(15)

B/117900323

CICERO, FRANCE, BARCH & ALEXANDER, P.C.
A Professional Corporation
Attorneys at Law
6323 EAST RIVERSIDE BOULEVARD
ROCKFORD, ILLINOIS 61114

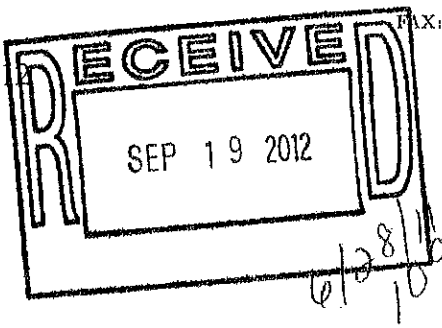
PAUL R. CICERO
JOHN W. FRANCE
RONALD A. BARCH
CHARLES P. ALEXANDER

CHANTEL R. BIELSKIS
ANDREW T. SMITH

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

RECD SEP 6 2012

September 4, 20



12811-ER
10381

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

COPIED BY
SEP 14 2012
COPY-RITE
MRV

RB:mj/subltr.records
encls.
cc: Attorney Hans A. Mast

Northern Illinois Medical Center TAX ID# 362338884
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
MCHENRY 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

Northern Illinois Medical Center TAX ID# 362338884
4201 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

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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

CentegraHealthSystem

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

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.

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

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

Susan Henn
Notary

OFFICIAL SEAL
SUSAN HENN
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:01/05/13

CENTEGRA Health System

DISCHARGE DATE | TIME

ACCOUNT NO.	ADMISSION DATE/TIME	BY	STATION ROOM	ACC	SERVICE	TYPE	AT	AS	UNIT NO/MEDICAL RECORD NO
B11179-00323	06/28/11 0246pm	MXC	EDB -		EMD	EDB	1	1	B0000109381

SEX	RG	MS	BIRTHDATE	SOC SEC NO	CLERGY	AD	OD	INJURY	FIN CLASS
M	3	S	03/19/70 41Y	323-76-4001		N		AT WORK	L LIAB-MVA/M

PATIENT

PATIENT NAME AND ADDRESS
ENGLISH
DULBERG,PAUL R
4606 HAYDEN CT (847)497-4250
CELL#
MCHENRY IL 60051-7918 *MCHENRY CNTY, IL

PREVIOUS NAME

GUARANTOR

GUARANTOR NAME AND ADDRESS
DULBERG,PAUL R
4606 HAYDEN CT (847)497-4250
SELF
MCHENRY IL 60051-7918 CELL#
SOC SEC NO 323-76-4001 PHI CONTACT: Y

EMERGENCY CONTACT/RELATIVE 1
DULBERG,HERBERT (847)497-4250
4606 HAYDEN CT *FATHER
MCHENRY IL 60051-7918
SOC SEC NO PHI CONTACT: Y

EMERGENCY CONTACT 2
DULBERG,BARBARA (847)497-4250
4606 HAYDEN CT *MOTHER
MCHENRY IL 60051-7918
PHI CONTACT: Y

EMPLOYER

PATIENT EMPLOYER
SHARP PRINTING
4606 HAYDEN CT (847)497-4250
SELF EMP
MCHENRY IL 60050

GUARANTOR EMPLOYER
SHARP PRINTING
4606 HAYDEN CT (847)497-4250
SELF EMP
MCHENRY IL 60050

RELATIVE 1 EMPLOYER

PATIENT ALTERNATE ADDRESS

INSURANCE

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
ER

COMMENT

ATTENDING PHYSICIAN
FORD,APIWAT W

ADMITTING PHYSICIAN
FORD,APIWAT W

PRIMARY CARE PHYSICIAN
SEK,FRANK

ADDITIONAL PHYSICIAN

STN:ERA

PRINCIPAL DIAGNOSIS

COMPLICATIONS AND COMORBIDITIES

PRINCIPAL PROCEDURE & DATE

OTHER PROCEDURES & DATE

PRINTED BY: MRV0127

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 _____

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 0000109361

☐ 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 Hand	☐ Left 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): [signature]

PRINTED BY: MRV0127
DATE 09/14/2012

ED 102 NIMC/MMC

EMCARE, INC

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 herbals) 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.

PRINTED BY: MRV0127
DATE 06/28/2011

Patient Name: PAUL R
Account Number, B1117900323

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 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, 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 medicaton.
- 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

PAUL DULBERG or Responsible Person

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

W.T. Dobio

RN Staff Signature

Pain 4
Time 1713.

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?

PRINTED BY: MRV0127
DATE 09/14/2012
Patient Name, PAUL R
Account Number, B1117900323

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

PRINTED BY: MRV0127
DATE 09/14/2012
Patient Name, PAUL R
Account Number, B1117900323

CentegraHealthSystem

☑ CH - M ☐ CH - W

☐ Other (Specify) _____

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

VV
Initials

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.

VV
Initials

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.

VV
Initials

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: MRV0127

DATE 09/14/2012

CentegraHealthSystem

1117800323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011 B 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 ~~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 PT
Patient/ Authorized Person _____ Relationship _____ Date 6/28/11

Witness

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) _____

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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

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EMERGENCY ADMISSION ASSESSMENT

TIME TRIAGED: 1458
TIME TO TREATMENT AREA: 1455
ED BED#: 16
EXPRESS BED #:
ESI: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Primary Physician: Seh
Height: 5'9" Weight: 145 # GCS: 15 RTS: 7.8 BP: 173 P 75 R 16 T 97.4 SPO2 97 Time of Injury:

BROUGHT BY:
☐ Self ☐ Relative
☐ Police ☒ Friend
☐ Other
Ambulance:

MODE OF ARRIVAL
☒ WC
☐ Stretcher
☐ Carried
☐ Walked

TREATMENT PTA
☐ Ice ☐ Elevate
☐ O2
☐ IV
☐ Med:

☒ Patient Band applied
☐ Hand Off Communication Band applied
☐ Security watch

☒ Room air ☐ O2 Pain Level: 9 - 10

Chief complaint/reason for visit: States chainsaw vs Rt arm 15 min ago @ home. c/o feeling lightheaded

Triage RN

CURRENT MEDS ☒ Denies		ALLERGIES ☒ NKA	REACTION
		Medications:	
		Food:	
		Other: ☐ Latex ☐ Dye	

Meds reviewed by:
Residence: ☐ Private ☒ Family ☐ Alone ☐ Nursing home ☐ Group home
Language barrier ☐ Yes Interpreter Name/ATT Number: ☐ Other:
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	Yes	Yes	Yes	Yes
☐ Autoimmune	☐ Dementia/ Alzheimer's	☐ Headaches/ migraines	☐ Pressure Ulcer	☐ Infectious diseases
☐ Asthma	☐ Endocrine	☐ Head inj past 3 months	☐ Recent exposure	☐ MRSA
☐ Back problems	☐ GI problems	☐ Hypertension	☐ Reproductive problems	☐ VRE
☐ Blood disorders	☐ GU Problems	☐ MusculoSkeletal problems	☐ Respiratory problems	☐ Chicken Pox
☐ Cancer	☐ Glaucoma	☐ Neuro problems	☐ Seizures	☐ Measles
☐ Cardiovascular	☐ HEENT problems	☐ PsychoSocial problems	☐ Skin problems	☐ Shingles
☐ CHF	☐ Heart murmur		☐ Vision problems	☐ Strep Throat
LMP:	☐ Normal ☐ Abnormal			☐ Other:
☐ Pregnant	☐ No ☐ Unsure	Grava Para Ab	FHT	

Expanded/surgical history: Lt arm surg

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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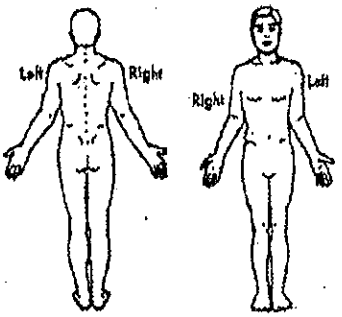
ADMISSION ASSESSMENT

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 PPD 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 ☐ <2Sec ☐ >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: _____

HPI: Pt accompanied to ED by co-worker for lac laceration by chainsaw to (R) forearm. Pt sent to Xray. (1505) Pt back in ER & Dr Ford at bedside (1522) Pt medicated as ordered (see MAR) Wound irrigated and cleaned. Dr Ford to suture. (1713) D/C instructions to pt. All questions addressed. Pt verbalized understanding.

Associate Signature/Initials: WD Dixon Associate Signature/Initials:_____

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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/diff		☐ Trichimonas				☐ 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 ☐ Pos ☐ Neg ☐ POC		☐ C-Spine		☐ ED Venous Duplx Ext	
☐ **MRSA**		☐ Urine Dip ☐ POC		☐ X-Table		☐ ED Trauma trans echo	
☐ PT		☐ Wet prep		☐ Pelvis		☐ ED Trauma abd ltd	

Rt [illegible]

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
[illegible]		1532		10	Norco	10mg	PO		[illegible]	[illegible]	[illegible]	4	[illegible]
		1532			[illegible]	500mg	PO		[illegible]				
					Bupivacaine	0.25%	per Dr [illegible]						

☐ 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: [illegible]
RN: [illegible] Initials: [illegible] Physician: [illegible] Initials: [illegible]
RN: [illegible] Initials: [illegible] 0703 Physician: ______ Initials: ______

Rev 04/04/11

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EMERGENCY ADMISSION ASSESSMENT

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

Treatments/Procedures:
☐ O_2 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
X ☐ Irrigation: 1 Liter NS
☐ Soak:_____
X ☐ Antiseptic Wash
☐ Other:_____

☐ Dressing:_____
☐ Antibiotic
☐ Adaptic
☐ 4X4
☐ Kling
☐ Tube gauze
☐ Steristrip
☐ Burn dressing

☐ Ortho Care:_____
☐ Ice Time:_____
☐ Elevate Time:_____
☐ Splint:_____
☐ Knee Immobilizer:_____
☐ Shoulder Immobilizer
☐ Ace Wrap
☐ SMV's after immobilization

☐ Cast
☐ Sling
☐ Tubi Grip

☐ Crutches
☐ Patient's own crutches
☐ Crutch walking instr/ret demo
☐ Velcro Splint:_____
☐ Posterior mold:_____
☐ Location:_____
☐ Width:_____
☐ Length:_____

Isolation Type:_____

DISPOSITION: X Home ☐ Jail ☐ Nursing home/ECC
☐ Other facility:_____ ☐ Expired ☐ AMA
Mode: ☐ W/C X Walk ☐ Carry ☐ Ambulance:_____
☐ Other:_____
LEFT WITH: ☐ Self ☐ Family X Friend ☐ Police
X ☐ Discharge Instructions given-expresses understanding
X ☐ Discharge Pain Level: 4 (0-10) GCS: 15 RTS:___
X ☐ Discharge by: WHEELCHAIR @ 1713
Discharge Vital Signs:
Discharge Summary:
RN: Initials:
Tech: Rebecca Rollins Initials: RR0120

☐ 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)

RN:_____ Initials:_____

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06

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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)
loss feeling / power arms / legs
headache / neck pain
double vision / hearing loss
nausea / vomiting

trouble breathing / chest pain
loss of bladder function
recent fever / illness
other injuries
☐ 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

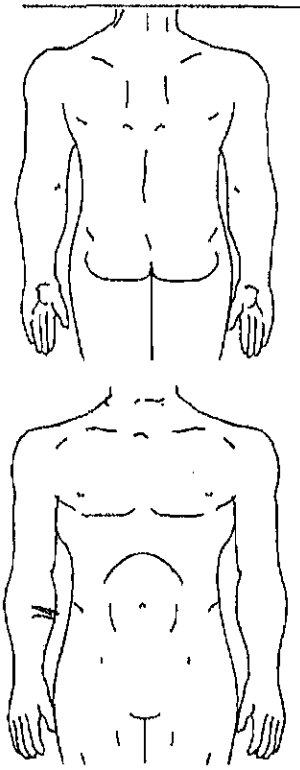
HAND
__nml inspection
__non-tender
__nml ROM*
__see diagram
__tenderness soft-tissue / bony
__swelling / ecchymosis
__deformity

WRIST
__nml inspection
__non-tender
__nml ROM*
__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*
__see diagram
__tenderness soft-tissue / bony
__swelling / ecchymosis
__limited ROM
__deformity

ARM / SHOULDER
__nml inspection
__non-tender
__nml ROM*
__see diagram
__tenderness soft-tissue / bony
__swelling / ecchymosis
__limited ROM
__deformity

SCAR LACERATION (R) FOREARM BELLY



T=Tenderness PtT=Point Tenderness S=Swelling E=Ecchymosis B=Burn C=Contusion
L=Laceration A=Abrasion M=Muscle spasm PW=Puncture Wound
(Ø= without m=mild mod=moderate sv=severe)
Example: Tsv= Tenderness on palpation (severe)

NEURO / VASC / TENDON
__sensation intact
__motor intact
__no vascular compromise
__tendon function normal
__sensory / motor deficit
__pallor / cool skin / abnml cap refill
__pulse deficit radial ulnar
__deficit in tendon function

Num bness @ fingers

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SKIN __diaphoretic / cool / cyanotic
__warm, dry

HEAD / ENT __tenderness
__nml inspection __swelling / ecchymosis
__pharynx nml

NECK / BACK __tenderness
__nml inspection __swelling / ecchymosis
__non-tender

RESPIRATORY __tenderness
__chest non-tender __swelling / ecchymosis / abrasions
__breath snds nml __crepitus / subcutaneous emphysema
__decreased breath sounds
__wheezes / rales / rhonchi

CVS __tachycardia / bradycardia
__heart sounds nml

GI (ABDOMEN) __tenderness / guarding
__non-tender
__no organomegaly
__nml bowel snds*

XRAYS ☐ Interp. by me ☐ Reviewed by me ☐ Discad w/ radiologist
R / L *hand wrist forearm elbow humerus shoulder*
__normal / NAD __DJD
__no fracture __dislocation
__nml alignment __soft-tissue swelling
__no foreign body __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

PROCEDURES

Wound Description / Repair
length 8cm cm 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: SHURCLENS TOPAZ
Betadine / scrub
irrigated / washed w/ saline 1L NSS 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 / steri-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*
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*

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.

Avitael 9025
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 listed*

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 DATE: 09/14/2012

CENTEGRA Health System

DISCHARGE DATE | TIME

ACCOUNT NO.	ADMISSION DATE/TIME	BY	STATION ROOM	ACC	SERVICE	TYPE	AT	AS	UNIT NO/MEDICAL RECORD NO
B11179-00323	06/28/11 0246pm	MXC	EDB -		EMD	EDB	1	1	B0000109381

SEX	RC	MS	BIRTHDATE	SOC SEC NO	CLERGY	AD	DD	INJURY	FIN CLASS
M	3	S	03/19/70 41Y	323-76-4001		N		AT WORK	L LIAB-MVA/M

PATIENT

PATIENT NAME AND ADDRESS
ENGLISH
DULBERG, PAUL R
4606 HAYDEN CT (847)497-4250
CELL#
MCHENRY IL 60051-7918 *MCHENRY CNTY, IL

PREVIOUS NAME

GUARANTOR

GUARANTOR NAME AND ADDRESS
DULBERG, PAUL R
4606 HAYDEN CT (847)497-4250
SELF
MCHENRY IL 60051-7918 CELL#
SOC SEC NO 323-76-4001 PHI CONTACT: Y

EMPLOYER

PATIENT EMPLOYER
SHARP PRINTING
4606 HAYDEN CT (847)497-4250
SELF EMP
MCHENRY IL 60050

GUARANTOR EMPLOYER
SHARP PRINTING
4606 HAYDEN CT (847)497-4250
SELF EMP
MCHENRY IL 60050

EMERGENCY

EMERGENCY CONTACT / RELATIVE 1
DULBERG, HERBERT (847)497-4250
4606 HAYDEN CT *FATHER
MCHENRY IL 60051-7918
PHI CONTACT: Y
SOC SEC NO

RELATIVE 1 EMPLOYER

EMERGENCY CONTACT 2
DULBERG, BARBARA (847)497-4250
4606 HAYDEN CT *MOTHER
MCHENRY IL 60051-7918
PHI CONTACT: Y

PATIENT ALTERNATE ADDRESS

INSURANCE

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	ATTENDING PHYSICIAN	PRIMARY CARE PHYSICIAN
ER	FORD, APIWAT W	SEK, FRANK
COMMENT	ADMITTING PHYSICIAN	ADDITIONAL PHYSICIAN
	FORD, APIWAT W	

STN: ERA

PRINCIPAL DIAGNOSIS

COMPLICATIONS AND COMORBIDITIES

PRINCIPAL PROCEDURE & DATE

OTHER PROCEDURES & DATE

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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

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EMERGENCY ADMISSION ASSESSMENT

TIME TRIAGED: 1450
TIME TO TREATMENT AREA: 1455
ED BED#: 18
EXPRESS BED #:
ESI: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Primary Physician: Sek
Height: 5'9" Weight: 165 # GCS: 15 RTS: 12 BP: 133 P 75 R 16 T 97.4 SPO2 97 ☒ Room air ☐ O2 Pain Level: 9 - 10

BROUGHT BY:
☐ Self ☐ Relative
☐ Police ☒ Friend
☐ Other
Ambulance:

MODE OF ARRIVAL
☒ WC
☐ Stretcher
☐ Carried
☐ Walked

TREATMENT PTA
☐ Ice ☐ Elevate
☐ O2
☐ IV
☐ Med:

☒ Patient Band applied
☐ Hand Off Communication Band applied
☐ Security watch

Time of Injury:

Chief complaint/reason for visit: States chainsaw vs Rt arm 15 min ago @ home. c/o feeling lightheaded

Triage RN

CURRENT MEDS ☒ Denies		ALLERGIES ☒ NKA	REACTION
		Medications:	
		Food:	
		Other: ☐ Latex ☐ Dye	

Meds reviewed by:
Residence: ☐ Private ☒ Family ☐ Alone ☐ Nursing home ☐ Group home
Language barrier ☐ Yes Interpreter Name/ATT Number: ☐ Other:
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	Yes	Yes	Yes	Yes
☐ Autoimmune	☐ Dementia/ Alzheimer's	☐ Headaches/ migraines	☐ Pressure Ulcer	☐ Infectious diseases
☐ Asthma	☐ Endocrine	☐ Head inj past 3 months	☐ Recent exposure	☐ MRSA
☐ Back problems	☐ GI problems	☐ Hypertension	☐ Reproductive problems	☐ VRE
☐ Blood disorders	☐ GU Problems	☐ MusculoSkeletal problems	☐ Respiratory problems	☐ Chicken Pox
☐ Cancer	☐ Glaucoma	☐ Neuro problems	☐ Seizures	☐ Measles
☐ Cardiovascular	☐ HEENT problems	☐ PsychoSocial problems	☐ Skin problems	☐ Shingles
☐ CHF	☐ Heart murmur		☐ Vision problems	☐ Strep Throat
LMP:	☐ Normal ☐ Abnormal			☐ Other:
☐ Pregnant	☐ No ☐ Unsure	Grava___Para __ Ab __	FHT __	

Expanded/surgical history: Lt arm surg

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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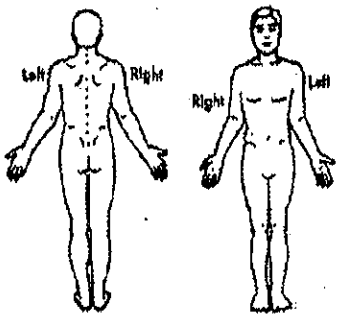
ADMISSION ASSESSMENT

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/D 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

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 ☐ <2Sec ☐ >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: _____

ANY POSITIVE ANSWER INDICATES ENHANCED FALL RISK ☐ No risks noted

1455 Pt accompanied to ED by co-worker for Lac Laceration by chainsaw to (R) forearm. Pt sent to xray (1505) Pt back in ED (1515) Dr Ford at bedside (1522) Pt medicated as ordered (see MAR) Wound irrigated and cleaned. Dr Ford sutured (1713) D/C instructions to pt. All questions addressed Pt verbalized understanding

Associate Signature/Initials: WJ Dalton Associate Signature/Initials:_____

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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/diff		☐ Trichimonas				☐ 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 ☐ Pos ☐ Neg ☐ POC		☐ C-Spine		☐ ED Venous Duplx Ext	
☐ 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
MP		1522		10	NORCO	10/325	PO		MP	1522		4	MP
		1522			Lidocaine 1% 30cc				MP				
					Bupivacaine 0.25% 30cc				MP				

☐ 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: TMW Physician: _____ Initials: _____

RN: _____ Initials: 0713 Physician: _____ Initials: _____

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EMERGENCY ADMISSION ASSESSMENT

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

Treatments/Procedures:
☐ O_2 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
X ☐ Irrigation: 1 Liter NS
☐ Soak: _____
☐ Antiseptic Wash
☐ Other: _____

☐ Dressing: _____ ☐ Ortho Care: _____
☐ Antibiotic ☐ Ice Time: _____ ☐ Cast
☐ Adaptic ☐ Elevate Time: _____ ☐ Sling
☐ 4X4 ☐ Splint: _____ ☐ Tubi Grip
☐ Kling ☐ Knee immobilizer: _____
☐ Tube gauze ☐ Shoulder immobilizer
☐ Steristrip ☐ Ace Wrap
☐ Burn dressing ☐ SMV's after immobilization

☐ Crutches
☐ Patient's own crutches
☐ Crutch walking instr/ret demo
☐ Velcro Splint: _____
☐ Posterior mold: _____
☐ Location: _____
☐ Width: _____
☐ Length: _____

Isolation Type: _____

DISPOSITION: X Home ☐ Jail ☐ Nursing home/ECC
☐ Other facility: _____ ☐ Expired ☐ AMA
Mode: ☐ W/C X Walk ☐ Carry ☐ Ambulance: _____
☐ Other: _____
LEFT WITH: ☐ Self ☐ Family X Friend ☐ Police
X Discharge Instructions given-expresses understanding
X Discharge Pain Level: 4 (0-10) GCS 15 RTS: 12
X Discharge by: Walked @ 1713

☐ 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: Rebecca Roth Initials: RR
Tech: _____ Initials: _____
RN: _____ Initials: _____

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06

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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)
loss feeling / power arms / legs
headache / neck pain
double vision / hearing loss
nausea / vomiting

trouble breathing / chest pain
loss of bladder function
recent fever / illness
other injuries
☐ 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 I 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

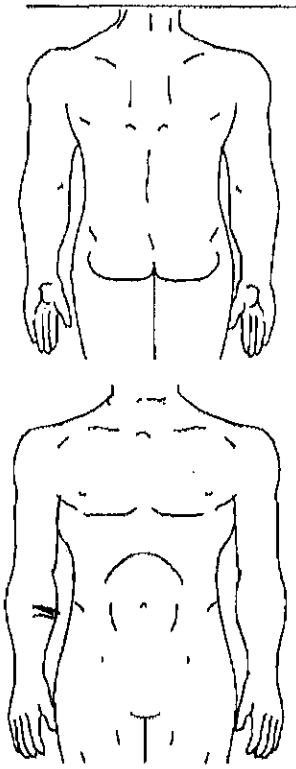
HAND
__nml inspection
__non-tender
__see diagram
__tenderness *soft-tissue / bony*
__swelling / ecchymosis
__deformity

WRIST
__nml inspection
__non-tender
__nml ROM*
__see diagram
__tenderness *soft-tissue / bony*
__tenderness in anatomical snuff box
__wrist pain on axial thumb load
__swelling / ecchymosis
__limited ROM
__deformity

FOREARM / ELBOW
✓ see diagram (FOREARM BRUISE)
__tenderness *soft-tissue / bony*
__swelling / ecchymosis
__limited ROM
__deformity

__nml inspection
__non-tender
__nml ROM*

ARM / SHOULDER
__see diagram
__tenderness *soft-tissue / bony*
__swelling / ecchymosis
__limited ROM
__deformity
__nml inspection
__non-tender
__nml ROM*



T=Tenderness PIT=Point Tenderness S=Swelling E=Ecchymosis B=Burn C=Contusion
L=Laceration A=Abrasion M=Muscle spasm PW=Puncture Wound
(Ø= without m=mild mod=moderate sv=severe)
Example- Tsv= Tenderness on palpation (severe)

NEURO / VASC / TENDON
✓ sensation intact
✓ motor intact
✓ no vascular compromise
✓ tendon function normal
__sensory / motor deficit
__pallor / cool skin / abnml cap refill
__pulse deficit *radial ulnar*
__deficit in tendon function

3EDTSN / Rev. 08 / 07

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SKIN — diaphoretic / cool / cyanotic
warm, dry

HEAD / ENT — tenderness
nml inspection — swelling / ecchymosis
pharynx nml

NECK / BACK — tenderness
nml inspection — swelling / ecchymosis
non-tender

RESPIRATORY — tenderness
chest non-tender — swelling / ecchymosis / abrasions
breath snds nml — crepitus / subcutaneous emphysema
decreased breath sounds
wheezes / rales / rhonchi

CVS — tachycardia / bradycardia
heart sounds nml

GI (ABDOMEN) — tenderness / guarding
non-tender
no organomegaly
nml bowel snds*

XRAYS ☐ Interp. by me ☐ Reviewed by me ☐ Discad w/ radiologist

R / L *hand wrist forearm elbow humerus shoulder*

normal / NAD — DJD
no fracture — dislocation
nml alignment — soft-tissue swelling
no foreign body — 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

PROCEDURES

Wound Description / Repair
length 8cm location RFOREARM 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: SURGICLENS TOWL
Betadine / scrub
irrigated / washed w/ saline 1L NACL debrided
*minimal / *moderate / *extensive *minimal / *moderate / *extensive
wound explored undermined
foreign material removed *minimal / *moderate / *extensive
*partially completely *wound margins revised
*minimal / *moderate / *extensive multiple flaps aligned
no foreign body identified

repair: Wound closed with: wound adhesive / steri-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 *Velcro 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*

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.

Buford — 9025
Physician Signature *RTI #* *turned care over at*

Physician Signature *RTI #* *assumed care at*

Underline *indicates organ system*
* *equivalent or minimum required for organ system exam*

☐ Template Complete ☐ Additional T-Sheet

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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 12/28/2011

PHYSICIAN SIGNATURE [signature] RN

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☐ 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

PRINTED BY: SJS0422
DATE 12/08/2011

ED 102 NIMC/MMC

EMCARE, INC

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 herbals) 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.

Patient Name: PAUL R
Account Number, B1117900323

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 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, 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 medicaton.
- 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

PAUL DULBERG or Responsible Person

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

WTDOBIO

RN Staff Signature

Pain 4
Time 1713.

DATE 02/01/2011 Patient Name: PAUL R
Account Number, B1117900323

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?

PRINTED BY: SJS0422
DATE 12/08/2011
Patient Name, PAUL R
Account Number, B1117900323

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

PRINTED BY: SJS0422
DATE 12/08/2011
Patient Name, PAUL R
Account Number, B1117900323

CentegraHealthSystem

1117800326
WELTER, KAITLYN O
F 10Y 11/28/2000
06/28/2011 B 0000297787

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 (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"**

Amanda J. Welter — Patient/ Authorized Person

Mother — Relationship

6/28/11 — Date

Witness

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) _____

PRINTED BY: SJS0422

1117900326
WELTER, KAITLYN D
F 10Y 11/28/2000
06/28/2011 B 0000297787

Centegra HealthSystem

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

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: SJS0422
DATE 12/08/2011

CentegraHealthSystem

☑ 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.

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VV

Initials

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Initials

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VV

Initials

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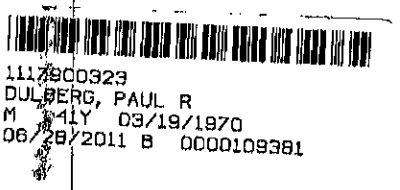
PRINTED BY: SJS0422

DATE 12/08/2011

CentegraHealthSystem



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.

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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

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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: _____
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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 PT
Patient/ Authorized Person _____ Relationship _____ Date 6/28/11

Witness

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) _____

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