO: H	11/08/05	03:00	VOLUNTARY ADM		ORGAN DNR	ISOL	INFANT AGE	
EMPLOYER: UNEMPLOYED					TELEPHONE: - -		EXT	OCCUPATION: UNEMPLOYED					
EMPLOYER ADDRESS													
CITY			STATE	ZIP						RETIREMENT DATE			
NEAREST RELATIVE NAME: LEE, VIRGINIA													
RLTN: B	ADDRESS: UNK												
CITY: CLIBARWATER			STATE: SC	ZIP: 29822-		PHONE: 803-663-1533		EXT					
EMERGENCY CONTACT NAME: LEE, MARIE													
RLTN: N	ADDRESS: 172 OLD INDIAN CHEROKEE RD												
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-		PHONE: 803-663-0560		EXT					
GUARANTOR NAME: LEE, BERNARD D										RLTN: S	SOCIAL SECURITY NUMBER: 251-45-2204		
ADDRESS: 172 OLD INDIAN CHEROKEE RD											PHONE: 803-663-0560		
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-		OCCUPATION: UNEMPLOYED					EXT		
GUARANTOR EMPLOYER: UNEMPLOYED					PHONE: - -		EXT						
ADDRESS													
CITY			STATE	ZIP									FC: F

INSURANCE NAME 1: PRIVATE PAY	CODE: 910	POLICY #:	GROUP #:	SUBSCRIBER: LEE, BERNARD S	REL:	AUTH #:	
INSURANCE NAME 2	CODE	POLICY #:	GROUP #:	SUBSCRIBER	REL:	AUTH #:	
INSURANCE NAME 3	CODE	POLICY #:	GROUP #:	SUBSCRIBER	REL:	AUTH #:	

ATTENDING PHYSICIAN: SCEMS, D	ATTENDING #: 044198	REF SRC	ADM BY: SHACED	PREV ADM DATE	PREVIOUS FACILITY	
ADM DIAGNOSIS: RECHECK	MED SVC: EMR	CODE	ALLERGIES: NKA			SURGERY DATE
ADMITTING PHYSICIAN: SCEMS, D	ADMITTING #: 044198	AUTHORIZED BY				
PROCEDURE	CLINICAL COMMENT			MODE OF ARRIVAL/ACCOMPANIED BY: SLF SELF		

RELEASE INFO	ADV DIR	LIVING WILL	LOCATION OF WILL/DIRECTIVE	FAMILY DOCTOR
Y				SCEMS, D 044198

FINAL DIAGNOSES (FIRST DIAGNOSIS PRINCIPAL UNLESS NOTED)

CODE

V59.3

AUGUSTA DATA STORAGE, INC.
F-00001124126

PROCEDURES

CONSULTING PHYSICIANS

DRG

LOS

TRANS TO: ACUTE ☐ SNF ☐ REHAB ☐ HOSPICE ☐ HOME HEALTH ☐ HOME IV ☐ AGAINST MED ADV ☐ HOME ☐

DISCHARGE DATE | TIME | OTHER

EXPIRED ☐ TIME _____ <48HRS ☐ >48HRS ☐ CORONER ☐ AUTOPSY YES ☐ NO ☐

ATTENDING PHYSICIAN SIGNATURE & DATE

RxLASER, INC. C2488-20051 (714) 986-1559 (2/99) **CHART COPY – 205 – T REMOVE FROM CHART**

Admission Date: 11/9/05
Med. record No.: 177273
Visit No.: 102075173
Attending Phys.: Scems D, MD
Allergies: Not yet reviewed

Quick Triage

Patient: Lee, Bernard D
D.O.B.: 4/30/1980 Age: 25
Gender: Male
Location: EMERGENCY ROOM
Room/Bed: I

Scheduled: 11/9/05 09:19 User: David Shackford,RN
Performed: 11/9/05 09:19 Status: Finished

Quick Triage Info

Patient triaged as non-urgent. Primary complaint is recheck stitches placed 10 days prior.. Patient's level of pain is 0 (no pain). There is no evidence of abuse and/or neglect Temperature 98.3 F (36.83 C) orally. Pulse 70 bpm. Resp rate 18. O2 SAT 100%. Patient on room air. BP 128/ 97 mmHg. via machine while patient sitting. Patient's stated height is 6 Ft 0 in (1 Meter 82.9 cm). Patient's stated weight is 185 lb 0 oz (83 kg 914.6 gm). No treatment given in triage. After triage patient went to express care, and went to waiting room.

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Chief Complaint: Wound check

HPI: Dog #10 / Sutures

Current Meds: See ED nurses notes

PMD

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, & ROS Unobtainable due to: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF

☐ As Above ☐ Other:

Past Surgical History:

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☐ Yes Amt ETOH ☐ No ☐ Yes Amt ☐ Other

Review Of Systems: Check ☐ if normal Check ○ if abnormal (If not Checked then not applicable.)

☐ Other ROS Neg

Eyes:	☐ ○ Diplopia	☐ ○ Blurred	☐ ○ Vision chgs
ENT:	☐ ○ Rhinitis	☐ ○ Sore throat	☐ ○ Nose bleeds
Card:	☐ ○ CP	☐ ○ Palpitation	
Respir:	☐ ○ SOB	☐ ○ Cough	☐ ○ Hemoptysis
GI:	☐ ○ Nausea	☐ ○ Vomiting	☐ ○ Diarrhea
	☐ ○ Abd pain	☐ ○ Melena	☐ ○ Hematochez
GU:	☐ ○ Dysuria	☐ ○ Urgency	☐ ○ Hematuria
MS:	☐ ○ Myalgia	☐ ○ Back pain	☐ ○ Neck pain
Neuro:	☐ ○ Seizures	☐ ○ Dizziness	☐ ○ Syncope
	☐ ○ Weakness	☐ ○ Numbness	
Endo:	☐ ○ Polyuria	☐ ○ Hypoglyc	☐ ○ Thyroid Dys
Hem/Lym:	☐ ○ Anemia	☐ ○ Bleeding	

☐ For allergies see ED nurses notes

Other ROS

TETANUS STATUS:

ALLERGIES: 0

Physical Exam: WEIGHT

TIME	PULSE	OX:	TEMP	P	R	BP

☐ For vitals see ED nurses notes

Check ☐ if normal Check ○ if abnormal

			Abn Findings:
General:	☐ ○ Mental Status		
Eyes:	☐ ○ Conjun NL	☐ ○ Lids	☐ ○ PERRL
Head:	☐ ○ NL cephalic	☐ ○ Sinuses	☐ ○ Nose
ENT:	☐ ○ Oropharynx	☐ ○ Right TM	☐ ○ Left TM
Neck:	☐ ○ Palpation	☐ ○ Thyroid	☐ ○ Trachea
Chest:	☐ ○ Palpation	☐ ○ Excurtion	☐ ○ Symmetry
Cardio:	☐ ○ Heart sounds	☐ ○ R & R	
Respir:	☐ ○ Respir effort	☐ ○ Lung sounds	
Abdom:	☐ ○ Palpation	☐ ○ Bowel Sounds	
MS:	☐ ○ RUE	☐ ○ RLE	☐ ○ Digits
	☐ ○ LUE	☐ ○ LLE	☐ ○ Back
	☐ ○ Pelvis	☐ ○ Gait	
Skin:	☐ ○ Temp	☐ ○ Appear	☐ ○ Color
Neuro:	☐ ○ CNS	☐ ○ Strength	☐ ○ Sensation

Foot

2 cm wound w/ active bleeding NOT REPAIRED

Med Decision Making:

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME:

Diff Dx:

Consult/s:

NAME OF PHYSICIAN THAT ADMITTED PT:

NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

DISCHARGE DIAGNOSIS: Healing Staph wound

Physician Signature:

ED Encounter Record
630.70

☑ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

CODES

STABLE

☐ UNSTABLE SEE NOTE

Time MD IN:

TEST:	ORD	Initial	TIME INITIAL ✓TEST ORDERED
CBC W DIFF:			
CHEM 8:			
URINE PREG:			
CCUA:			
CATH UA:			
URINE C&S:			
EKG:			
OLD EKGS:			
TROPONIN:			
PUPTT:			
FINGER ST GL:			
BLOOD CULT X			
TYPE & SCREEN:			
TYPE CROSS UNITS:			
LIVER PANEL:			
CMP:			
AMYLASE:			
LIPASE:			
HEMOCULT:			
TYPE & RH:			
HCG QUANT:			
URINE DRUG S:			
ALCOHOL:			
ED ABG:			
PA/LAT CXR:			
PCXR:			
C-SPINE:			
L-SPINE:			
ACUTE ABD:			
OLD RECORDS:			
OLD ED Record:			

PHYSICIAN'S ORDERS: TIME ORD: TIME COMPL

→ URINE PREG RESULTS:

Remove Sutures

D/C Home

Name: Race: Sex: Age:

Addressograph

102075173

LEE , BERNARD D
DOB: 04/30/1980 25 SX: M EMR
MRN: 177273 ADM/REG DT: 11/09/05
AIKEN REGIONAL MEDICAL CENTER

10-241

AIKEN REGIONAL MEDICAL CENTERS

302 University Parkway • Aiken, South Carolina 29802

TREATMENT AREA Room # 9 Time 1200 Report to Corinne VIA W/C

☐ Normal Adult Pattern ☑ Normal Pediatric Pattern

MENTATION ☐ Disoriented ☐ Agitated ☐ Resp to verbal stim ☐ Combative ☐ Unresponsive ☐ Resp to painful stim

PUPILS ☐ Equal ☐ Unequal
Size R____ mm L____ mm
R ☐ Fixed ☐ Dilated ☐ Non-reactive ☐ Pinpoint ☐ Sluggish
L ☐ Fixed ☐ Dilated ☐ Non-reactive ☐ Pinpoint ☐ Sluggish

Visual Acuity R:____ L:____ Both:____

SENSATIONS

		DECREASED	ABSENT
ARM	R		
ARM	L		
LEG	R		
LEG	L		

ROM

		DECREASED	ABSENT
ARM	R		
ARM	L		
LEG	R		
LEG	L		

Review above information, assess patient, document changes.

☐ Normal Adult Pattern ☑ Normal Pediatric Pattern
☐ Dyspnea ☐ Stridor ☑ Retraction ☐ Nasal Flaring
COUGH ☐ Productive Describe:____
☐ Non-Productive

LUNG SOUNDS

	RIGHT	LEFT
Wheezes		
Rales		
Crackles/Course		
Diminished		

CHEST EXPANSION ☐ SYMMETRICAL ☐ ASYMETRICAL ☐ TENDERNESS Describe:____

☐ Normal Adult Pattern ☐ Normal Pediatric Pattern
ABDOMEN ☐ Firm ☐ Distended: ☐ Tenderness Describe:____
APPETITE ☐ Fair ☐ Poor ☐ Special Diet at home:____
STOOL ☐ Diarrhea ☐ Incontinence ☐ Incontinence ☐ Last BM:____ ☐ Nausea ☐ Vomiting

☐ Normal Adult Pattern ☑ Normal Pediatric Pattern
HEART ☐ Chest pain Describe:____
EXTREMITIES ☐ Edema ☐ Obvious deformity ____ Describe:____
CAP REFILL ☐ < 2 Sec ☐ > 2 Sec
PULSES

		DECREASED	ABSENT
RADIAL	R		
RADIAL	L		
FEMORAL	R		
FEMORAL	L		
PEDAL	R		
PEDAL	L		

☐ Normal Adult Pattern ☐ Normal Pediatric Pattern
FEMALE ☐ Vaginal Discharge Color:____ ☐ Vaginal Bleeding Describe:____ ☐ Breast Problem ☐ R ☐ L Describe:____
MALE ☐ Prostate Problem Describe:____ ☐ Genitalia tenderness / swelling / discharge Describe:____
VOIDING ☐ Frequency ☐ Urgency ☐ Hematuria ☐ Incontinence ☐ Last Void: ☐ Catheter

☐ Normal Adult Pattern ☐ Normal Pediatric ☐ Laceration
☐ Abrasion ☐ Amputation ☐ Avulsion ☐ Bruising ☐ Burn ☐ Bleeding ☐ Diaphoresis ☐ Abnormal Skin Color ☐ Lesions ☐ Rash
Describe: sutured to back

Eyes: ☐ Contact Lenses ☐ Glasses ☐ Foreign Body ☐ Cataracts ☐ Mucous Membranes Moist/Dry ☐ Injury:____
Ear/Nose/Throat/Mouth:____
Visual Acuity: L____ R____
☐ Dentures ☐ Glasses ☐ Contacts ☐ Disposition____

RN/LPN Signatures:

PAIN ASSESSMENT

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

ADDRESSOGRAPH

102075173
LEE , BERNARD D
DOB: 04/30/1980 25 SX: M EMR
MRN: 177273 ADM/REG DT: 11/09/05
AIKEN REGIONAL MEDICAL CENTER

ED NURSING ASSESSMENT RECORD

630.64 (Rev. 3/03) 10-20214

TIME	PROCEDURE	COMMENTS	BY WHOM	RESULTS	INITIALS
	☐ NG ☐ OG	Side/Location placement verified by auscultation		Amount	
	Pulse oximeter			O_2 Saturation	
	REG replacement			Size:	
	Pelvic Exam			Cultures obtained: ☐ Yes ☐ No	
	Ring Removal	Given to:		Skin color/temp. cap. refill: _____ sec	
	Side rails up x _____ for patient safety & call bell given			Verbalized understanding	
	Sling			Skin color/temp. cap. refill: _____ sec	
	Suture placement	Supplies		Wound edges approximated	
	Other				
	Other				
	Wound Care			Verbalized understanding	

Clothing: ☐ Shirt ☐ Sweater ☐ Coat ☐ Vest ☐ Pants ☐ Underwear ☐ Tie/Scarf ☐ Socks/Hose ☐ Hat/Cap ☐ Gloves ☐ Cutoff PTA/ETC (ED)

Accessories: ☐ Shoes ☐ Purse ☐ Wallet ☐ Keys ☐ Other _____

Jewelry: ☐ Yellow Metal (describe): _____ ☐ Yellow Metal (describe): _____

Miscellaneous: ☐ Home Meds ☐ W/Patient ☐ W/Family ☐ to Pharmacy

☐ Dentures ☐ Upper ☐ Lower ☐ Partial ☐ Glasses ☐ Contact Lenses R / L ☐ Hearing Aid R / L ☐ Walker/Cane

Valuables: ☐ W/Patient ☐ W/Family ☐ Security ☐ Other _____

Admitting Physician _____

Room # _____ **Time of Admission** _____

VIA ☐ Nurse ☐ Escort ☐ Neg. Agent

Report:

Time: _____

Called to: _____

Portable Monitor: ☐ Yes ☐ No Rhythm: _____

Portable Oxygen: ☐ Yes ☐ No _____ L/M Via _____

Transfer Restraints: ☐ Yes ☐ No

☐ Unchanged From Initial Assessment _____ Time _____ Int.

☒ Unchanged From Initial Assessment _____ Time _____ Int.

☐ Unchanged From Initial Assessment _____ Time _____ Int.

Assessment changes (time & initials)

1020 sutures out —— TS

DISPOSITION	TYPE	INSTRUCTIONS
	☐ Morgue	☒ See Discharge Instruction Sheet
	☐ LWBS	☐ Verbal/Written Instruction Given To/By:
	☐ AMA	_____
	☐ Elopement	☒ Expresses Understanding
VIA:	☒ Discharge	☐ Discharged by Physician
☒ Ambulatory	☐ Transfer - See	☐ Instructed not to drive
☐ Wheelchair	Transfer Record	
☐ Stretcher		
☐ Carried		

VS: BP _____ P _____ T _____ RTS _____ GCS _____

Signature: _____ Time 1020

Medications/Procedure ordered by _____ M.D.

102075173

LEE , BERNARD D

DOB: 04/30/1980 25 SX: M EMR

MRN: 177273 ADM/REG DT: 11/09/05

AIKEN REGIONAL MEDICAL CENTER

Aiken Regional Medical Centers

Emergency Services

102075173
LEE , BERNARD D
DOB: 04/30/1980 25 SX: M EMR
MRN: 177273 ADM/REG DT: 11/09/05
AIKEN REGIONAL MEDICAL CENTER

GENERAL INSTRUCTIONS:

☐ Call the next business day and make an appointment to see: _____

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in _____ days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within _____ days.

☐ Return to the Emergency Department after 12:30 p.m. in _____ days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☑ Work / school excuse from Presumptive thru To work 11/9/05

☐ See your company doctor per your company's policy. Light duty until _____.

(No use of _____ No lifting over _____ lbs.)

☐ Return if any problems

Your diagnosis was:

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone -

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diptheria booster***
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave If you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X_Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physicia
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Department.

Physician / Staff

11-9-05
Date

Patient or Responsible Person

630.06 Rev. 10/02 WHITE - RECORDS CANARY - PATIENT – 210 – EMERGENCY DEPARTMENT GOLDENROD - PATIENT FORM 10-2183 3/

AIKEN REGIONAL MEDICAL CENTERS
302 University Parkway
Aiken, SC 29802

PATIENT NAME: Lee, Bernard DATE OF SERVICE/ADMISSION 11.9.05

CONSENT FOR TREATMENT, GUARANTY OF PAYMENT AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION AND ASSOCIATED NOTICES AND AUTHORIZATION.

NOTICE TO PATIENT AND ALL SIGNATORIES OF THIS DOCUMENT: By your signature below, each signatory of this document is agreeing to be jointly and severally bound by all of the terms and conditions hereinafter set forth unless otherwise noted. In consideration of the hospital care and treatment to be rendered to Patient by Hospital, the undersigned agree and consent to the following:

1. Consent and Conditions of Admission: The undersigned hereby agrees and gives consent to Hospital for the admission/treatment/testing of Patient. The undersigned hereby consents to any and all hospital care encompassing: X-Ray examination, laboratory procedures, diagnostic procedures, anesthesia and nursing or medical/surgical treatment which Patient's physician, his associates, partners or designees, may deem necessary or advisable under the general and special instructions of the same, during Patient's hospitalization.

2. Medical and Surgical Treatment: The undersigned agrees and understands that all physicians, dentists and/or oral surgeons treating Patient are responsible and liable for their own acts or omissions and the Hospital is not responsible or liable for the acts omissions of the aforementioned. The undersigned is aware that the practice of medicine is not an exact science and further state that no guarantee has been made or can be made as to the results of the treatments or examinations in the Hospital.

The undersigned certifies that they have read all of this document, including the reverse side hereof, and that the undersigned is the Patient, or is duly authorized by the Patient or by law, to execute the above Agreement and understands its terms.

All Patients shall receive treatment or service within the hospital's capability and policies. Our hospital is committed to patient's impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care.

3. Assignment of Insurance Benefits and Release of Medical Information: The undersigned hereby assign to Hospital, its successors and assigns, all benefits that may be payable to or on behalf of the Patient under any policy of insurance, (hospitalization, major medical, automobile, workmen's compensation, personal injury benefits available because of liability of a third party, or any other) and authorize Hospital to release specifically requested medical information related to Patient to include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assaults, tests for HIV, ARC and/or AIDS, or other infectious diseases necessary for settlement of benefit payment or money payable because of Patient's hospitalization, treatment or injury during this encounter. The undersigned further direct that the payer of any such payment make such payment directly to Hospital. In addition, the undersigned assign to Hospital, its successor and assigns, the proceeds of injury claim resulting from liability to Patient of a third party. Any payments to Hospital under authority of this Assignment shall not exce the actual charges set forth in Hospital's billing statements issued in connection with Patient's account.

If Patient is eligible for Medicare, the undersigned requests Medicare services and benefits. The undersigned further agree that this Assignment will not be withdrawn c voided at any time until Patient's account is paid in full. The undersigned acknowledge that it is their responsibility to pay Hospital for any charges not covered by insurance. Further, undersigned agree and understand that if the Patient, or his duly authorized representative, requests a private room for the Patient the undersigned is responsible for the entire room difference.

The undersigned hereby authorize any agency or employee of the U.S., any State or Municipal Government to release to the Hospital, its employee, employees and/or i attorney, any and all information concerning governmental programs under which the above named Patient is or may be qualified to receive benefits due and further authorize payment of any and all such benefits direct to Hospital.

The insured whose signature appears in this item one (1), hereby represents to the Hospital that the following insurance policies are the only insurance policies offering coverage to the patient in this matter and hereby assigns to Hospital all benefits payable to or on behalf of Patient thereunder:

Written authorization for HMO/PPO plans: I understand that if my insurance carrier, HMO plan or PPO network requires preauthorization, the Hospital/Provider/Physician is unable to guarantee that my visit will be covered without a written authorization for the services rendered to me or my family members. the Hospital/Provider/Physician is unable to obtain authorization for my visit, I will be responsible for any unpaid balance. I will be financially responsible for those charges that coincide with any service/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the Hospital accepts no liability for failu to meet any pre/post certification procedures which may be required of me by my coverage carrier. I agree that any such procedures have been or will be properly executed by me.

Primary Insurance Co. Self-Pay

Patient [signature]

Insured

Secondary Insurance Co.

Patient

Insured

Addressograph

102075173
LEE , BERNARD D
DOB: 04/30/1980 25 SX: M EMR
MRN: 177273 ADM/REG DT: 11/09/05
AIKEN REGIONAL MEDICAL CENTER

Form 902.02 (Rev 10/04) 10-1983

PHYSICIANS NOT AS EMPLOYEES: [illegible] Physician or facilitating services including but not limited to radiologists, anesthesiologists, emergency department physicians, consultants and specialists (MDs) who see you are not employees of the Hospital [illegible] Hospital has no responsibility for any charges of these providers for services rendered.

4. Guaranty of Payment: The undersigned jointly and severally promise to be bound to Hospital for payment and do hereby guarantee payment to Hospital on demand of all charges hereafter incurred by Patient at Hospital and authorize Hospital to release [illegible] Hospital. This is a continuing guaranty of payment and does not end at the entire unpaid balance of charges incurred during the period from the date of this agreement [illegible] Patient is discharged from Hospital. This guaranty of payment of outpatient charges for services rendered on the date noted above and any other services rendered thereafter. Such charges shall be in accordance with the regular rates and charges of the Hospital in effect at the time of the rendering of the service or the furnishing of the goods for which the charge is incurred.

In the event Patient's account is turned over to any attorney for collection or legal proceedings of any kind, the undersigned jointly and severally agree to pay Patient all costs and expenses incurred by Hospital in connection with such collection action and/or legal proceedings, including reasonable attorney's fees not to exceed fifteen (15) percent of the unpaid balance due.

The undersigned also agrees that any overpayments collected in connection with any particular admission or outpatient treatment of Patient may be applied directly to a delinquent account of Patient or any delinquent account for which Patient or any undersigned is legally responsible at the time of collection of the overpayment. Hospital may make a Repayment Agreement with any one or more of the undersigned, which Agreement shall be considered ancillary to and not in lieu of this Agreement and shall not be construed as limiting or modifying the liability of any other signatory to this Agreement.

Patient signatures, Spouse of Patient signatures, Guarantor signatures, and Parent of minor patients' signatures are jointly and severally bound by all the terms hereof including liability for payment to Hospital under this Guaranty of Payment agreement.

5. Assignment of Physician Benefits: In the event that Patient, in addition to Hospital benefits, is entitled to any physician benefits of any type whatsoever arising out of policy of insurance insuring Patient or any other parties liability to Patient, the undersigned hereby assigns said benefits to any physician rendering care or treatment during the stay associated with this admission or any outpatient visits, to be applied to Patient's bill.

6. Medicare Patient Certification: The undersigned certify that the information given by the undersigned in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for a Medicare claim related to patient. The undersigned authorize and direct that a copy of this Authorization may be used in place of the original and request payment of authorized benefits be made on behalf of the Patient.

7. Personal Valuables and Belongings: The undersigned acknowledge and agree that the Hospital maintains a safe for the safekeeping of valuables. The Hospital shall not be held responsible or liable for the loss or damage to any articles of personal property while Patient is hospitalized unless said articles are deposited with the Hospital or the safe and receipts are issued describing said items. If the patient is unable to sign and in the event no relative is present, the Hospital shall retain possession of valuables and obtain acknowledgement at the first available opportunity.

8. Cameras and Surveillance Equipment: Patient has been advised that Aiken Regional Medical Center uses cameras and like devices to monitor [illegible] employees and visitors. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and such devices, unless prohibited by law.

9. [illegible] the right to file a grievance regarding care at this facility. The agency you may contact is:

Department of Health and Environmental Control OFFICE OF [illegible]
2600 Bull Street
Columbia, South Carolina 29201
803-[illegible]

10. Smoking is prohibited except in certain areas. Please discuss your special needs with your physician.

11. I acknowledge that Emergency Medicine may be provided at the above facility by physicians who are employed by, or contracted with, Emergency Medicine Associates of [illegible]. Patient shall receive a copy of this agreement.

A COPY OF THIS AGREEMENT SHALL BE ACCEPTED AS THE ORIGINAL
ORIGINAL SIGNATURE REQUIRED ONLY IF SIGNATURE IS TO BE NOTARIZED.

11-7-05 [signature] [signature]

Aiken Regional Medical Centers
Emergency Department Health History Questionnaire

Name of Patient: Bernard Lee DOB 4-30-1900 Age: 25 Sex: M

Medications (prescribed, herbal, and over-the-counter) See Attached List: ☐

Nurse Review

Name of Medication:	Dose:	Frequency(times/day):	Time of Last Dose:
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			

Allergies (drug, environmental, food, etc.):

Nurse Review

Name of allergy:	Type of Reaction (ex: hives, nausea, etc.)	Severity(Mild, Moderate, Severe):
1)		
2)		
3)		
4)		
5)		
6)		

Doctors Who Treat You:

Vaccination History (Shots):

Nurse Review

Y	N		Date of Last Vaccination	Y	N		Date
		Pneumonia				Flu	
		Tetanus				Other (List)	
		Hepatitis					
		TB Testing					

Aiken Regional Medical Centers
Emergency Department Health History Questionnaire

Nurse Review

History (check all that apply):

Y	N		Y	N	
	✓	Heart Disease (type)		✓	Cancer (type)
	✓	Heart Surgery		✓	Seizures
	✓	Heart Catheterization (date of last)		✓	Arthritis
	✓	Dementia/Alzheimers		✓	HIV
	✓	Stroke (when and any deficits)		✓	Migraines (bad headaches)
	✓	Asthma		✓	Mental Illness
	✓	COPD/Emphysema		✓	Gastric Ulcers/GERD
	✓	Hypertension (High Blood Pressure)		✓	Glaucoma
	✓	Diabetes ("Sugar")	✓		Alcohol Use (amount/week) 2
	✓	High Cholesterol		✓	Drug Use (type)
	✓	Hepatitis	✓		Tobacco Use (type) 2
		Other (list)			

Nurse Review

Surgical History:

Type of Surgery	Date of Surgery

Primary Language Spoken: _____

Females Only:

Pregnant (circle): Yes No Unknown

Last menstrual cycle (period): _____

Nurse Review

Pain Scale:

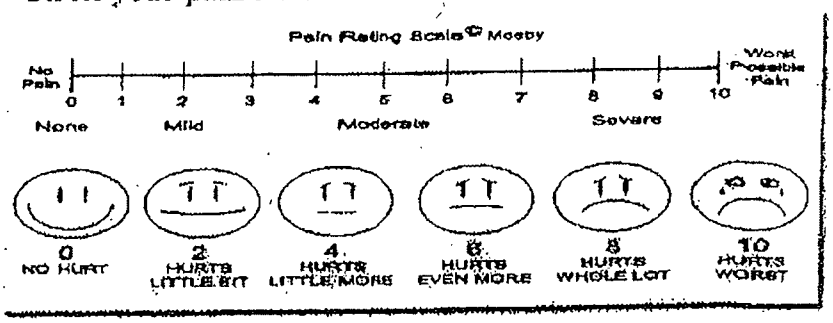
Location: _____

How long have you had the pain? _____

Is the pain constant or does it come and go?

_____

Circle your pain level at this time.



Other helpful information:

_____

_____

_____

_____

Signature Of Person Completing Form: _____

Relationship (self, mother, son, etc.): _____

Nurse Signature: _____

Date: 11/9/16 Time: 1645

☐ Information available for physician review upon arrival to Emergency Dept.

Aiken Regional Medical Centers

Admission Date: 11/9/05
Med. record No.: 177273
Visit No.: 102075173
Attending Phys.: Scems D, MD
Allergies: Not yet reviewed

ER Discharge Assessment

Patient: Lee, Bernard D
D.O.B.: 4/30/1980, Age: 25
Gender: Male
Location: EMERGENCY ROOM
Room/Bed: I

Scheduled: 11/9/05 09:19 User: Kelly Schumpert,RN
Performed: 11/9/05 11:42 Status: Finished

ER Discharge

ER Discharge Date/Time: 11/09/2005 10:20. Patient discharged to home. Patient ambulated off the unit, Transported by private vehicle. Patient condition is stable. Discharge instructions given to patient. Medications instructions given to patient. Patient verbalized understanding. Room checked. No personal belongings found.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

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Aiken Regional
MEDICAL CENTERS
The Health Choice

202 University Parkway, Aiken, SC 29801

MED. REC. NO. 177273

PT. NO. 10335185	PATIENT NAME LEE, BERNARD D													PT STS: ET	
ADDRESS 172 OLD CHEROKEE INDIAN RD														COUNTY 2	
CITY GRANITEVILLE		STATE SC	ZIP 29829-0000	PHONE 803-663-0560			EXT.				SOCIAL SECURITY NO. 251-45-2204				
AGE 26	DOB 04/30/1980	SEX M	RACE 2	MS S	PREVIOUS NAME BLDLESS,						RELIGION BAP	W/S EMER	ARMBED EMER18		
ADM DATE 09/23/06	TIME 02:36	SRC EO	PT TYPE T	PRI X	ACCIDENT INFO H	09/23/06	02:00	VOLUNTARY ADM		ORGAN DNR		ISOL	INFANT AGE		
PT EMPLOYER BAE					TELEPHONE 706-	-	EXT	OCCUPATION WELDER							
EMPLOYER ADDRESS															
CITY GRANITEVILLE		STATE SC	ZIP 29829-							RETIREMENT DATE					
NEAREST RELATIVE NAME LEE, VIRGINIA															
R/T/N B	ADDRESS UNK														
CITY CLEARWATER		STATE SC	ZIP 29822-	PHONE 803-663-1533			EXT								
EMERGENCY CONTACT NAME LEE, MARIE															
R/T/N N	ADDRESS 172 CHEROKEE INDIAN RD														
CITY GRANITEVILLE		STATE SC	ZIP 29829-	PHONE 803-663-0560			EXT								
GUARANTOR NAME LEE, BERNARD D										R/T/N S	SOCIAL SECURITY NUMBER 251-45-2204				
ADDRESS 172 OLD CHEROKEE INDIAN RD											PHONE 803-663-0560				
CITY GRANITEVILLE		STATE SC	ZIP 29829-	OCCUPATION WELDER							EXT				
GUARANTOR EMPLOYER BAE				PHONE 706-	-	EXT									
ADDRESS															
CITY GRANITEVILLE		STATE SC	ZIP 29829-											FC F	
INSURANCE NAME 1 PRIVATE PAY		CODE	POLICY # 910251452204	GROUP #		SUBSCRIBER LEE, BERNA		REL S	AUTH #						
INSURANCE NAME 2		CODE	POLICY #	GROUP #		SUBSCRIBER		REL	AUTH #						
INSURANCE NAME 3		CODE	POLICY #	GROUP #		SUBSCRIBER		REL	AUTH #						
ATTENDING PHYSICIAN STAGGS CLIFFORD D			ATTENDING # 003301	REF SRC	ADM BY GARMAR	PREV ADM DATE		PREVIOUS FACILITY							
ADM DIAGNOSIS DIARRHEA				MED SVC EMR	CODE	ALLERGIES							SURGERY DATE		
ADMITTING PHYSICIAN STAGGS CLIFFORD D			ADMITTING # 003301	AUTHORIZED BY											
PROCEDURE				CLINICAL COMMENT				MODE OF ARRIVAL/ACCOMPANIED BY POV							
R/I OF INFO Y	ADV DIR	LIVING WILL	LOCATION OF WILL/DIRECTIVE			FAMILY DOCTOR STAGGS CLIFFORD D 003301									

FINAL DIAGNOSES (FIRST DIAGNOSIS PRINCIPAL UNLESS NOTED)

CODE

079.99

AUGUSTA DATA STORAGE, INC.
F0000011241131

PROCEDURES

CONSULTING PHYSICIANS

DRG

LOS

TRANS TO: ACUTE ☐ SNF ☐ REHAB ☐ HOSPICE ☐ HOME HEALTH ☐ HOME IV ☐ AGAINST MED ADV ☐ HOME ☐

DISCHARGE DATE | TIME | OTHER

EXPIRED ☐ TIME _____ , <48HRS ☐ >48HRS ☐ CORONER ☐ AUTOPSY YES ☐ NO ☐

ATTENDING PHYSICIAN SIGNATURE & DATE

RxLASER, INC. C2488-20051 (714) 986-1559 (2/99) **CHART COPY – 216 – REMOVE FROM CHART**

Admission Date: 9/23/06
Med. record No.: 177273
Visit No.: 103351185
Attending Phys.: Staggs, C.D, 003301, MD

Quick Triage

Patient: Lee, Bernard D
D.O.B.: 4/30/1980; Age: 26
Gender: Male
Location: TRIG
Room/Bed: TRIG/26

Scheduled: 9/23/06 02:36 *User:* Mary Garcia, RN
Performed: 9/23/06 02:36 *Status:* Finished

Quick Triage Info

TRIAGE STATUS NON-URGENT. Pt states having diarrhea for 2 days. Denies n/v. Rates pain as 3 on a scale of 0 to 10. Patient ambulated onto unit by himself/herself. Transported by private vehicle. No treatment prior to arrival. Oral Temperature 98.1 F (36.72 C). Pulse 79 bpm. Resp rate 18. O2 SAT 100%. Patient on room air. BP 148/99 mmHg. There is no evidence of abuse and/or neglect.

Allergies & Home Meds

No known allergies. Patient taking no medications.

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Aiken Regional Medical Centers

Admission Date: 9/23/06
Med. record No.: 177273
Visit No.: 103351185
Attending Phys.: Staggs, C.D. 003301, MD

ER Discharge Assessment

Patient: Lee, Bernard D
D.O.B.: 4/30/1980, Age: 26
Gender: Male
Location: EMER
Room/Bed: EMER/18

Scheduled: 9/23/06 02:36 User: Mylene Milan, RN
Performed: 9/23/06 03:31 Status: Finished

ER Discharge

ER Discharge Date/Time: 09/23/2006 03:25. Patient discharged to home. Patient ambulated off the unit, Transported by private vehicle. Patient condition is stable. Discharge instructions given to patient. Medications instructions given to patient. Patient verbalized understanding, Room checked. No personal belongings found.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

2 c
0242
Viral Syndrome
0325

Staggs

Reported: 9/23/06 at 03:32 Patient (Hosp/Visit) No.: 103351185 Lee, Bernard D

©2005, Opus Healthcare Solutions, Inc.

3 HORIZONTAL MOUNT

AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC

C. Stagge - SC#14516 - DEA BS1078955
S. Platte - SC#20087 - DEA BP5052509
S. Grant - SC#15672 - DEA BG2720793
R. Kogel - SC#24037 - DEABK8295479
M. James - SC#14208 - DEA BJ1588384
E. Yeh - SC#20098 - DEA BY4915673
D. Wodtke - SC#20749 - DEA BW4632508
W. Jackson - SC#23797 - DEABJ6464225
C. Lavigne, PA-C - SC#A512EM
H. Fountain, PA-C - SC#A770EM
B. Taylor, PA-C - SC#A605EM

302 University Pkwy. Aiken, South Carolina 29801 Phone 641-5000

For _____ Age _____

Address _____ Date _____

Rx

Please dispense _____ Medications * NO REFILLS * prefers / does not prefer generic substitute

Dispense as Written _____ M.D. _____ Substitution Permitted M.D.

This prescription can be filled next door at

410 University Parkway Suite 2800 Medical Center Pharmacy ...n, South Carolina 29801 (803) 648-2985

103351185

LEE , BERNARD D
DOB: 04/30/1980 26 SX: M EMR
MRN: 177273 ADM/REG DT: 09/23/06
AIKEN REGIONAL MEDICAL CENTER

FORM ON SOLID LINE FIRMLY

...ES ...OUNT ...ICAL MOUNT

3 VERTICAL MOUNT

1 HORIZONTAL MOUNT

REMOVE TAPES

PLACE EDGE OF FORM AGAINST SOLID LINE AND PRESS FIRMLY

LABORATORY

HCAIS 9

Aiken Regional Medical Centers

Emergency Services

103351185
LEE , BERNARD D
DOB: 04/30/1980 26 SX: M RMR
MRN: 177273 ADM/REG DT: 09/23/06
AIKEN REGIONAL MEDICAL CENTER

GENERAL INSTRUCTIONS:

☐ Call the next business day and make an appointment to see: _____

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: _____ days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within _____ days.

☐ Return to the Emergency Department after 12:30 p.m. in _____ days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☑ Work/school excuse from 9/24/06 thru 9/23/06 May return to work _____

☐ See your company doctor per your company's policy. Light duty until _____.

(No use of _____ No lifting over _____ lbs.)

☐ If Ellen/pt with your Neyton plan if BB improvement

Your diagnosis was:

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diptheria booster***
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of m routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X_Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physicia
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Department.

_____ Physician
_____ Staff

9/23/06 Date

_____ Patient or Responsible Person

630.06 Rev. 10/05 WHITE - RECORDS CANARY - PATIE – 220 – - EMERGENCY DEPARTMENT GOLDENROD - PATIENT FORM 10-2183 3

Home Medication List
Physician's Order - Outpatient

Height:	feet	inches		
Weight:	pounds	actual	stated	estimated
Allergies:	NKDA			
Nurse Signature				Date/Time

Home Medications
(Include Herbals/OTC/Vitamins) Do NOT administer herbals during hospitalization

Medication/Dose	Route	Frequency	Last dose taken
☑ No home medications	☐ Unable to obtain list		

Changes to home medications: ☐ None ☐

Based on your visit to Aiken Regional Medical Centers, you may safely continue your home medications with the changes written above, if any. Please contact your prescribing physician if you have any questions about your home medications.

Prescriptions given at discharge

☐ No new medications

Medication/Dose	*Route*	*Frequency*	*Reason for taking*
Phenergan 25mg	Oral	every 6hrs	as needed for nausea/vomiting

Physician Signature

Patient Signature

Licensed Staff Signature

Rev. 8/08

103351185
LEE , BERNARD D
DOB: 04/30/1980 26 SX: M EMR
MRN: 177273 ADM/REG DT: 09/23/06
AIKEN REGIONAL MEDICAL CENTER

AIKEN REGIONAL MEDICAL CENTERS

302 University Parkway • Aiken, South Carolina 29802

TREATMENT AREA Room# 18 Time 0242 Report to Clay VIA amb

NURSING ASSESSMENT RECORD

☐ Normal Adult Pattern ☐ Normal Pediatric Pattern

MENTATION ☐ Disoriented ☐ Agitated ☐ Resp to verbal stim
☐ Combative ☐ Unresponsive ☐ Resp to painful stim

PUPILS ☐ Equal ☐ Unequal
Size R____mm L____mm
R ☐ Fixed ☐ Dilated ☐ Non-reactive
☐ Pinpoint ☐ Sluggish
L ☐ Fixed ☐ Dilated ☐ Non-reactive
☐ Pinpoint ☐ Sluggish

Visual Acuity R:____ L:____ Both:____

SENSATIONS

		DECREASED	ABSENT
ARM	R		
ARM	L		
LEG	R		
LEG	L		

ROM

		DECREASED	ABSENT
ARM	R		
ARM	L		
LEG	R		
LEG	L		

CARDIOVASCULAR

☐ Normal Adult Pattern ☐ Normal Pediatric Pattern

HEART ☐ Chest pain Describe:____

EXTREMITIES ☐ Edema ☐ Obvious deformity ____
Describe:____

CAP REFILL ☐ < 2 Sec ☐ > 2 Sec

PULSES

		DECREASED	ABSENT
RADIAL	R		
RADIAL	L		
FEMORAL	R		
FEMORAL	L		
PEDAL	R		
PEDAL	L		

Review above information, assess patient, document changes.

☒ Normal Adult Pattern ☐ Normal Pediatric Pattern
☐ Dyspnea ☐ Stridor ☐ Retraction ☐ Nasal Flaring

COUGH ☐ Productive Describe:____
☐ Non-Productive

LUNG SOUNDS

	RIGHT	LEFT
Wheezes		
Rales		
Crackles/Course		
Diminished		

CHEST EXPANSION Describe:____
SYMMETRICAL ____
ASYMETRICAL ____
TENDERNESS ____

GI / NUTRITIONAL STATUS ☐ N/A

☐ Normal Adult Pattern ☐ Normal Pediatric Pattern

ABDOMEN ☐ Firm ☐ Distended:
☐ Tenderness Describe:____

APPETITE ☐ Fair ☐ Poor
☐ Special Diet at home:____

STOOL ☒ Diarrhea ☐ Incontinence ☐ Incontinence
☐ Last BM:____ ☐ Nausea ☐ Vomiting

GU / REPRODUCTIVE ☐ N/A

☒ Normal Adult Pattern ☐ Normal Pediatric Pattern

FEMALE ☐ Vaginal Discharge Color:____
☐ Vaginal Bleeding Describe:____
☐ Breast Problem ☐ R ☐ L Describe:____

MALE ☐ Prostate Problem Describe:____
☐ Genitalia tenderness / swelling / discharge
Describe:____

VOIDING ☐ Frequency ☐ Urgency ☐ Hematuria ☐ Incontinence
☐ Last Void: ☐ Catheter

INTEGUMENT

☒ Normal Adult Pattern ☐ Normal Pediatric ☐ Laceration
☐ Abrasion ☐ Amputation ☐ Avulsion ☐ Bruising ☐ Burn ☐ Bleeding ☐ Diaphoresis ☐ Abnormal Skin Color ☐ Lesions ☐ Rash
Describe:____

ENT

Eyes: ☐ Contact Lenses ☐ Glasses ☐ Foreign Body ☐ Cataracts ☐ Mucous Membranes Moist/Dry
☐ Injury:____

Ear/Nose/Throat/Mouth:____

Visual Acuity: L____ R____
☐ Dentures ☐ Glasses ☐ Contacts ☐ Disposition____

RN/LPN Signatures: MB

PAIN ASSESSMENT

No Pain 0 1 2 (3) 4 5 6 7 8 9 10 Worst Pain

ADDRESSOGRAPH

103351185

LEE , BERNARD D
DOB: 04/30/1980 26 SX: M EMR
MRN: 177273 ADM/REG DT: 09/23/06
AIKEN REGIONAL MEDICAL CENTER

ED NURSING ASSESSMENT RECORD

630.64 (Rev. 3/03) 10-20214

PROCEDURES / INTERVENTIONS

TIME	PROCEDURE	COMMENTS	BY WHOM	RESULTS	INITIALS
	☐ NG ☐ OG	Side/Location placement verified by auscultation		Amount	
	Pulse oximeter			O_2 Saturation	
	Paracentesis/Thoracentesis			Cisterna/Amount	
	PEG replacement			Size	
	Pelvic Exam			Cultures obtained: ☐ Yes ☐ No	
	Ring Removal	Given to:		Skin color/temp. cap refill ____ sec	
	Side rails up x ____ for patient safety & call bell given			Verbalized understanding	
	Sling			Skin color/temp. cap refill ____ sec	
	Suture placement	Supplies		Wound edges approximated	
	Tracheostomy/Cricothyrotomy				
	Other				
	Other				
	Wound Care			Verbalized understanding	

BELONGINGS CHECKLIST FOR ADMISSIONS OR TRANSFERS

Clothing: ☒ Shirt ☐ Sweater ☒ Coat ☐ Vest ☒ Pants ☐ Underwear ☒ Tie/Scarf ☐ Socks/Hose ☒ Hat/Cap ☐ Gloves ☐ Cutoff PTA/ETC (ED)

Accessories: ☒ Shoes ☐ Purse ☐ Wallet ☐ Keys ☐ Other ____

Jewelry: ☐ Yellow Metal (describe): ____ ☐ Yellow Metal (describe): ____

Miscellaneous: ☒ Home Meds ☐ W/Patient ☐ W/Family ☐ to Pharmacy

☒ Dentures ☐ Upper ☐ Lower ☐ Partial ☐ Glasses ☐ Contact Lenses R / L ☐ Hearing Aid R / L ☐ Walker/Cane

Valuables: ☒ W/Patient ☐ W/Family ☐ Security ☐ Other ____

ADMISSION INFORMATION

Admitting Physician ____

Room # ____ Time of Admission ____

VIA ☐ Nurse ☐ Escort ☐ Neg. Agent

Report:

Time: ____

Called to: ____

Portable Monitor: ☐ Yes ☐ No Rhythm: ____

Portable Oxygen: ☐ Yes ☐ No ____ L/M Via ____

Transfer Restraints: ☐ Yes ☐ No

ASSESSMENTS

Review above information, assess patient, document changes

☒ Unchanged From Initial Assessment ____ Time: ____ Int.

☒ Unchanged From Initial Assessment ____ Time: ____ Int.

☒ Unchanged From Initial Assessment ____ Time: ____ Int.

Assessment changes (time & initials)

0225> Pt. @ Room 18, alert. Discharge teaching, home medicine & precautions & follow up & MD instructed. Discharged alert & ambulatory. ____ VM

DISPOSITION

DISPOSITION	TYPE	INSTRUCTIONS
	☐ Morgue	☐ See Discharge Instruction Sheet
	☒ LWBS	☒ Verbal/Written Instruction Given To/By: pt.
	☐ AMA	
VIA:	☐ Elopement	☐ Expresses Understanding
☒ Ambulatory	☒ Discharge	☐ Discharged by Physician
☐ Wheelchair	☐ Transfer - See Transfer Record	☐ Instructed not to drive
☐ Stretcher		
☐ Carried		

VS: BP ____ P ____ R ____ T ____ RTS ____ GCS ____

Signature: ____ Time 0225

SIGNATURE / TITLE	INITIALS
____, RN	____

Medications/Procedure ordered by ____ M.D.

103351185

LEE , BERNARD D

DOB: 04/30/1980 26 SX: M EMR

MRN: 177273 ADM/REG DT: 09/23/06

AIKEN REGIONAL MEDICAL CENTER

Aiken Regional ER Emergency Department

☐ Full Admission ☐ 23 Hr Observation

Chief Complaint:

HPI

Current Meds: ☐ See ED nurses notes

PMD

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, & ROS Unobtainable due to: ☐ As Above ☐ Other: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF

Past Surgical History:

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☒ Yes Amt ETOH ☐ No ☐ Yes Amt ☐ Other

Review Of Systems: (Check ☐ if normal / Check ○ if abnormal / If not Checked then not applicable)

Eyes:	☐ Diplopia	☐ Blurred	☐ Vision chgs	GU:	☐ Dysuria	☐ Urgency	☐ Hematuria	
ENT:	☐ Rhinitis	☐ Sore throat	☐ Nose bleeds	MS:	☐ Myalgia	☐ Back pain	☐ Neck pain	
Card:	☐ CP	☐ Palpitation		Neuro:	☐ Seizures	☐ Dizziness	☐ Syncope	
Respir:	☐ SOB	☐ Cough	☐ Hemoptysis		☐ Weakness	☐ Numbness		
GI:	☐ Nausea	☐ Vomiting	☐ Diarrhea	Endo:	☐ Polyuria	☐ Hypoglyc	☐ Thyroid Dy	
	☐ Abd pain	☐ Melena	☐ Hematochez	Hem/Lym:	☐ Anemia	☐ Bleeding		

☐ Other ROS Neg

☐ For allergies see ED nurses notes

Other ROS

TETANUS STATUS:

ALLERGIES:

Physical Exam: WEIGHT TIME PULSE OX: TEMP P R BP

☐ For vitals see ED nurses notes

Check ☐ if normal / Check ○ if abnormal / Abn Findings:

General:	○ Mental Status				
Eyes:	○ Conjun NL	☐ Lids	○ PERRL		
Head:	○ NL cephalic	☐ Sinuses	○ Nose		
ENT:	○ Oropharynx	☐ Right TM	○ Left TM		
Neck:	○ Palpation	☐ Thyroid	○ Trachea		
Chest:	○ Palpation	☐ Excursion	○ Symmetry		
Cardio:	○ Heart sounds	☐ R & R			
Respir:	○ Respir effort	☐ Lung sounds			
Abdom:	○ Palpation	☐ Bowel Sounds			
MS:	○ RUE	☐ RLE	○ Digits		
	○ LUE	☐ LLE	○ Back		
	○ Pelvis	☐ Gait			
Skin:	○ Temp	☐ Appear	○ Color		
Neuro:	○ CNS	Strength	○ Sensation		

TEST:	ORD	Initial	TIME INITIAL ✓TEST ORDERED
CBC W DIFF:			PHYSICIAN'S ORDERS: TIME ORD: TIME COMP Initia
CHEM 8:			
URINE PREG:			→ URINE PREG RESULTS:
CCUA:			
CATH UA:			
URINE C&S:			
EKG:			
OLD EKGS:			
TROPONIN:			
PT/PTT:			
FINGER ST GL:			
BLOOD CULT X			
TYPE & SCREEN:			
TYPE CROSS UNITS:			
LIVER PANEL:			
CMP:			
AMYLASE:			
LIPASE:			
HEMOCULT:			
TYPE & RH:			
HCG QUANT:			
URINE DRUG S:			
ALCOHOL:			
ED ABG:			
PA/LAT CXR:			
PCXR:			
C-SPINE:			
L-SPINE:			
ACUTE ABD:			
OLD RECORDS:			
OLD ED Record:			

Med Decision Making:

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME:

Diff Dx:

Consult/s:

NAME OF PHYSICIAN THAT ADMITTED PT:

NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

DISCHARGE DIAGNOSIS:

☐ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

CODES
☐ STABLE
☐ UNSTABLE SEE NOTE

Name: Lee

Addressograph

Race: Sex: Age:

103351185

LEE , BERNARD D
DOB: 04/30/1980 26 SX: M EMR
MRN: 177273 ADM/REG DT: 09/23/06
AIKEN REGIONAL MEDICAL CENTER

Physician Signature:

Time MD IN:

ED Encounter Record
630.70

10-241

AIKEN REGIONAL MEDICAL CENTERS
302 University Parkway
Aiken, SC 29802

PATIENT NAME: Lee, Bernard D DATE OF SERVICE/ADMISSION 09-23-06

CONSENT FOR TREATMENT, GUARANTY OF PAYMENT AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION AND ASSOCIATED NOTICES AND AUTHORIZATION.

NOTICE TO PATIENT AND ALL SIGNATORIES OF THIS DOCUMENT: By your signature below, each signatory of this document is agreeing to be jointly and severally bound by all of the terms and conditions hereinafter set forth unless otherwise noted. In consideration of the hospital care and treatment to be rendered to Patient by Hospital, the undersigned agree and consent to the following:

1. Consent and Conditions of Admission: The undersigned hereby agrees and gives consent to Hospital for the admission/treatment/testing of Patient. The undersigned hereby consents to any and all hospital care encompassing: X-Ray examination, laboratory procedures, diagnostic procedures, anesthesia and nursing or medical/surgical treatment which Patient's physician, his associates, partners or designees, may deem necessary or advisable under the general and special instructions of the same, during Patient's hospitalization.

2. Medical and Surgical Treatment: The undersigned agrees and understands that all physicians, dentists and/or oral surgeons treating Patient are responsible and liable for their own acts or omissions and the Hospital is not responsible or liable for the acts/omissions of the aforementioned. The undersigned is aware that the practice of medicine is not an exact science and further state that no guarantee has been made or can be made as to the results of the treatments or examinations in the Hospital.

The undersigned certifies that they have read all of this document, including the reverse side hereof, and that the undersigned is the Patient, or is duly authorized by the Patient or by law, to execute the above Agreement and understands its terms.

All Patients shall receive treatment or service within the hospital's capability and policies. Our hospital is committed to patient's impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care.

3. Assignment of Insurance Benefits and Release of Medical Information: The undersigned hereby assign to Hospital, its successors and assigns, all benefits that may be payable to or on behalf of the Patient under any policy of insurance, (hospitalization, major medical, automobile, workmen's compensation, personal injury benefits available because of liability of a third party, or any other) and authorize Hospital to release specifically requested medical information related to Patient to include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assaults, tests for HIV, ARC and/or AIDS, or other infectious diseases necessary for settlement of benefit payment or money payable because of Patient's hospitalization, treatment or injury during this encounter. The undersigned further direct that the payer of any such payment make such payment directly to Hospital. In addition, the undersigned assign to Hospital, its successo and assigns, the proceeds of injury claim resulting from liability to Patient of a third party. Any payments to Hospital under authority of this Assignment shall not exce the actual charges set forth in Hospital's billing statements issued in connection with Patient's account.

If Patient is eligible for Medicare, the undersigned requests Medicare services and benefits. The undersigned further agree that this Assignment will not be withdrawn voided at any time until Patient's account is paid in full. The undersigned acknowledge that it is their responsibility to pay Hospital for any charges not covered by insurance. Further, undersigned agree and understand that if the Patient, or his duly authorized representative, requests a private room for the Patient the undersigned is responsible for the entire room difference.

The undersigned hereby authorize any agency or employee of the U.S., any State or Municipal Government to release to the Hospital, its employee, employees and/or attorney, any and all information concerning governmental programs under which the above named Patient is or may be qualified to receive benefits due and further authorize payment of any and all such benefits direct to Hospital.

The insured whose signature appears in this item one (1), hereby represents to the Hospital that the following insurance policies are the only insurance policies offering coverage to the patient in this matter and hereby assigns to Hospital all benefits payable to or on behalf of Patient thereunder:

Written authorization for HMO/PPO plans: I understand that if my insurance carrier, HMO plan or PPO network requires preauthorization, the Hospital/Provider/Physician is unable to guarantee that my visit will be covered without a written authorization for the services rendered to me or my family members. the Hospital/Provider/Physician is unable to obtain authorization for my visit, I will be responsible for any unpaid balance. I will be financially responsible for those charges that coincide with any service/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the Hospital accepts no liability for failu to meet any pre/post certification procedures which may be required of me by my coverage carrier. I agree that any such procedures have been or will be properly executed by me.

Primary Insurance Co. PP

Patient [signature]

Insured

Secondary Insurance Co.

Patient

Insured

Addressograph

10335118S
LEE , BERNARD D
DOB: 04/30/1980 26 SX: M EMR
MRN: 177273 ADM/REG DT: 09/23/06
AIKEN REGIONAL MEDICAL CENTER

Form 902.02 (Rev 10/04) 10-1983

PHYSICIANS NOT AS EMPLOYEES: I acknowledge that all physicians furnishing services including but not limited to radiologists, pathologists, anesthesiologists, emergency department physicians, consultants and assistants to the physicians are not employees of the Hospital. I understand that I may receive separate billing from each of these providers for services rendered.

1. **Guaranty of Payment:** The undersigned jointly and severally agree to be bound to Hospital for payment and absolutely guarantee payment to hospital on demand of all now or hereafter incurred for goods and services furnished by Hospital to Patient in connection with Patient's treatment and or stay at Hospital. This is a continuing guaranty of payment on demand of the entire unpaid balance of charges incurred during the period from the date of service or admission above named Patient is discharged and includes guaranty of payment of outpatient charges for services rendered for the care period above and any follow up outpatient charges. Such charges shall be in accordance with the regular rates and charges of the Hospital in effect at the time of the rendering of the service or the furnishing of the goods for which the charge is incurred.

Should patient's account be turned over to any attorney for collection or legal proceedings of any kind I the undersigned jointly and severally, absolutely guarantee payment to Hospital of all costs and expenses incurred by Hospital in connection with such collection action and/or legal proceeding, including a reasonable attorney's fee not to exceed fifteen (15) percent of the unpaid balance due.

The undersigned also agrees that any over payments collected in connection with any prior or future admission or outpatient treatment of Patient may be applied directly to a delinquent account of Patient or any delinquent account for which Patient or may at the time of collection of the over payment be liable. Hospital may make a Repayment Agreement with any one or more of the undersigned, which Agreement shall be considered ancillary to and not in lieu of this Agreement and shall not be construed as limiting or modifying the liability of any other signatory to this Agreement.

Parent signatories, Spouse of Patient signatories, Guarantor signatories and Parent of minor patient signatories do jointly and severally be bound by all the terms hereof including liability for payment to Hospital under this Guaranty of Payment provision.

2. **Assignment of Physician Benefits:** In the event that Patient in addition to Hospital benefits is entitled to any physician benefits or any type of insurance arising out of salary or insurance insuring Patient or any other parties liability to Patient, the undersigned hereby authorize payment of such benefits to any physician rendering care or treatment to the Patient during the stay associated with this admission or any outpatient visits, to be applied to Patient's bill.

3. **Medicare Patient Certification:** The undersigned certify that the information given by the undersigned in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorize any holder of medical or other information about Patient's sickness to release to the Social Security Administration or its intermediaries or carriers any information needed for a Medicare claim related to patient. The undersigned authorize and direct that a copy of this Authorization may be used in place of the original and request payment of authorized benefits be made on behalf of the Patient.

4. **Personal Valuables and Belongings:** The undersigned acknowledge and agree that the Hospital maintains a safe for the safekeeping of valuables. The Hospital shall not be held responsible or liable for the loss or damage to any articles of personal property while patient is hospitalized unless said articles are deposited with the Hospital in the safe and receipts are issued describing said items. If the patient is unable to sign and if the next of kin is present, the Hospital shall return possession of valuables and obtain acknowledgment at the first available opportunity.

5. **Cameras and Surveillance Equipment:** Patient has been advised that Aiken Regional Medical Center uses cameras and other surveillance equipment to monitor employee activities. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment.

6. You have the right to file a grievance regarding concerns with our quality. The agency you may contact is:

Department of Health and Environmental Control (DHEC) Licensing Division
2600 Bull Street
Columbia, South Carolina 29202
803-737-7370

7. Smoking is prohibited except in certain areas. Please discuss any special needs with your physician.

8. I acknowledge that laboratory studies may be performed in the event a health care worker is exposed to my blood or body fluid.

I, the undersigned, state that the information that I have provided Aiken Regional Medical Centers is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
ORIGINAL SIGNATURE ON FILE AT AIKEN REGIONAL MEDICAL CENTERS.

Date Time Patient Parent/Guardian
Relationship to Patient

Witness

Witness

Witness

Address

City State Zip

Relationship to Patient

Patient was given the option to deposit valuables in safe

Witness	Patient Name
Witness	Relationship
Witness	Date Time

Aiken Regional
MEDICAL CENTERS
The Health Choice

202 University Parkway, Aiken, SC 29801

MED. REC. NO. 177223

PT NO: 104544838	PATIENT NAME: LEE, BERNARD D												PT STS: ET
ADDRESS: 172 OLD CHEROKEE INDIAN RD													COUNTY: 2
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-0000	PHONE: 803-663-0560		EXT.		SOCIAL SECURITY NO: 251-45-2204				
AGE: 27	DOB: 04/30/1980	SEX: M	RACE: 2	MS: S	PREVIOUS NAME:					RELIGION: BAP	M/S: TRIG	EMPLOY: TRIG02	
ADMIT DATE: 07/05/07	TIME: 04:58	SRC: EO	PT TYPE: T	PRI: X	ACCIDENT INFO: H 07/05/07 04:02			VOLUNTARY ADM		ORGAN DNR	ISOL	INFANT AGE	
EMPLOYER: SHEET METAL ENG					TELEPHONE: 706-999-9999		EXT	OCCUPATION: WELDER					
EMPLOYER ADDRESS: MIKE PADGET HWY													
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-				RETIREMENT DATE					
NEAREST RELATIVE NAME: LEE VERGINIA													
RLTN: B	ADDRESS: UNK												
CITY: CEDARWATER			STATE: SC	ZIP: 29822-	PHONE: 803-663-1533		EXT						
EMERGENCY CONTACT NAME: LEE MARIE													
RLTN: N	ADDRESS: 172 CHEROKEE INDIAN RD												
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-	PHONE: 803-663-0560		EXT						
GUARANTOR NAME: LEE BERNARD D									RLTN: S	SOCIAL SECURITY NUMBER: 251-45-2204			
ADDRESS: 172 OLD CHEROKEE INDIAN RD										PHONE: 803-663-0560			
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-	OCCUPATION: WELDER				EXT				
GUARANTOR EMPLOYER: BAP					PHONE: 706-999-9999		EXT						
ADDRESS: MIKE PADGET HWY													
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-								FC: Z	
INSURANCE NAME 1: CHARITY PENDING		CODE: 90	POLICY #: 4251452204		GROUP #:			SUBSCRIBER: LEE, BERNARD S		REL:	AUTH #:		
INSURANCE NAME 2:		CODE:	POLICY #:		GROUP #:			SUBSCRIBER:		REL:	AUTH #:		
INSURANCE NAME 3:		CODE:	POLICY #:		GROUP #:			SUBSCRIBER:		REL:	AUTH #:		
ATTENDING PHYSICIAN: JACKSON WALTER			ATTENDING #: 045187	REF SRC:	ADM BY: WESTLI		PREV ADM DATE:		PREVIOUS FACILITY:				
ADM DIAGNOSIS: ABSCESS			MED SVC: EMR	CODE:	ALLERGIES:						SURGERY DATE:		
ADMITTING PHYSICIAN: JACKSON WALTER			ADMITTING #: 045187	AUTHORIZED BY:									
PROCEDURE:			CLINICAL COMMENT:					MODE OF ARRIVAL/ACCOMPANIED BY: POV					
RESPIRD: Y	ADV DIR:	LIVING WILL:	LOCATION OF WILL/DIRECTIVE:		FAMILY DOCTOR: JACKSON WALTER 045187								

FINAL DIAGNOSES (FIRST DIAGNOSIS PRINCIPAL UNLESS NOTED) CODE



PROCEDURES

CONSULTING PHYSICIANS

DRG

LOS

TRANS TO: ACUTE SNF ☐ REHAB ☐ HOSPICE ☐ HOME HEALTH ☐ HOME IV ☐ AGAINST MED ADV ☐ HOME ☐

DISCHARGE DATE | TIME | OTHER

EXPIRED ☐ TIME _____ <48HRS ☐ >48HRS ☐ CORONER ☐ AUTOPSY YES ☐ NO ☐

ATTENDING PHYSICIAN SIGNATURE & DATE

RxLASER, INC. C2488-20051 (714) 986-1559 (2/99) **CHART COPY – 227 – T REMOVE FROM CHART**

Chief Complaint: 12M c 4 days of 7/10 5/7 ☐ 23 Hr Observation

HPI: Pain on ⓔ buttock R/A chills, has had some recurrence for 4 years. Bartholin cyst I&D 2 days ago. WBM & pain; chills to ER.

Current Meds: See ED nurses notes

PMD

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, & ROS Unobtainable due to: ☐ As Above ☐ Other: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF

Past Surgical History:

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☑ COPD ☐ CHF

Social History: Tobacco ☐ No ☐ Yes Amt ETOH ☐ No ☐ Yes Amt ☐ Other

Review Of Systems: (Check ☐ if normal, Check ○ if abnormal, If not Checked then not applicable.)

Eyes:	☑ ○	Diplopia	☐ ○	Blurred	☐ ○	Vision chgs	GU:	☑ ○	Dysuria	☐ ○	Urgency	☐ ○ Hematuria
ENT:	☑ ○	Rhinitis	☐ ○	Sore throat	☐ ○	Nose bleeds	MS:	☐ ○	Myalgia	☐ ○	Back pain	☐ ○ Neck pain
Card:	☐ ○	CP	☐ ○	Palpitation			Neuro:	☐ ○	Seizures	☑ ○	Dizziness	☐ ○ Syncope
Respir:	☐ ○	SOB	☐ ○	Cough	☐ ○	Hemoptysis		☑ ○	Weakness	☑ ○	Numbness	
GI:	☐ ○	Nausea	☐ ○	Vomiting	☐ ○	Diarrhea	Endo:	☐ ○	Polyuria	☐ ○	Hypoglyc	☐ ○ Thyroid Dys
	☐ ○	Abd pain	☐ ○	Melena	☐ ○	Hematochez	Hem/Lym:	☐ ○	Anemia	☐ ○	Bleeding	

Other ROS ☐ Other ROS Neg ☑ For allergies see ED nurses notes

TETANUS STATUS:

ALLERGIES:

Physical Exam: WEIGHT TIME PULSE OX: TEMP P R BP

☑ For vitals see ED nurses notes

98 98 84 20 142/98

Check ☐ if normal Check ○ if abnormal

								Abn Findings:
General:	☑ ○	Mental Status						A&Ox3 NAD
Eyes:	☐ ○	Conjun NL	☐ ○	Lids	☐ ○	PERRL		
Head:	☐ ○	NL cephalic	☐ ○	Sinuses	☐ ○	Nose		
ENT:	☑ ○	Oropharynx	☐ ○	Right TM	☐ ○	Left TM		
Neck:	☐ ○	Palpation	☐ ○	Thyroid	☐ ○	Trachea		
Chest:	☐ ○	Palpation	☐ ○	Excurtion	☐ ○	Symmetry		
Cardio:	☐ ○	Heart sounds	☑ ○	R & R				
Respir:	☑ ○	Respir effort	☐ ○	Lung sounds				
Abdom:	☑ ○	Palpation	☐ ○	Bowel				
MS:	☑ ○	RUE	☐ ○	Sounds	☑ ○	Digits		
	☑ ○	LUE	☐ ○	RLE	☑ ○	Back		
	☑ ○	Pelvis	☐ ○	LLE				
Skin:	☐ ○	Temp	☑ ○	Gait	☐ ○	Color		
Neuro:	☑ ○	CNS	☑ ○	Appear Strength	☑ ○	Sensation		

TEST:	ORD	Initial
CBC W DIFF:		
CHEM 8:		
URINE PREG:		
CCUA:		
CATH UA:		
URINE C&S:		
EKG:		
OLD EKGS:		
TROPONIN:		
PT/PTT:		
FINGER ST GL:		
BLOOD CULT X		
TYPE & SCREEN:		
TYPE CROSS UNITS:		
LIVER PANEL:		
CMP:		
AMYLASE:		
LIPASE:		
HEMOCULT:		
TYPE & RH:		
HCG QUANT:		
URINE DRUG S:		
ALCOHOL:		
ED ABG:		
PA/LAT CXR:		
PCXR:		
C-SPINE:		
L-SPINE:		
ACUTE ABD:		
OLD RECORDS:		
OLD ED Record:		

TIME INITIAL ✓TEST ORDERED

PHYSICIAN'S ORDERS: TIME ORD: TIME COMP Initial

→ URINE PREG RESULTS...

LAC Troy
Lidocaine c EPI
#11 Scalpel
Packing gauze
Betadine
Sat
wnl
cost
LA

Med Decision Making:

☑ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME: #11 blade used, probed & ⓔ purulent

Diff Dx: Bartholin cyst, MRSA, abscess

Consults: Packed c 3/2 Iodoform gauze.

NAME OF PHYSICIAN THAT ADMITTED PT:

NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

☑ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

Name: Race: Sex: Age:

Addressograph

DISCHARGE DIAGNOSIS: ⓔ Bartholin cyst I&D

CODES

☑ STABLE

☐ UNSTABLE SEE NOTE

104544838
LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 07/05/07
AIKEN REGIONAL MEDICAL CENTER

Physician Signature: Time MD IN: 0501

ED Encounter Record
630.70

10-241

20

Aiken Regional Medical Centers

Admission Date: 7/5/07
Med. record No.: 177273
Visit No.: 104544838
Attending Phys.: JACKSON, Walter, MD
Allergies:

Quick Triage

Patient: Lee, Bernard
D.O.B.: 4/30/1980, Age: 27
Gender: Male
Location: TRIG
Room/Bed: TRIG/02

Scheduled: 7/5/07 04:59 User: Linda West RN
Performed: 7/5/07 04:59 Status: Finished

Quick Triage Info

TRIAGE STATUS NON-URGENT . pt in with c/o cyst inbetween buttocks
Rates pain as 7 on a scale of 0 to 10.
Vital Signs: Oral Temperature 98 F (36.67 C) .
Pulse 84 bpm .
Resp rate 20 . O2 SAT 99% .
BP 142/ 98 mmHg .
Patient's stated height is 5 Ft 11 in ( ) Meter 80.3 cm) .
Patient's stated weight is 190 lb 0 oz (86 kg 182.6 gm) .
There is no evidence of abuse and/or neglect .

Home Meds

Patient denies taking prescription or OTC meds, denies use of herbal supplements.

Occurrence History for Quick Triage

Effective	*Status*	*User*
7/5/07 05:01	Finished	West RN, Linda

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Aiken Regional Medical Centers

Admission Date: 7/5/07
Med. record No.: 177273
Visit No.: 104544838
Attending Phys.: JACKSON, Walter, MD
Allergies:

ER Discharge Assessment

Patient: Lee, Bernard
D.O.B.: 4/30/1980, Age: 27
Gender: Male
Location: EMER
Room/Bed: ERDC/37

Scheduled: 7/5/07 04:59 User: Rebecca Gardner
Performed: 7/5/07 06:45 Status: Finished

ER Discharge

ER Discharge Date/Time: 07/05/2007 06:45 . Patient discharged to home .
Patient ambulated off the unit, accompanied by parent .
Transported by private vehicle .
Patient condition is stable.
Discharge instructions given to patient .
Medications instructions given to patient .
Patient verbalized understanding.
Room checked.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Occurrence History for ER Discharge Assessment

Effective	Status	User
7/5/07 07:11	Finished	Gardner, Rebecca

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☐ Room: 20 Time: 0512 AMB

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Report To: Rebecca

HYSICAL ASSESSMENT: TIME PERFORMED: 0515

PULMONARY ☒ pt denies C/O

Respirations: ☒ even ☒ nonlabored ☐ labored ☐ use of accessory muscles ☒ Smoker ☒ yes ☐ no 1/4/day PPD _____ yrs. ☐ other* ☐ Former Smoker

Breath Sounds: ☐ bilateral ☒ clear ☐ labored ☐ diminished ☐ absent* ☐ crackles ☐ wheezes ☐ rhonchi

*describe: _____

Airway: ☒ oral ☐ nasal ☐ self maintained

Cough: ☐ productive ☐ non-productive ☐ Describe secretions: _____

Chest Tube: ☐ Right ☐ Left _____ cm. suction

ETT Placement: _____ cm ☐ oral ☐ nasal size ETT: _____ Trach: ☐ Yes ☐ No _____ size

Oxygen Supplement: ☒ No ☐ Yes (type) _____

CARDIOVASCULAR ☒ pt denies C/O

Capillary Refill: ☐ brisk ☐ sluggish Edema: ☒ absent ☐ present

Pulses:												
	Palpable	RADIAL:	☐ Rt	☐ Lt	FEMORAL:	☐ Rt	☐ Lt	PEDAL:	☐ Post Tibial		☐ Dorsal	
	Doppler		☐ Rt	☐ Lt		☐ Rt	☐ Lt		☐ Rt	☐ Lt	☐ Rt	☐ Lt
	Absent		☐ Rt	☐ Lt		☐ Rt	☐ Lt		☐ Rt	☐ Lt	☐ Rt	☐ Lt
									☐ Rt	☐ Lt	☐ Rt	☐ Lt

Pacemaker: ☐ Yes ☐ No Chest Pain: ☐ Yes ☒ No Describe: _____

JVD: ☐ Yes ☐ No EKG Rhythm: _____

NEUROLOGICAL ☒ pt denies C/O

LOC: ☒ Alert ☒ Oriented ☐ Responds to Voice ☐ Responds to Pain ☐ Unresponsive

Speech: ☒ Clear ☐ Slurred ☐ Aphasic ☐ Intubated / Trached Other:

Activity Level: ☒ Sitting / Lying Still ☐ Sleeping ☐ Fidgeting ☐ Pacing

Pupillary Response: ☒ Reactive ☐ Non-reactive ☒ Equal ☐ Unequal Comments _____

Verbal Response: ☒ Speaks Calmly ☐ Speaks In Phrases ☐ Raises Voice ☐ Shouting / Screaming ☐ Whispers / Moans

Facial Expression: ☒ Relaxed ☐ Grimace ☐ Crying ☐ Smiling

ENT

Eyes: ☐ contact lenses ☐ glasses ☐ foreign body ☐ cataracts ☒ mucous membranes moist / dry

☐ injury: _____

Ears / Nose / Throat / Mouth: _____

GENITOURINARY ☒ pt denies C/O

Urine: _____ ☐ clear ☐ color _____ ☐ cloudy ☐ hematuria ☐ incontinent ☐ other: _____

Dialysis: ☐ Yes ☒ No Access Site: _____ Comments: _____

Foley Size: _____

GASTROINTESTINAL ☒ pt denies C/O

☐ Nausea ☐ Vomiting Emesis Color: _____ ☐ Diarrhea

Abdomen: ☒ Soft ☐ Tender ☐ Distended

Bowel Sounds: ☒ Present ☐ Absent

Comments: _____

☐ G Tube / PEG Tube

INTEGUMENTARY ☒ pt denies C/O

Skin: ☒ warm ☐ dry ☐ cool ☐ pale ☐ clammy ☐ diaphoretic ☐ flushed ☐ mottled ☐ cyanotic ☐ jaundiced ☐ pink

If injury, ☐ unintentional ☐ Intentional by: _____

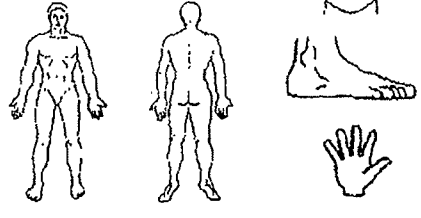
Previous injury by same person? ☐ Yes ☐ No

☐ Laceration ☐ Abrasion ☐ Bruising ☐ Burn

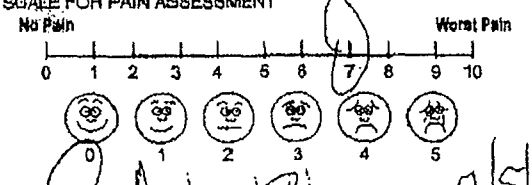
☐ Bleeding ☐ Avulsion ☐ Rash

LABEL AREAS INVOLVED ☐ ICE ☐ Elevated

A - Abrasion
AV - Avulsion
B - Burn
D - Deformity
E - Ecchymosis
ED - Edema
L - Laceration
P - Pain
PU - Puncture Wounds
R - Rash
RE - Redness



NUMERIC SCALE FOR PAIN ASSESSMENT



PATIENT LABEL

104544838

LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 07/06/07
AIKEN REGIONAL MEDICAL CENTER

RN Signature: _____ Date: 7/5/07

E.D. NURSING ASSESSMENT RECORD

630.64 (Rev. 4/07)

INFUSION DATA

Time	Infusion Site	Solution (amount / type)	Total Infusion	Rate	D/Cd– Cath Intact	Cath Size / Type	# Attempts	Initials
MS								

INTAKE AND OUTPUT

INTAKE	TOTAL	INITIALS	OUTPUT	OUTPUT CHARACTER	TOTAL	INITIALS
Blood Products			Foley / Voided			
IV / a			NG / Emesis			
NG			Chest Tubes			
PO			Other			
Other						
Total Intake		cc	Total Output		cc	

II. ADDITIONAL ASSESSMENT 0645 Pt RA 0600 Dr. Jackson performing EVD c this time. R Andrews RN
0645 Pt d/c'd to Trauma. C Gardner RN

Time	SaO_2	Temp.	Pulse	Resp.	B/P
0645	100%	—	86	18	156/99

Time	Dose	Medication Administered

DISCHARGE STATUS

DATE: TIME:

☐ ROUTINE (HOME) ☐ AMA
☐ ADMIT TO: _____
PHYSICIAN: _____
☐ TRANSFERRED TO: _____
☐ ACCEPTING PHYSICIAN
☐ TRANSFER FORMS COMPLETED
☐ RECORDS WITH PATIENT

EXPIRED

☐ IN ER ☒ CORONER'S CASE
☐ DOA ☐ AUTOPSY

CONDITION ON DISCHARGE

☒ STABLE
☐ UNSTABLE
EXPLAIN: Stable

METHOD OF DISCHARGE

☐ AMBULATORY ☐ AMBULANCE
☒ WHEELCHAIR ☒ STRETCHER

ACCOMPANIED BY

☐ SELF ☐ RELATIVE ☐ POLICE
☒ OTHER ☐ FRIEND
EXPLAIN:

METHOD INSTRUCTIONS

☐ VERBAL ☐ WRITTEN
☐ NOT GIVEN (WHY) _____
☐ PT VERBALIZES UNDERSTANDING

ED FALL SCALE

HISTORY OF FALLS	☐ YES	☑ NO
AGE >65 YEARS	☐ YES	☑ NO
TRANSFERS IMPAIRED	☐ YES	☑ NO
ORIENTATION CONFUSED/ BEHAVIORIAL ISSUES	☐ YES	☑ NO

INTERVENTIONS

FALL RISK ASSESSMENT
☑ LOW RISK ☐ HIGH RISK
FALL INTERVENTION
☐ SIDE RAILS ☐ BED IN POSITION
☑ CALL LIGHT ☐ BS OBSERVATION

LOW RISK IF 0 OR 1 MARKED AS YES
HIGH RISK IF 2 OR > MARKED AS YES

RECEIVING NURSE FOR ADMISSION:

Signature: _____ ***Date / Time:*** _____ / _____

R Andrews RN

2 HORIZONTAL MOUNT

AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC

C. Staggs - SC#14516 - DEA BS1978355 | M. James - SC#14208 - DEA BJ1586084 | W. Jackson - SC#23797 - DEABJ5484225
S. Platte - SC#20087 - DEA BP5052509 | E. Yoh - SC#20098 - DEA BY4916873 | C. Lavigne, PA-C - SC#A512EM
S. Grant - SC#15672 - DEA BG2720793 | D. Waddle - SC#20749 - DEA BW4632508 | B. Taylor, PA-C - SC#A505EM

302 University Pkwy. Aiken, South Carolina 29801 Phone 641-5000

For Lee Kennard Age 27

Address _____ Date 7/5/07

Vicodin 5/500

30 Tablets - 1 Prescription Refill

Rx Take 2 (two) tablets every 4 hours as needed for pain

Please dispense 120 Medications · NO REFILLS · prefers / does not prefer generic substitute

_____ M.D. _____ M.D.
Dispense as Written Substitution Permitted

This prescription can be filled next door at

410 University Parkway Suite 2800 **Medical Center Pharmacy** Aiken, South Carolina 29801 (803) 648-2985

M-F 8-6 & SAT 9-12

104544838

LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 07/05/07
AIKEN REGIONAL MEDICAL CENTER

3 VERTICAL MOUNT

1 HORIZONTAL MOUNT

REMOVE TAPES

PLACE EDGE OF FORM AGAINST SOLID LINE AND PRESS FIRMLY

LABORATORY

HCAIS 9

Lee

Home Medication List
Physician's Order - Outpatient

Height:	feet	inches		
Weight:	pounds	actual	stated	estimated
Allergies: NKDA				
Nurse Signature				Date/Time

Home Medications
(Include Herbal/OTC/Vitamins) Do NOT administer herbals during hospitalization

Medication/Dose	Route	Frequency	Last Dose Taken
Unapproved abbreviations: IU, Mg, MSO4, MgSO4, O.D., q.d., q.o.d. U, u, trailing zeros, no zeros before decimal			
☑ No home medications	☐ Unable to obtain list		

Changes to home medications: ☑ None ☐ _____

Based on the treatment prescribed by your physician(s) and the list of medications that you provided, you may continue your home medications with the changes written above, if any. Please contact your prescribing physician if you have any questions about your home medications.

Prescriptions Given at Discharge

☐ No new medications

Medication/Dose	Route	Frequency	Reason for taking
Vicodin 5/500	Oral	every 6 hours	Pain

Physician Signature

Patient Signature

Licensed Staff Signature

Patient

104544838

LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 07/05/07
AIKEN REGIONAL MEDICAL CENTER

10-07038 (12/06)

GENERAL INSTRUCTIONS:

- ☐ Call the next business day and make an appointment to see: _____
  Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: _____ days or less or _____ days or less if still ill.
- ☐ Have your blood pressure checked at _____ within _____ days.
- ☐ Return to the Emergency Department after 12:30 p.m. in _____ days for suture removal or re-check.
- ☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.
- ☐ Work / school excuse from _____ thru _____. May return to work _____.
- ☐ See your company doctor per your company's policy. Light duty until _____.
  (No use of _____ No lifting over _____ lbs.)
- ☐ Wound Check in 2 days - Return if Pus / Fever, Redness Soaking every shower after

Your diagnosis was: Left Buttock Abscess / Bowel Pilonidal Cyst / Wound

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☒ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☒ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☒ Otitis Media*
- ☐ Chicken Pox*
- ☒ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diptheria booster***
- ☐ Blood/Body Fluid Exposure Follow-u

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement (my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X_Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physic
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Departm

_____ *Physician*

_____ *Staff*

07/05/07 *Date*

_____ *Patient or Responsible Person*

Aiken Regional Medical Center
302 University Parkway
Aiken, SC 29801

EMERGENCY SERVICES

ER0023

10-2163
630.08
Rev. 5/07

Patient Identification

104544838
LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 07/05/07
AIKEN REGIONAL MEDICAL CENTER

WHITE - RECORDS CANARY - I – 235 – PINK - EMERGENCY DEPARTMENT GOLDENROD - PATIENT

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29802

PATIENT NAME: LEE, BERNARD DATE OF SERVICE/ADMISSION 7-05-07

CONSENT FOR TREATMENT, GUARANTY OF PAYMENT AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION AND ASSOCIATED NOTICES AND AUTHORIZATION.

NOTICE TO PATIENT AND ALL SIGNATORIES OF THIS DOCUMENT: By your signature below, each signatory of this document is agreeing to be jointly and severally bound by all of the terms and conditions hereinafter set forth unless otherwise noted. In consideration of the hospital care and treatment to be rendered to Patient by Hospital, the undersigned agree and consent to the following:

1. Consent and Conditions of Admission: The undersigned hereby agrees and gives consent to Hospital for the admission/treatment/testing of Patient. The undersigned hereby consents to any and all hospital care encompassing: X-Ray examination, laboratory procedures, diagnostic procedures, anesthesia and nursing or medical/surgical treatment which Patient's physician, his associates, partners or designees, may deem necessary or advisable under the general and special instructions of the same, during Patient's hospitalization.

2. Medical and Surgical Treatment: The undersigned agrees and understands that all physicians, dentists and or oral surgeons treating Patient are responsible and liable for their own acts or omissions and the Hospital is not responsible or liable for the acts omissions of the aforementioned. The undersigned is aware that the practice of medicine is not an exact science and further state that no guarantee has been made or can be made as to the results of the treatments or examinations in the Hospital.

The undersigned certifies that they have read all of this document, including the reverse side hereof, and that the undersigned is the Patient, or is duly authorized by the Patient or by law, to execute the above Agreement and understands its terms.

All Patients shall receive treatment or service within the hospital's capability and policies. Our hospital is committed to patient's impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care.

3. Assignment of Insurance Benefits and Release of Medical Information: The undersigned hereby assign to Hospital, its successors and assigns, all benefits that may be payable to or on behalf of the Patient under any policy of insurance, (hospitalization, major medical, automobile, workmen's compensation, personal injury benefits available because of liability of a third party, or any other) and authorize Hospital to release specifically requested medical information related to Patient to include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assaults, tests for HIV, ARC and/or AIDS, or other infectious diseases necessary for settlement of benefit payment or money payable because of Patient's hospitalization, treatment or injury during this encounter. The undersigned further direct that the payer of any such payment make such payment directly to Hospital. In addition, the undersigned assign to Hospital, its successors and assigns, the proceeds of injury claim resulting from liability to Patient of a third party. Any payments to Hospital under authority of this Assignment shall not exceed the actual charges set forth in Hospital's billing statements issued in connection with Patient's account.

If Patient is eligible for Medicare, the undersigned requests Medicare services and benefits. The undersigned further agree that this Assignment will not be withdrawn or voided at any time until Patient's account is paid in full. The undersigned acknowledge that it is their responsibility to pay Hospital for any charges not covered by insurance. Further, undersigned agree and understand that if the Patient, or his duly authorized representative, requests a private room for the Patient the undersigned is responsible for the entire room difference.

The undersigned hereby authorize any agency or employee of the U.S., any State or Municipal Government to release to the Hospital, its employee, employees and/or it attorney, any and all information concerning governmental programs under which the above named Patient is or may be qualified to receive benefits due and further authorize payment of any and all such benefits direct to Hospital.

The insured whose signature appears in this item one (1), hereby represents to the Hospital that the following insurance policies are the only insurance policies offering coverage to the patient in this matter and hereby assigns to Hospital all benefits payable to or on behalf of Patient thereunder:

Written authorization for HMO/PPO plans: I understand that if my insurance carrier, HMO plan or PPO network requires preauthorization, the Hospital/Provider/Physician is unable to guarantee that my visit will be covered without a written authorization for the services rendered to me or my family members. I the Hospital/Provider/Physician is unable to obtain authorization for my visit, I will be responsible for any unpaid balance. I will be financially responsible for those charges that coincide with any service/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the Hospital accepts no liability for failur to meet any pre/post certification procedures which may be required of me by my coverage carrier. I agree that any such procedures have been or will be properly executed by me.

Primary Insurance Co. CHARITY PENDING

X Patient [signature]

Insured

Secondary Insurance Co.

Patient

Insured

Addressograph

104544838
LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 07/05/07
AIKEN REGIONAL MEDICAL CENTER

ICIANS NOT AS EMPLOYEES: I acknowledge that all physicians furnishing services including but not limited to radiologists, pathologists, anesthesiologists, emergency department physicians, consultants and assistants to the physician are not employees of the Hospital. I understand that I may receive separate billing from each of these providers for services rendered.

4. Guaranty of Payment: The undersigned jointly and severally agree to be bound to Hospital for payment and absolutely guarantee payment to hospital on demand of all charges now or hereafter incurred for goods and services furnished by Hospital to Patient in connection with Patient's treatment and/or stay at Hospital. This is a continuing guarantee of payment on demand of the entire unpaid balance of charges incurred during the period from the date of service or admission above until Patient is discharged and includes guaranty of payment of outpatient charges for services rendered on the date noted above and any follow-up outpatient charges. Such charges shall be in accordance with the regular rates and charges of the Hospital in effect at the time of the rendering of the service or the furnishing of the goods for which the charge is incurred.

Should patient's account be turned over to any attorney for collection or legal proceedings of any kind, the undersigned jointly and severally, absolutely guarantee payment to Hospital of all costs and expenses incurred by Hospital in connection with such collection action and/or legal proceeding, including a reasonable attorney's fee not to exceed fifteen (15) percent of the unpaid balance due.

The undersigned also agrees that any over payments collected in connection with any particular admission or outpatient treatment of Patient may be applied directly to a delinquent account of Patient or any delinquent account for which Patient or any undersigned is legally responsible at the time of collection of the over payment. Hospital may make a Repayment Agreement with any one or more of the undersigned, which Agreement shall be considered ancillary to and not in lieu of this Agreement and shall not be construed as limiting or modifying the liability of any other signatory to this Agreement.

Patient signatories, Spouse of Patient signatories, Guarantor signatories, and Parent of minor parent signatories are jointly and severally bound by all the terms hereof including liability for payment to Hospital under this Guaranty of Payment agreement.

5. Assignment of Physician Benefits: In the event that Patient, in addition to Hospital benefits, is entitled to any physician benefits of any type whatsoever arising out of policy of insurance insuring Patient or any other parties liability to Patient, the undersigned hereby assign said benefits to any physician rendering care or treatment during the stay associated with this admission or any outpatient visits, to be applied to Patient bill.

6. Medicare Patient Certification: The undersigned certify that the information given by the undersigned in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carries any information needed for a Medicare claim related to patient. The undersigned authorize and direct that a copy of this Authorization may be used in place of the original and request payment of authorized benefits be made on behalf of the Patient.

Personal Valuables and Belongings: The undersigned acknowledge and agree that the Hospital maintains a safe for the safekeeping of valuables. The Hospital shall not be responsible or liable for the loss or damage to any articles of personal property while Patient is hospitalized unless said articles are deposited with the Hospital in the safe and receipts are issued describing said items. If the patient is unable to sign and in the event no relative is present, the Hospital shall retain possession of valuables and obtain acknowledgment at the first available opportunity.

8. Cameras and Surveillance Equipment: Patient has been advised that Aiken Regional Medical Center uses cameras and other surveillance equipment to monitor patient/employee activities. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment.

9. You have the right to file a grievance regarding concerns with our quality. The agency you may contact is:

Department of Health and Environmental Control (DHEC) Licensing Division
2600 Bull Street
Columbia, South Carolina 29202
803/737-7370

10. Smoking is prohibited except in certain areas. Please discuss any special needs with your physician.

11. I acknowledge that laboratory studies may be performed in the event a health care worker is exposed to my blood or body fluid.

I, the undersigned, state that the information that I have provided Aiken Regional Medical Center is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
ORIGINAL SIGNATURE ON FILE AT AIKEN REGIONAL MEDICAL CENTERS.

7.05.07 X _____ Diana Lyon
Date Time Patient/Parent/Guardian Witness
Relationship to Patient

Address _____ Witness _____

No ID
No Insurance Card
Address
Correct on ID

City State Zip

Reason Patient Did Not Sign _____ ☐ Patient was given the option to deposit valuables in safe.

TELEPHONE CONSENT	Patient Name
	Obtained From / Relationship
Witness	Date/Time

Aiken Regional
MEDICAL CENTERS
The Health Choice

202 University Parkway, Aiken, SC 29801

MED. REC. NO. 177273

PT NO: 104556865	PATIENT NAME: LEE, BERNARD D														PT STS: ET
ADDRESS: 172 OLD CHEROKEE INDIAN RD														COUNTY: 2	
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-0000		PHONE: 803-663-0560		EXT		SOCIAL SECURITY NO: 251-45-2204					
AGE: 27	DOB: 04/30/1980	SEX: M	RACE: 2	MS: S	PREVIOUS NAME						RELIGION: BAP	NS: TRTG	AM/RED: TRTG04		
ADMIT DATE: 07/07/07	TIME: 13:31	SRC: EO	PT TYPE: T	PRI: X	ACCIDENT: N	ACCIDENT INFO: 07/07/07 00:00			VOLUNTARY ADM		ORGAN DNR	ISOL	INFANT AGE		
PT EMPLOYER: SHEET METAL ENG					TELEPHONE: 706-999-9999		EXT		OCCUPATION: WELDER						
EMPLOYER ADDRESS: MILKE PADGET HWY															
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-						RETIREMENT DATE					
NEAREST RELATIVE NAME: LEE, VIRGINIA															
RLTN: B	ADDRESS: UNK														
CITY: CLEARWATER			STATE: SC	ZIP: 29822-		PHONE: 803-663-1533		EXT							
EMERG/NOK CONTACT NAME: LEE, MARIE															
RLTN: N	ADDRESS: 172 CHEROKEE INDIAN RD														
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-		PHONE: 803-663-0560		EXT							
GUARANTOR NAME: LEE, BERNARD D										RLTN: S	SOCIAL SECURITY NUMBER: 251-45-2204				
ADDRESS: 172 OLD CHEROKEE INDIAN RD											PHONE: 803-663-0560				
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-		OCCUPATION: WELDER					EXT				
GUARANTOR EMPLOYER: BAE					PHONE: 706-999-9999		EXT								
ADDRESS: MILKE PADGET HWY															
CITY: GRANITEVILLE			STATE: SC	ZIP: 29829-										FC: Z	

INSURANCE NAME 1: CHARITY PENDING	CODE	POLICY #: 904251452204	GROUP #:	SUBSCRIBER: LEE, BERNARD	REL: S	AUTH #:		
INSURANCE NAME 2:	CODE	POLICY #:	GROUP #:	SUBSCRIBER:	REL:	AUTH #:		
INSURANCE NAME 3:	CODE	POLICY #:	GROUP #:	SUBSCRIBER:	REL:	AUTH #:		

ATTENDING PHYSICIAN: JAMES MARTIN F	ATTENDING #: 003442	REF SRC:	ADM BY: WARDAS	PREV ADM DATE:	PREVIOUS FACILITY:	
ADMDIAGNOSIS: ABSCESS RECHECK	MED SVC: EMR	CODE:	ALLERGIES:			SURGERY DATE:
ADMITTING PHYSICIAN: JAMES MARTIN F	ADMITTING #: 003442	AUTHORIZED BY:				
PROCEDURE:	CLINICAL COMMENT:			MODE OF ARRIVAL/ACCOMPANIED BY: SLF SELF		

RELEASE INFO	ADV DIR	LIVING WILL	LOCATION OF WILL/DIRECTIVE	FAMILY DOCTOR
Y				JAMES MARTIN F 003442

FINAL DIAGNOSES (FIRST DIAGNOSIS PRINCIPAL UNLESS NOTED)

CODE



PROCEDURES

CONSULTING PHYSICIANS

DRG

LOS

TRANS TO: ACUTE ☐ SNF ☐ REHAB ☐ HOSPICE ☐ HOME HEALTH ☐ HOME IV ☐ AGAINST MED ADV ☐ HOME ☐

DISCHARGE DATE | TIME | OTHER

EXPIRED ☐ TIME _____ , <48HRS ☐ >48HRS ☐ CORONER ☐ AUTOPSY YES ☐ NO ☐

ATTENDING PHYSICIAN SIGNATURE & DATE

Admission Date: 7/7/07
Med. Record No.: 177273
Visit No.: 104556865
Attending Phys.: JAMES, Martin F, MD
Allergies:

Quick Triage

Patient: Lee, Bernard
D.O.B.: 4/30/1980 Age: 27
Gender: Male
Location: TRIG
Room/Bed: TRIG/04

Scheduled: 7/7/07 13:32 User: Ashlynn Ward, RN
Performed: 7/7/07 13:33 Status: Finished

Quick Triage Info

TRIAGE STATUS NON-URGENT . pt here for recheck of abscess
Rates pain as 7 on a scale of 0 to 10.
Patient ambulated onto unit by himself/herself .
Transported by private vehicle .
No treatment prior to arrival.
Vital Signs: Oral Temperature 98.9 F (37.17 C) .
Pulse 84 bpm .
Resp rate 18 . O2 SAT 100% .
BP 160/ 105 mmHg .
Patient's stated height is 6 Ft 0 in (1 Meter 82.9 cm) .
Patient's stated weight is 190 lb 0 oz (86 kg 182.6 gm) .
There is no evidence of abuse and/or neglect .
Patient went to ED

Home Meds

See attached medication list.
Home medications comments: nkda .

Occurrence History for Quick Triage

Effective	Status	User
7/7/07 13:34	Finished	Ward, RN, Ashlynn

©2005, Opus Healthcare Solutions, Inc.

Aiken Regional ED Encounter

· Chief Complaint: Cyst Recheck

☐ 23 Hr Observation

HPI: 22 y/o male with small cysts with healing abscess to buttocks - onset 7-5-07.

Current Meds: Norco 5/325 mg

☐ See ED nurses notes

PMD

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, & ROS Unobtainable due to: ☐ As Above ☐ Other: None ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF

Past Surgical History: None

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☒ Yes Amt ETOH ☒ No ☐ Yes Amt ☐ Other

Review Of Systems: ☐ Other ROS Neg ☐ For allergies see ED nurses notes

Check ☐ if normal Check ○ if abnormal (If not Checked then not applicable.)

Eyes:	☐	○ Diplopia	☒	○ Blurred	☒	○ Vision chgs	GU:	☐	○ Dysuria	☐	○ Urgency	☐	○ Hematuria
ENT:	☐	○ Rhinitis	☐	○ Sore throat	☒	○ Nose bleeds	MS:	☐	○ Myalgia	☐	○ Back pain	☐	○ Neck pain
Card:	☐	○ CP	☐	○ Palpitation			Neuro:	☐	○ Seizures	☐	○ Dizziness	☐	○ Syncope
Respir:	☒	○ SOB	☐	○ Cough	☒	○ Hemoptysis		☐	○ Weakness	☐	○ Numbness		
GI:	☒	○ Nausea	☒	○ Vomiting	☐	○ Diarrhea	Endo:	☐	○ Polyuria	☐	○ Hypoglyc	☐	○ Thyroid Dys
	☒	○ Abd pain	☒	○ Melena	☒	○ Hematochez	Hem/Lym:	☐	○ Anemia	☐	○ Bleeding		

Other ROS

TETANUS STATUS:

ALLERGIES: Norvasc

TEST | ORD | Initial | TIME INITIAL ✓TEST ORDERED

Physical Exam: WEIGHT | TIME | PULSE | OX: | TEMP | P | R | BP

120 98% 160/95

☐ For vitals see ED nurses notes

Check ☐ if normal Check ○ if abnormal

General:	☐	○ Mental Status					
Eyes:	☐	○ Conjun NL	☐	○ Lids	☐	○ PERRL	
Head:	☐	○ NL cephalic	☐	○ Sinuses	☐	○ Nose	
ENT:	☐	○ Oropharynx	☐	○ Right TM	☐	○ Left TM	
Neck:	☐	○ Palpation	☐	○ Thyroid	☐	○ Trachea	
Chest:	☐	○ Palpation	☐	○ Excurtion			
Cardio:	☐	○ Heart sounds	☐	○ R & R			
Respir:	☐	○ Respir effort	☐	○ Lung sounds			
Abdom:	☐	○ Palpation	☐	○ Bowel Sounds			
MS:	☐	○ RUE	☐	○ RLE	☐	○ Digits	
	☐	○ LUE	☐	○ LLE	☐	○ Back	
	☐	○ Pelvis	☐	○ Gait			
Skin:	☐	○ Temp	☐	○ Appear	☐	○ Color	
Neuro:	☐	○ CNS		Strength	☐	○ Sensation	

Abn Findings: Tenderness to palpation + erythema

PIC

TIME ORD: | TIME COMPLETED

PHYSICIAN'S ORDERS:

→ URINE PREG RESULTS:

repeat BP. 156/98

PI Chandler MD

CBC W DIFF:			
CHEM 8:			
URINE PREG:			
CCUA:			
CATH UA:			
URINE C&S:			
EKG:			
OLD EKGS:			
TROPONIN:			
PT/PTT:			
FINGER ST GL:			
BLOOD CULT X			
TYPE & SCREEN:			
TYPE CROSS			
UNITS:			
LIVER PANEL:			
CMP:			
AMYLASE:			
LIPASE:			
HEMOCULT:			
TYPE & RH:			
HCG QUANT:			
URINE DRUG S:			
ALCOHOL:			
ED ABG:			
PA/LAT CXR:			
PCXR:			
C-SPINE:			
L-SPINE:			
ACUTE ABD:			
OLD RECORDS:			
OLD ED Record:			

Med Decision Making:

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME:

Diff Dx:

Consult/s:

NAME OF PHYSICIAN THAT ADMITTED PT:

NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

☒ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

Name: | Race: | Sex: | Age:

Addressograph

DISCHARGE DIAGNOSIS:

(1) Pilonidal cyst - healing
(2) HTN

CODES

STABLE ☐ UNSTABLE SEE NOTE

Physician Signature: Time MD IN:

104556865

LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 07/07/07
AIKEN REGIONAL MEDICAL CENTER

ED Encounter Record
630.70

10-24

-240-

Room: 2 Time: 1410

Aiken Regional Medical Centers

Report To: Karen

302 University Parkway • Aiken, South Carolina 29802

PHYSICAL ASSESSMENT: TIME PERFORMED: 1410

PULMONARY ☒ pt denies C/O

Respirations: ☐ even ☐ nonlabored ☐ labored ☐ use of accessory muscles ☐ Smoker ☐ yes ☐ no ____ PPD ____ yrs. ☐ Former Smoker ☐ other*: ____

Breath Sounds: ☐ bilateral ☐ clear ☐ labored ☐ diminished ☐ absent* ☐ crackles ☐ wheezes ☐ rhonchi *describe: ____

Airway: ☐ oral ☐ nasal ☑ self-maintained

Cough: ☑ productive ☐ non-productive ☐ Describe secretions: ____

Chest Tube: ☐ Right ☐ Left ____ cm suction ____

ETT Placement: ____ cm ☐ oral ☐ nasal size ETT: ____ Trach: ☐ Yes ☐ No ____ size

Oxygen Supplement: ☐ No ☐ Yes (type) ____

CARDIOVASCULAR ☒ pt denies C/O

Capillary Refill: ☐ brisk ☐ sluggish Edema: ☑ absent ☐ present

Pulses:		RADIAL:	FEMORAL:	PEDAL:	
	Palpable	☑ Rt ☑ Lt	☑ Rt ☑ Lt	☑ Post Tibial ☑ Rt ☑ Lt	☑ Dorsal ☑ Rt ☑ Lt
	Doppler	☑ Rt ☑ Lt	☑ Rt ☑ Lt	☑ Rt ☑ Lt	☑ Rt ☑ Lt
	Absent	☑ Rt ☑ Lt	☑ Rt ☑ Lt	☑ Rt ☑ Lt	☑ Rt ☑ Lt

Pacemaker: ☑ Yes ☐ No Chest Pain: ☑ Yes ☐ No Describe: ____

JVD: ☑ Yes ☐ No EKG Rhythm: ____

NEUROLOGICAL ☒ pt denies C/O

LOC: ☐ Alert ☐ Oriented ☐ Responds to Voice ☐ Responds to Pain ☑ Unresponsive

Speech: ☑ Clear ☐ Slurred ☑ Aphasic ☑ Intubated / Trached Other:

Activity Level: ☑ Sitting / Lying Still ☐ Sleeping ☑ Fidgeting ☐ Pacing

Pupillary Response: ☐ Reactive ☑ Non-reactive ☐ Equal ☐ Unequal Comments ____

Verbal Response: ☑ Speaks Calmly ☐ Speaks in Phrases ☐ Raises Voice ☐ Shouting / Screaming ☐ Whispers / Moans

Facial Expression: ☐ Relaxed ☑ Grimace ☑ Crying ☑ Smiling

EENT

Eyes: ☐ contact lenses ☑ glasses ☐ foreign body ☐ cataracts ☒ mucous membranes moist / dry ☑ injury: ____

Ears / Nose / Throat / Mouth: ____

GENITOURINARY ☒ pt denies C/O

Urine: ____ ☒ clear ☐ color ____ ☐ cloudy ☐ hematuria ☐ incontinent ☐ other: ____

Dialysis: ☐ Yes ☐ No Access Site: ____ Comments: ____

Foley Size: ____

GASTROINTESTINAL ☒ pt denies C/O

☑ Nausea ☐ Vomiting Emesis Color: ____ ☐ Diarrhea

Abdomen: ☐ Soft ☑ Tender ☑ Distended

Bowel Sounds: ☑ Present ☐ Absent

Comments: ____

☑ G Tube / PEG Tube

INTEGUMENTARY ☑ pt denies C/O ethere for echo pt

Skin: ☑ warm ☑ dry ☐ cool ☐ pale ☑ clammy ☐ diaphoretic ☑ flushed ☑ mottled ☐ cyanotic ☐ jaundiced ☐ pink Karen

If injury: ☐ unintentional ☑ intentional by: ____

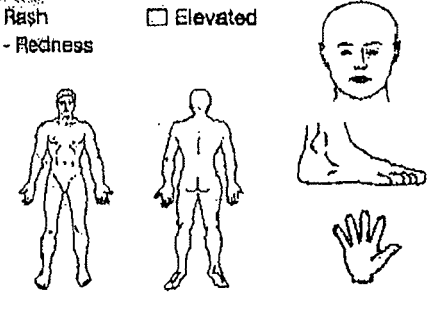
Previous injury by same person? ☐ Yes ☑ No

☐ Laceration ☑ Abrasion ☐ Bruising ☐ Burn ☑ Bleeding ☐ Avulsion ☐ Rash

LABEL AREAS INVOLVED

A - Abrasion
AV - Avulsion
B - Burn
D - Deformity
E - Ecchymosis
ED - Edema
L - Laceration
P - Pain
PU - Puncture Words
R - Rash
RE - Redness

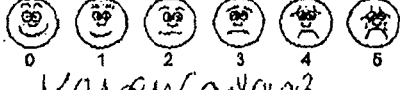
☐ ICE ☐ Elevated



NUMERIC SCALE FOR PAIN ASSESSMENT

No Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10



0 1 2 3 4 5

PATIENT LABEL

1045568 65

LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 07/07/07
AIKEN REGIONAL MEDICAL CENTER

RN Signature: KarenCarter Date: 07/07/07

E.D. NURSING ASSESSMENT RECORD

630.84 (Rev. 4/07)

INFUSION DATA

Time	Infusion Site	Solution (amount / type)	Total Infusion	Rate	D/C'd-- Cath Intact	Cath Size / Type	# Attempts	Initials
MS:								

INTAKE AND OUTPUT

INTAKE	TOTAL	INITIALS	OUTPUT	OUTPUT CHARACTER	TOTAL	INITIALS
Blood Products			Foley / voided			
IVF's			NG / Emesis			
NG			Chest Tubes			
PO			Other			
Other						
Total Intake	cc		Total Output		cc	

II. ADDITIONAL ASSESSMENT (410) pt to ExpCare Rm H2. Assessment Completed. PA to Ale pt. (509) pt was d/c'd as ordered. Rx given pt verbalized understanding.

Time	SaO_2	Temp.	Pulse	Resp.	B/P

Time	Dose	Medication Administered

DISCHARGE STATUS

DATE: 01/07/07 TIME: 1509

☑ ROUTINE (HOME) ☐ AMA

☐ ADMIT TO: _____

PHYSICIAN: _____

☐ TRANSFERRED TO:

_____

☐ ACCEPTING PHYSICIAN

_____

☐ TRANSFER FORMS COMPLETED

☑ RECORDS WITH PATIENT

EXPIRED

☐ IN E.R. ☐ CORONER'S CASE

☐ DOA ☐ AUTOPSY

CONDITION ON DISCHARGE

☑ STABLE

☐ UNSTABLE

EXPLAIN: _____

_____

METHOD OF DISCHARGE

☑ AMBULATORY ☐ AMBULANCE

☐ WHEELCHAIR ☐ STRETCHER

ACCOMPANIED BY

☑ SELF ☐ RELATIVE ☐ POLICE

☐ OTHER ☐ FRIEND

EXPLAIN: _____

METHOD INSTRUCTIONS

☑ VERBAL ☐ WRITTEN

☐ NOT GIVEN (WHY) _____

☐ PT VERBALIZES UNDERSTANDING

ED FALL SCALE

HISTORY OF FALLS	☐ YES	☑ NO
AGE > 65 YEARS	☐ YES	☑ NO
TRANSFERS IMPAIRED	☐ YES	☑ NO
ORIENTATION CONFUSED/ BEHAVIORIAL ISSUES	☐ YES	☑ NO

INTERVENTIONS

FALL RISK ASSESSMENT

☑ LOW RISK ☐ HIGH RISK

FALL INTERVENTION

☐ SIDE RAILS ☐ BED IN POSITION

☑ CALL LIGHT ☐ BS OBSERVATION

LOW RISK IF 0 OR 1 MARKED AS YES

HIGH RISK IF 2 OR > MARKED AS YES

RECEIVING NURSE FOR ADMISSION:

Signature: Karen Carter RN ***Date / Time:*** 01/07/07 1509

Home Medication List
Physician's Order - Outpatient

Height:	6 feet	0 inches		
Weight:	140 pounds	actual	stated	estimated
Allergies:	NKDA			
Nurse Signature			Date/Time	

Home Medications
(Include Herbals/OTC/Vitamins) Do NOT administer herbals during hospitalization

Medication/Dose	Route	Frequency	Last Dose Taken
Unapproved abbreviations: IU, Ms, MSO4, MgSO4, Q.D., q.d., q.o.d, U, u, trailing zeros, no zeros before decimal			
☐ No home medications	☐ Unable to obtain list		
Motrin			
Nexium			

Changes to home medications: ☐ None ☐ _____

Based on the treatment prescribed by your physician(s) and the list of medications that you provided, you may continue your home medications with the changes written above, if any. Please contact your prescribing physician if you have any questions about your home medications.

Prescriptions Given at Discharge

☐ No new medications

Medication/Dose	Route	Frequency	Reason for taking

Physician Signature

Licensed Staff Signature

Patient Signature

10-37036 (12/06)

Pat

104556865

LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 07/07/07
AIKEN REGIONAL MEDICAL CENTER

GENERAL INSTRUCTIONS:

☐ Call the next business day and make an appointment to see: _____

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: _____ days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within 2-3 days. 1/7/07

☐ Return to the Emergency Department after 12:30 p.m. in _____ days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☐ Work / school excuse from _____ thru _____. May return to work _____.

☐ See your company doctor per your company's policy. Light duty until _____.

(No use of _____ No lifting over _____ lbs.)

☐ _____

_____

_____

Your diagnosis was: _____

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diptheria booster***
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement o my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physicia
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Departmer

_____ 07/07/07 _____

Physician/Staff *Date* *Patient or Responsible Person*

Aiken Regional Medical Center
302 University Parkway
Aiken, SC 29801

EMERGENCY SERVICES

ER0023

10-2163
630.06
Rev. 5/07

Patient Identification

104556865
LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 07/07/07
AIKEN REGIONAL MEDICAL CENTER

WHITE - RECORDS CANARY - PA – 244 – NK - EMERGENCY DEPARTMENT GOLDENROD - PATIENT

MEDICAL CENTERS Aiken, SC 29802

PATIENT NAME: Lee, Bernard DATE OF SERVICE/ADMISSION 7/7/07

CONSENT FOR TREATMENT, GUARANTY OF PAYMENT AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION AND ASSOCIATED NOTICES AND AUTHORIZATION.

NOTICE TO PATIENT AND ALL SIGNATORIES OF THIS DOCUMENT: By your signature below, each signatory of this document is agreeing to be jointly and severally bound by all of the terms and conditions hereinafter set forth unless otherwise noted. In consideration of the hospital care and treatment to be rendered to Patient by Hospital, the undersigned agrees and consent to the following:

1. Consent and Conditions of Admission: The undersigned hereby agrees and gives consent to Hospital for the admission/treatment/testing of Patient. The undersigned hereby consents to any and all hospital care encompassing: X-Ray examination, laboratory procedures, diagnostic procedures, anesthesia and nursing or medical/surgical treatment which Patient's physician, his associates, partners or designees, may deem necessary or advisable under the general and special instructions of the same, during Patient's hospitalization.

2. Medical and Surgical Treatment: The undersigned agrees and understands that all physicians, dentists and or oral surgeons treating Patient are responsible and liable for their own acts or omissions and the Hospital is not responsible or liable for the acts omissions of the aforementioned. The undersigned is aware that the practice of medicine is not an exact science and further state that no guarantee has been made or can be made as to the results of the treatments or examinations in the Hospital.

The undersigned certifies that they have read all of this document, including the reverse side hereof, and that the undersigned is the Patient, or is duly authorized by the Patient or by law, to execute the above Agreement and understands its terms.

All Patients shall receive treatment or service within the hospital's capability and policies. Our hospital is committed to patient's impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care.

3. Assignment of Insurance Benefits and Release of Medical Information: The undersigned hereby assign to Hospital, its successors and assigns, all benefits that may be payable to or on behalf of the Patient under any policy of insurance, (hospitalization, major medical, automobile, workmen's compensation, personal injury benefits available because of liability of a third party, or any other) and authorize Hospital to release specifically requested medical information related to Patient to include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assaults, tests for HIV, ARC and/or AIDS, or other infectious diseases necessary for settlement of benefit payment or money payable because of Patient's hospitalization, treatment or injury during this encounter. The undersigned further direct that the payer of any such payment make such payment directly to Hospital. In addition, the undersigned assign to Hospital, its successors and assigns, the proceeds of injury claim resulting from liability to Patient of a third party. Any payments to Hospital under authority of this Assignment shall not exceed the actual charges set forth in Hospital's billing statements issued in connection with Patient's account.

If Patient is eligible for Medicare, the undersigned requests Medicare services and benefits. The undersigned further agree that this Assignment will not be withdrawn or voided at any time until Patient's account is paid in full. The undersigned acknowledge that it is their responsibility to pay Hospital for any charges not covered by insurance. Further, undersigned agree and understand that if the Patient, or his duly authorized representative, requests a private room for the Patient the undersigned is responsible for the entire room difference.

The undersigned hereby authorize any agency or employee of the U.S., any State or Municipal Government to release to the Hospital, its employee, employees and/or attorney, any and all information concerning governmental programs under which the above named Patient is or may be qualified to receive benefits due and further authorize payment of any and all such benefits direct to Hospital.

The insured whose signature appears in this item one (1), hereby represents to the Hospital that the following insurance policies are the only insurance policies offering coverage to the patient in this matter and hereby assigns to Hospital all benefits payable to or on behalf of Patient thereunder:

Written authorization for HMO/PPO plans: I understand that if my insurance carrier, HMO plan or PPO network requires preauthorization, the Hospital/Provider/Physician is unable to guarantee that my visit will be covered without a written authorization for the services rendered to me or my family members. If the Hospital/Provider/Physician is unable to obtain authorization for my visit, I will be responsible for any unpaid balance. I will be financially responsible for those charges that coincide with any service/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the Hospital accepts no liability for failure to meet any pre/post certification procedures which may be required of me by my coverage carrier. I agree that any such procedures have been or will be properly executed by me.

Primary Insurance Co. _____

Patient _____

Insured _____

Secondary Insurance Co. _____

Patient _____

Insured _____

A/

104556865

LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 07/07/07
AIKEN REGIONAL MEDICAL CENTER

Form 902.02 (Rev 10/04) 10-1983

- 245 -

418

PHYSICIANS NOT AS EMPLOYEES: I acknowledge that all physicians furnishing services including but not limited to radiologists, pathologists, anesthesiologists, emergency department physicians, consultants and assistants to the physician are not employees of the Hospital. I understand that I may receive separate billing from each of these providers for services rendered.

4. Guaranty of Payment: The undersigned jointly and severally agree to be bound to Hospital for payment and absolutely guarantee payment to hospital on demand of all charges now or hereafter incurred for goods and services furnished by Hospital to Patient in connection with Patient's treatment and/or stay at Hospital. This is a continuing guarantee of payment on demand of the entire unpaid balance of charges incurred during the period from the date of service or admission above until Patient is discharged and includes guaranty of payment of outpatient charges for services rendered on the date noted above and any follow-up outpatient charges. Such charges shall be in accordance with the regular rates and charges of the Hospital in effect at the time of the rendering of the service or the furnishing of the goods for which the charge is incurred.

Should patient's account be turned over to any attorney for collection or legal proceedings of any kind, the undersigned jointly and severally, absolutely guarantee payment to Hospital of all costs and expenses incurred by Hospital in connection with such collection action and/or legal proceeding, including a reasonable attorney's fee not to exceed fifteen (15) percent of the unpaid balance due.

The undersigned also agrees that any over payments collected in connection with any particular admission or outpatient treatment of Patient may be applied directly to a delinquent account of Patient or any delinquent account for which Patient or any undersigned is legally responsible at the time of collection of the overpayment. Hospital may make a Repayment Agreement with any one or more of the undersigned, which Agreement shall be considered ancillary to and not in lieu of this Agreement and shall not be construed as limiting or modifying the liability of any other signatory to this Agreement.

Patient signatories, Spouse of Patient signatories, Guarantor signatories, and Parent of minor parent signatories are jointly and severally bound by all the terms hereof including liability for payment to Hospital under this Guaranty of Payment agreement.

5. Assignment of Physician Benefits: In the event that Patient, in addition to Hospital benefits, is entitled to any physician benefits or any type whatsoever arising out of policy of insurance insuring Patient or any other parties liability to Patient, the undersigned hereby assign said benefits to any physician rendering care or treatment during the stay associated with this admission or any outpatient visits, to be applied to Patient Bill.

6. Medicare Patient Certification: The undersigned certify that the information given by the undersigned in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for a Medicare claim related to patient. The undersigned authorize and direct that a copy of this Authorization may be used in place of the original and request payment of authorized benefits be made on behalf of the Patient.

7. Personal Valuables and Belongings: The undersigned acknowledge and agree that the Hospital maintains a safe for the safekeeping of valuables. The Hospital shall not be held responsible or liable for the loss or damage to any articles of personal property while Patient is hospitalized unless said articles are deposited with the Hospital in the safe and receipts are issued describing said items. If the patient is unable to sign and in the event no relative is present, the Hospital shall retain possession of valuables and obtain acknowledgment at the first available opportunity.

8. Cameras and Surveillance Equipment: Patient has been advised that Aiken Regional Medical Center uses cameras and other surveillance equipment to monitor patient and employee activities. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment.

9. You have the right to file a grievance regarding concerns with our quality. The agency you may contact is:

Department of Health and Environmental Control (DEHEC) Licensing Division
2600 Bull Street
Columbia, South Carolina 29202
803/737-7370

10. Smoking is prohibited except in certain areas. Please discuss any special needs with your physician.

11. I acknowledge that laboratory studies may be performed in the event a health care worker is exposed to my blood or body fluid.

I, the undersigned, state that the information that I have provided Aiken Regional Medical Center is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
ORIGINAL SIGNATURE ON FILE AT AIKEN REGIONAL MEDICAL CENTERS.

7/10/07 — Time — Patient/Parent/Guardian — Witness

Relationship to Patient

Address — Witness

☐ No ID
☐ No Insurance Card
☐ Address Correct on ID

City — State — Zip

Reason Patient Did Not Sign _____ ☐ Patient was given the option to deposit valuables in safe.

TELEPHONE CONSENT	Patient Name
Witness	Obtained From — Relationship
Witness	Phone # — Date/Time

```
T NAME:     LEE ,BERNARD D                                          AGE:    27
URS STA:                    PT TYPE:      T        PT NO:          105023369
OOM/BED:                    HOSP SVC:     EMR      MED REC NO: 177273
T STATUS:   EA              MARITAL STS:  S        RACE:       2       REL:  BAP
SN:         251-45-2204     SEX:          M        BIRTHDATE:  04/30/1930
 NAME:                                             INFANT AGE:
 .ESS:      172 OLD CHEROKEE INDIAN RD              PHONE: 803 - 663-0560
                                                    DISTRICT CD:    2
ITY:        GRANITEVILLE                        ST:  SC  ZIP:  29829-0000

MPLOYER:    SHEET METAL ENG
DDRESS:     MIKE PADGET HWY

ITY:        GRANITEVILLE                        ST:  SC     ZIP:  29829-
CCUPATION:  WELDER                              PHONE:  706 - 999-9999  EXT
UARANTOR:   LEE ,BERNARD
ADDRESS:    172 OLD CHEROKEE INDIAN RD                  GUAR SSN:  251452204
                                                        REL:       S
CITY:       GRANITEVILLE                        ST:  SC     ZIP:  29829-
OCCU:       WELDER                              PHONE:  803 - 663-0560  EXT
GUAR EMPL:  BAE
ADDRESS:    MIKE PADGET HWY                             PHONE: 706  999-9999
                                                        EXT
CITY:       MIKE PADGET HWY                     ST:  SC     ZIP:  29829-
MER CONTACT: LEE ,MARIE                                                 REL: N
ADDRESS:      172 CHEROKEE INDIAN RD
CITY:         GRANITEVILLE                        ST:  SC   ZIP:  29829-
            HOME PHONE: 803  663-0560  WORK PHONE:                 EXT:
NEXT OF KIN: LEE ,VIRGINIA                      PHONE: 803  663-1533
NSURANCE INFO:                  FC:  Z
INS PL 1:   904   CHARITY PENDING               POLICY #:  251452204
OB:         1     PAYOR ID: 600  VERIFIED: Y    GROUP #:
 L TO:      ARMC                                GROUP NAME:
 DRESS:     302 UNIVERSITY PKWY                         PHONE:
CITY:       AIKEN          ST:  SC   ZIP:  29801       UR PHONE:     -    -
AUTH #:                                         SUBSCRIBER NAME: LEE ,BERNARD
INS PL 2:                                       POLICY #:
COB:            PAYOR ID:       VERIFIED:       GROUP #:
MAIL TO:                                        GROUP NAME:
ADDRESS:                                                PHONE:
CITY:                      ST:          ZIP:            UR PHONE:     -    -
AUTH #:                                         SUBSCRIBER NAME:
INS PL 3:                                       POLICY #:
COB:            PAYOR ID:      VERIFIED:        GROUP #:
MAIL TO:                                        GROUP NAME:
ADDRESS:                                                 PHONE:
CITY:                      ST:          ZIP:            UR PHONE:     -    -
AUTH #                                          SUBSCRIBER NAME:
PREADM:              REG/UPG: TURNEA             PREREG:                 ER REG: WESTLI
ACC IND: H   ACC DT/TM: 102307  20:37            ADM DT/TM: 10/23/07   20:52
ACC LOC:                                        ADM SOURCE:     EO      ADM PRI:   X
DSCH DT/TM:                DISP: AHR            ADM DR: 003848  GRANT STEPHEN
REF DR:                                         ATN DR: 003848  GRANT STEPHEN
PROCEDURE:                                      DIAGNOSIS: DIZZINESS
CLIN COMM:                                      SURGERY DATE:
PREV STAY:    N                                 PREV ADM DTE:
FAM DR:  PLATTE STEPHEN          044537         PREV DSCH DTE:
MODE ARRIVAL: SLF SELF                          REL OF INFO:    N
AN DONOR:       LIV WILL/ADV DIR:               LOCATION:                    @X4
```

Aiken Regional Medical Centers

Admission Date: 10/23/07
Med. record No.: 1771273
Visit No.: 105028369
Attending Phys.: Stephen Grant, MD

Visit Record

Patient: Lee, Bernard D
D.O.B.: 4/30/1980 Age: 27
Gender: Male
Location:
Room/Bed: N/A

Entered by:	Scheduled:	Performed:	Effective:	Status:

Charted Activities

Quick Triage

West RN, Linda — 10/23/07 20:52 — 10/23/07 20:52 — 10/23/07 20:55 — **Finished**

Quick Triage Info

TRIAGE LEVEL 4 NON-URGENT. pt in with c/o dizziness left work due to it
Rates pain as zero on a scale of 0 to 10.
Vital Signs: Oral Temperature 98.4 F (36.89 C).
Pulse 76 bpm.
Resp rate 18. O2 SAT 100%.
BP 169/ 110 mmHg.
Patient's stated height is 5 Ft 11 in (1 Meter 80.3 cm).
Patient's stated weight is 190 lb 0 oz (86 kg 182.6 gm).
There is no evidence of abuse and/or neglect.

Home Meds

See attached medication list.

ER Discharge Assessment

Crowell, RN, Michelle — 10/23/07 20:52 — 10/24/07 01:51 — 10/24/07 01:54 — **Finished**

ER Discharge

ER Discharge Date/Time: 10/24/2007 00:38. Patient discharged to home.

Pulse 80 bpm.
Resp rate 16.
BP 164/ 106 mmHg.
Patient ambulated off the unit, by himself/herself.
Transported by private vehicle.
Patient condition is stable.
Discharge instructions given to patient.
Medications instructions given to patient.
Patient verbalized understanding.
Room checked. No personal belongings found.
Discharge notes: D/c & med instructions reviewed with pt. Pt strongly encouraged to monitor bp & f/u with PMD regarding bp. Pt verbalized understanding, voiced no concerns or questions.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Entered by:	Scheduled:	Performed:	Effective:	Status:

Charted Activities

Quick Triage

West RN, Linda — 10/23/07 20:52 — 10/23/07 20:52 — 10/23/07 20:55 — **Finished**

Quick Triage Info

TRIAGE LEVEL 4 NON-URGENT. pt in with c/o dizziness left work due to it
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Home Meds

See attached medication list.

ER Discharge Assessment

Crowell, RN, Michelle — 10/23/07 20:52 — 10/24/07 01:51 — 10/24/07 01:54 — **Finished**

ER Discharge

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Room checked. No personal belongings found.
Discharge notes: D/c & med instructions reviewed with pt. Pt strongly encouraged to monitor bp & f/u with PMD regarding bp. Pt verbalized understanding, voiced no concerns or questions.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Lee

Home Medication List
Physician's Order - Outpatient

Height:	feet	inches		
Weight:	pounds	actual	stated	estimated
Allergies:	NKDA			
Nurse Signature			Date/Time	

Home Medications
(Include Herbals/OTC/Vitamins) Do NOT administer herbals during hospitalization

Medication/Dose	Route	Frequency	Last Dose Taken
Unapproved abbreviations: IU, MS, MSO4, MgSO4, QD, q.d., qod, U, u, trailing zeros, no zero before decimal			
☑ No home medications	☐ Unable to obtain list		

Changes to home medications: ☐ None ☐ _____

Based on the treatment prescribed by your physician(s) and the list of medications that you provided, you may continue your home medications with the changes written above, if any. Please contact your prescribing physician if you have any questions about your home medications.

Prescriptions Given at Discharge

☐ No new medications

Medication/Dose	Route	Frequency	Reason for taking
Hydrochlorothiazide 25 mg		Daily	High Blood Pressure

Physician Signature

Patient Signature

Licensed Staff Signature

Patient

105028369
LEE, BERNARD O
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 10/23/07
AIKEN REGIONAL MEDICAL CENTER

PO0010

601.126

Aiken Regional ED Encounter Record

☐ Full Admission ☐ 23 Hr Observation

Chief Complaint: Dizziness and fatigue

27 yr old BM w/ dizziness today at work and one occasion last wk. Complains of dysuria and blood in x 3wks. Attributed fatigue to work in past. Denies syncope or weight loss. Blacks Teacher today. Wk 9 yr mo

Current Meds: none Nu di KUP/L NV el/ oAM/ Aluminum/mault

☐ see ED nurses notes

PMD: none

Past Medical History: ☐ HPI, Rvwed Hx, Social Hx, Fam Hx, ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF
& ROS Unobtainable due to: ☐ As Above ☐ Other:

Past Surgical History: Ø

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☐ Yes Amt ____ ETOH ☐ No ☐ Yes Amt ____ ☐ Other ____

Review Of Systems: ☑ Other ROS Neg ☐ For allergies see ED nurses notes

Check ☐ if normal / Check ○ if abnormal / If not Checked then not applicable

Eyes:	☑ ○ Diplopia	☐ ○ Blurred	☐ ○ Vision chgs	GU:	☐ ○ Dysuria	☐ ○ Urgency	☐ ○ Hematuria	
ENT:	☑ ○ Rhinitis	☐ ○ Sore throat	☐ ○ Nose bleeds	MS:	☑ ○ Myalgia	☐ ○ Back pain	☐ ○ Neck pain	
Card:	☑ ○ CP	☑ ○ Palpitation		Neuro:	☑ ○ Seizures	☐ ○ Dizziness	☐ ○ Syncope	
Respir:	☑ ○ SOB	☑ ○ Cough	☑ ○ Hemoptysis		☐ ○ Weakness	☐ ○ Numbness		
GI:	☐ ○ Nausea	☑ ○ Vomiting	☑ ○ Diarrhea	Endo:	☐ ○ Polyuria	☐ ○ Hypoglyc	☐ ○ Thyroid Dys	
	☑ ○ Abd pain	☑ ○ Melena	☑ ○ Hematochez	Hem/Lym:	☐ ○ Anemia	☐ ○ Bleeding		

Other ROS: ____

ALLERGIES: NKDA

TETANUS STATUS: ____

Physical Exam: ☐ For vitals see ED nurses notes

WEIGHT	TIME	PULSE	OX	TEMP	P	R	BP
196 lb	0552	106	98		2618	169	110

Check ☐ if normal / Check ○ if abnormal

						Abn Findings:
General:	☑ ○ Mental Status					
Eyes:	☑ ○ Conjun NL	☐ ○ Lids	☑ ○ PERRL			
Head:	☑ ○ NL cephalic	☐ ○ Sinuses	☐ ○ Nose			
ENT:	☑ ○ Oropharynx	☐ ○ Right TM	☐ ○ Left TM			
Neck:	☑ ○ Palpation	☐ ○ Thyroid	☑ ○ Trachea			
Chest:	☑ ○ Palpation	☐ ○ Excursion	☑ ○ Symmetry			
Cardio:	☑ ○ Heart sounds	☒ ○ R & R				
Respir:	☑ ○ Respir effort	☐ ○ Lung sounds				
Abdom:	☑ ○ Palpation	☐ ○ Bowel Sounds				
MS:	☐ ○ RUE	☑ ○ RLE	☑ ○ LLE	☐ ○ Digits		
	☐ ○ LUE	☑ ○ Pelvis		☐ ○ Back		
Skin:	☑ ○ Temp	☑ ○ Gait		☐ ○ Color		
Neuro:	☑ ○ CNS	☑ ○ Appear		☐ ○ Sensation		
		Strength				

Med Decision Making:

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME: ____

Diff Dx: ____

Consults: ____

NAME OF PHYSICIAN THAT ADMITTED PT: ____

NAME OF PHYSICIAN THAT PT IS ADMITTED TO: ____

☑ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

DISCHARGE DIAGNOSIS:
1. Hematuria/UTI w/ ?

CODES
☑ STABLE
☐ UNSTABLE SEE NOTE

Physician Signature: [signature] **Time MD IN:** 0615

TEST:	ORD	TIME	TIME INITIAL: ✓TEST ORDERED:
CBC W DIFF:			PHYSICIAN'S ORDERS: / TIME ORD: / TIME COMP Initials:
CHEM 8:			
URINE PREG:			→ URINE PREG RESULTS:
CCUA:			
CATH UA:			FSG Qo e 0017
URINE C&S:			Ken sp 10/11/06
EKG:			
OLD EKGS:			
TROPONIN:			Urine 0615 - Done
PHPT:			
FINGER ST GL:			
BLOOD CULT X ____:			
TYPE & SCREEN:			
TYPE CROSS ____ UNITS:			
LIVER PANEL:			
CMP:			
AMYLASE:			
LIPASE:			
HEMOCULT:			
TYPE A RH:			
HCG QUANT:			
URINE DRUG S:			
ALCOHOL:			
ED ABG:			
PA/LAT CXR:			
PCXR:			
C-SPINE:			
L-SPINE:			
ACUTE ABD:			
OLD RECORDS:			
OLD ED Record:			

Name: ____ Race: B Sex: M Age: ____

Addressograph
105028369
LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 10/23/07
AIKEN REGIONAL MEDICAL CENTER

ER0010

MEDICAL – 250 –

830.70 10-24129 5/07

☐ Room: 24 Time: 2345

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Report To: Michelle

TIME PERFORMED: 0010

PHYSICAL ASSESSMENT:

PULMONARY ☑ pt denies C/O

Respirations: ☑ even ☐ nonlabored ☐ labored ☐ use of accessory muscles ☐ Smoker ☐ yes ☐ no _____ PPD _____ yrs.
☐ other* _____ ☐ Former Smoker

Breath Sounds: ☐ bilateral ☐ clear ☐ labored ☑ diminished ☐ absent* ☐ crackles ☐ wheezes ☐ rhonchi
*describe: _____

Airway: ☐ oral ☐ nasal ☐ self maintained

Cough: ☐ productive ☐ nonproductive ☐ Describe secretions: _____

Chest Tube: ☐ Right ☐ Left: _____ cm. suction

ETT Placement: _____ cm ☐ oral ☐ nasal Size ETT: _____ Trach: ☐ Yes ☐ No _____ size

Oxygen Supplement: ☐ No ☐ Yes (type) _____

CARDIOVASCULAR ☑ pt denies C/O

Capillary Refill: ☑ brisk ☐ sluggish Edema: ☑ absent ☐ present

Pulses:		RADIAL:		FEMORAL:		PEDAL: Post Tibial		Dorsal	
Palpable		☐ Rt	☐ Lt	☐ Rt	☐ Lt	☐ Rt	☐ Lt	☐ Rt	☐ Lt
Doppler		☐ Rt	☐ Lt	☐ Rt	☐ Lt	☐ Rt	☐ Lt	☐ Rt	☐ Lt
Absent		☐ Rt	☐ Lt	☐ Rt	☐ Lt	☐ Rt	☐ Lt	☐ Rt	☐ Lt
						☐ Rt	☐ Lt	☑ Rt	☑ Lt

Pacemaker: ☐ Yes ☐ No Chest Pain: ☐ Yes ☐ No Describe: _____

JVD: ☐ Yes ☐ No EKG Rhythm: _____

NEUROLOGICAL ☐ pt denies C/O Reports mild dizziness

LOC: ☑ Alert ☐ Confused ☐ Responds to Voice ☐ Responds to Pain ☐ Unresponsive

Speech: ☑ Clear ☐ Slurred ☐ Aphasic ☐ Intubated / Trached Other: Steady gait

Activity Level: ☐ Sitting / Lying Still ☐ Sleeping ☑ Fidgeting ☐ Pacing

Pupillary Response: ☑ Reactive ☐ Non-reactive ☑ Equal ☐ Unequal Comments _____

Verbal Response: ☑ Speaks Calmly ☐ Speaks in Phrases ☐ Raises Voice ☐ Shouting / Screaming ☐ Whispers / Moans

Facial Expression: ☑ Relaxed ☐ Grimace ☐ Crying ☐ Smiling

ENT

Eyes: ☐ contact lenses ☐ glasses ☐ foreign body ☐ cataracts ☐ mucous membranes moist / dry
☐ Injury: _____

Ears / Nose / Throat / Mouth: _____

GENITOURINARY ☑ pt denies C/O

Urine: _____ ☐ clear ☐ color _____ ☐ cloudy ☐ hematuria ☐ incontinent ☐ other: _____

Dialysis: ☐ Yes ☐ No Access Site: _____ Comments: _____

Foley Size: _____

GASTROINTESTINAL ☑ pt denies C/O

☐ Nausea ☐ Vomiting Emesis Color: _____ ☐ Diarrhea

Abdomen: ☑ Soft ☐ Tender ☐ Distended

Bowel Sounds: ☑ Present ☐ Absent

Comments: _____

☐ G Tube / PEG Tube

INTEGUMENTARY ☑ pt denies C/O

Skin: ☑ warm ☐ dry ☐ cool ☐ pale ☐ clammy ☐ diaphoretic
☐ flushed ☐ mottled ☐ cyanotic ☐ jaundiced ☐ pink

If injury: ☐ unintentional ☐ intentional by: _____

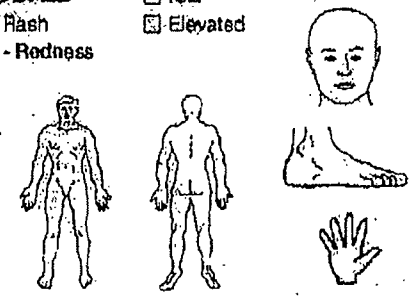
Previous injury by same person? ☐ Yes ☐ No

☐ Laceration ☐ Abrasion ☐ Bruising ☐ Burn
☐ Bleeding ☐ Avulsion ☐ Rash

LABEL AREAS INVOLVED

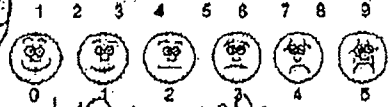
A - Abrasion
AV - Avulsion
B - Burn
D - Deformity
E - Ecchymosis
ED - Edema
L - Laceration
P - Pain
PU - Puncture Words
R - Rash
RE - Redness

☐ ICE
☑ Elevated



NUMERIC SCALE FOR PAIN ASSESSMENT

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain



0 1 2 3 4 5

RN Signature: _____ Date: 10/24/07

1050283 69
LEE , BERNARD D
DOB: 04/30/1980 27 SX: M EMR
MRN: 177273 ADM/REG DT: 10/23/07
AIKEN REGIONAL MEDICAL CENTER

E.D. NURSING ASSESSMENT RECORD

630.64 (Rev. 4/07) 10-20214 ER0807

INFUSION DATA

Time	Infusion Site	Solution (amount / type)	Total Infusion	Rate	D/C'd – Cath Intact	Cath Size / Type	# Attempts	Initials
MS								

INTAKE AND OUTPUT

INTAKE	TOTAL	INITIALS	OUTPUT	OUTPUT CHARACTER	TOTAL	INITIALS
Blood Products			Emesis / Voided			
IVP's			NG / Emesis			
NG			Chest Tubes			
PO			Other			
Other						
Total Intake	cc		Total Output		cc	

ADDITIONAL ASSESSMENT: (10/12) FSG 91, Dr Moon and Anne Mcentire (10/13) Up adc, results to Anne Mcentire

Time	SaO_2	Temp.	Pulse	Resp.	B/P	Time	Dose	Medication Administered
1990					104/66			

DISCHARGE STATUS

DATE: 10/13/07 TIME: 1028

☐ ROUTINE (HOME) ☐ AMA

☐ ADMIT TO:

PHYSICIAN:

☐ TRANSFERRED TO: See Cindee

☐ ACCEPTING PHYSICIAN

☐ TRANSFER FORMS COMPLETED

☐ RECORDS WITH PATIENT

EXPIRED

☐ E.R. ☐ CORONER'S CASE

☐ DOA ☐ AUTOPSY

CONDITION ON DISCHARGE

☐ STABLE

☐ UNSTABLE

EXPLAIN:

Steady gait

METHOD OF DISCHARGE

☐ AMBULATORY ☐ AMBULANCE

☐ WHEELCHAIR ☐ STRETCHER

ACCOMPANIED BY

☐ SELF ☐ RELATIVE ☐ POLICE

☐ OTHER ☐ FRIEND

EXPLAIN:

METHOD INSTRUCTIONS

☐ VERBAL ☐ WRITTEN

☐ NOT GIVEN (WHY)

☐ PT VERBALIZES UNDERSTANDING

ED FALL SCALE

HISTORY OF FALLS	☐ YES	☐ NO
AGE >65 YEARS	☐ YES	☐ NO
TRANSFERS IMPAIRED	☐ YES	☐ NO
ORIENTATION CONFUSED/ BEHAVIORAL ISSUES	☐ YES	☐ NO

INTERVENTIONS

FALL RISK ASSESSMENT

☐ LOW RISK ☐ HIGH RISK

FALL INTERVENTION

☐ SIDE RAILS ☐ BED IN POSITION

☐ CALL LIGHT ☐ BS OBSERVATION

LOW RISK IF 0 OR 1 MARKED AS YES

HIGH RISK IF 2 OR > MARKED AS YES

1050283 69

LEE, BERNARD D
DOB: 04/00/1930 77 SX: M EMR
MRN: 177273 ADM/REG DT: 10/13/07
AIKEN REGIONAL MEDICAL CENTER

RECEIVING NURSE FOR ADMISSION:

Signature: _____ Date / Time: _____

ER0807

1038

GENERAL INSTRUCTIONS:

☐ Call the next business day and make an appointment to see: _____

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: _____ days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within _____ days.

☐ Return to the Emergency Department after 12:30 p.m. in _____ days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☑ Work / school excuse from 10/23/07 thru 10/24/07 May return to work 10/25/07.

☐ See your company doctor per your company's policy. Light duty until _____

(No use of _____ No lifting over _____ lbs.)

☐ _____

_____

_____

Your diagnosis was: High blood pressure

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ Tetanus/Diptheria booster*
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X-Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physician.
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Department.

_____ Physician

_____ Staff

10/23/07 Date

_____ Patient or Responsible Person

Aiken Regional Medical Center
302 University Parkway
Aiken, SC 29801

EMERGENCY SERVICES

ER0023

10-2183
630.06
Rev. 5/07

Patient Ident

1050283659

LEE, BERNARD D
DOB: 04/30/1960 27 SX: M ENR
MRN: 177273 ADM/REG DT: 10/23/07
AIKEN REGIONAL MEDICAL CENTER

WHITE - RECORDS CANARY - PAT – 253 – - EMERGENCY DEPARTMENT GOLDENROD - PATIENT

AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC
302 University Pkwy.
Aiken, South Carolina 29801
Phone 641-5000
For
Age
Date
Address
Please dispense
Dispense as Written
Substitution Permitted
M.D
This prescription can be filled next door at
Medical Center Pharmacy
M-F 9-6 & SAT 9-12
HORIZONTAL MOUNT
HORIZONTAL MOUNT
2 VERTICAL MOUNT
3 VERTICAL MOUNT
1050289369
LEE, BERNARD O
DOB: 04/30/1960 27 SX: M EMR
MRN: 177273 ADM/REG DT: 10/23/07
AIKEN REGIONAL MEDICAL CENTER
1 HORIZONTAL MOUNT
REMOVE TAPES
PLACE EDGE OF FORM AGAINST SOLID LINE AND PRESS FIRMLY

Aiken Regional MEDICAL CENTERS

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29802

PATIENT NAME: Lee, Bernard DATE OF SERVICE/ADMISSION 10-23-07

CONSENT FOR TREATMENT, GUARANTY OF PAYMENT AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION AND ASSOCIATED NOTICES AND AUTHORIZATION.

NOTICE TO PATIENT AND ALL SIGNATORIES OF THIS DOCUMENT: By your signature below, each signatory of this document is agreeing to be jointly and severally bound by all of the terms and conditions hereinafter set forth unless otherwise noted. In consideration of the hospital care and treatment to be rendered to Patient by Hospital, the undersigned agree and consent to the following:

1. Consent and Conditions of Admission: The undersigned hereby agrees and gives consent to Hospital for the admission/treatment/testing of Patient. The undersigned hereby consents to any and all hospital care encompassing: X-Ray examination, laboratory procedures, diagnostic procedures, anesthesia and nursing or medical/surgical treatment which Patient's physician, his associates, partners or designees, may deem necessary or advisable under the general and special instructions of the same, during Patient's hospitalization.

2. Medical and Surgical Treatment: The undersigned agrees and understands that all physicians, dentists and or oral surgeons treating Patient are responsible and liable for their own acts or omissions and the Hospital is not responsible or liable for the acts omissions of the aforementioned. The undersigned is aware that the practice of medicine is not an exact science and further state that no guarantee has been made or can be made as to the results of the treatments or examinations in the Hospital.

The undersigned certifies that they have read all of this document, including the reverse side hereof, and that the undersigned is the Patient, or is duly authorized by the Patient or by law, to execute the above Agreement and understands its terms.

All Patients shall receive treatment or service within the hospital's capability and policies. Our hospital is committed to patient's impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care.

3. Assignment of Insurance Benefits and Release of Medical Information: The undersigned hereby assign to Hospital, its successors and assigns, all benefits that may be payable to or on behalf of the Patient under any policy of insurance, (hospitalization, major medical, automobile, workmen's compensation, personal injury benefits available because of liability of a third party, or any other) and authorize Hospital to release specifically requested medical information related to Patient to include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assaults, tests for HIV, ARC and/or AIDS, or other infectious diseases necessary for settlement of benefit payment or money payable because of Patient's hospitalization, treatment or injury during this encounter. The undersigned further direct that the payer of any such payment make such payment directly to Hospital. In addition, the undersigned assign to Hospital, its successors and assigns, the proceeds of injury claim resulting from liability to Patient of a third party. Any payments to Hospital under authority of this Assignment shall not exceed the actual charges set forth in Hospital's billing statements issued in connection with Patient's account.

If Patient is eligible for Medicare, the undersigned requests Medicare services and benefits. The undersigned further agree that this Assignment will not be withdrawn or voided at any time until Patient's account is paid in full. The undersigned acknowledge that it is their responsibility to pay Hospital for any charges not covered by insurance. Further, undersigned agree and understand that if the Patient, or his duly authorized representative, requests a private room for the Patient the undersigned is responsible for the entire room difference.

The undersigned hereby authorize any agency or employee of the U.S., any State or Municipal Government to release to the Hospital, its employee, employees and/or its attorney, any and all information concerning governmental programs under which the above named Patient is or may be qualified to receive benefits due and further authorize payment of any and all such benefits direct to Hospital.

The insured whose signature appears in this item one (1), hereby represents to the Hospital that the following insurance policies are the only insurance policies offering coverage to the patient in this matter and hereby assigns to Hospital all benefits payable to or on behalf of Patient thereunder.

Written authorization for HMO/PPO plans: I understand that if my insurance carrier, HMO plan or PPO network requires preauthorization, the Hospital/Provider/Physician is unable to guarantee that my visit will be covered without a written authorization for the services rendered to me or my family members. If the Hospital/Provider/Physician is unable to obtain authorization for my visit, I will be responsible for any unpaid balance. I will be financially responsible for those charges that coincide with any service/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the Hospital accepts no liability for failure to meet any pre/post certification procedures which may be required of me by my coverage carrier. I agree that any such procedures have been or will be properly executed by me.

Primary Insurance Co. P.P

Patient Bernard Lee

Insured

Secondary Insurance Co.

Patient

Insured

Addressograph

1050283669
LEE , BERNARD D
DOB: 04/30/1961 27 SX: M EMR
MRN: 177273 ADM/REG DT: 10/23/07
AIKEN REGIONAL MEDICAL CENTER

CO0010

10-1983
902.02
Rev. 6/07

MEDICAL RECORDS
-255-

PHYSICIANS NOT AS EMPLOYEES: I acknowledge that all physicians furnishing services including but not limited to radiologists, pathologists, anesthesiologists, emergency department physicians, consultants and assistants to the physicians are not employees of the Hospital. I understand that I may receive separate billing from each of these providers for services rendered.

Guaranty of Payment: The undersigned jointly and severally agree to be bound to Hospital for payment and absolutely guarantee payment to hospital on demand of all services now or hereafter incurred for goods and services furnished by Hospital to Patient in connection with Patient's treatment and/or stay at Hospital. This is a continuing guarantee of payment on demand of the entire unpaid balance of charges incurred during the period from the date of service or admission above until Patient is discharged and includes guaranty of payment of outpatient charges for services rendered on the date noted above and any follow-up outpatient charges. Such charges shall be in accordance with the regular rates and charges of the Hospital in effect at the time of the rendering of the service or the furnishing of the goods for which the charge is incurred.

Should patient's account be turned over to any attorney for collection or legal proceedings of any kind, the undersigned jointly and severally, absolutely guarantee payment to Hospital of all costs and expenses incurred by Hospital in connection with such collection action and/or legal proceeding, including a reasonable attorney's fee not to exceed fifteen (15) percent of the unpaid balance due.

The undersigned also agrees that any over payments collected in connection with any pre-paid admission or outpatient treatment of Patient may be applied directly to a delinquent account of Patient or any delinquent account for which Patient or any undersigned is legally responsible at the time of collection of the over payment. Hospital may make a Reciprocity Agreement with any one or more of the undersigned, which Agreement shall be considered ancillary to and not in lieu of this Agreement and shall not be construed as limiting or modifying the liability of any other signatory to this Agreement.

Patient's guarantor, Spouse of Patient signatories, Custodian signatories, and Parent of minor Patient signatories are jointly and severally bound by all the terms hereof including liability for payment to Hospital under this Guaranty of Payment agreement.

5. Assignment of Physician Benefits: In the event the Patient, in addition to Hospital benefits, is entitled to any physician benefits or any type whatsoever arising out of policy of insurance insuring Patient or any other parties liability to Patient, the undersigned hereby assign said benefits to any physician rendering care or treatment during the stay in accordance with this admission or any outpatient visits, to be applied to Patient's bill.

6. Medicare Patient Certification: The undersigned certify that the information provided by the undersigned in applying for payment under Title XVIII of the Social Security Act, is correct. The undersigned authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for a Medicare claim related to Patient. The undersigned authorize and direct that a copy of this Authorization may be used in place of the original and request payment of authorized benefits be made on behalf of the Patient.

7. Personal Valuables and Belongings: The undersigned acknowledge and agree that the Hospital maintains a safe for the safekeeping of valuables. The Hospital shall not be held responsible or liable for the loss or damage to any articles of personal property while Patient is hospitalized unless said articles are deposited with the Hospital in the safe and receipts are issued describing said items. If the patient is unable to sign and in the event no relative is present, the Hospital shall retain possession of valuables and obtain acknowledgment at the first available opportunity.

8. Cameras and Surveillance Equipment: Patient has been advised that Aiken Regional Medical Center uses cameras and other surveillance equipment to monitor patient/employee activities. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment.

You have the right to file a grievance regarding concerns with our quality. The agency you may contact is:

Department of Health and Environmental Control (DHEC) Licensing Division
2600 Bull Street
Columbia, South Carolina 29202
803/737-7370

10. Smoking is prohibited except in certain areas. Please discuss any special needs with your physician.

11. I acknowledge that laboratory studies may be performed in the event a healthcare worker is exposed to my blood or body fluid.

I, the undersigned, state that the information that I have provided Aiken Regional Medical Center is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. ORIGINAL SIGNATURE ON FILE AT AIKEN REGIONAL MEDICAL CENTERS.

Date _____ Time _____ Patient Parent/Guardian Relationship/Patient _____ Witness _____

Address _____ Witness _____

☐ No ID
☐ No Insurance Card
☐ Address Correct on ID

City _____ State _____ Zip _____

Reason Patient Did Not Sign _____ ☐ Patient was given the opt on to deposit valuables in safe.

TELEPHONE CONSENT	Patient Name
Witness	Obtained From / Relationship
Witness	Phone # / Date/Time

CO0010

10-1888
902.03
Rev. 6/07

Urinalysis by Clinitek 50:

Analyte	P	Reference Ranges
Color		Straw - Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketones		Negative
Specific Gravity		1.000 - 1.025
Blood		Negative
PH		5.0 - 7.0
Protein		Negative
Urobilinogen		0.2 EU/dl
Nitrites		Negative
Leukocyte Esterase		Negative
Date:	T	Associate

ID:
782 [illegible]
CLARITY: Clear
COLOR: LT. YELLOW
MULTISTIX 10 SG
GLU NEGATIVE
BIL NEGATIVE
KET NEGATIVE
SG 1.015
BLO NEGATIVE
pH 6.5
PRO NEGATIVE
URO 0.2 E.U./dL
NIT NEGATIVE
LEU NEGATIVE
UC

Occult Blood

Negative Positive

Date:____/____/____ Time: ____:____

Associate:_____

Normal: Negative

Nitrazine Paper

Result:_____

Date:____/____/____ Time: ____:____

Associate:_____

Normal: Negative

Rapid Strep

Negative Positive

Date:____/____/____ Time: ____:____

Associate:_____

Normal: Negative

Bedside Urine Pregnancy

Negative

Positive

Date:____/____/____ Time: ____:____

Associate:_____

Normal: Negative

Signature and title of associate performing:

_____

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

POINT - OF - CARE REPORT FORM

LB0010

10-37374
710.28
Rev. 8/07
Page 1 of 1

Patient Identification

105028369

LEE , BERNARD D
DOB: 04/30/1980 27 8X: M BMR
MRN: 177273 ADM/REG DT: 10/23/07
AIKEN REGIONAL MEDICAL CENTER

```
PT NAME:     LEE ,BERNARD D                                          AGE:   29
NURS STA:                  PT TYPE:      T          PT NO:        107813032
ROOM/BED:                  HOSP SVC:     EMR        MED REC NO:   177273
PT STATUS:   EA            MARITAL STS:  S          RACE:         2      REL:  BAP
SSN:         251-45-2204   SEX:          M          BIRTHDATE:    04/30/1930
PREV NAME:                                          INFANT AGE:
ADDRESS:     172 OLD CHEROKEE INDIAN RD             PHONE: 803 - 663-0560
                                                    DISTRICT CD:   2
CITY:        GRANITEVILLE                     ST: SC  ZIP:  29829-3613

EMPLOYER:    BONDEX
ADDRESS:     MIKE PADGET HWY

CITY:        GRANITEVILLE                     ST: SC     ZIP:  29829-
OCCUPATION:  MACHINE OPERATOR                 PHONE:  706 - 999-9999  EXT
GUARANTOR:   LEE ,BERNARD
 ADDRESS:    172 OLD CHEROKEE INDIAN RD                GUAR SSN:  251452204
                                                       REL:       S
 CITY:       GRANITEVILLE                     ST: SC     ZIP:  29829-3613
 OCCU:       MACHINE OPERATOR                 PHONE:  803 - 663-0560  EXT
 GUAR EMPL:  BONDEX
 ADDRESS:    MIKE PADGET HWY                           PHONE: 706  999-9999
                                                       EXT
 CITY:       GRANITEVILLE                     ST: SC     ZIP:  29829-
EMER CONTACT: LEE ,MARIE                                              REL: N
 ADDRESS:      172 CHEROKEE INDIAN RD
 CITY:         GRANITEVILLE                      ST: SC   ZIP:  29829-
               HOME PHONE: 803  663-0560  WORK PHONE:                EXT:
 NEXT OF KIN: LEE ,VIRGINIA                      PHONE: 803  663-1533
INSURANCE INFO:                    FC:  Z
 INS PL 1:   904   CHARITY PENDING              POLICY #:  251452204
 COB:        1     PAYOR ID: 600  VERIFIED: Y   GROUP #:
 MAIL TO:    LEE ,BERNARD                       GROUP NAME:
 ADDRESS:    172 OLD CHEROKEE IND                        PHONE:   803  663-0560
 CITY:       GRANITEVILL       ST:  SC   ZIP:  29829     UR PHONE: 803-663-1533
 AUTH #:                                  SUBSCRIBER NAME: LEE ,BERNARD
 INS PL 2:                                      POLICY #:
 COB:              PAYOR ID:       VERIFIED:    GROUP #:
 MAIL TO:                                       GROUP NAME:
 ADDRESS:                                              PHONE:
 CITY:                          ST:          ZIP:      UR PHONE:     -    -
 AUTH #:                                  SUBSCRIBER NAME:
 INS PL 3:                                      POLICY #:
 COB:              PAYOR ID:       VERIFIED:    GROUP #:
 MAIL TO:                                       GROUP NAME:
 ADDRESS:                                              PHONE:
 CITY:                          ST:          ZIP:      UR PHONE:     -    -
 AUTH #                                   SUBSCRIBER NAME:
PREADM:                REG/UPG: BONEPS      PREREG:                ER REG: NEALOG
ACC IND: H   ACC DT/TM: 082109   19:00      ADM DT/TM:  08/21/09   19:40
ACC LOC:                                    ADM SOURCE:     EO      ADM PRI:   X
DSCH DT/TM:                  DISP: AHR      ADM DR: 003848  GRANT STEPHEN
REF DR:    999870  NO REFERRING DOCTOR      ATN DR: 003848  GRANT STEPHEN
PROCEDURE:                                  DIAGNOSIS: RAISED AREA RT. WRIST
CLIN COMM:                                  SURGERY DATE:
PREV STAY:                                  PREV ADM DTE:
FAM DR:  NO PCP NO FAMILY DR     999987     PREV DSCH DTE:
MODE ARRIVAL: POV                           REL OF INFO:    N
ORGAN DONOR:      LIV WILL/ADV DIR:         LOCATION:                          @X4
```

Date 8/21/09 Arrival Time 1935 Mode of Arrival: ☐ POV ☐ EMS ☒ Ambulatory ☐ Carried ☐ W/C

Name Lee, Bernard DOB 4-30-80

Current Complaint (in patient's own words) "I have this knot on my wrist."

Name/Title R. Gardner RN

Triage Time 1935

Communication Assessment:

Primary Language: ☒ English ☐ Spanish ☐ Other

Translation: ☒ N/A ☐ Language Line ☐ Other

Hearing: ☒ No apparent deficit ☐ Wearing hearing aid Vision: ☒ No apparent deficit ☐ Wearing glasses

Allergies: NKDA

T 98.3 P 70 R 18 B/P 158/101 160/85 SaO_2 100% RA

Pain: Location (RT) FA Scale (0-10) 10/10

LMP — Wt. 190 lbs. ☐ Actual ☒ Stated

Assessment C/o "raised area" to (RT) FA causing pain to rest 8 hrs.

Triage Level: ☐ 5 ☒ 4 ☐ 3 ☐ 2 ☐ 1 **Disposition:** ☐ **Major ER** ☒ **Minor ER**

Triage interventions: ☐ Ice ☐ Elevation ☐ Sling ☐ Splint ☐ Bleeding control ☐ Fever med ☐ ASA (per ACS protocol) ☐ Other

Triage RN Signature R. Gardner RN

Reassessment: Date Time

Evaluation: ☐ No change from previous assessment ☐ Change (describe)

Action/Intervention

RN Signature Date Time

To ER Room # 6 @ 1942 Report to Suc QPI done ☒ yes ☐ no

LWBS: Date Time Reason

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

TRIAGE ASSESSMENT

650.78
Rev. 06/09
Page 1 of 1

ER0515 - Triage Form

Patient Identification

1943

107813032
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 08/21/2009
Aiken Regional Medical Centers

Aiken Regional ED ENCOUNTER Record

☐ Full Admission
☑ 23 Hr Observation

Chief Complaint: (L) FA Cut

HPI: (L) wrist tendon & artery + lacer arm cut by knife, ulnar & radial pulses, ? distal neurovascular deficit

Current Meds: Does not recall, will confirm after ED

☐ See ED nurses notes

PMD: ?

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, ☒ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF
& ROS Unobtainable due to:
☐ As Above ☐ Other:

Past Surgical History:

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☒ Yes Amt: 1-1½ ppd ETOH ☐ No ☒ Yes Amt: occas ☐ Other

Review Of Systems: (Check ☐ if normal, Check ○ if abnormal, if not Checked then not applicable)

☐ Other ROS Neg

Eyes:	☐	○ Diplopia	☐	○ Blurred	☐	○ Vision chgs	GU:	☐	○ Dysuria	☐	○ Urgency	☐ ○ Hematuria
ENT:	☐	○ Rhinitis	☐	○ Sore throat	☐	○ Nose bleeds	MS:	☐	○ Myalgia	☐	○ Back pain	☐ ○ Neck pain
Card:	☐	○ CP	☐	○ Palpitation			Neuro:	☐	○ Seizures	☐	○ Dizziness	☐ ○ Syncope
Respir:	☐	○ SOB	☐	○ Cough	☐	○ Hemoptysis		☐	○ Weakness	☐	○ Numbness	
GI:	☐	○ Nausea	☐	○ Vomiting	☐	○ Diarrhea	Endo:	☐	○ Polyuria	☐	○ Hypoglyc	☐ ○ Thyroid Dys
	☐	○ Abd pain	☐	○ Melena	☐	○ Hematochez	Hem/Lym:	☐	○ Anemia	☐	○ Bleeding	

☐ For allergies see ED nurses notes

Other ROS

TETANUS STATUS:

ALLERGIES: NKDA

Physical Exam: WEIGHT | TIME | PULSE OX | TEMP | P | R | BP
1700 | 98 | 70 | 18 | 165/85

☐ For vitals see ED nurses notes

Check ☐ if normal, Check ○ if abnormal, Abn Findings:

General:	☑	○ Mental Status					
Eyes:	☐	○ Conjun NL	☐	○ Lids	☐	○ PERRL	
Head:	☐	○ NL cephalic	☐	○ Sinuses	☐	○ Nose	
ENT:	☐	○ Oropharynx	☐	○ Right TM	☐	○ Left TM	
Neck:	☐	○ Palpation	☐	○ Thyroid	☐	○ Trachea	
Chest:	☐	○ Palpation	☐	○ Excursion		○ Symmetry	
Cardio:	☐	○ Heart sounds	☐	○ R & R			
Respir:	☐	○ Respir effort	☐	○ Lung sounds			
Abdom:	☐	○ Palpation	☐	○ Bowel Sounds			
MS:	☐	○ RUE	☐	○ RLE	☐	○ Digits	
	☐	○ LUE	☐	○ LLE	☐	○ Back	
	☐	○ Pelvis					
Skin:	☐	○ Temp	☐	○ Gait	☐	○ Color	
Neuro:	☐	○ CNS	☐	○ Appear Strength	☐	○ Sensation	

Med Decision Making:

☐ Med records reviewed
☑ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME:

Diff Dx:

Consults:

NAME OF PHYSICIAN THAT ADMITTED PT:

NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

☐ Encounter only
☐ Dictated only
☑ Temp sheet only
☑ Dictated & Encounter
☐ Dictated & Temp sheet

DISCHARGE DIAGNOSIS:
1. (R) wrist cellulitis
2. HTN med refill

CODES
STABLE ☐
UNSTABLE SEE NOTE ☐

Physician Signature: Time MD IN: 2037

TEST	ORD	COMP
CBC W/DIFF:		
CHEM 8:		
URINE PREG:		
UCUA:		
CATH UA:		
URINE C&S:		
EKG:		
OLD EKGS:		
TROPONIN:		
PT/PTT:		
FINGER ST GL:		
BLOOD CULT X:		
TYPE & SCREEN:		
TYPE CROSS:		
UNITS:		
LIVER PANEL:		
CMP:		
AMYLASE:		
LIPASE:		
HEMOCULT:		
DRUG SCR:		
HCG QUANT:		
URINE DRUG S:		
ALCOHOL:		
ED ABG:		
R/LAT CXR:		
RCXR:		
C/SPINE:		
L/SPINE:		
ACUTE ABD:		
OLD RECORDS:		
OLD ED Record:		

PHYSICIAN'S ORDERS: TIME ORD: TIME COMP Initials:

☐ URINE PREG RESULTS:

(R) Wrist splint alone SK

D/C

210

Vicryl 4-0

HCTZ

Victoza #12

Name: Race: Sex: Age:

Address/Paragraph

1078113032

LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: *77273 ADM/REG DT: 08/21/2009
Aiken Regional Medical Centers 630.70 10-24:29 6/07

ER0010

AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC

C. Stepp - SC#14610 - DEA#BS1978353 | M. James - SC#14208 - DEA#BJ1600384 | W. Jackson - SC#23797 - DEA#BJ6404226
S. Rialls - SC#12067 - DEA#BR5632099 | C. Yin - SC#30099 - DEA#BY4136871 | D. Brandham - SC#30080 - DEA#BB2544403
B. Grant - SC#15972 - DEA#BG2726798 | G. Wade - SC#20749 - DEA#BW4032508 | B. Taylor, PA-C - SC#A5056M

302 University Pkwy Aiken, South Carolina 29801 Phone 641-5000

For [illegible] Age

Address Date 8/21/05

[illegible]

Rx [illegible]

Please dispense [illegible] Medications. NO REFILLS prefers/ does not prefer generic substitute

M.D. M.D.

Dispense as Written Substitution Permitted

TLC Medical Centre, Inc.
In Home Medical - Pharmacy
(803)648-7800
zoominrx.com

This prescription may be filled at TLC Medical Centre, Inc.
Home Medical Equipment Pharmacy

Silver Bluff Road at
190 Crepe Myrtle Drive
Aiken, SC 29803

1078813032
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177213 ADM/REG DT: 08/21/2005
Aiken Regional Medical Centers

INST BROKEN LINE FORM ID PRESS FIRMLY

VERTICAL MOUNT

1 HORIZONTAL MOUNT

REMOVE TAPES

PLACE EDGE OF FORM AGAINST SOLID LINE AND PRESS FIRMLY

LABORATORY

HCAIS 9

LABORATORY

GENERAL INSTRUCTIONS:

☐ Call the next business day and make an appointment to see: _____

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: _____ days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within _____ days.

☐ Return to the Emergency Department in _____ days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☐ Work / school excuse from _____ thru _____. May return to work _____.

☐ See your company doctor per your company's policy. Light duty until _____.

(No use of _____ No lifting over _____ lbs.)

☐ Start prescribed medications today. You must continue to have blood pressure checked and follow-up with a primary care MD

Your diagnosis was: R wrist pain / high blood pressure

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ Tetanus/Diphtheria booster*
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X-Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physician.
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Department.
8. If you feel you want to harm yourself or are suicidal, call 1-800-784-2433 (National Suicide Hotline).

_____ Physician

_____ Staff

8/21/09 Date

_____ Patient or Responsible Person

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

EMERGENCY SERVICES

ER0023

630.08
Rev. 9/08

Patient Identification

1078813032
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 08/21/2009
Aiken Regional Medical Centers

WHITE - RECORDS CANARY - PATIENT GOLDENROD - PATIENT

Physical Assessment: Time Performed 1457
☐ Head-to-toe ☒ Focused Assessment

Past Surgical History: ☒ Denies any significant surgical history
☐ Appendectomy ☐ Hysterectomy
☐ Cholecystectomy ☐ Tubal Ligation
☐ CABG ☐ Cardiac Stents
☐ Other

RMD

Pain:
Score: 10 Location: R wrist → R shoulder
Scale: ☒ Numeric ☐ Faces ☐ F.A.C.C ☐ Nips
Onset: 2 ☐ Hours ☐ Days ☐ Weeks ☐ Months ☐ Years
Description: ☐ Constant ☒ Intermittent ☐ Dull ☐ Sharp ☐ Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Cramping ☐ Pressure PAIN CAN NOT DESCRIBE pain
Aggravates: ☐ Nothing ☒ Activity ☐ Food ☐ Palpation ☐ Cough ☐ Deep Breath
Alleviates: ☐ None ☐ Medication ☐ Positioning ☐ Heat ☐ Cold Other

Past Medical History: ☐ Denies any significant medical history
☐ CAD ☐ CHF
☐ Cancer (type)
☐ Diabetes ☐ Asthma
☐ COPD ☐ CVA/TIA
☒ HTN ☐ Hypercholesterolemia
☐ GI Bleeding/Ulcer ☐ Hepatitis
☐ Kidney Stones ☐ Renal Failure
☐ Migraines ☐ Seizures
☐ HIV/Aids ☐ Other
Home Oxygen: ☐ N/A L/m via

GU/GYN ☐ Assessment WNL
Urine: ☐ Hematuria ☐ Cloudy ☐ Odor ☐ Dark ☐ Burning ☐ Frequency ☐ Inconsistency ☐ Foley present on admission
Dialysis access/site location ☐ N/A
Menses: ☐ Irregular ☐ Painful ☐ Vaginal bleeding Pad Count #
LMP EDC G P Ab
☐ Vaginal/Penile discharge color:

Current Assessment
Pulmonary: ☐ Assessment WNL
Respirations: ☐ Labored ☐ Rapid ☐ Slow ☐ Deep ☐ Shallow ☐ SOB
Breath Snds: ☐ Diminished ☐ Absent ☐ Crackles ☐ Wheezes ☐ Rhonchi
Cough: ☐ Productive ☐ Non productive Sputum
Location of abnormalities ☐ Right ☐ Left ☐ Bilateral
Other

Gastrointestinal ☐ Assessment WNL
☐ Nausea ☐ Vomiting Emesis color
☐ Diarrhea # stools
☐ Constipated # days ☐ Rectal bleeding
Abdomen: ☐ Pendulous ☐ Distended ☐ Tender ☐ Rigid
Bowel sounds: ☐ Absent ☐ Hyperactive ☐ Hypoactive

Cardiovascular: ☐ Assessment WNL
Chest Pain: ☐ Yes ☐ No Describe
Heart Sounds: ☐ Regular ☐ Irregular ☐ Muffled ☐ Rub
Pulses: ☐ Not Palpable Location
EKG Rhythm
JVD ☐ Yes ☐ No

Integumentary ☐ Assessment WNL
☐ Cool ☐ Pale ☐ Clammy ☐ Diaphoretic ☐ Flushed ☐ Mottled ☐ Cyanotic ☐ Jaundiced ☐ Pink
Last Tetanus: Date ☐ Unknown

Neurological ☐ Assessment WNL
Responsiveness: ☐ Unresponsive ☐ Responds to painful stimuli
Speech: ☐ Slurred ☐ Incoherent ☐ Aphasic
Activity level: ☐ Pacing ☐ Restless ☐ Combative ☐ Sleeping ☐ Seizure Activity
Other

Orthopedic ☐ Assessment WNL
R wrist - swelling
☐ Impaired Circulation (Location)
☐ Deformity (Location) from recent injury
☐ Limited ROM (Location) Avg 15, limited both on hand
☐ Amputation (Location)

HEENT ☐ Assessment WNL
☐ Asymmetrical ☐ Numbness ☐ Paresthesia ☐ Difficulty swallowing
☐ Nystagmus Other

Psychosocial ☐ Assessment WNL
☐ Uncooperative ☐ Anxious ☐ Agitated ☐ Threatening ☐ Angry
☐ Depressed ☐ Suicidal ☐ Homicidal ☐ Avoids eye contact
Affect: ☐ Flat ☐ Crying ☐ Non-verbal
Hallucinations ☐ Visual ☐ Auditory

Assessment RN
Signature
1457 8/21/09
Date/Time

RN Signature: Date:

Patient Identification

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

030.64

Rev. 7/09
Page 1 of 4

ER0807

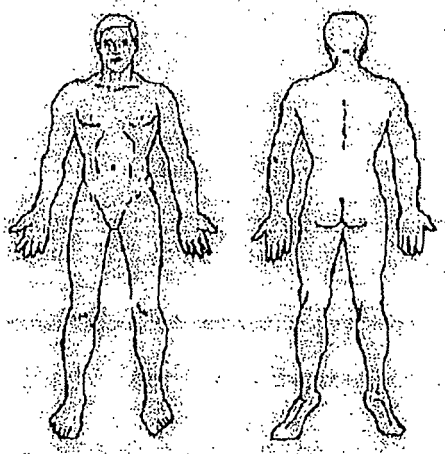
1078130321
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 08/21/2009
Aiken Regional Medical Centers

Physical Findings Diagram

Right



1 – Abrasion
2 – Amputation
3 – Burn
4 – Deformity
5 – Ecchymosis
6 – Edema
7 – Hematoma
8 – Insect Bites
9 – Laceration



Label Areas Involved
10 – Pain
11 – Puncture wound
12 – Rash
13 – Redness
14 – Scar
15 – Skin Breakdown
16 – Skin Tear
17 – Storm

Left



HISTORY OF FALLS	☐ YES ☒ NO	FALL RISK ASSESSMENT (1 or less yes answers = low)	SKIN ASSESSMENT
AGE > 65 YEARS	☐ YES ☐ NO	☐ LOW RISK ☐ HIGH RISK	☒ Y ☐ N > 65 YO
TRANSFERS IMPAIRED	☒ YES ☐ NO	FALL INTERVENTION	☐ Y ☐ N Impaired Mobility
ORIENTATION CONFUSED/		☐ SIDE RAILS ☐ BED IN POSITION	☒ Y ☐ N Impaired Sensory Perception
BEHAVIORAL ISSUES	☐ YES ☐ NO	☐ CALL LIGHT ☐ 1S OBSERVATION	☐ Y ☐ N Inadequate Nutrition
		☐ YELLOW ARM BAND	Yes to one or more = skin assessment w/in 2 hours of admission orders

ABUSE AND NEGLECT SCREEN

Have you been hit, slapped, kicked, or otherwise physically or socially hurt by someone? ☐ Yes ☐ No

IV THERAPY

TIME	VOLUME	SOLUTION OF LOCK	RATE	BLOOD#	SITE	GAUGE	# ATTEMPTS	INITIALS	TIME D/C	INITIALS	TOTAL INFUSED

INTAKE			OUTPUT			Time	Blood Sugar (finger stick)	Education/Symptoms/Comments	Initials
Time	Type	Volume	Time	Type	Volume				
Total Intake:			Total Output:			Normal range: 70-110 mg/dl Critical range: less than 50 mg/dl or greater than 500 mg/dl			

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

630.64

Rev. 7/09
Page 2 of 4

ER0807

Patient Identification

1078130321
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 08/21/2009
Aiken Regional Medical Centers

Procedures/Interventions

Time	Procedure	Results	Initials	Time	Procedure	Results	Initials
	Ace wrap application Site:	☐ Pt able to give return demonstration of reapplication and understanding of vascular checks			Foley Catheter ☐ Regular ☐ I/O ☐ Coude	Size Amount Color	
	Arterial Line Site:	☐ Distal pulse palpated after insertion			Gait Training with crutches	☐ Able to provide return demonstration for safe & proper use of crutches	
	Cast/Splint Location: Type: Supplies:	Post Procedure: Cap Refill: sec Skin color/temp ☐ Pt able to give return demonstration and verbalize understanding of vascular checks			Intubation ETT Size cm @ ☐ Lips ☐ Nares	Tube placement verified by ☐ End Tidal CO2 ☐ Bilateral breath sounds ☐ Absence of epigastric sounds	
	Central Line Site:	☐ Sterile dressing applied using sterile technique			Hemoccult Normal / Not	☐ Positive ☐ Negative	
	Chest Tube Placement	Size ☐ R ☐ L			Knee Immobilizer ☐ R ☐ L	☐ Pt able to give return demonstration of reapplication and understanding of vascular checks	
	Dressing Applied	Type: Supplies:			☐ NG ☐ OG Size	☐ Placement verified by auscultation	
	Ear Irrigation ☐ R ☐ L ☐ Bilat	Fluid type: Amount: ml			Pelvic Exam per MD	Specimen ☐ Yes ☐ No	
	Eye Irrigation ☐ R ☐ L ☐ Bilat	Fluid type: Amount: ml			Ring Cutting Given to:	Skin color/temp Cap refill sec	
	Fetal Heart Tones	FHT Mother's Pulse			Sling applied ☐ R ☐ L	Skin color/temp Cap refill sec	

PAIN MANAGEMENT

Time	Score 0-10	Location	Intervention #	Reassessment Time	Score	Level Acceptable to Patient	Initials
	10	R wrist	splint + sling		DTC	☐ Yes ☐ No	
						☒ Yes ☐ No	SK
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	

1. None 2. Narcotic 3. Analgesic 4. Heat 5. Cold 6. Positioning 7. Other (specify)

Time											
B/P											
HR											
RR											
Temp											
SpO2											
Rhythm											

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

630.04

Rev. 7/09

ER0807

Patient Identification

1078173032

LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 08/21/2009
Aiken Regional Medical Centers

8/21/09

Date/Time	Nurses Notes
1957	Pt ambulated to ED w/ C/O (L) wrist/ arm pain. Pt received injury Aug 18 and stated forearm was severed. wtp

Initials	Signature/Title	Initials	Signature/Title	Initials	Signature/Title
WTP	[illegible]				

DISCHARGE STATUS

DATE 8/21/09 TIME 2110
☒ ROUTINE (HOME) ☐ AMA ☐ LWBS
☐ ADMIT TO:
PHYSICIAN:
☐ TRANSFERRED TO:
☐ ACCEPTING PHYSICIAN:
☒ EXPIRED

METHOD OF DISCHARGE

☒ AMBULATORY ☐ AMBULANCE
☐ WHEELCHAIR ☐ CARRIED

DISCHARGE VITAL SIGNS

BP _____ P _____ R _____
T _____ SAO2 _____ PAIN _____

ACCOMPANIED BY

☐ SELF ☐ RELATIVE ☐ POLICE
☐ FRIEND ☐ OTHER EXPLAIN:

DISCHARGE INSTRUCTIONS

☒ Verbal
☐ Written ☐ Not Given (why):
☒ VERBALIZES UNDERSTANDING

Patient Identification

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

630.84
Rev. 7/09
Page 4 of 4

ER0807

1078130B2
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 08/21/2009
Aiken Regional Medical Centers

Home Medication List
Physician's Order

		ADMISSION		DISCHARGE	
Height: 5 feet 11 inches		At time of entry, please check which medications should be continued and sign below to authenticate order		At time of discharge, check which medications should be continued and sign below to authenticate order	
Weight: 195 pounds actual stated estimated					
Allergies: NKDA					
8/21/09					
Nurse Signature: [signature] Date/Time: 8/21/09 1357		Give med upon adm.	Do not give med upon adm.	Continue at discharge	Do not continue at discharge
Unapproved abbreviations: U, Ms, MSO4, MgSO4, QD, qd, q.o.d, U.U, trailing zeros, no zero before decimal					
Medication/Dose	Route / Frequency / Reason for taking / Last dose taken				
Information obtained from: ☑ Patient ☐ Patient Representative	☐ No home medications ☐ Unable to obtain list				
Include Insulin, inhalers, eye drops, aspirin, herbals, vitamins, and OTC					
Naprosyn 500mg	PO BID				

Physician Signature (on admission): Date:

Physician Signature (on discharge): Date:

Outpatients Only

Changes to home medications: ☐ None ☐ _____

Based on the treatment prescribed by your physician(s) and the list of medications that you provided, you may continue your home medications with the changes written above, if any. Please contact your prescribing physician if you have any questions about your home medications.

New Discharge Medications

☐ No new medications @ discharge

Medication/Dose	Route	Frequency	Reason for taking
Ultram	as	directed	
Bactrim			
Vicoprofen			

Outpatients Only

Physician Signature: Licensed Staff's Signature: Patient's Signature:

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

PO0010

Home Medication List
Physician's Order

10-37036
601.126
Rev. 11/07

CHART COPY

1078813032
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 08/21/2009
Aiken Regional Medical Centers

9/15

Notice To All Persons Signing This Document:
By my signature on this document, I agree and consent to all terms and conditions detailed below regarding hospital care and treatment to be given to me by the hospital unless otherwise noted.

Consent to Hospital Procedures:
I consent to medical and surgical procedures that might be performed during this hospitalization or outpatient visit, including emergency treatment or services for the patient. These services may include but are not limited to laboratory tests, X-rays, medical or surgical treatment or procedures, anesthesia, and hospital services rendered to me under the general and special instructions of the attending physician or surgeon.

I hereby authorize AIKEN to recognize my attending physician as the manager of my medical and/or surgical care and treatment. I consent to and authorize my attending physician and/or his/her designee, to administer treatment (medical, surgical, anesthetic, obstetrical and /or any other therapeutic or diagnostic procedure) that he/she/they may dictate as advisable for my wellbeing. Please be advised that this Treatment Authorization also authorizes AIKEN to inform my primary care physician of my condition unless I specifically request otherwise.

I understand that the hospital may have affiliations with a variety of health care related educational programs. These programs may include but are not limited to: Nursing, Medical, EMT, surgical technician and physical medicine. I consent to have students participate in my care under the supervision of their instructor(s) and understand that I must express any refusal to have them participate to a management representative such as charge nurse, nurse manager, shift manager, department director, senior manager, etc.

The nature of the operation/treatment has been explained to me. I am aware that the practice of medicine and surgery is not an exact science. *No* warranty or guarantee has been made to me as to a cure or the treatment's result.

I authorize AIKEN to retain, preserve, and to use for scientific or teaching purposes, and properly dispose of, any specimen or tissue removed from my body during this hospitalization or outpatient visit.

I understand that pictures may be taken of my medical/surgical condition or treatment. I understand that pictures might be used for purposes of my diagnosis, treatment, or for educational training programs conducted by the hospital. These pictures will be part of the documentation in my medical record.

Special Consent for HIV Testing and Other Blood Borne Pathogens
I understand that this consent form covers testing for blood borne infectious diseases, including but not limited to hepatitis, acquired immune deficiency syndrome (AIDS), and human immunodeficiency virus (HIV). A physician may order such test(s) for diagnostic purposes to determine the appropriate treatment and/or treatment procedures for me or to protect the attending physician and/or any employee or agent of the hospital exposed to my bodily fluids in a manner which could transmit such disease.

Physician Providers Are Not Hospital Employees
I acknowledge and agree that AIKEN is not responsible for the judgment or conduct of any physician who treats or provides a professional service to me, but rather each physician is an independent contractor who is not the agent, servant, or employee of the hospital. The hospital or affiliate agency is not liable for any acts or omission made by any physician or in following the order of the physician.

Aiken Regional Medical Centers
302 University Pkwy
PO Drawer 1117
Aiken, SC 29801

Treatment Authorization

Patient Identification
1078130321
LEE, BERNARD D
DOB: 04/30/1986 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 08/21/2009
Aiken Regional Medical Centers

UHS-9010
Rev. 12/08
-268-

Signatures (Please read before signing.)
This is to certify that I, the undersigned, being the patient, or another person legally authorized to act for the patient, have carefully read and fully understand this treatment authorization and am duly authorized to execute the above and accept its terms.

The undersigned acknowledges having read and received copy of this document. A copy of this authorization shall be as valid as the original.

Patient Signature	Date: 8.21.09	Time: 8:35 p.m.
Patient Authorized Rep's Signature	Relationship to Patient	
Witness Signature	2nd Witness Signature for Verbal Consent	

The patient could not sign because: _____

Aiken Regional Medical Centers
302 University Pkwy
PO Drawer 1117
Aiken, SC 29801

Treatment Authorization

UHS-8010
-269-3

Patient Identification
1078130032
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 06/21/2009
Aiken Regional Medical Centers

PT NAME: LEE ,BERNARD D AGE: 29
NURS STA: PT TYPE: T PT NO: 107992075
ROOM/BED: HOSP SVC: EMR MED REC NO: 177273
PT STATUS: EA MARITAL STS: S RACE: 2 REL: BAP
SSN: 251-45-2204 SEX: M BIRTHDATE: 04/30/1930
P V NAME: INFANT AGE:
A RESS: 172 OLD CHEROKEE INDIAN RD PHONE: 803 - 663-0560
DISTRICT CD: 2
CITY: GRANITEVILLE ST: SC ZIP: 29829-3613

EMPLOYER: BONDEX
ADDRESS: MIKE PADGET HWY

CITY: GRANITEVILLE ST: SC ZIP: 29829-
OCCUPATION: MACHINE OPERATOR PHONE: 706 - 999-9999 EXT
GUARANTOR: LEE ,BERNARD
ADDRESS: 172 OLD CHEROKEE INDIAN RD GUAR SSN: 251452204
REL: S
CITY: GRANITEVILLE ST: SC ZIP: 29829-3613
OCCU: MACHINE OPERATOR PHONE: 803 - 663-0560 EXT
GUAR EMPL: BONDEX
ADDRESS: MIKE PADGET HWY PHONE: 706 999-9999
EXT
CITY: GRANITEVILLE ST: SC ZIP: 29829-
EMER CONTACT: LEE ,MARIE REL: N
ADDRESS: 172 CHEROKEE INDIAN RD
CITY: GRANITEVILLE ST: SC ZIP: 29829-
HOME PHONE: 803 663-0560 WORK PHONE: EXT:
NEXT OF KIN: LEE ,VIRGINIA PHONE: 803 663-1533
INSURANCE INFO: FC: Z
INS PL 1: 904 CHARITY PENDING POLICY #: 251452204
COB: 1 PAYOR ID: 600 VERIFIED: Y GROUP #:
MAIL TO: LEE ,BERNARD GROUP NAME:
ADDRESS: 172 OLD CHEROKEE IND PHONE: 803 663-0560
CITY: GRANITEVILLE ST: SC ZIP: 29829 UR PHONE: 803-663-1533
AUTH #: SUBSCRIBER NAME: LEE ,BERNARD
INS PL 2: POLICY #:
COB: PAYOR ID: VERIFIED: GROUP #:
MAIL TO: GROUP NAME:
ADDRESS: PHONE:
CITY: ST: ZIP: UR PHONE: - -
AUTH #: SUBSCRIBER NAME:
INS PL 3: POLICY #:
COB: PAYOR ID: VERIFIED: GROUP #:
MAIL TO: GROUP NAME:
ADDRESS: PHONE:
CITY: ST: ZIP: UR PHONE: - -
AUTH # SUBSCRIBER NAME:
PREADM: REG/UPG: SHILET PREREG: ER REG: PRICED
ACC IND: H ACC DT/TM: 092909 07:00 ADM DT/TM: 09/29/09 08:41
ACC LOC: ADM SOURCE: EO ADM PRI: X
DSCH DT/TM: DISP: AHR ADM DR: 003301 STAGGS CLIFFORD D
REF DR: 999870 NO REFERRING DOCTOR ATN DR: 003301 STAGGS CLIFFORD D
PROCEDURE: DIAGNOSIS: RIGHT WRIST PAIN
CLIN COMM: SURGERY DATE:
PREV STAY: PREV ADM DTE:
FAM DR: NO PCP NO FAMILY DR 999987 PREV DSCH DTE:
MODE ARRIVAL: POV REL OF INFO: N HLDLESS MED IND:
ORGAN DONOR: LIV WILL/ADV DIR: LOCATION:

Date 9/29/09 Arrival Time 0835 Mode of Arrival: ☑ POV ☐ EMS ☑ Ambulatory ☐ Carried ☐ W/C

Name Lee, Bernard DOB 4/3/80

Current Complaint (in patient's own words) _____

Name/Title _____

Triage Time 0835

Communication Assessment:

Primary Language: ☑ English ☐ Spanish ☐ Other _____

Translation: ☑ N/A ☐ Language Line ☐ Other _____

Hearing: ☑ No apparent deficit ☐ Wearing hearing aid Vision: ☑ No apparent deficit ☐ Wearing glasses

Allergies: NKA

T 98.1 P 70 R 18 B/P 159/107 SaO_2 100

Pain: Location (R) chest Scale (0-10) 10/10

LMP _____ Wt. _____ lbs ☐ Actual ☐ Stated

Assessment Rt chest pain for over 6 month + laceration to Rt forearm

Triage Level: ☑ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 **Disposition:** ☑ **Major ER** ☐ **Minor ER**

Triage Interventions: ☐ Ice ☐ Elevation ☐ Sling ☐ Splint ☐ Bleeding control ☐ Fever med ☐ ASA (per ACS protocol) ☐ Other _____

Triage RN Signature _____

Reassessment: Date _____ Time _____

Evaluation: ☐ No change from previous assessment ☐ Change (describe) _____

Action/Intervention _____

RN Signature _____ Date _____ Time _____

To ER Room # _____ @ _____ Report to _____ QPI done ☑ yes ☐ no

LWBS: Date _____ Time _____ Reason _____

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

TRIAGE ASSESSMENT

830.78
Rev. 08/09
Page 1 of 1

ER0515 - Triage Form

Patient Identification

29

1007992075
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 09/29/2009
Aiken Regional Medical Centers

AIKEN REGIONAL MEDICAL CENTERS RADIOLOGICAL CONSULTATION

PT NAME: LEE, BERNARD D
ROOM #: ERDC-23
ACCT#: 107992075
DOB: 04/30/1980
SEX: M
STUDY DATE: 09/29/09
STUDY: XR WRIST 3V R/T
STUDY:
STUDY:

VT: ER
XRAY#: 962389
MEDREC#: 177273
REF PHYS: CLIFFORD STAGGS
PRI PHYS:

CPT#1: 73110RT
CPT#2:
CPT#3:

CONFIDENTIAL - IF NOT INTENDED FOR YOU, PLEASE CALL (803) 641-5060

RIGHT WRIST

Indication: Right wrist pain.

Technique: Three views of the wrist were obtained.

Findings: The bony structures are intact. The joint spaces are preserved. No fractures or bone destruction are noted.

Impression:

No displaced fractures in the right wrist.

ED Code 3

Dictated By: Anthony Toomer, M.D.
DID 45443

D:/T:kv/T329850 /Job ID 1479685 /DT:09/29/2009 10:47:28/TD:09/29/2009 11:11:49 /Rev: 10/01/2009 12:00:07
CC:

This document was electronically signed by Anthony Toomer, M.D. on 10/02/2009 13:18:47 EST.

Physical Assessment: Time Performed 1925
☐ Head-to-toe ☐ Focused Assessment

Past Surgical History: ☐ Denies any significant surgical history
☐ Appendectomy ☐ Hysterectomy
☐ Cholecystectomy ☐ Tubal Ligation
☐ CABG ☐ Cardiac Stents
☐ Other

RMD

Past Medical History: ☐ Denies any significant medical history
☐ CAD ☐ CHF
☐ Cancer (type)
☐ Diabetes ☐ Asthma
☐ COPD ☐ CVA/TIA
☐ HTN ☐ Hypercholesterolemia
☐ GI Bleeding/Ulcer ☐ Hepatitis
☐ Kidney Stones ☐ Renal Failure
☐ Migraines ☐ Seizures
☐ HIV/Aids ☐ Other
Home Oxygen: ☐ N/A L/m via

Current Assessment
Pulmonary: ☒ Assessment WNL
Respirations: ☐ Labored ☐ Rapid ☐ Slow ☐ Deep ☐ Shallow ☐ SOB
Breath Sods: ☐ Diminished ☐ Absent ☐ Crackles ☐ Wheezes ☐ Rhonchi
Cough: ☐ Productive ☐ Non-productive Sputum
Location of abnormalities ☐ Right ☐ Left ☐ Bilateral
Other

Cardiovascular: ☒ Assessment WNL
Chest Pain: ☐ Yes ☐ No Describe
Heart Sounds: ☐ Regular ☐ Irregular ☐ Muffled ☐ Rub
Pulses: ☐ Not Palpable Location
EKG Rhythm
JVD ☐ Yes ☐ No

Neurological: ☒ Assessment WNL
Responsiveness: ☐ Unresponsive ☐ Responds to painful stimuli
Speech: ☐ Slurred ☐ Incoherent ☐ Aphasic
Activity level: ☐ Pacing ☐ Restless ☐ Combative ☐ Sleeping
☐ Seizure Activity
Other

HEENT: ☒ Assessment WNL
☐ Asymmetrical ☐ Numbness ☐ Paresthesia ☐ Difficulty swallowing
☐ Nystagmus Other

Pain: 5/
Score: 10 Location: Back
Scale: ☐ Numeric ☐ Faces ☐ FLACC ☐ Nips
Onset: 2 ☐ hours ☐ days ☐ weeks ☐ months ☐ years
Description: ☐ Constant ☒ Intermittent ☐ Dull ☐ Sharp ☐ Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Cramping ☐ Pressure
Aggravates: ☐ Nothing ☐ Activity ☐ Food ☐ Palpation ☐ Cough ☐ Deep Breath
Alleviates: ☐ None ☐ Medication ☐ Positioning ☐ Heat ☐ Cold Other:

GU/GYN ☒ Assessment WNL
Urine: ☐ Hematuria ☐ Cloudy ☐ Odor ☐ Dark ☐ Burning ☐ Frequency ☐ Inconsistency ☐ Foley present on admission
Dialysis access site/location ☐ N/A
Menses: ☐ Irregular ☐ Painful ☐ Vaginal bleeding Pad Count #
LMP EDC G P Ab
☐ Vaginal/Penile discharge color:

Gastrointestinal: ☒ Assessment WNL
☐ Nausea ☐ Vomiting Emesis color
☐ Diarrhea # stools
☐ Constipated # days ☐ Rectal bleeding
Abdomen: ☐ Protuberous ☐ Distended ☐ Tender ☐ Rigid
Bowel sounds: ☐ Absent ☐ Hyperactive ☐ Hypoactive

Integumentary: ☒ Assessment WNL
☐ Cool ☐ Pale ☐ Clammy ☐ Diaphoretic ☐ Flushed ☐ Mottled
☐ Cyanotic ☐ Jaundiced ☐ Pink
Last Tetanus: Date ☐ Unknown

Orthopedic: ☒ Assessment WNL
☐ Impaired Circulation (Location)
☐ Deformity (Location)
☐ Limited ROM (Location)
☐ Amputation (Location)

Psychosocial: ☒ Assessment WNL
☐ Uncooperative ☐ Anxious ☐ Agitated ☐ Threatening ☐ Angry
☐ Depressed ☐ Suicidal ☐ Homicidal ☐ Avoids eye contact
Affect: ☐ Flat ☐ Crying ☐ Non-verbal
Hallucinations: ☐ Visual ☐ Auditory

Assessment RN Signature 9/28/2009 Date/Time

RN Signature: Date:

Alken Regional Medical Centers
3[illegible]
A[illegible]

ED NURSING ASSESSMENT
830.64
Rev. 7/09
Page 1 of 4

ER0807 - ED Assessment

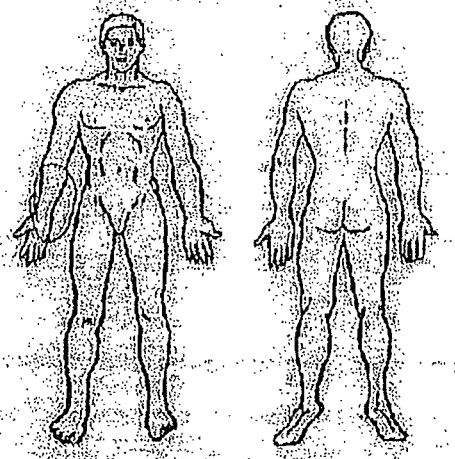
Patient Identification
1079920751
LEE, BERNARD D
DOB: 04/30/1960 29 Y SX: M EMR
MRN: 1172731 ADM/REG DT: 09/29/2009
Alken Regional Medical Centers
SX:

Physical Findings Diagram

Right

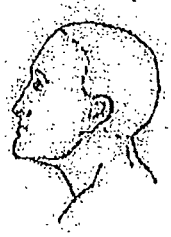


1 – Abrasion
2 – Amputation
3 – Burn
4 – Deformity
5 – Ecchymosis
6 – Edema
7 – Hematoma
8 – Insect Bites
9 – Laceration



Label Areas Involved
10 – Pain
11 – Puncture wound
12 – Rash
13 – Redness
14 – Scar
15 – Skin Breakdown
16 – Skin Tear
17 – Stoma

Left



HISTORY OF FALLS	☐ YES ☒ NO	FALL RISK ASSESSMENT (If ≥ 4 on any answer = high)	SKIN ASSESSMENT
AGE >65 YEARS	☐ YES ☒ NO	☐ LOW RISK ☐ HIGH RISK	☐ Y ☒ N > 65 YO
TRANSFERS IMPAIRED	☐ YES ☒ NO	FALL INTERVENTION	☐ Y ☒ N Impaired Mobility
ORIENTATION CONFUSED/		☒ SIDE RAILS ☐ BED IN POSITION	☐ Y ☒ N Impaired Sensory Perception
BEHAVIORAL ISSUES	☐ YES ☒ NO	☐ CALL LIGHT ☐ ES OBSERVATION	☐ Y ☒ N Inadequate Nutrition
		☐ YELLOW ARM BAND	Yes to one or more = skin assessment w/in 2 hours of admission orders

ABUSE AND NEGLECT SCREEN

Have you been hit, slapped, kicked, or otherwise physically or socially hurt by someone? ☐ Yes ☒ No

IV THERAPY

TIME	VOLUME	SOLUTION OR LOCK	RATE	BLOOD#	SITE	GAUGE	# ATTEMPTS	INITIALS	TIME D/C	INITIALS	TOTAL INFUSED

						Time	Blood Sugar (finger stick)	Education/Symptoms/Comments	Initials
Time	Type	Volume	Time	Type	Volume				
Total Intake			Total Output			Normal range: 70-110 mg/dl Critical range: Less than 50 mg/dl or greater than 500 mg/dl			

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

690.04
Rev. 7/09
Page 2 of 4

ER0807

Patient Identification

1078920759
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 09/28/2009
Aiken Regional Medical Centers

Procedures/Interventions

Time	Procedure	Results	Initials	Time	Procedure	Results	Initials
	Ace wrap application Site:	☐ PL able to give return demonstration of reapplication and understanding of vascular checks			Foley Catheter ☐ Regular ☐ I/O ☐ Coude	Size: Amount: Color:	
	Arterial Line Site:	☐ Distal pulse palpated after insertion			Gait Training with crutches	☐ Able to provide return demonstration for safe & proper use of crutches	
	Cast/Splint Location: Type: Applied	Post Procedure: Cap Refill: sec Skin color/temp ☐ PL able to give return demonstration and verbalize understanding of vascular checks			Intubation ETT Size: cm @ ☐ Lips ☐ Nares	Tube placement verified by ☐ End Tidal CO2 ☐ Bilateral breath sounds ☐ Absence of epigastric sounds	
	Central Line Site:	☐ Sterile dressing applied using sterile technique			Hemoccult Normal: Neg	☐ Positive ☐ Negative	
	Chest Tube Placement	Site: ☐ R ☐ L			Knee Immobilizer ☐ R ☐ L	☐ PL able to give return demonstration of reapplication and understanding of vascular checks	
	Dressing Applied	Type: Supplies:			☐ NG ☐ OG Size	☐ Placement verified by auscultation	
	Ear Irrigation ☐ R ☐ L ☐ Bilat	Fluid type: Amount: ml			Pelvic Exam per MD	Specimen: ☐ Yes ☐ No	
	Eye Irrigation ☐ R ☐ L ☐ Bilat	Fluid type: Amount: ml			Sling Ordered Given to:	Skin color/temp Cap refill sec	
	Fetal Heart Tones	FHT: Mother's Pulse:			Sling Applied ☐ R ☐ L	Skin color/temp Cap refill sec	

PAIN MANAGEMENT

Time	Score 0-10	Location	Intervention #	Reassessment Time	Score	Level Acceptable to Patient	Initials
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	

1. None 2. Narcotic 3. Analgesic 4. Heat 5. Cold 6. Positioning 7. Other (specify)

Time											
B/P											
HR											
RR											
Temp											
SpO2											
Rhythm											

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

530.64

Rev. 7/09
Page 3 of 4

ER0807

Patient Identification

1079920 75
LEE, BERNARD B
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 09/29/2009
Aiken Regional Medical Centers

Date/Time	Nursing Notes
0905	Pt admitted to room # 25 c w/c to ED with family from location 1 month ago. RLE splint applied to ER by EMS. Ecchymosis noted to R knee & leg. All questions answered. RN

DISCHARGE STATUS

DATE: 1/24/09 TIME: 1104
☑ ROUTINE (HOME) ☐ AMA ☐ LWBS
☐ ADMIT TO:
PHYSICIAN:
☐ TRANSFERRED TO:
☐ ACCEPTING PHYSICIAN:
☐ EXPIRED

METHOD OF DISCHARGE

☑ AMBULATORY ☐ AMBULANCE
☐ WHEELCHAIR ☐ CARRIED

ACCOMPANIED BY

☐ SELF ☐ RELATIVE ☐ POLICE
☐ FRIEND ☐ OTHER EXPLAIN:

DISCHARGE VITAL SIGNS

BP _____ P _____ R _____
T _____ SAO2 _____ PAIN _____

DISCHARGE INSTRUCTIONS

☐ Verbal
☐ Written ☐ Not Given (why):
☑ PT VERBALIZES UNDERSTANDING

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

Patient Identification

ED NURSING ASSESSMENT

ER0807

630.64
Rev. 7/09
Page 4 of 4

107992075
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 09/29/2009
Aiken Regional Medical Centers

GENERAL INSTRUCTIONS:

- ☐ Call the next business day and make an appointment to see: _____
  Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in _____ days or less or _____ days or less if still ill.
- ☐ Have your blood pressure checked at _____ within _____ days.
- ☐ Return to the Emergency Department in _____ days for suture removal or re-check.
- ☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.
- ☐ Work / school excuse from _____ thru _____ May return to work _____.
- ☐ See your company doctor per your company's policy. Light duty until _____
  (No use of _____ No lifting over _____ lbs.)
- ☒ If Pain Worsen Go to ER Or Your Doctor Or Urgent Care

Your diagnosis was:

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ Tetanus/Diphtheria booster*
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X-Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physician.
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Department.
8. If you feel you want to harm yourself or are suicidal, call 1-800-784-2433 (National Suicide Hotline).

_____ Physician
_____ Staff
4/29/09 Date
_____ Patient or Responsible Person

Patient Identification

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

EMERGENCY SERVICES




ER0028

530.06
Rev. 9/08

WHITE - RECORDS CANARY - PATIENT GOLDENROD - PATIENT

Aiken Regional ED ENCOUNTER Record

☐ Full Admission
☐ 23 Hr Observation

Chief Complaint: R wrist pain

HPI: Pt w/ c/o 29 yo who presents to ED c/o R wrist pain s/p fall. Pain & limited ROM. Lac to R forearm

Current Meds: See ED nurses notes

PMD

Past Medical History: ☐ HPI, Rmed Hx, Social Hx, Fam Hx, ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF
& ROS Unobtainable due to: ☐ As Above ☐ Other:

Past Surgical History:

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☐ Yes Amt ETOH ☐ No ☐ Yes Amt ☐ Other

Review Of Systems: ☐ Other ROS Neg — Check ☐ if normal / Check ○ if abnormal (If not Checked then not applicable)

Eyes:	☐ ○ Diplopia	☐ ○ Blurred	☐ ○ Vision chgs	GU:	☐ ○ Dysuria	☐ ○ Urgency	☐ ○ Hematuria
ENT:	☐ ○ Rhinitis	☐ ○ Sore throat	☐ ○ Nose bleeds	MS:	☐ ○ Myalgia	☐ ○ Back pain	☐ ○ Neck pain
Card:	☐ ○ CP	☐ ○ Palpitation		Neuro:	☐ ○ Seizures	☐ ○ Dizziness	☐ ○ Syncope
Respir:	☐ ○ SOB	☐ ○ Cough	☐ ○ Hemoptysis		☐ ○ Weakness	☐ ○ Numbness	
GI:	☐ ○ Nausea	☐ ○ Vomiting	☐ ○ Diarrhea	Endo:	☐ ○ Polyuria	☐ ○ Hypoglyc	☐ ○ Thyroid Dys
	☐ ○ Abd pain	☐ ○ Melena	☐ ○ Hematochez	Hem/Lymi:	☐ ○ Anemia	☐ ○ Bleeding	

☐ For allergies see ED nurses notes

Other ROS

TETANUS STATUS:

ALLERGIES

Physical Exam: WEIGHT TIME PULSE OX TEMP P R BP

100 9/1/2018 15 167

☐ For Vitals see ED nurses notes

Check ☐ if normal Check ○ if abnormal Abn Findings:

General:	☒ ○ Mental Status						
Eyes:	☒ ○ Conjun NL	☐ ○ Lids	☐ ○ PERRL				
Head:	☐ ○ NL cephalic	☐ ○ Sinuses	☐ ○ Nose				
ENT:	☐ ○ Oropharynx	☐ ○ Right TM	☐ ○ Left TM				
Neck:	☐ ○ Palpation	☐ ○ Thyroid	☐ ○ Trachea				
Chest:	☐ ○ Palpation	☐ ○ Excursion	☐ ○ Symmetry				
Cardio:	☐ ○ Heart sounds	☐ ○ R & R					
Respir:	☐ ○ Respir effort	☐ ○ Lung sounds					
Abdom:	☐ ○ Palpation	☐ ○ Bowel					
MS:	☒ RUE	☐ ○ Sounds	☐ ○ Digits				
	☐ LUE	☐ ○ RLE	☐ ○ Back				
	☐ ○ Pelvis	☐ ○ LLE					
Skin:	☐ ○ Temp	☐ ○ Gait	☐ ○ Color				
Neuro:	☐ ○ CN3	☐ ○ Appear Strength	☐ ○ Sensation				

Med Decision Making:

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

TEST:	ORD Initial	TIME INITIAL ✓TEST ORDERED:
CBC W/DIFF:		PHYSICIAN'S ORDERS: TIME ORD: TIME COMP Initials:
CHEM 8:		
URINE PREG:		→ URINE PREG RESULTS:
COUA:		
CATH UA:		
URINE C&S:		
EKG:		
OLD EKGS:		
TROPONIN:		
PURTT:		
FINGER ST GL:		
BLOOD CULT X		
TYPE & SCREEN:		
TYPE CROSS UNITS:		
LIVER PANEL:		
CMP:		
AMYLASE:		
LIPASE:		
HEMOCCULT:		
TYPE & RH:		
HCG QUANT:		
URINE DRUG S:		
ALCOHOL:		
ED ABG:		
HA/LAT CXR:		
PCXR:		
C-SPINE:		
L-SPINE:		
ACUTE ABD:		
OLD RECORDS:		
OLD ED Record:		

Velcro wrist splint - Dora

DC

ER0010 - ED Physician Record

CC TIME:
Diff Dx:
Consult/s:
NAME OF PHYSICIAN THAT ADMITTED PT:
NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

DISCHARGE DIAGNOSIS: 1) Mass to R wrist.

☐ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

CODES
☐ STABLE
☐ UNSTABLE SEE NOTE

Name: Lee Bernard Race: Sex: Age:
Addressograph

Physician Signature:

Time MD IN:

ER0010

White - Medical Records Copy, White - Diagnostic

1078992075
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 09/29/2009
Aiken Regional Medical Centers

10-24129 4/00

Home Medication List
Physician's Order

Height: 6 feet 0 inches

Weight: 190 pounds actual stated estimated

Allergies: PCN

Nurse Signature [signature] Date/Time 9/29/09 1054

ADMISSION — At time of entry, please check which medications should be continued and sign below to authenticate order.

DISCHARGE — At time of discharge, check which medications should be continued and sign below to authenticate order.

Home Medications

Unapproved Abbreviations: IU, Ms, MSO4, MgSO4, c.d., n.s., q.o.d., U.u. trailing zeros, no zeros before decimal

Medication/Dose	Route	Frequency	Reason for taking	Last dose taken	Give med upon adm.	Do not give med upon adm.	Continue at discharge	Do not continue at discharge
Information obtained from: ☐ Patient ☐ Patient Representative	☐ No home medications ☐ Unable to obtain list							
Include insulin, inhalers, eye drops, aspirin, herbals, vitamins, and OTC								
SMZ/TMP								

Physician Signature (on admission): Date:

Physician Signature (on discharge): Date:

Outpatients Only

Changes to home medications: ☐ None ☐ _____

Based on the treatment prescribed by your physician(s) and the list of medications that you provided, you may continue your home medications with the changes written above, if any. Please contact your prescribing physician if you have any questions about your home medications.

New Discharge Medications

☐ No new medications @ discharge

Medication/Dose	Route	Frequency	Reason for taking

Outpatients Only

Physician Signature [signature] Licensed Staff's Signature Patient's Signature

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

PC0010

Home Medication List
Physician's Order

10-37038
601:126
Rev. 11/07

Patient Label

107992075
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 09/29/2009
Aiken Regional Medical Centers

CHART COPY

Notice To All Persons Signing This Document:
By my signature on this document, I agree and consent to all terms and conditions detailed below garding hospital care and treatment to be given to me by the hospital unless otherwise noted.

Consent to Hospital Procedures:
I consent to medical and surgical procedures that might be performed during this hospitalization or outpatient visit, including emergency treatment or services for the patient. These services may include but are not limited to laboratory tests, X-rays, medical or surgical treatment or procedures, anesthesia, and hospital services rendered to me under the general and special instructions of the attending physician or surgeon.

I hereby authorize AIKEN to recognize my attending physician as the manager of my medical and/or surgical care and treatment. I consent to and authorize my attending physician and/or his/her designee, to administer treatment (medical, surgical, anesthetic, obstetrical and /or any other therapeutic or diagnostic procedure) that he/she/they may dictate as advisable for my wellbeing. Please be advised that this Treatment Authorization also authorizes AIKEN to inform my primary care physician of my condition unless I specifically request otherwise.

I understand that the hospital may have affiliations with a variety of health care related educational programs. These programs may include but are not limited to: Nursing, Medical, EMT, surgical technician and physical medicine. I consent to have students participate in my care under the supervision of their instructor(s) and understand that I must express any refusal to have them participate to a management representatiive such as charge nurse, nurse manager, shift manager, department director, senior manager, etc.

The nature of the operation/treatment has been explained to me. I am aware that the practice of medicine d surgery is not an exact science. ***No*** warranty or guarantee has been made to me as to a cure or the atment's result.

I authorize AIKEN to retain, preserve, and to use for scientific or teaching purposes, and properly dispose of, any specimen or tissue removed from my body during this hospitalization or outpatient visit.

I understand that pictures may be taken of my medical/surgical condition or treatment. I understand that pictures might be used for purposes of my diagnosis, treatment, or for educational training programs conducted by the hospital. These pictures will be part of the documentation in my medical record.

Special Consent for HIV Testing and Other Blood Borne Pathogens
I understand that this consent form covers testing for blood borne infectious diseases, including but not limited to hepatitis, acquired immune deficiency syndrome (AIDS), and human immunodeficiency virus (HIV). A physician may order such test(s) for diagnostic purposes to determine the appropriate treatment and/or treatment procedures for me or to protect the attending physician and/or any employee or agent of the hospital exposed to my bodily fluids in a manner which could transmit such disease.

Physician Providers Are Not Hospital Employees
I acknowledge and agree that AIKEN is not responsible for the judgment or conduct of any physician who treats or provides a professional service to me, but rather each physician is an independent contractor who is not the agent, servant, or employee of the hospital. The hospital or affiliate agency is not liable for any acts or omission made by any physician or in following the order of the physician.

Aiken Regional Medical Centers
302 University Pkwy
PO Drawer 1117
Aiken, SC 29801

Treatment Authorization

Patient Identification



107992075
LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 09/29/2009
Aiken Regional Medical Centers

Signatures (Please read before signing.)
This is to certify that I, the undersigned, being the patient, or another person legally authorized to act for patient, have carefully read and fully understand this treatment authorization and am duly authorized to execute the above and accept its terms.

The undersigned acknowledges having read and received copy of this document. A copy of this authorization shall be as valid as the original.

X _____ 9/29/09 9W

Patient Signature | Date | Time

_____ _____

Patient Authorized Rep's Signature | Relationship to Patient

9 Warren PAR _____

Witness Signature | 2nd Witness Signature for Verbal Consent

The patient could not sign because: _____

Aiken Regional Medical Centers
302 University Pkwy
PO Drawer 1117
Aiken, SC 29801

Treatment Authorization

Patient Identification

107992075

LEE, BERNARD D
DOB: 04/30/1980 29 Y SX: M EMR
MRN: 177273 ADM/REG DT: 08/29/2009
Aiken Regional Medical Centers

STATE OF SOUTH CAROLINA	)	BEFORE THE
	)	SOUTH CAROLINA WORKERS'
COUNTY OF EDGEFIELD	)	COMPENSATION COMMISSION
BERNARD LEE,	)	W.C.C. File No. 0906951
	)	
Claimant,	)	
	)	NOTICE OF WITNESSES AND WRITTEN
vs.	)	REPORT(S)/PHYSICIAN OR OTHER
	)	EVIDENCE TO BE INTRODUCED ON
BONDEX,	)	BEHALF OF CLAIMANT
	)	
Employer/Defendant.	)	

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND E. ROS HUFF, ESQUIRE, ATTORNEY FOR EMPLOYER/DEFENDANT:

YOU ARE HEREBY NOTIFIED THAT the Claimant, pursuant to the provisions of the South Carolina Workers' Compensation Act and S.C. Code Ann §1-23-330 (1985), submits the following medical reports as direct evidence on behalf of the Claimant:

NAME OF REPORT(S)/PHYSICIAN OR OTHER EVIDENCE	DATE OF REPORT	NUMBER OF PAGES
1. Accident Report	6/2/09	1
2. University Hospital	6/3/09	2 - 7
3. Dr. Jeffrey Broder	6/5/09 to 7/1/09	8 - 18
4. Sports Plus	6/5/09 to 7/28/09	19 - 29
5. University Open MRI	6/26/09	30
6. Dr. James Bethea	7/16/09	31 - 34
7. Aiken Regional Medical Center	7/18/09 to 7/28/09	35 - 51
8. Dr. Sylva Al-Soudi	8/6/09 to 10/5/09	52 - 58
9. Dr. Timothy Shannon	8/17/09 to 5/25/10	59 - 80
10. Dr. David Goltra	1/14/10	81 - 83
11. Dr. Ty Carter	1/25/10	84 - 85
12. Dr. W. Daniel Westerkam	6/10/10	86 - 87
13. Dr. William Robinson	7/20/10	88

14. Unpaid Medical Bills	89 - 98
15. Consent Orders	99 - 104
16. Correspondence requesting medical treatment	105 - 115
17. Repair Bill from Personnel File	116 - 127
18. Curriculum Vitae of Dr. Timothy Shannon	128 - 131
19. American Medical Association Certifications	132 - 133

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination, and should you desire to exercise that right, you are to forthwith schedule the deposition(s) of any of the physicians or other person(s) whose reports are submitted, for the purpose of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred to herein, or photocopies received from said physicians/others, will be submitted at the Hearing before the South Carolina Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission 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:

All witnesses listed on both parties pre-trial briefs, to include but not be limited to the Claimant. Claimant reserves the right to amend this list of witnesses.

MICKLE & BASS, LLC.

BY: _____

Ann McCrowey Mickle
Attorney for Claimant
930 Oakland Avenue
Post Office Box 10751
Rock Hill, South Carolina 29731
Telephone: (803) 980-0083

Rock Hill, South Carolina
July 28, 2010

STATE OF SOUTH CAROLINA)	BEFORE THE
)	SOUTH CAROLINA WORKERS'
COUNTY OF EDGEFIELD)	COMPENSATION COMMISSION
BERNARD LEE,)	W.C.C. File No. 0906951
)	
Claimant,)	
)	
vs.)	CERTIFICATE OF SERVICE BY MAIL
)	
BONDEX,)	
)	
Employer/Defendant.)	

The undersigned employee of ***Mickle & Bass, LLC*** does hereby certify that she has served a copy of the below referenced document(s) in the above captioned case on the below referenced individuals, entity, employer/carrier by depositing the same by first class postage in the United States mail on the 28th day of July, 2010.

Documents served: Form 58 and Notice of Witnesses and Written Report(s)/Physician or Other Evidence to be Introduced on Behalf of Claimant

Parties served:

The Honorable Avery Wilkerson
SC Workers' Compensation Commission
P. O. Box 1715
Columbia, South Carolina 29202-1715

E. Ros Huff, Jr., Esquire
Huff Law Firm, LLC
P.O. Box 1935
Irmo, SC 29063

Erin M. Wiedel

Rock Hill, South Carolina

ACCIDENT REPORT

(Report # 090602LEE
Bondex Report # 09/2-2

BONDEX INC.
ACCIDENT REPORT

DATE: 6-2-9 **TIME:** 9:25 pm

EMPLOYEE'S NAME: Bernard Lee

DESCRIPTION OF ACCIDENT:
Employee Stated he was trying to help install the front Top door on the #3 Coat machine, by Lifting it with his hands And Shoulder. He said he guess he was pushing to hard on the door, and he said he damage his Left Shoulder and Neck, he Stated he was in A lot of PAIN, with pain Also going down his back.

TREATMENT:
Took Goody Powder, and Rub with BIO Freeze Pain Relieving Gel.
Sent to University Hospital ER at 1:45 am

WITNESSES:
Tom Harrison

SUPERVISOR'S SIGNATURE: Lowell M. Sh.

00001

UNIVERSITY HOSPITAL

University Health Care System
Emergency Services
1350 Walton Way
Augusta, GA 30901
706-774-5060

Final

Emergency Department Chart

Patient Name: LEE, BERNARD D.	Account Number: 0003001309154
Medical Rec. Number: 000300130	Birthdate: 04/30/1980
Arrival Date: 06/03/2009 03:04	Primary MD.
Visit Date: 06/03/2009 03:08	

Chief Complaint

Soft tissue injury to left scapular area. (KGA 06/03/2009 03:08)

Clinician History of Present Illness

PT STATES THAT A HOOD FROM A MACHINE FELL AND HIT HIS LEFT SHOULDER. (KGA) 06/03/2009 03:08 Exam started at 03:34 Presenting problem started 3 hours ago. History comes from patient. Have reviewed and agree with RN note. Source is a poor historian. Patient was injured by machine hood fell on his shoulder. No history to suggest any head injury. The patient states that this problem is job related. Problem occurred at machine hood fell and struck the patient in the left upper shoulder about 9pm. sent for workmans comp. (SMT) 06/03/2009 03:34

Non-Pharmacy Orders

X-Ray of left shoulder
Entered (SMT 06/03/2009 03:27) Secretary Entered (MN1 03:33) In Progress (MLC2 03:28) Completed (MLC2 04:01) MD Sign (SMT 03:27) Indications: Arm injury Arm pain
sling left arm.
Entered (SMT 06/03/2009 03:59) Secretary Entered (MN1 04:02) In Progress (MLC2 04:01) Completed (MLC2 04:12) MD Sign (SMT 03:59)

Vital Signs/Data

Time	Temperature	Pulse	Respiration	Blood Pressure	Pulse Oximetry	Pain
03:08	36.7 C Oral	77 /min	22 /min	136/82 mm hg.	100% on Room air	5/10
05:18		77 /min	20 /min	131/78 mm hg.		6/10

Pre-Hospital Treatment

Patient arrived by private transportation. (KGA) 06/03/2009 03:08

Triage

4 Less Urgent (KGA 06/03/2009 03:08)
No language barrier. (KGA 03:08)
History comes from patient. (KGA 03:08)
Presents with acute injury. (KGA 03:10)
Patient was struck by a HOOD. (KGA 03:10)

Current Medications

Patient takes no medications. (SMT 06/03/2009 03:34)

Nursing Assessment

GENERAL
NEGLECT/ABUSE: Survey shows NEGATIVE risk for this patient. (KGA) 06/03/2009 03:08

Nursing Continuation Notes - Refer to Order

Sling fitted and applied to left arm, adjusted to comfort. Distal CMS intact post application. (MLC2 06/03/2009 04:54)

00002

University Health Care System
Emergency Services
1350 Walton Way
Augusta, GA 30901
706-774-5060

Emergency Department Chart

Patient Name: LEE, BERNARD D.	Account Number: 0003001309154
Medical Rec. Number: 000300130	Birthdate: 04/30/1980
Arrival Date: 06/03/2009 03:01	Primary MD:
Visit Date: 06/03/2009 03:08	

Past Medical and Surgical History

No significant past medical history. Has no prior surgeries. (SMT) 06/03/2009 03:34

Review of Systems

Except as noted all other ROS negative. Except as noted all other ROS negative. (SMT) 06/03/2009 03:34

Social History

is a non-smoker. Denies use of alcohol. Patient is not employed. Does not take any drugs. (SMT) 06/03/2009 03:34

Family History

No relevant family history related to current problem. (SMT) 06/03/2009 03:34

Physical Exam

GENERAL:
This is a well developed well nourished alert adult male. He does not appear to be acute distress. No evidence of significant external trauma. Vital signs OK. (SMT) 06/03/2009 03:34

PULMONARY:
Unlabored respiration No respiratory distress. No evidence of local chest wall tenderness or external injury. (SMT) 06/03/2009 03:34

ABDOMEN:
Soft abdomen. No external trauma. No local tenderness. (SMT) 06/03/2009 03:34

NEUROLOGIC:
Symmetric reflexes normal strength and tone. Good coordination. (SMT) 06/03/2009 03:34

MUSCULOSKELETAL:
Normal cervical spine exam with full ROM. No bony or significant soft tissue tenderness. No significant muscle spasm. Soft tissue of the anterior neck is OK. (SMT) 06/03/2009 03:34

SKIN:
The skin over the neck is intact without evidence of laceration or significant abrasion. (SMT) 06/03/2009 03:34

SOFT TISSUE:
The rest of the soft tissue exam is normal. (SMT) 06/03/2009 03:34

Diagnosis

shoulder contusion - SMT

Soft tissue injury left scapular area (SMT 06/03/2009 03:57)

Results

X-Ray of left shoulder - this film was independently interpreted by me as the initial reviewer. (SMT 06/03/2009 03:57)
No radiographic evidence of acute fracture (SMT 03:57)

University Health Care System
Emergency Services
1350 Walton Way
Augusta, GA 30901
706-774-5060

Final

Emergency Department Chart

Patient Name: LEE, BERNARD D.	Account Number: 0003001309154
Medical Rec. Number: 000300130	Birthdate: 04/30/1980
Arrival Date: 06/03/2009 03:04	Primary MD:
Visit Date: 06/03/2009 03:08	

Disposition

Patient discharged from department. Condition at discharge - stable. I have reviewed the chart of BERNARD DERRICK LEE and it is ready for final disposition - STEVEN M TIERNAN MD. (SMT) 06/03/2009 03:57 Patient discharged from department. Discharged home. Patient left by self. Verbalizes understanding of after-care instructions. Verbalizes understanding of need for follow-up and how to access follow-up care. Verbalizes understanding of signs and symptoms to return to ED. Discharge instructions given to patient A disposition has been done for BERNARD DERRICK LEE. The dispositioning nurse is MARTHA LANELL COBB RN (electronic signature). Patient removed from Tracking Board by MARTHA LANELL COBB RN. (MLC2) 06/03/2009 05:20

Discharge Prescriptions

Skelaxin 400 mg PO PRN [muscle pain/spasm] (40) (SMT 06/03/2009 03:57)
Ibuprofen 800 mg PO [every 8 hours] (30) (SMT 03:57)

Discharge Instructions

IBUPROFEN
Your doctor has prescribed ibuprofen for you. Examples of this drug include: Advil, Midol 200, Medipren, Motrin, and Nuprin. Ibuprofen helps reduce pain and inflammation. It can be is used for injuries, fever, arthritis, bursitis, tendonitis, and menstrual cramps. This medicine is most effective when it is taken on an empty stomach, but if it causes stomach upset, take it with meals, milk, or antacids. Ibuprofen comes in tablets and as a suspension (Children's Advil, PediaProfen) which can be used for fever and pain in children. Short term pain treatment with ibuprofen is very safe and effective in most people. However, ibuprofen is not safe to take if you are pregnant or if you have an allergy to aspirin. The most common side effects of treatment are: heartburn, nausea, drowsiness, and headache. Be sure you know how you react to your medicine before you drive a car or operate dangerous equipment. Avoid aspirin while taking Ibuprofen to help reduce stomach irritation. Call your doctor or go to the emergency room right away if you have any of the following symptoms:

- *Allergy reaction (itching, rash, hives, fever, breathing problems).
- *Severe stomach pain, vomiting, black or bloody stools.
- *Severe headache, blurred vision, confusion, mental depression.

SKELETAL MUSCLE RELAXANTS
Your doctor has prescribed a muscle relaxant for you. Examples of these drugs include Flexoril, Norflex, Skelaxin, Soma, and benzodiazepine drugs. They are usually prescribed to help reduce painful muscle spasms and improve motion in neck and back injuries. They are most effective for a brief period after an injury, because muscle spasm does not usually last a long time. These medicines add to drowsiness associated with taking pain pills, antihistamines, or tranquilizers, and with drinking alcohol. We advise you not to drive a car or operate dangerous equipment while taking this medicine. Besides drowsiness the common side effects include dry mouth, dizziness, mental depression. Muscle relaxants should not be taken during pregnancy. Contact your doctor right away if you have any allergy symptoms (itching, rash, hives, fever), excessive sedation, or other troublesome side effects.

X-RAY STUDIES
You have had x-ray studies done today as part of your medical evaluation. These x-ray films have been examined by your doctor. They will also be checked by a radiology specialist and a report is available for your doctor. You will be called if a review of your x-rays shows that further examinations or treatment are needed. Please call your doctor if you have any questions about your x-ray results.

Staff Legend
KGA KEITH ALBERT RN
MLC2 MARTHA COBB RN
SMT STEVEN TIERNAN MD

00004

UNIVERSITY HOSPITAL
An Affiliate of University Health Care System

LEE, BERNARD DERRICK
04/30/80 29Y BM ERWR -
300 130 0003001309154
ENG MED AUGUSTA, PHYSICIAN

WORKER'S COMPENSATION FLOWSHEET

BREATHALIZER (CALL 706/303-2760) YES ___ ACCESS INITIALS _____

PATIENT REQUIRES BLOOD/ALCOHOL TEST ___YES ___NO TEST REQUIRED

PATIENT REQUIRES DRUG SCREEN ✓YES ___NO 10P-6

IF DRUG SCREEN or ALCOHOL TEST IS REQUIRED, Dismissal/Nurse/Transport escorts patient to the laboratory with paper work, i.e. copy of E.R. chart face sheet.

DATE 6-03-09

PATIENT NAME Lee, Bernard MEDICAL RECORD NBR 300-130

EMPLOYER NAME Bordex Inc

EMPLOYER ADDRESS Two Maxwell Dr. Trenton SC 29847

COMPANY PHYSICIAN OCC-med MEDICAL REVIEW OFFICE _____

✓ 1. Triage nurse identifies as on-the-job injury.

✓ 2. Registrar verifies workers' compensation.

✓ 3. Registrar ascertains contact person.
NAME Albert Martin PHONE NUMBER 803-663 1922

___4. Patient Representative is notified.

___5. Patient Representative calls company contact person.

___6. Physician completes E.R. record, follow-up recommendations and Medical Treatment Form.

___7. Nurse dismisses patient according to E.R. standards

___8. Dismissal/admitting nurse calls the respective company contact person to give a brief synopsis of the findings, treatment and recommendations.

___9. Dismissal nurse prepares required papers and sends them with the patient. (Check company profile for specifics).

___10. Dismissal registrar completes flowsheet.

___11 If admitted, the Patient Representative calls the employer.

FLOWSHEET COMPLETED BY _____

Form # 0110 Rev. (10/2003) Page 1 of 1 Page

00005

New Physical Profile

Workers Compensation Company Profile

LEE, BERNARD DERRICK
04/30/80 29Y BM ERWB
300 130 P
ENG 0003001309164
MED AUGUSTA, PHYSICIAN G

Mailing Address

Company Name **Bondex Inc**

Carrier Information		Company Information	
Address	**Two Maxwell Drive**	Address	**Two Maxwell Drive**
City	**Trenton**	City	**Trenton**
State	**SC**	State	**SC**
Zip	**29841**	Zip	**29841**
Phone:		Phone:	
Fax	**803-663-9626/Phone: 803-663-1922**	Fax	**803-663-9626/Phone: 803-663-1922**

Workers Comp Verification During Business Hours

Name	Phone	Cell / Pager	Email
Bowers, Nancy	**803-663-1922**		
Williams, Gene	**803-663-1922**		
Waters, Charlie	**803-663-1922**		

Workers Comp Verification After Business Hours

Name	Phone	Cell / Pager	Email
Bowers, Nancy	**803-278-2628**	**803-439-1778**	

Substance Abuse Screening

DRUG SCREENING

Drug Screen Driver	**Yes**	Drug Screen Non-Driver	**Yes**
Drug Test	**IDP6**	Drug Test	**IDP6**

ALCOHOL SCREENING

Alcohol Screen	**Yes**	Alcohol Test	**Breathalyzer**

Special Instructions

Light Duty
Pharmacy
Special Instructions

Referring Physician

1
2
3
4
5
6

Primary Location
South Richmond County

Audit Information

Entered by **Susan Brega 07/06/2004**
Updated by **Susan Brega on 07/06/2004 03:23:54 PM**

00006

University Health Augusta, GA

RADIOLOGY REPORT

LEE, BERNARD
Date of Birth : 04/30/1980
PATIENT ID: 000300130
ACCOUNT NUMBER : 0003001309154
PATIENT LOCATION : ERWR

ORDERING PROVIDER : TIERNAN, STEVEN

REQUISITION NUMBER: B09IC38
DATE INTERPRETED : 06/03/2009

PROCEDURE / CPT CODE	: SHOULDER, LEFT	73030
ORDERING PRIORITY	: STAT	
CLINICAL INDICATIONS	: SHOULDER INJURY	
ORDERING PHYSICIAN	: TIERNAN, STEVEN	
DICTATING RADIOLOGIST	: BULLOCK, M.D., HUEY	

DATE PERFORMED: 06/03/2009 03:45

Left shoulder, three views

Three views show no fracture or dislocation. There is no significant arthritic change. The acromioclavicular joint is normal.

Impression:
Unremarkable left shoulder.
Electronically Signed by BULLOCK, M.D., HUEY
06/03/2009 16:03

00007

DR. JEFFREY BRODER

NORTH AUGUSTA URGENT CARE

Bernard D. Lee
BM-29
NKOR

JUN 5 2009

CC: Injured (L) arm Wed at work c BP.

BP 140/100
WT 192
P 60
T 98.3
R 18

HT 6'0"
Bondex
Substitutes
Cons operator
D.O.I
Wed 6/3/09 @ 9:30pm
@ UHER 6/4/09 1:30AM
Meds
Ibuprofen 800mg TID
Cyclobenzaprine 10mg TID
→ Never filled
PMH
Nerve
Right Hand Dominant

(L) Shoulder pain x 2 days. States he was trying to Bring a Metal Cover down when it got caught, States the Shock gave way and at that time @ Left Shoulder area (2 yrs Ago per pt) States then @ UHER Early th Morning of 6/4/09. States xrays ok, given Sling, given prescription for Ibuprofen & Skelaxin - never filled. Meds States used for a Short Time Ibuprofen does help but not, States he worked Duty to Pain @ R Scapular Chest ; O X ; NAD Alert Sling @ (L) Shoulder - @ Flexion - Pt to Just Below area, @ Elevation FROM - Pain @ Mild Tenderness - Resistance to Abduction mild pain to Left

(R) @ (L) Shoulder pain 7/9/11
- Prayers for Comfort / pain Meds
- Do not Fill Prescriptions for UHER
- Ibuprofen 800mg TID & RSP for pain
- Wait for Xrays to Result
- Fu to Review Xrays & MSK Referral

00008

NORTH AUGUSTA URGENT CARE
FAMILY & OCCUPATIONAL MEDICINE CENTER

Occupational Medicine Program
1201 West Avenue • North Augusta, SC 29841 • (803) 279-1030

PROCESSING FORM

Date 6-5-09

This Section to Filled Out at Company

Employee's Name Bernard Lee Social Security # 251452204 Date of Birth 4/30/86
Company Name Bondex Dept.
Supervisor Name Phone 663-1922 Ext.
Reason for Visit: ☑ On-The-Job Injury ☐ Job Related Illness
☐ Other
Nature of Complaint: lft. arm injury
Time Left Work : AM PM Processed By: M. Frye
Date Injury Occured 6/3/09 Verified By: Nancy Bowers

This Section to be Filled Out by Receptionist at Physician's Office

Time In: 1:40 AM PM Time Out: 4:35 AM PM Date 6-5-09
Disposition: PT MRI pending
☐ Patient May Return to Work Without Restriction
☑ Patient May Return to Work With the Following Restrictions:
(See Codes on Reverse Side.)
A B C D E F G H_R (H_L) I J K L M_R M_L
N O P Q
(Patient Will Contact Supervisor for Evaluation in Performing Alternate Work)
☐ Patient Will be Unable to Work For _____ Days.
(Patient Will Contact Supervisor Within 24 Hours to Report Status)

☐ Patient Referred to Specialist: Ortho
MD
Appointment Date 6-12-09
At 2:00 AM PM
☑ Company Contact Called.
By: M
To: Nancy Bowers
At: 4:26 AM PM

Physician Report and Treatment: Dx: L Shoulder pain
Rx Vicodin 5mg one tab 4 times per day for pain with food
PT visit
Ice x 1-2 days, then moist heat
Rest x 1 week

Physician's Signature 6/5/09 Date

I hereby authorize the Physician and Hospital to disclose the information contained on this form concerning my condition to my employer, and herby release the Physician and Hospital from any liability arising from such disclosure.

Employee's Signature 6/5/09 Date

Instructions:
1. Company fills out top section and retains gold copy. Remaining copies are put in an envelope and given to employee.
2. Employee gives envelope with forms to clerk/receptionist on arrival.
3. After evaluation and treatment, Physician retains pink copy.
4. Yellow copy is mailed to employer the same day of treatment.
5. Employee retains white copy and shows to supervisor on return to work.

00009

RESTRICTION CODES

An explanation of restrictions applying to your employee is included for your reference. Please consider the restriction(s) applicable until your employee has been re-evaluated by one of the physicians at the North Augusta Urgent Care Family & Occupational Medicine Center.

A. No work requiring depth perception, driving, climbing or operating machinery.

B. Keep wound clean and dry until sutures are removed.

C. No stooping, bending or twisting.

D. No lifting greater than 10 lbs.

E. No lifting greater than 20 lbs.

F. No lifting greater than 30 lbs.

G. Sitting work only.

H_R No right handed work.

H_L No left handed work.

I. No work with arms over head.

J. No excessive walking.

K. Must use crutches.

L. Must wear splint.

M_R No gripping, twisting, or forceful turning - right hand.

M_L No gripping, twisting, or forceful turning - left hand.

N. No prolonged sitting or standing

O. No climbing.

P. Medication may cause drowsiness. Should not drive, operate dangerous machinery or be at unguarded heights.

Q. Other - Refer to chart.

00010

Bernard Lee
29 yo Bm
NKDA Cl # 56455128

6-9-09
Mary Shaw calls & approves P.T. referra
thru Align Network IO

6-10-09 8:15
Align Network contacted & Rx faxed
for P.T. referral, they will schedule
w/ Pt. IO

00011

JUN 12 2009

Bernard D. Lee
BM-29
55
NCDA

B/P 144/96
WT 186
P 76
T 98.0
R 15
(R)handed

CC: neck + shoulder pain. AA

Has 1st PT scheduled 6-17-09.
States he cannot take arm out of sling but "too much pain" even though he has tried to stretch free
PS 10/10 "all the time"
Has been taking the naprosyn bid @ muscle relaxant
Restless sleep trying to get in comfortable position

O: alert & NAD smoker wearing sling.
Shoulder Ht ⊜
Mod severe tenderness over (L) trapezius into shoulder base @ scapula
Difficult to abduct @ arm overhead laterally but easier ventrally
MS 4/5 (L) 5/5 (R) @ pulses

DTRI
⊜ lateral

A: (L) shoulder pain 719.41
P: Wear out of sling - left it on
Add skelaxin as given by previous provider
Continue naprosyn as given by Dr Broder
Heat/stretches/exercises as reviewed
Avoid smoking & tobacco
Keep PT appt
RTC same resident as given by Dr Broder
in 1 wk

Candace Waters
MSN, RN, CS, CDE
Nurse Practitioner

00012

NORTH AUGUSTA URGENT CARE
FAMILY & OCCUPATIONAL MEDICINE CENTER

Occupational Medicine Program
1201 West Avenue • North Augusta, SC 29841 • (803) 279-1030

PROCESSING FORM

Date 6-12-09

This Section to Filled Out at Company

Employee's Name Bernard Lee Social Security # 251452204 Date of Birth 4-30-8[illegible]
Company Name Bonded Dept.
Supervisor Name Phone 663 1922 Ext.
Reason for Visit: ☑ On-The-Job Injury ☐ Job Related Illness
☐ Other
Nature of Complaint: Rev
Time Left Work : AM PM Processed By: Mary Faye
Date Injury Occured 6/3/09 Verified By: Nancy Bowers

This Section to be Filled Out by Receptionist at Physician's Office

Time In: 1:51 AM (PM) Time Out: 2:25 AM (PM) Date 6-12-09

Disposition:
☐ Patient May Return to Work Without Restriction
☒ Patient May Return to Work With the Following Restrictions: (See Codes on Reverse Side.)
A B C D E F G H_R H_L I J K L M_R (M$_L$)
N O P Q as given by Dr Broder
(Patient Will Contact Supervisor for Evaluation in Performing Alternate Work)
☐ Patient Will be Unable to Work For _____ Days.
(Patient Will Contact Supervisor Within 24 Hours to Report Status)

~~☐ Patient Referred to Specialist:~~
J. Broder MD
Appointment Date 6-19-09
At 2:30 AM PM
☐ Company Contact Called.
By: cw
To: N Bowers VM
At: 2:30 AM PM

Physician Report and Treatment: (L) shoulder pain not improved Keep PT appts as scheduled. Ice as much as possible. Avoid sling. Stretch as reviewed. Add back for Skelaxin as previously given. Continue Celebrex 200 naproxen as given by Dr Broder for work
Physician's Signature 6/20/09 Date

I hereby authorize the Physician and Hospital to disclose the information contained on this form concerning my condition to my employer, and herby release the Physician and Hospital from any liability arising from such disclosure
Employee's Signature Date

Instructions:
1. Company fills out top section and retains gold copy. Remaining copies are put in an envelope and given to employee.
2. Employee gives envelope with forms to clerk/receptionist on arrival.
3. After evaluation and treatment, Physician retains pink copy.
4. Yellow copy is mailed to employer the same day of treatment.
5. Employee retains white copy and shows to supervisor on return to work.

00013

Bernard D. Lee
Bm-29
NKDA

JUN 19 2009

B/P 100/100
WT 189
P 80
T 98.4
R 15

1st Appt
12 June 09

CC: follow up. AC

Ⓟ 29y/o ♂ here to rf/u ⓒ Shoulder.
Hx MVA impact ~ 8/10, Sharp sev
ⓒ PT x1. - Mild relief
PT Sharp No radiation of injury down arm
Hx Shoulder Mobility limited but No pain
relief.

ⓒ c/s Neck + Hx DJD

ⓒ Shoulder - Flexion: pain
ⓔ Limited: resistance
+ Abduction
Pain +2 Hx
Ⓟ Scaption: Hx + Bur Adhesive
are

Ⓐ ⓒ Shoulder pain 719.41 (Rx Rotator cuff
tear)

Ⓟ - MRI ⓒ Shoulder
- Pharm for Cyclobenzaprine / retain from Celebrex
- Custom Neoprene Sling / ⓐ DIP of
Rx
rtl Ltr

- No ⓒ heavy lifting / Stop Smoking.

00014

NORTH AUGUSTA URGENT CARE
FAMILY & OCCUPATIONAL MEDICINE CENTER

Occupational Medicine Program
1201 West Avenue • North Augusta, SC 29841 • (803) 279-1030

PROCESSING FORM

Date JUN 19 2009

This Section to Filled Out at Company

Employee's Name Bernard Lee Social Security # 251452201 Date of Birth 4-30-80
Company Name Bondex Dept.
Supervisor Name Phone 663-1922 Ext.
Reason for Visit: ☑ On-The-Job Injury ☐ Job Related Illness
☐ Other
Nature of Complaint: Re ✓
Time Left Work ___:___ AM PM Processed By: M. Frye
Date Injury Occured 6-3-09 Verified By: Nancy Bowers

This Section to be Filled Out by Receptionist at Physician's Office

Time In: 2:22 AM PM Time Out: ___:___ AM PM Date JUN 19 2009
Disposition: MRI ⓛ Shoulder - okay'd by Bowers Faxing letter ☐ ~~Patient Referred to Specialist:~~ Ltr Brtr MD
☐ Patient May Return to Work Without Restriction
☑ Patient May Return to Work With the Following Restrictions: (See Codes on Reverse Side.)
A B C D E F G H_R (H) I J K L M_R M_L
N O P Q
(Patient Will Contact Supervisor for Evaluation in Performing Alternate Work)
☐ Patient Will be Unable to Work For ___ Days.
(Patient Will Contact Supervisor Within 24 Hours to Report Status)

Appointment Date 6-26-09
At 9:30 AM PM
☑ Company Contact Called.
By: JH
To: Nancy Bowers
At: 3:19 AM PM

Physician Report and Treatment: Dx ⓛ Shoulder pain (719.71).
ⓟ : Continue Wrap as you are to 2 hrs per day for pain with ice
a. Wear brace for Comfort
c. Ref Ortho if needed

Physician's Signature 6/19/09 Date

I hereby authorize the Physician and Hospital to disclose the information contained on this form concerning my condition to my employer, and herby release the Physician and Hospital from any liability arising from such disclosure.

Employee's Signature 6/19/09 Date

Instructions:
1. Company fills out top section and retains gold copy. Remaining copies are put in an envelope and given to employee.
2. Employee gives envelope with forms to clerk/receptionist on arrival.
3. After evaluation and treatment, Physician retains pink copy.
4. Yellow copy is mailed to employer the same day of treatment.
5. Employee retains white copy and shows to supervisor on return to work.

00815

Bernard Lee
29 40 BM
NRDA

Claim #
090602LEE

6-23-09
Called Nancy Bowers to check status of MRI referral. Stated she would speak w/ Janis Napier in H.R.

Janis calls back & states she spoke w/ Mary Shaw w/ Strategic who approved MRI thru one Call Medical.

6-25-09
8:00 One Call Medical contacted the will call pt & schedule MRI & then fax us appt info D

00016

NORTH AUGUSTA URGENT CARE
FAMILY & OCCUPATIONAL MEDICINE CENTER

PROCESSING FORM

Occupational Medicine Program
1201 West Avenue • North Augusta, SC 29841 • (803) 279-1000

Date 6/26/09

This Section to Filled Out at Company

Employee's Name Bernard Lee Social Security # 251452204 Date of Birth 4/30/80
Company Name Borax Dept.
Supervisor Name Phone 803-1922 Ext. 200
Reason for Visit: ☒ On-The-Job Injury ☐ Job Related Illness
☐ Other
Nature of Complaint: RC √
Time Left Work : AM PM Processed By: Chelsy Smith
Date Injury Occured 6-3-09 Verified By: Nancy Bowers

This Section to be Filled Out by Receptionist at Physician's Office

Time In: 9:32 AM PM Time Out: 10:30 AM PM Date 6/26/09

Disposition:
☐ Patient May Return to Work Without Restriction
☒ Patient May Return to Work With the Following Restrictions:
(See Codes on Reverse Side.)
A B C D E F G H_R (H_L) I J K L M_R M_L
N O P Q
(Patient Will Contact Supervisor for Evaluation in Performing Alternate Work)
☐ Patient Will be Unable to Work For _____ Days.
(Patient Will Contact Supervisor Within 24 Hours to Report Status)

☐ ~~Patient Referred to Specialist:~~
Barker MD
Appointment Date 8/7/09
At 2:00 AM PM
☒ Company Contact Called.
By: [signature]
To: Nancy Bowers
At: 10:30 AM PM

Physician Report and Treatment: Dx' @ Shoulder pain / Elevated Blood Pressure
① Continue Naproxen 500 mg BID for the 2nd prescription
If he has not the evening / return sooner if
& See your family Doctor About High Blood Pressure Meds

[signature] 6/26/09
Physician's Signature Date

I hereby authorize the Physician and Hospital to disclose the information contained on this form concerning my condition to my employer, and herby release the Physician and Hospital from any liability arising from such disclosure.

[signature] 6/26/09
Employee's Signature Date

Instructions:
1. Company fills out top section and retains gold copy. Remaining copies are put in an envelope and given to employee.
2. Employee gives envelope with forms to clerk/receptionist on arrival.
3. After evaluation and treatment, Physician retains pink copy
4. Yellow copy is mailed to employer the same day of treatment.
5. Employee retains white copy and shows to supervisor upon return to work.

00017

NORTH AUGUSTA URGENT CARE

Occupational Medicine Program
1201 West Avenue • North Augusta, SC 29841 • (803) 279-1000

PROCESSING FORM

Date JUL 1 2009

This Section to Filled Out at Company

Employee's Name Bernard D. Lee Social Security # 251452201 Date of Birth 4-30-80
Company Name Bondex Dept.
Supervisor Name Phone 663-1922 Ext. 2020
Reason for Visit: ☑ On-The-Job Injury ☐ Job Related Illness
☐ Other
Nature of Complaint: Rc ✓
Time Left Work ___ : ___ AM PM Processed By: Mary Frye
Date Injury Occured 6-3-09 Verified By: Nancy Bowers / Jenny Wagner

This Section to be Filled Out by Receptionist at Physician's Office

Time In: 1:56 AM PM Time Out: 4:15 AM PM Date JUL 1 2009
Disposition: Continue PT
☐ Patient May Return to Work Without Restriction
☑ Patient May Return to Work With the Following Restrictions: (See Codes on Reverse Side.)
A B C D E F G H_R (H) I J K L M_R M_L
N O P Q
(Patient Will Contact Supervisor for Evaluation in Performing Alternate Work)
☐ Patient Will be Unable to Work For ___ Days.
(Patient Will Contact Supervisor Within 24 Hours to Report Status)

☑ Patient Referred to Specialist: ORTHO
Pending Approval MD
Appointment Date
At ___ : ___ AM PM
☑ Company Contact Called. 803-663-66[illegible]
By: Jenny Wagner
To: Mary Frye
At: 4:40 AM PM

Physician Report and Treatment: Dx: ROTATOR CUFF TEAR
R/O Continue PT
Keep Sling on
NO Skidpan / Continue Naproxen Tramadol 50 Ultram
Physician's Signature Date 7/1/09

I hereby authorize the Physician and Hospital to disclose the information contained on this form concerning my condition to my employer, and herby release the Physician and Hospital from any liability arising from such disclosure.

Employee's Signature 7/1/09 Date

Instructions:

1. Company fills out top section and retains gold copy. Remaining copies are put in an envelope and given to employee.
2. Employee gives envelope with forms to clerk/receptionist on arrival.
3. After evaluation and treatment, Physician retains pink copy.
4. Yellow copy is mailed to employer the same day of treatment.
5. Employee retains white copy and shows to supervisor on return to work.

80018

SPORTS PLUS

PROGRESS NOTES

COMPPN 031309

PATIENT Lee, Bernard DOCTOR Broder

DIAGNOSIS (L) shoulder pain (2) NEXT MD APPT 6/26/09

Date 6/05/09 Total Timed Code Min. ___ Total Treatment Time Min. ___

SUBJECTIVE Pt. stated his back seemed to hurt after last visit "I feel something in other shld. too. I'm not so sure about the E-stim"

OBJECTIVE

___ Interf.	___ min	(2) MH	20 min	(2) CTX/PTX	20	#lbs Int/static	20	___ fluido	___ min		
___ E-stim	___ min	___ manual	___ min	___ ther ex per flow sheet	___ min			___ paraffin			
___ CP	___ min	___ other	___ min	(1) US cont/pulse	8 min	1.8 w/cm2		___ Ionto	___ mA/		

ASSESSMENT: Response to treatment / Goal Status Pt. seemed hesitant about having the E-stim combination treatment 2° TP therefore performed only US tx fraction

PLAN: Pt. to have MRI performed tomorrow; cont. PT once Pt. has results

Therapist Signature: Michelle Maynard PTA

Date 6-29-09 (3) Total Timed Code Min. ___ Total Treatment Time Min. ___

SUBJECTIVE Pt to RTD this Wednesday for results of MRI. Pt reports ↑ (L) shoulder blade/back pain p c-txn last 2 times. Reports most pain felt (L) anterior shoulder.

OBJECTIVE

___ Interf.	___ min	___ MH	___ min	___ CTX/PTX	___	#lbs Int/static	___	___ fluido	___ min		
___ E-stim	___ min	___ manual	___ min	(2) ther ex per flow sheet	15 min			___ paraffin			
___ CP	___ min	___ other	___ min	(1) US cont/pulse	8 min	1.8 w/cm2	1MHz	___ Ionto	___ mA/m		

No soft tissue dysfunction noted (R) UT/lapular mm. (L) ant/post GH jt. mm tenderness (L) ant/post GH jt.

ASSESSMENT: Response to treatment / Goal Status d/cd cont. txn 2° no benefit & possible irritation (L) shoulder. Ad. focus to (L) RTC/GH jt. Moved very slowly on sci-fit. Tolerated addition of exs well.

PLAN: Cont. PT 2x/wk - 3x/wk per POC. May Δ WU to phono NV for RTC involvement/p

Therapist Signature: Paula K. Belton, PT

00019

MAILED
6/19/09

SPORTS PLUS

170 University Parkway • Aiken, SC 29801 • Phone (803) 649-9975 • Fax (803) 649-3357

06/17/2009

PHYSICAL THERAPY EVALUATION

PATIENT: Lee, Bernard
PHYSICIAN: Dr. Broder
DOB: 04/30/1980
DIAGNOSIS: Left shoulder pain.

SUBJECTIVE:
CURRENT HISTORY/MECHANISM: The patient reports that on 06/02/2009 while at work, a 700-pound hood that goes on a machine fell between his neck and left shoulder.
PREVIOUS HISTORY/SURGERY: Surgery for broken bone in the left hand approximately 6 years ago; otherwise, unremarkable.
MAJOR COMPLAINTS: The patient complains of left arm from the shoulder down forearm into hand becomes numb, constant burning left side of neck and shoulder; complains of increased pain with working. The patient reports that he was released about 3 days after injury to return to work, working with right upper extremity only but patient states that now his right side is starting to hurt and his left side is beginning to hurt more. The patient is also having sharp pains in the posterior region of his left shoulder. The patient rates pain in left arm between 7 and 9/10.
ASSISTIVE DEVICE/SPLINT/BRACE: None.
MEDS: Skelaxin. The patient reports he was given that initially at the emergency room then it was changed to Naprosyn and then changed back to Skelaxin.
OCCUPATION/HOBBIES: The patient works at Bondex as a machine operator. The patient has been back to work with limitations on left arm movements since approximately 3 days after initial injury. The patient does state that pain is affecting his sleep. The patient usually sleeps on his back.
DIAGNOSTIC TESTS: The patient reports x-rays were negative.

OBJECTIVE:
The patient is right-hand dominant.
POSTURE/GAIT: Anterior view: Right shoulder elevated. Posterior view: Increased window space right. Lateral view: Increased lumbar lordosis, increased abdominal mass, forward head. Sitting: Forward head, increased thoracic kyphosis.
ROM: Cervical: Within functional limits throughout with increased pulling noted left shoulder with right rotation and right side flexion. Upper extremities: Left shoulder external rotation and internal rotation limited; all motions painful throughout left shoulder testing. Bilateral cervical rotation right at 40%, left at 20%.
STRENGTH: The patient is unable to straighten arm to 90° due to pain. Significant weakness or weak resistance given per patient felt with left shoulder abduction, external rotation and elbow flexion. Grip strength of Jamar level 2: Right equals 131 pounds, left equals 85 pounds.
NEUROLOGICAL: Decreased to light touch throughout left upper extremity. DTR: +2 bilateral biceps and brachioradialis; unable to elicit bilateral triceps.
PALPATION: Increased tenderness upper to mid thoracic spine, left medial and lateral scapular region, left upper trapezius and left anterior glenohumeral joint.
EDEMA/ATROPHY: None noted.

TREATMENT:
The patient received ICTX with moist heat x 15 minutes at 15 pounds with 40-second hold, 20-second rest cycle.

00020

Lee, Bernard 06/17/2009

ASSESSMENT:
The patient is a 29-year-old male status post work injury in which a 700-pound hood fell on his neck and left shoulder. The patient with decreased sensation to light touch, decreased strength and function with left upper extremity, tenderness noted throughout cervical and thoracic spine, left shoulder girdle and anterior left glenohumeral joint.

GOALS:
1. The patient will have WNL left upper extremity ROM and strength to allow for normal function including work activities within 4 weeks.
2. The patient will rate pain at 0/10 at worst to allow for normal functional activities within 4 weeks.
3. The patient will be independent with HEP to prevent re-injury within 4 weeks.
4. The patient will return to normal ADL function with left upper extremity including work activities within 4 weeks.

Rehabilitation potential is good.

PLAN:
PT 2-3 x a week x 4 weeks for ICTX with moist heat, ultrasound versus phonophoresis, electrical stimulation, manual therapy and therapeutic exercises/HEP.

Thank you for your referral of Bernard Lee. If you have any further questions regarding this treatment plan, please feel free to contact me.

Paula K. Bolton, PT

nd

00021

PATIENT EVALUATION WORKSHEET

_____See attached addendum

SUBJECTIVE:

Current History / Mechanism: Pt states 100 lb hood fell on a machine fell between his neck + (L) shoulder June 2, 2009 (Tues.)

Date: 6-17-09
Patient: Lee, Bernard DOB: 4-30
Physician: Dr. Broder
Diagnosis: (L) shoulder pain
Frequency:
Next MD appointment: 6-19-09

Previous History / Surgery: SX for broken (L) hand bone ~ 6 yrs. ago

Pain Rating

Major Complaints: C/o (L) forearm + hand numbness/tingling constant 1-2-3-4-5-6-7-8-9-10 burning (L) side neck + shoulder. C/o ↑ pain c working. now (R) side is starting to hurt. sharp pains post. (L) shld.

Asst. Device / Splint / Brace: Ø

Medication: Skelaxin initially, Δ to Naprosyn → then was told to start back c Skelaxin.

Occupation / Hobbies: Pt works @ Border as a machine operator. Pt has been back to work (limited (L) arm movements) since ~ 3 days p initial injury. Pain affects sleeping, pt sleeps on back

Diagnostic Tests: x-rays (L)

OBJECTIVE: (R) hand dom.

Posture / Gait: Ant: (R) shldr. elevated, Post: ↑ wnd. space (R)
Lat: ↑ lumb. lord, ↑ abd. mass, FH, Sitting: FH, ↑ thor. kyph.,

ROM: Cervical: Lft throughout c ↑ pulling (L) shldr. c (R) rot + side ✓
(L) shldr: ER & IR limited, all motions painful (L) shldr.

Goniometer: (R) @ 40° (L) @ 20°

Special tests:

Strength: Pt unable to straighten arm (flex to 90°) 2° pain. Weakness / or weak resist: Felt c abd, ER and elbow ✓

Level 2
Grip: (R) = 131 # (L) = 85 #

Neurological: ↓ to LT throughout (L) UE
DTR: +2 (R) biceps + brachioradialis / unable to elicit (R) triceps

Palpation: ↑ tenderness upper / mid - + rsping (L) medial / lat scapula, UT, (L) ant G-H j't

Edema / Atrophy: None noted

ICT x c MH
40/20
15# x 15min

Precautions: NKDA

00022

PT/OT PROGRESS NOTES

COMPPN 031309

PATIENT Lee, Bernard DOCTOR Broder

DIAGNOSIS (R) shoulder pain NEXT MD APPT 6-19-09

Date 6-17-09 Total Timed Code Min. Eval Total Treatment Time Min. —

SUBJECTIVE Eval dictated

OBJECTIVE

Pain 6 40/20

___ Interf.	___ min	(2) MH	15 min	(2) CTX/PTX	15	#lbs Int/static	15	___ fluido	___ mi
___ E-stim	___ min	___ manual	___ min	___ ther ex per flow sheet	___ min			___ paraffin	
___ CP	___ min	(1) other Eval	___ min	___ US cont/pulse	___ min			___ Ionto	___ mA

ASSESSMENT: Response to treatment / Goal Status Pt is a 39 y/o ♂ s/p work injury in which a tool fell on his neck & (R) shoulder. Pt c/ soreness to LT UE strength and function c (L) UE, Tenderness c thoracic/cervical/thoracic spine, (R) shoulder girdle and anterior (R) chest. Goals: 1. Pt will have WNL (L) UE ROM and strength c/n 4wks. 2. Pt will rate pain @ 0-2/10 @ work c/n 4wks. 3. Pt will be (I) c HEP c/n 4wks. 4. Pt will return to normal ADL function c (L) UE incl. work activities c/n 4wks. Rehab pot. is good.

PLAN: PT 2-3x/wk x 4wks for ECTx c MH, US v. pheno, e-stim, manual therapy and ther ex/HEP

Therapist Signature: Renee K. Bolton, PT

Date 6-23-09 Total Timed Code Min. (1) Total Treatment Time Min. —

SUBJECTIVE Pt reports ↑ pain + swelling/numbness (L) hand and arm p work. Pt worked heavy task right hand/wrist work tonight. Pt is unable to perform work c/ sx. (R) UE 9/10 pain (R) side of neck now. RTO this Friday. Pt instructed to call Dr. Broder to inform him of the ↑ in symptoms. Pt to have MRI scheduled. RN & S 40/20

OBJECTIVE

___ Interf.	___ min	(2) MH	20 min	(2) CTX/PTX	20	#lbs Int/static	20	___ fluido	___ min
(1) E-stim EMA c/s	10 min	___ manual	___ min	___ ther ex per flow sheet	___ min			___ paraffin	
___ CP	___ min	___ other	___ min	(1) US cont/pulse	10 min			___ Ionto	___ mA/m

E-stim 1.5w/cm² 1 MHz (2) side-lying, 4T ↑ (L) hand swelling (mild) noted.

ASSESSMENT: Response to treatment / Goal Status Held off ex today, 2° ↑ sx.

PLAN: Cont PT 2-3x/wk for modalities / manual tx as indicated. Will await MD visit to progress to active ther ex. May add gentle stretching NL

Therapist Signature: Renee Bolton, PT

00023

ACC'T #/DOB 4/30/80

Patient Portion ⊗

Frequency/Duration 2-3x/wk

Authorized Treatment

REHABILITATION RECORD

Max. Benefits _____ Deductible/Remaining _____

Misc. Notes: _____

Initial Therapist

Paula (Cor Michele)

Date of Visit	Therapist	PE - PT Evaluation R - Re-eval	OE - OT Evaluation R - Re-eval	TP - Therapeutic Procedure	N - Neuromuscular Reeducation	G - Gait Training	O - Orthotics / N - Night Splint	TA - Therapeutic Activity (funct'l)	W - Work Hardening initial 2 hours	W+ - Work Hardening add'l hours	M - Manual Therapy Tech	B - Biodex Exercise	BT - Biodex Test	H - Hot Pack	C - Cold Pack	E - Electrical Stimulation	WP - Whirlpool	PT - Pelvic Traction	F - Fluido	I - Iontophoresis	CT - Cervical Traction	U - Ultrasound	P - Paraffin	D - Debridement/Dressing	T - Tens Fitting	S - Supply	Ph - Physical Performance Test	Patient Portion Due	Patient Portion Paid -	Initials
1st																														
6-23-09	63													H,	E,			CT,				U,								
6-25-09	132													H,				CT,				U,								
6-29-09	63			TP										C,								U,								
7-1-09	132			TP																		U,								
7-7-09	132			TP											E,							U,								
7-9-09	132			TP											E,							Ph,								
8th																														
7-28-09	63	R,																												
16th																														

486
Friday, July 30, 2010 (16).max

PROGRESS NOTES

COMPPN 031309

PATIENT Lee, Bernard DOCTOR Broeder

DIAGNOSIS (L) shld (P) NEXT MD APPT

Date 7/1/09 Total Timed Code Min. (9) Total Treatment Time Min.

SUBJECTIVE no changes per pt. report "I do get headaches @ times"

OBJECTIVE

___ Interf.	___ min	___ MH	___ min	___ CTX/PTX	___ #lbs Int/static	___	___ fluido	___ min
___ E-stim	___ min	___ manual	___ min	(1) ther ex per flow sheet	15 min		___ paraffin	
___ CP	___ min	___ other	___ min	___ US cont/pulse	___ min		___ Ionto	___ mA

ASSESSMENT: Response to treatment / Goal Status Pt. s changes since beginning PT; only 1 c/o (P)

PLAN: awaiting MRI results; cont per MD

Therapist Signature: Michelle Maynard PTA

Date 7/7/09 Total Timed Code Min. (5) Total Treatment Time Min.

SUBJECTIVE pt. not sure what the MRI results were "they are going to send me to a specialist"

OBJECTIVE

(3) Interf.	15 min	___ MH	___ min	___ CTX/PTX	___ #lbs Int/static	___	___ fluido	___ min
___ E-stim	___ min	___ manual	___ min	(1) ther ex per flow sheet	15 min		___ paraffin	
2 (rt) (2) CP	___ min	___ other	___ min	(2) US cont/pulse	8 min 1.8 w/cm²		___ Ionto	___ mA/n

ASSESSMENT: Response to treatment / Goal Status Please see Alignetworks Progress note

PLAN: cont. per POC until pt. to see specialist

Therapist Signature: Michelle Maynard PTA

00025

ALIGNETWORKS

We have not received a recent progress summary in two weeks. Please fax this back to 904-309-8942.

FAXED 7/7/09

Patient Progress Note

Provider Name: Clemson Sports Medicine and Rehab (RAN)
Today's Date: Jul 6 2009 8:30PM
DOB: 04/30/1980
Eval Date: 6/17/2009 10:00:00 AM
# of visits auth from eval: 12
Diagnosis: Shoulder Joint Pain
Guideline: 12

Patient's Name: Bernard Lee
Claim #: 564551282
Surgery Date:
RX. Expiration Date:

Service: Physical Therapy

Last DOS: 7-1-09 # Of Visits seen from Eval: 5 # of CX/NS Visits: 0

Patient has met 0 % Goals from Evaluation

AROM/PROM Joint:	Eval Date __/__/__	Re-Assess: __/__/__	Re-Assess: __/__/__
PAIN LEVEL			

STRENGTH Joint:	Eval Date __/__/__	Re-Assess __/__/__	Re-Assess __/__/__

Progress toward work related goals: pt has made 0 progress towards goals; able to tolerate AProm exer. & light resistive exer.

Remaining Deficits: pt still c c/o (P) throughout (D) shld. & now c/o (P) in cervical region & midback region

New Goals: same as initial evaluation; pt had MRI although he doesn't recall results of the MRI

Summary of treatment provided: ther-ex, ultrasound, interferential current

Recommendations:

☐ _____ **Visits remaining, cont. POC**

☐ **Add'l Auth Requested to Continue therapy** _____ **x wk for** _____ **wks**

☐ **Follow up with MD and continue per MD Recommendation**

☐ **Discharge** _____ **% Goals Met** ☐ **D/C – poor compliance** ☐ **D/C – plateau – f/u MD**

Plan for D/C?	< 2 wks	2-4 wks	4-6 wks	>6 wks	D/C expected within current or requested auth? Y/N
	☐	☐	☐	☐	

Summary of Communication with MD: _____

Therapist Name: Michele Maynard PTA Signature: Michele Maynard PTA Date: 7-1-09

00026

7

PROGRESS NOTES

COMPPH 031309

PATIENT Lee, Bernard DOCTOR Broeker

DIAGNOSIS (L) shld. (P) NEXT MD APPT

Date 7/9/09 Total Timed Code Min. (6) Total Treatment Time Min.

SUBJECTIVE Pt. brought in MRI report today
Pt. reports the e-stim didn't bother him last time

OBJECTIVE

(3) Interf.	30 min	MH	min	CTX/PTX	#lbs Int/static	fluido	ml
E-stim	min	manual	min	(1) ther ex per flow sheet	20 min	paraffin	
CP	min	other	min	(2) US cont/pulse	8 min	ionto	m/

phono 1.8 w/cm²
(L) shld.

ASSESSMENT: Response to treatment / Goal Status ↓difficulty assessing pt.'s (P) levels and/or benefit from attempting phono in conjuction c IFC to ↓ inflammation. Pt. c/o (P) c standing, scaption. Tolerated ↑ resistance c fatigue

PLAN: assess benefit of phono @ IV

Therapist Signature: Michelle Maynard PTA

Date 7-14-09 Total Timed Code Min. (7) Total Treatment Time Min.

SUBJECTIVE Pt cont. to c/o pain, states his whole (L) side is "messed up". "Now my (L) shoulder is hurting". C/o sharp pain every time he takes a deep breath. "Will I ever be able to lift anything heavy again".

OBJECTIVE

Interf.	min	MH	min	CTX/PTX	#lbs Int/static	fluido	min
E-stim	min	(3) manual	10 min	(1) ther ex per flow sheet	20 min	paraffin	
(4) CP	15 min	other	min	(2) US cont/pulse	5 min	ionto	mA/

50% phono 1.8 w/cm², 1mHz

(L) wall CH; +/- biceps tend

3) Rm (L) SL + AL ↓t., Prom

ASSESSMENT: Response to treatment / Goal Status Tol Rx well, moved slowly c SLI fit

PLAN: Pt to see orthopedist this Thursday, needs to R/S PT appt

Therapist Signature: Pamela K. Bolton PT

00027

SPORTS PLUS +

PHYSICAL THERAPY SERVICES

Physician Follow Up / Re-Evaluation / Discharge

Date: 7-28-09 Physician: Dr. Brooks / Dr. Bethea

Patient Name: Lee, Bernard DOB: 4-30-80 Initial Eval. Date: 6-17-09 Last Visit: 7-28-09

Diagnosis: left shoulder pain / mechanical upper back / neck pain Number of Visits: 9

Patient's treatment has consisted of:

Ther ex / HEP, manual therapy for (L) shoulder, added MET for possible (L) subluxed 1st rib, STM/FM to (L) side c-spine (L) pectoralis major + minor mm and FM to (L) SC + AC jts. on 7-28-09 tried IFC x c MH, US c e-stim and pulsed phase c no success. Have also tried IFC.

Objective Measurements/Progress: Pt c same pain level of 7-9/10, constant and sharp. Pt c/o inability to perform full breath occasionally. (L) shoulder AROM (supine) & V = 80°, Abd = 90°, FE = 30°, IR = 65°. Pt c ~20° ↑ (L) shoulder V + Abd PROM and (L) shoulder FE + IR are full passively. Pt c significant soft tissue restriction of (L) pectoralis major + minor mm c-spine and jt. restrictions @ (L) SC + AC jts.

Assessment/Progress: Pt has had no benefit thus far c PT. Pt most likely c mechanical back, shoulder and neck pain 2° traumatic injury. Initiated manual therapy to address these issues on 7-28-09. Pt should respond more positively c this new approach.

Plan/Goals/Reason for DC:

Cont PT 2-3x / wk for manual therapy as indicated for myokinematic, arthrokinematic dysfunction of neck, (L) shoulder, thoracic spine and costal cage. Modalities including US and e-stim as needed.

Thank you very much for this referral. Please feel free to contact our clinic if you have any questions or concerns regarding this patient's treatment.

New MD orders or written comments: **Frequency & Duration:**

Therapist signature: Brooke K. Boston, PT MD signature:

00028

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PROGRESS NOTES

COMPPH.031309

PATIENT Lee, Bernard DOCTOR Broder

DIAGNOSIS (L) shld. pain NEXT MD APPT 7-30-09

Date 7-28-09 Total Timed Code Min. Re-eval Total Treatment Time Min. _____

SUBJECTIVE Pt saw orthopedist. x-ray of back & neck taken. Pt to return this Thursday. Pt still on light duty, not using (L) arm. Pt states he is having a hard time keeping up

OBJECTIVE c work sch using one arm. Pt still standing up 2 hrs. Pt c/o LE pain up to neck, can't lift (L) arm c constant sharp pain around (L) shoulder joint. Pt still c/o 7-9/10 pain.

_____ Interf. _____ min _____ MH _____ min _____ CTX/PTX _____ #lbs Int/static _____ _____ fluido _____ ml

_____ E-stim _____ min _____ manual _____ min _____ ther ex per flow sheet _____ min _____ paraffin

_____ CP _____ min (1) other Re-eval _____ min _____ US cont/pulse _____ min _____ Ionto _____ mA

Pt has been using ice @ home. Pt can't sleep @ night. 2° the pain.

(L) shoulder AROM: (supine): √=80° c ↑pain Abd = 90, Ele = 30° IR = 105°

↑ROM c passive movement ~20 more degrees c √ + Abd, ↑ROM c passive ELEV c capsular end-feel.

ASSESSMENT: Response to treatment / Goal Status See re-eval

PLAN:

Therapist Signature: Paula K. Bolton, PT

Date _____ Total Timed Code Min. (1) Total Treatment Time Min. _____

SUBJECTIVE _____

OBJECTIVE

_____ Interf. _____ min _____ MH _____ min _____ CTX/PTX _____ #lbs Int/static _____ _____ fluido _____ min

_____ E-stim _____ min _____ manual _____ min _____ ther ex per flow sheet _____ min _____ paraffin

_____ CP _____ min _____ other _____ min _____ US cont/pulse _____ min _____ Ionto _____ mA/

ASSESSMENT: Response to treatment / Goal Status _____

PLAN: _____

Therapist Signature: _____

00029

UNIVERSITY OPEN MRI

UNIVERSITY
OPEN MRI

PATIENT: Lee, Bernard
SSN: 2204
DOB: 04/30/1980
EXAM DATE: 06/26/2009
REFERRING PHYSICIAN: Jeffrey Broder, MD

MRI LEFT SHOULDER

HISTORY: Injury, possible rotator cuff tear.

FINDINGS: There is AC joint arthropathy. There is medial arch impingement of a mild degree. There is fluid in the biceps tendon sheath. The tendon appears to be intact. There is no bone edema or fracture. There is no specific evidence for rotator cuff tear.

CONCLUSION:
Acromioclavicular joint arthropathy with mild impingement. Bicipital tendonitis.

Richard Six M.D. Southeast Radiology, PA

D: 06/29/2009/Job#: 4821238
T: 06/29/2009 16:19:43/228646/Doc#: 3878347
Copy:
Document authenticated by Richard Six M.D. Southeast Radiology, PA. on 06/30/2009 09:48:31 ET

00030

DR. JAMES BETHEA

COLUMBIA ORTHOPAEDIC

SPECIALISTS

Columbia Orthopaedic *Specialists, LLC*
1301 Taylor Street, Suite 3-O
Columbia, SC 29202-0306

DATE: 07/16/09

PATIENT: Bernard D. Lee
SSN: 251-45-2204

CHIEF COMPLAINT: Left shoulder, neck and back pain.

PRESENT ILLNESS: This is a 29-year-old male, who states that he was involved in an accident at work June 2nd, 2009, in which he injured his left shoulder, but also his neck and lower back. In the early morning of June 3rd, 2009 he was seen at the emergency room in Augusta, where he was diagnosed with a shoulder contusion. Shoulder x-rays were negative and he was prescribed Skelaxin and ibuprofen.

Following that he states that he was seen by Dr. Broder five or six times. According to the notes provided to me, Dr. Broder saw him June 5th and prescribed naproxen and physical therapy. June 12th Dr. Broder noted no improvement in his left shoulder and Skelaxin was also prescribed.

Six or seven sessions of physical therapy have been completed so far without any real benefit and he does continue with these treatments twice a week.

Today he was kindly sent here for consultation.

A deep breath makes his pain worse. After standing 30-60 minutes he does have more pain. Walking can be uncomfortable. He knows that he can lift about 15 lb.

Skelaxin did help him, but his employer told him to stop taking it if he wanted to work.

The pain does radiate to his left hand.

He states that at work he is being asked to do more than he can perform.

Numbness in the left hand was mentioned. Pain radiates to the left hand. Sleep is a problem. Even bathing is a problem. He denied any previous episode.

PAST MEDICAL HISTORY: His only medication is naproxen, which he does take twice a day. No drug allergy or previous surgery was mentioned.

PHYSICAL EXAMINATION: General appearance is that of a pleasant 6'0" 186 lb. male with a normal station and gait. There was some tenderness at his left trapezius. Active flexion of the left shoulder was limited to 70° and active abduction was limited to 70°. External rotation and internal rotation were both possible to 90°. O'Brien's test, Speed's test, cross body adduction, apprehension maneuver and the impingement test were all negative. Distal neurovascular status was intact.

At the lumbar spine he had 100° of flexion with 30° of extension. Lateral bending was possible to 30° in either direction and lateral rotation was possible to 60° either to the right or left. Distal neurovascular status was intact in both the upper extremities and lower extremities. Straight leg raising was negative.

At the cervical spine he had at least 30° of lateral rotation in either direction with the maneuver to the right more uncomfortable. Flexion was possible to 60°, extension was possible to 30°. Lateral rotation was possible to 30° either to the right or left.

RADIOGRAPHS: AP and lateral x-rays of his cervical spine failed to reveal any evidence of any injury. AP and lateral x-rays of his lumbar spine were normal. Three x-rays of his left shoulder done June 3rd were reported as showing no significant pathology.

MRI SCAN: Multiple images of his left shoulder done June 26th, 2009 revealed AC joint arthropathy with mild impingement, as well as tendinitis of the biceps.

IMPRESSION:

1. IMPINGEMENT SYNDROME LEFT SHOULDER.
2. NECK AND BACK PAIN.

DISPOSITION: Under sterile technique, I did inject the left shoulder subacromial space with 40 mg Depo-Medrol and 2 cc 2% Xylocaine.

I do want him to continue with his physical therapy for his left shoulder.

I reassured him that the neck and back pain do not represent any serious injury.

For now he will limit pushing, pulling, lifting and carrying with his left upper extremity to 15 lb. He is not allowed any overhead work with his left upper extremity.

I did dispense (#60) 500 mg naproxen to be taken one twice a day on food.

I will see him back in about two weeks.

James F. Bethea, M.D.
JFB/prf

(Next Appointment 07/30/09 @ 3:00 p.m.)

Cc: Strategic Comp Services
Att: Steve Anthony
P.O. Box 1445
Alpharetta, GA 30009

JUL-23-2009 11:44 From:8038068178 COLUMBIA ORTHOPAEDIC Page:4/4

Columbia Orthopaedic Specialists, LLC
P.O. Box 306
Columbia, SC 29202-0306
803.806.8198
803.806.8176

WORK STATUS

DATE: 7/16/09

PATIENT: Bernard Lee

____ REGULAR DUTY DATE TO RETURN TO WORK ____

__/__ LIGHT DUTY DATE TO RETURN TO WORK 7/16/09

____ REMAIN OUT OF WORK APPROX. DURATION ____

PHYSICAL LIMITATIONS:

____ NONE
____ NO WALKING OR CLIMBING
____ NO STANDING
____ NO PROLONGED STANDING
____ NO SITTING
____ NO BENDING OR STOOPING
____ NO TWISTING OR STRETCHING
____ NO CHANGE FROM PREVIOUS STATUS
____ OTHER: ____

__/__ PUSHING&PULLING LIMIT 15 LBS
__/__ LIFTING&CARRYING LIMIT 15 LBS
____ SEDENTARY DUTIES ONLY
____ NO KNEELING, SQUATTING, CRAWLING
____ NO WORK INVOLVING R/L ARM/HAND (L arm)
__/__ NO OVERHEAD WORK
____ NO WORK AT HEIGHTS

FOLLOWUP:

__/__ 14 DAYS ____ MONTHS
____ WEEKS ____ PRN(AS NEEDED)
____ DISCHARGED

____ NEXT APPOINTMENT ____

PHYSICIAN SIGNATURE

JAMES F. BETHEA, M.D.

www.OrthoDoc.aaos.org/JimBethea

00034

AIKEN REGIONAL MEDICAL CENTER

Date 7/18/09 Arrival Time 1839 Mode of Arrival: ☐ POV ☐ EMS ☐ Ambulatory ☐ Carried ☐ W/C

Name Lee, Bernard DOB 4/8/80

Current Complaint (in patient's own words) "I cut my (R) wrist on a piece of glass"

Name/Title Hall CTT

Triage Time 1845

Communication Assessment:

Primary Language: ☒ English ☐ Spanish ☐ Other

Translation: ☒ N/A ☐ Language Line ☐ Other

Hearing: ☒ No apparent deficit ☐ Wearing hearing aid Vision: ☒ No apparent deficit ☐ Wearing glasses

Allergies NKDA

T 98.4 P 96 R 18 B/P 133/76 SAO_2 97

Pain: Location R palm Scale (0-10) 10/10

LMP — Wt. 190 lbs. ☐ Actual ☐ Stated

Assessment (R) Lower forearm & 2-3 cm laceration w/ glass 1" ago. Unable to move hand - fingers resp. ly.

Triage Level: ☐ 5 ☒ 4 ☐ 3 ☐ 2 ☐ 1 Disposition: ☐ Major ER ☐ Minor ER

Triage Interventions: ☐ Ice ☐ Elevation ☐ Sling ☐ Splint ☐ Bleeding Control ☐ Fever med ☐ ASA (per ACS protocol) ☐ Other Gauze applied

Triage RN Signature

Reassessment: Date Time

Evaluation: ☐ No change from previous assessment ☐ Change(describe)

Action/Intervention

RN Signature Date Time

To ER Room # @ Report to QPI done ☒ yes ☐ no

LWBS: Date Time Reason

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

TRIAGE ASSESSMENT

ER0515 - Triage Form

107662058
LEE , BERNARD D
DOB 04/10/1980 29 SX: M EMR
MRN 177273 ADM/REG DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

AXD

00035

Triple 1/4 2 3/4 c-o-c

Physical Assessment: Time Performed 2010
☒ Head-to-toe ☐ Focused Assessment

Past Surgical History: ☐ Denies any significant surgical history
☐ Appendectomy ☐ Hysterectomy
☐ Cholecystectomy ☐ Tubal Ligation
☐ CABG ☐ Cardiac Stents
☐ Other Nasal sprain (Shand

PMD _____

Past Medical History: ☐ Denies any significant medical history
☐ CAD ☐ CHF
☐ Cancer (type) _____
☐ Diabetes ☐ Asthma
☐ COPD ☐ CVA/TIA
☒ HTN ☐ Hypercholesterolemia
☐ GI Bleeding/Ulcer ☐ Hepatitis
☐ Kidney Stones ☐ Renal Failure
☐ Migraines ☐ Seizures
☐ HIV/Aids ☐ Other _____
Home Oxygen: ☐ N/A _____ L/m via _____

Current Assessment
Pulmonary: ☒ Assessment WNL
Respirations: ☐ Labored ☐ Rapid ☐ Slow ☐ Deep ☐ Shallow ☐ SOB
Breath Snds: ☐ Diminished ☐ Absent ☐ Crackles ☐ Wheezes ☐ Rhonchi
Cough: ☐ Productive ☐ Non productive Sputum _____
Location of abnormalities ☐ Right ☐ Left ☐ Bilateral
Other _____

Cardiovascular: ☒ Assessment WNL
Chest Pain: ☐ Yes ☐ No Describe _____
Heart Sounds: ☒ Regular ☐ Irregular ☐ Muffled ☐ Rub
Pulses: ☐ Not Palpable Location _____
EKG Rhythm _____
JVD ☐ Yes ☐ No

Neurological ☒ Assessment WNL
Responsiveness ☐ Unresponsive ☐ Responds to painful stimuli
Speech: ☐ Slurred ☐ Incoherent ☐ Aphasic
Activity level: ☐ Pacing ☐ Restless ☐ Combative ☐ Sleeping
☐ Seizure Activity
Other _____

HEENT ☒ Assessment WNL
☐ Asymmetrical ☐ Numbness ☐ Paresthesia ☐ Difficulty swallowing
☐ Nystagmus Other _____

Pain:
Score: _____ Location: _____
Scale: ☐ Numeric ☐ Faces ☐ FLACC ☐ Nips
Onset: _____ ☐ hours ☐ days ☐ weeks ☐ months ☐ years
Description: ☐ Constant ☐ Intermittent ☐ Dull ☐ Sharp ☐ Aching
☐ Throbbing ☐ Stabbing ☐ Burning ☐ Cramping
☐ Pressure
Aggravates: ☐ Nothing ☐ Activity ☐ Food ☐ Palpation
☐ Cough ☐ Deep Breath
Alleviates: ☐ None ☐ Medication ☐ Positioning ☐ Heat ☐ Cold
Other _____

GU/GYN ☒ Assessment WNL
Urine: ☐ Hematuria ☐ Cloudy ☐ Odor ☐ Dark ☐ Burning
☐ Frequency ☐ Inconsistency ☐ Foley present on admission
Dialysis access site location _____ ☐ N/A
Menses: ☐ Irregular ☐ Painful ☐ Vaginal bleeding Pad Count ___ #
LMP _____ EDC _____ G ___ P _____ Ab _____
☐ Vaginal/Penile discharge color _____

Gastrointestinal ☒ Assessment WNL
☐ Nausea ☐ Vomiting Emesis color _____
☐ Diarrhea # stools _____
☐ Constipated # days _____ ☐ Rectal bleeding
Abdomen: ☐ Pendulous ☐ Distended ☐ Tender ☐ Rigid
Bowel sounds: ☐ Absent ☐ Hyperactive ☐ Hypoactive

Integumentary ☒ Assessment WNL
1" Lateral laceration inner R FA
☐ Cool ☐ Pale ☐ Clammy ☐ Diaphoretic ☐ Flushed ☐ Mottled
☐ Cyanotic ☐ Jaundiced ☐ Pink
Last Tetanus: Date _____ ☐ Unknown

Orthopedic ☒ Assessment WNL
☐ Impaired Circulation (Location) _____
☐ Deformity (Location) _____
☐ Limited ROM (Location) _____
☐ Amputation (Location) _____

Psychosocial ☒ Assessment WNL
☐ Uncooperative ☐ Anxious ☐ Agitated ☐ Threatening ☐ Angry
☐ Depressed ☐ Suicidal ☐ Homicidal ☐ Avoids eye contact
Affect: ☐ Flat ☐ Crying ☐ Non-verbal
Hallucinations: ☐ Visual ☐ Auditory

Assessment RN _____ (Signature) 7/18/09 2010 (Date/Time)

RN Signature: _____ Date: _____

Aiken Regional Medical Centers
302 University Parkway

ED NURSING ASSESSMENT
E30.84
Rev. 7/09
Page 1 of 4

ER0807 - ED Assessment

Patient Identification
107662058
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M EMR
MRN: 177273 ADM/REG DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

00036

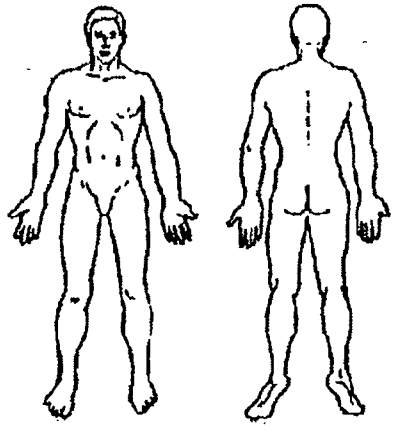
2 Hole 1/4 2 3/4 c-to-c

Physical Findings Diagram

Right



1 – Abrasion
2 – Amputation
3 – Burn
4 – Deformity
5 – Ecchymosis
6 – Edema
7 – Hematoma
8 – Insect Bites
9 – Laceration



Label Areas Involved

10 – Pain
11 – Puncture wound
12 – Rash
13 – Redness
14 – Scar
15 – Skin Breakdown
16 – Skin Tear
17 – Stoma

Left



Right 1/4 1/4 c-to-c

HISTORY OF FALLS	☐ YES ☒ NO	FALL RISK ASSESSMENT (1 or less yes answers = low)	SKIN ASSESSMENT
AGE >65 YEARS	☐ YES ☐ NO	☒ LOW RISK ☐ HIGH RISK	☐ Y ☒ N > 65 YO
TRANSFERS IMPAIRED	☐ YES ☒ NO	FALL INTERVENTION	☐ Y ☒ N Impaired Mobility
ORIENTATION CONFUSED/		☐ SIDE RAILS ☐ BED IN POSITION	☐ Y ☒ N Impaired Sensory Perception
BEHAVIORAL ISSUES	☐ YES ☒ NO	☐ CALL LIGHT ☐ BS OBSERVATION	☐ Y ☒ N Inadequate Nutrition
		☐ YELLOW ARM BAND	Yes to one or more = skin assessment w/in 2 hours of admission orders

ABUSE AND NEGLECT SCREEN

Have you been hit, slapped, kicked, or otherwise physically or socially hurt by someone? ☐ Yes ☒ No

IV THERAPY

TIME	VOLUME	SOLUTION OF LOCK	RATE	BLOOD#	SITE	GAUGE	# ATTEMPTS	INITIALS	TIME D/C	INITIALS	TOTAL INFUSED

INTAKE			OUTPUT			Time	Blood Sugar (finger stick)	Education/Symptoms/Comments	Initials
Time	Type	Volume	Time	Type	Volume				
Total Intake:			Total Output:			Normal range: 70-110 mg/dl Critical range: Less than 50 mg/dl or greater than 500 mg/dl			

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

834.84

Rev. 7/08
Page 2 of 4

ER0807

Patient Identification

107562058
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M RNR
MRN: 177273 ADM/REG DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

00037

Single (F4-1)

2-Triple 1/4 2 3/4 c-to-c

3-Triple 1/4 4 1/4 c-to-c

Date/Time	Nurses Notes
7/18/09 (2025)	Assess. Complete - Rt. 1" laceration to R inner FA. Bleeding controlled - Tetnus given (2025) - Notified Rt. to Tetnus - DSD Applied to (R) inner FA - cleaned & Betadine - Dermabond applied & 2x2 & Ace Strip - Thumb splint (2030) D/C instructions given to pt & verbal understanding - Rt. D/C'd Ambulatory with Father driving - TAR

Initials	Signature/Title	Initials	Signature/Title	Initials	Signature/Title

DISCHARGE STATUS

DATE: 7/18/09 TIME: 2030
☒ ROUTINE (HOME) ☐ AMA ☐ LWBS
☐ ADMIT TO:
PHYSICIAN:
☐ TRANSFERRED TO:
☐ ACCEPTING PHYSICIAN:
☐ EXPIRED

METHOD OF DISCHARGE

☒ AMBULATORY ☐ AMBULANCE
☐ WHEELCHAIR ☐ CARRIED

DISCHARGE VITAL SIGNS

BP 138/56 P 92 R 16
T _____ SAO2 100% PAIN _____

ACCOMPANIED BY

☐ SELF ☒ RELATIVE ☐ POLICE
☐ FRIEND ☐ OTHER EXPLAIN: Father

DISCHARGE VITAL SIGNS

☒ Verbal
☒ Written ☐ Not Given (why): _____
☒ PT VERBALIZES UNDERSTANDING

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

530.64
Rev. 7/08
Page 4 of 4

ER0807

Patient Identification

107662058
LEE , BERNARD D
DOB: 04/10/1980 29 SX: M ENR
MRN: 177273 ADM/REG DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

00038

age 4 of 4

GENERAL INSTRUCTIONS:

☐ Call the next business day and make an appointment to see: _____

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: _____ days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within _____ days.

☐ Return to the Emergency Department in _____ days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☐ Work / school excuse from _____ thru _____. May return to work _____.

☐ See your company doctor per your company's policy. Light duty until _____.

(No use of _____ No lifting over _____ lbs.)

☐ _____

_____

_____

Your diagnosis was: _____

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diphtheria booster***
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X_Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physician.
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Department.
8. If you feel you want to harm yourself or are suicidal, call 1-800-784-2433 (National Suicide Hotline).

_____ 7/18/09 _____

Physician / Staff — Date — Patient or Responsible Person

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

EMERGENCY SERVICES

ER0023

53006
Rev. 9/08

Patient Identification

107662058

LEE , BERNARD D
DOB: 04/30/1986 29 SX: M EMR
MRN: 177273 ADM/REC DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

WHITE - RECORDS CANARY - PATIENT GOLDENROD - PATIENT

00039

Home Medication List
Physician's Order

Height: 6 feet 0 inches

Weight: 190 pounds actual stated estimated

Allergies: NKDA

Nurse Signature: [signature] 7/18/09 Date/Time

ADMISSION		DISCHARGE	
At time of entry, please check which medications should be continued and sign below to authenticate order		At time of discharge, check which medications should be continued and sign below to authenticate order	
Give med upon adm.	Do not give med upon adm.	Continue at discharge	Do not continue at discharge

Home Medications

Unapproved abbreviations: IU, Ms, MSO4, MgSO4, Q.D., q.d., q.o.d., U, u, trailing zeros, no zeros before decimal

Medication/Dose	Route	Frequency	Reason for Taking	Last dose taken
Information obtained from: ☑ Patient ☐ Patient Representative	☐ No home medications ☐ Unable to obtain list			
Include insulin, inhalers, eye drops, aspirin, herbals, vitamins, and OTC.				
Skelaxin 800 mg	PO			7/17/09
Naproxen	PO			7/17/09

Physician Signature (on admission): Date:

Physician Signature (on discharge): Date:

Outpatients Only

Changes to home medications: ☐ None ☐ _____

Based on the treatment prescribed by your physician(s) and the list of medications that you provided, you may continue your home medications with the changes written above, if any. Please contact your prescribing physician if you have any questions about your home medications.

New Discharge Medications

☐ No new medications @ discharge

Medication/Dose	*Route*	*Frequency*	*Reason for taking*
Keflex	take	as directed	

Outpatients Only

Physician Signature: [signature] Licensed Staff's Signature: [signature] Patient's Signature: [signature]

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

PO0010

Home Medication List
Physician's Order

10-37036
601.126
Rev 11/07

CHART COPY

Patient Label

107662058

LEE , BERNARD D
DOB: 04/30/1930 29 SX: M EMR
MRN: 177273 ADM/REG DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

00040

Date 7-28-09 Arrival Time 2147 Mode of Arrival: ☒ POV ☐ EMS ☐ Ambulatory ☐ Carried ☐ W/C

Name Bernard Lee DOB 8-30-80

Current Complaint (in patient's own words) Back neck shoulder pain

Name/Title [illegible]

Triage Time 2147
Communication Assessment:

Primary Language: ☒ English ☐ Spanish ☐ Other

Translation: ☒ N/A ☐ Language Line ☐ Other

Hearing: ☐ No apparent deficit ☐ Wearing hearing aid Vision: ☐ No apparent deficit ☐ Wearing glasses

Allergies NKMA

T 98.4 P 81 R 18 B/P 154/90 SAO_2 100

Pain: Location Neck. Back & Shoulder. Scale (0-10) 10.

LMP _____ Wt 190 lbs. ☐ Actual ☐ Stated

Assessment Something fell on neck 2 mo ago - pain getting worse

Triage Level: ☐ 5 ☒ 4 ☐ 3 ☐ 2 ☐ 1 Disposition: ☐ Major ER ☒ Minor ER

Triage Interventions: ☐ Ice ☐ Elevation ☐ Sling ☐ Splint ☐ Bleeding Control ☐ Fever med ☐ ASA (per ACS protocol) ☐ Other

Triage RN Signature [signature]

Reassessment: Date _____ Time _____

Evaluation: ☐ No change from previous assessment ☐ Change(describe)

Action/Intervention

RN Signature _____ Date _____ Time _____

To ER Room # _____ @ _____ Report to _____ QPI done ☒ yes ☐ no

LWBS: Date _____ Time _____ Reason _____

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

TRIAGE ASSESSMENT

ER0515 - Triage Form

Patient Identification
107705220
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M RNR
MRN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

00041

Triple 1/4 2 3/4 c-to-c

Physical Assessment: Time Performed 2150
☐ Head-to-toe ☑ Focused Assessment

Past Surgical History: ☐ Denies any significant surgical history
☐ Appendectomy ☐ Hysterectomy
☐ Cholecystectomy ☐ Tubal Ligation
☐ CABG ☐ Cardiac Stents
☐ Other Bland

PMD None

Pain:
Score: 10/10 Location: neck/back/shoulder
Scale: ☐ Numeric ☐ Paces ☐ FLACC ☐ Nips
Onset: 2 ☐ hours ☐ days ☐ weeks ☑ months ☐ years
Descriptions: ☐ Constant ☐ Intermittent ☐ Dull ☐ Sharp ☐ Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Cramping ☐ Pressure
Aggravates: ☐ Nothing ☐ Activity ☐ Food ☐ Palpation ☐ Cough ☐ Deep Breath
Alleviates: ☐ None ☐ Medication ☐ Positioning ☐ Heat ☐ Cold Other

Past Medical History: ☐ Denies any significant medical history
☐ CAD ☐ CHF
☐ Cancer (type)
☐ Diabetes ☐ Asthma
☐ COPD ☐ CVA/TIA
☐ HTN ☐ Hypercholesterolemia
☐ GI Bleeding/Ulcer ☐ Hepatitis
☐ Kidney Stones ☐ Renal Failure
☐ Migraines ☐ Seizures
☐ HIV/Aids ☐ Other
Home Oxygen: ☐ N/A L/m via

GU/GYN ☑ Assessment WNL
Urine: ☐ Hematuria ☐ Cloudy ☐ Odor ☐ Dark ☐ Burning ☐ Frequency ☐ Inconsistency ☐ Foley present on admission
Dialysis access site location ☐ N/A
Menses: ☐ Irregular ☐ Painful ☐ Vaginal bleeding Pad Count #
LMP EDC G P Ab
☐ Vaginal/Penile discharge color:

Current Assessment
Pulmonary: ☑ Assessment WNL
Respirations: ☐ Labored ☐ Rapid ☐ Slow ☐ Deep ☐ Shallow ☐ SOB
Breath Snds: ☐ Diminished ☐ Absent ☐ Crackles ☐ Wheezes ☐ Rhonchi
Cough: ☐ Productive ☐ Non productive Sputum
Location of abnormalities ☐ Right ☐ Left ☐ Bilateral
Other

Gastrointestinal ☑ Assessment WNL
☐ Nausea ☐ Vomiting Emesis color
☐ Diarrhea # stools
☐ Constipated # days ☐ Rectal bleeding
Abdomen: ☐ Pendulous ☐ Distended ☐ Tender ☐ Rigid
Bowel sounds: ☐ Absent ☐ Hyperactive ☐ Hypoactive

Cardiovascular: ☑ Assessment WNL
Chest Pain: ☐ Yes ☐ No Describe
Heart Sounds: ☐ Regular ☐ Irregular ☐ Muffled ☐ Rub
Pulses: ☐ Not Palpable Location
EKG Rhythm
JVD ☐ Yes ☐ No

Integumentary ☑ Assessment WNL
☐ Cool ☐ Pale ☐ Clammy ☐ Diaphoretic ☐ Flushed ☐ Mottled ☐ Cyanotic ☐ Jaundiced ☐ Pink
Last Tetanus: Date ☐ Unknown

Neurological ☑ Assessment WNL
Responsiveness: ☐ Unresponsive ☐ Responds to painful stimuli
Speech: ☐ Slurred ☐ Incoherent ☐ Aphasic
Activity level: ☐ Pacing ☐ Restless ☐ Combative ☐ Sleeping ☐ Seizure Activity
Other

Orthopedic ☐ Assessment WNL
☐ Impaired Circulation (Location) neck/back/
☐ Deformity (Location) shoulder s/p
☐ Limited ROM (Location) injury 2 months
☐ Amputation (Location) L 950

HEENT ☑ Assessment WNL
☐ Asymmetrical ☐ Numbness ☐ Paresthesia ☐ Difficulty swallowing ☐ Nystagmus Other

Psychosocial ☑ Assessment WNL
☐ Uncooperative ☐ Anxious ☐ Agitated ☐ Threatening ☐ Angry ☐ Depressed ☐ Suicidal ☐ Homicidal ☐ Avoids eye contact
Affect: ☐ Flat ☐ Crying ☐ Non-verbal
Hallucinations: ☐ Visual ☐ Auditory

Assessment RN [signature] 7/28/09
Signature Date/Time

RN Signature: Date:

ER0907 - ED Assessment

ED NURSING ASSESSMENT

Patient Identification
107705220
LEE , BERNARD D
DOB: 04/30/1960 29 SX: M EMR
MRN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

00042

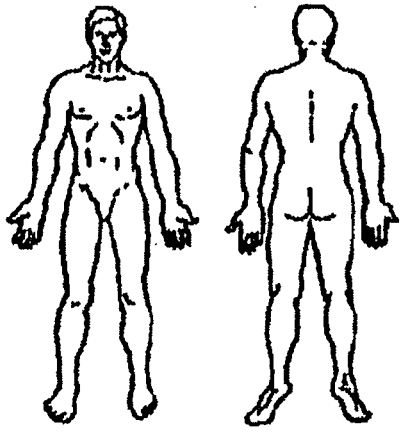
Triple 1/4 2 3/4 c-to-c

Physical Findings Diagram

Right



1 – Abrasion
2 – Amputation
3 – Burn
4 – Deformity
5 – Ecchymosis
6 – Edema
7 – Hematoma
8 – Insect Bites
9 – Laceration



Label Areas Involved
10 – Pain
11 – Puncture wound
12 – Rash
13 – Redness
14 – Scar
15 – Skin Breakdown
16 – Skin Tear
17 – Stoma

Left



Triple 1/4 4 1/4 c-to-c

HISTORY OF FALLS	☐ YES	☐ NO	FALL RISK ASSESSMENT (1 or less yes answers = low)	SKIN ASSESSMENT	
AGE >65 YEARS	☐ YES	☐ NO	☐ LOW RISK ☐ HIGH RISK	☐ Y ☐ N > 65 YO	
TRANSFERS IMPAIRED	☐ YES	☐ NO	FALL INTERVENTION	☐ Y ☐ N Impaired Mobility	
ORIENTATION CONFUSED/			☐ SIDE RAILS ☐ BED IN POSITION	☐ Y ☐ N Impaired Sensory Perception	
BEHAVIORAL ISSUES	☐ YES	☐ NO	☐ CALL LIGHT ☐ BS OBSERVATION	☐ Y ☐ N Inadequate Nutrition	
			☐ YELLOW ARM BAND	Yes to two or more = skin assessment with 2 hours of admission orders	

ABUSE AND NEGLECT SCREEN

Have you been hit, slapped, kicked, or otherwise physically or socially hurt by someone? ☐ Yes ☐ No

IV THERAPY

TIME	VOLUME	SOLUTION OF LOCK	RATE	BLOOD?	SITE	GAUGE	# ATTEMPTS	INITIALS	TIME D/C	INITIALS	TOTAL INFUSED

INTAKE			OUTPUT			Time	Blood Sugar (finger stick)	Education/Symptoms/Comments	Initials
Time	Type	Volume	Time	Type	Volume				
Total Intake:			Total Output:			Normal range: 70-110 mg/dl Critical range: Less than 50 mg/dl or greater than 500 mg/dl			

Aiken Regional Medical Centers
102 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

600.04
Rev 7/09

Patient Identification



107705220
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M ENR
MRN: 177271 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

00043

Home Medication List
Physician's Order

						ADMISSION		DISCHARGE	
Height:	6	feet	inches			At time of entry, please check which medications should be continued and sign below to authenticate order		At time of discharge, check which medications should be continued and sign below to authenticate order	
Weight:	190	pounds	actual	Stated	estimated				
Allergies:	NKDA								
Nurse Signature				Date/Time		Give med upon adm.	Do not give med upon adm.	Continue at discharge	Do not continue at discharge
Home Medications									
Unapproved abbreviations: IU, Ms, MSO4, MgSO4, Q.D., q.d., q.o.d.,U, u, trailing zeros, no zeros before decimal									
Medication/Dose	Route	Frequency	Reason for Taking	Last dose taken					
Information obtained from: ☐ Patient ☐ Patient Representative	☐ No home medications ☐ Unable to obtain list								
Include insulin, inhalers, eye drops, aspirin, herbals, vitamins, and OTC.									
Naproxen.									
Ibuprofen.									

Physician Signature (on admission): Date:

Physician Signature (on discharge): Date:

Completions Only

Changes to home medications: ☐ None ☐ _____

Based on the treatment prescribed by your physician(s) and the list of medications that you provided, you may continue your home medications with the changes written above, if any. Please contact your prescribing physician if you have any questions about your home medications.

New Discharge Medications

☐ No new medications @ discharge

Medication/Dose	Route	Frequency	Reason for taking
Ibuprofen			
Naproxen			

Completions Only

Physician Signature | Licensed Staff's Signature | Patient's Signature

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

PO0010

Home Medication List
Physician's Order

1030035
801.126
Rev. 11/07

CHART COPY

Patient Label
107705220
LEE , BERNARD D
DOB: 04/30/1960 29 SX: M RMR
MRN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

00044

ingle (F4-1)

Hole 1/4 2 3/4 c-to-c

Hole 1/4 4 1/4 c-to-c

TIME/DATE	
2248	Tylor - Pt given RX x 2 Medication Rec Cautions & D/C instructions Rev

DISCHARGE STATUS	METHOD OF DISCHARGE	ACCOMPANIED BY
DATE: 7/30/09 TIME: 2345 ☒ ROUTINE (HOME) ☐ AMA ☐ LWBS ☐ ADMIT TO: PHYSICIAN: ☐ TRANSFERRED TO: ☐ ACCEPTING PHYSICIAN: ☐ EXPIRED	☐ AMBULATORY ☐ AMBULANCE ☐ WHEELCHAIR ☐ CARRIED DISCHARGE VITAL SIGNS BP ____ P ____ R ____ T ____ SAO2 ____ PAIN ____	☒ SELF ☐ RELATIVE ☐ POLICE ☐ FRIEND ☐ OTHER EXPLAIN: ____ DISCHARGE VITAL SIGNS ☐ Verbal ☐ Written ☐ Not Given (why): ____ ☐ PT VERBALIZES UNDERSTANDING

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

Patient Identification

107705220
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M SNR
MRN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

00045

age 4 of 4

GENERAL INSTRUCTIONS:

☑ Call the next business day and make an appointment to see: Dr Bethea or Carter

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: 5-7 days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within _____ days.

☐ Return to the Emergency Department in _____ days for suture removal or re-check.

☐ Take Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☑ Work school excuse from 7/28/09 thru 7/28/09. May return to work 7/29/09

☐ See your company doctor per your company's policy. Light duty until _____.

(No use of _____ No lifting over _____ lbs.)

☑ Meds as written
Return for worsening Symptoms

Your diagnosis was: Cervical / Shoulder Pain

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ Tetanus/Diphtheria booster*
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X_Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physician.
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Department.
8. If you feel you want to harm yourself or are suicidal, call 1-800-784-2433 (National Suicide Hotline).

Staff _____ Date 7/28/09 Patient or Responsible Person _____

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

EMERGENCY SERVICES

ER0023

830.08
Rev. 9/08

Patient Identification

107705220
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M SMR
MRN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

WHITE - RECORDS CANARY - PATIENT GOLDENROD - PATIENT

00046

3 HORIZONTAL MOUNT

2 HORIZONTAL MOUNT

PLACE EDGE AGAINST BRD AND PRESS

REMOVE

1 VERTICAL

3 VERTICAL MOUNT

LEE , BERNARD D
DOB: 04/30/1980 29 Sex: M EMR
ARN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

(roy) x 1420 EM

AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC

C. Boggs - SC#14618 - DEA BS1978356 M. Jagoes - SC#14308 - DEA BJ1585584 W. Jackson - SC#30707 - DEA BJ6404325
S. Platts - SC#20067 - DEA FP4052509 E. Yeh - SC#20099 - DEA EY4015573 D. Bridgman - SC#30960 - DEA FB0264402
S. Grant - SC#18472 - DEA BG2720793 C. Weddle - SC#20761 - DEA BW4612508 R. Taylor, PA-C - SC#A10624

302 University Pkwy. Aiken, South Carolina 29801 Phone 641-5000

For Bernard Lee Age

Address Date 7-28-09

① Ultram 50mg TPO Q4-6° PRN Pain #30 (Thirty)

② Valium 5mg TPO Q8° PRN Spasm #15 (Fifteen)

℞

Please dispense Two Medications NO REFILLS / prefers / does not prefer generic substitute

Dispense as Written M.D. Substitution Permitted M.D.

TLC Medical Centre, Inc.
Home Medical • Pharmacy
(803)648-7800

This prescription may be filled at TLC Medical Centre, Inc. Home Medical Equipment Pharmacy — Silver Bluff Road at 190 Crepe Myrtle Drive Aiken, SC 29803

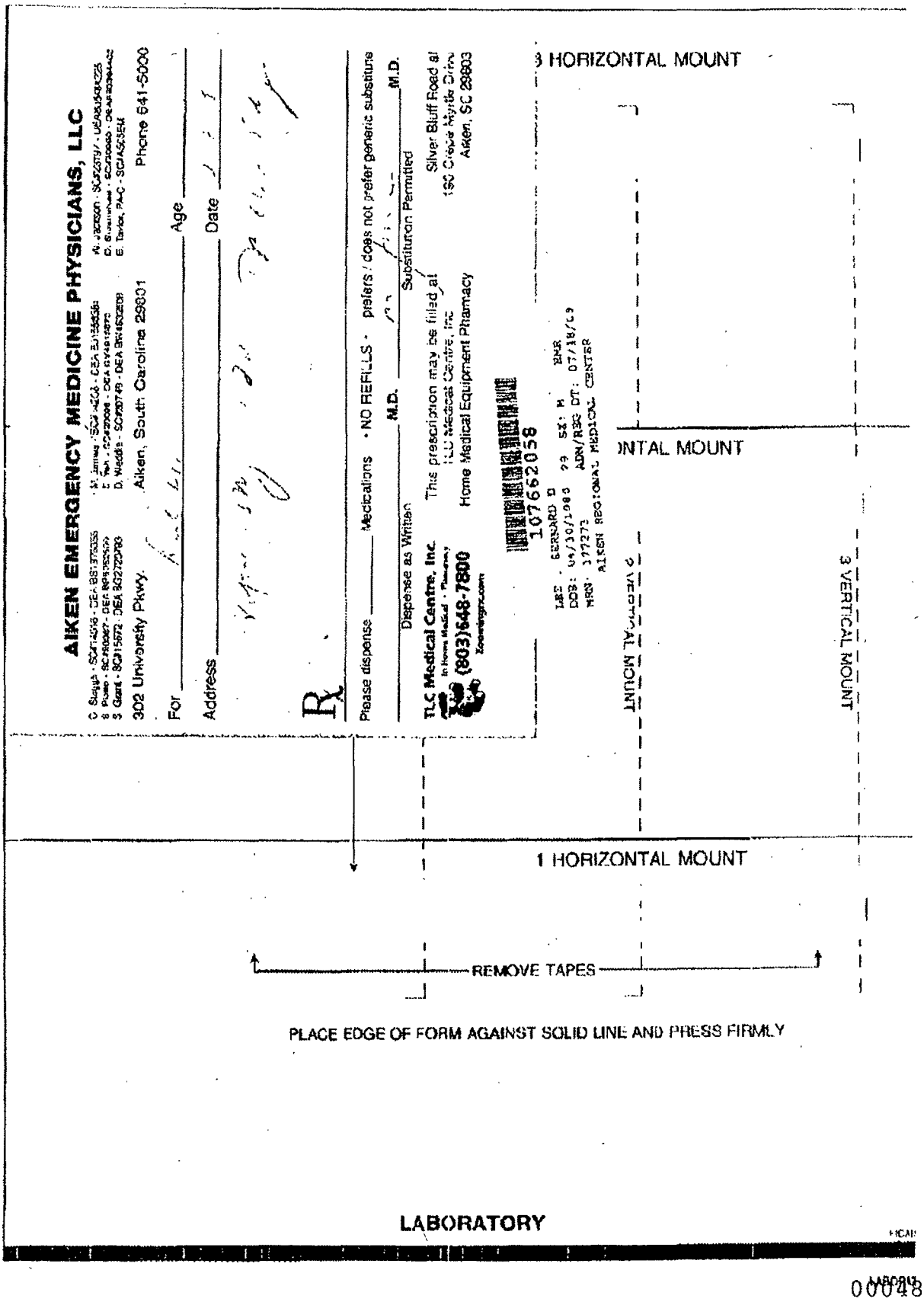
LABORATORY

HCA 8 9

LABORATORY 00047

age 2 of 2

512


AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC
302 University Pkwy.
Aiken, South Carolina 29801
Phone 641-5000
For
Age
Address
Date
Please dispense
Medications
• NO REFILLS •
prefers / does not prefer generic substitute
M.D.
Dispense as Written
Substitution Permitted
TLC Medical Centre, Inc.
(803)648-7800
This prescription may be filled at
Home Medical Equipment Pharmacy
Silver Bluff Road at
190 Crepe Myrtle Drive
Aiken, SC 29803
3 HORIZONTAL MOUNT
3 VERTICAL MOUNT
1 HORIZONTAL MOUNT
REMOVE TAPES
PLACE EDGE OF FORM AGAINST SOLID LINE AND PRESS FIRMLY
LABORATORY

Aiken Regional ED ENCOUNTER Record

☐ Full Admission ☐ 23 Hr Observation

Chief Complaint: Neck / Shoulder Pain increasing over last few days

HPI: 24 yom Presents to ED c c/o neck and shoulder pain and T Spine Pain s/p work related injury after 800# machine fell on shoulder 2wks ago. Dr Betsa in Columbia (ortho) Follows. ⊕HA's (none currently) ⊕numbness ⊕Pain ⊕weakness ⊕P/C/N/V/D/Constipation this had XR's and MRI

Current Meds: Naproxyn, Ibuprofen

☐ See ED nurses notes

PMD Betsa

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, ☐HTN ☐IDDM ☐NIDDM ☐CAD ☐Renal Disease ☐Asthma ☐COPD ☐CHF

& ROS Unobtainable due to: ☐ As Above ☐ Other:

Past Surgical History: C-Section x2

Family History: ☐HTN ☐IDDM ☐NIDDM ☐CAD ☐Asthma ☐COPD ☐CHF

Social History: Tobacco ☐ No ☒ Yes Amt _____ ETOH ☒ No ☐ Yes Amt _____ ☐ Other _____

Review Of Systems: ☐ Other ROS Neg

Check ☐ if normal, Check ⊕ if abnormal, (if not Checked then not applicable)

Eyes:	☐ ○ Diplopia	☐ ○ Blurred	☐ ○ Vision chgs	GU:	☐ ○ Dysuria	☐ ○ Urgency	☐ ○ Hematuria
ENT:	☐ ○ Rhinitis	☐ ○ Sore throat	☐ ○ Nose bleeds	MS:	☐ ○ Myalgia	☐ ○ Back pain	☐ ○ Neck pain
Card:	☐ ○ CP	☐ ○ Palpitation		Neuro:	☐ ○ Seizures	☐ ○ Dizziness	☐ ○ Syncope
Respir:	☐ ○ SOB	☐ ○ Cough	☐ ○ Hemoptysis		☐ ○ Weakness	☐ ○ Numbness	
GI:	☐ ○ Nausea	☐ ○ Vomiting	☐ ○ Diarrhea	Endo:	☐ ○ Polyuria	☐ ○ Hypoglyc	☐ ○ Thyroid Dys
	☐ ○ Abd pain	☐ ○ Melena	☐ ○ Hematochez	Hem/Lym:	☐ ○ Anemia	☐ ○ Bleeding	

☐ For allergies see ED nurses notes

Other ROS _____

ALLERGIES: NKDA

TETANUS STATUS: _____

Physical Exam:

WEIGHT	TIME	PULSE	OX:	TEMP	P	R	BP

☐ For vitals see ED nurses notes

Check ☐ if normal, Check ⊕ if abnormal

						Abn Findings:
General:	☐ ○ Mental Status					
Eyes:	☐ ○ Conjun NL	☐ ○ Lids	☐ ○ PERRL			
Head:	☐ ○ NL cephalic	☐ ○ Sinuses	☐ ○ Nose			
ENT:	☐ ○ Oropharynx	☐ ○ Right TM	☐ ○ Left TM			
Neck:	☐ ○ Palpation	☐ ○ Thyroid	☐ ○ Trachea			
Chest:	☐ ○ Palpation	☐ ○ Excursion	☐ ○ Symmetry			
Cardio:	☐ ○ Heart sounds	☐ ○ R & R				
Respir:	☐ ○ Respir effort	☐ ○ Lung sounds				
Abdom:	☐ ○ Palpation	☐ ○ Bowel Sounds	☐ ○ Digits			
MS:	☐ ○ RUE	☐ ○ RLE	☐ ○ Back			
	☐ ○ LUE	☐ ○ LLE				
	☐ ○ Pelvis	☐ ○ Gait	☐ ○ Color			
Skin:	☐ ○ Temp	☐ ○ Appear	☐ ○ Sensation			
Neuro:	☐ ○ CNS	Strength				

Med Decision Making:

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME:

Diff Dx:

Consults:

NAME OF PHYSICIAN THAT ADMITTED PT:

NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

☐ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

DISCHARGE DIAGNOSIS: Cervical / Shoulder Pain

CODES ☐ STABLE ☐ UNSTABLE SEE NOTE

Physician Signature: _____ **Time MD IN:**

TEST:	ORD	result	TIME INITIAL ✓TEST ORDERED:
CBC W DIFF:			
CHEM 8:			
URINE PREG:			
CCUA:			
CATH UA:			
URINE C&S:			
EKG:			
OLD EKGS:			
TROPONIN:			
PUPTT:			
FINGER ST GL:			
BLOOD CULT X____			
TYPE & SCREEN:			
TYPE CROSS UNITS:			
LIVER PANEL:			
CMP:			
AMYLASE:			
LIPASE:			
HEMOCULT:			
TYPE & RH:			
HCG QUANT:			
URINE DRUG S:			
ALCOHOL:			
ED ABG:			
W/LAT CXR:			
PCXR:			
C-SPINE:			
L-SPINE:			
ACUTE ABD:			
OLD RECORDS:			
OLD ED Record:			

PHYSICIAN'S ORDERS:	TIME ORD:	TIME COMP Initials:
→ URINE PREG RESULTS:		
D/C		
Rx Ultram		
Vicodin		

Name: _____ Race: _____ Sex: _____ Age: _____

Addressograph

107705220

LEE , BERNARD D
DOB: 04/30/1980 29 SX: M ENR
MRN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

ER0010

MEDICAL RECORDS

J 10-2e129 5/07

00049

Aiken Regional ED ENCOUNTER Record

Chief Complaint: [illegible]

☐ Full Admission
☐ 23 Hr Observation

HPI

Current Meds:
☐ See ED nurses notes

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ PMD Renal Disease ☐ Asthma ☐ COPD ☐ CHF
& ROS Unobtainable due to:
☐ As Above ☐ Other:

Past Surgical History:

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☐ Yes Amt ETOH ☐ No ☐ Yes Amt ☐ Other.

Review Of Systems: Check ☐ if normal Check ○ if abnormal *If not Checked then not applicable.)*

☐ Other ROS Neg

Eyes:	☐ ○ Diplopia	☐ ○ Blurred	☐ ○ Vision chgs	*GU:*	☐ ○ Dysuria	☐ ○ Urgency	☐ ○ Hematuria	
ENT:	☐ ○ Rhinitis	☐ ○ Sore throat	☐ ○ Nose bleeds	*MS:*	☐ ○ Myalgia	☐ ○ Back pain	☐ ○ Neck pain	
Card:	☐ ○ CP	☐ ○ Palpitation		*Neuro:*	☐ ○ Seizures	☐ ○ Dizziness	☐ ○ Syncope	
Respir:	☐ ○ SOB	☐ ○ Cough	☐ ○ Hemoptysis		☐ ○ Weakness	☐ ○ Numbness		
GI:	☐ ○ Nausea	☐ ○ Vomiting	☐ ○ Diarrhea	*Endo:*	☐ ○ Polyuria	☐ ○ Hypoglyc	☐ ○ Thyroid Dys	
	☐ ○ Abd pain	☐ ○ Melena	☐ ○ Hematochez	*Hem/Lym:*	☐ ○ Anemia	☐ ○ Bleeding		

For allergies see nurses notes

ALLERGIES: [illegible]

TETANUS STATUS:

Other ROS

Physical Exam: WEIGHT TIME PULSE OX: TEMP P R BP

☐ For vitals see ED nurses notes

Check ☐ if normal Check ○ if abnormal *Abn Findings:*

General:	☐ ○ Mental Status			
Eyes:	☐ ○ Conjun NL	☐ ○ Lids	☐ ○ PERRL	
Head:	☐ ○ NL cephalic	☐ ○ Sinuses	☐ ○ Nose	
ENT:	☐ ○ Oropharynx	☐ ○ Right TM	☐ ○ Left TM	
Neck:	☐ ○ Palpation	☐ ○ Thyroid	☐ ○ Trachea	
Chest:	☐ ○ Palpation	☐ ○ Excursion	☐ ○ Symmetry	
Cardio:	☐ ○ Heart sounds	☐ ○ R & R		
Respir:	☐ ○ Respir effort	☐ ○ Lung sounds		
Abdom:	☐ ○ Palpation	☐ ○ Bowel Sounds	☐ ○ Digits	
MS:	☐ ○ RUE	☐ ○ RLE	☐ ○ Back	
	☐ ○ LUE	☐ ○ LLE		
	☐ ○ Pelvis	☐ ○ Gait	☐ ○ Color	
Skin:	☐ ○ Temp	☐ ○ Appear	☐ ○ Sensation	
Neuro:	☐ ○ CNS	Strength		

Med Decision Making:

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME:
Diff Dx:
Consults:
NAME OF PHYSICIAN THAT ADMITTED PT:
NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

DISCHARGE DIAGNOSIS:

☐ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

CODES

STABLE ☐
UNSTABLE SEE NOTE ☐

Physician Signature: Time MD IN:

TEST:	ORD	Initial	TIME INITIAL ✓TEST ORDERED:
CBC W DIFF:			PHYSICIAN'S ORDERS:
CHEM 8:			TIME ORD:
URINE PREG:			TIME COMP Initials
CCUA:			→ URINE PREG RESULTS.
CATH UA:			
URINE C&S:			
EKG:			
OLD EKGS:			
TROPONIN:			
PUPTT:			
FINGER ST GL:			
BLOOD CULT X			
TYPE & SCREEN:			
TYPE CROSS UNITS.			
LIVER PANEL:			
CMP:			
AMYLASE:			
LIPASE:			
HEMOCULT:			
TYPE & RH:			
HCG QUANT:			
URINE DRUG S:			
ALCOHOL:			
ED ABG:			
PA/LAT CXR:			
PCXR:			
C-SPINE:			
L-SPINE:			
ACUTE ABD:			
OLD RECORDS:			
OLD ED Record:			

IRU2934AA [illegible] SMART1
Tobramycin and Dexamethasone Ophthalmic Ointment
For Adm Thru DECAVACS
119 Gov Lot #1234
Mfd by: Alcon Pharmaceuticals, Ltd.
Fort Worth, TX 76134 USA
CPRS Code: 60714

0.5mL
Rx only
5168

Name: Race: Sex: Age:

Addressograph

107662058
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M END
MRN: 177213 ADM/REQ DT: 07/30/07
AIKEN REGIONAL MEDICAL CENTER

ER0010

630.70 10-24129 5/07

00050

MEDICAL RECORDS

GENERAL INSTRUCTIONS:

☑ Call the next business day and make an appointment to see: Dr Bolton or Coles

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visi

in: 5-7 days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within _____ days.

☐ Return to the Emergency Department in _____ days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☐ Work / school excuse from _____ thru _____. May return to work _____

☐ See your company doctor per your company's policy. Light duty until _____.

(No use of _____ No lifting over _____ lbs.)

☑ Meds as ordered
Return for worsening Symptoms

Your diagnosis was: Cervical / Shoulder Pain

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diphtheria booster***
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X_Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physicia
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Departmer
8. If you feel you want to harm yourself or are suicidal, call 1-800-784-2433 (National Suicide Hotline).

Physician _____ Date 7/28/09 _____ Patient or Responsible Person

Staff _____

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

EMERGENCY SERVICES

ER0023

630.06
Rev. 0/08

Patient Identification

107705220
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M EMR
MRN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

00051

WHITE - RECORDS CANARY - PATIENT GOLDENROD - PATIENT

DR. SYLVA AL-SOUDI

MARGARET J. WESTON COMMUNITY HEALTH CENTERS

NJWCHC - Age 18-49 Progress N[illegible]

Date: 8/6/09	HT:	WT: 18[illegible]	BP: 138/110	P: 78	R:	☐ Appt	Ti:
Age: 29	BMI:	WT:	BP:	T:	O2: 98	☐ Walk In	TO:

CC: hurt @ work - having neck, back & shoulder pain - went through workers comp. Needs to discuss about his job and what his limitations are for his job - EE - needs letter for his job -

as above

MRI: hand → bursitis, shoulder atrophy + mild impgn

Review of Systems: (Circle all positives and strike through all negatives)

Con:	WNL	Fever	Chills	Sweats	Wt. Loss	Wt. Gain	Dec. Appetite	Dizzyness	Insomnia	Fati
Eyn:	WNL	Redness	Discharge	Pain	Itchy	(R) (L)	Blurry Vision			
ENT:	WNL	Ear Pain - R L		Hearing loss	Runny nose	Congestion	Nose Bleed	Sore throat	Hoarse	PN
Resp:	WNL	Cough: prod / non prod		Hemoptysis	Wheeze	SOB	Pleuritic CP	DOE	Nocturnal Dyspnea	
CV:	WNL	Chest Pain	Chest P[illegible]ssure		LE edema	Palpitations				
GI:	WNL	Nausea	Vomiting	Diarrhea	Constipation	GERD	Dysphagia	Pain: Epi., RUQ, RLQ, LUQ, LLQ		
GU:	WNL	Incontinence	Dysuria	Frequency	Flank pain	Hematuria	Hesitancy	Nocturia		
Gyn:	WNL	Breast Pain	Breast Mass	Vag. D/C	Vag. Itch	Vag. Odor	Dyspareunia	Painful, Heavy, Irregular Menses		
Neuro:	WNL	Headache	Numbness	Gen. Weakness	LOC	Dizzyness	Change Speech	Unsteady Gait		
Psych:	WNL	Agitated	Confused	Unmotivated	Anxious	Tearful	Excited	Suicidel	Fatigue	
MS:	WNL	Myalgia	Neck Pain	Leg: Pain / Wkness R L		Arm: Pain / Wkness R L		Lumbar Pain	Jt: Pain, Stiff., Swell	
Skin:	WNL	Dry	Itchy	Flaking	Red	Irritated	Rash:			

Physical Examination (Circle all positive and strike through all negatives)

Eye:	WNL	Lid Lag	Jaundice	Unequal pupils / eye invl	Drainage: Purulent / Clear	Conjunctiva Inflamed		
ENT:	WNL	TM: Bulging Red		Cannal: Wax, Swollen, D/C	Naris: Swollen Turbinate, D/C	Pharynx: Red, Swollen, D/C		
Neck	WNL	TTP	Dec. ROM	Thyromegaly	Lymph node Swelling	JVD	Carotid Bruits: R L	
Resp:	WNL	Labored Breathing		Wheezing	Rales	Ronchi	Decreased Aeration (R) (L)	
CV:	WNL	Rubs	Gallops	Grade ___ Murmur	Irregular: Rhythm - Rate	Cap. Refill <2sec	Unequal Rad. Pulse	
GI:	WNL	Hepato-Splenomegaly		BS: Increased Decreased	Epi., RUQ, RLQ, LUQ, LLQ: Tenderness, Guarding, Rebound, Mass			
GU:	WNL	Urethra: Red Swollen		Bladder: TTP	Vagina: Ab. NI Rugae, Discharge	Cervix: Beefy Red, Friable, Tender		
Mus ext.	WNL	L shoulder Arm, Elbow, Wrist,		Hand, Hip, Leg, Knee, Ankle, Foot: Tenderness, Swelling, Dec. ROM			Foot Exam	R L
Spine:	WNL	Scoliosis	SLR pain ( ) (R)	Thoracic, Lumbar, Sacrum: Tenderness, Dec. ROM,			Pulse	- -
Psych:	WNL	Flat Affect	Anxious	Tearful	Agitated	Distracted	Paranoid	Suspicious	Sensation	- -
Skin:	WNL	Cold	Clammy	Red	Dry	Scaly	Jaundice	Weeping	Cold to tch	+ +

Assessment/ Plan: (1) muscle spasm - Rx Skelaxin

(2) tendonitis bursitis - Rx Prednisone

Cont PT + see CNI on 8/17

☐ Career / Education counseling	☐ ETOH ca[illegible]ation counseling	☐ Low Fat Diet counseling	☐ Reviewed labs dated: / /
☐ Discuss Problem Solving Skills	☐ Smoking [illegible]assation counseling	☐ Low Salt Diet counseling	☐ Stress Follow Up Compliance
☐ Safe Sex Education	☐ Drug use [illegible]ssation counseling	☐ Calorie reduction counseling	☐ Stress med. comp. & bring to visit
☐ Birth control Counseling	☐ Inc. Fruit. Veg. Counseling	☐ Caffeine reduction couns.	Couns / Coord time_____ min
☐ Hygiene / Grooming Education	☐ Physical a[illegible]tivity counseling	☐ Drink More H2O counseling	☐ Couns / Coord > 50% of visit

PROVIDER SIGNATURE:

Next Visit: PRN ___ Days ___ Weeks ___ Months W. EX FROM 8/3

Next Visit Nursing: GYN / BCN Br. Only Labs: _____ BS UA Hg

NAME: Bernard Lee CHART # 40523 8/8/18

00052

10/01/2009 00:59 FAX 803 649 2231 MARGARET J WESTON 003/003

518

Friday, July 30, 2010 (16).max

MARGARET J. WESTON
COMMUNITY HEALTH CENTERS
Dedicated to Your Health

4645 Augusta Road; Clearwater, SC 29822
Phone: (803) 593-9283 Fax: (803) 593-0607

210 Atomic Road; Jackson, South Carolina 29831
Phone: (803) 471-9200 Fax: (803) 471-9100 (fax)

1211 University Lane; Aiken, SC 29801
Phone: (803) 648-4744 Fax: (803) 649-2231 (fax)

School / Work Excuse

Type of Excuse:

_____ Late arrival to school

_____ Early dismissal from school

_____ Absence from school

_____ Late arrival to work

_____ Early dismissal from work

✓ Absence from work

Bernard Lee was evaluated at the Margaret J. Weston Community Health Centers for medical reasons. Please excuse their absence for:

_____ Today only

✓ The following dates: 8/3/09 to 8/18/09.

Additional Comments: _____

Sharon J. Davis

☐ Julie Kappes, PNP
☐ Brandon Daniels, MD
☐ Eric M. Schlueter, MD
☒ Sylva Al-Soudi, MD
☐ C. Luis McTier, FNP
☐ Uday Doppalapudi, MD
☐ Lloyd B. Daniels, MD
☐ Peggy Lampkin, PA

8/6/09
Date

00053

MJ NCHC - Age 18-49 Progress Note

DOS: 10/5/09	HT:	WT: 190	BP: 140/100	P: 85	R:	☑ Appt	TI:
Age: 29	BMI:	WT:	BP:	T:	O2: 100	☐ Walk In	TO:

CC: f/up appt on bx R & Shoulder —

Hx (PMH, F, S Hx updated ☐):

11 spot on the (R) wrist 9 weeks, to have it removed

Review of Systems: (Circle all positives and strike through all negatives)

Con:	WNL	Fever	Chills	Sweats	Wt. Loss	Wt. Gain	Dec. Appetite	Dizzyness	Insomnia	Fatigue	
Eye:	WNL	Redness	Discharge	Pain	Itchy	(R) (L)	Blurry Vision				
ENT:	WNL	Ear Pain - R L		Hearing loss	Runny nose	Congestion	Nose Bleed	Sore throat	Hoarse	PND	
Resp:	WNL	Cough: prod / non prod		Hemoptysis	Wheeze	SOB	Pleuritic CP	DOE	Nocturnal Dyspnea		
CV:	WNL	Chest Pain	Chest Press	ure	LE edema	Palpitations					
GI:	WNL	Nausea	Vomiting	Diarrhea	Constipation	GERD	Dysphagia	Pain: Epi., RUQ, RLQ, LUQ, LLQ			
GU:	WNL	Incontinence	Dysuria	Frequency	Flank pain	Hematuria	Hesitancy	Nocturia			
Gyn:	WNL	Breast Pain	Breast Mass	Vag. D/C	Vag. Itch	Vag. Odor	Dyspareunia	Painful, Heavy, Irregular Menses			
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Eye:	WNL	Lid Lag	Jaundice	nequal pupils / eye mvt	Drainage: Purulent / Clear		Conjunctiva Inflamed		
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Resp:	WNL	Labored Breathing		Wheezing	Rales	Ronchi	Decreased Aeration (R) (L)		
CV:	WNL	Rubs	Gallops	Grade ___ Murmur	Irregular: Rhythm - Rate		Cap. Refill <2sec	Unequal Rad. Pulse	
GI:	WNL	Hepato-Splenomegaly		S: Increased Decreased	Epi., RUQ, RLQ, LUQ, LLQ: Tenderness, Guarding, Rebound, Mass				
GU:	WNL	Urethra: Red Swollen		ladder: TTP	Vagina: Ab. Nl Rugae, Discharge		Cervix: Beefy Red, Friable, Tender		
Mus ext.	WNL	Shoulder, Arm, Elbow, Wrist,		Hand, Hip, Leg, Knee, Ankle, Foot: Tenderness, Swelling, Dec. ROM				Foot Exam	R L
Spine:	WNL	Scoliosis	SLR pain (L) (R)		Thoracic, Lumbar, Sacrum: Tenderness, Dec. ROM,			Pulse	- -
Psych:	WNL	Flat Affect	Anxious	Tearful	Agitated	Distracted	Paranoid	Suspicious	Sensation	- -
Skin:	WNL	Cold	Clammy	Red	Dry	Scaly	Jaundice	Weeping	Cold to tch	+ +

Assessment/ Plan: rupture on (R) wrist

1) pursuit o shoulder/arm - seen by ortho, needs MRI/stud
2) HTN - stbl HCTZ
3) gang. ion - refer to hand surgeon

☐ Career / Education counseling	☐ ETOH c	sation counseling	☐ Low Fat Diet counseling	☐ Reviewed labs dated: / /
☐ Discuss Problem Solving Skills	☐ Smoking	cessation counseling	☐ Low Salt Diet counseling	☐ Stress Follow Up Compliance
☐ Safe Sex Education	☐ Drug us	cessation counseling	☐ Calorie reduction counseling	☐ Stress med. comp. & bring to visit
☐ Birth control Counseling	☐ Inc. Fru	/ Veg. Counseling	☐ Caffeine reduction couns.	Couns / Coord time_____ min
☐ Hygiene / Grooming Education	☐ Physical	ctivity counseling	☐ Drink More H2O counseling	☐ Couns / Coord > 50% of visit

PROVIDER SIGNATURE:

Next Visit: PRN ___ Days ___ Weeks ___ Months 1 — re V BP

Next Visit Nursing: GYN / BCN Br. Only Labs: _____ BS UA Hg

NAME: Bernard Lee CHART # 40523

00054

10/16/2009 04:17 FAX 803 648 2231 MARGARET J WESTON 002/004

MARGARET J. WESTON
COMMUNITY HEALTH CENTERS
Dedicated to Your Health

☐ Jackson Office
210 Atomic Road
Jackson, SC 29831
Ph: (803) 471-9200
Fax: (803) 471-9100

☐ Clearwater Office
PO Box 277
4645 Augusta Road
Clearwater, SC 29822
Ph: (803) 593-9283
Fax: (803) 593-0607

☒ Aiken Office
1211 University Lane
Aiken, SC 29801
Ph: (803) 648-4744
Fax: (803) 649-2231

REFERRAL

Last Name: LEE First Name: BERNARD Middle: _____

Address: 172 Cherokee Fall Rd. State: SC Zip Code: 29829

Home Phone: 803-663-0[illegible]60 Work Phone: _____

Social Security #: 251-45-220[illegible] Date of Birth: 4/30/80 Sex: ☒ Male ☐ Female

Insurance: ☐ SC Medicaid ☐ GA Medicaid ☐ Medicare ☐ Self-Pay

☐ Blue Cross Blue Shield ☒ Other: _____

Referral To: hand surgery Phone Number: _____

Address: _____

Appointment Date: ___/___/___ Time: _____ am/pm

ICD-9 Codes: (1) _____ (2) _____ (3) _____ (4) _____

Clinical Indications: ganglion on the (R) wrist

☐ Evaluate & Treat ☐ Evaluate & Recommend Treatment Options ☐ Urgent Referral

10/5/09
Date

☐ Julie Kappes, PNP ☒ C. Travis McTier, FNP
☐ Brandon Daniels, MD ☐ Udai Doppalapudi, MD
☐ Eric M. Schlueter, MD ☐ Lloyd B. Daniels, MD
☐ Sylva Al-Soudi, MD ☐ Peggy Lampkin, PA

ATTACHMENTS

☐ Lab Result(s) ☐ X-Ray Report(s) ☐ Progress Note(s) ☐ Other: _____

ADMINISTRATIVE

☐ Appointment Made ☐ Records Faxed ☐ Patient Contacted
☐ Chart Number: _____ ☐ Reminder Call ☐ Appointment Kept
☐ Note Received

Date

00055

10/15/2009 04:17 FAX 803 649 2231 MARGARET J WESTON ☒004/004

641-5810

Aiken Regional Medical Centers @ Hosp.

Outpatient Services Order Form

Schedule Test: 803-641-5808
Imaging Center of Aiken Fax: 803-648-2099
Radiology Fax: 803-641-5033
Women's Lifecare Diagnostics Fax: 803-641-5810
Cardiology/EKG Fax: 803-641-5378

Date of Appointment Oct. 19, 2009 Time 8.00 AM Insurance Principle #

Patient Name LEE BERNARD DOB Phone

Physician SALNA ALSOUDI Phone/Fax 6484744

Symptoms/Indication shoulder pain

EKG/ECHO

Prep #		
4		EKG
4		Holter Monitor
5		Stress Test
5		Nuclear Stress Test
4		Echocardiogram, Adult
4		Echocardiogram, Pediatric
5		Echocardiogram w/bubble
5		Stress Echocardiogram
5		Dobutrex stress echo
3		TEE
2		Tilt Table

EEG/VASCULAR

Prep #		
		EEG, routine
		EEG, sleep deprived
4		Arterial Vascular Study
4		ABI (Ankle Brachial Index)
7		VEP
7		BAER

RESPIRATORY

Prep #		
		Arterial Blood Gas
		Arterial Blood Gas w/exercise
1		Pulmonary Function Screen (PFT)
1		PFT w/bronchodilator
1		PFT w/ DLCO
1		Methacholine Challenge PFT
1		Metabolic Cart
3		Bronchoscopy
3		Bronchoscopy w/ Fluoro
		BioZ
		Thoracentesis

ULTRASOUND

Circle all that apply:

Prep #		
		Abdomen (RUQ, GB, Pancreas, Liver)
2		Aorta
3		Breast (Rt, LL Biat, Bx, Aspiration)
		Carotid Doppler ☐R ☐L
1		Kidneys (Bx, Aspiration)
4		Obstetrical
4		Pelvic
		Scrotal
		Thyroid (Bx, Aspiration)
		Venous Doppler ☐Upper ☐Lower

CT

Prep #		
1		Abdomen W O Contrast
1,2	C	Abdomen W Contrast
1		Abdomen & Pelvis WO
1,2	C	Abdomen & Pelvis W Contrast
2	C	Abdomen & elvis & Thoracic W
1		Abdomen & elvis & Thoracic WO
		Cervical S ne
		Head WO C ntrast
2	C	Head WO/ Contrast
		Lumbar Sp c WO
2	C	Neck (soft ssue) W Contrast
		Orbits WO ontrast
2	C	Orbits WO / Contrast
1		Pelvis WO ontrast
1,2	C	Pelvis W C ntrast
		Renal Colis
		Sinuses Co plete WO
		Sinuses Ma WO
		Temporal B nes WO
2	C	Chest W Co trast
		Chest WO

GI/GI

Prep #		
1		Barium Ene a - Air Contrast
1		Barium Ene a - Full Column
3		Barium Swa low
1		Defecogram
2	C	IVP with or ithout Tomograms
3		Small Bowe
3		UGI
3		UGI with Sm follow through
	C	Voiding Cys ogram

NUCLEAR MED

Prep #		
		Bone Scan
2		Cardiac
1		HIDA Scan
		Lung Perfus on and Vent
		Parathyroid ican
2		Renal Scar
2		Thyroid Sca

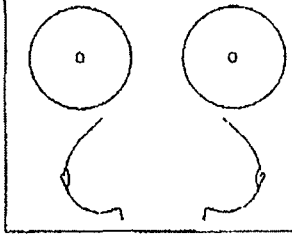
MRI

Prep #		
	M	Brain
1	M	Brain WO/W Contrast
1	M	Brain MR Angio
1	M	MR Angio Neck
	M	Cervical Spine
	M	Lumbar Spine
1	M	Lumbar Spine WO/W Contrast
	M	Spine Limited (specify)
	M	Thoracic Spine
1	M	Aorta
1	M	Peripheral
1	M	Abdomen (specify below)
	M	Ankle ☐L ☐R
	M	Elbow ☐L ☐R
	M	Hip(s) ☐L ☐R
	M	Knee ☐L ☐R
	M	Shoulder ☐L ☐R
	M	Wrist ☐L ☐R
2	M	MR Cholangiogram

BREAST IMAGING

Prep #		
		Mammogram Screening
		Mammogram Diagnostic
		Mammo with Implants
		Bone Densitometry
		Breast Core Biopsy
		Breast Cyst Biopsy
		Clinical Consult/2nd Opinion
		Breast Ultrasound
		Galactography

Diagram of Masses



RADIOLOGY

Prep #		
		Abdomen (KUB)
		Abdomen Acute Series
		Ankle ☐L ☐R
		Cervical Spine Routine
		Cervical Spine (flex & ext)
		Chest
		Clavicle ☐L ☐R
		Elbow ☐L ☐R
		Facial Bones ☐L ☐R
		Femur ☐L ☐R
		Fingers (Identity) ☐L ☐R
		Foot ☐L ☐R
		Forearm ☐L ☐R
		Hand ☐L ☐R
		Heel ☐L ☐R
		Hip ☐L ☐R
		Hip Survey Child
		Humerus ☐L ☐R
		Knee Routine (3 views) ☐L ☐R
		Knee Routine (4 views) ☐L ☐R
		Knee AP & Lat both standing
		Lumbar Spine Routine
		Mandible
		Nasal Bones
		Neck Soft Tissue
		Orbits ☐L ☐R
		Pelvis
		Pelvis & Lat Hip ☐L ☐R
		Ribs ☐L ☐R
		Sacrum Coccyx
		Scapula ☐L ☐R
		Scoliosis Series
		Shoulder ☐L ☐R
		Sinus
		Skull
		Sternum
		Thoracic Spine
		Thumb ☐L ☐R
		Tib/Fib ☐L ☐R
		Toe ☐L ☐R
		Wrist ☐L ☐R

Physicians Office: (Indicate location of appointment on the map located on the reverse side)

C = If exam is preceded by C, please ask the following questions.
Diabetic: ☐ No ☐ Yes On Glucophage: ☐ No ☐ Yes
If over 65 years old, need Bun and Creatinine within 30 days. Where drawn

M = If exam is preceded by M, please ask the following questions.
Heart Pacemaker: ☐ No ☐ Yes Metal: ☐ No ☐ Yes

X-ray 10-9-09

Other Exam:

Special Instructions:

Pt. not claustrophobic Pt. aware

Physician Signature: 10/15/09

00056

(32.29 (8/05) 10-31542

PATIENT INSTRUCTIONS ON BACK

MARGARET J WESTON

10/15/2009 04:17 FAX 803 649 2231

003/004

JWCHC - Age 18-49 Progress

DOS: 10/5/09	HT:	WT: 190	BP: 140/100	P: 85	R	☑ Appt	TL:
Age: 29	BMI:	WT:	BP:	T:	O2: 100	☐ Walk In	TO:

CC: f/up appt on back & shoulder

Hx (PMH, F, S Hx updated ☐):

11 Smart on the (R) wrist 9 wks to have it removed

Review of Systems: (Circle all positives and strike through all negatives)

Con:	WNL	Fever	Chills	Sweats	Wt. Loss	Wt Gain	Dec. Appetite	Dizzyness	Insomnia	Fa
Eye:	WNL	Redness	Discharge	Pain	Itchy	(R) (L)	Blurry Vision			
ENT:	WNL	Ear Pain - R L		Hearing loss	Runny nose	Congestion	Nose Bleed	Sore throat	Hoarse	F
Resp:	WNL	Cough, prod / non prod		Hemoptysis	Wheeze	SOB	Pleuritic CP	DOE	Nocturnal Dyspn	
CV:	WNL	Chest Pain	Chest Pressure		LE edema	Palpitations				
GI:	WNL	Nausea	Vomiting	Diarrhea	Constipation	GERD	Dysphagia	Pain: Epi., RUQ, RLQ, LUQ, LLQ		
GU:	WNL	Incontinence	Dysuria	Frequency	Flank pain	Hematuria	Hesitancy	Nocturia		
Gyn:	WNL	Breast Pain	Breast Mass	Vag. D/C	Veg. Itch	Vag. Odor	Dyspareunia	Painful, Heavy, Irregular Menses		
Neuro:	WNL	Headache	Numbness	Gen. Weakness	LOC	Dizzyness	Change Speech	Unsteady Gait		
Psych:	WNL	Agitated	Confused	Unmotivated	Anxious	Tearful	Excited	Suicidal	Fatigue	
MS:	WNL	Myalgia	Neck Pain	Leg: Pain / Wkness R L		Arm: Pain	Wkness R L	Lumbar Pain	Jt: Pain, Stiff, Sw	
Skin:	WNL	Dry	Itchy	Flaking	Red	Irritated	Rash:			

Physical Examination (Circle all positives and strike through all negatives)

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GU:	WNL	Urethra: Red Swollen		Bladder: TTP	Vagina: Ab. Nl Rugae	Discharge	Cervix: Beefy Red, Friable, Tender	
Mus ext.	WNL	Shoulder, Arm, Elbow, Wrist, Hand, Hip, Leg, Knee, Ankle, Foot: Tenderness, Swelling, Dec. ROM					Foot Exam	H
Spine:	WNL	Scoliosis	SLR pain (L) (R)		Thoracic, Lumbar, Sacrum: Tenderness, Dec. ROM		Pulse	
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Skin:	WNL	Cold	Clammy	Red	Dry	Scaly	Jaundice	Weeping	Cold to tch	

Assessment/ Plan: ganglion on (R) wrist

1) buzzes shoulder - see ortho, needs MRI sh
2) HTN - stable HCTZ
3) ganglion - refer to hand surgeon

☐ Career / Education counseling	☐ ETOH cessation counseling	☐ Low Fat Diet counseling	☐ Reviewed labs dated: / /
☐ Discuss Problem Solving Skills	☐ Smoking cessation counseling	☐ Low Salt Diet counseling	☐ Stress Follow Up Compliance
☐ Safe Sex Education	☐ Drug use cessation counseling	☐ Calorie reduction counseling	☐ Stress med. comp. & bring to visit
☐ Birth control Counseling	☐ Inc. Fruit / Veg. Counseling	☐ Caffeine reduction couns.	Couns / Coord time ___ min
☐ Hygiene / Grooming Education	☐ Physical activity counseling	☐ Drink More H2O counseling	☐ Couns / Coord > 50% of visit

PROVIDER SIGNATURE:

Next Visit: PRN ___ Days ___ Weeks (1) Months — re BP

Next Visit Nursing: GYN / BCN Br. Only Labs: BS UA

NAME: Renaud (Lee

CHART # 40523

00057

MJWCHC - Age 18-49 Progress Note

Date: 11/11/09	HT:	WT: 194	BP: 130/88	P: 66	R:	☑ Appt	TI:	
Age: 29	BMI:	WT:	BP:	T:	O2: 98	☐ Walk In	TO:	

CC: Shoulder, neck, & back pain — wj

Hx (PMH, F, S Hx updated ☐):

as above
going to ortho
ate hx

Review of Systems: (Circle all positives and strike through all negatives)

Con:	WNL	Fever	Chills	Sweats	Wt. Loss	Wt. Gain	Dec. Appetite	Dizzyness	Insomnia	Fatigu
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MS:	WNL	Myalgia	Neck Pain	Leg: Pain / Wkness R L		Arm: Pain / Wkness R L		Lumbar Pain	Jt: Pain, Stiff., Swell	
Skin:	WNL	Dry	Itchy	Flaking	Red	Irritated	Rash:			

Physical Examination (Circle all positives and strike through all negatives)

Eye:	WNL	Lid Lag	Jaundice	Unequal pupils / eye mvt	Drainage: Purulent / Clear		Conjunctiva Inflamed		
ENT:	WNL	TM: Bulging Red		Canal: Wax, Swollen, D/C	Naris: Swollen Turbinate, D/C		Pharynx: Red, Swollen, D/C		
Neck	WNL	TTP	Dec. ROM	Thyromegaly	Lymph node Swelling	JVD	Carotid Bruits: R L		
Resp:	WNL	Labored Breathing		Wheezing	Rales	Ronchi	Decreased Aeration (R) (L)		
CV:	WNL	Rubs	Gallops	Grade ___ Murmur	Irregular: Rhythm - Rate		Cap. Refill <2sec	Unequal Rad. Pulse	
GI:	WNL	Hepato-Splenomegaly		BS: Increased Decreased	Epi., RUQ, RLQ, LUQ, LLQ: Tenderness, Guarding, Rebound, Mass				
GU:	WNL	Urethra: Red Swollen		Bladder: TTP	Vagina: Ab. NI Rugae Discharge		Cervix: Beefy Red, Friable, Tender		
Mus ext.	WNL	Shoulder, Arm, Elbow, Wrist, Hand, Hip, Leg, Knee, Ankle, Foot: Tenderness, Swelling, Dec. ROM						Foot Exam	R L
Spine:	WNL	Scoliosis	SLR pain (L) (R)		Thoracic, Lumbar, Sacrum Tenderness, Dec. ROM,			Pulse	-
Psych:	WNL	Flat Affect	Anxious	Tearful	Agitated	Distracted	Paranoid	Suspicious	Sensation	-
Skin:	WNL	Cold	Clammy	Red	Dry	Scaly	Jaundice	Weeping	Cold to tch	+

Assessment/ Plan:

(1) shoulder pain — needs to see Ortho ? MRI shoulder
w comes
(2) HTN controlled
(3) Hyp Dm2 — ✓ A1C

☐ Career / Education counseling	☐ ETOH cessation counseling	☐ Low Fat Diet counseling	☐ Reviewed labs dated: / /
☐ Discuss Problem Solving Skills	☐ Smoking cessation counseling	☐ Low Salt Diet counseling	☐ Stress Follow Up Compliance
☐ Safe Sex Education	☐ Drug use cessation counseling	☐ Calorie reduction counseling	☐ Stress med. comp. & bring to visit
☐ Birth control Counseling	☐ Inc. Fruit / Veg. Counseling	☐ Caffeine reduction couns.	Couns / Coord time ___ min
☐ Hygiene / Grooming Education	☐ Physical activity counseling	☐ Drink More H2O counseling	☐ Couns / Coord > 50% of visit

PROVIDER SIGNATURE:

Next Visit: PRN ___ Days ___ Weeks (2) Months — ✓ Pcr
Next Visit Nursing: GYN / BCN Br. only Labs: BS UA Hg

NAME: Bernard Lee CHART # 40523

00058

DR. TIMOTHY SHANNON

CAROLINA MUSCULOSKELETAL INSTITUTE

NEW PATIENT/PROBLEM TELEPHONE QUESTIONNAIRE

PATIENT # BELE **TYPE OF APPT** 2/BA / TX 6/4

REF BY DR _____ APPOINTMENT Mon. (DAY) 8/17 (DATE) 8:45/8:15 (TIME)

REF DR'S TELEPHONE _____ REF DR'S FAX _____

TODAY **1ST AVAILABLE** **WITHIN** _____ **DAYS** **REQ** **CALL**

DATE 7/30/09 MADE BY MK CDM DEH TJS TWC RVM MML

1. NAME Bernard Lee SS# 251 45 2204 DOB 4-30-80

PERSON REQUESTING APPT, IF NOT SELF _____ RELATIONSHIP _____

2. INS YES NO TYPE Southern Felt Co Serv. PPO IN/OUT NETWORK INS # _____

MCD # _____ MEDICAID MAN/CARE AUTHOR. # _____

CO-PAY ____ CO-INS ____ PRE-PAY ____ $200 $400 **CASH ONLY!!**

3. HOME TELEPHONE (803) 663-0560 ~~WORK~~ Cell TELEPHONE (706) 496-1562 EXT ____

4. ST 172 Old Cherokee Indian Rd CITY Graniteville ST SC ZIP 29829

5. HAVE YOU EVER BEEN SEEN BY ONE OF OUR DOCTORS? YES NO YEAR ____

6. PROBLEM PATIENT WANTS TO BE SEEN FOR BA

7. HOW LONG HAS CURRENT PROBLEM BEEN BOTHERING YOU? 2 mos.

8. WAS THIS AN ACCIDENT? YES NO If yes, how did it happen? head fell on him

UNKNOWN ___ INJURY ___ INJURY DATE June 2, 2009 Where? HOME WORK AUTO ACC OTHER

9. HAVE YOU HAD PREVIOUS TREATMENT? YES NO WHEN NA Urgent Center June 4

TREATED BY Dr. Broder WHERE North Augusta, SC SURGERY? YES NO

OFFICE NOTES REQ? YES NO TO BE: MAILED FAXED BRING **ER REPT REQ?** YES NO

10. HAVE YOU HAD X-RAYS, MRI, CT SCAN, ETC. FOR CURRENT PROBLEM? YES NO

If yes, where? Urgent Center

11. IS PATIENT TO BRING X-RAYS/TEST TO APPT? YES NO **REQ FROM ER?** YES NO

12. DO YOU HAVE AN ATTORNEY? YES NO IS LITIGATION PENDING? YES NO

13. PATIENT TOLD TO BRING ALL MEDICATIONS? YES NO

14. WAS CHART REQUESTED FROM STORAGE? YES NO Date Requested _____

15. MAIL PAPERWORK, IF APPOINTMENT IS 3 DAYS OR MORE AWAY. YES NO

00059

ADDITIONAL INFORMATION PWM & pt to bring x-rays & MRI & arrive 20 mins earlier

12/04/08

CAROLINA MUSCULOSKELETAL INSTITUTE, P.A.
ORTHOPEDIC HISTORY FORM

TODAY'S DATE 8/12/09 PATIENT NAME Bernard Lee AGE 29

PRESENT PROBLEM:
When did it happen? 7/2/09 Time 9:30 a.m. (p.m.)

Describe in your own words the problem or injury you are being seen for. Include what happened, how it happened, when it happened and how long you have had this problem or injury: On 7/2/09 I was on a step ladder with 2 other employees attempting two lift a 800 pct hood on top a Machine. The load then came down and landed between My Neck an shoulder and it pinned Me down.

What treatment has been done and by whom? I have recieve treatment from Dr Brader, Dr Bethea as well as Dr Al-Sendi

PAIN HISTORY:

Describe your pain
Sharp pains running through My Back, Neck, shoulder
How long does it last?
Constant pain and Headaches
Where is it located?
Neck, shoulder, Back
What makes it worse?
Walking, standing to long, Breathing hard, trouble sleeping
Does it wake you up at night?
Yes
Are you stiff in the morning?
Yes

Occupation Machine Operator

Have you been off work? Yes ☑ No ☐ Since when 6/29/09

Why? Medications and pain of Injury

Do you require:
Crutches Walker Braces Other:
Cane Splints Shoes

List any allergies None

AS

Physician's Comments

B/M 29y/o
(R) handed
Smoker 5cig q wk
DOI 6/2/09 not 7/2
C/o Back, Neck + Sh
pt was injured w load metal hood being lifted by forklift came down and lif of hood hit p in neck + shld and had him pin down.
- Shooting and burning pains i neck shld + back
- pain is constan
- walking + standi too long make pain worse
- Trouble sleeping
- Stiff in AM

Tx- Dr Brader Naproxen + Dr. Bethe didn't do anything different

DATE 8/18/09

CMI EMPLOYEE 00060 BW

CANCELLED OR MISSED APPOINTMENTS
DATE 4/17/09
☐ PT CANCELLED
☐ DR. CANCELLED

Better shoulder inject

Broader neck: ☐ first then ☒ too
shoulder" " " "
☐ should MRI — in August ⇒ A-C JD
→ P.T. x4-6 wks
Sports Plus
for all 3 areas

00061

Current ID Card

Front of Card

SOUTHERN FELT CO., INC.
ISSUER (80840)
ID # 906-84-6153
NAME BERNARD LEE
Care Type: Medical, Dental, Prescription/Mail Rx
PROVIDER NETWORK
[redacted]

PAYOR # SEE BACK
ACCOUNT # H2281-2
EFFECTIVE 09/23/2008

PRINCIPAL LOGO

SUPER MEDPPO LOGO

THE PRINCIPAL PLAN DENTAL
BENEFIT PH # 800-533-5044
CAREMARK 877-683-6838 RXPCN: PCS
RX Group # 0189 3211 RX BIN 610415
RX Copay $10/$25/$40
RX Mail Service $20/$50/$80

AMERITAS LOGO

CARE MARK LOGO

Back of Card

( ) PHYSICIAN COPAY $20.00
AUTHORIZATION IS REQUIRED PRIOR TO HOSPITAL
ADMISSIONS & SOME ELECTIVE SURGERIES & TREATMENT.
- IN ADVANCE FOR NON-EMERGENCY ADMISSION
- WITHIN 2 WORKING DAYS FOR EMERGENCY ADMISSION
FAILURE TO COMPLY MAY REDUCE BENEFITS.
FOR AUTHORIZATION CALL THE PHONE # ON CARD FRONT.
SUPERMED PPO CLAIMS TO: SEND ALL OTHER CLAIMS TO:

SUPERMED PPO	PRINCIPAL LIFE INSURANCE CO
PO BOX 94648	PO BOX 39710
CLEVELAND OH	COLORADO SPGS CO
44101-4648	80949-3910
PAYOR # 90440	PAYOR # 61271

OUTSIDE OF YOUR PROVIDER NETWORK SERVICE AREA CALL
800-241-6350 FOR PHCS HEALTHY DIRECTIONS PROVIDER

LAB CARD LOGO

MULT PLAN LOGO

(800) 258-3152
TJS - In Network
w/ Super Med PPO
per Vanessa
Ref #092298026 9000
$20.00 Copay /CAH

00062

https://secure02.principal.com/GroupEmployer/GroupEmployer/sinpcomm.asp 8/10/2009

MEDICATIONS LIST FOR PATIENT: Lee, Bernard ACCOUNT# 123899

DATE	MEDICATION	# OF TABS & REFILLS	DATE GIVEN	COMPLICATIONS
8/18/09	Naproxen / BW			

ALLERGIES AND COMPLICATIONS	WARNINGS - REASON
8/18/09 NKDA	☐ MRI
	☐ HEPATITIS A, B, C, non-A/B/C
	☐ HIV
	☐ TB
	☐ Med Review
	☐ 00063 MEDLIST

Pharmacy: CVS - Clearwater Family Doctor: _____

Lee, Bernard 123899

08/18/2009 INITIAL OFFICE VISIT

HISTORY OF PRESENT ILLNESS: The patient is a 29-year-old male who was injured on the job 06/02/2009 (the patient reports that he wrote the wrong date in our chart, i.e., he wrote 07/02/2009). He states that he and other people were attempting to lift a metal hood by forklift when it came down and the lip of the hood struck him on the left side of his neck and superior aspect of his shoulder. He states that he was pinned down for a little while. He was subsequently evaluated by Dr. Jeff Broder in North Augusta, who ordered an MRI of the left shoulder and prescribed physical therapy at Sports Plus for neck, left shoulder, and low back problems. The patient was then referred to Dr. James Bethea who injected the left shoulder. When the worker's compensation carrier dropped this patient's claim, he states that he did not follow up with Dr. Broder or with Dr. Bethea. The patient states that symptoms initially began on the left side of the neck and superior aspect of the left shoulder, but over the past few weeks, he has started to have some problems with his right side of his neck and his right shoulder, he thinks because of increased use of the right shoulder due to the left shoulder problems. In addition, the patient complains of pain localized to the low back region. The patient denies any bladder or bowel changes. No radiation of the shoulder pains into the distal portion of the upper extremities or radiation of the low back pain into the lower extremities at all. Walking, standing too long, breathing, coughing, or sneezing all seem to make all problems worse. The patient states that prior to the on the job injury of 06/02/2009, he had no problems with his neck, shoulders, or low back.

HISTORY AND PHYSICAL EXAM:
The history form of 08/18/2009 reviewed.
ALLERGIES: Noncontributory.
MEDICATIONS: Noncontributory.
PAST MEDICAL/SURGICAL HISTORY: Noncontributory.
FAMILY/SOCIAL HISTORY: Noncontributory.
REVIEW OF SYSTEMS: Noncontributory.

PHYSICAL EXAMINATION:
VITAL SIGNS: Height: 6 feet. Weight: 189 pounds. Blood Pressure: 140/108.
GENERAL: No acute distress.
HEENT: Within normal limits.
NEUROLOGIC: Normal motor and deep tendon reflex examination. No upper motor neuron signs. No evidence of muscle spasm, atrophy or gait disturbance.
CARDIOVASCULAR: Normal peripheral pulses and no peripheral lymphedema.
NECK: Tenderness to palpation of the cervical paraspinal muscles, left greater than right. Negative Lhermitte's sign. Range of motion: Full.
UPPER EXTREMITIES: Right shoulder: Normal vascular exam. Full range of motion of

the shoulder and no intrinsic shoulder signs. Left shoulder: Normal neurovascular exam. Full range of motion with no impingement signs. No instability or AC joint signs.
BACK: Low back: Tenderness to palpation of the lumbosacral muscles bilaterally. Range of motion: Full.
LOWER EXTREMITIES: Bilateral lower extremities: Negative straight leg raising sign bilaterally. Negative hip signs. Normal vascular exam. Thomas' test not performed.

X-RAYS: (Dr. Bethea's office, unknown date.) AP and lateral views of the lumbosacral spine are normal. AP and lateral views of the cervical spine demonstrate decrease in normal cervical lordosis. No other malalignment seen. No fractures seen. No findings suggestive of degenerative disk seen.

IMPRESSION:
1. Neck pain due to contusion of paraspinal muscles with perhaps an element of strain.
2. Left shoulder pain, rule out referred pain from neck, rule out contusion to shoulder producing rotator cuff impingement syndrome.
3. Low back pain, presumably secondary to paraspinal strain sustained at the time of the injury.

* To a reasonable degree of medical certainty, based on the patient's history alone, these problems are probably due to the on the job injury of 06/02/2009. Pain and dysfunction in the left shoulder and on the left side of the neck could lead to secondary overuse of the right side of the neck and the right shoulder, to a reasonable degree of medical certainty.

PLAN: Modified duty statement written. The skin was sterilely prepped with alcohol. 1 cc of Depo-Medrol and 9 cc of 2% lidocaine was placed in a syringe with a 22-gauge 1.5" needle and this was then used to inject the left shoulder subacromial space. A band aid dressing was applied to the area. See how he is doing clinically when he returns. Send him off for MRIs of the neck and the low back. We should have the studies and the reports available when he returns and proceed accordingly. In addition, **we should repeat his blood pressure and if it is still elevated, strongly encourage him to follow up with a primary care physician. We did so today when we noted his blood pressure and notified him of the potential adverse consequences if he did not seek follow up.**

Timothy J. Shannon, M.D.

TJS/ITS/5154

Lee, Bernard 123899

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HISTORY OF PRESENT ILLNESS: The patient is a 29-year-old male who was injured on the job 06/02/2009 (the patient reports that he wrote the wrong date in our chart, i.e., he wrote 07/02/2009). He states that he and other people were attempting to lift a metal hood by forklift when it came down and the lip of the hood struck him on the left side of his neck and superior aspect of his shoulder. He states that he was pinned down for a little while. He was subsequently evaluated by Dr. Jeff Broder in North Augusta, who ordered an MRI of the left shoulder and prescribed physical therapy at Sports Plus for neck, left shoulder, and low back problems. The patient was then referred to Dr. James Bethea who injected the left shoulder. When the worker's compensation carrier dropped this patient's claim, he states that he did not follow up with Dr. Broder or with Dr. Bethea. The patient states that symptoms initially began on the left side of the neck and superior aspect of the left shoulder, but over the past few weeks, he has started to have some problems with his right side of his neck and his right shoulder, he thinks because of increased use of the right shoulder due to the left shoulder problems. In addition, the patient complains of pain localized to the low back region. The patient denies any bladder or bowel changes. No radiation of the shoulder pains into the distal portion of the upper extremities or radiation of the low back pain into the lower extremities at all. Walking, standing too long, breathing, coughing, or sneezing all seem to make all problems worse. The patient states that prior to the on the job injury of 06/02/2009, he had no problems with his neck, shoulders, or low back.

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Timothy J. Shannon, M.D.

TJS/ITS/5154

STATE OF SOUTH CAROLINA)) COUNTY OF EDGEFIELD)	BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
BERNARD LEE,)) Claimant,)) vs.)) BONDEX,)) Employer/Defendant.)	W.C.C. File No. 0906951 NOTICE OF WITNESSES AND WRITTEN REPORT(S)/PHYSICIAN OR OTHER EVIDENCE TO BE INTRODUCED ON BEHALF OF CLAIMANT

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND E. ROS HUFF, ESQUIRE, ATTORNEY FOR EMPLOYER/DEFENDANT:

YOU ARE HEREBY NOTIFIED THAT the Claimant, pursuant to the provisions of the South Carolina Workers' Compensation Act and S.C. Code Ann §1-23-330 (1985), submits the following medical reports as direct evidence on behalf of the Claimant:

NAME OF REPORT(S)/PHYSICIAN OR OTHER EVIDENCE	DATE OF REPORT	NUMBER OF PAGES
1. Accident Report	6/2/09	1
2. University Hospital	6/3/09	2 - 7
3. Dr. Jeffrey Broder	6/5/09 to 7/1/09	8 - 18
4. Sports Plus	6/5/09 to 7/28/09	19 - 29
5. University Open MRI	6/26/09	30
6. Dr. James Bethea	7/16/09	31 - 34
7. Aiken Regional Medical Center	7/18/09 to 7/28/09	35 - 51
8. Dr. Sylva Al-Soudi	8/6/09 to 10/5/09	52 - 58
9. Dr. Timothy Shannon	8/17/09 to 5/25/10	59 - 80
10. Dr. David Goltra	1/14/10	81 - 83
11. Dr. Ty Carter	1/25/10	84 - 85
12. Dr. W. Daniel Westerkam	6/10/10	86 - 87
13. Dr. William Robinson	7/20/10	88

14. Unpaid Medical Bills	89 - 98
15. Consent Orders	99 - 104
16. Correspondence requesting medical treatment	105 - 115
17. Repair Bill from Personnel File	116 - 127
18. Curriculum Vitae of Dr. Timothy Shannon	128 - 131
19. American Medical Association Certifications	132 - 133

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination, and should you desire to exercise that right, you are to forthwith schedule the deposition(s) of any of the physicians or other person(s) whose reports are submitted, for the purpose of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred to herein, or photocopies received from said physicians/others, will be submitted at the Hearing before the South Carolina Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission 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:

All witnesses listed on both parties pre-trial briefs, to include but not be limited to the Claimant. Claimant reserves the right to amend this list of witnesses.

MICKLE & BASS, LLC.

BY: _____

Ann McCrowey Mickle
Attorney for Claimant
930 Oakland Avenue
Post Office Box 10751
Rock Hill, South Carolina 29731
Telephone: (803) 980-0083

Rock Hill, South Carolina
July 28, 2010

STATE OF SOUTH CAROLINA	)	BEFORE THE
	)	SOUTH CAROLINA WORKERS'
COUNTY OF EDGEFIELD	)	COMPENSATION COMMISSION
BERNARD LEE,	)	W.C.C. File No. 0906951
Claimant,	)	
vs.	)	CERTIFICATE OF SERVICE BY MAIL
BONDEX,	)	
Employer/Defendant.	)	

The undersigned employee of ***Mickle & Bass, LLC*** does hereby certify that she has served a copy of the below referenced document(s) in the above captioned case on the below referenced individuals, entity, employer/carrier by depositing the same by first class postage in the United States mail on the 28th day of July, 2010.

Documents served: Form 58 and Notice of Witnesses and Written Report(s)/Physician or Other Evidence to be Introduced on Behalf of Claimant

Parties served:

The Honorable Avery Wilkerson
SC Workers' Compensation Commission
P. O. Box 1715
Columbia, South Carolina 29202-1715

E. Ros Huff, Jr., Esquire
Huff Law Firm, LLC
P.O. Box 1935
Irmo, SC 29063

Erin M. Wiedel

Rock Hill, South Carolina

ACCIDENT REPORT

(Report # 090602LEE
Bondex Report # 09/2-2

BONDEX INC.
ACCIDENT REPORT

DATE: 6-2-9 **TIME:** 9:25 pm

EMPLOYEE'S NAME: Bernard Lee

DESCRIPTION OF ACCIDENT:
Employee Stated he was trying to help install the front Top door on the #3 Cart machine, by lifting it with his hands and Shoulder a he said he guess he was pushing to hard on the door, and he said he damage his left Shoulder and Neck, he stated he was in a lot of Pain, with pain also going down his back.

TREATMENT:
Took Body Powder, and Rub with BIO Freeze Pain Relieving Gel.
Sent to University Hospital ER at 1:45 am

WITNESSES:
Tom Harrison

SUPERVISOR'S SIGNATURE: Lonnie M. Sh...

00001

UNIVERSITY HOSPITAL

University Health Care System
Emergency Services
1350 Walton Way
Augusta, GA 30901
706-774-5060

Final

Emergency Department Chart

Patient Name: LEE, BERNARD D.	Account Number: 0003001309154
Medical Rec. Number: 000300130	Birthdate: 04/30/1980
Arrival Date: 06/03/2009 03:04	Primary MD:
Visit Date: 06/03/2009 03:08	

Chief Complaint

Soft tissue injury to left scapular area. (KGA 06/03/2009 03:08)

Clinician History of Present Illness

PT STATES THAT A HOOD FROM A MACHINE FELL AND HIT HIS LEFT SHOULDER. (KGA) 06/03/2009 03:08 Exam started at 03:34 Presenting problem started 3 hours ago. History comes from patient. Have reviewed and agree with RN note. Source is a poor historian. Patient was injured by machine hood fell on his shoulder. No history to suggest any head injury. The patient states that this problem is job related. Problem occurred at machine hood fell and struck the patient in the left upper shoulder about 9pm. sent for workmans comp. (SMT) 06/03/2009 03:34

Non-Pharmacy Orders

X-Ray of left shoulder
Entered (SMT 06/03/2009 03:27) Secretary Entered (MN1 03:33) In Progress (MLC2 03:28) Completed (MLC2 04:01) MD Sign (SMT 03:27) Indications: Arm injury Arm pain
sling left arm.
Entered (SMT 06/03/2009 03:59) Secretary Entered (MN1 04:02) In Progress (MLC2 04:01) Completed (MLC2 04:12) MD Sign (SMT 03:59)

Vital Signs/Data

Time	Temperature	Pulse	Respiration	Blood Pressure	Pulse Oximetry	Pain
03:08	36.7 C Oral	77 /min	22 /min	136/82 mm hg.	100% on Room air	5/10
05:18		77 /min	20 /min	131/78 mm hg.		6/10

Pre-Hospital Treatment

Patient arrived by private transportation. (KGA) 06/03/2009 03:08

Triage

4 Less Urgent (KGA 06/03/2009 03:08)
No language barrier. (KGA 03:08)
History comes from patient. (KGA 03:08)
Presents with acute injury. (KGA 03:10)
Patient was struck by a HOOD. (KGA 03:10)

Current Medications

Patient takes no medications. (SMT 06/03/2009 03:34)

Nursing Assessment

GENERAL
NEGLECT/ABUSE: Survey shows NEGATIVE risk for this patient. (KGA) 06/03/2009 03:08

Nursing Continuation Notes - Refer to Order

Sling fitted and applied to left arm, adjusted to comfort. Distal CMS intact post application. (MLC2 06/03/2009 04:54)

00002

University Health Care System
Emergency Services
1350 Walton Way
Augusta, GA 30901
706-774-5060

Final

Emergency Department Chart

Patient Name: LEE, BERNARD D.	Account Number: 0003001309154
Medical Rec. Number: 000300130	Birthdate: 04/30/1980
Arrival Date: 06/03/2009 03:01	Primary MD:
Visit Date: 06/03/2009 03:08	

Past Medical and Surgical History

No significant past medical history. Has no prior surgeries. (SMT) 06/03/2009 03:34

Review of Systems

Except as noted all other ROS negative. Except as noted all other ROS negative. (SMT) 06/03/2009 03:34

Social History

.s a non-smoker. Denies use of alcohol. Patient is not employed. Does not take any drugs. (SMT) 06/03/2009 03:34

Family History

No relevant family history related to current problem (SMT) 06/03/2009 03:34

Physical Exam

GENERAL:
This is a well developed well nourished alert adult male. He does not appear to be acute distress. No evidence of significant external trauma. Vital signs OK. (SMT) 06/03/2009 03:34

PULMONARY:
Unlabored respiration. No respiratory distress. No evidence of local chest wall tenderness or external injury. (SMT) 06/03/2009 03:34

ABDOMEN:
Soft abdomen. No external trauma. No local tenderness. (SMT) 06/03/2009 03:34

NEUROLOGIC:
Symmetric reflexes normal strength and tone. Good coordination. (SMT) 06/03/2009 03:34

MUSCULOSKELETAL:
Normal cervical spine exam with full ROM. No bony or significant soft tissue tenderness. No significant muscle spasm. Soft tissue of the anterior neck is OK. (SMT) 06/03/2009 03:34

SKIN:
The skin over the neck is intact without evidence of laceration or significant abrasion. (SMT) 06/03/2009 03:34

SOFT TISSUE:
The rest of the soft tissue exam is normal. (SMT) 06/03/2009 03:34

Diagnosis

shoulder contusion - SMT

Soft tissue injury left scapular area (SMT 06/03/2009 03:57)

Results

X-Ray of left shoulder - this film was independently interpreted by me as the initial reviewer. (SMT 06/03/2009 03:57)
No radiographic evidence of acute fracture. (SMT 03:57)

University Health Care System
Emergency Services
1350 Walton Way
Augusta, GA 30901
706-774-5060

Final

Emergency Department Chart

Patient Name: LEE, BERNARD D.	Account Number: 0003001309154
Medical Rec. Number: 000300130	Birthdate: 04/30/1980
Arrival Date: 06/03/2009 03:04	Primary MD:
Visit Date: 06/03/2009 03:08	

Disposition

Patient discharged from department. Condition at discharge - stable. I have reviewed the chart of BERNARD DERRICK LEE and it is ready for final disposition - STEVEN M TIERNAN MD. (SMT) 06/03/2009 03:57 Patient discharged from department. Discharged home. Patient left by self. Verbalizes understanding of after-care instructions. Verbalizes understanding of need for follow-up and how to access follow-up care. Verbalizes understanding of signs and symptoms to return to ED. Discharge instructions given to patient A disposition has been done for BERNARD DERRICK LEE. The dispositioning nurse is MARTHA LANELL COBB RN (electronic signature). Patient removed from Tracking Board by MARTHA LANELL COBB RN. (MLC2) 06/03/2009 05:20

Discharge Prescriptions

Skelaxin 400 mg PO PRN [muscle pain/spasm] (40) (SMT 06/03/2009 03:57)
Ibuprofen 800 mg PO [every 8 hours] (30) (SMT 03:57)

Discharge Instructions

IBUPROFEN
Your doctor has prescribed ibuprofen for you. Examples of this drug include: Advil, Midol 200, Medipren, Motrin, and Nuprin. Ibuprofen helps reduce pain and inflammation. It can be is used for injuries, fever, arthritis, bursitis, tendonitis, and menstrual cramps. This medicine is most effective when it is taken on an empty stomach, but if it causes stomach upset, take it with meals, milk, or antacids. Ibuprofen comes in tablets and as a suspension (Children's Advil, PediaProfen) which can be used for fever and pain in children. Short term pain treatment with ibuprofen is very safe and effective in most people. However, ibuprofen is not safe to take if you are pregnant or if you have an allergy to aspirin. The most common side effects of treatment are: heartburn, nausea, drowsiness, and headache. Be sure you know how you react to your medicine before you drive a car or operate dangerous equipment. Avoid aspirin while taking Ibuprofen to help reduce stomach irritation. Call your doctor or go to the emergency room right away if you have any of the following symptoms.

*Allergy reaction (itching, rash, hives, fever, breathing problems).
*Severe stomach pain, vomiting, black or bloody stools.
*Severe headache, blurred vision, confusion, mental depression.

SKELETAL MUSCLE RELAXANTS
Your doctor has prescribed a muscle relaxant for you. Examples of these drugs include Flexeril, Norflex, Skelaxin, Soma, and benzodiazepine drugs. They are usually prescribed to help reduce painful muscle spasms and improve motion in neck and back injuries. They are most effective for a brief period after an injury, because muscle spasm does not usually last a long time. These medicines add to drowsiness associated with taking pain pills, antihistamines, or tranquilizers, and with drinking alcohol. We advise you not to drive a car or operate dangerous equipment while taking this medicine. Besides drowsiness the common side effects include dry mouth, dizziness, mental depression. Muscle relaxants should not be taken during pregnancy. Contact your doctor right away if you have any allergy symptoms (itching, rash, hives, fever), excessive sedation, or other troublesome side effects.

X-RAY STUDIES
You have had x-ray studies done today as part of your medical evaluation. These x-ray films have been examined by your doctor. They will also be checked by a radiology specialist and a report is available for your doctor. You will be called if a review of your x-rays shows that further examinations or treatment are needed. Please call your doctor if you have any questions about your x-ray results.

Staff Legend
KGA KEITH ALBERT RN
MLC2 MARTHA COBB RN
SMT STEVEN TIERNAN MD

UNIVERSITY HOSPITAL
An Affiliate of University Health Care System

LEE, BERNARD DERRICK
04/30/80 29Y BM ERWR -
300 130 0003001309154
ENG MED AUGUSTA, PHYSICIAN

WORKER'S COMPENSATION FLOWSHEET

BREATHALIZER (CALL 706/303-2760) YES ___ ACCESS INITIALS _____

PATIENT REQUIRES BLOOD/ALCOHOL TEST ___YES ___NO TEST REQUIRED

PATIENT REQUIRES DRUG SCREEN ✓YES ___NO 1DP-6

IF DRUG SCREEN or ALCOHOL TEST IS REQUIRED, Dismissal/Nurse/Transport escorts patient to the laboratory with paper work, i.e. copy of E.R. chart face sheet.

DATE 6-03-09

PATIENT NAME Lee, Bernard MEDICAL RECORD NBR 300-130

EMPLOYER NAME Bordex Inc

EMPLOYER ADDRESS Two Maxwell Dr. Trenton SC 29847

COMPANY PHYSICIAN OCC-med MEDICAL REVIEW OFFICE _____

✓ 1. Triage nurse identifies as on-the-job injury.

✓ 2. Registrar verifies workers' compensation.

✓ 3. Registrar ascertains contact person.
NAME Albert Martin PHONE NUMBER 803-663 1972

___ 4. Patient Representative is notified.

___ 5. Patient Representative calls company contact person.

___ 6. Physician completes E.R. record, follow-up recommendations and Medical Treatment Form.

___ 7. Nurse dismisses patient according to E.R. standards

___ 8. Dismissal/admitting nurse calls the respective company contact person to give a brief synopsis of the findings, treatment and recommendations.

___ 9. Dismissal nurse prepares required papers and sends them with the patient. (Check company profile for specifics).

___ 10. Dismissal registrar completes flowsheet.

___ 11. If admitted, the Patient Representative calls the employer.

FLOWSHEET COMPLETED BY [signature]

Form # 0110 Rev. (10/2003) Page 1 of 1 Page

00005

New Physical Profile

Workers Compensation Company Profile

LEE, BERNARD DERRICK
04/30/80 29Y 8M ERWR
300 130
P ENG
0003001309154
MED AUGUSTA, PHYSICIAN G

Mailing Address

Company Name **Bondex Inc**

Carrier Information		Company Information	
Address	**Two Maxwell Drive**	Address	**Two Maxwell Drive**
City	**Trenton**	City	**Trenton**
State	**SC**	State	**SC**
Zip	**29841**	Zip	**29841**
Phone:		Phone:	
Fax	**803-663-9626/Phone: 803-663-1922**	Fax	**803-663-9626/Phone: 803-663-1922**

Workers Comp Verification During Business Hours

Name	Phone	Cell / Pager	Email
Bowers, Nancy	**803-663-1922**		
Williams, Gene	**803-663-1922**		
Waters, Charlie	**803-663-1922**		

Workers Comp Verification After Business Hours

Name	Phone	Cell / Pager	Email
Bowers, Nancy	**803-278-2628**	**803-439-1778**	

Substance Abuse Screening

DRUG SCREENING

Drug Screen Driver	**Yes**	Drug Screen Non-Driver	**Yes**
Drug Test	**IDP6**	Drug Test	**IDP6**

ALCOHOL SCREENING

Alcohol Screen	**Yes**	Alcohol Test	**Breathalyzer**

Special Instructions

Light Duty
Pharmacy
Special Instructions

Referring Physician

1
2
3
4
5
6

Primary Location
South Richmond County

Audit Information

Entered by **Susan Brega 07/06/2004**
Updated by **Susan Brega on 07/06/2004 03:23:54 PM**

00006

University Health Augusta, GA

RADIOLOGY REPORT

LEE, BERNARD
Date of Birth : 04/30/1980
PATTENT ID: 000300130
ACCOUNT NUMBER : 0003001309154
PATIENT LOCATION : ERWR

ORDERING PROVIDER : TIERNAN, STEVEN

REQUISITION NUMBER: BD91C38
DATE INTERPRETED : 06/03/2009

PROCEDURE / CPT CODE	: SHOULDER, LEFT	73030
ORDERING PRIORITY	: STAT	
CLINICAL INDICATIONS	: SHOULDER INJURY	
ORDERING PHYSICIAN	: TIERNAN, STEVEN	
DICTATING RADIOLOGIST	: BULLOCK, M.D., HUEY	

DATE PERFORMED: 06/03/2009 03:45

Left shoulder, three views

Three views show no fracture or dislocation. There is no significant arthritic change. The acromioclavicular joint is normal.

Impression:
Unremarkable left shoulder.
Electronically Signed by BULLOCK, M.D., HUEY
06/03/2009 16:03

00007

DR. JEFFREY BRODER

NORTH AUGUSTA URGENT CARE

Bernard D. Lee
BM-29
NKOR

JUN 5 2009

CC: Injured (L) arm Wed at work — BP

BP 140/100
WT 192
P 60
T 98.3
R 18

HT 6'0"
Bandaid
Job Hx
Cert operator
D.O.I
Wed 6/3/09 @ 9:30pm
ER 6/4/09 1:30AM
Meds
Ibuprofen 800mg TID
Tylenol 500mg TID
→ Were filled
PMH
Meds
Right Handed

@ 2pm/06 of @ Shoulder pain x 2 days. Stated he was trying to Bring a Metal Cover down when 2 poles collided, States the Shock gave pain and at that time @ Ant Shoulder area (7 10/10 Crampy pain) Stated then @ UHER Evening the Morning of 6/4/09. Stated was able to give Sling, given prescription for Ibuprofen and Tylenol - were filled/Meds. Stated used one of them Ibuprofen Does whether or not, Stated for workers Due to fall

@ Biceps Bent 90° X 3 NAD Wears Sling of @ Bicep

(L) Shoulder - (review ER record UH) - @ flexion = Pain to Ant Deltoid area, @ Elevation Forward = Pain
@ Pull Testing = Resistance to Abduction pull pain +2/+4

@ @ Shoulder pain 7:19:41
- Prayer for Comfort / pain Meds
- Do not Fill prescriptions for UHER
- Ibuprofen 800mg TID @ BID for pain
- Wrist brace
- Ice to the Shoulder
RT Mike

00008

NORTH AUGUSTA URGENT CARE
FAMILY & OCCUPATIONAL MEDICINE CENTER

PROCESSING FORM

Occupational Medicine Program
1201 West Avenue • North Augusta, SC 29841 • (803) 279-1030

Date 6-5-09

This Section to Filled Out at Company

Employee's Name Bernard Lee Social Security # 251452204 Date of Birth 4/30/86
Company Name Bondex Dept.
Supervisor Name Phone 663-1922 Ext.
Reason for Visit: ☑ On-The-Job Injury ☐ Job Related Illness
☐ Other
Nature of Complaint: Lt. arm injury
Time Left Work : AM PM Processed By: M. Frye
Date Injury Occured 6/3/09 Verified By: Nancy Bowers

This Section to be Filled Out by Receptionist at Physician's Office

Time In: 1:40 AM PM Time Out: 4:35 AM PM Date 6-5-09
Disposition: PT MRI pending
☐ Patient May Return to Work Without Restriction
☑ Patient May Return to Work With the Following Restrictions:
(See Codes on Reverse Side.)
A B C D E F G H_R (H_L) I J K L M_R M_L
N O P Q
(Patient Will Contact Supervisor for Evaluation in Performing Alternate Work)
☐ Patient Will be Unable to Work For _____ Days.
(Patient Will Contact Supervisor Within 24 Hours to Report Status)

☐ ~~Patient Referred to Specialist:~~ Ortho
Snider MD
Appointment Date 6-12-09
At 2:00 AM PM
☑ Company Contact Called.
By:
To: Nancy Bowers
At: 4:26 AM PM

Physician Report and Treatment: DX: L Shoulder pain
Rx Vicodin 5mg one tab 2 times per day for pain with food
PT visit 2
Ice x 1-2 days, then moist heat
Rest if Work Injury

Physician's Signature 6/5/09 Date

I hereby authorize the Physician and Hospital to disclose the information contained on this form concerning my condition to my employer, and herby release the Physician and Hospital from any liability arising from such disclosure.

Employee's Signature 6/5/09 Date

Instructions:
1. Company fills out top section and retains gold copy Remaining copies are put in an envelope and given to employee.
2. Employee gives envelope with forms to clerk/receptionist on arrival.
3. After evaluation and treatment, Physician retains pink copy.
4. Yellow copy is mailed to employer the same day of treatment.
5. Employee retains white copy and shows to supervisor on return to work.

00009

RESTRICTION CODES

An explanation of restrictions applying to your employee is included for your reference. Please consider the restriction(s) applicable until your employee has been re-evaluated by one of the physicians at the North Augusta Urgent Care Family & Occupational Medicine Center.

A. No work requiring depth perception, driving, climbing or operating machinery.

B. Keep wound clean and dry until sutures are removed.

C. No stooping, bending or twisting.

D. No lifting greater than 10 lbs.

E. No lifting greater than 20 lbs.

F. No lifting greater than 30 lbs.

G. Sitting work only.

H_R No right handed work.

H_L No left handed work.

I. No work with arms over head.

J. No excessive walking.

K. Must use crutches.

L. Must wear splint.

M_R No gripping, twisting, or forceful turning - right hand.

M_L No gripping, twisting, or forceful turning - left hand.

N. No prolonged sitting or standing

O. No climbing.

P. Medication may cause drowsiness. Should not drive, operate dangerous machinery or be at unguarded heights.

Q. Other - Refer to chart.

00010.

Bernard Lee
29 yo BM
NKDA Cl # 56455128

6-9-09
Mary Shaw calls & approves P.T. referra
thru Align Network PO

6-10-09 8:15
Align Network contacted & Rx faxed
for P.T. referral, they will Schedule
w/ Pt. PO

00011

JUN 12 2009

Bernard D. Lee
BM-29
55
NICDA

B/P 144/96
WT 186
P 76
T 98.0
R 15
@Randall

CC: neck + shoulder pain. AC

Has 1st PT scheduled 6-17-09.
States he cannot take arm out of sling but "too much pain" even though he has tried to stretch it
PS 10/10 "all the time"
Has been taking the naproxyn bid @ muscle relaxant
Restless sleep trying to get in comfortable position
O: alert wd wn WNAD sweeping sling.
Shoulder Ht @
Mod severe tenderness over @ trapezius into shoulder Tense @ scapula
Difficult to abduct @ arm rotad laterally but easier ventrally
MS 4/5 @ 5/5 @ +pulses

DTRI
@ clavicle

1: @ shoulder pain 719.41
P: Wean out of sling - left it on
Add skelaxin as given by previous provider
Continue naproxyn as given by Dr Broder
Heat/stretches as demonstrated
Avoid smoke & tobacco
Keep PT appt
RTC same restrictions as given by Dr Broder
1 wk

Candace Waters
MSN, RN, CS, CDE 00012
Nurse Practitioner

NORTH AUGUSTA URGENT CARE
FAMILY & OCCUPATIONAL MEDICINE CENTER

Occupational Medicine Program
1201 West Avenue • North Augusta, SC 29841 • (803) 279-1030

PROCESSING FORM

Date 6-12-09

This Section to Filled Out at Company

Employee's Name ~~Francisco~~ Bernard Lee Social Security # 251452204 Date of Birth 4-30-80
Company Name Bonded Dept.
Supervisor Name Phone 663 1922 Ext.
Reason for Visit: ☒ On-The-Job Injury ☐ Job Related Illness
☐ Other
Nature of Complaint: Rev
Time Left Work : AM PM Processed By: Mary Frye
Date Injury Occured 6/3/09 Verified By: Nancy Bowers

This Section to be Filled Out by Receptionist at Physician's Office

Time In: 1 51 : AM (PM) Time Out: 2 : 25 AM (PM) Date 6-12-09

Disposition:

☐ Patient May Return to Work Without Restriction

☒ Patient May Return to Work With the Following Restrictions. (See Codes on Reverse Side.)

A B C D E F G H_n H_L I J K L M_n (M) N O P Q as given by Dr Broder

(Patient Will Contact Supervisor for Evaluation in Performing Alternate Work)

☐ Patient Will be Unable to Work For _____ Days.
(Patient Will Contact Supervisor Within 24 Hours to Report Status)

~~☐ Patient Referred to Specialist:~~
J Broder MD
Appointment Date 6-19-09
At 2:30 AM PM
☐ Company Contact Called.
By: CW
To: N Bowers VM
At: 2 : 2C AM (PM)

Physician Report and Treatment: (2) shoulder pain not improved Keep PT appts as scheduled. Ice as much as possible. Avoid sling. Stretch as reviewed add back to shoulder as previously given. Continue Celebrex 200 Naproxen as given by Dr Broder for 1 wk 6/12/09

Physician's Signature Date

I hereby authorize the Physician and Hospital to disclose the information contained on this form concerning my condition to my employer, and herby release the Physician and Hospital from any liability arising from such disclosure

Employee's Signature Date

Instructions:

1. Company fills out top section and retains gold copy. Remaining copies are put in an envelope and given to employee.
2. Employee gives envelope with forms to clerk/receptionist on arrival.
3. After evaluation and treatment, Physician retains pink copy.
4. Yellow copy is mailed to employer the same day of treatment.
5. Employee retains white copy and shows to supervisor on return to work.

00013

Bernard D. Lee
BM-29
NKDA

JUN 19 2009

B/P 100/108
WT 139
P 80
T 98.4
R 15

1st Appt
17 June 09

CC: follow up. AC

Ⓟ 29yo ♂ here to rvw hx ⓒ Shoulder.
Hx MVC 8/10, fell on
ⓒ PT x1. - Mild ache
PT Sx No numbness or tingly down arm
Hx Shoulder Mildly sore first but No pain
today.

ⓒ Lat Pull DYSFX

ⓒ Shoulder - From ⓒ pec
ⓒ tendon resection
to Bicep
Pulls +2 ITY
Ⓓ Jobs (Hx + Bicep Deltoid
area

Ⓐ ⓒ Shoulder pain 719.41 (Rx Rotator Cuff
tear)
Ⓟ - MRI ⓒ Shoulder
- Pain Mgt Center / refer to Ortho
- Continue Naproxen 500 mg 1 PO BID pc
for pain
- No ⓒ lifting until / Step Taken.

00014

NORTH AUGUSTA URGENT CARE
FAMILY & OCCUPATIONAL MEDICINE CENTER

Occupational Medicine Program
1201 West Avenue • North Augusta, SC 29841 • (803) 279-1030

PROCESSING FORM

Date JUN 19 2009

This Section to Filled Out at Company

Employee's Name Bernard Lee Social Security # 251452204 Date of Birth 4-30-80
Company Name Bondex Dept.
Supervisor Name Phone 663-1922 Ext.
Reason for Visit: ☑ On-The-Job Injury ☐ Job Related Illness
☐ Other
Nature of Complaint: Re ✓
Time Left Work : AM PM Processed By: M. Frye
Date Injury Occured 6-3-09 Verified By: Nancy Bowers

This Section to be Filled Out by Receptionist at Physician's Office

Time In: 2:22 AM PM Time Out: : AM PM Date JUN 19 2009

Disposition: MRI L Shoulder - okked by Bowers Faxing letter ☐ ~~Patient Referred to Specialist:~~ Ht Brdr MD

☐ Patient May Return to Work Without Restriction

☒ Patient May Return to Work With the Following Restrictions: (See Codes on Reverse Side.)
A B C D E F G H_a (H) I J K L M_a M_t N O P Q
(Patient Will Contact Supervisor for Evaluation in Performing Alternate Work)

☐ Patient Will be Unable to Work For _____ Days.
(Patient Will Contact Supervisor Within 24 Hours to Report Status)

Appointment Date 6-26-09
At 9 : 30 AM PM

☑ Company Contact Called.
By: J Matthews
To: Nancy Bowers
At: 3 : 19 AM PM

Physician Report and Treatment: Dx L Shoulder pain (719.91).
R: Continue Naproxen 500 mg po bid x 2 wks prn for pain with ROM
c Work Restrictions: Continue
c Refer to Ortho if needed

Physician's Signature 6/19/09 Date

I hereby authorize the Physician and Hospital to disclose the information contained on this form concerning my condition to my employer, and herby release the Physician and Hospital from any liability arising from such disclosure.

Employee's Signature 6/19/09 Date

Instructions:

1. Company fills out top section and retains gold copy. Remaining copies are put in an envelope and given to employee.
2. Employee gives envelope with forms to clerk/receptionist on arrival.
3. After evaluation and treatment, Physician retains pink copy.
4. Yellow copy is mailed to employer the same day of treatment.
5. Employee retains white copy and shows to supervisor on return to work.

00015

Bernard Lee
29 40 BM
NRDA

Claim #
090602LEE

6-23-09
Called Nancy Bowers to check status of MRI referral. Stated she would speak w/ Janis Napier in H.R.

Janis calls back & states she spoke w/ Mary Shaw w/ Strategic who approved MRI thru One Call Medical.

6-25-09
8:00 One Call Medical contacted the will call pt & schedule MRI & then fax us appt info D

00016

NORTH AUGUSTA URGENT CARE
FAMILY & OCCUPATIONAL MEDICINE CENTER

Occupational Medicine Program
1201 West Avenue • North Augusta, SC 29841 • (803) 279-1030

PROCESSING FORM

Date 6/26/09

This Section to Filled Out at Company

Employee's Name Bernard Lee Social Security # 251452204 Date of Birth 4/30/80
Company Name Bonacx Dept.
Supervisor Name Phone 663-1922 Ext. 260
Reason for Visit: ☒ On-The-Job Injury ☐ Job Related Illness
☐ Other
Nature of Complaint: RC √
Time Left Work : AM PM Processed By: Chicsy Smith
Date Injury Occured 6-3-09 Verified By: Nancy Bowers

This Section to be Filled Out by Receptionist at Physician's Office

Time In: 9:32 AM PM Time Out: 10:30 AM PM Date 6/26/09

Disposition:
☐ Patient May Return to Work Without Restriction
☒ Patient May Return to Work With the Following Restrictions:
(See Codes on Reverse Side.)
A B C D E F G H_R (H_L) I J K L M_R M_L
N O P Q
(Patient Will Contact Supervisor for Evaluation in Performing Alternate Work)
☐ Patient Will be Unable to Work For _____ Days.
(Patient Will Contact Supervisor Within 24 Hours to Report Status)

~~☐ Patient Referred to Specialist:~~
Baxter MD
Appointment Date 7/1/09
At 2:00 AM PM
☐ Company Contact Called.
By:
To: Nancy Bowers
At: 10:30 AM PM

Physician Report and Treatment: Dx' @ Shoulder pain / Elevated Blood Pr w/continue Naproxen soon as he can get appt w/ LHD for f/u Pt has MRI this evening / Return Soon if * See your family Doctor About High Blood pressure Meds

Physician's Signature 6/26/09 Date

I hereby authorize the Physician and Hospital to disclose the information contained on this form concerning my condition to my employer, and herby release the Physician and Hospital from any liability arising from such disclosure.

Employee's Signature 6/26/09 Date

Instructions:
1. Company fills out top section and retains gold copy. Remaining copies are put in an envelope and given to employee.
2. Employee gives envelope with forms to clerk/receptionist on arrival.
3. After evaluation and treatment, Physician retains pink copy
4. Yellow copy is mailed to employer the same day of treatment.
5. Employee retains white copy and shows to supervisor on return to work.

NORTH AUGUSTA URGENT CARE
FAMILY & OCCUPATIONAL MEDICINE CENTER

Occupational Medicine Program
1201 West Avenue • North Augusta, SC 29841 • (803) 279-1000

PROCESSING FORM

Date JUL 1 2009

This Section to Filled Out at Company

Employee's Name Bernard D. Lee Social Security # 251452204 Date of Birth 4-30-80
Company Name Bandex Dept.
Supervisor Name Phone 663-1922 Ext. 2020
Reason for Visit: ☑ On-The-Job Injury ☐ Job Related Illness
☐ Other
Nature of Complaint: Rc ✓
Time Left Work ____ : ____ AM PM Processed By: Mary Frye
Date Injury Occured 6-3-09 Verified By: Nancy Bowers / Jenny Wapp

This Section to be Filled Out by Receptionist at Physician's Office

Time In: 1:56 AM PM Time Out: 4:15 AM PM Date JUL 1 2009
Disposition: Continue P.T.
☐ Patient May Return to Work Without Restriction
☑ Patient May Return to Work With the Following Restrictions:
(See Codes on Reverse Side.)
A B C D E F G H_R (H) I J K L M_R M_L
N O P Q
(Patient Will Contact Supervisor for Evaluation in Performing Alternate Work)
☐ Patient Will be Unable to Work For ____ Days.
(Patient Will Contact Supervisor Within 24 Hours to Report Status)

☑ Patient Referred to Specialist: Ortho
Pending Approval MD
Appointment Date
At ____ : ____ AM PM
☑ Company Contact Called. 803-663-66[illegible]
By: [signature] / Jenny Wapp
To: Mary Frye
At: 4:40 AM PM

Physician Report and Treatment: Dx: Rt Shoulder pain - / Repeat treatments
Continue PT
Keep Same restrictions / Wean Exercises
No Shelves / Continue Naproxen Surgery DO Thurs pm
day before pm last pt 7/1/09
Physician's Signature Date

I hereby authorize the Physician and Hospital to disclose the information contained on this form concerning my condition to my employer, and herby release the Physician and Hospital from any liability arising from such disclosure.

Employee's Signature 7/1/09 Date

Instructions:

1. Company fills out top section and retains gold copy. Remaining copies are put in an envelope and given to employee.
2. Employee gives envelope with forms to clerk/receptionist on arrival.
3. After evaluation and treatment, Physician retains pink copy.
4. Yellow copy is mailed to employer the same day of treatment.
5. Employee retains white copy and shows to supervisor on return to work.

00018

SPORTS PLUS

PROGRESS NOTES

COMPPN 031309

PATIENT Lee, Bernard DOCTOR Broder

DIAGNOSIS (1) L shoulder pain (2) NEXT MD APPT 6/26/09

Date 6/05/09 Total Timed Code Min. — Total Treatment Time Min. —

SUBJECTIVE Pt. states his back seemed to hurt after last visit "I feel something in other shld. too, I'm not 40/50 to sure about E-stim"

OBJECTIVE

___ Interf.	___ min	(2) MH	20 min	(2) CTX/PTX	20	#lbs Int/static	20	___ fluido	___ min		
___ E-stim	___ min	___ manual	___ min	___ ther ex per flow sheet	___ min	___ paraffin					
___ CP	___ min	___ other	___ min	(1) US cont/pulse	8 min	___ Ionto	___ mA/				

1.8 w/cm2

ASSESSMENT: Response to treatment / Goal Status Pt. seemed hesitant about having the E-stim combination treatment 2° ↑P therefore performed only US 4x c distraction

PLAN: Pt. to have MRI performed tomorrow cont. PT once Pt. has results

Therapist Signature: Michelle Maynard PTA

Date 6-29-09 (3) Total Timed Code Min. — Total Treatment Time Min. —

SUBJECTIVE Pt to RTD this Wednesday for results of MRI. Pt reports ↑ (L) shoulder blade/back pain p c-txn last 2 times. Reports max pain felt (L) anterior shoulder.

OBJECTIVE

___ Interf.	___ min	___ MH	___ min	___ CTX/PTX	___	#lbs Int/static	___	___ fluido	___ min		
___ E-stim	___ min	___ manual	___ min	(2) ther ex per flow sheet	15 min	___ paraffin					
___ CP	___ min	___ other	___ min	(1) US cont/pulse	8 min	___ Ionto	___ mA/m				

1.8 w/cm2 1 MHz

No soft tissue dysfunction noted (R) UT/levator mm. (L) ant/post GH jt. min tenderness (L) ant/post GH jt.

ASSESSMENT: Response to treatment / Goal Status d/c'd cont. txn 2° no benefit & possible irritation (L) shoulder. Adv focus to (L) RTC/GH jt. Mod verbal cueing on sci-fit. Tolerated addition of exs well.

PLAN: Cont Pt 2x/wk - 3x/wk per POC. may d/c to phone MV for RTC involvement/Pt

Therapist Signature: Renee K. Belton, PT

00019

MAILED
6/19/09

SPORTS PLUS

170 University Parkway • Aiken, SC 29801 • Phone (803) 649-9975 • Fax (803) 649-3357

06/17/2009

PHYSICAL THERAPY EVALUATION

PATIENT: Lee, Bernard
PHYSICIAN: Dr. Broder
DOB: 04/30/1980
DIAGNOSIS. Left shoulder pain.

SUBJECTIVE:
CURRENT HISTORY/MECHANISM: The patient reports that on 06/02/2009 while at work, a 700-pound hood that goes on a machine fell between his neck and left shoulder.
PREVIOUS HISTORY/SURGERY: Surgery for broken bone in the left hand approximately 6 years ago; otherwise, unremarkable.
MAJOR COMPLAINTS: The patient complains of left arm from the shoulder down forearm into hand becomes numb, constant burning left side of neck and shoulder; complains of increased pain with working. The patient reports that he was released about 3 days after injury to return to work, working with right upper extremity only but patient states that now his right side is starting to hurt and his left side is beginning to hurt more. The patient is also having sharp pains in the posterior region of his left shoulder. The patient rates pain in left arm between 7 and 9/10.
ASSISTIVE DEVICE/SPLINT/BRACE: None.
MEDS: Skelaxin. The patient reports he was given that initially at the emergency room then it was changed to Naprosyn and then changed back to Skelaxin.
OCCUPATION/HOBBIES: The patient works at Bondex as a machine operator. The patient has been back to work with limitations on left arm movements since approximately 3 days after initial injury. The patient doe state that pain is affecting his sleep. The patient usually sleeps on his back.
DIAGNOSTIC TESTS: The patient reports x-rays were negative.

OBJECTIVE:
The patient is right-hand dominant.
POSTURE/GAIT: Anterior view: Right shoulder elevated. Posterior view: Increased window space right Lateral view: Increased lumbar lordosis, increased abdominal mass, forward head. Sitting: Forward head, increased thoracic kyphosis.
ROM: Cervical: Within functional limits throughout with increased pulling noted left shoulder with right rotation and right side flexion. Upper extremities: Left shoulder external rotation and internal rotation limited; all motions painful throughout left shoulder testing. Bilateral cervical rotation right at 40%, left at 20%.
STRENGTH: The patient is unable to straighten arm to 90° due to pain. Significant weakness or weak resistance given per patient felt with left shoulder abduction, external rotation and elbow flexion. Grip strength of Jamar level 2: Right equals 131 pounds, left equals 85 pounds.
NEUROLOGICAL: Decreased to light touch throughout left upper extremity. DTR: +2 bilateral biceps and brachioradialis; unable to elicit bilateral triceps.
PALPATION: Increased tenderness upper to mid thoracic spine, left medial and lateral scapular region, left upper trapezius and left anterior glenohumeral joint.
EDEMA/ATROPHY: None noted.

TREATMENT:
The patient received ICTX with moist heat x 15 minutes at 15 pounds with 40-second hold, 20-second rest cycle.

00020

Lee, Bernard 06/17/2009

ASSESSMENT:
The patient is a 29-year-old male status post work injury in which a 700-pound hood fell on his neck and left shoulder. The patient with decreased sensation to light touch, decreased strength and function with left upper extremity, tenderness noted throughout cervical and thoracic spine, left shoulder girdle and anterior left glenohumeral joint.

GOALS:
1. The patient will have WNL left upper extremity ROM and strength to allow for normal function including work activities within 4 weeks.
2. The patient will rate pain at 0/10 at worst to allow for normal functional activities within 4 weeks.
3. The patient will be independent with HEP to prevent re-injury within 4 weeks.
4. The patient will return to normal ADL function with left upper extremity including work activities within 4 weeks.

Rehabilitation potential is good.

PLAN:
PT 2-3 x a week x 4 weeks for ICTX with moist heat, ultrasound versus phonophoresis, electrical stimulation, manual therapy and therapeutic exercises/HEP.

Thank you for your referral of Bernard Lee. If you have any further questions regarding this treatment plan, please feel free to contact me.

Paula K. Bolton, PT
Paula K. Bolton, PT

nd

PATIENT EVALUATION WORKSHEET

_____See attached addendum

SUBJECTIVE:

Current History / Mechanism: Pt states 100 lb hood that got on a machine fell between his neck + (L) shoulder June 2, 2009 (Tues.)

Date: 6-17-09
Patient: Lee, Bernard DOB: 4-30
Physician: Dr. Broder
Diagnosis: (L) shoulder pain
Frequency:
Next MD appointment: 6-19-09

Previous History / Surgery: SX for broken (L) hand bone ~ 6 yrs. ago

Pain Rating

Major Complaints: 4/0 (L) forearm + hand numbness/constant 1-2-3-4-5-6-7-8-9-10
burning (L) side neck + shoulder. 4/0 ↑ pain c working. now (R) side is starting to hurt: sharp pain post. (L) shld.

Asst. Device / Splint / Brace: Ø

Medication: Skelaxin initially, Δ to Naprosyn → then was told to start back c Skelaxin.

Occupation / Hobbies: Pt works @ Border as a machine operator. Pt has been back to work (limited (L) arm movements) since ~ 3 days p initial injury. Pain Affects sleeping, pt sleeps on back

Diagnostic Tests: x-rays (L)

OBJECTIVE: (R) hand dom.

Posture / Gait: Ant.: (R) shldr. elevated, Post.: ↑ mid. spine (R)
Lat: ↑ lumb. lord, ↑ abd. mass, FH,
Sitting: FH, ↑ thor. kyph.,

ROM: Cervical: WFL throughout c ↑ pulling (L) shldr. c (R) rot + side ✓
(L)shldr. ER & IR limited; all motions painful (L) shldr.

Neuro not: (R) @ 40% (L) @ 20%
Special tests:

Strength: Pt unable to straighten arm (flex to 90°) 2° pain. Weakness / or weak resist.: felt c abd, ER and elbow ✓

Level 2
Grip: (R) = 131 # (L) = 85 #

Neurological: ↓ to LT throughout (L) UE's
DTR: +2 (R) biceps + brachioradialis / unable to elicit (R) triceps

Palpation: ↑ tenderness upper / mid - trapezius (L) medial / lat scapula, UT, (L) ant GH j't

Edema / Atrophy: None noted

ICTx c MH
40/20
15# x 15 min

Precautions: NKDA

00022

PHYSICAL THERAPY NOTES

COMPPN 031309

PATIENT Lee, Bernard DOCTOR Broder

DIAGNOSIS (R) shoulder pain NEXT MD APPT 6-19-09

Date 6-17-09 Total Timed Code Min. Eval Total Treatment Time Min. —

SUBJECTIVE Eval dictated

OBJECTIVE Rom LE 40/20

___ Interf.	___ min	(2) MH	15 min	(2) CTX/PTX	15	#lbs (1) int/static	15	___ fluido	___ mi
___ E-stim	___ min	___ manual	___ min	___ ther ex per flow sheet		___ min		___ paraffin	
___ CP	___ min	(1) other Eval	___ min	___ US cont/pulse		___ min		___ lonto	___ mv

ASSESSMENT: Response to treatment / Goal Status Pt is a 29 y/o ♂ s/p work injury in which a 700# bed fell on his neck & (R) shoulder. Pt c/o severe pain (L) UE, Tenderness c thoracic spine, cervical/thoracic spine (R) shoulder girdle and anterior (L) chest. Goals: 1. Pt will have WNL (L) UE ROM and strength c/n 4wks 2. Pt will rate pain @ 0-2/10 @ work c/n 4wks, 3. Pt will be (I) c HEP c/n 4wks. 4. Pt will return to normal ADL function c (L) UE incl. work activities c/n 4wks. Pt's pot. is good.

PLAN: PT 2-3x/wk x 4wks for ELTx c MH, US v. phono, e-stim, manual therapy and ther exs/HEP

Therapist Signature: Renee K. Bolton, PT

Date 6-23-09 Total Timed Code Min. (1) Total Treatment Time Min. —

SUBJECTIVE Pt reports ↑ pain + swelling / numbness (R) hand and arm 2 work. Pt worked 1 hour last night. Pt is unable to perform work c/ (R) UE, 9/10 pain (R) side of neck/head. Pt to RTO this Friday. Pt instructed to call Dr. Broder to inform him of the ↑ in symptoms. Pt to have MRI scheduled.

OBJECTIVE Rom LE 40/20

___ Interf.	___ min	(2) MH	20 min	(2) CTX/PTX	20	#lbs (1) int/static	20	___ fluido	___ min
(1) E-stim (IFC)	10 min	___ manual	___ min	___ ther ex per flow sheet		___ min		___ paraffin	
___ CP	___ min	___ other	___ min	(1) US cont/pulse (E-stim)	10	min (1.5 w/cm², 1 MHz)		___ lonto	___ mA/m

(R) Sidelying: hand swelling (min) noted.

ASSESSMENT: Response to treatment / Goal Status Held off exs today, 2° ↑ sx.

PLAN: Cont PT 2-3x/wk for modalities / manual Rx as indicated. Will await MD visit to progress to active ther ex. May add gentle stretching NV.

Therapist Signature: Renee K. Bolton, PT

00023

ACC'T #/DOB 4/20/80

Patient Portion

Frequency/Duration 2-3x/wk

Initial Therapist

Paula (for michele)

Authorized Treatment

REHABILITATION RECORD

Max. Benefits _____ Deductible/Remaining _____

Misc. Notes: _____

Date of Visit	Therapist:	PE - PT Evaluation R - Re-eval	OE - OT Evaluation R - Re-eval	TP - Therapeutic Procedure	N - Neuromuscular Reeducation	G - Gait Training	O - Orthotics / N - Night Splint	TA - Therapeutic Activity (funct'l)	W - Work Hardening initial 2 hours	W+ - Work Hardening add'l hours	M - Manual Therapy Tech	B - Biodex Exercise BT - Biodex Test	H - Hot Pack C - Cold Pack	E - Electrical Stimulation WP - Whirlpool F - Fluido	PT - Pelvic Traction CT - Cervical Traction	I - Iontophoresis U - Ultrasound	P - Paraffin D - Debridement/Dressing	T - Tens Fitting S - Supply	Ph - Physical Performance Test	Patient Portion Due	Patient Portion Paid	Initials
1st (6th)																						
6-23-09	63											H,	E,		CT,	U,						
6-25-09	132											H,			CT,	U,						
6-29-09	63			TP,								C,				U,						
7-1-09	130			TP,												U,						
7-7-09	132			TP,									E,			U,						
7-9-09	132			TP,									E,			Ph,						
8th (14th)				TP,					M			C,				Ph,						
7-28-09	63R,								M,													
16th																						

Friday, July 30, 2010 (16).max

PROGRESS NOTES

COMPPN 031309

PATIENT Lee, Bernard DOCTOR Broder

DIAGNOSIS (L) shld (P) NEXT MD APPT

Date 7/1/09 Total Timed Code Min. (9) Total Treatment Time Min.

SUBJECTIVE no changes per pt. report
"I do get headaches @ times"

OBJECTIVE

___ Interf.	___ min	___ MH	___ min	___ CTX/PTX	___ #lbs Int/static	___	___ fluido	___	mir
___ E-stim	___ min	___ manual	___ min	(1) ther ex per flow sheet	15 min		___ paraffin		
___ CP	___ min	___ other	___ min	___ US cont/pulse	___ min		___ Ionto	___	mA

ASSESSMENT: Response to treatment / Goal Status pt. s changes since beginning PT; only 1 c/o (P)

PLAN: awaiting MRI results; cont. per MD

Therapist Signature: Michelle Maynard PTA

Date 7/7/09 Total Timed Code Min. (5) Total Treatment Time Min.

SUBJECTIVE pt. not sure what the MRI results were
"they are going to send me to a specialist"

OBJECTIVE

(3) Interf.	15 min	___ MH	___ min	___ CTX/PTX	___ #lbs Int/static	___	___ fluido	___	min
___ E-stim	___ min	___ manual	___ min	(1) ther ex per flow sheet	15 min		___ paraffin		
~~2~~ (1) CP	___ min	___ other	___ min	(2) US cont/pulse	8 min		___ Ionto	___	mA/n

1.8 w/cm²

ASSESSMENT: Response to treatment / Goal Status Please see Alignnetworks Progress note

PLAN: cont. per POC until pt. to see specialist

Therapist Signature: Michelle Maynard PTA

00025

ALIGNETWORKS

We have not received a recent progress summary in two weeks. Please fax this back to 904-309-8942.

FAXED 7/7/09

Patient Progress Note

Provider Name: Clemson Sports Medicine and Rehab (RAN)
Today's Date: Jul 6 2009 8:30PM
DOB: 04/30/1980
Eval Date: 6/17/2009 10:00:00 AM
# of visits auth from eval: 12
Diagnosis: Shoulder Joint Pain
Guideline: 12

Patient's Name: Bernard Lee
Claim #: 564551282
Surgery Date:
RX. Expiration Date:
Service: Physical Therapy

Last DOS: 7-1-09 # Of Visits seen from Eval: 5 # of CX/NS Visits: 0

Patient has met 0 % Goals from Evaluation

AROM / PROM Joint:	Eval Date __/__/__	Re-Assess: __/__/__	Re-Assess: __/__/__
PAIN LEVEL			

STRENGTH Joint:	Eval Date __/__/__	Re-Assess __/__/__	Re-Assess __/__/__

Progress toward work related goals: pt has made Ø progress towards goals; able to tolerate Abem exer. & light resistive exer.

Remaining Deficits: pt still c/o (P) throughout (D) shld & nad c/o (P) in cervical region & midback region

New Goals: same as initial evaluation; pt had MRI although he doesn't recall results of the MRI

Summary of treatment provided: ther.ex, ultrasound, Interferential current

Recommendations:

☐ _____ **Visits remaining, cont. POC**

☐ **Add'l Auth Requested to Continue therapy** ____ x wk for ____ wks

☐ **Follow up with MD and continue per MD Recommendation**

☐ **Discharge** _____ **% Goals Met** ☐ **D/C – poor compliance** ☐ **D/C – plateau – f/u MD**

Plan for D/C?	< 2 wks	2-4 wks	4-6 wks	>6 wks	D/C expected within current or requested auth? Y/N
	☐	☐	☐	☐	

Summary of Communication with MD: _____

Therapist Name: Michele Maynard PTA Signature: Michele Maynard PTA Date: 7-7-09

00026

PROGRESS NOTES

COMPPN 031309

PATIENT Lee, Bernard DOCTOR Brooker

DIAGNOSIS (L) shld. (P) NEXT MD APPT

Date 7/9/09 Total Timed Code Min. (6) Total Treatment Time Min.

SUBJECTIVE Pt. brought in MRI report today
Pt. reports the e-stim didn't bother him last time

OBJECTIVE

(3) Interf.	20 min	MH	min	CTX/PTX	#lbs Int/static	fluido	ml
E-stim	min	manual	min	(1) ther ex per flow sheet	20 min	paraffin	
CP	min	other	min	(2) US cont/pulse	8 min	ionto	mA

phono 1.8 w/cm²
(L) shld.

ASSESSMENT: Response to treatment / Goal Status ↓difficulty assessing pt.'s (P) levels and/or benefit from attempting phono in conjunction c IFC to ↓ inflammation. Pt. c/o (P) c standing, scaption. Tolerated ↑ resistance c fatigue

PLAN: assess benefit of phono @ IV

Therapist Signature: Michelle Maynard PTA

Date 7-14-09 Total Timed Code Min. (7) Total Treatment Time Min.

SUBJECTIVE Pt cont. to c/o pain, states his whole (L) side is "messed up". "Now my (L) shoulder is hurting". C/o sharp pain when he takes a deep breath. "Will I ever be able to lift anything heavy again".

OBJECTIVE

Interf.	min	MH	min	CTX/PTX	#lbs Int/static	fluido	min
E-stim	min	(3) manual	10 min	(1) ther ex per flow sheet	20 min	paraffin	
(9) CP	15 min	other	min	(2) US cont/pulse	5 min	ionto	mA

50% phono 1.8 w/cm², 1MHz
(L) wall CH, I/bicep/ends

3) Fm (L) SC + AC jt., Pmon

ASSESSMENT: Response to treatment / Goal Status Tol fairly, moved slowly c sl. fx

PLAN: Pt to see orthopedist this Thursday, needs to R/S PT appt

Therapist Signature: Paula K. Bolton, PT

00027

SPORTS PLUS +

PHYSICAL THERAPY SERVICES

Physician Follow Up / Re-Evaluation / Discharge

Date: 7-28-09 Physician: Dr. Brooker / Dr. Bethea

Patient Name: Lee, Bernard DOB: 4-30-80 Initial Eval. Date: 6-17-09 Last Visit: 7-28-09

Diagnosis: Left shoulder pain / mechanical upper back / neck pain Number of Visits: 9

Patient's treatment has consisted of:

Thur ex / HEP, manual therapy for (L) shoulder, added MET for possible (L) subluxed 1st rib, STM/FM to (L) side C-spine (L) pectoralis major-minor mm and FM to (L) SC + AC jts. on 7-28-09 tried ICTx c MH, US c e-stim and pulsed phono c no success. Have also tried IFC.

Objective Measurements/Progress: Pt c same pain level of 7-9/10, constant and sharp. Pt c/o inability to perform full breath diaphragmatically. (L) shoulder AROM (supine) & V = 80°, Abd = 96°, ER = 30°, IR = 65°. Pt c ~20° ↑ (L) shoulder V + Abd PROM and (L) shoulder ER + IR are WNL passively. Pt c significant soft tissue restriction of (L) pectoralis major + minor mm c-spine and lt. rib jts @ (L) SC + AC jt.

Assessment/Progress: Pt has had no benefit thus far c PT. Pt most likely c mechanical back, shoulder and neck pain 2° traumatic injury. Initiated manual therapy to address these issues on 7-28-09. Pt should respond more positively c this new approach.

Plan/Goals/Reason for DC:

Cont PT 2-3x / wk for manual therapy as indicated for myofascial, articular osseokinematic dysfunction of neck, (L) shoulder, thoracic spine and costal cage. Modalities including IFC and e-stim as needed.

Thank you very much for this referral. Please feel free to contact our clinic if you have any questions or concerns regarding this patient's treatment.

New MD orders or written comments: **Frequency & Duration:**

Therapist signature: Brook K. Bolton, PT MD signature:

00028

170 University Parkway • Aiken, SC 29801 • (803) 649-9975 • Fax (803) 649-3357 • www.csmr.org

PROGRESS NOTES

COMPPN.031309

PATIENT Lee, Bernard DOCTOR Bader

DIAGNOSIS (L) shld. pain NEXT MD APPT 7-30-09

Date 7-28-09 Total Timed Code Min. Re-eval Total Treatment Time Min. _____

SUBJECTIVE Pt saw orthopedist. X-rays of back + neck taken. Pt to return this Thursday. Pt still on light duty, not using (L) arm. Pt states he is having a hard time keeping up with work just using one arm. Pt still standing up 2 hrs. Pt c/o LB pain up to neck, can't lift (L) arm. Constant sharp pain around (L) shoulder joint. Pt still c/o 7-9/10 pain.

OBJECTIVE

____ Interf.	____ min	____ MH	____ min	____ CTX/PTX	____ #lbs int/static	____ fluidо	____ ml
____ E-stim	____ min	____ manual	____ min	____ ther ex per flow sheet	____ min	____ paraffin	
____ CP	____ min	(1) other Re-eval	____ min	____ US cont/pulse	____ min	____ ionto	____ mA

Pt has been using ice @ home. Pt can't sleep @ night. 2° the pain.

(L) shoulder AROM: (supine): √=80° c Pain Abd= 90, Ele= 30° IR= 105°

↑ROM c passive movement ~20 more degrees c √ + Abd, ↓ROM c passive ER ER c complaints of pain.

ASSESSMENT: Response to treatment / Goal Status See re-eval

PLAN:

Therapist Signature: Paula K. Bolton, PT

Date _____ Total Timed Code Min. (1) Total Treatment Time Min. _____

SUBJECTIVE

OBJECTIVE

____ Interf.	____ min	____ MH	____ min	____ CTX/PTX	____ #lbs int/static	____ fluidо	____ min
____ E-stim	____ min	____ manual	____ min	____ ther ex per flow sheet	____ min	____ paraffin	
____ CP	____ min	____ other	____ min	____ US cont/pulse	____ min	____ ionto	____ mA/

ASSESSMENT: Response to treatment / Goal Status

PLAN:

Therapist Signature: _____

00029

UNIVERSITY OPEN MRI

UNIVERSITY
OPEN MRI

PATIENT: Lee, Bernard
SSN: 2204
DOB: 04/30/1980
EXAM DATE: 06/26/2009
REFERRING PHYSICIAN: Jeffrey Broder, MD

MRI LEFT SHOULDER

HISTORY: Injury, possible rotator cuff tear.

FINDINGS: There is AC joint arthropathy. There is medial arch impingement of a mild degree. There is fluid in the biceps tendon sheath. The tendon appears to be intact. There is no bone edema or fracture. There is no specific evidence for rotator cuff tear.

CONCLUSION:
Acromioclavicular joint arthropathy with mild impingement. Bicipital tendonitis.

Richard Six M.D. Southeast Radiology, PA

D: 06/29/2009/Job#: 4821238
T: 06/29/2009 16:19:43/228646/Doc#: 3878347
Copy:
Document authenticated by Richard Six M.D. Southeast Radiology, PA. on 06/30/2009 09:48:31 ET

00030

DR. JAMES BETHEA

COLUMBIA ORTHOPAEDIC

SPECIALISTS

Columbia Orthopaedic *Specialists, LLC*
1301 Taylor Street, Suite 3-O
Columbia, SC 29202-0306

DATE: 07/16/09

PATIENT: Bernard D. Lee
SSN: 251-45-2204

CHIEF COMPLAINT: Left shoulder, neck and back pain.

PRESENT ILLNESS: This is a 29-year-old male, who states that he was involved in an accident at work June 2nd, 2009. in which he injured his left shoulder, but also his neck and lower back. In the early morning of June 3rd, 2009 he was seen at the emergency room in Augusta, where he was diagnosed with a shoulder contusion. Shoulder x-rays were negative and he was prescribed Skelaxin and ibuprofen.

Following that he states that he was seen by Dr. Broder five or six times. According to the notes provided to me, Dr. Broder saw him June 5th and prescribed naproxen and physical therapy. June 12th Dr. Broder noted no improvement in his left shoulder and Skelaxin was also prescribed.

Six or seven sessions of physical therapy have been completed so far without any real benefit and he does continue with these treatments twice a week.

Today he was kindly sent here for consultation.

A deep breath makes his pain worse. After standing 30-60 minutes he does have more pain. Walking can be uncomfortable. He knows that he can lift about 15 lb.

Skelaxin did help him, but his employer told him to stop taking it if he wanted to work.

The pain does radiate to his left hand.

He states that at work he is being asked to do more than he can perform.

Numbness in the left hand was mentioned. Pain radiates to the left hand. Sleep is a problem. Even bathing is a problem. He denied any previous episode.

PAST MEDICAL HISTORY: His only medication is naproxen, which he does take twice a day. No drug allergy or previous surgery was mentioned.

PHYSICAL EXAMINATION: General appearance is that of a pleasant 6'0" 186 lb. male with a normal station and gait. There was some tenderness at his left trapezius. Active flexion of the left shoulder was limited to 70° and active abduction was limited to 70°. External rotation and internal rotation were both possible to 90°. O'Brien's test, Speed's test, cross body adduction, apprehension maneuver and the impingement test were all negative. Distal neurovascular status was intact.

At the lumbar spine he had 100° of flexion with 30° of extension. Lateral bending was possible to 30° in either direction and lateral rotation was possible to 60° either to the right or left. Distal neurovascular status was intact in both the upper extremities and lower extremities. Straight leg raising was negative.

At the cervical spine he had at least 30° of lateral rotation in either direction with the maneuver to the right more uncomfortable. Flexion was possible to 60°, extension was possible to 30°. Lateral rotation was possible to 30° either to the right or left.

RADIOGRAPHS: AP and lateral x-rays of his cervical spine failed to reveal any evidence of any injury. AP and lateral x-rays of his lumbar spine were normal. Three x-rays of his left shoulder done June 3rd were reported as showing no significant pathology.

MRI SCAN: Multiple images of his left shoulder done June 26th, 2009 revealed AC joint arthropathy with mild impingement, as well as tendinitis of the biceps.

IMPRESSION:

1. IMPINGEMENT SYNDROME LEFT SHOULDER.
2. NECK AND BACK PAIN.

DISPOSITION: Under sterile technique, I did inject the left shoulder subacromial space with 40 mg Depo-Medrol and 2 cc 2% Xylocaine.

I do want him to continue with his physical therapy for his left shoulder.

I reassured him that the neck and back pain do not represent any serious injury.

For now he will limit pushing, pulling, lifting and carrying with his left upper extremity to 15 lb. He is not allowed any overhead work with his left upper extremity.

I did dispense (#60) 500 mg naproxen to be taken one twice a day on food.

I will see him back in about two weeks.

James F. Bethea, M.D.
JFB/prf

(Next Appointment 07/30/09 @ 3:00 p.m.)

Cc: Strategic Comp Services
Att: Steve Anthony
P.O. Box 1445
Alpharetta, GA 30009

00033

JUL-23-2009 11:44 From:8035806817B COLUMBIA ORTHOPAEDIC Page:4/4

Columbia Orthopaedic Specialists, LLC
P.O. Box 306
Columbia, SC 29202-0306
803.806.8192
803.806.8175

WORK STATUS

DATE: 7/16/09

PATIENT: Bernard Lee

___ REGULAR DUTY DATE TO RETURN TO WORK ___

/ LIGHT DUTY DATE TO RETURN TO WORK 7/16/09

___ REMAIN OUT OF WORK APPROX. DURATION ___

PHYSICAL LIMITATIONS:

___ NONE
___ NO WALKING OR CLIMBING
___ NO STANDING
___ NO PROLONGED STANDING
___ NO SITTING
___ NO BENDING OR STOOPING
___ NO TWISTING OR STRETCHING
___ NO CHANGE FROM PREVIOUS STATUS
___ OTHER: ___

/ PUSHING&PULLING LIMIT 15 LBS
/ LIFTING&CARRYING LIMIT 15 LBS
___ SEDENTARY DUTIES ONLY
___ NO KNEELING, SQUATTING, CRAWLING
___ NO WORK INVOLVING R/L ARM/HAND
/ NO OVERHEAD WORK (L) arm
___ NO WORK AT HEIGHTS

FOLLOWUP:

/4 DAYS ___ MONTHS
___ WEEKS ___ PRN(AS NEEDED)
___ DISCHARGED

___ NEXT APPOINTMENT ___

PHYSICIAN SIGNATURE

JAMES F. BETHEA, M.D.

www.OrthoDoc.aaos.org/JimBethea

00034

AIKEN REGIONAL MEDICAL CENTER

Date 7/18/09 Arrival Time 1839 Mode of Arrival: ☐ POV ☐ EMS ☐ Ambulatory ☐ Carried ☐ W/C

Name Lee, Bernard DOB 4/B/80

Current Complaint (in patient's own words) "I cut my (R) wrist on a piece of glass"

Name/Title HHSP CTT

Triage Time 1845

Communication Assessment

Primary Language: ☑ English ☐ Spanish ☐ Other

Translation: ☑ N/A ☐ Language Line ☐ Other

Hearing: ☑ No apparent deficit ☐ Wearing hearing aid Vision: ☑ No apparent deficit ☐ Wearing glasses

Allergies NKDA

T 98.4 P 86 R 18 B/P 133/70 SAO2 97

Pain: Location R arm Scale (0-10) 10/10

LMP — Wt. 190 lbs. ☐ Actual ☐ Stated

Assessment (R) Lower forearm c 2-3 cm laceration w glass 1° ago. Moves hand - fingers req. Ex.

Triage Level: ☐ 5 ☑ 4 ☐ 3 ☐ 2 ☐ 1 Disposition: ☐ Major ER ☐ Minor ER

Triage Interventions: ☐ Ice ☐ Elevation ☐ Sling ☐ Splint ☐ Bleeding Control ☐ Fever med ☐ ASA (per ACS protocol) ☐ Other glass applied

Triage RN Signature

Reassessment: Date Time

Evaluation: ☐ No change from previous assessment ☐ Change(describe)

Action/Intervention

RN Signature Date Time

To ER Room # @ Report to QPI done ☑ yes ☐ no

LWBS: Date Time Reason

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

TRIAGE ASSESSMENT

ER0515 - Triage Form

Patient Identification

107662058

LEE , BERNARD D
DOB 04/30/1980 29 SX: M EMR
MRN: 177273 ADM/REG DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

AND

00035

Hole 1/4 2 3/4 c-o-c

Hole 1/4 2 3/4 c-o-c

Physical Assessment: Time Performed 2010
☒ Head-to-toe ☐ Focused Assessment
Past Surgical History: ☐ Denies any significant surgical history
☐ Appendectomy ☐ Hysterectomy
☐ Cholecystectomy ☐ Tubal Ligation
☐ CABG ☐ Cardiac Stents
☐ Other Mental patient (Shard

PMD _____

Pain:
Score: _____ Location: _____
Scale: ☐ Numeric ☐ Faces ☐ FLACC ☐ Nips
Onset: _____ ☐ hours ☐ days ☐ weeks ☐ months ☐ years
Description: ☐ Constant ☐ Intermittent ☐ Dull ☐ Sharp ☐ Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Cramping ☐ Pressure
Aggravates: ☐ Nothing ☐ Activity ☐ Food ☐ Palpation ☐ Cough ☐ Deep Breath
Alleviates: ☐ None ☐ Medication ☐ Positioning ☐ Heat ☐ Cold
Other _____

Past Medical History: ☐ Denies any significant medical history
☐ CAD ☐ CHF
☐ Cancer (type) _____
☐ Diabetes ☐ Asthma
☐ COPD ☐ CVA/TIA
☒ HTN ☐ Hypercholesterolemia
☐ GI Bleeding/Ulcer ☐ Hepatitis
☐ Kidney Stones ☐ Renal Failure
☐ Migraines ☐ Seizures
☐ HIV/Aids ☐ Other _____
Home Oxygen: ☐ N/A _____ L/m via _____

GU/GYN ☒ Assessment WNL
Urine: ☐ Hematuria ☐ Cloudy ☐ Odor ☐ Dark ☐ Burning ☐ Frequency ☐ Inconsistency ☐ Foley present on admission
Dialysis access site location _____ ☐ N/A
Menses: ☐ Irregular ☐ Painful ☐ Vaginal bleeding Pad Count ____ #
LMP _____ EDC _____ G ____ P _____ Ab _____
☐ Vaginal/Penile discharge color: _____

Current Assessment
Pulmonary: ☒ Assessment WNL
Respirations: ☐ Labored ☐ Rapid ☐ Slow ☐ Deep ☐ Shallow ☐ SOB
Breath Snds: ☐ Diminished ☐ Absent ☐ Crackles ☐ Wheezes ☐ Rhonchi
Cough: ☐ Productive ☐ Non productive Sputum _____
Location of abnormalities ☐ Right ☐ Left ☐ Bilateral
Other _____

Gastrointestinal ☒ Assessment WNL
☐ Nausea ☐ Vomiting Emesis color _____
☐ Diarrhea # stools _____
☐ Constipated # days _____ ☐ Rectal bleeding
Abdomen: ☐ Pendulous ☐ Distended ☐ Tender ☐ Rigid
Bowel sounds: ☐ Absent ☐ Hyperactive ☐ Hypoactive

Cardiovascular: ☒ Assessment WNL
Chest Pain: ☐ Yes ☐ No Describe _____
Heart Sounds: ☒ Regular ☐ Irregular ☐ Muffled ☐ Rub
Pulses: ☐ Not Palpable Location _____
EKG Rhythm _____
JVD ☐ Yes ☐ No

Integumentary ☒ Assessment WNL
1" Lateral laceration inner R-A
☐ Cool ☐ Pale ☐ Clammy ☐ Diaphoretic ☐ Flushed ☐ Mottled
☐ Cyanotic ☐ Jaundiced ☐ Pink
Last Tetanus: Date _____ ☐ Unknown

Neurological ☒ Assessment WNL
Responsiveness ☐ Unresponsive ☐ Responds to painful stimuli
Speech: ☐ Slurred ☐ Incoherent ☐ Aphasic
Activity level: ☐ Pacing ☐ Restless ☐ Combative ☐ Sleeping ☐ Seizure Activity
Other _____

Orthopedic ☒ Assessment WNL
☐ Impaired Circulation (Location) _____
☐ Deformity (Location) _____
☐ Limited ROM (Location) _____
☐ Amputation (Location) _____

HEENT ☒ Assessment WNL
☐ Asymmetrical ☐ Numbness ☐ Paresthesia ☐ Difficulty swallowing
☐ Nystagmus Other _____

Psychosocial ☒ Assessment WNL
☐ Uncooperative ☐ Anxious ☐ Agitated ☐ Threatening ☐ Angry
☐ Depressed ☐ Suicidal ☐ Homicidal ☐ Avoids eye contact
Affect: ☐ Flat ☐ Crying ☐ Non-verbal
Hallucinations: ☐ Visual ☐ Auditory

Assessment RN _____ Signature _____ 7/15/09 2045 Date/Time

RN Signature: _____ Date: _____

Patient Identification
107662058
LEE , BERNARD D
DOB: 04/20/1980 29 SX: M EMR
MRN: 177273 ADM/REG DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

Aiken Regional Medical Centers
302 University Parkway

ED NURSING ASSESSMENT
ED0.84
Rev. 7/09
Page 1 of 4

ER0807 - ED Assessment

00036

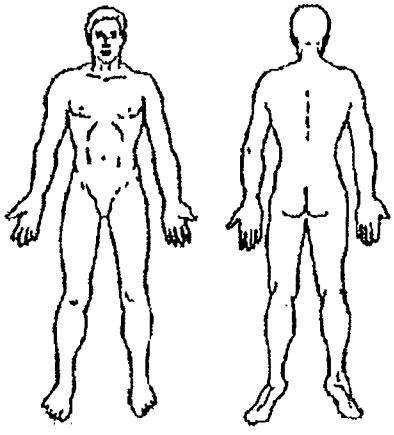
2-Hole 1/4 2 3/4 c-to-c

Physical Findings Diagram

Right



1 – Abrasion
2 – Amputation
3 – Burn
4 – Deformity
5 – Ecchymosis
6 – Edema
7 – Hematoma
8 – Insect Bites
9 – Laceration



Label Areas Involved

10 – Pain
11 – Puncture wound
12 – Rash
13 – Redness
14 – Scar
15 – Skin Breakdown
16 – Skin Tear
17 – Stoma

Left



3-Hole 1/4 4 1/4 c-to-c

HISTORY OF FALLS	☐ YES ☒ NO	**FALL RISK ASSESSMENT** (1 or less yes answers = low)	**SKIN ASSESSMENT**
AGE >65 YEARS	☐ YES ☐ NO	☒ LOW RISK ☐ HIGH RISK	☐ Y ☒ N > 65 YO
TRANSFERS IMPAIRED	☐ YES ☐ NO	**FALL INTERVENTION**	☐ Y ☐ N Impaired Mobility
ORIENTATION CONFUSED/		☐ SIDE RAILS ☐ BED IN POSITION	☐ Y ☐ N Impaired Sensory Perception
BEHAVIORAL ISSUES	☐ YES ☐ NO	☐ CALL LIGHT ☐ BS OBSERVATION	☐ Y ☐ N Inadequate Nutrition
		☐ YELLOW ARM BAND	Yes to one or more – skin assessment w/in 2 hours of admission orders

ABUSE AND NEGLECT SCREEN

Have you been hit, slapped, kicked, or otherwise physically or socially hurt by someone? ☐ Yes ☒ No

IV THERAPY

TIME	VOLUME	SOLUTION OF LOCK	RATE	BLOOD#	SITE	GAUGE	# ATTEMPTS	INITIALS	TIME D/C	INITIALS	TOTAL INFUSED

INTAKE			OUTPUT			Time	Blood Sugar (finger stick)	Education/Symptoms/Comments	Initials
Time	Type	Volume	Time	Type	Volume				
Total Intake:			Total Output:			Normal range: 70-110 mg/dl Critical range: Less than 50 mg/dl or greater than 500 mg/dl			

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

630.84

Rev. 7/08
Page 2 of 4

ER0807

Patient Identification

107662058
LEE , BURNARD D
DOB: 04/30/1980 29 SX: M Blk
MRN: 177273 ADM/REC DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

00037

Page 2 of 4

Single (E4-1)

2-Triple 1/4 2 3/4 c-to-c

Date/Time	Nurses Notes
7/18/09 2025	Assess. Complete - Pt. 1" laceration to R inner FA - bleeding controlled - Tetnus given 2025 - Notified Resident re: Tetnus - DSG applied to R inner FA - cleansed & Betadine - Loop pressure applied & 7x2 + Ax Strip - Pt. ambulatory 2030 DC instructions given pt & verbal understanding - Pt. DC'd Ambulatory with father driving - EMR

Initials	Signature/Title	Initials	Signature/Title	Initials	Signature/Title
					Van Burkhart

DISCHARGE STATUS

DATE: 7/18/09 TIME: 20:30
☒ ROUTINE (HOME) ☐ AMA ☐ LWBS
☐ ADMIT TO:
PHYSICIAN:
☐ TRANSFERRED TO:
☐ ACCEPTING PHYSICIAN:
☐ EXPIRED

METHOD OF DISCHARGE

☒ AMBULATORY ☐ AMBULANCE
☐ WHEELCHAIR ☐ CARRIED

DISCHARGE VITAL SIGNS

BP 138/86 P 92 R 16
T _____ SAO2 100% PAIN _____

ACCOMPANIED BY

☐ SELF ☒ RELATIVE ☐ POLICE
☐ FRIEND ☐ OTHER EXPLAIN: Father

DISCHARGE VITAL SIGNS

☒ Verbal
☒ Written ☐ Not Given (why): _____
☒ PT VERBALIZES UNDERSTANDING

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

530.64
Rev. 7/09
Page 4 of 4

ER0607

Patient Identification

107662058
LEE , BERNARD D
DOB: 04/10/1980 29 SX: M ENR
MRN: 177273 ADM/REG DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

00038

Page 4 of 4

GENERAL INSTRUCTIONS:

☐ Call the next business day and make an appointment to see: _____

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: _____ days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within _____ days.

☐ Return to the Emergency Department in _____ days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☐ Work / school excuse from _____ thru _____. May return to work _____.

☐ See your company doctor per your company's policy. Light duty until _____.

(No use of _____ No lifting over _____ lbs.)

☐ _____

Your diagnosis was: _____

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diphtheria booster***
- ☐ Blood/Body Fluid Exposure Follow up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X_Rays. If cultures were obtained, results will not be final for 3 or more days
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physician.
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x rays) not received or completed during your stay in the Emergency Department.
8. If you feel you want to harm yourself or are suicidal, call 1-800-784-2433 (National Suicide Hotline).

Physician / Staff _____ Date 7/18/09 _____ Patient or Responsible Person

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

EMERGENCY SERVICES

ER0023

63006
Rev. 9/08

Patient Identification

107662058
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M EMR
MRN: 177223 ADM/REG DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

WHITE - RECORDS CANARY - PATIENT GOLDENROD - PATIENT

00039

Home Medication List
Physician's Order

Height: 6 feet 0 inches

Weight: unknown pounds actual stated estimated

Allergies: NKDA

Nurse Signature: [signature] Date/Time: 7/18/09

ADMISSION		DISCHARGE	
At time of entry, please check which medications should be continued and sign below to authenticate order		At time of discharge, check which medications should be continued and sign below to authenticate order	
Give med upon adm.	Do not give med upon adm.	Continue at discharge	Do not continue at discharge

Home Medications

Unapproved abbreviations: IU, Ns, MSO4, MgSO4, Q.D., q.d., q.o.d., U, u, trailing zeros, no zeros before decimal

Medication/Dose	Route	Frequency	Reason for Taking	Last dose taken
Information obtained from: ☑ Patient ☐ Patient Representative	☐ No home medications ☐ Unable to obtain list			
Include insulin, inhalers, eye drops, aspirin, herbals, vitamins, and OTC.				
Skelaxin	po			7/17/09
Naproxen	po			

Physician Signature (on admission): Date:

Physician Signature (on discharge): Date:

Outpatients Only

Changes to home medications: ☐ None ☐

Based on the treatment prescribed by your physician(s) and the list of medications that you provided, you may continue your home medications with the changes written above, if any. Please contact your prescribing physician if you have any questions about your home medications.

New Discharge Medications

☐ No new medications @ discharge

Medication/Dose	Route	Frequency	Reason for taking
Keflex	take	as directed	

Outpatients Only

Physician Signature: [signature] Licensed Staff's Signature: [signature] Patient's Signature: [signature]

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

PC0001D

Home Medication List
Physician's Order

10/3/036
601.126
Rev. 11/07

CHART COPY

Patient Label

107662058

LEE , BERNARD D
DOB: 04/30/1980 29 SEX: M RMR
MRN: 177273 ADM/REG DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

00040

Date 7-28-09 Arrival Time 2147 Mode of Arrival: ~~POV~~ ☐ EMS ☐ Ambulatory ☐ Carried ☐ W/C

Name Bernard Lee DOB 8-30-80

Current Complaint (in patient's own words) Back neck shoulder pain

Name/Title

Triage Time 2147
Communication Assessment:

Primary Language: ~~☐ English~~ ☐ Spanish ☐ Other

Translation ~~☐ N/A~~ ☐ Language Line ☐ Other

Hearing: ☐ No apparent deficit ☐ Wearing hearing aid Vision: ☐ No apparent deficit ☐ Wearing glasses

Allergies NKMA

T 98.4 P 81 R 18 B/P 154/90 SAO_2 100

Pain: Location Neck. Back & Shoulder. Scale (0-10) 10.

LMP Wt. 190 lbs. ☐ Actual ~~☐ Stated~~

Assessment Something fell on neck 2 mo ago - pain getting worst

Triage Level: ☐ 5 ~~☐ 4~~ ☐ 3 ☐ 2 ☐ 1 **Disposition:** ☐ **Major ER** ~~☐ Minor ER~~

Triage Interventions: ☐ Ice ☐ Elevation ☐ Sling ☐ Splint ☐ Bleeding Control ☐ Fever med ☐ ASA (per ACS protocol) ☐ Other

Triage RN Signature

Reassessment: Date Time

Evaluation: ☐ No change from previous assessment ☐ Change(describe)

Action/Intervention

RN Signature Date Time

To ER Room # @ Report to QPI done ~~☐ yes~~ ☐ no

LWBS: Date Time Reason

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

RIAGE
SSMENT

ER0515 - Triage Form

Patient Identification
10770522O
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M RMR
MRN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

00041

Triple 1/4 2 3/4 c-to-c

Hold

Hole 1/4 4 1/4 c-to-c

Physical Assessment: Time Performed 2150
☐ Head-to-toe ☑ Focused Assessment

Past Surgical History: ☐ Denies any significant surgical history

☐ Appendectomy	☐ Hysterectomy
☐ Cholecystectomy	☐ Tubal Ligation
☐ CABG	☐ Cardiac Stents
☐ Other Head	

PMD None

Pain:
Score: 10/10 Location: neck/back/shoulder
Scale: ☐ Numeric ☐ Faces ☐ FLACC ☐ Nips
Onset: 2 ☐ hours ☐ days ☐ weeks ☑ months ☐ years
Description: ☐ Constant ☐ Intermittent ☐ Dull ☐ Sharp ☐ Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Cramping ☐ Pressure
Aggravates: ☐ Nothing ☐ Activity ☐ Food ☐ Palpation ☐ Cough ☐ Deep Breath
Alleviates: ☐ None ☐ Medication ☐ Positioning ☐ Heat ☐ Cold
Other

Past Medical History: ☐ Denies any significant medical history

☐ CAD	☐ CHF
☐ Cancer (type)	
☐ Diabetes	☐ Asthma
☐ COPD	☐ CVA/TIA
☐ HTN	☐ Hypercholesterolemia
☐ GI Bleeding/Ulcer	☐ Hepatitis
☐ Kidney Stones	☐ Renal Failure
☐ Migraines	☐ Seizures
☐ HIV/Aids	☐ Other

Home Oxygen: ☐ N/A ____ Lpm via ____

GU/GYN ☑ Assessment WNL
Urine: ☐ Hematuria ☐ Cloudy ☐ Odor ☐ Dark ☐ Burning ☐ Frequency ☐ Inconsistency ☐ Foley present on admission
Dialysis access site location ____ ☐ N/A
Menses: ☐ Irregular ☐ Painful ☐ Vaginal bleeding Pad Count ____#
LMP ____ EDC ____ G ____ P ____ Ab ____
☐ Vaginal/Penile discharge color: ____

Current Assessment
Pulmonary: ☑ Assessment WNL
Respirations: ☐ Labored ☐ Rapid ☐ Slow ☐ Deep ☐ Shallow ☐ SOB
Breath Snds: ☐ Diminished ☐ Absent ☐ Crackles ☐ Wheezes ☐ Rhonchi
Cough: ☐ Productive ☐ Non productive Sputum ____
Location of abnormalities ☐ Right ☐ Left ☐ Bilateral
Other

Gastrointestinal ☑ Assessment WNL
☐ Nausea ☐ Vomiting Emesis color ____
☐ Diarrhea # stools ____
☐ Constipated # days ____ ☐ Rectal bleeding
Abdomen: ☐ Pendulous ☐ Distended ☐ Tender ☐ Rigid
Bowel sounds: ☐ Absent ☐ Hyperactive ☐ Hypoactive

Cardiovascular: ☑ Assessment WNL
Chest Pain: ☐ Yes ☐ No Describe ____
Heart Sounds: ☐ Regular ☐ Irregular ☐ Muffled ☐ Rub
Pulses: ☐ Not Palpable Location ____
EKG Rhythm ____
JVD ☐ Yes ☐ No

Integumentary ☑ Assessment WNL
☐ Cool ☐ Pale ☐ Clammy ☐ Diaphoretic ☐ Flushed ☐ Mottled ☐ Cyanotic ☐ Jaundiced ☐ Pink
Last Tetanus: Date ____ ☐ Unknown

Neurological ☑ Assessment WNL
Responsiveness: ☐ Unresponsive ☐ Responds to painful stimuli
Speech: ☐ Slurred ☐ Incoherent ☐ Aphasic
Activity level: ☐ Pacing ☐ Restless ☐ Combative ☐ Sleeping ☐ Seizure Activity
Other

Orthopedic ☐ Assessment WNL
☐ Impaired Circulation (Location) neck/back/shoulder
☐ Deformity (Location) shoulder
☐ Limited ROM (Location) upper 2 months
☐ Amputation (Location) ____ 950

HEENT ☑ Assessment WNL
☐ Asymmetrical ☐ Numbness ☐ Paresthesia ☐ Difficulty swallowing
☐ Nystagmus Other ____

Psychosocial ☑ Assessment WNL
☐ Uncooperative ☐ Anxious ☐ Agitated ☐ Threatening ☐ Angry
☐ Depressed ☐ Suicidal ☐ Homicidal ☐ Avoids eye contact
Affect: ☐ Flat ☐ Crying ☐ Non-verbal
Hallucinations: ☐ Visual ☐ Auditory

Assessment RN [signature] 7/28/09
Signature Date/Time

RN Signature: ____ Date: ____

ER0907 - ED Assessment

ED NURSING ASSESSMENT

Patient Identification
107705220
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M EMR
MRN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

00042

Triple 1/4 2 3/4 c-to-c

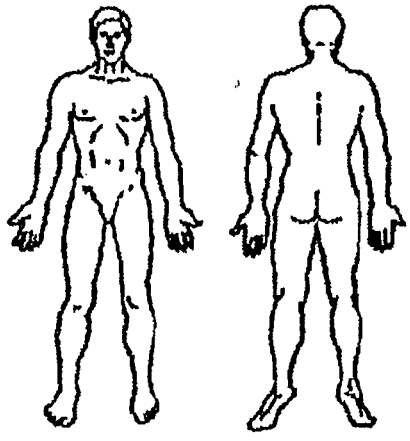
Physical Findings Diagram

Right



Left





1 – Abrasion
2 – Amputation
3 – Burn
4 – Deformity
5 – Ecchymosis
6 – Edema
7 – Hematoma
8 – Insect Bites
9 – Laceration

Label Areas Involved
10 – Pain
11 – Puncture wound
12 – Rash
13 – Redness
14 – Scar
15 – Skin Breakdown
16 – Skin Tear
17 – Stoma

Triple 1/4 4 1/4 c-to-c

HISTORY OF FALLS	☐ YES ☐ NO	FALL RISK ASSESSMENT (if on box you answer = low)
AGE >65 YEARS	☐ YES ☐ NO	☐ LOW RISK ☐ HIGH RISK
TRANSFERS IMPAIRED	☐ YES ☐ NO	FALL INTERVENTION
ORIENTATION CONFUSED/		☐ SIDE RAILS ☐ BED IN POSITION
BEHAVIORAL ISSUES	☐ YES ☐ NO	☐ CALL LIGHT ☐ BS OBSERVATION
		☐ YELLOW ARM BAND

SKIN ASSESSMENT
☐ Y ☐ N > 65 YO
☐ Y ☐ N Impaired Mobility
☐ Y ☐ N Impaired Sensory Perception
☐ Y ☐ N Inadequate Nutrition
Yes to two or more = skin assessment w/in 2 hours of admission orders

ABUSE AND NEGLECT SCREEN

Have you been hit, slapped, kicked, or otherwise physically or socially hurt by someone? ☐ Yes ☐ No

IV THERAPY

TIME	VOLUME	SOLUTION OF LOCK	RATE	BLOOD#	SITE	GAUGE	# ATTEMPTS	INITIALS	TIME D/C	INITIALS	TOTAL INFUSED

INTAKE			OUTPUT			Time	Blood Sugar (finger stick)	Education/Symptoms/Comments	Initials
Time	Type	Volume	Time	Type	Volume				
Total Intake:			Total Output:			Normal range: 70-110 mg/dl Critical range: Less than 50 mg/dl or greater than 500 mg/dl			

Aiken Regional Medical Centers
402 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

800.04
Rev. 7/09

Patient Identification

107705220
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M EMR
MRN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

00043

Home Medication List
Physician's Order

					ADMISSION		DISCHARGE	
Height:	6	feet	inches		At time of entry, please check which medications should be continued and sign below to authenticate order		At time of discharge, check which medications should be continued and sign below to authenticate order	
Weight:	190	pounds	actual	stated estimated				
Allergies:	NKDA							
Nurse Signature				Date/Time	Give med upon adm.	Do not give med upon adm.	Continue at discharge	Do not continue at discharge

Home Medications

Unapproved abbreviations: IU, Ms, MSO4, MgSO4, Q.D., qd., q.o.d.,U, u, trailing zeros, no zeros before decimal

Medication/Dose	Route	Frequency	Reason for Taking	Last dose taken				
Information obtained from: ☐ Patient ☐ Patient Representative	☐ No home medications ☐ Unable to obtain list							
Include insulin, inhalers, eye drops, aspirin, herbals, vitamins, and OTC.								
Naprosyn.								
Ibuprofen.								

Physician Signature (on admission): Date:

Physician Signature (on discharge): Date:

Outpatients Only

Changes to home medications: ☐ None ☐ _____

Based on the treatment prescribed by your physician(s) and the list of medications that you provided, you may continue your home medications with the changes written above, if any. Please contact your prescribing physician if you have any questions about your home medications.

New Discharge Medications

☐ No new medications @ discharge

Medication/Dose	Route	Frequency	Reason for taking
Ultram			
Valium			

Outpatients Only

Physician Signature | Licensed Staff's Signature | Patient's Signature

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

PO0010

Home Medication List
Physician's Order

1032036
801.126
Rev. 11/07

CHART COPY

Patient Label

107705220

LEE , BERNARD D
DOB: 04/30/1980 29 SX: M RMR
MRN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

00044

Single (F4-1)

2-Hole 1/4 2 3/4 c-to-c

3-Hole 1/4 4 1/4 c-to-c

2248 7/28/09 Pt given RX 2 Medication Precautions & D/C instructions Rx's

[illegible] [illegible]

DISCHARGE DATA | TRANSPORTATION | MEDICATIONS GIVEN

DATE: 7/28/09 TIME: 2345
☒ ROUTINE (HOME) ☐ AMA ☐ LWBS
☐ ADMIT TO:
PHYSICIAN:
☐ TRANSFERRED TO:
☐ ACCEPTING PHYSICIAN:
☐ EXPIRED

☐ AMBULATORY ☐ AMBULANCE
☐ WHEELCHAIR ☐ CARRIED

☒ SELF ☐ RELATIVE ☐ POLICE
☐ FRIEND ☐ OTHER EXPLAIN:

DISCHARGE VITAL SIGNS

BP _____ P _____ R _____
T _____ SAO2 _____ PAIN _____

DISCHARGE VITAL SIGNS

☐ Verbal
☐ Written ☐ Not Given (why): _____
☒ PT VERBALIZES UNDERSTANDING

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

ED NURSING ASSESSMENT

850.04

Patient Identification

107705220

LEE , BERNARD D
DOB: 04/30/1980 29 SX: M SMR
MRN: 177273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

00045

Page 4 of 6

GENERAL INSTRUCTIONS:

☑ Call the next business day and make an appointment to see: Dr Bethea or Carter

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visit in: 5-7 days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within _____ days.

☐ Return to the Emergency Department in _____ days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☑ Work / school excuse from 7/28/09 thru 7/28/09. May return to work 7/29/09

☐ See your company doctor per your company's policy. Light duty until _____.

(No use of _____ No lifting over _____ lbs.)

☑ meds as written
Return for worsening symptoms

Your diagnosis was: Cervical / Shoulder Pain

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ Tetanus/Diphtheria booster*
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X_Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physician.
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Department.
8. If you feel you want to harm yourself or are suicidal, call 1-800-784-2433 (National Suicide Hotline).

Physician / Staff _____ Date 7/28/09 _____ Patient or Responsible Person

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

EMERGENCY SERVICES

ER0023

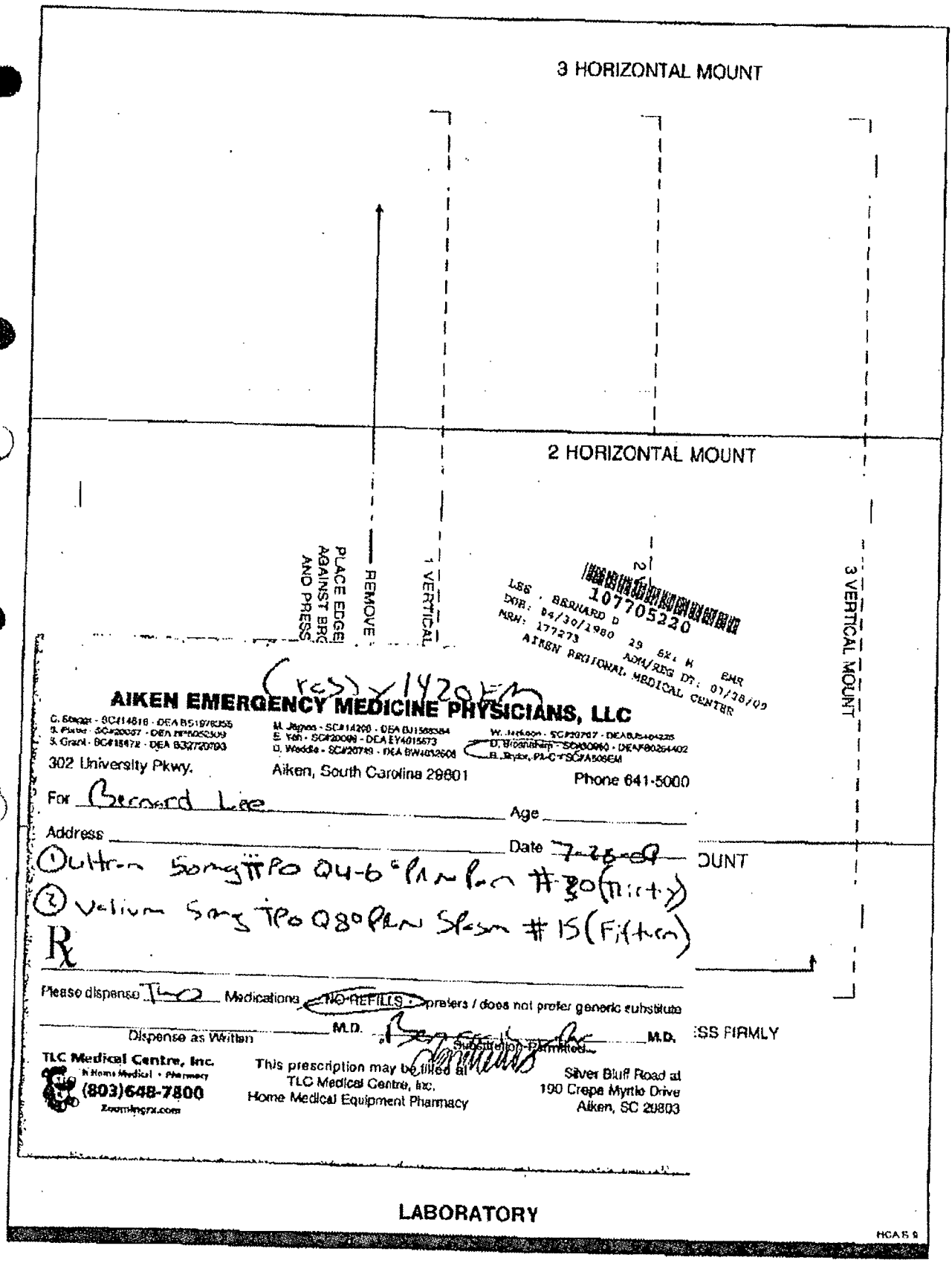
830.06
Rev. 9/08

Patient Identification

107705220
LEE , BERNARD D
DOB: 06/30/1980 29 SX: M EMR
MRN: 177273 ADM/REQ DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

WHITE - RECORDS CANARY - PATIENT GOLDENROD - PATIENT

00046



LABORATORY

00047

age 2 of 2

AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC

C. Sloyd - SC#14516 - DEA BS1370355 · M. James - SC#14206 - DEA BJ1555361 · N. Jackson - SC#26797 - DEA BJ5484725
B. Pinto - SC#20067 - DEA BP3052430 · E. Yon - SC#20006 - DEA BY4815475 · D. Smallwood - SC#20983 - DEA BS3984462
S. Grant - SC#15572 - DEA BG2702793 · D. Weddle - SC#20749 - DEA BW4632209 · B. Taylor, PA-C - SC#A36544

302 University Pkwy. Aiken, South Carolina 29801 Phone 641-5000

For _____ Age _____

Address _____ Date _____

Rx

Please dispense _____ Medications · NO REFILLS · prefers / does not prefer generic substitute

_____ M.D. _____ M.D.
Dispense as Written Substitution Permitted

TLC Medical Centre, Inc.
In Home Medical · Pharmacy
(803)648-7800
Zoomingmc.com

This prescription may be filled at
TLC Medical Centre, Inc
Home Medical Equipment Pharmacy

Silver Bluff Road at
190 Crepe Myrtle Drive
Aiken, SC 29803

107662058
LEE , BERNARD D
DOB: 04/30/1988 29 SX: M EMR
MRN: 177273 ADM/RSC DT: 07/18/09
AIKEN REGIONAL MEDICAL CENTER

LABORATORY

PLACE EDGE OF FORM AGAINST SOLID LINE AND PRESS FIRMLY

REMOVE TAPES

1 HORIZONTAL MOUNT

3 HORIZONTAL MOUNT

3 VERTICAL MOUNT

3 VERTICAL MOUNT

00048

Aiken Regional ED ENCOUNTER Record

☐ Full Admission ☐ 23 Hr Observation

Chief Complaint: Neck / Shoulder Pain increasing over last few days

HPI: 24 yom Presents to ED c/o neck and Shoulder Pain and T Spine Pain s/p work related injury after 800# machine fell on shoulder 2wks ago. Dr Reha in Columbia (ortho) Follows. ⊕HA's (more currently) ⊕numbness ⊕Arm Soreness ⊖F/C/N/V/D/Constipation this had XRay and MRI

Current Meds: Naproxyn, Ibuprofen

☐ See ED nurses notes

PMD Reha

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF

& ROS Uncobtainable due to: ☐ As Above ☐ Other:

Past Surgical History: Ohana SX

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☒ Yes Amt _____ ETOH ☒ No ☐ Yes Amt _____ ☐ Other _____

Review Of Systems: ☐ Other ROS Neg

Check ☐ If normal Check ⊕ If abnormal (If not Checked then not applicable)

Eyes:	☐ ○ Diplopia	☐ ○ Blurred	☐ ○ Vision chgs	GU:	☐ ○ Dysuria	☐ ○ Urgency	☐ ○ Hematuria
ENT:	☐ ○ Rhinitis	☐ ○ Sore throat	☐ ○ Nose bleeds	MS:	☐ ○ Myalgia	☐ ○ Back pain	☐ ○ Neck pain
Card:	☐ ○ CP	☐ ○ Palpitation		Neuro:	☐ ○ Seizures	☐ ○ Dizziness	☐ ○ Syncope
Respir:	☐ ○ SOB	☐ ○ Cough	☐ ○ Hemoptysis		☐ ○ Weakness	☐ ○ Numbness	
GI:	☐ ○ Nausea	☐ ○ Vomiting	☐ ○ Diarrhea	Endo:	☐ ○ Polyuria	☐ ○ Hypoglyc	☐ ○ Thyroid Dys
	☐ ○ Abd pain	☐ ○ Melena	☐ ○ Hematochez	Hem/Lym:	☐ ○ Anemia	☐ ○ Bleeding	

☐ For allergies see ED nurses notes

Other ROS _____

ALLERGIES: NKDA

TETANUS STATUS: _____

Physical Exam: WEIGHT | TIME | PULSE OX: | TEMP | P | R | BP

☐ See vitals see ED nurses notes

Check ☐ If normal Check ⊕ If abnormal

						Abn Findings:
General:	☐ ○ Mental Status					
Eyes:	☐ ○ Conjun NL	☐ ○ Lids	☐ ○ PERRL			
Head:	☐ ○ NL cephalic	☐ ○ Sinuses	☐ ○ Nose			
ENT:	☐ ○ Oropharynx	☐ ○ Right TM	☐ ○ Left TM			
Neck:	☐ ○ Palpation	☐ ○ Thyroid	☐ ○ Trachea			
Chest:	☐ ○ Palpation	☐ ○ Excursion	☐ ○ Symmetry			
Cardio:	☐ ○ Heart sounds	☐ ○ R & R				
Respir:	☐ ○ Respir effort	☐ ○ Lung sounds				
Abdom:	☐ ○ Palpation	☐ ○ Bowel Sounds	☐ ○ Digits			
MS:	☐ ○ RUE	☐ ○ RLE	☐ ○ Back			
	☐ ○ LUE	☐ ○ LLE				
	☐ ○ Pelvis	☐ ○ Gait	☐ ○ Color			
Skin:	☐ ○ Temp	☐ ○ Appear	☐ ○ Sensation			
Neuro:	☐ ○ CNS	Strength				

TEST:	ORD	Initial	TIME INITIAL ✓TEST ORDERED:
CBC W DIFF:			PHYSICIAN'S ORDERS:
CHEM 8:			
URINE PREG:			→ URINE PRES RESULTS,
CCUA:			
CATH UA:			
URINE C&S:			
EKG:			
OLD EKGS:			
TROPONIN:			
PT/PTT:			
FINGER ST GL:			
BLOOD CULT X____			
TYPE & SCREEN:			
TYPE CROSS UNITS:			
LIVER PANEL:			
CNP:			
AMYLASE:			
LIPASE:			
HEMOCULT:			
TYPE & RH:			
HCG QUANT:			
URINE DRUG 8:			
ALCOHOL:			
ED ABG:			
PA/LAT CXR:			
PCXR:			
C-SPINE:			
L-SPINE:			
ACUTE ABD:			
OLD RECORDS:			
OLD ED Record			

TIME ORD: | TIME COMP (blank)

D/C

Rx ibuprofen

Vicodin

Med Decision Making:

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME: _____

Diff Dx: _____

Consults: _____

NAME OF PHYSICIAN THAT ADMITTED PT: _____

NAME OF PHYSICIAN THAT PT IS ADMITTED TO: _____

☐ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

DISCHARGE DIAGNOSIS: Cervical / Shoulder Pain

CODES
☐ STABLE
☐ UNSTABLE SEE NOTE

Physician Signature: _____ **Time MD IN:** _____

Name: _____ Race: Sex. Age:

Addressograph

107705220

LEE , DERNARD D
DOB: 04/30/1980 29 SX: M ENR
MRN: 127273 ADM/REG DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

J 10-2a129 5/07

00049

ER0010

MEDICAL RECORDS

Aiken Regional ED ENCOUNTER Record

Chief Complaint:

☐ Full Admission
☐ 23 Hr Observation

HPI

Current Meds:
☐ See ED nurses notes

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF
& ROS Unobtainable due to:
☐ As Above ☐ Other:

PMD

Past Surgical History:

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☐ Yes Amt ETOH ☐ No ☐ Yes Amt ☐ Other

Review Of Systems: Check ☐ if normal Check ○ if abnormal *If not Checked then not applicable.*

☐ Other ROS Neg

Eyes:	☐ ○ Diplopia	☐ ○ Blurred	☐ ○ Vision chgs	*GU:*	☐ ○ Dysuria	☐ ○ Urgency	☐ ○ Hematuria	
ENT:	☐ ○ Rhinitis	☐ ○ Sore throat	☐ ○ Nose bleeds	*MS:*	☐ ○ Myalgia	☐ ○ Back pain	☐ ○ Neck pain	
Card:	☐ ○ CP	☐ ○ Palpitation		*Neuro:*	☐ ○ Seizures	☐ ○ Dizziness	☐ ○ Syncope	
Respir:	☐ ○ SOB	☐ ○ Cough	☐ ○ Hemoptysis		☐ ○ Weakness	☐ ○ Numbness		
GI:	☐ ○ Nausea	☐ ○ Vomiting	☐ ○ Diarrhea	*Endo:*	☐ ○ Polyuria	☐ ○ Hypoglyc	☐ ○ Thyroid Dys	
	☐ ○ Abd pain	☐ ○ Melena	☐ ○ Hematochez	*Hem/Lym:*	☐ ○ Anemia	☐ ○ Bleeding		

For allergies see nurses notes

ALLERGIES:

TETANUS STATUS:

Other ROS

Physical Exam: WEIGHT TIME PULSE OX: TEMP P R BP

For vitals see ED nurses notes

Check ☐ if normal Check ○ if abnormal *Abn Findings:*

General:	☐ ○ Mental Status				
Eyes:	☐ ○ Conjun NL	☐ ○ Lids	☐ ○ PERRL		
Head:	☐ ○ NL cephalic	☐ ○ Sinuses	☐ ○ Nose		
ENT:	☐ ○ Oropharynx	☐ ○ Right TM	☐ ○ Left TM		
Neck:	☐ ○ Palpation	☐ ○ Thyroid	☐ ○ Trachea		
Chest:	☐ ○ Palpation	☐ ○ Excursion	☐ ○ Symmetry		
Cardio:	☐ ○ Heart sounds	☐ ○ R & R			
Respir:	☐ ○ Respir effort	☐ ○ Lung sounds			
Abdom:	☐ ○ Palpation	☐ ○ Bowel Sounds	☐ ○ Digits		
MS:	☐ ○ RUE	☐ ○ RLE	☐ ○ Back		
	☐ ○ LUE	☐ ○ LLE			
	☐ ○ Pelvis	☐ ○ Gait	☐ ○ Color		
Skin:	☐ ○ Temp	☐ ○ Appear	☐ ○ Sensation		
Neuro:	☐ ○ CNS	Strength			

TEST: ORD Initial TIME INITIAL / TEST ORDERED:

CBC W DIFF:
CHEM 8:
URINE PREG:
CCUA:
CATH UA:
URINE C&S:
EKG:
OLD EKGS:
TROPONIN:
PUPTT:
FINGER ST GL:
BLOOD CULT X
TYPE & SCREEN:
TYPE CROSS
UNITS:
LIVER PANEL:
CMP:
AMYLASE:
LIPASE:
HEMOCULT
TYPE & RH:
HCG QUANT:
URINE DRUG S:
ALCOHOL:
ED ABG:
PA/LAT CXR:
PCXR:
C-SPINE:
L-SPINE:
ACUTE ABD:
OLD RECORDS:
OLD ED Record:

PHYSICIAN'S ORDERS: TIME ORD: TIME COMP Initials:

→ URINE PREG RESULTS:

Med Decision Making:

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☐ Labs reviewed by me:

CC TIME:
Diff Dx:
Consults:
NAME OF PHYSICIAN THAT ADMITTED PT:
NAME OF PHYSICIAN THAT PT IS ADMITTED TO:

☐ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

DISCHARGE DIAGNOSIS:

CODES

☐ STABLE
☐ UNSTABLE SEE NOTE

Physician Signature: Time MD IN:

IDU2634AA 07MAR11
Tetanus and Diphtheria Toxoids Adsorbed For Adult Use (DECAVAC®)
US Govt Lic #1725
Mfd by: Sanofi Pasteur Inc.
Swiftwater PA 18370 USA
CPRO Code: 90714
0.5mL
Route
Site

Name: Race: Sex: Age:

Addressograph

107662058
LEE , BERNARD D
DOB: 04/30/1980 29 SX: M EMR
MRN: 177215 ADM/REQ DT: 07/30/10
AIKEN REGIONAL MEDICAL CENTER

ER0010

630.70 10-24129 5/07

00050

MEDICAL RECORDS

Page 1 of 1

GENERAL INSTRUCTIONS:

☑ Call the next business day and make an appointment to see: Dr Bolton or Carter

Be sure to tell them you were seen in our Emergency Department and the emergency physician feels you need a followup visi

in: 5-7 days or less or _____ days or less if still ill.

☐ Have your blood pressure checked at _____ within _____ days.

☐ Return to the Emergency Department in _____ days for suture removal or re-check.

☐ Give Tylenol (acetaminophen) _____ every four hours for three days as needed for pain or fever.

☐ Work / school excuse from _____ thru _____. May return to work _____

☐ See your company doctor per your company's policy. Light duty until _____

(No use of _____ No lifting over _____ lbs.)

☑ Meds as prescribed
Return for worsening symptoms

Your diagnosis was: Cervical / Shoulder Pain

INSTRUCTION SHEETS You may receive one or more of the following:

Abdominal (green sheet)
- ☐ Abdominal Pain in Adults*
- ☐ Abdominal Pain in Children*
- ☐ Nausea, Vomiting, Diarrhea, Adults*
- ☐ Vomiting, Diarrhea, Children*
- ☐ Kidney Stone –

OB/GYN (pink sheet)
- ☐ Threatened Miscarriage*
- ☐ Pelvic Inflammatory Disease*

Orthopedics (white sheet)
- ☐ Splints and Casts*
- ☐ Sprains and Strains*
- ☐ Walking with Crutches*
- ☐ Low Back Pain*
- ☐ Cervical Strain

Environmental (grey sheet)
- ☐ Bug Bites*
- ☐ Allergic Reactions*

Trauma (red sheet)
- ☐ Accident*
- ☐ Head Injury*
- ☐ Wound Care*
- ☐ Burns*
- ☐ Corneal Abrasion*
- ☐ Animal Bite*
- ☐ Hematoma

Respiratory (blue sheet)
- ☐ Croup*
- ☐ Asthma*
- ☐ Bronchiolitis*
- ☐ Bronchitis
- ☐ Sore Throat*
- ☐ Nose Bleed*
- ☐ Sinusitis in Adults

Infection (yellow sheet)
- ☐ Fever in Adults*
- ☐ Fever in Children*

*Preprinted Instructions
- ☐ Taking Temperatures*
- ☐ Otitis Media*
- ☐ Chicken Pox*
- ☐ Skin Infection / Abscess*
- ☐ Urinary Tract Infection*
- ☐ Conjunctivitis
- ☐ Scabies and Lice

General (orange sheet)
- ☐ Pediatric Followup*
- ☐ Medication Precautions*
- ☐ Test Results*
- ☐ Antibiotics*
- ☐ **Tetanus/Diphtheria booster***
- ☐ Blood/Body Fluid Exposure Follow-up

Other (on computer)
- ☐ _____
- ☐ _____

IMPORTANT (Please read carefully before signing. Do not leave if you have unanswered questions.)

1. I have received the instruction sheets indicated above.
2. I realize the care I received in your Emergency Department was intended to rule out emergencies and not to be a substitute or replacement of my routine and complete care. I will arrange for followup care.
3. I realize that all diseases change with time, so I will return here if I think something has gone wrong or if unexpected symptoms occur. RETURN IF YOU WORSEN IN ANY UNEXPECTED WAY.
4. Aiken Regional Medical Centers Emergency Services obtains a second reading on EKGs and X_Rays. If cultures were obtained, results will not be final for 3 or more days.
5. I hereby authorize Aiken Regional Medical Centers Emergency Services to release today's emergency department medical record to my followup physicia
6. The Medical Records Department is open Monday-Friday, 8:00 a.m. to 4:30 p.m. to obtain copies of your medical records.
7. Call your followup Physician for any results (including cultures, labs, x-rays) not received or completed during your stay in the Emergency Departmen
8. If you feel you want to harm yourself or are suicidal, call 1-800-784-2433 (National Suicide Hotline).

Physician _____ Date 1/28/09 _____ Patient or Responsible Person

Staff _____

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

EMERGENCY SERVICES

ER0023

630 06
Rev. 9/08

Patient Identification

107705220

LEE , BERNARD D
DOB: 04/30/1980 29 SX: M EMR
MRN: 177273 ADM/REC DT: 07/28/09
AIKEN REGIONAL MEDICAL CENTER

00051

WHITE - RECORDS CANARY - PATIENT GOLDENROD - PATIENT

DR. SYLVA AL-SOUDI

MARGARET J. WESTON COMMUNITY HEALTH CENTERS

NJWCHC - Age 18-49 Progress N...e

Date: 8/6/09	HT:	WT: 18[illegible]	BP: 138/110	P: 78	R:	☐ Appt	TI:
Age: 29	BMI:	WT:	BP:	T:	O2: 98	☐ Walk In	TO:

CC: hurt @ work - injured neck, back & shoulder - pain - went through workers comp. Needs to discuss about his job and what his limitations are for his job - EE - needs letter for his job -

as above

MBL - chronic bursitis, shoulder arthropathy + mild impingement

Review of Systems: (Circle all positives and strike through all negatives)

Con:	WNL	Fever	Chills	Sweats	Wt. Loss	Wt. Gain	Dec. Appetite	Dizzyness	Insomnia	Fati
Eye:	WNL	Redness	Discharge	Pain	Itchy	(R) (L)	Blurry Vision			
ENT:	WNL	Ear Pain - R L		Hearing loss	Runny nose	Congestion	Nose Bleed	Sore throat	Hoarse	PN
Resp:	WNL	Cough: prod / non prod		Hemoptysis	Wheeze	SOB	Pleuritic CP	DOE	Nocturnal Dyspnea	
CV:	WNL	Chest Pain	Chest Pressure		LE edema	Palpitations				
GI:	WNL	Nausea	Vomiting	Diarrhea	Constipation	GERD	Dysphagia	Pain: Epi., RUQ, RLQ, LUQ, LLQ		
GU:	WNL	Incontinence	Dysuria	Frequency	Flank pain	Hematuria	Hesitancy	Nocturia		
Gyn:	WNL	Breast Pain	Breast Mass	Vag. D/C	Vag. Itch	Vag. Odor	Dyspareunia	Painful, Heavy, Irregular Menses		
Neuro:	WNL	Headache	Numbness	Gen. Weakness	LOC	Dizzyness	Change Speech	Unsteady Gait		
Psych:	WNL	Agitated	Confused	Unmotivated	Anxious	Tearful	Excited	Suicidal	Fatigue	
MS:	WNL	Myalgia	Neck Pain	Leg: Pain / Wkness R L		Arm: Pain / Wkness R L		Lumbar Pain	Jt: Pain, Stiff., Swell	
Skin:	WNL	Dry	Itchy	Flaking	Red	Irritated	Rash:			

Physical Examination (Circle all positive and strike through all negatives)

Eye:	WNL	Lid Lag	Jaundice	Unequal pupils / eye mvt		Drainage: Purulent / Clear		Conjunctiva Inflamed	
ENT:	WNL	TM: Bulging Red		Canal: Wax, Swollen, D/C		Naris: Swollen Turbinate, D/C		Pharynx: Red, Swollen, D/C	
Neck	WNL	TTP	Dec. ROM	Thyromegaly	Lymph node Swelling		JVD	Carotid Bruits: R L	
Resp:	WNL	Labored Breathing		Wheezing	Rales	Ronchi	Decreased Aeration (R) (L)		
CV:	WNL	Rubs	Gallops	Grade ___ Murmur		Irregular: Rhythm - Rate		Cap. Refill <2sec	Unequal Rad. Pulse
GI:	WNL	Hepato-Splenomegaly		BS: Increased Decreased		Epi., RUQ, RLQ, LUQ, LLQ: Tenderness, Guarding, Rebound, Mass			
GU:	WNL	Urethra: Red Swollen		Bladder: TTP	Vagina: Ab. NI Rugae, Discharge			Cervix: Beefy Red, Friable, Tender	
Msk ext.	WNL	L shoulder Arm, Elbow, Wrist,		Hand, Hip, Leg, Knee, Ankle, Foot:	Tenderness, Swelling, Dec. ROM			Foot Exam	R L
Spine:	WNL	Scoliosis	SLR pain ( ) (R)		Thoracic, Lumbar, Sacrum: Tenderness, Dec. ROM,			Pulse	-
Psych:	WNL	Flat Affect	Anxious	Tearful	Agitated	Distracted	Paranoid	Suspicious	Sensation	-
Skin:	WNL	Cold	Clammy	Red	Dry	Scaly	Jaundice	Wheeping	Cold to teh	+

Assessment/ Plan: (1) muscle spasm - Rx Skelaxin - cervical

(2) tendonitis bursitis - Rx Prednisone

Cont PT + seen CHI on 8/17

☐ Career / Education counseling	☐ ETOH cessation counseling	☐ Low Fat Diet counseling	☐ Reviewed labs dated: / /
☐ Discuss Problem Solving Skills	☐ Smoking cessation counseling	☐ Low Salt Diet counseling	☐ Stress Follow Up Compliance
☐ Safe Sex Education	☐ Drug use cessation counseling	☐ Calorie reduction counseling	☐ Stress med. comp. & bring to visit
☐ Birth control Counseling	☐ Inc. Fruit, Veg. Counseling	☐ Caffeine reduction couns.	Couns / Coord time ___ min
☐ Hygiene / Grooming Education	☐ Physical activity counseling	☐ Drink More H2O counseling	☐ Couns / Coord > 50% of visit

PROVIDER SIGNATURE:

Next Visit: PRN ___ Days ___ Weeks ___ Months W. EX FROM 8/3

Next Visit Nursing: GYN / BCN Br. Only Labs: ___ BS UA Hg

NAME: Bernard Lee CHART # 40523 8/8/09

00052

MARGARET J. WESTON
COMMUNITY HEALTH CENTERS
Dedicated to Your Health

4645 Augusta Road; Clearwater, SC 29822
Phone: (803) 593-9283 Fax: (803) 593-0607

210 Atomic Road; Jackson, South Carolina 29831
Phone: (803) 471-9200 Fax: (803) 471-9100 (fax)

1211 University Lane; Aiken, SC 29801
Phone: (803) 648-4744 Fax: (803) 649-2231 (fax)

School / Work Excuse

Type of Excuse:

_____ Late arrival to school

_____ Early dismissal from school

_____ Absence from school

_____ Late arrival to work

_____ Early dismissal from work

✓ Absence from work

Bernard Lee was evaluated at the Margaret J. Weston Community Health Centers for medical reasons. Please excuse their absence for:

_____ Today only

✓ The following dates: 8/3/09 to 8/18/09.

Additional Comments: _____

Sharon J. Davis

☐ Julie Kappes, PNP
☐ Brandon Daniels, MD
☐ Eric M. Schlueter, MD
☒ Sylva Al-Soudi, MD
☐ C. Luis McTier, FNP
☐ Uday Doppalapudi, MD
☐ Lloyd B. Daniels, MD
☐ Peggy Lampkin, PA

8/6/09
Date

00053

MJ NCHC - Age 18-49 Progress Le

DOV: 10/5/09	HT:	WT: 190	BP: 140/100	P: 85	R:	☑ Appt	TI:
Age: 29	BMI:	WT:	BP:	T:	O2: 100	☐ Walk In	TO:

CC: f/up appt on both R & shoulder —

Hx (PMH, F, S Hx updated ☐):

11 fract on the (R) wrist 9
wants to have it removed

Review of Systems: (Circle all positives and strike through all negatives)

Con:	(WNL)	Fever	Chills	Sweats	Wt. Loss	Wt. Gain	Dec. Appetite	Dizzyness	Insomnia	Fatigue
Eye:	WNL	Redness	Discharge	Pain	Itchy	(R) (L)	Blurry Vision			
ENT:	WNL	Ear Pain - R L		Hearing loss	Runny nose	Congestion	Nose Bleed	Sore throat	Hoarse	PND
Resp:	WNL	Cough: prod / non prod		Hemoptysis	Wheeze	SOB	Pleuritic CP	DOE	Nocturnal Dyspnea	
CV:	(WNL)	Chest Pain	Chest Pressure		LE edema	Palpitations				
GI:	(WNL)	Nausea	Vomiting	Diarrhea	Constipation	GERD	Dysphagia	Pain: Epi., RUQ, RLQ, LUQ, LLQ		
GU:	WNL	Incontinence	Dysuria	Frequency	Flank pain	Hematuria	Hesitancy	Nocturia		
Gyn:	WNL	Breast Pain	Breast Mass	Vag. D/C	Vag. Itch	Vag. Odor	Dyspareunia	Painful, Heavy, Irregular Menses		
Neuro:	(WNL)	Headache	Numbness	Gen. Weakness	LOC	Dizzyness	Change Speech	Unsteady Gait		
Psych:	WNL	Agitated	Confused	Unmotivated	Anxious	Tearful	Excited	Suicidal	Fatigue	
MS:	WNL	Myalgia	Neck Pain	Leg: Pain / Wkness R L		Arm: Pain / Wkness R L		Lumbar Pain	Jt: Pain, Stiff., Swell	
Skin:	WNL	Dry	Itchy	Flaking	Red	Irritated	Rash:			

Physical Examination (Circle all positives and strike through all negatives)

Eye:	WNL	Lid Lag	Jaundice	Unequal pupils / eye mvt	Drainage, Purulent / Clear		Conjunctiva Inflamed	
ENT:	WNL	TM: Bulging Red		Canal: Wax, Swollen, D/C	Naris: Swollen Turbinate, D/C		Pharynx: Red, Swollen, D/C	
Neck:	(WNL)	TTP	Dec. ROM	Thyromegaly	Lymph node Swelling	JVD	Carotid Bruits: R L	
Resp:	WNL	Labored Breathing		Wheezing	Rales	Ronchi	Decreased Aeration (R) (L)	
CV:	(WNL)	Rubs	Gallops	Grade ___ Murmur	Irregular Rhythm - Rate		Cap. Refill <2sec	Unequal Rad. Pulse
GI:	WNL	Hepato-Splenomegaly		BS: Increased Decreased	Epi., RUQ, RLQ, LUQ, LLQ: Tenderness, Guarding, Rebound, Mass			
GU:	WNL	Urethra: Red Swollen		Bladder: TTP	Vagina: Ab. NI Rugae, Discharge		Cervix: Beefy Red, Friable, Tender	
Mus ext.	WNL	Shoulder, Arm, Elbow, Wrist,		Hand, Hip, Leg, Knee, Ankle, Foot:	Tenderness, Swelling, Dec. ROM			Foot Exam R L
Spine:	WNL	Scoliosis	SLR pain (L) (R)		Thoracic, Lumbar, Sacrum: Tenderness, Dec. ROM,			Pulse - -
Psych:	WNL	Flat Affect	Anxious	Tearful	Agitated	Distracted	Paranoid	Suspicious	Sensation - -
Skin:	WNL	Cold	Clammy	Red	Dry	Scaly	Jaundice	Weeping	Cold to tch + +

Assessment/ Plan: s/p fxn on (R) wrist

(1) pain in shoulder - seen by ortho, needs MRI/shulz
(2) HTN - Rx'd HCTZ
(3) ganglion - refer to hand surgeon

☐ Career / Education counseling	☐ ETOH cessation counseling	☐ Low Fat Diet counseling	☐ Reviewed labs dated: / /
☐ Discuss Problem Solving Skills	☐ Smoking cessation counseling	☐ Low Salt Diet counseling	☐ Stress Follow Up Compliance
☐ Safe Sex Education	☐ Drug use cessation counseling	☐ Calorie reduction counseling	☐ Stress med. comp. & bring to visit
☐ Birth control Counseling	☐ Inc. Fruit / Veg. Counseling	☐ Caffeine reduction couns.	Couns / Coord time ___ min
☐ Hygiene / Grooming Education	☐ Physical activity counseling	☐ Drink More H2O counseling	☐ Couns / Coord > 50% of visit

PROVIDER SIGNATURE:

Next Visit: PRN ___ Days ___ Weeks ___ (1) Months — re V BP
Next Visit Nursing: GYN / BCN Br. Only Labs: ___ BS UA - Hg

NAME: Bernard Lee CHART # 40523

00054

10/15/2009 04:17 FAX 803 649 2231 MARGARET J WESTON 002/004

MARGARET J. WESTON
COMMUNITY HEALTH CENTERS
Dedicated to Your Health

☐ Jackson Office
210 Atomic Road
Jackson, SC 29831
Ph: (803) 471-9200
Fax: (803) 471-9100

☐ Clearwater Office
PO Box 277
4645 Augusta Road
Clearwater, SC 29822
Ph: (803) 593-9283
Fax: (803) 593-0607

☒ Aiken Office
1211 University Lane
Aiken, SC 29801
Ph: (803) 648-4744
Fax: (803) 649-2231

REFERRAL

Last Name: LEE First Name: BERNARD Middle: _____

Address: 172 Cherokee Fl. Rd. State: SC Zip Code: 29829

Home Phone: 803-663-0960 Work Phone: _____

Social Security #: 251-45-2201 Date of Birth: 4/30/80 Sex: ☒ Male ☐ Female

Insurance: ☐ SC Medicaid ☐ GA Medicaid ☐ Medicare ☐ Self-Pay

☐ Blue Cross Blue Shield ☐ Other: _____

Referral To: hand surgery Phone Number: _____

Address: _____

Appointment Date: ___/___/___ Time: _____ am/pm

ICD-9 Codes: (1) _____ (2) _____ (3) _____ (4) _____

Clinical Indications: ganglion on the (R) wrist

_____

_____

☐ Evaluate & Treat ☐ Evaluate & Recommend Treatment Options ☐ Urgent Referral

10/5/09
Date

☐ Julie Kappes, PNP ☐ C. Travis McTier, FNP
☐ Brandon Daniels, MD ☐ Udai Doppalapudi, MD
☐ Eric M. Schlueter, MD ☐ Lloyd B. Daniels, MD
☐ Sylva Al-Soudi, MD ☐ Peggy Lampkin, PA

ATTACHMENTS

☐ Lab Result(s) ☐ X-Ray Report(s) ☐ Progress Note(s) ☐ Other: _____

ADMINISTRATIVE

☐ Appointment Made ☐ Records Faxed ☐ Patient Contacted
☐ Chart Number: _____ ☐ Reminder Call ☐ Appointment Kept
☐ Note Received

Date

00055

10/15/2009 04:17 FAX 803 649 2231 MARGARET J WESTON ☒004/004

Aiken Regional Medical Centers
Outpatient Services Order Form

641-5810 @ Hosp.

Schedule Test: 803-641-5808
Imaging Center of Aiken Fax: 803-648-2099
Radiology Fax: 803-641-5033
Women's Lifecare Diagnostics Fax: 803-641-5810
Cardiology/EKG Fax: 803-641-5378

Date of Appointment Oct. 19, 2009 Time 8:00 AM Insurance Principle #

Patient Name LEE BERNARD DOB Phone

Physician SYLVIA ALSOUD Phone/Fax 6484744

Symptoms/Indication shoulder pain

Prep #		EKG/ECHO
4		EKG
4		Holter Monitor
5		Stress Test
5		Nuclear Stress Test
4		Echocardiogram, Adult
4		Echocardiogram, Pediatric
5		Echocardiogram w/bubble
5		Stress Echocardiogram
5		Dobutrex stress echo
3		TEE
2		Tilt Table

Prep #		EEG/VASCULAR
		EEG, routine
		EEG, sleep deprived
4		Arterial Vascular Study
4		ABI (Ankle Brachial Index)
7		VEP
7		BAER

Prep #		RESPIRATORY
		Arterial Blood Gas
		Arterial Blood Gas w/exercise
1		Pulmonary Function Screen (PFT)
1		PFT w/bronchodilator
1		PFT w/ DLCO
1		Methacholine Challenge PFT
1		Metabolic Cart
3		Bronchoscopy
3		Bronchoscopy w/ Fluoro
		BioZ
		Thoracentesis

Prep #		ULTRASOUND Circle all that apply:
		Abdomen (RUQ, GB, Pancreas, Liver)
2		Aorta
3		Breast (Rt, Lt, Bilat, Bx, Aspiration)
		Carotid Doppler ☐ R ☐ L
1		Kidneys (Bx, Aspiration)
4		Obstetrical
4		Pelvic
		Scrotal
		Thyroid (Bx, Aspiration)
		Venous Doppler ☐ Upper ☐ Lower

Prep #		CT
1		Abdomen W O Contrast
1,2	C	Abdomen W Contrast
1		Abdomen & Pelvis WO
1,2	C	Abdomen & Pelvis W Contrast
2	C	Abdomen & elvis & Thoracic W
1		Abdomen & elvis & Thoracic WO
		Cervical Sp ne
		Head WO C ntrast
2	C	Head WO/ Contrast
		Lumbar Sp e WO
2	C	Neck (soft ssue) W Contrast
		Orbits WO ontrast
2	C	Orbits WO / Contrast
1		Pelvis WO ontrast
1,2	C	Pelvis W C ntrast
		Renal Colic
		Sinuses Co plete WO
		Sinuses Mi WO
		Temporal B nes WO
2	C	Chest W C ntrast
		Chest WO

Prep #		MRI
	M	Brain
1	M	Brain WO/W Contrast
1	M	Brain MR Angio
1	M	MR Angio Neck
	M	Cervical Spine
	M	Lumbar Spine
1	M	Lumbar Spine WO/W Contrast
	M	Spine Limited (specify)
	M	Thoracic Spine
1	M	Aorta
1	M	Peripheral
1	M	Abdomen (specify below)
	M	Ankle ☐L ☐R
	M	Elbow ☐L ☐R
	M	Hip(s) ☐L ☐R
	M	Knee ☐L ☐R
	M	Shoulder ☐L ☐R
	M	Wrist ☐L ☐R
2	M	MR Cholangiogram

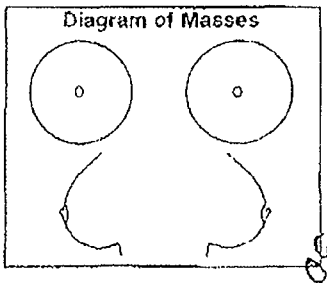
Prep #		BREAST IMAGING
		Mammogram Screening
		Mammogram Diagnostic
		Mammo with Implants
		Bone Densitometry
		Breast Core Biopsy
		Breast Cyst Biopsy
		Clinical Consult/2nd Opinion
		Breast Ultrasound
		Galactography

Prep #		RADIOLOGY
		Abdomen (KUB)
		Abdomen Acute Series
		Ankle ☐L ☐R
		Cervical Spine Routine
		Cervical Spine (flex & ext)
		Chest
		Clavicle ☐L ☐R
		Elbow ☐L ☐R
		Facial Bones ☐L ☐R
		Femur ☐L ☐R
		Fingers (Identify) ☐L ☐R
		Foot ☐L ☐R
		Forearm ☐L ☐R
		Hand ☐L ☐R
		Heel ☐L ☐R
		Hip ☐L ☐R
		Hip Survey Child
		Humerus ☐L ☐R
		Knee Routine (3 views) ☐L ☐R
		Knee Routine (4 views) ☐L ☐R
		Knee AP & Lat both standing
		Lumbar Spine Routine
		Mandible
		Nasal Bones
		Neck Soft Tissue
		Orbits ☐L ☐R
		Pelvis
		Pelvis & Lat Hip ☐L ☐R
		Ribs ☐L ☐R
		Sacrum Coccyx
		Scapula ☐L ☐R
		Scoliosis Series
		Shoulder ☐L ☐R
		Sinus
		Skull
		Sternum
		Thoracic Spine
		Thumb ☐L ☐R
		Tib/Fib ☐L ☐R
		Toe ☐L ☐R
		Wrist ☐L ☐R

Prep #		GI/GI
1		Barium Enema - Air Contrast
1		Barium Enema - Full Column
3		Barium Swallow
1		Defecogram
2	C	IVP with or without Tomograms
3		Small Bowel
3		UGI
3		UGI with Sm follow through
	C	Voiding Cystogram

Prep #		NUCLEAR MED
		Bone Scan
2		Cardiac
1		HIDA Scan
		Lung Perfusion and Vent
		Parathyroid Scan
2		Renal Scan
2		Thyroid Scan

Diagram of Masses



Physicians Office: (Indicate location of appointment on the map located on the reverse side.)

C = If exam is preceded by C, please ask the following questions.
Diabetic: ☐ No ☐ Yes On Glucophage: ☐ No ☐ Yes
If over 65 years old, need Bun and Creatinine within 30 days. Where drawn

M = If exam is preceded by M, please ask the following questions.
Heart Pacemaker: ☐ No ☐ Yes Metal: ☐ No ☐ Yes

Other Exam:

Special Instructions:

Pt. not coltrophobic Pt. aware

Physician Signature: 10/15/09

00056

732.28 (8/05) 10-31842

PATIENT INSTRUCTIONS ON BACK

MARGARET J WESTON

10/15/2009 04:17 FAX 803 649 2231

003/004

601

Friday, July 30, 2010 (16).max

JWCHC - Age 18-49 Progress

DOS: 10/5/09	HT:	WT: 190	BP: 140/100	P: 85	R:	☑ Appt	TT:
Age: 29	BMI:	WT:	BP:	T:	O2: 100	☐ Walk In	TO:

CC: f/up appt on back & shoulder

Hx (PMH, F, S Hx updated ☐):

11 fract on the (R) wrist 4 yrs
had to have it removed

Review of Systems: (Circle all positives and strike through all negatives)

Gen:	WNL	Fever	Chills	Sweats	Wt. Loss	Wt Gain	Dec. Appetite	Dizzyness	Insomnia	Fa
Eye:	WNL	Redness	Discharge	Pain	Itchy	(R) (L)	Blurry Vision			
ENT:	WNL	Ear Pain - R L		Hearing loss	Runny nose	Congestion	Nose Bleed	Sore throat	Hoarse	F
Resp:	WNL	Cough: prod / non prod		Hemoptysis	Wheeze	SOB	Pleuritic CP	DOE	Nocturnal Dyspn	
CV:	WNL	Chest Pain	Chest Pressure		LE edema	Palpitations				
GI:	WNL	Nausea	Vomiting	Diarrhea	Constipation	GERD	Dysphagia	Pain: Epi., RUQ, RLQ, LUQ, LLQ		
GU:	WNL	Incontinence	Dysuria	Frequency	Flank pain	Hematuria	Hesitancy	Nocturia		
Gyn:	WNL	Breast Pain	Breast Mass	Vag. D/C	Veg. Itch	Vag. Odor	Dyspareunia	Painful, Heavy, Irregular Menses		
Neuro:	WNL	Headache	Numbness	Gen. Weakness	LOC	Dizzyness	Change Speech	Unsteady Gait		
Psych:	WNL	Agitated	Confused	Unmotivated	Anxious	Tearful	Excited	Suicidal	Fatigue	
MS:	WNL	Myalgia	Neck Pain	Leg: Pain / Weakness R L		Arm: Pain	Weakness R L	Lumbar Pain	Jt Pain, Stiff., Sw	
Skin:	WNL	Dry	Itchy	Flaking	Red	Irritated	Rash:			

Physical Examination (Circle all positives and strike through all negatives)

Eye:	WNL	Lid Lag	Jaundice	Unequal pupils / eye mvt		Drainage:	Purulent / Clear	Conjunctiva inflamed	
ENT:	WNL	TM: Bulging Red		Canal: Wax, Swollen, D/C		Nasal: Swollen Turbinate, D/C		Pharynx: Red, Swollen, D/C	
Neck	WNL	TTP	Dec. ROM	Thyromegaly	Lymph node Swelling		JVD	Carotid Bruits: R L	
Resp:	WNL	Labored Breathing		Wheezing	Rales	Ronchi	Decreased Aeration (R) (L)		
CV:	WNL	Rubs	Gallops	Grade ___ Murmur		Irregular: Rhythm - Rate		Cap. Refill <2sec	Unequal Rad Pu
GI:	WNL	Hepato-Splenomegaly		BS: Increased Decreased		Epi., RUQ, RLQ, LUQ, LLQ: Tenderness, Guarding, Rebound, Mass			
GU:	WNL	Urethra: Red Swollen		Bladder: TTP		Vagina: Ab. Ni Rugae, Discharge		Cervix: Beefy Red, Friable, Tender	
Mus ext.	WNL	Shoulder, Arm, Elbow, Wrist, Hand, Hip, Leg, Knee, Ankle, Foot: Tenderness, Swelling, Dec. ROM						Pont Exam	P
Spine:	WNL	Scoliosis	SLR pain (L) (R)			Thoracic, Lumbar, Sacrum: Tenderness, Dec. ROM		Pulse	
Psych:	WNL	Flat Affect	Anxious	Tearful	Agitated	Distracted	Paranoid	Suspicious	Sensation	
Skin:	WNL	Cold	Clammy	Red	Dry	Scaly	Jaundice	Weeping	Cold to tch	

Assessment/ Plan: ganglion on (R) wrist

(1) pain to shoulder - see ortho, needs MRI sh
(2) HTN - start HCTZ
(3) ganglion - refer to hand surgeon

☐ Career / Education counseling	☐ ETOH cessation counseling	☐ Low Fat Diet counseling	☐ Reviewed labs dated: / /
☐ Discuss Problem Solving Skills	☐ Smoking cessation counseling	☐ Low Salt Diet counseling	☐ Stress Follow Up Compliance
☐ Safe Sex Education	☐ Drug use cessation counseling	☐ Calorie reduction counseling	☐ Stress med. comp. & bring to visit
☐ Birth control Counseling	☐ Inc. Fruit / Veg. Counseling	☐ Caffeine reduction couns.	Couns / Coord time ___ min
☐ Hygiene / Grooming Education	☐ Physical activity counseling	☐ Drink More H2O counseling	☐ Couns / Coord > 50% of visit

PROVIDER SIGNATURE:

Next Visit: PRN ___ Days ___ Weeks (1) Months

Next Visit Nursing: GYN / BCN

Br. Only Labs: BS UA

NAME: Renard Rice

CHART # 40523

00057

MJWCHC - Age 18-49 Progress Note

Date: 11/11/09	HT:	WT: 194	BP: 130/88	P: 66	R:		☐ Appt	TI:	
Age: 29	BMI:	WT:	BP:	T:	02: 98		☐ Walk In	TO:	

CC: Shoulder, neck & back pain — wc

Hx (PMH, F, S Hx updated ☐):

to above
go to ortho

ate tor

Review of Systems: (Circle all positives and strike through all negatives)

Con:	WNL	Fever	Chills	Sweats	Wt. Loss	Wt. Gain	Dec. Appetite	Dizzyness	Insomnia	Fatigu
Eye:	WNL	Redness	Discharge	Pain	Itchy	(R) (L)	Blurry Vision			
ENT:	WNL	Ear Pain - R L		Hearing loss	Runny nose	Congestion	Nose Bleed	Sore throat	Hoarse	PND
Resp:	WNL	Cough: prod / non prod		Hemoptysis	Wheeze	SOB	Pleuritic CP	DOE	Nocturnal Dyspnea	
CV:	WNL	Chest Pain	Chest Pressure		LE edema	Palpitations				
GI:	WNL	Nausea	Vomiting	Diarrhea	Constipation	GERD	Dysphagia	Pain: Epi., RUQ, RLQ, LUQ, LLQ		
GU:	WNL	Incontinence	Dysuria	Frequency	Flank pain	Hematuria	Hesitancy	Nocturia		
Gyn:	WNL	Breast Pain	Breast Mass	Vag. D/C	Vag. Itch	Vag. Odor	Dyspareunia	Painful, Heavy, Irregular Menses		
Neuro:	WNL	Headache	Numbness	Gen. Weakness	LOC	Dizzyness	Change Speech	Unsteady Gait		
Psych:	WNL	Agitated	Confused	Unmotivated	Anxious	Tearful	Excited	Suicidal	Fatigue	
MS:	WNL	Myalgia	Neck Pain	Leg: Pain / Wkness R L		Arm: Pain / W	ness R	Lumbar Pain	Jt: Pain, Stiff., Swell	
Skin:	WNL	Dry	Itchy	Flaking	Red	Irritated	Rash:			

Physical Examination (Circle all positives and strike through all negatives)

Eye:	WNL	Lid Lag	Jaundice	Unequal pupils / eye mvt		Drainage: Pur	ient / Clear	Conjunctiva Inflamed	
ENT:	WNL	TM: Bulging Red		Canal: Wax, Swollen, D/C		Naris: Swollen	Turbinate, D/C	Pharynx: Red, Swollen, D/C	
Neck	WNL	TTP	Dec. ROM	Thyromegaly	Lymph node Swelling		JVD	Carotid Bruits: R L	
Resp:	WNL	Labored Breathing		Wheezing	Rales	Ronchi	Decreased Aeration (R) (L)		
CV:	WNL	Rubs	Gallops	Grade ___ Murmur		Irregular: Rhy	hm - Rate	Cap. Refill <2sec	Unequal Rad. Pulse
GI:	WNL	Hepato-Splenomegaly		BS: Increased Decreased		Epi., RUQ, RL	, LUQ, LLQ: Tenderness, Guarding, Rebound, Mass		
GU:	WNL	Urethra: Red Swollen		Bladder: TTP	Vagina: Ab. NI Rugae	Di	charge	Cervix: Beefy Red, Friable, Tender	
Mus ext.	WNL	Shoulder, Arm, Elbow, Wrist, Hand, Hip, Leg, Knee, Ankle, Foot: Tender					ess, Swelling, Dec. ROM	Foot Exam	R L
Spine:	WNL	Scoliosis	SLR pain (L) (R)		Thoracic, Lumbar, Sacrum		Tenderness, Dec. ROM,	Pulse	-
Psych:	WNL	Flat Affect	Anxious	Tearful	Agitated	Distracted	Paranoid	Suspicious	Sensation	-
Skin:	WNL	Cold	Clammy	Red	Dry	Scaly	Jaundice	Weeping	Cold to tch	+

Assessment/ Plan:

(1) shoulder pain — will do radiculopathy MRI shoulder w contrast
(2) HTN controlled
(3) Hyperlipidemia — ✓ A1C

☐ Career / Education counseling	☐ ETOH cessation counseling	☐ Low Fat Diet counseling	☐ Reviewed labs dated: / /
☐ Discuss Problem Solving Skills	☐ Smoking cessation counseling	☐ Low Salt Diet counseling	☐ Stress Follow Up Compliance
☐ Safe Sex Education	☐ Drug use cessation counseling	☐ Caloric reduction counseling	☐ Stress med. comp. & bring to visit
☐ Birth control Counseling	☐ Inc. Fruit / Veg. Counseling	☐ Caffeine reduction couns.	Couns / Coord time _____ min
☐ Hygiene / Grooming Education	☐ Physical activity counseling	☐ Drink More H2O counseling	☐ Couns / Coord > 50% of visit

PROVIDER SIGNATURE:

Next Visit: PRN ___ Days ___ Weeks (2) Months — ✓ Fax

Next Visit Nursing: GYN / BCN Br. Only Labs: BS UA Hg

NAME: Bernard Lee CHART # 40523

00058

DR. TIMOTHY SHANNON

CAROLINA MUSCULOSKELETAL INSTITUTE

NEW PATIENT/PROBLEM TELEPHONE QUESTIONNAIRE

PATIENT # BELE — **TYPE OF APPT** 2/BA / TX 6/4

REF BY DR — APPOINTMENT Mon. (DAY) 8/17 (DATE) 8:45/8:15 (TIME)

REF DR'S TELEPHONE — REF DR'S FAX

TODAY **1ST AVAILABLE** **WITHIN** ____ **DAYS** **REQ** **CALL**

DATE 7/30/09 MADE BY MK CDM DEH TJS TWC RVM MML

1. NAME Bernard LEE SS# 251 45 2204 DOB 4-30-80

PERSON REQUESTING APPT, IF NOT SELF — RELATIONSHIP

2. INS YES NO TYPE Southern Felt Co Serv. PPO IN/OUT NETWORK INS #

MCD # — MEDICAID MAN/CARE AUTHOR. #

CO-PAY ____ CO-INS ____ PRE-PAY ____ $200 $400 **CASH ONLY!!**

3. HOME TELEPHONE (803) 663-0560 ~~WORK~~ Cell TELEPHONE (706) 496-1562 Ext.

4. ST 172 Old Cherokee Indian Rd CITY Graniteville ST SC ZIP 29829

5. HAVE YOU EVER BEEN SEEN BY ONE OF OUR DOCTORS? YES NO YEAR —

6. PROBLEM PATIENT WANTS TO BE SEEN FOR BA

7. HOW LONG HAS CURRENT PROBLEM BEEN BOTHERING YOU? 2 mos

8. WAS THIS AN ACCIDENT? YES NO If yes, how did it happen? hood fell on him

UNKNOWN ___ INJURY ___ INJURY DATE June 2, 2009 Where? HOME WORK AUTO ACC OTHER

9. HAVE YOU HAD PREVIOUS TREATMENT? YES NO WHEN NA Urgent Center June 4

TREATED BY Dr. Broder WHERE North Augusta SC SURGERY? YES NO

OFFICE NOTES REQ? YES NO TO BE: MAILED FAXED BRING **ER REPT REQ?** YES NO

10. HAVE YOU HAD X-RAYS, MRI, CT SCAN, ETC. FOR CURRENT PROBLEM? YES NO

If yes, where? Urgent Center

11. IS PATIENT TO BRING X-RAYS/TEST TO APPT? YES NO **REQ FROM ER?** YES NO

12. DO YOU HAVE AN ATTORNEY? YES NO IS LITIGATION PENDING? YES NO

13. PATIENT TOLD TO BRING ALL MEDICATIONS? YES NO

14. WAS CHART REQUESTED FROM STORAGE? YES NO Date Requested ____

15. MAIL PAPERWORK, IF APPOINTMENT IS 3 DAYS OR MORE AWAY. YES NO

00059

ADDITIONAL INFORMATION PWM & Pt to bring x-rays & MRI & arrive 30 mins early

12/04/08

CAROLINA MUSCULOSKELETAL INSTITUTE, P.A.
ORTHOPEDIC HISTORY FORM

TODAY'S DATE 8/12/09 PATIENT NAME Bernard Lee AGE 29

PRESENT PROBLEM:
When did it happen? 7/2/09 Time 9:30 a.m. (p.m)

Describe in your own words the problem or injury you are being seen for. Include what happened, how it happened, when it happened and how long you have had this problem or injury: On 7/2/09 I was on a step ladder with 2 other employees attempting two lift a 800 pd hood on top a Machine. The load then came down and landed between My Neck an shoulder and it pinned Me down.

What treatment has been done and by whom? I have recieve treatment from Dr Broder, Dr Bethea as well as Dr Al-Sendi

PAIN HISTORY:

Describe your pain
Sharp pains running through My Back, Neck, shoulder
How long does it last?
Constent pain and Headaches
Where is it located?
Neck, shoulder, Back
What makes it worse?
walking, standing to long, Breathing hard, trouble sleeping
Does it wake you up at night?
Yes
Are you stiff in the morning?
Yes

Occupation Machine Operator

Have you been off work? Yes ☑ No ☐ Since when 6/29/09

Why? Medications and pain of Injury

Do you require:
Crutches Walker Braces Other:
Cane Splints Shoes

List any allergies None

Physician's Comments

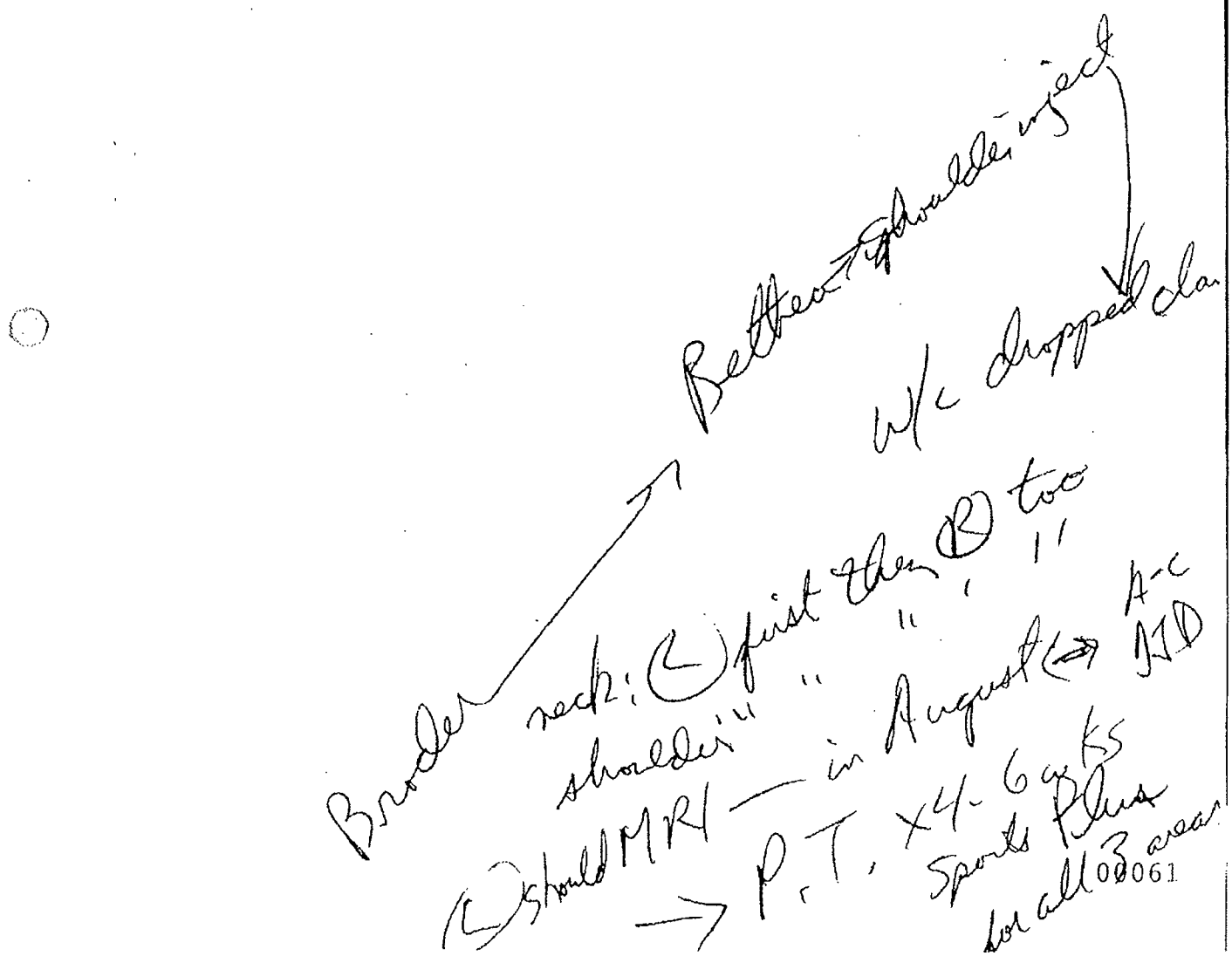
B/M 29y/o
(R) handed
Smoker 5cig q wk
DOI 6/2/09 not 7/2
C/o Back, Neck + S
pt was injured w load metal hood being lifted by forklift came down and lif of hood hit p in neck + shld and had him pin down.
- Shooting and burning pains i neck shld + back
- pain is constan
- walking + stand too long make pain worse
- Trouble sleeping
- Stiff in AM

Tx- Dr Broder Naproxen + Dr. Bethe didn't do anything different

DATE 8/18/09

CMI EMPLOYEE 00060 BW

CANCELLED OR MISSED APPOINTMENTS
DATE 4/17/09
☐ PT CANCELLED
☐ DR. CANCELLED
☐ PT RESCHEDULED
☐ PT NO SHOW/CANCELLED



00061

Current ID Card

Front of Card

SOUTHERN FELT CO., INC.
ISSUER (80840)
ID # 906-84-6153
NAME BERNARD LEE
Care Type: Medical, Dental, Prescription/Mail Rx
PROVIDER NETWORK
[redacted]

PAYOR # SEE BACK
ACCOUNT # H2281-2
EFFECTIVE 09/23/2008

PRINCIPAL LOGO

SUPER MEDPPO LOGO

THE PRINCIPAL PLAN DENTAL
BENEFIT PH # 800-533-5044
CAREMARK 877-683-6838 RXPCN: PCS
RX Group # 0189 3211 RX BIN 610415
RX Copay $10/$25/$40
RX Mail Service $20/$50/$80

AMERITAS LOGO

CARE MARK LOGO

Back of Card

( ) PHYSICIAN COPAY $20.00
AUTHORIZATION IS REQUIRED PRIOR TO HOSPITAL
ADMISSIONS & SOME ELECTIVE SURGERIES & TREATMENT.
- IN ADVANCE FOR NON-EMERGENCY ADMISSION
- WITHIN 2 WORKING DAYS FOR EMERGENCY ADMISSION
FAILURE TO COMPLY MAY REDUCE BENEFITS.
FOR AUTHORIZATION CALL THE PHONE # ON CARD FRONT.
SUPERMED PPO CLAIMS TO: SEND ALL OTHER CLAIMS TO:

SUPERMED PPO	PRINCIPAL LIFE INSURANCE CO
PO BOX 94648	PO BOX 39710
CLEVELAND OH	COLORADO SPGS CO
44101-4648	80949-3910
PAYOR # 90440	PAYOR # 61271

OUTSIDE OF YOUR PROVIDER NETWORK SERVICE AREA CALL
800-241-6350 FOR PHCS HEALTHY DIRECTIONS PROVIDER

LAB CARD LOGO

MULT PLAN LOGO

(800) 258-3152
TJS - In Network
w/ Super Med PPO
per Vanessa
Ref #092298026900
$20.00 Copay /CRH

00062

https://groups02.principal.com/GroupEmployer/GroupEmployer/vippcomm.gpi 8/10/2009

MEDICATIONS LIST FOR PATIENT: Lee Bernard ACCOUNT# 123899

DATE	MEDICATION	# OF TABS & REFILLS	DATE GIVEN	COMPLICATIONS
8/18/09	Naproxen / BW			

ALLERGIES AND COMPLICATIONS	WARNINGS - REASON
8/18/09 NKDA	☐ MRI
	☐ HEPATITIS A, B, C, non-A/B/C
	☐ HIV
	☐ TB
	☐ Med Review
	☐ 00063 MEDLIST

Pharmacy: CVS - Clearwater Family Doctor: _____

Lee, Bernard 123899

08/18/2009 INITIAL OFFICE VISIT

HISTORY OF PRESENT ILLNESS: The patient is a 29-year-old male who was injured on the job 06/02/2009 (the patient reports that he wrote the wrong date in our chart, i.e., he wrote 07/02/2009). He states that he and other people were attempting to lift a metal hood by forklift when it came down and the lip of the hood struck him on the left side of his neck and superior aspect of his shoulder. He states that he was pinned down for a little while. He was subsequently evaluated by Dr. Jeff Broder in North Augusta, who ordered an MRI of the left shoulder and prescribed physical therapy at Sports Plus for neck, left shoulder, and low back problems. The patient was then referred to Dr. James Bethea who injected the left shoulder. When the worker's compensation carrier dropped this patient's claim, he states that he did not follow up with Dr. Broder or with Dr. Bethea. The patient states that symptoms initially began on the left side of the neck and superior aspect of the left shoulder, but over the past few weeks, he has started to have some problems with his right side of his neck and his right shoulder, he thinks because of increased use of the right shoulder due to the left shoulder problems. In addition, the patient complains of pain localized to the low back region. The patient denies any bladder or bowel changes. No radiation of the shoulder pains into the distal portion of the upper extremities or radiation of the low back pain into the lower extremities at all. Walking, standing too long, breathing, coughing, or sneezing all seem to make all problems worse. The patient states that prior to the on the job injury of 06/02/2009, he had no problems with his neck, shoulders, or low back.

HISTORY AND PHYSICAL EXAM:
The history form of 08/18/2009 reviewed.
ALLERGIES: Noncontributory.
MEDICATIONS: Noncontributory.
PAST MEDICAL/SURGICAL HISTORY: Noncontributory.
FAMILY/SOCIAL HISTORY: Noncontributory.
REVIEW OF SYSTEMS: Noncontributory.

PHYSICAL EXAMINATION:
VITAL SIGNS: Height: 6 feet. Weight: 189 pounds. Blood Pressure: 140/108.
GENERAL: No acute distress.
HEENT: Within normal limits.
NEUROLOGIC: Normal motor and deep tendon reflex examination. No upper motor neuron signs. No evidence of muscle spasm, atrophy or gait disturbance.
CARDIOVASCULAR: Normal peripheral pulses and no peripheral lymphedema.
NECK: Tenderness to palpation of the cervical paraspinal muscles, left greater than right. Negative Lhermitte's sign. Range of motion: Full.
UPPER EXTREMITIES: Right shoulder: Normal vascular exam. Full range of motion of

the shoulder and no intrinsic shoulder signs. Left shoulder: Normal neurovascular exam. Full range of motion with no impingement signs. No instability or AC joint signs.
BACK: Low back: Tenderness to palpation of the lumbosacral muscles bilaterally. Range of motion: Full.
LOWER EXTREMITIES: Bilateral lower extremities: Negative straight leg raising sign bilaterally. Negative hip signs. Normal vascular exam. Thomas' test not performed.

X-RAYS: (Dr. Bethea's office, unknown date.) AP and lateral views of the lumbosacral spine are normal. AP and lateral views of the cervical spine demonstrate decrease in normal cervical lordosis. No other malalignment seen. No fractures seen. No findings suggestive of degenerative disk seen.

IMPRESSION:
1. Neck pain due to contusion of paraspinal muscles with perhaps an element of strain.
2. Left shoulder pain, rule out referred pain from neck, rule out contusion to shoulder producing rotator cuff impingement syndrome.
3. Low back pain, presumably secondary to paraspinal strain sustained at the time of the injury.

* To a reasonable degree of medical certainty, based on the patient's history alone, these problems are probably due to the on the job injury of 06/02/2009. Pain and dysfunction in the left shoulder and on the left side of the neck could lead to secondary overuse of the right side of the neck and the right shoulder, to a reasonable degree of medical certainty.

PLAN: Modified duty statement written. The skin was sterilely prepped with alcohol. 1 cc of Depo-Medrol and 9 cc of 2% lidocaine was placed in a syringe with a 22-gauge 1.5" needle and this was then used to inject the left shoulder subacromial space. A band aid dressing was applied to the area. See how he is doing clinically when he returns. Send him off for MRIs of the neck and the low back. We should have the studies and the reports available when he returns and proceed accordingly. In addition, **we should repeat his blood pressure and if it is still elevated, strongly encourage him to follow up with a primary care physician. We did so today when we noted his blood pressure and notified him of the potential adverse consequences if he did not seek follow up.**

Timothy J. Shannon, M.D.

TJS/ITS/5154

Lee, Bernard 123899

08/18/2009 INITIAL OFFICE VISIT

HISTORY OF PRESENT ILLNESS: The patient is a 29-year-old male who was injured on the job 06/02/2009 (the patient reports that he wrote the wrong date in our chart, i.e., he wrote 07/02/2009). He states that he and other people were attempting to lift a metal hood by forklift when it came down and the lip of the hood struck him on the left side of his neck and superior aspect of his shoulder. He states that he was pinned down for a little while. He was subsequently evaluated by Dr. Jeff Broder in North Augusta, who ordered an MRI of the left shoulder and prescribed physical therapy at Sports Plus for neck, left shoulder, and low back problems. The patient was then referred to Dr. James Bethea who injected the left shoulder. When the worker's compensation carrier dropped this patient's claim, he states that he did not follow up with Dr. Broder or with Dr. Bethea. The patient states that symptoms initially began on the left side of the neck and superior aspect of the left shoulder, but over the past few weeks, he has started to have some problems with his right side of his neck and his right shoulder, he thinks because of increased use of the right shoulder due to the left shoulder problems. In addition, the patient complains of pain localized to the low back region. The patient denies any bladder or bowel changes. No radiation of the shoulder pains into the distal portion of the upper extremities or radiation of the low back pain into the lower extremities at all. Walking, standing too long, breathing, coughing, or sneezing all seem to make all problems worse. The patient states that prior to the on the job injury of 06/02/2009, he had no problems with his neck, shoulders, or low back.

HISTORY AND PHYSICAL EXAM:
The history form of 08/18/2009 reviewed.
ALLERGIES: Noncontributory.
MEDICATIONS: Noncontributory.
PAST MEDICAL/SURGICAL HISTORY: Noncontributory.
FAMILY/SOCIAL HISTORY: Noncontributory.
REVIEW OF SYSTEMS: Noncontributory.

PHYSICAL EXAMINATION:
VITAL SIGNS: Height: 6 feet. Weight: 189 pounds. Blood Pressure: 140/108.
GENERAL: No acute distress.
HEENT: Within normal limits.
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CARDIOVASCULAR: Normal peripheral pulses and no peripheral lymphedema.
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UPPER EXTREMITIES: Right shoulder: Normal vascular exam. Full range of motion of

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* To a reasonable degree of medical certainty, based on the patient's history alone, these problems are probably due to the on the job injury of 06/02/2009. Pain and dysfunction in the left shoulder and on the left side of the neck could lead to secondary overuse of the right side of the neck and the right shoulder, to a reasonable degree of medical certainty.

PLAN: Modified duty statement written. The skin was sterilely prepped with alcohol. 1 cc of Depo-Medrol and 9 cc of 2% lidocaine was placed in a syringe with a 22-gauge 1.5" needle and this was then used to inject the left shoulder subacromial space. A band aid dressing was applied to the area. See how he is doing clinically when he returns. Send him off for MRIs of the neck and the low back. We should have the studies and the reports available when he returns and proceed accordingly. In addition, **we should repeat his blood pressure and if it is still elevated, strongly encourage him to follow up with a primary care physician. We did so today when we noted his blood pressure and notified him of the potential adverse consequences if he did not seek follow up.**

Timothy J. Shannon, M.D.

TJS/ITS/5154

Carolina Musculoskeletal Institute, PA

410 University Parkway, Suite 1000
Aiken, SC 29801
(803) 644-4264 • Fax (803) 649-0543
www.CMI.md

CMI Orthopedics
CLARK D. MOORE, M.D.
DOUGLAS E. HOLFORD, M.D.
TIMOTHY J. SHANNON, M.D.
TY W. CARTER, M.D.
R. VAUGHAN MASSIE, M.D.

CMI Imaging
DAVID D. GOLTRA, M.D.

CMI Pain Management
RUSSELL K. DANIEL, M.D.

CMI Neurology
MICHELLE M. LYON, M.D.

CMI Rheumatology & Osteoporosis
EDWIN MARTINEZ de ANDINO, M.D.

CMI Podiatry
MACKIE J. WALKER, D.P.M.
JAMES S. ZAREMBA, D.P.M.

RESTRICTED DUTY STATEMENT

PATIENT NAME: LEE Bernard DATE: 8/19/09

DIAGNOSIS: _____ DOI: _____

Restrictions apply to: R (L) BILAT (U/E) L/E; (NECK), (BACK)

Work status: No disability No change Restricted Off work: _____ Day(s) Week(s) Month(s) Perm

Per 8 hour day	Continuously 5-8 hours Repetition=500+	Frequently = 3-5 hours Repetition = 100 - 500	Occasionally = 0-3 hours Repetitions = 1 - 100	Infrequently	Not at all	Not applicable
Stand	✓					
Sit	✓					
Walk	✓					
Bend/stoop			✓			
Squat/crouch			✓			
Crawl				✓		
Push/pull		✓				
Stairs/ladders				→	✓	
Reach above shoulder	(R)		(L)			
Repetitive hand work	✓					
Repetitive foot work	✓					
Drive auto			✓		~~✓~~ Lenox 7-15	
Operate hazardous equipment					✓	
Lifting: Sedentary	Negligible	Negligible	Less than 10 lb			
			✓			
Lifting: Light	Negligible	Up to 10 lb	Less than 20 lb			
				✓		
Lifting: Medium	Up to 10 lb	Less than 21	Less than 50 lb			
					✓	
Lifting: Heavy	Less than 21 lb	Less than 50	Over 50 lb			
					✓	
Hours/work	OT	40	20			
Other: Explain other instructions						

Medications _____

Shannon MD

Signature of Physician

00068

8/10/09

AI AV D

SURGERY CHARGE SLIP/TEST SCHEDULING CHECKLIST

PATIENT: Bernard Lee DOB: 4/1900 CHART #: 23399 SS #: _____

TELEPHONE #: _____ DOI: __/__/__ REFERRING DR. TJS

TEST/PC	SIDE	REGION	SITE
(MRI)	R B L	HEAD	ARMC
CT		CHEST	OR
MYELO		ABDOMEN	X-RAY
BONE SCAN		SPINE	CMI
DENSITOMETRY		C D L	ECH
ULTRASOUND		PELVIS	SCA
ARTHROGRAM		U/E	POD
X-RAY		SHLDR	
VENOGRAM		ARM	
ARTERIAL STUDIES		ELBOW	
EDS		FOREARM	
EKG		WRIST	
IVP		HAND	
ESI		DIGIT____	
EKG		L/E	
N CLINIC		HIP	
		THIGH	
LAB PROFILE		KNEE	
EXEC		LEG	
CHEM		ANKLE	
COMP METABOL		FOOT	
RHEUMATOID		TOE____	
ARTHRITIS			
NSAID			
TUMOR			
PT/INR			

OP IP SDA 23HR TODAY/URGENT/ROUTINE

DX _____ 726.1

_____ 726.

R/O degen. disk disease 847.

_____ 847.

HX injured at work 6/2/09

PCD	CPT CODE/MOD	CHARGE
	TOTAL $	

ICD9

REFER TO: _____
Eval + Assume Care
2nd Opinion
Surgical Clearance

SPECIAL EQUIPMENT/INSTRUCTIONS

4-Swks 9/10/09 1:45

DEXA

____ Women over 65

Surgical meno[illegible]

SCHEDULING NOTES
STAT RESULTS_____ CALL RESULTS TO_____
SEDATION IV_____ ORAL_____
SPECIAL NOTES_____
NO SHOW_____ RESCHEDULE_____

TECH NOTES
CONTRAST_____ SEDATION_____
PRIOR STUDIES_____ PROTOCOL FROM_____
CLINICAL NOTES_____
IMAGES SENT_____ PREG._____ TECH._____

o 7.5mg or

[illegible]/Osamax/Actonel to eval treatment V67.51+733.00

____ Every 2 years while on treatment to monitor therapy V67.59 + 733.00

____ Recurrent Stress Fracture_____

____ Other_____

CX Dr Gottlieb

80% afraded 100% Active 9/23/09 • nothing not

PREPAY REQUIRED $ 120.00

DATE 8/24/09 TIME 11:00 DATE _____ TIME _____

AUTHORIZED _____ NOTES SENT _____ CMI Employee DM

INSURANCE CARRIER Supermed 9068461533 DAYS OK'D _____ Premier

Precert Number no pre auth req (left DANA 8/19/09 DATE OF ACCIDENT _____ will do precert)

Contact DANA 8/19/09 10:20am Phone Number 800 241 - 6350

mark ... benefits ins. co. administrator 800-523-5044

OR XRAY
Port
C-Arm
Mini C-Arm

SURGERY ASST.
CDM TWC
DEH RVM
TJS

OVER

SURGERY	Y	N
METAL FB	Y	N
WORKED AROUND	Y	N
METAL PACEMAKER	Y	N
BRAIN CLIPS	Y	N
NITROPATCH	Y	N
DIABETIC	00869	N
CLAUSTROPHOBIC	Y	N

615

8/18/09 1

PI PV 66
AI AV D

SURGERY CHARGE SLIP/TEST SCHEDULING CHECKLIST

PATIENT: Bernard Lee DOB: 4/1900 CHART #: 23899 SS #:

TELEPHONE #: DOI: / / REFERRING DR. TJS

TEST/PC	SIDE	REGION	SITE
(MRI)	R B L	HEAD	ARMC
CT		CHEST	OR
MYELO		ABDOMEN	X-RAY
BONE SCAN		SPINE	CMI
DENSITOMETRY		(C) D L	ECH
ULTRASOUND		PELVIS	SCA
ARTHROGRAM		U/E	POD
X-RAY		SHLDR	
VENOGRAM		ARM	
ARTERIAL STUDIES		ELBOW	
EDS		FOREARM	
EKG		WRIST	
IVP		HAND	
ESI		DIGIT	
(KG)		L/E	
(IN CLINIC)		HIP	
		THIGH	
LAB PROFILE		KNEE	
EXEC		LEG	
CHEM		ANKLE	
COMP METABOL		FOOT	
RHEUMATOID		TOE	
ARTHRITIS			
NSAID			
TUMOR			
PT/INR			

OP IP SDA 23HR TODAY/URGENT/ROUTINE

DX

R/O degen. disk disease

HX injured at work 6/2/09

PCD

ICD9: 722.91, 726., 847, 847.

CPT CODE/MOD	CHARGE
TOTAL $	

REFER TO:
Eval + Assume Care
2nd Opinion
Surgical Clearance

SPECIAL EQUIPMENT/INSTRUCTIONS

4-Subs 9/10/09 1:45

DEXA

_____ Women over 65

Surgical meno...

SCHEDULING NOTES
STAT RESULTS_____ CALL RESULTS TO_____
SEDATION IV_____ ORAL_____
SPECIAL NOTES_____
NO SHOW_____ RESCHEDULE_____

TECH NOTES
CONTRAST_____ SEDATION_____
PRIOR STUDIES_____ PROTOCOL FROM_____
CLINICAL NOTES_____
IMAGES SENT_____ PREG._____ TECH._____

o 7.5mg or

_____ I ... Fosamax/Actonel to eval treatment V67.51+733.00
_____ Every 2 years while on treatment to monitor therapy V67.59 + 733.00
_____ Recurrent Stress Fracture_____
_____ Other_____

PREPAY REQUIRED $ 120.00

DATE 8/24/09 TIME 11:00 DATE _____ TIME _____

AUTHORIZED _____ NOTES SENT _____ CMI Employee DW

INSURANCE CARRIER Supermed 906846153 DAYS OK'D _____

Precert Number _____ DATE OF ACCIDENT _____

Contact _____ Phone Number ___-___-_____

OR XRAY	SURGERY ASS
Port	CDM TW
C-Arm	DEH RVP
Mini C-Arm	TJS

SURGERY	Y	N
METAL FB	Y	N
WORKED AROUND	Y	N
METAL PACEMAKER	Y	N
BRAIN CLIPS	Y	N
NITROPATCH 00070	Y	N
DIABETIC	Y	N
CLAUSTROPHOBIC	Y	N

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
2002 – 2008

Associates:
Tyler Bolhrick

COLUMBIA:
1116 BLANDING STREET
2ND FLOOR
COLUMBIA, SC 29201
(803) 929-0029

ROCK HILL:
930 OAKLAND AVENUE
P.O. BOX 10751
ROCK HILL, SC 29731
(803) 980-0088
(803) 328-2525 FAX

MYRTLE BEACH:
1039 44TH AVENUE NORTH
SUITE 102
MYRTLE BEACH, SC 29577
(843) 839-2501
(843) 839-2507 FAX

Reply to: Rock Hill office

October 14, 2009

Dr. Timothy J. Shannon
Carolina Musculoskeletal Institute, P.A.
410 University Parkway
Aiken, South Carolina 29801

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: 0906951
DOB: 4-30-80
SSN: 251-45-2204

Dear Dr. Shannon,

My office represents Mr. Bernard Lee for injuries arising out his employment with Bondex. It is my understanding the Mr. Lee was treated by you on August 17, 2009. As you will recall, Mr. Lee is employed as a machine operator. On June 2, 2009, he and two other co-workers were lifting a machine hood when the hood fell onto the left side of Mr. Lee's shoulder and neck. After reporting the accident to his supervisor, the employer sent Mr. Lee to University Hospital for treatment. There, x-rays of the left shoulder were taken. He was placed in a sling and provided Skelaxin and Ibuprofen.

Mr. Lee next came under the care of Dr. Broder of North Augusta Urgent Care. Dr. Broder's treatment consisted of continued medications and physical therapy. When Mr. Lee's symptoms persisted, an MRI of the left shoulder was ordered. On June 26, 2009, he underwent an MRI of the left shoulder which showed an, "Acromioclavicular joint arthropathy with mild impingement" and "Bicipital tendonitis."

On July 16, 009, the employer sent Mr. Lee for an evaluation with Dr. James Bethea. At that time, Mr. Lee was making complaints of pain in his left shoulder, neck and back. Dr. Bethea's diagnosis consisted of impingement syndrome of the left shoulder and neck and back pain. He provided a cortisone injection for the shoulder, medications and recommended continuing physical therapy. A follow-up visit was scheduled for July 30, 2009. On July 29, 2009, we were informed by opposing counsel that Mr.

Lee's appointment with Dr. Bethea had been canceled as the employer was now denying the claim. As a result, Mr. Lee contacted your office on July 30, 2009 to schedule an appointment with you. He was subsequently seen by you on August 18, 2009.

Presently, we are attempting to determine what benefits, if any, Mr. Lee is entitled to under the workers' compensation laws of South Carolina. Because we have a hearing scheduled to address these matters, I am requesting that you confirm your opinions in the below questionnaire. Please check "yes" or "no" and explain if necessary.

1) That I am one of Mr. Bernard Lee's treating physicians. I have treated Mr. Lee from August 18, 2009 to the present.

X Yes _____ No

Explanation:_____

2) That on August 18, 2009, Mr. Lee provided the following history, "He states that he and other people were attempting to lift a metal hood by forklift when it came down and the lip of the hood struck him on the left side of his neck and superior aspect of the shoulder. He states he was pinned down for a little while."

X Yes _____ No

Explanation:_____

3) That Mr. Lee also told me during his initial visit on August 18, 2009, that, "...symptoms initially began on the left side of the neck and superior aspect of the left shoulder, but over the past few weeks, he has started to have some problems with his right side of his neck and his right shoulder, he thinks because of increased use of the right shoulder due to the left shoulder problems. In addition, the patient complains of pain localized to the low back region."

X Yes _____ No

Explanation:_____

4) Based on the history and symptoms provided by Mr. Lee and my understanding of how the June 2, 2009 accident occurred, it is my opinion, "most probably and to a reasonable degree of medical certainty" (greater than 50% probability) that the injuries Mr. Lee sustained to his left shoulder, neck and back are consistent with the mechanism injury that occurred on June 2, 2009.

X
Yes

No

Explanation:

5) It is my opinion, "most probably and to a reasonable degree of medical certainty" (greater than 50% probability) that Mr. Lee suffers from neck pain, left shoulder pain, and low back pain as a direct result of his work accident of June 2, 2009.

X
Yes

No

Explanation:

6) It is further my opinion, "most probably and to a reasonable degree of medical certainty" (greater than 50% probability) that as a result of Mr. Lee's, "Pain and dysfunction in the left shoulder and left side of the neck..." that he now suffers from pain and problems in his right shoulder and right side of his neck which was caused by secondary overuse of his right arm and right shoulder.

X
Yes

No

Explanation:

Dr. Timothy J. Shannon

10/15/09
Date

Thank you for your assistance in this matter. Should you have any questions, please do not hesitate to contact my office.

Very truly yours,

By: Ann McGrowey Mjeklo
Ann McGrowey Mjeklo

cc: Mr. Bernard Lee

00073

WORKERS' COMPENSATION INFORMATION (Required to precertify and file claims)

TODAY'S DATE 1/12/10 INJURY DATE 6/2/09 BODY PART multiple body parts

PATIENT NAME Bernard Lee PATIENT ACCOUNT # 123899-1

SSN: 251-45-2204

EMPLOYER NAME AND ADDRESS
Southern Felt DBA Bordex
2 Max Well Dr.
Trenton, SC 29860

APPT SCHEDULED FOR ✓ VERIFIED WORKER'S COMP INJURY

_____ APPROVED 1ST VISIT BY EMPLOYER (W/C NOT YET VERIFIED)

SEND CLAIMS TO: ____ EMPLOYER ✓ INS. CARRIER ____ OTHER ____

COMPANY NAME Strategic Comp Services

MAILING ADDRESS PO Box 1445
Alpharetta, GA 30009

CONTACT PERSON OR ADJUSTER Steve Anthony

PHONE NO. 803-448-5520 VERIFIED WITH Steve Anthony (COMPANY EMPLOYEE) BY ____

FAX NO. 770-325-1432 DATE 1/12/10

PRE-CERTIFICATION COMPANY NAME: ____

PRE-CERTIFICATION COMPANY PHONE NO. ____

PRE-CERTIFICATION COMPANY FAX NO. ____

PRE-CERTIFICATION COMPANY CONTACT PERSON: ____

00074

LEE, BERNARD
123899

OFFICE VISIT
05/25/2010

HISTORY OF PRESENT ILLNESS: The patient presents for reevaluation of the problem for which I saw him on 08/18/2009. Since that time, the patient reports that the pain continues to be burning in quality and continues to be localized to the left shoulder, left upper chest, left posterior neck and left upper back region. He states that the pain frequently radiates down to but not beyond his left elbow. He states he has had difficulty raising his left arm. He saw Dr. Carter in January of this year, after undergoing a MRI of the C-spine and LS-spine. Dr. Carter recommended that he start back in physical therapy. However, he reports that the physical therapy was denied, and so he has not started back in therapy.

The orthopedic history form of 05/25/2010 is reviewed.

REVIEW OF SYSTEMS: The patient continues to complain of low back pain, as he did on 08/18/2009.

PHYSICAL EXAMINATION:
Height 6 feet. Weight 197 pounds. Blood Pressure 130/80.
Neck: Tenderness to palpation of the left cervical paraspinal muscles. Negative Lhermitte sign. Range of motion: Full.
Right upper extremity: Right shoulder: Normal neurovascular examination. Full range of motion with no impingement signs. No instability or AC joint signs.
Left upper extremity: Full passive range of motion without impingement signs. The patient appears to have weakness to active abduction and forward flexion of the shoulder; although rotation with the arm at the side is normal. No deformity of the shoulder.
Low back: Mild tenderness to palpation of the lumbosacral muscles. Bilateral range of motion: Full.

X-RAYS: AP and axillary views of the left shoulder are normal.

IMPRESSION:
1. Low back pain, probably secondary to paraspinal strain sustained at the time of the on-the-job injury on 06/02/2009.
2. Neck pain, probably due to contusion of paraspinal muscles perhaps with an element of strain, also due to the on-the-job injury of 06/02/2009.
3. Left upper extremity pain and weakness, rule out simple inhibition of musculature contraction due to pain, rule out contusion of muscles and roots of brachial plexus. Based on the patient's history, this is also probably due to the on-the-job injury of 06/02/2009.

*To a reasonable degree of medical certainty, I believe the above diagnoses to be true and with the above noted etiologies.

PLAN: Because the patient's C-spine MRI, as read by Dr. Carter, did not show any obvious nerve root impingement that might be the source of his upper extremity pain, I would proceed with electrodiagnostic studies to eliminate either a peripheral nerve compression (i.e. in the roots or origins of the brachial plexus) or to detect a subtle cervical radiculopathy. We should have the report available when he returns. In addition, I would recommend that he be restarted on physical therapy, as Dr. Carter suggested on his office note earlier this year.

Timothy J. Shannon, M.D.

TJS/sbs/2908

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
2002 – 2008

Associates:
Tyler Bathrick

COLUMBIA:
1110 BLANDING STREET
2ND FLOOR
COLUMBIA, SC 29201
(803) 930-0020

ROCK HILL:
930 OAKLAND AVENUE
P.O. BOX 10701
ROCK HILL, SC 29731
(803) 980-0088
(803) 328-2096 FAX

MYRTLE BEACH:
1039 44TH AVENUE NORTH
SUITE 109
MYRTLE BEACH, SC 29577
(843) 839-2501
(843) 839-2607 FAX

Reply to: Rock Hill office

May 25, 2010
~~October 14, 2009~~

Dr. Timothy J. Shannon
Carolina Musculoskeletal Institute, P.A.
410 University Parkway
Aiken, South Carolina 29801

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: 0906951
DOB: 4-30-80
SSN: 251-45-2204

Dear Dr. Shannon,

My office represents Mr. Bernard Lee for injuries arising out his employment with Bondex. It is my understanding the Mr. Lee was treated by you on August 17, 2009. As you will recall, Mr. Lee is employed as a machine operator. On June 2, 2009, he and two other co-workers were lifting a machine hood when the hood fell onto the left side of Mr. Lee's shoulder and neck. After reporting the accident to his supervisor, the employer sent Mr. Lee to University Hospital for treatment. There, x-rays of the left shoulder were taken. He was placed in a sling and provided Skelaxin and Ibuprofen.

Mr. Lee next came under the care of Dr. Broder of North Augusta Urgent Care. Dr. Broder's treatment consisted of continued medications and physical therapy. When Mr. Lee's symptoms persisted, an MRI of the left shoulder was ordered. On June 26, 2009, he underwent an MRI of the left shoulder which showed an, "Acromioclavicular joint arthropathy with mild impingement" and "Bicipital tendonitis."

On July 16, 009, the employer sent Mr. Lee for an evaluation with Dr. James Bethea. At that time, Mr. Lee was making complaints of pain in his left shoulder, neck and back. Dr. Bethea's diagnosis consisted of impingement syndrome of the left shoulder and neck and back pain. He provided a cortisone injection for the shoulder, medications and recommended continuing physical therapy. A follow-up visit was scheduled for July 30, 2009. On July 29, 2009, we were informed by opposing counsel that Mr.

00077

On January 25, 2010 Dr. Ty Carter reviewed cervical and lumbar MRI(s) before noting, "I feel that the patient mostly has some shoulder and scapular strain issues." Dr. Carter recommended physical therapy for the neck and back and noted, "I will see the patient back here as needed or he can follow back up with Dr. Shannon for his shoulder issues...." (See Attachment).

Mr. Lee is scheduled to return to your office on May 25, 2010. At the conclusion of your evaluation, please indicate in the below questionnaire your medical opinions relating to his current physical condition. (Please check "yes" or "no" and explain if necessary).

1) I am one of Mr. Bernard Lee's treating physicians. I have treated Mr. Lee from August 18, 2009 through the present and continuing.

✓ Yes _____ No

Explanation: _____

2) On May 25, 2010 Mr. Lee presented to my office with a burning pain in his left shoulder, neck, and scapula region. Mr. Lee indicated that the pain often radiates to his left elbow. During a physical examination Mr. Lee was unable to lift his left arm.

X Yes x No

Explanation: _____

3) It is my expert medical opinion that Mr. Lee has not reached maximum improvement with regard to his left shoulder.

X Yes _____ No

Recommended Medical Treatment: 5'ei office visits

Explanation: _____

00078

4) On October 14, 2009 I noted, "It is my opinion, "most probably and to a reasonable degree of medical certainty" (greater than 50% probability) that Mr. Lee suffers from neck pain, left shoulder pain, and low back pain as a direct result of his work accident of June 2, 2009." (See Attachment).

X Yes _____ No

Explanation: _____

5) It is my expert medical opinion, "most probably and to a reasonable degree of medical certainty" (greater than 50% probability) that all medical treatment recommended in question #3 above is causally related to and necessary because of Mr. Lee's June 2, 2009 work related injury.

X Yes _____ No

Explanation: _____

6) It is my expert medical opinion that Mr. Lee is in need of the following work restrictions with regard to the left shoulder/arm: (Please check all applicable, and provide an explanation, if necessary).

X No lifting

X No use of the left shoulder/arm

_____ No repetitive use

X No overhead work

Explanation: see note

00079

7) All opinions and boxes checked in this questionnaire are my expert medical opinions, stated most probably and to a reasonable degree of medical certainty (greater than 50% probability), and should be given the same weight as the opinions provided in my dictated notes.

X Yes _____ No

Explanation: _____

Dr. Timothy J. Shannon 5/25/10 Date

Thank you for your assistance in this matter. Should you have any questions, please do not hesitate to contact my office.

Very truly yours,

By: _____
Tyler Bathrick

Enclosure: referenced medical records

00080

DR. DAVID D. GOLTRA, JR.

CAROLINA MUSCULOSKELETAL INSTITUTE

1-27

Carolina Musculoskeletal Institute, PA

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Aiken, SC 29801
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DOUGLAS E. HOLFORD, M.D.
TIMOTHY J. SHANNON, M.D.
TY W. CARTER, M.D.
R. VAUGHAN MASSIE, M.D.

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MACKIE J. WALKER, D.P.M
JAMES S. ZAREMBA, D.P.M.

PATIENT: LEE, BERNARD
DOB: 4-30-80
FILE: 123899
PHYSICIAN: Timothy J. Shannon, M.D.
EXAM: MRI lumbar spine without contrast
DATE: 1-14-10

CLINICAL INDICATION:
Degenerative disc disease and remote injury, unspecified.

TECHNIQUE:
The study was performed on the Siemens Magnetom Viva Open MRI Scanner, which performs at 0.2 Tesla. The following pulse sequences were performed: sagittal T2, sagittal T1, sagittal STIR, axial T2, axial T1, and coronal T1.

Contrast: None.
Comparison: None.

FINDINGS:
Overview: In the visualized abdomen and pelvis no soft tissue mass or abnormal fluid collection is identified. The bone marrow signal intensity within the visualized bones of the pelvis and both proximal femurs is normal. Paraspinal and parapelvic musculature are normal.

Lumbar and lower thoracic spine: No acute fracture or subluxation. Vertebral body heights are preserved and the bone marrow signal intensity is normal. The L5 vertebral body is transitional and predominantly sacralized.

Intervertebral discs:
From the level of T11-12 through L1-2, the intervertebral discs are normal in height and signal intensity. No focal or broad based disc abnormality identified. Central canal and neural foramen are patent. Termination of the spinal cord is normal.

OPINION:
There is sacralization of the L5 vertebral body. Remainder of examination is normal.

SIGNATURE:

David D. Goltra, Jr., M.D./ Richard Clinton, M.D.
RC/ng

00081

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JAMES S. ZAREMBA, D.P.M.

PATIENT: LEE, BERNARD
DOB: 4-30-80
FILE: 123899
PHYSICIAN: Timothy J. Shannon, M.D.
EXAM: MRI cervical spine without contrast
DATE: 1-14-10

CLINICAL INDICATION:
Degenerative disc disease and remote prior injury, unspecified.

TECHNIQUE:
The study was performed on the Siemens Magnetom Viva Open MRI Scanner, which performs at 0.2 Tesla. The following pulse sequences were performed: sagittal T2, sagittal T1, sagittal STIR, coronal T1, and axial T2.

Contrast: None.

Comparison: None.

FINDINGS:
Overview: No soft tissue mass or abnormal fluid collection is seen in the neck. Neck musculature is normal in signal intensity and symmetry. Central brachial plexus appears unremarkable. Lung apices are grossly clear.

Cervical spine: There is straightening of the cervical spine with loss of normal cervical lordosis. No acute fracture or subluxation. Facets are intact and appear unremarkable.

Intervertebral discs:
The intervertebral discs of the cervical and upper thoracic spine are normal in height and signal intensity with the exception of mild disc desiccation at the level of T1-2. No focal or broad based disc abnormality identified. Central canal and neural foramen are patent. Spinal cord is normal.

Continued on page 2

00082

PATIENT: LEE, BERNARD
DOB: 4-30-80
FILE: 123899
PHYSICIAN: Timothy J. Shannon, M.D.
EXAM: MRI cervical spine without contrast
DATE: 1-14-10

OPINION:

1. There is straightening of the cervical spine which may be positional or related to muscle spasm.
2. Mild degenerative disc change is noted at T1-2. Remainder of examination is normal.

SIGNATURE:

David D. Goltra, Jr., M.D./ Richard Clinton, M.D.
RC/ng

00083

DR. TY CARTER

CAROLINA MUSCULOSKELETAL INSTITUTE

LEE, BERNARD
123899

OFFICE VISIT
01/25/2010

HISTORY OF PRESENT ILLNESS:
This is a gentleman that Dr. Shannon had seen on one occasion on 08/18/2009. The patient is now 29 years old and he was involved in a work related incident on 06/02/2009. He says that a forklift came down on his left shoulder and neck region. He has been evaluated through Worker's Compensation physicians and by Dr. Shannon. He was having symptoms of neck and left posterior shoulder pain. He was complaining of some numbness going down his arms. He also has low back pain. The patient has tried medicines, physical therapy which was stopped, and just recently had MRI's. The patient was sent to follow-up with me for review of his MRI's. The patient has been out of work since his injury date.

PHYSICAL EXAMINATION: The patient says that his left shoulder and posterior neck is the area where he hurts the most. He says that it radiates to the medial border of the scapula. He has difficulty raising his left arm. The examination of the neck shows the patient's neck is actually non-tender to palpation. He has full range of motion. Negative Lhermitte testing. He has some mild tenderness on the superior portion of the trapezius and he is tender of the scapula spine and the medial border of the scapula. There is no redness, swelling, or warmth. Active abduction of the left shoulder is 15 to 20 degrees. Forward flexion is 15 to 20 degrees. Passively, he can go to 90 degrees with abduction and has difficulty holding his arm up and his arm gives way. The patient has intact sensation, good capillary refill and strength the remainder of his left upper extremity.

The MRI of the cervical spine is within normal limits. MRI of the lumbar spine is within normal limits.

PLAN: I feel that the patient mostly has some shoulder and scapular strain issues. I am uncertain why he is truly having weakness. He has had two injections in his shoulder without relief. He was starting physical therapy and was told to stop that. I definitely do not see anything that is going to require any surgical intervention for his neck or low back. If this is a primary shoulder issue or scapular contusion issue, I just think he needs to be started back in physical therapy again and I am going to arrange for that. I feel that the patient has reached his maximum medical improvement since there is nothing further than can be done for him. I will see the patient back here as needed or he can follow back up with Dr. Shannon for his shoulder issues, but there is definitely nothing in regards to his cervical spine or lumbar spine that is too problematic based on the MRI's. I will see the patient back here as needed.

Ty W. Carter, M.D.

TWC/slg/0087

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123899-1

RESTRICTED DUTY STATEMENT

PATIENT NAME: Bernard Lee DATE: 1/25/10

DIAGNOSIS: _____ DOI: _____

Restrictions apply to: R L BILAT. U/E L/E; (NECK) (BACK) (USH

Work status: No disability No change Restricted Off work: ____ Day(s) Week(s) Month(s) Perm

Per 8 hour day	Continuously 5-8 hours Repetition=500+	Frequently = 3-5 hours Repetition = 100 - 500	Occasionally = 0-3 hours Repetitions = 1 - 100	Infrequently	Not at all	Not applicable
Stand	✓					
Sit	✓					
Walk	✓					
Bend/stoop	✓					
Squat/crouch			✓			
Crawl			✓			
Push/pull	(R) hand only					
Stairs/ladders			✓			
Reach above shoulder	(L) only					
Repetitive hand work	(R) > (L)					
Repetitive foot work	✓					
Drive auto	✓					
Operate hazardous equipment						
Lifting: Sedentary	Negligible	Negligible	Less than 10 lb			
Lifting: Light	Negligible	Up to 10 lb	Less than 20 lb			
Lifting: Medium	Up to 10 lb	Less than 21	Less than 50 lb			
Lifting: Heavy	Less than 21 lb	Less than 50	Over 50 lb			
Hours/work	OT	40	20			
Other: Explain other instructions	(R) UE work only / (L) UE work					

Medications _____

_____

_____
Signature of Physician

00085

DR. W. DANIEL WESTERKAM

REHABILITATION AND GERIATRIC SERVICES

REHABILITATION and GERIATRIC SERVICES
COLUMBIA, SC
INDEPENDENT MEDICAL EXAMINATION

PATIENT NAME: BERNARD LEE
MR#.

DATE: 06/10/2010
RM#:

DATE OF INJURY: 06/02/2009

SOCIAL SECURITY NUMBER: 251452204

EMPLOYER: Bondex

CLAIM NUMBER: 564551282

DATE OF BIRTH: 04/30/1980

HISTORY OF PRESENT ILLNESS: Mr. Lee is a 30-year-old gentleman who was working for Bondex and was attempting to position a hood along with three other gentlemen while at work on 6/02/2009. The hood apparently weighs anywhere between 300-700 pounds. A forklift is supposed to position the hood, but there apparently was some problem with the forklift. There was some indication that the hood struck the patient's left shoulder and neck. It is unclear with what amount of force this occurred. Subsequently the patient complained of severe pain and was seen at the University Hospital and underwent an evaluation. He had x-rays which were essentially negative and was given some pain medications. The patient subsequently followed up at North Augusta Urgent Care with Dr. Broder and was started in physical therapy and given Naprosyn. Naprosyn apparently caused some drowsiness. The patient had followup visits with North Augusta Urgent Care. He was instructed to take Tylenol during the day and Naprosyn at night. The patient was placed on light duty. The patient complained of pain in the neck and shoulder region radiating down the arm. The patient had very limited range of motion. Notes from Sports Plus Physical Therapy were reviewed, as well as from North Augusta Urgent Care. The patient had open MRI of the shoulder which showed no tear in the rotator cuff. There was some acromioclavicular joint arthropathy with mild impingement and some bicipital tendonitis. The patient continued with Sports Plus Physical Therapy without any significant improvement and started to complain of some headaches, as well as the right shoulder hurting. Eventually the patient was referred to Columbia Orthopedic Specialists. The patient's diagnosis was impingement syndrome. The patient also was seen at Margaret Weston Community Health Center by Dr. Sylva Al-Soudi. The patient was diagnosed with muscle spasm and bursitis. He also was seen by Dr. Shannon, who noted the patient to have pain in the shoulder and neck region and frequent headaches. He also had some indication of depression. The patient had an IME done by Dr. Charles Thomas and MRIs of the cervical and thoracic spine were then ordered. The results were reviewed and there were no significant abnormalities noted. The patient presents today complaining of severe pain in the shoulder and arm region with very limited range of motion and weakness. The patient does not take any pain medications at this point. He is no longer participating in a rehab program. He has not worked even light duty since 7/28/2009.

PAST MEDICAL HISTORY: Significant for hypertension.

SOCIAL HISTORY: The patient denies any tobacco, alcohol or drug use. He used to smoke.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: The patient denies fevers, chills, night sweats, chest pain, shortness of breath, nausea or vomiting. He does occasionally have some numbness and tingling going down the arm. The pain is mostly in the shoulder, scapula and neck region. He occasionally has headaches.

06/15/2010 09:22 8034011178 RGS PAGE 03/04

PHYSICAL EXAMINATION:
General: The patient is 6 feet tall. He weighs 190 pounds. He is well-developed, well-nourished gentleman in no acute distress.
HEENT: Pupils equal, round and reactive to light. Extraocular movements intact.
Neck: Supple. There is some tenderness along the left trapezius and along the medial border of the left scapula and supraspinatus muscle. There is some tenderness over the left subacromial bursa. The right shoulder has full range of motion. The left shoulder can only abduct 10 degrees, flex 10 degrees. No internal or external rotation noted.
Chest: Clear to auscultation.
Cardiac: Regular rate and rhythm.
Abdomen: Soft, nontender, nondistended with positive bowel sounds.
Neurologic: Sensation is intact through both upper extremities to light touch. DTRs are 2+ and symmetric at the biceps, 1+ at the brachial radialis and triceps bilaterally. Manual muscle test reveals wrist extension, grip and triceps with 5/5 strength. The patient has no movement at the biceps or at the deltoid. The patient also has limited left shoulder shrug.

IMPRESSION: This is a 30-year-old gentleman that had an injury that occurred on 6/02/2009. He has received appropriate medical treatment by several different physicians. The workup to date has been negative. To a reasonable degree of medical certainty, the patient appears to have myofascial pain involving the left shoulder, neck and scapular region. I cannot explain the severe limited range of motion and weakness in the biceps and deltoid from a physiological standpoint. I think the patient should at this time continue a home exercise program working with wall walks and range of motion, as well as nonsteroidal anti-inflammatories. This can be over-the-counter ibuprofen. I think the patient can return to work. I would recommend that he not lift the left upper extremity above shoulder height, but he should have no restrictions with the right upper extremity or lower extremities. He can sit and stand and walk a full eight hour day. He should not lift anything greater than 10 pounds with the left upper extremity. The patient appears to have an impairment based on the American Medical Association Guide to Evaluation of Permanent Impairment 5th Edition, page 392, diagnostic related estimate category for the cervical spine II on table 15-5. This would give him a 5% spine impairment. If there are any questions regarding this recommendation or if there is additional information which may change or alter these findings, please do not hesitate to call.

W. Daniel Westerkam, MD
Physical Medicine and Rehabilitation

6/15/10 09:10
Date/Time

WW/am1885

dd: 06/13/2010 03:20 PM
dt: 06/14/2010 12:24 AM
JobID: 2590023

DR. WILLIAM ROBINSON

MARGARET J. WESTON COMMUNITY HEALTH CENTERS

MJWCHC - Age 18-49 Progress Note

Date: 7/20/10	HT:	WT: 198	BP: 157/103	P: 83	R:	☑ Appt	TI:
Age: 29	BMI:	WT:	BP: 130/88	T:	O2: 100	☐ Walk In	TO:

Allergies NKA

CC: Still having shoulder, neck & back pain - Work related injury - under workers comp - (7/2016. hood fell on him) -

Medications

(PMH, F, S Hx updated ☐):

Hx of continued pain and muscle spasm in L shoulder and L MRI of shoulder shows degeneration and a tear of biceps tendon. Reflexes 0 cuff ... Impression ... Plan ... Will RTC 2 weeks ... Refer to ... Pt ... Will RTC in 2 weeks ... Pt ... Will RTC in 2 weeks ... Pt ... Will RTC in 2 weeks

UNPAID MEDICAL BILLS

CAROLINA MUSCULOSKELETAL INSTI 123899
PO BOX 455
AIKEN SC 29802

ADDRESS SERVICE REQUESTED

STATEMENT

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(803) 649-0563	03/01/10	123899	01	294.00
OFFICE PHONE NUMBER	CLOSING DATE	YOUR ACCOUNT NUMBER	PAGE NO.	PATIENT BALANCE

>39165 7528409 001 092096
BERNARD D LEE
172 OLD CHEROKEE IND R
GRANITEVILLE SC 29829

CAROLINA MUSCULOSKELETAL INSTI
PO BOX 455
AIKEN SC 29802-0455

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

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CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS
122909		BALANCE FORWARD		294.00	
012910		PMT SUPERMED PPO c# 11649191			0.00

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CURRENT	30-60 DAYS	60-90 DAYS	> 90 DAYS	TOTAL	INS PENDING	PATIENT BALANCE PAY THIS AMOUNT
			294.00	294.00	0.00	294.00

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(803) 649-0563
YOUR ACCOUNT IS DUE & PAYABLE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. PLEASE REMIT PROMPT PAYMENT. THANK YOU.

02006S1100

39165 7528409 039165 039165 0000100001 920965904

00089

640

Friday, July 30, 2010 (16).max

CAROLINA MUSCULOSKELETAL INSTI
PO BOX 455
AIKEN SC 29802

123899

0220 8169 TU02

STATEMENT

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☐ CHECK HERE For Credit Card Payment
SHOW AMOUNT PAID HERE $_____

(803) 649-0563	02/02/10	123899	01	294.00
OFFICE PHONE NUMBER	CLOSING DATE	YOUR ACCOUNT NUMBER	PAGE NO	PATIENT BALANCE

>32369 7505433 001 092096
BERNARD D LEE
172 OLD CHEROKEE IND R
GRANITEVILLE SC 29829

CAROLINA MUSCULOSKELETAL INSTI
PO BOX 455
AIKEN SC 29802-0455

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

PLEASE RETURN THIS PORTION WITH PAYMENT

CHARGES APPEARING ON THIS STATEMENT ARE **NOT** INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS
120109		BALANCE FORWARD		294.00	
121409		PMT SUPERMED PPO c#	11649191		0.00
121409		DENIED SUPERMED (PRINICPAL) c#	11649191		0.00
012910		PMT SUPERMED PPO c#	11649191		0.00

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*** www.cmi.md ***

STATEMENT CLOSING DATE: 02/02/10 PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 123899

CURRENT	30-60 DAYS	60-90 DAYS	> 90 DAYS	TOTAL	INS PENDING	PATIENT BALANCE PAY THIS AMOUNT
			294.00	294.00	0.00	294.00

SEND INQUIRIES TO:
CAROLINA MUSCULOSKELETAL INSTI
PO BOX 455
AIKEN SC 29802

(803) 649-0563
YOUR ACCOUNT IS DUE & PAYABLE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. PLEASE REMIT PROMPT PAYMENT. THANK YOU

92096S1109

00090

641

Friday, July 30, 2010 (16).max

CAROLINA RADIOLOGICAL ASSOC
PO BOX 3847
AUGUSTA GA 30914-3847

MASTERCARD VISA DISCOVER AMEX

CARD NUMBER | 4 DIG CID | EXP. DATE

SIGNATURE | AMOUNT

ADDRESS SERVICE REQUESTED

Billing Questions Please Call:
866-481-3992

Patient : LEE BERNARD D

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
10/15/09	$ 40.00	107992075

SHOW AMOUNT PAID HERE $

ADDRESSEE

BERNARD D LEE
172 OLD CHEROKEE INDIAN RD
GRANITEVILLE SC 29829-3613

REMIT TO

CAROLINA RADIOLOGICAL ASSOC
P O BOX 3847
AUGUSTA GA 30914

PLEASE MAKE ADDRESS CHANGES ON BACK.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT.

DATE	CODE	DESCRIPTION	DX	PHYS SITE	AMOUNT

PAYMENT IS DUE UPON RECEIPT IF YOU HAVE INSURANCE AND WISH OUR OFFICE TO FILE A CLAIM, PLEASE CALL WITHIN THE NEXT TEN DAYS AND GIVE US THAT INFORMATION. **THANK YOU**

09/29/09	73110	WRIST COMPLETE MINIMUM 3 VIEWS	719.43	622 NC	40.00

THIS STATEMENT IS FOR THE RADIOLOGIST THAT READ YOUR X-RAY. THE HOSPITAL BILL WILL INCLUDE A CHARGE FOR THE USE OF THE EQUIPMENT, THE FILM SUPPLIES AND TECHNICAL PERSONNEL ONLY

THIS IS A DOCTOR BILL WHICH IS SEPARATE FROM THE HOSPITAL BILL.

Patient : LEE BERNARD D
Account : 107992075
Site : AIKEN REGIONAL MEDICAL CEN
Ref Phys : CLIFFORD D STAGGS
Att Phys : ANTHONY TOOMER MD

AMOUNT DUE $ 40.00

Billing Questions Please Call:
866-481-3992

Tax ID: 202148722

00091

MEDICAL CREDIT SERVICES
PO Box 3864
AUGUSTA, GEORGIA 30914
888-737-4856 EXT 452

12/21/09

BERNARD D LEE
172 OLD CHEROKEE INDIAN RD
GRANITEVILLE SC 29829-3613

PATIENT NAME: BERNARD D LEE
ACCOUNT NUMBER: 107992075
ACCOUNT BALANCE: $ $40.00

REGARDING YOUR ACCOUNT WITH:

CAROLINA RADIOLOGICAL ASSOC

THIS HEALTHCARE PROVIDER HAS ADVISED US THAT THIS DEBT HAS NOT BEEN PAID. WE ARE HANDLING THIS ACCOUNT FOR COLLECTIONS.

PLEASE CONTACT US AT (706) 667-7452 WITHIN 72 HOURS IN ORDER TO MAKE ARRANGEMENTS FOR PAYMENT, OR REMIT PAYMENT TO THE FOLLOWING ADDRESS. PLEASE MAKE YOUR CHECK OR MONEY ORDER PAYABLE TO CAROLINA RADIOLOGICAL ASSOC , AND PLEASE REFERENCE YOUR ACCOUNT #107992075 ON YOUR CHECK OR MONEY ORDER.

CAROLINA RADIOLOGICAL ASSOC
P O BOX 3847
AUGUSTA GA 30914....

***** IMPORTANT NOTICE *****

UNLESS THE DEBTOR, WITHIN THIRTY DAYS AFTER RECEIPT OF THIS NOTICE, DISPUTES IN WRITING THIS DEBT OR ANY PORTION THEREOF, THE DEBT WILL BE ASSUMED TO BE VALID BY THE DEBT COLLECTOR.

IF WITHIN THIS THIRTY DAY PERIOD THE DEBTOR NOTIFIES THE DEBT COLLECTOR IN WRITING THAT THE DEBT OR ANY PORTION THEREOF IS DISPUTED, THE DEBT COLLECTOR WILL OBTAIN VERIFICATION OF THE DEBT, AND A COPY OF SUCH VERIFICATION WILL BE MAILED TO THE DEBTOR BY THE DEBT COLLECTOR.

PO Box 15519
Savannah GA 31416-2219

RETURN SERVICE REQUESTED

3270222

February 24, 2010

LANIER COLLECTION AGENCY & SERVICES, INC.
ESTABLISHED 1955

18 Park of Commerce Boulevard
Savannah, GA 31405
Tel:912-238-5252 1-800-595-0280
Fax: 912-234-7209
www.laniercollections.com

204

BERNARD D LEE
172 OLD CHEROKEE INDIAN RD
GRANITEVILLE SC 29829-3613

LCA SERVICES
PO BOX 15519
SAVANNAH GA 31416-2219

DN 3270222
PIN# 7729

DN

DETACH UPPER PORTION AND RETURN WITH YOUR PAYMENT

Re: CAROLINA RADIOLOGY ASSOCIATES

Service for: LEE,BERNARD D

Balance: $40.00

This account has been placed with Lanier Collection Agency for collection. Please direct all payments and correspondence to LCA Services.

Call us about QUICK COLLECT and PHONE PAY Services.

Unless you notify this office within 30 days after receiving this notice that you dispute the validity of this debt or any portion thereof, this office will assume this debt is valid. If you notify this office in writing within 30 days from receiving this notice that you dispute the validity of this debt or any portion thereof, this office will: obtain verification of the debt or obtain a copy of a judgment and mail you a copy of such judgment or verification. If you request this office in writing within 30 days after receiving this notice, this office will provide you with the name and address of the original creditor, if different from the current creditor.

Contact LCA SERVICES EXT 0

THIS COMMUNICATION IS FROM A DEBT COLLECTOR. THIS IS AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

I88R0412

00093

AIKEN REGIONAL MED CENTERS
302 UNIVERSITY PKWY
AIKEN, SC 29802

11/10/09

BERNARD LEE
172 OLD CHEROKEE INDIAN RD

GRANITEVILLE SC 29829-3613

PATIENT NAME: BERNARD LEE
ADMISSION/REGISTRATION DATE: 07/28/09
ACCOUNT NUMBER: 107705220
TOTAL CHARGES: $ 161.00

DEAR BERNARD LEE

IN ORDER TO BILL YOUR INSURANCE COMPANY, WE NEED YOU TO COMPLETE THE ENCLOSED FORM AND RETURN IT TO US WITH A COPY OF BOTH SIDES OF YOUR INSURANCE CARD.

IF WE DO NOT RECEIVE THIS INFORMATION WITHIN 14 DAYS, THE BALANCE WILL BE YOUR RESPONSIBILITY.

NATASHA SMITH
CSR
866-772-0072

WE ACCEPT MAJOR CREDIT CARDS. PLEASE INDICATE THE TYPE OF CARD AND COMPLETE THE FOLLOWING INFORMATION. RETURN TO THE HOSPITAL.

TYPE OF CARD: VISA ___ MASTERCARD ___ DISCOVER ___ AMERICAN EXPRESS ___

PAYMENT AMOUNT: $_____ NAME ON CARD: _____

CREDIT CARD NO: _____ EXP. DATE: _____

AUTHORIZED SIGNATURE: _____ DATE: _____
CL05A/ 107705220 / LEE ,BERNARD D

00094

AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC
PO BOX 7343
COLUMBIA, SC 29202-7343

0101

34495*TVA03Y595003737

TRANSACTIONS AFTER THE CLOSING DATE
WILL APPEAR ON YOUR NEXT STATEMENT

ACCOUNT NUMBER
177273 LEE,BERNARD D

PAGE
1

STATEMENT DATE
02/16/10

PAY THIS AMOUNT $ 620.00

AMOUNT ENCLOSED $

IF PAYING BY CREDIT CARD, PLEASE SEE REVERSE SIDE

BERNARD D LEE
172 OLD CHEROKEE INDIAN
RD
GRANITEVILLE, SC 29829-3613

AIKEN EMERGENCY MEDICINE PHYSICIANS, LL
PO BOX 7343
COLUMBIA, SC 29202-7343

Please check box if above address is incorrect or insurance information has changed and indicate changes on the reverse side

STATEMENT OF ACCOUNT

PLEASE DETACH AND RETURN WITH YOUR PAYMENT

DATE	DESC	CHARGE	INSUR CREDITS	PATIENT CREDITS	BALANCE
07/18/09	EMERGENCY DEPT VISIT	155.00	0.00	0.00	155.00
07/28/09	EMERGENCY DEPT VISIT	155.00	0.00	0.00	155.00
08/21/09	EMERGENCY DEPT VISIT	155.00	0.00	0.00	155.00
09/29/09	EMERGENCY DEPT VISIT	155.00	0.00	0.00	155.00

PHYSICIAN OR PA CHARGE ONLY! HOSPITAL CHARGES ARE BILLED SEPARATELY. IF YOUR ACCOUNT IS OVER 120 DAYS PAST DUE FROM DATE OF SERVICE, IT MAY BE TURNED OVER TO A COLLECTION/CREDIT AGENCY IN THE NEXT 30 DAYS. PLEASE CALL OUR OFFICE IMMEDIATELY (803-643-3965) TO AVOID THIS PROCESS. FINAL NOTICE.

"Y" IN INS COLUMN = INSURANCE FILED,"*" AFTER BALANCE = PENDING INSURANCE

MAKE CHECKS PAYABLE TO: AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC

PROVIDER/PRACTICE NAME: AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC

FOR BILLING INQUIRIES, CALL: 803-643-3965

* AN ASTERISK APPEARS ON CHARGES FILED FOR INSURANCE	ACCOUNT NUMBER	DATE OF LAST PAYMENT	INSURANCE PENDING	PAYMENT DUE DATE
	177273 LEE,BERN		0.00	03/03/10

STATEMENT DATE	CURRENT	Over 30 Days	Over 60 Days	Over 90 Days	Over 120 Days	
02/16/10	0.00	0.00	0.00	0.00	620.00	00095 620.00

PLEASE PAY THIS AMOUNT

TRANSACTIONS AFTER THE CLOSING DATE WILL APPEAR ON YOUR NEXT STATEMENT

AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC
PO BOX 7343
COLUMBIA, SC 29202-7343

0101

34495*TW403QLCY003140

TRANSACTIONS AFTER THE CLOSING DATE
WILL APPEAR ON YOUR NEXT STATEMENT

ACCOUNT NUMBER
177273 LEE,BERNARD D

PAGE
1

STATEMENT DATE
03/18/10

PAY THIS AMOUNT $ 620.00

AMOUNT ENCLOSED $

IF PAYING BY CREDIT CARD, PLEASE SEE REVERSE SIDE

BERNARD D LEE
172 OLD CHEROKEE INDIAN
RD
GRANITEVILLE, SC 29829-3613

AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC
PO BOX 7343
COLUMBIA, SC 29202-7343

If address or insurance information has changed, please note change(s) on reverse side.

STATEMENT OF ACCOUNT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	DESC	CHARGE	INSUR CREDITS	PATIENT CREDITS	BALANCE
07/18/09	EMERGENCY DEPT VISIT	155.00	0.00	0.00	155.00
07/28/09	EMERGENCY DEPT VISIT	155.00	0.00	0.00	155.00
08/21/09	EMERGENCY DEPT VISIT	155.00	0.00	0.00	155.00
09/29/09	EMERGENCY DEPT VISIT	155.00	0.00	0.00	155.00

PHYSICIAN OR PA CHARGE ONLY! HOSPITAL CHARGES ARE BILLED SEPARATELY. IF YOUR ACCOUNT IS OVER 120 DAYS PAST DUE FROM DATE OF SERVICE, IT MAY BE TURNED OVER TO A COLLECTION/CREDIT AGENCY IN THE NEXT 30 DAYS. PLEASE CALL OUR OFFICE IMMEDIATELY (803-643-3965) TO AVOID THIS PROCESS. FINAL NOTICE.

"Y" IN INS COLUMN = INSURANCE FILED,"*" AFTER BALANCE = PENDING INSURANCE

MAKE CHECKS PAYABLE TO: AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC

PROVIDER/PRACTICE NAME					FOR BILLING INQUIRIES, CALL	
AIKEN EMERGENCY MEDICINE PHYSICIANS, LLC						803-643-3965
ACCOUNT NUMBER		DATE OF LAST PAYMENT		INSURANCE PENDING		PAYMENT DUE DATE
177273 LEE,BERN				0.00		04/02/10
03/18/10 STATEMENT DATE	0.00 CURRENT	0.00 Over 30 Days	0.00 Over 60 Days	0.00 Over 90 Days	620.00 Over 120 Days	620.00 PLEASE PAY THIS AMOUNT

00096

TRANSACTIONS AFTER THE CLOSING DATE WILL APPEAR ON YOUR NEXT STATEMENT

UNIVERSITY HOSPITAL
An Affiliate of University Health Care System
ADDRESS SERVICE REQUESTED

PATIENT STATEMENT OF ACCOUNT

PATIENT'S NAME	ACCOUNT NUMBER	ADMISSION DATE	DISCHARGE DATE	STMT DATE
LEE, BERNARD DERRICK	000300130-9154	06/03/09	06/03/09	06/19/09

PLEASE REFER TO PATIENT'S NAME AND ACCOUNT NO. ON ALL INQUIRIES AND CORRESPONDENCE
FOR INFORMATION REGARDING THIS STATEMENT, PLEASE PHONE (706) 828-2333 LOCALLY, OR TOLL FREE LONG DISTANCE 1-800-762-0250

ACCOUNT NAME

BERNARD DERRICK LEE
172 CHEROKEE RD
RT 1 BOX 102 CC
GRANITEVILLE SC 29829

001

THIS IS A STATEMENT OF ITEMIZED CHARGES INCURRED FOR THE SERVICE DATE REFERRED ABOVE.

THIS STATEMENT IS FOR INFORMATIONAL PURPOSES ONLY AND IS NOT INTENDED AS A BILLING STATEMENT.

WC WORK COMP-OUT OF STATE J99

NOTE "INSURANCE PORTION" COLUMN FOR CHARGES FILED TO YOUR INSURANCE CARRIER

PATIENT'S NAME	ACCOUNT NUMBER	STMT DATE	PAGE NO.
LEE, BERNARD DERRICK	000300130-9154	06/19/09	1

INSURANCE PORTION IS COMPUTED ACCORDING TO INFORMATION SUPPLIED BY YOUR INSURANCE CARRIER(S)

SERVICE DATE	REF. NO.	DESCRIPTION	TOTAL AMOUNT	INSURANCE PORTION	PATIENT PORTION
06/03/09	01250972	ER LEVEL 3	345.00	345.00	
06/03/09	00500047	SHOULDER 2 VIEWS	282.00	282.00	
06/03/09	01450358	SLING ARM LG	29.00	29.00	
		TOTAL OF ALL CHARGES	656.00	656.00	
		TOTAL CHARGES AND INSURANCE	656.00	656.00	

Acceptance of the assignment of insurance benefits is with recourse. (The patient or guarantor assumes full responsibility to the hospital for charges not paid or covered by insurance.) The Anesthesiologist, Pathologist, Radiologists and Emergency Room Physicians who might have provided services to you while you were in the hospital are private physicians functioning as independent contractors and will bill separately. Date of charge may not correspond with the actual date service was rendered.

00097

THIS WILL BE YOUR ONLY ITEMIZED STATEMENT FOR ABOVE TRANSACTIONS

LEE, BERNARD D.
172 CHEROKEE IND RD
GRANITEVILLE SC 29829

Doctor A9 AL-SOUDI, SYLVA Lic#26910

ACCT: 15100

RECEIPT DATE 10/05/09
RECEIPT FOR LEE, BERNARD D.

DATE	PATIENT	DR	CODE	DESCRIPTION	ICD-9	CHARGES	RECEIPTS
10/05/09	BERNARD D.	A9	99213	ESTABLISHED PATIENT/INTERM	401.0	106.44	
10/05/09			CASH				20.00

Outstanding Patient Balance as of 10/05/09 -------> -40.00

00098

CONSENT ORDERS

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC File No. 0906951

Bernard Lee, Employee

Claimant,

v.

Southern Felt dba Bodex, Employer

and

Great American
Insurance Company of NY, Carrier

Defendants,

CONSENT ORDER

Comes now E. Ros Huff, Jr., Esquire, counsel for the Employer/Carrier along with the consent of Tyler Bathrick, Esquire, counsel for the Claimant and consents to the following:

A hearing was scheduled before the undersigned Commissioner on January 19, 2010 in North Augusta, South Carolina to determine the issues as outlined in the Form 40 and the Defendants' subsequent response.

Prior to the hearing, the Claimant was been scheduled for an MRI with Dr. Ty Carter on January 14, 2010 and a follow up appointment with Dr. Carter on January 25, 2010 as agreed upon in the previous Consent Order signed by Commissioner Bryan Lyndon on December 7, 2009.

THEREFORE, the parties agree that the hearing scheduled for January 19, 2010 is no longer necessary. All other issues are hereby held in abeyance and will not be considered until further request is made by either party.

WE CONSENT:

Tyler Bathrick, Esquire
Attorney for the Claimant

E. Ros Huff Jr. /cfr
E. Ros Huff, Jr., Esquire
Attorney for the Defendants

00099

IT IS HEREBY ORDERED that the hearing scheduled for January 19, 2010 is cancelled as an agreement was reached by both parties.

IT IS FURTHER ORDERED that all issues are held in abeyance and the claim will be returned to general files until a hearing request is made by either party.

IT IS ORDERED!

Commissioner Derrick Williams

April 21, 2010
Columbia, S.C.

T.B
ERH

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties.

This 27th day of April, 2010

By Rene G Smith
Administrative Assistant to the Commissioner

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Bernard Lee, Employee Claimant, v. Southern Felt dba Bodex, Employer and Great American Insurance Company of NY, Carrier Defendants,	WCC File No. 0906951 CONSENT ORDER

Comes now E. Ros Huff, Jr., Esquire, counsel for the Employer/Carrier along with the consent of Ann Mickle, Esquire, counsel for the Claimant and consents to the following:

A hearing was held before the undersigned Commissioner on November 3, 2009 on which date the parties and their representatives appeared to determine the issues as outlined in the Form 50 and Form 51.

Prior to hearing arguments from both sides, the parties reached an agreement relative to the issues regarding medical treatment. Defendants have hereby agreed to pay the Claimant a lump sum payment of $5,000. In addition, they have agreed to send the Claimant for an MRI and for follow up treatment with Dr. Ty Carter in Aiken, South Carolina.

All other issues are hereby held in abeyance and will not be considered until further request is made by either party.

THEREFORE, the parties agree that the hearing scheduled for November 3, 2009 is hereby postpone until a request is filed by either party.

WE CONSENT:

Ann Mickle, Esquire
Attorney for the Claimant

E. Ros Huff, Jr., Esquire
Attorney for the Defendants

IT IS HEREBY ORDERED that this hearing is postponed as an agreement was reached by both parties.

IT IS FURTHER ORDERED that all issues are held in abeyance and the claim will be returned to general files until a hearing request is made by either party.

IT IS ORDERED!

Commissioner G. Bryan Lyndon

December 7, 2009
Columbia, S.C.

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties.

This 8th day of December, 2009

By Deborah Morris
Administrative Assistant to the Commissioner

AM
EKH J

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO.: 0906951

Bernard Lee, Employee Claimant, v. Southern Felt dba Bodex, Employer and Great American Insurance Company of NY, Carrier Defendants,	CONSENT ORDER

To the South Carolina Workers' Compensation Commission, comes now the Defendants by and through their attorney, E. Ros Huff Jr., Esquire along with the Claimant through his attorney, Tyler Bathrick, Esquire and consents to the following:

1. That by subpoena dated June 19, 2009, the Claimant demanded production of certain materials including but not limited to video footage of the Claimant's job site or video footage of the Claimant recorded since the date of the accident.
2. That on June 30, 2009 the Defendant served the Claimant and the Commission with a Motion to Quash in regards to any video footage in possession of the Defendants.
3. That a hearing was set for August 19, 2009 and then reset for August 27, 2009 in front of Commissioner Susan Barden in Aiken, South Carolina to determine the merits of the Defendants' motion.

00103

4. That the Defendant are not now nor have they been in possession of job site footage or video surveillance of the Claimant either on the date of accident or at any time since.

5. That the Defendants are in possession of certain video footage of the Claimant's job site and have agreed to hand this footage over to the Claimant through his attorney.

6. That the hearing set for August 27, 2009 is no longer necessary and should be removed from the judicial docket.

7. That all other issues are held in abeyance.

WE CONSENT:

Tyler Bathrick
Attorney for the Claimant

E. Ros Huff, Jr.
Attorney for the Employer/Carrier

IT IS HEREBY ORDERED that this hearing is cancelled pursuant to the consent agreement by both parties.

IT IS FURTHER ORDERED that this file will be returned to general filing until such time as a request for hearing is made by either party.

IT IS ORDERED!

Commissioner Susan Barden

Columbia, South Carolina
August 28, 2009

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties.

This 28th day of August, 2009.

By Kristi Love
Administrative Assistant to the Commissioner

00104

CORRESPONDENCE REQUESTING MEDICAL TREATMENT

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
2002 – 2008

Associates:
Tyler Bathrick

COLUMBIA:
1116 BLANDING STREET
2ND FLOOR
COLUMBIA, SC 29201
(803) 929-0090

ROCK HILL:
950 OAKLAND AVENUE
P.O. BOX 10751
ROCK HILL, SC 29731
(803) 980-0085
(803) 328-2525 FAX

MYRTLE BEACH:
1039 44TH AVENUE NORTH
SUITE 102
MYRTLE BEACH, SC 29577
(843) 839-2501
(843) 839-2507 FAX

Reply to: Rock Hill office

July 2, 2009

E. Ros Huff. Jr.,
Huff Law Firm
PO Box 1935
Irmo, SC 29063

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: (not assigned)
Your Claim #: 564551282

Dear Ros:

It is my understanding that the Carrier is currently only providing medical treatment to the left arm/shoulder. Please be advised that Mr. Lee also injured his whole back and neck in this injury. (See attached supervisor's accident report date 6-2-09).

Mr. Lee remains symptomatic with pain in his whole back, neck and left arm/shoulder. Please accept this letter as claimant's formal written request for medical treatment to all injured body parts. If I fail to receive a timely response (10 days) I will have no choice but to advise my client to seek his own treatment and request a reimbursement through a hearing.

I look forward to hearing from you in theses regards.

Sincerely,

MICKLE & BASS, LLC.

By: _____
Tyler Bathrick, Esquire

TB
Enclosure: accident report

00105

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
2002 – 2008

Associates:
Tyler Bathrick

COLUMBIA:
1116 BLANDING STREET
2ND FLOOR
COLUMBIA, SC 29201
(803) 929-0029

ROCK HILL:
930 OAKLAND AVENUE
P.O. BOX 10751
ROCK HILL, SC 29731
(803) 980-0085
(803) 328-2525 FAX

MYRTLE BEACH:
1039 44TH AVENUE NORTH
SUITE 102
MYRTLE BEACH, SC 29577
(843) 839-2601
(843) 839-2607 FAX

Reply to: Rock Hill office

July 14, 2009

Via Mail and Facsimile
E. Ros Huff. Jr.,
Huff Law Firm
PO Box 1935
Irmo, SC 29063

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: (not assigned)
Your Claim #: 564551282

Dear Ros:

Based on your July 14, 2009 letter, it is my understanding that you are not interested in providing medical treatment through a reputable doctor. Hopefully my client's condition does not deteriorate.

On July 14, 2009 you requested that my client bring all diagnostic films to his July 16, 2009 appointment. As the carrier requested Dr. Bethea and we were only provided with two days notice that my client needed to bring his films, please have the Carrier forward all diagnostic films to Dr. Bethea's attention.

Once again, please confirm that medical treatment is being provided to all injured body parts including the whole back, neck, and left arm/shoulder.

Feel free to call with any questions or concerns.

Sincerely,

MICKLE & BASS, LLC.

By: _____
Tyler Bathrick, Esquire

TB

00106

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
2002 – 2008

Associates:
Tyler Bathrick

COLUMBIA:
1116 BLANDING STREET
2ND FLOOR
COLUMBIA, SC 29201
(803) 929-0029

ROCK HILL:
930 OAKLAND AVENUE
P.O. BOX 10761
ROCK HILL, SC 29731
(803) 980-0083
(803) 328-2525 FAX

MYRTLE BEACH:
1039 44TH AVENUE NORTH
SUITE 102
MYRTLE BEACH, SC 29577
(843) 839-2501
(843) 839-2507 FAX

Reply to: Rock Hill office

July 15, 2009

Via Mail and Facsimile
E. Ros Huff. Jr.,
Huff Law Firm
PO Box 1935
Irmo, SC 29063

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: (not assigned)
Your Claim #: 564551282

Dear Ros:

My client has indicated that the employer has been unable to provide work on the following days:

1) June 3, 2009 – Bernard Lee was written out of work per the emergency room.

2) June 23, 2009 through July 1, 2009 – Bernard Lee was sent home due to medication use. Janice Napier, human resource director for Bondex, informed my client that he could not work around machines while on Skelaxin,

3) July 1, 2009 through July 14, 2009 – Bernard Lee was not provided with any light duty work.

4) The Employer has indicated that they will not have work on July 15th or July 16th.

5) Note: Mr. Lee did take a vacation day on July 6, 2009.

Please accept this letter as claimant's formal written request for temporary total and temporary partial compensation for the above referenced dates.

Feel free to contact our office with any questions or concerns.

00107

Sincerely,

MICKLE & BASS, LLC.

By: _____
Tyler Bathrick, Esquire

TB

00108

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
2002 – 2008

Associates:
Tyler Bathrick

COLUMBIA:
1116 BLANDING STREET
2ND FLOOR
COLUMBIA, SC 29201
(803) 929-0020

ROCK HILL:
930 OAKLAND AVENUE
P.O. BOX 10761
ROCK HILL, SC 29731
(803) 980-0083
(803) 328-2525 FAX

MYRTLE BEACH:
1039 44TH AVENUE NORTH
SUITE 102
MYRTLE BEACH, SC 29577
(843) 839-2501
(843) 839-2507 FAX

Reply to: Rock Hill office

July 20, 2009

Via Mail and Facsimile
E. Ros Huff. Jr.,
Huff Law Firm
PO Box 1935
Irmo, SC 29063

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: (not assigned)
Your Claim #: 564551282

Dear Ros:

My client contacted our office regarding his current light work duties. Mr. Lee is using his right arm to repeatedly lift fiber, tear it apart, and place it on a conveyor belt. Mr. Lee indicated that this is a rigorous position and it is hard for non-injured employees to keep up. Mr. Lee continues to attempt this position with only his right arm. I am putting you on notice of Mr. Lee's current work duties because I am fearful that rigorous one armed work will result in an overuse injury with regard to the right arm. Any help in getting him reassigned to another light duty position would be greatly appreciated.

Feel free to contact our office with any questions or concerns.

Sincerely,

MICKLE & BASS, LLC

By: _____
Tyler Bathrick, Esquire

TB

00109

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
2002 – 2008

Associates:
Tyler Bathrick

COLUMBIA:
1116 BLANDING STREET
2ND FLOOR
COLUMBIA, SC 29201
(803) 929-0029

ROCK HILL:
930 OAKLAND AVENUE
P.O. BOX 10751
ROCK HILL, SC 29731
(803) 980-0083
(803) 328-2525 FAX

MYRTLE BEACH:
1039 44TH AVENUE NORTH
SUITE 102
MYRTLE BEACH, SC 29577
(843) 839-2501
(843) 839-2507 FAX

Reply to: Rock Hill office

July 22, 2009

Via Mail and Facsimile
E. Ros Huff. Jr.,
Huff Law Firm
PO Box 1935
Irmo, SC 29063

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: (not assigned)
Your Claim #: 564551282

Dear Ros:

It is my understanding that the employer no longer has light duty work available for my client. Please accept this letter as claimant's formal written request for temporary total compensation.

Feel free to contact our office with any questions or concerns.

Sincerely,

MICKLE & BASS, LLC.

By: _____
Tyler Bathrick, Esquire

TB

00110

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
2002 – 2008

Associates:
Tyler Bathrick

COLUMBIA:
1116 BLANDING STREET
2ND FLOOR
COLUMBIA, SC 29201
(803) 929-0029

ROCK HILL:
930 OAKLAND AVENUE
P.O. BOX 10751
ROCK HILL, SC 29731
(803) 980-0085
(803) 328-2525 FAX

MYRTLE BEACH:
1039 44TH AVENUE NORTH
SUITE 102
MYRTLE BEACH, SC 29577
(843) 839-2501
(843) 839-2507 FAX

Reply to: Rock Hill office

July 30, 2009

E. Ros Huff. Jr.,
Huff Law Firm
PO Box 1935
Irmo, SC 29063

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: (not assigned)
Your Claim #: 564551282

Dear Ros:

This letter will serve as follow up to our July 29, 2009 telephone conversation. During that conversation you informed me that the Carrier is now denying this claim, although you do not know why, and will no longer be providing medical treatment. You then informed me that my client's July 30, 2009 appointment with Dr. Bethea had been canceled.

Based on our July 30, 2009 telephone conversation and the Carrier's cancellation of my client's appointment, I am advising my client to seek his own medical treatment. We will request a reimbursement through a hearing.

Please contact our office if I am mistaken in any way or if the Carrier is willing to provide medical treatment.

Sincerely,

MICKLE & BASS, LLC.

By: _____
Tyler Bathrick, Esquire

TB

00111

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
2002 – 2008

Associates:
Tyler Bathrick

COLUMBIA:
1116 BLANDING STREET
2ND FLOOR
COLUMBIA, SC 29201
(803) 929-0029

ROCK HILL:
930 OAKLAND AVENUE
P.O. BOX 10751
ROCK HILL, SC 29731
(803) 980-0088
(803) 328-2526 FAX

MYRTLE BEACH:
1039 44TH AVENUE NORTH
SUITE 102
MYRTLE BEACH, SC 29577
(843) 839-2501
(843) 839-2507 FAX

Reply to: Rock Hill office

December 21, 2009

Via Mail and Facsimile
E. Ros Huff. Jr.,
Huff Law Firm
PO Box 1935
Irmo, SC 29063

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: 09069514

Dear Ros:

On December 9, 2009 both parties entered into a Consent Order in which the Defendants agreed to provide an MRI and follow up treatment with Dr. Ty Carter. To date, Mr. Lee has not received the MRI or appointment. Please accept this letter as claimant's formal written request for all medical treatment outlined in the December 9, 2009 Consent Order.

I look forward to hearing from you in these regards.

Sincerely,

MICKLE & BASS, LLC.

By: _____
Tyler Bathrick, Esquire

TB
Enclosure: Consent Order
cc: Mr. Bernard Lee

00112

MICKLE & BASS, LLC
930 Oakland Avenue
Post Office Box 10751
Rock Hill, South Carolina 29731

(803) 980-0083
(803) 328-2525 fax

Myrtle Beach:
(843) 839-2501

Columbia:
(803) 929-0029

Reply to:
Rock Hill office

Facsimile Transmission

FAX NO: 803-252-2231

TO: E. Ros Huff, Jr. Esquire

DATE: January 25, 2010

RE: Bernard Lee v. Bondex

FROM: Erin M. Wiedel, Paralegal to Ann Mickle

PAGES: 3 (including cover page)

Attached please find the most recent work status note and recommendation for physical therapy. Please advise if the carrier will authorize and schedule the therapy. I look forward to hearing from you in these regards.

CONFIDENTIALITY NOTICE

The information contained in this facsimile message is legally privileged information intended only for the use of the designated recipient. You are hereby notified that any use, dissemination, distribution or copy of this facsimile is strictly prohibited by law. If you have received this facsimile in error, please immediately notify the sender by telephone (803) 980-0083 and return the original message to the address shown above via the U.S. Postal Service.

00113

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
2002 – 2008

Associates:
Tyler Bathrick

COLUMBIA:
1116 BLANDING STREET
2ND FLOOR
COLUMBIA, SC 29201
(803) 929-0929

ROCK HILL:
930 OAKLAND AVENUE
P.O. BOX 10751
ROCK HILL, SC 29731
(803) 980-0088
(803) 328-2526 FAX

MYRTLE BEACH:
1039 44TH AVENUE NORTH
SUITE 102
MYRTLE BEACH, SC 29577
(843) 839-2501
(843) 839-2507 FAX

Reply to: Rock Hill office

February 16, 2010

Via Mail and Facsimile
E. Ros Huff. Jr.,
Huff Law Firm
PO Box 1935
Irmo, SC 29063

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: 09069514

Dear Ros:

Attached please find Dr. Carter's recommendation for a follow up appointment with Dr. Shannon for the shoulder and physical therapy for the shoulder. Please accept this letter as Claimant's formal written request for all medical treatment recommended by Dr. Carter.

I look forward to hearing from you in these regards.

Sincerely,

MICKLE & BASS, LLC.

By: _____
Tyler Bathrick, Esquire

TB
cc: Mr. Bernard Lee

00114

MICKLE & BASS, LLC.

Ann Mickle
Former S. C. Workers' Compensation Commissioner
1996 – 2002

J. Alan Bass
Former S. C. Workers' Compensation Commissioner
2002 – 2008

Associates:
Tyler Bathrick

COLUMBIA:
1116 BLANDING STREET
2ND FLOOR
COLUMBIA, SC 29201
(803) 929-0029

ROCK HILL:
930 OAKLAND AVENUE
P.O. BOX 10751
ROCK HILL, SC 29731
(803) 980-0088
(803) 328-2525 FAX

MYRTLE BEACH:
1039 44TH AVENUE NORTH
SUITE 102
MYRTLE BEACH, SC 29577
(843) 839-2501
(843) 839-2507 FAX

Reply to: Rock Hill office

May 14, 2010

Via Mail and Facsimile
E. Ros Huff, Jr.,
Huff Law Firm
PO Box 1935
Irmo, SC 29063

Re: Bernard Lee v. Bondex
Our file: WC2009-252 RH
SCWCC file: 09069514

Dear Ros:

Mr. Lee remains symptomatic with pain in his neck, low back and left shoulder. The left shoulder is frozen and Mr. Lee has little to no use of his left arm. On January 25, 2010 Dr. Carter indicated that Mr. Lee should follow up with Dr. Shannon for the left shoulder. Please accept this letter as Claimant's formal written request for additional medical treatment to the left shoulder.

Claimant would prefer to return to Dr. Shannon, the authorized treating physician. However, if I fail to receive a timely response (10 days) from your office, I will have no choice but to advise Mr. Lee to seek his own medical treatment.

I look forward to hearing from you in these regards.

Sincerely,

MICKLE AND BASS, LLC.

Tyler Bathrick

00115

REPAIR BILL

TOYOTA
FORKLIFTS
OF ATLANTA

5111 E. Ponce de Leo
Scottdale, GA 30
East Telephone 404
Augusta Telephone 706
West Telephone 678
FED ID# 58
WWW.ATLANTAFORKLI

Customer
A09155
Document
504888

I N V O I C E

Invoice
R30127

6/03/09

Sold To
BONDEX INC
2 MAXWELL DR
TRENTON SC 29847

RECEIVED
JUN 0 8 2009
BY:

Ship To
BONDEX INC
2 MAXWELL DR
TRENTON SC 29847

803/663-1922

803/663-1922

Dr Trk	Make	Model	Serial	Equipment	Meter	Sls	Customer P.O.
005						7	6685

PAID
JUN 10 2009
BY:

Ordr	Ship	Description	Each	Amount
		Rental Contract 504888 Period: 6/03/09 Thru 6/09/09		
1	1	TO 613A 7FGCU25 81225 EXEL, NM, 189, SS, 4WAY, FIRE EXT	8 365.00	365.0
	1	PICKUP/DELIVERY	190.00	190.0
		NON TAX S C RESALE 57-1058950		.0

AS REQUIRED BY OSHA STANDARDS, THIS EQUIPMENT
IS TO BE OPERATED ONLY BY COMPETENT, FULLY
TRAINED, EMPLOYEES.
DRIVER TRAINING PROGRAMS ARE AVAILABLE
THROUGH THIS DEALERSHIP.

WE NOW OFFER DOCK & DOOR SERVICE IN THE
ATLANTA MARKET

555.0

TERMS AND CONDITIONS — TERMS: NET DUE UPON RECEIPT OF INVOICE

PLEASE REMIT TO
dba TOYOTA FORKLIFTS OF ATLANTA
P.O. Box 102883, Atlanta, GA 30368-2883

ils invoice is subject to all of the terms, provisions, conditions and limitations of the parts order or lease agreement concerning the
ods, services or equipment sold or leased as described therein. Examine this invoice carefully as it will be deemed correct unless
ror is reported to Toyota Forklifts of Atlanta 10 days of the date hereof.
e purchaser or lessee shall pay a service charge of 1 1/2% (18% ANNUAL RATE) on all amounts not paid within 30 days
llowing the date of such sale or lease, ad all costs of collection or enforcement including reasonable attorney's fees.
TURNED ITEMS ARE SUBJECT TO A SERVICE AND RESTOCKING CHARGE.
CUSTOMER COPY

TOYOTA
INDUSTRIAL EQUIPMENT

16

(Date) 10-5-09 FROM Bondex Trenton

Consigned TO Toyota Forklift (Mail or street address for purposes of notification only.)

On Collect on Delivery Shipments, the letters "COD" must appear before consignee's name or as otherwise provided in Item 430, Sec. 1.

Destination _____ Street _____ City _____

County _____ State _____ Zip _____

Route _____ Delivery Address * _____

(*To be filled in only when shipper desires and governing tariffs provide for delivery thereat.)

Delivering Carrier _____ Car or Vehicle Initials and No. _____

Collect on Delivery $ _____ And Remit to _____

Street _____ City _____ State _____

No. Packages	Mat.	Kind of Package, Description of Articles, Special Marks, and Exceptions	*Weight (Subject to Correction)	Class or Rate	Check Column
1		Toyota Forklift M=6FGCU25 S=69892			

Subject to Section 7 of conditions, if this shipment is to be delivered to the consignee without recourse on the consignor, the consignor shall sign the following statement:
The carrier shall not make delivery of this shipment without payment of freight and all other lawful charges.

(Signature of consignor)

C. O. D. Charges to be Paid by
☐ Shipper ☐ Consignee

If charges are to be prepaid, write or stamp here, "To be Prepaid."

Received $ _____ to apply in prepayment of the charges on the property described hereon.

Agent or Cashier

Per _____
(The signature here acknowledges only the amount prepaid.)

Charges advanced:

$ _____

*The fibre containers used for this shipment conform to the specifications set forth in the box maker's certificate thereon, and all other requirements of Rule 41 of the Uniform Freight Classification and Rule 5 of the National Motor Freight Classification."

†Shipper's imprint in lieu of stamp; not a part of bill of lading approved by the Interstate Commerce Commission.

Shipper, Per _____

Agent must detach and retain this Shipping Order and must sign the Original Bill of Lading.

2

HR METER IN _____

HR METER OUT 1844

0117

...LE FOR REPAIR OR REPLACEMENT OF DAMAGE OR ...N THIS RENTAL EQUIPMENT. ...REPAIRS WHEN YOU RECEIVE THE EQUIPMENT. ...IPPING DOCUMENTS. WE WILL DO SO ALSO WHEN ...NED TO US.

PAGE 1

$7400 MINIMUM

36560

TO TERMINATE THIS RENTAL AGREEMENT

YOU MUST CALL THE RENTAL DEPARTMENT

Rentals, under this agreement, are payable in cash in advance.
Any option to purchase this equipment, upon any basis whatsoever, given by Lessor or Lessee, must be a separate written option duly signed by an officer of Lessor.
When option is actually given to Lessee, it is understood that no option of any kind, verbal or otherwise, has been given.

THIS IS NOT AN INVOICE

671

Friday, July 30, 2010 (16).max

PURCHASE ORDER

Bondex, Inc.
Two Maxwell Drive
Trenton, SC 29847
(803) 663-1922

P.O. NUMBER:
ORDER DATE : 06/02/09

VENDOR NUMBER : 01-TOYOTAF

VENDOR :
Toyota Forklifts of Atlanta
PO Box 102883
Atlanta, GA 30368-2883

SHIP TO :
Bondex, Inc.
Two Maxwell Drive
Trenton, SC 29847

CONFIRM TO :

REQUIRED DATE	SHIP VIA	F.O.B.	TERMS
06/08/09	VENDOR DEL		Net 7

ITEM NUMBER	UNIT	ORDERED	RECEIVED	BCK ORDER	UNIT COST	AMO
*EQUIP RENTAL	EACH	1.00	0.00	0.00	555.0000	5
Forklift Rental						
*OUTSIDE CONT	EACH	1.00	0.00	0.00	0.0000	
Repair of Mast Ext Hydraulic C						
** Price for Repair TBA **						

APPROVED BY _____
QAF 012 REV(0)

Net Order: 5
Sales Tax:
Freight:
Order Total: 5

00118

00119

Make TO
Model 42-LFG-CW25
Serial: L9242
Hour Meter: 8144

P.O. #

Customer Notified Yes ☐ Initials ____ Additional work ☐ Approved ☐ Denied

☐SV ☐WE ☐EW ☐RM ☐PM ☐MA ☐CU

Hyd. leak (Service Call)

PARTS FROM VAN STOCK

Qty	Part No.	Description

Drive to customer location located LIFT
Trouble shot Hyd. leak found that the Right
Lift cylinder was leaking out of the upper
seal. Informed customer of what I found. Customer
requested a Rental forklift at his charges and
wanted truck to go to the shop to get Removed.
Ordered a rental. Removed attachment off
Customer truck. Waited until Rental arrived.
Installed Attachment onto Rental. Operated
Rental and checked for leaks (GOOD) Brought truck
in and blocked mast up. Removed + Disassembled
Cylinder. Cleaned. Installed new seal kit.
Reassembled, Reinstalled Cylinders. Tested operation.

PARTS DEPARTMENT

Qty	Part No.	Description
2	04654-UZ010-71	packing kit
	AW ASKED FOR BOTH CYLINDERS TO BE FIXED. KEVIN WITH AX CONFIRMED ON BOTH CYLINDERS	

Arrival Time	8:30				
Date	6/3/09	/ /	/ /	/ /	/ /
Travel	Yes No	Yes No	Yes No	Yes No	Yes No
Technician	Travis	Tech # 8990	Truck # 107		
Authorized Signature	[signature]	Date: 6.3.9			

Warr claim #: | Mast #
Parts Returned Yes No | Attachment:
Cylinder # | Model: | Serial:

NOTE: THIS FORM IS ONLY A DELIVERY TICKET OF SERVICE WORK PERFORMED. AN INVOICE WILL FOLLOW.

LINDA.

PURCHASE REQUISITION

• BE EXPLICIT — GIVE FULL INSTRUCTIONS •

STREET: TOYOTA FORKLIFTS.

CITY & STATE:

DELIVERY REQUIRED: ROUTING:

CONFIRMING:

CODE:

PROJECT #:

BUYER: [illegible]

TERMS: 13 30

SALESTAX: 8% CHECK TO: CW

ITEM	QUANTITY	UNIT	DESCRIPTION	UNIT PRICE	EXTENDED
1	1	EA	FORKLIFT RENTAL	965.00 PER WK.	
2	1	EA	P&D	150.00	
3	1	EA	REPAIR OF MAST EXTENSION TBA. & HYDRAULIC CYLINDERS		

Jim Pritchard
6/5/09

QAF 011 REV

00120

8994

RECEIVING RECORD

RECEIVED FROM: TOYOTA FORKLIFTS

ADDRESS:

PURCHASE ORDER NO. ~~OR RETURNED GOODS~~: 6685 | FREIGHT BILL NO. | DATE: 6.5.9

VIA: | PREPAID | COLLECT

QUANTITY		ITEM NUMBER	DESCRIPTION
1	1	EA	RENTAL FORKLIFT
	2		
1	3	EA	REPAIR of BOX FORKLIFT.
	4		
	5		
	6		
	7		
	8		
	9		
	10		
	11		
	12		

REMARKS: CONDITIONS, ETC.

NO. PACKAGES	WEIGHT	RECEIVED BY:	CHECKED BY:	DELIVERED TO:

BE SURE TO MAKE THIS RECORD ACCURATE AND COMPLETE

©2001 REDIFORM 2L259

REPAIRS NOW

Customer Notified. Yes ☐ Initials _____ Additional work ☐ Approved ☐

PARTS FROM VAN STOCK

Qty	Part No.	Description

PARTS DEPARTMENT

2	04859-42010-71	PACKING KIT
2	W ASKED FOR BOTH CYLINDERS TO BE FIXED. KEVIN WITH AUX CONFIRMING ON BOTH CYLINDERS	

Ware claim #: Mast #

Parts Returned Yes No Attachment

00121

Friday, July 30, 2010 (16).max

LINDA...
GM.

PURCHASE REQUISITION

• BE EXPLICIT — GIVE FULL INSTRUCTIONS •

FORKLIFTS.

CODE

P.O. NO. 6685

PROJECT #

DATE 6.3.9

DAY REQUIRED

ROUTING

BUYER CW

CONFIRMING

TERMS N.30

SALES TAX YES NO X

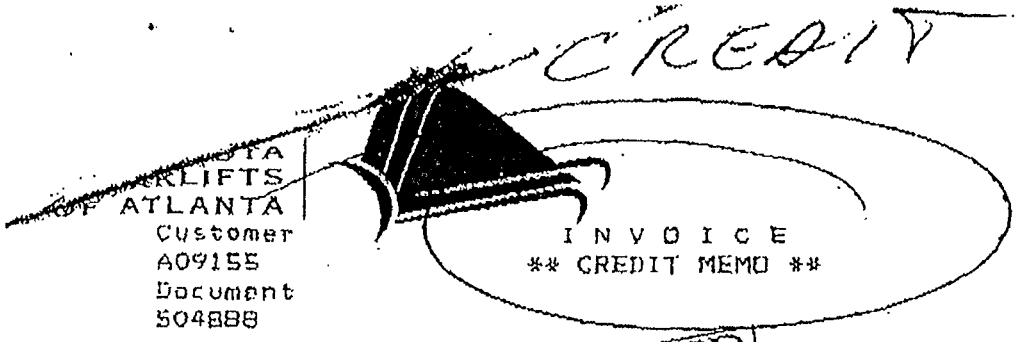
ORIGINATOR CW

ITEM	QUANTITY	UNIT	DESCRIPTION	UNIT PRICE	EXTENDED P
1	1	EA	FORKLIFT RENTAL	565.00 per WK.	
2	1	EA	P&D	150.00	
3	1	EA	REPAIR OF MAST EXTENSION & HYDRAULIC CYLINDERS	TBA.	
			PARTS	200.00	400.00
			SHOP LABOR		486.00
			FIELD LABOR		567.00
			ENVIRONMENTAL		5.00
			Fuel SURCHARGE		5.00
			SERVICE SUPPLIES		57.70
			SHIP & HANDLING		2.88
			TOTAL		1349

QAF 011 R

00122

CREDIT



TA
RKLIFTS
F ATLANTA

3111 E. Ponce de Lo
Scottdale, Geor
East Telephone 404
Augusta Telephone 706
West Telephone 678
FED ID# 5
WWW.ATLANTAFORKLI

Customer
A09155
Document
504888

I N V O I C E
** CREDIT MEMO **

Invoice
R30136

6/08/09

RECEIVED
JUN 16 2009
BY:

Sold To
BONDEX INC
2 MAXWELL DR
TRENTON SC 29847

Ship To
ATTN CHARLIE WATERS
CREDIT APPLIES TO INVOICE
R30127 ONLY...
****MAIL****
*****MAIL*****
TRENTON SC 29847

803/663-1922

803/663-1922

Tr	Trk	Make	Model	Serial	Equipment	Meter	Sls	Customer P.O
005							7	6685

Ordr	Ship	Description	Each	Amount
	Apply To	R30127		
		Rental Contract 504888 Period: 6/03/09 Thru 6/05/09		
1	1	TO 613A 7FGCU25 81225 S EXEL, NM, 189, SS, 4WAY, FIRE EXT Hours: 6.00	115.00-	115.
		HAD 2 DAYS OF WERX BILLED @ $125.00 DAILY. CREDIT APPLIES TO INVOICE R30127 ONLY...		
		NON TAX S C RESALE 57-1058950		

PAID
JUN 17 2009
BY:

WE NOW OFFER DOCK & DOOR SERVICE IN THE ATLANTA MARKET

Credit Amount 115.

ERMS AND CONDITIONS

his invoice is subject to all of the terms, provisions, conditions and limitations of the parts order or lease agreement concerning the oods, services or equipment sold or leased as described therein. Examine this invoice carefully as it will be deemed correct unless rors are reported to Toyota Forklifts of Atlanta 10 days of the date hereof.
e purchaser or lessee shall pay a service charge of 1 1/2% (18% ANNUAL RATE) on all amounts not paid within 30 days lowing the date of such sale or lease, and all costs of collection or enforcement including reasonable attorney's fees.
ETURNED ITEMS ARE SUBJECT TO A SERVICE AND RESTOCKING CHARGE.

CUSTOMER COPY

TERMS: NET DUE UPON RECEIPT OF INVOICE

PLEASE REMIT TO
dba TOYOTA FORKLIFTS OF ATLANTA
P.O. Box 102883, Atlanta, GA 30368-2883

TOYOTA
INDUSTRIAL EQUIPMENT

8994

RECEIVING RECORD

RECEIVED FROM: TOYOTA FORKLIFTS

ADDRESS:

PURCHASE ORDER NO. OR RETURNED GOODS: 6685 | FREIGHT BILL NO. | DATE: 6.5.9

VIA: | PREPAID | COLLECT

QUANTITY	ITEM NUMBER	DESCRIPTION
1	EA	RENTAL FORKLIFT
1	EA	REPAIR of BDX FORKLIFT.

REMARKS: CONDITIONS, ETC.

NO. PACKAGES	WEIGHT	RECEIVED BY:	CHECKED BY:	DELIVERED TO:
		AW.		

BE SURE TO MAKE THIS RECORD ACCURATE AND COMPLETE

©2001 REDIFORM 21259

PARTS ROWE

Customer Notified Yes ☐ Initials ____ Additional work ☐ Approved ☐ Denied ☐

PARTS FROM VAN STOCK

Qty	Part No.	Description

PARTS DEPARTMENT

2	04254-42010-71	packing kit

AW ASKED for BOTH CYLINDERS TO BE priced. Kevin will fax confirming on BOTH CYLINDERS

Warr claim #: Mast #:

Parts Returned Yes No Attachment:

Friday, July 30, 2010 (16).max

Bondex, Inc.
Two Maxwell Drive
Trenton, SC 29847
(803) 663-1922

ORDER DATE [illegible]

VENDOR NUMBER : 01-TOYOTAF

VENDOR :
Toyota Forklifts of Atlanta
PO Box 102883
Atlanta, GA 30368-2883

SHIP TO :
Bondex, Inc.
Two Maxwell Drive
Trenton, SC 29847

CONFIRM TO :

REQUIRED DATE	SHIP VIA	F.O.B.	TERMS
06/08/09	VENDOR DEL		Net 7

ITEM NUMBER	UNIT	ORDERED	RECEIVED	BCK ORDER	UNIT COST	AMO
*EQUIP RENTAL Forklift Rental	EACH	1.00	~~1.00~~	0.00	555.0000	~~55.~~
*OUTSIDE CONT Repair of Mast Ext Hydraulic C	EACH	1.00	0.00	0.00	0.0000	

** Price for Repair TBA **

✓ Rec - 6/5/09

$1349.

OK pm
CW

COMPLETED
6/5/09

APPROVED BY _____
OAF 012 REV(0)

Net Order:	55
Sales Tax:	
Freight:	
Order Total:	55

00125

TOYOTA FORKLIFTS OF ATLANTA

Customer
A09155

INVOICE

3111 E. Ponce de L
Scottdale, Ge
East Telephone 40
Augusta Telephone 7(
West Telephone 67
FED ID#
WWW.ATLANTAFORKI

Invoice
M84162

6/08/09

Sold To	Ship To
BONDEX INC	BONDEX INC
2 MAXWELL DR	2 MAXWELL DR
TRENTON SC 29847	TRENTON SC 29847
803/663-1922	803/663-1922

)r	Trk	Make	Model	Serial	Equipment	Meter	Sls	Customer P.I
)05		TO	42-6FGC25	69892	12057	8,144	17	

Ordr	Ship	B/O	Description	Each	Amount
			Closed	6/08/09	
			HYDRAULIC LEAK DROVE TO CUSTOMER LOCATION. LOCATED LIFT. TROUBLE SHOT HYDRAULIC LEAK. FOUND RIGHT LIFT CYLINDER WAS LEAKING OUT OF THE WIPER SEAL. INFORMED CUSTOMER. CUSTOMER REQUESTED RENTAL LIFT AT HIS CHARGE AND WANTED TRUCK TO GO TO THE SHOP FOR REPAIR. ORDERED RENTAL. REMOVED ATTACHMENT OFF CUSTOMER TRUCK AND INSTALLED ATTACHMENT ON RENTAL. OPERATED RENTAL AND CHECKED FOR LEVELS. AT SHOP: BROUGHT TRUCK IN AND BLOCKED MAST UP. REMOVED AND DISASSEMBLED CYLINDERS. CLEANED. INSTALLED NEW SEAL KIT. REASSEMBLED. REINSTALLED CYLINDERS. TESTED OPERATION. BOTH SECONDARY LIFT CYLINDERS WERE RESEALED.		
2	2		TO 04654-U2010-71 CYLINDER O/H KIT, LI	102.94	205.
4	4		ZZ 10W HYDR OIL-H32 [QT]	3.87	15.
			TOTAL PARTS		221.
	1		SHIPPING AND HANDLING	7.88	7
			FIELD LABOR HOURS		567.

CONTINUED

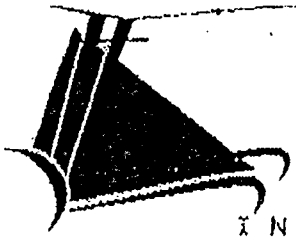
RMS AND CONDITIONS
Is invoice is subject to all of the terms, provisions, conditions and limitations of the parts order or lease agreement concerning the ods, services or equipment sold or leased as described therein. Examine this invoice carefully as it will be deemed correct unless ors are reported to Toyota Forklifts of Atlanta 10 days of the date hereof.
e purchaser or lessee shall pay a service charge of 1 1/2% (18% ANNUAL RATE) on all amounts not paid within 30 days lowing the date of such sale or lease, ad all costs of collection or enforcement including reasonable attorney's fees.
TURNED ITEMS ARE SUBJECT TO A SERVICE AND RESTOCKING CHARGE.
CUSTOMER COPY

TERMS: NET DUE UPON RECEIPT OF INVOICE

PLEASE REMIT TO
dba TOYOTA FORKLIFTS OF ATLANTA
P.O. Box 102883, Atlanta, GA 30368-2883

TOYOTA INDUSTRIAL EQUIPMENT

TOYOTA
FORKLIFTS
OF ATLANTA
Customer
A09155



INVOICE

3111 E. Ponce de
Scottdale, G
East Telephone 4
Augusta Telephone 7
West Telephone 6
FED ID
WWW.ATLANTAFORI

RECEIVED
JUN 16 2009
BY:

Invoice
MB4162

6/08/09

Sold To
BONDEX INC
2 MAXWELL DR
TRENTON SC 29847

Ship To
BONDEX INC
2 MAXWELL DR
TRENTON SC 29847

803/663-1922

803/663-1922

Br	Trk	Make	Model	Serial	Equipment	Meter	Sls	Customer P.
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			ENVIRONMENTAL CHARGE		5
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7

CURRICULUM VITAE
OF
DR. TIMOTHY SHANNON

CURRICULUM VITAE

Timothy J. Shannon, M.D.
Carolina Musculoskeletal Associates, PA
41University Parkway, Suite 1000
Aiken South Carolina 29801
803-649-0563

Home Address:	121 Pine Needle Road Aiken SC29803
Date of Birth:	December 9. 1959
Place of Birth:	Milwaukee WI
Personal Data:	Married May 28. 1983 Son and 2 daughters (dates of birth: August 28. 1985; April 4. 1989; March 6. 1992)
Military Service:	United States Air Force Rank MJR/04 June 1991 to July 1995
Residency:	Northwestern University McGaw Medical Center Chicago IL Orthopedic Surgery 1987-1991
Internship:	Northwestern University McGaw Medical Center Chicago IL General Surgery 1986-1987
Medical School:	St. Louis University School of Medicine St. Louis MO Doctor of Medicine 1982-1986
University:	Loyola University of Chicago Chicago IL B.A. Latin Magna Cum Laude 1978-1982
Secondary School:	Libertyville High School Libertyville IL 1974-1978

Honors:

U. S. Air Force Health Professions Scholarship
St. Louis University School of Medicine 1982-1986

Loyola University Varsity Letterman Cross Country and Track
Loyola University of Chicago 1978-1982

Honors Program Deans List (Eight Semesters)
Loyola University of Chicago 1978-1982

Athletic Scholarship Illinois State Academic Scholarship
Loyola University of Chicago 1978-1982

N.A.S.S.P. Scholarship Elks Club Scholarship
Loyola University of Chicago 1978-1979

Professional Affiliations:

Carolina Musculoskeletal Institute, PA
410 University Parkway, Suite 1000
Aiken SC 29801
July 1995 to Present

Aiken Regional Medical Centers
302 University Parkway
Aiken SC 29801
Active Staff, July 1995 to Present

Licenses:

South Carolina	#17950	Issued May 1995
Louisiana	#10159R	Issued September 1993
Illinois	#036075948	Issued June 1987
DEA	#BS4415789	Issued June 1995

Certifications:

Advanced Cardiac Life Support	1994
American Board of Orthopaedic Surgery	1993
National Board of Medical Examiners, Parts I-III	1984/86/87

Appointments:

Second Medical Group, Barksdale Air Force Base
Orthopaedic/Podiatry Services, Staff Surgeon, July 1991-June 1992;
Chief Surgeon, June 1992-June 1995

Louisiana State University Shreveport Medical Center
Department of Orthopaedics, Gratis Faculty, September 1992-June 1995
Dr. James Albright, Chairman
1541 Kings Highway Shreveport LA 71103-3932

Shriners Hospitals for Crippled Children, Shreveport Unit
Consultant Medical Staff, February 1993-June 1995
Dr. Richard E. McCall, Chief of Staff
310Samford Avenue Shreveport LA 71103

00129

Professional Societies:	American Academy of Orthopaedic Surgeons	1995 to Present
	South Carolina Orthopaedic Association	1996 to Present
	Secretary/Treasurer	2002 to 2004
	President Elect	2004 to 2005
	President	2005 to 2006
	South Carolina Medical Association	1996 to Present
	American Medical Association	1996 to Present

Scientific Paper Presentations:

"Influence of Hyperhydration on Body Fluid Dynamics During Rhythmic Exercise."
Presented April 1984 to the Federation of Americal Societies of Experimental Biology (FASEB) in St. Louis MO

"Treatment of the Symptomatic Bunion with a Modified Chevron Osteotomy Screw Fixation."
Presented in 1992 at the AAOS 59th Annual Meeting, American Orthopaedic Foot and Ankle Society Specialty Day in Washington DC

"Terminal Symes Amputation."
Presented August 7, 1998 at South Carolina Orthopaedic Association Meeting in Myrtle Beach SC

"The Kelikian Procedure."
Presented July 2001 at South Carolina Orthopaedic Association Meeting in Kiawah Island SC

Professional Presentations:

"Common Disorders of the Shoulder"
Presented October 4, 1995 at Aiken Regional Medical Centers Continuing Education Conference

"The Knee"
Presented February 21, 1996 at Aiken Regional Medical Centers Continuing Medical Education Conference

"Lumbosacral Spine Disease - Part I"
Presented April 24, 1996 at Aiken Regional Medical Centers Continuing Education Conference

"Lumbosacral Spine Disease - Part II"
Presented May 11, 1996 at Aiken Regional Medical Centers Continuing Education Conference

"Compartment Syndrome"
Presented in 1997 at Aiken Regional Medical Centers for ICU Nurses

"Perioperative Considerations in Shoulder Surgery"
Presented in 1998 at CSRA Nurses Association

Professional Presentations:

"Pediatric Osteomyelitis and Adult Upper Extremity Occupational Soft Tissue Injuries"
Presented June 25-27, 1998 at International Medical and Scientific Conference, Haiti

Community Presentations:

"Arthritis" - Presented in 1997 to CSRA Seniors Group

Presentation to Sunny Mondays Senior Group at St. Johns United Methodist Church in 1998

Presentation to AARP Local Group in 1999

Total Joint Replacements Presented to Aiken Rotary Club

Presentation at Cedar Creek April 28, 2004

"Minimally Invasive Arthritis Surgery" - Presentation at Woodside September 29, 2004

"Orthopedic Emergencies" - Presented to Aiken County EMS October 12, 2004

Healthcare Day 2005 - "Joint Replacements and Therapy"

"Total Joints" - Presented to Sunny Mondays Senior Group at St. Johns Methodist Church January 23, 2006

"What's New In Arthritis Surgery" - Presented to Aiken County Medical Society June 2007; Presented at Cedar Creek Country Club May 13, 2008; Presented at Senior Extravaganza September 17, 2008; Presented at Lighthouse Baptist Church September 23, 2008; Presented at O'Dell Weeks Recreation Center October 2, 2008

Committee Service:

Hitchcock Healthcare Ethics Committee

Hitchcock Healthcare Board of Directors

Hitchcock Healthcare CORF Physician

South Carolina Medical Association CME Committee

Aiken Regional Medical Center CME Committee

Aiken Regional Medical Center Peer Review Committee

Aiken Regional Medical Center Credentials Committee

Aiken Regional Medical Center MEC Committee

Aiken Regional Medical Center Board of Governors

AMERICAN MEDICAL ASSOCIATION CERTIFICATIONS

DoctorFinder

This online physician locator helps you find a perfect match for your medical needs. DoctorFinder provides you with basic professional information on virtually every licensed physician in the United States. This includes more than 814,000 doctors.

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Frequently asked questions

Search hints

Member benefits and services

AMA Membership: Join/Renew

Is your doctor an AMA member?

AMA member physicians are offered an expanded listing that contains additional information such as office hours, accepted insurance providers, educational history and other helpful information.

All AMA members must adhere to the AMA's Principles of Medical Ethics.

DoctorFinder

The information contained in the AMA DoctorFinder report does NOT meet the primary source equivalency requirement as set forth in the credentialing standards of accreditation organizations such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the National Committee for Quality Assurance (NCQA).

William D Westerkam , MD (Non-Member)

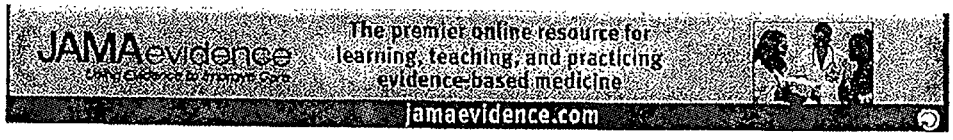
Primary Specialty (Self Designated)(note):
PHYSICAL MEDICINE AND REHABILITATION

Location:
Columbia, SC 29203

Office Phone:
803-254-7777

American Board of Medical Specialties Certification:
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Physical Medicine & Rehabilitation

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00132

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Frequently asked questions

Search hints

Member benefits and services

AMA Membership: Risk/Reward

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Timothy John Shannon , MD (Non-Member)

Primary Specialty (Self Designated)(note):
ORTHOPEDIC SURGERY

Location:
Aiken, SC 29801

Office Phone:
803-649-0563

American Board of Medical Specialties Certification:
Orthopaedic Surgery

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WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
SOUTHERN FELT COMPANY, INC. 2 Maxwell Drive Trenton SC 29860			00
	JURISDICTION: SC	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER: 09 0602LEE		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT): 1695 Edgefield Road North Augusta SC 29841		LOCATION #: N00000009685
INJURY CODE: 2299	EMPLOYER FEIN: 58-1730352		PHONE #: 803-663-1922

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Great American Alliance Ins Co 580 Walnut Street Cincinnati OH 45202	04/01/2009 TO 04/01/2010 CHECK IF APPROPRIATE ☐ SELF INSURANCE	Strategic Comp P. O. Box 1445 Alpharetta 300091445 800-467-7725

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
	WC 61720900504	72-1331800

AGENT NAME & CODE NUMBER:

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
Lee, Bernard	04/30/1980	251-45-2204	08/23/2008	SC

ADDRESS (INCL ZIP)	SEX	MARITAL STATUS	OCCUPATION/JOB TITLE
172 Old Cherokee Indian Rd Graniteville SC 29829	X MALE ☐ FEMALE ☐ UNKNOWN	X UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	Line Operator EMPLOYMENT STATUS Full Time
PHONE: 803-663-0560	# OF DEPENDENTS		NOS/LOSS CODE

RATE				DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?			
PER: 13.71	☐ DAY / WEEK	☐ MONTH	X OTHER: HOUR		DID SALARY CONTINUE?	X YES	☐ NO	
						☐ YES	☐ NO	

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
08:00 ☐ AM X PM	08/02/2009	09:25 ☐ AM X PM ☐ CANNOT BE DETERMINED		08/02/2009	

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
Nancy Bowers 803-663-1922	Noc Specific Injury, All Others Not Classified	Multiple Body - Multiple Body Parts

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE
X YES ☐ NO	59	90

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
2 Maxwell Drive Trenton SC 29847	Strain - Pushing/pulling
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: Installing a door on machine	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

Ee stated while installing the door on number three card machine he was guiding it to its position and pushing with his left arm, felt pain in left shoulder and neck and pain started running down his

CAUSE OF INJURY CODE: 57

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		
			☐ YES	X NO
		WERE THEY USED?	☐ YES	X NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
	University Hospital Of Augusta	X NO MEDICAL TREATMENT ☐ MINOR, BY EMPLOYER ☐ MINOR CLINIC/HOSP X EMERGENCY CARE ☐ HOSPITALIZED > 24 HOURS ☐ FUTURE MAJOR MEDICAL / LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #):

SAFE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER
	06/03/2009	Nancy Bowers	

WCC FORM 12-A REV. DATE 04/06 — SEE INSTRUCTIONS FOR IMPORTANT INFORMATION — REPRINTED WITH PERMISSION OF IAIABC

NOTICE #	09 0602LEE	N00000009685	06/03/2009	POLICY	WC 61720900504

Certificate of Counsel

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material. The following documents, which were proposed by the Respondent in its Designation of Matter, cannot be a part of the Record pursuant to SCACR 210(c) and were not included: (1) Decision and Order of Commissioner Barden 3/5/12; Decision and Order of Commissioner Barden 4/2/12; Defendants Form 30 Appeal 4/13/12; and Decision and Order of Commissioner Lyndon 4/24/12.

August 3, 2012

E. Ros Huff, Jr.
HUFF LAW FIRM, LLC
Post Office Box 1935
Irmo, South Carolina 29063
(803) 252-2232

Attorneys for the Appellant

Certificate of Counsel

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August 3, 2012

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HUFF LAW FIRM, LLC
Post Office Box 1935
Irmo, South Carolina 29063
(803) 252-2232

Attorneys for the Appellant

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SC WORKERS COMPENSATION COMMISSION

Appellate Panel:
Commissioner Andrea Pope Roche
Commissioner Derrick L. Williams
Commissioner David W. Huffstetler

WCC File No. 0906951

Bernard D. Lee,,..... Respondent,

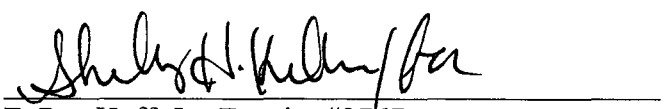
v.

Bondex Inc. and Great American Alliance Insurance Company, ...Appellants.

PROOF OF SERVICE

I certify that I have served the Record on Appeal on Bernard Lee by depositing a copy of the same in the United States Mail, postage prepaid, on August 3, 2012, addressed to his attorney of record Ann M. Mickle, Esquire at Mickle & Bass, LLC, 930 Oakland Avenue, PO Box 10751, Rock Hill, SC 29731

August 3, 2012



E. Ros Huff, Jr., Esquire #2767
Shelby H. Kellahan, Esquire #74731
HUFF LAW FIRM, LLC
Post Office Box 1935
7244 Woodrow Street
Irmo, South Carolina 29063
(803) 252-2232
Attorneys for Appellants

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SC WORKERS COMPENSATION COMMISSION

Appellate Panel:
Commissioner Andrea Pope Roche
Commissioner Derrick L. Williams
Commissioner David W. Huffstetler

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SC Court of Appeals

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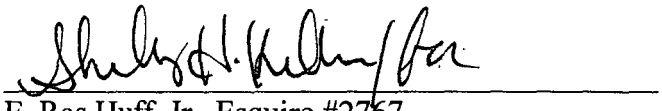
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Attorneys for Appellants