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SH6001 (2 of 2), Rev 10, 02/06 Copyright 2001- 2006 ScanHentih, Inc. (Page 2)	EH .	6001 (24	7 21. F	Rev 1	10. 0	2/08				<u>_</u>		Copy	vright	200	1- 20	Q6 S	canhi	epith	, Inc.			1 L.	<u>.</u>					(P	990	2)		



SCHOOLCRAFT, ADRIAN 1298984 M DOB: 081X STAFE, PHYSICIAN

ADM: 10/31/2009 130381015

#### **CONSULTATION REPORT**

THIS SECTION TO BE FULLY COMPLETED BY THE	REQUESTING PHYSICIAN
REQUEST TO: Dr. Patel / Dr. Livin	DEPTIDIVISION: Prychistry & R
REQUEST FROM: Dr. NWaishia nyii	DEPTIDIVISION: Medical SLR
IMPRESSION: psycholic disorder, NOO	
REASON FOR CONSULTATION:	
CONSULTATION ONLY CONSULTATION WITH ORDERS	CONSULTATION WITH FOLLOW-UP
SIGNATURE:	DATE: 4/1/09 TIME: 6:30 am
OPINION OF CONSULTANT:	
34 years old ringle white mole,	police officer, living by
himself was brought in by NYP.	D of 81" Premint, in
hand ent to medical ER with a	emplaint of sholominal
hand cold to medical ER with a	patient Ataked he took
Nyauil.	
lych consult was called and repo	irted as patient acting
hizzare, hand culted and in I	Police enotody.
the new patient, he was not peeling	well questionally, head
funny pain / Abdomiral pain and tol	ld his apprecion that ha ,
leaving Patient ways while deeping	
open the door and his colleagues	
and braight him to Tamaica harpi'l	tal, He rays he is worried
short the situation going on. days	this is hoppening become
he has been reporting to his superior	ors and committed oney about
internal ellistes of politice department	nt. Pays he knows his
superview supervisors are hiding rol	bbery and amoust cases to
get higher reanhor/ porition, soys h	he has poper documentation
about this orime and reporting	since last year.
•	> continhe

Signature:

**ORIGINAL - MEDICAL RECORD** 

**CARBON COPY - CONSULTANT** 

Date:

Time:

FORM: 110 TTEM: 849 REV. 1/07

Consultant Print Name:



SCHOOLCRAFT, ADRIAN 1298984 M DOB: ADM:10/31/2009 081X STAFF, PHYSICIAN 130381015 01

### CONSULTATION REPORT CONTINUATION

Denier nest may hornitalization for treatment com missidal
denies post psy haspitalization (or) treatment cons unicidal attempt.
As per Jargent James of 81st Precint . nationt complain
As per Jergent James of 81st precint, patient complains of not feeling well genterday afternoon and left his work
early after getting agitated and curring supervisor. They
follow hi'm home and he had barricaled himself and
The door had to be broken to get to him. It e initially
the door had to be broken to get to him. It initially egreed to go with them for evaluation but once outvide,
he ran and had to be chosed and brought to The
medical E12, Landenfled.
In the medical ER, he became agitated, uncooperative
and verbally abasive over telephone use and hold his
Treating MD that ' they are all against me! Ho land
As per Jergeont Former, Le won exclusted by NYPD
prychiatrist and can not carry a gun or a badge for
nearly a year.
Denier any drug (or) Alcohol abuse
Denize any history of Jamily mental illhers
No acute medical problem, complained of abdomited
pain yesterday and has rinunitis.
Mental Atata Examination - 34 years old, white mole
appropriately dressed and groomad, appears to his stated age.
He is coherent, relevant with goal directed speech and
good eye confact. He is irritable with appropriated abbect.
He denies hallowinstion . He is ? paranoid about his
supervisor. He denies suicidal ideation, homicidal ideation of
Cure
Consultant Print Name: Signature: Date: Time:
A Maria and a second a second and a second and a second and a second and a second a

ORIGINAL - MEDICAL RECORD

**CARBON COPY - CONSULTANT** 

MORM- HO TOM- 1974 DEV 1/07



SCHOOLCRAFT, ADRIAN
1208884 M DOB:
110/31/2009 081X 130381015 01

#### CONSULTATION REPORT CONTINUATION

	AL RECORD CARBON		
Consultant Print Name:	Skgnature:	Date:	Time:
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A		Psychiatric Resid	ent
		Khin Mar Lwin	MD
che discussed with	Dr. Patel	0	·
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and escape risk	100 100	MARIETER	DZPAVIOL
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Diagnosis	As a language		
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The present Time His	memory and conc	entration is	intact.
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SCHOOLCRAFT, ADRIAN 1288984 M DOB: T ADM:10/31/2009 081X STAFF, PHYSICIAN JAMAICA HOSPITAL MEDICAL CENTER 130381015 01 PATIENT CLOTHINGWALUABLES INVENTORY 1. ALL PATIENTS CLOTHINGWALUABLES/SENT HOME \_ **2**1\_NO YES YES D NO 2. DENTURES TAKEN HOME BY FAMILY MEMBER TRAUSFER TRANSFER [ADMISSION DATE/THE UNIT CLEAT SU BOOM INVENTORY OF ITEMS KEP AT BEDSIDE UPPER DENTURE ABELED CUP PROVIDED u/ LABELED CUP PROVIDED LOWER LABELED CUP PROVIDED PARTIAL COATMACKET DRESSMOUSECOAT PAJAMAS/NIGHTGOWN. SLACKS/PANTS/JEANS PLOUSET-SHETT/SWEATER SIGRT/SHORTS ٥ UNDERWEAR/BUT GLASSES/CONTACTS HATEL TENTERELT PASIEMIONE/SOCKS ø EATHROSE CHOES/SNEAKERS BIOOTS/SLIPPERS POCKETBOOK CELL PHONE/BEEPER(S) WALKER/CANE HEARING AID OSPITAL MEDI SCHOOLCRAFT, ADRIA 128984 M DOB:1 ADM:10/31/2009 081X STAFF, PHYSICIAN OTHER: EXPLACELET (8) EARRING (8) RING (S) 0 OTHER: MONEY AMOUNT VALUABLES SUBMITTED TO THE CASHIER AND VALUABLES PLACED GLASSES/CONTACT(S) HEARING AID POMETRICKY WALLEY RADIO CELL PHONE/BEEPER OTHER: ENVELOPE RECEIPT ISIBLE FOR ITEMS LEFT AT THE PATIENT'S BEDSIDE( Print N " PLEASE NOTE THE INSTITUTION IS PATIENTISIGNIFICANT OTHER: STAFF RECEIVING PROPERTY

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

White Copy : Medical Record

RELATIONSHIP:

Yellow Copys Nursing Pl ......

SEC:URITY/CASHIER SIGNATURE: STAFF NEMBER RELEASING PROPERTY:

22731-FORM 554

PATIENT/FAMILY MEMBER RECEIVING PROPERTY:



SCHOOLCRAFT, ADRIAN 1298984 M DOB: 11976 34Y F/C: 01 ADM: 10/31/2009 23:03 081X 1303810 STAFF, PHYSICIAN 130381015

Authorization to Jamaica Hospital for release of information:	•
hereby authorize and direct Jamaica Hospital having treated who are financially liable for my hospitalization and medical care, medical care and to permit representatives thereof to eand treatment.	me, to release to governmental agencies, insurance carriers, or others all information needed to substantiate payment for such hospitalization and examine and make copies of all records relating to such care
Date	Signature of Petient or Authorized Representative
Assignment to Jamaica Hospital	
hereby assign, transfer, and set over to Jamaica Hospita governmental agencies, insurance carriers, or others who are costs of the care and treatment rendered to myself or my depende	i sufficient monies and/or benefits to which I may be entitled from financially liable for my hospitalization and medical care to cover the man said hospital.
Date	Signature of Insured or Authorized Representative
Bafe Medical Device Act	
he event that a medical device, which is implanted in my body,	nufacturer of any device that must betracked pursuant to the mandates of Mill be given my social security number only for the purpose of finding me in or used in my home is defective.
Date	Signature of Insured or Authorized Representative
certify that the information given by me in applying for the paymodder of medical or other information about me to release to the State Intermediaries or carries any information product for the State Intermediaries or carries any information product for the State Intermediaries or carries any information product for the State Intermediaries or carries any information product for the State Intermediaries or carries any information and the State Intermediaries or carries and intermediaries or carries or carries a	Social Security Administration and Health Care Financing Administration or
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certify that the information given by me in applying for the paymoder of medical or other information about me to release to the state intermediaries or cardes any information needed for this or a remade on my behalf. I assign the benefits payable for the physician or organization to submit a claim to authorize such physician or organization to submit a claim to a Date  Date  Financial Agreement  For and in consideration of services rendered or to be rendered undersigned (jointly and severally, if more than once) hereby against a submitted by the Hospital on the account of said payable as submitted by the Hospital on the account of said payable as all Hospital, it is further agreed that the charges as incurred accordance with the posted charges of the Hospital which are failure to demand payment of the patient shall not be a prerequisition.	isted Medicare dalm. I request that payment of the authorized benefits be iclan services to the physician or organization furnishing the services or Medicare for payment on my behalf.  Signature of insured or Authorized Representative  if by the Jamaica Haspital, to the patient whose name appears below, the gree(s) to be fully and totally responsible to the hospital for payment of alternat and make payment in accordance with the policy of payment of bills of represent the fair and reasonable value of services rendered and are in a valiable upon request. Payment may be demanded at any time, and to my (our) immediate responsibility for payment.
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SCHOOLCRAFT, ADRIAN 1298984 M DOB: ADM: 10/31/2009 081X

STAFF, PHYSICIAN

01 130381015

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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	WITNESS
SIGNATURE:	SKINATURE
PFINT NAME	PRINT NAME
RELATIONSHIP, IF SKINED BY PERSONOTHER THAN PATIENT	DATE
ARANTEE OF PAYMENT	
FOR AND IN CONSIDERATION OF SERVICES RENDERED OR TO PAY THE JAMAICA HOSPITAL, THE FULL AND ENTIRE AM I HEREBY AUTHORIZE THE HOSPITAL TO RELEASE ALL MED TREATMENT.	TO BE RENDERED TO THE HEREIN NAMED PATIENT, I DO HEREBY GUARANTEE OUNT OF ANY AND ALL BILLS RENDERED FOR SAID TREATMENT. NOAL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH CARE AND
PATIE TIRELATIVE OR GUARDIAN	WITHESS
NATURE	SIGNATURE
PR NT NAME	PRINT NAME
RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT	DATE
CARE TO COVER THE COSTS OF THE CARE AND TREATMEN  PATIENT/REVATIVE OR GUARDIAN	NICA HOSPITAL SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED IS, AND OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL IT RENDERED TO MYSELF OR MY DEPENDENT.  WITNESS
	MINEGO
SIGNATURE	SIGNATURE
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relationship, if bigned by Perbon Other than Patient	DATE
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	FORM NO. J00018-2C



#### 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 3900 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 suthorize 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.

Form No. J00023



SCHOOLCRAFT, ADRIAN 1298984 M DOB: 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
my health plan. I authorize my HMO, insurer, or treatment records, including my name and other admission, assessment results and history even	cause of a retrospective adverse determination of provider to release all relevant medical or personal identifying information, date of
information, or alcohol/substance abuse treatm appeal, to the external appeal agent I sutbody	riv-related information, mental health treatment tent information, related to my provider's external
minumation solely to make a determination on r	ny provider's appeal.
that information disclosed pursuant to this authorized regulations, however, state privacy prof	ections may still apply. I understand that my ent, eligibility, or payment on whether I sign this
This release is valid for one year from	(today's date).
- W	_
Signature of Patieni (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.



#### Patient Fact Sheet

Name and Address	Employer
SCHOOLCRAFT, ADRIAN	UNEMPLOYED
82 60 88 PL	
RIDGEWOOD NY 11885	
(718)570-6224 S-sx; M	Phone: (959)989-8999
Marital Status S	
Race: W Religion NO	
BirthDate: 1975 (recupation: UNEMPLOY	YED
Patient's Maiden Name:	·
Nearest Relative	Admission Data
SCHOOLCRAFT, SELF	
82 60 88 PL	
RIDGEWOOD NY 11385	Admit Date Admit Time ER MD
Home Phone: (718)570-6224 Ref: 01	10/31/2009 23:03 FF, PHYSI
Business Phone:	Triage Time Prim Care MD
esouvee CHUII9.	NA .
Guarantor	Emergency Contact
SCHOOLCRAFT, ADRIAN	SCHOOLCRAFT
82 60 88 PL	SOLO SESIVAL I
RIDGEWOOD NY 1385	
Home Phone (718)57C-6224	Home Phone: (718)570-6224 Rel: 01
Business Phone	Business Phone:
Rel: 01 <b>SS:</b> 999-99-999	evinitudes Litritia.
Occ: UNEMPLQYEI)	
Employer UNEMPLOYED	
Insurance Information	
ine: NO COVERAGE/CHARITY CA Insured:	SCHOOLCRAFT, ADRIAN
Policy Number: Group Number:	
82 60 88 PL	
RIDGEWOOD NY . 11385	√,
Phone Number (718)570-6:224	FIN 99
Auth Number	

Patient Name SCHOOLGRAFT, ADRIAN
Account Number 130381015

Medical Récord No. 1298984

Date 10/31/2009

(D 130381015

#### **Jamaica Hospital Medical Center**

Emergency Departmen: Record History of Present illness 34 Year Old Male Petent Presents with Accommal Pain Epigastric for 15 Hour(s). The Onsel is Sudden, The symptoms are filld, sharp, intermittent, unknown duration. Symptoms Improve with without treatment. Additional Symptoms or Particent History also involve. None. Furthermore, the Patient/Family Deales Anorsta; Feer; Genital Pain; Back Pain; Patient states exacerbating Factors that occur are ulknown. Radiating Symptoms include No Radiations. Patient is a Police Officer brought in handcuff by his colleagues. As per Patient he wearn feeling well about 16hrs ago and at about 2 pm he told his superiors that he was leaving for home. His colleagues from his Prescinct went to his home and hand outfloecause the EMS said Patient was behaving Review of Systems (Symptoms and Signs not covered in the HPI) GU Neg Neuro Neo Etil Neg Resp Neg Musculoskeletsi Naci Hemistologic/Lymphatic Neg Skin Nes Psych Neo Heart Nea Gi Nea Endocrine Nea Allergic/immunologic Neg All other ROS negative Constitutional Sxs Neg Eyes Neg [] Hx unobtainable due to Tx ☑ Vital Signs/Triage/Nursing Notes Additional Information from Police, Old Medical Records Reviewed and Agree urgency or poor historian(s) Ambulance, Nursing Home or Relatives Past Medical History No Relevant PMHx . Asthma COPD CAD Cancer CHF CVA Other PMHx Diabetes ☐ HTN ☐ Psychiatric ☐ Renal ☐ Seizures Social History No Relevant SoHic ETOH Drugs Smoking Additional Sx No Relevant FmHx No Significant FMHx Family History Physical Exam Exam Time 0:05 General Appearance Awake A&Ox3 HEENT PERRL EOMI Most Mucous Membranes No Interus Chest RRR No M Lungs CTA No Ret Chest Wall NT Abdomen No Pulsating Masses 83-NL/No Brutts Tenderness-None GU Extremilles Throughout all extremities enythematous impressions on the wrist bilaterally at the site of handouffs application CBR < 2 sec Active ROM-Full mild tenderness on the wrist where the hancuffs were applied Neuro No pallor/ rashes warm & moist Skin NT no CVAT, Back Flexion 90 Back NT Full ROM No JVD Neck Repeat or Additional Clinical Notes MD SNW The following Life or Limb Threatening Differential Diagnosis were considered; 11/1/2009 Appendicitis; AAA Leaking or Rupture; Incarcerated Hernia; Mesenterio ischemia or Thrombosis; Myocardial Infarction or CAD; Testicular Ovarian or Salping Torsion; Large or Small Bowel Volvulus; Liver Fallure Pancreatitis; Rupture Viscous (Liver Spieen Bowel); Intraabdominal Abscess; Ectopic Pregnancy; Intussusception; Hemolytic Uremic Syndrome; SNW 0:03 Looks Comfortable; Not III Appearing; No Peritoneal Signs; Genitals Non Tender; 11/1/2009 No Hemias; No Pulsating Masses; Murphy's Sign Negative; McBurneys & Roysing Sign Neg: Femoral Pulses 2+ Bilaterally; Psoas Sign Negative; Obturator Sign Negative; 11/1/2009 SNW Pt Sx(s) improving. No Sx(s) or Objective findings that are life or Ilmb 0:14

threatening. Medically Screened and Stable for disposition(Transfer) from the ED.

Patient Name SCHOOLCRAFT, ADRIAN

Medical Record No. 1298984

MD Initials Time Diagnosth: Ordered Result Interpret GLE 10/31/200 23:10 Pulse O'x £7%	Result Roviewed RN By Initials Tim
GLE 10/31/200 23:10 Pulse O'K 67%	ON OLE 23:1
	ON OLC 2017
SNW 11/1/2009 0:12 Amylasc) Amylasc 44, Status	FRINAL SN VCA 0:14
SNW 11/1/2009 0:12 Troponin Cantel	SN VCA 0:14
11.0,Eo4-0.2,Bsao 87.6,MPV-8.6,RBO 0.0,Aba L.ymph-1.3	i.8.Hct-44.0.Platelois-281,Nss.4-82.4,Lymph-SN VCA 0:14 -0.7,Mono-5.7,McH-29.4,McHc-33.6,McV- -5.0.2,RDVV-13.7,Abs Baso-0.1,Abs Eos- A,bbs Mono-7,Abs Sags-10.1,Smear Review- sted RBC-0,NRBC Inst-0.00,Status-FINAL
1.0,G(1100se-94,Cs	38,K-4.1,CH104,OO2-24,BUN-14,CR-SN VCA 0:14 8-04,A8T-48,ALT-51,Alk Phos-57,Albumin- bin-8.2,Anion Gep-10.00,Bistus-Final
NRI 11/1/2009 0:22 Lipase Lipase Lipase-55, Status-F	FINAL SN NRI 0:33
Medical Orders	

MD Procedures	3		
Procedure Descrip	tion	Comments	
Time 8-67	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 ICO-9
Psychosis NOS	298.9 ICD-9

MD Disposition SNW

SNW

MD Time

Transfer Psychiatric ED

Admit to RN Date/

VCA 11/1/2009 **6:58** 

RN

6:58

Condition

6:56 6:56

Nwaishienyi, Silez (MO)

Stable

Other Physicians

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

Physician (Print)

Physician Signature

Patient Name SCHOOLGRAFT, ADRIAN
Account Number 130381015

Primary RN (Print) Calderone, Virnalyri (RN)

Medical Record No. 1298984

Date 10/31/2009

Other Nurses

Ledbetter, Glenda (RN)~Calderone, Vimalyn (RN)~Shanker, Koesmawade

(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

Time	Entered:	11/1/2009		4:52	Vitals Taken E	ly: NRI		
Temp	erature	Pulse		Bio	ood Pressure	Respirations	Pulse Ox	Pain Scale
Q	98.0	Right Left	81	R	125/77	21	100%	Discomfort 1-2
R		Leit		-				

Nursing Note	3			<del></del>
Time Hote Entered		RN Initials	Note	
11/1/2009	0:00	VÇA	Brought in per stretcher by EMT on Police custody, A & O x3, U quadrant abd. Pain 3-4/10 x 15 hrs ago. Denies nauses & vomitin BS(+) normosctive. Skin warm, moist, intact. w/ good capillary re	No.Abd. soft, non-tender.
11/1/2009	2:00	NRU	Noted w/ redness on the Rt wrist with the hand cuff.Poice office loosen a little bit yet refused.Will closely monitor for poor circulations.	r made aware & requested to lon.
11/1/2009	4:39	NRI	pt. Resting;A & O x 3, no distress, waiting for evaluation and disp	position under police custody.
11/1/2009	5:54	VCA	Payche consult in progress w/ recommendation to transfer to Pa cleared.Pt. Verbalized, "My wrist is numb, I dont feel anything if on bed.Avoid unnecessary movements.Conversant to his fathe	oht now."Encouraged to stay still
11/1/2009	<b>6</b> :58	VCA	Psyche ED made aware of pt. For transfer.ML pulled out.Awaitin	ng transfer.
Primary Nurse Diagra	igals		Primary Nurse Outcome	Achieved
Comfort, Altered			Demonstrate Decrease S & S	
Primary RN (Print)	Calderor	e, Virnallyr	(RN)	

Jamaica nospital Medical C	renter triage Categor	ツ 3 ESI-3 (Urgent)
	100 CO	
10/31/2009 23:03 23:03	23:03	SCHOOLCRAFT,ADRIAN
<b>建设建筑市、平洋市中港市</b>	Transported by Mode	With Great the contrary with a
None NA	JHMC Ambulanca Stretcher	1298984
Self Custody Yea N	oufication Beat # PCT-81, #27009	Thought that the first
		130381015
Abdominal Pain (Lower)	14 Hour(s)	1975
		34 Years
<b>建筑建筑。1000年1000年1000</b> 年1		
Denies vomiting and diarrhea. Pt under police cu	uslody, Pt became anxious with increased BP @ the s	scente.
		Marks 165
Additional:		Tem
No Significant PMFtx		Oral 99.0
	Cancer CHF CVA	Rectal
DM HTN Psych Penal	Seizuree 🔳 Substance Abuse	Tympanic
☑ No Meds 🔲 Unknown		Pulse
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		Left [115
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No Known Drug Alfergies	TB Hx, PPD Pos or	No 18
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	*If yes to TR or Infect	TOUS OURSTON
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I Chemistry and the second	Are you being hurt by someone you live with or who takes care of you?  Yes/No No ** Mandatory completion of	Primary Language English Assessed Disability No Disability
No Fall Risks Identified	Are you being hurt by someone you live with or who takes care of you? Yes/No No	Primary Language English Assessed Disability No Disability Communication Barrier
No Fall Risks Identified	Are you being hurt by someone you live with or who takes care of you?  Yes/No No ** Mandatory completion of	Primary Language English Assessed Disability No Disability
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Patient Name SCHOOLCRAFT, ADRIAN

Medical Record No. 1298984

Account Number 130381015

10/31/2009

### Emergency Department Pharmacy and Supply Charges

Interventions				· · · · · · · · · · · · · · · · · · ·
intervention Name	***	Commenta	Oharge Gode	
Haplock			•	
Diagnostics				
Diagnostic Ordered	- <u></u>		Charge Code	
Pulse Ox			0	
CBC			0	
Nurse LOS	5	612 APC	Charge Code	0

# **Jamaica Hospital Medical Center**

### Medication Reconciliation

Patient Name SC

SCHOOLCRAFT, ADRIAN

Medical Record No.

1298984

Account Number 130381015

Date of ED Visit

10/31/2009

Aliergies

No Known Drug Ailergies

Home Medications

Medications Administered in the Emergency Department

Medication Prescription provided on Discharge

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By Signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have illieratore been altyped of him health thoroughter assist me may be used and disclosed by the Hospital and the facilities have health thoroughter assist me small have I may obtain access to said control this information. I also acknowledge and another that i may request copies of departure notices explaining special between processions that apply to HIV-respect. Information, also be also stables abuse transfers information, means begin information, and genetic information through a significant for the use and disclosure of my health information to mean me may be apply for the business operations of the hospital, has suff, and the facilities listed at the back of this form.

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## AFFIRMATION OF PRIOR RACEIPT

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

Signature of patient or authorized representative Relationship to patient Date

THIS FORM IS PART OF THE MEDICAL RECORD



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08/06/2010 14:02:00 TTH JAMAICA HOSPITAL MEDICAL CENTER 8900 VAN WYCK EXPRESSWAY JAMAICA, NEW YORK 11418-2897

Pt. Name: ADRIAN SCHOOLCRAFT

MR#: 001298984 ACCT#: 130381015 Att Phys: NWAISHIENYI, SILAS DOB: (A) 1975 Age: 35Yr Sex: M Ord By: STAFF, PHYSICIAN

Location: Discharged

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

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Pt Name: ADRIAN SCHOOLCRAFT Location: Discharged MR#: 001298984 ACCT#: 130381015 Att Phys: NWAISHIENYI, SILAS DOB: 41/45/1975 Age: 35Yr Sex: M Ord By: NWAISHIENYI, SILAS

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

Pat Name: ADRIAN SCHOOLCRAFT

Loc: Discharged

Pat Numb: 130381015

Sex: M

Race: W

Att Phys: NWAISHIENYI, SILAS

DOB: (\*\*/1975

Age: 35Yr 

Department: 004210 LABORATORY SERVICES

Order: 00009564 TROPONIN-I LEVEL

Priority: S

Status: CANCELLED

Pt, Ord #: 0002 Req Date/Time: 11/01/2009 0012 Ord By: NWAISHIENYI, SILAS

Comment:

.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 DOB: ( ) 1975 Age: 35Yr Sex: M Att Phys: NWAISHIENYI, SILAS Ord By: NWAISHIENYI, SILAS Test: CBC WITH AUTO DIFFERENTA Status: FINAL Seq #: 0003 Page 1 of Collected: 11/01/09 0:12 By: J081X Received: 11/01/09 0:36 Lab#: D1010449 TEST RESULT ABN REFERENCE UNITS 12.3 WBC 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 80.0-94.0 MCV 87.6 fL MCH 29.4 27.0-31.0 pg MCHC 33.6 g/dL 32.0-36.0 RDW 13.7 11.5-14.5 \* MPV 8.5 fL 7,2-10.4 Platelet Count 251 130-400 K/uL Neutrophils Auto 82.4 H 44.0-80.0 \* Lymphocytes Auto. 13,0-43,0 11.0 **₽** L Monocytes Auto 5.7 2.0-15.0 Eosinophils Auto. 0.2 0.0-3.0 왐 0.7 0.0-3.0 Basophils Auto. 10.1 Segs, Absolute 2.1-8.6 K/uL Lymphs, Absolute 1.3 0.6-4.6 K/uL Monos, Absolute 0.7 K/uL 0.1-1.6 Eos, Absolute 0.0 0.0-0.9 K/uL Basos, Absolute 0.1 0.0-0.4 K/uL NRBC Inst. %/100 WBC C.00 None Nucleated RBC С None /100 WBC NRBC Absolute 0.00 K/uL None Smear Review: Completed

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.08/06/2010 14:02:08 TTH

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

Location: Discharged Pt Name: ADRIAN SCHOOLCRAFT MR#: 001298984 ACCT#: 130381015 Att Phys: NWAISHIENYI, SILAS DOB: 1975 Age: 35Yr Sex: M Ord By: NWAISHIENYI, SILAS == Test: COMP METABOLIC PANEL Page 1 of Status: FINAL Seq #: 0004 Collected: 11/01/09 C:22 By: J081X Received: 11/01/09 0:36 Lab#: D1010449 UNITS ABN REFERENCE FESULT TEST mg/dL 74-106 Glucose 9-20 mg/dL 1.4 BUN 0.7-1.3 mg/dL Creatinine 3.,0 137-145 mEq/L 1.38 Sodium mEq/L Potassium 4.1 3.5-5.1 98-107 mEq/L Chloride 7.04 22-30 mEq/L 24 CO2 mg/dL 8.4-10.2 Calcium 9.4 10.00 mEq/L Anion Gap mmoL/L Anion Gap With K 14.10 g/dL 6.3-8.2 8.2 Protein g/dL 3.5-5.0 Albumin 4.7 mg/dL 0.2 - 1.3Bilirubin (Total) 0.6 !5**1** 21-72 U/L ALT (SGPT) U/L 17.-59 AST (SGOT) 46 37-126 U/L Alkaline Phosphatase 57

\* \* \* \* 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: // / / / / / / / / / Age: 35Yr Sex: M Ord By: NWAISHIENYI, SILAS

Seq #: 0006 Test: BILL CBC W/AUTO DIFF Status: FINAL Page 1 of

Collected: 11/01/09 0:12 By: J081X Received: 11/01/09 1:03 Lab#: D1010449

RESULT Bill CBC Automated D PILLING ABN REFERENCE

\* \* \* \* END OF REPORT \* \* \* \*

# NEW ENCOUNTER

EUDHI NV THUNUA

Jun 3/12/0 Acharan FACE SHEET

	ACCOUNT NUMBER MEDICAL RECORD NUM				UMBER	ADMIT DATE & TIME				BAR CODE-MEDICAL RECORD NUMBER					
	130381874		1298984			11/03/2009 15:00									
	LOCATION		IN. CLASS SOURCE TYPE		f		DISCHARGE DATE & TIME			BAR CODE-ACCOUNT NUMBER					
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-	SCHOOLCRAFT		<del></del>	ADRIAN		,									N
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-	ADDRESS				CITY				STA	TE			219		
P A	82 60 88 PL				RID	GEWO	OD		NY				11385		
	TELEPHONE NUMBER			occu	PATION			SOCIAL SECURITY			Y NUMB	ER			
	(718)570-6224									*****	****				
	EMPLOYER NAME			ADI	ORESS				(	YTK		STATE	ZΙP	TELEPH	ONE NUMBER
	UNKNOWN			····										(999)	999-9999
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	EMERGENCY CONTACT NAME		RE	HENOITAL	Þ	AD	DRESS								KONE NUMBER
L_	SCHOOLCRAFT,		<del></del>	09		*****									570-6224
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₹	HOVANESIAN, SHUSH			590	J4 	S	<u>;</u>							P	ÿΥ
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ጟ	SCHOOLCRAFT, ADR	AN								OCCUPA	MOIT		\$0		IRMY NUMBER
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# 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 PFLESENT 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. Brior 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 COLIRSE: 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

#### **PAGE TWO**

NAME: SCHOOLCRAFT, ADRIAN

**MEDICAL RECORD NO.: 1298984** 

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

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

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SCHOOLCRAFT, ADRIAN

M/R: 1298984 PT#: 130381874

DOB: 1975 34Y M F/C: 19 S

ADM: 11/03/2009 15:00 03MH9HAL 01

PROCEETS NOTE

<u> </u>	ROGRESS	OTES ADM:11/03/2009 15:00 03MH 9HAL 01
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
		Patient left unit via Ambulatory, wheel chair, stretcher accompanied by:
		Mental Status:
Assessment		$A \times 0 \times 3$
Condition of pati- cluted to admitti or problem(s) on dimission or dur- pertinent physics chavioral assess ondition, breathly	ent upon discharge ing diagnosis and ing hospitalization il psychosocial	AXOX3  Pt is calm and in Consult Devices 81/H1  Devices PT~ H.
	· A	ccomplished Goals (NCP & Teaching Goals)
	1	It verbaland important of
		ollow up care. De isducino
	9	inen to pt and pt
7		
		resoliced understanding of
		Dic instructions  Ignature: Associate Title: RV



8900 van wyck exi'ressway, Jamaica, n.y. 11418

### PROGRESS NOTES

SCHOOLCRAFT, ADRIAN
M/R: 1298984 PT#: 130381874
DOB: 1975 34Y M F/C: 19 6
ADM: 11/03/2009 15:00 03MH 9HAL 01
HOVANESIAN, SHUSHAN

Inpatient Ps	ychiatry: Social Work Discharge/T	ransfer Summary
Patient Description: Pt is O Known Osych h	×34 year old (Exulto who sty	Lucasian malegro
his rellengtes am		NYPD brame concerned
Date of Discharge/ Vansfer:	09/	about his behavior
Discharge Destination ( Check: One):	·	•
5/Home	☐ State Psychiatric Hospital	☐ Inpatient Substance Abuse Treatment
Skilled Nursing Facility	☐ Supportive Housing	☐ Other:
(Please provide details)		
		•
Aftercare:  © Continuing Day Treatment	Mental Health Clinic     Partial Hospitalization Program	☐ Assertive Community Treatment Team ☐ Assisted Outpatient Treatment
Case Management	Partial Hospitalization Program  Other: Private Sychiatr	12:1
fflease provide details);		
It will down	actor to make	ea pointment
Mode of Transport:	Family/Friend	CI Ambulance CI Ambulette
(Please provide details)		
	•	
Medications:     Prescriptions   Prescriptions	☐ Medicationsweek supply	
More-prion	no meds.	
Additional Comments/Referrals:	☐ Financial Office ☐ SSI/SSD	CI Medication Grant Program
Pt S Non on	2000 m + C1	Deperative Mas
bems. He is	a paramate in	his affect and be
havior Demi	es Replina do	messed auxious a
Suicidaolha	micidal. De W	es maricsx. deis
Allother Weller	cinations (a) presen	nt. Pt. has been reco.
Whender to se	e an arbatien	tpsychiatrist andle
agreed to dose	<u>),</u> an	ease see Progress Notes for Additional Information
Social Work Signature:	their McMahon,	Date/Time: 16(10) 11/6/9-13
THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW	i men	Series I 70 Ma



SCHOOLCRAFT, ADRIAN
M/R: 1298984 PT#: 130381874
DOB: 1975 34Y M F/C: 18 S
ADM: 17/03/2009 15:00 03MH 9HAL 01
HOVANESIAN, SHUSHAN

# SOUJALWORK CONTINUING-CARE AGREEMENT

Dear N	Myms/mrs Schoolcraft.
Your S develop	ocial Worker, in collaboration with the Interdisciplinary Treatment Team, worked with you in ping the following plan.
You wi	11 reside at: 82-60 88th Pl. Glendale, N. Y. 1/385
The fo	llowing appointments/referrals were scheduled for you:
Outp	atient Program:
1.	Clinia/Private Referral: Dr. Lucl - 917) 921-3264 Vrivate Psychiatrist - 14-06 QUEDOS Brup.
2.	Continuing Day Treatment Program: Folks (1715 Ny. 11375
3.	Partial Hospitalization/Intensive Psych Rehab:
4.	Other Clinic:
Income	Maintenance Center:
Social S	ecurity Administration:
Case Ma	anager's Name:
Other: _	
T games A	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	and have received a copy of the above Discharge Plan.
The	tient Signature  Tel. No.  Social Worker Signature  Date
Fai	nily/Guardian Signature [if applicable] Date
FO256 12/9	5 WHITE MEDICAL RECORD YELLOW SOCIAL WORK
	TELLOW SOCIAL WORK



# lamaica Hospital Medical Center

## DISCHARGE INSTRUCTIONS

SCHOOLCRAFT, ADRIAN
M/R: 1298984
PT#: 130381874

DOB: 5/1975 34Y M F/C: 19 ADM:11/03/2009 15:00 03MH9HAL 01

PHYSICIAN: DISCHARGE DATE: TIME: DIAGNOSIS: ALLERGIES: Call your doctor or come to the ER If MEDICATIONS: PRESENT LIST OF MEDICATIONS TO YOUR PROVIDER you develop: 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 Check off those medications deemed contraindicated at the time of discharge: FOR PATIENTS WITH AMUCHE Ejection Fraction: DAce inhibitor DARB ☐Beta Blocker Diet: CILow Salt • Avoid high sodium food (cenned vegetables & soups, frozen dinners, crackers, dell food, fast food, soy sauce, tried food, etc.) Add no salt when cooking or eating • Read food labels for sodium amounts • Check with doctor before using salt substitutes □Limit delly fluid intake to \_\_ \_quarts CIOther: □Diabetic: Always eat lean meets, whole grains, fresh fruits and vegetables □Weigh yourself each morning • Same time, after you empty your bladder • Same scale & emount of clothing • Show your log to your doctor Weight gains mean you are retaining fuld
 Report weight gains of 2-4 lbs. over 1-3 days Activity and Exercise: immunizations | Pneumococcal | Given | Contra/not-indicated | CPt. refused influenza GGiven: GContra/not-indicated GPt refuse APPOINTMENT WITH: PETIVATE MD DJH ACC ☐MediSys Center REFERRAL TO: ITVisiting Nurse! Home Care ☐Social Service ☐Other(s): Offier Required Follow-up If any: PHYSICIAN'S SIGNATURE: Date NURSE: NURSE'S SIGNATURE: 2.150 Date: I have received discharge instructions and understand the information that has been given to me. PATIENT/SIGNIFICANT OTHER: Signature: Date: SIGNIFICANT OTHER ONLY: Print Namé: 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

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$\Box$	•	_
_	4	- 1

Jamaica Hospital Medical Center Triage	Category 3 ESI-3 (	
10/31/2009 23:03 . 23:03	40.40	SCHOOLCRAFT, ADRIAN
Transport	· ·	
	imbulance Stretcher	1298984
Police Dept		Meaning Charles and
	Beat # PCT- 81, #27009	130381015
Abdominal Pain (Lower) 14 Hou		Bisis (2) 1975
A State of the sta	1/0/	34 Years
Denies vomiting and diarrhea, Pt under police custody, Pt became a	nxious with increased BP @ the scene.	System Male
		Margar V
Additional:		Temp
No Significant PMHx		Oral <b>99.0</b>
	CVA	Rectal
DM HTN Psych Renal Selzures	Y	Tympanic
J No Meda 🔲 Unknown		Pulse
		Right
• }		Left 115
Hinduigh.	TO THE REPORT OF THE	Respirations
No Known Drug Allergies	TB Hx, PPD Pos or No	18
	Infectious Exposures?  *If yes to TB or infectious questions.	n Blood Pressure
	take precautions	Right
The still distribution of the still		Left 139/80
/ Orlented Eye		Pulse Ox
Verbal Verbal	G P Ab Miscarriag	97%
R L R L Motor	0000	Weight (Kg)
Clear 📝 📝 Equal 🔲 Total 0  Diminished 🖰 🗍 Reactivo 🗍 🗍		109 Kg
Mheezes   Fixed	多能性時	Head
Constricted	Puises	Height Circumference
Dilated Color Normal		
Retractions Cataract Moist Normal	ROM	Pain Scale
		Mild 3-4
Nomal	A SASSING TO SUSTAIN A LINE OF	<b>到的社会部队为中央部队</b>
Are you being hurt	by someone you live	<b>中央中国</b> 医二种 中国
No Fall Risks identified	' ' ' ' ' ' ' ' ' '	,
Yes/No No		Disability No Disability
No risk identified * Mandatory comp of Domestic Violence	Referral	cation Barrier
	Language	Translator
43-09 23:03 Dally Living	1	Ivation Level Med
Hage Nurse: Leobetter, Glenos (KN)	Kno	wiedge Level Med
Friage II: GLE  Friage III: GLE  Going Home with	Self	esion Ability Med



SCHOOLCRAFT, ADRIAN

M/R: 1298984

PT#: 130381874

FIC: 19 9

DOB: 1975 34Y M

ADM: 1703/2009 15:00 03MH 9HAL 01

HOVANESIAN, SHUSHAN

I. ADMISSION	
-Datel 1 3 09 Time PER Information Received From: Gratient Gother Language	Spoken_ English
Age 34 Religion W. W. Previous Jamaica Hospita	al Admission II-No II Yes Date
Admitted via:  Wheelchair Stretcher Other	Admission: Elective Benergency RANS FLED From MER -> PER
Prosthesis/Assistive Devices	☐Hearing Aid Man
Dentures [Nerre   Clower   Clupper   Full   Clarital	□Denture Cup Provided □Other
Instructions to Patient @Call Light	ables Procedure BP 130 Ht 6 0" Wt 21/10
Nursing Staff Admitting the Patient Sharon Varna by	Title80
II. ADMISSION DATA	
Admitting Diagnosis PitChosis Nos General Appe	parance(emaciated, well developed, phese, thin)
Patient's Chief complaint (as stated by patient, onset, duration, list of symptoms  Will taken unit 4 mg house by mg bass  Previous health History	
PAIN HOD Yes (If Yes circle intensity)	Prescribed medication (CNo Erres
0 1 2 3 4 5 6 7 8 9 10	Over-the-counter medications
Description	
(Location & Duration)-	Herbal Medications/Alternative Treatments
Previous Blood Transfusion No LiYes When	QNo Lives
Blood Transfusion Reaction QNo QYes If YES Specify	Medication Taken Prior to Admission Ho TYe
Allergies: Medication/Food/Environmental DNo Tyes If YES Specify	Medications brought to hospital/disposition
VACCINATIONS Pneurnococcal ONo OYes Date Received	Mo □Yes Date Received
PSYCHO-SOCIAL ASSESSMENT Status   Single   Married   Divorced   Widowed   Se	pnamtod
Occupation N110 VAL Retired, Prior Occupation	
Cultural Beliefs / Practices Oen Cas	
Substance/Alcohol Use THO Tes Explain	
Smoke No Yes; Frequency	
Living Arrangement: Live with Home Person Person	to Assist You after DischargeM ~_/

4
Home Factors Affecting Hospitalization (Children, elderly, parent(s), pets, alting family member/significant other)
Home factors affecting discharge  Private home  Apartment house  Nursing home  Other
III. REVIEW OF SYSTEMS-
HEENT 1. Head Denies.complaint Dendache Denies Denies.complaint Dendache Denies.complaint Dendache Denies.complaint Denies.co
2. Ear Deniertiomplaint DHearing Loss-explainDDischarges DEar achet
3. Eyes Denies complaint Dimpaired vision QNo QYes QO.D. QO.S. QO.U. Explain
4. Nose/Sinus ☐Bantes complaint ☐Discharges ☐Epistaxis ☐Pain
5. Throat Øbenies complaint Othoarseness OSore Throat OLaryngitis OOther
CARDIO-RESPIRATORY Denies complaint
□Cough □Sputum □Herroptysts □Wheezing □Dyspnea □Edema □Hypertension □Palpitation
GASTROINTESTINAL Denies complaint Hematemesis Tarry stools Heartburn Hemorrhoids Jaundice
☐ Weight loss ☐ Mouth sonss ☐ 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 onsetLMP
Regularity D No D Yes Duration Date of last Pap Smear
Vag.nal 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
MUSCULO-SKELETAL & Denies complaint A Muscle pain A Sprains A Neck pain A Deformity
☐ Stiffness ☐ Fractures ☐ Extremity pain ☐ Limited range of joint motion ☐ Redness ☐ Back pain
ENDOCRINE  Oneries Complaint  Goiter  Heat/cold intolerance
NEUROLOGY
Mental Status: Oriented to Time Place Person Canxious Clethargic Coisoriented Cstuporous Comato
☐ Deries complaint ☐ Tremor ☐ Muscle atrophy ☐ Muscle tenderness ☐ Headache ☐ Convulsions
☐ Syncope ☐ Epilepsy ☐ Paralysts ☐ Dizzlness ☐ Paresthesia ☐ Ataxia
PSYCHIATRIC HISTORY AND ASSESSMENT
A. Appearance: Neat
B. Behavior. / Mm lo-spendick.
C. Mood/Affect: D. Hallucinations; Yes D No D-Describe
E. Delusions: Yes (1) No (1) Describe
F. Paranold Thoughts: Yes D. No D Explain.
H. Homocidal: Yes () No to Explain
i. Recent impulsive/Unpredictable behavior. Yes No Explain
J. Use of restraints/seclusion prior to unit admission; Yes D No D Explain
· · · · · · · · · · · · · · · · · · ·

Г	iv EAL DIEK	ACCECGMENT		Skin Turgor	Skin Co	lor	Skin Condition	MARK SITE OF A	BNORMAL
	IV. FALL RISK ASSESSMENT  Directions: Use the following assessment tool to identify pat			ØMormal	Normal		☐Moist	SKIN FINDINGS O	N PSO
	rick farfalla Clima H	he score for each risk factor that and	ias to vour 💢	OPoor OPale		•	CIDry	arawa occo	"
Ì	nations. Patients with a score of 5 or more must be placed of		ton the fall	<b>C</b>	☐Cyan	otic	☐Warm	A	$\mathbf{C}$
	prevention program (Spot the Dot).				Claundice		CICold .	- XX	ر کا اور
ŀ	RIS	SK FACTORS	SCORE	Mucous	Nails		Abrasions	\tau = \( \frac{1}{2} \)	$\lambda \lambda$
Į	Age 65 & older			Membrane	□ Norm	ıal	☐Ecchymosis	11/2/11	$M \cdot M$
	-		5	<b>OPInk</b>	C)Pale		☐Blisters	SIX IS	初大八
Į	History of previo	us Falls	5	☐Pale	(C)Cyar	otic	□Rash		)//(
1				☐ Cyanotic	Club	bing	<b>□</b> Edema		17 ()
1	Mental Status: D	ementia;Psychoses; Delirium	6	()Moist	(JBrittl	8	☐Burn	1 01 15	
	Tremens; Seizures	ļ		☐ Dry	(JOthe	r	Pressure	1 4	_
							Ulcer		
	Debilitation/wes	kness/cachexia	5	V. PRES	SURE L	LCER	RISK ASSES	SMEN!	at rick for
				nmeeting tile	are Circle	the sco	re for each risk fa	ctor that applies to	o vour
	Communication	Deficits: Dysanthia; Aphasia;	1	patient. The	care plan	should i	e initiated for a p	atient with a score	of 5 or
	No verbalization; La			more.		<del></del>		**************************************	****
	Mobility Deficits:	Hemiparesis; Paraparesis;	5	RISK FACT	OR	Α	SSESSMENT IN	DICATOR	SCORE
	Hemiplegia; Parapk	egia; Ataxia; Use of prosthetic e/crutches; Amputee; Parkinson's		Age		<65			0
	disease	acidicida, Parpaido, 1 ariamenta		1,490		<b>≻6</b> 5	•	· ·	1
	Visual Deficits:	Bladage		Mobility		Ambula	itory, bed rest < 3	days	0
١	Slumed vision:	Night blindness; Post-op eye	5	,,,,,,,,,		Ambul	atory only w/assist	t; bed rest > 3	1
'	surgery		1			Non-ar	nbulatory, quadrit	alegia,	5
	♣ Use of eye gla	sses /contact lenses				parapk	agic, hemiplegic		
	Medications:		<del>                                     </del>	Pattern o	<u> </u>		ontinent		0
	○ Barbiturates: 1	(ranquilizers; Parenteral Pain meds;	5	Elimination			roontinent of urine roontinent of urine		2 3
	Hypnotics; An	esthetics		Chilinau			riented	STILL (DOS)	0
• .	Antihypertensi	ives; Diuretics; Laxatives; n Meds, Eyn gits, pain p.o./patch.	1	Mental S	tatus		séd, disoriented		2
	Alteration in bla	dder function	1	1		Coma	tose		5
1	<ul> <li>Medical/Surgical</li> </ul>	cal 7nt/ with FC, incontinent of urine)	1	Nutrition			feeds self		0
	<ul> <li>Rehabilitation</li> </ul>	Unit (pt. bowel/bladder program)	5	Status			wassist; TPN, tub xia, obese, NPO		2
			<del>                                     </del>	Clás	.,	Intact		- b days	
	Auditory Deficit	S.	<b>'</b>	Skill ,	•	Poort	шrgor, dry, cracke		-
				<u> </u>			ed areas, pressur	re ulcer	5
	Orthostasis/Hy		5	Health S	itatus	Good			
	Syncopal epis Vertigo	sodes				Poor	الم سائد		3 5
!	* Voluge		1			Morib	······································	<del>~~~~</del> ~	
	RISK ASSESS	MENT SCORE	10	RISK A	SSESSI	VIENT :	SCORE		-6
	VI. FUNCTION	NAL SCREEN		VII. NU	RITION	SCRE	EN II score is 6	points or more, a	Nutrition
		re, notify physician		consult must be reported to the Nutrition Department via to or enter into the computer.		artment via teleph	one ext. 403		
			1 000		clated Pa				SCOR
		sessment Indicator	SCORE 3				<del></del>		
	Transfer skills Bed-Chair	Moderate/minimum assist	2	Waight lo	ss/gam la	81 3U <b>08</b> 5	rs: + or ~ 10 lbs.		6
		Independent	0	<del> </del>					
	Antibulation skills	Total assist Moderate/minimum assist	3 2	Pressure	Ulcer: an	y stage	•		6
	BerCBathroom	Independent	. 0	_	<del> </del>				<del> </del>
	Self care skills	Total assist Moderate/minimum assist	3 2	Feeding/	niwoilawe	g difficult	A		2
	Feeding/Eating	Independent	0						-
	Tolleting	Total assist Moderate/minimum assist	3 2	1	and vomit		ays		3
		Independent	ő	Food Allergy/Intolerance  Pre-hospital diet/diet restriction: Diabetic, Renal Tube feeding, Parenteral			1		
	Dressing/	Total assist	3				2		
١	Hygiene	Moderate/minimum assist	2 0						
. '	Range of	Total assist	3	Socio/C	ultural/Rel	lgious ne	eds relating to nu	atrition	1
	motion all	Moderate/minimum assist	2						(Z)
	extremities	Active		_			······································	· · · · · · · · · · · · · · · · · · ·	
	TOTAL SCO	RE	do	ATOT	L SCO	RE			

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