Banner Churchill
Community Hospital

801 East Williams Ave
Fallon, NV 89406
775-423-3151

BannerHealth.com

BUSINESS RECORDS AFFIDAVIT

I, Robin Eastwood, declare as follows:

1. I am a duly authorized custodian of records of Banner Churchill Community Hospital and have authority to certify such records. Banner Churchill Community Hospital business offices are located at: 801 E. Williams Avenue, Fallon, NV 89406.

2. On September 28, 2010, Banner Churchill Community Hospital received correspondence dated September 24, 2010, from the Justice Office, Marine Corps Air Station Miramar, requesting "all medical records maintained by Banner Churchill Community Hospital pertaining to LCPL Wiley's treatment on 04May10" for the case of United States v. LCPL Michael Wiley.

3. I have made, or have caused to be made, a diligent search at the offices of Banner Churchill Community Hospital for the records as described in the subpoena.

4. The accompanying copies are true copies of all the records that are in my possession as a custodian of records of Banner Churchill Community Hospital.

5. These records were prepared by the personnel of Banner Churchill Community Hospital and/or by other persons acting under the control of those personnel, in the ordinary course of business, at or near the time of the acts, conditions or events recorded herein.

I declare under penalty of perjury under the laws of Nevada that the foregoing is true and correct, executed this 18th day of October, 2010 at Fallon, Nevada.

Sincerely,

Robin Eastwood, Sr. Manager
Health Information Management Services
Banner Churchill Community Hospital
801 E. Williams Avenue
Fallon, NV 89406
(775)867-7047

Witness

Flowsheet Print Request

Patient: WILEY, MICHAEL
MRN: 139552

Printed by: DuranGlover, Krista M
Printed on: 10/18/2010 15:06 PDT

Last 100 Results

05/04/2010 10:50 PDT	WBC	6.4	(4.0 - 11.0)
	RBC	5.16	(4.30 - 6.00)
	Hgb	14.9	(13.5 - 17.0)
	Hct	44.6	(40.0 - 53.0)
	MCV	86	(86 - 110)
	MCH	28.9	(27.0 - 34.0)
	MCHC	33.4	(31.0 - 37.0)
	RDW	13.6	(11.0 - 16.0)
	Platelet	160	(130 - 450)
	Diff Type	Auto Diff Perf	
	Segs	53	(40 - 85)
	Lymphs	39	(10 - 45)
	Monos	6	(3 - 15)
	Eos	2	(0 - 7)
	Basos	1	(0 - 2)
	Absolute Neutrophil Count	3.39 '	(>=1.00 -)
	Glucose Level	220 H	(65 - 99)
	BUN	17	(8 - 25)
	Creatinine	1.2	(0.4 - 1.4)
	Estimated Glomerular Filtration Rat	>60 *	(>=61 -)
	BUN/Creat Ratio	14	(10 - 28)
	Sodium	136	(135 - 145)
	Potassium	3.5	(3.5 - 5.2)
	Chloride	102	(96 - 110)
	CO2	18	(13 - 29)
	Anion Gap	16	(4 - 16)
	Calcium	8.5	(8.4 - 10.2)
	Protein, Total	6.8	(5.4 - 7.8)
	Albumin	4.2	(2.9 - 4.8)
	Alb/Glob Ratio	1.6	(1.0 - 2.0)
	Bilirubin Total	0.7	(0.3 - 1.2)
	AST	39	(10 - 70)
	ALT	29	(4 - 60)
	Alkaline Phos	55	(52 - 390)
	Acetaminophen Level	<5 L	(10 - 20)
	Salicylate	<4.0	(4.0 - 30.0)
	Ethanol, Plasma	<5 *	(- <=10)
05/04/2010 10:56 PDT	Amphetamine Screen, UR	Negative	(Negative -)
	Barbiturate Screen, UR	Negative	(Negative -)
	Benzodiazepine Screen, UR	Negative	(Negative -)
	Cannabinoid (THC) Screen, UR	Negative	(Negative -)
	Cocaine Screen, UR	Negative	(Negative -)
	Methadone Screen, UR	Negative	(Negative -)
	Opiate Screen, UR	Negative	(Negative -)
	Phencyclidine Screen, UR	Negative	(Negative -)
	Tricyclic Screen, UR	Negative	(Negative -)

Nevada EMS Report

Service Name	Station	Unit Name, No. & Type	PCR No.	Date
Banner Churchill Community Hospital	BCCH EMS	Amb 904 / 02291548 / MICU	1001126	05/04/2010

Incident Location	County, Municipality & Incident Zip	PSAP Incid. No.
NAS, 4755 Pasture Rd 380, Fallon, NV 89406 Other Location	Churchill, Fallon Naval Air Station, 89406	

Receiving Agency: Banner Churchill Community Hospital

Patient Name			
Michael Wiley			
Street Address			
4755 Pasture Rd 380			
City		State	Zip
Fallon		NV	89406
Sex	Age	DOB	Phone No.
Male	20 Years	01/24/1990	775
Patient Number	Social Sec. No.	Pt. Weight	
139552			
Private Physician	Driver's License		
	-		

C1: Ice, Tim	EMT-P 11466
C2: Northrup, Judy	EMT-I 11512
C3:	
C4:	
Primary Caregiver: C1	Driver: C2

Out	On-Scene	Dest.	In
0	13	13	26

Transporting Assist Units	Assist OS		
Response Outcome: Treated, Transp. by EMS	Nature of Incident: ALS		
Response Mode: Lights and Sirens	Transport Mode: Lights and Sirens		
Patient Condition on Scene: Emergent	Patient Condition at Facility: Unchanged		

Response Time:	1	911:	
ER Time:	10	Dispatch:	09:50
OS Time:	12	Enroute:	09:51
ERH Time:	10	Arrive Scene:	10:01
Destination Time:	13	Contact:	10:01
Total Time:	46	Depart Scene:	10:13
Time Out of Quarters:	47	Arrive:	10:23
		Available:	10:36
		In Quarters:	10:38

Chief Complaint:	Inappropriate Behavior
Current Meds:	Tylenol, Unable to obtian accurate Medication list
Allergies (meds):	Unable to obtain
PMHx:	Unable to obtain

WILEY, MICHAEL
MR 0139552 01/24/1990
SVC EER M 020Y
Acct 00064181555 5/04/10
CCH BANNER LABEL

1001126

83110778

904 was dispatched to NAS for an inappropriate male. Upon arrival we find NAS with a 20 yo male in the back of their ambulance, NAS fire states that witnesses saw the Pt jump from a 2nd story window get to his feet, run across rocks, and finally dive face first. NAS fire found Pt cyanotic with an SpO2 of 53% and that Pt then improved and increased to a SpO2 of 98% on room air. Pt is very combative upon arrival, and has 4 crew members of NAS fire holding down the Pt arms. Pt is secured to a back board upon, without any head straps to secure Pt head. Pt was able to answer a few questions but was very confused and unable to answer any orientation question. Pt was able to give his first name, and NAS fire was able to locate Pt room and found Tylenol and a substance called K2. Pt was unable to give any

Provider

Printed On: 05/04/2010 13:07

Ambulance Run Sheet 1604

Nevada EMS Report

Service Name	Unit No	PCR No.	Date
Banner Churchill Community Hospital	Amb 904 / 02291548 / MICU	1001126	05/04/2010

Patient Name	Date of Birth	Social Security Number	PSAP
Michael Wiley	01/24/1990		

information regarding past medical history, medications, or drug allergies.

Initial Assessment: ABC's in tact

Secondary Assessment: No lacerations, contusions, or swelling noted on the head Pt did have some white frothy sputum in his mouth. Pupils are PERRL. Neck showed no JVD, or tracheal deviation noted, no crepatis or swelling noted on posterior portion of the neck. Chest had no laceration, swelling, or signs of a flail chest segment. Breath sounds are clear and present bilaterally. Abdomen shows no signs of distention or rigidity. Pelvis is stable. Lower extremities have no signs of crepatis or swelling, minor superficial laceration were present on the distal portion of the extremities. Upper extremities show no sign of crepatis or swelling, minor superficial lacerations were present on the distal portion of the extremities.

Treatment: Plan of care is to obtain Blood Glucose levels, obtain IV access, Sedate Pt, EKG Monitoring, Monitor Vital signs, rapid transport to BCCH. IV access was obtained in 2 attempts the first attempt was unsuccessful because of Pt movement, second attempt was successful with a 20 G in the right antecubital, a 150 cc bolus given in order to increase Pt original BP of 90/50 after fluid challenge Pt BP increased to 110/P and lung sounds remained clear bilaterally. Due to Pt combativeness and risk to Pt safety and safety of crew member safety Pt was sedated using 1 Mg of Ativan, after administration of Ativan Pt much more cooperative and pulse dropped from 150 to 120. Pt arms were restrained to the gurney using soft restraints for the safety of the Pt and crew members. Pt was attached to the monitor which showed Sinus Tach at a rate of around 150 with visible P-waves. Blood Glucose levels were obtained reading 131. Pt was transported to BCCH Lights and Sirens and Head was secured upon arrival to the hospital.

10:01	Immob: Spinal Immobilization	Other	Immobalized Upon Arrival by NAS Fire
10:03	Misc: Blood Glucose Analysis; Success: 1/1; Pt. Response: Unchanged	Northrup, Judy	131
10:05	Vitals: Pulse: 150; Resp: 16; Oximetry: 98%; FiO2: On Room Air; BGL: 131; B.P.: 90/50 (Manual Cuff); GCS: 4/5/6; Resp. Effort: Normal	Northrup, Judy	
10:07	IV/IO: Venous Access-Extremity; Success: 2/1; Location: Antecubital-Right; Fluid: Normal Saline; Size: 20 G; Rate: Wide; Pt. Response: Unchanged	Northrup, Judy	
10:10	Med: Lorazepam (Ativan); Dose: 1 Mg; Qty: 1; Route: Intravenous; Pt. Response: Improved	Ice, Tim	Pt became less combative
10:15	Vitals: Pulse: 130; Resp: 12; Oximetry: 98%; FiO2: On Oxygen; B.P.: 110/P (Palpated Cuff); GCS: 3/4/6 (Chemically Sedated); Resp. Effort: Normal	Ice, Tim	
10:15	Vitals: Pulse: 120; Resp: 12; Oximetry: 98%; FiO2: On Oxygen; B.P.: 110/P (Palpated Cuff); GCS: 3/4/6; Resp. Effort: Normal	Ice, Tim	
10:15	Oxygen: Pulse Oximetry; Oximetry: 98; Liters: 4	Ice, Tim	Nasal Cannula

Provider

Nevada EMS Report

Service Name	Unit No	PCR No.	Date
Banner Churchill Community Hospital	Amb 904 / 02291548 / MICU	1001126	05/04/2010

Patient Name	Date of Birth	Social Security Number	PSAP
Michael Wiley	01/24/1990		

10:15	Oxygen: Pulse Oximetry; Oximetry: 98; Liters: 4	Ice, Tim	Nasal Cannula
10:15	EKG/Defib: Cardiac Monitor; Rhythm: Sinus Tachycardia; Rhythm at Hospital: Sinus Tachycardia	Ice, Tim	
10:20	Vitals: Pulse: 120; Resp: 12; Oximetry: 98%; B.P.: 110/P (Palpated Cuff); GCS: 3/4/6 (Chemically Sedated); Resp. Effort: Normal	Ice, Tim	

Provider

Printed On: 05/04/2010 13:07

Banner Health
BANNER CHURCHILL COMMUNITY HOSPITAL
801 East Williams Ave
Fallon, NV, 89406
Patient Location: 28 EER
Attending Physician: BUNUELJORDANA DO, LEO R

Patient: WILEY, MICHAEL
DOB: 1/24/1990 **Sex:** Male **Age:** 20 years
MR#: 139552
FIN: 64181555
Admit Date: 5/4/2010 10:35:00 MST
Discharge Date: 5/4/2010 13:52:00 MST
Patient Type: Emergency

HEMATOLOGY

CBC

Date 5/4/2010
Time 10:50:00 PDT

Procedure		Units	Ref Range
WBC	6.4	K/MM3	[4.0-11.0]
RBC	5.16	M/MM3	[4.30-6.00]
Hgb	14.9	g/dL	[13.5-17.0]
Hct	44.6	%	[40.0-53.0]
MCV	86	fL	[86-110]
MCH	28.9	pg	[27.0-34.0]
MCHC	33.4	g/dL	[31.0-37.0]
RDW	13.6	%	[11.0-16.0]
Platelet	160	K/MM3	[130-450]
Diff Type	Auto Diff Perf		
Segs	53	%	[40-85]
Lymphs	39	%	[10-45]
Monos	6	%	[3-15]
Eos	2	%	[0-7]
Basos	1	%	[0-2]
Absolute Neutrophil Count	3.39	K/ul	[>=1.00]

CHEMISTRY

General Chemistry

Date 5/4/2010
Time 10:50:00 PDT

Procedure		Units	Ref Range
Glucose Level	**220 H**	mg/dL	[65-99]
BUN	17	mg/dL	[8-25]
Creatinine	1.2	mg/dL	[0.4-1.4]
Estimated Glomerular Filtration Rate i	>60 f	mL/min/1.73 m2	[>=61]
BUN/Creat Ratio	14		[10-28]
Sodium	136	mmol/L	[135-145]
Potassium	3.5	mmol/L	[3.5-5.2]
Chloride	102	mmol/L	[96-110]
CO2	18	mmol/L	[13-29]
Anion Gap	16		[4-16]
Calcium	8.5	mg/dL	[8.4-10.2]
Protein, Total	6.8	g/dL	[5.4-7.8]

Albumin	4.2	g/dL	[2.9-4.8]
Alb/Glob Ratio	1.6		[1.0-2.0]
Bilirubin Total	0.7	mg/dL	[0.3-1.2]
AST	39	IU/L	[10-70]
ALT	29	IU/L	[4-60]
Alkaline Phos	55	IU/L	[52-390]

5/4/2010 10:50:00 PDT Estimated Glomerular Filtration Rate:
Multiply eGFR result by 1.21 if patient is African American.

5/4/2010 10:50:00 PDT Estimated Glomerular Filtration Rate:
The GFR calculated and is age and sex adjusted

THERAPEUTIC DRUGS

Therapeutic Drugs

Date 5/4/2010
Time 10:50:00 PDT

Procedure		Units	Ref Range
Acetaminophen Level	<5 L	ug/mL	[10-20]
Salicylate	<4.0	mg/dL	[4.0-30.0]

TOXICOLOGY

Urine Drugs

Date 5/4/2010
Time 10:56:00 PDT

Procedure		Units	Ref Range
Amphetamine Screen, UR	Negative		[Negative]
Barbiturate Screen, UR	Negative		[Negative]
Benzodiazepine Screen, UR	Negative		[Negative]
Cannabinoid (THC) Screen, UR	Negative		[Negative]
Cocaine Screen, UR	Negative		[Negative]
Methadone Screen, UR	Negative		[Negative]
Opiate Screen, UR	Negative		[Negative]
Phencyclidine Screen, UR	Negative		[Negative]
Tricyclic Screen, UR	Negative		[Negative]

Banner Health
BANNER CHURCHILL COMMUNITY HOSPITAL
801 East Williams Ave
Fallon, NV
89406

Patient: WILEY, MICHAEL
MR#: 139552
DOB: 1/24/1990 **Sex:** Male **Age:** 20 years
Patient Location: 28 EER
Attending Physician: BUNUELJORDANA DO, LEO R

Plasma Drugs

Date 5/4/2010
Time 10:50:00 PDT

Procedure		Units	Ref Range
Ethanol, Plasma i	<5	mg/dL	[<=10]

5/4/2010 10:50:00 PDT Ethanol, Plasma:
Nevada legal intoxication level is >/= to 80 mg/dl.

MEDICAL IMAGING

Chest Single View Adult Portable

Exam Date / Time: 5/4/2010 10:58:01 PDT

Accession Number: 28-RA-10-0005800

Reason for exam:
TRAUMA

Report:
Portable Chest, 1 View

HISTORY:
Drug overdose.

COMPARISON:
None provided.

TECHNIQUE:
A single portable anteroposterior view of the chest was provided.

FINDINGS:
Visualization is limited by overlying backboard artifact. No significant osseous abnormalities are identified. The cardiac and mediastinal silhouettes have a normal appearance for an anteroposterior radiograph. No focal consolidation, pleural fluid collections, or pneumothoraces are identified. The stomach is distended with gas.

IMPRESSION:
1. No evidence of active cardiopulmonary disease.
2. Gastric distention.

Banner Health
BANNER CHURCHILL COMMUNITY HOSPITAL
801 East Williams Ave
Fallon, NV
89406

Patient: WILEY, MICHAEL
MR#: 139552
DOB: 1/24/1990 **Sex:** Male **Age:** 20 years
Patient Location: 28 EER
Attending Physician: BUNUELJORDANA DO, LEO R

jej
d. 05/04/10 11:04 a.m.
t. 05/04/10 12:25 p.m.

***** Final Report *****

Transcribed Date: 05/04/2010
Signature Date: 05/04/2010 :JDH

Interpreted By: Houston, MD, Jeffrey D
Electronically Signed

Exam Date / Time:	Accession Number:
5/4/2010 12:25:08 PDT	28-CT-10-0002006

CT Abd/Pelvis W/Contrast

Reason for exam:
TRAUMA

Report:
CT Abdomen With Contrast
CT Pelvis With Contrast

HISTORY:
Trauma. Jumped out of a two story balcony and then collapsed.

COMPARISON:
None provided.

TECHNIQUE:
Multidetector CT of the abdomen and pelvis was performed on the Toshiba Aquilion system using a detector configuration of 16 x 1.0 mm. Axial 3 mm reconstructions were provided. Imaging was performed following the intravenous administration of 96 mL Optiray 320. Oral contrast was also used.

FINDINGS:
There is minimal basilar subsegmental atelectasis. The visualized portions of the heart and pericardium are unremarkable.

The liver and gallbladder have a normal appearance. A calcified granuloma is present in the spleen. The pancreas, adrenal glands, kidneys, and abdominal aorta all have a normal appearance. There is a tiny fat-containing umbilical hernia.

The appendix has a normal appearance. The urinary bladder is decompressed with a Foley catheter. The prostate is within normal limits in size. No free intraperitoneal fluid or air are detected. No significant osseous abnormalities are identified.

Banner Health
BANNER CHURCHILL COMMUNITY HOSPITAL
801 East Williams Ave
Fallon, NV
89406

Patient: WILEY, MICHAEL
MR#: 139552
DOB: 1/24/1990 **Sex:** Male **Age:** 20 years
Patient Location: 28 EER
Attending Physician: BUNUELJORDANA DO, LEO R

IMPRESSION:
1. No evidence of acute intra-abdominal trauma.
2. Old granulomatous disease.
3. Tiny fat-containing umbilical hernia.

jej
d. 05/04/10 12:25 p.m.
t. 05/04/10 2:05 p.m.

***** Final Report *****

Transcribed Date: 05/04/2010
Signature Date: 05/04/2010 :JDH

Interpreted By: Houston, MD, Jeffrey D
Electronically Signed

Exam Date / Time:	Accession Number:
5/4/2010 12:25:08 PDT	28-CT-10-0002003

CT Cervical Spine W/O Contrast

Reason for exam:
TRAUMA

Report:
CT Cervical Spine Without Contrast

HISTORY:
Neck pain following trauma.

COMPARISON:
None available.

TECHNIQUE:
Multidetector CT of the cervical spine was performed on the Toshiba Aquilion system using a detector configuration of 16 x 1.0 mm. Multiplanar reconstructions were provided. No contrast was administered.

FINDINGS:
There is preservation of the normal cervical lordosis. The cervical vertebrae are in anatomic alignment. The vertebral body heights and disc spaces appear preserved. There is no evidence of acute fracture or pre-vertebral soft tissue swelling. The visualized portions of the skull base are unremarkable.

IMPRESSION:
Normal CT of the cervical spine.

Banner Health
BANNER CHURCHILL COMMUNITY HOSPITAL
801 East Williams Ave
Fallon, NV
89406

Patient: WILEY, MICHAEL
MR#: 139552
DOB: 1/24/1990 **Sex:** Male **Age:** 20 years
Patient Location: 28 EER
Attending Physician: BUNUELJORDANA DO, LEO R

jej
d. 05/04/10 12:17 p.m.
t. 05/04/10 1:55 p.m.

***** Final Report *****

Transcribed Date: 05/04/2010
Signature Date: 05/04/2010 :JLG

Interpreted By: GRIFFITH, MD, JOHN L
Electronically Signed

Exam Date / Time:	Accession Number:
5/4/2010 12:25:08 PDT	28-CT-10-0002004

CT Head/Brain W/O Contrast

Reason for exam:
TRAUMA

Report:
CT Head Without Contrast

HISTORY:
Trauma. Patient under influence of unknown drug and jumped out of two story balcony and then collapsed.

COMPARISON:
None provided.

TECHNIQUE:
Multidetector CT of the head was performed on the Toshiba Aquilion system using a detector configuration of 16 x 1.0 mm. Axial 3 mm reconstructions were provided. No contrast was administered.

FINDINGS:
The ventricles are normal in size, shape, and position. There is no evidence of abnormal extra-axial fluid collections, mass effect, or midline shift. The basal cisterns appear patent. There is no evidence of acute hemorrhage, obvious infarction, or abnormal areas of parenchymal attenuation. The visualized portions of the paranasal sinuses, mastoid air cells, and orbits are unremarkable. No calvarial abnormalities are identified.

IMPRESSION:
Normal CT of the brain without contrast.

jej

Banner Health
BANNER CHURCHILL COMMUNITY HOSPITAL
801 East Williams Ave
Fallon, NV
89406

Patient: WILEY, MICHAEL
MR#: 139552
DOB: 1/24/1990 **Sex:** Male **Age:** 20 years
Patient Location: 28 EER
Attending Physician: BUNUELJORDANA DO, LEO R

d. 05/04/10 12:12 p.m.
t. 05/04/10 2:54 p.m.

***** Final Report *****

Transcribed Date: 05/04/2010
Signature Date: 05/04/2010 :JDH

Interpreted By: Houston, MD, Jeffrey D
Electronically Signed

CARDIOPULMONARY REPORTS

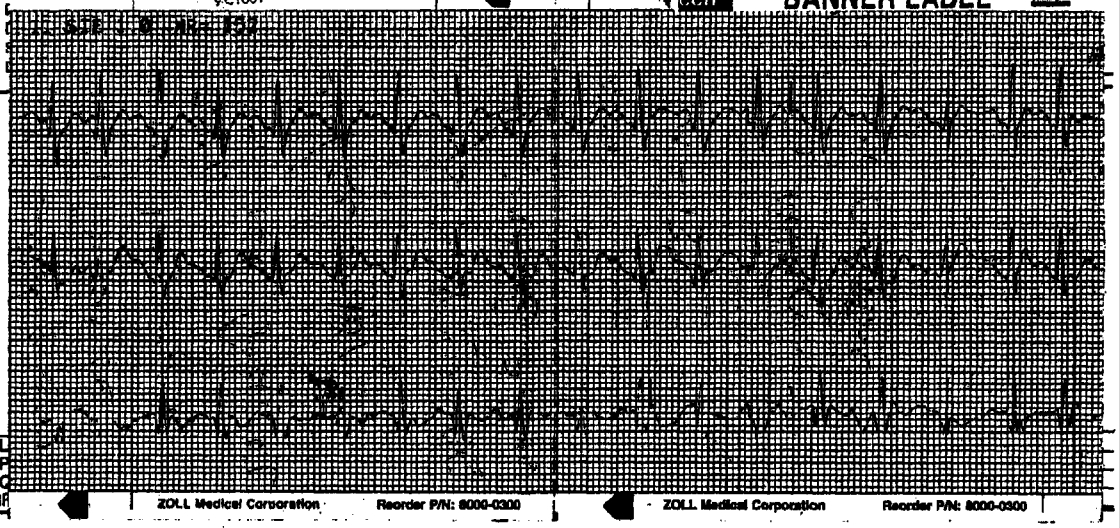
Document Name: .Mounting Forms
Signed by:
Signed Date:

Banner Health

MONITOR RECORD

WILEY, MICHAEL
MR 0139552 01/24/1990
SVC EER M 020Y
Acct 00064181555 5/04/10
CCH BANNER LABEL

PROCEDURE:
1.)
2.)
3.)
4.)



EKG:
INTERP:

REMOVE TO EXPOSE ADHESIVE ENLEVER POUR EXPOSER L'ADHESIF QUITAR PARA EXPONER LA GOMA DE PEGAR

EKG: LEAD _____ QT _____ ARTERIAL: SBP _____ PULMONARY PAS _____ CVP: _____
PR _____ RATE _____ DBP _____ ARTERY: PAD _____ OTHER _____
QRS _____ ALARMS: HIGH _____ LOW _____ PAWP _____ SCALE/CAL: _____
INTERP: _____ SIGNATURE _____

REMOVE TO EXPOSE ADHESIVE ENLEVER POUR EXPOSER L'ADHESIF QUITAR PARA EXPONER LA GOMA DE PEGAR

EKG: LEAD _____ QT _____ ARTERIAL: SBP _____ PULMONARY PAS _____ CVP: _____
PR _____ RATE _____ DBP _____ ARTERY: PAD _____ OTHER _____
QRS _____ ALARMS: HIGH _____ LOW _____ PAWP _____ SCALE/CAL: _____
INTERP: _____ SIGNATURE _____

6001
(07/2007)

6001 Cardiopulmonary Reports

Document Name: .Mounting Forms
Signed by:
Signed Date:

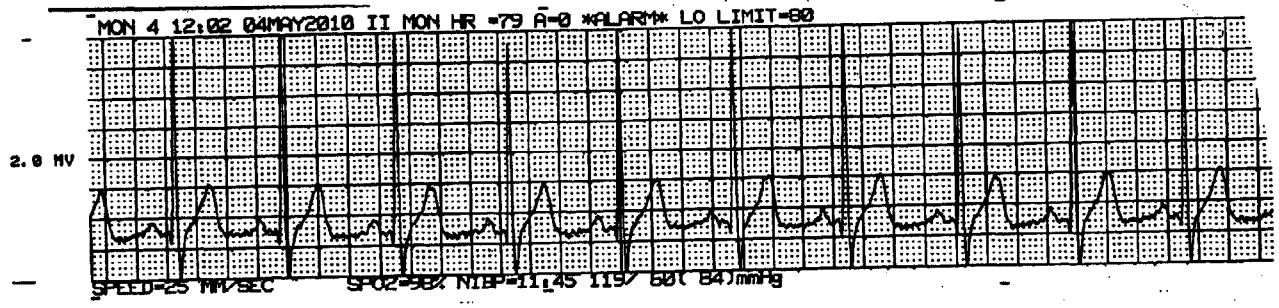
Banner Health

MONITOR RECORD

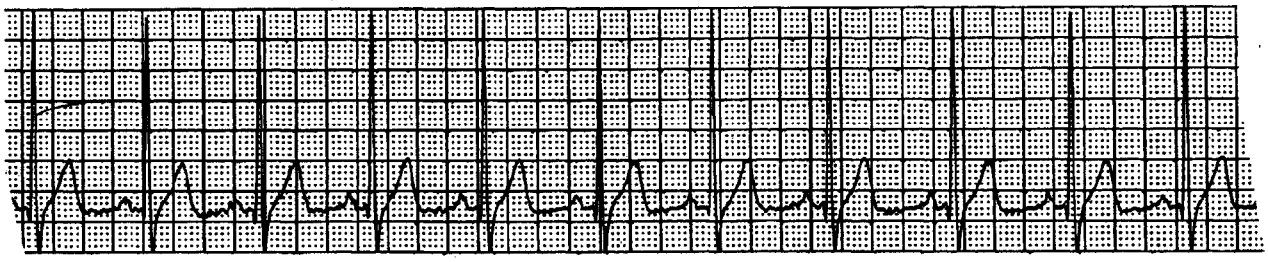
PROCEDURE:

1.) DOCUMENT DATE, TIME, AND PATIENT'S NAME ON EACH STRIP.
2.) DOCUMENT ALL INFORMATION INDICATED FOR EKG READING.
3.) DOCUMENT CRITERIA AS INDICATED FOR OTHER WAVEFORMS INCLUDING SCALE/CAL. AND ALARM LIMITS.
4.) DOCUMENT SIGNATURE AS INDICATED.

WILEY, MICHAEL
MR 0139552 01/24/1990
SVC EER M 020Y
Acct 00064181555 5/04/10
ECH BANNER LABEL



EKG: LEAD ____ QT ____ ARTERIAL: SBP ____ PULMONARY PAS ____ CVP: ____
PR ____ RATE ____ DBP ____ ARTERY: PAD ____ OTHER ____
QRS ____ ALARMS: HIGH ____ LOW ____ PAWP ____ SCALE/CAL: ____
INTERP: ____ SIGNATURE ____



EKG: LEAD ____ QT ____ ARTERIAL: SBP ____ PULMONARY PAS ____ CVP: ____
PR ____ RATE ____ DBP ____ ARTERY: PAD ____ OTHER ____
QRS ____ ALARMS: HIGH ____ LOW ____ PAWP ____ SCALE/CAL: ____
INTERP: ____ SIGNATURE ____

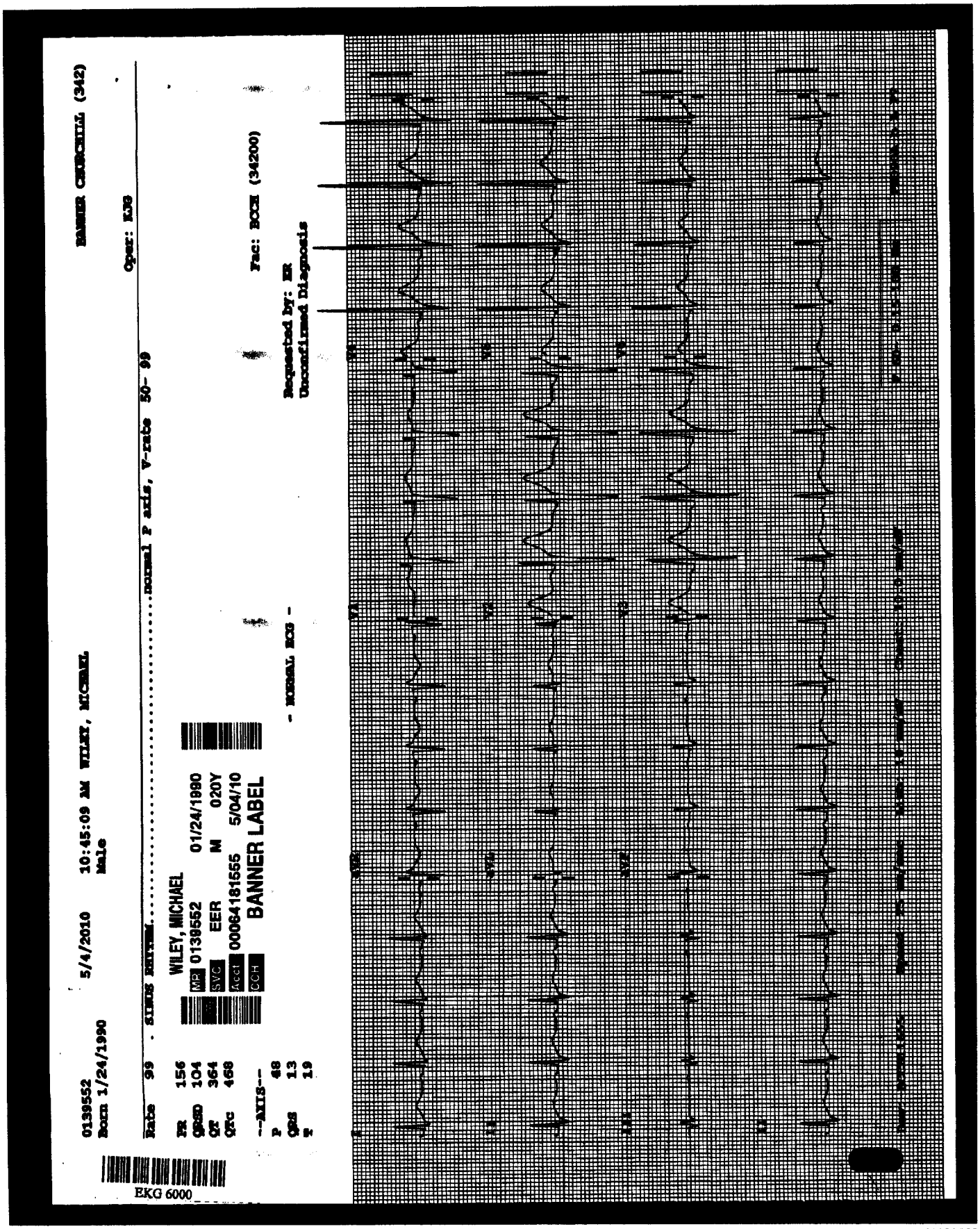
REMOVE TO EXPOSE ADHESIVE ENLEVER POUR EXPOSER L'ADHESIF QUITAR PARA EXPONER LA GOMA DE PEGAR

EKG: LEAD ____ QT ____ ARTERIAL: SBP ____ PULMONARY PAS ____ CVP: ____
PR ____ RATE ____ DBP ____ ARTERY: PAD ____ OTHER ____
QRS ____ ALARMS: HIGH ____ LOW ____ PAWP ____ SCALE/CAL: ____
INTERP: ____ SIGNATURE ____

6001
(07/2007)

6001 Cardiopulmonary Reports

Document Name: .EKG
Signed by:
Signed Date:


BANNER CHURCHILL (342)
0139552
Born 1/24/1990
5/4/2010 10:45:09 AM WILEY, MICHAEL
Male
Qser: KJS
Rate 99 . Sinus Rhythm.....Normal P axis, V-rate 50- 99
PR 156
QRSD 104
QT 364
QTc 468
--AXIS--
P 48
QRS 13
T 19
WILEY, MICHAEL
MR 0139552 01/24/1990
SVC EER M 020Y
Acct 00064181555 5/04/10
DCH BANNER LABEL
- NORMAL ECG -
Fac: BCCH (34200)
Requested by: ER
Unconfirmed Diagnosis
EKG 6000

ALL CLINICALLY PERTINENT INFORMATION HAS BEEN PRINTED ON THE PREVIOUS PAGE(S).

Banner Churchill Community Hospital
EMERGENCY FLOW SHEET RECORD
Name: Wiley, Michael Age: 20Y MR: 0139552 Acct: 00064181555

VITAL SIGNS	PH3	PH3	JDS	PH3	PH3
TIME	5/4/2010 14:04	5/4/2010 13:54	5/4/2010 13:28	5/4/2010 12:41	5/4/2010 11:41
BP	136/73	136/73	134/73		113/59
PULSE	78	78	74		95
RESP	16	16	14		18
TEMP					
PAIN	0	0			0
O2 SAT	96 on ra	98 on ra			98 on ra

VITAL SIGNS	PH3	PH3	PH3	PH3	PH3
TIME	5/4/2010 11:35	5/4/2010 11:15	5/4/2010 10:55	5/4/2010 10:45	5/4/2010 10:44
BP	87/60	116/52	110/58100	99/59	124/77
PULSE	93	93	16	99	120
RESP	18	18		16	16
TEMP					99.4
PAIN	0			unkn	0
O2 SAT	96 on ra	97 on ra	95 on 4 L	95 on 4 L	94 on 4 L

BANNER CHURCHILL COMMUNITY HOSPITAL
PRIMARY

Wiley, Michael
DOB: 1/24/1990 M20
Wt/Ht:
MedRec: 0139552
AcctNum: 00064181555

Patient Data

Complaint: ALOC
Triage Time: Tue May 04, 2010 10:54
Urgency: Level 2
Bed: ED TRAUMA
Initial Vital Signs: 5/4/2010 10:44
BP:124/77
P:120
O2 sat:94 on 4 L

ED Attending: Bunuel, DO, Leo
Primary RN: Taylor, LPN, Anne

R:16
T:99.4
Pain:0

DISPOSITION

PATIENT: Disposition: Discharged to Home , Condition: Improved . (13:01 LB1)
Destinations: Other , Remove from ER. (14:08 PH3)

DIAGNOSIS (13:01 LB1)

FINAL: PRIMARY: **ALTERED MENTAL STATUS**, ADDITIONAL: **ABRASIONS, SUBSTANCE ABUSE.**

CURRENT MEDICATIONS (10:55 PH3)

Unknown

KNOWN ALLERGIES

Unknown

TRIAGE (Tue May 04, 2010 10:54 PH3)

COMMENT: Pt on back board and c-spine precautions. (Tue May 04, 2010 10:54 PH3)
COMPLAINT: ALOC. (Tue May 04, 2010 10:54 PH3)
PROVIDERS: TRIAGE NURSE: Pam Hendrix, RN. (Tue May 04, 2010 10:54 PH3)
ADMISSION: URGENCY: Level 2 , ADMISSION SOURCE: Home , TRANSPORT: Ambulance/ALS , BED: TRAUMA 1. (Tue May 04, 2010 10:54 PH3)
PATIENT: NAME: Wiley, Michael, AGE: 20, GENDER: male, DOB: Wed Jan 24, 1990, TIME OF GREET: Tue May 04, 2010 11:35, LANGUAGE: ENGLISH , SSN: 595929201, Zip Code: 89406, MEDICAL RECORD NUMBER: 0139552, ACCOUNT NUMBER: 00064181555, PERSON ID: 300051679, PCP: NAS Fallon. (Tue May 04, 2010 10:54 PH3)
PRE-HOSPITAL TREATMENT/CARE PTA: See EMS Record, C-Collar in place, Backboard/Spineboard in place, Patient on cardiac monitor, Rhythm: ST, IV in place, Size: 20 g , Site: Rt FA, Patient on oxygen, via nasal canullae, Medications Given, Ativan 1 mg IVP by EMS. (Tue May 04, 2010 10:54 PH3)
ARRIVAL INFORMATION: History obtained, from EMS personnel. (Tue May 04, 2010 10:54 PH3)
TRIAGE ASSESSMENT: **PEr EMS, witnesses stated pt jumped from 2 story balcony and ran across rocks and fell into ditch. Pt was alerted on arrival. Pt placed on backboard and c-collar. 20 g to rt FA inserted. PT opens eyes to verbal stimuli, will answer some questions. Per EMS, K-2 found in pt's room. Pt remains altered, Responses to verbal stimuli. Pt to trauma placed on monitor. IV inserted into lt FA by C. Greer, RN. Foley cath inserted without problem. POC discussed with MD, staff verbalized understanding.** . (Tue May 04, 2010 10:54 PH3)
VITAL SIGNS: BP 124/77, Pulse 120, Resp 16, Temp 99.4, Pain 0, O2 Sat 94, on 4 L, Time 5/4/2010 10:44. (10:44 PH3)

VITAL SIGNS

VITAL SIGNS: BP: 124/77, Pulse: 120, Resp: 16, Temp: 99.4, Pain: 0, O2 sat: 94 on 4 L, Time: 5/4/2010 10:44. (10:44 PH3)
BP: 99/59, Pulse: 99, Resp: 16, Pain: unkn, O2 sat: 95 on 4 L, Time: 5/4/2010 10:45. (10:45 PH3)
BP: 110/58100, Pulse: 16, O2 sat: 95 on 4 L, Time: 5/4/2010 10:55. (10:55 PH3)
BP: 116/52, Pulse: 93, Resp: 18, O2 sat: 97 on ra, Time: 5/4/2010 11:15. (11:15 PH3)
BP: 87/60, Pulse: 93, Resp: 18, Pain: 0, O2 sat: 96 on ra, Time: 5/4/2010 11:35. (11:35 PH3)
BP: 113/59, Pulse: 95, Resp: 18, Pain: 0, O2 sat: 98 on ra, Time: 5/4/2010 11:41. (11:41 PH3)
(12:41 PH3)
BP: 134/73, Pulse: 74, Resp: 14, Time: 5/4/2010 13:28. (13:28 JDS)
BP: 136/73, Pulse: 78, Resp: 16, Pain: 0, O2 sat: 98 on ra, Time: 5/4/2010 13:54. (13:54 PH3)
BP: 136/73, Pulse: 78, Resp: 16, Pain: 0, O2 sat: 96 on ra, Time: 5/4/2010 14:04. (14:04 PH3)

MEDICATION ADMINISTRATION SUMMARY

Drug Name	Dose Ordered	Route	Status	Time
*Ativan	1 milligram(s)	IV	Given	12:10 5/4/2010
*Sodium Chloride 0.9%, Intravenous	2 liter(s)	IV	Given	12:09 5/4/2010
*Ativan	1 milligram(s)	IV	Given	12:07 5/4/2010

*Additional information available in notes, Detailed record available in Medication Service section.

HPI MENTAL STATUS CHANGES (12:29 LB1)

SEVERITY: Maximum severity is **moderate**, Currently **symptoms are moderate**. *CHIEF COMPLAINT:* Patient presents for the evaluation of **mental status changes, confusion**. *HISTORIAN:* History obtained from patient, History obtained from EMS. *TIME COURSE:* **Time of onset is unknown, Patient currently has symptoms**. *QUALITY:* GCS: **13, confusion**. *EXACERBATED BY:* Patient's condition exacerbated by nothing. *RELIEVED BY:* Patient's condition relieved by **nothing**. *NOTES:* **PER EMS PT JUMPED OFF BALCONY AND RAN ACROSS ROAD IN UNDERWEAR THEN JUMPED INTO DITCH. COMBATIVE DURING TRAN**

PAST MEDICAL HISTORY

MEDICAL HISTORY: **UNKN.** (Tue May 04, 2010 10:54 PH3)
SURGICAL HISTORY: **UNKN.** (Tue May 04, 2010 10:54 PH3)
PSYCHIATRIC HISTORY: **UNKN.** (Tue May 04, 2010 10:54 PH3)
NOTES: Nursing records reviewed, Agree with nursing records. (12:30 LB1)

ROS (12:30 LB1)

NOTES: All systems not reviewed as the information is unavailable, **Emergency room caveat invoked due to patient with mental status changes.**

PHYSICAL EXAM (12:30 LB1)

CONSTITUTIONAL: Patient is afebrile, Vital signs reviewed, Patient has normal blood pressure, Patient has normal respiratory rate, Well appearing, **Tachycardic, ALERT, SPEECH GARBLED**.
HEAD: Atraumatic, Normocephalic.
EYES: Eyes are normal to inspection, Pupils equal, round and reactive to light, No discharge from eyes, Extraocular muscles intact, Sclera are normal, Conjunctiva are normal.
ENT: Ears normal to inspection, Nose examination normal, Posterior pharynx normal, Mouth normal to inspection.
NECK: Normal ROM, No jugular venous distention, No meningeal signs, Cervical spine nontender.
RESPIRATORY CHEST: Chest is nontender, Breath sounds normal, No respiratory distress.

CARDIOVASCULAR: No murmurs, Normal S1 S2, No rub, No gallop, **Rate is tachycardic.**
ABDOMEN: Abdomen is nontender, No masses, Bowel sounds normal, No distension, No peritoneal signs, **ABRASIONS LAT ABD.**
BACK: There is no CVA Tenderness, There is no tenderness to palpation, Normal inspection.
UPPER EXTREMITY: Inspection normal, No cyanosis, No clubbing, No edema, Normal range of motion, Normal pulses.
LOWER EXTREMITY: Inspection normal, No cyanosis, No clubbing, No edema, Normal range of motion, No calf tenderness, Normal pulses, **MULTIPLE ABRASIONS TO FEET LOWER LEGS AND THIGHS.**
NEURO: GCS is 15, No focal motor deficits, Cranial nerves intact, **MOVING ALL 4 PUPOSEFULLY, WILL NOT COOPERATE WITH EXAM.**
SKIN: **AS ABOVE.**
NOTES: **INITIAL EXAM ON BOARD, IN COLLAR. POST IMAGING CLEARED FROM COLLAR AND BOARD.**

RADIOLOGY INTERPRETATION (12:33 LB1)

HEAD: Interpretation of the Head CT shows, head negative, no bleed, no mass, no acute ischemic stroke, no acute changes.
NECK: Interpretation of C-spine CT shows, C-spine negative, no fracture, no subluxation, no bony lesion, no cord compression.
ABDOMEN: Interpretation of CT Abdomen/Pelvis shows, abdomen/pelvis negative, no AAA, no appendicitis, no diverticulitis, no kidney stones, no injuries, no masses, no obstruction, no free air, no hydronephrosis.

DOCTOR NOTES (12:33 LB1)

TEXT: **REPEAT EXAM PT STATES HE TOOK "SPICE". ORIENTED NOW TO PERSON AND PLACE. SPEECH CLEAR AND CONTENT LOGICAL. .**

INSTRUCTION (13:01 LB1)

DISCHARGE: SUBSTANCE / DRUG ABUSE .
SPECIAL: SEE BASE MEDICAL TOMORROW AM.

PRESCRIPTION

No recorded prescriptions

RESULTS (11:32 LB1)

LABORATORY:

Measurement	Result	Units	Range
Drugs of Abuse Screen Tue May 04, 2010 10:56			
Phencyclidine Screen, UR	Negative		Negative
Amphetamine Screen, UR	Negative		Negative
Cocaine Screen, UR	Negative		Negative
Tricyclic Screen, UR	Negative		Negative
Cannabinoid (THC) Screen, UR	Negative		Negative
Benzodiazepine Screen, UR	Negative		Negative
Opiate Screen, UR	Negative		Negative
Barbiturate Screen, UR	Negative		Negative
Methadone Screen, UR	Negative		Negative
Testing performed at Banner Churchill Community Hospital Laboratory			
801 East Williams Ave			
Fallon			
NV 89406			

BANNER CHURCHILL COMMUNITY HOSPITAL
PRIMARY

Wiley, Michael
DOB: 1/24/1990 M20
Wt/Ht:
MedRec: 0139552
AcctNum: 00064181555

Measurement	Result	Units	Range
Ethanol Quant Tue May 04, 2010 10:50			
Ethanol, Plasma	<5	mg/dL	<=10
Nevada legal intoxication level is >/= to 80 mg/dl.			
Testing performed at Banner Churchill Community Hospital Laboratory			
801 East Williams Ave			
Fallon			
NV 89406			

Measurement	Result	Units	Range
Comprehensive Metabolic Panel GFR Tue May 04, 2010 10:50			
Sodium	136	mmol/L	135–145
Potassium	3.5	mmol/L	3.5–5.2
Chloride	102	mmol/L	96–110
CO2	18	mmol/L	13–29
Anion Gap	16		4–16
Glucose Level	**220**	**mg/dL**	**65–99**
BUN	17	mg/dL	8–25
Creatinine	1.2	mg/dL	.4–1.4
BUN/Creat Ratio	14		10–28
Protein, Total	6.8	g/dL	5.4–7.8
Albumin	4.2	g/dL	2.9–4.8
Alb/Glob Ratio	1.6		1.0–2.0
Calcium	8.5	mg/dL	8.4–10.2
Alkaline Phos	55	IU/L	52–390
ALT	29	IU/L	4–60
AST	39	IU/L	10–70
Bilirubin Total	0.7	mg/dL	0.3–1.2
Estimated Glomerular Filtration Rate	>60	mL/min/1.73 m2	>=61
The GFR calculated and is age and sex adjusted			
Multiply eGFR result by 1.21 if patient is African American.			
Testing performed at Banner Churchill Community Hospital Laboratory			
801 East Williams Ave			
Fallon			
NV 89406			

Measurement	Result	Units	Range
Acetaminophen Level Tue May 04, 2010 10:50			
Acetaminophen Level	**<5**	**ug/mL**	**10–20**
Testing performed at Banner Churchill Community Hospital Laboratory			
801 East Williams Ave			
Fallon			
NV 89406			

Measurement	Result	Units	Range
Salicylate Level Tue May 04, 2010 10:50			
Salicylate	<4.0	mg/dL	4.0–30.0
Testing performed at Banner Churchill Community Hospital Laboratory			
801 East Williams Ave			
Fallon			
NV 89406			

Measurement	Result	Units	Range
Differential Cell Count Tue May 04, 2010 10:50			
Result Below			
Automated Diff Added by System			
Segs	53	%	40–85
Lymphs	39	%	10–45
Monos	6	%	3–15
Eos	2	%	0–7
Basos	1	%	0–2

Absolute Neutrophil Count	3.39	K/ul	>=1.00
Calculated by Cerner Rule			
Diff Type	Auto Diff Perf		
Testing performed at Banner Churchill Community Hospital Laboratory			
801 East Williams Ave			
Fallon			
NV 89406			

Measurement	Result	Units	Range
Complete Blood Count Tue May 04, 2010 10:50			
WBC	6.4	K/MM3	4.0–11.0
RBC	5.16	M/MM3	4.30–6.00
Hgb	14.9	g/dL	13.5–17.0
Hct	44.6	%	40.0–53.0
MCV	86	fL	86–110
MCH	28.9	pg	27.0–34.0
MCHC	33.4	g/dL	31.0–37.0
RDW	13.6	%	11.0–16.0
Platelet	160	K/MM3	130–450
Testing performed at Banner Churchill Community Hospital Laboratory			
801 East Williams Ave			
Fallon			
NV 89406			

GREET (11:35)
GREET: Greet: Tue May 04, 2010 11:35.

NURSING ASSESSMENT: HEAD-TO-TOE (11:00 PH3)
CONSTITUTIONAL: Patient's skin is warm and dry, Patient's mucous membranes are moist and pink, Complex assessment performed, Patient arrives to treatment area **via EMS, History obtained from EMS, Patient appears intoxicated, Patient is uncooperative, Patient is confused, Patient has slurred speech,** Patient is **oriented to person,** Skin color is normal, Skin temperature is warm, Skin moisture is **dry.**
SKIN: Skin warm and dry, No rashes present, No Drainage, No skin ulcers noted, **Pt has multiple abrasions to lt and rt great toes and second toes on both feet. .**
NEURO: Patient denies paresthesias, No facial droop noted, Patient denies headache, Patient denies nausea, Patient denies vomiting, GCS Eye Opening: **3**, GCS Verbal Response: **4**, GCS Motor Response: **5**, The GCS total is **12, Left pupil is 5mm, Right pupil is 5mm,** Left pupil is **dilated, sluggish,** Right pupil is **dilated, sluggish, PT found down in ditch, with low O2 sat. .**
NECK: Patient denies neck pain, Trachea midline, Patient's neck nontender, No jugular venous distention noted, Spinal immobilization maintained with **cervical collar, use of long board, Pt, per witnesses, jumped from 2nd story balcony, then ran across a field and into a ditch. .**
BACK: Patient denies back pain, Patient denies CVA tenderness, No obvious signs of trauma noted to back, Patient has strong pulses to upper and lower extremities bilaterally, **Pt on back board at this time. .**
RESPIRATORY/CHEST: Breath sounds clear bilaterally, Equal chest expansion, No complaint of pain, No acute respiratory distress, No intercostal retractions, No supraclavicular retractions, No nasal flaring, No cough, No jugular vein distension, No orthopnea, Left breath sounds clear, Right breath sounds clear, Continuous pulse oximetry 97%.
CARDIOVASCULAR: Patient denies chest pain, No extremity edema noted, Positive peripheral pulses bilaterally, Bilateral blood pressures equal, No muffled heart tones, Patient on cardiac monitor showing **sinus tachycardia,** Left radial pulse normal, Left pedal pulse normal, Right radial pulse normal, Right pedal pulse normal.
ABDOMEN: Patient denies abdominal pain, Abdomen is soft to palpation, nontender, non-distended, Positive bowel sounds in all 4 quadrants, Patient denies nausea, Patient denies vomiting, Patient denies diarrhea, Patient

denies constipation, Patient denies flank tenderness, No pulsatile masses noted to abdomen.
GENITOURINARY MALE: No discharge, No urinary complaints, No priapism, No scrotal swelling, No scrotal discoloration, No hernias noted, Patient is uncircumcised, **Cath placed by C. Greer, RN.**
LEFT UPPER EXTREMITY: Normal pulses, Brisk capillary refill, Sensation intact, No numbness/tingling, Full range of motion.
RIGHT UPPER EXTREMITY: Normal pulses, Brisk capillary refill, Sensation intact, No numbness/tingling, Full range of motion.
LEFT LOWER EXTREMITY: No complaint of pain, Pedal pulses present, Brisk capillary refill, Sensation intact, Patient denies numbness/tingling, Normal pulses, No external rotation, No shortening, Homan's sign negative, **Pt has abrasions to great and second toe.** .
RIGHT LOWER EXTREMITY: Pedal pulses present, Brisk capillary refill, Sensation intact, Patient denies numbness/tingling, Full range of motion, Normal pulses, No external rotation, No shortening, Homan's sign negative, **PT has abrasions to great and second toes.** .
SAFETY: Side rails up, Cart in lowest position, Call light within reach, Friend at bedside, Physician notified of above findings.

NURSING PROCEDURE: NURSE NOTES

TIME: Time: 1055, **Pt to CT scan via gurney, pt on monitor with RN. Pt given Ativan 1 mg IVP into rt AC for agitation. Pt remains confused, agitated at this time. Will cont to monitor.** . (11:00 PH3)
Time: 1155, **Pt returned from CT scan, pt more alert and oriented. Pt removed from c-collar and back board. Pt no longer on O2, O2 sat remains >90% on RA. Soft restraints removed in CT without problem. Pt cooperative at this time. Given apple juice to drink. Abrasions to feet cleaned with SNS and patted dry. Pt continues to c/o having to void. Explained that he has catheter. Pt verbalized understanding. Pt now sleeping in trauma. IV fluids cont to infuse. POC discussed with pt who verbalized understanding.** . (12:27 PH3)
Time: 1240, **Foley catheter d/ced without problem. 10 ml saline removed from balloon. Foley bag had 800ml yellow urine. Pt tolerated procedure without problem.** . (13:14 PH3)
Time: 1315, **Pt up to stand by gurney, voided 30 ml yellow urine. C/O pain with urination, explained that he had had a catheter and that was what was causing the burning. Pt verbalized understanding. Assisted back to gurney, and pt fell asleep.** . (14:02 PH3)

NURSING PROCEDURE: DISCHARGE NOTE (14:04 PH3)

VITAL SIGNS: BP: 136, / 73, Pulse: 78, Resp: 16, Pain: 0, O2 sat: 96, on: ra, Time: 1354.
TIME: Patient discharged at 1352, Patient discharged to, work, other, Patient, ambulates without assistance, Transported via friend/family driving, Accompanied by friend, Patient instructed not to drive home, IV discontinued with catheter intact. Dressing placed to IV site, Discharge instructions given to, patient, Simple/moderate discharge teaching performed, Teaching performed by P HEndrix,RN, Name of prescription(s) given: none, Above Person(s) verbalized understanding of discharge instructions and follow-up care, Patient treated and evaluated by physician.

NURSING PROCEDURE: IV

VITAL SIGNS: BP: 134, / 73, Pulse: 74, Resp: 14. (13:28 JDS)
SITE 1: Patient's identity verified by, hospital ID bracelet, Indications for procedure: fluid replacement, Indications for procedure: medication administration, Procedure performed at 1100, IV established for hydration, IV established for venous access, 20 gauge catheter inserted, into left forearm, in 1 attempt, Saline lock established, flushed with normal saline, Labs drawn at time of placement. (12:09 CG1)
IV discontinued with catheter intact, at 1329, Discontinued due to, patient being discharged. (13:28 JDS)
SITE 2: IV discontinued with catheter intact, at 1329, Discontinued due to, patient being discharged, Procedure done by d tabbert, rn. (13:28 JDS)

NURSING PROCEDURE: URINE COLLECTION (10:54 PH3)
URINE COLLECTION MALE: Patient's identity verified by, hospital ID bracelet, Other indication for procedure ALOC, Procedure performed at 1040, 16fr simple foley catheter inserted, in 1 attempt, Amount **200**, ml, Specimen labeled in the presence of the patient and sent to lab, **Catheter placed by C. Greer, RN.**

ADMIN
DIGITAL SIGNATURE: Greer, RN, Cindy. (12:11 CG1)
Bunuel, DO, Leo. (Wed May 05, 2010 07:35 LB1)
PATIENT DATA CHANGE: Attending changed from (none) to Leo Bunuel, DO. (10:58 LB1)
Primary Nurse changed from (none) to Pam Hendrix, RN. (12:12 PH3)
Primary Nurse changed from Pam Hendrix, RN to Anne Taylor, LPN. (13:36 AT1)

MEDICATION SERVICE
Ativan: Order: Ativan (Lorazepam) : Solution – **Dose:** 1 milligram(s) : IV
Notes: MAY REPEAT IN 15MIN PRN AGITATION
Ordered by: Leo Bunuel, DO
Entered by: Leo Bunuel, DO Tue May 04, 2010 11:59
Documented as given by: Pam Hendrix, RN Tue May 04, 2010 12:07
Patient, Medication, Dose, Route and Time verified prior to administration.
Amount given: 1mg at 1055, IV SITE #1 IVP, initial medication, Slowly, Pre-administration assessment shows O2 saturation reading 96%, Pre-administration assessment shows O2 AMT: 4L, Pre-administration assessment shows On oxygen, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient in position of comfort, Side rails up, Cart in lowest position, Pt in soft restraints, ALOC at this time.
: *Follow Up :* Response assessment performed, No signs or symptoms of allergic reaction noted, Site inspection shows, No swelling at administration site, No drainage at administration site, No bleeding at site, No bruising noted at site, Pt to CT via gurney. Pt calmer during transport, became agitated in CT. . (11:10 PH3)
Ativan: Order: Ativan (Lorazepam) : Solution – **Dose:** 1 milligram(s) : IV
Notes: MAY REPEAT IN 15MIN PRN AGITATION
Ordered by: Leo Bunuel, DO
Entered by: Pam Hendrix, RN Tue May 04, 2010 12:10
Documented as given by: Pam Hendrix, RN Tue May 04, 2010 12:10
Patient, Medication, Dose, Route and Time verified prior to administration.
Amount given: 1 mg at 1110, IV SITE #1 IVP, subsequent different medication, Slowly, Pre-administration assessment shows O2 saturation reading 96%, Pre-administration assessment shows O2 AMT: R.A., Pre-administration assessment shows on room air, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient in position of comfort, Side rails up, Cart in lowest position.
: *Follow Up :* Response assessment performed, No signs or symptoms of allergic reaction noted, Pt calmer at this time. . (11:30 PH3)

Sodium Chloride 0.9%, Intravenous: Order: Sodium Chloride 0.9%, Intravenous (Sodium Chloride) : Solution – **Dose:** 2 liter(s) : IV
Notes: BOLUS 2 LITRES I.V.
Ordered by: Leo Bunuel, DO
Entered by: Leo Bunuel, DO Tue May 04, 2010 11:58
Documented as given by: Pam Hendrix, RN Tue May 04, 2010 12:09
Patient, Medication, Dose, Route and Time verified prior to administration.
Amount given: 1 ltier hung at 1130, IV SITE #1 IV fluids established for hydration, IV SITE #1 into left wrist, IV SITE #1 1st bag hung, IV SITE #1 bolus of 1000 ml established, IV SITE #1 Rate of bolus, wide open, via gravity tubing, Pre–administration assessment shows O2 saturation reading 96%, Pre–administration assessment shows O2 AMT: R.A., Pre–administration assessment shows on room air, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side–effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient in position of comfort, Side rails up, Cart in lowest position, Friend at bedside.
: *Follow Up :* Response assessment performed, No signs or symptoms of allergic reaction noted, No change in pain, 1st bag completed at 1240, 2nd bag hung at 1242.
2nd bag completed at 1325. . (14:08 PH3)

Key:
AT1=Taylor, LPN, Anne CG1=Greer, RN, Cindy JDS=Schultz, RN, Joy LB1=Bunuel, DO, Leo PH3=Hendrix, RN, Pam

BANNER CHURCHILL COMMUNITY HOSPITAL
LAB RESULTS

Wiley, Michael
DOB: 1/24/1990 M20
Wt/Ht:
MedRec: 0139552
AcctNum: 00064181555

RESULTS (11:32 LB1)
LABORATORY:

Measurement	Result	Units	Range
Drugs of Abuse Screen Tue May 04, 2010 10:56			
Phencyclidine Screen, UR	Negative		Negative
Amphetamine Screen, UR	Negative		Negative
Cocaine Screen, UR	Negative		Negative
Tricyclic Screen, UR	Negative		Negative
Cannabinoid (THC) Screen, UR	Negative		Negative
Benzodiazepine Screen, UR	Negative		Negative
Opiate Screen, UR	Negative		Negative
Barbiturate Screen, UR	Negative		Negative
Methadone Screen, UR	Negative		Negative
Testing performed at Banner Churchill Community Hospital Laboratory			
801 East Williams Ave			
Fallon			
NV 89406			

Measurement	Result	Units	Range
Ethanol Quant Tue May 04, 2010 10:50			
Ethanol, Plasma	<5	mg/dL	<=10
Nevada legal intoxication level is >/= to 80 mg/dl.			
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Fallon			
NV 89406			

Measurement	Result	Units	Range
Comprehensive Metabolic Panel GFR Tue May 04, 2010 10:50			
Sodium	136	mmol/L	135–145
Potassium	3.5	mmol/L	3.5–5.2
Chloride	102	mmol/L	96–110
CO2	18	mmol/L	13–29
Anion Gap	16		4–16
Glucose Level	**220**	**mg/dL**	**65–99**
BUN	17	mg/dL	8–25
Creatinine	1.2	mg/dL	.4–1.4
BUN/Creat Ratio	14		10–28
Protein, Total	6.8	g/dL	5.4–7.8
Albumin	4.2	g/dL	2.9–4.8
Alb/Glob Ratio	1.6		1.0–2.0
Calcium	8.5	mg/dL	8.4–10.2
Alkaline Phos	55	IU/L	52–390
ALT	29	IU/L	4–60
AST	39	IU/L	10–70
Bilirubin Total	0.7	mg/dL	0.3–1.2
Estimated Glomerular Filtration Rate	>60	mL/min/1.73 m2	>=61
The GFR calculated and is age and sex adjusted			
Multiply eGFR result by 1.21 if patient is African American.			
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801 East Williams Ave			
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Measurement	Result	Units	Range
Acetaminophen Level Tue May 04, 2010 10:50			
Acetaminophen Level	**<5**	**ug/mL**	**10–20**
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801 East Williams Ave			
Fallon			

BANNER CHURCHILL COMMUNITY HOSPITAL
LAB RESULTS

Wiley, Michael
DOB: 1/24/1990 M20
Wt/Ht:
MedRec: 0139552
AcctNum: 00064181555

NV 89406

Measurement	Result	Units	Range
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Salicylate	<4.0	mg/dL	4.0–30.0
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801 East Williams Ave			
Fallon			
NV 89406			

Measurement	Result	Units	Range
Differential Cell Count Tue May 04, 2010 10:50			
Result Below			
Automated Diff Added by System			
Segs	53	%	40–85
Lymphs	39	%	10–45
Monos	6	%	3–15
Eos	2	%	0–7
Basos	1	%	0–2
Absolute Neutrophil Count	3.39	K/ul	>=1.00
Calculated by Cerner Rule			
Diff Type	Auto Diff Perf		
Testing performed at Banner Churchill Community Hospital Laboratory			
801 East Williams Ave			
Fallon			
NV 89406			

Measurement	Result	Units	Range
Complete Blood Count Tue May 04, 2010 10:50			
WBC	6.4	K/MM3	4.0–11.0
RBC	5.16	M/MM3	4.30–6.00
Hgb	14.9	g/dL	13.5–17.0
Hct	44.6	%	40.0–53.0
MCV	86	fL	86–110
MCH	28.9	pg	27.0–34.0
MCHC	33.4	g/dL	31.0–37.0
RDW	13.6	%	11.0–16.0
Platelet	160	K/MM3	130–450
Testing performed at Banner Churchill Community Hospital Laboratory			
801 East Williams Ave			
Fallon			
NV 89406			

Key:
LB1=Bunuel, DO, Leo