Assessment/Response Key
✓ = Within Normal Limits/Tolerated
A = No Change UTA = Unable to Assess
* = See Significant findings, or Progress note.
DC = Discontinued

		Date	3/9/05							
		Time	0630							
Standard	Bold print under assessment = Basic Assessment. Minimum assessment for all patients is Neurological, Cardiovascular, Respiratory, Comfort/Coping, Safety and additional standards based on patient need or risk.									
Neuro-logical	✓ – **Alert/oriented x3, attentive (age appropriate), absence of seizures, tremors, posturing. Responsive to verbal/light tactile stimuli, speech clear (age appropriate).**	✓								
	✓ – Obeys commands. Facial symmetry, equal movement/strength of extremities. No blurred/ double vision. Gag, swallow, cough & blink reflexes intact.									
Cardio-vascular	✓ – **HR, BP WNL for age. Rhythm regular.**	✓								
	✓ – Heart sounds (S1, S2) audible. No extra sounds, murmurs/rubs. Neck veins flat at 45°	✓								
Resp-iratory	✓ – **Rate, rhythm, effort & chest movement WNL for age. No cough, SOB, sputum. Absence of supplemental oxygen.**	✓								
	✓ – BS clear, no stridor, tubes patent.	✓								
Comfort/ Coping	✓ – **Absence of physical discomfort/pain. Verbalize/demo ability to cope with current stressors.**									
	– Location:									
	– Pain intensity scale 0-10 (10 = worst pain)	see								
	– Pain goal (0-10 scale)	Date								
	– Radiates to:	base								
	– Aggravating factors:									
	– Characteristics:									
	– Observations/behaviors:									
	✓ – Identify coping behaviors, skills, patterns. Support system.									
Safety	✓ – **Routine care. Oriented to care delivery system, department, side rails, bed/chair, telephone and call system. Smoking and visiting policy reviewed. Valuables secured.**	✓								
	Isolation/Precautions: TYPE									
Integ-umentary	✓ – **Skin warm, dry, intact, color normal for race, oral mucous membranes pink, moist.**									
	✓ – No lesion, rash, abrasion, ulcer, bruising, petechiae, burns, crepitus, fistula, skin tear or needle marks. Dressing clean, dry, intact. Tubes patent									
	✓ – Incision – no redness, ecchymosis, edema, unusual drainage, unapproximated edges, surrounding skin normal.									
	✓ – **VAD - No redness, drainage, edema. Dressing intact.** Site: Type/gauge:									
GI	✓ – **No diarrhea, constipation, N/V, blood in stool/vomitus. Continent.**									
	✓ – Abdomen soft/flat/nontender. BS present. passing flatus. Tubes patent.									
Nutrition	✓ – **Appears well nourished and hydrated.**									
GU	✓ – **Voiding without pain, frequency, urgency. Continent.**									
	✓ – Tubes patent. Urine clear, yellow. No bladder tension. No genital edema/drainage/bleeding except menses.									
Musculo-skeletal	✓ – **Gross motor movement unrestricted/coordinated.**									
	✓ – Unrestricted ROM; Fine motor movement unrestricted and coordinated. Balance in sitting/standing. Absence of prosthetic/assistive device. Motor strength 5/5. No swelling, inflammation of joints. Tone not flaccid, spastic or atrophied. Deformity if present not restrictive.									
Peripheral Vascular	✓ – **Sensation intact. No edema.**									
	✓ – CRT ≤ 3 sec. Radial/pedal pulses + 2/4. No calf tenderness, bleeding.									
	Initials	RS								

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL
5000 W. Chambers St. • Milwaukee, WI 53210
1000 W. Bluemound Rd. • Milwaukee, WI 53226

OUTPATIENT ASSESSMENT RECORD

PARKS LARRY E
DOB: 03/26/57 47Y SEX: M MR: 778667
MLSNA JACQUELINE S
ACCT# 71258136

POC Therapy	03/10
PT Plan of Care	08:24
Treatment plan	&
LTG start date	03/10/2005
Long term goals	
LTG #1	&
LTG #2	&
LTG #3	&
LTG #4	&
LTG #5	&
LTG #6	&
LTG #7	&
Tx goals discuss	
With patient	agree

03/10/05 08:24 Treatment plan(CMK1): see BID for 3 days for crutch walking quad sets and SLR with orthostatic precautions

03/10/05 08:24 LTG #1(CMK1): I bed mobility

03/10/05 08:24 LTG #2(CMK1): mod I basic transfers

03/10/05 08:24 LTG #3(CMK1): mod i ambulation 100 feet

03/10/05 08:24 LTG #4(CMK1): mod I up/down 10 steps with rail and AD

03/10/05 08:24 LTG #5(CMK1): I HEP

03/10/05 08:24 LTG #6(CMK1): min assist car transfer

03/10/05 08:24 LTG #7(CMK1): pain 3 or less for above goals

CARE PROVIDERS	CMK1

KLINGBEIL, CYNTHIA M(CMK1)PT

PROCEDURAL

Topic	Content/Methods *Information provided to patient unless otherwise indicated:* *Other* _____	Date/Time/Initials Verbalize Understanding	 Need to reinforce
Knowledge deficit related: ☑ Pre-Procedure	**Pre-procedure instructions:** ☒ Date of procedure: 3-9-05 Arrival time 0600 or 2 hours prior to procedure. Procedure Time 0800 Arrival location ☒ Day Surgery ☐ Other _____ ☑ NPO (eat, drink smoke) after ☑ midnight ☐ other _____ ☐ NA (This includes water, gum, hard candy, alcohol, street drugs, medications unless instructed by your MD) ☒ Diet Prior Light Supper ☒ Shower or bathe and shampoo hair prior to surgery ☒ Scrub Reviewed Prep (bowel) _____ ☒ You will be asked to sign a consent – minors will need a parent/legal guardian to sign ☒ Printed Pre-op information given ☐ NA _____ ☐ Blood transfusion brochure given ☐ instructed to leave band on ☐ NA ☒ Anesthesia call ☐ Anesthesia to see pre-op ☒ Should have post op assistance at home ☒ Visitation (minors to have parent/legal guardian/adult remain in facility) ☒ **Items to left at home:** valuables, credit cards, IDs, check books, cash, jewelry ☒ **Items to be removed DOS:** make up – jewelry – piercing - contact lens nailpolish / artificial nails (procedure specific) – metal hair clips ☒ **Instructed to bring:** ☐ hearing aides ☒ glasses/case ☐ inhalers ☐ eyedrops ☐ assistive devices ☐ insurance cards ☐ Security object / Pediatrics ☐ wear nonskid foot wear and loose fitting clothing ☐ list of medications ☐ other _____ ☐ Possible additional lab or testing day of procedure ☐ Instructed pt. to call MD regarding: ☐ medications ☐ questions regarding procedure ☐ Current symptoms of illness (cold sore throat, cough or fever) ☐ Other _____ ☐ Additional instructions: _____	3-8-05 @ 1145	
☒ Pain Management	**Pain Management Instructions:** ☒ Pain Scale ☐ Pain Booklet ☐ Pain Medication ☐ Non pharmacologic comfort measures ☐ Other: _____	3-8-05 @ 1145	
☐ Procedure	**Procedural Instructions:** ☐ Activities during procedure ☐ Oriented to environment ☐ IV therapy ☐ Surgical Site Marking ☐ NA ☐ Monitoring ☐ Pre-op Medication ☐ Usual recovery process-length of stay ☐ Anesthesia/Sedation ☐ NA ☐ Diet ☐ Pain management ☐ Leg exercises ☐ Activity restrictions after procedure ☐ Other _____ ☐ Deep breathing and coughing ☐ Dressings, drains, tubes		
☐ Other	**Other instructions:** _____		

PARKS LARRY E
DOB 03/26/57 47Y SEX: M MR: 778667
MLSNR JACQUELINE S
ACCT#: 71258136

Assessments	03/10							
Comfort/Pain	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Assessment	WNL except	WNL except	WNL &	WNL except		WNL except		
L leg								
Pain rating							7/10	
Intensity							moderate	
Characteristics							aching dull	
Location							incisional	
Behaviors							resting	
L knee								
Pain rating	10/10	7/10				9/10 at rest		
Pt goal	3	3				3		
Intensity	severe	moderate		mild		severe		
Characteristics	stabbing intermittent	stabbing		sharp		aching burning		
Location	anterior			incisional				
Behaviors	reluctnt to move resting	quietness resting		quietness resting		grimacing guarding holding		
Intervention	cold/ice applied med given reposition	cold/ice applied diversion		cold/ice applied diversion		ambulate diversion notified RN	cold/ice applied med given relax tech reposition	
Pt response						improved		improved
Inst pain manage	done needs reinforcmt	done needs reinforcmt		done needs reinforcmt		done needs reinforcmt		
Inst cold/ice	done needs reinforcmt							

03/10/05 03:00 Assessment(AM): Patient is sleeping.

Analg/Anesth Inf	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Morphine-PCA								
Dose/Injection	2mg						2mg	
Lockout	10min						10min	
Demands				2				
Injections				6				
Total shift dose				12mg				
Inst pain manage	done needs reinforcmt							
Inst PCA use	done needs reinforcmt							

Neuro-Musculskel	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Assessment	WNL except			unchanged			WNL except	
LOC	sedated							
Opens eyes to	voice touch						voice	
Extrem Strength								
R arm	full resist/norm							
L arm	full resist/norm							
R leg	full resist/norm							
L leg	no resist/fair							
Move/Strgth/Prob								
L leg	limited ROM weak						stiff ROM	
Ice applied	done							
Extrem elevated	done							

Cardiac	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Assessment	WNL except						WNL	
HR/BP	see vital signs							
Heart Sounds	WNL						WNL	
CARE PROVIDERS	AM	AM	AM	AM		CMK1	FM	FM

KLINGBEIL, CYNTHIA M(CMK1)PT
MCMILLIAN, FELICIA(FM)RN
MUHAMMAD, ANEESAH(AM)RN

CONTINUED

Assessments	03/10							
Perphrl Vascular	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Assessment	WNL except			unchanged			WNL	
Pulse character								
Radial/Pedal							strong palpable	
Bilateral radial	strong palpable							
Bilateral pedal	bounding							
CRT	WNL						WNL	
Problems								
L toe(s)	numbness							
Extrem elevated	done							
Respiratory	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Assessment	WNL except						WNL except	
Breath sounds								
All lobes	decreased							
Bibasiliar							decreased	
Assoc activity	at rest							
O2 L	2L nasal cannula							
HOB elevated C and DB Inst C and DB	 done needs reinforcmt						30degrees done	
Gastrointestinal	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Assessment	WNL except						WNL except	
Bowel sounds								
all quads	hypoactive						hypoactive	
Abdomen								
all quads	WNL							
Problems	no flatus							
Genitourinary	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Assessment	WNL except						WNL	
Urine descript								
Void	amber						WNL	
Patient mgmt GU								
Bedpan/Urinal					independent			
Skin	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Assessment	WNL except						WNL except	
Invasive Lines	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
L hand								
Type of line	peripheral						peripheral	
Site Assessment	WNL						WNL	
Incision	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
L leg								
Dressing(s)							dry + intact	
Cast	dry + intact							
Tubes/Drains	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
J-Vac #1								
Dressing(s)	dry + intact			dry + intact				
Drng thru tube	small bloody			small bloody				
Drg around tube	none			none				
Nutrition	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Assessment							WNL	
Safety/Risk	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Braden Scale								
Sensory/Percptn								
Activity								
Moisture								
Mobility								
Nutrition								
CARE PROVIDERS	AM			AM	SB		FM	

BROOKSHIRE, SANDRA(SB)PCA MCMILLIAN, FELICIA(FM)RN MUHAMMAD, ANEESAH(AM)RN

CONTINUED

Assessments	03/10							
Safety/Risk-Cont.	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Friction/Shear								
Braden score								
Notification	00:55	01:45	03:00	05:58	05:59	08:24	08:46	09:46
Consulted w/RN								
Regarding						change in VS dizziness plan of care result of eval		
CARE PROVIDERS						CMK1		

KLINGBEIL, CYNTHIA M(CMK1)PT

Assessments	03/10			
Comfort/Pain	13:27	16:25	20:00	21:00
Assessment		WNL except		
L knee				
Pain rating		5/10		
Intensity		moderate		
Characteristics		throbbing constant		
Behaviors		resting		
Intervention		cold/ice applied reposition		
Analg/Anesth Inf	13:27	16:25	20:00	21:00
Morphine-PCA				
Dose/Injection		2mg		2mg
Lockout		10min		10min
Demands	6			21
Injections	7			12
Total shift dose	15.9mg			24mg
Inst PCA use		done understands		
Neuro-Musculskel	13:27	16:25	20:00	21:00
Assessment		WNL except		
Opens eyes to		voice touch		
Extrem Strength				
R arm		full resist/norm		
L arm		full resist/norm		
R leg		full resist/norm		
L leg		no resist/weak		
Move/Strgth/Prob				
L toe(s)		tingling		
L knee		localize to pain limited ROM		
Ice applied		done		
Extrem elevated		done		
Cardiac	13:27	16:25	20:00	21:00
Assessment		WNL		
HR/BP		see vital signs		
Heart Sounds		WNL		
Perphrl Vascular	13:27	16:25	20:00	21:00
Assessment		WNL except		
Pulse character				
Bilateral radial		strong palpable		
Bilateral pedal		strong palpable		
Edema				
L ankle		non pitting small (+2)		
CRT		WNL		
Plexipulse		per order		
Respiratory	13:27	16:25	20:00	21:00
Assessment		WNL		
Breath sounds				
Bibasilar		decreased		
HOB elevated C and DB Incent spirom		25degrees done done		
Inst C and DB		done understands		
Inst incent spir		done demonstrates		
CARE PROVIDERS	FM	JJ		JJ

JONES, JEANNA(JJ)GN
MCMILLIAN, FELICIA(FM)RN

CONTINUED

Assessments	03/10			
Gastrointestinal	13:27	16:25	20:00	21:00
Assessment	✓	WNL		
Problems		no flatus		
Genitourinary	13:27	16:25	20:00	21:00
Urine descript				
Void		WNL		
Skin	13:27	16:25	20:00	21:00
Assessment		WNL except		
Invasive Lines	13:27	16:25	20:00	21:00
L hand				
Type of line		peripheral		
Site Assessment		WNL		
Incision	13:27	16:25	20:00	21:00
L knee				
Cast		dry + intact		
Nutrition	13:27	16:25	20:00	21:00
Assessment		WNL		
Coping	13:27	16:25	20:00	21:00
Assessment		WNL		
Safety/Risk	13:27	16:25	20:00	21:00
Fall risk screen				
Pharmaceutical			PCA/narc/opia(1)	
Total score			1	
Braden Scale				
Sensory/Perceptn	4-no impairment			
Activity	3-walks occas			
Moisture	3-occas moist			
Mobility	3-slight limited			
Nutrition	2-inadeq intake			
Friction/Shear	3-no problem			
Braden score	18			
CARE PROVIDERS	FM	JJ	JJ	

POC Evaluation	03/10
Injury/Risk for	20:00
Fall prevention	
No agit/restless	5-total adequate
Asks/assistance	5-total adequate
Comp phys limits	3-mod adequate
Use asstv device	3-mod adequate
Use eyeglasses	1-not adequate
Use hearing aid	1-not adequate
CARE PROVIDERS	JJ

JONES, JEANNA(JJ)GN

MCMILLIAN, FELICIA(FM)RN

Legend Charting

Type of line **R hand**
(O) Perform Date: 03/10/05 16:25 Chart Date: 03/10/05 22:18 Chart Inits.: JJ
Value: Prphrl
(I) Inact Date: 03/10/05 22:21 Inact Inits.: JJ

Site Assessment **R hand**
(O) Perform Date: 03/10/05 16:25 Chart Date: 03/10/05 22:18 Chart Inits.: JJ
Value: Wnl
(I) Inact Date: 03/10/05 22:21 Inact Inits.: JJ

Care Providers:
JJ JONES, JEANNA, GN

Assessments	03/09							
Comfort/Pain	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Assessment	WNL except			WNL except			WNL except	
POC DX								
Actual		acute pain						
POC GOALS								
Acute Pain		satsfd pain mgmt						
POC INTERVENTION								
Acute/Chron pain		use of meds repositioning distraction cold						
POC EVAL								
Acute pain		initiated						
L leg								
Pain rating				10/10 at rest			9/10	
Pt goal				3				
Intensity				severe			severe	
Characteristics							burning stabbing &	
Behaviors				grimacing quietness			reluctnt to move resting	
L knee								
Pain rating	10/10 &					11/10		
Intensity						severe		
Characteristics						&		
Location						anterior		
Behaviors						grimacing guarding holding irritability reluctnt to move		
Intervention				cold/ice applied emotional supp med given quiet environmnt			cold/ice applied med given quiet environmnt reposition &	
Pt response					improved			
Inst pain manage				done needs reinforcmt	done needs reinforcmt			

03/09/05 12:00 Pain rating(LAK2): pain left knee and left thigh pt sleepy

03/09/05 15:30 Characteristics(SJB1): "feels like leg is swelling in cast"

03/09/05 17:00 Characteristics(JJ): pulling

03/09/05 17:00 Intervention(JJ): per pca pump

Analg/Anesth Inf	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Morphine-PCA								
Dose/Injection	1mg			2mg &			2mg	
Lockout	10min			10min			10min	
Demands								96
Injections								18
Total shift dose								30.1mg
Inst PCA use	done needs reinforcmt				done needs reinforcmt		done demonstrates	

03/09/05 13:00 Dose/Injection(KE): increased

Neuro-Musculskel	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Assessment	WNL				unchanged		WNL except	
LOC				sedated			sedated	
Opens eyes to				voice touch			voice touch	
CARE PROVIDERS	LAK2	LAK2		KE	KE	SJB1	JJ	JJ

BAATZ, SANDRA J(SJB1)PT
KOTTKE, LAURA A(LAK2)RN
ENLI, KRISTINE(KE)RN
JONES, JEANNA(JJ)GN

CONTINUED

Assessments	03/09							
Neuro-Musculskel-Cont	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Extrem Strength								
R arm							full resist/norm	
L arm							full resist/norm	
R leg							full resist/norm	
L leg							no resist/weak	
Move/Strgth/Prob								
All extremities	WNL							
R finger(s)							tingling	
L toe(s)							tingling	
L leg							localize to pain limited ROM	
Cardiac	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Assessment	WNL						WNL	
HR/BP							see vital signs	
Heart Sounds	WNL						WNL	
Perphrl Vascular	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Assessment	WNL						WNL	
Pulse character								
Radial/Pedal							strong palpable	
L pedal	strong palpable							
CRT	WNL						WNL	
Extrem elevated Plexipulse	per order						done	
Ice applied							done	
Respiratory	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Assessment	WNL except						WNL except	
Breath sounds								
Bibasiliar							decreased	
O2 L	2L nasal cannula							
HOB elevated C and DB Incent spirom							25degrees done done	
Inst C and DB	done needs reinforcmt						done understands	
Inst incent spir							done demonstrates	
Gastrointestinal	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Assessment	WNL except						WNL except	
Bowel sounds								
all quads	absent						hypoactive	
LUQ							hypoactive	
RUQ							absent	
LLQ							absent	
RLQ								
Abdomen								
all quads	WNL						no flatus	
Problems								
Genitourinary	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Assessment							WNL	
Urine descript								
Void							WNL per urinal	
Skin	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Assessment	WNL except						WNL except	
Invasive Lines	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
L hand								
Type of line	peripheral						peripheral	
Site Assessment	WNL						WNL	
CARE PROVIDERS	LAK2						JJ	

JONES, JEANNA(JJ)GN

KOTTKE, LAURA A(LAK2)RN

CONTINUED

Assessments	03/09							
Incision	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Surgical site								
Cast	dry + intact &							
L leg								
Cast							dry + intact	
03/09/05 12:00 Cast(LAK2): split								
Tubes/Drains	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
J-Vac #1								
Dressing(s)	dry + intact						dry + intact	
Drng thru tube	small bloody						moderate bloody	
Nutrition	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Assessment	WNL						WNL	
Coping	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Assessment	WNL						WNL	
Continuity/Care	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
DC needs assessd	yes							
Anticipated dest	home alone &							
03/09/05 12:00 Anticipated dest(LAK2): has parents and fiancee who can help								
Safety/Risk	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
POC DX								
Actual	risk for injury							
POC GOALS								
Safety/Risk	minimize risk							
POC INTERVENTION								
Fall prevention	asst w trsfr/amb med for pain							
POC EVALUATION								
Risk for injury	initiated							
Fall risk screen								
Altered mobility	bedrest (1)							
Pharmaceutical	PCA/narc/opia(1)							
Total score	2							
Strict fall prec	initiated							
Nutr Risk Factrs								
No risk	0 points							
Total score	0points							
Braden Scale								
Sensory/Perceptn	4-no impairment							
Activity	1-bedfast							
Moisture	4-rare moist							
Mobility	4-no impairment							
Nutrition	3-adeq intake							
Friction/Shear	3-no problem							
Braden score	19							
Notification	12:00	12:30	12:55	13:00	14:00	15:30	17:00	18:45
Notified (MD)			&					
Regarding			pain					
Response			POC updated &					
03/09/05 12:55 Notified (MD)(KE): Mlsna								
03/09/05 12:55 Response(KE): pca dose increased								
CARE PROVIDERS	LAK2		KE				JJ	

ENLI, KRISTINE(KE)RN JONES, JEANNA(JJ)GN KOTTKE, LAURA A(LAK2)RN

Assessments	03/09	
Analg/Anesth Inf	21:00	22:00
Morphine-PCA		
Demands		9
Injections		5
Total shift dose		10mg
Safety/Risk	21:00	22:00
Fall risk screen		
Pharmaceutical	PCA/narc/opia(1)	
Total score	1	
CARE PROVIDERS	JJ	JJ

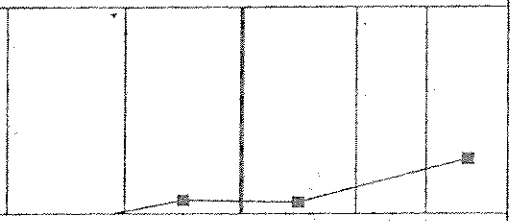
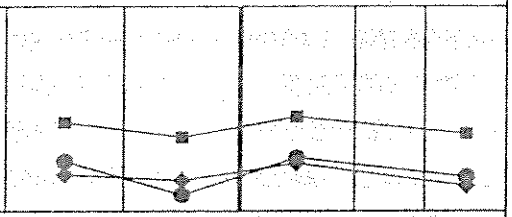
POC Evaluation	03/09
Injury/Risk for	21:00
Fall prevention	
No agit/restless	5-total adequate
Asks/assistance	4-substan adeq
Comp phys limits	3-mod adequate
Use asstv device	3-mod adequate
Use eyeglasses	1-not adequate
Use hearing aid	1-not adequate
CARE PROVIDERS	JJ

JONES, JEANNA(JJ)GN

Nc nasal cannula Wnl WNL
O2rest O2 at rest

HT/WT Table		
Admit Weight 03/09/05 167lb	Height 5ft7in	
Previous Weight	Current Weight 03/09/05 167lb	Pre-Op WT

PARKS, LARRY E
St. Joseph Regional Medical Center
Vital Signs Flowsheet (vitals_det)
FROM: 03/05/05 22:00 TO: 03/09/05 21:59
ROOM: 5208-A ADM: 03/09/05 08:00
AGE: 47Y SEX: M Dr.: MLSNA, JACQUELINE
DOB: 03/26/1957 ID: 71258136 MR: 778667
REQUESTED:03/10/05 01:34

PATIENT	03/09				
FLOWSHEET	12:00	13:00	16:50	17:00	21:08
Temp Graph					
TEMP ■ 105 104 103 102 101 100 99 98					
VITAL SIGN GRAPH					
SYSTOLIC ■ DIASTOLIC ◆ PULSE ● 200 180 160 140 120 100 80 60					
Vital Signs					
TEMP	96.6F	97.6F	97.5F		99.4F
PULSE	84	54	87		70
Heart Sounds	Wnl			Wnl	
RESPIRATIONS	12	16	20		20
BP	118/72	105/67	123/82		108/62
O2 SAT	97 O2rest	99 O2rest	98 O2rest		
O2 L	2L Nc				
WEIGHT	167lb				
HEIGHT	67in				
CARE PROVIDERS	LAK2	KE	CG	JJ	CG

KOTTKE, LAURA A(LAK2)RN ENLI, KRISTINE(KE)RN GLENN, CARLISSA(CG)PCA JONES, JEANNA(JJ)GN

HT/WT Table		
Admit Weight 03/09/05 167lb	Height 5ft7in	
Previous Weight	Current Weight 03/09/05 167lb	Pre-Op WT

PARKS, LARRY E
St. Joseph Regional Medical Center
I & O Detail report (fluids_det)
FROM: 03/05/05 22:00 TO: 03/09/05 21:59
ROOM: 5/208-A ADM: 03/05/05 08:00
AGE: 47Y SEX: M Dr.: MLSNA, JACQUELINE
DOB: 03/26/1957 ID: 71258136 MR: 778667
REQUESTED:03/10/05 01:34

PATIENT	03/09
FLOWSHEET	18:45
OUTPUT	
Voided Urine	360
Output Total	360
I&O SUMMARY	
Output Total	360
NET	-360
CARE PROVIDERS	JJ

JONES, JEANNA(JJ)GN

St Joseph's Hospital
A MEMBER OF Covenant HEALTHCARE
St. Joseph's Hospital is Sponsored by the Wheaton Franciscan Sisters
5000 W. Chambers St. • Milwaukee, WI 53210-1688
10010 W. Bluemound Rd. • Milwaukee, WI 53226-4387

WHITE - MEDICAL RECORDS
YELLOW - OUTPATIENT LAB

FORM 3437 9/98 R1

INFORMED CONSENT FOR HIV TESTING AND RESULTS DISCLOSURE

PARKS LARRY E
DOB 03/26/57 47Y SEX M MR: 778667
MLSNR JACQUELINE S
ACCT# 71258136

Patient Name: _____

Physician Ordering HIV Test: _____

1. I hereby authorize St. Joseph's Hospital, its agents, subcontractors and employees, to test my blood for the presence of antibody/antigen to the Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS).

2. The proposed test(s) and the procedures for obtaining a specimen have been explained to me, including the risks, benefits and possibilities of complications, which include, but are not limited to, bruising, soreness and minor risk of infection.

3. I understand that the purpose of the test is to determine whether I have developed antibodies to HIV, the virus that cause AIDS. I understand that a positive test result does not necessarily mean that I have or may develop AIDS, nor does a negative test result guarantee that I do not have or will not develop AIDS.

4. I understand that under section 252.15 of the Wisconsin Statutes, my test results may be released to certain persons, as listed on the reverse side of this form without my informed consent. I further understand that the Hospital and/or any agent or subcontractor of the Hospital providing health care services to me will maintain a record of this consent, my test results, and my consent, if any, to disclosure of my test results to any additional individuals.

5. I hereby authorize the Hospital and/or any agent or subcontractor of the Hospital to place my test results in my medical record, and I consent to disclosure of the test results to those individuals allowed access to my medical record within the Hospital and/or agent or subcontractor of the Hospital. This consent to disclosure is effective for the entire time that the Hospital providing health care services to me maintains a medical record for me.

6. I authorize the Hospital and/or agent or subcontractor of the Hospital to disclose any and all information that the Hospital has or may hereafter acquire relating to the performance of a test for HIV or an antibody to HIV or any information that the Hospital and/or any agent or subcontractor of the Hospital has or may hereafter acquire indicating a diagnosis of asymptomatic HIV infection or symptomatic infection, including AIDS, to any and all third party payors who may be responsible for paying my medical expenses. Such disclosure may be made for the sole purpose of obtaining payment for the medical expenses that I incur while I am a patient at the Hospital.

7. I hereby consent to the disclosure of my HIV antibody/antigen test results by my physician, the Hospital and/or any agent or subcontractor of the Hospital to the following persons or entitites, for the time periods specified below:

_____ From: _____ To: _____
(Name of Person/Entity to Whom Disclosure May be Made) (Date) (Date)

8. **My signature below constitutes my acknowledgement that: (1) I have read and agreed to the foregoing; (2) the proposed testing has been satisfactorily explained to me and that I have all the information I desire; and (3) I hereby consent to testing for the presence of antibody/antigen to HIV, the virus that causes AIDS, and to the release of the test results as specified above.**

Cindy Jurk Signed Asst
Signature of Witness

Larry Parks
Signature of Test Subject

3-8-05
Date Signed

1123 AM/PM
Time Signed

SJRMC, Milwukee, WI
Dept of Surgery

SIGNATURE PROFILE for O.R.

-	RN		
Lorfeld, Joyce	RN	Joyce Lorfeld RN	
McCluskey, Mary	RN		
McNeil, Kay	AT		
Meier,Nashelle	ST		
Muth,Amy	ST		
Nixon, Cynthia	RN		
Pader,Mary	ST		
Patla, Heather	ST		
Powell, Christine	RN		
Powell,Reginald	ST		
Pradjinski, Carol	RN		
Reichert, Marcie	RN		
Rickaby, Elizabeth	RN		
Salyers, Charlene	ST		
Scharf, Nicole	ST		
Schneeberg, Jan	RN		
Schroeder, Nancy	RN		
Schulze,Karen	ST		
Sembratowicz,Roman	SA		
Shoman, Sandra	RN		
Walloch, Moira	RN		
Somers, Inez	RN		
Stein, Naomi	RN		
Stokes, Mekerra	ST		
Strupp, Kathleen	RN		
Ullenberg,Ellen	ST		
Van Sluys, Edith	RN		
Vandenheuvel, Lisa	ST		
Vitas, Kelly	ST		
Voskoboynik,Svetlana	RN		
Whitaker,Lisa	ST		
Wilke, Judy	AT		
Williams, Christina	ST		
Yogerst, Barbara	RN		
Mahn,Joan	RN		
Vogt, Kathryn	RN		
Swan, Maribeth	RN		
Lutes, Patricia	RN		
Wakefield, Rosalind	RN		

PARKS LARRY E
DOB: 03/26/57 47Y SEX: M MR: 778667
MLSNA JACQUELINE S
ACCT: 712581136

SJRMC, Milwukee, WI
Dept of Surgery

SIGNATURE PROFILE for O.R.

NAME	TITLE	SIGNATURE as you would sign it on record	INITIALS
Acker, Wendy	AT		
Bach, Karen	RN		
Bergmann,Dawn	ST		
Greasby, Janice	ST		
Birkenbach,Kristina	RN		
Borchardt, Denise	RN		
Bruce, Marie	RN		
	RN		
	RN		
Cottone, Angie	RN		
Cousert,Skylar	ST		
Debbink, Danielle	RN		
Decker, Sarah	ST		
Demmer, Shannon	AT		
Donahue, Sheryl	AT		
Doolin, David	AT		
Doss,Victoria	ST		
Douglas,Yolanda	ST		
Drees, Judy	SA		
Duros, George	SA		
Ehleiter, Janis	RN		
Fangmann, Sheri	RN		
Geigle-Mietla,Constance	RN		
Gellert, Bonnie	RN		
Griep,Susan	RN		
Groth,Patricia	ST		
Hamilton, Deasha	ST		
Hebein, Michelle	RN		
Hein,Sharon	ST		
Henderson,Jane	ST		
Heppe, Rita	RN		
James, Twyla	RN		
Jaskolski, Jeremy	AT		
Junior,Dana	ST		
Kartz, Diane	RN		
Kassulke, Tom	AT		
Kraus, Laura	ST		
Krueger, Lois	AT		
Wesley, Kimberly	ST		
Larson, Karin	ST		
Laur, Barbara	RN		
Lewis,Calvin	ST		

COVENANT SIGNATURE PROFILE

Date	Initials *as you would use in charting (Write Legibly)	Print Full Name	Written Signature	Title
3-7-05	[illegible]	Brenda Hadley-Magee	[illegible]	HUC
3-8-05	[illegible]	Gregory Jerke	[illegible]	[illegible]
3/8/05	MSK	Mary Sue Klotz	[illegible]	RN
3-8-05	[illegible]	KATHRYN MILLARD	K Millard	US
3/8/05	JH	Julie Heisl	J Heisl	RN
3/9/05	PB	Pamela Bannister	[illegible]	RN
3/9/05	CA	Caroline Alberty	[illegible]	RN
3.9.05	JJ	Jeanna Jones	Jeanna Jones	GN
3.10.05	AM	Aneesah Muhammad	A Muhammad	RN
3/10	FM	Felicia [illegible]	[illegible]	[illegible]
3/10	[illegible]	Chris Loberg	[illegible]	DTR
3/11/05	[illegible]	Jan Jones	[illegible]	RN

FACILITY ____________

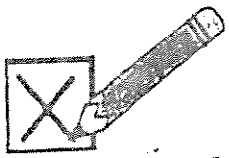
Covenant HEALTHCARE

COVENANT SIGNATURE PROFILE

55531 10/02 R1

PARKS LARRY E
DOB: 03/26/57 47Y SEX: M MR: 778667
MLSNA JACQUELINE S
ACCT#:
71258136

THIS IS NOT A PART OF PATIENT'S PERMANENT MEDICAL RECORD



FINANCIAL COUNSELING CHECKLIST:

PATIENT'S NAME PARK LARRY

ACCOUNT NUMBER 7125813

INTERVIEW DATE 3-10-05

GAMP:

☑ APPEARS ELIGIBLE ☐ NOT ELIGIBLE
OVER INCOME
DECLINED INS
NOT RESIDENT
OTHER

☐ PENDING VERIFICATION
COPY OF ID
PROOF OF RESIDENCY
PROOF OF INCOME

CLINIC CHOICE IVLK

ADDRESS _____ PHONE _____

☐ PATIENT IS A VETERAN-REFER TO THE VA FOR FOLLOW-UP CARE

TITLE 19: ☐ APPLICATION COMPLETED

☐ REGULAR ☐ DISABILITY ☐ ALIEN EMERGENT-COVERS THIS STAY ONLY

☐ PRESUMPTIVE DISABILITY FORM TO BE COMPLETED BY DR

COMMUNITY CARE APPLICATION GIVEN _____

COMMENTS Grant Ends 3/10/05 - Did Continue appl 3/10 to 3/11/05 Pass 3 wk wait But u/rend Urgent

FINANCIAL COUNSELOR _____ X _____

Carol x315

COVENANT SIGNATURE PROFILE

Date	Initials "as you would use in charting (Write Legibly)	Print Full Name	Written Signature	Title
3/9/05	ZK	Lauren Kotthe	L Kotthe	RN
3/9/05	KE	KRISTINE EARLY	[illegible]	RN
3/10	FW	FELICIA NOLLNER	[illegible]	[illegible]
3/10/05	[illegible]	Dan Jones	[illegible]	[illegible]

FACILITY Covenant HEALTHCARE

5208

COVENANT SIGNATURE PROFILE

55531 10/02 R1

PARKS LARRY E
DOB 03/26/57 47Y SEX M MR: 778667
MLSNA JACQUELINE S
ACCT# 71258136

Significant findings = further description of an abnormal assessment, change in condition and action taken, difficulty tolerating interventions and/or activity, expected outcomes requiring a change in the Plan of Care, MD notification for a specific problem and outcome of call.

DATE	TIME	DISCIPLINE	SIGNIFICANT FINDINGS	INITIALS

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL

5000 W. Chambers St • Milwaukee, WI 53210
0010 W. Bluemound Rd • Milwaukee, WI 53226

SIGNIFICANT FINDINGS

PARKS LARRY E
DOB 03/26/57 47Y SEX: M MR: 778667
MLSNA JACQUELINE S
ACCT#
71258126

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

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

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

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

Larry Parks
Signature of Patient/Authorized Representative

03-08-05
Date

Relationship of Authorized Representative

If unable to sign document, state reason: _____

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

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

Inpatient and Outpatient
Consent for Treatment &
Financial Agreement

1820 2/03 R8

PARKS LARRY E
DOB 03/26/57 47Y SEX: M MR: 778667
MLSNA JACQUELINE S
ACCT# 71258136

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.

PARKS LARRY E
DOB 03/26/57 47Y SEX M MR: 778667
MLSNA JACQUELINE S
ACCT# 71258136

ST. JOSEPH REGIONAL MEDICAL CENTER
A MEMBER OF COVENANT HEALTHCARE

Account No: 71313273
Sched Date: 05/25/05 01:30 PM

MR#: 0778667

PATIENT INFORMATION

PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212

Phone: 414 264-3716
DOB: 03/26/1957 Age: 48
Gender: M MS: LEGALLY SEPARAT
SS#: 397-64-6801
Religion: BAPTIST
Employer: NONE
Phone #:
Occupation:

NEAREST RELATIVE

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

ADDITIONAL CONTACT

Name:
Phone:
Bus Phone:
Relat:
Notify:

VISIT INFORMATION

Admit Reason: F/U L KNEE CL
Comment: WYS

Visit Type: G
Location: SJH ORTHOPEDIC CLINIC#
Last Inp Date: 03/09/05
Last Outpt Date: 04/27/05

INTERPRETER NEEDED: NO
Language: ENGLISH

PHYSICIAN INFO

Adm:
Att: MLSNA JACQUELINE S
PCP: NONE

INSURANCE INFORMATION

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

GUARANTOR INFORMATION

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

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

PRINTED COPY Date: 05/24/05 Time: 06:44 PM

HISTORY & PHYSICAL/PROCEDURE RECORD

DATE OF HISTORY: 5.25.05 TIME:

INFORMANT

ROOM/LOCKER NO

PROCEDURE

CURRENT MEDICATION AND DOSAGE PRESCRIBED AND NON-PRESCRIBED

PERSON TO ACCOMPANY PATIENT HOME

REASON FOR HOSPITALIZATION

SMOKING HABITS

PAST SURGERIES

ALCOHOL/DRUG/CAFFEINE USAGE

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

EXISTING CO-MORBID CONDITIONS

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

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

HEIGHT	WEIGHT (IN LBS)	(IN KG)

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

TYPE OF REACTION

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

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

INDICATIONS/SYMPTOMS FOR PROCEDURE OR ☐ SEE DICTATION

PHYSICIAN ORDERS/NURSING NOTES

Left knee post op xam done by Dr. J. Mlsna.
Xray of left knee taken.

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

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

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

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

☐ SEE PATIENT'S PROGRESS NOTES

TIME PATIENT RETURNED TO DAY SURGERY

☐ LOCAL ANESTHETIC
☐ IV SEDATION IN O.R.

TREATMENT OR OPERATIVE REPORT OR ☐ SEE DICTATION

POST-PROCEDURE/DISCHARGE OUTCOMES

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

FINAL DIAGNOSIS

Recurrent patellar dislocation

DISCHARGE PLANS

DISCHARGE TIME: 15 C. Singer Ortho Tech INITIALS:

PHYSICIAN SIGNATURE DATE 5/25/05

RN SIGNATURE INIT. RN SIGNATURE INIT.

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL
5900 W. Chambers St. • Milwaukee, WI 53210
9010 W. Bluemound Rd. • Milwaukee, WI 53226
6400 W. North Ave. • Wauwatosa, WI 53226

HISTORY & PHYSICAL/ PROCEDURE RECORD

PARKS LARRY E
DOB: 03/26/57 48Y SEX: M MR: 778667
MLSNA JACQUELINE S
ACCT#: 71313273

OUTPATIENT NOTE

ORIGINAL
cc:

DATE OF SERVICE: 05/25/2005

Larry comes in followup of his tibial tubercle osteotomy about 2-1/2 months since the time of his surgery. He does not come with his brace today.

His physical examination shows he has very limited range of motion with no better than 50 degrees of flexion. He is able to straight leg raise. He has some mild tenderness over the tibial tubercle.

X-rays taken today demonstrate on the AP view patella appeared to be well aligned although on the sunrise view, he clearly has some subluxation of the patella. The tibial tubercle osteotomy is incompletely healed although was unchanged in position.

Larry needs physical therapy. He was given a prescription for this today. I told him he is likely to have further significant difficulty with the knee for which there will be very little appropriate treatment. He needs to work harder on his range of motion. I will see him again in three weeks.

JACQUELINE MLSNA, MD

JM/jah D.06/01/2005 07:20:26 T.06/02/2005 08:32:36
Doc ID #: 4214471 Voice ID #: 4064312

ST. JOSEPH REGIONAL MEDICAL CENTER

PROVIDER: JACQUELINE MLSNA, MD
VISIT TYPE: C
ROOM #: ORTC

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

DATE: 05/25/2005
ACCT #: 71313273
AGE: 48Y

OUTPATIENT NOTE

Covenant

Elmbrook Memorial Hospital
19333 West North Avenue
Brookfield, WI 53045

St. Francis Hospital
3237 16th Street
Milwaukee, WI 53215

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

St. Michael Hospital
2400 West Villard
Milwaukee, WI 53209

RADIOLOGY

ORIGINAL
cc: JACQUELINE MLSNA, MD, Ordering Physician

ORDERING PHYSICIAN: Dr. Jacqueline Mlsna
OCCURRENCE NUMBER: 83010836 **EXAM DATE:** 05/25/2005

EXAM LOCATION: St. Joseph Regional Medical Center

EXAM: LEFT KNEE

CLINICAL HISTORY: Patellofemoral abnormality.

FINDINGS: Comparison is made to multiple recent studies, with the most recent exam obtained 04/27/2005.

There is stable appearance to the displacement osteotomy of the tibial tuberosity. The tuberosity fragment is again secured by a single cancellous screw. There is persistent lucency at the osteotomy site that is evident on the lateral radiograph. Soft tissue prominence of the patellar ligament persists. Advanced degenerative changes of the patellofemoral articulation are again evident. There is also modest degenerative narrowing of the medial and lateral compartments. There are two small corticated fragments again seen superficial to the patella.

This document was electronically signed by KARI KLUESSENDORF, MD on behalf of MARK T. LAWTON, MD on 05/26/2005 10:35:54.

Radiologist:_____
MARK T. LAWTON, MD

MTL/jab D.05/25/2005 16:01:55 T.05/26/2005 08:14:52
Doc ID #: 4202667 Voice ID #: 4055130

ST. JOSEPH REGIONAL MEDICAL CENTER
NAME: PARKS, LARRY E **MRN:** 778667 **VISIT TYPE:** C
DOB: 03/26/1957 **ACCT #:** 71313273 **ROOM #:** ORTC

RADIOLOGY

Covenant Healthcare

Inpatient and Outpatient Consent for Treatment & Financial Agreement

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

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

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

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

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

PARKS LARRY E
DOB: 03/26/57 48Y SEX: M MR: 778667
MLSNA JACQUELINE S
ACCT#: 71313273

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

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

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

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

Larry Parks — 5-25-05

Signature of Patient/Authorized Representative — Date

Relationship of Authorized Representative

If unable to sign document, state reason: _____

Covenant HEALTHCARE

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

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

Inpatient and Outpatient
Consent for Treatment &
Financial Agreement

1820 2/03 R8

PARKS LARRY E
DOB: 03/26/57 48Y SEX: M MR: 778667
MLSNA JACQUELINE S
ACCT#: 71313273

ST. JOSEPH REGIONAL MEDICAL CENTER
A MEMBER OF COVENANT HEALTHCARE

Account No: 71294028 MR#: 0778667
Sched Date: 04/27/05 01:30 PM

PATIENT INFORMATION

PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212

Phone: 414 264-3716
DOB: 03/26/1957 Age: 48
Gender: M MS: LEGALLY SEPARAT
SS#: 397-64-6801
Religion: BAPTIST
Employer: NONE
Phone #:
Occupation:

NEAREST RELATIVE

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

ADDITIONAL CONTACT

Name:
Phone:
Bus Phone:
Relat:
Notify:

VISIT INFORMATION

INTERPRETER NEEDED: NO
Language: ENGLISH

Admit Reason: LT LEG FRACTURE CLINIC
Comment: BM

Visit Type: G
Location: SJH ORTHOPEDIC CLINIC#
Last Inp Date: 03/09/05
Last Outpt Date: 03/23/05

PHYSICIAN INFO

Adm:
Att: MLSNA JACQUELINE S
PCP: NONE

INSURANCE INFORMATION

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

GUARANTOR INFORMATION

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

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

PRINTED COPY Date: 04/26/05 Time: 07:45 PM

OUTPATIENT NOTE

ORIGINAL
cc:

DATE OF SERVICE: 04/27/2005

Larry comes in followup of his tibial tubercle transfer for a recurrent patellar disk location. He has been a bit noncompliant. He is not performing his exercises as I recommended and was not seen for his last followup in a timely fashion.

PHYSICAL EXAMINATION: Shows he still has some tenderness of the osteotomy site. His wound is nicely healed. Swelling is well controlled. He has difficulty in performing straight leg raising maneuver but can do so. There is some marked quadriceps atrophy.

X-rays taken today show the patella appears to be well located. The tibial tubercle osteotomy is still easily seen and is incompletely healed. The hardware has been changed.

Larry needs to work on his strength. We discussed an exercise program for this today. He is given a brace to provide him with some support but will begin flexion to 60 degrees. I will see him again in 2 weeks and advance him at that time. The need for appropriate followup and following of instructions is discussed. He is given a prescription for Vicodin today.

JACQUELINE MLSNA, MD

JM/dg D.04/28/2005 15:55:23 T.04/28/2005 16:09:56
Doc ID #: 4149325 Voice ID #: 4007691

ST. JOSEPH REGIONAL MEDICAL CENTER

PROVIDER: JACQUELINE MLSNA, MD
VISIT TYPE: C
ROOM #: ORTC

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

DATE: 04/27/2005
ACCT #: 71294028
AGE: 48Y

OUTPATIENT NOTE

Covenant

Elmbrook Memorial Hospital
19333 West North Avenue
Brookfield, WI 53045

St. Francis Hospital
3237 16th Street
Milwaukee, WI 53215

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

St. Michael Hospital
2400 West Villard
Milwaukee, WI 53209

RADIOLOGY

ORIGINAL
cc: JACQUELINE MLSNA, MD, Ordering Physician

ORDERING PHYSICIAN: Dr. Jacqueline Mlsna
OCCURRENCE NUMBER: 82111457 **EXAM DATE:** 04/27/2005

EXAM LOCATION: St. Joseph Regional Medical Center

EXAM: LEFT KNEE 2 VIEWS

CLINICAL INFORMATION: Followup leg fracture.

FINDINGS: Severe degenerative changes involve the patellofemoral joint with large marginal osteophytes, joint space narrowing, as well as apparent erosion of the posterior aspect of the patella. Degenerative changes involve the lateral and medial compartments as well.

A moderate size joint effusion is again incidentally noted. The metallic screw traverses the tibial tuberosity.

The presumed calcified loose body overlying the intracondylar notch posterior is noted and unchanged.

This document was electronically signed by STEVEN M. GRYNIEWICZ, MD on 04/28/2005 08:08:46.

Radiologist:_____
STEVEN M. GRYNIEWICZ, MD

SG/ss D.04/27/2005 16:51:00 T.04/27/2005 19:32:24
Doc ID #: 4147291 Voice ID #: 4005668

ST. JOSEPH REGIONAL MEDICAL CENTER
NAME: PARKS, LARRY E MRN: 778667 VISIT TYPE: C
DOB: 03/26/1957 ACCT #: 71294028 ROOM #: ORTC

RADIOLOGY

HISTORY & PHYSICAL/PROCEDURE RECORD

DATE OF HISTORY | TIME | INFORMANT | ROOM/LOCKER NO.

PROCEDURE

CURRENT MEDICATION AND DOSAGE PRESCRIBED AND NON-PRESCRIBED

PERSON TO ACCOMPANY PATIENT HOME

REASON FOR HOSPITALIZATION

SMOKING HABITS

PAST SURGERIES

ALCOHOL/DRUG/CAFFEINE USAGE

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

EXISTING CO-MORBID CONDITIONS

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

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

ALLERGIES (FOOD, MED, TAPE, DYE, LATEX, ETC.) | TYPE OF REACTION

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

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

INDICATIONS/SYMPTOMS FOR PROCEDURE OR ☐ SEE DICTATION

PHYSICIAN ORDERS/NURSING NOTES

Recurrent ⓛ knee done by Dr. J. Allen. Cast removed ⓛ. Hinged rehab knee brace fitted. 4/27/05

x-ray ⓛ knee [illegible]

☐ SEE PATIENT'S PROGRESS NOTES

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

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

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

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

TIME PATIENT RETURNED TO DAY SURGERY | ☐ LOCAL ANESTHETIC ☐ IV SEDATION IN O.R.

TREATMENT OR OPERATIVE REPORT OR ☐ SEE DICTATION

FINAL DIAGNOSIS

Recurrent patellar dislocation

DISCHARGE PLANS

POST-PROCEDURE/DISCHARGE OUTCOMES

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

DISCHARGE TIME: | INITIALS:

PHYSICIAN SIGNATURE [signature] | DATE 4/27/05

RN SIGNATURE [signature] | INIT. | RN SIGNATURE | INIT.

ST. JOSEPH REGIONAL MEDICAL CENTER
Covenant HOSPITAL
☐ 5000 W. Chambers St • Milwaukee, WI 53210
☐ 10010 W. Bluemound Rd • Milwaukee, WI 53226
☐ 8400 W. North Ave • Wauwatosa, WI 53226

HISTORY & PHYSICAL/ PROCEDURE RECORD

PARKS LARRY E
DOB 03/26/57 48Y SEX M MR: 778667
MLSNA JACQUELINE S
ACCT#
71294028

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

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Larry Parks
Signature of Patient/Authorized Representative

Date

Relationship of Authorized Representative

If unable to sign document, state reason: _____

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

Inpatient and Outpatient Consent for Treatment & Financial Agreement

1820 2/03 R8

PARKS LARRY E
DOB: 03/26/57 46Y SEX: M MR: 778667
MLSNA JACQUELINE S
ACCT#: 71294028

Covenant Healthcare

Inpatient and Outpatient Consent for Treatment & Financial Agreement

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

☐ Elmbrook Memorial Hospital ☐ St. Francis Hospital

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

PARKS LARRY E
DOB 03/26/57 AGE SEX M MR: 778667
MLSNA JACQUELINE S
ACCT# 71294028

ST. JOSEPH REGIONAL MEDICAL CENTER
A MEMBER OF COVENANT HEALTHCARE

Account No: 71270704
Sched Date: 03/23/05 12:03 PM

MR#: 0778667

PATIENT INFORMATION

PARKS LARRY E
3757 N 3 ST
MILWAUKEE WI 53212

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

NEAREST RELATIVE

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

ADDITIONAL CONTACT

Name:
Phone:
Bus Phone:
Relat:
Notify:

VISIT INFORMATION

INTERPRETER NEEDED: NO
Language: ENGLISH

Admit Reason: LEFT KNEE POST OP
Comment: NK

Visit Type: C
Location: SJH ORTHOPEDIC CLINIC#
Last Inp Date: 03/09/05
Last Outpt Date: 03/14/05

PHYSICIAN INFO

Adm:
Att: MLSNA JACQUELINE S
PCP: NONE

INSURANCE INFORMATION

PRIMARY: SELF PAY

GUARANTOR INFORMATION

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

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

PRINTED COPY Date: 03/23/05 Time: 12:04 PM

FILE

Covenant

Elmbrook Memorial Hospital
19333 West North Avenue
Brookfield, WI 53045

St. Francis Hospital
3237 16th Street
Milwaukee, WI 53215

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

St. Michael Hospital
2400 West Villard
Milwaukee, WI 53209

OUTPATIENT NOTE

ORIGINAL
cc:

DATE OF SERVICE: 03/23/2005.

Larry comes in for follow up of his recurrent patellar dislocation with tibial tubercle transfer. He has been reasonably comfortable. He says his pain is quite a bit less.

PHYSICAL EXAMINATION: Shows his wound is healing well without evidence of infection. The staples are removed. Cylinder cast is applied today. Post casting expectations are discussed. We will see him again in 4 weeks for a cast removal and x-ray. He is given a renewal on his Vicodin, which he states he is only using at night.

JACQUELINE MLSNA, MD

JM/ea D.03/23/2005 23:10:23 T.03/25/2005 22:46:15
Doc ID #: 4083394 Voice ID #: 3944396

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

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

DATE: 03/23/2005
ACCT #: 71270704
AGE: 47Y

OUTPATIENT NOTE

HISTORY & PHYSICAL/PROCEDURE RECORD

DATE OF HISTORY: 3-23-05 TIME:

INFORMANT

ROOM/LOCKER NO.

PROCEDURE

CURRENT MEDICATION AND DOSAGE PRESCRIBED AND NON-PRESCRIBED

PERSON TO ACCOMPANY PATIENT HOME

REASON FOR HOSPITALIZATION

SMOKING HABITS

PAST SURGERIES

ALCOHOL, DRUG, CAFFEINE USAGE

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

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

HEIGHT	WEIGHT (IN LBS)	(IN KG)

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

TYPE OF REACTION

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

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

INDICATIONS/SYMPTOMS FOR PROCEDURE OR ☐ SEE DICTATION

PHYSICIAN ORDERS/NURSING NOTES

Surgical staples were removed, wound clean and dry. Cast change and exam post patellar dislocation done by Dr. J. Mlsna

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

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

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

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

☐ SEE PATIENT'S PROGRESS NOTES

TIME PATIENT RETURNED TO DAY SURGERY

☐ LOCAL ANESTHETIC
☐ IV SEDATION IN O.R.

TREATMENT OR OPERATIVE REPORT OR ☐ SEE DICTATION

POST-PROCEDURE/DISCHARGE OUTCOMES

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

FINAL DIAGNOSIS

Recurrent patellar dislocation

DISCHARGE PLANS

DISCHARGE TIME: 0515 INITIALS: C. Singer CNTP Tech

PHYSICIAN SIGNATURE

DATE: 3/23/05

RN SIGNATURE | DAT | RN SIGNATURE | INIT

ST. JOSEPH REGIONAL MEDICAL CENTER
Ennard HOSPITAL
5000 W. Chambers St. • Milwaukee, WI 53210
Oscar A. Rennebohm Rd. • Milwaukee, WI 53222
5000 W. North Ave. • Wauwatosa, WI 53208

HISTORY & PHYSICAL/ PROCEDURE RECORD

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