

EXHIBIT "B"

ST RITAS MEDICAL CENTER
730 WEST MARKET STREET
LIMA, OH 45801
419/226-9050

BADP01/MEDICAL RECORDS

ACCT# 6943108 JOH EMERGENCY 8/14/2012 15.57 D.D. DAYS: MR# 1264822

JOHNSON, PAUL R Age: 044Y 11-30-1967 Prior Nm: AT-ED PHYSICIANS 3
2238 N WEST ST Sex: M Rel: P SSN: *****2027
LIMA OH 45801 M/S: S Iso: NO Race: 1 Maiden: PC-PEREZ, CARLOS A, 83024
ALLEN 419 224-8000 Echn: N Pl Birth: MI

Spouse - HIPAA Contact: HIPAA Contact: JOHN COLEMAN 419 224-8000 OTHER RELATIONSHI HIPAA Contact: RI

Injury: ACI Date: 8/14/12 Arrived: MEDC MEDC () Attend Note NOP: 6/02/2006
Diag:
Patient Statement: AMPUTATED FINGER
ACK YES ED 34
Comments:

Allergies: NKDA Iso: NO Triage Time: See Dictation Note (2101) PAAT:
MDAT: 1606

Physician:	Fax to	Time:	Call	Resp	Arriv	ORD	Discharge Instructions:			
FD:							Abd Pain	Chest	Head Inj	Scabies
Con 1:							Accident	Crutch	Hepatitis	Sprain
Con 2:							Back Pain	Eye	Kidney Stn	URI
Con 3:							Bruise	Fever	Nose Bleed	Wounds
Physician Orders:							Burn	GI/N.V	Pelvic Inf	UTI

See Order Sheet ()

Primary Diagnosis:

Procedures Performed:

Init. Ac: III Discharge Ac: III VLEVEL: Verbalize Understand Inst. () Photos ()
Notified: () Relative () Authorities () Coroner () Other Intake Output
Disposition: () Treated/Released/Time: () Walk () WC () Ambulance
() Admitted/Room # /Time: Release to: () Self () Parents () Authorities () Guard
() InPatient Hold /Time: () Morgue () AMA () Other
() Observation Room/Time: Nurse:
() Transferred To /Time: [Handwritten signatures]

EMERGENCY REGISTRATION

ST RITAS MEDICAL CENTER
730 WEST MARKET STREET
LIMA, OH 45801
419/226-9050

BADP01/MEDICAL RECORDS

ACCT# 6943108 JOH EMERGENCY 8/14/2012 15.57 D.D. DAYS: MR# 1264822

JOHNSON, PAUL R Age: 044Y 11-30-1967 Prior Nm: AT-ED PHYSICIANS 3
2238 N WEST ST Sex: M Rel: P SSN: *****2027
LIMA OH 45801 M/S: S Race: 1 Maiden: PC-PEREZ, CARLOS A, 83024
ALLEN 419 224-8000 Ethn: N Pl Birth: MI

Isolation: NO DPA: LW: PHYSICIAN NOTIFIED:
Room: Injury: 8/14/12 S/V: ED FC: J St: Emp: N A/C: ED Ch: CH OF THE BRET

Diag: Patient Statement: AMPUTATED FINGER
ACK YES ED 34

Comments:

Spouse - HIPAA Contact: HIPAA Contact: HIPAA Contact:
JOHN COLEMAN 419 224-8000 RI
Relation to Pat: OTHER RELATIONSHIP Relation to Pat:

Employer Information for Patient: IN MATE
ALLEN
Id:
Status: UNEMPLOYED
Father: DOB: 0/00/0000
Mother: DOB: 0/00/0000
NOP: 6/02/2006 Info: N
CC: ED

Primary Insurance: CAREWORK USA ACT, / *****0000 799 1 J ACCOUNTS
PO BOX 18208 364942024 A637985
ATTN MAE SMITH 419 224-8000 J ACCOUNTS RI: Y
COLUMBUS OH 43218 AB: Y Id:
Relation to Pat: OTHER RELATIONSHIP Sex: Status: UNKNOWN
DOB: 1/01/1959

Secondary Insurance: Relation to Pat:
DOB: 0/00/0000
RI: Id:
AB: Status: UNKNOWN
Sex:

Tertiary Insurance: Relation to Pat:
DOB: 0/00/0000
RI: Id:
AB: Status:
Sex:

Bill Condition Codes: Occurance Codes:
1: 05 ACC/NO MED OR LIA COVERAG 8/14/12 15:30
2:
3:
4:
5:
Source: 1 PHYSICIAN OFFICE REFERRAL Physician Signature:
Prior: 6/07/10 - 6/10/10 Signature Date: Time:

ID Ver: Inits: INS Ver: Inits:
WCDTERNS16 KASL 8/14/12 16.09 JOHNSON, PAUL R 6943108 CHART
PNEMER07 Guar-E-ED -1-ED 1-001

JOHNSON, PAUL R
ED PHYSICIANS

8/14/12

St. Rita's Medical Center
Lima, OH

**CONSENT FOR TREATMENT,
GUARANTOR OF ACCOUNTS AND RELEASE OF MEDICAL RECORDS**

4261374

11-30-1967 E 1 M 044Y LE
MR# 1264822 A# 6943108

1 AUG 14 353 PM

34

I, the undersigned patient, hereby consenting to requiring medical care, do hereby voluntarily consent to be given all Inpatient/Emergency/ Outpatient medical care, encompassing routine diagnostic procedures and medical/surgical treatment by an attending physician(s), assistant(s), consultant(s), or designee(s) as necessary in their judgment.

This consent is for treatment rendered under this account number and all subsequent account numbers for _____ Service, from the dates of _____ to _____.

I understand and acknowledge that St. Rita's Medical Center is not responsible for certain independent medical practitioners who may render professional services to me while I am in St. Rita's Medical Center. I understand that these care providers include, but are not limited to: emergency room physicians, anesthesiologists, certified registered nurse anesthetists, physician assistants, radiologists, pathologists, residents, hospitalists and any attending or on-call physician participating or consulting in the care provided. Such care providers are not employees or agents of St. Rita's Medical Center, but are independent contractors who are granted staff privileges to provide medical care to patients in St. Rita's Medical Center. I understand that the actions of such practitioners are not directed or controlled by the Hospital, and that St. Rita's Medical Center relies upon these independent contractors to use appropriate professional judgment in providing care to me. St. Rita's Medical Center is not responsible for the acts or omissions of any independent contractor.

If this is an obstetric case, the within consent shall extend to medical care, diagnostic procedures and medical treatment for any child or children born to this patient.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in St. Rita's Medical Center.

I consent to being photographed or being recorded by videotape in connection with my diagnosis, care and treatment.

Authorization is hereby granted to release medical record information of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse to another health care provider, including faxing of this information, upon my transfer for further care.

I consent to have blood drawn and tested for HIV / Hepatitis in the event of an employee exposure. This information will remain confidential. I understand I am not financially responsible for the fees connected with this testing process.

I certify and acknowledge that I have read and understand all of the above information. By signing this document I confirm that I accept the terms of this document, and confirm that any questions have been asked and answered. I further certify that I am the patient or his/her duly authorized representative, and that I am signing voluntarily.

Paul Johnson
Witness _____ Date _____ Time _____

Pt unable to sign
Signature of Patient _____ Date _____ Time _____

Patient is unable to sign because: Minor Patient's Condition

Auth. Representative/Relationship to Patient _____ Date _____ Time _____

FINANCIAL GUARANTEE AGREEMENT AND RELEASE OF INFORMATION

In consideration of hospitalization and all hospital services, the undersigned agrees to the following:

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to St. Rita's Medical Center and/or the attending physicians or their designees of all insurance benefits, or payments from any other third-party payor, otherwise payable to me.

GUARANTEE OF ACCOUNT: I understand that I am financially responsible to St. Rita's Medical Center and/or any attending physicians or their designees for all charges incurred in the treatment of patient. If payment is not made by an insurance company or third-party payor, I understand that I am financially responsible for the charges for the services provided, even if determined by my employer, insurance company or other third-party payor to be, in their judgment, not necessary. I authorize St. Rita's Medical Center's release of information to its business partners / associates in their efforts to assist me in resolution of my financial liabilities.

RELEASE OF INFORMATION: I hereby authorize St. Rita's Medical Center, its representatives and the attending physicians and designees to release such treatment information from my medical record to my insurance companies, third-party payors, Medicare/Medicaid, welfare agency or any other person or agency responsible for payment and collections for such treatment, and to such consultants and attorneys who need such information for the efficient operation of the medical center. Such information may include psychiatric and drug and alcohol abuse treatment records. (Released subject to Chapter 5122 of the ORC and 42 CFR, part 2).

COMMUNICATION: I authorize my healthcare provider and / or entity authorized by my healthcare provider, including those using automated dialing systems, to communicate with me for any reason by calling any telephone number provided.

MEDICAL RECORD REVIEW: To secure payment, your hospital record may be reviewed by a representative of your employer, insurance company, or third-party payor. I, as a patient and/or responsible party hereby authorize any representative of St. Rita's Medical Center and/or the attending physicians or their designees to release any and all information about this claim to any person or organization including, but not limited to, insurance carriers or employers.

MEDICARE PATIENTS ONLY: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers or the Peer Review Organizations any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

INPATIENTS ONLY: Pursuant to Sec. 3727.12 of the ORC, you are entitled, upon request, to a list of the usual and customary charges for room and board, and the usual and customary charges for a selected number of x-ray, laboratory, emergency, operating room, delivery room, physical therapy, occupational therapy and respiratory therapy services. I also acknowledge receipt of a copy of patient rights and responsibilities.

Paul Johnson
Witness _____ Date _____ Time _____

Paul Johnson
Signature of Patient or Auth. Representative _____ Date _____ Time _____

Account Number _____ Medical Record Number _____

DSP075

Rev. 06/20/12

TAB - CONSENT

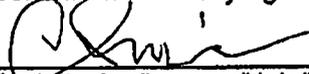
8/14/12
JOHNSON, PAUL R
ED PHYSICIANS
11-30-1967 E 1 M 044Y LE
MR# 1264822 A# 6943108
[Barcode]

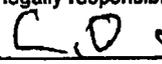
ST. RITA'S MEDICAL CENTER
LIMA, OHIO

PATIENT'S REQUEST / REFUSAL / CONSENT
TO TRANSFER

4260582

I have been informed of my rights regarding examination, treatment, and transfer.



Signature of patient or legally responsible individual signing on patient's behalf


Relationship to patient

Witness

Date

Time

I. Transfer Request

I acknowledge that my medical condition has been evaluated and *explained to me* by the Emergency Department physician or other qualified medical person and/or my attending physician, who has recommended and offered to me further medical examination and treatment. The potential benefits of such further medical examination and treatment as well as the potential risks associated with transfer to another facility have been explained to me and I fully understand them. In spite of this understanding, I refuse to consent to the further medical examination and treatment which has been offered to me, and request transfer to:

Signature of patient or legally responsible individual signing on patient's behalf

Relationship to patient

Witness

Date

Time

II. Transfer Refusal

I acknowledge that my medical condition has been evaluated and *explained to me* by the Emergency Department physician or other qualified medical person and/or my attending physician, who has recommended that I be transferred to the service of Dr. _____ at _____. The potential benefits of such transfer, the potential risks associated with transfer, and the probable risks of not being transferred have been explained to me and I fully understand them. Even though Dr. _____ believes it is in my best interest to be transferred, I refuse to be transferred and I request instead to continue receiving treatment at _____.

Signature of patient or legally responsible individual signing on patient's behalf

Relationship to patient

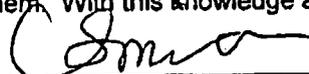
Witness

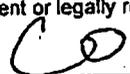
Date

Time

III. Transfer Consent

I acknowledge that my medical condition has been evaluated and *explained to me* by the Emergency Department physician or other qualified medical person and/or my attending physician, who has recommended that I be transferred to the service of Dr. _____ at _____. The potential benefits of such transfer, the potential risks associated with transfer, and the probable risks of not being transferred have been explained to me and I fully understand them. With this knowledge and understanding, I agree and consent to be transferred.



Signature of patient or legally responsible individual signing on patient's behalf


Relationship to patient

Witness

Date

Time



03/11/11

TAB - CONSENTS

PATIENT'S REQUEST / REFUSAL / CONSENT
TO TRANSFER
4260582

PHYSICIAN ASSESSMENT AND CERTIFICATION

Patient Condition

- The patient has been stabilized such that within reasonable medical probability, no material deterioration of the patient's condition or the condition of the unborn child(ren) is likely to result from transfer.
- The patient's condition has not stabilized.
- The patient is in labor.

Patient Diagnosis: Partial Amputation of 4/5th fingers

Transfer Requirements

- The receiving facility, OSU, has available space and qualified personnel for treatment as acknowledged by:
Name / Title / Phone Number Dr. Zebinski / Transfer Unit Date _____ Time _____
- The receiving facility has agreed to accept transfer and to provide appropriate medical treatment as acknowledged by:
Physician Name / Phone Number _____ Date _____ Time _____
- Appropriate medical records of the examination and treatment of the patient are provided at the time of transfer:
(Initial as completed) [Signature]
- The patient will be transferred by qualified personnel and transportation equipment as required including the use of necessary and medically appropriate life support measures.
Transport Agency _____

Provider Certification

I have examined the patient and explained the following risks and benefits of being transferred/refusing transfer to the patient:
Immediate ACI

Based on these reasonable risks and benefits to the patient and/or the unborn child(ren), and based on the information available at the time of the patient's examination, I certify that the medical benefits reasonably to be expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks, if any, to the individual's medical condition from effecting the transfer.

Signature of physician or other qualified medical person [Signature] Date 03/14/12 Time 1645
Title _____





Ambulance

Certification of Medical Necessity

1. Patient	JOHNSON, PAUL R	8/14/12
2. Provider	ED PHYSICIANS	
	11-30-1967 E 1 M 044Y LE	
	MR# 1264822	A# 6943108
3. Patient's		
4. Ambulance Medicaid Provider Name		
5. Ambulance Medicaid Provider Number		

6. Date(s) of (First) Transport

7. Why must the patient use an Ambulance instead of other types of transport? (Check One)

- Non-ambulatory The patient is non-ambulatory and is unable to get up from bed without assistance. The patient is unable to sit in a chair or wheelchair and the patient can only be moved by a stretcher or needs to be restrained.
- Medical Supervision Patient requires continuous medical supervision or treatment during transport.
- Oxygen Administration Patient requires oxygen administration during transport and the patient is unable to self-administer or self-regulate the oxygen or the patient requiring oxygen administration has been discharged from a hospital to a nursing facility.

8. What medical condition requires the patient to use an Ambulance?

Please describe the patient's medical condition that requires the patient to use an ambulance in terms that an average person could understand. The description of the patient's medical condition should support the item(s) checked in number 7.

Medical Supervision / finger amputations - has IV in place

9. How long may the patient require an Ambulance for transportation?

- Temporary (not to exceed 90 days) Patient is expected to need an Ambulance for transport for days from the date of first transport because of the reason(s) checked in number 7 and the medical condition(s) identified in number 8. This certification form is valid for the estimated length of time as designated by the attending practitioner.
- Permanent The patient is expected to need an Ambulance for transport for at least 365 days from the date of the first transport.

10. Are there any other comments or explanations? (Optional)

11. Who is the attending practitioner that has ordered the Ambulance transport?

A. Attending Practitioner ordering this medical transport: (Please Print Name) B. Attending Practitioner Provider Number (Do not use 911115)

12. Who is the attending practitioner or R.N./discharge planner that is signing?

A. Signature & Professional Letters (i.e. MD, DO, RN, APN, LSW etc.) B. Signature Date

8/14/12

JOHNSON, PAUL R
 ED PHYSICIANS
 Patient Nam 11-30-1967 E 1 M 044Y LE
 Date of Birth MR# 1264822 A# 6943108 in _____
 Acct. # _____

St. Rita's Medical Center
 Lima, OH
EMERGENCY DEPARTMENT
PRE-HOSPITAL REPORT
 4243877

EMS Time: _____ AGE: 44 GENDER: (M) F

ETA: 3 LIFEFLIGHT

EMS SQUAD: LACP MEDCORP SHAWNEE AMERICAN TOWNSHIP DELPHOS

OTHER ACI

EMS REPORT: Chest Pain Stroke Sx SOB Abd Pain Injury/Trauma
sliced last 2 fingers @ ~~padding~~ 1st joint

VITALS: BP 93, 70 P 68 R _____ P.Ox 100 T _____ GCS: _____

REPEAT VITALS: BP 103, 108 P _____ R _____ P.Ox _____

EMS TREATMENT:
 OXYGEN: 3 LITERS/MIN Nasal Cannula NRB Intubated Airway _____

MONITOR: SR

EKG TRANSMITTED: No 18 Yes Shown to Dr. _____

IV SOLUTION: Saline @ 18 /Hr Other _____ Backboard C-Collar

MEDS & OTHER Rx: _____

Signature: KW

08/13/2012

8/14/12

JOHNSON, PAUL R
ED PHYSICIANS
11-30-1967 E 1 M 044Y LE
MR# 1264822 A# 6943108

St. Rita's Medical Center
Lima, OH

PATIENT TRANSFER FORM

4250377

1. PATIENT: Johnson Paul Female Male Age 44
LAST FIRST MIDDLE

Acct. #: _____ Med. Rec. #: _____ Date: _____ Transfer In Transfer Out

2. REFERRING FACILITY DATA:

Referring Facility: ACT

Individual Calling: _____ Telephone Number: () _____

Referring Physician: _____ Transferring Specialist: _____

Reason for Transfer: Sliced ~~off~~ palmar amputee 2 digits

RECEIVING FACILITY DATA: Frey 4 hand

Receiving Facility: _____

Receiving Facility Notified: _____ Time: _____ AM / PM

Individual Taking Report: _____ Time: _____ AM / PM

Receiving Physician: _____ Time: _____ AM / PM

3. PATIENT'S PRESENT MEDICAL CONDITION: (See Attached Medical Records or Reports)

Diagnosis: _____

Condition: _____

Vital Signs: BP 106/60 P 72 R 18 TEMP 98.0 97.1 Time: _____ AM / PM

Level of Consciousness: _____

Brief HX or Illness or Injury: _____

Allergies: _____

Present Medication: _____

Current Treatment / IV / O₂ / Meds: _____

X-Rays/Labs Done: _____

Transfer Documents Received: X-Rays: Yes No Lab work: Yes No Nurse Signature _____

Nurse Print Name: _____ Date: _____ Time: _____

Other: _____

4. PATIENT FAMILY(REPRESENTATIVE):

Family Member or Representative: _____ Notified: _____ Time: _____ AM / PM

Telephone Number: () _____

5. RESULT OF TRANSFER REQUEST:

12 Patient Accepted for Transfer; Patient Transferred To:

Emergency Room: _____ Date: _____ Inpatient Floor: _____ Date: _____

Type of Transport: Ambulance: _____ Other: _____

Patient Not Accepted for Transfer. Document Reason: _____

Medications have been reconciled and communicated to patient and/or significant other/next care provider. Yes

Physician's Signature: (For Transfer Out Only) _____ Date: _____ Time: _____

Physician Print Name: _____

Nurse Signature: _____ Nurse Print Name: _____ Date: _____ Time: _____



TAB - SOCIAL SERV./DISCH PLAN



Johnson, Paul R #001264822 (Acct:WR6943108) (46 y.o. M) (Adm: 08/14/12)

STR ED-34-034A

Allergies as of 8/14/2012

Reviewed on: 8/14/2012

No Known Allergies

ED Arrival Information

Expe- cted Ad- mission	Arrival	Acuity	Means of Arrival	Escorted By	Service	Admission Type	Arrival Complaint
-	8/14/20 12 15:59	3- Ur- ge- nt	Medcor p EMS	-	ED Rapid Treatmen t	-	AMPUTATED FINGER ACK YES ED 34

Chief Complaint

Hand Injury [160258] 4th and 5th digits

Diagnosis

Traumatic amputation of other finger(s)
(complete) (partial), complicated

ED Events

Date/Time	Event	User	Comments
08/14/12 1559	Patient arrived in ED	EDI, REGISTRATION	
08/14/12 1600	Triage Started	SNIDER, JENNIFER S	
08/14/12 1601		EDI, REGISTRATION	
08/14/12 1601		EDI, REGISTRATION	
08/14/12 1603	Patient roomed in ED	TULLIS, CHRISTINA L	To room 34
08/14/12 1606	Assign Attending	KOHN, LAWRENCE H	KOHN, L assigned as Attending
08/14/12 1606	Vitals Assessment	SNIDER, JENNIFER S	
08/14/12 1606	Assign Physician/Midlevel	KOHN, LAWRENCE H	Physician/APN/PA First Provider Contact
08/14/12 1610		WOOD, KELLI M	
08/14/12 1614	Transfer Disposition Selected	KOHN, LAWRENCE H	ED Disposition set to Transferred to Another Facility
08/14/12 1614	Disposition Selected	KOHN, LAWRENCE H	
08/14/12 1615	Registration Completed	SLOVIK, KAYLA M	Event logged by interface (984717,2445834)
08/14/12 1616	Triage Completed	SNIDER, JENNIFER S	
08/14/12 1618	Assign Nurse	SNIDER, JENNIFER S	SNIDER, J assigned as Registered Nurse
08/14/12 1740	Patient discharged	SNIDER, JENNIFER S	
08/14/12 1740	Patient departed from ED	SNIDER, JENNIFER S	
08/14/12 1757		SNIDER, JENNIFER S	
08/14/12 1931	Charting Complete	SNIDER, JENNIFER S	
08/17/12 2252	Charting Complete	KOHN, LAWRENCE H	
08/18/12 0402	Send ED Chart to Billing	EPIC, USER	



Patient Education (continued)

ED Events (continued)

Date/Time	Event	User	Comments
08/19/12 0402	Send ED Chart to Billing	EPIC, USER	

ED Treatment Team

Provider	Role	From	To	Phone	Pager
Lawrence Kohn, DO	Attending Provider	08/14/12 1606	--	419-226-9024	
Jennifer S Snider, RN	Registered Nurse	08/14/12 1618	--		

Discharge Orders (720h ago through future)

Start	Status	Ordering User
-- albuterol (PROVENTIL HFA; VENTOLIN HFA) 108 (90 BASE) MCG/ACT inhaler EVERY 6 HOURS PRN	Ordered	WOOD, KELLI M
-- fluticasone-salmeterol (ADVAIR HFA) 115-21 MCG/ACT inhaler 2 TIMES DAILY	Ordered	WOOD, KELLI M
-- nitroGLYCERIN (NITROSTAT) 0.4 MG SL tablet EVERY 5 MIN PRN	Ordered	WOOD, KELLI M
-- clopidogrel (PLAVIX) 75 MG tablet DAILY	Ordered	WOOD, KELLI M
-- pravastatin (PRAVACHOL) 80 MG tablet DAILY	Ordered	WOOD, KELLI M
-- ibuprofen (ADVIL; MOTRIN) 600 MG tablet EVERY 6 HOURS PRN	Ordered	WOOD, KELLI M

Home Medications

Medication	Active?	Last Dose	Start Date	End Date	Provider
albuterol (PROVENTIL HFA; VENTOLIN HFA) 108 (90 BASE) MCG/ACT inhaler			--	--	Historical Provider, MD
amLODIPine (NORVASC) 10 MG tablet			--	--	Historical Provider, MD
aspirin 325 MG EC tablet			--	--	Historical Provider, MD
carvedilol (COREG) 12.5 MG tablet			--	--	Historical Provider, MD
clopidogrel (PLAVIX) 75 MG tablet			--	--	Historical Provider, MD
fenofibrate (TRIGLIDE) 160 MG tablet			--	--	Historical Provider, MD
fluocinonide (LIDEX) 0.05 % cream			--	--	Historical Provider, MD
fluticasone-salmeterol (ADVAIR HFA) 115-21 MCG/ACT inhaler			--	--	Historical Provider, MD



Patient Education (continued)

Home Medications (continued)

	Active?	Last Dose	Start Date	End Date	Provider
hydrALAZINE (APRESOLINE) 50 MG tablet			--	--	Historical Provider, MD
hydrochlorothiazide (HYDRODIURIL) 50 MG tablet			--	--	Historical Provider, MD
ibuprofen (ADVIL; MOTRIN) 600 MG tablet			--	--	Historical Provider, MD
isosorbide mononitrate (IMDUR) 60 MG CR tablet			--	--	Historical Provider, MD
lisinopril (PRINIVIL; ZESTRIL) 20 MG tablet			--	--	Historical Provider, MD
nitroGLYCERIN (NITROSTAT) 0.4 MG SL tablet			--	--	Historical Provider, MD
omeprazole (PRILOSEC) 20 MG capsule			--	--	Historical Provider, MD
potassium chloride (KLOR-CON) 10 MEQ CR tablet			--	--	Historical Provider, MD
pravastatin (PRAVACHOL) 80 MG tablet			--	--	Historical Provider, MD

ED Provider Notes

ED Provider Notes signed by Lawrence Kohn, DO at 8/16/2012 3:39 AM

Author:	Lawrence Kohn, DO	Service:	(none)	Author Type:	Physician
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Filed:	8/16/2012 3:39 AM	Note Time:	8/14/2012 6:59 PM
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ST. RITA'S MEDICAL CENTER
LIMA, OHIO

EMERGENCY DEPARTMENT PHYSICIAN DICTATION

PATIENT NAME: Johnson, Paul R.	DOB: 11/30/1967
MEDICAL RECORD NO: 001264822	ROOM: ED
ACCOUNT NO: 6943108	DATE: 08/14/2012
PHYSICIAN: Lawrence Kohn, M.D.	

This dictation is an adjunct to the Emergency Department Physician Documentation Form.

CHIEF COMPLAINT: Hand injury.

HISTORY OF PRESENT ILLNESS: This is a 44-year-old male who is an inmate at the ACI Prison. He was working in the kitchen and he got his left hand

Patient Education (continued)**ED Provider Notes (continued)**

caught in the cheese slicer accidentally. He has avulsions of the fourth and fifth fingers of the left hand. He avulsed the lateral aspect of the small finger from the tip down about 4 cm. It goes past the DIP joint and the bone is visible and the soft tissue is visible. This whole area of soft tissue overlying is missing. On the adjacent finger, the fourth finger there is a similar lesion, although the rest of the finger was somewhat blocked by the fifth finger. There is a large soft tissue deficit in both fingers. He describes his pain as 10/10 and he was apparently bleeding the whole way over so they put a large bandage on him. Nursing notes reviewed.

REVIEW OF SYSTEMS: He denies any chest pain, shortness of breath or abdominal pain. The remainder of review of systems otherwise reviewed as negative.

PAST MEDICAL HISTORY: Hypertension, hyperlipidemia, coronary artery disease, COPD and hernia repair.

SOCIAL HISTORY: He is currently incarcerated.

PHYSICAL EXAMINATION: Temperature 98.5, pulse 67, respiratory rate 16, blood pressure 166/106. HEAD: Atraumatic appearing. Pupils grossly equivalent, equal and reactive. EARS: Externally normal. NOSE: No epistaxis. MOUTH: Moist mucous membranes. NECK: No tenderness, good range of motion. CHEST WALL: Nontender. LUNGS: Clear. HEART: Regular rate without murmur. LEFT UPPER EXTREMITY: When the bandages were removed large soft tissue deficit of the small finger on the lateral aspect where the lateral part is basically avulsed out. That whole area is oozing from the entirety of it. The bone is visible, I can see subcutaneous fat and underlying musculature. This is about 4 cm. There is a smaller wound, very similar location on the fourth finger of the left hand as well. 2/4 distal pulses there and intact sensation throughout the hand. MENTAL STATUS: Alert and oriented.

MEDICAL DECISION MAKING: He is an inmate at ACI, he will need to have his procedures done at OSU. He does not appear to have any imminent life threat at this point, however he has large soft tissue defects of the fourth and fifth finger that were not going to be repairable here. He may need to have something along the lines of skin grafting done. There may be a fracture there. We are going to defer the x-rays to OSU since I am sure they would rather have them done in their system. We are rebandaging the hand and arranging to transfer.

DIAGNOSTIC RESULTS: None.

EMERGENCY DEPARTMENT COURSE: He received a tetanus shot, he received Ancef, he received 2 mg of Dilaudid and 4 mg of Zofran. I have contacted the OSU Transfer Line, I spoke to their Hand Surgeon and he asked that the patient be transferred through the Emergency Department. Dr. Zelinski is the accepting physician. He was transferred by ground vehicle.

CRITICAL CARE: 5 minutes.

PROCEDURES: None.

CONSULTATIONS: As above.



Patient Education (continued)

ED Provider Notes (continued)

DIAGNOSIS:

1. Avulsion/partial amputation of the fourth and fifth finger of the left hand with significant bleeding.

PLAN: Transfer to OSU.

A face to face evaluation and direct participation in all aspects of patient care was performed by the emergency physician signing this dictation.

Lawrence Kohn, M.D.

D: 08/14/2012 18:59

T: 08/14/2012 20:46 kmb

ED Provider Notes signed by Cerner Scanning at 8/15/2012 12:28 PM

Author:	Cerner Scanning	Service:	(none)	Author	(none)
				Type:	
Filed:	8/15/2012 12:28 PM	Note Time:	8/15/2012 12:28 PM		

Scan on 8/14/2012 3:57 PM by Cerner Scanning (below)
Exception in getDocumentContent Method : The remote server returned an error: (500) Internal Server Error.

ED Notes

ED Notes signed by Jennifer S Snider, RN at 8/14/2012 5:41 PM

Author:	Jennifer S Snider, RN	Service:	(none)	Author	Registered Nurse
				Type:	
Filed:	8/14/2012 5:41 PM	Note Time:	8/14/2012 5:40 PM		

Patient transported to OSU via med corp.

Jennifer S Snider, RN
08/14/12 1741

ED Notes signed by Jennifer S Snider, RN at 8/14/2012 4:43 PM

Author:	Jennifer S Snider, RN	Service:	(none)	Author	Registered Nurse
				Type:	
Filed:	8/14/2012 4:43 PM	Note Time:	8/14/2012 4:42 PM		

Patient's dressing reinforced. Updated on plan of care.



Patient Education (continued)

ED Notes (continued)

Jennifer S Snider, RN
08/14/12 1643

ED Notes signed by Jennifer S Snider, RN at 8/14/2012 4:18 PM

Author:	Jennifer S Snider, RN	Service:	(none)	Author	Registered Nurse
				Type:	

Filed: 8/14/2012 4:18 PM Note Time: 8/14/2012 4:17 PM

Patient at facility working in kitchen slicing cheese and sliced lateral aspect of 4th and 5th digits. No other injuries noted. Bleeding controlled upon arrival. Adaptive, wet-dry dressing applied with kerlex to secure.

Jennifer S Snider, RN
08/14/12 1618

ED Orders

Start		Status	Ordering Provider
08/14/12 1745	HYDROmorphone (DILAUDID) injection 1 mg ONCE	Last MAR action: Given - by SNIDER, JENNIFER S on 08/14/12 at 1731	KOHN, LAWRENCE
08/14/12 1630	tetanus & diphtheria toxoids (adult) 5-2 LFU injection 0.5 mL ONCE	Last MAR action: Given - by SNIDER, JENNIFER S on 08/14/12 at 1629	KOHN, LAWRENCE
08/14/12 1630	ceFAZolin (ANCEF) 1 g IVPB 50mL minibag D5W ONCE	Last MAR action: Given - by SNIDER, JENNIFER S on 08/14/12 at 1637	KOHN, LAWRENCE
08/14/12 1630	HYDROmorphone (DILAUDID) injection 1 mg ONCE	Last MAR action: Given - by SNIDER, JENNIFER S on 08/14/12 at 1633	KOHN, LAWRENCE
08/14/12 1630	ondansetron (ZOFTRAN) injection 4 mg ONCE	Last MAR action: Given - by SNIDER, JENNIFER S on 08/14/12 at 1632	KOHN, LAWRENCE

Lab Results

None

Radiology Results

No matching results found

EKG Results

None

ED Current OP Medications

Medication	Sig	Dispense	Start Date	End Date	Doc. Provider
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Patient Education (continued)

ED Current OP Medications (continued)

Medication	Sig	Dispense	Start Date	End Date	Doc. Provider
albuterol (PROVENTIL HFA; VENTOLIN HFA) 108 (90 BASE) MCG/ACT inhaler	Inhale 1 puff into the lungs every 6 hours as needed.				Historical Provider, MD
fluticasone-salmeterol (ADVAIR HFA) 115-21 MCG/ACT inhaler	Inhale 1 puff into the lungs 2 times daily. 250/50 mcg				Historical Provider, MD
nitroGLYCERIN (NITROSTAT) 0.4 MG SL tablet	Place 0.4 mg under the tongue every 5 minutes as needed.				Historical Provider, MD
clopidogrel (PLAVIX) 75 MG tablet	Take 75 mg by mouth daily.				Historical Provider, MD
pravastatin (PRAVACHOL) 80 MG tablet	Take 80 mg by mouth daily.				Historical Provider, MD
ibuprofen (ADVIL; MOTRIN) 600 MG tablet	Take 600 mg by mouth every 6 hours as needed.				Historical Provider, MD
hydrochlorothiazide (HYDRODIURIL) 50 MG tablet	Take 50 mg by mouth daily.				Historical Provider, MD
omeprazole (PRILOSEC) 20 MG capsule	Take 20 mg by mouth daily. Take two tabs daily				Historical Provider, MD
potassium chloride (KLOR-CON) 10 MEQ CR tablet	Take 10 mEq by mouth daily.				Historical Provider, MD
aspirin 325 MG EC tablet	Take 81 mg by mouth daily.				Historical Provider, MD
isosorbide mononitrate (IMDUR) 60 MG CR tablet	Take 90 mg by mouth daily.				Historical Provider, MD
lisinopril (PRINIVIL; ZESTRIL) 20 MG tablet	Take 40 mg by mouth daily.				Historical Provider, MD
fenofibrate (TRIGLIDE) 160 MG tablet	Take 160 mg by mouth daily.				Historical Provider, MD
amlodipine (NORVASC) 10 MG tablet	Take 10 mg by mouth daily.				Historical Provider, MD
MULTIPLE MINERALS-VITAMINS PO	Take by mouth.				Historical Provider, MD
docusate sodium (COLACE) 100 MG capsule	Take 100 mg by mouth 2 times daily.				Historical Provider, MD
isosorbide mononitrate (IMDUR) 30 MG CR tablet	Take 1 tablet by mouth nightly.	14 tablet	5/15/2013		Mary Zelenak, MD
cloNIDine (CATAPRES) 0.1 MG tablet (Expired)	Take 2 tablets by mouth 2 times daily for 30 doses.	30 tablet	1/1/2013	1/16/2013	Bruce Staeheli, MD



Patient Education (continued)

ED Current OP Medications (continued)

Medication	Sig	Dispense	Start Date	End Date	Doc. Provider
fluocinonide (LIDEX) 0.05 % cream	Apply topically 2 times daily. Apply topically 2 times daily.				Historical Provider, MD
carvedilol (COREG) 12.5 MG tablet	Take 25 mg by mouth 2 times daily (with meals).				Historical Provider, MD
hydrALAZINE (APRESOLINE) 50 MG tablet	Take 50 mg by mouth 2 times daily. 2 tabs BID				Historical Provider, MD

Last reviewed by Kelli Wood, RN on 08/14/12 1617

Medication Comments

** No Medication Comments Found **

ED Prescriptions

None

Follow-up Information

None

Discharge Instructions

None



All Flowsheet Data (08/14/12 0000--08/14/12 2359)

Data

	08/14/12 1731	08/14/12 1633	08/14/12 1612	08/14/12 1606
Vitals				
BP				! 166/106 mmHg -JS
Temp				98.5 °F (36.9 °C) -JS
Temp src				Oral -JS
Pulse				67 -JS
Resp				16 -JS
SpO2				98 % -JS
Weight				230 lb (104.327 kg) -JS
Recorded by				[JS] Jennifer S Snider, RN 08/14/12 1612

Pain 0-10				
Pain Level	10 -JS	10 -JS	10 -JS	
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1732	[JS] Jennifer S Snider, RN 08/14/12 1633	[JS] Jennifer S Snider, RN 08/14/12 1613	

Custom Formula Data

08/14/12 1606	
OTHER	
Percent Weight Change Since Birth	0 -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1612

Relevant Labs and Vitals	
Temp (in Celsius)	36.94 -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1612



Patient Education (continued)

All Flowsheet Data (08/14/12 0000--08/14/12 2359) (continued)

Pain Assessment

	08/14/12 1731	08/14/12 1633	08/14/12 1612
Pain			
Patient Currently in Pain?			Yes -JS
Recorded by			[JS] Jennifer S Snider, RN 08/14/12 1613
Pain Assessment			
Pain Assessment			0-10/Faces -JS
Pain Level	10 -JS	10 -JS	10 -JS
Pain Type			Acute pain -JS
Pain Location			Finger (Comment which one) 4th and 5th -JS
Pain Orientation			Left -JS
Pain Descriptors			Patient unable to describe -JS
Pain Frequency			Continuous -JS
Multiple Pain Sites			No -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1732	[JS] Jennifer S Snider, RN 08/14/12 1633	[JS] Jennifer S Snider, RN 08/14/12 1613

Triage Start

	08/14/12 1600
Triage Start	
Triage Start	Start -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1603



Patient Education (continued)

All Flowsheet Data (08/14/12 0000--08/14/12 2359) (continued)

Vital Signs

08/14/12 1615 08/14/12 1606

Vitals Assessment

Assess vitals? Yes -JS
Recorded by [JS] Jennifer S Snider, RN 08/14/12 1612

Vital Signs

Temp 98.5 °F (36.9 °C) -JS
Temp src Oral -JS
Pulse 67 -JS
Heart Rate Monitor -JS
Source
BP ! 166/106 mmHg -JS
MAP (mmHg) 127 -JS
Patient Position Supine -JS
Resp 16 -JS
SpO2 98 % -JS
O2 Device None (Room air) -JS
Level of Consciousness 0 -JS
MEWS Score 1 -JS
Recorded by [JS] Jennifer S Snider, RN 08/14/12 1612

Height and Weight

Weight 230 lb (104.327 kg) -JS
Weight Method Stated -JS
Percent Weight Change Since Birth 0 -JS
Recorded by [JS] Jennifer S Snider, RN 08/14/12 1612

Screening

Last immunization for Tetanus? Unable to Obtain -JS
Is this a Work Injury? No -JS
Is patient at risk for suicide? No -JS
Recorded by [JS] Jennifer S Snider, RN 08/14/12 1616 [JS] Jennifer S Snider, RN 08/14/12 1612

Safe Environment



Patient Education (continued)

All Flowsheet Data (08/14/12 0000--08/14/12 2359) (continued)

Arm Bands On	ID -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1612

Transfer Checklist

08/14/12-1650

Transfer Checklist

Reason for Transfer	Physician Request -JS
Accepting Hospital	OSU -JS
Accepting Physician	Dr. Zelinski -JS
Sending Physician	Dr. Kohn -JS
Report to Transfer Team	Yes -JS
Report to Receiving Facility	Yes -JS
Receiving Facility Phone Number	614-293-8333 -JS
EMTALA Transfer Form Signed by Patient	Yes -JS
Copy of Records and DI Obtained	Yes -JS
Faxed Records to Receiving Facility	No -JS
Risks/Benefits/ Alternatives to Transport Explained	Yes -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1653

Respiratory

08/14/12 1616

Respiratory

Respiratory (WDL)	WDL -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1616



Patient Education (continued)

All Flowsheet Data (08/14/12 0000--08/14/12 2359) (continued)

Cardiac/Telemetry

08/14/12 1616

Cardiac

Cardiac (WDL) WDL -JS

Recorded by [JS] Jennifer S
Snider, RN
08/14/12 1616

Skeletal/Orthopedic

08/14/12 1616

Skeletal/Orthopedic

Skeletal/Ortho X -JS
(WDL)

LUE Injury/trauma; Am
putation
4th and 5th digits
laterally -JS

Recorded by [JS] Jennifer S
Snider, RN
08/14/12 1617



Patient Education (continued)

All Flowsheet Data (08/14/12 0000--08/14/12 2359) (continued)

Departure Condition

	08/14/12 1756	08/14/12 1731	08/14/12 1633	08/14/12 1612	08/14/12 1606
Departure Condition	Stable -JS				
Departure Condition	Stable -JS				
Mobility at Departure	Stretcher -JS				
Departure Acuity	3-Urgent -JS				
Departure Mode	Other (Comment) via med corp to OSU -JS				
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1756				

Vital Signs

Temp					98.5 °F (36.9 °C) -JS
Temp src					Oral -JS
Pulse					67 -JS
Heart Rate Source					Monitor -JS
Resp					16 -JS
BP					! 166/106 mmHg -JS
MAP (mmHg)					127 -JS
Patient Position					Supine -JS
Level of Consciousness					0 -JS
MEWS Score					1 -JS
Recorded by					[JS] Jennifer S Snider, RN 08/14/12 1612

Pain Assessment

Pain Level	10 -JS	10 -JS	10 -JS	
Pain Type				Acute pain -JS
Pain Location				Finger (Comment which one) 4th and 5th -JS
Pain Orientation				Left -JS
Pain Descriptors				Patient unable to describe -JS
Pain Frequency				Continuous -JS
Multiple Pain Sites				No -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1732	[JS] Jennifer S Snider, RN 08/14/12 1633	[JS] Jennifer S Snider, RN 08/14/12 1613	

Height and Weight



Patient Education (continued)

All Flowsheet Data (08/14/12 0000--08/14/12 2359) (continued)

Weight	230 lb (104.327 kg) -JS
Weight Method	Stated -JS
Percent Weight Change Since Birth	0 -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1612
Oxygen Therapy	
SpO2	98 % -JS
O2 Device	None (Room air) -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1612

Registration Info

	08/14/12 1616
Registration	
Financial Status	-- j accounts -KS
Recorded by	[KS] Kayla M Slovik 08/14/12 1616

Triage Plan

	08/14/12 1616
Triage Plan	
Patient Acuity	3-Urgent -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1616

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key

Initials	Name	Provider Type
KS	Kayla M Slovik	-
JS	Jennifer S Snider, RN	Registered Nurse

Encounter-Level All Encounter and Order Scans:

There are no encounter-level all encounter and order scans.

Order-Level All Encounter and Order Scans:

There are no order-level all encounter and order scans.

Johnson, Paul R #001264822 (Acct:WR6943108) (46 y.o. M) (Adm: 08/14/12)

STR ED-34-034A



Patient Education (continued)

Admission Information

Attending Provider Lawrence Kohn, DO	Admitting Provider	Admission Type	Admission Date/Time 08/14/12 1557
Discharge Date/Time 08/14/12 1557	Hospital Service ED Rapid Treatment	Auth/Cert Status Incomplete	Service Area LIMA
Unit STR EMERGENCY DEPT	Room/Bed 34/034A	Admission Status Discharged (Confirmed)	Referring Provider

Admission Orders

No orders found

Discharge Information

Discharge Provider (none)	Date/Time 08/14/12 1557	Disposition OTHER ACUTE FACILITY	Destination Other
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Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
08/14/12 1559	ED Arrival		STR EMERGENCY DEPT		
08/14/12 1603	ED Roomed	Lima Emergency	STR EMERGENCY DEPT	34/034A	ED Rapid Treatment
08/14/12 1740	Discharge	Lima Emergency	STR EMERGENCY DEPT	34/034A	ED Rapid Treatment

Review Complete On: 8/14/2012 By: Jennifer S Snider, RN

Allergies as of 8/14/2012

No Known Allergies

Immunizations as of 8/14/2012

Never Reviewed

Td	8/14/2012
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ED Records

ED Arrival Information

Expedite	Arrival	Acuity	Means of Arrival	Escorted By	Service Type	Admission Type	Arrival Complaint
-	8/14/2012 15:59	3-Urgent	Medcor p EMS	-	ED Rapid Treatment	-	AMPUTATED FINGER ACK YES ED 34

ED Disposition

Decision to Transfer: Transfer to OSU. Accepted - transfer to ER.

ED Notes

ED Provider Notes signed by Lawrence Kohn, DO at 8/16/2012 3:39 AM

Author:	Lawrence Kohn, DO	Service:	(none)	Author Type:	Physician
Filed:	8/16/2012 3:39 AM	Note Time:	8/14/2012 6:59 PM		



ED Records (continued)

ED Notes (continued)

rather have them done in their system. We are rebandaging the hand and arranging to transfer.

DIAGNOSTIC RESULTS: None.

EMERGENCY DEPARTMENT COURSE: He received a tetanus shot, he received Ancef, he received 2 mg of Dilaudid and 4 mg of Zofran. I have contacted the OSU Transfer Line, I spoke to their Hand Surgeon and he asked that the patient be transferred through the Emergency Department. Dr. Zelinski is the accepting physician. He was transferred by ground vehicle.

CRITICAL CARE: 5 minutes.

PROCEDURES: None.

CONSULTATIONS: As above.

DIAGNOSIS:

1. Avulsion/partial amputation of the fourth and fifth finger of the left hand with significant bleeding.

PLAN: Transfer to OSU.

A face to face evaluation and direct participation in all aspects of patient care was performed by the emergency physician signing this dictation.

Lawrence Kohn, M.D.

D: 08/14/2012 18:59

T: 08/14/2012 20:46 kmb

ED Provider Notes signed by Cerner Scanning at 8/15/2012 12:28 PM

Author:	Cerner Scanning	Service:	(none)	Author	(none)
				Type:	
Filed:	8/15/2012 12:28 PM	Note Time:	8/15/2012 12:28 PM		

Scan on 8/14/2012 3:57 PM by Cerner Scanning (below)
Exception in getDocumentContent Method : The remote server returned an error: (500) Internal Server Error.

ED Records (continued)**ED Notes (continued)**

ED Notes signed by Jennifer S Snider, RN at 8/14/2012 5:41 PM

Author:	Jennifer S Snider, RN	Service:	(none)	Author	Registered Nurse
Filed:	8/14/2012 5:41 PM	Note Time:	8/14/2012 5:40 PM	Type:	

Patient transported to OSU via med corp.

Jennifer S Snider, RN
08/14/12 1741

ED Notes signed by Jennifer S Snider, RN at 8/14/2012 4:43 PM

Author:	Jennifer S Snider, RN	Service:	(none)	Author	Registered Nurse
Filed:	8/14/2012 4:43 PM	Note Time:	8/14/2012 4:42 PM	Type:	

Patient's dressing reinforced. Updated on plan of care.

Jennifer S Snider, RN
08/14/12 1643

ED Notes signed by Jennifer S Snider, RN at 8/14/2012 4:18 PM

Author:	Jennifer S Snider, RN	Service:	(none)	Author	Registered Nurse
Filed:	8/14/2012 4:18 PM	Note Time:	8/14/2012 4:17 PM	Type:	

Patient at facility working in kitchen slicing cheese and sliced lateral aspect of 4th and 5th digits. No other injuries noted. Bleeding controlled upon arrival. Adaptic, wet-dry dressing applied with kerlex to secure.

Jennifer S Snider, RN
08/14/12 1618**Surgery Notes****Periop Results**

No matching results found**Orders**



Medication Orders (08/14/12 - 08/14/12)

HYDROmorphone (DILAUDID) 1 MG/ML injection [130433565] Discontinued

Ordering user: Wcoh Incoming Ads Dispense And Load/Unload Edi 08/14/12 1729 Authorized by: Lawrence Kohn, DO
Frequency: 08/14/12 1729 - 1 Occurrences
Electronically signed by: Wcoh Incoming Ads Dispense And Load/Unload Edi 08/14/12 1729
Discontinued by: Automatic Discharge Provider 08/14/12 1957 [Patient Discharge]
Medication comments: JENNIFER SNIDER: cabinet override

HYDROmorphone (DILAUDID) injection 1 mg [130433564] Completed

Ordering user: Lawrence Kohn, DO 08/14/12 1728 Ordering provider: Lawrence Kohn, DO
Authorized by: Lawrence Kohn, DO Frequency: Once 08/14/12 1745 - 1 Occurrences
Electronically signed by: Lawrence Kohn, DO 08/14/12 1728

albuterol (PROVENTIL HFA; VENTOLIN HFA) 108 (90 BASE) MCG/ACT inhaler [130433558] Active

Ordering user: Kelli Wood, RN 08/14/12 1617 Authorized by: Historical Provider, MD
Frequency: Q6H PRN - Until Discontinued
Electronically signed by: Kelli Wood, RN 08/14/12 1617

fluticasone-salmeterol (ADVAIR HFA) 115-21 MCG/ACT inhaler [130433559] Active

Ordering user: Kelli Wood, RN 08/14/12 1617 Authorized by: Historical Provider, MD
Frequency: BID - Until Discontinued
Electronically signed by: Kelli Wood, RN 08/14/12 1617

nitroGLYCERIN (NITROSTAT) 0.4 MG SL tablet [130433560] Active

Ordering user: Kelli Wood, RN 08/14/12 1617 Authorized by: Historical Provider, MD
Frequency: Q5 Min PRN - Until Discontinued
Electronically signed by: Kelli Wood, RN 08/14/12 1617

clopidogrel (PLAVIX) 75 MG tablet [130433561] Active

Ordering user: Kelli Wood, RN 08/14/12 1617 Authorized by: Historical Provider, MD
Frequency: Daily - Until Discontinued
Electronically signed by: Kelli Wood, RN 08/14/12 1617

pravastatin (PRAVACHOL) 80 MG tablet [130433562] Active

Ordering user: Kelli Wood, RN 08/14/12 1617 Authorized by: Historical Provider, MD
Frequency: Daily - Until Discontinued
Electronically signed by: Kelli Wood, RN 08/14/12 1617

ibuprofen (ADVIL; MOTRIN) 600 MG tablet [130433563] Active

Ordering user: Kelli Wood, RN 08/14/12 1617 Authorized by: Historical Provider, MD
Frequency: Q6H PRN - Until Discontinued
Electronically signed by: Kelli Wood, RN 08/14/12 1617



Medication Orders (08/14/12 - 08/14/12) (continued)

ondansetron (ZOFRAN) injection 4 mg [130433557] Completed

Ordering user: Lawrence Kohn, DO 08/14/12 1607	Ordering provider: Lawrence Kohn, DO
Authorized by: Lawrence Kohn, DO	Frequency: Once 08/14/12 1630 - 1 Occurrences
Electronically signed by: Lawrence Kohn, DO 08/14/12 1607	

tetanus & diphtheria toxoids (adult) 5-2 LFU injection 0.5 mL [130433554] Completed

Ordering user: Lawrence Kohn, DO 08/14/12 1607	Ordering provider: Lawrence Kohn, DO
Authorized by: Lawrence Kohn, DO	Frequency: Once 08/14/12 1630 - 1 Occurrences
Electronically signed by: Lawrence Kohn, DO 08/14/12 1607	

ceFAZolin (ANCEF) 1 g IVPB 50mL minibag D5W [130433555] Completed

Ordering user: Lawrence Kohn, DO 08/14/12 1607	Ordering provider: Lawrence Kohn, DO
Authorized by: Lawrence Kohn, DO	Frequency: Once 08/14/12 1630 - 1 Occurrences
Electronically signed by: Lawrence Kohn, DO 08/14/12 1607	

HYDROmorphone (DILAUDID) injection 1 mg [130433556] Completed

Ordering user: Lawrence Kohn, DO 08/14/12 1607	Ordering provider: Lawrence Kohn, DO
Authorized by: Lawrence Kohn, DO	Frequency: Once 08/14/12 1630 - 1 Occurrences
Electronically signed by: Lawrence Kohn, DO 08/14/12 1607	

Laboratory Orders

No orders found

Imaging Orders

No orders found

Procedure Orders

No orders found

Other Orders

No orders found

Clinical Lab Results

All Results

No matching results found

Radiology Results

Radiology Results

No matching results found

ECG/EMG Results



ECG/EMG Results (continued)

ECG/EMG Results

No matching results found

Medications

All Meds and Administrations

tetanus & diphtheria toxoids (adult) 5-2 LFU injection 0.5 mL
[130433554]

Status: Completed (Past End Date/Time)

Ordering Provider: Lawrence Kohn, DO
Ordered On: 08/14/12 1607
Dose (Remaining/Total): 0.5 mL (0/1)
Route: Intramuscular
Admin Instructions:

Starts/Ends: 08/14/12 1630 - 08/14/12 1629
Frequency: ONCE
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given By
08/14/12 1629	Given	0.5 mL	Intramuscular	Right Arm	Jennifer S Snider, RN

ceFAZolin (ANCEF) 1 g IVPB 50mL minibag D5W [130433555]

Status: Completed (Past End Date/Time)

Ordering Provider: Lawrence Kohn, DO
Ordered On: 08/14/12 1607
Dose (Remaining/Total): 1 g (0/1)
Route: Intravenous
Admin Instructions:

Starts/Ends: 08/14/12 1630 - 08/14/12 1707
Frequency: ONCE
Rate/Duration: 100 mL/hr / 30 Minutes
Comments:

Administration	Status	Dose	Route	Site	Given By
08/14/12 1637	Given	1 g	Intravenous		Jennifer S Snider, RN
		Rate: 100 mL/hr	Duration: 30 Minutes		

HYDRomorphone (DILAUDID) injection 1 mg [130433556]

Status: Completed (Past End Date/Time)

Ordering Provider: Lawrence Kohn, DO
Ordered On: 08/14/12 1607
Dose (Remaining/Total): 1 mg (0/1)
Route: Intravenous
Admin Instructions:

Starts/Ends: 08/14/12 1630 - 08/14/12 1633
Frequency: ONCE
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given By
08/14/12 1633	Given	1 mg	Intravenous		Jennifer S Snider, RN

ondansetron (ZOFTRAN) injection 4 mg [130433557]

Status: Completed (Past End Date/Time)

Ordering Provider: Lawrence Kohn, DO
Ordered On: 08/14/12 1607
Dose (Remaining/Total): 4 mg (0/1)
Route: Intravenous
Admin Instructions:

Starts/Ends: 08/14/12 1630 - 08/14/12 1632
Frequency: ONCE
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given By
08/14/12 1632	Given	4 mg	Intravenous		Jennifer S Snider, RN



Medications (continued)

All Meds and Administrations (continued)

HYDROmorphone (DILAUDID) injection 1 mg [130433564] Status: Completed (Past End Date/Time)

Ordering Provider: Lawrence Kohn, DO

Ordered On: 08/14/12 1728

Dose (Remaining/Total): 1 mg (0/1)

Route: Intravenous

Admin Instructions:

Starts/Ends: 08/14/12 1745 - 08/14/12 1731

Frequency: ONCE

Rate/Duration: - / -

Comments:

Administration	Status	Dose	Route	Site	Given By
08/14/12 1745	Due				
08/14/12 1731	Given	1 mg	Intravenous		Jennifer S Snider, RN
08/14/12 1730	Due				

Historical Medications Entered This Encounter

albuterol (PROVENTIL HFA; VENTOLIN HFA) 108 (90 BASE) MCG/ACT inhaler

Sig: Inhale 1 puff into the lungs every 6 hours as needed.

Class: Historical Med

Route: Inhalation

fluticasone-salmeterol (ADVAIR HFA) 115-21 MCG/ACT inhaler

Sig: Inhale 1 puff into the lungs 2 times daily. 250/50 mcg

Class: Historical Med

Route: Inhalation

nitroGLYCERIN (NITROSTAT) 0.4 MG SL tablet

Sig: Place 0.4 mg under the tongue every 5 minutes as needed.

Class: Historical Med

Route: Sublingual

clopidogrel (PLAVIX) 75 MG tablet

Sig: Take 75 mg by mouth daily.

Class: Historical Med

Route: Oral

pravastatin (PRAVACHOL) 80 MG tablet

Sig: Take 80 mg by mouth daily.

Class: Historical Med

Route: Oral

ibuprofen (ADVIL; MOTRIN) 600 MG tablet

Sig: Take 600 mg by mouth every 6 hours as needed.

Class: Historical Med

Route: Oral

Multi-Disciplinary Problems (Active)

Care Plan

There are no active problems.

Multi-Disciplinary Problems (Resolved)

There are no resolved problems.

Patient Education



Care Plan (continued)

Patient Education

None

Discharge Instructions

Johnson, Paul R (MR # 001264822)

None

Discharge Instructions

Johnson, Paul R (MR # 001264822)

None

Current Discharge Medication List

Medication list as of: 8/14/2012 5:57 PM

CONTINUE these medications which have NOT CHANGED

Medication	AM	Noon	PM	Bedtime
albuterol (PROVENTIL HFA; VENTOLIN HFA) 108 (90 BASE) MCG/ACT inhaler	[]	[]	[]	[]
fluticasone-salmeterol (ADVAIR HFA) 115-21 MCG/ACT inhaler	[]	[]	[]	[]
nitroGLYCERIN (NITROSTAT) 0.4 MG SL tablet	[]	[]	[]	[]
clopidogrel (PLAVIX) 75 MG tablet	[]	[]	[]	[]
pravastatin (PRAVACHOL) 80 MG tablet	[]	[]	[]	[]
ibuprofen (ADVIL; MOTRIN) 600 MG tablet	[]	[]	[]	[]
hydrochlorothiazide (HYDRODIURIL) 50 MG tablet	[]	[]	[]	[]
omeprazole (PRILOSEC) 20 MG capsule	[]	[]	[]	[]
potassium chloride (KLOR-CON) 10 MEQ CR tablet	[]	[]	[]	[]
aspirin 325 MG EC tablet	[]	[]	[]	[]
isosorbide mononitrate (IMDUR) 60 MG CR tablet	[]	[]	[]	[]
lisinopril (PRINIVIL; ZESTRIL) 20 MG tablet	[]	[]	[]	[]
fenofibrate (TRIGLIDE) 160 MG tablet	[]	[]	[]	[]
amLODIPine (NORVASC) 10 MG tablet	[]	[]	[]	[]
fluocinonide (LIDEX) 0.05 % cream	[]	[]	[]	[]
carvedilol (COREG) 12.5 MG tablet	[]	[]	[]	[]
hydrALAZINE (APRESOLINE) 50 MG tablet	[]	[]	[]	[]



STR EMERGENCY DEPT

IP Encounter Report

JOHNSON, PAUL R

MRN: 001264822

DOB: 11/30/1967, Sex: M

Adm: 8/14/2012, D/C: 8/14/2012

Patient Education (continued)



All Flowsheet Data (08/14/12 0000--08/14/12 2359)

Data

	08/14/12 1731	08/14/12 1633	08/14/12 1612	08/14/12 1606
Vitals				
BP				! 166/106 mmHg -JS
Temp				98.5 °F (36.9 °C) -JS
Temp src				Oral -JS
Pulse				67 -JS
Resp				16 -JS
SpO2				98 % -JS
Weight				230 lb (104.327 kg) -JS
Recorded by				[JS] Jennifer S Snider, RN 08/14/12 1612

Pain 0-10				
Pain Level	10 -JS	10 -JS	10 -JS	
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1732	[JS] Jennifer S Snider, RN 08/14/12 1633	[JS] Jennifer S Snider, RN 08/14/12 1613	

Custom Formula Data

08/14/12 1606	
OTHER	
Percent Weight Change Since Birth	0 -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1612

Relevant Labs and Vitals	
Temp (in Celsius)	36.94 -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1612



Patient Education (continued)

All Flowsheet Data (08/14/12 0000--08/14/12 2359) (continued)

Pain Assessment

	08/14/12 1731	08/14/12 1633	08/14/12 1612
Pain			
Patient Currently in Pain?			Yes -JS
Recorded by			[JS] Jennifer S Snider, RN 08/14/12 1613
Pain Assessment			
Pain Assessment			0-10/Faces -JS
Pain Level	10 -JS	10 -JS	10 -JS
Pain Type			Acute pain -JS
Pain Location			Finger (Comment which one) 4th and 5th -JS
Pain Orientation			Left -JS
Pain Descriptors			Patient unable to describe -JS
Pain Frequency			Continuous -JS
Multiple Pain Sites			No -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1732	[JS] Jennifer S Snider, RN 08/14/12 1633	[JS] Jennifer S Snider, RN 08/14/12 1613

Triage Start

	08/14/12 1600
Triage Start	
Triage Start	Start -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1603



Patient Education (continued)

All Flowsheet Data (08/14/12 0000--08/14/12 2359) (continued)

Vital Signs

	08/14/12 1615	08/14/12 1606
Vitals Assessment		
Assess vitals?		Yes -JS
Recorded by		[JS] Jennifer S Snider, RN 08/14/12 1612
Vital Signs		
Temp		98.5 °F (36.9 °C) -JS
Temp src		Oral -JS
Pulse		67 -JS
Heart Rate Source		Monitor -JS
BP		! 166/106 mmHg -JS
MAP (mmHg)		127 -JS
Patient Position		Supine -JS
Resp		16 -JS
SpO2		98 % -JS
O2 Device		None (Room air) -JS
Level of Consciousness		0 -JS
MEWS Score		1 -JS
Recorded by		[JS] Jennifer S Snider, RN 08/14/12 1612

Height and Weight		
Weight		230 lb (104.327 kg) -JS
Weight Method		Stated -JS
Percent Weight Change Since Birth		0 -JS
Recorded by		[JS] Jennifer S Snider, RN 08/14/12 1612

Screening		
Last immunization for Tetanus?	Unable to Obtain -JS	
Is this a Work Injury?		No -JS
Is patient at risk for suicide?		No -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1616	[JS] Jennifer S Snider, RN 08/14/12 1612

Safe Environment



Patient Education (continued)

All Flowsheet Data (08/14/12 0000--08/14/12 2359) (continued)

Arm Bands On	ID -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1612

Transfer Checklist

	08/14/12 1650
Transfer Checklist	
Reason for Transfer	Physician Request -JS
Accepting Hospital	OSU -JS
Accepting Physician	Dr. Zelinski -JS
Sending Physician	Dr. Kohn -JS
Report to Transfer Team	Yes -JS
Report to Receiving Facility	Yes -JS
Receiving Facility Phone Number	614-293-8333 -JS
EMTALA Transfer Form Signed by Patient	Yes -JS
Copy of Records and DI Obtained	Yes -JS
Faxed Records to Receiving Facility	No -JS
Risks/Benefits/ Alternatives to Transport Explained	Yes -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1653

Respiratory

	08/14/12 1616
Respiratory	
Respiratory (WDL)	WDL -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1616



Patient Education (continued)

All Flowsheet Data (08/14/12 0000--08/14/12 2359) (continued)

Cardiac/Telemetry

08/14/12 1616

Cardiac

Cardiac (WDL) WDL -JS

Recorded by [JS] Jennifer S
Snider, RN
08/14/12 1616

Skeletal/Orthopedic

08/14/12 1616

Skeletal/Orthopedic

Skeletal/Ortho X -JS
(WDL)

LUE Injury/trauma; Am
putation
4th and 5th digits
laterally -JS

Recorded by [JS] Jennifer S
Snider, RN
08/14/12 1617



Patient Education (continued)

All Flowsheet Data (08/14/12 0000--08/14/12 2359) (continued)

Departure Condition

	08/14/12 1756	08/14/12 1731	08/14/12 1633	08/14/12 1612	08/14/12 1606
Departure Condition	Stable -JS				
Departure Condition	Stable -JS				
Mobility at Departure	Stretcher -JS				
Departure Acuity	3-Urgent -JS				
Departure Mode	Other (Comment) via med corp to OSU -JS				
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1756				

Vital Signs

Temp				98.5 °F (36.9 °C) -JS
Temp src				Oral -JS
Pulse				67 -JS
Heart Rate Source				Monitor -JS
Resp				16 -JS
BP				! 166/106 mmHg -JS
MAP (mmHg)				127 -JS
Patient Position				Supine -JS
Level of Consciousness				0 -JS
MEWS Score				1 -JS
Recorded by				[JS] Jennifer S Snider, RN 08/14/12 1612

Pain Assessment

Pain Level	10 -JS	10 -JS	10 -JS
Pain Type			Acute pain -JS
Pain Location			Finger (Comment which one) 4th and 5th -JS
Pain Orientation			Left -JS
Pain Descriptors			Patient unable to describe -JS
Pain Frequency			Continuous -JS
Multiple Pain Sites			No -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1732	[JS] Jennifer S Snider, RN 08/14/12 1633	[JS] Jennifer S Snider, RN 08/14/12 1613

Height and Weight



Patient Education (continued)

All Flowsheet Data (08/14/12 0000--08/14/12 2359) (continued)

Weight	230 lb (104.327 kg) -JS
Weight Method	Stated -JS
Percent Weight Change Since Birth	0 -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1612
Oxygen Therapy	
SpO2	98 % -JS
O2 Device	None (Room air) -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1612

Registration Info

	08/14/12 1616
Registration	
Financial Status	-- j accounts -KS
Recorded by	[KS] Kayla M Slovik 08/14/12 1616

Triage Plan

	08/14/12 1616
Triage Plan	
Patient Acuity	3-Urgent -JS
Recorded by	[JS] Jennifer S Snider, RN 08/14/12 1616

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key

Initials	Name	Provider Type
KS	Kayla M Slovik	-
JS	Jennifer S Snider, RN	Registered Nurse

Encounter-Level All Encounter and Order Scans:

There are no encounter-level all encounter and order scans.

Order-Level All Encounter and Order Scans:

There are no order-level all encounter and order scans.

Harper Surgery Clinic

JOHNSON, PAUL - H-801465578

* Final Report *

EXHIBIT "C"

Result type: Harper Surgery Clinic
Result date: March 18, 2015 00:00
Result status: Modified
Result title: 65
Performed by: GURSEL MD, TOLGA on March 27, 2015 08:25
Verified by: GURSEL MD, TOLGA on March 27, 2015 13:58
Encounter info: 180004558680, AMB HA SURHHP, Amb Outpatient-Active Chgs, 03/18/2015 - 03/28/2015
Contributor system: NUANCE

*** Final Report ***
Document Contains Addenda

65

DETROIT MEDICAL CENTER
HARPER UNIVERSITY HOSPITAL

SURGERY CLINIC

PATIENT: JOHNSON, PAUL
LOCATION: SURHHP
ROOM/BED: /

PTID #: 07226781
ACCT #: 180004558680
DOB: 11/30/1967

DATE OF NOTE: 03/18/2015

ATTENDING PHYSICIAN: Tolga Gursel, MD

HISTORY OF PRESENT ILLNESS: Ms. Johnson is a 47-year-old male who was sent by his primary care doctor for evaluation of his left ring and small finger which was amputated approximately a year ago according to the patient. This was a chain saw injury. He states it was repaired in the Emergency Department. It looks like he is describing a composite graft. He complains of pain and weakness in those fingertips. He does not complain of any numbness. The patient has not had any physical or occupational therapy.

REVIEW OF SYSTEMS: Negative for nausea, vomiting, fever, chills, chest pain, shortness of breath, constipation, diarrhea, headache or dizziness.

PAST MEDICAL HISTORY: Coronary artery disease, hypertension, hypercholesterolemia, COPD, mood disorder and antisocial personality disorder.

PAST SURGICAL HISTORY: Angioplasty.

FAMILY HISTORY: Hypertension.

SOCIAL HISTORY: Positive for tobacco. Negative for alcohol or drugs.

ALLERGIES: No known drug allergies.

MEDICATIONS: Amlodipine, aspirin, carvedilol, clonidine, Plavix, gemfibrozil,

Printed by: WILSON, AMBER
Printed on: 05/27/2015 15:19

Page 1 of 2
(Continued)

Harper Surgery Clinic

JOHNSON, PAUL - H-801465578

* Final Report *

hydralazine, hydrochlorothiazide, naproxen, omeprazole and pravastatin.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temp is 36.0, heart rate is 74, blood pressure is 138/74 and respiratory rate is 18.

HEENT: Normocephalic and atraumatic. Pupils equal, round and reactive to light and accommodation. Extraocular movements intact. No scleral icterus.

NECK: Supple and nontender.

CHEST: Clear to auscultation bilaterally.

HEART: Regular rate and rhythm.

ABDOMEN: Soft, nontender and nondistended.

EXTREMITIES: No clubbing, no cyanosis and no edema. Left ring and small fingers show healed distal tips to the finger. Both FDS and FDP are intact. There is no boutonniere or mallet deformity. Sensation is intact. There is some sensitivity to palpation. No exposed structures.

IMPRESSION: Status post composite graft to left small and ring fingers, well-healed with sensitivity. The patient was counseled on range of motion exercises and desensitizing maneuvers. I have also written a formal consultation with occupational therapy for desensitization and mobilization of the joints and soft tissues. The patient needs rehabilitation and then reevaluation in 3 months.

If the report has been electronically signed, see completed action list below.

Tolga Gursel, MD
Signature/Date

D: 03/27/2015 08:25:21
T: 03/27/2015 10:21:54
JOB #1149178/DID #1286168
Edited By:

Dictated By: Tolga Gursel, MD

Addendum by GURSEL MD, TOLGA on May 14, 2015 11:18 (Verified)
change chain saw injury to meat slicer injury. per patient's lawyer's request.

Completed Action List:

- * Perform by GURSEL MD, TOLGA on March 27, 2015 08:25
- * Transcribe by TRANSCRIPTION, NUANCE on March 27, 2015 10:21
- * Sign by GURSEL MD, TOLGA on March 27, 2015 13:58 Requested on March 27, 2015 10:22
- * VERIFY by GURSEL MD, TOLGA on March 27, 2015 13:58
- * Sign by GURSEL MD, TOLGA on May 14, 2015 11:18
- * Modify by GURSEL MD, TOLGA on May 14, 2015 11:18

Printed by: WILSON, AMBER
Printed on: 05/27/2015 15:19

Page 2 of 2
(End of Report)

4/29/15 Bx C

- Physical Therapy
- Occupational Therapy

REHABILITATION DAILY PROGRESS NC

EXHIBIT "D"

TIME: 1P DATE: 4/30/15 Total of Timed Treatment: 60" Billable Units 1WP, 1TE, 2TA TX# 9
 S: Current pain level 8/10 Described as: _____ Med/Sx Reviewed: _____
 Functional / Pain Status: Better Worse No Change no change change
 Subjective complaints: _____

- O: Treatment
- Therapeutic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet
 - Therapeutic Activities :To improve ability with ADL's Functional Activities Body mechanics/Lifting
 - Gait Training: To improve Balance Strength Coordination Stairs
 - Neuro Re-ed: To improve Balance Strength Coordination
 - Aquatic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet
 - Manual
 - HEP/Education/self care: Issued Understood Pt Demonstrated with: Assist. Required Independent

Comments: Tendon gliding hrs x 12. Velcro cube removal with R, SF and thumb putty.
press and punch for full grasp using red punch for strengthening

Modalities: US Pump MHP CP Fluid/WP Paraffin CTX PTX ES
 Parameters 20" (C) hand/wrist for desensitizing

A: Pain after treatment: 7/10 No change Better Worse
 Patient progress towards functional goals: Reports 6 improvement in pain on R, sensitivity in L hand
 Patient's response to treatment _____

Requires cueing to perform correct ex techniques Min Mod Type of Cueing Verbal Tactile Demonstration
 Comments: sup 30, 29, 25 28/PP 18/15 # pain 3/10 Digit to MPC
the patient not using hand correctly for tasks

P: Plan / recommendations include: Wound 2: HEP not needed

Patient did not attend therapy: Cancelled Reason: _____ Failed to Show
 Therapist Signature Joni J. Tomalak OTR Date 4/30/15

TIME: _____ DATE: _____ Total of Timed Treatment: _____ Billable Units _____ TX# _____
 S: Current pain level _____/10 Described as: _____ Med/Sx Reviewed: _____
 Functional / Pain Status: Better Worse No Change no change change
 Subjective complaints: _____

- O: Treatment
- Therapeutic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet
 - Therapeutic Activities :To improve ability with ADL's Functional Activities Body mechanics/Lifting
 - Gait Training: To improve Balance Strength Coordination Stairs
 - Neuro Re-ed: To improve Balance Strength Coordination
 - Aquatic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet
 - Manual
 - HEP/Education/self care: Issued Understood Pt Demonstrated with: Assist. Required Independent

Comments: _____

Modalities: US Pump MHP CP Fluid/WP Paraffin CTX PTX ES
 Parameters _____

A: Pain after treatment: _____/10 No change Better Worse
 Patient progress towards functional goals: _____
 Patient's response to treatment _____

Requires cueing to perform correct ex techniques Min Mod Type of Cueing Verbal Tactile Demonstration
 Comments: _____

P: Plan / recommendations include: _____

Patient did not attend therapy: Cancelled Reason: _____ Failed to Show
 Therapist Signature _____ Date _____

4/29/15 BXC

- Physical Therapy Occupational Therapy

REHABILITATION DAILY PROGRESS NC

TIME: 1P DATE: 4/24/15 Total of Timed Treatment: 60" Billable Units: 1W, 1TE, 2TA TX# 7
S: Current pain level 8/10 Described as: Functional / Pain Status: Better Worse No Change Med/Sx Reviewed: no change change
Subjective complaints: "My hand feels good after I come out of the sand."

- Treatment: Therapeutic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet
Therapeutic Activities: To improve ability with ADL's Functional Activities Body mechanics/Lifting
Gait Training: To improve Balance Strength Coordination Stairs
Neuro Re-ed: To improve Balance Strength Coordination
Aquatic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet
Manual
HEP/Education/self care: Issued Understood Pt Demonstrated with: Assist. Required Independent

Comments: ROM of the (L) hand 10 x 5 in desensitizing with words 5-8
2 min in desensitizing and in hand manipulation to it

Modalities: US Pump MHP CP Fluid/WP Paraffin CTX PTX ES
Parameters: 20" post tx of end activities

A: Pain after treatment: 6/10 No change Better Worse

Patient progress towards functional goals: No changes in pain levels or use of (L)
Patient's response to treatment: Pt demonstrates good ROM in all (L) digits with some tx

Requires cueing to perform correct ex techniques: Min Mod Type of Cueing Verbal Tactile Demonstration
Comments: activities, others the R: SFG are held rigidly. He reports following through with tx and desensitizing at home

P: Plan / recommendations include: Desensitizing activities, ROM of end activities to (L) hand motion

Patient did not attend therapy: Canceled Reason: Failed to Show
Therapist Signature: Date: 4/24/15

TIME: 1P DATE: 4/23/15 Total of Timed Treatment: 60" Billable Units: 1W, 1TE, 2TA TX# 8
S: Current pain level 8/10 Described as: Functional / Pain Status: Better Worse No Change Med/Sx Reviewed: no change change
Subjective complaints: Shooting pain in my fingers to forearm

- Treatment: Therapeutic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet
Therapeutic Activities: To improve ability with ADL's Functional Activities Body mechanics/Lifting
Gait Training: To improve Balance Strength Coordination Stairs
Neuro Re-ed: To improve Balance Strength Coordination
Aquatic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet
Manual
HEP/Education/self care: Issued Understood Pt Demonstrated with: Assist. Required Independent

Comments: Desensitizing with words 7-10 3 min ea. Tendon gliding info, abled +
Hand to do finger manipulation of washers and by picking up multiple

Modalities: US Pump MHP CP Fluid/WP Paraffin CTX PTX ES
Parameters: as above

A: Pain after treatment: 8/10 No change Better Worse Instructed in red putty info with tx

Patient progress towards functional goals: Reports B. improvement about
Patient's response to treatment: Not far difficulty with R: SFG for tip pinch

Requires cueing to perform correct ex techniques: Min Mod Type of Cueing Verbal Tactile Demonstration
Comments:

P: Plan / recommendations include: ROM/strengthening of activities for (L) hand desensitizing

Patient did not attend therapy: Canceled Reason: Failed to Show
Therapist Signature: Date: 4/23/15

4/29/15 BxC

- Physical Therapy
Occupational Therapy

REHABILITATION DAILY PROGRESS N



TIME: 1P DATE: 4/17/15 Total of Timed Treatment: 60" Billable Units 1WP, 1TE, 2TA TX# 5

S: Current pain level 8/10 Described as: Functional/Pain Status: Better Worse No Change Med/Sx Reviewed: no change change

Subjective complaints: "I got some tingling last night in my hand. I was going to go to the hospital."

- O: Treatment
Therapeutic Ex: To increase ROM/strength for improvement in ADL's Functional Activities See log sheet
Therapeutic Activities: To improve ability with ADL's Functional Activities Body mechanics/Lifting
Gait Training: To improve Balance Strength Coordination Stairs
Neuro Re-ed: To improve Balance Strength Coordination
Aquatic Ex: To increase ROM/strength for improvement in ADL's Functional Activities See log sheet
Manual
HEP/Education/self care: Issued Understood Pt Demonstrated with: Assist. Required Independent

Comments: ARM (stretching) hand 10 reps with towel walk, desensitizing rubbing with different materials 3 min ea, baseball retrieved for desensitizing

Modalities: US Pump MHP CP Fluids/WP Paraffin CTX PTX ES
Parameters 20 min (L) hand; wrist

A: Pain after treatment: 7/10 No change Better Worse

Patient progress towards functional goals: Minimal use of (L) 2" pain and paraesthesia

Patient's response to treatment: Tol reporting not feeling material because he is numb and

Requires cueing to perform correct ex techniques Min Mod Type of Cueing Verbal Tactile Demonstration

Comments: Reporting return of stiffness in hand after being out of fluids and moving hand

P: Plan / recommendations include: Desensitizing, ROM exp and activities (L) wrist

Patient did not attend therapy: Cancelled Reason: Failed to Show

Therapist Signature: Date: 4/17/15

TIME: 1P DATE: 4/23/15 Total of Timed Treatment: 60" Billable Units 1WP, 1TE, 2TA TX# 6

S: Current pain level 8/10 Described as: Functional/Pain Status: Better Worse No Change Med/Sx Reviewed: no change change

Subjective complaints: High hand still hurts

- O: Treatment
Therapeutic Ex: To increase ROM/strength for improvement in ADL's Functional Activities See log sheet
Therapeutic Activities: To improve ability with ADL's Functional Activities Body mechanics/Lifting
Gait Training: To improve Balance Strength Coordination Stairs
Neuro Re-ed: To improve Balance Strength Coordination
Aquatic Ex: To increase ROM/strength for improvement in ADL's Functional Activities See log sheet
Manual
HEP/Education/self care: Issued Understood Pt Demonstrated with: Assist. Required Independent

Comments: Rem eyes for the (L) hand x 10 ea Paper secured x 10 ea (L) desensitizing used 4-5 2 min ea. Prog VA task allowing by 3's then reporting with all ad

Modalities: US Pump MHP CP Fluids/WP Paraffin CTX PTX ES
Parameters ca above

A: Pain after treatment: 7/10 No change Better Worse

Patient progress towards functional goals: Limited use of (L) continues 2" ongoing pain (usually 8/10)

Patient's response to treatment: Tol, reporting fluids really makes the hand feel better

Requires cueing to perform correct ex techniques Min Mod Type of Cueing Verbal Tactile Demonstration

Comments:

P: Plan / recommendations include: ROM exp and activity, desensitizing activities for the (L) hand

Patient did not attend therapy: Cancelled Reason: Failed to Show

Therapist Signature: Date: 4/23/15

4/29/15 BXS

- Physical Therapy
- Occupational Therapy

REHABILITATION DAILY PROGRESS I



TIME: 1P DATE: 4/14/15 Total of Timed Treatment: _____ Billable Units 100, ERROR 4 TX# 10
 S: Current pain level 10 Described as: _____ Med/Sx Reviewed: _____
 Functional / Pain Status: Better Worse No Change
 Subjective complaints: _____ Med/Sx Reviewed: no change change

O: Treatment
 Therapeutic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet
 Therapeutic Activities :To improve ability with ADL's Functional Activities Body mechanics/Lifting
 Gait Training: To improve Balance Strength Coordination Stairs
 Neuro Re-ed: To improve Balance Strength Coordination
 Aquatic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet
 Manual
 HEP/Education/self care: Issued Understood Pt Demonstrated with: Assist. Required Independent

Comments: _____
 Modalities: _____ US Pump MHP CP Fluido/WP Paraffin CTX PTX ES
 Parameters
 Other: _____

A: Pain after treatment: 10 No change Better Worse
 Patient progress towards functional goals: _____
 Patient's response to treatment _____
 Requires cueing to perform correct ex techniques Min Mod Type of Cueing Verbal Tactile Demonstration
 Comments: Patient called 12:15pm having trouble with transportation

P: Plan / recommendations include: as written
 Patient did not attend therapy: Cancelled Reason: transportation Failed to Show
 Therapist Signature [Signature] Date 4/14/15

TIME: 1P DATE: 4/16/15 Total of Timed Treatment: 60" Billable Units 100, ITE, 2TA TX# 4
 S: Current pain level 8 /10 Described as: _____ Med/Sx Reviewed: _____
 Functional / Pain Status: Better Worse No Change
 Subjective complaints: _____ Med/Sx Reviewed: no change change

O: Treatment
 Therapeutic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet
 Therapeutic Activities :To improve ability with ADL's Functional Activities Body mechanics/Lifting
 Gait Training: To improve Balance Strength Coordination Stairs
 Neuro Re-ed: To improve Balance Strength Coordination
 Aquatic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet
 Manual
 HEP/Education/self care: Issued Understood Pt Demonstrated with: Assist. Required Independent

Comments: Room 205 L. hand 10ea. desensitizing for R: 205 E. After both pushing out time with L.
 Modalities: _____ US Pump MHP CP Fluido/WP Paraffin CTX PTX ES
 Parameters
 Other: Materials 3 min ea.

A: Pain after treatment: 7 /10 No change Better Worse @ additional use of L. for tasks
 Patient progress towards functional goals: Pre patient following L. and desensitizing as directed
 Patient's response to treatment tol reporting hand to (fluido therapy) was wearing off
 Requires cueing to perform correct ex techniques Min Mod Type of Cueing Verbal Tactile Demonstration
 Comments: _____

P: Plan / recommendations include: Desensitizing activities, Roll of and activities for L. to facilitate motion and use
 Patient did not attend therapy: Cancelled Reason: _____ Failed to Show
 Therapist Signature [Signature] Date 4/16/15

4/29/15 Bxc

DMC Rehabilitation Institute of Michigan

IN: 46000186532 PTID: 07726781 JOHNSON, PAUL DOS: 04/01/15 BD: 11/30/1967 MRN: xxxxxx8261 M ATTN: NO ATTENDING/NO R RNDRNW

REHABILITATION DAILY PROGRESS NC



- Physical Therapy Occupational Therapy

TIME: 1P DATE: 4/9/15 Total of Timed Treatment: Billable Units TX# 2

S: Current pain level 10 Described as: Med/Sx Reviewed: Functional / Pain Status: Better Worse No Change no change change

O: Treatment Therapeutic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet Therapeutic Activities: To improve ability with ADL's Functional Activities Body mechanics/Lifting Gait Training: To improve Balance Strength Coordination Stairs Neuro Re-ed: To improve Balance Strength Coordination Aquatic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet Manual HEP/Education/self care: Issued Understood Pt Demonstrated with: Assist. Required Independent

Comments: Modalities: US Pump MHP CP Fluido/WP Paraffin CTX PTX ES Parameters Other:

A: Pain after treatment: 10 No change Better Worse Patient progress towards functional goals: Patient's response to treatment Requires cueing to perform correct ex techniques Min Mod Type of Cueing Verbal Tactile Demonstration Comments:

P: Plan / recommendations include: as written

Patient did not attend therapy: Canceled Reason: Meeting with attorney Failed to Show Therapist Signature Date 4/9/15

TIME: 1P DATE: 4/10/15 Total of Timed Treatment: 60" Billable Units 1WP, 1TE, 2TA TX# 3

S: Current pain level 8/10 Described as: Med/Sx Reviewed: Functional / Pain Status: Better Worse No Change no change change

Subjective complaints: "My hand is getting stiffer." O: Treatment Therapeutic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet Therapeutic Activities: To improve ability with ADL's Functional Activities Body mechanics/Lifting Gait Training: To improve Balance Strength Coordination Stairs Neuro Re-ed: To improve Balance Strength Coordination Aquatic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet Manual HEP/Education/self care: Issued Understood Pt Demonstrated with: Assist. Required Independent

Comments: Review of ROMs and towel walk, paper scissors x 8 by pag flip then 2 at a time. become frustrated & 2 pages Modalities: US Pump MHP CP Fluido/WP Paraffin CTX PTX ES Parameters 20 min (-) hand for desensitizing Other:

A: Pain after treatment: 8/10 No change Better Worse Patient progress towards functional goals: guarded to use use 2" stiffness and reactivity Patient's response to treatment Tot fair c/o 1 digit stiffness and getting a workout with pag activity Requires cueing to perform correct ex techniques Min Mod Type of Cueing Verbal Tactile Demonstration Comments: Patient requesting a brace to correct his "cracked" fingers. Recommended following desensitizing his hand so he can comfortably use his fingers.

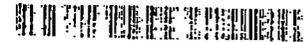
P: Plan / recommendations include: Coordination of end activities, desensitizing for hand

Patient did not attend therapy: Canceled Reason: Therapist Signature Date 4/10/15

4/27/15 BxC

- Physical Therapy Occupational Therapy

REHABILITATION DAILY PROGRESS NO



TIME: 1st DATE: 4/1/15 Total of Timed Treatment: 50" Billable Units 2w, 1TA TX# 1

S: Current pain level 10/10 Described as: Functional / Pain Status: Better Worse No Change Med/Sx Reviewed: no change change

Subjective complaints: "My fingers feel funny" O: Treatment

- Therapeutic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet Therapeutic Activities: To improve ability with ADL's Functional Activities Body mechanics/Lifting Gait Training: To improve Balance Strength Coordination Stairs Neuro Re-ed: To improve Balance Strength Coordination Aquatic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet Manual

HEP/Education/self care: Issued Understood Pt Demonstrated with: Assist. Required Independent

Comments: Patient presents with hyperactivity (L) dominant R-SFS S/P computation (?) and hyper 1yr ago. Tx up to this point 20 incarceration. Digits well Parameters heated pad, mild stiffness, words (L) hand use

Modalities: US Pump MHP CP Fluido/WP Paraffin CTX PTX ES Other: Instructed in desensitizing, used words 1-3 for 3 min ea

A: Pain after treatment: 8-10/10 No change Better Worse Patient progress towards functional goals: Now using non-dm (R) as primary hand (X 1 yr)

Patient's response to treatment: Tol fair stated contract feels funny Requires cueing to perform correct ex techniques Min Mod Type of Cueing Verbal Tactile Demonstration

Comments: Patient asked about how fingers could access medical records P: Plan / recommendations include: See what for goals

Patient did not attend therapy: Canceled Reason: Failed to Show Therapist Signature: [Signature] Date: 4/1/15

TIME: 1st DATE: 4/7/15 Total of Timed Treatment: 45" Billable Units 1WP, 2TE, 1TA TX# 2

S: Current pain level 8/10 Described as: Functional / Pain Status: Better Worse No Change Med/Sx Reviewed: no change change

Subjective complaints: O: Treatment Therapeutic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet

- Therapeutic Activities: To improve ability with ADL's Functional Activities Body mechanics/Lifting Gait Training: To improve Balance Strength Coordination Stairs Neuro Re-ed: To improve Balance Strength Coordination Aquatic Ex: To increase ROM /strength for improvement in ADL's Functional Activities See log sheet Manual HEP/Education/self care: Issued Understood Pt Demonstrated with: Assist. Required Independent

Comments: Instructed in ROM/stretching etc for the (L) hand in see form

Modalities: US Pump MHP CP Fluido/WP Paraffin CTX PTX ES Other: Parameters 15" (L) hand 112°/100% air for desensitizing of R-E SFS

A: Pain after treatment: 6-7/10 No change Better Worse Patient progress towards functional goals: Tol fair did like the fluidotherapy which I'd pain

Patient's response to treatment: Tol fair did like the fluidotherapy which I'd pain Requires cueing to perform correct ex techniques Min Mod Type of Cueing Verbal Tactile Demonstration

Comments: He walked in door at 1:45 spent 15" on phone prior to starting tx P: Plan / recommendations include: ROM exp, desensitizing (L) hand (R-SFS)

Patient did not attend therapy: Canceled Reason: Failed to Show Therapist Signature: [Signature] Date: 4/7/15

DMC
Rehabilitation Institute
of Michigan

FIN: 460000186532 PTLID: 07226781
 JOHNSON, PAUL DOS: 04/01/15
 BD: 11/30/1967 MRN: xxxxx8261 M
 ATTN: NO ATTENDING/NO R RNDRNW



PT OT **FUNCTIONAL STATUS/LONG-TERM GOALS AND TREATMENT PLAN**
 (determined in collaboration with patient)

2-6/10

	Pain range (0-10) <u>4-10/10 (L) Digits</u>	Initial Function	Long Term Goal
1. Dressing			NG
2. Grooming			
3. Bathing			
4. Toileting			
5. Meal Preparation			
6. Self Feeding/cutting		2	0-1
7. Housework			NG
8. Child/Elder Care			
9. Holding objects in palm			
10. Putting hand in pocket			
11. Lifting and carrying	(L) UE	3	1-2
12. Gripping tightly	(R)	2	0-1
13. Writing		2	0-1
14. Performing Fine Motor Tasks	(L)	2-3	1-2
15. Driving			NG
16. Overhead/Reaching Activities			
17. Work/School Performance			
18. Sleeping			
19. Range of Motion	(L) Hand	2	0-1
20. Strength	(L) hand	2	0-1
21. Home Program Performance		4	0
22.			
G-Code Initial			
Severity Modifier Initial			

Diagnosis: (L) R/SF Sensitivity
Affness S/P amputation. Lysage

- Treatment Plan:**
 (applies to all diagnoses unless specified)
- Therapeutic exercise
 - Strengthening
 - Mobility/
 - Balance/Coordination/Stabilization
 - Conditioning
 - Functional Training
 - Mobilization
 - Soft Tissue
 - Joint
 - Gait Training
 - Muscle Stretching
 - Postural Training
 - Body Mechanics/Joint Protection
 - Home Program Instruction
 - Modalities - PRN
 - HP
 - CP/Ice
 - US
 - Electrical Stim.
 - Phonophoresis (10% Hydrocortisone)
 - Ionophoresis (10mg/1mL Dexamethasone)
 - Paraffin
 - Whirlpool/Fluidotherapy
 - Traction
 - manual
 - mechanical
 - Pool Therapy
 - Unweighted exercise
 - Orthotics
 - Other Desensitizing
- Frequency: 2x/week
 Duration: 4 weeks

Goal Scale:
 0 = no difficulty/normal 1 = min difficulty/impairment
 2 = mod difficulty/impairment 3 = severe difficulty/impairment
 4 = unable to do/max impairment
 NA = not applicable to patient NG = not a goal at this time

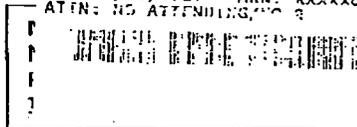
Therapist Signature: Priscilla Trumble OT

Date: 4/1/15

I certify the need for services furnished under this plan of treatment and while under my care.
 *Physician Signature: _____ * Date: _____
 Dear Physician: Please sign AND date above and fax back to _____ Thank you.
 Rev: 9-14 CM

DMC Rehabilitation Institute of Michigan

LINE: 460000185532 PID: 07226781
 JOHNSON, PAUL DOB: 04/01/15
 RD: 11/30/1967 HRN: XXXXX8201 M
 ATEN: NO ATTENDING, M M RNDORNW



OCCUPATIONAL THERAPY HAND EVALUATION

Diagnosis: (L) R: SF Sensitivity, stiffness S/P amputation 1yr ago
 Rx ordered: See script
 Equipment/Splints: Dresses
 Precautions:

Dr. Murriel re ✓

HTyo M

SUBJECTIVE:

Hand Dominance: Left Right
 Onset/Surgery Dates/Tests: Digits cut off with cheese slicer 1yr ago

Job/Home/Avocational Activities: not currently working, living in 2 family flat main level, not currently driving

Initial Symptoms:

Present Symptoms:

Painful + tingling S: RF ulnar aspect of hand

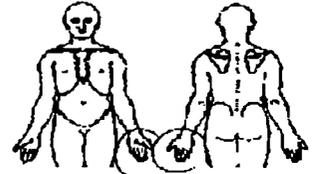
Currently 10/10

Pain Range (0-10):

Pain Range (0-10): 4-10/10

Pain Freq:

Pain Freq: constant



Key:
 /// = pain
 . = paresthesia

Comments (At rest, during activity, after activity):

Dresses taking pain

OBJECTIVE:

Posture/Cervical: NT

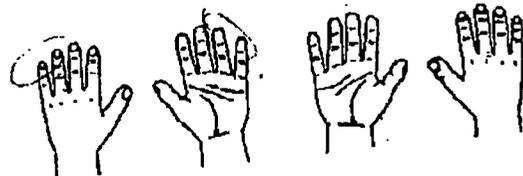
Hand Appearance (color, temperature, scars, etc.): Scarring around tips of R: SF with partial new nails

Sensation	(L) Hand	(R) Hand
Light touch	<u>Hyper sensitive</u>	<u>+</u>
Deep pressure		<u>+</u>

Comments: (Steriognosis, proprioception, etc.)

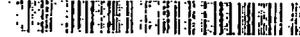
NT

Semmes-Weinstein Monofilament



○ Normal
 ○ Diminished light touch
 ○ Diminished protective
 ○ Loss of protective
 ○ Deep Pressure only

Name
 MRN



Upper Extremity	Active ROM		Passive ROM		Mu: Left
	Left	Right	Left	Right	
Scapular					
Elevation		<i>wpl (B)</i>			<i>NT</i>
Depression					
Protraction					
Retraction					
Shoulder					
Extension (0-60)					
Flexion (0-180)					
Abduction (0-180)					
Horizontal Abduction (0-90)					
Horizontal Adduction (0-45)					
Internal Rotation (0-70)*					
External Rotation (0-90)*					
Elbow					
Extension (0)					
Flexion (0-150)					
Forearm					
Supination (0-90)					
Pronation (0-90)					
Wrist					
Extension (0-70)					
Flexion (0-80)					
Radial deviation(0-20)					
Ulnar deviation (0-45)					

*Note: Shoulder rotation to be assessed in scapular plane.

Left Hand ROM - Digits

See below

TAM 290	MP		PIP		DIP		TAM/TPM 290
	0-90		0-110		0-90		
NORM	AROM	PROM	AROM	PROM	AROM	PROM	%
Index							
Middle							
Ring							
Little							

NT

Provocative Testing	+/-
Adison/Allen	
Medial/lateral epicondylitis	
Phalens'	
Tinel's	
Finkelstein's	
Pinch	
Allen	

Right Hand ROM - Digits

wpl

TAM 290	MP		PIP		DIP		TAM/TPM 290
	0-90		0-110		0-90		
NORM	AROM	PROM	AROM	PROM	AROM	PROM	%
Index							
Middle							
Ring							
Little							

Thumb	Left			Right		
	AROM	PROM	TAM/TPM	AROM	PROM	TAM/TPM
MP extension/flexion						
IP extension/flexion						
Composite						
Radial abduction						
Palmar abduction						

	Composite Flexion Distance to DPC		Composite Flexion Distance to MCP	
	Left	Right	Left	Right
I			<i>0cm</i>	<i>0cm</i>
M			<i>2cm</i>	<i>2cm</i>
R			<i>3cm</i>	<i>3cm</i>
L				

Name: _____
 MRN#: _____



Grip Strength (per dynamometer)		
Left		Right
45	trial 1	82
41	trial 2	87
31	trial 3	67
39#	Avg.	79#
	norm	

Lateral Pinch Strength							
Left		Right		Left		Right	
9#	Trial 1	23#		9#	Trial 1	19#	
	Trial 2				Trial 2		
	Trial 3				Trial 3		
	Avg.				Avg.		
	Norm				Norm		

Edema	Left	Right
Volumeter		
Circumference	NT	NT
Comments:	is noted during eval	

Coordination

Coordination (9-hole Peg)		
Left		Right
43 sec	Time	25 sec
	Norm	

Activities of Daily Living Pate now with (R) assisted to cut food, (R) performs oral grooming, toilet hygiene, uses thumb I-M's only when assisting with dominant (L).

Instrumental Activities of Daily Living Bedfriend does most held tasks, patient may assist occasionally, ↓ efficiency opening containers and item retrieval

ASSESSMENT:

- Summary of deficits/limitations: 1. Hypersensitive, stiff, painful (L) dominant R - SFs S/P trauma 1yr ago
 2. ↓ (L) hand strength, R - SF ROM
 3. Assisted with self-care; now using (R) as dominant, working R - SF all on (L)
 4. ↓ efficiency opening containers, retrieving items with (L), writing with (L)

Patient Goals: "Get my hand as ml as possible, use my hand again"

- Short Term Goals: 1. (I) in a Hld for desensitizing activities, ROM exp (L) hand.
 2. ↓ sensitivity in R - SFs on (L) to ↑ efficiency of use during self care.
 3. _____
 4. _____
 5. _____

- Additional Long Term Goals: 1. _____
 2. _____
 3. _____
 4. _____
 5. See Initial Goal Form

Therapist Signature: Traci Tomalak OTC Date: 4/1/15

Neurology
 M.D.
 Phy
 Inso

**Past Medical History
 Summary Form**

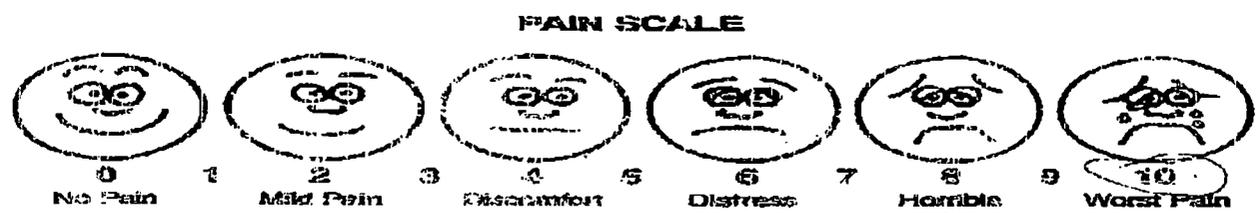
**Rehabilitation Institute
 of Michigan**

PLEASE LET US KNOW IF

You need help filling this form Y N Today's Date: 4-1-15
 You need an interpreter Y N Your age: 47 Circle: M F
 You have trouble hearing Y N Current diagnosis: _____
 What is your preferred language? _____
 Are you being seen by a NURSE, THERAPIST or DOCTOR in your home? Yes No
 If you answered yes, for what? _____ Agency: _____
 What did you do? _____
 Have you ever had Physical, Occupational, or Speech Therapy? Yes No
 When? _____ What for? _____ Did treatment help? Y N

MEDICAL HISTORY:						Have you recently had:		
Have you ever had:								
Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	HIV +	<input type="checkbox"/> Y	<input type="checkbox"/> N	Headaches	<input type="checkbox"/> Y	<input checked="" type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Anemia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Nausea/vomiting	<input type="checkbox"/> Y	<input type="checkbox"/> N
High blood pressure	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	Gynecological problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Unexplained weight changes	<input type="checkbox"/> Y	<input type="checkbox"/> N
Heart Disease	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	Urinary tract infection	<input type="checkbox"/> Y	<input type="checkbox"/> N	Bowel/bladder problems	<input type="checkbox"/> Y	<input type="checkbox"/> N
Heart Murmur	<input type="checkbox"/> Y	<input type="checkbox"/> N	Fainting spells	<input type="checkbox"/> Y	<input type="checkbox"/> N	Muscular weakness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Angina/Chest pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tuberculosis	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	Dizziness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Epilepsy/Seizures	<input type="checkbox"/> Y	<input type="checkbox"/> N	Night pain	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N
Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney disease	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	Fever/chills	<input type="checkbox"/> Y	<input type="checkbox"/> N
Emphysema	<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney stones	<input type="checkbox"/> Y	<input type="checkbox"/> N	Numbness/tingling	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N
Chronic bronchitis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Osteoporosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Open sores or skin lesions	<input type="checkbox"/> Y	<input checked="" type="checkbox"/> N
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Currently pregnant	<input type="checkbox"/> Y	<input type="checkbox"/> N	Other problems: PAIN E HARD TO MOVE MY FINGER		
Shortness of breath	<input type="checkbox"/> Y	<input type="checkbox"/> N	Allergies:	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Pneumatic retractor	<input type="checkbox"/> Y	<input type="checkbox"/> N	If yes, list all:					
Polio	<input type="checkbox"/> Y	<input type="checkbox"/> N	<i>Dances</i>					

FOR YOUR CURRENT PROBLEM, PLEASE RATE YOUR PAIN IN THE SCALE BELOW:



Visual Analogue Scale (VAS)

GO TO NEXT PAGE →

Travel History Screening Form

Place complete form and place in patient's chart

1) Have you or someone you've had close contact with (who is ill) traveled outside the US or Canada within the last 30 days?

- a- "NO" or no contact with recent traveler (Do not continue, place form in chart)
- b- "YES" or close contact with recent traveler (Continue to question #2)
- c- Reports no travel but had close contact with sick traveler (Continue to question #2)
- d- Reports unawareness of exposure (Continue to question #2)

2) What was the location of travel?

- West Africa
- Spain
- Western Europe
- Central America
- China
- Indonesia
- Mexico
- South America
- Middle East
- Russia
- Unawareness of Exposure
- Other Parts of Africa
- Other _____

West Africa countries of Liberia, Sierra, Leone and Guinea require immediate isolation, don PPE and contact Infectious Disease physician On-Call

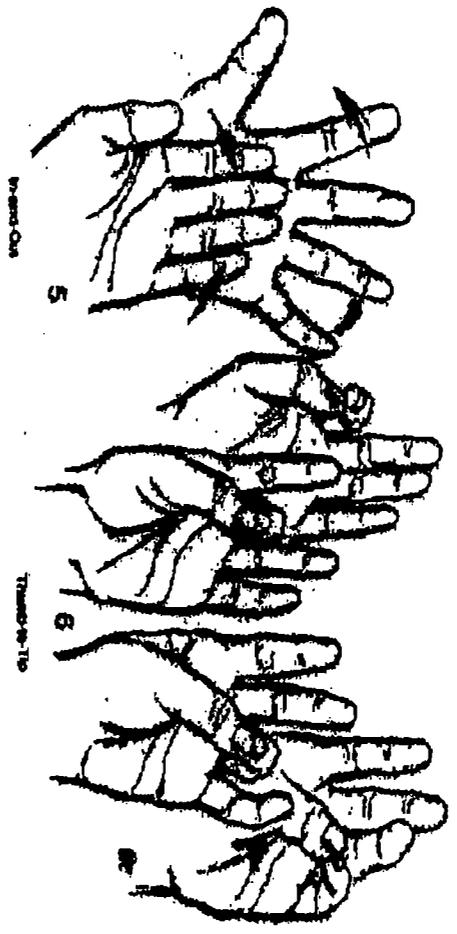
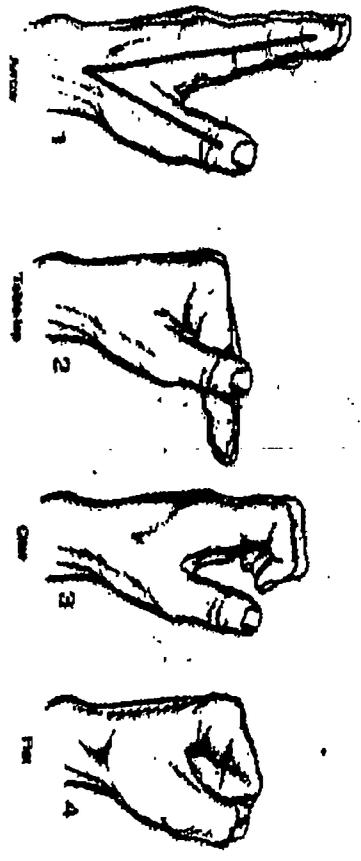
3) Does patient have any of the following symptoms?

- Abdominal Pain
- Bloody Sputum
- Bruising/Unusual Bleeding
- Chills
- Cough
- Decreased Consciousness
- Difficulty Breathing
- Fatigue
- Fever > 100.4 F
- Headache
- Jaundice
- Joint Achea
- Muscle Aches
- Night Sweats
- Paralysis (Recent onset)
- Persistent Cough
- Persistent Diarrhea
- Persistent Vomiting
- Poor Appetite
- Shortness of Breath
- Skin Rash
- Unexplained Lesion
- Unexplained Weight Loss/
Loss of Appetite
- Vomiting
- Weakness
- Other _____

Patients reporting unawareness of exposure and are symptomatic should be placed in Isolation and contact Infectious Disease physician On-Call

4) What interventions were implemented?

- ED Physician Notified
- Patient placed in Isolation
- Droplet Precautions
- Contact Precautions
- Infectious Disease Physician On Call notified
- Airborne Precautions
- Site Infection Control notified
- PPE worn by hospital staff



11/2009 - W.H.

DMC

**Physical Therapy and
Sports Medicine**

REHABILITATION INSTITUTE OF MICHIGAN

**DISCHARGE INSTRUCTIONS and
RECOMMENDATIONS**

Discharged due to the following

- Goals achieved
- Patient goals discussed
- Discharge due to little/no progress
- Patient not present at discharge

- Recommendations following discharge
- Attend Back Basics Class or Joint Basics Class
 - Information provided
 - Continue with home program
 - Home program reviewed
 - Follow up with post-rehab program
 - Post-rehab program handout provided
 - Follow-up with physician

Patient's Signature

Date

DMC
Rehabilitation Institute
of Michigan

165

Rehabilitation

FIN: 180004558680 PTID: 07226781
JOHNSON, PAUL
11/30/1967 M MRN: XXXXX5578
SURHP // DCS: 03/18/15 09:03
PCP: HUSSAIN MD, MURTAZA
ATTN: GURSEL MD, TOLGA

Patient Name: Paul Johnson (313) 948-6656 (cell)

Diagnosis: Amputation tips of DRFISF

Precautions: DOI: ~ 1 Year Ago.



<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Functional Training	<input checked="" type="checkbox"/> Occupational Therapy	<input type="checkbox"/> ADL/Functional Activities
<input type="checkbox"/> Evaluation/Treatment	<input type="checkbox"/> Transfer Training	<input type="checkbox"/> Evaluation/Treatment	<input type="checkbox"/> Joint Protection
<input type="checkbox"/> Range of Motion	<input type="checkbox"/> Joint Mobilization	<input type="checkbox"/> Splints	<input type="checkbox"/> Joint Mobilization
<input type="checkbox"/> Strengthening	<input type="checkbox"/> Soft Tissue Mobilization	<input type="checkbox"/> Transfer Training	<input type="checkbox"/> Joint Mobilization
<input type="checkbox"/> Stretching	<input type="checkbox"/> Muscle Re-education	<input checked="" type="checkbox"/> Range of Motion/Strengthening	<input type="checkbox"/> Joint Mobilization
<input checked="" type="checkbox"/> Gait Training	<input type="checkbox"/> Pool Therapy	<input checked="" type="checkbox"/> Soft Tissue Mobilization/Joint Mobilization	

<input checked="" type="checkbox"/> Modalities	<input checked="" type="checkbox"/> PRN	<input type="checkbox"/> Phonophoresis	<input type="checkbox"/> Lymphedema PT	<input type="checkbox"/> OT
<input type="checkbox"/> Moist Heat/Cold Packs	<input type="checkbox"/> Electrical Stimulation	<input type="checkbox"/> Fluid Therapy	<input checked="" type="checkbox"/> Hand Therapy PT	<input checked="" type="checkbox"/> OT
<input type="checkbox"/> Paraffin	<input type="checkbox"/> Traction	<input type="checkbox"/> Whirlpool	<input type="checkbox"/> Pelvic Floor Rehab/Incontinence	
<input type="checkbox"/> Ultrasound		<input type="checkbox"/> Iontophoresis Dexamethasone 10 mg/ml or _____	<input type="checkbox"/> Return to Work Services	
			<input type="checkbox"/> Functional Capacity Evaluation	
			<input type="checkbox"/> Job Site/Ergonomic Evaluation	
			<input type="checkbox"/> Work Hardening/Work Re-Conditioning	

Other/Comments: * Desensitization @ RPTSF

Frequency: Daily 2x/wk 3x/wk Duration: 4 weeks
3-18-15 Physician's Phone/Pager: (313) 745-4195

Physician's Signature: T. Gursel, MD.
 I certify that I have examined the patient and physical/occupational therapy is necessary and the services will be furnished while the patient is under my care and that the plan is established and will be reviewed every 30 days or more often, if the patient's condition requires.
 3225807M (02/14)

* Pt to be scheduled at RIM Northwest

Blue Cross Complete

Patient Name: Paul Johnson (313) 948-6656 (cell)

Diagnosis: Amputation tips of DRF5F

Precautions: DOF: ~ 1 Year Ago.



<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Functional Training	<input checked="" type="checkbox"/> Occupational Therapy	<input type="checkbox"/> ADL/Functional Activities
<input type="checkbox"/> Evaluation/Treatment	<input type="checkbox"/> Transfer Training	<input type="checkbox"/> Evaluation/Treatment	<input type="checkbox"/> Joint Protection
<input type="checkbox"/> Range of Motion	<input type="checkbox"/> Joint Mobilization	<input type="checkbox"/> Splints	<input type="checkbox"/> Joint Mobilization
<input type="checkbox"/> Strengthening	<input type="checkbox"/> Soft Tissue Mobilization	<input checked="" type="checkbox"/> Transfer Training	<input type="checkbox"/> Joint Mobilization
<input type="checkbox"/> Stretching	<input type="checkbox"/> Muscle Re-education	<input checked="" type="checkbox"/> Range of Motion/Strengthening	<input type="checkbox"/> Soft Tissue Mobilization/
<input type="checkbox"/> Gait Training	<input type="checkbox"/> Pool Therapy	<input type="checkbox"/> Soft Tissue Mobilization/	<input type="checkbox"/> Joint Mobilization
<input checked="" type="checkbox"/> Modalities	<input type="checkbox"/> Phonophoresis	<input checked="" type="checkbox"/> Lymphedema	PT <input type="checkbox"/> OT <input type="checkbox"/>
<input type="checkbox"/> Moist Heat/Cold Packs	<input type="checkbox"/> Fluid Therapy	<input checked="" type="checkbox"/> Hand Therapy	PT <input type="checkbox"/> OT <input checked="" type="checkbox"/>
<input type="checkbox"/> Electrical Stimulation	<input type="checkbox"/> Whirlpool	<input type="checkbox"/> Pelvic Floor Rehab/Incontinence	
<input type="checkbox"/> Paraffin	<input type="checkbox"/> Iontophoresis Dexamethasone	<input type="checkbox"/> Return to Work Services	
<input type="checkbox"/> Traction	<input type="checkbox"/> 10 mg/ml or	<input type="checkbox"/> Functional Capacity Evaluation	
<input type="checkbox"/> Ultrasound		<input type="checkbox"/> Job Site/Ergonomic Evaluation	
		<input type="checkbox"/> Work Hardening/Work Re-Conditioning	

Other/Comments: * Desensitization DRF5F

Frequency: Daily 2x/wk 3x/wk Duration: 4 weeks
Physician's Signature: T. Gursel, MD. Date: 3-18-15 Physician's Phone/Pager: (313) 745-4195

I certify that I have examined the patient and physical/occupational therapy is necessary and the services will be furnished while the patient is under my care and that the plan is established and will be reviewed every 30 days or more often, if the patient's condition requires.

* Pt to be scheduled at RM Northwest

Blue Cross Complete

DMC
Rehabilitation Institute
of Michigan

Home Exercise Program for: P. Johnson Date: 4/1/16

Your Therapy appointments are scheduled for:

Therapist/Team Members: Lore Tomalak OTR

Schedule: Tues, Thur, Fri 1PM
Starting Apr 7 Tues

Your Therapy Goals:

1. "Use my hand as much as possible"
2. TRY TO GET IT BETTER!
3. Attend and participate in all therapy sessions

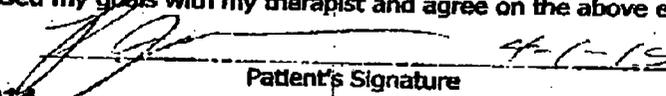
- Please remember in the therapy area no children, food, or cell phones are allowed.
- **Attendance policy-** If you cancel three (3) or more times or fail to show to your therapy appointments two (2) times your therapy may be discontinued. If you are more than 15 minutes late we may not be able to see you or we may have to shorten the session.

If you have any **questions or concerns**, please be sure to call or ask during your treatment session!!

Clinic number: (313) 342-4679

THANK YOU FOR CHOOSING US FOR YOUR THERAPY!
OUR GOAL IS TO PROVIDE YOU WITH
VERY GOOD SERVICE!

I have discussed my goals with my therapist and agree on the above established goals.


Patient's Signature 4-1-16

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420 5 MB 1.614
SWOPE AND SWOPE
RICHARD F SWOPE
6480 E MAIN ST STE 102

000420

REYNOLDSBURG, OH 43068-2391

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ATTENTION

Confidential Information enclosed.
To be viewed by authorized persons only.

If you have questions regarding any information you have requested,
please call the phone number on the enclosed invoice.

Health information is reproduced by HealthPort, a health information management outsourcing service. Your healthcare provider contracts with HealthPort to process authorized requests for copies of health records.

Reproductions are made from the medical facility's original records. The confidentiality of these records is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

If you requested items that are not maintained in the medical record, your request for those items was forwarded to the appropriate department and will be sent under separate cover. Likewise, information that you asked to have delivered to another address is sent separately.

This package may or may not contain medical records, depending on what was requested and how it was processed.

You may not make any disclosure or use of these records without the permission of the individual who is the subject of the records.

Swope and Swope

ATTORNEYS AT LAW

RICHARD F. SWOPE
KRISTY SWOPE

6480 EAST MAIN STREET, SUITE 102
REYNOLDSBURG, OHIO 43068
TELEPHONE (614) 866-1492
FAX (614) 864-5553

January 4, 2016

Court of Claims of Ohio
Attn: Clerk of Courts
65 South Front Street, Third Floor
Columbus, Ohio 43215

FILED
COURT OF CLAIMS
OF OHIO

2016 JAN -6 AM 10:25

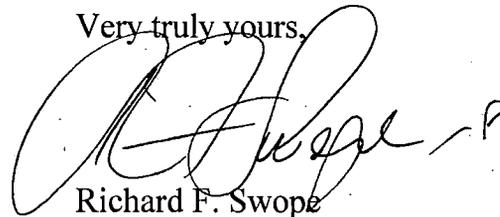
Re: *Paul Johnson v. Ohio Dept. of Rehab. & Corr.*
Case No. 2012-08907

Dear Sir or Madam:

Please find enclosed an original and two copies of a Mediation Statement of Plaintiff Paul Johnson which we wish to file with the Court in the above-captioned case.

We would appreciate your filing the same and returning a file-stamped copy in the enclosed self-addressed envelope. Thank very much you for your cooperation. *AC*

Very truly yours,



Richard F. Swope

RFS/sr
Enclosures
cc: client