REQUEST FOR PRIVATE MEDICAL INFORMATION

For use of this form, see AR 40-66; the proponent agency is the OTSG

1. Date (YYYYMMDD): 20100908

2. Patient's Name and SSN.
Chaji HOUDA, 804-81-8483
Dependant of Khalid BELKHATIR, 131-88-4949

3. Medical Treatment Facility (Name and Location)
Weed Army Community Hospital,
Fort Irwin, CA 92310

4. Reason for Request.
Request the below listed documents or information in accordance with AR 40-66, Ch 2-4(1); AR 340-21, Ch 3-1 (a); and AR 195-2, Ch 3-15 (a&b) which are required for a matter currently under investigation by this office.
1. This request is made pursuant to HIPAA, paragraph 45 CFR, 164.512 (f)(1)(ii)(c), as an administrative request and authorized investigation demand authorized by law. I certify that:
A. The information sought is relevant and material to a legitimate law enforcement inquiry.
B. The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which is sought; and
C. There is no de-identified information that could reasonably be used due to the requirement for specific information on

5. Private Medical Information Sought (*Specify dates of hospitalization or clinic visits and diagnosis, if known)*

Medical Records pertaining to dates: 16 Aug 10 to current.

6. Requestor's Name, Title, Organization and SSN.
Special Agent Pierre D. TRAN:
Fort Irwin Resident Agency (CID)
Fort Irwin, CA 92310

Signature

FOR USE OF MEDICAL TREATMENT FACILITY ONLY

7. Check applicable box.

☒ Approved ☐ Disapproved *(State reason for disapproval)*

8. Summary of Private Medical Information Released.
- SF600 8-20-10, 8-22-10
Nothing Follows

9. Signature of Approving Official.
Claudia Beck

10. Date (YYYYMMDD): 20100928

DA FORM 4254, FEB 2003 DA FORM 4254-R, NOV 91, IS OBSOLETE. APD PE v1.02ES

Patient: **CHAJI, HOUDA**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **20 Aug 2010 1112 PDT**
Clinic: **EMERGENCY ROOM WACH**

Appt Type: **ACUT**
Provider: **FINMAN,JOEL R**

Reason for Appointment: LOC

AutoCites Refreshed by MYATT,CRYSTAL L @ 20 Aug 2010 1122 PDT

Problems
Chronic:
- Recent weight gain
- General counseling on contraception
- Cervical Pap smear
- Insomnia
- Gastroenteritis
- Xerosis cutis

Family History
- Family medical history (General FHx)
- No Family History of heart disease (General FHx)
- No Family History of cancer (General FHx)

Allergies
- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Tri-Cyclen/Tri-Nessa/Tri-Sprintec Tablet Oral	Active	TAKE ONE TAB BY MOUTH ONCE DAILY, START ON 1ST SUNDAY AFTER ONSET OF MENSES #3 RF3	3 of 3	08 Apr 2010
ISOMETH-D-CHLORALPHENAZ-APAP (ISOMETHEPT/ACETAMINOP/DICHLPHN), 65-325-100, CAPSULE, ORAL, AMNEAL PHARMACE, 100 ea. BOTTLE	Active		5 of 5	30 Aug 2009
NECON (NORETHINDRONE-ETHINYL ESTRAD), 1 MG-35MCG, TABLET, ORAL, WATSON LABS, 28 ea. BLIST PACK	Active		12 of 12	30 Aug 2009
FLUTICASONE PROPIONATE (FLUTICASONE PROPIONATE), 50 MCG, SPRAY SUSP, NASAL, APOTEX CORP, 16 g AER W/ADAP	Active		1 of 1	03 May 2009
CEPHALEXIN (CEPHALEXIN MONOHYDRATE), 500 MG, CAPSULE, ORAL, TEVA USA, 500 ea. BOTTLE	Active		NR	03 May 2009
FEXOFENADINE HCL (FEXOFENADINE HCL), 180 MG, TABLET, ORAL, DR.REDDY'S LAB, 500 ea. BOTTLE	Active		1 of 1	03 May 2009
BUSPIRONE HCL (BUSPIRONE HCL), 10 MG, TABLET, ORAL, MYLAN, 100 ea. BOTTLE	Active		1 of 1	05 Jan 2009

LMP: 25 Jan 2010. Date Basis: unknown.

Vitals
Vitals Written by BROOKER,NICOLE A @ 20 Aug 2010 1153 PDT
BP: 122/81, HR: 101, SpO_2: 100%
Vitals Written by BROOKER,NICOLE A @ 20 Aug 2010 1139 PDT
BP: 103/69, HR: 81, SpO_2: 100%
Vitals Written by BROOKER,NICOLE A @ 20 Aug 2010 1131 PDT
BP: 109/70, HR: 61, RR: 16, T: 99.7 °F, SpO_2: 100%

SO Note Written by BROOKER,NICOLE A. @ 20 Aug 2010 1129 PDT
Chief complaint
The Chief Complaint is: 30 y/o female brought to ER by EMS for c/o 'LOC'. Pt. was at the MWC and reports states that she was fasting for Ramadan. Bld. glucose level 81 on scene. PT. arrived in ER with GCS of 6, stable BP and HR. NRB mask applied and O2 sat is 100%. Written by NBrooker RH.
History of present illness
The Patient is a 30 year old female.
She reported: Past medical history reviewed and updated in patient problem list and medication list reviewed . Home medication list (to include OTC- herbals- and nutritional supplements) was reviewed with the patient/family member and updated if medications were changed- added- or deleted. List was returned to the patient/family member.
No anxiety, no high irritability, no hostility, and no depression.

Allergies
No allergies Reviewed allergy information and updated as necessary. No allergy to latex.
Past medical/surgical history
Reported History:
Recent events: Patient not observed being agitated.
Surgical / procedural: Surgical / procedural history reviewed and updated in patient problem list.
Legal documents on file for health care management: Health care proxy not in chart Advance Directives.
Personal history
Category: 1-5 1.
Home environment: Difficulty understanding spoken English . Requires an interpreter No pt. speaks english per pharmacist Cpt. Douchi and the native language is.
Abuse / neglect: Not physically abused and no physical neglect.
Physical findings
Lungs:
- Respiration rhythm and depth was abnormal. ° No intercostal inspiratory retraction was observed. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Therapy
- Immunizations reviewed and current. Transportation to a medical facility in a private vehicle.
- Disposition - Pt. brought to the trauma room. MD and Anesthesia at bedside.

SO Note Written by FINMAN,JOEL R @ 22 Aug 2010 1232 PDT
Reason for Visit
Visit for: collapse at clinic, nonresponsive.
Past medical/surgical history
Reported History:
Past medical history: Autocites reviewed.
Subjective
Pt arrives via EMS after incident at Clinic where she apparently reported feeling dizzy and ultimately collapsed. Evaluated promptly by medical personnel on scene, with no response to stimuli. Additional history not available at time of arrival at ED, other than report that pt may be fasting.
Physical findings
Vital signs:
° Current vital signs reviewed, WNL on arrival, breathing unassisted, with good radial pulses on my exam.
General appearance:
- General appearance: pt not responding to noxious stimuli on initial presentation, though subsequently observed to have brief but deliberate and directed eye contact/tracking with me within minutes after arrival. GCS 6 on arrival. Respirations remain steady, vitals WNL. Glucometer reading at scene reported at 86.

Head:
° Normal, no blood, no hematoma or other sign of injury.
Eyes:
General/bilateral:
- Eyes: eyes open intermittently, unrelated to stimuli initially. Pupils equal, reactive, with brief but purposeful tracking.

Ears, Nose, Throat:
° ENT: normal, no blood or vomitus.
Lungs:
° Normal, clear, symmetric breath sounds.
Cardiovascular system:
° Normal, regular rhythm, palpable radial pulses.
Abdomen:
° Normal, soft, no mass, no ecchymosis or distention.
Musculoskeletal system:
General/bilateral: ° Musculoskeletal system: normal no gross deformity or evident injury.
Neurological:
- System: pt not responding to stimuli initially, despite intermittent/inconsistent eye opening. No movement of extremities, flaccid arm drop.

Skin:
° Normal.
Objective
See timeline below regarding specific times; IV access obtained x 2, NS infusing. Labs drawn. D50 amp given without change in status. Narcan 0.4mg given with initial eye opening (brief), but no lasting change. No change with second Narcan dose. Pt observed to respond with eye blink to forehead tap, and opens eyes with deliberate/purposeful eye contact and tracking briefly but

inconsistently. Foley placed, urine sample collected. Pt to Radiology for head/neck CT, with increased responsiveness beginning while in CT. CT report negative from Radiologist. EKG WNL, normal rhythm. Vitals remain stable. Pt monitored and observed to open eyes and ask to go home after returning from CT, with steady improvement in responsiveness and communication. Tearful at times. Communicating well with CPT Douchi. Labs reviewed as they return, with no alarming findings nor explanation for pt's transient aleration of awareness/responsiveness. IM/FP on call contacted, with subsequent admission to MedSurg for observation, with pt demonstrating normalization of responsiveness/communication and no evident neurologic deficits.

Lab Result Cited by FINMAN,JOEL R @ 22 Aug 2010 1256 PDT

Blood Gas Venous	**Site/Specimen**	**20 Aug 2010 1203**
pO2	BLOOD	**37 (L*)**
pCO2	BLOOD	**31.0 (L*)**
Base Excess	BLOOD	-2
pH	BLOOD	**7.449 (H)**
Bicarbonate	BLOOD	**21.5 (L)**
Lactate	BLOOD	1.43 <r>
TCO2	BLOOD	**22 (L)**
Hemoglobin	BLOOD	**11.9 (L)**
Oxyhemoglobin	BLOOD	73.8
Carboxyhemoglobin	BLOOD	0.0 <i>
Methemoglobin/Hemoglobin	BLOOD	**1.2 (H)**

Ketones	**Site/Specimen**	**20 Aug 2010 1203**
Ketones	SERUM	NEGATIVE <i>

Reducing Substances Clinitest	**Site/Specimen**	**20 Aug 2010 1126**
Reducing Substances Clinitest	URINE	**750-1000 (H*)**

Urinalysis W/Microscopic	**Site/Specimen**	**20 Aug 2010 1126**
Appearance	URINE	CLOUDY
Color	URINE	YELLOW
Leukocyte Esterase	URINE	NEGATIVE
Specific Gravity	URINE	1.020
Bilirubin	URINE	NEGATIVE
Blood	URINE	TRACE-LYSED
Glucose	URINE	500 <r>
Ketones	URINE	>=80
Nitrite	URINE	NEGATIVE
Protein	URINE	NEGATIVE
Urobilinogen	URINE	0.2 <r>
Mucus	URINE	MODERATE
RBC	URINE	0-2
Epithelial Cells Squamous	URINE	0-4

Toxicology Screen Urine	**Site/Specimen**	**20 Aug 2010 1126**
Barbiturates	URINE	NEGATIVE <i>
Benzodiazepines	URINE	NEGATIVE <i>
Cocaine	URINE	NEGATIVE <i>
Opiates	URINE	NEGATIVE <i>
Phencyclidine	URINE	NEGATIVE <i>
Amphetamines	URINE	NEGATIVE <i>
Tetrahydrocannabinol	URINE	NEGATIVE <i>

P10 Panel	**Site/Specimen**	**20 Aug 2010 1125**
Glucose	SERUM	104
Urea Nitrogen	SERUM	10
Creatinine	SERUM	0.74
Sodium	SERUM	138
Potassium	SERUM	3.6
Chloride	SERUM	105
Carbon Dioxide	SERUM	**20 (L) <i>**
Phosphate	SERUM	**2.1 (L)**
Calcium	SERUM	9.6

Magnesium	SERUM	2.1

Hepatic Function Panel	Site/Specimen	20 Aug 2010 1125
Albumin	SERUM	4.4
Bilirubin	SERUM	0.591
Alkaline Phosphatase	SERUM	102 <i>
Aspartate Aminotransferase	SERUM	29
Alanine Aminotransferase	SERUM	32
Bilirubin Direct	SERUM	0.2
Protein	SERUM	7.4

A/P Last updated by FINMAN,JOEL R @ 22 Aug 2010 1255 PDT

1. transient alteration of awareness: deeply nonresponsive on presentation, with subsequently normalization; evaluation/treatment course as above. Medical explanation for episode not clear; no neurologic sequelae evident. Pt alert, talking, stable at transport to MedSurg floor.

Procedure(s): -INFUSION, NORMAL SALINE SOLUTION , 1000 CC x 1
-ECG 12-Lead x 1

Laboratory(ies): -AMYLASE (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R; CARDIAC PANEL (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R; CBC/AUTO (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R; COAG PANEL (PT/PTT/INR) (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R; GLUCOSE (POCT) (Routine) Ordered By: TILLERY,MICHAEL E Ordering Provider: FINMAN, JOEL R; HEPATIC FUNCTION PANEL (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R; KETONES (Routine) Ordered By: TILLERY,MICHAEL E Ordering Provider: FINMAN, JOEL R; P10 (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R; QUALITATIVE HCG (CARDS,Q.S.) (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R; UA/MICROSCOPIC (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R; URINE TOX SCREEN (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R; VENOUS BLOOD GAS (Routine) Ordered By: TILLERY,MICHAEL E Ordering Provider: FINMAN, JOEL R

Radiology(ies): -CT, HEAD (W/O CONTRAST) (STAT) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R Impression: LOC

Disposition Written by FINMAN,JOEL R @ 22 Aug 2010 1255 PDT

Admitted - Comments:

Discussed: Diagnosis with Patient who indicated understanding.

Note Written by BROOKER,NICOLE A @ 20 Aug 2010 1136 PDT

Nursing

Progress Note

1140 Critical report from lab of urine glucose of 500 and ketones >80. Report given to DR. Finman and fluids were opened.

1155 Pt. returned from radiology. Pt. note to move her eyes to the L when asked to do so.

1157 Pt. is talking but appears to be disoriented and is asking "what happened"

1200 A 1SG Hartlerode from the pt's husband's company 51st TICO is here to inquire about pt's condition. He was informed as per Dr. Finman that the pt. is now alert and talking. Unclear at this time if pt. will be transported or admitted.

Note Written by TILLERY,MICHAEL E @ 20 Aug 2010 1136 PDT

Nursing

Reiage

1112 ESI2 30 y/o female presents to the ED with CC of ALOC from mary walker clinic. Pt VSS upon arrival, pt unresponsive other than occasional puposeful gaze in response to verbal communication. Pt reported to have been fasting for romadon. Pt met immediatly by DR. Finman, DR. stone, Maj, Buehner, Maj hitchcock accompanied pt upon arrival

Note Written by TILLERY,MICHAEL E @ 20 Aug 2010 1143 PDT

nursing

Progress

1115 18G IV started L/AC, blood drawn and dsent to LAB , 1000ml NS satrted. 1 amp d-50 given IVP upon arrival by MAj B per Dr. Finman.

1120 Folery cath placed, By. Brooker RN, per Dr. Finman.

1121 CT called for CT head /c-spine.

1124 128/68, p81, 100% mask @8L, 24R,

1125 0.4, narcan given , per DR. finman, minimal response noted.

1128 0.4 narcan given sivp per DR. Finman.

1132 110/85, r23, p82, 100% mask, 8L t99.7R

1135 Pt off the floor to CT, on monitor and with Maj Hitchcock.

1150 Pt back from CT.

1152 122//81, p95, 1002L, r21,. VBG drawn sent to LAB. Rapid BS 213.
1155 pt is responsive to verbal stemuli at this time, asking"what happened". Dr. Finman at bedside to reassess pt.

1159 Pt taken off back board per DR. Stone.

1200 109/95, p-101, 1002l, r20.

1201 Medics at bedside for EKG.

1205 EKg shown to DR. Finman.

1210 pt more alert, asking to go home, Dr. Finman at bedside.

1220 CPT Douchi at bedside to translate for pt.

1235 Dr. Mandeville on the floor to see pt. Pad called for admission.

1250 113/75. p-81, r20, 1002L, r19, CPT Douchi at bedside with command rep.

1320 Pt alert at this time, VSS, CPt Douchi at bedside.

1409 Pt in NAD, VSS, GCS=15 at transfer to Medical surgical. Report called to CPT Andrews.

Note Written by MYATT,CRYSTAL L @ 20 Aug 2010 1241 PDT
Additional A/P Information:

--> Unassociated orders and procedures <--

CT, HEAD (W/O CONTRAST) (STAT) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R Impression: LOC
CT, C-SPINE (W/O CONTRAST) (STAT) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R Impression: ALOC
CBC/AUTO (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
P10 (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
HEPATIC FUNCTION PANEL (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
CARDIAC PANEL (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
COAG PANEL (PT/PTT/INR) (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R

AMYLASE (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
UA/MICROSCOPIC (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
URINE TOX SCREEN (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
QUALITATIVE HCG (CARDS,Q.S.) (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R

Signed By FINMAN, JOEL R (Physician/Workstation, Weed ACH Fort Irwin, CA) @ 22 Aug 2010 1257

CHANGE HISTORY
The following A/P Note Was Overwritten by FINMAN,JOEL R @ 22 Aug 2010 1255 PDT:
A/P section was last updated by FINMAN,JOEL R @ 22 Aug 2010 1255 PDT - see above.Previous Version of A/P section was entered/updated by TILLERY,MICHAEL E @ 20 Aug 2010 1149 PDT

--> Unassociated orders and procedures <--
CT, HEAD (W/O CONTRAST) (STAT) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R Impression: LOC
CBC/AUTO (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
P10 (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
HEPATIC FUNCTION PANEL (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
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UA/MICROSCOPIC (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
URINE TOX SCREEN (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
QUALITATIVE HCG (CARDS,Q.S.) (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
VENOUS BLOOD GAS (Routine) Ordered By: TILLERY,MICHAEL E Ordering Provider: FINMAN, JOEL R
GLUCOSE (POCT) (Routine) Ordered By: TILLERY,MICHAEL E Ordering Provider: FINMAN, JOEL R
KETONES (Routine) Ordered By: TILLERY,MICHAEL E Ordering Provider: FINMAN, JOEL R
The following A/P Note Was Overwritten by TILLERY,MICHAEL E @ 20 Aug 2010 1139 PDT:
A/P section was last updated by TILLERY,MICHAEL E @ 20 Aug 2010 1139 PDT - see above.Previous Version of A/P section was entered/updated by MYATT,CRYSTAL L @ 20 Aug 2010 1128 PDT

--> Unassociated orders and procedures <--
CT, HEAD (W/O CONTRAST) (STAT) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R Impression: LOC
CBC/AUTO (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
P10 (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
HEPATIC FUNCTION PANEL (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
CARDIAC PANEL (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
COAG PANEL (PT/PTT/INR) (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
AMYLASE (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
UA/MICROSCOPIC (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
URINE TOX SCREEN (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R
QUALITATIVE HCG (CARDS,Q.S.) (Routine) Ordered By: MYATT,CRYSTAL L Ordering Provider: FINMAN, JOEL R

Patient: **CHAJI, HOUDA**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **22 Aug 2010 1812 PDT**
Clinic: **EMERGENCY ROOM WACH**

Appt Type: **ACUT**
Provider: **FINMAN,JOEL R**

Reason for Appointment: personal

Screening Written by SANTAMARIA,MANUEL R @ 22 Aug 2010 2038 PDT
Reason For Appointment: personal
Reason(s) For Visit (Chief Complaint): The Chief Complaint is: (New) : POSS. ASSAULT;

LMP: 25 Jan 2010. Date Basis: unknown.

Vitals
Vitals Written by SANTAMARIA,MANUEL R @ 22 Aug 2010 2037 PDT
BP: 116/67, HR: 78, RR: 22, T: 98.6 °F Oral, SpO_2: 96%

Questionnaire AutoCites Refreshed by FINMAN,JOEL R @ 22 Aug 2010 1830 PDT
Questionnaires

SO Note Written by FINMAN,JOEL R @ 22 Aug 2010 1856 PDT
Chief complaint
The Chief Complaint is: Hyperventilating, report of assault.
Past medical/surgical history
Reported History:
Past medical history: Autocites reviewed. Pt in ER 2 days ago following marked but transient alteration of awareness; hospitalized overnight for observation and released the following day.
Subjective
Pt brought by EMS with report of hyperventilation at home; pt indicates she has been giving report to Police earlier this afternoon related to an assault by a man she knows who she says raped her on Thursday (i.e. 19th) and then returned today and threatened her and held her down with his hand across her neck/throat and arm across her upper abdomen, telling her he knows how to kill someone without anyone ever finding out. Pt reportedly became very distraught while reviewing circumstances with Police, and developed rapid/agitated breathing. Brought to ER accordingly.
Review of systems
Pt reports feeling very upset. She points out markings on her skin which she indicates are from the incident today, but is not describing acute or localized pain. She volunteers that she is cold, and that "I just want to sleep and forget it".
Physical findings
Vital signs:
° Current vital signs reviewed.
General appearance:
• General appearance: pt upset and crying at times, speaking very fast at times describing how the man threatened her; able to be calmed by friend including CPT Douchi who helped 2 days ago as well. Pt does not appear to be in physical distress.
Head:
• Head: no gross trauma, no blood. No facial ecchymosis noted.
Neck:
• Neck: moving normally. No evident soft tissue injury/swelling/discoloration on neck. Very small pinpoint petechiae at submental area, midline. No skin break there.
Eyes:
General/bilateral:
° Eyes: normal.
Ears, Nose, Throat:
° ENT: normal no blood.
Chest:
• Chest: no bruising or markings noted along lower neck/clavicle area. Mild tenderness with palpation of lower ribs anteriorly, with no stepoff or deformity.
Lungs:
° Normal.
Abdomen:
• Abdomen: soft, no bruising or markings seen, no mass or tenderness.
Musculoskeletal system:
General/bilateral: • Musculoskeletal system: moving arms/legs normally.

Skin:

- Skin: small petechiae under chin as above. Very superficial fine linear cut/scratch at flexor side of right ulna distally near wrist; not open, no blood (not full thickness). Ecchymosis at dorsum of right wrist, possibly related to venous blood gas draw from two days ago; small puncture site at proximal end of bruise. Superficial erythema at both antecubital fossae, consistent with adhesive markings from Opsite (two IV placed 2 days ago). Prominent bruising at left wrist, suggestive of ABG draw attempt from 2 days ago; single well-circumscribed marking adjacent to radial artery. Superficial linear cuts/scratches to upper left arm medially. Pt not reporting additional marks or bruising. No lower extremity complaints (other than being cold). Pt points out tear to top of T-shirt (collar seam torn from upper part of shirt front) and a triangular cut in the front of the shirt consistent with penetration from cutting instrument.

Objective

Pt brought in with hyperventilation following stressful circumstances as above; hyperventilation controlled during ED evaluation, though pt does have episodic agitation/crying. Pt not reporting to me or translator thoughts of hurting herself or anyone else; she indicates to translator she is afraid someone might come after her and she just wants to get away from the situation. Composed for the most part, with friends at her side. Pt reporting sexual assault Thursday (relayed to me through translator CPT Douchi). Medically stable. Law enforcement involved. Pictures taken earlier today pt reports. CID arrives to speak with pt.

SO Note Written by TILLERY,MICHAEL E @ 22 Aug 2010 1857 PDT

Chief complaint

The Chief Complaint is: 30 y/o female presents to the ED with CC alleged rap that took place last thursday. Pt also presents very anxious and agitated. Pt states alleged perp attempted to assault her and threatened her and her family today. Pt presents with no physical signs of abuse, however is extreamly agitates. Pt was seen in the ED and admited on friday after collapsing and becoming unresponsice at MWC. Tillery RN.

History of present illness

The Patient is a 30 year old female.
She reported: Anxiety. No high irritability and no hostility.
Past medical history not reviewed and updated in patient problem list and medication list not reviewed . Home medication list (to include OTC- herbals- and nutritional supplements) was reviewed with the patient/family member and updated if medications were changed- added- or deleted. List was returned to the patient/family member.

Allergies

No allergies Reviewed allergy information and updated as necessary. No allergy to latex.

Past medical/surgical history

Reported History:

Recent events: Patient observed being agitated.
Surgical / procedural: Surgical / procedural history reviewed and updated in patient problem list.

Personal history

Home environment: Native language.
Abuse / neglect: Physically abused and physical neglect.

Physical findings

Lungs:

° Respiration rhythm and depth was normal. ° No intercostal inspiratory retraction was observed. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Therapy

- Transportation to a medical facility in an ambulance.

SO Note Written by FINMAN,JOEL R @ 22 Aug 2010 2047 PDT

Objective

Vital signs normalized on recheck. Pt composed and in no distress on my recheck now, speaking with SARC representative at bedside. Pt reporting no needs now other than being thirsty; I brought a cup of water. Stable.

SO Note Written by FINMAN,JOEL R @ 22 Aug 2010 2101 PDT

Objective

Pt reporting no complaints now other than wanting to be in safe place with her two children and her husband (who is home tomorrow per 1SG report). Pt again confirms no thoughts or plan or hurting self or others. Unit reportedly arranging safe lodging for tonight. Pt medically stable for outpatient followup. Pt has PCP followup tomorrow as well.

A/P Last updated by FINMAN,JOEL R @ 22 Aug 2010 2107 PDT
1. **SUPERFICIAL INJURY**: nonspecific skin findings as above. Pt reports assault. Law enforcement involved. Pt medically stable.
2. **HYPERVENTILATION SYNDROME**: observed by personnel at scene/home, resolved in ER, with episodic agitation/upset when recounting recent events but consolable.
3. **visit for: administrative purpose**: medical screen related to report of assault; see exam and comments above. Pt medically stable. No reports of SI/HI at my exam. CID/SARC involved at this point; pending completion of their evaluation, pt is stable for outpatient followup.

Disposition Last Updated by FINMAN,JOEL R @ 22 Aug 2010 2109 PDT
Released w/o Limitations
Follow up: with PCM. - Comments: follow up per CID/SARC. Pt has PCP appt tomorrow related to recent hospital stay. Behavioral Health F/U recommended in the morning as well.
Discussed: Diagnosis with Patient who indicated understanding.

Note Written by TILLERY,MICHAEL E @ 22 Aug 2010 1831 PDT
Nursing
Prodress
1805 FIPD present and states CID will take the lead on invesitgation.

1810 Dr. Finman at bedside.

1825 Advised by FIPD at CID will arrive in approx 45min.

1820 SARC aware and is sending rep.

Note Written by WILEY,GEORGENA D @ 22 Aug 2010 1951 PDT
Nursing
Progress notes
1955 CID in facility speaking with pt, awaiting SARC to send representative, MAJ Buehner made aware of situation and will inform staff of next step. CID is requesting forensic testing due to allegation Dr. Finman aware of status. Written by LT G Wiley, RN

2005 SACC paged @ 1888-774-4756 & SANE paged @ 1-888-503-9074 per OIC awaiting return call. Pt is very anxious and crying CPT Douche and CID Tran is in with pt presently. No acute distress noted at this time. Written by LT G Wiley, RN

2020 Dr. Kelly of BH has been notified per Dr. Finman with possible BH labs based on outcome of investigation. Written by LT G Wiley, RN

2030 No response from SACC & SANE per MAJ Bheuner pt needs to be transported to Fontana. Written by LT G Wiley, RN

2050 Victim advocate Christina Chavez has arrived and is speaking with pt presently. Spoke with Chris Riley @ LEMS 909-427-9227 that the 72 hour window has passed and unable to obtain factual data due to area of investigation has been compromised from prev admission and time frame of the alleged incident. Informed necessary personnel of updated status. Written by LT G Wiley, RN

Signed By FINMAN, JOEL R (Physician/Workstation, Weed ACH Fort Irwin, CA) @ 22 Aug 2010 2112

Note Written by WILEY,GEORGENA D @ 22 Aug 2010 2220 PDT
(Added after encounter was signed.)
Nursing
Discharge Summary
2220 Pt discharged in care of Victim advocate with the understanding that pt must remain in a safe place with children. VA verbalizes understanding and has made the necessary arrangements with the understanding of maintaining already scheduled appt in AM and also to f/u with BH after PMD appt. No acute distress noted. Written by LT G Wiley, RN

CHANGE HISTORY
The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by FINMAN,JOEL R @ 22 Aug 2010 2112 PDT:
Signed FINMAN, JOEL R (Physician/Workstation, Weed ACH Fort Irwin, CA) @ 22 Aug 2010 2112
The following Disposition Note Was Overwritten by FINMAN,JOEL R @ 22 Aug 2010 2109 PDT:
Disposition section was last updated by FINMAN,JOEL R @ 22 Aug 2010 2109 PDT - see above.Previous Version of Disposition section was entered/updated by FINMAN,JOEL R @ 22 Aug 2010 2109 PDT.
Released w/o Limitations

Name/SSN:	**CHAJI, HOUDA**	Sex:	**F**	Sponsor/SSN:	BELKHATIR, KHALID/[redacted]4949
FMP/SSN:	**30[redacted]4949**	Tel H:	404-453-6760	Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:	404-453-6760	Unit:	WJTEAAFC
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

Follow up: with PCM. - Comments: follow up per CID/SARC. Pt has PCP appt tomorrow related to recent hospital stay. Behavioral Health F/U recommended in the morning as well.
Discussed: Diagnosis with Patient who indicated understanding.

The following Disposition Note Was Overwritten by FINMAN,JOEL R @ 22 Aug 2010 2109 PDT:
Disposition section was last updated by FINMAN,JOEL R @ 22 Aug 2010 2109 PDT - see above.Previous Version of Disposition section was entered/updated by FINMAN,JOEL R @ 22 Aug 2010 2026 PDT.
Released w/o Limitations
Follow up: with PCM. - Comments: followup as determined by CID/SARC or BH if indicated.
Discussed: Diagnosis with Patient who indicated understanding.

The following A/P Note Was Overwritten by FINMAN,JOEL R @ 22 Aug 2010 2107 PDT:
A/P section was last updated by FINMAN,JOEL R @ 22 Aug 2010 2107 PDT - see above.Previous Version of A/P section was entered/updated by FINMAN,JOEL R @ 22 Aug 2010 2025 PDT.
1. **SUPERFICIAL INJURY:** nonspecific skin findings as above. Pt reports assault. Law enforcement involved. Pt medically stable.
2. **HYPERVENTILATION SYNDROME:** observed by personnel at scene/home, resolved in ER, with episodic agitation/upset when recounting recent events but consolable.
3. **visit for: administrative purpose:** medical screen related to report of assault; see exam and comments above. Pt medically stable. No reports of SI/HI at my exam. CID/SARC involved at this point. My exam and background information provided briefly by telephone to Behavioral Health doctor on call, should additional BH evaluation be deemed appropriate tonight.

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by FINMAN,JOEL R @ 22 Aug 2010 2034 PDT:
Signed FINMAN, JOEL R (Physician/Workstation, Weed ACH Fort Irwin, CA) @ 22 Aug 2010 2029

The following SO Note Was Overwritten by TILLERY,MICHAEL E @ 22 Aug 2010 1857 PDT:
SO Note Written by FINMAN,JOEL R @ 22 Aug 2010 1853 PDT
Chief complaint
The Chief Complaint is: 30 y/o female presents to the ED with CC alleged rap that took place last thursday. Pt also presents very anxious and agitated. Pt states alleged perp attempted to assault her and threatened her and her family today. Pt presents with no physical signs of abuse, however is extreamly agitates. Pt was seen in the ED and admited on friday after collapsing and becoming unresponsice at MWC.
History of present illness
The Patient is a 30 year old female.
She reported: Anxiety. No high irritability and no hostility.
Past medical history not reviewed and updated in patient problem list and medication list not reviewed . Home medication list (to include OTC- herbals- and nutritional supplements) was reviewed with the patient/family member and updated if medications were changed- added- or deleted. List was returned to the patient/family member.
Allergies
No allergies Reviewed allergy information and updated as necessary. No allergy to latex.
Past medical/surgical history
Reported History:
Recent events: Patient observed being agitated.
Surgical / procedural: Surgical / procedural history reviewed and updated in patient problem list.
Personal history
Home environment: Native language.
Abuse / neglect: Physically abused and physical neglect.
Physical findings
Lungs:
° Respiration rhythm and depth was normal. ° No intercostal inspiratory retraction was observed. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.
Therapy
• Transportation to a medical facility in an ambulance.

The following SO Note Was Overwritten by FINMAN,JOEL R @ 22 Aug 2010 1853 PDT:
SO Note Written by TILLERY,MICHAEL E @ 22 Aug 2010 1818 PDT
Chief complaint
The Chief Complaint is: 30 y/o female presents to the ED with CC alleged rap that took place last thursday. Pt also presents very anxious and agitated. Pt states alleged perp attempted to assault her and threatened her and her family today. Pt presents with no physical signs of abuse, however is extreamly agitates. Pt was seen in the ED and admited on friday after collapsing and becoming unresponsice at MWC.
History of present illness
The Patient is a 30 year old female.
She reported: Anxiety. No high irritability and no hostility.
Past medical history not reviewed and updated in patient problem list and medication list not reviewed . Home medication list (to include OTC- herbals- and nutritional supplements) was reviewed with the patient/family member and updated if medications were changed- added- or deleted. List was returned to the patient/family member.
Allergies
No allergies Reviewed allergy information and updated as necessary. No allergy to latex.
Past medical/surgical history
Reported History:
Recent events: Patient observed being agitated.
Surgical / procedural: Surgical / procedural history reviewed and updated in patient problem list.
Personal history
Home environment: Native language.
Abuse / neglect: Physically abused and physical neglect.
Physical findings
Lungs:
° Respiration rhythm and depth was normal. ° No intercostal inspiratory retraction was observed. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.
Therapy
• Transportation to a medical facility in an ambulance.

Patient: **CHAJI, HOUDA**
Treatment Facility: **WEED ACH**
Patient Status: **Outpatient**

Date: **22 Aug 2010 0025 PDT**
Clinic: **ER URGENT CARE-WACH**

Appt Type: **ACUT**
Provider: **JEFFRIES,REX G**

****Limited System Patient Data at time of Encounter****

Reason for Appointment: Back Pain, Vomiting

AutoCites Refreshed by PERRELL,JONATHAN M @ 22 Aug 2010 0045 PDT

Problems
Chronic:
- Xerosis cutis
- Gastroenteritis
- Insomnia
- Recent weight gain
- General counseling on contraception
- Cervical Pap smear

Family History
- Family medical history
- No Family History of heart disease
- No Family History of cancer

Allergies
- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
ORTHO TRI-CYCLEN/TRINESSA/TRI-SPRINTEC	Active	TAKE ONE TAB BY MOUTH ONCE DAILY, START ON 1ST SUNDAY AFTER ONSET OF MENSES #3 RF3	3 of 3	08 Apr 2010

Screening Written by SANTAMARIA,MANUEL R @ 22 Aug 2010 0041 PDT
Reason For Appointment: Back Pain, Vomiting
Reason(s) For Visit (Chief Complaint): The Chief Complaint is: (New) : abdominal pain/pain management;

LMP: 10 Aug 2010. Date Basis: unknown.

Vitals
Vitals Written by SANTAMARIA,MANUEL R @ 22 Aug 2010 0041 PDT
BP: 145/118, HR: 77, RR: 16, T: 97.9 °F, HT: 61 in, SpO_2: 97%, Tobacco Use: Yes, Alcohol Use: No,
Pain Scale: 8/10 Severe, Pain Scale Comments: abdominal pain
Comments: 30 y/o F c/o needing pain management
PMH: none
PSH: none

SO Note Written by WILEY,GEORGENA D. @ 22 Aug 2010 0038 PDT
Chief complaint
The Chief Complaint is: 30y/o F AOX4 presents with abd pain and vomiting since yesterday.
History of present illness
The Patient is a 30 year old female.
She reported: Past medical history reviewed and updated in patient problem list and medication list reviewed . Home medication list (to include OTC- herbals- and nutritional supplements) was reviewed with the patient/family member and updated if medications were changed- added- or deleted. List was returned to the patient/family member.
No high irritability, no hostility, and no depression.
Allergies
An allergy Reviewed allergy information and updated as necessary. No allergy to latex.
Past medical/surgical history
Reported History:
Recent events: Patient not observed being agitated.
Surgical / procedural: Surgical / procedural history reviewed and updated in patient problem list.
Legal documents on file for health care management: Health care proxy not in chart Advance Directives.
Personal history
Category: 5.
Home environment: Native language English.
Abuse / neglect: Not physically abused and no physical neglect.
Physical findings
Lungs:

° Respiration rhythm and depth was normal. ° No intercostal inspiratory retraction was observed. ° No wheezing was heard. ° No rhonchi were heard. ° No rales/crackles were heard.

Therapy

• Transportation to a medical facility in a private vehicle. Initial injury treatment /Illness in Triage:

SO Note Written by JEFFRIES,REX G @ 22 Aug 2010 0223 PDT

History of present illness

The Patient is a 30 year old female.
She reported: Past medical history reviewed: Reviewed Autocite Content.

Additional problems: Patient had apparent syncopal episode at MWC on 8/20/10. Was brought to the emergency room and after evaluation was admitted overnight by Dr. Mandeville. Apparently patient had had little EEG or drink that day prior to the syncope. She had large amount of ketones in her urine, glucosuria secondary to administration empirically of D50 W. and some abnormalities on her arterial blood gases. She was discharged at noon on 8/21/10 in no pain and on no medications although the record does not immediately available. About 3 hours before coming to ED R. patient ate and then had 2 episodes of vomiting and then noted 8/10 pain in the chest just below the breast. It was slightly pleuritic in nature it did not radiate. There is no associated diaphoresis, dyspnea, or other symptoms. Patient presents to the emergency room stating that she wants no tests of any kind only some pain medication. Previously seen here by the undersigned on 6/25/10 4 days after a scorpion sting on the thigh having been brought in by ambulance. She had over those 4 days lightheadedness, "high fever" but did not take temperature, and epigastric pains. By 620 3D leg pain in the region of the scorpion stain was 9/10 and was having difficulty ambulating. On 624 had 10/10 abdominal pain and vomiting x12-15 episodes. Evaluation was essentially normal except for an elevated amylase of 170. Internal medicine consultation (Dr. Williams) was obtained who felt that the patient should be treated symptomatically and that pancreatitis was not likely. She responded to the symptomatic treatment and symptoms did not recur. Dr. Mandeville was consulted and advised that the patient was having current symptoms but refuses any evaluation only pain medication. He relates that patient did relate she is under an unusual amount of stress but did not care to elaborate. He has made an appointment for her at 1100 on 8/23/10. He felt that it would be appropriate to give IM Toradol and one tablet of Percocet, then.
Additional HPI: (Continued) release patient AMA. She relates that she will return later this morning with symptoms persist.

Allergies

No allergies: Reviewed Allergy Information in CHCS.

Past medical/surgical history

Reported History:

Reported medications: Medication history: Reviewed Autocite Content.

Physical findings

Vital signs:

° Current vital signs reviewed Initial elevated blood pressure of 145 /118 was 122/84 when taken a short time later manually without medications being given.

General appearance:

° Well-appearing. ° Alert. ° Well nourished. ° Well hydrated.

Head:

Appearance: ° Head normocephalic.

Neck:

Palpation: ° Of the neck revealed no abnormalities.

Eyes:

General/bilateral:
Pupils: ° Normal.
Right eye:
° Normal.
Left eye:
° Normal.

Ears:

General/bilateral:
° Ears: normal.

Nose:

General/bilateral:
° Nose: normal.

Pharynx:

° Normal.

Chest:

• Palpation revealed abnormalities Localized tenderness of 2 costochondral junctions on the left immediately below the breast.

Lungs:

° Clear to auscultation.

Cardiovascular system:

Heart Rate And Rhythm: ° Normal.
Murmurs: ° No murmurs were heard.

Abdomen:
Auscultation: ° Abdominal auscultation revealed no abnormalities.
Palpation: ° Abdomen was soft.

Musculoskeletal system:
Leg (Below Knee):
Right leg: ° No tenderness on palpation.
Left leg: ° No tenderness on palpation.

A/P Last updated by JEFFRIES,REX G @ 22 Aug 2010 0238 PDT

1. ATYPICAL CHEST PAIN

Medication(s): -KETOROLAC TROMETHAINE 60MG/2ML INJECTION - 60 MG GIVEN IM IN ER #1 RF0 Qt: 1 Rf: 0
-PERCOCET(5/325MG)-PO TAB--PO TAB - ONE HALF TO ONE TABLET EVERY 4 HOURS AS NEEDED #1 RF0 Qt: 1 Rf: 0

Laboratory(ies): -URINE CULTURE (Routine) Start Date: 08/21/2010 Ordered By: WILEY,GEORGENA D Ordering Provider: JEFFRIES, REX G; UA/MICROSCOPIC (Routine) Start Date: 08/21/2010 Ordered By: WILEY,GEORGENA D Ordering Provider: JEFFRIES, REX G

Disposition Written by JEFFRIES,REX G @ 22 Aug 2010 0240 PDT

Left Against Medical Advice - Comments:

Follow up: 2 day(s) with PCM or sooner if there are problems. - Comments: Patient advised that although she is leaving AMA, she is welcome to return at any time for evaluation if she changes her mind. Although not discussed with patient it is very possible the patient has a costochondral rib separation secondary to the vomiting but of course this would not explain why she vomited. She is only slightly nauseated at present and does have Phenergan at home left over from 6/25/10 if needed. If she does not return to ER, she is to be seen at 1100 Dr. Mandeville tomorrow.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by WILEY,GEORGENA D @ 22 Aug 2010 0041 PDT

Nursing

Progress notes

0045 Pt was discharged from MSW on 21 AUG 10 @ 1200 with no d/c'd meds but to instructed to f/u @ MWC in am. Pt verbalized that pain onset was after eating. Pt verbalized that after meal vomitous episodes and pain upper left quadrant. Pt vervalized LBM yesterday with no s/s of constipation or diarrhea. UA obtained and awaiting for Dr. Jeffries to assess. Written by LT G Wiley, RN

0130 Toradol 60mg w/ 0.5ml of lidocaine in rt. deltoid. No acute distress noted. Pt refuses to allow MD to complete treatment regimen and is leaving facility AMA. Dr. Jeffries is explaining the importance of treatment and pt continues to refuse. Written by LT G Wiley, RN

Note Written by PERRELL,JONATHAN M @ 22 Aug 2010 0044 PDT

MOA

POV Dependent
51st TYCO, 916th SPT

Note Written by WILEY,GEORGENA D @ 22 Aug 2010 0142 PDT

Nursing

Discharge Summary

0145 Toradol 60mg w/lidocaine in lt outer btks has an escort to and understands the risk of not driving due to narcotic. Discharge instructions given and 1 Percocet with instructions to keep f/u appt on Monday as previously scheduled. No acute distress noted all concerns addressed. Written by LT G Wiley, RN

Signed By JEFFRIES, REX G (Physician, Weed ACH Fort Irwin, CA) @ 22 Aug 2010 0241

CHANGE HISTORY

The following A/P Note Was Overwritten by JEFFRIES,REX G @ 22 Aug 2010 0238 PDT:

A/P section was last updated by JEFFRIES,REX G @ 22 Aug 2010 0238 PDT - see above.Previous Version of A/P section was entered/updated by WILEY,GEORGENA D @ 22 Aug 2010 0030 PDT.

--> Unassociated orders and procedures <--

URINE CULTURE (Routine) Start Date: 08/21/2010 Ordered By: WILEY,GEORGENA D Ordering Provider: JEFFRIES, REX G

Name/SSN:	**CHAJI, HOUDA**	Sex:	**F**	Sponsor/SSN:	BELKHATIR, KHALID [redacted]4949
FMP/SSN:	**30[redacted]4949**	Tel H:	404-453-6760	Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:	404-453-6760	Unit:	WJTEAAFC
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	

22 Aug 2010 0029

Facility: Weed ACH Fort Irwin, CA **Clinic: ER Urgent Care-WACH** **Provider: JEFFRIES, REX G**

UA/MICROSCOPIC (Routine) Start Date: 08/21/2010 Ordered By: WILEY,GEORGENA D Ordering Provider: JEFFRIES, REX G

Name/SSN:	**CHAJI, HOUDA**	Sex:	F	Sponsor/SSN:	BELKHATIR, KHALID[redacted]4949
FMP/SSN:	**30[redacted]4949**	Tel H:	404-453-6760	Rank:	SPECIALIST
DOB:	**08 Apr 1980**	Tel W:	404-453-6760	Unit:	WJTEAAFC
PCat:	A41 USA FAM MBR AD	CS:		Outpt Rec. Rm:	
MC Status:		Status:		PCM:	ROBERTS,MICAH J
Insurance:	No			Tel. PCM:	