

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

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APPEAL FROM CHARLESTON COUNTY  
Court of Common Pleas

The Honorable Mikell R. Scarborough, Master in Equity

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Appellate Case No. 2018-001386  
Common Pleas Case No.: 2015-CP-10-2178

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**RECEIVED**  
MAR 25 2019  
SC Court of Appeals

Stacy Singletary, Individually and as Personal Representative of Sheldon Singletary....Respondent

vs.

Kelvin Shuler..... Appellant

---

**RECORD ON APPEAL**

**VOLUME II**

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**ORIGINAL**

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"ANESTHESIA"

Anesthesia/PACU Record

MRN: 002673589	Height(cm):
Name: SINGLETARY, SHELTON J.	Weight(kg): 100
DOB: 09/10/1969	BMI:
PatCom: 496961732	Sex: Male
Surgeon: Crookes, Bruce	Age: 42 years

Surgery Date: 04/19/2012

Case Times					
Anest Start: 04/19 16:46	Surg Start: 04/19 16:47	Proc Start: 04/19 16:57	PACU Start:	Stepdown Start:	
Anest End: 04/19 19:06	Surg End: 04/19 18:55	Proc End: 04/19 18:37	PACU End:	Stepdown End:	
Anest Total: 02:20	Surg Total: 02:08	Proc Total: 01:40	PACU Total:	Stepdown Total:	
Surgical Procedure		Staff and Electronic Signature Legend (Initials)			
EXPLORATION OF ABDOMEN SEPARATE PROCEDURE		Role: Scheduled Surgeon - Crookes, Bruce (brcS1) Role: Primary Surgeon - Crookes, Bruce (brcS1) Role: Anesthesia Attending - Wilson, Sylvia (SHW56) Role: CRNA - Grannell, Timothy (TG)			
Pre-op Diagnosis		Anesthesia Attending Documentation Electronically Signed By:			
		04/19 16:49 SHWSI Anesthesiologist assessed patient, reviewed chart and formulated anesthesia plan 04/19 16:49 SHWSI Anesthesiologist medically directing case and present for all critical portions. 04/19 16:49 SHWSI Anesthesiologist present for induction 04/19 16:49 SHWSI Anesthesiologist present for airway device placement 04/19 16:49 SHWSI Anesthesiologist present for line placement 04/19 16:49 SHWSI Emergency case 04/19 16:49 SHWSI Controlled hypotension goal of MAP 60 to decrease blood loss from arterial bleed 04/19 18:48 SHWSI Anesthesiologist present for emergence 04/19 18:48 SHWSI (or another attending anesthesiologist) was immediately available throughout			
Post-op Diagnosis					
Allergies					
Anesthesia Type		ASA			
General Anesthesia		IV E			
Anesthesia Events					
04/19 16:46	TG Anesthesia machine checked, alarms on and functioning	04/19 16:49 SHWSI Emergency case	04/19 18:49	TG To ICU with O2 and monitors	
04/19 16:46	TG Integrity of Anesthesia circuit confirmed	04/19 16:49 SHWSI Controlled hypotension goal of MAP 60 to decrease blood loss from arterial bleed	04/19 18:49	TG Transported via stretcher/bed; Siderals up	
04/19 16:46	TG Standard monitors available, alarms on and functioning	04/19 16:49	TG Patient evaluated immediately prior to induction	04/19 19:05	TG Memo in STICU. Updated report given to RN @ bedside. VSS. Patient attached to vent and monitors.
04/19 16:46	TG Suction available and functioning	04/19 16:49	TG Standard monitors applied	04/19 19:06	TG SBAR report given
04/19 16:46	TG Airway equipment available and functioning	04/19 16:49	TG INHALATION INDUCTION		
04/19 16:46	TG Anesthesia and resuscitation drugs available	04/19 16:49	TG Position supine		
04/19 16:46	TG NPO status verified	04/19 16:49	TG Eye(s) taped closed		
04/19 16:46	TG Patient chart and preoperative assessment reviewed	04/19 17:14	TG Arterial line placed by Resident		
04/19 16:46	TG Patient identified by 2 methods	04/19 17:14	TG Left radial artery		
04/19 16:46	TG Pre-op vital signs reviewed	04/19 17:14	TG Sterile technique maintained after chlorhexidine application		
04/19 16:46	TG Surgical consent verified and appropriate	04/19 17:14	TG 20 ga arterial catheter over wire		
04/19 16:46	TG Risks, benefits, and complications of anesthetic plan discussed and understood	04/19 17:14	TG Existing peripheral IV access in place		
04/19 16:46	TG Procedural site marking(s) verified where appropriate	04/19 17:14	TG 16 gauge peripheral IV catheter in bilateral ACs		
04/19 16:46	TG Memo pt received OR front desk, to OR 1, hand ambu, full monitors	04/19 17:30	TG Easily and atraumatically		
04/19 16:47	TG Patient evaluated immediately prior to anesthesia	04/19 17:30	TG NGT/OGT/RRC to suction		
04/19 16:47	TG Standard monitors applied	04/19 17:30	TG NGT lubricated and placed through left nares (size): 18 fr		
04/19 16:47	TG Airway device already in place from ICU/ED 8.0 ETT in situ, BBS, positive EICO2	04/19 18:21	TG PERIPHERAL IV PLACEMENT. Details:		
04/19 16:49 SHWSI	Anesthesiologist assessed patient, reviewed chart and formulated anesthesia plan	04/19 18:21	TG Skin prep with chlorhexidine		
04/19 16:49 SHWSI	Anesthesiologist medically directing case and present for all critical portions.	04/19 18:21	TG Aseptic technique used		
04/19 16:49 SHWSI	Anesthesiologist present for induction	04/19 18:21	TG Peripheral IV placed (Site and Gauge): #18 G left arm		
04/19 16:49 SHWSI	Anesthesiologist present for airway device placement	04/19 18:21	TG Sterile transparent dressing placed over insertion site		
04/19 16:49 SHWSI	Anesthesiologist present for line placement	04/19 18:48 SHWSI	Anesthesiologist present for emergence		
		04/19 18:48 SHWSI	(or another attending anesthesiologist) was immediately available throughout and present for all key/critical portions of case		
		04/19 18:49	TG Patient reassessed, ready for transfer		



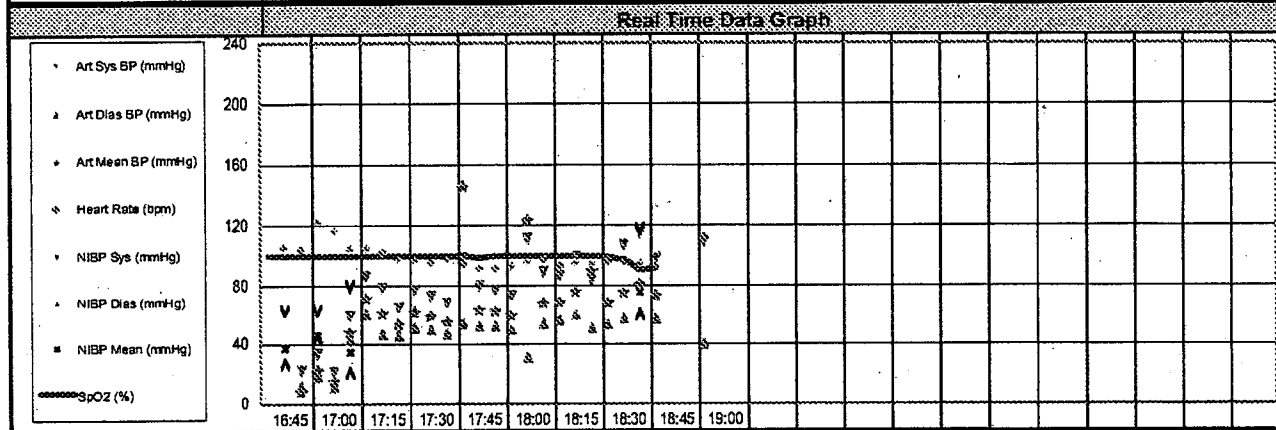


**\*ANESTHESIA\***  
**Anesthesia/PACU Record**

MRN: 002573589	Height(cm):
Name: SINGLETARY, SHELTON J.	Weight(kg): 100
DOB: 09/10/1969	BMi:
PatCom: 496951732	Sex: Male
Surgeon: Crookes, Bruce	Age: 42 years

Surgery Date: 04/19/2012

Real Time Variables												
TIME	16:45	17:00	17:15	17:30	17:45	18:00	18:15	18:30	18:45	19:00		
SpO2 (%)	100	100	100	100	100	100	100	95.9	92.6	95		
Esophageal Temp (°C)		35.42	35.3	35.13	35.28	35.14	35.08	35.02	35.02	35.3		
EKG Rhythm	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST		
SpO2 Heart Rate bpm	95	103	96	97	92	92	97	95	92			
Resp Rate from pCO2 cart	12	14	15	15	15	15	15	17	21			
Vent Resp Rate/min	12	14	15	15	15	15	15	11	22			
FiO2 (%)	97	97	95	95	95	95	95	95	95			
EiCO2 (mmHg)	34	40	22	29	27	34	31	30	30			
Iso out (%)			0.4	0.3	0.5	0.5	0.6	0.8	1			
Exp. Tidal volume (mL)	559	436	730	824	704	574	592	84	708			



Laboratory Results												
TIME	16:45	17:00	17:15	17:30	17:45	18:00	18:15	18:30	18:45	19:00		
PH ARTERIAL	6.99		7.1		7.08	7.17		7.18				
PCO2 ARTERIAL	65		39		40	36		40				
PO2 ARTERIAL	35		286		413	361		308				
BICARB ARTERIAL	15.2		11.6		11.7	13.1		14.6				
TOTAL CO2 ARTERIAL	17.3		12.8		13	14.3		16				
O2 SAT ARTERIAL	60.4		99.8		99.7	99.7		99.7				
HCT WHL BLD ARTERIAL	22		23		28	21		22				
HGB WHL BLD ARTERIAL	7.1		7.3		9.1	6.8		7				
HA WHL BLD ARTERIAL	145		143		141	143		142				
K WHL BLD ARTERIAL	4.2		4.4		6.3	5.6		6				
IONIZED CA ARTERIAL	0.59		0.81		0.96	0.76		0.92				
GLU WHL BLD ARTERIAL	217		266		302	235		193				
HEMOGLOBIN					8.8							
GLUCOSE						251						





\*ANESTHESIAN\*

Anesthesia/PACU Record

MRN: 002673589	Height(cm):
Name: SINGLETARY, SHELTON J.	Weight(kg): 99.9974
DOB: 09/10/1969	BM:
PatCom: 496951732	Sex: Male
Surgeon: Crookes, Bruce	Age: 42 years

Surgery Date: 04/19/2012

Case Times	
Anest Start: 04/19 20:41	Surg Start: 04/19 20:43
Anest End: 04/19 23:41	Surg End: 04/19 23:29
Anest Total: 03:00	Surg Total: 02:46
Proc Start: 04/19 20:55	PACU Start:
Proc End: 04/19 23:15	PACU End:
Proc Total: 02:20	PACU Total:
Stepdown Start:	Stepdown End:
Stepdown Total:	
Surgical Procedure	
EXPLORATION OF ABDOMEN SEPARATE PROCEDURE	
Staff and Electronic Signatures Legend (Initials):	
Role: Scheduled Surgeon - Crookes, Bruce (brc51)	
Role: Primary Surgeon - Crookes, Bruce (brc51)	
Role: Anesthesia Attending - Whiteley, Joseph (JRW)	
Role: Anesthesia Resident - Matos, Jennifer (JRM)	
Role: Anesthesia Resident - Buck, Matthew (MVB)	
Pre-op Diagnosis	
Anesthesia Attending Documentation Electronically Signed By:	
04/19 21:27 JRW Anesthesiologist assessed patient, reviewed chart and formulated anesthesia p	
04/19 21:27 JRW Anesthesiologist medically directing case and present for all critical portions.	
04/19 21:27 JRW Anesthesiologist present for induction	
04/19 21:27 JRW Anesthesiologist present for airway device placement	
04/19 21:27 JRW Anesthesiologist present for line placement	
04/19 23:04 JRW Anesthesiologist present for emergence	
04/19 23:04 JRW I (or another attending anesthesiologist) was immediately available throughout	
Allergies	
Anesthesia Type	
General Anesthesia	ASA IV E
Anesthesia Events	
04/19 20:41 JRM Anesthesia machine checked, alarms on and functioning	for all key/critical portions of case
04/19 20:41 JRM Integrity of Anesthesia circuit confirmed	04/19 23:04 JRW Memo Transferring to STICU
04/19 20:41 JRM Standard monitors available, alarms on and functioning	04/19 23:23 JRM Patient reassessed, ready for transfer
04/19 20:41 JRM Suction available and functioning	04/19 23:23 JRM To ICU with O2 and monitors
04/19 20:41 JRM Airway equipment available and functioning	04/19 23:23 JRM Transported via stretcher/bed; Siderails up
04/19 20:41 JRM Anesthesia and resuscitation drugs available	04/19 23:41 JRM SBAR report given
04/19 20:41 JRM NPO status verified	
04/19 20:41 JRM Patient chart and preoperative assessment reviewed	
04/19 20:41 JRM Patient identified by 2 methods	
04/19 20:41 JRM Pre-op vital signs reviewed	
04/19 20:41 JRM Surgical consent verified and appropriate	
04/19 20:41 JRM Risks, benefits, and complications of anesthetic plan discussed and understood	
04/19 20:41 JRM Procedural site marking(s) verified where appropriate	
04/19 20:47 JRM Patient evaluated immediately prior to anesthesia	
04/19 20:47 JRM Standard monitors applied	
04/19 20:47 JRM Airway device already in place from ICU/ED	
04/19 21:27 JRW Anesthesiologist assessed patient, reviewed chart and formulated anesthesia plan	
04/19 21:27 JRW Anesthesiologist medically directing case and present for all critical portions.	
04/19 21:27 JRW Anesthesiologist present for induction	
04/19 21:27 JRW Anesthesiologist present for airway device placement	
04/19 21:27 JRW Anesthesiologist present for line placement	
04/19 23:04 JRW Anesthesiologist present for emergence	
04/19 23:04 JRW I (or another attending anesthesiologist) was immediately available throughout and present	



\*ANESTHESIAN\*

Anesthesia/PACU Record

MRN: 002673589	Height(cm):
Name: SINGLETARY, SHELTON J.	Weight(kg): 99.9974
DOB: 09/10/1969	BMI:
PatCom: 496951732	Sex: Male
Surgeon: Crookes, Bruce	Age: 42 years

Surgery Date: 04/19/2012

TIME	20:45	21:00	21:15	21:30	21:45	22:00	22:15	22:30	22:45	23:00	23:15	23:30	23:45	0:00	0:15	0:30	0:45	1:00	1:15	1:30	Totals	
<b>Medications</b>																						
Calcium Chloride 10% (mg) (IV)		2000	2000			3000	5000	1000	1000												14000	
Cefazolin (Ancef) (gram) (IV)			2																		2	
Epinephrine (microgram) (IV)	1048	200						80													1328	
Epinephrine (microgram) (IV)						32															32	
Factor VIIa (microgram) (IV)									10000												10000	
Fentanyl (microgram) (IV)					10000																10000	
Magnesium Sulfate (gram) (IV)					2		2														4	
Scopolamine (mg) (IV)		0.4																			0.4	
Sodium Bicarbonate 8.4% (mEq) (IV)	50	50	150			100	100	50													500	
Vasopressin (unit) (IV)	10							10													20	
Vecuronium (mg) (IV)		10				10															20	
<b>Drips</b>																						
Epinephrine(microgram/kg/min) / D5W								0.1>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	390	
Norepinephrine (microgram/min)	75>	4>	4>	8>	* 10>	* 14>	10>	* 40>	30>	30>	30>	30>	30>	30>	30>	30>	30>	30>	30>	30>	909	
Phenylephrine (microgram/kg/min)			X																		0	
Phenylephrine(microgram/min) / Normal	300>	* 200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	2618	
<b>Fluids IN</b>																						
Lactated Ringers (mL)						1000>	>	>	1000>	>	>	>	>	>	>	>	>	>	>	>	1000	
Plasmalyte (mL)	700>	1000>	>	>	>	1000>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	1700	
Vancocycin(mg) / D5W			X																		0	
Magnesium Sulfate(gram) / D5W (mL)					100		100														200	
RBC (Blood Bank) (mL)	= 900	= 2100	= 1500	= 900	= 900	= 900	= 600	= 1500	= 900	= 600											10800	
RBC (Cell Saver) (mL)						650															650	
Cryoprecipitate (mL)					= 800					= 480											1280	
Fresh Frozen Plasma (mL)	300	= 900	= 1200	= 900	= 600	= 1200	= 1500	= 3300													9900	
Platelets (mL)			= 401	200					200	= 560											1361	
Voluven (6% hetastarch 130/0.4 in NS)			500																		500	
<b>Fluids OUT (mL)</b>																						
Urine			100																		100	



\*ANESTHESIA\*

Anesthesia/PACU Record

MRN: 002673589	Height(cm):
Name: SINGLETARY, SHELTON J.	Weight(kg): 99.99974
DOB: 09/10/1969	BMI:
PatCom: 496951732	Sex: Male
Surgeon: Crookes, Bruce	Age: 42 years

Surgery Date: 04/19/2012

TIME	1:45	2:00	2:15	2:30	2:45	3:00	3:15	3:30	3:45	4:00	4:15	4:30	4:45	5:00	5:15	5:30	Totals
<b>Medications</b>																	
Calcium Chloride 10% (mg) (IV)																	14000
Cefazolin (Ancef) (gram) (IV)																	2
Epinephrine (microgram) (IV)																	1328
Epinephrine (microgram) (IV)																	32
Factor Vlla (microgram) (IV)																	10000
Fentanyl (microgram) (IV)																	10000
Magnesium Sulfate (gram) (IV)																	4
Scopolamine (mg) (IV)																	0.4
Sodium Bicarbonate 8.4% (mEq) (IV)																	500
Vasopressin (unit) (IV)																	20
Vecuronium (mg) (IV)																	20
<b>Drips</b>																	
Epinephrine(microgram/kg/min) / D5W	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	0.15>	390
Norepinephrine (microgram/min)	30>	30>	30>	30>	30>	30>	30>	30>	30>	30>	30>	30>	30>	30>	30>	30>	909
Phenylephrine (microgram/kg/min)																	0
Phenylephrine(microgram/min) / Normal	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	200>	2618
<b>Fluids IN</b>																	
Lactated Ringers (mL)	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	1000
Plasmalyte (mL)	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	1700
Vancocycin(mg) / D5W																	0
Magnesium Sulfate(gram) / D5W (mL)																	200
RBC (Blood Bank) (mL)																	10800
RBC (Cell Saver) (mL)																	650
Cryoprecipitate (mL)																	1280
Fresh Frozen Plasma (mL)																	9900
Platelets (mL)																	1361
Voluven (6% hetastarch 1300.4 in NS)																	500
<b>Fluids OUT (mL)</b>																	
Urine																	100

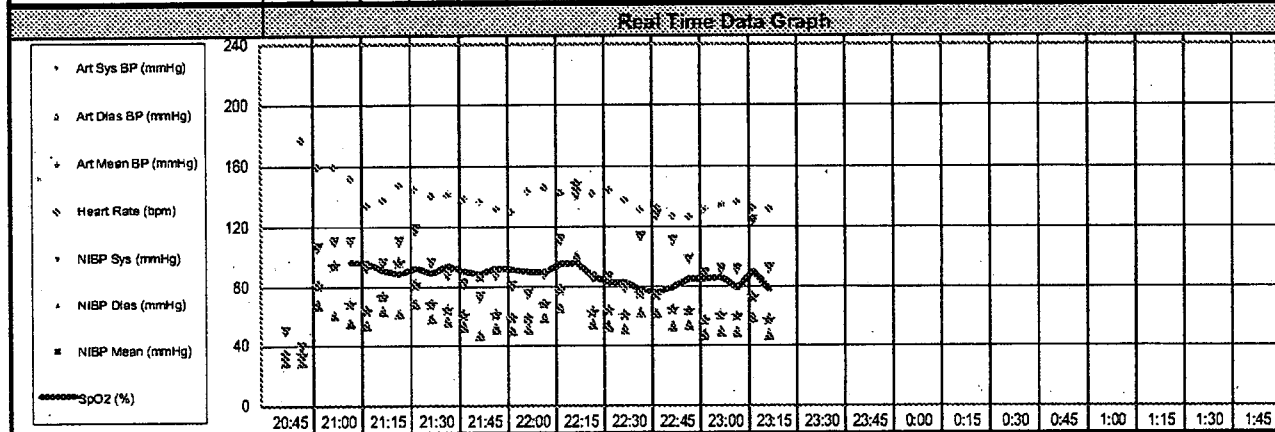


**\*ANESTHESIA\***  
**Anesthesia/PACU Record**

MRN: 002873589	Height(cm):
Name: SINGLETARY, SHELTON J.	Weight(kg): 99.9974
DOB: 09/10/1969	BMI:
PatCom: 496961732	Sex: Male
Surgeon: Crookes, Bruce	Age: 42 years

Surgery Date: 04/19/2012

Real Time Variables																						
TIME	20:45	21:00	21:15	21:30	21:45	22:00	22:15	22:30	22:45	23:00	23:15	23:30	23:45	0:00	0:15	0:30	0:45	1:00	1:15	1:30	1:45	
SpO2 (%)		100	89.9	96.4	97.6	91.4	83.6	74.6	84.4	78.3	77.4											
Temperature (°C)	35.59	35.5	35.36	35.21	35.18	35.15	35.2	35.26	35.03	34.93	34.89											
EKG Rhythm		ST	ST	ST	ST	ST	ST	ST	ST	ST	ST											
SpO2 Heart Rate bpm		124	147	141	131	148	143	138	134	138	123											
Vent Resp Rate/min		15	22	22	18	18	16	16	16	16	16											
FiO2 (%)	99	93	92	94	94	91	92	92	94	93.5	94											
EtCO2 (mmHg)	0	27	4	1	10	26	27	24	1	25	0											
Iso out (%)	0	0	0	0	0	0	0	0	0	0	0											
Exp. Tidal volume (mL)		509	515	538	652	663	689	665	672	662	757											



Laboratory Results																					
TIME	20:45	21:00	21:15	21:30	21:45	22:00	22:15	22:30	22:45	23:00	23:15	23:30	23:45	0:00	0:15	0:30	0:45	1:00	1:15	1:30	1:45
PH ARTERIAL		7.19	7.25		7.22		7.14							6.99							
PCO2 ARTERIAL		55	65		42		48							46							
PO2 ARTERIAL		206	42		44		59							47							
BICARB ARTERIAL		20.9	28.4		17.4		16.1							10.9							
TOTAL CO2 ARTERIAL		22.7	30.6		18.8		17.7							12.4							
O2 SAT ARTERIAL		99.3	82.6		86.9		93.6							86							
HCT WHL BLD ARTERIAL		12	25		20		26							7							
HGB WHL BLD ARTERIAL		3.6	8.1		6.2		8.5							1.9							
HA WHL BLD ARTERIAL		153	156		147		151							147							
K WHL BLD ARTERIAL		2.5	3.7		3.5		4.1							3.2							
IONIZED CA ARTERIAL		0.68	1.34		0.87		0.88							1.05							
GLU WHL BLD ARTERIAL		86	146		146		208							39							

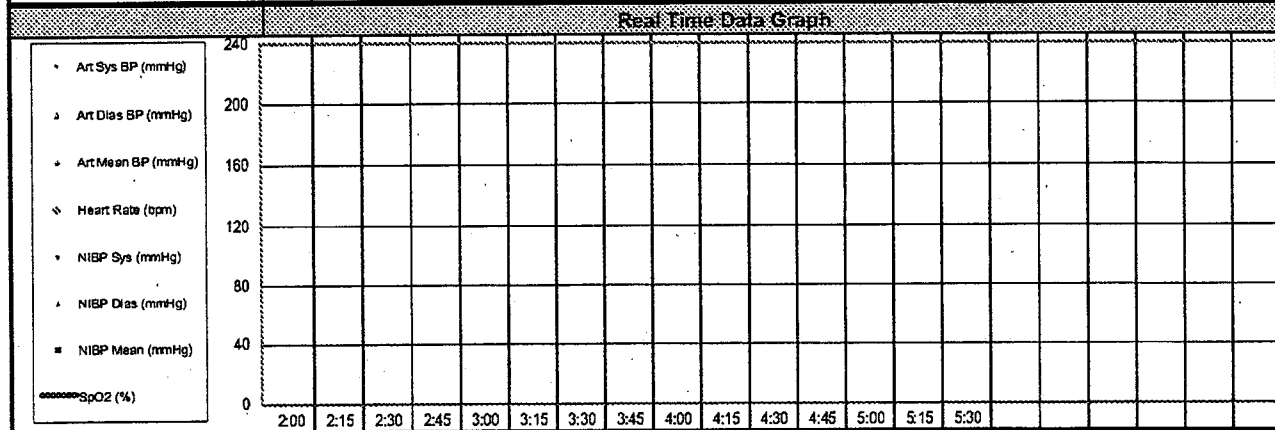


**\*ANESTHESIA\***  
**Anesthesia/PACU Record**

MRN: 002673589	Height(cm):
Name: SINGLETARY, SHELTON J.	Weight(kg): 99.9974
DOB: 09/10/1969	BMI:
PatCom: 496951732	Sex: Male
Surgeon: Crookes, Bruce	Age: 42 years

Surgery Date: 04/19/2012

Real Time Variables																	
TIME	2:00	2:15	2:30	2:45	3:00	3:15	3:30	3:45	4:00	4:15	4:30	4:45	5:00	5:15	5:30		
SpO2 (%)																	
Temperature (°C)																	
EKG Rhythm																	
SpO2 Heart Rate bpm																	
Vent Resp Rate/min																	
FiO2 (%)																	
EtCO2 (mmHg)																	
Iso out (%)																	
Exp. Tidal volume (mL)																	



Laboratory Results																	
TIME	2:00	2:15	2:30	2:45	3:00	3:15	3:30	3:45	4:00	4:15	4:30	4:45	5:00	5:15	5:30		
PH ARTERIAL																	
PCO2 ARTERIAL																	
PO2 ARTERIAL																	
BICARB ARTERIAL																	
TOTAL CO2 ARTERIAL																	
O2 SAT ARTERIAL																	
HCT WHL BLD ARTERIAL																	
HGB WHL BLD ARTERIAL																	
HA WHL BLD ARTERIAL																	
K WHL BLD ARTERIAL																	
IONIZED CA ARTERIAL																	
GLU WHL BLD ARTERIAL																	



**"ANESTHESIA"**  
**Anesthesia/PACU Record**

MRN: 002673589	Height(cm):
Name: SINGLETARY, SHELTON J.	Weight(kg): 99.9974
DOB: 09/10/1969	BMi:
PatCom: 496951732	Sex: Male
Surgeon: Crookes, Bruce	Age: 42 years

Surgery Date: 04/19/2012

Assessments			
04/19/2012 20:50 JRM	Pressure Points	•Supine - Checked	
04/19/2012 21:05 JRM	Pressure Points	•Supine - Checked	
04/19/2012 21:20 JRM	Pressure Points	•Supine - Checked	
04/19/2012 21:35 JRM	Pressure Points	•Supine - Checked	
04/19/2012 21:50 JRM	Pressure Points	•Supine - Checked	
04/19/2012 22:30 JRM	Pressure Points	•Supine - Checked	
Nursing Care			
PACU Score and/or FLACC Pain Scale			

MUSC Medical Center  
OPERATIVE NOTE

PATIENT NAME: SINGLETARY, SHELTON  
MRN: 002673589  
PATCOM: 496951732  
DATE OF SURGERY: 04/19/2012  
SERVICE: Surgery, Traumatic  
SURGEON: Bruce A Crookes, MD  
ASSISTANTS:

PREOPERATIVE DIAGNOSIS: Gunshot wound to the abdomen.

POSTOPERATIVE DIAGNOSES:

1. Left external iliac artery injury.
2. Ascending lumbar vein injury.
3. Small bowel injury x6.

PROCEDURES:

1. Repair of left external iliac artery.
2. Ligation of the ascending lumbar vein.
3. Small bowel resection x6.

CO-SURGEONS: Ralph Barker, MD

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: Massive.

FLUIDS: 19 units of packed red blood cells, 18 units of FFP, 2 units of platelets, 2 units of cryoprecipitate, 750 cc of Cell Saver, and 8 L of crystalloid.

SPECIMEN:

1. Bullet fragment.
2. Small bowel.

FINDINGS:

1. Left external iliac artery injury.
2. Ascending lumbar vein injury.
3. Multiple small bowel injuries with mesenteric tear.

COUNTS: Sponge and instrument count was incorrect. 10 packs were left in the patient's abdomen as well as 2 vessel loops.

DISPOSITION: The patient was discharged to the surgical trauma ICU in critical condition.

PREPROCEDURE HISTORY: This is an African-American male of unknown age who was brought in emergently to MUSC Medical Center with a single gunshot wound to the abdomen. The patient had been intubated in the field and came in with a systolic blood pressure of 123/62 and heart rate of 75. Of note, a left femoral pulse could not be identified in the patient. He was obviously hemodynamically unstable and had a base deficit of -13. After performing a chest x-ray in the emergency room and requiring IV access, the patient was brought emergently to the operating room for exploratory laparotomy for trauma.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and after proper identification placed supine on the operating

table. After the induction of general endotracheal anesthesia, the patient's chest, abdomen, and thighs were prepped and draped in standard surgical fashion. A midline incision was made utilizing a skin knife and dissection was carried down through the skin and subcutaneous tissue utilizing skin knife. The fascia was identified and divided utilizing skin knife. Upon entrance to the patient's abdomen, he was noted to have a massive amount of hemoperitoneum. The patient's 4 quadrants were rapidly packed as anesthesia infused fluids in order to maintain the patient's blood pressure. Each quadrant was then serially unpacked. The patient was noted to have minimal bleeding from his left upper quadrant, minimal bleeding from his right upper quadrant, multiple obvious small bowel injuries as well as massive hemorrhage from his left lower quadrant. The patient's upper abdomen was repacked. A Bookwalter retractor was brought into the field, and attention was turned towards the left lower quadrant. The left colon had been mobilized by a large hematoma in that area. The hematoma was opened as the small bowel colon reflected the patient's right-hand side. The patient was noted to have a left external iliac artery tangential injury causing massive blood loss in this area. The artery was carefully dissected free from the surrounding tissues and proximal and distal control were obtained utilizing 2 vessel loops. At this point, the patient was noted to have a 1-cm tangential artery injury. This was then repaired utilizing a running 4-0 Prolene suture. Prior to closing the stitch, the patient was back bled, fore bled, and back bled again, by releasing the vessel loops. The suture was then tied. Vascular control was then released and the patient was also noted to have a small injury measuring approximately 2 mm superior to the aforementioned 1-cm injury. Vascular control was then reobtained utilizing the vessel loops. This injury was then repaired utilizing a single figure-of-eight 4-0 Prolene suture. Vascular control was then relinquished by loosening the vessel loops although 2 vessel loops were loosely held in place utilizing vascular clamps. At this point, the patient was noted that path of the bullet was noted to pass posterior to the iliac artery and adjacent to the patient's left iliac vein. The patient's ascending lumbar vein was noted to be transected at this point. This was controlled utilizing vascular clips. There was noted to be bone bleeding back from the spine. A small bullet fragment was identified and passed off field as specimen although the actual bullet itself could not be fully identified. This wound was packed. Attention was then turned towards the remainder of the patient's abdomen. The patient's small bowel was run from the ligament of Treitz distal to the ileocecal valve. He was noted to have multiple mesenteric injuries all of which required serial clamping and tying with interrupted 2-0 silk sutures. The patient was noted to have at least 6 segments of small bowel, which were through-and-through injured and could not be primarily repaired. The patient's right colon, transverse colon, and left colon were again examined and noted to be without evidence of significant injury. There was noted to be a serosal tear in the patient's rectum, although at this point in time this did not require a formal repair.

At this point, attention was turned towards control of the patient's bowel spillage. At each of the 6 enterotomy sites, a proximal and distal defect was made in the antimesenteric surface of the small bowel. GIA staples were placed through these defects and then fired thus dividing these intervening segments. All 6 segments of small bowel were then formally resected. The intervening small bowel mesentery was then carefully clamped and divided utilizing a LigaSure vascular segment. Each segment of small bowel was passed off field as specimen. The bowel was left in discontinuity due to the patient's

hemodynamic instability. At this point, the packs were removed from the patient's abdomen and was carefully reexamined. The patient was noted to have no evidence of liver or gallbladder injuries. The patient's stomach appeared to be intact on the anterior surface. The lesser sac was not opened at this point in time based on patient's hemodynamic instability. His spleen and left upper quadrant appeared to be hemostatic. The small bowel resection appeared to be hemostatic. The colon appeared to be hemostatic. Examination of the vascular repair by the iliac artery noted a small amount of bleeding in the area of the left ureter. The ureter could not be identified at this point in time. A small venous bleed was identified in the medial surface of the distal portion of what was presumed to be the ureter. This was clamped and tied utilizing interrupted 3-0 silk ties. At this point, decision was made by myself to turn towards damage control procedure due to the patient's hemodynamic instability, his coagulopathy, his acidosis, and hypothermia. The patient's abdomen was packed with 10 laparotomy pads. The 2 vessel loops were left in place although not occluding in the patient's left iliac artery. The patient's left femoral artery was palpated prior to closure to ascertain that the femoral pulse was adequate. A Foley catheter was also inserted by myself and the patient is noted to have pink-tinged urine. A bowel bag was brought into the field and fenestrated and placed over the patient's small intestine. Two stab wound incisions were made in the patient's upper abdomen and 2 NG tubes were passed through the subcutaneous tissue utilizing Schnidt clamps. The ends of the NG tubes were wrapped and cleaned with blue towels and each NG tube was placed in paracolic gutter. The patient's occlusive dressing was applied over the patient's abdomen utilizing an Ioban gauze. The patient was then transferred from the operating room to the surgical trauma ICU in critical condition.

Please note that Dr. Crookes was present and scrubbed for the entire procedure.

Dictated by: Bruce A Crookes, MD

---

Bruce A Crookes, MD  
Surgeon

510549693/medq/

JOB: 1049284

DD: 04/19/2012 19:23:30

DT: 04/20/2012 10:01:02

Authenticated by BRUCE A. CROOKES, MD On 04/23/2012 07:58:16 AM

MUSC Medical Center  
OPERATIVE NOTE

PATIENT NAME: SINGLETARY, SHELTON  
MRN: 002673589  
PATCOM: 496951732  
DATE OF SURGERY: 04/19/2012  
SERVICE: Surgery, Traumatic  
SURGEON: Bruce A Crookes, MD  
ASSISTANTS:

PREOPERATIVE DIAGNOSIS: Gunshot wound to the abdomen with hemorrhagic shock.

POSTOPERATIVE DIAGNOSES: Gunshot wound to the abdomen with hemorrhagic shock..

PROCEDURE: Reopening of recent laparotomy.

CO-SURGEON: Dr. Leshner.

TYPE OF ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: Massive.

FLUIDS: 34 units of packed red blood cells, 35 units of FFP, 8 units of cryoprecipitate, 6 units of platelets, and 2 doses of factor VIIa.

FINDINGS: Include massive hemorrhage from a posterior spinal column with coagulopathic bleeding.

COMPLICATIONS: There were no complications.

DRAINS: There were no drains placed. The sponge and instrument counts were incorrect, 11 lap pads were left in the patient's abdomen.

DISPOSITION: The patient was discharged to Surgical Trauma ICU in a critical condition.

PREOPERATIVE HISTORY: This is an African American male of unknown age who was originally brought to the operating room for a gunshot wound to the abdomen on the day of 04/19/2012. There, he was found to have an iliac artery injury and multiple small bowel injuries. The iliac artery injury was easily controlled and fully repaired. The bullet was noted to pass lateral to the iliac artery and posterior to the spine. At that point in time, the patient's abdomen was packed and he was brought to the Surgical Trauma ICU for resuscitation. Within an hour of being in the ICU, the patient was found to have ongoing hemorrhage and be volume dependent. In light of these findings, he was brought back to the operating room for reopening of his laparotomy.

PROCEDURE IN DETAIL: The patient was brought to the operating room, and after proper identification, he was placed supine on the operating table. After induction of general endotracheal anesthesia, the patient's abdomen was prepped and draped in a standard surgical fashion. The patient's midline damage control dressing was taken down. The patient was found to have a large amount of blood clot in his abdomen. Attention was turned towards the left lower quadrant where he was found to have a large amount of blood which accumulated

rapidly. Previously placed vessel loops from the proximal and distal iliac artery repair were easily identified and pulled up. Thus, controlling iliac artery. There was noted to be no hemorrhage from the iliac artery itself. The iliac vein was mobilized laterally. The patient was noted to be bleeding from the deep recess lateral to the iliac vein and from the base of the bullet track passing up to the spine. This area was carefully examined, and there was noted to be no visible blood vessel which could be identified and ligated. Blood continued to well from this area, which was then packed with Gelfoam and pressure was applied, and it was allowed Anesthesia time to catch up. The patient was administered large volume of blood products at this point in time, which resulted in improvement of his pressure, and a decision was made by myself and the Anesthesia team to give the patient a dose of factor VIIa in light of the patient's ongoing coagulopathy and his worsening hemodynamic status. Once factor VIIa had infused and Anesthesia felt they caught up, the packs were removed. The patient was noted to have a massive bleeding again from the spinal area. The iliac vein was clamped utilizing Sinsky clamp, but the blood continued to well up in this area. The iliac artery again was retracted laterally as the iliac vein and artery were mobilized along the length to provide full expose of this area. There was noted to be a plexus of veins in this area which despite the attempts with multiple clips resulted in no cessation of the bleeding. It was felt that bleeding was secondary to coagulopathy and injury to the spinal column itself. The patient became increasingly stable during the course of this operation, had intermittent episodes of bradycardia with intractable acidosis. In light of these findings and in light of the fact that no surgical etiology for the bleed could be identified, a decision was made by myself to pack the patient and transfer him to the ICU for attempted rewarming. The area of the bleeding was packed with multiple patties of bone wax. 11 lap pads were applied over this area. The patient was given an additional dose of factor VIIa. Damage control dressing was then applied. A bowel bag was brought into the field and fenestrated and placed over the patient's intestines. Two NG tubes were passed through subcutaneous tissue and placed on either pericolic gutter. An Ioban gauze was applied to the patient's abdomen. The patient was then transferred from the operating room to the Surgical Trauma ICU in critical condition.

Please note that Dr. Crookes was present and scrubbed for the entire procedure.

Dictated by: Bruce A Crookes, MD

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Bruce A Crookes, MD  
Surgeon

510567931/medq/

JOB: 1049300

DD: 04/19/2012 23:19:28

DT: 04/20/2012 23:09:33

Authenticated by BRUCE A. CROOKES, MD On 04/23/2012 07:58:19 AM

Patient: SINGLETARY, SHELDON M

MRN: 2673589

Encounter: 496951732

Page 2 of 2



PATIENT REQUEST FOR CONFIDENTIALITY OF LOCATION INFORMATION

Akaman

This release of information form is intended to provide MUSC personnel, primarily switchboard and information desk staff, with your wishes on how you would prefer staff to respond to your visitors or callers.

If you sign this form, then Medical Center staff will not acknowledge that you are a patient at the Medical University Hospital or the Institute of Psychiatry to any caller or visitor nor will staff provide any information on how you can be reached in person or by phone. You or your family members may still provide this information to whomever you wish at



P:496951732 DOB:09/10/1989\_U\_M

SINGLETARY  
SHELTON

I TVJA

Adm:04/19/12 M:2673589

hereby request that the

staff of the Medical University Hospital and the Institute of Psychiatry not acknowledge my presence as a patient at the Medical Center or at the Institute of Psychiatry to any visitors or callers.

(Patient or Guardian)

4/19/12

(Date)

I \_\_\_\_\_, hereby request that the

(Patient or Guardian)

confidential status be removed from my record.

(Date)

I have explained this document to the patient or guardian and have received verbal acknowledgement from the patient or guardian that he or she fully understands the information contained in this document.

(Staff Member as Witness)

(Date)

White Copy - Hospital Patient Admissions  
Yellow Copy - Nursing Station

OTC NO. 801094 6/99



PATIENT REQUEST FOR CONFIDENTIALITY OF LOCATION INFORMATION

This release of information form is intended to provide MUSC personnel, primarily switchboard and information desk staff, with your wishes on how you would prefer staff to respond to your visitors or callers.

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I TVJA Bed 1, hereby request that the (print name)

staff of the Medical University Hospital and the Institute of Psychiatry not acknowledge my presence as a patient at the Medical Center or at the Institute of Psychiatry to any visitors or callers.

[Signature] (Patient or Guardian)

4/19/12 (Date)



P496951732 DOB:01/01/1900 M TRAUMA VICTIM JA Adm:04/19/12 M2673589

I, hereby request that the (Patient or Guardian) confidential status be removed from my record. (Date)

I have explained this document to the patient or guardian and have received verbal acknowledgement from the patient or guardian that he or she fully understands the information contained in this document.

[Signature] (Staff Member as Witness)

(Date)

White Copy - Hospital Patient Admissions Yellow Copy - Nursing Station

OTC NO. 801094 699

MUSC ANATOMIC PATHOLOGY  
DEPT OF PATHOLOGY/LAB MEDICINE  
165 ASHLEY AVE., SUITE 309  
PO BOX 250908  
CHARLESTON, SC 29425-0701

DIAGNOSIS:

A. SMALL INTESTINE, RESECTION:

BENIGN SMALL BOWEL SEGMENTS WITH MULTIPLE SITES OF PERFORATION AND SUBMUCOSAL AND SEROSAL HEMORRHAGE CONSISTENT WITH TRAUMA  
TOTAL RESECTION LENGTH = 53 CM

TISSUE SOURCE:

A. SM INT, RES, XT Small Bowel

CLINICAL DATA AND HISTORY:

None provided.

GROSS DESCRIPTION:

A. The specimen is received in formalin, labeled with the patient's name and hospital number with additional labeling as TRAUMA VICTIM JA. Specimen A is further identified as SMALL BOWEL per the requisition form. It is given an accession number. The specimen is unoriented. It consists of a long segment of tan to brown small bowel measuring approximately 53 cm in length with an average diameter of 2 cm. This long segment of bowel is divided into individual segments which have a stapled end on each bowel margin with all of the segments attached by the mesentery. Four perforations with jagged irregular edges are identified on the long segment of bowel. These perforations are associated with surrounding serosal hemorrhage as well as hemorrhage into the mesentery. One of the surgical edges of the long segment of small bowel has a stapled surgical margin which appears intact. The other edge possibly corresponding to a surgical margin is not stapled and is hemorrhagic with a jagged irregular opening. This area may have corresponded to a perforation. Additionally received in the bucket are four smaller segments of bowel measuring 7.2 x 6 x 1 cm in aggregate. These small segments of bowel range in size from 3 x 1.8 x 0.5 cm up to 5.5 x 2.5 x 1 cm. These smaller additional pieces also have irregular hemorrhagic edges and perforations. The stapled surgical margin of the large segment of small bowel is shaved and submitted in cassette A1. The hemorrhagic opening on the other end of the large segment of bowel is submitted in cassette A2. The bowel is opened to reveal a tan mucosal surface and lumen filled green semi-solid fecal material and red to brown hemorrhagic fluid. No masses or lesions are identified. Representative sections of the perforated areas are submitted in cassettes A3-A4. Representative sections of normal appearing bowel are submitted in cassette A5.

Cassette Summary:

A1: Intact stapled surgical margin  
A2: Hemorrhagic opening, ? surgical margin  
A3-A4: Representative sections of perforated areas  
A5: Normal appearing bowel

MICROSCOPIC DESCRIPTION:

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

CERTIFICATION STATEMENT:

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

Dictating: Daniel Teague, M.D./ RM

Attending: Daniel Teague, M.D. (Electronically signed by)

Verified: 04/24/2012 10:24

Name: Shelton Singletary

Age: 42 Sex: (M) F



MRN: \_\_\_\_\_ Acct #: \_\_\_\_\_

Temp: 97 Pulse: 67 BP: 123/62 RR: 18 Pulse Ox: 100% Wt: \_\_\_\_\_

P496951732 DOB: 01/01/1900 U

Provider: Malone Prov #: \_\_\_\_\_ Time Seen: EMT

TRAUMA  
VICTIM JA

Chief Complaint: gunshot wound inferior to xyphoid process

EAdm: 12/31/12 M2673589

HPI:

MODE OF ARRIVAL:  POV  Ambulance  Immobilized  
SOURCE:  Patient  Family Member  Friend  \_\_\_\_\_  
TIMING:  Began  Occurred  PTA \_\_\_\_\_ hrs ago \_\_\_\_\_ days ago  this morning  this afternoon  this evening  during the night  
 last night  yesterday  Gradual /  Sudden Onset

LOCATION OF INJURY:  None  Head  Face  Mouth  Neck  Chest  Back  Abdomen  Pelvis  
Right:  Shoulder  Humerus  Elbow  Forearm  Wrist  Hand  Hip  Thigh  Knee  Lower Leg  Ankle  Foot  
Left:  Shoulder  Humerus  Elbow  Forearm  Wrist  Hand  Hip  Thigh  Knee  Lower Leg  Ankle  Foot

CONTENT:  None Recent  Alcohol Use /  Illicit Drug Use  
TYPE OF ACCIDENT:  MVC  MCA  Peds vs. Auto  Assault  Other  
 MVC:  Unrestrained  Restrained ( Airbag /  Shoulder Strap /  Lap Belt)  Driver /  Passenger  
 Single Vehicle /  Multi Vehicle  Head-On Side Impact: ( Driver Side /  Passenger Side)  Rear Impact /  Roll-Over  
 Ambulatory At The Scene /  Non-Ambulatory /  Ejected

ASSAULT: Alleged Assailant's Name:  Unknown  
Method of Assault:  Punched  Kicked  Struck with Object GSW

PRE-HOSPITAL: GCS: 3T At Scene: \_\_\_\_\_ During Transport \_\_\_\_\_

INTERVENTION PRIOR TO ED:  None  IV  Splint  Intubation \_\_\_\_\_  
SEVERITY:  Mild  Moderate  Severe  Pain Free 1 2 3 4 5 6 7 8 9 10  Unable to quantify

DURATION OF SYMPTOMS: \_\_\_\_\_ Mins \_\_\_\_\_ Hrs \_\_\_\_\_ Days \_\_\_\_\_ Wks  Intermittent /  Continuous in Nature  Currently Present /  Absent  
MODIFYING FACTORS: A = Aggravated by R = Relieved by N = No change with (A R N) Nothing (A R N) C-Collar (A R N) Icepack  
(A R N) Lifting (A R N) Activity (A R N) Weight-bearing (A R N) Backboard (A R N) Immobilization  
(A R N) Movement (A R N) Splint (A R N) Medication(s): \_\_\_\_\_

ASSOCIATED SIGNS & SYMPTOMS: (+) = Report (-) = Denies  None (+) LOC (+) SOB (+) Bleeding (+ -) HA  
(+ -) Abdominal Pain (+ -) Back Pain (+ -) Neck Pain (+ -) Laceration (+ -) Chest Pain  
pt brought by EMS for GSW to chest. unresponsive. intubated on scene

Unable to obtain additional information from patient. Reason: pt intubated at scene ECP#: \_\_\_\_\_

ROS:  All Other Systems Reviewed And Negative (unless written or circled)  
CONST: Wt. Loss \_\_\_\_\_ Night Sweats \_\_\_\_\_ GI: \_\_\_\_\_ PSYCH: \_\_\_\_\_  
EYES: \_\_\_\_\_ unable to obtain \_\_\_\_\_ ENDO: \_\_\_\_\_  
ENT: \_\_\_\_\_ MS: \_\_\_\_\_ HEMA/LYMPH: \_\_\_\_\_  
CV: \_\_\_\_\_ SKIN: \_\_\_\_\_ ALL/IMMUN: \_\_\_\_\_  
RESP: \_\_\_\_\_ NEURO: \_\_\_\_\_ OTHER: \_\_\_\_\_

PAST MEDICAL/FAMILY/SOCIAL HISTORY:

PMH ALLERGIES:  NKDA  PCN  Sulfa  Codeine  Iodine / IVP Dye  
MEDICATIONS:  See Nurse's Note  
PAST/CURRENT ILLNESSES:  None  
SURGERIES/PROCEDURES:  None  Appy  
IMMUNIZATIONS:  UTD  Tetanus >5yrs  Tetanus >10yrs  
FH  Negative  
SH OCCUPATION: \_\_\_\_\_ LIVING SITUATION: \_\_\_\_\_  
HABITS: Alcohol Y N H/O Tobacco Y N H/O Drugs Y N H/O  Counseling Given

PHYSICAL EXAM:

CONSTITUTIONAL VITAL SIGNS:  Normal  Abnormal  Orthostatic APPEARANCE:  Well  Ill  Poor Hygiene / Grooming  
✓ Airway:  Normal  Intubated  Obstructed  
✓ Breathing:  Normal  Bagged  Agonal  
✓ Circulation:  Carotid Pulse Present  Pulseless thready pulses, but present throughout  
PSYCHIATRIC:  Normal intubated  
SKIN:  Normal 1 cm penetrating wound to upper abdomen right  
EYES:  Normal  Raccoon's Eye 2 mm 2 mm sluggish below xyphoid process  
H/F/ENT:  Normal  Hemotympany  Midface Instability  Malocclusion intubated poor wound bleeding

NAVIGATOR PC

ED RECORD  
MULTI-TRAUMA - MALE





P496951732 DOB:01/01/1900 U  
TRAUMA  
VICTIM JA  
EAdm:12/31/12 M2673589

THORAX/RESP:  Normal  Unequal Breaths  
 CV:  Normal  Tachycardic  Diminished Pulses  Hypotensive *bedside ultrasound - good*  
 ABDOMEN/GI:  Normal  Tender *Guaiac (+ -) @ rigid abdomen*  
 GU:  Normal *Distention normal cardiac function, EF > 40%*  
 MS (includes neck and back):  Normal  Neck Tenderness  Back Tenderness *as above*  
 RUE: 0/5 LUE: 0/5  
 RLE: 0/5 LLE: 0/5  
 HEMA/LYMPH:  Normal *FAST RUQ*  
 NEURO:  Normal  Lethargic  Obtunded  Disoriented  Focal Deficit GCS: 3T

MEDICAL DECISION MAKING:  Discussed with family  Old chart reviewed  Findings

DDX:  Skull Fx  Hemothorax  Flail Chest / Multiple Rib Fxs  General Aches  Pneumothorax  Solid Organ Injury  Diaphragmatic Rupture  Scapular Fx  
 Chest Contusion  Esophageal Rupture  Cervical Strain  Traumatic Aortic Dissection  Subdural Hematoma  Spine Injury  Hemorrhagic Shock

LAB PERFORMED:  Labs Essentially Normal Unless Noted Below  
 CBC: WBC Hg Hct Plts PT / PTT:      /       T&S  T&C  
 CHEMISTRIES: Na K Cl HCO3 BUN Cr Glu  
 URINALYSIS: pH SG Protein Glu WBCs RBCs Bacteria *trauma A panel*  
 ETOH:       URINE DRUG SCREEN *FAST @ RUQ*

EKG INTERPRETATION:  NSR  No ST Abnormality  
 Compared To EKG On      /      /     ;  No Significant Change  
 RHYTHM STRIP: PULSE OX INTERPRETATION:  Normal  Hypoxic

IMAGING:  C SPINES  Normal  
 CXR:  Normal  PTX  Rib Fx  Widened Mediastinum  
 ABD SERIES:  Normal  
 PELVIS X-RAY:  Normal  
 CT of Head:  Normal  
 CT of ABD / Pelvis:  Normal  
 Preliminary /  Read By Radiologist

ADDITIONAL PROCEDURES (Done by Physician):  NGT Insertion  Foley Insertion  ABG  See Procedure Note  See Addendum  
 Blood Transfusion  Venous Cutdown  Splint  Application /  Inspection  ABG  Vaso-Active Drips  
 IV Hydration /  IV Infusion /  Injection directly supervised by me. *RLNK bolus*

RE-EVALUATION: Time:       Improved  Worsened  No Change  
*Admit STICU -> to OR*  
*DX: GSW, respiratory failure*

CRITICAL CARE: I as ED Attending have spent      minutes in the direct care of this critically ill patient, excluding procedure time.  Comfort measures only  
 CONSULTATION: Dr:      @      Returned @     ; Dr:      @      Returned @       
 To See @  ED  Hospital  Office Rec.

ADMITTING TEAM:

ATTENDING PHYSICIAN NOTE:

HISTORY: *Scant exam. Sp GSW to epigastric area*  
*Tended by EMS. No response to anal.*  
 EXAM: *FAST @ - ribs clear. to OR - 2 Dr. Cr. U.*  
 MEDICAL DECISION MAKING:

FINAL IMPRESSION: GSW

DISPOSITION:  Discharge ( Improved /  Stable)  Admit OR  Transfer  AMA  LWT  LDT  DOA  ED Death  
 Prescriptions:      Follow-up:  PMD

I performed /  I was present for the H & P on the patient. I have discussed treatment / management options with the ( PA /  NP /  Resident /  Student).  
 I agree with the documented findings and the plan of care. Comments:  
 PA / ARNP:      DATE/TIME:       
 MD'S SIGNATURE:      DATE/TIME:     



ED RECORD  
MULTI-TRAUMA - MALE





\*PRGRECRD\*

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00  
Version: 4

Version Date: 2/10



P:496951732 DOB:09/10/1969 U M  
SINGLETARY  
SHELTON  
Adm:04/19/12 M:2673589

PATIENT IDENTIFICATION LABEL

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO <sub>4</sub>	MgSO <sub>4</sub>

Drug names will not be abbreviated (e.g., AZT, HCTZ, NEO)

Do not write a whole number with a trailing zero:

USE: 5 mg NOT: 5.0 mg

Write a decimal point with a leading zero:

USE: 0.5 mg NOT: .5 mg

Date	Time	
04/19/12	08:30 PM	<p><u>TRAUMA ATTENDING:</u></p> <p>Pt is anxious. Trauma team requirements and increased pressure requirements. pH 7.1</p> <p>Will bring back to OR for repeat exploratory case w/ PCS family (wife, mother, brothers).</p> <p>Critical Care Time: 35 min.</p> <p><i>[Signature]</i> Cramer</p>
04/19/12	12:16 PM	<p><u>TRAUMA ATTENDING:</u></p> <p>Wound arrival in ER, pt went into PEA.</p> <p>Wife family @ bedside, 3 rounds of CPR were carried out. During his 3<sup>rd</sup> arrest a defusing rhythm could not be obtained - Mr. Singletary was pronounced dead by MKEP @ 12:16 AM on 04/19/12. His family was present and was resuscitated.</p> <p>Total Critical Care Time: 75 min.</p> <p><i>[Signature]</i> Cramer - MKEP</p>

# 496951732



South Carolina  
PCR Form

Patient Care Report 18471930  
Shelton Singletary | Thu, Apr 19 2012 15:57:00

<b>Unit Agency</b>				
Agency Name and Number	Charleston County EMS (015)		Unit Response Number	-15
Incident Number	0363390		Primary Response Role	Transport
Type of Service Requested	911 Response (Scene)		Response Delay(s)	None
Dispatch Delay(s)	None	Scene Delay(s)	None	Turnaround Delay(s)
Vehicle	-15	Call Sign	M01	Vehicle Dispatch Location
Zone	GPS Location			

Odometer Start	Odometer at Scene	Odometer at Destination	Odometer End	Response Mode to Scene	Loaded Mileage
1	1	5	5	Lights and Sirens	4

<b>Unit Call</b>			
Complaint	Traumatic Injury	EMD Performed	Not Known
		EMD Card #	m1

<b>Crew</b>			
Role	Name	Local ID	Level
Primary Patient Caregiver	Weirick, Jamie Leigh	SC018623	EMT Paramedic
Secondary Patient Caregiver	Brown, Deborah Carolyn	SC014711	EMT Paramedic

<b>Patient</b>					
Name	Shelton -20 Singletary		Incident Date/Time	Thu, Apr 19 2012 15:54:00	
Home Address	2318 Odessa St -25 N4 -20		PSAP Date/Time	Thu, Apr 19 2012 15:54:00	
Home County	Not Recorded	SSN	000000000	Dispatch Notified Date/Time	Thu, Apr 19 2012 15:57:00
Home Country		Driver's License		Unit Notified Date/Time	Thu, Apr 19 2012 15:57:00
Gender	Male	Race	Black or African American	Unit Enroute Date/Time	Thu, Apr 19 2012 15:57:00
Ethnicity	Not Hispanic or Latino	Phone		Unit On Scene Date/Time	Thu, Apr 19 2012 16:06:00
Date of Birth		Age	35 Years	Unit at Patient's Side Date/Time	Thu, Apr 19 2012 16:07:00
				Patient Transferred Date/Time	
				Unit Left Scene Date/Time	Thu, Apr 19 2012 16:15:00
				Unit at Destination Date/Time	Thu, Apr 19 2012 16:28:00
				Unit Back in Service Date/Time	Thu, Apr 19 2012 16:50:00
				Unit Cancelled Date/Time	
				Unit Back at Home Date/Time	Thu, Apr 19 2012 16:51:00

<b>Billing</b>			
Primary Method of Payment	Self Pay	Cert. of Medical Necessity	Not Recorded
Patient's Occupational History	Not Applicable	Patient's Occupation	Not Recorded
Patient's Employer		Patient's Employer's Work Phone	
Patient's Employer's Address	null	Work Related	Not Recorded
Name of Closest Relative/Guardian	null	Closest Relative/Guardian Phone Number	
Closest Relative/Guardian Relationship	Not Recorded	Closest Relative/Guardian Street Address	
Response Urgency	Immediate	CMS Service Level	ALS, Level 1 Emergency
Condition Codes	Other Trauma (suspected internal injuries) (ALS-869.0)	ICD9 Code	INTERNAL INJURY TO UNSPECIFIED OR ILL-DEFINED ORGA
Condition Code Modifiers	Not Known		
Insurance Company Information			

<b>Scene</b>			
Other Agencies at Scene	SIERRA02	Other Services at Scene	Fire Law
Date/Time Differential Between Initial Responder and EMS Arrival	Not Recorded	Date/Time Initial Responder Arrived	
Number of Patients at Scene	Single	Mass Casualty Incident	No
Incident Facility Code		Incident Location Type	Home/Residence

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496951732

South Carolina  
PCR Form

Patient Care Report 18471930  
Shelton Singletary | Thu, Apr 19 2012 15:57:00

Incident Address 2318 Odessa St -20 GPS Coordinates  
Incident County Not Recorded Agency Zone

**Situation**  
Chief Complaint and Duration GSW Lasting 5 Minutes  
Secondary Complaint and Duration UNRESPONSIVE Lasting 5 Minutes  
Organ System of Complaint Not Known Anatomic Location of Complaint Chest  
Primary Symptom Change in responsiveness Other Symptoms Not Recorded  
Primary Impression 959.90-Traumatic Injury Secondary Impression Not Recorded  
Prior Aid Provider(s) EMS Provider Prior Aid Outcome Improved

**Situation Trauma**  
Injury? No Intent of Injury Not Applicable  
Cause of Injury Not Applicable Fall Height  
Mechanism(s) of Injury Not Applicable  
Vehicular injury indicator(s) Not Applicable Vehicle Impact Area(s) Not Applicable  
Patient Position in Seat Not Applicable Seat Row Location  
Safety Equipment in Use Not Applicable Airbag Deployment Not Applicable

**Situation CPR**  
Cardiac Arrest No Cardiac Arrest Etiology Not Applicable  
Resuscitation Attempts Not Applicable Cardiac Arrest Witness Not Applicable  
First Monitored Rhythm Not Applicable Return of Spontaneous Circulation Not Applicable  
Neurological Outcome at Discharge Not Recorded Time Patient Down Before EMS Response Not Applicable  
Date/Time CPR Discontinued Reason CPR Discontinued Not Applicable  
Cardiac Rhythms at Destination

**Patient Medical History**  
Barriers to Patient Care Unconscious Advance Directives Not Recorded  
Sending Facility Medical Record Number -20 Primary Practitioner Name null  
Destination Medical Record Number -20 Patient Pregnant? Not Recorded  
Medical History Source Not Recorded Alcohol or Drug Use Indicators Not Known  
Surgery History Emergency Form Present? Not Recorded  
Medication Allergies Unknown Immunization History  
Environmental Food Allergies Not Recorded

Current Medications Not Known ( Not Recorded Not Recorded)

**Narrative**  
Pt is a mid 30 y/o male. Pt has a single GSW entrance wound to his midline sternum. No noted exit wound. GCS 3. RTS 8. Per Sierra 2 first on scene pt was found supine on the ground and unresponsive with agonal respirations. Sierra 2 intubated the pt with a size 8 ET tube. Pt information is unknown. Pts head is atraumatic. Pupils are fixed and constricted at 2mm. Pt has no noted drainage from his eyes/nose/mouth. No noted JVD. No noted tracheal deviation. Pt has superior equal chest rise and fall. No noted sub-q air in the pt chest. Pt has bilateral breath sounds in his superior lobes. Noted diminished breath sounds in the inferior lobes. Pts abdomen is distended with noted guarding in all quadrants. Pts abdomen is hot to the touch. Pts pelvis is stable. Pts back is atraumatic with no noted deformity, bleeding, or sub-q air. Pts extremities are atraumatic. An occlusive dressing is placed on the pts entry wounds. Pt is then placed on the monitor showing sinus tachycardia. Pt is fully immobilized. Tube placement is reconfirmed with bilateral breath sounds. IV access is established in the pts right AC with 16 and is administered 1L of NS. IV access is established in the pts left AC with 18 and received 250cc of NS. Pt is monitored for any acute changes and is monitored and treated for shock. Pts GCS increased to 6 upon arrival. Vitals second BP was unable to read. Pts radial pulses got very thready.

496951732

South Carolina  
PCR Form

Patient Care Report 18471930  
Shelton Singletary | Thu, Apr 19 2012 15:57:00

Vital Signs Assessment												
Date/Time Vital Signs Taken					Thu, Apr 19 2012 16:07:00						Obtained Prior to this Unit's EMS Care	Yes
Blood Pressure	Heart Rate	Pulse Oximetry	Respiratory Rate	CO2 Level	Blood Glucose Level	GCS Eye	GCS Motor	GCS Verbal	Total GCS			
null/null						1	1	1	3			
Method of Blood Pressure	Not Recorded				GCS Qualifier	Not Recorded						
Respiratory Effort	Not Recorded				Electronic Monitor Rate							
Temperature (°C)					Temperature Method							
Level of Responsiveness	Unresponsive				APGAR Score							
Pain Scale					Stroke Scale	Not Recorded						
Pediatric Trauma Score					Revised Trauma Score	8						
Thrombolytic Screen	Not Recorded				Cardiac Rhythm	Not Applicable						
Date/Time Vital Signs Taken					Thu, Apr 19 2012 16:09:00						Obtained Prior to this Unit's EMS Care	No
Blood Pressure	Heart Rate	Pulse Oximetry	Respiratory Rate	CO2 Level	Blood Glucose Level	GCS Eye	GCS Motor	GCS Verbal	Total GCS			
null/null	111		10									
Method of Blood Pressure	Not Recorded				GCS Qualifier	Not Recorded						
Respiratory Effort	Labored				Electronic Monitor Rate							
Temperature (°C)					Temperature Method							
Level of Responsiveness	Not Recorded				APGAR Score							
Pain Scale					Stroke Scale	Not Recorded						
Pediatric Trauma Score					Revised Trauma Score							
Thrombolytic Screen	Not Recorded				Cardiac Rhythm	Not Recorded						
Date/Time Vital Signs Taken					Thu, Apr 19 2012 16:13:00						Obtained Prior to this Unit's EMS Care	No
Blood Pressure	Heart Rate	Pulse Oximetry	Respiratory Rate	CO2 Level	Blood Glucose Level	GCS Eye	GCS Motor	GCS Verbal	Total GCS			
127/97	107		12	22		1	1	1	3			
Method of Blood Pressure	Automated Cuff				GCS Qualifier	Not Recorded						
Respiratory Effort	Labored				Electronic Monitor Rate							
Temperature (°C)					Temperature Method							
Level of Responsiveness	Unresponsive				APGAR Score							
Pain Scale					Stroke Scale	Not Recorded						
Pediatric Trauma Score					Revised Trauma Score							
Thrombolytic Screen	Not Recorded				Cardiac Rhythm	Sinus Tachycardia						
Date/Time Vital Signs Taken					Thu, Apr 19 2012 16:26:00						Obtained Prior to this Unit's EMS Care	No
Blood Pressure	Heart Rate	Pulse Oximetry	Respiratory Rate	CO2 Level	Blood Glucose Level	GCS Eye	GCS Motor	GCS Verbal	Total GCS			
null/null	100		12	29		4	1	1	6			
Method of Blood Pressure	Not Recorded				GCS Qualifier	Not Recorded						
Respiratory Effort	Labored				Electronic Monitor Rate							
Temperature (°C)					Temperature Method							
Level of Responsiveness	Not Recorded				APGAR Score							
Pain Scale					Stroke Scale	Not Recorded						
Pediatric Trauma Score					Revised Trauma Score							
Thrombolytic Screen	Not Recorded				Cardiac Rhythm	Normal Sinus Rhythm						

Injury Assessment										
External/Skin										
Head										
Face										
Neck										
Thorax										
Abdomen										
Spine										
Upper Extremities										
Pelvis										
Lower Extremities										
Unspecified										

Exam Assessment											
Estimated Body Weight (kg)					91		Broselow/Luten Color				Not Recorded

496951732

South Carolina  
PCR Form

Patient Care Report 18471930  
Shelton Singletary | Thu, Apr 19 2012 15:57:00

Date/Time of Assessment	Head/Face	Neck	Chest/Lungs
Skin	Not Applicable	Not Applicable	Not Applicable
Heart	Abdomen Left Upper	Abdomen Left Lower	Abdomen Right Upper
Not Applicable	Not Applicable	Not Applicable	Not Applicable
Abdomen Right Lower	GU	Back Cervical	Back Thoracic
Not Applicable	Not Applicable	Not Applicable	Not Applicable
Back Lumbar/Sacral	Extremities Right Upper	Extremities Right Lower	Extremities Left Upper
Not Applicable	Not Applicable	Not Applicable	Not Applicable
Extremities Left Lower	Eyes Left	Eyes Right	Mental Status
Not Applicable			
Neurological Assessment			
Not Applicable			

**Intervention Protocols**  
Protocols Used

**Intervention Medications and Procedures**

Functional IV Sites Forearm-Right  
Forearm-Left

Initial Tube Confirmations

Destination Confirmations of Tube Placements

Date/Time of Procedure	Procedure Name	Size of Equipment	Successful?	Number of Attempts	Complications	Procedure Performed Prior to Unit's EMS Care	No
Thu, Apr 19 2012 16:07:00	Wound Care	-25	Yes	1	None		No
	Response	Authorization	Personnel Performing Procedure		Authorizing Physician		
	Unchanged	Not Recorded	Weirick, Jamie Leigh		-25		
Thu, Apr 19 2012 16:08:00	Cardiac Monitor	-25	Yes	1	None		No
	Response	Authorization	Personnel Performing Procedure		Authorizing Physician		
	Unchanged	Not Recorded	Weirick, Jamie Leigh		-25		
Thu, Apr 19 2012 16:09:00	Spinal Immobilization	-25	Yes	1	None		No
	Response	Authorization	Personnel Performing Procedure		Authorizing Physician		
	Unchanged	Not Recorded	Weirick, Jamie Leigh		-25		
Thu, Apr 19 2012 16:09:00	Spinal Immobilization	-25	Yes	1	None		No
	Response	Authorization	Personnel Performing Procedure		Authorizing Physician		
	Unchanged	Not Recorded	Weirick, Jamie Leigh		-25		
Thu, Apr 19 2012 16:12:00	Venous Access-Extremity	16.0	Yes	1	None		No
	Response	Authorization	Personnel Performing Procedure		Authorizing Physician		
	Unchanged	Not Recorded	Weirick, Jamie Leigh		-25		
Thu, Apr 19 2012 16:14:00	Venous Access-Extremity	16.0	Yes	1	None		No
	Response	Authorization	Personnel Performing Procedure		Authorizing Physician		
	Unchanged	Not Recorded	Brown, Deborah Carolyn		-25		
	Procedure Name	Size of Equipment	Successful?	Number of Attempts	Complications	Procedure Performed Prior to Unit's EMS Care	Yes
	Spinal Immobilization	-25	Yes	1	Not Reporting		
	Response	Authorization	Personnel Performing Procedure		Authorizing Physician		
	Not Applicable	Not Recorded			-25		
Date/Time of Medication Administered	null					Medication Administered Prior to Unit's EMS Care	Not Recorded
Medication Given	Dosage and Units					Administration Route	Personnel Administering Medication
Not Applicable						Not Recorded	
Response	Complications					Medication Authorization	Authorizing Physician
Not Recorded	Not Applicable					Not Recorded	

**Disposition**

Disposition Treated, Transported by EMS Reason for Choosing Specialty Resource Center

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496951732

South Carolina  
PCR Form

Patient Care Report 18471930  
Shelton Singletary | Thu, Apr 19 2012 15:57:00

Destination Name	MUSC - Medical University of South Carolina	Destination Code	F00004807
Destination Street Address	169 Ashley Avenue 99019 SC 294258905	Destination Type	Hospital
GPS Location		Destination County	Charleston
How Patient Was Moved To Ambulance	Not Recorded	Zone	
Position of Patient During Transport	Not Recorded	How Patient Was Moved From Ambulance	Not Recorded
Transport Mode From Scene	Lights and Sirens	Transport Mode From Scene	Lights and Sirens
		Condition of Patient at Destination	Unchanged

<b>Outcome and Linkage</b>		
Patient Disposition from Hospital	Not Recorded	Fire Incident Report Number
Patient Disposition from Emergency Dept.	Not Recorded	Law Enforcement Crash Report Number
Patient ID Band Tag Number	-25	
Trauma Registry ID	-20	

<b>Miscellaneous</b>		
Does Form Need Review?	Not Recorded	Potential Registry Candidate
Protective Equipment Used	Not Applicable	Suspected Disaster Cause(s)
Suspected Contact With Bodily Fluids?	Not Applicable	Reportable Condition?
Type of Exposure	Not Applicable	Person Exposed
Additional Research		
Report Author	Brown, Deborah Carolyn	

**Signatures**

Crew Member Signature \_\_\_\_\_

Treatment Authorized by Signature \_\_\_\_\_

Patient Received by Signature \_\_\_\_\_

Medical Control Signature \_\_\_\_\_

**Data Quality: 5**  
 -20 is not a valid county code for Patient's Home County E06\_06  
 -10 is not a valid county code for Incident County E08\_13  
 Crew Member -25 not recognized as valid Technician Id. E19\_09  
 Incident address is missing City E08\_12  
 Incident address is missing State E08\_14



\*RADIOREQST\*  
**TRAUMA SURVEY RADIOLOGY REQUEST FORM**  
 Phone: 843-792-9729  
 Fax: 843-792-9364

Form Origination Date: 2/08  
 Version: 2

Version Date: 9/09



P496951732 DOB:01/01/1900 U  
**TRAUMA**  
**VICTIM JA**  
 EAdm:12/31/12 M2673589

PATIENT IDENTIFICATION LABEL

**Request Type:**

- New Study**  
 **Reinterpretation of outside films**

**Use "Pan scan single pass technique" (CT Angio neck/CT Chest/CT Abdomen/CT Pelvis)**  
 (Requires attending trauma surgeon signature prior to scan)

- HEAD:** Indication(s)
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Head / Brain CT Scan          | <input type="checkbox"/> Head / Brain MRI                             | <input type="checkbox"/> CT Angio of Cerebral Vessels                               |
| <input type="checkbox"/> Coma                          | <input type="checkbox"/> Transient alteration of awareness            | <input type="checkbox"/> Altered mental status                                      |
| <input type="checkbox"/> Penetrating injury            | <input type="checkbox"/> No written report of outside films available | <input type="checkbox"/> Need for urgent expert reinterpretation of outside studies |
| <input type="checkbox"/> Syncope and collapse          |   |   |
| <input type="checkbox"/> Acute head pain due to trauma |   |   |
| <input type="checkbox"/> Other: _____                  |   |   |

- FACE:** Indication(s)
- |  |   |
|--|---|
| <input type="checkbox"/> Facial CT Scan                          | <input type="checkbox"/> Facial Series  |
| <input type="checkbox"/> Cerebrospinal fluid otorrhea/rhinorrhea | <input type="checkbox"/> Injury of face   |
| <input type="checkbox"/> Penetrating injury                      | <input type="checkbox"/> No written report of outside films available               |
| <input type="checkbox"/> Acute facial pain due to trauma         | <input type="checkbox"/> Need for urgent expert reinterpretation of outside studies |
| <input type="checkbox"/> Other: _____                            |   |

- NECK:** Indication(s)
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cervical Spine CT Scan        | <input type="checkbox"/> Soft Tissue Neck CT Scan                                   | <input type="checkbox"/> CT Angio of Cervical Vessels |
| <input type="checkbox"/> Cervical Spine Series         | <input type="checkbox"/> C. Spine Soft Tissue Series                                |   |
| <input type="checkbox"/> Acute neck pain due to trauma | <input type="checkbox"/> Injury of neck   |   |
| <input type="checkbox"/> Paralysis                     | <input type="checkbox"/> No written report of outside films available               |   |
| <input type="checkbox"/> Penetrating injury            | <input type="checkbox"/> Need for urgent expert reinterpretation of outside studies |   |
| <input type="checkbox"/> Other: _____                  |   |   |

- CHEST:** Indication(s)
- |  |  |                              |                             |   |
|--|--|------------------------------|-----------------------------|---|
| <input type="checkbox"/> CXR                                       | <input checked="" type="checkbox"/> AP                               | <input type="checkbox"/> Lat | <input type="checkbox"/> PA | <input type="checkbox"/> Chest CT   |
| <input checked="" type="checkbox"/> Acute chest pain due to trauma | <input type="checkbox"/> Mediastinal hematoma (abnormal mediastinum) |                              |                             | <input type="checkbox"/> Respiratory insufficiency                                  |
| <input type="checkbox"/> Injury of chest wall                      | <input type="checkbox"/> Paralysis                                   |                              |                             | <input type="checkbox"/> No written report of outside films available               |
| <input type="checkbox"/> Pain in thoracic spine                    | <input type="checkbox"/> Hemothorax / Pneumothorax                   |                              |                             | <input type="checkbox"/> Need for urgent expert reinterpretation of outside studies |
| <input type="checkbox"/> Penetrating injury                        |  |                              |                             |   |
| <input type="checkbox"/> Other: _____                              |  |                              |                             |   |

- ABD/PELVIS:** Pelvis  AP  I/O  Judet  Lat
- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Abdomen / Pelvis CT                | <input type="checkbox"/> Abdomen CT Only  | <input type="checkbox"/> Pelvis CT Only | <input type="checkbox"/> CT Cystogram |
| <input type="checkbox"/> Acute abdominal pain due to trauma | <input type="checkbox"/> Acute pelvic pain due to trauma                            |   |                                       |
| <input type="checkbox"/> Paralysis                          | <input type="checkbox"/> Pain in joint involving pelvic region / thigh              |   |                                       |
| <input type="checkbox"/> Pain in lumbar spine               | <input type="checkbox"/> Hematuria  |   |                                       |
| <input type="checkbox"/> Penetrating injury                 | <input type="checkbox"/> Intra-abdominal hemorrhage                                 |   |                                       |
| <input type="checkbox"/> Hemorrhagic shock                  | <input type="checkbox"/> No written report of outside films available               |   |                                       |
| <input type="checkbox"/> Pelvis fracture                    | <input type="checkbox"/> Need for urgent expert reinterpretation of outside studies |   |                                       |
| <input type="checkbox"/> Other: _____                       |   |   |                                       |

**OTHER:** \_\_\_\_\_ Indication: \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Contrast Allergy      | <input type="checkbox"/> Respiratory Isolation needed |
| <input type="checkbox"/> Premedication Ordered | <input type="checkbox"/> Contact Isolation needed     |
| <input type="checkbox"/> Creatinine _____      | <input type="checkbox"/> Possible Pregnancy           |

ACCESSION # **6651340**  
 TECHNOLOGIST \_\_\_\_\_  
 COMPLETION DATE / TIME \_\_\_\_\_

Requesting Provider: Dr. Lancaster

Attending Physician: Dr. Crookes  
 (if different from requestor) Last Name, First Name

Pager ID _____	Phone _____	Date <u>04/19/12</u>	Time _____
Pager ID _____	Phone _____	Date <u>04/19/12</u>	Time _____

ah\_critcare\_1w\_request\_traumaradrequest

OTE 700319 Rev. 9/09

GSW to abdomen

Technologist: ROBERT BECK  
Radiologist 1: STEPHEN SCHABEL  
Radiologist 2:  
Radiologist 3:

Transcribed by: Tech IntTalk  
Date Dictated:  
Proxy Signer:  
Authenticating Radiologist: STEPHEN SCHABEL  
Date Authenticated: 04/20/2012 07:30

EXAMINATION: CHEST 04/19/12 20:33:00

ACCESSION NUMBER: 6651436

INDICATION: assess ET placement for respiratory failure GSW to abdomen

COMPARISON: 4 19 12 .

FINDINGS: Single frontal radiograph of the chest demonstrates no change size and contour of the cardiomeastinal silhouette endotracheal tube and nasogastric tube/ The lungs show bilateral patchy air space opacities worse in the lung base right likely areas of atelectasis. Otherwise , lungs and Bones structures are unchanged..

IMPRESSION:

1. patchy bilateral lung opacities likely atelectasis

VOICE DICTATED BY: Dr. STEPHEN M.D. SCHABEL

TRAUMA/GSW

\  
\

Technologist: ELIZA DOOLEY  
Radiologist 1: STEPHEN SCHABEL  
Radiologist 2: WILLIAM WEATHERS  
Radiologist 3:

Transcribed by: Tech IntTalk  
Date Dictated:  
Proxy Signer:  
Authenticating Radiologist: STEPHEN SCHABEL  
Date Authenticated: 04/19/2012 16:52

EXAMINATION: CHEST 04/19/12 16:32:00

ACCESSION NUMBER: 6651340

INDICATION: TRAUMA/GSW TRAUMA/GSW

COMPARISON: None

FINDINGS: Single frontal view of the chest demonstrates a cardiomediastinal silhouette that is within normal limits. No evidence of focal air space disease, effusions or pneumothorax. Endotracheal tube overlies the tracheal air column. No acute bony abnormalities.

IMPRESSION:

1. No evidence of acute cardiopulmonary disease. Recommend upright PA and lateral when patient is off backboard.

VOICE DICTATED BY: Dr. William Weathers  
I have reviewed the study and agree with the findings in this report.

Therapies Performed:  
Therapist In Attendance,  
ABG,  
Ventilator / Day,  
Manual Ventilation (15 min),  
Patient Transport w/ CO2 Detector  
Trauma

Therapist in attendance for trauma. Patient manually ventilated with 100% oxygen. Arterial blood gas sample obtained from right brachial artery. The sample obtained was 1.5 ml or less. Patient on 100 percent oxygen. Site held for less than 5 minutes, no bleeding. No complications noted. Patient placed on mechanical ventilator. See ventilator flowsheet. Patient transported to nursing unit. A carbon dioxide detector was utilized during transport. 45 minutes spent at patient bedside.

Signed by: Julie A. Wood, RRT, RCP4/19/2012 6:41:11 PM

Therapies Performed:  
Cuff Pressure Check,  
Ventilator / Day,

Patient receiving mechanical ventilation via Servo i. See ventilator flowsheet for complete documentation of ventilator settings. Manual resuscitator and mask on at bedside at 10 L/min at 1.0 FiO2. SpO2: 90 %. Endotracheal cuff pressure = 30 centimeters of water pressure (cmH2O). ST attending aware of low saturations, switched patient over to Bivent.

Signed by: Matthew Yeager, CRT, RRT4/20/2012 1:56:02 AM

Therapies Performed:  
Patient Transport w/o CO2 Detector

Patient transported on mechanical ventilator. A carbon dioxide detector was not utilized during transport. SpO2: 90 %.

Signed by: Matthew Yeager, CRT, RRT4/20/2012 1:58:31 AM

Therapies Performed:  
Therapist In Attendance,  
Mayday,  
Manual Ventilation (15 min),

Therapist in attendance for "Mayday". Patient manually ventilated with 100% oxygen. 1 hour spent at patient bedside.

Signed by: Matthew Yeager, CRT, RRT4/20/2012 1:59:28 AM



"VENTDOC"

Ventilator Flowsheet for ALL Conventional Modes PLUS BiVent & HFOV - Adult

Page 1 of 2

Form Origination Date: 1/03  
Version: 7

Version Date: 7/11



P:496951732 DOB:09/10/1969 U M  
SINGLETARY  
SHELTON  
Adm:04/19/12 M:2673589

PATIENT IDENTIFICATION LABEL

Dx: CEW Date: 4-11-12 Ventilator: SENDI #59 Ventilator day #: 1  
Airway type / size: 5.0 ETT @ 5 cm Placement:  Left  Center  Right  Nasal  Sutured KEY: BiVent

Time	1000	1110	1115	1118	1135
Mode	PRVC		(Pront)	Pr	Pr
Tidal Volume / PIP set / P High	500		25	77	77
RR set / Spont RR	16	1	14		
Exhaled Tidal Volume	522		509		
Spontaneous Tidal Volume					
Minute Volume	3.4		6.6		
Peak pressure / MAP	35	11	35	22	
HFOV: Delta (Δ) P / Power					
HFOV: Frequency / Insp Time %	X		X		back
HFOV: Bias Flow					from
PEEP / Auto PEEP	5	0	11		OR
Pressure Support					
FiO2 Set / Analyzed	.40	.40	.40	.40	
Flow / Insp time	10				
T High / T PEEP			25	06	vent
Insp:Exp Ratio	1:2.6		1:3.1		Y0
Sensitivity / Plateau Pressure	HT	22	HT		
Compliance (Static / Dynamic)	26	26			0.1
Pressure Limit Hi / Low	50		50		
Minute Volume Hi / Low	10	3	10	3	
Alarms Audible %	100%		100%		
Circuit Temperature	4 ME		4 ME		
Heart Rate	111		109		
Blood Pressure	111/36		105/45		
SpO2 / EtCO2	92%		92%		
Suction: Quantity					
Consistency					
Color					
Cuff Pressure / Supraglottic sx	30		30		
ABG Time					
pH / Pco2					
PO2 / HCO3					
SaO2					
Initials	MY	MY	MY	MY	MY

Weaning Parameters:

Time \_\_\_\_\_ RR \_\_\_\_\_ Minute Volume \_\_\_\_\_ Tidal Volume \_\_\_\_\_ RSBI \_\_\_\_\_ NIF \_\_\_\_\_  
ah\_all\_docu\_adultventdoc OTE 700055 Rev. 7/11



SINGLETARY, SHELTON  
 MUSC  
 Chaplain Services  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 18:18  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:  
 Page: 1

FLWSHEET	04/20
Chaplain Svcs	02:07
Type of Visit	death &
Referred by	chapln initiated
Plan of Care	no f/up needed
04/20/12 02:07 Type of Visit(GMH): Pt passed, but chaplain was not called as family has multiple clergy members.	
CARE PROVIDERS	GMH

HUGGINS, GERIG M(GMH)CHAPLAIN

LAST PAGE

SINGLETARY, SHELTON MR:002673589 ID:496951732 DOB:09/10/1969 - Chaplain Services  
 ROOM: \*478F-12\* Page: 1



orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 16:37 TO: 04/20/12 08:08

SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MFC: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

ALLERGY						
Charted	Allergy name	Type	Reaction	Severity	Comment	
04/19 17:11	NO ALLERGY INFORMATION AVAILABLE	Drug Allergy				

**DIAGNOSIS**  
 (Unknown)

**BB**

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
9	New	Type and Crossmatch	ONCE	ROUTINE	1 Occr	04/19 16:45	04/19 16:45

Ordered by: CC SYSTEM, ID  
 Entered by: CC SYSTEM, ID - 04/19/12 16:45  
 Modified by: CC SYSTEM, ID - 04/19/12 16:45  
 Mode: Written

**DIAG**

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
103	Cancelled	DIAG: Chest 1 View	ONCE	STAT	1 Time	04/19 20:17	04/19 20:20

Ordered by: JEWETT, BRENT M  
 Entered by: JEWETT, BRENT M - 04/19/12 20:17  
 Modified by: CC SYSTEM, ID - 04/19/12 20:20  
 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:10  
 Mode: Direct  
 Is the patient pregnant?: No  
 Is isolation required?: No  
 Should this test be portable?: Yes  
 Clinical history: gsv to abdomen  
 Indication for Test: assess placement of new left subclavian central line and assess for right pneumothorax

102	Cancelled	DIAG: Chest 1 View	ONCE	STAT	1 Time	04/19 20:16	04/19 20:20
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Ordered by: RES JORDAN, MARY  
 Entered by: RES JORDAN, MARY - 04/19/12 20:17  
 Modified by: CC SYSTEM, ID - 04/19/12 20:20  
 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:10  
 Mode: Direct  
 Is the patient pregnant?: No  
 Is isolation required?: No  
 Should this test be portable?: Yes  
 Clinical history: s/p central line placement  
 Indication for Test: s/p central line placement

67	Complete	DIAG: Chest Portable 1 View	ONCE	STAT	1 Time	04/19 19:15	04/19 19:15
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Ordered by: JEWETT, BRENT M  
 Entered by: JEWETT, BRENT M - 04/19/12 19:16  
 Modified by: BECK, ROBERT - 04/19/12 20:33  
 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:10  
 Mode: Direct  
 Is the patient pregnant?: No  
 Is isolation required?: No  
 Should this test be portable?: Yes  
 Clinical history: GSW to abdomen  
 Indication for Test: assess ET placement for respiratory failure

2	Complete	DIAG: Chest Portable 1 View	ONCE	ROUTINE	1 Occr	04/19 16:35	04/19 16:35
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Ordered by: FERRELL, CASSANDRA  
 Entered by: FERRELL, CASSANDRA - 04/19/12 16:35  
 Modified by: FERRELL, CASSANDRA - 04/19/12 16:39  
 Mode: Written

**DTY**

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
45	D/C'd	NPO Diet	MEAL	ROUTINE		04/19 19:15	Indefinite

Ordered by: JEWETT, BRENT M  
 Entered by: JEWETT, BRENT M - 04/19/12 19:16  
 Modified by: , - 04/20/12 08:07  
 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:10  
 Mode: Direct

CONTINUED

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SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:09

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
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GLAB

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
130		Complete Glucose PCX, Whole Blood (POCT) Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/20/12 07:43 Modified by: CC SYSTEM, ID - 04/20/12 07:43 Mode: Written	ONCE	ROUTINE	1 Occr	04/19 19:04	04/19 19:04
129		Complete Arterial Blood Gas, Long Panel (OR Lab) (ABGL) 99 Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/20/12 00:09 Modified by: CC SYSTEM, ID - 04/20/12 00:13 Mode: Written	ONCE	STAT	1 Occr	04/20 00:05	04/20 00:05
126		Complete PTT Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 22:25 Modified by: CC SYSTEM, ID - 04/19/12 22:43 Mode: Written	ONCE	STAT	1 Occr	04/19 22:20	04/19 22:20
125		Complete Platelet Count Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 22:25 Modified by: CC SYSTEM, ID - 04/19/12 22:38 Mode: Written	ONCE	STAT	1 Occr	04/19 22:20	04/19 22:20
124		Complete Arterial Blood Gas, Long Panel (OR Lab) (ABGL) 99 Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 22:24 Modified by: CC SYSTEM, ID - 04/19/12 22:26 Mode: Written	ONCE	STAT	1 Occr	04/19 22:20	04/19 22:20
121		Complete Arterial Blood Gas, Long Panel (OR Lab) (ABGL) 99 Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 21:55 Modified by: CC SYSTEM, ID - 04/19/12 21:57 Mode: Written	ONCE	STAT	1 Occr	04/19 21:50	04/19 21:50
118		Complete Arterial Blood Gas, Long Panel (OR Lab) (ABGL) 99 Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 21:27 Modified by: CC SYSTEM, ID - 04/19/12 21:29 Mode: Written	ONCE	STAT	1 Occr	04/19 21:27	04/19 21:27
117		Complete Fibrinogen Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 21:11 Modified by: CC SYSTEM, ID - 04/19/12 21:40 Mode: Written	ONCE	STAT	1 Occr	04/19 21:00	04/19 21:00
116		Complete PTT Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 21:11 Modified by: CC SYSTEM, ID - 04/19/12 21:40 Mode: Written	ONCE	STAT	1 Occr	04/19 21:00	04/19 21:00
115		Complete Prothrombin Time (PT) / INR Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 21:11 Modified by: CC SYSTEM, ID - 04/19/12 21:40 Mode: Written	ONCE	STAT	1 Occr	04/19 21:00	04/19 21:00
114		Complete Platelet Count Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 21:11 Modified by: CC SYSTEM, ID - 04/19/12 21:41 Mode: Written	ONCE	STAT	1 Occr	04/19 21:00	04/19 21:00

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SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 09:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 09:08

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
113	complete	Arterial Blood Gas, Long Panel (OR Lab) (ABGL) 99	ONCE	STAT	1 Occr	04/19 21:00	04/19 21:00
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 21:11 Modified by: CC SYSTEM, ID - 04/19/12 21:17 Mode: Written					
101	complete	Arterial Blood Gas, Short Panel (OR Lab) (ABGS) 99	ONCE	STAT	1 Occr	04/19 19:44	04/19 19:44
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 19:49 Modified by: CC SYSTEM, ID - 04/19/12 19:54 Mode: Written					
95	complete	Phosphorus, Serum	ONCE	STAT	1 Occr	04/19 18:19	04/19 18:19
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 19:23 Modified by: CC SYSTEM, ID - 04/19/12 19:53 Mode: Written					
72	complete	Fibrinogen	ONCE	STAT	1 Time	04/19 19:17	04/19 19:17
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: CC SYSTEM, ID - 04/19/12 19:54 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:11 Mode: Direct					
71	complete	PIT	ONCE	STAT	1 Time	04/19 19:17	04/19 19:17
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: CC SYSTEM, ID - 04/19/12 19:57 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:11 Mode: Direct					
65	complete	Magnesium, Serum	ONCE	STAT	1 Time	04/19 19:15	04/19 19:15
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: CC SYSTEM, ID - 04/19/12 19:53 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:11 Mode: Direct					
64	complete	Prothrombin Time (PT) / INR	ONCE	STAT	1 Time	04/19 19:15	04/19 19:15
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: CC SYSTEM, ID - 04/19/12 19:45 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:11 Mode: Direct					
63	complete	Metabolic Panel, Basic - BMP	ONCE	STAT	1 Time	04/19 19:15	04/19 19:15
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: CC SYSTEM, ID - 04/19/12 19:53 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:11 Mode: Direct					
62	complete	CBC	ONCE	STAT	1 Time	04/19 19:15	04/19 19:15
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: CC SYSTEM, ID - 04/19/12 19:38 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:11 Mode: Direct					
25	complete	Arterial Blood Gas, Long Panel (OR Lab) (ABGL) 99	ONCE	STAT	1 Occr	04/19 18:30	04/19 18:30
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 18:32 Modified by: CC SYSTEM, ID - 04/19/12 18:35 Mode: Written					
24	complete	Lactate - Blood Gas, Whole Blood (OR Lab) (Lac WB) 99	ONCE	STAT	1 Occr	04/19 18:02	04/19 18:02
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 18:10 Modified by: CC SYSTEM, ID - 04/19/12 18:16 Mode: Written					

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SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
23	Complete	Arterial Blood Gas, Long Panel (OR Lab) (ABGL) 99	ONCE	STAT	1 Occr	04/19 18:02	04/19 18:02
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 18:08 Modified by: CC SYSTEM, ID - 04/19/12 18:16 Mode: Written					
22	Complete	Lactate - Blood Gas, Whole Blood (OR Lab) (Lac WB) 99	ONCE	STAT	1 Occr	04/19 17:45	04/19 17:45
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 17:51 Modified by: CC SYSTEM, ID - 04/19/12 17:55 Mode: Written					
21	Complete	CBC	ONCE	ROUTINE	1 Occr	04/19 17:51	04/19 17:51
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 17:51 Modified by: CC SYSTEM, ID - 04/19/12 18:07 Mode: Written					
20	complete	Arterial Blood Gas, Long Panel (OR Lab) (ABGL) 99	ONCE	STAT	1 Occr	04/19 17:45	04/19 17:45
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 17:51 Modified by: CC SYSTEM, ID - 04/19/12 17:55 Mode: Written					
19	Complete	Lactate - Blood Gas, Whole Blood (OR Lab) (Lac WB) 99	ONCE	STAT	1 Occr	04/19 17:19	04/19 17:19
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 17:24 Modified by: CC SYSTEM, ID - 04/19/12 17:26 Mode: Written					
18	Complete	Arterial Blood Gas, Long Panel (OR Lab) (ABGL) 99	ONCE	STAT	1 Occr	04/19 17:19	04/19 17:19
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 17:24 Modified by: CC SYSTEM, ID - 04/19/12 17:26 Mode: Written					
17	Complete	Fibrinogen	ONCE	STAT	1 Occr	04/19 16:57	04/19 16:57
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 17:13 Modified by: CC SYSTEM, ID - 04/19/12 17:37 Mode: Written					
16	Complete	PTT	ONCE	STAT	1 Occr	04/19 16:57	04/19 16:57
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 17:13 Modified by: CC SYSTEM, ID - 04/19/12 17:46 Mode: Written					
15	Complete	Prothrombin Time (PT) / INR	ONCE	STAT	1 Occr	04/19 16:57	04/19 16:57
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 17:13 Modified by: CC SYSTEM, ID - 04/19/12 17:37 Mode: Written					
14	Complete	Platelet Count	ONCE	STAT	1 Occr	04/19 16:57	04/19 16:57
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 17:13 Modified by: CC SYSTEM, ID - 04/19/12 17:25 Mode: Written					
13	Complete	Lactate - Blood Gas, Whole Blood (OR Lab) (Lac WB) 99	ONCE	STAT	1 Occr	04/19 16:57	04/19 16:57
		Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 17:13 Modified by: CC SYSTEM, ID - 04/19/12 17:21 Mode: Written					

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SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496551732 MFR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
12		Complete Arterial Blood Gas, Long Panel (OR Lab) (ABGL) 99 Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 17:12 Modified by: CC SYSTEM, ID - 04/19/12 17:21 Mode: Written	ONCE	STAT	1 Occr	04/15 16:57	04/19 16:57
8		Complete Arterial Point Of Care Panel Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 16:44 Modified by: CC SYSTEM, ID - 04/19/12 16:44 Mode: Written	ONCE	ROUTINE	1 Occr	04/15 16:41	04/19 16:41
7		Complete Alcohol, Ethyl Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 16:43 Modified by: CC SYSTEM, ID - 04/19/12 17:07 Mode: Written	ONCE	STAT	1 Occr	04/15 15:37	04/19 15:37
6		Complete CBC Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 16:43 Modified by: CC SYSTEM, ID - 04/19/12 16:52 Mode: Written	ONCE	ROUTINE	1 Occr	04/15 16:43	04/19 16:43
5		Complete Metabolic Panel, Basic - BMP Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 16:43 Modified by: CC SYSTEM, ID - 04/19/12 17:07 Mode: Written	ONCE	STAT	1 Occr	04/15 15:37	04/19 15:37
4		Complete PTT Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 16:43 Modified by: CC SYSTEM, ID - 04/19/12 17:01 Mode: Written	ONCE	STAT	1 Occr	04/15 15:37	04/19 15:37
3		Complete Prothrombin Time (PT) / INR Ordered by: CC SYSTEM, ID Entered by: CC SYSTEM, ID - 04/19/12 16:43 Modified by: CC SYSTEM, ID - 04/19/12 17:02 Mode: Written	ONCE	STAT	1 Occr	04/15 15:37	04/19 15:37
90	D/C'ed	PTT Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:22 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:10 Mode: Direct	Q 4 HOJRS	ROUTINE		04/15 19:20	04/20 01:05
89	D/C'ed	Fibrinogen Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:22 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:10 Mode: Direct	Q 4 HOJRS	ROUTINE		04/15 19:19	04/20 01:05
88	D/C'ed	Prothrombin Time (PT) / INR Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:22 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:11 Mode: Direct	Q 4 HOJRS	ROUTINE		04/15 19:19	04/20 01:05
87	D/C'ed	Phosphorus, Serum Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:22 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:10 Mode: Direct	Q 4 HOJRS	ROUTINE		04/15 19:19	04/20 01:05
86	D/C'ed	Magnesium, Serum Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:22 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:10 Mode: Direct	Q 4 HOJRS	ROUTINE		04/15 19:19	04/20 01:05

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orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08

SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 18:18  
 AGE 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:06  
 OPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
85	D/C'ed	Metabolic Panel, Basic - BMP	Q 4 HOURS	ROUTINE		04/15 19:19	04/20 01:05
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:22 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:10 Mode: Direct					
84	D/C'ed	CBC	Q 4 HOURS	ROUTINE		04/15 19:18	04/20 01:05
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:22 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:10 Mode: Direct					

HEO

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
29	D/C'ed	CONDITION:: Critical	CONTIN	ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Mode: Direct Condition: Critical					

NSG

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
66	New	Blood Gas with Ionized Calcium	ONCE	STAT	1 Time	04/19 19:15	04/19 19:15
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: JEWETT, BRENT M - 04/19/12 19:18 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:11 Mode: Direct Details: Complete Red laboratory request card and label container with form fast label. Deliver form and specimens to the fourth floor OR Lab. Select Short or Long Panel: Short Panel					
38	New	IMMUNIZATION:: For pt. with open wounds, confirm administration of tetanus vaccine given prior to ICU admission. If not given, contact physician to complete Adult Immunization Order Form	ONCE	ROUTINE	1 Time	04/19 19:15	04/19 19:15
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: JEWETT, BRENT M - 04/19/12 19:18 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details: For pt. with open wounds, confirm administration of tetanus vaccine given prior to ICU admission. If not given, contact physician to complete Adult Immunization Order Form					
37	New	CORE MEASURES:: Complete the Adult Pneumococcal Screening in Clindoc if indicated, administer Pneumococcal Vaccine. Send RxComm to pharmacy to receive dose or to discontinue if patient does not meet criteria or refuses dose.	ONCE	ROUTINE	1 Time	04/19 19:15	04/19 19:15
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: JEWETT, BRENT M - 04/19/12 19:18 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details: Complete the Adult Pneumococcal Screening in Clindoc if indicated, administer Pneumococcal Vaccine. Send RxComm to pharmacy to receive dose or to discontinue if patient does not meet criteria or refuses dose.					

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orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:09

SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:09  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MFC: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
36	New	CORE MEASURES:: Complete the Adult Influenza Screening in clindoc if indicated, administer Influenza Vaccine. Send RxComm to pharmacy to receive dose or to discontinue if patient does not meet criteria or refuses dose.	ONCE	ROUTINE	1 Time	04/19 19:15	04/19 19:15
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: JEWETT, BRENT M - 04/19/12 19:18 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details: Complete the Adult Influenza Screening in clindoc if indicated, administer Influenza Vaccine. Send RxComm to pharmacy to receive dose or to discontinue if patient does not meet criteria or refuses dose.							
33	New	CORE MEASURES:: pt. education <<Recent smoker >> have patient watch the Get Well network video	<<ONCE	ROUTINE	1 Time	04/19 19:15	04/19 19:15
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: JEWETT, BRENT M - 04/19/12 19:18 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details: pt. education << Recent smoker >> have patient watch the Get Well network video							
107	D/C'ed	PROTOCOL: Titration Instructions: << Norepinephrine - for MAP > 60 >> : : : :	DO	ROUTINE		04/19 20:33	Indefinite
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 20:33 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details: << Norepinephrine - for MAP > 60 >>							
105	D/C'ed	PROTOCOL: Titration Instructions: << vasopressin - for MAP > 60 >> : : : :	DO	ROUTINE		04/19 20:30	Indefinite
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 20:30 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:13 Mode: Direct Details: << vasopressin - for MAP > 60 >>							
92	D/C'ed	PROTOCOL: Titration Instructions: << PHENYLEphrine - 180 >> : : : :	DO	ROUTINE		04/19 19:22	Indefinite
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:22 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:13 Mode: Direct Details: << PHENYLEphrine - 180 >>							
77	D/C'ed	PROTOCOL: Hypoglycemia: ( see details )	PRN	ROUTINE		04/19 19:18	Indefinite
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct * Refer to the Hypoglycemia - Adult protocol at Orders/Nursing Protocols. details: ( see details ) Details: Give 4 glucose tablets ( 4 gm/tablet ) PO per hypoglycemia protocol ( Fast Sixteen First ) Details: Administer dextrose 50% by intravenous push as per hypoglycemia							

CONTINUED

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orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08

SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE 42Y SEX M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
protocol							
Details: Administer glucagon intramuscularly as per hypoglycemia protocol							
75	D/C'ed	MONITOR: Finger Stick by GlucoseAS Meter: now and Q1H	DIRECTED	ROUTINE		04/19 19:18	Indefinite
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details (how often, etc.): now and Q1H							
74	D/C'ed	Target Glucose, Range --: 80-110 PRN mg /dL ** Starting Multiplier 0.03	PRN	ROUTINE		04/19 19:18	Indefinite
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:13 Mode: Direct Range --: 80-110 mg /dL ** Starting Multiplier 0.03							
73	D/C'ed	Insulin Infusion Monitoring: ( See Details )	PRN	ROUTINE	1 Time	04/19 19:18	04/20 01:05
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct See Details below Details: ( See Details ) 4.: Hang insulin, flush line, and then waste additional 20 mL of insulin solution for initial bag and all IV tubing changes. ...: (Primary IV fluid and insulin solution to be run through separate pump channels, insulin solution to be attached to tubing access closest to patient.) 5.: Start insulin infusion on pump at rate determined by the IV Insulin Infusion Calculator: <a href="https://www.musc.edu/medcenter/nursing/insulin-drip-calculator/index.htm">https://www.musc.edu/medcenter/nursing/insulin-drip-calculator/index.htm</a> 6.: Use the MUSC Web-based IV Insulin Infusion Calculator to change the rate as ordered: <a href="https://www.musc.edu/medcenter/nursing/insulin-drip-calculator/index.htm">https://www.musc.edu/medcenter/nursing/insulin-drip-calculator/index.htm</a> ...: Note: The insulin dose must be recalculated every time FSBG is checked with the latest result, even if the multiplier does not change. ...: Note: If patient is eating PO, Resident / Fellow will write for subcutaneous insulin to cover carbohydrate intake. 8.: Initiate Hypoglycemia Prevention and Treatment Standing Orders 9.: Obtain Serum Glucose if FSBG is less than 40 mg / dL or if FSBG is greater than 350 mg / dL							
60	D/C'ed	PROTOCOL: Initiate STICU Glucose Management guideline:	CONTINUOUS	ROUTINE		04/19 19:15	Indefinite
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct							
59	D/C'ed	PROTOCOL: Initiate STICU hypothermia reversal guideline:	CONTINUOUS	ROUTINE		04/19 19:15	Indefinite
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct							

CONTINUED

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orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:09

SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:09  
 ROOM: \*478F-12\* ADM: 04/19/12 18:18  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1989 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
58	D/C'ed	Initiate Clinical Protocol:: << CONTINUOUS Initiate ICU electrolyte protocol >>		ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Enter Protocol: << Initiate ICU electrolyte protocol >>					
55	D/C'ed	Adult Ventilator Management:: (see details)	AS DIRECTED	ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct obtain chlorhexidine gluconate 0.12% from central supply ...: (see details) Details: - ABC 30 min. after initial vent setting - Mouthcare Q2H and PRN - Brush teeth BID - Lacrilube to both eyes BID and Q1H PRN dry eyes - Supraglottic suctioning if hi-lo evac endotracheal tube in place - Scrub ETT and oral surfaces w/ chlorhexidine glucon					
54	D/C'ed	NOTIFY: Critical Care Resident for 2 bgl >110 mg/dL OR 1 bgl >140 mg/dL	PRN	ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details: Critical Care Resident for 2 bgl >110 mg/dL OR 1 bgl >140 mg/dL					
53	D/C'ed	MONITOR: Finger stick by GlucoseQ4H Neter:		ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct					
52	D/C'ed	SAFETY: HOB: elevate 30 degrees	CONTINUOUS	ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details: elevate 30 degrees					
51	D/C'ed	MSG: Spinal Protection: Log Roll Only	CONTINUOUS	ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Select all that apply: Log Roll Only					
50	D/C'ed	APPLY: Sequential Compression Devices:: Bilateral : Knee High	CONTINUOUS	ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Select: Bilateral Select Type: Knee High					

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orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 16:37 TO: 04/20/12 08:08

SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
49	D/C'ed	MONITOR: << - ECG - Pulse ox - CONTINUOUS Art line * Temp probe >>		ROUTINE		04/19 23:59	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:13 Mode: Direct Nurse Instructions: Monitor Details: << - ECG - Pulse ox - Art line * Temp probe >>					
48	D/C'ed	Notify Physician: ( see details PRN )		ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details: ( see details ) SBP: < 90 or > 180 mm Hg DBP: < 45 or > 110 mm Hg HR: < 50 or > 110 BPM Temp: < 95 or > 100.4 F RR: < 8 or > 25 breaths/min If SaO2: < 92% If Telemetry alarms: < 50 or > 100 BPM If Urine Output: < 30 mL/hr If Pain Score: > 6 If ICP: > 20 mmHG, sustained for 5 min If Nausea / Vomiting: New Onset					
47	D/C'ed	TUBES/DRAINS: Nasogastric Tube Placement / Management: << To continuous low suction; >>	CONTINUOUS	ROUTINE		04/19 23:59	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:13 Mode: Direct Details: << To continuous low suction; >>					
46	D/C'ed	TUBES/DRAINS: Foley Catheter: to gravity drainage	CONTINUOUS	ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:13 Mode: Direct Details: to gravity drainage					
44	D/C'ed	ACTIVITY: Out of Bed Ad Lib:	CONTINUOUS	ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:11 Mode: Direct					
43	D/C'ed	ASSESS: Weight	QAM	ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct					
42	D/C'ed	I&O: Intake and Output:	CONTINUOUS	ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct << Strict >> Q1H					

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SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:09

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
41	D/C'ed	ASSESS: Neuro Checks: << Q1H >>	CONTINUOUS	ROUTINE		04/19 19:15	Indefinite
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details: << Q1H >>							
40	D/C'ed	ASSESS: Vascular Checks: << Q1H >>	CONTINUOUS	ROUTINE		04/19 19:15	Indefinite
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details: << Q1H >>							
39	D/C'ed	VITAL SIGNS: Q1H :	CONTINUOUS	ROUTINE		04/19 19:15	Indefinite
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details (Frequency, etc.): Q1H							
26	D/C'ed	NOTIFICATION PARAMETERS: InsulinPRN Infusion: ( see details ) :		ROUTINE		04/19 19:18	Indefinite
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , 04/20/12 08:07 Acknowledge: RN STRAHAN, ERIN - 04/19/12 21:12 Mode: Direct Details: ( see details ) ***: Notify Service Resident / Fellow if: ***: Four occurrences of FSBG greater than 200 after the first 4 hours of running the insulin solution ***: Patient requires greater than 25 units / hour of insulin ***: Two serial FSBG less than 70 mg / dL, or one FSBG > 350 mg /dL ***: Patient is scheduled for surgery ***: Other physicians order insulin ( SC, IV, or in PN ) or turn off insulin infusion for any reason							

REG

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
31	New	Referring Physician: MUSC - -	ONCE	ROUTINE	1 Time	04/19 19:15	04/19 19:15
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: JEWETT, BRENT M - 04/19/12 19:18 Mode: Direct Referring Physicians: MUSC - -							
30	New	Attending: Crookes	ONCE	ROUTINE	1 Time	04/19 19:15	04/19 19:15
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: JEWETT, BRENT M - 04/19/12 19:18 Mode: Direct Attending Name And Pager ID: Crookes							
27	New	SERVICES: STICU	ONCE	ROUTINE	1 Time	04/19 19:15	04/19 19:15
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: JEWETT, BRENT M - 04/19/12 19:18 Mode: Direct Service Line or Team: STICU							

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SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 08/10/1989 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:09

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
32	D/C'ed	DIAGNOSIS:: GSW to abdomen	CONTIN	ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Mode: Direct Diagnosis: GSW to abdomen					
28	D/C'ed	Admission Status:: Inpatient	CONTINUOUS	ROUTINE		04/19 19:15	Indefinite
		Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: , - 04/20/12 08:07 Mode: Direct Admission Status: Inpatient					

**RX**

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
122	New	FACTOR VIIA RECOMBINANTFACTOR VIIA RECOMBINANT (10000MCG)/SYRINGE (1EACH)	ONCE	ROUTINE	4 Hours	04/19 23:00	04/20 02:59
		Ordered by: MD CROOKES, BRUCE Entered by: KETCHAM, KATHLEEN - 04/19/12 22:24 Modified by: KETCHAM, KATHLEEN - 04/19/12 22:24 Mode: Written Dose (include unit of measure. Ex: MG, MICROGRAM, etc.) (Do not exceed 45 characters): 10000 MCG Route: IV RxComment 1: **TIME MED LABEL** **FOR IV BOLUS ADMINISTRATION ONLY** **GIVE SLOWLY OVER 2 TO 5 MINUTES** ***SEE ENCLOSED STICKER FOR PRESCRIBER CODING ALERT***					
119	New	FACTOR VIIA RECOMBINANTFACTOR VIIA RECOMBINANT (10000MCG)/SYRINGE (1EACH)	ONCE	ROUTINE	4 Hours	04/19 22:00	04/20 01:59
		Ordered by: MD CROOKES, BRUCE Entered by: STAFFID, GRH6 - 04/19/12 21:31 Modified by: STAFFID, GRH6 - 04/19/12 21:31 Mode: Written Dose (include unit of measure. Ex: MG, MICROGRAM, etc.) (Do not exceed 45 characters): 10000 MCG Route: IV RxComment 1: **TIME MED LABEL** **FOR IV BOLUS ADMINISTRATION ONLY** **GIVE SLOWLY OVER 2 TO 5 MINUTES** ***SEE ENCLOSED STICKER FOR PRESCRIBER CODING ALERT***					
108	Canceled	NOREPINEPHRINE INJ [ LEVOPHED ]: 4 MCG/MIN: IV		STAT		04/19 20:34	04/19 20:34
		Reason for action: Discontinued/Replaced Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 20:33 Modified by: JEWETT, BRENT M - 04/19/12 20:34 Mode: Direct Dose: 4 MG Rate: (Range is 0.5 - 80 MCG/MIN): 4 MCG/MIN Route: IV Ingredient: **PHARMACY: Change base solution to NS/250 and then type QS in dose (to 250mL)**					
106	Canceled	VASOPRESSIN INJ [ PITRESSIN ]: 0.04 UNITS/MIN: IV		STAT		04/19 20:36	04/19 20:36
		Reason for action: Discontinued/Replaced Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 20:30 Modified by: JEWETT, BRENT M - 04/19/12 20:36 Mode: Direct Dose: 100 UNIT Rate: 0.04 UNITS/MIN Route: IV					

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orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08

SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:19  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOS: 09/10/1989 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop	
		Ingredient: **PHARMACY: Change base solution to NS/100 and then type QS in dose (to 100mL)**						
91	Canceled	PHENYLEPHRINE INJ [ NEO-SYNEPHRINE ]: 180 MCG/MIN: IV	180 MCG/MIN	NEXT SCH		04/19 19:25	04/19 19:25	
		Reason for action: Discontinued/Replaced Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:22 Modified by: JEWETT, BRENT M - 04/19/12 19:25 Mode: Direct Dose: 160 MG Rate: 180 MCG/MIN Route: IV Ingredient: **PHARMACY: Change the base solution to NS/250 and then type QS in dose (to 250mL) to maximally concentrate**						
76	Canceled	INSULIN REGULAR HUMAN DRIP [ NOVOLIN R ]: IV	0	STAT		04/19 19:20	04/19 19:20	
		Reason for action: Discontinued/Replaced Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: JEWETT, BRENT M - 04/19/12 19:20 Mode: Direct Target Glucose Range 80-110 mg /dL ** Starting Multiplier 0.03 Rate: 0 Dose: 100 unit Route: IV						
69	Canceled	LORAZEPAM DRIP [ ATIVAN ]: 1 MG/HR: IV	1 MG/HR	NEXT SCH		04/19 19:22	04/19 19:22	
		Reason for action: Discontinued/Replaced Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: JEWETT, BRENT M - 04/19/12 19:22 Mode: Direct To achieve and maintain a RASS score of 0 to -3. Do not exceed 5mg/hr total infusion + boluses Dose: 40 MG Rate: 1 MG/HR Route: IV						
34	Canceled	INFLUENZA TRI-SPLIT VACCINE INJ: ONCALL 0.5 ML: IM		NEXT SCH		04/19 19:20	04/19 19:20	
		Reason for action: Discontinued/Replaced Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: JEWETT, BRENT M - 04/19/12 19:20 Mode: Direct Dose: 0.5 ML Route: IM Dose Type: MAINTENANCE						
127	D/C'ed	NOREPINEPHRINE INJ [ LEVOPHED ] [NOREPINEPHRINE INJ [ LEVOPHED ] (4MG)/SODIUM CHLORIDE 0.9% INJ (246ML)	QBAG	ROUTINE	4 Hours	04/19 23:00	04/19 23:01	
		Ordered by: MD CROOKES, BRUCE Entered by: STAFFID, GRH6 - 04/19/12 22:57 Modified by: STAFFID, GRH6 - 04/19/12 23:01 Mode: Written Dose: 4 MG Route: IV RxComment 1: >>NURSING: HIGH ALERT!!!<< *EQUIVALENT TO LEVOPHED* FINAL CONCENTRATION = 16 MICROGRAMS/ML						

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FERM

orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08

SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
111	D/C'ed	VASOPRESSIN INJ [ PITRESSIN ] VASOPRESSIN INJ [ PITRESSIN ] (100UNIT)/SODIUM CHLORIDE 0.9% INJ (95ML)	QBAG	ROUTINE	5 Hours	04/19 20:30	04/20 01:05
Ordered by: JEWETT, BRENT M Entered by: STAFFID, TER9 - 04/19/12 20:36 Modified by: STAFFID, ADT - 04/20/12 04:56 Mode: Written Dose: 100 UNIT Route: IV Infusion Instructions: **NOTE: Base solution is NaCl 0.9%** FINAL CONCENTRATION = 1 UNIT/ML							
109	D/C'ed	NOREPINEPHRINE INJ [ LEVOPHED ] NOREPINEPHRINE INJ [ LEVOPHED ] (4MG)/NOREPINEPHRINE INJ [ LEVOPHED ] (4MCG/MIN) (+)	4 MCG/MIN	ROUTINE	5 Hours	04/19 20:32	04/20 01:05
Ordered by: JEWETT, BRENT M Entered by: STAFFID, TER9 - 04/19/12 20:34 Modified by: STAFFID, ADT - 04/20/12 04:56 Mode: Written Dose: 4 MG Rate: (Range is 0.5 - 80 MCG/MIN): 4 MCG/MIN Route: IV Infusion Instructions: **NOTE: Base solution is NaCl 0.9%** FINAL CONCENTRATION = 16 MICROGRAM/ML							
104	D/C'ed	PIPERACILLIN - TAZOBACTAM INJ [ Q8HA ZOSYN ]: 4.5 GM: IV : **PREMIX-DO NOT ADD ANYTHING TO BAG** **REFRIGERATE** INFUSE OVER 4 HOURS		STAT	5 Hours	04/19 20:26	04/20 01:05
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 20:26 Modified by: STAFFID, ADT - 04/20/12 04:56 Mode: Direct Dose: 4.5 GM Route: IV RxComment 1: **PREMIX-DO NOT ADD ANYTHING TO BAG** **REFRIGERATE** INFUSE OVER 4 HOURS							
98	D/C'ed	SODIUM CHLORIDE 0.9% SODIUM CHLORIDE 0.9% (20ML)/LORAZEPAM DRIP [ ATIVAN ] (40MG) (+)	DEMAND	ROUTINE	5 Hours	04/19 20:00	04/20 01:05
Ordered by: JEWETT, BRENT M Entered by: STAFFID, KML3 - 04/19/12 19:29 Modified by: STAFFID, ADT - 04/20/12 04:56 Mode: Written >>>NURSING: HIGH ALERT!!<< ***PROTECT FROM LIGHT*** **CLIPBOARD MEDICATION*** *FINAL CONCENTRATION = 1 MG/ML* **MAKE IN GLASS ONLY** INFUSE USING LOW PVC OR PVC-FREE TUBING. NEED ONLY CHANGE TUBING EVERY 72 HOURS. TOTAL VOLUME = 40ML TO ACHIEVE AN Dose (include unit of measure. Ex: MG, MICROGRAM, etc.) (Do not exceed 45 characters): 20 ML Route: IV							
96	D/C'ed	PHENYLEPHRINE INJ [ NEO-SYNEPHRINE ] PHENYLEPHRINE INJ [ NEO-SYNEPHRINE ] (160MG)/SODIUM CHLORIDE 0.9% INJ (234ML)	QBAG	ROUTINE	6 Hours	04/19 19:22	04/20 01:05
Ordered by: JEWETT, BRENT M Entered by: STAFFID, KML3 - 04/19/12 19:25 Modified by: STAFFID, ADT - 04/20/12 04:56 Mode: Written Dose: 160 MG Route: IV Infusion Instructions: **NOTE: This drip is maximally concentrated and the base							

CONTINUED

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orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08

SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE: 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:06  
 OPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
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solution is NaCl 0.9% \*\* FINAL CONCENTRATION = 640 MICROGRAM/ML

93	D/C'ed	LORAZEPAM DRIP [ ATIVAN ] ]LORAZEPAM DRIP [ ATIVAN ] (40MG)/DEXTROSE 5% IN WATER IV (20ML)	OBAG	ROUTINE		04/19 20:00	04/19 19:30
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Ordered by: JEWETT, BRENT M  
 Entered by: STAFFID, KML3 - 04/19/12 19:22  
 Modified by: JEWETT, BRENT M - 04/19/12 19:31  
 Mode: Written

To achieve and maintain a RASS score of 0 to -3. Do not exceed 5mg/hr total infusion + boluses

Dose: 40 MG

Route: IV

Infusion Instructions: \*\* NOTE: Base solution is D5W \*\* FINAL CONCENTRATION = 1 mg/ mL

83	D/C'ed	INFLUENZA TRI-SPLIT VACCINE INJ: ONCALL 45 MCG: IM		ROUTINE	6 Hours	04/19 19:15	04/20 01:05
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Ordered by: JEWETT, BRENT M  
 Entered by: STAFFID, KML3 - 04/19/12 19:20  
 Modified by: STAFFID, ADT - 04/20/12 04:56  
 Mode: Written

Dose: 45 MCG

Route: IM

81	D/C'ed	INSULIN REGULAR HUMAN DRIP [ ] NOVOLIN R ]INSULIN REGULAR HUMAN DRIP [ NOVOLIN R ] (100UNIT)/INSULIN REGULAR HUMAN DRIP [ NOVOLIN R ] (0UNIT/HR) (+)	0 UNIT/HR	ROUTINE	6 Hours	04/19 19:18	04/20 01:05
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Ordered by: JEWETT, BRENT M  
 Entered by: STAFFID, KML3 - 04/19/12 19:20  
 Modified by: STAFFID, ADT - 04/20/12 04:56  
 Mode: Written

Target Glucose Range 80-110 mg /dL \*\* Starting Multiplier 0.03

Rate: 0 UNIT/HR

Dose: 100 UNIT

Route: IV

RxComment 1: >>NURSING: HIGH ALERT!!<< FINAL CONCENTRATION = 1UNIT/ML

80	D/C'ed	GLUCAGON INJ [ GLUCAGEN ]: 1 MG: ONCALL IM : (1MG=DOSE FOR PATIENTS >20KG) (RECONSTITUTE VIAL WITH 1ML OF STERILE DILUENT. GENTLY ROLL VIAL TO DISSOLVE)		NEXT SCH	6 Hours	04/19 19:18	04/20 01:05
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Ordered by: JEWETT, BRENT M  
 Entered by: JEWETT, BRENT M - 04/19/12 19:18  
 Modified by: STAFFID, ADT - 04/20/12 04:56  
 Mode: Direct

AS PER HYPOGLYCEMIA PROTOCCL

Dose: 1 MG

Route: IM

RxComment 1: (1MG=DOSE FOR PATIENTS >20KG) (RECONSTITUTE VIAL WITH 1ML OF STERILE DILUENT. GENTLY ROLL VIAL TO DISSOLVE)

79	D/C'ed	DEXTROSE 50% IN WATER INJ: 25 GM: IV	ONCALL	NEXT SCH	6 Hours	04/19 19:18	04/20 01:05
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Ordered by: JEWETT, BRENT M  
 Entered by: JEWETT, BRENT M - 04/19/12 19:18  
 Modified by: STAFFID, ADT - 04/20/12 04:56  
 Mode: Direct

AS PER HYPOGLYCEMIA PROTOCCL

Dose: 25 GM

Route: IV

CONTINUED

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PERM

orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08

SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 18:18  
 AGE 42Y SEX M MD: CROOKES, BRUCE  
 DOB: 08/10/1969 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
78	D/C'ed	GLUCOSE TAB [ DEX4 ]: 16 GM: PO	ONCALL	NEXT SCH	6 Hours	04/19 19:18	04/20 01:05
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: STAFFID, ADT - 04/20/12 04:56 Mode: Direct AS PER HYPOGLYCEMIA PROTOCCL Dose: 16 GM Route: PO							
70	D/C'ed	FENTANYL DRIP [ SUBLIMAZE ]: 50	50 MCG/HR	NEXT SCH	5 Hours	04/19 20:00	04/20 01:05
NCG/HR: IV ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: STAFFID, ADT - 04/20/12 04:56 Mode: Direct Do not exceed maximum dosage micrograms/hr total infusion + boluses. Dose: 2.5 MCG=50 ML Rate: 50 MCG/HR Route: IV							
68	D/C'ed	FAMOTIDINE [ PEPCID ]: 20 MG: PO	Q12HB	NEXT SCH	4 Hours	04/19 21:00	04/20 01:05
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: STAFFID, ADT - 04/20/12 04:56 Mode: Direct Dose: 20 MG Route: PO							
61	D/C'ed	SODIUM CHLORIDE 0.9% IV: 200	200 ML/HR	1ST NOW	6 Hours	04/19 19:15	04/20 01:05
ML/HR: IV Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: STAFFID, ADT - 04/20/12 04:56 Mode: Direct Dose: 1000 ML Rate: 200 ML/HR ROUTE: IV							
57	D/C'ed	OPHTHALMIC LUBRICANT OINT [ LACRILUBE ]: 1 RIBBON: EYE_BOTH	Q1BP	NEXT SCH	6 Hours	04/19 19:15	04/20 01:05
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: STAFFID, ADT - 04/20/12 04:56 Mode: Direct *For dry eyes Dose: 1 RIBBON Route: EYE_BOTH							
56	D/C'ed	OPHTHALMIC LUBRICANT OINT [ LACRILUBE ]: 1 RIBBON: EYE_BOTH	BID	NEXT SCH	4 Hours	04/19 21:00	04/20 01:05
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: STAFFID, ADT - 04/20/12 04:56 Mode: Direct Dose: 1 RIBBON Route: EYE_BOTH							
35	D/C'ed	PNEUMOCOCCAL VACCINE INJ [ PNEUMOVAX 23 ]: 0.5 ML: IM	ONCALL	NEXT SCH	6 Hours	04/19 19:15	04/20 01:05
Ordered by: JEWETT, BRENT M Entered by: JEWETT, BRENT M - 04/19/12 19:18 Modified by: STAFFID, ADT - 04/20/12 04:56 Mode: Direct Dose: 0.5 ML Route: IM Dose Type: MAINTENANCE							

CONTINUED

Page 16 PERM

SINGLETARY, SHELTON  
 MUSC  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08  
 ROOM: \*478F-12\* ADM: 04/19/12 19:18  
 AGE 42Y SEX: M MD: CROOKES, BRUCE  
 DOB: 09/10/1969 ID: 496951732 MR: 002673589  
 REQUESTED: 04/20/12 14:05  
 OPT OUT:

orderHistDC - SINGLETARY, SHELTON  
 DEPT: ROOM: \*478F-12\* MR: 002673589  
 FROM: 04/19/12 15:37 TO: 04/20/12 08:08

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
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10	D/C'ed	VASOPRESSIN INJ [ PITRESSIN ] [VASOPRESSIN INJ [ PITRESSIN ] (100UNIT)/SODIUM CHLORIDE 0.9% INJ (95ML)	QBAG	ROUTINE	7 Hours	04/19 18:00	04/20 01:05
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Ordered by: STAFFID, HCLTA  
 Entered by: STAFFID, HCLTA - 04/19/12 17:12  
 Modified by: STAFFID, ADT - 04/20/12 04:56  
 Mode: written

Dose: 100 UNIT

Route: IV

RxComment 1: >>NURSING: HIGH ALERT!!<< FINAL CONCENTRATION = 1 UNIT/ML \*\*NOTE:  
 BASE FLUID IS NACL 0.9%\*\*

No unsigned orders found.

LAST PAGE

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Patient: SINGLETARY, SHELDON M

MRN: 2673589

Encounter: 496951732

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ROA 442

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
4/20/12 12:05 AM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		100 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		6.97	7.35 - 7.45	C	OR LAB	
	PCO2 AT 37 DEGREES C		50 MM HG	35 - 45	H	OR LAB	
	PO2 AT 37 DEGREES C		52 MM HG	80 - 100	L	OR LAB	
	BODY TEMPERATURE		35.2 DegC			OR LAB	
	PH AT PATIENT TEMP		6.99	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		46 MM HG	35 - 45	H	OR LAB	
	PO2 AT PATIENT TEMP		47 MM HG	80 - 100	L	OR LAB	
	% O2 SATURATION		86.0 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		-17.9 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		10.9 MMOL/L	22.0 - 26.0	L	OR LAB	
	TOTAL CO2 CONTENT		12.4 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		1.9 GM/DL	14.0 - 18.0	C	OR LAB	
	HEMATOCRIT-- BLOOD GAS		7 %	42 - 52	C	OR LAB	
	SODIUM (NA)		147 MMOL/L	135 - 145	H	OR LAB	
	POTASSIUM (K)		3.2 MMOL/L	3.5 - 5.0	L	OR LAB	
	CHLORIDE		113 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		39 MG/DL	70 - 100	C	OR LAB	
	CA++ MEASURED		1.05 MMOL/L	1.14 - 1.29	L	OR LAB	
4/19/12 10:20 PM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		90 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	

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Medical University of South Carolina  
 Charleston, SC  
 843-792-2123  
 Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PH AT 37 DEGREES C		7.11	7.35 - 7.45	L	OR LAB	
	PCO2 AT 37 DEGREES C		53 MM HG	35 - 45	H	OR LAB	
	PO2 AT 37 DEGREES C		66 MM HG	80 - 100	L	OR LAB	
	BODY TEMPERATURE		35.2 DegC			OR LAB	
	PH AT PATIENT TEMP		7.14	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		48 MM HG	35 - 45	H	OR LAB	
	PO2 AT PATIENT TEMP		59 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		93.6 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		-12.4 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		16.1 MMOL/L	22.0 - 26.0	L	OR LAB	
	TOTAL CO2 CONTENT		17.7 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		8.5 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		26 %	42 - 52	L	OR LAB	
	SODIUM (NA)		151 MMOL/L	135 - 145	H	OR LAB	
	POTASSIUM (K)		4.1 MMOL/L	3.5 - 5.0		OR LAB	
	CHLORIDE		109 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		208 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		0.88 MMOL/L	1.14 - 1.29	L	OR LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		18 K/CUMM	140 - 440	C	GEN LAB	*
	MPV		10.50 FL	9.15 - 12.31		GEN LAB	
	APTT	Finished	106.9 SEC	23.3 - 35.7	H	GEN LAB	*
4/19/12 9:50 PM	ARTERIAL BLOOD GAS	Finished					*
	FRACTION OF INSPIRED OXYGEN		94 %			OR LAB	

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ROA 444 MUSC255 OF 287

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.20	7.35 - 7.45	L	OR LAB	
	PCO2 AT 37 DEGREES C		46 MM HG	35 - 45	H	OR LAB	
	PO2 AT 37 DEGREES C		49 MM HG	80 - 100	L	OR LAB	
	BODY TEMPERATURE		35.2 DegC			OR LAB	
	PH AT PATIENT TEMP		7.22	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		42 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		44 MM HG	80 - 100	C	OR LAB	*
	% O2 SATURATION		86.9 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		-9.4 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		17.4 MMOL/L	22.0 - 26.0	L	OR LAB	
	TOTAL CO2 CONTENT		18.8 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		6.2 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		20 %	42 - 52	L	OR LAB	
	SODIUM (NA)		147 MMOL/L	135 - 145	H	OR LAB	
	POTASSIUM (K)		3.5 MMOL/L	3.5 - 5.0		OR LAB	
	CHLORIDE		110 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		146 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		0.87 MMOL/L	1.14 - 1.29	L	OR LAB	
4/19/12 9:27 PM	ARTERIAL BLOOD GAS	Finished					*
	FRACTION OF INSPIRED OXYGEN		100 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.23	7.35 - 7.45	L	OR LAB	
	PCO2 AT 37 DEGREES C		70 MM HG	35 - 45	H	OR LAB	

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Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PO2 AT 37 DEGREES C		46 MM HG	80 - 100	L	OR LAB	
	BODY TEMPERATURE		35.4 DegC			OR LAB	
	PH AT PATIENT TEMP		7.25	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		65 MM HG	35 - 45	H	OR LAB	
	PO2 AT PATIENT TEMP		42 MM HG	80 - 100	C	OR LAB	
	% O2 SATURATION		82.6 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		0.7 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		28.4 MMOL/L	22.0 - 26.0	H	OR LAB	
	TOTAL CO2 CONTENT		30.6 MMOL/L	23.0 - 27.0	H	OR LAB	
	HEMOGLOBIN		8.1 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		25 %	42 - 52	L	OR LAB	
	SODIUM (NA)		156 MMOL/L	135 - 145	H	OR LAB	
	POTASSIUM (K)		3.7 MMOL/L	3.5 - 5.0		OR LAB	
	CHLORIDE		113 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		146 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		1.34 MMOL/L	1.14 - 1.29	H	OR LAB	
4/19/12 9:00 PM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		100 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.18	7.35 - 7.45	L	OR LAB	
	PCO2 AT 37 DEGREES C		59 MM HG	35 - 45	H	OR LAB	
	PO2 AT 37 DEGREES C		211 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		35.6 DegC			OR LAB	
	PH AT PATIENT TEMP		7.19	7.35 - 7.45	L	OR LAB	

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Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PCO2 AT PATIENT TEMP		55 MM HG	35 - 45	H	OR LAB	
	PO2 AT PATIENT TEMP		206 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.3 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-6.0 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		20.9 MMOL/L	22.0 - 26.0	L	OR LAB	
	TOTAL CO2 CONTENT		22.7 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		3.6 GM/DL	14.0 - 18.0	C	OR LAB	
	HEMATOCRIT - BLOOD GAS		12 %	42 - 52	C	OR LAB	
	SODIUM (NA)		153 MMOL/L	135 - 145	H	OR LAB	
	POTASSIUM (K)		2.5 MMOL/L	3.5 - 5.0	C	OR LAB	
	CHLORIDE		115 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		86 MG/DL	70 - 100		OR LAB	
	CA++ MEASURED		0.68 MMOL/L	1.14 - 1.29	L	OR LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		11 K/CUMM	140 - 440	C	GEN LAB	*
	MPV		12.00 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		34.8 SEC	12.0 - 15.1	H	GEN LAB	*
	INR		3.43			GEN LAB	
	APTT	Started	SEC		C		*
	FIBRINOGEN	Finished	60 MG/DL	231 - 486	C	GEN LAB	*
4/19/12 7:44 PM	ARTERIAL BLOOD GAS	Finished					*
	FRACTION OF INSPIRED OXYGEN		100 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	

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ROA 447

MUSC258 OF 287

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PH AT 37 DEGREES C		7.07	7.35 - 7.45	C	OR LAB	
	PCO2 AT 37 DEGREES C		62 MM HG	35 - 45	H	OR LAB	
	PO2 AT 37 DEGREES C		94 MM HG	80 - 100		OR LAB	
	BODY TEMPERATURE		34.8 DegC			OR LAB	
	PH AT PATIENT TEMP		7.10	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		55 MM HG	35 - 45	H	OR LAB	
	PO2 AT PATIENT TEMP		82 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		96.2 %	96.0 - 97.0		OR LAB	
	BASE EXC/D		-12.3 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		17.0 MMOL/L	22.0 - 26.0	L	OR LAB	
4/19/12 7:04 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	237	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/19/12 6:30 PM	ARTERIAL BLOOD GAS	Finished					
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.15	7.35 - 7.45	L	OR LAB	
	PCO2 AT 37 DEGREES C		44 MM HG	35 - 45		OR LAB	
	PO2 AT 37 DEGREES C		316 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		35.1 DegC			OR LAB	
	PH AT PATIENT TEMP		7.18	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		308 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.7 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-12.8 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		14.6 MMOL/L	22.0 - 26.0	L	OR LAB	

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Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	TOTAL CO2 CONTENT		16.0 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		7.0 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		22 %	42 - 52	L	OR LAB	
	SODIUM (NA)		142 MMOL/L	135 - 145		OR LAB	
	POTASSIUM (K)		6.0 MMOL/L	3.5 - 5.0	H	OR LAB	
	CHLORIDE		109 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		193 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		0.92 MMOL/L	1.14 - 1.29	L	OR LAB	
4/19/12 6:19 PM	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		4.56 K/CUMM	4.80 - 10.80	L	GEN LAB	
	RED BLOOD CELL COUNT		2.33 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		6.7 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		20.8 %	42.0 - 52.0	L	GEN LAB	
	MCV		89.3 FL	80.0 - 94.0		GEN LAB	
	MCH		28.8 pg	27.0 - 31.0		GEN LAB	
	MCHC		32.2 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		15.5 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		56 K/CUMM	140 - 440	L	GEN LAB	
	MPV		10.00 FL	9.15 - 12.31		GEN LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		145.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		4.80 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		110.0 MMOL/L	98.0 - 107.0	H	GEN LAB	

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Charleston, SC

843-792-2123

Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	CO2 CONTENT (BICARBONATE)		21 MMOL/L	22 - 32	L	GEN LAB	
	ANION GAP		14 MMOL/L	2 - 11	H	GEN LAB	
	GLUCOSE, SERUM		113.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		9.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.2 MG/DL	0.6 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR		>59 mL/min			GEN LAB	*
	CALCIUM		8.8 MG/DL	8.4 - 10.2		GEN LAB	
	HEMOLYSIS INDEX		3.0	0.0 - 1.9	H	GEN LAB	*
	MAGNESIUM (MG)	Finished	2.9 MG/DL	1.6 - 2.3	H	GEN LAB	
	HEMOLYSIS INDEX		3.0	0.0 - 1.9	H	GEN LAB	*
	PROTHROMBIN TIME (PT)	Finished					*
	PT		21.8 SEC	12.0 - 15.1	H	GEN LAB	*
	INR		1.89			GEN LAB	
	APTT	Finished	83.1 SEC	23.3 - 35.7	H	GEN LAB	*
	FIBRINOGEN	Finished	146 MG/DL	231 - 486	L	GEN LAB	*
	PHOSPHORUS (PO4)	Finished	5.0 MG/DL	2.4 - 4.7	H	GEN LAB	
	HEMOLYSIS INDEX		3.0	0.0 - 1.9	H	GEN LAB	*
4/19/12 6:02 PM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		100 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.15	7.35 - 7.45	L	OR LAB	
	PCO2 AT 37 DEGREES C		39 MM HG	35 - 45		OR LAB	
	PO2 AT 37 DEGREES C		370 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		35.2 DegC			OR LAB	

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Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PH AT PATIENT TEMP		7.17	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		36 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		361 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.7 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-14.2 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		13.1 MMOL/L	22.0 - 26.0	L	OR LAB	
	TOTAL CO2 CONTENT		14.3 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		6.6 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		21 %	42 - 52	L	OR LAB	
	SODIUM (NA)		143 MMOL/L	135 - 145		OR LAB	
	POTASSIUM (K)		5.6 MMOL/L	3.5 - 5.0	H	OR LAB	
	CHLORIDE		108 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		235 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		0.76 MMOL/L	1.14 - 1.29	L	OR LAB	
	LACTATE - WHOLE BLOOD	Finished	6.9 MMOL/L	0.5 - 1.6	C	OR LAB	*
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		143.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		6.10 MMOL/L	3.50 - 5.00	H	GEN LAB	
	CHLORIDE		105.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		16 MMOL/L	22 - 32	L	GEN LAB	
	ANION GAP		22 MMOL/L	2 - 11	H	GEN LAB	
	GLUCOSE, SERUM		251.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		11.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.3 MG/DL	0.6 - 1.3		GEN LAB	

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Charleston, SC

843-792-2123

Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	ESTIMATED GLOMERULAR		50 mL/min			GEN LAB	*
	CALCIUM		10.9 MG/DL	8.4 - 10.2	H	GEN LAB	
	HEMOLYSIS INDEX		2.0	0.0 - 1.9	H	GEN LAB	*
	MAGNESIUM (MG)	Finished	2.5 MG/DL	1.6 - 2.3	H	GEN LAB	
	HEMOLYSIS INDEX		2.0	0.0 - 1.9	H	GEN LAB	*
	PHOSPHORUS (PO4)	Finished	9.3 MG/DL	2.4 - 4.7	C	GEN LAB	*
	HEMOLYSIS INDEX		2.0	0.0 - 1.9	H	GEN LAB	*
4/19/12 5:45 PM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		94 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.06	7.35 - 7.45	C	OR LAB	
	PCO2 AT 37 DEGREES C		43 MM HG	35 - 45		OR LAB	
	PO2 AT 37 DEGREES C		423 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		35.2 DegC			OR LAB	
	PH AT PATIENT TEMP		7.08	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		413 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.7 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-17.4 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		11.7 MMOL/L	22.0 - 26.0	L	OR LAB	
	TOTAL CO2 CONTENT		13.0 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		9.1 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		28 %	42 - 52	L	OR LAB	
	SODIUM (NA)		141 MMOL/L	135 - 145		OR LAB	

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843-792-2123

Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	POTASSIUM (K)		6.3 MMOL/L	3.5 - 5.0	C	OR LAB	
	CHLORIDE		111 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		302 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		0.96 MMOL/L	1.14 - 1.29	L	OR LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		8.71 K/CUMM	4.80 - 10.80		GEN LAB	
	RED BLOOD CELL COUNT		3.07 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		8.8 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		28.8 %	42.0 - 52.0	L	GEN LAB	
	MCV		93.8 FL	80.0 - 94.0		GEN LAB	
	MCH		28.7 pg	27.0 - 31.0		GEN LAB	
	MCHC		30.6 GM/DL	30.7 - 34.4	L	GEN LAB	
	RDW		15.9 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		80 K/CUMM	140 - 440	L	GEN LAB	
	MPV		10.80 FL	9.15 - 12.31		GEN LAB	
	LACTATE - WHOLE BLOOD	Finished	8.6 MMOL/L	0.5 - 1.6	C	OR LAB	*
4/19/12 5:19 PM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		100 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.08	7.35 - 7.45	C	OR LAB	
	PCO2 AT 37 DEGREES C		41 MM HG	35 - 45		OR LAB	
	PO2 AT 37 DEGREES C		290 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		36.0 DegC			OR LAB	

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Medical University of South Carolina

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Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PH AT PATIENT TEMP		7.10	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		39 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		286 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.8 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-16.8 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		11.6 MMOL/L	22.0 - 26.0	L	OR LAB	
	TOTAL CO2 CONTENT		12.8 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		7.3 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		23 %	42 - 52	L	OR LAB	
	SODIUM (NA)		143 MMOL/L	135 - 145		OR LAB	
	POTASSIUM (K)		4.4 MMOL/L	3.5 - 5.0		OR LAB	
	CHLORIDE		113 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		266 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		0.81 MMOL/L	1.14 - 1.29	L	OR LAB	
	LACTATE - WHOLE BLOOD	Finished	8.1 MMOL/L	0.5 - 1.6	C	OR LAB	*
4/19/12 4:57 PM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		100 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		6.98	7.35 - 7.45	C	OR LAB	
	PCO2 AT 37 DEGREES C		69 MM HG	35 - 45	H	OR LAB	
	PO2 AT 37 DEGREES C		38 MM HG	80 - 100	C	OR LAB	
	BODY TEMPERATURE		36.0 DegC			OR LAB	
	PH AT PATIENT TEMP		6.99	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		65 MM HG	35 - 45	H	OR LAB	

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Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: SINGLETARY, SHELDON M

MRN: 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PO2 AT PATIENT TEMP		35 MM HG	80 - 100	C	OR LAB	*
	% O2 SATURATION		60.4 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		-15.5 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		15.2 MMOL/L	22.0 - 26.0	L	OR LAB	
	TOTAL CO2 CONTENT		17.3 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		7.1 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		22 %	42 - 52	L	OR LAB	
	SODIUM (NA)		145 MMOL/L	135 - 145		OR LAB	
	POTASSIUM (K)		4.2 MMOL/L	3.5 - 5.0		OR LAB	
	CHLORIDE		111 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		217 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		0.59 MMOL/L	1.14 - 1.29	L	OR LAB	
	LACTATE - WHOLE BLOOD	Finished	7.1 MMOL/L	0.5 - 1.6	C	OR LAB	*
	PLATELET COUNT	Finished					
	PLATELET COUNT		95 K/CUMM	140 - 440	L	GEN LAB	
	MPV		10.40 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		19.2 SEC	12.0 - 15.1	H	GEN LAB	*
	INR		1.61			GEN LAB	
	APTT	Finished	50.8 SEC	23.3 - 35.7	H	GEN LAB	*
	FIBRINOGEN	Finished	153 MG/DL	231 - 486	L	GEN LAB	*
4/19/12 4:41 PM	ARTERIAL POINT OF CARE PANEL	Finished					
	FIO2		100 %			POCT	
	PH		7.19	7.35 - 7.45	L	POCT	

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ROA 455  
 MUSC266 OF 287

**Medical University of South Carolina  
Charleston, SC  
843-792-2123**

**Laboratory Results Report**

ROA 456

**Patient:** SINGLETARY, SHELDON M

**MRN:** 002673589

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PCO2		36 MM HG	35 - 45		POCT	
	PO2		417 MM HG	80 - 100	H	POCT	
	O2 SATURATION		100 %	96 - 97	H	POCT	
	BICARBONATE		14 MMOL/L	22 - 26	L	POCT	
	TOTAL CO2		15 MMOL/L	23 - 27	L	POCT	
	BASE EXC/DEF		-13 MMOL/L	-2 - 3	L	POCT	
	HEMOGLOBIN		6.8 GM/DL	14.0 - 18.0	L	POCT	
	HEMATOCRIT		20 %	42 - 52	L	POCT	
	SODIUM		145 MMOL/L	135 - 145		POCT	
	POTASSIUM		3.8 MMOL/L	3.5 - 4.9		POCT	
	GLUCOSE		73 MG/DL	70 - 100		POCT	
	IONIZED CALCIUM		1.03 MMOL/L	1.14 - 1.29	L	POCT	
	PERFORMING LAB		See Note			POCT	*
4/19/12 4:37 PM	ABO AND RH BLOOD TYPE	Finished					
	ABO RH INTERPRETATION		O POS			GEN LAB	
	ANTIBODY SCREEN (INDIRECT)	Finished					
	ANTIBODY SCREEN INTERP		Negative ABSC			GEN LAB	
4/19/12 3:37 PM	APTT	Finished	29.2 SEC	23.3 - 35.7		GEN LAB	*
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		142.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		3.70 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		110.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		18 MMOL/L	22 - 32	L	GEN LAB	
	ANION GAP		14 MMOL/L	2 - 11	H	GEN LAB	

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Grp 3-10003 University Medical Associates  
 PO Box 600077  
 Raleigh, NC 27675

SINGLETARY, SHELDON M  
 4112 EASTBURY CT MS 819  
 NORTH CHARLESTON, SC 29420-8430

Admit Date 4/19/2012

Discharge Date 4/20/2012

ROA 457

ITEMIZED STATEMENT

Transaction Code	Proc Code	Revenue Code	Description	Transaction Date	Quantity	Amount
<b>Invoice #: 11480409</b>						
21			PMT/CA-BLUE SHIELD	4/19/2012	0	\$941.80
37220	37220		REVASCULARIZATION ILIAC ARTERY ANGIOPL 1ST VSL	4/19/2012	1	\$6,000.00
44111	44111		EXC 1 GREATER THAN LES INTST NO ANAST;MX ENTROT	4/19/2012	1	\$5,032.00
49002	49002		REOPENING OF RECENT LAPAROTOMY	4/19/2012	1	\$4,305.00
621			PMT/CA-BLUE SHIELD EDI	4/19/2012	0	(\$941.80)
621			PMT/CA-BLUE SHIELD EDI	4/19/2012	0	(\$1,263.80)
66			ADJ-UNINSURED 50% DISCOUNT	4/23/2012	0	(\$7,668.50)
66			ADJ-UNINSURED 50% DISCOUNT	5/8/2012	0	\$7,668.50
99			BPROCESSED IN EXCESS OF CHARGES	5/23/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	5/23/2012	0	\$0.00
99			BCHARGE IS INCLUDED IN THE FEE FOR MEDICAL CARE	5/23/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	5/23/2012	0	\$0.00
621-A			PMT/CA-BLUE SHIELD EDI	6/27/2012	0	(\$9,854.75)
99			BPAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE	6/27/2012	0	\$0.00

Grp 3-10003 University Medical Associates  
 PO Box 600077  
 Raleigh, NC 27675

SINGLETARY, SHELDON M  
 4112 EASTBURY CT MS 819  
 NORTH CHARLESTON, SC 29420-8430

Admit Date 4/19/2012  
 Discharge Date 4/20/2012

ROA 458

ITEMIZED STATEMENT

Transaction Code	Proc Code	Revenue Code	Description	Transaction Date	Quantity	Amount
<b>Invoice #: 11480409</b>						
99			BCHARGE IS INCLUDED IN THE FEE FOR MEDICAL CARE	6/27/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	6/27/2012	0	\$0.00
99			BPAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE	6/27/2012	0	\$0.00
99			BCOINSURANCE AMOUNT	6/27/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	6/27/2012	0	\$0.00
99			BCHARGES ARE ADJUSTED BASED ON M	6/27/2012	0	\$0.00
99			BPROCESSED IN EXCESS OF CHARGES	6/27/2012	0	\$0.00
99			BCOINSURANCE AMOUNT	6/27/2012	0	\$0.00
99			BPROCESSED IN EXCESS OF CHARGES	6/27/2012	0	\$0.00
621-A			PMT/CA-BLUE SHIELD EDI	10/10/2012	0	(\$3,902.50)
99			BCOINSURANCE AMOUNT	10/10/2012	0	\$0.00
99			BCOINSURANCE AMOUNT	10/10/2012	0	\$0.00
99			BCHARGES ARE ADJUSTED BASED ON M	10/10/2012	0	\$0.00
99			BCHG EXCEEDS OUR FEE SCHEDULE	10/10/2012	0	\$0.00

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Grp 3-10003 University Medical Associates  
 PO Box 600077  
 Raleigh, NC 27675

SINGLETARY, SHELDON M  
 4112 EASTBURY CT MS 819  
 NORTH CHARLESTON, SC 29420-8430

Admit Date 4/19/2012  
 Discharge Date 4/20/2012

ROA 459

ITEMIZED STATEMENT

Transaction Code	Proc Code	Revenue Code	Description	Transaction Date	Quantity	Amount
<b>Invoice #: 11480409</b>						
99			BCOINSURANCE AMOUNT	10/10/2012	0	\$0.00
99			BCHARGES ARE ADJUSTED BASED ON M	10/10/2012	0	\$0.00
87-A			PMT/ADJ-PT ESTATE	1/25/2013	0	(\$315.95)
<b>Invoice Total</b>						<b>\$0.00</b>
<b>Invoice #: 11482244</b>						
71010	71010		RAD EX CHST; SINGLE VIEW FRNTL	4/19/2012	1	\$46.00
71010	71010		RAD EX CHST; SINGLE VIEW FRNTL	4/19/2012	1	\$46.00
66			ADJ-UNINSURED 50% DISCOUNT	4/24/2012	0	(\$46.00)
66			ADJ-UNINSURED 50% DISCOUNT	5/8/2012	0	\$46.00
621			PMT/CA-BLUE SHIELD EDI	5/21/2012	0	(\$32.00)
621-A			PMT/CA-BLUE SHIELD EDI	5/21/2012	0	(\$52.00)
66			ADJ-UNINSURED 50% DISCOUNT	5/21/2012	0	(\$4.00)
66			ADJ-UNINSURED 50% DISCOUNT	5/21/2012	0	\$4.00
99			BCOINSURANCE AMOUNT	5/21/2012	0	\$0.00
99			BCOINSURANCE AMOUNT	5/21/2012	0	\$0.00



Grp 3-10003 University Medical Associates  
 PO Box 600077  
 Raleigh, NC 27675

SINGLETARY, SHELDON M  
 4112 EASTBURY CT MS 819  
 NORTH CHARLESTON, SC 29420-8430

Admit Date 4/19/2012  
 Discharge Date 4/20/2012

ROA 460

ITEMIZED STATEMENT

Transaction Code	Proc Code	Revenue Code	Description	Transaction Date	Quantity	Amount
<b>Invoice #: 11482244</b>						
99			BCHG EXCEEDS OUR FEE SCHEDULE	5/21/2012	0	\$0.00
99			BCHG EXCEEDS OUR FEE SCHEDULE	5/21/2012	0	\$0.00
91			PMT/CA-ORG/AGENCY	9/13/2012	0	(\$8.00)
<b>Invoice Total</b>						<b>\$0.00</b>
<b>Invoice #: 11495890</b>						
621			PMT/CA-BLUE SHIELD EDI	4/19/2012	0	(\$150.40)
91			PMT/CA-ORG/AGENCY	4/19/2012	0	(\$37.60)
99285	99285		ER VISIT E&M HIGH-SEVER SIG THREAT	4/19/2012	1	\$605.00
66			ADJ-UNINSURED 50% DISCOUNT	4/25/2012	0	(\$302.50)
66			ADJ-UNINSURED 50% DISCOUNT	5/8/2012	0	\$302.50
621-A			PMT/CA-BLUE SHIELD EDI	5/23/2012	0	(\$417.00)
66			ADJ-UNINSURED 50% DISCOUNT	5/23/2012	0	(\$18.80)
66			ADJ-UNINSURED 50% DISCOUNT	5/23/2012	0	\$18.80
99			BCHG EXCEEDS OUR FEE SCHEDULE	5/23/2012	0	\$0.00

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 Raleigh, NC 27675

SINGLETARY, SHELDON M  
 4112 EASTBURY CT MS 819  
 NORTH CHARLESTON, SC 29420-8430

Admit Date 4/19/2012  
 Discharge Date 4/20/2012

ROA 461

**ITEMIZED STATEMENT**

Transaction Code	Proc Code	Revenue Code	Description	Transaction Date	Quantity	Amount
<b>Invoice #: 11495890</b>						
99			BCOINSURANCE AMOUNT	5/23/2012	0	\$0.00
<b>Invoice Total</b>						<b>\$0.00</b>
<b>Invoice #: 11497572</b>						
88307	88307		LEVEL V- SURG PATH GROSS MICRO EXAM	4/19/2012	1	\$400.00
66			ADJ-UNINSURED 50% DISCOUNT	4/26/2012	0	(\$200.00)
66			ADJ-UNINSURED 50% DISCOUNT	5/8/2012	0	\$200.00
621			PMT/CA-BLUE SHIELD EDI	5/23/2012	0	(\$165.60)
621-A			PMT/CA-BLUE SHIELD EDI	5/23/2012	0	(\$193.00)
66			ADJ-UNINSURED 50% DISCOUNT	5/23/2012	0	(\$20.70)
66			ADJ-UNINSURED 50% DISCOUNT	5/23/2012	0	\$20.70
99			BCOINSURANCE AMOUNT	5/23/2012	0	\$0.00
99			BCHG EXCEEDS OUR FEE SCHEDULE	5/23/2012	0	\$0.00
91			PMT/CA-ORG/AGENCY	9/13/2012	0	(\$41.40)
<b>Invoice Total</b>						<b>\$0.00</b>

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Raleigh, NC 27675

SINGLETARY, SHELDON M

4112 EASTBURY CT MS 819

NORTH CHARLESTON, SC 29420-8430

Admit Date 4/19/2012

Discharge Date 4/20/2012

ROA 462

### ITEMIZED STATEMENT

Transaction Code	Proc Code	Revenue Code	Description	Transaction Date	Quantity	Amount
<b>Invoice #: 11504288</b>						
36556	36556		INSRT NON-TUNNL CNTRL CVC; 5 GREATER THAN	4/19/2012	1	\$1,269.00
36556	36556		INSRT NON-TUNNL CNTRL CVC; 5 GREATER THAN	4/19/2012	1	\$1,269.00
621			PMT/CA-BLUE SHIELD EDI	4/19/2012	0	(\$678.80)
91			PMT/CA-ORG/AGENCY	4/19/2012	0	(\$169.70)
99291	99291		CRITICAL CARE E&M; 1ST 30-74 MIN	4/19/2012	1	\$900.00
99292	99292		CRITICAL CARE E&M; EA ADD 30 MIN	4/19/2012	3	\$1,350.00
66			ADJ-UNINSURED 50% DISCOUNT	4/26/2012	0	(\$2,394.00)
66			ADJ-UNINSURED 50% DISCOUNT	5/8/2012	0	\$2,394.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	5/30/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	5/30/2012	0	\$0.00
99			BNO BENEFITS FOR MED CARE BY MORE THAN ONE PROVIDER PER DAY	5/30/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	5/30/2012	0	\$0.00
621-A			PMT/CA-BLUE SHIELD EDI	6/27/2012	0	(\$3,939.50)
66			ADJ-UNINSURED 50% DISCOUNT	6/27/2012	0	(\$84.85)

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Created on 12/2/2015

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Grp 3-10003 University Medical Associates

PO Box 600077

Raleigh, NC 27675

SINGLETERY, SHELDON M

4112 EASTBURY CT MS 819

NORTH CHARLESTON, SC 29420-8430

Admit Date 4/19/2012

Discharge Date 4/20/2012

ROA 463

### ITEMIZED STATEMENT

Transaction Code	Proc Code	Revenue Code	Description	Transaction Date	Quantity	Amount
<b>Invoice #: 11504288</b>						
99			BCOINSURANCE AMOUNT	6/27/2012	0	\$0.00
99			BCHG EXCEEDS OUR FEE SCHEDULE	6/27/2012	0	\$0.00
99			BCHG EXCEEDS OUR FEE SCHEDULE	6/27/2012	0	\$0.00
99			BCOINSURANCE AMOUNT	6/27/2012	0	\$0.00
99			BCOINSURANCE AMOUNT	6/27/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	6/27/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	6/27/2012	0	\$0.00
99			BCHARGES ARE ADJUSTED BASED ON M	6/27/2012	0	\$0.00
99			BNO BENEFITS FOR MED CARE BY MORE THAN ONE PROVIDER PER DAY	6/27/2012	0	\$0.00
99			BCOINSURANCE AMOUNT	6/27/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	6/27/2012	0	\$0.00
99			BCHG EXCEEDS OUR FEE SCHEDULE	6/27/2012	0	\$0.00
66			ADJ-UNINSURED 50% DISCOUNT	9/13/2012	0	\$84.85
66			ADJ-UNINSURED 50% DISCOUNT	9/14/2012	0	\$84.85

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SINGLETARY, SHELDON M  
 4112 EASTBURY CT MS 819  
 NORTH CHARLESTON, SC 29420-8430

Admit Date 4/19/2012  
 Discharge Date 4/20/2012

ROA 464

**ITEMIZED STATEMENT**

Transaction Code	Proc Code	Revenue Code	Description	Transaction Date	Quantity	Amount
<b>Invoice #: 11504288</b>						
87-A			PMT/ADJ-PT ESTATE	11/30/2012	0	(\$84.85)
<b>Invoice Total</b>						<b>\$0.00</b>
<b>Invoice #: 11514663</b>						
00880	00880		ANES-PROC MAJOR LOWER ABD VES; NOS	4/19/2012	0	\$3,510.00
21			PMT/CA-BLUE SHIELD	4/19/2012	0	\$77.60
36620	36620		ART CATH-SAMPL-SEP PROC; PERQ	4/19/2012	1	\$417.00
621			PMT/CA-BLUE SHIELD EDI	4/19/2012	0	(\$77.60)
621			PMT/CA-BLUE SHIELD EDI	4/19/2012	0	(\$722.04)
91			PMT/CA-ORG/AGENCY	4/19/2012	0	(\$180.51)
99140	99140		ANES-COMPLICATED EMERGENCY CONDS	4/19/2012	1	\$260.00
66			ADJ-UNINSURED 50% DISCOUNT	4/30/2012	0	(\$2,093.50)
66			ADJ-UNINSURED 50% DISCOUNT	5/8/2012	0	\$2,093.50
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	6/13/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	6/13/2012	0	\$0.00

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SINGLETARY, SHELDON M  
 4112 EASTBURY CT MS 819  
 NORTH CHARLESTON, SC 29420-8430

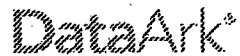
Admit Date 4/19/2012

Discharge Date 4/20/2012

ROA 465

**ITEMIZED STATEMENT**

Transaction Code	Proc Code	Revenue Code	Description	Transaction Date	Quantity	Amount
<b>Invoice #: 11514663</b>						
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	6/13/2012	0	\$0.00
621-A			PMT/CA-BLUE SHIELD EDI	6/27/2012	0	(\$320.00)
99			BDUPLICATE CLAIMSERVICE	6/27/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	6/27/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	6/27/2012	0	\$0.00
99			BRENDERNG PROV NOT ELIG TO PERFORM SRV BILLED	6/27/2012	0	\$0.00
99			BCHG EXCEEDS OUR FEE SCHEDULE	6/27/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	6/27/2012	0	\$0.00
99			BCOINSURANCE AMOUNT	6/27/2012	0	\$0.00
900			ADJ-BUNDLED CHARGE	6/29/2012	0	(\$130.00)
621-A			PMT/CA-BLUE SHIELD EDI	12/5/2012	0	(\$2,704.45)
99			BCOINSURANCE AMOUNT	12/5/2012	0	\$0.00
99			BCOINSURANCE AMOUNT	12/5/2012	0	\$0.00
99			BCHG EXCEEDS OUR FEE SCHEDULE	12/5/2012	0	\$0.00



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PO Box 600077

Raleigh, NC 27675

SINGLETARY, SHELDON M

4112 EASTBURY CT MS 819

NORTH CHARLESTON, SC 29420-8430

Admit Date 4/19/2012

Discharge Date 4/20/2012

ROA 466

### ITEMIZED STATEMENT

Transaction Code	Proc Code	Revenue Code	Description	Transaction Date	Quantity	Amount
<b>Invoice #: 11514663</b>						
99			BCHG EXCEEDS OUR FEE SCHEDULE	12/5/2012	0	\$0.00
99			BPAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE	12/5/2012	0	\$0.00
87-A			PMT/ADJ-PT ESTATE	1/25/2013	0	(\$310.51)
900			ADJ-BUNDLED CHARGE	3/11/2013	0	\$130.00
91-A			PMT/CA-ORG/AGENCY	3/11/2013	0	(\$79.49)
87-A			PMT/ADJ-PT ESTATE	4/29/2013	0	\$130.00
<b>Invoice Total</b>						<b>\$0.00</b>
<b>Invoice #: 11520786</b>						
00790	00790		ANES-INTRAPER UP ABD W LAP;NOS	4/19/2012	0	\$2,730.00
621			PMT/CA-BLUE SHIELD EDI	4/19/2012	0	(\$503.88)
91			PMT/CA-ORG/AGENCY	4/19/2012	0	(\$125.97)
66			ADJ-UNINSURED 50% DISCOUNT	5/1/2012	0	(\$1,365.00)
66			ADJ-UNINSURED 50% DISCOUNT	5/8/2012	0	\$1,365.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	5/23/2012	0	\$0.00

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Raleigh, NC 27675

SINGLETARY, SHELDON M

4112 EASTBURY CT MS 819

NORTH CHARLESTON, SC 29420-8430

Admit Date 4/19/2012

Discharge Date 4/20/2012

ROA 467

### ITEMIZED STATEMENT

Transaction Code	Proc Code	Revenue Code	Description	Transaction Date	Quantity	Amount
<b>Invoice #: 11520786</b>						
621-A			PMT/CA-BLUE SHIELD EDI	6/27/2012	0	(\$2,100.15)
66			ADJ-UNINSURED 50% DISCOUNT	6/27/2012	0	(\$62.98)
99			BCHG EXCEEDS OUR FEE SCHEDULE	6/27/2012	0	\$0.00
99			BCOINSURANCE AMOUNT	6/27/2012	0	\$0.00
99			BCLAIM OR SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION	6/27/2012	0	\$0.00
66			ADJ-UNINSURED 50% DISCOUNT	9/13/2012	0	\$62.98
66			ADJ-UNINSURED 50% DISCOUNT	9/14/2012	0	\$62.98
87-A			PMT/ADJ-PT ESTATE	11/30/2012	0	(\$62.98)
<b>Invoice Total</b>						<b>\$0.00</b>
<b>Total Balances</b>						<b>\$0.00</b>
<b>Total Charges</b>						<b>\$28,139.00</b>
<b>Total Payments</b>						<b>\$4,079.70</b>
<b>Total Adjustments</b>						<b>\$24,059.30</b>

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ID: PA1500-03  
USER: gadsdeal

MUSC Medical Center  
Header Information

DATE: 12/02/15  
TIME: 08:13:34

Pat#: 49695173-2 Name: SINGLETARY, SHELDON CV: C MR#: 002673589-811-001

Patient Class.....I INPATIENT  
Patient Type.....I INPAT.GENERAL (IP)  
Detail Financial Class.....BX BLUE CROSS/SP F/U  
Summary Financial Class.....BX BLUE CROSS  
Final-billed Financial Class....FX SELF PAY  
Attending Physician..... 3661 CROOKES, BRUCE  
Medical Service.....SUR SUR:GEN SURGERY  
UB92 Disposition Code.....20 EXPIRED  
Logs Category .....  
Logs Action Flag.....  
Readmission Code.....  
Length of Stay/Approved LOS..... 1/ 7  
Leave Days.....  
Bill Flag/Cycle Counter.....R/ 1

Enter Choice: \_\_\_\_\_  
(ESC-Exit, F3-Nxtscr, Scrn#)

MUSC LIVE - a310.30.8

Msgs

ID: PA1500-04  
USER: gadsdeal

MUSC Medical Center  
General Information

DATE: 12/02/15  
TIME: 08:13:42

-----  
Pat#: 49695173-2 Name: SINGLETARY, SHELDON CV: C MR#: 002673589-811-001  
-----

Drq Billed.....957	Birth date/Age.....09/10/1969/042
Outlier.....	Admission date.....04/19/12
Baby/Mother flag.....	Discharge Date.....04/20/12
Baby Account Number.....	Bill From Date.....04/19/12
Mother Account Number.....	Bill Thru Date.....04/20/12
Mother admit date.....	Final Bill Date.....04/30/12
Mother discharge date.....	Bill Gen. Date.....08/27/12
Coinsurance amount.....	Acute Stop Date.....
Lifetime amount.....	Acute Restart Date...
Deductible.....	Benefits Exhausted...
Blood Deductible.....	R.O.E. Date.....
	Last claim sent date.08/28/12

-----  
Enter Choice: \_\_\_\_\_  
(ESC-Exit, F3-Nxtscr, Scrn#)

MUSC LIVE - a310.30.8

Msgs

ID: PA1500-08  
USER: gadsdeal

MUSC Medical Center  
Billing Activity

DATE: 12/02/15  
TIME: 08:13:46

Pat#: 49695173-2 Name: SINGLETARY, SHELDON CV: C MR#: 002673589-811-001

	Billing Activity	Billing Gen Date	Billing From Date	Billing Thru Date	Fin Class	Prim Ins	Billed Amount
01.	Final	4/30/12	4/19/12	4/20/12	FX	FX01	203,251.25
02.	Rebill	8/27/12	4/19/12	4/20/12	BX	BL90	.00

Enter Choice: \_\_\_\_\_

(ESC-Exit, F3-Nxtscr, F4-Bkwr, F5-Fwrd, Scrn#)

MUSC LIVE - a310.30.8

Msgs

ID: PA1500-12  
USER: gadsdeal

MUSC Medical Center  
Charge List

DATE: 12/02/15  
TIME: 08:13:54

Pat#: 49695173-2 Name: SINGLETARY, SHELDON CV: C MR#: 002673589-811-001

Dept Code Description	Rvnu Code Description	Billed Amount
01. 360 TREATMENT 1-WEST 1ESV	260 IV THERAPY	288.00
02. 360 TREATMENT 1-WEST 1ESV	361 MINOR SURGERY	946.00
03. 360 TREATMENT 1-WEST 1ESV	450 EMERGENCY ROOM	1,850.00
04. 360 TREATMENT 1-WEST 1ESV	681 TRAUMA RESPONSE LEVEL 1	3,010.00
05. 363 OPERATING ROOM TIME	360 OR SERVICES	24,990.00
06. 375 MEDICAL SUPPLIES	270 MED/SURG SUPPLIES	880.00
07. 375 MEDICAL SUPPLIES	272 STERILE SUPPLY	898.00
08. 375 MEDICAL SUPPLIES	278 SUPPLY/IMPLANTS	383.00
09. 377 I.V. SOLUTION	258 IV SOLUTIONS	630.00
10. 378 SURGICAL SUPPLIES II	270 MED/SURG SUPPLIES	90.00
11. 378 SURGICAL SUPPLIES II	272 STERILE SUPPLY	1,493.00
12. 380 OPERATING ROOM-HOSPITAL	270 MED/SURG SUPPLIES	428.00
13. 380 OPERATING ROOM-HOSPITAL	272 STERILE SUPPLY	1,228.00
14. 381 MAIN OR SUPPLIES	270 MED/SURG SUPPLIES	146.00

Enter Choice: \_\_\_\_\_

(ESC-Exit, F3-Nxtscr, F4-Bkwr, F5-Frwr, Scrn#, Itm#)

MUSC LIVE - a310.30.8

Msgs

ID: PA1500-12  
USER: gadsdeal

MUSC Medical Center  
Charge List

DATE: 12/02/15  
TIME: 08:13:58

Pat#: 49695173-2 Name: SINGLETARY, SHELDON CV: C MR#: 002673589-811-001

Dept Code Description	Rvnu Code Description	Billed Amount
01. 381 MAIN OR SUPPLIES	272 STERILE SUPPLY	1,498.00
02. 382 AMBULATORY SURGERY	258 IV SOLUTIONS	319.00
03. 382 AMBULATORY SURGERY	272 STERILE SUPPLY	762.00
04. 430 PHARMACY	250 PHARMACY	3,109.67
05. 430 PHARMACY	258 IV SOLUTIONS	302.00
06. 430 PHARMACY	636 DRUGS/DETAIL CODE	667.58
07. 430 PHARMACY	637 SELF ADMIN DRUG	74.00
08. 430 PHARMACY	639 DRUGS MISC	49,200.00
09. 435 ANESTHESIA	370 ANESTHESIA	14,720.00
10. 436 RESPIRATORY THERAPY	410 RESPIRATORY SVC	911.00
11. 436 RESPIRATORY THERAPY	929 OTHER DIAGNOSTIC SERVICES	72.00
12. 467 RADIOLOGY VII	324 RADIOLOGY/DX X-RAY/CHEST	540.00
13. 686 HISTOPATHOLOGY	312 PATHOLOGICAL LAB/HISTOLOG	692.00
14. 836 I STAT	301 LABORATORY/CHEMISTRY	504.00

Enter Choice: \_\_\_\_\_

(ESC-Exit, F3-Nxtscr, F4-Bkwr, F5-Frwr, Scrn#, Itm#)

MUSC LIVE - a310.30.8

Msgs

ID: PA1500-12  
USER: gadsdeal

MUSC Medical Center  
Charge List

DATE: 12/02/15  
TIME: 08:14:02

Pat#: 49695173-2 Name: SINGLETARY, SHELDON CV: C MR#: 002673589-811-001

Dept Code Description	Rvnu Code Description	Billed Amount
01. 836 I STAT	305 LABORATORY/HEMOTOLOGY	46.00
02. 853 FAST FLOW LABORATORY	300 LABORATORY	321.00
03. 853 FAST FLOW LABORATORY	301 LABORATORY/CHEMISTRY	428.00
04. 853 FAST FLOW LABORATORY	305 LABORATORY/HEMOTOLOGY	1,023.00
05. 859 ACUTE CARE LABORATORY	301 LABORATORY/CHEMISTRY	6,419.00
06. 859 ACUTE CARE LABORATORY	305 LABORATORY/HEMOTOLOGY	430.00
07. 892 TRANSFUSION MEDICINE	300 LABORATORY	1,088.00
08. 892 TRANSFUSION MEDICINE	302 LABORATORY/IMMUNOLOGY	3,240.00
09. 895 BLOOD & BLOOD PRODUCTS	390 BLOOD/STOR-PROC	76,876.00
10. 995 SPECIAL CARE	200 INTENSIVE CARE	2,749.00

Enter Choice: \_\_\_\_\_

(ESC-Exit, F3-Nxtscr, F4-Bkwr, F5-Fwrd, Scrn#, Itm#)

MUSC LIVE - a310.30.8

Msgs

ID: PA1500-15  
USER: gadsdeal

MUSC Medical Center  
Payment/Adjustment List

DATE: 12/02/15  
TIME: 08:14:06

Pat#: 49695173-2 Name: SINGLETARY, SHELDON CV: C MR#: 002673589-811-001

Icode	Eff Date	Ins	Description	Payment Type	Amount
01.	A942	10/30/12	1 ADM ADJ NO PRE CERT AUTH	WRITE OFFS	.00
02.	D000	09/14/13	5 A/R TO B/D WRITE OFF	OTHER PAYMENT	992.75-
				TRLR: A/R --> B/D WO	
03.	E010	09/14/13	5 SELF PAY B/D ADJUSTMENT	OTHER PAYMENT	992.75
				TRLR: A/R --> B/D WO	
04.	H100	09/25/12	1 BLUE CROSS PYMT	OTHER PAYMENT	.00
				TRLR: R/A DATE: 09/24/12 NBR: 000009 DRG: 957 DAYS: 0000 OL: 00 ASC:	
05.	H100	10/30/12	1 BLUE CROSS PYMT	OTHER PAYMENT	53,207.00-
				TRLR: R/A DATE: 10/29/12 NBR: 000012 DRG: 957 DAYS: 0000 OL: 00 ASC:	
06.	H100	02/19/13	1 BLUE CROSS PYMT	OTHER PAYMENT	13,196.25-
				TRLR: R/A DATE: 02/18/13 NBR: 418694 DRG: 957 DAYS: 0000 OL: 00 ASC:	
07.	H111	12/05/12	1 BLUE CROSS NON ERA	OTHER PAYMENT	.00
				TRLR: CORRES ZERO/BC	

Enter Choice: 1

(ESC-Exit, F3-Nxtscr, F4-Bkwr, F5-Frwr, Scrn#, Itm#)

MUSC LIVE - a310.30.8

Msgs

ID: PA1500-15  
USER: gadsdeal

MUSC Medical Center  
Payment/Adjustment List

DATE: 12/02/15  
TIME: 08:14:09

Pat#: 49695173-2, Name: SINGLETARY, SHELDON CV: C MR#: 002673589-811-001

Tcode	Eff Date	Ins	Description	Payment Type	Amount
01.	H111	08/26/13	1 BLUE CROSS NON ERA	OTHER PAYMENT	2,749.00-
				TRLR: G7536-BC STATE	
02.	W002	04/30/12	1 UNINSURED/INDIGENT DISCNT	WRITE OFFS	101,625.63-
				TRLR: INS CONTRACTUAL (SYS)	
03.	W002	04/30/12	5 UNINSURED/INDIGENT DISCNT	WRITE OFFS	101,625.63
				TRLR: REV W/O TO BILL INS	
04.	W197	10/30/12	1 BLUE CROSS CONTRACT MGMT	CONTRACTUAL A	133,106.25-
05.	W197	02/19/13	1 BLUE CROSS CONTRACT MGMT	CONTRACTUAL A	.00
06.	W805	08/05/14	2 B/D INDIGENT W/O	OTHER PAYMENT	992.75-
				TRLR: TIMELY BILLING PT	

Enter Choice: \_\_\_\_\_

(ESC-Exit, F3-Nxtscr, F4-Bkwr, F5-Frwr, Scrn#, Itm#)

MUSC LIVE - a310.30.8

Msgs

**Rae H. Wooten, Coroner**

Chief Deputy Coroner  
Bobbi Jo O'Neal

Deputy Coroner  
Dottie Lindsay  
Kelly Kraus  
Brittney W. Martin  
Kimberly Rhoton  
Scott Ramsey



**OFFICE OF THE CORONER**

4050 BRIDGE VIEW DRIVE  
SUITE 500, PERIMETER CENTER  
NORTH CHARLESTON, SC 29405

PHONE: (843) 746-4030  
FAX: (843) 746-4033

June 29, 2012

**VIA U. S. CERTIFIED MAIL**

Mrs. Stacey Singletary  
4112 Eastbury Court  
North Charleston, South Carolina 29420

re: Sheldon Singletary, decedent

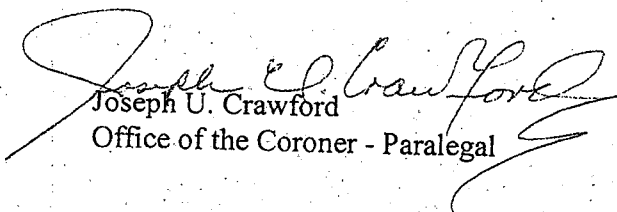
Dear Mrs. Singletary,

Pursuant to your request, you will find enclosed herein a copy of the autopsy report pertaining to your husband, Sheldon Singletary.

If this office can be of further assistance, please do not hesitate to contact us.

With kind regards,

COUNTY OF CHARLESTON

  
Joseph U. Crawford  
Office of the Coroner - Paralegal

ROA 476

Patient: SINGLETARY, SHELDON  
Med Rec: SINGLETARYS042012  
DOB: 9/10/1969  
Male Race: Black  
ACCESSION: FA-12-00242  
Date Received: 4/20/2012  
Date Collected: 4/20/2012

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**F o r e n s i c A u t o p s y F i n a l  
R e p o r t**

**Autopsy Information**

Date of Death: 4/20/12                      Time: 12:06 a.m.  
Date of Autopsy: 4/20/12                    Time: 9:00 a.m.  
County: Charleston  
Coroner: Kimberly Rhoton, Deputy  
Attending Pathologist: Ellen C. Riemer, MD, JD  
Pathologist Assistant: Eowyn Corcraun  
Autopsy Technician: Raymond Edwards  
Prosecutor(s): Ellen C. Riemer, MD, JD

(If Injury) How occurred: Subject was shot  
Date of Injury: 4/19/12                      Time: ~ 3:52 p.m.  
Place of Injury: A residence                At Work: No

**Cause of Death**

Gunshot wound to abdomen

**Manner of Death**

Homicide

**CASE HISTORY**

According to the Coroner and medical records, the decedent was a 42 year old African-American man who was shot in the upper abdomen on April 19, 2012 at approximately 3:52 p.m. Decedent was at the residence of an acquaintance when an argument between decedent and another individual ensued resulting in decedent's being shot with a .45 caliber revolver. EMS personnel transported decedent to the Emergency Department after being intubated at the scene. The patient was taken emergently to the operating room for an exploratory laparotomy and massive transfusion protocol was initiated. In the operating room it was identified that

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**F o r e n s i c A u t o p s y F i n a l  
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decedent had sustained multiple intra-abdominal injuries including a serosal tear, colonic injuries; multiple small bowel injuries, a paravertebral artery injury and a left external iliac artery injury. Intraoperatively, decedent underwent multiple small bowel segmental resections and the left external iliac artery was repaired in addition to repair of ascending lumbar vein and paraspinal artery. Post-operatively, the patient was transferred to the Surgical Trauma ICU in critical condition and underwent massive resuscitation including transfusion of multiple units of blood, 8 liters of crystalloid and additional blood products. There was significant hemorrhagic fluid being drained from his abdominal VAC pack and as the patient was not stabilizing, a decision was made to return to the operating room. There, the patient continued to require massive transfusions of blood and bleeding was unable to be controlled. He returned to the Surgical Trauma ICU, still in critical condition, and expired despite aggressive resuscitative efforts. Decedent was pronounced deceased at 12:06 a.m. on April 20, 2012.

**GROSS DESCRIPTION**

**EXTERNAL EXAMINATION**

The body is that of a well-developed, well-nourished, adult black male, who weighs approximately 187 pounds, is 68 inches in length, and appears compatible with the stated age of 42 years.

The body is identified by the Coroner and a hospital identification tag around the right ankle and an identification tag is also around the right great toe. The body is received unclad. The body is cool to room temperature to the touch. Rigor mortis is partially fixed (3/4) in all extremities and jaw. Diffuse, unfixated, purple livor extends over the posterior surfaces of the body, except in areas exposed to pressure.

The scalp hair is black and up to ¼ inch in length over the crown. The irides are brown; the pupils are bilaterally equal. The corneae are clear. The sclerae and conjunctivae are unremarkable. The nose and ears are not unusual. The lips and gums are intact. The teeth are natural and atraumatic. Facial hair consists of a trimmed beard and mustache. The neck is without masses, and the larynx is in the midline. The thorax is symmetrical with an anteroposterior/lateral ratio of about 1:2. The penis is unremarkable; the testes are bilaterally descended within the scrotum. The anus and back are unremarkable. The upper and lower extremities are well-developed and symmetrical, without absence of digits. Identifying marks and scars consist of a pale patch of skin measuring 1 ½ x 1 ½ inches overlying the right knee.

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Forensic Autopsy Final  
Report

Evidence of emergency resuscitation and / or medical therapy includes a nasogastric tube in the left nostril, an endotracheal tube in the mouth, a triple-lumen line in the left subclavian region, a gauze pad taped to the right subclavian region over fresh needle puncture marks, intravascular lines in the right and left antecubital fossa, an intravascular line in the ventral aspect of the left wrist, a intravascular line in the right femoral region, an intravascular line on the dorsum of the left hand, a pulse oximeter band on the left fifth finger, and surgical film over an open abdominal surgical incision covering exposed stomach and multiple bowel loops, with drainage tubes extending from beneath the surgical film (VAC pack). Within the abdominal cavity multiple pieces of surgical packing are removed including surgical rags and gel foam. Sutures are observed in multiple locations within the small bowel at sites of segmental resection and sutures in blood vessels in the left iliac and paraspinal region.

**EVIDENCE OF INJURY**

**Gunshot wound to Abdomen:** A gunshot wound is to the midline of the upper abdomen approximately 6.5 inches superior to the umbilicus. The entrance wound on the skin is not assessable at autopsy due to alteration by medical intervention (midline abdominal incision through the wound). Nonetheless, a gunshot defect is seen in the anterior abdominal wall musculature to left of midline. The wound path continues intra-abdominally and goes through multiple loops of small bowel and mesentery and continues through left external iliac artery, left paravertebral artery, and injury to surrounding soft tissues and small vessels. The wound path terminated in the musculature to the left of the lumbar vertebral column from where a deformed projectile jacket, a deformed projectile core, and a fragment of a projectile core were recovered. No exit wound is identified. The wound path was directed from front to back, downward, and right to left. The wound was associated with 400 ml of residual blood in the peritoneal cavity. In addition, there is 300 ml of serosanguineous fluid in the right pleural cavity and 350 ml of serosanguineous fluid in the left pleural cavity.

**Sharp Force Injury of Scalp:** A 1 ¼ inch vertically oriented curvilinear incised (cutting) wound measuring less than 1/16 inch in depth is present behind the right ear on the right lateral aspect of the scalp, located 5 inches below the top of the head. The incised wound goes through skin only, without injury to underlying subcutaneous tissue or other structures.

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**RADIOGRAPHS:** X-rays of abdomen identify a cluster of radioopaque projectile pieces in the left paralumbar region of the back.

**EVIDENCE TRANSFER:** The following items of evidence were transferred to MPO Jennifer Wooley of the Charleston Police Department on April 20, 2012 at 3:25 PM: deformed projectile core, deformed projectile jacket, fragment of projectile core, pulled scalp hair, right fingernail clippings, left fingernail clippings, blood spot card, paper bag from left hand. In addition, a CD containing images from the autopsy were transferred to MPO Wooley along with items of evidence.

**INTERNAL EXAMINATION**

**BODY CAVITIES:** 350 ml of serosanguineous fluid is in the left pleural cavity and 300 ml of serosanguineous fluid is in the right pleural cavity. 400 ml of blood is in the peritoneal cavity. All body organs are present in normal anatomical positions.

**HEAD (CENTRAL NERVOUS SYSTEM):** The brain weighs 1310 grams. The dura mater and falx cerebri are intact. The leptomeninges are thin and delicate. The cerebral hemispheres are symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels, are intact and free of abnormality. Sections through the cerebral hemispheres reveal no lesions within the cortex, subcortical white matter, or deep parenchyma of either hemisphere. The basal ganglia, thalami, and hippocampi are unremarkable. The cerebral ventricles are of normal caliber. Sections through the brainstem and cerebellum are unremarkable.

**NECK:** Examination of the soft tissues of the neck, including strap muscles, thyroid gland, and large vessels, reveals no abnormalities. The hyoid bone and larynx are intact. The lingual mucosa is intact; the underlying firm red-brown musculature is devoid of hemorrhage.

**CARDIOVASCULAR SYSTEM:** The heart weighs 540 grams. The pericardial and epicardial surfaces are smooth, glistening and unremarkable; the pericardial sac is free of significant fluid or adhesions. The coronary arteries arise normally, follow the usual distribution and are patent, without evidence of significant atherosclerosis although affected by a mild to moderate degree of atherosclerosis in the diagonal branch of the left anterior descending

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Forensic Autopsy Final  
Report

coronary artery with up to 40% luminal stenosis thereof. The chambers and valves bear the usual size-position relationships and are unremarkable. The myocardium is dark red-brown, firm, and unremarkable; the atrial and ventricular septa are intact. The left ventricular thickness = 1.5 cm, right ventricular thickness = 0.4 cm, and the interventricular septum = 1.5 cm. The aorta and its major branches arise normally, follow the usual course and are patent, free of significant atherosclerosis and other abnormality. The venae cavae and their major tributaries return to the heart in the usual distribution and are free of thrombi.

**RESPIRATORY SYSTEM:** The right and left lungs weigh 1050 and 800 grams, respectively. The upper airway is clear of debris and foreign material; the mucosal surfaces are smooth, yellow-tan and unremarkable. The pleural surfaces are smooth, glistening and unremarkable. Lobar divisions are of the usual configuration. The pulmonary parenchyma is pink to red, exuding abundant amounts of blood and frothy fluid; no focal lesions are noted. The pulmonary arteries are normally developed, patent, and without thrombus or embolus.

**LIVER AND BILIARY SYSTEM:** The liver weighs 1840 grams. The hepatic capsule is smooth, glistening and intact, covering red-brown parenchyma, with no focal lesions noted. The gallbladder contains 30 ml of red-brown, slightly mucoid bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of calculi. The portal vein and its tributaries are unremarkable.

**ALIMENTARY TRACT:** Injury to the small bowel is described in "Evidence of Injury." The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is arranged in the usual rugal folds, and the lumen contains less than 5 ml of tan mucoid fluid. The small and large bowel show no organic lesions. The appendix is present and unremarkable. The pancreas has a normal gray-white, lobulated appearance, and the ducts appear clear.

**GENITOURINARY TRACT:** The right and left kidneys weigh 190 grams each. The renal capsules are smooth and thin, semi-transparent, and strip with ease from the underlying pale, firm, cortical surfaces. The cortices are sharply delineated from the medullary pyramids, which are red-purple to tan and unremarkable. The calyces, pelves, and ureters are unremarkable. The relationships at the trigone are unremarkable. The urinary bladder contains no urine; the mucosa is gray-tan and smooth. The testes, prostate and seminal vesicles are unremarkable.

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**RETICULOENDOTHELIAL SYSTEM:** The spleen weighs 190 grams and has a smooth, intact capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles are unremarkable. The regional lymph nodes appear normal. The bone marrow is red-purple and homogeneous, without evidence of focal abnormality.

**ENDOCRINE SYSTEM:** The pituitary, thyroid, and adrenal glands are unremarkable.

**MUSCULOSKELETAL SYSTEM:** The bony framework, supporting musculature, and soft tissues are not unusual.

ECR:saw  
04/22/12  
04/24/12  
05/09/12

Ellen C Riemer, M.D., J.D. (1-4726)/ MTR

**CASE SUMMARY**

A complete autopsy was performed on the body of Sheldon Singletary at the Medical University of South Carolina Autopsy Suite on April 20, 2012. The postmortem examination began at 9:00 a.m. The prosecutor was Dr. Ellen C. Riemer. The autopsy technician was Mr. Raymond Edwards. The autopsy was authorized by the Charleston County Deputy Coroner, Ms. Kimberly Rhoton.

Significant findings at autopsy included a gunshot wound to the abdomen which went through the abdominal wall; multiple loops of small bowel, and blood vessels in the left iliac and left paralumbar region. No exit wound was identified. Pieces of a projectile, consisting of a deformed projectile core, a deformed projectile jacket and a fragment of a projectile core, were recovered in the musculature of the left paralumbar region of the lower back. Other injury to the body included a 1 ¼ inch curvilinear superficial incised wound behind the right ear which injured skin only.

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**Forensic Autopsy Final Report**

Toxicologic analysis of decedent's hospital admission blood is being performed at NMS Laboratories. However, results thereof are not expected to influence a determination of the cause and manner of death.

In light of the historical information and the findings at autopsy, it is the opinion of the pathologist that the decedent died as the result of a gunshot wound to the abdomen. Furthermore, the manner of death is best deemed homicide.

**FINAL DIAGNOSIS**

- A. Gunshot wound to abdomen
1. Entrance on midline of upper abdominal region, inferior to sternum
  2. Injury to anterior abdominal wall, multiple small bowel loops and mesentery, left iliac artery, left paravertebral artery, left lumbar vein, and associated soft tissue and musculature
  3. No exit wound identified
  4. Projectile core, projectile jacket and core fragment recovered, left paralumbal region
  5. Trajectory of wound path: front to back, downward, right to left
  6. Associated injuries: hemoperitoneum
  7. Evidence of surgical intervention includes: resection of small bowel loops; sutures in left paravertebral and iliac vessels
- B. Sharp force injury to scalp
1. Incised wound right temporal region of scalp (posterior to right external ear)
  2. Injury to skin only

**CERTIFICATION**

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

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Forensic Autopsy Final  
Report

rendered the above diagnosis(es).

Ellen C Riemer, M.D., J.D. (1-4726)  
(Electronically signed by)  
Verified: 05/09/2012 03:36  
ECR/MTR

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THE STATE OF SOUTH CAROLINA  
In the Supreme Court

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APPEAL FROM CHARLESTON COUNTY  
Court of Common Pleas

The Honorable Mikell R. Scarborough, Master in Equity

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Appellate Case No. 2018-001386  
Common Pleas Case No.: 2015-CP-10-2178

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RECEIVED  
MAR 25 2019  
SC Court of Appeals

Stacy Singletary, Individually and as Personal Representative of Sheldon Singletary...Respondent

vs.

Kelvin Shuler..... Appellant

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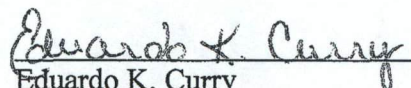
**CERTIFICATE OF COUNSEL**

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I certify that I have served the **Appellant's Record on Appeal** on Respondent Stacy Singletary, Individually and as Personal Representative of Sheldon Singletary, by depositing a copy of it in the United States Mail, postage prepaid, on March 5, 2019, addressed to their attorney of record, Thad Doughty, 6650 Rivers Avenue, North Charleston, SC 29406.

I certify that the Record on Appeal contains no matter which is irrelevant to the appeal.

March 5, 2019

  
Eduardo K. Curry  
Curry Law Firm, LLC  
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North Charleston, SC 29423  
(843) 767-5284