JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

4420/2391 FILE [redacted] 646-957-2486 (FATHER) P1

LOCATION: SCAN EMP. INITIAL

EMERGENCY MEDICINE RECORD

DATE AND TIME OF ARRIVAL 10/31/2009 23:03

MEDICAL RECORD NO. 1298984 | PATIENT TYPE E | PATIENT ACCOUNT NO. 130381015

PATIENT'S NAME		SOCIAL SECURITY NO.	DATE OF BIRTH	AGE
SCHOOLCRAFT	ADRIAN		[redacted]/1975	34Y

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.	PLACE OF BIRTH
82-60 88 PL			11385	718 570 6224	

FIN CL.	SEX	RACE	RELIGION	MARITAL STATUS	FATHER'S NAME	MOTHER'S MAIDEN NAME, FIRST NAME
01	M	W	N	S		

PRIVATE M.D. NAME OR CLINIC NAME	PATIENT COMPLAINT	LANGUAGE	INTERP. REQ.
		ENG	N

MODE OF ARRIVAL	ACCOMPANIED BY	RELATIONSHIP	TELEPHONE NO.	INJURED AT WORK?	AUTO ACCIDENT?

DATE AND TIME OF ACCIDENT	POLICE OFFICER NAME & BADGE NO.	PCT. NO.	REFERRED FROM: ☐ PMD ☐ TRUMP ☐ CLINIC ☐ FP ☐ OTHER

NEXT OF KIN	TELEPHONE NO.	NEXT OF KIN ADDRESS	RELATIONSHIP TO PATIENT

GUARANTOR'S NAME	STREET ADDRESS	CITY	STATE	ZIP CODE
WORK				

GUARANTOR'S SOC. SEC. NO.	TELEPHONE NO.	GUARANTOR'S EMPLOYER	ADDRESS	TELEPHONE NO.

PATIENT'S EMPLOYER NAME	STREET ADDRESS	CITY	STATE	ZIP CODE

	NAME	GROUP NO.	POLICY NO.
INSURANCE #1:			
INSURANCE #2:			

HOSPITALIZED PAST 60 DAYS?	IF YES, WHERE AND WHEN?	PLACE OF ACCIDENT	CRIME VICTIM PCT. NO.	CRIME VICTIM COMPLAINT NO.

11/1 [illegible] AIKER X-Ro 65 [illegible]

TIME	B.P.	PULSE	RESP	TEMP

☐ OXYGEN GIVEN

☐ EKG ____ INITIALS ☐ CARDIAC MONITOR ____ INITIALS ☐ IV ANGIO# ____ INITIALS FLUID ____ INITIALS METHOD ____ INITIAL

☐ ADVANCED DIRECTIVES DISCUSSED HEALTH CARE PROXY ☐ YES ☐ NO AGENT'S NAME:

RN SIGNATURE

DATE	TIME		MD SIGNATURE	RN SIGNATURE	TIME

DATE	TIME	MEDICATION	DOSE	ROUTE	MD SIGNATURE	RN SIGNATURE	TIME

ACCOUNTING DEPT COPY FORM NO. J00018

Agency Name: JAM [illegible]

ePCR

5581845

Agency ID	Branch #	Shift #	Today's Date	1st Resp. Agency	Call #
731		3	10/31/09		

Call Times (24hr) / Call Information

Time Call Received	Patient Contact Time
	2140
Dispatched	**Left Scene**
2106	2214
En Route	**At Destination**
2106	2225
On Scene	**In Service**
2115	

Miles (to nearest .1): Start; On Scene; At Destination 41.0

Crew Member ID: Driver To Scene / Hosp.; Documentation

1. 6577
2. 7621

Vehicle Unit #: 5DE3

Other Vehicle

Requested By: ☑ 911 ☐ Private; Requested By Code

Factors Affecting Delivery: To Scene / To Patient / To Hospital / At Hospital

Run Disposition

☑ Treated / Transported
☐ Treated / Transferred Care
☐ Treated / No Transport
☐ Transported / Refused Care
☐ Cancelled
☐ Pronounced Dead
☐ Treat/Transport Private Veh
☐ No Transport/Refused Care
☐ Other
☐ No Patient Found

Dispatch Reason: EMD Code; Type (1-99); Priority (A-G); Omega (1-9)

Run Type: ☑ Emergency (Immediate); ☐ Non-Emergency; ☐ Mutual Aid; ☐ Intercept; ☐ Stand-By; ☐ Intercept; ☐ Scheduled; Resource Code

Lights/Siren: ☑ To Scene; ☐ To Destination; Upgraded; Downgraded

Destination Determination: ☑ Nearest Facility; ☐ Weather / Supervisor; ☐ Law Enforcement; ☐ Hospital Diversion; ☐ Medical Protocol; ☐ Online Physician; ☐ Mass Casualty; ☐ Special Resources; ☐ Patient / Family Choice; ☐ Managed Care; ☐ Patient Physician; ☐ Other

Diverted From Code; Nearest Facility Passed; Est. Miles Beyond; Diverted Time

Transport From: ☑ Home / Residence; ☐ Residential, Custodial Facility; Scene of Accident or Acute Event: ☐ Educational Inst. ☐ Street/Hwy ☐ Farm ☐ Other ☐ Industrial Place ☐ Unspecified ☐ Mine / Quarry ☐ Public Building ☐ Recreation/Sport; ☐ Site of Transfer (Between Ambulances)

-- Or Use -- Transport From Code

Transport To Code: 34

# of Patients Transported: 1; # of Patients at Scene: 1

Patient Information

Incident Address: ☐ (Check the Box if same as Transport From Code): 82 60 88 PL; Apt. Number: 2

City: Glendale; County Code: 81; State: NY; Zip Code: 11385

First Name: Adrian; MI; Last Name: Schoolcraft

Street Address: ☐ (Check the Box if same as Incident Address): 82 60 88 PL; Apt. Number; County Code: 81; Age: 34 ☐ Days ☐ Months ☑ Years

City: Glendale; State/Prov.: NY; Zip Code: 11385; Gender: ☑ M ☐ F; Weight: 250 (lbs)

Home Phone; Social Security Number; Date of Birth: [redacted] 1975

Medicare #; Medicaid #

Ethnicity: ☐ Unknown ☐ Black, Hispanic ☐ Asian ☐ Native American ☐ Black ☐ Pacific Islander ☐ White ☐ White, Hispanic

Insurance Company Name; Payer ID

☐ Auto Ins. ☐ Private Ins. ☐ Supplemental ☐ Workers Comp. ☐ Self Pay

Policy Number; Group Number

Policy Holder First Name ☐; Policy Holder Last Name ☐; Same As Patient Address ☐; Phone

Guarantor First Name (Needed if under 18 or Disabled); Guarantor Last Name ☐; Same As Patient Address ☐; Phone

Initial Assessment

Airway: ☑ Patent; Partially Obstructed: ☐ Stridor ☐ Choking ☐ Drooling ☐ Grunting ☐ Difficulty Swallowing ☐ Nasal Flaring ☐ Intercostal Retraction ☐ Other; ☐ Completely Obstructed

Breathing: Rate: ☑ Normal ☐ Slow ☐ Rapid ☐ Apneic; Quality: ☑ Unlabored ☐ Labored ☐ Shallow ☐ Irregular

Lung Sounds (L / R): ☑ Clear ☑; ☐ Wet ☐; ☐ Wheeze ☐; ☐ Diminished ☐; ☐ Absent ☐

Circulation / Skin: Color: ☑ Normal ☐ Cyanotic ☐ Pale ☐ Flush; Temp.: ☑ Normal ☐ Hot ☐ Cool ☐ Cold; Cond.: ☑ Normal ☐ Diaphoretic ☐ Moist ☐ Dry; ☐ Hives ☐ Itchy ☐ Rash ☐ Swollen ☐ Erythema; Cap. Refill: ☐ <2Sec ☐ >2Sec ☐ Absent; Edema: ☑ Normal ☐ 1+ ☐ 2+ ☐ 3+ ☐ Pitting

Pupils (L / R): ☑ Reacts ☑; ☐ Sluggish ☐; ☐ Unreactive ☐; ☐ Dilated ☐; ☐ Constricted ☐

Rhythm: ☐ NSR ☐ S. Tach. ☐ S. Brady. ☐ PAC's ☐ SVT ☐ A. Flutter ☐ Atrial Fib. ☐ PVC's ☐ PVC's >6 ☐ Bi / Trigem ☐ AV Block ☐ Junctional ☐ V. Tach ☐ V. Fib ☐ P.E.A. ☐ Asystole ☐ Paced

Glasgow: 2145 2155

Eyes: ☑ 4 Spontaneous; 3 To Speech; 2 To Pain; 1 Not at all
Verbal: ☑ 5 Oriented; 4 Confused; 3 Inappr. Words; 2 Inappr. Sounds; 1 None
Motor: ☑ 6 Obeys Command; 5 Localized Pain; 4 Withdraws to Pain; 3 Flexes to Pain; 2 Extends to Pain; 1 None
Totals (3 to 15): 15

Provider Impression

☑ Abdominal Pain ☐ GI - Bleed ☐ GI - Constipation ☐ GI - Diarrhea ☐ Vomiting ☐ Vomiting Blood ☐ Nausea ☐ Dehydration Symp. ☐ Urinary Bleeding ☐ Urination Problem ☐ Anxiety ☐ Behavioral Disorder ☐ Depression (acute) ☑ Dizziness ☐ Weakness ☐ Psychiatric Emerg. ☐ Headache (no trauma) ☐ Migraine ☐ Alt. Level Conscious ☐ Seizure ☐ CVA/Stroke ☐ Unconscious ☐ Cardiac Symptoms ☐ Chest Pain ☐ Syncope / Fainting

☐ Cardiac Arrest ☐ Asthma Symptoms ☐ Hyperventilation ☐ Dyspnea-SOB ☐ Apnea ☐ Cough W/Blood ☐ Airway Obstruction ☐ Pulmonary Edema ☐ Pneumonia Symptoms ☐ Respiratory Failure ☐ Respiratory Arrest ☐ Newborn ☐ Ob / Gyn ☐ OB-GYN (complicated) ☐ Flu Symptoms ☐ Elevated Temp / Fever ☐ Sore Throat ☐ Nose Bleed (severe) ☐ Allergic Reaction ☐ Medication Reaction ☐ Diabetic Symptoms ☐ Back Pain (no trauma) ☐ Hyperthermia ☐ Hypothermia ☐ Poisoning

☐ General Illness Pain ☐ Obvious Death ☐ Hemorrhage (severe medical) ☐ Shock ☐ Trauma Injury (multiple) ☐ Post-Op Complication ☐ Eye Symp. (no trauma) ☐ Restraint Required ☐ Monitoring Required ☐ Seclusion Required; Special Handling: ☐ Isolation Required ☐ Orth. Device Required ☐ Positioning Required ☐ Unknown Medical ☐ No Medical Problem

(1) Other PI (2)

1° Protocol: 416

2° Protocol

Mechanism of Injury

☐ Alcohol Intox. Suspect ☐ Alcohol Intox Severe ☐ Animal Bite ☐ Assault Firearm ☐ Assault Sexual ☐ Assault Stabbing ☐ Bicycle Accident ☐ Blunt Trauma ☐ Burn/Scald-Non Fire ☐ Diving Injury ☐ Near Drowning ☐ Drug Overdose ☐ Elderly Abuse ☐ Electrocution ☐ Excessive Cold ☐ Excessive Heat

☐ Fall 20 ft Height ☐ Fall > 20 ft ☐ Fall ☐ Fight / Brawl ☐ Fire ☐ Hazardous Materials ☐ Machinery ☐ Med. Device Failure ☐ MVA / Bicycle ☐ MVA / Fixed Object ☐ MVA / MVA ☐ MVA Non-Traffic ☐ MVA to Pedestrian ☐ Smoke Inhalation ☐ Suicide ☐ NA ☐ Unknown

Injury Intent: ☐ Unintentional ☐ Unknown ☐ Unintentional ☐ Intentional Self; Other MOI: 5[illegible]

Injury

Body regions: Head, Face, Eye, Neck, Chest, Back, Shoulder, Upper Arm, Elbow / Forearm, Wrist, Hand, Fingers, Abdomen, Pelvis / Hip, Genitals, Upper Leg, Knee, Lower Leg, Ankle / Foot, Toes

Injury types: Amputation, Penetrating, Bleeding, Bruising, Burn, Dislocation, Fracture, Pain, Laceration, Paralysis / Numbness, Swelling, Soft Tissue Injury

Chief Complaint

SH6001 (1 of 2), Rev 10, 02/06

1 gm 4 mcg 7 mcg/min 10 LPM 13 mcg/kg/min
2 mg 5 unit 8 gtt/min 11 ml/hr 14 units/hr
3 meq 6 ml 9 mg/min 12 joules 15 inch

IV IM ETT RECtal
IO SQ NEB INHal
SL PO AUTo TRAnsdermal

5581845

VITALS

Time	Staff	Systolic B.P.	Diastolic	Pulse	Respirations	SpO2	CO2	Blood Sugar	Pain (0-10)	Temp
2145	1	160	120	120	20					
2155	2	160	110	118	20					

FLOW CHART

Treatment/Medication	Time	Staff	Treat. Code	Med. Code	Dose	Unit	Route	Attempt	Comment

Narrative History

Medical Necessity: ☒ Medically Necessary ☐ Bed Confined ☐ Required Stretcher ☐ Unconscious ☐ Severe Pain ☐ Needed Restraining ☐ Visible Bleeding ☐ Non-Ambulatory

Illness/Injury Onset Date: 10/31/09

PMH: ☐ Asthma ☐ Amputee ☐ Chronic Renal Failure ☐ Chronic Respiratory Failure ☐ Cancer ☐ Cardiac ☐ CVA / Stroke ☐ Diabetes ☐ Dialysis ☐ Emphysema ☐ HIV / AIDS ☐ Hypertension ☐ Psychiatric Problems ☐ Seizure Disorder ☐ Substance Abuse ☐ Tracheostomy ☐ Tuberculosis ☐ Other

Allergies: ☒ No

Medication: denies

34 y/o male found ambulatory alert and oriented, pt states he has abd pain, nausea and dizziness, pt states he took Nyquil this evening, pt denies taking any other meds upon obtaining vitals pt has ↑BP pt denies med hx, upon entry of ESU NYPD 30E3 and C513 pt was aggitated and resistant pt was [illegible] placed in custody and assisted onto stretcher for tx. Capt Broschart accom pt. pe reveals patent airway, neg SOB, neg cyanosis, lungs clear bilat, neg chest pain, abd soft x4 quads, pos nausea x1 day, neg vomiting, pos distal pulses motor sensory x4 ext, pt tried to kiss 3rd WAI. (Before pt was detained pt walked down w/ESU and NYPD, as pt approached bus he turned around stated he did not need help and walked away, pt was then detained and tx resumed. Pt is an officer w/ 81 PCT)

Moved to Ambulance By: ☒ Chair ☐ Stretcher ☐ Scoop Stretcher ☐ Carried ☐ Walked with Assist ☐ Met at Ambulance

Transport Position: ☐ Supine ☐ Sitting ☐ Shock ☐ Prone ☒ Semi / Full Fowlers ☐ Left Lateral Recumbent

Medication / Treatment Authorization: ☒ Protocol ☐ On-Line ☐ Written Orders ☐ NA ☐ On-Scene

On-Line Physician:
On-Line Med. Facility:

SUPPLY

Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code

Agency Definable: 1 2

Authorization for Billing / Release of Patient Information / Assumption of Financial Responsibility: I request that payment of authorized Medicare/Medicaid and/or other insurance benefits be made to the pre-hospital care provider ("Provider") for any services furnished to me. I authorize any holder of hospital or medical information about me to be released to the Provider, Centers for Medicare and Medicaid Services, and/or my insurance carriers and their agents, including any other information needed to determine these benefits or other benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand this authorization may be used by the Provider for all services furnished in the future until such time as I revoke this authorization in writing. I agree to assume full financial responsibility for payment of all charges not covered by my insurance carrier as well as any collection costs and/or attorney's fees as allowed by law. Patient: ☐ Unable to Sign ☐ Refused to Sign ☐ PCS Collected ☐ Other Insurance Collected

Authorization Signature: Date: Guarantor Signature:

Privacy Notice: I hereby acknowledge that I have been provided with a copy of the Provider's Notice of Privacy Practices explaining how my personal health information is used and understand my individual rights related to this information:

Privacy Notice Signature: Date:

Patient's Physician Name (please print):

Receiving RN/MD Signature: [signature]

Technician Signature: Jessica Marquez

I Refuse Treatment / Transportation and understand the consequences of my refusal:

Witness Signature for Refusal:

On-Line Medical Control Signature:

JAMAICA HOSPITAL MEDICAL CENTER

1/3

SCHOOLCRAFT, ADRIAN
1295984 M DOB: [redacted]/1975 34Y
081X STAFF, PHYSICIAN
ADM: 10/31/2009 130381015 01

CONSULTATION REPORT

THIS SECTION TO BE FULLY COMPLETED BY THE REQUESTING PHYSICIAN	
REQUEST TO: Dr. Patel / Dr. Lwin	DEPT/DIVISION: Psychiatry ER
REQUEST FROM: Dr. Nwaishienyi	DEPT/DIVISION: Medical ER
IMPRESSION: psychotic disorder, NOS	
REASON FOR CONSULTATION:	
☐CONSULTATION ONLY ☐CONSULTATION WITH ORDERS ☐CONSULTATION WITH FOLLOW-UP	
SIGNATURE:	DATE: 11/1/09 TIME: 6:30 am

OPINION OF CONSULTANT:

34 years old single white male, police officer, living by himself was brought in by NYPD of 81st Precinct, in hand cuffs to Medical ER with complaint of abdominal pain, nausea and dizziness and patient had stated he took Nyquil.

Psych consult was called and reported as patient acting bizzare, hand cuffed and in Police custody.

As per patient, he was not feeling well yesterday, had "tummy pain / Abdominal pain and told his supervisor that he is leaving. Patient says while sleeping in his bed, landlord open the door and his colleagues entered and hand cuffed and brought him to Jamaica hospital. He says he is worried about the situation going on. Says this is happening because he has been reporting to his superiors and commissioner about internal affairs of police department. Says he knows his ~~supervisors~~ K.L supervisors are hiding robbery and assault cases to get higher ranks / position. Says he has paper documentation about this crime and reporting since last year.

→ continue

Consultant Print Name: Signature: Date: Time:

ORIGINAL - MEDICAL RECORD CARBON COPY - CONSULTANT

FORM: 110 ITEM: 849 REV. 1/07

JAMAICA HOSPITAL MEDICAL CENTER 1/3

SCHOOLCRAFT, ADRIAN [redacted]/1975 34Y
1298984 M DOB: [redacted]/1975 34Y
ADM:10/31/2009 081X 130381015 01
STAFF, PHYSICIAN

CONSULTATION REPORT CONTINUATION

Denies past psy hospitalization(or) treatment (or) suicidal attempt.
As per Sergeant James of 81st Precint, patient complain of not feeling well yesterday afternoon and left his work early after getting agitated and nursing supervisor. They follow him home and he had barricaded himself and the door had to be broken to get to him. He initially agreed to go with them for evaluation but once outside, he ran and had to be chased and brought to the medical ER, handcuffed.
In the medical ER, he became agitated, uncooperative and verbally abusive over telephone use and told his treating MD that 'they are all against me'.
As per Sergeant James, he was evaluated by NYPD psychiatrist and can not carry a gun or a badge for nearly a year.
Denies any drug (or) Alcohol abuse
Denies any history of family mental illness
No acute medical problem, complained of abdominal pain yesterday and has rhinnitis.
Mental Status Examination - 34 years old, white male appropriately dressed and groomed, appears to his stated age. He is coherent, relevant with goal directed speech and good eye contact. He is irritable with appropriated affect. He denies hallucination. He is ? paranoid about his supervisors. He denies suicidal ideation, homicidal ideation or

Cont

Consultant Print Name: Signature: Date: Time:

ORIGINAL - MEDICAL RECORD **CARBON COPY - CONSULTANT**

FORM 112 FORM 1976 REV 1/07

JAMAICA HOSPITAL MEDICAL CENTER

3/3

SCHOOLCRAFT, ADRIAN
1298984 M DOB: [redacted]1975
ADM:10/31/2009 081X 34Y
STAFF, PHYSICIAN 130381015 01

CONSULTATION REPORT CONTINUATION

the present time. His memory and concentration is intact. He is alert and oriented. His insight and judgement are impaired.

Diagnosis

Axis I - psychotic disorder, NOS
II - deferred
III - s/p Abdominal pain, chronic sinusitis
IV - conflict at worksite
V - 40

Recommendation

1. continue 1:1 observation for unpredictable behaviour and escape risk
2. Transfer to psy ER after medical clearance
3. Discussed with Dr. Nwaishianyii and Sergeant James

Case discussed with Dr. Patel.

Khin Mar Lwin, MD
Psychiatric Resident

11/1/09 Concur c above Dr's recommendations.
6 Am

[signature]

Consultant Print Name: Signature: Date: Time:

ORIGINAL - MEDICAL RECORD **CARBON COPY - CONSULTANT**

FORM: 112 ITEM: 1875 REV. 1/07

JAMAICA HOSPITAL MEDICAL CENTER

SCHOOLCRAFT, ADRIAN
1288984 M DOB: [redacted]1975 34Y
ADM:10/31/2009 081X 130381015 01
STAFF, PHYSICIAN

PATIENT CLOTHING/VALUABLES INVENTORY

1. ALL PATIENTS CLOTHING/VALUABLES SENT HOME ☐ YES ☑ NO
2. DENTURES TAKEN HOME BY FAMILY MEMBER ☐ YES ☐ NO

	ADMISSION	TRANSFER	TRANSFER
DATE/TIME:	11-01-09		
ROOM		TO	

UNIT Urgent Care

INVENTORY OF ITEMS KEPT AT BEDSIDE

		QUANTITY	DESCRIPTION	QUANTITY	DESCRIPTION
DENTURES	UPPER DENTURE	1	LABELED CUP PROVIDED ☐		
	LOWER		LABELED CUP PROVIDED ☐		
	PARTIAL		LABELED CUP PROVIDED ☐		
CLOTHING/ OUTWEAR/ FOOTWEAR	COAT/JACKET				
	DRESS/HOUSECOAT				
	PAJAMAS/NIGHTGOWN				
	SLACKS/PANTS/JEANS				
	BLOUSE/T-SHIRT/SWEATER				
	SKIRT/SHORTS				
	UNDERWEAR/BRA				
	GLASSES/CONTACTS				
	HAT/SCARF/TIE/BELT				
	PANTYHOSE/SOCKS				
	BATHROBE				
	SHOES/SNEAKERS				
	BOOTS/SLIPPERS				
MISCELLANEOUS	POCKETBOOK				
	CELL PHONE/BEEPER(S)				
	WALKER/CANE				
	HEARING AID				
	OTHER:				
JEWELRY: DESCRIPTION	BRACELET (S)				
	EARRING (S)				
	NECKLACE (S)				
	RING (S)				
	WATCH				
	OTHER:				
MONEY AMOUNT		$		$	

VALUABLES SUBMITTED TO THE CASHIER AND VALUABLES PLACED	
GLASSES/CONTACT(S)	
HEARING AID	
POCKETBOOK/ WALLET	✓
RADIO	
CELL PHONE/BEEPER	
OTHER:	
ENVELOPE RECEIPT #	83323

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway
Jamaica, N.Y. 11418

SCHOOLCRAFT, ADRIAN
1288984 M DOB: [redacted]1975 34Y
ADM:10/31/2009 081X 130381015 01
STAFF, PHYSICIAN

Name
Address
This slip serves as receipt for deposit

** PLEASE NOTE THE INSTITUTION IS NOT RESPONSIBLE FOR ITEMS LEFT AT THE PATIENT'S BEDSIDE(Print Name/Sign Below)

PATIENT/SIGNIFICANT OTHER:

STAFF RECEIVING PROPERTY:

WITNESS/TRANSFERRING STAFF:

NOTE: VALUABLES WILL BE HELD IN SECURITY/CASHIER FOR NO MORE THAN 30 DAYS AFTER DISCHARGE

SECURITY/CASHIER SIGNATURE:

STAFF MEMBER RELEASING PROPERTY:

PATIENT/FAMILY MEMBER RECEIVING PROPERTY: RELATIONSHIP:

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

SCHOOLCRAFT, ADRIAN
1298984 M DOB: [redacted]/1976 34Y F/C: 01
ADM: 10/31/2009 23:03 081X 130381015
STAFF, PHYSICIAN

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Authorization to Jamaica Hospital for release of information:

I hereby authorize and direct Jamaica Hospital having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Date

Signature of Patient or Authorized Representative

Assignment to Jamaica Hospital

I hereby assign, transfer, and set over to Jamaica Hospital sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said hospital.

Date

Signature of Insured or Authorized Representative

Safe Medical Device Act

I consent to the provision of my social security number to the manufacturer of any device that must betracked pursuant to the mandates of the Safe Medical Device Act. I understand that the manufacturer will be given my social security number only for the purpose of finding me in the event that a medical device, which is implanted in my body, or used in my home is defective.

Date

Signature of Insured or Authorized Representative

Patient Entitled to Medicare Benefits

I certify that the information given by me in applying for the payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment on my behalf.

Date

Signature of Insured or Authorized Representative

Financial Agreement

For and in consideration of services rendered or to be rendered by the *Jamaica Hospital*, to the patient whose name appears below, the undersigned (jointly and severally, if more than once) hereby agree(s) to be fully and totally responsible to the hospital for payment of all charges as submitted by the Hospital on the account of said patient and make payment in accordance with the policy of payment of bills at said Hospital. It is further agreed that the charges as incurred represent the fair and reasonable value of services rendered and are in accordance with the posted charges of the Hospital which are available upon request. Payment may be demanded at any time, and failure to demand payment of the patient shall not be a prerequisite to my (our) immediate responsibility for payment.

The undersigned has read the above, been informed of its nature and significance and acknowledges the contents of same and has received a copy of this agreement.

Dated

Guarantor

SCHOOLCRAFT, ADRIAN
Name of Patient

Address - Guarantor

10/31/2009 23:03
Hospital No. Date of Admission

Telephone - Guarantor

Date of Discharge

Witness Date

FORM NO. J00123

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

SCHOOLCRAFT, ADRIAN
1298984 M DOB: [redacted]1975 34Y
ADM: 10/31/2009 081X 01 130381015
STAFF, PHYSICIAN

[redacted]

PERMISSION FOR TREATMENT

I HEREBY AUTHORIZE THE JAMAICA HOSPITAL, THROUGH ITS MEDICAL STAFF, TO PERFORM OR HAVE PERFORMED, UPON THE PATIENT WHOSE NAME APPEARS HEREIN, SUCH MEDICAL AND SURGICAL SERVICES, SURGICAL OPERATION AND/OR OTHER PROCEDURES OR THERAPY UNDER ANESTHESIA OR OTHERWISE, AS MAY BE DEEMED NECESSARY IN RELATION TO EMERGENCY TREATMENT ON THIS DATE.

PATIENT/RELATIVE OR GUARDIAN

SIGNATURE

PRINT NAME

RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

GUARANTEE OF PAYMENT

FOR AND IN CONSIDERATION OF SERVICES RENDERED OR TO BE RENDERED TO THE HEREIN NAMED PATIENT, I DO HEREBY GUARANTEE TO PAY THE JAMAICA HOSPITAL, THE FULL AND ENTIRE AMOUNT OF ANY AND ALL BILLS RENDERED FOR SAID TREATMENT. I HEREBY AUTHORIZE THE HOSPITAL TO RELEASE ALL MEDICAL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH CARE AND TREATMENT.

PATIENT/RELATIVE OR GUARDIAN

SIGNATURE

PRINT NAME

RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

AUTHORIZE OF PAYMENT

I HEREBY ASSIGN, TRANSFER AND SET OVER TO THE JAMAICA HOSPITAL SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM THE GOVERNMENT AGENCIES, INSURANCE CARRIERS, AND OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT.

PATIENT/RELATIVE OR GUARDIAN

SIGNATURE

PRINT NAME

RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

JAMAICA HOSPITAL MEDICAL CENTER

Jamaica Hospital Medical Center
8900 Van Wyck Expressway, Jamaica, New York 11418
Telephone # 718 206-6000

LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION ("LIMITED POWER OF ATTORNEY")

By signing this document, I give the Health Care Provider, identified below, a Limited Power of Attorney to pursue payment from my health insurer, heath maintenance organization, self-insurance plan, governmental program, or other payer ("Heath Plan") for medical services provided to me by the Health Care Provider, and I authorize the release of medical information.

I, the undersigned Patient/Principal, appoint JAMAICA HOSPITAL MEDICAL CENTER ("Health Care Provider"), located at 8900 VAN WYCK EXPRESSWAY, JAMAICA, N.Y. 11418 my Attorney-In-Fact and authorized representative to act in any way which I myself could do, if I was personally present, and to take all reasonable action, as determined by the Health Care Provider, to pursue payment from my Health Plan and/or pursue any appeals available to me under my Health Plan's policies or procedures and all applicable law, including but not limited to External Appeals under all State and Federal laws, relating to health care services provided by the Health Care Provider. The Health Care Provider, as my agent, may pursue payment and/or appeal, only when my Health Plan has denied payment based on medical necessity. The Health Care Provider will not charge me for its services in pursuing payment and/or an appeal on my behalf. I agree that my Health Plan will pay any amount owed directly to the Health Care Provider for these services. In pursuing such payment and/or an appeal:

I authorize the Health Care provider and my Health Plan to release all relevant medical information, including (if applicable) any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, relating to my treatment which is necessary to pursue payment from my Health Plan. I understand that this information may be released, but only as necessary, to my Health Plan, an external appeal agent, arbitrator, court of law, and/or other third party reviewer ("Independent Reviewer") responsible for deciding if the Health Care Provider's claim for services should be paid. I understand that my Health Plan and/or the Independent Reviewer will use this information to make a decision about payment to the Health Care Provider. I also understand that the decision by the Independent Reviewer will be final and binding on me, the Health Care Provider, and the Health Plan, and:

I authorize the Health Care Provider to complete, execute, acknowledge, seal, and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, to request, on my behalf, payment and/or appeal to my Health Plan and, if applicable, to the Independent Reviewer, the New York State Department of Health, the State Insurance Department, the U.S. Department of Health and Human Services, the U.S. Department of Labor, and/or any other applicable agency or body.

This Limited Power of Attorney shall not be affected by my subsequent disability or incompetence and MAY BE REVOKED BY ME AT ANY TIME upon prior notice to the Health Care Provider. This Limited Power of Attorney, including authorization for release of medical information, will terminate one (1) year from today's date unless I agree to extend it beyond that date.

Any person or entity receiving this document may rely on a copy as if it were and executed original.

IN WITNESS WHEREOF, I have signed my name this ___ day of _____, 200__.

YOU SIGN HERE: _____

PRINTED NAME: SCHOOLCRAFT ADRIAN

ADDRESS: _____

MEDICAL RECORD # 1298984

WITNESS: _____

PRINT NAME/TITLE: _____

ADDRESS: 8900 Van Wyck Expressway, Jamaica, New York 11418

JAMAICA HOSPITAL MEDICAL CENTER

SCHOOLCRAFT, ADRIAN
1298984 M DOB: [redacted]/1975 34Y F/C: 01
ADM: 10/31/2009 23:03 081X 130381015
STAFF, PHYSICIAN

ACKNOWLEDGEMENT OF THE REQUEST FOR EXTERNAL APPEAL AND RELEASE OF MEDICAL RECORDS TO BE SIGNED BY THE PATIENT.

In order for a provider to appeal a health plan's payment denial for a patient's treatment, the patient must sign and date the following consent to the release of medical records. A certified external appeal agent assigned by the New York State Insurance Department will use this consent to obtain the patient's medical information relating to the external appeal request from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I SCHOOLCRAFT ADRIAN, acknowledge that my health care provider may request or is requesting an external appeal because of a retrospective adverse determination of my health plan. I authorize my HMO, insurer, or provider to release all relevant medical or treatment records, including my name and other personal identifying information, date of admission, assessment results and history, summary of treatment plan, progress and compliance, treatment recommendations, any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, related to my provider's external appeal, to the external appeal agent. I authorize the external appeal agent to use this information solely to make a determination on my provider's appeal.

I understand that my records are protected under federal and/or state law and cannot be disclosed without my written consent unless otherwise provided for in regulations. I understand that information disclosed pursuant to this authorization may no longer be protected by federal privacy regulations, however, state privacy protections may still apply. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it, by contacting the New York State Insurance Department in writing.

This release is valid for one year from _____ (today's date).

_____
Signature of Patient (or legal representative) (Date)

_____
Description of legal representative's authority to act on behalf of the patient.

Patient's Health Plan ID#: _____

If you have any questions contact the New York State Insurance Department at: 1-800-400-8882 or visit our Web site at www.ins.state.ny.us.

Form No. J00027

Patient Fact Sheet

Name and Address
SCHOOLCRAFT, ADRIAN
82 60 88 PL
RIDGEWOOD NY 11385
Phone: (718)570-6224
SS No: [redacted]
Race: W
BirthDate: [redacted]1975
Patient's Maiden Name:

Employer
UNEMPLOYED
Phone: (999)999-9999
Sex: M
Marital Status S
Religion NO
Occupation: UNEMPLOYED

Nearest Relative
SCHOOLCRAFT, SELF
82 60 88 PL
RIDGEWOOD NY 11385
Home Phone: (718)570-6224 Rel: 01
Business Phone:

Admission Data

Account Number	Unit Number
130381015	1298984

Admit Date	Admit Time	ER MD
10/31/2009	23:03	FF, PHYSI

Triage Time	Prim Care MD
	NA

Guarantor
SCHOOLCRAFT, ADRIAN
82 60 88 PL
RIDGEWOOD NY 11385
Home Phone (718)570-6224
Business Phone
Rel: 01 SS: 999-99-9999
Occ: UNEMPLOYED
Employer UNEMPLOYED

Emergency Contact
SCHOOLCRAFT
Home Phone: (718)570-6224 Rel: 01
Business Phone:

Insurance Information
Ins: NO COVERAGE/CHARITY CA Insured: SCHOOLCRAFT, ADRIAN
Policy Number: Group Number: Rel: SELF
82 60 88 PL
RIDGEWOOD NY 11385
Phone Number (718)570-6224 FIN 99
Auth Number

Patient Name **SCHOOLCRAFT, ADRIAN** Medical Record No. **1298984**

Account Number **130381015** Date **10/31/2009**

ID 130381015

Jamaica Hospital Medical Center

Emergency Department Record

History of Present Illness

SNW

34 Year Old Male Patient Presents with Abdominal Pain Epigastric for 15 Hour(s). The Onset is Sudden. The symptoms are Mild, sharp, Intermittent, unknown duration. Symptoms Improve with without treatment. Additional Symptoms or Pertinent History also Involve None. Furthermore, the Patient/Family Denies Anorexia; Fever; Genital Pain; Back Pain;. Patient states exacerbating Factors that occur are unknown. Radiating Symptoms include No Radiations. Patient is a Police Officer brought in handcuff by his colleagues.As per Patient he wasn't feeling well about 15hrs ago and at about 2 pm he told his superiors that he was leaving for home.His colleagues from his Precinct went to his home and hand cuff because the EMS said Patient was behaving irrationally.

Review of Systems

(Symptoms and Signs not covered in the HPI)

GU Neg	Neuro Neg	ENT Neg	Resp Neg	Musculoskeletal Neg	Hematologic/Lymphatic Neg
Skin Neg	Psych Neg	Heart Neg	GI Neg	Endocrine Neg	Allergic/Immunologic Neg
☑ All other ROS negative				Constitutional Sx Neg	Eyes Neg

☑ Vital Signs/Triage/Nursing Notes Reviewed and Agree ☐ Hx unobtainable due to Tx urgency or poor historian(s) ☐ Additional Information from Police, Ambulance, Nursing Home or Relatives ☐ Old Medical Records Reviewed

Past Medical History ☑ No Relevant PMHx ☐ Asthma ☐ COPD ☐ CAD ☐ Cancer ☐ CHF ☐ CVA

Other PMHx ☐ Diabetes ☐ HTN ☐ Psychiatric ☐ Renal ☐ Seizures

Social History ☑ No Relevant SoHx ☐ ETOH ☐ Drugs ☐ Smoking Additional Sx

Family History ☑ No Relevant FmHx No Significant FMHx

Physical Exam

Exam Time 0:05

SNW

General Appearance	Awake A&Ox3
HEENT	PERRL EOMI Moist Mucous Membranes No Icterus
Chest	RRR No M Lungs CTA No Ret Chest Wall NT
Abdomen	No Pulsating Masses BS-NL/No Brutts Tenderness-None
GU	
Extremities	Throughout all extremities erythematous impressions on the wrist bilaterally at the site of handcuffs application CBR < 2 sec Active ROM-Full mild tenderness on the wrist where the handcuffs were applied
Neuro	
Skin	No pallor/ rashes warm & moist
Back	NT no CVAT, Back Flexion 90
Neck	NT Full ROM No JVD
Lymphatics	No LAD

Repeat or Additional Clinical Notes

MD	Notes	Time	
SNW	The following Life or Limb Threatening Differential Diagnosis were considered; Appendicitis; AAA Leaking or Rupture; Incarcerated Hernia; Mesenteric Ischemia or Thrombosis; Myocardial Infarction or CAD; Testicular Ovarian or Salping Torsion; Large or Small Bowel Volvulus; Liver Failure Pancreatitis; Rupture Viscous (Liver Spleen Bowel); Intraabdominal Abscess; Ectopic Pregnancy; Intussusception; Hemolytic Uremic Syndrome;	11/1/2009	0:03
SNW	Looks Comfortable; Not Ill Appearing; No Peritoneal Signs; Genitals Non Tender; No Hernias; No Pulsating Masses; Murphy's Sign Negative; McBurneys & Rovsing Sign Neg; Femoral Pulses 2+ Bilaterally; Psoas Sign Negative; Obturator Sign Negative;	11/1/2009	0:03
SNW	Pt Sx(s) improving. No Sx(s) or Objective findings that are life or limb threatening. Medically Screened and Stable for disposition(Transfer) from the ED.	11/1/2009	0:14

Patient Name **SCHOOLCRAFT, ADRIAN** Medical Record No. **1298984**

Account Number **130381015** Date **10/31/2009**

Diagnostics

Specimen Collected / ECG /Rad Ordered

MD Initials	Time	Diagnostic Ordered	Result Interpretation	Result Reviewed By	RN Initials	Time
GLE	10/31/200 23:10	Pulse Ox	97%	SN	GLE	23:10
SNW	11/1/2009 0:12	Amylase	Amylase-44,Status-FINAL	SN	VCA	0:14
SNW	11/1/2009 0:12	Troponin	Cancel	SN	VCA	0:14
SNW	11/1/2009 0:12	CBC	WBC-12.3,Hgb-14.6,Hct-44.0,Platelets-251,Neut-62.4,Lymph-11.0,Eos-0.2,Baso-0.7,Mono-5.7,MCH-29.4,MCHC-33.6,MCV-87.6,MPV-8.5,RBC-5.02,RDW-13.7,Abs Baso-0.1,Abs Eos-0.0,Abs Lymph-1.3,Abs Mono-0.7,Abs Segs-10.1,Smear Review-Completed,Nucleated RBC-0,NRBC Inst.-0.00,Status-FINAL	SN	VCA	0:14
SNW	11/1/2009 0:12	Chem 20/CMP	AGPK-14.10,Na-136,K-4.1,Cl-104,CO2-24,BUN-14,CR-1.0,Glucose-94,Ca-9.4,AST-46,ALT-51,Alk Phos-57,Albumin-4.7,T-bili-0.6,Protein-8.2,Anion Gap-10.00,Status-FINAL	SN	VCA	0:14
NRI	11/1/2009 0:22	Lipase	Lipase-55,Status-FINAL	SN	NRI	0:33

Medical Orders

MD Initials	Time	Order	RN Initials	Time	Location-Response-Quantity	RN Remarks
SNW	11/1/2009 0:14	Heplock	VCA	0:14		

MD Procedures

Procedure Description	Comments
Time 0:57	MD GLE
Pulse Ox	94760-26 CPT

Recommended LOS/CPT/ICD-9 Code

Physician's LOS = 4 99284-26

Nurse's LOS = 5 612 APC

Diagnoses

Abdominal Pain	789.00 ICD-9
Psychosis NOS	298.9 ICD-9

	MD	MD Time		RN	RN Date/ Time	Admit to	
Disposition	SNW	6:56	Transfer Psychiatric ED	VCA	11/1/2009		6:58
Condition	SNW	6:56	Stable	VCA	6:58		

Physician (Print) Nwaishienyi, Silas (MD)

Physician Signature

Other Physicians

Nwaishienyi, Silas (MD)~Lwin, Khin Mar (RES)

Patient Name **SCHOOLCRAFT, ADRIAN**

Medical Record No. **1298984**

Account Number **130381015**

Date **10/31/2009**

Primary RN (Print) Calderone, Vimalyn (RN)

Other Nurses
Ledbetter, Glenda (RN)~Calderone, Vimalyn (RN)~Shanker, Koosmawatie (PIR)~Rinehart, Nedie (RN)~Ward, Germaine (Reg)~West, Juanita (RN)~Charran, Donna (PIR)~Paris-Taylor, Elyane (WC)~Bido-Rosa, Ana (Reg)
This chart has been electronically signed via the EmpowER software.

Patient Name **SCHOOLCRAFT, ADRIAN** Medical Record No. **1298984**

Account Number **130381015** Date **10/31/2009**

Jamaica Hospital Medical Center

Emergency Department Nursing Notes and Vital Sign

TimeEntered: 11/1/2009 4:52 Vitals Taken By: NRI

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O 98.0	Right	81	R 125/77	21	100%	Discomfort 1 - 2
T	Left		L			
R						

Nursing Notes

Time Note Entered		RN Initials	Note
11/1/2009	0:00	VCA	Brought in per stretcher by EMT on Police custody.A & O x3. Unlabored resp.(+)Left Lower quadrant abd. Pain 3-4/10 x 15 hrs ago.Denies nausea & vomiting.Abd, soft, non-tender, BS(+)normoactive. Skin warm, moist, intact. w/ good capillary refill.
11/1/2009	2:00	NRI	Noted w/ redness on the Rt wrist with the hand cuff.Police officer made aware.& requested to loosen a little bit yet refused.Will closely monitor for poor circulation.
11/1/2009	4:39	NRI	pt. Resting;A & O x 3, no distress,waiting for evaluation and disposition,under police custody.
11/1/2009	5:54	VCA	Psyche consult in progress w/ recommendation to transfer to Psyche ED until medically cleared.Pt. Verbalized, "My wrist is numb, I dont feel anything right now."Encouraged to stay still on bed.Avoid unneccessary movements.Conversant to his father by phone.
11/1/2009	6:58	VCA	Psyche ED made aware of pt. For transfer.ML pulled out.Awaiting transfer.

Primary Nurse Diagnosis	Primary Nurse Outcome	Achieved
Comfort, Altered	Demonstrate Decrease S & S	

Primary RN (Print) Calderone, Vrnalyn (RN)

Jamaica Hospital Medical Center Triage

Category: 3 ESI-3 (Urgent)

10/31/2009 23:03	23:03		23:03

SCHOOLCRAFT,ADRIAN

1298984

130381015

1975

34 Years

Male

None | NA | Transported by: JHMC Ambulance | Mode: Stretcher

Self

Police Dept — Custody: Yes | Notification | Beat #: PCT-81, #27008

Abdominal Pain (Lower) | 14 Hour(s)

Denies vomiting and diarrhea. Pt under police custody. Pt became anxious with increased BP @ the scene.

Additional:

- [x] No Significant PMHx
- [ ] Asthma [ ] COPD [ ] CAD [ ] Cancer [ ] CHF [ ] CVA
- [ ] DM [ ] HTN [ ] Psych [ ] Renal [ ] Seizures [■] Substance Abuse

- [x] No Meds [ ] Unknown

No Known Drug Allergies

UTD

TB Hx, PPD Pos or Infectious Exposures? No

*If yes to TB or Infectious question take precautions

Alert Oriented

	R	L
Clear	☑	☑
Diminished	☐	☐
Wheezes	☐	☐
Rales	☐	☐
Rhonchi	☐	☐
Retractions	☐	☐

	R	L
Equal	☐	☐
Reactive	☐	☐
Fixed	☐	☐
Constricted	☐	☐
Dilated	☐	☐
Cataract	☐	☐

Eye

Verbal

Motor

Total 0

G	P	Ab	Miscarriages
0	0	0	0

Color Normal

Temp Normal

Moist Normal

Pulses

ROM

Tem

Oral 99.0

Rectal

Tympanic

Pulse

Right

Left 115

Respirations 18

Blood Pressure

Right

Left 139/80

Pulse Ox 97%

Weight (Kg 109 Kg

Height | Head Circumferenc

Pain Scal Mild 3 - 4

Normal

No Fall Risk Identified

No risk identified

A3-09 | 23:03

Triage Nurse: Ledbetter, Glonda (RN)

Triage II: GLE

Triage III: GLE

Are you being hurt by someone you live with or who takes care of you?

Yes/No No

* Mandatory completion of Domestic Violence Referral.

Daily Living Independent

Living Conditions Alone

Going Home with Self

Primary Language English

Assessed Disability No Disability

Communication Barrier ☐

Language Translator ☐

Motivation Level Med

Knowledge Level Med

Comprehension Ability Med

☐ LWBS ☐ LW Completed Tx/ Eloped ☐ AMA ☐ AMA Refused ☑ Patient Rights and Responsibilities and Guide to Pain Management given to Patient, Family, and/or Caretaker

Patient Name SCHOOLCRAFT, ADRIAN | Medical Record No. 1288984

Account Number 130381015 | 10/31/2009

Emergency Department Pharmacy and Supply Charges

Interventions

Intervention Name	Comments	Charge Code
Heplock		

Diagnostics

Diagnostic Ordered	Charge Code
Pulse Ox	0
CBC	0

Nurse LOS 5 **612 APC** **Charge Code** 0

Jamaica Hospital Medical Center

Medication Reconciliation

Patient Name	SCHOOLCRAFT, ADRIAN	Medical Record No.	1298984
Account Number	130381016	Date of ED Visit	10/31/2009

Allergies

No Known Drug Allergies

Home Medications

Medications Administered In the Emergency Department

Medication Prescription provided on Discharge

ePCR

Agency Name: JHMC

5581845

Agency ID	Branch #	Shift #	Today's Date	1st Resp. Agency	Call #
7311		3	10/31/09		

Call Times (24hr)

Time Call Received	Patient Contact Time
	2140
Dispatched	**Lft. Scene**
2106	2214
En Route	**At Destination**
2106	2225
On Scene	**In Service**
2115	

Mileage (odometer)

Start:

On Scene:

At Destination: 4.0

Crew Member ID

Crew Member ID	Documenter
6577	
7621	☒

Vehicle Unit

5553

Other Vehicle:

Requested By

☒ 911 ☐ Private

Transport From Code: 60

Transport To Code: 39

# of Patients Transported: 1

Patient this Incident: 1

Patient Information

Incident Location: 82 60 88 PL

Apt. Number: 2

City: Glendale — County Code: 81 — State: NY — Zip Code: 11385

First Name: Adrian — Last Name: Schoolcraft

Street Address: 82 60 88 PL — County Code: 81 — Age: 34 — ☒ Years

City: Glendale — State/Prov: NY — Zip Code: 11385 — Gender: ☒ M — Weight: 250

Date of Birth: [redacted] 1975

Assessment

Airway: ☒ Patent

Breathing — Rate: ☒ Normal; Quality: ☒ Unlabored; Lung Sounds: Clear

Circulation (skin) — Color: Normal; Temp: Normal; Cond: Normal; Edema: Normal

Pupils: Reactive

Glasgow Coma Scale: E4 V5 M6 — Total (3 to 15): 15

Provider Impression

Mechanism of Injury

Injury

Unit Measure: 1 gm 4 mcg 7 mcg/min 10 LPM 13 mcg/kg/min | 2 mg 5 unit 8 gtt/min 11 ml/hr 14 units/hr | 3 meq 6 ml 9 mg/min 12 joules 15 lpm

Route: IV IM ETT RECtal | IO SQ NEB INHal | SL PO AUTO TRANsdermal

5581845

VITALS

Time	Staff #	Systolic	Diastolic	Pulse	Respiration	SPO2	CO2	Blood Sugar	Pain (0-10)	Temperature
2145	1	160	120	120	20					
2155	2	160	110	118	20					

FLOW CHART

Treatment / Medication	Time	Staff #	Treat Code	Med Code	Dose	Unit	Route	Attempt	Succ	Comments

NARRATIVE HISTORY

Illness / Injury Onset Date: 10/31/09

Medical Need: ☐ Medically Necessary ☐ Bed Confined ☐ Required Stretcher ☐ Unconscious ☐ Severe Pain ☐ Needed Restraining ☐ Visible Bleeding ☐ Non-Ambulatory

PMH: ☐ Asthma ☐ Chronic Renal Failure ☐ Cancer ☐ CVA / Stroke ☐ Dialysis ☐ HIV / AIDS ☐ Psychiatric Problems ☐ Substance Abuse ☐ Tuberculosis ☐ Arrhythmia ☐ Chronic Respiratory Failure ☐ Cardiac ☐ Diabetes ☐ Emphysema ☐ Hypertension ☐ Seizure Disorder ☐ Tracheostomy ☐ Other

Allergies: [illegible]

Medications: denies

34 y/o male found ambulatory alert and oriented pt states he has abd pain nausea and dizziness pt states he took Nyquil this evening pt denies taking any other meds upon obtaining vitals pt has ↑BP pt denies med hx [illegible] ESU NYPD [illegible] pt was agitated and resistant pt was [illegible] placed in custody and assisted onto stretcher for txp [illegible] Breached account pt. Pe reveals patent airway neg SOB neg Lungs sounds clear bilat neg chest pain abd soft x4 quads [illegible] nausea x1 day neg vomiting [illegible] [illegible] x4 [illegible] pt txp to hosp 34 [illegible]. (Before pt was detained pt walked [illegible] [illegible] as pt approached bus pt turned around stated he did not need help [illegible] walked away pt was [illegible] pt is on [illegible] [illegible])

Moved to Ambulance By: ☒ Chair ☐ Scoop Stretcher ☐ Walked with Assist. ☐ Stretcher ☐ Carried ☐ Met at Ambulance

Transport Position: ☐ Supine ☐ Shock ☒ Semi / Full Fowlers ☐ Sitting ☐ Prone ☐ Left Lateral Recumbent

Medication / Treatment Authorization: ☒ Protocol ☐ Written Orders ☐ On-Line ☐ NA ☐ On-Scene

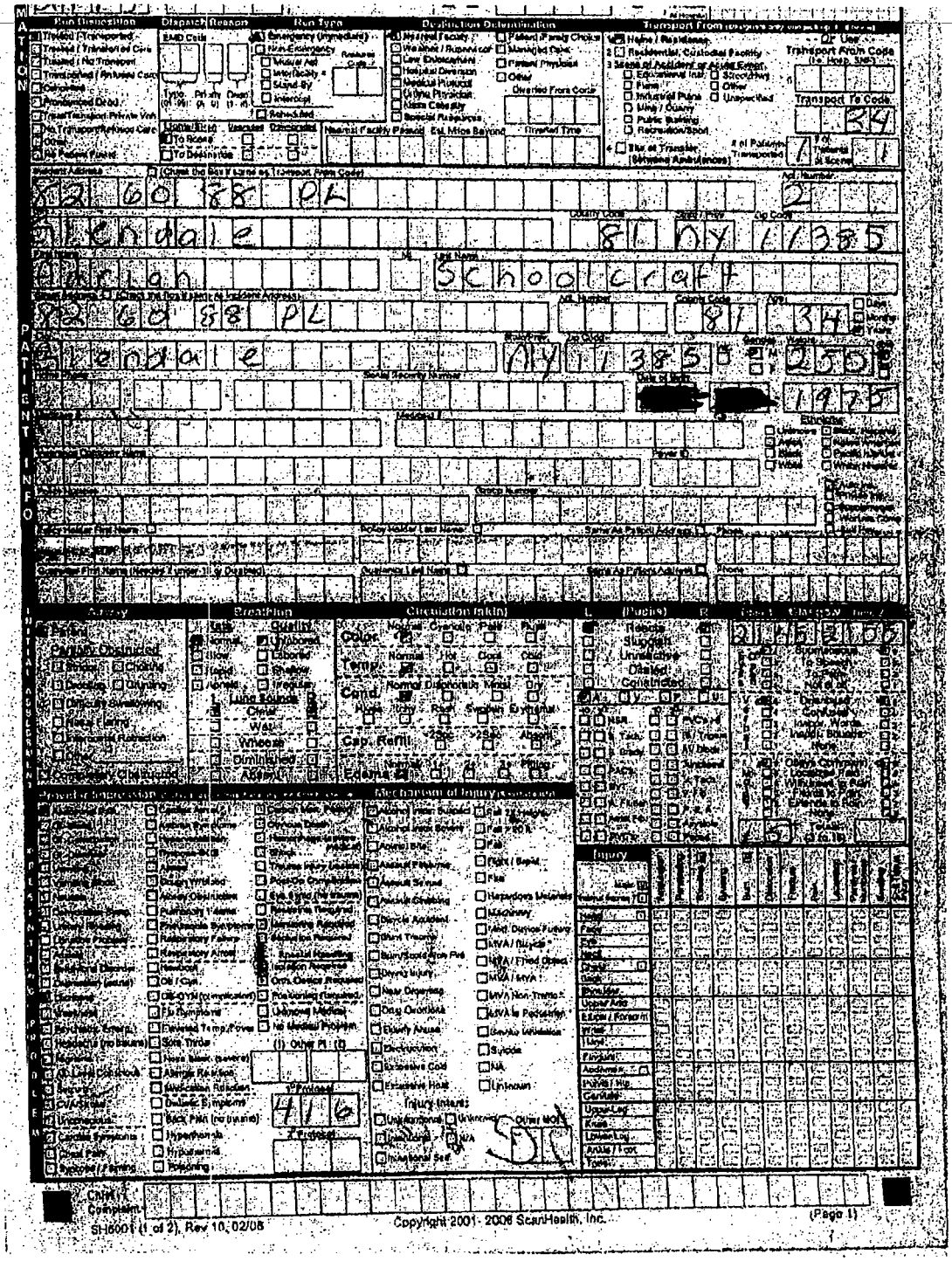
On Line Physician / On Line Med. Facility:

SUPPLY

Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code

Agency Definable 1 / 2

Authorization for Billing / Release of Patient Information / Assumption of Financial Responsibility: I request that payment of authorized Medicare/Medicaid and/or other insurance benefits be made to the pre-hospital care provider ("Provider") for any services furnished to me. I authorize any holder of hospital or medical information about me to be released to the Provider, Centers for Medicare and Medicaid Services, and/or my insurance carriers and their agents, including any other information needed to determine these benefits or



FLOW CHART

Narrative History: Illness/Injury Onset Date 10/31/09

Medically Necessary / Bed Confined / Required Stretcher / Unconscious / Severe Pain / Needed Restraining / Visible Bleeding / Non-Ambulatory

PMH: Asthma / Chronic Renal Failure / Cancer / CVA / Stroke / Dialysis / HIV / AIDS / Psychiatric Problems / Substance Abuse / Tuberculosis / Chronic Respiratory Failure / Cardiac / Diabetes / Emphysema / Hypertension / Seizure Disorder / Tracheostomy / Other

Allergies: [illegible]

Medication: denies

34 y/o male found ambulatory alert and oriented pt states he has abd pain, nausea and dizziness pt states he took Nyquil this evening pt denies taking any other meds upon obtaining vital signs [illegible] ↑ BP pt denies [illegible] [illegible] [illegible] and CS 3 pt was aggitated and resistant pt was [illegible] placed in custody and assisted onto stretcher for [illegible] [illegible] pt [illegible] patent airway [illegible] [illegible] [illegible] [illegible] [illegible] chest pain, abd soft [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] pt [illegible] to hosp 34 [illegible] (Before pt was detained & walked down [illegible] [illegible] as pt approached bus he turned around stated he did not need help and walked away [illegible] [illegible] [illegible] [illegible] pt is on [illegible] [illegible] [illegible])

Moved to Ambulance by: Chair / Scoop Stretcher / Walked with Assist / Stretcher / Carried / Not at Ambulance

Transport Position: Supine / Shock / Semi / Full Fowlers / Sitting / Prone / Left Lateral Recumbent

Medication / Treatment Authorization: Protocol / Written Orders / On-Line / NA / On-Scene

SUPPLY: Qty / Supply Code

Agency Defined

Authorization for Billing / Release of Patient Information / Assumption of Financial Responsibility: I request that payment of authorized Medicare/Medicaid and/or other insurance benefits be made to the pre-hospital care provider ("Provider") for any services furnished to me. I authorize any holder of medical information about me to be released to the Provider, Centers for Medicare and Medicaid Services, and/or my insurance carriers and their agents including any other information needed to determine these benefits or other benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand this authorization may be used by the Provider for all services furnished in the future until such time as I revoke this authorization in writing. I agree to assume full financial responsibility for payment of all charges not covered by my insurance carrier as well as any collection costs and/or attorney's fees as allowed by law. Patient: Unable to Sign / Refused to Sign / PCS Collected / Other Insurance Collected

Authorization Signature: | Date: | Guarantor Signature:

Privacy Notice: I hereby acknowledge that I have been provided with a copy of the Provider's Notice of Privacy Practices explaining how my personal health information is used and understand my individual rights related to this information. | Privacy Notice Signature: | Date:

Patient's Physician Name (please print): | Receiving RN/MD Signature: [illegible] 5?2 | Technician Signature: [illegible]

I Refuse Treatment / Transportation and understand the consequences of my refusal: | Witness Signature for Refusal: | On-Line Medical Control Signature:

646-957-2486 (FATHER)

FILE 6417

LOCATION: 081X

JAMAICA HOSPITAL MEDICAL CENTER

[redacted]

EMERGENCY MEDICINE RECORD

DATE AND TIME OF ARRIVAL 10/31/2008 23:03

REGISTRATION

MEDICAL RECORD NO: 1298984 | PATIENT TYPE: E | PATIENT ACCOUNT NO: 130361015

PATIENT'S NAME		SOCIAL SECURITY NO:	DATE OF BIRTH	AGE
SCHOOLCRAFT	ADRIAN		[redacted]/1975	34Y

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.	PLACE OF BIRTH
82-60 86 AV			11385	1917 470 6234	

PRC CL	SEX	RACE	RELIGION	MARITAL STATUS	FATHER'S NAME	MOTHER'S MAIDEN NAME, FIRST NAME
01	M	W	N	S		

PRIVATE M.D. NAME OR CLINIC NAME	PATIENT COMPLAINT	LANGUAGE	INTERP. REQ.
		ENG	N

MODE OF ARRIVAL	ACCOMPANIED BY	RELATIONSHIP	TELEPHONE NO.	INJURED AT WORK?	AUTO ACCIDENT?

DATE AND TIME OF ACCIDENT	POLICE OFFICER NAME & BADGE NO.	PCT. NO.	REFERRED FROM: ☐ PMD ☐ TRUMP ☐ CLINIC ☐ FP ☐ OTHER

NEXT OF KIN	TELEPHONE NO.	NEXT OF KIN ADDRESS	RELATIONSHIP TO PATIENT

FINANCIAL/INSURANCE

GUARANTOR'S NAME	STREET ADDRESS	CITY	STATE	ZIP CODE
WEAK				

GUARANTOR'S NAME (M.I., JR.)	TELEPHONE NO.	GUARANTOR'S EMPLOYER	ADDRESS	TELEPHONE NO.

PATIENT'S EMPLOYER NAME	STREET ADDRESS	CITY	STATE	ZIP CODE

INSURANCE #1: NAME	GROUP NO.	POLICY NO.

INSURANCE #2: NAME	GROUP NO.	POLICY NO.

HOSPITALIZED PAST 90 DAYS?	IF YES, WHERE AND WHEN?	PLACE OF ACCIDENT	CRIME VICTIM PCT. NO.	CRIME VICTIM COMPLAINT NO.

PHYSICIAN COMMENTS: n/c DATE/TIME: CHECK-A 45

NURSING

VITAL SIGNS

TIME	B.P.	PULSE	RESP.	TEMP.
TIME	B.P.	PULSE	RESP.	TEMP

PLAN OF CARE: CHECK WHEN COMPLETED

☐ OXYGEN GIVEN

☐ EKG INITIALS ☐ CARDIAC MONITOR ☐ IV ANGIO# FLUID: INITIALS METHOD INITIALS

NURSES NOTES ☐ ADVANCED DIRECTIVES DISCUSSED HEALTH CARE PROXY ☐ YES ☐ NO AGENT'S NAME:

RN SIGNATURE

DATE	TIME	NON-MEDICATION ORDERS (EKG, LABS, CULTURES, ETC)	MD SIGNATURE	RN SIGNATURE	TIME

DATE	TIME	MEDICATION ORDERS: MEDICATION	DOSE	ROUTE	MD SIGNATURE	RN SIGNATURE	TIME

ACCOUNTING DEPT COPY

FORM NO. J00018

JAMAICA HOSPITAL MEDICAL CENTER

SCHOOLCRAFT, ADRIAN [redacted] M DOB: [redacted] 1978 34Y
1298844 ADM:10/31/2008 081X 130381018 01
STAFF PHYSICIAN

CONSULTATION REPORT CONTINUATION

Consultant Print Name: Signature: Date: Time:

ORIGINAL - MEDICAL RECORD CARBON COPY - CONSULTANT

FORM 112 ITEM(S) 1173 REV 10/08

JAMAICA HOSPITAL MEDICAL CENTER

SCHOOLCRAFT, ADRIAN
M DOB /1973 34Y
ADM: 10/31/2004 08:1X
STAFF PHYSICIAN 1303816165 01

CONSULTATION REPORT CONTINUATION

Consultant Print Name: Signature: Date: Time:

ORIGINAL - MEDICAL RECORD CARBON COPY - CONSULTANT

FORM 112 (REV. 12/1 | REV. 10/

JAMAICA HOSPITAL MEDICAL CENTER

SCHOOLCRAFT, ADRIAN
1298984 M DOB: [redacted]/1975 34Y
ADM:10/31/2009 081X 130381015 01
STAFF, PHYSICIAN

PATIENT CLOTHING/VALUABLES INVENTORY

1. ALL PATIENTS CLOTHING/VALUABLES SENT HOME ☐ YES ☑ NO
2. DENTURES TAKEN HOME BY FAMILY MEMBER ☐ YES ☐ NO

	ADMISSION	TRANSFER	TRANSFER
DATE/TIME:	11-01-09	DATE/TIME:	
UNIT:		ROOM: TO	

INVENTORY OF ITEMS KEPT AT BEDSIDE

	AMOUNT	DESCRIPTION	AMOUNT	DESCRIPTION
UPPER DENTURE		LABELED CUP PROVIDED ☐		
LOWER		LABELED CUP PROVIDED ☐		
PARTIAL		LABELED CUP PROVIDED ☐		
COAT/JACKET				
DRESS/HOUSECOAT				
PAJAMAS/NIGHTGOWN				
BLACK/PANTS/JEANS				
BLOUSE/SHIRT/SWEATER				
SKIRT/SHORTS				
UNDERWEAR/BRA				
GLASSES/CONTACTS				
HAT/SCARF/BELT				
SNEAKERS/SOCKS				
BATHROBE				
SNEAKERS/SNEAKERS				
BOOTS/SLIPPERS				
POCKETBOOK				
CELL PHONE/BEEPER(S)				
WALKER/CANE				
HEARING AID				
OTHER:				
BRACELET (S)				
EARRING (S)				
NECKLACE (S)				
RING (S)				
WATCH				
OTHER:				
MONEY AMOUNT				

VALUABLES SUBMITTED TO THE CASHIER AND VALUABLES PLACED

GLASSES/CONTACT(S)	
HEARING AID	
POCKETBOOK/ WALLET	✓
RADIO	
CELL PHONE/BEEPER	
OTHER:	
ENVELOPE RECEIPT #	83323

JAMAICA HOSPITAL MEDICAL CENTER
83323
SCHOOLCRAFT, ADRIAN
1298984 M DOB: [redacted]/1975 34Y
ADM:10/31/2009 081X 130381015
STAFF, PHYSICIAN
Name
Address

** PLEASE NOTE THE INSTITUTION IS NOT RESPONSIBLE FOR ITEMS LEFT AT THE PATIENT'S BEDSIDE (Print Name/Sign Below)

PATIENT/SIGNIFICANT OTHER:
STAFF RECEIVING PROPERTY:
WITNESS/TRANSFERRING STAFF:

NOTE: VALUABLES WILL BE HELD IN SECURITY/CASHIER FOR NO MORE THAN 30 DAYS AFTER DISCHARGE

SECURITY/CASHIER SIGNATURE:
STAFF MEMBER RELEASING PROPERTY:
PATIENT/FAMILY MEMBER RECEIVING PROPERTY: RELATIONSHIP:

7273T-FORM 554 White Copy : Medical Record Yellow Copy: Nursing Pl

JAMAICA HOSPITAL MEDICAL CENTER

SCHOOLCRAFT, ADRIAN
1396964 M DOB [redacted]/1975 34Y P/C 01
ADM 10/31/2009 23:03 081X 130981016
STAFF, PHYSICIAN

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Authorization to Jamaica Hospital for release of information

I hereby authorize and direct Jamaica Hospital having treated me, to release to governmental agencies, insurance carriers, or others [illegible] financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Date ______________________ Signature of Patient or Authorized Representative ______________________

Assignment to Jamaica Hospital

I hereby assign, transfer, and set over to Jamaica Hospital sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care to cover the cost of the care and treatment rendered to myself or my dependent by said hospital.

Date ______________________ Signature of Insured or Authorized Representative ______________________

Safe Medical Device Act

I consent to the provision of my social security number to the manufacturer of any device that must be tracked pursuant to the mandates of the Safe Medical Device Act. I understand that the manufacturer will be given my social security number only for the purpose of finding me in the event that a medical device, which is implanted in my body, or used in my home is defective.

Date ______________________ Signature of Insured or Authorized Representative ______________________

Patient Entitled to Medicare Benefits

I certify that the information given by me in applying for the payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment on my behalf.

Date ______________________ Signature of Insured or Authorized Representative ______________________

Financial Agreement

For and in consideration of services rendered or to be rendered by the *Jamaica Hospital* to the patient whose name appears below, the undersigned (jointly and severally if more than one) hereby agree(s) to be fully and totally responsible to the hospital for payment of all charges as submitted by the Hospital on the account of said patient and make payment in accordance with the policy of payment of this [illegible]. It is further agreed that the charges as incurred represent the fair and reasonable value of services rendered and are in accordance with the posted charges of the hospital which are available upon request. Payment may be demanded at any time, and failure to demand payment of the patient shall not be a period [illegible] immediate responsibility for payment.

The undersigned has read the above, been informed of its nature and significance and acknowledges the contents of same and has received a copy of this agreement.

Dated ______________________ Guarantor ______________________

SCHOOLCRAFT, ADRIAN
Name of Patient ______________________ Address - Guarantor ______________________

10/31/2009 23:03
Hospital No. ______________________ Date of Admission ______________________ Telephone - Guarantor ______________________

Date of Discharge ______________________ Witness ______________________ Date

FORM NO. J00123

[redacted]

SCHOOLCRAFT, ADRIAN
2408964 M DOB: [redacted] 1975 34Y
ADM: 10/31/2009 09:1X DIS: 11/03/2009
STAFF PHYSICIAN

[redacted]

AUTHORIZATION TREATMENT

I HEREBY AUTHORIZE THE JAMAICA HOSPITAL THROUGH ITS MEDICAL STAFF, TO PERFORM OR HAVE PERFORMED, UPON THIS PATIENT, ANY EXAMINATIONS, MEDICAL OR SURGICAL AND SURGICAL SERVICES, SURGICAL OPERATION AND/OR OTHER PROCEDURES OR TREATMENTS DEEMED BY OR OTHERWISE, WE MAY BE DEEMED NECESSARY IN RELATION TO EMERGENCY TREATMENT ON THIS DATE.

SIGNATURE RELATIVE OR GUARDIAN

PRINT NAME

RELATIONSHIP IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

GUARANTEE OF PAYMENT

IN CONSIDERATION OF SERVICES RENDERED OR TO BE RENDERED TO THE HEREIN NAMED PATIENT, I DO HEREBY GUARANTEE PERSONALLY, THE PROMPT PAYMENT IN FULL AND ENTIRE AMOUNT OF ANY AND ALL BILLS RENDERED FOR SAID TREATMENT. I ALSO AUTHORIZE THE HOSPITAL TO RELEASE ALL MEDICAL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH CARE AND TREATMENT.

SIGNATURE RELATIVE OR GUARDIAN

PRINT NAME

RELATIONSHIP IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

AUTHORIZE PAYMENT

I HEREBY ASSIGN, TRANSFER AND SET OVER TO THE JAMAICA HOSPITAL SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM THE GOVERNMENT, MEDICARE, MEDICAID, INSURANCE CARRIERS, AND OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT.

SIGNATURE RELATIVE OR GUARDIAN

PRINT NAME

RELATIONSHIP IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

FORM NO. [illegible]

[redacted]

SCHOOLCRAFT, ADRIAN
[redacted] M DOB: [redacted] 1976 34Y
ADM: 02/02/09 08:1X
STAFF PHYSICIAN 01 13031018

ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed on the back of this form, and how I may obtain access to and control this information. I also acknowledge that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the hospital, its staff, and the facilities listed at the back of this form.

Signature of patient or authorized representative

Relationship to patient

Date

AFFIRMATION OF PRIOR RECEIPT

By signing below, I acknowledge that I have already received a copy of the Notice of Privacy Practices, and have given my consent for the use of my health information for the purposes noted above. I do not wish to receive another copy of the Notice Privacy Practices at this time.

Signature of patient or authorized representative

Relationship to patient

Date

THIS FORM IS PART OF THE MEDICAL RECORD

[redacted]

[redacted] 0006

Jamaica Hospital Medical Center
8900 Van Wyck Expressway, Jamaica, New York 11418
Telephone # 718 206-6000

LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION
("LIMITED POWER OF ATTORNEY")

By signing this document, I give the Health Care Provider identified below, a Limited Power of Attorney to pursue payment from my health insurer, health maintenance organization, self-insurance plan, governmental program, or other payer ("Health Plan") for medical services provided to me by the Health Care Provider, and I authorize the release of medical information.

I, the undersigned Patient/Principal, appoint JAMAICA HOSPITAL MEDICAL CENTER ("Health Care Provider"), located at 8900 VAN WYCK EXPRESSWAY, JAMAICA, N.Y. 11418, my Attorney-in-Fact and authorized representative to act in any way which I myself could do, if I were personally present, and to take all reasonable actions, as determined by the Health Care Provider, to pursue payment from my Health Plan and/or pursue any appeals available to me under my Health Plan's policies or procedures and all applicable law, including but not limited to External Appeals under all State and federal laws, relating to health care services provided by the Health Care Provider. The Health Care Provider, at any time, may pursue payment and/or appeal, only when my Health Plan has denied payment based on medical necessity. The Health Care Provider will not charge me for its services in pursuing payment and/or an appeal on my behalf. I agree that my Health Plan will pay any amounts owed directly to the Health Care Provider for these services in pursuing such payment and/or an appeal.

I authorize the Health Care provider and my Health Plan to release all relevant medical information, including (if applicable) any HIV related information, mental health treatment information, or alcohol/substance abuse treatment information, relating to any treatment which is necessary to pursue payment from my Health Plan. I understand that this information may be released, but only as necessary, to my Health Plan, an external appeal agent, arbitrator, court of law, and/or other third party reviewer ("Independent Reviewer") responsible for deciding if the Health Care Provider's claim for services should be paid. I understand that my Health Plan and/or the Independent Reviewer will use this information to make a decision about payment to the Health Care Provider. I also understand that the decision by the Independent Reviewer will be final and binding on me, the Health Care Provider, and the Health Plan, and;

I authorize the Health Care Provider to complete, execute, acknowledge, seal and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, to request, on my behalf, payment and/or appeal to my Health Plan and, if applicable, to the Independent Reviewer, the New York State Department of Health, the State Insurance Department, the U.S. Department of Health and Human Services, the U.S. Department of Labor, and/or any other applicable agency or body.

This Limited Power of Attorney shall not be affected by my subsequent disability or incompetence and MAY BE REVOKED BY ME AT ANY TIME upon prior notice to the Health Care Provider. This Limited Power of Attorney, including authorization for release of medical information, will terminate one (1) year from today's date unless I agree to extend it beyond that date.

Any person or entity receiving this document may rely on a copy as if it were and executed original.

IN WITNESS WHEREOF, I have signed my name this ___ day of __________, 200 __.

YOU SIGN HERE: ______________________

PRINTED NAME: SCHOOLCRAFT , ADRIAN

ADDRESS: ______________________

MEDICAL RECORD # 1296984

WITNESS: ______________________

PRINT NAME/TITLE: ______________________

ADDRESS: 8900 Van Wyck Expressway, Jamaica, New York 11418

Form No. J00023

SCHOOLCRAFT, ADRIAN
1298384 M DOB: [redacted]/1975 34Y F/C: 01
ADM: 10/31/2009 23:03 081X 1993/4015
STAFF, PHYSICIAN

ACKNOWLEDGEMENT OF THE REQUEST FOR EXTERNAL APPEAL AND RELEASE OF MEDICAL RECORDS TO BE SIGNED BY THE PATIENT.

In order for a provider to appeal a health plan's payment denial for a patient's treatment, the patient must sign and date the following consent to the release of medical records. A certified external appeal agent assigned by the New York State Insurance Department will use this consent to obtain the patient's medical information relating to the external appeal request from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I SCHOOLCRAFT ADRIAN ______ acknowledge that my health care provider may request or is requesting an external appeal because of a retrospective adverse determination of my health plan. I authorize my HMO, insurer or provider to release all relevant medical or treatment records, including my name and other personal identifying information, date of admission, assessment results and history, summary of treatment plan, progress and compliance, treatment recommendations, any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, related to my provider's external appeal, to the external appeal agent. I authorize the external appeal agent to use this information solely to make a determination on my provider's appeal.

I understand that my records are protected under federal and/or state law and cannot be disclosed without my written consent unless otherwise provided for in regulations. I understand that information disclosed pursuant to this authorization may no longer be protected by federal privacy regulations, however, state privacy protections may still apply. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it, by contacting the New York State Insurance Department in writing.

This release is valid for one year from ______________ (today's date).

____
Signature of Patient (or legal representative) (Date)

____
Description of legal representative's authority to act on behalf of the patient.

Patient's Health Plan ID#: ______________________________

If you have any questions contact the New York State Insurance Department at: 1-800-400-8882 or visit our Web site at www.ins.state.ny.us.

Form No. J00627

08/06/2010
14:02:00 TTH

JAMAICA HOSPITAL MEDICAL CENTER
8900 VAN WYCK EXPRESSWAY
JAMAICA, NEW YORK 11418-2897

Pt Name: ADRIAN SCHOOLCRAFT Location: Discharged
MR#: 001298984 ACCT#: 130381015 Att Phys: NWAISHIENYI, SILAS
DOB: [redacted]/1975 Age: 35Yr Sex: M Ord By: STAFF, PHYSICIAN

Seq #: 0005 Test: LIPASE Status: FINAL Page 1 of 1
Collected: 11/01/09 0:22 By: J081X Received: 11/01/09 0:36 Lab#: D1010449

TEST	RESULT	ABN	REFERENCE	UNITS
Lipase	55		23-300	U/L

* * * * E N D O F R E P O R T * * * *

08/06/2010
14:02:02 TTH

JAMAICA HOSPITAL MEDICAL CENTER
8900 VAN WYCK EXPRESSWAY
JAMAICA, NEW YORK 11418-2897

==========

Pt Name: ADRIAN SCHOOLCRAFT Location: Discharged
MR#: 001298984 ACCT#: 130381015 Att Phys: NWAISHIENYI, SILAS
DOB: [redacted]/1975 Age: 35Yr Sex: M Ord By: NWAISHIENYI, SILAS

==========

Seq #: 0001 Test: AMYLASE SERUM Status: FINAL Page 1 of 1
Collected: 11/01/09 0:22 By: J081X Received: 11/01/09 0:36 Lab#: D1010449

TEST	RESULT	ABN	REFERENCE	UNITS
Amylase	44		30-110	U/L

* * * * E N D O F R E P O R T * * * *

08/06/2010
14:02:04 TTH

JAMAICA HOSPITAL MEDICAL CENTER
8900 VAN WYCK EXPRESSWAY
JAMAICA, NEW YORK 11418-2897

Pat Name: ADRIAN SCHOOLCRAFT
Pat Numb: 130381015
Att Phys: NWAISHIENYI, SILAS

Loc: Discharged
Sex: M
DOB: [redacted]/1975

Race: W
Age: 35Yr

==========

Department: 004210 LABORATORY SERVICES

Order: 00009564 TROPONIN-I LEVEL
Pt.Ord #: 0002
Req Date/Time: 11/01/2009 0012
Comment:

Priority: S
Status: CANCELLED
Ord By: NWAISHIENYI, SILAS

08/06/2010 14:02:06 TTH

JAMAICA HOSPITAL MEDICAL CENTER
8900 VAN WYCK EXPRESSWAY
JAMAICA, NEW YORK 11418-2897

Pt Name: ADRIAN SCHOOLCRAFT Location: Discharged
MR#: 001298984 ACCT#: 130381015 Att Phys: NWAISHIENYI, SILAS
DOB: [redacted]/1975 Age: 35Yr Sex: M Ord By: NWAISHIENYI, SILAS

Seq #: 0003 Test: CBC WITH AUTO DIFFERENTA Status: FINAL Page 1 of 1
Collected: 11/01/09 0:12 By: J081X Received: 11/01/09 0:36 Lab#: D1010449

TEST	RESULT	ABN	REFERENCE	UNITS
WBC	12.3	H	4.8-10.8	K/uL
RBC	5.02		4.50-5.90	M/uL
HGB	14.8		14.0-18.0	g/dL
HCT	44.0		42.0-52.0	%
MCV	87.6		80.0-94.0	fL
MCH	29.4		27.0-31.0	pg
MCHC	33.6		32.0-36.0	g/dL
RDW	13.7		11.5-14.5	%
MPV	8.5		7.2-10.4	fL
Platelet Count	251		130-400	K/uL
Neutrophils Auto	82.4	H	44.0-80.0	%
Lymphocytes Auto.	11.0	L	13.0-43.0	%
Monocytes Auto	5.7		2.0-15.0	%
Eosinophils Auto.	0.2		0.0-3.0	%
Basophils Auto.	0.7		0.0-3.0	%
Segs, Absolute	10.1		2.1-8.6	K/uL
Lymphs, Absolute	1.3		0.6-4.6	K/uL
Monos, Absolute	0.7		0.1-1.6	K/uL
Eos, Absolute	0.0		0.0-0.9	K/uL
Basos, Absolute	0.1		0.0-0.4	K/uL
NRBC Inst.	0.00		None	%/100 WBC
Nucleated RBC	0		None	/100 WBC
NRBC Absolute	0.00		None	K/uL
Smear Review:	Completed			

* * * * E N D O F R E P O R T * * * *

08/06/2010 14:02:08 TTH

JAMAICA HOSPITAL MEDICAL CENTER
8900 VAN WYCK EXPRESSWAY
JAMAICA, NEW YORK 11418-2897

Pt Name: ADRIAN SCHOOLCRAFT Location: Discharged
MR#: 001298984 ACCT#: 130381015 Att Phys: NWAISHIENYI, SILAS
DOB: [redacted]/1975 Age: 35Yr Sex: M Ord By: NWAISHIENYI, SILAS

Seq #: 0004 Test: COMP METABOLIC PANEL Status: FINAL Page 1 of 1
Collected: 11/01/09 0:22 By: J081X Received: 11/01/09 0:36 Lab#: D1010449

TEST	RESULT	ABN	REFERENCE	UNITS
Glucose	94		74-106	mg/dL
BUN	14		9-20	mg/dL
Creatinine	1.0		0.7-1.3	mg/dL
Sodium	138		137-145	mEq/L
Potassium	4.1		3.5-5.1	mEq/L
Chloride	104		98-107	mEq/L
CO2	24		22-30	mEq/L
Calcium	9.4		8.4-10.2	mg/dL
Anion Gap	10.00			mEq/L
Anion Gap With K	14.10			mmoL/L
Protein	8.2		6.3-8.2	g/dL
Albumin	4.7		3.5-5.0	g/dL
Bilirubin (Total)	0.6		0.2-1.3	mg/dL
ALT (SGPT)	51		21-72	U/L
AST (SGOT)	46		17-59	U/L
Alkaline Phosphatase	57		37-126	U/L

**** END OF REPORT ****

08/06/2010 14:02:10 TTH

JAMAICA HOSPITAL MEDICAL CENTER
8900 VAN WYCK EXPRESSWAY
JAMAICA, NEW YORK 11418-2897

Pt Name: ADRIAN SCHOOLCRAFT Location: Discharged
MR#: 001298984 ACCT#: 130381015 Att Phys: NWAISHIENYI, SILAS
DOB: [redacted]/1975 Age: 35Yr Sex: M Ord By: NWAISHIENYI, SILAS

Seq #: 0006 Test: BILL CBC W/AUTO DIFF Status: FINAL Page 1 of 1
Collected: 11/01/09 0:12 By: J081X Received: 11/01/09 1:03 Lab#: D1010449

TEST	RESULT	ABN	REFERENCE	UNITS
Bill CBC Automated D	BILLING			

* * * * E N D O F R E P O R T * * * *

NEW ENCOUNTER

SCHOOLCRAFT , ADRIAN

P40

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

FACE SHEET

5/22/10

PATIENT

ACCOUNT NUMBER	MEDICAL RECORD NUMBER	ADMIT DATE & TIME	BAR CODE-MEDICAL RECORD NUMBER
130381874	1298984	11/03/2009 15:00	

LOCATION	FIN. CLASS	SOURCE	TYPE	DISCHARGE DATE & TIME	BAR CODE-ACCOUNT NUMBER
03MH 9HAL 01	19	7	P	11/4/09	

LAST NAME	FIRST NAME	M.I.	AKA	VETERAN
SCHOOLCRAFT	ADRIAN			N

DATE OF BIRTH	AGE	SEX	REL.	MAR ST.	RACE	PLACE OF BIRTH	LANGUAGE	INTERPRETER NEEDE
[redacted]1975	34Y	M	NO	S	W	NY	ENG	N

ADDRESS	CITY	STATE	ZIP
82 60 88 PL	RIDGEWOOD	NY	11385

TELEPHONE NUMBER	OCCUPATION	SOCIAL SECURITY NUMBER
(718)570-6224		***-**-****

EMPLOYER NAME	ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBE
UNKNOWN					(999)999-9999

NEXT OF KIN	RELATIONSHIP	ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
SCHOOLCRAFT, SELF	09	82 60 88 PL	RIDGEWOOD	NY	11385	(718)570-6224

EMERGENCY CONTACT NAME	RELATIONSHIP	ADDRESS	TELEPHONE NUMBER
SCHOOLCRAFT,	09		(718)570-6224

MEDICAL

ATTENDING PHYSICIAN / CODE		PVT./SERV.	OTHER PHYSICIAN / CODE	MEDICAL SERVICE
HOVANESIAN, SHUSHAN	5904	S		PSY

ADMITTING DIAGNOSIS	ICD-9-CM CODE
PSYCHOSIS NOS	298.9

ADMITTING PHYSICIAN / CODE		NEWBORN WEIGHT	RESERVATION DATE & TIME		TEAM COLOR
HOVANESIAN, SHUSHAN	5904		11/03/2009	15:00	

GUARANTOR

GUARANTOR NAME	RELATIONSHIP	OCCUPATION	SOCIAL SECURITY NUMBER
SCHOOLCRAFT, ADRIAN	01		999-99-9999

ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
82 60 88 PL	RIDGEWOOD	NY	11385	(718)570-6224

EMPLOYER	ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
UNKNOWN					(999)999-9999

INSURANCE

PLAN CODE / PRIMARY INSURANCE	POLICY NUMBER	SEQ. / GROUP #	AUTHORIZATION NUMBER
AETN AETNA US HEALTHCARE	BBM6PBBA	US0080410090	PENDING

ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
PO BOX 981109	EL PASO	TX	799981109	(800)451-8843

SUBSCRIBERS NAME	RELATIONSHIP CD	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SCHOOLCRAFT, ADRIAN	01	06/21/1975	***-**-****

SECONDARY CARRIER	POLICY NUMBER	SEQ. / GROUP #	AUTHORIZATION NUMBER

ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER

SUBSCRIBERS NAME	RELATIONSHIP CD	DATE OF BIRTH	SOCIAL SECURITY NUMBER

TERTIARY CARRIER	POLICY NUMBER	SEQ. / GROUP #	AUTHORIZATION NUMBER

ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER

SUBSCRIBERS NAME	RELATIONSHIP CD	DATE OF BIRTH	SOCIAL SECURITY NUMBER

DATE OF PREVIOUS HOSPITAL ADMISSION	FACILITY NAME	ADMITTED BY
	UNSPECIFIED	n09ad

FORM NO. M00001

JAMAICA HOSPITAL MEDICAL CENTER

Jamaica, New York 11418

DISCHARGE SUMMARY

NAME: SCHOOLCRAFT, ADRIAN | MEDICAL RECORD NO.: 1298984

ADM. DATE: 11/3/09 | DIS. DATE: 11/6/09

ATTENDING PHYSICIAN: Isak Isakov, MD

DICTATING PHYSICIAN: Same.

HISTORY OF PRESENT ILLNESS: This is a 34-year-old white, single, male, a police officer, with no past psychiatric history and was not taking any psychotropic medications in the past. He denied any substance abuse history. He stated that he has been working in the police department for approximately six years and, from the beginning of his career, he was not "happy" with "how the precinct was run" and was making multiple complaints that were not "addressed". Instead, he was "declared emotionally unstable" and his gun was taken away from him for approximately six months after psychiatric evaluation by police department psychiatrist. Since then, he started collecting "evidence" to "prove his point" and became suspicious "They are after him".

On the day of admission, he had a verbal alteration with one of the officers who was "threatening" him. He left his job before his shift was over. Prior to leaving the work station, he excused himself that he was not feeling well. According to him, he came home and took Nyquil and fell asleep. He was awakened by police officers in his room. He doesn't know how they entered his room, who asked him to come with them to the precinct. After he refused to comply to go voluntarily, they involuntarily put him in the car handcuffed, and brought him to the emergency room of Jamaica Hospital where he was evaluated by psychiatrist after medical clearance, and transferred to Psychiatric emergency room with questionable diagnosis of psychosis NOS and admitted to Psych Unit 3 on 11/3/09 for further evaluation.

On evaluation today, he was feeling anxious. He was suspicious and guarded. He was demanding to be discharged and appeared restless. He denied any suicidal or homicidal ideations, denied any auditory or visual hallucinations. He expressed questionable paranoid ideas of conspiracy and cover-ups going in the precinct. His cognition and memory were intact. Insight and judgment were partial. He was admitted with the diagnosis of psychosis NOS, rule out adjustment disorder with anxiety.

HOSPITAL COURSE: A decision was made to obtain additional information prior to initiation of treatment. Patient was not taking any medications. The next day, a meeting was held with the patient's father and a representative from the precinct. Patient repeated his story which was of concern to his father. During the observation in the unit without taking any medications, patient was appropriate in interaction, calm and not agitated. He denied any suicidal or homicidal ideations. He was not experiencing any

paranoid ideations, but was concerned about issues in the precinct. After observation for a few days on the unit, there were no significant psychiatric symptoms to treat with medications.

Patient was discharged on his own on 11/6/09 with recommendation to follow-up with the psychotherapist and, if he becomes symptomatic, to see a psychiatrist for medication.

DIAGNOSIS ON DISCHARGE:

Axis I: Adjustment disorder with anxious mood.
Axis II: Deferred.
Axis III: None.
Axis IV: Related to stress at job.
Axis V: On admission 40; on discharge 65.

Isak Isakov, MD

II:rps
D: 3/22/10
T: 3/26/10
7070

SCHOOLCRAFT, ADRIAN
M/R: 1298984 PT#:130381874
DOB: [redacted]/1975 34Y M F/C: 19 S
ADM:11/03/2009 15:00 03MH9HAL 01
HOVANESIAN, SUSHAN

PROGRESS NOTES

DATE & TIME	START MD NOTES HERE	START RN AND ALL OTHER NOTES HERE
11/6/09	Focus	Nursing Discharge Summary Notes
	Data	Patient Discharge Date to Home, Home w/ Homehealth, Referral PMR Facility adult, Home Skilled Nursing Facility (SNF) Specialized Facility other
		Patient left unit via Ambulatory, wheel chair, stretcher accompanied by: father
		Mental Status: A x O x 3
Assessment: Condition of patient upon discharge related to admitting diagnosis and or problem(s) on Admission or during hospitalization (pertinent physical psychosocial behavioral assessment e.g. skin condition, breathing pattern, presence of pain condition s/p surgery)		Pt is calm and in Control. Denies SI/HI. Denies AVH.
		Accomplished Goals (NCP & Teaching Goals)
		Pt verbalized importance of follow up care. D/C instructions given to pt and pt verbalized understanding of D/C instructions.
		Signature: [signature] **Title:** RN

JAMAICA HOSPITAL MEDICAL CENTER

8900 VAN WYCK EXPRESSWAY, JAMAICA, N.Y. 11418

PROGRESS NOTES

SCHOOLCRAFT, ADRIAN
M/R: 1298984 PT#: 130381874
DOB: [redacted]1975 34Y M F/C: 19 S
ADM: 11/03/2009 15:00 03MH 8HAL 01
HOVANESIAN, SHUSHAN

Inpatient Psychiatry: Social Work Discharge/Transfer Summary

Patient Description: Pt. is a 34 year old Caucasian male w/ hx known Psych. hx who was BIB EMS/NYPD after his colleagues and superiors in the NYPD became concerned about his behavior

Date of Discharge/Transfer: 11/6/09

Discharge Destination (✓Check One):

☐ Home ☐ State Psychiatric Hospital ☐ Inpatient Substance Abuse Treatment
☐ Skilled Nursing Facility ☐ Supportive Housing ☐ Other:_____

(Please provide details)

Aftercare:
☐ Mental Health Clinic ☐ Assertive Community Treatment Team
☐ Continuing Day Treatment ☐ Partial Hospitalization Program ☐ Assisted Outpatient Treatment
☐ Case Management ☑ Other: Private Psychiatrist

(Please provide details):
Pt. will contact Dr. to make appointment.

Mode of Transport: ☐ Self ☑ Family/Friend ☐ Motor Transport ☐ Ambulance ☐ Ambulette

(Please provide details)

Medications: ☐ Prescriptions ☐ Medications ___week supply

(Please provide details:)
None - Pt. on no Meds.

Additional Comments/Referrals: ☐ Financial Office ☐ SSI/SSD ☐ Medication Grant Program

☐ Resource Lists given:

Pt. is Open, pleasant, cooperative. No problems. He is appropriate in his affect and behavior. Denies feeling depressed, anxious, suicidal/homicidal. Denies manic sx. Denies AH/other hallucinations @ present. Pt. has been recommended to see an outpatient psychiatrist and he agreed to do so.

☐ Please see Progress Notes for Additional Information

Social Work Signature: Christine McMahon, LMSW Date/Time: ~~10~~ (CW error) 11/6/09 - 1:35 p.m.

WHITE COPY – MEDICAL RECORD YELLOW COPY – SOCIAL WORK DEPT.

FO 000121 REV.3/08

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418 • 718-206-6000
Department of Psychiatry
INPATIENT DIVISION

SCHOOLCRAFT, ADRIAN
M/R: 1298984 PT#: 130381874
DOB: [redacted]/1975 34Y M F/C: 18 S
ADM: 11/03/2009 15:00 03MH 9HAL 01
HOVANESIAN, SHUSHAN

SOCIAL WORK CONTINUING-CARE AGREEMENT

Dear Mr/Ms/Mrs Schoolcraft :

Your Social Worker, in collaboration with the Interdisciplinary Treatment Team, worked with you in developing the following plan.

You will reside at: 82-60 88th Pl. Glendale, N.Y. 11385

The following appointments/referrals were scheduled for you:

Outpatient Program:

1. *Clinic/Private Referral:* Dr. Lurel – (917) 921-3264 (Private Psychiatrist) – 14-06 Queens Blvd.
2. *Continuing Day Treatment Program:* Forest Hills, NY. 11375 11/7 - 12:30 p.m. w/ Dr. Lurel office 891
3. *Partial Hospitalization/Intensive Psych Rehab:* _____
4. *Other Clinic:* _____

Income Maintenance Center: _____

Social Security Administration: _____

Case Manager's Name: _____

Other: _____

I agree with and have received a copy of the above Discharge Plan.

[signature] (718) 570-6224 Christine McMahon, LCSW 11/6/09
Patient Signature *Tel. No.* *Social Worker Signature* *Date*

_____ _____
Family/Guardian Signature [if applicable] *Date*

FO256 12/95

WHITE MEDICAL RECORD YELLOW SOCIAL WORK

Jamaica Hospital Medical Center

DISCHARGE INSTRUCTIONS

SCHOOLCRAFT, ADRIAN
M/R: 1298984 PT#: 130381874
DOB: [redacted]/1975 34Y M F/C: 19 S
ADM: 11/03/2009 15:00 03MH 9HAL 01
HOVANESSIAN, SHUSHAN

PHYSICIAN: Isaac Isquith
DISCHARGE DATE: 11/6/09 TIME:
DIAGNOSIS: Adjustment d/o with anxiety
ALLERGIES: NKDA

Call your doctor or come to the ER if you develop:

MEDICATIONS: PRESENT LIST OF MEDICATIONS TO YOUR PROVIDER
Attention Physicians: All Drugs Written Below must be Noted in the Discharge Note

NAME OF DRUG	DOSAGE	ROUTE	FREQUENCY

☐ Smoking cessation advised.

☐ Medication reconciliation was performed

PHYSICIAN'S REFERENCE ONLY FOR PATIENTS WITH AMI/CHF — Ejection Fraction: ____

Check off those medications deemed contraindicated at the time of discharge:
☐ Ace Inhibitor ☐ ARB ☐ Beta Blocker ☐ Aspirin

Diet: ☐ Low Salt • Avoid high sodium food (canned vegetables & soups, frozen dinners, crackers, deli food, fast food, soy sauce, fried food, etc.) • Add no salt when cooking or eating • Read food labels for sodium amounts • Check with doctor before using salt substitutes

☐ Limit daily fluid intake to _____ quarts ☐ Other: _____

☐ Diabetic: _____ Always eat lean meats, whole grains, fresh fruits and vegetables

☐ Weigh yourself each morning • Same time, after you empty your bladder • Same scale & amount of clothing • Show your log to your doctor • Weight gains mean you are retaining fluid • Report weight gains of 2-4 lbs. over 1-3 days

Activity and Exercise: as tolerated

Immunizations | Pneumococcal ☐ Given ☐ Contra/not-indicated ☐ Pt. refused | Influenza ☐ Given ☐ Contra/not-indicated ☐ Pt. refuse

APPOINTMENT WITH: ☑ Private MD ☐ JH ACC ☐ MediSys Center Dr. Lyel Date: 11/7 Time: 12:30 pm

REFERRAL TO: ☐ Visiting Nurse/ Home Care ☐ Social Service ☐ Other(s): _____

Other Required Follow-up if any: Dr Lyel private psychiatrist

PHYSICIAN'S SIGNATURE: [signature] Date: 11/6/09 Time: _____

NURSE: [signature]

NURSE'S SIGNATURE: [signature] Date: 11/6/09 Time: 2:15p

I have received discharge instructions and understand the information that has been given to me.

PATIENT/SIGNIFICANT OTHER:	Signature: [signature]		Date:
SIGNIFICANT OTHER ONLY:	Print Name:		Relationship:
INTERPRETER:	Print Name:	Signature:	Date:

WHITE - MEDICAL RECORD YELLOW - PATIENT'S COPY

1357 – Form 214 Revised 04/04, 06/05, 10/05, 3/08

Jamaica Hospital Medical Center Triage

Category: 3 ESI-3 (Urgent) | ID: 130381015

10/31/2009 23:03	23:03		23:03

Transported by: JHMC Ambulance | Mode: Stretcher

NA

Self

Police Dept — Custody Yes | Notification | Beat # PCT- 81, #27009

Abdominal Pain (Lower) | 14 Hour(s)

Denies vomiting and diarrhea. Pt under police custody, Pt became anxious with increased BP @ the scene.

SCHOOLCRAFT,ADRIAN

1298984

130381015

[redacted]1975

34 Years

Male

Additional:

☑ No Significant PMHx

☐ Asthma ☐ COPD ☐ CAD ☐ Cancer ☐ CHF ☐ CVA
☐ DM ☐ HTN ☐ Psych ☐ Renal ☐ Seizures

☑ No Meds ☐ Unknown

No Known Drug Allergies

UTD

TB Hx, PPD Pos or Infectious Exposures? No

*If yes to TB or Infectious question take precautions

Oriented

	R	L
Clear	☑	☑
Diminished	☐	☐
Wheezes	☐	☐
[illegible]	☐	☐
[illegible]	☐	☐
Retractions	☐	☐

	R	L
Equal	☐	☐
Reactive	☐	☐
Fixed	☐	☐
Constricted	☐	☐
Dilated	☐	☐
Cataract	☐	☐

Eye
Verbal
Motor
Total 0

G	P	Ab	Miscarriages
0	0	0	0

Color Normal
Temp Normal
Moist Normal

Pulses

ROM

Temp
Oral 99.0
Rectal
Tympanic

Pulse
Right
Left 115

Respirations 18

Blood Pressure
Right
Left 139/80

Pulse Ox 97%

Weight (Kg) 109 Kg

Height | Head Circumference

Pain Scale: Mild 3 - 4

Normal

No Fall Risks Identified

No risk identified

Are you being hurt by someone you live with or who takes care of you? Yes/No No

* Mandatory completion of Domestic Violence Referral.

A3-09 23:03

Triage Nurse: Ledbetter, Glenda (RN)

Triage II: GLE

Triage III: GLE

Daily Living Independent

Living Conditions Alone

Going Home with Self

Primary Language English
Assessed Disability No Disability
Communication Barrier ☐
Language Translator ☐
Motivation Level Med
Knowledge Level Med
Comprehension Ability Med

☐ VBS ☐ LW Completed Tx/ Eloped ☐ AMA ☐ AMA Refused ☑ Patient Rights and Responsibilities and Guide to Pain Management given to Patient, Family, and/or Caretaker

JAMAICA HOSPITAL MEDICAL CENTER
PATIENT HISTORY & ASSESSMENT
PSYCHIATRIC NURSING

SCHOOLCRAFT, ADRIAN PT#: 130381874
M/R: 1298984 P/C: 19 S
DOB: [redacted]1975 34Y M
ADM: 11/03/2009 15:00 03MH 9HAL 01
HOVANESIAN, SHUSHAN JJ 015

I. ADMISSION

Date 1/3/09 Time _____ PER
Information Received From: ☐ Patient ☒ Other Language Spoken English

Age 34 Religion None. Previous Jamaica Hospital Admission ☒ No ☐ Yes Date _____

Admitted via: ☐ Wheelchair ☒ Stretcher ☐ Other _____ Admission: ☐ Elective ☒ Emergency
From: ☐ Home ☐ Nursing Home ☒ Other TRANSFERED FROM MER → PER

Prosthesis/Assistive Devices ☐ Eyeglasses ☐ Contact Lens ☐ Hearing Aid None
Dentures ☒ None ☐ Lower ☐ Upper ☐ Full ☐ Partial ☐ Denture Cup Provided ☐ Other

Instructions to Patient ☑ Call Light ☒ Bed Control ☒ TV ☒ Telephone ☐ Sideralls
☒ Smoking Rules ☒ Visiting Hours ☒ Valuables Procedure

T 98.6 P 78 R 20
BP 130 Ht 6' 0" Wt 210

Nursing Staff Admitting the Patient Sharon Barnaby Title RN 80

II. ADMISSION DATA

Admitting Diagnosis Psychosis NOS General Appearance (emaciated, well developed, obese, thin) _____

Patient's Chief complaint (as stated by patient, onset, duration, list of symptoms and characteristics)
I was taken out of my house by my boss

Previous health History

PAIN ☒ No ☐ Yes (If Yes circle intensity)

0 1 2 3 4 5 6 7 8 9 10

Description _____
(Location & Duration)

Previous Blood Transfusion ☐ No ☐ Yes When _____

Blood Transfusion Reaction ☐ No ☐ Yes
If YES Specify _____

Allergies: Medication/Food/Environmental ☒ No ☐ Yes
If YES Specify _____

Prescribed medication ☒ No ☐ Yes

Over-the-counter medications ☒ No ☐ Yes

Herbal Medications/Alternative Treatments
☒ No ☐ Yes

Medication Taken Prior to Admission ☒ No ☐ Ye
None

Medications brought to hospital/disposition
N.

VACCINATIONS Pneumococcal ☑ No ☐ Yes Date Received _____ Influenza ☒ No ☐ Yes Date Received _____

PSYCHO-SOCIAL ASSESSMENT

Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Occupation NYPD Officer ☐ Retired, Prior Occupation _____
Cultural Beliefs / Practices Denies
Substance/Alcohol Use ☐ No ☐ Yes Explain _____
Smoke ☒ No ☐ Yes Frequency _____ second hand smoke ☒ No ☐ Yes
Living Arrangement: Live with Alone Person to Assist You after Discharge Ma.

Home Factors Affecting Hospitalization (Children, elderly, parent(s), pets, ailing family member/significant other) _____

Home factors affecting discharge ☐ Private home ☐ Apartment house ☐ Nursing home ☐ Other _____

III. REVIEW OF SYSTEMS

HEENT 1. Head ☑Denies complaint ☐Headache ☐Facial Pain ☐Other

2. Ear ☑Denies complaint ☐Hearing Loss – explain _____ ☐Discharges ☐Ear ache

3. Eyes ☑Denies complaint ☐Impaired vision ☐No ☐Yes ☐O.D. ☐O.S. ☐O.U. Explain_____

4. Nose/Sinus ☐Denies complaint ☐Discharges ☐Epistaxis ☐Pain

5. Throat ☑Denies complaint ☐Hoarseness ☐Sore Throat ☐Laryngitis ☐Other _____

CARDIO-RESPIRATORY ☑Denies complaint ☐Chest pain ☐Nocturnal dyspnea ☐Diaphoresis ☐Pleuritic pain ☐Cough ☐Sputum ☐Hemoptysis ☐Wheezing ☐Dyspnea ☐Edema ☐Hypertension ☐Palpitation

GASTROINTESTINAL ☑Denies complaint ☐ Hematemesis ☐ Tarry stools ☐ Heartburn ☐ Hemorrhoids ☐ Jaundice ☐ Weight loss ☐ Mouth sores ☐ Thirst ☑ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation

GENITO-URINARY ☑Denies complaint ☐ Nocturia ☐ Retention ☐ Burning ☐ Frequency ☐ Urgency ☐ Enuresis ☐ Discharge ☐ Ostomy ☐ Oliguria ☐ Dysuria ☐ Stones ☐ Pain ☐ Polyuria ☐ Incontinence ☐ Hematuria ☐ Hesitancy

1. Female History Age at menstrual onset_____ LMP_____

Regularity ☐ No ☐ Yes Duration_____ Date of last Pap Smear_____

Vaginal bleeding/discharge ☐ No ☐ Yes Mammogram ☐ No ☐ Yes Date_____

Last Breast exam ☐ No ☐ Yes Date_____ Last rectal exam ☐ No ☐ Yes Date_____

Post-menopausal bleeding ☐ No ☐ Yes Menopause age_____

2. Male Genital Tract ☐ Penile discharge ☐ Lesions ☐ Testicular pain ☐ Swelling Denied

MUSCULO-SKELETAL ☑Denies complaint ☐ Muscle pain ☐ Sprains ☐ Neck pain ☐ Deformity ☐ Stiffness ☐ Fractures ☑ Extremity pain ☐ Limited range of joint motion ☐ Redness ☐ Back pain

ENDOCRINE ☑Denies Complaint ☐ Goiter ☐ Heat/cold intolerance

NEUROLOGY

Mental Status: Oriented to ☑Time ☑Place ☑Person ☐Anxious ☐Lethargic ☐Disoriented ☐Stuporous ☐Comatose ☐ Denies complaint ☐ Tremor ☐ Muscle atrophy ☐ Muscle tenderness ☐ Headache ☐ Convulsions ☐ Syncope ☐ Epilepsy ☐ Paralysis ☐ Dizziness ☐ Paresthesia ☐ Ataxia

PSYCHIATRIC HISTORY AND ASSESSMENT

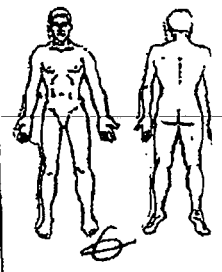
A. Appearance: Neat
B. Behavior: Calm Co-operative.
C. Mood/Affect: Calm
D. Hallucinations: Yes ☐ No ☐ Describe _____
E. Delusions: Yes ☐ No ☐ Describe _____
F. Paranoid Thoughts: Yes ☐ No ☐ Explain _____
G. Suicidal: Yes ☐ No ☐ Explain _____
H. Homocidal: Yes ☐ No ☐ Explain _____
I. Recent impulsive/Unpredictable behavior: Yes ☐ No ☐ Explain _____
J. Use of restraints/seclusion prior to unit admission: Yes ☐ No ☐ Explain _____

IV. FALL RISK ASSESSMENT

Directions: Use the following assessment tool to identify patients at risk for falls. Circle the score for each risk factor that applies to your patient. Patients with a score of 6 or more must be placed on the fall prevention program (Spot the Dot).

RISK FACTORS	SCORE
Age 65 & older	5
History of previous Falls	5
Mental Status: Dementia;Psychoses; Delirium Tremens; Seizures	6
Debilitation/weakness/cachexia	5
Communication Deficits: Dysarthria; Aphasia; No verbalization; Language barrier	1
Mobility Deficits: Hemiparesis; Paraparesis; Hemiplegia; Paraplegia; Ataxia; ; Use of prosthetic devices; Use of cane/crutches; Amputee; Parkinson's disease	5
Visual Deficits: Blindness; ❖ Blurred vision; Night blindness; Post-op eye surgery ❖ Use of eye glasses /contact lenses	5 1
Medications: ❖ Barbiturates; Tranquilizers; Parenteral Pain meds; Hypnotics; Anesthetics ❖ Antihypertensives; Diuretics; Laxatives; PO/Patch Pain Meds, Eye gtts, pain p.o./patch.	5 1
Alteration in bladder function ❖ Medical/Surgical (pt/ with FC, incontinent of urine) ❖ Rehabilitation Unit (pt. bowel/bladder program)	1 5
Auditory Deficits	1
Orthostasis/Hypotension ❖ Syncopal episodes ❖ Vertigo	5
RISK ASSESSMENT SCORE	0

Skin Turgor	Skin Color	Skin Condition	MARK SITE OF ABNORMAL SKIN FINDINGS ON DIAGRAM BELOW P50
☑Normal	☑Normal	☐Moist	
☐Poor	☐Pale	☐Dry	
	☐Cyanotic	☑Warm	
	☐Jaundice	☐Cold	
		☐Abrasions	
Mucous Membrane	Nails	☐Ecchymosis	
☑Pink	☐Normal	☐Blisters	
☐Pale	☐Pale	☐Rash	
☐Cyanotic	☐Cyanotic	☐Edema	
☐Moist	☐Clubbing	☐Burn	
☐Dry	☐Brittle	☐Pressure Ulcer	
	☐Other		



V. PRESSURE ULCER RISK ASSESSMENT

Directions: Use the following assessment tool to identify patients at risk for pressure ulcers. Circle the score for each risk factor that applies to your patient. The care plan should be initiated for a patient with a score of 5 or more.

RISK FACTOR	ASSESSMENT INDICATOR	SCORE
Age	<65 >65	0 1
Mobility	Ambulatory, bed rest < 3 days Ambulatory only w/assist; bed rest > 3 days restrained Non-ambulatory, quadriplegic, paraplegic, hemiplegic	0 1 5
Pattern of Elimination	Fully continent Fully incontinent of urine or feces Fully incontinent of urine and feces	0 2 3
Mental Status	Fully oriented Confused, disoriented Comatose	0 2 5
Nutritional Status	Good; feeds self Feed w/assist; TPN, tube feeding Cachexia, obese, NPO > 3 days	0 2 4
Skin	Intact Poor turgor, dry, cracked/peeled areas, inflamed areas, pressure ulcer	0 5
Health Status	Good Fair Poor Moribund	0 2 3 5
RISK ASSESSMENT SCORE		0

VI. FUNCTIONAL SCREEN

If score is 6 or more, notify physician

Assessment Indicator		SCORE
Transfer skills Bed-Chair	Total assist Moderate/minimum assist Independent	3 2 0
Ambulation skills Bed-Bathroom	Total assist Moderate/minimum assist Independent	3 2 0
Self care skills Feeding/Eating	Total assist Moderate/minimum assist Independent	3 2 0
Toileting	Total assist Moderate/minimum assist Independent	3 2 0
Dressing/ Hygiene	Total assist Moderate/minimum assist Independent	3 2 0
Range of motion all extremities	Total assist Moderate/minimum assist Active	3 2 0
TOTAL SCORE		0

VII. NUTRITION SCREEN

If score is 6 points or more, a Nutrition consult must be reported to the Nutrition Department via telephone ext. 403 or enter into the computer.

Risk Associated Parameters	SCOR
Weight loss/gain last 30 days: + or – 10 lbs.	6
Pressure Ulcer: any stage	6
Feeding/swallowing difficulty	2
Nausea and vomiting > 3 days	3
Food Allergy/Intolerance	1
Pre-hospital diet/diet restriction: Diabetic, Renal	2
Tube feeding, Parenteral	6
Socio/Cultural/Religious needs relating to nutrition	1
TOTAL SCORE	0