**St. Joseph Regional Medical Center** | **Emergency Department QualChart®**

**GENERAL COMPLA** | Fill in, circle pertinent positive findings. Complete all sections.

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

| | | Normal Findings: | Abnormal Findings: | Complaint-Specific Findings |
|---|---|---|---|---|
| Appearance | Normal | Well-Appearing / No Pain Distress / Well-Nourished | *Ill-Appearing: Mild Mod Severe* / *Pain Distress: Mild Mod Severe* / *Obese / Thin / Cachectic* | |
| Eyes | Normal | PERL / EOMI / Conjunctiva Clear | *R Pupil ___ L Pupil ___* / *Conjunctiva Inflammed* | C-Spine Cleared Collar removed |
| ENT | Normal | Ears Normal / Nose Normal / Oropharynx Normal | *TMs Occluded* / *Rhinorrhea / Epistaxis* / *Erythema / Exudate / Dry Mucosa* | |
| Neck | Normal | Supple | *Nonsupple* | |
| Respiratory | Normal | Airway Patent / CTA / Breath Sounds Equal / Respiration Nonlabored | *Airway Obstructed* / *Rales @* / *Rhonchi @* / *Wheezes @* / *Retractions* | |
| Cardiovascular | Normal | RRR / Pulses Normal / No Rub / Murmur | *IRR Tachycardia Bradycardia* / *Abn. Pulses @* / *Murmur* | |
| GI / GU | Normal | Soft / Nontender / No Masses / Bowel Sounds Normal / No Organomegaly | *Tender @* / *Mass @* / *Bowel Sounds Hypo Hyper* / *Hepatomegaly / Splenomegaly* | |
| MS | Normal | Strength / ROM Intact / No Edema / No Calf Tenderness | *Limited @* (L) knee / *Edema @* (L) knee / *Calf Tenderness* | Able to flex, Patella back in place but pops back out laterally |
| Skin | Normal | Warm & Dry / Color Normal | *Pale / Diaphoretic* / *Cyanosis @* | |
| Neuro | Normal | Sensory / Motor Intact / Reflexes Intact / CN Intact / A & O x 3 | *Focal Deficit @* / *Abn. Reflex @* / *CN ___ Palsy* / *A V P U Disoriented* | |
| Psychiatric | Normal | Affect / Mood Appropriate | *Anxious / Depressed* | |

Other: [illegible handwriting]

**RE-EVALUATION:** [illegible handwriting] Pain Scale (0-10)

Time:______ Unchanged Improved Worse VSS

Time:______ Unchanged Improved Worse VSS

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

Ancillary Tests and ED Treatment: See Orders Sheet

**ED PHYSICIAN DIAGNOSES:**

1. Dislocated (L) Patella
2. Cervical Strain
3. Contusion [illegible] Head

CRITICAL CARE PROVIDED FOR ______ MIN.

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

Discussed case/management/disposition of patient with:

Name: [illegible] at 1235 a.m. / p.m.

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

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

Admit OBS Transfer Consult Follow-up:

**DISPOSITION:** RX:

Discharge to: Home Work Nursing Home OR ICU Tele Floor Deceased AM

Condition: Stable Unstable

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

Transfer to: Transfer Form Completed

Disposition Rationale:

Discussed with: Patient Family Other:

*Standard After-Care Instructions Given to Patient Upon Discharge from ED.*

Supervising / Management / Procedure / Progress Notes Attached: Yes No

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

(Initials) ______ MD/DO

______ MD/DO

______ PA / NP / Resident

Disposition Time: 1245 a.m. / p.m.

Chart / Addendum Dictated: Yes No

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

* 0 C 2 1 8 0 0 1 0 2 1 4 0 5 0 2 7 2 *

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 1/1/04 (c) 1997-2004 Emergency Consultants, Inc.

02/14/05 09:17 am

6595 Mark A Mitchell DO FACOEP

SDK'd out
Copied

NAME Parks, Larry ☑M ☐F
DOB 3/26/57
AGE
DATE/TIME OF TRIAGE 2/14/05 0940
1 ☐ Black 2 ☐ Red 3 ☑ Orange 4 ☐ Green 5 ☐ Blue

CHIEF COMPLAINT: fell in pot hole (L) knee neck & (R) 3rd finger pain hurt
PRIVATE PHYSICIAN
☐ ECI ☐ PMD
MODE OF ARRIVAL ☐ AMBULATORY ☐ W/C ☐ CARRIED ☑ AMBULANCE Medacare

PRE-HOSPITAL TREATMENT: ☐ NONE ☐ OXYGEN ☐ C-COLLAR ☐ BACKBOARD ☑ SPLINTING ☐ IV ☐ MEDS ☐ OTHER:
FAMILY WITH PATIENT ☐ YES ☐ NO

| VITAL SIGNS | | | | | |
|---|---|---|---|---|---|
| TIME | BP 105/69 | P. 86 | RR 20 | TEMP 97' | $O_2$SAT |
| TIME | BP | P | RR | TEMP | $O_2$SAT |

HEAD CURCUM

ADDITIONAL TRIAGE ASSESSMENT

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

MEDICATIONS: Ø

PAST MEDICAL HISTORY: ☐ CARDIAC ☐ RESP. ☐ CANCER ☐ NEURO ☐ RENAL ☐ SEIZURE ☐ DIABETES ☐ PSYCH ☐ AODA ☐ OTHER (L) knee surgery [illegible]
☐ TB ☐ Exposure to/HX of Blood Borne Diseases

HERBAL OR ALTERNATIVE MEDICATIONS:

TRIAGE PLAN: ☑ DIVERT REGISTRATION ☐ REGISTER AND WAIT TO BE CALLED ☐ REASSURANCE ☐ W/C ☐ ICE ☐ ELEVATION ☐ DRESSING ☐ SPLINT ☐ SLING ☐ OTHER
TRIAGE EDT
TRIAGE RN: [signature] T Robertson RN

(SUBJECTIVE) TIME 0910
REASON FOR SEEKING CARE: Pt was running across street & stepped in pot hole fell left knee pop out c/o (L) knee neck & (R) 3rd finger pain no LOC

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 1308 ☐ left AMA
☐ INSTRUCTIONS GIVEN
Patient preferred: ☑ Verbal ☑ Written ☐ Demo ☐ Practice ☐ Video ☐ Repetition
Barriers to learning
☑ VERBALIZES UNDERSTANDING
☑ REFERRED TO Dr. Mison
☑ LEFT WITH self - cab
☑ CONDITION improved
☑ SCRIPTS GIVEN 1 T, 1 R
☑ AMBULATORY ☐ W/C ☐ CARRIED
☐ AMBULANCE

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] T Robertson RN
SHIFT REPORT RN
PRIMARY EDT
SHIFT REPORT EDT

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5000 W. Chambers Street
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EMERGENCY DEPARTMENT
RECORD PAGE 1

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

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

| | Initial | Time | Time Returned | Initial |
|---|---|---|---|---|
| EKG | | | | |
| Lab | | | | |
| Urine | | | | |
| Rad | LTR | 1030 | 1110 | LTR |
| 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: LTR Linda T Robertson 0950

| 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<br>☐ 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 | $O_2$SAT/$O_2$ | * | ASSESSMENTS/INTERVENTIONS/MEDICATIONS/EVALUATIONS | INITIALS |
|---|---|---|---|---|---|---|---|---|
| 0930 | | | | | | | MD notified (L) knee deformity dislocation - CSM intact | |
| ↓ | | | | | | | C-Collar applied to neck has point tenderness | |
| | | | | | | | (R) third digit hand tender to palp PIP MCP joint ? deformity | |
| 0945 | | | | | | * | Morphine SO4 8mg IM (R) VL | LTR |
| | | | | | | * | Lidocaine 1% to knee injected by MD | LTR |
| 0955 | | | | | | | Pain 0/10 to knee 0/10 Neck 3/10 Finger | LTR |
| 1020 | 106/69 | 64 | 16 | | | | Pain free except neck 3/10 knee back in place | LTR |

| 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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

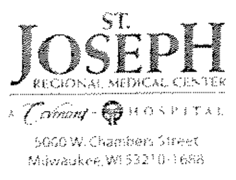
[1]Please place a ★ in column if medications are documented on that line.

______ INITIALS/SIGNATURE

______ INITIALS/SIGNATURE

LTR Linda T Robertson
INITIALS/SIGNATURE

______ INITIALS/SIGNATURE




**EMERGENCY DEPARTMENT RECORD PAGE 2**

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

| TIME | BP | P | R | T | $O_2SAT/O_2$ | * | ASSESSMENTS/INTERVENTIONS/MEDICATIONS/ EVALUATIONS | INITIALS |
|---|---|---|---|---|---|---|---|---|
| 1255 | 104/74 | 72 | 16 | | | | Applied Knee immobilizer to (L) knee | |
| | | | | | | | Issued & instructed c̄ crutches. Pt | |
| | | | | | | | steady | JW |
| 1308 | | | | | | | Pt. discharged improved (L) knee [illegible] | |
| | | | | | | | knee [illegible] pain 3/10 Discussed | |
| | | | | | | | pain management c̄ pt. Agreeable to plan | [illegible] |

†Please place a * in the column if medications are documented on that line.

JW Jean Wagner EST
INITIALS/SIGNATURE

INITIALS/SIGNATURE

INITIALS/SIGNATURE

INITIALS/SIGNATURE

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

**EMERGENCY DEPARTMENT RECORD ADDENDUM**

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

# RADIOLOGY

ORIGINAL
cc: MARK A. MITCHELL, DO, Ordering Physician

**ORDERING PHYSICIAN:** Dr. Mark Mitchell
**OCCURRENCE NUMBER:** 79737383 **EXAM DATE:** 02/14/2005

**EXAM LOCATION:** St. Joseph Regional Medical Center

**EXAM: CERVICAL SPINE AP AND LATERAL VIEW**

**CLINICAL HISTORY:** Fell.

The cervical spine appears mildly straightened. There is no subluxation or fracture seen. There is mild intervertebral disk space narrowing at the C4-5 and C5-6 levels. Facet joint spaces appear preserved.

**CONCLUSION:** Mild facet arthropathy.

**This document was electronically signed by SARA ARNOLD, MD on 02/14/2005 16:12:52.**

Radiologist:________________________________
SARA ARNOLD, MD

SA/jah D.02/14/2005 13:21:48 T.02/14/2005 15:26:12
Doc ID #: 4003346 Voice ID #: 3874211



M. Cullen, MD - J. Grum, MD - J. Grogan, MD - J. Hartwick, MD - D. Lye, MD - S. Gryniewicz, MD - R. Neimon, MD - L. Gilles, MD - W. MacDonald, MD - P. Grebe, MD
M. Lawton, MD - K. Kluessendorf, MD - E. Conti, MD - J. Smith, MD - D. Reasa, MD - E. Kinsfogel, MD - S. Arnold, MD - S. VanBlarcom, MD - J. Lee, DO - Q. Rose, MD

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St. Francis Hospital
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Milwaukee, WI 53215

St. Joseph Regional Medical Center
5000 West Chambers
Milwaukee, WI 53210

St. Michael Hospital
2400 West Villard
Milwaukee, WI 53209

# RADIOLOGY

ORIGINAL
cc: MARK A. MITCHELL, DO, Ordering Physician

**ORDERING PHYSICIAN:** Dr. Mark Mitchell
**OCCURRENCE NUMBER:** 79737385

**EXAM DATE:** 02/14/2005

**EXAM LOCATION:** St. Joseph Regional Medical Center

**EXAM: THREE VIEWS OF THE LEFT KNEE**

**CLINICAL HISTORY:** Fell.

**FINDINGS:** There is abnormal soft tissue swelling along the course of the patellar tendon. The patella is observed as somewhat oblique lateral projection. The patella appears to lie relatively lateralward and is likely dislocated, possibly secondary to chronic dilatation. There is subcutaneous emphysema along the ventral aspect of the patella, and this may be due to focal alteration or possible laceration. Clinical correlation is recommended. Soft tissue calcification is also noted adjacent. A superficial foreign body fragment could appear similarly.

There is dense calcification seen along the intercondylar notch. This could represent a loose body within the joint space. There is no vascular calcification.

**CONCLUSION:** Deformity of the left knee, as described. See above.

**This document was electronically signed by SARA ARNOLD, MD on 02/14/2005 16:12:48.**

Radiologist:____________________
SARA ARNOLD, MD

SA/pt D.02/14/2005 13:20:19 T.02/14/2005 15:20:37
Doc ID #: 4003337 Voice ID #: 3874201

**ST. JOSEPH REGIONAL MEDICAL CENTER**
**NAME:** PARKS, LARRY E
**DOB:** 03/26/1957

**MRN:** 778667
**ACCT #:** 71244888

**VISIT TYPE:** E
**ROOM #:** EDT

**RADIOLOGY**

M. Cullen, MD - J. Grum, MD - J. Grogan, MD - J. Hartwick, MD - D. Lye, MD - S. Gryniewicz, MD - R. Neimon, MD - L. Gilles, MD - W. MacDonald, MD - P. Grebe, MD
M. Lawton, MD - K. Kluessendorf, MD - E. Conti, MD - J. Smith, MD - D. Reasa, MD - E. Kinsfogel, MD - S. Arnold, MD - S. VanBlarcom, MD - J. Lee, DO - Q. Rose, MD

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Milwaukee, WI 53215

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Milwaukee, WI 53210

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2400 West Villard
Milwaukee, WI 53209

# RADIOLOGY

ORIGINAL
cc: MARK A. MITCHELL, DO, Ordering Physician

**ORDERING PHYSICIAN:** Dr. Mark Mitchell
**OCCURRENCE NUMBER:** 79737387 **EXAM DATE:** 02/14/2005

**EXAM LOCATION:** St. Joseph Regional Medical Center

**EXAM: RIGHT HAND, 3 VIEWS**

**CLINICAL HISTORY:** Fell.

At the base of the second digit, proximal phalanx, there is a focal cortical irregularity along the ulnar aspect and a small osteophyte fragment, with adjacent bone erosion along the radial aspect. The remainder of the digits appear intact. No acute fracture is seen.

**CONCLUSION:** Probable old avulsion chip fracture deformity and probable old healed proximal phalanx base fracture, with secondary deformity. No acute fracture identified.

**This document was electronically signed by SARA ARNOLD, MD on 02/14/2005 16:12:39.**

Radiologist:______________________________
SARA ARNOLD, MD

SA/cs D.02/14/2005 13:18:51 T.02/14/2005 15:17:16
Doc ID #: 4003321 Voice ID #: 3874192



M. Cullen, MD - J. Grum, MD - J. Grogan, MD - J. Hartwick, MD - D. Lye, MD - S. Gryniewicz, MD - R. Neimon, MD - L. Gilles, MD - W. MacDonald, MD - P. Grebe, MD
M. Lawton, MD - K. Kluessendorf, MD - E. Conti, MD - J. Smith, MD - D. Reasa, MD - E. Kinsfogel, MD - S. Arnold, MD - S. VanBlarcom, MD - J. Lee, DO - Q. Rose, MD

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# PROVISIONAL RADIOLOGY REPORT
# ED-MAJOR

THE FINAL REPORT WILL FOLLOW IN THE USUAL MANNER

Original Copy
cc:

**OCCURRENCE NUMBER:** 79737387

**EXAM DATE:** 02/14/2005

**EXAM:** ED-Hand RT 3+ Views

**RESULTS:** two millimeter ossific density base of second proximal phalanx – avulsion injury – considered likely old.

RADIOLOGIST:______________________________
ERNEST CONTI, MD

EC/cjt T: 02/14/2005 11:32:23

**ST. JOSEPH REGIONAL MEDICAL CENTER**
**PATIENT NAME:** PARKS, LARRY E
**ACCT #:** 71244888

**MRN:** 778667

**DOB:** 03/26/1957
**ROOM #:** EDT

**THIS IS PART OF THE PERMANENT MEDICAL RECORD**



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D.J. Lye, MD • S.M. Gryniewicz, MD • R.E. Neimon, MD • L.M. Gilles, MD • W.B. MacDonald, MD
P.J. Grebe, MD • M.T. Lawton, MD • K.A. Kluessendorf, MD • E.A. Conti, MD • J. Smith, MD • D. Reasa, MD

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# PROVISIONAL RADIOLOGY REPORT
## ED-MAJOR

THE FINAL REPORT WILL FOLLOW IN THE USUAL MANNER

Original Copy
cc:

**OCCURRENCE NUMBER:** 79737383

**EXAM DATE:** 02/14/2005

**EXAM:** ED-Spine Cervical 2/3 Views

**RESULTS:** Cervical spine: Moderate degenerative changes. No acute disease.

Left knee: Patella Alta – consider ligament rupture. Effusion. Prominent degenerative joint disease.

RADIOLOGIST:______________________________
ERNEST CONTI, MD

EC/cjt T: 02/14/2005 11:28:45

**ST. JOSEPH REGIONAL MEDICAL CENTER**
**PATIENT NAME:** PARKS, LARRY E
**ACCT #:** 71244888
**MRN:** 778667
**DOB:** 03/26/1957
**ROOM #:** EDT

**THIS IS PART OF THE PERMANENT MEDICAL RECORD**



M. Cullen, MD • J. T. Grum, MD • J. P. Grogan, MD • J.M. Hartwick, MD
D.J. Lye, MD • S.M. Gryniewicz, MD • R.E. Neimon, MD • L.M. Gilles, MD • W.B. MacDonald, MD
P.J. Grebe, MD • M.T. Lawton, MD • K.A. Kluessendorf, MD • E.A. Conti, MD • J. Smith, MD • D. Reasa, MD

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☐ I. Aisiku, 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. Hanrie, 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 3/14/05

℞

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☐ I. Aisiku, MD
☐ O. Alvarez, MD
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☐ J. Lee, DO
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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 257-2525
  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

## GENERAL DISCHARGE INSTRUCTIONS ED-SJRMC

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

[illegible] information in this document is confidential under Wis. Stat. 146.5[illegible]

Chief Complaint: (Lt) Knee Pain

Onset Time: [illegible]

Mechanism of Injury: ☑ Medical — Stand Fall

Witnessed Arrest: ☐ No ☐ Yes By: N/A

Bystander AED: ☐ No ☐ Yes

CPR Provider(s): ☑ N/A ☐ Bystander ☐ First Responder ☐ Unknown ☐ Fire Dept. ☐ Police Dept. ☐ Other E.M.S.

Down Time: | Time Started: | Discontinued:

## Head to Toe Survey

Abrasion, Amputation, Angulation, Avulsion, Bleeding, Blunt Trauma, Bruise/Contusion, Burn, Deformity, Dislocation, Edema, Hematoma, Laceration, Pain, Po fu Swel. Deform., Puncture, Tenderness

☐ N/A

## Cause of Injury

☐ Assault
☐ Aircraft Related
☐ Athletic Event
☐ Bicycle Crash
☐ Bite
  ☐ Animal (Non-Snake)
  ☐ Human
  ☐ Insect
  ☐ Snake (Non-Venomous)
  ☐ Snake (Venomous)
☐ Chemical Exposure
☐ Child Battery (Suspected)
☐ Drowning/Near Drowning
☐ Drug/Alcohol Ingestion
☐ Electrocution
☐ Excessive Cold
☐ Excessive Heat
☑ Fall
  ☑ Standing Height
  ☐ <10'
  ☐ >10' <15'
  ☐ ≥15'
☐ Fire / Flame(s)
☐ Firearm
  ☐ Accidental
  ☐ Assault
  ☐ Self Inflicted
☐ Lightening
☐ Machinery
☐ Mech. Suffocation
☐ Motor Vehicle
  ☐ Vehicle Occup.
  ☐ Pedestrian
☐ Poisoning
☐ Radiation
☐ Smoke Inhalation
☐ Stabbing
  ☐ Accidental
  ☐ Assault
  ☐ Self Inflicted
☐ Sting
  ☐ Insect/Animal
  ☐ Plant
☐ Unknown
☐ Water Trans. Injury
☐ Other
☐ N/A

## Provider Impression

☑ Abd. Pn./Problem
☐ Airway Obstruction
☐ Allergic Reaction
☐ Altered L.O.C.
☐ Bed Confined Patient; Reason:
☐ Behavior/Psych
☐ Cardiac Arrest
☐ Cardiac Rhythm Disturb.
☐ Chest Pain Discomfort
☐ Diabetic Symptoms
☐ Electrocution
☐ GI Bleed
☐ Headache
☐ Hypertension
☐ Hyperthermia/Fever
☐ Hypothermia
☐ Hypovolemia/Shock
☐ Intoxication (Suspected) / Alcohol Ingestion
☐ Obvious Death
☐ Poison/Drug Ingestion
☐ Pregnancy/Ob Delivery
☐ Respiratory Arrest
☐ Respiratory Distress
☐ Seizure
☐ Sexual Assault/Rape
☐ Toxic Inhalation
☐ Sting(s)/Bite(s)
☐ Stroke/CVA/TIA
☐ Syncope/Fainting
☑ Traumatic Injury
☐ Vaginal Hemorrhage
(Rt) Middle Fing. [illegible]
☐ N/A
☐ Unknown [illegible]
☑ Other: (Lt) Knee Pn. poss. dislocat deform.

## MVC Data

☐ N/A

P = Patient Location in Vehicle
X = Location of Damage to Vehicle
E = Ejected From Vehicle

Type: ☐ Car ☐ Truck ☐ Van ☐ Semi ☐ Bus ☐ Motorcycle ☐ ATV ☐ Snowmobile ☐ Watercraft ☐ Aircraft

Est. MPH

Exterior Damage: ☐ None ☐ Minor ☐ Moderate ☐ Major ☐ Rollover

Interior Damage: ☐ None ☐ Spidered Window ☐ St. Wh. Bent ☐ Compart. Intrusion ___ inches ☐ Dash Board Broken ☐ Patient Ejected

| Restraints | Obs | Rpt |
| --- | --- | --- |
| Airbag | ☐ | ☐ |
| Lap Belt | ☐ | ☐ |
| Shoulder Belt | ☐ | ☐ |
| Child Seat | ☐ | ☐ |

Safety Equipment: ☐ None ☐ Helmet ☐ Eye Prot. ☐ Prot. Clothing ☐ Float. Dev. ☑ Unknown ☐ N/A

Multi-Carry Vehicle Information: Vehicle Type: ☐ City/County Bus ☐ School Bus ☐ Charter Bus ☐ Para-Transit ☐ Taxi Cab ☐ Other:

Vehicle Unit Number:
Vehicle Lic. Number:

## Action

☐ Advanced Airway
☐ Assisted Ventilation
☐ Bandaging
☐ Bleeding Control
☐ Burn Care
☐ Cervical Collar
☐ C.I.D.
☐ C.P.R.
☐ PATIENT REFUSED CARE/IMMOBILIZATION
☐ DNR Protocol
☐ ECG Monitoring
☐ Epi Admin.
  ☐ Meda-Care's
  ☐ Patients
☐ External Defib.
☐ Glucose Administration
  ☐ Oral ☐ Glucagon
☐ I.V. Catheter/Fluids
☐ K.E.D.
☐ Long Spine Board
  ☐ Via Log Roll
  ☐ Via K.E.D.
  ☐ Via Multi Person Incline Assist
  ☐ Via Rapid Extrication
  ☐ Via Other (See Notes)
☐ MAST/PASG
☐ Medication Admin.
☐ Nasopharyngeal Airway
☐ Obstetric Care/Delivery
☐ Oropharyngeal Airway
☐ $O_2$ Via Mask @ ___ lpm
☐ $O_2$ Via Cannula @ ___ lpm
☐ $O_2$ Via Trach. Mask @ ___ lpm
☐ Pediatric Imobilization Device
☑ Physical Examination
☐ Respirator/B.V.M.
☐ Scoop Stretcher
☐ Short Spine Board
☐ Splint of Extremity
~~☐ Pro Splint~~ KED
Size:
☑ Board Splint
☐ Traction Splint
☐ Other
☑ Vital Signs
☑ OTHER: Ice Pack

## EMT Notes

Dispatched code 3 to [illegible] for a knee injury. Arrived on scene to find [illegible] [illegible] [illegible] while walking [illegible] he slipped on a manhole [illegible] he felt something pop in his (Lt) [illegible]. No loss of cons. No back or neck pain. Pt [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] secured [illegible] [illegible] [illegible] [illegible]

Patient Movement Via: ☐ Slide Board ☐ Draw Sheet ☐ 1 Person Assist ☑ 2 Person Assist ☐ ___ Person Assist ☐ Other Device (St. [illegible])

## Miscellaneous

**Disposition of Call**

☐ No Treatment Needed
☐ Cancelled On-Scene By:
  ☐ Fire Department
  ☐ Police Dept.
  ☐ Medical Examiner
  ☐ Other
☐ Treatment Refused
☐ At Scene Care Only
☑ Treated/Transported by Meda-Care
☐ Treated by Meda-Care
  ☐ Transported by Med. Unit
  ☐ Transported by Police Dept.
  ☐ Transported by Family/Friend
  ☐ Transported by Other
  ☐ Transported by AeroMedical
  ☐ Transport Refused
☐ N/A

**Patient Transported**

☐ Prone
☑ Supine
☐ Sitting
☑ Head Elevated
☐ Feet Elevated
☐ In ___ Lateral Position
☐ Patient Restrained
☐ Other
☐ N/A

**Patients Arrival Status**

[illegible]
☑ Unchanged
☐ Changed
  ☐ Better
  ☐ Worse
    ☐ Resp. Arrest
    ☐ Card. Arrest
☐ Patient Restrained
☐ Other
☐ D.O.A.
☐ N/A

**Contact With Facility**

☑ Radio
☐ Phone
  ☐ Report Only
  ☐ Fax Trans.
  ☐ EKG Telemetry
☐ Via Dispatch
☐ Unable
☐ No Need
☐ N/A

**Personal Protective Equipment Used**

☑ Gloves 4 Pair(s)
  ☐ Latex
  ☐ Nitrile
  ☐ Vinyl
☐ Other:
☐ Mask(s) ___
  ☐ Surgical
    ☐ W/O Eyeshield
    ☐ W/ Eyeshield
☐ T.B.
☐ Gown(s) ___
☐ Goggles
☐ Disp. BP Cuff
☐ Disp. Stethescope
☐ Sleeve Cover(s)
☐ "ICK" Suit

☐ Blood/Body Fluid Exposure ☑ N/A

Nature of Exposure:

Patient Care Transferred At: [illegible] (Time)

TO: ☐ Facility
☐ Fire Department
☐ Other

[signature]
Patient Received By: (Signature)

DRIVERS SIGNATURE | PRIMARY ATTENDANTS SIGNATURE



Completion of this form meets the requirements of administrative rule HSS 110.04(3)(b)

MEDA-CARE AMBULANCE SERVICE, INC. - Provider ID: 60-00115 - PATIENT ENCOUNTER RECORD
Dispatch: (414) 342-4444 Administration: (414) 342-1148 Medical Records: (414) 327-[illegible] E-Mail: stat@meda-care.com
Patient information in this document is confidential under Wis. Stat. 14[illegible].

RESPONSE INFORMATION

Date Of Call: 02/19/05 | 2N NNNNN | Unit Number: 212 | Station: 2 | 1: 7004256 | 2: 54880 | 3 | 4

Call Address/Location: 76 & Center | County of: ☑ Milw.

Dispatch Urgency: ☐ N/A
☐ No Lights or Siren ☐ Upgrade To Lights and Siren
☑ Lights and Siren ☐ Downgrade To No Lights or Siren

Transported To: St Jo's

Transport Urgency: ☐ N/A
☑ No Lights or Siren ☐ Upgrade To Lights and Siren
☐ Lights and Siren ☐ Downgrade To No Lights or Siren

Destination reason: ☐ Closest ☐ Diversion ☐ EMT ☐ Family ☐ Insurance ☐ Law Enforce. ☐ Managed Care ☐ Med. Direction ☑ Patient ☐ Physician ☐ Protocol ☐ Spec. Centr. ☐ Other

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

USE 24-HR CLOCK

| Patient Detected | Call Received | En Route | At Scene | At Patient | Depart Scene | At Destination | In Service |
|---|---|---|---|---|---|---|---|
| | | 825 | 0830 | 0832 | 0851 | 0858 | |

Response Type: ☐ Scheduled ☑ Non-Sched ☐ Back-Up ☐ Std Al. ☐ Stnd-By ☐ Mut. Aid ☐ Intercept ☐ Unknown ☐ N/A

Other Units At Scene ☐ ___ FD ☐ Eng ☐ Lad ☐ Sqd ☐ Med ☐ ___ PD Sqd ☐ OTHER

| Starting Odometer | Ending Odometer | TOTAL MILES |
|---|---|---|
| 080 | 73 | |

Diff. encountered en route / at scene: ☑ None ☐ Other ☐ Disp Error ☐ Extrication ☐ Haz. Material ☐ Language Barrier ☐ Road Condition ☐ Road Work ☐ Unsafe Scene ☐ Veh. Problem ☐ Weather
Diff. encountered en route / at destination: ☑ None ☐ Other ☐ Disp Error ☐ Extrication ☐ Haz. Material ☐ Language Barrier ☐ Road Condition ☐ Road Work ☐ Unsafe Scene ☐ Veh. Problem ☐ Weather

PATIENT DEMOGRAPHICS

Patient Last Name/First/M.I.: Pavics Larry | Mailing Address: 5?? N 30 | City ☑ Milwaukee | State ☑ WI | Zip Code: 532

Phone: 264 3?6 | Social Security #: 397 64580 | Age: 47 | Gender: ☑ Male ☐ Female | Date Of Birth: MM/DD/YY | Weight: ☑ lbs ☐ kg 148 | Work Related Injury: ☐ Yes ☑ No

Race: ☐ Asian/Pacific Islander ☐ Am.Indian/Alaska Native ☑ Black ☐ Hispanic ☐ White ☐ Other ☐ Unknown
Demographics Obtained From: ☑ Patient ☐ Family ☐ Facility ☐ Card/s ☐ Face Sheet ☐ Other ☐ N/A
Personal Physician: None

Emergency Contact Name | Address | City ☐ Milwaukee | State ☐ WI | Zip Code | Phone ( )

Employer | Address | City ☐ Milwaukee | State ☐ WI | Zip Code | Phone ( )

Insurance #1 | Group # | Insured #

Insurance #2 If MVC, Agency | Address | Phone | Group # | Insured #

Medicaid T-19: 397-64-680 | Effective Dates: TO | Medicare T-18 | HMO

MED HISTORY

Allergies: ☐ None ☐ N/A ☑ N.K.D.A ☐ Aspirin ☐ Codeine ☐ Sulfa ☐ Penicillin
Patient's Current Medications/Dose ☐ With Patient ☐ N/A ☑ None ☐ UNKNOWN

Past Medical History: ☐ N/A ☑ None ☐ Unknown
☐ Asthma ☐ Angina ☐ Arrhythmia ☐ Cancer ☐ Cardiac Disease ☐ C.H.F. ☐ C.O.P.D. ☐ C.V.A. ☐ Diabetes ☐ Dialysis ☐ Emphysema ☐ Headache ☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ Hypotension ☐ Kidney Disease ☐ M.I. ☐ Osteoporosis ☐ Psychiatric ☐ Pulmon. Edema ☐ Seizure Disorder ☐ Sickle Cell/Trait ☐ Substance Abuse ☐ Syncope ☐ T.B. ☐ Thyroid Disease ☐ T.I.A. ☐ Other
All Other and Additional Items are to be noted in the EMT notes.
☐ Surgery(s) | Last Oral Intake

PATIENT ASSESSMENT

Signs/Symptoms: ☐ Abdominal Pain ☐ Back Pain ☐ Bleeding ☐ Bloody Stool ☐ Breathing Difficulty ☐ Cardioresp. Arrest ☐ Chest Pain ☐ Choking ☐ Convulsion ☐ Diaphoresis ☐ Diarrhea ☐ Dizziness ☐ Ear Pain ☐ Eye Pain ☐ Fever ☐ Headache ☐ Hypertension ☐ Hypotension ☐ Hyperthermia ☐ Hypothermia ☐ Nausea ☐ Numbness ☐ Paralysis ☐ Palpitations ☐ Pregnancy/Childbirth ☐ Seizures ☐ Syncope ☑ Trauma ☐ Unresp./Unconscious ☐ Vaginal Hemorrhage ☐ Vomiting ☑ Weakness ☐ Unknown ☑ Other
(handwritten: Swelling, Pain, pass Distress)

| V/S | Time | Taken By | Resp. Rate | Resp. Qual. | Pulse Rate | Pulse Qual. | Blood Pressure | Breath Sounds | Vitals Taken | LOC / Mental State |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 0838 | 92 | 24 | | 86 | ☑ Reg | 132/84 | CL CL | ☑ SITTING | ☑ Alert; X 4 - Event |
| 2 | 0849 | 92 | 20 | | 84 | ☑ Reg | 134/86 | CL CL | ☑ SITTING | ☑ Alert; X 4 - Event |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |

Eyes: ☑ P.E.R.R.L.
☐R ☑L Reactive; ☐R ☐L Nonreactive; ☐R ☐L Dilated; ☐R ☑L Mid Range; ☐R ☐L Constricted; ☐R ☐L Pin Point; ☐R ☐L Blind; ☐R ☐L Cataracts; ☐R ☐L Glaucoma; ☐R ☐L Prosthesis; ☐R ☐L ___

Skin:
Color: ☑ Normal ☐ Cyanotic ☐ Pale ☐ Ashen ☐ Flushed ☐ Cherry ☐ Jaundice
Moisture: ☑ Normal ☐ Dry ☐ Moist ☐ Diaph.
Temp: ☑ Normal ☐ Cool/Cold ☐ Warm/Hot
Capillary Refill: ☑ Normal ☐ >2 sec

Body Temp.: Temp ___ ☐ Oral ☐ Axillary ☐ Rectal ☐ Ear; Taken By: ___
Blood Glucose mg/dL ___ Taken By: ___

Pain (Medical Patients) ☐ N/A
Location: ___
Quality: ☐ Sharp ☐ Dull ☐ Cramp ☐ Crushing ☐ Constant
Time Since Onset: ☐ 0-15 Min ☐ 15-60 Min ☐ 1-12 Hour ☐ 12-24 Hour ☐ Other
Severity (1 To 10) ___
Radiate ☐ No ☐ Yes: ___
Provoke ___

Mental Status/Behavior
Initial: ☑ Normal ☐ Acute Confusion ☐ Usually Confused ☐ Aphasic ☐ Incoherent ☐ Intermittent Consc. ☐ Combative
At Destination: ☑ Unchanged ☐ Changed ☐ Better ☐ Worse

GLASGOW SCORE (Initial - En Route)
GLASGOW 1 Time: 0838 Score: 15
GLASGOW 2 Time: 0849 Score: 15

APGAR SCORE
Initial: APGAR 1 Time: ___ Score: ___
After 5 Min: APGAR 2 Time: ___ Score: ___


See Back Of Yellow Page For Infant / Peds. Rule of Nines, Breath Sound Abbreviations, APGAR and Glasgow Formulas

## 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.**

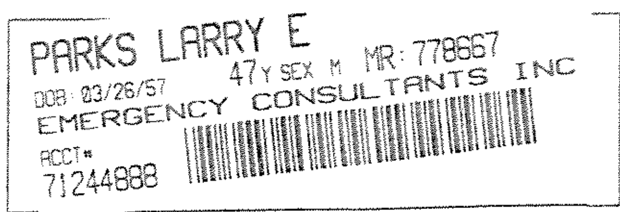
A. **Consent for Treatment**: I am entering the above named facility (the "Facility") for the purpose of medical and/or surgical treatment or diagnosis. I consent to my physician, other attending, consulting and/or referring physicians and their assistants and designees, and other Facility personnel, 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.

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





**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: Pat strap down on board [illegible]
unable to lift up

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