THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

The Honorable John C. Hayes, III

Case No. 2017-CP-26-1571
Appellate Case No. 2019-001665

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SC Court of Appeals

David L. Scheer, as Personal Representative of the Estate of Matthew J. Scheer,.....Respondent,

v.

Southern Myrtle Inpatient Services, LLC, Nirlep A. Patel, M.D. and Rachel Ash-Bernal M.D. ..... Defendants,

Of which
Southern Myrtle Inpatients Services, LLC is.....Appellant.

RECORD ON APPEAL
VOLUME III
Pages 0911-1369

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MS. SPEARS: It's been sent to the printer.

THE COURT: Okay.

MR. PADGET: Judge, just I'm --

THE COURT: Oh, I didn't even seen you over --

MR. PADGET: -- with this printer it may take about two or three minutes for this to print because it's --

THE COURT: Okay. That's fine. Plaintiff ready?

MR. HINSON: Yes, Your Honor.

THE COURT: Defense ready?

MR. GRESH: We are, Your Honor. Thank you.

THE COURT: All right. Bring in the jury.

(Whereupon, the following takes place in the presence the jury.)

THE COURT: All right. Mr. Gresh.

MR. GRESH: Thank you, Your Honor. May it please the Court?

Good afternoon, ladies and gentlemen. Let me start where Mr. Hinson did and thank everybody for their time. You all didn't have a choice to be here. You had a choice to listen and be respectful of the witnesses, the parties, the experts, the Court as everybody tried to give you all information to do your task and everybody, everybody appreciates that.

So here's kind of what we're going to do. We're going to remove sympathy from the equation. On Monday the Court said, "Can you all be jurors? Will you take an oath with me that

you will remove sympathy from the equation?" We all said yes. Facts matter, documentation matters, common sense matters, but speculation, hindsight and sympathy don't, and that's the end of the story. This is a court of law. We must prove things. If you didn't hear it from here and you don't see it in there then it's speculation. Why? Because nobody's proven it. So then we have to think, "Wait a minute, what could have possibly happened or maybe happened?" No, sir. No, ma'am. Speculation. That doesn't matter. Hindsight, if we look back and say, "Wait a minute, we know what happens," and we look back and judge the quality of somebody's actions based on how it turned out, that's not fair. We can't do that either, and sympathy, the Judge is going to charge you on what that means and what you can do with it.

So what do we do? We decide three issues. Liability, did somebody do something wrong. Number two, if you did something wrong, did it cause, number three, harm. All three of those must be met. Your job now is to take the documents, discuss them and reach a unanimous verdict as it applies to this case. Did Dr. Patel or Ash-Bernal breach the standard of care in their treatment of Matthew Scheer. If so, has the Plaintiff proven that the breach was a proximate cause to any injuries to Matthew Scheer. If so, how much?

Why didn't I put Southern Myrtle in there? It's not a typo. Right? Now, let's just dispense with that real quick.

Southern Myrtle is the corporation that employed the two doctors. They along with Grand Strand, along with every other hospital, every other medical school, every other conference that these doctors have all went to help train on certain issues. Southern Myrtle is no different than anybody else. The only allegation against them here is some HIPAA training. Everybody's talked a lot about HIPAA. There's really no evidence that Southern Myrtle did anything. This case is about doctors and about Matthew Scheer. This is not some corporation trying the case. So let's keep the focus on what the two doctors did and didn't do.

Your Honor -- His Honor is going to charge us that what we mean by the burden of proof and he's going to tell you imagine the scales of justice. He's going to tell you that the Plaintiff bears the burden of proof, and they must prove it by a preponderance of the evidence. That means the greater weight of the evidence, and he's going to tell you look at a scales of justice. Put up in your mind. Well, here's one up on the screen. If you don't think the Defendants did anything wrong, whether they proximately caused harm or that there were any damages on any one of those issues, that that's a defense verdict. If you find it evenly balanced, the scales don't move, that also is a defense verdict. If you get back there and all we're doing is this, right, "I don't know, I don't know." That's a defense verdict. What is required is that

the Plaintiffs push it.

Standard of care, that's a word that you all've heard so much this week. Medical malpractice is a failure of a professional to exercise that degree of care and skill which is ordinarily employed by the profession under like and surrounding circumstances. That's pretty easy. What that means as it applies to this case is twofold. As to Dr. Patel, Plaintiff alleges there was poor communication with Dr. Ash-Bernal and he didn't order a PRN, that's as needed medication for Matthew Scheer. The allegation against Dr. Ash-Bernal is that she should have overruled Matthew Scheer's decision to leave the hospital and call his father. We talked a lot about involuntary commitment. The type there's tiny, but what's going to happen is the Judge is going to read all of this to you. We're not making this stuff up. Nobody is. Everybody who has sat here has said, "When you're going to commit somebody involuntarily," and he's done it for 50 years, and he's done it two or 300 times. That's not a lot for a guy who that's all he does every day is to strip people's rights two or 300 times.

"Substantial risk of physical harm to the person himself as manifested by evidence of threats or attempts at suicide." Evidence or threats of violent harm to others, "or a very substantial risk of physical impairment to the person manifested by evidence the person is disabled, gravely

disabled and reasonable provision for the person's protection is not available in the community." Folks, this is the community with a dad at the house with a house here. He'd been a resident for two years with an aunt and uncle that live next door, with friends and family surrounding him, surrounded by hospitals and doctors. This is the community. There is plenty of care available for Matthew Scheer should he have chosen to seek it. When we look at the standard of care we don't look at it in a vacuum. Plaintiff's Exhibits One and Two, Three, all of them are to kind of put perspective on this, let's see what people do when people are confronted by Matthew Scheer, not just Defendants who have experts against them or for them, what do the nonparties do when surrounded and faced with the same or worst circumstances. Does that help shed some light on what's been done right or wrong? So we start with this very notion of him coming to the emergency department and seeing Dr. Battisti, paranoia, hallucinations, voices, plotting against him, poisoning him. What does she write next? Patient denies suicidal or homicidal thoughts. Why? Because that's the issue. The issue is not whether Matthew Scheer has voices that he hears or that he thinks food is poisoned or any of those things. Dr. Battisti knows the answer, knows that, "I can't lock him up." Why? Because he has no homicidal or suicidal thoughts. That's the answer.

We go to the psychiatric, auditory hallucination, visual

hallucination, insomnia. What's the important part? Denies depression, suicide or homicide. Dr. Battisti is there for hours with Matthew. Look at Plaintiff's Exhibit One and Two or Defense exhibit. It doesn't matter. She's there for hours with him talking to him. Why? Because he's hearing things that are concerning, but she does her job. She says, "Wait a minute, it's not enough. Matthew, you're telling me that you've got stuff crawling on you that's not there," but she doesn't go grab the pink papers. She doesn't. She documents the next line no suicidal thoughts, no homicidal thoughts because she knows, like everybody knows, that's the standard. Her note continues, talks a lot about things, but always right after whatever concern she's seeing in somebody's head what does she always say, but stop, denies suicide, denies homicidal intention and plan. Remember you have to have evidence, not just evidence that somebody might do something, evidence of a plan. She's going as far as to say, "I've talked to the guy over and over. There is no evidence of anything." She thinks he's got acute psychosis, but she can't lock him up. Nobody can lock him up. He's not a danger to himself or others. She says, "Matthew, you need psychiatric treatment. You need help. You hear things, see things, feel things that aren't there. Go to Dr. Oduwole. Go to Lighthouse. Go get some help," and he's agreeable. He's like, "Yeah. I'm with my dad. Let's go, let's go do this."

"Patient understands and agrees with the plan." If she thinks he's so demented and can't possibly make a decision for himself, this wouldn't say patient. This would say, "I'm not going to waste my time talking to Matthew. He can't understand me. David, take him to Lighthouse." No ma'am, no sir, patient understands the plan.

What did the ER nurses? We didn't hear a lot about ER nurses, but just like Mr. Hinson, look at the records, yes, look at them, what everybody tells you in the records. I asked a lot of questions. Remember Dr. Malone, the forms are great. Ask all those questions on the form. They're all answered in the negative. What does -- form signed for involuntary commitment. No. Everybody is thinking, "Wow, I'm hearing, I'm hearing stuff that sounds psychiatric in nature. Do I need to go get the pink papers?" No homicidal thoughts or plans. No suicidal thoughts or plans. No commitment. So he goes to Lighthouse.

Plaintiff's Exhibit Two is what this is up on the screen. I'll tell you I can't read it. It is -- it's bigger. You'll have to take it back, but there's lines that cut there. What I did is I wrote it out here. This what I tried to do verbatim with misspellings and all right from here just so that we could talk about what Lighthouse did and didn't do for the patient. "Review the case with Dr. Oduwole." He's the psychiatrist. "Patient not medically stable and needs

attention. Case closed." "Very delusional. Confused. Disorganized thinking, but when asked a direct question he answers it and then goes right back into his thinking."

Where else have we heard that? Where else have we heard, "Wait a minute, he's on a rant but when I talk to him he stops, he listens, he answers directly." We'll see that again. Is Lighthouse so concerned that we're going to lock him up and say, "Don't let this guy leave." Remember Dr. Malone said, "We can tell, folks, hey, this is all voluntary because he's cooperative and friendly, but if he changes his mind lock him up." What does it say? Is there one of those notes telling providers what to look out for? Yes. "Pay special attention to his bilirubin and white blood cell count." There's no premonition. There's no warning, no cause for concern from the psychiatric facility back to either Conway or Grand Strand, "Hey, you all be on the lookout. This guy is having all of these concerning findings. If he tries to leave, stop him." What do they warn him about? "Work up his bilirubin levels and his white blood cell count. Pay special attention to that. As long as everything looks good medically no problem with him coming back." That's exactly the plan here. It's exactly the plan, and she goes on to say, "I talked to the -- ran this case by my doctor again and Dr. Oduwole's comfortable with this." I've got a masters level social worker. I've got a direct medical director and a

psychiatrist who are all involved in this decision-making process. None of them pick up the phone and say, "Hey, Conway, hey, Grand Strand, don't let this guy leave. I'm really concerned about what my social worker is telling me." Nobody puts in the notes be really concerned about the psychiatric issues.

So he comes back to Grand Strand, sees Dr. Battisti again, "No change in patient's symptoms since the last visit." Look at the psych again, "Auditory hallucinations, visual hallucinations, insomnia, denies depression, suicide or homicide." Dr. Battisti goes a step further and thinks, "Wait a minute, you know, what, what about that prong three. Right. Maybe, maybe homicide's not enough. Maybe suicide's not enough. Maybe this is one of those rare cases that we need to think what happens when he goes out. Let's make a note in the chart." What does she say? "Good social support, local resident, dad's here, aunt and uncle live next door, been a resident here for two years." Psychiatric again, again goes out of her way to say, "I know I'm writing all of these things which might seem concerning, but anybody who reads this later, please understand, please understand that Matthew Scheer denied, suicide, homicide and a plan to do anything bad."

You know, it's true that apparently David Scheer signed out Matthew Scheer after the first visit. I don't know why. We can all speculate, right? Did anybody take the stand right

here and say, "No, no, no, I made, I made David sign that because Matthew couldn't do it." No. No. How do I know that's not the case unless we're just speculating? Because he comes back and Dr. Battisti, after talking to Matthew, says, "Discussed with patient ED findings and plan for admission. Patient understands and agrees with the plan. All questions are answered." If Matthew Scheer is so incapacitated he can't possibly make medical decisions for himself, this would not be here. This would say, "I pulled the dad aside, and I said, 'Dad, I'm concerned your son is not all there. I need your help. Dad, I'm going to get your permission to admit Matthew.'" They formulate the plan with Dr. Oduwole. Look how long it takes Dr. Oduwole to get involved. That's okay, but, "He supposed to go to Conway. He came to Grand Strand. Threw me for a loop, but that's okay you're here, admit Matthew, get a hospitalist involved. Dr. Patel, you work up Matthew for the medical. I'll come by tonight, maybe tomorrow morning. I'll see Matthew for the psychiatric. That's the plan. Everybody got it? Great. Now, let's tell Patel, get him involved in this." That's what you see there. Patel says, "Yep. I'll see the patient. I agree with the evaluation. I agree with the plan."

The social worker comes by. Heard a lot about social workers. Didn't hear from one. Heard a lot about it. "Appears to be manic." What, if you're going to write that in

the chart you better also write what's in blue. "Patient's voluntary, is not suicidal or homicidal. They sent him back for medical clearance."

Dr. Patel, "Sent over for two things, one, psychiatric evaluation from Dr. Oduwole and abnormal white cell count and bilirubin levels." What does Dr. Patel do? "Good workup, acute psychiatric episode, tangential thinking, having visions." Here we have again, "Possible psych complaints, possible psych complaints, evaluate." You're thinking to yourself, "Wait a minute, I'm hearing things. I'm seeing things in this patient that are concerning. What do I do? Denies hallucinations. Denies suicidal ideations. Denies homicidal ideations." Everybody's looking for it. Everybody's thinking about it. Nobody finds it. Patel's note continues, "Possible psychosis." Why possible? It's not happening in front of Dr. Patel. It happened in front of Dr. Battisti. He reads the note. He talked to Dr. Battisti. He knows about that. "Currently not suicidal or homicidal. Very calm, cooperative with me during my interview and my exam. Let's keep working up the leukocytosis, the hyperbilirubinemia, disposition, additional testing in light of the above laboratory findings while he's being evaluated by Dr. Oduwole." That's the plan. Everybody knew it. Everybody agreed with it.

Now, we say -- we don't. Plaintiff says nobody did

anything for Matthew. Okay. Let's look at the chart. Right? There's a lot of lab stuff. There's a lot of psychiatric -- there's psychiatric consult, liver stuff, kidney stuff, orders the Keppra be restarted, puts him back on IV fluids. Says, "Give me an ultrasound of the abdomen. I don't know what's causing the bilirubin levels but let me see what's going on in your abdomen." There's a lot of medical clearance going on while we were waiting for the psychiatric consult, Dr. Oduwole to come see the patient but Plaintiffs say, "Well, he didn't order PRN Ativan." Right? That was PRN, PRN means as needed. Was it needed? The patient's calm, cooperative, talkative. You don't need Ativan in that situation. What did the psychiatrist with 50 years experience say? "No. Don't just drug up people who are calm. Let me evaluate them. Let me talk to them. If anybody needs it," yeah, maybe he used a little hyperbole here. "It's like water. Yeah. It's on every floor. If somebody needs it a nurse'll ask for it. It'll be given. It just takes a phone call."

Folks, we know what happens seven hours later. We know there's a phone call that the nurses say, "Hey, Dr. Ash-Bernal, can you give me some Ativan?" No. No. No. No. The nurses do the right thing and they say, "I need to get a doctor involved. We need an evaluation of this guy." This Ativan, you know, I put the red herring there on purpose. Red

herrings are things we used to drag on the ground to get foxes away from dogs, to distract people on hunting trips. That's all this is, is just a distraction. Everybody knows this has nothing to do with anything. Nobody ever asks for Ativan. Ativan was never indicated. It's just a distraction.

Dr. Patel's shift ends around 7:00 p.m. Heard a lot about Bethany Bell. I, I used with Dr. Malone, I really tried to introduce us to Bethany Bell because she's there from 7 p.m. all the way through the time that Dr. Ash-Bernal and the patient had this communication and the patient leaves AMA. Dr. -- Nurse Bell, nobody's critical of her. "Patient is calm and cooperative." Nurse Bell, as part of her initial assessment, says, "All these questions are answered to the no at the bottom, patient is at risk for suicide." Folks, the reason Plaintiffs have, you know, Exhibits One through Six and we just have one doesn't mean I'm trying to hide anything from anybody. I've shown you every record in the chart where somebody has addressed Matthew's psychiatric concerns and what their response was. This is not a game of obfuscation. I'm not trying to hide anything. There's nothing -- I'm not trying to hide anything here. Everybody wants the records. They have the burden of proof. They have to go first. If they didn't put in Lighthouse records, we'd had Defendant's Exhibit Two. Right? They said -- if they didn't put in the transfer record, it's got acute psychosis on it. Nobody's

running from that. If it said, "Acute psychosis, don't let him leave if he tries to leave," yeah, we would all be talking about that, but it doesn't. Instead everybody who sees Matthew asks him in whatever their education, training and experience allows, "Talk to me Matthew. What's going on? Why are you here? Are you sad? Has anything big, bad happened in the last couple of weeks that we should talk about?" No. No. No. Patient is at risk for suicide: no. From the time he gets there about 7 p.m., excuse me, the time Bethany Bell gets there about 7 until one there is no change. He's always cooperative. He's always calm.

1:13, from the nurses' perspective this is a change in behavior, absolutely. Matt was just calm, cool, collected. Now he's got his shirt off and his armband off. That's a change. It's -- maybe if we look at all of the record, maybe if the nurse went all the way back to the ER and saw, "Wait a minute. He'd already been complaining about psychiatric stuff, hallucinations and otherwise," maybe it wouldn't be a big change, but it is to these nurses. They did the right thing. Okay. They called the doctor, called the doctor in for evaluation at 1:13, and Dr. Ash-Bernal, thank goodness, she's walking down the hallway. This isn't a page and 30 minutes later there's a return phone call and a, "Yeah, I'm finishing up this, you know, thing. I'll be up there in 30 minutes." She's walking down the hallway when the nurses go

grab her. She immediately talks to the nurses. "What's going on?" Patient starts with this idea that, "I'm here voluntarily and I know you can't keep me." Really? Somebody who doesn't know where they are or what they're thinking starts with, "Man, I know my constitutional rights. I'm voluntary. I know that by being voluntary means you can't keep me."

Nobody thought of HIPAA until a lawsuit? Come on, let's look at the chart, "Offered to call patient's father for him to speak to, patient refused." Why would that be in there if it didn't happen, if it wasn't important. Of course it's important. This is not some excuse that people make up on the witness stand. It's the truth. They document it at the time. Everybody knew this. They go tell Dr. Ash-Bernal, "Come see this patient. Can't call his dad. I just talked to the patient. He doesn't want his father involved." It's not something that's made up later. What does Dr. Ash-Bernal do? I think everybody says the standard of care requires you to listen to the nursing staff. The standard of care would require you to review the chart. The standard of care would require you to go evaluate Matthew. The standard of care would require you to make a judgment call. Everybody who stood here or sat here said that. Some people on the Plaintiff's side say, "I know you did all of those things, but you made the wrong decision." Other people said, "I know you

did all those things and you made the right decision." This is a judgment call. This is not any kind of -- what is it -- what's the word here? Willful and wanton and recklessness. That's -- no. No, not for anybody, not at any time. This is a judgment call. What does she document? The same thing that Lighthouse did, "Not homicidal, not suicidal. He's voluntary. I can't do anything about that, and he stops his rant to talk to me." Lighthouse, the guy's all kinds of things in the Lighthouse record but he stops. He pauses. He's able to have a conversation, and they tell him to go back to the hospital, get medically cleared and come back. "You need treatment, voluntary treatment as an outpatient." If they thought, if anybody thought, "You need treatment and you need it now because you are a danger to yourself or others," this would not be Matthew's call. Lighthouse, Battisti times two, Patel, all of the nurses, everybody recognizes it does not meet that standard, but he wants to leave. There's actually agreement between Dr. Ash-Bernal and one of the Plaintiff's experts. "Folks, when a lot of people want to leave the hospital you go talk to them. Most people with a good talking to won't leave." She said that, their expert said that, our expert say that. Everybody agrees with that. Some folks just want somebody to talk to. They want answers and they stay. Some folks still say, "You know what, I'm leaving anyway." So we arm them with one more tool and say, "Hey, see if we can get

them to sign this form. Maybe if I put the words death, injury, infection, maybe that will help visual learners see it and maybe then I can keep them in the hospital. Maybe I can't just talk them into it. Maybe if they see that though they'll stay." This isn't -- that's what we did. That's what Dr. Ash-Bernal did. She said, "I have tried to talk to you. I can't do it. I'm going to try one more time. I'm going to put this form in front of you to try and scare you," and it doesn't work, but, "I'm going to tell you you need treatment. Please follow up for your possible infection. Please follow up for your seizures that you're now at risk for. Please follow up for your psychosis." Bethany Bell's there the whole time. What does she say? Remember? Dr. Malone says, "She's there for the entire conversation. She hears the questions asked, and she hears the responses." The responses are coherent. The responses are as expected. Bethany Bell doesn't go running to the charge nurse or to the president of the hospital saying, "We need to keep the patient here." It's a second witness who witnessed all of this in real time and came to the same decision, and Dr. Ash-Bernal herself went so far as to say, "I certify that he has the capacity to understand the questions. He can make reasoned decisions other than may be against medical advice." They may not be reasonable, but if you stop, you think about the question, you weigh the risks and benefits of it and you decide, "I don't

want an IV or Keppra or to stay here against my will," that's their right if they have the mental capacity. She's the only one there, her and Bethany Bell and they both agree he did.

Get this, the Judge is going to tell you that I don't prove, Mr. Hinson doesn't prove compliance with or deviation from the standard of care based on the number of witnesses, and I think that's true. I think that's true as a matter of law, that we ought not to think about it and say, "Who had an opportunity to evaluate Matthew? Who talks to him when he was there? Who looked him in the eye and said, 'Why are you here? What are you thinking? Are you a suicide risk? Are you a homicide risk?'" Every one of those people, except for the bottom two on the left and the bottom two on the right, had that opportunity. Those that were there at the time, without the benefit of hindsight, without the benefit of sympathy, looked at Matthew Scheer and said, "You need help but I can't force you to take it."

Standard of care experts, in a case like this where it's medical malpractice, everybody has to call experts, and the Plaintiffs called Tim Malone. He's a psychiatrist, and he says in his deposition, "I'm not sure what hospitalists do. I don't know how they give handoffs. I don't know -- I've never been a hospitalist. I don't know what they do but I do know Patel did it wrong." "Well, how you know that?" "I don't know but I know he did it wrong." We'll come back to that.

And then he's asked the question, "Well," and we've heard a lot about it, "Let's go up the chain of command. What does the hospital think? Does the hospital think we can call the dad?" What did Dr. Malone say? "No. Yeah. I read that deposition." The guy at the top of the food chain says, "Wow, in this situation I defer to the hospital." Don't you think if the president of Grand Strand said, "No, the father should have been called," he'd be sitting right there or she, I don't know who it is, would be sitting right there saying, "I apologize to all of you, the community."

MR. HINSON: Objection, Your Honor.

THE COURT: Yeah. I sustain the objection as to what some, some witness would say.

MR. GRESH: But what he did say --

THE COURT: Just, just disregard that argument, members of the jury.

MR. GRESH: Because we know what he did say and he did say, "I would defer to the judgment of the physician that's there," and then Dr. Malone apparently has the opinion that when you look at South Carolina law it's not just homicide or suicide. Anybody who's delusional or has paranoia or religious beliefs that are too concerning we have to lock all of them up. They're not free to leave on their own. If that were the case, do you think in 50 years you would have locked up 200 people, 300 people? It'd be thousands. This is

something we see very day. Two-thirds of the people in a family care office have some form of mental issue. If the law said delusions, lock them up, don't you think number three would say, "If delusions, lock them up"? Why all -- why would it be so wordy. Right? Why wouldn't it say, "Hey, if they're paranoid, lock them up." The standard is if they're homicidal or suicidal lock them up, and Dr. Rob Robinson, I like that, that guy, hospitalist, came here and only had criticisms of Dr. Ash-Bernal, the hospitalist. Whoa, whoa, whoa, whoa, whoa. Where's the criticism of Ativan? Where's the criticism of the handoff? If you want to know how a hospitalist does a handoff don't ask a psychiatrist who says, "I don't know how they do it," ask this guy. What did this guy say about it? He did not mention Dr. Patel's name. Why? Because he knows Dr. Patel did it right. So he focused his criticism exclusively on Dr. Ash-Bernal. This idea of a corporation negligently training somebody? "This is the 70 power -- 70 page PowerPoint that I had didn't say does and don'ts. It just said don'ts," because then he says, "But yeah, they would get this training everywhere, lots of different places," negligent PowerPointing.

Oversight of nurses, I heard that today for the first time. Somehow Dr. Patel was supposed to stand over Bethany Bell and make her know what's going on? Who said that? We've been here for a week. Who took the stand and said that?

Folks, going back to what matters and what doesn't, sympathy doesn't matter, hindsight doesn't matter, the attorneys don't matter. If you think I object too much, I apologize. If you think he objects too much, I'm sure he would apologize. We don't matter. Don't find against my clients because I stand up too much or but he says, "I can't mention big giant numbers but here's some big giant numbers," don't hold things against the attorneys. This case is too important for all of the parties, but let's think about it, coming up with brand new criticisms without being a hospitalist, a doctor or anything, Patel has oversighted nurses.

Who did you hear from? Oscar Lovelace, was a hospitalist before the term hospitalist existed. Why? Because he's a small town doc. Everybody's talked about this is a new thing, the last 10 or 15 years we've really had hospitalists, but if you've been practicing in the eighties and when you went home for the night, your patients were without a physician. Holy cow. Now what if they need Ativan? I've got to wake a doctor up at three a.m. and then order Ativan? No. No. No. We've progressed as a society and said why not have hospitalists who are there all the time, 24 hours a day. We don't have to worry about continuity of care. I've always got somebody in house, and then -- you know, did I forget to ask Dr. Malone or Dr. Robinson how much they make? No. Well, it doesn't matter

in this case, how much an expert witness makes. If you can't attack an expert witness on their opinions or the basis for them, then stand up and talk about dollars. Right? "You get paid for doing this. You get paid a lot of money for doing this." Doctors are expensive. Right? We all know this, but if you've got nothing to say about the credibility of somebody or their opinions then talk about dollars. We tried to be respectful of time. Yes, everybody makes hundreds of dollars an hour to look at records, but both sides do that.

We talked a lot about facts and opinions. He simply could not be held against his will, and we called Dr. Ballenger. That's wrong. I'm not good at typing, 30 year career in South Carolina. Okay. That's right. Thirty years in South Carolina. He had 20 more in the State of Virginia. He built the Institute of Psychiatry at MUSC. If you go see a psychiatrist in this state and they trained in this state there's a really good chance they learned all that they learned about psychiatry from this guy, world-renowned expert, 16 books. I haven't read 16 books in my life. I promise you. "I stopped counting at a thousand times I lectured to folks just like Dr. Patel and Dr. Ash-Bernal and Dr. Malone about how to do this."

You start from the very basic premise, voluntary patients cannot be held against their will. You can walk into a hospital at any time you want. You can walk out of the

hospital unless, unless a doctor says, "No, ma'am, no, sir, nope, nope, nope, you came here, you're not leaving because you are homicidal or suicidal," and at that point the law has said, "I know you're not a cop. I know you're not a judge or a jury, but you as a doctor with a stroke of a pen can decide, 'I'm taking away this person's rights. They no longer know what is best for them. I do and you're so far out there I'm going to stop you.'" Simply no evidence to commit him. What if he did? Doc, what if Dr. Ash-Bernal was kind of like Dr. Malone and said, "Ethics, hogwash, standard of care acknowledged, what if I locked him up anyway?" Unethical, illegal and below the standard of care to lock up Matthew Scheer in these circumstances.

Goes without saying, this is a sad case. If the disappearance and death of Matthew Scheer does not pull at your heartstrings, I just don't even know what to say about that, but what I do know to say about that is we must take that and set that aside and focus on the medicine. Hindsight, we are not going to hold people liable for things that only at the end when we know the outcome where everybody might have a different opinion. That's not fair.

When we think about did Dr. Patel and Dr. Ash-Bernal deviate from the standard of care, it's just not there. They also have to prove proximate cause.

We go to law school first year class they teach you is

torts. Half of your torts class for an entire year is on proximate cause. You all are about to get a four-minute crash course in what proximate cause is and is not and that's the best that we allow as a society. As for Dr. Patel you have to think did his failure to order PRN medicine or talk to Ash-Bernal do anything? Folks, we talked about Ativan. Let's leave that alone.

What about this issue of a handoff? Well, they're hospitalists. The only hospitalist on their side didn't even say you had to have one, but what if he did? Is Dr. Ash-Bernal going to learn anything from that handoff that she didn't learn from Dr. Patel's three-page dictated note? That's amazing to me that we can have a note that is immediately after this case, after he sees the patient that's three pages long. It's done on the stat line. It's typed and it's in the chart and available for somebody before 8:00 o'clock that evening. That's amazing. If anything happens, what's the first place any hospitalist is going to look to see what to do with their patient? Their partner's note. When the best the Plaintiff could come up with is, "Well, then he -- she would have known he has psychosis." Take a look at Defendant's Exhibit One, Plaintiff's Exhibit One. Take a look at the ten slides I've shown you. That's not a secret or a mystery to anybody. When a nurse runs out to you saying somebody's ripped off their shirts and their armbands, you're

thinking it whether your partner told it to you or not. Proximate cause means if I had done something would it have changed the outcome? Who took this stand and said if only Dr. Ash-Bernal knew something the outcome would be different. What's that something? How would the outcome be different? A complete failure there on proximate cause. As to Dr. Ash-Bernal, that her decision to recognize his rights to refuse treatment and let him leave the hospital, then what? We can't guess. We can't. We're going to hear the jury charge on speculation. Things must be proven.

So what, what have we heard from the Plaintiffs? That after being out all night at a country music bar Duane Doherty uses his hands as, as binoculars. That's fine. Keeps an eye on the ocean. Sees something that, that concerns him. Calls 911, concerned citizen. Takes his binoculars off of his eyes, goes down five flights of stairs, crosses lawn, causeway, whatever it is, gets down to the beach, looks right back where he was and doesn't see anything, but then says, "I'm a surfer and I know that in rip surf, you know, two feet swells like this one was in seconds would be 150 years down the beach." Folks, if we, if in our collective 531 --

MR. HINSON: Eighty-one.

MR. GRESH: -- 581 years of experience, have we ever felt a riptide like this? Yes. Then if we sit here and we can go down here but nobody can testify what happened 150 yards in

either direction of this. What we can testify to is that no body was ever found.

Now, how could he see all of this? There's, there's a thousand year flood. Noah's building an ark. No. No. What did he say? Right. Full moon.

Only if Plaintiff proves Dr. Patel and/or Dr. Ash-Bernal deviated from the standard of care and that deviation caused harm to Matthew would it be appropriate to return a verdict. Proximate cause also requires foreseeability. The Defendant cannot be held responsible for something that could not be expected to happen.

Look at Defendant's Exhibit One, Plaintiff's Exhibit One. Find me any person with any -- any person who says, "I suspect Matthew Scheer is in danger of homicide." There's no evidence that he hurt anybody. Find me anybody that says that Matthew Scheer is at risk for suicide. There's nobody. You cannot be held liable for something you can't expect to happen. We have 581 years. How much if we added up all the nursing staff, Battisti, Oduwole, medical director, licensed social worker, Patel, Ash-Bernal, add that up. Nobody had any idea what was going to happen, and David Scheer pulls at your heartstrings and he says he's angry and frustrated, and I am, too. Our mental health system needs fixing. Everybody recognizes Matthew Scheer needs help. Everybody knows that. Look at the chart. Look at how many times we talk about it. Our laws say

if he doesn't want it we can't help him. This isn't the old days where you had sanitariums, mental asylums. We used to lock people up all the time, willy-nilly things, we locked them up. Look around. They don't exist anymore. Why? Because the law is you have to be homicidal and suicidal. Maybe that's too high. Right? Maybe our burden should be like Tim Malone says that anybody that talks too much about religion or had -- has delusional thoughts. Maybe they should be locked up. Folks, we are not going to hold doctors responsible for the way we think the laws should be. We may all take out our pens and write letters to our congressmen and say, "For last week I sat through a trial. I learned about the mental health system and I think it stinks." I might do that, but I can't say that this is a good idea to say, "You followed the law, but I'm going to find against you anyway," because we, you as jurors, took an oath and you said, "Judge, I know I'm not a judge. Judge, you're going to tell me the law, and Judge, when you tell me the law, I put my right hand on this Bible, my left hand here and I promise, I swear that I will follow the law, even if following that law leaves me angry, leaves me frustrated." The standard of care is to follow the law. The standard of care is not to lock somebody up when that would be immoral, unethical and below the standard of care.

So now what? I'm done talking, but the Plaintiffs have

the burden of proof. Mr. Hinson gets to stand back up and talk -- get back at this podium and tell you more about why you should find against the Defendants, but I don't get to stand back up, and that's okay. If I haven't said all that I need to say at this point it's probably on me, but think to yourself, "What would he say if he did stand up?" We all know the facts. Nobody's tried to hide anything. We went through all of it. We all know or about to learn the law. When you look at this, you're going to be handed a verdict form. When you think about the standard of care, when you think about proximate cause, you will next think, "We, the jury, unanimously find in favor of all Defendants." Thank you very much for your time.

THE COURT: Mr. Hinson.

MR. HINSON: Thank you, Your Honor.

This case is not about locking people up. This case is not at all about sanitariums. This case is about doing your duty and giving your best efforts. The Defendants had done their duty and given their best efforts there never would have been a, been a reason to put a temporary hold on Matthew. The record reflects he calmed down after this outburst about devil worshipers and Obama and all this other stuff. If the Defendant Ash-Bernal had done her duty and she had given her best efforts, that would have been all it took. Dr. Malone testified that the vast majority of people with proper

intervention, proper intervention, best efforts can be calmed down and convinced to stay but Dr. Ash-Bernal wanted a loud, disruptive patient who was disrupting other people's rest time out of her hospital. Everybody who saw Matthew previously saw him when he was calm, cooperative and not wanting to leave, and they saw him with his dad. Of course no one put a hold on Matthew. You don't do that unless it's necessary, absolutely necessary, and it was never, ever necessary, and it probably wouldn't have even been necessary at 1:30 had Dr. Ash-Bernal given her best efforts. Well, what are we taught as children? That the law doesn't require a doctor to be perfect, but it does require best efforts. That's what our parents taught us. They didn't ask that we made straight A's and perfect on every spelling test, but they wanted us to try our best. That is her legal obligation and it's her ethical obligation. The Defendants are wrong on the medicine, they're wrong on the law and they're wrong on the morals of this case.

Everybody else who was involved in Matthew's care communicated with one another except for these two doctors. Everybody else seemed to have a good understanding of how serious this condition was. Defense counsel wants to get up and yell about how there was no evidence of him ever having suicidal thoughts or homicidal thoughts. Matthew Scheer did take his own life. The death certificates says suicide. He

did take his own life, but people who aren't in their right mind don't do it intentionally. Matthew wasn't trying to kill himself. He didn't know what was going on. When you have a patient suffering from severe mental illness, paranoid delusions, you can't just say, "Are you suicidal?" "No. Okay. You're not." "Are you homicidal?" "Oh, okay. You're not. Okay. Good." Doctors are taught better than that. We're taught -- we know better than that. We know that people having hallucinations don't always recognize they're having hallucinations. That's part of what a hallucination is. Sure there's people who say, "I was seeing things." The people who are in the active stage of having hallucinations don't realize they're not real and we have to protect those people. Matthew could have been treated. No one has said anything different. He could have been treated and made well, but he never got that opportunity. Proximate cause, you don't think if Dr. Ash-Bernal had done her duty and tried her best, arrow one in her quiver, let's just put in everything to talk to him, that probably would have worked right there and he never would have left. Arrow two, call his dad, call David. It's right there available to you, and you know the law, and you're going to see the law does not prevent that. It does not. And if necessary, which it almost surely wouldn't have come to, put a temporary hold on him, and Dr. Malone explained to you, this is not sending him away. It's a temporary hold.

They could have put him on a hold, gotten in touch with the family, put him on some Ativan or some Haldol and then released that hold. This didn't have to be permanent. This isn't handcuffs and straitjackets. This is simply saying, "Matthew, you can't leave. I'm not going to, I'm not going to give you forms and let you walk out the door. I care about my patients, and I'm not going to let you just walk out the door into a storm." That's all that was necessary. Don't be misled into thinking that this is about locking people up. This case is about trying your best because that's our duty. It's our duty -- it was my duty to the Scheers, trying my best with this family who had their hearts just ripped out from them because somebody wasn't willing to spend the time to take the choice that was a little bit harder, just a little bit harder. It's easy just to say, "Sign here, there's the door," and it would have taken some time to calm Matthew or to keep Matthew in that hospital I don't deny that. Nobody has denied that. It would have taken some work, but isn't human safety and the lives of others worth it?

I'm going to close -- I think it's appropriate to close with a quote from one of America's great presidents, John F. Kennedy, and he had a lot of memorable quotes, but there's one that I think is particularly important to this case and he said, "A country isn't graded or evaluated and as history one day looks back at our civilization and reflects the United

States it will not be thought of in terms of how powerful it was or how rich it was. The basic question that will be asked is how it treats its citizens, and more particularly, the litmus test, the real standard to judge any country or government or system is how it treats those who are most vulnerable and least able to help themselves." How do we as a society want to treat people with mental illness? Do we want to give them our best efforts or we want to have them sign a form, put them out in a storm alone at 1:30 in the morning with no cell phone, car keys, wallet or anything? We ask you to find justice for Matthew.

THE COURT: Can counsel move the TV and the podium? That's good.

Members of the jury panel, I appreciate the way you've paid attention to the attorneys and the witnesses. I'm now going to ask you to pay attention to me as I charge you the law which you are to apply to the facts as you determine them to be in this case.

I apologize for not looking up all the time but I need to read this to make sure I get it accurate. I remind you that during this trial you and I have certain duties to perform. As the trial judge it is my responsibility to preside over the trial of this case and I also have the duty to rule on the admissibility of evidence offered during the trial. You are to consider only the evidence before you. If there was any

testimony ordered stricken from the record during the trial you must disregard that testimony. You are to consider only the testimony which is presented from this witness stand and exhibits which have been made part of the record in this case and any stipulations of counsel. I have the additional duty to charge you the law applicable to this case. It is your duty as jurors to accept and apply the law as I now state it to you. If you think you have an idea as to what the law is or what the law ought to be and it does not agree with what I tell you the law is you must forget that idea because you are sworn to accept the law and apply the law exactly as I state it to you.

In every case tried in this court before a jury the jury becomes the sole and exclusive judge of the facts. A trial judge cannot comment on or make any statement about the facts in a case. Since you are the sole judges of the facts do not think by anything that I have said during the trial that I have any opinion about the facts in this case. Our law does not allow me to have an opinion about the facts. The burden of proof in this case is by a preponderance of the evidence. This simply means the greater weight of the evidence. It is evidence which as a whole shows that the facts sought to be proven is more likely true than not true. It can be illustrated by imagining a set of scales. When the case begins the scales are even. After all the evidence has been

presented if the scales remain even or if they tip slightly in favor of the Defendant, then the Plaintiff has failed to meet the burden of proof and would not be entitled to recovery. If on the other hand, the scales tip even slightly in favor of the Plaintiff, the Plaintiff will have met the burden of proof and should return a verdict for the Plaintiff -- and you should return a verdict for the Plaintiff.

The preponderance of the evidence is not determined by the number of witnesses. Instead, it must be determined by the greater weight of all the evidence.

There are two types of evidence generally presented during a trial, direct evidence and circumstantial evidence. Direct evidence is the testimony of a person who claims to have actual knowledge of a fact, such as an eyewitness. It is evidence which immediately establishes the main fact to be proven. Circumstantial evidence is proof of a chain of facts and circumstances indicating the existence of a fact. It is evidence which immediately establishes collateral facts from which the main fact may be inferred. Circumstantial evidence is based on inference and not on personal knowledge or observation. It is proof that does not actually establish the fact in question but that asserts or describes something else from which you may either reasonably infer the truth of the fact or at least reasonably infer an increase in the probability that the fact is true. For circumstantial to be

-- evidence to be sufficient to warrant the finding of a fact circumstantial evidence must lead to that fact with reasonable certainty. The facts and circumstances should be considered in light of ordinary experience and common sense. The existence of a fact cannot be based on speculation, surmise or conjecture. Our law makes absolutely no distinction between the weight or value to be given either direct or circumstantial evidence, nor is there a greater degree of certainty required of circumstantial evidence than of direct evidence. As judges of the facts you must determine the credibility of the witnesses who have testified. Credibility simply means believability. It becomes your duty as jurors to evaluate the evidence and determine which evidence convinces you it is true. In determining the believability of witnesses who have testified in this case you may believe one witness over several witnesses or several witnesses over one. You may believe a part of the testimony of a witness and reject the remaining part of the testimony of that same witness. You may believe the testimony of a witness in its entirety or reject the testimony of a witness in its entirety. You may consider whether the witness has an interest in the result of the trial, whether the witness is prejudiced toward either the Plaintiff or the Defendant. You can consider the opportunity the witness had to have seen the matters and things which the witness testified to, and you can consider the way the witness

acts on the stand. Our rules of evidence ordinarily do not permit witnesses to testify to opinions or conclusions. An exception to this rule exists for witnesses we call expert witnesses. A witness who by education and experience has become expert in some art, science or profession may give an opinion as to the subject the witness claims to be an expert in and may also give the reasons for their opinion. You should consider any expert opinion given by a witness and like other evidence give it the weight you think it deserves. If you decide that an expert witness's opinion is not based on sufficient education and experience or if you decide that the reasons given in support of the opinion are not sound or that the opinion is outweighed by other evidence, you may disregard the opinion entirely. An expert witness's testimony is to be given no greater weight than that of other witnesses simply because the witness is an expert and you do not have to accept an expert's opinion even though it is uncontradicted. Expert witness's testimony is allowed to assist the jury. It's not binding on you.

In our courts no distinction is made between corporations and individuals. A corporation is a person in the eyes of the law. A corporation is entitled to the same fair and impartial consideration and to justice by the same legal standard as an individual. One Defendant here is a corporate entity. Such entities can act directly through persons who are known as

agents or employees. A corporation is responsible for all the actions or inactions of its agents or employees that are performed within the course and scope of that agency relationship. Here it is undisputed that Dr. Rachel Ash-Bernal and Nirlep Patel were employees of Southern Myrtle Inpatient Services, LLC, at all relevant times. You should consider any acts or omissions of Drs. Ash-Bernal or Patel to be the acts of Southern Myrtle Inpatient Services, Inc. In addition, Plaintiff has alleged and Defendant Southern has denied that it, Southern Myrtle, failed to provide education and training to Dr. Ash-Bernal and Dr. Patel relating to the applicable standard to detain a mentally ill patient and permission -- permissive disclosure of health information. You may consider these alleged actions or failures of the corporation Defendant along with the other allegations.

Here the Plaintiffs claim that the Defendant committed medical malpractice, which is a form of carelessness or negligence. In order to recover for medical malpractice Plaintiff must prove by a preponderance or greater weight of the evidence, keeping in mind those scales, one, the standard of care; two, a breach of the standard of care; and three, proximate cause; and four, damages. Plaintiff must prove the standard of care the Defendant owed to the Plaintiff in treating the Plaintiff. When a doctor treats a patient the law does not require perfection either in the practice -- in

his practice or his judgment. Our law does not hold a physician to the standard of infallibility, nor does it require of him the utmost degree of care and skill of which the human mind is capable. Our law requires that the doctor use that degree of knowledge, care and skill ordinarily possessed and used by doctors in good standing in the doctor's field of medicine under the same or similar circumstances and that the doctor followed the generally accepted practices and procedures in the profession.

Next, the Plaintiff must prove that the Defendant negligently departed from this standard of care in treating the Plaintiff. Negligence is the failure to do what an ordinary careful doctor in the Defendant's field of medicine would have done under the same or similar circumstances or the doing of something that an ordinarily careful doctor would not have done under the same or similar circumstances. A doctor is not an insurer of a cure or even of a positive result. Therefore, the mere fact that a treatment does not benefit the patient or that even harms a patient does not in and of itself mean that the Defendant was negligent. A bad result, injury, death or failure to cure is not by itself enough to show that the Defendant was negligent. Negligence is not presumed from the fact that a treatment is unsuccessful. Accordingly, a physician is not liable to a patient if proper treatment is prescribed even though it does not produce good results.

Since lack of skill and competence on the part of a physician cannot be inferred from the failure to effect a cure because the physician may do everything reasonably expected of a competent physician without achieving a successful result. Even the fact that the unfortunate results might have been avoided does not render a physician liable if he used proper skill and care. Similarly, a doctor's mistake or error in making a decision alone does not constitute negligence. The difficulties and uncertainties in the practice of medicine and the unpredictable variations in the response to treatment are such that no doctor can guarantee results. Where there's more than one recognized care or treatment and no one of them is used exclusively and uniformly by all doctors in good standing, it is not negligence for a doctor in making a decision to choose one of the approved methods even when the choice later turns out to be the wrong selection. Qualified doctors and experts may differ as to what constitutes the best course of treatment, and these differences do not amount to malpractice. Where doctors in good standing disagree or when medical authorities are divided with regard to a specific course or treatment of care, of treatment or care then the doctor is bound only to exercise his or her best judgment in determining which course on the whole is best for the patient. Just because another doctor might have used a different course of treatment does not make the Defendant negligent. In

considering whether the Defendants made a reasonable decision, you must consider the decision in relation to the facts as they existed at the time the doctors were rendering treatment. You're not to consider the facts according to what hindsight may reveal.

Finally, Plaintiff must prove that the Defendant's negligence proximately caused Plaintiff's damages. Proximate cause is something that produces a natural chain of events which in the end brings about the injury. Proximate cause is a direct cause of the injury. To prove that the Defendant's negligence proximately caused the Plaintiff's injury, Plaintiff must first prove causation in fact. This is proven by showing that the injury would not have occurred but for the Defendants' negligence. The Plaintiff must also prove legal cause. Legal cause is proven by showing that the injury was foreseeable. This means that the injury occurred as a natural and probable consequence of the Defendant's negligence. The Plaintiff must prove that some injury from the Defendants' negligence was foreseeable but does not have to prove that the particular injury that occurred was foreseeable. However, the Defendant cannot be held responsible for something which could not be expected to happen. Proximate cause does not mean the only cause. There may be more than one proximate cause. The Defendants' act can be a proximate cause of Plaintiff injury if it was at least one of the direct concurring causes of the

injury. The chain of causation between a Defendant's negligence and, and any injury may be broken by the independent intervening acts or omissions of another person over whom the Defendant has no control. In order to decide whether an intervening act breaks the chain of causation, you must determine whether the intervening act or omission was reasonably foreseeable by the Defendant. If the intervening act or omission was a probable consequence of the Defendant's negligence, the Defendant is responsible for Plaintiff's injuries. If, however, you find that the intervening act or omission was not foreseeable, the Defendant is not liable unless his actions alone would have caused the Plaintiff's injury even without the intervening act or omission.

Here Defendants claim that Plaintiff's own negligence proximately caused Plaintiff's injuries. If you find that the Defendant was negligent you must then decide whether the Plaintiff was negligent. The Defendant must prove by a preponderance or greater weight of the evidence that the Plaintiff breached a duty of care which proximately caused Plaintiff's injuries. The same law which I have told you to use in deciding whether the Defendant was negligent should be used in deciding whether the Plaintiff was negligent.

If you find the negligence of both Plaintiff and the Defendant proximately caused Plaintiff's injury, you must then decide how much negligence of the Plaintiff contributed to

Plaintiff's injuries and how much the Defendant's negligence contributed to Plaintiff's injuries. In deciding the percentages of negligence of the Plaintiff and the Defendant you may consider among other things the following factors: whether each party's conduct was only inadvertent or whether it was engaged in with an awareness of the danger involved; two, the magnitude of the risks created by each party's conduct, including the number of persons endangered and the possible severity of the injury; three, the significance of the goal that each party was trying to reach and the need to achieve the goal in that manner; four, each party's capabilities and abilities to realize and eliminate the risk involved; five, the particular circumstances confronting each party at the time the conduct occurred such as the existence of an emergency requiring a quick decision, the relative closeness of the causal relationship of the negligent conduct of the Defendant and the harm to Plaintiff; and seven, whether the conduct of either party involved a violation of a safety statute or regulation. If you find that Matthew Scheer was not competent when he left the hospital then you may not find Matthew Scheer comparatively negligent.

Negligence is a failure to exercise due care. Gross negligence is the failure to exercise even the slightest care. Gross negligence is a relative term and means the absence of care that is necessary under the circumstances. Gross

negligence connotes the failure to exercise a slight degree of care. Gross negligence involves an intentional conscious failure to do something which one ought to do or the doing of something one ought not to do. Gross negligence may be found if a Defendant is so indifferent to the consequences of his or her conduct as not to give slight care to what he or she is doing. The word recklessness, willfulness and wantonness are synonymous. These terms are used to describe a conscious failure to exercise and observe reasonable or due care.

Recklessness implies a doing of a negligent act knowingly. Recklessness is distinguished from negligence. Negligence is a failure to use due care as a person of ordinary reason and prudence would exercise in the same or similar circumstances. Recklessness is a higher degree of culpability and responsibility. Recklessness signifies a conscious failure to exercise due care. Recklessness is a conscious indifference to the rights of a Plaintiff or a reckless disregard to the rights of the Plaintiff. Recklessness is an awareness of wrongful conduct and a continuation to act regardless of consequences. In other words, while a negligent person is one who acts carelessly, a person whose behavior is reckless, willful and wanton is not only careless in their actions but is also aware that they are being careless. A test for determining whether a tort may be deemed reckless, willful, or wanton is whether it has been

committed in such a manner and under such circumstances that a person of ordinary reason and prudence would have been conscious of it.

In this case one of the allegations the Plaintiff alleges is that the Defendant, Dr. Ash-Bernal should have involuntarily committed Matthew Scheer and that such a failure proximately caused his death. Before an individual may be involuntarily confined to a hospital, there are particularized, particularized set of conditions that must be found to exist. It is constitutionally impermissible to confine a non-dangerous individual who is capable of surviving safely in freedom by themselves or with the help of willing and responsible family members or friends. In order for an individual to be involuntary committed, involuntarily committed there must exist a belief that the person is mentally ill, one, mentally ill, and two, because of the mental illness is likely to cause serious harm to themselves or others if not immediately hospitalized. However, a finding of mental illness alone is not enough. The law defines a person with a mental illness is a person with a mental disease to such an extent that for the person's own welfare or the welfare of others or of the community the person requires care, treatment or hospitalization. Our law defines likelihood of serious harm as meaning because of mental illness there is, one, a substantial risk of physical harm to

the person themselves as manifested by evidence of threats of or attempts at suicide or serious bodily harm; two, a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior and serious harm to them; or, three, a very substantial risk of physical impairment or injury to the person themselves as manifested by evidence that the person is gravely disabled and that reasonable provisions for the person's protection is not available in the community. Gravely disabled means a person who due to mental illness lacks sufficient insight or capability to make reasonable decisions with respect to their treatment and because of this condition is likely to cause harm to themselves through neglect, inability to care for themselves, personal injury or otherwise. Unable to consent means unable to appreciate the nature and implication of the patient's condition and proposed healthcare, to make a reasoned decision concerning the proposed healthcare or communicate that decision in an unambiguous manner. Let me read that one again. I, I think I -- the term unable to consents means unable to appreciate the nature and implications of the patient's condition and proposed healthcare, to make a reasoned decision concerning the proposed healthcare or to communicate that decision in an unambiguous manner. My page 25 is blank so I --

MR. PADGET: I believe that's correct, Your Honor.

THE COURT: Okay. Plaintiff has brought a survival action against the Defendants. The test for a survival action in South Carolina is whether the decedent suffered conscious pain and suffering. To recover damages for conscious pain and suffering there must be proof beyond speculation and conjecture that the decedent Matthew Scheer consciously suffered pain prior to death. Plaintiff has also brought a wrongful death action against Defendants. This means that the Plaintiff as personal representative of the deceased estate claims that the deceased wrongfully died as a result of the negligent acts or omission of the Defendants. Whether the death of a person is proximately caused by the wrongful act or neglect of another -- I'm sorry. Whenever the death of a person is proximately caused by the wrongful act or neglect of another and the act or neglect is one which have entitled -- which would have entitled the deceased to recover damages if the deceased had not died, the personal representative of the estate of the deceased may bring an action for wrongful death. The personal representative may recover compensatory damages for the wrongful death. In a wrongful death action, unlike a survival action where the damages recoverable are for the decedent's conscious pain and suffering, the damages recoverable under a wrongful death action are those sustained by the statutory beneficiaries resulting from the death of the decedent. Thus, the question of damages is not directed

toward the value of human life that was lost but rather the damages suffered by the beneficiaries as a result of the wrongful death. The damages in an action for wrongful death include mental shock and suffering, wounded feelings, grief and sorrow, loss of companionship, loss of the use and comfort of the deceased's society, including the loss of the deceased's experience, knowledge and judgment in managing the affairs of the deceased and his beneficiaries.

Damages may not be left to conjecture, guess or speculation. This means there must be testimony or other evidence of damages that rises above the level of speculation or conjecture. Although damages need not be proven with mathematical certainty, they must be susceptible to ascertainment with reasonable certainty.

On the wrongful death claim only Plaintiff may recover such non-economic damages are proven to be reasonably certain to occur in the future. The question is not whether future damages might occur. The question is whether the Plaintiff has proven with reasonable certainty and by the greater weight of the evidence that those damages probably will materialize. Any future damages you award must be reduced to their present-day value.

To assist you in valuating the issue of damages, if you deem it appropriate, the legislature has enacted a life expectancy chart that you may consider along with other

evidence in the case including the health, constitution, habits, environment and other factors related to the person's lifestyle to determine the life expectancy of that individual. With regard to the decedent's, this chart lists the life expectancy of a male closest to 26 years of age to be 51.57 years. With regard to the father the same chart of life expectancy -- let me read this again. I'm, I'm getting a little -- to assist you in evaluating the issue of damages if you deem it appropriate the legislature has enacted a life expectancy chart that you may consider along with other evidence in the case including health, constitution, habits, environment and other factors related to a person's lifestyle to determine the life expectancy of that individual. With regard -- here's where I'm -- I got a problem. It's got male twice. Is the first one is the female?

MR. PADGET: The first, Your Honor, is the decedent Matthew Scheer's expectancy.

THE COURT: Oh, okay. This chart lists the life expectancy of a male closest to 26 years of age, that would be Matthew Scheer, to be 51.57 years. With regard to the father, Mr. Scheer, the chart of life expectancy of a male closest to 66 years of age to be 16.8 years. With regard to the mother, Mrs. Scheer, the chart lists a female closest to 61 years of age to be 23.27 years.

I'm now going to go over the verdict form with you. I'm

going to ask the bailiff to come up and hand the, the foreman a copy of this so you can be looking at it, Mr. Foreman, because you ultimately would have to fill it out, but I'm going to go over it, but I want you to have it while I'm going over it.

There are several questions. The first says please check one of the two options below. Well, first, the, the, the fact that one is above the other is of no importance. I have to put them in some order. So I've put them in that order. That does not mean that one is favored over the other or that one has any more weight than the other. The first says, we, the -- we, the jury, unanimously find in favor of the Plaintiff. If that's your decision based on the charge and the law you'd put an X or a check in front of that line or if you find -- the juror unanimously has found in favor of all of the Defendants you would put a checkmark on that line. If you find unanimously for the Defendants, you have completed your deliberations and, Mr. Foreman, you should sign and date at the end of the verdict form. If you answered number one in favor of the Plaintiff you must answer the following: what percentage of the total fault do the following bear. Listed is Southern Myrtle Inpatient Services, Dr. Patel, Dr. Ash-Bernal and Matthew Scheer. Now, these totals must come out to a hundred -- I mean, these percentages must equal a hundred percent when added together. Note, any of the above may be

between zero and a hundred percent at fault, but if you're answering this question the total percentage of fault must add up to 100 percent. If you find Matthew to have been mentally incompetent at the time he left the hospital you cannot designate any fault to him for his death.

The next is number three. If you answered question one in favor of the Plaintiff you must also answer number three. For the survival -- it, it reads, [as read], "For the survival claim brought by the Estate of Matthew Scheer list the amount of damages you find for any conscious pain, agony, sorrow, mental anguish and emotional distress suffered by Matthew Scheer as a result of Defendants' negligence." Below that is a blank line and then it says for the Estate of Matthew Scheer. What you would do, Mr. Foreman, is if the jury has determined Mr. -- that, that, that there is to be an award for the, for the Estate of Matthew Scheer for survival, you would write that figure there in that line. The next question is number four. If you answered one in favor of the Plaintiff also answer the following: for the wrongful death claim brought by the Estate of Matthew Scheer list the amount of damages you find for the -- for any grief, shock, sorrow, wounded feelings, loss of Matthew's companionship and society and loss of Matthew's advice on family matters that each parent has suffered or will suffer in the future as a result of Matthew's death. Like, like the question number three,

there's a blank for David Scheer, a blank for Debra Scheer, and if the jury determines that based on the charge and the law and the evidence that David or Debra or both are entitled to an award of monetary damages, you would put that in that line on the blank line, blank line. Number five, again, if you've answered question number one in favor of Plaintiff you would answer number five. That has yes and no answers, yes and no choices. It says, "Do you find that any of the Defendants acted in a grossly negligent, willful, wanton or reckless manner," and I've defined those for you, "and that such conduct was a proximate cause," and I've defined that for you, "of Matthew Scheer's death," and if you find that one or more of the Defendants have -- well, you'd mark yes or no for each Defendant, marking yes if you find that a Defendant acted in a grossly negligent, willful, wanton or reckless manner and that such was a proximate cause of Matthew Scheer's death. Finally there's a place for you to sign and date there at the bottom. There's a note at the bottom that says, [as read], "Please let the bailiffs know when you have finished your deliberations." I will say more about that in just a moment.

All 12 of you must agree on the verdict. Your verdict cannot be based on sympathy, passion, prejudice, emotion or any other consideration not in evidence in this case. This means that you may not decide the case solely because a person died or because a parent lost a child. Mr. Foreperson, when

the jury agrees on the verdict you will sign your name as foreperson on the line underneath the jury verdict, then knock on the door -- jury room door and inform the bailiff that you have reached a verdict. At that time we will receive you back into the courtroom. We're not starting another trial. So we can probably send for you very promptly.

If while you're deliberating you have any questions, please write them down, give them to the bailiff. The bailiff will deliver them to me. I will confer with the attorneys, and, and I'll respond to the, to the question. It may be that I can answer the question by simply writing an answer on the note and sending it back, and if I do that, make sure you keep the note because they have to be part of the record, or I may bring you back in and answer any such questions you have in open court. I do not have a written charge on the law to send in to you -- with you while you deliberate, but if you want me to go over any parts of the -- my charge, please let me know and I'll bring you back in here in open court, I'll answer, I'll, I'll answer -- I'll, I'll recharge you. If we reach the point where you feel like you need an evening meal or dinner or supper, I think we call it supper here in the South, just let the bailiff know in plenty of time. It probably takes about an hour to get a meal here, but if you want -- if you get to the point where you want us to order something let us know and we'll certainly do that with no questions asked.

In a moment I'm going to ask you to return to the jury room but don't begin deliberations until you're told by the bailiff to do so. When you are told to do so, the bailiff will bring in the exhibits to you and he will tell you to start deliberating, but don't do that yet because I'm not quite -- I may have to -- if I have made any errors in my charge I'll have to bring you back in and correct it. If I have not made any errors in my charge, the bailiff will come in and give you the exhibits, the verdict form and tell you to start deliberating.

Now, the alternates will go with the bailiff. The bailiff will tell you -- well, you won't go back in the jury room. The bailiff will escort you to another part somewhere else. All right. I'm going to let you go to the jury room now -- the jury room, everybody but the alternates.

(Whereupon, the following takes place outside the presence of the jury.)

THE COURT: I apologize for fumbling on the mortality table. It just seeing male twice just threw me for a minute.

MR. PADGET: Understood.

THE COURT: Any exceptions by the --

MR. PADGET: None from the Plaintiff, Your Honor.

THE COURT: Any by Defense?

MR. GRESH: Your Honor, I think for the record I would request that the jury be charged on habit. I think it is a

proper statement of the law. We did have habit testimony. The jury is left to now wonder is habit worse or less than independent recollection, and without a charge from this Court saying you may consider it like any other testimony I think it's improper --

THE COURT: Well, I, I think I addressed 406, I believe. I don't have it in front of me now and I addressed that earlier and chose not to -- did not believe it was an applicable charge. Now, I'm going to ask you to -- first, I want to thank all the attorneys for their professionalism and courteous in the way they've approached the trial and the way they've dealt with me. It's always a comfort to deal with well-respected and competent and good, seasoned counsel, which we certainly had here.

Now, I'm going to ask you to take a look at the exhibits and make sure they're right, and we'll save them -- send them, send them in to deliberate. I'll go ahead and tell you now because -- yes, ma'am.

MS. GOODHUE: Are the attorneys the only ones that are allowed to talk in this trial, in a civil trial?

THE COURT: Unless you're called as a -- unless they're called as a -- unless somebody's called as a witness, yes, ma'am.

MS. GOODHUE: So even though somebody else has information it doesn't matter?

THE COURT: Well, I would suggest if you have some information that's pertinent to this case that you talk to somebody that's, that's involved in this case. I, I don't know who you are -- why don't you tell me your name so I can have a record?

MS. GOODHUE: My name is Christy Goodhue.

THE COURT: What's your last name?

MS. GOODHUE: Goodhue, G-O-O-D-H-U-E.

THE COURT: All right. Well, I'll leave it up to the attorneys whether any -- either or both of them want to, want to talk to you.

After you send this back the attorneys certainly can go eat lunch or mid-afternoon snack, whatever you want to call it, go, and just if you do, make sure you leave a number with the clerk so that we can call you if we need you to come back based on a question or a verdict.

All right. Thank you. I'm going to exit and let you all see that everything's in -- yes.

MR. GRESH: For something -- I don't know when I'm supposed to object formally on the record to the verdict form.

THE COURT: Now.

MR. GRESH: We had talked about it back in chambers yesterday that it's my opinion that it's improper, that it lists both Mr. and Mrs. Scheer as separate claimants, and I think it should be the beneficiary of the estate. We talked

about it yesterday. I understood Your Honor's ruling. I just want to make sure it was on the record.

THE COURT: Yeah. Based on prior rulings by a very competent, well-respected judge I'm going to go with it, too.

MR. GRESH: Thank you, Your Honor.

THE COURT: Thank you.

(Exhibits reviewed and approved by counsel for Plaintiff and Defendants. Deliberations begin at 3:04 p.m.)

OFF THE RECORD

(On the record. The following takes place outside the presence of the jury.)

THE COURT: Informally I told the attorneys that the bailiff overheard a lady say something to the effect of, "Let's hurry, we've got a 5:00 o'clock deadline," and I told counsel that I'm going to bring the jury in and tell them they're not under any deadline and please don't rush this thing. All right. Bring in -- any, any objection?

MR. HINSON: No, Your Honor.

MR. GRESH: None from the Defense.

THE COURT: All right. Bring in the jury.

BAILIFF: Just want to tell you, when I took them in I did tell them there's no deadline.

THE COURT: All right. Well, I want to put it on the record. So I, I don't want to --

(Whereupon, the following takes place in the presence of

the jury. Jury enters courtroom at 4:31 p.m.)

THE COURT: Members of the jury panel, I just wanted to make sure you understand that there is no deadline. You're not -- don't have a 5:00 o'clock or any other deadline. This case has taken a long time to prepare, a good while to try, a lot of hard work's gone into it, and it's a very important decision you have to render. I know you don't take it lightly, but I just want to make sure you understand that there is no deadline. That's one reason I said we'd order dinner if you wanted it later on. So I'm going to let you go back and continue deliberations, but keep in mind you don't -- you're not on the clock. Thank you.

(Whereupon, the following takes place outside the presence of the jury.)

THE COURT: All right. The jury has exited. Anything from the Plaintiff on that?

MR. HINSON: No, Your Honor.

THE COURT: Anything from the Defense?

MR. GRESH: Nothing, Your Honor.

THE COURT: Could I see counsel up here, and this is off the record.

OFF THE RECORD

(On the record. Question from jury at 4:40 p.m. The following takes place outside the presence of the jury.)

THE COURT: The jury has a question or a request. The

jury wants a recharge on negligence and gross negligence. Would you all look through? I'm having trouble finding negligence in mine. I know I charged it.

(Attorneys and Court confer at bench.)

THE COURT: All right. The jury has requested a recharge on negligence and gross -- grossly negligent. On page 12 of my charge, and I think I'll make this charge a Court's Exhibit, under the breach of standard of care, we're going through the standard of care, and I do define negligence and also at another place -- that's on page 12. On page 20 I define gross negligence. I'm going to open by going back to page 10, which the medical malpractice, Plaintiff claims Defendant committed medical malpractice, which is a form of carelessness or negligence. Then I'm going to finish and say, "Plaintiff must prove by a preponderance or the greater weight of evidence, which I've charged you, the standard of care. I've charged you about that, breach of the standard of care, about that, proximate cause, charged you about that and damages." Negligence -- can I -- anybody object to me saying in this context is the failure to do what an ordinary careful doctor?

MR. PADGET: None from the Plaintiff, Your Honor.

MR. GRESH: Your Honor, I would, I would respectfully request that when we're talking about negligence I know that to mean four elements. I also know that in a case like this

that it's especially defined as medical malpractice. I think to just say negligence is a failure to do something would completely forget about proximate cause and damages. It'd go straight back to not even the full standard of care charge.

THE COURT: I, I understand. I'm going to, I'm going to charge what I said I was and the gross negligence. You're on, you're on record. All right. Bring in the jury.

(Whereupon, the following takes place in the presence of the jury.)

THE COURT: All right. Mr. Foreman, and members of the jury panel, I'm going to -- hopefully I answer what you're asking. If not, come -- when -- just send out another note and I'll try to --

FOREPERSON: The question is on the definition of malice and gross --

THE COURT: Not, not malice, negligence.

FOREPERSON: Negligence and gross negligence.

THE COURT: And right, I got that. What I'm saying is I'm going to charge -- recharge you on those two things and if anyone -- if, if you need more after that you can just send out another note.

All right. This, of course, is a medical malpractice case. Here Plaintiff claims that the Defendant or more -- one or more committed medical malpractice, which is a form of carelessness or negligence. In order to recover for medical

malpractice Plaintiff must prove by a preponderance or greater weight of the evidence, and I've charge you what that means -- the, the -- must prove, number one, the standard of care. I've charged you about that. Two, a breach of the standard of care, and that's where negligence comes in. Three, proximate cause and four, damages.

In this context negligence is the failure to do what an ordinary careful doctor in a Defendant's field of medicine would have done under the same or similar circumstances or it is the doing of something that an ordinary careful doctor would not have done under the same or similar circumstances. Gross negligence is defined as follows: as I just told you, negligence is the failure to exercise due care, while gross negligence is the failure to exercise even the slightest care. Gross negligence is a relative term. It means the absence of care that is necessary under the circumstances. Gross negligence connotes the failure to exercise a slight degree of care. Gross negligence involves an intentional, conscious failure to do something which one ought to do or the doing of something one ought not to do. Gross negligence may be found if a Defendant is so indifferent to the consequences of their conduct as not to give slight care as to what they are doing. That's the recharge on negligence in the context of this -- and, and gross negligence. That helpful?

I'm getting some nods. Yeah. Okay. I'll let you go

back.

(Whereupon, the following takes place outside the presence of the jury.)

THE COURT: All right. Anything from Plaintiff?

MR. HINSON: Nothing, Your Honor.

THE COURT: Defense?

MR. GRESH: Just renew what I had said earlier.

THE COURT: Okay. All right. We'll be at ease.

OFF THE RECORD

(On the record. Question from jury at 5:21 p.m. The following takes place outside the presence of the jury.)

THE COURT: Bring in the jury. You can bring them in.

(Whereupon, the following takes place in the presence of the jury.)

THE COURT: All right. I've received your note and there was some question about three cards. Those cards were used in closing arguments. They're not into evidence, but I'm going to charge you the law on involuntary commitment.

In this case one of the allegations Plaintiff alleges is that Defendant Dr. Ash-Bernal should have involuntarily committed Matthew Scheer and that such a failure proximately caused his death. Before an individual may be involuntarily confined to a hospital, there are a particularized set of conditions that must be found to exist. It is constitutionally impermissible to confine a non-dangerous

individual who's capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends. In order for an individual to be involuntarily committed, there must exist a belief that the person is: one, mentally ill; and two, because of the mental illness is likely to cause serious harm to himself or others if not immediately hospitalized. However, a finding of mental illness alone is not enough. The law defines a person with mental illness as a person with a mental disease to such an extent that for the person's own welfare or the welfare of others or of the community the person requires care, treatment or hospitalization. The law defines likelihood of serious harm as meaning because of mental illness there is: one, a substantial risk of physical harm to the person themselves as manifested by evidence of threats of or attempts at suicide or serious bodily harm; two, a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior and serious harm to them; or three, a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that the person is gravely disabled and that reasonable provisions for the person's protection is not available in the community. Gravely disabled means a person who due to mental illness lacks sufficient insight or capacity to make reasonable decisions with respect to his treatment and because of this

condition is likely to cause harm to themselves through neglect, inability to care for themselves, personal injury or otherwise. That's, that's the charge on that.

(Whereupon, the following takes place outside the presence of the jury.)

THE COURT: Anything from Plaintiff?

MR. HINSON: No, Your Honor.

THE COURT: Defendant?

MR. GRESH: No, Your Honor.

THE COURT: Of course I don't know what they're going to do, but we need to be thinking if in the event they find recklessness how we approach punitive damages.

MR. HINSON: Well, Your Honor, I would -- if they do find recklessness ask that my motion for contempt be heard or considered by Your Honor because I, quite frankly, would not be in a position to discuss with the jury and show them the financial status of, of one of the Defendants and, and that -- not the other two Defendants, but the one Defendant Southern Myrtle I think since Defense did not provide their financials until, until I think trial had already begun, I think it would be appropriate just to instruct the jury simply that they -- the inference should be that Southern Myrtle has the ability to pay a punitive damages award, whatever punitive damages award they see fit, but again, I would, I would say that that instruction would only apply to Southern Myrtle and not to

Defendants Patel and, and Ash-Bernal. That would not be my request.

THE COURT: And how long would you need to argue if we get to that?

MR. HINSON: Very briefly Your Honor.

THE COURT: Twenty minutes?

MR. HINSON: Probably not even that.

MR. GRESH: The day he asked for the financials he got the financials. Right? There is no -- I understand that. I sent him -- if I've got to make this an exhibit and if we're going to the supreme to talk about civility and professionalism, when I send you an email saying, "This is coming. This is coming. I assume you've got everything you need on this other one." I get -- I give you what I said was coming. I give you what I said was coming. Then you show up on Monday and said, "Ah-hah. Here's a motion for contempt." There is nothing willful here. As soon as I saw the contempt motion you got the documents the same day. If he had written back, "Oh, I need more than that which you've already provided," then he would have had it the day he asked for it then. This is a got you game, and it's a gotcha game that's now going to set a precedent that this is how we should do it in this state. This is how when I send you an email saying, "I assume you've got everything, if I'm wrong, let me know," don't say wrong on Monday with a contempt motion. Write me

back and say, "Hey, I appreciate the Ash-Bernal stuff. I appreciate the Patel stuff and you're wrong. Hey, buddy, I also need more from Southern Myrtle even though they've been dissolved for two years. I need more from that." If I had that, Your Honor, of course he would have had it the same day. I think this is something that's -- and I, and I hate to even cast these type of dispersions because I like Brink, I like his firm. He may be incapable of committing all of these things, but I think it's not professionalism. I think it goes exactly to the heart of what we as South Carolina lawyers are, and to pull this and say on the Monday of trial, "Hey, now, I'm going to let you finally know that we don't have enough information from one of the Defendants."

MR. HINSON: Your Honor, this issue has been going on since long before Mr., Mr. Gresh became involved. It was more than a year ago that we requested these financials. Judge Seals ordered them be produced before trial and then I get an email from Mr. Gresh that says, "We're not giving them. You gave -- you got all you needed from the 30(B)(6) deposition." That's what his email said. There was no point to respond when I get an email from Defense counsel that literally says, "We're not giving it to you. We think you got enough information from the 30(B)(6) deposition," and for him, for him, for him to characterize it any other way, Your Honor, is, is inaccurate. That email was before you in the memo. It

clearly says, "We're not giving it to you, Mr. Hinson." That's what it said, and for him to characterize it anything differently the email speaks for itself. There was already a court order ordering the production of these documents, and he said, "We're not going it. You got everything you needed from the deposition," which to me was completely nonsensical because there was nothing ever discussed in that deposition about finances, nothing.

THE COURT: I don't see the email. It may be in here. There's a lot of stuff in here. Oh, here it is. Here it is.

So Mr. Gresh is saying you got enough from the 30(B)(6), and you're saying there wasn't anything from the 30(B)(6).

MR. HINSON: There's nothing in the 30(B)(6) about financials.

MR. GRESH: May I see that email, Your Honor? I'm sorry. I don't have it in front of me. There may have been multiple communications.

THE COURT: Well, that's the only one I see.

MR. HINSON: Your Honor, I would also note how would I even take this deposition about financials when no documents had been given to me? I mean, I couldn't, I couldn't possibly do -- take such a deposition without the documents.

MR. GRESH: You asked -- Friday, May 17 he asks for them. We have trial on Monday May 20th.

THE COURT: Well, but the order had been pending for a

good while.

MR. HINSON: And, and there were letters weeks beforehand.

THE COURT: I know you've had a change in -- I know you had a change in --

MR. GRESH: The email from Brink to me saying, "Oh, yeah and by the way it's now on the eve of trial, I'd like these documents," that was timely responded to.

MR. HINSON: Mr. Gresh, I sent you, I sent you a letter a month before that you entirely didn't respond to at all whatsoever, and if Your Honor would like to see that I'm sure I can provide it.

MR. PADGET: It should be attached to the motion.

MR. HINSON: I believe it may be attached to the motion.

THE COURT: All right. Well, here, see if you can find it. There's a lot in here. I found, I found the email but I don't know if I can find any letter.

MR. HINSON: I'll be happy to, Your Honor. Beg your indulgence, Your Honor. It's not attached -- I'll be happy -- I have it. I'll be happy to provide you a copy.

THE COURT: All right.

MR. GRESH: If at any time the reply would have been, "I think I need more than that," I would have done it.

MR. HINSON: How many times do I have to ask, Mr. Gresh?

MR. GRESH: Your Honor, there's been -- there's nothing

nefarious.

THE COURT: Well, it doesn't have to be nefarious. It just has to be -- it just has to be -- it just has to be an unresponsive, unresponsive or lack of response to a judge's order, that's my concern, without casting any aspersions on anybody.

MR. HINSON: We just found the letter, Your Honor, and soon as we did -- I screwed it up but beg your indulgence one second more. Your Honor, Jack, would you like to see?

MR. GRESH: Absolutely.

MR. HINSON: Nearly a month before trial, April 30th, 2019, I wrote to Mr. Gresh and just about different trial things, and the end of the letter is, [as read], "Please be reminded that Judge Seals granted Plaintiff's motions to compel Defendants' financial information but added the caveat that for the time-being the information could be held by Defense counsel but should the case proceed to trial the documents were to be provided for use at trial in a timely manner. In granting the Plaintiff's prior motion to compel, the Court ruled that the following were to be made available. With regard to Drs. Patel and Ash-Bernal," which I -- I readily acknowledge he provided. Then the next it says, [as read], "With regard to Southern Myrtle Inpatient Services," and then I highlight the four different things that Judge Seals had ordered be provided, and then I add to the letter,

[as read], "As Plaintiff has not yet, not yet received and reviewed Defendant's financial documents that are to be produced, I cannot yet say whether I will need Dr. Alford's expertise," he was one of our experts, Your Honor, "to explain to the jury what the financial information means with regard to the Defendant's ability to pay punitive damages. Should Plaintiff require an economist to make sense of and explain/present this information and the supporting documents to the jury, Plaintiff reserves the right to call Dr. Alford." I did not get these documents until the day of trial, Your Honor, and this was not what Judge Seals had ordered, and I did remind Defense counsel nearly a month before trial.

MR. GRESH: Nineteen days before trial I asked for it, when I thought all of this was taken care of. When I found out it wasn't taken care of, it was immediately produced.

MR. HINSON: I reminded you again by email and your response was, "I think you got all you needed in the 30(B)(6)."

THE COURT: Has he ever -- have you ever gotten what you -- what Judge Seals ordered?

MR. HINSON: The day of trial. My expert is unavailable. He's on vacation, and I've been busy with trial and been unable -- this was exactly what Judge Seals didn't want to happen, Your Honor, was for it to be dumped on Plaintiff at trial and then unable to do anything with it. I'm unable to

go before this jury and put together any sort of argument about Defendant's ability to pay because I didn't get this information until I was knee deep in trial, and I have asked, and we filed a motion to compel. This information should have been sitting ready to go as soon as we got a few weeks from trial, and instead I get it the day trial begins.

MR. GRESH: And then going back to the 30(B)(6), it was testified to there that the corporation is defunct. It doesn't have any assets. It hasn't been in business since 2016. So I can pull tax returns and other things, but they -- the income is, is zero. The assets are zero, and so there's lots of documentation that was produced because it's an entity within other entities, but if you look at all the document -- I even gave a statement of net worth where I had the accountants literally go out and do for '15, '16 and '17 trying to be in compliance here, but there's zero. There's, there's nothing there. This asset doesn't exist, and, and that's why perhaps my wording was a bit or can be construed as being, you know, flippant or anything like that, but I think if you look at it in the series of the thousands of emails that we've sent back and forth, I don't think that Brink when he read that thought, "Oh, he's refusing to comply with the court order." I was trying to say if you need something else let me know and I'd give it to you, but the answer is zero. It doesn't matter how many accountants I line up to say how

much can Southern Myrtle pay, they haven't received an income or paid money in three years.

MR. HINSON: What about my accountant expert that I've retained in this case to review this information?

THE COURT: All right. Well, let me -- I'm going to, I'm going to think about it.

MR. HINSON: Thank you, Your Honor.

THE COURT: And also I'll need whatever charge you all want on that if we get there, and, and out of an abundance of caution, Mr. Hinson, would you or office make sure they're holding my room for me because it --

(Lodging discussed.)

THE COURT: All right. We'll be at ease.

OFF THE RECORD

(On the record. Question from Jury at 7:23 p.m. The following takes place outside the presence of the jury.)

THE COURT: We've gotten a note from the jury that they want a written charge, and I've asked both parties how they stand on that and both object. Is that right Plaintiff?

MR. PADGET: That's --

MR. HINSON: Yes, Your Honor.

MR. PADGET: That's correct, Your Honor.

THE COURT: Is that right, Defense?

MR. GRESH: It is.

THE COURT: All right. Over objection I'm going to send

it in. A lot of judges send them in all the time. I, I never have done it, but this has some complexities that maybe they can, if they can see it in print that they'll be able to not squabble so much, they'll have some reference.

MR. GRESH: If Your Honor, if I could, just on that, on that issue, we had talked about the time and I mean it's 7:25. So if we're going to give them the written charge, is there any appetite for doing it tomorrow morning at 9:30?

THE COURT: Well, I, I'm not sure they want to come back in the morning. I mean, that's -- I can, I can send them this note and I often do, "It's almost 7:30. Would you like to stop today and come back tomorrow?"

MR. HINSON: I, I, I --

MR. GRESH: I think that would be good.

MR. HINSON: -- think that would be good, Your Honor.

THE COURT: All right.

All right. Let both of you look and see what I scrawled out here.

(Attorneys review note.)

MR. PADGET: Yes, sir.

THE COURT: Just I'll write -- I'm going to ask the bailiff to tell them to just let him know.

OFF THE RECORD

(On the record. Note from jury at 8:20 p.m. The following takes place outside the presence of the jury.)

THE COURT: All right. We've received this message, and I'm going to ask kind of input because it's -- well, I'll just read it. [As read], "If we, if we cannot come to a unanimous decision and do not foresee ever being able to reach a unanimous decision what will happen?" Signed by the foreperson. I think it's time for me to give them what's sometimes called the Allen charge. Any objection? I mean I think that's where we are.

MR. HINSON: No objection from the Plaintiff, Your Honor.

MR. GRESH: No objection.

THE COURT: All right. Bring them in.

MR. GRESH: And before, does Your Honor have a standard Allen charge?

THE COURT: Well, I just do it off the top of my head pretty much because I've done it so many times before. I just basically tell them that -- well, I, I can't remember what -- I don't -- I don't, I don't have it written down.

(Whereupon, the following takes place in the presence of the jury.)

THE COURT: Members of the jury panel, I've got your note saying you are unable to reach a unanimous decision and what happens next. I'm going to chat with you just a minute and then ask you to go back and deliberate some more. I know

you've been working hard and it's always -- it's often hard for two people to agree, let alone 12. So I know it's tough to do a unanimous decision, but what I'm going to ask you to do is to go back and continue to deliberate. I'm not going to ask anybody to give up any firmly held positions. If you have a firmly held position maintain it and discuss it with the others. I'm going to ask all of you to listen to each other's positions, and again, without giving up any firmly held position I'm going to ask you to listen to each other and see if you can't move forward and, and reach a verdict. I, I -- as to your question about what will happen if you don't reach a verdict, the case will simply be tried again. It will be tried by another 12 jurors, same lawyers may come probably, same witnesses and they hear the same evidence and they'll be put in the same position you're in now. So that's what'll happen next, and it's hard for me to believe that 12 other reasonable Horry County citizens would be any better able to reach a decision than you 12 are. So I'm going to ask you to return to deliberations, again discuss the case keeping in mind your firmly held positions and sharing them with each other and listen to other people's firmly held positions. So I'm going to ask you go back and see if you can work a little more. Thank you.

(Whereupon, the following takes place outside the presence of the jury.)

THE COURT: Anything from the Plaintiff?

MR. HINSON: No, Your Honor.

THE COURT: Defendant?

MR. GRESH: No, Your Honor.

THE COURT: All right. Thank you.

OFF THE RECORD

(On the record. Note from jury at 9:30 p.m. The following takes place outside the presence of the jury.)

THE COURT: A note that it's got me scratching my head but -- and I'm -- obviously got to report whatever notes we get out. This one I don't know exactly how to answer it. So I'll throw it out and let the parties give some collective thought to it and make suggestions. He said -- it says, [as read], "If we give zero percent fault to any Defendants would they be guilty of malpractice?"

MR. HINSON: Your Honor, I think we tell them no because that would be essentially that there was no verdict found against that Defendant, and we could have made the jury form do you find in the Plaintiff versus Ash-Bernal do you find for the Plaintiff or Ash-Bernal; in the Plaintiff versus Patel do you find for the Plaintiff or Patel. We could have broken it down like that, and the way it was broken down now they could just simply say zero percent for whichever Defendant they want to say zero percent for.

THE COURT: So the answer is and then basically that is

the answer if they get zero percent then there's no under --

MR. HINSON: Malpractice.

THE COURT: -- no liability. I mean, no malpractice.

MR. HINSON: That would be acceptable to the Plaintiff, Your Honor, because I believe that would be a Defense verdict for that Defendant.

MR. GRESH: I'm thinking real -- just real quick.

THE COURT: Well, you know, it's got all kind of ramifications because if, if they -- I mean, obviously, they can give zero percent, but if they -- then, then the other part of that hundred percent's got to go somewhere if they give zero on somebody, so somebody else or some other Defendant, not somebody. I don't know. Think about it just a minute because it's, it's, it's one I've never seen before in 20 something years.

MR. GRESH: Yeah. Let me go -- we all can talk.

OFF THE RECORD

(On the record. The following takes place outside the presence of the jury.)

MR. GRESH: Your Honor, I know it's late. Would you read that question to me one more time?

THE COURT: [As read], "If, if we give zero percent of fault to any Defendants, would they be guilty of malpractice?" If there's zero fault it would -- there, there would be no

malpractice.

MR. HINSON: It would be Plaintiff's position that that -- the answer should be given yes because that would essentially be a finding that that Defendant did nothing wrong.

THE COURT: No. They say would they be guilty of malpractice. I think the answer would be no.

MR. HINSON: I'm sorry. Would be no. I misspoke. The answer would be no because it would be a finding that that Defendant did nothing wrong.

MR. GRESH: Can I see the jury verdict form again? Thank you, Your Honor.

THE COURT: It was in the trash, but I've gone through several iterations of it. Now, I don't know whether it's just grammar or what, but they, they used the word S, Defendants to any, instead of saying any Defendant they say any Defendants. I point that out for whatever value that has.

MR. HINSON: Jack, I think we say -- respond back and say any Defendants with zero percent fault have been found not guilty of medical malpractice.

THE COURT: I'm just going to say -- I can just answer it no. I mean, I can just answer it just no.

MR. HINSON: And I think for clarity then though I would just suggest, Your Honor, to say, no -- well, just say --

THE COURT: I'm afraid to say too much.

MR. HINSON: I agree.

THE COURT: Because there you'll open up a can of worms.

MR. HINSON: Yeah.

THE COURT: Or a can of something.

MR. GRESH: Your Honor, may I have two more minutes?

THE COURT: Yes.

MS. SPEARS: Can we take this?

THE COURT: Yeah. You can keep it.

OFF THE RECORD

(On the record. The following takes place outside the presence of the jury.)

THE COURT: All right. Have you developed any thoughts on it?

MR. GRESH: Your Honor, the only thought I had would be we all came up with this jury verdict form together collectively. I think to go in and explain the ramifications of any one box versus any of the other boxes is not what was intended by anybody.

MR. HINSON: Your Honor, it would be Plaintiff's position that the answer to that is the Defendant with zero percent fault did not commit malpractice, and that we should send back a note that says, "Any Defendant with zero percent fault would be found to have not committed malpractice," because that is the only way to clarify to them that there's a way to find for one Defendant or against one Defendant but not against

another.

MR. GRESH: But they're not -- malpractice isn't the issue here. All right. This verdict form doesn't use the word malpractice. I think for us to talk about it -- I understand your position, Brink, and I'm trying to make my position known as well. I think we're -- are we answering a question that maybe they're not asking by putting a zero there.

THE COURT: Well, I, I think I'm going to answer it -- the answer is no. I mean, they -- I think that's the correct answer to the way they posed the question.

MR. GRESH: Thank you, Your Honor.

THE COURT: And I know we work -- everybody works hard to get these verdict forms like they want and have some wrinkle that we, you know, what's that the law of unintended consequences is, I don't know if that applies here, but you, you can't ever cover every contingency even though you try. All right. We'll be at ease then.

OFF THE RECORD

(Whereupon, the following takes place outside the presence of the jury. Verdict reached at 10:30 p.m.)

THE COURT: I understand we have a verdict. The Plaintiff ready to receive it?

MR. HINSON: Yes, Your Honor.

THE COURT: Defense?

MR. GRESH: Yes, Your Honor.

THE COURT: All right. Bring in the jury.

(Whereupon, the following takes place in the presence of the jury.)

THE COURT: All right. Mr. Foreman, I understand the jury has reached a verdict.

FOREPERSON: Yes, we have, Your Honor.

THE COURT: If you'll hand it to the bailiff he'll hand it up to me.

(Complies with request and Court reviews.)

THE COURT: Thank you. Yeah. I, I'll publish it.

THE CLERK: Okay.

THE COURT: All right. This is the verdict form in the case of David L. Scheer, Personal Representative for the Estate of Matthew Scheer versus Southern Myrtle Inpatient Services, Dr. Patel and Dr. Ash-Bernal. Number one, we, the jury unanimously find in favor of the Plaintiff. Number two, what percentage of the total fault do the following bear? Southern Myrtle Inpatient Services 100 percent; Dr. Patel zero percent; Ash-Bernal zero percent; Matthew Scheer zero percent.

For the survival claim brought by the estate, this is the answer to number three, the award for the Estate of Matthew Scheer is $500,000. For the wrongful death claim by, by the Estate of Matthew Scheer the award is for David Scheer 1.5 million, for Debra Scheer, 1.5 million. Number five is do you find the Defendant acted in a grossly negligent manner?

Southern Myrtle Inpatient Services yes; Dr. Patel no; Dr. Ash-Bernal no.

Is this the jury's verdict, Mr. Foreman?

FOREPERSON: Yes. It is, sir.

THE COURT: So say you all by raising your right hand.

(All jurors raise right hand.)

THE COURT: All have confirmed their verdict. Now, I'm going to let you go back to the jury room just for a minute. I know you've been in there a while but I'm going to have to let you go back for just a couple of minutes.

(Whereupon, the following takes place outside the presence of the jury.)

THE COURT: All right. I'm going to give each side ten days to, to make any post-trial motions, but we've got the grossly negligent issue to deal with. So let's go ahead and -- do you have -- go ahead.

MR. GRESH: Well, Your Honor, I would, I would suggest that this is -- there's a mistrial. You can't have a verdict for or against Southern Myrtle for training that doesn't involve conduct of either Ash-Bernal or Patel. There can be no proximate cause otherwise. Right? And so what you have is the only allegation against them was that Southern Myrtle didn't train the physicians. Well, how can that cause harm to Matthew Scheer but for conduct of one of the physicians. Where the agents are exculpated, we must also exculpate the

principals. It should be a Defense verdict.

THE COURT: Well, I'll take that under advisement. What, what, what says the Plaintiff?

MR. HINSON: Your Honor, a direct liability theory against Southern Myrtle went back that they failed to train and properly train their doctors, and the jury could find that the doctors' best judgment was hampered by the Defendant physicians -- the physician corporation's failure to train the doctors.

THE COURT: All right. Well, I'm going to give you -- both of you ten days on the -- to, to, to brief that because I, I, I follow what Mr. Gresh says, and when you look at proximate cause -- well, we'll, we'll deal with that. Now, do you -- what do we do about the punitives? Do you have a --

MR. HINSON: Your Honor, I guess our options are to bring them -- do it now or bring them back on Tuesday.

THE COURT: No. We're not going to bring them back on Tuesday.

MR. HINSON: Well, I guess, Your Honor, I'd move to argue that now very briefly.

THE COURT: All right. Okay. Have you got a charge for me?

MR. HINSON: Well, I do, Your Honor, and I have a proposed charge on the sanction.

THE COURT: All right. Well, what I'm going to do on

that I, I, I find that I'm not going to hold Southern Myrtle in contempt of court, but under Rule 37 there are other options which would include basically a sanction and so I'm going to give a charge as requested as a sanction for Myrtle -- on Myrtle, Southern Myrtle.

MR. HINSON: Yes, Your Honor.

THE COURT: I, I, I'll just be very candid, the jury's at probably the long end of its leash. So I would suggest that whatever presentations --

MR. HINSON: It will be very brief, Your Honor.

THE COURT: Yeah. All right. Has that got clear and convincing and all?

MR. HINSON: We had a separate one for clear and convincing, Your Honor.

THE COURT: Do you have a verdict form, too?

MR. HINSON: Yes, Your Honor. I realized we didn't print that out. Your Honor, I'm going to slightly modify the verdict form.

OFF THE RECORD

(On the record. The following takes place outside the presence of the jury.)

THE COURT: We're, we're not ready yet.

MR. HINSON: Your Honor, Plaintiff has a proposed verdict form. I guess I could take out Southern Myrtle in that. I -- I'll take out Southern Myrtle -- just a yes or no. Just kind

of took out the -- the other one had Southern Myrtle again. It seemed kind of --

THE COURT: Okay.

MR. HINSON: -- confusing.

THE COURT: All right. Plaintiff, 15 minutes be sufficient?

MR. PADGET: Your Honor, if I go that long it'll be a problem.

THE COURT: All right. Well --

MR. PADGET: It'll be less than that.

THE COURT: Okay.

MR. GRESH: Fifteen.

THE COURT: All right. Let's bring the jury back in.

(Whereupon, the following takes place in the presence of the jury.)

THE COURT: Members of the jury panel, I've got one more chore for you to do. I don't want you to rebel and I, you know, it's something that's got to be done either today or come back Tuesday, which I don't think anybody wants to do, and that is because you found gross negligence, recklessness on behalf of Southern Myrtle, the two parties, Matthew Scheer and, well, three, Debra and David are entitled to have you consider whether or not because of that conduct they should be awarded punitive damages. So I'm going to give each attorney no more than 15 minutes to tell you their position on punitive

damages, and I will give you a short charge, and we'll have this back to you to consider whether or not to award what are called punitive damages. So, again, I'm -- I know it's been a long day. It's been a long day for all of us, and you all have worked hard, and I think you've done a yeoman's job, but I've got to let them cover this today or we'll have to come back Tuesday, and I don't think any of us want to do that. All right. Counsel.

MR. PADGET: May it please the Court?

Ladies and gentlemen of the jury, on behalf of the Scheers we thank you for your time and your patience and your work so far to get this where we are so far here tonight. I will be extraordinarily brief, and I will cut this to the very shortest it could be.

Punitive damages serve a very different function than the compensatory damages that you just awarded. In this case punitive or compensatory damages are to, to compensate Matthew Scheer's Estate and the Scheers for what you have determined they have been through and you've done that.

Punitive damages serve a completely different purpose. The Judge is going to tell you that the purpose of punitive damages is to punish the Defendant for the conduct that resulted in Matthew Scheer's death that you have all found.

A punitive damages award serves a couple of important purposes. It serves to deter this type of conduct in the

future by other medical entities and, and companies that employ doctors and compensation for the reckless, willful and invasion of the Plaintiff's rights. The paramount purpose of awarding these types of damages is not to compensate the Plaintiff, but again, to punish the Defendant. When you consider these type of an award, forgive me, it's been a long day. There are ten, ten items that you can look at, and I'd suggest, and the Judge will tell you what they are, charge you. There's really four that really apply to this case: the character and nature of the Defendant's acts; the nature and extent of the harm to the Plaintiff which the Defendant caused or intended to cause; and the likelihood that such an award will deter the Defendant or others from conduct; lastly, the Defendant's wealth or ability to pay. The Judge is going to instruct you that for this Defendant, Southern Myrtle, that you may presume that it has the ability to pay any punitive damages award that you deem appropriate. I'm not going to argue this case again, ladies and gentlemen. Going to give it to you and I'm going to let you do what you've been doing all day and do justice for this family, but not just for this family with this type of award. This is to protect this community from this type of conduct. Thank you.

THE COURT: All right. Counsel.

MR. GRESH: Thank you all for your service and thanks to the Court. You all have found against Southern Myrtle

Inpatient Services. The question before you now, has the Plaintiff proven to you by clear and convincing evidence, a different standard. Right? Before I stood in front of you with the scales of justice. Well, he's going to charge you now it's different. Now the question before us is, wow, did they really prove this by a lot, the highest burden that we have in civil court when the Defendants brought in folks with 50 years of psychiatry experience, 30 years of hospital experience, Hopkins trained folks, this is clear and convincing evidence? I think not. It may have been a tough judgment call, but clear and convincing evidence that needs to be punished, deterred? Southern Myrtle is the employer of the physicians. The allegation is that they somehow should have trained on a particular issue better than they did when all of the physicians and everybody else has had all kinds of years and years and years of experience. I will not belabor the point. If you all find that we should send a message, your burden is already done. If you say we need to send a different message and you were to find that this is by clear and convincing evidence $1.00 in punitive. Why? Why? What kind of message does that send? That tells them whatever you want them to know about, "Hey, this was bad Southern Myrtle. Understand this," but to punish doctors and degree of culpability, no. Awareness of concealment, existence of past conduct, there's no evidence of any of these things which would want to deter

this type of behavior. I appreciate very much your time, and would strongly suggest this is not a case where it's been proven by clear and convincing evidence that punitive damages are appropriate in this. Thank you.

THE COURT: All right. Members of the jury panel, I'm going to give you a charge, it's not that long, on punitive damages. As I told you we now are in the part of the case where Plaintiff seeks punitive damages in addition to the actual damages you've already award, awarded. Punitive damages are also known as exemplary damages and are imposed as punishment. They're not intended to compensate. Punitive damages are allowed in the interest of society in the nature of punishment and as a warning and example to deter the wrongdoer and others from committing like offenses in the future. Moreover, they serve to vindicate a private right by requiring the wrongdoer to pay money to the injured party. Punitive damages serve at least three important purposes: punishment of the Defendants for their reckless, willful, wanton or malicious conduct; deterrence of similar future conduct by the Defendant or others; and compensation for the reckless or willful invasion of the Plaintiff's private rights. The paramount purpose for awarding punitive damages is not to compensate the Plaintiff but to punish and set an example for others.

What would justify an award of punitive damages? As you

consider this issue, the highest burden of proof known to the civil law is applicable, that is clear and convincing evidence. That is the -- as to punitive damages, the Plaintiff has a burden of proving same by clear and convincing evidence, and I'll charge you what that means in just a moment. Well, I'll go ahead and charge you that now.

Clear and convincing evidence is evidence that is more than just a preponderance of evidence or more than the greater weight of the evidence, which require only proof which persuades you that a party's claim is more likely than not. You remember my scales. On the other hand, clear and convincing proof is not as high a standard as the burden of proof in criminal cases, which is proof beyond a reasonable doubt. Clear and convincing proof leaves no substantial doubt in your mind. It means that the evidence is not ambiguous, doubtful, equivocal or contradictory. Convincing means persuading by proof or argument causing one to believe in the truth of what is asserted. Clear and convincing proof establishes in your mind not only the fact is probable but it is highly probable.

Punitive damages can only be awarded where the Plaintiff proves by clear and convincing evidence that the Defendant's actions were willful, wanton, malicious or in reckless disregard of Plaintiff's rights. A conscious failure to exercise due care constitutes willfulness. It is a present

consciousness of wrongdoing that justifies the assessment of punitive damages against the wrongdoer. Punitive damages will be allowed even when the Defendant does not realize he is invading the Plaintiff's rights, so long as the act is committed in such a manner that a person of ordinary prudence would conclude it was done in reckless disregard of the rights of another. The Plaintiff cannot recover punitive damages based on negligent conduct. Negligence is the doing of some act which a person of ordinary prudence would not have done under similar circumstances or the failure to do what a person of ordinary prudence would have done under similar circumstances. Mere negligence will not support a punitive damages award. To recover punitive damages the Plaintiff must prove by clear and convincing evidence that the Defendant, and here when I use the word Defendant, of course I'm talking about Southern Myrtle, that the Defendant's actions were willful, wanton or reckless. The words reckless, recklessness willfulness and wantonness are synonyms. The terms are all used to describe a conscious failure to exercise and observe reasonable or due care. Recklessness is distinguished from negligence. Negligence is the failure to use due care. Negligence is carelessness. Negligence is failure by omission or commission to exercise due care as a person of ordinary reason and prudence would exercise in the same circumstances.

Recklessness is a higher degree of culpability and

responsibility. Recklessness signifies a conscious failure to exercise due care. Recklessness is a conscious indifference to the rights of the Plaintiff or a reckless disregard of the rights of the Plaintiff. Recklessness is an awareness of wrongful conduct and a continuation to act regardless of consequences. The test for determining whether a tort may be deemed reckless, willful or wanton is whether it has been committed in such a manner and under such circumstances that a person of ordinary reason or prudence would have been conscious of it as an invasion of the rights of the injured party. There's no formula or standard that can be used as a measure for assessing punitive damages. However, factors relevant to your consideration are: one, the character of the Defendant's acts; two, the nature and extent of the harm to Plaintiff which Defendant caused or intended to cause; three, the Defendant's degree of culpability; four, the punishment that should be imposed; five, the duration of such conduct; Defendant's awareness, six, Defendant's awareness or concealment; seven, the existence of similar past conduct; eight, likelihood the award will deter the Defendant or others from like conduct; nine, whether the award is reasonably related to the harm likely to result from such conduct; and ten, Defendant's wealth or ability to pay.

The financial condition of a Defendant is a factor you should consider in awarding punitive damages. However,

there's no requirement that the Defendant be a person of means before you are justified in awarding punitive damages. While the wealth of a Defendant is a relevant factor in assessing punitive damages, it is not necessarily controlling. In other words, the financial worth of a Defendant is a fact properly to be considered by you in determining the amount, if any, to be awarded as punitive damages, but evidence of net worth is not a prerequisite to a punitive damages award. When under proper allegations a Plaintiff proves by clear and convincing evidence a willful, wanton, reckless, malicious violation of their rights it is not only the right but the duty of the jury to award punitive damages. Accordingly, if you should find that the Plaintiff is entitled to recover punitive damages in addition to actual damages it would be your duty to include such damages in your verdict and award such an amount as you may deem reasonable and proper in light of the facts and circumstances. I charge you that Myrtle Inpatient Services, LLC [sic], has sufficient assets to satisfy any punitive damages you may award, if any.

We have another verdict form. Number one says, "Do you find by clear and convincing evidence that Defendant Southern Myrtle Inpatient Services, LLC's conduct was done in a wanton or willful or reckless manner? The answers are yes or no. If you answered yes you'll go to number two. If you answered no your deliberation is over. If you answered yes you'd go to

number two. It says, "Please state the amount of punitive damages you render against Defendant Southern Myrtle Inpatient Services, LLC," and if you make such an award you will write it on that line like you did in the other verdict form. So I'm going to let you go to the jury room. Don't start deliberating quite yet. I have to go over, as I did the first time, with the attorneys and make sure I've not made any error. If I have not made any error, I will send in the verdict form and the bailiff will tell you to start deliberating. Thank you.

(Whereupon, the following takes place outside the presence of the jury.)

THE COURT: All right. Anything from Plaintiff?

MR. HINSON: No, Your Honor.

THE COURT: Anything from Defendant?

MR. GRESH: Yeah. We would renew I think that it's a mistrial or Defense verdict, at this point would be improper to allow the jury to even consider the imposition of punitive damages, but I think that the charge as read on punitive damages was appropriate until we got to the, the discovery sanction. I don't think there was anything that was intentional, willful, wanton or of this sort, a day delay type of thing. I understand your ruling, Your Honor, but just wanted to put it out there in the record.

THE COURT: All right. Well, I'm, I'm, of course, give

each side ten days to make motions. Again, it's almost 11 on Friday night on Memorial Day weekend, and I don't know any of us after a five-day trial and us sitting around five or six hours waiting on the jury are in any real shape to, to tackle anything else. So I'm going to take a copy of the verdict form with me so I'll have it when I get your motions and send them to me. Let me give you my home address because I don't have an office. (Home address given.)

All right. Tell the bailiff to stick his head in here. They can start deliberating.

BAILIFF: Okay. Thank you, sir.

THE COURT: We'll be at ease. I'm just going to sit in here. I'm tired of sitting back in that office by myself. So I'm just, just sitting here.

OFF THE RECORD

(On the record. Verdict on punitive damages reached at 11:18 p.m. The following takes place outside the presence of the jury.)

THE COURT: Plaintiff ready?

MR. HINSON: Yes, Your Honor.

THE COURT: Defense?

MR. GRESH: Yes, Your Honor.

THE COURT: Bring in the jury.

(Whereupon, the following takes place in the presence of the jury.)

THE COURT: All right. I understand the jury has reached a verdict, Mr. Foreman?

FOREPERSON: Yes.

THE COURT: If you'll hand the verdict form to the bailiff he'll hand it up to me.

(Complies with request and Court reviews.)

THE COURT: In the case of David L. Scheer, Personal Representative of Matthew Scheer versus Southern Myrtle Inpatient Services, LLC, et al., answer number one, "Do you find by clear and convincing evidence that Defendant Southern Myrtle Inpatient Services, LLC's conduct was done in a wanton, willful or reckless manner?" The answer is yes. Please state the amount of punitive damages you render against Defendant Southern Myrtle Inpatient Services, $250.00. Is that correct?

FOREPERSON: Correct, sir.

THE COURT: All right. Is this your verdict so say you all?

(Jurors indicate affirmatively.)

THE COURT: All right. Anything before the jury is dismissed from Plaintiff?

MR. HINSON: Nothing, Your Honor.

THE COURT: Anything from the Defense?

MR. GRESH: Nothing, Your Honor.

THE COURT: All right. Thank you all. It was a tough week, long week, appreciate your help.

(Whereupon, the following takes place outside the presence of the jury.)

THE COURT: All right. As to the punitive damages award, I also give you ten days to comment on that or make any such motions, and again, thank everybody for their courtesies and professionalism and it was a hard case and a hard week. Here we are on Friday before Memorial Day at 11:20 and time to knock off. I call it quits.

MR. PADGET: Thank you, Judge.

MR. HINSON: Thank you, Your Honor.

MS. SPEARS: Thank you, Your Honor.

(Adjourned.)

C E R T I F I C A T E

I, the undersigned, Grace L. Hurley, Official Court Reporter for the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete transcript of the trial held in the case of David L. Scheer, as Personal Representative of the Estate of Matthew J. Scheer versus Southern Myrtle Inpatient Services, et al., held in the Court of Common Pleas for Horry County, Horry County Courthouse, Conway, South Carolina, on May 20 through 24, 2019.

I do hereby certify that I am neither of kin, counsel, nor interest to any party hereto.

Grace L. Hurley

Grace L. Hurley, CVR-CM-M
Official Reporter

October 1, 2019.

STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

COUNTY OF HORRY

DAVID L. SCHEER, AS PERSONAL REPRESENTATIVE OF THE ESTATE OF MATTHEW J. SCHEER,

Plaintiff,

vs.

CASE NO.: 2017-CP-26-1571

SOUTHERN MYRTLE INPATIENT SERVICES, LLC, NIRLEP A. PATEL, M.D., RACHEL ASH-BERNAL, M.D., AND GRAND STRAND REGIONAL MEDICAL CENTER, LLC,

Defendants.

VIDEO DEPOSITION OF: RACHEL ASH-BERNAL, M.D.

DATE: December 6, 2017

TIME: 10:30 AM

LOCATION: Grand Strand Business Center
1293 Professional Drive, Suite D
Myrtle Beach, South Carolina

TAKEN BY: Counsel for the Plaintiff

REPORTED BY: TIA SHEAN, Professional Reporter

A. WILLIAM ROBERTS, JR., & ASSOCIATES

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Videographer, Michael Carr

(INDEX AT REAR OF TRANSCRIPT)

Examination by Mr. Hinson

RACHEL ASH-BERNAL, M.D.

being first duly sworn, testified as follows:

E X A M I N A T I O N

BY MR. HINSON:

Q. Doctor, would you state your full name.

A. Rachel Ash-Bernal.

Q. And, Dr. Ash-Bernal, have you ever had occasion to give a deposition before?

A. Not to my recollection.

Q. Okay. And I imagine your attorneys have explained much of the process to you. We're taking your deposition today so I can learn what your testimony would be a trial to learn what your recollection and opinions are with regard to Matthew Scheer. If at any point you have a question about my question -- if you don't understand my question, please let me know and I'll be happy to rephrase or repeat. It's important to me that you understand the question asked.

A. Okay.

Q. And if at any point I cut you off, that's not my intention. Just let me know. I'll be happy to let you finish your answer. Likewise, I'd appreciate it if you would let me finish my question. In typical

conversation people tend to interject or interrupt but for purposes of today it makes our court reporter's job tough if we speak over one another.

A. (Inaudible sound.)

Q. And you, kind of, -- that leads me to my next -- my next point, if you could answer out-loud. You're welcome to shrug your head -- or shrug your shoulders or nod your head but for our court reporter, she needs a verbal answer, you know?

A. Okay.

Q. From time-to-time there may be objections to my questions. Unless your attorney instructs you not to answer I'd ask that you answer the question in spite of the objection, okay?

A. Okay.

Q. Doctor, what's your date of birth?

A. 04-16-1966.

Q. And what is your current address?

A. XXXXX.

Q. All right, and how long have you lived at that address?

A. Going on three years.

Q. Okay. Were you living at that address at the time of the events of this case which would be, I believe, October of 2015?

A. Yes.
Q. And Dr. Ash-Bernal, what is -- what's your profession?
A. I'm a medical doctor.
Q. And you are boarded in what?
A. Internal medicine.
Q. And you practice as a hospitalist; is that correct?
A. That's correct.
Q. Is there a board in hospitaling -- or --
A. Just internal medicine.
Q. And you could take a number of boards -- one could take a number of boards and still work at a -- as a hospitalist, correct?
A. I don't really follow you.
Q. Well, I -- all hospitalists aren't internal medicine doctors, correct? Aren't some of them family practice and some other specialties?
A. Sometimes.
Q. And at present there is no board for hospitalists?
A. It's just internal medicine.
Q. Or family practice or a similar field?
A. I don't know about family practice.
Q. Well, but you know -- I guess my question

is that you know folks who have boards in family practice who are working as hospitalists?

A. Occasionally I've met some. The common thing is to be an internal medicine doctor.

Q. And describe for me what the role of a hospitalist?

A. Admitting patients to the medicine service, rounding on them, managing their care and -- and discharging them.

Q. As a hospitalist would these patients consider you to be their primary care physician?

A. Not generally.

Q. You're providing a patient who comes to the hospital medical care in the hospital.

A. Yes.

Q. Doctor, I've been provided a -- a copy of your CV.

A. Yes.

MR. HINSON: If we could mark that as Exhibit 1, please. Well actually, lets mark that as Exhibit 2. I think we've made the -- the medical record a continuing exhibit and --

(PLF. EXH. 2, Curriculum Vitae, was marked for identification.)

BY MR. HINSON:

Q. Better housekeeping here, Doctor. I'm going to provide you with what we have previously marked as Plaintiff's Exhibit 1, which is -- pages have been Bates stamped: Scheer GSRMC_MedRecs 1-132 and these -- when I say -- these are the Bates numbers down in -- what we call Bates numbers down in the bottom right-hand corner.

A. What's a Bates number?

Q. I'm sorry?

A. What's a Bates number?

Q. A Bates number is essentially like a serial number that we give to a -- to a document in a -- in litigation.

A. Okay.

Q. So every page that's produced in litigation is assigned a number that's unique to that page and so these 132 pages each have a Bates number on them. If at any point -- this is what is produced as the medical record for Mr. Scheer, and if at any point you need to look at that record to refresh your recollection you are certainly welcome to do so. I will just ask that you let me know what page it is you're looking at.

A. This has 89 pages. This has 89 pages and then this last page says 132.

Q. Doctor, it goes through 132 pages. There

is -- It's this right here --(Indicating).

A. Is this what you're referring to here --(Indicating)-- this number?

Q. Yes. That number right there. So this is broken up. Doctor, Exhibit 1 is broken up. There's two sets in here. There's the set from Matthew's initial trip to Grand Strand, I believe is what you're speaking of, and that would be Bates stamps 1-142, which is right here. And then Bates stamps 43 --

A. So you're looking at the numbers with the checkered background.

Q. That's correct.

A. Okay.

Q. And then Bates stamped 43-132 is the second --

A. Okay.

Q. -- trip to Grand Strand.

A. I understand.

Q. Okay.

A. It's on the -- it's on the -- right there --(indicating)-- near the black box --

Q. Okay. Got you. And so, Doctor, I was asking you about Exhibit 2, --

A. Yes. Yes.

Q. -- which was provided to me. Could

you identify Exhibit 2, please?

A. Are you speaking to me?

Q. Yes, ma'am.

A. Okay. This looks like my CV.

Q. Is it current and up-to-date?

A. There's one other site that I'm currently going to that's not listed because it just started a week ago.

Q. Okay. And what site is that?

A. Orangeburg --

Q. Okay.

A. -- Medical Center.

Q. And is that working as a locum tenens doctor?

A. Yes.

Q. And what employ -- who's your employer there?

A. MDA.

Q. And that's Medical Doctors Associates?

A. That's correct.

Q. Okay. And does -- largely what we're going to be talking about today, Doctor, is October 2nd and 3rd 2015 at Grand Strand Regional Medical Center. It is my understanding that you were working as a hospitalist there at that time.

A. Yes.

Q. And at -- in that time, on October 2nd and 3rd 2015, who was your employer?

A. EmCare.

Q. Okay. And that's on page two of your CV; is that correct?

A. Yes.

Q. Well, Doctor, I -- this -- so I understand what is -- what, if any, is the association of EmCare with Southern Myrtle Inpatient Services, LLC?

A. That might have been the billing group or who dealt with our paychecks; I'm not sure. It's been a while.

Q. Okay. You're familiar with Southern Myrtle Inpatient in the sense that you've seen their name on some of your work paperwork?

A. Somewhere.

Q. Okay.

A. It sounds familiar.

Q. Okay, but as you understood it your employer was EmCare?

A. That's correct.

Q. In October, early October 2015 -- October 2nd and 3rd, where were you -- what hospitals were you working?

A. In October?

Q. Of '15, yes.

A. Primarily just Grand Strand. At that time I may have -- I might have done a few shifts at Georgetown but I'm not really sure. It was a long time ago. I was primarily working at Grand Strand Hospital.

Q. Okay. The reason I ask -- I'm just trying to understand what -- looking at your CV, --

A. Uh-huh.

Q. -- we've got Locum Connections, and it looks like you were there --

A. What -- what page are you on?

Q. I'm on page one.

A. Page one. Okay.

Q. From September '15 until about mid-2017 at Georgetown Hospital you've got Locum Connections from July '15 through January '17 at Mcleod Seacoast and Mcleod Loris, and then there -- I know there's EmCare, and there's also LocumTenens.com in Spartanburg, and that's July '15 through October '15, so I was just trying to understand if you were running back and forth between four hospitals at that time or --

A. Right.

Q. -- how your schedule was working.

A. No, this is primarily referring to the

companies that I was credentialed with that had active credentialing --

Q. Okay.

A. -- and then, active credentialing at hospitals, which has a variable time length. So at Grand Strand it's four years --

Q. Okay.

A. -- once you get credentialed. This is primarily because I -- I do locum tenens. It's just, you know, other companies want to know who you're credentialed with, where you have admitting privileges, where you have worked. It's not necessarily meaning that I worked every single place that's listed here during that time period every week or every month. There were places that I didn't do a single shift in months.

Q. Okay. Thank you, that helps.

A. So it's just sort of a -- a running list primarily geared towards the locum tenens companies because these are frequent questions.

Q. I see. Okay. Well, that helps me understand, Doctor. I appreciate that. So --

A. It would not be possible for me to run back and forth between all these hospitals every week or every month.

Q. So when you were doing locum tenens work at

Grand Strand, did you have one stint that you were there... did you have multiple stints that you were there?

A. I started at Grand Strand Hospital as a locum tenens for Staff Care.

Q. Okay. And when was that?

A. I think that probably was August of 2016, from what I recollect.

Q. Okay. And where are you looking on your CV for that?

A. I'm just thinking about the timeline, actually, in my own mind. Staff Care -- yes, so -- what, August of 2014 until 04/2015, and then I signed a full-time contract with EmCare.

Q. Okay.

A. So that's why that's -- that's broken up like that.

Q. Okay. So I'm looking -- we're looking at page one, there's a reference to Staff Care. Then there's a -- on page two there's EmCare. Did --

A. Correct.

Q. Did Staff Care stop doing locum tenens work at Grand Strand? Did the company change names? How did this come about?

A. I don't know if there's anyone else

employed by Staff Care doing locum tenens there. There were many locum tenens physicians working for many different companies. Staff Care actually had to be paid by EmCare to buy me out of my contract.

Q. What was the impetus from changing from -- if you're still working at -- well --

MR. HINSON: Strike that.

A. Mm-hum.

Q. So when you were working at Staff Care you were working as a hospitalist doing locum tenens work at Grand Strand at some point, correct?

A. Yes.

Q. Okay. And then at some point, you were working as a hospitalist at Grand Strand doing locum tenens work through EmCare.

A. That's correct.

Q. Why the impetus to change from Staff Care to EmCare?

A. They wanted me to sign a full-time contract.

Q. Okay.

A. They -- they liked my work and they wanted me as a full-timer.

Q. I see. And are you presently doing locum tenens work at --

A. Yes.

Q. -- Grand Strand?

A. Oh, I haven't done a shift in a few months, but I'm still credentialed there and I just haven't gone there. These things, sort of, cycle. You know, so it's -- it's difficult to predict. That's why there's so many hospitals that I'm credentialed at. Hospitals -- their needs change for a variety of reasons, many reasons and sometimes they don't need locum tenens anymore. Sometimes they call you back, months later, next day, emergency.

Q. And how long is a shift, typically, in one of these assignments? What shift -- the one shift I'm not familiar with -- I don't know, they might --

A. I'm sorry.

Q. How long are they typically?

A. Typically, 12 hours but there are shorter shifts.

Q. Okay. So well, I guess -- maybe that's -- so they would call you just to work one shift or would they say, you know: Dr. Ash-Bernal, we need you for the month of October. We need you for the first week of October.

A. It varies from place to place. Some -- Some hospitals and the -- whoever is putting the

schedule together can be very proactive. They may contact me through my locums rep and say: Hey, we have these shifts available. Can you work them? Or some of them would prefer that I submit a series of dates that I'm available and then they pick and choose. And there's sort of everything in-between. Sometimes an emergency comes up and I've been contacted directly. You know, can you come and work this shift tomorrow? We have somebody out sick. Something like that. So there's a lot of different scenarios. Typically, for routine work it's scheduled ahead of time.

Q. Okay. In October 2015, with regard to Grand Strand, do you -- do you recall what your schedule was for that month?

A. Not -- I don't recollect completely, no. But, I was typically working -- I think 14 shifts was there requirement for night shift. So it was like --

Q. So you would work 14 shifts in a month? When you say 14 shifts --

A. In a month.

Q. Okay. And those would typically be, you said, 12-hour shifts?

A. At Grand Strand I was typically working a -- a 10-hour shift, I think, so...

Q. Have you, prior to sitting down at this

deposition today, had the opportunity to look over Matthew Scheer's medical record?

A. I've read some of it.

Q. Do you have a -- what would -- what -- have you read both the initial presentation, Friday, October 2, 2013, and the second presentation at Grand Strand later that afternoon?

A. Could you tell me where you're specifically looking?

Q. Sure. Well, earlier we broke the -- broke the medical record up --

A. Um-hum.

Q. -- in two different sections. I think it was 1-42 -- was the initial --

A. Yes.

Q. -- occasion, and then 43 on was the second occasion where Matthew presented to Grand Strand. Had -- in the records you reviewed they include portions from both of those encounters at Grand Strand.

A. Could you tell me, specifically, where -- where you're referring to?

Q. Well, I'm not asking about any specific page. I'm just asking, have you looked at pages from both of those sets of records?

A. Some of them, yes.

Q. Okay. Do you have an independent recollection of Matthew Scheer?

A. I don't recall.

Q. Okay. And so there are -- there is a note in the -- in the file, which appears to have been made by you, did you see that note?

A. Yes.

Q. Okay. And do you have any independent recollection -- I know we can read the note, but do you have any independent recollection of your encounter with Matthew in the early morning hours of October 3, 2015?

A. -- I really don't remember.

Q. Okay. Have you ever spoken with Dr. Nirlep Patel about Matthew Scheer that you can recall?

A. Not that I remember.

Q. Okay. Have you ever spoken, that you recall, to any of the nurses involved in Matthew's care, either Nurse Bell or Nurse Freeman, with regard to Matthew Scheer?

A. Not that I remember.

Q. Okay. Any other -- and I know I've limited my question then to two nurses -- any other nurses at Grand Strand or other physicians, that you can recall speaking to them with regard to Matthew Scheer?

A. Not that I remember.

Q. Doctor, let's turn to page 68 in the record. So again, that's the -- in the gray checkered box in the bottom right-hand corner.

A. Okay.

Q. So from the set it looks like we're on the same page. From the second set of records on page 26 of 89.

A. You said page 68, correct?

Q. Yes, page -- I think we're looking at the same pages. Page 25 of 6 -- of 89. The second set of records that's been --

A. Okay.

Q. -- Bates stamped as Scheer_GSRMC_MedRecs68.

A. Yes.

Q. Could you identify what that page is in the record?

A. This is a clinical note that was signed by me on 10/3/2015 at 1:40 AM.

Q. Okay. And this is with regard to Matthew Scheer, correct?

A. Correct.

Q. Okay. And the note starts off: Patient refused IV p.o. Keppra. What's p.o. in that sentence mean?

A. It's Latin for: By mouth.

Q. So he's refusing to take Keppra medication -- pills?

A. Yes, and he refused an IV as well.

Q. Okay. And what is Keppra?

A. It's a medication for seizures.

Q. Okay. And it can be used to -- in some occasion -- on some occasions it's used to treat epileptic seizures, correct?

A. Yes.

Q. Would you agree with me that epileptic seizures can be dangerous to a patient?

A. Possibly.

Q. And would you agree with me that epileptic seizures can potentially have a serious impact on a patient?

A. Possibly.

Q. And would you agree with me that a patient can potentially, possibly, die from epileptic seizures?

A. Possibly.

Q. They can be fatal at times.

A. Often, it's the effect of the seizure, depending on what they're doing at the time.

Q. So the effect of the seizure can --

A. Yes.

Q. -- in some instances, be fatal to an epileptic?

A. Yes.

Q. The note goes on, it says: I was called to patient room by nursing staff since patient was yelling at nursing staff stating they were all: Devil worshipers and Obama is Satan, see that?

A. Yes.

Q. And, as I understand, you don't have an independent recollection of being called by the nursing staff to Matthew's room, correct?

A. I get many calls at night.

Q. And so you don't have any --

A. So at this particular time, no, I don't remember.

Q. Okay. And suffice to say you've no reason to think that -- Am I correct that you don't have any reason to think that the nursing staff at Grand Strand Regional Medical Center are devil worshipers?

A. I don't know.

Q. You don't have any reason to believe that to be true, do you?

A. I don't really know.

Q. The next part of the note states: Patient is a voluntary psychiatric admission and asked -- and

when asked if he wanted to leave the hospital against medical advice or stay in-house for treatment, he states: I want to leave right now, do you see that?

A. Yes.

Q. Okay. Suffice to say, you don't have an independent recollection of that conversation with Matthew, correct?

A. Not the specifics, no.

Q. Well, do you have any general recollection?

A. It's difficult. It was a long time ago.

Q. Okay. Do you have any -- I mean, this is my opportunity, Doctor, to find out what you remember, if anything, about this encounter and I understood you to say a minute ago that you had no recollection -- independent recollection of Matthew --

A. No.

Q. So, you --

A. I don't remember.

Q. Okay. So you don't remember that conversation with him?

A. No.

Q. Doctor, if a -- if there is concern that a patient, due to some sort of psychiatric illness may harm himself or harm others, does a physician in South

Carolina have the ability to temporarily restrain that patient against his or her will?

A. If there's an eminent danger that he may -- he or she may harm him or herself or someone else, yes.

Q. And what's the process by which one can involuntarily keep or detain a patient who the physician thinks is in eminent danger of harming him or herself?

A. The physician would have to assess the patient and be able to decide that there was eminent danger to the patient's person or others and then here's paperwork that can be signed -- that needs to be signed by two physicians who agree that the patient needs to be involuntarily committed for their own safety and the safety of others.

Q. What things would the physician, assessing the patient, look for?

A. I mean, the first thing is just walking in the room and looking at the patient and seeing their general appearance, what their posture is like, what they're doing, and then just talking to the patient. Seeing what they think, what -- see what their perspective is on what's going on and ask him specific questions.

Q. What type of questions would -- should

the physician ask?

A. I mean, initially, the most basic questions are, just make sure the patient knows who they are, knows where they are, knows the date, so that they're oriented.

Q. What is the term: Delusion of thoughts, mean?

A. A delusion is a thought of something that's not based in reality.

Q. Can a person who has delusion of thoughts potentially harm him or herself?

A. I really -- I don't know because I'm not a psychiatrist.

Q. As a general principal, would you agree with me that the person who has delusion of thoughts could potentially harm themselves or him or herself due to those delusions?

A. I think it depends what the delusions are.

Q. But -- well, how so?

A. If someone was having a delusion that they were being attacked, and they were responding to that, they could harm themselves or others if that were the case.

Q. Would you agree with me that in determining whether one is a risk to him or herself one of the

questions or some of the questions that should be asked should focus on whether or not the patient has a grasp on reality?

A. I'm sorry, I'm not following your question.

Q. Sure. I'm asking if it's important when assessing if a patient might be a harm to him or herself that determining whether or not the patient has a -- a grasp on the reality around himself, is that part of what the physician should assess?

A. When I interview a patient many of the questions I ask are dictated based on what the patient is telling me, because every patient is an individual and every situation is unique.

Q. When you -- I understand that you don't have an independent recollection of it, but -- so when you wrote this cross-cover note that's signed October 3, 2015, at 1:40 in the morning --

A. Yes.

Q. -- would you have had access to Matthew's records from his prior time that day, the day before, at Grand Strand Regional Medical Center?

A. I may have had access to some of those records.

Q. Well, why do you say some, not all?

A. There's paperwork that comes up from the emergency department that has to be put in a -- in a binder and if notes were incomplete or unsigned in the medical record -- incomplete -- people are still working on them -- might not all be available.

Q. Sitting here today is there any part of the medical record that you believe would've been unavailable to you on the early morning hours of October 3, 2015?

A. I don't know.

Q. What type of paperwork comes up from the ER? You said earlier that paperwork comes up from the ER that has to be put in a binder, what -- what type of paperwork are you speaking of?

A. Any type of paperwork that was in the emergency department used for the patient care.

Q. Okay. Is that paperwork or that information not also in the computer system?

A. A lot of hardcopy paperwork is scanned into the system at some later date.

Q. Okay. The electronic information, the stuff that's not scanned, you would expect to be in the computer system, correct?

A. I would hope so.

Q. So you're signing this note at approximately one -- what, 1:40 on October 3, 2015 -- was

Matthew Scheer your patient at that point, at that time?

A. I was the cross-covering physician at night.

Q. And tell me what that means in -- in layperson's terms.

A. After the day shift hospitalists go home the night staff, the night shift physicians, are -- and nurse practitioners cover any questions about other medical patients on the medicine floor.

Q. So for the purposes of those hours you were -- you were Mr. Scheer's doctor?

A. I was the cross-covering physician.

Q. You were able to provide him medical care as you thought needed at that point, correct?

A. If I was called by the nursing staff and they had questions, I answered them.

Q. Okay. How many patients would you be seeing in that capacity, as the cross-covering physician?

A. I don't follow your question.

Q. Well, okay. So Matthew -- you didn't admit Matthew Scheer to the hospital, correct?

A. Yes.

Q. Yes, you didn't? I just want --

A. I'm -- I'm agreeing with what you said.

No, I did not admit him to the hospital.

Q. And Dr. Patel was the physician that admitted him, would you agree with that from your review of the record?

A. Yes.

Q. Okay. And so Dr. Patel, at some point, his shift ends, he goes home or to dinner or wherever. He leaves the hospital, correct?

A. Correct.

Q. And at that point you're the physician covering for Dr. Patel's patients, which would include Matthew Scheer, correct?

A. The nurse practitioner was cross-covering the patients up until her shift was over. That's typically what happens and I believe her shift was over around 1:00 AM.

Q. Okay. And at that point, you become the physician cross-covering for Matthew Scheer?

A. At that point, if the -- if the nurses have a question they would look up on the intranet website to see who was on, of the overnight physicians, and page who was appropriate.

Q. Okay. Which -- is it fair to presume it was you since you were the one called at around 1:00 AM that morning?

A. There was two other physicians on that night.

Q. So how would they know who to call?

A. I think I happened to be walking by. I was on the floor admitting another patient.

Q. Okay.

A. Nurses often stop and ask questions if they see me on the floor. They know I'm on at night. They probably could have just as easily contacted another physician, one of the other two that were on.

Q. Okay. So I -- looking back at that note, it says: I was called to patient room by nurses -- nursing staff since patient was yelling it goes on to talk about the devil worshipers and Obama being Satan. So your understanding is that -- that the nurses just called you into the room because you were walking by or in the neighborhood?

A. Or they say that I was on until three o'clock in the morning.

Q. Okay. So at the point when you came in -- you would expect that at some point you came into Matthew's room, correct?

A. Yes.

Q. And at the point you had come into Matthew's room what, if anything, would you have

reviewed from Matthew's medical chart?

A. I don't remember the specific instance.

Q. What would you expect you would have reviewed?

A. You mean what's my general practice?

Q. Sure.

A. I would review the available information and then go and talk to the patient.

Q. The available information would include stuff from the electronic medical record, correct?

A. I can't say specifically what was available to me at that moment in time.

Q. Okay. What reason would the electronic medical record not be available to you at Grand Strand Regional at that time?

A. I don't know. Things are missing from the record sometimes.

Q. Sitting here today there's nothing in the record that you can point to --(Indicating)-- that you believe wasn't available to you at that time.

A. I'm not really following your question.

Q. Sure. Well, you've got 132 pages of medical record in front of you, the vast majority of which is electronic, is there anything in that record that sitting here today you would point to and say, I

don't believe this was available to me at the time I saw Matthew Scheer.

A. I don't know how I could comment on something that's not in the medical record.

Q. Well, I'm talking about what's in the medical record now. Is there anything that you would contend wasn't in the medical record at 1:00 AM?

A. I don't know.

Q. And Doctor, I just want to make sure -- the reason I'm asking is I want to make sure at the trial of this case there's nothing you would point to --(Indicating)-- and tell the jury, this part of the record --(Indicating)-- wasn't available to me at the time I was seeing Matthew Scheer. There's nothing you would point to right -- and say, I don't believe that was available to me at approximately 1:00 AM on October 3rd?

A. I don't know.

Q. Okay. You don't know of any such thing?

A. I don't recall.

Q. Doctor, looking back at that record on Bates stamp 68 of Exhibit 1 -- I'm looking at about halfway through that cross-cover note, it says: Patient indicated he understood that it was recommended he remain in the hospital for further evaluation of his psychiatric issues, but he refused to stay. Patient 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 the result of his psychiatric illness and he insisted on leaving. Do you see that sentence?

A. Yes.

Q. What do you -- based on your habit, practice, custom -- what do you believe you would've explained to Matthew Scheer with regard to -- that he could die from infection, seizures or as a result of his psychiatric illness. I understand that you don't have a recollection of this conversation with Matthew, but what would you anticipate that you would've said to him?

A. I can't comment on what I anticipate I would say, but I would say in general -- and doing evening shift, like I do, I get called about a lot of patients and my preference -- my -- what I vigorously try to do with the patients is if they want to leave in the middle of the night, I try to understand why. Some people are scheduled and they just don't have a -- a bed available at a facility where they might be getting transferred. That happens a lot at night but I don't have a problem with a person leaving to a higher level of care if it's been prearranged and -- however, I vigorously would try and keep somebody in the hospital to continue

their work-up and I would do everything I can to do that.

Q. How would you do that? How would you go about trying to keep them there?

A. First, I would try and understand what the -- why the patient wanted to leave and try to address those issues. Many patients -- if you just address what is concerning them the most and why they want to leave they -- they often stay. Sometimes they just want someone to talk to.

Q. Do you have any understanding, sitting here today, of why Matthew Scheer wanted to leave?

A. If he told me specifically I believe I would've documented it so it's not a reflection of, you know, a lack of attempt to obtain the information, but I'm not a mind-reader and I can't make people tell me things if they don't want to tell me.

Q. You understood he was a psychiatric admission, correct?

A. From Dr. Patel's note it seemed he was admitted to the medicine service for evaluation of leukocytosis.

Q. High white blood cells count?

A. Yes.

Q. Your note says, Doctor: Patient is a

voluntary psychiatric admission. That's the second sentence of your cross -- no, your third sentence of your cross-cover note, do you see that?

A. Yes.

Q. Okay. So you -- would you agree with me, you understood at that time, the time that Matthew's leaving, that in addition to a concern about leukocytosis there was also a concern about Matthew's psychiatric state?

A. I may have been referring to the psychiatric consultation that was pending.

Q. Okay. Well, leukocytosis --

A. Leukocycosis.

Q. Leukocytosis --

A. Sorry. It's habit. I'm sorry. I didn't mean to act like I'm --

Q. No problem.

A. I'm sorry.

Q. Leukocytosis --

A. Yes.

Q. -- isn't mentioned in this cross-cover note, is it?

A. Not that I see.

Q. Okay. Sitting here today, having reviewed Matthew's chart or portions of Matthew's chart prior to

this deposition, what's your understanding of the reason Matthew presented to Grand Strand on the morning of October 2, 2015?

A. My understanding is that his father brought him to the emergency department because of a change in the way he was acting.

Q. It was concern of a psychiatric illness of some type; is that fair?

A. From what I read in the initial admission I don't think that was what the initial work-up was necessarily about.

Q. What do you believe the initial work-up was initially about?

A. The father was concerned because his behavior changed and it looks like Dr. Battisti did a standard work-up to look for causes of that.

Q. After the work-up, do you believe the principal concern with regard to Matthew was some sort of acute psychiatric event?

A. It's possible.

Q. Doctor, let's turn to page 12 in the record. Can you identify what we're looking at there, what is that page?

A. This is a History of Present Illness. It was transcribed by Morgan Bendick.

Q. Do you know Morgan Bendick?

A. I do not know him.

Q. And so, this is the HPI, the History of Present Illness, that would've been filled out by the staff at Grand Strand Regional Medical Center when Matthew, accompanied by his father, first presented to the emergency department that morning, correct?

A. It appears so.

Q. Could you read for me the additional HPI notes there on that page. And if there's an abbreviation read the words. So in other words if it says, you know: H.O. If you would read out: History of, instead of just H.O., for example.

A. History of Present Illness, confirm patient, yes. Complaint: Paranoid and hallucinations. Source of History: Patient, family, timing onset. Days: 2-3. Quality: Hallucinations, paranoid. Additional HPI notes: Mr. Scheer is a 26-year-old male with a history of epilepsy who presents to the emergency department complaining of paranoia and hallucinations. Associated symptoms include insomnia, anorexia due to believing that all the food he used to eat is contaminated now. Patient's father reported that he had extended complex vision last night lasting a couple of hours. Patient reports hearing voices, believes that someone is lotting

against him by poisoning him. Patient denies suicidal or homicidal thoughts. Patient reported not eating today or yesterday. Patient reports not taking his prescribed Keppra for the last 2-3 days. No other symptoms at this time. Portions of this section were transcribed by Bendick, Morgan M. On 10/02/2015 at 16:42.

Q. All right. Thank you, Doctor.

A. And it's signed by Dr. Battisti. It's electronically signed by Bellue, Michael, P.A. on 10/02/2015 at 20:39 hours and then signed by Dr. Battisti, Amanda, D.O. on 10/08 at 08:51.

Q. Okay. Do you know Michael Bellue?

A. I don't recall him.

Q. Okay. And getting back to the notes that were -- that you just read -- so Matthew presents with a history of epilepsy and not taking his prescribed Keppra for the last 2-3 days. Is that a fair assessment of what that note reflects? Correct?

A. That's what it says.

Q. And the purpose of -- we talked about this a little bit earlier -- the purpose of Keppra for epileptic is typically to control seizures, correct?

A. It's to diminish the chance of having a seizure.

Q. Would you agree that it can be harmful

for an epileptic who is prescribed some sort of anti-seizure medication to stop taking that anti-seizure medication?

A. Possibly.

Q. And -- the patient reported not eating today or yesterday. Would you agree with me that is not advisable -- not to eat for two days? People should eat daily.

A. Is that a statement or a question?

Q. I'm asking, would you agree with me that people should eat daily, generally speaking?

A. I think it depends on the person. Some people fast, some people don't feel like eating. I think that, you know, we eat because we enjoy it and we need the nutrition.

Q. Well, he's not eating because he believes the food he used to eat is contaminated now, at least according to the record, do you see that?

A. Can you tell me what page you're looking at?

Q. Sure. I'm looking at that same page, page 12. It's part of what you just read.

A. Yes.

Q. Associated symptoms including insomnia, anorexia due to believing that: Food he used to eat is

contaminated now, do you see that?

A. Yes.

Q. Okay. Do you believe that would be a wise decision, for a person to quit eating due to a belief that all the food one used to eat is contaminated?

A. I don't know.

Q. Okay. You don't have any reason to believe all food in the Myrtle Beach area was contaminated on October 2, 2015, do you?

A. I don't know.

Q. This description here in the HPMI -- HPI, would you agree that this would be consistent with someone who's having delusions of thoughts?

A. I don't know. I didn't assess the patient.

Q. I didn't ask if you assessed, but would you agree that this description would be consistent with somebody having delusion of thoughts?

A. Possible.

THE WITNESS: Do you mind if I take a break to use the bathroom?

MR. HINSON: No, that's perfectly fine, Doctor. I should have mentioned that at the beginning. If at any point you need to take -- we can go off the record.

(Off the record.)

(A recess transpired 11:26 AM to 11:34 AM)

E X A M I N A T I O N

BY MR. HINSON:

Q. Dr. Ash-Bernal, would you agree with me that acute psychosis is a medical condition?

A. Yes.

Q. Okay. Would you agree with me that acute psychosis is a medical condition that requires treatment?

A. Possibly.

Q. Would you agree that mental health is important?

A. Yes.

Q. From your review of Matthew Scheer's chart, do you have any reason to believe that his psychiatric condition, whatever psychiatric condition he suffered from was untreatable?

A. I don't understand the question.

Q. I'm merely asking if -- if you have any reason to believe that whatever psychiatric condition he suffered from in early October 2015 -- if you have any reason to believe that it couldn't have been treated with appropriate medical interventions.

A. I don't know. I'm not a psychiatrist.

Q. And you'd said you're -- you're boarded in

internal medicine, correct?

A. That's correct.

Q. And in medical school you would have had class -- some classes in psychiatry, correct?

A. Yes.

Q. How -- tell me about your -- what psychiatric training and education would you have through medical school?

A. There was a lecture class on psychiatry and in third year of medical school rotations on psychiatry.

Q. Okay. So in your third year of medical school you did a psychiatric rotation?

A. Yes.

Q. And how long is a rotation?

A. It's been a long time. That would've been 1998. Possibly six weeks.

Q. And where did you -- where would you -- what hospital or facility did you do that rotation?

A. Monmouth Medical Center.

Q. And where's that?

A. That's on the North New Jersey coast.

Q. And what type of facility was that? Psychiatric? Was that an in-patient facility?

A. Yes.

Q. They had out-patient services as well?

A. I don't know.

Q. Did you see in the chart where a psychiatric consultation had been ordered for Matthew?

A. Could you tell me the specific place you're looking?

Q. Sure. I'm looking at the paperwork where Matthew comes back to the hospital in the afternoon of October 2.

A. Can you give me a page number?

Q. Yes, I'm looking for the exact page number if you'll give me just a second.

MR. JOHNSON: Page 74.

MR. HINSON: Thank you, Weldon.

BY MR. HINSON:

Q. Doctor, I'm looking at: Scheer_GSRMC_MedRecs74, do you see that?

A. Is this --(Indicating)-- the one you're looking at?

Q. Yes, it is.

A. Okay. Yes.

Q. All right. And so you see down there at the bottom left-hand corner a psych consult is ordered for Matthew?

A. You're looking at the bottom page?

Q. I'm sorry, yes, the bottom left-hand

corner.

A. Yes. Psych consult.

Q. And what time was that ordered?

A. It was ordered on 10/2/2015.

Q. I'm looking at the next page. It looks to me like it was ordered at 17:31 or maybe 19:14.

A. Yes, I see where you're looking.

Q. So would you agree with me that the record reflects that a psych consult was ordered for Matthew?

A. Yes.

Q. Okay. And do you see on the page 74, it says: Consult Reason: Acute psychosis, do you see that?

A. Yes.

Q. What is -- what is acute psychosis? What does that term mean?

A. It would mean a recent or rapid onset of a change in his mental status with certain constellation of signs or symptoms.

Q. Generally speaking, what is psychosis?

A. It's an acute change in mental status with certain symptoms.

Q. Psychosis is associated with a disconnection from reality; is that fair?

A. Yes, but there are other things that -- you know, to be able to diagnosis psychosis. I think

most of the time when -- and I say this as an admitting physician as well. You have working diagnosis. You have a working diagnosis. For every order I have to put down a diagnosis, you know, in one form or the other. So I mean, when somebody comes into the hospital it doesn't necessarily mean that-that is their diagnosis. It means it's -- it's what you suspect. It's a working diagnosis. It's what you want the consultation team to look into.

Q. Well, so in this situation what -- what healthcare providers at Grand Strand wanted from Matthew, among other things, was a psychiatric consultation with regard to Matthew suffering from some sort of psychiatric issues.

A. Yes, that's what you would consult a psychiatric team for.

Q. Did you see any record that a psych consult ever took place for Matthew? That any psychiatrist ever saw him?

A. I don't recall.

Q. How long -- if you ordered a psych consult for someone suffering from acute psychosis, someone who was having auditory and visual hallucinations, someone who had epilepsy and reported not taking his anti-seizure medication for 2-3 days -- how quickly would you anticipate that consultation would take place?

A. I'm sorry, could you repeat your question?

Q. Sure. If you ordered -- you didn't order the psych consult for Matthew, correct?

A. That's correct.

Q. Okay. Had you been the physician placing that order, for Matthew Scheer, how soon, how quickly would you desire that consultation to take place?

A. I don't think I can gauge that at this facility because I was a night worker, you know. It varies from hospital to hospital. So I don't know that I can comment.

Q. Do you have any knowledge regarding the availability of a psychiatric consult at Grand Strand in October of 2015?

A. I don't recall.

Q. Okay. Did you read any of the depositions that have been taken in this case?

A. Some parts.

Q. Okay. Which? We've had Mr. And Mrs. Scheer, David and Deborah, Dr. Patel, and Nurse Bell have been deposed. Have you been provided a copy of all of those depositions?

A. Yes.

Q. Okay. And you've read parts of each one of

them?

A. Parts of some of them.

Q. Nurse Bell recalled that there were rooms on this hall where Matthew was that were psych rooms, did you see that portion?

A. Can you tell me where in the record?

Q. Sure. Well, Ms. -- I'll just represent to you Ms. Bell said that the floor -- and I would be happy to pull out the deposition if you want, but Ms. Bell testified that the floor -- the floor of the wing where Matthew was -- there were five psych rooms on that -- on that floor. Do you recall these --

A. Can you show me in the record where you're referencing?

Q. Well, I'm referencing Nurse Bell's deposition. Do you recall reading that in the deposition?

A. I don't recall.

Q. Okay. Looking at Matthew's record -- I mean -- look at any number of pages. Right now, I'm looking at -- at page -- at page 74, where we were looking just a second ago.

A. Okay.

Q. And it says: Room F-1285, do you see that?

A. Where are you reading that?

Q. At the top of the page, right here --(Indicating).

A. Okay.

Q. Do you know what room that is at Grand Strand? Can you visualize where that room is in the hospital?

A. Just on the second floor.

Q. Can you visualize the hallway though, where it would be?

A. Not specifically where this room is, no.

Q. Okay. Do you know if there are psych rooms at -- well, if -- in October of 2015, there were psych rooms in Grand Strand?

A. There was an area of the second floor where they tended to put psychiatric patients.

Q. Okay. And --

A. But it was a medicine floor.

Q. What types of things, if any, differ from a -- from those rooms, from that area of the hospital, from other patient rooms?

A. Well, there are patients that are involuntarily admitted there and there's a security person at the end of the hall.

Q. Do those rooms have cameras in them; do you recall?

A. I don't recall.

Q. Do those rooms have objects removed from the room which a person might injure him or herself?

A. Could you repeat the question again?

Q. Do the -- do the rooms in that area -- you said there's an area that has psychiatric patients --

A. Um-hum.

Q. Do the rooms in that area of the hospital -- have they had things removed from the rooms, things by which a patient might harm him or herself?

A. It depends what the room is being used for.

Q. Does Grand Strand have rooms like that though? That have items by which somebody might hurt themselves removed from the room?

A. Well, that would be standard protocol for anyone if there was concern that they would harm themselves with something in the room.

Q. Does Grand Strand have rooms that are prepared that way?

A. Possibly.

Q. In your time working at Grand Strand, did you ever have the occasion to keep a patient temporarily against his or her will?

A. Could you repeat the question again?

Q. Sure. When -- in your time working locum tenens at Grand Strand did you have -- ever have the occasion -- did you ever keep a patient against his or her will?

A. Are you referring to the time period when Matthew Scheer was there?

Q. At any time when you --

A. At any time.

Q. -- were working at Grand Strand?

A. Uh-huh.

Q. Have you done that before at Grand Strand?

A. Involuntarily committed someone?

Q. Yes.

A. Where I initiated it or was a co-signer?

Q. Let's start with where you initiated it.

A. I don't recall at Grand Strand.

Q. Do you recall ever doing it as a co-signer at Grand Strand?

A. I have been a co-signer with the emergency department physicians.

Q. Okay. And tell me what you do as a co-signer.

A. Generally, the paperwork for involuntary -- committing someone requires two physicians to sign.

Q. Where would you find that paperwork?

A. In the emergency department I'd usually ask the unit secretary for it and print off a copy.

Q. What about the floor where Matthew was, the second floor?

A. I would ask the unit secretary to located it for me and print it off.

MR. HINSON: Doctor, I'll provide you with what I'll mark as Exhibit 3.

(PLF. EXH. 3, GSRMC Application for Involuntary Emergency Hospitalization for Mental Illness, was marked for identification.)

MR. MCKAY: Thank you.

BY MR. HINSON:

Q. Doctor, can you identify that document?

A. At the top is says: Part I, Application for Involuntary Emergency Hospitalization for Mental Illness, and then there are, all together, four pages of paper with it.

Q. All right. Is this the form you used when you said you were a co-signer in the -- keeping somebody involuntarily because of mental illness?

A. I'm reviewing it.

Q. Sure. Take your time.

A. The last two pages appear more familiar to

me. Licensed Physician Examination for Emergency Admission. Certificate of Licensed Physician Examination for Emergency Admission.

Q. And, Doctor, I don't see anything on this -- these pages that requires a co-signer and I'm curious, do you recall there being some requirement for a co-signer?

A. This is for an emergency admission. Let's see, -- I'm sorry, could you repeat your question?

Q. Sure. Earlier, Doctor, I had asked you about involuntarily keeping somebody because of concern for mental illness and it was my understanding that you said that there was a need for two -- two folks to --

A. I said --

Q. -- sign off on that.

A. I said, typically.

Q. And --

A. So in the emergency department at Grand Strand Hospital if an emergency medicine physician wants to admit someone for suicidal ideation -- they believe they're potentially a harm to themselves or others, the hospitalist is also asked to sign the paperwork.

Q. Okay. And so I -- where -- is this the paperwork that you would sign?

A. I -- I don't recall.

Q. Okay. Do you believe there is some different paperwork?

A. I don't know. But this is -- this is a Certificate for Licensed Physician Examination for Emergency Admission.

Q. How --

A. So this has -- this has one signature area at the bottom.

Q. Do you believe you could have filled out such paperwork for Matthew on October 3, 2015, and temporarily hospitalized him involuntarily?

A. If I felt any patient was a danger to themselves or others I am able to involuntarily commit them.

Q. With a patient, with a history of epilepsy, reporting not taking his Keppra for two days, a patient with paranoia and hallucinations, a patient with anorexia due to believing that all food he used to eat is contaminated, a patient who reports hearing voices and believes someone is plotting against him by poisoning him -- do you believe you could've filled out this paperwork for Matthew Scheer and temporarily kept him involuntarily?

MR. MCKAY: Object to form. Go ahead and answer it if you can.

THE WITNESS: I'm sorry, what?

MR. MCKAY: I said, go ahead and answer it if you can.

A. My clinical assessment at the time, based on my documentation, was that-that was not necessary and as I don't really recall this patient I have to go by my own documentation.

Q. What part of your documentation leads you to -- to that conclusion?

A. Could you give me a specific page number?

Q. Sure. Well, the documentation we were looking at earlier, which I presume you're -- you're speaking of is on page 68.

A. Okay.

Q. But if there's some other, I want you to point it out to me.

A. And, I'm sorry, what was your question again?

Q. Sure. I asked earlier -- I asked if given Matthew's medical condition if you, in the early morning hours of October 3, 2015 --

A. Um-hum.

Q. -- could've filled out this involuntary admission paperwork and temporarily kept Matthew in the hospital against his --

A. If at the time of evaluation, I thought he was a danger -- eminent danger to himself or others, yes, I would've filled it out.

Q. Okay. And how do you define eminent danger?

A. Well, patient's that admit to being suicidal or -- and/or have a plan, that could be eminent danger. Someone who threatens someone, either the staff or discloses a plan that they intend to harm someone and -- I think I -- I mean, my general habit is to press people. If I'm not sure, if I have questions -- it's not something that I would just take lightly. I would attempt to get the information that I could and take the time to do it as well.

Q. What about somebody with delusion of thoughts suffering from hallucinations, even if he or she doesn't have an intent to harm himself, could they still be in danger of unintentionally harming themselves?

A. Well, depends if it's a delusion and it depends if it's -- what the delusion is.

Q. So you would agree that a person with delusion of thoughts could, depending on the delusions stand the -- be in a position where they may cause substantial harm to him or herself?

A. It's possible.

Q. And I -- earlier I had asked you about why it was you didn't think to fill out an involuntary form -- an involuntary admission form for Matthew and you said -- you referenced your note. And so my question that I think that we had a few minutes ago was, what about your note leads you to determine that you didn't think Matthew was at risk of harming himself or others?

A. Well, I would've asked him about if he had -- if he had any suicidal thoughts or thought about harming himself, that's standard although that's not reflected here, which does not necessarily mean I didn't ask it. It's a pretty standard thing. Have you -- have you thought about harming yourself? Have you thought about harming anyone else, and specifically using language that's straight-forward and direct that the patient can understand? I wouldn't have said: Suicidal ideation, you know? I mean -- and just very direct, simple questions. You know, I did remark that he -- that he seemed to weigh the information. That's definitely something that I look for.

Q. Do you agree with me that he was having some sort of religious rant according to your note?

A. Yes. I documented that.

Q. Okay. And you explained to him that he could die from -- and then it goes on to say his

psychiatric illness. What would you explain to him how he could die from his psychiatric illness?

A. Say, in general, somebody is trying to leave the hospital against medical advice at night, which generally I don't think is a good idea -- that -- I would try to explain in every way I could what's possible if they did not continue getting medical care.

MR. HINSON: Doctor, the court -- the videographer needs to change some tapes so we'll go off the record for just a second.

THE WITNESS: Okay.

(Off the record.)

E X A M I N A T I O N

BY MR. HINSON:

Q. Doctor, I'm looking at page -- wow -- page 51 in the -- of Exhibit 1 in front of you.

A. Okay. The -- this page --(Indicating)--

Q. The admission page. Yes, ma'am.

A. Okay.

Q. And you see it says: Person to notify, over there -- David Scheer, kind of, on the right-hand side, a little bit below the --

A. Yes.

Q. -- bottom part of the page. And has David Scheer's phone number in there, correct?

A. 609-226-4952.

Q. Okay. It says: Relation: Father. So meaning that's --

A. Yes.

Q. -- the father of the patient, correct?

A. Yes.

Q. All right. And we saw earlier that Matthew came to the hospital accompanied by his father, correct?

A. Yes.

Q. And, per your note, you never encountered -- or came in contact with David Scheer that you recall or that the --

A. Not that I recall.

Q. And not that the record reflects; would you agree?

A. Yes.

Q. Okay. And if you go a couple pages back, we're looking at page 42. Would you identify what that page is?

A. Is this --(Indicating)-- what you're talking about?

Q. It is, yes.

A. Okay. Discharge summary, chart copy. The date at the top is 10/2/2015. Time is 12:36 PM. Do

you want me to continue?

Q. Sure. Well, just generally speaking, what's this page?

A. It's a discharge summary.

Q. Okay. So it's the paperwork the patient is given when -- when he or she leaves the hospital or leaves the emergency department?

A. Generally, that's what a discharge summary is.

Q. Okay. And so, this was -- this is Matthew's discharge summary from his initial presentation to the -- to the ED at Grand Strand, is that --

A. I --

Q. -- statement a fair representation of what that document is?

A. I don't know. I don't recall seeing this before, but --

Q. Okay. Well, from your review of the document and the record, does that seem to be what this -- what this is? When he's being -- it's a discharge summary from 12:30 on the 2nd of October, 2015.

A. I don't see where it says -- let me just see. I don't see where it says -- it's Amanda Battisti up at the top. I don't see anything about the emergency department though, so I -- I can't comment on that.

Q. Well, would you agree with me Matthew, it appears in this document -- he's being referred to Lighthouse Care Center? See that about midway through the page?

A. It states: You should follow-up with the following physician immediately. Physician Name: Lighthouse Care Center. Specialty: Mental Health. Address is 152 Waccamaw Medical Park Drive, Conway, South Carolina, 29526.

Q. Okay.

A. And there's a phone number.

Q. All right. And so, Doctor, would you agree that this document appears to be directing Matthew to follow-up immediately with a mental health care facility?

A. It appears so.

Q. Okay. And my question actually about this was -- there's a signature there on the page. It's on the bottom left-hand side, do you see that?

A. I see a scrawl.

Q. Yes. It looks like three letters, kind of, in cursive -- are we looking in the same place?

A. Are you talking about --(Indicating)--this?

Q. Yes, ma'am.

A. Okay. Yes.

Q. And I just want to compare that to later signatures for Matthew. Let's look at page 49, there's a couple of Matthew's signatures there.

A. Okay.

Q. Do you see those signatures on that page?

A. You're referring to this page --(Indicating)--?

Q. I am, yes.

A. Okay. Yes, I see signatures on this page.

Q. All right. And then on the next page -- page 50, there's some initials -- the patient's initials. See those down at the bottom, a little bit towards the left?

A. Yes.

Q. It looks like: MJS Matthew Jaggard Scheer, I believe, do you see that?

A. I can't really make it out.

Q. Would you just agree with me -- would you agree with me that those appear to be a different signature than what appeared on page 42?

A. I don't know.

Q. You can't agree that-that appears to be a different signature on 42 than it does on 49?

A. I really can't comment. I'm not a

handwriting expert.

Q. Okay. Well, Doctor, I represent to you that's David Scheer's signature on page 42. Presuming that to be correct --

A. I don't know.

Q. Well, presuming that to be correct, Doctor, we've got a patient who presents to the hospital with his -- with his dad. His dad is listed as the person to notify and his dad is even signing the discharge summary paperwork -- did anything prevent you from calling Matthew's dad at approximately 1:15 AM on October 3, 2015?

A. Only if the patient declined me being able to call his parent or whoever he wanted.

Q. Why do you say that?

A. Well, he has a right to privacy of his medical care and if he declined, which is what the nurses stated, then I could not reveal his medical care or call his father if he did not want me to call his father.

Q. Are you --

A. I'd -- I'd make the distinction too -- I mean, being able to and wanting to are two different things, you know.

Q. Are you aware of HIPPA provisions that

provide that when a patient is suffering from a mental incapacitation a healthcare provider may share the patient's information with family, friends, and others involved in the patient's care so long as the healthcare provider determines, based on his or her professional judgement, that doing so is in the best interest of the patient?

MR. MCKAY: Object to the form.

BY MR. HINSON:

Q. Are you aware of such provisions of the HIPPA laws?

A. Could you repeat the question?

Q. Sure. Are you aware of provisions in the HIPPA law that provides that where a patient suffering from mental incapacity a healthcare provider may share the patient's information with family, friends, or others involved in the patient's care so long as the healthcare provider determines, based on his or her professional judgement, that doing so is in the best interest of the patient?

A. I think if the patient declined contact -- having any of the staff contact his father that we had to respect his wishes.

Q. Even if it would be in the best interest of the patient?

A. I -- I can't comment on what is in the best interest of the patient in that exact moment. What I can comment on is that the patient definitively stated he did not want his father called. I do not know why.

Q. Why can't you comment on what would be in the patient's best interest at that exact moment?

A. If he's able to describe his wishes to me, whether or not I agree with them, you know, I need to comply with that.

Q. Doctor, if a provision in HIPPA provided that if a patient objects to a provider sharing information with the patient's family member, the provider may share the information if doing so is consistent with the applicable laws and ethical conduct, and the provider has a good faith belief that the patient poses a threat to the safety of him/herself or others and that family member is reasonably able to lessen or prevent that threat.

MR. MCKAY: Object to the form.

BY MR. HINSON:

Q. Are you familiar with such provisions within HIPPA?

A. It's possible.

Q. Are you familiar, though, with them?

A. I mean, it sounds like you're reading directly from the document. So it's possible.

Q. My question was if you were familiar with such a provision?

A. I think that when a patient states that he does not want -- he or she does not want certain people contacted they may share with me why they want that or not, but it's my duty to respect the patient.

Q. What if the patient is suffering from an acute psychotic episode, does that change the analysis?

A. If the patient was in eminent danger of self or endangering others, it's possible.

Q. How do you define eminent in that sentence?

A. Eminent, meaning right there or within a short period of time?

Q. How short? Minutes --

A. I don't know.

Q. -- hours, days, weeks.

A. I can't say. I mean...

Q. Are you familiar with the Notice of Privacy Practices used at Grand Strand Medical Center?

A. They were reviewed in my orientation possibly, yes.

Q. There is a portion of those privacy

practices used at Grand Strand -- well, you would expect that patients admitted to the hospital sign-off that they've received some sort of copy of the privacy practices, correct? That's typical operating procedure?

A. That's not something that I would be directly involved with, but typically hospitals have their procedure for that.

Q. We're going to look at page 48, if you would.

A. Okay. Oops.

Q. Matthew Scheer, it appears on page 48, signed off acknowledgment of the Notice of Privacy Practices. Do you see that about one-third down the page?

A. Okay. I see number 15, Notice of Privacy Practices.

Q. Yes.

A. I acknowledge that I have received the hospital's Notice of Privacy Practices, that paragraph?

Q. Yes.

A. Yes.

Q. If the privacy practices at Grand Strand state: We may also use and disclose health information for the following types of entities, including but not limited to and then it goes on to list: A person or

person's able to prevent or lessen a serious threat to health or safety.

A. Yes, I see that.

Q. Do you believe Matthew's father could've been in a position to prevent or lessen any danger to Matthew?

A. I don't know. I can't answer to a hypothetical like that.

Q. Do you believe Matthew was at risk of serious injury due to his psychiatric illness, correct?

MR. MCKAY: Object to form.

A. If during my clinical assessment of him I had thought that, I would've documented it.

Q. Well, Doctor, you wrote --

A. Can you tell me the page number you're looking at?

Q. Sure. Looking back at 68 your cross-cover note --

A. Uh-huh.

Q. -- you wrote: It was explained to him that he could die from -- then it lists infection, seizures, --

A. Mm-huh.

Q. -- were to result of his psychiatric illness. You wrote that note, correct?

A. Yes.

Q. Okay. So would you agree that Matthew was at risk -- well, you would agree that death would be serious injury, correct?

A. I think injury and death are two different things.

Q. Uh-huh.

A. Death is a terminal event.

Q. Fair enough.

A. Injury is not.

Q. You wrote that he could die from his psychiatric illness. You wrote those words, correct?

A. Yes.

Q. Okay. And --

A. In an effort, I'm sorry, I don't mean to interrupt you, but in an effort to keep the patient in the hospital. To clarify the gravity of them leaving.

Q. Okay. So him leaving the hospital -- he was posing a risk to himself that he could die from his psychiatric illness?

A. No, this is a hypothetical.

Q. Well, I'm looking at your note.

A. I agree.

Q. You explained to him that he could die

from his psychiatric illness if he left the hospital.

A. You could die -- walking across the street.

Q. Would you explain that to me if I was trying to leave the hospital?

A. I -- anyone that leaves against medical advice I try and emphasize that many things depending on what they were getting worked-up for, if they don't get worked-up, could be dangerous.

Q. Matthew leaving, against medical advice --

A. Mm-huh. I'm sorry, yes.

Q. -- he had the possibility of dying for his -- because of his psychiatric illness, correct?

A. That's a statement. What's the question?

Q. Is that correct? Doctor, I'm asking -- Matthew choosing to leave against medical advice, he posed the risk of dying due to his psychiatric illness.

A. I cannot agree with that.

Q. Okay. You wrote, Doctor: It was explained to him that he could die from psychiatric -- his psychiatric illness. And so you don't agree that him leaving -- he posed the risk of dying from psychiatric illness.

A. If in my clinical assessment, when I was talking to the patient -- if I thought that he posed a clinical risk to himself or others, I would've kept him

from leaving.

Q. Okay.

A. And I can only go by my notes and my routine seeing patients.

Q. Doctor, turn to page 85 in that record, please.

A. Yes.

Q. All right. Doctor, what is page 5 -- or page 85 and 86?

A. Grand Strand Regional Medical Center Informed Refusal for Partial Refusal of Care and AMA, Against --

Q. Is that your hand -- I'm sorry, go ahead.

A. Against Medical Advice.

Q. Is that --

A. And the top says: The sections below are for partial refusal of care and 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 patient. Do you want me to continue?

Q. No, I'm just asking, Doctor, what the page is. What -- if you could just, in layman's terms, tell us what we're looking at?

A. It's the AMA form that's used.

Q. Okay. Did you complete that form?
A. Yes, it looks like my handwriting.
Q. Okay. And then you signed the form on the next page, correct? Page 86 of Exhibit 1?
A. Yes, that's my signature.
Q. Okay. And I'm looking on page 85 --
A. Yes.
Q. It says: Risk of such refusal of care -- and you -- the first thing you wrote was death, correct?
A. No, the first thing I wrote was IV peripheral line, Keppra.
Q. I'm looking at the column entitled: Risk of --
A. Risk of refusal.
Q. -- Refusal of care?
A. Yes.
Q. And the first thing you wrote was the risk was death, correct?
A. It does say death there, yes.
Q. Okay. So my question is, Doctor, Matthew leaving the hospital against medical advice posed a risk that he might die, correct?
A. I disagree with that.
Q. Okay. How --

A. This is not a prediction. It's not a prediction. This says, I asked the questions I wanted to ask and that I still refused the test, examination, and/or treatments as follows. This just means that I reviewed these possibilities with him and he still refused.

Q. Okay. Doctor, what does the word: Risk, mean?

A. Risk means there's a possibility of something happening.

Q. Okay. Matthew leaving the hospital against medical advice posed the possibility that he might die due to his psychiatric illness, correct?

A. There is a possibility.

Q. And you wrote that that was one of the risks that he was enduring -- that he -- that was one of the risks that him leaving the hospital posed. You wrote that on this form, didn't you, Doctor?

A. I would've discussed any one of these things with him.

Q. That wasn't my -- I didn't ask what you discussed. My question was, you wrote on this form --

A. Um-hum.

Q. -- that one of the risks leaving the hospital posed was the risk of death.

A. Yes.

Q. Okay. Do you believe that calling his father, who had accompanied him to the hospital and could have lessened or prevented the risk of death?

MR. MCKAY: Object to form.

A. He didn't allow me to call his father.

Q. Well, he had signed that he had read the Notice of Privacy Practices, we established that earlier, correct? He had signed he had received and read those. And if the privacy practices for Grand Strand say: We may also use and disclose healthcare information to a person or persons able to prevent or lessen a serious threat to health or safety. He had agreed that someone who could lessen threats to his safety could be called, didn't he?

A. He apparently signed that. I don't know.

Q. Okay. Would you agree with me that Matthew's father may have been able, if called -- may have been able to lessen the risk of death Matthew faced?

MR. MCKAY: Object to the form.

A. I can't comment on a hypothetical like that. I just don't know.

Q. What would you need to know?

MR. MCKAY: Object to form.

A. The only thing I can draw on is past experience with other situations. There have been many

situations where family members have requested information about a patient and the patient, for whatever reason -- and many times there are reasons that are not elucidated immediately -- that they do not want the family members to know and out of respect for the patient -- I mean, I can ask -- I can ask why. If they say, no, they don't want to tell me why, that's kind of the end of the discussion. I have to respect their right to privacy and their desire not to reveal information about their healthcare, and if you were my patient in the hospital I would do the same for you.

Now, it's very possible that over time, developing a relationship with a patient, that if there's trust that they may actually start revealing reasons. And I can honestly say there have been many situations where information was revealed that was very surprising, you know, about the patient and I've learned from a lot of experience, you know, not to assume that I know why somebody would say: You know, I don't want you to call my father or my mother, and I would do the same for you, as a patient, or any of the lawyers here, or the stenographer, because that's my duty as a physician.

Q. You're cross-cover note doesn't reflect asking Matthew about calling his father, does it?

A. I believe the -- the nurse mentioned it.

Q. Okay.
A. But, routinely, I would also ask that.
Q. Your cross-cover note doesn't make any mention of asking about calling his father, does it?
A. Not that I see, no.
Q. Okay. And you had no independent recollection of asking Matthew about calling his father, do you?
A. I remember the nurses telling me that they did -- that he didn't want his father called.
Q. Okay. So now, Doctor, you have some independent recollection of your treatment of Matthew?
A. When I was reading the deposition by Ms. Bell, the nurse --
Q. Um-hum.
A. -- some of what she was saying was familiar and I also note, just by routine, these are some of the most basic, most important, things that I would ask as well. And also, information that the nurses would communicate to me.
Q. So earlier, Doctor, I asked if you had any independent recollection of your treatment with regard to Matthew, and I understood that you didn't. Now as I understand your testimony, you have some recollection of

a nurse speaking to you about Matthew?

A. No, when I read her deposition, at least that section of it, it sounded familiar.

Q. Okay. Anything else that you -- sounds familiar, to use your words?

A. Some of the things in her deposition sounded familiar, others did not.

Q. Such as what? What sounded familiar to you?

A. Can you give me a page number?

Q. Well, I -- I'm -- you're the one that said certain things sounded familiar to you.

A. I -- I can't point to a specific paragraph. I mean, there was a lot of paperwork I went through and I just recall thinking, that sounds kind of familiar.

Q. Okay. But you --

A. Other -- other parts didn't sound familiar. I mean, this is over two years ago.

Q. But, you don't -- again, so as I understand you don't have an independent recollection of Matthew Scheer and being the --

A. I don't remember what he looks like.

Q. -- medical care -- but you don't have independent recollection of the events of the morning of October 3, 2015?

A. Not specifically.

Q. Well again, Doctor, when you say not specifically, do you have generally a recollection? I had thought we had established that you didn't, but now I'm -- I -- I'm unsure. Do you have an independent, any independent, recollection of Matthew Scheer and the medical care he was provided -- conversations with nurses with regard to Matthew? Anything with regard to Matthew Scheer from October 3rd, --

A. I can only say that when --

Q. -- 2015?

A. I can only say that when I -- when I read Ms. Bell's deposition some of the things that she was saying sounded familiar, that's -- that's all. It's not a completely specific memory of the entire event or talking to him, it just seemed familiar and with seeing many patients, like we do and -- I mean, that's sort of common.

Q. Nothing more you can add then besides what's already in the medical record; is that fair?

A. I have not read all of the medical records, so I can't make that statement. I haven't read every single page, every line.

Q. But you have no independent recollection. You wouldn't come to trial and say, I remember this, I

remember X, I remember Y?

A. I can't deal in hypotheticals like that.

Q. Doctor, I'm trying --

A. I'm -- I'm not trying to -- I'm really not trying to give you a hard time. I'm trying to answer the question, but it's -- you're asking these hypotheticals that, you know, -- I mean, I honestly -- I didn't even know about this, all of this, until a bunch of months ago.

Q. But Doctor, what I am trying to understand is --

A. Uh-huh.

Q. -- what you would come to trial and testify to and if you have a recollection of Matthew, which I had thought we had established that you didn't --

A. Uh-huh.

Q. -- then that's one thing. If you have some memory of him and some memory of conversations with nurses I'd like to know what your memory is of that?

A. I think when I was reading Ms. Bell's deposition I had a vague recollection of some of the things. I do not remember what he looks like.

Q. Okay.

A. And other than what I documented, I don't know what else to say.

Q. Okay. So that -- so you have nothing additional to add. There's nothing you can point to, sitting here today -- I remember this conversation. I remember this being said to me.

THE WITNESS: I'm sorry, my microphone fell off.

MR. HINSON: Quite all right.

VIDEOGRAPHER: Just put it back -- yes.

A. I'm sorry, repeat the question please.

Q. Sure. And so I'm asking -- you have nothing more to add, as I understand it -- I remember a nurse telling me something along the lines of X-Y-Z. I remember Matthew saying such-and-such to me. You don't have any independent recollection of things like that?

A. What I've told you is the best of my recollection. That's all I can tell you.

Q. There's nothing more to add from what we've discussed?

A. At this time, no.

Q. Okay. Doctor, was there, and I want to be clear in my question -- I am not asking you in any way for the substance of anything that was done or said, but were you a part of any sort of committee or investigation

with regard to Mr. Matthew Scheer?

A. No, not that I recall.

Q. You don't recall any sort of peer review or sentinel event or some type of committee that was formed and looked into Matthew's medical care on October 3rd -- 2nd and 3rd, 2015?

MR. JOHNSON: I'm going to object to the question because it's privileged, but you may answer.

A. I'm a little confused -- what to do now?

Q. You can answer, Doctor. Again, and I want to be clear -- all I'm asking is if you recalled in any way participating in any sort of committee like that?

A. I don't recall.

Q. Do you recall ever being questioned by any sort of police department personnel with regard to Matthew?

A. I don't recall.

Q. Okay. Is elevated white blood cell count of 14.4 -- is that a serious medical condition, typically?

A. It's possibly.

Q. Can stress and anxiety raise one's white blood cell count?

A. You can get a mile leukocytosis with

stress, yes.

Q. What do you define as a mild leukocytosis?

A. Well, the upper limit of normal is about 10, depends on the facility. They might have a slightly different range than that but anything in the range over 10, but less than 15.

Q. Okay. Would be a mild leukocytosis?

A. Mild-to-moderate, could be. It depends on which end you're talking about of that range, but in a -- in a young, healthy person -- and you have to keep in mind the age of the patient as well. I mean, someone who is young and healthy can -- can mount a pretty -- a pretty good response to things and, you know, someone who is older or immunocompromised might not be able to. So it's really in the context of the patient and the -- what they're presenting with. You know that -- I don't mean to flavor this. Labs are only meaningful in the context, is what I'm saying.

Q. If Matthew had an elevated white blood cell count of 14.4, is one possible explanation for this 14.4 anxiety and stress for a 26-year-old male?

A. It's possible.

Q. And if Matthew -- if Matthew had an elevated bilirubin of 5.5, could one explanation of that elevated bilirubin be malnutrition for a few days?

A. I'm not sure about that. There are other more common reasons for something like that, and I'm not -- I was a little puzzled about that in the medical record, but I saw that Dr. Battisti, you know, ordered a work-up of that.

Q. What sort of things can cause an elevated bilirubin to 5.5?

A. Well, I mean, the most common thing would be like an obstruction in the common bile duct, which -- although I don't recall her specifically saying in her note what she was working-up, but that would be a common reason to get a right-upper quadrant ultrasound that she ordered and...

Q. What other things could elevate bilirubin?

A. Any kind of gallbladder disease or disease of the liver. There would have to be further work-up of it to start narrowing down.

Q. And we don't -- and we don't have that work-up to -- to know, correct?

A. I -- I didn't see anything.

Q. Was there anything that prevented you from calling Dr. Patel on the morning of October 3, 2015?

A. Well, my shift ended at 3:00 AM. It's very likely I was sleeping.

Q. Well, but at the time period I'm speaking

of around 1:15 when you were -- had encountered Matthew, at least per the record, was there anything that prevented you from paging or calling Dr. Patel?

A. Well, he wasn't on-duty.

Q. Do physicians sometimes get called when -- when they're outside of their shift?

A. For hospitalists or are you talking -- can you be more specific? I guess --

Q. What about hospitalists? Do they ever get called outside of their --

A. Not typically.

Q. Have you ever done that? Called a hospitalist outside of his or her shift hours to ask a question about a patient?

A. I don't recall.

Q. What's a discharge plan? What does that term mean, generally speaking?

A. It's a plan of care for after the patient leaves the hospital.

Q. And when is one of those made?

A. Well, as far as the physician, it's likely it would start to be made once the decision was made to discharge.

Q. Was there ever a discharge plan made for Matthew?

A. I don't recall. He left against medical advice.

Q. You saw that Nurse Bethany Bell did the intake information for Matthew. Did you see that in her deposition? She talked about doing the intake.

A. Could you give me a specific page number, please?

Q. I would be happy to. Do you have a copy of her deposition?

A. I have the --(Indicating)-- pages that you gave me. While you're looking, do you mind if I take another bathroom break?

MR. MCKAY: Yes, that's fine.

MR. HINSON: Yes, sure. That would be fine.

THE WITNESS: Okay.

(Off the record.)

E X A M I N A T I O N

BY MR. HINSON:

Q. Doctor, what I'm looking at here is the assessment done by Nurse Bethany J. Bell, and I believe it starts on page 109 and goes through to about page -- well, up to about page 129 of Exhibit 1, do you see where I'm looking?

A. Yes.

Q. And my question is this, the -- at Grand

Strand when a nurse does an initial assessment of a patient, what's your understanding, if any, of what information the nurse has been given prior to doing that nursing assessment?

A. I'm sorry, could you --

Q. Sure. I --

A. -- say the question again?

Q. My question asked, when a nurse at Grand Strand does a nursing assessment of a patient that's being admitted, what's your understanding of what information the nurse will have been provided about the patient prior to doing the assessment?

A. They do their nursing assessment.

Q. I understand, but they have to know to go into the room to do it. They have to know that there's a patient there that needs a nursing assessment, correct?

A. Since I'm not a nurse, I don't know.

Q. Okay. So then it's fair to say you're unaware of what information a nurse would have about a patient at the time he or she begins doing a nursing assessment?

A. I -- I don't think I've ever looked at -- in fact, I can't look at the same screen. For instance, in the electronic medical record, what -- what they see is different than what a physician necessarily

sees in some screens because its geared towards the person that is using it -- the physician, the nurse. Do you understand? I mean, there's times I've talked to nurses and they -- they can show me something on their screen because their view looks different than mine and depending on the electronic medical record it can look completely different.

And so I'm not trying to be evasive, it's just that -- I mean, sometimes even when a nurse points out what she's pointing at the screen looks very different to me and they would literally have to point it out to me.

Q. Okay.

A. You know. And sometimes it looks similar to what my screen looks like, and that's very common with electronic medical records. They're geared towards the user.

Q. That information on the screen is still available to you as the physician though, correct?

A. If I went looking into the nursing section, it could be.

Q. You wouldn't anticipate there is information that's being withheld from you as a physician, would you, that's unavailable to you? You wouldn't anticipate that there was patient information in the computer system at Grand Strand Regional Medical

Center that would be available to a nurse, but not available to you as the physician, would you?

A. I would hope they would tell me anything relevant.

Q. That's a little different than my question, Doctor. You would not anticipate that there's information in the computer system, the patient's medical -- electronic medical chart that would be unavailable to you as a physician, but available to a nurse. You wouldn't expect that, would you?

A. Yes, I don't know. That's a hypothetical.

Q. I -- I don't intend it as a hypothetical at all. Would you anticipate that there would be information about a patient that would be available to a nurse, but not available to a physician? That wouldn't be the way you anticipate a computer system to work at Grand Strand Medical Center.

A. Well it's -- it's difficult to answer because there's -- there's times where, although in theory it's available, it may not be very easily discoverable. In other words, I would have to go into the nursing section and -- and look around and try to find if this is something that, you know, I thought that there might be something more in the nursing notes. And

on occasion I have done that, but on routine the types of things that I look at are somewhat different than what the nurse looks at. We both look at the labs, for instance. There's things -- there's commonalities, and then because we're doing different things, our responsibilities are different, we may be looking in different areas of the chart. It's almost like you have to imagine the -- like we're talking about a file cabinet --(Indicating)-- filled with papers and we go into certain sections and look. That's our routine.

Q. Okay. You would expect, as the physician, caring for a patient to have access to any information in the patient's medical chart that a nurse would have access to?

A. That was relevant to their medical care, yes.

Q. Okay. And earlier I was asking you about what you would anticipate a nurse would know, if anything, about a patient at the time he or she begins doing an initial nursing assessment, and I don't know that I ever got an answer to that question. Do you have no comment on what you would expect a nurse to know during an initial nursing assessment? What you would expect the nurse to know about the patient?

A. I'm sorry, you're really confusing me.

Q. I'm -- I'm sorry. That's really the worst question, I will admit. My question deals with -- nurse -- nurses do the nursing assessments, correct?

A. Yes.

Q. Okay. At some point, the patient comes to the hospital, a nurse is going to walk in and go through a nursing assessment with the patient, correct?

A. Yes.

Q. Okay. At the point the nurse walks into the room, to do this assessment, what would you as the physician expect the nurse to already know about the patient? I mean, obviously the nurse knows the patient's in the room because he or she knew to go perform the assessment. What other information about the patient would you expect the nurse to already be aware of at the time he or she goes to perform that assessment?

A. The patient's name, possibly date of birth, the gender.

Q. Would you anticipate the nurse should know the general purpose of the patient's presence at the hospital, the reason he or she's there?

A. Generally, yes.

Q. Okay. Would you agree that patients who are having suicidal ideations do not often readily admit to having suicidal --

MR. HINSON: Strike that. I'm going to ask that a different way.

Q. Doctor, do you agree that patients having suicidal ideations sometimes will not admit to having had suicidal ideations?

MR. MCKAY: Object to the form.

A. Can you repeat the question?

Q. Sure. Do you agree that patients having suicidal ideations do not always admit to having had suicidal ideations?

A. Well, I'm not a mind-reader. If a patient doesn't tell me something I can't know what's in their head.

Q. Okay. I understand that, Doctor. I didn't ask if you had the ability to know what's in their head, but would you agree that patients who are having suicidal ideations sometimes won't admit to it?

A. Possibly.

Q. Likewise, patients having homicidal ideations don't always admit to having had homicidal ideations?

A. Possibly.

THE WITNESS: Can we pause for a moment?

MR. HINSON: Sure.

THE WITNESS: Can I have another bottle of

water? Thank you. Thank you.

BY MR. HINSON:

Q. Doctor, do you agree that good doctors sometimes make mistakes in judgement?

A. I think people make mistakes in judgement sometimes.

Q. So you agree that doctors sometimes make mistakes in judgement?

A. As far as I know doctors are people too.

Q. So you would agree with me that doctors sometimes make mistakes in judgement?

A. I think people make mistakes sometimes.

Q. Doctor, do you agree that good doctors sometimes make mistakes in judgement?

A. I would say, people make mistakes in judgement sometimes.

Q. Okay. And doctors are people, correct?

A. I would like to think so.

Q. Okay. So good doctors sometimes make mistakes in judgement?

A. I'm not exactly -- know what you're referring to as a good doctor.

Q. Competent doctors still make mistakes in judgement.

A. What you're stating is a -- is a

judgement about what is good or bad, and so I can't completely agree with that statement.

Q. Okay. Do you agree that competent doctors sometimes make mistakes in judgement? And you can agree or disagree with that statement.

A. I can't agree or disagree.

Q. Okay. Do you agree that a doctor should not be reckless?

A. I don't think people should be reckless.

Q. Do you agree that a doctor should not be reckless?

A. Doctors are people too.

Q. Okay. So do you agree that a doctor should not be reckless?

A. I believe that people should not be reckless.

Q. That wasn't my question, Doctor. Do you agree that a physician should not be reckless?

A. I believe people should not be reckless, and doctors are people.

Q. Okay. So therefore, you agree with the statement, a physician should not be reckless?

A. I agree with the statement that people should not be reckless, and that doctors are people.

Q. So you can neither agree or disagree with

the statement that a physician should not be reckless? Doctor, I don't mean this as a trick question. Do you agree that a physician should not be reckless?

A. I stated what my answer was.

Q. So you can neither agree nor disagree with the statement that a physician should not be reckless? You will not agree nor disagree with statement?

A. I stated that people should not be reckless. I believe that.

Q. Okay.

A. And that doctors are people too.

Q. Okay. Do you agree that when treating a patient, a physician should take all known risks into consideration?

MR. MCKAY: Object to form.

A. Could you repeat the question?

Q. Sure. Do you agree that when treating a patient, a physician should take all known risks into consideration?

A. I think as a careful physician you need to take as many risks as possible into consideration.

Q. Do you agree that a prudent and cautious physician should seek to minimize the risks to his or her patient?

MR. MCKAY: Object to form.

A. I think as physicians and -- it's important to minimize risks to the patient and attempt to formulate a plan for the best outcome, whatever that situation is.

Q. What does the term: Standard of Care, mean to you?

A. It's treating patients so that they have the least risks with the most benefit.

Q. Do you agree that if a physician is negligent in his or her treatment of a patient, resulting in injury to the patient, that the physician should be held financially responsible for the injury?

MR. MCKAY: I will object to form. That's a legal question. You can go ahead and answer it if you can.

A. I don't know. I'm not a lawyer.

Q. Okay. So you cannot -- neither agree or disagree that if a physician is negligent in his or her treatment of a patient, resulting in injury to the patient, the physician should be held financially responsible for the injury caused?

A. I don't know. I'm not a lawyer.

Q. What about a negligent driver on the highway? Should he or she be responsible for injury caused for negligence driving?

A. I don't know.

Q. So if a person negligently runs a red light, hits another car, causes injury to the people in the other car, you can't speak as to whether the person who ran the red light should be held financially responsible for the injury that resulted?

A. I don't know.

Q. Have you ever been involved in a lawsuit before, besides this one?

A. In fact, that very situation you're talking about happened to me.

Q. Okay. Where you were in a car wreck?

A. No, my car was hit.

Q. You were involved in a car wreck?

A. I wasn't in the car.

(The proceedings were interrupted.)

Q. Oh, okay. Tell me what happened, Doc.

A. I had left a shift at Grand Strand Hospital at about two o'clock in the morning and I pulled out on Business 17, and my engine cut out.

(The proceedings were interrupted.)

MR. HINSON: Weldon, do you want us to pause for a second? I'm about done.

MR. JOHNSON: I got a call from my nurse and she's not out here.

THE WITNESS: Okay.

MR. JOHNSON: (Unintelligible)-- Are you almost done?

MR. MCKAY: Do you really want to know about a wreck?

MR. HINSON: Well, yes, sure.

BY MR. HINSON:

Q. Doc, if you'd finish the -- your account of what occurred.

A. Yes. So I pulled out of Grand Strand and my -- my gas was low and I -- I pulled out and my engine cut out.

Q. And your car got hit later?

A. It got hit, like, 12 minutes later.

Q. But you were in the car?

A. I wasn't in the car.

Q. You were in the car?

A. No, I was not in the car.

Q. And was there a claim made against somebody's insurance in that situation?

A. There was a claim made against my State Farm insurance.

Q. Okay. But it was not a lawsuit filed?

MR. JOHNSON: I've got to take this.

(The proceedings were interrupted.)

THE WITNESS: Uh-huh. I have yet to meet about that.

(The proceedings were interrupted.)

MR. JOHNSON: Yes.

BY MR. HINSON:

Q. Doctor, this is recent? Is this fairly recent?

A. I don't know if I can remember the exact date.

Q. Approximately how many months ago?

A. March. Sometime in March of 2017.

Q. Have you ever been involved in a lawsuit?

A. Besides this one?

Q. Besides this one?

A. Not previously that I recall. My -- my State Farm insurance, I think, is what's being sued, I believe.

Q. Have you ever been involved in any sort of claim against you with regard to your work as a physician?

(The proceedings were interrupted.)

A. As a physician?

Q. Yes.

A. Not that I recall.

Q. Okay. Have you ever had your license

-- and I see from your CV you've had medical licenses in a number of states, correct?

A. Yes, throughout my training, you know, if I got a license I -- I typically kept it up.

Q. Okay.

A. So I trained in a lot of different places.

Q. Other than letting your license lapse due to failure to renew, have you ever had your license suspended or revoked in any of the states in which you practice?

A. No.

Q. Okay. What, if any, family do you have in Horry County? And Doctor, I'm not trying to get into your private life, I just want to identify folks who may have some relation to you if we -- when we draw a jury in this case.

A. I'm married.

Q. Okay. And your spouse's name?

A. Christie Goodhue.

Q. Okay. And any other family? Does Christie have family in this area?

A. No.

Q. Okay. And you're not from here orginally, correct?

A. No.

Q. So neither you nor Christie have any in the Horry -- in Horry County?

A. That's correct.

Q. And what about clubs or organizations that you belong to in the area? Again, I just -- if there's somebody that you go to rotary club with or go to church with I just want to be able to identify those people if -- when we draw a jury in this case.

A. So what was the question again?

Q. Any organizations, churches, social groups that you belong to in the area?

A. The YMCA.

Q. Okay. Anything else?

A. No.

Q. Okay. And you said you haven't spoken with Dr. Patel with regard to this case, correct?

A. Not that I recall.

Q. Okay. Nor any of the nurses?

A. Not that I recall.

Q. Okay. And journals and articles you subscribe to -- tell me what you read on a regular basis.

A. Because I belong to the American College of Physicians I get some journals sent to me, but most of the resources I use are all electronic. It's, sort of, where everything's gone.

Q. Okay. Where -- UpToDate, is that somewhere you would go?

A. UpToDate is a good resource.

Q. PubMed, ever used that one?

A. I have. I'm published in PubMed.

Q. Anything else that you typically go to as a resource?

A. That's tough to say because, you know, UpToDate links to a lot of resources, does that make sense?

Q. Sure.

A. So if I'm following a -- a -- a trail of something that I'm interested in I'll often be going within the website and outside of the website so it's hard to really quantify. I mean, including, you know, reading specific papers that are referenced. You know, and then of course, it depends if the paper is, you know, free access or do you have to, you know, have a subscription to it or something like that. So there's just a lot of -- I mean, I wish it was all just free out there, you know? I mean, but a lot of times you hit roadblocks and you have to, sort of, worm your way around, I guess, is the way I would say.

Q. Okay. But nothing else that you would say you regularly consult on a regular basis?

A. Martha Stewart Living in the bathroom.

Q. Nothing else in the medical field, Doc?

A. It's good bathroom reading. I'm sorry.

Q. So no other subscriptions that you have. I mean, different folks in different professions say the regularly read such-and-such journal. I'm just trying to understand what you regularly look at in your practice of medicine.

A. Most of what I regularly look at is electronic.

Q. Okay. And we said UpToDate and PubMed and then, of course, wherever they may take you down the wormhole?

A. Yes.

Q. Okay. Nothing more regularly?

A. Not that I recall.

Q. Will you agree with me that South Carolina has a provision allowing someone to be involuntarily kept for concerned mental incapacity and harm to him or herself?

A. If there's eminent danger to the person or to somebody else, yes.

Q. And we -- I presume the other states in which you've been licensed have had some sort of similar legal provision; is that fair?

A. I don't recall specifically, but it seems every state does.

Q. Would you agree that holding someone temporarily against his or her desires if there's a concern of, as you put it, eminent danger is the standard of care in medicine?

MR. MCKAY: Object to form.

A. Could you repeat the question?

Q. Sure. Would you agree with me that holding a patient involuntarily, temporarily, in the situation where there is a concern of eminent danger to him -- to the patient because of some sort of mental infirmity, is the standard of care in medicine?

MR. MCKAY: Object to form.

A. I'm a little confused what to do now.

Q. You can --

A. You guys are fighting among yourselves. I'm just confused.

Q. You can answer, Doc.

MR. JOHNSON: She's looking at you, Jay.

MR. MCKAY: Oh, yes, if you could -- do you know what the question is?

A. As a physician I'm allowed to involuntarily commit someone that may be in eminent danger of harming themselves or others, yes.

MR. HINSON: All right. Nothing further.

MR. JOHNSON: I have nothing.

MR. MCKAY: No questions.

(Off the record.)

(The deposition was adjourned at 12:46 PM)

(Signature Reserved)

SIGNATURE OF DEPONENT

DEPONENT: RACHEL ASH-BERNAL, M.D.
DEPOSITION DATE: WEDNESDAY, DECEMBER 6, 2017
REPORTER: TIA SHEAN
CASE CAPTION: DAVID L. SCHEER, AS PERSONAL REPRESENTATIVE OF THE ESTATE OF MATTHEW J. SCHEER vs. SOUTHERN MYRTLE INPATIENT SERVICES, LLC, NIRLEP A. PATEL, M.D., RACHEL ASH-BERNAL, M.D., AND GRAND STRAND REGIONAL MEDICAL CENTER, LLC.

(Please return both Signature of Deponent pages)

I, the undersigned, Rachel Ash-Bernal, M.D., do hereby certify that I have read the foregoing deposition and find it to be a true and accurate transcription of my testimony, with the following corrections, if any:

PAGE	LINE	CHANGE	REASON

AWR

SIGNATURE OF DEPONENT (CONTINUED)

DEPONENT: RACHEL ASH-BERNAL, M.D.
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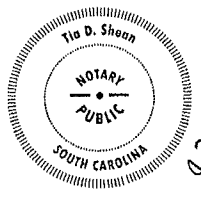
PAGE	LINE	CHANGE	REASON

Rachel Ash-Bernal, M.D.

I, Tia Shean, Notary Public for the State of South Carolina at Large, do hereby certify that the deponent was advised of his or her right to read and sign said deposition both verbally and return foregoing Signature of Deponent pages within the thirty (30) days allowed pursuant to the Rules of Civil Procedure, the original transcript may be filed with the court.



Tia Shean, Court Reporter
My Commission Expires
February 10, 2024

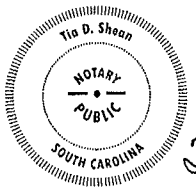
AWR

CERTIFICATE OF REPORTER

I, Tia Shean, Professional Reporter and Notary Public for the State of South Carolina at Large, do hereby certify that the foregoing transcript is a true, accurate and complete record.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof.

Witness my hand, I have hereunto affixed my official seal this 10th day of December, 2017 at Myrtle Beach, Horry County, South Carolina.



Tia Shean

Tia Shean, Court Reporter
My Commission Expires
February 10, 2024

AWR

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*PLF. EXH. 1,	Documents Bates stamped: Scheer GSRMC_MedRecs 1-132 (Medical Record of Mr. Scheer) (Referenced Only)	07/03
PLF. EXH. 2,	Rachel Ash-Bernal, MD Curriculum Vitae (7pgs)	06/23
PLF. EXH. 3,	GSRMC Application for Involuntary Emergency Hospitalization for Mental Illness form (4pgs)	50/10

* PLF. EXH. 1 - Exhibit was marked in a previous deposition so the Original Exhibit will not be attached. It is a continuing exhibit.

AWR

STATE OF SOUTH CAROLINA IN THE COURT OF COMMON PLEAS

COUNTY OF HORRY C.A. No. 2017-CP-26-1571

DAVID L. SCHEER, as Personal Representative of the Estate of MATTHEW J. SCHEER

Plaintiff

vs.

NIRLEP A. PATEL, M.D., SOUTHERN MYRTLE INPATIENT SERVICES, LLC, RACHEL ASH-BERNAL, M.D.

Defendants

_____/

The Videotaped deposition of GREGORY PHEABUS was held on Monday, January 7, 2019, commencing at 10:35 a.m., at the Hampton Inn Hagerstown, Hagar Room, 1716 Dual Highway, Hagerstown, Maryland 21740, before Susan M. Liebrecht, Notary Public.

REPORTED BY: Susan M. Liebrecht, RPR

APPEARANCES:

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APPEARANCES: (Continued on next page.)

APPEARANCES CONTINUED:

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ALSO PRESENT: Curtis Roginski, Videographer

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Deposition of GREGORY PHEABUS

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STIPULATION

It is stipulated and agreed by and between counsel for the respective parties that the reading and signing of this deposition by the witness be and the same is hereby waived.

- - - - - - -

PROCEEDINGS

THE VIDEO OPERATOR: Good morning. We are going on the record at 10:35 A.M. on December 7, 2019.

This is Media Unit 1 of the video recorded deposition of Gregory Pheabus taken in the Matter of David L. Scheer as Personal Representative of the Estate of Matthew Scheer v. Southern Myrtle Inpatient Services, et al. filed in the Court of Common Pleas, State of South Carolina, County of Horry. Case number 2017-C-26-1571-P.

This deposition is being held at The Hampton Inn located at 1716 Dual Highway, Hagerstown, Maryland, 21740. My name is Curtis Roginski and I'm the videographer. The court reporter is Susan Liebrecht.

Examination by Ms. Peavy

Will counsel please identify yourselves and state whom you represent?

MS. PEAVY: My name is Rachel Peavy with The McKay Firm. I represent Dr. Nirlep Patel, Dr. Rachel Ash-Bernal and Southern Myrtle Inpatient services.

MR. HINSON: Francis "Brink" Hinson for the Plaintiff.

MS. BRUDVIG: Kelsey Brudvig at Collins & Lacy and we represent G4S Secure Solutions who are not a party to this action.

THE VIDEO OPERATOR: Will the court reporter please swear in the witness?

Whereupon,

GREGORY PHEABUS

called as a witness, having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION BY MS. PEAVY:

Q Mr. Pheabus, Greg, we met off the record, but I'll introduce myself. My name is Rachel Peavy and

I represent two doctors, Dr. Nirlep Patel and Dr. Rachel Ash-Bernal, and their employer, Southern Myrtle Inpatient Services, in a lawsuit that's been brought by the father of Matthew Scheer for medical malpractice and wrongful death.

The lawsuit generally alleges that these doctors failed to properly treat Mr. Scheer when he came into the hospital on October 2nd of 2015 and that they are responsible for his subsequent death.

I'm here today just to ask you some questions. Have you ever had your deposition taken before?

A Yes, I have. I think it was 2011. I was a police officer for Hagerstown City Police, but that's the only time I've ever been in court for any type of deposition.

Q Okay.

A But nothing for this case prior.

Q Okay. And when you were a police officer for the Hagerstown Police Department were you just giving your deposition in a court case? Was it, like,

an automobile accident? Can you describe that for me?

A The only time for the short amount I was in, it was just for a case involving a firearm.

Q Okay. All right. And were you a witness that you were called to testify?

A No, I was one of the charging officers and I was --

Q So you had written the ticket or the arrest?

A Yes. Yes, I was part of the arrest report that I had to give to the court.

Q Okay. All right. Well, so you're maybe somewhat familiar, but I'm going to -- this is a civil proceeding, so basically I'm here today just to ask you a series of questions to find out what you know about a very discreet period of time --

A Uh-huh.

Q -- when you were working down at Grand Strand Hospital.

I'm going to ask you a series of questions. If my question is unclear or confusing in any way, will

you please let me know? Because then I can rephrase it.

A Absolutely.

Q Okay. And if you answer my question, then it's safe to assume that you have understood the question. Is that also okay?

A That's understood, yes.

Q Okay. Finally, Madam Court Reporter is transcribing everything.

A Okay.

Q So it's important to give verbal answers. I know sometimes you can nod or shrug.

A Right, okay.

Q So just try to remember that.

Finally, if you need to take a break at any time, just let me know and we will do so. Okay?

A Yes.

Q It's not a problem.

And there may be some objections that the attorneys make during the deposition. Those are just for -- to preserve the record and you'll continue to

answer unless there is something that would need to be taken up with the judge or something like that.

A Okay.

Q But otherwise, just assume that those are legal issues that the attorneys just want to preserve for down the road, okay?

A Right, okay.

Q I assume you have a little bit of knowledge about legal proceedings if you worked in law enforcement.

A A little bit.

Q Yeah. Well, first, I'll just have you state your full name for the record.

A Okay. My name is Gregory Thomas Vincent Pheabus.

Q And spell Vinton for me.

A I'm sorry?

Q Spell the third name.

A Vincent.

Q Vincent.

A V-I-N-C-E-N-T.

Q Okay. And what is your date of birth?

A 5/26/91.

Q And where were you born?

A In Washington County, Hagerstown, Maryland at the Washington County Hospital.

Q Okay. And where did you grow up?

A I grew up -- I spent the first five years of my life in the west end of Hagerstown and then I spent the remaining in Maugansville, Maryland.

Q Okay. And how do you spell Maugansville?

A M-A-U-G-A-N-S-V-I-L-L-E.

Q Okay. And where did you graduate from high school?

A I graduated high school at North Hagerstown High School in 2010.

Q Okay. And who did you grow up with? Do you have parents and siblings?

A I grew up with -- well, when I was five years old what made us move from the west end to Maugansville was my parents separated when I was five, so I grew up with my stepfather --

Q Okay.

A -- and my mother and my youngest brother.

Q Okay. And do you have any other siblings besides your brother?

A Yes, I have a half brother that is now deceased and then I have another half brother that is -- he lives in Hagerstown.

Q Okay. And are those children of your mother's marriage to your stepfather?

A No. My biological father and my biological mother had two children before they met and then when they met, they had me and my youngest brother.

Q Oh, okay. I get it. Okay. All right. So your mom and stepdad didn't have any kids together?

A No.

Q Okay. And what is your mom's maiden name and married name?

A My mother's maiden name is Julia Helene.

Q Uh-huh.

A And then her married name is Julia Mikoloski, and I can give you my best way to spell that

even though I've been around it my whole life.

Q That's okay. And then where does your dad live?

A My biological father lives in Hagerstown.

Q Okay. And what is his name?

A His name is Greg Pheabus.

Q Okay. Are you a junior?

A No. It's Gregory, it's Eugene Pheabus.

Q Okay. So slightly different.

A Yeah.

Q Okay. And is he remarried? Your dad?

A No.

Q Okay. All right. And what is your current address?

A My current address is 1105 --

Q Uh-huh.

A -- West Church Street.

Q Okay.

A Hagerstown, Maryland.

Q Okay.

A 21740.

Q Okay. And who lives with you at that address?

A That is my home and it's me, my girlfriend.

Q Okay.

A My son.

Q Okay.

A And my grandmother.

Q Okay. All right. And is your girlfriend the mother of your son?

A Yes.

Q Okay. All right. And is this a home that you rent or own?

A I own.

Q And how long have you lived there for?

A It will be going on five months.

Q Oh, okay. All right. So you all just moved in?

A Yeah, just bought it from my grandmother five months ago.

Q That's nice. So it was a family home?

A Yes.

Q Okay. All right. How old is your son?
A He's three.
Q Oh, okay. You got your hands full.
A And another one on the way.
Q Oh, my goodness. Congratulations.
A Thank you.
Q And where are you -- you graduated from North Hagerstown High in 2010. Kind of walk me through what you have done since graduation.
A Okay. Since graduation I went to Hagerstown Community College.
Q Okay.
A And that's where I studied criminal justice.
Q Okay.
A And I made it about three quarters of the way through the program.
Q Okay.
A And they introduced the Hagerstown Community College Police Academy.
Q Okay.

A So I talked to the -- I don't know, the president of the school.

Q Yeah.

A And he said he would be able to transfer me out of that program, refund me my money for that semester and switch it into the program at the police academy.

Q Oh, neat.

A So that's what I did.

Q Uh-huh.

A And I dropped out of that and went through the police academy for six months.

Q Okay.

A And then during the police academy I was hired at the Hagerstown Police Department.

Q Okay.

A After graduation, I can't give you exact dates --

Q Uh-huh.

A -- but I joined the police department, worked there for a year.

Q Okay.

A And during my stint with the police department that's when I met my girlfriend.

Q Okay.

A And we decided we wanted to move to Myrtle Beach, South Carolina.

Q Okay.

A And when we moved, I was going to join the police force down there, but then I figured how much they got paid and I decided to go with G4S Secure Solutions.

Q Uh-huh.

A And I worked down there for the Grand Strand assignment down there when they first opened.

Q Okay.

A So I was one of the first officers there whenever they first started the contract.

Q Okay.

A And then I did my time down there and then my current girlfriend got pregnant.

Q Okay.

A And we decided we needed more family help than nice weather.

Q Yeah.

A So we moved back to Maryland.

Q Uh-huh.

A And I stuck with G4S through that time because I knew I could transfer back to Maryland with that company.

Q Oh, yeah. Okay.

A So I transferred back and then I started with G4S down here in Maryland at the Ravens stadium --

Q Okay.

A -- for a short while --

Q Uh-huh.

A -- and then I decided to go into driving tractor-trailers. So I got my CDLs, went through two months of school there.

Q Uh-huh.

A And here I sit.

Q Okay. Neat.

So the CDL, are you working for a company

or are you doing it on your own?

A No, I work for a company, Hoffman Transportation.

Q Okay.

A And they're right there at Greencastle, Pennsylvania.

Q Okay. And what kind of -- are you away from home much or what kinds of hauls are you doing?

A No, I'm home every single day.

Q Oh, that's great.

A So it's normally, right now, since my girlfriend is pregnant, I'm trying to get more home time so I can get stuff done because I'm remodeling the whole entire house. So I'm trying to get all that stuff done before the child is born.

Q Oh, okay.

A So I work Sunday through Wednesday.

Q Uh-huh.

A And then I'm off Thursday, Friday, Saturday. So I'm home every single day in between the time I work.

Q Okay. So it's not classic long haul type?
A No.
Q Okay. And in terms of getting -- in terms of when you joined G4S down in Myrtle Beach, that was when the contract was just starting with Grand Strand?
A Yes.
Q Okay. And what was your position at G4S at the time when you started doing the Grand Strand contract?
A My position was the third shift armed supervisor.
Q Okay. All right. And describe to me third shift. Is that 7 to 7?
A No, it was 11 to 7:15; 11 P.M. to 7:15 A.M.
Q Okay. And you mentioned you chose G4S instead of doing law enforcement down at the beach just for salary reasons?
A Yeah, for that and then I knew -- I knew eventually we wanted to move back.
Q Uh-huh.
A And I knew I didn't want to be a police

officer anymore. Because even in Hagerstown they didn't pay that much.

Q Yeah.

A And I knew I wanted to do something with my life other than that.

Q Yeah.

A And so I chose G4S because I knew if I couldn't find anything, I knew I could transfer back to that company and have a job immediately.

Q Okay.

A And then she got pregnant and then that was a good opportunity for me to use that company to transfer back.

Q Yeah, okay. All right.

And then you got to work at the Ravens stadium for a bit?

A Yes.

Q And just decided to change career paths?

A Yes.

Q Okay. All right. And my understanding is that you were one of the security guards on duty on

October 3, 2015.

A Yes.

Q Okay. At that time, what were your duties?

A My duties were the -- if you could remind me what time --

Q It would have been, like --

A -- the patient came in?

Q Well, the time period when the patient was discharged was around 1:30 in the morning on October 3rd.

A That's what time he was discharged?

Q Yeah.

A Do you know what time he came in?

Q I think it shows that he came in around, I think it was -- he was admitted around 7:00 that evening before.

A Okay.

Q As a voluntary admission.

A My duties as third shift supervisor was I was, at that time, whenever I was on duty, there would be me and one other armed supervisor.

Q Uh-huh.

A Or one other armed guard. I'd be the supervisor and then there would be a front desk guard that would be armed.

Q Uh-huh.

A And my duty was to just basically roam the hospital, make sure all person, place and property is safe and secure.

Q Okay.

A Just make sure there is no incidents.

Q Okay.

A And pretty much make sure the guards are doing what they're supposed to be doing and make sure breaks are given.

Q All right. Other than you and the one other armed guard at that time -- I'll call it night, but it's actually about 1:30 in the morning -- at that time of night, are there other guards also on duty or is it just the two of you?

A Yeah, now that I'm thinking about it, on the night shift, that actual G4S guard wouldn't be

armed, but there was an armed sheriff --

Q Okay.

A -- that would be there from Horry County.

Q Okay.

A Now that I can recall. So I would be the only armed guard there --

Q Uh-huh.

A -- in the beginning.

Q Uh-huh.

A But then sooner or later they transferred and did two armed guards there, I believe.

Q Okay. But you don't remember the exact timeframe on the staffing necessarily?

A Well, on the staffing there would be -- see, we had the initial psyche patients, so there would be an unarmed guard down in the actual ER. There would be four rooms they would be responsible for and it was an armed guard that would sit outside.

Q Uh-huh.

A And then up on 2 North on the second floor would be, like, the long-term patients for the psyche.

Q Right.

A They would go upstairs and there would be an unarmed guard there sitting at the computer monitor.

Q Uh-huh.

A And I think, I can't recall the numbers, but I think it is one guard for either four to six patients. I believe it's four. So every four patients there would have to be a guard.

Q Okay. And 2 North had regular rooms and then my understanding is there were some rooms that were designated for psyche patients that didn't have TVs and things like that, correct?

A Right. I see you got a diagram there, but you would walk -- from the elevator you would walk down there and then you could take a left on 2 North.

Q Uh-huh.

A And they basically have the whole end of the hallway dedicated to psyche patients.

Q Uh-huh.

A And people we had to look after.

Q Okay.

A That didn't have TVs or any of the amenities that a normal patient would have, I believe.

Q Okay. And I will submit to you that the evidence in this case has shown that Mr. Scheer was not in one of those special psyche rooms. He was not in one of the, sort of, safe rooms.

A Okay. Yeah, if they started to -- if we started to gather way too many patients, I mean, it would just flood up toward the normal rooms. I mean, there was nothing --

Q Uh-huh.

A -- they could do to keep the rooms from --

Q Uh-huh.

A -- being just strictly the psyche rooms.

Q Okay. At some point around 1:30 in the morning on October 3rd did you escort a man out in his 20's from the 2 North wing?

A Yeah, after -- after the incident happened with that patient, I believe the end call was to discharge a patient and I did escort him. Me and another officer did escort him from his room to the

exit.

Q Uh-huh. And is that because there aren't -- the exits are locked, certain exits are locked, at that time of night?

A Yeah, at a certain time what they would do is they would have the main entrance --

Q Uh-huh.

A -- and then they would have the emergency entrance.

Q At the ER.

A And at a certain time, I don't know the -- I can't recall the time they would close the main entrance, but at that time the main entrance would be closed.

Q Okay.

A So if you got off the elevator, you took a wrong turn, you'd be at a whole other end of the hospital.

Q Okay.

A So when somebody's -- if they need help getting out, we would just escort them to the correct

exit and entrance.

Q Okay.

A And I do not know whether, because whenever they're a psyche patient, we would collect their belongings.

Q Uh-huh.

A So they wouldn't have anything in their room that would be their personal belongings.

Q Uh-huh.

A We would keep them down at the emergency desk.

Q Uh-huh.

A And I believe we took his stuff up there before he was discharged because they knew they were discharging him or we gave them to him at the emergency entrance. But that's where we would keep the patient's belongings.

Q Okay. Now, in terms of discharging someone in the middle of the night, when -- did you later learn that the man that you escorted out was Matthew Scheer?

A I still didn't know his name.

Q Right.

A But I believe the next night I came in I found out that -- that a patient that left committed suicide.

Q Uh-huh.

A And then later I found out, after deduction, that he was the patient that I walked out.

Q Okay. And when you walked out with Mr. Scheer, did he appear calm?

A Yeah, I mean, he was not calm up in his room.

Q Okay. Did you observe him in his room?

A Yeah, because I would have been the roaming supervisor on the shift whenever they called and said they had an incident up on 2 North.

Q Okay.

A I can't remember his exact room, but I do remember going up there and there was an incident where he wasn't happy. He was disgruntled.

Q Yeah.

A And -- but as your question, when we walked

him down?

Q Uh-huh.

A He just walked right behind us and we didn't have any small talk or anything.

Q Right.

A But he didn't seem agitated whenever he was leaving.

Q Okay.

A I mean, he followed right behind us.

Q Uh-huh.

A I mean, he left calm, shook our hand and said, thank you.

Q Okay. All right. And your understanding that he was not happy and disgruntled, did that come from him wanting to leave the hospital? Because he was there voluntarily.

A Right. Whenever you get up in that room they have -- he was in a normal patient room.

Q Right.

A So the door would be open.

Q Uh-huh.

A And if you're an adult being watched on a monitor and the door is open and you're told you can't pass that threshold, and all of sudden your parents are gone and all this, I can understand why he was disgruntled and why all of sudden this has happened to him. And when I got up there he was distraught, he wanted to leave.

Q Okay.

A And basically me and the other officer stood there while he had a conversation with the nurse and the doctor that arrived.

Q Okay.

A And we were just there to make sure nothing was damaged or no persons or property were harmed at all.

Q Okay.

A And once he -- once the doctor said, if you're ready to go, if you want to go, you can go, he completely switched.

Now I do remember, we did bring him his clothes upstairs, I believe.

Q Uh-huh.

A So he was able to put his shoes on and everything. And then after that we just walked down and we showed him the proper way to go.

Q Yeah, okay. Did he mention if -- my understanding at the time when he checked himself out, it was drizzling, but there was a full moon.

Do you recall the weather?

A I don't remember if it was drizzling or not.

Q Uh-huh.

A But I do remember when he left I believe he did, he said, thank you very much. I remember him saying thank you.

Q Yeah.

A And then I just watched the doors open. He did go off on a light jog.

Q Okay.

A So he didn't walk calmly off. He just went off on a light jog.

Q Okay. Kind of ready to get on his way?

A Yeah.

Q Okay. All right.

A But once he knew he was leaving he completely calmed down.

Q Okay. All right. Prior to walking out with him had you spoken with Mr. Scheer before or had you just --

A No, I never had contact with him before.

Q Okay. And when you went to the room when he was wanting to leave, you just stood there, correct?

A Yeah, me and the other security guard. It would have been me, the security guard down at the monitors, and I would have had a roaming unarmed security guard that probably would have been up there with me.

Q Okay. And that's standard operating procedure when people want to leave?

A Yeah, depending on how much our staff varied.

Q Okay.

A How many people we had on staff.

Q Okay. All right. And during -- do you recall anything about Mr. Scheer's interaction with the nurse or the doctor that came?

A Yeah, I just remember him -- he was very adamant that he just didn't want to be there.

Q Yeah.

A And once the nurse takes so much, she just gets a doctor there and she just passes the buck on to the doctor and the doctor makes the determination whether stay or go. And I think at that time of the night normally they would have a -- I don't know if they're a therapist or a psychiatrist, somebody to go in and determine and just talk to the patient.

But I don't know at that time of the night if they were on-call or there was one on duty, but I just remember a doctor being there.

Q Right.

A And I think it was a female.

Q Okay. And you just observed her --

A Yeah, I just observed and just made sure everything, place and property and person, was safe and

secure.

Q Okay. And you didn't prepare any kind of incident report about it or anything like that?

A No, no.

Q Okay.

A Now, there would have been a report from the security guard down at the monitor saying that a doctor arrived or patient is distraught. There would have been a --

Q Medical record.

A Either it was a half an hour or every hour --

Q Uh-huh.

A -- the guard would have monitored the patients' status. And any time there was an incident, like, a nurse went in to give meds, the guard down at the monitor would have wrote that down.

Q Uh-huh. But that's for patients that are there --

A Yeah, that's for every patient.

Q -- committed.

A Yeah.

Q I'm talking about committed psychiatric patients. Not people who are there voluntarily?

A Well, any patient that we would have been watching.

Q Uh-huh.

A Any patient that a guard would have been watching.

Q Okay.

A Now, if he was voluntarily committed as a psyche patient he would have been on the -- if we were watching him? I don't know if he was checked in as a regular patient or a psyche patient.

Q Yeah, he was checked in -- I'll submit to you the medical records show he was checked in as a medical patient voluntarily.

A Okay.

MR. HINSON: Object to the representation. Object to the form.

Q Okay. Now, so the incident report you're referencing would have been prepared for psychiatric

patients?

A Yeah, if he would have been a psyche patient that we would have had monitor on --

Q Okay.

A -- he would have had one of those checklists.

Q Okay. But if he's just a voluntarily medical patient, he doesn't?

A Yeah, if he's a voluntarily medical patient and we would have had a call there for an incident --

Q Uh-huh.

A -- there wouldn't have been anything.

Q Okay. All right.

A Unless there was a physical altercation or something that would have deemed a report.

Q Uh-huh. Okay. But in this case, to your recollection, you don't have any report --

A No, he was just distraught and we just stood there and observed and made sure nothing happened.

Q Okay.

A And nothing did happen, except for just verbal.

Q Okay. Then is it fair to say that at the time you observed Mr. Scheer and walked him out the exit you did not believe that he was an imminent threat to himself or others?

A No.

MR. HINSON: Object to the form.

Q You can answer.

A My time escorting him, I didn't feel any presence of danger or any type of ration towards him that would believe that he would want to hurt me or himself.

Q Okay. Do you recall the gentleman, the other security guard, who walked out with you all?

A It would either be -- I can't recall who it was.

Q Okay.

A But it would either be, because I kept a rotation, I didn't have one particular person that I kept on there because the guards would have been a

little angry at me if I kept one person, but it would either be a person named Kevin Stewart.

Q Okay.

A Charles Fitzgerald.

Q Uh-huh.

A Tim Delisle, and there was one other security guard that -- Kyle Rutledge.

Q Okay.

A That would have been in the rotation and I can't remember which one it was at the time.

Q Okay. All right. Delisle, what was the first name?

A Excuse me. It would have been Timothy, Tim.

Q Tim, okay.

Prior to going up to the room while the doctors and nurses were talking to Mr. Scheer, you hadn't been called to his room before?

A No.

Q Okay. And you hadn't, in fact, had any interaction with him from the time he had come to the

hospital that you recall?

A No, I would have got there at 11:00.

Q Okay.

A Or 10:30. And if he was already up in his room, I wouldn't have had any interaction with him at all.

Q Okay. All right. From 2 North would you have to take an elevator down to get to the one exit that was opened?

A Yeah. I mean, there is different ways that I had access to with my security card that I could get there, but for any regular patient or any visitor --

Q Yeah.

A -- there would be an elevator that you would take from the emergency room.

Q Okay.

A To, like, the main corridor where you could turn off and go to any other branch, but there was an elevator in the middle that you could take straight up to 2 North.

Q Okay. So did you take the elevator with

Mr. Scheer or did you all take the stairs?

A We took the elevator.

Q Okay. And that dropped you in the ER department?

A It dropped you right in that little corridor where you could -- you could either take the wrong turn or the right turn and be somewhere you don't want to be or somewhere lost.

Q Right, okay.

A So, but, yeah, we dropped right in the elevator, took a left out of it and went stright through the emergency department entrance and exit.

Q Okay. About how long do you think it took you to walk with him from when he was discharged to the ER exit?

A Maybe four to six minutes, I'd say.

MS. PEAVY: All right. I'm going to look over my notes.

THE WITNESS: Okay.

MS. PEAVY: I think that's all I have, though.

THE WITNESS: Be my guest.

MS. PEAVY: Thanks.

BY MS. PEAVY:

Q Do you recall if there was a full moon at the time when you walked him out?

A No, I don't recall what --

Q Okay. Do you have any recollection of the weather?

A I just know it was dark.

Q Okay.

A But I didn't really go outside that night and roam around.

Q Okay. Had you escorted other medical patients out at different times during your shift during the course of your employment at G4S?

A Oh, yeah, we escorted patients a good bit.

Q Okay.

A Either from, to or from, rooms, to or from exits, two or from rooms, exits and entrances.

Q Okay. And the main purpose of that is because at that time of night there is only one exit

that's opened?

A For this individual patient, that would have been the reason. If he was discharged and there was no reason, it would have just been to show him the proper way to go.

Q Okay.

A Especially if he was just a regular voluntary patient.

Q Okay.

A We would have had no reason other than to show him the proper way to go.

Q Okay. Do you recall how long you were in the -- by the room before you walked Mr. Scheer out?

A I don't know the exact time I would have been there, but it was a very short time from -- by the time I made it up there to the time they discharged him.

Q Okay.

A Probably up there, I'd say, maybe ten minutes, if I can give you a guess.

Q Okay.

A By the time I was up there.

Q Right, right.

A Now, I don't know how long before they actually called us before he was actually disgruntled in the room.

Q Okay.

A But that's about the time I'd say I was just standing there.

Q Okay. And during your employment at Grand Strand with G4S did you have occasion to observe patients wanting to be discharged who became disgruntled or just wanted to go?

A Probably every day.

Q Okay. It wasn't unusual?

A It wasn't unusual for a patient to want to leave a room that doesn't want to be there.

Q Okay. All right. Other than speaking with G4S's attorney about this discharge have you spoken with anyone else about it?

A No, I haven't.

Q Okay. Did you speak with any of your

co-workers about it once you found out the police had come by because Mr. Scheer had been reported missing?

A You mean at the time whenever I was employed?

Q Yeah.

A Let's see here.

Q And if you don't recall, that's fine.

A I don't recall.

Q Okay.

A But I do remember the initial time whenever they -- my next time going on duty them talking about it, but other than that I don't recall any other information.

MS. PEAVY: Okay. That's all I have. Thank you, Mr. Pheabus.

THE WITNESS: Thank you.

MR. HINSON: Good morning, Mr. Pheabus.

THE WITNESS: Good morning.

MR. HINSON: We met just a few minutes ago, but my name is Brink Hinson and I'm representing Matthew Scheer's family in a case that's been brought

Examination by Mr. Hinson

regarding his death.

THE WITNESS: Okay.

EXAMINATION BY MR. HINSON:

Q You understand that you haven't been named in this lawsuit, correct?

A Right, right.

Q No one has alleged you did anything wrong. You understand that.

A That's correct.

Q Mr. Pheabus, have you looked at any documents in preparation for today?

A No, I haven't.

Q And I want to show you, then, just for a second. This is a copy of Matthew's medical records in this case.

A Okay.

Q The young man who seems you may have been involved in escorting out of the hospital.

A Right.

Q And at the time you were instructed to escort him out of the hospital you were unaware of any

of his -- the reasons, medically, why he had been taken to the hospital; is that correct?

A That's correct.

Q If you would, and these documents, let me show you, they have what we call a Bates stamp and you may be familiar with that, too, with police work, but the Bates stamp, and it's kind of hard to read. It's this one that's kind of the black highlight here in the bottom right-hand corner?

A Okay.

Q If you would, turn to Page 12.

MS. PEAVY: Are you looking at the ones that are Scheer_GSRMC?

MR. HINSON: Yeah, we're looking at the records that are stamped Scheer, underscore, GSRMC underscore, MedRecs.

MS. PEAVY: Okay.

BY MR. HINSON:

Q And Mr. Pheabus, do you see there on Page 12 where it talks about Matthew was hearing voices?

A Let's see here. Yes, I do.

Q And what is the complaint right here? What's been given as the complaint?

A It looks like his complaint says, paranoia and hallucinations.

Q Do you see where it says that he's having auditory and visual hallucinations?

A I just see where it says paranoia, hallucinations, insomnia.

Q Maybe the next page, then.

A Yes, I see the psyche. Auditory hallucinations and visual hallucinations.

Q And Mr. Pheabus, at the time you were escorting Matthew out of the hospital you were unaware that at the time of his admission it was reported that Matthew was having auditory and visual hallucinations. Is that fair?

A Yeah, due to my prior knowing him, I had no knowledge of his prior medical history or whether he was suffering from auditory hallucinations or visual hallucinations.

Q And as a security guard it wasn't your duty or your job to make a determination as to whether or not he was having some sort of psychosis at that time?

A Right, that's not my responsibility.

Q Your responsibility was simply to escort him out of the hospital, correct?

A Right.

Q And you didn't undertake to make a determination in any way of what his mental status was at that time, did you?

A No, I didn't.

Q Do you have any training in assessing a person's mental capacity?

A No, I've no knowledge and no education to make that determination.

Q If a young man is having auditory and visual hallucinations does that sound like a young man who is in a right state of mind to you?

MS. PEAVY: Object to the form.

A Due to my short amount of time I had with him I would have had no time even to observe even my

basic knowledge of it.

Q But if he was having -- if he -- it was determined earlier that he was having auditory and visual hallucinations, would that sound like a young man that was in his right mind to you?

MS. PEAVY: Object to the form.

A I mean, I guess whoever looked at his medical records and was able to examine him, they would have knowledge to know that.

Q And you have no reason to disbelieve -- you have no reason to believe that that's not true, do you? Would you have any reason to believe it wasn't --

A I have no knowledge to know whether that's true or false.

Q Was it the physician who instructed you to escort Matthew out of the hospital?

A I do believe, once he was discharged, I do believe they did ask to escort him, but I'm not certain.

Q And did you -- you said a little bit ago that you had to go get his belongings.

A Well, now that we talked about it, that he was a voluntary patient, and if he was there as just a regular patient he would have had all his belongings. That's why I couldn't recall whether we walked them down or brought them up.

Q What if he was there for psychosis? You said a minute ago you remembered going to get his belongings.

A I think I was trying to piece it together whether we got his belongings or not. Because I do remember him having his shoes with him.

Q What kind of shoes did he have?

A I think they were just tennis shoes. They were older tennis shoes.

That's why I thought another guard might have brought his shoes up to him before I got there, but I do remember getting down to the emergency desk and him just saying thank you and going out the door. That's why I believe -- that's why I thought to myself that we would have brought his belongings up before.

But due to us talking and him being a

voluntary patient, he would have had his belongings with him the entire time.

Q What about folks who were brought to the hospital for psychosis and they come voluntarily? You don't think they might have taken his belongings for that reason?

MS. PEAVY: Object to the form.

A Now, if he would have went up there and whoever would have seen him, if they would have said that he was one of our patients, one of the G4S psyche patients, then we would have collected his belongings and had them down at the emergency desk. They would have been inventoried and brought down to the emergency desk.

Q Okay. Turn to Page 17 there.

What's the primary impression for which he's being brought into the hospital?

A The primary impression looks like acute psychosis.

Q Okay. And so if a patient comes in for acute psychosis they wouldn't have their belongings

taken then?

MS. PEAVY: Object to the form.

A Well, I'm not entirely knowledgeable about what acute psychosis is, so I don't know if a doctor would have looked at that and determined whether that was -- a doctor would know more than I know, but I'm looking at that and I don't know what the full meaning of that would be, so I can't make that determination.

Q Okay. So you think Matthew was wearing tennis shoes?

A I believe.

Q What about the rest of his clothes?

A I think he had jeans and a T-shirt on.

Q What color was his T-shirt?

A I think it was gray.

Q Okay.

A But I'm not entirely sure.

Q How would you describe Matthew Scheer?

A I would say he was between 20 and 25. I think he was, like, five foot eleven, five foot ten, had glasses. Shorter brown hair. Slender build.

Q Any other distinguishing features?

A When I saw him I just thought he was another normal young man. Just distraught in the hospital.

Q Beard, clean shaven?

A He was clean shaven. Might have had a straggly mustache, but.

Q But you don't recall?

A No.

Q So you're called up to the room.

A Uh-huh.

Q And what were you doing at the time you were called up?

A I would have either have been down sitting at the front desk helping patients check in or I would have been down in the ER visiting that security guard.

I don't know what, if any, incidents happened prior to him, but those would have been the things I would have been doing.

Q You don't remember where you were when you were called up to Matthew's room?

A No.

Q And would you have been called over the radio?

A Yes.

Q And that would that be some sort of, like, walkie-talkie style radio you would have with you?

A Either the radio that would have been a radio on my hip and had a lapel that went up to my shoulder, or, the 2 North, now that would have been the guard that's sitting at the monitor up there on 2 North, maybe the nurse went down and said something, or, the 2 North nursing station would have called the front desk and they would have called me over the radio.

Q But you don't recall how you got the call?

A It would have been over the radio or they would -- I don't recall the exact thing -- or they would have called me on the cell phone.

Q And at the time you were called, it was because there was a patient who was being disruptive and upset?

A Yes.

Q It was not at the time to discharge him, it was because he was being disruptive?

A That's correct.

Q Okay. If you would, turn to Page 100 in there.

A Okay. This only goes to 89. Unless you're talking about the little marking?

Q Here. I'll be happy to get it for you.

A I have it right here. Page 100.

Q Yeah. I'll be happy to show you where. There is a lot of writing on this page.

MS. PEAVY: What are you highlighting, Brink?

MR. HINSON: The nurse's note on Page 100, Bates stamp 100.

MS. PEAVY: Okay. I see, sorry.

BY MR. HINSON:

Q Mr. Pheabus, if you see, there is a note from a nurse that says: Patient approached nurse's station and was pacing shirtless. Patient ripped off

arm bands and threw on the floor. Patient started yelling stating, quote, that we could not control him, nor could Obama, end quote. Patient accusing staff of being Devil worshipers.

Do you see that?

A Yes, I do see that on the page.

Q Then there is another note.

A Yep.

Q Right there. Then there is another note up here that says: Patient pacing in hallways. Approach nursing unit saying that we cannot control him. Patient escorted back to the room. Patient very verbal with staff. Becoming aggressive with staff. Stating that we are all with the Devil. Security at bedside. Patient verbalizing that he is here voluntarily and we cannot keep him here.

Do you see that part?

A Yes, I do.

Q So the security at bedside, is that you most likely?

A I don't exactly remember being at bedside.

I don't know if they meant bedside by standing at the door, but I don't think we ever breached his threshold of his door.

Q Okay.

A At least I didn't. I don't know if the security guard prior to me being there was, just to talk to him, but when I got there I just stood at the door.

Q Okay. Do you recall him being verbal with staff and yelling?

A Yes, but I do not recall -- when I got there he was in his room. Or right at the threshold of his door.

Q Was he being loud and disruptive?

A Yes, he was.

Q Describe how he was being loud and disruptive.

A Just at a high volume just saying that he just didn't want to be there anymore. He said -- I do remember him saying, you guys can't keep me here. I'm here voluntarily. I do believe he was knowledgeable

about that and said he didn't want to be there anymore.

Q Do you recall the nurse that was there with him?

A I do not recall the nurse.

Q Okay. Do you recall any of the nurses that were there?

A There was a select few that would be there every shift that I was, but I don't recall which exact one it was.

Q Okay. Do you recall him yelling things about the staff being with the Devil?

A No, I don't recall that.

Q Do you recall him yelling and being aggressive with the staff in his tone and his behavior?

A In his tone and behavior it was more aggressive than just yelling.

Q Describe what you mean.

A Instead of just talking in a high volume, he was doing a lot of movement. I mean, it was more like an aggressive just stating that he didn't want to be there and he just showed that he was ready to go.

It was more of a -- he was more physical about it. More just he was just pacing and wanting to go. In his room. It wasn't out in the hallways or anything.

Q So you never saw him at the time he was out in the hallway --

A No.

Q -- ripping off his arm bands?

A Uh-uh.

MR. HINSON: Object to the form.

Q You got there after?

A Yes.

MR. HINSON: What's the objection to the form there, Rachel?

MS. PEAVY: I'm sorry, what?

MR. HINSON: What was your objection to the form of my question? How can I correct the form?

MS. PEAVY: Just go on, I'll withdraw that objection, Brink. Thank you.

BY MR. HINSON:

Q And at the time you got there, the doctor had not yet arrived; is that correct?

A I don't believe so, no.

Q Okay. Do you recall the doctor who arrived?

A I don't recall her name, but I do believe it was a female.

Q Okay. Do you recall if she was tall, short?

A She was short. Had, I'm saying, a little bit below shoulder length brunette, brown hair. Brown hair.

Q Approximate age?

A Approximate age, probably between 25 and 30.

Q Okay. And so the doctor arrives after you and then shortly thereafter you're instructed to escort Matthew out of the building?

A I don't know if we were instructed to, but shortly thereafter the doctor got there he was discharged.

Q Okay.

A Under the doctor's orders.

Q Okay. So exactly who gave that instruction to you? You're not sure, it was either a nurse or a doctor, but somebody asked you to please escort Matthew out of the building?

A Yeah, I mean, he was escorted. I don't know if it was us saying, do you need help, do you know where you're going, if you just want to follow us, we'll show you the exit or if it was a -- or the doctor or nurse saying, could you just show him where to go.

Q And were you present when the doctor was speaking with Matthew?

A Yes.

Q How long would you estimate that was? Two, three minutes?

A I'd say about anywhere between two and four minutes --

Q Approximately.

A -- before she got there and was pretty much just, if you don't want to be here, you don't have to be here.

Q So, okay, you're saying you were there

about two to four minutes before the doctor arrived.

A I was there -- yeah, I'd say approximately four minutes when I was up there just observing his behavior in his room and before the doctor got there.

Q Okay. And then the doctor basically says, if you don't want to be here, we can't keep you?

A Pretty much.

Q Anything else you recall about that interaction?

A No, not in particular.

Q Did the doctor do any sort of exam on Matthew or anything?

A Now, I don't know what she did prior to getting to the room, if she went over his medical records or what conversations they had, but she didn't do any evaluations from the time I was there to her meeting him to the time he was discharged.

Q So whether or not she had looked at his record prior you don't know and whether or not at some point prior she had talked to him earlier that night or the day before you don't know, but as far as at and

around the time of discharge she shows up, if you don't want to go -- if you don't want to stay, we can't keep you and then he leaves?

A Right.

Q You never saw the doctor perform any kind of psychiatric exam or anything on Matthew? Nothing like that?

A No, I didn't.

Q You never saw the doctor do any sort of evaluation to determine if he was presently having hallucinations?

A No, I did not.

Q Never saw any sort of exam or questions from the doctor to determine if Matthew was hearing voices at present?

A No.

Q Never saw any sort of exam or evaluation take place by the doctor to determine if he was having a belief that all the food in the word had been poisoned?

MS. PEAVY: Object to the form.

A No.

Q Never saw any sort of exam or evaluation from the doctor to determine if he was having extreme paranoia?

MS. PEAVY: Object to the form.

A No.

Q The doctor simply showed up and said, if you don't want to stay, we can't keep you and the next thing you know you're escorting Matthew out of the hospital?

MS. PEAVY: Objection.

A That's pretty much what it boils down to.

Q And through this case one of the things -- one of the things we have received is a copy of the floor plan.

A Okay.

Q I'll show you this.

A Yes.

Q Do you recognize that?

A Yes.

MS. PEAVY: I've got it. Thanks.

Q What are we looking at there?

A There would be three or four floors to the Grand Strand Hospital and this is pretty much a layout of each floor, but there would be -- this would be the 2 North layout here.

Q Okay. Do you recall where the patient's room was?

A Somewhere in the middle here of 2 North.

Q Can you kind of mark where it was?

A Yeah, yeah. (Witness complies.) I don't know the -- it's one of these rooms there.

Q That you have circled?

A Yeah.

Q Can you write Patient Room underneath that or Patient's Room?

MS. PEAVY: Can we mark that as an exhibit?

MR. HINSON: Sure.

A (Witness complies.) It would be one of those rooms.

Q And where would you have taken the patient to escort him out?

A After he would have been discharged we would have walked down the hallway, and this would be the nurse's station here, and then we would have taken a right, went down here, toward the elevator. And the elevator would have been right down here.

Q Can you just write Elevator down there?

A Yeah, sure. (Witness complies.)

MR. HINSON: We can mark this as Exhibit 1.

(Pheabus Exhibit 1 was marked for purposes of identification.)

BY MR. HINSON:

Q When you were working with G4S, were there -- was there written policies and procedures that the company had for security guards?

A Yeah, there would have been.

Q Okay. When did you leave G4S?

A I mean, I would have to look up that information on my phone to tell whether I'd be able to leave or not, but it was sometime, let's see here, maybe sometime -- I couldn't give you an exact date without looking through my phone.

Q Was it 2016, '17?

A No, it would have been 2000 and -- I think it was 2013 or '14?

Q When you left employment with G4S?

A Oh, employment from Myrtle Beach from there to Maryland would have been 2015, I believe.

Q Spring, summer?

A Fall, I think. Without going through my phone. I'd have to --

Q Do you recall how long it was after this incident?

A After this incident it would have been, because I moved back to Myrtle Beach -- or I moved back to Maryland, it probably had been, like, eight months.

Q Eight months after this?

A I think so.

Q Okay. Do you recall G4S having new policies and procedures issued at some point during your employment?

A Well, I know things -- especially at Grand Strand I know a lot of things were changing. A lot of

things changed, especially when they took over the new contract, they were still feeling things out and there was a lot of troubles with staffing and getting people in there and I know a lot of things changed back and forth, so.

Q When you say a lot of things changed back and forth, I'm sorry, what do you mean by that exactly?

A When we first took over the contract they had a lot of trouble getting staff in there and then we had an abrupt switch in a general manager that was in there. So there was a lot of -- I mean, just a lot of stress trying to get things figured out.

Q Got you.

A If you have any specific guidelines or --

Q Well, I've got a set of policies and procedures here from G4S.

A Okay.

Q And the effective date on that set is from February 2, 2016.

A Okay.

Q Here. Do you remember G4S having a similar

set of policies and procedures? You're welcome to take a look through that.

A I do not remember guards being given a specific handbook like this or to show as policies and procedures. There might have been one stuffed under a desk somewhere that somebody could have got if they asked, but I don't remember one being handed out.

Q Okay. Were there times in your work at Grand Strand where you were asked to assist in restraining a patient with some sort of mental health issue?

A Yes.

Q How often would you estimate that occurred? A handful of times?

A Maybe once -- yeah, a handful of times.

Q One a month? Couple times of month? How often would you estimate?

A I'd say about two to three times a month.

Q And were there times that a patient who was having some sort of mental illness wanted to leave and the instruction was, we can't let this patient go and

you were asked to help restrain the patient?

A Now, if they were -- if they were under our supervision, classified as a psyche patient, they wouldn't even be able to pass the threshold of their door. And if they tried to leave, then the guard would restrain them or do whatever they could to get them back into the room.

Q And so there were times, then, where you had a patient with some sort of mental illness, some psyche patient, who had to be restrained to prevent from leaving the hospital?

A Either to harm themselves or harm somebody else, there would be times.

Q And you were involved with that personally?

A Yeah.

Q You would do that if a physician or a nurse asked you for assistance with that. You and other guards would assist in that, correct?

A If we felt that it was a practical time to do so.

Q And the need to or the occasion where you

would restrain a patient you estimate happened two or three times a month you said?

A I believe so.

Q The majority of patients are discharged from the hospital without any escort from security. Is that fair?

A It depends. I mean, it all depends on where they are, where they're located or what the circumstances are.

Q Sure, but as far as the entire patient population, the vast majority of them simply are discharged from the hospital without the need for security?

MS. PEAVY: Object to the form.

A I'd say without proper direction, no. But I'd say there is somebody giving them direction where to go most of the time. Whether it's pointing a finger or them asking a question.

Q Have you ever -- well, tell me what you did to prepare for today.

A As far as reading any documents or

anything, nothing.

Q Are you being represented by counsel right now?

A No.

Q And tell me, have you -- when were you contacted first about this case and this --

A I'd say about maybe a month and a half ago, two month ago.

Q How were you contacted?

A I was contacted -- well, first I got a letter. I moved from an address and then the person who lived at that address said, hey, you got a letter and I saw the letter and then I called the phone number on it and it pretty much started there.

Q Okay. And who contacted you?

A I believe it's actually the representative listening on the phone right now.

Q Okay.

MS. BRUDVIG: Brink, just in full -- to be fully candid, it was me who had contacted Greg Pheabus just so the record is clear.

MR. HINSON: Okay. Thank you, Kelsey.

BY MR. HINSON:

Q And before that about two months ago nobody had contacted you before about this?

A No, no.

Q And what were you asked in that conversation?

A If I could just recall what I remembered from the incident.

Q And that was the first time anybody had asked you about that?

A Yeah, that's the first time I had any knowledge about this.

Q Have you ever spoken with Ms. Peavy prior to this morning?

A No.

Q And were you -- did you ever talk to the police after Matthew was discharged from the hospital?

A I don't recall. Because they would come in pretty frequent asking about things, so I can't recall if they came in and asked any questions about it.

Q Did Dr. -- did one of the doctors from the hospital ever talk to you about Matthew Scheer?

A No.

Q Did the discharging doctor ever talk to you about it or any of the nurses?

A No.

Q So after this incident occurred nobody asked you anything about it to your recollection until just a couple months ago?

A No. The only time I heard about it was saying that the patient had committed suicide after me escorting him. Then after that it was nothing.

Q Okay. And you didn't have to fill out any kind of evaluation or speak at any sort of a peer review committee or anything like that?

A No.

Q And how did you find out that Matthew had died? Who told you?

A I came in my next shift on duty and I guess it started the morning shift, or after it happened, I guess, word got back to the hospital and then word

spread from person to person and eventually it got to me from another security guard.

Q So you just kind of heard through the grapevine --

A Just heard.

Q -- so to speak?

A Yeah, yes.

Q Earlier you talked about the psyche rooms here on 2 North?

A Right.

Q And as I understood, you said sometimes they would fill up and then it would -- the psyche patients would be in other rooms besides the designated psyche rooms?

A Right. Now, with my time being there at 2 North, it would never extend passed the nurse's station. Now, there would be occasions where there would be a psyche patient up in another unit, but we would have to get an individual guard there. Like, maybe pediatrics. There would be a child up there that would be a psyche patient and they would be up there.

A guard would be in, like, the pediatrics unit.

But at 2 North, if it ever extended up passed, yeah, we would have another guard there. So, yes, it would extend up passed the normal rooms.

Q Okay. So rooms there on 2 North such as the one this patient was in would sometimes have psyche patients in them?

A Yeah. And even sometimes if they were not enough psyche patients, they would put normal patients down into the psyche rooms just to make them accommodations for normal patients.

Q What type of report would have been filled out about this of any type?

A Just from the -- just the nurse's responsibility. If it was a nurse's patient, she would have filled out her -- I believe, since you showed me those notes from the nurses, I believe that was the only thing that would have been just a voluntarily regular patient.

Q Okay. But you wouldn't have filled anything out for your involvement?

A No.

Q Do you remember, while you were in Myrtle Beach, Hurricane Joaquin?

A I don't think so.

Q The big flood and rain storm?

A Oh, yeah, yeah. I do remember a big flood and rain storm that flooded out pretty good, but I don't remember which one it was.

Q What do you remember about that storm?

A I just remember getting in my truck ready to go to the gym or to work and I just remember the water being up to the curb where I was.

Q And it rained for several days almost non-stop?

A Yeah, I remember all the golf courses all flooded out.

Q It was a -- generally speaking it was a bad storm, was it not?

A Yeah, I'd say so.

Q At the time Matthew, you took him to the exit, do you know if he had any form of transportation?

Examination by Ms. Peavy

A I do not know. I just remember him lightly jogging away.

Q At approximately 1:30 in the morning?

A Yeah, yeah.

Q Did you ask him at any point, where you going, where you planning to go?

A No.

Q Did you ever see one of the nurses or one of the doctors ask him, where do you plan to go, what do you plan to do?

A No.

MR. HINSON: Thank you, Mr. Pheabus.

THE WITNESS: Thank you.

MS. PEAVY: I've just got a few follow-up questions, Mr. Pheabus.

THE WITNESS: Uh-huh.

MS. PEAVY: Thanks.

EXAMINATION BY MS. PEAVY:

Q If the nurse who was in the room at the time the doctor came to examine Mr. Scheer before he was discharged testified she thought that the doctor

was in the room about ten or 15 minutes, would you have any reason to dispute the nurse's testimony?

A I wouldn't have any reason to agree or disagree with her because I wasn't present.

Q Okay. And obviously you have testified you can't offer any kind of medical opinions --

A Right.

Q -- about any treatment rendered to Matthew by the doctors and the nurses, correct?

A Correct.

Q Okay. So if the doctor was at the bedside communicating with Matthew and speaking with Mr. Scheer at that time you would have no knowledge of what kind of exam or questions she was asking or not asking, correct?

A That's correct.

Q Okay. And is it fair to say you were surprised to hear that Mr. Scheer had committed suicide after you walked him out the exit?

A Yeah, of course I was surprised.

Q Okay.

A Because nobody wants to hear that news.

Q Okay. And there was nothing in his behavior, that you observed, that made you think he was going to harm himself or others, correct?

A That's correct.

Q Okay. And if you, or any of the other security guards, had believed that Mr. Scheer was an imminent threat to himself or others you would have taken appropriate action, correct?

A That's correct.

Q And I want to show you one of the medical records that says Medical Record 0130. In you go to the stack, which is right there?

MR. HINSON: Right here.

Q And if you look at Number 0130.

A 0131?

Q 0130.

A 0130?

Q Yes. You got in front of you there.

And looking at the Comments section.

A Okay.

Q Does this reflect October 2, 2015 at, well, military time is given.

A Right.

Q But is that 6:44 in the evening?

A That is what's time stamped on there, yes.

Q Okay. And looking at this first -- looking at this final sentence under that note, does it state that Matthew Scheer is not on papers and is voluntary?

A The very last sentence of that Comment section does say he is not on papers and is voluntary.

Q Okay. And then looking at the bottom note there?

A Okay.

Q October 2, 2015, again military time, 5:29 in the evening. In the middle of the paragraph, does it state that: Patient is voluntary and is not suicidal or homicidal?

A That's what this note says, yes.

Q Okay. And then, one more minute, I'm sorry. I just need to check something in my notes.

When patients are discharged from Grand

Strand during your time there, they're given direction one way or the other; is that correct?

A Yes, I'd say so.

Q And in the middle of the night if someone is being discharged is it fair to say they're given direction in the sense that the hospital's exits are limited down to one and so you need to show them how to get out?

A Yeah, there is also times where a patient is discharged and the nurses call and say, hey, can you just come up and give them an escort down to the appropriate exit.

Q Okay. And again, you were never given any manual or handbook by G4S when you started on at Grand Strand, correct?

A We would have went over basic policies and the procedures during the initial training.

Q Right.

A But I don't believe actually being on the premises being handed rules and regulations --

Q Okay.

Examination by Mr. Hinson

A -- to keep on us.

MS. PEAVY: All right. That's all I have. Thank you, Mr. Pheabus.

EXAMINATION BY MR. HINSON:

Q Mr. Pheabus, you never witnessed -- well, back up for a second.

You go up to Matthew's -- you're called, you go up to Matthew's room, he's loud and disorderly, yelling, as you described earlier.

A Yes.

Q Did you ever witness anyone imploring Matthew, asking Matthew: Please, Matthew, we want you to stay.

Did you see anyone doing that to Matthew?

A During my time in that hallway, no.

Q Did you ever witness anybody discussing whether or not Matthew's father could be called? You know, having a discussion, does the law allow us to call his dad?

A During my time there, no.

Q Have you ever been involved in restraining

a patient who was being committed?

A Yes.

Q So somebody came to the hospital and then once they were there it was determined that they were going to be on an involuntary hold?

A Yes.

Q And in that point security would come, if necessary, and restrain the patient?

A If necessary, yes.

Q And in that situation the physician had made a determination that the patient, for whatever reason, would need to be involuntarily kept?

A If the physician would have made that determination --

Q You have seen that occur in your practice?

A Oh, yeah, yeah, I've seen that, yes.

MR. HINSON: Okay. Thank you, Mr. Pheabus.

THE WITNESS: Thank you.

MS. PEAVY: Thank you.

THE VIDEO OPERATOR: This concludes today's videotaped testimony of Gregory Pheabus. This is Media

Unit 1 of 1. Going off the record. The time is 11:53 A.M.

(A discussion was held off the record.)

MS. BRUDVIG: Madam Court Reporter, this is Kelsey Brudvig at Collins & Lacy. I do not believe that G4S would like a copy of the transcript.

THE REPORTER: Okay.

MS. BRUDVIG: Are we off the record?

THE REPORTER: We can do this off, sure.

(A discussion was held off the record.)

THE REPORTER: And Counsel, would you both like a copy of the transcript?

MS. PEAVY: Yes.

MR. HINSON: Yes, please.

(Deposition concluded at 11:55 a.m.)

State of Maryland

City of Baltimore, to wit:

I, SUSAN M. LIEBRECHT, a Notary Public of the State of Maryland, Carroll County, do hereby certify that the within-named witness personally appeared before me at the time and place herein set out, and after having been duly sworn by me, according to law, was examined by counsel.

I further certify that the examination was recorded stenographically by me and this transcript is a true record of the proceedings.

I further certify that I am not of counsel to any of the parties, nor in any way interested in the outcome of this action.

As witness my hand this 17th day of January, 2019.

Susan M. Liebrecht

Susan M. Liebrecht, RPR
Notary Public

My Commission Expires:

September 8, 2021

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: 8.2.15 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 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):

_____

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

Patient Information/Label

ADMIN 3400301179 (08/18/15) 453952

NAME: SCHEER,MATTHEW ACCT#: F01034274115
FORM:

ADM DATE: 10/02/15 1014
ATTEND PHYS: Battisti,Amanda DO UNIT#: F000838076
DIS DT/TM: 10/02/15 1304 SEX: M
DIS DISP: LIGHTHOUSE AGE: 26
LOS: : 1 DOB: 01/19/89
PT CLASS: ER.ALL 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: ABS STATUS DATE: 10/08/15
CODER: R.HIM.WLT 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

IN/OUT/ER PATIENT ADMISSION RECORD

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

PATIENT INFORMATION

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

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:
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

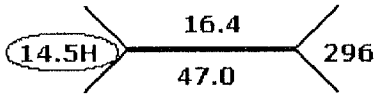
Initial VS reviewed: yes
General: alert, eating and drinking poorly
Head/Eyes: normocephalic, PERRL, EOMI
Neck: atraumatic, full range of motion
Respiratory/Chest: no respiratory distress, breath sounds normal
Cardiovascular: regular rate and rhythm, normal heart sounds
Abdomen: soft, non-tender
Extremities:
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

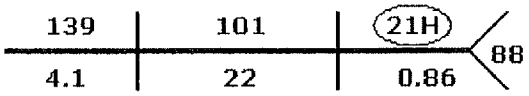
Portions of this section were transcribed by BENDIK,MORGAN M on 10/02/15 at 1642

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 uIU/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: F0103427411S
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 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 Date	Time	User	Recorded 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 Date	Time	User	Recorded 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 Date	Time	User	Recorded Date	Time	User
10/02/15	1032	AGUIRRE,MARY J, RN	10/02/15	1032	AGUIRRE,MARY J, RN

Pain Assessment/Reassessment

Occurred Date	Time	User	Recorded 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 Date	Time	User	Recorded 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
Scheer_GSRMC_MedRecs_0020
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Patient: SCHEER,MATTHEW Age/Sex: 26/M Acct No: F0103427411S
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: F0103427411S
1221
Scheer_GSRMC_MedRecs_0021
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Patient: SCHEER,MATTHEW Age/Sex: 26/M Acct No: F01034274115
EDM Provider: Battisti,Amanda DO, 2hcaActive 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

Readiness

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 M\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	14.3 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	10.7 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 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	FEW	(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	5.3 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(c)	(10.0-30.0)	mcg/mL	
=> SALICYLATE	1	OCT 2	1042	< 1.0 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 POP 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

SCHEER 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

- 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
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

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	10/02/15 1042		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) Verified Date Time	mg/dL
TOTAL BILIRUBIN	5.5 H 10/02/15 1115		(0.2-1.0) Verified Date Time	mg/dL
SGOT/AST	30 10/02/15 1113		(15-37) Verified Date Time	Units/L
SGPT/ALT	35 10/02/15 1115		(30-65) Verified Date Time	Units/L
ALK PHOS TOTAL	64 10/02/15 1118		(20-130) Verified Date Time	Units/L

********** THYROID FUNCTION STUDIES **********

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

********** DRUG MONITORING **********

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

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	10/02/15 1155		Reference	Units
UR COCAINE	NEG		(NEGATIVE)	
	10/02/15 1218		Verified Date Time	
UR THC	NEG		(NEGATIVE)	
	10/02/15 1218		Verified Date Time	
UR AMPHETAMINE	NEG		(NEGATIVE)	
	10/02/15 1218		Verified Date Time	
UR BARB	NEG		(NEGATIVE)	
	10/02/15 1218		Verified Date Time	
UR BENZO	NEG		(NEGATIVE)	
	10/02/15 1218		Verified Date Time	
UR OPIATES	NEG		(NEGATIVE)	
	10/02/15 1218		Verified Date Time	
UR PCP QUAL	NEG(b)		(NEGATIVE)	
	10/02/15 1218		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	10/02/15			
Time	1155		Reference	Units
UA COLOR	Yellow		(YELLOW)	
	10/02/15 1211		Verified Date Time	
UA APPEARANCE	Clear		(CLEAR)	
	10/02/15 1211		Verified Date Time	
UA GLUCOSE	NEGATIVE		(NORMAL)	mg/dL
	10/02/15 1211		Verified Date Time	
UA BILIRUBIN	NEGATIVE		(NEGATIVE)	mg/dL
	10/02/15 1211		Verified Date Time	
UA KETONES	80 mg/dl *		(NEGATIVE)	mg/dL
	10/02/15 1211		Verified Date Time	
UA SPEC GRAVITY	1.032		(1.001-1.035)	
	10/02/15 1211		Verified Date Time	
UA BLOOD	NEGATIVE		(NEGATIVE)	mg/dl
	10/02/15 1211		Verified Date Time	
UA PH	5.0		(5.0-8.5)	
	10/02/15 1211		Verified Date Time	
UA PROTEIN	30 mg/dl *		(NEGATIVE)	
	10/02/15 1211		Verified Date Time	
UA UROBILINOGEN	NEGATIVE		(NEG-1mg/dL)	mg/dl
	10/02/15 1211		Verified Date Time	
UA NITRITE	NEGATIVE		(NEGATIVE)	
	10/02/15 1211		Verified Date Time	
UA LK ESTERASE	NEGATIVE		(NEGATIVE)	WBCS/uL
	10/02/15 1211		Verified Date Time	
UA RBC	0-1		(0-1 RBC/HPF)	
	10/02/15 1214		Verified Date Time	
UA WBC	0-1		(0-1 WBC/HPF)	
	10/02/15 1214		Verified Date Time	
UA MUCUS	FEW *		(NEGATIVE)	/LPF
	10/02/15 1214		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

$ 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: MS _____ (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 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 Adams 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

Page 1 of 1

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 **CONDITION CODES**
11 10/02/15

INSURANCE INFORMATION

PRIMARY: BC12 - 32104	SECONDARY:	TERTIARY:
401 BC OF NJ PP0		
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

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: ADM 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: FNUR.TWS ON: 10/02/15 1855

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

RUN DATE: 10/08/15 GSRMC ABS *LIVE*
RUN TIME: 0311 CODING SUMMARY
RUN USER: HPF.FEED

NAME: SCHEER,MATTHEW ACCT#: F01034276833
FORM:

ADM DATE: 10/02/15 1719
ATTEND PHYS: Patel,Nirlep A MD UNIT#: F000838076
DIS DT/TM: 10/03/15 0145 SEX: M
DIS DISP: Against Medical Advice AGE: 26
LOS: : 1 DOB: 01/19/89
PT CLASS: IN.ALL 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-10 865 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 ABS STATUS DATE: 10/07/15
CODER: 1FSRGE8181 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 250 MG PO TWICE DAILY Discontinue Reason: 5	Reported			10/02/15

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 Age/Sex: 26/M Acct No.: F01034276833
EDM Provider: Battisti,Amanda DO, ZhcaActive Unit No.: F000838076

Gm: 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 Age/Sex: 26/M Acct No: F010342768333
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

NURSE DEFINED PARAMETERS

~~ ASSESSMENT PARAMETERS ~~

Patient: SCHEER, MATTHEW MRN: F000838076 Encounter: F010342768333
1263
Scheer_GSRMC_MedRecs_0063
Page 27 of 89

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

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
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
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

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

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

Category	Procedure Name	Order Number	Service 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

Category	Procedure Name	Order Number	Service 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

Category	Procedure Name	Order Number	Service 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

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

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
				—Service—					
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
				—Service—					
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	Service 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.

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

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

	Date/Time		Reference	Units
	10/02/15 1741			
HAPT	68.1(~a)		(30-200)	mg/dL
	10/04/15 0239		Verified Date/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
CODED ALLERGIES No Known Drug Allergies
CODED ADRs
UNCODED ALLERGIES
UNCODED ADRs

ADMIT DATE: 10/02/15
DISCHARGE DATE: 10/03/15
STATUS: DIS IN

AGE: 26
SEX: M

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) 50268468ll 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 ***
This document is part of the legal medical record.

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

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

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*
EVOLUTION PLAN OF CARE HPF

Printed 10/04/15 at 0032

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: 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	

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	

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	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 | | |

| Diagnosis/Goals/Intervention Description | | |

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

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: 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 Time by	Recorded Date 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

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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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 / Documented 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 / Documented 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								D	PRN		CP
To be completed on patients going to another acute facility.											
- 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								D	PRN		CP
Complete upon intrahospital transfer.											
- 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									
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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Age/Sex:	26 M	SCHEER,MATTHEW (ADM IN)	
Unit #:	F000838076	F.2N-F.1285-A	
Account#:	F01034276833	Patel,Nirlep A MD	
Admitted:	10/02/15 at 1719 GSRMC	NUR *LI	Initial Assessment

F01034276833

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
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!!!

F01034276833

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?

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

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
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 **

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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?
Unexplained weight loss?
Fatigue?
Body Aches?
Rash?
Nasal Congestion (not related to allergies or sinus infections)?

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

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

TB Point of Entry Screen: Contagious Respiratory Infection Point of Entry Screen-

Mask applied, patient isolated, and receiving unit/department notified?

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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.

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

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
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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:					

This profile is a part of the PERMANENT PATIENT MEDICAL RECORD
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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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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:
Active ROM in all Extremities:
Location of Limited ROM:
Pt. Turned:
New Position:
Mobility Aids:
Mode of transport (to/from unit): WC
MUSCULOSKELETAL WNL Y
: Patient has no traction, pins, braces, or casts.

Traction in use:
Type of Traction:
Extremity:
Wt. (lbs):
Type of Traction:
Extremity:
Wt (lbs.):

Pins in use:
Orthopedic Pin Location:
Pin Site Appearance:
Orthopedic Pin Location:
Pin Site Appearance:

Braces in use:
Type of Brace:
Extremity:
Type of Brace:
Extremity:

Cast in use:
Cast location:
Cast type:
Cast condition:
Cast Location:
Cast Type:
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):

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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

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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: N 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

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Initial Assessment Part B 10/02/15 1915 BJB

Call Light: Y | Bed Control: Y | Television: Y
Phone: Y | Lights: Y | Smoking: Y
Siderails: Y | Visiting Hours: 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

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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:

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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
3810                                   Inquiry Call Update                              4/22/19
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. . . . . I City. . . . . County. . . . . State. SC
Caller Home Phone. . 0          0 Work Ph  843 6921919  Use this #. W
Relation to Patient. I 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 Sfx)
Patient Address Line 1, 2. 5750 OYSTER CATCHER DR   BLD 11 UNIT 1135
Patient City/St/Zip. . . . MYRTLE BEACH                SC 29582
Patient Birth Date . . . . 7/19/1989  Pat Age. 26 Y Sex. M SSN #. 0
Primary Language . . . . . ENG English Employer/School. 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)
```


Lighthouse_Records_0001

```
CP0100RU                              Inquiry Call                              AS400E
38 10                                 Inquiry Call Update                       4/22/16
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 . . . . PI 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
6810
FALASCOR

Inquiry Call

Inquiry Call Notes Update

AS400E
4/22/16
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 INSTANT THAT HE NEEDS MEDICAL ATTENTION. I CALLED CMC AND GAVE THEM 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

Lighthouse_Records_0003

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

Lighthouse_Records_0004

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 Schreck 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 6.5
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

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Certification of transfer 828 5740 **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 + bulirubin 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

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C216 Approved 08/2013

PRINTED BY:mva7372 DATE 12/1/2017

F01034276833

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:
00245201S 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

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

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

HIPAA

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.

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.

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.

Notice of Privacy Practices

Sub Menu

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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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.

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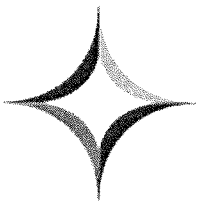
- FACILITY PRIVACY OFFICIAL: Please dial the telephone number below and ask for the facility privacy official.
- Telephone Number: (843) 692-1000



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 *Patient'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
_____, M.D.	_____
TYPED OR PRINTED NAME	PHONE NUMBER
_____	
ADDRESS	

_____
NAME OF CENTER
_____
SIGNATURE OF FACE TO FACE SCREENER AND DATE
_____
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