Covenant Healthcare

Inpatient and Outpatient Consent for Treatment & Financial Agreement

☐ St. Joseph Regional Medical Center ☐ St. Michael Hospital

☐ Elmbrook Memorial Hospital ☐ St. Francis Hospital

Covenant Healthcare Hospitals have a number of ambulatory/outpatient sites that are covered by this Agreement.

A. **Consent for Treatment:** I am entering the above named facility (the "Facility") for the purpose of medical and/or surgical treatment or diagnosis. I consent to my physician, other attending, consulting and/or referring physicians and their assistants and designees, and other Facility personnel, to provide me with such medical, surgical, diagnostic or other treatment services judged necessary and/or appropriate by my physician. This consent includes my consent for hospital services, diagnostic procedures and all medical treatment rendered under the instructions of my physician(s) including x-ray and laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of diagnosis and treatment, cells, tissues and/or parts may be removed from my body. I authorize Facility personnel to preserve or use such cells, tissues or parts for teaching purposes and/or to dispose of any cells, tissues or parts that are removed.

B. **General Acknowledgments:** I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury, and even death. No guarantees have been made to me with respect to the results of my examinations or treatments in the Facility. I understand that many of the physicians on the Facility's staff are not employees or agents of the Facility but, rather, are independent contractors who have been granted the privilege of using this Facility for the care and treatment of their patients. I understand that the Facility is not liable for any actions or omission of, or the instructions given by, such independent contractors who treat me while I am in the Facility. I understand and agree that I may be observed and/or receive care from medical, nursing, and other health care students in training at the Facility. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care. I understand that I may review and obtain a copy my medical record, at my own expense, and that this review shall take place in the Facility, during regular business hours.

C. **Medicare Payments:** I acknowledge receipt of the "Important Message from Medicare," as applicable.

Covenant HEALTHCARE

A member of Covenant Healthcare, which is sponsored by the Wheaton Franciscan and Felician Sisters

St. Francis Hospital
St. Michael Hospital
Elmbrook Memorial Hospital
St. Joseph Regional Medical Center

Inpatient and Outpatient Consent for Treatment & Financial Agreement

1820 2/03 R8

PARKS LARRY E
DOB 03/26/57 47Y SEX M MR: 778667
MLSNA
ACCT# 71270704
JACQUELINE S

FOLD-OUT ... BOX APPEARS ... HERE OR IS

D. Assignment and Agreement to Pay: I understand that I am responsible for payment for the services that I receive and guarantee payment for these services. I hereby assign to Facility and the physicians and professionals associated with the Facility, for application to my bill for services, all of my rights and claims for reimbursement under any federal or state healthcare plan (including but not limited to Medicare or Medicaid), insurance policy, any managed care arrangement or any other similar third party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. I understand that I am responsible for any applicable co-payment, deductibles, co-insurance and/or non-covered costs and charges. I understand that not all insurance companies pay the usual and customary fees of the Facility, the physicians and/or the professionals associated with the Facility. Therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or others for billing purposes. I also understand that I may receive separate bills from independent physicians involved in my care including radiologists, anesthesiologists, pathologists, emergency room physicians and other independent physicians. These physicians may or may not participate in all insurance networks.

E. Valuables: Keeping valuables (such as cash, jewelry, documents) in the Facility is strongly discouraged. I understand that the Facility has a place where my valuables may be stored. If I choose to keep valuables in the Facility, I do so at my own risk and I understand and agree that Facility is not liable for loss or damage to any valuables that I do not turn over for storage.

F. Photographing: I understand and agree that the Facility may take photographic, electronic and/or video images of me in cases when it is required to assist with my treatment or for my safety. If my care involves the delivery of a baby, I give consent for my baby to be photographed for security and/or personal use.

G. Privacy Notice: I acknowledge that I was provided with a copy of Covenant Healthcare's Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for more information regarding release of your health information and your right to access your health information.

Larry Parks
Signature of Patient/Authorized Representative

3/23/05
Date

Relationship of Authorized Representative

If unable to sign document, state reason: _____

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St. Joseph Regional Medical Center

Inpatient and Outpatient Consent for Treatment & Financial Agreement

1820 2/03 R8

PARKS LARRY E. RE
DOB 03/26/57 47Y SEX M MR: 778667
MLSNA JACQUELINE S
ACCT# 71270704

ST. JOSEPH REGIONAL MEDICAL CENTER
A MEMBER OF COVENANT HEALTHCARE

Account No: 71264283 MR#: 0778667
Sched Date: 03/14/05 10:28 AM

PATIENT INFORMATION

PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212

Phone: 414 264-3716
DOB: 03/26/1957 Age: 47
Gender: M MS: LEGALLY SEPARAT
SS#: 397-64-6801
Religion: BAPTIST
Employer: NONE
Phone #:
Occupation:

NEAREST RELATIVE

Name: SELLERS SHERESA
Phone: 414 418-0186
Bus Phone:
Relat: OTHER RELATIONS
Notify: Y

ADDITIONAL CONTACT

Name:
Phone:
Bus Phone:
Relat:
Notify:

VISIT INFORMATION

INTERPRETER NEEDED: NO
Language: ENGLISH

Admit Reason: POST-OP LEFT KNEE SURGERY
Comment: EJL PT NOT ELIGIBLE REC#1

Visit Type: C
Location: SJH ORTHOPEDIC CLINIC#
Last Inp Date: 03/09/05
Last Outpt Date: 03/08/05

PHYSICIAN INFO

Adm:
Att: MLSNA JACQUELINE S
PCP: NONE

INSURANCE INFORMATION

PRIMARY: SELF PAY

GUARANTOR INFORMATION

Name: PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212-0000

Phone #: 414 264-3716
SS#: 397-64-6801
Employer: NONE
Phone #:

HISTORY & PHYSICAL/PROCEDURE RECORD

DATE OF HISTORY: 3-14-05 TIME:

INFORMANT:

ROOM/LOCKER NO:

PROCEDURE:

CURRENT MEDICATION AND DOSAGE PRESCRIBED AND NON-PRESCRIBED

PERSON TO ACCOMPANY PATIENT HOME:

REASON FOR HOSPITALIZATION:

SMOKING HABITS:

PAST SURGERIES:

ALCOHOL/DRUG/CAFFEINE USAGE:

PRE-PROCEDURE MENTAL STATUS
☐ ALERT AND ORIENTED
☐ OTHER:

EXISTING CO-MORBID CONDITIONS

- ☐ ASTHMA/EMPHYSEMA
- ☐ TB
- ☐ CHEST PAIN
- ☐ IRREG. BEATS
- ☐ HEART ATTACK
- ☐ PACEMAKER
- ☐ VALVULAR HEART DISEASE
- ☐ VASCULAR DISEASE
- ☐ HYPERTENSION
- ☐ DIABETES ☐ INSULIN DEP.
- ☐ CANCER
- ☐ KIDNEY DISEASE
- ☐ OTHER:
- ☐ OTHER:
- ☐ OTHER:
- ☐ SEIZURES
- ☐ CIRRHOSIS
- ☐ INFECTIOUS DISEASES (I.E., HEPATITIS, ETC.)
- ☐ ARTHRITIS
- ☐ ULCER, GI PROBLEMS
- ☐ BLEEDING PROBLEMS (I.E. SICKLE CELL)
- ☐ BLOOD TRANSFUSION DATE:
  REACTION:
- ☐ ANES. PROBLEMS
- ☐ COLD SYMPTOMS PRESENTLY OR WITHIN LAST 2 WEEKS
- ☐ NONE OF THE ABOVE

HEIGHT	WEIGHT (IN LBS)	(IN KG)

ALLERGIES (FOOD, MED, TAPE, DYE, LATEX, ETC.):

TYPE OF REACTION:

☐ LIVING WILL ☐ POWER OF ATTORNEY FOR HEALTH CARE ☐ NONE
☐ OTHER:
☐ PATIENT UNABLE TO RESPOND ☐ COPY OF ADVANCE DIRECTIVES ON CHART ☐ YES ☐ NO

TIME/INITIALS	BP	P	R	T	TIME/INITIALS	BP	P	R	T

INDICATIONS/SYMPTOMS FOR PROCEDURE OR ☐ SEE DICTATION

PHYSICIAN ORDERS/NURSING NOTES

Presents c complaints of cast discomfort. Dr. J. Mlsna was notified and gave a VORB to change dressing and cast. This was done by D. Duvall, S.A. Will return in follow-up, as originally directed.

RISKS/BENEFITS/COMPLICATIONS/ALTERNATIVES EXPLAINED RELATED TO ☐ PROCEDURE ☐ SEDATION ☐ BLOOD

PHYSICAL EXAMINATION SPECIFIC TO THE PROCEDURE AND ANY CO-MORBID CONDITIONS

IV SEDATION: ALSO INCLUDE PHYSICAL EXAM OF HEART/LUNGS BY AUSCULTATION

LUNG	HEART	OTHER
☐ CLEAR	☐ REGULAR RHYTHM	
☐ OTHER	☐ OTHER	

☐ SEE PATIENT'S PROGRESS NOTES

TIME PATIENT RETURNED TO DAY SURGERY:

☐ LOCAL ANESTHETIC
☐ IV SEDATION IN O.R.

TREATMENT OR OPERATIVE REPORT OR ☐ SEE DICTATION

FINAL DIAGNOSIS: Recurrent patellar dislocation

DISCHARGE PLANS:

PHYSICIAN SIGNATURE: DATE: 3/14/05

POST-PROCEDURE/DISCHARGE OUTCOMES

	MET	NOT MET	N/A
MENTAL STATUS			
ALERT/ORIENTED			
RETURN TO PRE-PROCEDURE LEVEL			
PHYSICAL/EMOTIONAL COMFORT NEEDS			
PAIN CONTROLLED			
DRSG DRY/DRNG CONTROLLED			
AMBULATES SAFELY			
PATIENT/FAMILY VERBALIZES			
UNDERSTANDING DISCHARGE/ MEDICATION INSTRUCTIONS			
OTHER:			

DISCHARGE TIME: 0 C. Lungu OTR/L INITIALS:

RN SIGNATURE: INIT: RN SIGNATURE: INIT:

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL
[illegible]

HISTORY & PHYSICAL/ PROCEDURE RECORD

PARKS LARRY E
DOB: 03/26/57 47Y SEX: M MR: 778667
MLSNA JACQUELINE S
ACCT#: 71264283

ST. JOSEPH REGIONAL MEDICAL CENTER
A MEMBER OF COVENANT HEALTHCARE

Account No: 71263992
Sched Date: 03/13/05 06:13 PM

MR#: 0778667

PATIENT INFORMATION

PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212

Phone: 414 264-3716
DOB: 03/26/1957 Age: 47
Gender: M MS: LEGALLY SEPARAT
SS#: 397-64-6801
Religion: BAPTIST
Employer: NONE
Phone #:
Occupation:

NEAREST RELATIVE

Name: SELLERS SHERESA
Phone: 414 418-0186
Bus Phone:
Relat: OTHER RELATIONS
Notify: Y

ADDITIONAL CONTACT

Name:
Phone:
Bus Phone:
Relat:
Notify:

VISIT INFORMATION

INTERPRETER NEEDED: NO
Language: ENGLISH

Admit Reason: EXTREMITY PAIN
Comment: BJC T05072

Visit Type: E
Location: EMERGENCY DEPT#TRAUMA/MAJ
Last Inp Date: 03/09/05
Last Outpt Date: 03/08/05

PHYSICIAN INFO

Adm:
Att: EMERGENCY CONSULTANTS INC
PCP: NONE

INSURANCE INFORMATION

PRIMARY: SELF PAY

GUARANTOR INFORMATION
Name: PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212-0000

Phone #: 414 264-3716
SS#: 397-64-6801
Employer: NONE
Phone #:

FILE

St. Joseph Regional Medical Center | Emergency Department QualChart®

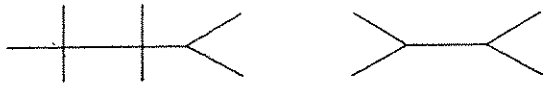
ORDER SHEET / LOWER EXTREMITY MPLAINT | Height: Weight: lbs / kgs Allergies:

Medical Records: Old Chart Recent ED Chart Previous EKG Additional Records:

LABORATORY: Circle specific orders	By:	Time:
CBC Manual Diff		
BMP CMP Mg		
UA UA w/o Micro CC Cath		
UCG HCG: Qual / Quant		
D - Dimer BNP Myoglobin		
ESR Uric Acid		
Rh Type Screen Type Cross ____ units		
PT PTT		
ADDITIONAL LAB ORDERS:		

RADIOLOGY: Circle specific orders	By:	Time:
CXR (2 view) Portable CXR		
C-Spine XT C-Spine Port-C		
T-Spine L-Spine		
Hip Pelvis Right Left Portable		
Femur Right Left		
Knee Right Left		
Tibia / Fibula Right Left		
Ankle Right Left		
Foot Right Left		
CT: Abdomen / Pelvis With Without		
CT: Hip / Lower Extremities Right Left Bilateral		
Venous Doppler: Right Left Bilateral		
ADDITIONAL RADIOLOGY ORDERS:		
Post-Reduction X-Ray		

Pertinent Lab Values: WNL WNL Except:



Signs / Symptoms Necessitating Xray / CT / US: _____

Xray Interp: ED Physician Radiologist Discussed With _____

No Acute Changes Positive Fracture/Dislocation @ _____

Displaced / Angulated / Comminuted / Open

CARDIAC MONITOR / EKG INTERP:

Monitor EKG

Interpretation: _____

Rate: Normal Brady Tachy

Rhythm: Sinus AFIB Junctional

Ectopy: None PVCs PACs

EKG Comparison: No Significant Change / Other: _____

ORDERS:	By:	Time:	Time:	CLINICAL RESPONSE / RE-EVALUATION
Pulse Ox O2 @ ____ l/min via NC / Mask / NRB				NL Hypoxic ____ % on O2 @ ____ l/min
Saline Lock IV NS LR ____ ml Bolus / Rate ____ ml / hr				
Td 0.5 ml IM Lot # _____				
Procedural Sedation *See Hospital Flow Sheet*				
Knee Immobilizer Velcro Splint / OCL: _____				
Crutches / Walker				
Repeat Vital Signs: All BP Pulse RR Temp O2 Sat				VSS except:
pt. seen and examined				

Fracture / Dislocation Treatment Location: _____

Time: _____ a.m. / p.m. By: MD / DO / PA / NP

Anesthesia: Procedural Sedation / Local / Digital / None

Medication: Lidocaine / Other: _____

Procedure/Technique Used: _____

Splint / Immobilizing Devise Applied By: MD / DO / PA / NP / ED Tech / RN

Type: _____

Referral: Contacted / Referred to: PCP / Orthopedic Surgeon / On-Call Physician

Will See Patient in: ED / Office / Hospital in ____ Days / Immediately

Procedure Successful / _____

Reduction Acceptable / _____

RE-EVALUATION: Unchanged Improved Worse

Time: _____ a.m. / p.m. _____

VSS except: _____ Pain: ____(0-10)

Appearance: NAD / _____

Lower Extremity: Joint Stabilized / _____

Skin: Warm & Dry / _____

Neuro: NV Bundle Intact / _____

SIGNATURE:

Time of Initial Orders: 1902 a.m. / p.m.

MD / DO

PA / NP

RN / Init

RN / Init

PARKS LARRY E

DOB 03/26/57 47Y SEX M MR: 778667

EMERGENCY CONSULTANTS INC

ACCT# 71263992

QC2180010313051191

This form is to assist the physician's documentation of clinical care and treatment. It is not intended to supplant that judgement or create a standard of care.

Rev. 21970 Joseph C Lee DO 03/13/05 06:26 pm

St. Joseph Regional Medical Center | Emergency Department QualChart® | Page 1 of 1

KNEE PAIN

Fill in, circle pertinent p[illegible] findings. Complete all sections.

Exam Time: 1820 a.m. / p.m. | Mode of Arrival: EMS (Other) | Nurse's Triage Notes Reviewed: (Yes) No

(VSS) Except: BP _____ Pulse _____ Resp. Rate _____ Temp _____

Pulse Ox: NL Hypoxic (Not Applicable) _____ % on R/A or O_2 @ _____ L/min

Last Tetanus: _____ Unknown Last Menstrual Period: _____ Unknown

HISTORY: HX from Pt Unobtainable due to: Dementia Altered MS Extremis HX from: Family/Caretaker EMS Interpreter

CHIEF COMPLAINT: This is a 47 year old (male) female who presents with a chief complaint of pain at: Right (Left) / Bilateral (Knee)

Mechanism of Injury: Straight leg Raise heard "pop" No Known Trauma

Onset / Duration: _____ Minutes Hours Days Weeks Ago Severity: ____ (0-10) Mild Moderate Severe Worse Since: _____

Aggravated By: Standing Ambulation Stairs _____ (Nothing) Alleviated By: Rest Elevation Ice OTC Meds ~~Nothing~~

Related HX: Able to Bear Weight: Yes (No) Sx 3/4 tibial tubercle transfer c 2 cm Steel cast.

Occupational Injury

REVIEW OF SYSTEMS: 2° Cast

Motor Complaint: ~~Negative~~ ↓ROM Swelling

Neurovascular Complaint: ~~Negative~~ Weakness (Numbness) / Tingling

Other Ortho Complaints: _____

PAST MEDICAL/FAMILY/SOCIAL HISTORY: (Previously Healthy)

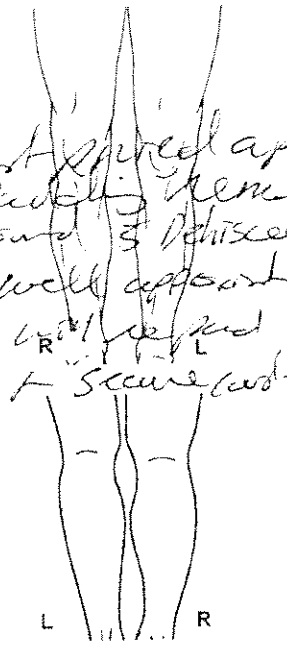
Patient: (Prior Knee Injury) / Surgery s/p arthroscopy

Occupation: _____

Family Hx: _____ Lives: Alone With Family At Nursing Home

PHYSICAL EXAMINATION: EXAM LIMITED DUE TO: Dementia Altered MS Extremis Other:

		Normal Findings:	Abnormal Findings:
Appearance	(Normal)	Well-Appearing No Pain Distress Well-Nourished	*Ill-Appearing: Mild Mod Severe* *Pain Distress: Mild Mod Severe* *Obese / Thin / Cachectic*
MS	(Normal)	Strength / ROM Intact No Edema No Calf Tenderness	*Limited @ _____* *Edema @ _____* *Calf Tenderness*
Skin	(Normal)	Warm & Dry Color Normal	*Pale / Diaphoretic* *Cyanosis @ _____*
Neuro-Vascular	(Normal)	Pulses Normal A & O x 3 NV Bundle Intact Distal to Injury	*Abnormal @ _____* *A V P U Disoriented* *Abnormal @ _____*



Complaint-Specific Findings:

Swelling / Ecchymosis

Abnormal Contour / Rotation

Effusion at: Prepatellar Joint Posterior

Ligamentous Instability On: Medial / Lateral Stress Anterior / Posterior Stress

Unable Due to Pain

Erythema / Warmth / Blisters

Foreign Body

Tenderness:

Pre-patellar: Medial / Lateral

Joint: Medial / Lateral

Tibial Tuberosity

Lachman Test + / -

McMurray Test + / -

Limited Range of Motion:

Flexion to _____ Deg

Active / Passive

Extension to _____ Deg A / P

Patellar Apprehension

MEDICAL DECISION MAKING: Consideration of the following circled conditions may be warranted for the presenting problem.

Burn / Localized	DVT / Phlebitis	Patellofemoral Syndrome
Bursitis / Tendonitis	Foreign Body	Puncture Wound
Cellulitis / Infection	Fracture: Closed / Open	Sprain / Strain
Contusion / Abrasion	Internal Derangment of Knee	Gout
Dislocation	Osgood-Schlatter Disease	

Other: _____

Ancillary Tests and ED Treatment: See Orders Sheet

RE-EVALUATION: Pain Scale (0 - 10)

Time: _____ Unch. Imp. Worse Distal N/V Status Intact _____

Time: _____ Unch. Imp. Worse _____

PHYS. NOTIFICATION/CONSULTS: *Chart Copy Avail. to Addt'l Care Providers*

Discussed case/management/disposition of patient with: (ED) → home.

Name: Kornmesser for dehisc if at _____ a.m. / p.m.

Name: _____ at _____ a.m. / p.m.

Admit OBS Transfer Consult Follow-up: _____

ED PHYSICIAN DIAGNOSES:

1 Knee pain S/P Surgery

2

3

DISPOSITION: RX: _____

Discharge (Home) Work Nursing Home OR Tele Floor Deceased AMA

Condition: (Stable) Unstable

Care Endorsed to: _____ @ _____ a.m. / p.m.

Transfer to: _____ Transfer Form Completed

Standard After-Care Instructions Given to Patient Upon Discharge From ED

Supervising / Management / Progress / Procedure Notes Attached Yes No

SIGNATURE: (Initials) I have reviewed the ancillary/nursing staff documentation. Physician attests performing History, Pertinent Physical Examination, and Medical Decision Making

_____ MD/DO

_____ MD/DO

_____ PA / NP / Resident

Chart / Addendum Dictated: Yes No

Disposition Time: 1900 a.m. / p.m.

PARKS LARRY E

DOB 03/26/57 47 Y SEX M MR: 778667

EMERGENCY CONSULTANTS INC

ACCT# 71263992

* Q C 2 1 8 0 0 1 0 3 1 3 0 5 1 0 1 1 *

[illegible] Joseph C Lee DO

22

SDK'd out ___ Copied ___

NAME	☒M ☐F	DOB	AGE	DATE/TIME OF TRIAGE
Parks, Larry		3/26/57	47	1 ☐ Black 2 ☐ Red 3 ☒ Orange 4 ☐ Green 5 ☐ Blue

CHIEF COMPLAINT: (L) leg swelling under cast

PRIVATE PHYSICIAN: MIS, MD ☐ ECI ☐ PMD

MODE OF ARRIVAL ☐ AMBULATORY ☐ W/C ☐ CARRIED ☐ AMBULANCE ___

PRE-HOSPITAL TREATMENT: ~~☒ NONE~~ ☐ OXYGEN ☐ C-COLLAR ☐ BACKBOARD ☐ SPLINTING ☐ IV ___ ~~☐ MEDS~~ Percocet ☐ OTHER:

FAMILY WITH PATIENT ☐ YES ☒ NO

VITAL SIGNS	TIME	BP	P	RR	TEMP	O_2SAT
	1601	118/73	86	18	98.9	
	TIME	BP	P	RR	TEMP	O_2SAT

ADDITIONAL TRIAGE ASSESSMENT: c/o finding (L) leg, wetness

HEAD CURCUM

ALLERGIES	ADVANCED DIRECTIVES	LMP/EDC	WT(KG)	OFC	FINGERSTICK/ DEVICE	TETANUS/IMMUNIZATIONS ☐ UTD
☒ NONE ☐ LATEX	☐ YES ☐ NO ☐ INFO ☐ REFERRAL GIVEN				see normal values back of page 2	☐ >10 YRS ☐ NEVER

MEDICATIONS: Percocet

HERBAL OR ALTERNATIVE MEDICATIONS:

PAST MEDICAL HISTORY: ☐ CARDIAC ☐ RESP. ☐ CANCER ☐ NEURO ☐ RENAL ☐ SEIZURE ☐ DIABETES ☐ PSYCH ☐ AODA ☒ OTHER post op (L) knee surg 3/9

☐ TB ☐ Exposure to/HX of Blood Borne Diseases

TRIAGE PLAN: ☒ DIVERT REGISTRATION ☐ REGISTER AND WAIT TO BE CALLED ☐ REASSURANCE ☐ W/C ☐ ICE ☐ ELEVATION ☐ DRESSING ☐ SPLINT ☐ SLING ☐ OTHER ___

TRIAGE EDT

TRIAGE RN [signature]

(SUBJECTIVE) TIME 1522

REASON FOR SEEKING CARE: pt c/o (L) ankle swelling, (L) foot numbness since this AM

pt able to move (L) toes, strong pedal pulse (L) foot warm to touch & redness noted.

PLAN OF CARE: ☒ INITIATE STANDING ORDERS/TREATMENT PROTOCOL ☐ OTHER:

DISPOSITION

ADMIT: TIME ___ ☐ CHECKLIST DONE ☐ REPORT TO ___ ☐ TO ___ VIA ☐ W/C ☐ CART ☐ Condition ___ for transport

NOTIFIED: ☐ FAMILY ☐ CLERGY ☐ POLICE ☐ NURSING HOME

DISCHARGE: TIME 1910 ☐ left AMA

~~☒~~ INSTRUCTIONS GIVEN

Patient preferred: ~~☒~~ Verbal ☐ Written ☐ Demo ☐ Practice ☐ Video ☐ Repetition

Barriers to learning ___

~~☒~~ VERBALIZES UNDERSTANDING

~~☒~~ REFERRED TO Ortho MD

~~☒~~ LEFT WITH S/C

~~☒~~ CONDITION Stable

~~☒~~ SCRIPTS GIVEN no

~~☒~~ AMBULATORY ☐ W/C ☐ CARRIED ☐ AMBULANCE no

DEATH: ☐ FAMILY NOTIFIED; ☐ PMD NOTIFIED ☐ MEDICAL EXAMINER NOTIFIED ☐ DONOR NETWORK CALLED (1-800-432-5405) ☐ PT IS CANDIDATE ☐ PT IS NOT CANDIDATE

NAME/RELATIONSHIP OF FAMILY APPROACHED

RESPONSE

PRIMARY NURSE [signature] RN

PRIMARY EDT

SHIFT REPORT RN 1955 [signature]

SHIFT REPORT EDT

ST. JOSEPH REGIONAL MEDICAL CENTER
A Trinity Hospital
5000 W Chambers Street
Milwaukee, WI 53210-1688

EMERGENCY DEPARTMENT RECORD PAGE 1

PARKS LARRY E
DOB: 03/26/57 47Y SEX: M MR: 778667
EMERGENCY CONSULTANTS INC
ACCT# 71263992

SYSTEM	BASIC	SYSTEM	BASIC
NEUROLOGICAL	✓	INTEGUMENTARY (SKIN)	✓
CARDIAC	✓	MUSCULOSKELETAL/ MOBILITY	✓
RESPIRATORY	✓	PERIPHERAL/NEURO VASCULAR	✓
GI		PAIN/COMFORT 3/10	X
GU		SEXUAL/ REPRODUCTIVE	
EENT ☐ GLASSES/CONTACTS			

	Initial	Time	Time Returned	Initial
EKG				
Lab				
Urine				
Rad				
CT				
US				
☐ Isolation			☐ Type	
Monitor			Rhythmn	

SAFETY ☑ CALL LIGHT IN REACH ☑ BED LOW/LOCKED ☑ SIDERAILS UP ☐ PARENTS AT BEDSIDE (FOR CHILD) ☐ FAMILY AT BEDSIDE
☐ INVASIVE DEVICES: ______________________

Patient Assessment Screens: (see screening questions on back of this sheet; screens are required on each patient as warranted by their condition)
Nutritional: ☑ **completed; Discharge Planning:** ☑ **completed; Functional Health:** ☑ **completed; Personal Safety:** ☑ **completed**

KEY: ✓ = WITHIN NORMAL LIMITS; X = WITHIN NORMAL LIMITS EXCEPT; NA = NOT ASSESSED
A BASIC NEUROLOGICAL, CARDIAC, RESPIRATORY AND PAIN/COMFORT ASSESSMENT IS REQUIRED ON EVERY PATIENT; OTHER ASSESSMENTS ARE FOCUSED BASED UPON PATIENT'S CHIEF COMPLAINT AND/OR EXHIBITING SIGNS AND SYMPTOMS

TIME/INITIALS OF RN COMPLETING 1823 [initials]

ORTHO-STATICS	TIME	LYING		SITTING		STANDING		INITIALS
		BP	P	BP	P	BP	P	
		BP	P	BP	P	BP	P	

Point of Care Testing [normals are bolded or in ( )]

Test	Results	Initials
Hemoccult	☐ Pos ☐ **Neg** ☐ QC Confirmed	
Gastroccult	☐ Pos ☐ **Neg** ☐ QC Confirmed	
Pregnancy	☐ Pos ☐ **Neg** ☐ QC in past 24 hours ☐ Urine Sp Grav______ (less than or #1.010 may indicate false negative)	
Nitrazine	pH______ ☐ tested eyes (7.0-7.2) ☐ amniotic fluid (7.0-7.5)	

TIME	BP	P	R	T	O_2SAT/O_2	*[1]	ASSESSMENTS/INTERVENTIONS/MEDICATIONS/EVALUATIONS	INITIALS
1825							Pt c/o (L) foot/ankle swelling + numbness	
							(+) toe movement (+) pedal pulse	
							good CMS	[initials]
1910							Pt given verbal & written discharge	
							inst. offers no questions.	[initials]

Time	Initials	IV #	Type of Solution	Medication Added	Rate	Site	Gauge	Amount Infused

INTAKE RECORD

Time	IV	NG	PO	Other

OUTPUT RECORD

Time	Urine	NG	Other

[1]Please place a * in column if medications are documented on that line.

______________________ INITIALS/SIGNATURE

______________________ INITIALS/SIGNATURE

[initials] Jen Tennhauer RN
INITIALS/SIGNATURE

[initials] / [signature]
INITIALS/SIGNATURE

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL
5000 W. Chambers Street
Milwaukee, WI 53210-1688

EMERGENCY DEPARTMENT RECORD PAGE 2

PARKS LARRY E
DOB: 03/26/57 47Y SEX: M MR: 778667
EMERGENCY CONSULTANTS INC
ACCT#:
71263992

58042 6/04 89

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL
5000 W. Chambers Street
Milwaukee, WI 53210-1688

- L. Aiuku, MD
- O. Alvarez, MD
- J. Faber, MD
- W. Kumprey, MD
- L. LaCrosse, MD
- J. Lee, DO
- J.B. Lindberg, MD
- M. Mitchell, DO
- R. Skrupky, MD
- G. Walker, MD
- M. Bender, PA-C
- J. Harine, PA-C
- J. McCommons, PA-C
- D. Pacey, PA-C
- D. Prohaska, PA-C
- J. Robinson, PA-C

Emergency Dept. 414-447-2171

Patient Name | Date

℞

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL
5000 W. Chambers Street
Milwaukee, WI 53210-1688

- L. Aiuku, MD
- O. Alvarez, MD
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- J. McCommons, PA-C
- D. Pacey, PA-C
- D. Prohaska, PA-C
- J. Robinson, PA-C

Emergency Dept. 414-447-2171

Patient Name | Date

℞

Provisional Diagnosis _____ Physician who cared for you _____

We have examined and treated you today on an emergency/urgent care/outpatient basis only. If symptoms or medical problem(s) fail to improve, call us at 447-2171, see your doctor, or return here.

- ☐ You must arrange for an exam with your physician in _____ days.
- ☐ You should arrange for an exam with your physician if your condition does not improve in _____ days.
- ☐ Physician _____
- Telephone _____
- Additional Instructions _____

- ☐ You had _____ sutures/staples. They must be removed in _____ days.
- ☐ You were prescribed sedatives or pain medications that may make you drowsy. Do not drink alcohol, drive, or operate machinery while you are taking those medications.
- ☐ Cultures were done today. Results will not be available for 72 hours. We will call you if the culture is positive and additional treatment is required.

Please follow the instructions below as indicated for:

- ❑ Abdominal Complaint
- ❑ Animal Bite
- ❑ Asthma
- ❑ Back Pain
- ❑ Burn Care
- ❑ Cast Care
- ❑ Chest Pain
- ❑ Cold - Adult/Child
- ❑ Crutch Walking/Crutches
- ❑ Culture
- ❑ Eye Injury
- ❑ Fever - Child
- ❑ Febrile Convulsion
- ❑ Headache
- ❑ Head Injury - Adult/Child
- ❑ High Blood Pressure
- ❑ Neck Strain/Sprain
- ❑ Nosebleed
- ❑ Otitis Media (Ear ache)
- ❑ Pelvic Inflammatory Disease
- ❑ Seizure
- ❑ Sore Throat
- ❑ Strain, Sprain, Fracture
- ❑ Tetanus
- ❑ Threatened Miscarriage
- ❑ Urinary Tract Infection
- ❑ Venereal Disease
- ❑ Vomiting/Diarrhea - Adult/Child
- ❑ Wound Care/Suture After Care
- ❑ IV Conscious Sedation

Other _____

- ☐ If you received x-rays, they do not always show injury or disease. Fractures (breaks in the bones) are not always revealed on the initial x-rays but may be revealed on subsequent x-rays. **Your x-ray has been read on a preliminary basis.** Final reading will be made by the Radiologist. You or your referral physician will be notified of any additional findings through the Emergency Department.
- ☐ **If you received an EKG it has been read on a preliminary basis** by the **physician on duty.** A final reading will be made and you or your referral physician will be contacted if additional treatment is required.

I have received discharge instructions and understand that I have received emergency care only. I am to call or see my family physician for further care.

I also understand my primary care physician may receive a copy of my ED record

Patient signature: _____

Work/School Release: _____ Today's date: _____

- _____ May return to work/school immediately with no limitations.
- _____ Off work/school today, may return next scheduled shift/day.
- _____ Off work/school for _____ days. Re-check by family/company doctor or preferred doctor prior to return recommended.
- _____ May return to work/school with the following limitations: _____

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL
5000 W. Chambers Street
Milwaukee, WI 53210-1688

GENERAL DISCHARGE INSTRUCTIONS ED-SJRMC

PARKS LARRY E
DOB 03/26/57 47Y SEX: M MR: 778667
EMERGENCY CONSULTANTS INC
ACCT# 71263992

Covenant Healthcare

Inpatient and Outpatient Consent for Treatment & Financial Agreement

☐ St. Joseph Regional Medical Center
☐ Elmbrook Memorial Hospital
☐ St. Michael Hospital
☐ St. Francis Hospital

Covenant Healthcare Hospitals have a number of ambulatory/outpatient sites that are covered by this Agreement.

A. **Consent for Treatment:** I am entering the above named facility (the "Facility") for the purpose of medical and/or surgical treatment or diagnosis. I consent to my physician, other attending, consulting and/or referring physicians and their assistants and designees, and other Facility personnel, to provide me with such medical, surgical, diagnostic or other treatment services judged necessary and/or appropriate by my physician. This consent includes my consent for hospital services, diagnostic procedures and all medical treatment rendered under the instructions of my physician(s) including x-ray and laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of diagnosis and treatment, cells, tissues and/or parts may be removed from my body. I authorize Facility personnel to preserve or use such cells, tissues or parts for teaching purposes and/or to dispose of any cells, tissues or parts that are removed.

B. **General Acknowledgments:** I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury, and even death. No guarantees have been made to me with respect to the results of my examinations or treatments in the Facility. I understand that many of the physicians on the Facility's staff are not employees or agents of the Facility but, rather, are independent contractors who have been granted the privilege of using this Facility for the care and treatment of their patients. I understand that the Facility is not liable for any actions or omission of, or the instructions given by, such independent contractors who treat me while I am in the Facility. I understand and agree that I may be observed and/or receive care from medical, nursing, and other health care students in training at the Facility. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care. I understand that I may review and obtain a copy my medical record, at my own expense, and that this review shall take place in the Facility, during regular business hours.

C. **Medicare Payments:** I acknowledge receipt of the "Important Message from Medicare," as applicable.

PATIENT LABELS MUST BE PLACED HERE ON ALL PAGES (PARTS) – SIDES OR FOLD-OUT (PANELS) THAT THIS BOX APPEARS ON.

D. **Assignment and Agreement to Pay:** I understand that I am responsible for payment for the services that I receive and guarantee payment for these services. I hereby assign to Facility and the physicians and professionals associated with the Facility, for application to my bill for services, all of my rights and claims for reimbursement under any federal or state healthcare plan (including but not limited to Medicare or Medicaid), insurance policy, any managed care arrangement or any other similar third party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. I understand that I am responsible for any applicable co-payment, deductibles, co-insurance and/or non-covered costs and charges. I understand that not all insurance companies pay the usual and customary fees of the Facility, the physicians and/or the professionals associated with the Facility. Therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or others for billing purposes. I also understand that I may receive separate bills from independent physicians involved in my care including radiologists, anesthesiologists, pathologists, emergency room physicians and other independent physicians. These physicians may or may not participate in all insurance networks.

E. **Valuables:** Keeping valuables (such as cash, jewelry, documents) in the Facility is strongly discouraged. I understand that the Facility has a place where my valuables may be stored. If I choose to keep valuables in the Facility, I do so at my own risk and I understand and agree that Facility is not liable for loss or damage to any valuables that I do not turn over for storage.

F. **Photographing:** I understand and agree that the Facility may take photographic, electronic and/or video images of me in cases when it is required to assist with my treatment or for my safety. If my care involves the delivery of a baby, I give consent for my baby to be photographed for security and/or personal use.

G. **Privacy Notice:** I acknowledge that I was provided with a copy of Covenant Healthcare's Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for more information regarding release of your health information and your right to access your health information.

_____ _____

Signature of Patient/Authorized Representative Date

_____

Relationship of Authorized Representative

If unable to sign document, state reason: _____

_____

Covenant HEALTHCARE

A member of Covenant Healthcare, which is sponsored by the Wheaton Franciscan and Felician Sisters

St. Francis Hospital
St. Michael Hospital
Elmbrook Memorial Hospital
St. Joseph Regional Medical Center

Inpatient and Outpatient Consent for Treatment & Financial Agreement

1820 2/03 R8

PARKS LARRY E
DOB 03/26/57 47Y SEX M MR: 778667
EMERGENCY CONSULTANTS INC
ACCT# 71263992

HERE
OR

ST. JOSEPH REGIONAL MEDICAL CENTER
A MEMBER OF COVENANT HEALTHCARE

Account No: 71260192
Sched Date: 03/08/05 11:00 AM

MR#: 0778667

PATIENT INFORMATION
PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212

Phone: 414 264-3716
DOB: 03/26/1957 Age: 47
Gender: M MS: LEGALLY SEPARAT
SS#: 397-64-6801
Religion: BAPTIST
Employer: NONE
Phone #:
Occupation:

NEAREST RELATIVE
Name: SELLERS SHERESA
Phone: 414 418-0186
Bus Phone:
Relat: OTHER RELATIONS
Notify: Y

ADDITIONAL CONTACT
Name:
Phone:
Bus Phone:
Relat:
Notify:

VISIT INFORMATION

INTERPRETER NEEDED: NO
Language: ENGLISH

Admit Reason: RECURRENT DISLOCATION PATELLA
Comment: BM

CLINIC

Visit Type: G
Location: PRE ADMISSION CENTER#
Last Inp Date:
Last Outpt Date: 02/23/05

PHYSICIAN INFO
Adm:
Att: MLSNA JACQUELINE S
PCP: NONE

INSURANCE INFORMATION

PRIMARY: GA-MP MILWAUKEE CNTY
Plan: STANDARD
PO BOX 8190
MADISON WI 53708
Phone #: 414 257-7200
Subr: PARKS LARRY E
Relat: PATIENT IS INSURED
Policy#: 397646801
Group#: 99999
Group Name: MLK HERITAGE

GUARANTOR INFORMATION
Name: PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212-0000

Phone #: 414 264-3716
SS#: 397-64-6801
Employer: NONE
Phone #:

FILE

Covenant Laboratory

St. Joseph Regional Medical Center
5000 W. Chambers
Milwaukee, WI 53210
(414) 447-2229

ADMITTED: 03/08/2005 **DOCTOR:** PHYSICIAN NOT, ON FILE, MD

HIV TESTING

			RESULT	REFERENCE
03/08/2005 12:00	HIV1,HIV2 ELISA Ab Screen	HIV 1,2	Non-Reactive	Non-Reactive

Performed at Midwest Clinical Laboratories, 11020 W Plank Court, Wauwatosa, WI, USA, 53226

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Larry Parks
Signature of Patient/Authorized Representative

03/08/05
Date

Relationship of Authorized Representative

If unable to sign document, state reason: _____

Covenant HEALTHCARE
A member of Covenant Healthcare, which is sponsored by the Wheaton Franciscan and Felician Sisters

St. Francis Hospital
St. Michael Hospital
Elmbrook Memorial Hospital
St. Joseph Regional Medical Center

Inpatient and Outpatient Consent for Treatment & Financial Agreement

1820 2/03 R8

PARKS LARRY E
DOB: 03/26/57 47Y SEX M MR: 778667
MILSNA JACQUELINE S
ACCT#: 71260192

Covenant Healthcare

Inpatient and Outpatient Consent for Treatment & Financial Agreement

☐ St. Joseph Regional Medical Center
☐ Elmbrook Memorial Hospital
☐ St. Michael Hospital
☐ St. Francis Hospital

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PARKS LARRY E
DOB: 03/26/57 47Y SEX M MR: 778667
MILSNA JACQUELINE S
ACCT#
71260.92

ST. JOSEPH REGIONAL MEDICAL CENTER
A MEMBER OF COVENANT HEALTHCARE

Account No: 71251169
Sched Date: 02/23/05 01:00 PM

MR#: 0778667

PATIENT INFORMATION

PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212

Phone: 414 264-3716
DOB: 03/26/1957 Age: 47
Gender: M MS: LEGALLY SEPARAT
SS#: 397-64-6801
Religion: BAPTIST
Employer:
Phone #:
Occupation:

NEAREST RELATIVE

Name: SELLERS SHERESA
Phone: 414 418-0186
Bus Phone:
Relat: OTHER RELATIONS
Notify: Y

ADDITIONAL CONTACT

Name:
Phone:
Bus Phone:
Relat:
Notify:

VISIT INFORMATION

INTERPRETER NEEDED: NO
Language: ENGLISH

Admit Reason: POST OPERATIVE EXAM FOLLOW UP CLINIC
Comment: KDM

Visit Type: G
Location: SJH ORTHOPEDIC CLINIC#
Last Inp Date:
Last Outpt Date:

PHYSICIAN INFO

Adm:
Att: MLSNA JACQUELINE S
PCP: NONE

INSURANCE INFORMATION

PRIMARY: GA-MP MILWAUKEE CNTY
Plan: STANDARD
PO BOX 8190
MADISON WI 53708
Phone #: 414 257-7200
Subr: PARKS LARRY E
Relat: PATIENT IS INSURED -
Policy#: 397646801
Group#: 99999
Group Name: MLK HERITAGE

GUARANTOR INFORMATION

Name: PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212-0000

Phone #: 414 264-3716
SS#: 397-64-6801
Employer:
Phone #:

FILE

HISTORY & PHYSICAL/PROCEDURE RECORD

DATE OF HISTORY TIME

INFORMANT

ROOM/LOCKER NO.

PROCEDURE

CURRENT MEDICATION AND DOSAGE PRESCRIBED AND NON-PRESCRIBED

PERSON TO ACCOMPANY PATIENT HOME

REASON FOR HOSPITALIZATION

SMOKING HABITS

PAST SURGERIES

ALCOHOL/DRUG/CAFFEINE USAGE

PRE-PROCEDURE MENTAL STATUS

☐ ALERT AND ORIENTED

☐ OTHER:

HEIGHT | WEIGHT (IN LBS) | (IN KG)

EXISTING CO-MORBID CONDITIONS

☐ ASTHMA/EMPHYSEMA
☐ TB
☐ CHEST PAIN
☐ IRREG. BEATS
☐ HEART ATTACK
☐ PACEMAKER
☐ VALVULAR HEART DISEASE
☐ VASCULAR DISEASE
☐ HYPERTENSION
☐ DIABETES ☐ INSULIN DEP.
☐ CANCER
☐ KIDNEY DISEASE
☐ OTHER:
☐ OTHER:
☐ OTHER:

☐ SEIZURES
☐ CIRRHOSIS
☐ INFECTIOUS DISEASES (I.E., HEPATITIS, ETC.)
☐ ARTHRITIS
☐ ULCER, GI PROBLEMS
☐ BLEEDING PROBLEMS (I.E. SICKLE CELL)
☐ BLOOD TRANSFUSION
DATE:
REACTION:
☐ ANES. PROBLEMS
☐ COLD SYMPTOMS PRESENTLY OR WITHIN LAST 2 WEEKS
☐ NONE OF THE ABOVE

ALLERGIES (FOOD, MED, TAPE, DYE, LATEX, ETC.)

TYPE OF REACTION

☐ LIVING WILL ☐ POWER OF ATTORNEY FOR HEALTH CARE ☐ NONE
☐ OTHER:
☐ PATIENT UNABLE TO RESPOND ☐ COPY OF ADVANCE DIRECTIVES ON CHART ☐ YES ☐ NO

TIME/INITIALS	BP	P	R	T	TIME/INITIALS	BP	P	R	T
/					/				
/					/				

INDICATIONS/SYMPTOMS FOR PROCEDURE OR ☐ SEE DICTATION

RISKS/BENEFITS/COMPLICATIONS/ALTERNATIVES EXPLAINED RELATED TO ☐ **PROCEDURE** ☐ **SEDATION** ☐ **BLOOD**

PHYSICAL EXAMINATION SPECIFIC TO THE PROCEDURE AND ANY CO-MORBID CONDITIONS

IV SEDATION: ALSO INCLUDE PHYSICAL EXAM OF HEART/LUNGS BY AUSCULTATION

LUNG	HEART	OTHER
☐ CLEAR	☐ REGULAR RHYTHM	
☐ OTHER	☐ OTHER	

TREATMENT OR OPERATIVE REPORT OR ☐ SEE DICTATION

FINAL DIAGNOSIS

Recurrent patellar dislocation

DISCHARGE PLANS

PHYSICIAN SIGNATURE [signature]

DATE 2/23/05

PHYSICIAN ORDERS/NURSING NOTES

Prepared ® knee done by D. J. Nelson. c-spine at [illegible].

2/23/0[illegible]

☐ SEE PATIENT'S PROGRESS NOTES

TIME PATIENT RETURNED TO DAY SURGERY

☐ LOCAL ANESTHETIC
☐ IV SEDATION IN O.R.

POST-PROCEDURE/DISCHARGE OUTCOMES

MENTAL STATUS	MET	NOT MET	N/A
ALERT/ORIENTED	☐	☐	☐
RETURN TO PRE-PROCEDURE LEVEL	☐	☐	☐
PHYSICAL/EMOTIONAL COMFORT NEEDS	☐	☐	☐
PAIN CONTROLLED	☐	☐	☐
DRSG DRY/DRNG CONTROLLED	☐	☐	☐
AMBULATES SAFELY	☐	☐	☐
PATIENT/FAMILY VERBALIZES UNDERSTANDING DISCHARGE/ MEDICATION INSTRUCTIONS	☐	☐	☐
OTHER:	☐	☐	☐

DISCHARGE TIME: INITIALS:

RN SIGNATURE [signature] INIT. RN SIGNATURE INIT.

ST. JOSEPH REGIONAL MEDICAL CENTER

Covenant HOSPITAL

5000 W. Chambers St • Milwaukee, WI 53210
2301 N. Bluemound Rd • Milwaukee, WI 53226
10400 W. North Ave • Wauwatosa, WI 53226

HISTORY & PHYSICAL/ PROCEDURE RECORD

PARKS LARRY E
DOB: 03/26/57 47Y SEX M MR: 778667
MLSNA JACQUELINE S
ACCT#
7251169

OUTPATIENT NOTE

ORIGINAL
cc:

DATE OF SERVICE: 02/23/2005.

CHIEF COMPLAINT: Left knee pain.

HISTORY OF PRESENT ILLNESS: This patient is a 47-year-old man who comes in for evaluation of recurrent patellar dislocation. It appears he had surgery in the remote past, probably to address his recurrent patellar dislocations. He does not specifically recall whether this is the case. He says he had some cartilage and ligament problems which were addressed with an open procedure. He says he did well until a few years ago when he began experiencing recurrent patellar dislocations. He has had several events since that time. He tells me that approximately 10 days ago, he fell striking his knee and developed a dislocation. He was seen in the emergency room where attempted reduction was made. This was, unfortunately, unsuccessful in achieving a permanent reduction. He was placed in a knee immobilizer and is presenting now for further evaluation and treatment. He did not wear the immobilizer for this exam. He has been able to relocate his own patella but has recurrent dislocation immediately on flexion of the knee.

PAST MEDICAL HISTORY: Patient denies any current medical problems.

MEDICATIONS: Tylenol with Codeine.

ALLERGIES: PENICILLIN but does not specifically recall the reaction and says that he has been given Penicillin since that time without the problem.

HABITS: The patient smokes a pack of cigarettes per day. He specifically denies use of alcohol or street drugs.

REVIEW OF SYSTEMS: Obtained but is noncontributory.

SOCIAL HISTORY: He is employed as a laborer at a car wash.

PHYSICAL EXAMINATION: Shows there is an old peritoneal, parapatellar surgical scar. Patient clearly has a dislocated patella which is reducible but immediately unreduced with any motion of the knee. Mild

OUTPATIENT NOTE

tenderness is present. He is not asked to flex his knee, and no other provocative maneuvers are performed. Distally, motor function is intact. Neurologic function is intact.
X-rays taken in the emergency room demonstrate arthritic change notable in the medial compartment. There appears to be a loose body within the knee. The patella is completely dislocated, and there are some arthritic changes noted there.

IMPRESSION:

1. Recurrent patellar dislocation with absolute instability.
2. Osteoarthritis with loose body.

RECOMMENDATIONS: Spoke with Mr. Parks at length with reference to his options. He does not appear to have had a tibial tubercle osteotomy. I think it would be in his best interest to consider a tibial tubercle osteotomy with soft tissue realignment in the hopes of maintaining patellar stability. If this is unsuccessful, he can consider a patellectomy; although, the problems with consideration of this procedure are discussed as well as potential risks of surgery to include medical/anesthetic complications of a significant degree, DVT, pulmonary embolus infection, failure of the operation to achieve its desired results, failure of fixation, and failure of the osteotomy to heal are discussed. He is concerned about loss of work time. I offered him an operation this week which he declined. He says that he will need time to make appropriate arrangements, and so, we will make every attempt to perform his surgery next week. In the meantime, we will help him with his financial difficulties due to the fact that he has no reasonable insurance coverage.

JACQUELINE MLSNA, MD

JM/tp D.02/27/2005 23:39:23 T.02/28/2005 15:20:32
Doc ID #: 4032241 Voice ID #: 3899246

ST. JOSEPH REGIONAL MEDICAL CENTER
PROVIDER: JACQUELINE MLSNA, MD
VISIT TYPE: C
ROOM #: ORTC

NAME: PARKS, LARRY E
MRN: 778667
DOB: 03/26/1957

DATE: 02/23/2005
ACCT #: 71251169
AGE: 47Y

OUTPATIENT NOTE

D. **Assignment and Agreement to Pay:** I understand that I am responsible for payment for the services that I receive and guarantee payment for these services. I hereby assign to Facility and the physicians and professionals associated with the Facility, for application to my bill for services, all of my rights and claims for reimbursement under any federal or state healthcare plan (including but not limited to Medicare or Medicaid), insurance policy, any managed care arrangement or any other similar third party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. I understand that I am responsible for any applicable co-payment, deductibles, co-insurance and/or non-covered costs and charges. I understand that not all insurance companies pay the usual and customary fees of the Facility, the physicians and/or the professionals associated with the Facility. Therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or others for billing purposes. I also understand that I may receive separate bills from independent physicians involved in my care including radiologists, anesthesiologists, pathologists, emergency room physicians and other independent physicians. These physicians may or may not participate in all insurance networks.

E. **Valuables:** Keeping valuables (such as cash, jewelry, documents) in the Facility is strongly discouraged. I understand that the Facility has a place where my valuables may be stored. If I choose to keep valuables in the Facility, I do so at my own risk and I understand and agree that Facility is not liable for loss or damage to any valuables that I do not turn over for storage.

F. **Photographing:** I understand and agree that the Facility may take photographic, electronic and/or video images of me in cases when it is required to assist with my treatment or for my safety. If my care involves the delivery of a baby, I give consent for my baby to be photographed for security and/or personal use.

G. **Privacy Notice:** I acknowledge that I was provided with a copy of Covenant Healthcare's Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for more information regarding release of your health information and your right to access your health information.

Larry Parks
Signature of Patient/Authorized Representative

2-23-05
Date

Relationship of Authorized Representative

If unable to sign document, state reason: _____

Covenant HEALTHCARE
A member of Covenant Healthcare, which is sponsored by the Wheaton Franciscan and Felician Sisters

St. Francis Hospital
St. Michael Hospital
Elmbrook Memorial Hospital
St. Joseph Regional Medical Center

Inpatient and Outpatient Consent for Treatment & Financial Agreement

1820 2/03 R8

PARKS LARRY E
DOB 03/26/57 47Y SEX M MR: 778667
MLSNA JACQUELINE S
ACCT# 71251169

Covenant Healthcare

Inpatient and Outpatient Consent for Treatment & Financial Agreement

☐ St. Joseph Regional Medical Center
☐ Elmbrook Memorial Hospital
☐ St. Michael Hospital
☐ St. Francis Hospital

Covenant Healthcare Hospitals have a number of ambulatory/outpatient sites that are covered by this Agreement.

A. **Consent for Treatment:** I am entering the above named facility (the "Facility") for the purpose of medical and/or surgical treatment or diagnosis. I consent to my physician, other attending, consulting and/or referring physicians and their assistants and designees, and other Facility personnel, to provide me with such medical, surgical, diagnostic or other treatment services judged necessary and/or appropriate by my physician. This consent includes my consent for hospital services, diagnostic procedures and all medical treatment rendered under the instructions of my physician(s) including x-ray and laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of diagnosis and treatment, cells, tissues and/or parts may be removed from my body. I authorize Facility personnel to preserve or use such cells, tissues or parts for teaching purposes and/or to dispose of any cells, tissues or parts that are removed.

B. **General Acknowledgments:** I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury, and even death. No guarantees have been made to me with respect to the results of my examinations or treatments in the Facility. I understand that many of the physicians on the Facility's staff are not employees or agents of the Facility but, rather, are independent contractors who have been granted the privilege of using this Facility for the care and treatment of their patients. I understand that the Facility is not liable for any actions or omission of, or the instructions given by, such independent contractors who treat me while I am in the Facility. I understand and agree that I may be observed and/or receive care from medical, nursing, and other health care students in training at the Facility. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care. I understand that I may review and obtain a copy my medical record, at my own expense, and that this review shall take place in the Facility, during regular business hours.

C. **Medicare Payments:** I acknowledge receipt of the "Important Message from Medicare," as applicable.

PARKS LARRY E
DOB 03/28/57 47Y SEX M MR: 778567 E
MLSNA JACQUELINE S
ACCT# 71251169

ST. JOSEPH REGIONAL MEDICAL CENTER
A MEMBER OF COVENANT HEALTHCARE

MR#: 0778667

Account No: 71244888
Sched Date: 02/14/05 09:23 AM

PATIENT INFORMATION

PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212

Phone: 414 264-3716
DOB: 03/26/1957 Age: 47
Gender: M MS: LEGALLY SEPARAT
SS#: 397-64-6801
Religion: BAPTIST
Employer:
Phone #:
Occupation:

NEAREST RELATIVE

Name: SELLERS SHERESA
Phone: 414 418-0186
Bus Phone:
Relat: OTHER RELATIONS
Notify: Y

ADDITIONAL CONTACT

Name:
Phone:
Bus Phone:
Relat:
Notify:

VISIT INFORMATION

INTERPRETER NEEDED: NO
Language: ENGLISH

Admit Reason: FALL
Comment: TSG

Visit Type: E
Location: EMERGENCY DEPT#TRAUMA/MAJ
Last Inp Date:
Last Outpt Date:

PHYSICIAN INFO

Adm:
Att: EMERGENCY CONSULTANTS INC
PCP: NONE

INSURANCE INFORMATION

PRIMARY: GA-MP MILWAUKEE CNTY
Plan: STANDARD
PO BOX 8190
MADISON WI 53708
Phone #: 414 257-7200
Subr: PARKS LARRY E
Relat: PATIENT IS INSURED -
Policy#: 397646801
Group#: 99999
Group Name: MLK HERITAGE

GUARANTOR INFORMATION

Name: PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212-0000

Phone #: 414 264-3716
SS#: 397-64-6801
Employer:
Phone #:

St. Joseph Regional Medic[illegible]l Center | Emergen[illegible] Department QualChart®

ORDER SHEET / GEN[illegible]AL | Height: Weight: lbs / kgs Allergies:

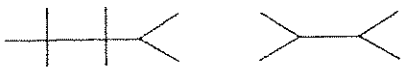
Medical Records: Old Chart Recent ED Chart Previous EKG Additional Records:

PANELS: Cardiac Abdominal Pain Trauma AMS Adult Sepsis Pediatric Fever STD / GYN Entered by: Time:

LABORATORY: Circle specific orders	By:	Time:
CBC Manual Diff		
BMP CMP Mg		
Amylase Lipase Ammonia		
UA UA w/o Micro CC Cath		
UCG HCG: Qual / Quant		
Drug Screen: Urine / Serum ETOH		
CPK CKMB Troponin		
D - Dimer BNP Myoglobin		
ESR Uric Acid		
Rh Type Screen Type Cross ____ units		
PT PTT		
ASA Acetaminophen		
Digoxin		
Dilantin Depakote		
Tegretol Phenobarb		
CSF Analysis		
Rapid Strep Mono RSV Influenza		
Cultures: Urine Sputum Wound		
Blood Blood x 2 Stool		
Stool: Leukocytes O & P Rotavirus		
GC Chlamydia Wet Prep KOH		
Hemoccult Gastroccult		
ADDITIONAL LAB / RADIOLOGY ORDERS:		

RADIOLOGY: Circle specific orders	By:	Time:
CXR (2 view) Portable CXR		
C-Spine XT C-Spine Port XT C-Spine		
AAS KUB		
T-Spine L-Spine		
Ribs Right Left		
Finger Right Left		
Hand Right Left		
Wrist Right Left		
Forearm Right Left		
Elbow Right Left		
Humerus Right Left		
Shoulder Right Left		
Clavicle Right Left		
Hip Pelvis Right Left Portable		
Femur Right Left		
Knee Right Left		
Tibia / Fibula Right Left		
Ankle Right Left		
Foot Right Left		
CT: Head / Facial Bones With Without		
CT: C-Spine T-Spine L-Spine		
CT: Chest With Without		
CT: Abdomen / Pelvis With Without		
Ultrasound of: GB ABD Pelvis		

Pertinent Lab Values: WNL WNL Except:



Signs / Symptoms Necessitating Xray / CT / US: ____

Xray Interp: ED Physician Radiologist Discussed With ____

No Acute Changes Positive ____

CARDIAC MONITOR / EKG INTERP:	By:	Time:
Monitor EKG Repeat EKG @ ____		

Rate: Normal Brady Tachy ____

Rhythm: Sinus AFIB Junctional ____

Ectopy: None PVCs PACs ____

EKG #1 Interp: ____

EKG #2 Interp: ____

EKG Comparison: No Significant Change / Other: ____

RESPIRATORY THERAPY:	By:	Time:
ABG On Room Air		
Albuterol Unit Dose or mg x 1 2 3 q min		
Atrovent Unit Dose or mg x 1 2 3 q min		
Xopenex Unit Dose or mg x 1 2 3 q min		
Rac Epi Unit Dose or mg x 1 2 3 q min		
Continuous Albuterol / Xopenex		
Peak Flow: Pre-Tx: ____ Post-Tx #1: ____ Post-Tx #2: ____		

ORDERS:	By:	Time:	Time:	**CLINICAL RESPONSE / RE-EVALUATION**
Pulse Ox O2 @ ____ l/min via NC / Mask / NRB				NL Hypoxic ____ % on R/A or O2 @ ____ l/min
Saline Lock IV NS LR ____ ml Bolus / Rate ____ ml / hr				
Repeat Vital Signs: All BP Pulse RR Temp O2 Sat				VSS except:
Morphine 8mg IM		1945		
Zofran 4mg IM				

RE-EVALUATION: Unchanged Improved Worse

Time: ____ a.m. / p.m. ____

VSS except: ____ Pain: ____ (0-10)

Appearance: NAD / ____

Lungs: Clear / ____

Abdomen: Non-Tender / ____

Neuro: A & O x 3 / ____

SIGNATURE:

Time of Initial Orders: 1925 a.m. / p.m.

MD DO:

PA / NP

RN / Init

RN / Init

PARKS LARRY E
DOB 03/26/57 47Y SEX M MR: 778667
EMERGENCY CONSULTANTS INC
ACCT# 7244888

 02/14/05 09:17 am

QC218001021405050501

St. Joseph Regional Medical Center	Emergency Department QualChart® Page 1 of 2
GENERAL COMPLAINT	Fill in, circle pertinent positive findings. Complete all sections.

Exam Time: 0920 a.m. / p.m.

Mode of Arrival: (EMS) Other

Nurse's Triage Notes Reviewed (Yes) No

(VSS) Except: BP ____ Pulse ____ R Rate ____ Temp ____

Pulse Ox: NL Hypoxic Not Applicable ____ % on R/A or O_2 @ ____ L/min

Cardiac Monitor (Not Applicable) Interp.

Rate: NL Brady Tachy
Rhythm: Sinus Afib Junctional
Ectopy: None PVCs PACs

Other:

HISTORY:

HX from Patient Unobtainable due to: Dementia Altered MS Extremis
HX from: (Patient) Family / Caretaker EMS Interpreter
LMP: ____ Last Tetanus: ____

CHIEF COMPLAINT: This is a 47 year old (male) / female who presents with a complaint of: Rump fell, bus — tripped in hole —

Onset/Duration	Started 30 (Min) Hours Days Weeks Ago (Still Present) Resolved Worse Since: ____
Timing	(Constant) Intermittent Episodes Lasting ____ Sec Min Hours Days Weeks
Severity	Initially: (Mild) Moderate Severe Currently: (Mild) Moderate Severe
Location	— Prior Surgery (L) Knee — in Madison
Character	— ØLOC —
Aggravating	— ⊕ Neck pain — (R) 3rd Finger
Alleviating	
Associated Signs and Symptoms	Negative
Related HX:	Similar Episode / Dx as:

Pertinent Surgical HX:

REVIEW OF SYSTEMS: Pertinent Positives

Constitutional	Negative	Fever	Chills
Eyes	Negative	Photophobia	Blurred Vision
ENT	Negative	Sore Throat	Ear Ache
CV	Negative	Palpitations	Chest Pain
Respiratory	Negative	SOB	Cough
GI	Negative	Vomiting	Diarrhea
GU	Negative	Dysuria	Hematuria
MS	Negative	Arthralgia	Myalgia
Skin	Negative	Rash	Bruising
Neuro	Negative	Headache	Weakness
Psych	Negative	Anxious	Depressed

(YES) / NO All other systems either reviewed and negative or non-contributory for chief complaint

Additional Pertinent History:

Prior care for this complaint by: PCP ED EMS Date:
Dx: Rx:

PAST MEDICAL HISTORY: (Previously Healthy)

Endocrine	NIDDM	IDDM	Hypothyroid	Hyperthyroid	Hyperlipidemia
CV	CAD / MI	HTN	DVT	CHF	Afib
Respiratory	COPD	Asthma	Bronchitis	Pneumonia	PE
GI / GU	PUD / GERD	GI Bleed	Urosepsis	Diverticulitis	Gall / Kidney Stones
Neuro / Psych	TIA / CVA	Migraine	Anxiety	Depression	Seizure
Cancer:	Lung	Colon	Breast	Prostate	

Other: (L) Knee S

FAMILY HISTORY: Negative

Heart
HTN
Cancer N/A
Diabetes
Other:

SOCIAL HISTORY: Negative

Smoking: 1/2 ppd
ETOH / Drug Use: No —
Occupation: Driver —
Lives Alone Lives W/Family Nursing Home
Other:

PARKS LARRY E 47Y SEX M MR 778667
DOB 03/26/57
EMERGENCY CONSULTANTS INC
ACCT# 71244888

6585 Mark A Mitchell DO FACOEP

02/14/05 09:17 am