33111 11111192979
GAINES , BARTON
11111192979

440987
6/27/2007 Admit Date
10/25/1982DOB M 24Y
MERCER, LEO

unitedregional

PHYSICIANS ORDER SHEET

rev 05/07 phyorder.jsn

Place a mark in the box if this is a STAT order. ☐ **STAT**

Place Stat Label Here

DATE 6.27.07 TIME

HEIGHT: WEIGHT: ALLERGIES:

DC 18
Return Trauma
Clinic per
4/27/07
1140

May Use Formulary Drug Unless Checked

Authenticated: X
Physician's Signature Date/Time Signed

DATE TIME

May Use Formulary Drug Unless Checked

Authenticated: X
Physician's Signature Date/Time Signed

DATE TIME

May Use Formulary Drug Unless Checked

Authenticated: X
Physician's Signature Date/Time Signed

Verbal/Telephone Orders Written Down Then Read Back

PHYSICIANS ORDERS - Page 3 of 3	UNITED REGIONAL HEALTH CARE SYSTEM		Printed: 05/19/2008 11:49
Patient: GAINES, BARTON	MR#: 440987	Discharged: 06/27/2007	Service Dates: 06/27/2007-06/27/2007
Copy for: ROI MGT TGREEN	REQ: 137011, DET: 1188568 IK: 13642979 ITK: 21553 EK: 3094426 VER: 1		

UNITED REGIONAL HEALTH CARE SYSTEM
44-09-87
GAINES, BARTON 11111192979 Admit Date
CHAPA, PHILLIP
DOB 10/25/1982 M24Y ADM 6/26/2007 DOB

77777

UNITED REGIONAL HEALTHCARE SYSTEM

PATIENT'S PROGRESS NOTES

rev 8/06 ptprogressnotes.jsn

SERVICE	ROOM	CASE NO.
HOUSE STAFF	ADMITTED	DISCHARGED

6/27/07 Trauma Consult
0020 Stabbed c̄ 4" nail Ⓛ chest, abd, thigh ⇒ small pneumo on CT.
Admit for serial exams.
[signature]

6.27.07
s/p SW (L) chest
CT only PTX.
CXR - Ø PTX
abdm - s/p
chest - Cl =
DC
TRS clinic 1 wk
[signature]

PATIENT'S PROGRESS NOTES

PROGRESS NOTE - Page 1 of 1	UNITED REGIONAL HEALTH CARE SYSTEM	Printed: 05/19/2008 11:49
Patient: GAINES, BARTON	MR#: 440987 / Discharged: 06/27/2007	Service Dates: 06/27/2007-06/27/2007
Copy for: ROI MGT TGREEN	REQ: 137011, DET: 1188569 IK: 13642980 ITK: 21514 EK: 3094427 VER: 1	

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GAINES , BARTON

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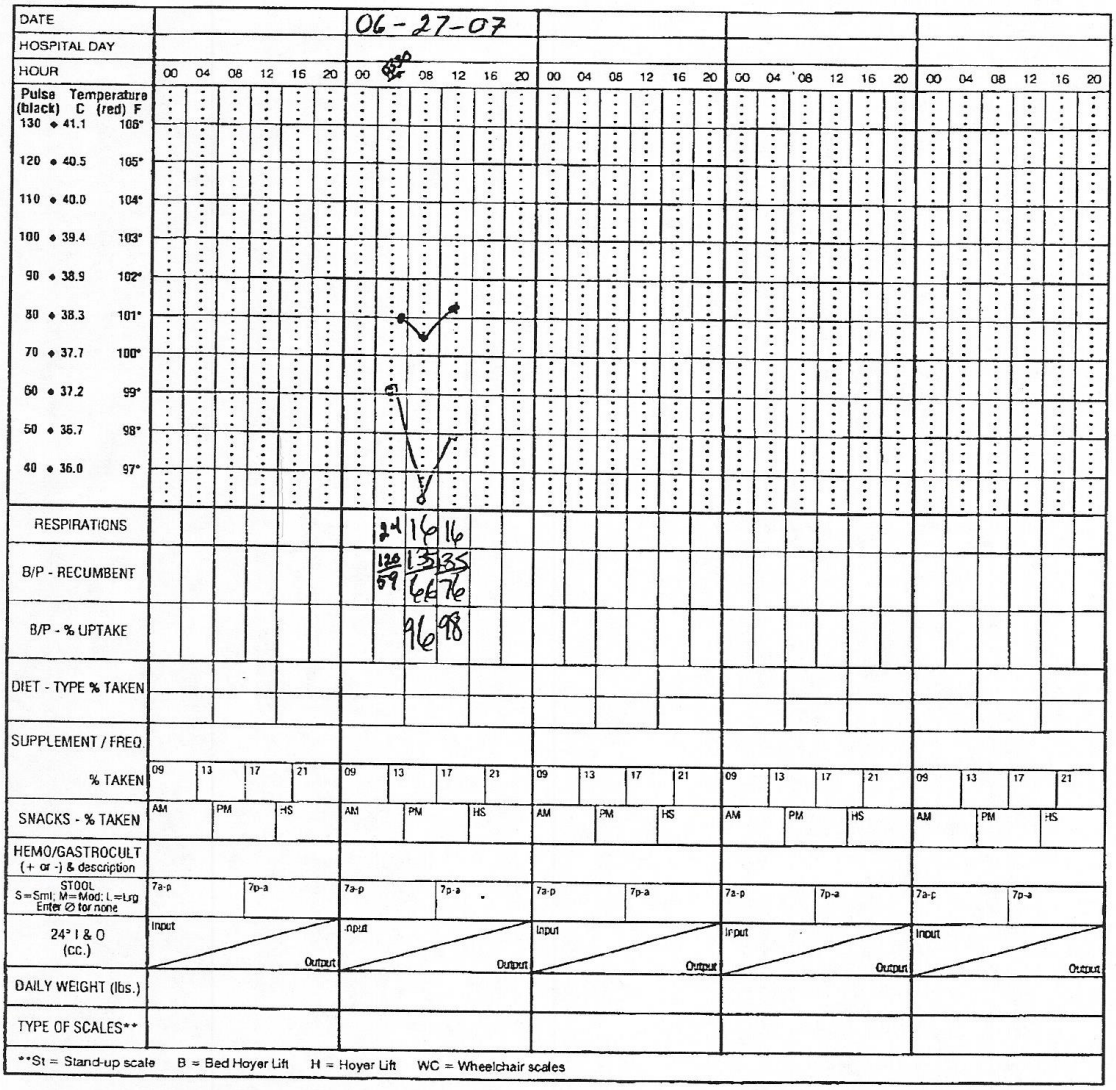
UNITED REGIONAL HEALTHCARE SYSTEM

Patient Care Record Trends

rev 10/06 pctrends.jsn

**Liquid stool (cc's) will be recorded in the I & O also. Stool not WNL of Color, Consistency, Frequency, etc., will be marked with an asterisk (*) in RED indicate f/u description in Narrative Notes.*



PATIENT CARE TRENDS - Page 1 of 1	UNITED REGIONAL HEALTH CARE SYSTEM		Printed: 05/19/2008 11:49
Patient: GAINES, BARTON	MR#: 440987	Discharged: 06/27/2007	Service Dates: 06/27/2007-06/27/2007
Copy for: ROI MGT TGREEN	REQ: 137011, DET: 1188570 IK: 13642982 ITK: 22236 EK: 3094429 VER: 1		

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UNITED REGIONAL HEALTHCARE SYSTEM

INPATIENT ADMISSION ASSESSMENT

rev 12/06 inpatientadmissionassessmentpage1of6.taw

DATE: 6/27/07 ROOM #: 444

ADMISSION HISTORY

ADMISSION DATA

Reason for Admission (Onset, Duration, Patient's Perception): Partial collapsed lung
Date/Time: 0220
Primary Physician: Allred Unit
Other Physicians:

Arrived Via: ☐ Wheelchair ☑ Stretcher ☐ Ambulatory ☐ Other:
Admitted From: ☐ Admitting ☐ ER ☐ Home ☐ OR ☐ Clinic ☐ Other:

VITAL SIGNS	BP: 133/73	PULSE: 99	TEMP: 97.8	RESP: 18 SpO2: 100%	WEIGHT: 180 Stated SCALE USED:	HEIGHT: 71 inches

Source Providing Information: ☑ Patient ☐ Other: ☐ Unable to Obtain History, Reason:

VACCINATION HISTORY (Received in past 5 years)

Pneumonia Vaccine	Influenza Vaccine	Hepatitis B Vaccine
☐ Yes, Date: ☐ No	☐ Yes, Date: ☑ No	☐ Yes, Date: ☑ No

MEDICATIONS (Include OTC, Herbal Supplements) ■ N/A ■ See Physician Order Sheet for List

Pharmacy Used: per Allred Unit
☐ No Home Medications ☑ See Medication Reconciliation Form
Disposition of Medications: ☐ With Patient ☐ Pharmacy ☐ Taken Home by Family

ALLERGIES & REACTIONS ■ None ■ Unable To Determine

MEDICATIONS WITH SIGNS/SYMPTOMS OF DRUG REACTION	MEDICATIONS WITH SIGNS/SYMPTOMS OF DRUG REACTION
NKDA	

FOOD / OTHER WITH SIGNS/SYMPTOMS OF REACTION	FOOD / OTHER WITH SIGNS/SYMPTOMS OF REACTION
NKA	

☐ Blood Reaction ☐ Soap ☐ Tape ☐ Anesthesia/Dye Reaction ☐ Latex ☐ IVP Dye

PAST SURGERIES / PROCEDURES & HOSPITALIZATIONS ■ None

SURGERY/PROCEDURE	DATE	OTHER HOSPITALIZATIONS / REASON	DATE
Tonsillectomy, Adenoidectomy	7yrs ago	None	

PSYCHOSOCIAL HISTORY

Marital Status: ☑ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Suicidal Have you ever been hospitalized for psychiatric or substance abuse problems? ☑ Yes ☐ No 14yrs old outpatient tx for marijuana
Victim of Abuse or Neglect? ☐ Yes ☑ No If Yes, Explain:

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UNITED REGIONAL HEALTHCARE SYSTEM

INPATIENT ADMISSION ASSESSMENT

rev 12/06 inpatientadmissionassessmentpage2of6.taw

DATE: 6/27/07 ROOM #: 44U

MEDICAL HISTORY (Enter Additional Comments on Bottom of This Page)

HEENT Hx
- [x] No History Stated
- [ ] Cataracts
- [ ] Glaucoma
- [ ] Hearing Loss
- [ ] Hearing Aid
- [ ] Chronic Ear Infection
- [ ] Deaf
- [ ] Blind
- [ ] Other: ____

NEUROLOGICAL Hx
- [ ] No History Stated
- [ ] Seizures
- [ ] Problem Swallowing
- [ ] Confusion
- [ ] Aphasic
- [ ] Headaches
- [ ] Dizziness/Fainting
- [ ] Paralysis
- [ ] Parkinson's
- [x] Problem Sleeping
- [ ] Stroke
- [ ] Other: ____

CARDIOVASCULAR Hx
- [x] No History Stated
- [ ] Chest Pain
- [ ] CHF
- [ ] Angina
- [ ] Dysrhythmia
- [ ] Hypertension
- [ ] Hypotension
- [ ] MI
- [ ] PVD
- [ ] Valve Disease
- [ ] Edema
- [ ] Other: ____

RESPIRATORY Hx
- [x] No History Stated
- [ ] Shortness of Breath
- [ ] Asthma
- [ ] Bronchitis
- [ ] COPD
- [ ] Emphysema
- [ ] Pneumonia
- [x] TB exposure
- [ ] Hemoptysis
- [ ] Home Oxygen
- [ ] Other: See below

MUSCULOSKELETAL Hx
- [ ] No History Stated
- [x] Fractures
- [ ] History of Falls
- [ ] Arthritis
- [ ] Osteoporosis
- [ ] Chronic Back Pain
- [ ] Chronic Joint Pain
  Location: ____
- [ ] Other: ____

GI Hx
- [x] No History Stated
- [ ] Bleeding
- [ ] Ulcers
- [ ] Liver Disease
- [ ] Diarrhea
- [ ] Constipation
- [ ] Heartburn
- [ ] Hiatal Hernia
- [ ] Gall Bladder Disease
- [ ] Incontinence
- [ ] Other: ____

GU Hx
- [x] No History Stated
- [ ] Renal Failure
- [ ] Dialysis
- [ ] Hematuria
- [ ] UTI
- [ ] Urgency
- [ ] Prostate Problems
- [ ] Kidney Stones
- [ ] Nocturia
- [ ] Incontinence
- [ ] Frequency
- [ ] Burning
- [ ] Anuria
- [ ] Other: ____

GYN Hx
- [x] Does Not Apply
- [ ] No History Stated
- [ ] Pregnant
- [ ] LMP: ____
- [ ] Hysterectomy
- [ ] Unusual Bleeding
- [ ] Dysmenorrhea
- [ ] Menopausal
- [ ] Lactation
- [ ] Other: ____

CANCER Hx
Have you ever been diagnosed with cancer? .... [ ] Yes [x] No
*If yes, Oncology Referral Needed
If yes, Are you currently being treated for cancer [ ] Yes* [ ] No
Have you been treated for cancer in the last 10 years? [ ] Yes [ ] No
When was your treatment? ____
Did you have: [ ] Chemotherapy [ ] Radiation
Do you have side effects or symptoms from your cancer or your treatment? [ ] Yes [ ] No
*Oncology Specialist Referral? .... [ ] Yes [ ] No

PSYCHO/SOCIAL Hx
- [x] WNL-Accepts situation and facial expressions are appropriate. Family support available. Able to communicate without assistance.
- [ ] Anxious
- [ ] Tearful
- [ ] Withdrawn
- [ ] Angry
- [ ] Poor Eye Contact
- [ ] Suspicious/Guarded

Recent Stresses: ____
Past Coping Skills: ____

SKIN Hx
- [ ] No History Stated
- [ ] Skin Tears
  Location: ____
- [x] Wound Location: punctures Rt ab d. from "nail"
- [ ] Bruises Easily
- [ ] Difficulty Healing
  Location: ____
- [ ] Ostomy
- [ ] Pressure Ulcers
  Location: ____
- [ ] Other: multiple tattoos

ENDOCRINE Hx
- [x] No History Stated
- [ ] NIDDM
- [ ] IDDM
- [ ] Thyroid Problems
- [ ] Other: ____

IMPLANTABLE DEVICE Hx
- [x] No History Stated
- [ ] Pacemaker AICD
- [ ] Graft/Shunt
- [ ] Infusion Device
- [ ] Stent
- [ ] Central Venous Access
  Type: ____
- [ ] Joint Replacement
  Type: ____
- [ ] Other: ____

COMMUNICABLE DISEASE HX
- [x] No History Stated
- [ ] MRSA
- [ ] Hepatitis
- [ ] STD
- [ ] Recent Varicella Exposure
- [ ] VRE
- [ ] Other: ____

SUBSTANCE USE HISTORY

Tobacco Use *Refer to RT if Yes	[x] No	[ ] Yes Type/Amount/Frequency:
Alcohol Use	[x] No	[ ] Yes Type/Amount/Frequency:
Illegal Drug Use (IV/Oral/Inhaled)	[ ] No	[x] Yes Type/Amount/Frequency: marijuana as a teenage
Caffeine Use	[ ] No	[x] Yes Type/Amount/Frequency: coffee, cokes

ADDITIONAL COMMENTS

exposed to TB in county jail. 9 months prophylactic meds given in 2001.

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UNITED REGIONAL HEALTHCARE SYSTEM

INPATIENT ADMISSION ASSESSMENT

rev 12/06 inpatientadmissionassessmentpage3of6.taw

DATE: 6/27/07 ROOM #: 444

CULTURAL / SPIRITUAL PREFERENCES

Primary Language: ☑ English ☐ Spanish ☐ Other: _____
Translator Needed: ☑ No ☐ Yes Translator's Name: _____ Phone Number: _____
Request Pastoral Care: ☑ No ☐ Yes If Outside Facility, Name: _____ Phone Number: _____
Do you have any religious or cultural traditions that will affect your care the hospital? ☑ No ☐ Yes, _____

EDUCATIONAL AND LEARNING NEEDS

Highest grade completed: 6th for some college
Reading Preference: ☑ English ☐ Spanish ☐ Other: _____
Desires to learn about disease process? ☑ Yes ☐ No Reason: _____
Preferred learning method? ☐ Verbal ☐ Video ☑ Written ☐ Braille ☐ Sign Language
Comprehension Ability: Reads/Understands English ☑ Yes ☐ No
Understands Written Instructions ☑ Yes ☐ No
Understands Verbal Instructions ☑ Yes ☐ No
Responds Appropriately ☑ Yes ☐ No

FUNCTIONAL ASSESSMENT (I - Independent A- With Assistance D- Dependent)

ACTIVITIES OF DAILY LIVING	STATUS (Circle One)	NEW ONSETS?	
Dressing	I – A* – D*	☐ Yes*	☐ No
Grooming	I – A* – D*	☐ Yes*	☐ No
Ambulating	I – A* – D*	☐ Yes*	☐ No
Eating	I – A* – D*	☐ Yes*	☐ No
Toileting	I – A* – D*	☐ Yes*	☐ No
Bathing	I – A* – D*	☐ Yes*	☐ No
Transferring	I – A* – D*	☐ Yes*	☐ No
Job Related Tasks	I – A* – D*	☐ Yes*	☐ No

N/A - Nonapplicable BS - Bedside S-Safe H - Home	N/A	BS	S	H
☑ None	☐	☐	☐	☐
☐ Cane/Crutches	☐	☐	☐	☐
☐ Braces	☐	☐	☐	☐
☐ Walker	☐	☐	☐	☐
☐ Hearing Aid	☐	☐	☐	☐
☐ Dentures (Full, Upper, Lower, Partial)	☐	☐	☐	☐
☐ Glasses/Contacts	☐	☐	☐	☐
☐ Orthopedic Device:	☐	☐	☐	☐
☐ Prosthesis:	☐	☐	☐	☐
☐ Other:	☐	☐	☐	☐
☐ Environmental	☐	☐	☐	☐

SPEECH NEEDS ASSESSMENT: Do you have any speech, language or communication problems? ☐ Yes ☑ No
Do you have any swallowing, chewing and/or choking difficulties? ☐ Yes ☑ No
If yes to above is this new onset? *IF NEW ONSET, appropriate screen required ☐ Yes* ☐ No

PAIN MANAGEMENT ASSESSMENT (Scale: 0 =No Pain 10=Worst Pain)

Do you currently have pain? ☑ No ☐ Yes If yes, complete the following questions:
Where is the pain? _____
Describe the character of the pain (sharp, stabbing, throbbing, etc.) : _____
How intense is your pain at this time on a scale of 0-10? _____
Any special words or phrases to indicate pain? _____
When did the pain start? _____
Is the pain constant or intermittent? _____
Does the pain radiate/where? _____
What makes the pain worse/better'? _____
What do you think is the cause of the pain? _____
What your goal for pain relief on a scale of 0-10 (desired level of pain control): _____

ORIENTATION TO UNIT (Y - Yes N - No N/A - Nonapplicable BS - Bedside S - Safe H -Home)

	Y	N	N/A
Arm Band Correct	☑		
Allergy Band	☐		☑
Bed Controls	☐	☐	☐
Call Lights	☑	☐	☐
Telephone	☑	☐	☐
Visiting Hours	☑	☐	☐

	Y	N	N/A
Fall Precautions	☑	☐	☐
Unit Routine	☐	☐	☐
Meal Times	☑	☐	☐
No Tobacco Policy	☑	☐	☐
Pt. Owned Equip:	☐	☐	☐

VALUABLES	N/A	BS	S	H
Money/Purse/Wallet	☐	☐	☐	☑
Clothing	☐	☑	☐	☐
Other (describe):	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

If valuables sent home, with who/relationship to patient:

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UNITED REGIONAL HEALTHCARE SYSTEM

INPATIENT ADMISSION ASSESSMENT

rev 05/07 inpatientadmissionassessmentpage4.taw

FALL RISK ASSESSMENT

ITEM	SCALE	SCORE	ITEM	SCALE	SCORE
1. History of Failing; Immediate or Within 3 Months	No = 0 Yes = 25	25	5.Gait/Transfening Normal/Bedrest/Immobile Weak Impaired	0 10 20	0
2. Secondary Diagnosis	No = 0 Yes = 15	0	6. Mental status Oriented to Own Ability Forgets Limitations	0 15	0
3. AmbulatoryAid Bed Rest/Nurse Assist Crutches/Cane/Walker Furniture	0 15 30	0	Medications may increase the risk of falls (i.e. vasoactive, diuretics, narcotics).	TOTAL	45
4. IV/Trippable Tubing	No = 0 Yes = 20	20			

TOTAL SCORE 51 = High Fall Risk; Implement Fall Level 3 Intervention; *Request PT Screen

FALL RISK: ☐ Level 1 (0-24) ☐ Level 2 (25-50) ☐ Level 3 = (≥ 51)

Fall Precautions Initiated: ☐ No ☑ Yes - Door marked and armband on Date/Time Initiated: 6/27/07 0035

NUTRITION SCREENING

Special Diet Regimen: (i.e., low cholesterol, cardiac, diabetic, renal, vegetarian)	☐ No ☐ Yes - What:		
Cultural Food Preferences	☐ No ☐ Yes - What:		
Diagnosed with diabetes in past 6 months?	☐ No ☐ Yes * (Diabetic education referral for positive answer)		
Home Tube Feedings (Specify product/routine)	☐ No ☐ Yes - What:		
Unintentional Weight Loss of > 10 lbs over 6 months or 5 lbs in past month?	☐ No ☐ Yes - How much:		
Do you want nutritional education information?	☐ No ☐ Yes		
Difficulty Chewing/Eating	☐ Yes ☐ No	Nausea/Vomiting > 3 days	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Diarrhea 3 days	☐ Yes ☐ No
>80 & surgery in past 2 mo. or admitted for surgery			☐ Yes ☐ No
Poor Appetite > 3 days	☐ Yes ☐ No		
Pressure wounds, skin breakdown	☐ Yes ☐ No		
Initiate Referral If yes to any of above			

DISCHARGE PLANNING (Initiate Referral to Social Services for * items)

Where do you live now? Allred
☐ Home alone ☐ Home with family ☐ Assisted Living Facility: ☐ Nursing Home:

Planned Discharge: Allred
☐ Home-Self Care ☐ Nursing Home* ☐ Home with Caregivers ☐ Assisted Living Facility* ☐ Rehabilitation* ☐ Hospice* ☐ Does anyone at your home need assistance? ☐ Pastorial Care needed?

While you are in the hospital, do you have concerns for someone at home?	☐ No	☐ Yes* - Describe:
Do you have appropriate resources to maintain health at home (money for medications, food, transportation, etc.)?	☑ Yes	☐ No* - Describe:
At discharge, will someone be available to assist you.	Yes: ☐ Partner/Spouse ☐ Neighbor/Friend ☐ Other: Transport	☐ No*
Do you currently receive assistance from community agencies?	☐ No	☐ Home Health* ☐ Public Health Department ☐ MHMR ☐ Meals on Wheels* ☐ Other:

☐ Substance-use Disorders ☐ *Emotional, Behavioral and/or Mental Disorders ☐ *Admitting Diagnosis of Abuse and/or Neglect

Signature of RN or LVN Completing Form: X [signature] Date: 6/27/07 Time: 0035

REGISTERED NURSE ADMISSION NOTE

☑ Complete Assessment Reviewed
☑ Care Plan Initiated
☑ Identification armband in place
☑ NKDA or ☐ Allergy armband in place
☑ Full Code or ☐ DNR armband in place

Precautions Initiated:
☑ Falls; yellow armband inplace, door marked
☐ Suicide
☐ Potential or actual wound protocol

Referrals initiated as indicated below: (9)
☐ None ☑ Social Services* ☐ Diabetic Education ☐ Dietary ☐ Wound Care ☐ Respiratory Therapy (smoking cessation) ☐ Pastoral Care ☐ Speech Therapy ☐ PT/OT ☐ Advanced Directives
[signature] Adm. & Team

RN Signature: X [signature] RNC Date: 6/27/07 Time: 0300

DATE: ROOM #:

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Evaluator's Name: DATE OF ASSESSMENT ⇨

SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation. -OR- Limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. -OR- Has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**3. Slightly Limted** Responds to verbal commands but cannot always communicate discomfort or the need to be turned. -OR- Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
MOISTURE Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.
ACTIVITY Degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chair-Fast** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Occasionally Walks** Walks occasionally during day but for very short distances with or without assistance. Spends majority of each shift in bed or chair.	**4. Frequently Walks** Walks outside the room at least twice a day and inside room at least once every two hours during waking hours.
MOBILITY Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitations** Makes major and frequent changes in position without assistance.
NUTRITION Usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement -OR- Is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. -OR- Receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal but will usually take a supplement when offered. -OR- TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.	

* Score of 18 or less indicates that patient is at risk for skin breakdown. For 12 or less consult wound care. TOTAL

If additional risk factors present age > 65 fever poor dietary intake of protein diastolic pressure < 60 or hemodynamic instability, advance to next level of risk.

Indicate patient's risk according to Braden total score and implement interventions

☐ **Not At Risk (19-23)**	☐ **Low Risk (15-18) or**	☐ **Moderate Risk (13-14)**
	• See specialty bed decision tree and protocols • Frequent turning (determined by assessing skin for reactive erythema)	• Maximal remobilization • Protect heels • Manage moisture, nutrition, friction and shear
☐ **High Risk (10-12) or**	☐ **Severe Risk (9 and below)**	
• Implement same interventions as low and moderate risk plus • Consult wound care team via computer and indicate score • Initiate q 2 hour turning schedule	• Use pillows or foam wedges for 30 degrees lateral positioning • See protocol	

Indicate if patient scored 1 or 2 in any subscale and implement interventions

☐ **Sensory Perception**	☐ **Moisture**	☐ **Mobility**
• Reposition patient q 2 hours at 30 degrees turn • See positioning guidelines in Alteration in Skin/Integrity Protocol Potential • Float heels off bed at all times	• Keep skin, especially folds clean and dry • Use skin barrier ointment • See Incontinence Protocols for incontinent patients • If patient score is 1, refer to specialty bed protocols for low air loss surface	• Reposition patient q 2 hours at 30 degrees turn • See positioning guidelines in Alteration in Skin/Integrity Protocol Potential
☐ **Friction and Shear**	☐ **Nutrition**	☐ **Activity**
• Do not drag or slide patient. Use turn sheet to lift and position • If able, offer overhead trapeze to assist patient in positioning • Keep HOB at 30 degrees and below when not contraindicated • If HOB > 30 degrees, raise knee gatch to limit sliding • Apply protective ointment or thin hydrocolloid to protect at risk sites (especially sacrum, heels and elbows) • See protocol	• Maintain adequate nutrition • Offer fluids frequently if not contraindicated • Collaborate with physician to obtain albumin level • Initiate nutrition referral	• Keep HOB at 30 degrees and below when not contraindicated • Reposition patient q 2 hours at 30 degrees turn • OOB at least TID if consistent with medical condition • 4 inch chair cushion for chair fast patients with position shifts at least hourly while in chair • Initiate PT referral

Check appropriate action and initial

☐ Patient not at risk for breakdown Continue daily assessment Initials: _____	• Patients total score 18 or less interventions implemented for Alteration in Skin/Integrity Protocol Potential according to level of risk Initials: _____	
Bed surface: _____	Specialty seating surface: ☐ No ☐ Yes: _____	

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UNITED REGIONAL HEALTHCARE SYSTEM

INPATIENT ADMISSION ASSESSMENT

rev 12/06 inpatientadmissionassessmentpage6.taw

DATE: **ROOM #:**

NUTRITIONAL MEDICINE REFERRAL NOTE

Calculation of Nutrition Care Priority Points *(To be filled out by Dietitian or Dietetic Technician as Indicated)*

See Nutritional Inpatient Screening Section on Page 2	
Nutrition Care Indicator Category:	**Highest Points Assigned**
Nutritional History	
Feeding Modality	
Unintended Weight Loss	
Weight Status	
Serum Albumin	
DX/Condition	
Total Points:	Nutrition Status Classification:

Patient history and referral information reviewed. Recommendations:

- ☐ No recommendations at this time, continue diet as ordered
- ☐ Will continue to monitor nutritional status
- ☐ Will provide nutrition education
- ☐ Will request MD referral for outpatient education
- ☐ Refer to dietitian for assessment
- ☐ Speech Therapy Referral

PALLIATIVE CARE SCREENING TOOL

Criteria - Please consider the following Criteria when determining the palliative care score of this patient

1. Basic Disease Process — **SCORING** *Score 2 points EACH*

a. Cancer (Metastatic/Recurrent) c. Stroke e. Advanced cardiac disease
b. Advanced COPD d. End stage renal disease f. Other life-limiting illness

2. Concomitant Disease Processes — *Score 1 point overall*

a. Liver disease c. Moderate COPD e. Other condition complicating cure
b. Moderate renal disease d. Moderate congestive heart failure

3. Functional status of patient — *Score as specified below*

Using ECOG Performance Status (Eastern Cooperative Oncology Group)

ECOG	Grade	Scale	
	0	Fully Active, able to carry on all pre-disease activities without restriction.	Score 0
	1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work.	Score 0
	2	Ambulatory and capable of all self-care but unable to carry out any Work activities. Up and about more than 50% of waking hours.	Score 1
	3	Capable of only limited self-care; confined to bed or chair more than 50% of waking hours.	Score 2
	4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.	Score 3

4. Other criteria to consider in screening — *Score 1 point EACH*

The patient:
a. is not a candidate for curative therapy
b. has a life-limiting illness and chosen not to have life prolonging therapy
c. has unacceptable level of pain >24 hours
d. has uncontrolled symptoms (i.e. nausea, vomiting)
e. has uncontrolled psychosocial or spiritual issues
f. has frequent visits to the Emergency Department (> 1 x mo for same diagnosis)
g. has more than one hospital admission for the same diagnosis in last 30 days
h. has prolonged length of stay without evidence of progress
i. has prolonged stay in ICU or transferred from ICU to ICU without evidence of progress
j. Is in an ICU setting with documented poor or futile prognosis

SCORING GUIDELINES: TOTAL SCORE ≥ 4 = Palliative Care Team Consult | **TOTAL SCORE:**

Dietitian or Dietetic Technician Signature: X _____ **Date:** _____ **Time:** _____

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UNITED REGIONAL HEALTHCARE SYSTEM

INPATIENT ADMISSION ASSESSMENT
rev 12/06 inpatientadmissionassessmentpage7.taw

DATE: **ROOM#:**

RESPIRATORY THERAPY REFERRAL NOTE

Reason Referred: **Order #:**

Patient history and referral information reviewed. Pt. referred for.
- ☐ Smoking cessation
- ☐ Pt. receptive: educational materials provided
- ☐ Pt. not receptive; contact information provided for future reference
- ☐ Other: _____

Therapist Signature: X _____ **Date** _____ **Time:** _____

PT / OT / ST THERAPY REFERRAL NOTE

Reason Referred: **Order #:**

Patent history and referral information reviewed. Recommendations:
- ☐ No recommendations for therapy at this time
- ☐ Deferred D/T medical status
- ☐ Request MD consult
- ☐ Other:

Therapist Signature: X _____ **Date:** _____ **Time:** _____

SOCIAL SERVICES REFERRAL NOTE

Reason Referred: **Order #:**

Patient history and referral information reviewed. Recommendations:
- ☐ No recommendations at this time
- ☐ Deferred D/T medical status
- ☐ Request MD consult
- ☐ See detailed note for plan

Social Services Signature: X _____ **Date:** _____ **Time:** _____

DIABETIC EDUCATION REFERRAL NOTE

Reason Referred: **Order #:**

Patient history and referral information reviewed. Recommendations:
- ☐ No recommendations for education at this time
- ☐ Pt. receptive; educational materials provided
- ☐ Pt. not receptive; contact information provided for future reference
- ☐ Other: _____

Educator Signature: X _____ **Date:** _____ **Time:** _____

INPATIENT ONCOLOGY REFERRAL NOTE

Reason Referred: **Order #:**

Patent history and referral information reviewed. Recommendations:
- ☐ No recommendations for education at this time
- ☐ Pt. receptive; educational materials provided
- ☐ Pt. not receptive; contact information provided for future reference
- ☐ Other: _____

Educator Signature: X _____ **Date:** _____ **Time:** _____

WOUND CARE REFERRAL NOTE

Reason Referred: **Order #:**

Patient history and referral information reviewed. Recommendations:
- ☐ No recommendations for therapy at this time
- ☐ Continue use of potential wound care protocol
- ☐ Initiate potential wound care protocol
- ☐ Initiate actual wound care protocol
- ☐ Continue use of actual care wound care protocol
- ☐ See additional orders

Educator Signature X _____ **Date:** _____ **Time:** _____

PASTORAL CARE REFERRAL NOTE

Reason Referred: **Order #:**

Patent history and referral information reviewed. Recommendations:
- ☐ No recommendations at this time
- ☐ Deferred D/T medical status
- ☐ Consultation with patient
- ☐ Consultation with family
- ☐ Will continue to follow as requested by patient or family

Pastoral Care Signature: X _____ **Date:** _____ **Time:** _____

PALLIATIVE CARE REFERRAL NOTE

Reason Referred: **Order #:**

Patient history and referral information reviewed. Recommendations:
- ☐ No recommendations at this time
- ☐ Future Palliative Care Patient
- ☐ Admit to Palliative Care team

Palliative Care Signature: X _____ **Date:** _____ **Time:** _____

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PATIENT CARE RECORD
INTAKE/OUTPUT
rev 12/06 inputoutput.jsn

DATE: 6-26-07 **ROOM #:** S444 1

* Residuals are not included in the I & O unless discarded
≠ Indicate with 'V' the first void after D/C of Foley
§ Include liquid stool (cc's) in Output

TIME	SOLN SITE	SOLN SITE	SOLN SITE	SOLN SITE	SOLN SITE	SOLN SITE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	TUBE FEEDING	PO	DIET %	HOURLY SUB TOTAL	RESID*		URINE ≠	NGT	BM §	EMESIS	DRAIN	DRAIN
07																		07						
08																		08						
09																		09						
10																		10						
11																		11						
12																		12						
13																		13						
14																		14						
15																		15						
16																		16						
17																		17						
18																		18						
TOTAL																		TOTAL						
													TOTAL 12° INTAKE					TOTAL 12° OUTPUT						

	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	TUBE FEEDING	PO	DIET %	HOURLY SUB TOTAL	RESID*		URINE ≠	NGT	BM §	EMESIS	DRAIN	DRAIN
19																		19						
20																		20						
21																		21						
22																		22						
23																		23						
00																		00						
01	Received to Floor.													NPO				01	850					
02														↓				02						
03																		03						
04																		04						
05																		05						
06	152																	06	500					
TOTAL																		TOTAL						
													TOTAL 12° INTAKE			152		TOTAL 12° OUTPUT	1350					

TOTAL 24° INTAKE	TOTAL 24° OUTPUT	24° VARIANCE

1

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UNITED REGIONAL HEALTHCARE SYSTEM

PATIENT CARE RECORD
REFERENCE SHEET
rev 12/06 inputoutput2.jsn

DATE: 6-26-07 | ROOM #: S444 1

FALL RISK ASSESSMENT

ITEM	SCALE	SCORE AM	SCORE PM
1. History of Falling; Immediate or Within 3 Months	No 0 Yes 25		0
2. Secondary Diagnosis	No 0 Yes 15		0
3. Ambulatory Aid: Bed Rest/Nurse Assist / Crutches/Cane/Walker / Furniture	0 / 15 / 30		0
4. IV/Trippable Tubing	No 0 Yes 20		20
5. Gait/Transferring: Normal/Bedrest/Immobile / Weak / Impaired	0 / 10 / 20		0
6. Mental status: Oriented to Own Ability / Forgets Limitations	0 / 15		0
Medications may increase the risk of falls (i.e. vasoactive, diuretics, narcotics).	TOTAL		20

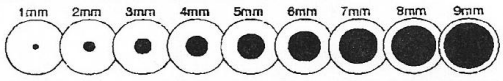
RISK LEVEL SCALE

RISK LEVEL	MFS SCORE	ACTION
Level 1	0-24	Good Basic Nursing Care
Level 2	25-50	Implement Standard Fall Prevention Interventions
Level 3	≥ 51	(1) Implement High Risk Fall Prevention Interventions (2) Mandatory P.T. Referral

GLASGOW COMA SCALE

EYE OPENING	VERBAL RESPONSE	MOTOR RESPONSE
Spontaneous 4	Oriented 5	Obeys Commands 6
To Voice 3	Confused 4	Localizes Pain 5
To Pain 2	Inappropriate Words .. 3	Withdraws (Pain) 4
None 1	Incomprehensible Words . 2	Flexion (Pain) 3
	None 1	Extension (Pain) 2
		None 1

PUPILS



EXTREMITIES

STRENGTH (Grips): 3 - Strong, 2 - Fair, 1 - Weak, 0 - Absent

PULSES

P = Palpable, D = Doppler, P1 = Weak, P2 = Fair, P3 = Strong, D1 = Monophasic, D2 = Biphasic, D3 = Triphasic

FALL LEVEL INTERVENTIONS

LEVEL I (NO RISK) – 0-24

1. Fall Prevention Protocol
2. Respond promptly to call light
3. Reduce environmental hazards (i.e. clear path to bathroom, check that patient has non-skid, adequately fitting, low-heeled footwear, and if not, order hospital issued non-skid socks; check that clothing fits adequately and is not likely to trip patient while ambulating)
4. Orient patient to room and bathroom location. Re-orient as necessary. Encourage frequent toileting assistance
5. Assist patient ambulating as appropriate
6. Maintain bed in low position with brakes locked
7. Use brakes on wheelchair, Gen chair and stretcher to maintain stability whenever not moving
8. Validate that patient knows how and is able to use call light, call light is in reach and call light works
9. Validate that personal items that are requested are in reach (i.e. glasses, urinal, water, dentures, tissues, cosmetic kit)
10. Use siderails as appropriate
11. Validate that patients who need them wear glasses as appropriate and glasses are clean
12. Wipe up spills
13. Conduct safety checks for the bed in low position, call light within reach and a clear path to the bathroom
14. Assess/examine medication regimen for side effects and peak times.

LEVEL II (LOW RISK) – 25-50

1. FALL PREVENTION PROTOCOL
2. LEVEL I INTERVENTIONS
3. Inform patient/family of risk for falling and interventions being used
4. Instruct patient/family to call for assistance when the patient wants to get out of bed. Frequently reinforce
5. Nurse should request Physical Therapy Screening
6. Provide adequate lighting when dark
7. Check patient at least q 2 hours to see if patient needs anything (i.e. help with toileting, hygiene assistance, etc.) This is especially important during change of shift if patient is disoriented, and at night.
8. Use a gait belt to assist during transfers/ambulation as appropriate.
9. Monitor orthostatic vital signs as appropriate.
10. Instruct patient to get up slowly from a lying position.
11. Avoid sitting patient on side of bed during meals. Instruct patient to eat meals either in or out of bed
12. Consider bed alarm on patient bed; consider chair alarm while in chair
13. Use a yellow identification system to identify the patient at high risk for falls according to the following.
    a. Yellow wrist band
    b. Yellow dot/marking by patient's door

LEVEL III (HIGH RISK) – >/= 51

1. FALL PREVENTION PROTOCOL
2. LEVEL I INTERVENTIONS
3. LEVEL II INTERVENTIONS
4. Patients that are a Level III as a result of a fall, either prior to hospitalization where the fall was the reason for the hospitalization, or during the hospital, should remain a Fall Level III during the entire hospitalization.
5. Assign patient to a room as close as possible to nurses' station
6. Stay in close visual or verbal contact when patient is on bedside commode, in bathroom, shower or at sink
7. Consider patient sitter
8. Seek cooperation from patient's family to stay with the patient during the day and/or night. Instruct patient/family to call for help when the patient wants to get out of bed
9. If less restrictive measures are insufficient, consider vest, limb or other passive restraints
10. Nurse will request Physical Therapy Screening

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UNITED REGIONAL HEALTHCARE SYSTEM

PATIENT CARE RECORD
ASSESSMENT (Page 1 of 2)
rev 02/07 inputoutput3.jsn

DATE: 6/26/07 | ROOM #: S444 1

	ASSESSMENT	AM	PM
SAFETY	Bed in low position		✓
	Call light in reach		✓
	Identification armband in place		✓
	If DNR, armband in place		
	If allergies, armband in place		
	Precaution measures: Fall/Seizure/Suicide		
	Potential for violence		
NEUROLOGICAL	Alert / Lethargic	/	✓
	Cooperative / Uncooperative	/	✓
	Anxious / Restless / Agitated		
	Confused		
	Speech Clear / Slurred	/	✓
	Unresponsive / Comatose	/	
CARDIAC	Apical pulse regular / irregular	/	✓
	Capillary refill <2 sec / >2 sec	/	✓
	Neck veins flat / Distended	/	
	EKG rhythm		
	Telemetry box #: ____	/	
SKIN	Intact		✓
	Breakdown noted* Use Wound Care Flow Sheet		
	Braden score		23
	Warm / Cool	/	✓
	Dry / Clammy / Diaphoretic		✓
	Pink / Pale (mucous membranes/ nailbeds)	/	✓
	Cyanotic / Flushed / Jaundice		
	Edema (+1, +2, +3, Pit)		
OTHER	Routine daily care		
	Traction setup		
	Isolation		
	Brace		

	ASSESSMENT	AM	PM
PULMONARY	Breath Sounds Cl R / L	/	✓ ✓
	Crackles R / L	/	/
	Wheezes R / L	/	/
	Rhonchi R / L	/	/
	Diminished R / L	/	✓
	Absent R / L	/	/
	Resp effort Reg/ Irreg	/	✓
	Unlabored / Labored	/	✓
	Accessory muscle use		
	Symmetrical expansion		✓
	Denies / c / o SOB	/	✓
	Cough: Productive / Nonprod	/	/
	Color:		
	O2 per:		
	Liters/minute		
	Tracheostomy		
	Cuff Up / Down	/	
	Tube secured in place	/	
GI - GU	Urine color		yellow
	Clear / Cloudy / Bloody		✓
	Voids / Foley / CBI		✓
	Abd: Soft / Firm		✓
	Flat / Distended		✓
	Nontender / Tender		✓
	Bowel sound: Present / Absent		✓
	Hypo / Hyper		
	Expels flatus		✓
	NGT / PEG / OGT		
	Sx / Clamp / Feed		
	Urostomy/Ileostomy/Colostomy		
	Stoma pink / Other*		

	ASSESSMENT	AM	PM
			SCORE
FALLS	Falls Level 1 (0-24)		20
	Falls Level 2 (25-50)		
	Falls Level 3 (≥ 51) *Mandatory P.T. Referral		
RESTRAINTS	If patient is restrained, initiate 24 Hour Restraint Flow Record.		
DRAINS	Drain Tube: Site / Type		
	Drainage: Sero / Serosang / Sang		
	Drain Tube: Site / Type		
	Drainage: Sero / Serosang / Sang		
	Care Plan Reviewed		✓
	Care Plan Revised		

	IV ACCESSES	D	E	N
PERIPH	Peripheral IV Sites			5
	No Inflammation			✓
	No Infiltration			✓
	Dsgs Dry & Intact			✓
CENTRAL	Quinton Cath Site			
	Triple Lumen Cath Site			
	No Inflammation			
	No Infiltration			
	Dsgs Dry & Intact			
	Peripheral Hep Lock Sites			

CODES

1. Rt. Jugular	4. Lt. Subclavian	7. Rt. Hand
2. Lt. Jugular	5. Rt. Arm	8. Lt. Hand
3. Rt. Subclavian	6. Lt. Arm	9. Other (*)

	ASSESSMENT	AM	PM	ASSESSMENT	AM	PM
CHEST TUBES	CT #1 site:			CT #2 site:		
	Sx: cm H20 / Gravity / Wall			Sx: cm H20 / Gravity / Wall		
	Air leak / Crepitus	/	/	Air leak / Crepitus	/	/
	Fluctuation in chamb			Fluctuation in chamb		
	Tube connections secure			Tube connections secure		
	Drainage: Sero / Serosang / Sang			Drainage: Sero / Serosang / Sang		
	Dressing Dry / Intact			Dressing Dry / Intact		

	ASSESSMENT	AM	PM	ASSESSMENT	AM	PM
SURGICAL	Incision #1 Site:			Incision #2 Site:		
	Open to Air / Dressing	/	/	Open to Air / Dressing	/	/
	Dressing Dry, Intact / Drainage	/	/	Dressing Dry, Intact / Drainage	/	/
	Edges Approximated / Open*	/	/	Edges Approximated / Open*	/	/
	With: Staples / Sutures / Steri strips			With: Staples / Sutures / Steri strips		
	Redness / Induction / Swelling	/		Redness / Induction / Swelling	/	
	Drainage: Sero / Serosang / Sang			Drainage: Sero / Serosang / Sang		
	Purulent			Purulent		
	Amount: Sm / Mod / Lg			Amount: Sm / Mod / Lg		

Data Collected By — AM
X _____ LVN

Review — AM
X _____ RN

Data Collected By — PM
X JoBrandon, LVN

Review — PM
X Patterson RNC 7P-7a RN

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PATIENT CARE RECORD
ASSESSMENT (Page 2 of 2)
rev 02/07 inputoutput4.jsn

DATE: 6/26/07 | ROOM #: 1 S444

PRN MEDICATION ASSESSMENT *(PAIN SCALE: 0 = No Pain & 10 = Maximum Pain)*

❑ Pt has PCA: See Pain Management 24° Flow Sheet for Documentation R/T Pain Management

PAIN INTERVENTION					EVALUATION OF INTERVENTION			
TIME	INIT.	PAIN LEVEL	PROBLEM / FOCUS	INTERVENTION	TIME	INIT.	PAIN LEVEL	ASSESSMENT
0150	JGB	0						

	HOUR ⇨	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06	07
HEMODYNAMICS	Respirations O2 Sat %																			JGB						
	Pain																			4						
NEURO	Eye Opening																			5						
	Verbal Response																			6						
	Motor Response																			15						
	TOTAL (≤7 indicates coma)																			3						
	Pupils R																			3						
	Pupils L																			3						
EXTREMITY MOVEMENT	Arm R																			3						
	Arm L																			3						
	Leg R																			3						
	Leg L																			3						
PULSES	Time																									
	Radial R																			P						
	Radial L																			P						
	Dorsalis Pedis R																			P						
	Dorsalis Pedis L																			P						
	Posterior Tibial R																									
	Posterior Tibial L																									

VENIPUNCTURES

TIME	DESCRIPTION OF NEEDLE	PLACEMENT	HEP LOC	DC'd	COMMENTS	# OF ATTEMPTS	SIGNATURE

SITE VERIFICATION: _____ (Location) TIME OUT PRIOR TO PROCEDURE: ❑

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UNITED REGIONAL HEALTHCARE SYSTEM

PATIENT CARE RECORD
NARRATIVE NOTES
DISCHARGE
rev 02/07 inputoutput5.jsn

DATE:	ROOM #:
6/26/07	S444 1

DATE	TIME	NARRATIVE NOTES
	0150	Received to room 444 from ER via stretcher. 2 guards in accompaniment. No distress noted. PM assessment complete. QpB, LVN. 0558 Awake, alert, oriented. Denies wants or needs @ this time. 2 Guards in room. QpB, LVN

SIGNATURE KEY

NAME, TITLE	INIT.	NAME, TITLE	INIT.
QpBrandon, LVN	QpB		

DISCHARGE / TRANSFER

Time: _____
Via: ☐ WC ☐ Stretcher ☐ Ambulatory
To: ☐ Car ☐ Ambulance ☐ Room: _____
Accompanied by: _____
Condition: _____
Disposition: ☐ Home ☐ Other: _____
Left with Personal Belongings: ☐ Yes ☐ No
Signature: _____

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UNITED REGIONAL HEALTHCARE SYSTEM

PATIENT CARE RECORD
PRESSURE WOUND RISK ASSESSMENT
rev 02/07 inputoutput6.jsn

DATE: 6/26/07 | ROOM #: S444 1

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Evaluator's Name: | DATE OF ASSESSMENT ⇨ 6/26

SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation). -OR- Limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. -OR- Has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. -OR- Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	4
MOISTURE Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.	4
ACTIVITY Degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chair-Fast** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair	**3. Occasionally Walks** Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Frequently Walks** Walks outside the room at least twice a day and inside room at least once every two hours during waking hours	4
MOBILITY Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitations** Makes major and frequent changes in position without assistance.	4
NUTRITION Usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement -OR- Is NPO and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. -OR- Receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered. -OR- Is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.		3

* Score of 18 or less indicates that patient is at risk for skin breakdown. For 12 or less consult wound care. | **TOTAL** 23

If additional risk factors present, age > 65, fever, poor dietary intake of protein, diastolic pressure < 60, or hemodynamic instability, advance to next level of risk.

Indicate patient's level of risk according to Braden total score and implement interventions

☐ Not At Risk (19-23)	☐ Low Risk (15-18) or	☐ Moderate Risk (13-14)
	• See specialty bed decision tree and protocols • Frequent turning (determined by assessing skin for reactive erythema)	• Maximal remobilization • Protect heels • Manage moisture, nutrition, friction and shear
☐ High Risk (10-12) or	**☐ Severe Risk (9 and below)**	
• Implement same interventions as low and moderate risk plus • Consult wound care team via computer and indicate score • Initiate q 2 hour turning schedule	• Use pillows or foam wedges for 30 degrees lateral positioning • See protocol	

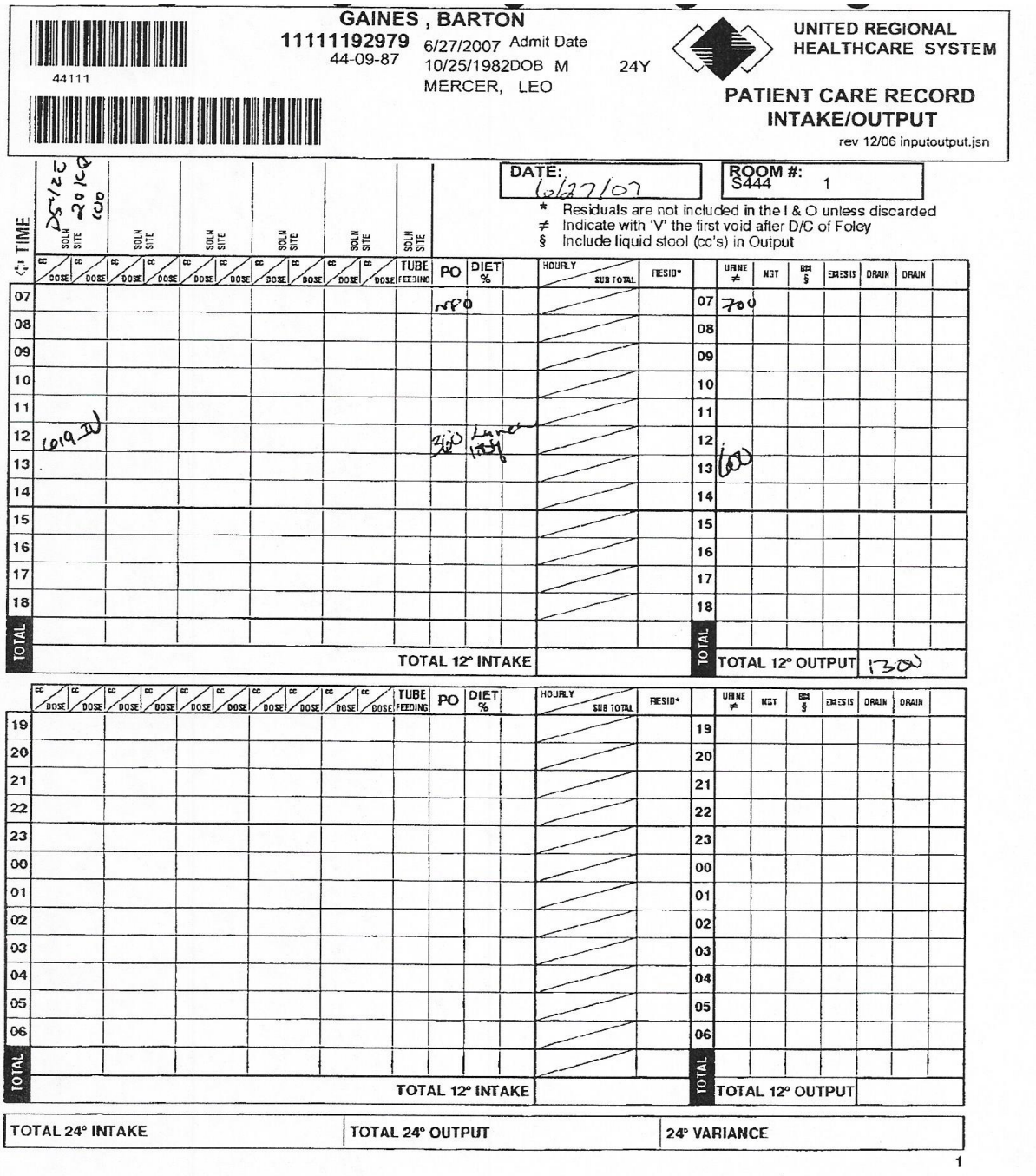
Indicate if patient scored 1 or 2 in any subscale and implement interventions

☐ Sensory Perception	☐ Moisture	☐ Mobility
• Reposition patient q 2 hours at 30 degrees turn • See positioning guidelines in Alteration in Skin/Integrity Protocol Potential • Float heels off bed at all times	• Keep skin, especially folds clean and dry • Use skin barrier ointment • See Incontinence Protocols for incontinent patients • If patient score is 1, refer to specialty bed protocols for low air loss surface	• Reposition patient q 2 hours at 30 degrees turn • See positioning guidelines in Alteration in Skin/Integrity Protocol Potential
☐ Friction and Shear	**☐ Nutrition**	**☐ Activity**
• Do not drag or slide patient. Use turn sheet to lift and position • If able, offer overhead trapeze to assist patient in positioning • Keep HOB at 30 degrees and below when not contraindicated • If HOB > 30 degrees, raise knee gatch to limit sliding • Apply protective ointment or thin hydrocolloid to protect at risk sites (especially sacrum, heels and elbows) • See protocol	• Maintain adequate nutrition • Offer fluids frequently if not contraindicated • Collaborate with physician to obtain albumin level • Initiate nutrition consult	• Keep HOB at 30 degrees and below when not contraindicated • Reposition patient q 2 hours at 30 degrees turn • OOB at least TID if consistent with medical condition • 4 inch chair cushion for chair fast patients with position shifts at least hourly while in chair • Initiate PT consult

Check appropriate action and initial

☐ Patient not at risk for breakdown. Continue daily assessment Initials:	• Patient's total score 18 or less. Interventions implemented for Alteration in Skin/Integrity Protocol Potential according to level of risk Initials:	
Bed surface: _____	Specialty seating surface: ☐ No ☐ Yes: _____	

6



GAINES , BARTON
11111192979 6/27/2007 Admit Date
44-09-87 10/25/1982DOB M 24Y
MERCER, LEO
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UNITED REGIONAL HEALTHCARE SYSTEM

PATIENT CARE RECORD
INTAKE/OUTPUT
rev 12/06 inputoutput.jsn

DATE: 6/27/07
ROOM #: S444 1

* Residuals are not included in the I & O unless discarded
≠ Indicate with 'V' the first void after D/C of Foley
§ Include liquid stool (cc's) in Output

24 TIME	SOLN SITE	cc DOSE	PO	DIET %	HOURLY SUB TOTAL	RESID*	URINE ≠	NGT	BM §	EMESIS	DRAIN	DRAIN
07	D5 1/2 NS 20 KCL 100		NPO				700					
08												
09												
10												
11												
12	6019 IV		240	Lunch 175%								
13							100					
14												
15												
16												
17												
18												
TOTAL		TOTAL 12° INTAKE					TOTAL 12° OUTPUT					1300

	cc DOSE	TUBE FEEDING	PO	DIET %	HOURLY SUB TOTAL	RESID*	URINE ≠	NGT	BM §	EMESIS	DRAIN	DRAIN
19												
20												
21												
22												
23												
00												
01												
02												
03												
04												
05												
06												
TOTAL		TOTAL 12° INTAKE					TOTAL 12° OUTPUT					

TOTAL 24° INTAKE	TOTAL 24° OUTPUT	24° VARIANCE

1

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11111192979 6/27/2007 Admit Date
44-09-87 10/25/1982DOB M 24Y
MERCER, LEO

UNITED REGIONAL HEALTHCARE SYSTEM

PATIENT CARE RECORD
REFERENCE SHEET

rev 12/06 inputoutput2.jsn

DATE:	ROOM #:
6/27/07	S444 1

FALL RISK ASSESSMENT

ITEM	SCALE	SCORE AM	SCORE PM
1. History of Falling; Immediate or Within 3 Months	No 0 Yes 25	0	
2. Secondary Diagnosis	No 0 Yes 15	15	
3. Ambulatory Aid: Bed Rest/Nurse Assist 0; Crutches/Cane/Walker 15; Furniture 30		0	
4. IV/Trippable Tubing	No 0 Yes 20	20	
5. Gait/Transferring: Normal/Bedrest/Immobile 0; Weak 10; Impaired 20		0	
6. Mental status: Oriented to Own Ability 0; Forgets Limitations 15		0	
Medications may increase the risk of falls (i.e. vasoactive, diuretics, narcotics).	TOTAL	35	

RISK LEVEL SCALE

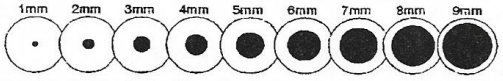
RISK LEVEL	MFS SCORE	ACTION
Level 1	0-24	Good Basic Nursing Care
Level 2	25-50	Implement Standard Fall Prevention Interventions
Level 3	≥ 51	(1) Implement High Risk Fall Prevention Interventions (2) Mandatory P.T. Referral

GLASGOW COMA SCALE

EYE OPENING	VERBAL RESPONSE	MOTOR RESPONSE
Spontaneous 4	Oriented 5	Obeys Commands 6
To Voice 3	Confused 4	Localizes Pain 5
To Pain 2	Inappropriate Words .. 3	Withdraws (Pain) 4
None 1	Incomprehensible Words . 2	Flexion (Pain) 3
	None 1	Extension (Pain) 2
		None 1

PUPILS

1mm 2mm 3mm 4mm 5mm 6mm 7mm 8mm 9mm



EXTREMITIES

STRENGTH (Grips): 3 - Strong; 2 - Fair; 1 - Weak; 0 - Absent

PULSES

P = Palpable; D = Doppler; P1 = Weak; P2 = Fair; P3 = Strong; D1 = Monophasic; D2 = Biphasic; D3 = Triphasic

FALL LEVEL INTERVENTIONS

LEVEL I (NO RISK) – 0-24

1 Fall Prevention Protocol
2 Respond promptly to call light
3 Reduce environmental hazards (i.e. clear path to bathroom, check that patient has non-skid, adequately fitting, low-heeled footwear, and if not, order hospital issued non-skid socks; check that clothing fits adequately and is not likely to trip patient while ambulating)
4 Orient patient to room and bathroom location. Re-orient as necessary. Encourage frequent toileting assistance.
5. Assist patient ambulating as appropriate
6 Maintain bed in low position with brakes locked
7 Use brakes on wheelchair, Geri chair and stretcher to maintain stability whenever not moving
8 Validate that patient knows how and is able to use call light; call light is in reach and call light works
9 Validate that personal items that are requested are in reach (i.e. glasses, urinal, water, dentures, tissues, cosmetic kit)
10 Use siderails as appropriate
11 Validate that patients who need them wear glasses as appropriate and glasses are clean
12 Wipe up spills.
13. Conduct safety checks for the bed in low position, call light within reach and a clear path to the bathroom
14. Assess/examine medication regimen for side effects and peak times.

LEVEL II (LOW RISK) – 25-50

1 FALL PREVENTION PROTOCOL
2 LEVEL I INTERVENTIONS
3 Inform patient/family of risk for falling and interventions being used
4 Instruct patient/family to call for assistance when the patient wants to get out of bed. Frequently reinforce
5 Nurse should request Physical Therapy Screening
6 Provide adequate lighting when dark
7. Check patient at least q 2 hours to see if patient needs anything (i.e. help with toileting, hygiene assistance, etc.) This is especially important during change of shift if patient is disoriented, and at night.
8 Use a gait belt to assist during transfers/ambulation as appropriate.
9. Monitor orthostatic vital signs as appropriate.
10 Instruct patient to get up slowly from a lying position.
11 Avoid sitting patient on side of bed during meals. Instruct patient to eat meals either in or out of bed.
12. Consider bed alarm on patient bed; consider chair alarm while in chair
13 **Use a yellow identification system to identify the patient at high risk for falls** according to the following:
a. Yellow wrist band
b. Yellow dot/marking by patient's door

LEVEL III (HIGH RISK) – >/= 51

1. FALL PREVENTION PROTOCOL
2. LEVEL I INTERVENTIONS
3. LEVEL II INTERVENTIONS
4. Patients that are a Level III as a result of a fall, either prior to hospitalization where the fall was the reason for the hospitalization, or during the hospital, should remain a Fall Level III during the entire hospitalization.
5. Assign patient to a room as close as possible to nurses' station
6. Stay in close visual or verbal contact when patient is on bedside commode, in bathroom, shower or at sink
7. Consider patient sitter
8. Seek cooperation from patient's family to stay with the patient during the day and/or night. Instruct patient/family to call for help when the patient wants to get out of bed
9. If less restrictive measures are insufficient, consider vest, limb or other passive restraints
10 Nurse will request Physical Therapy Screening

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GAINES , BARTON
11111192979 6/27/2007 Admit Date
44-09-87 10/25/1982 DOB M 24Y
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UNITED REGIONAL HEALTHCARE SYSTEM

PATIENT CARE RECORD
ASSESSMENT (Page 1 of 2)
rev 02/07 inputoutput3.jsn

DATE: 6/27/07 | ROOM #: S444 1

ASSESSMENT	AM	PM
SAFETY		
Bed in low position	✓	
Call light in reach	✓	
Identification armband in place	✓	
If DNR, armband in place		
If allergies, armband in place		
Precaution measures: Fall/Seizure/Suicide	✓	
Potential for violence		
NEUROLOGICAL		
Alert / Lethargic	✓	
Cooperative / Uncooperative	✓	
Anxious / Restless / Agitated		
Confused		
Speech Clear / Slurred	✓	
Unresponsive / Comatose		
CARDIAC		
Apical pulse regular / irregular	✓	
Capillary refill <2 sec / >2 sec	✓	
Neck veins flat / Distended	✓	
EKG rhythm		
Telemetry box #:		
SKIN		
Intact	✓	
Breakdown noted* Use Wound Care Flow Sheet		
Braden score		
Warm / Cool	✓	
Dry / Clammy / Diaphoretic	✓	
Pink / Pale (mucous membranes/ nailbeds)	✓	
Cyanotic / Flushed / Jaundice		
Edema (+1, +2, +3, Pit)		
Stab wounds	✓	
OTHER		
Routine daily care	✓	
Traction setup		
Isolation		
Brace		

ASSESSMENT	AM	PM
PULMONARY		
Breath Sounds Cl R / L	✓	✓
Crackles R / L		
Wheezes R / L		
Rhonchi R / L		
Diminished R / L	✓	✓
Absent R / L		
Resp effort Reg/ Irreg	✓	
Unlabored / Labored	✓	
Accessory muscle use	cp	
Symmetrical expansion	✓	
Denies / c / o SOB	✓	
Cough: Productive / Nonprod		
Color:		
O2 per:	RA	
Liters/minute		
Tracheostomy		
Cuff Up / Down		
Tube secured in place		
GI - GU		
Urine color		
Clear / Cloudy / Bloody	✓	
Voids / Foley / CBI	✓	
Abd: Soft / Firm	✓	
Flat / Distended	✓	
Nontender / Tender	✓	
Bowel sound: Present / Absent	✓	
Hypo / Hyper	.	
Expels flatus		
NGT / PEG / OGT		
Sx / Clamp / Feed		
Urostomy/Ileostomy/Colostomy		
Stoma pink / Other*		

ASSESSMENT	AM	PM
		SCORE
FALLS		
Falls Level 1 (0-24)		
Falls Level 2 (25-50)	DJ	
Falls Level 3 (≥ 51) *Mandatory P.T. Referral		
RESTRAINTS		
If patient is restrained, initiate 24 Hour Restraint Flow Record.		
DRAINS		
Drain Tube: Site / Type		
Drainage: Sero / Serosang / Sang		
Drain Tube: Site / Type		
Drainage: Sero / Serosang / Sang		
Care Plan Reviewed		
Care Plan Revised		

IV ACCESSES	D	E	N
PERIPH			
Peripheral IV Sites	Le		
No Inflammation	—		
No Infiltration	—		
Dsgs Dry & Intact	—		
CENTRAL			
Quinton Cath Site			
Triple Lumen Cath Site			
No Inflammation			
No Infiltration			
Dsgs Dry & Intact			
Peripheral Hep Lock Sites	5		

CODES

1. Rt. Jugular	4. Lt. Subclavian	7. Rt. Hand
2. Lt. Jugular	5. Rt. Arm	8. Lt. Hand
3. Rt. Subclavian	6. Lt. Arm	9. Other (*)

ASSESSMENT	AM	PM	ASSESSMENT	AM	PM
CHEST TUBES					
CT #1 site:			CT #2 site:		
Sx: cm H2O / Gravity / Wall			Sx: cm H2O / Gravity / Wall		
Air leak / Crepitus			Air leak / Crepitus		
Fluctuation in chamb			Fluctuation in chamb		
Tube connections secure			Tube connections secure		
Drainage: Sero / Serosang / Sang			Drainage: Sero / Serosang / Sang		
Dressing Dry / Intact			Dressing Dry / Intact		

ASSESSMENT	AM	PM	ASSESSMENT	AM	PM
SURGICAL					
Incision #1 Site:			Incision #2 Site:		
Open to Air / Dressing			Open to Air / Dressing		
Dressing Dry, Intact / Drainage			Dressing Dry, Intact / Drainage		
Edges Approximated / Open*			Edges Approximated / Open*		
With: Staples / Sutures / Steri strips			With: Staples / Sutures / Steri strips		
Redness / Induction / Swelling			Redness / Induction / Swelling		
Drainage: Sero / Serosang / Sang			Drainage: Sero / Serosang / Sang		
Purulent			Purulent		
Amount: Sm / Mod / Lg			Amount: Sm / Mod / Lg		

Data Collected By X [signature] AM LVN

Review X [signature] (AM) RN

Data Collected By X PM LVN

Review X PM RN

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GAINES , BARTON
11111192979 6/27/2007 Admit Date
44-09- 10/25/1982DOB M 24Y
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UNITED REGIONAL HEALTHCARE SYSTEM

PATIENT CARE RECORD
ASSESSMENT (Page 2 of 2)
rev 02/07 inputoutput4.jsn

DATE: 6/27/07 | ROOM #: 1 S444

PRN MEDICATION ASSESSMENT *(PAIN SCALE: 0 = No Pain & 10 = Maximum Pain)*

☐ Pt has PCA: See Pain Management 24° Flow Sheet for Documentation R/T Pain Management

PAIN INTERVENTION					EVALUATION OF INTERVENTION			
TIME	INIT.	PAIN LEVEL	PROBLEM / FOCUS	INTERVENTION	TIME	INIT.	PAIN LEVEL	ASSESSMENT
1200p	PB	<1	Pain	Scheduled Toradol 30 IVP				

HOUR ⇨	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06	07
HEMODYNAMICS: Respirations / O2 Sat %					20																				
HEMODYNAMICS: Pain			0			0																			
HEMODYNAMICS: Rounds			✓	✓	✓	✓	✓	✓																	
NEURO: Eye Opening			4																						
NEURO: Verbal Response			5																						
NEURO: Motor Response			6																						
NEURO: TOTAL (≤7 indicates coma)			15																						
NEURO: Pupils R																									
NEURO: Pupils L																									
EXTREMITY MOVEMENT: Arm R			3																						
EXTREMITY MOVEMENT: Arm L			3																						
EXTREMITY MOVEMENT: Leg R			3																						
EXTREMITY MOVEMENT: Leg L			3																						
PULSES: Time																									
PULSES: Radial R			2																						
PULSES: Radial L			2																						
PULSES: Dorsalis Pedis R			2																						
PULSES: Dorsalis Pedis L			2																						
PULSES: Posterior Tibial R																									
PULSES: Posterior Tibial L																									

VENIPUNCTURES

TIME	DESCRIPTION OF NEEDLE	PLACEMENT	HEP LOC	DC'd	COMMENTS	# OF ATTEMPTS	SIGNATURE

SITE VERIFICATION: _____ (Location) TIME OUT PRIOR TO PROCEDURE: ☐

RB RN Signature

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GAINES, BARTON
11111192979 6/27/2007 Admit Date
44-09-87 10/25/1982 DOB M 24Y
MERCER, LEO

UNITED REGIONAL HEALTHCARE SYSTEM

PATIENT CARE RECORD
NARRATIVE NOTES
DISCHARGE

rev 02/07 inputoutput5.jsn

DATE: 6/27/07 | ROOM #: S444 1

DATE	TIME	NARRATIVE NOTES
6/27	0935	Pt alert et oriented c̄ ⊘ complaints stab wounds dry intact
		x 8 : guards @ bedside — [illegible]
	1130	Dr mercer in to examine Pt & has cleared him to be discharged.
		Pt to eat lunch & then go back to Allred. c̄ guards. Reading [illegible]
	(14)	Pt returns to Allred unit [illegible] removed [illegible]
		report called @ 1435 — [illegible]

SIGNATURE KEY

NAME, TITLE	INIT.	NAME, TITLE	INIT.
[illegible]	[illegible]	Mahaffey	[illegible]

DISCHARGE / TRANSFER

Time: 1422
Via: ☐ WC ☐ Stretcher ☐ Ambulatory
To: ☐ Car ☐ Ambulance ☐ Room: ______
Accompanied by: guards
Condition: good
Disposition: ☐ Home ☑ Other: ______
Left with Personal Belongings: ☐ Yes ☐ No
Signature: Mahaffey

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NURSES NOTES - Page 18 of 19	UNITED REGIONAL HEALTH CARE SYSTEM	Printed: 05/19/2008 11:49
Patient: GAINES, BARTON	MR#: 440987 / Discharged: 06/27/2007	Service Dates: 06/27/2007-06/27/2007
Copy for: ROI MGT TGREEN	REQ: 137011, DET: 1188588 IK: 13642984 ITK: 21810 EK: 3094451 VER: 1	

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GAINES , BARTON
11111192979 6/27/2007 Admit Date
44-09-87 10/25/1982DOB M 24Y
MERCER, LEO

UNITED REGIONAL HEALTHCARE SYSTEM

PATIENT CARE RECORD
PRESSURE WOUND RISK ASSESSMENT
rev 02/07 inputoutput6.jsn

DATE: 6/27/07 | ROOM #: S444 1

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Evaluator's Name: | DATE OF ASSESSMENT ⇨

SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. -OR- Limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. -OR- Has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. -OR- Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	4
MOISTURE Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.	4
ACTIVITY Degree of physical activity	**1. Bedfast** Confined to bed	**2. Chair-Fast** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair	**3. Occasionally Walks** Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Frequently Walks** Walks outside the room at least twice a day and inside room at least once every two hours during waking hours	3
MOBILITY Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently	**4. No Limitations** Makes major and frequent changes in position without assistance.	4
NUTRITION Usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement -OR- Is NPO and/or maintained on clear liquids or IVs for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. -OR- Receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered. -OR- Is on a tube feeding or IV's regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.		3
* Score of 18 or less indicates that patient is at risk for skin breakdown. For 12 or less consult wound care.				TOTAL	22

If additional risk factors present, age > 65, fever, poor dietary intake of protein, diastolic pressure < 60, or hemodynamic instability, advance to next level of risk.

Indicate patient's level of risk according to Braden total score and implement interventions

☑ Not At Risk (19-23)	☐ Low Risk (15-18) or	☐ Moderate Risk (13-14)
	• See specialty bed decision tree and protocols • Frequent turning (determined by assessing skin for reactive erythema)	• Maximal remobilization • Protect heels • Manage moisture, nutrition, friction and shear
☐ High Risk (10-12) or	☐ Severe Risk (9 and below)	
• Implement same interventions as low and moderate risk plus • Consult wound care team via computer and indicate score • Initiate q 2 hour turning schedule	• Use pillows or foam wedges for 30 degrees lateral positioning • See protocol	

Indicate if patient scored 1 or 2 in any subscale and implement interventions

☐ Sensory Perception	☐ Moisture	☐ Mobility
• Reposition patient q 2 hours at 30 degrees turn • See positioning guidelines in Alteration in Skin/Integrity Protocol Potential • Float heels off bed at all times	• Keep skin, especially folds clean and dry • Use skin barrier ointment • See Incontinence Protocols for incontinent patients • If patient score is 1, refer to specialty bed protocols for low air loss surface	• Reposition patient q 2 hours at 30 degrees turn • See positioning guidelines in Alteration in Skin/Integrity Protocol Potential
☐ Friction and Shear	☐ Nutrition	☐ Activity
• Do not drag or slide patient. Use turn sheet to lift and position • If able, offer overhead trapeze to assist patient in positioning • Keep HOB at 30 degrees and below when not contraindicated • If HOB > 30 degrees, raise knee gatch to limit sliding • Apply protective ointment or thin hydrocolloid to protect at risk sites (especially sacrum, heels and elbows) • See protocol	• Maintain adequate nutrition • Offer fluids frequently if not contraindicated • Collaborate with physician to obtain albumin level • Initiate nutrition consult	• Keep HOB at 30 degrees and below when not contraindicated • Reposition patient q 2 hours at 30 degrees turn • OOB at least TID if consistent with medical condition • 4 inch chair cushion for chair fast patients with position shifts at least hourly while in chair • Initiate PT consult

Check appropriate action and initial

☑ Patient not at risk for breakdown. Continue daily assessment Initials: MM	• Patient's total score 18 or less. Interventions implemented for Alteration in Skin/Integrity Protocol Potential according to level of risk Initials:	
Bed surface: \	Specialty seating surface: ☐ No ☐ Yes:	

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66333

UNITED REGIONAL HEALTH CARE SYSTEM
44-09-87 11111192979
GAINES, BARTON
MERCER, LEO
DOB 10/25/1982 M 24YADM 6/27/2007

United Regional Health Care System

DEPARTMENT OF NURSING
PATIENT DISCHARGE INSTRUCTION SHEET
(Items that apply to your discharge care are checked)

8331/59 (Rev. 10/06) Page 1 of 2

Please follow these instructions carefully. If you have any questions, please call:

Dr. Mercer Phone: 764 3608

Instructions given to: ☐ Pt ☐ Other: _____ ☐ Physician Discharge Form given

I. DIET: Your diet will be: Reg

* ☐ Low Sodium Heart Healthy ☐ Fluid Restrictions _____

II. PRESCRIPTIONS: ☐ See Admission/Discharge Medication Reconciliation List (If Applicable)
☐ Prescriptions Given ☐ Medication Instructions Given
☐ Patients 65 years and older screened for Pneumonia / Flu Vaccination
☐ O_2 _____ Liters/minute ☐ Nebulizer

- Keep an updated list of your medications. Take the list with you to your Doctor's office visit.
- It is important that you are aware that interactions may occur among drugs and between drugs and food. If you have any questions in this regarding, you should seek the advice of your personal physician, the pharmacist, or the hospital dietician.

III. EQUIPMENT & SUPPLIES: (List)
☐ Sent Home With: CD

IV. DRAINS/FOLEYS/WOUNDCARE: (List)
☐ Sent Home With: ∅
Report to your physician if wound becomes reddened, swollen, shows pus or red streaks or gets sore as the days go by.

V. ACTIVITY LEVEL: (Limitations & Expectations)
Instructions: T as tolerated

* ☐ Gradually resume usual activities.

VI. SPECIAL INSTRUCTIONS: * ☐ Given Heart Failure Packet
* ☐ Your dry weight is _____ * ☐ Weigh yourself daily & record * ☐ Scales given
* ☐ Smoking cessation information given * ☐ See back of sheet for more information on Heart Failure
* ☐ The pumping power (ejection fraction) of your heart is _____
☐ _____
☐ _____

FOLLOW-UP CARE:
☑ No Appointment. Return Only if Problems Develop.
* ☐ Return to Doctor: _____
☐ Other Health Referral Made to: _____

PATIENT DISCLAIMER:
I understand that the patient teaching material and instruction that I have received regarding discharge is not intended to represent a complete listing of all information necessary for my care. My physician is the primary source for the information. If I have any questions regarding my care, I understand that I should contact my personal physician.

Discharge Date: 6-27-07 Time: 1412

Nurse's Signature 7a-7p

Patient's Signature

*Heart Failure Discharge Instructions **WHITE** - Chart Copy **CANARY** - Patient's Signature

DISCHARGE INSTRUCTIONS - Page 1 of 1	UNITED REGIONAL HEALTH CARE SYSTEM		Printed: 05/19/2008 11:49
Patient: GAINES, BARTON	MR#: 440987	Discharged: 06/27/2007	Service Dates: 06/27/2007-06/27/2007
Copy for: ROI MGT TGREEN	REQ: 137011, DET: 1188590 IK: 13642983 ITK: 20904 EK: 3094430 VER: 1		

44235 11111192979
GAINES , BARTON
11111192979

440987
6/27/2007 Admit Date
10/25/1982DOB M 24Y
MERCER, LEO

UNITED REGIONAL HEALTHCARE SYSTEM

INTERDISCIPLINARY PLAN OF CARE

rev 10/06 interdisciplinaryplanofcarepage1of2.taw

DISCIPLINES:

- CM = Case Management
- D = Dietitian
- N = Nursing
- RT = Respiratory Therapy
- WC = Wound Care
- P = Pharmacy
- PC = Pastoral Care
- PT = Physical Therapy
- DE = Diabetic Educator
- SLP = Speech Language Pathology
- SW = Social Work
- OT = Occupational Therapy
- O = Other (specify)

DATE	TIME	PATIENT CARE PROBLEM	GOAL(S) OR OUTCOME(S)	DATE MET	GOAL REVISED DATE	DISCIPLINE RESPONSIBLE
6/27/07	0240 D	Pneumothorax 1. Establish a normal/effective respiratory pattern with ABG's within patient normal range; 02 sat ≥90% on RA; VS and labs WNL. 2. Be free of cyanosis and other s/s of hypoxia. 3. Verbalize relief of pain to level of comfort or tolerance.				N
6/27/07	0240 D	Criteria for Fall Risk Protocol 1. Impaired orientation, balance or gait. Weakness/paralysis. 2. Evidenced of CVA. Fainting/dizziness. Psycho tropic meds. 3. History of falls/6 months ago. 4. Decrease LOC.				N

SIGNATURE / INITIALS	DISCIPLINE	SIGNATURE / INITIALS	DISCIPLINE
		Patterson RNC/CP	N
		D Kendrick/D Admit Team	N

PLAN OF CARE - Page 1 of 1 | UNITED REGIONAL HEALTH CARE SYSTEM | Printed: 05/19/2008 11:49
Patient: GAINES, BARTON | MR#: 440987 | Discharged: 06/27/2007 | Service Dates: 06/27/2007-06/27/2007
Copy for: ROI MGT TGREEN | REQ: 137011, DET: 1188591 IK: 13642990 ITK: 22174 EK: 3094464 VER: 1

77333 11111192979

FINANCIAL #: 11111192979
AGE: 24 YRS SEX: M
ADMITTING DR:
SARTOR, T.
INPATIENT

CLINICAL LABORATORY REPORT

HEMATOLOGY

DATE COLL	06/27/07	06/26/07	
TIME COLL	0508	2235	
			UNITS REF RANGE
	-----CELL COUNT-----		
WBC	9.7	16.0H	K/CMM (4.8-10.8)
RBC	4.12L	4.62L	M/CMM (4.70-6.10)
HGB	13.8L	15.3	GMS/DL(14.0-18.0)
HCT	39.3L	44.3	% (42.0-52.0)
MCV	95.5H	95.9H	FL (80.0-94.0)
MCH	33.6H	33.1H	PG (27.0-31.0)
MCHC	35.2	34.5	G/DL (33.0-37.0)
PLT	243	254	K/CMM (150-400)
RDW	13.1	13.1	% (11.5-14.5)
MPV	8.6	8.2	FL (7.4-10.4)
	-----DIFFERENTIAL-----		
PERFORMED:	AUTOMAT	MANUAL	
BAND		1	% (1-7)
SEG		87H	% (42-78)
LYMPH		8L	% (21-51)
LYMPHOCYTE	14L		% (20-50)
MONO		4	% (2-9)
MONOCYTE	6		% (2-9)
NEUTROPHIL	80H		% (42-78)
EOSINOPHIL	0L		% (1-5)
BASOPHIL	0		% (0-1)

Footnotes
L = Low, H = High
Section Index: HEMATOLOGY

PATIENT: GAINES, BARTON
MEDICAL RECORD #: (0000)44-09-87

DATE/TIME: 06/27/07 2202
PAGE: 1 ROOM: S444-01

PERMANENT MEDICAL RECORD F I N A L R E P O R T

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United Regional Health Care System
1600 11th Street, Wichita Falls, Texas 76301-4388 (940)764-3184

77333 11111192979

FINANCIAL #: 11111192979
AGE: 24 YRS SEX: M
ADMITTING DR:
SARTOR, T.
INPATIENT

CLINICAL LABORATORY REPORT

URINALYSIS

DATE COLL 06/26/07
TIME COLL 2255

		UNITS REF RANGE
-----MACROSCOPIC URINALYSIS-----		
COLOR	Yellow	
CHARACTER	Clear	(CLEAR)
SPEC GRAVITY	<=1.005 *	(1.003-1.035)
PH	6.5	(4.5-8.0)
PROTEIN	NEG	(NEG)
GLUCOSE	NEG	(NEG)
KETONE	NEG	(NEG)
BILIRUBIN	NEG	(NEG)
UROBILINOGEN	0.2	(0.2)
BLOOD	NEG	(NEG)
NITRITE	NEG	(NEG)
LEUKOCYTES	NEG	(NEG)
COLL METH	VOIDED	
-----MICROSCOPIC URINALYSIS-----		
MICROSCOPIC:	N/A	

CHEMISTRY

-----SURVEY 14-----

TEST	SODIUM	POTASSIUM	CHLORIDE	CO2	GLUCOSE	BUN	CREATININE
REF RANGE	135-153	3.5-5.3	101-111	22-30	70-110	5-25	0.5-1.5
UNITS	MEQ/L	MEQ/L	MEQ/L	MEQ/L	MG/DL	MG/DL	MG/DL
06/26/07 2305	135	3.6	100 L	27	122 H	11	1.1

Footnotes
L = Low, H = High, * = Abnormal
Section Index: URINALYSIS CHEMISTRY

PATIENT: GAINES, BARTON
MEDICAL RECORD #: (0000)44-09-87

DATE/TIME: 06/27/07 2202
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PERMANENT MEDICAL RECORD FINAL REPORT

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United Regional Health Care System
1600 11th Street, Wichita Falls, Texas 76301-4388 (940)764-3184

77333 11111192979

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AGE: 24 YRS SEX: M
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SARTOR, T.
INPATIENT

CLINICAL LABORATORY REPORT

CHEMISTRY

-----SURVEY 14-----

TEST	TOT PROT	ALBUMIN	ALK PHOS	T BIL	AST	ALT	CALCIUM
REF RANGE	6.1-7.9	3.2-5.5	36-92	0.0-1.4	8-40	8-53	8.0-10.4
UNITS	GM/DL	GM/DL	U/L	MG/DL	U/L	U/L	MG/DL
06/26/07 2305	6.4	4.2	64	0.7	26	16	8.7

CHEMISTRY

-----SURVEY 8-----

TEST	SODIUM	POTASSIUM	CHLORIDE	CO2	BUN	CREATININE	GLUCOSE	CALCI
REF RANGE	135-153	3.5-5.3	101-111	22-30	5-25	0.5-1.5	70-110	8.0-1
UNITS	MEQ/L	MEQ/L	MEQ/L	MEQ/L	MG/DL	MG/DL	MG/DL	MG/D
06/27/07 0508	140	3.4 L	106	27	7	1.0	113 H	8.7

-----ROUTINE CHEMISTRY-----

TEST	AMYLASE	LIPASE
REF RANGE	10-130	7-60
UNITS	U/L	IU/L
06/26/07 2305	27	27

-----URINE ABUSE DRUG -----

TEST	OPIATE SCREEN	BARBITURATE SCR	AMPHETAMINE SC	METAMPHETAM SCR
REF RANGE	<300 NEG	<300 NEG	<1000NEG	<1000NEG
UNITS	ng/mL	ng/mL	ng/mL	ng/mL
06/26/07 2255	<300 NEG	<300 NEG	<1000NEG	<1000NEG

OPIATE SCREEN (05/13/99 -- Current)
FOR MEDICAL USE ONLY

Footnotes
L = Low, H = High

Section Index: CHEMISTRY CHEMISTRY

PATIENT: GAINES, BARTON
MEDICAL RECORD #: (0000)44-09-87

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PERMANENT MEDICAL RECORD F I N A L R E P O R T

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United Regional Health Care System
1600 11th Street, Wichita Falls, Texas 76301-4388 (940)764-3184

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FINANCIAL #: 11111192979
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INPATIENT

CLINICAL LABORATORY REPORT

CHEMISTRY

BARBITURATE SCR (05/13/99 -- Current)
FOR MEDICAL USE ONLY
AMPHETAMINE SC (08/04/04 -- Current)
FOR MEDICAL USE ONLY!
METAMPHETAM SCR (08/04/04 -- Current)
FOR MEDICAL USE ONLY!

TEST REF RANGE UNITS	COCAINE <300 NEG ng/mL	CANNAB SCREEN <50 NEG ng/mL	PCP SCREEN <25 NEG ng/mL	BENZODIAZ SCR <300 NEG ng/mL	TCA SCREEN <1000NEG ng/mL
06/26/07 2255	<300 NEG	<50 NEG	<25 NEG	<300 NEG	<1000NEG

COCAINE (01/23/07 -- Current)
FOR MEDICAL USE ONLY

CANNAB SCREEN (05/13/99 -- Current)
FOR MEDICAL USE ONLY
PCP SCREEN (05/13/99 -- Current)
FOR MEDICAL USE ONLY
BENZODIAZ SCR (05/13/99 -- Current)
FOR MEDICAL USE ONLY
TCA SCREEN (07/12/04 -- Current)
FOR MEDICAL USE ONLY

ABUSE DRUG: This test provides only a preliminary test result. A more specific alternate chemical method must be used in order to obtain a confirmed analytical result. GC/MS is the preferred confirmatory method.

A positive result is produced when the established threshold for a given drug or drugs is met or exceeded. Negative results indicate that a given drug or drugs are not present in a concentration sufficient to meet or exceed the established threshold.

Section Index: CHEMISTRY

PATIENT: GAINES, BARTON
MEDICAL RECORD #: (0000)44-09-87

DATE/TIME: 06/27/07 2202
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PERMANENT MEDICAL RECORD FINAL REPORT

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United Regional Health Care System
1600 11th Street, Wichita Falls, Texas 76301-4388 (940)764-3184

77333 11111192979

FINANCIAL #: 11111192979
AGE: 24 YRS SEX: M
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INPATIENT

C L I N I C A L L A B O R A T O R Y R E P O R T

COAGULATION

TEST	PROTIME	INR	PTT	AVG PTT CONT
REF RANGE	12.0-15.6		25.3-39.1	
UNITS	SEC		SEC	SEC
06/26/07 2305	14.3 f	1.05	26.7 f	32.2

PROTIME (06/10/02 -- Current)

INDICATION:	INR RANGE:
Prophylaxis of venous thrombosis (high-risk surgery)	2.0 - 3.0
Treatment of venous thrombosis	
Treatment of PE	
Prevention of systemic embolism	
Tissue heart valves	
AMI (to prevent systemic embolism)*	
Valvular heart disease	
AF	
Bileaflet mechanical valve in aortic position	
Mechanical prosthetic valves (high risk)	2.5 - 3.5
Certain patients with thrombosis and the antiphospholipd syndrome	>2.0 - 3.0

If oral anticoagulant therapy is elected to prevent recurrent MI, an INR of 2.5 to 3.5 is recommended, consistent with Food and Drug Administration recommendations.

Hirsh, J, Dalen, JE, Anderson, DR, et al. Oral anticoagulants: mechanism of action, clinical effectiveness, and optimal therapeutic range. (Chest 2001;119(1 Suppl):8S.

PTT (04/18/05 -- Current)
A commonly recommended therapeutic range is a PTT ratio of 1.5 to 2.5 times the control value. Based on a dose of 0.20 U/ml to 0.40 U/ml observed correlation (CV=8.5%) with current use heparin lots has been acceptable.

Footnotes
f = Footnote

Section Index: COAGULATION

PATIENT: GAINES, BARTON DATE/TIME: 06/27/07 2202
MEDICAL RECORD #: (0000)44-09-87 PAGE: 5 ROOM: S444-01

PERMANENT MEDICAL RECORD F I N A L R E P O R T continued on next page...

United Regional Health Care System
1600 11th Street, Wichita Falls, Texas 76301-4388 (940)764-3184

77333 11111192979

FINANCIAL #: 11111192979
AGE: 24 YRS SEX: M
ADMITTING DR:
SARTOR, T.
INPATIENT

C L I N I C A L L A B O R A T O R Y R E P O R T

COAGULATION

PTT (04/18/05 -- Current)
For details of heparin response curves, please contact the Coagulation Department of the Laboratory.

Hematocrit levels 55% or greater could produce falsely abnormal high results.

BLOOD BANK CURRENT RESULTS

DATE COLL	06/26/07
TIME COLL	2235
ABO RH TYPE	A POS
ANTIBODY SCREEN	NEG

Section Index: BB CUMULATIVE

PATIENT: GAINES, BARTON
MEDICAL RECORD #: (0000)44-09-87

DATE/TIME: 06/27/07 2202
PAGE: 6 ROOM: S444-01

PERMANENT MEDICAL RECORD F I N A L R E P O R T * * *END OF REPORT* * *

444

UNITED REGIONAL HEALTH CARE SYSTEM
WICHITA FALLS, TEXAS

RADIOLOGY REPORT

PATIENT: GAINES, BARTON
SEX: M **DOB:** 10/25/1982
RM/BED: S444-01
ATTENDING PHYSICIAN: MERCER JR., LEO C.
ORDERING PHYSICIAN: CHAPA, PHILLIP E.

EXAM DATE: 06/26/2007
ACCOUNT #: 11111192979
SEQ #: 00003
MED REC #: 440987
PT. TYPE I

CT ABDOMEN PELVIS (11)

HISTORY
Stabbed

TECHNIQUE
5 mm axial images were obtained to the abdomen and pelvis with oral contrast only.

FINDINGS
The liver, spleen, pancreas, gallbladder, adrenal glands and kidneys are all intact. No solid organ injury is identified. There is no free air identified. No free fluid is seen.

IMPRESSION
No intraabdominal injury identified.

Klonie L. Berend, M.D.
Electronically Signed
06/27/2007
By PAUL N. RENTON JR, M.D.

KLB/jo
D: 06/27/2007 12:55:00
T: 06/27/2007 13:12:22

JOB #: 490824
RADIOLOGY REPORT

Report subject to transcription variance. This report is a preliminary result until signed by the radiologist.

UNITED REGIONAL HEALTH CARE SYSTEM
WICHITA FALLS, TEXAS

RADIOLOGY REPORT

PATIENT: GAINES, BARTON
SEX: M **DOB:** 10/25/1982
RM/BED: S444-01
ATTENDING PHYSICIAN: MERCER JR., LEO C.
ORDERING PHYSICIAN: CHAPA, PHILLIP E.

EXAM DATE: 06/26/2007
ACCOUNT #: 11111192979
SEQ #: 00015
MED REC #: 440987
PT. TYPE I

CT CHEST (THORAX) (11)

HISTORY
Stabbed

TECHNIQUE
5 mm axial images were obtained to the chest with intravenous contrast.

FINDINGS
There is some soft tissue air seen involving the left chest wall. In addition, there is a small pneumothorax seen on the left. Some focal opacity is seen in the lingula, consistent with a small pulmonary contusion due to a puncture wound. There is no hemothorax seen. No mediastinal hematoma is identified. Thoracic aorta is unremarkable. Right lung is clear.

IMPRESSION
Puncture wound is seen involving the left chest wall with a small left pneumothorax.

Klonie L. Berend, M.D.
Electronically Signed
06/27/2007
By PAUL N. RENTON JR, M.D.

KLB/jo
D: 06/27/2007 12:55:57
T: 06/27/2007 13:10:38

JOB #: 490824
RADIOLOGY REPORT

Report subject to transcription variance. This report is a preliminary result until signed by the radiologist.

UNITED REGIONAL HEALTH CARE SYSTEM
WICHITA FALLS, TEXAS

RADIOLOGY REPORT

PATIENT: GAINES, BARTON
SEX: M **DOB:** 10/25/1982
RM/BED: S444-01
ATTENDING PHYSICIAN: MERCER JR., LEO C.
ORDERING PHYSICIAN: SARTOR, TAMMY L.

EXAM DATE: 06/27/2007
ACCOUNT #: 11111192979
SEQ #: 00013
MED REC #: 440987
PT. TYPE I

CHEST 1 VW (11)

HISTORY
Stab wound

FINDINGS
Portable AP upright film of the chest at 06:22 hours date 06/27/07 demonstrates residual gas along the left lateral chest wall. No evidence of residual pneumothorax is apparent. The lungs are clear. The cardiomediastinal silhouette is within limits. Skeletal structures show no significant abnormality. There is no evidence of significant change in chest appearance from yesterday's study.

David R. Spencer, M.D.
Electronically Signed
06/27/2007
By DAVID R. SPENCER, M.D.

DRS/jo
D: 06/27/2007 08:40:41
T: 06/27/2007 08:43:33

JOB #: 490589
RADIOLOGY REPORT

Report subject to transcription variance. This report is a preliminary result until signed by the radiologist.

UNITED REGIONAL HEALTH CARE SYSTEM
WICHITA FALLS, TEXAS

RADIOLOGY REPORT

PATIENT: GAINES, BARTON
SEX: M **DOB:** 10/25/1982
RM/BED: S444-01
ATTENDING PHYSICIAN: MERCER JR., LEO C.
ORDERING PHYSICIAN: CHAPA, PHILLIP E.

EXAM DATE: 06/26/2007
ACCOUNT #: 11111192979
SEQ #: 00002
MED REC #: 440987
PT. TYPE I

CHEST 1 VW (11)

HISTORY
Stab wound to chest.

Single view of the chest dated June 26, 2007 at 2236 hours shows unremarkable heart, mediastinum and lungs. No pneumothorax.

IMPRESSION
No significant abnormalities.

Paul N. Renton Jr, M.D.
Electronically Signed
06/27/2007
By PAUL N. RENTON JR, M.D.

PNR/sla
D: 06/27/2007 09:15:33 JOB #: 490641
T: 06/27/2007 09:44:01 RADIOLOGY REPORT

Report subject to transcription variance. This report is a preliminary result until signed by the radiologist.

Emergency Department Medical Record

77111 11111192979

Patient Name:	**GAINES, BARTON**			**Patient No:**	**11111192979**
Medical Record:	**440987**			**Sex:**	**M**
Date of Birth:	**10/25/1982**			**Race:**	**W**
Arrival Date:	**06/26/2007**	**Discharge Date:**	**06/27/07**	**Age:**	**24 Years**
Time Seen:	**22:25**	**FC:**		**Arrival By:**	**Ambulance.**
Discharge Time:	**00:00**	**5**		**Physician:**	**PChapa**

Patient Complaint: 24 years old Male presented to the Emergency Department with stab wound.

Chief Complaint(s)

Chief Complaints: (1)Stab Wound

History of Present Illness

Timing: Date of occurrence was today,.
Context: FROM ALLRED S/P MULTIPLE STAB WOUNDS TO CHEST AND ABD W/ 4" NAIL
Location: Abdomen= left upper quadrant,, Chest= Left side, Anterior, Right side,.
Modifying Factors: Patient reported no relief with rest,.
Quality, Description: Problem is acute.
Severity: NAD
Associated Signs and Symptoms: Positive for shortness of breath at rest, shortness of breath, Location= Abdomen, Chest,, penetrating wound,

Review of Systems

Constitutional Symptoms: Reviewed and no significant abnormalities.
Ears, Nose, Mouth, Throat: Reviewed and no significant abnormalities.
Eyes: Reviewed and no significant abnormalities.
Cardiovascular: Positive for shortness of breath at rest. No current chest pain.
Respiratory: Positive for shortness of breath.
Gastrointestinal: Reviewed and no significant abnormalities.
Musculoskeletal: No back pain, No neck pain.
Neurological: Reviewed and no significant abnormalities.
Psychiatric: Reviewed and no significant abnormalities.
Integumentary: Positive for Location= Abdomen, Chest,, penetrating wound.

Histories

Social History: Patient denies using street drugs.
Current Medications: See Medication Reconciliation Form.
Allergies: Patient has no known medical allergies.
Past Surgical History: No previous history.
Past Medical History: No previous history.

Physical Exam

General Impression: No Apparent Distress.
Respiratory Pattern: Normal.
Constitutional Symptoms: No fever, No lethargy.
Ears, Nose, Mouth, Throat: TMI and clear bilaterally. No nasal discharge. Throat / Mouth without exudate or asymmetry. Oral mucosa moist. Phonation normal, and no cervical adenopathy palpable.

CHART COPY

Eyes:	Pupils are equal, round, regular and react to light. Extra occular muscles intact, and patient exhibits no nystagmus.
Cardiovascular:	There is a regular rate and rhythm without murmurs, rubs, clicks, gallops, or heaves. No jugular venous distension. Patient exhibits no peripheral edema.
Respiratory:	The lungs are clear to auscultation bilaterally without wheezes, rales, rubs, rhonchi, or strider.
Gastrointestinal:	Abdomen is soft, flat, nontender, nondistended and symmetrical. Bowel sounds normal with no masses or bruits.
Genitourinary:	No CVAT to percussion.
Musculoskeletal:	Chest/Trunk exam= Positive for crepitation, LEFT LATERAL CHEST.
Neurological:	Patient is oriented X 3, active, exhibits no focal deficits, alert, affect is appropriate with memory intact.
Psychiatric:	Limited psychiatric, affect normal, patient cooperative and pleasant.
Integumentary:	Positive for multiple puncture wounds.
Hematologic, Lymp, Immun:	Positive for ecchymosis.

Vital Signs

Tetanus Status: Up to Date.

Medical Decision Making

Orders:	Laboratory Orders= TRAUMA PANEL, Radiology Orders= CXR- AP Portable, CT- Chest, Abdomen/Pelvis,.
Results:	Laboratory Results (1)= See attached lab report,, Radiology Results (1)= Interpretation of X-Ray by ER Physician, CHEST X-RAY: No acute abnormality noted,, Radiology Results (2)= Interpretation of X-Ray by Radiologist, BEREND--SMALL LEFT PTX O/W NAF ..
Dr. Interval Exam, Time:	Constant attendance of this critically ill patient was 30 minutes,.
Consultants:	Discussed admission with Dr. Tammy Sartor
Disposition:	Admit orders written by Private physician,.

Differential / Diagnosis

Differential Diagnosis:

Diagnosis: MULTIPLE STAB WOUNDS LEFT CHEST AND ABDOMEN; LEFT PNEUMOTHORAX S/P STAB WOUND

Documented By

Phillip E. Chapa, M.D.

02:06 06/27/2007 Phillip E. Chapa, M.D.
Electronically Signed by:

Electronically Signed by:

CHART COPY

77111

unitedregional

EMERGENCY DEPARTMENT MEDICAL RECORD

FORM NO. 784361500 (Rev. 5/07)

UNITED REGIONAL HEALTH CARE SYSTEM
44-09-87 1111192979
GAINES, BARTON
CHAPA, PHILLIP
DOB 10/25/1982 M 24Y ADM 6/26/2007

Date	Time In	Time to Tx Area	D.O.B.	Age	TRIAGE CATEGORY	TRAUMA	Activation Time	Room #
10-26-07	2230	arrival	10-25-82	24	1 (2) 3 4 5	I II III		1

Arrival Mode: ☐ POV ☑ Amb. ☐ Aeromedical ☐ Other: PD Notified (Time/Agency):

Date of LMP: ☐ Lactating ☐ HYST ☐ Postmenopausal ☐ Premenarchal ☐ Tubal ☐ BCP ☐ NA | Tetanus: ☐ UTD ☐ 5 yrs or more Child Immun. ☐ UTD ☐ No | Workers Comp: ☐ Yes ☐ No Employer: Date of Injury: Time of Injury:

BP	P	R	Temp	O2 Sat ☐ RA	GCS	Pain	HT ☐S ☐A	WT ☐S ☐A	Visual Acuity
133/73	99	18	97.8	100%	456	5 /10	5'11"	180#	☐ Right ☐ Left ☐ Both

☐ On Job ☐ Trauma: RTS ☐ Patient Requests ER Physician

TREATMENT PTA: ☐ None ☐ See EMS Report ☐ See NN

Triage RN Signature: L. [illegible] RN ☐ 2nd Visit 24 hrs.

Chief Complaint: Started ____ min / hrs ago
Stabbed w/ 4" nail (L) ribs + (L) side of abd (L) ↑ back C/O SOB

ER Physician: Notified / With Patient
☐ WBH ☐ Orders
☐ Refer ER DR ☐ To ☐ Wo — Called / Replied / Arrived
Physician: Ahmed
Consult:

TIME / TILT → ↑ ↑ INITIALS

TIME	BP	P	R	T	O2 SAT	GCS	PAIN SCALE	MONITOR RHYTHM	INITIALS
2300	144/79	88	27	—	NO	456	5	SR	[illegible]
2310	139/53	84	17	—	100	456	5	SR	[illegible]
2345	127/63	94	27	—	99	456	3	SR	[illegible]
0015	135/60	78	24	—	99	456	3	SR	[illegible]
0045	133/56	90	31	—	98	456	3	SR	[illegible]
0110	125/57	79	15	—	99	356	0	SR	[illegible]
0150	131/60	78	14	—	98	356	0	SR	[illegible]

ALLERGIES: NKDA

INITIAL PHYSICIAN ORDERS

PROTOCOL:			ORDER TIME	COLLECT TIME	INITIALS
CBC	UA	(CXR) (P) / 2V	MD		
SMA	UDS	C-Spine			
PT PTT	BHCG, Urine	Acute Abd			
C. Markers 1 2 3	BHCG, Qual.	EKG/Time:			
BNP	BHCG, Quan.	Viewed By:	2237		
Type/Screen/RH		Blood Cultures x			
Amylase/Lipase	LFT	Old Records	UC		

TIME ORDERED	TREATMENTS/MEDICATIONS/ROUTE/DOSE	SITE	TIME/INITIALS	RESPONSE/PAIN SCALE/AMT. INFUSED	TIME/INITIALS
	☑ H.L./ Cath Size: 20g (L) 3(R) hand			# Attempts:	N/A
2220	Transportwell				
	CT chest				
	[illegible]				
	NSP 200 / hr		2220 [illegible]		

DISPOSITION:
☐ Discharged: ☐ Home ☐ Police ☐ Nursing Home ☐ Morgue ☐ Funeral Home
☐ Verbal / Written Instructions / Rx Given to: ☐ Patient ☐
☐ Verbalized Understanding Given By: ☐ RN ☐ Provider
☐ Accompanied By / Driver:
☑ Admitted / Transferred to: 444
☑ Report to: 4 West Time: 0140
☐ Transfer Documentation Completed
☐ Notified Family / Police / ME
☐ Left AMA / LWBS ☐ Signed AMA Sheet ☐ Refused
☐ Physician Notified of:
☐ IV Catheter(s) appeared intact when removed Time/Initials:

DISCHARGE VITALS:
BP: ____ HR: ____ RR: ____ Temp: ____ O2 Sat: ____
Pain at Discharge: ____ / 10 Time of Death:
CONDITION: ☐ Unchanged ☑ Improved ☐ Stable ☐ Expired
Depart Time: 0150 ☐ WC ☐ Walk ☐ Crutches ☑ Stretcher ☐ Ambulance

SIGNATURE		INITIALS
PRIMARY NURSE	[signature]	[initials]
PERSONNEL		
DISCHARGE NURSE		
NP/PA	MD	

Diagnosis:

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ER RECORD - Page 3 of 9	UNITED REGIONAL HEALTH CARE SYSTEM		Printed: 05/19/2008 11:49
Patient: GAINES, BARTON	MR#: 440987	Discharged: 06/27/2007	Service Dates: 06/27/2007-06/27/2007
Copy for: ROI MGT TGREEN	REQ: 137011, DET: 1188604 IK: 13642988 ITK: 21693 EK: 3094455 VER: 1		

77111

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EMERGENCY DEPARTMENT MEDICAL RECORD

FORM NO. 784361500 (Rev. 5/07)

UNITED REGIONAL HEALTH CARE SYSTEM
44-09-87 11111192979
GAINES , BARTON
CHAPA, PHILLIP
DOB 10/25/1982 M 24Y ADM 6/26/2007

AIRWAY

AIRWAY: ☑ Patent ☐ Oral Airway ☐ Nasal Airway ☐ ET #: ____ ☐ Trach ☐ Crico
BREATHING: ☐ Suctioning ☐ Nasal Cannula ☐ Non Rebreather Mask ☐ O2 ____ L ☐ Spontaneous ☐ Assisted ☐ Apnea ☐ Labored ☐ Shallow
Comments: ____

R	L	LUNG SOUNDS	ABNORMAL FINDINGS
✓		Clear	
		Crackles	
		Rhonchi/Wheezes	
		Decreased	
		Absent	

HEAD/NECK ☐ NA
☐ Otorrhea ☐ Rhinorrhea ☐ Facial Fractures ☐ Pupils L/R ____
TRACHEA: ☑ Midline ☐ Deviated
PAIN: ☐ No ☐ Yes
☐ C-Collar Removed by: ____ Time: ____

HEART/CHEST ☐ NA
Monitored: ☐ Regular Sinus ☐ Other: ____
Chest Pain: ☐ No ☑ Yes Injuries: ☐ No ☐ Yes 5cm in left lateral chest
THORAX: ☐ Symmetrical ☐ Asymmetrical ☐ Crepitus
HEART TONES: ☑ Normal ☐ Distant ☐ Muffled

SKIN ☐ NA
☐ Cool ☐ Hot ☐ Diaphoretic ☐ Pink ☐ Pale/Ashen ☐ Acyanotic
☑ Warm ☐ Moist ☐ Dry ☐ Flushed ☐ Cyanotic
Capillary Refill: ☐ < 1 Sec (Normal) ☐ None ☐ > 2 Sec (Delayed)
Abnormal Findings: ____

LACERATIONS & ABRASIONS
Time: ____ Location: ____ ☐ See Diagram
Cleaned With: ____
☐ Suture ☐ Steri Strip ☐ Staples ☐ Dermabond # of Pkg.: ____
☐ Ointment: ____ ☐ Dressing: ____
☐ Dermabond D/C Sheet Nurse Signature: ____

ABDOMEN ☐ NA
BOWEL SOUNDS: ☑ Present ☐ Decreased ☐ Hypoactive ☐ Hyperactive ☐ Absent
ABDOMEN: ☑ Soft ☐ Distended ☐ Tender ☐ Non Tender ☐ Pregnant ☐ Rigid
PAIN: ☐ No ☑ Yes Vomit: ____ Stool: ____ Rectal Tone: ____
INJURIES: ☐ No ☑ Yes ____ ☐ RUQ ☐ LUQ ☐ RLQ ☐ LLQ

NGT
Time: ____
Size ____
Return ____
Nurse: ____

GU ☐ NA
Blood at Meatus: ☑ No ☐ Yes Urinary: Hematuria: ☑ No ☐ Yes Incontinence: ☑ No ☐ Yes
Injuries ☑ No ☐ Yes ____

CATHETER
Time: ____ Size: ____
Return: ____
Nurse: ____
☐ Foley ☐ Mini ☐ Straight
☐ Specimen sent to Lab

EXTREMITIES ☐ NA
EXTREMITIES: ☑ Moves Extremities x 4 ☑ Adequate Pulses x 4 ☐ Longboard Removed by: ____ Time: ____
☐ Extremities Warm/Pink ☐ No Edema
☑ No Major Deformities ☑ No Burns/Abrasions/Lacerations
Exceptions to Above Parameters: ____

FRACTURE / SPRAIN

Time: ____ Location: ____ ☐ See Diagram
☐ Splint: ____
☐ Ice ☐ Elevate ☐ Sling
☐ Crutches with crutch walking instructions given
Pre-Splint Assessment
☐ CMS Within Normal Limits
☐ Other: ____
Post-Splint Assessment
☐ CMS Within Normal Limits
☐ Other: ____
☐ Post OCL Instruction Sheet for Discharge

Nurse Signature: ____

** RISK SCREENS ☐ No Risk Identified

☐ Yes ☑ No Risk for Self Harm/Elopement
☐ Security Observing Patient
☐ Restraints Applied (Refer to Restraint Form)
☐ Yes ☑ No Fall Risk
☐ Side Rails Up x 2 ☐ Family/Staff at Patient Bedside
☐ Other: ____
☐ Yes ☑ No Nutrition Risk: Change in appetite/unplanned weight loss
☐ Yes ☑ No Alcohol Use: ____
☐ Yes ☑ No Drug Use: ____
☐ Yes ☑ No Tobacco Use: ____ cigs / packs per day
☐ Yes ☑ No Exposure to Second Hand Smoke: ____ hours/day

Primary Language: English Deaf: ____
Do you want an interpreter? (Limited English, Hearing Impaired): ☐ Yes ☐ No
If yes, met by: ☐ Language Line ☐ Interpreter Contacted

** ABUSE: Interview Patient Alone

☐ Yes ☑ No Have you ever been emotionally abused or had your children/pets threatened by your partner or someone important to you?
☐ Yes ☑ No Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
☐ Yes ☑ No Within the last year, has anyone forced you to have sexual activities?
☐ Yes ☑ No Are you afraid of anyone and/or afraid to return home?
☐ Yes ☑ No Since your pregnancy, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

Additional Considerations: Unexplained bruises/injury, loss of Interest in self care, excessive fear, unkempt/poor hygiene, resignation. If yes, notify Social Work.
SOCIAL WORK NOTIFIED:Time: ____ Initials: ____

CHART COPY

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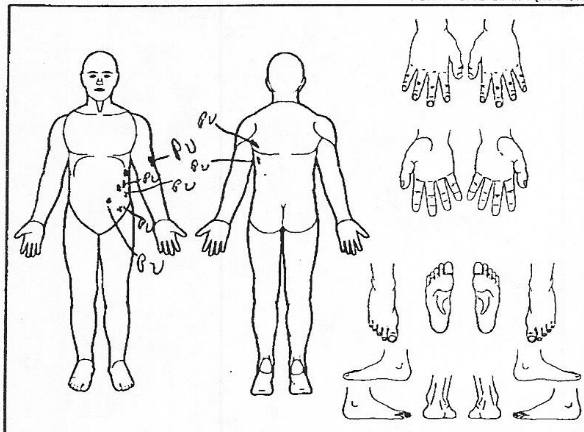
EMERGENCY DEPARTMENT MEDICAL RECORD

FORM NO. 784361500 (Rev. 5/07)

UNITED REGIONAL HEALTH CARE SYSTEM
44-09-87 1111192979
GAINES, BARTON
CHAPA, PHILLIP
DOB 10/25/1982 M 24Y ADM 6/26/2007



INTAKE			OUTPUT		
TIME	TYPE	AMT.	TIME	TYPE	AMT.
0100	IV-NS	1000	2355	600	Urine
0145	IV	100	0055	250	Urine

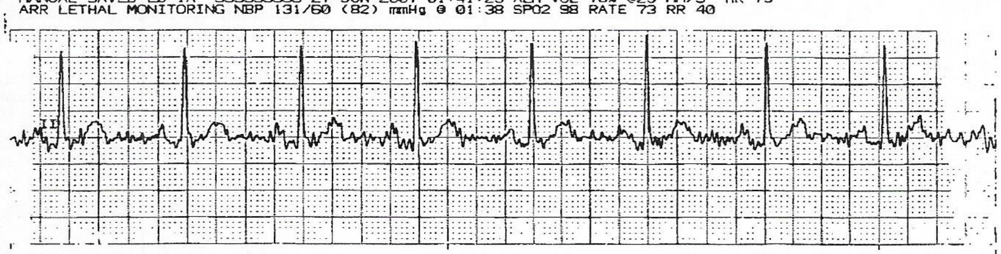
PROCEDURE VERIFICATION

☐ TIME OUT CONDUCTED Time: ____________ Intials: ____________
Correct patient ID, Correct side and site, Agreement on the procedure to be done, Correct patient position, Correct implants or any special equipment or special requirements available.

LABEL AREAS INVOLVED		PAIN QUALITY	
A - Abrasion	L - Laceration	Pressure	Sharp/Stabbing
AV - Avulsion	P - Pain	Tightness	"Pain"
B - Burn	PU - Puncture Wound	Indigestion	"Numbness"
D - Deformity	R - Rash	Burning	"Like Prior MI"
E - Ecchymosis	RE - Redness	Dull/Aching	
ED - Edema			

Time: 0140 Initials: TW **ECG MONITOR STRIP** Cardiac Monitor Rhythm: SR

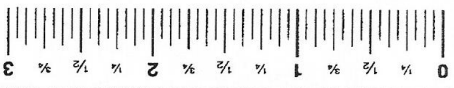
MANUAL SAVED ED-1A 999999999 27-JUN-2007 01:41:23 ALM VOL 70% @25 MM/S HR 75
ARR LETHAL MONITORING NBP 131/60 (82) mmHg @ 01:38 SPO2 98 RATE 73 RR 40



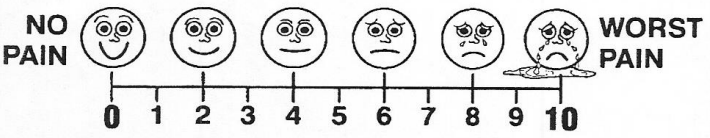
TIME	B/P	P	RESP	T	O2 SAT	GCS	PUPILS L/R	PAIN SCALE	CARDIAC RHYTHM	NURSES NOTES	INIT.
										(2230) Dr. Chapa in room	
										Pt AOx3. C/O SOB.	KW

CHART COPY

ER RECORD - Page 5 of 9	UNITED REGIONAL HEALTH CARE SYSTEM		Printed: 05/19/2008 11:49
Patient: GAINES, BARTON	MR#: 440987	Discharged: 06/27/2007	Service Dates: 06/27/2007-06/27/2007
Copy for: ROI MGT TGREEN	REQ: 137011, DET: 1188606 IK: 13642988 ITK: 21693 EK: 3094457 VER: 1		



PAIN SCALE



VISUAL ANALOG SCALE (VAS)

FLACC BEHAVIOR PAIN MANAGEMENT SCALE

The FLACC is a behavior pain assessment scale is for use with non-verbal patients who are unable to provide reports of pain.

	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
ACTIVITY	Lies quietly, normal position, moves easily	Squirms, shifts back & forth, tense	Arched, rigid, or jerking
CRY	No crying (awake or asleep)	Moans or whimpers, occasionally complains	Cries steadily, screams or sobs, frequent complaints
CONSOLABILITY	Content, relaxed	Reassured easily, distractible	Difficult to console or comfort

METRIC CONVERSIONS

VOLUME

1 Teaspoon	= 5ml
1 Tablespoon	= 15 ml
1 Fluid oz	= 30 ml
1 Cup	= 240 ml
1 Pint	= 473 ml
1 Quart	= 946 ml

WEIGHT

1 g	= 1,000 mg
1 mg	= 1,000 mcg
1 gr	= 60 mg
1/100 gr	= 0.6 mg
1/150 gr	= 0.4 mg
1 kg	= 2.2 lbs

PRESSURE

1 mmHg	= 1.36 cmH2O
1 cmH2O	= 0.73 mmHg

TEMP		WEIGHT	
C°	F°	kg	lbs
40.6	105.1	125	275
40.4	104.7	120	264
40.2	104.3	115	253
40.0	104.0	110	242
39.8	103.7	105	231
39.6	103.3	100	220
39.4	102.9	95	209
39.2	102.6	90	198
39.0	102.2	85	187
38.8	101.8	80	176
38.6	101.5	75	165
38.4	101.2	70	154
38.2	100.8	65	143
38.0	100.4	60	132
37.8	100.1	55	121
37.6	99.7	50	110
37.4	99.3	45	99
37.2	99.0	40	88
37.0	**98.6**	35	77
36.0	96.8	30	66
35.0	95.0	25	55
34.0	93.2	20	44
33.0	91.4	15	33
32.0	89.6	10	22
31.0	87.8	7	15
30.0	86.0	5	11
29.0	85.2	3.5	7.5
28.0	82.4	1.5	3.0
27.0	80.6	1	2.2

INITIAL ASSESSMENT

TRAUMA SCORE

RESPIRATORY RATE:
10-24/min 4
23-35/min 3
36/min or greater 2
1-9/min 1
None 0

SYSTOLIC BLOOD PRESSURE:
90 mmHg or greater 4
70-89 mmHg 3
50-69 mmHg 2
0-49 mmHg 1
No Pulse 0

GLASGOW COMA SCALE

EYE OPENING:
Spontaneous 4
To Voice 3
To Pain 2
None 1

VERBAL RESPONSE:
Oriented 5
Confused 4
Inappropriate Words ... 3
Incomprehensible Words 2
None 1

MOTOR RESPONSE:
Obeys Command 6
Localizes Pain 5
Withdrew (Pain) 4
Flexion (Pain) 3
Extension (Pain) 2
None 1

TOTAL GLASGOW COMA SCALE POINTS

13-15 = 4
9-12 = 3
6-8 = 2
4-5 = 1
<4 = 0

REVISED TRAUMA SCORE

PEDIATRIC TRAUMA SCORE

(Check One Category For Each Component)

COMPONENT	CATEGORY +2	+1	−1
Size	≥ 20 kg	10-20 kg	< 10 kg
Airway	Normal	Maintainable	Unmaintainable
Systolic B/P	≥ 90 mmHg	90-50 mmHg	< 5 mmHg
CNS	Awake	Obtunded/L.O.C	Coma/Decerebrate
Open Wound	None	Minor	Major/Penetrating
Skeletal	None	Closed Fracture	Open Multiple Fractures

SUM: _____ (PTS)

If proper sized B/P cuff not available B/P can be assessed by assigning:
+2 Pulse Palpable at Wrist +1 Pulse Palpable at Groin −1 No Pulse Palpable

PEDIATRIC COMA SCALE

	CHILD:	INFANT:
MOTOR	Obeys Command 6	Spont. Movements 6
	Localizes 5	Withdraws to Touch ... 5
	Withdraws 4	Withdraws to Pain 4
	Flexion 3	Flexion 3
	Extension 2	Extension 2
	Nil 1	Nil 1
VERBAL	Oriented 5	Coos & Babbles 5
	Confused 4	Irritable Cry 4
	Inappropriate 3	Cries to Pain 3
	Incomprehensible 2	Moans to Pain 2
	Nil 1	Nil 1
EYES	CHILD & INFANT: Opens Spont. 4	
	Opens to Speech . 3	
	Opens to Pain 2	
	Nil 1	

PEDIATRIC GLASGOW COMA SCORE

DRIP FORMULAS

mg/mL: = mg of med / mL of solution

mg/hr: = mg of med / mL of solution x infusion rate (mL/hr)

mg/min: = mg of med / mL of solution x infusion rate (mL/hr) ÷ 60

mg/kg/min = mg of med / mL of solution x infusion rate (mL/hr) ÷ 60 ÷ pt's weight in kg

µg/mL: = mg of Med x 1000 / mL of solution

µg/hr: = mg of med x 1000 / mL of solution x infusion rate (mL/hr)

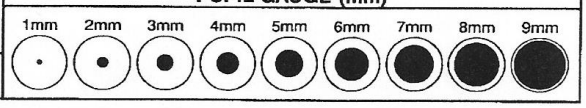
µg/min: = mg of med x 1000 / mL of solution x infusion rate (mL/hr) ÷ 60

µg/kg/min = mg of med x 1000 / mL of solution x infusion rate (mL/hr) ÷ 60 ÷ pt's weight in kg

Rate in gtts/min = volume to be given / hrs to be given x # of gtts/ml of IV set ÷ 60

Rate in mL/hr = µ/kg/min to be given x 60 x pt weight in kg / drip concentration in µg/mL

PUPIL GAUGE (mm)



FORM NO. 784361500 (Rev. 5/07)

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UNITED REGIONAL HEALTH CARE SYSTEM 11111192979
44-09-87
GAINES , BARTON
CHAPA, PHILLIP
DOB 10/25/1982 M 24Y ADM 6/26/2007

United Regional Health Care System

EMERGENCY DEPARTMENT NURSES NOTES (Continuation)

8221-12 (Rev 10/06)

HOME MEDICATIONS

DRUG	DOSE	FREQUENCY	DRUG	DOSE	FREQUENCY

TIME	BP	P	R	T	O2 SAT	GCS E	GCS V	GCS M	PAIN	CARDIAC RHYTHM
2235	—	81	17	—	100	4	5	6		ST
2305	139/53	84	24	—	100	4	5	6	—	ST
2345	121/63	94	21	—	99	4	5	6		ST
0015	159/62	78	24	—	99	4	5	6		ST
0045	123/56	90	31	—	99	4	5	6		ST

INTERVENTIONS / EVALUATIONS

(2235) pt to CT via cart c̄ nurse escort —

(2250) pt back from CT.

(2300) UA obtained —

([illegible]) Dr. Santos in to assess pt —

(0100) IVF NS [illegible] started @ 100cc/hr. Pt medicated c̄ Toradol for pain —

([illegible]) pt transported to 4[illegible] via cart —

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
[illegible]	[illegible]				

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UNITED REGIONAL HEALTH CARE SYSTEM
44-09-87
GAINES , BARTON
CHAPA, PHILLIP
DOB 10/25/1982 M
11111192979
24Y ADM 6/26/2007
Admit Date
DOB

HEALTHCARE SYSTEM

TRAUMA CALL LOG

rev 01/07 traumacalllog.jsn

Charge Nurse: Mike Gardner
Activation Time: 2223
Authorized By: _____

Name	Time Notified	Time in ED
Trauma Surgeon	Savior 2235	2332
Trauma Nurse		
Respiratory	Shannon 2223	2225
X-Ray	Mark 2223	2225
CT	Sherry 2223	2225
Blood Bank/Lab		2225
House Supervisor	Cindy 2226	
Social Services		
ICU		
Surgery	Jaime 2224	
Other	Chaplain 2225	

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Admit Date

DOB

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Emergency Department Ambulance Call Record

rev 03/07 amb.jsn

ATE: 6-26-07 TIME: 2215
NIT:
TTENDENT:
RANSPORT CODE: ① 2 3
ONDITION CODE: ① 2 3
TA: 45 min AGE: 24 SEX: (M) F

HIEF COMPLAINT:
4" nail
(L) chest + back

'S: B/P 142/76 P 93 R 20
O2 99% BBG
RHYTHM:
TREATMENT:
O2
V: @
C-COLLAR BACKBOARD

OTHER:

MEDICAL CONTROL PHYSICIAN/RN: [signature]

COMMUNICATION QUALITY: (GOOD) FAIR POOR

TIME OF TRAUMA ACTIVATION:

CIRCLE ALL THAT APPLY:

Category 1 patients are emergent major trauma and require immediate activation of the trauma team.

1. CLINICAL ASSESSMENT
   - A. Glasgow Coma Scale < 13 or
   - B. Systolic BP < 90 past pre-hospital fluid challenge or
   - C. Systolic BP < 80 on ER Arrival or
   - D. Pediatric Trauma Score < 9 or

2. ANATOMY ASSESSMENT:
   - A. Patients requiring intubation
   - B. Flail Chest
   - C. Penetrating injury to head, chest, or abdomen
   - D. Open pelvic Fracture
   - E. 2 or more long bone fractures
   - F. Amputations proximal to the wrist or ankle
   - G. Burns > 15% BSA or respiratory comprise
   - H. Loss of sensation or movement to lower extremities
   - I. Pregnant trauma patient 20 wks gestation or (Must meet another Level 1 criteria)

3. MECHANISM ASSESSMENT:
   - A. Ejection from vehicle
   - B. Auto-Pedestrian/Auto-Bicycle impact
   - C. Motorcycle impact
   - D. Falls > 20 feet
   - E. Extrication time > 20 minutes
   - F. MVA unrestrained rollover
   - G. Gunshot wound to head, chest or abdomen

** For Level 1 Activation
ANY element within the Clinical or Anatomic Groups
For mechanism based activation MUST have element from Mechanism Group AND at least one element from either Clinical or Anatomic Groups

Revised: January 2007

ER RECORD - Page 9 of 9	UNITED REGIONAL HEALTH CARE SYSTEM		Printed: 05/19/2008 11:49
Patient: GAINES, BARTON	MR#: 440987	Discharged: 06/27/2007	Service Dates: 06/27/2007-06/27/2007
Copy for: ROI MGT TGREEN	REQ: 137011, DET: 1188610 IK: 13642988 ITK: 21693 EK: 3094461 VER: 1		

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GAINES , BARTON
11111192979 6/27/2007 Admit Date
44-09-87 10/25/1982DOB M 24Y
MERCER, LEO

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MULTIDISCIPLINARY PATIENT FAMILY EDUCATION TRENDING RECORD

rev 06/07 multidisiplnarypatient familyeducationtrendingrecord.jsp

I. TEACHING TOPICS

1. Illness/Disease
2. Plan of Care
3. Medications
4. Equipment
5. Nutrition/Diet
6. Pre-Op/Post-Op
7. Pain Management
8. Potential Food/Drug Interaction
9. Rehabilitation Techniques
10. Available Community Resources
11. When/How to Obtain Further Help
12. Personal Hygiene/Grooming
13. Smoking Cessation
14. Advanced Directive
15. Patient Safety
16. Other

II. LEARNER

Pt - Patient
F - Family
SO - Significant Other
P - Parent
O - Other

III. LEARNING BARRIER

N - None
S - Sight
H - Hearing
L - Language
C - Culture/Religion
MS - Mental Status

IV. TEACHING METHOD

E - Explanation
D - Demonstration
HO - Handouts
V - Video
O - Other

V. LEARNER RESPONSE

VU - Verbalized Understanding
RD - Return Demonstration
NR - Needs Reinforcement
R - Refused
N - No Interest/Denial
I - Inability to Learn

* INDIVIDUALIZED PATIENT NEEDS ARE INDICATED. EXCEPTIONS WILL BE MARKED WHEN NEEDED*

DATE / INITIALS	I. TEACHING TOPIC	INFO PROVIDED	II. LEARNER	III. LEARNING BARRIER	IV. TEACHING METHOD	V. LEARNER RESPONSE	HANDOUTS PROVIDED
6/27/07 D	1, 4	Orientation to Hospital/Room/Equipment	(Pt) / F	N	E, HO	VU	Patient Handbook
	15	Fall Reduction	(Pt) / F	N	E, HO	VU	
	7	Pain Education	(Pt) / F	N	E, HO	VU	
	13	Smoking Cessation	(Pt) / F	N	E, HO	VU	
	14	Advanced Directives	(Pt) / F	N	E, HO	VU	
6/27/07 cp	2	Initial Plan	Pt / F	N	E, HO	VU	
6/27/07 cp	1	Illness/Disease	Pt / F	N	E, HO	VU	
6/27/07 cp	3	Medication/Vaccination Education	Pt / F	N	E, HO	VU	
	6	Pre-Op / Post-Op	Pt / F	N	E, HO	VU	
	*1, 3, 5, 9, 11	CHF Packet	Pt /F	N	E, HO	VU	• A patient's guide to managing Heart Failure. • Heart Failure weight and well being chart.. Reach your goal with low-sodium eating. Meal plan for people with congestive Heart Failure.
	1, 3, 10, 11	Diabetes Packet	Pt /F	N	E, HO	VU	• Diabetes Basics • Reminders for Diabetes Care • Information Diabetes Self Management Program • Medic Alert information • Diabetes Support group information
	1, 2, 9, 11, 13, 16	Stroke	Pt /F	N	E, HO, V	VU	Booklet– Stroke Center Video: Stroke–What every person needs to know

INIT.	SIGNATURE / TITLE	INIT.	SIGNATURE / TITLE	INIT.	SIGNATURE / TITLE
				CP	Patterson RN C
				JO	JOKEN RN Admit Team

*FOR CHF PATIENTS ONLY

EDUCATION - Page 1 of 1	UNITED REGIONAL HEALTH CARE SYSTEM	Printed: 05/19/2008 11:49
Patient: GAINES, BARTON	MR#: 440987 Discharged: 06/27/2007	Service Dates: 06/27/2007-06/27/2007
Copy for: ROI MGT TGREEN	REQ: 137011, DET: 1188611 IK: 13642991 ITK: 22196 EK: 3094465 VER: 1	

Trans Star Ambulance – Patient Care Report

Bart Gaines #1139507 — Patient Name

EMS Signature

N2306 29712 — ID Number

Date	Time Dispatched	Time Enroute	1st Responder Arrived	Arrived Scene	Departed Scene	Arrived Destination	Time Available	Incident Run Number
6-26-07	2131	2146	—	2200	2215	2226	2230	28800

RESP/TRANSP

To Scene:
- ☒ Emergent
- ☐ Non-Emergent
- ☐ Exception

From Scene:
- ☒ Emergent
- ☐ Non-Emergent
- ☐ Exception

(1) 3 / (1) 2 3 N/A

TYPE OF CALL

- ☐ Multi Trauma
- ☐ MVC
- ☐ Motorcycle
- ☐ Pedestrian
- ☐ Bicycle
- ☐ Bite/Sting
- ☐ Cardiac
- ☐ Drown/Nr Drown
- ☐ Explosion
- ☐ Fall
- ☐ Fire/Burn
- ☐ Haz Mat Exposure
- ☐ Machinery/Equip
- ☐ Poison/OD
- ☐ Respiratory
- ☐ Sports/Play Injury
- ☐ Sexual Assault
- ☐ Other Assault
- ☐ Shooting
- ☒ Stabbing
- ☐ Strangle/Suff
- ☐ OB/Pregnancy
- ☐ Medical Illness
- ☐ Inter Facil Trnsf
- ☐ Air/Ground Trnsf
- ☐ Dismissal
- ☐

SUSPECTED MEDICAL ILLNESS (For medical Calls Only)

Primary: Puncture wounds to chest x5

Secondary: Stabbing c 4" Nail

LEVEL OF CARE
- ☒ ALS
- ☐ BLS

10/05

GENDER
☒ M ☐ F

BIRTH DATE
10 | 25 | 82

AGE
24
- ☐ Months
- ☐ Days

RACE
- ☒ White
- ☐ Hispanic
- ☐ Black
- ☐ Asian
- ☐ Nat Amer.
- ☐ Multirac
- ☐ Other

PRIOR AID

☐ None

	Extric	CPR	AED	Other
Bystan/Fam	☐	☐	☐	☐
1st Res.	☐	☐	☐	☐
Fire	☐	☐	☐	☐
Health Prof.	☐	☐	☐	☒
Police	☐	☐	☐	☐

HISTORY
NONE

INJURY SITE/TYPE

☐ None
☐ Major

		Amputate	Blunt	Burn	Fx/Disloc	Pain	Paralysis	Penetrate	Soft-Open	Soft-Clsd
Head		☐	☐	☐	☐	☐	☐	☐	☐	☐
Face		☐	☐	☐	☐	☐	☐	☐	☐	☐
Eye	☐ R ☐ L		☐	☐	☐	☐	☐	☐	☐	☐
Neck			☐	☐	☐	☐	☐	☐	☐	☐
Chest			☐	☐	☐	☐	☐	☒	☒	☒
Back			☐	☐	☐	☐	☐	☒	☒	☒
Abdomen			☐	☐	☐	☐	☐	☐	☐	☐
Hip/Pelv	☐ R ☐ L		☐	☐	☐	☐	☐	☐	☐	☐
Genitalia		☐	☐	☐	☐	☐	☐	☐	☐	☐
Arm	☐ R ☒ L	☐	☐	☐	☐	☐	☐	☐	☐	☒
Hand	☐ R ☐ L	☐	☐	☐	☐	☐	☐	☐	☐	☐
Leg	☐ R ☐ L	☐	☐	☐	☐	☐	☐	☐	☐	☐
Foot	☐ R ☐ L	☐	☐	☐	☐	☐	☐	☐	☐	☐

INJURY SITUATION

- ☐ MV-Head On
- ☐ MV-Lateral
- ☐ MV-Rear
- ☐ MV-Roll Over
- ☐ MV-Rotational
- ☐ Axle Displaced
- ☐ Death same MV
- ☐ Deformity >20"
- ☐ Ejection
- ☐ Intrusion >12"
- ☐ Pedest Hit >5mph
- ☐ Pedest Run Over
- ☐ Speed >40 mph
- ☐ Burn >10% <6/>55
- ☐ Burn >15%
- ☐ Extric >15 min
- ☐ Fall >20 ft
- ☐ Impalement
- ☐ Inhalation Inj
- ☐ >2 Long Bn FX
- ☐ Pen Trauma
- ☐ Self-Extrac
- ☐ Self-Inflict
- ☐ Transprt >25 min

SAFETY DEVICES
- ☐ Airbag Only (deployed)
- ☐ Airbag/Belt
- ☐ Lap/Shoulder Belt
- ☐ Child Restraint
- ☐ Helmet
- ☐ Other
- ☐ None
- ☐ Not Used

PATIENT LOCATION
- ☐ Driver
- ☐ Unknown
- ☐ Front
- ☐ Other
- ☐ Rear

INITIAL VITAL SIGNS

Syst	Diast	Pulse	Resp	O_2Sat
142	76	90	20	97

☐ Unable To Take ☐ Not Taken r.a.

ER VITAL SIGNS

Syst	Diast	Pulse	Resp	O_2Sat
123	73			

☐ Unable To Take ☐ Not Taken

INITIAL GLASCOW COMA SCALE/LOC

Eyes	Verbal	Motor
☒ Spontan	☒ Oriented	☒ Obeys
☐ Speech	☐ Confused	☐ Localizes
☐ To Pain	☐ Inapprop	☐ Withdraw
☐ None	☐ Garbled	☐ Flexion
	☐ None	☐ Extends
		☐ None

ER GLASCOW COMA SCALE/LOC

Eyes	Verbal	Motor
☒ Spontan	☒ Oriented	☒ Obeys
☐ Speech	☐ Confused	☐ Localizes
☐ To Pain	☐ Inapprop	☐ Withdraw
☐ None	☐ Garbled	☐ Flexion
	☐ None	☐ Extends
		☐ None

EKG

Sinus Rhythm	☐ I ☐ L
Asystole	☐ I ☐ L
Atrial Fibrillation	☐ I ☐ L
Atrial Flutter	☐ I ☐ L
Junctional	☐ I ☐ L
PEA	☐ I ☐ L
Heart Block	☐ I ☐ L
Sinus Brady	☐ I ☐ L
Sinus Tach	☐ I ☐ L
SV Tach	☐ I ☐ L
Vent Tach	☐ I ☐ L
Vent Fibrillation	☐ I ☐ L
Paced	☐ I ☐ L
AICD	☐ I ☐ L
Other	☐ I ☐ L

PVC's

MEDICAL CONTROL
- ☒ Protocol
- ☐ Not Required
- ☐ Hospital Contact
- ☐ MD on Scene
- ☐ Written Orders

COMMUNICATIONS
- ☒ Radio
- ☑ Cell Phone
- ☐ Other

INIT. RTS | **ER RTS**

CPR

CPRT ☐ Y ☐ N
DNRO ☐

Time: Min	<4	4-8	8-15	>15
Arrest to CPR	☐	☐	☐	☐
Arrest to ALS	☐	☐	☐	☐
Arrest to Shock	☐	☐	☐	☐

Witnessed Arrest ☐ Y ☐ N
Pulse Restored ☐ Y ☐ N

PATIENT CONDITION

On Scene	On Arrival
☐ Minor	☒ Minor
☐ Moderate	☐ Moderate
☐ Serious	☐ Serious
☐ Critical	☐ Critical
☐ Arrest	☐ Arrest
☐ DOS	☐ DOA

TRANSPORT TO:
- ☐ Hospital ED
- ☐ Hosp CCU / ICU
- ☐ Outpatient Dept
- ☐ Hospital Bed
- ☐ Nursing Home
- ☐ Residence
- ☐ Other Med Facil
- ☐

DEST DECISION
- ☐ Pt/Family Req
- ☑ Physician Req
- ☐ Most Accessible
- ☐ Trauma Triage
- ☐ Bypass
- ☐ Diversion
- ☐

BLS/ALS TREATMENT

	P1 P2 P3 P4		P1 P2 P3 P4		P1 P2 P3 P4
Pt Assess	☑ ☑ ☐ ☐	Bleed Cntrl	☐ ☐ ☐ ☐	Trac Splint	☐ ☐ ☐ ☐
Vital Signs	☑ ☐ ☐ ☐	Bandaging	☐ ☐ ☐ ☐	Vac Mat	☐ ☐ ☐ ☐
Pulse Ox	☑ ☐ ☐ ☐	Blood Draw	☐ ☐ ☐ ☐	Mobile Vent	☐ ☐ ☐ ☐
Airwy/Man	☑ ☐ ☐ ☐	Gluc Test	☐ ☐ ☐ ☐	OB Delivery	☐ ☐ ☐ ☐
Oxygen 5L	☑ ☐ ☐ ☐	IV-Ext Jug	☐ ☐ ☐ ☐	Nebulizer	☐ ☐ ☐ ☐
NRB Ven	NC BVM	IV-IO	☐ ☐ ☐ ☐	Drugs	☐ ☐ ☐ ☐
Suction	☐ ☐ ☐ ☐	IV-Periph	☐ ☐ ☐ ☐		
Nsphryngl	☐ ☐ ☐ ☐	IV-Monitor	☐ ☐ ☐ ☐	**Attempts**	1 2 3+ U
Orphryngl	☐ ☐ ☐ ☐	IV-Pump	☐ ☐ ☐ ☐	IV-Ext Jug	☐ ☐ ☐ ☐
CombiTube	☐ ☐ ☐ ☐	Cricothy	☐ ☐ ☐ ☐	IV-IO	☐ ☐ ☐ ☐
ET-Nasal	☐ ☐ ☐ ☐	Ndle Thor	☐ ☐ ☐ ☐	IV-Periph P^1	☐ ☐ ☐ ☐
ET-Oral	☐ ☐ ☐ ☐	Gstrc Tube	☐ ☐ ☐ ☐	IV-Periph P^2	☐ ☐ ☐ ☐
Magill Frcp	☐ ☐ ☐ ☐	Irrigation	☐ ☐ ☐ ☐	IV-Periph P^3	☐ ☐ ☐ ☐
CPAP	☐ ☐ ☐ ☐	Restraints	☐ ☐ ☐ ☐	ET-Nasal	☐ ☐ ☐ ☐
CPR	☐ ☐ ☐ ☐	MAST	☐ ☐ ☐ ☐	ET-Oral P^1	☐ ☐ ☐ ☐
AED	☐ ☐ ☐ ☐	Extricate	☐ ☐ ☐ ☐	ET-Oral P^2	☐ ☐ ☐ ☐
EKG	☐ ☐ ☐ ☐	Splint	☐ ☐ ☐ ☐	ET-Oral P^3	☐ ☐ ☐ ☐
Defib/Card	☐ ☐ ☐ ☐	Spinal Imm	☐ ☐ ☐ ☐	Cricothy	☐ ☐ ☐ ☐
Pacing	☐ ☐ ☐ ☐	CCOL CID	KED LSB	Ndle Thor	☐ ☐ ☐ ☐

MEDICATIONS

☒ None

- ☐ Adenosin
- ☐ Albuterol
- ☐ Anectine
- ☐ Atropine
- ☐ Benadryl
- ☐ Breathine
- ☐ Cardizem
- ☐ Cordaron
- ☐ Dopamne
- ☐ Flumaze
- ☐ Glucagon
- ☐ Labetolol
- ☐ Lidocaine
- ☐ Norcuron
- ☐ Phenergan
- ☐ SoluMedrol
- ☐ ASA
- ☐ ActChar
- ☐ Bicarb
- ☐ D50W
- ☐ D25W
- ☐ Epi1:1
- ☐ Epi1:10
- ☐ Isoptin
- ☐ Lasix
- ☐ Narcan
- ☐ Nitro
- ☐ Pitocin
- ☐ Toradol
- ☐ Thiamin
- ☐ Xopenx

NARCOTICS
- ☐ Demerol
- ☐ Valium
- ☐ Morphine
- ☐ Versed

IV RATE/TYPE

LR	TKO	WO	BOL
NS	TKO	WO	BOL
Other	TKO	WO	BOL

# Lines	Total Vol
1	
2	NONE
3	

#29712

PATIENT NAME [redacted] Gaines [redacted] 1139507 [redacted] **PATIENT** [redacted] of 1

INCIDENT LOCATION

PATIENT TRANSFERRED FROM James V. Allred TDCJ **TO** URHCS 11th St ER #1

CURRENT MEDS Prozac **ALLERGIES** (medical) NKDA

TIME										
AVPU										
Heart Rate										
Resp. Rate										
BP										
Pupils										
Skin										
Pulse Ox										
EKG										
DC Shock										
Epinephrine										
Nitro										
Other										

NARRATIVE TS-3 dispatched to James V. Allred Unit TDCJ for pt stabbed several times. On arrival found 24 y/o w/m walking to back of ambulance c̄ two officers. Pt c̄ wrist and ankle shackles. Pt A&O x4 c̄ complaint at this time. Pt states that he was confronted by another inmate in the shower room and was punched in (L) side a few times. Pt states the other inmate had 4" nail in (R) hand, stabbing him. Pt has noted puncture wounds to (L) side; three c̄ bleeding to front (L) chest approximately midaxial @ 6th rib, one to upper (L) quadrant abdomen c̄ bleeding, one to (L) back approximately mid scapula @ 5th rib c̄ small amount of bleeding, one to (L) bicep c̄ bleeding and one to (L) hip c̄ small amount of bleeding noted. Pt denies pain. Denies SOB. Pt stepped c̄ minimal assist to back of ambulance and sat on cot. Pt secured x 3 belts. Respirations 20 nonlabored. Abdomen soft nontender to palpation. Lung sounds clear = bilateral to auscultation. Radial pulses strong regular 90. Skin PWD to touch. No cyanosis noted. BP 142/76 O2 sat 99% on room air. Monitored pt in position of comfort. Report called to [illegible] EN @ 11th St ER. On arrival to 11th St pt continues to deny SOB, pain. No guarding noted [illegible] deep breathing. On arrival to 11th St ER pt was able to move on own to bed #1. Report and care released to staff. No incident EMT

DOCUMENTOR'S SIGNATURE [signature]

CREW MEMBERS	ID NUMBER	CREW MEMBERS	ID NUMBER
1. Stac. P[illegible] LP	506	3.	
2. Jarad Cook EMT-I	229	4.	

PERSON RECEIVING PATIENT	DATE	TIME	NAME	SIGNATURE

MISCELLANEOUS - Page 2 of 2	UNITED REGIONAL HEALTH CARE SYSTEM	Printed: 05/19/2008 11:49
Patient: GAINES, BARTON	MR#: 440987 / Discharged: 06/27/2007	Service Dates: 06/27/2007-06/27/2007
Copy for: ROI MGT TGREEN	REQ: 137011, DET: 1188613 IK: 13642989 ITK: 22134 EK: 3094463 VER: 1	

11555

GAINES , BARTON
11111192979 6/26/2007 Admit Date
44-09-87 10/25/1982DOB M 24Y
CHAPA, PHILLIP

unitedregional

PATIENT AUTHORIZATION RECORD

rev 03/07 admpataud jsn

AUTHORIZATION FOR CARE

I authorize representatives of United Regional Health Care System (URHCS) to render nursing and hospital care to me during my inpatient, outpatient, or emergency room services and to carry out the orders of my attending physician, including consultants, associates, and assistants of his choice

HIV/AIDS TESTING

Texas law authorizes a hospital or physician to require that a patient be tested for possible exposure to the human immunodeficiency virus, the virus associated with AIDS, in the following situations 1) if donation of blood, blood products, organs or tissues is contemplated (2) if a health care worker is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick; or (3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids You may be tested if any of these situations occur during your hospitalization

PATIENT HEALTH CARE INFORMATION

"State and Federal Legislation permit the disclosure of health care information without authorization in certain situations Most of these disclosures will be sharing information to provide treatment or care for you, also for billing purposes and to conduct normal hospital operations Other situations where the law allows us to disclose health care information without authorization are listed in URHCS' Notice of Privacy Practices
provided at time of admission

PATIENT ACKNOWLEDGEMENT OF RECEIPT

- ☐ I acknowledge and understand that URHCS provides safekeeping for money, jewelry or other valuables; otherwise, I assume personal responsibility for them URHCS does not accept responsibility for dentures, eyeglasses, contact lenses, hearing aids, or any other type of prosthesis
- ☐ I acknowledge receipt of the written documentation "Notice of Privacy Practices" explaining my rights in regards to privacy and release of my healthcare information
- ☐ I acknowledge my right to have an advance directive and understand that if I do not have an advance directive, the Patient Representative or Social Worker will give me additional information, answer my questions, and help me complete an advance directive
- ☐ I acknowledge, if being admitted to the hospital as inpatient or observation, receiving a copy of the written documentation "An Important Message from Medicare/Tricare explaining my rights" _____No MCR/Tricare

PRIVACY PRACTICES

1 I would like my name withheld from the Hospital Directory (I understand the hospital will not acknowledge my presence as a patient to anyone, including my family and friends, who call or come to the Information Desk) Y (N)

2. **I, THE UNDERSIGNED, HAVE BEEN EXPLAINED THE CONTENTS OF THIS FORM AND I UNDERSTAND AS INDICATED BY MY SIGNATURE.**

X Sgt. Morales J — SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

WITNESS

1/23/2010 — DATE

1/23/2010 — DATE

Guardian — RELATIONSHIP TO PATIENT

AUTHORIZATION - Page 1 of 1	UNITED REGIONAL HEALTH CARE SYSTEM		Printed: 05/19/2008 11:49
Patient: GAINES, BARTON	MR#: 440987	Discharged: 06/27/2007	Service Dates: 06/26/2007-
Copy for: ROI MGT TGREEN	REQ: 137011, DET: 1188614 IK: 13632536 ITK: 20888 EK: 3060640 VER: 1		

11556

GAINES , BARTON
11111192979 6/26/2007 Admit Date
44-09-87 10/25/1982DOB M 24Y
CHAPA, PHILLIP

unitedregional

INSURANCE ASSIGNMENT

rev 03/07 adminsas jsn

1 This is a ***lifetime financial consent concerning outpatient service records,*** which shall continue in effect unless and until I revoke it by written request to the Admitting Department at United Regional Health Care System Inpatient services, outpatient invasive procedures and emergency services will require that I sign an additional consent for each date of service

2 In consideration of services rendered, I hereby irrevocably assign and transfer my rights, title and interest in any benefits payable to or for my benefit under hospitalization, sickness or accident insurance coverage, to include major medical, or employee benefits, for the payment of such services rendered by URHCS

A **AUTHORIZATION FOR AND CONSENT TO RELEASE OF INFORMATION**
Authorization is hereby granted to the Hospital and service related to physicians to release to my insurance company or companies, their agents, Workers Compensation carrier or employer and other third party payers, any information (including Diagnostic and financial information) as may be requested or necessary for the completion of claim processing relative to my treatment I also authorize disclosure of said information to any physician or hospital to which I am referred.

B **ASSIGNMENT OF INSURANCE BENEFITS**
The undersigned, jointly and severally, hereby authorizes payment directly to the Hospital and treating physicians for the insurance benefits otherwise payable to him/her or due to become payable to him/her for this medical treatment I further agree that in the event hospital, surgical and medical insurance benefits exceed the amount due to the Hospital for services in connection with my treatment, that any such excess amount may first be applied as payment of other indebtedness due the Hospital from me or my immediate family on account of other treatments or hospitalization, and the balance, if any remains, refunded appropriately This assignment includes PIP "Personal Injury Protection" and insurance benefits accruing to me under uninsured motorist coverage

C **ASSIGNMENT OF MEDICARE INSURANCE BENEFITS**
I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim I assign the benefits payable for the services rendered by the Hospital and treating physicians I authorize the Hospital and treating physicians to submit claims to Medicare for payment

D **FINANCIAL RESPONSIBILITY**
I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered, including payment of services denied or not covered by my insurance benefit plan I further agree that all amounts are due upon request and are payable to URHCS, Wichita Falls, Wichita County, Texas All accounts are due upon dismissal unless arrangements have been made in advance with the Business Office

I, THE UNDERSIGNED, HAVE BEEN EXPLAINED THE CONTENTS OF THIS FORM AND I UNDERSTAND AS INDICATED BY MY SIGNATURE.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE — DATE 6/26/07 — RELATIONSHIP TO PATIENT Guardian/mate

SIGNATURE OF INSURED IF OTHER THAN PATIENT Sgt Morales, J — DATE 6/26/07 — WITNESS

INSURANCE ASSIGNMENT - Page 1 of 1	UNITED REGIONAL HEALTH CARE SYSTEM		Printed: 05/19/2008 11:49
Patient: GAINES, BARTON	MR#: 440987	Discharged: 06/27/2007	Service Dates: 06/26/2007-
Copy for: ROI MGT TGREEN	REQ: 137011, DET: 1188615 IK: 13632535 ITK: 22314 EK: 3060638 VER: 1		

DOC 7: MOWLA'S FILE: 11/2/2009

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collection box.

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Online Label Record (Label 1 o

Delivery Confirmation™ Number:
9405 5036 9930 0030 0635 79

Paid Online

Transaction #:	152708820	Priority Mail® Postage:	$1
Print Date:	11/02/2009	Total:	$1
Ship Date:	11/02/2009		
Weight:	5 lb 0 oz		

From: M. MICHAEL MOWLA
ATTORNEY AT LAW
1414 W WHEATLAND RD
STE 250
DUNCANVILLE TX 75116-4201

To: BARTON GAINES - TDCJ #1139507
ALLRED UNIT
2101 FM 369 N
IOWA PARK TX 76367-6568

* Commercial Base Pricing Priority Mail rates apply. There is no fee for Deli
Confirmation service on Priority Mail service with use of this electronic rate s
label. Delivery information is not available by phone for the electronic rate. I
for unused postage paid labels can be requested online 10 days from the pri
For Carrier Pickup or tracking call 1-800-222-1811.

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package with PC Postage®, you a Carrier pickup online, hand to rier, take to a Post Office™, or S collection box.

age on the "Ship Date" you creating this label.

Online Label Record (Label 2 c

Delivery Confirmation™ Number:

9405 5036 9930 0030 0635 62

Paid Online

Transaction #:	152708820	Priority Mail® Postage:	$
Print Date:	11/02/2009	Total:	$
Ship Date:	11/02/2009		
Weight:	6 lb 0 oz		

From: MICHAEL MOWLA
ATTORNEY AT LAW
1414 W WHEATLAND RD
STE 250
DUNCANVILLE TX 75116-4201

To: BARTON GAINES - TDCJ #1139507
ALLRED UNIT
2101 FM 369 N
IOWA PARK TX 76367-6568

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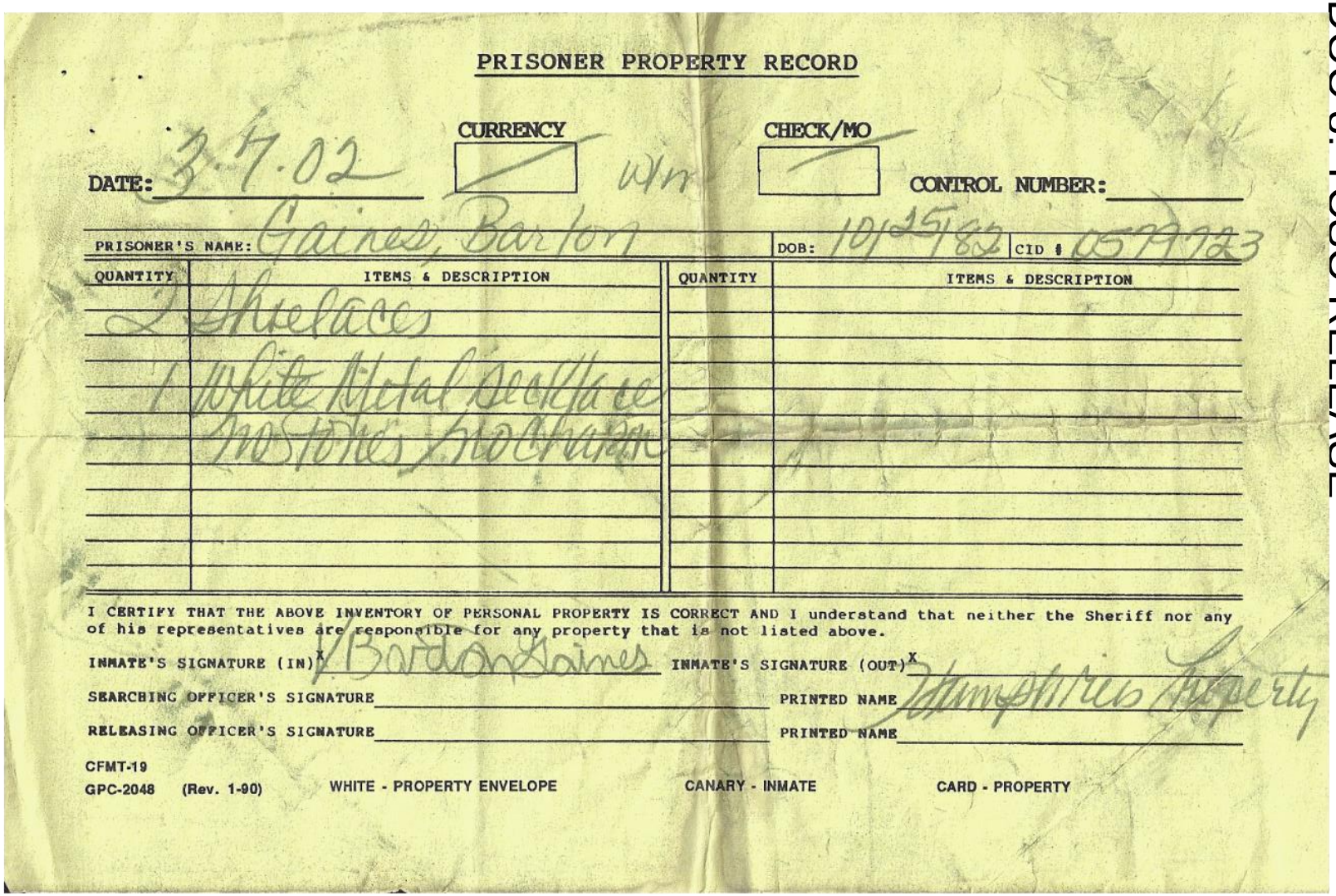
the status of your shipment on the Track & Confirm page at usps.com



PRISONER PROPERTY RECORD

DATE: 3.7.02 CURRENCY [ ] Win CHECK/MO [ ] CONTROL NUMBER: _____

PRISONER'S NAME: Gaines, Barlon DOB: 10/25/82 CID # 05997123

QUANTITY	ITEMS & DESCRIPTION	QUANTITY	ITEMS & DESCRIPTION
2	Shoelaces		
1	White Metal Necklace		
	No Shirt, No Shoes		

I CERTIFY THAT THE ABOVE INVENTORY OF PERSONAL PROPERTY IS CORRECT AND I understand that neither the Sheriff nor any of his representatives are responsible for any property that is not listed above.

INMATE'S SIGNATURE (IN) X /Barlon Gaines INMATE'S SIGNATURE (OUT) X

SEARCHING OFFICER'S SIGNATURE _____ PRINTED NAME Humphries Property

RELEASING OFFICER'S SIGNATURE _____ PRINTED NAME _____

CFMT-19
GPC-2048 (Rev. 1-90) WHITE - PROPERTY ENVELOPE CANARY - INMATE CARD - PROPERTY

Clothing Record

GAINES, BARTON — Inmate's Name

1025-82 — DOB

0579723 — Cid#

182B15 — Cntrl#

Date: 3-7-02 — Floor Assgn: _____

Item	Color	Description	Date Received Into Property	Date Released To Inmate
COAT / JACKET		(BU) (BU) (ZU) (PO)		
SWEATER		(BU) (PO) (LS)		
SHIRT / BLOUSE		(BU) (BU) (PO) (SS) (LS)		
TROUSERS / SHORTS	BLU	JEANS		
BELT (with buckle)				
HAT / CAP (BB)				
SHOES / BOOTS	BRN	(LQ) (HT) (SO) (LU)	1 PR	
SKIRT / SLACKS				
BRA				
PURSE				
BOXER				
JAIL TENNIS SHOES		(LQ) (HT)	1 PR	

Note the color of the shoes/boots

IN PROCESSING: I certify that I have been issued: (1 each) mattress cover; blanket; towel; uniform; slides.) NOTE: All county issued property must be returned prior to my release from this facility.

X Barton Gaines — INMATE'S SIGNATURE

J. TUCK — RELEASE OFFICER'S SIGNATURE

OUT PROCESSING: I certify that I have returned all county property that was issued to me.

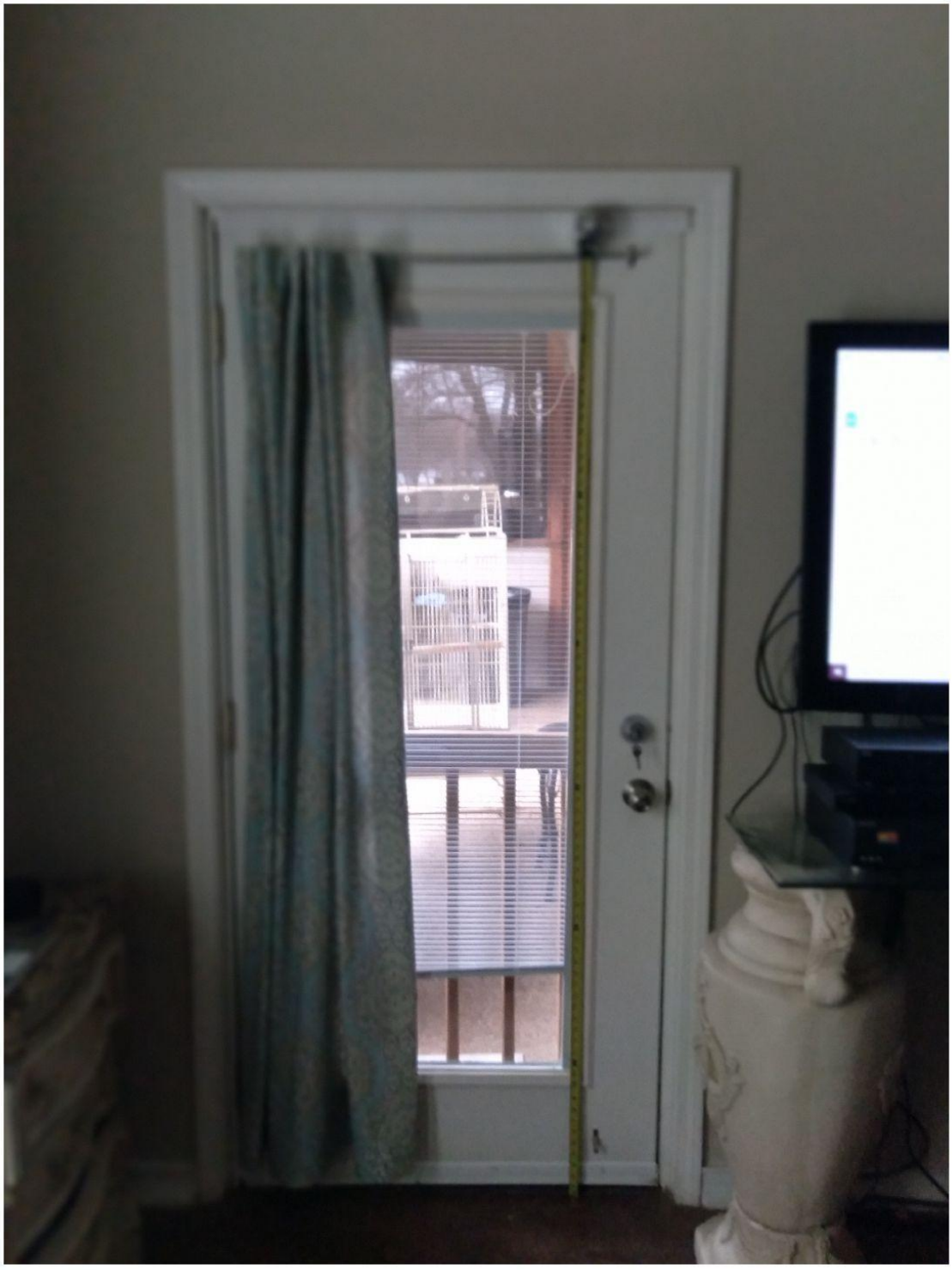
_____ INMATE'S SIGNATURE

_____ RELEASE OFFICER'S SIGNATURE

CARD-Property / WHITE-Inmate
CFMT-33 GPC-1540 (Rev. 1/00)

DOC 9: MY PICTURES: HEIGHT


1
2
3
4
5
6

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Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Envelope ID: 56940592
Status as of 9/3/2021 9:25 AM CST

Associated Case Party: BARTON RAYGAINES

Name	BarNumber	Email	TimestampSubmitted	Status
Barton RGaines		bartongaines@gmail.com	9/3/2021 9:05:55 AM	SENT