* Auth (Verified) *

KALEIDA HEALTH

- ☐ Buffalo General Hospital
- ☐ DeGraff Memorial Hospital
- ☐ Millard Fillmore Gates Circle Hospital
- ☐ Millard Fillmore Suburban Hospital
- ☐ Women & Children's Hospital of Buffalo
- ☐ Others:

Patient ID Area

MR: 1001428581 PT:
DOB: AGE: 014Y SEX: F
ATT: TENNEY EMILY F
PCP:
FC: EMR E ADM DT: 10/07/09
WOMENS AND CHIL

FACE SHEET 1 of 1

MEDICAL RECORD NO.	PATIENT NUMBER	PATIENT NAME (LAST FIRST MIDDLE)	SVC AREA	LOCATION	ROOM NO BED
1001428581			EMR	CER	

STREET ADDRESS CITY, STATE, ZIP CODE	COUNTY	SOCIAL SECURITY NO.	BIRTHDATE	AGE
	29	NOT DISPLAYED		014Y

SEX	MAR STAT	RACE	RELIGION	ADMIT TYPE	ADMIT PRIORITY	ADMIT SOURCE	HIPAA	MODE OF ARRIVAL	ADMIT DATE	ADMIT TIME
F	S	W	BAP	EMERGENCY	EMERGENCY	EMER ROOM	Y	3	10/07/09	16:31

HEALTH CARE AGENT	LAS LEP	VIP
	001 ENGLISH	

PRIOR STAY LOCATION	PRIOR STAY DATES	HOME PHONE	ALTERNATE PHONE	HOSPICE INDICATOR	ORGAN DONOR?	VISIT TYPE
				N	N	E

ATTENDING PHYSICIAN	REFERRING PHYSICIAN	ADMIT BY (LOGIN ID)	RECEIVED BILL OF RIGHTS?
TENNEY EMILY F		INT	N/A

PRIMARY CARE PROVIDER	STREET ADDRESS CITY, STATE, ZIP CODE	OFFICE PHONE	OFFICE FAX

EMERGENCY CONTACT 1	REL	HOME PHONE	WORK PHONE	CELL PHONE	PAGER NUMBER
	PARENT		--	--	--

EMERGENCY CONTACT 2	REL	HOME PHONE	WORK PHONE	CELL PHONE	PAGER NUMBER
		--	--	--	--

ADMITTING DIAGNOSIS (CODE & VERBIAGE)	CHIEF COMPLAINT
	SA

GUARANTOR

LAST NAME, FIRST, MI	STREET ADDRESS, CITY, STATE, ZIP CODE, COUNTY

SOCIAL SECURITY NO.	TELEPHONE NUMBER	RELATIONSHIP OF GUARANTOR	EMPLOYER	EMPLOYER TELEPHONE NUMBER
NOT DISPLAYED		MOTHER		--

COMMENTS
ACT NOVA LEFT CARD AT HOME ACT SANE INS

SMOKING CESSATION INFORMATION PROVIDED TO PATIENT / CAREGIVER: YES

INS. NO. 1

INSURANCE CARRIER	PLAN NAME	CERTIFICATE/POLICY NO	SECOND POLICY NUMBER	EFFECTIVE DATE
GOVERNMENT	SANE	555555555		/ /

INSURED NAME	DATE OF BIRTH	REL TO PT	ACC (Y/N)	DATE OF ACCIDENT	AUTHORIZATION NUMBER
AMBER HOOPER		1	N		

INS. NO. 2

INSURANCE CARRIER	PLAN NAME	CERTIFICATE/POLICY NO	SECOND POLICY NUMBER	EFFECTIVE DATE
	SELF PAY			

INSURED NAME	DATE OF BIRTH	REL TO PT	ACC (Y/N)	DATE OF ACCIDENT	AUTHORIZATION NUMBER
		1			

INS. NO. 3

INSURANCE CARRIER	PLAN NAME	CERTIFICATE/POLICY NO	SECOND POLICY NUMBER	EFFECTIVE DATE

INSURED NAME	DATE OF BIRTH	REL TO PT	ACC (Y/N)	DATE OF ACCIDENT	AUTHORIZATION NUMBER

INS. NO. 4

INSURANCE CARRIER	PLAN NAME	CERTIFICATE/POLICY NO	SECOND POLICY NUMBER	EFFECTIVE DATE

INSURED NAME	DATE OF BIRTH	REL TO PT	ACC (Y/N)	DATE OF ACCIDENT	AUTHORIZATION NUMBER

ISOLATION INDICATOR 1	ISOLATION INDICATOR 2	ISOLATION INDICATOR 3	ISOLATION INDICATOR 4	ISOLATION INDICATOR 5	ISOLATION INDICATOR 6

PRINCIPAL DIAGNOSIS

SECONDARY DIAGNOSIS

PROCEDURES

ATTENDING PHYSICIAN DATE

KH01181 Rev. 01/07/09 10/07/2009 17:33

* Auth (Verified) *

KALEIDA HEALTH

☐ Buffalo General Hospital
☐ DeGraff Memorial Hospital
☐ Millard Fillmore Gates Circle Hospital
☐ Millard Fillmore Suburban Hospital
☐ Women & Children's Hospital of Buffalo
☐ Others: _____

Patient ID Area

MR- 1001428581 PT- 68927647
DOB- C AGE- 014Y SEX- F
ATT- TENNEY EMILY F
PCP-
FC- EMR E ADM DT- 10/07/09
WOMENS AND CHIL

FACE SHEET 1 of 1

MEDICAL RECORD NO.	PATIENT NUMBER	PATIENT NAME (LAST, FIRST, MIDDLE)	SVC AREA	LOCATION	ROOM NO BED
			EMR	CER	

STREET ADDRESS, CITY, STATE, ZIP CODE	COUNTY	SOCIAL SECURITY NO.	BIRTHDATE	AGE
	29	NOT DISPLAYED		014Y

SEX	MAR STAT	RACE	RELIGION	ADMIT TYPE	ADMIT PRIORITY	ADMIT SOURCE	HIPAA	MODE OF ARRIVAL	ADMIT DATE	ADMIT TIME
F	S	W	BAP	EMERGENCY	EMERGENCY	EMER ROOM	Y	3	10/07/09	16:31

HEALTH CARE AGENT	LAS/LEP	VIP
	001 ENGLISH	

PRIOR STAY LOCATION	PRIOR STAY DATES	HOME PHONE	ALTERNATE PHONE	HOSPICE INDICATOR	ORGAN DONOR?	VISIT TYPE
				N	N	E

ATTENDING PHYSICIAN	REFERRING PHYSICIAN	ADMIT BY (LOGIN ID)	RECEIVED BILL OF RIGHTS?
TENNEY EMILY F		INT	N/A

PRIMARY CARE PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE	OFFICE PHONE	OFFICE FAX

EMERGENCY CONTACT 1	REL	HOME PHONE	WORK PHONE	CELL PHONE	PAGER NUMBER
	PARENT		-	-	-
EMERGENCY CONTACT 2	REL	HOME PHONE	WORK PHONE	CELL PHONE	PAGER NUMBER
		-	-	-	-

ADMITTING DIAGNOSIS (CODE & VERBIAGE)	CHIEF COMPLAINT
\	SA

GUARANTOR

LAST NAME, FIRST, MI	STREET ADDRESS, CITY, STATE, ZIP CODE, COUNTY	
		0

SOCIAL SECURITY NO.	TELEPHONE NUMBER	RELATIONSHIP OF GUARANTOR	EMPLOYER	EMPLOYER TELEPHONE NUMBER
NOT DISPLAYED		MOTHER		-

COMMENTS:	SMOKING CESSATION INFORMATION PROVIDED TO PATIENT / CAREGIVER: YES
ACT NOVA LEFT CARD AT HOME ACT SANC INS	

INS. NO. 1

INSURANCE CARRIER	PLAN NAME	CERTIFICATE/POLICY NO	SECOND POLICY NUMBER	EFFECTIVE DATE
GOVERNMENT	SANE	555555555		//

INSURED NAME	DATE OF BIRTH	REL TO PT	ACC (Y/N)	DATE OF ACCIDENT	AUTHORIZATION NUMBER
		1	N		

INS. NO. 2

INSURANCE CARRIER	PLAN NAME	CERTIFICATE/POLICY NO	SECOND POLICY NUMBER	EFFECTIVE DATE
	SELF PAY			

INSURED NAME	DATE OF BIRTH	REL TO PT	ACC (Y/N)	DATE OF ACCIDENT	AUTHORIZATION NUMBER
		1			

INS. NO. 3

INSURANCE CARRIER	PLAN NAME	CERTIFICATE/POLICY NO	SECOND POLICY NUMBER	EFFECTIVE DATE

INSURED NAME	DATE OF BIRTH	REL TO PT	ACC (Y/N)	DATE OF ACCIDENT	AUTHORIZATION NUMBER

INS. NO. 4

INSURANCE CARRIER	PLAN NAME	CERTIFICATE/POLICY NO	SECOND POLICY NUMBER	EFFECTIVE DATE

INSURED NAME	DATE OF BIRTH	REL TO PT	ACC (Y/N)	DATE OF ACCIDENT	AUTHORIZATION NUMBER

ISOLATION INDICATOR 1	ISOLATION INDICATOR 2	ISOLATION INDICATOR 3	ISOLATION INDICATOR 4	ISOLATION INDICATOR 5	ISOLATION INDICATOR 6

PRINCIPAL DIAGNOSIS

SECONDARY DIAGNOSIS

PROCEDURES

ATTENDING PHYSICIAN DATE

KH01181 Rev. 01/07/09

10/07/2009 17:33

Consents Documents

* Auth (Verified) *

KALEIDA HEALTH

☐ Buffalo General Hospital
☐ DeGraff Memorial Hospital
☐ Millard Fillmore Gates Circle Hospital
☐ Millard Fillmore Suburban Hospital
☐ Millard Fillmore Surgery Center
☐ Women & Children's Hospital of Buffalo
☐ Others: _____

MR- 1001428581 PT- 6892/647
DOB- AGE- 014Y SEX- F
ATT- REFERRING DOC
PCP-
FC- EMR E ADMDT- 10/07/09
Patient ID Area WOMENS AND CHIL

CONSENT FOR TREATMENT AND PAYMENT AGREEMENT 1 of 2

HI Claim Number: _____

AUTHORIZATION FOR CARE & TREATMENT: I hereby agree that Kaleida Health may perform care and treatment, and may conduct such examinations, laboratory tests and procedures, administer such local anesthetics, medication and treatment, as may be directed by my physician or treating practitioner. I acknowledge that no guarantees have been made to me as to the effect of such examinations, tests, procedures or treatment of my condition.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I consent to the use and disclosure of my Protected Health Information by Kaleida Health for purposes of treatment, payment, and health care operations. For example, my attending physician or treating practitioner at Kaleida Health may furnish Protected Health Information maintained by Kaleida Health in the course of my care and treatment. Also, as Kaleida Health is a teaching hospital, I consent to the use and disclosure of my Protected Health Information (I) for training and educational purposes to faculty physicians, residents, and medical, dental, pharmacy, nursing or other students in health-related professions from local colleges and universities affiliated with Kaleida Health, and (ii) for review in preparation for possible research. Release of medical records and information will be made according to state and federal regulations. I understand that Kaleida Health may release medical information to any third party, including my employer, which may be responsible for payment of my hospital or medical expenses. (Release of medical information to employers is limited to those employers who are directly liable for the costs of the patient's health care benefits through and employer, self-insured group health plan or worker's compensation, or in other circumstances in which such disclosure is legally allowed).

INSURANCE AUTHORIZATION: I understand that I am responsible for knowing the terms and conditions of my insurance coverage. I further understand that I may be responsible for obtaining prior authorization for certain services in order for my insurance company to pay for those services and I understand that I may be personally responsible for payment if I do not obtain any necessary prior authorization or my insurance benefits are denied, reduced, or terminated. (In accordance with federal law, the hospital will not deny or delay necessary care or treatment in the Emergency Department because of a person's inability to pay for such necessary emergency treatment.)

ASSIGNMENT OF BENEFITS, INSURANCE PROCEEDS, SETTLEMENTS: If I am entitled to health care services under any insurance policy from any person or organization which may become liable to me to provide such benefits, I assign such benefits to the hospital and physicians employed by the hospital who render such services to me. I further authorize payment directly to Kaleida Health and such physicians of all such insurance benefits payable to me. Such insurance may include, but is not limited to, private commercial insurance, auto liability insurance, worker's compensation, programs such as Medicare and Medicaid, or other governmental sources.

I certify that the information given regarding my insurance is accurate and current to the best of my knowledge.

I further assign to Kaleida Health any payments for medical benefits payable to me as a result of any settlement or judgement in a lawsuit.

CERTIFICATION OF MEDICARE BENEFITS TO HOSPITAL AND/OR PHYSICIANS: (Applicable to Medicare beneficiaries only) I hereby authorize Kaleida Health to bill Medicare and receive payment on my behalf for any authorized Medicare benefits for services furnished to me by Kaleida Health, including physician services. I certify that the information given by me in applying for such payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information or other information about me to release it to Medicare or its agents, as necessary, for payment of this, or any related Medicare claim.

KH00207 Rev. 07/15/08

CONSENT

* Auth (Verified) *

KALEIDA HEALTH

CONSENT FOR TREATMENT AND PAYMENT AGREEMENT 2 of 2

MR: 1001428581 PT: 68927647
DOB: AGE: 014Y SEX: F
ATT: REFERRING DOC
PCP:
FC: EMR E ADM DT: 10/07/09
Patient ID Area: WOMENS AND CHIL

FINANCIAL AGREEMENT: In consideration for services rendered by Kaleida Health and physicians employed by Kaleida Health, I guarantee prompt payment of all such services not paid by insurance carriers or third parties within thirty (30) days. I understand that any amounts not covered by my insurance carrier or other third party payor is my personal responsibility, and I agree to make payment for any such amounts. If Kaleida Health does not receive such payment within thirty (30) days from the date such balance is due, the bill may be turned over to an attorney or a collection agency and, if so, I agree to pay all reasonable collection costs including attorney's fees and/or collection fees in addition to the payment owed. I give the hospital the right to examine my consumer credit report for financial information relating to my responsibility to pay for medical services. I understand that, in most cases, my attending physician, emergency department physician, radiologist, anesthesiologist and other consultants and/or surgeons of Kaleida Health are independent practitioners, and not hospital employees. I will receive a separate bill from them for their services.

RELEASE OF LIABILITY FOR VALUABLES: I understand and agree that money, jewelry, and other valuables should not be brought into the hospital. I understand and agree that Kaleida Health shall not be liable for loss or damage to any personal property.

TELEPHONE: If I request telephone services, I will be personally responsible for payment of the bill. I understand that phone services may be billed to my home telephone.

ADVANCED DIRECTIVES: I acknowledge that I received or had made available to me information on advance directives and a copy of "Your Patient Bill of Rights," prepared by New York State.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: I acknowledge that I have received the Kaleida Health Notice of Privacy Practices.

PATIENT DIRECTORY: I understand that I am automatically included in the hospital's Patient Directory, which allows Kaleida Health to relay my location and general condition if asked for by name and my religious affiliation to clergy without asking by name. **If I do not want this information disclosed from the Patient Directory, I will indicate that by checking the box below.**

☐ Restriction: I do not want to be listed in the Patient Directory. I understand that, by checking this box, if family members, my clergy, neighbors, friends or others inquire about me while I am a patient, my presence here will not be disclosed, and any mail or flowers addressed to me will be returned.

DISCLOSURE TO FAMILY OR FRIENDS INVOLVED IN MY CARE: I understand that I may limit the disclosure of my health information to family members, other relatives or close personal friends by notifying a member of the staff assigned to care for me.

I have read all the above statements and accept the terms and conditions as stated.

Patient/Parent/Agent/Guardian Signature	Date	Witness Signature	Date
	10/7/09		10/7-09
Interpreter (if used) Signature	Date	Witness Signature	Date

NOTE: If the individual signing is the Health Care Agent or Guardian(s), he/she must provide written documentation to authorize his/her legal authority to consent. A copy of the documentation must be placed in the patient's medical record.

KH00287 Rev. 07/15/08

Discharge Instructions

* Auth (Verified) *

KALEIDA HEALTH

☐ Buffalo General Hospital
☐ DeGraff Memorial Hospital
☐ Millard Fillmore Gates Circle Hospital
☐ Millard Fillmore Suburban Hospital
☐ Women & Children's Hospital of Buffalo
☐ Others: _____

MR- 1001428581 PT- 68927647
DOB- AGE- 014Y SEX- F
ATT- TENNEY EMILY F
PCP-
FC- EMR E ADM DT- 10/07/09
Patient ID Area

DISCHARGE MEDICATION HISTORY AND ORDER (MEDICATION RECONCILIATION)

ALLERGIES: REFER TO ALLERGY PROFILE

☐ Actual ☐ Estimated Height cm ☐ Actual ☐ Estimated Weight kg

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER THE COUNTER AND HERBAL MEDICATIONS. THIS FORM MUST BE COMPLETED IN LAYMAN'S TERMS.

Source of Medication List (check all used):

☐ Patient Medication List ☒ Patient/Family Recall ☐ Patient's Medication Bottles ☐ Record from Facility (MAR or Discharge Summary)

☐ Other: _____ Pharmacy: _____

PREVIOUS MEDICATIONS

Discharge Instruction Continue? Yes	No	Rx Given?	Medication Name (write legibly)	Weight Based Dosing (Peds)	Dose mg, mcg, meq	Route	How Often?	Indication	Time of Next Dose
		✓	☐ PATIENT NOT TAKING MEDICATION						
☐	☐		1. eff pen			☐ By Mouth ☐			
☐	☐		2.			☐ By Mouth ☐			
☐	☐		3.			☐ By Mouth ☐			
☐	☐		4.			☐ By Mouth ☐			
☒	☐		5.			☐ By Mouth ☐			
☐	☐		6.			☐ By Mouth ☐			
☐	☐		7.			☐ By Mouth ☐			
☐	☐		8.			☐ By Mouth ☐			
☐	☐		9.			☐ By Mouth ☐			
☐	☐		10.			☐ By Mouth ☐			
☐	☐		11.			☐ By Mouth ☐			

NEW MEDICATIONS ☐ No New Medications ☐ Additional Page Needed 1 of ____

					New Drug or Dose Change?	Rx Given?
1.			☐ By Mouth ☐		☐ New Drug ☐ New Dose	
2.			☐ By Mouth ☐		☐ New Drug ☐ New Dose	
3.			☐ By Mouth ☐		☐ New Drug ☐ New Dose	
4.			☐ By Mouth ☐		☐ New Drug ☐ New Dose	
5.			☐ By Mouth ☐		☐ New Drug ☐ New Dose	

KALEIDA HEALTH

Date: _____ **Time:** _____ **Physician/NP/PA Signature:** _____

Print Name: _____ **Phone/Pager:** _____

Date: _____ **Time:** _____ **RN Entry (if needed):** _____

This medication list is the responsibility of YOU (the patient), it was created by information that YOU provided. This list is not an order or a prescription, but is provided for your information. You should not make any changes to your medications without consulting your primary care provider.
I have received a copy and understand this Medication Reconciliation form. I have been instructed to give this form to my next healthcare provider.

Patient Signature: _____

KH00742A Rev. 11/18/08

MEDICATION RECONCILIATION

WHITE - CHART (DO NOT Separate pages 2&3 until discharge) Affix to Top/Front of Discharge Chart for Medical Records Scanning to Next Provider
CANARY - PATIENT DISCHARGE COPY

Orders

* Auth (Verified) *

KALEIDA HEALTH

☐ Buffalo General Hospital
☐ DeGraff Memorial Hospital
☐ Millard Fillmore Gates Circle Hospital
☒ Millard Fillmore Suburban Hospital
☐ Women & Children's Hospital of Buffalo
☐ Others: _____

MR: 1001428581 PT: 68927647
DOB: AGE: 014Y SEX: F
ATT: TENNEY EMILY F
PCP:
FC: EMR E ADM DT: 10/07/09
Patient ID Area

MEDICATION HISTORY AND ORDER (MEDICATION RECONCILIATION)

ALLERGIES: REFER TO ALLERGY PROFILE

☐ Actual ☐ Estimated Height cm ☐ Actual ☐ Estimated Weight kg

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER THE COUNTER AND HERBAL MEDICATIONS. THIS FORM MUST BE COMPLETED IN LAYMAN'S TERMS.

Source of Medication List (check all used):

☐ Patient Medication List ☒ Patient/Family Recall ☐ Patient's Medication Bottles ☐ Record from Facility (MAR or Discharge Summary)
☐ Other: _____ Pharmacy: _____

CURRENT MEDICATIONS

	Medication Name (write legibly)	Weight Based Dosing (Peds)	Dose mg, mcg, meq	Route	How Often?	Indication	Last Dose (time/ date)	Initials	Admission Orders Continue? Yes	No
☐ PATIENT NOT TAKING MEDICATION										
1.	epi pen			☐ By Mouth					☐	☐
2.				☐ By Mouth					☐	☐
3.				☐ By Mouth					☐	☐
4.				☐ By Mouth					☐	☐
5.				☐ By Mouth					☐	☐
6.				☐ By Mouth					☐	☐
7.				☐ By Mouth					☐	☐
8.				☐ By Mouth					☐	☐
9.				☐ By Mouth					☐	☐
10.				☐ By Mouth					☐	☐
11.				☐ By Mouth					☐	☐

☐ **Additional Page Needed 1 of ____**

KALEIDA HEALTH

1646
Date/Time: 10/09 Recorded By: Patricia A Fellows Initials: Date/Time: _____ Additional Entry By: _____ Initials: ____

Date: _____ Time: _____ Physician/NP/PA (Print & Sign): _____

☐ TORB: Date/Time: _____ From/By: _____ Transcribed: By: _____ Date/Time: _____

KALEIDA HEALTH

PRESS FIRMLY WHEN WRITING ON THIS FORM. USE A BALLPOINT PEN ONLY.

KI 100712 Rev. 11/10/08

(Do not scan or transcribe without MD signature date and time)
Scan to Pharmacy

ORDERS

WHITE - CHART (Do Not Thin)
WHITE - CHART
CANARY - PATIENT DISCHARGE COPY

ED MD Note

KALEIDA HEALTH

- ☐ Buffalo General Hospital
- ☐ DeGraff Memorial Hospital
- ☐ Millard Fillmore Gates Circle Hospital
- ☐ Millard Fillmore Suburban Hospital
- ☐ Women & Children's Hospital of Buffalo
- ☐ Others: ____________

MR- 1001428581 PT- 68927647
DOB- AGE- 014Y SEX- F
ATT- LAWRENCE, LYNN M
PCP-
FC- EMR E ADM DT- 10/07/09
Patient ID Area WOMENS AND CHIL

EMERGENCY DEPARTMENT PHYSICIAN'S PEDIATRIC HISTORY & TREATMENT RECORD 1 of 2

Time Evaluated	VITALS	Temperature	Pulse	Respirations	Blood Pressure	Weight
5pm		36.7	92	18	103/69	75 ☒ kg ☐ lbs

Pulse Oximetry: ____ % FiO_2: ____ ☐ Hypoxic ☒ Non-Hypoxic

ALLERGIES: Bees - dry? Pumpkins

Nurses Note reviewed? ☒ Yes ☐ No
History limited due to: ☐ Mental Status ☐ Critical Illness
Additional history from: ☐ Old records ☒ Family ☐ Emergency Medical Services ☐ SNF records
☐ DNR/ Advance Directives

Chief Complaint: Sexual assault

Immunizations: ☒ Current ☐ Deficient ☐ Unknown
Last Tetanus: Last Menses:

History of Present Illness (Discuss location, quality, severity, duration, context, associated signs & symptoms, modifying factors)

Today @ school
Male class mate
Please see SANE description
transfer from Mt. St Mary's
* Pt stated was instructed to wipe genitals prior to urine collection at Mt St Mary's

Past Medical History

	Yes	No		Yes	No
Prematurity	☐	☐	Cardiac	☐	☐
Weeks gestation:			Respiratory	☐	☐
Seizures	☐	☐	Intubation	☐	☐
Sickle Cell Disease	☐	☐	Diabetes Mellitus	☐	☐
Concussion	☐	☐			
Other:					

Past Surgical History

	Yes	No
Appendectomy	☐	☐
Cholecystectomy	☐	☐
Hernia Repair	☐	☐
Other:		

Social History

	Yes	No	Hx of
Alcohol	☐	☐	☐
Smoking	☐	☐	☐
Drugs	☐	☐	☐
Other:			

Family History

	Yes	No		Yes	No
Cardiac	☐	☐	Respiratory	☐	☐
Hypertension	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Diabetes Mellitus	☐	☐
Other:					

☐ HISTORY & PHYSICAL DICTATED

Medication Comments:
☒ Medication Reconciliation Form reviewed and agree

REVIEW OF SYSTEMS Key: Circle word if positive / Back slash if negative / Blank if not assessed

Constitutional: Fever Weight change Fainting Dizziness Decreased activity/Fatigue Diaphoresis All Negative
Eyes: Visual changes Photophobia Pain All Negative
Ears, Nose, Throat/Mouth: Hearing loss Tinnitus Earache Headache Toothache Nasal discharge Nose bleed Sore throat All Negative
Cardiovascular: Chest pain Edema Palpitations All Negative
Respiratory: SOB Wheezing Cough Sputum Hemoptysis All Negative
Gastrointestinal: Nausea Vomiting Diarrhea Constipation Hematochezia Hematemesis Decreased oral intake Melena Abdominal pain All Negative
Genitourinary: Dysuria Urgency Hesitancy Frequency Flank Pain Hematuria Testicular pain Vaginal/penile discharge Vaginal bleeding All Negative
Musculoskeletal: Joint pain/swelling Myalgias Deformity Back/neck pain All Negative
Skin: Rash Ulcer Laceration All Negative
Neurological: Altered mental status Focal weakness Seizure Paresthesias Gait disturbance All Negative
Psychiatric: Depression Anxiety Suicidal thoughts Psychosis All Negative
Endocrine: Polydipsia Polyuria Hot/cold intolerance All Negative
Hematologic/Lymphatic: Easy bruising Adenopathy All Negative
Allergic/Immunologic: Pruritus Urticaria Angioedema All Negative

Physical Exam:

General	A+O VSS
Head	NC
Eyes	PERRL
Ears	Clear
Nose	Clear
Throat	Clear
Neck	Supple
Heart	RRR S1 S2 ⊖ M
Lung	CTA (B)
Abdominal	Soft NTND
Rectal	See SANE Exam
Genitalia	
Derm	⊖ bruising or rashes
Musculoskeletal	⊖ limited [illegible]
Lymphatic	⊖ LAN
Neurologic	⊖ focal deficits
Psychiatric	Calm

Occult Blood In: ____ Result: ☐ Positive ☐ Negative ☐ QC: ☐ Pass ☐ Fail Initials: ____

Resident/Student/Mid-level Printed Name	Resident/Student/Mid-level Signature	Emergency Medicine Attending Printed Name	Emergency Medicine Attending Signature
Rusl	Rusl NP	Lawrence	[signature]

10/11/09 0800

KH00025-001 Rev. 04/03/08 (Pediatric)

EMERGENCY DEPARTMENT MD NOTE

* Auth (Verified) *

KALEIDA HEALTH

☐ Buffalo General Hospital
☐ DeGraff Memorial Hospital
☐ Millard Fillmore Gates Circle Hospital
☐ Millard Fillmore Suburban Hospital
☐ Women & Children's Hospital of Buffalo
☐ Others: _____

EMERGENCY DEPARTMENT PHYSICIAN'S PEDIATRIC HISTORY & TREATMENT RECORD 2002

MR- 1001428581 PT- 68927647
AGE- 014Y SEX- F
ATT- LAWRENCE, LYNN M
PCP-
FC- EMR E ADM DT- 10/07/09
Patient ID Area WOMENS AND CHIL

Medical Decision Making:

Sexual assault

Procedure/Treatment/Additional Notes:

SANE Exam
HIV STI PEP
CBC CMP HIV RPR
Hep B, C
Plan B
Zofran 4mg ODT

☐ MEDICAL DECISION MAKING DICTATED

Emergency Medicine Teaching Attending Note (Relevant History & Physical Exam Assessment Plan):

☐ I have seen and evaluated the patient. I have reviewed the details of service as indicated on the resident note. I agree with the above treatment, plan and diagnosis below. I have indicated any amendments or additions to the resident note below:

Time Evaluated: 1h PMD

patient unavailable
U. County SAC

☐ TEACHING NOTE DICTATED
☐ See Continuation Note CHART COMPLETE ☐

Imaging:

Interpreted by: _____

EKG:

MONITOR:

CBC	URINALYSIS
WBC	☐ Clean Catch
HGB	☐ Catheter
HCT	Leuks
PLAT	Nitrites
CHEMISTRY	Urobili
Na	Protein
K	pH
Cl	Blood
TCO2	Specific Gravity
BUN	Ketones
CREAT	Bili
CA	Glucose
Glucose	
Total Bili	**PREGNANCY**
Alk Phos	HCG
SGOT/AST	☐ Positive
SGPT/ALT	☐ Negative
Lipase	Quant
Amylase	**CSF**
Troponin	WBC
CK	RBC
BN Peptide	Glucose
COAGS	Protein
PT	**CULTURES SENT**
INR	☐ Blood
aPTT	☐ Urine
BLOOD GAS	☐ Sputum
FIO2	☐ CSF
pH	☐ Throat
PCO2	☐ GC/ Chlamydia
PO2	Other:
HCO3	
TCO2	
B.E.	
SAT	

Impression:

Sexual assault

Primary Physician: _____ Notified: ☐ Yes ☐ No Time paged: _____ Time answered: _____
Consultant: _____ Time paged: _____ Time answered: _____ Time of arrival: _____
Condition on Disposition: ☒ Good/Improved ☐ Critical Critical Care Time: _____ ☐ Home ☐ Transfer ☐ Expired
Disposition time: _____ ☐ Admit: Floor: _____ Attending: _____

Resident/Student/Mid-level Printed Name	Resident/Student/Mid-level Signature	Emergency Medicine Attending Printed Name	Emergency Medicine Attending Signature
		Lawrence	10/11/09 0800

KH00025-001 Rev. 04/08/08 (Pediatric)

EMERGENCY DEPARTMENT MD NOTE

* Auth (Verified) *

KALEIDA HEALTH

☐ Buffalo General Hospital
☐ DeGraff Memorial Hospital
☐ Millard Fillmore Gates Circle Hospital
☐ Millard Fillmore Suburban Hospital
☐ Women & Children's Hospital of Buffalo
☐ Others: _____

MR- 1001428581 FT- 68927647
DOB- AGE- 014Y SEX- F
ATT- LAWRENCE, LYNN M
PCP-
FC- EMR E ADMDT- 10/07/09
Patient ID Area WOMENS AND CHIL

PEDIATRIC EMERGENCY DEPARTMENT ORDERS Ver 01

ALLERGIES

☐ Actual ☐ Estimated Weight ____ kg
☐ Actual ☐ Estimated Height ____ ☐ cm ☐ ft

DO NOT USE THESE UNSAFE ABBREVIATIONS: "U" and "IU" should be unit, "Ug" should be mcg, "QD" should be daily, "QOD" should be every other day, "BIW" should be two times a week, "TIW" should be three times a week, "AU," "AS," "AD," "OS," and "OD" should be written out in full. Correct Use of Leading and Trailing Zeros - Always Leading Never Trailing .1 should be 0.1 and 1.0 should be 1

LABS ☐ Computerized Physician Order Entry (CPOE)

	☐BMP	☐Urine CX	☐CSF C&S/Gm Stain	☐Chest Pain Order Set
☐CBC with diff	☐CMP	☐U/A Dip	☐CSF Glucose/Protein	☐Diabetic: Order Set
☐Blood Culture x ____ sets	☐D-Stick	☐Clean Catch	☐CSF Cell Count/Diff	☐Type and Screen
☐ESR	☐Liver Profile	☐Catheter	☐CSF Viral Culture	☐ABO Rh Type & Antibody Screen ____ units
☐Retic	☐Amylase	☐U/A Micro	☐CSF PCR_____	☐Urine Toxicology Screen
☐Monospot	☐Lipase	☐Urine HCG	☐Rapid Strep	☐Serum Salicylates
☐ABG	☐T Bili	☐GC/Chlam	☐Throat C&S	☐Serum Acetaminophen
☐VBG	☐Direct Bili	Source: _____		☐Serum ETOH
☐PT		☐Culture:		
☐aPTT		Source: _____		
☐INR				

ADDITIONAL LABS:

☐IV Fluids: ☐Intermittent Infusion Device Fluid: _____ Amount: _____ ml/kg Bolus: _____ ml over _____ minutes
☐Maintenance: Fluid: _____ Rate: _____ ml/hour
☐SaO_2 ☐Oxygen via _____ at _____ FIO_2 ☐Cardiac Monitor ☐EKG
☐NG ☐Lavage ☐Low Suction ☐Straight Catheterization ☐Indwelling Urinary Catheterization
☐Other: _____

Imaging: (specify clinical indications) ☐ Computerized Physician Order Entry (CPOE)

☐Abdominal series w/PA chest
☐Abdomen: ☐single view
☐Ankle Complete: ☐Left ☐Right
☐Calcaneus: ☐Left ☐Right
☐Chest PA & Lateral
☐Chest: ☐Portable
☐Clavicle: ☐Left ☐Right
☐Elbow 2 view: ☐Left ☐Right
☐Femur 2 view: ☐Left ☐Right
☐Fingers Complete: ☐Left ☐Right
☐Foot 3 view: ☐Left ☐Right
☐Forearm 2 view: ☐Left ☐Right
☐Hand 3 view: ☐Left ☐Right
☐Hip Complete: ☐Bilateral ☐Left ☐Right
☐Humerus: ☐Left ☐Right
☐Knee Complete: ☐Left ☐Right
☐Mandible Complete
☐Nasal Bones
☐Neck Soft Tissue
☐Orbits
☐Pelvis: ☐1 or 2 views ☐Complete
☐Ribs w/PA chest: ☐Left ☐Right ☐Bilateral
☐Sacrum & Coccyx
☐Scapula Complete: ☐Left ☐Right
☐Shoulder Complete: ☐Left ☐Right
☐Spine Cervical: ☐1 view ☐Complete
☐Spine Lumbosacral - 2 or 3 views
☐Spine Thoracic: ☐1 view ☐2 view
☐Sternum
☐Tibia/Fibula: ☐Left ☐Right
☐Toes Complete: ☐Left ☐Right
☐Wrist Complete: ☐Left ☐Right
☐Other: _____

☐CT Head
☐CT Abdomen
☐CT Pelvis
☐CT _____
☐with contrast
☐without contrast
☐IV
☐PO
☐Rectal

US
☐Abdomen
☐Pelvic
☐Testicular
☐Other: _____

Reason List: *Check Primary Reason for Exam*

☐Abdominal distension	☐Deformity	☐Limp	☐Stridor
☐Aspiration	☐Dysphagia	☐Mental status changes	☐Foreign body: _____
☐Bloody Stool	☐Fever	☐Pain: _____	☐Swelling
☐Constipation	☐Headache	☐Post-Reduction: _____	☐Vomiting
☐Cough	☐Hematuria	☐Respiratory Distress	☐Wheeze
		☐Seizure	☐Other: _____

Clinical Information:

ALL MEDICATIONS ARE FOR ONE TIME ONLY, UNLESS OTHERWISE INDICATED

Date	Time	Medication	Dose per kg	Dose	Route	Interval	Indication
		Acetaminophen	15 mg/kg				
		Ibuprophen	10 mg/kg				
			mg/kg				

DATE: _____ TIME: _____ PROVIDER SIGNATURE: _____

KH00695 Rev. 04/08/08

HISTORY & PHYSICAL/CONSULT

Place STAT barcode sticker within this box only on form copy being scanned

ED Pre-Arrival

* Auth (Verified) *

KALEIDA HEALTH

☐ Buffalo General Hospital
☐ DeGraff Memorial Hospital
☐ Millard Fillmore Gates Circle Hospital
☐ Millard Fillmore Suburban Hospital
☐ Millard Fillmore Surgery Center
☐ Women & Children's Hospital of Buffalo
☐ Others:

EXPECT NOTE - EMERGENCY DEPARTMENT REFERRAL FORM 1 of 1

Patient Ma
Medical R MR- 68927647
DOB- AGE- 014Y SEX- F
Date: ATT- TENNEY EMILY F
PCP-
Date of Bi FC- EMR E ADM DT- 10/07/09
Patient ID Area

Call From: St Mary's **Phone Number/Pager:**

Respond To: **Phone Number/Pager:**

Coming From: ☐ Home ☐ Office ☐ Facility:

Estimated Time of Arrival:

Transport Via:

Reason for Referral:

Sexassault
occurred 0730 AM

VSS
HT

Plan/Recommendation: Ambulance

Call Taken By: **Time:**

KH00020 Rev. 08/29/07

* Auth (Verified) *

KALEIDA HEALTH

☐ Buffalo General Hospital
☐ DeGraff Memorial Hospital
☐ Millard Fillmore Gates Circle Hospital
☐ Millard Fillmore Suburban Hospital
☐ Women & Children's Hospital of Buffalo
☐ Others: _____

MR- 1001428581 PT- 68927647
DOB- AGE- 014Y SEX- F
ATT- LAWRENCE, LYNN M
PCP-
FC- EMR E ADM DT- 10/07/09
Patient ID Area WOMENS AND CHIL

EMERGENCY DEPARTMENT PEDIATRIC NURSING CARE RECORD 1 of 4

Date: 10-7-09 Time: 6P

Significant Other: ☐ Present ☐ Not Available ☐ None ☐ Notified ☐ Notified Deferred

Advance Directive(s): ☐ None ☐ Unknown ☐ Health Care Proxy ☐ Living Will ☐ DNR ☐ Organ Donor

Information Source: ☐ Patient ☐ Family Member ☐ Emergency Medical Service ☐ Transfer Documentation

CARDIOVASCULAR

☐ Non-contributing ☐ Pain 0-10 ___ ☐ Site ___
☐ Normal ☐ Pressure ☐ Palpitations
☐ Edema ☐ Dizziness ☐ Diaphoresis
☐ Syncope ☐ Numbness ☐ Cap Refill
Pulse Quality: ☐ strong ☐ weak ☐ irregular ☐ absent

PULMONARY

☑ Non-contributing ☐ Pain 0-10 ___ ☐ Site ___
☐ Normal ☐ Cough ☐ Dyspnea
☐ Othopnea ☐ Sputum ☐ Accessory muscle use
Color ☐ pink ☐ pallor ☐ cyanosis ☐ trach
Breath Sounds: ☐ clear ☐ abnormal ___

GASTROINTESTINAL

☑ Non-contributing ☐ Pain 0-10 ___ ☐ Site ___
☐ Normal ☐ Nausea ☐ Vomiting
☐ Diarrhea ☐ Constipation ☐ Bowel Sounds
☐ Distension ☐ Firmness ☐ Tenderness
☐ Guarding ☐ Rebound

NEUROLOGIC

☑ Non-contributing ☐ Pain 0-10 ___ ☐ Site ___
Mentation: ☐ A & O ☐ Abnormal ___
☐ Weakness RT___ LT___ ☐ Paralysis RT___ LT___
☐ Facial droop Speech ___
☐ Behavior change ☐ Headache
☐ Ataxia ☐ Seizure ☐ Gag
Pupils: ☐ PEARRLA ☐ Abnormal ___
☐ Unequal ☐ Sluggish
☐ Deviated ☐ Right ☐ Left

GU/REPRODUCTIVE

☐ Non-contributing ☐ Pain 0-10 ___ ☐ Site ___
☐ Normal ☐ Frequency ☐ Dysuria
☐ Urgency ☐ Retention ☐ Odor
☐ Hematuria ☐ Incontinence ☐ Suprapubic
☐ Indwelling Catheter (foley) sexual assault
☐ Vaginal/Penile Lesions ☐ Vaginal/Penile Discharge
☐ Vaginal Bleeding ☐ Contractions
☐ G___ P___ AB___ ☐ FHR___ ☐ EDC___

MUSCULOSKELETAL

☑ Non-contributing ☐ Pain 0-10 ___ ☐ Site ___
☐ Normal ☐ Injury ☐ Decreased ROM
☐ Deformity ☐ Gait deficit ☐ Weakness
☐ Numbness ☐ Int/Ext Rotation ☐ Joint swelling
Neurovascular ☐ Intact ☐ Pulse___ ☐ Cap refill___
☐ Decreases sensation

GLASGOW COMA SCALE: 15

Eye Opening:	Best Verbal:	Best Motor:	Pain Reaction:
4 Spontaneous	5 Oriented	3 Obeys commands	3 Reaction to pain
3 To Speech	4 Confused	2 Localizes pain	2 Extension to pain
2 To pain	3 Inappropriate words	1 Withdraws	1 None
1 None	2 Inappropriate sounds		
	1 None		

INTEGUMENTARY

☐ Skin intact upon arrival ☐ Non-contributing
☐ Pain 0-10___ ☐ Site ___
☐ Rash ☐ Itching ☐ Redness ☐ Burn
☐ Ulcer ☐ Petechiae ☐ Abrasion ☐ Ecchymosis
☐ Incision ☐ Lesion ☐ Edema ☐ Drainage
☐ Pallor ☐ Cyanosis ☐ Jaundice ☐ Decreased Turgor
☐ Warm ☐ Cool ☐ Diaphoretic

INJURIES

☑ Non-contributing ☐ Pain 0-10 ___ ☐ Cleansed
☐ Site ___ Length ___
☐ Time of Injury Bleeding Controlled
Neuro-vascular: Distal Pulse___ Cap refill
How Injury Occurred ___
Location (i.e. school, home, work) ___

HEENT

☑ Non-contributing ☐ Pain 0-10 ___ ☐ Site ___
☐ Normal ☐ Injury ___ ☐ Epistaxis
☐ Edema ___ ☐ Stridor ☐ Redness
☐ Foreign Body ☐ Abnormal mucosa
Mucous Membranes: ☐ Moist ☐ Dry
☐ Drainage___ ☐ Headache
☐ Sensory deficit ☐ Toothache ☐ Eyes Sunken
Fontanelle (less than 18 months): ☐ Bulging ☐ Flat
Tears: ☐ Yes ☐ No

NUTRITIONAL

☑ Non-contributing ☐ Normal
☐ Diabetes - newly diagnosed
☐ Congestive Heart Failure - newly diagnosed
☐ Unplanned weight loss greater than 10% of usual weight

KEY:
P - PARA AB - Abortion FHR - Fetal Heart Rate

VASCULAR CATHETER

☐ Vascular Catheter present upon arrival to Emergency Department
Type: NA
SITE ASSESSMENT
☐ Clean, dry, without redness
☐ Other: ___

FALLS

Is the patient at risk for fall?
☐ YES ☐ NO
SAFETY PLAN
☐ Side rails up
☐ Call bell in reach
☐ Out of bed with assistance only

LIFT/TRANSFER MODE (refer to policy CL.73)
☐ Independent (no lift device)
☐ Non-Friction or Air Matt
☐ Transfer/Gait Belt (1+ assist)
☐ Sit/Stand Mechanical Lift
Harness type:
☐ Band Harness
☐ Total Transfer Harness:
☐ with leg straps
☐ without leg straps
☐ Total Mechanical Lift
Sling type:
☐ Hygiene Sling
☐ Hammock Sling
Size: ___
Method:
☐ Cradle
☐ Cross thru

☐ Limited English Proficiency 20 ☐ Hearing Impaired 20 ☐ Visually Impaired 20
Personal Belongings: ☐ Glasses ☐ Hearing aid: ☐ Left ☐ Right ☐ Both
☐ Dental Appliances: ☐ Upper ☐ Lower ☐ Both
☐ Other: ___

RN Signature: Rebecca Roloff RN Sane A-P

TIME	NURSING NOTES	INITIALS

PAGE POINTS

KH00487 Rev. 02/19/08

* Auth (Verified) *

KALEIDA HEALTH

- ☐ Buffalo General Hospital
- ☐ DeGraff Memorial Hospital
- ☐ Millard Fillmore Gates Circle Hospital
- ☐ Millard Fillmore Suburban Hospital
- ☐ Women & Children's Hospital of Buffalo
- ☐ Others

MR: 1001428581 PT: 68927647
DOB: AGE: 014Y SEX: F
ATT: LAWRENCE, LYNN M
PCP:
FC: EMR E ADM DT: 10/07/09
Patient ID Area: WOMENS AND CHIL

EMERGENCY DEPARTMENT PEDIATRIC NURSING CARE RECORD 1 of 4

TIME	Axillary Temperature	Color	Resp. Rate	Respiratory Assessment	SaO2 % O2	Heart Rate	Blood Pressure	Capillary Refill	Pulses	Level of Consciousness	Pain Scale 0-10	COMMENTS	INITIALS

NURSING INTERVENTIONS

- ☐ Pulse Oxygen ☐ Oxygen 10
- Cardiac Monitor 20
  Start Time: _____
- EKG
- IV INSERTION
  size: _____ location: _____
  time: _____
- Peak flow 10
  pre: _____ post: _____
  X _____
- LP Assist
- Indwelling Catheter 15
- Nasogastric Tube Care 20
  _____ fr.
- Suction Airway 20
- Child Protection Services/Photography 20
- Enema 30
- Monitor Chest Tube 20
- Social Services/Family Needs 20
- Moderate Sedation
- ~~Warming Measures~~ 20
- Sexual Assault/Nurse Examiner (SANE) 50
- Pelvic Exam 10
- Wound Care Simple 10 Complex 15
- Dressing Care/Change Simple 10 Complex 15
- Extensive Patient Care 30

Mediport Access 15
Straight Catheter 15
Gastric Care 20
Decontamination 30
Monitor CVP 20
Eye Wash 20
~~Over Dose/Suicide~~ 30
Isolation 20

LABORATORY

TIME SENT:
CBC
BMP/CMP
Blood Culture
URINE Culture
Respiratory Screen
CSF
PT/aPTT
Urinalysis
Toxicology
ABG/VBG
Specimen Transport 5
Obtain Other Specimen 15
X HIV
Hepatitis RPR

RN TRANSPORT 10

Continuous Monitoring RN transport 25

RADIOLOGY

Chest X-ray
CT
OTHER

POINT OF CARE TESTING

Urinalysis
HCG Neg
Blood Glucose Test
RAPID STREP

TIME	NURSING NOTES	INITIALS

PAGE POINTS

KH00487 Rev. 02/19/08

* Auth (Verified) *

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EMERGENCY DEPARTMENT PEDIATRIC NURSING CARE RECORD 1 of 4

CONTINUOUS INTRAVENOUS INFUSIONS

Start Time	Site	Gauge	Fluid Type	Rate ml/hour	Amount Infused	Stop Time/ Transfer Time	Initials

INTERMITTENT INTRAVENOUS PIGGYBACK, DRIPS

Start Time	Site	Medication	Indication	Rate ml/hour	Amount Infused	Stop Time/ Transfer Time	Initials

INTRAMUSCULAR/ SUBCUTANEOUS/ INTRAVENOUS PUSH/ BOLUS/ ORAL

Time	Medication	Dose	Route	Site	Indication	Effect	Vaccine Lot Number	Initials
635p	Plan B	2 pills	oral		EC			RR
635p	Zithromax	1gm	oral		STI			RR
635p	Ceftriaxone	125mg	IV		STI			RR
635p	Flagyl	2gms	oral		STI			RR
635p	Viread	300mg	oral		HIV PEP			RR
635p	Combivir	1 pill	oral		HIV PEP			RR
6p	Zofran	4mg	oral		nausea			RR

Initials	Signature/Title	Initials	Signature/Title	Initials	Signature/Title
RR	Rebecca Rale RN				

KH00487 Rev. 02/19/08

* Auth (Verified) *

☐ Buffalo General Hospital
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KALEIDA HEALTH

EMERGENCY DEPARTMENT PEDIATRIC NURSING CARE RECORD 1 of 1

MR: 1001428581 PT: 68927647
DOB: AGE: 014Y SEX: F
ATT: LAWRENCE, LYNN M
PCP:
FC: EMR E ADM DT: 10/07/09
Patient ID Area: WOMENS AND CHIL

PATIENT EDUCATION RECORD

INSTRUCTED: 1 - PATIENT, 2 - SIGNIFICANT OTHER, 3 - CARETAKER, 4 - NONE GIVEN
MODE: 1 - VERBAL, 2 - DEMONSTRATION, 3 - WRITTEN, 4 - VIDEO
EVALUATION: 1 - VERBAL RECALL, 2 - DEMONSTRATE, 3 - RECALL/DEMONSTRATE WITH ASSIST, 4 - REINFORCEMENT NEEDED

INSTRUCTED	MODE	TEACHING	EVALUATION	INITIAL	INSTRUCTED	MODE	TEACHING	EVALUATION	INITIAL
1,3	1	Illness/Injury Process					Lifestyle Managment		
1,3	1	• Treatments/Tests/Procedures			1,3	1	• Medications		
1,3	1	• When to contact primary care provider					• Dietary		
1,3	1	Medical equipment/Treatments					• Activity		
		Advance Directives					Communication Resources		

INTERDISCIPLINARY ASSESSMENT AND PLAN OF CARE

Barriers to a safe patient discharge identified

- ☒ None identified
- ☐ Unknown capacity of caregiver
- ☐ Limited family/social support
- ☐ Lack of primary care provider
- ☐ Lack of resources/equipment
- ☐ Family Concerns
- ☐ Guardianship Issues
- ☐ Pregnant adolescent/ adolescent mother
- ☐ MHA/Suicidal
- ☐ Potential Against Medical Advice
- ☐ Other _____

TIME: 1350 INITIAL: RR

Interdisciplinary Provider Utilization:

- ☒ N/A
- ☐ Social Work
- ☐ Pastoral Care
- ☐ Home Care Agency
- ☐ Physical Therapy
- ☐ Language Interpreter
- ☐ Crisis Management
- ☐ Rape Crisis
- ☐ Psychiatry
- ☐ Police Department
- ☐ Other _____

TIME: 1350 INITIAL: RR

DISPOSITION OUTCOMES

☐ Barriers and high risks addressed ☐ Plan of care in place ☐ Patient/Family verbalizes comprehension of plan of care

☐ Admit Time: _____ ☒ Discharge Time: 1350 ☐ Transfer Time: _____

☐ ICU 30 ☐ OR 30 ☐ Telemetry 10 ☐ Med/Surg 10 ☐ CPC 10 ☒ Home ☐ Abscond 20 ☐ AMA 20

Bed #: _____ Time bed assigned: _____ ☐ Out of facility with RN 30 ☐ Other: _____

Report called to: _____ Time: _____ ☒ Stable ☐ Alert ☐ Other: _____

Time of transfer: _____ ☐ Discharge instruction sheet _____ ☐ Transfer Form 30

Mode: _____ ☐ Simple ☐ Moderate 20 ☒ Extensive 25

Accompanied by: _____ ☒ Pain level on discharge (0-10): 0

Pain level on transfer (0-10): _____ Mode of Transport: ☒ Private vehicle

☐ Patient Expired Time: _____ ☐ Ambulance/Transport Service: _____

☐ Postmortem Documentation Sheet completed 20 ☐ Other: _____

Initials: _____ Initials: RR

Disposition Vital Signs: ☐ N/A T: _____ P: _____ R: _____ BP: _____ B

Initials	Signature/Title

Initials	Signature/Title
RR	Rebecca Roloff RN

PAGE POINTS

TOTAL POINTS

KH00487 Rev. 02/19/08

ED Triage

SERVICE DATE/TIME: 10/07/2009 16:31
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: FILBERT,PATRICIA (10/07/2009 16:31)
SIGN INFORMATION: FILBERT,PATRICIA (10/07/2009 16:31)

ED WCHOB Triage Entered On: 10/7/2009 16:39
Performed On: 10/7/2009 16:31 by FILBERT, PATRICIA

Acuity
Age Range Adult: No
Age Range Ped: 18 & under

FILBERT, PATRICIA - 10/7/2009 16:31

DCP GENERIC CODE
Visit Reason: SA
Triage Date/Time: 10/7/2009 16:31
Triage Acuity: Yellow
Tracking Group: CHOB Tracking Group

FILBERT, PATRICIA - 10/7/2009 16:31

Chief Complaint - Adult/Peds
Chief Complaint: Code R

FILBERT, PATRICIA - 10/7/2009 16:31

General Peds
Arrival Date/Time: 10/07/2009 16:27
ED Information Given By: Family member
Mode of Arrival: Ambulance/BLS
Chief Complaint-Adult/Ped: Open
Chief Complaint Description: transfer from St mary's - SA
Do you have pain?: No
ED Condensed Assessment: Yes
Vital Signs Assessed: Yes
Allergies/HT/WT: Yes
Pregnancy Status: Patient denies
Last Mentrual Period ED: 09182009
Significant Medical History: Patient denies
Medication History ED: Completed Med Recon Form
High Risk/Psychosocial Screen: N/A
Immunizations Current: Yes
Pre Hospital/Triage Treatment: Yes

FILBERT, PATRICIA - 10/7/2009 16:31

Vitals
Vital Sign (1) D/T: 10/7/2009 16:35
Temperature: 36.7degC(Converted to: 98.1degF)
Temperature Route: Oral
Heart Rate: 92bpm
Respiratory Rate: 18BR/min
Systolic Blood Pressure: 103mmHg
Diastolic Blood Pressure: 69mmHg
Oxygen Saturation: 99%
Oxygen Therapy: Room Air

ED Triage

FILBERT, PATRICIA - 10/7/2009 16:31

Height/Weight/Allergies
Height Measurement Type: ED Only - Not Required per policy
Weight Kg: 45.00kg(Converted to: 99.21lb)
Weight: 45.00kg
Body Surface Area: 0.00
Identified or Suspected Allergy: No

FILBERT, PATRICIA - 10/7/2009 16:31

Allergies (Active)

Benadryl — *Estimated Onset Date:* Unspecified ; *Created By:* FILBERT, PATRICIA; *Reaction Status:* Active ; *Category:* Drug ; *Substance:* Benadryl ; *Type:* Allergy ; *Updated By:* FILBERT, PATRICIA; *Reviewed Date:* 10/7/2009 16:33

Condensed Assessment
Level of Consciousness: Alert
Orientation: Oriented x 3
Affect/Behavior: Calm

FILBERT, PATRICIA - 10/7/2009 16:31

Triage Treatment
Pre-hospital/Triage Treatment Grid
IV Insertion: Pre-Arrival
(Comment: 20 g R a c [FILBERT, PATRICIA - 10/7/2009 16:31])

FILBERT, PATRICIA - 10/7/2009 16:31

Ambulance Documents

* Auth (Verified) *

Lights & Sirens to scene / from destination

100709 | 108314 | 4- 8255995 | 001479 | 560 | ALS / BLS Amb level

RURAL METRO MEDICAL SERVICES

NATURE AS DISPATCHED COLD ... GET ...
MSM ... CHOB ... / CALL ...

LOCATION CODE 2001

ODOMETER READINGS 376974 / 376737

CALL REC'D	
ENROUTE	1445
AT SCENE	1524
FROM SCENE	1547
AT DESTINATION	1621
IN SERVICE	
IN QUARTERS	

PATIENT INFOR... ○ Residence ● Health ○ Farm ○ Industrial ○ Other Work ○ Road ○ Other

Call Received as ○ EMERGENCY ● NON-EMERGENCY ○ STANDBY ○ INTERCEPT

AGE 14 — F ● M ○

Physician

CARE IN PROGRESS ON ARRIVAL: ○ None ○ Citizen ○ PD/FD/Other First Responder ○ Other EMS ○ PAD used

MECHANISM OF INJURY: ○ MVA (✓ seat belt used ——▶) ○ Struck by vehicle ○ Fall of ____ feet ○ Unarmed assault ○ GSW ○ Knife ○ Machinery / Other: Medical
○ Extrication required ____ minutes | Seat belt used ○ Yes ○ No ○ Unknown | Seat Belt Use Reported By ○ Crew ○ Patient ○ Police ○ Other

CHIEF COMPLAINT s/p sexual assault

SUBJECTIVE ASSESSMENT 14 y/o ♂ pt found seated in bed @ Mount Saint Mary. pt to Be Tx to CHOB, Two bags of clothing and 1 bag of specimens tx with pt - chain of custody pt tx COLD to CHOB with Mother on Board

PRESENTING PROBLEM Fill in circle
○ Airway Obstruction ○ Respiratory Arrest ○ Respiratory Distress ○ Cardiac Related (Potential) ○ Cardiac Arrest ○ Allergic Reaction ○ Syncope ○ Stroke/CVA ○ General Illness/Malaise ○ Gastro-Intestinal Distress ○ Diabetic Related (Potential) ○ Pain ○ Unconscious/Unresp. ○ Seizure ○ Behavioral Disorder ○ Substance Abuse (Potential) ○ Poisoning (Accidental) ○ Shock ○ Head Injury ○ Spinal Injury ○ Fracture/Dislocation ○ Amputation ○ Major Trauma ○ Trauma-Blunt ○ Trauma-Penetrating ○ Soft Tissue Injury ○ Bleeding/Hemorrhage ○ OB/GYN ○ Burns Environmental ○ Heat ○ Cold ○ Hazardous Materials ○ Obvious Death ● Other s/p sexual assault

PAST MEDICAL HISTORY
● None ○ Allergy to Benadryl ○ Hypertension ○ Stroke ○ Seizures ○ Diabetes ○ COPD ○ Cardiac ○ Other (List) ○ Asthma

Current Medications (List)

VITAL SIGNS

TIME	RESP	PULSE	B.P.	LEVEL OF CONSCIOUSNESS	GCS	R PUPILS L	SKIN	STATUS
1545	Rate: 18, ● Regular	Rate: 106, ● Regular	110/70	● Alert	15	● Normal ●	● Unremarkable	● S
1605	Rate: 18, ● Regular	Rate: 104	106/P	● Alert	15	● Normal ●		● S
	Rate:	Rate:						

OBJECTIVE PHYSICAL ASSESSMENT 14 y/o ♂ pt found seated in bed. pt denies c/c - appears anxious. (+)ABC, CAO×4, Heent intact PERRL, ⊖JVD ⊖TI DEV, pt to be tx to CHOB for Pediatric SANE Exam. pt is s/p sexual assault Two paper bags tx along with pt chain of custody maintained. Bags transfered over to CHOB SANE

COMMENTS examiner along with bag of specimen. Pt vitals stable. pt tx (COLD) to CHOB and left in care of Mother and CHOB SANE examiner

MEDICAL REASON FOR AMBULANCE TRANSPORT Saline trap / Chain of custody of clothing — REPORT GIVEN TO: RN

TREATMENT GIVEN FILL IN CIRCLE
○ Moved to ambulance on stretcher / backboard / stairchair
○ Moved ON / OFF stretcher via Stand pivot
○ I chose to walk to ambulance. Signature
○ Airway Cleared
○ Oral / Nasal Airway
○ Esophageal Obturator Airway / Esophageal Gastric Tube Airway (EOA/EGTA)
○ EndoTracheal Tube (E/T) SUX ____ Size ____ Time ____
○ Oxygen Administered @ ____ L.P.M., Method ____
○ Suction Used
○ Artificial Ventilation Method ____
○ C.P.R. in progress on arrival by: ○ Citizen ○ PD/FD/Other First Responder ○ Other
○ C.P.R. Started @ Time ▶ ____ Time from Arrest Until C.P.R. ▶ ____ Minutes
○ EKG Monitored (Attach Tracing) [Rhythm(s) ____]
○ Defibrillation/Cardioversion No. Times ____ ○ Manual ○ Semi-automatic
○ Medical control contacted. Physician name ____
○ Hospital Transfer Diagnosis ____
○ Medication Administered (Use Continuation Form) ____ # Meds Given
○ IV Established Fluid ____ Cath. Gauge ____
○ Mast Inflated @ Time ____
○ Bleeding / Hemorrhage Controlled (Method Used: ____)
○ Spinal Immobilization Neck and Back
○ Limb Immobilized by ○ Fixation ○ Traction
○ (Heat) or (Cold) Applied
○ Vomiting Induced @ Time ____ Method ____
○ Restraints Applied, Type ____
○ Baby Delivered @ Time ____ In County ____ ○ Alive ○ Stillborn ○ Male ○ Female
○ Transported in Trendelenburg position
○ Transported in left lateral recumbent position
○ Transported with head elevated
○ ALS assessment performed by ____
○ Other

DISPOSITION (See list) Pt. left where/how CHOB 4th Floor — DISP. CODE 937 — CONTINUATION FORM USED YES

CREW
TECH F. BARBER ● EMT ○ AEMT-I ○ AEMT-P 358582
DRIVER'S NAME C. GREEN ● EMT ○ AEMT-I ○ AEMT-P 371592
NAME ○ EMT ○ AEMT-I ○ AEMT-P
NAME ○ EMT ○ AEMT-I ○ AEMT-P

HOSPITAL PATIENT RECORD COPY

DOH 3283 (7/07) RM REV 10/07

* Auth (Verified) *

HOSPITAL NAME	DISPOSITION CODE
Bertrand Chaffee Hospital	641
Brooks Memorial Hospital	061
Buffalo General Hospital	643
Buffalo Mercy Hospital	657
Childrens Hospital	937
De Graff Memorial Hospital	317
Erie County Medical Center	646
Genesee Memorial Hospital	181
Inter-Community Hospital/Newfane	312
Jones Memorial Hospital	023
Kenmore Mercy Hospital	648
Lakeshore Hospital	063
Lockport Memorial Hospital	313
Medina Memorial Hospital	362
Millard Fillmore Hospital	651

HOSPITAL NAME	DISPOSITION CODE
Millard Fillmore Suburban	652
Mount St. Mary's Hospital	314
Niagara Falls Memorial Medical Ctr.	316
Olean General Hospital	041
Our Lady of Victory Hospital	653
Sheehan Memorial Hospital	647
Sisters of Charity Hospital	654
St. Jerome Hospital	182
St. Joseph Hospital	656
Tri-County Memorial Hospital	662
Veterans Admin. Medical Center	655
W.C.A. Hospital	062
Westfield Memorial Hospital	064
Wyoming County Community Hosp.	601

NON-HOSPITAL DISPOSITION CODES:

NURSING HOME 001
OTHER MEDICAL FACILITY 002
RESIDENCE 003
TREATED BY THIS UNIT, TRANSPORTED BY ANOTHER UNIT 004
REFUSED MEDICAL AID OR TRANSPORT 005
CALL CANCELLED 006
STANDBY ONLY (NO PATIENT) 007
NO PATIENT FOUND 008
OTHER 010

HOSPITAL COMPLETES THIS SECTION

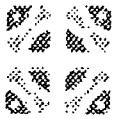
COMPLETE ON YELLOW (RESEARCH) COPY ONLY

This Patient was:
0 ☐ Classified for critical care →
1 ☐ Discharged
2 ☐ Admitted and given hospital I.D.# ___
3 ☐ Transferred to another facility ( )
4 ☐ Left hospital against medical advice
5 ☐ Expired in the Emergency Department
6 ☐ D.O.A.

Classified for critical care
1 ☐ Cardiac
2 ☐ Multiple Trauma
3 ☐ Poison
4 ☐ Neonatal
5 ☐ Burns
6 ☐ Behavioral
7 ☐ CNS

The admission diagnosis was: _____

☐☐ ☐
☐☐☐☐☐
☐☐☐☐☐



Medical Record Request

Med Rec Nbr:		*UI Nbr:*	1001428581
Financial Nbr:	68927647	*Patient Name:*	
Client Med Rec Nbr:		*Organization:*	KH CHOB
DOB:		*Patient Location:*	ZZC-Emergency Rm
Sex:	Female	*Physician:*	FRASER-BRANCHE,EMILY MD
Adm: 10/07/2009	*Dsch:* 10/07/2009		LAWRENCE,LYNN M

Hematology

Complete Blood Count

Orderable Name	Ordering Provider	Accession Number	Specimen Type	Collected Date/Time	Received Date/Time
CBC w/ Differential		09-280-07416		10/07/2009 17:45	

Procedure	Result	Result Symbol	Units	Reference Range	Report Date/Time	Footnote Symbol
WBC	6.9		x10^9/L	[4.0-10.5]	10/07/2009 20:56	@1
RBC	4.97		x10^12/L	[4.10-5.30]	10/07/2009 20:56	@1
Hgb	14.9		g/dL	[12.0-15.0]	10/07/2009 20:56	@1
Hct	44.3		%	[35.0-45.0]	10/07/2009 20:56	@1
MCV	89.3		fL	[78.0-95.0]	10/07/2009 20:56	@1
MCH	30.1		pg	[26.0-32.0]	10/07/2009 20:56	@1
MCHC	33.7		g/dL	[32.0-36.0]	10/07/2009 20:56	@1
RDW	11.9		%	[11.5-15.0]	10/07/2009 20:56	@1
Platelet	320		x10^9/L	[150-450]	10/07/2009 20:56	@1
MPV	8.4		fL	[7.4-10.4]	10/07/2009 20:56	@1
Neut Abs	5.2		x10^9/L	[1.5-6.6]	10/07/2009 20:56	@1
Lymp Abs	1.2		x10^9/L	[1.0-3.5]	10/07/2009 20:56	@1
Mono Abs	0.5		x10^9/L	[<=1.0]	10/07/2009 20:56	@1
Eos Abs	0.0		x10^9/L	[<=0.7]	10/07/2009 20:56	@1
Baso Abs	0.0		x10^9/L	[<=0.1]	10/07/2009 20:56	@1
Neutrophils	**75.3**	H	%	[30.0-60.0]	10/07/2009 20:56	@1
Lymph	**17.0**	L	%	[20.0-50.0]	10/07/2009 20:56	@1
Mono	7.3		%	[<=12.0]	10/07/2009 20:56	@1
Eos	0.0		%	[<=6.0]	10/07/2009 20:56	@1
Basophils	0.4		%	[<=3.0]	10/07/2009 20:56	@1

Performing Locations

@1: This test was performed at:
CH Labs. Kaleida Health Children's Hospital Laboratory. 219 Bryant Street, Buffalo, NY 14222, P: (716) 878-7403, F: (716) 878-7464

Chemistry

Routine Chemistry

Orderable Name	Ordering Provider	Accession Number	Specimen Type	Collected Date/Time	Received Date/Time
Comprehensive Metabolic Panel (CMP)		09-280-07417		10/07/2009 17:45	

Procedure	Result	Result Symbol	Units	Reference Range	Report Date/Time	Footnote Symbol
Sodium Level	138		mmol/L	[135-145]	10/07/2009 21:01	@1
Potassium Level	3.6		mmol/L	[3.5-5.0]	10/07/2009 21:01	@1
Chloride	105		mmol/L	[98-110]	10/07/2009 21:01	@1
Carbon Dioxide	24		mmol/L	[20-30]	10/07/2009 21:01	@1
BUN	10		mg/dL	[5-19]	10/07/2009 21:01	@1
Creatinine	0.66		mg/dL	[0.40-0.90]	10/07/2009 21:01	@1
Calcium Level	9.6		mg/dL	[9.0-10.8]	10/07/2009 21:01	@1
Bilirubin	1.0		mg/dL	[0.2-1.2]	10/07/2009 21:01	@1
Alkaline Phosphatase	211		unit/L	[64-480]	10/07/2009 21:01	@1
AST	18		unit/L	[5-50]	10/07/2009 21:01	@1
ALT	11		unit/L	[5-50]	10/07/2009 21:01	@1
Protein	6.9		g/dL	[4.8-7.8]	10/07/2009 21:01	@1
Albumin Level	4.5		g/dL	[3.5-5.0]	10/07/2009 21:01	@1
Glucose Level	103		mg/dL	[60-110]	10/07/2009 21:01	@1

Performing Locations

@1: This test was performed at:
CH Labs, Kaleida Health Children's Hospital Laboratory, 219 Bryant Street, Buffalo, NY 14222, P: (716) 878-7403, F: (716) 878-7464

Infectious Disease Analysis

Syphilis Testing

Orderable Name	Ordering Provider	Accession Number	Specimen Type	Collected Date/Time	Received Date/Time
RPR - Reagin Ab (RPR Screen)		09-280-07424		10/07/2009 17:46	

Procedure	Result	Result Symbol	Units	Reference Range	Report Date/Time	Footnote Symbol
RPR -Reagin Ab	Non Reactive			[Non Reactive]	10/08/2009 12:15	@1

Miscellaneous Viral Testing

Orderable Name	Ordering Provider	Accession Number	Specimen Type	Collected Date/Time	Received Date/Time
HIV 1&2 Abs	BUSH,LINDA L	09-280-08715		10/07/2009 16:00	

Procedure	Result	Result Symbol	Units	Reference Range	Report Date/Time	Footnote Symbol
HIV-1/2 Ag/Ab Screen	Negative			[Negative]	10/08/2009 12:09	i1 @1

Interpretive Data

i1: HIV-1/2 Ag/Ab Screen

This information has been disclosed to you from CONFIDENTIAL RECORDS, which are protected by State law. State law PROHIBITS you from making any further disclosures of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any further disclosure in violation of State law may result in a FINE or JAIL SENTENCE or BOTH.

Disclosure of CONFIDENTIAL HIV information that occurs as a result of a general authorization for the release of medical or other information will be in violation of the State law and may result in a FINE or JAIL SENTENCE or BOTH.

Hepatitis Testing

Orderable Name	Ordering Provider	Accession Number	Specimen Type	Collected Date/Time	Received Date/Time
Hepatitis B Virus Core Ab (HBV Core Ab)		09-280-07418		10/07/2009 17:45	

Procedure	Result	Result Symbol	Units	Reference Range	Report Date/Time	Footnote Symbol
Hepatitis B Virus Core Ab	Negative			[Negative]	10/08/2009 11:11	@1

Infectious Disease Analysis

Hepatitis Testing

Orderable Name	Ordering Provider	Accession Number	Specimen Type	Collected Date/Time	Received Date/Time
Hepatitis B Virus Surface Ab (HBS Ab)		09-280-07418		10/07/2009 17:45	

Procedure	Result	Result Symbol	Units	Reference Range	Report Date/Time	Footnote Symbol
Hepatitis B Virus Surface Ab	<3		milliUnit/mL	[0-10]	10/08/2009 11:11	i2 @1

Orderable Name	Ordering Provider	Accession Number	Specimen Type	Collected Date/Time	Received Date/Time
Hepatitis B Virus Surface Ag (HBS Ag)		09-280-07418		10/07/2009 17:45	

Procedure	Result	Result Symbol	Units	Reference Range	Report Date/Time	Footnote Symbol
Hepatitis B Virus Surface Ag	Negative			[Negative]	10/08/2009 11:11	@1

Interpretive Data

i2: Hepatitis B Virus Surface Ab

```
Hepatitis B Virus Surface Antibody Interpretation:

< 10 milliUnit/mL    Negative / Non-immune.
>=10 milliUnit/mL    Values greater than or equal to
                     10 milliUnit/mL signify immunity to HBV.

See MMWR 39 (SS): 1-33, Feb. 9 1990 for guidelines on
Hepatitis B vaccination.
```

Performing Locations

@1: This test was performed at:
FL Labs, Kaleida Health Center for Laboratory Medicine, 115 Flint Road, Williamsville, NY 14221, P: (716) 626-7200, F: (716) 633-2361

Allergy

Recorded Date/Time	Recorded By	Substance: Benadryl
10/07/2009 16:33	FILBERT,PATRICIA	**Reaction Status:** Active; **Allergy Type:** Allergy; **Category Drug**; **Recorded On Behalf Of:** FILBERT,PATRICIA; **Reviewed Date/Time:** 10/07/2009 16:33 ; **Reviewed By:** FILBERT, PATRICIA

Orders

Laboratory

Order: HIV 1&2 Abs

Order Date/Time: 10/07/2009 23:40

Department Status: Completed | Catalog Type: Laboratory | Activity Type: General Lab

End-state Date/Time: 10/08/2009 12:09 | End-state Reason:

Ordering Physician: BUSH,LINDA L | Consulting Physician:

Entered & Electronically Signed By: COLWELL,HOLLIE D on 10/07/2009 23:40

Order Details: Routine, 10/7/09 4:00:00 PM EDT, Once, Blood, 4628522

Order Comment:

Action Type: Complete | Action Date/Time: 10/08/2009 12:09 | Action Personnel: BARYZA,KAREN A

Order Details: Routine, 10/07/09 16:00:00, Once, Blood, 4628522

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 23:40 | Action Personnel: System,System

Order Details: Routine, 10/07/09 16:00:00, Once, Blood, 4628522

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Order | Action Date/Time: 10/07/2009 23:40 | Action Personnel: COLWELL,HOLLIE D

Order Details: Routine, 10/07/09 16:00:00, Once, Blood, 4628522

Review Information:

Doctor Cosign: Not Required

Order Comment:

Orders

Laboratory

Order: RPR -Reagin Ab (RPR Screen)

Order Date/Time: 10/07/2009 17:45

Department Status: Completed | Catalog Type: Laboratory | Activity Type: General Lab

End-state Date/Time: 10/08/2009 12:15 | End-state Reason:

Ordering Physician: | Consulting Physician:

Entered & Electronically Signed By: ERB,BRITTANY M on 10/07/2009 17:45

Order Details: Stat, 10/7/09 5:46:00 PM EDT, Once, days, 1, Blood

Order Comment:

Action Type: Complete | Action Date/Time: 10/08/2009 12:15 | Action Personnel: GAUL,RUTH E

Order Details: Stat, 10/07/09 17:46:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 23:41 | Action Personnel: SHERRELL,MARY E

Order Details: Stat, 10/07/09 17:46:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 22:23 | Action Personnel: KIJ,PAMELA J

Order Details: Stat, 10/07/09 17:46:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 20:46 | Action Personnel: KIJ,PAMELA J

Order Details: Stat, 10/07/09 17:46:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Order | Action Date/Time: 10/07/2009 17:46 | Action Personnel: ERB,BRITTANY M

Order Details: Stat, 10/07/09 17:46:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Orders

Laboratory

Order: CBC w/Differential

Order Date/Time: 10/07/2009 17:43

Department Status: Completed | Catalog Type: Laboratory | Activity Type: General Lab
End-state Date/Time: 10/07/2009 20:56 | End-state Reason:
Ordering Physician: | Consulting Physician:
Entered & Electronically Signed By: ERB,BRITTANY M on 10/07/2009 17:43
Order Details: Stat, 10/7/09 5:45:00 PM EDT, Once, days, 1, Blood
Order Comment:

Action Type: Complete | Action Date/Time: 10/07/2009 20:56 | Action Personnel: HODGSON,KAREN A
Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood
Review Information:
Doctor Cosign: Not Required
Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 20:46 | Action Personnel: KIJ,PAMELA J
Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood
Review Information:
Doctor Cosign: Not Required
Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 20:46 | Action Personnel: KIJ,PAMELA J
Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood
Review Information:
Doctor Cosign: Not Required
Order Comment:

Action Type: Order | Action Date/Time: 10/07/2009 17:45 | Action Personnel: ERB,BRITTANY M
Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood
Review Information:
Doctor Cosign: Not Required
Order Comment:

Orders

Laboratory

Order: Comprehensive Metabolic Panel (CMP)

Order Date/Time: 10/07/2009 17:43

Department Status: Completed | Catalog Type: Laboratory | Activity Type: General Lab

End-state Date/Time: 10/07/2009 21:01 | End-state Reason:

Ordering Physician: | Consulting Physician:

Entered & Electronically Signed By: ERB,BRITTANY M on 10/07/2009 17:43

Order Details: Stat, 10/7/09 5:45:00 PM EDT, Once, days, 1, Blood

Order Comment:

Action Type: Complete | Action Date/Time: 10/07/2009 21:01 | Action Personnel: MUNSON,ROBERT E

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 20:46 | Action Personnel: KIJ,PAMELA J

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 20:46 | Action Personnel: KIJ,PAMELA J

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Order | Action Date/Time: 10/07/2009 17:45 | Action Personnel: ERB,BRITTANY M

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Orders

Laboratory

Order: Hepatitis B Virus Core Ab (HBV Core Ab)

Order Date/Time: 10/07/2009 17:43

Department Status: Completed | Catalog Type: Laboratory | Activity Type: General Lab

End-state Date/Time: 10/08/2009 11:11 | End-state Reason:

Ordering Physician: | Consulting Physician:

Entered & Electronically Signed By: ERB,BRITTANY M on 10/07/2009 17:43

Order Details: Stat, 10/7/09 5:45:00 PM EDT, Once, days, 1, Blood

Order Comment:

Action Type: Complete | Action Date/Time: 10/08/2009 11:11 | Action Personnel: SZCZPIEROWSKI,NANCY C

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 23:41 | Action Personnel: SHERRELL,MARY E

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 22:23 | Action Personnel: KIJ,PAMELA J

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 20:46 | Action Personnel: KIJ,PAMELA J

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Order | Action Date/Time: 10/07/2009 17:45 | Action Personnel: ERB,BRITTANY M

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Orders

Laboratory

Order: Hepatitis B Virus Surface Ab (HBS Ab)

Order Date/Time: 10/07/2009 17:43

Department Status: Completed | Catalog Type: Laboratory | Activity Type: General Lab

End-state Date/Time: 10/08/2009 11:11 | End-state Reason:

Ordering Physician: | Consulting Physician:

Entered & Electronically Signed By: ERB,BRITTANY M on 10/07/2009 17:43

Order Details: Stat, 10/7/09 5:45:00 PM EDT, Once, days, 1, Blood

Order Comment:

Action Type: Complete | Action Date/Time: 10/08/2009 11:11 | Action Personnel: SZCZPIEROWSKI,NANCY C

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 23:41 | Action Personnel: SHERRELL,MARY E

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 22:23 | Action Personnel: KIJ,PAMELA J

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 20:46 | Action Personnel: KIJ,PAMELA J

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Order | Action Date/Time: 10/07/2009 17:45 | Action Personnel: ERB,BRITTANY M

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Orders

Laboratory

Order: Hepatitis B Virus Surface Ag (HBS Ag)

Order Date/Time: 10/07/2009 17:43

Department Status: Completed | Catalog Type: Laboratory | Activity Type: General Lab

End-state Date/Time: 10/08/2009 11:11 | End-state Reason:

Ordering Physician: | Consulting Physician:

Entered & Electronically Signed By: ERB,BRITTANY M on 10/07/2009 17:43

Order Details: Stat, 10/7/09 5:45:00 PM EDT, Once, days, 1, Blood

Order Comment:

Action Type: Complete | Action Date/Time: 10/08/2009 11:11 | Action Personnel: SZCZPIEROWSKI,NANCY C

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 23:41 | Action Personnel: SHERRELL,MARY E

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 22:23 | Action Personnel: KIJ,PAMELA J

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Status Change | Action Date/Time: 10/07/2009 20:46 | Action Personnel: KIJ,PAMELA J

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Order | Action Date/Time: 10/07/2009 17:45 | Action Personnel: ERB,BRITTANY M

Order Details: Stat, 10/07/09 17:45:00, Once, days 1, Blood

Review Information:

Doctor Cosign: Not Required

Order Comment:

Orders

Patient Care

Order: FCT Task

Order Date/Time: 10/07/2009 16:28

Department Status: Completed	Catalog Type: Patient Care	Activity Type: Emergency Department
End-state Date/Time: 10/19/2009 08:10		End-state Reason:
Ordering Physician: System,System		Consulting Physician:

Entered & Electronically Signed By: System,System on 10/07/2009 16:28

Order Details: Routine, 10/7/09 4:28:15 PM EDT, Once

Order Comment: This is a discern rule which fired upon ED sign in..

Action Type: Complete	Action Date/Time: 10/19/2009 08:10	Action Personnel: FORGIONE,THERESA M

Order Details: Routine, 10/07/09 16:28:15, Once

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Order	Action Date/Time: 10/07/2009 16:28	Action Personnel: System,System

Order Details: Routine, 10/07/09 16:28:15, Once

Review Information:

Doctor Cosign: Not Required

Order Comment: This is a discern rule which fired upon ED sign in..

Event Assessment

Recorded By	HODGSON,KAREN A	MUNSON,ROBERT E	FILBERT,PATRICIA
Recorded Date	10/07/2009	10/07/2009	10/07/2009
Recorded Time	17:45	17:45	16:31
Procedure			
Respiratory Rate	-	-	18
Oxygen Therapy	-	-	Room Air
Systolic Blood Pressure	-	-	103
Diastolic Blood Pressure	-	-	69
Level of Consciousness	-	-	Alert
Hgb	14.9	-	-
Hct	44.3	-	-
AST	-	18	-
Platelet	320	-	-
Albumin Level	-	4.5	-
WBC	6.9	-	-
RBC	4.97	-	-
Neut Abs	5.2	-	-
Lymp Abs	1.2	-	-
Mono Abs	0.5	-	-
Eos Abs	0.0	-	-
Baso Abs	0.0	-	-
Bilirubin	-	1.0	-
BUN	-	10	-
Calcium Level	-	9.6	-
Chloride	-	105	-
Carbon Dioxide	-	24	-
Creatinine	-	0.66	-
Potassium Level	-	3.6	-
Protein	-	6.9	-
Sodium Level	-	138	-
ALT	-	11	-
ED Information Given By	-	-	Family member
Affect/Behavior	-	-	Calm
Mode of Arrival	-	-	Ambulance/BLS
Temperature	-	-	36.7
Temperature Route	-	-	Oral
Heart Rate	-	-	92
Oxygen Saturation	-	-	99

Measurements

Recorded By	FILBERT,PATRICIA		
Recorded Date	10/07/2009		
Recorded Time	16:31		
Procedure		**Units**	**Reference Range**
Weight.	45.00	kg	
Vital Signs Assessed	Yes		

Vital Signs

Recorded By	***FILBERT,PATRICIA***
Recorded Date	***10/07/2009***
Recorded Time	***16:31***

Procedure		***Units***	***Reference Range***
Systolic Blood Pressure	103	mmHg	[100-140]
Diastolic Blood Pressure	69	mmHg	
Respiratory Rate	18	BR/min	[16-28]
Temperature	36.7	degC	[36.0-39.0]
Temperature Route	Oral		
Heart Rate	92	bpm	[70-105]

Respiratory

Respiratory Assessment

Recorded By	FILBERT,PATRICIA
Recorded Date	10/07/2009
Recorded Time	16:31
Procedure	
Oxygen Therapy	Room Air

Neurological

Neurological Assessment

Recorded By	FILBERT,PATRICIA
Recorded Date	10/07/2009
Recorded Time	16:31
Procedure	
Level of Consciousness	Alert
Affect/Behavior	Calm

General Info

Miscellaneous Information

Recorded By	FILBERT,PATRICIA
Recorded Date	10/07/2009
Recorded Time	16:31
Procedure	
ED Information Given By	Family member

Other Facility Records

* Auth (Verified) *

KALEIDA HEALTH

MR- 1001428581 PT- 68927647
DOB 14Y SEX- F
ATT- TENNEY EMILY F
PCP-
FC- EMR E ADM DT- 10/07/09

Chart Scanning

OTHER FACILITY RECORDS

* Auth (Verified) *

MOUNT ST. MARY'S HOSPITAL LABORATORY OF NIAGARA FALLS
5300 Military Road, Lewiston, NY 14092 Phone: (716)298-2200

Room: MERT -
Acct#: M000020937033 MRN:
Attending: BROWN, LLOYD
Req. physician: BROWN, LLOYD

Patient:
DOB:
Order #: D0073107

TEST-NAME	RESULT	ABN	REFERENCE RANGE	UNITS	TEST LOC
Collected 10/07/09 11:50 by SH Received 10/07/09 13:22 by JR558 Reported 10/07/09 13:2					
Pregnancy Test, Urine	Negative		NEGATIVE		m
Tested by	sh				m

Testing location key (TST LOC):
m = Mount St. Mary's Hospital q = Quest Smithtown Laboratories r = Referred Laboratory
Printed: 10/07/2009 13:33 FINAL autoreporting slab

PAGE: 1 of 1

* Auth (Verified) *

MOUNT ST. MARY'S
HOSPITAL AND HEALTH CENTER

MR- 385429 .5937333
PCP- SUMMIT PEDS

MEDICATION RECONCILIATION
DOCTOR'S ORDERS

ALL ORDERS MUST BE DATED AND SIGNED BY THE DOCTOR

Allergies: Penicillins & Related DOS 10/07/09
Benadryl - Sleeps heavily Quinolones - rash - Ibuprofen

List below all of the patient's medications including OTC (Over the Counter), vitamins, and herbal meds. New medications or medication changes should be written on admission orders.

What Pharmacy do you use to get your prescriptions? _____

Source of Medication list (check all used):

☐ Patient medication list ☐ Patient/Family recall ☐ Pharmacy _____
☐ Primary care physician list ☐ Previous discharge paperwork ☐ MAR from facility ☑ no medications at home
☐ Unable to obtain Medical History: Reason _____

MEDICATION HISTORY RECORDED: (Nurse's Signature) _____
VERIFIED: (Nurse's Signature) _____ DATE RECORDED: 10/7/09

Medication Name (Write Legibly)	Dose	Route	Frequency	Last Dose Date/ Time	Physician Medication Orders on Admission (Check Only One)			Verbal Read Back	Medications Reconciled Upon Discharge			Verbal Read Back
					Same Order	Change (Use Order Sheet)	Do Not Order		Same Order	Change (Use Order Sheet)	Do Not Order	
1. Took no medication (OTC) today				10/7/09	☐	☐	☐		☐	☐	☐	
2.					☐	☐	☐		☐	☐	☐	
3.					☐	☐	☐		☐	☐	☐	
4.					☐	☐	☐		☐	☐	☐	
5.					☐	☐	☐		☐	☐	☐	
6.					☐	☐	☐		☐	☐	☐	
7.					☐	☐	☐		☐	☐	☐	
8.					☐	☐	☐		☐	☐	☐	
9.					☐	☐	☐		☐	☐	☐	

Admission Physician's Signature: _____
Date: ____/____/____ Time: _____ ☐ a.m. ☐ p.m.

☐ OVER

EMSTAR/OUT-PATIENT USE ONLY: NEW MEDICATIONS/PREVIOUS HOME MEDICATIONS WITH CHANGES

Medication Name	Dose	Route	Frequency	Duration

Discharge Reconciliation Signature

Discharge Physician's Signature: _____
Date: ____/____/____ ***Time:*** ____ ☐ ***a.m.*** ☐ ***p.m.*** ☐ ***Copy to Patient*** ***RN Initials*** _____

8100-03w-062005PCS (01-9030) (Revised 1-8-08)

* Auth (Verified) *

MR- 335929 20937033
PCP- SUMMIT PEDS
REG- BROWN, LLOYD D
F 14
EMR ER
DOS 10/07/09

MOUNT ST. MARY'S

PATIENT TRANSFER FORM

(This form must be completed for any patient leaving the Hospital for another facility)

Patient Name:

Next of Kin Notified: ☑ Yes ☐ No
Name
Phone

Physician
☐ Male ☑ Female
Age 14 D.O.B.

MR#
Date of Transfer 10/7/09
Time: 1500 am/pm
Expected to Return
☐ Yes ☑ No

Medical Screening Examination Completed
☑ Determined to have emergency medical condition
☐ Determined not to have emergency medical condition

Reason for Transfer
☐ Patient/Family Request
☑ Higher Level of Care Required
☐ Required service not provided
☐ Other

Transferred to care of Dr. Tepper M.D. at WCHOB Hospital
(Accepting Physician) (Address)
Report Given to Tepper MD by Dr. MD. Report Given to RN by M. Mountain RN
Means of Transport: ☐ Ambulance/ALS ☐ Ambulance/BLS ☐ Helicopter/Agency Rural Metro
Orders: BLS Patient IV: (Include IV med and rate)
Special Equipment: none Accompanied By
Condition of Patient: Stable Vital Signs (TPR and BP)
Patient's Working Diagnosis: Sexual Assault Allergies:

Brief History and Treatment Rendered (Include Medications Given)
Sexual assault this AM labs drawn tubes sent
Urine HCG ⊖

Documentation Included:
☐ Face Sheet ☐ History and Physical ☐ Consults
☑ All Diagnostics (Lab/ECG/X-Ray Report/Films) ☑ MD Progress Notes ☑ ED Record/Nurse Assessment ☑ Other (Specify) blood tubes
☑ Completed Transfer Form ☐ Current List of Medications ☑ Personal Effects Sent ☐ Advanced Directives

MEDICAL RISKS AND BENEFITS

I hereby certify that based upon the information available to me at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical care at another medical facility outweighs the increased risk to the individual, and in the case of labor, to the unborn child, from effecting the transfer. THIS CERTIFICATION IS BASED ON THE FOLLOWING:

Medical Benefits: [illegible]

Medical Risks: [illegible]

All transfers have the risks of traffic delays, accidents during transport, inclement weather, rough terrain or turbulence and the limitations of equipment and personnel present in the vehicle.

Physician's Signature [signature], MD at 1415 am/pm

☑ **CONSENT TO TRANSFER**

I hereby consent to transfer to another medical facility. I understand that it is the opinion of the physician responsible for my car that the transfer outweighs the risks of transfer. I have been informed of the risks and benefits upon which this transfer is being made. I have considered these risks and benefits and consent to the transfer. I authorize the release of information pertaining to my treatment at Mount St. Mary's Hospital.

☐ **PATIENT REQUEST TRANSFER**

After considering the risks and benefits given to me, I hereby request upon my own suggestion and not that of the Hospital, Physicians, or other person associated with the Hospital, that the patient be transferred to the above Hospital. I authorize the release of information pertaining to my treatment at Mount St. Mary's Hospital.

Signature of Patient or Responsible Person [signature] Date & Time 10/7/09 1415 am/pm
Witness M. Mountain Edwards RN
Form Completed by M. Mountain Edwards Nursing Supervisor Signature [signature]
Signature of person transporting these documents with patient [signature] Date 10/7/09
Follow-Up Telephone Call if Applicable:

Copies: WHITE-Patient Record YELLOW-Transferred with Patient PINK-Ambulance GOLD-Quality Management
FAX TOP PAGE SHOWING ADDRESSOGRAPH TO FISCAL SERVICES (2112) AND EMERGENCY SERVICES (2331) UPON PATIENT TRANSFER

MOUNT ST. MARY'S
HOSPITAL AND HEALTH CENTER
Patient Care Services

Nurse's Notes

MR- 385424 23937033
PCP- SUMMIT PEDS
REG- BROWN, LLOYD W
F 14
EMR ER
10/07/09

Date & Time	Notes
10/7/09 1335	but calm. Sees Mother [illegible] [illegible] for recounting of story of assault. NFPD Officer Det. [illegible] in to see pt. Child has never been sexually active nor had a pelvic exam in past. Has poor understanding of sex or sexually related issues
1330	discussed c̄ mother need for transfer to WCHOB for pediatric sexual assault exam. Mother agrees. Also discussed c̄ Dr. L. Brown who also agrees. ——— MC
1400	Pt resting in bed. listening to I POD. Appears calm. requesting food + drink - explained why she cannot at present until exam is done - pt was undressed prior to my arrival. - All clothing bagged in paper bags and signed across tape and given to Ambulance EMT - Barber, Emily ——— MC who signed bags also to maintain chain of custody. Report given to WCHOB ——— MC
1515	Ambulance here for transport. mother + Child reassured on confidentiality. No Δ in Childs condition ——— M. Mountain-Edwards RN

8100-33-082005PCS (018039) ☐ Check if notes written on the reverse side. Page 1 of 2

* Auth (Verified) *

MOUNT ST. MARY'S HOSPITAL - EMERGENCY ROOM FACE SHEET
5300 MILITARY ROAD, LEWISTON NY 14092

PT NAME:
ADDRESS:
CITY: STATE: NY
PHONE:
SEX: F RACE: 1 MARITAL ST: S
SSN:
MAIDEN NAME:
ISOLATION INDICATOR NONE
DOB: AGE: 14
BIRTHPLACE: NIAGARA FALLS
FACILITY DIRECTORY: Y

PT NO: 20937033 MR NO: 385429
PT TYPE: E EMERGENCY ROOM
ADMIT DATE: 10/07/09 11:22
TRIAGE TIME: 1122 RELIG: OTH
CHURCH: NONE
ADV DIRECTIVE? N TYPE
PREVIOUS TETANUS DT:
BROUGHT IN BY: 19
NOTIFIED POLICE: Y TIME:
POLICE SIGNATURE:

PRIMARY EMERGENCY CONTACT

NAME:
ADDRESS:
CITY/ STATE:
ZIP :
HOME PHONE:
WORK PHONE: EXT
RELATION: M MOTHER

SECONDARY CONTACT INFORMATION

NAME:
ADDRESS:
CITY/ STATE:
ZIP:
HOME PHONE:
WORK PHONE: - - EXT
RELATION: T GRANDPARENT

INSURANCE INFORMATION

PLAN 1: CRIME VICTIMS
CERT NO:
PRE/POL#: 083849375 Tommy
GROUP NO: 999
PRIORITY: 1

PLAN 2:
CERT NO:
PRE/POL#:
GROUP NO:
PRIORITY:

CLINICAL INFORMATION

PROVISIONAL DIAG: POSSIBLE RAPE
ACCIDENT DATE/TIME: 10/07/09 07:25
ACCIDENT INDICATOR: C
ACCIDENT LOCATION BEHIND SCHOOL WEIGHT ROOM

ATTN PHYS: BROWN, LLOYD W
PCP PHYS: CLARK,FALLS JENNIFER

PHYSICIAN/CONSULTANT NOTIFICATION: DR. Tommy CHOB

DIFFERENTIAL DIAGNOSIS/MEDICAL DECISION MAKING

PRIMARY DIAGNOSIS OR IMPRESSION: Possible Rape

SECONDARY DIAGNOSIS:

PROCEDURES BY PHYSICIAN PA/NP

CRITICAL CARE TIME: ____ MINUTES
DISPOSTION TIME: 2:40 pm

DISPOSTION: ___ DISCHARGE ___ NO CHANGE SATISFACTORY ___ IMPROVED
___ ADMIT ✓ TRANSFER CHOB DOA ___ DIED IN ED
___ LEFT BEFORE EXAM ___ LEFT BEFORE COMPLETED SERVICE ___ REFUSED ADMMISSION

PA/NP SIGNATURE PRINT OR STAMP NAME PHYSICIAN SIGNATURE Brown MD. PRINT OR STAMP NAME

* Auth (Verified) *

MOUNT ST. MARY'S
HOSPITAL AND HEALTH CENTER

EMSTAR
PATIENT CONSENT FORM

MEDICAL EVIDENCE REPORT FOR VICTIMS OF SEXUAL ASSAULT

MR- 285429 20937033
PCP- SUMMIT PEDS
REG- BROWN, LLOYD W
F 14
EMR ER
DOS 10/07/09
Addressograph

Name	Patient ER # 20937033
Address:	Date Arrived: 10/7/09 Time Arrived: 1150 a.m. ____ p.m.
	Brought By:
Birthdate:	Referred By: Self
Telephone No.:	Mode of Transportation: private Car

PATIENT CONSENT/REFUSAL

I understand that if I consent, an examination for evidence of sexual assault and collection of possible evidence will be conducted. I understand that I may refuse to consent, or I may withdraw consent at any time for any portion of the examination. I understand that the collection of evidence may include photographing injuries, which may include injuries to the genital area.

I consent to:

Physical Examination:	☐ Yes	☐ No
Photographing of Injuries:	☐ Yes	☐ No
Collection of Evidence:	☐ Yes	☐ No

I understand that if I consent, such evidence will be released to the police at this time. If I do not consent to release of evidence at this time, such evidence will be preserved at the Hospital for not less than 30 days and I may consent to its release or destruction at any time during this 30 day period.

Release of Evidence to Police: ☐ Yes ☐ No

X _____
Signature of Witness

/ /
Date

Time

X _____
Signature of Patient

Patient's Agent or Representative

Relationship to Patient

7450-192-072008PC

* Auth (Verified) *

MR# 355429 10937033

PCP- SUMMIT PEDS

Patient Name: BROWN, LLOYD W

MR #: F 11

EMR ER

DOS 10/07/09

MOUNT ST. MARY'S HOSPITAL AND HEALTH CENTER
EMSTAR

MEDICAL EVIDENCE REPORT FOR VICTIMS OF SEXUAL ASSAULT

Date of Assault: 10/7/09	Time: [illegible] a.m. p.m.
Date of Examination: 10/7/09	Time: 12:40 a.m. p.m.
Name of Examining Physician(s):	

PHYSICIAN / SAFE NURSE
SECTION A - STATEMENT OF CHIEF COMPLAINT

1. Identity of the assailant and specific details of assault is not necessary. Document only information for this Medical assessment.

Pt states was in a stairwell at school + this boy bent her over a railing, pulled down her pants + had "rectal penetration" but pt states it was not painful. Then boy pushed her down to floor + had Vaginal penetration. Pt denies any pain or injuries from assault.

NOTE: R.N. may complete " * " questions; initial your comment and sign page 5.

*2. Pre-pubertal: Yes ☐ No ☐ If yes, proceed to A-9
*3. Gravida: ++ Parity: ++ Menarche: 9/2/09 LMP 9/2/09 Normal Yes ☐ No ☒ 2 day period
*4. Vaginal tampon used? Yes ☐ No ☒ Age began:
*5. Any symptoms of pregnancy? Yes ☐ No ☒ If yes, describe
*6. Is patient currently using a contraceptive device? Yes ☐ No ☒
Method used:
*7. Has patient had a venereal disease (past or present)? Yes ☐ No ☒
Describe therapy:
*8. Is patient on any medication now? Yes ☒ No ☐ Epi pen PRN
*9. Has patient received vaccination for Hepatitis B? Yes ☒ No ☐
Completed series? Yes ☒ No ☐

7450-792-072006PC

* Auth (Verified) *

MA- [illegible] 0937033
PCP- SUBMIT PCPS
REG- BROWN, CLOYD H
F 1A
EMR ER
005 10/07/09
Addressograph

MOUNT ST. MARY'S HOSPITAL AND HEALTH CENTER
EMSTAR

MEDICAL EVIDENCE REPORT
FOR VICTIMS OF SEXUAL ASSAULT

SECTION B - EVIDENTIAL INFORMATION (FEMALE)

*1. Most recent coitus prior to incident:
Date: _____ 20 None Time: _____ ☐ a.m. ☐ p.m.

*2. According to Patient:

Did penis penetrate vulva?	☒ Yes	☐ No	☐ Don't Know
Did penis penetrate anus?	☒ Yes	☐ No	☐ Don't Know
Was there oral sex to victim?	☐ Yes	☒ No	☐ Don't Know
Was there oral sex by victim?	☒ Yes	☐ No	☐ Don't Know
Did assailant wear a condom?	☐ Yes	☐ No	☒ Don't Know
Was a foreign object used?	☐ Yes	☒ No	☐ Don't Know

Describe: _____

*3. Since the incident, has the patient:

Changed clothes	☐ Yes	☒ No
Douched	☐ Yes	☒ No
Bathed	☐ Yes	☒ No
Defecated	☐ Yes	☒ No
Urinated	☒ Yes	☐ No

Complains pain in left wrist

*4. Clothing:

Neat	☐ Yes	☐ No	Foreign Matter	☐ Yes	☐ No
Disheveled	☐ Yes	☐ No	Blood	☐ Yes	☐ No
Torn	☐ Yes	☐ No	Hair	☐ Yes	☐ No
Soiled	☐ Yes	☐ No	Stains	☐ Yes	☐ No

SECTION C - PHYSICIAN EXAMINATION

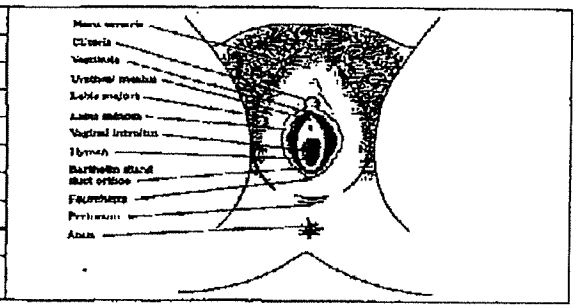
1. Pulse 95 B.P. 111/72 Temp 98 Resp. 18
2. Emotional State: (Give general description at time of examination (e.g. calm, depressed, angry, crying):
Apprehensive but calm
3. Body (Check appropriate boxes):

	Head	Face	Neck	Chest	Abdomen	Back	Buttocks	Arms	Legs
Trauma									
Bruise									
Laceration									
Fracture									
Sprain									

If any of the above boxes are checked, please describe the injury below

4. Pelvic Examination (describe findings):

Vulva
Vagina
Cervix
Perineum
Unable to complete, Why?



5. Rectal Exam: _____

7450-192-072005PC

* Auth (Verified) *

MR- 20C4D4 20037033
PCP- SUMMIT PEDS
REG- BROWN, LLOYD W
Patient Name:
MR #:
EMR CR
DOS 10/07/09

MOUNT ST. MARY'S HOSPITAL AND HEALTH CENTER
EMSTAR

MEDICAL EVIDENCE REPORT FOR VICTIMS OF SEXUAL ASSAULT

SECTION B - EVIDENTIAL INFORMATION (MALE)

*1 According to Patient:

Did penis penetrate anus?	☐ Yes	☐ No	☐ Don't Know
Was there oral sex to victim?	☐ Yes	☐ No	☐ Don't Know
Was there oral sex by victim?	☐ Yes	☐ No	☐ Don't Know
Did assailant wear a condom?	☐ Yes	☐ No	☐ Don't Know
Was a foreign object used?	☐ Yes	☐ No	☐ Don't Know

Describe: _____

*2. Since the incident, has the patient:

Changed clothes	☐ Yes	☐ No
Bathed	☐ Yes	☐ No
Defecated	☐ Yes	☐ No
Urinated	☐ Yes	☐ No

*3. Clothing:

Neat	☐ Yes	☐ No	Foreign Matter	☐ Yes	☐ No
Disheveled	☐ Yes	☐ No	Blood	☐ Yes	☐ No
Torn	☐ Yes	☐ No	Hair	☐ Yes	☐ No
Soiled	☐ Yes	☐ No	Stains	☐ Yes	☐ No

SECTION C - PHYSICIAN EXAMINATION

1. Pulse _____ B.P. _____ Temp _____ Resp. _____
2. Emotional State: (Give general description at time of examination (e.g. calm, depressed, angry, crying):

_____

3. Body (Check appropriate boxes):

	Head	Face	Neck	Chest	Abdomen	Back	Buttocks	Arms	Legs
Trauma									
Bruise									
Laceration									
Fracture									
Sprain									

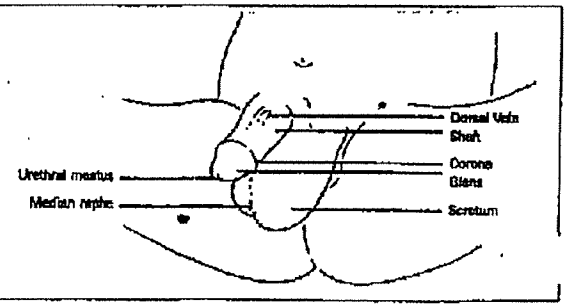
If any of the above boxes are checked, please describe the injury below

4. Pelvic Examination (describe findings):

Penis

Scrotum

Unable to complete, Why?



5. Rectal Exam: _____

7450-192-072006PC

* Auth (Verified) *

MOUNT ST. MARY'S HOSPITAL AND HEALTH CENTER
EMSTAR

MEDICAL EVIDENCE REPORT
FOR VICTIMS OF SEXUAL ASSAULT

MR- [illegible] 0937033
POP- SUPRIT PODS
REG- BROWN, LLOYD L
F 14
EMR ER
Addressograph
DOS 10/07/09

SECTION D- LAB TESTING (HOSPITAL CONDUCTED)

1. Pregnancy Test ☐ N/A ☐		Results
2. Blood for:		
a. Hepatitis B Surface Antigens, Hepatitis B Surface Antibodies, Hepatitis C Antibodies ☐		
b. HIV ☐ (requires patient counseling and consent)		

SECTION E - FORENSIC LAB TESTING (HOSPITAL COLLECTED)

(Use Police Evidence Collection Kit)

		Yes	No	Collectors Initials
1. * Oral swabs and smears				
2. * Buccal specimen				
3. * Trace evidence				
4. * Clothing and underwear (list below)				
5. * Debris collection				
6. * Dried secretions and/or bite marks				
7. * Fingernail scrapings	Right Left			
8. * Pulled head hairs				
9. Pubic hair combings				
10. Pulled pubic hairs				
11. Anal swabs and smears				
12. Vaginal/penile swabs and smears				
13. * DFSA Kit				
Other (Describe):				

*** May be collected by RN**

Clothing Retained ☐Yes ☐No

Damp stains should be air-dried. Care should be taken so that stained areas are not damaged. The suspected stained material or areas should be **PACKAGED SEPARATELY** to avoid contamination.

SPECIFY ARTICLES COLLECTED:

The above specimens and articles were collected, secured and:

☐ Released to Law Enforcement Agency
(Complete "**An Authorization for Release of Information and Evidence Form**")

☐ Stored in a locked refrigerator in the Emergency Department
Lock #_____ Date _____ Time _____ ☐ a.m. ☐ p.m.

Signature_____
(Person Securing Evidence)

7450-192-072008PC

* Auth (Verified) *

MR- 385429 10937033

PCP- SUMMIT PEDS

Patient Name: LLOYD W

MR #:

EMR ER

DOS 10/07/09

MOUNT ST. MARY'S HOSPITAL AND HEALTH CENTER

EMSTAR

MEDICAL EVIDENCE REPORT FOR VICTIMS OF SEXUAL ASSAULT

SECTION F - TREATMENT RECORD

SECTION F - FOLLOW-UP ASSESSMENT AND PLAN

	Yes	No
Patient Information Form		
Referral to Patient Resource Management Department		
Referral to Rape Crisis Services		
"Emergency Contraception for Rape Survivors" Brochure NYS DOH		
Victims of Crime Brochure		
Referral to Private Physician/OB/GYN		
Referral to Child Advocacy Center		
HIV Post Exposure Prophylaxis Sheet		

This record contains medical/evidentiary information as given to me by the above named patient and is an accurate account of the medical findings based on an examination of said patient.

_____ M.D./D.O. _____ _____ ☐a.m. ☐p.m.
Examiner's Signature Date Time

_____ R.N. _____ _____ ☐a.m. ☐p.m.
Examiner's Signature Date Time

7450-192-072006PC

MOUNT ST. MARY'S
EmStar
Physician's Record

KA- 385424 -937033
PCP- SUMMIT PLUS
REG- BROWN, LLOYD K
EMR ER F 14
DOS 10/07/09

P.E. ☒ Vital signs reviewed and norm. except for: ______ Pulse Ox: ___ on ___ norm. not hypoxemic

General: well developed, well nourished, NAD

Head/Face: atraumatic; battle sign

Eyes: EOMI PERRL conjuntiva: injected pink pale yellow sclera nystagmus

ENT: mucosa: moist dry lesions:

Pharynx: enlarged tonsils erythematous exudate TMs: hemotympanum red bulging perforated discharge

Neck: supple not tender; JVD Thyroid: not palp enlarged

Chest/Breasts: tender

Resp. Norm. effort Breath sounds: clear decreased wheezes rales rub

Heart: regular; irregular gallop murmur rub Edema/varicosities:

Pulses: Radial: = bilat Carotid: no bruits Aorta: not palpable Fem: = bilat Pedal: = bilat

GI: soft, not tender, distended rebound guarding mass B.S.:

Rectal: mass tender Stool: brown black bloody none Heme: - + Pos control + - Neg control - +

GU: CVA tenderness N/A

Pelvic:

Lymph Nodes: Occipital: enlarged tender Cervical: enlarged tender Axillary: enlarged tender Groin: enlarged tender

Neuro: Norm. strength Norm. sensation Norm. coordination CNs II-XII intact pronator drift kernig DTR's:

no focal deficit

GCS:

MS: swelling tender

Skin: warm dry diaphoretic pale rash yellow

Lac Length:

Psych: alert appropriate oriented norm. speech anxious hallucinations suicide ideation norm / flat / depressed affect

Additional Information, Procedures, Reassessment, Transfer of care, Test interpretation by Physician:

Reason for delay in Thrombolytics:

=> Same neuro exam.
After discussion with
[illegible] decision
was made to transfer
to [illegible] for further
evaluation.

WBC	Glu
seg	Na
band	K
Hgb	Cl
Plt	CO_2
INR	BUN
Hct	Creat
UA	Ca
	Trop
	CKMB

Size/ # Sutures / Staples:

EKG Interpretation: ☐ Old EKG from ___ reviewed ☐ No significant change

X-Ray interpretation:

☐ Imaging studies interpreted by Radiologist

[signature] MD

PA/NP/physician signature

2nd physician signature

745C-07-032007PCS (01-26728)

MR- 3F5424 .5937033
PCP- SUMMIT PEDS
REG- BROWN, LLOYD R
F 14
EMR ER
DOS 10/07/09

MOUNT ST. MARY'S

EmStar
Physician's Record

Date: 10/7/09 **Time Seen:** ______ ☐ a.m. ☐ p.m.

Condition on Admission: ☐ Good ☑ Fair ☐ Poor ☐ DOA

Hx Obtained From: ☑ Patient ☐ Family ☑ EMS ☐ Transfer notes ☐ Nurse's Notes ☐ Other: ______

CC: alleged rape   Started: ______

HPI: 14 y/o Af Am female ☑ Nurse's Notes Reviewed

Location: brought in for evaluation

Quality: of possible rape @ school today

Severity: pt. explained that an adult

Duration: pushed her over the railing

Context (e.g. recent trauma): of stairs pulled her pants

down and penetrated her rectally

Associated Symptoms: ☐ See ROS: with his penis for a few

Modifying Factors: ☐ None seconds. She pulled away

but was pulled down to the ground

where he penetrated her vaginally

☐ Hx & ROS limited due to patient condition: ☐ poor historian ☐ demented ☐ illness ☐ injury ☐ pain ☐ other: with his penis per pt seen

ROS: ☑ All systems negative unless noted below (Circle) or ☑=positive "/"slash=negative

Constitutional: ~~fever~~ ~~chills~~ ~~weak~~ ______

GU: ~~dysuria~~ ~~hematuria~~ ~~frequency~~ urgency pregnant incontinent
vaginal bleeding/discharge LMP: ______

Eyes: ~~blurred~~ ~~pain~~ ~~photophobia~~ ______

Neuro: ~~syncope~~ ~~headache~~ ~~dizzy~~ stiff neck focal numbness / weakness

ENT: ~~sore throat~~ ~~earache~~ ______

MS: ~~swelling~~ ~~pain~~ ~~neck pain~~ ______

CV: ~~Chest pain~~ ~~palpitations~~ PND orthopnea ______

Skin: ~~itching~~ ~~rash~~ ~~sweaty~~ ______

Resp: ~~SOB~~ ~~cough~~ ~~bloody phlegm~~ wheezing ______

Endo: polyuria polydipsia heat/cold intolerance ______

Immune: hives throat swelling ______ Last tet: ______

GI: ~~pain~~ ~~nausea~~ ~~vomiting~~ ~~hematemesis~~ melena hematochezia
loose stool constipated incontinent ______

Heme/Lymph: easy bruising/bleeding adenopathy ______

Psych: anxious depressed stressed voices ______

PMH: ☑ None; anemia anxiety / depression arthritis asthma/COPD A-fib CHF CVA/TIA dementia DM - type 1 2 Htn hypothyroid MI seizures

Past Surgical Hx: ☑ None, appendectomy cholecystectomy hernia repair hysterectomy angioplasty CABG stent G: ______ P: ______

Cancer: ______

Old records from: ______ reviewed

Allergies: ☐ NKDA; PCN sulfa ASA codeine iodine seafood/shellfish IV dye Benadryl

Social HX: Smokes 0 packs/day Quit ___ years ago

ETOH: ☑ denies;

Addiction Hx: ☑ denies;

Drugs: ☑ denies, cocaine ______

Medications: ☐ none
see nurses note

☐ Lives alone parents

Recent travel: ☐ none ______

OTC Meds/Herbs: ☐ denies daily ASA vits ______

Family Hx: (parents/siblings/grandparents/children): ☑ no significant; cardiac stroke psych ______

* Auth (Verified) *

MOUNT ST. MARY'S HOSPITAL AND HEALTH CENTER

EmStar

Order Sheet

MR- 3[illegible] .3937033
PCP- SUMMIT PEDS
REG- BROWN, LLOYD W
[illegible] 14
EMR ER
DOS 10/07/09

Addressograph

Date/Time of Initial Orders: _____

All ordered at this time unless otherwise noted below

Entered/Done Time	Initial	Results Interpreted by Physician INITIAL ORDERS
		Allergies: ☐ NKDA
		☐ Saline Trap ☐ IV:
		☐ Albuterol/Ipratropium aerosol ☐ pre & post peak-flow
		☐ Td 0.5ml IM
		☐ May suspend cardiac monitor for imaging
		Reason for Imaging:

MD/PA Time	Entered/Done Time	Initial	SUBSEQUENT ORDERS
			☐ Home Care ☐ Social Services

Entered/Done Time	Initial	Initial Orders
		Abdominal Panel
		Altered LOC Panel
		Sepsis Panel
		Major Bleeding Panel
		Trauma Panel
		Cardiac POC
		Cardiac - BNP - POC
		CBC Diff
		BMP
		Hepatic
		PT/INR PTT
		Amylase/Lipase
		UA cath culture
		Urine Pregnancy POC
		HCG quantitative
		GC/Chlamydia & VDRL/RPR
		Culture: blood sputum
		Digoxin Phenytoin
		CKMB/Trop
		EKG
		Glucose stat
		Type & Screen
		Cross: Units
		CXR PA & Lat port
		Abd & 1 view chest
		Spine: cervical lumbar
		CT: head abd pelvis
		Sono: abd pelvis vag
		Cardiac monitor
		Pulse Ox on RA or on:
		O_2

Page 1 of 1

PA/NP/Physician Signature

Initial	Signature

7450-04-082006 (01-26723)