KELIN R. OLSON, S.C.
LAW OFFICES

Dedicated - Determined - Dependable

September 12, 2006

CITY OF MILWAUKEE
2006 SEP 15 PM 3:55
RONALD D. LEONHARDT
CITY CLERK

Milwaukee City Clerk
200 East Wells Street
Room 205
Milwaukee, Wisconsin 53202

Re: RE: My Clients: Nimiko Miner
Claim #: 06-V-83

Dear Mr. Langley:

Pursuant to your denial received on September 12, 2006 I am hereby requesting a hearing regarding my client Nimiko Miner. However, I would ask that the hearing be postponed as I also represent Erica Lieg, who was also injured as a result of the accident that occurred on April 9, 2006 but whose claim is still being compiled, and I would like to have them heard at the same time.

If you have any questions or concerns, please feel free to call me.

Thank you in advance for your anticipated cooperation.

Very truly yours,

KELIN R. OLSON

KRO/el

CITY OF MILWAUKEE
RECEIVED
2006 SEP 18 PM 3:55
OFFICE OF
CITY ATTORNEY

Offices in Milwaukee and Waukesha
Mailing Address: 407 W. Silver Spring, Milwaukee, WI 53217
Milwaukee (414) 961-8700 / Waukesha (262) 544-5529 / Fax: (414) 961-1675
www.kelinolsonlaw.com

KELIN R. OLSON, S.C.
LAW OFFICES

Dedicated - Determined - Dependable

April 27, 2006

CITY OF MILWAUKEE
2006 APR 28 PM 1:23
RONALD D. LEONHARDT
CITY CLERK

City Clerk
City of Milwaukee
200 East Wells St., Room 205
Milwaukee, Wisconsin 53202-3567

RE: Notice of Injury Form
My Client: Nimiko Miner
Incident of: April 9, 2006

To Whom It May Concern:

Enclosed please find the original and four (4) copies for the Notice of Injury forms relative to the above matter.

Please indicate the date of receipt and filing on one of the enclosed copies, and then return same to my office.

Thank you for your assistance.

Sincerely,

Kelin R. Olson, Sr.

KRO/el
Enclosure

Offices in Milwaukee and Waukesha
Mailing Address: 407 W. Silver Spring, Milwaukee, WI 53217
Milwaukee (414) 961-8700 / Waukesha (262) 544-5529 / Fax: (414) 961-1675
www.kelinolsonlaw.com

NOTICE OF INJURY FORM

TO: CITY CLERK
200 EAST WELLS STREET
MILWAUKEE, WISCONSIN 53202

PLEASE TAKE NOTICE, that the undersigned will be making a claim for injuries and damages against you by virtue of the reasons set forth hereafter:

NAME OF CLAIMANT:

NIMIKO MINER

DATE AND TIME OF INJURIES AND OR DAMAGES SUSTAINED:

April 9, 2006 at approximately 6:00 p.m.

PLACE OR LOCATION WHERE INJURY OR DAMAGES OCCURRED:

West Locust Street & North 22nd Street
Milwaukee, Wisconsin

MANNER IN WHICH DAMAGES OR INJURIES WERE RECEIVED OR OCCURRED:

Claimant was injured when a City of Milwaukee Fire Department truck, driven by Michael Scwade, made a right hand turn and struck the vehicle the claimant was in, which had stopped for the fire truck.

GROUNDS ON WHICH CLAIM IS MADE:

Negligence on the part of the City of Milwaukee Fire Department by its agents, servants and employees, including but not limited to failure to properly manage and control the vehicle.

GENERAL DESCRIPTION OF INJURIES AND DAMAGES:

PERSONAL INJURIES:

LEG PAIN
BACK PAIN

MEDICAL EXPENSES
PAIN AND SUFFERING

PLEASE TAKE NOTICE that satisfaction for such injuries or damages will be claimed, but that the amount of said demand is **UNKNOWN** at the present time.

THIS IS NOT A NOTICE OF CLAIM PURSUANT TO SECTION 893.80, WISCONSIN STATUTES

Dated at Milwaukee, Wisconsin, this 27th day of April, 2006.

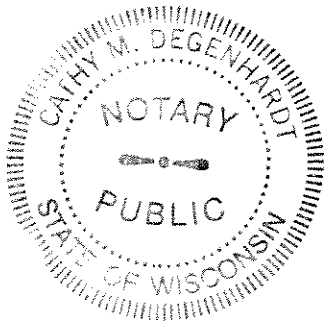
Claimant: NIMIKO MINER
2444 NORTH 40TH STREET
MILWAUKEE, WISCONSIN 53210

KELIN R. OLSON, S.C. LAW OFFICES

BY: _____
KELIN R. OLSON, SR.,
Attorney for the Claimant
407 West Silver Spring Drive
Milwaukee, Wisconsin 53217
Telephone: (414) 961-8700

Subscribed and sworn to before me
this 27th day of April, 2006.

_____
Notary Public, State of Wisconsin
My Commission Expires: 8/30/09



CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true copy of the attached:

NOTICE OF INJURY FORM

was served upon the hereinafter named:

CITY CLERK
200 EAST WELLS STREET
MILWAUKEE, WISCONSIN 53172

By enclosing same in an adequately postpaid envelope, bearing the sender's name and address which was duly deposited in a U.S. Mailbox on the 27th day of April, 2006, pursuant to Section 801.14(2), Wisconsin Statutes.

Erica Liegl

ERICA LIEGL

POST OFFICE ADDRESS:
407 West Silver Spring Drive
Milwaukee, Wisconsin 53217
Telephone: (414) 961-8700

00-V-83-1

KELIN R. OLSON, S.C.
LAW OFFICES

Dedicated - Determined - Dependable

August 28, 2006

City of Milwaukee
C/O City Attorney's Office
200 East Wells Street
Room 205
Milwaukee, Wisconsin 53202

RE: My Client : Nimiko Miner
Accident of : April 9, 2006
Insured : City of Milwaukee
Claim # : unknown

To Whom It May Concern:

Enclosed herewith are copies of the following items of medical information and special damages regarding the above client:

St. Joseph's Hospital	
Records of 4/9/06	In
Statement of 4/9/06	1,494.20
St. Joseph's EP, LLP	
Statement of 4/9/06	194.00
Capitol Rehabilitation Clinic	
Records of 4/27/06 - 8/10/06	In
Statement of 4/27/06 - 8/10/06	1,775.00
TOTAL	**$ 3,463.20**

Please contact me at your earliest convenience to discuss settlement.

Very truly yours,

Kelin R. Olson, Sr.

KRO/el

Offices in Milwaukee and Waukesha
Mailing Address: 407 W. Silver Spring, Milwaukee, WI 53217
Milwaukee (414) 961-8700 / Waukesha (262) 544-5529 / Fax: (414) 961-1675
www.kelinolsonlaw.com

ST. JOSEPH REGIONAL MEDICAL CENTER
A MEMBER OF COVENANT HEALTHCARE

Account No: 71486994
Sched Date: ~~07/01/06~~ 04:26 AM
1-5-06

MR#: 1053171

PATIENT INFORMATION

MINER NIMIKO D
2444 N 40 ST
MILWAUKEE WI 53210

Phone: 414 449-1392
DOB: 10/06/1987 Age: 18
Gender: F MS: SINGLE

Religion: NONE
Employer: NONE
Phone #:
Occupation:

NEAREST RELATIVE

Name: ZIGGLER CELIA D
Phone: 414 449-1392
Bus Phone: 414 476-0025
Relat: PARENT
Notify: Y

ADDITIONAL CONTACT

Name: MINER BETTY
Phone: 414 263-2947
Bus Phone:
Relat: OTHER RELATIONSHIP
Notify: Y

VISIT INFORMATION

Admit Reason: \PREGNANCY
Comment: QW-PASSPORT DOWN

Visit Type: P
Location:
Last Inp Date:
Last Outpt Date:

INTERPRETER NEEDED: NO
Language: ENGLISH

PHYSICIAN INFO

Adm: PALABRICA CYNTHIA L.
Att: PALABRICA CYNTHIA L.
PCP: PALABRICA CYNTHIA L.

INSURANCE INFORMATION

PRIMARY: SELF PAY

GUARANTOR INFORMATION

Name: MINER NIMIKO D
2444 N 40 ST
MILWAUKEE WI 53210-0000

Phone #: 414 449-1392

Employer: NONE
Phone #:

PRINTED COPY Date: 02/22/06 Time: 04:27 AM

371
4-9-6

115-31-71

PREGNANCY DISCHARGE INSTRUCTIONS

1. **Diet** - At home you should eat:
   - ☒ Anything you wish
   - ☐ _____ Calorie ADA diet
   - ☐ _____ Gram Sodium-restricted diet
   - ☐ Other: _____

2. **Push fluids** - drink at least eight 8-ounce glasses of fluid per day.

3. No alcohol, beer or wine, or smoking.

4. You have the following **activity** restrictions:
   - ☒ None.
   - ☐ Pace activities as instructed.
   - ☐ Frequent rest periods.
   - ☐ Strict bedrest with bathroom only privileges.
   - ☐ Left side-lying position
   - ☐ Stay home from work/school for _____ day(s).
   - ☐ Sexual activity not allowed.

5. Continue taking your previously **prescribed medication**.

6. You have received and reviewed the following **prescribed medication** instruction sheets:
   Take as directed.

   _____

   _____

   _____

7. Review the following information:
   - ☐ Fetal Movement Counting
   - ☐ How Will I Know I'm In Labor
   - ☒ Five Reasons to Call Your Doctor
   - ☐ Decreased Activity in Pregnancy
   - ☐ Pregnancy, Childbirth, Parenting Binder
   - ☐ Other: _____

8. **Follow-up Doctor's Appointment**
   - ☒ Keep next doctor appointment on April 26th
   - ☐ Call to make next doctor appointment for _____ day(s) / week(s):
     - ☐ as soon as you get home **OR** ☐ on Monday when office reopens.

9. **Call your doctor** if you have any of the following or if any of the following persists:
   - Headache
   - Fever
   - Visual changes
   - Sudden weight gain
   - Contractions 5 minutes apart
   - Any questions
   - Decreased Fetal (Baby) Movement
   - Vaginal drainage or bleeding
   - Abdominal cramping/tightening
   - Return of symptoms
   - Ruptured bag of waters or fluid leaking from vagina

10. Other:

I understand and have received a copy of these instructions. They have been explained to me.

Patient Signature: Nimiko Miner Date: 4/9/16

RN Signature: K Waghorn RN Date: 4/9/16

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

Pregnancy Discharge Instructions

63128 3/00

MINER NIMIKO D
DOB 10/06/87 16Y 3EK F MR: 1053171
PALABRICA CYNTHIA L.
ACCT# 71486994

WHITE - MEDICAL RECORDS YELLOW - PATIENT COPY

☐ Substitution with therapeutic drug alternatives as approved by the Medical Executive Committee is acceptable unless initialed.

☐ Another brand of drug identical in form and content may be dispensed unless checked.

PATIENT ORDERS

PLEASE CHECK ALL ORDERS WHICH ARE TO BE FOLLOWED.

DATE	TIME	ORDERS
4-6-06	2015	

Reason for visit _____

Visit Type: ☒ **Observation**

Known Drug Allergies _____ **Known Latex Allergy:** ☐ **Yes** ☐ **No**

Environmental Allergies _____

1. **Assessments:**
   - ☐ Doppler for < 25 weeks
   - ☐ 20 minute initial continuous external fetal monitor strip. If reassuring, may ambulate.
   - ☐ Other: _____

2. **Diet:** ☐ As tolerated ☒ Clear liquids ☐ Ice Chips ☐ NPO

3. **Activity:** ☐ Ambulatory ☐ BR with BRP ☐ Bed rest

4. **Treatments**
   Ultrasound for:
   - ☐ Biophysical Profile
   - ☐ Amniotic Fluid Index
   - ☐ Presentation
   - ☐ Other: _____

5. **Labs:**
   - ☐ CBC, stat
   - ☐ T&S, stat
   - ☐ Kleihauer-Betke, stat
   - ☐ PIH panel (AST, ALT, LDH, uric acid, creatinine, CBC), stat
   - ☐ Urinalysis: ☐ Midstream ☐ Catheter ☐ Voided
     - ☐ Routine and micro, hold for C & S, send if results indicate UTI - stat
     - ☐ Toxicology screen (drugs) - requires signed informed consent - stat
   - ☐ Cervical culture for Chlamydia, routine and GC.
   - ☐ Vaginal/rectal swab to culture for Group B Strep.
   - ☐ Other: _____

6. **Medications:**
   Terbutaline ☐ 0.25 mg subq q20 min x 3 ☐ 2.5 mg po ☐ 5 mg po ☐ q _____ hr. Hold if pulse > 120.
   - ☐ Other: _____

7. **IV Fluids:** LR 1000 ml at _____ ml/hr. ☐ Bolus _____ ml over _____ min.
   D5LR 1000 ml at _____ ml/hr. ☐ Bolus _____ ml over _____ min.

8. **Other:**
   - ☐ Call provider for orders.
   - ☐ Other: _____

4-22-06

Provider: _____ RN taking phone order: _____

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

Obstetric Observation Orders

MINER NIMIKO D
DOB 10/06/87 18Y SEX F MR: 1053171
PALABRICA CYNTHIA L.
ACCT# 71486994

Medication Administration Record

Name: MINER NIMIKO D
DOB 10/06/87 19y SEX F MR: 1053171
PALABRICA CYNTHIA L
ACCT# 71486994

Account #

MR#

Unit:

Room:

Allergie

Admit Date

Sex:

Hgt:

Age

Wgt:

CrCl:

Comments:

ADMINISTRATION PERIOD FROM 4/8/24 23:01 TO 4/9/24 23:00

MEDICATION	NIGHTS 23:01 - 07:00	DAYS 07:01 - 15:00	PMS 15:01 - 23:00
prn) Tylenol 1000mg po x 1 DOSE now			2210 4/8

M A R RECONCILED

BY _____

INJECTION SITES

A. RIGHT DORSAL GLUTEUS	H. LEFT LOWER QUAD
B. LEFT DORASAL GLUTEUS	I. RIGHT VASTUS
C. RIGHT VENTROGLUTEAL	J. LEFT VASTUS LATERALIS
D. LEFT VENTROGLUTEAL	K. RIGHT DELTOID
E. RIGHT UPPER QUAD	L. LEFT DELTOID
F. LEFT UPPER QUAD	M. RIGHT THIGH
G. RIGHT LOWER QUAD	N. LEFT THIGH

ST JOSEPH REGIONAL MEDICAL CENTER
A Covenant HealthCare
5000 W Chambers Street
Milwaukee, WI 53210-1656

57052 1/04 ES

St JOSEPH'S HOSPITAL
5000 W Chambers St · Milwaukee 53210 · 414-447-2000

COLLABORATIVE CARE PLAN LABOR & BIRTH - TRIAGE SUPPLEMENT

#355 is not applicable if #310 is met

MOTHER ADDRESSOGRAPH
MINER NIMIKO D
DOB: 10/06/87 18Y SEX F MR: 1053171
PALABRICA CYNTHIA L
ACCT#: 71486994

Day & Date	Triage Date/Time: 4/19/06 2200
Expected Patient/ *Process Outcomes	[ ] #310 Triage criteria met: • regular uterine contractions with cervical change and/or • ROM [✓] #355 *Discharged within 4 hours of arrival to unit if in false labor; no ROM [ ] #353 *Admitted in computer within 10 min of arrival to unit [✓] #354 *Prenatal record available in L&D if > 37 weeks [✓] #350 *Plan of care shared with P/SO [✓] #351 *Teaching provided to P/SO per plan
Other Expected Outcomes	
Teaching (By unit RN and other specified discipline)	[✓] #343 Time 2215 P/SO verb S/S: • true labor • warning signs
Teaching & Reinforcement noted by date/ initials following items	[✓] #344 Time 2215 P/SO verb understanding of when to notify physician
Initials in box note outcome achievement. Date entered if other than column date.	(Continued next column)

Initials/Signature: ____ / ____

Day & Date	Triage Date/Time: 4/19/06 2200
Teaching (Cont.)	[✓] #348 Time 2200 P/SO verb knowledge of procedures performed (circle): • SSE • cultures • straight cath • IV • (vaginal exam) • (monitor) • ultrasound • lab work • ____ • ____
Patient Care Priorities	• Anxiety r/t questionable labor & admission
Other Patient Priorities	
Assess-ments	• Triage criteria: - cervical change regular uterine contractions ROM • VS • Prenatal course & labs • Assess anxiety/coping • Follow-up/referral needs
Tests	• EFM baseline strip • Urine dipstick • Nitrazine/ferning if indicated

KBW Kildaymccu RN

Day & Date	Triage Date/Time: 4/19/06 2200
Diet	• Clear liquids or as ordered
Activity	• Encourage ambulation as tolerated
Treat-ments	
Medica-tions	• Possible home prescriptions
Other Inter-ventions	
Multi-discipli-nary Consults	• Possible SW • Possible CNS
Discharge Planning	• Alert social services for any evidence of special needs/follow up

GRAV 1	TERM 0	PRETERM 0	AB 0	0 LIVE

EDD DATES	GEST (WKS)	EDD U/S June 1st	GEST (WKS) 32 3/7

PRIMARY COMPLAINT	ALLERGIES/ ☐ None SENSITIVITIES *	REACTION
☐ abdominal pain/cramps ☐ contractions ☐ PROM/SROM ☐ vaginal bleeding ☐ ↓ fetal activity ☒ MVA/fall/altercation MVA ☐ fever/nausea/vomiting ☐ pain, other ☐ other ______	Respital (for ADHD)	
	MEDICATIONS **	Last dose
	PNV	
*Including but not limited to allergies/sensitivities to medications, food, tape, LATEX, iodine ** Prescription, OTC, nutritional supplements, herbal remedies, other		

Pain: Do you have pain? ☐ No ☒ Yes, pain intensity? 4 Location: abd. cramps & back pain Pain intensity goal: ______

Describe: ______

☐ See Significant Findings

Mobility: ☒ Ambulatory ☐ Bedrest ☐ Needs Assist ☐ Recent change: Comment: ______

Learning needs: ______ Barriers: ______ Preferences: ______

Safety: ☒ No needs ☐ Auditory deficit ☐ Speech deficit

☐ Visual deficit ☐ Evidence of physical, emotional or verbal abuse Comment: ______

Discharge: Do you have concerns about going home? ☒ No ☐ Yes ☐ Social work referral ______

Nutrition: ☒ No needs ☐ Therapeutic diet ☐ Recent weight loss Lives c mom

Dentures: ☒ No ☐ Upper ☐ Lower ☐ Partial ☐ Loose teeth

Height: 5'6" Weight: 152 Scale: ______ Per pt: prepreg. 130

☐ Dietitian referral: ______

Social history: Smoking ☒ No ☐ Yes ______

Alcohol: ☒ No ☐ Yes, Last drink? ______

Street drugs: ☒ No ☐ Yes, how much? ______

Religious/Cultural: ______

Patient Rights: ☒ None ☐ Unknown ☐ Living Will

☐ Durable POA for Healthcare ☐ Copy on chart

Information: ☐ Given ☒ Declined

Tonsillectomy 3yrs ago

PREGNANCY COMPLICATIONS	MEDICAL PROBLEMS
PAST: ☒ Denies ☐ See Risks CURRENT: ☒ Denies ☐ See Risks	☒ Denies ☒ See Risks ☐ See Notes
MATERNAL / FETAL RISKS / PROBLEMS	☒ None
	ADHD (not on meds)
	& Lameers Disease - blood disorder
	- Had blood clot in

neck - got blood thinner & was hospitalized for a month about 2yrs ago. Not on meds since then.

RN Signature [illegible] RN

Date 4/9/16 Time 2140

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL
5000 W Chambers St • Milwaukee, WI 53210
201 North Mayfair Road • Wauwatosa, WI 53226
10400 W North Ave • Wauwatosa, WI 53226

Obstetric Outpatient Nursing History

87623 2/05

MINER NIMIKO D
DOB 10/06/87 18Y SEX F MR: 1053171
PALABRICA CYNTHIA L
ACCT# 71486994

Time in Date 4/9/06 Time 2133

Date	Time	2133 / 2140	2200	2224	
VITAL SIGNS	Temperature	97.1			
	Pulse / Respirations	132 / 20 / 120			
	Blood Pressure	[illegible]			
CERVICAL EXAM	Effacement %				
	Dilatation (cm)			closed	
	Station (+ - cm)				
UTERINE ACTIVITY	Frequency (min)	irrit - NT	irrit		
	Duration (sec)				
	Intensity				
FETAL STATUS	Baseline FHR (bpm)	115-125	115-125	115-125	
	Long Term Variability	WNL 4 135	WNL	WNL	
	Reactivity	↓	R	R	
	Decelerations				
POINT OF CARE	Blood glucose/ Meter ID				

Key: √ = Assessment WNL * = See Notes Δ = no change	Time 2140	Time
Neurological/Mental State	√	
Cardiovascular	√	
Respiratory	√	
Integumentary	√	
Invasive Line		
Gastrointestinal	√	
Nutrition/Hydration	√	
Genitourinary	√	
Musculoskeletal	*	
Peripheral-Vascular	√	
Comfort	*	
Coping	√	
Spiritual / Valuing	√	
Continuity of Care	√	
Safety	√	
Patient Education	√	
Initials	KMW	

PHYSICAL ASSESSMENT

MEMBRANES ☒ Intact ☐ Bulging
☐ Ruptured Date ___/___/___ Time ______
☐ Nitrazine Test ☐ neg ☐ equivocal ☐ pos
☐ Fern Test ☐ neg ☐ pos

URINE
Protein ______
Glucose ______
Ketones ______
Nitrites ______
Leukocytes ______

☐ Sterile Speculum Exam (findings ______________________)
FLUID ☐ Clear ☐ Bloody ☐ Foul Odor ☐ Meconium Stained

REFERRALS
☐ Social Services ☐ Interpreter ☐ ______________

PLAN OF CARE: ☐ Initiate standing orders/treatment protocol
☐ Other

FOCUS NOTES/SIGNIFICANT FINDINGS

Time		Initial
2133 -	Pt here s MVA @ 1800.	
2140	Was an passenger side car was parked. Fire truck came [illegible] and [illegible] & hit the drivers side. Pt. was wearing her seatbelt & car just jerked forward. Did not hit her abdomen. Is having mild abd. cramps & back pain. [illegible] fetal movement [illegible]	
2205	Dr. [illegible] here to accept.	
2210	[illegible] MD.	KW

☐ See Significant Findings Sheet for further charting

FINAL ASSESSMENT: ☐ RNST ☐ Reassuring for GA
18 y/o G1P0 @ 30 3/7 here for s/p MVA. Pt was restrained passenger, pt [illegible] behind [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

PE: [illegible] [illegible]

PLAN [illegible] [illegible]

A/P: 18 y/o s/p MVA
[illegible] FWB
. D/c to home [illegible] [illegible]

DISPOSITION: ☒ Discharge ☐ Admit - L&D ☐ Admit - Antepartum
DISCUSSED WITH Dr. [illegible] @ 2210
Provider Signature [illegible] Date 4/9/06
Co-signature ______________ Date ______

Time disposition decision made 2210 Time out 2220
To: ☒ Home ☐ ______
By ☒ Walk ☐ Wheelchair ☐ Alone ☒ With Mother

Discharge instructions reviewed Patient verbalizes understanding

RN Signature K [illegible] RN Date 4/9/06

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A Covenant HOSPITAL
5000 W. Chambers St. • Milwaukee, WI 53210
201 North Mayfair Road • Wauwatosa, WI 53226
10400 W. North Ave. • Wauwatosa, WI 53226

Obstetric Outpatient Assessment Record Triage

MINER NIMIKO D
DOB 10/06/87 18Y SEX F MR: 1053171
PALABRICA CYNTHIA L
ACCT# 71486994

COVENANT SIGNATURE PROFILE

Date	Initials *as you would use in charting (Write Legibly)	Print Full Name	Written Signature	Title
4/9/06	KBW	Kami B Wagner	Kami B Wagner	RN

Covenant HEALTHCARE

Sponsored by the Wheaton Franciscan and Felician Sisters

FACILITY ____________

Covenant Signature Profile

55531 10/02 R1

MINER NIMIKO D
DOB: 10/06/87 18Y SEX F MR: 1053171
PALABRICA CYNTHIA L
ACCT# 71486994

D. <u>Assignment and Agreement to Pay</u>: I understand that I am responsible [illegible] for the services that I receive and guarantee payment for these services. I hereby assign to [illegible] and the physicians and professionals associated with the Facility for application to my bill for [illegible] 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. <u>Valuables</u>: 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. <u>Photographing</u>: 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. <u>Privacy Notice</u>: 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] — 4-9-06

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 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

MINER NIMIKO D
DOB 10/06/87 18Y SEX F MR 1053171
PALABRICA CYNTHIA L
ACCT#
71486994

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

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

Inpatient and Outpatient Consent for Treatment & Financial Agreement

1820 2/03 R8

MINER NIMIKO D
DOB 10/06/87 [illegible] MR: 1053171 RE
PALABRICA CYNTHIA L
ACCT: 71486994

ST. JOSEPH REGIONAL MEDICAL CENTER
A MEMBER OF COVENANT HEALTHCARE

Account No: 71517538 **MR#: 1053171**
Sched Date: 04/09/06 07:31 PM

PATIENT INFORMATION

MINER NIMIKO D
2444 N 40 ST
MILWAUKEE WI 53210

Phone: 414 449-1392
DOB: 10/06/1987 Age: 18
Gender: F MS: SINGLE

Religion: NONE
Employer: NONE
Phone #:
Occupation:

NEAREST RELATIVE

Name: ZIGGLER CELIA D
Phone: 414 449-1392
Bus Phone: 414 476-0025
Relat: PARENT
Notify: Y

ADDITIONAL CONTACT

Name: MINER BETTY
Phone: 414 263-2947
Bus Phone:
Relat: OTHER RELATIONSHIP
Notify: Y

VISIT INFORMATION

INTERPRETER NEEDED: NO
Language: ENGLISH

Admit Reason: BACK PAIN
Comment: WYS T1079874

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

PHYSICIAN INFO

Adm:
Att: ROSIER THOMAS A
PCP: PALABRICA CYNTHIA L.

INSURANCE INFORMATION

PRIMARY: UNITEDHEALTHCARE T19
Plan: STANDARD
PO BOX 659770
SAN ANTONIOTX 78265
Phone #: 866 592-2364
Subr: MINER NIMIKO D
Relat: PATIENT IS INSURED -
Policy#: 3920299460
Group#:
Group Name:

GUARANTOR INFORMATION

Name: MINER NIMIKO D
2444 N 40 ST
MILWAUKEE WI 53210-0000

Phone #: 414 449-1392

Employer: NONE
Phone #:

PRINTED COPY Date: 04/12/06 Time: 11:03 AM

St. Joseph Regional Medica enter

Emergenc epartment QualChart®

ORDER SHEET / TRAUMA/MAJOR

Height: Weight: lbs / kgs Allergies:

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

	LABORATORY: Circle specific orders	By:	Time:
	Trauma Panel		
	CBC Manual Diff		
	BMP CMP LFT Mg		
	Amylase Lipase Ammonia		
	UA UA w/o Micro CC Cath		
	UCG HCG: Qual / Quant		
	Drug Screen: Urine / Serum ETOH		
	CPK CKMB Troponin		
	Myoglobin		
	Rh Type Screen Type Cross _____ units		
	PT / INR PTT		
	Hemoccult Gastroccult		

	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 Contrast: IV PO None		
	CT: C-Spine T-Spine L-Spine		
	CT: Chest Contrast: IV PO None		
	CT: Abdomen / Pelvis Contrast: IV PO None		
	Ultrasound of: GB ABD Pelvis		

Pertinent Lab Values: WNL WNL Except:

Indication(s) for Xray / CT / US: _____

Xray Interp: No Acute Changes Positive _____

By: ED Physician Radiologist _____

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

EKG Interpretation: _____

EKG Comparison: No Signficant Change / Other: _____

Cardiac Monitor:

Rate: Normal Brady Tachy _____

Rhythm: Sinus AFIB Junctional _____

Ectopy: None PVCs PACs _____

	TREATMENT ORDERS:	By:	Time:	Time:	CLINICAL RESPONSE / RE-EVALUATION
	Repeat Vital Signs: All BP Pulse RR Temp O2 Sat				VSS except:
	Pulse Ox O2 @ _____ l/min via NC / Mask / NRB				NL Hypoxic _____ % on R/A or O2 @ _____ l/min
	Saline Lock IV: NS LR Bolus _____ ml over _____ min/hr				
	Second IV Site: _____ Large Bore NS LR Rate of _____ ml / hr				
	Transfuse _____ units PRBCs / _____				
	NPO NG Tube / OG Tube Foley Catheter				
	Td 0.5 ml IM Lot # _____				
	Disposition Orders: Discharge Admit Observation Transfer				

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 / _____

Critical Care Provided for: 30-74 min / 75-104 min / _____ min

SIGNATURE:

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

_____ MD / DO

_____ PA / NP

_____ RN / Init

_____ RN / Init

MINER NIMIKO D

DOB 04/06/87 18 yr F MR 1053171

EMERGENCY CONSULTANTS INC

04/09/06 08:34 pm

St. Joseph Regional Medic Center | Emergency Depar ent QualChart® |

MOTOR VEHICLE ACCIDENT — Circle pertinent positive findings. Backslash pertinent negative findings.

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

Mode of Arrival: EMS Other

✱ DENOTES QUALITY INDICATOR

Vital Signs Stable except: BP ___/___ Pulse ______ R Rate ______ Temp ______
Pulse Ox: NL Hypoxic Not Applicable ______ % on R/A or O_2 @ ______ L/min

Cardiac Monitor Interp.: Not Applicable — Rate: NL Brady Tachy; Rhythm: Sinus Afib Junctional; Ectopy: None PVCs PACs

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

CHIEF COMPLAINT: This is a ______ year old male / female who presents with a complaint of MVA with pain at: Head Neck Back Chest Abdomen Extremities ______

OCCURRED ______ Minutes Hours Days Prior to Arrival

ONSET OF PAIN Immediate ______ Minutes Hours Days Post Accident

SEVERITY OF PAIN Initially: ______ (0 - 10) Mild Moderate Severe Currently: ______ (0 - 10) None Mild Moderate Severe

MECHANISM OF INJURY Car Truck Motorcycle Bicycle ATV Pedestrian
VS Car Truck Motorcycle Bicycle ATV Pedestrian Stationary Object

PATIENT LOCATION Driver Passenger Front Back Pedestrian

ASSOCIATED SIGNS AND SYMPTOMS Negative Headache Seizure Active Bleeding Motor / Sensory Deficit SOB
LOC Duration: ______ Seconds Minutes Hours Unknown
Extremity Deformity: ______

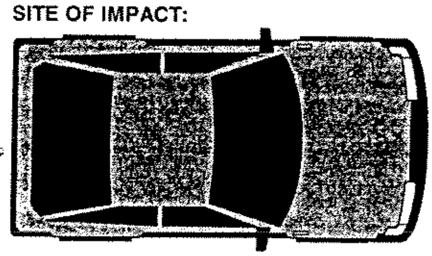
CONTEXT Lost Control Fell Asleep Distracted Seizure Intoxicated Other: ______
Ambulatory at Scene Backboard / C-Collar Applied PTA

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

SITE OF IMPACT:



Force: Low Moderate High Direct Glancing

Restraints: None Lap / Shoulder Helmet / No Helmet Car Seat Ejected From Vehicle Prolonged Extrication Air Bag Deployed

PAST MEDICAL HISTORY: Previously Healthy DNR / Comfort Care Only

Endocrine	DM I	DM II	Hypothyroid	Hyperthyroid	Hyperlipidemia
CV	CAD / MI	HTN	CHF	Afib	DVT
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	
Surgical Hx	None	Cervical / Lumbar Fusion	Herniated Disc		

Immunizations: Unknown Tetanus UTD Not UTD
✱ Pneumococcal ✱ Influenza within 12 months

FAMILY HISTORY: Negative
Heart / HTN ______
Diabetes ______
Other: ______

SOCIAL HISTORY: Negative
Smoking ______ ppd x ______ yrs. ✱ Patient Advised to Stop
ETOH / Drug Use ______
Occupation ______
Lives Alone / With Family Nursing Home Assisted Living

MINER NIMIKO D
MR 1053171
EMERGENCY CONSULTANTS INC

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

 04/09/06 08:34 pm

MOTOR VEHICLE ACCIDENT

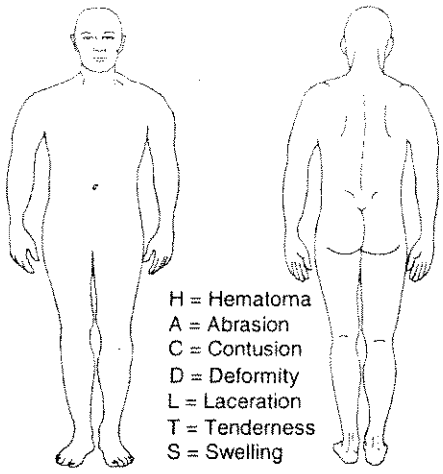
Circle pertinent positive findings. Backslash pertinent negative findings.

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*
Eyes	Normal	PERL / EOMI Conjunctiva Clear	*R Pupil _____ L Pupil _____* *Conjunctiva Inflammed*
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 @ _____* *Edema @ _____* *Calf Tenderness*
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*

Complaint-Specific Findings

C-Collar / Backboard (PTA / ED)
Removed w/consent post exam
GCS _____
Tenderness / Spasm:
Paraspinal
Cervical
Thoracic
Lumbar
Diminished Breath Sounds Right / Left
Pelvis / Hip Stable / Unstable
Extremity Injury / Deformity



H = Hematoma
A = Abrasion
C = Contusion
D = Deformity
L = Laceration
T = Tenderness
S = Swelling

MEDICAL DECISION MAKING: Consideration of the following conditions may be warranted for the presenting problem. These conditions are not final diagnoses.

DIFFERENTIAL DIAGNOSES:

Abdominal Injury
Abrasions / Contusions
Chest Injury
Head / Facial Injury
Lower Extremity Injury
Neck / Spinal Injury
Normal Exam
Upper Extremity Injury
Other: _____

RE-EVALUATION: Pain Scale (0-10)

Time: _____ Unchanged Improved Worse VSS _____

Time: _____ Unchanged Improved Worse VSS _____

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

Discussed case/management/disposition of patient with:
Name: _____ at _____ 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: Home Work Nursing Hm ED Obs ICU Tele Floor Deceased AMA
Condition: Stable Unstable
Patient Endorsed To/Discussed With: _____ @ _____ 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.

ED PHYSICIAN DIAGNOSES:

1 [illegible]
2 [illegible]
3 [illegible]

Critical Care Provided For: _____ min

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

SIGNATURE: _____ MD/DO

_____ MD/DO

_____ PA / NP / Resident

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

Supervising Physician attests performing pertinent History, Physical Examination, and Medical Decisions _____ *(Initials)*

Chart / Addendum Dictated: Yes No

MINER NIMIKO D
DOB: 10/05/87 [illegible] MR: 1053171
EMERGENCY CONSULTANTS INC
[illegible]

I have reviewed available Ancillary / Nursing Staff documentation.

QC21800111210504021

04/09/06 08:34 pm

INITIAL ASSESSMENT / TRIAGE

NAME	M / F	DOB	Private Physician /ECI	1 2 3 4 5	Date/Time of Triage
Miner, Nimiko	F ☒	10/6/87	Bando ☒ PMD	3☒	4/9/06 1920

Chief Complaint	Age	Wt (Kg)	OFC	B.S./Device	Family with patient	Mode of Arrival: W.C
Back Pain s/p MVA	18				Yes No ☒	Ambulatory ☒

Allergies: Keflex None ☐ Latex
LMP/EDC: 6/1
Lactating Y ☐ N ☐
See Nursing notes for type of Reaction.

Advanced Directives: Yes ☐ No ☒ Info ☐ Referral Given ☐
Tetanus Immunizations: UTD ☐ >10 years ☐ Never ☐
Car / Carried / Ambulance / Med. Unit / Police

Medications: PNV None ☐ See Admission Med. Record ☐
Herbal or Alternative Med:

Additional Triage Assessment: 32 weeks pregnant

Pre-Hospital Treatment: None ☒ Oxygen ☐ C-Collar ☐ IV ☐ Backboard ☐ Splinting ☐ Meds ____ Other ____

Past Medical History: CARDIAC ☐ RESP. ☐ CANCER ☐ NEURO ☐ RENAL ☐ SEIZURE ☐ NICOTINE ☐ INFECTIOUS DZ ☐ None ☐ DIABETES ☐ PSYCH ☐ AODA ☐ HTN ☐ OTHER LeBross

TB Screen: Cough Yes ☐ No ☐ Hemoptysis Yes ☐ No ☐ Either greater than 3 weeks Yes ☐ No ☐
If any of the above are yes, cont. Malaise ☐ Fever ☐ Decrease Appetite ☐ NOC Sweat ☐ Chills ☐ Unintended Wt. loss ☐ None ☐

VS	Time	BP 120/79	P 101	RR 20	Temp. O 97.4 A R	O2Sat.

Divert Registration ☒ Register & Wait ☐ Reassurance ☐ W/C ☐ Ice ☐
Elevation ☐ Dressing ☐ Splint ☐ Sling ☐ Other
Triage EDT
Triage RN: M Randay CRN

(Subjective) TIME: 19.40
Reason For Seeking Care: pt reports being in an MVA with [illegible] in front passenger seat, pt in [illegible] ... hitting head, but results [illegible] feeling [illegible]

PLAN OF CARE: ☐ INITIATE STANDING ORDERS/TREATMENT PROTOCOL ☒ OTHER: [illegible] comfort

SYSTEM	BASIC	FOCUSED	SYSTEM	BASIC	FOCUSED
NEUROLOGICAL	—	GCS	INTEGUMENTARY	—	
CARDIAC	X	RHYTHM ? [illegible]	MUSCULOSKELETAL/ MOBILITY	X	Back, LW, Pain
RESPIRATORY	—		PERIPHERAL/NEURO	—	
GI	—		PAIN/COMFORT LOCATION/QUALITY	X	Scale 0-10 4/10 [illegible]
GU	—		SEXUAL/ REPRODUCTIVE	—	FHT
EENT	—		PSYCH/SOCIAL	—	

R EYE ____ L EYE ____
BOTH EYES ____
TIME/SIGN OF RN COMPLETING ASSESSMENT [illegible] 19:40

SCREEN

Safety ☑ Side Rails ☐ Seizure Precautions Yes ☐ No ☐ Isolation Yes ☐ No ☐ Type ____ Nutritional ☐
Discharge Planning ☐ Functional Health ☑ Personal Safety ☐ (see screening questions on back of this sheet; screens are required on each patient as warranted by their condition)

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

DISPOSITION

TIME OF DISPOSITION: 20 40
TO: L+D [illegible]
Condition: Stable
ADMIT
Report to:
Initials/Sign
Initials/Sign

Left With: EDT
Via: w/c
Instructions Given: yes
Scripts Given: no
Follow up with: OB [illegible]
Verbalized Understanding: yes
Initials/Sign
Initials/Sign Km [illegible] RN

Death:
Family notified:
PMD notified:
Donor Network called:
1-800-432-5405
Medical Examiner Notified:

ST. JOSEPH REGIONAL MEDICAL CENTER

EMERGENCY DEPARTMENT
RECORD PAGE 1

MINER NIMIKO D
DOB 10/06/87 18Y SEX F MR: 1053171
EMERGENCY CONSULTANTS INC
ACCT# 71517538

5K041 12/2005 R11

Time	BP	P	RR	TEMP	O2Sat	PAIN 0-10 QUALITY	*	ASSESSMENT/INTERVENTION/EVALUATION	INITIALS
19:45								Pt assessed [illegible]	
								[illegible]	
20 [illegible]								[illegible]	
20 [illegible]								[illegible]	
								[illegible]	
20 [illegible]								[illegible] 1 gm [illegible]	
								[illegible]	
20:[illegible]								[illegible]	
								[illegible] assessment [illegible]	

	TIME	INITIALS	TIME RETURN	INITIALS		TIME	INITIALS	ORTHO VS	Time BP	Time P	INITIALS
EKG					LAB			LIE			
RAD					URINE			SIT			
CT					CULTURES			Stand			
US					WET PREP						
WND PRP					PELV. EX						

IV START TIME	SITE	GUAGE	BAG #	SOLN.	RATE	IV STOP TIME	AMOUNT	INITIALS	On Monitor/Interp./Time

Initials/Sign______ Initials/Sign______

Initials/Sign______ Initials/Sign______

Initials/Sign______ Initials/Sign______

Initials/Sign______ Initials/Sign [illegible signature]

	INTAKE	OUTPUT
IV		
PO		
URINE		
OTHER		

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

EMERGENCY DEPARTMENT
RECORD PAGE 2

MINER NIMIKO D
DOB 10/06/87 18Y SEX F MR 1053171
EMERGENCY CONSULTANTS INC
ACCT#

56042 08/2005 R12

ST. JOSEPH
REGIONAL MEDICAL CENTER
Covenant

Emergency Dept. 414-447-2171

Patient Name _____ Date _____

Rx

ST. JOSEPH
REGIONAL MEDICAL CENTER
Covenant

Emergency Dept. 414-447-2171

Patient Name _____ Date _____

Rx

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.

FOLLOW-UP

- ☐ 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 _____
- ☐ Community Clinic _____
- Telephone _____
- ☐ To find a doctor, call our Covenant Physician Referral Service, 877-226-8362

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.

If 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: _____ Time: _____ Date: _____ Staff Initials: _____

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
Covenant

GENERAL DISCHARGE INSTRUCTIONS ED-SJRMC

MINER NIMIKO D
DOB 10/06/87 18Y SEX F MR 1053171
EMERGENCY CONSULTANTS INC
ACCT# 21512530

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 and agree that my health information may be re-disclosed in accordance with applicable state and federal laws. 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

MINER NIMIKO D MR 1053171
DOB 10/06/87
EMERGENCY CONSULTANTS INC
ACCT# 7151 7538

D. <u>Assignment and Agreement to Pay</u>: 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 and related purposes. This may include re-disclosure of information obtained from other health care providers and required for payment 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. <u>Valuables</u>: 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. <u>Photographing</u>: 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. <u>Privacy Notice</u>: 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.

X Nimiko Miner ________________ 4-9-06 ________________

Signature of Patient/Authorized Representative — Date

____

Relationship of Authorized Representative

If unable to sign document, state reason: _______________________________________

Covenant

[illegible]

Inpatient and Outpatient
Consent for Treatment &
Financial Agreement

1820 11/2005 R9

MINER NIMIKO D
DOB 10/06/87 18Y SEX F MR 1053171
EMERGENCY CONSULTANTS INC
ACCT#
71517538

ST JOSEPH REGIONAL MEDICAL CTR
BOX 68-9510
MILWAUKEE, WI 53268-9510
Statement on: 05/03/06 at 12:13 PM

Guarantor: MINER NIMIKO D
2444 N 40 ST
MILWAUKEE, WI 53210-0000

Patient: MINER NIMIKO D
Visit #: 71517538
AR Seg: 04/09/06 to 04/09/06

Date	Svc Code	Description	Units	Debits	Credits
04/09/06	12808186	ACETAMIN TAB 325MG UD	3	11.07	
04/09/06	61549282	ED CARE LEVEL 2	1	279.25	
04/14/06	9848064	ALLOW T19 UHC	-1		148.27-
* - Not posted				Balance:	142.05

ST JOSEPH REGIONAL MEDICAL CTR
BOX 68-9510
MILWAUKEE, WI 53268-9510

Statement on: 05/03/06 at 12:12 PM

Guarantor: MINER NIMIKO D
2444 N 40 ST
MILWAUKEE, WI 53210-0000

Patient: MINER NIMIKO D
Visit #: 71486994
AR Seg: 04/09/06 to 04/09/06

Date	Svc Code	Description	Units	Debits	Credits
04/09/06	12808186	ACETAMIN TAB 325MG UD	2	7.38	
04/09/06	56382755	OUTPATIENT IN BED/HOU	1	35.00	
04/09/06	56382850	OBSTETRICAL ADMISSION	1	663.25	
04/09/06	56382860	REGULAR CARE/HOUR	1	219.00	
04/09/06	61549282	ED CARE LEVEL 2	1	279.25	
04/14/06	9848064	ALLOW T19 UHC	-1		1061.83-

* - Not posted

Balance: 142.05

ST JOSEPH'S EMER PHYS LLP
ST JOSEPH REGIONAL MEDICAL CTR
75 REMITT. DR #1574
CHICAGO IL 60675 1574

PHONE
800 219 9811

NIMIKO D MINER
2444 N 40 ST
MILWAUKEE WI 53210

218001
432591

04/09/06

DATE
05/23/06

432591

ACCOUNT NUMBER

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT OF $_____

DATE MO DY YR	PHYSICIAN	TRANSACTION DESCRIPTION	PROC CODE	AMOUNT
***PATIENT NAME - NIMIKO MINER		432591		
04 09 06	ROSIER	EMERGENCY DEPT VISIT	99283	194.00
		Dx1 64873 Dx2 7245		
		ACCOUNT BALANCE		194.00
		PENDING INS CONSIDERATION		-194.00
		PATIENT BALANCE		0.00

Please make check payable to St. Joseph's Emergency Physicians, LLP. Payment may be made by check, money order, or major credit card. This bill is for the Physician services-not for the hospital charges.
Notice: If you have already paid this bill, please disregard this statement. Thank you.
You can email your insurance information or billing questions to apollobilling@eci-med.com or call 1-800-219-9811.

ACCOUNT NUMBER	PREVIOUS BALANCE	PAYMENT/CREDIT	CHARGES	BALANCE DUE
432591		0.00	194.00	0.00

05/23/06 MAKE CHECK PAYABLE TO: ST JOSEPH'S EMER PHYS LLP

CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS AND OVER
194.00	0.00	0.00	0.00	0.00

TAX ID 38-3420925

TGARMON

MAKE CHECKS PAYABLE TO:

CAPITOL REHABILITATION CLINIC
7220 WEST CAPITOL DRIVE
MILWAUKEE, WISCONSIN 53216
(414) 464-4888
FAX (414) 464-1850

Account # 010082-00

RETURN UPPER PORTION OF
STATEMENT WITH PAYMENT

NOTE: charges and payments not appearing on this statement will appear on next month's statement.

SHOW AMOUNT PAID IN THIS BOX

NIMIKO MINER
2444 N. 40TH ST.

MILWAUKEE,WI 53210

CLOSING DATE	AGE	NEW BALANCE
08/23/06	01	$ 1775.00

NIMIKO MINER

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE		EXPLANATION OF ACTIVITY	PROC CODE	DIAG CODE	CHARGES & DEBITS	PAYMENTS & CREDITS
04/27/06	BG1	COMPREHENSIVE OFFICE VISIT			230.00	
05/12/06	BG1	EST. PT. INTERMEDIATE OFFIC			98.00	
06/02/06	BG1	EST. PT. INTERMEDIATE OFFIC			98.00	
06/15/06	BG1	ELECTRICAL STIMULATION			46.00	
06/15/06	BG1	THERAPEUTIC EXERCISE 15 MIN			100.00	
06/19/06	BG1	ELECTRICAL STIMULATION			46.00	
06/19/06	BG1	THERAPEUTIC EXERCISE 15 MIN			100.00	
06/19/06	BG1	P T MINI EVAL-FIRST PT CONT			50.00	
06/26/06	BG1	ELECTRICAL STIMULATION			46.00	
06/26/06	BG1	THERAPEUTIC EXERCISE 15 MIN			100.00	
06/29/06	BG1	ELECTRICAL STIMULATION			46.00	
06/29/06	BG1	THERAPEUTIC EXERCISE 15 MIN			100.00	
07/06/06	BG1	EST. PT. INTERMEDIATE OFFIC			98.00	
07/10/06	BG1	ELECTRICAL STIMULATION			46.00	
07/10/06	BG1	THERAPEUTIC EXERCISE 15 MIN			100.00	
07/10/06	BG1	P T MINI RE-EVAL			35.00	
07/11/06	BG1	ELECTRICAL STIMULATION			46.00	
07/11/06	BG1	THERAPEUTIC EXERCISE 15 MIN			100.00	
07/19/06	BG1	ELECTRICAL STIMULATION			46.00	
07/19/06	BG1	THERAPEUTIC EXERCISE 15 MIN			100.00	

LAST CLOSING DATE	DATE OF LAST PAYMENT	AMT. OF LAST PAYMENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	CHARGES & DEBITS	PAYMENTS & CREDITS
08/23/06	**/**/**	0.00	0.00	0.00	0.00	0.00	1775.00	0.00

PLEASE PAY THIS AMOUNT ➡ 1775.00

MAKE CHECKS PAYABLE TO:

CAPITOL REHABILITATION CLINIC
7220 WEST CAPITOL DRIVE
MILWAUKEE, WISCONSIN 53216
(414) 464-4888
FAX (414) 464-1850

Account # 010082-00

RETURN UPPER PORTION OF
STATEMENT WITH PAYMENT

...charges and payments not ...g on this statement will ...n next month's statement.

NIMIKO MINER
2444 N. 40TH ST.

MILWAUKEE,WI 53210

	NIMIKO MINER	
CLOSING DATE	SEQ	NEW BALANCE
08/23/06	02	$ 1775.00

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE		EXPLANATION OF ACTIVITY	PROC. CODE	DIAG. CODE	CHARGES & DEBITS	PAYMENTS & CREDITS
08/10/06	BG1	EST. PT. EXTENDED OFFICE VI			144.00	

STATEMENT CLOSING DATE	DATE OF LAST PAYMENT	AMT. OF LAST PAYMENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	CHARGES & DEBITS	PAYMENTS & CREDITS
08/23/06	**/**/**	0.00	0.00	0.00	0.00	0.00	1775.00	0.00

CAPITOL REHABILITATION CLINIC, 7220 WEST CAPITOL DRIVE, MILWAUKEE, WI 53216, (414) 464-4888 **PLEASE PAY THIS AMOUNT** ▶ 1775.00

PROGRESS NOTES

7 1/2 preg.

NAME MINER, NIMIKO DATE OF BIRTH PG# **Formedic**

DATE - TIME HT
CPT CODE WT BMI BP P T ALLERGIES

MVA 4.9.06

4.27.06 cc: Back + (L) leg [illegible]

HPI: [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] Pt SFT BONS. [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible] [illegible] to SF [illegible]

[illegible] [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] - [illegible] [illegible] [illegible] [illegible] [illegible] 7/10

↑ [illegible] [illegible] [illegible] [illegible] (-) [illegible]

(-) [illegible]

[illegible] (L) [illegible] [illegible] [illegible]

[illegible]: [illegible]

[illegible]: (-)

[illegible]: [illegible]

Allergies: [illegible] [illegible]

[illegible] [illegible] [illegible] FSTVP [illegible]

Fam Hx: HTN, [illegible] - [illegible]

ROS: (-)

PE: [illegible] (B) [illegible], F 80, c 0. [illegible]

[illegible]

(-) Sk / Slr / Tab

[illegible]: (1) [illegible]

(2) (L) [illegible]

[illegible]: (1) [illegible] [illegible] [illegible]

(2) [illegible]

(3) [illegible]

5.12.06 S> [illegible] [illegible] to [illegible]

Will see OB-GYN [illegible]

O: [illegible] (B) [illegible] [illegible]

A [illegible] (L) [illegible] [illegible] [illegible]

Miner Nimiko

DATE - TIME / CPT CODE	HT / WT	BMI	BP	P	T	ALLERGIES

Formedic

6-2-06 S> Pt. [illegible] May 22 [illegible]. [illegible] [illegible] [illegible] [illegible]

O> [illegible] [illegible] [illegible]

A> ① [illegible] ② [illegible]

P> ① ~~[illegible]~~ start PT
② [illegible] ~~[illegible]~~ [illegible]
③ RR [illegible]

[signature]

~~7-5-06~~ pt R/S
~~JUL 0 6 2006~~ error [illegible]
JUL 0 6 2006 S> Pt. [illegible] [illegible]. [illegible] [illegible]

O> [illegible] [illegible] [illegible]

A> ① [illegible] ② [illegible]

P> ① cont PT
② [illegible] [illegible] [illegible]
③ RR [illegible]

[signature]

JUL 2 0 2006 pt R/S
JUL 2 1 2006 Pt R/S
JUL 2 4 2006 No show
AUG 1 0 2006 S> [illegible] [illegible].

O> WNL

A> ① [illegible] ② [illegible]

P> D/C

[signature]

CAPITOL REHABILITATION CLINIC
7220 WEST CAPITOL DRIVE
MILWAUKEE, WISCONSIN 53216
(414) 464-4888
FAX (414) 464-1850

AUGUST 10, 2006

FINAL EVALUATION
RE: NIMIKO MINER
DOI: 4-9-06

Nimiko Miner comes to the clinic today for re-evaluation of injuries sustained relating to an MVA on 4-9-06.

She is an 18 year old African American right-handed female who was involved in an MVA on 4-9-06. She was initially seen in our clinic on 4-27-06 and assessed to have sustained a lumbar sprain/strain injury and a left hip contusion. At that point the patient was 7-1/2 months pregnant. Physical therapy was deferred and patient was urged to follow-up regularly. Patient gave birth on 5-22-06 and was recommended to start physical therapy for persistent low back and left hip complaints on her visit with me on 6-2-06. Patient gained improvements with therapies. She received a total of 7 therapy sessions. The last session was received on 7-19-06. Patient reports to have continued to make further improvements thereafter.

On follow-up today patient reports complete resolution of low back and left hip symptoms. She has not needed to take medications for pain and has been going about her activities of normal daily living and has been caring for her newborn baby.

PHYSICAL EXAMINATION shows full and functional range of motion over the neck and upper extremities as well as the mid and low back and lower extremities with no pain, tenderness or discomfort in any of these areas at this time.

The rest of the systemic and neurological examination findings are unremarkable.

IMPRESSION:
1). Lumbar sprain/strain, resolved.
2). Left contusion, resolved.

PLAN:
1). Discharge the patient from my care and supervision at this time.
2). Patient was advised to continue her home exercise program for her own benefit and well-being.
3). May discontinue medications.
4). Patient was advised to call on the clinic for any future questions or concerns.

Benjamin S. Gozon, M.D.
Physiatrist

BG/cmz

NIMIKO MINER
DOI: 4-9-06
TODAY: 7-6-06

Nimiko Miner comes to the clinic today for re-evaluation of injuries sustained relating to an MVA on 4-9-06.

Patient had tolerated therapies over the past few weeks. Patient reports continued improvement along the low back symptoms. Low back pain however still comes and goes and seems to be exacerbated with periods of increased activity.

PHYSICAL EXAMINATION today shows some mild tightness along the bilateral lumbar paraspinal region with functional range of motion.

IMPRESSION:
1). Lumbar sprain/strain.
2). Left hip contusion, resolved.

PLAN:
1). Continue physical therapy to the affected areas of the low back with emphasis on therapeutic exercise and strengthening and stabilization.
2). Continue current medications and restrictions.
3). Return to clinic in a few weeks for re-evaluation and follow-up.

Benjamin S. Gozon, M.D.
Physiatrist

BG/cmz

NIMIKO MINER
DOI: 4-9-06
TODAY: 6-2-06

Nimiko Miner comes to the clinic today for re-evaluation of injuries sustained relating to an MVA on 4-9-06.

Patient gave birth to her baby girl on 5-22-06. Low back pain symptoms seem to have improved somewhat. Patient however still has some bothersome discomfort and occasional tightness with periods of increased activity in the area. Left hip pain has resolved.

PHYSICAL EXAMINATION shows some mild tenderness along the bilateral lumbar paraspinal region. Range of motion is quite functional over the lumbar spine with moderate stiffness, mild guarding and some weakness on end range.

IMPRESSION:
1). Lumbar sprain/strain.
2). Left hip contusion, resolved.

PLAN:
1). Start physical therapy to the affected areas of the low back twice weekly with emphasis on therapeutic exercise and lumbar stabilization. I believe that the patient will benefit from a short course of therapy given her situation.
2). Recommended intake of regular Tylenol as needed for pain.
3). Return to clinic in a few weeks for re-evaluation and follow-up.

Benjamin S. Gozon, M.D.
Physiatrist

BG/cmz

NIMIKO MINER
DOI: 4-9-06
TODAY: 5-12-06

Miss Miner comes to the clinic today for re-evaluation of injuries sustained relating to an MVA on 4-9-06.

Currently patient reports that his low back pain symptoms are unchanged. They are still quite bothersome at this time with significant left hip discomfort. Patient sees her OB/GYN very regularly at this point and was advised that she may be giving birth any day now.

PHYSICAL EXAMINATION today shows some tender spasms noted along the bilateral lumbar paraspinal region. Range of motion is functional over the lumbar spine with significant stiffness and guarding at end range.

There is some tenderness noted along the left hip as well.

IMPRESSION:
1). Lumbar sprain/strain.
2). Left hip contusion.

PLAN:
1). Patient was advised to return to clinic after child birth.
2). I will make a determination whether physical therapy will be beneficial for the patient at that point.

Benjamin S. Gozon, M.D.
Physiatrist

BG/cmz

CAPITOL REHABILITATION CLINIC
7220 WEST CAPITOL DRIVE
MILWAUKEE, WISCONSIN 53216
(414) 464-4888
FAX (414) 464-1850

APRIL 27, 2006

INITIAL EVALUATION
RE: NIMIKO MINER
DOI: 4-9-06

Nimiko Miner comes to the clinic today for the chief complaint of low back and left leg pain.

HISTORY OF PRESENT ILLNESS: She is an 18 year old African American right-handed female victim of an MVA on 4-9-06. Patient was a restrained front seat passenger of a parked vehicle that was suddenly hit on the rear driver's side by another vehicle. Patient was jerked forward and thrown back into her seat. No head injury was sustained. Onset of symptoms was hours later which prompted a visit to St. Joseph's Hospital Emergency Room. Patient was released the same day after having monitored fetal movement. Persistent symptoms prompted consult to our clinic.

Currently patient reports mid low back pain which is characterized as dull and achy with sharp and stabbing exacerbations rated at 4/10. This is worsened by range of motion activities and certain positions of sitting. She denies any radiation into the lower extremities or paresthesias in these areas.

Tenderness is noted on palpation along the left hip and with laying on this area as well as with walking activities. Patient reports that she has some difficulty with laying on her left side during sleep at night.

PAST MEDICAL HISTORY: Unremarkable.

MEDICATIONS: Prenatal vitamins.

ALLERGIES are to Risperdal which produces edema and hives.

PERSONAL SOCIAL HISTORY: Patient is single and is a senior in high school. She is 7-1/2 months pregnant.

FAMILY HISTORY: Positive for hypertension and diabetes on both sides of her family.

REVIEW OF SYSTEMS: Denies any history of loss of consciousness or seizures. Denies any chest pain, shortness of breath, nausea, vomiting, fevers, chills, weight loss or any bowel or bladder problems.

PHYSICAL EXAMINATION shows a well developed, well nourished age appropriate African American female who is currently not in distress.

SYSTEMIC EXAMINATION shows pink conjunctivae and anicteric sclerae.

CHEST is clear to auscultation.

HEART has regular rate and rhythm.

ABDOMEN shows fundic height appropriate for gestational age.

MUSCULOSKELETAL EXAMINATION shows tender spasms noted along the bilateral lumbar paraspinal region. Flexion is limited to 80 degrees, extension 5 degrees and lateral flexion 20 degrees with moderate pain, stiffness and guarding at end range.

Tenderness is noted along the left hip region. Sitting root sign, straight leg raise test and Fabere's testing are all negative.

NEUROLOGICAL EXAMINATION: Within normal limits.

IMPRESSION:
1). Lumbar sprain/strain.
2). Left hip contusion.

PLAN:
1). Patient may benefit from physical therapy to the affected areas of the low back and left hip at this time. Patient however reports that as per her OB/GYN her cervix has started to efface. The station of the baby's head seems to be descending. Due to this, I would defer from physical therapy in the clinic at this point. Patient was advised to carry out delivery of the baby and I will re-assess her after childbirth.
2). Patient was advised continued use of Tylenol as needed.
3). Return to clinic after childbirth if symptoms continue to persist.

Benjamin S. Gozon, M.D.
Physiatrist

BG/cmz

7 1/2 months preg Since June 1, 06

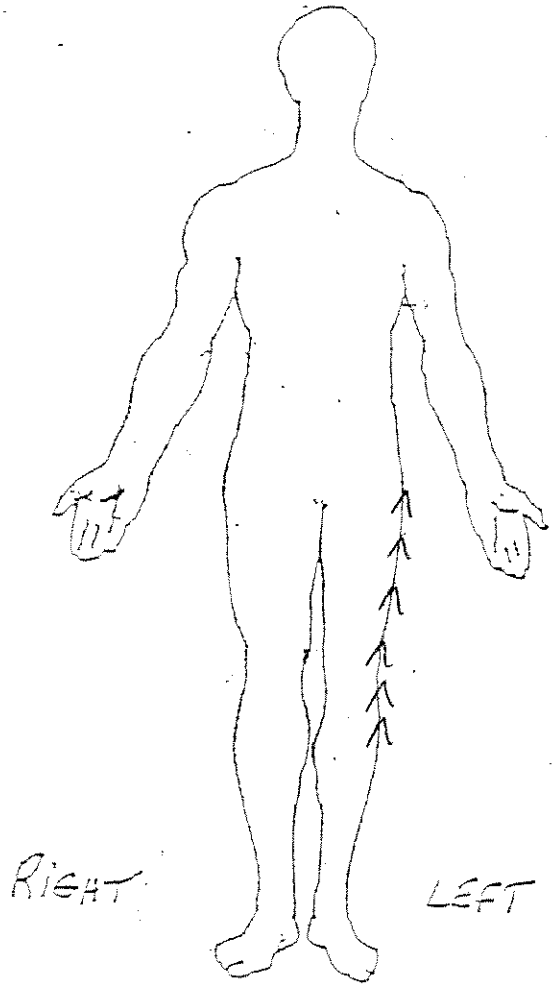
Patient History Questionaire

Name: Yamiko D.M. Miner Occupation: School N/A Age: 18

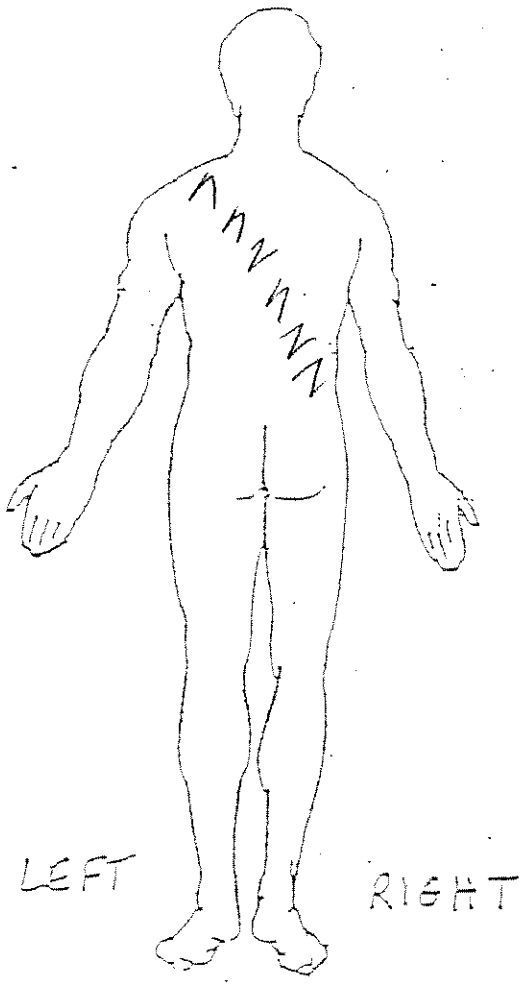
1. When did your present pain start? April 9, 2006
2. What was the cause of your pain? (check all applicable)
   - ☐ Suddenly ☐ Pulling ☐ Gradually ☐ Injured at Work
   - ☐ Lifting ☒ Car Accident ☐ Twisting ☐ Hit from Behind
   - ☐ Fall ☐ Bending ☐ Sports Injury ☐ No Cause
3. What activities make the pain worse? (check all applicable)
   - ☐ Exercise (during) ☐ Bending Forward ☒ Sitting
   - ☐ Exercise (after) ☒ Standing ☐ Coughing
   - ☒ Bending Backward ☐ Sneezing ☒ Walking
4. What reduces your pain? (check all applicable)
   - ☐ Injections for Pain ☐ Lying Down ☐ Standing
   - ☐ Muscle Relaxants ☐ Sitting ☐ Exercise, Therapy
   - ☐ Anti-Inflammatory Drugs ☒ Pain Pills ☐ Nothing
   - ☐ Manipulation ☒ Walking ☐ Other
5. How long have you had this pain? April 9, 2006
   Years _____ Months _____ Weeks X Days _____
6. Have you had any of these diagnostic studies? (check all applicable)
   - ☐ CT (computerized tomography) Scan ☐ Diagnostic X-Rays
   - ☐ Myelogram (x-ray with dye injection) ☐ Electromyogram (EMG)
   - ☒ Arthrogram or (Sonogram) ☐ Discogram
   - ☐ MRI (magnetic resonance imaging) ☐ Injections
7. Have you been hospitalized for your problem? N/A
   How many times? N/A
   Have you had surgery for this problem? NO
8. List any other problems you have been hospitalized for? N/A
9. What medications are you currently taking? Prenatal ~~Teen~~ Vitamins
10. Do you take Antacids? NO 11. Do you have Allergies? YES
11. Do you Smoke? NO 13. Do you drink alcoholic beverages? NO
14. Do you have any of the following: (check all applicable)
    - ☐ HIV/AIDS ☐ Heart Problems ☐ Cancer
    - ☐ Hepatitis ☐ Stomach Problems ☐ Epilepsy
    - ☐ Bowel/Bladder Problems ☐ Weight Loss ☐ Arthritis
    - ☐ Sexual Difficulties ☐ Diabetes
15. What other types of doctors have you seen for this pain? OB/GYN
16. Describe areas of pain or injury: _____

17. If you were in a motor vehicle accident, was your seatbelt ☑ On ☐ Off
18. If you were in a motor vehicle accident, were you the ☐ Driver ☑ Passenger ☐ Pedestrian
19. Where is your pain now? Mark the areas on your body where you feel the sensations as described below using the appropriate symbols. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing
^^^^^^	==========	----------	XXXX	//////



Front view



Back view

Name: Nimiko Miner

DOI: 4-9-06

Frequency of treatment:

3x/wk ____
2x/wk X
1x/wk ____
DAILY ____

New Note

Injury as a result of: 6-2-06 7-6-06 8-10-04 Final D/C

W/C ____
MVA X
FALL ____
OTHER ____

TYPE OF TREATMENT

ES & HP X
IP/HP CONTRAST ____
U/S PHONO ____
DIATHERMY ____
FLUIDO ____

WHIRLPOOL ____
TRACTION CER./LUM. ____
PARAFFIN ____
IONTO ____
EVAL ____

TENS ____
OMT ____
TPI 1ST ____

CAPITOL REHABILITATION CLINIC
7220 W. CAPITOL DRIVE
MILWAUKEE, WI. 53216
(414) 464-4888 FAX (414) 464-1850

DATE: 8/10/04

NAME: Nimiko Miner

THE ABOVE NAMED PATIENT WAS SCHEDULED FOR A DOCTOR'S/THERAPY APPOINTMENT ON _____ AT _____. THE PATIENT LEFT THE CLINIC AT _____.

THE PATIENT IS PHYSICALLY CAPABLE OF THE FOLLOWING:

PHYSICAL DEMAND LEVEL	0-33% OCCASIONAL	34-66% FREQUENT	67-100% CONTINUOUS
-MAY PUSH, PULL OR CARRY UNDER _____ LBS.	_____	_____	_____
-MAY LIFT UNDER _____.	_____	_____	_____
-MAY SQUAT OR CRAWL.	_____	_____	_____
-MAY BEND OR TWIST @ WAIST	_____	_____	_____
-MAY CLIMB OR REACH ABOVE SHOULDER HEIGHT	_____	_____	_____
-MAY USE THE RIGHT/LEFT HAND	_____	_____	_____

-TO WORK _____ HOURS A DAY. TO WORK _____ DAYS PER WEEK.

* capable of ers 5 restrictions

THE PATIENT IS INCAPACITATED FROM — THROUGH —.

A DETERMINATION OF PHYSICAL CAPABILITIES STATUS WILL BE MADE ON Discharged WHEN THE PATIENT SEES THE DOCTOR AGAIN.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT THIS OFFICE AT (414) 464-4888.

Ben Gozon M.D. JS
BENJAMIN S. GOZON, M.D.

E.B. ZUSSMAN, D.O.

CAPITOL REHABILITATION CLINIC
7220 W. CAPITOL DRIVE
MILWAUKEE, WI. 53216
(414) 464-4888 FAX (414) 464-1850

DATE: 7-6-06

NAME: Nimiko Miner

THE ABOVE NAMED PATIENT WAS SCHEDULED FOR A DOCTOR'S/THERAPY APPOINTMENT ON ________ AT ________. THE PATIENT LEFT THE CLINIC AT ________.

THE PATIENT IS PHYSICALLY CAPABLE OF THE FOLLOWING:

PHYSICAL DEMAND LEVEL	0-33% OCCASIONAL	34-66% FREQUENT	67-100% CONTINUOUS
-MAY PUSH, PULL OR CARRY UNDER ______ LBS.	______	______	______
-MAY LIFT UNDER ______.	______	______	______
-MAY SQUAT OR CRAWL.	______	______	______
-MAY BEND OR TWIST @ WAIST	______	______	______
-MAY CLIMB OR REACH ABOVE SHOULDER HEIGHT	______	______	______
-MAY USE THE RIGHT/LEFT HAND	______	______	______

-TO WORK ______ HOURS A DAY. TO WORK ______ DAYS PER WEEK.

Pt is capable of working without restrictions

THE PATIENT IS INCAPACITATED FROM ________ THROUGH ________.

A DETERMINATION OF PHYSICAL CAPABILITIES STATUS WILL BE MADE ON ________ WHEN THE PATIENT SEES THE DOCTOR AGAIN.

7/20/06 @ 11:10am

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT THIS OFFICE AT (414) 464-4888.

Ben Gozon, MD

BENJAMIN S. GOZON, M.D. E.B. ZUSSMAN, D.O.

CAPITOL REHABILITATION CLINIC
7220 W. CAPITOL DRIVE
MILWAUKEE, WI. 53216
(414) 464-4888 FAX (414) 464-1850

DATE: 6-3-00

NAME: Nimiko Miner

THE ABOVE NAMED PATIENT WAS SCHEDULED FOR A DOCTOR'S/THERAPY APPOINTMENT ON _____ AT _____. THE PATIENT LEFT THE CLINIC AT _____.

THE PATIENT IS PHYSICALLY CAPABLE OF THE FOLLOWING:

PHYSICAL DEMAND LEVEL	0-33% OCCASIONAL	34-66% FREQUENT	67-100% CONTINUOUS
-MAY PUSH, PULL OR CARRY UNDER 10 LBS.			
-MAY LIFT UNDER 10.			
-MAY SQUAT OR CRAWL.			
-MAY BEND OR TWIST @ WAIST			
-MAY CLIMB OR REACH ABOVE SHOULDER HEIGHT			
-MAY USE THE RIGHT/LEFT HAND			

-TO WORK 8 HOURS A DAY. TO WORK 5 DAYS PER WEEK.
* Pt capable of working without restrictions
THE PATIENT IS INCAPACITATED FROM 6/20/00 THROUGH 7/1/00.

A DETERMINATION OF PHYSICAL CAPABILITIES STATUS WILL BE MADE ON _____ WHEN THE PATIENT SEES THE DOCTOR AGAIN.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT THIS OFFICE AT (414) 464-4888.

Ben Gozon, M.D.
BENJAMIN S. GOZON, M.D.

E.B. ZUSSMAN, D.O.

CAPITOL REHABILITATION CLINIC
7220 W. CAPITOL DRIVE
MILWAUKEE, WI. 53216
(414) 464-4888 FAX (414) 464-1850

DATE ISSUED: 4/27/06

PLEASE EXCUSE Nimiko Miner FROM WORK/SCHOOL FROM _____ THROUGH _____.

PLEASE EXCUSE _____ FROM WORK/SCHOOL ON 4/27/06 AS HE/SHE HAD A DOCTOR'S/THERAPY APPOINTMENT SCHEDULED AT 9:00. THE PATIENT LEFT THE CLINIC AT 10:10

1. THE PATIENT REPORTS TO BE A STUDENT AND MAY RETURN TO SCHOOL ON _____ WITH NO RESTRICTIONS.
2. THE PATIENT MAY RETURN TO WORK ON _____ WITH NO RESTRICTIONS.
3. THE PATIENT MAY RETURN TO WORK/SCHOOL ON _____ WITH THE FOLLOWING RESTRICTIONS:

RESTRICTIONS

-NO/LIMITED PUSHING, PULLING OR CARRYING OVER _____ LBS..

-NO/LIMITED LIFTING OVER _____ LBS..

-NO/LIMITED BENDING OR TWISTING AT THE WAIST.

-NO/LIMITED CLIMBING OR REACHING ABOVE SHOULDER HEIGHT.

-NO/LIMITED USE OF THE RIGHT/LEFT HAND.

-ALTERNATE SITTING & STANDING ACTIVITIES.

-5 MINUTE REST BREAK FOR EVERY HOUR WORKED.

-TO WORK _____ HOURS A DAY.

-NO PARTICIPATION IN GYM CLASS.

-SEDENTARY WORK ONLY.

A DETERMINATION OF WORK/SCHOOL STATUS WILL BE MADE ON _____ WHEN THE PATIENT SEES THE DOCTOR AGAIN.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT THIS OFFICE AT (414) 464-4888.

Benjamin Gozon M.D.

BENJAMIN S. GOZON, M.D.

_____

E.B. ZUSSMAN, D.O.

Therapy Record

Patient Name: Nimiko Miner DOI: 4-4-06

Diagnosis: lumbar sprain/strain, (L) hip contusion

Treatment Ordered: ES & HP lumbar

Ther. Ex.

Pt. position: Prone Frequency of Rx: 2x/wk

Date Of Rx	6-2-06	6-7-06	6-8-06	6-12-06	6-15-06	6-19-06	6-22-06	6-26-06	6-28-06	6-29-06	7-6-06	7-10-06	7-11-06	7-17-06	7-19-06	8-10-06
Electric Stimulation					|	|		|		|		|	|		|	
Hot pack	Dr Appt.	No Show	No Show	No Show	|	|	pt cancel'd	|	pt R/S	|	Dr. Appt.	|	|	Pt. R/S	|	| Final D/C
IP/HP Contrast																
Paraffin																
Diathermy																
Ultrasound/Phono																
Whirlpool																
Fluidotherapy																
Therapeutic Exercise					15	15		15		15		15	15		15	
Traction Cervical																
Traction Lumbar																
Iontophoresis																
Body Mechanics Education										X						
Trigger Point Injection																
Joint Injection																
OMT																

Capitol Rehabilitation Clinic 7220 W. Capitol Dr. Milwaukee WI 53216 (414) 464-4888 fax (414) 464-1850

Thomas Malone, PT Julie Bauer, PTA Mary Spath, PTA
Lea Minerley, aide Aaron Rivera, aide

Therapy Record

Pt. Name: N: Mike Miner DOI: 4-9-06

Date	Area(s) being Rx	Rx received this date:
6-2-06	lumbar	None —> pt's tmp limits - MS PTA
		Modality tolerance: ——
		Therapeutic exercise: ——

See Therapy Intake Form for Work Status:

Physical therapy Orders: ES & HP lumbar & ther ex, 3x/wk for 2wks - MS PTA

Physician: Dr Cozon P.T.: Thomas Malone

Date	Area(s) being Rx	Rx received this date:
6/15/06	Lumbar	ES/HP Lumbar
		— JB PTA
		Modality tolerance: Good
		Therapeutic exercise:
		Pt. performed seated LB stretch
		& trunk rotation demonstrating
		good tolerance. Pt. directed to per-
		form Ex's @ home twice daily

Comments: — JB PTA.

Therapy clinician form completed this session — JB PTA.

Date	Area(s) being Rx	Rx received this date: ES/HP lumbar
6/19/06	lumbar	
		Modality tolerance: Good
		Therapeutic exercise:
		Pt. completed all previously
		assigned Ex's c̄ good tolerance.
		Added SKTC & DKTC to pro-
		gram. Pt. directed to cont

Comments: c̄ hep. Will cont c̄ POC — JB PTA.

Therapy Record

Pt. Name: Nimiko Miner DOI: 4-9-06

Date	Area(s) being Rx	Rx received this date: ES+HP Lumbar — SSC
6·26·06	Lumbar	
		Modality tolerance:
		Therapeutic exercise:
		Pt. completed Ther Ex's c̄
		good tolerance. Added hamstring
		stretch to program. Pt.
		directed to cont Ther. Will
		cont c̄ POC — JB PTA.

Comments:

Date	Area(s) being Rx	Rx received this date: ES+HP Lumbar — SSC
6·29·06	Lumbar	
		Modality tolerance:
		Therapeutic exercise: Pt completed
		all ex's as instructed.
		Added POE. Body Mechanics
		handouts given. [illegible signature]

Comments:

Date	Area(s) being Rx	Rx received this date:
7/6/06	Lumbar	None (Pt. unable to stay for
		Rx) - JB PTA
		Modality tolerance:
		Therapeutic exercise:

Comments:

Pt. in to see Dr. Gozon for rev. Pt. to cont to receive ES/HP Lumbar + Ther Ex 2x/wk for 2 wks. Pt. currently unemployed (capable of RTW 7/6/06 - no restrictions) per Dr. Gozon — JB PTA.

Capitol Rehabilitation Clinic 7220 W. Capitol Dr. Milwaukee, WI 53216 (414) 464-4888

Therapy Record

Pt. Name: Nimiko Miner DOI: 4-9-06

Date	Area(s) being Rx	Rx received this date: ES&HP Lumbar – ssc
7-10-06	Lumbar	
		Modality tolerance:
		Therapeutic exercise:
		Pt. completed her ther exs c good tolerance. Added the Rehab
		Unit (Abd curls / Back ext)
		10 x 15# each. Pt. directed to
		cont c hep — JS PTA

Comments:

Date	Area(s) being Rx	Rx received this date:
7-11-06	lumbar	ES & HP lumbar ——— MS PTA
		Modality tolerance: Good
		Therapeutic exercise: The pt continues to
		complete her exs as instructed.
		Today the wt was ↑d on the
		Rehab unit which she tol well —
		——— MS PTA

Comments:

Date	Area(s) being Rx	Rx received this date:
7-19-06	lumbar	ES & HP lumbar ——— M.S. PTA
		Modality tolerance: Good
		Therapeutic exercise: Pt completed exs
		as instructed, ↑wt on
		rehab unit to 25# this
		date —
		[signature]

Comments:

Therapy Record

Pt. Name: Nimke Mina DOI: 4-9-06

Date	Area(s) being Rx	Rx received this date:
8/10/06	Final Pt	None
		Modality tolerance:
		Therapeutic exercise:

Comments:

Pt. in to see Dr. Gozon for rev. will D/C all Therapy orders as pt. was given a Final Discharge per Physician. Pt currently Unemployed (Capable of RTW 8/10/06 - No Restrictions) Per Dr. Gozon - JS PTA

Date	Area(s) being Rx	Rx received this date:
		Modality tolerance:
		Therapeutic exercise:

Comments:

Date	Area(s) being Rx	Rx received this date:
		Modality tolerance:
		Therapeutic exercise:

Comments:

Therapy Intake Form **Physician** [illegible]

Patient Name: [illegible]

DOI: [illegible] W/C MVA Fall Chronic

Other: —

Type of Pain: [illegible] Pain Scale (1<10) 4

H/A yes Dizziness/Blurred Vision denies Lacerations/Bruises denies Edema denies

Sensation	WNL	✓	Altered	
ROM	WNL		Altered	✓ 2° pain
Strength	WNL		Altered	✓ 2° pain
Endurance	WNL		Altered	✓ 2° pain

Prior Medical History: Tonsils, C-section

Assistive Device: None

Occupation: Unemployed

Work Status: Capable of [illegible] w/o restrictions

GOALS

Goal Status Key:

M= Met
PM= Partially Met/ Improved
W= Worse
I= Met Inconsistently
NP= No Progress
NC= Non-compliant

Short Term Goals: Estimated Time to Achieve: 3-4 wks	GOALS
1. On a pain scale of 1 to 10 pt. will ↓ from a 4 to a 2	M-JB OTA
2. Pt. will demonstrate understanding & knowledge of proper body mechanics c̄ all activities	M-JB OTA

Long Term Goals: Estimated Time to Achieve: 6-8 wks	
1. Pt. will be (I) c̄ HEP	M-JB OTA
2. Pt will obtain knowledge useful in ↓ing/eliminating pain & ↑ functional independence prior to d/c	M-JB OTA
* Pt's goals achieved. JB OTA 8/10/06	

JBauer OTA TM PT. 6/15/06

Therapist Signature Date

Capitol Rehab Clinic 7220 W. Capitol Dr. Milwaukee, WI 53216
(414)464-4888 Fax (414)464-1850

PT. NAME: _____ DOI: 4-9-09

THER EX: TRUNK	3-25-09	3-30-09	4-2-09	6-29-09	7-10-09	7-11-09	9-19-09
BACK							
SEATED LOW BACK (SLB)	X	X	X	X	X	X	X
WILLIAMS PELVIC TILT (PT)							
SINGLE KNEE TO CHEST (SKTC)		X	X	X	X	X	X
DOUBLE KNEE TO CHEST (DKTC)		X	X	X	X	X	X
TRUNK ROTATION	X	X	X	X	X	X	X
HAMSTRING STRETCH			X	X	X	X	X
GLUTEAL SETS				X			
MCKENZIES PRONE ON ELBOWS(POE)				X	X	X	X
ALTERNATE ARM/LEG							
STATIONARY BIKE							
TREADMILL							
BACK VIDEO TAPES							
REHABILITATOR BACK EXTENSION					10X 15#	20# X10	25# X10
ABDOMINAL CURLS					10X 15#	20# X10	25# X10
CERVICAL							
NECK ROM							
CHIN TUCKS							
CAUDAL GLIDES							
UPPER TRAP STRETCH							
LEVATOR STRETCH							
NECK STRETCH							
ACTIVE RESISTIVE ROM							

Capitol Rehabilitation Clinic

Physical Therapy Initial Evaluation

Patient Name: [illegible] **Date:** [illegible]

Dx: LBP [illegible]

Subjective :

Objective: Patient stated her pain [illegible] LB. Describes pain as aching and intermittent. [illegible] sleeping difficulties. Can complete ADLs and daily tasks @ a slow pace. Prolonged standing increases pain level. Functional active range of motion is WNL, moderate aching of the lower back area.

Assessment: Patient is experiencing moderate distress 2° to MVA 4/9/06 Rehab potential is good

Plan: See PPOC
Decrease or Eliminate painful symptoms
Resume functional level prior to MVA

Thomas E. Malone Jr. PT.
Physical Therapist signature

Capitol Rehabilitation Clinic
7220 W. Capitol Dr.
Milwaukee WI. 53216

Physical Therapy Follow Up

Name: Nimiko Minor

Date: 7/10/06 LBP 2 TxT

Changes Noted and RX Response

Comments: Patient stated her pain level has decreased to 2 describes pain as pricking and intermittent Rx's received to date have been beneficial in pain relief.

P.T. initial TM

Date:____________

Changes Noted and Rx Response

Comments:

P.T. initial ______

Date:____________

Changes Noted and RX Response

Comments:

P.T. initial ______

Office Policies

Appointments: It is important for you to receive the treatments your doctor has ordered for you to recover from your injury. Please phone the office if you will be late or unable to attend your scheduled appointment.

Therapy Services: When making your appointment it's a must that you schedule on days you can complete your entire treatment regime. As part of your recovery it's essential to complete exercises in the clinic. If you are unable to stay for your full treatment you must reschedule your appointment. If you wear loose clothing that will move with you stretching will be easier and more beneficial.

Due to the nature of our equipment it is **extremely important small/young children are supervised by you at all times.** They could become seriously injured if they are exploring any of the therapy equipment.

Work Status: It is important for you to discuss your work status with your doctor at each doctor visit. Please inform the staff of any changes in your status between visits. **Be sure to ask for your updated work status sheet when scheduling your appointments.**

Contagious Diseases: If you are ill with a contagious disease (flu, chicken pox etc), both for yourself, other patients and our staff, please phone the office and reschedule your appointment. For lengthy illnesses treatments and doctor appointments will be at our discretion.

Confirmation of Appointments: If is the policy of this office to confirm scheduled appointments. If you are unavailable when we call, we would like to leave a message stating
"this is Capitol Rehab Clinic calling, I'd like to leave a message for *patient name* to confirm the appointment for *patient name* on *date* at *time.*"

Please check below to indicate your preference:

☒ OK to leave a message ☐ Do not leave a message

Patient signature

6/15/06
Date

You may change your preference at anytime by notifying our staff. We will require you to sign a new form indicating your change.

Thank you,

The Capitol Rehab Clinic Staff

Capitol Rehabilitation Clinic Irrevocable Lien

Patient Name: Mineko D'M Miner Date of Injury: 4.9.06

I fully understand that I am directly and personally responsible to Capitol Rehabilitation Clinic for all fees of medical services rendered. This Lien authorizes the appropriate Insurance Company to pay directly to Capitol Rehabilitation Clinic such sums as may be due and owing for medical services rendered. I understand that this Lien is Irrevocable. I also understand that I will be held responsible for any attorney's fees, collection agency costs, court costs or any other expense incurred in order to collect the amount owed to Capitol Rehabilitation Clinic.

This lien authorizes Capitol Rehabilitation Clinic to provide the said insurance company with any medical information necessary to process claims for payment.

Insurance Company

Insurance Co. Name: United Health Phone: _____

Address: _____

Adjuster: _____

Potential or Pending Litigation

This Lien authorizes the Attorney representing me to withhold such sums from settlement, judgment or verdict as may be necessary to adequately protect fees for medical services rendered by Capitol Rehabilitation Clinic. This Lien authorizes the Attorney representing me to pay directly to Capitol Rehabilitation Clinic such sums as may be due and owing for medical services rendered by reason of the above listed date of injury.

This Lien is made regardless of the outcome of any pending or potential litigation. This agreement is made solely for Capitol Rehabilitation Clinic's additional protection and in consideration of awaiting payment.

I agree that a photocopy of this original authorization shall be considered equally authentic as the original.

Patient Signature: Mineko Miner Date: 4.27.06

Parent/Guardian Signature: Celia L. Ziegler Date: 4.27.06

Relationship to patient: Mother

Capitol Rehabilitation Clinic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, Mimiko D.M. Miner, have received a copy of this Office's Notice of Privacy Practices.

Mimiko D.M. Miner
Please Print Name

Mimiko Miner
Signature

April 27, 2006
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not Be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____

_____

Consent for Disclosure of Medical Record Information

Print Patient's Name: Mimiko D.M. Miner

Address: 2444 No. 40th St. City/State/Zip: Milwaukee, WI 53210

Birth date: 10/22/87 Social Security #: 392-62-9942 Phone #: (414) 449-1392

I, _____, do hereby authorize St. Joseph's

to release to: CAPITOL REHABILITATION CLINIC
7220 W. CAPITOL DR.
MILWAUKEE, WI 53216

The following information: Concerning the following dates: 4/9/06 ___/___/___ I understand that the information disclosed includes: ☑ Physical Illness ☐ Emotional Illness ☐ Alcohol, Drug Abuse ☐ HIV results or related diagnosis

Check one: ☐ Complete Chart
☐ Limited inpatient (includes: Face Sheet, Discharge Summary, History & Physical, Consultation Reports, Lab Reports, X-ray Reports, Operative Reports, Pathology Reports)
☑ Outpatient services (includes: Emergency room reports, Physician Progress Notes, Lab Work, X-ray Reports, Other)
☐ Other _____

PURPOSE FOR NEED OF DISCLOSURE: (check applicable categories) ☑ **Continuing Medical Care**
☐ Claim resolution ☐ Coordinating care for dependent/spouse ☐ Insurance Eligibility/Benefits

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to Receive Copy of this authorization-I understand that if I sign this authorization, I may be provided with a copy of this authorization. **Right to refuse to sign this authorization**-I understand that I am under no obligation to sign this form and that **Capitol Rehabilitation Clinic** may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment b) health plan enrollment or eligibility c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. WI law requires the patient's authorization to disclose 252.15 or 51.30 records for payment purposes.
Right to Withdraw This Authorization-I understand I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to **Capitol Rehabilitation Clinic.** I am aware that my withdrawal will not be effective until received by **Capitol Rehabilitation Clinic** and will not be effective regarding the uses and/or disclosures of my health information that **Capitol Rehabilitation Clinic** has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. **Right to inspect or copy Health Information to be Used or Disclosed**- I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting **Capitol Rehabilitation Clinic-Medical Records Dept. Redisclosure Notice**-I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards. **Expiration date**-If no prior notice or revocation is received, this consent will expire automatically one year after the date indicated herein.

PATIENT'S SIGNATURE: Mimiko Miner **Date:** 4.27.06

PARENT/GUARDIAN SIGNATURE: Celia L. Zigler **Date:** 4.27.06
Relationship to patient: Mother

Witness: _____ **Date:** 4.27.06

105-31-71

Consent for Disclosure of Medical Record Information

Print Patient's Name: Mimiko D.M. Miner

Address: 2444 No. 46th St. City/State/Zip: ~~Apt~~ Milwaukee, WI 5321_

Birth date: 10.26.87 Social Security #: 392.62.9946 Phone #: (414) 449.1392

I, ______________________, do hereby authorize St. Josephs

RECEIVED MAY 1 6 2006

to release to: CAPITOL REHABILITATION CLINIC
7220 W. CAPITOL DR.
MILWAUKEE, WI 53216

R#1167

The following information: Concerning the following dates: 4/9/06/__/__/__ I understand that the information disclosed includes: ☑ Physical Illness ☐ Emotional Illness ☐ Alcohol, Drug Abuse ☐ HIV results or related diagnosis

Check one: ☐ Complete Chart
☐ Limited inpatient (includes: Face Sheet, Discharge Summary, History & Physical, Consultation Reports, Lab Reports, X-ray Reports, Operative Reports, Pathology Reports) MAY - 9 2006
☑ Outpatient services (includes: Emergency room reports, Physician Progress Notes, Lab Work, X-ray Reports, Other)
☐ Other ______________________

PURPOSE FOR NEED OF DISCLOSURE: (check applicable categories) ☑ **Continuing Medical Care**
☐ Claim resolution ☐ Coordinating care for dependent/spouse ☐ Insurance Eligibility/Benefits

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of this authorization-I understand that if I sign this authorization, I may be provided with a copy of this authorization. **Right to refuse to sign this authorization-**I understand that I am under no obligation to sign this form and that **Capitol Rehabilitation Clinic** may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment b) health plan enrollment or eligibility c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. WI law requires the patient's authorization to disclose 252.15 or 51.30 records for payment purposes.
Right to Withdraw This Authorization-I understand I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to **Capitol Rehabilitation Clinic.** I am aware that my withdrawal will not be effective until received by **Capitol Rehabilitation Clinic** and will not be effective regarding the uses and/or disclosures of my health information that **Capitol Rehabilitation Clinic** has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. **Right to inspect or copy Health Information to be Used or Disclosed-** I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting **Capitol Rehabilitation Clinic-Medical Records Dept. Redisclosure Notice-**I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards. **Expiration date-**If no prior notice or revocation is received, this consent will expire automatically one year after the date indicated herein.

(X)

PATIENT'S SIGNATURE: Mimiko Miner Date: 4.27.06

PARENT/GUARDIAN SIGNATURE: Celia A. Ziegler Date: 4.27.06
Relationship to patient: Mother

Witness: [signature] Date: 4.27.06

DM 4-9-06ER

GRAV	TERM	PRETERM	AB	LIVE
1	0	0	0	0

EDD DATES	GEST (WKS)	EDD U/S	GEST (WKS)
		June 1st	32 3/7

PRIMARY COMPLAINT
- ☐ abdominal pain/cramps
- ☐ contractions
- ☐ PROM/SROM
- ☐ vaginal bleeding
- ☐ ↓ fetal activity
- ☒ MVA/fall/altercation 2/15/10
- ☐ fever/nausea/vomiting
- ☐ pain, other
- ☐ other _____

*Including but not limited to allergies/sensitivities to medications, food, tape, LATEX, iodine
** Prescription, OTC, nutritional supplements, herbal remedies, other

ALLERGIES/ SENSITIVITIES * ☐ None	REACTION
Risperdal (for ADHD)	

MEDICATIONS **	Last dose
PNV	

Pain: Do you have pain? ☐ No ☒ Yes, pain intensity? 4 Location: abd. cramps & back pain Pain intensity goal: _____
Describe: _____
☐ See Significant Findings
Mobility: ☒ Ambulatory ☐ Bedrest ☐ Needs Assist ☐ Recent change: Comment: _____
Learning needs: _____ Barriers: _____ Preferences: _____
Safety: ☒ No needs ☐ Auditory deficit ☐ Speech deficit
☐ Visual deficit ☐ Evidence of physical, emotional or verbal abuse Comment: _____
Discharge: Do you have concerns about going home? ☒ No ☐ Yes ☐ Social work referral _____
Nutrition: ☒ No needs ☐ Therapeutic diet ☐ Recent weight loss Lives in MLM
Dentures: ☒ No ☐ Upper ☐ Lower ☐ Partial ☐ Loose teeth
Height: 5'1" Weight: 152 Scale: _____ Per pt: prepreg. 130
☐ Dietitian referral: _____
Social history: Smoking ☒ No ☐ Yes _____
Alcohol: ☒ No ☐ Yes, Last drink? _____
Street drugs: ☒ No ☐ Yes, how much? _____
Religious/Cultural: _____
Patient Rights: ☒ None ☐ Unknown ☐ Living Will
☐ Durable POA for Healthcare ☐ Copy on chart
Information: ☐ Given ☒ Declined

Tonsillectomy 3yrs ago

PREGNANCY COMPLICATIONS	MEDICAL PROBLEMS
PAST: ☒ Denies ☐ See Risks	☒ Denies ☐ See Risks
CURRENT: ☒ Denies ☐ See Risks	☐ See Notes

MATERNAL / FETAL RISKS / PROBLEMS ☐ None

ADHD (not on meds)
? Lumeers Disease - blood disorder
- had blood clot in neck - got headaches, was hospitalized for a month about 2yrs ago. Not on meds since then.

RN Signature KLAGNORK
Date 4/9/10 Time 2140

ST. JOSEPH REGIONAL MEDICAL CENTER
Covenant HOSPITAL
5000 W. Chambers St. • Milwaukee, WI 53210
201 North Mayfair Road • Wauwatosa, WI 53226
10400 W. North Ave. • Wauwatosa, WI 53226
A ministry of Covenant Ministries

Obstetric Outpatient Nursing History

87623 2/05

MINER NIMIKO D
DOB 10/06/87 16y BLK F MR: 1053171
PALABRICA CYNTHIA L.
ACCT# 71486994

Time in: Date 4/9/06 Time 2133

Date	Time	2133 / 2140	2200	2210	
VITAL SIGNS	Temperature	97.1			
	Pulse/ Respirations	132 / 120 / 20			
	Blood Pressure	[illegible] / 83			
CERVICAL EXAM	Effacement (%)				
	Dilatation (cm)			closed	
	Station (+/- cm)				
UTERINE ACTIVITY	Frequency (min)	irrt NT		irrr	
	Duration (sec)				
	Intesity				
FETAL STATUS	Baseline FHR (bpm)	115-135	115-135	115-135	
	Long Term Variability	WNL	WNL	WNL	
	Reactivity	↓	R	R	
	Decelerations				
POINT OF CARE	Blood glucose/ Meter ID				

Key: √ = Assessment WNL * = See Notes Δ = no change	Time 2140	Time
Neurological/Mental State	√	
Cardiovascular	√	
Respiratory	√	
Integumentary	√	
Invasive Line		
Gastrointestinal	√	
Nutrition/Hydration	√	
Genitourinary	√	
Musculoskeletal	*	
Peripheral-Vascular	√	
Comfort	*	
Coping	√	
Spiritual / Valuing	√	
Continuity of Care	√	
Safety	√	
Patient Education	√	
Initials	KW	

PHYSICAL ASSESSMENT

MEMBRANES ☒ Intact ☐ Bulging
☐ Ruptured Date __/__/__ Time ____
☐ Nitrazine Test ☐ neg ☐ equivocal ☐ pos
☐ Fern Test ☐ neg ☐ pos

URINE
Protein ____
Glucose ____
Ketones ____
Nitrites ____
Leukocytes ____

☐ Sterile Speculum Exam (findings ____)
FLUID ☐ Clear ☐ Bloody ☐ Foul Odor ☐ Meconium Stained

REFERRALS
☐ Social Services ☐ Interpreter ☐ ____

PLAN OF CARE: ☐ Initiate standing orders/treatment protocol
☐ Other:

FOCUS NOTES/SIGNIFICANT FINDINGS

Time		Initial
2133	Pt. here ̄c MVA @ 1800.	
2140	Was on passenger side	
	car was parked. Fire truck	
	came around the	
	corner & hit the driver's	
	side. Pt. was wearing	
	her seatbelt & car just	
	jerked forward. Did	
	not hit her abdomen.	
	Is having mild abd. cramps	
	& back pain. ⊕ fetal movement	
2205	Dr. Hershner here to see pt.	
2210	VE per MD.	KW

☐ See Significant Findings Sheet for further charting

FINAL ASSESSMENT: ☐ RNST ☐ Reassuring for GA

18 y/o G1P0 @ 32 3/7 here for s/p MVA. Pt was restrained passenger, pt [illegible] behind while stopped. [illegible] airbag deployed. [illegible] [illegible] abd. [illegible] LOC [illegible] ↓ FM x 45 mins after accident. ⊕ FM now [illegible] [illegible] [illegible] [illegible] [illegible]

PE: FHTs [illegible] 7000 [illegible] SVE long thick [illegible]

PLAN [illegible] [illegible] [illegible] L [illegible] Abd. ⊕ BS soft, [illegible] NT

[illegible] 18 y/o s/p MVA
* ⊕ FWB
. d/c to home Tylenol for pain

DISPOSITION: ☒ Discharge ☐ Admit - L&D ☐ Admit - Antepartum

DISCUSSED WITH: Dr. Penny @ 2210
Provider Signature [signature] Date 4-9-06
Co-signature ____ Date ____

Time disposition decision made 2210 Time out 2220
To: ☒ Home ☐ ____
By: ☒ Walk ☐ Wheelchair ☐ Alone ☒ With Mother

Discharge instructions reviewed Patient verbalizes understanding

RN Signature K Wagner RN Date 4/9/06

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☐ 5000 W. Chambers St. · Milwaukee WI 53210
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Obstetric Outpatient Assessment Record Triage

MINER NIMIKO D
DOB: 10/06/87 18Y SEX F MR: 1053171
PALABRICA CYNTHIA L.
ACCT#:
71486994

St. Joseph Regional Medica[illegible]nter | Emergenc[illegible]epartment QualChart®

ORDER SHEET / TRAUMA/MAJOR

Height: Weight: lbs / kgs Allergies:

Medical Records: Ol[illegible] Chart Recent ED Chart Previous EKG Additional Records:

LABORATORY: Circle specific orders	By:	Time:
Trauma Panel		
CBC Manual Diff		
BMP CMP LFT Mg		
Amylase Lipase Ammonia		
UA UA w/o Micro CC Cath		
UCG HCG: Qual / Quant		
Drug Screen: Urine / Serum ETOH		
CPK CKMB Troponin		
Myoglobin		
Rh Type Screen Type Cross ____ units		
PT / INR PTT		
Hemoccult Gastroccult		

Pertinent Lab Values: WNL WNL Except:

Indication(s) for Xray / CT / US: ____

Xray Interp: No Acute Changes Positive ____

By: ED Physician Radiologist ____

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 Contrast: IV PO None		
CT: C-Spine T-Spine L-Spine		
CT: Chest Contrast: IV PO None		
CT: Abdomen / Pelvis Contrast: IV PO None		
Ultrasound of: GB ABD Pelvis		

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

EKG Interpretation: ____

EKG Comparison: No Signficant Change / Other: ____

Cardiac Monitor:

Rate: Normal Brady Tachy ____

Rhythm: Sinus AFIB Junctional ____

Ectopy: None PVCs PACs ____

TREATMENT ORDERS:	By:	Time:
Repeat Vital Signs: All BP Pulse RR Temp O2 Sat		
Pulse Ox O2 @ ____ l/min via NC / Mask / NRB		
Saline Lock IV: NS LR Bolus ____ ml over ____ min/hr		
Second IV Site: ____ Large Bore NS LR Rate of ____ ml / hr		
Transfuse ____ units PRBCs / ____		
NPO NG Tube / OG Tube Foley Catheter		
Td 0.5 ml IM Lot # ____		
[illegible handwriting]	[illegible]	[illegible]
[illegible handwriting]	[illegible]	[illegible]
Disposition Orders: Discharge Admit Observation Transfer		

Time:	CLINICAL RESPONSE / RE-EVALUATION
	VSS except:
	NL Hypoxic ____ % on R/A or O2 @ ____ l/min
	→ [illegible handwriting]

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 / ____

Critical Care Provided for: 30-74 min / 75-104 min / ____ min

SIGNATURE:

Time of Initial Orders: [illegible] a.m. / p.m.

[signature] MD / DO

PA / NP

[signature] RN / Init

RN / Init

MINER NIMIKO D
[illegible] 18y [illegible] MR 1053171
EMERGENCY CONSULTANTS INC
[illegible]
715175[illegible]

QC21800111210512 41

04/09/06 08:34 pm

St. Joseph Regional Medic Center | **Emergency Depar ent QualChart®**

MOTOR VEHICLE ACCIDENT | Circle pertinent positive findings. Backslash pertinent negative findings.

Exam Time: 8:3_ a.m. / p.m.

Mode of Arrival: EMS Other

✱ DENOTES QUALITY INDICATOR

Vital Signs Stable except: BP ___ / ___ Pulse ___ R Rate ___ Temp ___

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

Cardiac Monitor Interp. Not Applicable — Rate: NL Brady Tachy; Rhythm: Sinus Afib Junctional; Ectopy: None PVCs PACs

HISTORY: HX from Patient Unobtainable due to: Dementia Altered MS Extremis Other: ___

HX from: Patient Family / Caretaker EMS Interpreter

CHIEF COMPLAINT: This is a ___ year old male / female who presents with a complaint of MVA with pain at: Head Neck Back Chest Abdomen Extremities ___

/ [illegible] 32 wks

OCCURRED ___ Minutes Hours Days Prior to Arrival

ONSET OF PAIN Immediate ___ Minutes Hours Days Post Accident

SEVERITY OF PAIN Initially: ___ (0 - 10) Mild Moderate Severe **Currently:** ___ (0 - 10) None Mild Moderate Severe

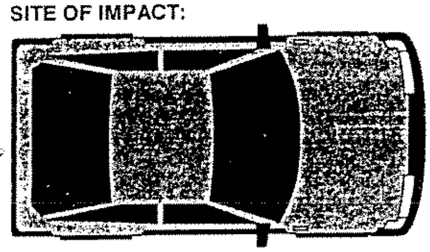
MECHANISM OF INJURY Car Truck Motorcycle Bicycle ATV Pedestrian
VS Car Truck Motorcycle Bicycle ATV Pedestrian Stationary Object

PATIENT LOCATION Driver Passenger Front Back Pedestrian

ASSOCIATED SIGNS AND SYMPTOMS Negative Headache Seizure Active Bleeding Motor / Sensory Deficit SOB
LOC Duration: ___ Seconds Minutes Hours Unknown
Extremity Deformity: ___

CONTEXT Lost Control Fell Asleep Distracted Seizure Intoxicated Other: ___
Ambulatory at Scene Backboard / C-Collar Applied PTA

SITE OF IMPACT:



Rearended

Force: Low Moderate High Direct Glancing

Restraints: None — Lap / Shoulder — Helmet / No Helmet — Car Seat — Ejected From Vehicle — Prolonged Extrication — Air Bag Deployed

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

PAST MEDICAL HISTORY: Previously Healthy — DNR / Comfort Care Only

Endocrine	DM I	DM II	Hypothyroid	Hyperthyroid	Hyperlipidemia
CV	CAD / MI	HTN	CHF	Afib	DVT
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	___
Surgical Hx	None	Cervical / Lumbar Fusion		Herniated Disc	

Immunizations: Unknown Tetanus UTD Not UTD
✱ Pneumococcal ✱ Influenza within 12 months

FAMILY HISTORY: Negative
Heart / HTN ___
Diabetes ___
Other: ___

SOCIAL HISTORY: Negative
Smoking ___ ppd x ___ yrs. ✱ Patient Advised to Stop
ETOH / Drug Use ___
Occupation ___
Lives Alone / With Family Nursing Home Assisted Living

MINER NIMIKO D
DOB 08/06/87 18Y SEX F MR 1053171
EMERGENCY CONSULTANTS INC
ACCT# 7191753R

0021800111210504 01

04/09/06 08:34 pm

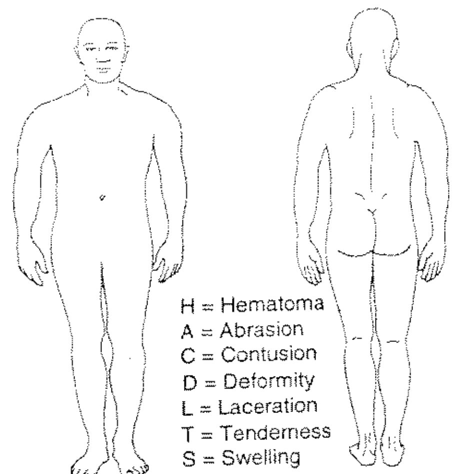
St. Joseph Regional Medic[illegible] Center	Emergency Departr[illegible]nt QualChart®	
MOTOR VEHICLE ACCIDENT	Circle pertinent positive [illegible]ings. Backslash pertinent negative findings.	

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*
Eyes	Normal	PERL / EOMI Conjunctiva Clear	*R Pupil ____ L Pupil ____* *Conjunctiva Inflammed*
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 @ ____* *Edema @ ____* *Calf Tenderness*
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*

Complaint-Specific Findings

C-Collar / Backboard (PTA / ED)
Removed w/consent post exam
GCS [illegible]
Tenderness / Spasm:
Paraspinal
Cervical
Thoracic
Lumbar
Diminished Breath Sounds Right / Left
Pelvis / Hip Stable / Unstable
Extremity Injury / Deformity



MEDICAL DECISION MAKING: Consideration of the following conditions may be warranted for the presenting problem. These conditions are not final diagnoses.

DIFFERENTIAL DIAGNOSES:

- Abdominal Injury
- Abrasions / Contusions
- Chest Injury
- Head / Facial Injury
- Lower Extremity Injury
- Neck / Spinal Injury
- Normal Exam
- Upper Extremity Injury

Other: ____

RE-EVALUATION: Pain Scale (0-10)

Time: ____ Unchanged Improved Worse VSS ____

Time: ____ Unchanged Improved Worse VSS ____

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

Discussed case/management/disposition of patient with:

Name: ____ at ____ 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: Home Work Nursing Hm ED-Obs ICU Tele Floor Deceased AMA
Condition: Stable Unstable [illegible]
Patient Endorsed To/Discussed With: ____ @ ____ 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.

ED PHYSICIAN DIAGNOSES:

1. [illegible]
2. [illegible]
3. [illegible]

Critical Care Provided For: ____ min

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

SIGNATURE: [illegible] MD/DO
____ MD/DO
____ PA / NP / Resident

Chart / Addendum Dictated: Yes No

Disposition Time: [illegible] a.m. / p.m.

Supervising Physician attests performing pertinent History, Physical Examination, and Medical Decisions ____ *(Initials)*

I have reviewed available Ancillary / Nursing Staff documentation.

MINER NIMIKO D
DOB 10/06/87 18Y SEX F MR 1053171
EMERGENCY CONSULTANTS INC
ACCT# 7161758

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.

04/09/06 08:34 pm

* 0 2 1 8 0 0 1 1 1 2 1 0 5 0 4 0 2 *

NAME Miner, Nimiko M ☐ F ☒
DOB 10/6/87
Private Physician /ECI ☒ Bando PMD ☐
1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐
Date/Time of Triage 4/9/06 1920

Chief Complaint Back Pain s/p MVA
Age 18
Wt (Kg)
OFC
B.S./Device
Family with patient Yes ☐ No ☒
Mode of Arrival: W/C ____ Ambulatory ✗ ____ Car ____ Carried ____ Ambulance ____ Med. Unit ____ Police ____

Allergies Risperdal None ☐ Latex ☐
See Nursing notes for type of Reaction.
LMP/EDC 6/17
Lactating Y ☐ N ☐
Advanced Directives Yes ☐ No ☒ Info ☐ Referral Given ☐
Tetanus immunizations UTD ☐ >10 years ☐ Never ☐

Medications PNV None ☐ See Admission Med. Record ☐
Additional Triage Assessment 32 weeks pregnant
Pre-Hospital Treatment: None ☒ Oxygen ☐ C-Collar ☐ IV ☐ Backboard ☐ Splinting ☐ Meds ____ Other ____

Herbal or Alternative Med:
Past Medical History: CARDIAC ☐ RESP. ☐ CANCER ☐ NEURO ☐ RENAL ☐ SEIZURE ☐ NICOTINE ☐ INFECTIOUS DZ ☐
None ☐ DIABETES ☐ PSYCH ☐ AODA ☐ HTN ☐ OTHER LeBores
TB Screen: Cough Yes ☐ No ☐ Hemoptysis Yes ☐ No ☐ Either greater than 3 weeks Yes ☐ No ☐
If any of the above are yes, cont. Malaise ☐ Fever ☐ Decrease Appetite ☐ NOC Sweat ☐ Chills ☐ Unintended Wt. loss ☐ None ☐

VS	Time	BP 120/79	P 101	RR 20	Temp. O 97.4 A ____ R ____	O2Sat.

Divert Registration ☒ Register & Wait ☐ Reassurance ☐ W/C ☐ Ice ☐ Triage EDT Triage RN [signature] RN
Elevation ☐ Dressing ☐ Splint ☐ Sling ☐ Other ____

(Subjective) TIME: 19:40
Reason For Seeking Care: pt reports being in an MVA 3 [illegible] ago, pt in rear passenger seat, restrained in front, [illegible] hitting head, but [illegible] feeling [illegible]
PLAN OF CARE: ☐ INITIATE STANDING ORDERS/TREATMENT PROTOCOL ☒ OTHER: [illegible] Comfort

SYSTEM	BASIC	FOCUSED	SYSTEM	BASIC	FOCUSED
NEUROLOGICAL	—	GCS	INTEGUMENTARY	—	
CARDIAC	✗	RHYTHM [illegible]	MUSCULOSKELETAL/ MOBILITY	✗	Back, low, Pain
RESPIRATORY	—		PERIPHERAL/NEURO	—	
GI	—		PAIN/COMFORT LOCATION/QUALITY	✗	Scale 0-10 4/10 [illegible] sharp
GU	—		SEXUAL/ REPRODUCTIVE	—	FHT
EENT	—		PSYCH/SOCIAL	—	

R EYE ____ L EYE ____
BOTH EYES ____
TIME/SIGN OF RN COMPLETING ASSESSMENT [initials] 19:40

Safety ☑ Side Rails ☐ Seizure Precautions Yes ☐ No ☐ Isolation Yes ☐ No ☐ Type ____ Nutritional ☐
Discharge Planning ☐ Functional Health ☒ Personal Safety ☐ (see screening questions on back of this sheet; screens are required on each patient as warranted by their condition)

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

TIME OF DISPOSITION: 20 40
TO: L&D thru [illegible]
Condition: Stable
ADMIT: ____
Report to: ____
Initials/Sign ____
Initials/Sign ____

Left With: EDT
Via: W/C
Instructions Given: Yes
Scripts Given: No
Follow up with: OB/ [illegible]
Verbalized Understanding: Yes
Initials/Sign ____
Initials/Sign [signature]

Death: ____
Family notified: ____
PMD notified: ____
Donor Network called: ____
1-800-432-5405
Medical Examiner Notified: ____

INITIAL ASSESSMENT / TRIAGE — SCREEN — DISPOSITION

ST. JOSEPH REGIONAL MEDICAL CENTER
Covenant Healthcare
5000 W Chambers Street
Milwaukee WI 53210-1650

EMERGENCY DEPARTMENT RECORD PAGE 1

MINER NIMIKO D
DOB 10/06/87 18Y SEX F MR 1053171
EMERGENCY CONSULTANTS INC
ACCT# 71517538

Time	BP	P	RR	TEMP	O2Sat	PAIN 0-10 QUALITY	*	ASSESSMENT/INTERVENTION/EVALUATION	INITIALS
19:45								[illegible] assessment [illegible]	
								[illegible]	
20:[illegible]								[illegible]	
20:[illegible]								[illegible]	
								[illegible]	
20:[illegible]								[illegible] 1 gm [illegible]	
								[illegible]	
20:40								[illegible] to [illegible]	
								[illegible] assessment [illegible]	

	TIME	INITIALS	TIME RETURN	INITIALS		TIME	INITIALS	ORTHO VS	Time BP	Time P	INITIALS
EKG					LAB			LIE			
RAD					URINE			SIT			
CT					CULTURES			Stand			
US					WET PREP						
WND PRP					PELV. EX						

IV START TIME	SITE	GUAGE	BAG #	SOLN.	RATE	IV STOP TIME	AMOUNT	INITIALS	On Monitor/Interp./Time

	INTAKE	OUTPUT
IV		
PO		
URINE		
OTHER		

Initials/Sign ______ Initials/Sign ______

Initials/Sign ______ Initials/Sign ______

Initials/Sign ______ Initials/Sign ______

Initials/Sign ______ Initials/Sign [illegible signature]

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

EMERGENCY DEPARTMENT
RECORD PAGE 2

MINER NIMIKO D
DOB 10/06/87 18Y SEX F MR: 1053171
EMERGENCY CONSULTANTS INC

TODAY'S DATE: 4.27.06

CAPITOL REHABILITATION CLINIC

Patient Name: Yumiko D.M. Miner Birth Date: Oct. 6, 1987
If patient is a minor, sign/consent below
Address: 2444 No. 40th St. Marital Status: S Sex: F Age: 18
City: Milwaukee State: WI Zip Code: 53210 Home Phone: (414) 449-1392
Employer: N/A Occupation: N/A Work Phone: N/A
Cell Phone: N/A
Social Security# 392.62.9946
Spouse's Name: N/A Birth Date: N/A SS# 392-62-9946
Spouse's Address: N/A Spouse's Employer: N/A
Parent/Guardian Name, (if patient is a minor) N/A
Parent Employer Name & Phone# (if patient is a minor) N/A
Referring Physician Name: N/A

Insurance Information
(if applicable)

Insurance Name: United Health Subscriber :
Address: City: State: Zip:
Policy# ID# Group#
List any other Insurance Coverage:

Accident Information
(if applicable)

Date of Injury: April 9, 2006 Work Related: ☐ yes ☒ no Auto Accident: ☒ yes ☐ no
Did Injury Occur in Wisconsin? ☒ yes ☐ no If no, State Where Injury Occurred:

Consent to Treat a Minor
(if applicable)

This authorization provides consent for Capitol Rehabilitation Clinic (including physicians and staff) to examine and treat the minor patient listed above.

Celia A. Zyglis Date: 4.27.06
Parent or Legal Guardian Signature

Date:
Witness

Payment Agreement and Assignment of Insurance Benefits

I understand that I am fully responsible for payment of the medical services rendered by Capitol Rehabilitation Clinic. I hereby assign insurance benefits payable for medical services rendered to me (or minor patient) by Capitol Rehabilitation Clinic to be paid directly to Capitol Rehabilitation Clinic. I understand that I am responsible for any applicable co-payment, deductible, co-insurance and/or non-covered costs deemed by the insurance company. I agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account.

Celia A. Zyglis, Yumiko Miner Date: 4.27.06
Signature of Patient, Parent or Legal Guardian

Hamilton High School
6215 W. Warnimont Ave.
Milwaukee, WI 53220

MINER, NIMIKO
LAST FIRST

10/06/87 **12**
DOB GRADE

2005-06
Lighted
Schoolhouse

7310390

Forward

5077 0805 2800 1555

ID No. 3920299460
NIMIKO D MINER

Veri # V06118
IS Elig → 5/31/06
Primecare