

The Denial
I wish to appeal-my claim

Linda Gossen

Linda Gossen

920-217-8647

CITY OF MILWAUKEE
2008 MAY 16 PM 1:06
RONALD D. LEONHARD
CITY CLERK

RECEIVED
CITY CLERK

NOV 10 11 31 AM '08

RECEIVED

CITY OF MILWAUKEE DEPT OF METRO

RECEIVED

2008 JAN 29 PM 3:05

RONALD D. LEONHART
CITY CLERK

LINDA GOSSEN
304 N ADAMS
GREEN BAY, WI 54301

City Clerk Attn: Claims

I reporting a claim of injury that took place on Friday December 28th 2007. The time the injury took happened is 2:16 PM. On the corner of 6th and Wisconsin

I walk across the street till a got hafe way. I fell on the road and landed on my left knee on the left side of the knee.

I have copies of the Hospital report, ambulance report, Orthopedic doctor Austin Boyle. I'll have his report for you.

Here is my name and phone number Linda Gossen
920-217-8647

MILWAUKEE

MR Knee LEFT

GOSSEN, LINDA M - SSMC-00531189

* Final Report *

Result Type: MR Knee LEFT
 Result Date: January 03, 2008 15:45
 Result Status: Auth/Verified
 Result Title: MR Knee LEFT
 Performed By: Moore, Nicholas J E on January 03, 2008 16:26
 Verified By: Moore, Nicholas J E on January 04, 2008 08:36
 Encounter info: SSMC-05827322, ASMC, Imaging/Radiology, 1/3/2008 - 1/4/2008

*** Final Report ***

Reason For Exam

left knee pain and effusion

MR Report

MRI OF THE LEFT KNEE

Indication: Knee pain and effusion after fall.

Discussion: Multiplanar, multisequence high field MR imaging of the left knee was performed without contrast.

Tendons of the extensor mechanism are intact. The anterior and posterior cruciate ligaments are normal. The medial collateral ligament, fibular collateral ligament, iliotibial band, and biceps femoris tendon are intact.

No meniscal tear is identified.

There is a fracture in the lateral tibial plateau, in the sagittal plane, just lateral to the tibial spines. The fracture is essentially nondisplaced. No measurable depression is present. Associated marrow edema is seen in the lateral tibial plateau. The fracture does reach both the anterior and posterior cortices of the lateral tibial plateau. A small knee joint effusion is present. No articular cartilage defects are identified.

IMPRESSION:

Nondisplaced lateral tibial plateau fracture extending from anterior to posterior cortex just lateral to the tibial spines. No appreciable depression or significant displacement is present.

I telephoned Dr. Boyle's Milwaukee office and discussed this case with his assistant at the time of dictation.



Aurora Health Care

Milwaukee, Wisconsin

125996

MRN / Chart #: 531189

1) Linda Gossen 304 N Adams Green Bay WI 54301
Name Address City State Zip

9/4/1958 920-217-8647
Date of Birth Daytime Phone cell phone

Previous Name _____
12-28-07 ER

2) **AUTHORIZES:**

Aurora Sinai Medical Center
Attn: Medical Records/MMRA
1020 North 12th Street

Name of Health Care Provider Roman P. Guter
Milwaukee, WI 53233

Address _____

3) **TO DISCLOSE TO:**

Self [I hereby authorize _____ to pick up my records.] (Photo ID required.)

Name of Health Care Provider / Plan / Other

Address _____
I all so want a cope of the MRI Report from Dec 3rd

4) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From Dec. 28, 2007 to report from Abilene report
information from the past two (2) years will be disclosed. one emergency room report
(month/year) (month/year) If left blank, only

5) **INFORMATION TO BE DISCLOSED:**

- All medical records related to (specify condition, treatment, etc.): _____
- All billing records related to (specify condition, treatment, etc.): _____
- Radiology films/images (specify test): x ray of left leg. And all so MRI x ray
- Specific records/information as follows: which took place on Jan 3rd.

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):

- Alcohol/Drug Abuse
- HIV Test Results
- Mental Health / Developmental Disabilities

6) **EXPIRATION:** This Authorization is good until the following date / event: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) **PURPOSE** (check all that apply):
 Insurance Eligibility / Benefits Further Medical Care Legal Investigation / Action
 Personal (at my request) Other: _____

8) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation JAN 8 2008 will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) **SIGNATURE OF PATIENT / LEGAL REP:** Linda Gossen DATE: Jan 8, 2008
if signed by a person other than the patient, complete the following:


- 1. Individual is: a minor legally incompetent or incapacitated deceased
- 2. Legal authority: parent* legal guardian next of kin / executor of deceased activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only:



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
(Pre Tab / Corres)

Aurora Sinai Medical Center
 AuroraHealthCare®
945 North 12th Street
Milwaukee, WI 53233
414-219-2000

MRN: SSMC-00531189
Patient: GOSSEN, LINDA M
DOB: 09/04/1958
Case #: SSMC-05825773
Admit Date: 12/28/2007
Pt. Loc/Type/Rm: ED-ASMC Emergency Department ED
CC: EMPEC, X
CC: EMPEC, X

R A D I O L O G Y R E P O R T

<u>Exam</u> DX Knee 3 View LEFT	<u>Exam Date/Time</u> 12/28/2007 16:30:00	<u>Accession Number</u> DX-07-0952254	<u>Ordering MD</u> Blum, Michelle S
------------------------------------	--	--	--

Reason for Exam:
Trauma

DX Report
LEFT KNEE

Clinical History: Status post fall with left knee pain.

Comparison: None.

Findings: There is no acute fracture or dislocation. The bony matrix is unremarkable.

IMPRESSION:

No acute radiographic finding.

Dictated By: Lee, Sarha
Dictated Date/Time 12/28/07 19:01:00
Electronically Signed By: Lee, Sarha
Signed Date/Time: 12/31/07 09:34:11

Transcribed By: SLR
Transcribed Date/Time: 12/28/07 20:00:50

12-28-07 16:04





Aurora Health Care Milwaukee, Wisconsin

GOSSEN, LINDA M

MRN: SSMC-00531189
REG: 12/28/07

- ALMC AMCO ASMC SLMC
- AMCK AMCWC ASMMC SLSS
- AMCMC APH MHOB WAMH

DOB: 09/04/1958 F 49 Y
ATT: EMPEC, X

FIN: SSMC-05825773



General Consent to Care

I consent to medical care and treatment as ordered by my physician(s). My consent includes all hospital services, diagnostic procedures and medical treatment rendered including, without limitation, examinations, x-rays, laboratory procedures and other tests, treatments and medications, monitoring, electrocardiograms (EKGs), and all other procedures that do not require my specific informed consent. I understand that as a patient, I am under the direct and indirect care of licensed physicians that are on the medical staff of the hospital, some of whom may be employed by the State of Wisconsin or an affiliate of the State and, thus, claims against them may be treated differently. I further understand that the physicians who provide treatment to me while I am here are not employees of the hospital. I realize that, in an effort to provide proper treatment for me, my physician may consult with other physicians on the medical staff that I may not meet, such as a radiologist, pathologist, anesthesiologist, etc. **I realize these physicians will likely produce a bill for services that is separate from the hospital's bill.** I agree and acknowledge that the hospital and its employees, agents and representatives are not liable for the actions or omissions of, or for carrying out the instructions given by, the physicians who treat me while I am in the hospital. **I am aware that some physicians may not participate in the health plan or payment program that pays for my care and, thus, I may be subject to additional or out-of-network charges.** In addition, I understand that the hospital has educational affiliations with medical schools and other education institutions, and I agree to medical resident and student participation in my care, under supervision as appropriate.

Consent to Photographs/Videotapes/Recordings

I authorize the hospital to obtain photographs, videotapes and/or recordings of me for identification, diagnosis, treatment, and internal health care operations. I understand I may revoke this consent up until a reasonable time before such images/recordings are used. Any further use and/or disclosure of these images/recordings is restricted to those purposes I consent to at a later time.

Valuables

I understand and agree that the hospital assumes no liability for any loss or damage to any money, jewelry, documents, furs, or other articles brought by or for me to the hospital. I understand the hospital maintains a safe for the storage of valuables and other articles during inpatient hospitalizations that I may utilize upon request. No employee or other person is authorized to suggest or recommend storage of such articles by any other means.

Disclosure of Information for Payment and Health Care Operations

I understand that the hospital is authorized by law to use and disclose my general patient health care records for payment and health care operations without my authorization. However, I recognize that the hospital needs my authorization to disclose, if applicable, my HIV test results and treatment records related to mental health, developmental disabilities or alcohol and drug abuse (collectively, 'Sensitive Information') for payment and health care operations. Accordingly, I hereby authorize the hospital to disclose my Sensitive Information, as applicable, to Aurora Health Care billing personnel, my health plan and any other identified payers as necessary for the purpose of billing, collection or payment of claims. I further authorize the hospital to disclose my Sensitive Information to other Aurora Health Care affiliated entities for health care operations. This authorization will remain in effect for as long as my Sensitive Information is needed for these purposes. I am aware that I may revoke my authorization in writing at any time except to the extent the hospital has already acted in reliance upon the authorization. In addition, I understand that I have a right, upon request, to inspect and receive a copy of all such information being disclosed. **Please refer to the hospital's Notice of Privacy Practices for a detailed description of how the hospital may use and/or disclose your health information.**





Aurora Health Care Milwaukee, Wisconsin

GOSSEN, LINDA M

MRN: SSMC-00531189
REG: 12/28/07

- ALMC
- AMCO
- ASMC
- SLMC
- AMCK
- AMCWC
- ASMMC
- SLSS
- AMCMC
- APH
- MHOB
- WAMH

DOB: 09/04/1958 F 49 Y
ATT: EMPEC, X

FIN: SSMC-05825773



Assignment of Insurance Benefits / Charges / Refunds

I hereby authorize and assign payment directly to the hospital for such health expense insurance and other benefits and payments otherwise payable to me, but not to exceed the hospital's regular charge for the hospital services it renders. I understand that I am financially responsible to the hospital and the independent physicians who render services to me. I agree to pay the hospital the hospital's regular charges as set forth in its then current chargemaster and pay all charges of physicians and others, including co-insurance and deductibles, not covered by my insurance, subject to applicable Medicare and Medicaid advance notice requirements. To the fullest extent permitted by law, I authorize the hospital to transfer payments made by, or on my behalf, and otherwise refundable to me, to other Aurora Health Care accounts for which I am responsible. The assignment in this paragraph is valid until my accounts are paid in full.

Notice of Privacy Practices, Payment Policy and Patient Rights

I acknowledge that the hospital (an affiliate of Aurora Health Care, Inc.) has provided me a copy of its Notice of Privacy Practices, Payment Policy and Patient Rights. I understand the Notices describe the hospital's privacy practices regarding the use and/or disclosure of health information, the hospital's payment policy regarding charges for hospital services, collection, charity care and payment assistance programs, and other patient rights. I may not have elected to retain these brochures.

Home Health, Hospice and Durable Medical Equipment

Even at the time of admission/registration, it is important to start considering and planning for post-discharge care. I understand that I have the freedom to choose and the right to select my provider/supplier for post-discharge care and equipment I may need. I am aware that for home health care and hospice services and durable medical equipment after discharge, the hospital will generally use Aurora Visiting Nurse Association (an affiliate of the hospital) or another affiliate of the hospital, unless I select a different provider/supplier. I understand that I have received a list of other available home care agencies in my Admissions/Registration materials, and that I may ask a nurse for another copy of the list at any time.

My signature below certifies that I have read and understand this Treatment Agreement and I have provided the hospital accurate information to the best of my knowledge including, without limitation, information regarding financial assistance.

Linda Gosson
Signature of Patient

12-28-07
Date Signed

Signature of Legally Authorized Agent(s) and relationship to patient

Date Signed

For Aurora Personnel Use Only

Brochures Offered:

- Notice of Privacy Practices: Accepted Declined
- Payment Policy: Accepted Declined
- Patients Rights: Accepted Declined
- Home Health Provider List: Accepted Declined

Initials *KS*



- ✓ = Assessment done and findings are within the established criteria below
- = Assessment not done
- * = Assessment done, detail any abnormal findings
- = Assessment unchanged
- EVENT ✓ = Assessment done according to established criteria for circled portion of a multiple selection
- ✓ E or *e = Assessment done according to established criteria except for stated items

ASSESSMENT PARAMETERS	EXAMPLES OF ABNORMAL ASSESSMENT FINDINGS
Neurological Assessment. Alert and oriented to person, place and time. Memory intact. Behavior and communications appropriate to situation and age. Pupils equal and reactive to light. Active ROM of extremities with symmetry of strength.	- altered mental status - paralysis - paresthesia - dizziness - asymmetric weakness - ataxia
Respiratory Assessments. Chest symmetrical. Trachea midline. Respirations quiet and regular. Breath sounds vesicular through both lung fields, bronchial over major airways, with no adventitious sounds. No cough. Rate regular (see below for age appropriate rates)	- wheezing - obstruction/stridor - congestion - rapid respirations - cough - retractions - sputum production - accessory muscle use
Cardio/Peripheral Vascular Assessment. (cardiac) S ₁ & S ₂ audible. Neck veins flat at 45 degrees. Regular apical pulse (see below for age appropriate rates) (Neurovascular) CRT <3 sec. Peripheral pulses palpable. No edema. No numbness or tingling	- Irregular rhythm - distended neck veins - ectopy - murmur, etc - rapid/slow rate - edema - calf tenderness - paresthesia to an affected extremity - decreased or absent pulses
Gastrointestinal Assessment. Abdomen soft and nontender. Active bowel sounds in all 4 quadrants. By history tolerates prescribed diet without nausea and vomiting. Having BMs within own normal pattern and consistency. Nutritional status / eating habits appear appropriate to meet caloric needs.	- nausea, vomiting - hypo or hyperactive bowel sounds - under/over nourished - rectal bleeding - abdominal distention or tenderness - rebound/guarding - hematemesis
Genitourinary Assessment. By history able to empty bladder without dysuria. By history urine clear and yellow to amber. No current infection, drainage, trauma, abnormal bleeding. Normal menses. Normally progressing pregnancy. Normal pattern of wet diapers	- dysuria - threatened abortion - trauma during pregnancy - cloudy/dark urine - foul-smelling urine- penile drainage or abnormal bleeding - CVA tenderness - bladder distention
Integumentary Assessment. Skin color within patient's usual color. Skin warm, dry and intact with normal turgor. Mucous membranes pink, moist, and intact.	- any break in skin - burn - ecchymosis - rash - dry mucosa - petechiae - active bleeding - poor turgor - purpura
Musculoskeletal Assessment. Normal ROM of affected joints. No muscle weakness. Normal posture. No joint swelling, inflammation, or cramping. Absence of deformities. Pediatrics: Appropriate physical growth and gait.	- inflamed joint - trauma/deformity - point tenderness - limited or absent ROM - Weakness - lack of appropriate motor skills
Eyes, Ears, Nose and Throat Assessment. Senses intact, with aids if needed. No foreign body, infection, bleeding or trauma present. No photosensitivity.	- Inflammation/irritation - bleeding - enlarged lymph node - deaf/HOH - exudate - FB - visual disturbance - blind
Psychosocial Assessment. Characteristics of appearance, behavior and verbalizations appropriate to situation, age and development status. Affect appropriate. No mood swings noted. Ability to do activities of daily living at same level as before illness/injury. Social history as related to discharge planning. No obvious signs of alcohol or other drug abuse.	- depression - inability to do ADLs - psychosis - need of community resources - maladaptive behavior - withdrawn/acting out - injurious behavior to self/others - lack of appropriate motor skills - inappropriate verbal/communication skills
Abuse. Absence of child, domestic, and/or elder abuse by answering "no" when asked about current abuse: being hit, hurt, threatened, or frightened by someone close to him/her. The RN has no indications to suspect abuse.	- acknowledges that he/she is currently experiencing: physical abuse sexual abuse emotional abuse financial abuse - or exhibits sx &/or hx highly suggestive of current abuse
Pain Assessment. Pain free.	Documentation should include the following parameters: acute vs. chronic. Description, location, frequency, duration, pain scale, pain rating on that scale, methods to relieve pain at home, analgesic history. Pain scale = number 0 - 10 (10 = worst) or other appropriate pain scale related to age, culture, cognition.
Educational Needs Assessment. No barriers to learning apparent at this time. Pediatrics: family/caregiver expectations assessed and no problems identified.	- any barriers (language cognitive emotional, physical) - difficulty reading (stated or assumed) - lack of family/social support
Safety Assessment. Alterations in patient's condition do not indicate need for additional safety measures.	- altered mental status - sensory deficit - self-harm potential

AGE	Resp Rate	Pulse	Height / Length at:	Rule of Thumb Guide
Newborn	30 - 60	100 - 150		
1 Year	20 - 30	80 - 140	2 - 12 yrs = age (yrs) x 2 1/2 + 30 = length in inches	
3 Years	20 - 30	80 - 120		
6 Years	18 - 25	70 - 115		
10 Years	15 - 20	70 - 115	Weight at:	
15 Years	15 - 18	70 - 90	6 mo = 2 x birth weight At 1 yr. = 3 x birth weight	
18 & older	12 - 20	60 - 100	1 - 9 yrs = age (years) x 5 + 17 = wt (lbs.) 9 - 12 yrs = age (years) x 9 - 20 = wt (lbs.)	



ASMC



MRN

PT PREFERRED NAME

GOSSEN, LINDA M
304 N ADAMS ST APT 220

GREEN BAY, WI 54301
H: (920) 217-8647

A:
MAIDEN NAME

SS# 391-72-5898

DOB 09/04/1958 AGE 49 Y GENDER Female PT EMPLOYER None

LANGUAGE INTERP English

MARITAL STATUS Single

RELIGION Catholic CHURCH None CLERGY VISIT

Status: Not Employed
Occ:
Ret Date:
ENC TYPE: Emergency Department

MRU: SSMC-00531189
FIN NUM: SSMC-05825773
ADM DATE: 12/28/2007 14:5
CPI: SSMC-105628010
LOC/UNIT: ED-ASMC
ROOM: ED
BED:
SERVICE: Emergency I
ADM TYPE: Emergency
ADDL LOC:

GUARANTOR

GOSSEN, LINDA M
304 N ADAMS ST APT 220

GREEN BAY, WI 54301
H: (920) 217-8647

SS# 391-72-5898 DOB 09/04/1958 GUARANTOR EMPLOYER None

GENDER Female

PT REL TO GUA Self
A:

Status: Not Employed
Occ:
Ret Date:

PRI INSURANCE

414
*Medicare Part B
UB82 Claims
PO Box 2019
Milwaukee, WI 53201
POL#: 398266492C1
GRP#:
GRP NAME:

SUBSCRIBER

DOB 09/04/1958
GOSSEN, LINDA M
SS#: 391-72-5898
PT REL TO SUB Self

NETWORK

SEC INSURANCE 608
*Medicaid Wisconsin
6406 W Bridge Road

Madison, WI 53784
POL#: 3917258980
GRP#:
GRP NAME:

SUBSCRIBER
DOB 09/04/1958
GOSSEN, LINDA M
SS#: 391-72-5898
PT REL TO SUB Self
NETWORK

3RD INSURANCE

POL#:
GRP#:
GRP NAME:
SUBSCRIBER
DOB

SS#: 000-00-0000
PT REL TO SUB
NETWORK

PHYSICIANS

Admit: EMPEC, X
Attending: EMPEC, X
Procedure:

Family: Gennis, Mark A
Referring: None, None
Resident:



FIN

COMPLAINT/FALL

ACCIDENT

No Injury

OTHER ALLERGIES

YES

ACC DATE

*** VERIFY THAT THIS IS THE MOST CURRENT CONTACT INFO ***

1ST CONTACT PERSON

GOSSEN, CARL
(920) 832-9107

PT REL TO CONTACT

Child - Insured Not Financial Repon

2ND CONTACT PERSON

PT REL TO CONTACT

COMMENTS:



S S E R 0 0 0 1



Pre-Admit By:
Admit By:
Last Updated By: TE
Print Date: 12/28/07 14:58



From: 6th + Wisconsin
To: SINA
Incident Municipality: Milwaukee

Finish Odometer: 12/28/07
Date: 4/42
Squad: 3178
Crew 1: 3252
Crew 2: 3252
Crew 3: -

Total Odometer: 8
At Pt: 1
Tlx: 24
Desl: 24

Response To Scene: No Lights or Siren
 Lights and Siren
 Downgrade To No Lights and Siren
 Upgrade To Lights and Siren

Location Type: Airport, Clinic/Medical, Educational Inst., Farm, Highway/Street, Home/Residence, Hospital, Industrial, Mine/Quarry, Nursing Home, Public Building, Public Outdoors, Recreational/Sport, Residential Inst., Restaurant/Bar, Waterway, Unspecified, Other

Response Type: Mutual Aid, Intercept, Response To Scene, Scheduled Interfacility Transfer, Standby, Unscheduled Interfacility Transfer, Unknown

Client Last Name/First/M.I.: Gossen Linda
Mailing Address: 304 N Adams St #220 Green Bay WI 54301
City: Green Bay, State: WI, Zip Code: 54301, Phone: (920) 217-861

Emergency Contact (Name): Self
Address: 304 N Adams St, City: Green Bay, State: WI, Zip Code: 54301, Phone: (920) 217-861

Date of Birth: 9/4/58, Age: 49, Weight: 100, Gender: Male, Personal Physician: Phillips

Social Security #: 39-72-5898, Race: White, Black, American Indian/Alaska Native, Other, Work Related Injury: Yes, No

Employer: _____, Address: _____, City: _____, State: _____, Zip Code: _____, Phone: _____

Insurance #1: _____, Group #: _____, Insured #: _____

Insurance #2: _____, Address: _____, Phone: _____, Group #: _____, Insured #: _____

Medicaid (T-19): 3917258980, HMO: _____, Medicare (T-18): 398266492C1

Driver's License Number: _____, Failure to Obtain Copy of Insurance Cards: Information from Transfer Sheet, No Card with the Client, Copy Machine not Available

Allergies: Unknown, Codeine, Asprin / ASA, Penicillin, Sulfu

Client's Current Medications / Dose: Advair, Albuterol, Singulair

Other: _____

Last Oral Intake: PM

Pre-Existing Medical Condition: Cancer, Chronic Renal Failure, Chronic Resp. Failure, COPD, Asthma, Bleeding Disorders, Diabetes, Gastrointestinal, Headaches, Hepatitis, Hypertension, Hypotension, Seizures/Convulsions, Tuberculosis, Cardiac, Osteoporosis, Other

Signs/Symptoms: Bleeding, Bloody Stool, Abdominal Pain, Altered LOC, Back Pain, Choking, Cough, Diarrhea, Dizziness, Ear Pain, Eye Pain, Fever/Hyperthermia, Headache, Hypertension, Hypotension, Nausea, Numbness, Paralysis, Palpitations, Hypothermia, Pregnancy/Childbirth, Seizures/Convulsions, Syncope, Trauma, Unresp./Unconscious, Vaginal Bleeding, Vomiting, Weakness, Other

Time	BP	Pulse Rate	Resp. Rate	Resp. Effort	Level of Consciousness	Mental Status/Behavior	Eyes	Breath Sounds	
								Quality	Character
1937	136/80	84	20	Normal	A - Alert V - Verbal P - Pain U - Unresp	<input checked="" type="checkbox"/> Normal (A&Ox4) <input type="checkbox"/> Acute Confusion <input type="checkbox"/> Usually Confused <input type="checkbox"/> Incoherent <input type="checkbox"/> Intermittent Consciousness <input type="checkbox"/> Combative	<input checked="" type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Constricted <input type="checkbox"/> Dilated <input type="checkbox"/> Blind <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma	<input checked="" type="checkbox"/> Clear <input type="checkbox"/> Wet <input type="checkbox"/> Decreased <input type="checkbox"/> Wheeze <input type="checkbox"/> Absent <input type="checkbox"/> Stridor	

Glasgow Coma Scale - Total: 15

Eyes: 4 (Opens spontaneously), Verbal: 5 (Oriented), Motor: 6 (Moves spontaneously)

Blood Glucose: _____

Skin: Normal, Cool/Cold, Warm/Hot, Moist, Diaph, Dry, Pale-Ashen, Cherry, Flushed, Jaundice

Pain Provoke: Sharp, Dull, Cramp, Crushing, Constant

Quality: _____, Radiate: _____, Severity: 4, Time (Onset): 15-Min

NEURO STATUS

PUPILS

+ Reactive - Nonreactive ± Sluggish

PUPIL GAUGE (MM)



GLASGOW COMA SCALE

Eyes	Open	Spontaneous	4
			3
			2
			1
Best motor response			6
		Localizes pain	5
		Flexion-withdrawal	4
		Flexion-abnormal (decorticate rigidity)	3
		Extension (decerebrate rigidity)	2
		No response	1
Best verbal response**		Oriented and converses	5
		Disoriented and converses	4
		Inappropriate words	3
		Incomprehensible sounds	2
		No response	1
Total			3-15

CHARTING CODE: EXTREMITIES

MOVEMENT	ABBREVIATIONS	STRENGTH
Voluntary	V	+ Strong
Command	C	- Weak
Stim (Purposeful)	S	Ø Absent
Withdraws	W	
None	Ø	
Decorticate	T	
Decerebrate	B	

GOSSEN, LINDA M F 49Y
 MRN: SSMC-00531189
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 DOB: 09/04/1958

087525773

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APGAR SCORE

SIGN	0	1	2
A - Appearance	Blue, Pale	Body Pink Extremities Blue	Completely Pink
P - Pulse	Absent	Below 100	Above 100
G - Grimace	No Response	Grimace	Cough or Sneeze
A - Activity	Limp	Some Flexion	Well Flexed
R - Respirations	No Effort	Weak, Irregular	Strong Cry

IV DRIPS & DRUG CALCULATIONS

To Determine Drops per Minute:

Drop factor or gtt/ (in IV box)
Time in m

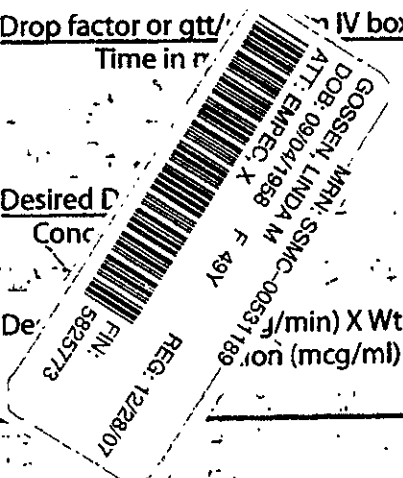
X Total Hourly Volume

To Determine Infusion Rate:
From mg/min to ml/hr:

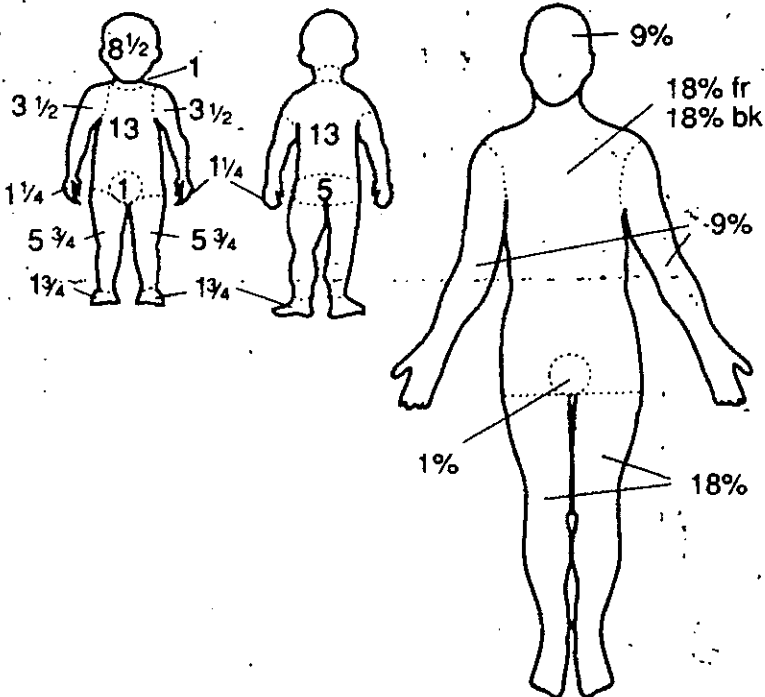
Desired D
Conc

From mcg/kg/min to ml/hr:

Desired Dose (mcg/min) X Wt. (kg) X 60
Concentration (mcg/ml)



Burn Management



Parkland Formula

Fluid for first 24 hours:
LR 4 ml/kg x % burned

Give half of the calculated fluid
within the first 8 hours of the
burn, give the second half over
the next 16 hours.

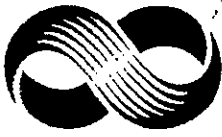
Major Burn

25% of the body surface or greater
Significant involvement of hands, face,
feet, or perineum

Electrical injury
Inhalation injury
Concomitant injury
Severe preexisting medical problems
Major burns should be treated at a burn unit

American Burn Association

23072



Aurora Sinai Medical Center
945 N 12th Street
Milwaukee, WI 53233

Med Rec#: 531189
Patient: GOSSEN, LINDA M
Account#: 5825773
Age: 49 yr
DOB: September 4, 1958
Triage Date: December 28, 2007
Sex: Female

Chief Complaint: 1. Left Ankle Injury (f)

Basic Information: Hx: P/ Spouse / S.O. / Father / Mother / Child / Guardian / Interp / Other // Time: 11:10 // Amb: BLS ALS // Police

Vital signs: Per nurse notes / WNL / Except / T / P / R / BP / O2 sat

Medications: Per nurse notes / None / Per list / Unknown

Allergies - intolerances: Per nursing notes: substances reactions / NKMA / Unknown

Immunizations: Per nurse notes / Influenza / Pneumococcal / Tetanus: < 5 yrs 5 - 10 yrs >10 yrs never

Menstrual - preg hx: Per nurse notes / LMP / Menopausal / G P SAb TAB

History limitation: None / Clinical condition / Physical impairment / Language barrier

History of Present Illness: pt slipped & fell today while waiting for the bus. She fell on O knee. disc & ankle pain

Duration/Timing: Occurrence: Unknown / 10 mins hrs days wks mos PTA / Date Time

Location: Unknown / Anterior / Posterior / Medial / Lateral /

Quality/Severity: lower knee & tibial tenderness

Bleeding degree: None / Mild / Mod / Sev

Pain degree: None / Mild / Mod / Sev

Assoc. Signs & Symps: Neuro - L foot: None / Tingling / Numbness / Weakness / Inability to move

Injury - other: None / Describe

Modifying Factors: Mitigating: None / Res / Ice / Immobilization / Analgesics

Context: MOI: Unknown / As noted / Fall / Direct blow / Twisted / Intoxication

Accident location: Unknown / Home / Work / Private property / Government property / Street @ bus stop

Review of Systems: See HPI for - MS Neuro Heme

Const: Neg / Fever / Chills / Diaphoresis / Malaise / Gen weakness / Decreased LOC

Other significant: All systems otherwise neg

Past Medical History: See HPI / See dictation / See med record dated

Med/Surg: None / CAD HTN Angina A.Fib MI CHF Murmur / Asthma COPD / CVA / CA / CRF / NIDDM / IDDM / Fx(s) / Sprain(s) / RA / Gout

Social History: Social concerns: None / Neglect / Abuse / Living situation

Habits: None / ETOH: occ reg amt per day wk / Tobacco: occ reg ppd x yrs / Marijuana / Cocaine / Heroin / Amphetamines

Occupation: None / Describe

Examination: Limited by: General: WNL Mild distress / Mod distress / Sev distress / Ext

Ext

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Aurora Sinai Medical Center

Medical Record Department

1020 N. 12th Street

(414) 219-6036 • Copy Service Hours: Monday - Friday 8 A.M. to 5 P.M.

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Aurora Sinai Medical Center

www.AuroraHealthCare.org

X19625b (10/07) ©AHC

AUSTIN J. BOYLE III, M.D.

GOSSEN, Linda
DOB: 09/04/1958

09-24-95

01/03/08 PHONE CALL:

I was contacted today by Dr. Morris, a radiologist over at Aurora Sinai Medical Center who had read Ms. Gossen's MRI scan, which revealed a non-displaced lateral tibialis plateau fracture without any sign of depression. Ms. Gossen was contacted about remaining non-weightbearing and how to go about getting crutches to remain non-weightbearing. Further discussion will be made on her follow up appointment. She is asked to contact our office at 414-274-7220 for confirmation that she understands and that she is non-weightbearing.

Dictated by Corina D. Gretch-Welch, PA-C, ATC for SJK/mtskk

A handwritten signature in black ink, appearing to be 'SJK', located to the right of the dictation text.

09-24-05
1/18
AJB

Patient: GOSSEN, LINDA M
MRN: SSMC-00531189
DOB: 09/04/1958
Case #: SSMC-05827322
Pl. Loc/Type: MRI-ASMC Imaging/Radiology

R A D I O L O G Y R E P O R T

<u>Exam</u> MR Knee LEFT	<u>Exam Date/Time</u> 01/03/2008 15:45:00	<u>Accession Number</u> MR-08-0007018	<u>Ordering MD</u> Boyle, Austin Joseph
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Reason for Exam:
left knee pain and effusion

MR Report

MRI OF THE LEFT KNEE

Indication: Knee pain and effusion after fall.

Discussion: Multiplanar, multisequence high field MR imaging of the left knee was performed without contrast.

Tendons of the extensor mechanism are intact. The anterior and posterior cruciate ligaments are normal. The medial collateral ligament, fibular collateral ligament, iliotibial band, and biceps femoris tendon are intact.

No meniscal tear is identified.

There is a fracture in the lateral tibial plateau, in the sagittal plane, just lateral to the tibial spines. The fracture is essentially nondisplaced. No measurable depression is present. Associated marrow edema is seen in the lateral tibial plateau. The fracture does reach both the anterior and posterior cortices of the lateral tibial plateau. A small knee joint effusion is present. No articular cartilage defects are identified.

IMPRESSION:

Nondisplaced lateral tibial plateau fracture extending from anterior to posterior cortex just lateral to the tibial spines. No appreciable depression or significant displacement is present.

Signature
17 of

ew

R A D I O L O G Y R E P O R T

<u>Exam</u>	<u>Exam Date/Time</u>	<u>Accession Number</u>	<u>Ordering MD</u>
MR Knee LEFT	01/03/2008 15:45:00	MR-08-0007018	Boyle, Austin Joseph

I telephoned Dr. Boyle's Milwaukee office and discussed this case with his assistant at the time of dictation.

Dictated By: Moore, Nicholas J E
Dictated Date/Time 01/03/08 16:26:00
Electronically Signed By: Moore, Nicholas J E
Signed Date/Time: 01/04/08 08:36:08

Transcribed By: JJ
Transcribed Date/Time: 01/03/08 17:34:27