

(15)

2111 1700 32

CICERO, FRANCE, BARCH & ALEXANDER, P.C.

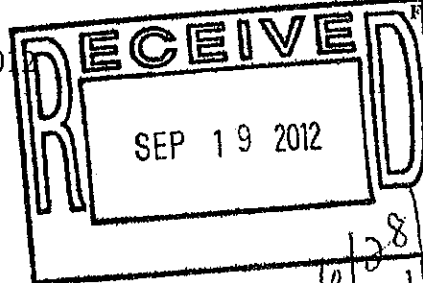
A Professional Corporation
Attorneys at Law
6323 EAST RIVERSIDE BOULEVARD
ROCKFORD, ILLINOIS 61114

PAUL R. CICERO
JOHN W. FRANCE
RONALD A. BARCH
CHARLES P. ALEXANDER
CHANTEL R. BIELSKIS
ANDREW T. SMITH

TEL: (815) 226-7700
FAX: (815) 226-7701

REC'D SEP 6 2012

September 4, 2012



Release of Information/Medical Records Custodian
c/o Centegra Northern Illinois Medical Center
4201 Medical Center Drive
McHenry, IL 60050

Re: Paul Dulberg v. Carolyn McGuire and Bill McGuire
McHenry County Case No. 12 LA 178
Records of: Paul Dulberg (B/D: 3/19/70)

Dear Medical Records Custodian:

Enclosed with this letter is a Subpoena for Deposition, a HIPAA Records Release Authorization and a check in the amount of \$20.00, the legal witness fee.

Please be advised that your appearance on the date indicated is not necessary. You may comply with the subpoena by mailing legible copies of all medical records, medical statements for services and medical reports of Paul Dulberg for the dates requested in the subpoena, in your possession or subject to your control.

Please note that we represent Carolyn McGuire and Bill McGuire in this case and not your patient. Since we do not represent the patient, we cannot discuss the substance of your care or the pending lawsuit with you outside the presence of your patient's attorney. If you have questions about how to comply with the subpoena, you may call my secretary, but neither she nor I can talk to you about any aspect of the lawsuit or the patient's medical treatment. Thank you in advance for your professional cooperation.

Very truly yours,

Cicero, France, Barch & Alexander, P.C.

RONALD A. BARCH

RB:mj/subltr.records
encls.

cc: Attorney Hans A. Mast

COPIED BY

SEP 14 2012

COPY-RITE
MRV

4201 Medical Center Dr
McHenry, IL 60050
(815) 338-2544

F/C:SI P/T:EDB

DULBERG, PAUL R

11179-00323

06/28/11 06/28/11 1

APIWAT W FORD

PAUL R DULBERG
4606 HAYDEN CT
MCHEMRY IL

60051-7918

601067 PAUL DULBERG/ACCIDENT

99999 999999999 09/14/12

	CODE	DESCRIPTION	QTY	
	***250	PHARMACY		
06/28	000196	CEFADROXIL MONOH 500MG, CAPSUL	1	19.00
06/28	002870	HYDROCODONE-AC 10-325MG, TABLE	1	7.50
06/28	000630	BUPIVACAINE HCL 0. 0.25%, 30 M	1	26.50
		AREA TOTAL ***		53.00
	***258	PHARMACY IV SOLUTIONS		
06/28	012251	SODIUM CHLORIDE 0.9% 1000ML IRRIG	2	184.00
		AREA TOTAL ***		184.00
	***272	STERILE SUPPLIES		
06/28	012458	TRAY LACERATION	1	125.00
		AREA TOTAL ***		125.00
	***320	RADIOLOGY		
06/28	010135	FOREARM XR	1	225.00
		AREA TOTAL ***		225.00
	***450	EMERGENCY DEPARTMENT		
06/28	012004	REPAIR SIMPLE 12.5 CM	1	271.25
06/28	019283	ED LEVEL III	1	310.00
		AREA TOTAL ***		581.25
	***636	QUANTIFIED DRUGS		
06/28	003507	DIPHThERIA-PERTUSSIS-TE, .5 ML	1	155.50
		AREA TOTAL ***		155.50

TOTAL CHARGES 1,323.75

TOTAL PAYMENTS/ADJUSTMENTS 0.00

1,323.75

0.00

1,323.75

*201 Medical Center Dr
McHenry, IL 60050
(815) 338-2544

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258	PHARMACY IV SOLUTIONS		184.00
272	STERILE SUPPLIES		125.00
320	RADIOLOGY		225.00
450	EMERGENCY DEPARTMENT		581.25
636	QUANTIFIED DRUGS		155.50
TOTAL CHARGES			1,323.75
TOTAL PAYMENTS/ADJUSTMENTS			0.00

1,323.75

0.00

1,323.75

4201 Medical Center Dr
McHenry, IL 60050
(815) 338-2544

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11179-00323

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4606 HAYDEN CT
MCHENRY IL

60051-7918

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99999 999999999 09/14/12

CODE	DESCRIPTION	QTY
	Total Charges:	
	250 PHARMACY	53.00
	258 PHARMACY IV SOLUTIONS	184.00
	272 STERILE SUPPLIES	125.00
	320 RADIOLOGY	225.00
	450 EMERGENCY DEPARTMENT	581.25
	636 QUANTIFIED DRUGS	155.50

Insurance Benefits 601067
COB. 1

Total Charges 1,323.75
Non-Covered Chgs 0.00
Deductibles/Co-Ins 0.00

Patient

COB/Plan Amt Due 1,323.75 0.00

Payments 0.00 0.00
Adjs/Refunds 0.00 0.00
Balance Transfers 1,323.75CR 1,323.75

Balance Due 0.00 1,323.75

Third Party Excess 0.00
Account Balance 1,323.75

1,323.75

0.00

1,323.75

State of Illinois)
) SS
County of McHenry)

CERTIFICATION

The affiants, being duly sworn, do hereby state and certify that

1. Vicki Wheaton is employed by Centegra Health System, as Director of the Health Information Services.
2. Vicki Wheaton, as part of her employment duties in Medical Records Department, is authorized by the hospital to certify and/or testify concerning the hospital's medical record-keeping procedures, including customary practices and the completeness, accuracy, and/or authenticity of any original or copy of a hospital medical record.
3. The documents enclosed are medical records made in the regular course of the business of Centegra Health System and that it was in the regular course of such business to make such records, at the time of the act, transaction, occurrence, or event, or within a reasonable time thereafter.
4. With the exception of any documents excluded pursuant to court order, the documents enclosed are any and all records within our possession responsive to the subpoena under which the documents are being released.

Subscribed to and sworn before me this
13 day of January, 2010.

Susan Henn
Notary



Vicki Wheaton, RHIT
Vicki Wheaton, RHIT
Director, HIS
Centegra Health System

ACCOUNT NO.		ADMISSION DATE/TIME		BY	STATION ROOM	ACC	SERVICE	TYPE	AT	AS	
B11179-00323		06/28/11 0246pm		MXC	EDB		EMD	EDB	1	1	
SEX	PO	MS	BIRTHDATE	BOG SEC NO	CLEAR	AD	OD	#COUN			
M	3	S	03/19/70 41Y	323-76-4001		N			AT WORK		
PATIENT NAME AND ADDRESS						PATIENT EMPLOYER					
DULBERG, PAUL R 4606 HAYDEN CT ENGLISH (847) 497-4250 CELL#						SHARP PRINTING 4606 HAYDEN CT (847) 497-4250 SELF EMP					
MCHENRY IL 60051-7918 *MCHENRY CNTY, IL						MCHENRY IL 60050					
PREVIOUS NAME											
QUARTANT NAME AND ADDRESS						QUARTANT EMPLOYER					
DULBERG, PAUL R 4606 HAYDEN CT (847) 497-4250 SELF						SHARP PRINTING 4606 HAYDEN CT (847) 497-4250 SELF EMP					
MCHENRY IL 60051-7918 CELL#						MCHENRY IL 60050					
BOG SEC NO 323-76-4001 PHI CONTACT: Y											
EMERGENCY CONTACT/RELATIVE 1						RELATIVE 1 EMPLOYER					
DULBERG, HERBERT 4606 HAYDEN CT (847) 497-4250 *FATHER											
MCHENRY IL 60051-7918 PHI CONTACT: Y											
BOG SEC NO											
EMERGENCY CONTACT 2						PATIENT ALTERNATE ADDRESS					
DULBERG, BARBARA 4606 HAYDEN CT (847) 497-4250 *MOTHER											
MCHENRY IL 60051-7918 PHI CONTACT: Y											
INSURANCE 1						INSURANCE 2					
PAUL DULBERG/ACCIDENT 1 601067 4606 HAYDEN CT JOHNSBURG IL 60051 DOB: 03/19/70 ACCIDENT DULBERG, PAUL R 99999 999999999 (847) 497-4250						DOB:					
INSURANCE 3						INSURANCE 4					
DOB:						DOB:					
DIAGNOSIS/COMPLAINT						ATTENDING PHYSICIAN					
ER						FORD, APIWAT W					
COMMENT						ADMITTING PHYSICIAN					
						FORD, APIWAT W					
						PRIMARY CARE PHYSICIAN					
						SEK, FRANK					
						ADDITIONAL PHYSICIAN					

PRINCIPAL DIAGNOSIS

STN: ERA

COMPLICATIONS AND COMORBIDITIES

PRINCIPAL PROCEDURE & DATE

OTHER PROCEDURES & DATE

I CERTIFY THAT THE NARRATIVE DESCRIPTIONS OF THE PRINCIPAL AND SECONDARY DIAGNOSES & THE MAJOR PROCEDURES PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

SIGNATURE _____ MD DATE _____

RESTRICTIONS / RELEASE FORM



Northern Illinois Medical Center
Emergency Department
4201 Medical Center Drive
McHenry, Illinois 60050
(815) 344-5000



Memorial Medical Center
3701 Doty Rd.
Woodstock, Illinois 60098
(815) 334-3900

PATIENT NAME Paul Dulberg DATE 10/28/2011

PHYSICIAN SIGNATURE [Signature]



1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011 B 0000109381

☐ May return to ☐ work ☐ school ☐ gym without restriction.

☒ May not return to ☒ work ☐ school ☐ gym for 2 day(s).

☐ May return to school with the following restrictions:

☐ Gym/Sports restrictions are _____ for _____ day(s).

☐ Must take prescription medication for _____ day(s).

☐ May return to work with the following restrictions:

☐ No lifting greater than _____ lbs. for _____ day(s).

☐ Machinery/Driving restriction while on medication that can cause drowsiness.

☐ No continuous ☐ standing ☐ sitting for _____ day(s).

☐ Must keep _____ elevated for _____ day(s).

☐ Sedentary work only for _____ day(s).

☐ Must use crutches for _____ day(s).

☐ No overhead work for _____ day(s).

☐ No bending or twisting for _____ day(s).

☐ Must wear immobilizer for _____ day(s).

☐ No climbing on ladder or stairs for _____ day(s).

☐ Other _____

☐ See your physician in _____ days for reevaluation.

☐ LIMITED WORK WITH
☐ NO WORK WITH

☐ Right	☐ Left
☐ Hand	☐ Hand
☐ Arm	☐ Arm
☐ Foot	☐ Foot
☐ Leg	☐ Leg

For _____ Days

All patients are referred to their personal physicians or a doctor on the staff of this hospital. Release from restriction must be obtained from that doctor and not the Emergency Department.

I (or responsible person) have/has received and understand(s) the instructions to follow as noted above.

Patient signature (or responsible person):

Paul Dulberg

PRINTED BY: MRV0127

DATE

09/14/2012

EMCARE, INC

ED 102 NIMC/MMC

MEDICAL RECORDS COPY

Centegra Northern Illinois Medical Center
4201 Medical Center Drive
McHenry, IL 60050
(815) 344-5000

Patient: PAUL DULBERG, Med. Rec. #: B0000109381, Visit #:
B1117900323, Date: 06/28/2011 Time: 17:02

Home Care Instructions

IMPORTANT: We examined and treated you today on an emergency basis only. This was not a substitute for, or an effort to provide, complete medical care. In most cases, you must let your doctor check you again. Tell your doctor about any new or lasting problems. We cannot recognize and treat all injuries or illnesses in one Emergency Department visit. If you had special tests, such as EKG's or X-rays, we will review them again within 24 hours. We will call you if there are any new suggestions. You were treated today by: Ford, Apiwat W..

After your visit to our Emergency Department, you may receive a survey in the mail. We want to be sure we have given you very good care and we ask that you please fill out the survey and return it in the mail.

After you leave, please follow the instructions below.

This Information Is About Your Follow Up Care

Call as soon as possible to make an appointment to see your doctor in 10 days for suture removal. You can reach your doctor by calling their clinic phone number.

Please return to the Emergency Department in 10 days for suture removal if you would prefer to have the sutures removed in the ER. We do recommend that you follow-up with your Primary Care Physician but you can return to the ER for removal of your stitches if you choose..

This Information Is About Your Illness and Diagnosis

WOUND CARE (with stitches)

Your wound was closed with stitches. These are small threads that keep the skin closed to help it heal. You have 3 internal and 11 external stitches. These should be removed in 10 days.

At home, please follow these instructions:

- Wash your hands before touching the dressing or wound.
- Keep the wound clean and dry.
- After 2 days, wash the wound gently with warm water and soap. Pat it dry.
- Put a light dressing on it if it rubs or there is drainage.

Call your doctor if:

- you have redness, pain, or swelling in the area of your stitches.
- your wound drains pus.
- your stitches come out before your wound is healed.
- you have any new or bothersome symptoms.

This is Information About Your New Medications - Start taking as prescribed.

HYDROCODONE and ACETAMINOPHEN (Vicodin, Vicodin ES, Lortab, Lortab elixir, Zamicet, Norco, Zydone, Anexsia, Anolor, Bancap HC)

Take this medicine by mouth with food in the following dose: one 10mg/325mg tablet every 4 to 6 hours if needed for pain. Do not take more than as directed per day (24 hours).

This is a mixture of medicines (hydrocodone and acetaminophen) used to relieve moderate to severe pain. This medicine may be used for other reasons, as prescribed by your doctor.

Side effects may include:

- sleepiness or dizziness
- upset stomach, nausea or vomiting
- constipation

Other side effects may occur, but are not as common. Allergy would show up as: rash or itching, facial or throat swelling, wheezing or shortness of breath. This medicine can be habit forming if used for a long period of time.

Follow these instructions:

- Never take more of this medicine than prescribed. Too much acetaminophen in your body can cause liver damage.
- Read the labels of non-prescription medicines before taking them. Many contain acetaminophen. To avoid an overdose, do not take any other medicines that contain acetaminophen.
- Talk to your doctor or pharmacist before taking medicines for sleep, colds or allergies. Severe drowsiness may occur.
- Do not share this medicine with others as this medicine is a controlled-substance. Sharing this medicine with others is against the law.
- To avoid constipation while taking this medicine:
 - Drink plenty of liquids. Try to drink 8 to 10 eight-ounce glasses of water or juice each day.
 - Include extra fiber in your diet.
 - Exercise daily.
- Watch for signs of dependence:
 - feeling that you "cannot live without this medicine".
 - you need more of this medicine than before to get the same relief.
- Do not drink alcohol, drive or operate machinery until you know how this medicine affects you.
- Store this medicine away from heat, moisture or direct light.
- If you are taking this on a regular schedule and you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and return to your regular schedule. Do not double the doses.
- Talk with your doctor before taking any other medicines (including vitamins and herbs) as you may require additional monitoring.

Call your doctor if you have:

- any sign of dependence or allergy.
- increased pain not helped by the pain medicine.
- slow, weak breathing.
- seizures.
- slow or irregular heart beat.
- a yellow-color to your skin or eyes, or dark urine.
- stomach pain.
- unusual or extreme tiredness.
- any new or severe symptoms.

CEFADROXIL (Duricef)

Take this medicine until gone in the following dose: 500 mg by mouth 2 times a day for 5 days.

Centegra Northern Illinois Medical Center
4201 Medical Center Drive
McHenry, IL 60050
(815) 344-5000

Cefadroxil is an antibiotic used to treat infections caused by bacteria. Antibiotics kill bacteria or prevent them from growing inside your body. This medicine may be used for other reasons, as prescribed by your doctor.

Side effects may include:

- diarrhea
- upset stomach, nausea or vomiting
- headache

Other side effects may occur, but are not as common. An upset stomach is not a sign of allergy. Allergy would show up as rash or itching, facial or throat swelling, wheezing or shortness of breath.

Follow these instructions:

- Space your medicine doses evenly throughout the day. This medicine works best if there is a constant amount in your blood.
- Take this medicine with food to avoid an upset stomach.
- Swallow the capsule and tablet form of this medicine whole with a full 8-ounce glass of water.
- For diabetics, this medicine can cause false test results when testing your urine for sugar. Talk with your doctor if you have questions.
- Store the tablet or capsule form of this medicine away from heat, moisture or direct light.
- Store the liquid form of this medicine in the refrigerator. Shake the liquid well before each use.
- If you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose. Do not double the doses.
- Talk with your doctor before taking any other medicines (including vitamins and herbs) as you may require additional monitoring.

Call your doctor if you have:

- any sign of allergy.
- no improvement after you've taken all the medicine.
- a seizure.
- any sign of a new infection (fever, general aches, chills, or unusual tiredness or weakness).
- ongoing nausea, vomiting or stomach pain.
- white patches in your mouth.
- women: itching in or change in discharge from your vagina.
- inflammation (pain and swelling) in your intestine during treatment or up to weeks after you've finished this medicine:
 - ongoing diarrhea
 - stomach pain or cramping
 - blood or mucus in your bowel movements
- any new or bothersome symptoms.

SMOKING CESSATION

Smoking is the nation's leading preventable cause of death. It significantly increases the risk of coronary heart disease, stroke and cancer. In fact, more than half of all smoking related deaths in America each year are from heart disease, stroke, or other cardiovascular diseases. The good news is, that one year after quitting, the risk of heart disease is cut in half. After five to fifteen smoke-free years, the risk is that of a person who never smoked!

If you or someone you love is interested in quitting, consider joining our "Freedom From Smoking" classes for adults. Centegra Health System and the McHenry County Department of Health have partnered together to bring you an effective program that will help you quit smoking. Call 877-CENTEGRA, (877-236-8347) for more information regarding this program. To speak with a counselor immediately, call the Illinois Tobacco line at 1-866-QUIT-YES.

PAIN MANAGEMENT AFTER DISCHARGE:

A person may feel less pain just by being in familiar surroundings. Here are some frequently asked questions about your pain management:

- What can I do to help my pain management? A person's level of relaxation and their environment can affect their pain. If you are tired, over stimulated (too many visitors) are anxious about your diagnosis, or a past experience with a hospitalization, your pain perception may be impacted and your tolerance decreased. Ask questions, and inform us about any problems or concerns that you may have, re: pain. Partner with your health team for your best pain management.
- What if the medication is not working? Tell your health-care provider; physician, home health nurse, etc. You may need a different dose or type of medication.
- What if I feel I'm not getting enough pain control? Talk to your physician or home health nurse about it. Together you may be able to develop a plan to prevent or ease your pain. Depending on the cause of your pain, your health-care provider may suggest exercise, use of heat/cold, massage, repositioning, immobilization of the affected part, or distraction such as music or rest.
- There are other methods of pain management. Let your health-care provider assist you in finding the best one for you.

Weight management is one step to help maintain a healthy lifestyle. For certain medical problems, such as congestive heart failure, weight should be monitored daily.

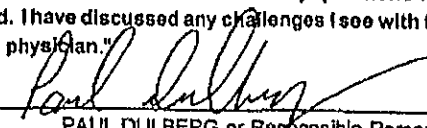
YOU ARE THE MOST IMPORTANT FACTOR IN YOUR RECOVERY.

Follow the above instructions carefully. Take your medicines as prescribed. Most important, see a doctor again as discussed.

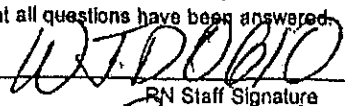
If you have problems that we have not discussed, or your problem changes or gets worse, call or visit your doctor right away. If you cannot reach your doctor, return to the Emergency Department immediately.

Centegra Health System is very concerned about your safety and well being. As part of our efforts to always provide very good care, any medications you received during this visit were reconciled with medication you are currently taking. This reconciliation was based on the information you or your representative provided regarding your current medications and allergies.

"I have received this information and my questions have been answered. I have discussed any challenges I see with this plan with the nurse or physician."


PAUL DULBERG or Responsible Person

PAUL DULBERG or Responsible Person has received this information and tells me that all questions have been answered.


RN Staff Signature

Centegra Northern Illinois Medical Center
4201 Medical Center Drive
McHenry, IL 60050
(815) 344-5000

PAUL DULBERG was discharged on 06/28/2011 at 17:06 from the hospital. The following is a summary of the discharge instructions given to PAUL before discharge:

This Information Is About Your Follow Up Care

Call as soon as possible to make an appointment to see your doctor in 10 days for suture removal. You can reach your doctor by calling their clinic phone number.

Please return to the Emergency Department in 10 days for suture removal if you would prefer to have the sutures removed in the ER. We do recommend that you follow-up with your Primary Care Physician but you can return to the ER for removal of your stitches if you choose..

This Information Is About Your Illness and Diagnosis

WOUND CARE (with stitches)

This is Information About Your New Medications - Start taking as prescribed.

HYDROCODONE and ACETAMINOPHEN (Vicodin, Vicodin ES, Lortab, Lortab elixir, Zamicet, Norco, Zydone, Anexsia, Anolor, Bancap HC).

one 10mg/325mg tablet every 4 to 6 hours if needed for pain. Do not take more than as directed per day (24 hours).

CEFADROXIL (Duricef)

500 mg by mouth 2 times a day for 5 days.

1. How are you and/or your family doing today?
2. Is your pain/or symptoms better today?
3. Did you understand your discharge instructions?
4. Are you following up with a Doctor?

Centegra Northern Illinois Medical Center
4201 Medical Center Drive
McHenry, IL 60050
(815) 344-5000

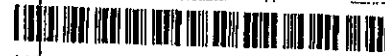
5. Comments:

Signature of nurse making phone call; _____
Date: _____ Time: _____

FORM GOES TO MEDICAL RECORDS

Centegra Health System

☒ CH - M ☐ CH - W
☐ Other (Specify) _____



1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
08/28/2011 B 0000109381

GENERAL CONSENT AND ACKNOWLEDGMENT

Account Number/Effective Date: _____

CONSENT FOR MEDICAL TREATMENT

I have come to Centegra Health System (CHS) for medical treatment and consent to the customary examinations, tests, and procedures performed on patients in my condition. I understand and consent that independent professionals (such as my attending physician, on-call physicians, emergency medicine physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, consultants, nurse practitioners, physician assistants, certified registered nurse anesthetists and other specialists) may participate in my care as deemed necessary.

I agree to follow the Patient Rights & Responsibilities of CHS and to participate with independent professionals and CHS personnel in my care and treatment.

I understand the practice of Medicine is not an exact science and, therefore, no guarantees have been made regarding the likelihood of success or outcomes of any diagnosis, treatment, test, surgery or examination performed at CHS.

I understand this General Consent and Acknowledgement will remain in effect for this episode of care and will be provided to those areas of CHS where I receive care.

I understand the language in this Consent guides and controls all other forms and consents I may sign during my treatment with Centegra Health System and any inconsistencies shall be interpreted consistent with terms of this document.

PATIENT ACKNOWLEDGMENT OF INDEPENDENT PHYSICIANS

Initials _____

I acknowledge the independent professional(s) who provide services to me at CHS are not employees or agents of CHS, but are independent medical practitioners who have been permitted to use its facilities for the care and treatment of their patients. They include but are not limited to, my attending physician, on-call physicians, emergency medicine physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, consultants, nurse practitioners, physician assistants, certified registered nurse anesthetists and other specialists. My decision to seek care is not based upon any representation or advertisement of the independent professionals and I understand they are not employees or agents of CHS. CHS bills do not include physician, surgeon, or other independent professional services and I understand I will receive a separate bill directly from the independent professional. I have read and understand the above terms and confirm I am the patient or am authorized to sign on the patient's behalf.

PATIENT ACKNOWLEDGMENT OF INDEPENDENT SERVICES

Initials _____

During the course of my hospital stay, my physician may determine I require care at another medical facility, or I may request care at an alternate facility. I acknowledge that all transportation services provided in connection with my transfer to another facility are provided by an independent third party and I will receive a separate bill directly from the service provider for which I may be responsible.

USE AND DISCLOSURE OF HEALTH INFORMATION

Unless I request otherwise, CHS will provide my room location or telephone number to visitors and callers.

I understand CHS will use and disclose my health information for the purposes of treatment, payment, and health care operations, as permitted by law as described in the CHS Notice of Privacy Practices. Certain information can be used without obtaining my consent. I fully understand that the use or disclosure of my health information may include history, diagnosis and/or diagnostic treatment of mental health/ developmental disabilities conditions, alcohol or drug abuse and Acquired Immune Deficiency Syndrome (AIDS/ HIV).

I understand that if I refuse to allow disclosure of my health information to process my insurance claim, I may be financially responsible for all costs incurred by me for treatment. I agree to release and hold harmless CHS, its agents, and employees from any liability that may arise from the use or disclosure of my health information.

PICTURES/IMAGES

Initials _____

I understand photographs, videotapes or other images may be taken to document my care. These images may be kept by CHS and/or by the independent professional involved in my care. I understand I have the right to view or obtain copies of these materials which are in possession of CHS upon written request. It is my responsibility to confirm if such photographs, videotapes or other images have been taken. I understand images identifying me will only be released as allowable under law or with my written authorization.

PRINTED BY: MRV0127

DATE 09/14/2012

GENERAL CONSENT AND ACKNOWLEDGMENT

Page 1 of 2

ADC10000-00 01/07 01/08 10/08 04/09

3CNTG





1117900323
DULBERG, PAUL R
M 341Y 03/19/1970
06/28/2011 8 0000109381

Verbal
Initials

RELEASE FROM LIABILITY FOR VALUABLES

I understand my belongings are my responsibility and I have been advised to send any items of value home. I release CHS from any liability for the loss, damage to, or theft of any of my belongings. Safes or lockers are available at the hospital facilities and may be used to store valuables.

PATIENT PRE-CERTIFICATION RESPONSIBILITY

I understand I am responsible for the notification to my insurance company to obtain authorization before service is rendered. I further understand that if I do not pre-certify I may incur a reduction or loss of paid benefits to the hospital for which I will be liable.

ASSIGNMENT OF BENEFITS/ AGREEMENT FOR PAYMENT

I hereby authorize payment to be made directly to CHS and to the Independent professional(s) for all insurance benefits otherwise payable to me. I understand I am financially responsible to CHS and independent professionals for all charges incurred. Patient "out-of-pocket" amounts will be requested prior to or upon discharge. In the event of default or non-payment, CHS shall be entitled to the right of recovery of all collection expenses, including court costs and reasonable attorney's fees for the purpose of securing payment. It is further agreed that any credit balance may be applied on any other account owed CHS by the guarantor/responsible party, or any open account for his/her dependent family.

PATIENT INFORMATION OFFERED

- | | | | |
|---|-----|-----------------|-----------------------|
| • Patient Rights/Responsibilities | Yes | <u>Declined</u> | If No, Explain: _____ |
| • Advance Directive Information | Yes | <u>Declined</u> | If No, Explain: _____ |
| • Notice of Privacy Practices | Yes | <u>Declined</u> | If No, Explain: _____ |
| • Patient Billing Information | Yes | <u>Declined</u> | If No, Explain: _____ |

PATIENT CERTIFICATION

By signing this General Consent and Acknowledgement Form, I acknowledge I have read and understand the information contained in this form and accept its terms. I also acknowledge I have received a copy of this form for my records.

INPATIENTS ONLY:

TRICARE (Military) Insurance PATIENTS _____ Yes, I have received TRICARE "Important Message"

Verbal Ren DT
Patient/Authorized Person
Biggs / JBS
Witness

Relationship _____

Date 6/28/11

I, _____, have interpreted/translated the above form to the patient. The patient has informed me he/she fully understands and agrees to the terms set out in this consent form.

Interpreter/Translator (Please Print Name) _____

Language _____

Interpretation/Translation Provider (Company name or Relationship to Patient) _____

Northern Illinois Medical Center NIMC Radiology
Patient Name: DULBERG, PAUL R
Account Number: 81117900323

Northern Illinois Medical Center

06/28/2011 10135 RIGHT FOREARM 2139703
HISTORY: Chain saw versus forearm, forearm laceration.

IMPRESSION: Right forearm films demonstrate no fracture or
radiopaque foreign body. There is deep soft tissue
laceration along the ventral surface of the mid
forearm.

FINDINGS: This exam consists of two views of the right forearm
which demonstrate deep laceration on the ventral
aspect of the mid forearm as best visualized on the
lateral view. No fracture or radiopaque foreign body
is identified.

cc: Apiwat W. Ford, D.O.
Donald R Kennard, M.D.
Frank Sek, M.D.

Electronically Authenticated
Donald R Kennard, M.D. 06/28/2011 18:18
815-759-4683

D 06/28/2011
T 06/28/2011 5:19 P / LBA
Northern Illinois Medical Center NIMC Radiology

PRINTED BY: MRV0127
DATE 09/14/2012

B1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011
0000109381

TIME TRIAGED: <u>1450</u>	BROUGHT BY:	MODE OF ARRIVAL	TREATMENT PTA	☒ Patient Band applied
TIME TO TREATMENT AREA: <u>1455</u>	☐ Self ☐ Relative	☒ SVC	☐ Ice ☐ Elevate	☐ Hand Off Communication
ED BED# <u>18</u>	☐ Police ☒ Friend	☐ Stretcher	☐ O2	Band applied
EXPRESS BED #	☐ Other	☐ Carried	☐ IV	☐ Security watch
ESI: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Ambulance: _____	☐ Walked	☐ Med:	
Primary Physician: <u>Seh</u>				
Height: <u>5'9"</u> Weight: <u>165#</u>	GCS: <u>15</u> RTS: <u>12</u> BP: <u>128</u>	P <u>75</u> R <u>14</u> T <u>97.4</u>	SPO ₂ <u>97</u>	Time of Injury: _____
				☐ Room air ☐ O ₂ Pain Level: <u>9-10</u>

Chief complaint/reason for visit: States chainsaw vs Rt arm
15 min ago at home, also feeling lightheaded

Triage RN <i>7/1/03</i>			
CURRENT MEDS ☒ Denies		ALLERGIES ☒ NKA <i>True</i>	REACTION
		Medications:	<i>6703</i>
		Food:	
		Other: ☐ Latex ☐ Dye	

Meds reviewed by: _____
 Language barrier ☐ Yes Interpreter Name/ATT Number: _____
 Do you feel safe at home? ☒ Yes ☐ No Is there anyone in your life that threatens, intimidates or harms you in any way? ☐ Yes ☒ No
 Crisis/Social Worker ☐ Notified: _____ ☐ Here: _____ ☐ DNR Resources called: _____ Time: _____

Past Medical History ☐ None	Yes ☐ Autoimmune ☐ Asthma ☐ Back problems ☐ Blood disorders ☐ Cancer ☐ Cardiovascular ☐ CHF LMP: _____ ☐ Pregnant Expanded/surgical history: <u>left arm surg</u>	Yes ☐ Dementia/ Alzheimer's ☐ Endocrine ☐ GI problems ☐ GU Problems ☐ Glaucoma ☐ HEENT problems ☐ Heart murmur ☐ Normal ☐ Abnormal ☐ No ☐ Unsure	Yes ☐ Headaches/ migraines ☐ Head inj past 3 months ☐ Hypertension ☐ MusculoSkeletal problems ☐ Neuro problems ☐ PsychoSocial problems	Yes ☐ Pressure Ulcer ☐ Recent exposure _____ ☐ Reproductive problems ☐ Respiratory problems ☐ Seizures ☐ Skin problems ☐ Vision problems	Yes ☐ Infectious diseases ☐ MRSA ☐ VRE ☐ Chicken Pox ☐ Measles ☐ Shingles ☐ Strep Throat ☐ Other: _____
	Implanted medical device: ☐ Pacemaker ☐ IV access ☐ Eye ☐ Knee ☐ Hip ☐ AICD ☐ Other: _____				
	TB History ☐ None Ever had a positive TB test? ☐ Yes ☒ No ☐ Self-history of TB ☐ Family history of TB ☐ Cough ☐ Fever ☐ Bloody sputum ☐ Weight loss ☐ Night sweats ☐ Loss of appetite ☐ Fatigue ☐ Recent international travel ☐ Denies signs & symptoms				
	Vaccine ☐ Flu ☐ Tetanus ☐ N/A ☒ Up to date ☐ >5 years ☐ Unsure ☐ Pediatric immunization ☐ Up to date ☐ No ☐ Unsure				



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B1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011
0000109381

ADMISSION ASSESSMENT

Do you currently have pain? ☒ Yes 9-10 (1-10) ☐ No If yes, is it ☐ Chronic ☐ New Onset
Type of pain: ☐ Burning ☐ Dull Pressure ☐ Cramping ☐ Heavy ☐ Sharp ☐ Achy
☐ Other: _____
Pain Scale used: ☐ Wong Baker ☐ FLACC ☐ Numeric

ALCOHOL INTAKE: ☒ Never ☐ Occasionally ☐ DAILY

Type: _____ Amount: _____ Last Drink: _____

STREET/REC DRUGS: ☒ Never ☐ Occasionally ☐ DAILY

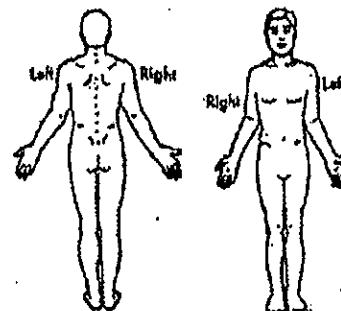
Type: _____ Amount: _____ Last Used: _____

TOBACCO HISTORY: ☐ Never ☐ Occasionally ☒ DAILY

Type: 1 PK 10 Amount: _____ Date Quit: _____

Mark drawing with number:

1. Abrasion
2. Amputation
3. Avulsion
4. Bleeding
5. Burn
6. Bruise
7. Deformity
8. Fracture
9. GSW
10. Hematoma
11. Laceration
12. Pain
13. Stab wound
14. Foreign body
15. Pressure ulcer
16. Leg ulcer



Neurological ☐ NA

LOC ☐ Yes ☐ No

☒ Conscious ☐ Unconscious

☒ Alert ☒ Oriented X 3

☐ Crying ☐ Lethargic ☐ MAE

☐ Slurred speech

☐ Irritable

☐ Combative

Pupils ☐ NA ☒ PERL R L

Reactive ☐ ☐ ☐

Sluggish ☐ ☐ ☐

Fixed ☐ ☐ ☐

Nonreactive ☐ ☐ ☐

Pupil size

AVPU ☐ A ☐ V ☐ P ☐ U

GCS: _____

FALL RISK ASSESSMENT

☐ Medically unsafe to be

☐ Independently mobile

☐ Unaware or forgetful

☐ of physical limitations

☐ Recent history of falls

ANY POSITIVE ANSWER INDICATES ENHANCED FALL RISK ☐ No risks noted

Cardiac/Circulatory: ☐ NA

☒ Pink ☐ Warm ☐ Dry ☐ Cool

☐ Hot ☐ Flushed ☐ Diaphoretic

☐ Dusky ☐ Ashen ☐ Jaundice

☐ Pale ☐ Clammy ☐ Cyanotic

RADIAL PULSES R L

Present ☒ ☒

Absent ☐ ☐

PEDAL Present: ☒

Absent ☐ ☐

Cap Refill ☒ <2 Sec ☐ >2 Sec

Ankle edema ☐ Yes ☒ No

Monitor: _____

Respiratory ☒ NA

☐ Distress ☐ None ☐ Mild

☐ Moderate ☐ Severe

☐ Stridor ☐ Nasal Flaring

☐ Retractions

☐ Productive cough: _____

☐ Unproductive cough

Lung Sounds ☐ NA R L

Clear ☒ ☒

Rales ☐ ☐

Wheezing ☐ ☐

Rhonchi ☐ ☐

Diminished ☐ ☐

Absent ☐ ☐

EENT: ☐ NA ☒ Denies

VISUAL ACUITY ☐ NA

L. _____ R. _____

☐ Correction ☐ No Correction

Ear Drainage: ☐ Yes ☐ No

Describe: _____

Epistaxis: ☐ NA R L

Controlled ☐ ☐

Uncontrolled ☐ ☐

THROAT:

☐ Diff. swallowing

☐ Diff. speaking

☐ Drooling

GI/Abdominal: ☐ NA ☐ Denies

☐ Soft ☐ Distended ☐ Firm

☒ Nontender ☐ Tender

Bowel sounds: ☐ Present ☐ Absent

☐ Hypoactive ☐ Hyperactive

Last BM: _____

☐ Diarrhea x _____ ☒ Denies

☐ Vomiting x _____ ☒ Denies

☐ Nausea ☐ Yes ☒ No

Last oral intake: _____

Comments: _____

Genito-Urinary: ☐ NA ☒ Denies

URINARY ☐ NA

☐ Frequency ☐ Pain

☐ Hematuria ☐ Incontinent

☐ Unable to void ☐ CUD

VAGINAL/PENILE ☐ NA

☐ Discharge ☐ Bleeding

Character: _____

Amount: _____

Associate Signature/Initials: WJ Dubois

Associate Signature/Initials: _____

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B1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011
0000109381

ADMISSION ASSESSMENT

Lab	MD/DO Order Time MD/DO Initial	Lab	MD/DO Order Time MD/DO Initial	Lab	MD/DO Order Time MD/DO Initial	Medical Imaging	MD/DO Order Time MD/DO Initial
☐ ABG		☐ PTT		☐ wound culture		☐ T Spine	
☐ Amylase		☐ RSV		☐		☐ LS Spine	
☐ Blood Culture		☐ Salicylate				☐ Ultrasound-	
☐ BMP		☐ Sputum culture				☐ CT Scan-Brain	
☐ BNP		☐ Strep				☐ CT Scan-C Spine	
☐ CBC w/diff		☐ Trichomonas				☐ CT Scan-Chest	
☐ CMPL		☐ Troponin ☐ POC		Other/Miscellaneous		☐ CT Scan-Chest PE	
☐ D. Oimer		☐ Tylenol		☐ O ₂		☐ CT Scan-Abd/Pelvis	
☐ Digoxin Level		☐ Type & screen		☐ EKG Time Acquired		☐ MRI	
☐ ETOH		☐ Type & cross		Time Read		☐ FAST Scan	
☐ GC/Chlamydia		☐ of units		☐ EKG Time Acquired		☐ ED Preg Ltd US	
☐ Hepatic Panel		☐ UA		Time Read		☐ ED Preg follow up US	
☐ HCG Qualitative		☐ UA/Reflex culture		Medical Imaging		☐ ED Pelvis Ltd US	
☐ HCG Quantitative		☐ Urine Culture		☐ Chest PA/Lat		☐ ED Abd Aorta US	
☐ Influenza Screen		☐ Urine Drug Screen		☐ Chest Port		☐ ED Doppler pelvis	
☐ Lipase		☐ Urine HCG		☐ C-Spine		☐ ED Venous Duplex Ext	
		☐ Pos ☐ Neg ☐ POC					
☐ MRSA		☐ Urine Dip ☐ POC		☐ X-Table		☐ ED Trauma trans echo	
☐ PT		☐ Wet prep		☐ Pelvis		☐ ED Trauma abd ltd	

MD/DO Order Time & Initials	ORB	Start Time	Stop Time	IV Solution & Amount	Warm Y/N	Additives	Site	Cath Size	Rate	Amt Infused	Initials

Pt Height: 5'09" Pt Weight: 165 Allergies: NKDA

MD/DO Order Time & Initials	ORB	Time Given	Stop Time	Pain Scale	Medication/Order	Dosage	Route	Site	Initials	Time	Effects	Pain Scale	Initials
<u>MD/DO</u>		<u>15:00</u>		<u>1/10</u>	<u>NORCO</u>	<u>10mg</u>	<u>PO</u>		<u>MD/DO</u>				<u>MD/DO</u>
<u>MD/DO</u>		<u>15:00</u>			<u>ALPRICO</u>	<u>500mg</u>	<u>PO</u>		<u>MD/DO</u>				<u>MD/DO</u>
					<u>Bupivacaine</u>	<u>0.25%</u>	<u>perid</u>	<u>PO</u>					

☐ Td 0.5mL ☐ Tdap 0.5mL ☐ TT 0.5mL Time: Site: RN: Lot# Exp Mfr ☐ VIS Given

☐ Nursing Assessment and Medication Reconciliation Reviewed

☐ Vitals Reviewed

Tech: Initials: Tech: Initials:

RN: Initials: RN: Initials:

RN: Initials: RN: Initials:



B1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011
0000109381

EMERGENCY ADMISSION ASSESSMENT

Time	Blood pressure	Pulse	Resp	Temp	SpO2	O2	GCS E/V/M	Monitor	Intake	Output
							/ / /			
							/ / /			
							/ / /			
							/ / /			
							/ / /			
							/ / /			
							/ / /			
							/ / /			
							/ / /			
Orthostatic Lying:		Sitting:		Standing:						

Treatments/Procedures:

☐ O₂ Therapy: _____ ☐ Intubated _____ ☐ Respiratory treatment: _____ Neb Tx: _____ ☐ Cont Pulse Ox _____
☐ Chest tube: _____ ☐ Time Out: _____ ☐ Eye irrigation: _____ ☐ Ear irrigation: _____
☐ NG tube # _____ @ _____ Character: _____ ☐ Gastric lavage: _____
☐ Lumbar puncture: _____ ☐ Time Out: _____ ☐ See neuro assessment sheet
☐ Pelvic exam: _____ Straight Cath/CUD @ _____ ☐ Bladder scan Amount: _____
 Blood Glucose value: _____ Time: _____ By: _____ ☐ Continuous Cardiac Monitoring
 Normal Values Age 60 or more (80-99 mg/dl), 13-60 yr. (75-99), 1 mo.-13 yr. (60-99) Critical Value less than 40 or more than 400
 Normal Value: Age newborn to 1d (40-60 mg/dl) 1d-1 Mo. (50-99) Critical Value less than 40 or more than 200

☒ Wound Care: 1 Lacer NS ☐ Dressing: _____ ☐ Ortho Care: _____ ☐ Crutches
☒ Irrigation: 1 Lacer NS ☐ Antibiotic _____ ☐ Ice Time: _____ ☐ Cast _____ ☐ Patient's own crutches
☐ Soak: _____ ☐ Adaptive _____ ☐ Elevate Time: _____ ☐ Sling _____ ☐ Crutch walking instr/ret demo
☒ Antiseptic Wash _____ ☐ 4X4 _____ ☐ Splint: _____ ☐ Tubi Grip _____ ☐ Velcro Splint: _____
☐ Other: _____ ☐ Kling _____ ☐ Knee immobilizer: _____ ☐ Posterior mold: _____
☐ Tube gauze _____ ☐ Shoulder immobilizer _____ ☐ Location: _____
☐ Steristrip _____ ☐ Ace Wrap _____ ☐ Width: _____
 Isolation Type: _____ ☐ Burn dressing _____ ☐ SMV's after immobilization _____ ☐ Length: _____

DISPOSITION: ☒ Home ☐ Jail ☐ Nursing home/ECC

☐ Other facility: _____ ☐ Expired ☐ AMA

Mode: ☒ W/C ☐ Walk ☐ Carry ☐ Ambulance: _____

☐ Other: _____

LEFT WITH: ☐ Self ☐ Family ☒ Friend ☐ Police

☒ Discharge instructions given-expresses understanding

☒ Discharge Pain Level: 4 (0-10) GCS: 15 RTS: _____

☒ Discharge by: WIDOBIC @ 1713

Discharge Vital Signs:

Discharge Summary:

RN: WIDOBIC

Tech: Rebecca Roth

Initials: WIDOBIC

☐ Inpatient ☐ Observation ☐ Surgical

☐ Mode: _____ Time: _____ Accompanied by: _____

☐ ER hold from _____ to _____

☐ To unit/room # _____

☐ No old chart ☐ Old chart in ED ☐ Chart to floor

☐ Discharge Pain Level: _____ (0-10)

GCS: _____ RTS: _____

Skin Integrity Intact ☐ Yes ☐ No (see documentation)

EMERGENCY ADMISSION ASSESSMENT
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DATE 09/14/2012

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06

Centegra HealthSystem

EMERGENCY PHYSICIAN RECORD

Upper Extremity Injury (4)

DATE: 6/28/11 TIME: 1457 ☐ on arrival
 ROOM: 18 EMS Arrival ☐
 EMS treatments ordered _____
 HISTORIAN: ☒ patient ☐ spouse ☐ paramedics
 HX / EXAM LIMITED BY: _____

HPI

chief complaint: Injury to: right / left
 hand wrist forearm elbow arm
 shoulder collar-bone area

duration / occurred:
 just prior to arrival _____
 today _____
 yesterday _____
 _____ days ago

where:
 home _____ school _____
 neighbor's _____ park _____
 work _____ street _____

severity of pain:
 mild _____ moderate _____ severe _____
 worse / persistent since _____
 pain intermittent / lasting _____

context: fall blow incised crushed burn

associated symptoms: tingling / numbness distally _____

ROS

suspected FB (skin lac) _____ trouble breathing / chest pain _____
 loss feeling / power arms / legs _____ loss of bladder function _____
 headache / neck pain _____ recent fever / illness _____
 double vision / hearing loss _____ other injuries _____
 nausea / vomiting _____ ☐ all systems neg except as marked

SOCIAL HX smoker ☒ drug use / abuse _____
 recent ETOH _____ lives alone _____
 lives at home _____ lives in nursing home _____

FAMILY HX negative

PAST HX ☒ negative R / L HANDED prior injury _____
 diabetes Type 1 Type 2 diet / oral / insulin _____
 HTN heart disease Diabetes Mellitus _____
 Meds- none / see nurses note _____
 Allergies- NKDA / see nurses note _____

☒ Nursing Assessment Reviewed ☒ Vitals Reviewed ☐ Tetanus Immun. UTD

PHYSICAL EXAM

GENERAL APPEARANCE c-collar (PTA / In ED) / backboard _____
 no acute distress _____ mild / moderate / severe distress _____
 alert _____ anxious _____

EXTREMITIES

HAND
 see diagram _____
 tenderness soft-tissue / bony _____
 swelling / ecchymosis _____
 deformity _____

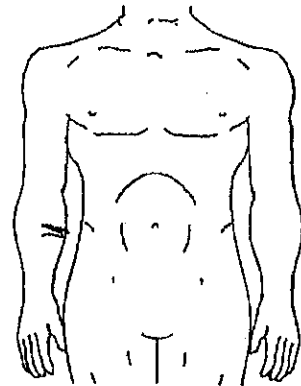
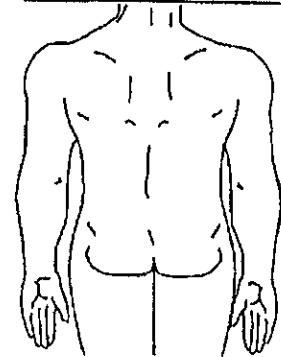
WRIST
 see diagram _____
 tenderness soft-tissue / bony _____
 tenderness in anatomical snuff box _____
 wrist pain on axial thumb load _____
 swelling / ecchymosis _____
 limited ROM _____
 deformity _____

FOREARM / ELBOW
 nml inspection _____
 non-tender _____
 nml ROM* _____

ARM / SHOULDER
 nml inspection _____
 non-tender _____
 nml ROM* _____

☒ see diagram _____
 tenderness soft-tissue / bony _____
 swelling / ecchymosis _____
 limited ROM _____
 deformity ✓ _____

☒ see diagram _____
 tenderness soft-tissue / bony _____
 swelling / ecchymosis _____
 limited ROM _____
 deformity _____



T=Tenderness PtT=Point Tenderness S=Swelling E=Ecchymosis B=Burn C=Cantusion
 L=Laceration A=Abraction M=Muscle spasm PW=Puncture Wound
 (0=without m=mild mod=moderate n=severe)
 Example: Tw = Tenderness on palpation (severe)

NEURO / VASC / TENDON

sensation intact _____ sensory / motor deficit _____
 motor intact _____
 no vascular _____
 compromise _____
 tendon function normal _____
 pallor / cool skin / abnml cap refill _____
 pulse deficit radial ulnar _____
 deficit in tendon function _____





B1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011
0000109381

SKIN _____
warm, dry _____
HEAD / ENT _____
nml inspection _____
pharynx nml _____
NECK / BACK _____
nml inspection _____
non-tender _____
RESPIRATORY _____
chest non-tender _____
breath snds nml _____
CVS _____
heart sounds nml _____
GI (ABDOMEN) _____
non-tender _____
no organomegaly _____
nml bowel snds* _____
diaphoretic / cool / cyanotic _____
tenderness _____
swelling / ecchymosis _____
tenderness _____
swelling / ecchymosis _____
tenderness _____
swelling / ecchymosis / abrasions _____
crepitus / subcutaneous emphysema _____
decreased breath sounds _____
wheezes / rales / rhonchi _____
tachycardia / bradycardia _____
tenderness / guarding _____

PROCEDURES

Wound Description / Repair
length 8cm location R FOREARM BELLY
linear _____ irregular _____ flap _____ stellate _____
superficial _____ subcut _____ muscle _____ through-and-through _____
contused tissue _____ lip laceration _____
clean _____ contaminated _____ minimally _____ moderately / *heavily _____
with _____
distal NVT: neuro & vascular status intact no tendon injury
anesthesia: local LET / tetracaine / adrenaline / cocaine 15 mL
marcaine 0.25% 0.5% lidoc 1% 2% epi / bicarb digital / metacarpal block
moderate sedation required; see attached 23d template
prep: SAURCLENS TORN
Betadine / scrub _____
irrigated / washed w/ saline 1L MAC debrided _____
minimal / mod. / *extensive _____ minimal / mod. / *extensive _____
wound explored _____ undermined _____
foreign material removed _____ minimal / mod. / *extensive _____
partially completely _____ *wound margins revised _____
minimal / mod. / *extensive _____ multiple flaps aligned _____
no foreign body identified _____
repair: Wound closed with: wound adhesive / start-strips _____
SKIN- # 11 4-0 nylon / prolene / staples _____
interrupted running simple mattress (h/v) _____
*SUBCUT- # 3 4-0 vicryl / chromic _____
interrupted running simple mattress (h/v) _____
OTHER- # _____ -0 material _____
interrupted running simple mattress (h/v) _____
*may indicate intermediate repair *may indicate complex repair

splint Vekro OGI / Ortho-glass / Plaster Aluminum-foam _____
Valar Thumb spica Ulnar Wrist Sugar-Tong Cock-up Colles _____
applied by ED Physician / Orthopedist / Tech _____
examined post splint application NV intact alignment good _____
deformity reduced no compartment syndrome _____
sling _____
nursemaid's elbow reduced with supination _____
foreign body removed with forceps with incision _____
closed reduction finger traps traction _____

Underline indicates organ system

* equivalent or minimum required for organ system

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XRAYS ☐ Interp. by me ☐ Reviewed by me ☐ Discard w/ radiologist
R/L hand wrist forearm elbow humerus shoulder
normal / NAD DJO
no fracture _____
nml alignment _____
no foreign body _____
dislocation _____
soft-tissue swelling _____
positive anterior fat-pad sign _____
positive posterior fat-pad sign _____
foreign body _____
fracture non-displaced displaced _____
transverse oblique comminuted angulated _____
impacted torus _____
Other study: _____
☐ See separate report

PROGRESS

Time _____ unchanged _____ improved _____ re-examined _____

Initial fracture care provided: follow-up on _____
Rx given _____
referred to / discussed with Dr. _____
will see patient in: ED / hospital / office in _____ days

CLINICAL IMPRESSION Fall Alleged Assault

Contusion R/L shoulder forearm wrist
Hematoma arm elbow hand
Sprain / Strain _____
Dislocation _____
Laceration _____
Fracture R/L radius distal / shaft / proximal
ulna distal / shaft / proximal / ulnar styloid
humerus distal / shaft / proximal / supracondylar
Colles fracture stabilized / restorative

DISPOSITION- ☐ transferred ☒ home ☐ admitted ☐ expired
Time _____ ☐ AMA
CONDITION- ☐ good ☒ fair ☐ poor ☐ critical ☒ improved
☐ stable ☐ unchanged

RESIDENT / PA / NP SIGNATURE

ATTENDING NOTE:
Resident / PA / NP's history reviewed, patient interviewed and examined.
Briefly, pertinent HPI is: _____
My personal exam of patient reveals: _____
Assessment and plan reviewed with resident / midlevel. Lab and ancillary studies show: _____
I confirm the diagnosis of: _____
Care plan reviewed. Patient will need: _____
Please see resident / midlevel note for details.

Physician Signature

RTI #

turned care over at

Physician Signature

RTI #

assumed care at

☐ Template Complete ☐ Additional T-Sheet

ACCOUNT NO. B11179-00323		ADMISSION DATE/TIME 06/28/11 0246pm		BY MXC	STATION ROOM EDB -		ACC	SERVICE	TYPE	AT	AS	UNIT NO./MEDICAL RECORD NO. B0000109381
SEX M	AGE 3	BIRTHDATE 03/19/70 41Y	DOC SEC NO 323-76-4001	CLEPNOY N	AD	OD	INJURY AT WORK		FMD	EDB	1	1
PATIENT NAME AND ADDRESS DULBERG, PAUL R 4606 HAYDEN CT MCHENRY IL 60051-7918 *MCHENRY CNTY, IL						PATIENT EMPLOYER SHARP PRINTING 4606 HAYDEN CT MCHENRY IL 60050 (847) 497-4250 SELF EMP						
PREVIOUS NAME DULBERG, PAUL R 4606 HAYDEN CT MCHENRY IL 60051-7918 CELL# 323-76-4001 PHI CONTACT: Y						GUARANTOR EMPLOYER SHARP PRINTING 4606 HAYDEN CT MCHENRY IL 60050 (847) 497-4250 SELF EMP						
EMERGENCY CONTACT / RELATIVE 1 DULBERG, HERBERT 4606 HAYDEN CT MCHENRY IL 60051-7918 PHI CONTACT: Y						RELATIVE 1 EMPLOYER						
EMERGENCY CONTACT 2 DULBERG, BARBARA 4606 HAYDEN CT MCHENRY IL 60051-7918 PHI CONTACT: Y						PATIENT ALTERNATE ADDRESS						
INSURANCE 1 PAUL DULBERG/ACCIDENT 1 601067 4606 HAYDEN CT JOHNSBURG IL 60051 DOB: 03/19/70 ACCIDENT DULBERG, PAUL R 99999 999999999 (847) 497-4250						INSURANCE 2 DOB:						
INSURANCE 3 DOB:						INSURANCE 4 DOB:						
MISC. DIAGNOSIS/COMPLAINT TBR OCCLUSION						ATTENDING PHYSICIAN FORD, APIWAT W			PRIMARY CARE PHYSICIAN SEK, FRANK			
						ADMITTING PHYSICIAN FORD, APIWAT W			ADDITIONAL PHYSICIAN			

PRINCIPAL DIAGNOSIS

COMPLICATIONS AND COMORBIDITIES

PRINCIPAL PROCEDURE & DATE

OTHER PROCEDURES & DATE

STN: ERA

I CERTIFY THAT THE NARRATIVE DESCRIPTIONS OF THE PRINCIPAL AND SECONDARY DIAGNOSES & THE MAJOR PROCEDURES PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

SIGNATURE _____ M D DATE _____

Northern Illinois Medical Center NIMC Radiology
Patient Name: DULBERG, PAUL R
Account Number: B1117900323

Northern Illinois Medical Center

06/28/2011 10135 RIGHT FOREARM 2139703
HISTORY: Chain saw versus forearm, forearm laceration.

IMPRESSION: Right forearm films demonstrate no fracture or
radiopaque foreign body. There is deep soft tissue
laceration along the ventral surface of the mid
forearm.

FINDINGS: This exam consists of two views of the right forearm
which demonstrate deep laceration on the ventral
aspect of the mid forearm as best visualized on the
lateral view. No fracture or radiopaque foreign body
is identified.

CC: Apiwat W. Ford, D.O.
Donald R Kennard, M.D.
Frank Sek, M.D.

Electronically Authenticated
Donald R Kennard, M.D. 06/28/2011 18:18
815-759-4683

D 06/28/2011
T 06/28/2011 5:19 P / LBA
Northern Illinois Medical Center NIMC Radiology

PRINTED BY: SJS0422
DATE 12/08/2011

B1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011
0000109381

TIME TRIAGED: <u>1450</u>	BROUGHT BY: ☐ Self ☐ Relative ☐ Police ☒ Friend ☐ Other Ambulance: _____	MODE OF ARRIVAL ☒ W/C ☐ Stretcher ☐ Carried ☐ Walked	TREATMENT PTA ☐ Ice ☐ Elevate ☐ O2 ☐ IV ☐ Med: _____	☒ Patient Band applied ☐ Hand Off Communication Band applied ☐ Security watch
TIME TO TREATMENT AREA: <u>1455</u>				
ED BED# <u>75</u>				
EXPRESS BED# _____				
ESI: ☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5				
Primary Physician: <u>Sek</u>				
Height: <u>5'9"</u> Weight: <u>165#</u>	GCS: <u>15</u> RTS: <u>12</u> BP: <u>75</u> P: <u>75</u> R: <u>16</u> T: <u>97.4</u> SPO ₂ : <u>97</u>			Time of Injury: _____
				☐ Room air ☐ O ₂ Pain Level: <u>9-10</u>

Chief complaint/reason for visit: States chainsaw vs Rt arm
15 min ago @ home, she feeling lightheaded

[illegible]

Other: ☐ Latex ☐ Dye

Meds reviewed by: _____

Language barrier ☐ Yes Interpreter Name/ATT Number: _____

Residence: ☐ Private ☒ Family ☐ Alone ☐ Nursing home ☐ Group home

Do you feel safe at home? ☒ Yes ☐ No Is there anyone in your life that threatens, intimidates or harms you in any way? ☐ Yes ☒ No

Crisis/Social Worker ☐ Notified: _____ ☐ Here: _____ ☐ DNR Resources called: _____ Time: _____

Past Medical History	☐ None ☐ Yes ☐ Autoimmune ☐ Asthma ☐ Back problems ☐ Blood disorders ☐ Cancer ☐ Cardiovascular ☐ CHF LMP: _____ ☐ Pregnant	☐ None ☐ Yes ☐ Dementia/ Alzheimer's ☐ Endocrine ☐ GI problems ☐ GU Problems ☐ Glaucoma ☐ HEENT problems ☐ Heart murmur ☐ Normal ☐ Abnormal ☐ No ☐ Unsure	☐ None ☐ Yes ☐ Headaches/ migraines ☐ Head inj past 3 months ☐ Hypertension ☐ MusculoSkeletal problems ☐ Neuro problems ☐ PsychoSocial problems	☐ None ☐ Yes ☐ Pressure Ulcer ☐ Recent exposure _____ ☐ Reproductive problems ☐ Respiratory problems ☐ Seizures ☐ Skin problems ☐ Vision problems	☐ None ☐ Yes ☐ Infectious diseases ☐ MRSA ☐ VRE ☐ Chicken Pox ☐ Measles ☐ Shingles ☐ Strep Throat ☐ Other: _____
	Expanded/surgical history: <u>LT arm surg</u>				
	Implanted medical device: ☐ Pacemaker ☐ IV access ☐ Eye ☐ Knee ☐ Hip ☐ AICD ☐ Other: _____				
TB History	☐ None Ever had a positive TB test? ☐ Yes ☒ No ☐ Self-history of TB ☐ Family history of TB ☐ Cough ☐ Fever ☐ Bloody sputum ☐ Weight loss ☐ Night sweats ☐ Loss of appetite ☐ Fatigue ☐ Recent international travel ☐ Denies signs & symptoms				
Vaccine	☐ Flu ☐ Tetanus ☐ N/A ☒ Up to date ☐ >5 years ☐ Unsure ☐ Pediatric immunization ☐ Up to date ☐ No ☐ Unsure				





B1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011
0000109381

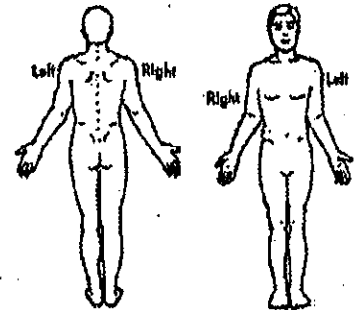
ADMISSION ASSESSMENT

Do you currently have pain? ☒ Yes 9-10 (1-10) ☐ No If yes, is it ☐ Chronic ☐ New Onset
Type of pain: ☐ Burning ☐ Dull Pressure ☐ Cramping ☐ Heavy ☐ Sharp ☐ Achy
☐ Other: _____
Pain Scale used: ☐ Wong Baker ☐ FLACC ☐ Numeric

ALCOHOL INTAKE: ☒ Never ☐ Occasionally ☐ DAILY
Type: _____ Amount: _____ Last Drink: _____
STREET/REC DRUGS: ☒ Never ☐ Occasionally ☐ DAILY
Type: _____ Amount: _____ Last Used: _____
TOBACCO HISTORY: ☐ Never ☐ Occasionally ☒ DAILY
Type: 1 PK 10 Amount: _____ Date Quit: _____

Mark drawing with number:

1. Abrasion
2. Amputation
3. Avulsion
4. Bleeding
5. Burn
6. Bruise
7. Deformity
8. Fracture
9. GSW
10. Hematoma
11. Laceration
12. Pain
13. Stab wound
14. Foreign body
15. Pressure ulcer
16. Leg ulcer



Neurological ☐ NA
LOC ☐ Yes ☐ No
☒ Conscious ☐ Unconscious
☒ Alert ☒ Oriented X 3
☐ Crying ☐ Lethargic ☐ MAE
☐ Slurred speech
☐ Irritable
☐ Combative
Pupils ☐ NA ☒ PERL R L
Reactive ☐ ☐
Sluggish ☐ ☐
Fixed ☐ ☐
Nonreactive ☐ ☐
Pupil size
AVPU ☐ A ☐ V ☐ P ☐ U
GCS: _____

Cardiac/Circulatory: ☐ NA
☒ Pink ☐ Warm ☐ Dry ☐ Cool
☐ Hot ☐ Flushed ☐ Diaphoretic
☐ Dusky ☐ Ashen ☐ Jaundice
☐ Pale ☐ Clammy ☐ Cyanotic
RADIAL PULSES R L
Present ☒ ☒
Absent ☐ ☐
PEDAL Present: ☒ ☒
Absent ☐ ☐
Cap Refill ☒ <2 Sec ☐ >2 Sec
Ankle edema ☐ Yes ☒ No
Monitor: _____

Lung Sounds ☐ NA R L
Clear ☒ ☒
Rales ☐ ☐
Wheezing ☐ ☐
Rhonchi ☐ ☐
Diminished ☐ ☐
Absent ☐ ☐

EENT: ☐ NA ☒ Denies
VISUAL ACUITY ☐ NA
L: _____ R: _____
☐ Correction ☐ No Correction

Ear Drainage: ☐ Yes ☐ No
Describe: _____
Epistaxis: ☐ NA R L
Controlled ☐ ☐
Uncontrolled ☐ ☐
THROAT:
☐ Diff. swallowing
☐ Diff. speaking
☐ Drooling

GI/Abdominal: ☐ NA ☐ Denies
☐ Soft ☐ Distended ☐ Firm
☐ Nontender ☐ Tender
Bowel sounds: ☐ Present ☐ Absent
☐ Hypoactive ☐ Hyperactive
Last BM: _____
☐ Diarrhea x _____ ☒ Denies
☐ Vomiting x _____ ☒ Denies
☐ Nausea ☐ Yes ☒ No
Last oral intake: _____
Comments: _____

Genito-Urinary: ☐ NA ☒ Denies
URINARY ☐ NA
☐ Frequency ☐ Pain
☐ Hematuria ☐ Incontinent
☐ Unable to void ☐ CUD
VAGINAL/PENILE ☐ NA
☐ Discharge ☐ Bleeding
Character: _____
Amount: _____

FALL RISK ASSESSMENT

☐ Medically unsafe to be
independently mobile
☐ Unaware or forgetful
of physical limitations
☐ Recent history of falls

Respiratory ☒ NA
☐ Distress ☐ None ☐ Mild
☐ Moderate ☐ Severe
☐ Stridor ☐ Nasal Flaring
☐ Retractions
☐ Productive cough: _____
☐ Unproductive cough

ANY POSITIVE ANSWER INDICATES ENHANCED FALL RISK ☐ No risks noted

1455 Pt accompanied to ED by co-worker for 40
laceration of chin saw to (R) forehead. Pt
out to X-ray (1505). Pt back in ER (1518)
Dr Ford at (1522) Pt medicated
as ordered. Wound irrigated and
cleaned. Dr Ford for sutures (1713) Dr
instructions to pt. All questions addressed.
Pt verbalized understanding.

Associate Signature/Initials: WJ DUBO

Associate Signature/Initials: _____



B1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011
0000109381

ADMISSION ASSESSMENT

Lab	MD/DO Order Time MD/DO Initials	Lab	MD/DO Order Time MD/DO Initial	Lab	MD/DO Order Time MD/DO Initial	Medical Imaging	MD/DO Order Time MD/DO Initial
☐ ABG		☐ PTT		☐ wound culture		☐ T Spine	
☐ Amylase		☐ RSV		☐		☐ LS Spine	
☐ Blood Culture		☐ Salicylate				☐ Ultrasound-	
☐ BMP		☐ Sputum culture				☐ CT Scan-Brain	
☐ BNP		☐ Strep				☐ CT Scan-C Spine	
☐ CBC w/dif		☐ Trichomonas				☐ CT Scan-Chest	
☐ CMPL		☐ Troponin ☐ POC		Other/Miscellaneous		☐ CT Scan-Chest PE	
☐ D. Dimer		☐ Tylenol		☐ O ₂		☐ CT Scan-Abd/Pelvis	
☐ Digoxin Level		☐ Type & screen		☐ EKG Time Acquired		☐ MRI	
☐ ETOH		☐ Type & cross		Time Read		☐ FAST Scan	
☐ GC/Chlamydia		☐ of units		☐ EKG Time Acquired		☐ ED Preg Ltd US	
☐ Hepatic Panel		☐ UA		Time Read		☐ ED Preg follow up US	
☐ HCG Qualitative		☐ UA/Reflex culture		Medical Imaging		☐ ED Pelvis Ltd US	
☐ HCG Quantitative		☐ Urine Culture		☐ Chest PA/Lat		☐ ED Abd Aorta US	
☐ Influenza Screen		☐ Urine Drug Screen		☐ Chest Port		☐ ED Doppler pelvis	
☐ Lipase		☐ Urine HCG		☐ C-Spine		☐ ED Venous Duplex Ext	
☐ MRSA		☐ Pos ☐ Neg ☐ POC		☐ X-Table		☐ ED Trauma trans echo	
☐ PT		☐ Urine Dip ☐ POC		☐ Pelvis		☐ ED Trauma abd lld	
		☐ Wet prep					

MD/DO Order Time & Initials	ORB	Start Time	Stop Time	IV Solution & Amount	Warm Y/N	Additives	Site	Cath Size	Rate	Amt Infused	Initials

Pt Height: 5'09" Pt Weight: 165 Allergies: NKDA

MD/DO Order Time & Initials	ORB	Time Given	Stop Time	Pain Scale	Medication/Order	Dosage	Route	Site	Initials	Time	Effects	Pain Scale	Initials
					WORLD 10mg PO								
					ADAMICIN 500mg								
					Epurcaine 0.25% perior FROD								

☐ Td 0.5mL ☐ Tdap 0.5mL ☐ TT 0.5mL Time: Site: RN: Lot# Exp Mfr ☐ VIS Given
☐ Nursing Assessment and Medication Reconciliation Reviewed
☐ Vitals Reviewed

Tech: Initials: Tech: Initials:
RN: Initials: RN: Initials:
RN: Initials: RN: Initials:

B1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011
0000109381

Time	Blood pressure	Pulse	Resp	Temp	SpO2	O2	GCS E/V/M	Monitor	Intake	Output
							/ \			
							/ \			
							/ \			
							/ \			
							/ \			
							/ \			
	Orthostatic	Lying:	Sitting:	Standing:			/ \			

Examinations/Procedures:

☐ O₂ Therapy: _____ ☐ Intubated _____ ☐ Respiratory treatment: _____ ☐ Neb Tx: _____ ☐ Cont Pulse Ox _____

☐ Chest tube: _____ ☐ Time Out: _____ ☐ Eye irrigation: _____ ☐ Ear irrigation: _____

☐ NG tube # _____ @ _____ Character: _____ ☐ Gastric lavage: _____

☐ Lumbar puncture: _____ ☐ Time Out: _____ ☐ See neuro assessment sheet

☐ Pelvic exam: _____ Straight Cath/CUD @ _____ ☐ Bladder scan Amount: _____

Blood Glucose value: _____ Time: _____ By: _____ ☐ Continuous Cardiac Monitoring

Normal Values Age 60 or more (80-99 mg/dl), 13-60 yr. (75-99), 1 mo.-13 yr. (60-99) Critical Value less than 40 or more than 400

Normal Value: Age newborn to 1d (40-60 mg/dl) 1d-1 Mo. (50-99) Critical Value less than 40 or more than 200

- ☒ Wound Care: 1 liter NS
☐ Dressing: _____
 ☐ Ortho Care: _____
 ☐ Crutches
- ☒ Irrigation: _____
 ☐ Antibiotic
 ☐ Ice Time: _____
 ☐ Cast
 ☐ Patient's own crutches
- ☐ Soak: _____
 ☐ Adaptic
 ☐ Elevate Time: _____
 ☐ Sling
 ☐ Crutch walking instr/ret demo
- ☒ Antiseptic Wash
 ☐ 4X4
 ☐ Splint: _____
 ☐ Tubi Grip
 ☐ Velcro Splint: _____
- ☐ Other: _____
 ☐ Kling
 ☐ Knee immobilizer: _____
 ☐ Posterior mold: _____
- ☐ Tube gauze
 ☐ Shoulder immobilizer
 ☐ Location: _____
- ☐ Steri-strip
 ☐ Ace Wrap
 ☐ Width: _____
- ☐ Burn dressing
 ☐ SMV's after immobilization
 ☐ Length: _____
- Isolation Type: _____

DISPOSITION: ☒ Home ☐ Jail ☐ Nursing home/ECC
☐ Other facility: _____ ☐ Expired ☐ AMA
 Mode: ☒ W/C ☒ Walk ☐ Carry ☐ Ambulance: _____
☐ Other: _____
 LEFT WITH: ☐ Self ☐ Family ☒ Friend ☐ Police
☒ Discharge Instructions given-expresses understanding
☒ Discharge Pain Level: 4 (0-10) GCS: 15 RTS: _____
☒ Discharge by: _____ WPD/BJL

☐ Inpatient ☐ Observation ☐ Surgical
☐ Mode: _____ Time: _____ Accompanied by: _____
☐ ER hold from _____ to _____
☐ To unit/room # _____
☐ No old chart ☐ Old chart in ED ☐ Chart to floor
☐ Discharge Pain Level: _____ (0-10)
 GCS: _____ RTS: _____

Skin Integrity Intact ☐ Yes ☐ No (see documentation)

Discharge Vital Signs:

Discharge Summary

RN: [Signature] Initials: [Signature]
Tech: [Signature] Initials: [Signature]

EMERGENCY ADMISSION ASSESSMENT
PRINTED BY: SJS0422
DATE 12/08/2011

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06

Centegra Health System

EMERGENCY PHYSICIAN RECORD

Upper Extremity Injury (4)

DATE: 6/28/11 TIME: 1457 ☐ on arrival
 ROOM: 18 EMS Arrival ☐
 EMS treatments ordered _____
 HISTORIAN: (patient) spouse paramedics
 HX / EXAM LIMITED BY: _____

HPI

chief complaint: injury to: right / left
 hand wrist forearm elbow arm
 shoulder collar-bone area

duration / occurred:
 just prior to arrival _____
 today _____
 yesterday _____ days ago _____

where:
 home school
 neighbor's park
 work street

severity of pain:
 mild moderate severe worse / persistent since _____
 pain intermittent / lasting _____

context: fall blow incised crushed burn

associated symptoms: tingling / numbness distally

ROS

suspected FB (skin lac) _____ trouble breathing / chest pain _____
 loss feeling / power arms / legs _____ loss of bladder function _____
 headache / neck pain _____ recent fever / illness _____
 double vision / hearing loss _____ other injuries _____
 nausea / vomiting _____ ☐ all systems neg except as marked

SOCIAL HX

smoker + drug use / abuse _____
 recent ETOH _____ lives alone _____
 lives at home + lives in nursing home _____

FAMILY HX

negative

PAST HX

negative R/L HANDED prior injury _____
 diabetes Type 1 Type 2 diet / oral / insulin _____
 HTN heart disease DEGENERATIVE DISC
 Meds- none / see nurses note _____
 Allergies- NKDA / see nurses note _____

☒ Nursing Assessment Reviewed ☒ Vitals Reviewed ☐ Tetanus Immun. UTD

PHYSICAL EXAM

GENERAL APPEARANCE c-collar (PTA / in ED) / backboard
 no acute distress _____ mild/moderate/severe distress _____
 alert _____ anxious _____

EXTREMITIES

HAND

see diagram
 tenderness soft-tissue / bony _____
 swelling / ecchymosis _____
 deformity _____

WRIST

see diagram
 tenderness soft-tissue / bony _____
 tenderness in anatomical snuff box _____
 wrist pain on axial thumb load _____
 swelling / ecchymosis _____
 limited ROM _____
 deformity _____

FOREARM / ELBOW

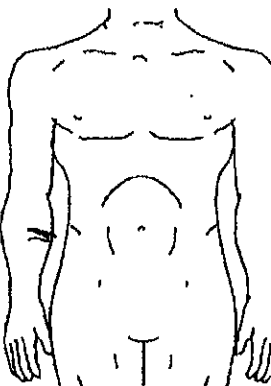
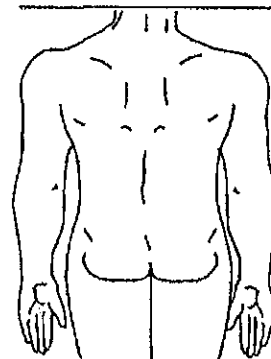
☐ nml inspection
☐ non-tender
☒ nml ROM*

ARM /

SHOULDER

☐ nml inspection
☐ non-tender
☒ nml ROM*

☒ see diagram
 tenderness soft-tissue / bony _____
 swelling / ecchymosis _____
 limited ROM _____
 deformity +
 see diagram
 tenderness soft-tissue / bony _____
 swelling / ecchymosis _____
 limited ROM _____
 deformity _____



T=Tenderness Pt=Point Tenderness S=Swelling E=Ecchymosis B=Burn C=Contusion
 L=Laceration A=Abrasion M=Muscle spasm PW=Puncture Wound
 (D=without M=mild Mod=moderate N=severe)
 Example: Tiv = Tenderness on palpation (severe)

NEURO / VASC / TENDON

sensation intact _____ sensory / motor deficit _____
☒ motor intact _____
☒ no vascular _____
 compromise _____ pallor / cool skin / abnml cap refill _____
☒ tendon function _____ pulse deficit radial ulnar _____
 normal _____ deficit in tendon function _____



NIMC orders @ 5710970000

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DULBERG, PAUL R

M 41Y 03/19/1970

06/28/2011

0000109381

SCALP LACERATION
 R/FOR BARM BELY



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DULBERG, PAUL R

M 41Y 03/19/1970

08/28/2011

0000109381

SKIN _____ diaphoretic / cool / cyanotic _____
 warm, dry _____

HEAD / ENT _____
 nml inspection _____
 pharynx nml _____

NECK / BACK _____
 nml inspection _____
 non-tender _____

RESPIRATORY _____
 chest non-tender _____
 breath snds nml _____

CVS _____
 heart sounds nml _____

GI (ABDOMEN) _____
 non-tender _____
 no organomegaly _____
 nml bowel snds* _____

PROCEDURES

Wound Description / Repair
 length 8cm location R FOREARM BELLY
 linear _____ irregular _____ flap _____ stellate _____
 superficial _____ subcut _____ muscle _____ through-and-through _____
 contused tissue _____ lip laceration _____
 clean _____ contaminated (minimally/moderately/heavily) _____
 with _____

distal NVT: neuro & vascular status intact no tendon injury
anesthesia: local LET / tetracaine / adrenaline / cocaine 15 mL
marcaine 0.25% 0.5% lidoc 1% 2% epi / bicarb digital / metacarpal block
☐ moderate sedation required; see attached 23d template
prep: SURGICENS TORN
 Betadine / scrub _____
 irrigated / washed w/ saline 1L MAR debrided _____
 minimal / mod. / *extensive _____
 wound explored _____ undermined _____
 foreign material removed _____ minimal / mod. / *extensive _____
 partially completely _____ *wound margins revised _____
 minimal / mod. / *extensive _____ multiple flaps aligned _____
 no foreign body identified _____

repair: Wound closed with: wound adhesive / start-strips _____
SKIN- # 11 4-0 nylon / prolene / staples _____
 interrupted running simple mattress (h/v) _____
***SUBCUT-** # 3 4-0 vicryl / chromic _____
 interrupted running simple mattress (h/v) _____
OTHER- # _____ -0 material _____
 interrupted running simple mattress (h/v) _____
 *may indicate intermediate repair *may indicate complex repair

splint: Vekro OCL / Ortho-glass / Plaster Aluminum-foam _____
 Volar Thumb spica Ulnar Wrist Sugar-Tong Cock-up Colles _____
 applied by ED Physician / Orthopedist / Tech _____
 examined post splint application NV intact alignment good _____
 deformity reduced no compartment syndrome _____

sling _____
 nursemaid's elbow reduced with supination _____
 foreign body removed with forceps with incision _____
 closed reduction finger traps traction _____

XRAYs ☐ Interp. by me ☐ Reviewed by me ☐ Disc'd w/ radiologist
(R) L hand wrist forearm elbow humerus shoulder
 normal / NAD _____
 no fracture _____
 nml alignment _____
 no foreign body _____

DJD _____
 dislocation _____
 soft-tissue swelling _____
 positive anterior fat-pad sign _____
 positive posterior fat-pad sign _____
 foreign body _____
 fracture non-displaced displaced _____
 transverse oblique comminuted angulated _____
 impacted torus _____

Other study: _____
☐ See separate report

PROGRESS

Time _____ unchanged _____ improved _____ re-examined _____

initial fracture care provided: follow-up on _____
 Rx given _____
 referred to / discussed with Dr. _____
 will see patient in: ED / hospital / office in _____ days

CLINICAL IMPRESSION

Fall Alleged Assault

Contusion R / L shoulder forearm wrist _____
Hematoma _____ arm elbow hand _____
Sprain / Strain _____
Dislocation _____
Laceration _____
Fracture R / L radius distal / shaft / proximal _____
 ulna distal / shaft / proximal / ulnar styloid _____
 humerus distal / shaft / proximal / supracondylar _____
 Colles fracture stabilized / restorative _____

DISPOSITION- ☐ transferred ☒ home ☐ admitted ☐ expired
Time _____
CONDITION- ☐ good ☒ fair ☐ poor ☐ critical ☒ improved
☐ stable ☐ unchanged

RESIDENT / PA / NP SIGNATURE

ATTENDING NOTE:
 Resident / PA / NP's history reviewed, patient interviewed and examined.
 Briefly, pertinent HPI is: _____
 My personal exam of patient reveals: _____
 Assessment and plan reviewed with resident / midlevel. Lab and ancillary studies show: _____
 I confirm the diagnosis of: _____
 Care plan reviewed. Patient will need: _____
 Please see resident / midlevel note for details.

Physician Signature

RTI #

turned care over at

Physician Signature

RTI #

assumed care at

☐ Template Complete ☐ Additional T-Sheet

Underline indicates organ system

* equivalent or minimum required for organ system

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RESTRICTIONS / RELEASE FORM



Northern Illinois Medical Center
Emergency Department
4201 Medical Center Drive
McHenry, Illinois 60050
(815) 344-5000



Memorial Medical Center
3701 Doty Rd.
Woodstock, Illinois 60098
(815) 334-3900

PATIENT NAME

Paul Dulberg

DATE

6/28/2011

PHYSICIAN SIGNATURE

[Signature]



1117900323
 DULBERG, PAUL R
 M 41Y 03/19/1970
 06/28/2011 B 0000109381

☐ May return to ☐ work ☐ school ☐ gym without restriction.

☒ May not return to ☒ work ☐ school ☐ gym for 2 day(s).

☐ May return to school with the following restrictions:

☐ Gym/Sports restrictions are _____ for _____ day(s).

☐ Must take prescription medication for _____ day(s).

☐ May return to work with the following restrictions:

☐ No lifting greater than _____ lbs. for _____ day(s).

☐ Machinery/Driving restriction while on medication that can cause drowsiness.

☐ No continuous ☐ standing ☐ sitting for _____ day(s).

☐ Must keep _____ elevated for _____ day(s).

☐ Sedentary work only for _____ day(s).

☐ Must use crutches for _____ day(s).

☐ No overhead work for _____ day(s).

☐ No bending or twisting for _____ day(s).

☐ Must wear immobilizer for _____ day(s).

☐ No climbing on ladder or stairs for _____ day(s).

☐ Other _____

☐ LIMITED WORK WITH
☐ NO WORK WITH

☐ Right	☐ Left
☐ Hand	☐ Hand
☐ Arm	☐ Arm
☐ Foot	☐ Foot
☐ Leg	☐ Leg

For _____ Days

☐ See your physician in _____ days for reevaluation.

All patients are referred to their personal physicians or a doctor on the staff of this hospital. Release from restriction must be obtained from that doctor and not the Emergency Department.

I (or responsible person) have/has received and understand(s) the instructions to follow as noted above.

Patient signature (or responsible person):

Paul Dulberg

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DATE 12/08/2011

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EO 102 NIM/MMC

Centegra Northern Illinois Medical Center
4201 Medical Center Drive
McHenry, IL 60050
(815) 344-5000

Patient: PAUL DULBERG, Med. Rec. #: B0000109381, Visit #:
B1117900323, Date: 06/28/2011 Time: 17:02

Home Care Instructions

IMPORTANT: We examined and treated you today on an emergency basis only. This was not a substitute for, or an effort to provide, complete medical care. In most cases, you must let your doctor check you again. Tell your doctor about any new or lasting problems. We cannot recognize and treat all injuries or illnesses in one Emergency Department visit. If you had special tests, such as EKG's or X-rays, we will review them again within 24 hours. We will call you if there are any new suggestions. You were treated today by: Ford, Apiwat W..

After your visit to our Emergency Department, you may receive a survey in the mail. We want to be sure we have given you very good care and we ask that you please fill out the survey and return it in the mail.

After you leave, please follow the instructions below.

This Information is About Your Follow Up Care

Call as soon as possible to make an appointment to see your doctor in 10 days for suture removal. You can reach your doctor by calling their clinic phone number.

Please return to the Emergency Department in 10 days for suture removal if you would prefer to have the sutures removed in the ER. We do recommend that you follow-up with your Primary Care Physician but you can return to the ER for removal of your stitches if you choose..

This Information is About Your Illness and Diagnosis

WOUND CARE (with stitches)

Your wound was closed with stitches. These are small threads that keep the skin closed to help it heal. You have 3 internal and 11 external stitches. These should be removed in 10 days.

At home, please follow these instructions:

- Wash your hands before touching the dressing or wound.
- Keep the wound clean and dry.
- After 2 days, wash the wound gently with warm water and soap. Pat it dry.
- Put a light dressing on it if it rubs or there is drainage.

Call your doctor if:

- you have redness, pain, or swelling in the area of your stitches.
- your wound drains pus.
- your stitches come out before your wound is healed.
- you have any new or bothersome symptoms.

This is Information About Your New Medications - Start taking as prescribed.

HYDROCODONE and ACETAMINOPHEN (Vicodin, Vicodin ES, Lortab, Lortab elixir, Zamiacet, Norco, Zydane, Anexsia, Anolor, Bancap HC)

Take this medicine by mouth with food in the following dose: one 10mg/325mg tablet every 4 to 6 hours if needed for pain. Do not take more than as directed per day (24 hours).

This is a mixture of medicines (hydrocodone and acetaminophen) used to relieve moderate to severe pain. This medicine may be used for other reasons, as prescribed by your doctor.

Side effects may include:

- sleepiness or dizziness
- upset stomach, nausea or vomiting
- constipation

Other side effects may occur, but are not as common. Allergy would show up as: rash or itching, facial or throat swelling, wheezing or shortness of breath. This medicine can be habit forming if used for a long period of time.

Follow these instructions:

- Never take more of this medicine than prescribed. Too much acetaminophen in your body can cause liver damage.
- Read the labels of non-prescription medicines before taking them. Many contain acetaminophen. To avoid an overdose, do not take any other medicines that contain acetaminophen.
- Talk to your doctor or pharmacist before taking medicines for sleep, colds or allergies. Severe drowsiness may occur.
- Do not share this medicine with others as this medicine is a controlled-substance. Sharing this medicine with others is against the law.
- To avoid constipation while taking this medicine:
 - Drink plenty of liquids. Try to drink 8 to 10 eight-ounce glasses of water or juice each day.
 - Include extra fiber in your diet.
 - Exercise daily.
- Watch for signs of dependence:
 - feeling that you "cannot live without this medicine".
 - you need more of this medicine than before to get the same relief.
- Do not drink alcohol, drive or operate machinery until you know how this medicine affects you.
- Store this medicine away from heat, moisture or direct light.
- If you are taking this on a regular schedule and you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and return to your regular schedule. Do not double the doses.
- Talk with your doctor before taking any other medicines (including vitamins and herbs) as you may require additional monitoring.

Call your doctor if you have:

- any sign of dependence or allergy.
- increased pain not helped by the pain medicine.
- slow, weak breathing.
- seizures.
- slow or irregular heart beat.
- a yellow-color to your skin or eyes, or dark urine.
- stomach pain.
- unusual or extreme tiredness.
- any new or severe symptoms.

CEFAUROXIL (Duricef)

Take this medicine until gone in the following dose: 500 mg by mouth 2 times a day for 5 days.

Cefadroxil is an antibiotic used to treat infections caused by bacteria. Antibiotics kill bacteria or prevent them from growing inside your body. This medicine may be used for other reasons, as prescribed by your doctor.

Side effects may include:

- diarrhea
- upset stomach, nausea or vomiting
- headache

Other side effects may occur, but are not as common. An upset stomach is not a sign of allergy. Allergy would show up as rash or itching, facial or throat swelling, wheezing or shortness of breath.

Follow these instructions:

- Space your medicine doses evenly throughout the day. This medicine works best if there is a constant amount in your blood.
- Take this medicine with food to avoid an upset stomach.
- Swallow the capsule and tablet form of this medicine whole with a full 8-ounce glass of water.
- For diabetics, this medicine can cause false test results when testing your urine for sugar. Talk with your doctor if you have questions.
- Store the tablet or capsule form of this medicine away from heat, moisture or direct light.
- Store the liquid form of this medicine in the refrigerator. Shake the liquid well before each use.
- If you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose. Do not double the doses.
- Talk with your doctor before taking any other medicines (including vitamins and herbals) as you may require additional monitoring.

Call your doctor if you have:

- any sign of allergy.
- no improvement after you've taken all the medicine.
- a seizure.
- any sign of a new infection (fever, general aches, chills, or unusual tiredness or weakness).
- ongoing nausea, vomiting or stomach pain.
- white patches in your mouth.
- women: itching in or change in discharge from your vagina.
- inflammation (pain and swelling) in your intestine during treatment or up to weeks after you've finished this medicine:
 - ongoing diarrhea
 - stomach pain or cramping
 - blood or mucus in your bowel movements
- any new or bothersome symptoms.

SMOKING CESSATION

Smoking is the nation's leading preventable cause of death. It significantly increases the risk of coronary heart disease, stroke and cancer. In fact, more than half of all smoking related deaths in America each year are from heart disease, stroke, or other cardiovascular diseases. The good news is, that one year after quitting, the risk of heart disease is cut in half. After five to fifteen smoke-free years, the risk is that of a person who never smoked!

If you or someone you love is interested in quitting, consider joining our "Freedom From Smoking" classes for adults. Centegra Health System and the McHenry County Department of Health have partnered together to bring you an effective program that will help you quit smoking. Call 877-CENTEGRA, (877-236-8347) for more information regarding this program. To speak with a counselor immediately, call the Illinois Tobacco line at 1-866-QUIT-YES.

PAIN MANAGEMENT AFTER DISCHARGE:

A person may feel less pain just by being in familiar surroundings. Here are some frequently asked questions about your pain management:

- What can I do to help my pain management? A person's level of relaxation and their environment can affect their pain. If you are tired, overstimulated (too many visitors) are anxious about your diagnosis, or a past experience with a hospitalization, your pain perception may be impacted and your tolerance decreased. Ask questions, and inform us about any problems or concerns that you may have, re: pain. Partner with your health team for your best pain management.
- What if the medication is not working? Tell your health-care provider; physician, home health nurse, etc. You may need a different dose or type of medication.
- What if I feel I'm not getting enough pain control? Talk to your physician or home health nurse about it. Together you may be able to develop a plan to prevent or ease your pain. Depending on the cause of your pain, your health-care provider may suggest exercise, use of heat/cold, massage, repositioning, immobilization of the affected part, or distraction such as music or rest.
- There are other methods of pain management. Let your health-care provider assist you in finding the best one for you.

Weight management is one step to help maintain a healthy lifestyle. For certain medical problems, such as congestive heart failure, weight should be monitored daily.

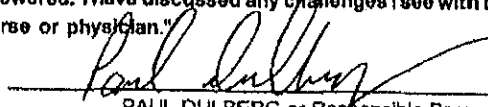
YOU ARE THE MOST IMPORTANT FACTOR IN YOUR RECOVERY.

Follow the above instructions carefully. Take your medicines as prescribed. Most important, see a doctor again as discussed.

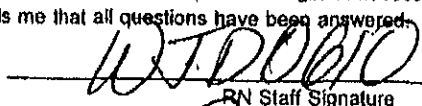
If you have problems that we have not discussed, or your problem changes or gets worse, call or visit your doctor right away. If you cannot reach your doctor, return to the Emergency Department immediately.

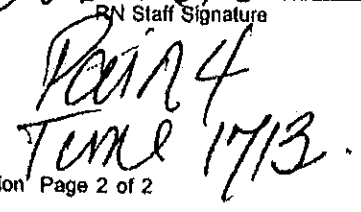
Centegra Health System is very concerned about your safety and well being. As part of our efforts to always provide very good care, any medications you received during this visit were reconciled with medication you are currently taking. This reconciliation was based on the information you or your representative provided regarding your current medications and allergies.

"I have received this information and my questions have been answered. I have discussed any challenges I see with this plan with the nurse or physician."


PAUL DULBERG or Responsible Person

PAUL DULBERG or Responsible Person has received this information and tells me that all questions have been answered.


RN Staff Signature



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PAUL DULBERG was discharged on 06/28/2011 at 17:06 from the hospital. The following is a summary of the discharge instructions given to PAUL before discharge:

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one 10mg/325mg tablet every 4 to 6 hours if needed for pain. Do not take more than as directed per day (24 hours).

CEFADROXIL (Duricef)

500 mg by mouth 2 times a day for 5 days.

1. How are you and/or your family doing today?
2. Is your pain/or symptoms better today?
3. Did you understand your discharge instructions?
4. Are you following up with a Doctor?

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(815) 344-5000

5. Comments:

Signature of nurse making phone call; _____

Date: _____ Time: _____

FORM GOES TO MEDICAL RECORDS

☐ CH - M ☐ CH - W

☐ Other (Specify) _____



1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011 B 0000109361

GENERAL CONSENT AND ACKNOWLEDGMENT

Account Number/Effective Date: _____

CONSENT FOR MEDICAL TREATMENT

I have come to Centegra Health System (CHS) for medical treatment and consent to the customary examinations, tests, and procedures performed on patients in my condition. I understand and consent that independent professionals (such as my attending physician, on-call physicians, emergency medicine physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, consultants, nurse practitioners, physician assistants, certified registered nurse anesthetists and other specialists) may participate in my care as deemed necessary.

I agree to follow the Patient Rights & Responsibilities of CHS and to participate with independent professionals and CHS personnel in my care and treatment.

I understand the practice of Medicine is not an exact science and, therefore, no guarantees have been made regarding the likelihood of success or outcomes of any diagnosis, treatment, test, surgery or examination performed at CHS.

I understand this General Consent and Acknowledgment will remain in effect for this episode of care and will be provided to those areas of CHS where I receive care.

I understand the language in this Consent guides and controls all other forms and consents I may sign during my treatment with Centegra Health System and any inconsistencies shall be interpreted consistent with terms of this document.

PATIENT ACKNOWLEDGMENT OF INDEPENDENT PHYSICIANS

I acknowledge the independent professional(s) who provide services to me at CHS are not employees or agents of CHS, but are independent medical practitioners who have been permitted to use its facilities for the care and treatment of their patients. They include but are not limited to, my attending physician, on-call physicians, emergency medicine physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, consultants, nurse practitioners, physician assistants, certified registered nurse anesthetists and other specialists. My decision to seek care is not based upon any representation or advertisement of the independent professionals and I understand they are not employees or agents of CHS. CHS bills do not include physician, surgeon, or other independent professional services and I understand I will receive a separate bill directly from the independent professional. I have read and understand the above terms and confirm I am the patient or am authorized to sign on the patient's behalf.

PATIENT ACKNOWLEDGMENT OF INDEPENDENT SERVICES

During the course of my hospital stay, my physician may determine I require care at another medical facility, or I may request care at an alternate facility. I acknowledge that all transportation services provided in connection with my transfer to another facility are provided by an independent third party and I will receive a separate bill directly from the service provider for which I may be responsible.

USE AND DISCLOSURE OF HEALTH INFORMATION

Unless I request otherwise, CHS will provide my room location or telephone number to visitors and callers.

I understand CHS will use and disclose my health information for the purposes of treatment, payment, and health care operations, as permitted by law as described in the CHS Notice of Privacy Practices. Certain information can be used without obtaining my consent. I fully understand that the use or disclosure of my health information may include history, diagnosis and /or diagnostic treatment of mental health/ developmental disabilities conditions, alcohol or drug abuse and Acquired Immune Deficiency Syndrome (AIDS/ HIV).

I understand that if I refuse to allow disclosure of my health information to process my insurance claim, I may be financially responsible for all costs incurred by me for treatment. I agree to release and hold harmless CHS, its agents, and employees from any liability that may arise from the use or disclosure of my health information.

PICTURES/IMAGES

I understand photographs, videotapes or other images may be taken to document my care. These images may be kept by CHS and/or by the independent professional involved in my care. I understand I have the right to view or obtain copies of these materials which are in possession of CHS upon written request. It is my responsibility to confirm if such photographs, videotapes or other images have been taken. I understand images identifying me will only be released as allowable under law or with my written authorization.

PRINTED BY: SJS0422

DATE 12/08/2011

GENERAL CONSENT AND ACKNOWLEDGMENT

Page 1 of 2

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1117800323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011 8 0000109381

Verbal

RELEASE FROM LIABILITY FOR VALUABLES

I understand my belongings are my responsibility and I have been advised to send any items of value home. I release CHS from any liability for the loss, damage to, or theft of any of my belongings. Safes or lockers are available at the hospital facilities and may be used to store valuables.

PATIENT PRE-CERTIFICATION RESPONSIBILITY

I understand I am responsible for the notification to my insurance company to obtain authorization before service is rendered. I further understand that if I do not pre-certify I may incur a reduction or loss of paid benefits to the hospital for which I will be liable.

ASSIGNMENT OF BENEFITS/ AGREEMENT FOR PAYMENT

I hereby authorize payment to be made directly to CHS and to the independent professional(s) for all insurance benefits otherwise payable to me. I understand I am financially responsible to CHS and independent professionals for all charges incurred. Patient "out-of-pocket" amounts will be requested prior to or upon discharge. In the event of default or non-payment, CHS shall be entitled to the right of recovery of all collection expenses, including court costs and reasonable attorney's fees for the purpose of securing payment. It is further agreed that any credit balance may be applied on any other account owed CHS by the guarantor/responsible party, or any open account for his/her dependent family.

PATIENT INFORMATION OFFERED

- | | | | |
|---|-----|---------------------|-----------------------|
| • Patient Rights/Responsibilities | Yes | Declined | If No, Explain: _____ |
| • Advance Directive Information | Yes | Declined | If No, Explain: _____ |
| • Notice of Privacy Practices | Yes | Declined | If No, Explain: _____ |
| • Patient Billing Information | Yes | Declined | If No, Explain: _____ |

PATIENT CERTIFICATION

By signing this General Consent and Acknowledgement Form, I acknowledge I have read and understand the information contained in this form and accept its terms. I also acknowledge I have received a copy of this form for my records.

INPATIENTS ONLY:

TRICARE (Military) Insurance PATIENTS _____ Yes, I have received TRICARE "Important Message"

Verbal Per [Signature]
Patient/Authorized Person
[Signature]
Witness

Relationship _____

Date *6/28/11*

I, _____, have interpreted/translated the above form to the patient. The patient has informed me he/she fully understands and agrees to the terms set out in this consent form.

Interpreter/Translator (Please Print Name) _____

Language _____

Interpretation/Translation Provider (Company name or Relationship to Patient) _____