RECEIVED
Oct 22 2020
SC Court of Appeals

Conditions of Admission and Consent for Outpatient Care

In this document, "**Patient**" means the person receiving treatment. "Patient Representative" means any person acting on behalf of the Patient and signing as the Patient's representative. Use of the word "I," "you," "your" or "me" may in context include both the Patient and the Patient Representative. With respect to financial obligations "I" or "me" may also, depending on the context, mean financial guarantor "Guarantor".

"Provider" means the hospital and may include healthcare professionals on the hospital's staff and/or hospital-based physicians, which include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, Anesthesiologists, Hospitalists, certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors or assignees acting on their behalf.

Legal Relationship between Hospital and Physicians. Most or all of the physicians performing services in the hospital are independent and are not hospital agents or employees. Independent physicians are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent physicians.

1. **Consent to Treatment.** I consent to the procedures which may be performed during this hospitalization or during an outpatient episode of care, including, but not limited to, emergency treatment or services, and which may include laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered as ordered by the Provider. I consent to allowing students as part of their training in health care education to participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that these students will be supervised by instructors and/or hospital staff. I further consent to the hospital conducting blood-borne infectious disease testing, including but not limited to, testing for hepatitis, Acquired Immune Deficiency Syndrome ("AIDS"), and Human Immunodeficiency Virus ("HIV"), if a physician orders such tests or if ordered by protocol. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.

2. **Consent to Photographs, Videotapes and Audio Recordings.** I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the hospital's quality improvement and/or risk management activities. I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.

3. **Financial Agreement.** In consideration of the services to be rendered to Patient, Patient or Guarantor individually promises to pay the Patient's account at the rates stated in the hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the Patient's account. Some special items will be priced separately if there is no price listed on the Charge Master. An estimate

of the anticipated charges for services to be provided to the Patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including, but not limited to, the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

Professional services rendered by independent contractors are not part of the hospital bill. These services will be billed to the Patient separately. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

The hospital will provide a medical screening examination as required to all Patients who are seeking medical services to determine if there is an emergency medical condition without regard to the Patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, Patient and Guarantor understand that if Patient does not qualify under the hospital's charity care policy or other applicable policy, Patient or Guarantor is not relieved of his/her obligation to pay for these services.

If supplies and services are provided to Patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the Patient or Guarantor will be determined by the terms of the governmental program or private health insurance plan. If the Patient is uninsured and not covered by a governmental program, the Patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital.

I also understand that, as a courtesy to me, the hospital may bill an insurance company offering coverage, but may not be obligated to do so. Regardless, I agree that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the Patient or Guarantor. I agree to pay for services that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions, or failure to comply with insurance plan requirements.

4. **Third Party Collection**. I acknowledge that the Providers may utilize the services of a third party Business Associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing. During the time that the medical account is being serviced by the EBO Servicer, the account shall not be considered delinquent, past due or in default, and shall not be reported to a credit bureau or subject to collection legal proceedings. When the EBO Servicer's efforts to obtain payment have been exhausted due to a number of factors (for e.g., Patient or Guarantor's failure to pay or make a payment arrangement after insurance adjustments and payments have been credited, and/or the insurer's denial of claim(s) or benefits is received), the EBO Servicer will send a final notice letter which will include the date that the medical account may be returned from the EBO Servicer to the Provider.

Upon return to the Provider by the EBO Servicer, the Provider may place the account back with the EBO Servicer, or, at the option of the Provider, may determine the account to be delinquent, past due and in default. Once the medical account is determined to be delinquent it may be subject to late fees, interest as stated, referral to a collection agency for collection as a delinquent account, credit bureau reporting and enforcement by legal proceedings.

I also agree that if the Provider initiates collection efforts to recover amounts owed by me or my Guarantor, then, in addition to amounts incurred for the services rendered, Patient or Guarantor will pay, to the extent permitted by law: (a) any and all costs incurred by the Provider in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the Provider.

5. **Assignment of Benefits.** Patient assigns all of his/her rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorizes direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient for the hospitalization or for outpatient services, including emergency services, if rendered. Patient understands that any payment received from these policies and/or plans will be applied to the amount that Patient or Guarantor has agreed to pay for services rendered during this admission and, that Provider will not retain benefits in excess of the amount owed to the Provider for the care and treatment rendered during the admission.

   I understand that any health insurance policies under which I am covered may be in addition to other coverage or benefits or recovery to which I may be entitled, and that Provider, by initially accepting health insurance coverage, does not waive its rights to collect or accept, as payment in full, any payment made under different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services and treatment.

   I hereby **irrevocably appoint** the Provider as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier or, any other responsible third party ("Responsible Party") for any and all benefits due me for the payment of charges associated with my treatment. This assignment shall not be construed as an obligation of the Providers to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right.

   I agree to take all actions necessary to assist the Provider in collecting payment from any such Responsible Party should the Provider(s) elect to collect such payment, including allowing the Provider(s) to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment acknowledge that it is my duty and responsibility to immediately pay any such payments to the Provider(s).

6. **Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

7. **Private Room.** I understand and agree that I am (or Guarantor is) responsible for any additional charges associated with the request and/or use of a private room.

8. **Outpatient Medicare Patients.** Medicare does not cover prescription drugs with only a few exceptions. According to Medicare regulations, I acknowledge that I am responsible for any drugs furnished to me while an outpatient that meet Medicare's definition of a prescription drug. These drugs are also referred to as self-administered drugs, as they are usually self-administered but they may be administered to me by hospital personnel. Medicare requires hospitals to bill Medicare Patients or other third party payers for these drugs. Medicare Part D beneficiaries may submit a paper claim to the Medicare Part D Plan for possible reimbursement of these drugs in accordance with Medicare Drug Plan enrollment materials.

9. **Communications About My Healthcare.** I authorize my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others I designate to be responsible for my care. I will provide those individuals with a password or other verification means specified by the hospital. I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

10. **Consent to Telephone Calls for Financial Communications.** I agree that, in order for you, or your EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that you or your EBO Servicer and collection agents may contact me by telephone at any telephone number I have provided or you or your EBO Servicer and collection agents have obtained or, at any number forwarded or transferred from that number, regarding the hospitalization, the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

11. **Consent to Email or Text Usage for Discharge Instructions and Other Healthcare Communications.** If at any time I provide an email or text address at which I may be contacted, I consent to receiving discharge instructions and other healthcare communications at that email or text address from the Providers. These discharge instructions may include, but not be limited to: post-operative instructions, physician follow-up instructions, dietary information, and prescription information. The other healthcare communications may include, but are not limited to communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

12. **Release of Information.** I hereby permit Providers to release healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician

progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

13. Other Acknowledgements.

Personal Valuables. I understand that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss of or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for the loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars ($500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the Patient. The hospital is not responsible for the loss or damage of cell phones, glasses or dentures or personal valuables unless they are placed in the hospital safe in accordance with the terms as stated above.

Weapons/Explosives/Drugs. I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may search my room and my belongings located anywhere on hospital property, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

Patient Visitation Rights. I understand that I have the right to receive the visitors whom I or my Patient Representative designates, without regard to my relationship to these visitors. I also have the right to withdraw or deny such consent at any time. I will not be denied visitation privileges on the basis of age, race, color, national origin, religion, gender, gender identity and gender expression, and sexual orientation or disability. All visitors I designate will enjoy full and equal visitation privileges that are no more restrictive than those that my immediate family members would enjoy. Further, I understand that the hospital may need to place clinically necessary or reasonable restrictions or limitations on my visitors to protect my health and safety in addition to the health and safety of other Patients. The hospital will clearly explain the reason for any restrictions or limitations if imposed. If I believe that my visitation rights have been violated, I or my representative has the right to utilize the hospital's complaint resolution system.

Additional Provision for Admission of Minors/ Incapacitated Patient. I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

14. **Patient Self Determination Act.**
I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). . Please initial or place a mark next to **one** of the following applicable statements:

	I executed an Advance Directive and have been requested to supply a copy to the hospital		I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive	✓	I have not executed an Advance Directive and do not wish to execute one at this time

15. **Notice of Privacy Practices.** I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other prescribed and permitted uses and disclosures. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. I understand that I may contact the hospital Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge: Matthew Scheer (Initial)

16. **Consent to Authorize Use of Email and Text for Patient Billing and Financial Obligations.** By my consent below, I authorize the use of any email address or cellular telephone number I provide for receiving **information** relating to my financial obligations, including, but not limited to, payment reminders, delinquent notifications, instructions and links to hospital Patient billing information.

Acknowledge: _____ (Initial) I consent to use of email for Patient billings and financial obligation purposes.

Acknowledge: _____ (Initial) I consent to use of text for Patient billings and financial obligation purposes.

17. **Acknowledgement**: I have been given the opportunity to read and ask questions about the information contained in this form, **specifically** including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers.

Acknowledge: Matthew Scheer (Initial)

18. **Acknowledgement of Notice of Patient Rights and Responsibilities**. I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship,

religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

Acknowledge: Matthew J Scheer (Initial)

Date: 10.2.15 Time: 11:34AM	I, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian, hereby certify I have read, and fully and completely understand this Conditions of Admission and Authorization for Medical treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Patient/Patient Representative Signature: X Matt J Scheer If you are not the Patient, please identify your Relationship to the Patient. **(Circle or mark relationship(s) from list below)**: Spouse Parent Legal Guardian Neighbor/Friend Sibling Healthcare Power of Attorney Guarantor Other (please specify): _____	**Witness Signature and Title:** X **Additional Witness Signature and Title:** (required for Patients unable to sign without a representative or Patients who refuse to sign) X HCA Corporate Standard COA-COS 03.17.2015

GRAND STRAND MEDICAL CENTER
PATIENT NOTICE - CLINICAL TRAINEES

Grand Strand Medical Center supports the education and development of clinical trainees: students, volunteers, vendors, and licensed professionals such as nurses, pharmacists, physical therapists, phlebotomists, radiology specialists, medical students, residents in training, or other healthcare providers.

Grand Strand Medical Center is a teaching hospital with an academic affiliation with University of South Carolina and contains embedded residency programs. As such, intern and resident physicians will be collaboratively involved in making treatment decisions under the supervision of experienced staff physicians.

Resident and intern physicians, Allied Health Professionals (physician assistants or nurse practitioners) may also be part of the treatment team in participating in surgery or other invasive procedures.

Non-physician clinical trainees may be involved in inpatient and outpatient care involving nursing, pharmacy, physical therapy, phlebotomy, radiology or other clinical services. Non-physician clinical trainees perform their duties under the supervision of an instructor, preceptor, physician or other professional healthcare provider within the scope of practice for their education and experience. All clinical trainees will be identified by wearing badges that clearly state their names, departments, and trainee titles.

Your attending physician is the person responsible for your care while you are hospitalized. The attending physician may change during a hospitalization depending upon the type of care or services required for your care. Some attending physicians work closely with physician assistants or nurse practitioners (Allied Health Professionals). In this instance, these Allied Health Professionals would be making treatment decisions and participating in your care. Allied Health Professionals are credentialed by the hospital.

At any time during your hospital stay, as an inpatient or for outpatient surgery, you may discuss your personal medical care with your attending physician, Intern Physician, Resident Physician, or his/her designee. If you ask that a nurse call your attending physician or other providers regarding your personal medical care, the nurse will place a call to your attending physician or his/ her designee. Upon request, the nurse will provide you with your attending physician's or his/her designee's phone number. If you are unable to communicate with, but wish to contact, your attending physician, a nurse will assist in placing the call and inform your attending physician or his/her designee of your concern and your need for one-one communication.

To access Grand Strand Medical Center's patient assistance system to discuss concerns about your treatment plan or hospital care during regular business hours, please call Administration (843) 692-1100; after hours, weekends and holidays call (843) 692-1000 and ask to speak to the Administrative Supervisor.

Your attending physician is: _____

Patient Initials: MJS

GRAND STRAND MEDICAL CENTER
PATIENT NOTICE - CLINICAL TRAINEES

ADMIN *3400301179 (08/18/15) 453952*

Patient Information/Label

Page 1 of 1

NAME: SCHEER,MATTHEW
ACCT#: F01034274115
FORM:

ADM DATE: 10/02/15 1014
ATTEND PHYS: Battisti,Amanda DO
DIS DT/TM: 10/02/15 1304
DIS DISP: LIGHTHOUSE
LOS: : 1
PT CLASS: ER.ALL

UNIT#: F000838076
SEX: M
AGE: 26
DOB: 01/19/89
FIN CLASS: 08
ABS STATUS: FINAL

DIAGNOSES POA INDICATOR CODESET

REASON FOR VISIT DX
F32.9 MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED ICD10
F22 DELUSIONAL DISORDERS ICD10

PRIMARY CODESET
PRINC DX F23 BRIEF PSYCHOTIC DISORDER ICD10
OTHER DX G40.909 EPILEPSY, UNSP, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS ICD10

OTHER CODESET
PRINC DX
OTHER DX

PROCEDURE
PRIMARY CODESET
DATE PROC CODE & NAME SURGEON ANESTHESIOLOGIST
OTHER CODESET

PRIMARY CODESET
DRG I-10
OTHER CODESET
DRG I-9

STATUS	$REIMB	MIN-LOS	STD-LOS	COST WT	GRP VERS	GRP FC
					32icd10	08

DRG STATUS DATE:
CODER: R.HIM.WLT

ABS STATUS DATE: 10/08/15
ABSTRACTOR: R.HIM.WLT

This form will be maintained as a permanent part of the medical record

Grand Strand Regional Medical Center
809 82nd Parkway, Myrtle Beach, South Carolina 29572 (843)692-1000

I N / O U T / E R P A T I E N T A D M I S S I O N R E C O R D

ACCOUNT#: F01034274115 ADM DATE: 10/02/15 UNIT RCRD #: F000838076 ARRIVAL: WI
ROOM/BED: ADM TIME: 1014 MARKET URN: F724867 CONF: VIP:
PT. TYPE: REG ER ADMIT PRI/SRC: EM / PR LOCATION(S): F.ED FC: 08

P A T I E N T I N F O R M A T I O N

NAME: SCHEER, MATTHEW J
STREET: 5750 OYSTER CATHCHER DR
STREET: BLD 11 UNIT 1135
C/S/ZP: MYRTLE BEACH, SC 29582
PHONE#: (609)457-0387 CNTY/RES: 026
EMAIL: MSCHEER89@MSN.COM

OTHER NAME:
DOB: 01/19/1989 SS#: XXX-XX-7777
AGE: 26 RACE: WHITE/CAUC
SEX: M MAR STATUS: M
REL: CATHOLIC LANG: ENGLISH

S P O U S E / N O K / C O M P A N I O N

SCHEER, DEBRA
5750 OYSTER CATHCHER DR
MYRTLE BEACH, SC 29582
(609)226-4952 RELTN: MOTHER
WORK PH:

P E R S O N T O N O T I F Y

SCHEER, DAVID
5750 OYSTER CATHCHER DR
MYRTLE BEACH, SC 29582
(609)226-4952 RELTN: FATHER
WORK PH:

P A T I E N T E M P L O Y E R

DUNES VILLAGE RESORT

MYRTLE BEACH, SC
(999)999-9999 OCC: EMPLOYEE

G U A R A N T O R

SCHEER, MATTHEW J
5750 OYSTER CATHCHER DR
BLD 11 UNIT 1135
MYRTLE BEACH, SC 29582
(609)457-0387 RELTN: SELF

G U A R A N T O R E M P L O Y E R

DUNES VILLAGE RESORT

MYRTLE BEACH, SC
(999)999-9999

OCCURRENCE CODES

11 10/02/15

CONDITION CODES

I N S U R A N C E I N F O R M A T I O N

PRIMARY: BC12 - 32104	SECONDARY:	TERTIARY:
401 BC OF NJ PPO		
ATTN: NATL ACCTS		
PO BOX 100300		
COLUMBIA, SC 29202		
POLICY #: NJX3HZN82483300	POLICY #:	POLICY #:
COVERAGE #:	COVERAGE #:	COVERAGE #:
INS PHONE #: (800)414-7427	INS PHONE #:	INS PHONE #:
GRP #: 00935000002	GRP#:	GRP#:
AUTH #:	AUTH #:	AUTH #:
AUTH DT: VER DT: 10/02	AUTH DT: VER DT:	AUTH DT: VER DT:
SUB: SCHEER, DEBRA	SUB:	SUB:
RELAT: MO DOB: 02/07/1958	RELAT: DOB:	RELAT: DOB:

P H Y S I C I A N I N F O R M A T I O N / D O C U M E N T A T I O N

ADM:
HCS:
ATT:
HCS:
ER: BATAM Battisti, Amanda DO, 6792

PCP: .NO PCP No Primary or Family Physician
HCS: 7943 .
REF: .SELF SELF REFERRED
HCS: 9715 .

REASON FOR VISIT/CHIEF COMPL: DEPRESSION - ANXIETY

PRINCIPAL DIAGNOSIS:

PRINCIPAL OPERATION/PROCEDURE:

CONSULTATIONS:

COMMENTS: SN
PRT BY: R.QV.ANT ON: 10/02/15 1306

ADVANCE DIRECTIVE: No: Info Offered/Refused
DISCH DATE: TIME: DISPO:

GRAND STRAND REGIONAL MEDICAL CENTER (COCQV)
EMERGENCY PROVIDER REPORT
REPORT#:1002-0336 REPORT STATUS: Signed
DATE:10/02/15 TIME: 1017

PATIENT: SCHEER,MATTHEW UNIT #: F000838076
ACCOUNT#: F01034274115 ROOM/BED: F.ED
AGE: 26 SEX: M PCP PHYS: No Primary or Family Physician
SERVICE DT: 10/02/15 AUTHOR: Beliew,Michael J PA

* ALL edits or amendments must be made on the electronic/computer document *

BELIEW,MICHAEL 10/02/15 1017:

HPI-Psychiatric Illness

HPI
Confirmed patient: Yes
Date/Time Seen by Provider 10/02/15 1017
Complaint: depressed

History-Medical/Family/Social

Home medications:
Reported Medications
levETIRAcetam XR (KEPPRA XR) 2,500 MG PO BEDTIME

Discontinued Reported Medications
levETIRAcetam (KEPPRA) 250 MG PO BID
levETIRAcetam XR (KEPPRA XR)

Phys Exam-Psychiatric Illness

Vital Signs

Results/Interpretations

Results:

Disposition-Psych. Illness

Vital signs:

BATTISTI,AMANDA 10/02/15 1027:

HPI-Psychiatric Illness

HPI
Confirmed patient: Yes
Complaint: paranoia and hallucinations
Source of history: patient, family (father)
Timing - onset: days (2-3)
Quality: hallucinations, paranoid
Additional hpi notes:
Mr. Scheer is a 26 y/o male with a h/o epilepsy who presents to the ED c/o paranoia and hallucinations. Associated sx include insomnia and anorexia due to believing that all "food he used to eat is contaminated now." Pt's father reported he had an extended complex vision last night lasting a couple of hours. Pt reports hearing voices and believes someone is plotting against him by poisoning him. Pt denies suicidal or homicidal thoughts. Pt reported not eating today or yesterday. Pt reports not taking his prescribed keppra for the last 2-3 days. No other sx at this time.

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1642

Risk Strat-Psychiatric Illness
Suicide risk factors: None

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1027

Review of Systems
Constitutional:
Denies: fever, chills.
Skin:
DENIES: redness, swelling.
ENT:
DENIES: sore throat, neck pain.
Respiratory:
DENIES: SOB, cough.
Cardiovascular:
DENIES: chest pain, edema, palpitations.
Gastrointestinal:
anorexia (due to hallucinations).
Musculoskeletal:
DENIES: extremity pain, extremity swelling.
Neuro:
Denies: headache, numbness.

Psych:
auditory hallucination, visual hallucination, insomnia. DENIES: depression, suicidal ideation, homicidal ideation.
Additional notes:
reports paranoid thoughts that others are against him and thought that his food is being poisoned.
All systems reviewed & negative except as marked.

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1642

History-Medical/Family/Social

)(Reviewed nursing notes: Yes
Additional Medical History:
reports h/o epilepsy and has been taking keppra since 2009.
Allergies:
Coded Allergies:
No Known Drug Allergies (10/02/15)

Past Surgical History:
Reports none
Smoking status 13 years/older: Never Smoker
Social history:
Reports: local resident. Denies: alcohol, drugs, smoker.
Occupation:
bar-back
Ambulatory status: independent

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1027

Phys Exam-Psychiatric Illness

Vital Signs
First Documented:

	Result	Date Time
Pulse Ox	99	10/02 1019
B/P	130/77	10/02 1019
Temp	36.9	10/02 1019
Pulse	130	10/02 1019
Resp	22	10/02 1019

Last Documented:

	Result	Date Time

Pulse Ox	99	10/02 1019
B/P	130/77	10/02 1019
Temp	36.9	10/02 1019
Pulse	130	10/02 1019
Resp	22	10/02 1019

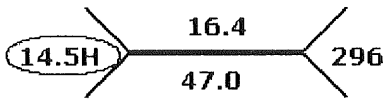
Initial VS reviewed: yes
General: alert, eating and drinking poorly
Head/Eyes: normocephalic, PERRL, EOMI
Neck: atraumatic, full range of motion
Respiratory/Chest: no respiratory distress, breath sounds normal
Cardiovascular: regular rate and rhythm, normal heart sounds
Abdomen: soft, non-tender
Extremities:
Assessment: normal inspection, full range of motion
Back: normal inspection, full range of motion
Skin: no rash, warm, dry
Neurologic: alert, heightened sense of smell and vision
Psychiatric: auditory hallucinations, visual hallucinations, pressured tangential speech, denies suicide and homicidal intention and plan, paranoid thoughts that others are against him, tactile hallucinations, paranoid thoughts that his food is being poisoned

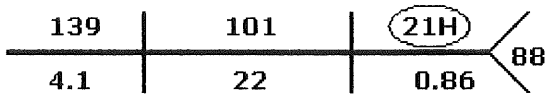
Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1642

Results/Interpretations

Results:
Laboratory Tests

10/02/15 1042:





Laboratory Tests:

	10/02 1155	10/02 1104	10/02 1042	10/02 1042
Chemistry				
Sodium (136 - 145 MMOL/L)				139

Potassium (3.5 - 5.1 MMOL/L)				4.1
Chloride (98 - 107 MMOL/L)				101
Carbon Dioxide (21 - 32 MMOL/L)				22
Anion Gap (3.0 - 11.0 mEq/L)				16.0H
BUN (7 - 18 mg/dL)				21H
Creatinine (0.6 - 1.3 mg/dL)				0.86
Estimated GFR (MDRD) (> =60)				> 60
BUN/Creatinine Ratio (10 - 20)				24H
Glucose (74 - 106 mg/dL)				88
POC Glucose (74 - 106 mg/dl)		80		
Calcium (8.5 - 10.1 mg/dL)				9.4
Total Bilirubin (0.2 - 1.0 mg/dL)				5.5H
AST (15 - 37 Units/L)				30
ALT (30 - 65 Units/L)				35
Alkaline Phosphatase (20 - 130 Units/L)				64
Total Protein (6.4 - 8.2 gm/dL)				7.9
Albumin (3.4 - 5.0 GM/dL)				4.8
Globulin (2.5 - 4.5 gm/dL)				3.1
Albumin/Globulin Ratio (0.7 - 1.5)				1.6H
TSH (0.36 - 3.74 ulU/mL)				1.45
Hematology				
WBC (3.7 - 10.1 K/mm3)				14.5H
RBC (4.55 - 5.47 M/mm3)				5.19
Hgb (14.0 - 16.4 gm/dl)				16.4
Hct (40.0 - 47.2 %)				47.0
MCV (81.8 - 94.6 fL)				90.6
MCH (27.9 - 33.1 pg)				31.5
MCHC (33.4 - 35.6 g/dl)				34.8
RDW (11.6 - 14.0 %)				12.6
Plt Count (150 - 400 K/mm3)				296
Neut % (Auto) (40.1 - 81.3 %)				74.8
Lymph % (Auto) (17.0 - 47.0 %)				14.3L
Mono % (Auto) (5.5 - 11.9 %)				9.6
Eos % (Auto) (0.0 - 5.5 %)				0.5
Baso % (Auto) (0.0 - 1.1 %)				0.8
Neut # (1.4 - 6.5 K/mm3)				10.9H
Lymph # (1.2 - 3.4 k/mm3)				2.1
Mono # (0.1 - 0.6 K/mm3)				1.4H
Eos # (0.0 - 0.7 K/mm3)				0.1
Baso # (0.0 - 0.2 K/mm3)				0.1
Toxicology				
Salicylates (2.8 - 20.0 mg/dL)			< 1.7L	

Urine Opiates Screen (NEGATIVE)	NEG			
Acetaminophen (10.0 - 30.0 mcg/mL)				< 2.0L
Ur Barbiturates, Qual (NEGATIVE)	NEG			
Ur Phencyclidine (PCP) (NEGATIVE)	NEG			
Urine Amphetamine (NEGATIVE)	NEG			
U Benzodiazepines Scrn (NEGATIVE)	NEG			
Urine Cocaine Screen (NEGATIVE)	NEG			
U Cannabinoids Screen (NEGATIVE)	NEG			
Plasma/Serum Alcohol (mg/dL)				< 3.0
Urines				
Urine Color (YELLOW)	Yellow			
Urine Appearance (CLEAR)	Clear			
Urine pH (5.0 - 8.5)	5.0			
Ur Specific Gravity (1.001 - 1.035)	1.032			
Urine Protein (NEGATIVE)	30 mg/dl*			
Urine Ketones (NEGATIVE mg/dL)	80 mg/dl*			
Urine Blood (NEGATIVE mg/dl)	NEGATIVE			
Urine Nitrite (NEGATIVE)	NEGATIVE			
Urine Bilirubin (NEGATIVE mg/dL)	NEGATIVE			
Urine Urobilinogen (NEG - 1mg/dL mg/dl)	NEGATIVE			
Ur Leukocyte Esterase (NEGATIVE WBCS/uL)	NEGATIVE			
Urine RBC (0 - 1 RBC/HPF)	0-1			
Urine WBC (0 - 1 WBC/HPF)	0-1			
Urine Mucus (NEGATIVE /LPF)	FEW*			
Urine Glucose (NORMAL mg/dL)	NEGATIVE			

Recent Impressions:
COMPUTERIZED TOMOGRAPHY - CT HEAD W/O CONTRAST 10/02 1130
*** Report Impression - Status: SIGNED Entered: 10/02/2015 1204

IMPRESSION:

1. No acute intracranial process.

Impression By: PHY.BROMI - MICHAEL H BROWN MD

Lab result interpretations: Labs reviewed
Urinalysis results and interpretation: U/A reviewed and normal
Pulse Oximetry
Pulse Ox % 99
On: room air

Interpretation: interpreted by me, pulse oximetry normal
Time of interpretation: 1019
Head CT interpretation:
Interpreted by radiologist: Yes
Reviewed by: ED physician
With contrast: No
General: IMPRESSION:

1. No acute intracranial process.

Impression By: PHY.BROMI - MICHAEL H BROWN MD

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1642

MDM-Psychiatric Illness

ED Course

Patient course: stable
)(Re-Evaluation/Progress 1
Time: 1043
Additional notes:
Discussed case with social worker.
)(Re-Evaluation/Progress 2
Time: 1220
Additional notes:
Discussed plan to transport to Lighthouse Care Center from the ER in care of his father. Social worker arranged for acceptance. Pt understands and agrees with the plan. No other questions at this time.

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1230

Disposition-Psych. Illness

Clinical Impression:
Primary Impression: Acute psychosis
)(Disposition:
Transported to: Yes (lighthouse care center)
Disposition time: 1226
Disposition date: 10/02/15
Vital signs:
First Documented:

	Result	Date Time
Pulse Ox	99	10/02 1019
B/P	130/77	10/02 1019

Temp	36.9	10/02 1019
Pulse	130	10/02 1019
Resp	22	10/02 1019

Last Documented:

	Result	Date Time
Pulse Ox	99	10/02 1019
B/P	130/77	10/02 1019
Temp	36.9	10/02 1019
Pulse	130	10/02 1019
Resp	22	10/02 1019

)(All prior VS reviewed: Yes
Condition: Stable
Counseled patient/family re: diagnosis, lab results, need for transportation
Supervising Physician Note:
BENDIK,MORGAN M (10/02/15/1226) scribing for and in the presence of Battisti,Amanda DO. (10/02/15/1226)
I personally performed the services described in this documentation, reviewed and edited the documentation which was dictated to the scribe in my presence, and it accurately records my words and actions.

Battisti,Amanda DO
(10/02/15/1226)

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1230

Electronically Signed by Beliew,Michael J PA on 10/02/15 at 2039
Electronically Signed by Battisti,Amanda DO on 10/08/15 at 0851

RPT #: 1002-0336
END OF REPORT

Patient: SCHEER,MATTHEW Age/Sex: 26/M Acct No: F010342741l5
EDM Provider: Battisti,Amanda DO, 2hcaActive Unit No: F000838076

GENERAL DATA

ED Physician: Battisti,Amanda DO, 2hcaActive
Practitioner:
Nurse: AGUIRRE,MARY J, RN

Arrival Date/Time: 10/02/15 - 1014
Triage Date/Time: 10/02/15 - 1019
Date of Birth: 01/19/1989

Stated Complaint: DEPRESSION - ANXIETY
Chief Complaint: Psych Related
Priority: 2

Status Event History:

10/02/15	1014	Reception
	1023	Triaged
	1023	Room
	1025	With Physician/Practitioner
	1237	Disposition - Depart
	1304	Departed
	1305	Off Tracker

MODE OF ARRIVAL

WALK IN

ALLERGIES

No Known Drug Allergies

Home Medications

Prescriptions/Reported Meds	Type	Issued	Provider	Last Edited
levETIRAcetam (KEPPRA) 250 MG TAB	Reported			10/02/15

250 MG PO TWICE DAILY
Discontinue Reason: 5
<Last Taken> => 09/25/15
<Reviewed> => AGUIRRE,MARY J 10/02/15 @ 1032

ASSESSMENTS

1st Point of Contact

Occurred Date	Time	User	Recorded Date	Time	User
10/02/15	1016	KIRK,MARGARET ROSE	10/02/15	1016	KIRK,MARGARET ROSE

Is Patient Present? Y
Able to perform TB & Contagious Respiratory Infection Point of Entry Screen Y
--In the past 3 weeks has the patient:--
Resided in or traveled to an African country: None
Had contact with anyone who has been to a West African country: No
Been in close contact with a person known or suspected to have Ebola: No
Fever greater than 100.4 F or 38.0 C: N
Is patient currently experiencing any of following in last 7 days:
Fever greater than 100.4? N
(38.0 C)
Cough? N
(not related to
allergy or COPD)
Sore Throat? N
Night sweats? N
Unexplained weight loss? N
Fatigue? N
Body Aches? N
Rash? N
Nasal Congestion (not related to allergies or sinus infections)? N
Pt reports prior history of TB or positive TB skin test? N
Close contact with a person who has TB? N
Close contact with any person having an Influenza-like Illness? N
Travel outside the US in the past 3 weeks: N
TB Point of Entry Screen: NEGATIVE
Contagious Respiratory Infection Point of Entry Screen- NEGATIVE

Rapid Assessment

Occurred Date	Time	User	Recorded Date	Time	User
10/02/15	1019	NORRIS,JENNA L, RN	10/02/15	1023	NORRIS,JENNA L, RN

First Point of Contact: No
Enter/Edit Allergies? Yes
Arrived By: WI
See next page
Subjective Assessment:
PT IS CONCERNED ABOUT MEDICAL HISTORY(STATES I AM CURIOUS)
PT HAS INAPPROPRIATE SPEECH, STATES "SINCE MONDAY I FEEL
LIKE I HAVE BEEN REBORN AND I AM CURED"
Objective Assessment:
PT ALERT,CALM AND COPPERATIVE
Neuro WDP? Yes
Cardiovascular WDP? Yes
Respiratory WDP? Yes
Pain scale: Numeric
See next page
OB/GYN History: (if noted below)
Flowsheet: Yes
Chief Complaint: Psych Related
Priority: ESI 2/EMERGENT
ESP? N
Facility ESP status:
ESP Enabled
See next page
Smoking status for patients 13 years old or older: Never Smoker
Last page
--In the past 3 weeks has the patient:--
Is patient currently experiencing any of following in last 7 days:
(38.0 C)
(not related to
allergy or COPD)
** FLACC Pain Assessment - Less than Age 3 or Sleeping **
Score of 4 or More, Consider Intervention
** Neonatal / Infant Pain Scale (NIPS) **
Temperature: 98.4
Temp source: Oral
Pulse: 130
Respirations: 22
Blood Pressure: 130/77
BP source: Non-invasive monitor
ABP M (mmHg): 94
BP location: Right arm

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F010342741l5
1219
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Patient: SCHEER,MATTHEW Age/Sex: 26/M Acct No: F01034274115
EDM Provider: Battisti,Amanda DO, 2hcaActive Unit No: F000838076

SpO2: 99
Airway adjunct: Room air
See next page
Height - Feet: 6
Inches: 0
Cm: 182.88
Source: Patient Stated
Kg: 69.8
Source: Actual
Body Mass Index (BMI): 21.0
: Normal
See next page
Glasgow Coma Scale:
===SEVERE SEPSIS SCREENING===
Temperature: N
Heart Rate: Y
Respirations: Y
WBC/Bands: N
:
No Results past 24 hrs
:
No Results past 24 hrs
If Y to 2 or more of above, proceed to next section: 2
===INFECTION===
Suspected/Documented Infection: NO
Antibiotic Therapy (Not Prophylaxis): NO
If Y to 1 of the above, proceed to next section: 0
See next page
===NEW ORGAN DYSFUNCTION within past 48 hours===
Last page
See next page
See next page

Physical Findings

Occurred			Recorded		
Date	Time	User	Date	Time	User
10/02/15	1027	AGUIRRE,MARY J, RN	10/02/15	1028	AGUIRRE,MARY J, RN

Neurological Assessment WDP: Yes
Musculoskeletal Assessment WDP: Yes
Eye Assessment WDP: Yes
Gastrointestinal Assessment WDP: Yes
ENT Assessment WDP: Yes
Genitourinary Assessment WDP: Yes
Respiratory Assessment WDP: Yes
Integumentary Assessment WDP: Yes
Cardiovascular Assessment WDP: Yes
Psychosocial Assessment WDP: No
Documented via Chief Complaint: Yes
Circulatory Assessment WDP: Yes
See next page
Last page
See next page
See next page
See next page
See next page
******** EAR ********
****** NOSE ******
****** THROAT ******
See next page
See next page
See next page

Medication History

Occurred			Recorded		
Date	Time	User	Date	Time	User
10/02/15	1031	AGUIRRE,MARY J, RN	10/02/15	1032	AGUIRRE,MARY J, RN

Takes Daily Medications, Vitamins, Herbal or OTC Medications Y
Attention Required: N

Family Health History

Occurred			Recorded		
Date	Time	User	Date	Time	User
10/02/15	1032	AGUIRRE,MARY J, RN	10/02/15	1032	AGUIRRE,MARY J, RN

Pain Assessment/Reassessment

Occurred			Recorded		
Date	Time	User	Date	Time	User
10/02/15	1039	AGUIRRE,MARY J, RN	10/02/15	1039	AGUIRRE,MARY J, RN

Acceptable pain level: 3
Assessment Type: Ongoing Monitoring
Pain scale: Numeric
Intensity: 01
See next page
See next page
Last page

Psych Related

Occurred			Recorded		
Date	Time	User	Date	Time	User
10/02/15	1039	AGUIRRE,MARY J, RN	10/02/15	1041	AGUIRRE,MARY J, RN

Presenting Signs & Symptoms: Altered Mental Status
Onset of Current Episode: 2 Days Ago
Acute Behavioral Change? Yes
See next page
Are you here because you tried to hurt yourself? No
In the past week, have you had thoughts about killing yourself? No
Prior to today, have you tried to hurt yourself in the past? No
Does Patient Exhibit Any Non-Verbal Behaviors of Concern? Yes
Explain:
pt believes food is poisoning him and doesn't want to eat.
pt has not slept in days as he is not tired. quit his
seizure medicines in days
Safety Precautions Implemented: See Pt from Nsg Station, Family with Patient,
Placed in Psych-Safe Room, Sharp Objects Removed, Sharps Box Secured
See next page
Forms Signed for Involuntary Commitment? No

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034274115
1220
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Patient: SCHEER,MATTHEW Age/Sex: 26/M Acct No: F010342741115
EDM Provider: Battisti,Amanda DO, ZhcaActive Unit No: F000838076

See next page
See next page
Patient Verbalizes/RN Observes Difficulty with ADLs: No
See next page
Level of consciousness: Alert
Questions: Both correct
Commands: Obeys both
See next page
Airway: Patent
Respiratory Effort: Unlabored
See next page
Patient on Cardiac Monitor? No
Skin Color: Normal for Ethnicity
Skin Temp: Warm
Last page

Detailed Assessment

Occurred			Recorded		
Date	Time	User	Date	Time	User
10/02/15	1041	AGUIRRE,MARY J, RN	10/02/15	1045	AGUIRRE,MARY J, RN

Suicide screening: No
Evidence of physical and/or psychological abuse: No
Do you currently think your safety is being threatened by anyone you know: No
See next page
Previous Medical History: Yes
Surgical History Tonsils and adenoids
Tetanus received within last 5 yrs No
See next page
Nutritional Assessment WDP? No
Explain Variance:
pt not eating
Functional Assessment WDP? No
Living arrangements: Lives alone
See next page
Tobacco history: No
Alcohol history: No
See next page
Are there cultural,religious,language,developmental or behavioral factors to consider in planning care: No
Any barriers to learning identified: No
Readiness to learn: Cooperative
Preferred method of learning: Discussion
See next page
OB/GYN History: (if noted below)
See next page
Do you feel a sense of hopelessness or helplessness that affects the care
See next page
Body Mass Index (BMI): 21.0
: Normal
See next page
See next page
ED plan of care
Chief Complaint: Psych Related
Expected outcome of chief complaint: Stabilized/Maintained
Last page
See next page
In the past few days have you been having
I want to ask you if your child attempted suicide
See next page
In the past week have you been having
See next page
See next page
Respiratory: No
Heart: No
GI: No
Neurological: Yes
: Seizures
Mental health: Yes
: Bi-polar
Cancer: No
Chronic/other: No
Risk factors: No
Comments:
stroke as an infant
Last page

Disposition - DC, TX, ADM, LPT

Occurred			Recorded		
Date	Time	User	Date	Time	User
10/02/15	1302	PRICE,JENNIFER, LPN	10/02/15	1303	PRICE,JENNIFER, LPN

Patient Disposition: Discharge
Disposition Category: Discharged
Question below will only be answered if patient is LPMSE:
ED plan of care
Chief Complaint: Psych Related
Expected outcome of chief complaint: Stabilized/Maintained
Actual outcome of chief complaint: Stabilized/Maintained
See next page
Primary ED Nurse: FED.MJA
For lookup by name, enter N\name then press <Lookup>
Arrival Date: 10/02/15
Arrival Time: 1014
ESP? N
Triage Date: 10/02/15
Triage Time: 1019
Placed in Bed Date: 10/02/15
Triage Level: ESI2/Emergent
Placed in Bed Time: 1023
MD/DO/PA/NP Initiates Contact/Greets Patient Date: 10/02/15
MD/DO/PA/NP Initiates Contact/Greets Patient Time: 1017
Date Patient Physically Leaves ED: 10/02/15
Time Patient Physically Leaves ED: 1303
Elapsed Time from Disposition to Depart:
0:00
See next page
Patient Left
Discharge information provided: Instructions
Discharge instructions given to and verbalized understanding by:
patient
Patient discharged from ED by Provider and not seen by RN: No
Patient Discharged:
To: Another facility

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F010342741115
1221
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Patient: SCHEER,MATTHEW Age/Sex: 26/M Acct No: F01034274115
EDM Provider: Battisti,Amanda DO, ZhcaActive Unit No: F000838076

With: Parent/guardian
Mode: Ambulatory
Via: Private Vehicle
Driver: Parent/Guardian
See next page
See next page
See next page
Last page
** FLACC Pain Assessment - Less than Age 3 or Sleeping **
Score of 4 or More, Consider Intervention

LEARNERS

Teaching Education

Occurred Date	Time	User	Recorded Date	Time	User
10/02/15	1027	AGUIRRE,MARY J, RN	10/02/15	1027	AGUIRRE,MARY J, RN

Learner: Patient, Family
Readiness to Learn: Cooperative
Barriers to Learning: None
Patient Rating of Current Knowledge Level: Good
Teaching method: Verbal
See next page
Patient/Family education subject items: plan of care
Learner(s) verbalized understanding and/or return demonstration of items: Yes
Pt/Family encouraged verbalize anxieties and reassurance given: Yes
Pt/Family/Significant other informed of condition and treatment plan: Yes
Pt/Family/Significant other encouraged give input and participate in tx: Yes
Last page

Fingerstick glucose/Accucheck

Occurred Date	Time	User	Recorded Date	Time	User
10/02/15	1105	AGUIRRE,MARY J, RN	10/02/15	1105	AGUIRRE,MARY J, RN

Fingerstick Blood Sugar (Mg/Dl): 80
MD Notified of Low/High Result: Yes

Collect UA

Occurred Date	Time	User	Recorded Date	Time	User
10/02/15	1156	AGUIRRE,MARY J, RN	10/02/15	1157	AGUIRRE,MARY J, RN

Specimen Collected #1: Voided Urine
Specimen #1 Sent To: Lab
See next page
See next page
Last page

Dashboard Data

Occurred Date	Time	User	Recorded Date	Time	User
10/03/15	0756	FIDLER,LISA, RN	10/03/15	0756	FIDLER,LISA, RN

Primary ED Nurse: FED.MJA
For lookup by name, enter N\name then press <Lookup>
Arrival Date: 10/02/15
Arrival Time: 1014
ESP? N
Triage Date: 10/02/15
Triage Time: 1019
Placed in Bed Date: 10/02/15
Triage Level: ESI2/Emergent
Placed in Bed Time: 1023
MD/DO/PA/NP Initiates Contact/Greets Patient Date: 10/02/15
MD/DO/PA/NP Initiates Contact/Greets Patient Time: 1017
MD/DO/PA/NP Makes Decision to Disposition Date: 10/02/15
MD/DO/PA/NP Makes Decision to Disposition Time: 1233
Date Patient Physically Leaves ED: 10/02/15
Time Patient Physically Leaves ED: 1303
Disposition Category: Discharged
Elapsed Time from Disposition to Depart:
0:30

Lab Results

Test	Day	Date	Time	Result	Reference	Units
=> WBC	1	OCT 2	1042	14.5 H	(3.7-10.1)	K/mm3
=> RBC	1	OCT 2	1042	5.19	(4.55-5.47)	M/mm3
=> HGB	1	OCT 2	1042	16.4	(14.0-16.4)	gm/dl
=> HCT	1	OCT 2	1042	47.0	(40.0-47.2)	%
=> MCV	1	OCT 2	1042	90.6	(81.8-94.6)	fL
=> MCH	1	OCT 2	1042	31.5	(27.9-33.1)	pg
=> MCHC	1	OCT 2	1042	34.8	(33.4-35.6)	g/dl
=> RDW	1	OCT 2	1042	12.6	(11.6-14.0)	%
=> PLT	1	OCT 2	1042	296	(150-400)	K/mm3
=> GRAN %	1	OCT 2	1042	74.8	(40.1-81.3)	%
=> LYMPH %	1	OCT 2	1042	14.3 L	(17.0-47.0)	%
=> MONO %	1	OCT 2	1042	9.6	(5.5-11.9)	%
=> EOS %	1	OCT 2	1042	0.5	(0.0-5.5)	%
=> BASO %	1	OCT 2	1042	0.8	(0.0-1.1)	%
=> GRAN #	1	OCT 2	1042	10.9 H	(1.4-6.5)	K/mm3
=> LYMPH #	1	OCT 2	1042	2.1	(1.2-3.4)	K/mm3
=> MONO #	1	OCT 2	1042	1.4 H	(0.1-0.6)	K/mm3
=> EOS #	1	OCT 2	1042	0.1	(0.0-0.7)	K/mm3
=> BASO #	1	OCT 2	1042	0.1	(0.0-0.2)	K/mm3
=> UA COLOR	1	OCT 2	1155	Yellow	(YELLOW)	
=> UA APPEARANCE	1	OCT 2	1155	Clear	(CLEAR)	
=> UA GLUCOSE	1	OCT 2	1155	NEGATIVE	(NORMAL)	mg/dL
=> UA BILIRUBIN	1	OCT 2	1155	NEGATIVE	(NEGATIVE)	mg/dL
=> UA KETONES	1	OCT 2	1155	80 mg/dl *	(NEGATIVE)	mg/dL
=> UA SPEC GRAVITY	1	OCT 2	1155	1.032	(1.001-1.035)	
=> UA BLOOD	1	OCT 2	1155	NEGATIVE	(NEGATIVE)	mg/dl
=> UA PH	1	OCT 2	1155	5.0	(5.0-8.5)	
=> UA PROTEIN	1	OCT 2	1155	30 mg/dl *	(NEGATIVE)	
=> UA UROBILINOGEN	1	OCT 2	1155	NEGATIVE	(NEG-1mg/dL)	mg/dl

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034274115
1222
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Patient: SCHEER,MATTHEW Age/Sex: 26/M Acct No: F01034274115
EDM Provider: Battisti,Amanda DO, ZhcaActive Unit No: F000838076

=> UA NITRITE	1	OCT	2	1155	NEGATIVE	(NEGATIVE)	
=> UA LK ESTERASE	1	OCT	2	1155	NEGATIVE	(NEGATIVE)	WBCS/uL
=> UA RBC	1	OCT	2	1155	0-1	(0-1 RBC/HPF)	
=> UA WBC	1	OCT	2	1155	0-1	(0-1 WBC/HPF)	
=> UA MUCUS	1	OCT	2	1155	TRACE	(NEGATIVE)	/LPF
=> NA	1	OCT	2	1042	139	(136-145)	MMOL/L
=> K	1	OCT	2	1042	4.1	(3.5-5.1)	MMOL/L
=> CL	1	OCT	2	1042	101	(98-107)	MMOL/L
=> CO2	1	OCT	2	1042	22	(21-32)	MMOL/L
=> ANION GAP	1	OCT	2	1042	16.0 H	(3.0-11.0)	mEq/L
=> GLUCOSE	1	OCT	2	1042	88	(74-106)	mg/dL
=> GLUC POC	1	OCT	2	1104	80	(74-106)	mg/dl
=> BUN	1	OCT	2	1042	21 H	(7-18)	mg/dL
=> CREATININE	1	OCT	2	1042	0.86	(0.6-1.3)	mg/dL
=> GFR BY MDRD	1	OCT	2	1042	> 60(a)	(>60)	
=> BUN/CREAT RATIO	1	OCT	2	1042	24 H	(10-20)	
=> TOTAL PROTEIN	1	OCT	2	1042	7.9	(6.4-8.2)	gm/dL
=> ALBUMIN	1	OCT	2	1042	4.8	(3.4-5.0)	GM/dL
=> GLOBULIN	1	OCT	2	1042	3.1	(2.5-4.5)	gm/dL
=> A/G RATIO	1	OCT	2	1042	1.6 H	(0.7-1.5)	
=> CALCIUM	1	OCT	2	1042	9.4	(8.5-10.1)	mg/dL
=> TOTAL BILIRUBIN	1	OCT	2	1042	0.3 H	(0.2-1.0)	mg/dL
=> SGOT/AST	1	OCT	2	1042	30	(15-37)	Units/L
=> SGPT/ALT	1	OCT	2	1042	35	(30-65)	Units/L
=> ALK PHOS TOTAL	1	OCT	2	1042	64	(20-130)	Units/L
=> TSH	1	OCT	2	1042	1.45(b)	(0.36-3.74)	uIU/mL
=> ACETAMINOPHEN	1	OCT	2	1042	< 2.0 L	(10.0-30.0)	mcg/mL
=> SALICYLATE	1	OCT	2	1042	< 1.7 L	(2.8-20.0)	mg/dL
=> ALCOHOL BLOOD	1	OCT	2	1042	< 3.0(c)		mg/dL
=> UR COCAINE	1	OCT	2	1155	NEG	(NEGATIVE)	
=> UR THC	1	OCT	2	1155	NEG	(NEGATIVE)	
=> UR AMPHETAMINE	1	OCT	2	1155	NEG	(NEGATIVE)	
=> UR BARB	1	OCT	2	1155	NEG	(NEGATIVE)	
=> UR BENZO	1	OCT	2	1155	NEG	(NEGATIVE)	
=> UR OPIATES	1	OCT	2	1155	NEG	(NEGATIVE)	
=> UR PCP QUAL	1	OCT	2	1155	NEG(d)	(NEGATIVE)	

NOTES: (a) *Reference Range:Greater than or equal to 60 mL/min/1.73m2**
NOTE:
eGFR less than 60 (ml/min/1.73) square meters may indicate chronic kidney disease.
This is an estimated GFR based on the Modification of Diet in Renal Disease (MDRD), results for which depend on race and gender. Approved 06/08/11 ELP

(b) Reference Range Units reported in:
Micro International Units/ML

(c) Alcohol results "Less than 3.0 mg/dl" are consistant with an absence of detectable Alcohol.

(d) URINE DRUG SCREEN IS A QUALITIVE SCREEN ONLY. POSITIVE RESULTS ARE NOT VERIFIED.
*Results to be used for Medical purposes only.
rev. 6/27/06

DEPARTURE INFORMATION

Primary Impression: Acute psychosis
Disposition: LIGHTHOUSE Departure Date/Time: 10/02/15 - 1304
Comment:

Condition: STABLE

Referrals:

Pt Instructions:

Departure Forms:

ADDITIONAL INSTRUCTIONS

WITHIN DEFINED PARAMETERS

~~ ASSESSMENT PARAMETERS ~~

These are the definitions of Within Defined Parameters by Body System

NEUROLOGICAL
- Alert & Oriented X 4
- Pupils equal
- Speech clear and appropriate for age
- Moves all extremities
- No paralysis
- Steady gait
- Ambulates independently

EENT
- Eyes - Clear, no tearing or redness
- Ears - No complaint of hearing difficulty, loss of hearing, or change in hearing, pain free, no drainage
- Nasal - Breathes freely through both nares
- Throat - No hoarseness or stated soreness, no cough

RESPIRATORY
- No respiratory distress
- No cough
- No O2 or assistive devices
- No nasal flaring or pursed lip breathing
- Respirations even & unlabored
- Skin pink & warm to touch

CARDIAC
- No stated calf tenderness
- No history of pacemaker or implanted defibrillator
- Denies current cardiac complaint
- Skin pink & warm to touch - no cyanosis, mottling, diaphoresis or flushing of skin

CIRCULATORY
- Oral mucosa pink and moist
- Skin color appropriate to ethnic color
- Denies sensory complaints
- No edema noted

MUSCULOSKELETAL
- Moves all extremities
- Ambulates independently

GASTROINTESTINAL
- Denies GI complaints

GENITO-URINARY
- Denies GU complaints

INTEGUMENTARY
- Skin warm, dry & intact
- No complaints of lesions, rash, wounds, bruises, petechiae or abrasions

PSYCHOSOCIAL
- With regards to cultural influences: mood/affect is appropriate
- Patient demonstrates effective coping skills/patterns for situation

These are the definitions of Within Defined Parameters for the Nutritional and Functional Screenings:

NUTRITIONAL
- No swallowing/chewing impairments

FUNCTIONAL
- No unexplained alteration in

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034274115
1223
Scheer_GSRMC_MedRecs_0023
Page 23 of 42

- No nasea and/or vomiting and/or diarrhea for 3 or more days
- No reported unintentional weight loss > 10 lbs in last 3 months
- No reported decrease in intake > 50% of usual in last two weeks
- No recent limitation performance of ADLs
- No recent alteration in ADLs that require assistance

This is the definition for the evidence of Physical and/or Psychological Abuse question:

ABUSE HISTORY TO INCLUDE, BUT NOT LIMITED TO:
PT DOES NOT REPORT/NO EVIDENCE OF ANY OF THE FOLLOWING: abuse/neglect, Hx. of abuse/neglect, withdrawn/fearful behavior, Unexplained or suspicious bruises/wounds, Patient/Caregiver story changes, Defensive about injuries, Undernourished despite good appetite, Recurrent/Suspicious injuries, Fear of return to previous arrangements, Injuries do not match event history.

*** PATIENT SAFETY PARAMETERS ***
** Allergy and Patient Identification Bands in Place and Validated
** If in a Bed, Side Rails Up and Bed in Low Position With Wheels Locked
** If in a Wheelchair, Wheels Locked
** Call Light Function Explained and Within Reach
** Standard Precautions Observed

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034274115
1224
Scheer_GSRMC_MedRecs_0024
Page 24 of 42

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034274115

ATTEND DR: Battisti,Amanda DO
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.ED
RM:
BD:

ADMIT: 10/02/15
DISCH/DEP: 10/02/15
STATUS: ER
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	COMPREHENSIVE METABOLIC PANEL	20151002-1325	10/02/15	1026	S		E	CMP	SCHRI

Other Provider : BELMI Sig Lvl Provider :

.
This is NOT required. Answer ONLY if needed.

**ADD ON TEST:

Order's Audit Trail of Events

1	10/02/15 1026	FPA.BELMI	Order ENTER in EDM/POM
2	10/02/15 1026	FPA.BELMI	Ordering Doctor: Schmitt,Richard A MD
3	10/02/15 1026	FPA.BELMI	Order Source: EPOM
4	10/02/15 1026	FPA.BELMI	Other Doctor: Beliew,Michael J PA
5	10/02/15 1026	FPA.BELMI	Signed by Beliew,Michael J PA
6	10/02/15 1026	interface	cc'd doctors edited in LAB
7	10/02/15 1026	interface	order's status changed from TRANS to LOGGED by LAB
8	10/02/15 1027	interface	order's status changed from LOGGED to IN PRO by LAB
9	10/02/15 1754	interface	order's status changed from IN PRO to COMP by LAB
10	10/02/15 1826	PHY.SCHRI	Signed by Schmitt,Richard A MD

Electronically signed by Beliew,Michael J PA on 10/02/15 at 1026

Electronically signed by Schmitt,Richard A MD on 10/02/15 at 1826

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CBC W/AUTO DIFFERENTIAL	20151002-1326	10/02/15	1026	S		E	CMP	SCHRI

Other Provider : BELMI Sig Lvl Provider :

.
This is NOT required. Answer ONLY if needed.

**ADD ON TEST:

Order's Audit Trail of Events

1	10/02/15 1026	FPA.BELMI	Order ENTER in EDM/POM
2	10/02/15 1026	FPA.BELMI	Ordering Doctor: Schmitt,Richard A MD
3	10/02/15 1026	FPA.BELMI	Order Source: EPOM
4	10/02/15 1026	FPA.BELMI	Other Doctor: Beliew,Michael J PA
5	10/02/15 1026	FPA.BELMI	Signed by Beliew,Michael J PA
6	10/02/15 1026	interface	cc'd doctors edited in LAB
7	10/02/15 1026	interface	order's status changed from TRANS to LOGGED by LAB
8	10/02/15 1026	interface	order's status changed from LOGGED to IN PRO by LAB
9	10/02/15 1055	interface	order's status changed from IN PRO to COMP by LAB
10	10/02/15 1826	PHY.SCHRI	Signed by Schmitt,Richard A MD

Electronically signed by Beliew,Michael J PA on 10/02/15 at 1026

Electronically signed by Schmitt,Richard A MD on 10/02/15 at 1826

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034274115
ATTEND DR: Battisti,Amanda DO
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.ED
RM:
BD:

ADMIT: 10/02/15
DISCH/DEP: 10/02/15
STATUS: ER
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	URINALYSIS DIPSTICK	20151002-1327	10/02/15	1026	S		E	CMP	SCHRI

Other Provider : BELMI Sig Lvl Provider :

This is NOT required. Answer ONLY if needed.

**ADD ON TEST:

Order's Audit Trail of Events

```
1    10/02/15 1026 FPA.BELMI  Order ENTER in EDM/POM
2    10/02/15 1026 FPA.BELMI  Ordering Doctor: Schmitt,Richard A  MD
3    10/02/15 1026 FPA.BELMI  Order Source: EPOM
4    10/02/15 1026 FPA.BELMI  Other Doctor: Beliew,Michael J  PA
5    10/02/15 1026 FPA.BELMI  Signed by Beliew,Michael J  PA
6    10/02/15 1026 FPA.BELMI  This procedure has reflexed the following order(s)
7    10/02/15 1026 FPA.BELMI  Specimen Instructions (NUREDM)
8    10/02/15 1026 interface  cc'd doctors edited in LAB
9    10/02/15 1026 interface  order's status changed from TRANS to LOGGED by LAB
10   10/02/15 1026 interface  order's status changed from LOGGED to IN PRO by LAB
11   10/02/15 1218 interface  order's status changed from IN PRO to COMP by LAB
12   10/02/15 1826 PHY.SCHRI  Signed by Schmitt,Richard A  MD

                 Electronically signed by Beliew,Michael J  PA on 10/02/15 at 1026

                 Electronically signed by Schmitt,Richard A  MD on 10/02/15 at 1826
```

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	UR DRUG SCREEN	20151002-1328	10/02/15	1026	S		E	CMP	SCHRI

Other Provider : BELMI Sig Lvl Provider :

This is NOT required. Answer ONLY if needed.

**ADD ON TEST:

Order's Audit Trail of Events

```
1    10/02/15 1026 FPA.BELMI  Order ENTER in EDM/POM
2    10/02/15 1026 FPA.BELMI  Ordering Doctor: Schmitt,Richard A  MD
3    10/02/15 1026 FPA.BELMI  Order Source: EPOM
4    10/02/15 1026 FPA.BELMI  Other Doctor: Beliew,Michael J  PA
5    10/02/15 1026 FPA.BELMI  Signed by Beliew,Michael J  PA
6    10/02/15 1026 interface  cc'd doctors edited in LAB
7    10/02/15 1026 interface  order's status changed from TRANS to LOGGED by LAB
8    10/02/15 1026 interface  order's status changed from LOGGED to IN PRO by LAB
9    10/02/15 1218 interface  order's status changed from IN PRO to COMP by LAB
10   10/02/15 1826 PHY.SCHRI  Signed by Schmitt,Richard A  MD

                 Electronically signed by Beliew,Michael J  PA on 10/02/15 at 1026

                 Electronically signed by Schmitt,Richard A  MD on 10/02/15 at 1826
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PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034274115

ATTEND DR: Battisti,Amanda DO
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.ED
RM:
BD:

ADMIT: 10/02/15
DISCH/DEP: 10/02/15
STATUS: ER
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	THYROID STIMULATING HORMONE	20151002-1329	10/02/15	1026	S		E	CMP	SCHRI

Other Provider : BELMI Sig Lvl Provider :

This is NOT required. Answer ONLY if needed.

**ADD ON TEST:

Order's Audit Trail of Events

1 10/02/15 1026 FPA.BELMI Order ENTER in EDM/POM
2 10/02/15 1026 FPA.BELMI Ordering Doctor: Schmitt,Richard A MD
3 10/02/15 1026 FPA.BELMI Order Source: EPOM
4 10/02/15 1026 FPA.BELMI Other Doctor: Beliew,Michael J PA
5 10/02/15 1026 FPA.BELMI Signed by Beliew,Michael J PA
6 10/02/15 1026 interface cc'd doctors edited in LAB
7 10/02/15 1026 interface order's status changed from TRANS to LOGGED by LAB
8 10/02/15 1026 interface order's status changed from LOGGED to IN PRO by LAB
9 10/02/15 1754 interface order's status changed from IN PRO to COMP by LAB
10 10/02/15 1826 PHY.SCHRI Signed by Schmitt,Richard A MD

Electronically signed by Beliew,Michael J PA on 10/02/15 at 1026

Electronically signed by Schmitt,Richard A MD on 10/02/15 at 1826

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	SALICYLATE (ASPIRIN)	20151002-1330	10/02/15	1026	S		E	CMP	SCHRI

Other Provider : BELMI Sig Lvl Provider :

This is NOT required. Answer ONLY if needed.

**ADD ON TEST:

Order's Audit Trail of Events

1 10/02/15 1026 FPA.BELMI Order ENTER in EDM/POM
2 10/02/15 1026 FPA.BELMI Ordering Doctor: Schmitt,Richard A MD
3 10/02/15 1026 FPA.BELMI Order Source: EPOM
4 10/02/15 1026 FPA.BELMI Other Doctor: Beliew,Michael J PA
5 10/02/15 1026 FPA.BELMI Signed by Beliew,Michael J PA
6 10/02/15 1026 interface cc'd doctors edited in LAB
7 10/02/15 1026 interface order's status changed from TRANS to LOGGED by LAB
8 10/02/15 1026 interface order's status changed from LOGGED to IN PRO by LAB
9 10/02/15 1337 interface order's status changed from IN PRO to COMP by LAB
10 10/02/15 1826 PHY.SCHRI Signed by Schmitt,Richard A MD

Electronically signed by Beliew,Michael J PA on 10/02/15 at 1026

Electronically signed by Schmitt,Richard A MD on 10/02/15 at 1826

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034274115

ATTEND DR: Battisti,Amanda DO
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.ED
RM:
BD:

ADMIT: 10/02/15
DISCH/DEP: 10/02/15
STATUS: ER
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	ACETAMINOPHEN (TYLENOL)	20151002-1331	10/02/15	1026	S		E	CMP	SCHRI

Other Provider : BELMI Sig Lvl Provider :

This is NOT required. Answer ONLY if needed.

**ADD ON TEST:

Order's Audit Trail of Events

1 10/02/15 1026 FPA.BELMI Order ENTER in EDM/POM
2 10/02/15 1026 FPA.BELMI Ordering Doctor: Schmitt,Richard A MD
3 10/02/15 1026 FPA.BELMI Order Source: EPOM
4 10/02/15 1026 FPA.BELMI Other Doctor: Beliew,Michael J PA
5 10/02/15 1026 FPA.BELMI Signed by Beliew,Michael J PA
6 10/02/15 1026 interface cc'd doctors edited in LAB
7 10/02/15 1026 interface order's status changed from TRANS to LOGGED by LAB
8 10/02/15 1026 interface order's status changed from LOGGED to IN PRO by LAB
9 10/02/15 1754 interface order's status changed from IN PRO to COMP by LAB
10 10/02/15 1826 PHY.SCHRI Signed by Schmitt,Richard A MD

Electronically signed by Beliew,Michael J PA on 10/02/15 at 1026

Electronically signed by Schmitt,Richard A MD on 10/02/15 at 1826

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	ALCOHOL (ETHANOL) BLOOD	20151002-1332	10/02/15	1026	S		E	CMP	SCHRI

Other Provider : BELMI Sig Lvl Provider :

This is NOT required. Answer ONLY if needed.

**ADD ON TEST:

Order's Audit Trail of Events

1 10/02/15 1026 FPA.BELMI Order ENTER in EDM/POM
2 10/02/15 1026 FPA.BELMI Ordering Doctor: Schmitt,Richard A MD
3 10/02/15 1026 FPA.BELMI Order Source: EPOM
4 10/02/15 1026 FPA.BELMI Other Doctor: Beliew,Michael J PA
5 10/02/15 1026 FPA.BELMI Signed by Beliew,Michael J PA
6 10/02/15 1026 interface cc'd doctors edited in LAB
7 10/02/15 1026 interface order's status changed from TRANS to LOGGED by LAB
8 10/02/15 1026 interface order's status changed from LOGGED to IN PRO by LAB
9 10/02/15 1754 interface order's status changed from IN PRO to COMP by LAB
10 10/02/15 1826 PHY.SCHRI Signed by Schmitt,Richard A MD

Electronically signed by Beliew,Michael J PA on 10/02/15 at 1026

Electronically signed by Schmitt,Richard A MD on 10/02/15 at 1826

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034274115

ATTEND DR: Battisti,Amanda DO
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.ED
RM:
BD:

ADMIT: 10/02/15
DISCH/DEP: 10/02/15
STATUS: ER
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUREDM	Specimen Instructions	20151002-0092	10/02/15	1026	S		E	TRN	SCHRI

Other Provider : BELMI Sig Lvl Provider :
Press [ENTER] for Order Details

Comment: UA Reflex clean catch: if patient unable to to collect a clean specimen, (obesity, menses lack of ability for any reason) order IN & OUT catheterization to insure a valid specimen is collected. Catheterizations will be performed after a patient has been placed in a treatment room NOT triage.

Order's Audit Trail of Events

1 10/02/15 1026 FPA.BELMI Order ENTER in EDM/POM
2 10/02/15 1026 FPA.BELMI Order from set: U/A REFLEX ED
3 10/02/15 1026 FPA.BELMI Ordering Doctor: Schmitt,Richard A MD
4 10/02/15 1026 FPA.BELMI Order Source: EPOM
5 10/02/15 1026 FPA.BELMI Other Doctor: Beliew,Michael J PA
6 10/02/15 1026 FPA.BELMI Signed by Beliew,Michael J PA
7 10/02/15 1026 FPA.BELMI This Procedure was triggered by :
8 10/02/15 1026 FPA.BELMI URINALYSIS DIPSTICK (LAB)
9 10/02/15 1826 PHY.SCHRI Signed by Schmitt,Richard A MD

Electronically signed by Beliew,Michael J PA on 10/02/15 at 1026

Electronically signed by Schmitt,Richard A MD on 10/02/15 at 1826

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUREDM	Saline Lock	20151002-0093	10/02/15	1026	S		E	TRN	SCHRI

Other Provider : BELMI Sig Lvl Provider :
Press [ENTER] for Order Details

Order's Audit Trail of Events

1 10/02/15 1026 FPA.BELMI Order ENTER in EDM/POM
2 10/02/15 1026 FPA.BELMI Ordering Doctor: Schmitt,Richard A MD
3 10/02/15 1026 FPA.BELMI Order Source: EPOM
4 10/02/15 1026 FPA.BELMI Other Doctor: Beliew,Michael J PA
5 10/02/15 1026 FPA.BELMI Signed by Beliew,Michael J PA
6 10/02/15 1826 PHY.SCHRI Signed by Schmitt,Richard A MD

Electronically signed by Beliew,Michael J PA on 10/02/15 at 1026

Electronically signed by Schmitt,Richard A MD on 10/02/15 at 1826

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034274115
ATTEND DR: Battisti,Amanda DO
REPORT STATUS: FINAL
A/S: 26 M
LOC: F.ED
RM:
BD:
ADMIT: 10/02/15
DISCH/DEP: 10/02/15
STATUS: ER
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CT	CT HEAD W/O CONTRAST	20151002-0050	10/02/15	1130	S		E	CMP	BATAM

Other Provider :
Sig Lvl Provider :

Order details below
Reason for Exam: Altered Mental Status
Comments:

Order's Audit Trail of Events

1 10/02/15 1041 PHY.BATAM Order ENTER in EDM/POM
2 10/02/15 1041 PHY.BATAM Ordering Doctor: Battisti,Amanda DO
3 10/02/15 1041 PHY.BATAM Order Source: EPOM
4 10/02/15 1041 PHY.BATAM Signed by Battisti,Amanda DO
5 10/02/15 1041 interface order's status changed from TRANS to LOGGED by RAD
6 10/02/15 1136 interface order's status changed from LOGGED to IN PRO by RAD
7 10/02/15 1152 interface order service time edited: old value - 1041
8 10/02/15 1205 interface order's status changed from IN PRO to COMP by RAD

Electronically signed by Battisti,Amanda DO on 10/02/15 at 1041

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUREDM	Fingerstick Glucose-Accucheck	20151002-0100	10/02/15	1041	S		E	TRN	BATAM

Other Provider :
Sig Lvl Provider :

Press [ENTER] for Order Details

.
Fingerstick Glucose/Accucheck Frequency
ONCE

Order's Audit Trail of Events

1 10/02/15 1041 PHY.BATAM Order ENTER in EDM/POM
2 10/02/15 1041 PHY.BATAM Ordering Doctor: Battisti,Amanda DO
3 10/02/15 1041 PHY.BATAM Order Source: EPOM
4 10/02/15 1041 PHY.BATAM Signed by Battisti,Amanda DO

Electronically signed by Battisti,Amanda DO on 10/02/15 at 1041

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	GLUCOSE BY MONITORING DEVICES	20151002-1400	10/02/15	1104	R	1		CMP	BATAM

Other Provider :
Sig Lvl Provider :

Order's Audit Trail of Events

1 10/02/15 1110 INFCE Order ENTER in LAB
2 10/02/15 1110 INFCE Ordering Doctor: Battisti,Amanda DO

** IDEV END OF REPORT **

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW J ACCT #: F01034274115 LOC: F.ED U #: F000838076
AGE/SX: 26/M ROOM: REG: 10/02/15
REG DR: Battisti,Amanda DO STATUS: DEP ER BED: DIS:

HEMATOLOGY

	Date / Time		Reference	Units
WBC	14.5	H	(3.7-10.1)	K/mm3
	10/02/15 1055		Verified Date Time	
RBC	5.19		(4.55-5.47)	M/mm3
	10/02/15 1055		Verified Date Time	
HGB	16.4		(14.0-16.4)	gm/dl
	10/02/15 1055		Verified Date Time	
HCT	47.0		(40.0-47.2)	%
	10/02/15 1055		Verified Date Time	
MCV	90.6		(81.8-94.6)	fL
	10/02/15 1055		Verified Date Time	
MCH	31.5		(27.9-33.1)	pg
	10/02/15 1055		Verified Date Time	
MCHC	34.8		(33.4-35.6)	g/dl
	10/02/15 1055		Verified Date Time	
RDW	12.6		(11.6-14.0)	%
	10/02/15 1055		Verified Date Time	
PLT	296		(150-400)	K/mm3
	10/02/15 1055		Verified Date Time	
GRAN %	74.8		(40.1-81.3)	%
	10/02/15 1055		Verified Date Time	
LYMPH %	14.3	L	(17.0-47.0)	%
	10/02/15 1055		Verified Date Time	
MONO %	9.6		(5.5-11.9)	%
	10/02/15 1055		Verified Date Time	
EOS %	0.5		(0.0-5.5)	%
	10/02/15 1055		Verified Date Time	
BASO %	0.8		(0.0-1.1)	%
	10/02/15 1055		Verified Date Time	
GRAN #	10.9	H	(1.4-6.5)	K/mm3
	10/02/15 1055		Verified Date Time	
LYMPH #	2.1		(1.2-3.4)	k/mm3
	10/02/15 1055		Verified Date Time	

Patient: SCHEER,MATTHEW J #F01034274115 (Continued)

Patient: SCHEER,MATTHEW J Age/Sex: 26/M Acct#F01034274115 Unit#F000838076

Patient: SCHEER,MATTHEW J #F01034274115 (Continued)

********** HEMATOLOGY *** (continued) **********

	Date / Time		Reference	Units
MONO #	1.4	H	(0.1-0.6)	K/mm3
	10/02/15 1055		Verified Date Time	
EOS #	0.1		(0.0-0.7)	K/mm3
	10/02/15 1055		Verified Date Time	
BASO #	0.1		(0.0-0.2)	K/mm3
	10/02/15 1055		Verified Date Time	

********** CHEMISTRY **********

	Date / Time		Reference	Units
NA	139		(136-145)	MMOL/L
	10/02/15 1107		Verified Date Time	
K	4.1		(3.5-5.1)	MMOL/L
	10/02/15 1107		Verified Date Time	
CL	101		(98-107)	MMOL/L
	10/02/15 1107		Verified Date Time	
CO2	22		(21-32)	MMOL/L
	10/02/15 1112		Verified Date Time	
ANION GAP	16.0	H	(3.0-11.0)	mEq/L
	10/02/15 1112		Verified Date Time	
GLUCOSE	88		(74-106)	mg/dL
	10/02/15 1113		Verified Date Time	
BUN	21	H	(7-18)	mg/dL
	10/02/15 1112		Verified Date Time	
CREATININE	0.86		(0.6-1.3)	mg/dL
	10/02/15 1115		Verified Date Time	
TOTAL PROTEIN	7.9		(6.4-8.2)	gm/dL
	10/02/15 1117		Verified Date Time	
ALBUMIN	4.8		(3.4-5.0)	GM/dL
	10/02/15 1112		Verified Date Time	
GLOBULIN	3.1		(2.5-4.5)	gm/dL
	10/02/15 1117		Verified Date Time	
A/G RATIO	1.6	H	(0.7-1.5)	
	10/02/15 1117		Verified Date Time	

Patient: SCHEER,MATTHEW J #F01034274115 (Continued)

Patient: SCHEER,MATTHEW J Age/Sex: 26/M Acct#F01034274115 Unit#F000838076

Patient: SCHEER,MATTHEW J #F01034274115 (Continued)

CHEMISTRY * (CONTINUED)**

	Date / Time		Reference	Units
CALCIUM	9.4 10/02/15 1109		(8.5-10.1)	mg/dL Verified Date Time
TOTAL BILIRUBIN	5.5 H 10/02/15 1115		(0.2-1.0)	mg/dL Verified Date Time
SGOT/AST	30 10/02/15 1113		(15-37)	Units/L Verified Date Time
SGPT/ALT	35 10/02/15 1115		(30-65)	Units/L Verified Date Time
ALK PHOS TOTAL	64 10/02/15 1118		(20-130)	Units/L Verified Date Time

THYROID FUNCTION STUDIES

	Date / Time		Reference	Units
TSH	1.45(a) 10/02/15 1127		(0.36-3.74)	uIU/mL Verified Date Time

DRUG MONITORING

	Date / Time	10/02/15 1042	Reference	Units
ACETAMINOPHEN		< 2.0 L 10/02/15 1754	(10.0-30.0)	mcg/mL Verified Date Time
SALICYLATE	< 1.7 L 10/02/15 1337		(2.8-20.0)	mg/dL Verified Date Time

NOTES: (a) Reference Range Units reported in:
Micro International Units/ML

Patient: SCHEER,MATTHEW J Age/Sex: 26/M Acct#F01034274115 Unit#F000838076

Patient: SCHEER,MATTHEW J #F01034274115 (Continued)

********** CHEMISTRY *** **********
(CONTINUED)
********** URINE DRUGS OF ABUSE **********

	Date	Time	Reference	Units
UR COCAINE	NEG	10/02/15 1218	(NEGATIVE)	Verified Date Time
UR THC	NEG	10/02/15 1218	(NEGATIVE)	Verified Date Time
UR AMPHETAMINE	NEG	10/02/15 1218	(NEGATIVE)	Verified Date Time
UR BARB	NEG	10/02/15 1218	(NEGATIVE)	Verified Date Time
UR BENZO	NEG	10/02/15 1218	(NEGATIVE)	Verified Date Time
UR OPIATES	NEG	10/02/15 1218	(NEGATIVE)	Verified Date Time
UR PCP QUAL	NEG(b)	10/02/15 1218	(NEGATIVE)	Verified Date Time

NOTES: (b) URINE DRUG SCREEN IS A QUALITIVE SCREEN ONLY. POSITIVE RESULTS ARE NOT VERIFIED.
*Results to be used for Medical purposes only.
rev. 6/27/06

Patient: SCHEER,MATTHEW J #F01034274115 (Continued)

********** URINALYSIS **********

	Date / Time		Reference	Units
UA COLOR	Yellow 10/02/15 1211		(YELLOW)	Verified Date Time
UA APPEARANCE	Clear 10/02/15 1211		(CLEAR)	Verified Date Time
UA GLUCOSE	NEGATIVE 10/02/15 1211		(NORMAL)	mg/dL Verified Date Time
UA BILIRUBIN	NEGATIVE 10/02/15 1211		(NEGATIVE)	mg/dL Verified Date Time
UA KETONES	80 mg/dl * 10/02/15 1211		(NEGATIVE)	mg/dL Verified Date Time
UA SPEC GRAVITY	1.032 10/02/15 1211		(1.001-1.035)	Verified Date Time
UA BLOOD	NEGATIVE 10/02/15 1211		(NEGATIVE)	mg/dl Verified Date Time
UA PH	5.0 10/02/15 1211		(5.0-8.5)	Verified Date Time
UA PROTEIN	30 mg/dl * 10/02/15 1211		(NEGATIVE)	Verified Date Time
UA UROBILINOGEN	NEGATIVE 10/02/15 1211		(NEG-1mg/dL)	mg/dl Verified Date Time
UA NITRITE	NEGATIVE 10/02/15 1211		(NEGATIVE)	Verified Date Time
UA LK ESTERASE	NEGATIVE 10/02/15 1211		(NEGATIVE)	WBCS/uL Verified Date Time
UA RBC	0-1 10/02/15 1214		(0-1 RBC/HPF)	Verified Date Time
UA WBC	0-1 10/02/15 1214		(0-1 WBC/HPF)	Verified Date Time
UA MUCUS	FEW * 10/02/15 1214		(NEGATIVE)	/LPF Verified Date Time

Patient: SCHEER,MATTHEW J Age/Sex: 26/M Acct#F01034274115 Unit#F000838076

Patient: SCHEER,MATTHEW J #F01034274115 (Continued)

Test	Date	Time	Result	Reference	Units	Ver Date/Time
GLUC POC	10/02/15	1104	80	(74-106)	mg/dl	10/02/15 1110
GFR BY MDRD	10/02/15	1042	> 60(A)	(>=60)		10/02/15 1115

(A) *Reference Range:Greater than or equal to 60 mL/min/1.73m2**
NOTE:
eGFR less than 60 (ml/min/1.73) square meters may indicate
chronic kidney disease.
This is an estimated GFR based on the Modification of Diet
in Renal Disease (MDRD), results for which depend on race
and gender. Approved 06/08/11 ELP

BUN/CREAT RATIO	10/02/15	1042	24	* (10-20)		10/02/15 1115
ALCOHOL BLOOD	10/02/15	1042	< 3.0(B)		mg/dL	10/02/15 1114

(B) Alcohol results "Less than 3.0 mg/dl" are consistant with an
absence of detectable Alcohol.

Patient: SCHEER,MATTHEW J Age/Sex: 26/M Acct#F01034274115 Unit#F000838076

DIAGNOSTIC IMAGING REPORT

GRAND STRAND REGIONAL - 809 82ND PARKWAY - MYRTLE BEACH, SC 2957
PHONE #: 8436921560 FAX #: 8436921555

Name: SCHEER,MATTHEW J Loc: F.ED Radiology No:

DOB: 01/19/1989 Age: 26 Sex: M Status: REG ER Unit No: F000838076

Phys: BATAM - Battisti,Amanda DO Acct: F01034274115

Reason For Exam: ? Exam Date: 10/02/2015

EXAMS: Reason for Exam::
002452015 CT HEAD W/O CONTRAST AMS - Altered Mental Status

HISTORY:

Altered mental status, confusion, history of seizures, recently stopped taking seizure medication

COMPARISON:
None

TECHNIQUE:
Axial CT images were obtained through the brain and posterior fossa without intravenous contrast.

FINDINGS:
Unenhanced images of the brain demonstrate no signs of acute infarct or hemorrhage. There is chronic cortical thinning and encephalomalacia in the bilateral parietal regions, left greater than right. Lateral ventricles midline structures are otherwise unremarkable. There are no acute extra-axial fluid collections. Orientation of the lateral ventricles suggest partial agenesis of the corpus callosum. There is no mass effect. There are no acute bony abnormalities.

IMPRESSION:

1. No acute intracranial process.

** Electronically Signed by MICHAEL H BROWN MD **
** on 10/02/2015 at 1200 **
Reported and signed by: MICHAEL H BROWN MD

CC: Amanda Battisti DO

Dictated Date/Time: 10/02/2015 (1200)

Technologist: STEWART,SYLVIA N RT (R) (CT); ...
Transcribed Date/Time: 10/02/2015 (1200)
Transcriptionist: RAD.VR
Electronic Signature Date/Time: 10/02/2015 (1200)
Printed Date/Time: 10/02/2015 (1205)

GRAND STRAND REGIONAL MEDICAL CENTER
MYRTLE BEACH, SC 29572

NAME: SCHEER,MATTHEW J
Unit #: F000838076 Acc #: F01034274115
Adm Date: 10/02/15
D/C Date: 10/02/15
Dictated By: Battisti,Amanda DO Loc:F.ED
Report Name: PATIENT DISCHARGE INSTRUCTIONS
==========

ScriptRx Emergency Room Visit Report
Grand Strand Medical Center
809 82nd Parkway , Myrtle Beach, SC 29572 (843) 692-1000
10/02/2015 1309

Patient: SCHEER, MATTHEW
Attending Provider: Amanda Battisti, DO
Discharging Provider: Amanda Battisti, DO
MRN: F000838076
Acct: F01034274115
Age: 26

----------DISCHARGE INSTRUCTIONS----------
BIPOLAR DISORDER (MANIC DEPRESSION)

BIPOLAR DISORDER (MANIC DEPRESSION)

This is a disorder that is characterized by extreme mood swings. The relationship between the moods and what is actually happening in the person's life is not direct.
Periods of unexplainable elation and over-activity:
- Feeling on top of the world and nothing, bad news or tragedy, will change your mood.
- Hyper-activity.
- Loss of ideas where thoughts race uncontrollably.
- Decreased need for sleep, allowing you to go with little or no sleep for days at a time without feeling tired.
- Poor judgment leading to spending sprees, poor business dealings, or unusual sexual behavior.
- Extreme self-confidence, sometimes reaching a point where you might feel a special connection with God or an ability to accomplish any task.
Left untreated, depression is likely to set in. Symptoms may include feelings of worthlessness, hopelessness, or helplessness; ongoing tiredness, thoughts of death or suicide, sleeping too much or too little; and withdrawal from activities which used to be enjoyable
- sex, work, and friends. Headaches, anxiety, unexplained physical complaints, and substance abuse are common. Researchers have found a genetic link to manic-depression, noting the risk of the disorder runs in families. Chemical changes in the brain are the likely cause of manic-depression. Manic-depression is one of the most treatable forms of mental illness. A combination of psychotherapy and medication helps most people return to a normal life. Lithium carbonate is often

prescribed to prevent manic and depressive episodes. Treatment with lithium requires careful monitoring to be sure the dose is correct. Talking with your friends or a counselor can help you understand the stresses in your life, repair damaged relationships with others, restore lost self-esteem, and work out ways to prevent a repeat episode of the illness. Close friends and family can act as an early warning system to help you avoid another bout with the illness. Resolve to avoid future episodes of the illness by living a healthier lifestyle, eating better, exercising more, and avoiding drugs and alcohol.
Following These Instructions Carefully Can Help:
1. Comply with the medication regimen provided by your doctor. Schedule regular office visits to monitor the effectiveness of the treatment and to watch for side effects.
2. Do not discontinue medication when you feel better. This may cause a relapse that may not respond well to medication.
3. Counseling can provide the methods needed to help you cope with the disorder. Family members should learn to recognize signs of an impending episode and how to help the person.
4. Seek support groups. Contact social agencies for help.
5. Call the local suicide prevention hot line if you feel suicidal.
6. No restrictions. Maintain daily activities, even if you don't feel like it.
7. Eat a normal well balanced diet, even if you have no appetite. Vitamin and mineral supplements may be necessary. Your doctor may advise you to avoid caffeine, as it is a stimulant.
8. For additional information, contact National Depressive and Manic Depressive Association, Merchandise Mart, Box 3395, Chicago, IL 60654 Tel: (800) 825-3632.

Follow up with your doctor or at this facility as instructed.

Return to this facility immediately or contact your doctor you begin to have any of the following:
- You or a family member has symptoms of depression or mania.
- You feel suicidal or hopeless.

FOLLOW-UP:
Physician: Lighthouse Care Center,
Follow-up When: Immediately
Follow-up Diagnosis: Refer to Discharge Instruction List
Specialty: Mental Health
Address: 152 Waccamaw Medical Park Drive CONWAY SC 29526
Phone: 8433478871
Follow-up Notes: go directly to Lighthouse

Patient Name: SCHEER,MATTHEW J Account #: F01034274115

$ 25

Grand Strand Regional Medical Center

Grand Strand Medical Center
809 82nd Parkway
Myrtle Beach, SC 29572
(843) 692-1000

Discharge Summary (Chart Copy)

Date: 10/02/2015
Time: 12:36 p.m.

Treating Provider: Amanda Battisti, DO
Phone:
Fax:

Provider Signature: Amanda Battisti

Supervised Provider:

Patient Name: MATTHEW SCHEER
MR#: F000838076
Account: F01034274115

Patient Address: 5750 OYSTER CATHCHER DR
MYRTLE BEACH, SC 29582
Phone: (609)457-0387

Your Discharge Instructions:	Your Medication Education:	Your Prescriptions:
BIPOLAR DISORDER (MANIC DEPRESSION)		

You should follow up with the following physician Immediately:

Physician Name: Lighthouse Care Center
Specialty: Mental Health

Address: 152 Waccamaw Medical Park Drive
CONWAY, SC 29526
Phone: (843) 347-8871

Follow-up Notes: On 10/02/2015 this patient was treated at Grand Strand Medical Center for Refer to Discharge Instruction List.
Additional Notes: go directly to Lighthouse.

I understand that the emergency care I received is not intended to be complete and definitive medical care and treatment. I acknowledge that I have been instructed to contact the above physician(s) as indicated for continued and complete medical diagnosis, care, and treatment. EKG's, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies. I also understand that my signature authorizes this Medical Center to release all or any part of my medical record (including, if applicable, information pertaining to AIDS and/or HIV testing, mental health records, and drug and/or alcohol treatment) to the follow-up physician indicated above.

I have read and understand the above, received a copy of applicable instruction sheets, and will arrange for follow-up care.

Signature	Patient/Parent/Guardian	Date/Time	Signature	Instructed By	Date/Time
		10/2/15		LPN	10/2/15

* P I N S *

Conditions of Admission and Consent for Outpatient Care

In this document, "**Patient**" means the person receiving treatment. "Patient Representative" means any person acting on behalf of the Patient and signing as the Patient's representative. Use of the word "I," "you," "your" or "me" may in context include both the Patient and the Patient Representative. With respect to financial obligations "I" or "me" may also, depending on the context, mean financial guarantor "Guarantor".

"Provider" means the hospital and may include healthcare professionals on the hospital's staff and/or hospital-based physicians, which include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, Anesthesiologists, Hospitalists, certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors or assignees acting on their behalf.

Legal Relationship between Hospital and Physicians. Most or all of the physicians performing services in the hospital are independent and are not hospital agents or employees. Independent physicians are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent physicians.

1. **Consent to Treatment.** I consent to the procedures which may be performed during this hospitalization or during an outpatient episode of care, including, but not limited to, emergency treatment or services, and which may include laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered as ordered by the Provider. I consent to allowing students as part of their training in health care education to participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that these students will be supervised by instructors and/or hospital staff. I further consent to the hospital conducting blood-borne infectious disease testing, including but not limited to, testing for hepatitis, Acquired Immune Deficiency Syndrome ("AIDS"), and Human Immunodeficiency Virus ("HIV"), if a physician orders such tests or if ordered by protocol. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.

2. **Consent to Photographs, Videotapes and Audio Recordings.** I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the hospital's quality improvement and/or risk management activities. I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.

3. **Financial Agreement.** In consideration of the services to be rendered to Patient, Patient or Guarantor individually promises to pay the Patient's account at the rates stated in the hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the Patient's account. Some special items will be priced separately if there is no price listed on the Charge Master. An estimate

of the anticipated charges for services to be provided to the Patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including, but not limited to, the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

Professional services rendered by independent contractors are not part of the hospital bill. These services will be billed to the Patient separately. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

The hospital will provide a medical screening examination as required to all Patients who are seeking medical services to determine if there is an emergency medical condition without regard to the Patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, Patient and Guarantor understand that if Patient does not qualify under the hospital's charity care policy or other applicable policy, Patient or Guarantor is not relieved of his/her obligation to pay for these services.

If supplies and services are provided to Patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the Patient or Guarantor will be determined by the terms of the governmental program or private health insurance plan. If the Patient is uninsured and not covered by a governmental program, the Patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital.

I also understand that, as a courtesy to me, the hospital may bill an insurance company offering coverage, but may not be obligated to do so. Regardless, I agree that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the Patient or Guarantor. I agree to pay for services that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions, or failure to comply with insurance plan requirements.

4. **Third Party Collection**. I acknowledge that the Providers may utilize the services of a third party Business Associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing. During the time that the medical account is being serviced by the EBO Servicer, the account shall not be considered delinquent, past due or in default, and shall not be reported to a credit bureau or subject to collection legal proceedings. When the EBO Servicer's efforts to obtain payment have been exhausted due to a number of factors (for e.g., Patient or Guarantor's failure to pay or make a payment arrangement after insurance adjustments and payments have been credited, and/or the insurer's denial of claim(s) or benefits is received), the EBO Servicer will send a final notice letter which will include the date that the medical account may be returned from the EBO Servicer to the Provider.

Upon return to the Provider by the EBO Servicer, the Provider may place the account back with the EBO Servicer, or, at the option of the Provider, may determine the account to be delinquent, past due and in default. Once the medical account is determined to be delinquent it may be subject to late fees, interest as stated, referral to a collection agency for collection as a delinquent account, credit bureau reporting and enforcement by legal proceedings.

I also agree that if the Provider initiates collection efforts to recover amounts owed by me or my Guarantor, then, in addition to amounts incurred for the services rendered, Patient or Guarantor will pay, to the extent permitted by law: (a) any and all costs incurred by the Provider in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the Provider.

5. **Assignment of Benefits.** Patient assigns all of his/her rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorizes direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient for the hospitalization or for outpatient services, including emergency services, if rendered. Patient understands that any payment received from these policies and/or plans will be applied to the amount that Patient or Guarantor has agreed to pay for services rendered during this admission and, that Provider will not retain benefits in excess of the amount owed to the Provider for the care and treatment rendered during the admission.

   I understand that any health insurance policies under which I am covered may be in addition to other coverage or benefits or recovery to which I may be entitled, and that Provider, by initially accepting health insurance coverage, does not waive its rights to collect or accept, as payment in full, any payment made under different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services and treatment.

   I hereby **irrevocably appoint** the Provider as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier or, any other responsible third party ("Responsible Party") for any and all benefits due me for the payment of charges associated with my treatment. This assignment shall not be construed as an obligation of the Providers to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right.

   I agree to take all actions necessary to assist the Provider in collecting payment from any such Responsible Party should the Provider(s) elect to collect such payment, including allowing the Provider(s) to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment acknowledge that it is my duty and responsibility to immediately pay any such payments to the Provider(s).

6. **Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

7. **Private Room.** I understand and agree that I am (or Guarantor is) responsible for any additional charges associated with the request and/or use of a private room.

8. **Outpatient Medicare Patients.** Medicare does not cover prescription drugs with only a few exceptions. According to Medicare regulations, I acknowledge that I am responsible for any drugs furnished to me while an outpatient that meet Medicare's definition of a prescription drug. These drugs are also referred to as self-administered drugs, as they are usually self-administered but they may be administered to me by hospital personnel. Medicare requires hospitals to bill Medicare Patients or other third party payers for these drugs. Medicare Part D beneficiaries may submit a paper claim to the Medicare Part D Plan for possible reimbursement of these drugs in accordance with Medicare Drug Plan enrollment materials.

9. **Communications About My Healthcare.** I authorize my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others I designate to be responsible for my care. I will provide those individuals with a password or other verification means specified by the hospital. I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

10. **Consent to Telephone Calls for Financial Communications.** I agree that, in order for you, or your EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that you or your EBO Servicer and collection agents may contact me by telephone at any telephone number I have provided or you or your EBO Servicer and collection agents have obtained or, at any number forwarded or transferred from that number, regarding the hospitalization, the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

11. **Consent to Email or Text Usage for Discharge Instructions and Other Healthcare Communications.** If at any time I provide an email or text address at which I may be contacted, I consent to receiving discharge instructions and other healthcare communications at that email or text address from the Providers. These discharge instructions may include, but not be limited to: post-operative instructions, physician follow-up instructions, dietary information, and prescription information. The other healthcare communications may include, but are not limited to communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

12. **Release of Information.** I hereby permit Providers to release healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician

progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

13. Other Acknowledgements.

Personal Valuables. I understand that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss of or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for the loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars ($500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the Patient. The hospital is not responsible for the loss or damage of cell phones, glasses or dentures or personal valuables unless they are placed in the hospital safe in accordance with the terms as stated above.

Weapons/Explosives/Drugs. I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may search my room and my belongings located anywhere on hospital property, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

Patient Visitation Rights. I understand that I have the right to receive the visitors whom I or my Patient Representative designates, without regard to my relationship to these visitors. I also have the right to withdraw or deny such consent at any time. I will not be denied visitation privileges on the basis of age, race, color, national origin, religion, gender, gender identity and gender expression, and sexual orientation or disability. All visitors I designate will enjoy full and equal visitation privileges that are no more restrictive than those that my immediate family members would enjoy. Further, I understand that the hospital may need to place clinically necessary or reasonable restrictions or limitations on my visitors to protect my health and safety in addition to the health and safety of other Patients. The hospital will clearly explain the reason for any restrictions or limitations if imposed. If I believe that my visitation rights have been violated, I or my representative has the right to utilize the hospital's complaint resolution system.

Additional Provision for Admission of Minors/ Incapacitated Patient. I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

14. **Patient Self Determination Act.**
I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). . Please initial or place a mark next to **one** of the following applicable statements:

	I executed an Advance Directive and have been requested to supply a copy to the hospital		I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive	✓	I have not executed an Advance Directive and do not wish to execute one at this time

15. **Notice of Privacy Practices.** I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other prescribed and permitted uses and disclosures. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. I understand that I may contact the hospital Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge: _____ (Initial)

16. **Consent to Authorize Use of Email and Text for Patient Billing and Financial Obligations.** By my consent below, I authorize the use of any email address or cellular telephone number I provide for receiving **information** relating to my financial obligations, including, but not limited to, payment reminders, delinquent notifications, instructions and links to hospital Patient billing information.

Acknowledge: _____ (Initial) I consent to use of email for Patient billings and financial obligation purposes.

Acknowledge: _____ (Initial) I consent to use of text for Patient billings and financial obligation purposes.

17. **Acknowledgement**: I have been given the opportunity to read and ask questions about the information contained in this form, **specifically** including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers.

Acknowledge: _____ (Initial)

18. **Acknowledgement of Notice of Patient Rights and Responsibilities**. I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship,

religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

Acknowledge: Matthew J Scheer (Initial)

Date: 10/2/15 Time: 4:53 pm	I, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian, hereby certify I have read, and fully and completely understand this Conditions of Admission and Authorization for Medical treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Patient/Patient Representative Signature:

X Matthew J Scheer

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse
Parent
Legal Guardian
Neighbor/Friend
Sibling
Healthcare Power of Attorney
Guarantor
Other (please specify):

Self

_____

Witness Signature and Title:

X Amanda Hodges RN RES

Additional Witness Signature and Title:
(required for Patients unable to sign without a representative or Patients who refuse to sign)

X _____

HCA Corporate Standard COA-COS
03.17.2015

GRAND STRAND MEDICAL CENTER
PATIENT NOTICE - CLINICAL TRAINEES

Grand Strand Medical Center supports the education and development of clinical trainees: students, volunteer vendors, and licensed professionals such as nurses, pharmacists, physical therapists, phlebotomists, radiolog specialists, medical students, residents in training, or other healthcare providers.

Grand Strand Medical Center is a teaching hospital with an academic affiliation with University of South Carolir and contains embedded residency programs. As such, intern and resident physicians will be collaborative involved in making treatment decisions under the supervision of experienced staff physicians.

Resident and intern physicians, Allied Health Professionals (physician assistants or nurse practitioners) ma also be part of the treatment team in participating in surgery or other invasive procedures.

Non-physician clinical trainees may be involved in inpatient and outpatient care involving nursing, pharmac physical therapy, phlebotomy, radiology or other clinical services. Non-physician clinical trainees perform the duties under the supervision of an instructor, preceptor, physician or other professional healthcare provide within the scope of practice for their education and experience. All clinical trainees will be identified by wearin badges that clearly state their names, departments, and trainee titles

Your attending physician is the person responsible for your care while you are hospitalized. The attendin physician may change during a hospitalization depending upon the type of care or services required for you care. Some attending physicians work closely with physician assistants or nurse practitioners (Allied Healtl Professionals). In this instance, these Allied Health Professionals would be making treatment decisions an participating in your care. Allied Health Professionals are credentialed by the hospital.

At any time during your hospital stay, as an inpatient or for outpatient surgery, you may discuss your persona medical care with your attending physician, Intern Physician, Resident Physician, or his/her designee. If you ask that a nurse call your attending physician or other providers regarding your personal medical care, the nurse will place a call to your attending physician or his/ her designee. Upon request, the nurse will provide you with your attending physician's or his/her designee's phone number. If you are unable to communicate with, but wish to contact, your attending physician, a nurse will assist in placing the call and inform your attending physician or his/her designee of your concern and your need for one-one communication.

To access Grand Strand Medical Center's patient assistance system to discuss concerns about your treatment plan or hospital care during regular business hours, please call Administration (843) 692-1100, after hours, weekends and holidays call (843) 692-1000 and ask to speak to the Administrative Supervisor.

Your attending physician is: Patel, Nirup

Patient Initials: MJS

GRAND STRAND MEDICAL CENTER
PATIENT NOTICE - CLINICAL TRAINEES

Patient Information/Label

ADMIN 3400301179 (08/18/15) 453952

Grand Strand Regional Medical Center
809 82nd Parkway, Myrtle Beach, South Carolina 29572 (843)692-1000

IN/OUT/ER PATIENT ADMISSION RECORD

ACCOUNT#: **F01034276833** ADM DATE:10/02/15 UNIT RCRD #: **F000838076** ARRIVAL:WI
ROOM/BED:F.1285-A ADM TIME:1719 MARKET URN:F724867 CONF: VIP:
PT. TYPE:DIS IN ADMIT PRI/SRC:EM / PR LOCATION(S):F.2N FC:08

PATIENT INFORMATION

NAME: **SCHEER,MATTHEW**
STREET: 5750 OYSTER CATHCHER DR
STREET: BLD 11 UNIT 1135
C/S/ZP: MYRTLE BEACH,SC 29582
PHONE#: (609)457-0387 CNTY/RES: 026
EMAIL: MSCHEER89@MSN.COM

OTHER NAME:
DOB: **01/19/1989** SS#: XXX-XX-0192
AGE: 26 RACE: WHITE/CAUC
SEX: M MAR STATUS: M
REL: CATHOLIC LANG: ENGLISH

SPOUSE/NOK/COMPANION

SCHEER,DEBRA
5750 OYSTER CATHCHER DR
MYRTLE BEACH,SC 29582
(609)226-4952 RELTN: MOTHER
WORK PH:

PERSON TO NOTIFY

SCHEER,DAVID
5750 OYSTER CATHCHER DR
MYRTLE BEACH,SC 29582
(609)226-4952 RELTN: FATHER
WORK PH:

PATIENT EMPLOYER

DUNES VILLAGE RESORT

MYRTLE BEACH,SC
(999)999-9999 OCC: EMPLOYEE

GUARANTOR

SCHEER,MATTHEW J
5750 OYSTER CATHCHER DR
BLD 11 UNIT 1135
MYRTLE BEACH,SC 29582
(609)457-0387 RELTN: SELF

GUARANTOR EMPLOYER

DUNES VILLAGE RESORT

MYRTLE BEACH,SC
(999)999-9999

OCCURRENCE CODES

11 10/02/15

CONDITION CODES

INSURANCE INFORMATION

PRIMARY: BC12 - 32104	SECONDARY:	TERTIARY:
401 BC OF NJ PPO		
ATTN: NATL ACCTS		
PO BOX 100300		
COLUMBIA, SC 29202		
POLICY #:NJX3HZN82483300	POLICY #:	POLICY #:
COVERAGE #:	COVERAGE #:	COVERAGE #:
INS PHONE #:(800)414-7427	INS PHONE #:	INS PHONE #:
GRP #:00935000002	GRP#:	GRP#:
AUTH #:	AUTH #:	AUTH #:
AUTH DT: VER DT: 10/02	AUTH DT: VER DT:	AUTH DT: VER DT:
SUB: SCHEER,DEBRA	SUB:	SUB:
RELAT: MO DOB: 02/07/1958	RELAT: DOB:	RELAT: DOB:

PHYSICIAN INFORMATION/DOCUMENTATION

ADM:PATNI3	Patel,Nirlep A MD	PCP:.NO PCP	No Primary or Family Physician
HCS:0551	(843)692-1765	HCS:7943	.
ATT:PATNI3	Patel,Nirlep A MD	REF:PATNI3	Patel,Nirlep A MD
HCS:0551	(843)692-1765	HCS:0551	(843)692-1765
ER: BATAM	Battisti,Amanda DO, 6792		

REASON FOR VISIT/CHIEF COMPL:LEUKOCYTOSIS

PRINCIPAL DIAGNOSIS:

PRINCIPAL OPERATION/PROCEDURE:

CONSULTATIONS:

COMMENTS: SEE NOTES
PRT BY:R.HIM.AXJ ON:10/03/15 2140

ADVANCE DIRECTIVE: No:Info Offered/Refused
DISCH DATE: 10/03/15 TIME: 0145 DISPO:AMA

F01034276833

Grand Strand Regional Medical Center
809 82nd Parkway, Myrtle Beach, South Carolina 29572 (843)692-1000

I N / O U T / E R P A T I E N T A D M I S S I O N R E C O R D

ACCOUNT#: F01034276833 ADM DATE:10/02/15 UNIT RCRD #: F000838076 ARRIVAL:WI
ROOM/BED:F.1285-A ADM TIME:1719 MARKET URN:F724867 CONF: VIP:
PT. TYPE:ADM IN ADMIT PRI/SRC:EM / PR LOCATION(S):F.2N FC:08

P A T I E N T I N F O R M A T I O N

NAME: SCHEER,MATTHEW
STREET: 5750 OYSTER CATHCHER DR
STREET: BLD 11 UNIT 1135
C/S/ZP: MYRTLE BEACH,SC 29582
PHONE#: (609)457-0387 CNTY/RES: 026
EMAIL: MSCHEER89@MSN.COM

OTHER NAME:
DOB: 01/19/1989 SS#: XXX-XX-0192
AGE: 26 RACE: WHITE/CAUC
SEX: M MAR STATUS: M
REL: CATHOLIC LANG: ENGLISH

S P O U S E / N O K / C O M P A N I O N

SCHEER,DEBRA
5750 OYSTER CATHCHER DR
MYRTLE BEACH,SC 29582
(609)226-4952 RELTN: MOTHER
WORK PH:

P E R S O N T O N O T I F Y

SCHEER,DAVID
5750 OYSTER CATHCHER DR
MYRTLE BEACH,SC 29582
(609)226-4952 RELTN: FATHER
WORK PH:

P A T I E N T E M P L O Y E R

DUNES VILLAGE RESORT

MYRTLE BEACH,SC
(999)999-9999 OCC: EMPLOYEE

G U A R A N T O R

SCHEER,MATTHEW J
5750 OYSTER CATHCHER DR
BLD 11 UNIT 1135
MYRTLE BEACH,SC 29582
(609)457-0387 RELTN: SELF

G U A R A N T O R E M P L O Y E R

DUNES VILLAGE RESORT

MYRTLE BEACH,SC
(999)999-9999

OCCURRENCE CODES

11 10/02/15

CONDITION CODES

I N S U R A N C E I N F O R M A T I O N

PRIMARY: BC12 - 32104	SECONDARY:	TERTIARY:
401 BC OF NJ PPO		
ATTN: NATL ACCTS		
PO BOX 100300		
COLUMBIA, SC 29202		
POLICY #:NJX3HZN82483300	POLICY #:	POLICY #:
COVERAGE #:	COVERAGE #:	COVERAGE #:
INS PHONE #:(800)414-7427	INS PHONE #:	INS PHONE #:
GRP #:00935000002	GRP#:	GRP#:
AUTH #:	AUTH #:	AUTH #:
AUTH DT: VER DT: 10/02	AUTH DT: VER DT:	AUTH DT: VER DT:
SUB: SCHEER,DEBRA	SUB:	SUB:
RELAT: MO DOB: 02/07/1958	RELAT: DOB:	RELAT: DOB:

P H Y S I C I A N I N F O R M A T I O N / D O C U M E N T A T I O N

ADM:PATNI3	Patel,Nirlep A	MD	PCP:.NO PCP	No Primary or Family Physician
HCS:0551	(843)692-1765		HCS:7943	.
ATT:PATNI3	Patel,Nirlep A	MD	REF:PATNI3	Patel,Nirlep A MD
HCS:0551	(843)692-1765		HCS:0551	(843)692-1765
ER: BATAM	Battisti,Amanda	DO, 6792		

REASON FOR VISIT/CHIEF COMPL:LEUKOCYTOSIS

PRINCIPAL DIAGNOSIS:

PRINCIPAL OPERATION/PROCEDURE:

CONSULTATIONS:

COMMENTS: SEE NOTES
PRT BY:FNUR.TWS ON:10/02/15 1855

ADVANCE DIRECTIVE: No:Info Offered/Refused
DISCH DATE: TIME: DISPO:

NAME: SCHEER,MATTHEW
ACCT#: F01034276833
FORM:

ADM DATE: 10/02/15 1719
ATTEND PHYS: Patel,Nirlep A MD
DIS DT/TM: 10/03/15 0145
DIS DISP: Against Medical Advice
LOS: : 1
PT CLASS: IN.ALL

UNIT#: F000838076
SEX: M
AGE: 26
DOB: 01/19/89
FIN CLASS: 08
ABS STATUS: FINAL

DIAGNOSES			POA INDICATOR	CODESET
ADMIT DX	F23	BRIEF PSYCHOTIC DISORDER		ICD10
REASON FOR VISIT DX				
PRIMARY CODESET				
PRINC DX	F23	BRIEF PSYCHOTIC DISORDER	Y	ICD10
OTHER DX	D72.829	ELEVATED WHITE BLOOD CELL COUNT, UNSPECIFIED	Y	ICD10
	E80.6	OTHER DISORDERS OF BILIRUBIN METABOLISM	Y	ICD10
	Z88.0	ALLERGY STATUS TO PENICILLIN	E	ICD10
OTHER CODESET				
PRINC DX				
OTHER DX				

PROCEDURE			
PRIMARY CODESET			
DATE	PROC CODE & NAME	SURGEON	ANESTHESIOLOGIST
OTHER CODESET			

PRIMARY CODESET
DRG I-10 885 PSYCHOSES
OTHER CODESET
DRG I-9

STATUS	$REIMB	MIN-LOS	STD-LOS	COST WT	GRP VERS	GRP FC
F	4839.93		5.4	0.9041	32icd10	08

DRG STATUS DATE: 10/07/15
CODER: 1FSRGE8181

ABS STATUS DATE: 10/07/15
ABSTRACTOR: 1FSRGE8181

This form will be maintained as a permanent part of the medical record

GRAND STRAND REGIONAL MEDICAL CENTER
MYRTLE BEACH, SC 29572

NAME: SCHEER,MATTHEW
Unit #: F000838076 Acc #: F01034276833
Adm Date: 10/02/15
D/C Date: 10/03/15
Dictated By: Patel,Nirlep A MD Loc:F.2N
Report Name: DISCHARGE SUMMARY
==========

PRINCIPAL DIAGNOSES:
Leukocytosis, unspecified; psychosis and hyperbilirubinemia.

MEDICATIONS ON DISCHARGE:
Keppra _____ mg p.o. at bedtime.

DISCHARGE DISPOSITION:
The patient left against medical advice.

CONSULTATIONS:
Psychiatry and case management.

SUMMARY OF CLINICAL COURSE:
The patient is a 26-year-old Caucasian male who is sent to the Emergency Room for abnormal labs. He was initially brought in by his father, who is accompanying him and offers much of the history. Apparently, he has been having tangential thoughts and pressured speech and signs of acute psychosis, although he was not a danger to himself nor did he have any suicidal or homicidal ideation. His verbal abnormalities prompted his father to seek medical attention _____. He has stopped taking his Keppra, which he takes nightly some days ago. Denies any chest pain, abdominal pain, nausea, diarrhea, bowel or bladder irregularities, hematuria, calf pain, joint pain, fevers, chills or sick contacts. For further information, please see H P dated 10/2/15.

LABORATORY DATA:
Relevant laboratory data on this admission shows essentially unremarkable labs except white count of 14.5 and bilirubin of 5.5.

The patient was admitted to the general medicine floor with diagnosis of leukocytosis. The main issue appears to be psychiatric. He was medically cleared for discharge to a psychiatric facility already; however, there was a concern about be nonspecific leukocytosis. No obvious source of infection could be found. CT head was unremarkable. Ultrasound of the abdomen did not reveal any gallbladder or liver abnormalities. Outpatient workup for these laboratory abnormalities can be pursued. However, later that evening, the patient became more agitated. He was not here under involuntary commitment, he was admitted under voluntary psychiatric evaluation and therefore he cannot be kept here against his will. The patient requests to leave against medical advice. He was advised that this could be potentially dangerous that he could potentially become ill either from infection, seizures or result of a psychiatric illness, but he still insisted on leaving. He understood the risks of that. Vitals were stable and unremarkable at the time of the patient leaving. The patient left against medical advice later that night. All questions were answered to the

best of my ability. The patient was seen and examined on the day of discharge.

Discharge planning took greater than 25 minutes.

Dictation ID / Confirmation #: 2158570 / 1944836
DD: 10/03/2015 08:00 / DT: 10/03/2015 08:18
Authenticated by NIRLEP A PATEL MD On 10/03/2015 11:26:23 AM

Electronically Signed by Nirlep A Patel, MD on 10/03/15 at 1226

Patient Name: SCHEER,MATTHEW Account #: F01034276833

GRAND STRAND REGIONAL MEDICAL CENTER (COCQV)
EMERGENCY PROVIDER REPORT
REPORT#:1002-0587 REPORT STATUS: Signed
DATE:10/02/15 TIME: 1604

PATIENT: SCHEER,MATTHEW UNIT #: F000838076
ACCOUNT#: F01034276833 ROOM/BED: F.2N
AGE: 26 SEX: M PCP PHYS: No Primary or Family Physician
SERVICE DT: 10/02/15 AUTHOR: Dorn,Frank Edward PA

* ALL edits or amendments must be made on the electronic/computer document *

DORN,FRANK 10/02/15 1604:
HPI-General Med

HPI
Date/Time Seen by Provider 10/02/15 1604
Additional hpi notes:
Sent by Lighthouse care center due to elevated WBC and Bilirubin, hx of seizures and depression. An initial examination was made on the patient in rapid triage, and it was determined a more comprehensive evaluation was necessary. The patient was transferred into the Emergency Department where an second provider assumed the evaluation, care and dispo of the patient.

History-Medical/Family/Social
Additional Medical History:
reports h/o epilepsy and has been taking keppra since 2009.
Home medications:
Reported Medications
levETIRAcetam XR (KEPPRA XR) 2,500 MG PO BEDTIME

Discontinued Reported Medications
levETIRAcetam (KEPPRA) 250 MG PO BID
levETIRAcetam XR (KEPPRA XR)

Allergies:
Coded Allergies:
No Known Drug Allergies (10/02/15)

Past Surgical History:
Reports none
Past Family History:
FATHER
Family History: Unremarkable

MOTHER
Family History: Unremarkable

Occupation:
bar-back

Phys Exam-General Med
Vital Signs

Disposition-General Med
Vital signs:

BATTISTI,AMANDA 10/02/15 1611:
HPI-General Med

HPI
Confirmed patient: Yes
Complaint:
high WBC count
Source of history: patient
Timing - onset: today
Additional hpi notes:
Mr. Scheer is a 26 y/o male who presents to the ED from Lighthouse Care Center as they sent him back to the ED for high WBC count. Initially, pt went to Lighthouse to be admitted. Dr. Oduwole then sent pt to conway hospital to be medically cleared as he was concerned for high wbc count. Pt came here instead of conway. No change in pt's sx since previous visit earlier today.

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1923

Review of Systems
Gastrointestinal:
anorexia (due to hallucinations).
Psych:
auditory hallucination, visual hallucination, insomnia. DENIES: depression, suicidal ideation, homicidal ideation.
All systems reviewed & negative except as marked.

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1642

History-Medical/Family/Social

)(Reviewed nursing notes: Yes
Social history:
Reports: good social support, local resident.

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1642

Phys Exam-General Med

Vital Signs
First Documented:

	Result	Date Time
Pulse Ox	100	10/02 1603
B/P	122/69	10/02 1603
Temp	36.5	10/02 1603
Pulse	95	10/02 1603
Resp	16	10/02 1603

Last Documented:

	Result	Date Time
Pulse Ox	100	10/02 1603
B/P	122/69	10/02 1603
Temp	36.5	10/02 1603
Pulse	95	10/02 1603
Resp	16	10/02 1603

Initial VS reviewed: yes
General: alert, no acute distress
Psychiatric: visual hallucination, flight of ideas, pressured tangenital speech, denies suicidal and homicidal intention and plan, paranoid thoughts that others are against him, tactile hallucinations, paranoid thoughts that his food is being poisoned

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1917

Results/Interpretations

Pulse Oximetry
Pulse Ox % 100
On: room air
Interpretation: interpreted by me, pulse oximetry normal

Time of interpretation: 1603

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1642

MDM-General Med

ED Course

Patient course: stable
)(Re-Evaluation/Progress
Time: 1834
Additional notes:
D/w pt ED findings and plan for admit. Pt understands and agrees with the plan. All questions addressed.
Consultation: 1
Referral/Consultant name:
Oduwole,Adedapo M MD
Consultant called: Psychiatry
Requested call time: 1658
Requested call date: 10/02/15
Call returned: call returned
Call returned time: 1831
Call returned date: 10/02/15
Consultation: 2
Referral/Consultant name:
; Patel,Nirlep A MD
Consultant called: Hospitalist
Requested call time: 1835
Requested call date: 10/02/15
Call returned: call returned
Call returned time: 1835
Call returned date: 10/02/15
Consultant: will see patient, agrees with eval, agrees with plan
Admit accepts: Yes

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1917

Disposition-General Med

Clinical Impression:
Primary Impression: Acute psychosis
)(Disposition:
Admitted: Yes

Disposition time: 1848
Disposition date: 10/02/15
Vital signs:
First Documented:

	Result	Date Time
Pulse Ox	100	10/02 1603
B/P	122/69	10/02 1603
Temp	36.5	10/02 1603
Pulse	95	10/02 1603
Resp	16	10/02 1603

Last Documented:

	Result	Date Time
Pulse Ox	100	10/02 1603
B/P	122/69	10/02 1603
Temp	36.5	10/02 1603
Pulse	95	10/02 1603
Resp	16	10/02 1603

)(All prior VS reviewed: Yes
Condition: Stable
Counseled patient/family re: diagnosis, need for admission
Care trans to:
Patel,Nirlep A MD
Care trans at: 1848
Supervising Physician Note:
BENDIK,MORGAN M (10/02/15/1848) scribing for and in the presence of Battisti,Amanda DO. (10/02/15/1848)
I personally performed the services described in this documentation, reviewed and edited the documentation which was dictated to the scribe in my presence, and it accurately records my words and actions.

Battisti,Amanda DO
(10/02/15/1848)

Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1917

Electronically Signed by Dorn,Frank Edward PA on 10/03/15 at 1046
Electronically Signed by Battisti,Amanda DO on 10/08/15 at 0852

RPT #: 1002-0587
END OF REPORT

Patient: SCHEER,MATTHEW Age/Sex: 26/M Acct No: F01034276833
EDM Provider: Battisti,Amanda DO, 2hcaActive Unit No: F000838076

GENERAL DATA

ED Physician: Battisti,Amanda DO, 2hcaActive
Practitioner:
Nurse: BOOTH,MICHAEL, RN

Arrival Date/Time: 10/02/15 - 1557
Triage Date/Time: 10/02/15 - 1603
Date of Birth: 01/19/1989

Stated Complaint: LEUKOCYTOSIS
Chief Complaint: Non-Urgent General Focus
Priority: 3
Status Event History:
10/02/15 1557 Reception
1604 With Physician/Practitioner
1605 Triaged
1605 Room
1722 Disposition - Admit
1907 Off Tracker

MODE OF ARRIVAL

WALK IN

Home Medications

Prescriptions/Reported Meds	Type	Issued	Provider	Last Edited
levETIRAcetam (KEPPRA) 250 MG TAB	Reported			10/02/15
250 MG PO TWICE DAILY				
Discontinue Reason: 5				

ASSESSMENTS

1st Point of Contact

Occurred Date	Time	User	Recorded Date	Time	User
10/02/15	1559	KIRK,MARGARET ROSE	10/02/15	1600	KIRK,MARGARET ROSE

Is Patient Present? Y
Able to perform TB & Contagious Respiratory Infection Point of Entry Screen Y
--In the past 3 weeks has the patient:--
Resided in or traveled to an African country: None
Had contact with anyone who has been to a West African country: No
Been in close contact with a person known or suspected to have Ebola: No
Fever greater than 100.4 F or 38.0 C: N
Is patient currently experiencing any of following in last 7 days:
Fever greater than 100.4? N
(38.0 C)
Cough? N
(not related to
allergy or COPD)
Sore Throat? N
Night sweats? N
Unexplained weight loss? N
Fatigue? N
Body Aches? N
Rash? N
Nasal Congestion (not related to allergies or sinus infections)? N
Pt reports prior history of TB or positive TB skin test? N
Close contact with a person who has TB? N
Close contact with any person having an Influenza-like Illness? N
Travel outside the US in the past 3 weeks: N
TB Point of Entry Screen: NEGATIVE
Contagious Respiratory Infection Point of Entry Screen- NEGATIVE

Rapid Assessment

Occurred Date	Time	User	Recorded Date	Time	User
10/02/15	1603	HARRELSON,AMY J, RN	10/02/15	1605	HARRELSON,AMY J, RN

First Point of Contact: No
Enter/Edit Allergies? Yes
Arrived By: WI
Onset of Symptoms Date: 10/02/15
See next page
Subjective Assessment:
WAS SEEN HERE FOR PYSCH ISSUES TODAY, WAS CLEARED AND SENT
TO LIGHTHOUSE. DR AT LIGHTHOUSE SENT HIM BACK DUE TO
ELEVATED WBC AND BILIRUBIN.
Objective Assessment:
ABCD INTACT
Neuro WDP? Yes
Cardiovascular WDP? Yes
Respiratory WDP? Yes
Pain scale: Numeric
Intensity: 0
See next page
OB/GYN History: (if noted below)
Flowsheet: Yes
Chief Complaint: Non-Urgent General Focus
Priority: ESI 4/SEMI-URGENT
ESP? Y
Facility ESP status:
ESP Enabled
See next page
Smoking status for patients 13 years old or older: Never Smoker
Last page
--In the past 3 weeks has the patient:--
Is patient currently experiencing any of following in last 7 days:
(38.0 C)
(not related to
allergy or COPD)
** FLACC Pain Assessment - Less than Age 3 or Sleeping **
Score of 4 or More, Consider Intervention
** Neonatal / Infant Pain Scale (NIPS) **
Temperature: 97.7
Temp source: Oral
Pulse: 95
Respirations: 16
Blood Pressure: 122/69
BP source: Monitor
ABP M (mmHg): 86
BP location: Left arm
SpO2: 100
Airway adjunct: Room air
See next page
Height - Feet: 6
Inches: 0

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833
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Patient: SCHEER,MATTHEW
EDM Provider: Battisti,Amanda DO, ZhcaActive

Age/Sex: 26/M

Acct No: F01034276833
Unit No: F000838076

Qm: 182.88
Source: Patient Stated
Weight - Lb: 168
Kg: 76.203
Source: Patient stated
Body Mass Index (BMI): 23.0
: Normal
See next page
Glasgow Coma Scale:
===SEVERE SEPSIS SCREENING===
Temperature: N
Heart Rate: Y
Respirations: N
WBC/Bands: Y
:
10/02/15 14.5H 1042
:
No Results past 24 hrs
If Y to 2 or more of above, proceed to next section: 2
===INFECTION===
Suspected/Documented Infection: UNABLE TO OBTAIN
Antibiotic Therapy (Not Prophylaxis): UNABLE TO OBTAIN
If Y to 1 of the above, proceed to next section: 0
See next page
===NEW ORGAN DYSFUNCTION within past 48 hours===
Last page
See next page
See next page

Family Health History

Occurred		Recorded	
Date	Time User	Date	Time User
10/02/15	1616 BOOTH,MICHAEL, RN	10/02/15	1616 BOOTH,MICHAEL, RN

Non Urgent General Focus

Occurred		Recorded	
Date	Time User	Date	Time User
10/02/15	1616 BOOTH,MICHAEL, RN	10/02/15	1616 BOOTH,MICHAEL, RN

Suicide screening: No
Evidence of physical and/or psychological abuse: No
Are you frequently being bullied: No
Do you currently think your safety is being threatened by anyone you know: No
See next page
Surgical History Tonsils and adenoids
See next page
Are there cultural,religious,language,developmental or behavioral factors
See next page
See next page
** Complete Physicial Assessment Deferred **
Select System for Focused Nursing Assessment:
See next page
ED plan of care
Chief Complaint: Non-Urgent General Focus
Expected outcome of chief complaint: Stabilized/Maintained
Last page
See next page
In the past few days have you been having
I want to ask you if your child attempted suicide
See next page
In the past week have you been having
See next page
See next page
Last page
Respiratory: No
Heart: No
GI: No
Neurological: Yes
: Seizures
Mental health: Yes
: Bi-polar
Chronic/other: No
Risk factors: No
Comments:
stroke as an infant
Recheck Lab -->
Med Refill -->
Injection -->
Onset of Symptoms Date: 10/02/15
Tooth Avulsion Questions -->
******** EAR ********
****** NOSE *******
****** THROAT *******
See next page
See next page
See next page
See next page
See next page
See next page

Medication History

Occurred		Recorded	
Date	Time User	Date	Time User
10/02/15	1616 BOOTH,MICHAEL, RN	10/02/15	1616 BOOTH,MICHAEL, RN

Takes Daily Medications, Vitamins, Herbal or OTC Medications N
Attention Required: N

Pain Assessment/Reassessment

Occurred		Recorded	
Date	Time User	Date	Time User
10/02/15	1617 BOOTH,MICHAEL, RN	10/02/15	1617 BOOTH,MICHAEL, RN

See next page
See next page
Last page

Disposition - DC, TX, ADM, LPT

Occurred		Recorded	
Date	Time User	Date	Time User

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833
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Patient: SCHEER,MATTHEW Age/Sex: 26/M Acct No: F01034276833
EDM Provider: Battisti,Amanda DO, ZhcaActive Unit No: F000838076

10/02/15 1907 FIDLER,LISA, RN 10/02/15 1907 FIDLER,LISA, RN

Patient Disposition: Admission
Disposition Category: Was Admitted & Treated
Question below will only be answered if patient is LPMSE:
ED plan of care
Chief Complaint: Non-Urgent General Focus
Expected outcome of chief complaint: Stabilized/Maintained
Actual outcome of chief complaint: Stabilized/Maintained
See next page
Primary ED Nurse: CSS.MB
For lookup by name, enter N\name then press <Lookup>
Arrival Date: 10/02/15
Arrival Time: 1557
ESP? Y
Triage Date: 10/02/15
ESP Status: ESP SCREENED & TREATED
Triage Time: 1603
Placed in Bed Date: 10/02/15
Triage Level: ESI3/Urgent
Placed in Bed Time: 1605
MD/DO/PA/NP Initiates Contact/Greets Patient Date: 10/02/15
MD/DO/PA/NP Initiates Contact/Greets Patient Time: 1604
Date Patient Physically Leaves ED: 10/02/15
Time Patient Physically Leaves ED: 1845
Elapsed Time from Disposition to Depart:
1:26
Delay Reasons: Waiting for Bed Assignmnt
Time handoff given : 1845
Handoff given to :
SBAR
Time patient transported to room : 1845
Transported via : Stretcher
See next page
Patient Left
Patient Discharged:
See next page
See next page
See next page
Last page
** FLACC Pain Assessment - Less than Age 3 or Sleeping **
Score of 4 or More, Consider Intervention

TREATMENTS

Teaching Education

Occurred Date	Time User	Recorded Date	Time User
10/02/15	1617 BOOTH,MICHAEL, RN	10/02/15	1617 BOOTH,MICHAEL, RN

See next page
Last page

Inpatient Room Assignment

Occurred Date	Time User	Recorded Date	Time User

10/02/15 1809 MOORE,TERESA L, RN 10/02/15 1809 MOORE,TERESA L, RN

Room: F.1285
Is room ready: Yes

Dashboard Data

Occurred Date	Time User	Recorded Date	Time User
10/03/15	0815 FIDLER,LISA, RN	10/03/15	0815 FIDLER,LISA, RN

Primary ED Nurse: CSS.MB
For lookup by name, enter N\name then press <Lookup>
Arrival Date: 10/02/15
Arrival Time: 1557
ESP? Y
Triage Date: 10/02/15
ESP Status: ESP SCREENED & TREATED
Triage Time: 1603
Placed in Bed Date: 10/02/15
Triage Level: ESI3/Urgent
Placed in Bed Time: 1605
MD/DO/PA/NP Initiates Contact/Greets Patient Date: 10/02/15
MD/DO/PA/NP Initiates Contact/Greets Patient Time: 1604
MD/DO/PA/NP Makes Decision to Disposition Date: 10/02/15
MD/DO/PA/NP Makes Decision to Disposition Time: 1835
Date Patient Physically Leaves ED: 10/02/15
Time Patient Physically Leaves ED: 1845
Disposition Category: Was Admitted & Treated
Elapsed Time from Disposition to Depart:
1:26
Delay Reasons: Waiting for Bed Assignmnt

DEPARTURE INFORMATION

Primary Impression:
Acute psychosis
Secondary Impressions:
Disposition: INPATIENT ADMIT THIS FACILITY Departure Date/Time: -
Comment:
Condition: STABLE

Referrals:

Pt Instructions:

Departure Forms:

ADDITIONAL INSTRUCTIONS

WITHIN DEFINED PARAMETERS

~~ ASSESSMENT PARAMETERS ~~

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833
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Patient: SCHEER,MATTHEW Age/Sex: 26/M Acct No: F01034276833
EDM Provider: Battisti,Amanda DO, ZhcaActive Unit No: F000838076

These are the definitions of Within Defined Parameters by Body System

NEUROLOGICAL
- Alert & Oriented X 4
- Pupils equal
- Speech clear and appropriate for age
- Moves all extremities
- No paralysis
- Steady gait
- Ambulates independently

EENT
- Eyes - Clear, no tearing or redness
- Ears - No complaint of hearing difficulty, loss of hearing, or change in hearing, pain free, no drainage
- Nasal - Breathes freely through both nares
- Throat - No hoarseness or stated soreness, no cough

RESPIRATORY
- No respiratory distress
- No cough
- No O2 or assistive devices
- No nasal flaring or pursed lip breathing
- Respirations even & unlabored
- Skin pink & warm to touch

CARDIAC
- No stated calf tenderness
- No history of pacemaker or implanted defibrillator
- Denies current cardiac complaint
- Skin pink & warm to touch - no cyanosis, mottling, diaphoresis or flushing of skin

CIRCULATORY
- Oral mucosa pink and moist
- Skin color appropriate to ethnic color
- Denies sensory complaints
- No edema noted

MUSCULOSKELETAL
- Moves all extremities
- Ambulates independently

GASTROINTESTINAL
- Denies GI complaints

GENITO-URINARY
- Denies GU complaints

INTEGUMENTARY
- Skin warm, dry & intact
- No complaints of lesions, rash, wounds, bruises, petechiae or abrasions

PSYCHOSOCIAL
- With regards to cultural influences: mood/affect is appropriate
- Patient demonstrates effective coping skills/patterns for situation

These are the definitions of Within Defined Parameters for the Nutritional and Functional Screenings:

NUTRITIONAL
- No swallowing/chewing impairments
- No nasea and/or vomiting and/or diarrhea for 3 or more days
- No reported unintentional weight loss > 10 lbs in last 3 months
- No reported decrease in intake > 50% of usual in last two weeks

FUNCTIONAL
- No unexplained alteration in movement/mobility in last four weeks
- No recent limitation performance of ADLs
- No recent alteration in ADLs that require assistance

This is the definition for the evidence of Physical and/or Psychological Abuse question:

ABUSE HISTORY TO INCLUDE, BUT NOT LIMITED TO:
PT DOES NOT REPORT/NO EVIDENCE OF ANY OF THE FOLLOWING: abuse/neglect, Hx. of abuse/neglect, withdrawn/fearful behavior, Unexplained or suspicious bruises/wounds, Patient/Caregiver story changes, Defensive about injuries, Undernourished despite good appetite, Recurrent/Suspicious injuries, Fear of return to previous arrangements, Injuries do not match event history.

*** PATIENT SAFETY PARAMETERS ***
** Allergy and Patient Identification Bands in Place and Validated
** If in a Bed, Side Rails Up and Bed in Low Position With Wheels Locked
** If in a Wheelchair, Wheels Locked
** Call Light Function Explained and Within Reach
** Standard Precautions Observed

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833
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GRAND STRAND REGIONAL MEDICAL CENTER
MYRTLE BEACH, SC 29572

NAME: SCHEER,MATTHEW
Unit #: F000838076 Acc #: F01034276833
Adm Date: 10/02/15
D/C Date: 10/03/15
Dictated By: Patel,Nirlep A MD Loc:F.2N
Report Name: HISTORY AND PHYSICAL
==========

CHIEF COMPLAINT:
Sent over for psychiatric evaluation and abnormal white cell count and bilirubin.

PAST MEDICAL HISTORY:
Seizure disorder. History of cerebrovascular incident at birth.

HOME MEDICATIONS:
Keppra 3000 mg daily at night.

ALLERGIES:
PENICILLIN, MILD ITCHING.

PAST SURGICAL HISTORY:
Tonsillectomy, skin graft.

SOCIAL HISTORY:
Denies alcohol, tobacco or drug use currently.

FAMILY HISTORY:
No history of coronary artery disease, hypertension, malignancy or hepatic disorders.

PRIMARY CARE PHYSICIAN:
The patient does not currently have one.

HISTORY OF PRESENT ILLNESS:
The patient is a 26-year-old Caucasian male with really no past medical history aside from seizures. He had been on Keppra for 6 years, recently stopped taking it, but he has been having what the father describes, who is accompanying the patient and provided most of the history, as an acute psychotic episode, tangential thinking. He has been having visions. The patient denies hallucinations, but he had what the father described as a psychotic episode where he ran out into the woods. He is not able to provide details in terms of what exactly the episode entailed. Denies any incontinence. No actual seizure activity. Denies any headaches, no blurry vision, no dizziness. Denies any current hallucinations. Denies any suicidal ideation and denies any homicidal ideation. No calf pain or joint pain, abnormal bleeding. No fevers, no chills. No sick contacts or travel history.

The patient has come down and lived down here in Myrtle Beach area for about a year and a half. Originally, it appears the family is from New Jersey.

The initial reason for sending him to the Emergency Room and for hospital admission is for abnormal white cell count of 14.5 and a bilirubin of 5.5. LFTs are unremarkable. The patient denies any abdominal pain or chest pain, no back pain. Denies any change in his urine color, no changes in bowel or bladder frequency. Denies any rashes.

REVIEW OF SYSTEMS:
Ten systems are reviewed and negative except as noted above.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temp 97, heart rate 95, blood pressure 120/69, respirations ____, satting 100% room air.
GENERAL: Alert and oriented x3, no acute distress.
HEENT: Normocephalic, atraumatic. Pupils equal, round, react to light. Mild icterus noted.
LUNGS: Respirations clear to auscultation bilaterally. No wheeze, rales, or rhonchi.
CARDIOVASCULAR: Normal rhythm regular. No murmurs, rubs, or gallops.
NECK: No JVD or thyromegaly. Supple, no bruits.
ABDOMEN: Soft, nontender, nondistended, positive bowel sounds, no rebound, no guarding, no organomegaly.
MUSCULOSKELETAL: No edema, no cyanosis, no clubbing. Normal range of motion.
SKIN: Warm, dry and intact.
PSYCHIATRIC: Not agitated, not confused. Mild tangential thinking and pressured speech, mild.

RELEVANT LABORATORY DATA:
On this admission shows a UA that is negative for nitrites, leukocyte esterase. UDS negative. Salicylate 1.7. Alcohol less than 3. Chem-7 and CBC essentially unremarkable with exception of white count 14.5, creatinine 0.86, total bili 5.5. AST and ALT 30 and 35 respectively, alk phos 64, TSH 1.4. CT head without contrast shows no acute findings.

ASSESSMENT AND PLAN:
1. Possible psychosis. We will place the psychiatric consultation for Dr. Oduwole for this evening as requested. Resume his Keppra 3000 mg daily at night, and p.r.n. Ativan for agitation. He is currently not suicidal or homicidal, and is very calm and cooperative with me during my interview and exam.
2. Leukocytosis, nonspecific. Urine is clear. No obvious signs of infection. The patient is afebrile. We will repeat laboratories in the morning.
3. Hyperbilirubinemia. No signs of active hemolysis or other acute abdominal process. We will check a right upper quadrant ultrasound to rule out any gallbladder etiology, although this is low suspicion given his lack of physical findings. We will check direct bilirubin and a GGT. I suspect he will need an outpatient workup with Hematology or Gastroenterology, but again this can be performed as an outpatient.
4. Disposition, full code. The patient has already been medically cleared; however, we will pursue additional testing in light of the above laboratory findings while he was evaluated by Psychiatry here.

Dictation ID / Confirmation #: 2157591 / 1943886

Patient Name: SCHEER,MATTHEW Account #: F01034276833

DD: 10/02/2015 17:29 / DT: 10/02/2015 19:54
Authenticated and Edited by NIRLEP A PATEL MD On 10/03/15 11:25:41 AM

Electronically Signed by Nirlep A Patel, MD on 10/03/15 at 1231

Patient Name: SCHEER,MATTHEW Account #: F01034276833

GRAND STRAND REGIONAL MEDICAL CENTER (COCQV)
Clinical Note
REPORT#:1003-0013 REPORT STATUS: Signed
DATE:10/03/15 TIME: 0129

PATIENT: SCHEER,MATTHEW UNIT #: F000838076
ACCOUNT#: F01034276833 ROOM/BED: F.1285-A
DOB: 01/19/89 AGE: 26 SEX: M ATTEND: Patel,Nirlep A MD
ADM DT: 10/02/15 AUTHOR: Ash Bernal,Rachel MD

* ALL edits or amendments must be made on the electronic/computer document *

Clinical Note

Note:

CROSS-COVER NOTE
Pt refused IV, PO Keppra. I was called to patient room by nursing staff since pt was yelling at nursing staff stating they were all "devil worshipers" and "Obama is Satan." Pt is a voluntary psychiatric admission and when asked if he wanted to leave the hospital against medical advice or stay in-house for treatment he state "I want to leave right now." Pt has was yelling in his room, disrupting the other pts rest time. Pt indicated he understood that it was recommended he remain in the hospital for further evalaution of his psychiatric issues but he refused to stay. Pt seemed able to weigh the information (he interrupted his religious rant to think about the question) and it was explained to him that he could die from infection, seizures or as a result of his psychiatric illness and he insisted on leaving. Pt may not be restrained in the hospital since he is a voluntary admission. Pt vitals stable. AMA papers signed, pt left the hospital.

Electronically Signed by Ash Bernal,Rachel MD on 10/03/15 at 0140

RPT #: 1003-0013
END OF REPORT

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833

ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A

ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
ADT	Admission Request (In/Out/Obs)	20151002-0223	10/02/15	1719	S		E	LOG	BATAM

Other Provider : Sig Lvl Provider : PATNI3

.
(Medicare generally considers patients who are expected to need hospital

services for at
least two midnights to be inpatients. Medicare generally considers patients

expected to
need hospital services for less than two midnights to be outpatients,

unless a patient
is receiving an 'inpatient only procedure' in which case they would be

inpatient.)
Expect patient to be here=>two midnights or have an inpt only procedure?

.

Patient Status:	Admit to Inpatient
Service:	Medical
Reason:	acute psychosis
Location:	
Telemetry:	N
Isolation:	N
Assign to Physician:	Patel,Nirlep A MD
.	N
Is this a Trauma pt:	
.	
Is this an ED Patient:	Yes

.
Comment:
I certify that the patient status is appropriate and is based on my best

clinical
judgement and the patient's condition as documented in the medical record.

Order's Audit Trail of Events

```
1    10/02/15 1719 PHY.BATAM  Order ENTER in EDM/POM
2    10/02/15 1719 PHY.BATAM  Order from set: ED BRIDGE ADMISSION
3    10/02/15 1719 PHY.BATAM  Ordering Doctor: Battisti,Amanda  DO
4    10/02/15 1719 PHY.BATAM  Order Source: EPOM
5    10/02/15 1719 PHY.BATAM  Sig Level Provider: Patel,Nirlep A  MD
6    10/02/15 1719 PHY.BATAM  Signed by Battisti,Amanda  DO
7    10/02/15 1719 PHY.BATAM  This procedure has reflexed the following order(s)
8    10/02/15 1719 PHY.BATAM  Universal Decolonization Proto (NUR.PHYS)
9    10/02/15 1719 PHY.BATAM  ED Unit Sec-Admit Notification (NUREDM)
10   10/02/15 1719 PHY.BATAM  Inpatient Room Assignment (NUREDM)
11   10/02/15 1731 R.QV.ANT   order's status changed from TRANS to LOGGED
12   10/02/15 1734 FNUR.AJH   order viewed from Order Management
13   10/05/15 1032 PHY.PATNI3 Signed by Patel,Nirlep A  MD

                 Electronically signed by Battisti,Amanda  DO on 10/02/15 at 1719

                 Electronically signed by Patel,Nirlep A  MD on 10/05/15 at 1032
```

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833

ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A

ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.PHYS	Notify	20151002-1257	10/02/15	1719			E	IPR	BATAM

Other Provider :
Sig Lvl Provider :
Press [ENTER] for Order Details

Comment: The care of this patient has been discussed with the accepting/admitting physician who agrees to immediately assume the care of the patient. Call Admitting physician for further orders, clarification of orders, or change in patient's condition.

Order's Audit Trail of Events

1 10/02/15 1719 PHY.BATAM Order ENTER in EDM/POM
2 10/02/15 1719 PHY.BATAM Order from set: ED BRIDGE ADMISSION
3 10/02/15 1719 PHY.BATAM Ordering Doctor: Battisti,Amanda DO
4 10/02/15 1719 PHY.BATAM Order Source: EPOM
5 10/02/15 1719 PHY.BATAM Signed by Battisti,Amanda DO
6 10/02/15 1719 interface order's status changed from TRANS to ACTIVE by NUR

Electronically signed by Battisti,Amanda DO on 10/02/15 at 1719

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
OSD	Notify Attending Physician	20151002-0393	10/02/15	1719	R		E	TRN	BATAM

Other Provider :
Sig Lvl Provider :
Press [ENTER] for Order Details

Comment: Notify attending physician when patient arrives to floor.

Order's Audit Trail of Events

1 10/02/15 1719 PHY.BATAM Order ENTER in EDM/POM
2 10/02/15 1719 PHY.BATAM Order from set: ED BRIDGE ADMISSION
3 10/02/15 1719 PHY.BATAM Ordering Doctor: Battisti,Amanda DO
4 10/02/15 1719 PHY.BATAM Order Source: EPOM
5 10/02/15 1719 PHY.BATAM Signed by Battisti,Amanda DO

Electronically signed by Battisti,Amanda DO on 10/02/15 at 1719

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.PHYS	Vital Signs	20151002-1258	10/02/15	1719			E	IPR	BATAM

Other Provider :
Sig Lvl Provider :
Press [ENTER] for Order Details

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833
ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL
A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A
ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

Frequency: Per Unit Protocol

Order's Audit Trail of Events

1 10/02/15 1719 PHY.BATAM Order ENTER in EDM/POM
2 10/02/15 1719 PHY.BATAM Order from set: ED BRIDGE ADMISSION
3 10/02/15 1719 PHY.BATAM Ordering Doctor: Battisti,Amanda DO
4 10/02/15 1719 PHY.BATAM Order Source: EPOM
5 10/02/15 1719 PHY.BATAM Signed by Battisti,Amanda DO
6 10/02/15 1719 interface order's status changed from TRANS to ACTIVE by NUR

Electronically signed by Battisti,Amanda DO on 10/02/15 at 1719

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.PHYS	Pulse Oximetry +	20151002-1259	10/02/15	1719			E	IPR	BATAM

Other Provider : **Sig Lvl Provider :**

Press [ENTER] for Order Details

Pulse Ox Frequency With Vitals

Order's Audit Trail of Events

1 10/02/15 1719 PHY.BATAM Order ENTER in EDM/POM
2 10/02/15 1719 PHY.BATAM Order from set: ED BRIDGE ADMISSION
3 10/02/15 1719 PHY.BATAM Ordering Doctor: Battisti,Amanda DO
4 10/02/15 1719 PHY.BATAM Order Source: EPOM
5 10/02/15 1719 PHY.BATAM Signed by Battisti,Amanda DO
6 10/02/15 1719 interface order's status changed from TRANS to ACTIVE by NUR

Electronically signed by Battisti,Amanda DO on 10/02/15 at 1719

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.PHYS	Intake & Output	20151002-1260	10/02/15	1719			E	IPR	BATAM

Other Provider : **Sig Lvl Provider :**

Press [ENTER] for Order Details

Frequency: Per Unit Protocol

Order's Audit Trail of Events

1 10/02/15 1719 PHY.BATAM Order ENTER in EDM/POM
2 10/02/15 1719 PHY.BATAM Order from set: ED BRIDGE ADMISSION
3 10/02/15 1719 PHY.BATAM Ordering Doctor: Battisti,Amanda DO
4 10/02/15 1719 PHY.BATAM Order Source: EPOM
5 10/02/15 1719 PHY.BATAM Signed by Battisti,Amanda DO
6 10/02/15 1719 interface order's status changed from TRANS to ACTIVE by NUR

Electronically signed by Battisti,Amanda DO on 10/02/15 at 1719

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW A/S: 26 M ADMIT: 10/02/15
ACCOUNT NO: F01034276833 LOC: F.2N DISCH/DEP: 10/03/15
RM: F.1285 STATUS: IN
ATTEND DR: Patel,Nirlep A MD BD: A UNIT NO: F000838076
REPORT STATUS: FINAL

Order Date: 10/02/15 ——Service——

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
OSD	ORDER SET NAME	20151002-0394	10/02/15	1719	R			TRN	BATAM

Other Provider : Sig Lvl Provider :

Order Set Used: ED BRIDGE ADMISSION hEDBRDG02
Version: 02
Approval Date: 10/07/14
ZYNX Set: hEDBRDG02
Comments: Changes per MEC request/approval 10/9/14.

Order's Audit Trail of Events

1 10/02/15 1719 PHY.BATAM Order ENTER in EDM/POM
2 10/02/15 1719 PHY.BATAM Order from set: ED BRIDGE ADMISSION
3 10/02/15 1719 PHY.BATAM Ordering Doctor: Battisti,Amanda DO
4 10/02/15 1719 PHY.BATAM Signed by Battisti,Amanda DO

Order Date: 10/02/15 ——Service——

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.PHYS	Universal Decolonization Proto	20151002-1261	10/02/15	1719		E		IPR	BATAM

Other Provider : Sig Lvl Provider :

Press [ENTER] for Order Details

Comment: MRSA Swab if score of 3 or more on infection control screening B for MRSA unless already done as part of this admission.

Order's Audit Trail of Events

1 10/02/15 1719 PHY.BATAM Order ENTER in EDM/POM
2 10/02/15 1719 PHY.BATAM Order from set: MRSA Swab (Floor)
3 10/02/15 1719 PHY.BATAM Ordering Doctor: Battisti,Amanda DO
4 10/02/15 1719 PHY.BATAM Order Source: EPOM
5 10/02/15 1719 PHY.BATAM Signed by Battisti,Amanda DO
6 10/02/15 1719 PHY.BATAM This Procedure was triggered by :
7 10/02/15 1719 PHY.BATAM Admission Request (In/Out/Obs) (ADT)
8 10/02/15 1719 interface order's status changed from TRANS to ACTIVE by NUR

Electronically signed by Battisti,Amanda DO on 10/02/15 at 1719

Order Date: 10/02/15 ——Service——

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUREDM	ED Unit Sec-Admit Notification	20151002-0262	10/02/15	1719	S		E	TRN	BATAM

Other Provider : Sig Lvl Provider :

Order's Audit Trail of Events

1 10/02/15 1719 PHY.BATAM Order ENTER in EDM/POM
2 10/02/15 1719 PHY.BATAM Order from set: ED Inpatient Room Request
3 10/02/15 1719 PHY.BATAM Ordering Doctor: Battisti,Amanda DO
4 10/02/15 1719 PHY.BATAM Order Source: EPOM
5 10/02/15 1719 PHY.BATAM Signed by Battisti,Amanda DO
6 10/02/15 1719 PHY.BATAM This Procedure was triggered by :
7 10/02/15 1719 PHY.BATAM Admission Request (In/Out/Obs) (ADT)

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833

ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A

ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

Electronically signed by Battisti,Amanda DO on 10/02/15 at 1719

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUREDM	Inpatient Room Assignment	20151002-0263	10/02/15	1719	S		E	TRN	BATAM

Other Provider :
Sig Lvl Provider :

Press [ENTER] for Order Details

.

Order's Audit Trail of Events

1 10/02/15 1719 PHY.BATAM Order ENTER in EDM/POM
2 10/02/15 1719 PHY.BATAM Order from set: ED Inpatient Room Request
3 10/02/15 1719 PHY.BATAM Ordering Doctor: Battisti,Amanda DO
4 10/02/15 1719 PHY.BATAM Order Source: EPOM
5 10/02/15 1719 PHY.BATAM Signed by Battisti,Amanda DO
6 10/02/15 1719 PHY.BATAM This Procedure was triggered by :
7 10/02/15 1719 PHY.BATAM Admission Request (In/Out/Obs) (ADT)

Electronically signed by Battisti,Amanda DO on 10/02/15 at 1719

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CBC W/AUTO DIFFERENTIAL	20151003-0442	10/03/15	0600	R		E	CNC	PATNI3

Other Provider :
Sig Lvl Provider :

.
This is NOT required. Answer ONLY if needed.

**ADD ON TEST:

Order's Audit Trail of Events

1 10/02/15 1729 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1729 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
3 10/02/15 1729 PHY.PATNI3 Order Source: EPOM
4 10/02/15 1729 PHY.PATNI3 AM was entered as Service Time
5 10/02/15 1729 PHY.PATNI3 Signed by Patel,Nirlep A MD
6 10/02/15 1914 FNUR.BJB1 order acknowledged
7 10/03/15 0003 interface cc'd doctors edited in LAB
8 10/03/15 0003 interface order's status changed from TRANS to LOGGED by LAB
9 10/03/15 0146 interface order's status changed from LOGGED to CANC by LAB

Cancel request comment: PATIENT DISCHARGED
Cancel comment: Cancelled via OE: PATIENT DISCHARGED
Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1729

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833
ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL
A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A
ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

Order Date: 10/02/15 —Service—

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	COMPREHENSIVE METABOLIC PANEL	20151003-0443	10/03/15	0600	R		E	CNC	PATNI3

Other Provider : Sig Lvl Provider :

This is NOT required. Answer ONLY if needed.

**ADD ON TEST:

Order's Audit Trail of Events

1 10/02/15 1729 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1729 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
3 10/02/15 1729 PHY.PATNI3 Order Source: EPOM
4 10/02/15 1729 PHY.PATNI3 AM was entered as Service Time
5 10/02/15 1729 PHY.PATNI3 Signed by Patel,Nirlep A MD
6 10/02/15 1914 FNUR.BJB1 order acknowledged
7 10/03/15 0003 interface cc'd doctors edited in LAB
8 10/03/15 0003 interface order's status changed from TRANS to LOGGED by LAB
9 10/03/15 0146 interface order's status changed from LOGGED to CANC by LAB

Cancel request comment: PATIENT DISCHARGED
Cancel comment: Cancelled via OE: PATIENT DISCHARGED
Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1729

Order Date: 10/02/15 —Service—

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CONS	Case Management	20151002-0140	10/02/15		R		E	TRN	PATNI3

Other Provider : Sig Lvl Provider :

Reason for Consult: D/C Planning

DME Type:
NPI #:
Comment:
Requires ORDERING MD's Mnemonic for NPI#

Order's Audit Trail of Events

1 10/02/15 1731 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1731 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
3 10/02/15 1731 PHY.PATNI3 Order Source: EPOM
4 10/02/15 1731 PHY.PATNI3 Signed by Patel,Nirlep A MD
5 10/02/15 1914 FNUR.BJB1 order acknowledged

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1731

Order Date: 10/02/15 —Service—

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CONS	Psych Consult	20151002-0141	10/02/15		R		E	TRN	PATNI3

Other Provider : Sig Lvl Provider :

Consult Reason: acute psychosis; voluntary admit

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833
ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL
A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A
ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

Order's Audit Trail of Events
1 10/02/15 1731 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1731 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
3 10/02/15 1731 PHY.PATNI3 Order Source: EPOM
4 10/02/15 1731 PHY.PATNI3 Signed by Patel,Nirlep A MD
5 10/02/15 1914 FNUR.BJB1 order acknowledged

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1731

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESUS	Resuscitation Status	20151002-0041	10/02/15	1733	R		E	TRN	PATNI3

Other Provider : Sig Lvl Provider :
Resuscitation Status: Full Code
F9 Lookup for Resuscitation Status Choices

FOR SPECIAL INSTRUCTION DETAIL ONLY

Chest Compressions:
Cardiac Defibrillation:
Intubation:
Ventilator:
Medications:

Order's Audit Trail of Events
1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Order from set: GENERAL MED/SURG DIRECT ADMIT
3 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
4 10/02/15 1733 PHY.PATNI3 Order Source: EPOM
5 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD
6 10/02/15 1914 FNUR.BJB1 order acknowledged

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.PHYS	Vital Signs	20151002-1281	10/02/15	1733			E	IPR	PATNI3

Other Provider : Sig Lvl Provider :
Press [ENTER] for Order Details

Frequency: Per Unit Protocol

Order's Audit Trail of Events
1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Order from set: GENERAL MED/SURG DIRECT ADMIT
3 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
4 10/02/15 1733 PHY.PATNI3 Order Source: EPOM
5 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD
6 10/02/15 1734 interface order's status changed from TRANS to ACTIVE by NUR
7 10/02/15 1914 FNUR.BJB1 order acknowledged

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833

ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A

ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.PHYS	Notify VS	20151002-1282	10/02/15	1733			E	IPR	PATNI3

Other Provider : Sig Lvl Provider :

Press [ENTER] for Order Details

.

Sys BP less than:	90
Sys BP greater than:	170
Dia BP less than:	
Dia BP greater than:	100
Heart Rate less than:	50
Heart Rate greater than:	110
Resp Rate less than:	12
Resp Rate greater than:	28
Temp less than:	
Temp greater than:	101.0
O2 Sat% less than:	92

Press [ENTER] for Additional Order Details

.

Order's Audit Trail of Events

1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Order from set: GENERAL MED/SURG DIRECT ADMIT
3 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
4 10/02/15 1733 PHY.PATNI3 Order Source: EPOM
5 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD
6 10/02/15 1734 interface order's status changed from TRANS to ACTIVE by NUR
7 10/02/15 1914 FNUR.BJB1 order acknowledged

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
FNS	Regular Diet	20151002-0139	10/02/15	D			E	TRN	PATNI3

Other Provider : Sig Lvl Provider :

.

Send Tray Now?
Fluid Restriction (mL's):

.

Oral Supp Frequency:
Prostat 1 oz. in applesauce BID:
(Group response undefined)

.

Order's Audit Trail of Events

1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Order from set: GENERAL MED/SURG DIRECT ADMIT
3 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
4 10/02/15 1733 PHY.PATNI3 Order Source: EPOM
5 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833

ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A

ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

6 10/02/15 1914 FNUR.BJB1 order acknowledged

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.PHYS	Activity	20151002-1283	10/02/15	1733			E	IPR	PATNI3

Other Provider : Sig Lvl Provider :

Press [ENTER] for Order Details

Activity: AS TOLERATED
Press [ENTER] for Additional Order Details

Other: AS TOLERATED

Order's Audit Trail of Events

1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Order from set: GENERAL MED/SURG DIRECT ADMIT
3 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
4 10/02/15 1733 PHY.PATNI3 Order Source: EPOM
5 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD
6 10/02/15 1734 interface order's status changed from TRANS to ACTIVE by NUR
7 10/02/15 1914 FNUR.BJB1 order acknowledged

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.PHYS	Sequential Compression Device	20151002-1284	10/02/15	1733			E	IPR	PATNI3

Other Provider : Sig Lvl Provider :

Press [ENTER] for Order Details

Extremity: Bilateral

Order's Audit Trail of Events

1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Order from set: GENERAL MED/SURG DIRECT ADMIT
3 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
4 10/02/15 1733 PHY.PATNI3 Order Source: EPOM
5 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD
6 10/02/15 1734 interface order's status changed from TRANS to ACTIVE by NUR
7 10/02/15 1914 FNUR.BJB1 order acknowledged

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833

ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A

ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MED.COCQV	MEDICATION	20151002-2460	10/02/15	1740	R		E	CMP	PATNI3

—Service—

Other Provider :
Sig Lvl Provider :

RX: 12157439
Start: 10/02/15 1740 PRN CMP
Stop:

Acetaminophen Tab (Tylenol Tab)
Dose: 650 MG
Route: PO
Direction: Q8H PRN
PRN Reason: PAIN OR ELEVATED TEMPERATURE

Order's Audit Trail of Events

1	10/02/15 1733	PHY.PATNI3	Order ENTER in POM
2	10/02/15 1733	PHY.PATNI3	Order from set: GENERAL MED/SURG DIRECT ADMIT
3	10/02/15 1733	PHY.PATNI3	Ordering Doctor: Patel,Nirlep A MD
4	10/02/15 1733	PHY.PATNI3	Order Source: EPOM
5	10/02/15 1733	PHY.PATNI3	Signed by Patel,Nirlep A MD
6	10/02/15 1733	interface	order's status changed from TRANS to LOGGED by PHA
7	10/02/15 1739	FPHA.ALN	VERIFIED in PHA
8	10/02/15 1739	interface	order's status changed from LOGGED to IN PRO by PHA
9	10/02/15 1914	FNUR.BJB1	order acknowledged
10	10/03/15 0146	DISCHARGE	DISCONTINUE in PHA
11	10/03/15 0146	interface	order's status changed from IN PRO to COMP by PHA

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MED.COCQV	MEDICATION	20151002-2461	10/02/15	1740	R		E	CMP	PATNI3

—Service—

Other Provider :
Sig Lvl Provider :

RX: 12157438
Start: 10/02/15 1740 PRN CMP
Stop:

diphenhydrAMINE Cap (Benadryl Cap)
Dose: 25 MG
Route: PO
Direction: BEDTIME PRN
PRN Reason: INSOMNIA

Order's Audit Trail of Events

1	10/02/15 1733	PHY.PATNI3	Order ENTER in POM
2	10/02/15 1733	PHY.PATNI3	Order from set: GENERAL MED/SURG DIRECT ADMIT
3	10/02/15 1733	PHY.PATNI3	Ordering Doctor: Patel,Nirlep A MD
4	10/02/15 1733	PHY.PATNI3	Order Source: EPOM
5	10/02/15 1733	PHY.PATNI3	Signed by Patel,Nirlep A MD
6	10/02/15 1733	interface	order's status changed from TRANS to LOGGED by PHA
7	10/02/15 1739	FPHA.ALN	VERIFIED in PHA
8	10/02/15 1739	FPHA.ALN	VERIFIED
9	10/02/15 1739	FPHA.ALN	Items Dispensed: 1 Doses Dispensed: 1
10	10/02/15 1739	FPHA.ALN	For: 10/02/15 - 1740
11	10/02/15 1739	interface	order's status changed from LOGGED to IN PRO by PHA
12	10/02/15 1914	FNUR.BJB1	order acknowledged
13	10/03/15 0146	DISCHARGE	DISCONTINUE in PHA
14	10/03/15 0146	interface	order's status changed from IN PRO to COMP by PHA

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833

ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A

ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.PHYS	Oxygen Therapy	20151002-1285	10/02/15	1733			E	IPR	PATNI3

Other Provider :
Sig Lvl Provider :

Press [ENTER] for Order Details

.

Delivery Method: Nasal Cannula
Liters per Minute/Percentage: 2-4
O2 Frequency: PRN to Keep SpO2 > 92%

Order's Audit Trail of Events

1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Order from set: GENERAL MED/SURG DIRECT ADMIT
3 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
4 10/02/15 1733 PHY.PATNI3 Order Source: EPOM
5 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD
6 10/02/15 1734 interface order's status changed from TRANS to ACTIVE by NUR

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
OSD	ORDER SET NAME	20151002-0405	10/02/15	1733	R			TRN	PATNI3

Other Provider :
Sig Lvl Provider :

Order Set Used: GENERAL MED/SURG Direct Admit hGENADMM03
Version: 01
Approval Date: 04/16/13
ZYNX Set: hGENADMM03

Order's Audit Trail of Events

1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Order from set: GENERAL MED/SURG DIRECT ADMIT
3 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
4 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
OSD	ORDER SET NAME	20151002-0406	10/02/15	1733	R			TRN	PATNI3

Other Provider :
Sig Lvl Provider :

Order Set Used: AM LABS hAMLABS02
Version: 01
Approval Date: 06/04/13
ZYNX Set: hAMLABS02

Order's Audit Trail of Events

1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Order from set: AM LABS
3 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
4 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833

ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A

ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	HAPTOGLOBIN	20151002-2073	10/02/15	1800	R		E	CMP	PATNI3

Other Provider : Sig Lvl Provider :

This is NOT required. Answer ONLY if needed.

**ADD ON TEST: TODAY *

Order's Audit Trail of Events

1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
3 10/02/15 1733 PHY.PATNI3 Order Source: EPOM
4 10/02/15 1733 PHY.PATNI3 TDAY was entered as Service Time
5 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD
6 10/02/15 1734 interface cc'd doctors edited in LAB
7 10/02/15 1734 interface order's status changed from TRANS to LOGGED by LAB
8 10/02/15 1751 interface order's status changed from LOGGED to IN PRO by LAB
9 10/02/15 1914 FNUR.BJB1 order acknowledged
10 10/04/15 0239 interface order's status changed from IN PRO to COMP by LAB

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	GAMMA GLUTAMYL TRANSPEPTIDASE	20151002-2074	10/02/15	1800	R		E	CMP	PATNI3

Other Provider : Sig Lvl Provider :

This is NOT required. Answer ONLY if needed.

**ADD ON TEST:

Order's Audit Trail of Events

1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
3 10/02/15 1733 PHY.PATNI3 Order Source: EPOM
4 10/02/15 1733 PHY.PATNI3 TDAY was entered as Service Time
5 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD
6 10/02/15 1734 interface cc'd doctors edited in LAB
7 10/02/15 1734 interface order's status changed from TRANS to LOGGED by LAB
8 10/02/15 1751 interface order's status changed from LOGGED to IN PRO by LAB
9 10/02/15 1820 interface order's status changed from IN PRO to COMP by LAB
10 10/02/15 1914 FNUR.BJB1 order acknowledged

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833

ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A

ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	DIRECT BILIRUBIN	20151002-2075	10/02/15	1800	R		E	CMP	PATNI3

Other Provider :
Sig Lvl Provider :

.
This is NOT required. Answer ONLY if needed.

**ADD ON TEST: TODAY *

Order's Audit Trail of Events

1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
3 10/02/15 1733 PHY.PATNI3 Order Source: EPOM
4 10/02/15 1733 PHY.PATNI3 TDAY was entered as Service Time
5 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD
6 10/02/15 1734 interface cc'd doctors edited in LAB
7 10/02/15 1734 interface order's status changed from TRANS to LOGGED by LAB
8 10/02/15 1751 interface order's status changed from LOGGED to IN PRO by LAB
9 10/02/15 1820 interface order's status changed from IN PRO to COMP by LAB
10 10/02/15 1914 FNUR.BJB1 order acknowledged

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	LACTIC DEHYDROGENASE (LDH)	20151002-2076	10/02/15	1800	R		E	CMP	PATNI3

Other Provider :
Sig Lvl Provider :

.
This is NOT required. Answer ONLY if needed.

**ADD ON TEST: TODAY *

Order's Audit Trail of Events

1 10/02/15 1733 PHY.PATNI3 Order ENTER in POM
2 10/02/15 1733 PHY.PATNI3 Ordering Doctor: Patel,Nirlep A MD
3 10/02/15 1733 PHY.PATNI3 Order Source: EPOM
4 10/02/15 1733 PHY.PATNI3 TDAY was entered as Service Time
5 10/02/15 1733 PHY.PATNI3 Signed by Patel,Nirlep A MD
6 10/02/15 1734 interface cc'd doctors edited in LAB
7 10/02/15 1734 interface order's status changed from TRANS to LOGGED by LAB
8 10/02/15 1751 interface order's status changed from LOGGED to IN PRO by LAB
9 10/02/15 1820 interface order's status changed from IN PRO to COMP by LAB
10 10/02/15 1914 FNUR.BJB1 order acknowledged

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1733

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MED.COCQV	MEDICATION	20151002-2470	10/02/15	2100	R		E	CMP	PATNI3

Other Provider :
Sig Lvl Provider :

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833
ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL
A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A
ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

RX: 12157451 Start: 10/02/15 2100 SCH CMP
Stop:

levETIRAcetam Tab (Keppra Tab)
Dose: 3000 MG
Route: PO Direction: BEDTIME

Order's Audit Trail of Events

1	10/02/15 1735 PHY.PATNI3	Order ENTER in POM
2	10/02/15 1735 PHY.PATNI3	Ordering Doctor: Patel,Nirlep A MD
3	10/02/15 1735 PHY.PATNI3	Order Source: EPOM
4	10/02/15 1736 PHY.PATNI3	Signed by Patel,Nirlep A MD
5	10/02/15 1736 interface	order's status changed from TRANS to LOGGED by PHA
6	10/02/15 1741 FPHA.ALN	EDIT in PHA
7	10/02/15 1741 FPHA.ALN	EDIT
8	10/02/15 1741 FPHA.ALN	Edit Dr: Patel,Nirlep A MD Edit Source: DPT Process/Procedur
9	10/02/15 1741 FPHA.ALN	FROM:
10	10/02/15 1741 FPHA.ALN	PENDING COMMENTS:
11	10/02/15 1741 FPHA.ALN	TO:
12	10/02/15 1741 FPHA.ALN	PENDING COMMENTS:
13	10/02/15 1741 FPHA.ALN	PAGED MD, CLARIFY DOSE
14	10/02/15 1741 FPHA.ALN	PENDING FLAG SET in PHA
15	10/02/15 1743 FPHA.ALN	EDIT in PHA
16	10/02/15 1743 FPHA.ALN	EDIT
17	10/02/15 1743 FPHA.ALN	Edit Dr: Patel,Nirlep A MD Edit Source: DPT Process/Procedur
18	10/02/15 1743 FPHA.ALN	FROM:
19	10/02/15 1743 FPHA.ALN	PENDING COMMENTS:
20	10/02/15 1743 FPHA.ALN	PAGED MD, CLARIFY DOSE
21	10/02/15 1743 FPHA.ALN	TO:
22	10/02/15 1743 FPHA.ALN	PENDING COMMENTS:
23	10/02/15 1743 FPHA.ALN	HOME DOSE PER MD. PT'S FATHER
24	10/02/15 1743 FPHA.ALN	STATES PT TAKES 6 500 MG TABS AT
25	10/02/15 1743 FPHA.ALN	NIGHT B/C HE GETS MOSTLY NOCTURNAL
26	10/02/15 1743 FPHA.ALN	SEIZURES
27	10/02/15 1743 FPHA.ALN	Items Dispensed: 6 Doses Dispensed: 1
28	10/02/15 1743 FPHA.ALN	For: 10/02/15 - 2100
29	10/02/15 1743 FPHA.ALN	PENDING FLAG REMOVED in PHA
30	10/02/15 1743 FPHA.ALN	VERIFIED in PHA
31	10/02/15 1743 FPHA.ALN	VERIFIED
32	10/02/15 1743 FPHA.ALN	Edit Dr: Patel,Nirlep A MD Edit Source: DPT Process/Procedur
33	10/02/15 1743 interface	order's status changed from LOGGED to IN PRO by PHA
34	10/02/15 1914 FNUR.BJB1	order acknowledged
35	10/02/15 2035 FPHA.JRE	DISCONTINUE in PHA
36	10/02/15 2035 interface	order's status changed from IN PRO to COMP by PHA
37	10/02/15 2036 FNUR.BJB1	order acknowledged

Electronically signed by Patel,Nirlep A MD on 10/02/15 at 1736

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
US	US ABDOMEN LIMITED	20151002-0072	10/02/15	1737	R		E	CMP	PATNI3

Other Provider : Sig Lvl Provider :
Order details below
Reason for Exam: Abnormal Lft
Comments: elevated bili; eval GB and liver

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833
ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL
A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A
ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

Order's Audit Trail of Events

1	10/02/15 1730	PHY.PATNI3	Order ENTER in POM
2	10/02/15 1730	PHY.PATNI3	Ordering Doctor: Patel,Nirlep A MD
3	10/02/15 1730	PHY.PATNI3	Order Source: EPOM
4	10/02/15 1730	PHY.PATNI3	Signed by Patel,Nirlep A MD
5	10/02/15 1730	interface	order's status changed from TRANS to LOGGED by RAD
6	10/02/15 1737	FRAD.TJ	order service time edited: old value -
7	10/02/15 1737	FRAD.TJ	order procedure edited:
8	10/02/15 1737	FRAD.TJ	old value - ABD - US ABDOMEN
9	10/02/15 1848	interface	order's status changed from LOGGED to IN PRO by RAD
10	10/02/15 1901	interface	order's status changed from IN PRO to COMP by RAD
11	10/02/15 1914	FNUR.BJB1	order acknowledged
12	10/05/15 1032	PHY.PATNI3	Signed by Patel,Nirlep A MD

Electronically signed by Patel,Nirlep A MD on 10/05/15 at 1032

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MED.COCQV	MEDICATION	20151002-2817	10/02/15	2100	R	1 T		CMP	HILSA

Other Provider :
Sig Lvl Provider :
RX: 12157901
Start: 10/02/15 2100 SCH CMP
Stop:

levETIRAcetam Tab (Keppra Tab)
Dose: 1500 MG
Route: PO
Direction: BEDTIME

Order's Audit Trail of Events

1	10/02/15 2035	FPHA.JRE	Order ENTER in PHA
2	10/02/15 2035	FPHA.JRE	Ordering Doctor: Hilbert,Sabrina NP
3	10/02/15 2035	FPHA.JRE	Order Source: Telephone & ReadBack
4	10/02/15 2036	FNUR.BJB1	order acknowledged
5	10/02/15 2109	FNP.HILSA	Signed by Hilbert,Sabrina NP
6	10/03/15 0146	DISCHARGE	DISCONTINUE in PHA
7	10/03/15 0146	interface	order's status changed from IN PRO to COMP by PHA

Electronically signed by Hilbert,Sabrina NP on 10/02/15 at 2109

Order Date: 10/02/15

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MED.COCQV	MEDICATION	20151003-0203	10/03/15	1000	R	1 T		CMP	HILSA

Other Provider :
Sig Lvl Provider :
RX: 12157905
Start: 10/03/15 1000 SCH CMP
Stop:

levETIRAcetam Tab (Keppra Tab)
Dose: 1000 MG
Route: PO
Direction: QAM

Order's Audit Trail of Events

1	10/02/15 2038	FPHA.JRE	Order ENTER in PHA
2	10/02/15 2038	FPHA.JRE	Ordering Doctor: Hilbert,Sabrina NP
3	10/02/15 2038	FPHA.JRE	Order Source: Telephone & ReadBack
4	10/02/15 2045	FNUR.BJB1	order acknowledged
5	10/02/15 2109	FNP.HILSA	Signed by Hilbert,Sabrina NP

PERMANENT MEDICAL RECORD COPY

PATIENT: SCHEER,MATTHEW
ACCOUNT NO: F01034276833

ATTEND DR: Patel,Nirlep A MD
REPORT STATUS: FINAL

A/S: 26 M
LOC: F.2N
RM: F.1285
BD: A

ADMIT: 10/02/15
DISCH/DEP: 10/03/15
STATUS: IN
UNIT NO: F000838076

6 10/03/15 0146 DISCHARGE DISCONTINUE in PHA
7 10/03/15 0146 interface order's cancel request denied
8 10/03/15 0146 interface order's status changed from IN PRO to COMP by PHA

Cancel request comment: PATIENT DISCHARGED
Cancel comment: Status updated by Pharmacy
Electronically signed by Hilbert,Sabrina NP on 10/02/15 at 2109

** IDEV END OF REPORT **

GRAND STRAND REGIONAL MEDICAL CENTER
INFORMED REFUSAL FOR PARTIAL REFUSAL OF CARE AND AMA

F01034276833

The sections below for **Partial Refusal of Care** and for **Against Medical Advice** are only applicable for those individuals who have been triaged and an ED physician or QMP has begun a Medical Screening Examination or any stabilizing treatment. NOT APPLICABLE FOR INDIVIDUALS WHO LPT OR LPMSE. Pregnant women in labor who are transferred to another facility should be transferred using a MOT and Physician certification.

☒ PARTIAL REFUSAL OF CARE

I acknowledge that I have begun receiving a medical screening examination and have decided that I do not want the tests, exams or treatments listed below. I acknowledge that I have been informed and do understand that the risks associated with my refusal of the test(s), examination(s) and/or treatment(s) or my withdrawal of consent to this test(s), examination(s) and/or treatment(s) may seriously harm my health or life, and if I am pregnant, the health and life of my unborn child.

I acknowledge that treatment options; the risk of refusal of the test(s), examination(s) and/or treatment(s) listed below; and the purpose and benefit of the test(s), examination(s) and/or treatment(s listed below were all explained to me,

I asked the questions I wanted to ask and that I still refuse the test(s), examination(s) and/or treatment(s) as follows:

	Test, Exam or Treatment Refused	Risk of such Refusal of Care
A.	IV PERIPHERAL LINE	DEATH, SEIZURES
B.	KEPPRA	TREATMENT OF PSYCHOSIS
C.		

☒ AGAINST MEDICAL ADVICE

INFORMED REFUSAL OF CARE

A Physician, other Qualified Medical Provider and/or an appropriate Clinical Staff Member of the ED has explained the risks to me of my leaving **Against Medical Advice** and my refusal of the care offered. I understand that if I am pregnant, this informed refusal of care applies to both me and my unborn child.

I understand the risks that were discussed with me and further understand that my refusal of further examination and/or treatment or my withdrawal of consent to a medical screening examination and/or treatment and leaving **Against Medical Advice** may result in serious harm to my body functions or serious harm to any organ or body part or may place my health or life in serious danger. Knowing these serious risks, knowing and understanding the treatment options explained to me and the risks and benefits of the treatment options, I still elect to leave **Against Medical Advice**,

I accept full responsibility for the refusal of further examination and/or selected medical treatment or tests (or this withdrawal of consent to permit further medical examination and/or treatment) for my medical condition. Because I am leaving **Against Medical Advice**, I hereby release and hold harmless, the hospital, its personnel, the physician(s), and any other persons participating in my care from any responsibility whatsoever for unfavorable or adverse results which I understand may occur as a consequence of my refusing any further examination or treatment offered and leaving against medical advice.

I also understand that I **may return** to this Hospital at any time in the event that I change my mind or if my condition worsens.

Describe examination or specific treatment modalities recommended by Physician or QMP and refused by individual:

A. PHYSICAL EXAM
B. IV LINE
C. ALL MEDICATIONS

I acknowledge that I understand that my Refusal of further recommended Examination and/or Treatment or my refusal to Consent to recommended Examination/Treatment by the Emergency Physician and/or Specialists may result in injury to me, including death or severe and permanent disability or deformity as otherwise specified below:

A. SEIZURES
B. PSYCHOSIS
C. INFECTION

GRAND STRAND REGIONAL MEDICAL CENTER
INFORMED REFUSAL FOR PARTIAL REFUSAL OF CARE AND AMA

RFTS 3400301312 (03/26/12) 852415

Patient Information/Label

SCHEER,MATTHEW MR F000838076
DOB:01/19/89 ADM IN 2N 1285-A
DOS:10/02/15 Patel,Nirlep A MD
A#F01034276833 26/M URN F724867

I acknowledge that I understand that the Benefits of Examination/Treatment Offered could include completion of a medical screening examination, further diagnostic evaluation and treatment for the condition for which I presented to the hospital, stabilizing and other medical and/or surgical treatment, and as otherwise specified below:

A. _____
B. _____
C. _____

F01034276833

INDIVIDUAL or LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE:

[signature] — Individual or Legally Authorized Representative

Self — Relationship to Individual

Bethany Bell RN — Witness

10/3/15 — Date

0129 — Time AM / PM

CLINICAL SIGNATURES:

The signature of the Physician certifies that the patient or the individual acting on the patient's behalf has the mental capacity to understand the risks and benefits of a partial refusal of care and/or leaving against medical advice and that the patient or caregiver has had an opportunity to ask questions about the benefits or risk of the refusal of care and/or leaving against medical advice.

Rachel Osborn, MD — Physician

10/3/15 — Date

01:27 — Time AM / PM

Asst-Bethany, Rachel — Health Care Personnel

10/3/15 — Date

01:27 — Time AM / PM

CERTIFICATION OF INTERPRETATION:

I certify that I have read the foregoing to the signor hereof in the _____ language.

_____
Interpreter

_____
Date Time AM / PM

GRAND STRAND REGIONAL MEDICAL CENTER
INFORMED REFUSAL FOR PARTIAL REFUSAL OF CARE AND AMA

RFTS 3400301312 (03/26/12) 852415

Patient Information/Label

SCHEER, MATTHEW MR F000838076
DOB:01/19/89 ADM IN 2N 1285-A
DOS:10/02/15 Patel,Nirlep A MD
A#F01034276833 26/M URN F724867

PATIENT: SCHEER,MATTHEW ACCT #: F01034276833 LOC: F.2N U #: F000838076
AGE/SX: 26/M ROOM: F.1285 REG: 10/02/15
REG DR: Patel,Nirlep A MD STATUS: DIS IN BED: A DIS: 10/03/15

********** CHEMISTRY **********

Date	10/02/15				
Time	1741			Reference	Units
DIR BILIRUBIN	0.20			(0.0-0.2)	mg/dL
	10/02/15			Verified Date	
	1808			Time	
GGT	20			(15-85)	Units/L
	10/02/15			Verified Date	
	1820			Time	
LDH	262	H		(100-190)	Units/L
	10/02/15			Verified Date	
	1810			Time	

********** REFERENCE LAB **********

Date	10/02/15				
Time	1741			Reference	Units
HAPT	68.1(~a)			(30-200)	mg/dL
	10/04/15			Verified Date	
	0239			Time	

NOTES: (~a) Integrated Regional Laboratory
Test Performed by: Integrated Regional Laboratories
5361 N.W. 33rd Ave Fort Lauderdale FL 33309

Patient: SCHEER,MATTHEW #F01034276833 (Continued)

********** CANCELLED SPECIMENS **********

1003:QV:H00092R CAN, Coll: 10/03/15-0600 Recd: - (R#05978091) Patel,Nirlep A
Ordered: CBC
Comment: Cancelled via OE: PATIENT DISCHARGED
1003:QV:C00169R CAN, Coll: 10/03/15-0600 Recd: - (R#05978091) Patel,Nirlep A
Ordered: COMP MET PANEL
Comment: Cancelled via OE: PATIENT DISCHARGED

DIAGNOSTIC IMAGING REPORT

GRAND STRAND REGIONAL - 809 82ND PARKWAY - MYRTLE BEACH, SC 2957
PHONE #: 8436921560 FAX #: 8436921555

Name: SCHEER,MATTHEW Loc: F.1285 A Radiology No:

DOB: 01/19/1989 Age: 26 Sex: M Status: ADM IN Unit No: F000838076

Phys: PATNI3 - Patel,Nirlep A MD Acct: F01034276833

Reason For Exam: Exam Date: 10/02/2015

EXAMS:	Reason for Exam::
002452277 US ABDOMEN LIMITED	ABLFT - Abnormal Lft

HISTORY:

Abnormal LFTs.

COMPARISON:No comparison images.

FINDINGS: The pancreas demonstrates normal echogenicity. The liver demonstrates normal echogenicity as well. There is no intrahepatic or extrahepatic biliary ductal dilatation. The hepatic vasculature is within normal limits. The gallbladder contains no evidence of stones or sludge. There is a negative sonographic Murphy's sign. The right kidney measures 11.4 cm in length. There is no hydronephrosis. There is no ascites or pleural effusion.

IMPRESSION:Normal examination.

** Electronically Signed by KEVIN DICKEY MD on 10/02/2015 at 1856 **
Reported and signed by: KEVIN DICKEY, MD

CC: Nirlep A Patel MD

Dictated Date/Time: 10/02/2015 (1856)

Technologist: T JAMES,RDMS(ABD),RVT
Transcribed Date/Time: 10/02/2015 (1856)
Transcriptionist: RAD.VR
Electronic Signature Date/Time: 10/02/2015 (1856)
Printed Date/Time: 10/02/2015 (1901)

10/04/15 0143 MEDICATION DISCHARGE SUMMARY PAGE: 1

NAME: SCHEER,MATTHEW
UNIT #: F000838076
ACCT #: F01034276833
ADMIT DATE: 10/02/15
DISCHARGE DATE: 10/03/15
STATUS: DIS IN
AGE: 26
SEX: M

CODED ALLERGIES No Known Drug Allergies
CODED ADRs
UNCODED ALLERGIES
UNCODED ADRs

ADMINISTRATION PERIOD: 0700 10/02/15 to 0659 10/03/15	START/ STOP	
KEPPRA (levETIRAcetam 500 MG TABLET) **3,000 MG** PO AT BEDTIME RX #: 12157451	10/02/15	1736 Order Entry PHY.PATNI3 1741 Pharmacy Edit or Verification FPHA.ALN 1741 Pending Flag Set FPHA.ALN 1743 Pharmacy Edit or Verification FPHA.ALN 1743 Pending Flag Removed FPHA.ALN 1743 Pharmacy Edit or Verification FPHA.ALN 1914 Nursing Acknowledged Order FNUR.BJB1 2035 Pharmacy Discontinue FPHA.JRE 2036 Nursing Acknowledged Order FNUR.BJB1 2047 DC Order Override FNUR.BJB1 med d/c'd 2100 Not Administered FNUR.BJB1 at 2047 DC 10/02/15-2047 File Document by FNUR.BJB1
KEPPRA (levETIRAcetam 500 MG TABLET) **1,500 MG** PO AT BEDTIME RX #: 12157901	10/02/15	2035 Order Entry FPHA.JRE 2036 Nursing Acknowledged Order FNUR.BJB1 2100 FNUR.BJB1 at 2046 GAVE: 1,500 MG NDC/DIN: (SOURCE: eMAR) 5026846811 KEPP500T - levETIRAcetam 500 MG TABLET Most common side effects reviewed with patient?: Yes :: KEPP500T:Refer to Clinical Pharmacology or contact Pharmacy 10/02/15-2047 File Document by FNUR.BJB1 0146 Pharmacy Discontinue DISCHARGE
KEPPRA (levETIRAcetam 500 MG TABLET) **1,000 MG** PO EVERY MORNING RX #: 12157905	10/03/15	2038 Order Entry FPHA.JRE 2045 Nursing Acknowledged Order FNUR.BJB1 0146 Pharmacy Discontinue DISCHARGE
TYLENOL (ACETAMINOPHEN 325 MG TAB) **650 MG** PO EVERY 8 HOURS AS NEEDED/PRN PRN Reason: PAIN OR ELEVATED TEMPERATURE Comments: Should not exceed 4000mg of acetaminophen daily Per Hospital policy MM 1046 RX #: 12157439	10/02/15	1733 Order Entry PHY.PATNI3 1739 Pharmacy Edit or Verification FPHA.ALN 1914 Nursing Acknowledged Order FNUR.BJB1 0146 Pharmacy Discontinue DISCHARGE

*** CONTINUED ON PAGE 2 ***

ADMINISTRATION PERIOD: 0700 10/02/15 to 0659 10/03/15 (Continued)	START/ STOP	
DIPHENHYDRAMINE HCL (diphenhydrAMINE HCL 25 MG CAP) **25 MG** PO AT BEDTIME AS NEEDED/PRN PRN Reason: INSOMNIA Comments: Per Hospital policy MM 1046 RX #: 12157438	10/02/15	1733 Order Entry PHY.PATNI3 1739 Pharmacy Edit or Verification FPHA.ALN 1914 Nursing Acknowledged Order FNUR.BJB1 0146 Pharmacy Discontinue DISCHARGE

ADMINISTRATION PERIOD: 0700 10/03/15 to 0659 10/04/15	START/ STOP	

*** CONTINUED ON PAGE 3 ***

This document is part of the legal medical record.

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833 1291 Scheer_GSRMC_MedRecs_0091 Page 49 of 89

ADMINISTRATION PERIOD: 0700 10/03/15 to 0659 10/04/15 (Continued)	START/ STOP

LEGENDS

REASON CODES
DC - ORDER DISCONTINUED

SITE CODES

ELECTRONICALLY SIGNED BY

USER	USER NAME/TYPE	USER	USER NAME/TYPE	USER	USER NAME/TYPE	USER	USER NAME/TYPE
FNUR.BJB1	BELL.BETHANY JEAN RN						

OTHER USERS

USER	USER NAME	USER	USER NAME	USER	USER NAME	USER	USER NAME
FNUR.BJB1	BELL.BETHANY JEAN	FPHA.ALN	NEACE.AMANDA L	FPHA.JRE	EARLEY.JAMES R	PHY.PATNI3	PATEL.NIRLEP

PHA ALLERGY HISTORY

DATE	PHA	USER	ALLERGY DETAILS	
10/02/15 1020	N	FRN.JLN - NORRIS.JENNA L	ADDED	by FRN.JLN
			No Known Drug Allergies	
			OLD:	
			NEW: No Known Drug Allergies added. NO KNOWN DRUG ALLERGIES	
10/02/15 1603	N	FNUR.AJH - HARRELSON.AMY J	FILED	by FNUR.AJH
			TEXT:	
			User filed without changing allergy record.	
10/02/15 2002	N	FNUR.BJB1 - BELL.BETHANY JEAN	EDITED	by FNUR.BJB1
			OLD:	
			NEW: Allergy List Confirmed: Date: 10/02/15 - Time: 2002	
			TEXT:	
			List Confirmed:	
			No Known Drug Allergies	

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833
1292
Scheer_GSRMC_MedRecs_0092
Page 50 of 89

Age/Sex: 26 M
Unit #: F000838076
Admitted: 10/02/15 at 1719
Status: DIS IN

Attending: Patel.Nirlep A MD
Account #: F01034276833
Location: F.2N
Room/Bed: F.1285-A

SCHEER.MATTHEW

GSRMC NUR *LIVE*
EVOLUTION PLAN OF CARE HPF

Printed 10/04/15 at 0032

Diagnosis/Goals/Intervention Description / Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Comment	Documented Units	From Change
Activity Date: 10/02/15		**Time: 2010**								
Diagnosis: STANDARD: Minimum Hospital SOC							A			
- Create	10/02/15	2010	BJB	10/02/15	2010	BJB				
Goals: Minimum hospital SOC will be maintained.							A	10/05/15		
- Create	10/02/15	2010	BJB	10/02/15	2010	BJB				
- Ed Target	10/02/15	2010	BJB	10/02/15	2010	BJB				None => 10/05/15
Diagnosis: Age Appropriate: YOUNG ADULT 18-40 yrs.							A			
- Create	10/02/15	2010	BJB	10/02/15	2010	BJB				
Goals: Return to blue screen and view protocol							A	10/05/15		
- Create	10/02/15	2010	BJB	10/02/15	2010	BJB				
- Ed Target	10/02/15	2010	BJB	10/02/15	2010	BJB				None => 10/05/15
Activity Date: 10/03/15		**Time: 0146**								
Diagnosis: STANDARD: Minimum Hospital SOC							D			
- Ed Status	10/03/15	0146	his	10/03/15	0146	his				A => D
Goals: Minimum hospital SOC will be maintained.							D	10/05/15		
- Ed Status	10/03/15	0146	his	10/03/15	0146	his				A => D
Diagnosis: Age Appropriate: YOUNG ADULT 18-40 yrs.							D			
- Ed Status	10/03/15	0146	his	10/03/15	0146	his				A => D
Goals: Return to blue screen and view protocol							D	10/05/15		
- Ed Status	10/03/15	0146	his	10/03/15	0146	his				A => D

Monogram Initials	Name	Nurse Type
BJB	FNUR.BJB1 BELL.BETHANY JEAN	RN
his	automatic by program	

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833
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Age/Sex: 26 M
Unit #: F000838076
Admitted: 10/02/15 at 1719
Status: DIS IN

Attending: Patel,Nirlep A MD
Account #: F01034276833
Location: F.2N
Room/Bed: F.1285-A

SCHEER,MATTHEW

GSRMC NUR *LIVE*
PLAN OF CARE HPF

Printed 10/04/15 at 0146

Diagnosis/Goals/Intervention Description / Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts / Comment	Directions / Documented Units	From / Change
Activity Date: 10/02/15	**Time: 2010**								
Diagnosis: STANDARD: Minimum Hospital SOC							A		
- Create	10/02/15	2010	BJB	10/02/15	2010	BJB			
Goals: Minimum hospital SOC will be maintained.							A	10/05/15	
- Create	10/02/15	2010	BJB	10/02/15	2010	BJB			
- Ed Target	10/02/15	2010	BJB	10/02/15	2010	BJB		None => 10/05/15	
2024 Care Plan Review Screen +							A		CP
- Create	10/02/15	2010	BJB	10/02/15	2010	BJB			
Diagnosis: Age Appropriate: YOUNG ADULT 18-40 yrs.							A		
- Create	10/02/15	2010	BJB	10/02/15	2010	BJB			
Goals: Return to blue screen and view protocol							A	10/05/15	
- Create	10/02/15	2010	BJB	10/02/15	2010	BJB			
- Ed Target	10/02/15	2010	BJB	10/02/15	2010	BJB		None => 10/05/15	
Activity Date: 10/03/15	**Time: 0146**								
Diagnosis: STANDARD: Minimum Hospital SOC							D		
- Ed Status	10/03/15	0146	his	10/03/15	0146	his			A => D
Goals: Minimum hospital SOC will be maintained.							D	10/05/15	
- Ed Status	10/03/15	0146	his	10/03/15	0146	his			A => D
2024 Care Plan Review Screen +							D		CP
- Ed Status	10/03/15	0146	his	10/03/15	0146	his			A => D
Diagnosis: Age Appropriate: YOUNG ADULT 18-40 yrs.							D		
- Ed Status	10/03/15	0146	his	10/03/15	0146	his			A => D
Goals: Return to blue screen and view protocol							D	10/05/15	
- Ed Status	10/03/15	0146	his	10/03/15	0146	his			A => D

Monogram	Initials	Name	Nurse Type
BJB	FNUR.BJB1	BELL,BETHANY JEAN	RN
his		automatic by program	

Diagnosis/Goals/Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Directions / Comment	Documented Units	From Change
Activity Date: 10/02/15 Time: 1719											
28111 Intake & Output								A			OE
Press [ENTER] for Order Details											
.											
Frequency: Per Unit Protocol											
Other:											
- Create		10/02/15	1719	AB	10/02/15	1719	AB				
28136 Notify								A			OE
Press [ENTER] for Order Details											
.											
Comment: The care of this patient has been discussed with the accepting/admitting physician who agrees to immediately assume the care of the patient. Call Admitting physician for further orders. clarification of orders. or change in patient's condition.											
- Create		10/02/15	1719	AB	10/02/15	1719	AB				
28181 Pulse Oximetry +								A			OE
Press [ENTER] for Order Details											
.											
Pulse Ox Frequency With Vitals											
Comment:											
- Create		10/02/15	1719	AB	10/02/15	1719	AB				
28222 Vital Signs								A			OE
Press [ENTER] for Order Details											
.											
Frequency: Per Unit Protocol											
Other:											
- Create		10/02/15	1719	AB	10/02/15	1719	AB				
90331 Universal Decolonization Protocol								A			OE
Press [ENTER] for Order Details											
.											
Comment: MRSA Swab if score of 3 or more on infection control screening B for MRSA unless already done as part of this admission.											
- Create		10/02/15	1719	AB	10/02/15	1719	AB				
Activity Date: 10/02/15 Time: 1733											
28004 Activity								A			OE
Press [ENTER] for Order Details											
.											
Activity: AS TOLERATED											
Press [ENTER] for Additional Order Details											
.											
Other: AS TOLERATED											
- Create		10/02/15	1733	NP	10/02/15	1733	NP				

Diagnosis/Goals/Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Directions / Comment	Documented Units	From Change
Activity Date: 10/02/15 Time: 1733											
28190 Sequential Compression Device								A			OE
Press [ENTER] for Order Details											
.											
Extremity: Bilateral											
Comment:											
- Create		10/02/15	1733	NP	10/02/15	1733	NP				
28222 Vital Signs								A			OE
Press [ENTER] for Order Details											
.											
Frequency: Per Unit Protocol											
Other:											
- Create		10/02/15	1733	NP	10/02/15	1733	NP				
90167 Notify VS								A			OE
Press [ENTER] for Order Details											
.											
Sys BP less than: 90 Dia BP less than: Heart Rate less than: 50											
Sys BP greater than: 170 Dia BP greater than: 100 Heart Rate greater than: 110											
Resp Rate less than: 12 Temp less than: O2 Sat% less than: 92											
Resp Rate greater than: 28 Temp greater than: 101.0											
Press [ENTER] for Additional Order Details											
.											
Comment:											
- Create		10/02/15	1733	NP	10/02/15	1733	NP				
90341 Oxygen Therapy								A			OE
Press [ENTER] for Order Details											
.											
Delivery Method: Nasal Cannula Liters per Minute/Percentage: 2-4											
O2 Frequency: PRN to Keep SpO2 > 92%											
Comment:											
- Create		10/02/15	1733	NP	10/02/15	1733	NP				
Activity Date: 10/02/15 Time: 1915											
2002 Initial Assessment Part B								A			AS
- Create		10/02/15	1915	BJB	10/02/15	2009	BJB				
- Document		10/02/15	1915	BJB	10/02/15	2009	BJB				
Medical Diagnosis/Reason for Visit: LEUKOCYTOSIS											
Arrival From: EMERGENCY DEPARTMENT											
Arrival Mode: STRETCHER											
Pt. ID Band On: Y											
Allergy Band On: NA											
Isolation #1: STANDARD											
Pressure alarm on: NA											
Negative Pressure Present: NA											
Is patient admitted with PNEUMONIA: N											
Enter or Edit Vaccine Screening: Y											
Emergency Contact: SCHEER.DAVID											
Local Number: (609)226-4952											

Diagnosis/Goals/Intervention Description								Sts	Directions		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment		Documented Units		Change

Activity Date: 10/02/15 Time: 1915 (continued)

2002 Initial Assessment Part B (continued)
Support Person: SCHEER,DEBRA
Phone: (609)226-4952
NEUROLOGICAL WNL Y
: Patient is alert and oriented to person, place,and time; able to move
: all extremities; extremity strength is strong and equal; no seizure
: activity. Patient is calm and cooperative with no speech alterations.
: and pupils are equal. No visual loss. Normal gaze. Sensation intact.
Extremity Strength:
RESPIRATORY WNL Y
: Patient's respirations are even and unlabored. There is no cough,
: no supplemental oxygen needed, no chest tubes, no tracheotome.
: Breaths sounds are clear in all lobes.
Is patient admitted for orthopedic joint surgery: N
CARDIOVASCULAR WNL Y
: Patient's heart rhythm is regular, bilateral pulses are palpable,
: absence of edema; capillary refill is less than 3 seconds.
: Patient voices no complaints of chest pain.
+++RIGHT+++
+++LEFT+++
If YES, see pain screen for details.
Anti-Embolism Stockings: N
Sequential Compression Device: NONE
EENT WNL Y
: Eyes are clear bilaterally, no nasal, mouth, or throat abnormalities
: observed or verbalized by the patient.
GASTROINTESTINAL/NUTRITION WNL Y
: Abdomen is non-distended and soft with active bowel sounds in all four
: quadrants. Patient denies complaints of nausea, vomiting,
: constipation, or diahrrea.
Has the pt had a BM in the last 48 hours: Y
Last BM: 10/01/15
GENITOURINARY WNL Y
: Patient is continent and voiding clear, yellow urine without difficulty.
Catheter: N
INTEGUMENTARY WNL Y
: Skin is warm and dry with normal elasticity and color.
: All skin is intact. Patient is not on a specialty bed.
Skin Risk Assessment: Y
Braden Risk Level: Standard
MOBILITY/ACTIVITY WNL Y
: Patient is up adlib with full mobility and a steady gait.
: Patient has active range of motion in all extremeties and is able to
: turn him/herself in bed.
Mode of transport (to/from unit): WC
MUSCULOSKELETAL WNL Y
: Patient has no traction, pins, braces, or casts.
FALL RISK ASSESSMENT: Y

Diagnosis/Goals/Intervention Description

Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Sts | Directions Documented Units | From Change

Activity Date: 10/02/15 Time: 1915 (continued)

2002 Initial Assessment Part B (continued)
===SEPSIS SCREENING===
Temperature: Y
Heart Rate: N
Respirations: N
: 10/02/15 14.5H 1042
: No Results past 24 hrs
WBC/Bands: Y
If Y to 2 or more of above, proceed to next section: 2
===INFECTION===
Suspected/Documented Infection: N
Antibiotic Therapy (Not Prophylaxis): N
If Y to 1 of the above, proceed to next section: 0
===NEW ORGAN DYSFUNCTION within past 48 hours===
Psychosocial Distress Screening for Cancer Patients
Are you experiencing a new or recurring Cancer diagnosis: N
Suicide Risk Assessment: Y
===PAIN===
. B
Instructed of Pain Scale: Y
Pain Scale Utilized: NUMERICAL
Pain Scale (0-10): 0
===FLACC PAIN ASSESSMENT===
===CPOT PAIN ASSESSMENT===
===NIPS PAIN ASSESSMENT===
IV MAINTENANCE
IV: N
DISCHARGE PLANNING
Lives with: ALONE
Lives in: OTHER
Comment: PT WOULD NOT SPECIFY
Currently has home health services: N
Are others dependent on you for their care: N
Concerns about managing at home after discharge: N
Suspect Abuse/Neglect N
High Risk Screening (Case Management Trigger): NONE
Diabetic Educator Screening: NONE
Does pt have order for comfort measures/palliative care: N
Preferred Language: English
Religion: CAT
Clergy visit requested/needed: N
Religious needs for care: N
Cultural needs for care: N
ADVANCE DIRECTIVE INFORMATION
Advanced Directive: NO/INFORE
4. If the patient has no health care surrogate or Living Will, was the
patient or family member given a copy of Appendix A? Y
PATIENT/FAMILY EDUCATION

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833
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Diagnosis/Goals/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Directions Documented Units	From Change

Activity Date: 10/02/15 Time: 1915 (continued)

2002 Initial Assessment Part B (continued)
Readiness to Learn: LACKS INTEREST
Learning Preference: VERBAL
Educational level: HIGH SCHOOL GRADUATE
Health knowledge: LOW
Limitations/Barriers to Learning: NONE
Does patient agree to plan of care and goals: Y
==SCREENING REFERRALS REQUESTED===
FNS: N
Case Mgmt: N
Inf Control: N
Wound Care: N
Pastoral Care: N
ST: N
Age Group: 26.0
Add hospital standards to care plan: Y
Weight - Lb: 168
Kg: 76.20
Height - Feet: 6
Inches: 0
Cm: 182.88
BMI: 22.8
. N
ORIENTED TO
Call Light: Y
Bed Control: Y
Television: Y
Phone: Y
Lights: Y
Smoking: Y
Siderails: Y
Visiting Hours: Y
BR Emergency Light: Y
PERSONAL ITEMS INVENTORY
PERSONAL ITEMS INVENTORY-------DISPOSITON
~~DISPOSTION CODES~~
H = sent home
B = At pt bedside
N = not brought to hosp
S = sent to security
NA = not applicable
PW = Patient Wearing
Glasses: NA
Contacts: NA
Hearing Aid(s)#: 0
: NA
Partials: NA
Dentures (Lowers): NA

Diagnosis/Goals/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Directions Documented Units	From Change

Activity Date: 10/02/15 Time: 1915 (continued)

2002 Initial Assessment Part B (continued)
Dentures (Uppers): NA
Shoes: B
: NA
: NA
: B
: NA
: NA
: NA
Home meds sent to Pharmacy: N
Would you like to enter a patient note: Y
Pt has 3 or more meds in drug classes known to
be indicator of fall risk: N
Is patient Responsive: Yes
Is patient following fall prevention directions: Y
High Risk for Falls: N
Sensory perception- No impairment
Moisture- Rarely moist
Activity- Walks frequently
Mobility- No limitation
Nutrition- Excellent
Friction and shear- No apparent problem
Braden Skin Score: 23
Braden Risk Level- Standard
Skin risk interventions: Manage moisture. Avoid drying the skin
Manage nutrition. Maintain good hydration
Manage friction and shear
No massage of reddened bony prominences
Are you here because you tried to hurt yourself: NO
See next page
In the past few days have you been having
I want to ask you if your child attempted suicide
See next page
In the past week have you been having
thoughts or making plans about hurting yourself: NO
Have you tried to hurt or kill yourself in the past year: NO
See next page
Has something very bad happened to
See next page
Has something very stressful
happened to you in the past few weeks: NO
See next page
See next page
Patient is at Risk for Suicide: NO
Last page
Patient or caregiver reports up to date on pneumococcal vaccine: N
Patient or caregiver reports up to date on influenza vaccine: N
Pregnant: No

Diagnosis/Goals/Intervention Description										Sts	Directions		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units					Change

Activity Date: 10/02/15 Time: 1915 (continued)

2002 Initial Assessment Part B (continued)
Comorbid factors: None
Contraindications: None
Patient or home caregiver agrees to receive influenza vaccine: No. REFUSES
Comment: PT REFUSES AT THIS TIME
Vaccine status: NOT A CANDIDATE
Influenza vaccination status- Pt or caregiver's refusal
Last page
--- External Device documentation ---
--- Surgically Placed Urinary Device documentation ---
2003 Initial Assessment Part A A AS
- Create 10/02/15 1915 BJB 10/02/15 2005 BJB
- Document 10/02/15 1915 BJB 10/02/15 2005 BJB
. Y
First Point of Contact: N
Able to Obtain History: Y
Update Family History Y
Communication Needs: NOT APPLICABLE
KDM = Key Decision Maker
Communication Methods Needed: NONE
Historian: SELF
Has the pt been hospitalized within the last 30 days (IP admit)? N
Has the pt taken hormone therapy or birth control pills
within the last 30 days? N
PT education packet available at bedside: Y
Patient and or family provided written and verbal safety information about:
Reporting concerns about care: Y
Patient identification process: Y
Site markings when having surgery or procedure: Y
Infection control measures for surgical patients: Y
Hand hygiene: Y
Respiratory hygiene: Y
Contact precautions according to patient condition: Y
Rapid Response Team: Y
Patient and or family verbalize understanding of location of education
folder/booklet and the need to review: Y
Instructed to follow-up with nurse if questions: Y
Enter/Edit home med reconciliation: Y
Attention Required: N
Was a BETA-BLOCKER a daily home med prior to arrival: N
Suspect neglect/abuse: N
Are you currently involved in research related to a drug or device: NO
Smoking status for patients 13 years old or older: Never Smoker
Adult cigarette smoking history w/in last year- NO
==========PAST MEDICAL HISTORY==
==========
CARDIOVASCULAR hx: N
CHF: N

Diagnosis/Goals/Intervention Description										Sts	Directions		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units					Change

Activity Date: 10/02/15 Time: 1915 (continued)

2003 Initial Assessment Part A (continued)
CHF info provided: N
RESPIRATORY hx: N
Hx of cigarette smoking: N
Smoked cigarettes in last 12 mos: N
Smoking info/Counseling provided: N
HEPATIC/ENDOCRINE hx: N
AUTO-IMMUNE DISORDER hx: N
NEUROLOGICAL hx: Y
Alzheimers/Dementia: N
Chronic Headaches: N
STROKE/TIA: N
STROKE info provided: N
Seizures: LOCALIZED
~ EPILEPSY
GASTROINTESTINAL hx: N
(Only pts >49)
MUSCULOSKELETAL hx: N
GENITOURINARY hx: N
ONCOLOGICAL hx: N
OTHER hx: N
Prev React Blood Trans: NA
Pregnant: N
Pertinent Medical Hx: EPILEPSY
===== INFECTION CONTROL SCREENING =====
INFECTION RISK SCREEN B
Resistant infections w/in last 3 yrs(MRSA,VRE,C.DIFF): N
: 0
Patient admitted/transferred from= Emergency Dept
: 0
Is reason for visit open joint replacement, open spine or open heart surg? N
: 0
Is the patient receiving dialysis? N
: 0
Invasive Device (PICC,urinary device,trach,feeding tube,implanted port): N
: 0
Total Points: 0
MRSA swab required: N
A Swab is required for a Score of 3 or Greater
INFECTION RISK SCREEN C
Occupational exposure to any person having an Influenza-like Illness? N
: 0
Contact with domestic poultry? N
: 0
Total Points: 0
===== NUTRITION SCREENING =====
Criteria
Points

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833
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Diagnosis/Goals/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 10/02/15 Time: 1915 (continued)

2003 Initial Assessment Part A (continued)
New Onset/Gestational Diabetes (7p): N
: 0
Pregnancy with nausea/vomiting (Hyperemesis) (7p): N
: 0
Surgical Patient > 65 (2p): N
: 0
Acute/Chronic Renal Diagnosis (2p): N
: 0
AIDS/HIV (4p): N
: 0
Pregnant and 17 years old or younger (7p): N
: 0
Total Points: 0
*** 4 or more Points will send a referral to Dietary ***
========FUNCTIONAL SCREENING========
Independent with mobility/ self care prior to this illness: Y
Have you had difficulty with transfers / walking in the past
two weeks: N
Have you fallen 2 or more times in the last month: N
Are you currently receiving Physical Therapy at home: N
** A Y answer to any of the last 3 questions will send a referral to PT **
======== SPEECH THERAPY SCREENING========
Is the patient able to sustain alertness for 20 minutes: Y
Does the patient have a PO diet: Y
Does the pt/caregiver report a history of dysphagia or
are they consuming a modified diet texture (i.e. thickened liquids/puree): N
Does the pt have difficulty managing secretions, a wet vocal sound, or
are they drooling: N
Is the pt coughing or clearing his/her throat with PO intake: N
===SCREENING REFERRALS REQUESTED===
Inf Control: N
ST: N
Home Medications: levETIRAcetam (KEPPRA) 250 MG
250 MG PO BID
--In the past 3 weeks has the patient:--
Is patient currently experiencing any of following in last 7 days:
(38.0 C)
(not related to
allergy or COPD)
Patient Notes: NURSE NOTES
- Create 10/02/15 1915 BJB 10/02/15 2009 BJB

PT ARRIVED TO 2 NORTH VIA STRETCHER FROM THE ED. PT A&OX4. PT DENIES CP, SOB, PAIN. PT ON RA. LUNG SOUNDS CLEAR BILATERALLY, RESPIRATIONS EVEN/UNLABORED. PT AMBULATING IN ROOM WITH STEADY GAIT. NO TELE. NO IV. PT REFUSING IV INSERTION. PT DENIES SI. PT ORIENTED TO BED, ROOM, CALL BELL, UNIT. PT DENIES NEEDS AT THIS TIME. CALL BELL WITHIN REACH. WILL MONITOR.

Diagnosis/Goals/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 10/02/15 Time: 1915 (continued)

Patient Notes: NURSE NOTES (continued)
Note Type Description
No Type None

Activity Date: 10/02/15 Time: 1921 (continued)

50157 VS: Capsule (continued)
- Create 10/02/15 1921 MFM 10/02/15 1921 MFM
- Document 10/02/15 1921 MFM 10/02/15 1921 MFM
Temperature: 96.8
Temp Source: ORL
Blood Pressure: 113/75
BP Source: RA
B/P Position: LYING
MAP (mm Hg): 88
Pulse: 83
Pulse Source: MON
Respirations: 18
Resp Source: OBS
SpO2: 98
LOC: Alert
Oxygen Device: NONE
MEWS: 1

Activity Date: 10/02/15 Time: 2010

Diagnosis: STANDARD: Minimum Hospital SOC A
- Create 10/02/15 2010 BJB 10/02/15 2010 BJB
Goals: Minimum hospital SOC will be maintained. A 10/05/15
- Create 10/02/15 2010 BJB 10/02/15 2010 BJB
- Ed Target 10/02/15 2010 BJB 10/02/15 2010 BJB None => 10/05/15
10999 Family History A .on admission CP
- Create 10/02/15 2010 BJB 10/02/15 2010 BJB
2011 Hygiene/I&O Documentation + A CP
- Create 10/02/15 2010 BJB 10/02/15 2010 BJB
2013 I&O A CP
- Create 10/02/15 2010 BJB 10/02/15 2010 BJB
2014 Weight + A CP
- Create 10/02/15 2010 BJB 10/02/15 2010 BJB
2015 Data Collection Tool + A CP
- Create 10/02/15 2010 BJB 10/02/15 2010 BJB
2016 IV Therapy/ Maintenance + A CP
- Create 10/02/15 2010 BJB 10/02/15 2010 BJB
2017 Vital Signs + A CP
- Create 10/02/15 2010 BJB 10/02/15 2010 BJB

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833
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Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833
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Diagnosis/Goals/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Comment	Documented Units	From Change
Activity Date: 10/02/15 Time: 2010											
2018-C SBAR Hand Off - Med Surg +								A	QS		CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
2020 S. MD Notification Record +								A			CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
2021 Discharge Instructions +								A			CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
2021-T TRANSFER INSTRUCTIONS FOR PATIENT To be completed on patients going to another acute facility.								A	PRN		CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
2023 Physician Visit								A			CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
2024 Care Plan Review Screen +								A			CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
2025 Medication Reconciliation +								A			CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
2041 FOLEY DOCUMENTATION								A	PRN		CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
2516 Monitor Tech:Rhythm Strip Interpretation								A			CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
52108 Vaccination Assessment								A	ONCE		CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
8101001 INTERDISCIPLINARY ROUNDS/PT EDUCATION								A			CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
8409 SUICIDE RISK ASSESSMENT Complete upon intrahospital transfer.								A	PRN		CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
857 Critical Values +								A	.PRN		CP
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
Diagnosis: Age Appropriate: YOUNG ADULT 18-40 yrs.								A			
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
Goals: Return to blue screen and view protocol								A	10/05/15		
- Create		10/02/15	2010	BJB	10/02/15	2010	BJB				
- Ed Target		10/02/15	2010	BJB	10/02/15	2010	BJB				None => 10/05/15
Activity Date: 10/03/15 Time: 0113											

Patient Notes: NURSE NOTES
- Create 10/03/15 0113 JF 10/03/15 0144 JF

PT APPROACHED NURSING STATION AND WAS PACING SHIRTLESS. PT RIPPED OFF ARMBANDS AND THREW ON THE FLOOR. PT STARTED YELLING STATING "THAT WE COULD NOT CONTROL HIM. NOR COULD OBAMA." PT ACCUSING STAFF OF BEING DEVIL WORSHIPERS. ONCALL MD ASH BERNAL CALLED TO SEE PT.

Note Type	Description
No Type	None

Diagnosis/Goals/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Comment	Documented Units	From Change
Activity Date: 10/03/15 Time: 0131											

Patient Notes: NURSE NOTES
- Create 10/03/15 0131 BJB 10/03/15 0138 BJB

PT PACING IN HALLWAYS, APPROACHED NURSING UNIT SAYING THAT WE CANNOT CONTROL HIM. PT ESCORTED BACK TO ROOM. PT VERY VERBAL WITH STAFF. BECOMING AGGRESSIVE WITH STAFF. STATING THAT WE ARE ALL WITH THE DEVIL. SECURITY AT BEDSIDE. PT VERBALIZING THAT HE IS HERE VOLUNTARILY AND THAT WE CANNOT KEEP HIM HERE. STAFF TRIED TO CALM PATIENT AND REINFORCE THAT WE ARE HERE TO HELP HIM. STAFF OFFERED TO CALL PT'S FATHER FOR HIM TO SPEAK TO. PT REFUSED. DR ASHBERNAL IN TO SEE PATIENT. PT STATED HE WANTS TO LEAVE. AMA PAPER SIGNED BY DR ASHBERNAL. PATIENT AND THIS RN. PT ESCORTED OFF UNIT BY SECURITY.

Note Type	Description
No Type	None

Diagnosis/Goals/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Comment	Documented Units	From Change
Activity Date: 10/03/15 Time: 0146											
2002 Initial Assessment Part B								D			AS
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2003 Initial Assessment Part A								D			AS
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
28004 Activity								D			OE
Press [ENTER] for Order Details											
.											
Activity: AS TOLERATED											
Press [ENTER] for Additional Order Details											
.											
Other: AS TOLERATED											
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
28111 Intake & Output								D			OE
Press [ENTER] for Order Details											
.											
Frequency: Per Unit Protocol											
Other:											
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
28136 Notify								D			OE
Press [ENTER] for Order Details											
.											
Comment: The care of this patient has been discussed with the accepting/admitting physician who agrees to immediately assume the care of the patient. Call Admitting physician for further orders. clarification of orders. or change in patient's condition.											
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
28181 Pulse Oximetry +								D			OE
Press [ENTER] for Order Details											
.											
Pulse Ox Frequency With Vitals											

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833

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Scheer_GSRMC_MedRecs_0101

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Diagnosis/Goals/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Comment	Documented Units	From / Change
Activity Date: 10/03/15 Time: 0146 (continued)											
28181 Pulse Oximetry + (continued)											
Comment:											
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
28190 Sequential Compression Device								D			OE
Press [ENTER] for Order Details											
.											
Extremity: Bilateral											
Comment:											
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
28222 Vital Signs								D			OE
Press [ENTER] for Order Details											
.											
Frequency: Per Unit Protocol											
Other:											
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
28222 Vital Signs								D			OE
Press [ENTER] for Order Details											
.											
Frequency: Per Unit Protocol											
Other:											
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
50157 VS: Capsule								D			MO
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
90167 Notify VS								D			OE
Press [ENTER] for Order Details											
.											
Sys BP less than: 90 Dia BP less than: Heart Rate less than: 50											
Sys BP greater than: 170 Dia BP greater than: 100 Heart Rate greater than: 110											
Resp Rate less than: 12 Temp less than: O2 Sat% less than: 92											
Resp Rate greater than: 28 Temp greater than: 101.0											
Press [ENTER] for Additional Order Details											
.											
Comment:											
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
90331 Universal Decolonization Protocol								D			OE
Press [ENTER] for Order Details											
.											
Comment: MRSA Swab if score of 3 or more on infection control screening B for MRSA unless already done as part of this admission.											
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
90341 Oxygen Therapy								D			OE
Press [ENTER] for Order Details											
.											
Delivery Method: Nasal Cannula Liters per Minute/Percentage: 2-4											
O2 Frequency: PRN to Keep SpO2 > 92%											
Comment:											
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D

Diagnosis/Goals/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Comment	Documented Units	From / Change
Activity Date: 10/03/15 Time: 0146											
Diagnosis: STANDARD: Minimum Hospital SOC								D			
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
Goals: Minimum hospital SOC will be maintained.								D	10/05/15		
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
10999 Family History								D	.on admission		CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2011 Hygiene/I&O Documentation +								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2013 I&O								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2014 Weight +								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2015 Data Collection Tool +								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2016 IV Therapy/ Maintenance +								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2017 Vital Signs +								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2018-C SBAR Hand Off - Med Surg +								D	QS		CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2020 S. MD Notification Record +								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2021 Discharge Instructions +								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2021-T TRANSFER INSTRUCTIONS FOR PATIENT To be completed on patients going to another acute facility.								D	PRN		CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2023 Physician Visit								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2024 Care Plan Review Screen +								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2025 Medication Reconciliation +								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2041 FOLEY DOCUMENTATION								D	PRN		CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
2516 Monitor Tech:Rhythm Strip Interpretation								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
52108 Vaccination Assessment								D	ONCE		CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
8101001 INTERDISCIPLINARY ROUNDS/PT EDUCATION								D			CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D
8409 SUICIDE RISK ASSESSMENT Complete upon intrahospital transfer.								D	PRN		CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his				A => D

Diagnosis/Goals/Intervention Description											
	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Directions Documented Comment	Units	From Change
Activity Date: 10/03/15 Time: 0146										
857	Critical Values +							D .PRN		CP
- Ed Status		10/03/15	0146	his	10/03/15	0146	his			A => D
Diagnosis: Age Appropriate: YOUNG ADULT 18-40 yrs.								D		
- Ed Status		10/03/15	0146	his	10/03/15	0146	his			A => D
Goals: Return to blue screen and view protocol								D 10/05/15		
- Ed Status		10/03/15	0146	his	10/03/15	0146	his			A => D

Monogram Initials	Name	Nurse Type
AB	PHY.BATAM BATTISTI.AMANDA	Provider
BJB	FNUR.BJB1 BELL.BETHANY JEAN	RN
JF	FNUR.JF FREEMAN.JACQUELINE	RN
MFM	FNUR.MFM MUSELLA.MARIA F	NA
NP	PHY.PATNI3 PATEL.NIRLEP	Provider
his	automatic by program	

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F01034276833
Scheer_GSRMC_MedRecs_0102
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Coded Allergies/Adverse Reactions

Name	Category	Severity	Ver?	Date	Time	User	Reaction
Allergies							
No Known Drug Allergies	Drug	Unknown	Y	10/02/15	2002	BJB	(NO KNOWN DRUG ALLERGIES)

Initial Assessment Part A 10/02/15 1915 BJB

First Point of Contact: N
Able to Obtain History: Y . Y
Update Family History Y
Reason:
Communication Needs: NOT APPLICABLE
Communication Methods Needed: NONE

KDM = Key Decision Maker

Historian: SELF

Has the pt been hospitalized within the last 30 days (IP admit)? N
Has the pt taken hormone therapy or birth control pills within the last 30 days? N

PT education packet available at bedside: Y
Patient and or family provided written and verbal safety information about:
Reporting concerns about care: Y
Patient identification process: Y
Site markings when having surgery or procedure: Y
Infection control measures for surgical patients: Y
Hand hygiene: Y
Respiratory hygiene: Y
Contact precautions according to patient condition: Y
Rapid Response Team: Y
Patient and or family verbalize understanding of location of education folder/booklet and the need to review: Y
Instructed to follow-up with nurse if questions: Y

Enter/Edit home med reconciliation: Y
Attention Required: N
Was a BETA-BLOCKER a daily home med prior to arrival: N

Suspect neglect/abuse: N Abuse Suspected:

Are you currently involved in research related to a drug or device: NO
Sponsor: Sponsor contact number:
Attending physician notified of patient's participation in clinical trial:

Smoking status for patients 13 years old or older: Never Smoker
Adult cigarette smoking history w/in last year- NO

==========PAST MEDICAL HISTORY==========

CARDIOVASCULAR hx: N
Hypertension:
RESPIRATORY hx: N
SOB:
HEPATIC/ENDOCRINE hx: N
Thyroid Problem:

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
DO NOT DISCARD!!!

Initial Assessment Part A 10/02/15 1915 BJB

MI:
CP/Angina:
Vascular disorder:
DVT:
CHF: N
CHF info provided: N
If not, why:
Murmur:
AICD/Pacemaker:
Heart Valve:
~

COPD:
Asthma:
Chronic lung disease:
PE:
BI-PAP/C-PAP:
Diagnosed with sleep apnea:
Hx of cigarette smoking: N
Smoked cigarettes in last 12 mos: N
Smoking info/Counseling provided: N
If not, why:
Other Tobacco Use:
~

Diabetic:
Insulin Pump:
Cirrhosis:
Pancreatitis:
Jaundice:
Hepatitis:
~

AUTO-IMMUNE DISORDER hx: N
Lupus:
Multiple Schlerosis:
Rheumatoid Arthritis:
Sarcoidosis:
Scleroderma:
Sjogren's Syndrome:
HIV/AIDS:
~

NEUROLOGICAL hx: Y
Alzheimers/Dementia: N
Chronic Headaches: N
STROKE/TIA: N
STROKE info provided: N
Seizures: LOCALIZED
Paralysis:
~EPILEPSY

GASTROINTESTINAL hx: N
Hiatal Hernia:
Ulcer:
Ostomy:
Bowel Difficulties:
Heartburn/GERD:
~

MUSCULOSKELETAL hx: N
Arthritis:
Amputation:
Artificial Joints:
Fibromyalgia:
~

Has the pt ever had a colonoscopy: (Only pts >49)

GENITOURINARY hx: N
Renal Disease:
Dialysis
Dialysis Access:
Frequent UTI:
Urostomy:
Prostate prob:
Hx STD:
~

ONCOLOGICAL hx: N
System Affected:
System Affected:
Chemotherapy:
Radiation:
IV Access Ports:
Date Inserted:
~

OTHER hx: N
Anesthesia complications:
Bleeding problems:
Sickle Cell:
Glaucoma:
Alcohol Use:
Illicit Drug Use:
~

Prev React Blood Trans: NA

GYNECOLOGICAL hx:
Pregnant: N
Est Date of Delivery:
Is patient breast or bottle feeding?
LMP:
~

Pertinent Medical Hx: EPILEPSY
:
Pertinent Surgical Hx:

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
DO NOT DISCARD!!!

Initial Assessment Part A 10/02/15 1915 BJB

Admit Com:

===== INFECTION CONTROL SCREENING =====

INFECTION RISK SCREEN B
Resistant infections w/in last 3 yrs(MRSA,VRE,C,DIFF): N If YES, what type: : 0
Patient admitted/transferred from= Emergency Dept : 0
Name of facility-
Is reason for visit open joint replacement, open spine or open heart surg? N : 0
Is the patient receiving dialysis? N : 0
Invasive Device (PICC,urinary device,trach,feeding tube,implanted port): N : 0
Total Points: 0
A Swab is required for a Score of 3 or Greater MRSA swab required: N
MRSA SWAB REQUIRED ON ALL CVICU & PCU PATIENTS:

INFECTION RISK SCREEN C
Occupational exposure to any person having an Influenza-like Illness? N : 0
Contact with domestic poultry? N : 0
Total Points: 0

Press Enter to Continue:

===== NUTRITION SCREENING =====

Criteria	Points
New Onset/Gestational Diabetes (7p): N	: 0
Pregnancy with nausea/vomiting (Hyperemesis) (7p): N	: 0
Surgical Patient > 65 (2p): N	: 0
Acute/Chronic Renal Diagnosis (2p): N	: 0
AIDS/HIV (4p): N	: 0
Pregnant and 17 years old or younger (7p): N	: 0
Total Points:	0

*** 4 or more Points will send a referral to Dietary ***

Press enter to continue:

=========FUNCTIONAL SCREENING========
Independent with mobility/ self care prior to this illness: Y
Have you had difficulty with transfers / walking in the past two weeks: N
Have you fallen 2 or more times in the last month: N
Are you currently receiving Physical Therapy at home: N

** A Y answer to any of the last 3 questions will send a referral to PT **

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
DO NOT DISCARD!!!

Initial Assessment Part A 10/02/15 1915 BJB

========= SPEECH THERAPY SCREENING========
Is the patient able to sustain alertness for 20 minutes: Y
Does the patient have a PO diet: Y
Does the pt/caregiver report a history of dysphagia or
are they consuming a modified diet texture (i.e. thickened liquids/puree): N
Does the pt have difficulty managing secretions, a wet vocal sound, or are they drooling: N
Is the pt coughing or clearing his/her throat with PO intake: N

===SCREENING REFERRALS REQUESTED===
PT/OT: FNS: Case Mgmt: Inf Control: N ST: N

Home Medications:
levETIRAcetam (KEPPRA) 250 MG
250 MG PO BID

Is Patient Present?
Able to perform TB & Contagious Respiratory Infection Point of Entry Screen
Reason-

--In the past 3 weeks has the patient:--
Resided in or traveled to an African country:

Had contact with anyone who has been to a West African country:
Been in contact with blood or body fluids of a person with Ebola:
Fever greater than 100.4 F or 38.0 C:

Mask applied, patient isolated, charge nurse or MD notified:

Is patient currently experiencing any of following in last 7 days:
Fever greater than 100.4? (38.0 C)
Cough? (not related to allergy or COPD)
Persistent Cough greater than 3 weeks?
Cough with blood produced?
Sore Throat?

Initial Assessment Part A 10/02/15 1915 BJB

Night sweats? [redacted]
Unexplained weight loss? [redacted]
Fatigue? [redacted]
Body Aches? [redacted]
Rash? [redacted]
Nasal Congestion (not related to allergies or sinus infections)? [redacted]

Pt reports prior history of TB or positive TB skin test? [redacted]
Close contact with a person who has TB? [redacted]
Close contact with any person having an Influenza-like Illness? [redacted]

Travel outside the US in the past 3 weeks: [redacted]
If yes, name of country: [redacted]

TB Point of Entry Screen: [redacted]

Contagious Respiratory Infection Point of Entry Screen- [redacted]

Mask applied, patient isolated, and receiving unit/department notified? [redacted]

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
DO NOT DISCARD!!!

Monogram Initials	Name	Nurse Type
BJB FNUR.BJB1	BELL,BETHANY JEAN	RN

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
DO NOT DISCARD!!!

Coded Allergies/Adverse Reactions

Name / Reaction	Category	Severity	Ver?	Date	Time	User
Allergies No Known Drug Allergies (NO KNOWN DRUG ALLERGIES)	Drug	Unknown	Y	10/02/15	2002	BJB

Initial Assessment Part A 10/02/15 1915 BJB

First Point of Contact: N
Update Family History Y
Able to Obtain History: Y . Y
Reason:
Communication Needs: NOT APPLICABLE
Communication Methods Needed: NONE

KDM = Key Decision Maker

Historian: SELF

Has the pt been hospitalized within the last 30 days (IP admit)? N
Has the pt taken hormone therapy or birth control pills within the last 30 days? N

PT education packet available at bedside: Y
Patient and or family provided written and verbal safety information about:
Reporting concerns about care: Y
Patient identification process: Y
Site markings when having surgery or procedure: Y
Infection control measures for surgical patients: Y
Hand hygiene: Y
Respiratory hygiene: Y
Contact precautions according to patient condition: Y
Rapid Response Team: Y
Patient and or family verbalize understanding of location of education folder/booklet and the need to review: Y
Instructed to follow-up with nurse if questions: Y

Enter/Edit home med reconciliation: Y
Attention Required: N
Was a BETA-BLOCKER a daily home med prior to arrival: N

Suspect neglect/abuse: N Abuse Suspected:

Are you currently involved in research related to a drug or device: NO
Sponsor: Sponsor contact number:
Attending physician notified of patient's participation in clinical trial:

Smoking status for patients 13 years old or older: Never Smoker
Adult cigarette smoking history w/in last year- NO

==========PAST MEDICAL HISTORY==========

CARDIOVASCULAR hx: N
Hypertension:
RESPIRATORY hx: N
SOB:
HEPATIC/ENDOCRINE hx: N
Thyroid Problem:

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
DO NOT DISCARD!!!

Initial Assessment Part A — 10/02/15 1915 BJB

MI:
CP/Angina:
Vascular disorder:
DVT:
CHF: N
CHF info provided: N
If not, why:
Murmur:
AICD/Pacemaker:
Heart Valve:
~

COPD:
Asthma:
Chronic lung disease:
PE:
BI-PAP/C-PAP:
Diagnosed with sleep apnea:
Hx of cigarette smoking: N
Smoked cigarettes in last 12 mos: N
Smoking info/Counseling provided: N
If not, why:
Other Tobacco Use:
~

Diabetic:
Insulin Pump:
Cirrhosis:
Pancreatitis:
Jaundice:
Hepatitis:
~

AUTO-IMMUNE DISORDER hx: N
Lupus:
Multiple Schlerosis:
Rheumatoid Arthritis:
Sarcoidosis:
Scleroderma:
Sjogren's Syndrome:
HIV/AIDS:
~

NEUROLOGICAL hx: Y
Alzheimers/Dementia: N
Chronic Headaches: N
STROKE/TIA: N
STROKE info provided: N
Seizures: LOCALIZED
Paralysis:
~EPILEPSY

GASTROINTESTINAL hx: N
Hiatal Hernia:
Ulcer:
Ostomy:
Bowel Difficulties:
Heartburn/GERD:
~

MUSCULOSKELETAL hx: N
Arthritis:
Amputation:
Artificial Joints:
Fibromyalgia:
~

Has the pt ever had a colonoscopy: (Only pts >49)

ONCOLOGICAL hx: N
System Affected:
System Affected:
Chemotherapy:
Radiation:
IV Access Ports:
Date Inserted:
~

OTHER hx: N
Anesthesia complications:
Bleeding problems:
Sickle Cell:
Glaucoma:
Alcohol Use:
Illicit Drug Use:
~

GENITOURINARY hx: N
Renal Disease:
Dialysis
Dialysis Access:
Frequent UTI:
Urostomy:
Prostate prob:
Hx STD:
~

Prev React Blood Trans: NA

GYNECOLOGICAL hx:
Pregnant: N
Est Date of Delivery:
Is patient breast or bottle feeding?
LMP:
~

Pertinent Medical Hx: EPILEPSY
:
Pertinent Surgical Hx:

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
DO NOT DISCARD!!!

Initial Assessment Part A 10/02/15 1915 BJB

Admit Com: [redacted]

===== INFECTION CONTROL SCREENING =====

INFECTION RISK SCREEN B

Resistant infections w/in last 3 yrs(MRSA,VRE,C,DIFF): N If YES, what type: [redacted]: 0

Patient admitted/transferred from= Emergency Dept : 0

Name of facility- [redacted]

Is reason for visit open joint replacement, open spine or open heart surg? N : 0

Is the patient receiving dialysis? N : 0

Invasive Device (PICC,urinary device,trach,feeding tube,implanted port): N : 0

Total Points: 0

A Swab is required for a Score of 3 or Greater MRSA swab required: N

MRSA SWAB REQUIRED ON ALL CVICU & PCU PATIENTS:

INFECTION RISK SCREEN C

Occupational exposure to any person having an Influenza-like Illness? N : 0

Contact with domestic poultry? N : 0

Total Points: 0

Press Enter to Continue:

===== NUTRITION SCREENING =====

Criteria	Points
New Onset/Gestational Diabetes (7p): N	0
Pregnancy with nausea/vomiting (Hyperemesis) (7p): N	0
Surgical Patient > 65 (2p): N	0
Acute/Chronic Renal Diagnosis (2p): N	0
AIDS/HIV (4p): N	0
Pregnant and 17 years old or younger (7p): N	0
Total Points:	0

*** 4 or more Points will send a referral to Dietary ***

Press enter to continue:

=========FUNCTIONAL SCREENING========

Independent with mobility/ self care prior to this illness: Y

Have you had difficulty with transfers / walking in the past two weeks: N

Have you fallen 2 or more times in the last month: N

Are you currently receiving Physical Therapy at home: N

** A Y answer to any of the last 3 questions will send a referral to PT **

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
DO NOT DISCARD!!!

Initial Assessment Part A 10/02/15 1915 BJB

========= SPEECH THERAPY SCREENING========
Is the patient able to sustain alertness for 20 minutes: Y
Does the patient have a PO diet: Y
Does the pt/caregiver report a history of dysphagia or
are they consuming a modified diet texture (i.e. thickened liquids/puree): N
Does the pt have difficulty managing secretions, a wet vocal sound, or are they drooling: N
Is the pt coughing or clearing his/her throat with PO intake: N

===SCREENING REFERRALS REQUESTED===
PT/OT: FNS: Case Mgmt: Inf Control: N ST: N

Home Medications:
levETIRAcetam (KEPPRA) 250 MG
250 MG PO BID

Is Patient Present?
Able to perform TB & Contagious Respiratory Infection Point of Entry Screen
Reason-

--In the past 3 weeks has the patient:--
Resided in or traveled to an African country:

Had contact with anyone who has been to a West African country:
Been in contact with blood or body fluids of a person with Ebola:
Fever greater than 100.4 F or 38.0 C:

Mask applied, patient isolated, charge nurse or MD notified:

Is patient currently experiencing any of following in last 7 days:
Fever greater than 100.4? (38.0 C)
Cough? (not related to allergy or COPD)
Persistent Cough greater than 3 weeks?
Cough with blood produced?
Sore Throat?

Initial Assessment Part A 10/02/15 1915 BJB

Night sweats? [redacted]
Unexplained weight loss? [redacted]
Fatigue? [redacted]
Body Aches? [redacted]
Rash? [redacted]
Nasal Congestion (not related to allergies or sinus infections)? [redacted]

Pt reports prior history of TB or positive TB skin test? [redacted]
Close contact with a person who has TB? [redacted]
Close contact with any person having an Influenza-like Illness? [redacted]

Travel outside the US in the past 3 weeks: [redacted]
If yes, name of country: [redacted]

TB Point of Entry Screen: [redacted]

Contagious Respiratory Infection Point of Entry Screen- [redacted]

Mask applied, patient isolated, and receiving unit/department notified? [redacted]

Initial Assessment Part B 10/02/15 1915 BJB

Medical Diagnosis/Reason for Visit: LEUKOCYTOSIS

Pt. ID Band On: Y
Allergy Band On: NA

Arrival From: EMERGENCY DEPARTMENT
Arrival Mode: STRETCHER

Isolation #1: STANDARD
Pressure alarm on: NA
Negative Pressure Present: NA

Is patient admitted with PNEUMONIA: N
Enter or Edit Vaccine Screening: Y

Emergency Contact: SCHEER,DAVID
Local Number:
Support Person: SCHEER,DEBRA

Local Number: (609)226-4952
Cell Number:
Phone: (609)226-4952

Name of person that will provide transportation at discharge:

Phone number(s) to contact the person above:

NEUROLOGICAL WNL Y
: Patient is alert and oriented to person, place,and time, able to move
: all extremities; extremity strength is strong and equal, no seizure
: activity. Patient is calm and cooperative with no speech alterations,
: and pupils are equal. No visual loss. Normal gaze. Sensation intact.

Level of conscious:
Oriented To:
Speech:
Extremity Strength:
Upper Body:
Lower Body:
Extremity Movement:
Neuro Comment:

Seizure activity:
Emotional Status:
Pupil Reaction Rt. Eye:
Pupil Reaction Lt. Eye:
Visual:
Best Gaze:
Sensory:

RESPIRATORY WNL Y
: Patient's respirations are even and unlabored. There is no cough,
: no supplemental oxygen needed, no chest tubes, no tracheotome.
: Breaths sounds are clear in all lobes

Initial Assessment Part B 10/02/15 1915 BJB

Resp Effort:
Cough:
Sputum:
Sputum Quality:
Sputum Amount:
Resp Comment:

O2:
Oxygen Device:
O2 Amount (lpm):
Chest Tube: # OF CHEST TUBES:
Trach:

Breath Sounds RUL:
Breath Sounds RML:
Breath Sounds RLL:
Breath Sounds LUL:
Breath Sounds LLL:

Location #1:
cm of Suction #1:
Water seal/amt H2Oml #1:
Clamp at Bedside #1:
Tube Patent #1:
Air Leak #1:
Drainage #1:

Location #2:
cm of Suction #2:
Water seal/amt H2Oml #2:
Clamp at Bedside #2:
Tube Patent #2:
Air Leak #2:
Drainage #2:

Chest Tube Comment:

Is patient admitted for orthopedic joint surgery: N CARDIOVASCULAR WNL Y

: Patient's heart rhythm is regular, bilateral pulses are palpable,
: absence of edema; capillary refill is less than 3 seconds.
: Patient voices no complaints of chest pain

Heart Sounds:
EKG Rhythm:
Cap. Refill:
Edema:
Edema Location:

Telemetry:
Temporary pacemaker:
+++RIGHT+++ +++LEFT+++
Radial Pulse:
Pedal Pulse:
Chest pain: If YES, see pain screen for details.

Anti-Embolism Stockings: N Sequential Compression Device: NONE

Cardiovasc Comment:

EENT WNL Y
: Eyes are clear bilaterally, no nasal, mouth, or throat abnormalities
: observed or verbalized by the patient.

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
DO NOT DISCARD!!!

Initial Assessment Part B 10/02/15 1915 BJB

Right Eye Assessment:
Left Eye Assessment:
Nasal Assessment:
Throat Assessment:
Mouth Assessment:
EENT Comment:

GASTROINTESTINAL/NUTRITION WNL Y
: Abdomen is non-distended and soft with active bowel sounds in all four
: quadrants. Patient denies complaints of nausea, vomiting,
: constipation, or diahrrea.

Has the pt had a BM in the last 48 hours: Y Last BM: 10/01/15
Abd. Appearance: Gastric tube: Nausea:
Bowel Sounds: Type: Vomiting:
Tube Feeding: Suction: Constipation:
Residual: NG Drainage: Diarrhea:
GI Comment:

GENITOURINARY WNL Y
: Patient is continent and voiding clear, yellow urine without difficulty.

Voiding Method: CBI: Dialysis:
Urine Color: Dysuria: Dysuria Type:
Urine Character:

Initial Assessment Part B 10/02/15 1915 BJB

Catheter: N
GU Comment:
INTEGUMENTARY WNL Y
: Skin is warm and dry with normal elasticity and color.
: All skin is intact. Patient is not on a specialty bed.

Skin Color: Incision: Decub/Pressure area:
Skin Temp: Ostomy: # OF WOUNDS: Other altered integrity:
Skin Turgor: Drains: # OF DRAINS: Latex sensitivity:
Skin Comment:
Skin Risk Assessment: Y Braden Risk Level: Standard

W. Loc:	W. Loc:	Drain/Tube Type #1:
Drainage:	Drainage:	Drain Location #1:
Drng Amt:	Drng Amt:	Drainage Type #1:
W. Color:	W. Color:	
W. Odor:	W. Odor:	Drain/Tube Type #2:
Margins:	Margins:	Drain Location #2:
Dressing:	Dressing:	Drainage Type #2:

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DO NOT DISCARD!!!

Initial Assessment Part B 10/02/15 1915 BJB

W. Loc:
Drainage:
Drng Amt:
W. Color:
W. Odor:
Margins:
Dressing:

W. Loc:
Drainage:
Drng Amt:
W. Color:
W. Odor:
Margins:
Dressing:

Drain/Tube Type #3:
Drain Location #3:
Drainage Type #3:

Drain/Tube Type #4:
Drain Location #4:
Drainage Type #4:

MOBILITY/ACTIVITY WNL Y
: Patient is up adlib with full mobility and a steady gait.
: Patient has active range of motion in all extremeties and is able to
: turn him/herself in bed.

Activity Level:
Gait:
Mobility Aids:
Active ROM in all Extremities:
Location of Limited ROM:
Pt. Turned: New Position:
Mode of transport (to/from unit): WC

MUSCULOSKELETAL WNL Y
: Patient has no traction, pins, braces, or casts.

Traction in use:
Type of Traction:
Type of Traction:
Extremity:
Extremity:
Wt. (lbs):
Wt (lbs.):

Pins in use:
Orthopedic Pin Location:
Orthopedic Pin Location:
Pin Site Appearance:
Pin Site Appearance:

Braces in use:
Type of Brace:
Type of Brace:
Extremity:
Extremity:

Cast in use:
Cast location:
Cast Location:
Cast type:
Cast Type:
Cast condition:
Cast Condition:

Musc. Comment:

FALL RISK ASSESSMENT: Y

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
DO NOT DISCARD!!!

Initial Assessment Part B 10/02/15 1915 BJB

===SEPSIS SCREENING===
Temperature: Y Respirations: N
Heart Rate: N WBC/Bands: Y :10/02/15 14:5H 1042 :No Results past 24 hrs
If Y to 2 or more of above, proceed to next section: 2

===INFECTION===
Suspected/Documented Infection: N
Antibiotic Therapy (Not Prophylaxis): N
If Y to 1 of the above, proceed to next section: 0

===NEW ORGAN DYSFUNCTION within past 48 hours===
Respiratory: Hematologic:
Cardiovascular: Hepatic:
Renal: CNS:
Metabolic: If Y to 1 of the above, positive for severe sepsis:
Severe Sepsis Comment:

Psychosocial Distress Screening for Cancer Patients

Are you experiencing a new or recurring Cancer diagnosis: N
Is this impacting your psychosocial wellbeing:
Distress Scale:

Suicide Risk Assessment: Y
===PAIN=== B Instructed of Pain Scale: Y Pain Scale Utilized: NUMERICAL
Pain Scale (0-10): 0

===FLACC PAIN ASSESSMENT===
Face:
Legs:
Activity:
Cry:
Consolability:
Total FLACC Scale:

===CPOT PAIN ASSESSMENT===
Facial Expression:
Body Movements:
Muscle Tension:
Compliance w/Vent:
Vocalization:
Total CPOT Score:

===NIPS PAIN ASSESSMENT===
Facial Expression:
Cry:
Breathing Patterns:
Arms:
Legs:
State of Arousal:
Total NIPS Score (0-7):

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
DO NOT DISCARD!!!

Initial Assessment Part B 10/02/15 1915 BJB

Location: Aggravating Factors:

Quality: Alleviating Factors:

Onset:

IV MAINTENANCE

IV: N # OF IV SITES: IV Type #1: IV Type #2:
IV Location #1: IV Location #2:
IV Size #1: IV Size #2:
#1 IV Site Appearance: #2 IV Site Appearance:
Blood Return: Blood Return:
Date of Insertion: Date of Insertion:
Date due to be changed: Date Due to be changed:

DISCHARGE PLANNING

Lives with: ALONE Comment:
Lives in: OTHER Comment: PT WOULD NOT SPECIFY

Currently has home health services: N
Are others dependent on you for their care: N Comment:
Concerns about managing at home after discharge: N Comment:

Suspect Abuse/Neglect N Abuse Suspected:

High Risk Screening (Case Management Trigger): NONE
Diabetic Educator Screening: NONE

Does pt have order for comfort measures/palliative care: N

Preferred Language: English
Religion: CAT Clergy visit requested/needed: N
Religious needs for care: N :
Cultural needs for care: N :

ADVANCE DIRECTIVE INFORMATION

Advanced Directive: NO/INFORE

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
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Initial Assessment Part B 10/02/15 1915 BJB

4. If the patient has no health care surrogate or Living Will, was the patient or family member given a copy of Appendix A? Y

PATIENT/FAMILY EDUCATION

Readiness to Learn: LACKS INTEREST
Educational level: HIGH SCHOOL GRADUATE
Limitations/Barriers to Learning: NONE
Learning Preference: VERBAL
Health knowledge: LOW

Does patient agree to plan of care and goals: Y

===SCREENING REFERRALS REQUESTED===

PT/OT: FNS: N Case Mgmt: N Inf Control: N Wound Care: N Pastoral Care: N ST: N

Age Group: 26.0 Add hospital standards to care plan: Y

Weight - Lb: 168
Oz:
Kg: 76.20
Wt Source:

Height - Feet: 6
Inches: 0
Cm: 182.88

BMI: 22.8 N

ORIENTED TO

Initial Assessment Part B 10/02/15 1915 BJB

Call Light: Y
Phone: Y
Siderails: Y
Bed Control: Y
Lights: Y
Visiting Hours: Y
Television: Y
Smoking: Y

PERSONAL ITEMS INVENTORY

PERSONAL ITEMS INVENTORY-------DISPOSITON

Glasses: NA
Contacts: NA
Hearing Aid(s)#:0 : NA
Partials: NA
Dentures (Lowers): NA
Dentures (Uppers): NA
Shoes: B
Jewelry: [redacted] : NA
Jewelry: [redacted] : NA
Clothing: [redacted] : B
Clothing: [redacted] : NA
Wallet/Purse: [redacted] : NA
Other Items: [redacted] : NA
Other Items: [redacted] :
Home meds sent to Pharmacy: N

--DISPOSTION CODES--
H = sent home
B = At pt bedside
N = not brought to hosp
S = sent to security
NA = not applicable
PW = Patient Wearing

BR Emergency Light: Y

Would you like to enter a patient note: Y
Pt has 3 or more meds in drug classes known to be indicator of fall risk: N
Is patient Responsive: Yes

Is patient following fall prevention directions: Y

Fall Risk Elements: [redacted]

Add'l Fall Risk Elements: [redacted]

Update Date of Last Fall:
Month/Year of Last Fall:

Fall Risk Comment: [redacted]

High Risk for Falls: N

Fall Precautions: [redacted]

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Initial Assessment Part B 10/02/15 1915 BJB

Fall Precautions Comment:

Fall this account/visit:

Sensory perception- No impairment
Moisture- Rarely moist
Activity- Walks frequently
Mobility- No limitation
Nutrition- Excellent
Friction and shear- No apparent problem
Braden Skin Score: 23
Braden Risk Level- Standard

Skin risk interventions: Manage moisture, Avoid drying the skin
Manage nutrition, Maintain good hydration
Manage friction and shear
No massage of reddened bony prominences

Add additional interventions:

Additional Interventions:

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Initial Assessment Part B 10/02/15 1915 BJB

Are you here because you tried to hurt yourself: NO

See next page

In the past few days have you been having thoughts or making plans about hurting yourself:

I want to ask you if your child attempted suicide in the past year:

See next page

In the past week have you been having thoughts or making plans about hurting yourself: NO

Have you tried to hurt or kill yourself in the past year: NO

See next page

Has something very bad happened to you/your family in the past few weeks:

See next page

Has something very stressful happened to you in the past few weeks: NO

See next page

New Behavior of Child:

See next page

Comment:

Patient is at Risk for Suicide: NO

Last page

Unable to assess:
Reason unable to assess:

Estimated pneumococcal vaccine admin date:
Estimated influenza vaccine admin date:
Patient or caregiver reports up to date on pneumococcal vaccine: N
Patient or caregiver reports up to date on influenza vaccine: N
Pregnant: No
Comorbid factors: None

Other conditions:

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Initial Assessment Part B 10/02/15 1915 BJB

Contraindications: None

Patient or home caregiver agrees to receive pneumococcal vaccine:
Patient or home caregiver agrees to receive influenza vaccine: No, REFUSES
Comment: PT REFUSES AT THIS TIME

Physician refusing to have patient receive vaccine(s):

Vaccine status: NOT A CANDIDATE
Influenza vaccination status- Pt or caregiver's refusal
Pneumococcal vaccination status-

Last page

Current urinary catheter has been inserted for at least:

Catheter documentation choice:

Urinary catheter present on arrival to facility:
Urinary symptoms at time of insertion

Indication for urinary catheter: Foley order obtained
Explain other indication for urinary catheter:

Urinary catheter type: Start Date:
Foley type Start Time
Urinary catheter size (Fr):

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Initial Assessment Part B 10/02/15 1915 BJB

Inserted by department:
Inserted by,if other than current documenter:
Urine amount returned from indwelling catheter:
Urine amount returned from straight catheter:
Urine collection device
Securement device

Inserted using an aseptic technique
Hand hygiene
Reason
Urethra prep with antiseptic or sterile solution
Reason
Sterile equipment
Reason
Sterile gloves
Reason
Drape
Reason
Urine bag below the bladder
Reason
Secure tubing with an appropriate device
Reason

Indication for urinary catheter today:

Urinary symptoms:

Daily foley care performed

Initial Assessment Part B 10/02/15 1915 BJB

Complication encountered in daily care

Additional Comment:

Reason for Foley removal:

Discontinue date: Discontinue time:

Complications during removal

Additional Comments:

--- External Device documentation ---

External device type:

Date external device applied:
Time external device applied:

Date external device removed:
Time external device removed:

External device comment:

Initial Assessment Part B 10/02/15 1915 BJB

--- Surgically Placed Urinary Device documentation ---

Urinary device method used:
Present on arrival:

Date surgical catheter inserted: Time surgical catheter inserted:
Date surgical catheter removed: Time surgical catheter removed:

Urinary device daily care performed:

Surgical urinary device comment:

Monogram Initials	Name	Nurse Type
BJB	FNUR.BJB1 BELL,BETHANY JEAN	RN

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
DO NOT DISCARD!!!

Grand Strand Regional Medical Center
809 82nd Parkway
Myrtle Beach, SC 29472

**** Case Management Report ****

PATIENT NAME: SCHEER,MATTHEW DOB: 01/19/89 AGE: 26
Account #: F01034276833 MRN: F000838076
Admit Date: 10/02/15
Attending Phy: Patel,Nirlep A MD

HCM SUPPORT SERVICES

HCM Support Services User Fields:

Discharge Disposition: 09 - Admitted inpt this facility

Date Entered: 10/2/2015
Service Type: *Case Management
Case Worker: Adams,Theresa
Worklist Date: 12/1/2015

Payer: 401 BC OUT OF STATE PPO

Comments:
---10/2/2015 1844 by Theresa Adams---
CM received call from Dr Battisti that she had spoken with Dr Oduwole regarding his reasoning for sending pt back here once he had been medically cleared and he apparently questioned whether or not patient is medically stable. This can be addressed with Lighthouse at a later date as is very inappropriate that he is voluntary, has a supportive parent with him, has commercial insurance and is in a manic state seeking inpatient treatment, everything had been faxed to Lighthouse earlier and pt was cleared and D/C'd from here to go there with his father then sent back for clearance again? Very difficult to understand. Pt was accepted for admission by hospitalist and will be followed by CM. He is not on papers and is voluntary.
---10/2/2015 1729 by Theresa Adams---
Met with pt and his father. They are from NJ but pt has been living and working here. He has 0 psych hx however appears to be in a manic state. Of note he has been on Keppra for seizure prevention for over 20 years and abruptly stopped 3 days ago. Dad drove from NJ to bring pt home however decided it best to seek medical attention first. Pt is voluntary and is not suicidal or homicidal. He was cleared medically and went to Lighthouse voluntarily to seek treatment. They did send him back here for medical clearance a second time. This will be addressed with appropriate people. Pt accepted by hospitalist for admission.

HCM DISCHARGE PLANNING
No HCM Discharge Planning data on file for this encounter in MIDAS+

==========

PATIENT NAME: SCHEER,MATTHEW ACCOUNT #: F01034276833

Updated by: Adams,Theresa (FCM.TA) - 12/1/2015 5:33 PM

PATIENT NAME: SCHEER,MATTHEW ACCOUNT #: F01034276833

Scheer_GSRMC_MedRecs_0132

CP0100RU Inquiry Call AS400E
38 10 Inquiry Call Update 4/23/19
FALASCOR LIGHTHOUSE BEHAV HEALTH 10:53:09

17655 Time. . 11:28 Date. . 10/02/2015 Length. . 10 By . . NARDINP
Caller Name. . . . . ADAMS THERESA
Caller Type. . . . . City. . . . . County. . . . . State. . SC
Caller Home Phone. . 0 0 Work Ph. 843 6921919 Use this #. W
Relation to Patient. 1 CASE MANAGER / ADMISSIONS Agency
Ref. Src. Primary. . 29 GRAND STRAND, MEDICAL CE 38 GRAND STRAND REG
Ref. Src. Secondary. 0 0
Ref. Src. Tertiary. . 0 0

Account #. . . . . 0 Medical Rec #. .
Patient Name (Last, First) SCHEER MATTHEW
Patient Name (Middle Ifx). .
Patient Address Line 1, 2. 5750 OYSTER CATCHER DR BLD 11 UNIT 1135
Patient City/St/Zip. . . . MYRTLE BEACH SC 29582
Patient Birth Date. . . . 11/19/1989 Pat Age. 26 Y Sex. M SSN #. 0
Primary Language. . . . . ENG English Employer/School. 0 0
Patient Home Phone. . . . 609 4570387 Work Phone. . 0 0 More. .
F3=Exit(No Save) F4=Prompt F8=Exit(Save) F9=Comments(Save) F12=Cancel
F17=Admit(Save) F18=Marketing/Demographics(Save)

CP0100RU Inquiry Call AS400E
38 10 Inquiry Call Update 4/22/19
FALASCOR LIGHTHOUSE BEHAV HEALTH 10:53:12

Insurance. 1) 2005 BLUE CROSS OUT 3) 0 *NONE
2) 1 SELF PAY BALANC 4) 0 *NONE

Presenting Problem. . PHP PHYSICAL PROBLEMS
Previous Treatment. .
Medical Problems. . .
Medications . . . .
Current Treatment . . N Where. 0 Pending Disp INFO
Assess Scheduled. . . N Time. 0:00 Date . 0/00/0000 Loc. Type.
Assess. Completed. . N By . .
Closed Disposition. . RETRS Inq Reason N/Adm. NCQMD NOT CLINICALLY QUALIFIED
Intake Explanation. . Call Entered By NARDINP
Refer To. . . . . 0 Agency . . 0
Physician Assigned. . 10 ODUWOLE, ADEDAPO Military Service? N
Program Code. . . . . IPL INPATIENT PSYCH ADULT Legal Status. . VOL
Follow up Date. . . 0/00/0000 Assigned.
Follow up Action Cod. Action Taken.
F3=Exit(No Save) F4=Prompt F8=Exit(Save) F9=Comments(Save) F12=Cancel
F17=Admit(Save) F18=Marketing/Demographics(Save)

CP0101RU
98 10
FALASCOR

Inquiry Call
Inquiry Call Notes Update

AS400E
4/22/19
10:51:10

Patient . . SCHEER, MATTHEW J
Address . . 5750 OYSTER CATCHER DR, BLD 11 UNIT 1135
City/St/Zip . MYRTLE BEACH, SC 29582

Age. 26 Y

Comments :
EVLEWED CASE WITH DR. ODUWOLE. PATIENT NOT MEDICALLY STABLE AND NEEDS MEDICAL ATTENTION. CASE CLOSED PN.
PT WALKED IN HERE AND WAS VERY DELUSIONAL AND CONFUSED. HE HAD VERY DISORGANIZED THINKING. WHEN ASKED A DIRECT QUESTION HE ANSWERED BUT WENT RIGHT BACK INTO HIS THINKING. ASKED SCOTT A HOW TO HANDLE THE SITUATION SINCE HE WAS ALREADY DECLINED BY DR O AND SHE SAID TO CALL HIM AGAIN. WHEN I CALLED HIM HE WAS STILL INSISTANT THAT HE NEEDS MEDICAL ATTENTION. I CALLED CMC AND GAVE THEN A HEADS UP THAT WE WERE SENDING THIS PATIENT OVER AND SPECIAL ATTENTION NEEDED TO BE GIVEN TO HIS BILIRUBIN AND WBC. EXPLAINED TO THE FATHER WHAT WAS GOING ON AND THAT AS

More...

F3=Exit F5=Refresh F12=Cancel F11=Insert

CP0101RU
98 10
FALASCOR

Inquiry Call
Inquiry Call Notes Update

AS400E
4/22/19
10:51:10

Patient . . . SCHEER, MATTHEW J
Address . . : 5750 OYSTER CATCHER DR, BLD 11 UNIT 1135
City/St/Zip : MYRTLE BEACH, SC 29582

Age. 26 Y

Comments :
LONG AS EVERYTHING WAS GOOD MEDICALLY, THERE WAS NO PROBLEM WITH HIM COMING BAC
K OVER FOR TREATMENT. LATER ON I WAS TOLD THAT DR BATTISTI WAS ON THE PHONE FOR
ME WHICH WAS THE DR THAT HE SAW AT GSRMC. SHE WAS QUESTIONING WHY HE WAS SENT B
ACK THERE AND WHY WHEN SHE SAYS HE IS MEDICALLY STABLE IS THAT NOT TAKEN AS TRU
TH. I EXPLAINED THAT I SENT THEM TO CMC AND THAT I RAN THE CASE BY MY DR AGAIN
AND HE AND MY DIRECTOR FELT HE NEEDED TO GO TO THE HOSP. SHE ASKED FOR DR O S P
AGER NUMBER SO THAT SHE COULD SPEAK TO HIM ABOUT THE SITUATION. NO FURTHER CONT
ACT HAPPENED. AM

More...

F3=Exit F5=Refresh F12=Cancel F11=Insert

Lighthor Care Center of Conway
152 Waccai Medical Park Dr.
Conway, SC 29526
(843) 347-8871

F01034276833

MEMORANDUM OF TRANSFER

Date of transfer: 10/2/15 Time of transfer: 1500

Patient name: Matthew Scheer Date of Birth: 1/19/89 Age: 26 Sex: (M) F

Parent/guardian: _____ Address: 5750 Oyster Catcher Dr
MB, SC 29582

Requirements to Transfer

: The transferring hospital has, within its capacity, provided medical treatment to minimize risk to the individual's health (and in the case of women in labor, the health of the unborn child)

: The receiving facility has agreed to accept the transfer, provide appropriate medical treatment and has available space and qualified personnel for the treatment of the patient.

Receiving hospital/facility: Conway ER Address: Conway SC

Nurse to nurse completed with accepting facility: (YES) NO N/A Name of nurse: Cookie

Receiving facility accepting physician _____ Date accepted. _____ Time accepted. _____

Reason for transfer (Medical) . Patient Request . Unavailable resources : Other

Clinical information/presenting problem:
pt. has a WBC of 14.5 + a bilirubin of 5.5
he is actively psychotic w/ delusions + disorganized thoughts

Primary diagnosis: psychosis Pertinent medical information: Hx of seizures

Special services needed: _____

Disabilities/impairments: None

ADL's: WNL

Allergies: _____

Medications: has been on Keppra for several years

Diet: Regular

Vital Signs: Time: _____ Blood Pressure. _____ Pulse. _____ Respirations _____ Temperature _____

Transfer of Patient

Patient condition upon transfer (per consulting physician) . Stable Unstable

Name of accompanying staff if applicable: NA Ambulance company. NA

Distribution: Original - Sent to Receiving Hospital ▪ Copy – patient chart or with patient's assessment paperwork ▪ Copy – MOT Binder

C216 Approved 08/2013

Lighthc : Care Center of Conway
152 Wacca...w Medical Park Dr.
Conway, SC 29526
(843) 347-8871

F01034276833

Certification of transfer ↱ 828574Φ **MEMORANDUM OF TRANSFER-PAGE 2**

Consulting physician: DR. Oduwole Physician recommendation: send to ER to check labs.
I certify, that based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks, if any, to the individual's medical condition (or in the case of labor, the unborn child) from the transfer.

This certification is based upon the following risks and benefits of the patient's condition:
= Deterioration of medical condition: _____
= Additional delay in receiving appropriate treatment
X Other: labs currently showing WBC 14.5 + bilirubin 5.5

Signature of certification of transfer by qualified personnel Amanda Morgenroth Date: 10/2/15

Physician signature. _____ Date: _____

Documents Sent with Patient
Assessment ✓ Demographic information Petition Certificate MH-5 Progress notes
Authorization for release of information = H & P _ Psychiatric evaluation = Demographic info/face sheet
Advance directives – Consent for medical treatment = Memorandum of Transfer ✓ Other: lab

Patient's Consent to Transfer
✓ Yes, the undersigned consents to transfer of the patient to CMC. I understand that transfers such as this may involve certain risks. Lighthouse Care Center staff has informed me of the medical risks and benefits of transfer, including the fact that during the period of transport the patient being transported is not within any hospital, and that an emergency occurring during transport can be treated only by the personnel and equipment carried in the transfer vehicle until arrival at the receiving facility.

I understand that all transfers have the inherent risk of traffic delays, accidents during transport, inclement weather, rough terrain or turbulence and limitations of equipment and personnel present in the vehicle, all of which are potentially a threat to the transported patient's health, medical safety and possible survival.

The undersigned releases Lighthouse Care Center, its respective officers, directors, employees and assigns and the transferring Lighthouse Care Center staff from any and all responsibility of any injury, damage or loss which may occur during or as a result of transfer.

= **No**, I refuse to consent to the suggested course of action. I _____ (patient name), have been advised of the medical risks and benefits reasonably expected from my refusal to be or allow the person on whose behalf I am acting, to be screened, stabilized and/or transferred.

= **Refusal** – Patient unwilling or unable to sign transfer form. Document reason below and obtain 2nd witness.

_____

_____

Signature of patient (12 y/o and older)	Date
Signature of parent/guardian	Date
Signature of witness	Date
Signature of 2nd witness (if applicable)	Date

Distribution Original - Sent to Receiving Hospital ▪ Copy – patient chart or with patient's assessment paperwork ▪ Copy – MOT Binder

C216 Approved 08/2013

PRINTED BY:mva7372 DATE 12/1/2017

DIAGNOSTIC IMAGING REPORT

GRAND STRAND REGIONAL - 809 82ND PARKWAY - MYRTLE BEACH, SC 2957
PHONE #: 8436921560 FAX #: 8436921555

F01034276833

Name: SCHEER,MATTHEW J Loc: F.ED Radiology No:

DOB: 01/19/1989 Age: 26 Sex: M Status: REG ER Unit No: F000838076

Phys: BATAM - Battisti,Amanda DO Acct: F01034274115

Reason For Exam: ? Exam Date: 10/02/2015

EXAMS:
002452015 CT HEAD W/O CONTRAST

Reason for Exam::
AMS - Altered Mental Status

HISTORY:

Altered mental status, confusion, history of seizures, recently stopped taking seizure medication

COMPARISON:
None

TECHNIQUE:
Axial CT images were obtained through the brain and posterior fossa without intravenous contrast.

FINDINGS:
Unenhanced images of the brain demonstrate no signs of acute infarct or hemorrhage. There is chronic cortical thinning and encephalomalacia in the bilateral parietal regions, left greater than right. Lateral ventricles midline structures are otherwise unremarkable. There are no acute extra-axial fluid collections. Orientation of the lateral ventricles suggest partial agenesis of the corpus callosum. There is no mass effect. There are no acute bony abnormalities.

IMPRESSION:

1. No acute intracranial process.

** Electronically Signed by MICHAEL H BROWN MD **
** on 10/02/2015 at 1200 **
Reported and signed by: MICHAEL H BROWN MD

POOR ORIGINAL

POOR ORIGINAL

PRINTED BY:mva7372 DATE 12/1/2017

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to:**

• **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

• **Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Facility Privacy Official. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

• **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

• **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to the Facility Privacy Official.

We are required to agree to your request ***only*** if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), **and** 2) your information pertains solely to health care services for which you have paid in full. **For other requests, we are not required to agree.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

• **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

• **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link. To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

FACILITY PRIVACY OFFICAL
Gina Trahey-Romanuk
843.692.4423

HCA

TOGETHER, PERFORMING AT A HIGHER STANDARD.™

Effective Date: September 23, 2013

GSH 05077

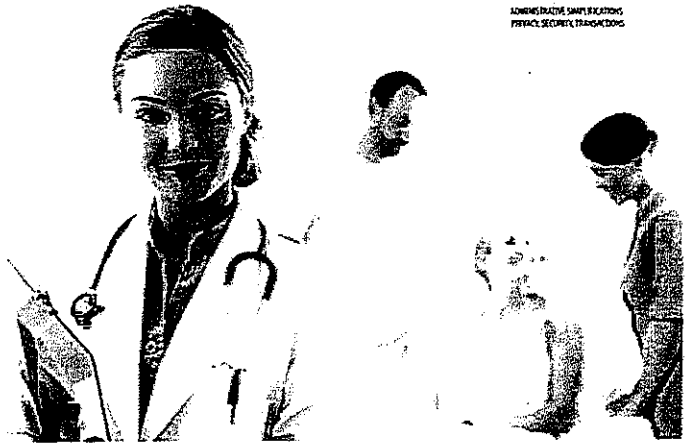
Grand Strand Medical Center

NOTICE OF PRIVACY PRACTICES

Please review it carefully

843-692-4423

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
HIPAA
ADMINISTRATIVE SIMPLIFICATIONS
PRIVACY, SECURITY, TRANSACTIONS



Resp. to Plff's 3rd RFP
001

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

Our Responsibilities: We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. We will abide by the terms of this notice.

Uses and Disclosures: How we may use and disclose Health Information about you. The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the facility also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays. We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

Fundraising: We may contact you to raise funds for the facility; however, you have the right to elect not to receive such communications.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Directory: We may include certain limited information about you in the facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (e.g., good, fair) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory please request the Opt Out Form from the admission staff or Facility Privacy Official.

Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort in order to assist with the provision of this notice.

Research: The use of health information is important to develop new knowledge and improve medical care. We may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). You may also be contacted to participate in a research study.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease management programs, wellness programs, research projects, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Affiliated Covered Entity: Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.

Health Information Exchange/Health Information Organization: Federal and state laws may permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

As required by law. We may disclose information when required to do so by law.

As permitted by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors and Coroners
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- A person or persons able to prevent or lessen a serious threat to health or safety

Law Enforcement: We may disclose health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

For Judicial or Administrative Proceedings: We may disclose protected health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

Authorization Required: We must obtain your written authorization in order to use or disclose psychotherapy notes, use or disclose your protected health information for marketing purposes, or to sell your protected health information.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

We may also use and disclose health information:

- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- For population based activities relating to improving health or reducing health care costs;
- For conducting training programs or reviewing competence of health care professionals; and
- To a Medicaid eligibility database and the Children's Health Insurance Program eligibility database, as applicable

When disclosing information, primary appointment reminders and billing/collections efforts, we may leave messages on your answering machine or voice mail.

Notice of Privacy Practices

En Español

Grand Strand Medical Center

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Official by dialing the main facility number at (843) 692-1000.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

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We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. We will abide by the terms of this notice.

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- FACILITY PRIVACY OFFICIAL: Please dial the telephone number below and ask for the facility privacy official.
- Telephone Number: (843) 692-1000

Grand Strand Health

Grand Strand Medical Center
809 82nd Pkwy
Myrtle Beach, SC 29572

Telephone: (843) 692-1000

Quick Links

HCA South Atlantic
115 Central Island St, Suite 400
Charleston, SC 29492
(855) 432-7285

HCA South Atlantic Hospitals

Coliseum Health System

Coliseum Northside Hospital

Coliseum Center for Behavioral Health

Colleton Medical Center

Doctors Hospital of Augusta

Fairview Park Hospital

Grand Strand Medical Center

HCA South Atlantic Division

Memorial Health

Memorial Hospital Jacksonville

Memorial Satilla Health

Moncks Corner Medical Center

Orange Park Medical Center

Summerville Medical Center

Trident System

Trident Medical Center

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Acceptable Use Policy HCA Nondiscrimination Notice Accessibility

Grand Strand Health

Origination:	*4/13/2004*
Approved:	*6/6/2014*
Last Revised:	*4/13/2004*
Next Review:	*6/5/2017*
Owner:	*David Brooks: VP of Operations/ Risk Management*
Policy Area:	*Patient Rights*
References:	

Informed Consent

SCOPE:

This policy applies to Grand Strand Medical Center (GSMC) and its Departments.

PURPOSE:

To provide patients with all the information about the risks, benefits and alternatives, in terms they can understand, to enable a competent person to make an informed decision to consent to or refuse an operation/ procedure(s). Additionally, this policy supports the patient's right to self determination and active participation in decisions about his or her care, to the extent permitted by law. No policy, however, can ensure that patients or surrogates understand all of the information provided to them.

POLICY:

It is the policy of GSMC and its Departments to provide patients and/or their surrogates with comprehensive information in order to enable them to make informed choices about their medical care, which fit within the framework of their individual circumstances and personal value system.

I. **Definitions**

A. **Informed Consent** has two elements: **Informed** refers to information given to the patient (and/or surrogate) about a proposed operation/procedure(s), sedation analgesia, or treatment; **consent** refers to the patient's voluntary and non-coerced acknowledgment of receipt of the information and agreement to the operation/procedure(s), sedation analgesia, or treatment.

B. **Unable to consent:** A patient is defined as unable to consent when unable to:

1. appreciate the nature and implications of his or her condition and proposed health care;
2. make a reasonable decision concerning the proposed health care; or
3. communicate that decision in a clear and unambiguous manner.

This includes patients who are under the influence of any level of consciousness altering substance, such as a narcotic. This definition does not apply to minors and does not affect the delivery of care to minors, unless they are married or have been determined, legally, to be emancipated.

A patient's inability to consent must be certified by two licensed medical practitioners, one of which is a

physician. Documentation of inability and physician signatures, along with the date and time must be noted on the Informed Consent form in the space provided. However, in an emergency, the patient's inability to consent may be certified by one physician responsible for the care of the patient. However, that physician should state in writing in the patient's medical record, that the delay caused by obtaining certification by two physicians would have been detrimental to the patient. A certifying physician should document an opinion regarding the cause, nature, extent, and expected duration of the patient's inability to consent.

PROCEDURE:

I. **When Informed Consent is Required**

A. **General Consent for Treatment** is obtained from patients upon admission and covers routine procedures. These include, but are not limited to, medication therapies, laboratory tests, non-invasive radiographic procedures and non-invasive cardio-pulmonary procedures.

B. **Situations Requiring Informed Consent** - Informed Consent for specific procedures will be obtained by the patient's physician prior to the initiation of any elective surgical intervention or special diagnostic or therapeutic procedure that meet any of the following criteria:

1. Surgical or invasive in nature
2. Sedation analgesia procedures
3. Presenting greater than minimal risk to the patient
4. Irreversible
5. Experimental or investigational

C. **Required Elements** – The information to be provided as part of the Informed Consent process includes, but is not limited to:

1. the name of the procedure (in legal and laymen terms, i.e. appendectomy/removal of appendix without the use of abbreviations)
2. the general nature of the proposed treatment or procedure
3. the potential risks, benefits, and drawbacks of the proposed treatment or procedure
4. reasonable therapeutic alternatives and the risks associated with such alternatives
5. the possible risks of non-treatment
6. the right to refuse
7. no guarantee implied
8. likelihood of success
9. disposition of tissue or organs
10. potential problems, related to recuperation
11. patient and/or family input
12. use of photography (including recordings, films or other images)
13. observations
14. presence and/or participation by manufacturer representative

15. name of practitioner(s) performing the procedure(s) or important aspects of the procedure(s), as well as, the names(s) and specific significant surgical tasks that will be conducted by practitioners other than the primary surgeon/practitioner. (Significant surgical tasks include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues.) Refer to Informed Consent Addendum Acknowledging Other Practitioner(s).

D. **Acknowledgement and Authorization** - The patient's (or surrogate's) signature on the Informed Consent form serves as acknowledgment that he or she has received at least the above-mentioned elements associated with the proposed operation/procedure(s) and is voluntarily agreeing to proceed. When a patient is not able to sign the Consent form and a surrogate is not available, document the reason(s) why the patient cannot sign the form at the bottom of the form. No signed form can guarantee that the patient has in fact received and understood the information provided. Every effort should be made to verify their understanding, but their acknowledgment and authorization must ultimately be accepted in good faith.

E. **Time Frame for Obtaining Informed Consent –**

1. The Informed Consent process should be initiated and completed as close to the performance of the operation/procedure(s) as possible. Surgical consents will be accepted if signed up to thirty (30) days prior to the operation/procedure.
2. If there is a change in circumstances or if the patient's condition changes, the consent should be updated and reconfirmed. The physician should be notified of the change in the patient's circumstance or condition and documented in the medical record.
3. Informed Consent may not be obtained within four (4) hours of receiving sedation or narcotics, or if the patient is still under the influence of that sedation or narcotic, unless physician validates exception, in writing, at the bottom of the Informed Consent form; (must include physician's signature, date and time who is making the exception).

F. **Completion of Informed Consent Form**

1. All consent forms must be completed in ink. All blank areas must be filled in legibly. No blanks are to be left open on the completed consent form except the box requiring initials in the "Other Risks/Complications" section if that is left blank. However, if there is anything pre printed in this space or written in by hand, the box must be initialed by the patient. Patient's name must be handwritten in the P*atient's Name area*. The operation/procedure(s), date and time must be handwritten in the allotted areas on the Informed Consent.
2. The patient's (or surrogate's) signature(s) on the form must be witnessed by an individual 18 years old or older who is physically present when the patient (or surrogate) signs the document. Witnesses are witnessing signature only. The witness must sign their signature(s) and professional designation in both the body and the anesthesia section.
3. Hospital employees may act as witness to Informed Consent.
4. There shall be no additions or deletions to the form after the signature is obtained unless, the addition or deletion is dated/timed and initialed by both the patient (or surrogate) and by the witness in the area on the form where the addition and/or deletion has been made.
5. Original consent forms or a faxed consent form shall be a part of the patient's permanent medical record.
6. **Retraction of Informed Consent** - Consent is subject to retraction at any time with physician notification.

II. **Responsibility for Obtaining Informed Consent**

A. **Physician –**

1. The physician, not Grand Strand Medical Center or it's Departments, is responsible for providing the patient with the information necessary (risks, benefits and alternatives) for the patient to make an informed decision. The physician should document in the Progress Notes what was explained to the patient, and that the patient verbalized understanding of and agreement to the proposed treatment.
2. The physician explaining the procedure should complete the consent form him or herself and have the patient sign it in the presence of a witness. If the physician wants nursing personnel to complete the Informed Consent form and obtain the signature(s), he or she will write a physician order that specifies, (the name of the procedure in legal and laymen terms, i.e. appendectomy/ removal of appendix) **without the use of abbreviations**, all information necessary to accurately complete the Informed Consent form.
3. In these cases, the nurse's duty is limited to making certain that an explanation by the physician has in fact taken place, and that the patient (or surrogate) is satisfied with the explanation before the operation/procedure(s) begins. The physician is then responsible for verifying the accuracy of the completed consent form prior to the beginning of the operation/procedure(s).
4. Anytime a physician is informed that a patient does not fully understand the proposed operation/ procedure, he or she should discuss it further with the patient and document this additional explanation and its outcome in the patient's medical record.

B. **Anesthesiologist/Physician –**

1. The Anesthesiologist/Physician who obtains consent for anesthesia should sign, date and time the Informed Consent after discussing the types of anesthesia with the patient including the risks, benefits and alternatives to each type.

C. **Nursing Personnel –**

1. In response to a physician order, nursing personnel may complete the Informed Consent and have the patient sign the consent on both signature lines (the main body and the anesthesia narrative).
2. In these cases, the nurse should ascertain, by querying the patient (or surrogate), that an explanation of the operation/procedure(s), has occurred, **by the physician requesting consent or another physician,** prior to having the patient sign the form.
3. An opportunity to ask questions should be provided. If the patient indicates that he or she does not fully understand the operation/procedure, the physician should be consulted prior to obtaining the patient's signature(s) on the consent form, and this should be documented in the patient's medical record.

D. **Hospital Personnel –**

1. If the individual who consented indicates that he or she doesn't fully understand the operation/ procedure(s) or treatment, hospital personnel should notify the physician and document it in the patient's medical record.

III. **Who May Consent**

A. **Adult Patient –**

1. A competent, adult patient may sign for his or her own medical care. Adult, defined by the state of South Carolina, is any individual who has reached the age of 18. If the patient is unable to write their name, GSMC will accept an "X" made by the patient, as long as there are two (2) witnesses to the patient marking an "X" with signature(s) of both witnesses on the Informed Consent.

B. **Adult Unable to Consent** – If an adult patient is unable to consent as previously defined in this policy, the following persons, in order of priority, may consent or withhold consent for any operation/ procedure:

1. A guardian appointed by the court pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of the guardianship;
2. An attorney-in-fact appointed by the patient in a durable power of attorney executed pursuant to Section 62-5-50 1, if the decision is within the scope of his or her designated authority;
3. A person given priority to make health care decisions for the patient by another statutory provision;
4. A spouse of the patient, unless the spouse and the patient are separated pursuant to one of the following:
    a. entry of a pendente lite (pending) order in a divorce or separate maintenance action;
    b. formal signing of a written property or marital settlement agreement;
    c. entry of a permanent order of separate maintenance and support, or of a permanent order approving a property or marital settlement between the parties;
5. A parent or adult child of the patient;
6. An adult sibling, grandparent, or adult grandchild of the patient;
7. Any other relative by blood or by marriage who reasonably believed by the health care professional to have a close relationship with the patient.
8. If persons of equal priority disagree about a consent decision, the Ethics Committee may serve as a mechanism for mediating the conflict. In cases unable to be resolved, the Probate Court may be petitioned.
9. An agent may not be appointed who is unable to consent (by definition), unavailable or unwilling to make decisions; or if there is prior knowledge that the patient did not want that person involved in decisions concerning their care.
10. An agent authorized to make decisions must make those decisions based upon the patient's wishes if known or in the patient's best interest.

C. **Minors (Any person under 18 years or age)** – The consent of a parent or legal guardian is required before medical treatment may be initiated. If parent or guardian is not available, consent should be obtained from someone in **loco parentis** (someone who occupies the place of the parent in their absence). Exceptions to the requirement for parental consent are as follows:

1. **Married Minors**: Any married minor may consent to any lawful diagnostic, therapeutic, surgical, or postmortem procedure on: (a) his or her own behalf, (b) behalf of his or her spouse if they are unable to give consent; (c) behalf of his or her minor children.
2. **Minor who has borne a child**: May consent to any health services for the child to include disposal of stillborn fetus and abortive contents.

3. **Unmarried Minor 16 Years or Older**: May consent to any health service for him or herself without the consent of another person, except no operation shall be performed on such minor unless it is essential to the health or life of the minor in the opinion of the physician performing the operation/procedure(s) and a consulting physician if one is available.
4. **Certain health services can be rendered to minors** of any age without the consent of parent or guardian: Minors of any age may be rendered health services of any kind without the consent of a parent or guardian when, in the judgment of authorized health care providers, such services are necessary; or if an operation/procedure(s) is required, such operation/procedure(s) is deemed to be necessary to the health or life of the minor in the opinion of the physician performing the operation/procedure(s), and a consulting physician if one is available.

IV. **Telephone Consent**

A. All telephone consents must be obtained from a competent family member or legal guardian, as listed in **Section III, "Who May Consent"**. The person giving verbal consent should be instructed to sign the consent form upon arrival at the Hospital.

B. All telephone consents must be witnessed by two (2) individuals other than the physician; the witnesses must listen to the telephone conversation and sign as witnesses on the consent form in both sections.

C. The following must be documented in the patient's medical record:

1. the name and relationship of the person giving consent;
2. any information and instruction given by the individual;
3. the name of the individual who witnessed the verbal consent.

V. **Refusal of Consent**

A. Any adult patient (or surrogate) has the right to refuse any medical or surgical operation/ procedure(s). In such situations the physician is encouraged to:

1. Advise the patient (or surrogate) of the medical consequences of the refusal, in the presence of a witness.
2. Document the discussion and refusal in the patient's medical record.

VI. **Implied Consent**

A. Emergency Situations (See **Section VII**)

B. Consent is implied when the patient has consented to operation/procedure(s) for the purpose of remedying a condition rather than to a specific procedure and additional operation/procedure(s) necessary to remedy the condition discovered during the performance of the initial operation/ procedure.

C. Consent is implied when the patient has consented to a particular surgical procedure and while the patient is under anesthesia, the surgeon finds an unrelated condition which can be cured or remedied by surgery, and it is not feasible to consult the patient or someone who can give consent on the patient's behalf at a time when the treatment decision must be made.

VII. **Emergency Situations**

A. No consent is required under certain circumstances that are defined by the patient's condition. Under such circumstances, the operation/procedure may be performed without the patient's expressed consent if the following criteria are met and fully documented by the physician in the patient's

medical record:

1. The patient is unable to give consent and if time permits, a reasonable effort is made to locate someone with the authority to consent for the patient or if there is not sufficient time to locate such person.
2. The patient is in danger of death, losing a vital organ or limb, permanent disfigurement or irreparable damage to his or her health.
3. The procedure is necessary to relieve intractable suffering and attempt to locate someone with the authority to consent has been unsuccessful.

VIII. **Communication Barriers**

A. If a foreign language communication barrier exists, appropriate steps as outlined in the Language/ Communication Assistance Policy – 410 (401.1 previous number) should be taken to ensure the accurate and effective exchange of information during the consent process

B. If there is a hearing or speech communication barrier, the Language/Communication Assistance Policy – 410 (401.1 previous number) outlines the steps that should be taken.

IX. **Documentation**

A. Any records of communication with the patient and/or surrogate decision maker, such as telephone calls or e-mails must be a part of the medical record.

REFERENCES:

Article 5, Part 3, South Carolina Probate Code, Section 62-5-501
GSMC's Patient Rights Policy 410 - Language Assistance Policy
The Joint Commission RI.01.03.01

ATTACHMENTS:

1. GSMC General Informed Consent for Operations/Procedure(s), Anesthetics, Sedation Analgesia and Other Medical Services
2. Informed Consent Addendum Acknowledging Other Practitioner(s)
3. Blood Refusal Form

Attachments:

400.00A General Inform Consent.pdf
400.00B InformedConsent Addendum.pdf
400.00C Refusal of Blood Form English and Spanish.pdf

Group/MD	Practitioner	Task(s)
Cardiothoracic		
Dr. Vu T. Hoang Dr. A. Brian McIntyre	Michael Wetzel, PA Ernest Stokes, PA	Assist in surgery; closure of incisions/ wounds; radial artery and saphenous vein harvesting (open/minimally invasive endoscopic); prep and drape in sterile fashion; debridement of wounds
General/Vascular		
Dr. Christopher Boullion	Amanda Barber, PA-C	Assist supervising surgeon or alternate supervising physician in operating room; insertion and removal of urinary catheter; removal of sutures; removal of drains; changing dressings; closure of incisions/wounds
Neurosurgery		
Dr. Eugene Giddens Dr. Tom Anderson	Aimi Dalness, PA Erin Finley, PA	Assist supervising surgeon or alternate supervising physician in operating room; insertion and removal of urinary catheter; removal of sutures; removal of drains; changing dressings; closure of incisions/ wounds
Strand Orthopaedics		
Dr. Wayne Bauerle Dr. Clark Butler Dr. Steven Callihan Dr. Thomas Chambers Dr. David Everman Dr. Joe Jarrett Dr. Robert Leak Dr. James Merritt Dr. Alexander Pappas Dr. Richard Ward	Joe Bethle, PA David B. Lee, PA Don McCawley, PA-C	Assist supervising surgeon or alternate supervising physician in operating room; insertion and removal of urinary catheter; removal of sutures; removal of drains; changing dressings; closure of incisions/ wounds

***Signature Lines on back of sheet**

GRAND STRAND REGIONAL MEDICAL CENTER
INFORMED CONSENT ADDENDUM
ACKNOWLEDGING OTHER PRACTITIONER(S)

Patient Information/Label

Strand Regional Ortho		
		Assist supervising surgeon or alternate supervising physician in operating room; insertion and removal of urinary catheter; removal of sutures; removal of drains; changing dressings; closure of incisions/ wounds
Other		

I have been informed the name(s) of any practitioner performing the procedure(s) or important aspects of the procedure(s), as well as the name(s) and specific significant surgical tasks that will be conducted by practitioners other than the primary surgeon/practitioner.

Signature of Patient or Surrogate	Date	Time
Witness to Signature Only	Date	Time

GRAND STRAND REGIONAL MEDICAL CENTER
INFORMED CONSENT ADDENDUM
ACKNOWLEDGING OTHER PRACTITIONER(S)

Patient Information/Label

TREAT *3400301332 (11/18/11) 852609*

GRAND STRAND REGIONAL MEDICAL CENTER
GENERAL INFORMED CONSENT FOR OPERATION/PROCEDURE(S), ANESTHETIC, SEDATION ANALGESIA AND OTHER MEDICAL SERVICES

DATE: _____ **TIME:** _____

1. I authorize the performance upon _____ , of the following
(PATIENT'S NAME)

operation/procedure(s) _____
In legal and laymen terms without the use of abbreviations

_____

_____

_____

to be performed by Dr. _____ and such associates as technical assistants,
(PHYSICIAN'S NAME)

other health care providers, students or manufacturing representatives as may be selected by him/her to perform such operation/procedure(s).

2. I recognize that during the course of the operation/procedure(s), sedation analgesia unforeseen conditions may necessitate additional or different procedures or services other than those set forth above. I further authorize and request that the above named surgeon and/or his/her associates, partners, assistants or designees perform such procedures as his/her professional judgement deem necessary and desirable.

3. I consent to the disposal by hospital authorities of any tissue, members or organs, which may be removed, from my person during the course of the operation/procedure(s). I have the right to request you give any explanted device(s) to me (the patient) or authorize the release of any explanted device(s) at the time of the surgery/procedure.

4. I **(Do)** _____ or, I **(Do NOT)**_____ consent to the use of blood &/or blood products as deemed necessary during this
Pt./Surrogate initials **Pt./Surrogate initials**
operation/procedure(s).
(Refusal requires completion and signature of the Blood Utilization Refusal Form.)

5. I **(Do)** _____ or, I **(Do NOT)**_____ consent to photographs (including recordings, films or other images) to be
Pt./Surrogate initials **Pt./Surrogate initials**
taken and/or utilized for teaching with no identifiable features shown in photograph(s).

6. I **(Do)** _____ or, I **(Do NOT)** _____ consent for an observer(s) for the purpose of education.
Pt./Surrogate initials **Pt./Surrogate initials**

7. The nature and purpose of this operation/procedure has been explained to me including possible **alternative methods** and **benefits** of treatment just as there may be **risks and hazards** in continuing my present condition without treatment. There are also **risks and hazards related to the performance of the surgical, any therapeutic, diagnostic procedure(s) and/or sedation analgesia** planned for me. I realize that common to surgical, medical, and/or diagnostic procedures is the potential for pain, infection, blood clots in veins and lungs, hemorrhage, allergic reactions, radiation burns, stroke, and even death.

(OTHER RISKS/COMPLICATIONS)

_____ Initials ☐

I am willing to accept these other risks/complications by affixing my initials on the line above. No guarantee or assurances have been given by anyone as to the results that may be obtained by the medical treatment or services rendered to me. I understand that my Advance Directive will **not** be honored when going into the operating room for a surgical procedure.

8. I understand the nature of the proposed operation/procedure(s) and attendant risks involved as described above. I have been given an opportunity to ask questions about my condition and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved. And, I believe that I have sufficient information to give this informed consent. I, the undersigned, have had this form explained to me and fully understand the contents of this authorization.

(PATIENT OR SURROGATE)	(WITNESS TO SIGNATURE ONLY)	(TITLE)
(RELATIONSHIP TO PATIENT)	(DATE OF SIGNATURES)	(TIME OF SIGNATURES)

*A telephone consent must be witnessed by two (2) individuals other than the physician; the witnesses must listen to the telephone conversation given by a competent family member or legal guardian as listed in **Section III, "Who May Consent"** (400 Informed Consent) listing their name and relationship to patient, then sign, date and time as witnesses on the consent in both the surgery section and anesthesia section.

I have counseled this patient as to the nature of the proposed operation/procedure(s), benefits, attendant risks involved and alternative forms of treatment and I have fully answered all of the patient's questions.

(PHYSICIAN OBTAINING CONSENT)	(DATE)	(TIME)

I, _____ (PATIENT'S NAME), acknowledge that I will receive the administration of such anesthetics/sedation analgesia as may be considered necessary or advisable by the person responsible for such service. I understand that anesthesia involves additional risks and hazards as indicated by the brochure I received and read. I request the use of anesthetics for the relief and protection from pain during the planned operation/procedure(s) and any additional procedure(s). I realize the type of anesthesia might have to be changed without explanation to me. I understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards, which may result from the use of general anesthetics, range from minor discomfort to injury to vocal cords, eyes or teeth. I understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain. I also acknowledge that I may not see my anesthesiologist until the day of surgery. My signature acknowledges that I understand that anesthesia will be explained to me prior to the administration of sedation or other anesthetic agents.

(PATIENT OR SURROGATE)	(WITNESS TO SIGNATURE ONLY)	(TITLE)
(RELATIONSHIP TO PATIENT)	(DATE OF SIGNATURES)	(TIME OF SIGNATURES)

I have counseled this patient as to the nature of the use of anesthetics/sedation analgesia, benefits, attendant risks involved and alternative forms of treatment and I have fully answered all of the patient's questions.

(ANESTHESIOLOGIST OBTAINING CONSENT)	(DATE)	(TIME)

Special circumstances related to inability to obtain informed consent: _____

_____

(PHYSICIAN SIGNATURE DOCUMENTING SPECIAL CIRCUMSTANCES)	(DATE)	(TIME)

GRAND STRAND REGIONAL MEDICAL CENTER
INFORMED CONSENT

Patient Information/Label

TREAT *3400305014 (09/28/11) 573942*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Director
Office for Civil Rights
Washington, D.C. 20201

January 15, 2013

Message to Our Nation's Health Care Providers:

In light of recent tragic and horrific events in our nation, including the mass shootings in Newtown, CT, and Aurora, CO, I wanted to take this opportunity to ensure that you are aware that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule does not prevent your ability to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when you believe the patient presents a serious danger to himself or other people.

The HIPAA Privacy Rule protects the privacy of patients' health information but is balanced to ensure that appropriate uses and disclosures of the information still may be made when necessary to treat a patient, to protect the nation's public health, and for other critical purposes, such as when a provider seeks to warn or report that persons may be at risk of harm because of a patient. When a health care provider believes in good faith that such a warning is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the Privacy Rule allows the provider, consistent with applicable law and standards of ethical conduct, to alert those persons whom the provider believes are reasonably able to prevent or lessen the threat. Further, the provider is presumed to have had a good faith belief when his or her belief is based upon the provider's actual knowledge (i.e., based on the provider's own interaction with the patient) or in reliance on a credible representation by a person with apparent knowledge or authority (i.e., based on a credible report from a family member of the patient or other person). These provisions may be found in the Privacy Rule at 45 CFR § 164.512(j).

Under these provisions, a health care provider may disclose patient information, including information from mental health records, if necessary, to law enforcement, family members of the patient, or any other persons who may reasonably be able to prevent or lessen the risk of harm. For example, if a mental health professional has a patient who has made a credible threat to inflict serious and imminent bodily harm on one or more persons, HIPAA permits the mental health professional to alert the police, a parent or other family member, school administrators or campus police, and others who may be able to intervene to avert harm from the threat.

In addition to professional ethical standards, most states have laws and/or court decisions which address, and in many instances require, disclosure of patient information to prevent or lessen the risk of harm. Providers should consult the laws applicable to their profession in the states where they practice, as well as 42 CFR Part 2 under federal law (governing the disclosure of substance abuse treatment records) to understand their duties and authority in situations where they have information indicating a threat to public safety.

We at the Office for Civil Rights understand that health care providers may at times have information about a patient that indicates a serious and imminent threat to health or safety. At those times, providers play an important role in protecting the safety of their patients and the broader community. I hope this letter is helpful in making clear that the HIPAA Privacy Rule does not prevent providers from sharing this information to fulfill their legal and ethical duties to warn or as otherwise necessary to prevent or lessen the risk of harm, consistent with applicable law and ethical standards.

Leon Rodriguez

APPLICATION FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR MENTAL ILLNESS

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

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

IN THE MATTER OF:

Person alleged to be mentally ill | Sex | Birthdate | Age | Race | Marital Status

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

TO THE HOSPITAL DIRECTOR:

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

or to _____
NAME OF NON-SCDMH HOSPITAL

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

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

_____

_____

2. That the applicant bases his/her belief on the following grounds:

_____

_____

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

_____

_____

4. That next-of-kin of allegedly mental ill person is _____
Name

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

In case of next-of-kin cannot be contacted, notify _____

_____
Relation | Address | City and State | Zip | Phone Number

SWORN to before me this

_____ day of _____,

_____
Notary Public for South Carolina or Probate Judge

My Commission Expires: _____

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

X _____
Applicant's Signature

_____
Name of Applicant (typed or printed)

_____
Address of Applicant

_____
Telephone Number of Applicant

_____
Relation to Patient or Title, if any

(See reverse side which must be completed)

APPLICATION FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR MENTAL ILLNESS

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

PERTINENT FINANCIAL RESPONSIBILITY INFORMATION

Present Name		Full Name at Birth if Different From Present	
Education Level	Social Security Number	Occupation	Monthly Income

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

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

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

MILITARY SERVICE

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

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

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

LIST OF SCDMH PSYCHIATRIC HOSPITAL

Division of Inpatient Services G. Werber Bryan Psychiatric Hospital 220 Faison Drive, Columbia, S.C. 29203 For information and prior to all admissions call: (803) 935-7143 – All Hours	Division of Inpatient Services Bryan Psychiatric Hospital Wellspring 2100 Bull Street, Columbia, S.C. 29202 For information and prior to all admissions call: (803) 898-2038 – All Hours	Division of Inpatient Services William S. Hall Psychiatric Institute 1800 Colonial Dr., P.O. Box 202 Columbia, S.C. 29202
Patrick B. Harris Psychiatric Hospital P.O. Box 2907, Anderson, S.C. 29622 For information and prior to all admissions call: (864) 231-2600 – All Hours	Division of Inpatient Services Forensics Evaluation and Treatment Services 7901 Farrow Road, Columbia, S.C. 29203 For information and prior to all admissions call: (803) 935-6334 or (803) 898-2038 – All Hours	Psychiatry Unit Forensic Unit Children's Unit For information and prior to all admissions call: (803) 898-1662 – All Hours

NOTE: ADMINISTRATIVE PROCEDURE – FORMS:

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

NOTE: TO LICENSED PHYSICIAN:

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

NOTE: TO POLICE AND OTHER OFFICERS OF THE PEACE:

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

NOTE: TO FRIENDS AND RELATIVES:

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

Date Signature of Friend or Relative/Relationship

PART II
CERTIFICATE OF LICENSED PHYSICIAN
EXAMINATION FOR EMERGENCY ADMISSION

NAME OF PERSON EXAMINED _____ AGE _____ COUNTY OF RESIDENCE _____

PLACE OF EXAMINATION _____ HOUR AND DATE OF EXAMINATION _____

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

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

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

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

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

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

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

_____, M.D. _____
TYPED OR PRINTED NAME PHONE NUMBER

_____
ADDRESS

All information MUST be typed or clearly printed

PART II
CERTIFICATE OF LICENSED PHYSICIAN
EXAMINATION FOR EMERGENCY ADMISSION

Name of Patient	Sex	County of Residence	Date of Birth	Age

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

Reasons for psychiatric admission (specify symptomatology) (Not necessary to repeat if completed on Page1, over).

Medical Condition of patient

Is patient medicated prior to transporting? ☐ Yes ☐ No	If yes, give type, amount, route and when administered.

Medication – Maintenance Drugs

HEALTH OF PATIENT

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

Patient's Operations

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

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

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

_____ ,M.D. _____	_____
SIGNATURE OF LICENSED PHYSICIAN / S.C. LICENSE NU MBER	NAME OF CENTER
_____ ,M.D. _____	_____
TYPED OR PRINTED NAME / PHONE NUMBER	SIGNATURE OF FACE TO FACE SCREENER AND DATE
_____	_____
ADDRESS	PRINTED NAME OF SCREENER, TITLE AND ID #

All information MUST be typed or clearly printed

STATE OF SOUTH CAROLINA COUNTY OF HORRY David L. Scheer, as Personal Representative of the Estate of Matthew J. Scheer, Plaintiff, vs. Southern Myrtle Inpatient Services, LLC, Nirlep A. Patel, M.D., and Rachel Ash-Bernal, M.D., Defendants.	)	IN THE COURT OF COMMON PLEAS Civil Action No.: 2017-CP-26-1571 **PLAINTIFF'S RULE 32 DEPOSITION DESIGNATIONS**

In accordance with Rule 32(a)(5) of the South Carolina Rules of Civil Procedure, Plaintiff, by and through his undersigned counsel, designate the following depositions, or excerpts therefrom, to be introduced as part of Plaintiff's case:

(1) **Rachel Ash-Bernal, M.D.** (video available)
- page 3 line 1 – page 103 line 3

(2) **Kenneth Scissors** (de bene esse) (video available)
- page 3, line 1 – page 85, line 4
- page 125, line 17 – page 135, line 23

(3) **Gregory Phaebus, M.D.** (video available)
- page 10, line 12 – page 65, line 12
- page 70, line 8 – page 72, line 3
- page 78, line 2 – page 79, line 11
- page 84, line 4 – page 85, line 17

(4) **Duane Doherty** (de bene esse) (video available)
- page 3, line 6 – page 18, line 11;
- page 23, line 5 – line 17

(5) **Lighthouse Behavioral Health Hospital**, taken pursuant to Rule 30(b)(6), SCRCP
- page 4, line 13 – page 16, line 7
- page 27, line 14 – page 29, line 29
- Exhibits 1-4

(6) **Grand Strand Regional Medical Center**, taken pursuant to Rule 30(b)(6), SCRCP

(a) Gina Trahey as corporate designee:

- page 5, line 17- page 24, line 25
- page 33, line 22- page 48, line 15
- page 49, line 17- page 52, line 13
- page 53, line 4 – page 59, line 6
- page 60, lines 8–18
- page 61, line 19 – page 63, line 3

(b) Turshara Rhodes as corporate designee

- page 4, line 14 – page 10, line 11
- page 11, line 6 – page 14, line 19
- page 15, line 17 – page 22, line 6
- page 24, line 7 – page 26, line 10

(7) **Southern Myrtle Inpatient Services, LLC**, taken pursuant to Rule 30(b)(6), SCRCP

- page 6, line 6 – page 10, line 3
- page 14, line 17 – page 15, line 9
- page 16, line 7 – page 18, line 21
- page 19, line 23 – page 20, line 17
- page 21, lines 12–14
- page 34, lines 16–21
- page 35, line 24 – page 42, line 25
- page 44, line 20 – page 46, line 11
- page 47, line 24 – page 60, line 19
- page 61, line 25 – page 62, line 6
- page 64, line 10 – line 22
- page 65, line 15 – line 23
- page 66, line 10 – page 69, line 25
- page 72, line 24 – page 74, line 24
- page 75, line 22 – page 76, page 84- line 11
- page 85, line 20 – page 86, line 14
- page 90, line 20–23

(8) **Jim Cinelli**

- page 3, line 5 – page 8, line 14
- page 10, line 2 – page 11, line 19
- page 14, line 8 – page 29, line 17
- page 29, line 24 – page 34, line 24

Respectfully submitted,

s/ *Francis M. Hinson, IV*

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May 17, 2019
Columbia, SC