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BEFORE THE  
SURFACE TRANSPORTATION BOARD

ALONZO BENTON

*Complainant*

v.

CSX TRANSPORTATION

*Defendant*

STB DOCKET NO.

NOR 42166

**COMPLAINT AND PETITION FOR RELIEF  
UNDER 49 U.S.C.S. § 10101(8)**

ALONZO BENTON  
2432 S Frazier Street  
Philadelphia, PA 19143

*Complainant*

JOHN J. LEONARD  
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*Attorney for Complainant*

FILED  
August 22, 2019  
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August 22, 2019  
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## **PREFACE PRESERVING FEDERAL CLAIM**

This matter is pending in the Federal Court for the Eastern District of Pennsylvania at Alonzo Benton v. CSX Transportation, Inc. No.: 19-0109 in Philadelphia. Because CSX Transportation, Inc. has put forth in that litigation the argument that this personal injury/tort case must be filed at the Surface Transportation Board in the first instance, we are compelled to file this claim to meet that potential argument if it is again argued by the CSX Transportation, Inc. Since the matter is proceeding in the Federal District Court where it was filed on January 8, 2019, Plaintiff respectfully requests that Surface Transportation Board hold this Complaint in abeyance pending the outcome of the litigation in the Federal District Court, which should be dispositive of this claim. A separate motion to hold the matter in abeyance will be filed by Claimant shortly.

## **COMPLAINT AND PETITION FOR RELIEF**

### **UNDER 49 U.S.C.S. § 10101(8)**

Pursuant to 49 U.S.C.S. § 10101(8), operation of transportation facilities and equipment without detriment to public health and safety, Complainant, ALONZO BENTON hereby complains against Defendant, CSX TRANSPORTATION (CSX), and respectfully petitions for the relief requested herein on the following grounds:

### **I.**

#### **NATURE OF THE CASE**

The Board is asked to grant relief in favor of Complainant under U.S.C. § 1320, in determining that Defendant CSX failed to properly maintain a Pedestrian Crosswalk over a railroad, in violation of their duty as an owner, operator, manager and/or possessor of same, causing Complainant to sustain damages from a slip and fall injury occurring on August 29<sup>th</sup>, 2017.

### **II.**

### **IDENTITY OF COMPLAINANT**

Alonzo Benton is a resident of 2432 Frazier Street Philadelphia Pennsylvania, 19143.

### **III.**

### **IDENTITY OF DEFENDANT**

Defendant CSX Transportation, Inc. is a rail carrier by virtue of their alleged ownership, possession, operation, maintenance, management, and control of a public pedestrian walkway that crosses railroad tracks located at or near the intersection of 58<sup>th</sup> Street and Woodland Avenue in Philadelphia Pennsylvania, (The Crossing).

### **IV.**

### **JURISDICTION AND VENUE**

The Board is alleged to have jurisdiction over the subject matter of this Complaint by virtue of its statutory authority under 49 U.S.C.S. § 10501(b)(1-2) in aid of its jurisdiction to determine remedies for liability in activity affecting lawful licensees on railroad property under 49 U.S.C.S. § 10101:

The jurisdiction of the board over transportation by rail carriers, and the remedies provided in this part, (49 U.S.C.S. § 10101 et seq.), with respect to rates, classifications, rules, practices, routes, services, and facilities of such carriers; and the construction, acquisition operation, abandonment, or discontinuance of spur, industrial, team, switching, or side tracks, or facilities, even if the tracks are located, or intended to be located entirely within one State, is exclusive.

The Board has personal jurisdiction over CSX Transportation, Inc. as a rail owner, operator, manager, possessor, or controlling entity of the railway located at or near the intersection of 58<sup>th</sup> Street and Woodland Avenue in Philadelphia, Pennsylvania.

Venue is proper before the Surface Transportation Board pursuant to 49 U.S.C. § 10501(b), as it is alleged to be granted exclusive jurisdiction over “transportation by rail carriers, and over the construction or operation of rail tracks and facilities.”

**V.**

**FACTS COMMON TO ALL COUNTS**

1. Complainant repeats and incorporates all averments contained in the previous sections as though same were fully set forth herein.

2. At all times material to this complaint, Defendant owned, operated, managed, possessed and/or controlled the railway tracks and it is alleged the public pedestrian walkway that crossed said tracks located at the intersection at 58<sup>th</sup> street and Woodland Avenue in Philadelphia, Pennsylvania.

3. At all times material to this complaint the defendant acted or failed to act by and through their agents, servants, workmen, and employees, all of whom were acting within the scope of their authority and course of employment for the Defendant.

4. Defendant was responsible for proper maintenance, safety, care, repair, and remediation of the tracks and The Crossing.

5. At all times material to this complaint, the Defendant by and through its agents, servants, workmen, and employees, were responsible for the inspection, safety, maintenance, care, repair, and remediation of defects and dangerous conditions on the tracks and The Crossing.

6. On or about August 29, 2017, and for some prior thereto, the Defendant negligently and carelessly permitted a dangerous and defective condition to exist and remain at the public pedestrian walkway located at The Crossing, including but not limited to concrete panels and metal

edges which featured varied and distinct slip resistances when wet, with no signs or warnings present to inform pedestrians.

7. The Defendant negligently and carelessly failed to remedy or repair the dangerous and defective conditions as described herein.

8. The aforesaid dangerous and defective conditions on The Crossing were caused by negligent and careless acts or omissions of the Defendant.

9. On August 29, 2017, Mr. Benton was lawfully walking on the public sidewalk or walkway at The Crossing on the way back from the grocery store to his home.

10. On that same day, Philadelphia had experienced heavy rain throughout the day, causing parts of the aforementioned panels to become wet, slippery and/or slick.

11. While walking through on the public sidewalk at The Crossing, the dangerous and defective conditions created by the Defendant caused Mr. Benton to slip and fall.

12. Complainant has retained Andres J. Calderton Ph.D. to conduct an inspection and evaluation of the site of the fall attached as **Exhibit A** hereto.

13. As seen in **Exhibit A**, the rails have precast concrete panels to fill the space of the railway bed between the rails for the purpose of pedestrian crossing. The concrete panels have metal edges which are approximately three (3) inches wide.

14. As more fully stated in Mr. Calderton's report, it is evident that at the time of Mr. Benton's fall that Defendants, CSX failed to properly design, construct, and/or maintain these concrete panels and metal edges.

15. As stated in the report, the slip resistance of the metal edge when wet was significantly less than that of the concrete surface of the panel.

16. Additionally, nothing was used at the site of the accident to warn Mr. Benton or any other pedestrian lawfully walking on that public sidewalk of the latent slippery surface, in violation of numerous construction and safety codes. (See Mr. Calderton's report attached as **Exhibit A** hereto).

17. As a direct and proximate result of the acts or omissions of the Defendant, and the resulting slip and fall, Mr. Benton proximately and foreseeably sustained injuries, which are serious and permanent in nature, including, but not limited to a severely comminuted left distal clavicle fracture with apex dorsal angulation, as well as other injuries as may be diagnosed by and/or are supplemented via reports from Mr. Benton's health care providers. All of Mr. Benton's injuries have in the past and may in the future caused Mr. Benton great pain and suffering as more fully stated below. (See medical reports pertaining to Mr. Benton's injuries and ongoing treatment as **Exhibit B**. Mercy Philadelphia Hospital Emergency Room records; **Exhibit C**. Mercy Philadelphia Hospital Operative Records; and **Exhibit D**. Report of Dr. Lynn W. Yang, M.D. as attachments hereto).

18. Mr. Benton underwent surgery for this injury on September 20, 2017 which involved open reduction and internal fixation of his left clavicle. He had a steel plate and screws inserted which did not take after surgery causing the metal plate and screws to protrude through his skin.

19. Mr. Benton underwent a second corrective surgery as a result of his injuries for the removal of this hardware on October 12, 2017.

20. These multiple surgeries have left Mr. Benton with a severe and grotesque scarring which can be seen in photographs attached hereto as **Exhibit E**.

21. Mr. Benton now suffers severely limited function and motion, along with pain that has dramatically reduced his quality of life. Dr. Yang opined that all of these symptoms and limitations are causally related to the injuries he sustained due to his fall at and on defendant's negligently maintained public sidewalk at The Crosswalk. (See **Exhibit D** as an attachment hereto.)

22. As described above, and as a direct and proximate result of the slip and fall, Mr. Benton has been and will be obliged to receive and undergo extensive medical treatment including, but not limited to, two surgeries which have already taken place, further radiological studies, doctor consultations, prescription drugs for severe pain, surgery, and physical therapy, all of which have and will continue to accrue significant costs and expenses.

23. As a further result of the slip and fall, Mr. Benton has incurred medical bills, expenses, and out-of-pocket costs.

24. As a further result of the slip and fall, Mr. Benton may hereafter incur other financial expenses to which he may otherwise be entitled to recover.

25. The aforesaid slip and fall was proximately caused by and due solely to the negligence and carelessness of the CSX Defendants, and was due in no manner whatsoever to any act or failure to act on the part of Mr. Benton.

### **COUNT ONE**

### **NEGLIGENCE**

### **(Mr. Benton v. CSX Transportation)**

26. Complainant hereby incorporates Paragraphs 1 through 25, by reference, as though the same were fully set forth at length herein.

27. As the owner, operator, manager, and/or possessor of the public pedestrian walkway at The Crosswalk, Defendant CSX Transportation owed Mr. Benton a duty to inspect, repair, remediate, and or maintain the safety of that walkway for lawfully traversing pedestrians.

28. The defective public pedestrian walkway as described herein posed an unreasonable risk of harm because it deprived Mr. Benton of the ability to safely cross the roadway in wet conditions thereby installing a latently defective condition on its business premises which law required Defendant CSX Transportation to ensure against.

29. Defendant CSX Transportation knew or reasonably should have known of the unreasonable risk of harm posed by the dangerous public pedestrian walkway at The Crosswalk at a sufficient time prior to the August 29, 2017 slip and fall to have taken the necessary measures to protect against the dangerous and/or defective condition(s).

30. Defendant CSX Transportation did not exercise reasonable care to protect Mr. Benton against said latent dangers through its own negligence and/or carelessness, including the following acts:

- (a) Allowing a dangerous and/or defective condition(s) of the public pedestrian walkway as described herein to exist which it knew or should have known existed through the exercise of reasonable care;
- (b) failing to correct said dangerous and/or defective condition(s) of which it knew or should have known and which constituted a danger to persons lawfully walking thereon;
- (c) failing to keep and maintain the public pedestrian walkway at The Crosswalk in a reasonably safe condition for use by Complainant and similarly situated lawful uses;
- (d) failing to warn persons at the Pedestrian Crosswalk of the existence of such latent dangerous conditions of which it knew or should have known and was negligent to ensure against;
- (e) failing to inspect the Pedestrian Crosswalk at reasonable intervals in order to determine the defective and dangerous condition(s) thereon;

- (f) disregarding the rights and safety of Mr. Benton and others;
- (g) failing to exercise due care given the need for Mr. Benton and other people similarly situated to use the Pedestrian Crosswalk to travel on the public pedestrian sidewalk alongside the public roadway;
- (h) negligently hiring others to perform work on the public pedestrian walkway at The Crosswalk including inspection, maintenance, repair, and remediation of the Pedestrian Crosswalk;
- (i) failing to repair, replace, restore, or renew the public pedestrian walkway at The Crosswalk and its components at or prior to the time of Mr. Benton's injury despite being informed of the unsafe condition(s);
- (j) failing to properly and adequately maintain the public pedestrian walkway at The Crosswalk in accordance with local ordinances and the laws of the Commonwealth of Pennsylvania, including but not limited to PM-302.5 Site hazard of the Philadelphia Property Maintenance Code;
- (k) failing to properly and adequately maintain the public pedestrian walkway at The Crosswalk in accordance with the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq. as described hereinbefore;
- (l) failing to properly supervise and/or hire competent individuals to make the public pedestrian walkway at The Crosswalk reasonably safe for lawful business licensees;
- (m) failing to inspect and/or negligently inspecting the work of any contractor or agent after any attempt to correct the defects located at and/or on the public pedestrian walkway at The Crosswalk;
- (n) failing to warn Mr. Benton of the dangerous and hazardous condition(s);
- (o) failing to ensure the reasonable safety of the public pedestrian walkway at The Crosswalk;

31. Said dangerous conditions created a reasonably foreseeable risk of the kind of injuries which were sustained by Mr. Benton

32. The aforementioned conduct of Defendant CSX Transportation constitutes a breach of duty owed to Mr. Benton as a lawful pedestrian walking on the public pedestrian walkway at The Crosswalk.

33. Upon information and belief, Defendant CSX Transportation had to ensure against and/or had actual notice or should have known by the exercise of reasonable care of, the existence of said latent dangerous conditions at a sufficient time prior to the accident to have taken the necessary measures to protect against the dangerous condition by correcting or otherwise remedying the defective condition of the public pedestrian walkway at The Crosswalk.

34. Equian is asserting a lien of \$10,849.64 for this claim. See the Equian Lien Statement, a true and correct copy of which is attached hereto as **Exhibit F**.

35. As a direct and proximate result of Defendant's negligence and/or carelessness Mr. Benton has suffered damages as set forth above.

**WHEREFORE**, Complainant , Alonzo Benton, demands judgment against Defendant CSX Transportation, for compensatory and incidental damages in excess of \$300,000.00 plus interest, attorney's fees and costs, and such other relief as this Honorable Board deems just and proper.

Respectfully submitted,

**LEONARD, SCIOLLA,  
LEONARD & TINARI, LLP**

BY: /s/ John J. Leonard

John J. Leonard, Esquire (PA ID #21745)  
Two Penn Center, Suite 1910  
1500 JFK Boulevard  
Philadelphia, PA 19102  
(215) 567-1530  
*Attorney for Complainant*

Dated: August 21, 2019

### **VERIFICATION**

I, John J. Leonard, Esquire, verify under penalty of perjury that the foregoing is true and correct. Further, I certify that I am qualified and authorized to file this Administrative Complaint.

Executed on: August 21, 2019

Signature: /s/ John J. Leonard

## **CERTIFICATION OF SERVICE**

I, John J. Leonard, Esquire, certify that I have this day served copies of this document upon all parties of record in this proceeding, by First-Class Mail at the following address:

CSX Transportation, Inc.  
c/o CT Corporation System  
1015 15th Street, NW  
Suite 1000  
Washington, District of Columbia 20005

Executed on: August 21, 2019

Signature: /s/ John J. Leonard

# EXHIBIT A



## Consulting Engineers & Scientists, Inc.

The Commons at Great Valley 41 General Warren Boulevard Malvern, PA 19355

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April 10, 2018

Benjamin E. Smith, Esquire  
Leonard, Sciolla, Hutchison, Leonard & Tinari, LLP  
Two Penn Center, Suite 1910  
1500 John F. Kennedy Boulevard  
Philadelphia, PA 19102

**RE: Alonzo Benton v. CSX Transportation and CSX Corporation**

**Our File No.: 17261**

**Subject: Slip and Fall on Metal Plate**

Dear Mr. Smith:

It was reported that on August 29, 2017, Mr. Alonzo Benton was walking to his home after shopping at a Save Lots store. When Mr. Benton approached the train tracks at 2213 South 58<sup>th</sup> Street in Philadelphia, Pennsylvania, he slipped on the metal edging plate along the train tracks. It was requested that I evaluate the incident circumstances to preliminarily determine the nature and cause of Mr. Benton's fall.

I reviewed the following submitted materials:

1. Medical Records from Mercy Hospital of Mr. Alonzo Benton.

### **Submitted Material Review**

#### *Medical Records of Mr. Benton*

The medical records indicated on the triage notes that Mr. Benton presented with left shoulder pain after a slip and fall in the rain. Mr. Benton described slipping when he was walking across the train tracks landing on his left shoulder. The left clavicle had an obvious deformity with swelling and tenderness. The CT of the left shoulder revealed a comminuted left distal fracture with apex dorsal angulation.

### **Examinations**

Examinations of the incident train tracks were performed on November 9 and December 11, 2017, at the railroad crossing of 2213 South 58<sup>th</sup> Street in Philadelphia, Pennsylvania. The purpose of these examinations was to observe conditions, take photographs, and obtain measurements.

West Coast Office

6911 East Septimo Street, Long Beach, CA 90815 Phone 562-596-1101 Fax 562-596-8901



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The incident location was on 58th Street. 58th Street traveled in a northwest to southeast direction. For the purpose of this report, 58th Street shall be considered a north-south traveled roadway. The 58th Street intersection with Woodland Avenue was north from the railroad tracks. Railroad tracks cross the 58th Street roadway at grade in an east-west direction. The incident location was on the west side of 58th Street and the north side of the railroad tracks, see Enclosure 1.

Precast concrete panels fill the railway bed between the train rails, as shown in Enclosure 2. These panels have a metal perimeter edging the concrete infill. The top/horizontal stepping/walking-surface of the metal edging was 3 inches wide. The panels were marked KSA and a plate had was marked 10-5-06, which appeared to be a date of manufacture. Other plates were similarly marked 10-20-06, 11-10-06, and 11-3-06. The concrete panels were anchored in place and had depressed pockets containing bolts and washers. A portion of the rail bed was also covered by a blacktop pavement. On the west side of the roadway was a public sidewalk.

The 58th Street roadway was blacktop paved and the sidewalks were concrete. Approaching the rail bed, the sidewalks transition to blacktop. The 58th Street roadway rail crossing included cross arms and signals.

The center to center rail spacing was approximately 4 feet 11 inches. There were two tracks crossing the intersection. The distance between two sets of tracks measured center to center of the rail was about 7 feet 5 inches. The panel width closest to the sidewalk was 27-5/16 inches and the panel length was 97-1/2 inches. Between the train rails there was a 50-1/2 inch wide panel. This panel length was 97-1/2 inches. The bed between rail lines, this is the center bed, had two 27-1/2 inch wide panels at either opposing rail with a central blacktop paved strip that was 26 inches wide. Thereafter, the pattern repeated between rails with a 50-1/2 inches wide panel and on the opposite side a 27-1/2 inch wide panel, which again abutted the blacktop walkway that leads to the concrete sidewalk. The distance or length of this blacktop was 16 feet across the track and about 19 feet 6 inches on the opposite side.

The incident panel was identified as the rightmost panel when facing south. The incident panel edge was toward the rail and the panel plate which was marked 10-5-06. The width of this metal edging was 3 inches, see Enclosure 3. The finish was smooth and nonabrasive visually and to the touch, as shown in Enclosure 4. In comparison, the asphalt had exposed sharp aggregate edges in the asphalt matrix resulting in an irregular surface profile. The concrete had a rough, sandy textured finish.

Slip resistance testing was performed using an English XL with Neolite sensor. Testing was performed on the metal edging, concrete and asphalt. The slip resistance coefficients were



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then compared to determine the differences between them. The metal edging was 32.1 percent less slip resistant than the cement of the sidewalk and 26.7 percent less slip resistant than the asphalt.

### **Discussion**

During wet weather conditions, Mr. Benton walked along the 58<sup>th</sup> Street concrete sidewalk that transitioned to blacktop and he fell after stepping onto the metal perimeter edging of the railway crossing precast concrete panel. The incident location was in the exterior environment and would expectedly be used by pedestrians during dry and wet conditions. Based on the incident circumstances, my site examination, and the medical records pertaining to Mr. Benton, his fall was consistent with a slip and fall that was caused by his footwear slipping on the metal edging plate of the walking surface panel. The 3-inch wide metal edge plate had a significant reduction in the available slip resistance coefficient as compared to the sidewalk concrete and asphalt Mr. Benton traveled across before stepping to the metal plate. As Mr. Benton was approaching the metal edging, he developed an expectation of frictional resistance of the sidewalk and/or asphalt. As his trailing foot was pushing off from the metal edging, his foot slipped and he fell onto his left shoulder, fracturing his clavicle. The injury of Mr. Benton was consistent with a slip and fall onto the left shoulder.

On the incident date, August 29, 2017, [www.weatherunderground.com](http://www.weatherunderground.com) reported that in Philadelphia, Pennsylvania, precipitation occurred between 7am to 10pm. Under these conditions, exterior walking surfaces were wet.

The wet slip resistance coefficient of the metal edging was significantly less than the coefficient for the wet concrete and the wet asphalt. When a person walks, they develop an expectation of friction. If a person is walking on a surface that is very slip resistant and unexpectedly transitions to a surface of less slip resistance, the person will instinctively continue ambulation in the same manner that they had experienced to be safe. Several factors of the walking gate of a person will determine the required friction for their gate and walking speed. For example, if a person steps with a longer stride and a faster gate, they will require greater slip resistance from the surface to prevent a slip than a person with shorter gait and slower walking speed. The differences in wet slip resistance between the rough concrete/asphalt and the smoother metal plate of the walking-surface resulted in a decrease in slip resistance in a manner in which a person would be exposed to an unreasonable risk of slipping. Therefore, a walking pedestrian has a greater likelihood of slipping when transitioning from wet concrete/asphalt to the metal edging of the concrete panel.

The metal edging was smooth to the touch and not abrasive. If this metal edging had been coated with an abrasive product or manufactured with an abrasive, the frictional slip



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resistance comparing the concrete, blacktop and metal would have been reasonably consistent. Altering the surface slip resistance is readily achievable in forms of paints and adhesives strips, such that the slip resistance coefficient of the metal inserts surface would have been similar to that of the asphalt and concrete sidewalk. Alternately, the metal plate should have been manufactured by a company like SlipNOT®, a provider of non-slip metal products.

During wet conditions of use, maintaining the walking-surface with a reasonably consistent slip resistance allows a walking pedestrian to develop and maintain a walking stride and gait without developing an unnecessary increased risk of slipping and falling. Mr. Benton was exposed to a change in walking-surface frictional resistance that was not marked or warned. This change in slip resistance was not readily discernible during walking ambulation. The walking-surface was within the lower portion of the walking cone of vision, which was not color discriminate. [Reference the U.S. Department of Transportation report Pedestrian Falling Accidents in Transit Terminals and Human Dimension & Interior Space, A Source Book of Design Reference Standards by Panero and Zelnik.] The reduction in walking-surface slip resistance was not readily apparent to a pedestrian like Mr. Benton, was not marked or warned and therefore was a hidden or camouflaged hazard. If the surface coefficient of the metal edging plate would have been reasonably similar to that of the concrete sidewalk or blacktop pavement, then the incident reduction in slip resistance, which was a hazard, would have been eliminated and the fall and injury of Mr. Benton would have been prevented.

To the extent that CSX Transportation and CSX Corporation believe that Mr. Benton should have recognized the metal plate as a walking-surface condition to avoid, the plate should have been marked in a distinct and attractive manner that defined the need for caution. Under this condition and/or until a safe maintenance repair was performed, the metal plate within the pedestrian walkway should have been marked by a yellow warning marker. The American National Standard Institute (ANSI), Safety Color Code, Z535.1 was a standard for the technical definitions, color standards and color tolerances for Safety Colors, and the applications of these Safety Colors to specific purposes in connection with accident prevention. ANSI Z535.1-1991 included safety yellow and stated safety yellow shall be the color for identification of CAUTION. This standard further recommended marking conditions that might result in stumbling, falling or tripping. Similarly, the National Safety Council, Accident Prevention Manual for Business and Industry stated, "Yellow is the standard color for marking (1) hazards that may result in accident from slipping, falling, striking against something, etc..." and described that Yellow is the Safety Color that designates Caution. In addition, ASTM International, Standard Practice for Safe Walking Surfaces - F1637 stated, "Bright yellow is a commonly used color for alerting users of the presence of certain walkway conditions." In addition, such a warning marker was warranted to include an abrasive additive for slip resistance.



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The 2010 ADA requirements state that a slip resistant surface “provides sufficient frictional counterforce to the forces exerted in walking to permit safe ambulation.” The sudden and unexpected decrease in wet slip resistance between the concrete or asphalt pavements and the incident metal edging plate failed to provide sufficient frictional counterforce for the expected forces exerted during ambulation for the incident site characteristics and thereby violated the ADA.

### **Preliminary Opinions**

The following preliminary opinions are based upon my education, training, experience, inspections, and the reviewed materials and are stated within a reasonable degree of biomechanical engineering certainty.

- The fall of Mr. Benton was consistent with a slip that occurred during the toe push off phase of walking.
- Mr. Benton fell when his trailing foot pushed off from a foot bearing position on the metal edging of a rail track concrete panel.
- The incident location was an intended pedestrian railway crossing.
- The incident reduced slip resistance of the metal plate within the pedestrian walkway was not marked or warned or otherwise readily discernible and was therefore a hidden or camouflaged hazard.
- The metal plate was within the lower non-color discriminate portion of the walking cone of vision and absent marking or warning was not a condition that attracted attention or defined a need for caution.
- The change in wet slip resistance between the concrete sidewalk and/or blacktop pavement as compared to the incident metal plate exposed Mr. Benton to an unreasonable risk of slipping, in that:
  - Mr. Benton developed an expectation of slip resistance based upon his experience walking on the concrete sidewalk and on the blacktop pavement. Mr. Benton experienced a sudden and unexpected decrease in this expected slip resistance was when his trailing foot pushed off from the concrete panel metal edging plate. And,



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The change in walking-surface slip resistance was a hidden or camouflaged condition of the property. And,

- The incident change in wet slip resistance was an unnecessary and unreasonable condition of the property, in that the incident metal edging plate could have been manufactured with the SlipNOT® metal finish or otherwise coated with a non-slip product.
- Until a safe maintenance repair was performed, the metal plate within the pedestrian walkway should have been marked by an ANSI/NSC/ASTM yellow warning marker defining the need for caution in a visually attractive manner.
- Mr. Benton was not provided a reasonable or visually effective opportunity to understand or otherwise recognize that a wet slip hazard was present and/or that avoidance was necessary.
- The incident railway crossing included expected use by pedestrians with disabilities.
- Independent from the opinions discussed above, the incident slip resistance conditions violated the ADA.

This report may be supplemented if additional information becomes available.

Very truly yours,

Andrés J. Calderón, Ph.D.

AJC



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### **REFERENCES:**

1. Fundamentals of Biomechanics: Equilibrium, Motion, and Deformation. Nihat Ozkaya and Margareta Nordin; Second Edition, Springer, NY 1999.
2. Biomechanics of Musculoskeletal Injury. William C. Whiting and Ronald F. Zernicke; Second Edition, Human Kinetics, 2008.
3. Orthopaedic Biomechanics: Mechanics and Design in Musculoskeletal Systems. Donald L. Bartel, Dwight T. Davy and Tony M. Keaveny; Pearson Prentice Hall, 2006.
4. Biomechanics Principles and Applications, edited by Donald R. Peterson and Joseph D. Bronzino; CRC Press, Taylor and Francis Group, LLC, 2008.
5. Principles of Biomechanics, Ronald L. Huston, CRC Press, Taylor and Francis Group, LLC, 2009.
6. Kinesiology Scientific Basis of Human Motion, Tenth Edition, Nancy Hamilton and Kathryn Luttgens, Mc Graw Hill, 2002.



## Consulting Engineers & Scientists, Inc.

Benjamin E. Smith, Esquire

April 10, 2018

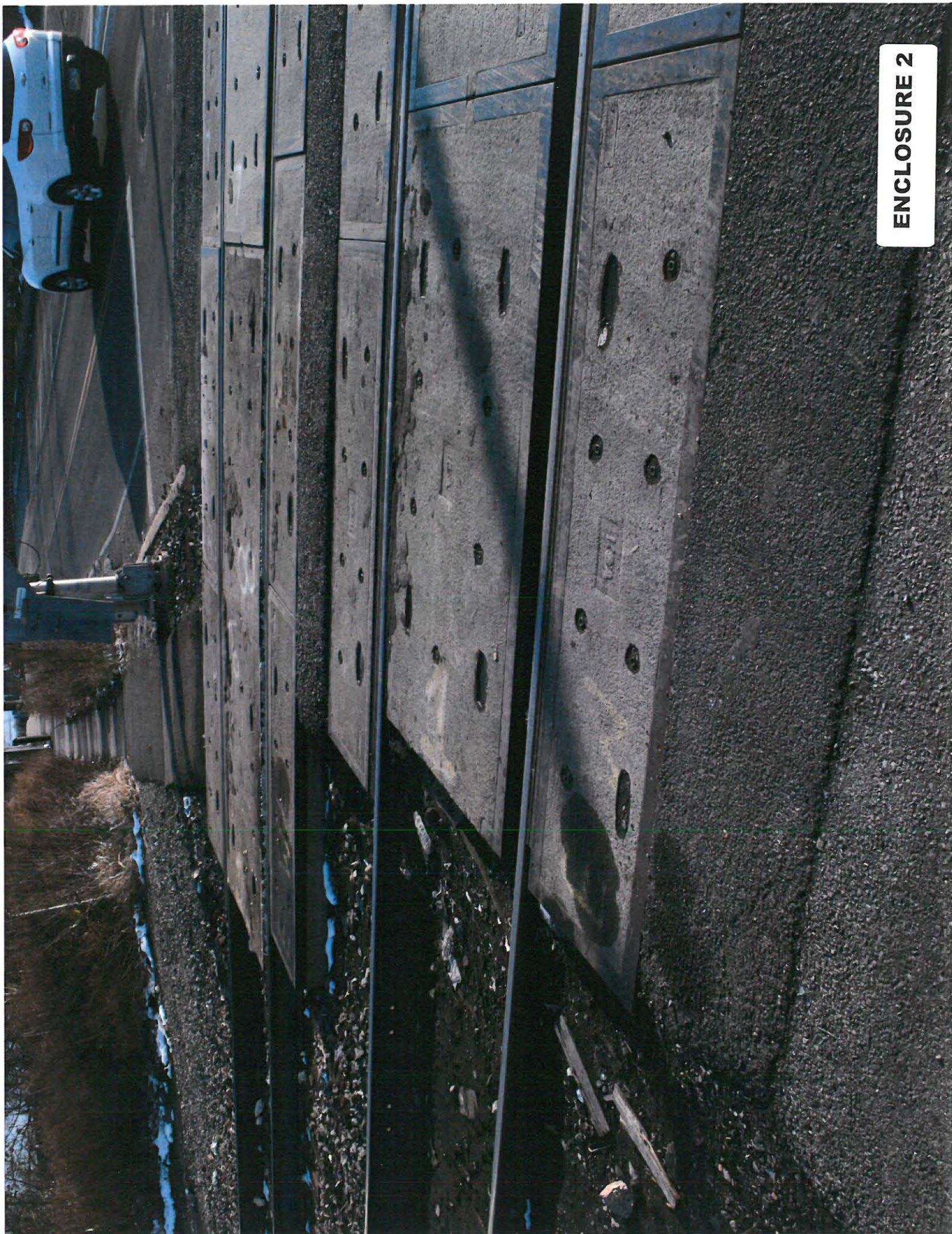
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### **LIST OF ENCLOSURES**

|                           |                          |
|---------------------------|--------------------------|
| ENCLOSURE 1<br>17261(5)   | INCIDENT SIDEWALK        |
| ENCLOSURE 2<br>17261(7)   | CONCRETE PANELS          |
| ENCLOSURE 3<br>17261(27)  | SIZE OF METAL EDGING     |
| ENCLOSURE 4<br>17261 (25) | CLOSE UP OF METAL EDGING |



ENCLOSURE 1





**ENCLOSURE 3**

ENCLOSURE 4



## **ANDRÉS J. CALDERÓN, Ph.D.**

Consulting Engineer in Biomechanical, Biomedical and Mechanical Engineering: Evaluation of the relationship of trauma to injury and between accident dynamics and injury potential; Analysis of human motion and response of a body relating to physical activity or the forces of an accident, Analysis of human motion as it relates to gait in fall injury, Evaluation of medical equipment and products as it relates to injury, Analysis of vascular procedures and devices related to injury, Evaluation of ergonomic design.

### **Consulting Engineers & Scientists, Inc.**

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Malvern, PA 19355  
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Office: (610) 889-0762  
acalderon@ces-experts.com  
Birth Date: 8-7-78

## **CERTIFICATION**

Certified as an Engineer in training in the Commonwealth of Puerto Rico, USA, 2001

## **EDUCATION**

Bachelor of Science in Mechanical Engineering, University of Puerto Rico, 2001  
Master of Science in Biomedical Engineering, University of Michigan, 2003  
Doctorate in Biomedical Engineering, University of Michigan, 2006

## **PROFESSIONAL BACKGROUND**

Employed by Consulting Engineers & Scientists, Inc. in 2010 as a Consulting Engineer. Responsibilities include the biomechanical evaluation of physical trauma and injury; the dynamic analysis of human motion; and the evaluation of injury resulting from automotive, industrial, construction, and slip, trip and fall accidents as well as sporting events and amusement rides. Other responsibilities include the evaluation of the safety and adequacy of products, including medical devices implants and pharmaceutical delivery systems. Additional responsibilities include the evaluation of vascular conditions (air emboli, clots, tissue damage, etc.) caused by trauma and/or medical equipment. While employed at Consulting Engineers and Scientists, Dr. Calderon has presented lectures and seminars in different topics of Biomechanic applications as it relates to accident evaluation.

Employed by the University of Pennsylvania, in Philadelphia, Pennsylvania from 2008-2010 as a Lecturer in the Department of Bioengineering teaching undergraduate and graduate level courses in Biomechanics and Biomaterials. This included teaching Engineering Principles of Human Physiology which analyzed systems-level physiology including bone and muscle relationship to injury and the kinematics of human motion. These courses in Biomechanics and Biomaterials relate the application of statics and dynamics to musculoskeletal system force analyses, biomechanics of soft and hard tissues, microstructure and mechanical properties of human joint biomechanics, classification and bulk properties of implantable materials, and how these related to torsional loading and bending. Additional courses included Continuum Biomechanics which covered deformation kinematics, stress, conservation of mass, momentum, energy and failure of bone and soft tissue (tendons, ligaments, vessels, etc.). Dr. Calderon taught Transport Processes of Living Systems which included fluid mechanics and mass transport applied to living systems and biomedical devices.

Employed by the University of Pennsylvania School of Medicine, in Philadelphia, Pennsylvania from 2006-2010 as a Research Fellow in the Department of Anesthesiology and Critical Care. Responsibilities included the design and experimentation of targeted drug delivery vehicles where anatomy and physiology of human vasculature and organs were analyzed under physiological biomechanical conditions. Other responsibilities included the development of testing protocols, medical testing devices, products and tools; and the collection, analysis, documentation, and interpretation of data.

## **ANDRÉS J. CALDERÓN, Ph.D.**

Employed by the University of Michigan, in Ann Arbor, Michigan from 2002-2006 as a Graduate Student Research Assistant in the Department of Biomedical Engineering. Responsibilities included the investigation of gas embolotherapy to occlude blood flow to tumors. The research involved the use of theoretical, experimental, and computational models to investigate how gas bubbles travel and lodge in the microcirculation of the brain, lung, kidney and liver. Other responsibilities included the investigation of how gas emboli form (e.g. diving decompression, major surgery, pulmonary trauma and vascular procedures) and how they can be treated. This work also included teaching fluid mechanics and biotransport courses as a substitute lecturer.

Employed by Purdue University, in West Lafayette, Indiana for the summer of 2000 as an undergraduate researcher. Responsibilities included the mechanical testing of naturally occurring biomaterials used for implants of ligaments, tendons, abdominal grafts, vocal chords and other tissues. The repair of these tissues could allow patients to regain the functionality of motion and strength in certain joints and organs. The research involved the use of tensile, porosity, ball bursting and dehydration/hydration tests of various biomaterials. This testing measured deformation, strength and failure of different biomaterials compared to healthy connective tissue. The research also involved the study of ligament and tendon properties and joint biomechanics.

### **OTHER EXPERIENCE**

Extensive experience in sports related injuries from sports activity and the shadowing of orthopedic surgeons and physical therapy physicians.

Lifetime basketball player and active runner with special interest in running biomechanics

Scientific and technical writing course with certification, UPENN, Philadelphia, PA

Summer medical training program, UPR, Health Science Campus, San Juan, PR

### **PUBLICATIONS AND PRESENTATIONS**

Available upon request

### **PROFESSIONAL SOCIETY MEMBERSHIPS**

Biomedical Engineering Society

American Society of Mechanical Engineers

American Physical Society

Tau Beta Pi, Engineering Honor Society

American Society for Testing and Materials

- Member of Committee F-13: Safety and Traction for Footwear

Certified Playground Safety Inspector by the National Playground Safety Institute

### **AWARDS**

NIH Supplemental Fellowship for Air Embolism Research (2008)

Post Doctoral Fellowship Recipient, NRSA, Dept. Anesthesiology, UPENN (2006)

Minority Supplement Fellowship for Gas Embolotherapy (2002)

Rackham NSF Fellowship Award, University of Michigan, Ann Arbor (2001)

# **EXHIBIT B**

AUTHORIZATION FOR RELEASE OF INFORMATION IN  
CONNECTION WITH CIVIL LITIGATION

|                                                                                                                                     |                            |
|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| <b>TO:</b><br><br><b>Custodian of Records</b><br><b>Mercy Philadelphia Hospital</b><br>501 S. 54th Street<br>Philadelphia, PA 19143 | <b>Name:</b> Alonzo Benton |
|                                                                                                                                     | <b>DOB:</b> 11/14/1958     |
|                                                                                                                                     | <b>SSN:</b> xxx-xx-9216    |
|                                                                                                                                     | <b>DOS:</b> 08/29/2017     |

- I. **Pursuant to my privacy rights under Health Insurance Portability and Accountability Act (HIPAA), by affixing my signature below I understand and voluntarily consent to the following:**

I hereby request and authorize that you disclose, make available and furnish to the Attorney/Paralegal whose name and address is:

LEONARD, SCIOCCA, HUTCHISON,  
LEONARD & TINARI, LLP  
Attn: Jared Tinari  
1500 J.F.K. Blvd., Ste. 1910  
Philadelphia, PA 19102  
Phone: (215) 567-1530  
Fax: (215) 564-4611

or the attorney authorized representative all medical records, bills and reports including:

1.) Office notes; 2.) Charts; 3.) Diagrams; 4.) Pathology reports; 5.) Operative reports; 6.) Physical and lab tests; 7.) X-ray/imaging reports; 8.) X-ray/imaging films; 9.) Prescription notes; 10.) Treatment plans; 11.) Discharge summary, with regard to the above named individual, from the inception of your records to the present; and 12.) Itemized billing statements.

**This authorization specifically excludes the release of health information related to psychiatric or mental health treatment, treatment of drug and/or alcohol abuse; treatment of Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV); and sexually transmitted diseases/viruses.**

II. **Rights and obligations under HIPAA:**

- A. **Purpose of this request:** I understand that the information listed above in Section I is being requested by the law firm of Leonard, Sciolla, Hutchison, Leonard & Tinari, LLP for the specific purpose of:

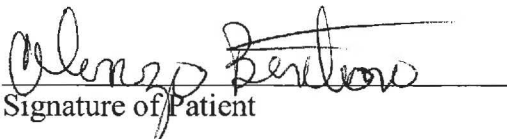
a.) investigating a potential or pending civil claim or b.) investigating a pending civil litigation lawsuit I filed and by signing this authorization I voluntarily consent to its release.

**B. Expiration Date:** Unless otherwise revoked, this authorization will expire six (6) months after the date of this authorization.

**C. Right to revoke:** I understand that I have the right to revoke this authorization at any time. I understand that the revocation must be in writing to the above named doctor/facility authorized to make this disclosure. I further understand that the revocation is only effective after it is received by the above named doctor/facility and does not apply to information that has already been released in response to this authorization.

**D. Impact on Medical Treatment:** I understand that my right to treatment, payment, enrollment or eligibility for benefits is not conditioned on me signing this authorization.

**E. Subsequent Disclosure:** I understand that any disclosure of information may be subject to re-disclosure by Leonard, Sciolla, Hutchison, Leonard & Tinari, LLP and may no longer be protected by federal or state law.

  
Signature of Patient

12/28/17  
Date

\_\_\_\_\_  
Signature Authorized Representative/Guardian

\_\_\_\_\_  
Date

By signing this authorization, the Authorized Representative and/or Guardian certifies that he or she has the authority to act on behalf of the person identified above on the basis of (please explain):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



A member of Mercy Health System

P

## EMERGENCY RECORD

|                                          |  |                                  |  |                                          |                               |                              |  |
|------------------------------------------|--|----------------------------------|--|------------------------------------------|-------------------------------|------------------------------|--|
| <b>Account No:</b> PA1304820416          |  | <b>Date:</b> 08/29/17            |  | <b>Time:</b> 1554                        |                               | <b>Unit No:</b> M000301370   |  |
| <b>PATIENT INFORMATION</b>               |  |                                  |  |                                          |                               |                              |  |
| <b>Name:</b> BENTON, ALONZO              |  | <b>DOB:</b> 11/12/1958           |  | <b>AGE:</b> 58                           |                               | <b>Pt Status:</b> DEP ER     |  |
| <b>Address:</b> 2432 S FRAZIER ST        |  | <b>SEX:</b> M                    |  | <b>MS:</b> S                             |                               | <b>LOC/Srvc:</b> PHER        |  |
| PHILADELPHIA, PA 19143                   |  | <b>RACE:</b> AA                  |  |                                          |                               | <b>Room/Bed:</b>             |  |
| <b>Phone:</b> (215) 681-6752             |  | <b>LANG:</b> ENGLISH             |  | <b>Accommodation:</b>                    |                               |                              |  |
| <b>SSN:</b> XXX-XX-9216                  |  | <b>ADM Src/Prior:</b> HOM /ER    |  | <b>Last DC Date:</b>                     |                               |                              |  |
|                                          |  | <b>Religion:</b> CHRISTIAN       |  |                                          |                               |                              |  |
|                                          |  | <b>Church:</b>                   |  |                                          |                               |                              |  |
| <b>Occurrence Code:</b> 11               |  | <b>Occurrence Date:</b> 08/31/17 |  |                                          |                               |                              |  |
| <b>PHYSICIAN INFORMATION</b>             |  |                                  |  |                                          |                               |                              |  |
| <b>Admitting Physician</b>               |  | <b>Attending or ER Physician</b> |  |                                          | <b>Primary Care Physician</b> |                              |  |
|                                          |  | YOON, RUSSELL MD                 |  |                                          | BARDEN, ABA, MD               |                              |  |
|                                          |  | (610) 237-4700                   |  |                                          | (215) 662-9900                |                              |  |
| <b>Att Group:</b> .                      |  |                                  |  |                                          |                               |                              |  |
| <b>NEXT OF KIN</b>                       |  |                                  |  | <b>PERSON TO NOTIFY</b>                  |                               |                              |  |
| <b>Name:</b> BENTON, APRIL               |  |                                  |  | <b>Name:</b> BENTON, APRIL               |                               |                              |  |
| <b>Addr:</b> 5600 OGONTZ AVE APT F       |  |                                  |  | <b>Addr:</b> 5600 OGONTZ AVE APT F4      |                               |                              |  |
| PHILADELPHIA, PA 19141                   |  |                                  |  | PHILADELPHIA, PA 19141                   |                               |                              |  |
| <b>Phone:</b> (000) 000-0000             |  |                                  |  | <b>Phone:</b> (000) 000-0000             |                               |                              |  |
| <b>Other:</b>                            |  |                                  |  | <b>Other:</b>                            |                               |                              |  |
| <b>Relat:</b> DAUGHTER                   |  |                                  |  | <b>Relat:</b> DAUGHTER                   |                               |                              |  |
| <b>EMPLOYER INFORMATION</b>              |  |                                  |  | <b>GUARANTOR INFORMATION</b>             |                               |                              |  |
| <b>Name:</b> UNEMPLOYED                  |  |                                  |  | <b>Name:</b> BENTON, ALONZO              |                               | <b>Emp:</b> UNEMPLOYED       |  |
| <b>Addr:</b>                             |  |                                  |  | <b>Addr:</b> 2432 S FRAZIER ST           |                               | <b>Addr:</b>                 |  |
| PHILADELPHIA, PA 19143                   |  |                                  |  |                                          |                               |                              |  |
| <b>Phone:</b> (000) 000-0000             |  |                                  |  | <b>Phone:</b> (215) 691-6752             |                               | <b>Phone:</b> (000) 000-0000 |  |
|                                          |  |                                  |  | <b>SSN:</b> XXX-XX-9216                  |                               | <b>Status:</b> UE            |  |
|                                          |  |                                  |  | <b>Relat:</b> SELF / SAME AS             |                               |                              |  |
| <b>INSURANCE INFORMATION</b>             |  |                                  |  |                                          |                               |                              |  |
| <b>Financial Class:</b> MCRMNG           |  |                                  |  |                                          |                               |                              |  |
| <b>GATEWYMCR</b>                         |  |                                  |  |                                          |                               |                              |  |
| <b>Pri:</b> GATEWAY MEDICARE ASSUR       |  |                                  |  | <b>INS#2:</b>                            |                               | <b>INS#3:</b>                |  |
| <b>Addr:</b> PO BOX 69359                |  |                                  |  | <b>Addr:</b>                             |                               | <b>Addr:</b>                 |  |
| HARRISBURG PA 17106-                     |  |                                  |  |                                          |                               |                              |  |
| <b>Phone:</b>                            |  |                                  |  | <b>Phone:</b>                            |                               | <b>Phone:</b>                |  |
| <b>Policy#:</b> 70113084                 |  |                                  |  | <b>Policy#:</b>                          |                               | <b>Policy#:</b>              |  |
| <b>Group#:</b>                           |  |                                  |  | <b>Group#:</b>                           |                               | <b>Group#:</b>               |  |
| <b>A#:</b>                               |  |                                  |  | <b>A#:</b>                               |                               | <b>A#:</b>                   |  |
| <b>Subscrbr:</b> BENTON, ALONZO          |  |                                  |  | <b>Subscrbr:</b>                         |                               | <b>Subscrbr:</b>             |  |
| <b>Sub Emp:</b> UNEMPLOYED               |  |                                  |  | <b>Sub Emp:</b>                          |                               | <b>Sub Emp:</b>              |  |
| <b>Relation:</b> SP                      |  |                                  |  | <b>Relation:</b>                         |                               | <b>Relation:</b>             |  |
| <b>Status:</b> VERIFIED                  |  |                                  |  | <b>Status:</b>                           |                               | <b>Status:</b>               |  |
| <b>INS#4:</b>                            |  |                                  |  |                                          |                               |                              |  |
| <b>Reason For Visit:</b> L SHOULDER PAIN |  |                                  |  |                                          |                               |                              |  |
| <b>Comment:</b> FALL 08/29/17            |  |                                  |  |                                          |                               |                              |  |
| <b>ISOLATION:</b>                        |  |                                  |  |                                          |                               |                              |  |
| <b>CO-Pay Collected:</b> N               |  |                                  |  | <b>Mode of Arrival:</b> WALK-IN          |                               |                              |  |
| <b>Registration Clerk:</b> PHSMITHS      |  |                                  |  | <b>Privacy Notice Given?:</b> Y (Date: ) |                               |                              |  |
| <b>email:</b> N/A                        |  |                                  |  | <b>COB Signed/Verified:</b>              |                               |                              |  |
|                                          |  |                                  |  | <b>use email:</b>                        |                               |                              |  |

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**Mercy Philadelphia Hospital**  
**EMERGENCY FLOW SHEET RECORD**

**Name: Benton, Alonzo Age: 58Y MR: M000301370 Acct: PA1304820416**

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| <b>VITAL SIGNS</b> | <b>KRIS</b>     |
|--------------------|-----------------|
| TIME               | 8/29/2017 16:02 |
| BP                 | 161/88          |
| PULSE              | 105             |
| RESP               | 17              |
| TEMP               | 98.3<br>(Oral)  |
| PAIN               | 10<br>(Achy)    |
| O2 SAT             | 97 on Room Air  |

# MERCY PHILADELPHIA HOSPITAL

## ED RECORD

Benton, Alonzo  
DOB: 11/12/1958 M58  
Wt/Ht: 77.11 Kg 175.26 cm.  
MedRec: M000301370  
AcctNum: PA1304820416

### Patient Data

**Complaint:** L SHOULDER PAIN  
**Triage Time:** Tue Aug 29, 2017 16:01  
**Urgency:** ESI5/FT  
**Bed:** ED FT  
**Initial Vital Signs:** 8/29/2017 16:02  
**BP:**161/88  
**P:**105  
**O2 sat:**97 on Room Air

**ED Attending:** Yoon, MD (9402), Russell  
**Primary RN:**

**R:**17  
**T:**98.3 (Oral)  
**Pain:**10 (Achy)

### ADMIN

**PATIENT DATA CHANGE:** Doctor Extender changed from (none) to Sara Morrison,  
CRNP. (16:07 ESM)  
Attending: Russell Yoon, MD (9402). (16:07 ESM)

### VITAL SIGNS (16:02 KRIS)

**VITAL SIGNS:** BP: 161/88, Pulse: 105, Resp: 17, Temp: 98.3 (Oral), Pain: 10 (Achy), O2 sat: 97  
on Room Air, Time: 8/29/2017 16:02.

### PRESENTING PROBLEM (16:01 KRIS)

Presenting problems: Shoulder Injury–Pain–Swelling.

### TRIAGE (Tue Aug 29, 2017 16:01 KRIS)

**TRIAGE NOTES:** pt presents with left shoulder pain s/p slip and fall in rain 1 hour ago. (Tue  
Aug 29, 2017 16:01 KRIS)

**PATIENT:** NAME: Benton, Alonzo, AGE: 58, GENDER: male, DOB: Wed Nov 12, 1958, TIME OF  
GREET: Tue Aug 29, 2017 15:55, EMS Haste: No, Foreign Travel: NO not in the past 30 days, MD  
Notified of Travel: \*Not Applicable, Patient Symptoms: \*No C/O Symptoms On Arrival, KG WEIGHT:  
77.11, HEIGHT/LENGTH: 175.26cm, BMI: 25.10, MEDICAL RECORD NUMBER: M000301370,  
ACCOUNT NUMBER: PA1304820416, PCP: Barden, Aba. (Tue Aug 29, 2017 16:01 KRIS)

**ADMISSION:** URGENCY: ESI5/FT, TRANSPORT: \*Walk in, BED: WAITING. (Tue Aug 29,  
2017 16:01 KRIS)

**COMPLAINT:** L SHOULDER PAIN. (Tue Aug 29, 2017 16:01 KRIS)

**ASSESSMENT:** Assessment: shoulder pain, Airway is patent, Respirations are unlabored,  
Speech is coherent, Patient is AAO X 3, Skin is warm, Skin is dry. (16:02 KRIS)

**PAIN ASSESSMENT:** aching pain, constant, on a scale 0–10 patient rates pain as 10, Pain  
exacerbated by, movement, Nothing has been tried to alleviate the pain. (16:02 KRIS)

**TREATMENTS IN PROGRESS:** None. (16:02 KRIS)

**FALL RISK ASSESSMENT:** male(1), Able to rise in a single movement; no loss of balance with  
steps(0), Total score 1, Score less than 5. Patient not high risk for falls. (16:02 KRIS)

**TRIAGE SCREENING:** Patient denies suicidal ideation, Patient denies presence of domestic  
violence, No history of infectious disease. (16:02 KRIS)

**ADVANCED DIRECTIVES:** Unable to determine if advanced directives are present for this  
patient. (16:02 KRIS)

**PROVIDERS:** TRIAGE NURSE: Kristen Marotta, RN. (Tue Aug 29, 2017 16:01 KRIS)

**PREVIOUS VISIT ALLERGIES:** No Known Drug Allergies. (Tue Aug 29, 2017 16:01 KRIS)  
No Known Drug Allergies. (16:02 KRIS)

### KNOWN ALLERGIES

Iodinated Contrast Media – IV Dye

### CURRENT MEDICATIONS (16:01 KRIS)

losartan:

**Patient Dose:** Daily.UNSURE OF DOSAGE.

omeprazole:

**Patient Dose:** 2 Times a day.

# MERCY PHILADELPHIA HOSPITAL

## ED RECORD

Benton, Alonzo  
DOB: 11/12/1958 M58  
Wt/Ht: 77.11 Kg 175.26 cm.  
MedRec: M000301370  
AcctNum: PA1304820416

*hydrochlorothiazide:*

**Patient Dose:** Daily.UNSURE OF DOSAGE.

### MEDICATION RECONCILIATION (16:54 ESM)

*hydrochlorothiazide – Continue as prescribed:* Patient had been taking: Daily. UNSURE OF DOSAGE.

*losartan – Continue as prescribed:* Patient had been taking: Daily. UNSURE OF DOSAGE.

*omeprazole – Continue as prescribed:* Patient had been taking: 2 Times a day. .

### PAST MEDICAL HISTORY (16:02 KRIS)

**MEDICAL HISTORY:** Past medical history includes history of hypertension, which has been treated, Patient is compliant, prostate CA.

**SURGICAL HISTORY MALE:** Surgical history of prostatectomy, HERNIA SURGERY 2015.

**PSYCHIATRIC HISTORY:** No previous psychiatric history.

**SOCIAL HISTORY:** Patient has no smoking history, Patient drinks socially, Patient currently uses drugs, Drug history notes: HEROIN 10/19/15.

### HPI SHOULDER (16:54 ESM)

**History of Present Illness:** 58-year-old male presents emergency department for evaluation of left shoulder pain occurred mealy prior to arrival. Patient reports was walking across intern tracks when he slipped and landed on left shoulder. Patient is right-hand dominant. **CHIEF COMPLAINT:** Patient presents for evaluation of injury, to the left shoulder, Patient presents for evaluation of pain, Patient presents for evaluation of tenderness. **HISTORIAN:** History provided by patient. **MECHANISM OF INJURY:** Known mechanism. **LOCATION:** Symptoms are localized, most severe in the acromioclavicular joint. **QUALITY:** Pain is dull in nature, described as aching, described as throbbing. **SEVERITY:** Maximum severity of symptoms moderate, Currently symptoms are moderate. **TIME COURSE:** Sudden onset of symptoms. **ASSOCIATED WITH:** Associated with swelling, No compartment involved. **EXACERBATED BY:** Patient's condition exacerbated by movement. **RELIEVED BY:** Patient's condition relieved by nothing, Patient's condition relieved by nothing because patient has not tried anything for relief.

### ROS (16:56 ESM)

**CONSTITUTIONAL:** Negative constitutional review of systems, Historian denies chills, Historian denies fatigue, Historian denies fever, Historian denies lethargy, Historian denies night sweats, Historian denies weight loss.

**EYES:** Negative eye review of systems, Historian denies eye pain, Historian denies eye redness, Historian denies vision changes.

**ENT:** Negative ears, nose, throat review of systems, Historian denies drooling, Historian denies dysphagia, Historian denies dysphasia, Historian denies otalgia.

**CARDIOVASCULAR:** Negative cardiovascular review of systems, Historian denies chest pain, Historian denies dyspnea on exertion, Historian denies syncope, Historian denies palpitations.

**RESPIRATORY:** Negative respiratory review of systems, Historian denies shortness of breath.

**GI:** Negative gastrointestinal review of systems, Historian denies abdominal pain.

**GENITOURINARY MALE:** Negative genitourinary review of systems, Historian denies hesitancy, Historian denies impotence, Historian denies incontinence, Historian denies urine output changes, Historian denies urinary retention.

**MUSCULOSKELETAL:** left shoulder pain and swelling.

**NEUROLOGIC:** Negative neurologic review of systems, Historian denies confusion, Historian denies dizziness.

**HEMO/LYMPHATIC:** Normal hematologic/lymphatic system review.

**PSYCHIATRIC:** Negative psychiatric review of systems.

# MERCY PHILADELPHIA HOSPITAL

## ED RECORD

Benton, Alonzo  
DOB: 11/12/1958 M58  
Wt/Ht: 77.11 Kg 175.26 cm.  
MedRec: M000301370  
AcctNum: PA1304820416

*NOTES:* All systems reviewed, negative except as described above.

### PHYSICAL EXAM (16:56 ESM)

*CONSTITUTIONAL:* Vital signs reviewed, Patient appears non toxic, Patient appears pain free, Patient alert and oriented to person, place and time.

*EYES:* Eye exam normal, Eye exam included findings of eyelids normal to inspection, Pupils equally round and reactive to light, Extraocular muscles intact, Conjunctiva normal, Sclera normal.

*NECK:* Neck exam normal, Neck exam included findings of normal range of motion, Trachea midline.

*RESPIRATORY CHEST:* Respiratory and chest exam normal, Breath sounds clear.

*CARDIOVASCULAR:* Cardiovascular assessment normal, Cardiovascular exam included findings of heart rate regular rate and rhythm, Heart sounds normal.

*UPPER EXTREMITY:* Left clavicle exam included findings of, obvious deformity, no erythema, swelling, tenderness, Right clavicle unaffected, Left shoulder exam included findings of, swelling, tenderness, active range of motion abnormal, passive range of motion abnormal, distal pulses normal, capillary refill less than 2 seconds, distal motor intact, distal sensory intact, axillary nerve intact, Right shoulder unaffected, Left elbow exam normal, no swelling, no tenderness to palpation, no warmth.

*LOWER EXTREMITY:* Lower extremity exam normal, Lower extremity exam included findings of inspection normal, Range of motion normal.

*NEURO:* Neuro exam normal, Neuro exam findings include patient oriented to person, place and time, Speech normal, Gait normal.

*SKIN:* Skin exam normal, Skin exam included findings of skin warm, dry, and normal in color.

*LYMPHATIC:* Lymphatic exam normal.

*PSYCHIATRIC:* Psychiatric exam normal, Psychiatric exam included findings of patient oriented to person place and time, Normal affect, Judgment normal.

### ORDERS (16:12 ESM)

*CR Shoulder LT Min 2 View:* Ordered for: Morrison, CRNP, Sara  
Status: Active.

### RADIOLOGY INTERPRETATION (16:51 ESM)

*UPPER EXTREMITIES:* Clavical films, of the left clavicle show, comminuted fracture.

### ORTHO SPLINTING (16:57 ESM)

*TIME OUT:* Timeout performed.

*ORTHO SPLINTING:* Side and/or site verified, Patient identification confirmed, Sterile procedures observed, Verbal consent obtained, Splinting indicated for fracture, Splinting indicated for pain control, Pre-procedure assessment: capillary refill less than 2 seconds, Distal sensation intact, Distal motor function normal, No signs of compartment syndrome, Sling applied, to the left arm, Post procedure assessment: capillary refill less than 2 seconds, Distal sensation intact, Distal motor function normal, No signs of compartment syndrome, Patient tolerated the procedure well.

### DOCTOR NOTES

*RX NOTES:* I accessed PA Prescription Drug Monitoring Program, findings:, last script given 3/17 for Percocet  
will give s hort course for acute fx. (16:47 ESM)

*PATIENT PLAN:* The patient will be discharged, The patient will follow up with Orthopedics.  
(16:58 ESM)

### ATTENDING (Thu Aug 31, 2017 06:24 PRY)

*CHIEF COMPLAINT:* i did not see the pt nor ppt in the care of the pt but was available for consult and to see the pt.

**MERCY PHILADELPHIA HOSPITAL**  
**ED RECORD**

**Benton, Alonzo**  
DOB: 11/12/1958 M58  
Wt/Ht: 77.11 Kg 175.26 cm.  
MedRec: M000301370  
AcctNum: PA1304820416

**DIAGNOSIS** (16:53 ESM)

*FINAL:* PRIMARY: Clavicle fracture.

**DISPOSITION**

*PATIENT:* Disposition Type: Discharge, Disposition: Discharge from Fast Track,

Disposition Transport: Walk, Condition: Stable. (16:53 ESM)

Patient left the department. (16:54 ESM)

**NURSING PROCEDURE: SPLINTING** (17:29 TTB)

*SPLINTING:* Splinting indicated for fracture care, Splint applied to, the left clavicle, by tb, sling applied.

*SAFETY:* Family at bedside, Hospital ID band on.

**NURSING PROCEDURE: TRANSPORT TO TESTS** (17:28 TTB)

*PATIENT IDENTIFIER:* Patient's identity verified by patient stating name, Patient's identity verified by patient stating birth date, Patient's identity verified by hospital ID bracelet.

*TRANSPORT TO TESTS:* Transport indicated to facilitate diagnosis, Patient transported to x-ray, ambulatory, Accompanied by emergency department technician.

*SAFETY:* Family at bedside, Hospital ID band on.

**INSTRUCTION** (16:51 ESM)

*DISCHARGE:* FRACTURE, CLAVICLE.

*FOLLOWUP:* Follow up with Primary Specialist in 2-3 days.

*SPECIAL:* Apply ice affected area 15-20 minutes at a time. There is reports a follow-up with orthopedics on Friday. Return to emergency department with any new or worsening symptoms including numbness tingling or worsening of pain.

**PRESCRIPTION** (16:48 ESM)

*Naprosyn:* TABLET : 500 mg : ORAL : Quantity: \*\*\* 1 \*\*\* Unit: Tab(s) Route: ORAL

Schedule: Every 12 hours Dispense: \*\*\* 20 \*\*\*

May substitute. Refills: \*\*\* No Refills \*\*\*.

*NOTES:* No Refills.

*Percocet:* TABLET : 5 mg-325 mg : ORAL : Quantity: \*\*\* 5 \*\*\* Unit: MG Route: ORAL

Schedule: Every 6 hours PRN Dispense: \*\*\* 10 \*\*\* Unit: Tab(s)

May substitute. Refills: \*\*\* No Refills \*\*\*.

*NOTES:* No Refills.

**EVENTS**

*DOCTOR EXTENDER:* Patient care initiated. (16:07 ESM)

*TRANSFER:* Triage to Emergency Waiting Room. (16:01 KRIS)

Emergency Waiting Room to Fast Track FT-2. (16:06 TTB)

Removed from Emergency Fast Track FT-2. (16:54 ESM)

**ADMIN**

*DIGITAL SIGNATURE:* Morrison, CRNP, Sara. (16:58 ESM)

Yoon, MD (9402), Russell. (Thu Aug 31, 2017 06:24 PRY)

**IMAGING** (17:28 TTB)

*DISCHARGE INSTRUCTIONS:* Image captured from scanner.

Page 2 added. Image captured from scanner.

**Key:**

ESM=Morrison, CRNP, Sara KRIS=Marotta, RN, Kristen PRY=Yoon, MD (9402), Russell TTB=Brown, Tymyca

DATE: 08/30/17 @ 0020                      Mercy Philadelphia Hospital OE \*\*LIVE\*\*                      PAGE 1  
 USER: COSYSTEM                                              PATIENT ORDER SUMMARY

PATIENT: PA1304820416 - BENTON, ALONZO  
 UNIT #: M000301370

| ORDER |      |          |           |           |     |     |        | SERVICE |      | ORDERED    |            |      |      |
|-------|------|----------|-----------|-----------|-----|-----|--------|---------|------|------------|------------|------|------|
| DATE  | TIME | CATEGORY | PROCEDURE | ORDER NUM | PRI | QTY | STATUS | DATE    | TIME | ORD DOCTOR | ORDERED BY | CHNG | FROM |

|          |      |    |          |           |      |   |     |          |      |        |          |   |    |
|----------|------|----|----------|-----------|------|---|-----|----------|------|--------|----------|---|----|
| 08/29/17 | 1612 | CR | SHOULDLT | 0829-0077 | STAT | 1 | RES | 08/29/17 | 1612 | MORRSA | COSYSTEM | C | OE |
|----------|------|----|----------|-----------|------|---|-----|----------|------|--------|----------|---|----|

Reason for Exam: Left shoulder pain

Is Patient Pregnant? N

When was patient's LMP? N/A

Comment:

|   | DATE     | TIME | USER       | DEVICE    | EVENT                                       |
|---|----------|------|------------|-----------|---------------------------------------------|
| 1 | 08/29/17 | 1612 | COSYSTEM   |           | order transmitted from OV                   |
| 2 | 08/29/17 | 1612 | COSYSTEM   | CAE-BG314 | order transmitted                           |
| 3 | 08/29/17 | 1613 | COSYSTEM   | CAE-BG314 | order's status changed from TRANS to LOGGED |
| 4 | 08/29/17 | 1637 | PHGEORST   | CAE-BG314 | order's status changed from LOGGED to TAKEN |
| 5 | 08/29/17 | 1650 | BKG DAEMON | CAE-BG314 | order's status changed from TAKEN to RESULT |

**Mercy Philadelphia Hospital**  
**Mercy Health System**  
**Department of Radiology**  
5301 Cedar Avenue  
Philadelphia, PA 19143  
215-748-9432

David P Mayer, MD,MS,FACR, Chairman  
Oleg Teytelboym, MD, Radiology Director  
Aparna Babu, MD  
Gerard Berry, MD  
Robert Borden, MD

Michael Brooks, MD, JD  
Fraser Brown, MD  
Brian Clark, MD  
Malgorzata Gorelczyk, MD  
Lulu He, DO  
Laryssa Hud, MD  
Caroline Ling, MD  
Justin Mackey, MD  
Timothy Nielsen, MD  
Scott Rotenberg, MD

Patient: **BENTON,ALONZO**  
Med Rec #: **M000301370**  
Date of Birth: 11/12/1958 Gender: M  
Phone #: (215)681-6752  
Ordering Physician: **MORRISON,SARA C CRNP**  
CC: ~  
Order Date: 08/29/17

Acct #: PA 1304820416  
Order #: 0829-0077  
Accession #: 834766.001  
Report #: 0829-0171

Exam Date: 08/29/17  
Status: REG ER  
Location:  
RAD #:

**Procedure Reason:** Left shoulder pain

**Exam: CR Shoulder LT Min 2 View**

**\*\*\* Signed Status \*\*\***

**IMPRESSION:** Comminuted left distal fracture with apex dorsal angulation

**INDICATION:** 58 years old; Male. Symptom/Location/Duration: Left shoulder pain.

**TECHNIQUE:** AP, external and internal rotation, Y left shoulder radiographs. Comparison: None.

**FINDINGS:**

**BONES:** Acute comminuted fracture of the distal clavicle with apex dorsal angulation.

**JOINTS:** Acromioclavicular joint space is maintained. Normal glenohumeral joint. Normal acromiohumeral interval.

**SOFT TISSUES:** No rotator cuff calcification. Visualized lung unremarkable.

Communication code 1: Final report is in agreement with ED preliminary interpretation.

**Thank you for choosing Mercy Health System**

**<Electronically signed by LULU HE, DO in OV>**

e-Sign Pager: 610-221-4559

Interpreting: HE, LULU DO

Dictated: 08/29/17 1646

Signoff: 08/29/17 1648

**PATIENT IMAGES or REPORTS: (215) 748-9432**

**SCHEDULING: (610) 237-2525**

DATE: 08/30/17 @ 0027  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 1

|                |                |                    |            |
|----------------|----------------|--------------------|------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | DOC, ED    |
| Account Number | PA1304820416   | Location           | PHER       |
| Age/Sex        | 58/M           | Room               |            |
| Status         | REG ER         | Bed                |            |
|                |                | Unit Number        | M000301370 |
|                |                | Registered Date    | 08/29/17   |
|                |                | Discharged Date    |            |

\*\*\*\*\*  
\* HEIGHT and WEIGHT are missing...PLEASE UPDATE!!! \*  
\*\*\*\*\*

Hem-Onc No

Drug Allergies iodine

ADRS

#### Creatinine Test Results

| Date     | Time Test | LABORATORY<br>Result | Flag Normal Range |
|----------|-----------|----------------------|-------------------|
| 10/22/15 | 1259 CREA | 0.9                  | 0.8-1.4 mg/dL     |

OXYC1TAB53 - oxyCODONE/ACETAMINOPHEN 5-325 MG TABLET (PERCOCET)

|                 |                        |                         |                       |
|-----------------|------------------------|-------------------------|-----------------------|
| Dose            | 1 TABLET (1 TABLET)    |                         |                       |
| Admin Route     | ROUTE                  |                         |                       |
| Start Date      | 08/29/17-1644          | Stop Date 08/29/17 1645 | DC Date 08/29/17-1645 |
| Ordering Doctor | DOCTOR, PYXIS OVERRIDE |                         |                       |
| Total Dispensed | 1                      | Total Costs \$0.35      | Total Charges \$3.40  |
| Rx Number       | 002089644              |                         |                       |

Discontinue Comments DC'd by SMORRISON

#### History

|                             |              |                    |
|-----------------------------|--------------|--------------------|
| 08/29/17 1643 - DISCONTINUE | by STK MED   | Eff: 08/29/17 1645 |
| FROM:                       |              |                    |
| DC COMMENTS:                |              |                    |
| TO:                         |              |                    |
| DC COMMENTS:                |              |                    |
| DC'd by SMORRISON           |              |                    |
| 08/29/17 1643 - PHL DM PHA  | by SMORRISON |                    |

This is the end of the MAR Summary for Patient PA1304820416 - BENTON, ALONZO.

DATE: 8/30/17 @ 0027  
USER: EKG DARMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Discharge Summary Report

PAGE 1

|                                |                       |                              |        |
|--------------------------------|-----------------------|------------------------------|--------|
| 08/30/17                       |                       | MEDICATION DISCHARGE SUMMARY |        |
| Name                           | BENTON, ALONZO        | Admit Date                   | Age 58 |
| Unit Num                       | M000301370            | Discharge Date               | Sex M  |
| Account Num                    | PA1304820416          | Status                       | REG ER |
| Allergies                      | iodine-Rash and hives |                              |        |
| ADMINISTRATION PERIOD:         |                       | START/                       |        |
| 0730 08/29/17 to 0729 08/30/17 |                       | STOP                         |        |

|                                                                                   |                    |           |
|-----------------------------------------------------------------------------------|--------------------|-----------|
| oxyCODONE HCl/ACETAMIN 5-325 (oxyCODONE/ACETAMINOPHEN 5-325 MG TABLET (PERCOCET)) | 08/29/17   DC 1643 | STX MED   |
| 1 TABLET .RCUTE .STX-MED/ONE                                                      | 08/29/17   DM 1643 | SMORRISON |
|                                                                                   |                    | 1644      |
| RX #: C02089644                                                                   |                    |           |

DATE: 08/30/17 @ 0027  
USER: EKG DAEWON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Discharge Summary Report

PAGE 2

08/30/17

Medication Discharge Summary

Name BENTON, ALONZO

Unit Num M000301370

Account Num PA1304820416

Legends

Activity Codes

DC - Discontinue  
DM - Dispensing Machine

Reason Codes

Site Codes

Administered By

User User Name/Type

User User Name/Type

User User Name/Type

User User Name/Type

Pharmacy

User User Name

User User Name

User User Name

User User Name

Allergy History

Date Time User Name  
20151021 0406 SALEM MOHAMMAD  
OLD:  
NEW: iodine added.  
20151021 0403 ASHISH PATEL  
OLD:  
NEW:

Database Type Allergy  
MRI.PHL ADD iodine  
PHA.PHL ACK

# CONSENT FOR HOSPITAL TREATMENT AND SERVICES

PATIENT NAME: BENTON, ALONZO

- I have presented myself for treatment and/or admission on 8/29/17 (date). I consent to routine medical care and treatment, including diagnostic procedures and blood tests, and to such emergency or additional care as may be deemed necessary, which will be provided by the Hospital and by my Attending Physician, his/her assistants and/or designees. The use of telemedicine technology may be included in the diagnostic process of my care.
- I understand that, except for emergency situations, this consent does not include operations and non-routine procedures or treatment. I may be asked to consent to such operations and procedures after the risks and alternatives have been explained to me by my Attending Physician or by another physician.
- I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in the Hospital.
- I realize that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law. If such treatments or procedures are my reason for hospitalization, refusal may result in discharge.
- I hereby authorize the Hospital to photograph my face for purposes of identification and camera monitoring as indicated. In addition, I authorize the Hospital to take photographs for clinical purposes as part of the diagnostic/treatment documentation process.
- In the event that the results of my diagnostic studies or procedures indicate the need for further coordination of care, the hospital's patient care coordinator may be notified of my results, as deemed appropriate, so as to assist me with further diagnostic and/or treatment options.
- I consent to the release of such information from my medical records as may be required by my health insurance company for the processing of claims for hospital or medical benefits, except for records containing mental health, drug and alcohol information. In these cases a separate written consent will be required. I consent to release medical information to any medical care provider for the purpose of continuity of care/discharge planning. I consent to the use of my medical information for research when federal law allows such use without my specific consent.
- I understand the Hospital will not be liable for loss of or damage to any money or personal property.
- I hereby assign to the Hospital payment of all hospital and insurance benefits otherwise payable to me or for my benefit in connection with my treatment and/or hospitalization.
- In consideration of the care and services to be furnished to me, I undertake and promise to pay for these services (to the extent that the charges are not covered by any insurance benefits) in accordance with Hospital terms and usual and customary charges.
- The professional services of physicians are billed separately from the hospital bill, such as the departments of Anesthesia, Pathology, Emergency, Radiology, Neurology, Cardiology, and Physician Medicine.
- (Managed Care Patients Only) A law was passed in Pennsylvania in 1998 called "Act 88" or the "Quality Health Care Accountability and Protection Act." This law allows you to give the Hospital consent to seek payment from your health insurance company for health care you received for the Hospital if your health insurance company (a) denies payment; (b) limits the scope of services; (c) only pays for a shorter stay in the hospital; or (d) only pays for an alternative service than the one you received. When a hospital seeks payment from a health insurance company it is called a "grievance". I hereby give consent to the Hospital (and/or its designees) to file a grievance on my behalf, including requesting an appeal of any decision by my health insurance company. If the Hospital files a grievance for me, all costs related to the grievance will be paid by the Hospital. I also understand and agree that (1) I will not file a grievance with my health insurance company unless I withdraw my consent in writing; (2) I have the right to rescind this consent at any time during the grievance process; and (3) my consent will be automatically rescinded if the Hospital does not file a grievance.
- (Medicare Patients Only) - Certification, Authorization to Release Information, and Payment Requests. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize the release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I will either assign any such benefits to be paid directly to the Hospital or to the physician or organization furnishing the services or authorize the Hospital or such physician or organization to submit a claim to Medicare on my behalf, for payment.
- I understand that Hospital, including their business associates, may contact me by telephone at any telephone number I have provided or that is associated with my record, including cell phone numbers, which could result in charges to me. Hospital may also contact me by sending text messages or e-mails, using the contact information provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.  
I am the patient or the person authorized to give consent for the patient. My signature certifies that I have read and understood this consent and that any questions have been answered to my satisfaction.

Signature of Patient

Date/Time

Witness to Signature

Date/Time

If Patient is a minor or incompetent/unable to give consent

Signature of Person authorized to give consent

Date/Time

Address

Relationship to Patient

Witness

Date/Time

Patient Rights and Responsibilities

☐ I have received the Patient Rights and Responsibilities form (40M)

Hospital Directory

The hospital directory contains your name, room number and general condition. It can be used to direct visitors, flower deliveries and phone callers to you. ☒ I want to be included in the directory ☐ I do not want to be included in the directory

Patient's Email Address:

Notice of Privacy Practices

The Notice of Privacy Practices explains how your Protected Health Information (medical and demographic information about you) may be used or disclosed. ☒ I have received the Notice of Privacy Practices.

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

Mercy Philadelphia Hospital  
A member of Mercy Health System

CONSENT FOR HOSPITAL TREATMENT AND SERVICES

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 08/29/17  
ACC: PA1304820416 MR: M000301370



Page 1 of 1  
Form AD404, Rev. 08/2015  
CST.X.TREAT



DATE: 09/06/17 @ 1452  
USER: COVARDHV

Mercy Philadelphia Hospital ABS \*LIVE\*  
ATTESTATION STATEMENT

PAGE 1

NAME: BENTON, ALONZO ACCT #: PA1304820416

ADM DATE: 08/29/17 UNIT #: M000301370  
ATTEND PHYS: YOON, RUSSELL MD SEX: M  
DIS DATE: 08/29/17 AGE: 58  
DISCH DISP: HOME, SELF-CARE DOB: 11/12/1958  
LOS: 1 FIN CLASS: MCRMNG  
PT CLASS: ER.MCR ABS STATUS: FINAL

DIAGNOSES:

ADMIT: M25.512 PAIN IN LEFT SHOULDER POA?  
PRINC: S42.002A FRACTURE OF UNSP PART OF LEFT CLAVICLE, INIT FOR CLOS FX  
SECOND: M25.512 PAIN IN LEFT SHOULDER  
M25.412 EFFUSION, LEFT SHOULDER  
I10 ESSENTIAL (PRIMARY) HYPERTENSION  
Z98.890 OTHER SPECIFIED POSTPROCEDURAL STATES  
Z91.041 RADIOGRAPHIC DYE ALLERGY STATUS  
Z79.899 OTHER LONG TERM (CURRENT) DRUG THERAPY  
W01.0XXA FALL SAME LEV FROM SLIP/TRIP W/O STRIKE AGAINST OBJECT, INIT  
Y92.89 OTH PLACES AS THE PLACE OF OCCURRENCE OF THE EXTERNAL CAUSE

OPERATIONS:

CPTS:

DRG:

| STATUS | \$ REIMB | MIN-LOS | MAX-LOS | STD-LOS | GRP VERS | GRP FC |
|--------|----------|---------|---------|---------|----------|--------|
|        |          |         |         |         | 34       | MCRMNG |

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

DATE: \_\_\_\_\_

DATE: 08/30/17 @ 1224  
USER: MT

Mercy Philadelphia Hospital AOM \*LIVE\*  
Ambulatory Prescriptions and Procedures

PAGE 1

Patient Name: BENTON, ALONZO

Admission/Registration Date: 08/29/17

Unit Number: M000301370

Discharge Date: 08/29/17

Account Number: PA1304820416

Admitting Physican:

Date of Birth: 11/12/1958 Age/Sex: 58 M

Attending Physican:

### Prescriptions

Claritin (Loratadine) 10 Mg Capsule

10 MG ORAL DAILY 30 Days

Rx# 0000000004 Days: 30 Refills: 0 CAPSULE

Entered Date: Oct 21, 2015 Compound Med: No

Ordering Provider: MOHASA01 Location: PH6NW

Diagnosis:

Losartan Potassium (Losartan Potassium) 50 Mg Tablet

50 MG ORAL DAILY 30 Days

Rx# 0000001916 Days: 30 Refills: 0

Entered Date: Oct 23, 2015 Compound Med: No

Ordering Provider: BABAFA Location: PH6NW

Diagnosis:

Pantoprazole Sodium (Pantoprazole Sodium) 20 Mg Tablet.dr

40 MG ORAL DAILY , #30 TABLET.DR

Rx# 0000001918 Qty: 30 Refills: 0 TABLET

Entered Date: Oct 23, 2015 Compound Med: No

Ordering Provider: BABAFA Location: PH6NW

Diagnosis:

### Referrals

Gastroenterology Ref

In 7 Days

To Practice:

To Provider: Danilewitz, Mervyn, Md

Referral Authorization Date:

Referral Expiration Date:

Referral Type:

Diagnosis:

# OF VISITS: Active Babar, Fatima, Md

# **EXHIBIT C**

AUTHORIZATION FOR RELEASE OF INFORMATION IN  
CONNECTION WITH CIVIL LITIGATION

|                                                                                                                                     |                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| <b>TO:</b><br><br><b>Custodian of Records</b><br><b>Mercy Philadelphia Hospital</b><br>501 S. 54th Street<br>Philadelphia, PA 19143 | <b>Name:</b> Alonzo Benton<br><br><b>DOB:</b> 11/12/1958<br><b>SSN:</b> xxx-xx-9216<br><b>D.O.S.: 08/30/17 – TO PRESENT</b> |
|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|

**I. Pursuant to my privacy rights under Health Insurance Portability and Accountability Act (HIPAA), by affixing my signature below I understand and voluntarily consent to the following:**

I hereby request and authorize that you disclose, make available and furnish to the Attorney whose name and address is:

LEONARD, SCIOLLA, HUTCHISON,  
LEONARD & TINARI, LLP  
1500 J.F.K. Blvd., Ste. 1910  
Philadelphia, PA 19102  
Phone: (215) 567-1530  
Fax: (215) 564-4611

or the attorney authorized representative all medical records, bills and reports including:

1.) Office notes; 2.) Charts; 3.) Diagrams; 4.) Pathology reports; 5.) Operative reports; 6.) Physical and lab tests; 7.) X-ray/imaging reports; 8.) X-ray/imaging films; 9.) Prescription notes; 10.) Treatment plans; 11.) Discharge summary, with regard to the above named individual, from the inception of your records to the present; 12.) Psychiatric or mental health treatment, and 13.) Itemized billing statements.

**This authorization specifically excludes the release of health information related to treatment of drug and/or alcohol abuse; treatment of Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV); and sexually transmitted diseases/viruses.**

**II. Rights and obligations under HIPAA:**

**A. Purpose of this request:** I understand that the information listed above in Section I is being requested by the law firm of Leonard, Sciollo, Hutchison, Leonard & Tinari, LLP for the specific purpose of:

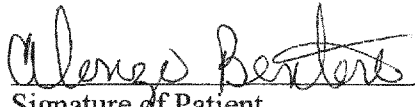
a.) investigating a potential or pending civil claim or b.) investigating a pending civil litigation lawsuit I filed and by signing this authorization I voluntarily consent to its release.

**B. Expiration Date:** Unless otherwise revoked, this authorization will expire six (6) months after the date of this authorization.

**C. Right to revoke:** I understand that I have the right to revoke this authorization at any time. I understand that the revocation must be in writing to the above named doctor/facility authorized to make this disclosure. I further understand that the revocation is only effective after it is received by the above named doctor/facility and does not apply to information that has already been released in response to this authorization.

**D. Impact on Medical Treatment:** I understand that my right to treatment, payment, enrollment or eligibility for benefits is not conditioned on me signing this authorization.

**E. Subsequent Disclosure:** I understand that any disclosure of information may be subject to re-disclosure by Leonard, Sciolla, Hutchison, Leonard & Tinari, LLP and may no longer be protected by federal or state law.

  
\_\_\_\_\_  
Signature of Patient

4/19/18  
\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Authorized Representative/Guardian

\_\_\_\_\_  
Date

By signing this authorization, the Authorized Representative and/or Guardian certifies that he or she has the authority to act on behalf of the person identified above on the basis of (please explain):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



A member of Mercy Health System

P

## OUTPATIENT RECORD

|                                                             |  |                                  |  |                                  |                               |                            |  |
|-------------------------------------------------------------|--|----------------------------------|--|----------------------------------|-------------------------------|----------------------------|--|
| <b>Account No:</b> PA1304917733                             |  | <b>Date:</b> 10/12/17            |  | <b>Time:</b>                     |                               | <b>Unit No:</b> M000301370 |  |
| <b>PATIENT INFORMATION</b>                                  |  |                                  |  |                                  |                               |                            |  |
| <b>Name:</b> BENTON, ALONZO                                 |  | <b>DOB:</b> 11/12/1958           |  | <b>AGE:</b> 58                   |                               | <b>Pt Status:</b> PRE SDC  |  |
| <b>Address:</b> 2432 S FRAZIER ST                           |  | <b>SEX:</b> M                    |  | <b>MS:</b> S                     |                               | <b>LOC/Srvc:</b> PHSPU     |  |
|                                                             |  | <b>RACE:</b> AA                  |  |                                  |                               | <b>Room/Bed:</b>           |  |
| <b>PHILADELPHIA, PA 19143</b>                               |  | <b>LANG:</b> ENGLISH             |  |                                  |                               | <b>Accommodation:</b>      |  |
| <b>Phone:</b> (215) 403-5705                                |  | <b>ADM Src/Prior:</b> PHY /EL    |  |                                  |                               | <b>Last DC Date:</b>       |  |
| <b>SSN:</b> XXX-XX-9216                                     |  | <b>Religion:</b> CHRISTIAN       |  |                                  |                               |                            |  |
|                                                             |  | <b>Church:</b>                   |  |                                  |                               |                            |  |
| <b>Occurrence Code:</b> 11                                  |  | <b>Occurrence Date:</b> 10/09/17 |  |                                  |                               |                            |  |
| <b>PHYSICIAN INFORMATION</b>                                |  |                                  |  |                                  |                               |                            |  |
| <b>Admitting Physician</b>                                  |  | <b>Attending or ER Physician</b> |  |                                  | <b>Primary Care Physician</b> |                            |  |
|                                                             |  | MELLER, MENACHEM M, MD           |  |                                  | BARDEN, ABA, MD               |                            |  |
|                                                             |  | (215) 746-9822                   |  |                                  | (215) 662-9900                |                            |  |
| <b>Att Group:</b> MHOP ORTHOPEDICS                          |  |                                  |  |                                  |                               |                            |  |
| <b>NEXT OF KIN</b>                                          |  |                                  |  | <b>PERSON TO NOTIFY</b>          |                               |                            |  |
| <b>Name:</b> BENTON, APRIL                                  |  |                                  |  | <b>Name:</b> BENTON, APRIL       |                               |                            |  |
| <b>Addr:</b> NOT SURE OF ADDRESS                            |  |                                  |  | <b>Addr:</b> NOT SURE OF ADDRESS |                               |                            |  |
|                                                             |  |                                  |  | <b>PHILADELPHIA, PA 19143</b>    |                               |                            |  |
| <b>Phone:</b> (267) 905-4367                                |  |                                  |  | <b>Phone:</b> (267) 905-4367     |                               |                            |  |
| <b>Other:</b>                                               |  |                                  |  | <b>Other:</b>                    |                               |                            |  |
| <b>Relat:</b> DAUGHTER                                      |  |                                  |  | <b>Relat:</b> DAUGHTER           |                               |                            |  |
| <b>EMPLOYER INFORMATION</b>                                 |  |                                  |  | <b>GUARANTOR INFORMATION</b>     |                               |                            |  |
| <b>Name:</b> DISABLED                                       |  | <b>Name:</b> BENTON, ALONZO      |  | <b>Emp:</b> DISABLED             |                               |                            |  |
| <b>Addr:</b>                                                |  | <b>Addr:</b> 2432 S FRAZIER ST   |  | <b>Addr:</b>                     |                               |                            |  |
|                                                             |  | <b>PHILADELPHIA, PA 19143</b>    |  |                                  |                               |                            |  |
| <b>Phone:</b>                                               |  | <b>Phone:</b> (215) 403-5705     |  | <b>Phone:</b>                    |                               |                            |  |
|                                                             |  | <b>SSN:</b> XXX-XX-9216          |  | <b>Status:</b> UE                |                               |                            |  |
|                                                             |  | <b>Relat:</b> SELF / SAME AS     |  |                                  |                               |                            |  |
| <b>INSURANCE INFORMATION</b>                                |  |                                  |  |                                  |                               |                            |  |
| <b>Financial Class:</b> MCRMNG                              |  |                                  |  |                                  |                               |                            |  |
| <b>GATEWYMCR</b>                                            |  |                                  |  |                                  |                               |                            |  |
| <b>Pri:</b> GATEWAY MEDICARE ASSUR                          |  | <b>INS#2:</b>                    |  | <b>INS#3:</b>                    |                               |                            |  |
| <b>Addr:</b> PO BOX 69359                                   |  | <b>Addr:</b>                     |  | <b>Addr:</b>                     |                               |                            |  |
| <b>HARRISBURG PA 17106-</b>                                 |  |                                  |  |                                  |                               |                            |  |
| <b>Phone:</b>                                               |  | <b>Phone:</b>                    |  | <b>Phone:</b>                    |                               |                            |  |
| <b>Policy#:</b> 70113084                                    |  | <b>Policy#:</b>                  |  | <b>Policy#:</b>                  |                               |                            |  |
| <b>Group#:</b>                                              |  | <b>Group#:</b>                   |  | <b>Group#:</b>                   |                               |                            |  |
| <b>A#:</b> NPR                                              |  | <b>A#:</b>                       |  | <b>A#:</b>                       |                               |                            |  |
| <b>Subscrbr:</b> BENTON, ALONZO                             |  | <b>Subscrbr:</b>                 |  | <b>Subscrbr:</b>                 |                               |                            |  |
| <b>Sub Emp:</b> DISABLED                                    |  | <b>Sub Emp:</b>                  |  | <b>Sub Emp:</b>                  |                               |                            |  |
| <b>Relation:</b> SP                                         |  | <b>Relation:</b>                 |  | <b>Relation:</b>                 |                               |                            |  |
| <b>Status:</b> VERIFIED                                     |  | <b>Status:</b>                   |  | <b>Status:</b>                   |                               |                            |  |
| <b>INS#4:</b>                                               |  |                                  |  |                                  |                               |                            |  |
| <b>Reason For Visit:</b> LEFT COMMUNUTED DISTAL CLAVICLE FX |  |                                  |  |                                  |                               |                            |  |
| <b>Comment:</b>                                             |  |                                  |  |                                  |                               |                            |  |
| <b>ISOLATION:</b>                                           |  |                                  |  |                                  |                               |                            |  |
| <b>CO-Pay Collected:</b> N                                  |  | <b>Mode of Arrival:</b>          |  | <b>Privacy Notice Given?:</b> Y  |                               | <b>(Date:</b> 09/15/17)    |  |
| <b>Registration Clerk:</b>                                  |  |                                  |  | <b>COB Signed/Verified:</b>      |                               |                            |  |
| <b>email:</b> N/A                                           |  |                                  |  | <b>use email:</b> N              |                               |                            |  |



A member of Mercy Health System

P

## OUTPATIENT RECORD

|                                                             |  |                                          |  |                                                         |  |                            |  |
|-------------------------------------------------------------|--|------------------------------------------|--|---------------------------------------------------------|--|----------------------------|--|
| <b>Account No:</b> PA1304917733                             |  | <b>Date:</b> 10/12/17                    |  | <b>Time:</b> 1139                                       |  | <b>Unit No:</b> M000301370 |  |
| <b>PATIENT INFORMATION</b>                                  |  |                                          |  |                                                         |  |                            |  |
| <b>Name:</b> BENTON, ALONZO                                 |  | <b>DOB:</b> 11/12/1958                   |  | <b>AGE:</b> 58                                          |  | <b>Pt Status:</b> DEP SDC  |  |
| <b>Address:</b> 2432 S FRAZIER ST                           |  | <b>SEX:</b> M                            |  | <b>MS:</b> S                                            |  | <b>LOC/Srvc:</b> PHSPU     |  |
| PHILADELPHIA, PA 19143                                      |  | <b>RACE:</b> AA                          |  | <b>Room/Bed:</b>                                        |  | <b>Accommodation:</b>      |  |
| <b>Phone:</b> (215) 403-5705                                |  | <b>LANG:</b> ENGLISH                     |  | <b>ADM Src/Prior:</b> PHY /EL                           |  | <b>Last DC Date:</b>       |  |
| <b>SSN:</b> XXX-XX-9216                                     |  | <b>Religion:</b> CHRISTIAN               |  | <b>Church:</b>                                          |  |                            |  |
| <b>Occurrence Code:</b> 11 <b>Occurrence Date:</b> 10/09/17 |  |                                          |  |                                                         |  |                            |  |
| <b>PHYSICIAN INFORMATION</b>                                |  |                                          |  |                                                         |  |                            |  |
| <b>Admitting Physician</b>                                  |  | <b>Attending or ER Physician</b>         |  | <b>Primary Care Physician</b>                           |  |                            |  |
|                                                             |  | MELLER, MENACHEM M, MD<br>(215) 746-9822 |  | BARDEN, ABA, MD<br>(215) 662-9900                       |  |                            |  |
| <b>Att Group:</b> MHOP ORTHOPEDICS                          |  |                                          |  |                                                         |  |                            |  |
| <b>NEXT OF KIN</b>                                          |  |                                          |  | <b>PERSON TO NOTIFY</b>                                 |  |                            |  |
| <b>Name:</b> BENTON, APRIL                                  |  |                                          |  | <b>Name:</b> BENTON, APRIL                              |  |                            |  |
| <b>Addr:</b> NOT SURE OF ADDRESS                            |  |                                          |  | <b>Addr:</b> NOT SURE OF ADDRESS                        |  |                            |  |
| PHILADELPHIA, PA 19143                                      |  |                                          |  | PHILADELPHIA, PA 19143                                  |  |                            |  |
| <b>Phone:</b> (267) 905-4367                                |  |                                          |  | <b>Phone:</b> (267) 905-4367                            |  |                            |  |
| <b>Other:</b>                                               |  |                                          |  | <b>Other:</b>                                           |  |                            |  |
| <b>Relat:</b> DAUGHTER                                      |  |                                          |  | <b>Relat:</b> DAUGHTER                                  |  |                            |  |
| <b>EMPLOYER INFORMATION</b>                                 |  |                                          |  | <b>GUARANTOR INFORMATION</b>                            |  |                            |  |
| <b>Name:</b> DISABLED                                       |  | <b>Name:</b> BENTON, ALONZO              |  | <b>Emp:</b> DISABLED                                    |  |                            |  |
| <b>Addr:</b>                                                |  | <b>Addr:</b> 2432 S FRAZIER ST           |  | <b>Addr:</b>                                            |  |                            |  |
|                                                             |  | PHILADELPHIA, PA 19143                   |  |                                                         |  |                            |  |
| <b>Phone:</b>                                               |  | <b>Phone:</b> (215) 403-5705             |  | <b>Phone:</b>                                           |  |                            |  |
|                                                             |  | <b>SSN:</b> XXX-XX-9216                  |  | <b>Status:</b> UE                                       |  |                            |  |
|                                                             |  | <b>Relat:</b> SELF / SAME AS             |  |                                                         |  |                            |  |
| <b>INSURANCE INFORMATION</b> <b>Financial Class:</b> MCRMNG |  |                                          |  |                                                         |  |                            |  |
| <b>GATEWYMCR</b>                                            |  | <b>INS#2:</b>                            |  | <b>INS#3:</b>                                           |  |                            |  |
| <b>Pri:</b> GATEWAY MEDICARE ASSUR                          |  | <b>Addr:</b>                             |  | <b>Addr:</b>                                            |  |                            |  |
| <b>Addr:</b> PO BOX 69359                                   |  |                                          |  |                                                         |  |                            |  |
| HARRISBURG PA 17106-                                        |  |                                          |  |                                                         |  |                            |  |
| <b>Phone:</b>                                               |  | <b>Phone:</b>                            |  | <b>Phone:</b>                                           |  |                            |  |
| <b>Policy#:</b> 70113084                                    |  | <b>Policy#:</b>                          |  | <b>Policy#:</b>                                         |  |                            |  |
| <b>Group#:</b>                                              |  | <b>Group#:</b>                           |  | <b>Group#:</b>                                          |  |                            |  |
| <b>A#:</b> NPR                                              |  | <b>A#:</b>                               |  | <b>A#:</b>                                              |  |                            |  |
| <b>Subscrbr:</b> BENTON, ALONZO                             |  | <b>Subscrbr:</b>                         |  | <b>Subscrbr:</b>                                        |  |                            |  |
| <b>Sub Emp:</b> DISABLED                                    |  | <b>Sub Emp:</b>                          |  | <b>Sub Emp:</b>                                         |  |                            |  |
| <b>Relation:</b> SP                                         |  | <b>Relation:</b>                         |  | <b>Relation:</b>                                        |  |                            |  |
| <b>Status:</b> VERIFIED                                     |  | <b>Status:</b>                           |  | <b>Status:</b>                                          |  |                            |  |
| <b>INS#4:</b>                                               |  |                                          |  |                                                         |  |                            |  |
| <b>Reason For Visit:</b> LEFT COMMUNUTED DISTAL CLAVICLE FX |  |                                          |  |                                                         |  |                            |  |
| <b>Comment:</b>                                             |  |                                          |  |                                                         |  |                            |  |
| <b>ISOLATION:</b>                                           |  |                                          |  | <b>Privacy Notice Given?:</b> Y <b>(Date:</b> 09/15/17) |  |                            |  |
| <b>CO-Pay Collected:</b> N <b>Mode of Arrival:</b>          |  |                                          |  | <b>COB Signed/Verified:</b>                             |  |                            |  |
| <b>Registration Clerk:</b> PHLEEMON                         |  |                                          |  |                                                         |  |                            |  |
| <b>email:</b> N/A                                           |  |                                          |  | <b>use email:</b> N                                     |  |                            |  |

10/10/17 Lm/Am to discuss  
at esthine

# Mercy Philadelphia Hospital

A member of Mercy Health System

## Pre-Admission Intake and Surgery Request Form

Co-pay 200.00

Pt. Name Alonzo Benton  
Address 2432 S Frazier Street  
City Philadelphia State PA Zip 19143  
Phone (215) 403-5705 CP  
DOB 11/12/58 Age 58 Gender Male  
PCP  
Phone  
Relative/Guardian  
Phone CP  
Does pt. live alone yes no ☒  
Allergies NKA

Allergic to Latex Yes No ☒  
Type of admission: AM ☒ PPU OBS. 23 hour

Diagnosis Left Comminuted Distal Clavicle Fracture

CPT Code 20680

ICD 9 Code S42.00A

Date of Surgery 10/12/17

Time requested 8.00am

Surgeon Dr. Meller

Procedure Removal of Hardware/Left Clavicle and  
Debre

Surgical Site Left Shoulder

Position

Positioning Device

Surgical Assist required: Yes No

Estimated length of procedure 2hrs

Implants required

Special Equipment

Ulatie notified yes no (internal use)

### Insurance:

1. Type Gateway Medicare

Policy# 70113084

Group#

Subscriber

SSN# 166-52-9216

Employer

Authorization # npr - per Branki

2.

Type

Policy#

Group#

Subscriber

SSN#

Employer

Authorization # Bliss - WP - 6700 - 3579

Special Needs: ☐ Child N/A relax

1. Does Pt. have a language barrier? Y ☒ N ☒

2. Does Pt. have a hearing impairment? Y ☒ N ☒

3. Does Pt. does Pt. have visual impairment? Y ☒ N ☒

Comments

4. Does Pt. require venous mapping? Y ☒ N ☒

5. Pt. has a Pacemaker or AICD Y ☒ N ☒

Have you consulted Cardiology? Y ☒ N ☒

Cardiologist consulted

6. Pt. is a diabetic and on Insulin or oral medication Y ☒ N ☒

What instructions have they been given for day of  
Surgery?

7. Pt. is on anticoagulants Y ☒ N ☒

When were they instructed to take their last dose, prior to  
surgery?

Pre-Admission Testing Yes PAT by Protocol (includes all required testing per anesthesia guidelines)

☐ Electrolytes ☐ CBC ☐ T&S ☐ Type & Cross Units ☐ FFP ☐ Platelets  
☐ Potassium ☐ Glucose ☐ BUN ☐ Creatinine ☐ Sodium ☐ Chloride ☐ CO2  
☐ PT ☐ PTT ☐ Liver Profile ☐ Uric Acid ☐ LDH ☐ Calcium ☒ MRSA Screen  
☐ Phosphorous ☐ Cholesterol ☐ Triglycerides ☐ Pregnancy Test (Serum HCG) \*Aspirin, Coumadin & contrast  
☐ EKG ☐ CXR ☐ Urinalysis Other: Pt doesn't need Potts per Shurley

☐ CT Scan Pt. weight Pt. Height ☒ POx in SPU Pre-Op  
☐ Accu Check pre-op LMP Allergy to dye

☐ Physical Therapy Training ☐ Visiting Nurse ☐ No labs necessary due to 2nd cataract

Physician Signature Date 10/09/17 Time 9:00am

### Scheduler Information

Sender Name Tyra Ruffin Phone (215)-748-9813 Fax # (215) 748-9717

Date scheduling information sent 10/09/17 Time sent 9:00 AM PM

Faxed to OR ☐ Fax Number 215-748-9512

If you experience any difficulty faxing, please call Gwen or Pat at 215-748-9425

### Scheduling Confirmation

Case Scheduled by \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
Procedure Scheduled \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
Booked in Picis ☐ Written in Schedule book \_\_\_\_\_  
Request Form faxed to PAT ☐ Registration ☐ Requesting Physicians Office ☐

NSB/OC (1/17)

# ASSIGNMENT OF RIGHTS AND BENEFITS AND REPRESENTATIVE AUTHORIZATION

## Assignment of Insurance Benefits

I hereby assign and transfer to Mercy Health System all health insurance and/or employer health plan benefits and/or insurance or other third-party reimbursement (including, without limitation, government benefits and automobile insurance) otherwise payable to me for services rendered or provided to me by Mercy Health System. I certify that the health insurance information, health benefits information, and any other third-party payor information that I provided to Mercy Health System is accurate as of the date set forth below.

I further designate and authorize Mercy Health System to the fullest extent permissible under the law and under any applicable insurance policy and/or employee health care benefit plan to act as my designated authorized representative in connection with any request, claim, appeal, right, or cause of action I may have under an insurance policy or benefit plan.

I also assign to Mercy Health System, as assignee and authorized representative, any and all rights or remedies arising out of any group health plan, employee benefits plan, other health insurance contract or other third-party reimbursement (including, without limitation, government benefits and automobile insurance) related to services rendered or provided to me by Mercy Health System. This assignment includes the right to file any insurance or benefit claims on my behalf, and the right to pursue any and all administrative or legal claims under both state and federal law. It also expressly includes any rights or remedies arising under ERISA and its corresponding regulations, including, without limitation, (1) obtaining information, documents and records about the claim and claim review process to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceeding; (5) pursuing any cause of action under ERISA that the assignor would otherwise be entitled to pursue.

## Authorization to Release Information

I hereby authorize Mercy Health System to: (1) release any information necessary to my health benefit plan, or its administrator, or my insurance company or any other third party payor regarding my medical care; (2) process insurance or benefits claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance or benefit claims. This assignment and authorization will remain in effect unless revoked by me in writing.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Alonzo Benton  
Patient Name  
Alonzo Benton 10.12.17  
Patient Signature Date

\_\_\_\_\_  
Name of authorized representative

\_\_\_\_\_  
Representative Signature

\_\_\_\_\_  
Date

 **Mercy Philadelphia Hospital**  
A member of Mercy Health System

ASSIGNMENT OF RIGHTS AND BENEFITS AND REPRESENTATIVE AUTHORIZATION



Page 1 of 1  
Form #R-0756BEN Rev. 02/2016  
ADIA X OTHER

BENTON, ALONZO  
DOB: 11/12/1958 SS M  
ADM: 10/12/17  
ACC: PA1304917733 MR: M0C0301370



# **Mercy Philadelphia Hospital**

A member of Mercy Health System

## Pre-Admission Intake and Surgery Request Form

Pt. Name Alonzo Benton  
 Address 2432 S Frazier Street  
 City Philadelphia State PA Zip 19143  
 Phone (215) 403-5705 CP \_\_\_\_\_  
 DOB 11/12/58 Age 58 Gender Male  
 PCP \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Relative/Guardian \_\_\_\_\_  
 Phone \_\_\_\_\_ CP \_\_\_\_\_  
 Does pt. live alone yes no ☒   
 Allergies NKA

Allergic to Latex Yes No ☒   
 Type of admission: AM ☒ SPU OBS. 23 hour

Diagnosis Left Comminuted Distal Clavicle Fracture  
 CPT Code 20680  
 ICD 9 Code S42.00A  
 Date of Surgery 10/12/17  
 Time requested 8:00am  
 Surgeon Dr. Meller  
 Procedure Removal of Hardware/Left Clavicle and  
Debre  
 Surgical Site Left Shoulder  
 Position \_\_\_\_\_  
 Positioning Device \_\_\_\_\_  
 Surgical Assist required: Yes No ☒   
 Estimated length of procedure 2hrs  
 Implants required \_\_\_\_\_  
 Special Equipment \_\_\_\_\_  
 Hattie notified yes no (internal use)

### Insurance:

1. Type Gateway Medicare  
 Policy# 70113084  
 Group# \_\_\_\_\_  
 Subscriber \_\_\_\_\_  
 SSN# 166-52-9216 - - - - -  
 Employer \_\_\_\_\_  
 Authorization # \_\_\_\_\_

2. Type \_\_\_\_\_  
 Policy# \_\_\_\_\_  
 Group# \_\_\_\_\_  
 Subscriber \_\_\_\_\_  
 SSN# \_\_\_\_\_ - - - - -  
 Employer \_\_\_\_\_  
 Authorization # \_\_\_\_\_

### Special Needs: ☐ Child N/A

1. Does Pt. have a language barrier? Y N ☒
2. Does Pt. have a hearing impairment? Y N ☒
3. Does Pt. does Pt. have visual impairment? Y N ☒  
Comments \_\_\_\_\_
4. Does Pt. require venous mapping? Y N ☒
5. Pt. has a Pacemaker or AICD Y N ☒  
Have you consulted Cardiology? Y N ☒  
Cardiologist consulted \_\_\_\_\_
6. Pt. is a diabetic and on Insulin or oral medication Y N ☒  
What instructions have they been given for day of Surgery? \_\_\_\_\_
7. Pt. is on anticoagulants Y N ☒  
When were they instructed to take their last dose, prior to surgery? \_\_\_\_\_

### Pre-Admission Testing Yes PAT by Protocol (includes all required testing per anesthesia guidelines)

|                                       |                                      |                                        |                                                     |                                 |                                   |                                                 |
|---------------------------------------|--------------------------------------|----------------------------------------|-----------------------------------------------------|---------------------------------|-----------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Electrolytes | <input type="checkbox"/> CBC         | <input type="checkbox"/> T&S           | <input type="checkbox"/> Type & Cross               | Units                           | <input type="checkbox"/> FFP      | <input type="checkbox"/> Platelets              |
| <input type="checkbox"/> Potassium    | <input type="checkbox"/> Glucose     | <input type="checkbox"/> BUN           | <input type="checkbox"/> Creatinine                 | <input type="checkbox"/> Sodium | <input type="checkbox"/> Chloride | <input type="checkbox"/> CO2                    |
| <input type="checkbox"/> PT           | <input type="checkbox"/> PTT         | <input type="checkbox"/> Liver Profile | <input type="checkbox"/> Uric Acid                  | <input type="checkbox"/> LDH    | <input type="checkbox"/> Calcium  | <input checked="" type="checkbox"/> MRSA Screen |
| <input type="checkbox"/> Phosphorous  | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Triglycerides | <input type="checkbox"/> Pregnancy Test (Serum HCG) | *except kids smile & cataract   |                                   |                                                 |
| <input type="checkbox"/> EKG          | <input type="checkbox"/> CXR         | <input type="checkbox"/> Urinalysis    | Other: _____                                        |                                 |                                   |                                                 |

☐ CT Scan Pt. weight \_\_\_\_\_ Pt. Height \_\_\_\_\_ ☒ POx in SPU Pre-Op  
☐ Accu Check pre-op LMP \_\_\_\_\_ Allergy to dye \_\_\_\_\_

☐ Physical Therapy Training ☐ Visiting Nurse ☐ No labs necessary due to 2nd cataract

Physician Signature \_\_\_\_\_ Date 10/09/17 Time 9:00am

### Scheduler Information

Sender Name Tyra Ruffin Phone (215)-748-9813 Fax # (215) 748-9717  
 Date scheduling information sent 10/09/17 Time sent 9:00 AM PM  
 Faxed to OR ☐ Fax Number 215-748-9512  
 you experience any difficulty faxing, please call Gwen or Pat at 215-748-9425

### Scheduling Confirmation

Case Scheduled by \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
 Procedure Scheduled \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
 Booked in Picts ☐ Written in Schedule book ☐  
 Request Form faxed to PAT ☐ Registration ☐ Requesting Physicians Office ☐

**Mercy Philadelphia Hospital  
Operative Note**

**Patient:** BENTON,ALONZO

**DOB:** 11/12/1958

**Sex:** M

**MR #** M000301370

**Acct #** PA1304917733

**Room/Bed:**

**\*\*\* Signed Status \*\*\***

**DATE OF OPERATION:** 10/12/2017

**PREOPERATIVE DIAGNOSIS:**

Exposed loose hardware, left shoulder distal clavicle 3 weeks post-implant.

**POSTOPERATIVE DIAGNOSIS:**

Exposed loose hardware, left shoulder distal clavicle 3 weeks post-implant.

**PROCEDURE:**

Hardware removal, I and D, culture, aerobic and anaerobic, and loose approximation.

**SURGEON:**

Menachem Meller, M.D.

**ANESTHESIA:**

General.

**ESTIMATED BLOOD LOSS:**

Minimal.

**TOURNIQUET:**

None used.

**DRAINS.**

None placed.

**SPECIMENS:**

Aerobic and anaerobic culture as well as debrided margins of the wound.

**COMPLICATIONS:**

None.

**DESCRIPTION OF PROCEDURE:**

Patient was brought to the operating room and placed in a supine position. General anesthesia was administered. Preoperative Ancef 2 grams IV and 100 mg of gentamicin was administered. A timeout was effected identifying the individuals in the operating room, the patient, the nature of the procedure, the surgical site.

The wound was examined and seen to have the exposed distal end of the plate with loose screws and loose hardware. There was some serous fluid, but no gross purulence.

The healed incision was reincised. The plate was grossly loose including the locking screws and the more proximal cortical screws. The hardware was removed without any difficulty. The wound was copiously irrigated and aspirated. A curette was used to debride the margins. A

CC:

REPORT #: 1012-0307

REPORT STATUS: Signed

**Mercy Philadelphia Hospital  
Operative Note**

**Patient:** BENTON,ALONZO

**MR #** M000301370

scalpel was used to further debride the margins including the skin and subcutaneous tissues. The underlying base had preserved and restored distal clavicle alignment. The wound was once again irrigated and aspirated and the edges were loosely approximated with single layer approximation of 3-0 nylon sutures. Sterile dressings were applied followed by a sling. The patient was then awakened and brought to the recovery room without any incident.

DICTATED BY: Menachem M. Meller, MD

Job #:895754 Doc #:2281959

<Electronically signed by MENACHEM M MELLER, MD> at 10/13/17

0831

---

MELLER, MENACHEM M MD

MELLME / NE / DD 10/12/17 1820 / DT 10/12/17 2108

# Poor Quality Original

Informant PT - Alonzo Benton  
Allergies Iodine

Date of Surgery 4/26/17  
LMP  
Corticosteroid Tx within Last Yr. ☐ Yes ☒ No

History  
Chief Complaint (2) claudication

History of Present Illness PT fell in street on 8/29/17. Still experiencing pain 10/10. Wearing sling. (2) Brown ing. ↓ mobility, swelling, tenderness. Denies numbness & in sensation. x Ray confirmed break. PT taking Percocet which relieves pain "Saherzhab".

Past Medical Hx Prostate P.R.  
GERD herniated disc.  
HTN

Previous Surgeries Prostatectomy ~2012  
(R) hernia repair

Medications  
Losartan 75 mg Hydrochlorothiazide  
Omeprazole 20 mg HCTZ 12.5

Family History  
Mother - CAD, DM  
Father - CAD

Social History  
former smoker (quit 10 yrs, 1 pack x 30 yrs) occ alcohol drugs

Review of Systems  
**NEURO** ☒ No C/O  
☐ headache ☐ paralysis  
☐ dizziness ☐ paresthesia  
☐ loss of consciousness  
☐ seizures  
Comments \_\_\_\_\_  
**HEENT** ☐ No C/O  
Eyes ☒ impaired vision ☐ tinnitus ☐ pain  
☒ tearing ☐ drainage ☐ hoarseness  
☐ discharge ☐ hearing loss  
Comments (2) glasses  
missing lens  
**CARDIO PULMONARY** ☐ No C/O  
☐ chest pain ☐ asthma  
☐ palpitations ☐ emphysema  
☐ DOE ☐ cough  
☐ pneumonia ☐ sputum  
Comments \_\_\_\_\_

**GASTROINTESTINAL** ☒ No C/O  
☐ nausea/vomiting ☐ abd pain  
☐ dysphagia ☐ rectal bleeding  
☐ weight loss ☐ change in bowel habits  
Comments \_\_\_\_\_  
**GENITOURINARY** ☒ No C/O  
☐ frequency ☐ hematuria  
☐ urgency ☐ nocturia  
☐ burning ☐ discharge  
Comments \_\_\_\_\_  
**MUSCULOSKELETAL** ☐ No C/O  
☒ pain ☐ rash  
☒ swelling ☐ bruises  
☒ joint restriction ☐ scars  
Comments (2) claudication  
Rib fx Fx

Other: \_\_\_\_\_

Mercy Philadelphia Hospital  
A member of Mercy Health System

PATIENT HISTORY & PHYSICAL



BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 10/12/17  
ACC: PA1304917733 MR: M000301370



# Poor Quality Original

PHYSICAL Pulse 80 Resp 18 B/P 13/89 HGT 5'9" WGT 170/65  
HEENT

PERRLA EOMI neck supple.  
NO TND - Neck supple.

## CHEST/HEART/LUNGS

Heart: S1S2 No murmur  
Lungs: B/L CTA - No wheezes

## ABDOMEN

soft. NTND (+) BS

## EXTREMITIES

(+) Shoulder sling, limited mobility, (+) ecchymosis  
tender to palpation. Full ROM, 5/5 strength (+) Hand grip.

## SKIN

bruising to (+) HE. Skin Intact. Warm. Dry. No lesions  
(+) Intact.

## NEUROLOGIC

AAOX3

## OTHER SPECIFIC FINDINGS

pt scheduled for DEXA scan 9/5/17.

## ASSESSMENT

Disp Fx of Lateral (+) Clavicle

## PLAN

ORIF Left distal Clavicle

## SIGNATURE:

Schiffman CRNP

## PRINT:

Sarah Solkes CRNP

## DATE/TIME:

9/5/17  
1251 PM

## ATTENDING ADDENDUM:

Electronically Signed by MELLER, MENACHEM M, MD on 09/25/17 at  
1455

## SIGNATURE:

## PRINT:

## DATE/TIME:

 Mercy Philadelphia Hospital  
A member of Mercy Health System

PATIENT HISTORY AND PHYSICAL



Page 2 of 2  
Form #OR102, Rev. 04/2014  
PHYSICIAN/PHY

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 09/20/17  
ACC: PA1304861964 MR: M000301370



PATIENT: PA1304917733 - BENTON,ALONZO  
 UNIT #: M000301370

| ORDER |      |          |           |           |                | SERVICE |      |            |            | ORDERED |      |
|-------|------|----------|-----------|-----------|----------------|---------|------|------------|------------|---------|------|
| DATE  | TIME | CATEGORY | PROCEDURE | ORDER NUM | PRI QTY STATUS | DATE    | TIME | ORD DOCTOR | ORDERED BY | CHNG    | FROM |

|          |      |     |         |           |   |     |          |      |        |          |   |     |   |
|----------|------|-----|---------|-----------|---|-----|----------|------|--------|----------|---|-----|---|
| 10/12/17 | 1412 | MIC | MRSAPCR | 1012-0018 | R | CMP | 10/12/17 | 1411 | MELIME | PHDURRAS | C | POM | P |
|----------|------|-----|---------|-----------|---|-----|----------|------|--------|----------|---|-----|---|

Collected by Nurse? Y  
 Comment:  
 Has specimen been obtained/collected? Y  
 MRSA Source: NARES LT  
 If Source = 'other', please specify:

| DIRECTIONS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STOP DATE/TIME: | ORDER SET: |           |                                                             |       |   |               |          |           |                                           |   |               |          |           |                                                             |   |               |          |           |                   |   |               |          |           |                                             |   |               |          |           |                                              |   |               |       |           |                                            |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------------|-----------|-------------------------------------------------------------|-------|---|---------------|----------|-----------|-------------------------------------------|---|---------------|----------|-----------|-------------------------------------------------------------|---|---------------|----------|-----------|-------------------|---|---------------|----------|-----------|---------------------------------------------|---|---------------|----------|-----------|----------------------------------------------|---|---------------|-------|-----------|--------------------------------------------|--|--|
| <table border="0" style="width: 100%;"> <tr> <th>DATE</th> <th>TIME</th> <th>USER</th> <th>DEVICE</th> <th>EVENT</th> </tr> <tr> <td>1</td> <td>10/12/17 1412</td> <td>PHDURRAS</td> <td>PH-ORC014</td> <td>order entered in POM by SHIRLEY A DURRANT</td> </tr> <tr> <td>2</td> <td>10/12/17 1412</td> <td>PHDURRAS</td> <td>PH-ORC014</td> <td>order source is PROTOCOL - no signature necessary for entry</td> </tr> <tr> <td>3</td> <td>10/12/17 1412</td> <td>COSYSTEM</td> <td>CAE-BG314</td> <td>order transmitted</td> </tr> <tr> <td>4</td> <td>10/12/17 1413</td> <td>COSYSTEM</td> <td>CAE-BG314</td> <td>order's status changed from TRANS to LOGGED</td> </tr> <tr> <td>5</td> <td>10/12/17 1419</td> <td>PHSCRUGP</td> <td>CAE-BG314</td> <td>order's status changed from LOGGED to IN PRO</td> </tr> <tr> <td>6</td> <td>10/13/17 1218</td> <td>INFCE</td> <td>CAE-BG314</td> <td>order's status changed from IN PRO to COMP</td> </tr> </table> | DATE            | TIME       | USER      | DEVICE                                                      | EVENT | 1 | 10/12/17 1412 | PHDURRAS | PH-ORC014 | order entered in POM by SHIRLEY A DURRANT | 2 | 10/12/17 1412 | PHDURRAS | PH-ORC014 | order source is PROTOCOL - no signature necessary for entry | 3 | 10/12/17 1412 | COSYSTEM | CAE-BG314 | order transmitted | 4 | 10/12/17 1413 | COSYSTEM | CAE-BG314 | order's status changed from TRANS to LOGGED | 5 | 10/12/17 1419 | PHSCRUGP | CAE-BG314 | order's status changed from LOGGED to IN PRO | 6 | 10/13/17 1218 | INFCE | CAE-BG314 | order's status changed from IN PRO to COMP |  |  |
| DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | TIME            | USER       | DEVICE    | EVENT                                                       |       |   |               |          |           |                                           |   |               |          |           |                                                             |   |               |          |           |                   |   |               |          |           |                                             |   |               |          |           |                                              |   |               |       |           |                                            |  |  |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10/12/17 1412   | PHDURRAS   | PH-ORC014 | order entered in POM by SHIRLEY A DURRANT                   |       |   |               |          |           |                                           |   |               |          |           |                                                             |   |               |          |           |                   |   |               |          |           |                                             |   |               |          |           |                                              |   |               |       |           |                                            |  |  |
| 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10/12/17 1412   | PHDURRAS   | PH-ORC014 | order source is PROTOCOL - no signature necessary for entry |       |   |               |          |           |                                           |   |               |          |           |                                                             |   |               |          |           |                   |   |               |          |           |                                             |   |               |          |           |                                              |   |               |       |           |                                            |  |  |
| 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10/12/17 1412   | COSYSTEM   | CAE-BG314 | order transmitted                                           |       |   |               |          |           |                                           |   |               |          |           |                                                             |   |               |          |           |                   |   |               |          |           |                                             |   |               |          |           |                                              |   |               |       |           |                                            |  |  |
| 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10/12/17 1413   | COSYSTEM   | CAE-BG314 | order's status changed from TRANS to LOGGED                 |       |   |               |          |           |                                           |   |               |          |           |                                                             |   |               |          |           |                   |   |               |          |           |                                             |   |               |          |           |                                              |   |               |       |           |                                            |  |  |
| 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10/12/17 1419   | PHSCRUGP   | CAE-BG314 | order's status changed from LOGGED to IN PRO                |       |   |               |          |           |                                           |   |               |          |           |                                                             |   |               |          |           |                   |   |               |          |           |                                             |   |               |          |           |                                              |   |               |       |           |                                            |  |  |
| 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10/13/17 1218   | INFCE      | CAE-BG314 | order's status changed from IN PRO to COMP                  |       |   |               |          |           |                                           |   |               |          |           |                                                             |   |               |          |           |                   |   |               |          |           |                                             |   |               |          |           |                                              |   |               |       |           |                                            |  |  |

|          |      |     |      |           |   |     |          |      |        |          |   |     |   |
|----------|------|-----|------|-----------|---|-----|----------|------|--------|----------|---|-----|---|
| 10/12/17 | 1733 | PHA | <IV> | 1012-0708 | 1 | CMP | 10/12/17 | 1731 | REISAN | COREISTA | C | POM | D |
|----------|------|-----|------|-----------|---|-----|----------|------|--------|----------|---|-----|---|

|                                                                                                                                                                |                                      |                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------|
| DIRECTIONS:                                                                                                                                                    | STOP DATE/TIME:                      | ORDER SET:                                         |
| <b>MEDICATION</b><br>One Time Medication<br>Discontinued 10/12/17 1832<br><Bag 1> Rate: 100 MLS/HR<br><b>GENTAMICIN SULFATE</b><br><b>Sodium Chloride 0.9%</b> | <b>DOSE</b><br>100 MG<br>Vol: 100 ML | <b>CLINICAL INDICATION</b><br>SURGICAL PROPHYLAXIS |

Comment: INDICATIONS: INFECTION  
 SIDE EFFECTS: (ALL RARE) OTOTOXICITY,  
 NEPHROTOXICITY

|                   |      |       |            |
|-------------------|------|-------|------------|
| TO BE GIVEN IN OR |      |       |            |
| ROUTE             | SIG  | SCHED | PRN REASON |
| IV                | ONCE | STA   |            |

|      |       |         |      |
|------|-------|---------|------|
| DAYS | HOURS | TOT VOL | BAGS |
| 0    | 1.03  |         |      |

Comment: Reached stop Date

| DATE | TIME          | USER      | DEVICE     | EVENT                                                       |
|------|---------------|-----------|------------|-------------------------------------------------------------|
| 1    | 10/12/17 1733 | COREISTA  | PH-ROVW001 | order entered in POM by ANDREW REISTER                      |
| 2    | 10/12/17 1733 | COREISTA  | PH-ROVW001 | order source is PROVIDER - signature is necessary for entry |
| 3    | 10/12/17 1733 | COREISTA  | PH-ROVW001 | order Signed by REISTER,ANDREW J MD                         |
| 4    | 10/12/17 1733 | COSYSTEM  | CAE-BG314  | order transmitted                                           |
| 5    | 10/12/17 1733 | COSYSTEM  | CAE-BG314  | order's status changed from TRANS to LOGGED                 |
| 6    | 10/12/17 1747 | PHPATEAS  | CAE-BG314  | order edited by PHA                                         |
| 7    | 10/12/17 1747 | PHPATEAS  | CAE-BG314  | order's status changed from LOGGED to IN PRO                |
| 8    | 10/12/17 1832 | PHABRGJOB | CAE-BG314  | order's status changed from IN PRO to COMP                  |

|          |      |     |     |           |   |     |          |      |        |          |   |     |   |
|----------|------|-----|-----|-----------|---|-----|----------|------|--------|----------|---|-----|---|
| 10/12/17 | 1756 | MIC | ANC | 1013-0026 | R | CMP | 10/12/17 | 1755 | MELIME | PHGIAMPE | C | POM | W |
|----------|------|-----|-----|-----------|---|-----|----------|------|--------|----------|---|-----|---|

DATE: 10/21/17 @ 0010  
USER: EKG DAEMON

Mercy Philadelphia Hospital OE \*\*LIVE\*\*  
PATIENT ORDER SUMMARY

PAGE 2

PATIENT: PA1304917733 - BENTON,ALONZO  
UNIT #: M000301370

| ORDER |      |          |           |           |     | SERVICE |        |      |      | ORDERED    |            |      |      |
|-------|------|----------|-----------|-----------|-----|---------|--------|------|------|------------|------------|------|------|
| DATE  | TIME | CATEGORY | PROCEDURE | ORDER NUM | PRI | QTY     | STATUS | DATE | TIME | ORD DOCTOR | ORDERED BY | CHNG | FROM |

Collected by Nurse? Y  
Comment: left shoulder/distal clavicle  
Has specimen been obtained/collected? Y  
Anaerobic Culture Source: CLAVICLE  
Specimen Description:

| DIRECTIONS: |               |          | STOP DATE/TIME: |                                                            | ORDER SET: |  |
|-------------|---------------|----------|-----------------|------------------------------------------------------------|------------|--|
| DATE        | TIME          | USER     | DEVICE          | EVENT                                                      |            |  |
| 1           | 10/12/17 1756 | PHGIAMFB | PH-ORC029       | order entered in POM by BARBARA GIAMPIETRO                 |            |  |
| 2           | 10/12/17 1756 | PHGIAMFB | PH-ORC029       | order source is Written - no signature necessary for entry |            |  |
| 3           | 10/12/17 1756 | COSYSTEM | CAE-BG314       | order transmitted                                          |            |  |
| 4           | 10/12/17 1756 | COSYSTEM | CAE-BG314       | order's status changed from TRANS to LOGGED                |            |  |
| 5           | 10/12/17 1938 | PHSCRUGP | CAE-BG314       | order's status changed from LOGGED to IN PRO               |            |  |
| 6           | 10/16/17 1027 | INFCE    | CAE-BG314       | order's status changed from IN PRO to COMP                 |            |  |

|               |     |       |           |   |     |               |        |          |   |     |   |
|---------------|-----|-------|-----------|---|-----|---------------|--------|----------|---|-----|---|
| 10/12/17 1756 | MIC | SURGC | 1012-0027 | R | CMP | 10/12/17 1755 | MELIME | PHGIAMFB | C | POM | W |
|---------------|-----|-------|-----------|---|-----|---------------|--------|----------|---|-----|---|

Collected by Nurse? Y  
Comment: left shoulder/distal clavicle  
Surgical Culture Source: CLAVICLE  
Specimen Description:

| DIRECTIONS: |               |          | STOP DATE/TIME: |                                                            | ORDER SET: |  |
|-------------|---------------|----------|-----------------|------------------------------------------------------------|------------|--|
| DATE        | TIME          | USER     | DEVICE          | EVENT                                                      |            |  |
| 1           | 10/12/17 1756 | PHGIAMFB | PH-ORC029       | order entered in POM by BARBARA GIAMPIETRO                 |            |  |
| 2           | 10/12/17 1756 | PHGIAMFB | PH-ORC029       | order source is Written - no signature necessary for entry |            |  |
| 3           | 10/12/17 1756 | COSYSTEM | CAE-BG314       | order transmitted                                          |            |  |
| 4           | 10/12/17 1756 | COSYSTEM | CAE-BG314       | order's status changed from TRANS to LOGGED                |            |  |
| 5           | 10/12/17 1938 | PHSCRUGP | CAE-BG314       | order's status changed from LOGGED to IN PRO               |            |  |
| 6           | 10/16/17 1239 | INFCE    | CAE-BG314       | order's status changed from IN PRO to COMP                 |            |  |

|               |    |         |           |      |   |     |               |        |          |   |     |   |
|---------------|----|---------|-----------|------|---|-----|---------------|--------|----------|---|-----|---|
| 10/12/17 1825 | CR | SHOULDT | 1012-0074 | ROUT | 1 | RES | 10/12/17 1824 | MELIME | COMELLEM | C | POM | D |
|---------------|----|---------|-----------|------|---|-----|---------------|--------|----------|---|-----|---|

Reason for Exam: post op in PACU  
Is Patient Pregnant?  
When was patient's LMP?  
Comment:

| DIRECTIONS: |               |            | STOP DATE/TIME: |                                                             | ORDER SET: |  |
|-------------|---------------|------------|-----------------|-------------------------------------------------------------|------------|--|
| DATE        | TIME          | USER       | DEVICE          | EVENT                                                       |            |  |
| 1           | 10/12/17 1825 | COMELLEM   | PH-ORC007       | order entered in POM by MENACHEM M MELLER                   |            |  |
| 2           | 10/12/17 1825 | COMELLEM   | PH-ORC007       | order source is PROVIDER - signature is necessary for entry |            |  |
| 3           | 10/12/17 1825 | COMELLEM   | PH-ORC007       | order Signed by MELLER,MENACHEM M, MD                       |            |  |
| 4           | 10/12/17 1825 | COSYSTEM   | CAE-BG314       | order transmitted                                           |            |  |
| 5           | 10/12/17 1825 | COSYSTEM   | CAE-BG314       | order's status changed from TRANS to LOGGED                 |            |  |
| 6           | 10/12/17 1825 | COSYSTEM   | CAE-BG314       | quantity edited via ITS: old value -                        |            |  |
| 7           | 10/12/17 1923 | PHEUDNIE   | CAE-BG314       | order's status changed from LOGGED to TAKEN                 |            |  |
| 8           | 10/13/17 0845 | EKG DAEMON | CAE-BG314       | order's status changed from TAKEN to RESULT                 |            |  |

|               |     |            |           |  |     |               |        |          |   |     |   |
|---------------|-----|------------|-----------|--|-----|---------------|--------|----------|---|-----|---|
| 10/12/17 1840 | PHA | OXYC1TAB53 | 1012-0770 |  | CMP | 10/12/17 1845 | MELIME | PHPATEAS | C | PHA | W |
|---------------|-----|------------|-----------|--|-----|---------------|--------|----------|---|-----|---|

DATE: 10/21/17 @ 0010      Mercy Philadelphia Hospital OE \*\*LIVE\*\*      PAGE 3  
 USER: EKG DAEMON      PATIENT ORDER SUMMARY

PATIENT: PA1304917733 - BENTON, ALONZO  
 UNIT #: M000301370

| ORDER |      |          |           |           |                | SERVICE |      |            |            | ORDERED |      |
|-------|------|----------|-----------|-----------|----------------|---------|------|------------|------------|---------|------|
| DATE  | TIME | CATEGORY | PROCEDURE | ORDER NUM | PRI QTY STATUS | DATE    | TIME | ORD DOCTOR | ORDERED BY | CHNG    | FROM |

MEDICATION DOSE  
 Discontinued 10/12/17 2100  
 oxycodone HCl/ACETAMIN 5-325 2 TABLET

ROUTE SIG SCHED PRN REASON  
 PO Q3H PRN PAIN

DAYS HOURS TOT VOL DOSES  
 0 2.26

Comment: Reached Stop Date  
 Comment: SIDE EFFECT: DIZZINESS, CONSTIPATION, FATIGUE,  
 BLURRED VISION, LIGHT HEADEDNESS

| DATE            | TIME      | USER        | DEVICE                                     | EVENT |
|-----------------|-----------|-------------|--------------------------------------------|-------|
| 1 10/12/17 1840 | PHPATEAS  | PH-PHAC007R | order entered in PHA by ASHISH PATEL       |       |
| 2 10/12/17 2100 | PHABKGJOB | CAE-BG314   | order's status changed from IN PRO to COMP |       |

10/13/17 0811 LAB PATHRTN 1013-0350 R CNC 10/13/17 0809 MELLME PHWILKIG X POM W

Collected by Nurse? Y  
 Comment: specimen in o.r. fridge  
 SOURCE INC LWR/UPR/RT/LFT/ ETC. granulation tissue lt. shoulder  
 CLINICAL INFO unk  
 COMMENT

| DIRECTIONS:     |            | STOP DATE/TIME: |                                                            | ORDER SET: |
|-----------------|------------|-----------------|------------------------------------------------------------|------------|
| DATE            | TIME USER  | DEVICE          | EVENT                                                      |            |
| 1 10/13/17 0811 | PHWILKIG   | PH-ORC016       | order entered in POM by GWENDOLYN WILKINS                  |            |
| 2 10/13/17 0811 | PHWILKIG   | PH-ORC016       | order source is Written - no signature necessary for entry |            |
| 3 10/13/17 0811 | COSYSTEM   | CAE-BG314       | order transmitted                                          |            |
| 4 10/13/17 0812 | COSYSTEM   | CAE-BG314       | order's status changed from TRANS to LOGGED                |            |
| 5 10/17/17 0006 | AutoCancel | CAE-BG314       | order's status changed from LOGGED to CANC                 |            |

10/13/17 0811 LAB PATHGROSS 1013-0351 R CNC 10/13/17 0810 MELLME PHWILKIG X POM W

Collected by Nurse? Y  
 Comment: specimen in o.r. fridge  
 SOURCE INC LWR/UPR/RT/LFT/ ETC. lt. shoulder hardware  
 CLINICAL INFO unk  
 COMMENT

| DIRECTIONS:     |            | STOP DATE/TIME: |                                                            | ORDER SET: |
|-----------------|------------|-----------------|------------------------------------------------------------|------------|
| DATE            | TIME USER  | DEVICE          | EVENT                                                      |            |
| 1 10/13/17 0811 | PHWILKIG   | PH-ORC016       | order entered in POM by GWENDOLYN WILKINS                  |            |
| 2 10/13/17 0811 | PHWILKIG   | PH-ORC016       | order source is Written - no signature necessary for entry |            |
| 3 10/13/17 0811 | COSYSTEM   | CAE-BG314       | order transmitted                                          |            |
| 4 10/13/17 0812 | COSYSTEM   | CAE-BG314       | order's status changed from TRANS to LOGGED                |            |
| 5 10/17/17 0006 | AutoCancel | CAE-BG314       | order's status changed from LOGGED to CANC                 |            |

# Poor Quality Original

Allergies: Check if: ☐ Patient is pregnant  
☐ Patient is lactating

## PREOPERATIVE ORDERS SHEET

### ANESTHESIA TO COMPLETE:

Patient is taking a Beta Blocker (BB) daily at home prior to arrival or as a current medication

☒ No ☐ Yes

Last Dose Date

Time

Has dose of BB been missed on the day of surgery? ☐ No ☐ Yes (Administer BB)

☐ No ☐ Yes (Administer BB)

yes ☐ Pre-operative BB given (drug/dose/route)

Date

Time

☐ Pre-operative BB (see anesthesia record)

Is BB in fact NOT GIVEN, reason:

Anesthesiologist signature

Date 10/12/17

Time 1640

### SURGERY TO COMPLETE: Must have an order for surgery procedure

Please Check: ☐ Admit to Hospital ☐ Outpatient ☐ Patient to stay ☐ greater than 2 nights

Preoperative antibiotics to be given within 1 hour of incision time (vancomycin within 2 hours of incision time)

|                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Peripheral vascular/General Surgery/PEG tube placement                                                                                                                                                                                                                                                                                                               | <input checked="" type="checkbox"/> Cefazolin (Ancef) 2 Gm IV<br><input type="checkbox"/> Cefazolin (Ancef) 3 Gm if weight $\geq 120$ kg<br><input type="checkbox"/> **Vancomycin 15 mg/kg Gm                                                                                                                                                                                                                                                              | If Beta lactam allergy:<br><input type="checkbox"/> Vancomycin 15 mg/kg Gm<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV                                                                                                                                                                     |
| <input checked="" type="checkbox"/> Orthopedic/Podiatric Surgery                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Cefazolin (Ancef) 2 Gm IV and Metronidazole (Flagyl) 500 mg IV<br><input type="checkbox"/> Cefazolin (Ancef) 3 Gm if weight $\geq 120$ kg and Metronidazole (Flagyl) 500 mg IV<br><input type="checkbox"/> Ceftriaxone (Rocephin) 2 Gm IV and Metronidazole (Flagyl) 500 mg IV<br><input type="checkbox"/> Ampicillin/Sulbactam (Unasyn) 3 Gm IV                                                                                  | If Beta lactam allergy:<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Ciprofloxacin (Cipro) 400 mg IV<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Aztreonam 2 Gm IV<br><input type="checkbox"/> Metronidazole (Flagyl) 500 mg IV and Ciprofloxacin (Cipro) 400 mg IV |
| GI Surgery                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Cefazolin (Ancef) 2 Gm IV<br><input type="checkbox"/> Cefazolin (Ancef) 3 Gm if weight $\geq 120$ kg<br><input type="checkbox"/> Ampicillin/Sulbactam (Unasyn) 3 Gm IV                                                                                                                                                                                                                                                            | If Beta lactam allergy:<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Ciprofloxacin (Cipro) 400 mg IV<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Aztreonam 2 Gm IV<br><input type="checkbox"/> Metronidazole (Flagyl) 500 mg IV and Ciprofloxacin (Cipro) 400 mg IV |
| Urology/Gynecologic/Obstetrician Surgery                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Cefazolin (Ancef) 2 Gm IV<br><input type="checkbox"/> Cefazolin (Ancef) 3 Gm if weight $\geq 120$ kg<br><input type="checkbox"/> Ampicillin/Sulbactam (Unasyn) 3 Gm IV                                                                                                                                                                                                                                                            | If Beta lactam allergy:<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Ciprofloxacin (Cipro) 400 mg IV<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Aztreonam 2 Gm IV<br><input type="checkbox"/> Metronidazole (Flagyl) 500 mg IV and Ciprofloxacin (Cipro) 400 mg IV |
| Outpatient<br><input type="checkbox"/> Prostate Biopsy                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Ciprofloxacin (Cipro) 500 mg PO (patient took prior to arrival)<br><input type="checkbox"/> Sulfamethoxazole / Trimethoprim DS (Bactrim) 800/160 mg PO (patient took prior to arrival)<br><input type="checkbox"/> Ciprofloxacin (Cipro) 400 mg IV<br><input type="checkbox"/> Cefazolin (Ancef) 2 Gm IV<br><input type="checkbox"/> Cefazolin (Ancef) 3 Gm if weight $\geq 120$ kg<br><input type="checkbox"/> Aztreonam 2 Gm IV |                                                                                                                                                                                                                                                                                                            |
| Outpatient<br><input type="checkbox"/> Puvovaginal sling                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Cefazolin (Ancef) 2 Gm IV<br><input type="checkbox"/> Cefazolin (Ancef) 3 Gm if weight $\geq 120$ kg<br><input type="checkbox"/> Ampicillin/Sulbactam (Unasyn) 3 Gm IV<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Aztreonam 2 Gm IV<br><input type="checkbox"/> Aztreonam 2 Gm IV and Metronidazole (Flagyl) 500 mg IV                                                                                       |                                                                                                                                                                                                                                                                                                            |
| Outpatient Penile Prosthesis insertion, removal, revision                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Ampicillin/Sulbactam (Unasyn) 3 Gm IV<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Aztreonam 2 Gm IV<br><input type="checkbox"/> **Vancomycin 15 mg/kg gm and Aztreonam 2 Gm IV                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                            |
| **Reason for Vancomycin use:<br><input type="checkbox"/> Beta Lactam Allergy<br><input type="checkbox"/> Pt high risk due to acute inpatient hospitalization within the last year or LTC setting within the last year prior to admission<br><input type="checkbox"/> MRSA colonization/infection<br><input type="checkbox"/> Chronic wound care or dialysis<br><input type="checkbox"/> Other | Preoperative antibiotics not indicated because:<br><input type="checkbox"/> Possible infection; intraoperative cultures to be drawn<br><input type="checkbox"/> Already on therapeutic antibiotics<br><input type="checkbox"/> No body cavity opened, no implanted devices and no foreign bodies inserted<br><input type="checkbox"/> Other                                                                                                                |                                                                                                                                                                                                                                                                                                            |
| Redosing with antibiotic is indicated if the duration of the procedure exceeds two half-lives of the drug                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                            |
| Antimicrobial w/ shorter half-life                                                                                                                                                                                                                                                                                                                                                            | Half-life (hr) in Adults (normal renal function)                                                                                                                                                                                                                                                                                                                                                                                                           | Recommended Redosing Interval (hr) from initiation of preoperative dose                                                                                                                                                                                                                                    |
| Ampicillin/Sulbactam (Unasyn)                                                                                                                                                                                                                                                                                                                                                                 | 0.8-1.3                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 2                                                                                                                                                                                                                                                                                                          |
| Aztreonam (Azactam)                                                                                                                                                                                                                                                                                                                                                                           | 1.3-2.4                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4                                                                                                                                                                                                                                                                                                          |
| Cefazolin (Ancef)                                                                                                                                                                                                                                                                                                                                                                             | 1.2-2.2                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                            |
| Clindamycin                                                                                                                                                                                                                                                                                                                                                                                   | 2-4                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                            |

SURGEON'S SIGNATURE:

Mercy Philadelphia Hospital  
 A member of Mercy Health System

SCIP PreOp Order Form

BENTON, ALONZO  
 DOB: 11/12/1958 58 M  
 ADM: 10/12/17  
 ACC: PA1304917733 MR: M000301370



Page 1 of 1  
 SCIP PreOp Order Form  
 CRD.Y

| Prohibited               | Allowed                  | Allergies: | Check if: <input type="checkbox"/> Patient is pregnant<br><input type="checkbox"/> Patient is lactating |
|--------------------------|--------------------------|------------|---------------------------------------------------------------------------------------------------------|
| U, IU                    | Unit, International Unit |            |                                                                                                         |
| QD, QID, qd, q d.        | Daily                    |            |                                                                                                         |
| D, Q, QID, qod, q o d.   | Every other day or q48h  |            |                                                                                                         |
| No leading zeros (.5 mg) | Leading zeros (0.5 mg)   |            |                                                                                                         |
| Trailing zeros (5 0 mg)  | No trailing zeros (5 mg) |            |                                                                                                         |
| MgSO <sub>4</sub>        | Magnesium Sulfate        |            |                                                                                                         |
| MS, MSO <sub>4</sub>     | Morphine Sulfate         |            |                                                                                                         |
| cc                       | mL                       |            |                                                                                                         |
| ug                       | mcg                      |            |                                                                                                         |

IMPORTANT: ACCORDING TO HOSPITAL POLICY DOSE-RANGE/FREQUENCY RANGE ORDERS ARE NOT ACCEPTABLE

| Date     | Time    | PATIENT CARE ORDERS<br>(MEDICATIONS, DIET, LABORATORY, X-RAY, ETC.)<br>POST OPERATIVE ORDERS FOR SPU PATIENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 10/12/17 | 6:15 pm | <ol style="list-style-type: none"> <li>1. Admit to PACU, then SPU</li> <li>2. Diagnosis: <i>Hardware Removal ITD @</i></li> <li>3. Allergies: <i>NCPA</i> <i>shoulder distal nerve</i></li> <li>4. Routine vital sign monitoring</li> <li>5. Diet: <i>House</i></li> <li>6. Activity: <i>LD</i> Ambulate with assistance when alert and awake</li> <li>7. IV: at <i>LD</i> ml/hr. Discontinue when patient tolerating po fluids and ambulatory</li> <li>8. Medications: <ul style="list-style-type: none"> <li>Pain: <i>Pericort 5/325 II 10 q 5 prn</i></li> <li>Antiemetic: <i>ice @ shoulder</i></li> </ul> </li> <li>9. Other: <i>thing in place</i><br/><i>x-ray AP @ shoulder in</i><br/><i>PACU</i></li> <li>10. Discharge order: (check one) <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Discharge when patient meets discharge criteria</li> <li><input type="checkbox"/> Physician will visit patient prior to discharge</li> </ul> </li> </ol> |
| 10/12/17 | 8:18:35 | <p>Physician Signature: <i>[Signature]</i> <i>10/12/17</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

Mercy Philadelphia Hospital  
Member of Mercy Health System

SPU Physician Orders



DOB: BENTON, ALONZO  
Adm: DOB: 11/12/1958 58 M  
Acc: ADM: 10/12/17  
ACC: PA1304917733 MR: M000301370



**Poor Quality Original** MPH- OR Specimen, Verbal Order

**Poor Quality Original** MPH- OR Specimen, Verbal Order

|                                                                                                                                                                                  |      |                                           |                                                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| BENTON, ALONZO<br>DOB: 11/12/1958 58 M<br>ADM: 10/12/17<br>ACC: PA1304917733 MR: M000301370<br> |      | Is this Stat?<br><input type="checkbox"/> | Allergies:<br><br>Is patient pregnant or lactating?<br><input type="checkbox"/> yes <input type="checkbox"/> no |
| Date                                                                                                                                                                             | Time | V.O. Dr. _____                            | Indication                                                                                                      |
|                                                                                                                                                                                  |      | Specimens:                                |                                                                                                                 |
|                                                                                                                                                                                  |      |                                           |                                                                                                                 |
|                                                                                                                                                                                  |      |                                           |                                                                                                                 |
|                                                                                                                                                                                  |      |                                           |                                                                                                                 |
|                                                                                                                                                                                  |      |                                           |                                                                                                                 |
|                                                                                                                                                                                  |      |                                           |                                                                                                                 |
|                                                                                                                                                                                  |      |                                           |                                                                                                                 |
|                                                                                                                                                                                  |      |                                           |                                                                                                                 |
|                                                                                                                                                                                  |      |                                           |                                                                                                                 |
| Read back and Verified By _____                                                                                                                                                  |      | RN                                        |                                                                                                                 |
| Physician Signature <i>Allen</i> 10/12/17                                                                                                                                        |      |                                           |                                                                                                                 |
|                                                                                                                                                                                  |      |                                           |                                                                                                                 |

# Poor Quality Original

## Pre-Procedural History and Physical Verification

|                                                                                |                                                                                           |                                                                                                         |
|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| Verified the H&P. Patient examined prior to procedure by                       | me                                                                                        |                                                                                                         |
| No Interval changes                                                            |                                                                                           |                                                                                                         |
| Change noted                                                                   | pt returned with exposed distal plate & serious drainage requiring early hardware removal |                                                                                                         |
| <input type="checkbox"/> Insert Foley Catheter                                 | <input type="checkbox"/> Apply Sequentials                                                | <input checked="" type="checkbox"/> Antibiotic Cefazolin 1g IV                                          |
| Other                                                                          |                                                                                           |                                                                                                         |
| Surgeon                                                                        | Michael Lee                                                                               | Date 10/12/17 Time 4:51 PM                                                                              |
| Patient Verification                                                           |                                                                                           |                                                                                                         |
| I have identified the patient on the Procedural table.                         |                                                                                           |                                                                                                         |
| Attending Proceduralist                                                        | Date                                                                                      | Time                                                                                                    |
| Post Procedural Note                                                           |                                                                                           |                                                                                                         |
| OPERATIVE NOTE:                                                                | Type of Anesthesia Administered                                                           |                                                                                                         |
| PREOPERATIVE DIAGNOSIS:                                                        | Exposed loose hardware left distal clavicle                                               |                                                                                                         |
| POST- OPERATIVE DIAGNOSIS                                                      | Same                                                                                      |                                                                                                         |
| NAME OF SURGEON / ASSISTANTS: Miller                                           |                                                                                           |                                                                                                         |
| PROCEDURE:                                                                     | Hardware Removal I/D                                                                      |                                                                                                         |
| FINDINGS:                                                                      | loose hardware exposed plate                                                              |                                                                                                         |
| SPECIMEN REMOVED:                                                              | Ex aerobic and anaerobic                                                                  |                                                                                                         |
| EBL:                                                                           | mm                                                                                        | FLUIDS:                                                                                                 |
| COMPLICATIONS                                                                  | None                                                                                      | DRAINS:                                                                                                 |
| The LIP signature also indicates orders for medications given during procedure |                                                                                           |                                                                                                         |
| Is the patient on Beta Blockers:                                               | YES <input type="radio"/> NO <input checked="" type="radio"/>                             | If yes did you include in post-op orders: YES <input type="radio"/> NO <input checked="" type="radio"/> |
| Staging                                                                        | T N M                                                                                     | Stage N/A                                                                                               |
| NOTES:                                                                         |                                                                                           |                                                                                                         |
| 195754                                                                         |                                                                                           |                                                                                                         |
| Signature:                                                                     | Michael Lee 10/12/17 6:04 PM                                                              |                                                                                                         |

Mercy Philadelphia Hospital  
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INTERDISCIPLINARY INTEGRATED O/P PROGRESS NOTES



Page 1 of 1  
Form M032; Rev. 06 2012  
POSS. OTHER

DOB: BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 10/12/17  
ACC: PA1304917733 MR: M000301370



MERCY HEALTH SYSTEM  
MERCY PHILADELPHIA LABORATORY  
501 SOUTH 54th STREET  
PHILADELPHIA PA, 19143  
SAMIA HENIEN, M.D. MEDICAL DIRECTOR

LABORATORY REPORT

NAME: BENTON, ALONZO                      DOS: 10/12/17                      LOC: PHSPU  
AGE/SEX: 58/M                      DOB: 11/12/1958                      ACCT: PA1304917733                      MR: M000301370  
ATTEND DR: MELLER, MENACHEM M, MD

KEY H - Abn High                      \*H - Critical High                      \* - High or Low(Alpha results)                      # - Delta Check  
L - Abn Low                      \*L - Critical Low                      \* - Microbiology Abn Result

Source Category: RESPIRATORY

Collection Date: 10/12/17

> MRSA PCR SCREEN (\*a)                      Final 10/13/17

Nasal colonization with MRSA is indicated: isolation or  
cohort room is required. A positive result does not  
necessarily indicate the presence of viable MRSA organisms  
RESULT: POSITIVE-MRSA DNA DETECTED

Source Category: WOUND

> ANAEROBIC CULTURE AND SMEAR (\*a)                      Final 10/16/17

CULTURE: NO ANAEROBES ISOLATED  
GRAM STAIN RESULT: \*  
FEW WHITE BLOOD CELLS  
NO ORGANISMS SEEN

> SURGICAL CULTURE (\*a)                      Final 10/16/17

Organism 1                      STAPHYLOCOCCUS AUREUS-MRSA  
Organism 2                      PSEUDOMONAS AERUGINOSA

GRAM STAIN RESULT: \*  
FEW WHITE BLOOD CELLS  
NO ORGANISMS SEEN

Organism : STAPHYLOCOCCUS AUREUS-MRSA  
GROWTH: HEAVY  
REPORTABLE: MRSA-PATIENT ISOLATION IS REQUIRED  
CALLED TO/READ BACK BY: PREVIOUS CALLED CRITICAL REPORT

Organism : PSEUDOMONAS AERUGINOSA  
GROWTH: RARE

NOTES: (\*a) FITZ LAB  
Test performed at:  
Mercy Fitzgerald Hospital                      1500 Lansdowne Ave                      Darby PA

NAME: BENTON, ALONZO

UNIT: M000301370

ACCT: PA1304917733

PRINTED: 10/18/17 0010

PAGE: 1 \*\* CONTINUED ON NEXT PAGE \*\*

MERCY HEALTH SYSTEM  
MERCY PHILADELPHIA LABORATORY  
501 SOUTH 54th STREET  
PHILADELPHIA PA, 19143  
SAMIA HENIEN, M.D. MEDICAL DIRECTOR

LABORATORY REPORT

NAME: BENTON, ALONZO      DOS: 10/12/17      LOC: PHSPU  
AGE/SEX: 58/M      DOB: 11/12/1958      ACCT: PA1304917733      MR: M000301370  
ATTEND DR: MELLER, MENACHEM M, MD

KEY H - Abn High      \*H - Critical High      \* - High or Low (Alpha results)      # - Delta Check  
L - Abn Low      \*L - Critical Low      \* - Microbiology Abn Result

Source Category: WOUND (continued)

Collection Date: 10/12/17 (continued)

**SURGICAL CULTURE**

(continued)

|               | MRSA   |    | PSE AERUGI |    |
|---------------|--------|----|------------|----|
|               | M.I.C. | RX | M.I.C.     | RX |
| TRIMET/SULFA  | <=10   | S  |            |    |
| CEFEPIME      |        |    | 2          | S  |
| CIPROFLOXACIN |        |    | <=0.25     | S  |
| CLINDAMYCIN   | 0.25   | S  |            |    |
| ERYTHROMYCIN  | <=0.25 | S  |            |    |
| GENTAMICIN    | <=0.5  | S  | <=1        | S  |
| LEVOFLOXACIN  | <=0.12 | S  |            |    |
| LINEZOLID     | 2      | S  |            |    |
| MEROPENEM     |        |    | <=0.25     | S  |
| OXACILLIN     | >=4    | R  |            |    |
| TETRACYCLINE  | <=1    | S  |            |    |
| TOBRAMYCIN    |        |    | <=1        | S  |
| VANCOMYCIN    | 1      | S  |            |    |
| AMIKACIN      |        |    | <=2        | S  |
| PIP/TAZO      |        |    | 8          | S  |

STAPHYLOCOCCUS AUREUS-MRSA: AST-GP75

This organism has been identified as Methicillin Resistant  
Staph aureus, MRSA.

**1. MRSA**

|              | M.I.C. | RX |
|--------------|--------|----|
| TRIMET/SULFA | <=10   | S  |
| CLINDAMYCIN  | 0.25   | S  |
| ERYTHROMYCIN | <=0.25 | S  |
| GENTAMICIN   | <=0.5  | S  |
| LEVOFLOXACIN | <=0.12 | S  |
| LINEZOLID    | 2      | S  |
| OXACILLIN    | >=4    | R  |
| TETRACYCLINE | <=1    | S  |
| VANCOMYCIN   | 1      | S  |

NAME: BENTON, ALONZO

UNIT: M000301370

ACCT: PA1304917733

PRINTED: 10/18/17 0010

PAGE: 2 \*\* CONTINUED ON NEXT PAGE \*\*

MERCY HEALTH SYSTEM  
MERCY PHILADELPHIA LABORATORY  
501 SOUTH 54th STREET  
PHILADELPHIA PA, 19143  
SAMIA HENIEN, M.D. MEDICAL DIRECTOR

LABORATORY REPORT

NAME: BENTON, ALONZO                      DOS: 10/12/17                      LOC: PHSPU  
AGE/SEX: 58/M                      DOB: 11/12/1958                      ACCT: PA1304917733                      MR: M000301370  
ATTEND DR: MELLER, MENACHEM M, MD

KEY H - Abn High                      \*H - Critical High                      \* - High or Low(Alpha results)                      # - Delta Check  
L - Abn Low                      \*L - Critical Low                      \* - Microbiology Abn Result

Source Category: WOUND (continued)

Collection Date: 10/12/17 (continued)

**SURGICAL CULTURE**

(continued)

This organism has been identified as Methicillin Resistant  
Staph aureus, MRSA.

2 PSE AERUGI

|               | M.I.C. | RX |
|---------------|--------|----|
| CEFEPIME      | 2      | S  |
| CIPROFLOXACIN | <=0.25 | S  |
| GENTAMICIN    | <=1    | S  |
| MEROPENEM     | <=0.25 | S  |
| TOBRAMYCIN    | <=1    | S  |
| AMIKACIN      | <=2    | S  |
| PIP/TAZO      | 8      | S  |

NAME: BENTON, ALONZO  
PRINTED: 10/18/17 0010

UNIT: M000301370  
ACCT: PA1304917733  
PAGE: 3 \*\* CONTINUED ON NEXT PAGE \*\*

MERCY HEALTH SYSTEM  
MERCY PHILADELPHIA LABORATORY  
501 SOUTH 54th STREET  
PHILADELPHIA PA,19143  
SAMIA HENIEN, M.D. MEDICAL DIRECTOR

LABORATORY REPORT

NAME: BENTON, ALONZO                      DOS: 10/12/17                      LOC: PHSPU  
AGE/SEX: 58/M                      DOB: 11/12/1958                      ACCT: PA1304917733                      MR: M000301370  
ATTEND DR: MELLER, MENACHEM M, MD

KEY H - Abn High                      \*H - Critical High                      \* - High or Low(Alpha results)                      # - Delta Check  
L - Abn Low                      \*L - Critical Low                      \* - Microbiology Abn Result

MERCY PHILADELPHIA CANCELED SPECIMEN LIST

PH1013:R00005R CAN, Coll: 10/13/17-0809 Recd: - (R01565461) MELLER, MENACHEM M, MD  
Ordered: PATHROUTN  
Comment: Auto-cancelled after 3 days.  
PH1013:R00006R CAN, Coll: 10/13/17-0810 Recd: - (R01565462) MELLER, MENACHEM M, MD  
Ordered: PATHLGROSS  
Comment: Auto-cancelled after 3 days.

NAME: BENTON, ALONZO

UNIT: M000301370

ACCT: PA1304917733

PRINTED: 10/18/17 0010

PAGE: 4 \*\* END OF REPORT \*\*

**Mercy Health Laboratory**  
Department of Pathology

Mercy Fitzgerald Hospital  
1500 Lansdowne Avenue  
Darby, PA 19023

Tel: (610) 237-4185 Fax: (610) 237-5688  
CLIA ID#: 39DO195649

MHL Staff Pathologists:  
Nabil Al-Annouf, MD, Chairman  
Samia R. Henien, MD  
Panda P. Hennawy, MD  
Joseph Jaworski, MD

**Patient Name:** BENTON, ALONZO

**Medical Record:** M000301370

**Account:** PA1304917733

**Admission Date:**

**Admitting Physician:** MELLER, MENACHEM M MD

**Date of Birth:** 11/12/1958

**Location:** PHSPU

**Room/Bed:**

**Gender:** M

**\*\*\* Signed Status \*\*\***

**SURGICAL PATHOLOGY REPORT**

CASE # S17-6273

Physician(s): MENACHEM M. MELLER, MD

Aba Barden, MD

Surgery date: 10/12/2017

Received: 10/13/2017

Reported: 10/16/2017 14:00

SPECIMEN(S) RECEIVED

A: Hardware left shoulder

B: Infected granulation tissue left shoulder

**FINAL PATHOLOGIC DIAGNOSIS**

A. Left Shoulder, Hardware, Removal:

- Metal plate and screws consistent with hardware pieces. Gross only.

Please see gross

description below.

B. Left Shoulder, Infected Granulation Tissue, Debridement:

- Fragments of skin and subcutaneous tissue with acute and chronic inflammation with

multinucleated giant cell reaction, focal necrosis, reactive fibrosis, and granulation tissue formation.

**Mercy Health Laboratory**  
Department of Pathology

**Patient Name:** BENTON,ALONZO  
**Medical Record:** M000301370  
**Account:** PA1304917733  
**Date of Birth:** 11/12/1958  
**Location:** PHSPU  
**Gender:** M

Pertinent history is important for optimal interpretation of tissue samples.  
The Gross Description and all Microscopic Slides have been reviewed and  
interpreted by the undersigned pathologist:

\*\*\*Electronically Signed Out By Randa P. Hennawy MD\*\*\*

at Mercy Philadelphia Hospital 54th and Cedar Avenues Philadelphia, PA 19143

Entered by:rph10/16/2017

**Clinical Diagnosis:**

Hardware loosening left shoulder.

Procedure: Removal hardware left shoulder

**Gross Description:**

A. The specimen is received without fixative in a container labeled with the patient's name, medical record number, and designated as Hardware Left Shoulder.

It consists of blood tinged silver hardware consisting of a curved metal plate with multiple holes inscribed with the numbers 0212013 and measuring 9.3 x 1.6 x

0.3 cm in overall dimension. Additionally there are 10 screws that range from 1.4 x 0.3 cm to 2.1 x 0.4 cm. There is no attached soft tissue. The specimen is a gross only.

B. The specimen is received in formalin in a container labeled with the patient's name, medical record number, and designated as Infected Granulation Tissue Left Shoulder. It consists of a 5 x 4 x 0.6 cm aggregate of gray tan-brown soft to cutaneous tissue fragments admixed with blood clot. The specimen is serially sectioned, and a representative portion is submitted in cassette B1. Her neck about

Entered by: Lisa Misner, PA (ASCP)

Gross Pathologist:Lisa Misner, PA (ASCP)

<Electronically signed by RANDA P HENNAWY MD in OV>

---

**Mercy Health Laboratory**  
Department of Pathology

**Patient Name:** BENTON,ALONZO

**Medical Record:** M000301370

**Account:** PA1304917733

**Date of Birth:** 11/12/1958

**Location:** PHSPU

**Gender:** M

HENNAWY,RANDA P MD  
10/16/17 1400

**DD:** 10/12/17 0846

**DT:** CI  
**Job:** 1016-0008

**Mercy Philadelphia Hospital**  
**Mercy Health System**  
**Department of Radiology**  
5301 Cedar Avenue  
Philadelphia, PA 19143  
215-748-9432

David P Mayer, MD, MS, FACR, Chairman  
Oleg Teytelboym, MD, Radiology Director  
Aparna Babu, MD  
Gerard Berry, MD  
Robert Borden, MD

Michael Brooks, MD, JD  
Fraser Brown, MD  
Brian Clark, MD  
Malgorzata Gorelczyk, MD  
Lulu He, DO  
Laryssa Hud, MD  
Caroline Ling, MD  
Justin Mackey, MD  
Timothy Nielsen, MD  
Scott Rotenberg, MD

Patient: **BENTON, ALONZO** Acct #: PA1304917733 Exam Date: 10/12/17  
Med Rec #: **M000301370** Order #: 1012-0074 Status: REG SDC  
Date of Birth: 11/12/1958 Gender: M Accession #: 852655.001 Location:  
Phone #: (215)403-5705 Report #: 1013-0011 RAD #:  
Ordering Physician: **MELLER, MENACHEM M, MD**  
CC: BARDEN, ABA, MD; MELLER, MENACHEM M, MD ~  
Order Date: 10/12/17  
Procedure Reason: post op in PACU

**Exam: CR Shoulder LT Min 2 View**

**\*\*\* Signed Status \*\*\***

**IMPRESSION:**

Interval removal of distal clavicle plate and screws.

Osteopenia and resorption of distal clavicular fragments without significant callus formation. Findings may be due to early healing, postsurgical change. Infection cannot be excluded.

INDICATION: 58 years old; Male. Symptom/Location/Duration: Postoperative exam.

TECHNIQUE: 2 AP portable radiographs of the left shoulder Comparison: None.

**FINDINGS:**

Interval removal of clavicular plate and screws since 9/20/2017. Persistent visualization of distal clavicle comminuted fracture with osteopenia/resorption of the distal fragments with indistinct cortices. AC joint space and alignment within normal limits. Small volume postsurgical subcutaneous gas overlying dressing.

Glenohumeral joint within normal limits. Visualized left lung is clear.

**Thank you for choosing Mercy Health System**

**<Electronically signed by LULU HE, DO in OV>**

e-Sign Pager: 610-221-4559

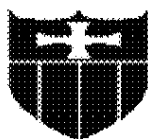
Interpreting: HE, LULU DO

Dictated: 10/13/17 0837

Signoff: 10/13/17 0843

**PATIENT IMAGES or REPORTS: (215) 748-9432**

**SCHEDULING: (610) 237-2525**



Mercy Philadelphia Hospital

Operating Room Case Record Report

BENTON, ALONZO

MR#: M000301370

Acct #: PA1304917733

DOB: 11/12/1958

DOS: 10/12/2017

58 / M

Surgeons and Procedures

Physician 1 MELLER, MENACHEM, MD Removal Hardware Lt. Clavicle

Preop Assess Holding

Time in Holding: 15:54

Admitted From: Scheduled Visit

Patient Identified: Y

Type and Screen: N/A

Verifies operative procedure: Y

Type and Cross: N/A

Verifies allergies: Y

Blood Permt: N/A

Chart reviewed and complete for relevant documents: Y

CXR: N/A

Operative Consent Complete and signed: Y

EKG: Y

Anesthesia consent complete and signed: Y

H and P: Y

Blood Work: Y

DVT Protocol: N/A

Site Marking by Attending Physician

|          |            |       |                                                   |
|----------|------------|-------|---------------------------------------------------|
| Site     | Laterality | Level | Procedure(s) as stated by patient/family/guardian |
| Clavicle | Left       |       | TAKE THIS PLATE OUT                               |

Family in Waiting Room: Y

Verified correct diagnostic and radiology test results are available and properly labeled: Y

Verified blood products equipment implants or special equipment are available labeled and matched to patients identifiers as appropriate: Y

Room Ready: N

RN: GIAMPIETRO, BARBARA

Significant PMH / PSH: HTN, GERD, HEP C

|                    |                   |
|--------------------|-------------------|
| Mobility           | Assistive Devices |
| Partial Assistance | Stretcher         |

|                        |       |               |       |                |       |
|------------------------|-------|---------------|-------|----------------|-------|
| Level of Consciousness | Other | Psychological | Other | Communication  | Other |
| Alert                  |       | Anxious       |       | No limitations |       |

|                 |       |                  |       |
|-----------------|-------|------------------|-------|
| Skin Appearance | Other | Musculo-skeleton | Other |
| Dry             |       | ROM limitations  |       |

Case Start / Personnel

|                        |                                     |                        |           |
|------------------------|-------------------------------------|------------------------|-----------|
| Patient in Room: 16:43 | Anesthesia Start: 16:43             | ASA Classification: II | Add On: N |
| Proc Start Time: 17:15 | Anesthesia Type: General Anesthesia |                        |           |

PreOp Diagnosis: HARDWARE LOOSENING LEFT SHOULDER

| Staff Role       | Staff Name              | Time In | Time Out | Time In | Time Out |
|------------------|-------------------------|---------|----------|---------|----------|
| Circulator       | BROXTON, DWAYNE, RN     | 16:43   | 17:02    |         |          |
| Scrub Technician | COWEN, KIMBERLY         | 16:43   | 17:44    |         |          |
| Circulator       | GIAMPIETRO, BARBARA, RN | 17:00   | 17:44    |         |          |

| Anesthesia Staff       | Name       | Role   |
|------------------------|------------|--------|
| GASKELL, MICHAEL, CRNA | A. RIESTER | ANESTH |

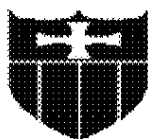
Prep / Positioning

| Position | Device               | Device    | Device | Device | Extremity             | Extremity Position |
|----------|----------------------|-----------|--------|--------|-----------------------|--------------------|
| Supine   | Foam Head Positioner | Heel Pads |        |        | Left upper extremity  | Armboard           |
|          |                      |           |        |        | Right upper extremity | Armboard           |

Positioned By: MELLER, MENACHEM, MD  
GASKELL, MICHAEL, CRNA  
BROXTON, DWAYNE, RN

Pad Bony Prominences: Y Safety belt applied and secured: Y

Skin Prep: Y Skin Prep: Betadine Paint (no pooling present)



# Mercy Philadelphia Hospital

## Operating Room Case Record Report

BENTON, ALONZO

MR#: M000301370

Acct #: PA1304917733

DOB: 11/12/1958

DOS: 10/12/2017

58 / M

Hair Removed in OR with Clipper: N

Hair removal 48hrs prior to surgery: N/A

DURAPREP OR ALCOHOL BASED SOLUTIONS: N/A

### ESU / Tourniquet / Counts

ELECTROSURGICAL UNIT Y

|       |                 |      |         |     |      |
|-------|-----------------|------|---------|-----|------|
| ESU # | Ground Pad Site | Side | Bipolar | Cut | Coag |
|       | Megadyne        |      |         | 0   | 40   |

TOURNIQUET: N/A

|          |               |                         |                 |
|----------|---------------|-------------------------|-----------------|
| COUNT: Y | Count         | Count Staff 1           | Count Staff 2   |
|          | In Count      | GIAMPIETRO, BARBARA, RN | COWEN, KIMBERLY |
|          | Closing Count | GIAMPIETRO, BARBARA, RN | COWEN, KIMBERLY |
|          | Final Count   | GIAMPIETRO, BARBARA, RN | COWEN, KIMBERLY |

Surgeon Notified of Counts: Y

Name of practitioner confirming count:

### Fire Risk/Patient Safety

Surgical site above Xiphoid? Yes = 1

Open oxygen source? No = 0

Available ignition source? Yes = 1

Fire Risk Scoring: TWO

#### Moderate/High Fire Risk Protocol:

Includes all routine protocols: Y

Use draping tech to minimize O2 concentration: Y

Minimize electrical surgical unit settings: Y

Encourage use of wet sponges: Y

Basin of sterile saline or H2O: Y

Anesthesia documents O2 concentration flow: Y

#### Surgical Safety Checklist:

How long will the case take? 30 M

What is the anticipated blood loss? MIN

Key concerns for patient recovery/management? PAIN, BLEEDING

### Final Verification

Patient in Room: 16:43 TIME OUT FOR PROCEDURE VERIFICATION: 17:14 Nurse: GIAMPIETRO, BARBARA

- |     |                                                                                          |
|-----|------------------------------------------------------------------------------------------|
| Y   | A. Attending Proceduralist verified correct patient                                      |
| Y   | B. Procedure consent is accurate and signed                                              |
| Y   | C. Safety Precautions - Allergies read aloud                                             |
| Y   | Acknowledgement of implant existing devices                                              |
| Y   | Sterility verified - no specific concerns                                                |
| Y   | D. Correct patient positioning                                                           |
| Y   | E. Site marking confirmed/correct and visible after patient is draped                    |
| Y   | F. Special Equipment                                                                     |
| N/A | G. Radiographic images properly labeled and displayed as appropriate                     |
| N/A | H. Implants available/fluids for irrigation available if appropriate                     |
| Y   | I. Antibiotics administered prior to incision per anesthesia                             |
| Y   | J. SCD present as ordered                                                                |
| Y   | K. Verified all relevant documents are available and matched to the patients identifiers |

Final Site Verification Completed? Y

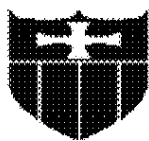
Does anyone have any questions or concerns with the procedure or anesthesia? N

Does anyone have any questions or concerns before proceeding? Is Everyone in agreement? Y

### Specimens / Caths / Drains

Catheter Indwelling on Arrival: N/A

Urinary Catheter: N/A



|                                                                                                                     |   |                                                     |         |                            |                         |
|---------------------------------------------------------------------------------------------------------------------|---|-----------------------------------------------------|---------|----------------------------|-------------------------|
| Specimen:                                                                                                           | Y | Specimen                                            | Type    | Fixative                   | Comments                |
|                                                                                                                     |   | LEFT SHOULDER                                       | Culture |                            |                         |
|                                                                                                                     |   | INFECTED GRANULATION                                | Routine | Formalin                   |                         |
|                                                                                                                     |   | TISSUE LEFT SHOULDER                                |         |                            |                         |
|                                                                                                                     |   | HARDWARE LEFT SHOULDER                              | Gross   |                            |                         |
| All Specimens Read Back and Verified: Y                                                                             |   |                                                     |         |                            |                         |
| Drains/Tubes: N/A                                                                                                   |   |                                                     |         |                            |                         |
| Packing: N/A                                                                                                        |   |                                                     |         |                            |                         |
| Dressings/Casts: Y                                                                                                  |   |                                                     |         |                            |                         |
| Type                                                                                                                |   |                                                     |         |                            |                         |
| 4x4                                                                                                                 |   |                                                     |         |                            |                         |
| ABD                                                                                                                 |   |                                                     |         |                            |                         |
| Adaptic                                                                                                             |   |                                                     |         |                            |                         |
| Tape                                                                                                                |   |                                                     |         |                            |                         |
| Laser                                                                                                               |   |                                                     |         |                            |                         |
| Laser Used: N/A                                                                                                     |   |                                                     |         |                            |                         |
| Implant Information                                                                                                 |   |                                                     |         |                            |                         |
| IntraOp Summary                                                                                                     |   |                                                     |         |                            |                         |
| Patient in Room: 16:43                                                                                              |   | Proc Start Time: 17:15                              |         | Anesthesia End: 17:44      |                         |
| Anesthesia Start: 16:43                                                                                             |   | Proc End Time: 17:36                                |         | Patient Out of Room: 17:44 |                         |
| Anesthesia Type: General Anesthesia                                                                                 |   | Wound Class: IV- Infected                           |         |                            |                         |
| Transferred To: PACU                                                                                                |   |                                                     |         |                            |                         |
| Urinary Catheter: N/A                                                                                               |   | Drains / Tubes: N/A                                 |         | Packing: N/A               |                         |
| Dressings/Casts: Y                                                                                                  |   | Implant: N/A                                        |         |                            |                         |
| Post OP Diagnosis: HARDWARE LOOSENING LEFT SHOULDER                                                                 |   |                                                     |         |                            |                         |
| Actual Procedure Performed: REMOVAL OF HARDWARE LEFT SHOULDER                                                       |   |                                                     |         |                            |                         |
| Complications: N Type:                                                                                              |   |                                                     |         |                            |                         |
| Evaluates postoperative tissue perfusion: Y                                                                         |   | Evaluates for signs of injury due to positioning: Y |         |                            |                         |
| Evaluates for signs/symptoms of electrical injury: Y                                                                |   | Evaluates for signs of injury to skin/tissue: Y     |         |                            |                         |
| Evaluates for signs/symptoms of chemical injury: Y                                                                  |   |                                                     |         |                            |                         |
| PNDS Outcomes                                                                                                       |   |                                                     |         |                            |                         |
| Outcome                                                                                                             |   |                                                     |         | Status                     | Staff                   |
| The patient has wound/tissue perfusion consistent with or improved from baseline levels established preoperatively. |   |                                                     |         | MET                        | GIAMPIETRO, BARBARA, RN |
| The patient is free from signs and symptoms of injury caused by extraneous objects.                                 |   |                                                     |         | MET                        | GIAMPIETRO, BARBARA, RN |
| The patient is free from signs and symptoms of chemical injury.                                                     |   |                                                     |         | MET                        | GIAMPIETRO, BARBARA, RN |
| The patient is free from signs and symptoms of electrical injury.                                                   |   |                                                     |         | MET                        | GIAMPIETRO, BARBARA, RN |
| The patient is free from signs and symptoms of injury related to positioning.                                       |   |                                                     |         | MET                        | GIAMPIETRO, BARBARA, RN |



# OR Efficiency

On Time Start ☐ Yes ☐ No ☒ N/A  
Reason for Delay ☐ Patient ☐ Facility ☐ Surgeon ☐ Anesthesia  
To Follow Same Room/Same Surgeon ☒ Yes ☐ No  
Pre Operative Assessment performed prior to date of procedure ☐ Yes ☒ No

## Glucose Control

Glucose levels monitored during the case? ☐ Yes ☐ No ☒ Not Applicable  
Post Operative Glucose less than 200 arrival in PACU/ICU ☐ Yes ☐ No

## Central Line Placement

☒ N/A ☐ Central Venous ☐ Pulmonary Artery  
Procedure Start Time: \_\_\_\_\_ Time Out at: \_\_\_\_\_ Marked by: \_\_\_\_\_  
Insertion site: ☐ RIJ ☐ LIJ ☐ RSC ☐ LSC ☐ RFem ☐ LFem  
Provider: \_\_\_\_\_ Assistant: ☐ None

Performed Universal Protocol (Time Out)? ☐ Yes ☐ No

All persons in procedure cleanse hands? ☐ Yes ☐ No

Prep Procedure: site with 2% Chlorhexidine? ☐ Yes ☐ No

Used large drape cover? ☐ Yes ☐ No

All personnel wore sterile gloves, hat, mask and sterile gown? ☐ Yes ☐ No

Maintain sterile field throughout procedure? ☐ Yes ☐ No

Regional Technique Time out at ☐ ☐ ☐ Marked by: \_\_\_\_\_

☐ Postop block requested by surgeon for pain management

☐ Placed by CRNA (complete discontinuous timings)

Drug \_\_\_\_\_ Dose \_\_\_\_\_ ☐ Epidural test dose neg

Level \_\_\_\_\_ Y/N Paresth \_\_\_\_\_

Needle \_\_\_\_\_ Y/N CSF \_\_\_\_\_

Y/N Heme \_\_\_\_\_

Epi \_\_\_\_\_

Cath \_\_\_\_\_

Attempts \_\_\_\_\_

Beta Blockers Patient on Beta-Blocker prior to admission? ☐ Yes ☒ No

If Yes, ☐ a) Beta-Blocker given either the day prior or the day of Surgery (date and time) \_\_\_\_\_

or ☐ b) Patient will be given Beta-Blocker

Intraoperatively (Drug/Dose): \_\_\_\_\_

or ☐ c) Beta-Blocker Contraindicated (Document reason): \_\_\_\_\_

☐ HR less than 50

Allergies (Drug/environmental/food) RX: \_\_\_\_\_

## POST ANESTHESIA CARE VITALS/NOTE

Response to Anesthesia ☐ No Apparent complications Other: \_\_\_\_\_

CV: ☒ Stable \_\_\_\_\_ RESP: ☒ Stable \_\_\_\_\_

LOC ☐ Responsive \_\_\_\_\_ Other: \_\_\_\_\_

☐ Meets criteria to bypass Phase 1 Recovery

Report given and responsibility for monitoring post transport to PACU: ☒ ICU: ☐ Other: \_\_\_\_\_

Signature/Title \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

BP 170/110

HR 80

RR 20

SpO<sub>2</sub> 97

TEMP 97.2

Final Vital Signs:

## POST ANESTHESIA ASSESSMENT

BP: 170/100 HR: 83 RR: 17 SpO<sub>2</sub>: 100 Temp: 97 VAS: \_\_\_\_\_

Alert/Patient Participation ☐ Yes ☐ No

Airway Patent ☐ Yes ☐ No

Hydration Adequate ☐ Yes ☐ No

Pain Control Adequate ☐ Yes ☐ No

PONV Present ☐ Yes ☒ No

Anesthesia Complications ☐ Yes ☒ No

Normothermia

Patient Temperature on arrival to PACU/ICU greater than (or equal to) 36°C/96.8°F

☐ Yes ☐ No ☐ N/A

Warming measures used:

☐ Forced Air Warmer

☐ Warm Water Garment

☐ Resistive Heating Blanket

PACU DISCHARGE TIME ☐ ☐ ☐

Signature/Title \_\_\_\_\_

10/3/17

10/12/17

1915

☐ Full report of pre-assessment, intraop plan and current status, received from \_\_\_\_\_  
Narcotics reconciled and care assumed at: \_\_\_\_\_

Initials \_\_\_\_\_

## RELIEF PROTOCOL

| IN | OUT | NAME      | IN | OUT | NAME |
|----|-----|-----------|----|-----|------|
|    |     | physician |    |     | cma  |
|    |     | physician |    |     | cma  |

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Anesthesia Record



Page 2 of 4  
Form #NSA-AR, Rev. 07/2017  
SURX-ANESTH

DOB: \_\_\_\_\_  
Adm: BENTON, ALONZO  
Acc: DOB: 11/12/1958 58 M  
ADM: 10/12/17  
ACC: PA1304917733 MR: M000301370



Continuation # 2 3 4 5[illegible]

| Physician Signature | Date | Time | Provider ID |
|---------------------|------|------|-------------|
|---------------------|------|------|-------------|

|                |      |      |             |
|----------------|------|------|-------------|
| CRNA Signature | Date | Time | Provider ID |
|----------------|------|------|-------------|

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### Anesthesia Record



Page 3 of 4  
Form #NSA-AR, Rev. 07/2017  
SURXANESTH

DOB - BENTON, ALONZO  
Adm DOB: 11/12/1958 58 M  
Acc ADM: 10/12/17  
ACC: PA1304917733 MR: M000301370



# Anesthesiology

PACU Anesthesiologist Order Sheet  
PACU Discharge Order  
Post-Anesthesia Evaluation Note

Allergies

IV contrast

- ☐ Admit to PACU, Monitoring as per protocol
- ☐ IV Fluid: Continue intraop fluids at 100ml/hr (40ml/hr for pediatric patients), follow with post-op fluid orders on PACU discharge
- ☐ Administer oxygen via nasal cannula or face mask to keep SaO<sub>2</sub> above 92%, continue on floor if SaO<sub>2</sub> greater than 92%
- ☐ Accucheck for insulin dependent patients, call anesthesiologist with results if less than 70 or greater than 200

Pain Management  
(choose only 1 PRN narcotic at a time)

\_\_\_\_\_ Fentanyl 25 mcg IV every 3 minutes for \_\_\_\_\_ doses PRN pain  
\_\_\_\_\_ Morphine 2 mg IV every 5 minutes for \_\_\_\_\_ doses PRN pain  
☒ Hydromorphone 0.5 mg IV every 5 minutes for 4 doses PRN pain  
\_\_\_\_\_ Ketorolac 30 mg IV x 1 dose (if not given in OR)  
\_\_\_\_\_ Percocet 5/325 mg 1 tab PO PRN mild pain (pain scale 1-5)  
\_\_\_\_\_ Percocet 5/325 mg 2 tabs PO PRN moderate pain (pain scale 6-10)

Sedation

\_\_\_\_\_ Midazolam \_\_\_\_\_ mg IV every 5 minutes for \_\_\_\_\_ doses PRN sedation

Antiemetic Therapy  
(choose only 1 PRN med for postop nausea/vomiting)

\_\_\_\_\_ Metoclopramide 10 mg slow IV push x 1 dose PRN nausea/vomiting  
\_\_\_\_\_ Droperidol 0.625 mg IV x 1 dose PRN nausea/vomiting  
\_\_\_\_\_ Dexamethasone 4 mg IV x 1 dose PRN nausea/vomiting  
☒ Ondansetron 4 mg IV x 1 dose PRN nausea/vomiting  
\_\_\_\_\_ Promethazine 25 mg IM x 1 dose PRN nausea/vomiting

Hypertension  
(choose only 1 PRN at a time)

For SBP greater than \_\_\_\_\_ mm Hg or DBP greater than \_\_\_\_\_ mm Hg or HR greater than \_\_\_\_\_  
\_\_\_\_\_ Labetalol \_\_\_\_\_ mg IV every \_\_\_\_\_ minutes x \_\_\_\_\_ doses PRN  
\_\_\_\_\_ Hydralazine \_\_\_\_\_ mg IV every \_\_\_\_\_ minutes x \_\_\_\_\_ doses PRN  
\_\_\_\_\_ Metoprolol \_\_\_\_\_ mg IV every \_\_\_\_\_ minutes x \_\_\_\_\_ doses PRN

Additional Orders

☒ Meperidine 12.5 mg IV every 5 minutes for 2 doses PRN shivering

Anesthesiologist

Date/Time 10/12/17 1750

PACU Nurse

[Signature] 10/12/17 1800

PACU Discharge Order

Patient reassessed and PACU record reviewed. Vital signs satisfactory. Patient meets discharge criteria and is stable for discharge from PACU.

Anesthesiologist

Date/Time 10/12/17 1750

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Anesthesiology Post Anesthesia Sheet



Page 1 of 1  
Form NS657, Rev. 5/2017  
ORDXORDERS

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 10/12/17  
ACC: PA1304917733 MR: M000301370



BENTON, ALONZO

ID:M000301370

15-SEP-2017 12:21:49

Poor Quality Original  
MERCY PHILADELPHIA HOSPITAL

12-NOV-1958 (58 yr)  
Male Black

|              |         |     |
|--------------|---------|-----|
| Vent. rate   | 75      | BPM |
| PR interval  | 166     | ms  |
| QRS duration | 92      | ms  |
| QT/QTc       | 398/444 | ms  |
| P-R-T axes   | 73 -18  | 41  |

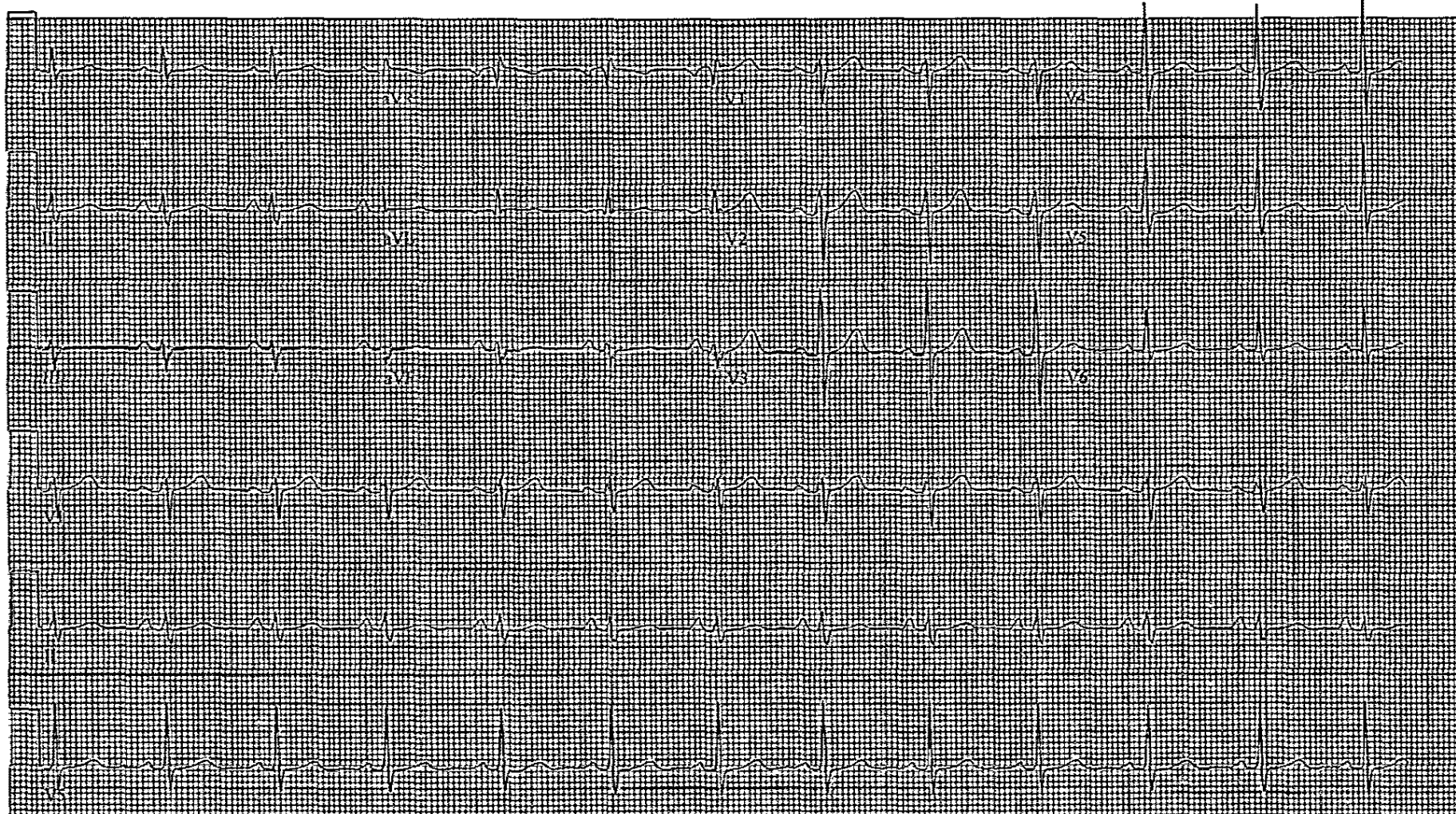
Room: Loc:3

Normal sinus rhythm  
Normal ECG  
When compared with ECG of 21-OCT-2015 00:13,  
Nonspecific T wave abnormality no longer evident in Anterolateral leads  
Confirmed by DEVAUGHN M.D., GERALD (1106) on 9/15/2017 3:56:50 PM

Technician: SAD  
Test ind:PREOP

Referred by: MENACHEM MELLER

Confirmed By: GERALD DEVAUGHN M.D.



25mm/s 10mm/mV 40Hz 8.0 SP2 12SL 237 CID: 11

EID:1106 EDT: 15:56 15-SEP-2017 ORDER:841381.001PHL ACCOUNT: PA1304861964

Page 1 of 1

DATE: 10/13/17 @ 0020  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 1

|                |                |                    |                          |
|----------------|----------------|--------------------|--------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD   |
| Account Number | PA1304917733   | Location           | PHSPU                    |
| Unit Number    | M000301370     |                    |                          |
| Age/Sex        | 58/M           | Room               | Registered Date 10/12/17 |
| Status         | REG SDC        | Bed                | Discharged Date          |

\*\*\*\*\*  
\* HEIGHT and WEIGHT are missing...PLEASE UPDATE!!! \*  
\*\*\*\*\*

Hem-Onc No

Drug Allergies iodine

ADRS

#### Creatinine Test Results

##### LABORATORY

| Date     | Time Test | Result | Flag | Normal Range  |
|----------|-----------|--------|------|---------------|
| 10/22/15 | 1259 CREA | 0.9    |      | 0.8-1.4 mg/dL |

GENT40VI - GENTAMICIN SULFATE 80 MG/2 ML INJECTION (GARAMYCIN) - 100 MG (2.5 ML)  
in SODI100I12 - Sodium Chloride 0.9% 100 ML IV SOLN - 100 ML

Admin Route IV

Site

Volume 102.5 Rate 100 MLS/HR

Duration 1 HR 2 MIN

Start Date 10/12/17-1731 Stop Date 10/12/17 1832 DC Date 10/12/17-1832

Ordering Doctor RIESTER, ANDREW J MD

Clinical Indication SURGICAL PROPHYLAXIS

Last Bag 1

Total Dispensed 1 Total Costs \$3.23

Total Charges \$75.00

Rx Number 002129735

#### Warnings

Type: SINGLE DOSE

Range: GENTAMICIN SULFATE (80 MG/2 ML)

Condition: ALL COMMON INDICATIONS

Warnings GENT40VI: Unable to check dose ranges for MG/KG/DAY (No Weight).

Discontinue Comments Reached Stop Date

#### History

10/12/17 1733 - POM ORDER

by COREISTA

10/12/17 1747 - EDIT

by PHPATEAS

FROM:

RX COMMENTS:

Order filed UNV:

Dose Warnings differ from order entry

TO:

RX COMMENTS:

10/12/17 1747 - VERIFIED

by PHPATEAS

Items Dispensed: 1 Doses Dispensed: 1

For: 10/12/17 - 1731

DATE: 10/13/17 @ 0020  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 2

|                |                |                    |                          |
|----------------|----------------|--------------------|--------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD   |
| Account Number | PA1304917733   | Location           | PHSPU                    |
| Age/Sex        | 58/M           | Room               | Unit Number M000301370   |
| Status         | REG SDC        | Bed                | Registered Date 10/12/17 |
|                |                |                    | Discharged Date          |

BENTON, ALONZO PA1304917733 (Continued)

10/12/17 1832 - DISCONTINUE by PHABKGJOB Eff: 10/12/17 1832  
FROM:  
DC COMMENTS:  
TO:  
DC COMMENTS:  
Reached Stop Date

MIDA1VIA13 - MIDAZOLAM HCL 2 MG/2 ML INJECTION (VERSED)

Dose 2 MG (2 ML)  
Admin Route .ROUTE  
Start Date 10/12/17-1410 Stop Date 10/12/17 1411 DC Date 10/12/17-1411  
Ordering Doctor DOCTOR, PYXIS OVERRIDE  
Total Dispensed 1 Total Costs \$0.29 Total Charges \$2.50  
Rx Number 002129594

Discontinue Comments DC'd by MGASKELL

History

10/12/17 1409 - PHL DM PHA by MGASKELL  
10/12/17 1409 - DISCONTINUE by STK MED Eff: 10/12/17 1411  
FROM:  
DC COMMENTS:  
TO:  
DC COMMENTS:  
DC'd by MGASKELL

FENT0.0533 - fentaNYL CITRATE/PF 100 MCG/2 ML (SUBLIMAZE)

Dose 100 MCG (2 ML)  
Admin Route .ROUTE  
Start Date 10/12/17-1410 Stop Date 10/12/17 1411 DC Date 10/12/17-1411  
Ordering Doctor DOCTOR, PYXIS OVERRIDE  
Total Dispensed 1 Total Costs \$0.27 Total Charges \$5.00  
Rx Number 002129595

Discontinue Comments DC'd by MGASKELL

History

10/12/17 1409 - DISCONTINUE by STK MED Eff: 10/12/17 1411  
FROM:  
DC COMMENTS:  
TO:  
DC COMMENTS:  
DC'd by MGASKELL  
10/12/17 1409 - PHL DM PHA by MGASKELL

DATE: 10/13/17 @ 0020  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 3

|                |                |                    |                          |
|----------------|----------------|--------------------|--------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD   |
| Account Number | PA1304917733   | Location           | PHSPU                    |
| Age/Sex        | 58/M           | Room               | Unit Number M000301370   |
| Status         | REG SDC        | Bed                | Registered Date 10/12/17 |
|                |                |                    | Discharged Date          |

BENTON, ALONZO

PA1304917733

(Continued)

PROP10VI7 - PROPOFOL 200 MG/20 ML INJECTION (DIPRIVAN)

Dose 200 MG (20 ML)  
Admin Route .ROUTE  
Start Date 10/12/17-1704 Stop Date 10/12/17 1705 DC Date 10/12/17-1705  
Ordering Doctor DOCTOR, PYXIS OVERRIDE  
Total Dispensed 1 Total Costs \$1.03 Total Charges \$8.50  
Rx Number 002129702

Discontinue Comments DC'd by MGASKELL

History

10/12/17 1703 - DISCONTINUE by STK MED Eff: 10/12/17 1705  
FROM:  
DC COMMENTS:  
TO:  
DC COMMENTS:  
DC'd by MGASKELL  
10/12/17 1703 - PHL DM PHA by MGASKELL

HYDR2DIS5 - HYDROMorphone HCL/PF 2MG/ML 2 MG/ML DISP.SYRIN (DILAUDID)

Dose 2 MG (1 ML)  
Admin Route .ROUTE  
Start Date 10/12/17-1707 Stop Date 10/12/17 1708 DC Date 10/12/17-1708  
Ordering Doctor DOCTOR, PYXIS OVERRIDE  
Total Dispensed 1 Total Costs \$1.15 Total Charges \$9.50  
Rx Number 002129711

Discontinue Comments DC'd by MGASKELL

History

10/12/17 1707 - DISCONTINUE by STK MED Eff: 10/12/17 1708  
FROM:  
DC COMMENTS:  
TO:  
DC COMMENTS:  
DC'd by MGASKELL  
10/12/17 1707 - PHL DM PHA by MGASKELL

DATE: 10/13/17 @ 0020  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 4

|                |                |                    |                        |
|----------------|----------------|--------------------|------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD |
| Account Number | PA1304917733   | Location           | PHSPU                  |
| Age/Sex        | 58/M           | Room               |                        |
| Status         | REG SDC        | Bed                |                        |
|                |                | Unit Number        | M000301370             |
|                |                | Registered Date    | 10/12/17               |
|                |                | Discharged Date    |                        |

BENTON, ALONZO

PA1304917733

(Continued)

ONDA2VIA2 - ONDANSETRON HCL/FF 4 MG/2 ML INJECTION (ZOFTRAN)

|                 |                        |               |               |
|-----------------|------------------------|---------------|---------------|
| Dose            | 4 MG (2 ML)            |               |               |
| Admin Route     | .ROUTE                 |               |               |
| Start Date      | 10/12/17-1724          | Stop Date     | 10/12/17 1725 |
| Ordering Doctor | DOCTOR, PYXIS OVERRIDE | DC Date       | 10/12/17-1725 |
| Total Dispensed | 1                      | Total Costs   | \$0.44        |
| Rx Number       | 002129716              | Total Charges | \$5.00        |

Discontinue Comments DC'd by MGASKELL

History

|                             |             |                    |
|-----------------------------|-------------|--------------------|
| 10/12/17 1723 - PHL DM PHA  | by MGASKELL |                    |
| 10/12/17 1723 - DISCONTINUE | by STK MED  | Eff: 10/12/17 1725 |
| FROM:                       |             |                    |
| DC COMMENTS:                |             |                    |
| TO:                         |             |                    |
| DC COMMENTS:                |             |                    |
| DC'd by MGASKELL            |             |                    |

KETO15VI4 - KETOROLAC TROMETHAMINE 15 MG/ML VIAL (TORADOL)

|                 |                        |               |               |
|-----------------|------------------------|---------------|---------------|
| Dose            | 30 MG (2 ML)           |               |               |
| Admin Route     | .ROUTE                 |               |               |
| Start Date      | 10/12/17-1726          | Stop Date     | 10/12/17 1727 |
| Ordering Doctor | DOCTOR, PYXIS OVERRIDE | DC Date       | 10/12/17-1727 |
| Total Dispensed | 2                      | Total Costs   | \$1.46        |
| Rx Number       | 002129717              | Total Charges | \$12.50       |

Discontinue Comments DC'd by MGASKELL

History

|                             |             |                    |
|-----------------------------|-------------|--------------------|
| 10/12/17 1725 - DISCONTINUE | by STK MED  | Eff: 10/12/17 1727 |
| FROM:                       |             |                    |
| DC COMMENTS:                |             |                    |
| TO:                         |             |                    |
| DC COMMENTS:                |             |                    |
| DC'd by MGASKELL            |             |                    |
| 10/12/17 1725 - PHL DM PHA  | by MGASKELL |                    |

DATE: 10/13/17 @ 0020  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 5

|                |                |                    |                          |
|----------------|----------------|--------------------|--------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD   |
| Account Number | PA1304917733   | Location           | PHSPU                    |
| Age/Sex        | 58/M           | Unit Number        | M000301370               |
| Status         | REG SDC        | Room               | Registered Date 10/12/17 |
|                |                | Bed                | Discharged Date          |

BENTON, ALONZO

PA1304917733

(Continued)

HYDR5DIS2 - HYDROmorphone HCL/Pf (DILAUDID) 0.5 MG/0.5 ML DISP.SYRIN

Dose 0.5 MG (0.5 ML)

Admin Route .ROUTE

Start Date 10/12/17-1811 Stop Date 10/12/17 1812 DC Date 10/12/17-1812

Ordering Doctor DOCTOR, PYXIS OVERRIDE

Total Dispensed 0 Total Costs \$0.00 Total Charges \$0.00

Rx Number 002129766

Discontinue Comments DC'd by GARRINGTON

History

10/12/17 1810 - DISCONTINUE by STK MED Eff: 10/12/17 1812

FROM:

DC COMMENTS:

TO:

DC COMMENTS:

DC'd by GARRINGTON

10/12/17 1810 - PHL DM PHA by GARRINGTON

10/12/17 1813 - CREDIT by GARRINGTON

ITEMS: 1 DOSES: 1

HYDR1DIS2 - HYDROmorphone HCL/PF (DILAUDID) 1MG/ML INJECTION

Dose 1 MG (1 ML)

Admin Route .ROUTE

Start Date 10/12/17-1826 Stop Date 10/12/17 1827 DC Date 10/12/17-1827

Ordering Doctor DOCTOR, PYXIS OVERRIDE

Total Dispensed 1 Total Costs \$1.11 Total Charges \$9.25

Rx Number 002129773

Discontinue Comments DC'd by GARRINGTON

History

10/12/17 1825 - DISCONTINUE by STK MED Eff: 10/12/17 1827

FROM:

DC COMMENTS:

TO:

DC COMMENTS:

DC'd by GARRINGTON

10/12/17 1825 - PHL DM PHA by GARRINGTON

DATE: 10/13/17 @ 0020  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 6

|                |                |                    |                        |
|----------------|----------------|--------------------|------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD |
| Account Number | PA1304917733   | Location           | PHSPU                  |
| Age/Sex        | 58/M           | Room               |                        |
| Status         | REG SDC        | Bed                |                        |
|                |                | Unit Number        | M000301370             |
|                |                | Registered Date    | 10/12/17               |
|                |                | Discharged Date    |                        |

BENTON, ALONZO

PA1304917733

(Continued)

OKYC1TAB53 - oxyCODONE/ACETAMINOPHEN 5-325 MG TABLET (PERCOCET)

Dose 2 TABLET (2 TABLETS)  
Admin Route PO  
Frequency Q3H (PRN) PAR= PRN REASON: PAIN - PAIN  
Start Date 10/12/17-1845 Stop Date 10/12/17 2100 DC Date 10/12/17-2100  
Ordering Doctor MELLER, MENACHEM M, MD  
Total Dispensed 2 Total Costs \$0.71 Total Charges \$6.80  
Rx Number 002129808

Discontinue Comments Reached Stop Date

History

|                             |                                 |
|-----------------------------|---------------------------------|
| 10/12/17 1840 - ENTER       | by PHPATEAS                     |
| 10/12/17 2040 - DEBIT       | by SBROWN                       |
| ITEMS: 2 DOSES: 1           |                                 |
| 10/12/17 2100 - DISCONTINUE | by PHABKGJOB Eff: 10/12/17 2100 |
| FROM:                       |                                 |
| DC COMMENTS:                |                                 |
| TO:                         |                                 |
| DC COMMENTS:                |                                 |
| Reached Stop Date           |                                 |

HYDR1DIS2 - HYDRomorphone HCL/PF (DILAUDID) 1MG/ML INJECTION

Dose 1 MG (1 ML)  
Admin Route ROUTE  
Start Date 10/12/17-1904 Stop Date 10/12/17 1905 DC Date 10/12/17-1905  
Ordering Doctor DOCTOR, PYXIS OVERRIDE  
Total Dispensed 1 Total Costs \$1.11 Total Charges \$9.25  
Rx Number 002129846

Discontinue Comments DC'd by GARRINGTON

History

|                             |                               |
|-----------------------------|-------------------------------|
| 10/12/17 1902 - PHL DM PHA  | by GARRINGTON                 |
| 10/12/17 1902 - DISCONTINUE | by STK MED Eff: 10/12/17 1905 |
| FROM:                       |                               |
| DC COMMENTS:                |                               |
| TO:                         |                               |
| DC COMMENTS:                |                               |
| DC'd by GARRINGTON          |                               |

This is the end of the MAR Summary for Patient PA1304917733 - BENTON, ALONZO.

DATE: 10/13/17 @ 0020  
USER: EKG DARMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Discharge Summary Report

PAGE 1

10/13/17

MEDICATION DISCHARGE SUMMARY

Name BENTON, ALONZO Admit Date Age 58  
Unit Num M000301370 Discharge Date Sex M  
Account Num PA1304917733 Status REG SDC  
Allergies Iodine-Rash and hives

ADMINISTRATION PERIOD:  
0730 10/12/17 to 0729 10/13/17

START/  
STOP

Midazolam HCL (MIDAZOLAM HCL 2 MG/2 ML INJECTION (VERSED)) | 10/12/17 | DM 1409 MGASK3LL  
2 MG .ROUTE .STK-MED/ONE | 10/12/17 | DC 1409 STK M3D  
| | 1410  
RX #: C02129594 | |

fentaNYL (fentaNYL CITRATE/PF 100 MCG/2 ML (SUBLIMAZE)) | 10/12/17 | DC 1409 STK M3D  
100 MCG .ROUTE .STK-MED/ONE | 10/12/17 | DM 1409 MGASK3LL  
| | 1410  
RX #: C02129595 | |

PROPOFOL (PROPOFOL 200 MG/20 ML INJECTION (DIPRIVAN)) | 10/12/17 | DC 1703 STK M3D  
200 MG .ROUTE .STK-MED/ONE | 10/12/17 | DM 1703 MGASK3LL  
| | 1704  
RX #: C02129702 | |

HYDROMorphone HCL/Pf (HYDROMorphone HCL/PF 2MG/ML 2 MG/ML DISP.SYRIN (DILAUDID)) | 10/12/17 | 1707  
2 MG .ROUTE .STK-MED/ONE | 10/12/17 | DC 1707 STK M3D  
| | DM 1707 MGASK3LL  
RX #: C02129711 | |

Ondansetron HCL/PF (ONDANSETRON HCL/PF 4 MG/2 ML INJECTION (ZOFTRAN)) | 10/12/17 | DM 1723 MGASK3LL  
4 MG .ROUTE .STK-MED/ONE | 10/12/17 | DC 1723 STK M3D  
| | 1724  
RX #: C02129716 | |

KETOROLAC TROMETHAMINE (KETOROLAC TROMETHAMINE 15 MG/ML VIAL (TORADOL)) | 10/12/17 | DC 1725 STK M3D  
30 MG .ROUTE .STK-MED/ONE | 10/12/17 | DM 1725 MGASK3LL  
| | 1726  
RX #: C02129717 | |

DATE: 10/13/17 @ 0020  
USER: EKG DARMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Discharge Summary Report

PAGE 2

10/13/17

Medication Discharge Summary

Name BENTON, ALONZO

Unit Num M000301370

Account Num PA1304917733

|                                            |        |  |
|--------------------------------------------|--------|--|
| ADMINISTRATION PERIOD:                     | START/ |  |
| 0730 10/12/17 to 0730 10/13/17 (Continued) | STOP   |  |

Sodium Chloride 0.9% 100 ML |10/12/17| 1731  
(Sodium Chloride 0.9% 100 ML IV SOLN) |10/12/17| ENTER 1733 COREISTA  
GENTAMICIN SULFATE 100 MG | | ED 1747 PHFATEAS  
(GENTAMICIN SULFATE 80 MG/2 ML INJECTION (GARAMYCIN)) | | ED 1747 PHFATEAS  
100 ML/HR IV ONCE/STA | | DC 1832 PHABKGJCB  
| |  
Comments: INDICATIONS: INFECTION | |  
SIDE EFFECTS: (ALL RARE) OTOTOXICITY, | |  
NEPHROTOXICITY | |  
| |  
TC BE GIVEN IN OR | |  
RX #: C02129735 | |

HYDROMORPHONE HCL/PF (HYDROMORPHONE HCL/PF (DILAUDID) 0.5 MG/0.5 ML DISP.SYRIN) |10/12/17| DC 1810 STK M3D  
0.5 MG .ROUTE .STK-MED/ONE |10/12/17| DM 1810 SARRINGTON  
| | 1811  
RX #: C02129766 | |

HYDROMORPHONE HCL/PF (HYDROMORPHONE HCL/PF (DILAUDID) 1MG/ML INJECTION) |10/12/17| DC 1825 STK M3D  
1 MG .ROUTE .STK-MED/ONE |10/12/17| DM 1825 SARRINGTON  
| | 1826  
RX #: C02129773 | |

HYDROMORPHONE HCL/PF (HYDROMORPHONE HCL/PF (DILAUDID) 1MG/ML INJECTION) |10/12/17| DM 1902 SARRINGTON  
1 MG .ROUTE .STK-MED/ONE |10/12/17| DC 1902 STK M3D  
| | 1904  
RX #: C02129846 | |

oxycODONE HCL/ACETAMIN 5-325 (oxycODONE/ACETAMINOPHEN 5-325 MG TABLET (PERCOCET)) |10/12/17| ENTER 1840 PHFATEAS  
2 TABLET PO EVERY 3 HOURS/PRN |10/12/17| DC 2100 PHABKGJCB  
| |  
PRN Reason: PAIN | |  
Comments: SIDE EFFECT: DIZZINESS, CONSTIPATION, FATIGUE, | |  
BLURRED VISION, LIGHT HEADEDNESS | |  
RX #: C02129808 | |

DATE: 10/13/17 @ 0020  
USER: EKG DARMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Discharge Summary Report

PAGE 3

10/13/17

Medication Discharge Summary

Name BENTON, ALONZO

Unit Num M000301370

Account Num PA1304917733

Legends

Activity Codes

DC - Discontinue  
DM - Dispensing Machine  
ED - Exit or Verification  
ENTER - Order Entry

Reason Codes

Site Codes

Administered By

User User Name/Type

User User Name/Type

User User Name/Type

User User Name/Type

Pharmacy

User User Name  
CORBISIA - ANDREW REISTER

User User Name  
PHEATEAS - ASHISH PATEL

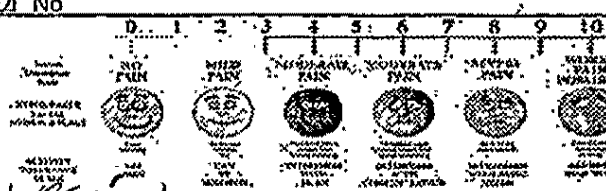
User User Name

User User Name

Allergy History

| Date     | Time | User Name          |
|----------|------|--------------------|
| 20151021 | 0400 | SALEN MOHAMMAD     |
|          |      | OLD:               |
|          |      | NEW: iodine added. |
| 20151021 | 0403 | ASHISH PATEL       |
|          |      | OLD:               |
|          |      | NEW:               |

| Database | Type | Allergy |
|----------|------|---------|
| MRI.PHL  | ADD  | iodine  |
| PHA.PHL  | ACK  |         |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| What procedure are you here for?<br><i>removal left shoulder surg</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | What is your primary language?<br><i>English</i>                                                                                                                                                                                                                                                          |  |
| Family History:<br><i>Mother CAD DM Father CAD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                           |  |
| Did you use body wash?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | ID Band On<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                               |  | Oriented to Unit Info<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                              |  | Call Bell within Reach<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                        |  |
| Isolation Precautions<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | Disposition of Medications<br><input type="checkbox"/> None <input type="checkbox"/> Sent Home <input type="checkbox"/> Pharmacy                                                                                                                                                                                                                                                                                                                |  | Emergency Contact<br><i>April</i>                                                                                                                                                                                                                                                                                                                                                                                                                              |  | Relationship of Contact<br><i>Daughter</i>                                                                                                                                                                                                                                                                |  |
| Home Phone No.<br><i>267-905-4367</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | Work Phone No.                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | Mode of Transportation at Discharge<br><i>car</i>                                                                                                                                                                                                                                                                                                                                                                                                              |  | Contact Phone No.                                                                                                                                                                                                                                                                                         |  |
| Height<br><i>5'9"</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | Weight (Actual)<br><i>170</i>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | BP<br><i>109/106</i>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | P<br><i>79</i>                                                                                                                                                                                                                                                                                            |  |
| R<br><i>16</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | POX<br><i>100%</i>                                                                                                                                                                                                                                                                                                                                                                                                                              |  | AccuCheck                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | ALLERGIES: Latex <input type="checkbox"/> Allergic to:<br><i>Codeine</i> <input type="checkbox"/> No known Allergies                                                                                                                                                                                      |  |
| Do you have an Advanced Directive? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Information given <input type="checkbox"/> Refused                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                           |  |
| <b>Valuables</b><br><input checked="" type="checkbox"/> Glasses<br><input type="checkbox"/> Contacts<br><input type="checkbox"/> Dentures<br><input type="checkbox"/> Upper<br><input type="checkbox"/> Lower<br><input type="checkbox"/> Hearing Aides <input type="checkbox"/> R <input type="checkbox"/> L                                                                                                                                                                                                                                                                                                                                                                                                                         |  | <b>Disposition</b><br><input type="checkbox"/> Home <input checked="" type="checkbox"/> Hospital<br><input type="checkbox"/> Home <input type="checkbox"/> Hospital<br><input type="checkbox"/> Home <input type="checkbox"/> Hospital<br><input type="checkbox"/> Home <input type="checkbox"/> Hospital<br><input type="checkbox"/> Home <input type="checkbox"/> Hospital<br><input type="checkbox"/> Home <input type="checkbox"/> Hospital |  | <b>Valuables</b><br><input checked="" type="checkbox"/> Clothing<br><input checked="" type="checkbox"/> Wallet / Purse<br><input type="checkbox"/> Jewelry (Describe) <i>None</i><br><input type="checkbox"/> Cash Amt <i>5.00</i><br><input type="checkbox"/> Locker #                                                                                                                                                                                        |  | <b>Disposition</b><br><input type="checkbox"/> Home <input checked="" type="checkbox"/> Hospital<br><input type="checkbox"/> Home <input type="checkbox"/> Hospital<br><input type="checkbox"/> Home <input type="checkbox"/> Hospital<br><input type="checkbox"/> Home <input type="checkbox"/> Hospital |  |
| <b>Past Medical History:</b><br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Seizures<br><input checked="" type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Circulation Problems<br><input type="checkbox"/> Diabetes - Type I or II<br><input type="checkbox"/> Thyroid Disease<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Kidney Disease<br><input checked="" type="checkbox"/> Stomach Ulcer<br><input checked="" type="checkbox"/> Cancer <i>prostate</i><br><input type="checkbox"/> Blood Disorders<br><input type="checkbox"/> Lung Disease (Asthma, Emphysema, Pneumonia)<br><input type="checkbox"/> Vision Problems |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | Do you drink alcohol or beer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, How often do you drink? <i>occass</i><br>Recreational Drug Use? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, How often and last time?<br>Drug of choice?                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                           |  |
| *Females Only: Date of Last Period _____ Cycle Regular _____ Cycle Irregular _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | Comments:<br><i>prostatectomy 2012 RTH repair ORIF clavicle 9/17</i>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                           |  |
| Surgical History: <i>prostatectomy 2012 RTH repair ORIF clavicle 9/17</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                           |  |
| Have you been hospitalized or had a surgical procedure performed within the past 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No history of surgery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                           |  |
| If yes, please list the reason for your hospitalization/surgery and place: <i>left shoulder surg</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                           |  |
| <b>PSYCHO-SOCIAL:</b><br>Have you had any of the following?<br>Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Panic Attacks <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Depression <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Suicidal Thoughts <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Type: <i>ETOH</i>                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | Any evidence of abuse <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Patient feels safe in environment <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Major life changes in the past year? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Describe?<br>Special requests relating to your cultural or religious traditions?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                                                                                                                                                                                                                                                                                                           |  |
| <b>PAIN ASSESSMENT:</b><br>Do you have pain now? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Rate your pain on a scale of 0 (none) -10 (worst) <i>9</i><br>What pain level would be acceptable to you?<br>What location(s) are you experiencing pain? <i>left shoulder</i><br>How do you manage pain? <i>Tylenol 10</i>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  Is it effective? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                           |  |

Mercy Philadelphia Hospital  
A member of Mercy Health System

SHORT PROCEDURE ASSESSMENT FORM

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 10/12/17  
ACC: PA1304917733 MR: M000301370

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Patient taking Anticoagulant</b><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Heparin<br><input type="checkbox"/> Warfarin (Coumadin)<br><input type="checkbox"/> Enoxiparin (Lovenox)<br><input type="checkbox"/> Daltiparin (Fragmin)<br><input type="checkbox"/> Fondaparinux (Arixta)<br><input type="checkbox"/> Aspirin<br><input type="checkbox"/> Clopidogrel (Plavix)<br><input type="checkbox"/> Other _____<br>Last Dose: _____ Date: _____ | <b>CARDIOVASCULAR:</b><br><input checked="" type="checkbox"/> Blood Pressure<br><input type="checkbox"/> Low <input checked="" type="checkbox"/> High<br><input type="checkbox"/> Heart disease<br><input type="checkbox"/> Heart attack<br><input type="checkbox"/> Palpitations<br><input type="checkbox"/> Heart murmur<br><input type="checkbox"/> Heart failure (CHF)<br><input type="checkbox"/> Aneurysm<br><input type="checkbox"/> Chest Pain<br><input type="checkbox"/> Implanted defibrillator<br><input type="checkbox"/> Pacemaker<br>If Yes: _____<br><input type="checkbox"/> O.R. Notified<br><input type="checkbox"/> Other _____<br><input type="checkbox"/> No Identified Problems |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**GENERAL ASSESSMENT:**

LOC: alert / lethargic / confused / unconscious    Eye Contact: good / minimal / none  
 Oriented to: time / place / person    Sociability: average / engaging / friendly / negativistic  
 Mood: hostile / calm / euphoric / anxious / depressed / labile / flat / suspicious  
 Appearance: neat / disheveled / casual  
 Memory: present time / adequate / impaired  
 Motor Activity: appropriate / hyperactive / restless / slowed

COMMENTS: \_\_\_\_\_

**RESPIRATORY STATUS:**

Breath Sounds: Right: clear / wheezing / congested    Left: clear / wheezing / congested

Smoking History: ☒ Yes ☐ No Pks/Day \_\_\_\_\_ X \_\_\_\_\_ years Date/Year Quit 10yrs  
 Shortness of Breath? ☐ Yes ☒ No WHEN? \_\_\_\_\_  
 Cough: ☐ Yes ☒ No Productive of: \_\_\_\_\_

h/o 1 p.p.d. x 30yrs

COMMENTS: \_\_\_\_\_

**CIRCULATORY STATUS:**

Skin Temperature: Right Hand: Warm / Cool    Right Foot: Warm / Cool    Left Hand: Warm / Cool    Left Foot: Warm / Cool  
 Edema? ☐ Yes ☒ No    Palpitations? ☐ Yes ☒ No    Cyanosis? ☐ Yes ☒ No

COMMENTS: \_\_\_\_\_

**ELIMINATION STATUS:** Last BM: 10/11/17    COMMENTS: \_\_\_\_\_  
 Urinary: No problems / frequency / dysuria / hematuria / nocturia

**PRE-PROCEDURE CHECKLIST:** (Check off all items that are present in chart)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Identification bracelet on patient<br><input checked="" type="checkbox"/> Permit<br><input checked="" type="checkbox"/> Medical Clearance (if applicable)<br><input checked="" type="checkbox"/> EKG report<br><input type="checkbox"/> Urinalysis report<br><input type="checkbox"/> Dentures/Caps/Hearing Aid<br><input type="checkbox"/> NPO after Midnight <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Comments: _____ | <input checked="" type="checkbox"/> H&P<br><input checked="" type="checkbox"/> Anesthesia permit<br><input checked="" type="checkbox"/> Breast surgery permit<br><input type="checkbox"/> Blood permit<br><input type="checkbox"/> Blood work reports<br><input type="checkbox"/> X ray reports | <input checked="" type="checkbox"/> Voided / catheterized<br><input checked="" type="checkbox"/> Contact lenses / glasses off<br><input type="checkbox"/> Jewelry removed / secured<br><input type="checkbox"/> Body piercing removed<br>Pre-op medications _____<br><input type="checkbox"/> Instructed to stay in bed    Call bell available |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

RN Signature: Karen King-Shannon

Mercy Philadelphia Hospital  
 Member of Mercy Health System

SHORT PROCEDURE ASSESSMENT FORM



DOB: BENTON, ALONZO  
 Adm: 11/12/1958 58 M  
 ACC: ADM: 10/12/17  
 ACC: PA1304917733 MR: M000301370



## FUNCTIONAL ASSESSMENT

☒ No Identified problems

### Recent History

- ☐ Limited movement/paralysis of extremities  
☐ Pain/swelling of extremities

- ☐ Open wound (decubitus, sores)  
☐ CVA with slurred or incoherent speech

## SPIRITUAL ASSESSMENT

Request for Spiritual Care? ☐ Yes ☐ No

Prayer card given? ☐ Yes ☐ No

## NUTRITIONAL ASSESSMENT

☒ No Identified problems

☐ Poor/Inadequate oral intake  $\geq$  3 days

☐ Recent unintentional wt. loss or gain of  $\geq$  10 lbs

☐ Poor Skin Turgor

☐ N/V/D  $\geq$  3 Days

☐ Emaciation or other sign of deficiency

☐ Nutritional Support (Tube Feed/TPN)

FALLS RISK ASSESSMENT - A X by a \*Indicator or 2 or more

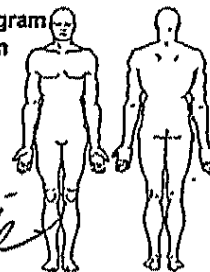
other indicators should initiate Falls Precaution Program

| Fall Assessment Indicators                            | Score                                                               |
|-------------------------------------------------------|---------------------------------------------------------------------|
| Age over 65                                           | 1                                                                   |
| *History of falls prior to admission                  | 1                                                                   |
| Dizziness                                             | 1                                                                   |
| Unsteady/shuffling gait/wide base                     | 1                                                                   |
| Weakness                                              | 1                                                                   |
| Impaired Vision                                       | 1                                                                   |
| *Confused/disoriented                                 | 1                                                                   |
| Incontinence                                          | 1                                                                   |
| Medications - diuretics, hypotensives CNS depressants | 1                                                                   |
| <b>TOTAL SCORE</b>                                    | <b>8</b>                                                            |
| Falls Precaution Program Initiated?                   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Falls ID Bracelet put on patient? Yellow Booties      | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

## SKIN STATUS

Draw an "X" on the diagram to indicate any variation in skin integrity.

- ☐ Rashes  
☐ Psoriasis ☐ Eczema  
☐ Any changes in skin color ☐ Yes ☐ No  
☐ At risk for developing Pressure Ulcer/s  
☐ Skin Breakdown  
☒ Other left shoulder scar & drainage  
☐ No identified problems



## NEEDS ASSESSMENT

### PATIENT FAMILY EDUCATION

Learning Readiness: ☒ Motivated ☐ Non-Motivated ☐ Unable to Learn

Barriers to Learning: ☐ Cognitive ☐ Cultural ☐ Educational ☐ Language ☐ Physical ☐ Religious

☐ Refuses at this time ☒ No Barriers ☐ Comments/Other \_\_\_\_\_

How do you Learn Best: ☐ Audio ☐ Visual ☒ Both

Teach Back Method Used: ☒ Yes

Plans to Overcome Barriers to Education: ☐ Family Involvement ☐ Reinforcement ☐ Written Materials ☐ Audiovisual Aids

☐ Interpreter ☐ Other \_\_\_\_\_

Education Provided: ☐ Disease Process ☐ Activity Level ☐ Diet ☒ Procedures ☒ Hygiene ☒ Pain Management

☐ Medications (Includes Drug and Food Interactions) ☐ Medical Equipment / Assistive Devices (if applicable)

☐ Smoking cessation information ☐ Given ☒ Refused

☐ Other \_\_\_\_\_

Plan for collaborative education: (X when indicated and notified) ☐ Nutrition ☐ OT ☐ PT ☐ Speech Therapy ☐ Respiratory

☐ Social Worker ☐ Case Manager ☐ Other \_\_\_\_\_

Teaching to be directed primarily to: ☒ Patient ☐ Family ☐ Other \_\_\_\_\_

## DISCHARGE PLANNING SCREEN

Living arrangements: ☐ Alone ☒ Family ☐ Retirement Community ☐ Nursing Home ☐ Other \_\_\_\_\_

Home environment: Stairs ☒ Yes ☐ No Are stairs a problem? ☐ Yes ☒ No

Assistive devices: ☐ None ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Other \_\_\_\_\_

Patient plans to be discharged to: home Caregiver at home: ☐ N/A ☐ Yes Specify Brought to Hospital daughter

If any questions are answered yes, as problematic, consult Social Service/Case Manager Consult

Mercy Philadelphia Hospital  
 member of Mercy Health System

SHORT PROCEDURE ASSESSMENT FORM

DOB: BENTON, ALONZO  
 Adm: DOB: 11/12/1958 58 M  
 Acc: ADM: 10/12/17  
 ACC: PA1304917733 MR: M000301370



# Post Procedure Data

|                                                           |                    |                    |                    |  |  |
|-----------------------------------------------------------|--------------------|--------------------|--------------------|--|--|
| Time                                                      | 10/12/17<br>1925   | 1935               | 1950               |  |  |
| Temperature                                               | 98                 |                    |                    |  |  |
| Pulse                                                     | 86                 | 78                 | 74                 |  |  |
| Respiratory Rate                                          | 13                 | 14                 | 14                 |  |  |
| Blood Pressure                                            | 148/110            | 155/112            | 146/100            |  |  |
| Side Rails Up                                             | ✓                  | ✓                  | ✓                  |  |  |
| Call Bell Within Reach                                    | ✓                  | ✓                  | ✓                  |  |  |
| Instructed Not to Get Out of Bed/Chair Without Assistance | ✓                  | ✓                  | ✓                  |  |  |
| Dressing Evaluated                                        | ✓                  | ✓                  | ✓                  |  |  |
| IV Site Checked                                           | ✓                  | ✓                  | ✓                  |  |  |
| IV Checked/Infusing at Correct Rate                       | ✓                  | ✓                  | ✓                  |  |  |
| Pain Scale: 0 (None) - 10 (Most)                          | 5/10               | 5/10               | 5/10               |  |  |
| RN Signature                                              | <i>[Signature]</i> | <i>[Signature]</i> | <i>[Signature]</i> |  |  |
| Nurses Notes:                                             |                    |                    |                    |  |  |

| Medications: Dose |  | Route | Time | RN Signature       | Yes | No | If No, Action Taken | RN Signature |
|-------------------|--|-------|------|--------------------|-----|----|---------------------|--------------|
| aspirin 5         |  | PO    | 1930 | <i>[Signature]</i> | ✓   |    |                     |              |
| aspirin 5         |  | PO    | 2042 | <i>[Signature]</i> | ✓   |    |                     |              |

|                                                                                                                                                                                |                                                                                                                                                          |                                                                                                                                                                      |                                                                                                                                                        |                                                                                                                                                                              |                                                                                                                                                                             |                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| <b>VITAL SIGNS</b><br><input checked="" type="checkbox"/> 2 within normal limits<br><input type="checkbox"/> 1 within acceptable limits<br><input type="checkbox"/> 0 unstable | <b>MOBILITY</b><br><input checked="" type="checkbox"/> 2 return to previous level<br><input type="checkbox"/> 1 return to previous level with assistance | <b>BLEEDING</b><br><input checked="" type="checkbox"/> 2 no bleeding<br><input type="checkbox"/> 1 minimal bleeding<br><input type="checkbox"/> 0 excessive bleeding | <b>ORAL INTAKE</b><br><input checked="" type="checkbox"/> 2 fluids / solids<br><input type="checkbox"/> 1 ice chips<br><input type="checkbox"/> 0 none | <b>NAUSEA/VOMITING</b><br><input checked="" type="checkbox"/> 2 minimal to none<br><input type="checkbox"/> 1 moderate<br><input type="checkbox"/> 0 severe, needs treatment | <b>PAIN ASSESSMENT at Discharge</b><br><b>SCORE</b><br><input checked="" type="checkbox"/> 2 (0-2)<br><input type="checkbox"/> 1 (3-8)<br><input type="checkbox"/> 0 (7-10) | <b>ABILITY TO VOID</b><br><input checked="" type="checkbox"/> 2 able to void / not applicable<br><input type="checkbox"/> 0 unable |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|

Comments: *Janet 815-700-5796*

MUST SCORE 10 OR GREATER FOR DISCHARGE - TOTAL SCORE *14*

Patient Discharged With: *ER in wheelchair* Relationship: \_\_\_\_\_

Transported To: *ER in wheelchair* Via: \_\_\_\_\_

☐ Discharge Instructions reviewed with pt. and \_\_\_\_\_. Pt. and family verbalized understanding of instructions.

Prescriptions given: ☒ Yes ☐ No ☐ N/A Filled by Mercy Pharmacy ☐ Yes ☒ No

Time: \_\_\_\_\_ RN Signature: *[Signature]*

Mercy Philadelphia Hospital  
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## SHORT PROCEDURE ASSESSMENT FORM



DOB: BENTON, ALONZO  
Adm: 11/12/1958 58 M  
Acc: ADM: 10/12/17  
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## Pre-Op Assessment

Name: Alonzo Benton Date: 10/12/17 Time: 11:50 AM/PM Surgeon: Meller  
 Procedure: Rem hardware lt clavicle & debr

Allergies: Iodine

Significant PMH: Surry left clavicle

Patient Verbalizes Knowledge of OR Procedure: Yes: X No: \_\_\_\_\_

Comments: \_\_\_\_\_

LEVEL OF CONSCIOUSNESS

alert X  
 sedated \_\_\_\_\_  
 disoriented \_\_\_\_\_  
 non-responsive to tactile or verbal stimuli \_\_\_\_\_

SKIN APPEARANCE

warm X  
 dry \_\_\_\_\_  
 cool \_\_\_\_\_  
 moist \_\_\_\_\_  
 diaphoretic \_\_\_\_\_  
 intact \_\_\_\_\_

PSYCHOLOGICAL

calm X  
 anxious \_\_\_\_\_  
 restless \_\_\_\_\_  
 crying \_\_\_\_\_

MUSCULO-SKELETAL

no limitations \_\_\_\_\_  
 ROM limitations X  
 paralysis \_\_\_\_\_  
 traction \_\_\_\_\_  
 amputation \_\_\_\_\_

COMMUNICATIONS

no limitations X  
 language barrier \_\_\_\_\_  
 hearing impaired \_\_\_\_\_  
 aphasia / dysphasia \_\_\_\_\_  
 blindness \_\_\_\_\_  
 retardation \_\_\_\_\_

HOLDING AREA:

Verification Nurse: \_\_\_\_\_ ID Band: \_\_\_\_\_ Pt Acknowledgement: \_\_\_\_\_

Chart Review: ☐ OR Permit ☐ Blood Permit ☐ T & C ☐ T & S  
☐ Blood Work ☐ CXR ☐ EKG ☐ H & P  
☐ Other \_\_\_\_\_ ☐ Site Verification

Comments: \_\_\_\_\_

RN Signature: \_\_\_\_\_

BENTON, ALONZO  
 DOB: 11/12/1958 58 M  
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☐ MERCY FITZGERALD HOSPITAL  
☒ MERCY HOSPITAL OF PHILADELPHIA  
☐ MERCY SUBURBAN HOSPITAL

OPERATING ROOM NURSES RECORD NS 196A (09/07)

INTRA-OPERATIVE SECTION:

Verification Nurse: \_\_\_\_\_ ID Band: \_\_\_\_\_

Patient Acknowledgement: \_\_\_\_\_ Operative Site: \_\_\_\_\_

Position: ☐ Safety Strap ☐ Supine ☐ Prone ☐ Lateral  
☐ Lithotomy ☐ Jackknife ☐ Warming Blanket ☐ Temp \_\_\_\_\_  
☐ Other: \_\_\_\_\_

Bovie: Pad Site: \_\_\_\_\_ Bovie Number: \_\_\_\_\_ Shaved: ☐ Yes ☐ No Settings: Cut \_\_\_\_\_ Coag \_\_\_\_\_  
Skin Intact When Pad Removed: ☐ Yes ☐ No Comments: \_\_\_\_\_

Tourniquet Site: \_\_\_\_\_ Tourniquet #: \_\_\_\_\_ Total Time: \_\_\_\_\_ Pressure: \_\_\_\_\_

Skin Prep: Clip: \_\_\_\_\_ Betadine: \_\_\_\_\_ PhisoHex: \_\_\_\_\_ Other: \_\_\_\_\_

Specimen: 1. \_\_\_\_\_ G \_\_\_\_\_ Rt \_\_\_\_\_ FS \_\_\_\_\_ R \_\_\_\_\_ Other \_\_\_\_\_  
2. \_\_\_\_\_ G \_\_\_\_\_ Rt \_\_\_\_\_ FS \_\_\_\_\_ R \_\_\_\_\_ Other \_\_\_\_\_  
3. \_\_\_\_\_ G \_\_\_\_\_ Rt \_\_\_\_\_ FS \_\_\_\_\_ R \_\_\_\_\_ Other \_\_\_\_\_

Cultures: 1. \_\_\_\_\_ Rt \_\_\_\_\_ Anaerobic \_\_\_\_\_  
2. \_\_\_\_\_ Rt \_\_\_\_\_ Anaerobic \_\_\_\_\_

Key:  
Gross G  
Routine Rt  
Frozen Section FS  
Rapid R

X-Rays: \_\_\_\_\_

Image: \_\_\_\_\_

Irrigation: ☐ NSS: ☐ H<sub>2</sub>O ☐ Glycine ☐ Lactated Ringers Meds: \_\_\_\_\_

Foley: ☐ Yes ☐ No Size: \_\_\_\_\_ With \_\_\_\_\_ mls balloon inflation  
Indwelling on Arrival to OR: \_\_\_\_\_ Comments: \_\_\_\_\_

Implants: ☐ Yes ☐ No ☐ Cement: ☐ See Progress Notes:

Drains: ☐ Yes ☐ No Type: ☐ Penrose ☐ Hemovac ☐ Jackson Pratt  
☐ Other \_\_\_\_\_

Local Anesthesia/IV Sedation/Meds: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ TEDS ☐ Sequential Compression Sleeves

Pt Transferred to: ☐ PACU ☐ SICU ☐ SPU ☐ Other \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
RN Signature

\_\_\_\_\_  
Date

## Pre-op Assessment Form

Date of Service: ☐ ☐ ☐ ☐ ☐ ☐MRN: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Last Name:

First Name:

Middle Initial:

BP 121 / 86 HR 79 R 11 T 97.8 ☒ F ☐ C 100%☐ Declines Response

| Allergies (drug/environmental/food/RXN) <input type="checkbox"/> NKA | Skin                     | Local                    | Abdominal                | Systemic                 | REACTION | Very Mild                | Mild                     | Moderate                 | Severe                   | START DATE |
|----------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------------------------|--------------------------|------------|
| <input type="checkbox"/> Penicillin                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |
| <input type="checkbox"/> Sulfa                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |
| <u>Edema contact</u>                                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |
|                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |
|                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |

Date of Birth: ☐ ☐ ☐ ☐ ☐ ☐Age: 58Sex: ☒ Male  
☐ FemaleWeight: ☐ ☐ ☐ lb ☐ ☐ ☐ kg Height: ☐ ☐ ☐ in ☐ ☐ ☐ cmProcedure: Removal of L clavicle hardwareDiagnosis: Symptomatic clavicle hardwareMedications: ☐ None Lasix, HCTZ, OmeprazolePatient on Beta Blocker prior to admission? ☐ Yes ☒ NoAnticoagulants: ☐ Yes ☒ NoPast Medical History: HTN, GERDPrevious Surgery and Anesthesia ☐ NoneORIF L clavicle 9/17, fracture

Patient Contact

Emergency Contact

Does Patient Have Advanced Directive? ☐ Yes ☐ NoIs it on file at this Facility? ☐ Yes ☐ NoAnesthesia Issues ☒ Negative

- ☐ PONV ☐ Malignant Hyperthermia  
☐ Difficult Airway  
☐ By Exam ☐ By History ☐ TMJ problems  
☐ Snoring ☐ OSA ☐ CPAP/BIPAP  
☐ Hoarseness ☐ Nasal Obstruction  
☐ Stridor/Croup ☐ Severe Anxiety  
☐ Fam Hx Anesth Problems  
☐ Obesity/Morbid (BMI greater than 35)  
☐ Organ Transplant  
☐ Other/Notes:

Neurologic ☒ Negative

- ☐ Seizure ☐ Elevated ICP ☐ Shunt  
☐ Spinal Cord Injury ☐ CVA/TIA  
☐ Cerebral Palsy ☐ Mental Retardation  
☐ Chronic Pain ☐ Neuropathy/Paresis/esthesia  
☐ Myopathy/Muscular Dystrophy Syncope  
☐ Hearing Loss ☐ Blind: Right/Left  
☐ Other/Notes:

Endocrine ☒ Negative

- ☐ Diabetes ☐ Thyroid ☐ Steroid Usage  
☐ Other/Notes:

Infections ☐ Negative

- ☐ SBE Prophylaxis ☐ HIV ☐ Sepsis  
☐ URI ☐ VRE ☐ MRSA: contact/resp.  
☐ Other/Notes:

Cardiovascular ☐ Negative

- ☐ MI: Date ☐ Hypertension ☐ CAD  
☐ Arrhythmia: Type ☐ Pacemaker ☐ AICD  
☐ Angina: ☐ Stable ☐ Unstable  
 CHF: Date ☐ EF ☐ %  
 Valve Disease: ☐ Mod ☐ Severe  
☐ PVD ☐ DVT ☐ PE ☐ Murmur  
☐ Hx Cardiac Surgery ☐ Angioplasty ☐ PCI  
☐ Stress test/Cardiac Cath  
☐ Other/Notes:

Pulmonary ☒ Negative

- ☒ Prev Smoker ☐ Current Smoker ☐ ppd  
☐ Asthma ☐ Hospitalized ☐ Steroid Use  
☐ Recent wheezing  
☐ COPD/BPD ☐ Cough: Active / Chronic  
☐ Other/Notes:

Gastrointestinal ☐ Negative

- ☐ GE reflux/Hiatal Hernia ☐ Bowel Obstruction  
☐ Ascites ☐ Ulcers ☐ GI Bleed ☐ Dysphagia  
☐ Other/Notes:

Hematol/Onc ☐ Negative

- ☐ Sickle Cell Disease ☐ Trait ☐ Coagulopathy  
☐ Anemia ☐ Hx Transfusion ☐ Refuses Transfusion  
☐ Tumor ☐ Chemo/Rad Therapy  
☐ Other/Notes:

Hepatic ☐ Negative

- ☐ Hepatitis ☐ Cirrhosis  
☐ Other/Notes: Hep C

Renal ☐ Negative

- ☐ Renal Insufficiency ☐ Dialysis  
☐ Other/Notes:

## Activity Level

- ☐ Bedridden ☐ Assistance with Self-Care  
☐ Less than 1 Flight of Stairs  
☐ 1-3 Flights of Stairs  
☐ Greater than 3 Flights of Stairs  
☐ Able to Lie Flat One Hour  
☐ Other/Notes:

Obstetrics ☐ Negative

- ☐ Pre-eclampsia/Eclampsia  
☐ Placenta Previa/Abruption  
☐ I/M ☐ HCG  
☒ Other/Notes:

Pediatrics ☒ Negative

- ☐ Prematurity ☐ Congenital Abnl.  
☐ Apnea ☐ Passive Smoking  
☒ Other/Notes:

Drug Use ☐ Negative

- ☐ ETOH ☐ Daily ☐ Never ☒ Occasional  
☐ Cocaine ☐ IVDA  
☐ Other/Notes:

Signature of provider performing preoperative assessment

Date/Time

Mercy Philadelphia Hospital  
A member of Mercy Health System

Pre-op Assessment Form



BENTON, ALONZO

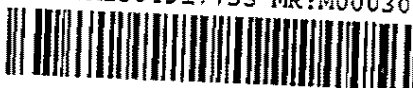
DOB: 11/12/1958 58 M

ADM: 10/12/17

DOB: ACC: PA1304917733 MR: M000301370

Adm:

Acc:



5.1 > 12.2 < 209  
39

PT  
INR  
PTT

Consults/Other Studies:

Eht - NSR

HCG Neg Pos

Other Notes:

BP  /  HR  R  T  ☐ F ☐ C SaO2  BMI

Airway Assessment: ☐ ETT In Situ

Oral Excursion: FB ☐ 1 ☐ 2 ☐ 3 ☐ 4

T-M Distance: FB ☐ 1 ☐ 2 ☐ 3 ☐ 4

Detention: ☐ Upper nl ☐ Dentures ☐ Caps ☐ Decayed ☐ Loose  
☐ Lower nl ☐ Dentures ☐ Caps ☐ Decayed ☐ Loose

Loose/Decayed #

Mallampati: ☐ I ☐ II ☐ III ☐ IV

Neck: Extension: ☐ nl ☐ ↓ ☐ ↓↓  
Flexion: ☐ nl ☐ ↓ ☐ ↓↓

ASA

☒ 1

☐ 2

☐ 3

☐ 4

☐ 5

☐ 6

☐ E

Comments/Extra Meds:

Anesthesia Attending Pre-Anesthesia Assessment and Consent

- ☒ Medical record and laboratory data reviewed  
☒ Patient is appropriate for the planned anesthesia  
☒ General  
☐ Block  
☐ Monitored anesthesia care  
☐ Spinal  
☐ Epidural/Caudal  
Planned post-operative care: ☒ PACU ☐ ICU ☐ Phase 2 Recovery ☐ Other

☒ Patient examined

Special Monitoring:

- ☐ Arterial Catheter  
☐ Central Venous Catheter  
☐ Pulmonary Catheter  
☐ Transesophageal Echo  
☐ Other

Preferred Language:

- ☒ English ☐ Hawaiian ☐ Portuguese  
☐ Spanish ☐ Italian ☐ Russian  
☐ French ☐ Japanese ☐ Other Language

Ethnicity:

- ☒ Non-Hispanic or Latino ☐ Hispanic

Race:

- ☐ Caucasian ☒ African or African American  
☐ Native American or Native Alaskan ☐ Native Hawaiian or Pacific Islander  
☐ Asian or Asian American ☐ Other Race

Signature of provider performing preoperative assessment:

Provider ID#

Date

Time

Mercy Philadelphia Hospital  
A member of Mercy Health System

Pre-op Assessment Form

BENTON, ALONZO

DOB: 11/12/1958 58 M

DOI: ADM: 10/12/17

Adi: ACC: PA1304917733 MR: M000301370

Act



# Operative / Invasive Procedures Plan of Care *Hardware removal*

DATE of Operative/ Invasive Procedure: *10/12/17 left shoulder & debridement/wound revision*

| Identified Problem/Need | Intervention                                                                                       | Expected Outcome                            | Outcome Achieved / Resolved ? |    |                   |                             |    |    |                           |    |    |                            |    |    |
|-------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------|----|-------------------|-----------------------------|----|----|---------------------------|----|----|----------------------------|----|----|
|                         |                                                                                                    |                                             | Pre-Procedure Date / Time     |    |                   | Intra-Procedure Date / Time |    |    | Pacu-Recovery Date / Time |    |    | Post-Procedure Date / Time |    |    |
|                         |                                                                                                    |                                             | Yes                           | No | RN                | Yes                         | No | RN | Yes                       | No | RN | Yes                        | No | RN |
| 1. Safety               | • Position patient per procedure                                                                   | • No patient discomfort                     | ✓                             |    | <i>1150 10/12</i> |                             |    |    |                           |    |    |                            |    |    |
|                         | • Patient airway maintained                                                                        | • No respiratory difficulty                 | ✓                             |    |                   |                             |    |    |                           |    |    |                            |    |    |
|                         | • Equipment checked/ maintained according to policy                                                | • No patient injury<br>No equipment failure | ✓                             |    |                   |                             |    |    |                           |    |    |                            |    |    |
|                         | • Site ID check performed                                                                          | • Correct site ID                           | ✓                             |    |                   |                             |    |    |                           |    |    |                            |    |    |
| 2. Discharge Planning   | • Assess need for further intervention<br><br>• Assessment of return to previous Level of function | • Needs Met                                 | ✓                             |    |                   |                             |    |    |                           |    |    |                            |    |    |
| 3. Deficit / education  | • Pre-Post procedure instructions written or verbal                                                | • Express understanding                     | ✓                             |    |                   |                             |    |    |                           |    |    |                            |    |    |

## Intra-Procedure Location

- ☐ OR complex      ☐ Radiology \_\_\_\_\_  
☐ Cardiac catheterization  
☐ Dialysis

☐ For Intraoperative care plan see Picis electronic documentation

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OPERATIVE/INVASIVE PLAN OF CARE

DOB:  
Adm:  
Acc:

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 10/12/17  
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| Identified Problem/need                    | Intervention                                                                                                                                                                                                    | Expected Outcome                                 | Outcome Achieved / Resolved? |             |                |                             |                |    |                           |    |    |                            |    |    |  |
|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------|-------------|----------------|-----------------------------|----------------|----|---------------------------|----|----|----------------------------|----|----|--|
|                                            |                                                                                                                                                                                                                 |                                                  | Pre-Procedure Date/Time      |             |                | Intra-Procedure Date / Time |                |    | Pacu-Recovery Date / Time |    |    | Post-Procedure Date / Time |    |    |  |
|                                            |                                                                                                                                                                                                                 |                                                  | Yes                          | No          | RN             | Yes                         | No             | RN | Yes                       | No | RN | Yes                        | No | RN |  |
| 4. Pain                                    | <ul style="list-style-type: none"> <li>Anxiety relieved by emotional support and reassurance</li> <li>Non Pharmacological Interventions</li> <li>Assess pain / Medicate PRN Reassess for pain relief</li> </ul> | • Decrease in anxiety level                      | /                            |             | RN             | /                           |                |    |                           |    |    |                            |    |    |  |
|                                            |                                                                                                                                                                                                                 | • Pain comfort                                   | /                            |             |                |                             |                |    |                           |    |    |                            |    |    |  |
|                                            |                                                                                                                                                                                                                 | • Pain relief evidenced                          | /                            |             |                |                             |                |    |                           |    |    |                            |    |    |  |
| 5. Potential for Cardio-Pulmonary distress | <ul style="list-style-type: none"> <li>Assess &amp; Monitor vital signs</li> <li>Notify doctor of unstable condition or changes</li> </ul>                                                                      | • Vital Signs are within patient's normal limits | /                            |             |                |                             |                |    |                           |    |    |                            |    |    |  |
|                                            |                                                                                                                                                                                                                 | • Document patient's care / condition            | /                            |             |                |                             |                |    |                           |    |    |                            |    |    |  |
| 6. Infection Control                       | <ul style="list-style-type: none"> <li>Standard precautions practiced</li> <li>Aseptic technique maintained</li> </ul>                                                                                          | • Patient & staff infection free                 | /                            |             |                |                             |                |    |                           |    |    |                            |    |    |  |
|                                            |                                                                                                                                                                                                                 | • No break in sterile technique                  | NA                           |             |                |                             |                |    |                           |    |    |                            |    |    |  |
| 7. Other                                   |                                                                                                                                                                                                                 |                                                  |                              |             |                |                             |                |    |                           |    |    |                            |    |    |  |
| Phase                                      | Prioritization of Patient's Needs                                                                                                                                                                               | RN                                               | Identified Problem / need    | Comments    |                |                             |                |    |                           |    |    | RN                         |    |    |  |
| Pre-Procedure                              | #1 #2 #4                                                                                                                                                                                                        | RN                                               |                              |             |                |                             |                |    |                           |    |    |                            |    |    |  |
| Intra-Procedure                            |                                                                                                                                                                                                                 |                                                  |                              |             |                |                             |                |    |                           |    |    |                            |    |    |  |
| PACU-Recovery                              |                                                                                                                                                                                                                 |                                                  |                              |             |                |                             |                |    |                           |    |    |                            |    |    |  |
| Post Procedure                             |                                                                                                                                                                                                                 |                                                  |                              |             |                |                             |                |    |                           |    |    |                            |    |    |  |
| RN Initials                                | Full Signature                                                                                                                                                                                                  | RN Initials                                      | Full Signature               | RN Initials | Full Signature | RN Initials                 | Full Signature |    |                           |    |    |                            |    |    |  |

OPERATIVE/INVASIVE PLAN OF CARE



DOB:  
Adm:  
Acc:

?

MR#:



| <b>NEUROLOGIC: POTENTIAL FOR ALTERATION IN NEUROLOGIC STATUS AND SENSORY PERCEPTION</b> | <p><b>LOC</b></p> <p><input checked="" type="checkbox"/> Awake <input type="checkbox"/> Alert</p> <p><input checked="" type="checkbox"/> Oriented <input type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time</p> <p><input type="checkbox"/> Unresponsive <input type="checkbox"/> Combative</p> <p><input type="checkbox"/> Confused <input type="checkbox"/> Restless</p> <p><input type="checkbox"/> Lethargic <input type="checkbox"/> Drowsy</p> <p><input type="checkbox"/> Agitated <input type="checkbox"/> Somnolent</p> <p><b>MOTOR</b></p> <p><input checked="" type="checkbox"/> MAE</p> <p><input type="checkbox"/> R Arm Comment _____</p> <p><input type="checkbox"/> L Arm Comment _____</p> <p><input type="checkbox"/> R Leg Comment _____</p> <p><input type="checkbox"/> L Leg Comment _____</p> <p>GOAL: Return to baseline.</p> <p>EVALUATION: Patient awake prior to discharge <input checked="" type="checkbox"/></p> <p>Comments: _____</p>                                                                                                                                                                                                                                       | <p><b>PUPILS (if applicable)</b></p> <p><input type="checkbox"/> Perf _____ mm</p> <p><input type="checkbox"/> Unequal Right _____ Left _____</p> <p><input type="checkbox"/> Dilated</p> <p><input type="checkbox"/> Constricted</p> <p><input type="checkbox"/> Sluggish</p> <p><input type="checkbox"/> Non-reactive</p> <p><input type="checkbox"/> Other _____</p> <p><b>SPEECH (if applicable)</b></p> <p><input type="checkbox"/> Clear</p> <p><input type="checkbox"/> Appropriate</p> <p><input type="checkbox"/> Inappropriate</p> <p><input type="checkbox"/> Garbled</p> <p><input type="checkbox"/> Intubated</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Gestures</p> |           |            |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------|-----------|-----------|------------|------------|-------|---|--|--|--|--|------|---|--|--|--|--|--|--|--|--|--|--|--|
| <b>PULMONARY: POTENTIAL FOR ALTERATION IN GAS EXCHANGE</b>                              | <p>Chest Expansion: <input type="checkbox"/> Symmetrical <input type="checkbox"/> Asymmetrical</p> <p>Breath Sounds: <input type="checkbox"/> Bilateral <input checked="" type="checkbox"/> CTA</p> <p>R: _____</p> <p>L: _____</p> <p>Cough/Sputum: <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Non-Productive</p> <p>Comments: <u>N/A</u></p> <p>Respirations: <input type="checkbox"/> Labored <input type="checkbox"/> Unlabored <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Spontaneous</p> <p>Comments: _____</p> <p>Chest Tubes: <input type="checkbox"/> Pleural <input type="checkbox"/> Right <input type="checkbox"/> Left No.</p> <p>Goal: Return to baseline <u>N/A</u></p> <p>Evaluation: Patient's Respiratory status has returned to baseline <input type="checkbox"/></p> <p>Comments: _____</p>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |            |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>CARDIOVASCULAR: POTENTIAL FOR ALTERATION IN CARDIAC OUTPUT/FLUID VOLUME DEFICIT</b>  | <p><b>PULSE SCALE</b></p> <p>D = Doppler</p> <p>+3 = Bouncing</p> <p>+2 = Normal</p> <p>+1 = Weak</p> <p>0 = Absent</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th></th> <th>RADIAL</th> <th>FEMORAL</th> <th>POPLITEAL</th> <th>DOR. PEDIS</th> <th>POST. TIB</th> </tr> <tr> <td>RIGHT</td> <td>2</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>LEFT</td> <td>2</td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <p>Comments: _____</p> <p>Edema: <input type="checkbox"/> Trace <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> +4</p> <p>Location: _____</p> <p>Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular</p> <p><b>INVASIVE MONITORING</b></p> <p><input checked="" type="checkbox"/> None</p> <p><input type="checkbox"/> Arterial Line Cuff Correlation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Site _____ Wave _____ Circ. _____</p> <p><input type="checkbox"/> Other _____</p> <p>GOAL: Adequate hydration. Adequate tissue perfusion</p> <p>Evaluation: Patient has adequate tissue perfusion. <input checked="" type="checkbox"/></p> <p>Comments: _____</p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           | RADIAL     | FEMORAL   | POPLITEAL | DOR. PEDIS | POST. TIB  | RIGHT | 2 |  |  |  |  | LEFT | 2 |  |  |  |  |  |  |  |  |  |  |  |
|                                                                                         | RADIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | FEMORAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | POPLITEAL | DOR. PEDIS | POST. TIB |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
| RIGHT                                                                                   | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |            |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
| LEFT                                                                                    | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |            |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>INTEGUMENTARY: POTENTIAL FOR ALTERATION IN SKIN INTEGRITY</b>                        | <p><b>SKIN INTEGRITY</b></p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Location: _____</p> <p>Site: <u>Left shoulder</u></p> <p>Pressure Reduction Measures</p> <p><input type="checkbox"/> Mattress</p> <p><input type="checkbox"/> Turning</p> <p>GOAL: Maintain Skin Integrity</p> <p>EVALUATION: Skin integrity is maintained <input checked="" type="checkbox"/></p> <p>Comments: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |            |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>GI: ALTERATION IN GASTRIC MOTILITY</b>                                               | <p>Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Obese <input type="checkbox"/> Firm</p> <p><input type="checkbox"/> Distended <input checked="" type="checkbox"/> Non-Distended</p> <p>Bowel Sounds: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Absent</p> <p>Comments: _____</p> <p>Tubes: <input type="checkbox"/> NG <input type="checkbox"/> Feeding</p> <p>Comments: <u>N/A</u></p> <p>Other: <input type="checkbox"/> NPO <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>GOAL: Patient will maintain normal GI Function</p> <p>EVALUATION: Patient will not exhibit abdominal distress <input checked="" type="checkbox"/></p> <p>Comments: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |            |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>GI: POTENTIAL FOR ALTERATION IN URINARY ELIMINATION</b>                              | <p>Voids: <input checked="" type="checkbox"/> Continent <input type="checkbox"/> Incontinent</p> <p><input type="checkbox"/> Foley <input type="checkbox"/> Other</p> <p>Urine: _____</p> <p>GOAL: Urinary output adequate.</p> <p>EVALUATION: Patient urinating without difficulty <input checked="" type="checkbox"/></p> <p>Comments: _____</p> <p>Foley Catheter D/C at _____ checked by: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |            |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>INCISION</b>                                                                         | <p>Dressing: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes</p> <p>Comments: <u>4x4, ABD tape</u></p> <p><input type="checkbox"/> Other _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |            |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRAINS</b>                                                                           | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>TYPE</th> <th>SITE</th> <th>SUCTION</th> <th>COLOR</th> <th>AMOUNT</th> </tr> <tr> <td><u>N/A</u></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | TYPE      | SITE       | SUCTION   | COLOR     | AMOUNT     | <u>N/A</u> |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
| TYPE                                                                                    | SITE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | SUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | COLOR     | AMOUNT     |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
| <u>N/A</u>                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |            |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |            |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |            |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |            |           |           |            |            |       |   |  |  |  |  |      |   |  |  |  |  |  |  |  |  |  |  |  |

Mercy Philadelphia Hospital  
A member of Mercy Health System

## PACU FLOWSHEET



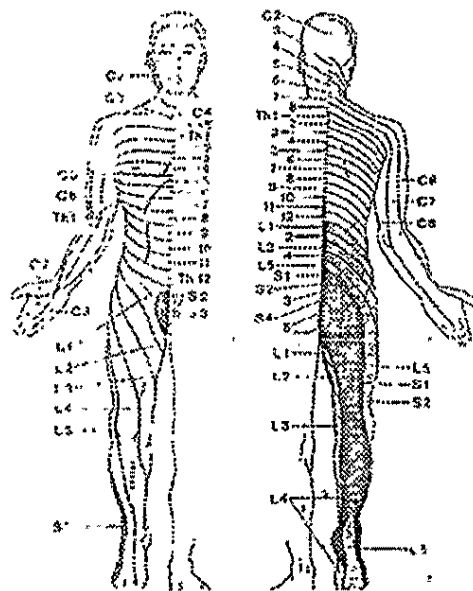
BENTON, ALONZO  
DOB: 11/12/1958 58Y M  
Adm: 10/12/2017  
Acc: PA1304917733 MR#: M000301370



| POST ANESTHESIA RECOVERY                             |   |               | ARR             | 30 MIN | HR | HR | HR | HR | DC |
|------------------------------------------------------|---|---------------|-----------------|--------|----|----|----|----|----|
| SCORE - ALDERETE'S                                   |   |               | TIME: 1717 1819 |        |    |    |    |    |    |
| ABLE TO MOVE 4 EXTREMITIES VOLUNTARILY OR ON COMMAND | 2 | ACTIVITY      | 46              | 46     | 14 | 14 |    |    |    |
| ABLE TO MOVE 2 EXTREMITIES VOLUNTARILY OR ON COMMAND | 1 |               |                 |        |    |    |    |    |    |
| ABLE TO MOVE 0 EXTREMITIES                           | 0 |               |                 |        |    |    |    |    |    |
| ABLE TO DEEP BREATHE & COUGH FREELY                  | 2 | RESPIRATION   | 22              | 22     | 2  | 2  |    |    |    |
| DYSPNEA OR LIMITED BREATHING                         | 1 |               |                 |        |    |    |    |    |    |
| APNEA                                                | 0 |               |                 |        |    |    |    |    |    |
| BP $\pm$ 20 OF PREANESTHESIA LEVEL                   | 2 | CIRCULATION   | 22              | 22     | 2  | 2  |    |    |    |
| BP $\pm$ 20 - 50 OF PREANESTHESIA LEVEL              | 1 |               |                 |        |    |    |    |    |    |
| BP $\pm$ 50 OF PREANESTHESIA LEVEL                   | 0 |               |                 |        |    |    |    |    |    |
| FULLY AWAKE                                          | 2 | CONSCIOUSNESS | 22              | 22     | 2  | 2  |    |    |    |
| AROUSABLE                                            | 1 |               |                 |        |    |    |    |    |    |
| NOT RESPONDING                                       | 0 |               |                 |        |    |    |    |    |    |
| O2 SAT GREATER THAN 92% R/A                          | 2 | COLOR         | 22              | 22     | 2  | 2  |    |    |    |
| 92% ON O2                                            | 1 |               |                 |        |    |    |    |    |    |
| LESS THAN 92% ON O2                                  | 0 |               |                 |        |    |    |    |    |    |
| TOTALS                                               |   |               | 22              | 22     | 2  | 2  |    |    |    |
| INITIALS                                             |   |               | [Signatures]    |        |    |    |    |    |    |

| TIME | LEVEL | COMMENTS |
|------|-------|----------|
|      |       |          |
|      |       |          |
|      |       |          |
|      |       |          |
|      |       |          |
|      |       |          |
|      |       |          |
|      |       |          |

☐ If applicable



### INTERVENTIONS

|                             |                                     |
|-----------------------------|-------------------------------------|
| Side Rails Up               | <input checked="" type="checkbox"/> |
| Alarms On/Audible           | <input checked="" type="checkbox"/> |
| Warm Blankets               | <input checked="" type="checkbox"/> |
| Warming Device              | <input checked="" type="checkbox"/> |
| Cold Pack                   | <input type="checkbox"/>            |
| Elevation                   | <input type="checkbox"/>            |
| Sequential                  | <input type="checkbox"/>            |
| TEDS                        | <input type="checkbox"/>            |
| Turning                     | <input checked="" type="checkbox"/> |
| Deep Breathing and Coughing | <input checked="" type="checkbox"/> |
| MuniNeb                     | <input type="checkbox"/>            |

|                                    |                                     |
|------------------------------------|-------------------------------------|
| Patient Identified as Fall Risk    | <input type="checkbox"/>            |
| Safety Belt Applied                | <input type="checkbox"/>            |
| Patient Wearing Fall Risk Bracelet | <input type="checkbox"/>            |
| PCA                                | <input type="checkbox"/>            |
| Epidural                           | <input type="checkbox"/>            |
| X-Ray                              | <input checked="" type="checkbox"/> |
| EKG                                | <input type="checkbox"/>            |
| Other                              | <input type="checkbox"/>            |
| Other                              | <input type="checkbox"/>            |

### DISCHARGE EVALUATION

|                                                   |                                                                            |
|---------------------------------------------------|----------------------------------------------------------------------------|
| Awake/Arousable                                   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |
| Respirations Full/Regular                         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |
| Dressings                                         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |
| Drains Patent & Secured                           | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No        |
| Vital Signs Stable                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |
| Post-Op Orders Reviewed                           | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |
| Patients pain was managed and medicated as needed | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |
| IV Site(s) <u>RT 20g hand</u>                     | Patent <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Last Narcotic Given <u>Fentanyl 0.5g IV</u>       |                                                                            |
| Discharge RN <u>Glance</u>                        | Time <u>1710</u>                                                           |

|                                    |                    |
|------------------------------------|--------------------|
| O2 Therapy <u>Roomies</u>          | O2 SAT <u>100%</u> |
| Report Given to:                   |                    |
| Pain Level @ discharge <u>5/10</u> |                    |
| Comments:                          |                    |
| Discharge to <u>Home</u>           | Time               |
| Via <u>Wheelchair</u>              | Monitor <u>SR</u>  |
| Discharge MD                       | Time               |

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PACU FLOWSHEET

BENTON, ALONZO  
DOB: 11/12/1958 58Y M  
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# PROGRESS DOCUMENTATION

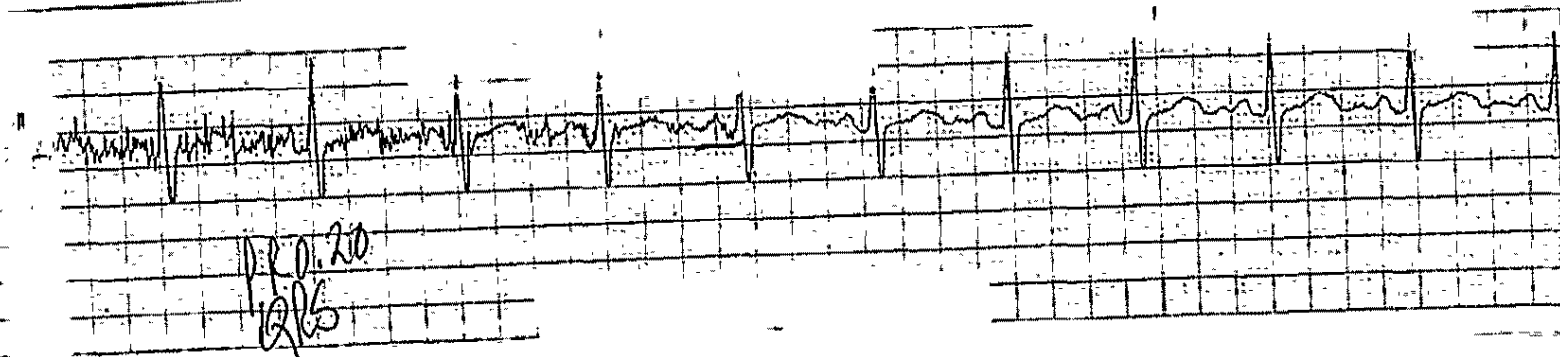
1830 Patient received awake, morning;  
 prior 10/10, given delayed 0.5g IV X 5  
 doses, pain full scale to 5/10 dressing, wound  
 given discharge instructions, with prescription  
 discontinued the stock given in pack &  
 supplies for dressing changes, burn is  
 rhythm on monitor 0 - 100% for RN -

(RAI) 2  
 12 C: 1/19  
 No Patient Admitted

HR 75 bpm  
 PVC 0 /min  
 SpO2 100 %  
 Pulse 73 bpm  
 Perf 0.70  
 HBP  
 RR

1 mV 0.5-40 Hz Non-Paced

ABP (Not available)



Nurse's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Mercy Philadelphia Hospital  
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PACU FLOWSHEET

BENTON, ALONZO

DOB: 11/12/1958 58Y M

Adm: 10/12/2017

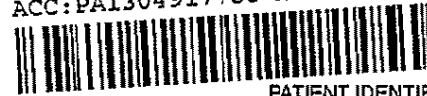
Acc: PA1304917733 MR#: M000301370



☐ MERCY FITZGERALD HOSPITAL  
☐ MERCY HOSPITAL OF PHILADELPHIA  
☐ MERCY SUBURBAN HOSPITAL

**OUTPATIENT MEDICATION  
RECONCILIATION AND  
DISCHARGE INSTRUCTIONS FORM**

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 10/12/17  
ACC: PA1304917733 MR: M000301370



PATIENT IDENTIFICATION

|                                 |                              |                                                                              |  |                                  |  |                                |  |
|---------------------------------|------------------------------|------------------------------------------------------------------------------|--|----------------------------------|--|--------------------------------|--|
| <b>Allergies (Food and Med)</b> | <b>Reaction/Side Effects</b> | Latex sensitive? <input type="checkbox"/> Yes <input type="checkbox"/> No    |  | Discharged To:                   |  | <b>Discharge Instructions:</b> |  |
| <i>clotene</i>                  |                              | Allergic to dyes? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  | <input type="checkbox"/> Home    |  |                                |  |
|                                 |                              | Allergic to iodine? <input type="checkbox"/> Yes <input type="checkbox"/> No |  | <input type="checkbox"/> Nursing |  |                                |  |
|                                 |                              | <input type="checkbox"/> Unknown                                             |  | <input type="checkbox"/> Trans.  |  |                                |  |
|                                 |                              |                                                                              |  | <input type="checkbox"/> Other   |  | <input type="checkbox"/> W/C   |  |
|                                 |                              |                                                                              |  | <input type="checkbox"/> Amb     |  |                                |  |

|                                                                                                                                                       |                                                                       |             |              |              |           |                          |      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------|--------------|--------------|-----------|--------------------------|------|
| List all medicines taken at home:<br>(Prescriptions, over the counter,<br>herbals, patches, inhalers,<br>eye drops & supplements)<br><b>Drug Name</b> | Use laymen's terms (oral, inject,<br>Daily, twice a day, bedtime etc) |             |              | Last dose    |           | Discharge<br>Initial ONE |      |
|                                                                                                                                                       | Dose                                                                  | Route       | Frequency    | Date         | Time      | Cont                     | Stop |
| <i>Lasix</i>                                                                                                                                          | <i>20 mg</i>                                                          | <i>P.O.</i> | <i>daily</i> | <i>10/12</i> | <i>PM</i> |                          |      |
| <i>HCTZ</i>                                                                                                                                           | <i>12.5 mg</i>                                                        | <i>P.O.</i> | <i>daily</i> | <i>10/12</i> | <i>AM</i> |                          |      |
| <i>Ono-prolole</i>                                                                                                                                    | <i>20 mg</i>                                                          | <i>P.O.</i> | <i>daily</i> | <i>10/12</i> | <i>AM</i> |                          |      |
| <i>Keep things in place</i>                                                                                                                           |                                                                       |             |              |              |           |                          |      |
| <i>No use left arm</i>                                                                                                                                |                                                                       |             |              |              |           |                          |      |
| <i>Change dressings daily after 8:30 AM</i>                                                                                                           |                                                                       |             |              |              |           |                          |      |

|                                                                                                                    |                                      |                                                                                                                                                    |  |
|--------------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input checked="" type="checkbox"/> I have reviewed the patient's medications and reconciled.                      |                                      | I, the outpatient physician have reviewed your medications on this visit. All medications continued will remain managed by the prescribing doctor. |  |
| Date: _____ Time: _____ Physician's signature: _____                                                               | Physician Signature: <i>10/12/17</i> |                                                                                                                                                    |  |
| <b>NEW MEDS OR CHANGES IN MEDS FOR DISCHARGE</b><br>Use Laymen's Terms (daily, twice a day, at bedtime etc)        |                                      | Date/Time: <i>6:20 PM</i>                                                                                                                          |  |
| <i>Keep things in place</i>                                                                                        |                                      |                                                                                                                                                    |  |
| <i>Per doctor's orders, take 2 up to 3 pills</i>                                                                   |                                      |                                                                                                                                                    |  |
| Other Instructions: <i>Keep things in place</i>                                                                    |                                      |                                                                                                                                                    |  |
| I, _____ have had the instructions discussed with me, understand them, and have no further questions at this time. |                                      |                                                                                                                                                    |  |
| Patient Signature: <i>Alonzo Benton</i>                                                                            | Family Member                        |                                                                                                                                                    |  |
| Nurse's Signature: <i>[Signature]</i>                                                                              | Physician                            |                                                                                                                                                    |  |

# CONSENT FOR HOSPITAL TREATMENT AND SERVICES

PATIENT NAME: BENTON, ALONZO

- I have presented myself for treatment and/or admission on 10/12/17 (date). I consent to routine medical care and treatment, including diagnostic procedures and blood tests, and to such emergency or additional care as may be deemed necessary, which will be provided by the Hospital and by my Attending Physician, his/her assistants and/or designees. The use of telemedicine technology may be included in the diagnostic process of my care.
- I understand that, except for emergency situations, this consent does not include operations and non-routine procedures or treatment. I may be asked to consent to such operations and procedures after the risks and alternatives have been explained to me by my Attending Physician or by another physician.
- I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in the Hospital.
- I realize that I have the right to refuse any drugs, treatment or procedures to the extent permitted by law. If such treatments or procedures are my reason for hospitalization, refusal may result in discharge.
- I hereby authorize the Hospital to photograph my face for purposes of identification and camera monitoring as indicated. In addition, I authorize the Hospital to take photographs for clinical purposes as part of the diagnostic/treatment documentation process.
- In the event that the results of my diagnostic studies or procedures indicate the need for further coordination of care, the hospital's patient care coordinator may be notified of my results, as deemed appropriate, so as to assist me with further diagnostic and/or treatment options.
- I consent to the release of such information from my medical records as may be required by my health insurance company for the processing of claims for hospital or medical benefits, except for records containing mental health, drug and alcohol information. In these cases a separate written consent will be required. I consent to release medical information to any medical care provider for the purpose of continuity of care/discharge planning. I consent to the use of my medical information for research when federal law allows such use without my specific consent.
- I understand the Hospital will not be liable for loss of or damage to any money or personal property.
- I hereby assign to the Hospital payment of all hospital and insurance benefits otherwise payable to me or for my benefit in connection with my treatment and/or hospitalization.
- In consideration of the care and services to be furnished to me, I undertake and promise to pay for these services (to the extent that the charges are not covered by any insurance benefits) in accordance with Hospital terms and usual and customary charges.
- The professional services of physicians are billed separately from the hospital bill, such as the departments of Anesthesia, Pathology, Emergency, Radiology, Neurology, Cardiology, and Physician Medicine.
- (Managed Care Patients Only) A law was passed in Pennsylvania in 1998 called "Act 68" or the "Quality Health Care Accountability and Protection Act." This law allows you to give the Hospital consent to seek payment from your health insurance company for health care you received for the Hospital if your health insurance company (a) denies payment; (b) limits the scope of services; (c) only pays for a shorter stay in the hospital; or (d) only pays for an alternative service than the one you received. When a hospital seeks payment from a health insurance company it is called a "grievance". I hereby give consent to the Hospital (and/or its designees) to file a grievance on my behalf, including requesting an appeal of any decision by my health insurance company. If the Hospital files a grievance for me, all costs related to the grievance will be paid by the Hospital. I also understand and agree that (1) I will not file a grievance with my health insurance company unless I withdraw my consent in writing; (2) I have the right to rescind this consent at any time during the grievance process; and (3) my consent will be automatically rescinded if the Hospital does not file a grievance.
- (Medicare Patients Only) - Certification, Authorization to Release Information, and Payment Requests. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize the release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I will either assign any such benefits to be paid directly to the Hospital or to the physician or organization furnishing the services or authorize the Hospital or such physician or organization to submit a claim to Medicare on my behalf, for payment.
- I understand that Hospital, including their business associates, may contact me by telephone at any telephone number I have provided or that is associated with my record, including cell phone numbers, which could result in charges to me. Hospital may also contact me by sending text messages or e-mails, using the contact information provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I am the patient or the person authorized to give consent for the patient. My signature certifies that I have read and understood this consent and that any questions have been answered to my satisfaction.

Signature of Patient: [Signature] Date/Time: 10/12/17 Witness to Signature: [Signature] Date/Time: 10/12/17

If Patient is a minor or incompetent/unable to give consent

Signature of Person authorized to give consent: \_\_\_\_\_ Date/Time: \_\_\_\_\_ Address: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Witness: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Patient Rights and Responsibilities ☐ I have received the Patient Rights and Responsibilities form (40M)

## Hospital Directory

The hospital directory contains your name, room number and general condition. It can be used to direct visitors, flower deliveries and phone callers to you. ☐ I want to be included in the directory ☐ I do not want to be included in the directory

Patient's Email Address: \_\_\_\_\_

## Notice of Privacy Practices

The Notice of Privacy Practices explains how your Protected Health Information (medical and demographic information about you) may be used or disclosed. ☐ I have received the Notice of Privacy Practices.

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

Mercy Philadelphia Hospital  
A member of Mercy Health System

CONSENT FOR HOSPITAL TREATMENT AND SERVICES

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 10/12/17  
ACC: FA1304917733 MR: M000301370



Page 1 of 1  
Form AD404, Rev. 08/2015  
CST-X TREAT



**MERCY HEALTH SYSTEM**  
**CONSENT TO SURGICAL/DIAGNOSTIC/THERAPEUTIC PROCEDURES**

PATIENT: \_\_\_\_\_

Alonzo Benton

DATE: \_\_\_\_\_

10/6/17

TIME: \_\_\_\_\_

4:15

AM/PM (PM)

**A. EXPLANATION:** (To be filled in by physician. Cross out any paragraphs that do not apply.)

1. I authorized Dr. Meller, and his/her assistants or associates to perform upon me the following surgical/diagnostic or therapeutic procedure ("procedure"):  
(List specific nature of procedure to be performed)

Hardware Removal left Shoulder  
Meller and Debridement/Wound Revision

2. Dr. \_\_\_\_\_ has explained to me and I understand the nature and purpose of the procedure. I also understand the following:

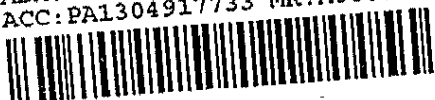
a. That there are some risks and there can be complications associated with this procedure, including but not necessarily limited to:

b. Alternatives to the proposed procedure, including doing nothing, and their risks have been explained to me.

3. I have been told that, in addition to the risks set forth in Item 2(a) above, there are other risks, such as severe loss of blood, infection, heart stoppage, etc., associated with any surgical procedure. I am also aware that the practice of medicine and surgery is not an exact science, that there is no certainty that the described benefits will be achieved and I acknowledge that no guarantees or assurances have been made to me concerning the outcome.
4. I have had sufficient opportunity to discuss my condition and treatment with Dr. Meller and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge to consent to the proposed procedure, and I consent voluntarily and freely.
5. I understand that my doctor will be assisted by other health professionals of Mercy Health System, and such others as my doctor considers necessary in my care.
6. I understand that unforeseen conditions may arise or be revealed during the course of the procedure which may require an extension of the procedure, the performance of procedures in addition to or different from those now contemplated or termination of the procedure. In such a situation, I authorize my doctor and his/her assistants to change or terminate the procedure and/or to perform such procedures as are deemed necessary and desirable in the exercise of their professional judgment.
7. There are no limitations on my consent except the following: (If none, so state) None
8. I permit Mercy Health System to use any tissue samples (biopsies) of my body taken during the procedure for microscopic examination and for scientific teaching purposes except as noted here:

9. I consent to the examination, photographic study and disposal of any bodily tissues or parts which may be removed during the course of my procedure.

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 10/12/17  
ACC: PA1304917733 MR: M000301370



- ☐ Mercy Fitzgerald Hospital  
☒ Mercy Hospital of Philadelphia  
☐ Mercy Community Hospital

**CONSENT TO**  
**SURGICAL/DIAGNOSTIC/THERAPEUTIC**  
**PROCEDURES**

Alonso Benitez  
Signature of Patient

**Witness to Signature of Patient**

Signature of Person authorized to give consent

### Relationship to Patient

Date: \_\_\_\_\_

**Witness**

Physician

Date: 11/11/78

PROCEDURE: NOTE \_\_\_\_\_

PROCEDURE: \_\_\_\_\_

REASON FOR PROCEDURE: \_\_\_\_\_

BENTON, ALONZO  
DOB: 11/12/1958  
ADM: 10/12/17  
ACC: PA1304917733 58 M  
MR: M000301370

DESCRIPTION OF PROCEDURE: \_\_\_\_\_

# CONSENT FOR HOSPITAL TREATMENT AND SERVICES

PATIENT NAME: BENTON, ALONZO

- I have presented myself for treatment and/or admission on 10/12/17 (date). I consent to routine medical care and treatment, including diagnostic procedures and blood tests, and to such emergency or additional care as may be deemed necessary, which will be provided by the Hospital and by my Attending Physician, his/her assistants and/or designees. The use of telemedicine technology may be included in the diagnostic process of my care.
- I understand that, except for emergency situations, this consent does not include operations and non-routine procedures or treatment. I may be asked to consent to such operations and procedures after the risks and alternatives have been explained to me by my Attending Physician or by another physician.
- I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in the Hospital.
- I realize that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law. If such treatments or procedures are my reason for hospitalization, refusal may result in discharge.
- I hereby authorize the Hospital to photograph my face for purposes of identification and camera monitoring as indicated. In addition, I authorize the Hospital to take photographs for clinical purposes as part of the diagnostic/treatment documentation process.
- In the event that the results of my diagnostic studies or procedures indicate the need for further coordination of care, the hospital's patient care coordinator may be notified of my results, as deemed appropriate, so as to assist me with further diagnostic and/or treatment options.
- I consent to the release of such information from my medical records as may be required by my health insurance company for the processing of claims for hospital or medical benefits, except for records containing mental health, drug and alcohol information. In these cases a separate written consent will be required. I consent to release medical information to any medical care provider for the purpose of continuity of care/discharge planning. I consent to the use of my medical information for research when federal law allows such use without my specific consent.
- I understand the Hospital will not be liable for loss of or damage to any money or personal property.
- I hereby assign to the Hospital payment of all hospital and insurance benefits otherwise payable to me or for my benefit in connection with my treatment and/or hospitalization.
- In consideration of the care and services to be furnished to me, I undertake and promise to pay for these services (to the extent that the charges are not covered by any insurance benefits) in accordance with Hospital terms and usual and customary charges.
- The professional services of physicians are billed separately from the hospital bill, such as the departments of Anesthesia, Pathology, Emergency, Radiology, Neurology, Cardiology, and Physician Medicine.
- (Managed Care Patients Only) A law was passed in Pennsylvania in 1998 called "Act 68" or the "Quality Health Care Accountability and Protection Act." This law allows you to give the Hospital consent to seek payment from your health insurance company for health care you received for the Hospital if your health insurance company (a) denies payment; (b) limits the scope of services; (c) only pays for a shorter stay in the hospital; or (d) only pays for an alternative service than the one you received. When a hospital seeks payment from a health insurance company it is called a "grievance". I hereby give consent to the Hospital (and/or its designee) to file a grievance on my behalf, including requesting an appeal of any decision by my health insurance company. If the Hospital files a grievance for me, all costs related to the grievance will be paid by the Hospital. I also understand and agree that (1) I will not file a grievance with my health insurance company unless I withdraw my consent in writing; (2) I have the right to rescind this consent at any time during the grievance process, and (3) my consent will be automatically rescinded if the Hospital does not file a grievance.
- (Medicare Patients Only) - Certification, Authorization to Release Information, and Payment Requests. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize the release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I will either assign any such benefits to be paid directly to the Hospital or to the physician or organization furnishing the services or authorize the Hospital or such physician or organization to submit a claim to Medicare on my behalf, for payment.
- I understand that Hospital, including their business associates, may contact me by telephone at any telephone number I have provided or that is associated with my record, including cell phone numbers, which could result in charges to me. Hospital may also contact me by sending text messages or e-mails, using the contact information provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.  
I am the patient or the person authorized to give consent for the patient. My signature certifies that I have read and understood this consent and that any questions have been answered to my satisfaction.

Alonzo Benton  
Signature of Patient

10/12/17  
Date/Time

[Signature]  
Witness to Signature

10/12/17 11:40  
Date/Time

If Patient is a minor or incompetent/unable to give consent

Signature of Person authorized to give consent

Date/Time

Address

Relationship to Patient

Witness

Date/Time

Patient Rights and Responsibilities

☐ I have received the Patient Rights and Responsibilities form (40M)

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Mercy Philadelphia Hospital  
A member of Mercy Health System

CONSENT FOR HOSPITAL TREATMENT AND SERVICES

BENTON, ALONZO

DOB: 11/12/1958 58 M

ADM: 10/12/17

ACC: PA1304917733 MR: M000301370

Patient

Alonzo Benton

I acknowledge that my doctor has explained to me that I will have an operation, treatment, or procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments, and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that I would experience much less pain, discomfort, or anxiety during my planned operation or procedure.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my anesthesia, procedure, or treatment. Although rare, severe and unexpected complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack, cardiac arrest, or death. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified as they may apply to a specific type of anesthesia.

I understand that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor will do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthetic technique which involves the use of local anesthetics may not succeed completely and therefore, another technique may have to be used, including general anesthesia. Furthermore, I understand that while I am receiving anesthesia, conditions may develop which require modifying or extending this consent. I therefore authorize modifications or extension of this consent that professional judgment indicates to be necessary under the circumstances.

|                                                                                                                                                                                                                                |                  |                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> General Anesthesia                                                                                                                                                                         | Expected Results | Total unconscious state, possible placement of breathing tube into throat or wind pipe                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                | Techniques       | Drug injected into the bloodstream, breathed into the lungs, or by other routes                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                | Risks            | Mouth, throat, or jaw pain, hoarseness, injury to mouth, gums, lips, or teeth, awareness under anesthesia, injury to blood vessels or nerves, aspiration of stomach contents into lungs, pneumonia, nausea and vomiting, muscle soreness, injury to the eyes                                                           |
| <input type="checkbox"/> Spinal or Epidural Anesthesia or Analgesia with IV sedation                                                                                                                                           | Expected Results | Temporarily decreased or total loss of feeling and/or movement to lower part of the body                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                | Techniques       | Drug injected through a needle/catheter placed either directly into the spinal fluid (spinal) or immediately outside this space (epidural)                                                                                                                                                                             |
|                                                                                                                                                                                                                                | Risks            | Headache, backache, infection, persistent weakness or numbness, decreased blood pressure, residual pain, injury to blood vessels or nerves, unexpected high level of spinal anesthetic block (causing upper body weakness or numbness), local anesthetic toxicity causing sudden drop in blood pressure or convulsions |
| <input type="checkbox"/> Nerve Block Anesthesia or Analgesia with IV sedation                                                                                                                                                  | Expected Results | Temporary loss of feeling and/or movement of a specific limb or area                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                | Techniques       | Drug injected near nerves, providing loss of sensation to the area of the operation                                                                                                                                                                                                                                    |
| <input type="checkbox"/> Axillary block<br><input type="checkbox"/> Interscalene block<br><input type="checkbox"/> Femoral nerve block<br><input type="checkbox"/> IV-regional (Bier block)<br><input type="checkbox"/> Other: | Risks            | Infection, convulsions, persistent weakness or numbness, residual pain, soreness at injection site, injury to blood vessels or nerves, local anesthetic toxicity causing sudden drop in blood pressure or convulsions                                                                                                  |
| <input type="checkbox"/> Monitored Anesthesia Care (local anesthesia with IV sedation)                                                                                                                                         | Expected Results | Reduced anxiety and pain, partial or total amnesia                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                | Techniques       | Drug injected into the bloodstream, breathed into the lungs, or by other routes producing a semi-conscious state                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                | Risks            | An unconscious state, depressed breathing                                                                                                                                                                                                                                                                              |

I certify that I have, to the best of my ability, told the anesthesiologist obtaining consent of all major illnesses I have had, of all past anesthetics I have received and any complications of these anesthetics known to me, of any drug allergies I have, and of all medications I have recently taken, including aspirin, over-the-counter medications, pain medications, herbal supplements, and recreational street drugs. I have also responded truthfully to any additional questions asked by the anesthesiologist.

I understand that my anesthesia care will be given to me by or under the supervision of an attending anesthesiologist. Knowing that Mercy Philadelphia Hospital is a teaching institution, I understand that along with my anesthesiologist and certified registered nurse anesthetist, other medical center personnel, such as student anesthetists, interns, residents, and other trainees, may be involved in my anesthesia care.

If I am pregnant, I understand that elective surgery should be postponed until after the baby is born. Although fetal complications of anesthesia during pregnancy are very rare, the risks to my baby include, but are not limited to, birth defects, premature labor, permanent brain damage and death of my newborn.

I have listened to Andy Rite CRNA/Anesthesiologist explain the type(s) of anesthesia/analgesia I may receive, its benefits, and common foreseeable risks and consequences, as well as those of its alternatives, and now accept his or her recommendation with the EXCEPTION of (check one):

Type of Anesthesia refused \_\_\_\_\_

☐ No exception to anesthetic recommendations

By signing this consent form, I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives, and expected results of the chosen anesthetic(s), and that I have had ample opportunity to ask questions and consider my decision. I agree to the above provisions, and hereby consent to the administration of the above checked anesthesia services for my operation, treatment, or procedure. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by the Anesthesiologist.

Signature of Patient

Alonzo Benton

Date/Time 10/12/17 1600

Signature of Patient's Guardian or POA \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

PHYSICIAN/CRNA CERTIFICATION: I have personally explained the above information to the patient, or the patient's representative if the patient is incompetent to consent.

Physician/CRNA

[Signature]

Date/Time 10/12/17 1600

CONSENT TO ANESTHESIA

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 10/12/17  
ACC: PA1304917733 MR: M000301370



DATE: 10/24/17 @ 1532      Mercy Philadelphia Hospital ABS \*LIVE\*      PAGE 1  
USER: COQUINNM      ATTESTATION STATEMENT

NAME: BENTON, ALONZO      ACCT #: PA1304917733

ADM DATE: 10/12/17      UNIT #: M000301370  
ATTEND PHYS: MELLER, MENACHEM M, MD      SEX: M  
DIS DATE: 10/12/17      AGE: 58  
DISCH DISP: HOME, SELF-CARE      DOB: 11/12/1958  
LOS: 1      FIN CLASS: MCRMNG  
PT CLASS: SDC      ABS STATUS: FINAL

DIAGNOSES:  
ADMIT: T84.84XA      PAIN DUE TO INTERNAL ORTHOPEDIC PROSTH DEV/GRFT, INIT      POA?  
PRINC: T84.84XA      PAIN DUE TO INTERNAL ORTHOPEDIC PROSTH DEV/GRFT, INIT  
SECOND: K21.9      GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS  
I10      ESSENTIAL (PRIMARY) HYPERTENSION

OPERATIONS:  
10/12/17 0XP70YZ      REMOVAL OF OTHER DEVICE FROM L UP EXTREM, OPEN APPROACH      B1

CPTS:  
10/12/17 20680      REMOVAL OF SUPPORT IMPLANT

DRG:  
STATUS      \$ REIMB      MIN-LOS      MAX-LOS      STD-LOS      GRP VERS      GRP FC  
35      MCRMNG

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

DATE: \_\_\_\_\_

DATE: 11/10/17 @ 0100  
USER: MT

Mercy Philadelphia Hospital AOM \*LIVE\*  
Ambulatory Prescriptions and Procedures

PAGE 1

|                                         |                                            |
|-----------------------------------------|--------------------------------------------|
| Patient Name: BENTON, ALONZO            | Admission/Registration Date: 10/12/17      |
| Unit Number: M000301370                 | Discharge Date: 10/12/17                   |
| Account Number: PA1304917733            | Admitting Physican:                        |
| Date of Birth: 11/12/1958 Age/Sex: 58 M | Attending Physican: MELLER, MENACHEM M. MD |

Preferred Pharmacy: \*Do Not ePrescribe - PRINT , PA  
Phone: Fax:  
Mail Order: LTC: Specialty: 24Hrs: eRx: EPCS:

#### Prescriptions

Claritin (Loratadine) 10 Mg Capsule  
10 MG ORAL DAILY 30 Days  
Rx# 0000000004 Days: 30 Refills: 0 CAPSULE  
Entered Date: Oct 21, 2015 Compound Med: No  
Ordering Provider: MOHASA01 Location: PH6NW  
Diagnosis:

Losartan Potassium (Losartan Potassium) 50 Mg Tablet  
50 MG ORAL DAILY 30 Days  
Rx# 0000001916 Days: 30 Refills: 0  
Entered Date: Oct 23, 2015 Compound Med: No  
Ordering Provider: BABAFA Location: PH6NW  
Diagnosis:

Pantoprazole Sodium (Pantoprazole Sodium) 20 Mg Tablet.dr  
40 MG ORAL DAILY , #30 TABLET.DR  
Rx# 0000001918 Qty: 30 Refills: 0 TABLET  
Entered Date: Oct 23, 2015 Compound Med: No  
Ordering Provider: BABAFA Location: PH6NW  
Diagnosis:

#### Referrals

Gastroenterology Ref  
In 7 Days  
To Practice:  
To Provider: Danilewitz, Mervyn, Md  
Referral Authorization Date:  
Referral Expiration Date:  
Referral Type:  
Diagnosis:  
# OF VISITS: Active Babar, Fatima, Md



PHILADELPHIA, PA 19143

N

# OUTPATIENT RECORD

Account No: PA1304854506

Date: 09/15/17

Time: 1000

Unit No: M000301370

## PATIENT INFORMATION

|                            |                     |         |                    |
|----------------------------|---------------------|---------|--------------------|
| Name: BENTON, ALONZO       | DOB: 11/12/1958     | AGE: 58 | Pt Status: SCH CLI |
| Address: 2432 S FRAZIER ST | SEX: M              | MS: S   | LOC/Srve: PHRAD    |
|                            | RACE: AA            |         | Room/Bed:          |
| PHILADELPHIA, PA 19143     | LANG: ENGLISH       |         | Accommodation:     |
| Phone: (215) 403-5705      | ADM Src/Prior: /    |         | Last DC Date:      |
| SSN: XXX-XX-9216           | Religion: CHRISTIAN |         |                    |
|                            | Church:             |         |                    |

Occurrence Code:

Occurrence Date:

## PHYSICIAN INFORMATION

Admitting Physician

Attending or ER Physician

Primary Care Physician

MELLER, MENACHEM M, MD  
(215) 746-9822

BARDEN, ABA, MD  
(215) 662-9900

Att Group: MHOP ORTHOPEDICS

## NEXT OF KIN

Name: BENTON, APRIL  
Addr: UNKNOWN

PHILADELPHIA, PA 19143  
Phone: (267) 905-4367  
Other:  
Relat: DAUGHTER

## PERSON TO NOTIFY

Name: BENTON, APRIL  
Addr: UNKNOWN

PHILADELPHIA, PA 19143  
Phone: (267) 905-4367  
Other:  
Relat: DAUGHTER

## EMPLOYER INFORMATION

Name: UNEMPLOYED  
Addr: NONE  
PHILADELPHIA, PA 19143  
Phone: (215) 000-0000

## GUARANTOR INFORMATION

Name: BENTON, ALONZO  
Addr: 2432 S FRAZIER ST  
PHILADELPHIA, PA 19143  
Phone: (215) 403-5705  
SSN: XXX-XX-9216  
Relat: SELF / SAME AS

Emp: UNEMPLOYED  
Addr: NONE  
PHILADELPHIA, PA 19143  
Phone: (215) 000-0000  
Status: UE

## INSURANCE INFORMATION

Financial Class: MCRMNG

GATEWYMCR  
Pri: GATEWAY MEDICARE ASSUR  
Addr: PO BOX 69359

INS#2:  
Addr:

INS#3:  
Addr:

HARRISBURG PA 17106-  
Phone:  
Policy#: 70113084  
Group#:  
A#: NPR  
Subscrib: BENTON, ALONZO  
Sub Emp: UNEMPLOYED  
Relation: SP  
Status: PENDING

Phone:  
Policy#:  
Group#:  
A#:  
Subscrib: BENTON, ALONZO  
Sub Emp:  
Relation:  
Status:

Phone:  
Policy#:  
Group#:  
A#:  
Subscrib:  
Sub Emp:  
Relation:  
Status:

INS#4:

Reason For Visit: AGE-RELATED OSTEOPOROSIS W/O CURRENT PATHOLOGICAL

Comment:

ISOLATION:

CO-Pay Collected:

Mode of Arrival:

Registration Clerk:

Email: N/A

Proc: DEXA BONE DENSITY

Phys name: MENACHEM M MELLER MD

Service date:

Res Taken: 09/12/17 1448 Res Date: 09/15/17 1000

Ref Phys:

Other phone:

Privacy Notice Given?: Y (Date: 09/12/17)

COB Signed/Verified:

## OUTPATIENT RECORD

|                                                                            |  |                                          |  |                                 |                                   |                            |  |
|----------------------------------------------------------------------------|--|------------------------------------------|--|---------------------------------|-----------------------------------|----------------------------|--|
| <b>Account No:</b> PA1304854506                                            |  | <b>Date:</b> 09/15/17                    |  | <b>Time:</b> 1000               |                                   | <b>Unit No:</b> M000301370 |  |
| <b>PATIENT INFORMATION</b>                                                 |  |                                          |  |                                 |                                   |                            |  |
| <b>Name:</b> BENTON,ALONZO                                                 |  | <b>DOB:</b> 11/12/1958                   |  | <b>AGE:</b> 58                  |                                   | <b>Pt Status:</b> PRE CLI  |  |
| <b>Address:</b> 2432 S FRAZIER ST                                          |  | <b>SEX:</b> M                            |  | <b>MS:</b> S                    |                                   | <b>LOC/Srve:</b> PHRAD     |  |
| PHILADELPHIA, PA 19143                                                     |  | <b>RACE:</b> AA                          |  | <b>Room/Bed:</b>                |                                   | <b>Accommodation:</b>      |  |
| <b>Phone:</b> (215) 403-5705                                               |  | <b>LANG:</b> ENGLISH                     |  | <b>ADM Src/Prior:</b> PHY /EL   |                                   | <b>Last DC Date:</b>       |  |
| <b>SSN:</b> XXX-XX-9216                                                    |  | <b>Religion:</b> CHRISTIAN               |  | <b>Church:</b>                  |                                   |                            |  |
| <b>Occurrence Code:</b> 11 <b>Occurrence Date:</b> 09/13/17                |  |                                          |  |                                 |                                   |                            |  |
| <b>PHYSICIAN INFORMATION</b>                                               |  |                                          |  |                                 |                                   |                            |  |
| <b>Admitting Physician</b>                                                 |  | <b>Attending or ER Physician</b>         |  |                                 | <b>Primary Care Physician</b>     |                            |  |
|                                                                            |  | MELLER, MENACHEM M, MD<br>(215) 746-9822 |  |                                 | BARDEN, ABA, MD<br>(215) 662-9900 |                            |  |
| <b>Att Group:</b> MHOP ORTHOPEDICS                                         |  |                                          |  |                                 |                                   |                            |  |
| <b>NEXT OF KIN</b>                                                         |  |                                          |  | <b>PERSON TO NOTIFY</b>         |                                   |                            |  |
| <b>Name:</b> BENTON, APRIL                                                 |  |                                          |  | <b>Name:</b> BENTON, APRIL      |                                   |                            |  |
| <b>Addr:</b> UNKNOWN                                                       |  |                                          |  | <b>Addr:</b> UNKNOWN            |                                   |                            |  |
| PHILADELPHIA, PA 19143                                                     |  |                                          |  | PHILADELPHIA, PA 19143          |                                   |                            |  |
| <b>Phone:</b> (267) 905-4367                                               |  |                                          |  | <b>Phone:</b> (267) 905-4367    |                                   |                            |  |
| <b>Other:</b>                                                              |  |                                          |  | <b>Other:</b>                   |                                   |                            |  |
| <b>Relat:</b> DAUGHTER                                                     |  |                                          |  | <b>Relat:</b> DAUGHTER          |                                   |                            |  |
| <b>EMPLOYER INFORMATION</b>                                                |  |                                          |  | <b>GUARANTOR INFORMATION</b>    |                                   |                            |  |
| <b>Name:</b> UNEMPLOYED                                                    |  | <b>Name:</b> BENTON, ALONZO              |  | <b>Emp:</b> UNEMPLOYED          |                                   |                            |  |
| <b>Addr:</b> NONE                                                          |  | <b>Addr:</b> 2432 S FRAZIER ST           |  | <b>Addr:</b> NONE               |                                   |                            |  |
| PHILADELPHIA, PA 19143                                                     |  | PHILADELPHIA, PA 19143                   |  | PHILADELPHIA, PA 19143          |                                   |                            |  |
| <b>Phone:</b> (215) 000-0000                                               |  | <b>Phone:</b> (215) 403-5705             |  | <b>Phone:</b> (215) 000-0000    |                                   |                            |  |
|                                                                            |  | <b>SSN:</b> XXX-XX-9216                  |  | <b>Status:</b> UE               |                                   |                            |  |
|                                                                            |  | <b>Relat:</b> SELF / SAME AS             |  |                                 |                                   |                            |  |
| <b>INSURANCE INFORMATION</b> <b>Financial Class:</b> MCRMNG                |  |                                          |  |                                 |                                   |                            |  |
| <b>GATEWYMCR</b>                                                           |  | <b>INS#2:</b>                            |  | <b>INS#3:</b>                   |                                   |                            |  |
| <b>Pri:</b> GATEWAY MEDICARE ASSUR                                         |  | <b>Addr:</b>                             |  | <b>Addr:</b>                    |                                   |                            |  |
| <b>Addr:</b> PO BOX 69359                                                  |  |                                          |  |                                 |                                   |                            |  |
| HARRISBURG PA 17106-                                                       |  |                                          |  |                                 |                                   |                            |  |
| <b>Phone:</b>                                                              |  | <b>Phone:</b>                            |  | <b>Phone:</b>                   |                                   |                            |  |
| <b>Policy#:</b> 70113084                                                   |  | <b>Policy#:</b>                          |  | <b>Policy#:</b>                 |                                   |                            |  |
| <b>Group#:</b>                                                             |  | <b>Group#:</b>                           |  | <b>Group#:</b>                  |                                   |                            |  |
| <b>A#:</b> NPR                                                             |  | <b>A#:</b>                               |  | <b>A#:</b>                      |                                   |                            |  |
| <b>Subscrib:</b> BENTON, ALONZO                                            |  | <b>Subscrib:</b>                         |  | <b>Subscrib:</b>                |                                   |                            |  |
| <b>Sub Emp:</b> UNEMPLOYED                                                 |  | <b>Sub Emp:</b>                          |  | <b>Sub Emp:</b>                 |                                   |                            |  |
| <b>Relation:</b> SP                                                        |  | <b>Relation:</b>                         |  | <b>Relation:</b>                |                                   |                            |  |
| <b>Status:</b> VERIFIED                                                    |  | <b>Status:</b>                           |  | <b>Status:</b>                  |                                   |                            |  |
| <b>INS#4:</b>                                                              |  |                                          |  |                                 |                                   |                            |  |
| <b>Reason For Visit:</b> AGE-RELATED OSTEOPOROSIS W/O CURRENT PATHOLOGICAL |  |                                          |  |                                 |                                   |                            |  |
| <b>Comment:</b>                                                            |  |                                          |  |                                 |                                   |                            |  |
| <b>ISOLATION:</b>                                                          |  |                                          |  | <b>Privacy Notice Given?:</b> Y |                                   | <b>(Date:</b> 09/12/17)    |  |
| <b>CO-Pay Collected:</b>                                                   |  | <b>Mode of Arrival:</b>                  |  | <b>COB Signed/Verified:</b>     |                                   |                            |  |
| <b>Registration Clerk:</b>                                                 |  |                                          |  |                                 |                                   |                            |  |
| <b>email:</b> N/A                                                          |  |                                          |  | <b>use email:</b>               |                                   |                            |  |



A member of Mercy Health System

P

## OUTPATIENT RECORD

|                                                                            |  |                                  |  |                                                  |                               |                            |  |
|----------------------------------------------------------------------------|--|----------------------------------|--|--------------------------------------------------|-------------------------------|----------------------------|--|
| <b>Account No:</b> PA1304854506                                            |  | <b>Date:</b> 09/15/17            |  | <b>Time:</b> 1139                                |                               | <b>Unit No:</b> M000301370 |  |
| <b>PATIENT INFORMATION</b>                                                 |  |                                  |  |                                                  |                               |                            |  |
| <b>Name:</b> BENTON,ALONZO                                                 |  | <b>DOB:</b> 11/12/1958           |  | <b>AGE:</b> 58                                   |                               | <b>Pt Status:</b> REG CLI  |  |
| <b>Address:</b> 2432 S FRAZIER ST                                          |  | <b>SEX:</b> M                    |  | <b>MS:</b> S                                     |                               | <b>LOC/Srve:</b> PHRAD     |  |
| PHILADELPHIA, PA 19143                                                     |  | <b>RACE:</b> AA                  |  |                                                  |                               | <b>Room/Bed:</b>           |  |
| <b>Phone:</b> (215) 403-5705                                               |  | <b>LANG:</b> ENGLISH             |  |                                                  |                               | <b>Accommodation:</b>      |  |
| <b>SSN:</b> XXX-XX-9216                                                    |  | <b>ADM Src/Prior:</b> PHY /EL    |  |                                                  |                               | <b>Last DC Date:</b>       |  |
|                                                                            |  | <b>Religion:</b> CHRISTIAN       |  |                                                  |                               |                            |  |
|                                                                            |  | <b>Church:</b>                   |  |                                                  |                               |                            |  |
| <b>Occurrence Code:</b> 11                                                 |  | <b>Occurrence Date:</b> 09/15/17 |  |                                                  |                               |                            |  |
| <b>PHYSICIAN INFORMATION</b>                                               |  |                                  |  |                                                  |                               |                            |  |
| <b>Admitting Physician</b>                                                 |  | <b>Attending or ER Physician</b> |  |                                                  | <b>Primary Care Physician</b> |                            |  |
|                                                                            |  | MELLER, MENACHEM M, MD           |  |                                                  | BARDEN, ABA, MD               |                            |  |
|                                                                            |  | (215) 746-9822                   |  |                                                  | (215) 662-9900                |                            |  |
| <b>Att Group:</b> MHOP ORTHOPEDICS                                         |  |                                  |  |                                                  |                               |                            |  |
| <b>NEXT OF KIN</b>                                                         |  |                                  |  | <b>PERSON TO NOTIFY</b>                          |                               |                            |  |
| <b>Name:</b> BENTON, APRIL                                                 |  |                                  |  | <b>Name:</b> BENTON, APRIL                       |                               |                            |  |
| <b>Addr:</b> NOT SURE OF ADDRESS                                           |  |                                  |  | <b>Addr:</b> NOT SURE OF ADDRESS                 |                               |                            |  |
| PHILADELPHIA, PA 19143                                                     |  |                                  |  | PHILADELPHIA, PA 19143                           |                               |                            |  |
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| <b>Other:</b>                                                              |  |                                  |  | <b>Other:</b>                                    |                               |                            |  |
| <b>Relat:</b> DAUGHTER                                                     |  |                                  |  | <b>Relat:</b> DAUGHTER                           |                               |                            |  |
| <b>EMPLOYER INFORMATION</b>                                                |  |                                  |  | <b>GUARANTOR INFORMATION</b>                     |                               |                            |  |
| <b>Name:</b> UNEMPLOYED                                                    |  | <b>Name:</b> BENTON, ALONZO      |  | <b>Emp:</b> UNEMPLOYED                           |                               |                            |  |
| <b>Addr:</b> NONE                                                          |  | <b>Addr:</b> 2432 S FRAZIER ST   |  | <b>Addr:</b> NONE                                |                               |                            |  |
| PHILADELPHIA, PA 19143                                                     |  | PHILADELPHIA, PA 19143           |  | PHILADELPHIA, PA 19143                           |                               |                            |  |
| <b>Phone:</b> (215) 000-0000                                               |  | <b>Phone:</b> (215) 403-5705     |  | <b>Phone:</b> (215) 000-0000                     |                               |                            |  |
|                                                                            |  | <b>SSN:</b> XXX-XX-9216          |  | <b>Status:</b> UE                                |                               |                            |  |
|                                                                            |  | <b>Relat:</b> SELF / SAME AS     |  |                                                  |                               |                            |  |
| <b>INSURANCE INFORMATION</b>                                               |  |                                  |  |                                                  |                               |                            |  |
| <b>Financial Class:</b> MCRMNG                                             |  |                                  |  |                                                  |                               |                            |  |
| <b>GATEWYMCR</b>                                                           |  |                                  |  |                                                  |                               |                            |  |
| <b>Pri:</b> GATEWAY MEDICARE ASSUR                                         |  | <b>INS#2:</b>                    |  | <b>INS#3:</b>                                    |                               |                            |  |
| <b>Addr:</b> PO BOX 69359                                                  |  | <b>Addr:</b>                     |  | <b>Addr:</b>                                     |                               |                            |  |
| HARRISBURG PA 17106-                                                       |  |                                  |  |                                                  |                               |                            |  |
| <b>Phone:</b>                                                              |  | <b>Phone:</b>                    |  | <b>Phone:</b>                                    |                               |                            |  |
| <b>Policy#:</b> 70113084                                                   |  | <b>Policy#:</b>                  |  | <b>Policy#:</b>                                  |                               |                            |  |
| <b>Group#:</b>                                                             |  | <b>Group#:</b>                   |  | <b>Group#:</b>                                   |                               |                            |  |
| <b>A#:</b> NPR                                                             |  | <b>A#:</b>                       |  | <b>A#:</b>                                       |                               |                            |  |
| <b>Subscrib:</b> BENTON, ALONZO                                            |  | <b>Subscrib:</b>                 |  | <b>Subscrib:</b>                                 |                               |                            |  |
| <b>Sub Emp:</b> UNEMPLOYED                                                 |  | <b>Sub Emp:</b>                  |  | <b>Sub Emp:</b>                                  |                               |                            |  |
| <b>Relation:</b> SP                                                        |  | <b>Relation:</b>                 |  | <b>Relation:</b>                                 |                               |                            |  |
| <b>Status:</b> VERIFIED                                                    |  | <b>Status:</b>                   |  | <b>Status:</b>                                   |                               |                            |  |
| <b>INS#4:</b>                                                              |  |                                  |  |                                                  |                               |                            |  |
| <b>Reason For Visit:</b> AGE-RELATED OSTEOPOROSIS W/O CURRENT PATHOLOGICAL |  |                                  |  |                                                  |                               |                            |  |
| <b>Comment:</b>                                                            |  |                                  |  |                                                  |                               |                            |  |
| <b>ISOLATION:</b>                                                          |  |                                  |  | <b>Privacy Notice Given?:</b> Y (Date: 09/15/17) |                               |                            |  |
| <b>CO-Pay Collected:</b> N <b>Mode of Arrival:</b>                         |  |                                  |  | <b>COB Signed/Verified:</b>                      |                               |                            |  |
| <b>Registration Clerk:</b> PHDAVIDP                                        |  |                                  |  |                                                  |                               |                            |  |
| <b>email:</b> N/A                                                          |  |                                  |  | <b>use email:</b>                                |                               |                            |  |

DATE: 09/16/17 @ 0012                      Mercy Philadelphia Hospital OE \*\*LIVE\*\*                      PAGE 1  
 USER: COASKEWK                                              PATIENT ORDER SUMMARY

PATIENT:    PA1304854506 - BENTON, ALONZO  
 UNIT #:      M000301370

| ORDER |      |          |           |           |     |     |        | SERVICE |      |            | ORDERED    |           |
|-------|------|----------|-----------|-----------|-----|-----|--------|---------|------|------------|------------|-----------|
| DATE  | TIME | CATEGORY | PROCEDURE | ORDER NUM | PRI | QTY | STATUS | DATE    | TIME | ORD DOCTOR | ORDERED BY | CHNG FROM |

|          |      |     |         |           |      |   |     |          |      |        |          |         |
|----------|------|-----|---------|-----------|------|---|-----|----------|------|--------|----------|---------|
| 09/12/17 | 1448 | WSC | BONEDEN | 0915-0001 | ROUT | 1 | RES | 09/15/17 | 1000 | MELIME | COASKEWK | C SCH W |
|----------|------|-----|---------|-----------|------|---|-----|----------|------|--------|----------|---------|

Reason for Exam: AGE-RELATED OSTEOPOROSIS W/O CURRENT PATHOLOGICAL FRACTURE

Is Patient Pregnant?

When was patient's LMP?

Comment:

|   | DATE     | TIME | USER       | DEVICE    | EVENT                                                      |
|---|----------|------|------------|-----------|------------------------------------------------------------|
| 1 | 09/12/17 | 1448 | COASKEWK   | FI-MCCC03 | order entered in Scheduling by KAREN ASKEW                 |
| 2 | 09/12/17 | 1448 | COASKEWK   | FI-MCCC03 | order source is Written - no signature necessary for entry |
| 3 | 09/15/17 | 0000 | COSYSTEM   | CAE-BG314 | order transmitted                                          |
| 4 | 09/15/17 | 0001 | COSYSTEM   | CAE-BG314 | order's status changed from TRANS to LOGGED                |
| 5 | 09/15/17 | 1340 | PHCOLEMM   | CAE-BG314 | order's status changed from LOGGED to TAKEN                |
| 6 | 09/15/17 | 1402 | BKG DAEMON | CAE-BG314 | order's status changed from TAKEN to RESULT                |

**Mercy Philadelphia Hospital**  
**Mercy Health System**  
**Department of Radiology**  
5301 Cedar Avenue  
Philadelphia, PA 19143  
215-748-9432

David P Mayer, MD, MS, FACR, Chairman  
Oleg Teytelboym, MD, Radiology Director  
Aparna Babu, MD  
Gerard Berry, MD  
Robert Borden, MD

Michael Brooks, MD, JD  
Fraser Brown, MD  
Brian Clark, MD  
Malgorzata Goralczyk, MD  
Lulu He, DO  
Laryssa Hud, MD  
Caroline Ling, MD  
Justin Mackey, MD  
Timothy Nielsen, MD  
Scott Rotenberg, MD

Patient: **BENTON, ALONZO** Acct #: PA 1304854506 Exam Date: 09/15/17  
Med Rec #: **M000301370** Order #: 0915-0001 Status: REG CLI  
Date of Birth: 11/12/1958 Gender: M Accession #: 841154.001 Location:  
Phone #: (215) 403-5705 Report #: 0915-0136 RAD #:  
Ordering Physician: **MELLER, MENACHEM M, MD**  
CC: BARDEN, ABA, MD; MELLER, MENACHEM M, MD ~  
Order Date: 09/15/17  
**Procedure Reason:** AGE-RELATED OSTEOPOROSIS W/O CURRENT PATHOLOGICAL FRACTURE

## Exam: Bone Density Measurement

### \*\*\* Signed Status \*\*\*

IMPRESSION: Osteopenia of the lumbar spine and both hips.

History: 58-year-old male presents for osteoporosis screening.

Comparison: None available.

Technique: Bone mineral density was evaluated with the Lunar DEXA scan.

### Findings:

**LUMBAR SPINE:** This evaluation is of L1 and L2. L3 and L4 are omitted secondary to vertebral body sclerosis. The bone mineral density of the lumbar spine measures 1.013 gm/cm<sup>2</sup>. The T-score is -1.6 and the Z-score is -1.9. This represents 84 % of the bone mineral density expected for a young adult.

**LEFT FEMORAL NECK:** The bone mineral density of hips, evaluated at the left femoral neck measures 0.825 gm/cm<sup>2</sup>. T-score is -1.9 and the Z-score is -2.0. This represents 77 % of the bone mineral density expected for a young adult.

**RIGHT FEMORAL NECK:** The bone mineral density of hips, evaluated at the right femoral neck measures 0.853 gm/cm<sup>2</sup>. The T-score is -1.7 and the Z-score is -1.8. This represents 80 % of the bone mineral density expected for a young adult.

**FRAX score:** The ten-year probability of major osteoporotic fractures is 2.7 % and hip fractures is 0.4 %.

Note: FRAX score is a WHO derived, FDA approved and ACR recommended reporting value which estimates the 10 year probability of a major osteoporotic fracture.

\* Limitations of FRAX score:

1. Should not be used in premenopausal woman.
2. Should not be used in patients previously treated for osteopenia.
3. Questionable utility in overweight young people and very elderly.

**PATIENT IMAGES or REPORTS: (215) 748-9432**

**SCHEDULING: (610) 237-2525**

**Mercy Philadelphia Hospital**

Mercy Health System  
Department of Radiology  
5301 Cedar Ave, Philadelphia, PA 19143  
Films or Reports: (215) 748-9432; Scheduling: (215) 748-9117

Patient : BENTON,ALONZO

DOB: 11/12/1958

MRN # M000301370

ADM # PA1304854506

RAD # M000301370

Order # 0915-0001

Sex: M

Status: REG CLI

Phone # (215)403-5705

Date of Exam: 09/15/17

Location:

Accession # 841154.001

**Thank you for choosing Mercy Health System**

**<Electronically signed by SCOTT E ROTENBERG, MD in OV>**

Clinical Assistant Professor of Radiology, Drexel Univ. College of Medicine

e-Sign Pager: (610) 221-0755

Interpreting: ROTENBERG, SCOTT E MD

Dictated: 09/15/17 1358

Signoff: 09/15/17 1400

**PATIENT IMAGES or REPORTS: (215) 748-9432**

**SCHEDULING: (610) 237-2525**

# CONSENT FOR HOSPITAL TREATMENT AND SERVICES

PATIENT NAME: BENTON, ALONZO

- I have presented myself for treatment and/or admission on 9/15/17 (date). I consent to routine medical care and treatment, including diagnostic procedures and blood tests, and to such emergency or additional care as may be deemed necessary, which will be provided by the Hospital and by my Attending Physician, his/her assistants and/or designees. The use of telemedicine technology may be included in the diagnostic process of my care.
- I understand that, except for emergency situations, this consent does not include operations and non-routine procedures or treatment. I may be asked to consent to such operations and procedures after the risks and alternatives have been explained to me by my Attending Physician or by another physician.
- I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in the Hospital.
- I realize that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law. If such treatments or procedures are my reason for hospitalization, refusal may result in discharge.
- I hereby authorize the Hospital to photograph my face for purposes of identification and camera monitoring as indicated. In addition, I authorize the Hospital to take photographs for clinical purposes as part of the diagnostic/treatment documentation process.
- In the event that the results of my diagnostic studies or procedures indicate the need for further coordination of care, the hospital's patient care coordinator may be notified of my results, as deemed appropriate, so as to assist me with further diagnostic and/or treatment options.
- I consent to the release of such information from my medical records as may be required by my health insurance company for the processing of claims for hospital or medical benefits, except for records containing mental health, drug and alcohol information. In these cases a separate written consent will be required. I consent to release medical information to any medical care provider for the purpose of continuity of care/discharge planning. I consent to the use of my medical information for research when federal law allows such use without my specific consent.
- I understand the Hospital will not be liable for loss of or damage to any money or personal property.
- I hereby assign to the Hospital payment of all hospital and insurance benefits otherwise payable to me or for my benefit in connection with my treatment and/or hospitalization.
- In consideration of the care and services to be furnished to me, I undertake and promise to pay for these services (to the extent that the charges are not covered by any insurance benefits) in accordance with Hospital terms and usual and customary charges.
- The professional services of physicians are billed separately from the hospital bill, such as the departments of Anesthesia, Pathology, Emergency, Radiology, Neurology, Cardiology, and Physician Medicine.
- (Managed Care Patients Only) A law was passed in Pennsylvania in 1998 called "Act 68" or the "Quality Health Care Accountability and Protection Act." This law allows you to give the Hospital consent to seek payment from your health insurance company for health care you received for the Hospital if your health insurance company (a) denies payment; (b) limits the scope of services; (c) only pays for a shorter stay in the hospital; or (d) only pays for an alternative service than the one you received. When a hospital seeks payment from a health insurance company it is called a "grievance". I hereby give consent to the Hospital (and/or its designee) to file a grievance on my behalf, including requesting an appeal of any decision by my health insurance company. If the Hospital files a grievance for me, all costs related to the grievance will be paid by the Hospital. I also understand and agree that (1) I will not file a grievance with my health insurance company unless I withdraw my consent in writing; (2) I have the right to rescind this consent at any time during the grievance process; and (3) my consent will be automatically rescinded if the Hospital does not file a grievance.
- (Medicare Patients Only) - Certification, Authorization to Release Information, and Payment Requests. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize the release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I will either assign any such benefits to be paid directly to the Hospital or to the physician or organization furnishing the services or authorize the Hospital or such physician or organization to submit a claim to Medicare on my behalf, for payment.
- I understand that Hospital, including their business associates, may contact me by telephone at any telephone number I have provided or that is associated with my record, including cell phone numbers, which could result in charges to me. Hospital may also contact me by sending text messages or e-mails, using the contact information provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I am the patient or the person authorized to give consent for the patient. My signature certifies that I have read and understood this consent and that any questions have been answered to my satisfaction.

Signature of Patient Alonzo Benton Date/Time 9/15/17 11:46am Witness to Signature Debra Davis Date/Time 9/15/17 11:46am

If Patient is a minor or incompetent/unable to give consent

Signature of Person authorized to give consent \_\_\_\_\_ Date/Time \_\_\_\_\_ Address \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Witness \_\_\_\_\_ Date/Time \_\_\_\_\_

Patient Rights and Responsibilities ☒ I have received the Patient Rights and Responsibilities form (40M)

## Hospital Directory

The hospital directory contains your name, room number and general condition. It can be used to direct visitors, flower deliveries and phone callers to you. ☐ I want to be included in the directory ☒ I do not want to be included in the directory

Patient's Email Address: \_\_\_\_\_

## Notice of Privacy Practices

The Notice of Privacy Practices explains how your Protected Health Information (medical and demographic information about you) may be used or disclosed. ☒ I have received the Notice of Privacy Practices.

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it: \_\_\_\_\_

 Mercy Philadelphia Hospital  
A member of Mercy Health System

CONSENT FOR HOSPITAL TREATMENT AND SERVICES

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 09/15/17  
ACC: PA1304854506 MR: M000301370



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N

## OUTPATIENT RECORD

Account No: PA1304851676

Date: 09/12/17

Time: 1200

Unit No: M000301370

## PATIENT INFORMATION

|          |                        |                |            |      |    |                |         |
|----------|------------------------|----------------|------------|------|----|----------------|---------|
| Name:    | BENTON, ALONZO         | DOB:           | 11/12/1958 | AGE: | 58 | Pt Status:     | SCH CLI |
| Address: | 2432 S FRAZIER ST      | SEX:           | M          | MS:  | S  | LOC/Srvc:      | PHDICAT |
|          | PHILADELPHIA, PA 19143 | RACE:          | AA         |      |    | Room/Bed:      |         |
| Phone:   | (215) 681-6752         | LANG:          | ENGLISH    |      |    | Accommodation: |         |
| SSN:     | XXX-XX-9216            | ADM Src/Prior: | /          |      |    | Last DC Date:  |         |
|          |                        | Religion:      | CHRISTIAN  |      |    |                |         |
|          |                        | Church:        |            |      |    |                |         |

Occurrence Code:

Occurrence Date:

## PHYSICIAN INFORMATION

Admitting Physician

Attending or ER Physician

Primary Care Physician

 MELLER, MENACHEM M, MD  
 (215) 746-9822

 BARDEN, ABA, MD  
 (215) 662-9900

Att Group: MHOP ORTHOPEDICS

## NEXT OF KIN

 Name: BENTON, APRIL  
 Addr: 5600 OGONTZ AVE APT F  
 PHILADELPHIA, PA 19141  
 Phone: (000) 000-0000  
 Other:  
 Relat: DAUGHTER

## PERSON TO NOTIFY

 Name: BENTON, APRIL  
 Addr: 5600 OGONTZ AVE APT F4  
 PHILADELPHIA, PA 19141  
 Phone: (000) 000-0000  
 Other:  
 Relat: DAUGHTER

## EMPLOYER INFORMATION

 Name: UNEMPLOYED  
 Addr:  
 Phone: (000) 000-0000

## GUARANTOR INFORMATION

|        |                        |         |                |
|--------|------------------------|---------|----------------|
| Name:  | BENTON, ALONZO         | Emp:    | UNEMPLOYED     |
| Addr:  | 2432 S FRAZIER ST      | Addr:   |                |
|        | PHILADELPHIA, PA 19143 |         |                |
| Phone: | (215) 691-6752         | Phone:  | (000) 000-0000 |
| SSN:   | XXX-XX-9216            | Status: | UE             |
| Relat: | SELF / SAME AS         |         |                |

## INSURANCE INFORMATION

Financial Class: MCRMNG

 GATEWYMCR  
 Pri: GATEWAY MEDICARE ASSUR  
 Addr: PO BOX 69359

 INS#2:  
 Addr:

 INS#3:  
 Addr:

 HARRISBURG PA 17106-  
 Phone:  
 Policy#: 70113084  
 Group#:  
 A#: 17254GWY349  
 Subscrib: BENTON, ALONZO  
 Sub Emp: UNEMPLOYED  
 Relation: SP  
 Status: PENDING

 Phone:  
 Policy#:  
 Group#:  
 A#:  
 Subscrib:  
 Sub Emp:  
 Relation:  
 Status:

 Phone:  
 Policy#:  
 Group#:  
 A#:  
 Subscrib:  
 Sub Emp:  
 Relation:  
 Status:

INS#4:

Reason For Visit: DISP FX OF LATERAL END OF LEFT CLAVICLE, INIT FOR

Comment:

ISOLATION:

CO-Pay Collected:

Mode of Arrival:

Privacy Notice Given?: Y (Date: )

COB Signed/Verified:

Registration Clerk:

Email: N/A

Proc: CT SHOULDER LEFT W/O CONTRAST

Phys name: MENACHEM M MELLER MD

Service date:

Res Taken: 09/11/17 1516 Res Date: 09/12/17 1200

Ref Phys:

Other phone:



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P

## OUTPATIENT RECORD

|                                                                            |  |                                  |  |                                          |  |                              |  |
|----------------------------------------------------------------------------|--|----------------------------------|--|------------------------------------------|--|------------------------------|--|
| <b>Account No:</b> PA1304851676                                            |  | <b>Date:</b> 09/12/17            |  | <b>Time:</b> 1200                        |  | <b>Unit No:</b> M000301370   |  |
| <b>PATIENT INFORMATION</b>                                                 |  |                                  |  |                                          |  |                              |  |
| <b>Name:</b> BENTON, ALONZO                                                |  | <b>DOB:</b> 11/12/1958           |  | <b>AGE:</b> 58                           |  | <b>Pt Status:</b> PRE CLI    |  |
| <b>Address:</b> 2432 S FRAZIER ST                                          |  | <b>SEX:</b> M                    |  | <b>MS:</b> S                             |  | <b>LOC/Srvc:</b> PHDICAT     |  |
| PHILADELPHIA, PA 19143                                                     |  | <b>RACE:</b> AA                  |  | <b>Room/Bed:</b>                         |  | <b>Accommodation:</b>        |  |
| <b>Phone:</b> (215) 681-6752                                               |  | <b>LANG:</b> ENGLISH             |  | <b>ADM Src/Prior:</b> PHY /EL            |  | <b>Last DC Date:</b>         |  |
| <b>SSN:</b> XXX-XX-9216                                                    |  | <b>Religion:</b> CHRISTIAN       |  | <b>Church:</b>                           |  |                              |  |
| <b>Occurrence Code:</b> 11 <b>Occurrence Date:</b> 09/11/17                |  |                                  |  |                                          |  |                              |  |
| <b>PHYSICIAN INFORMATION</b>                                               |  |                                  |  |                                          |  |                              |  |
| <b>Admitting Physician</b>                                                 |  | <b>Attending or ER Physician</b> |  | <b>Primary Care Physician</b>            |  |                              |  |
|                                                                            |  | MELLER, MENACHEM M, MD           |  | BARDEN, ABA, MD                          |  |                              |  |
|                                                                            |  | (215) 746-9822                   |  | (215) 662-9900                           |  |                              |  |
| <b>Att Group:</b> MHOP ORTHOPEDICS                                         |  |                                  |  |                                          |  |                              |  |
| <b>NEXT OF KIN</b>                                                         |  |                                  |  | <b>PERSON TO NOTIFY</b>                  |  |                              |  |
| <b>Name:</b> BENTON, APRIL                                                 |  |                                  |  | <b>Name:</b> BENTON, APRIL               |  |                              |  |
| <b>Addr:</b> 5600 OGONTZ AVE APT F                                         |  |                                  |  | <b>Addr:</b> 5600 OGONTZ AVE APT F4      |  |                              |  |
| PHILADELPHIA, PA 19141                                                     |  |                                  |  | PHILADELPHIA, PA 19141                   |  |                              |  |
| <b>Phone:</b> (000) 000-0000                                               |  |                                  |  | <b>Phone:</b> (000) 000-0000             |  |                              |  |
| <b>Other:</b>                                                              |  |                                  |  | <b>Other:</b>                            |  |                              |  |
| <b>Relat:</b> DAUGHTER                                                     |  |                                  |  | <b>Relat:</b> DAUGHTER                   |  |                              |  |
| <b>EMPLOYER INFORMATION</b>                                                |  |                                  |  | <b>GUARANTOR INFORMATION</b>             |  |                              |  |
| <b>Name:</b> UNEMPLOYED                                                    |  |                                  |  | <b>Name:</b> BENTON, ALONZO              |  | <b>Emp:</b> UNEMPLOYED       |  |
| <b>Addr:</b>                                                               |  |                                  |  | <b>Addr:</b> 2432 S FRAZIER ST           |  | <b>Addr:</b>                 |  |
| PHILADELPHIA, PA 19143                                                     |  |                                  |  | PHILADELPHIA, PA 19143                   |  |                              |  |
| <b>Phone:</b> (000) 000-0000                                               |  |                                  |  | <b>Phone:</b> (215) 691-6752             |  | <b>Phone:</b> (000) 000-0000 |  |
|                                                                            |  |                                  |  | <b>SSN:</b> XXX-XX-9216                  |  | <b>Status:</b> UE            |  |
|                                                                            |  |                                  |  | <b>Relat:</b> SELF / SAME AS             |  |                              |  |
| <b>INSURANCE INFORMATION</b> <b>Financial Class:</b> MCRMNG                |  |                                  |  |                                          |  |                              |  |
| <b>GATEWYMCR</b>                                                           |  |                                  |  |                                          |  |                              |  |
| <b>Pri:</b> GATEWAY MEDICARE ASSUR                                         |  |                                  |  | <b>INS#2:</b>                            |  | <b>INS#3:</b>                |  |
| <b>Addr:</b> PO BOX 69359                                                  |  |                                  |  | <b>Addr:</b>                             |  | <b>Addr:</b>                 |  |
| HARRISBURG PA 17106-                                                       |  |                                  |  |                                          |  |                              |  |
| <b>Phone:</b>                                                              |  |                                  |  | <b>Phone:</b>                            |  | <b>Phone:</b>                |  |
| <b>Policy#:</b> 70113084                                                   |  |                                  |  | <b>Policy#:</b>                          |  | <b>Policy#:</b>              |  |
| <b>Group#:</b>                                                             |  |                                  |  | <b>Group#:</b>                           |  | <b>Group#:</b>               |  |
| <b>A#:</b> 17254GWY349                                                     |  |                                  |  | <b>A#:</b>                               |  | <b>A#:</b>                   |  |
| <b>Subscrbr:</b> BENTON, ALONZO                                            |  |                                  |  | <b>Subscrbr:</b>                         |  | <b>Subscrbr:</b>             |  |
| <b>Sub Emp:</b> UNEMPLOYED                                                 |  |                                  |  | <b>Sub Emp:</b>                          |  | <b>Sub Emp:</b>              |  |
| <b>Relation:</b> SP                                                        |  |                                  |  | <b>Relation:</b>                         |  | <b>Relation:</b>             |  |
| <b>Status:</b> VERIFIED                                                    |  |                                  |  | <b>Status:</b>                           |  | <b>Status:</b>               |  |
| <b>INS#4:</b>                                                              |  |                                  |  |                                          |  |                              |  |
| <b>Reason For Visit:</b> DISP FX OF LATERAL END OF LEFT CLAVICLE, INIT FOR |  |                                  |  |                                          |  |                              |  |
| <b>Comment:</b>                                                            |  |                                  |  |                                          |  |                              |  |
| <b>ISOLATION:</b>                                                          |  |                                  |  | <b>Privacy Notice Given?:</b> Y (Date: ) |  |                              |  |
| <b>CO-Pay Collected:</b>                                                   |  |                                  |  | <b>COB Signed/Verified:</b>              |  |                              |  |
| <b>Registration Clerk:</b>                                                 |  |                                  |  |                                          |  |                              |  |
| <b>email:</b> N/A                                                          |  |                                  |  | <b>use email:</b>                        |  |                              |  |



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## OUTPATIENT RECORD

|                                                                            |  |                                          |  |                                                         |  |                            |  |
|----------------------------------------------------------------------------|--|------------------------------------------|--|---------------------------------------------------------|--|----------------------------|--|
| <b>Account No:</b> PA1304851676                                            |  | <b>Date:</b> 09/12/17                    |  | <b>Time:</b> 1208                                       |  | <b>Unit No:</b> M000301370 |  |
| <b>PATIENT INFORMATION</b>                                                 |  |                                          |  |                                                         |  |                            |  |
| <b>Name:</b> BENTON, ALONZO                                                |  | <b>DOB:</b> 11/12/1958                   |  | <b>AGE:</b> 58                                          |  | <b>Pt Status:</b> REG CLI  |  |
| <b>Address:</b> 2432 S FRAZIER ST                                          |  | <b>SEX:</b> M                            |  | <b>MS:</b> S                                            |  | <b>LOC/Srve:</b> PHDICAT   |  |
| PHILADELPHIA, PA 19143                                                     |  | <b>RACE:</b> AA                          |  | <b>LANG:</b> ENGLISH                                    |  | <b>Room/Bed:</b>           |  |
| <b>Phone:</b> (215) 403-5705                                               |  | <b>ADM Src/Prior:</b> PHY /EL            |  | <b>Accommodation:</b>                                   |  | <b>Last DC Date:</b>       |  |
| <b>SSN:</b> XXX-XX-9216                                                    |  | <b>Religion:</b> CHRISTIAN               |  | <b>Church:</b>                                          |  |                            |  |
| <b>Occurrence Code:</b> 11 <b>Occurrence Date:</b> 09/12/17                |  |                                          |  |                                                         |  |                            |  |
| <b>PHYSICIAN INFORMATION</b>                                               |  |                                          |  |                                                         |  |                            |  |
| <b>Admitting Physician</b>                                                 |  | <b>Attending or ER Physician</b>         |  | <b>Primary Care Physician</b>                           |  |                            |  |
|                                                                            |  | MELLER, MENACHEM M, MD<br>(215) 746-9822 |  | BARDEN, ABA, MD<br>(215) 662-9900                       |  |                            |  |
| <b>Att Group:</b> MHOP ORTHOPEDICS                                         |  |                                          |  |                                                         |  |                            |  |
| <b>NEXT OF KIN</b>                                                         |  |                                          |  | <b>PERSON TO NOTIFY</b>                                 |  |                            |  |
| <b>Name:</b> BENTON, APRIL                                                 |  |                                          |  | <b>Name:</b> BENTON, APRIL                              |  |                            |  |
| <b>Addr:</b> UNKNOWN                                                       |  |                                          |  | <b>Addr:</b> UNKNOWN                                    |  |                            |  |
| PHILADELPHIA, PA 19143                                                     |  |                                          |  | PHILADELPHIA, PA 19143                                  |  |                            |  |
| <b>Phone:</b> (267) 905-4367                                               |  |                                          |  | <b>Phone:</b> (267) 905-4367                            |  |                            |  |
| <b>Other:</b>                                                              |  |                                          |  | <b>Other:</b>                                           |  |                            |  |
| <b>Relat:</b> DAUGHTER                                                     |  |                                          |  | <b>Relat:</b> DAUGHTER                                  |  |                            |  |
| <b>EMPLOYER INFORMATION</b>                                                |  |                                          |  | <b>GUARANTOR INFORMATION</b>                            |  |                            |  |
| <b>Name:</b> UNEMPLOYED                                                    |  | <b>Name:</b> BENTON, ALONZO              |  | <b>Emp:</b> UNEMPLOYED                                  |  |                            |  |
| <b>Addr:</b> NONE                                                          |  | <b>Addr:</b> 2432 S FRAZIER ST           |  | <b>Addr:</b> NONE                                       |  |                            |  |
| PHILADELPHIA, PA 19143                                                     |  | PHILADELPHIA, PA 19143                   |  | PHILADELPHIA, PA 19143                                  |  |                            |  |
| <b>Phone:</b> (215) 000-0000                                               |  | <b>Phone:</b> (215) 403-5705             |  | <b>Phone:</b> (215) 000-0000                            |  |                            |  |
|                                                                            |  | <b>SSN:</b> XXX-XX-9216                  |  | <b>Status:</b> UE                                       |  |                            |  |
|                                                                            |  | <b>Relat:</b> SELF / SAME AS             |  |                                                         |  |                            |  |
| <b>INSURANCE INFORMATION</b> <b>Financial Class:</b> MCRMNG                |  |                                          |  |                                                         |  |                            |  |
| <b>GATEWYMCR</b>                                                           |  | <b>INS#2:</b>                            |  | <b>INS#3:</b>                                           |  |                            |  |
| <b>Pri:</b> GATEWAY MEDICARE ASSUR                                         |  | <b>Addr:</b>                             |  | <b>Addr:</b>                                            |  |                            |  |
| <b>Addr:</b> PO BOX 69359                                                  |  |                                          |  |                                                         |  |                            |  |
| HARRISBURG PA 17106-                                                       |  |                                          |  |                                                         |  |                            |  |
| <b>Phone:</b>                                                              |  | <b>Phone:</b>                            |  | <b>Phone:</b>                                           |  |                            |  |
| <b>Policy#:</b> 70113084                                                   |  | <b>Policy#:</b>                          |  | <b>Policy#:</b>                                         |  |                            |  |
| <b>Group#:</b>                                                             |  | <b>Group#:</b>                           |  | <b>Group#:</b>                                          |  |                            |  |
| <b>A#:</b> 17254GWY349                                                     |  | <b>A#:</b>                               |  | <b>A#:</b>                                              |  |                            |  |
| <b>Subscrib:</b> BENTON, ALONZO                                            |  | <b>Subscrib:</b>                         |  | <b>Subscrib:</b>                                        |  |                            |  |
| <b>Sub Emp:</b> UNEMPLOYED                                                 |  | <b>Sub Emp:</b>                          |  | <b>Sub Emp:</b>                                         |  |                            |  |
| <b>Relation:</b> SP                                                        |  | <b>Relation:</b>                         |  | <b>Relation:</b>                                        |  |                            |  |
| <b>Status:</b> VERIFIED                                                    |  | <b>Status:</b>                           |  | <b>Status:</b>                                          |  |                            |  |
| <b>INS#4:</b>                                                              |  |                                          |  |                                                         |  |                            |  |
| <b>Reason For Visit:</b> DISP FX OF LATERAL END OF LEFT CLAVICLE, INIT FOR |  |                                          |  |                                                         |  |                            |  |
| <b>Comment:</b>                                                            |  |                                          |  |                                                         |  |                            |  |
| <b>ISOLATION:</b>                                                          |  |                                          |  | <b>Privacy Notice Given?:</b> Y <b>(Date:</b> 09/12/17) |  |                            |  |
| <b>CO-Pay Collected:</b> N <b>Mode of Arrival:</b>                         |  |                                          |  | <b>COB Signed/Verified:</b>                             |  |                            |  |
| <b>Registration Clerk:</b> PHALTIDS                                        |  |                                          |  |                                                         |  |                            |  |
| <b>email:</b> N/A <b>use email:</b>                                        |  |                                          |  |                                                         |  |                            |  |

DATE: 09/13/17 @ 0016

Mercy Philadelphia Hospital OE \*\*LIVE\*\*

PAGE 1

USER: FIBARKSP

PATIENT ORDER SUMMARY

PATIENT: PA1304851676 - BENTON, ALONZO

UNIT #: M000301370

| ORDER |      |          |           | SERVICE   |     |     |        | ORDERED |      |            |            |      |      |
|-------|------|----------|-----------|-----------|-----|-----|--------|---------|------|------------|------------|------|------|
| DATE  | TIME | CATEGORY | PROCEDURE | ORDER NUM | PRI | QTY | STATUS | DATE    | TIME | ORD DOCTOR | ORDERED BY | CHNG | FROM |

|          |      |    |            |           |      |   |     |          |      |        |          |   |       |
|----------|------|----|------------|-----------|------|---|-----|----------|------|--------|----------|---|-------|
| 09/11/17 | 1517 | CT | CTSHLDLTWO | 0912-0005 | ROUT | 1 | RES | 09/12/17 | 1200 | MELIME | FIBARKSP | C | SCH W |
|----------|------|----|------------|-----------|------|---|-----|----------|------|--------|----------|---|-------|

Reason for Exam: DISP FX OF LATERAL END OF LEFT CLAVICLE, INIT FOR CLOS FX

Is Patient Pregnant? N

When was patient's LMP? N

Suspected Diagnosis

Physical Exam

Comment:

|   | DATE     | TIME | USER       | DEVICE    | EVENT                                                      |
|---|----------|------|------------|-----------|------------------------------------------------------------|
| 1 | 09/11/17 | 1517 | FIBARKSP   | FI-MCCC24 | order entered in Scheduling by PAMELA Y BARKS              |
| 2 | 09/11/17 | 1517 | FIBARKSP   | FI-MCCC24 | order source is Written - no signature necessary for entry |
| 3 | 09/12/17 | 0000 | COSYSTEM   | CAE-BG314 | order transmitted                                          |
| 4 | 09/12/17 | 0000 | COSYSTEM   | CAE-BG314 | order's status changed from TRANS to LOGGED                |
| 5 | 09/12/17 | 0000 | COSYSTEM   | CAE-BG314 | quantity edited via ITS: old value -                       |
| 6 | 09/12/17 | 1352 | PHDOYNEM   | CAE-BG314 | order's status changed from LOGGED to TAKEN                |
| 7 | 09/12/17 | 1412 | BKG DAEMON | CAE-BG314 | order's status changed from TAKEN to RESULT                |

**Mercy Philadelphia Hospital**  
**Mercy Health System**  
**Department of Radiology**  
**5301 Cedar Avenue**  
**Philadelphia, PA 19143**  
**215-748-9432**

David P Mayer, MD, MS, FACR, Chairman  
Oleg Teytelboym, MD, Radiology Director  
Aparna Babu, MD  
Gerard Berry, MD  
Robert Borden, MD

Michael Brooks, MD, JD  
Fraser Brown, MD  
Brian Clark, MD  
Malgorzata Gorelczyk, MD  
Lulu He, DO  
Laryssa Hud, MD  
Caroline Ling, MD  
Justin Mackey, MD  
Timothy Nielsen, MD  
Scott Rotenberg, MD

Patient: **BENTON, ALONZO** Acct #: PA 1304851676 Exam Date: 09/12/17  
Med Rec #: **M000301370** Order #: 0912-0005 Status: **REG CLI**  
Date of Birth: 11/12/1958 Gender: M Accession #: 839711.001 Location:  
Phone #: (215) 403-5705 Report #: 0912-0168 RAD #:  
Ordering Physician: **MELLER, MENACHEM M, MD**  
CC: BARDEN, ABA, MD; MELLER, MENACHEM M, MD ~  
Order Date: 09/12/17

**Procedure Reason:** DISP FX OF LATERAL END OF LEFT CLAVICLE, INIT FOR CLOS FX

**Exam: CT Shoulder LT WO**

**\*\*\* Signed Status \*\*\***

**\*\*\* Addendum \*\*\***

Addendum:

Healing nondisplaced left third rib fracture posteriorly.

<Electronically signed by LULU HE, DO in OV>  
e-Sign Pager: 610-221-4559

Addendum Interpreting Radiologist: LULU HE, DO  
Signoff Date/Time: 09/12/17 1418

Dictated Date/Time: 09/12/17 1417

**\*\*\* Original Report \*\*\***

**IMPRESSION:**

Comminuted distal clavicle fracture with apex dorsal angulation. Distal fragment demonstrates maintained acromioclavicular and coracoclavicular distance.

Rotator cuff grossly intact.

**INDICATION:** 58 years old; Male. Symptom/Location/Duration: Left shoulder pain 10 out of 10 after the patient fell on his left shoulder on 8/29/2017. Follow-up for distal clavicle fracture.

**TECHNIQUE:** CT left shoulder. Reformats: axial, coronal, sagittal and 3-D for assessment of bone/joint alignment. Contrast IV (Isovue-370): none. Ionizing radiation dose reduced via iterative reconstruction/FBP blend and body size kV/mA adjustment. Patient exposure information sent to ACR dose registry. Utilization of standard nomenclature applied.  
**COMPARISON:** Left shoulder x-ray 8/29/2017.

**FINDINGS:**

**PATIENT IMAGES or REPORTS: (215) 748-9432**

**SCHEDULING: (610) 237-2525**

**Mercy Philadelphia Hospital**

Mercy Health System  
Department of Radiology  
5301 Cedar Ave, Philadelphia, PA 19143  
Films or Reports: (215) 748-9432; Scheduling: (215) 748-9117

Patient : BENTON,ALONZO

DOB: 11/12/1958

MRN # M000301370

ADM # PA1304851676

RAD # M000301370

Order # 0912-0005

Sex: M

Status: REG CLI

Phone # (215)403-5705

Date of Exam: 09/12/17

Location:

Accession # 839711.001

**BONES:** Comminuted fracture of the distal third of the left clavicle with apex dorsal angulation of the major fragments. Fracture lines extends into the AC joint. The coracoclavicular distance with the distal fragment is maintained.

**JOINTS:** No AC joint widening. Normal glenohumeral joint space and alignment.

**MUSCLES/**

**TENDONS:** Rotator cuff grossly intact.

**SUBCUTANEOUS TISSUES:** Normal attenuation without mass/collection.

Mild emphysematous changes of the lung apices.

The study was reviewed with the attending radiologist Dr. Lulu He, who is in agreement.

**Thank you for choosing Mercy Health System**

**<Electronically signed by LULU HE, DO in OV>**

e-Sign Pager: 610-221-4559

Interpreting: PEDERSEN, CHRISTIAN K MD

Dictated: 09/12/17 1339

Signoff: 09/12/17 1409

**PATIENT IMAGES or REPORTS: (215) 748-9432**

**SCHEDULING: (610) 237-2525**

# CONSENT FOR HOSPITAL TREATMENT AND SERVICES

PATIENT NAME BENTON, ALONZO

- I have presented myself for treatment and/or admission on 9/12/17 (date). I consent to routine medical care and treatment, including diagnostic procedures and blood tests, and to such emergency or additional care as may be deemed necessary, which will be provided by the Hospital and by my Attending Physician, his/her assistants and/or designees. The use of telemedicine technology may be included in the diagnostic process of my care.
- I understand that, except for emergency situations, this consent does not include operations and non-routine procedures or treatment. I may be asked to consent to such operations and procedures after the risks and alternatives have been explained to me by my Attending Physician or by another physician.
- I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in the Hospital.
- I realize that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law. If such treatments or procedures are my reason for hospitalization, refusal may result in discharge.
- I hereby authorize the Hospital to photograph my face for purposes of identification and camera monitoring as indicated. In addition, I authorize the Hospital to take photographs for clinical purposes as part of the diagnostic/treatment documentation process.
- In the event that the results of my diagnostic studies or procedures indicate the need for further coordination of care, the hospital's patient care coordinator may be notified of my results, as deemed appropriate, so as to assist me with further diagnostic and/or treatment options.
- I consent to the release of such information from my medical records as may be required by my health insurance company for the processing of claims for hospital or medical benefits, except for records containing mental health, drug and alcohol information. In these cases a separate written consent will be required. I consent to release medical information to any medical care provider for the purpose of continuity of care/discharge planning. I consent to the use of my medical information for research when federal law allows such use without my specific consent.
- I understand the Hospital will not be liable for loss of or damage to any money or personal property.
- I hereby assign to the Hospital payment of all hospital and insurance benefits otherwise payable to me or for my benefit in connection with my treatment and/or hospitalization.
- In consideration of the care and services to be furnished to me, I undertake and promise to pay for these services (to the extent that the charges are not covered by any insurance benefits) in accordance with Hospital terms and usual and customary charges.
- The professional services of physicians are billed separately from the hospital bill, such as the departments of Anesthesia, Pathology, Emergency, Radiology, Neurology, Cardiology, and Physician Medicine.
- (Managed Care Patients Only):** A law was passed in Pennsylvania in 1998 called "Act 58" or the "Quality Health Care Accountability and Protection Act." This law allows you to give the Hospital consent to seek payment from your health insurance company for health care you received for the Hospital if your health insurance company (a) denies payment; (b) limits the scope of services; (c) only pays for a shorter stay in the hospital; or (d) only pays for an alternative service than the one you received. When a hospital seeks payment from a health insurance company it is called a "grievance". I hereby give consent to the Hospital (and/or its designee) to file a grievance on my behalf, including requesting an appeal of any decision by my health insurance company. If the Hospital files a grievance for me, all costs related to the grievance will be paid by the Hospital. I also understand and agree that (1) I will not file a grievance with my health insurance company unless I withdraw my consent in writing; (2) I have the right to rescind this consent at any time during the grievance process; and (3) my consent will be automatically rescinded if the Hospital does not file a grievance.
- (Medicare Patients Only) - Certification, Authorization to Release Information, and Payment Requests:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize the release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I will either assign any such benefits to be paid directly to the Hospital or to the physician or organization furnishing the services or authorize the Hospital or such physician or organization to submit a claim to Medicare on my behalf, for payment.
- I understand that Hospital, including their business associates, may contact me by telephone at any telephone number I have provided or that is associated with my record, including cell phone numbers, which could result in charges to me. Hospital may also contact me by sending text messages or e-mails, using the contact information provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I am the patient or the person authorized to give consent for the patient. My signature certifies that I have read and understood this consent and that any questions have been answered to my satisfaction.

Signature of Patient

Date/Time

Witness to Signature

Date/Time

If Patient is a minor or incompetent/unable to give consent

Signature of Person authorized to give consent

Date/Time

Address

Relationship to Patient

Witness

Date/Time

## Patient Rights and Responsibilities

☒ I have received the Patient Rights and Responsibilities form: (40M)

## Hospital Directory

The hospital directory contains your name, room number and general condition. It can be used to direct visitors, flower deliveries and phone callers to you. ☐ I want to be included in the directory ☒ I do not want to be included in the directory

## Patient's Email Address:

## Notice of Privacy Practices

The Notice of Privacy Practices explains how your Protected Health Information (medical and demographic information about you) may be used or disclosed. ☒ I have received the Notice of Privacy Practices.

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it.

 Mercy Philadelphia Hospital  
A member of Mercy Health System

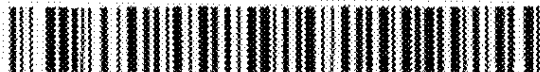
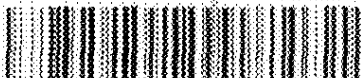
CONSENT FOR HOSPITAL TREATMENT AND SERVICES

BENTON, ALONZO

DOB: 11/12/1958 SS M

ADM: 09/12/17

ACC: RA1304951676 MR: M000301370





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## OUTPATIENT RECORD

|                                                                         |  |                                  |  |                                  |                               |                            |  |
|-------------------------------------------------------------------------|--|----------------------------------|--|----------------------------------|-------------------------------|----------------------------|--|
| <b>Account No:</b> PA1304861964                                         |  | <b>Date:</b> 09/20/17            |  | <b>Time:</b>                     |                               | <b>Unit No:</b> M000301370 |  |
| <b>PATIENT INFORMATION</b>                                              |  |                                  |  |                                  |                               |                            |  |
| <b>Name:</b> BENTON, ALONZO                                             |  | <b>DOB:</b> 11/12/1958           |  | <b>AGE:</b> 58                   |                               | <b>Pt Status:</b> PRE SDC  |  |
| <b>Address:</b> 2432 S FRAZIER ST                                       |  | <b>SEX:</b> M                    |  | <b>MS:</b> S                     |                               | <b>LOC/Srvc:</b> PHSPU     |  |
| PHILADELPHIA, PA 19143                                                  |  | <b>RACE:</b> AA                  |  |                                  |                               | <b>Room/Bed:</b>           |  |
| <b>Phone:</b> (215) 403-5705                                            |  | <b>LANG:</b> ENGLISH             |  |                                  |                               | <b>Accommodation:</b>      |  |
| <b>SSN:</b> XXX-XX-9216                                                 |  | <b>ADM Src/Prior:</b> PHY /EL    |  |                                  |                               | <b>Last DC Date:</b>       |  |
|                                                                         |  | <b>Religion:</b> CHRISTIAN       |  |                                  |                               |                            |  |
|                                                                         |  | <b>Church:</b>                   |  |                                  |                               |                            |  |
| <b>Occurrence Code:</b> 11                                              |  | <b>Occurrence Date:</b> 09/15/17 |  |                                  |                               |                            |  |
| <b>PHYSICIAN INFORMATION</b>                                            |  |                                  |  |                                  |                               |                            |  |
| <b>Admitting Physician</b>                                              |  | <b>Attending or ER Physician</b> |  |                                  | <b>Primary Care Physician</b> |                            |  |
|                                                                         |  | MELLER, MENACHEM M, MD           |  |                                  | BARDEN, ABA, MD               |                            |  |
|                                                                         |  | (215) 746-9822                   |  |                                  | (215) 662-9900                |                            |  |
| <b>Att Group:</b> MHOP ORTHOPEDICS                                      |  |                                  |  |                                  |                               |                            |  |
| <b>NEXT OF KIN</b>                                                      |  |                                  |  | <b>PERSON TO NOTIFY</b>          |                               |                            |  |
| <b>Name:</b> BENTON, APRIL                                              |  |                                  |  | <b>Name:</b> BENTON, APRIL       |                               |                            |  |
| <b>Addr:</b> NOT SURE OF ADDRESS                                        |  |                                  |  | <b>Addr:</b> NOT SURE OF ADDRESS |                               |                            |  |
| PHILADELPHIA, PA 19143                                                  |  |                                  |  | PHILADELPHIA, PA 19143           |                               |                            |  |
| <b>Phone:</b> (267) 905-4367                                            |  |                                  |  | <b>Phone:</b> (267) 905-4367     |                               |                            |  |
| <b>Other:</b>                                                           |  |                                  |  | <b>Other:</b>                    |                               |                            |  |
| <b>Relat:</b> DAUGHTER                                                  |  |                                  |  | <b>Relat:</b> DAUGHTER           |                               |                            |  |
| <b>EMPLOYER INFORMATION</b>                                             |  |                                  |  | <b>GUARANTOR INFORMATION</b>     |                               |                            |  |
| <b>Name:</b> UNEMPLOYED                                                 |  | <b>Name:</b> BENTON, ALONZO      |  | <b>Emp:</b> UNEMPLOYED           |                               |                            |  |
| <b>Addr:</b> NONE                                                       |  | <b>Addr:</b> 2432 S FRAZIER ST   |  | <b>Addr:</b> NONE                |                               |                            |  |
| PHILADELPHIA, PA 19143                                                  |  | PHILADELPHIA, PA 19143           |  | PHILADELPHIA, PA 19143           |                               |                            |  |
| <b>Phone:</b> (215) 000-0000                                            |  | <b>Phone:</b> (215) 403-5705     |  | <b>Phone:</b> (215) 000-0000     |                               |                            |  |
|                                                                         |  | <b>SSN:</b> XXX-XX-9216          |  | <b>Status:</b> UE                |                               |                            |  |
|                                                                         |  | <b>Relat:</b> SELF / SAME AS     |  |                                  |                               |                            |  |
| <b>INSURANCE INFORMATION</b>                                            |  |                                  |  |                                  |                               |                            |  |
| <b>Financial Class:</b> MCRMNG                                          |  |                                  |  |                                  |                               |                            |  |
| <b>GATEWYMCR</b>                                                        |  | <b>MCD</b>                       |  |                                  |                               |                            |  |
| <b>Pri:</b> GATEWAY MEDICARE ASSUR                                      |  | <b>INS#2:</b> MEDICAID           |  | <b>INS#3:</b>                    |                               |                            |  |
| <b>Addr:</b> PO BOX 69359                                               |  | <b>Addr:</b> PO BOX 8150         |  | <b>Addr:</b>                     |                               |                            |  |
| HARRISBURG PA 17106-                                                    |  | HARRISBURG PA 17105              |  |                                  |                               |                            |  |
| <b>Phone:</b>                                                           |  | <b>Phone:</b> (800) 537-8861     |  | <b>Phone:</b>                    |                               |                            |  |
| <b>Policy#:</b> 70113084                                                |  | <b>Policy#:</b> 166529216        |  | <b>Policy#:</b>                  |                               |                            |  |
| <b>Group#:</b>                                                          |  | <b>Group#:</b>                   |  | <b>Group#:</b>                   |                               |                            |  |
| <b>A#:</b> WIP                                                          |  | <b>A#:</b>                       |  | <b>A#:</b>                       |                               |                            |  |
| <b>Subscrib:</b> BENTON, ALONZO                                         |  | <b>Subscrib:</b> BENTON, ALONZO  |  | <b>Subscrib:</b>                 |                               |                            |  |
| <b>Sub Emp:</b> UNEMPLOYED                                              |  | <b>Sub Emp:</b> UNEMPLOYED       |  | <b>Sub Emp:</b>                  |                               |                            |  |
| <b>Relation:</b> SP                                                     |  | <b>Relation:</b> SP              |  | <b>Relation:</b>                 |                               |                            |  |
| <b>Status:</b> VERIFIED                                                 |  | <b>Status:</b> QUEUED            |  | <b>Status:</b>                   |                               |                            |  |
| <b>INS#4:</b>                                                           |  |                                  |  |                                  |                               |                            |  |
| <b>Reason For Visit:</b> COMMUNUTED DISTAL CLAVICLE FX OF LEFT SHOULDER |  |                                  |  |                                  |                               |                            |  |
| <b>Comment:</b>                                                         |  |                                  |  |                                  |                               |                            |  |
| <b>ISOLATION:</b>                                                       |  |                                  |  |                                  |                               |                            |  |
| <b>CO-Pay Collected:</b>                                                |  | <b>Mode of Arrival:</b>          |  | <b>Privacy Notice Given?:</b> Y  |                               | <b>(Date:</b> 09/15/17)    |  |
| <b>Registration Clerk:</b>                                              |  |                                  |  | <b>COB Signed/Verified:</b>      |                               |                            |  |
| <b>email:</b> N/A                                                       |  | <b>use email:</b>                |  |                                  |                               |                            |  |



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## OUTPATIENT RECORD

|                                                                         |  |                                  |  |                                                  |                               |                            |  |
|-------------------------------------------------------------------------|--|----------------------------------|--|--------------------------------------------------|-------------------------------|----------------------------|--|
| <b>Account No:</b> PA1304861964                                         |  | <b>Date:</b> 09/20/17            |  | <b>Time:</b> 1120                                |                               | <b>Unit No:</b> M000301370 |  |
| <b>PATIENT INFORMATION</b>                                              |  |                                  |  |                                                  |                               |                            |  |
| <b>Name:</b> BENTON, ALONZO                                             |  | <b>DOB:</b> 11/12/1958           |  | <b>AGE:</b> 58                                   |                               | <b>Pt Status:</b> DEP SDC  |  |
| <b>Address:</b> 2432 S FRAZIER ST                                       |  | <b>SEX:</b> M                    |  | <b>MS:</b> S                                     |                               | <b>LOC/Srve:</b> PHSPU     |  |
| PHILADELPHIA, PA 19143                                                  |  | <b>RACE:</b> AA                  |  |                                                  |                               | <b>Room/Bed:</b>           |  |
| <b>Phone:</b> (215) 403-5705                                            |  | <b>LANG:</b> ENGLISH             |  | <b>Accommodation:</b>                            |                               | <b>Last DC Date:</b>       |  |
| <b>SSN:</b> XXX-XX-9216                                                 |  | <b>ADM Src/Prior:</b> PHY /EL    |  |                                                  |                               |                            |  |
|                                                                         |  | <b>Religion:</b> CHRISTIAN       |  |                                                  |                               |                            |  |
|                                                                         |  | <b>Church:</b>                   |  |                                                  |                               |                            |  |
| <b>Occurrence Code:</b> 11                                              |  | <b>Occurrence Date:</b> 09/20/17 |  |                                                  |                               |                            |  |
| <b>PHYSICIAN INFORMATION</b>                                            |  |                                  |  |                                                  |                               |                            |  |
| <b>Admitting Physician</b>                                              |  | <b>Attending or ER Physician</b> |  |                                                  | <b>Primary Care Physician</b> |                            |  |
|                                                                         |  | MELLER, MENACHEM M, MD           |  |                                                  | BARDEN, ABA, MD               |                            |  |
|                                                                         |  | (215) 746-9822                   |  |                                                  | (215) 662-9900                |                            |  |
| <b>Att Group:</b> MHOP ORTHOPEDICS                                      |  |                                  |  |                                                  |                               |                            |  |
| <b>NEXT OF KIN</b>                                                      |  |                                  |  | <b>PERSON TO NOTIFY</b>                          |                               |                            |  |
| <b>Name:</b> BENTON, APRIL                                              |  |                                  |  | <b>Name:</b> BENTON, APRIL                       |                               |                            |  |
| <b>Addr:</b> NOT SURE OF ADDRESS                                        |  |                                  |  | <b>Addr:</b> NOT SURE OF ADDRESS                 |                               |                            |  |
| PHILADELPHIA, PA 19143                                                  |  |                                  |  | PHILADELPHIA, PA 19143                           |                               |                            |  |
| <b>Phone:</b> (267) 905-4367                                            |  |                                  |  | <b>Phone:</b> (267) 905-4367                     |                               |                            |  |
| <b>Other:</b>                                                           |  |                                  |  | <b>Other:</b>                                    |                               |                            |  |
| <b>Relat:</b> DAUGHTER                                                  |  |                                  |  | <b>Relat:</b> DAUGHTER                           |                               |                            |  |
| <b>EMPLOYER INFORMATION</b>                                             |  |                                  |  | <b>GUARANTOR INFORMATION</b>                     |                               |                            |  |
| <b>Name:</b> DISABLED                                                   |  |                                  |  | <b>Name:</b> BENTON, ALONZO                      |                               | <b>Emp:</b> DISABLED       |  |
| <b>Addr:</b>                                                            |  |                                  |  | <b>Addr:</b> 2432 S FRAZIER ST                   |                               | <b>Addr:</b>               |  |
|                                                                         |  |                                  |  | PHILADELPHIA, PA 19143                           |                               |                            |  |
| <b>Phone:</b>                                                           |  |                                  |  | <b>Phone:</b> (215) 403-5705                     |                               | <b>Phone:</b>              |  |
|                                                                         |  |                                  |  | <b>SSN:</b> XXX-XX-9216                          |                               | <b>Status:</b> UE          |  |
|                                                                         |  |                                  |  | <b>Relat:</b> SELF / SAME AS                     |                               |                            |  |
| <b>INSURANCE INFORMATION</b>                                            |  |                                  |  |                                                  |                               |                            |  |
| <b>Financial Class:</b> MCRMNG                                          |  |                                  |  |                                                  |                               |                            |  |
| <b>GATEWYMCR</b>                                                        |  |                                  |  |                                                  |                               |                            |  |
| <b>Pri:</b> GATEWAY MEDICARE ASSUR                                      |  |                                  |  | <b>INS#2:</b>                                    |                               | <b>INS#3:</b>              |  |
| <b>Addr:</b> PO BOX 69359                                               |  |                                  |  | <b>Addr:</b>                                     |                               | <b>Addr:</b>               |  |
| HARRISBURG PA 17106-                                                    |  |                                  |  |                                                  |                               |                            |  |
| <b>Phone:</b>                                                           |  |                                  |  | <b>Phone:</b>                                    |                               | <b>Phone:</b>              |  |
| <b>Policy#:</b> 70113084                                                |  |                                  |  | <b>Policy#:</b>                                  |                               | <b>Policy#:</b>            |  |
| <b>Group#:</b>                                                          |  |                                  |  | <b>Group#:</b>                                   |                               | <b>Group#:</b>             |  |
| <b>A#:</b> WIP                                                          |  |                                  |  | <b>A#:</b>                                       |                               | <b>A#:</b>                 |  |
| <b>Subscrib:</b> BENTON, ALONZO                                         |  |                                  |  | <b>Subscrib:</b>                                 |                               | <b>Subscrib:</b>           |  |
| <b>Sub Emp:</b> DISABLED                                                |  |                                  |  | <b>Sub Emp:</b>                                  |                               | <b>Sub Emp:</b>            |  |
| <b>Relation:</b> SP                                                     |  |                                  |  | <b>Relation:</b>                                 |                               | <b>Relation:</b>           |  |
| <b>Status:</b> VERIFIED                                                 |  |                                  |  | <b>Status:</b>                                   |                               | <b>Status:</b>             |  |
| <b>INS#4:</b>                                                           |  |                                  |  |                                                  |                               |                            |  |
| <b>Reason For Visit:</b> COMMUNUTED DISTAL CLAVICLE FX OF LEFT SHOULDER |  |                                  |  |                                                  |                               |                            |  |
| <b>Comment:</b>                                                         |  |                                  |  |                                                  |                               |                            |  |
| <b>ISOLATION:</b>                                                       |  |                                  |  |                                                  |                               |                            |  |
| <b>CO-Pay Collected:</b> N                                              |  |                                  |  | <b>Mode of Arrival:</b>                          |                               |                            |  |
| <b>Registration Clerk:</b> PHMALLOK                                     |  |                                  |  | <b>Privacy Notice Given?:</b> Y (Date: 09/15/17) |                               |                            |  |
| <b>email:</b> N/A                                                       |  |                                  |  | <b>COB Signed/Verified:</b>                      |                               |                            |  |
|                                                                         |  |                                  |  | <b>use email:</b>                                |                               |                            |  |



# Mercy Philadelphia Hospital

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## Pre-Admission Intake and Surgery Request Form

Pt. Name Alonzo Benton  
 Address 2432 S Frazier Street  
 City Philadelphia State PA Zip 19143  
 Phone (215) 403-5705 CP \_\_\_\_\_  
 DOB 11/12/58 Age 58 Gender Male  
 PCP \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Relative/Guardian \_\_\_\_\_  
 Phone \_\_\_\_\_ CP \_\_\_\_\_  
 Does pt. live alone yes no ☒   
 Allergies NKA

Allergic to Latex Yes No ☒   
 Type of admission: AM ☒ SPU OBS. 23 hour

Diagnosis Comminuted Distal Clavicle Fracture of Left  
 CPT Code Shoulder.....23515  
 ICD 9 Code S42.002A  
 Date of Surgery 09/20/17  
 Time requested 8:00am  
 Surgeon Dr. Meller  
 Procedure ORIF Left Distal Clavicle

Surgical Site Left Shoulder  
 Position \_\_\_\_\_  
 Positioning Device \_\_\_\_\_  
 Surgical Assist required: Yes No ☒   
 Estimated length of procedure 2hrs  
 Implants required \_\_\_\_\_  
 Special Equipment \_\_\_\_\_  
 Hattie notified yes no (internal use)

### Insurance:

1. Type Gateway Medicare  
 Policy# 70113084  
 Group# \_\_\_\_\_  
 Subscriber \_\_\_\_\_  
 SSN# 166-52-9216 - - - - -  
 Employer \_\_\_\_\_  
 Authorization # NO PRECERT REQUIRED PER ANNETT

2. Type \_\_\_\_\_  
 Policy# \_\_\_\_\_  
 Group# \_\_\_\_\_  
 Subscriber \_\_\_\_\_  
 SSN# \_\_\_\_\_ - - - - -  
 Employer \_\_\_\_\_  
 Authorization # \_\_\_\_\_

### Special Needs: ☐ Child N/A

- Does Pt. have a language barrier? Y N ☒
- Does Pt. have a hearing impairment? Y N ☒
- Does Pt. does Pt. have visual impairment? Y N ☒
- Does Pt. require venous mapping? Y N ☒
- Pt. has a Pacemaker or AICD Y N ☒  
 Have you consulted Cardiology? Y N ☒  
 Cardiologist consulted \_\_\_\_\_
- Pt. is a diabetic and on Insulin or oral medication Y N ☒  
 What instructions have they been given for day of Surgery? \_\_\_\_\_
- Pt. is on anticoagulants Y N ☒  
 When were they instructed to take their last dose, prior to surgery? \_\_\_\_\_

### Pre-Admission Testing Yes PAT by Protocol (includes all required testing per anesthesia guidelines)

|                                       |                                      |                                        |                                        |                                                     |                                   |                                                 |
|---------------------------------------|--------------------------------------|----------------------------------------|----------------------------------------|-----------------------------------------------------|-----------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Electrolytes | <input type="checkbox"/> CBC         | <input type="checkbox"/> T&S           | <input type="checkbox"/> Type & Cross  | Units                                               | <input type="checkbox"/> FFP      | <input type="checkbox"/> Platelets              |
| <input type="checkbox"/> Potassium    | <input type="checkbox"/> Glucose     | <input type="checkbox"/> BUN           | <input type="checkbox"/> Creatinine    | <input type="checkbox"/> Sodium                     | <input type="checkbox"/> Chloride | <input type="checkbox"/> CO2                    |
| <input type="checkbox"/> PT           | <input type="checkbox"/> PTT         | <input type="checkbox"/> Liver Profile | <input type="checkbox"/> Uric Acid     | <input type="checkbox"/> LDH                        | <input type="checkbox"/> Calcium  | <input checked="" type="checkbox"/> MRSA Screen |
| <input type="checkbox"/> Phosphorous  | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Urinalysis    | <input type="checkbox"/> Triglycerides | <input type="checkbox"/> Pregnancy Test (Serum HCG) | *except kids smile & cataract     |                                                 |
| <input type="checkbox"/> EKG          | <input type="checkbox"/> CXR         | Other: _____                           |                                        |                                                     |                                   |                                                 |

☐ CT Scan Pt. weight \_\_\_\_\_ Pt. Height \_\_\_\_\_ ☒ POx in SPU Pre-Op  
☐ Accu Check pre-op LMP \_\_\_\_\_ Allergy to dye \_\_\_\_\_

☐ Physical Therapy Training ☐ Visiting Nurse ☐ No labs necessary due to 2nd cataract

Physician Signature \_\_\_\_\_ Date 09/15/17 Time 9:00am

Sender Name Tyra Ruffin Scheduler Information  
 Date scheduling information sent 09/15/17 Phone (215)-748-9813 Fax # (215) 748-9717  
 Faxed to OR ☐ Fax Number 215-748-9512 Time sent 9:00 AM PM  
 If you experience any difficulty faxing, please call Gwen or Pat at 215-748-9425

### Scheduling Confirmation

Case Scheduled by \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
 Procedure Scheduled \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
 Booked in Picis ☐ Written in Schedule book  
 Request Form faxed to PAT ☐ Registration ☐ Requesting Physicians Office ☐

Mercy Philadelphia Hospital  
Mercy Health System  
Department of Cardiology

Patient: BENTON,ALONZO

MR # M000301370

Acct # PA1304861964

Phone # (215)403-5705

Order # 0915-0035

DOB: 11/12/1958

Exam Date: 09/15/17

Report #0915-0052

Sex: M

Status: PRE SDC

Ordering Physician: SULKES, SARAH K CRNP

CC: ~

Procedure Reason: PRE-OP

Study: Electrocardiogram

Order Date/Time: 09/15/17 1254

\*\*\*Signed Status\*\*\*

Date of Procedure:

Test Reason : PREOP

Blood Pressure : \*\*\*/\*\*\* mmHG

Vent. Rate : 075 BPM Atrial Rate : 075 BPM

P-R Int : 166 ms QRS Dur : 092 ms

QT Int : 398 ms P-R-T Axes : 073 -18 041 degrees

QTc Int : 444 ms

Normal sinus rhythm

Normal ECG

When compared with ECG of 21-OCT-2015 00:13,

Nonspecific T wave abnormality no longer evident in Anterolateral leads

Confirmed by DEVAUGHN M.D., GERALD (1106) on 9/15/2017 3:56:50 PM

Referred By: MENACHEM MELLER Confirmed By:GERALD DEVAUGHN M.D.

<Electronically signed by GERALD L DEVAUGHN, MD in OV>

DEVAUGHN,GERALD L, MD 09/15/17

DT: 09/15/17 1556

MI

JOB: 0915-0052

Mercy Philadelphia Hospital  
Mercy Health System  
Department of Cardiology  
5301 Cedar Ave, Philadelphia, PA 19143  
Reports: (215) 748-9195; Scheduling: (215) 748-9117

**Mercy Philadelphia Hospital  
Operative Note**

**Patient:** BENTON, ALONZO

**DOB:** 11/12/1958

**Sex:** M

**MR #** M000301370

**Acct #** PA1304861964

**Room/Bed:**

**\*\*\* Signed Status \*\*\***

**DATE OF OPERATION:** 09/20/2017

**PREOPERATIVE DIAGNOSIS:**

Severely comminuted left distal clavicle fracture acromial end.

**POSTOPERATIVE DIAGNOSIS:**

Severely comminuted left distal clavicle fracture acromial end.

**PROCEDURES PERFORMED:**

ORIF of the left distal clavicle using a Synthes stainless steel clavicle plate.

**SURGEON:**

Menachem Meller, MD.

**ANESTHESIA:**

General.

**ESTIMATED BLOOD LOSS:**

100 mL.

**DRAINS:**

No drains were placed.

**SPECIMENS:**

No specimens taken.

**COMPLICATIONS:**

No complications.

**DESCRIPTION OF PROCEDURE:**

Patient was brought to the operating room and placed in supine position. General anesthesia was administered. Preoperative vancomycin 1 gram IV was provided as he was MRSA nasal screen positive. He also was hepatitis C positive. He reported IV DYE allergy and Hibiclens was used to prep the shoulder and upper extremity.

X-ray was reviewed demonstrating severe comminution of the distal clavicle with high riding distal end with displacement and tenting of the trapezius.

A transverse incision was made overlying the distal clavicle, centered over the fracture site. I intercepted that there was no fracture or hematoma, which would suggest this occurred a few weeks prior. The intake information indicates that he had fallen on 08/29/2017. He was seen in the emergency room at that time. A CT scan confirmed the significant displacement and comminution. It also demonstrated a nondisplaced left third rib fracture posteriorly.

CC:

REPORT #: 0920-0324

REPORT STATUS: Signed

**Mercy Philadelphia Hospital  
Operative Note**

**Patient:** BENTON,ALONZO**MR #** M000301370

The distal clavicle was then subperiosteally demonstrated significant scar tissue and early callus formation. There was some resolving bruising at the anterior humerus, but no hematoma or fluctuance.

The distal clavicle was too severely comminuted to allow exclusive fixation. The superior aspect of the acromion was demonstrated and a distal clavicle plate was then applied. Cortical screws were used for lateral clavicle shaft. Cancellous screw was used for the comminuted fracture site and the plate extended over the top of the acromion. The locking screws were used for additional fixation. An alligator clamp was used to reduce the severe comminution to the plate and #5 Ethibond suture was used as a perosseous repair to maintain the bone in a tubularized manner. The wound was irrigated and aspirated. It was closed in layers using #1 Vicryl for the periosteum and muscle layer, followed by #1 Vicryl inverted subcutaneous sutures, followed by staples to the skin. Local anesthetic was injected into the fracture site. Sterile dressings applied followed by a sling. The patient was then awakened and brought to the recovery room without any incident.

DICTATED BY: Menachem M. Meller, MD

Job #:872750 Doc #:2246628

&lt;Electronically signed by MENACHEM M MELLER, MD&gt; at 09/22/17

1450

---

MELLER, MENACHEM M MD

MELLME / NE / DD 09/20/17 1547 / DT 09/20/17 2125

Informant Pt - Alonzo Benton  
Allergies Iodine  
History

Date of Surgery 9/20/17  
LMP  
Corticosteroid Tx within Last Yr. ☐ Yes ☒ No

Chief Complaint (2) claudication

History of Present Illness Pt fell in street on 8/29/17. Still experiencing pain 10/10. Wearing sling. (2) bruising, & mobility, swelling, tenderness. Denies numbness & in sensation. x-ray confirmed break. Pt taking Percocet which relieves pain "somehow".

Past Medical Hx Prostate CR  
GERD herniated disc  
HTN

Previous Surgeries Prostatectomy ~2012  
(R) hernia repair

Medications

Losartan 75 mg Hydrochlorothiazide  
Omeprazole 20 mg HCTZ 12.5

Family History

Mother - CAD, DM  
Father - CAD

Social History

former smoker (quit 10 yrs, 1 pack x 30 yrs) occ alcohol 6 drugs

Review of Systems

NEURO

☒ No C/O

- ☐ headache ☐ paralysis  
☐ dizziness ☐ paresthesia  
☐ loss of consciousness  
☐ seizures

Comments

GASTROINTESTINAL

☒ No C/O

- ☐ nausea/vomiting ☐ abd pain  
☐ dysphagia ☐ rectal bleeding  
☐ weight loss ☐ change in bowel habits

Comments

HEENT

☐ No C/O

- Eyes ☐ Ears/Nose/Throat  
☒ impaired vision ☐ tinnitus ☐ pain  
☐ tearing ☐ drainage ☐ hoarseness  
☐ discharge ☐ hearing loss

Comments

(2) glasses  
missing lens

GENITOURINARY

☒ No C/O

- ☐ frequency ☐ hematuria  
☐ urgency ☐ nocturia  
☐ burning ☐ discharge

Comments

CARDIO PULMONARY

☒ No C/O

- ☐ chest pain ☐ asthma  
☐ palpitations ☐ emphysema  
☐ DOE ☐ cough  
☐ pneumonia ☐ sputum

Comments

MUSCULOSKELETAL

☒ No C/O

- ☒ pain ☐ rash  
☒ swelling ☐ bruises  
☒ joint restriction ☐ scars

Comments

(2) claudication  
Rib fx Fx

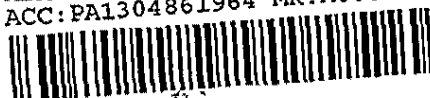
Other:

Mercy Philadelphia Hospital  
A member of Mercy Health System

PATIENT HISTORY & PHYSICAL



BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 09/20/17  
ACC: PA1304861964 MR: M000301370



PHYSICAL Pulse 80 Resp 18 B/P 131/89 HGT 5'9" WGT 170/65

HEENT

PERRLA EOMI neck supple.  
NO JVD - Neck supple.

CHEST/HEART/LUNGS

♡: S1S2 No murmur  
Lungs: B/L CTA - No wheezes

ABDOMEN

soft. NTND (+)BS

EXTREMITIES

(L) shoulder sling. limited mobility, (+) ecchymosis  
tender to palpation. Full ROM, 5/5 strength (L) Hand grip.

SKIN

bruising to (L) HE. Skin Intact. Warm. DRY. No lesions  
(+) Jtacos.

NEUROLOGIC

AAOX3

OTHER SPECIFIC FINDINGS

pt scheduled for DEXA scan 9/5/17.

ASSESSMENT

Disp Fx of Lateral (L) Clavicle

PLAN

ORIF Left distal Clavicle

SIGNATURE:

*Sarah Salkas* CRNP

PRINT:

Sarah Salkas CRNP

DATE/TIME:

9/5/17

1251 PM

ATTENDING ADDENDUM:

Electronically Signed by MELLER, MENACHEM M, MD on 09/25/17 at 1455

SIGNATURE:

PRINT:

DATE/TIME:

Mercy Philadelphia Hospital  
A member of Mercy Health System

PATIENT HISTORY AND PHYSICAL

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 09/20/17  
ACC: PA1304861964 MR: M000301370



DATE: 09/22/17 @ 0006  
USER: FISULKES

Mercy Philadelphia Hospital OE \*\*LIVE\*\*  
PATIENT ORDER SUMMARY

PAGE 1

PATIENT: PA1304861964 - BENTON,ALONZO  
UNIT #: M000301370

| ORDER                                   |          |          |                 |           |                                                             |            | SERVICE |          | ORDERED |            |            |           |
|-----------------------------------------|----------|----------|-----------------|-----------|-------------------------------------------------------------|------------|---------|----------|---------|------------|------------|-----------|
| DATE                                    | TIME     | CATEGORY | PROCEDURE       | ORDER NUM | PRI                                                         | QTY        | STATUS  | DATE     | TIME    | ORD DOCTOR | ORDERED BY | CHNG FROM |
| 09/15/17                                | 1258     | LAB      | CBCNO           | 0915-0660 | R                                                           |            | CMP     | 09/15/17 | 1254    | SULKSA     | FISULKES   | C POM D   |
| Collected by Nurse? Y                   |          |          |                 |           |                                                             |            |         |          |         |            |            |           |
| Comment:                                |          |          |                 |           |                                                             |            |         |          |         |            |            |           |
| DIRECTIONS:                             |          |          | STOP DATE/TIME: |           |                                                             | ORDER SET: |         |          |         |            |            |           |
|                                         | DATE     | TIME     | USER            | DEVICE    | EVENT                                                       |            |         |          |         |            |            |           |
| 1                                       | 09/15/17 | 1258     | FISULKES        | PH-ORC026 | order entered in POM by SARAH SULKES                        |            |         |          |         |            |            |           |
| 2                                       | 09/15/17 | 1258     | FISULKES        | PH-ORC026 | order source is PROVIDER - signature is necessary for entry |            |         |          |         |            |            |           |
| 3                                       | 09/15/17 | 1258     | FISULKES        | PH-ORC026 | order Signed by SULKES,SARAH K CRNP                         |            |         |          |         |            |            |           |
| 4                                       | 09/15/17 | 1259     | COSYSTEM        | CAE-BG314 | order transmitted                                           |            |         |          |         |            |            |           |
| 5                                       | 09/15/17 | 1259     | COSYSTEM        | CAE-BG314 | order's status changed from TRANS to LOGGED                 |            |         |          |         |            |            |           |
| 6                                       | 09/15/17 | 1314     | PHHARRER        | CAE-BG314 | order's status changed from LOGGED to IN PRO                |            |         |          |         |            |            |           |
| 7                                       | 09/15/17 | 1321     | PHABRAHM        | CAE-BG314 | order's status changed from IN PRO to COMP                  |            |         |          |         |            |            |           |
| 09/15/17                                | 1258     | CARD     | EKG             | 0915-0035 | ROUT                                                        | 1          | RES     | 09/15/17 | 1254    | SULKSA     | FISULKES   | C POM D   |
| Reason for Study? PRE-OP                |          |          |                 |           |                                                             |            |         |          |         |            |            |           |
| Other Reason for Study?                 |          |          |                 |           |                                                             |            |         |          |         |            |            |           |
| Comment:                                |          |          |                 |           |                                                             |            |         |          |         |            |            |           |
| DIRECTIONS:                             |          |          | STOP DATE/TIME: |           |                                                             | ORDER SET: |         |          |         |            |            |           |
|                                         | DATE     | TIME     | USER            | DEVICE    | EVENT                                                       |            |         |          |         |            |            |           |
| 1                                       | 09/15/17 | 1258     | FISULKES        | PH-ORC026 | order entered in POM by SARAH SULKES                        |            |         |          |         |            |            |           |
| 2                                       | 09/15/17 | 1258     | FISULKES        | PH-ORC026 | order source is PROVIDER - signature is necessary for entry |            |         |          |         |            |            |           |
| 3                                       | 09/15/17 | 1258     | FISULKES        | PH-ORC026 | order Signed by SULKES,SARAH K CRNP                         |            |         |          |         |            |            |           |
| 4                                       | 09/15/17 | 1259     | COSYSTEM        | CAE-BG314 | order transmitted                                           |            |         |          |         |            |            |           |
| 5                                       | 09/15/17 | 1259     | COSYSTEM        | CAE-BG314 | order's status changed from TRANS to LOGGED                 |            |         |          |         |            |            |           |
| 6                                       | 09/15/17 | 1259     | COSYSTEM        | CAE-BG314 | quantity edited via ITS: old value -                        |            |         |          |         |            |            |           |
| 7                                       | 09/15/17 | 1557     | BKG DAEMON      | CAE-BG314 | order's status changed from LOGGED to RESULT                |            |         |          |         |            |            |           |
| 09/15/17                                | 1258     | MIC      | MRSAPCR         | 0915-0021 | R                                                           |            | CMP     | 09/15/17 | 1254    | SULKSA     | FISULKES   | C POM D   |
| Collected by Nurse? Y                   |          |          |                 |           |                                                             |            |         |          |         |            |            |           |
| Comment:                                |          |          |                 |           |                                                             |            |         |          |         |            |            |           |
| Has specimen been obtained/collected? Y |          |          |                 |           |                                                             |            |         |          |         |            |            |           |
| MRSA Source: NARES RIGHT AND LEFT       |          |          |                 |           |                                                             |            |         |          |         |            |            |           |
| If Source = 'Other', please specify:    |          |          |                 |           |                                                             |            |         |          |         |            |            |           |
| DIRECTIONS:                             |          |          | STOP DATE/TIME: |           |                                                             | ORDER SET: |         |          |         |            |            |           |
|                                         | DATE     | TIME     | USER            | DEVICE    | EVENT                                                       |            |         |          |         |            |            |           |
| 1                                       | 09/15/17 | 1258     | FISULKES        | PH-ORC026 | order entered in POM by SARAH SULKES                        |            |         |          |         |            |            |           |
| 2                                       | 09/15/17 | 1258     | FISULKES        | PH-ORC026 | order source is PROVIDER - signature is necessary for entry |            |         |          |         |            |            |           |
| 3                                       | 09/15/17 | 1258     | FISULKES        | PH-ORC026 | order Signed by SULKES,SARAH K CRNP                         |            |         |          |         |            |            |           |
| 4                                       | 09/15/17 | 1259     | COSYSTEM        | CAE-BG314 | order transmitted                                           |            |         |          |         |            |            |           |
| 5                                       | 09/15/17 | 1300     | COSYSTEM        | CAE-BG314 | order's status changed from TRANS to LOGGED                 |            |         |          |         |            |            |           |
| 6                                       | 09/15/17 | 1314     | PHHARRER        | CAE-BG314 | order's status changed from LOGGED to IN PRO                |            |         |          |         |            |            |           |
| 7                                       | 09/16/17 | 1929     | INFCE           | CAE-BG314 | order's status changed from IN PRO to COMP                  |            |         |          |         |            |            |           |
| 09/15/17                                | 1258     | LAB      | CA              | 0915-0661 | R                                                           |            | CMP     | 09/15/17 | 1257    | SULKSA     | FISULKES   | C POM D   |

DATE: 09/22/17 @ 0006  
USER: FISULKES

Mercy Philadelphia Hospital OE \*\*LIVE\*\*  
PATIENT ORDER SUMMARY

PAGE 2

PATIENT: PA1304861964 - BENTON,ALONZO  
UNIT #: M000301370

| ORDER |      |          |           |           | SERVICE |     |        |      |      | ORDERED    |            |      |      |
|-------|------|----------|-----------|-----------|---------|-----|--------|------|------|------------|------------|------|------|
| DATE  | TIME | CATEGORY | PROCEDURE | ORDER NUM | PRI     | QTY | STATUS | DATE | TIME | ORD DOCTOR | ORDERED BY | CHNG | FROM |

Collected by Nurse? Y  
Comment:

| DIRECTIONS: |               |          | STOP DATE/TIME: |                                                             | ORDER SET: |
|-------------|---------------|----------|-----------------|-------------------------------------------------------------|------------|
| DATE        | TIME          | USER     | DEVICE          | EVENT                                                       |            |
| 1           | 09/15/17 1258 | FISULKES | PH-ORC026       | order entered in POM by SARAH SULKES                        |            |
| 2           | 09/15/17 1258 | FISULKES | PH-ORC026       | order source is PROVIDER - signature is necessary for entry |            |
| 3           | 09/15/17 1258 | FISULKES | PH-ORC026       | order Signed by SULKES,SARAH K CRNP                         |            |
| 4           | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order transmitted                                           |            |
| 5           | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order's status changed from TRANS to LOGGED                 |            |
| 6           | 09/15/17 1314 | PHHARRER | CAE-BG314       | order's status changed from LOGGED to IN PRO                |            |
| 7           | 09/15/17 1352 | PHANDERL | CAE-BG314       | order's status changed from IN PRO to COMP                  |            |

09/15/17 1258 LAB MG 0915-0662 R CMP 09/15/17 1257 SULKSA FISULKES C POM D

Collected by Nurse? Y  
Comment:

| DIRECTIONS: |               |          | STOP DATE/TIME: |                                                             | ORDER SET: |
|-------------|---------------|----------|-----------------|-------------------------------------------------------------|------------|
| DATE        | TIME          | USER     | DEVICE          | EVENT                                                       |            |
| 1           | 09/15/17 1258 | FISULKES | PH-ORC026       | order entered in POM by SARAH SULKES                        |            |
| 2           | 09/15/17 1258 | FISULKES | PH-ORC026       | order source is PROVIDER - signature is necessary for entry |            |
| 3           | 09/15/17 1258 | FISULKES | PH-ORC026       | order Signed by SULKES,SARAH K CRNP                         |            |
| 4           | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order transmitted                                           |            |
| 5           | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order's status changed from TRANS to LOGGED                 |            |
| 6           | 09/15/17 1314 | PHHARRER | CAE-BG314       | order's status changed from LOGGED to IN PRO                |            |
| 7           | 09/15/17 1352 | PHANDERL | CAE-BG314       | order's status changed from IN PRO to COMP                  |            |

09/15/17 1258 LAB PHOS 0915-0663 R CMP 09/15/17 1257 SULKSA FISULKES C POM D

Collected by Nurse? Y  
Comment:

| DIRECTIONS: |               |          | STOP DATE/TIME: |                                                             | ORDER SET: |
|-------------|---------------|----------|-----------------|-------------------------------------------------------------|------------|
| DATE        | TIME          | USER     | DEVICE          | EVENT                                                       |            |
| 1           | 09/15/17 1258 | FISULKES | PH-ORC026       | order entered in POM by SARAH SULKES                        |            |
| 2           | 09/15/17 1258 | FISULKES | PH-ORC026       | order source is PROVIDER - signature is necessary for entry |            |
| 3           | 09/15/17 1258 | FISULKES | PH-ORC026       | order Signed by SULKES,SARAH K CRNP                         |            |
| 4           | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order transmitted                                           |            |
| 5           | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order's status changed from TRANS to LOGGED                 |            |
| 6           | 09/15/17 1314 | PHHARRER | CAE-BG314       | order's status changed from LOGGED to IN PRO                |            |
| 7           | 09/15/17 1352 | PHANDERL | CAE-BG314       | order's status changed from IN PRO to COMP                  |            |

09/15/17 1258 LAB VITD125 0915-0664 R CMP 09/15/17 1257 SULKSA FISULKES C POM D

Collected by Nurse? Y  
Comment:

| DIRECTIONS: |      |      | STOP DATE/TIME: |       | ORDER SET: |
|-------------|------|------|-----------------|-------|------------|
| DATE        | TIME | USER | DEVICE          | EVENT |            |

PAGE 3

### PATIENT ORDER SUMMARY

UNIT #: M000301370

| ORDER                 |               |          |                 |                                                             |     |               | SERVICE |          |      | ORDERED    |            |      |      |
|-----------------------|---------------|----------|-----------------|-------------------------------------------------------------|-----|---------------|---------|----------|------|------------|------------|------|------|
| DATE                  | TIME          | CATEGORY | PROCEDURE       | ORDER NUM                                                   | PRI | QTY           | STATUS  | DATE     | TIME | ORD DOCTOR | ORDERED BY | CHNG | FROM |
| 1                     | 09/15/17 1258 | FISULKES | PH-ORC026       | order entered in POM by SARAH SULKES                        |     |               |         |          |      |            |            |      |      |
| 2                     | 09/15/17 1258 | FISULKES | PH-ORC026       | order source is PROVIDER - signature is necessary for entry |     |               |         |          |      |            |            |      |      |
| 3                     | 09/15/17 1258 | FISULKES | PH-ORC026       | order Esigned by SULKES,SARAH K CRNP                        |     |               |         |          |      |            |            |      |      |
| 4                     | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order transmitted                                           |     |               |         |          |      |            |            |      |      |
| 5                     | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order's status changed from TRANS to LOGGED                 |     |               |         |          |      |            |            |      |      |
| 6                     | 09/15/17 1314 | PHHARRER | CAE-BG314       | order's status changed from LOGGED to IN PRO                |     |               |         |          |      |            |            |      |      |
| 7                     | 09/18/17 1417 | INFCE    | CAE-BG314       | order's status changed from IN PRO to COMP                  |     |               |         |          |      |            |            |      |      |
| 09/15/17 1258         | LAB           | VITD25   | 0915-0665       | R                                                           | CMP | 09/15/17 1257 | SULKSA  | FISULKES | C    | POM        | D          |      |      |
| Collected by Nurse? Y |               |          |                 |                                                             |     |               |         |          |      |            |            |      |      |
| Comment:              |               |          |                 |                                                             |     |               |         |          |      |            |            |      |      |
| DIRECTIONS:           |               |          | STOP DATE/TIME: |                                                             |     | ORDER SET:    |         |          |      |            |            |      |      |
| DATE                  | TIME          | USER     | DEVICE          | EVENT                                                       |     |               |         |          |      |            |            |      |      |
| 1                     | 09/15/17 1258 | FISULKES | PH-ORC026       | order entered in POM by SARAH SULKES                        |     |               |         |          |      |            |            |      |      |
| 2                     | 09/15/17 1258 | FISULKES | PH-ORC026       | order source is PROVIDER - signature is necessary for entry |     |               |         |          |      |            |            |      |      |
| 3                     | 09/15/17 1258 | FISULKES | PH-ORC026       | order Esigned by SULKES,SARAH K CRNP                        |     |               |         |          |      |            |            |      |      |
| 4                     | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order transmitted                                           |     |               |         |          |      |            |            |      |      |
| 5                     | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order's status changed from TRANS to LOGGED                 |     |               |         |          |      |            |            |      |      |
| 6                     | 09/15/17 1314 | PHHARRER | CAE-BG314       | order's status changed from LOGGED to IN PRO                |     |               |         |          |      |            |            |      |      |
| 7                     | 09/15/17 1507 | INFCE    | CAE-BG314       | order's status changed from IN PRO to COMP                  |     |               |         |          |      |            |            |      |      |
| 09/15/17 1258         | LAB           | PTHI     | 0915-0666       | R                                                           | CMP | 09/15/17 1257 | SULKSA  | FISULKES | C    | POM        | D          |      |      |
| Collected by Nurse? Y |               |          |                 |                                                             |     |               |         |          |      |            |            |      |      |
| Comment:              |               |          |                 |                                                             |     |               |         |          |      |            |            |      |      |
| DIRECTIONS:           |               |          | STOP DATE/TIME: |                                                             |     | ORDER SET:    |         |          |      |            |            |      |      |
| DATE                  | TIME          | USER     | DEVICE          | EVENT                                                       |     |               |         |          |      |            |            |      |      |
| 1                     | 09/15/17 1258 | FISULKES | PH-ORC026       | order entered in POM by SARAH SULKES                        |     |               |         |          |      |            |            |      |      |
| 2                     | 09/15/17 1258 | FISULKES | PH-ORC026       | order source is PROVIDER - signature is necessary for entry |     |               |         |          |      |            |            |      |      |
| 3                     | 09/15/17 1258 | FISULKES | PH-ORC026       | order Esigned by SULKES,SARAH K CRNP                        |     |               |         |          |      |            |            |      |      |
| 4                     | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order transmitted                                           |     |               |         |          |      |            |            |      |      |
| 5                     | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order's status changed from TRANS to LOGGED                 |     |               |         |          |      |            |            |      |      |
| 6                     | 09/15/17 1314 | PHHARRER | CAE-BG314       | order's status changed from LOGGED to IN PRO                |     |               |         |          |      |            |            |      |      |
| 7                     | 09/15/17 1352 | PHANDERL | CAE-BG314       | order's status changed from IN PRO to COMP                  |     |               |         |          |      |            |            |      |      |
| 09/15/17 1258         | LAB           | FERR     | 0915-0667       | R                                                           | CMP | 09/15/17 1257 | SULKSA  | FISULKES | C    | POM        | D          |      |      |
| Collected by Nurse? Y |               |          |                 |                                                             |     |               |         |          |      |            |            |      |      |
| Comment:              |               |          |                 |                                                             |     |               |         |          |      |            |            |      |      |
| DIRECTIONS:           |               |          | STOP DATE/TIME: |                                                             |     | ORDER SET:    |         |          |      |            |            |      |      |
| DATE                  | TIME          | USER     | DEVICE          | EVENT                                                       |     |               |         |          |      |            |            |      |      |
| 1                     | 09/15/17 1258 | FISULKES | PH-ORC026       | order entered in POM by SARAH SULKES                        |     |               |         |          |      |            |            |      |      |
| 2                     | 09/15/17 1258 | FISULKES | PH-ORC026       | order source is PROVIDER - signature is necessary for entry |     |               |         |          |      |            |            |      |      |
| 3                     | 09/15/17 1258 | FISULKES | PH-ORC026       | order Esigned by SULKES,SARAH K CRNP                        |     |               |         |          |      |            |            |      |      |
| 4                     | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order transmitted                                           |     |               |         |          |      |            |            |      |      |
| 5                     | 09/15/17 1259 | COSYSTEM | CAE-BG314       | order's status changed from TRANS to LOGGED                 |     |               |         |          |      |            |            |      |      |
| 6                     | 09/15/17 1314 | PHHARRER | CAE-BG314       | order's status changed from LOGGED to IN PRO                |     |               |         |          |      |            |            |      |      |

DATE: 09/22/17 @ 0006  
USER: FISULKES

Mercy Philadelphia Hospital OE \*\*LIVE\*\*  
PATIENT ORDER SUMMARY

PAGE 4

PATIENT: PA1304861964 - BENTON,ALONZO  
UNIT #: M000301370

| ORDER |      |          |           |           | SERVICE |     |        |      |      | ORDERED    |            |      |      |
|-------|------|----------|-----------|-----------|---------|-----|--------|------|------|------------|------------|------|------|
| DATE  | TIME | CATEGORY | PROCEDURE | ORDER NUM | PRI     | QTY | STATUS | DATE | TIME | ORD DOCTOR | ORDERED BY | CHNG | FROM |

|   |          |      |          |           |  |  |                                            |  |  |  |  |  |  |
|---|----------|------|----------|-----------|--|--|--------------------------------------------|--|--|--|--|--|--|
| 7 | 09/15/17 | 1352 | PHANDERL | CAE-BG314 |  |  | order's status changed from IN PRO to COMP |  |  |  |  |  |  |
|---|----------|------|----------|-----------|--|--|--------------------------------------------|--|--|--|--|--|--|

|          |      |     |     |           |   |  |     |          |      |        |          |   |     |   |
|----------|------|-----|-----|-----------|---|--|-----|----------|------|--------|----------|---|-----|---|
| 09/15/17 | 1258 | LAB | ALB | 0915-0668 | R |  | CMP | 09/15/17 | 1257 | SULKSA | FISULKES | C | POM | D |
|----------|------|-----|-----|-----------|---|--|-----|----------|------|--------|----------|---|-----|---|

Collected by Nurse? Y  
Comment:

| DIRECTIONS: |          |      | STOP DATE/TIME: |           | ORDER SET:                                                  |
|-------------|----------|------|-----------------|-----------|-------------------------------------------------------------|
| DATE        | TIME     | USER | DEVICE          | EVENT     |                                                             |
| 1           | 09/15/17 | 1258 | FISULKES        | PH-ORC026 | order entered in POM by SARAH SULKES                        |
| 2           | 09/15/17 | 1258 | FISULKES        | PH-ORC026 | order source is PROVIDER - signature is necessary for entry |
| 3           | 09/15/17 | 1258 | FISULKES        | PH-ORC026 | order Signed by SULKES,SARAH K CRNP                         |
| 4           | 09/15/17 | 1259 | COSYSTEM        | CAE-BG314 | order transmitted                                           |
| 5           | 09/15/17 | 1300 | COSYSTEM        | CAE-BG314 | order's status changed from TRANS to LOGGED                 |
| 6           | 09/15/17 | 1314 | PHHARRER        | CAE-BG314 | order's status changed from LOGGED to IN PRO                |
| 7           | 09/15/17 | 1352 | PHANDERL        | CAE-BG314 | order's status changed from IN PRO to COMP                  |

|          |      |     |       |           |   |  |     |          |      |        |          |   |     |   |
|----------|------|-----|-------|-----------|---|--|-----|----------|------|--------|----------|---|-----|---|
| 09/15/17 | 1258 | LAB | PREAL | 0915-0669 | R |  | CMP | 09/15/17 | 1257 | SULKSA | FISULKES | C | POM | D |
|----------|------|-----|-------|-----------|---|--|-----|----------|------|--------|----------|---|-----|---|

Collected by Nurse? Y  
Comment:

| DIRECTIONS: |          |      | STOP DATE/TIME: |           | ORDER SET:                                                  |
|-------------|----------|------|-----------------|-----------|-------------------------------------------------------------|
| DATE        | TIME     | USER | DEVICE          | EVENT     |                                                             |
| 1           | 09/15/17 | 1258 | FISULKES        | PH-ORC026 | order entered in POM by SARAH SULKES                        |
| 2           | 09/15/17 | 1258 | FISULKES        | PH-ORC026 | order source is PROVIDER - signature is necessary for entry |
| 3           | 09/15/17 | 1258 | FISULKES        | PH-ORC026 | order Signed by SULKES,SARAH K CRNP                         |
| 4           | 09/15/17 | 1259 | COSYSTEM        | CAE-BG314 | order transmitted                                           |
| 5           | 09/15/17 | 1300 | COSYSTEM        | CAE-BG314 | order's status changed from TRANS to LOGGED                 |
| 6           | 09/15/17 | 1314 | PHHARRER        | CAE-BG314 | order's status changed from LOGGED to IN PRO                |
| 7           | 09/15/17 | 1352 | PHANDERL        | CAE-BG314 | order's status changed from IN PRO to COMP                  |

|          |      |    |            |           |      |   |     |          |        |          |   |     |
|----------|------|----|------------|-----------|------|---|-----|----------|--------|----------|---|-----|
| 09/20/17 | 1539 | CR | FLUROLESHR | 0920-0072 | ROUT | 1 | RES | 09/20/17 | MELIME | PHCARAND | C | RAD |
|----------|------|----|------------|-----------|------|---|-----|----------|--------|----------|---|-----|

Reason for Exam: ORIF LT CLAVICLE  
Is Patient Pregnant?  
When was patient's LMP?  
Comment:

| DATE | TIME     | USER | DEVICE     | EVENT      |                                             |
|------|----------|------|------------|------------|---------------------------------------------|
| 1    | 09/20/17 | 1539 | PHCARAND   | PH-RADC002 | order entered in ITS by DONNA GORDON        |
| 2    | 09/20/17 | 1545 | PHCARAND   | CAE-BG314  | order's status changed from LOGGED to TAKEN |
| 3    | 09/21/17 | 1635 | BKG DAEMON | CAE-BG314  | order's status changed from TAKEN to RESULT |



# Mercy Philadelphia Hospital

A member of Mercy Health System

## Pre-Admission Intake and Surgery Request Form

Pt. Name Alonzo Benton  
 Address 2432 S Frazier Street  
 City Philadelphia State PA Zip 19143  
 Phone (215) 403-5705 CP \_\_\_\_\_  
 DOB 11/12/58 Age 58 Gender Male  
 PCP \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Relative/Guardian \_\_\_\_\_  
 Phone \_\_\_\_\_ CP \_\_\_\_\_  
 Does pt. live alone yes no ☒   
 Allergies NKA

Allergic to Latex Yes No ☒   
 Type of admission: AM ☒ SPU OBS. 23 hour

Diagnosis Comminuted Distal Clavicle Fracture of Left  
 CPT Code Shoulder.....23515  
 ICD 9 Code S42.002A  
 Date of Surgery 09/20/17  
 Time requested 8:00am  
 Surgeon Dr. Meller  
 Procedure ORIF Left Distal Clavicle  
 Surgical Site Left Shoulder  
 Position \_\_\_\_\_  
 Positioning Device \_\_\_\_\_  
 Surgical Assist required: Yes No ☒   
 Estimated length of procedure 2hrs  
 Implants required \_\_\_\_\_  
 Special Equipment \_\_\_\_\_  
 Hattie notified yes no (internal use) ☒

Insurance:  
 1. Type Gateway Medicare  
 Policy# 70113084  
 Group# \_\_\_\_\_  
 Subscriber \_\_\_\_\_  
 SSN# 166-52-9216 - -  
 Employer \_\_\_\_\_  
 Authorization # NO PRECERT REQUIRED PER ANNETT

2. Type \_\_\_\_\_  
 Policy# \_\_\_\_\_  
 Group# \_\_\_\_\_  
 Subscriber \_\_\_\_\_  
 SSN# \_\_\_\_\_ - -  
 Employer \_\_\_\_\_  
 Authorization # \_\_\_\_\_

Special Needs: ☐ Child N/A  
 1. Does Pt. have a language barrier? Y N ☒   
 2. Does Pt. have a hearing impairment? Y N ☒   
 3. Does Pt. does Pt. have visual impairment? Y N ☒   
 Comments \_\_\_\_\_  
 4. Does Pt. require venous mapping? Y N ☒   
 5. Pt. has a Pacemaker or AICD Y N ☒   
 Have you consulted Cardiology? Y N ☒   
 Cardiologist consulted \_\_\_\_\_  
 6. Pt. is a diabetic and on Insulin or oral medication Y N ☒   
 What instructions have they been given for day of Surgery? \_\_\_\_\_  
 7. Pt. is on anticoagulants Y N ☒   
 When were they instructed to take their last dose, prior to surgery? \_\_\_\_\_

Pre-Admission Testing Yes PAT by Protocol (includes all required testing per anesthesia guidelines)

|                                       |                                      |                                        |                                                     |                                 |                                   |                                                 |
|---------------------------------------|--------------------------------------|----------------------------------------|-----------------------------------------------------|---------------------------------|-----------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Electrolytes | <input type="checkbox"/> CBC         | <input type="checkbox"/> T&S           | <input type="checkbox"/> Type & Cross               | Units                           | <input type="checkbox"/> FFP      | <input type="checkbox"/> Platelets              |
| <input type="checkbox"/> Potassium    | <input type="checkbox"/> Glucose     | <input type="checkbox"/> BUN           | <input type="checkbox"/> Creatinine                 | <input type="checkbox"/> Sodium | <input type="checkbox"/> Chloride | <input type="checkbox"/> CO2                    |
| <input type="checkbox"/> PT           | <input type="checkbox"/> PTT         | <input type="checkbox"/> Liver Profile | <input type="checkbox"/> Uric Acid                  | <input type="checkbox"/> LDH    | <input type="checkbox"/> Calcium  | <input checked="" type="checkbox"/> MRSA Screen |
| <input type="checkbox"/> Phosphorous  | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Triglycerides | <input type="checkbox"/> Pregnancy Test (Serum HCG) | *except kids smile & cataract   |                                   |                                                 |
| <input type="checkbox"/> EKG          | <input type="checkbox"/> CXR         | <input type="checkbox"/> Urinalysis    | Other: _____                                        |                                 |                                   |                                                 |

☐ CT Scan Pt. weight \_\_\_\_\_ Pt. Height \_\_\_\_\_ ☒ POx in SPU Pre-Op  
☐ Accu Check pre-op LMP \_\_\_\_\_ Allergy to dye \_\_\_\_\_  
☐ Physical Therapy Training ☐ Visiting Nurse ☐ No labs necessary due to 2nd cataract

Physician Signature \_\_\_\_\_ Date 09/15/17 Time 9:00am

Sender Name Tyra Ruffin Scheduler Information  
 Date scheduling information sent 09/15/17 Phone (215)-748-9813 Fax # (215) 748-9717  
 Faxed to OR ☐ Fax Number 215-748-9512 Time sent 9:00 AM PM  
 If you experience any difficulty faxing, please call Gwen or Pat at 215-748-9425

Scheduling Confirmation  
 Case Scheduled by \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
 Procedure Scheduled \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
 Booked in Picis ☐ Written in Schedule book ☐  
 Request Form faxed to PAT ☐ Registration ☐ Requesting Physicians Office ☐

POOR QUALITY ORIGINAL

⊕ MRSA

Allergic to INDYE

Allergies: Check if: ☐ Patient is pregnant  
(Check EMR) ☐ Patient is lactating

## PREOPERATIVE ORDERS SHEET

## ANESTHESIA TO COMPLETE:

Patient is taking a Beta Blocker (BB) daily at home prior to arrival or as a current medication

☐ No ☐ Yes

If yes, drug/dose: \_\_\_\_\_

Last Dose Date \_\_\_\_\_

Time \_\_\_\_\_

If yes, has a dose of BB been missed on the day of surgery? ☐ No ☐ Yes (Administer BB)If yes: ☐ Preoperative BB given (drug/dose/route) \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_☐ Intraoperative BB (see anesthesia record)

If BB is indicated BUT NOT GIVEN, reason: \_\_\_\_\_

Anesthesiologist Signature \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

## SURGEON TO COMPLETE: Must have an order to admit prior to performing inpatient surgery/procedure

Please Check: ☐ Admit to Inpatient ☐ Outpatient ☐ Patient expected to stay ☐ greater than 2 midnights

Preoperative antibiotics to be given within 1 hour of incision time (vancomycin within 2 hours of incision time)

|                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Peripheral vascular/General surgery/PEG tube placement                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Cefazolin (Ancef) 2 Gm IV<br><input type="checkbox"/> Cefazolin (Ancef) 3 Gm if weight $\geq 120$ kg<br><input type="checkbox"/> **Vancomycin 15 mg/kg _____ Gm                                                                                                                                                                                                                                                                              | If Beta lactam allergy:<br><input checked="" type="checkbox"/> Vancomycin 15 mg/kg _____ Gm<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV                                                                                                                                                    |
| <input checked="" type="checkbox"/> Orthopedic/Podiatric Surgery<br>GI Surgery                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Cefazolin (Ancef) 2 Gm IV and Metronidazole (Flagyl) 500 mg IV<br><input type="checkbox"/> Cefazolin (Ancef) 3 Gm if weight $\geq 120$ kg and Metronidazole (Flagyl) 500 mg IV<br><input type="checkbox"/> Ceftriaxone (Rocephin) 2 Gm IV and Metronidazole (Flagyl) 500 mg IV<br><input type="checkbox"/> Ampicillin/Sulbactam (Unasyn) 3 Gm IV                                                                                             | If Beta lactam allergy:<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Ciprofloxacin (Cipro) 400 mg IV<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Aztreonam 2 Gm IV<br><input type="checkbox"/> Metronidazole (Flagyl) 500 mg IV and Ciprofloxacin (Cipro) 400 mg IV |
| Urology/Gynecologic/Obstetrician Surgery                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> Cefazolin (Ancef) 2 Gm IV<br><input type="checkbox"/> Cefazolin (Ancef) 3 Gm if weight $\geq 120$ kg<br><input type="checkbox"/> Ampicillin/Sulbactam (Unasyn) 3 Gm IV                                                                                                                                                                                                                                                                       | If Beta lactam allergy:<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Ciprofloxacin (Cipro) 400 mg IV<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Aztreonam 2 Gm IV<br><input type="checkbox"/> Metronidazole (Flagyl) 500 mg IV and Ciprofloxacin (Cipro) 400 mg IV |
| Outpatient:<br><input type="checkbox"/> Prostate Biopsy                                                                                                                                                                                                                                                                                                                                             | <input checked="" type="checkbox"/> Ciprofloxacin (Cipro) 500 mg PO (patient took prior to arrival)<br><input type="checkbox"/> Sulfamethoxazole / Trimethoprim DS (Bactrim) 800/160 mg PO (patient took prior to arrival)<br><input type="checkbox"/> Ciprofloxacin (Cipro) 400 mg IV<br><input type="checkbox"/> Cefazolin (Ancef) 2 Gm IV<br><input type="checkbox"/> Cefazolin (Ancef) 3 Gm if weight $\geq 120$ kg<br><input type="checkbox"/> Aztreonam 2 Gm IV |                                                                                                                                                                                                                                                                                                            |
| Outpatient:<br><input checked="" type="checkbox"/> Puvovaginal sling                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Cefazolin (Ancef) 2 Gm IV<br><input type="checkbox"/> Cefazolin (Ancef) 3 Gm if weight $\geq 120$ kg<br><input type="checkbox"/> Ampicillin/Sulbactam (Unasyn) 3 Gm IV<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Aztreonam 2 Gm IV<br><input type="checkbox"/> Aztreonam 2 Gm IV and Metronidazole (Flagyl) 500 mg IV                                                                                                  |                                                                                                                                                                                                                                                                                                            |
| Outpatient: Penile Prosthesis Insertion, removal, revision                                                                                                                                                                                                                                                                                                                                          | <input checked="" type="checkbox"/> Ampicillin/Sulbactam (Unasyn) 3 Gm IV<br><input type="checkbox"/> Clindamycin (Cleocin) 900 mg IV and Aztreonam 2 Gm IV<br><input checked="" type="checkbox"/> **Vancomycin 15 mg/kg _____ gm and Aztreonam 2 Gm IV                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                            |
| **Reason for Vancomycin use:<br><input type="checkbox"/> Beta Lactam Allergy<br><input type="checkbox"/> Pt high risk due to acute inpatient hospitalization within the last year or LTC setting within the last year prior to admission<br><input type="checkbox"/> MRSA colonization/infection<br><input type="checkbox"/> Chronic wound care or dialysis<br><input type="checkbox"/> Other _____ | Preoperative antibiotics not indicated because:<br><input type="checkbox"/> Possible infection; intraoperative cultures to be drawn<br><input type="checkbox"/> Already on therapeutic antibiotics<br><input type="checkbox"/> No body cavity opened, no implanted devices and no foreign bodies inserted<br><input type="checkbox"/> Other _____                                                                                                                     |                                                                                                                                                                                                                                                                                                            |
| Redosing with antibiotics required if the duration of the procedure exceeds two half-lives of the drug                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                            |
| Antimicrobial w/ shorter half-life                                                                                                                                                                                                                                                                                                                                                                  | Half-life (hr) in Adults (normal renal function)                                                                                                                                                                                                                                                                                                                                                                                                                      | Recommended Redosing Interval (hr) from initiation of preoperative dose                                                                                                                                                                                                                                    |
| Ampicillin-sulbactam (Unasyn)                                                                                                                                                                                                                                                                                                                                                                       | 0.8 - 1.3                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2                                                                                                                                                                                                                                                                                                          |
| Aztreonam (Azactam)                                                                                                                                                                                                                                                                                                                                                                                 | 1.3 - 2.4                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4                                                                                                                                                                                                                                                                                                          |
| Cefazolin (Ancef)                                                                                                                                                                                                                                                                                                                                                                                   | 1.2 - 2.2                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4                                                                                                                                                                                                                                                                                                          |
| Clindamycin                                                                                                                                                                                                                                                                                                                                                                                         | 2 - 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6                                                                                                                                                                                                                                                                                                          |

SURGEON'S SIGNATURE: \_\_\_\_\_

Beeper# \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Mercy Philadelphia Hospital  
A member of Mercy Health System

SCIP PreOp Order Form



BENTON, ALONZO

DOB: 11/12/1958 58 M

ADM: 09/20/17

ACC: PA1304861964 MR: M000301370





Interdisciplinary Integrated  
Progress Notes

9/19/17 0457 AM plan faxed to Dr. Bellh  
JMO

Mercy Philadelphia Hospital  
member of Mercy Health System

Interdisciplinary Integrated  
Progress Notes



DOB: BENTON, ALONZO  
Adm: DOB: 11/12/1958 58 M  
Acc: ADM: 09/20/17  
ACC: PA1304861964 MR: M000301370



POOR QUALITY ORIGINAL

# Pre-Procedural History and Physical Verification

Verify the H&P: Patient examined prior to procedure by ME

No Interval changes

Change noted

## Pre-op Orders

☐ Insert Foley Catheter

☐ Apply Sequentials

☒ Antibiotic

Other

Surgeon

Wanda Lee

9/20/17

Date

1:30 pm

## Patient Verification

I have identified the patient on the Procedure table

Attending Proceduralist

Wanda Lee

Date

9/20/17

Time

3:30 pm

## Post Procedural Note

OPERATIVE NOTE:

Type of Anesthesia Administered

PREOPERATIVE DIAGNOSIS:

Crown crushed displaced  
@ distal clavicle fx

POST-OPERATIVE DIAGNOSIS

None

NAME OF SURGEON / ASSISTANTS

Muller

PROCEDURE

ORIF @ distal clavicle

FINDINGS

severely comminuted distal clavicle

SPECIMEN REMOVED:

None

EBL

None

FLUIDS

COMPLICATIONS

None

DRAINS

The LIP signature also indicates orders for medications given during procedure.

Is the patient on Beta Blockers.

YES

NO

If yes did you include in post-op orders

YES

NO

Staging

T

N

M

Stage

N/A

NOTES:

Signature:

Wanda Lee

9/20/17

3:30 pm

Mercy Philadelphia Hospital  
A member of Mercy Health System

INTERDISCIPLINARY INTEGRATED O/P PROGRESS NOTES



Page 1 of 1  
Form M832 Rev. 08/2012  
PCS.XO.THR

BENTON, ALONZO

DOB: 11/12/1958 58 M

ADM: 09/20/17

ACC: PA1304861964 MR: M000301370



MERCY HEALTH SYSTEM  
MERCY PHILADELPHIA LABORATORY  
501 SOUTH 54th STREET  
PHILADELPHIA PA, 19143  
SAMIA HENIEN, M.D. MEDICAL DIRECTOR

LABORATORY REPORT

NAME: BENTON, ALONZO      DOS: 09/20/17      LOC: PHSPU  
AGE/SEX: 58/M      DOB: 11/12/1958      ACCT: PA1304861964      MR: M000301370  
ATTEND DR: MELLER, MENACHEM M, MD

KEY H - Abn High      \*H - Critical High      \* - High or Low(Alpha results)      # - Delta Check  
L - Abn Low      \*L - Critical Low      \* - Microbiology Abn Result

HEMATOLOGY

| Date                 | SEP 15 |  |  | Reference   | Units   |
|----------------------|--------|--|--|-------------|---------|
| Time                 | 1313   |  |  |             |         |
| => WHITE BLOOD COUNT | 5.1    |  |  | (4.5-11.0)  | Thou/uL |
| => RED BLOOD COUNT   | 4.35 L |  |  | (4.70-6.10) | Mill/uL |
| => HEMOGLOBIN        | 12.2 L |  |  | (13.5-17.5) | g/dL    |
| => HEMATOCRIT        | 38.9 L |  |  | (41.0-53.0) | %       |
| => MCV               | 89.5   |  |  | (80-100)    | fL      |
| => MCH               | 28.0 L |  |  | (28.4-32.0) | pg      |
| => MCHC              | 31.3 L |  |  | (32.6-34.8) | g/dL    |
| => RDW               | 14.7 H |  |  | (11.5-14.5) | %       |
| => PLATELET COUNT    | 209    |  |  | (150-450)   | Thou/uL |
| => MPV               | 9.5    |  |  | (7.4-10.4)  | fL      |

| Test               | Day | Date   | Time | Result   | Reference  | Units |
|--------------------|-----|--------|------|----------|------------|-------|
| => CALCIUM LEVEL   | -5  | SEP 15 | 1313 | 9.1      | (8.8-10.5) | mg/dL |
| => PHOSPHOROUS LEV | -5  | SEP 15 | 1313 | 3.1      | (2.5-4.5)  | mg/dL |
| => MAGNESIUM LEVEL | -5  | SEP 15 | 1313 | 1.8      | (1.8-2.4)  | mg/dL |
| => ALBUMIN         | -5  | SEP 15 | 1313 | 3.7 L    | (4.1-5.4)  | gm/dL |
| => INTACT PTH      | -5  | SEP 15 | 1313 | 30.9     | (15-65)    | pg/mL |
| => PTH CA          | -5  | SEP 15 | 1313 | 9.1      | (8.8-10.5) | mg/dL |
| => FERRITIN        | -5  | SEP 15 | 1313 | 182.8(a) | (30-400)   | ng/mL |

NOTES: (a)

Adult Males      30 - 400 ng/mL  
Premenopausal Females      15 - 150 ng/mL  
Postmenopausal Females      30 - 300 ng/mL  
Children (6mo - 15yr)      15 - 150 ng/mL

Latent hypoferric anemia can be expected when ferritin values below 20 ng/mL are found

NAME: BENTON, ALONZO  
PRINTED: 09/21/17 0009

UNIT: M000301370  
ACCT: PA1304861964  
PAGE: 1 \*\* CONTINUED ON NEXT PAGE \*\*

MERCY HEALTH SYSTEM  
MERCY PHILADELPHIA LABORATORY  
501 SOUTH 54th STREET  
PHILADELPHIA PA, 19143  
SAMIA HENIEN, M.D. MEDICAL DIRECTOR

LABORATORY REPORT

|                                   |                 |                    |
|-----------------------------------|-----------------|--------------------|
| NAME: BENTON, ALONZO              | DOS: 09/20/17   | LOC: PHSPU         |
| AGE/SEX: 58/M                     | DOB: 11/12/1958 | ACCT: PA1304861964 |
| ATTEND DR: MELLER, MENACHEM M, MD |                 | MR: M000301370     |

|                  |                    |                                 |                 |
|------------------|--------------------|---------------------------------|-----------------|
| KEY H - Abn High | *H - Critical High | * - High or Low (Alpha results) | # - Delta Check |
| L - Abn Low      | *L - Critical Low  | * - Microbiology Abn Result     |                 |

| Test               | Day | Date   | Time | Result    | Reference   | Units |
|--------------------|-----|--------|------|-----------|-------------|-------|
| => VITAMIN D, 25-H | -5  | SEP 15 | 1313 | 25(b)     |             | ng/mL |
| => PREALBUMIN      | -5  | SEP 15 | 1313 | 19.0(d) L | (20.0-40.0) | mg/dL |
| => VIT D 1,25 DIHY | -5  | SEP 15 | 1313 | 58(e)     | (20 - 79)   | pg/mL |

NOTES: (b) Sufficiency > = 30 ng/mL  
 Insufficiency 21-29 ng/mL  
 Deficiency < = 20 ng/mL  
 See also (\*c)

(\*c) FITZ LAB

Test performed at:

Mercy Fitzgerald Hospital 1500 Lansdowne Ave Darby PA

(d) Prealbumin Interpretation

Mild Malnutrition: 10.0-15.0 mg/dL

Moderate Malnutrition: 5.0-9.9 mg/dL

Severe Malnutrition: <5.0 mg/dL

Low levels are associated with acute phase response, malnutrition,

viral hepatitis, chronic hepatocellular disease, and nephrotic syndrome.

Increased levels are seen in patients with renal failure and those taking steroids or non-steroidal anti-inflammatory drugs.

(e) Vitamin D 1, 25 dihydroxy levels should be primarily used to assess Vitamin D status in patients with renal disease and hypercalcemia. Vitamin D 1,25-dihydroxy levels are generally less than 5 pg/mL in end stage renal disease patients. The preferred initial test for assessing Vitamin D status in the general population is Vitamin D 25-hydroxy (VITD).

Test performed at Warde Medical Laboratory,

300 W. Textile Rd, Ann Arbor, MI 48108 800-876-6522

William G. Finn, MD - Medical Director

NAME: BENTON, ALONZO

UNIT: M000301370

ACCT: PA1304861964

PRINTED: 09/21/17 0009

PAGE: 2 \*\* CONTINUED ON NEXT PAGE \*\*

MERCY HEALTH SYSTEM  
MERCY PHILADELPHIA LABORATORY  
501 SOUTH 54th STREET  
PHILADELPHIA PA,19143  
SAMIA HENIEN, M.D. MEDICAL DIRECTOR

LABORATORY REPORT

NAME: BENTON, ALONZO                      DOS: 09/20/17                      LOC: PHSPU  
AGE/SEX: 58/M                      DOB: 11/12/1958                      ACCT: PA1304861964                      MR: M000301370  
ATTEND DR: MELLER, MENACHEM M, MD

KEY H - Abn High                      \*H - Critical High                      \* - High or Low(Alpha results)                      # - Delta Check  
L - Abn Low                      \*L - Critical Low                      \* - Microbiology Abn Result

Source Category: RESPIRATORY

Collection Date: 09/15/17

> MRSA PCR SCREEN (\*f)                      Final 09/16/17

RESULT: POSITIVE-MRSA DNA DETECTED

NOTES: (\*f) FITZ LAB

Test performed at:

Mercy Fitzgerald Hospital                      1500 Lansdowne Ave                      Darby PA

NAME: BENTON, ALONZO

UNIT: M000301370

ACCT: PA1304861964

PRINTED: 09/21/17 0009

PAGE: 3                      \*\* END OF REPORT \*\*

**Mercy Philadelphia Hospital**  
**Mercy Health System**  
**Department of Radiology**  
**5301 Cedar Avenue**  
**Philadelphia, PA 19143**  
**215-748-9432**

David P Mayer, MD,MS,FACR, Chairman  
Oleg Teytelboym, MD, Radiology Director  
Aparna Babu, MD  
Gerard Berry, MD  
Robert Borden, MD

Michael Brooks, MD, JD  
Fraser Brown, MD  
Brian Clark, MD  
Malgorzata Gorelczyk, MD  
Lulu He, DO  
Laryssa Hud, MD  
Caroline Ling, MD  
Justin Mackey, MD  
Timothy Nielsen, MD  
Scott Rotenberg, MD

Patient: **BENTON,ALONZO** Acct #: PA 1304861964 Exam Date: 09/20/17  
Med Rec #: **M000301370** Order #: 0920-0072 Status: **REG SDC**  
Date of Birth: 11/12/1958 Gender: M Accession #: 843358.001 Location:  
Phone #: (215)403-5705 Report #: 0921-0210 RAD #:  
Ordering Physician: **MELLER,MENACHEM M, MD**  
CC: BARDEN,ABA, MD; MELLER,MENACHEM M, MD ~  
Order Date: 09/20/17  
**Procedure Reason: ORIF LT CLAVICLE**

**Exam: CR Fluoro < 1 hour**

**\*\*\* Signed Status \*\*\***

IMPRESSION: Fluoroscopic operative guidance provided to facilitate performed procedure.

INDICATION: Operative guidance.

**TECHNIQUE:**

Fluoroscopic guidance of: ORIF left clavicle for Dr. Meller

Fluoroscopy time: 12 seconds

Number of spot images (on file for review): 1

**Thank you for choosing Mercy Health System**

**<Electronically signed by SCOTT E ROTENBERG, MD in OV>**

Clinical Assistant Professor of Radiology, Drexel Univ. College of Medicine

e-Sign Pager: (610) 221-0755

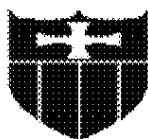
Interpreting: ROTENBERG, SCOTT E MD

D dictated: 09/21/17 1632

Signoff: 09/21/17 1632

**PATIENT IMAGES or REPORTS: (215) 748-9432**

**SCHEDULING: (610) 237-2525**



Mercy Philadelphia Hospital

Operating Room Case Record Report

BENTON, ALONZO

MR#: M000301370

Acct #: PA1304861964

DOB: 11/12/1958

DOS: 09/20/2017

58 / M

Surgeons and Procedures

Physician 1 MELLER, MENACHEM, MD Open Reduction, Internal Fixation Lt. Distal Clavicle

Preop Assess Holding

Time in Holding: 12:22

Admitted From: Scheduled Visit

Patient Identified: Y

Type and Screen: N/A

Verifies operative procedure: Y

Type and Cross: N/A

Verifies allergies: Y

Blood Permt: N/A

Chart reviewed and complete for relevant documents: Y

CXR: N/A

Operative Consent Complete and signed: Y

EKG: Y

Anesthesia consent complete and signed: Y

H and P: Y

Blood Work: Y

DVT Protocol: N/A

Site Marking by Attending Physician

|          |            |       |                                                   |
|----------|------------|-------|---------------------------------------------------|
| Site     | Laterality | Level | Procedure(s) as stated by patient/family/guardian |
| Clavicle | Left       |       | LEFT CLAVICLE SURGERY                             |

Family in Waiting Room: Y

Verified correct diagnostic and radiology test results are available and properly labeled: Y

Verified blood products equipment implants or special equipment are available labeled and matched to patients identifiers as appropriate: Y

Room Ready: N

RN: GIAMPIETRO, BARBARA

Significant PMH / PSH: PROSTATE CA, GERD, HTN, HERNIATED DISC

Mobility: Assistive Devices  
Partial Assistance Stretcher

|                        |       |               |       |                |       |
|------------------------|-------|---------------|-------|----------------|-------|
| Level of Consciousness | Other | Psychological | Other | Communication  | Other |
| Alert                  |       | Anxious       |       | No limitations |       |

|                 |       |                  |       |
|-----------------|-------|------------------|-------|
| Skin Appearance | Other | Musculo-skeleton | Other |
| Dry             |       | ROM limitations  |       |

Case Start / Personnel

|                        |                                     |                         |           |
|------------------------|-------------------------------------|-------------------------|-----------|
| Patient in Room: 13:31 | Anesthesia Start: 13:31             | ASA Classification: III | Add On: N |
| Proc Start Time: 13:58 | Anesthesia Type: General Anesthesia |                         |           |

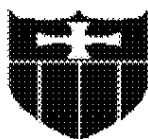
Comments: RECEIVED PT. AOX3. PT. WAS IDENTIFIED AND VERIFIED. SKIN WAS INTACT. SAFETY PRECAUTIONS MAINTAINED.....MDEROSA,RN

PreOp Diagnostics: LEFT DISTAL CLAVICLE FRACTURE

| Staff Role | Staff Name                 | Time In | Time Out | Time In | Time Out |
|------------|----------------------------|---------|----------|---------|----------|
| Circulator | DEROSA, MICHELLE, RN       | 13:00   | 15:31    |         |          |
| Scrub      | ELLERBE, TRACY             | 13:00   | 15:31    |         |          |
|            | Name                       |         | Role     |         |          |
|            | JONATHAN WILDY,CRNA        |         |          |         |          |
|            | DR. SISIRA ANDRAHENNADY,MD |         |          |         |          |
|            | (ANES)                     |         |          |         |          |

Prep / Positioning

| Position | Device | Device    | Device               | Device | Extremity             | Extremity Position |
|----------|--------|-----------|----------------------|--------|-----------------------|--------------------|
| Supine   | Pillow | Heel Pads | Foam Head Positioner |        | Left upper extremity  | At Side            |
|          |        |           |                      |        | Right upper extremity | Armboard           |



# Mercy Philadelphia Hospital

## Operating Room Case Record Report

BENTON, ALONZO

MR#: M000301370

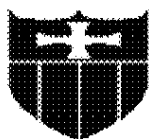
Acct #: PA1304861964

DOB: 11/12/1958

DOS: 09/20/2017

58 / M

|                                                                                    |                                                                                          |                                                  |                     |                                    |      |
|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------|------------------------------------|------|
| Positioned By: DEROSA, MICHELLE, RN<br>MELLER, MENACHEM, MD<br>BROXTON, DWAYNE, RN |                                                                                          | Pad Bony Prominences: Y                          |                     | Safety belt applied and secured: Y |      |
| Skin Prep: Y                                                                       |                                                                                          | Skin Prep: Betadine Paint (no pooling present)   |                     |                                    |      |
| Hair Removed in OR with Clipper: N                                                 |                                                                                          | Hair removal 48hrs prior to surgery: N/A         |                     |                                    |      |
| DURAPREP OR ALCOHOL BASED SOLUTIONS: N/A                                           |                                                                                          |                                                  |                     |                                    |      |
| <b>ESU / Tourniquet / Counts</b>                                                   |                                                                                          |                                                  |                     |                                    |      |
| ELECTROSURGICAL UNIT Y                                                             |                                                                                          |                                                  |                     |                                    |      |
| ESU #                                                                              | Ground Pad Site                                                                          | Side                                             | Bipolar             | Cut                                | Coag |
| php002197                                                                          | Megadyne                                                                                 |                                                  |                     | 75                                 | 75   |
| TOURNIQUET: N/A                                                                    |                                                                                          |                                                  |                     |                                    |      |
| COUNT: Y                                                                           | Count                                                                                    | Count Staff 1                                    | Count Staff 2       |                                    |      |
|                                                                                    | In Count                                                                                 | DEROSA, MICHELLE, RN                             | BROXTON, DWAYNE, RN |                                    |      |
|                                                                                    | Closing Count                                                                            | DEROSA, MICHELLE, RN                             | BROXTON, DWAYNE, RN |                                    |      |
|                                                                                    | Final Count                                                                              | DEROSA, MICHELLE, RN                             | BROXTON, DWAYNE, RN |                                    |      |
| Surgeon Notified of Counts: Y                                                      |                                                                                          |                                                  |                     |                                    |      |
| Name of practitioner confirming count: DR. MELLER                                  |                                                                                          |                                                  |                     |                                    |      |
| <b>Fire Risk/Patient Safety</b>                                                    |                                                                                          |                                                  |                     |                                    |      |
| Surgical site above Xiphoid? Yes = 1                                               |                                                                                          | Open oxygen source? No = 0                       |                     |                                    |      |
| Available ignition source? Yes = 1                                                 |                                                                                          | Fire Risk Scoring: TWO                           |                     |                                    |      |
| <b>Moderate/High Fire Risk Protocol:</b>                                           |                                                                                          |                                                  |                     |                                    |      |
| Includes all routine protocols: Y                                                  |                                                                                          | Use draping tech to minimize O2 concentration: Y |                     |                                    |      |
| Minimize electrical surgical unit settings: Y                                      |                                                                                          | Encourage use of wet sponges: Y                  |                     |                                    |      |
| Basin of sterile saline or H2O: Y                                                  |                                                                                          | Anesthesia documents O2 concentration flow: Y    |                     |                                    |      |
| <b>Surgical Safety Checklist:</b>                                                  |                                                                                          |                                                  |                     |                                    |      |
| How long will the case take? 1 HR                                                  |                                                                                          |                                                  |                     |                                    |      |
| What is the anticipated blood loss? 100cc                                          |                                                                                          |                                                  |                     |                                    |      |
| Key concerns for patient recovery/management?                                      |                                                                                          | PAIN, BLEEDING, INFECTION                        |                     |                                    |      |
| <b>Final Verification</b>                                                          |                                                                                          |                                                  |                     |                                    |      |
| Patient in Room: 13:31                                                             | TIME OUT FOR PROCEDURE VERIFICATION:                                                     |                                                  | 13:57               | Nurse: DEROSA, MICHELLE, R         |      |
| Y                                                                                  | A. Attending Proceduralist verified correct patient                                      |                                                  |                     |                                    |      |
| Y                                                                                  | B. Procedure consent is accurate and signed                                              |                                                  |                     |                                    |      |
| Y                                                                                  | C. Safety Precautions - Allergies read aloud                                             |                                                  |                     |                                    |      |
| N                                                                                  | Acknowledgement of implant existing devices                                              |                                                  |                     |                                    |      |
| Y                                                                                  | Sterility verified - no specific concerns                                                |                                                  |                     |                                    |      |
| Y                                                                                  | D. Correct patient positioning                                                           |                                                  |                     |                                    |      |
| Y                                                                                  | E. Site marking confirmed/correct and visible after patient is draped                    |                                                  |                     |                                    |      |
| N/A                                                                                | F. Special Equipment                                                                     |                                                  |                     |                                    |      |
| N/A                                                                                | G. Radiographic images properly labeled and displayed as appropriate                     |                                                  |                     |                                    |      |
| Y                                                                                  | H. Implants available/fluids for irrigation available if appropriate                     |                                                  |                     |                                    |      |
| Y                                                                                  | I. Antibiotics administered prior to incision per anesthesia                             |                                                  |                     |                                    |      |
| Y                                                                                  | J. SCD present as ordered                                                                |                                                  |                     |                                    |      |
| Y                                                                                  | K. Verified all relevant documents are available and matched to the patients identifiers |                                                  |                     |                                    |      |
| Final Site Verification Completed: Y                                               |                                                                                          |                                                  |                     |                                    |      |
| Does anyone have any questions or concerns with the procedure or anesthesia?       |                                                                                          | N                                                |                     |                                    |      |
| Does anyone have any questions or concerns before proceeding?                      |                                                                                          | Is Everyone in agreement? Y                      |                     |                                    |      |



## Meds / X Rays

INTRAOP MEDS ON STERILE FIELD: Medication: Y Administers prescribed meds and solutions: N

| Medication                                                  | Dose | Unit | Route     | Comment |
|-------------------------------------------------------------|------|------|-----------|---------|
| Bupivacaine 0.5% 30ml Single use Marcaine-MPF (Sensorcaine) | 12   | ml   | Injection |         |
| Normal Saline 500ML bag                                     |      |      |           |         |

IRRIGATION

X-Rays: Y Implements measures to prevent radiation injury: N/A

X-Ray Type: Fluro Total Time: 12S

## Specimens / Caths / Drains

Catheter Indwelling on Arrival: N/A

Urinary Catheter: N/A

Specimen: N/A

Comments: SLING APPLIED AFTYER THE PROCEDURE.....MDEROSA,RN

Drains/Tubes: N/A

Packing: N/A

| Dressings/Casts | Type    | Site     |
|-----------------|---------|----------|
| Y               | 4x4     | Shoulder |
|                 | ABD     |          |
|                 | Adaptic |          |
|                 | Tape    |          |

## Laser

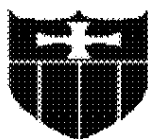
Laser Used: N/A

## Implant Information

## IntraOp Summary

|                                                                                                |                                                     |                            |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------|
| Patient in Room: 13:31                                                                         | Proc Start Time: 13:58                              | Anesthesia End: 15:30      |
| Anesthesia Start: 13:31                                                                        | Proc End Time: 15:20                                | Patient Out of Room: 15:30 |
| Anesthesia Type: General Anesthesia                                                            | Wound Class: I- Clean                               |                            |
| Transferred To: PACU                                                                           |                                                     |                            |
| Urinary Catheter: N/A                                                                          | Drains / Tubes: N/A                                 | Packing: N/A               |
| Dressings/Casts: Y                                                                             | Implant: Y                                          |                            |
| Post OP Diagnosis: LEFT DISTAL CLAVICLE FRACTURE                                               |                                                     |                            |
| Actual Procedure Performed: OPEN REDUCTION AND INTERNAL FIXATION LEFT DISTAL CLAVICLE FRACTURE |                                                     |                            |
| Complications: N Type:                                                                         |                                                     |                            |
| Evaluates postoperative tissue perfusion: Y                                                    | Evaluates for signs of injury due to positioning: Y |                            |
| Evaluates for signs/symptoms of electrical injury: Y                                           | Evaluates for signs of injury to skin/tissue: Y     |                            |
| Evaluates for signs/symptoms of chemical injury: Y                                             |                                                     |                            |

## PNDS Outcomes



**Mercy Philadelphia Hospital**

**Operating Room Case Record Report**

**BENTON, ALONZO**

**MR#: M000301370**

**Acct #: PA1304861964**

**DOB: 11/12/1958**

**DOS: 09/20/2017**

**58 / M**

| <i>Outcome</i>                                                                                                      | <i>Status</i> | <i>Staff</i>          |
|---------------------------------------------------------------------------------------------------------------------|---------------|-----------------------|
| The patient has wound/tissue perfusion consistent with or improved from baseline levels established preoperatively. | MET           | DEROSA, MICHELLE , RN |
| The patient is free from signs and symptoms of injury caused by extraneous objects.                                 | MET           | DEROSA, MICHELLE , RN |
| The patient is free from signs and symptoms of chemical injury.                                                     | MET           | DEROSA, MICHELLE , RN |
| The patient is free from signs and symptoms of electrical injury.                                                   | MET           | DEROSA, MICHELLE , RN |
| The patient is free from signs and symptoms of injury related to positioning.                                       | MET           | DEROSA, MICHELLE , RN |
| The patient is free from signs and symptoms of radiation injury.                                                    | N/A           | DEROSA, MICHELLE , RN |
| The patient receives appropriate medication(s), safely administered during the perioperative period.                | NOT MET       | DEROSA, MICHELLE , RN |

*Signature:* DEROSA, MICHELLE , RN

*Date Time:* 09/20/2017 16:15



# Mercy Philadelphia Hospital

## Operating Room Case Record Report

BENTON, ALONZO

MR#: M000301370

Acct #: PA1304861964

DOB: 11/12/1958

DOS: 09/20/2017

58 / M

### Surgeons and Procedures

Physician I MELLER, MENACHEM, MD Open Reduction, Internal Fixation Lt. Distal Clavicle

### Preop Assess Holding

Time in Holding: 12:22

Admitted From: Scheduled Visit

Patient Identified: Y

Type and Screen: N/A

Verifies operative procedure: Y

Type and Cross: N/A

Verifies allergies: Y

Blood Permit: N/A

Chart reviewed and complete for relevant documents: Y

CXR: N/A

Operative Consent Complete and signed: Y

EKG: Y

Anesthesia consent complete and signed: Y

H and P: Y

Blood Work: Y

DVT Protocol: N/A

### Site Marking by Attending Physician

| Site     | Laterality | Level | Procedure(s) as stated by patient/family/guardian |
|----------|------------|-------|---------------------------------------------------|
| Clavicle | Left       |       | LEFT CLAVICLE SURGERY                             |

Family in Waiting Room: Y

Verified correct diagnostic and radiology test results are available and properly labeled: Y

Verified blood products equipment implants or special equipment are available labeled and matched to patients identifiers as appropriate: Y

Room Ready: N

RN: GIAMPIETRO, BARBARA

Significant PMH / PSH: PROSTATE CA, GERD, HTN, HERNIATED DISC

| Mobility           | Assistive Devices |
|--------------------|-------------------|
| Partial Assistance | Stretcher         |

| Level of Consciousness | Other | Psychological | Other | Communication  | Other |
|------------------------|-------|---------------|-------|----------------|-------|
| Alert                  |       | Anxious       |       | No limitations |       |

| Skin Appearance | Other | Musculo-skelton | Other |
|-----------------|-------|-----------------|-------|
| Dry             |       | ROM limitations |       |

### Case Start / Personnel

Patient in Room: 13:31 Anesthesia Start: 13:31 ASA Classification: III Add On: N

Proc Start Time: 13:58 Anesthesia Type: General Anesthesia

Comments: RECEIVED PT. AOX3. PT. WAS IDENTIFIED AND VERIFIED. SKIN WAS INTACT. SAFETY PRECAUTIONS MAINTAINED.....MDEROSA,RN

PreOp Diagnosis: LEFT DISTAL CLAVICLE FRACTURE

| Staff Role | Staff Name           | Time In | Time Out | Time In | Time Out |
|------------|----------------------|---------|----------|---------|----------|
| Circulator | DEROSA, MICHELLE, RN | 13:00   | 15:31    |         |          |
| Scrub      | ELLERBE, TRACY       | 13:00   | 15:31    |         |          |

| Name                        | Role |
|-----------------------------|------|
| JONATHAN WILDY, CRNA        |      |
| DR. SISIRA ANDRAHENNADY, MD |      |
| (ANES)                      |      |

### Prep / Positioning

| Position | Device | Device    | Device               | Device | Extremity             | Extremity Position |
|----------|--------|-----------|----------------------|--------|-----------------------|--------------------|
| Supine   | Pillow | Heel Pads | Foam Head Positioner |        | Left upper extremity  | At Side            |
|          |        |           |                      |        | Right upper extremity | Armboard           |



# Mercy Philadelphia Hospital

## Operating Room Case Record Report

BENTON, ALONZO

MR#: M000301370

Acct #: PA1304861964

DOB: 11/12/1958

58 / M

DOS: 09/20/2017

|                                                                                           |                                                                                          |                                                                                       |                                                                                    |
|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| Positioned By: DEROSA, MICHELLE, RN<br>MELLER, MENACHEM, MD<br>BROXTON, DWAYNE, RN        |                                                                                          | Pad Bony Prominences: Y                                                               | Safety belt applied and secured: Y                                                 |
| Skin Prep: Y Skin Prep: Betadine Paint (no pooling present)                               |                                                                                          |                                                                                       |                                                                                    |
| Hair Removed in OR with Clipper: N                                                        |                                                                                          | Hair removal 48hrs prior to surgery: N/A                                              |                                                                                    |
| DURAPREP OR ALCOHOL BASED SOLUTIONS: N/A                                                  |                                                                                          |                                                                                       |                                                                                    |
| ESU / Tourniquet / Counts                                                                 |                                                                                          |                                                                                       |                                                                                    |
| ELECTROSURGICAL UNIT Y                                                                    |                                                                                          |                                                                                       |                                                                                    |
| ESU #<br>php002197                                                                        | Ground Pad Site<br>Megadyne                                                              | Side                                                                                  | Bipolar<br>Cut<br>75<br>Coag<br>75                                                 |
| TOURNIQUET: N/A                                                                           |                                                                                          |                                                                                       |                                                                                    |
| COUNT: Y                                                                                  | Count<br>In Count<br>Closing Count<br>Final Count                                        | Count Staff 1<br>DEROSA, MICHELLE, RN<br>DEROSA, MICHELLE, RN<br>DEROSA, MICHELLE, RN | Count Staff 2<br>BROXTON, DWAYNE, RN<br>BROXTON, DWAYNE, RN<br>BROXTON, DWAYNE, RN |
| Surgeon Notified of Counts: Y                                                             |                                                                                          |                                                                                       |                                                                                    |
| Name of practitioner confirming count: DR. MELLER                                         |                                                                                          |                                                                                       |                                                                                    |
| Fire Risk/Patient Safety                                                                  |                                                                                          |                                                                                       |                                                                                    |
| Surgical site above Xiphoid? Yes = 1                                                      |                                                                                          | Open oxygen source? No = 0                                                            |                                                                                    |
| Available ignition source? Yes = 1                                                        |                                                                                          | Fire Risk Scoring: TWO                                                                |                                                                                    |
| <u>Moderate/High Fire Risk Protocol:</u>                                                  |                                                                                          |                                                                                       |                                                                                    |
| Includes all routine protocols: Y                                                         |                                                                                          | Use draping tech to minimize O2 concentration: Y                                      |                                                                                    |
| Minimize electrical surgical unit settings: Y                                             |                                                                                          | Encourage use of wet sponges: Y                                                       |                                                                                    |
| Basin of sterile saline or H2O: Y                                                         |                                                                                          | Anesthesia documents O2 concentration flow: Y                                         |                                                                                    |
| <u>Surgical Safety Checklist:</u>                                                         |                                                                                          |                                                                                       |                                                                                    |
| How long will the case take? 1 HR                                                         |                                                                                          |                                                                                       |                                                                                    |
| What is the anticipated blood loss? 100cc                                                 |                                                                                          |                                                                                       |                                                                                    |
| Key concerns for patient recovery/management? PAIN, BLEEDING, INFCETION                   |                                                                                          |                                                                                       |                                                                                    |
| Final Verification                                                                        |                                                                                          |                                                                                       |                                                                                    |
| Patient in Room: 13:31                                                                    | TIME OUT FOR PROCEDURE VERIFICATION: 13:57                                               |                                                                                       | Nurse: DEROSA, MICHELLE, R                                                         |
| Y                                                                                         | A. Attending Proceduralist verified correct patient                                      |                                                                                       |                                                                                    |
| Y                                                                                         | B. Procedure consent is accurate and signed                                              |                                                                                       |                                                                                    |
| Y                                                                                         | C. Safety Precautions - Allergies read aloud                                             |                                                                                       |                                                                                    |
| N                                                                                         | Acknowledgement of implant existing devices                                              |                                                                                       |                                                                                    |
| Y                                                                                         | Sterility verified - no specific concerns                                                |                                                                                       |                                                                                    |
| Y                                                                                         | D. Correct patient positioning                                                           |                                                                                       |                                                                                    |
| Y                                                                                         | E. Site marking confirmed/correct and visible after patient is draped                    |                                                                                       |                                                                                    |
| N/A                                                                                       | F. Special Equipment                                                                     |                                                                                       |                                                                                    |
| N/A                                                                                       | G. Radiographic images properly labeled and displayed as appropriate                     |                                                                                       |                                                                                    |
| Y                                                                                         | H. Implants available/fluids for irrigation available if appropriate                     |                                                                                       |                                                                                    |
| Y                                                                                         | I. Antibiotics administered prior to incision per anesthesia                             |                                                                                       |                                                                                    |
| Y                                                                                         | J. SCD present as ordered                                                                |                                                                                       |                                                                                    |
| Y                                                                                         | K. Verified all relevant documents are available and matched to the patients identifiers |                                                                                       |                                                                                    |
| Final Site Verification Completed? Y                                                      |                                                                                          |                                                                                       |                                                                                    |
| Does anyone have any questions or concerns with the procedure or anesthesia? N            |                                                                                          |                                                                                       |                                                                                    |
| Does anyone have any questions or concerns before proceeding? Is Everyone in agreement? Y |                                                                                          |                                                                                       |                                                                                    |



Mercy Philadelphia Hospital  
Operating Room Case Record Report

BENTON, ALONZO  
MR#: M000301370  
Acct #: PA1304861964  
DOB: 11/12/1958  
DOS: 09/20/2017  
58 / M

Meds / X Rays

INTRAOP MEDS ON STERILE FIELD: Medication: Y Administers prescribed meds and solutions: N

| Medication                        | Dose | Unit | Route     | Comment |
|-----------------------------------|------|------|-----------|---------|
| Bupivacaine 0.5% /30ml Single use | 12   | ml   | Injection |         |
| Maracaine-MPF (Sensorcaine)       |      |      |           |         |
| Normal Saline 500ML bag           |      |      |           |         |

IRRIGATION

X-Rays: Y Implements measures to prevent radiation injury: N/A  
X-Ray Type: Fluro Total Time:

Specimens / Caths / Drains

Catheter Indwelling on Arrival: N/A  
Urinary Catheter: N/A

Specimen: N/A

Comments: SLING APPLIED AFTYER THE PROCEDURE.....MDEROSA,RN

Drains/Tubes: N/A

| Packing: | Dressings/Casts: | Type                          | Site     |
|----------|------------------|-------------------------------|----------|
| N/A      | Y                | 4x4<br>ABD<br>Adaptic<br>Tape | Shoulder |

Laser

Laser Used: N/A

Implant Information

IntraOp Summary

|                                     |                        |                            |
|-------------------------------------|------------------------|----------------------------|
| Patient in Room: 13:31              | Proc Start Time: 13:58 | Anesthesia End: 15:30      |
| Anesthesia Start: 13:31             | Proc End Time: 15:20   | Patient Out of Room: 15:30 |
| Anesthesia Type: General Anesthesia | Wound Class: I- Clean  |                            |
| Transferred To: PACU                |                        |                            |

|                       |                     |              |
|-----------------------|---------------------|--------------|
| Urinary Catheter: N/A | Drains / Tubes: N/A | Packing: N/A |
| Dressings/Casts: Y    | Implant: Y          |              |

Post OP Diagnosis: LEFT DISTAL CLAVICLE FRACTURE

Actual Procedure Performed: OPEN REDUCTION AND INTERNAL FIXATION LEFT DISTAL CLAVICLE FRACTURE

Complications: N Type:

|                                                      |                                                     |
|------------------------------------------------------|-----------------------------------------------------|
| Evaluates postoperative tissue perfusion: Y          | Evaluates for signs of injury due to positioning: Y |
| Evaluates for signs/symptoms of electrical injury: Y | Evaluates for signs of injury to skin/tissue: Y     |
| Evaluates for signs/symptoms of chemical injury: Y   |                                                     |

PNDS Outcomes



Mercy Philadelphia Hospital

Operating Room Case Record Report

BENTON, ALONZO

MR#: M000301370

Acct #: PA1304861964

DOB: 11/12/1958

DOS: 09/20/2017

58 / M

| <i>Outcome</i>                                                                                                      | <i>Status</i> | <i>Staff</i>          |
|---------------------------------------------------------------------------------------------------------------------|---------------|-----------------------|
| The patient has wound/tissue perfusion consistent with or improved from baseline levels established preoperatively. | MET           | DEROSA, MICHELLE, RN. |
| The patient is free from signs and symptoms of injury caused by extraneous objects.                                 | MET           | DEROSA, MICHELLE, RN  |
| The patient is free from signs and symptoms of chemical injury.                                                     | MET           | DEROSA, MICHELLE, RN  |
| The patient is free from signs and symptoms of electrical injury.                                                   | MET           | DEROSA, MICHELLE, RN  |
| The patient is free from signs and symptoms of injury related to positioning.                                       | MET           | DEROSA, MICHELLE, RN  |
| The patient is free from signs and symptoms of radiation injury.                                                    | N/A           | DEROSA, MICHELLE, RN  |
| The patient receives appropriate medication(s), safely administered during the perioperative period.                | NOT MET       | DEROSA, MICHELLE, RN  |

## Operating Room

## Implant Form

BENTON, ALONZO

DOB: 11/12/1958 58 M

ADM: 09/20/17

ACC: PA1304861964 MR: M000301370



| Amount | Name/Description of Implant                                                     | Catalog #                                          | Lot # | Site             | Implant/Wasted |
|--------|---------------------------------------------------------------------------------|----------------------------------------------------|-------|------------------|----------------|
| 1      | 3.5 LCP (LEFT)<br>SUPERIOR ANTERIOR<br>CLAVICLE PLATE WITH<br>LATERAL EXTENSION | 6650594<br>CEO123<br>① 4 HOLE PLATE<br>OX. 112-011 |       | LEFT<br>CLAVICLE | WASTED         |
| 1      | 3.5 LCP (LEFT)<br>SUPERIOR ANTERIOR<br>CLAVICLE PLATE WITH<br>LATERAL EXTENSION | 7837752<br>① 5 HOLE PLATE<br>OX. 112-013           |       |                  | IMPLANT        |
| 1      | 4.0 mm CANCELLOUS<br>BONE SCREW<br>18mm                                         | 206.018                                            |       |                  |                |
| 1      | 4.0 mm CANCELLOUS<br>BONE SCREW<br>20mm                                         | 206.020                                            |       |                  |                |
| 2      | 3.5 CORTICAL<br>SELF TAPPING<br>16mm                                            | 204.8XX                                            |       |                  |                |
| 3      | 2.7 mm<br>LOCKING SCREW<br>16 mm                                                | X02.216                                            |       |                  |                |
| 12     | 2.7 mm<br>LOCKING SCREW<br>18 mm                                                | X02.218                                            |       |                  |                |
| 1      | 2.7 mm<br>LOCKING SCREW<br>14 mm                                                | X02.214                                            |       | LEFT<br>CLAVICLE | IMPLANT        |

Procedure:

O.R. I.F LEFT DISTAL CLAVICLE FRACTURE

Implanting Surgeon:

DR. MELLER, MENACHEM, MD

Date:

9/20/17

Nurse's Signature

MICHIGANA, RN



## Same Day Surgery

### Health Survey

We welcome the opportunity to participate in your care. Patients requiring the services of the Department of Anesthesia will be seen by an Anesthesiologist prior to surgery. This health survey, along with the information provided by your surgeon, will help us plan your safe and comfortable care during your perioperative visit here: Mercy Hospital of Philadelphia.

|                           |                    |                   |                                              |              |                 |
|---------------------------|--------------------|-------------------|----------------------------------------------|--------------|-----------------|
| Name <u>Alonzo Benton</u> |                    |                   | Family Physician <u>Chester Co Prim care</u> |              |                 |
| Age <u>59</u>             | Height <u>5'9"</u> | Weight <u>170</u> | Physician Phone # <u>215 663 9990</u>        | Home Phone # | Daytime Phone # |

|                                                                       | YES                                 | NO                                  | COMMENT |
|-----------------------------------------------------------------------|-------------------------------------|-------------------------------------|---------|
| • Are you being treated for any medical problems?                     | <input type="checkbox"/>            | <input type="checkbox"/>            |         |
| • Do you have high blood pressure?                                    | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |         |
| • Do you have heart trouble?                                          | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |         |
| • Do you have a heart murmur?                                         | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |         |
| • Do you have angina or chest pain?                                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |         |
| • Have you had a heart attack?                                        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |         |
| • Have you had a cold recently?                                       | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |         |
| • Do you have a cough?                                                | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |         |
| • Have you had asthma?                                                | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |         |
| • Do you have emphysema or bronchitis?                                | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |         |
| • Can you walk up a flight of stairs without getting short of breath? | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |         |
| • Do you have diabetes?                                               | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |         |
| • Do you have a seizure disorder?                                     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |         |
| • Do you have a weakness of or paralysis of your arms or legs?        | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |         |
| • Have you had a stroke?                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |         |
| • Have you had hepatitis or jaundice?                                 | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |         |
| • Do you take a blood thinner?                                        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |         |

(• on side please)

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 09/20/17  
ACC: PA1304861964 MR: M000301370



|                                                                              | YES                                 | NO                                  | COMMENT          |
|------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|------------------|
| • Do you have any psychiatric problems?                                      | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |                  |
| • Could you be pregnant?                                                     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |                  |
| • Have you had anesthesia previously?                                        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |                  |
| • Have you ever had a problem with anesthesia other than nausea or vomiting? | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |                  |
| • Has anyone in your family had a problem with anesthesia?                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |                  |
| • Do you smoke presently? If so, how much?                                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |                  |
| • Do you drink alcohol? If so, how much?                                     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | 1 on \$ 1 a week |
| • Do you have any loose, false, capped or bonded teeth?                      | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |                  |
| • Do you have any problems with your neck or opening your mouth?             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |                  |

BENTON, ALONZO  
 DOB: 11/12/1958 58 M  
 ADM: 09/20/17  
 ACC: PA1304861964 MR: M000301370



Are you taking herbal medicines or vitamins? NO

List all medications you are taking regularly: Lansatan 25mg apmedbole  
Hydrocort 212 12.5

List all previous surgery:

Hernia Right groin

List all drug allergies:

Contrast dye

Do you have anything specific you want to discuss with the anesthesiologist? NO

Alonzo Benton  
 Signature (patient, parent, legal guardian)

9/12/17  
 Date

TO BE COMPLETED THE DAY OF SURGERY

I certify that I/the patient has had nothing to eat or drink since \_\_\_\_\_ a.m./p.m.

\_\_\_\_\_  
 Signature (patient, parent, legal guardian)

\_\_\_\_\_  
 Date

I certify that the following individual will escort me/the patient home

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Relationship

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature (patient, parent, legal guardian)

\_\_\_\_\_  
 Date

MRN: 

## Anesthesia Record

Date of Service: Date of Birth: 

Name:

First Name:

Middle Initial:

ASA: Post Op Dx: Anesth Print: 

Preinduction Assessment:

Ident

Time: 

Consent

Act Proc: Surgeon: CRNA: Inpatient ☐ Outpatient ☐OR: 

Same Day Add On

Medications

Time

Oxygen Liters/MN

Air/O<sub>2</sub> Liters/MNET % O<sub>2</sub>

Midazolam mg

Fentanyl mcg

Propofol mg

Sux (Roc) Vec mg

Agents/Drugs

Fluids

URINE OUTPUT

ESTIMATED BLOOD LOSS

O<sub>2</sub> SATURATION %

Temp C° F°

EKG LEAD

% O<sub>2</sub> NSPIRED

END TIDAL CO (mm HG)

BIS

P/PA

Pre-Oxygenation

Mask

Easy/Hard

Oral airway

Nasal airway

Trach

LMA#

Intubation

Easy/Hard

Oral/Nasal

Cuff cm

Rapid Seq

Bladder

ETT size

Attempts

View

Taped at

Leak at

ETOC2

Breath snds

FOB#

Dbl lumen

Bronch bl

Light wand

HME Humid

NG / OG tube

REMARKS/POSITION

TV/Rate

PIP/PEEP

Anesthesia Record

Mercy Philadelphia Hospital

Member of Mercy Health System

Anesthesia Record

Page 1 of 4

Form #NSA-AR, Rev. 07/2017

SURX-ANESTH

Present for ☐ Induction ☐ Emergence ☐ Regional Block ☐ Provided postop Care

Physician Signature

Date

Time

Provider ID

CRNA Signature

Date

Time

Provider ID

BENTON, ALONZO

DOB:

DOB: 11/12/1958 58 M

Adm:

ADM: 09/20/17

Acc:

ACC: PA1304861964 MR: M000301370



# OR Efficiency

Time Start ☐ Yes ☐ No N/A  
Reason for Delay ☐ Patient ☐ Facility ☐ Surgeon ☐ Anesthesia  
To Follow Same Room/Same Surgeon ☐ Yes ☐ No  
Pre Operative Assessment performed prior to date of procedure ☐ Yes ☐ No

## Glucose Control

Glucose levels monitored during the case? ☐ Yes ☐ No ☒ Not Applicable  
Post Operative Glucose less than 200 arrival in PACU/ICU ☐ Yes ☐ No

## Central Line Placement

N/A ☐ Central Venous ☐ Pulmonary Artery  
Procedure Start Time: \_\_\_\_\_ Time Out at: \_\_\_\_\_ Marked by: \_\_\_\_\_  
Insertion site: ☐ RIJ ☐ LIJ ☐ RSC ☐ LSC ☐ RFem ☐ LFem  
Provider: \_\_\_\_\_ Assistant: ☐ None \_\_\_\_\_

Performed Universal Protocol (Time Out)? ☐ Yes ☐ No  
All persons in procedure cleanse hands? ☐ Yes ☐ No  
Prep Procedure site with 2% Chlorhexidine? ☐ Yes ☐ No  
Used large drape cover? ☐ Yes ☐ No  
All personnel wore sterile gloves, hat, mask and sterile gown? ☐ Yes ☐ No  
Maintain sterile field throughout procedure? ☐ Yes ☐ No

Regional Technique Time out at ☐ ☐ ☐ Marked by: \_\_\_\_\_

☐ Postop block requested by surgeon for pain management  
☐ Placed by CRNA (complete discontinuous timings)

Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ ☐ Epidural test dose neg  
Level: \_\_\_\_\_ Y/N Paresth Epi: \_\_\_\_\_  
Needle: \_\_\_\_\_ Y/N CSF Cath: \_\_\_\_\_  
Y/N Heme Attempts: \_\_\_\_\_

Beta Blockers Patient on Beta-Blocker prior to admission? ☐ Yes ☒ No  
If Yes, ☐ a) Beta-Blocker given either the day prior or the day of Surgery (date and time) \_\_\_\_\_

or ☐ b) Patient will be given Beta-Blocker intraoperatively (Drug/Dose): \_\_\_\_\_

or ☐ c) Beta-Blocker Contraindicated (Document reason): \_\_\_\_\_  
☐ HR less than 50

Allergies (Drug/environmental/food) RX:

Contrast Dy + Iodine

## POST ANESTHESIA CARE VITALS/NOTE

Response to Anesthesia ☐ No Apparent complications Other: \_\_\_\_\_  
CV: ☐ Stable \_\_\_\_\_ RESP: ☒ Stable \_\_\_\_\_  
LOC ☐ Responsive \_\_\_\_\_ Other: \_\_\_\_\_  
☐ Meets criteria to bypass Phase 1 Recovery  
Report given and responsibility for monitoring post transport to PACU ☐ ICU ☐ Other: \_\_\_\_\_

Signature/Title [Signature] 12298 9/20/17 1935

BP 152/110

HR 68 Final

RR 20 Vital

SpO<sub>2</sub> 100 Signs:

TEMP 97.6

POST ANESTHESIA ASSESSMENT BP: \_\_\_\_\_ / \_\_\_\_\_ HR: \_\_\_\_\_ RR: \_\_\_\_\_ SpO<sub>2</sub>: \_\_\_\_\_ Temp: \_\_\_\_\_ VAS: \_\_\_\_\_

Art/Patient Participation ☐ Yes ☐ No  
Airway Patent ☐ Yes ☐ No  
Hydration Adequate ☐ Yes ☐ No  
Pain Control Adequate ☐ Yes ☐ No  
PONV Present ☐ Yes ☐ No  
Anesthesia Complications ☐ Yes ☒ No

Ax PO Skin

## Normothermia

Patient Temperature on arrival to PACU/ICU greater than (or equal to) 36°C/96.8°F

☐ Yes ☐ No ☐ N/A

Warming measures used:

☐ Forced Air Warmer

☐ Warm Water Garment

☐ Resistive Heating Blanket

PACU DISCHARGE TIME ☐ ☐ ☐

Signature/Title [Signature] 103737 Pho/17 1700

☐ Full report of pre-assessment, intraop plan and current status, received from \_\_\_\_\_  
Narcotics reconciled and care assumed at: \_\_\_\_\_

Initials \_\_\_\_\_

## RELIEF PROTOCOL

| IN | OUT | NAME      | IN | OUT | NAME |
|----|-----|-----------|----|-----|------|
|    |     | physician |    |     | cma  |
|    |     | physician |    |     | cma  |

Mercy Philadelphia Hospital  
Member of Mercy Health System

Anesthesia Record

DOB:  
Adm:  
Acc:

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 09/20/17  
ACC: PA1304861964 MR: M000301370

# Anesthesiology

PACU Anesthesiologist Order Sheet  
PACU Discharge Order  
Post-Anesthesia Evaluation Note

Allergies

contrast

☒ Admit to PACU, Monitoring as per protocol

☒ IV Fluid: Continue Intraop fluids at 100ml/hr (40ml/hr for pediatric patients), follow with post-op fluid orders on PACU discharge

☒ Administer oxygen via nasal cannula or face mask to keep SaO<sub>2</sub> above 92%, continue on floor if SaO<sub>2</sub> greater than 92%

☒ Accucheck for insulin dependent patients, call anesthesiologist with results if less than 70 or greater than 200

Pain Management  
(choose only 1 PRN  
narcotic at a time)

1 ☒ Fentanyl 25 mcg IV every 3 minutes for 2 doses PRN pain  
☒ Morphine 2 mg IV every 5 minutes for 2 doses PRN pain  
2 ☒ Hydromorphone 0.5 mg IV every 5 minutes for 2 doses PRN pain  
☒ Ketorolac 30 mg IV x 1 dose (if not given in OR)  
☐ Percocet 5/325 mg 1 tab PO PRN mild pain (pain scale 1-5)  
☐ Percocet 5/325 mg 2 tabs PO PRN moderate pain (pain scale 6-10)

given 9/20/17  
05:48 350 + 405m  
Pawmiller

Sedation

☐ Midazolam        mg IV every 5 minutes for        doses PRN sedation

Antiemetic Therapy  
(choose only 1 PRN med  
for postop  
nausea/vomiting)

☐ Metoclopramide 10 mg slow IV push x 1 dose PRN nausea/vomiting  
☐ Droperidol 0.625 mg IV x 1 dose PRN nausea/vomiting  
☐ Dexamethasone 4 mg IV x 1 dose PRN nausea/vomiting  
1 ☒ Ondansetron 4 mg IV x 1 dose PRN nausea/vomiting  
2 ☒ Promethazine 25 mg IM x 1 dose PRN nausea/vomiting

Hypertension  
(choose only 1 PRN at a  
time)

For SBP greater than 125 mm Hg or DBP greater than        mm Hg or HR greater than         
☐ Labetalol        mg IV every        minutes x        doses PRN  
☐ Hydralazine        mg IV every        minutes x        doses PRN  
☐ Metoprolol        mg IV every        minutes x        doses PRN

Additional Orders

☐ Meperidine 12.5 mg IV every 5 minutes for        doses PRN shivering

Anesthesiologist

Date/Time

PACU Nurse

Date/Time

PACU Discharge Order

Patient reassessed and PACU record reviewed. Vital signs satisfactory. Patient meets discharge criteria and is stable for discharge from PACU.

Anesthesiologist

Date/Time

Mercy Philadelphia Hospital  
member of Mercy Health System

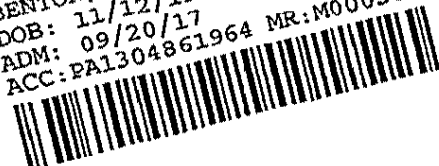
Anesthesiology Post Anesthesia Sheet



Page 1 of 1  
Form NS657, Rev. 5/2017  
ORD X ORDERS

DOB:  
Adm:  
Acc:

BENTON, ALONZO  
DOB: 11/12/1958 58. M  
ADM: 09/20/17  
ACC: PA1304861964 MR:M000301370



BENTON, ALONZO

ID:M000301370

15-SEP-2017 12:21:49

MERCY PHILADELPHIA HOSPITAL

12-NOV-1958 (58 yr)  
Male Black

Room:  
Loc:3

|              |         |     |
|--------------|---------|-----|
| Vent. rate   | 75      | BPM |
| PR interval  | 166     | ms  |
| QRS duration | 92      | ms  |
| QT/QTc       | 398/444 | ms  |
| P-R-T axes   | 73 -18  | 41  |

Normal sinus rhythm

Normal ECG

When compared with ECG of 21-OCT-2015 00.13,

Nonspecific T wave abnormality no longer evident in Anterolateral leads

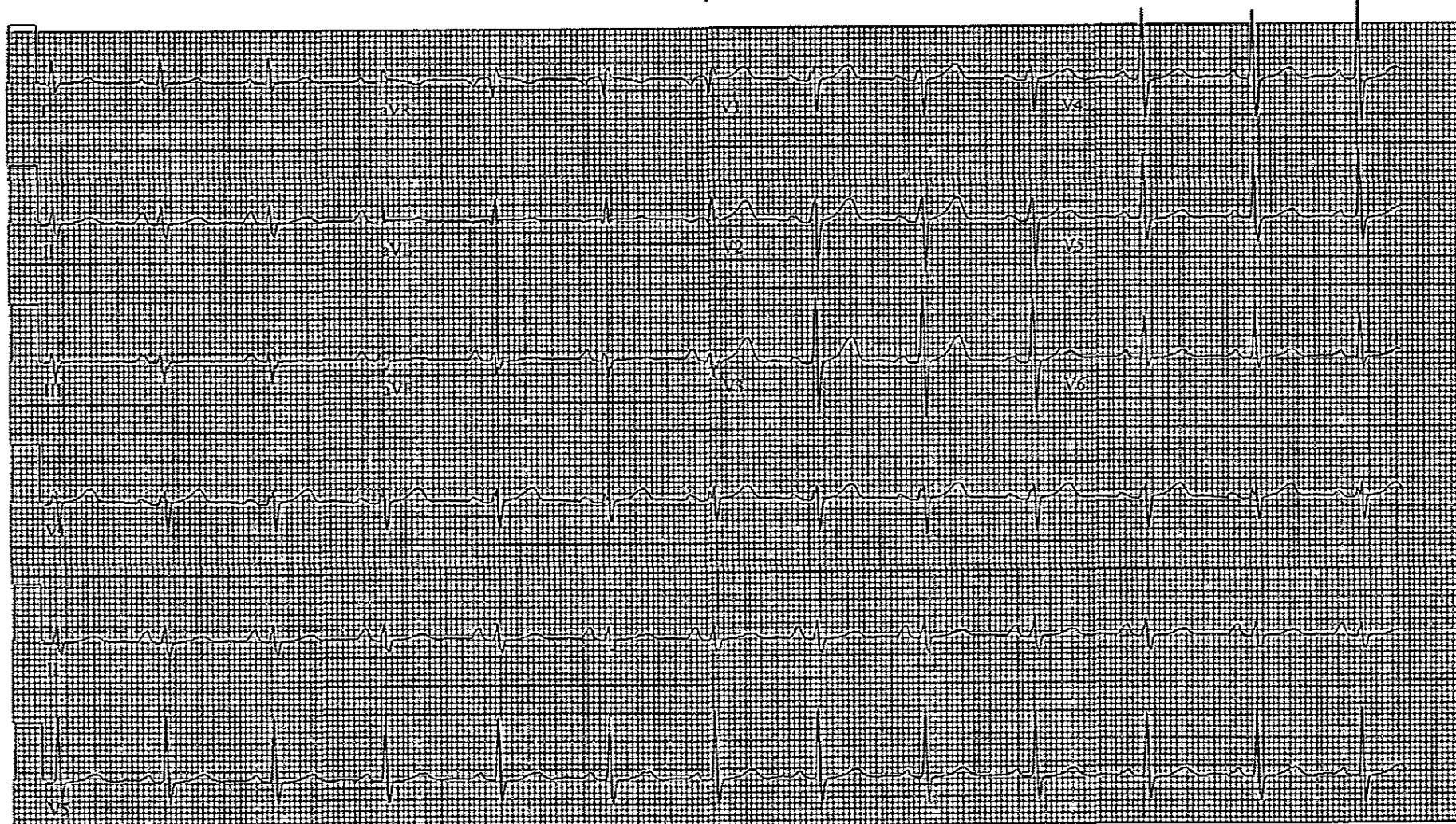
Confirmed by DEVAUGHN M.D., GERALD (1106) on 9/15/2017 3:56:50 PM

POOR QUALITY ORIGINAL

Technician: SAD  
Test ind:PREOP

Referred by: MENACHEM MELLER

Confirmed By: GERALD DEVAUGHN M.D.



DATE: 09/21/17 @ 0012  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 1

|                |                |                    |                          |
|----------------|----------------|--------------------|--------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD   |
| Account Number | PA1304861964   | Location           | PHSPU                    |
| Age/Sex        | 58/M           | Unit Number        | M000301370               |
| Status         | REG SDC        | Room               | Registered Date 09/20/17 |
|                |                | Bed                | Discharged Date          |

\*\*\*\*\*  
\* HEIGHT and WEIGHT are missing...PLEASE UPDATE!!! \*  
\*\*\*\*\*

Hem-Onc No

Drug Allergies iodine

ADRS

#### Creatinine Test Results

##### LABORATORY

| Date     | Time Test | Result | Flag | Normal Range  |
|----------|-----------|--------|------|---------------|
| 10/22/15 | 1259 CREA | 0.9    |      | 0.8-1.4 mg/dL |

MIDA1VIA13 - MIDAZOLAM HCL 2 MG/2 ML INJECTION (VERSED)

|                 |                        |             |               |               |               |
|-----------------|------------------------|-------------|---------------|---------------|---------------|
| Dose            | 4 MG (4 ML)            |             |               |               |               |
| Admin Route     | ROUTE                  |             |               |               |               |
| Start Date      | 09/20/17-1254          | Stop Date   | 09/20/17 1255 | DC Date       | 09/20/17-1255 |
| Ordering Doctor | DOCTOR, PYXIS OVERRIDE |             |               |               |               |
| Total Dispensed | 2                      | Total Costs | \$0.58        | Total Charges | \$5.00        |
| Rx Number       | 002109190              |             |               |               |               |

Discontinue Comments DC'd by ANDE

#### History

|                             |            |                    |
|-----------------------------|------------|--------------------|
| 09/20/17 1254 - DISCONTINUE | by STK MED | Eff: 09/20/17 1255 |
| FROM:                       |            |                    |
| DC COMMENTS:                |            |                    |
| TO:                         |            |                    |
| DC COMMENTS:                |            |                    |
| DC'd by ANDE                |            |                    |
| 09/20/17 1254 - PHL DM PHA  | by ANDE    |                    |

DATE: 09/21/17 @ 0012  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 2

|                |                |                    |                        |
|----------------|----------------|--------------------|------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD |
| Account Number | PA1304861964   | Location           | PHSPU                  |
| Age/Sex        | 58/M           | Room               |                        |
| Status         | REG SDC        | Bed                |                        |
|                |                | Unit Number        | M000301370             |
|                |                | Registered Date    | 09/20/17               |
|                |                | Discharged Date    |                        |

BENTON, ALONZO

PA1304861964

(Continued)

FENT0.0533 - fentaNYL CITRATE/PF 100 MCG/2 ML (SUBLIMAZE)

|                 |                        |               |               |
|-----------------|------------------------|---------------|---------------|
| Dose            | 100 MCG (2 ML)         |               |               |
| Admin Route     | .ROUTE                 |               |               |
| Start Date      | 09/20/17-1254          | Stop Date     | 09/20/17 1255 |
| Ordering Doctor | DOCTOR, PYXIS OVERRIDE | DC Date       | 09/20/17-1255 |
| Total Dispensed | 1                      | Total Costs   | \$0.27        |
| Rx Number       | 002109191              | Total Charges | \$5.00        |

Discontinue Comments DC'd by ANDE

History

|                             |            |                    |
|-----------------------------|------------|--------------------|
| 09/20/17 1254 - DISCONTINUE | by STK MED | Eff: 09/20/17 1255 |
| FROM:                       |            |                    |
| DC COMMENTS:                |            |                    |
| TO:                         |            |                    |
| DC COMMENTS:                |            |                    |
| DC'd by ANDE                |            |                    |
| 09/20/17 1254 - PHL DM PHA  | by ANDE    |                    |

PROP10VI7 - PROPOFOL 200 MG/20 ML INJECTION (DIPRIVAN)

|                 |                        |               |               |
|-----------------|------------------------|---------------|---------------|
| Dose            | 200 MG (20 ML)         |               |               |
| Admin Route     | .ROUTE                 |               |               |
| Start Date      | 09/20/17-1254          | Stop Date     | 09/20/17 1255 |
| Ordering Doctor | DOCTOR, PYXIS OVERRIDE | DC Date       | 09/20/17-1255 |
| Total Dispensed | 1                      | Total Costs   | \$1.03        |
| Rx Number       | 002109192              | Total Charges | \$8.50        |

Discontinue Comments DC'd by ANDE

History

|                             |            |                    |
|-----------------------------|------------|--------------------|
| 09/20/17 1254 - DISCONTINUE | by STK MED | Eff: 09/20/17 1255 |
| FROM:                       |            |                    |
| DC COMMENTS:                |            |                    |
| TO:                         |            |                    |
| DC COMMENTS:                |            |                    |
| DC'd by ANDE                |            |                    |
| 09/20/17 1254 - PHL DM PHA  | by ANDE    |                    |

DATE: 09/21/17 @ 0012  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 3

|                |                |                    |                          |
|----------------|----------------|--------------------|--------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD   |
| Account Number | PA1304861964   | Location           | PHSPU                    |
| Age/Sex        | 58/M           | Room               | Unit Number M000301370   |
| Status         | REG SDC        | Bed                | Registered Date 09/20/17 |
|                |                |                    | Discharged Date          |

BENTON, ALONZO

PA1304861964

(Continued)

ROCU10VI - ROCURONIUM 50 MG/5 ML VIAL (ZEMURON)

Dose 50 MG (5 ML)  
Admin Route .ROUTE  
Start Date 09/20/17-1254 Stop Date 09/20/17 1255 DC Date 09/20/17-1255  
Ordering Doctor DOCTOR, PYXIS OVERRIDE  
Total Dispensed 1 Total Costs \$20.41 Total Charges \$168.25  
Rx Number 002109193

Discontinue Comments DC'd by ANDE

History

09/20/17 1254 - DISCONTINUE by STK MED Eff: 09/20/17 1255  
FROM:  
DC COMMENTS:  
TO:  
DC COMMENTS:  
DC'd by ANDE  
09/20/17 1254 - PHL DM PHA by ANDE

BUPI5VIA3 - BUPIVACAINE HCL 0.5% 50 ML VIAL (MARCAINE)

Dose 50 ML (1 VIAL)  
Admin Route .ROUTE  
Start Date 09/20/17-1316 Stop Date 09/20/17 1317 DC Date 09/20/17-1317  
Ordering Doctor DOCTOR, PYXIS OVERRIDE  
Total Dispensed 1 Total Costs \$1.22 Total Charges \$10.25  
Rx Number 002109233

Discontinue Comments DC'd by MDEROSA

History

09/20/17 1315 - DISCONTINUE by STK MED Eff: 09/20/17 1317  
FROM:  
DC COMMENTS:  
TO:  
DC COMMENTS:  
DC'd by MDEROSA  
09/20/17 1315 - PHL DM PHA by MDEROSA

DATE: 09/21/17 @ 0012  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 4

|                |                |                    |                        |
|----------------|----------------|--------------------|------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD |
| Account Number | PA1304861964   | Location           | PHSPU                  |
| Age/Sex        | 58/M           | Room               |                        |
| Status         | REG SDC        | Bed                |                        |
|                |                | Unit Number        | M000301370             |
|                |                | Registered Date    | 09/20/17               |
|                |                | Discharged Date    |                        |

BENTON, ALONZO

PA1304861964

(Continued)

HYDR2DIS5 - HYDRomorphone HCL/FF 2MG/ML 2 MG/ML DISP.SYRIN (DILAUDID)

|                 |                        |               |               |
|-----------------|------------------------|---------------|---------------|
| Dose            | 4 MG (2 ML)            |               |               |
| Admin Route     | .ROUTE                 |               |               |
| Start Date      | 09/20/17-1346          | Stop Date     | 09/20/17 1347 |
| Ordering Doctor | DOCTOR, PYXIS OVERRIDE | DC Date       | 09/20/17-1347 |
| Total Dispensed | 2                      | Total Costs   | \$2.29        |
| Rx Number       | 002109284              | Total Charges | \$19.00       |

Discontinue Comments DC'd by ANDE

History

|                             |            |                    |
|-----------------------------|------------|--------------------|
| 09/20/17 1345 - PHL DM PHA  | by ANDE    |                    |
| 09/20/17 1345 - DISCONTINUE | by STK MED | Eff: 09/20/17 1347 |
| FROM:                       |            |                    |
| DC COMMENTS:                |            |                    |
| TO:                         |            |                    |
| DC COMMENTS:                |            |                    |
| DC'd by ANDE                |            |                    |

KETO15VI4 - KETOROLAC TROMETHAMINE 15 MG/ML VIAL (TORADOL)

|                 |                        |               |               |
|-----------------|------------------------|---------------|---------------|
| Dose            | 30 MG (2 ML)           |               |               |
| Admin Route     | .ROUTE                 |               |               |
| Start Date      | 09/20/17-1512          | Stop Date     | 09/20/17 1513 |
| Ordering Doctor | DOCTOR, PYXIS OVERRIDE | DC Date       | 09/20/17-1513 |
| Total Dispensed | 2                      | Total Costs   | \$1.46        |
| Rx Number       | 002109366              | Total Charges | \$12.50       |

Discontinue Comments DC'd by ANDE

History

|                             |            |                    |
|-----------------------------|------------|--------------------|
| 09/20/17 1511 - DISCONTINUE | by STK MED | Eff: 09/20/17 1513 |
| FROM:                       |            |                    |
| DC COMMENTS:                |            |                    |
| TO:                         |            |                    |
| DC COMMENTS:                |            |                    |
| DC'd by ANDE                |            |                    |
| 09/20/17 1511 - PHL DM PHA  | by ANDE    |                    |

DATE: 09/21/17 @ 0012  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

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|                |                |                    |                        |
|----------------|----------------|--------------------|------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD |
| Account Number | PA1304861964   | Location           | PHSPU                  |
| Age/Sex        | 58/M           | Room               |                        |
| Status         | REG SDC        | Bed                |                        |
|                |                | Unit Number        | M000301370             |
|                |                | Registered Date    | 09/20/17               |
|                |                | Discharged Date    |                        |

BENTON, ALONZO

PA1304861964

(Continued)

GLYC0.2V5 - GLYCOPYRROLATE 0.2 MG/ML (ROBINUL)

Dose 0.8 MG (4 ML)

Admin Route .ROUTE

Start Date 09/20/17-1512 Stop Date 09/20/17 1513 DC Date 09/20/17-1513

Ordering Doctor DOCTOR, PYXIS OVERRIDE

Total Dispensed 4 Total Costs \$30.47 Total Charges \$252.00

Rx Number 002109367

Discontinue Comments DC'd by ANDE

History

09/20/17 1511 - PHL DM PHA

by ANDE

09/20/17 1511 - DISCONTINUE

by STK MED

Eff: 09/20/17 1513

FROM:

DC COMMENTS:

TO:

DC COMMENTS:

DC'd by ANDE

NEOS5DIS - Neostigmine Methylsulfate 5 MG/5 ML SYRINGE (PROSTIGMIN)

Dose 5 MG (5 ML)

Admin Route .ROUTE

Start Date 09/20/17-1512 Stop Date 09/20/17 1513 DC Date 09/20/17-1513

Ordering Doctor DOCTOR, PYXIS OVERRIDE

Total Dispensed 1 Total Costs \$30.00 Total Charges \$247.25

Rx Number 002109368

Discontinue Comments DC'd by ANDE

History

09/20/17 1512 - DISCONTINUE

by STK MED

Eff: 09/20/17 1513

FROM:

DC COMMENTS:

TO:

DC COMMENTS:

DC'd by ANDE

09/20/17 1512 - PHL DM PHA

by ANDE

DATE: 09/21/17 @ 0012  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 6

|                |                |                    |                        |
|----------------|----------------|--------------------|------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD |
| Account Number | PA1304861964   | Location           | PHSPU                  |
| Age/Sex        | 58/M           | Room               |                        |
| Status         | REG SDC        | Bed                |                        |
|                |                | Unit Number        | M000301370             |
|                |                | Registered Date    | 09/20/17               |
|                |                | Discharged Date    |                        |

BENTON, ALONZO

PA1304861964

(Continued)

FENT0.0533 - fentaNYL CITRATE/PF 100 MCG/2 ML (SUBLIMAZE)

Dose 100 MCG (2 ML)  
Admin Route .ROUTE  
Start Date 09/20/17-1515 Stop Date 09/20/17 1516 DC Date 09/20/17-1516  
Ordering Doctor DOCTOR, PYXIS OVERRIDE  
Total Dispensed 1 Total Costs \$0.27 Total Charges \$5.00  
Rx Number 002109371

Discontinue Comments DC'd by ANJW

History

09/20/17 1515 - PHL DM PHA by ANJW  
09/20/17 1516 - DISCONTINUE by STK MED Eff: 09/20/17 1516  
FROM:  
DC COMMENTS:  
TO:  
DC COMMENTS:  
DC'd by ANJW

HYDR5DIS2 - HYDRomorphone HCL/Pf (DILAUDID) 0.5 MG/0.5 ML DISP.SYRIN

Dose 0.5 MG (0.5 ML)  
Admin Route .ROUTE  
Start Date 09/20/17-1550 Stop Date 09/20/17 1551 DC Date 09/20/17-1551  
Ordering Doctor DOCTOR, PYXIS OVERRIDE  
Total Dispensed 1 Total Costs \$1.68 Total Charges \$14.00  
Rx Number 002109416

Discontinue Comments DC'd by PWOMBLE

History

09/20/17 1548 - PHL DM PHA by PWOMBLE  
09/20/17 1548 - DISCONTINUE by STK MED Eff: 09/20/17 1551  
FROM:  
DC COMMENTS:  
TO:  
DC COMMENTS:  
DC'd by PWOMBLE

DATE: 09/21/17 @ 0012  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

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|                |                |                    |                        |
|----------------|----------------|--------------------|------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD |
| Account Number | PA1304861964   | Location           | PHSPU                  |
| Age/Sex        | 58/M           | Room               |                        |
| Status         | REG SDC        | Bed                |                        |
|                |                | Unit Number        | M000301370             |
|                |                | Registered Date    | 09/20/17               |
|                |                | Discharged Date    |                        |

BENTON, ALONZO

PA1304861964

(Continued)

HYDR5DIS2 - HYDRomorphone HCL/Pf (DILAUDID) 0.5 MG/0.5 ML DISP.SYRIN

Dose 0.5 MG (0.5 ML)

Admin Route .ROUTE

Start Date 09/20/17-1606 Stop Date 09/20/17 1607 DC Date 09/20/17-1607

Ordering Doctor DOCTOR, PYXIS OVERRIDE

Total Dispensed 1 Total Costs \$1.68 Total Charges \$14.00

Rx Number 002109439

Discontinue Comments DC'd by SBROWN

History

09/20/17 1606 - PHL DM PHA

by SBROWN

09/20/17 1606 - DISCONTINUE

by STK MED

Eff: 09/20/17 1607

FROM:

DC COMMENTS:

TO:

DC COMMENTS:

DC'd by SBROWN

FENT0.0533 - fentaNYL CITRATE/PF 100 MCG/2 ML (SUBLIMAZE)

Dose 100 MCG (2 ML)

Admin Route .ROUTE

Start Date 09/20/17-1632 Stop Date 09/20/17 1633 DC Date 09/20/17-1633

Ordering Doctor DOCTOR, PYXIS OVERRIDE

Total Dispensed 1 Total Costs \$0.27 Total Charges \$5.00

Rx Number 002109457

Discontinue Comments DC'd by SBROWN

History

09/20/17 1631 - PHL DM PHA

by SBROWN

09/20/17 1631 - DISCONTINUE

by STK MED

Eff: 09/20/17 1633

FROM:

DC COMMENTS:

TO:

DC COMMENTS:

DC'd by SBROWN

DATE: 09/21/17 @ 0012  
USER: BKG DAEMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 8

|                |                |                    |                          |
|----------------|----------------|--------------------|--------------------------|
| Patient        | BENTON, ALONZO | Responsible Doctor | MELLER, MENACHEM M, MD   |
| Account Number | PA1304861964   | Location           | PHSPU                    |
| Age/Sex        | 58/M           | Room               | Unit Number M000301370   |
| Status         | REG SDC        | Bed                | Registered Date 09/20/17 |
|                |                |                    | Discharged Date          |

BENTON, ALONZO

PA1304861964

(Continued)

OKYC1TAB53 - oxyCODONE/ACETAMINOPHEN 5-325 MG TABLET (PERCOCET)

Dose 2 TABLET (2 TABLETS)

Admin Route .ROUTE

Start Date 09/20/17-1637 Stop Date 09/20/17 1638 DC Date 09/20/17-1638

Ordering Doctor DOCTOR, PYXIS OVERRIDE

Total Dispensed 2 Total Costs \$0.71 Total Charges \$6.80

Rx Number 002109476

Discontinue Comments DC'd by SBROWN

#### History

09/20/17 1636 - DISCONTINUE by STK MED Eff: 09/20/17 1638

FROM:

DC COMMENTS:

TO:

DC COMMENTS:

DC'd by SBROWN

09/20/17 1636 - PHL DM PHA

by SBROWN

This is the end of the MAR Summary for Patient PA1304861964 - BENTON, ALONZO.

DATE: 09/21/17 @ 0012  
USER: EKG DARMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Discharge Summary Report

PAGE 1

09/21/17

MEDICATION DISCHARGE SUMMARY

Name BENTON, ALONZO Admit Date Age 58  
Unit Num M000301370 Discharge Date Sex M  
Account Num PA1304861964 Status REG SDC  
Allergies iodine-Rash and hives

ADMINISTRATION PERIOD:  
0730 09/20/17 to 0729 09/21/17

START/  
STOP

Midazolam HCL (MIDAZOLAM HCL 2 MG/2 ML INJECTION (VERSED)) | 09/20/17 | 1254  
4 MG .ROUTE .STK-MED/ONE | 09/20/17 | DC 1254 STK M3D  
| | DM 1254 ANDE  
RX #: C02109190 | |

fentaNYL (fentaNYL CITRATE/PF 100 MCG/2 ML (SUBLIMAZE)) | 09/20/17 | 1254  
100 MCG .ROUTE .STK-MED/ONE | 09/20/17 | DC 1254 STK M3D  
| | DM 1254 ANDE  
RX #: C02109191 | |

PROPOFOL (PROPOFOL 200 MG/20 ML INJECTION (DIPRIVAN)) | 09/20/17 | 1254  
200 MG .ROUTE .STK-MED/ONE | 09/20/17 | DC 1254 STK M3D  
| | DM 1254 ANDE  
RX #: C02109192 | |

ZEMURON (ROCURONIUM 50 MG/5 ML VIAL (ZEMJRON)) | 09/20/17 | 1254  
50 MG .ROUTE .STK-MED/ONE | 09/20/17 | DC 1254 STK M3D  
| | DM 1254 ANDE  
RX #: C02109193 | |

BUPIVACAINE HCL 0.5% 50ML (BUPIVACAINE HCL 0.5% 50 ML VIAL (MARCAINE)) | 09/20/17 | DC 1315 STK M3D  
50 ML .ROUTE .STK-MED/ONE | 09/20/17 | DM 1315 NDEROSA  
| | 1316  
RX #: C02109233 | |

HYDROMorphone HCL/Pf (HYDROMorphone HCL/PF 2MG/ML 2 MG/ML DISP.SYRIN (DILAUDID)) | 09/20/17 | DM 1345 ANDE  
4 MG .ROUTE .STK-MED/ONE | 09/20/17 | DC 1345 STK M3D  
| | 1346  
RX #: C02109204 | |

DATE: 09/21/17 @ 0012  
USER: EKG DARMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Discharge Summary Report

PAGE 2

09/21/17

Medication Discharge Summary

Name BENTON, ALONZO

Unit Num M000301370

Account Num PA1304861964

| ADMINISTRATION PERIOD:                     | START/ |
|--------------------------------------------|--------|
| 0730 09/20/17 to 0730 09/21/17 (Continued) | STOP   |

KETOROLAC TROMETHAMINE (KETOROLAC TROMETHAMINE 15 MG/ML VIAL (TORADOL))  
30 MG .ROUTE .STK-MED/ONE  
RX #: C02109366

|          |         |         |
|----------|---------|---------|
| 09/20/17 | DC 1511 | STK M3D |
| 09/20/17 | DM 1511 | ANDE    |
|          | 1512    |         |
|          |         |         |

GLYCOPYRROLATE (GLYCOPYRROLATE 0.2 MG/ML (ROBINUL))  
0.8 MG .ROUTE .STK-MED/ONE  
RX #: C02109367

|          |         |         |
|----------|---------|---------|
| 09/20/17 | DM 1511 | ANDE    |
| 09/20/17 | DC 1511 | STK M3D |
|          | 1512    |         |
|          |         |         |

Neostigmine Methylsulfate (Neostigmine Methylsulfate 5 MG/5 ML SYRINGE (PROSTIGMIN))  
5 MG .ROUTE .STK-MED/ONE  
RX #: C02109368

|          |         |         |
|----------|---------|---------|
| 09/20/17 | DC 1512 | STK M3D |
| 09/20/17 | DM 1512 | ANDE    |
|          | 1512    |         |
|          |         |         |

fentaNYL (fentaNYL CITRATE/PF 100 MCG/2 ML (SUBLIMAZE))  
100 MCG .ROUTE .STK-MED/ONE  
RX #: C02109371

|          |         |         |
|----------|---------|---------|
| 09/20/17 | 1515    |         |
| 09/20/17 | DM 1515 | ANJW    |
|          | DC 1516 | STK M3D |
|          |         |         |

HYDROMorphone HCL/Pf (HYDROMorphone HCL/Pf (DILAUDID)) 0.5 MG/0.5 ML DISP.SYRIN)  
0.5 MG .ROUTE .STK-MED/ONE  
RX #: C02109416

|          |         |         |
|----------|---------|---------|
| 09/20/17 | DM 1548 | PWOMBLE |
| 09/20/17 | DC 1548 | STK M3D |
|          | 1550    |         |
|          |         |         |

HYDROMorphone HCL/Pf (HYDROMorphone HCL/Pf (DILAUDID)) 0.5 MG/0.5 ML DISP.SYRIN)  
0.5 MG .ROUTE .STK-MED/ONE  
RX #: C02109439

|          |         |         |
|----------|---------|---------|
| 09/20/17 | 1606    |         |
| 09/20/17 | DM 1606 | SBROWN  |
|          | DC 1606 | STK M3D |
|          |         |         |

fentaNYL (fentaNYL CITRATE/PF 100 MCG/2 ML (SUBLIMAZE))  
100 MCG .ROUTE .STK-MED/ONE  
RX #: C02109457

|          |         |         |
|----------|---------|---------|
| 09/20/17 | DM 1631 | SBROWN  |
| 09/20/17 | DC 1631 | STK M3D |
|          | 1632    |         |
|          |         |         |

DATE: 09/21/17 @ 0012  
USER: EKG DARMON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Discharge Summary Report

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|                    |  |                     |                              |                          |  |
|--------------------|--|---------------------|------------------------------|--------------------------|--|
| 09/21/17           |  |                     | Medication Discharge Summary |                          |  |
| Name BENTON,ALONZO |  | Unit Num M000301370 |                              | Account Num PA1304861964 |  |

| ADMINISTRATION PERIOD:                     | START/ |
|--------------------------------------------|--------|
| 0730 09/20/17 to 0730 09/21/17 (Continued) | STOP   |

|                                                                                   |                           |
|-----------------------------------------------------------------------------------|---------------------------|
| oxyCODONE HCl/ACETAMIN 5-325 (oxyCODONE/ACETAMINOPHEN 5-325 MG TABLET (PERCOCET)) | 09/20/17  DC 1636 STK M3D |
| 2 TABLET ,ROUTE ,STK-MED/ONE                                                      | 09/20/17  DM 1636 SBROWN  |
|                                                                                   | 1637                      |
| RX #: 002109476                                                                   |                           |

DATE: 09/21/17 @ 0012  
USER: EKG DAEWON

Mercy Philadelphia Hospital PHA \*LIVE\*  
Medication Discharge Summary Report

PAGE 4

09/21/17

Medication Discharge Summary

Name BENTON, ALONZO

Unit Num M000301370

Account Num PA1304861964

Legends

Activity Codes

DC - Discontinue  
DM - Dispensing Machine

Reason Codes

Site Codes

Administered By

User User Name/Type

User User Name/Type

User User Name/Type

User User Name/Type

Pharmacy

User User Name

User User Name

User User Name

User User Name

Allergy History

Date Time User Name  
20151021 0406 SALEM MOHAMMAD  
OLD:  
NEW: iodine added.  
20151021 0403 ASHISH PATEL  
OLD:  
NEW:

Database Type Allergy  
MRI.PHL ADD iodine  
PHA.PHL ACK



A ministry of Catholic Health East  
Mercy Fitzgerald Mercy Philadelphia  
A healthcare ministry of the Sisters of Mercy

### \*STOP BANG Questionnaire\*

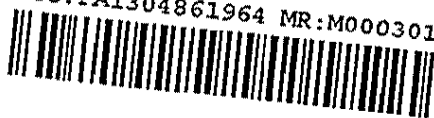
Tool to Screen Patients for Obstructive Sleep Apnea (OSA)

- ☐ Snoring: Do you Snore loudly (louder than talking or loud enough to be heard through closed doors)?
- ☐ Tired: Do you often feel Tired, fatigued, or sleepy during the daytime?
- ☐ Observed: Has anyone ever Observed you to stop breathing during your sleep?
- ☒ Blood Pressure: Do you have or are you being treated for high blood Pressure?
- ☐ BMI: BMI more than 35 kg/m<sup>2</sup> 59 170
- ☐ Age: Age over 50 years old?
- ☐ Neck circumference > 16 inches women; 17 inches men (measured at Adam's apple)
- ☒ Gender: Male?

\*\*\*Score of 3 or more = high risk for obstructive sleep apnea (OSA)\*\*\*

Screened by: [Signature] Date: 9/18/17 Time: 12

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 09/20/17  
ACC: PA1304861964 MR: M000301370



What procedure are you here for? LP Shoulder fix surgery What is your primary language? English

Family History: HTN - CVA - Heart condition - DM

Did you use body wash? ☒ Yes ☐ No ID Band On ☒ Yes ☐ No Oriented to Unit Info ☒ Yes ☐ No Call Bell within Reach ☒ Yes ☐ No Isolation Precautions ☒ Yes ☐ No Disposition of Medications ☐ None ☐ Sent Home ☐ Pharmacy

Emergency Contact Benton, April Relationship of Contact Daughter Home Phone No. 267-23567 (cell) Work Phone No. \_\_\_\_\_

Mode of Transportation at Discharge Janet Waddell Contact Phone No. 215-924-3609 215-235986

Height 5'9" Weight (Actual) 170 BP 132/100 T 97.2 P 83 R 20 POX 98% AccuCheck +

ALLERGIES: Latex \_\_\_\_\_ Allergic to: Iodine Contrast dye ☐ No known Allergies

Do you have an Advanced Directive? ☐ Yes ☒ No Information given ☐ Refused

| Valuables                                                                                    | Disposition                                                                | Valuables                                    | Disposition                                                     |
|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------|
| <input checked="" type="checkbox"/> Glasses                                                  | <input checked="" type="checkbox"/> Home <input type="checkbox"/> Hospital | <input checked="" type="checkbox"/> Clothing | <input type="checkbox"/> Home <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Contacts                                                            | <input type="checkbox"/> Home <input type="checkbox"/> Hospital            | <input type="checkbox"/> Wallet / Purse      | <input type="checkbox"/> Home <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Dentures                                                            | <input type="checkbox"/> Home <input type="checkbox"/> Hospital            | <input type="checkbox"/> Jewelry (Describe)  | <input type="checkbox"/> Home <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Upper                                                               | <input type="checkbox"/> Home <input type="checkbox"/> Hospital            | <input type="checkbox"/> Cash Amt _____      | <input type="checkbox"/> Home <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Lower                                                               | <input type="checkbox"/> Home <input type="checkbox"/> Hospital            | Locker # _____                               |                                                                 |
| <input type="checkbox"/> Hearing Aides <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Home <input type="checkbox"/> Hospital            |                                              |                                                                 |

Past Medical History: Hypertension  
☐ Headaches ☒ Liver Disease  
☐ Seizures ☐ Kidney Disease  
☒ High Blood Pressure ☒ Stomach Ulcer  
☐ Heart Disease ☒ Cancer  
☐ Circulation Problems ☐ Blood Disorders  
☐ Diabetes - Type I or II ☐ Lung Disease (Asthma, Emphysema, Pneumonia)  
☐ Thyroid Disease ☐ Vision Problems

Do you drink alcohol or beer? ☒ Yes ☐ No  
 If Yes, How often do you drink? 2-3 / week  
 Recreational Drug Use? ☐ Yes ☒ No  
 If Yes, How often and last time? 3 yrs  
 Drug of choice? Cocaine

\*Females Only: Date of Last Period N/A Cycle Regular \_\_\_\_\_ Cycle Irregular \_\_\_\_\_

Comments: prostatectomy TL (accident)

Surgical History: prostatectomy hernia repair LP hand surgery

Have you been hospitalized or had a surgical procedure performed within the past 30 days? ☐ Yes ☒ No ☐ No history of surgery

If yes, please list the reason for your hospitalization/surgery and place: \_\_\_\_\_

PSYCHO-SOCIAL:  
 Have you had any of the following?  
 Anxiety ☒ Yes ☐ No  
 Panic Attacks ☐ Yes ☒ No  
 Depression ☐ Yes ☒ No  
 Suicidal Thoughts ☐ Yes ☒ No  
 Addiction ☒ Yes ☐ No  
 Type: (Cocaine) 3 yrs

Any evidence of abuse ☐ Yes ☒ No  
 Patient feels safe in environment ☒ Yes ☐ No  
 Major life changes in the past year? ☐ Yes ☒ No  
 Describe? \_\_\_\_\_

Special requests relating to your cultural or religious traditions?  
☐ Yes ☒ No

PAIN ASSESSMENT:  
 Do you have pain now? ☒ Yes ☐ No  
 Rate your pain on a scale of 0 (none) - 10 (worst) 7  
 What pain level would be acceptable to you? 0  
 What location(s) are you experiencing pain? LP shoulder  
 How do you manage pain? Percocet Is it effective? ☒ Yes ☐ No

Mercy Philadelphia Hospital  
 Member of Mercy Health System

# SHORT PROCEDURE ASSESSMENT FORM

DOB: BENTON, ALONZO  
 ADM: 11/12/1958 58 M  
 ACC: ADM: 09/20/17  
 ACC: PA1304861964 MR:M000301370



|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Patient taking Anticoagulant</b><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Heparin<br><input type="checkbox"/> Warfarin (Coumadin)<br><input type="checkbox"/> Enoxiparin (Lovenox)<br><input type="checkbox"/> Daltiparin (Fragmin)<br><input type="checkbox"/> Fondaparinox (Arixta)<br><input type="checkbox"/> Aspirin<br><input type="checkbox"/> Clopidogrel (Plavix)<br><input type="checkbox"/> Other _____<br>Last Dose: _____ Date: _____ | <b>CARDIOVASCULAR:</b><br><input checked="" type="checkbox"/> Blood Pressure<br><input type="checkbox"/> Low <input checked="" type="checkbox"/> High<br><input type="checkbox"/> Heart disease<br><input type="checkbox"/> Heart attack<br><input type="checkbox"/> Palpitations<br><input type="checkbox"/> Heart murmur<br><input type="checkbox"/> Heart failure (CHF)<br><input type="checkbox"/> Aneurysm<br><input type="checkbox"/> Chest Pain<br><input type="checkbox"/> Implanted defibrillator<br><input type="checkbox"/> Pacemaker<br>If Yes: _____<br><input type="checkbox"/> O.R. Notified<br><input type="checkbox"/> Other _____<br><input type="checkbox"/> No Identified Problems |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**GENERAL ASSESSMENT:**

LOC: Alert / lethargic / confused / unconscious    Eye Contact: good / minimal / none  
 Oriented to: time / place / person    Sociability: average / engaging / friendly / negativistic  
 Mood: hostile / calm / euphoric / anxious / depressed / labile / flat / suspicious  
 Appearance: neat / disheveled / casual  
 Memory: present / time: adequate / impaired  
 Motor Activity: appropriate / hyperactive / restless / slowed

COMMENTS: \_\_\_\_\_

**RESPIRATORY STATUS:**

Breath Sounds: Right: clear / wheezing / congested    Left: clear / wheezing / congested

Smoking History: ☒ Yes ☐ No    Pks/Day: 10    X 30 years    Date/Year Quit: 10 yrs ago  
 Shortness of Breath? ☐ Yes ☒ No    WHEN? \_\_\_\_\_  
 Cough: ☐ Yes ☒ No    Productive of: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

**CIRCULATORY STATUS:**

Skin Temperature: Right Hand: Warm / Cool    Right Foot: Warm / Cool    Left Hand: Warm / Cool    Left Foot: Warm / Cool  
 Edema? ☐ Yes ☒ No    Palpitations? ☐ Yes ☒ No    Cyanosis? ☐ Yes ☒ No

COMMENTS: \_\_\_\_\_

**ELIMINATION STATUS:** Last BM: 9/19/17    COMMENTS: \_\_\_\_\_

Urinary: No problems / frequency / dysuria / hematuria / nocturia

**PRE-PROCEDURE CHECKLIST:** (Check off all items that are present in chart)

|                                                                                                                            |                                                        |                                                                  |
|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Identification bracelet on patient                                                     | <input checked="" type="checkbox"/> H&P                | <input checked="" type="checkbox"/> Voided / catheterized        |
| <input checked="" type="checkbox"/> Permit                                                                                 | <input type="checkbox"/> Anesthesia permit             | <input checked="" type="checkbox"/> Contact lenses / glasses off |
| <input checked="" type="checkbox"/> Medical Clearance (if applicable)                                                      | <input type="checkbox"/> Breast surgery permit         | <input checked="" type="checkbox"/> Jewelry removed / secured    |
| <input checked="" type="checkbox"/> EKG report                                                                             | <input checked="" type="checkbox"/> Blood permit       | <input checked="" type="checkbox"/> Body piercing removed        |
| <input checked="" type="checkbox"/> Urinalysis report                                                                      | <input checked="" type="checkbox"/> Blood work reports |                                                                  |
| <input checked="" type="checkbox"/> Dentures/Caps/Hearing Aid                                                              | <input checked="" type="checkbox"/> X ray reports      |                                                                  |
| <input checked="" type="checkbox"/> NPO after Midnight <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                        |                                                                  |

Comments: \_\_\_\_\_

Pre-op medications: \_\_\_\_\_  
 Instructed to stay in bed    Call bell available

RN Signature: [Signature]

Mercy Philadelphia Hospital  
 Member of Mercy Health System

**SHORT PROCEDURE ASSESSMENT FORM**

DOB: BENTON, ALONZO  
 Adm: DOB: 11/12/1958 58 M  
 Acc: ADM: 09/20/17  
 ACC: PA1304861964 MR: M000301370



## FUNCTIONAL ASSESSMENT

☒ No identified problems

Recent History

- ☐ Limited movement/paralysis of extremities  
☐ Pain/swelling of extremities

- ☐ Open wound (decubitus, sores)  
☐ CVA with slurred or incoherent speech

## SPIRITUAL ASSESSMENT

Request for Spiritual Care? ☐ Yes ☒ No

Prayer card given? ☐ Yes ☒ No

## NUTRITIONAL ASSESSMENT

☒ No identified problems

☐ Poor/Inadequate oral intake  $\geq 3$  days

☐ Recent unintentional wt. loss or gain of  $\geq 10$  lbs

☐ Poor Skin Turgor

☐ NV/D  $\geq 3$  Days

☐ Emaciation or other sign of deficiency

☐ Nutritional Support (Tube Feed/TPN)

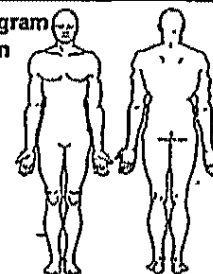
FALLS RISK ASSESSMENT - A X by a \*indicator or 2 or more other indicators should initiate Falls Precaution Program

| Fall Assessment Indicators                            | Score                                                               |
|-------------------------------------------------------|---------------------------------------------------------------------|
| Age over 65                                           | 1 0                                                                 |
| *History of falls prior to admission                  | 1 0                                                                 |
| Dizziness                                             | 0 0                                                                 |
| Unsteady/shuffling gait/wide base                     | 0 0                                                                 |
| Weakness                                              | 0 0                                                                 |
| Impaired Vision                                       | 0 0                                                                 |
| *Confused/disoriented                                 | 0 0                                                                 |
| Incontinence @ times                                  | 1 1                                                                 |
| Medications - diuretics, hypotensives CNS depressants | 1 1                                                                 |
| <b>TOTAL SCORE</b>                                    | <b>2 2</b>                                                          |
| Falls Precaution Program Initiated?                   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Falls ID Bracelet put on patient? Yellow Booties      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |

## SKIN STATUS

- ☐ Rashes  
☐ Psoriasis ☐ Eczema  
☐ Any changes in skin color ☐ Yes ☐ No  
☐ At risk for developing Pressure Ulcer/s  
☐ Skin Breakdown  
☐ Other Dry palm  
☒ No identified problems

Draw an "X" on the diagram to indicate any variation in skin integrity.



## NEEDS ASSESSMENT

### PATIENT FAMILY EDUCATION

Learning Readiness: ☒ Motivated ☐ Non-Motivated ☐ Unable to Learn

Barriers to Learning: ☐ Cognitive ☐ Cultural ☐ Educational ☐ Language ☐ Physical ☐ Religious

☐ Refuses at this time ☒ No Barriers ☐ Comments/Other \_\_\_\_\_

How do you Learn Best: ☐ Audio ☐ Visual ☒ Both

Teach Back Method Used: ☐ Yes

Plans to Overcome Barriers to Education: ☐ Family Involvement ☐ Reinforcement ☐ Written Materials ☐ Audiovisual Aids

☐ Interpreter ☐ Other \_\_\_\_\_

Education Provided: ☐ Disease Process ☐ Activity Level ☐ Diet ☐ Procedures ☐ Hygiene ☐ Pain Management

☐ Medications (includes Drug and Food Interactions) ☐ Medical Equipment / Assistive Devices (if applicable)

☐ Smoking cessation information ☐ Given ☐ Refused

☐ Other \_\_\_\_\_

Plan for collaborative education: (X when indicated and notified) ☐ Nutrition ☐ OT ☐ PT ☐ Speech Therapy ☐ Respiratory

☐ Social Worker ☐ Case Manager ☒ Other \_\_\_\_\_

Teaching to be directed primarily to: ☒ Patient ☐ Family ☐ Other \_\_\_\_\_

## DISCHARGE PLANNING SCREEN

Living arrangements: ☐ Alone ☒ Family ☐ Retirement Community ☐ Nursing Home ☐ Other \_\_\_\_\_

Home environment: Stairs ☒ Yes ☐ No Are stairs a problem? ☐ Yes ☒ No

Assistive devices: ☒ None ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Other \_\_\_\_\_

Patient plans to be discharged to: Home Caregiver at home: ☐ N/A ☐ Yes Specify \_\_\_\_\_ Brought to Hospital

If any questions are answered yes, as problematic, consult Social Service/Case Manager Consult

Mercy Philadelphia Hospital  
 member of Mercy Health System

SHORT PROCEDURE ASSESSMENT FORM



Page 2 of 4  
 Form SPUASS, Rev. 06/2014  
 4014 V 07/08

DOB:  
 Adm:  
 Acc:

BENTON, ALONZO  
 DOB: 11/12/1958 58 M  
 ADM: 09/20/17  
 ACC: PA1304861964 MR: M000301370



# Post Procedure Data

|                                                           |                                     |        |        |
|-----------------------------------------------------------|-------------------------------------|--------|--------|
| Date                                                      |                                     |        |        |
| Time                                                      | 1645                                | 1708   | 1723   |
| Temperature                                               |                                     |        |        |
| Pulse                                                     | 70                                  | 71     | 72     |
| Respiratory Rate                                          | 13                                  | 13     | 14     |
| Blood Pressure                                            | 128/80                              | 127/78 | 132/79 |
| Side Rails Up                                             | <input checked="" type="checkbox"/> |        |        |
| Call Bell Within Reach                                    | <input checked="" type="checkbox"/> |        |        |
| Instructed Not to Get Out of Bed/Chair Without Assistance |                                     |        |        |
| Dressing Evaluated                                        |                                     |        |        |
| IV Site Checked                                           | KUD                                 |        |        |
| IV Checked/Infusing at Correct Rate                       | 0/10                                |        |        |
| Pain Scale: 0 (None) - 10 (Most)                          |                                     |        |        |
| RN Signature                                              | Sophia Brown                        | SB     | SB     |

Nurses Notes: Pt D&B VSS Strong in place tolerating to well SB

| Medications: Dose | Route | Time | RN Signature | Effective                           |    | If No, Action Taken | RN Signature |
|-------------------|-------|------|--------------|-------------------------------------|----|---------------------|--------------|
|                   |       |      |              | Yes                                 | No |                     |              |
| Percocet 5/325    | PO    | 1645 | Sophia Brown | <input checked="" type="checkbox"/> |    |                     |              |

|                                                                                                                                                                                |                                                                                                                                                          |                                                                                                                                                                      |                                                                                                                                                        |                                                                                                                                                                               |                                                                                                                                                                   |                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| <b>VITAL SIGNS</b><br><input checked="" type="checkbox"/> 2 within normal limits<br><input type="checkbox"/> 1 within acceptable limits<br><input type="checkbox"/> 0 unstable | <b>MOBILITY</b><br><input checked="" type="checkbox"/> 2 return to previous level<br><input type="checkbox"/> 1 return to previous level with assistance | <b>BLEEDING</b><br><input checked="" type="checkbox"/> 2 no bleeding<br><input type="checkbox"/> 1 minimal bleeding<br><input type="checkbox"/> 0 excessive bleeding | <b>ORAL INTAKE</b><br><input checked="" type="checkbox"/> 2 fluids / solids<br><input type="checkbox"/> 1 ice chips<br><input type="checkbox"/> 0 none | <b>NAUSEA/ VOMITING</b><br><input checked="" type="checkbox"/> 2 minimal to none<br><input type="checkbox"/> 1 moderate<br><input type="checkbox"/> 0 severe, needs treatment | <b>PAIN ASSESSMENT at Discharge SCORE</b><br><input checked="" type="checkbox"/> 2 (0-2)<br><input type="checkbox"/> 1 (3-6)<br><input type="checkbox"/> 0 (7-10) | <b>ABILITY TO VOID</b><br><input checked="" type="checkbox"/> 2 able to void / not applicable<br><input type="checkbox"/> 0 unable |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|

MUST SCORE 10 OR GREATER FOR DISCHARGE - TOTAL SCORE 19

Comments:

Patient Discharged With: neighbor Relationship: \_\_\_\_\_

Transported To: EL entrance Via: w/c

☒ Discharge Instructions reviewed with pt. and only. Pt. and family verbalized understanding of instructions.

Prescriptions given: ☐ Yes ☐ No ☒ N/A

Filed by Mercy Pharmacy ☐ Yes ☒ No

Time: 1726 RN Signature: \_\_\_\_\_

Mercy Philadelphia Hospital  
Member of Mercy Health System  
SHORT PROCEDURE ASSESSMENT FORM

DOB:  
Adm:  
Acc:

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 09/20/17  
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## Pre-Op Assessment

Name: Alonzo Benton Date: 8/20/17 Time: 11<sup>20</sup> AM/PM Surgeon: Meller  
 Procedure: ORIF (L) Distal clavicle

Allergies: Iodine - ~~Pen~~ contrast dye

Significant PMH: \_\_\_\_\_

Patient Verbalizes Knowledge of OR Procedure: Yes: ☒ No: \_\_\_\_\_

Comments: \_\_\_\_\_

LEVEL OF CONSCIOUSNESS

alert ☒  
 sedated \_\_\_\_\_  
 disoriented \_\_\_\_\_  
 non-responsive to  
 tactile or verbal  
 stimuli \_\_\_\_\_

SKIN APPEARANCE

warm ☒  
 dry \_\_\_\_\_  
 cool \_\_\_\_\_  
 diaphoretic \_\_\_\_\_  
 intact ☒

PSYCHOLOGICAL

calm \_\_\_\_\_  
 anxious ☒  
 restless \_\_\_\_\_  
 crying \_\_\_\_\_

MUSCULO-SKELETAL

no limitations ☒  
 ROM limitations \_\_\_\_\_  
 paralysis \_\_\_\_\_  
 traction \_\_\_\_\_  
 amputation \_\_\_\_\_

COMMUNICATIONS

no limitations ☒  
 language barrier \_\_\_\_\_  
 hearing impaired \_\_\_\_\_  
 aphasia / dysphasia \_\_\_\_\_  
 blindness \_\_\_\_\_  
 retardation \_\_\_\_\_

*Ekin RN*

HOLDING AREA:

Verification Nurse: \_\_\_\_\_ ID Band: \_\_\_\_\_ Pt Acknowledgement: \_\_\_\_\_

Chart Review: ☐ OR Permit ☐ Blood Permit ☐ T & C ☐ T & S  
☐ Blood Work ☐ CXR ☐ EKG ☐ H & P  
☐ Other \_\_\_\_\_ ☐ Site Verification

Comments: \_\_\_\_\_

RN Signature: \_\_\_\_\_

BENTON, ALONZO  
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- ☐ MERCY FITZGERALD HOSPITAL  
☐ MERCY HOSPITAL OF PHILADELPHIA  
☐ MERCY SUBURBAN HOSPITAL

OPERATING ROOM NURSES RECORD NS 196A (09/07)

INTRA-OPERATIVE SECTION:

Verification Nurse: \_\_\_\_\_ ID Band: \_\_\_\_\_

Patient Acknowledgement: \_\_\_\_\_ Operative Site: \_\_\_\_\_

Position: ☐ Safety Strap ☐ Supine ☐ Prone ☐ Lateral  
☐ Lithotomy ☐ Jackknife ☐ Warming Blanket ☐ Temp \_\_\_\_\_  
☐ Other: \_\_\_\_\_

Bovie: Pad Site: \_\_\_\_\_ Bovie Number: \_\_\_\_\_ Shaved: ☐ Yes ☐ No Settings: Cut \_\_\_\_\_ Coag \_\_\_\_\_

Skin Intact When Pad Removed: ☐ Yes ☐ No Comments: \_\_\_\_\_

Tourniquet Site: \_\_\_\_\_ Tourniquet #: \_\_\_\_\_ Total Time: \_\_\_\_\_ Pressure: \_\_\_\_\_

Skin Prep: Clip: \_\_\_\_\_ Betadine: \_\_\_\_\_ PhisoHex: \_\_\_\_\_ Other: \_\_\_\_\_

Specimen: 1. \_\_\_\_\_ G \_\_\_\_\_ Rt \_\_\_\_\_ FS \_\_\_\_\_ R \_\_\_\_\_ Other \_\_\_\_\_

2. \_\_\_\_\_ G \_\_\_\_\_ Rt \_\_\_\_\_ FS \_\_\_\_\_ R \_\_\_\_\_ Other \_\_\_\_\_

3. \_\_\_\_\_ G \_\_\_\_\_ Rt \_\_\_\_\_ FS \_\_\_\_\_ R \_\_\_\_\_ Other \_\_\_\_\_

Cultures: 1. \_\_\_\_\_ Rt \_\_\_\_\_ Anaerobic \_\_\_\_\_

2. \_\_\_\_\_ Rt \_\_\_\_\_ Anaerobic \_\_\_\_\_

Key.  
Gross \_\_\_\_\_ G  
Routine \_\_\_\_\_ Rt  
Frozen Section \_\_\_\_\_ FS  
Rapid \_\_\_\_\_ R

X-Rays: \_\_\_\_\_

Image: \_\_\_\_\_

Irrigation: ☐ NSS: ☐ H<sub>2</sub>O ☐ Glycine ☐ Lactated Ringers Meds: \_\_\_\_\_

Foley: ☐ Yes ☐ No Size: \_\_\_\_\_ With \_\_\_\_\_ mls balloon inflation

Indwelling on Arrival to OR: \_\_\_\_\_ Comments: \_\_\_\_\_

Implants: ☐ Yes ☐ No ☐ Cement: ☐ See Progress Notes:

Drains: ☐ Yes ☐ No Type: ☐ Penrose ☐ Hemovac ☐ Jackson Pratt

☐ Other \_\_\_\_\_

Local Anesthesia/IV Sedation/Meds: \_\_\_\_\_

Comments: \_\_\_\_\_

☐ TEDS ☐ Sequential Compression Sleeves

Pt Transferred to: ☐ PACU ☐ SICU ☐ SPU ☐ Other \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
RN Signature Date

## Pre-op Assessment Form

Date of Service: 09 20 17

MRN: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Last Name: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

First Name: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

BP [ ] [ ] / [ ] [ ] HR [ ] [ ] R [ ] [ ] T [ ] [ ] [ ] [ ] ☐ F ☐ C☐ Declines Response

| Allergies (drug/environmental/food/RXN) <input type="checkbox"/> NKA | Skin                     | Local                    | Abdominal                | Systemic                 | REACTION | Very Mild                | Mild                     | Moderate                 | Severe                   | START DATE |
|----------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------------------------|--------------------------|------------|
| <input type="checkbox"/> Penicillin                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |
| <input type="checkbox"/> Sulfa                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |
| <u>Iodine</u>                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |
| <u>contrast dye</u>                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |
|                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |

Date of Birth: [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]

Age: 58

Sex: ☒ Male ☐ Female

Weight: 170 lb 77 kg Height: 69 in 175 cm

Procedure:

Open reduction internal  
fixation left distal clavicle

Diagnosis:

Medications: ☐ None

Losartan 9/20/17  
Omeprazole  
Hydrochlorothiazide

Patient on Beta Blocker prior to admission? ☐ Yes ☒ NoAnticoagulants: ☐ Yes ☒ No

Past Medical History:

Prostate Hypertension

Previous Surgery and Anesthesia ☐ None

Prostatectomy  
Right hemi hip arthroplasty  
Hand surgery

Patient Contact

Emergency Contact

Does Patient Have Advanced Directive? ☐ Yes ☒ NoIs it on file at this Facility? ☐ Yes ☒ No

Signature of provider performing preoperative assessment

Date/Time

Anesthesia Issues ☐ Negative☐ PONV ☐ Malignant Hyperthermia☐ Difficult Airway☐ By Exam ☐ By History ☐ TMJ problems☐ Snoring ☐ OSA ☐ CPAP/BIPAP☐ Hoarseness ☐ Nasal Obstruction☐ Stridor/Croup ☐ Severe Anxiety☐ Fam Hx Anesth Problems☐ Obesity/Morbid (BMI greater than 35)☐ Organ Transplant☐ Other/Notes:Neurologic ☐ Negative☐ Seizure ☐ Elevated ICP ☐ Shunt☐ Spinal Cord Injury ☐ CVA/TIA☐ Cerebral Palsy ☐ Mental Retardation☐ Chronic Pain ☐ Neuropathy/Paresthesia☐ Myopathy/Muscular Dystrophy Syncope☐ Hearing Loss ☐ Blind: Right/Left☐ Other/Notes:Endocrine ☐ Negative☐ Diabetes ☐ Thyroid ☐ Steroid Usage☐ Other/Notes:Infections ☐ Negative☐ SBE Prophylaxis ☐ HIV ☐ Sepsis☐ URI ☐ VRE ☐ MRSA contact/resp.☐ Other/Notes:Cardiovascular ☐ Negative☐ MI: Date ☐ Hypertension ☐ CAD☐ Arrhythmia: Type☐ Pacemaker ☐ AICD☐ Angina: ☐ Stable ☐ UnstableCHF: Date ☐ EF ☐ %Valve Disease: ☐ Mod ☐ Severe☐ PVD ☐ DVT ☐ PE ☐ Murmur☐ Hx Cardiac Surgery ☐ Angioplasty ☐ PCI☐ Stress test/Cardiac Cath☐ Other/Notes:Pulmonary ☐ Negative☒ Prev Smoker ☐ Current Smoker ☐ ppd☐ Asthma ☐ Hospitalized ☐ Steroid Use☐ Recent wheezing☐ COPD/BPD ☐ Cough: Active / Chronic☐ Other/Notes:Gastrointestinal ☐ Negative☐ GE reflux/Hiatal Hernia ☐ Bowel Obstruction☐ Ascites ☐ Ulcers ☐ GI Bleed ☐ Dysphagia☐ Other/Notes:Hematol/Onc ☐ Negative☐ Sickle Cell Disease ☐ Trait ☐ Coagulopathy☐ Anemia ☐ Hx Transfusion ☐ Refuses Transfusion☐ Tumor ☐ Chemo/Rad Therapy☐ Other/Notes:Hepatic ☐ Negative☐ Hepatitis C ☐ Cirrhosis☐ Other/Notes:Renal ☐ Negative☐ Renal Insufficiency ☐ Dialysis☐ Other/Notes:

Activity Level

☐ Bedridden ☐ Assistance with Self-Care☐ Less than 1 Flight of Stairs☐ 1-3 Flights of Stairs☐ Greater than 3 Flights of Stairs☐ Able to Lie Flat One Hour☐ Other/Notes:Obstetrics ☐ Negative☐ Pre-eclampsia/Eclampsia☐ Placenta Previa/Abruption☐ LMP ☐ HCG☐ Other/Notes:Pediatrics ☐ Negative☐ Prematurity ☐ Congenital Abnl.☐ Apnea ☐ Passive Smoking☐ Other/Notes:Drug Use ☐ Negative☐ ETOH ☐ Daily ☐ Never ☐ Occasional☐ Cocaine ☐ IVDA☐ Other/Notes:

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Pre-op Assessment Form



BENTON, ALONZO  
DOB: 11/12/1958 58 M  
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12.2  
209  
38.9

PT  
INR  
PTT

Consults/Other Studies:

Other Notes:

NP Oga used for

Heart RRR

Lungs clear

HCG Neg Pos

BP 137/100 HR 83 R 20 T 42.9 SpO2 98% BMI 22.2

Airway Assessment: ☐ ETT in Situ

Oral Excursion: FB ☐ 1 ☐ 2 ☒ 3 ☐ 4

T-M Distance: FB ☐ 1 ☐ 2 ☒ 3 ☐ 4

Detention: ☒ Upper nl ☐ Dentures ☐ Caps ☐ Decayed ☐ Loose

☒ Lower nl ☐ Dentures ☐ Caps ☐ Decayed ☐ Loose

Loose/Decayed # Cracked cervical

Mallampati: ☐ I ☒ II ☐ III ☐ IV multiple

Neck: Extension: ☐ nl ☐ ↓ ☐ ↓↓  
Flexion: ☐ nl ☐ ↓ ☐ ↓↓

ASA

☐ 1

☐ 2

☒ 3

☐ 4

☐ 5

☐ 6

☐ E

Comments/Extra Meds:

#### Anesthesia Attending Pre-Anesthesia Assessment and Consent

☒ Medical record and laboratory data reviewed

☒ Patient is appropriate for the planned anesthesia

☐ General

☐ Block

☒ Monitored anesthesia care

☐ Spinal

☐ Epidural/Caudal

Planned post-operative care: ☒ PACU ☐ ICU ☐ Phase 2 Recovery ☐ Other

☐ Patient examined

Special Monitoring:

☐ Arterial Catheter

☐ Central Venous Catheter

☐ Pulmonary Catheter

☐ Transesophageal Echo

☐ Other

Preferred Language:

☒ English ☐ Hawaiian ☐ Portuguese

☐ Spanish ☐ Italian ☐ Russian

☐ French ☐ Japanese ☐ Other Language

Ethnicity:

☐ Non-Hispanic or Latino ☐ Hispanic

Race:

☐ Caucasian

☐ Native American or Native Alaskan

☐ Asian or Asian American

☒ African or African American

☐ Native Hawaiian or Pacific Islander

☐ Other Race

Signature of provider performing preoperative assessment

103465

Provider ID#

9/20/17

Date

1230

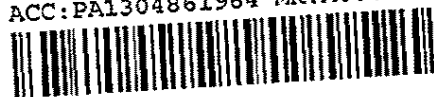
Time

Mercy Philadelphia Hospital  
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Pre-op Assessment Form



BENTON, ALONZO  
DOB: 11/12/1958 58 M  
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Ad ACC: PA1304861964 MR: M000301370  
Ac





| TIME | 380 | 405 | 420 | 435 | 450 | 465 | 480 | 495 | 510 | 525 | 540 | 555 | 570 | 585 | 600 | 615 | 630 | 645 | 660 | 675 | 690 | 705 | 720 | 735 | 750 | 765 | 780 | 795 | 810 | 825 | 840 | 855 | 870 | 885 | 900 | 915 | 930 | 945 | 960 | 975 | 990 | 1005 | 1020 | 1035 | 1050 | 1065 | 1080 | 1095 | 1110 | 1125 | 1140 | 1155 | 1170 | 1185 | 1200 | 1215 | 1230 | 1245 | 1260 | 1275 | 1290 | 1305 | 1320 | 1335 | 1350 | 1365 | 1380 | 1395 | 1410 | 1425 | 1440 | 1455 | 1470 | 1485 | 1500 | 1515 | 1530 | 1545 | 1560 | 1575 | 1590 | 1605 | 1620 | 1635 | 1650 | 1665 | 1680 | 1695 | 1710 | 1725 | 1740 | 1755 | 1770 | 1785 | 1800 | 1815 | 1830 | 1845 | 1860 | 1875 | 1890 | 1905 | 1920 | 1935 | 1950 | 1965 | 1980 | 1995 | 2010 | 2025 | 2040 | 2055 | 2070 | 2085 | 2100 | 2115 | 2130 | 2145 | 2160 | 2175 | 2190 | 2205 | 2220 | 2235 | 2250 | 2265 | 2280 | 2295 | 2310 | 2325 | 2340 | 2355 | 2370 | 2385 | 2400 | 2415 | 2430 | 2445 | 2460 | 2475 | 2490 | 2505 | 2520 | 2535 | 2550 | 2565 | 2580 | 2595 | 2610 | 2625 | 2640 | 2655 | 2670 | 2685 | 2700 | 2715 | 2730 | 2745 | 2760 | 2775 | 2790 | 2805 | 2820 | 2835 | 2850 | 2865 | 2880 | 2895 | 2910 | 2925 | 2940 | 2955 | 2970 | 2985 | 3000 | 3015 | 3030 | 3045 | 3060 | 3075 | 3090 | 3105 | 3120 | 3135 | 3150 | 3165 | 3180 | 3195 | 3210 | 3225 | 3240 | 3255 | 3270 | 3285 | 3300 | 3315 | 3330 | 3345 | 3360 | 3375 | 3390 | 3405 | 3420 | 3435 | 3450 | 3465 | 3480 | 3495 | 3510 | 3525 | 3540 | 3555 | 3570 | 3585 | 3600 | 3615 | 3630 | 3645 | 3660 | 3675 | 3690 | 3705 | 3720 | 3735 | 3750 | 3765 | 3780 | 3795 | 3810 | 3825 | 3840 | 3855 | 3870 | 3885 | 3900 | 3915 | 3930 | 3945 | 3960 | 3975 | 3990 | 4005 | 4020 | 4035 | 4050 | 4065 | 4080 | 4095 | 4110 | 4125 | 4140 | 4155 | 4170 | 4185 | 4200 | 4215 | 4230 | 4245 | 4260 | 4275 | 4290 | 4305 | 4320 | 4335 | 4350 | 4365 | 4380 | 4395 | 4410 | 4425 | 4440 | 4455 | 4470 | 4485 | 4500 | 4515 | 4530 | 4545 | 4560 | 4575 | 4590 | 4605 | 4620 | 4635 | 4650 | 4665 | 4680 | 4695 | 4710 | 4725 | 4740 | 4755 | 4770 | 4785 | 4800 | 4815 | 4830 | 4845 | 4860 | 4875 | 4890 | 4905 | 4920 | 4935 | 4950 | 4965 | 4980 | 4995 | 5010 | 5025 | 5040 | 5055 | 5070 | 5085 | 5100 | 5115 | 5130 | 5145 | 5160 | 5175 | 5190 | 5205 | 5220 | 5235 | 5250 | 5265 | 5280 | 5295 | 5310 | 5325 | 5340 | 5355 | 5370 | 5385 | 5400 | 5415 | 5430 | 5445 | 5460 | 5475 | 5490 | 5505 | 5520 | 5535 | 5550 | 5565 | 5580 | 5595 | 5610 | 5625 | 5640 | 5655 | 5670 | 5685 | 5700 | 5715 | 5730 | 5745 | 5760 | 5775 | 5790 | 5805 | 5820 | 5835 | 5850 | 5865 | 5880 | 5895 | 5910 | 5925 | 5940 | 5955 | 5970 | 5985 | 6000 | 6015 | 6030 | 6045 | 6060 | 6075 | 6090 | 6105 | 6120 | 6135 | 6150 | 6165 | 6180 | 6195 | 6210 | 6225 | 6240 | 6255 | 6270 | 6285 | 6300 | 6315 | 6330 | 6345 | 6360 | 6375 | 6390 | 6405 | 6420 | 6435 | 6450 | 6465 | 6480 | 6495 | 6510 | 6525 | 6540 | 6555 |
|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
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| POTENTIAL FOR ALTERATION COMFORT | PAIN ASSESSMENT AND MEDICATION RECORD |           |            |       |       |      |                  |             |               |       |
|----------------------------------|---------------------------------------|-----------|------------|-------|-------|------|------------------|-------------|---------------|-------|
|                                  | TIME                                  | PAIN CODE | MEDICATION | DOSE  | ROUTE | SITE | LOCATION OF PAIN | GIVEN BY    | EFFECTIVENESS | TIME  |
|                                  | 3:50                                  | 10        | Dolaudid   | 0.5mg | IV    |      | lt shoulder      | Debra Brown | med 100%      | 7:05  |
|                                  | 4:05                                  | 10        | Dolaudid   | 0.5mg | IV    |      | lt shoulder      | Debra Brown | med 100%      |       |
|                                  | 11:31                                 | 10        | ketanyl    | 10mg  | IV    |      | "                | Debra Brown |               | 11:36 |
|                                  | 11:37                                 | 7         | ketanyl    | 5mg   | IV    |      | "                | Debra Brown |               | 11:48 |

GOALS: Return to Baseline  
EVALUATION: Patient exhibits pain free behavior? ☒ Comments: \_\_\_\_\_

| I<br>&<br>O | IV SOLUTION |  |  |  |  |  | IV MED |  | COLLOID |  | TOTAL<br>IV<br>INTAKE | FEEDS |   | INTAKE<br>TOTALS | IV MED |     | CHEST<br>TUBES |  | GI |  | DRAINS |  | OUTPUT<br>TOTALS |
|-------------|-------------|--|--|--|--|--|--------|--|---------|--|-----------------------|-------|---|------------------|--------|-----|----------------|--|----|--|--------|--|------------------|
|             |             |  |  |  |  |  |        |  |         |  |                       | PO    | X |                  | URINE  | EBL |                |  | NG |  |        |  |                  |
| 42          |             |  |  |  |  |  |        |  |         |  | 600                   |       |   |                  |        |     |                |  |    |  |        |  |                  |
| OR*         | 600         |  |  |  |  |  |        |  |         |  |                       |       |   |                  |        |     |                |  |    |  |        |  |                  |
| PACU        | 15          |  |  |  |  |  |        |  |         |  |                       |       |   |                  |        |     |                |  |    |  |        |  |                  |
| SITE        | PU E        |  |  |  |  |  |        |  |         |  |                       |       |   |                  |        |     |                |  |    |  |        |  |                  |
| CREDIT      | 0           |  |  |  |  |  |        |  |         |  |                       |       |   |                  |        |     |                |  |    |  |        |  |                  |

Patient's Fluid deficit replaced? ☒ Comments: \_\_\_\_\_



Mercy Philadelphia Hospital

A member of Mercy Health System

BENTON, ALONZO

DOB: 11/12/1958 58Y M

Adm: 09/20/2017

Acc: PA1304861964 MR#: M000301370

PACU FLOWSHEET



| <b>NEUROLOGIC: POTENTIAL FOR ALTERATION IN NEUROLOGIC STATUS AND SENSORY PERCEPTION</b> | <p><b>LOC</b><br/> <input checked="" type="checkbox"/> Awake    <input type="checkbox"/> Alert<br/> <input type="checkbox"/> Oriented<br/>           <input type="checkbox"/> person    <input type="checkbox"/> place    <input type="checkbox"/> time<br/> <input type="checkbox"/> Unresponsive    <input type="checkbox"/> Combative<br/> <input type="checkbox"/> Confused    <input type="checkbox"/> Restless<br/> <input type="checkbox"/> Lethargic    <input type="checkbox"/> Drowsy<br/> <input type="checkbox"/> Agitated    <input type="checkbox"/> Somnolent</p> <p><b>PUPILS (if applicable)</b><br/> <input type="checkbox"/> Peril _____ mm<br/> <input type="checkbox"/> Unequal Right _____ Left _____<br/> <input type="checkbox"/> Dilated<br/> <input type="checkbox"/> Constricted<br/> <input type="checkbox"/> Sluggish<br/> <input type="checkbox"/> Non-reactive<br/> <input type="checkbox"/> Other _____</p> <p><b>MOTOR</b><br/> <input checked="" type="checkbox"/> MAE (Rt upper/lower/Lt lower)<br/> <input type="checkbox"/> R Arm Comment<br/> <input type="checkbox"/> L Arm Comment<br/> <input type="checkbox"/> R Leg Comment<br/> <input type="checkbox"/> L Leg Comment</p> <p><b>MOVEMENT</b><br/> <input type="checkbox"/> Spontaneous<br/> <input type="checkbox"/> To Command<br/> <input type="checkbox"/> To Pain<br/> <input type="checkbox"/> Weakness<br/> <input type="checkbox"/> None</p> <p><b>SPEECH</b><br/>           (if applicable)<br/> <input type="checkbox"/> Clear<br/> <input type="checkbox"/> Appropriate<br/> <input type="checkbox"/> Inappropriate<br/> <input type="checkbox"/> Garbled<br/> <input type="checkbox"/> Intubated<br/> <input type="checkbox"/> None<br/> <input type="checkbox"/> Gestures</p> <p>GOAL: Return to baseline.<br/>           EVALUATION:<br/>           Patient awake prior to discharge <input checked="" type="checkbox"/><br/>           Comments: _____</p> | <p><b>SKIN INTEGRITY</b><br/> <input type="checkbox"/> Yes    <input type="checkbox"/> No<br/>           Location: _____<br/>           Site: _____<br/>           Pressure Reduction Measures<br/> <input type="checkbox"/> Mattress<br/> <input type="checkbox"/> Turning<br/>           GOAL: Maintain Skin Integrity<br/>           EVALUATION: Skin integrity is maintained <input checked="" type="checkbox"/><br/>           Comments: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                |           |            |           |            |           |       |  |  |  |  |  |      |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |      |         |       |        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>PULMONARY: POTENTIAL FOR ALTERATION IN GAS EXCHANGE</b>                              | <p>Chest Expansion:    <input type="checkbox"/> Symmetrical    <input type="checkbox"/> Asymmetrical<br/>           Breath Sounds    <input type="checkbox"/> Bilateral    <input checked="" type="checkbox"/> LCTA<br/>           R: _____<br/>           L: _____<br/>           Cough/Sputum:    <input type="checkbox"/> Productive    <input type="checkbox"/> Non-Productive<br/>           Comments: _____</p> <p>Respirations:    <input type="checkbox"/> Labored    <input checked="" type="checkbox"/> Unlabored    <input checked="" type="checkbox"/> Regular    <input checked="" type="checkbox"/> Spontaneous<br/>           Comments: _____</p> <p>Chest Tubes:    <input type="checkbox"/> Pleural    <input type="checkbox"/> Right    <input type="checkbox"/> Left    No<br/>           Goal: Return to baseline<br/>           Evaluation: Patient's Respiratory status has returned to baseline <input type="checkbox"/><br/>           Comments: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <p><b>GI: ALTERATION IN GASTRIC MOTILITY</b><br/>           Abdomen:    <input type="checkbox"/> Soft    <input type="checkbox"/> Flat    <input type="checkbox"/> Obese    <input type="checkbox"/> Firm<br/> <input type="checkbox"/> Distended    <input type="checkbox"/> Non-Distended<br/>           Bowel Sounds:    <input type="checkbox"/> Normal    <input type="checkbox"/> Absent<br/>           Comments: _____</p> <p>Tubes:    <input type="checkbox"/> NG    <input type="checkbox"/> Feeding<br/>           Comments: _____</p> <p>Other:    <input type="checkbox"/> NPO    <input type="checkbox"/> Yes    <input type="checkbox"/> No<br/>           GOAL: Patient will maintain normal GI Function<br/>           EVALUATION: Patient will not exhibit abdominal distress <input checked="" type="checkbox"/><br/>           Comments: _____</p> |           |            |           |            |           |       |  |  |  |  |  |      |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |      |         |       |        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>CARDIOVASCULAR: POTENTIAL FOR ALTERATION IN CARDIAC OUTPUT/FLUID VOLUME DEFICIT</b>  | <p><b>PULSE SCALE</b><br/>           D = Doppler<br/>           +3 = Bouncing<br/>           +2 = Normal<br/>           +1 = Weak<br/>           0 = Absent</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td>RADIAL</td> <td>FEMORAL</td> <td>POPLITEAL</td> <td>DOR. PEDIS</td> <td>POST. TIB</td> </tr> <tr> <td>RIGHT</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>LEFT</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <p>Comments: _____</p> <p>Edema:    <input type="checkbox"/> Trace    <input type="checkbox"/> +1    <input type="checkbox"/> +2    <input type="checkbox"/> +3    <input type="checkbox"/> +4<br/>           Location: _____</p> <p>Pulse:    <input type="checkbox"/> Regular    <input type="checkbox"/> Irregular</p> <p><b>INVASIVE MONITORING</b><br/> <input type="checkbox"/> None<br/> <input type="checkbox"/> Arterial Line    Cuff Correlation    <input type="checkbox"/> Yes    <input type="checkbox"/> No<br/>           Site _____ Wave _____ Circ. _____<br/> <input type="checkbox"/> Other _____</p> <p>GOAL: Adequate hydration. Adequate tissue perfusion<br/>           Evaluation: Patient has adequate tissue perfusion. <input checked="" type="checkbox"/><br/>           Comments: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | RADIAL    | FEMORAL    | POPLITEAL | DOR. PEDIS | POST. TIB | RIGHT |  |  |  |  |  | LEFT |  |  |  |  |  | <p><b>GU: POTENTIAL FOR ALTERATION IN URINARY ELIMINATION</b><br/>           Voids:    <input type="checkbox"/> Continent    <input type="checkbox"/> Incontinent<br/> <input type="checkbox"/> Foley    <input type="checkbox"/> Other<br/>           Urine: _____<br/>           GOAL: Urinary output adequate.<br/>           EVALUATION: Patient urinating without difficulty <input type="checkbox"/><br/>           Comments: _____</p> <p>Foley Catheter D/C at _____ checked by: _____</p> <p>Dressing:    <input type="checkbox"/> No    <input checked="" type="checkbox"/> Yes<br/>           Comments: <u>4x4 ABD adaptive tape</u></p> <p><input type="checkbox"/> Other _____</p> |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |      |         |       |        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                                         | RADIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | FEMORAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | POPLITEAL | DOR. PEDIS | POST. TIB |            |           |       |  |  |  |  |  |      |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |      |         |       |        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| RIGHT                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |            |           |            |           |       |  |  |  |  |  |      |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |      |         |       |        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| LEFT                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |            |           |            |           |       |  |  |  |  |  |      |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |      |         |       |        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>INCISION</b>                                                                         | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>TYPE</th> <th>SITE</th> <th>SUCTION</th> <th>COLOR</th> <th>AMOUNT</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TYPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | SITE      | SUCTION    | COLOR     | AMOUNT     |           |       |  |  |  |  |  |      |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  | <p><b>DRAINS</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>TYPE</th> <th>SITE</th> <th>SUCTION</th> <th>COLOR</th> <th>AMOUNT</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table> | TYPE | SITE | SUCTION | COLOR | AMOUNT |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| TYPE                                                                                    | SITE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | SUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | COLOR     | AMOUNT     |           |            |           |       |  |  |  |  |  |      |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |      |         |       |        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |            |           |            |           |       |  |  |  |  |  |      |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |      |         |       |        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| TYPE                                                                                    | SITE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | SUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | COLOR     | AMOUNT     |           |            |           |       |  |  |  |  |  |      |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |      |         |       |        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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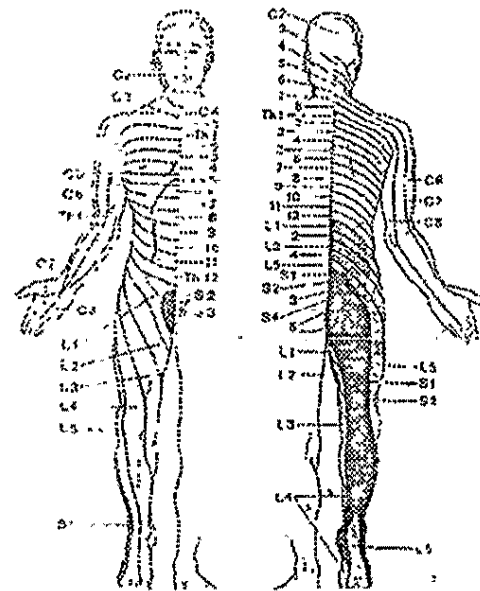


BENTON, ALONZO  
 DOB: 11/12/1958    58Y    M  
 Adm: 09/20/2017  
 Acc: PA1304861964    MR#: M000301370



| POST ANESTHESIA RECOVERY                             |   |               | ARR                  | 30 MIN | HR | HR | HR | HR | DO |
|------------------------------------------------------|---|---------------|----------------------|--------|----|----|----|----|----|
| SCORE - ALDERETE'S                                   |   |               | TIME: 3:30 4:15 4:45 |        |    |    |    |    |    |
| ABLE TO MOVE 4 EXTREMITIES VOLUNTARILY OR ON COMMAND | 2 | ACTIVITY      | 2                    | 2      | 2  |    |    |    |    |
| ABLE TO MOVE 2 EXTREMITIES VOLUNTARILY OR ON COMMAND | 1 |               |                      |        |    |    |    |    |    |
| ABLE TO MOVE 0 EXTREMITIES                           | 0 |               |                      |        |    |    |    |    |    |
| ABLE TO DEEP BREATHE & COUGH FREELY                  | 2 | RESPIRATION   | 1                    | 1      | 2  |    |    |    |    |
| DYSPNEA OR LIMITED BREATHING                         | 1 |               |                      |        |    |    |    |    |    |
| APNEA                                                | 0 |               |                      |        |    |    |    |    |    |
| BP $\pm$ 20 OF PREANESTHESIA LEVEL                   | 2 | CIRCULATION   | 2                    | 2      | 2  |    |    |    |    |
| BP $\pm$ 20 - 50 OF PREANESTHESIA LEVEL              | 1 |               |                      |        |    |    |    |    |    |
| BP $\pm$ 50 OF PREANESTHESIA LEVEL                   | 0 |               |                      |        |    |    |    |    |    |
| FULLY AWAKE                                          | 2 | CONSCIOUSNESS | 2                    | 1      | 2  |    |    |    |    |
| AROUSABLE                                            | 1 |               |                      |        |    |    |    |    |    |
| NOT RESPONDING                                       | 0 |               |                      |        |    |    |    |    |    |
| O2 SAT GREATER THAN 92% R/A                          | 2 | COLOR         | 2                    | 2      | 2  |    |    |    |    |
| 92% ON O2                                            | 1 |               |                      |        |    |    |    |    |    |
| LESS THAN 92% ON O2                                  | 0 |               |                      |        |    |    |    |    |    |
| TOTALS                                               |   |               | 9                    | 8      | 10 |    |    |    |    |
| INITIALS                                             |   |               | Benton               |        |    |    |    |    |    |

☐ If applicable



| TIME | LEVEL | COMMENTS |
|------|-------|----------|
|      |       |          |
|      |       |          |
|      |       |          |
|      |       |          |
|      |       |          |
|      |       |          |

#### INTERVENTIONS

|                             |                                                |
|-----------------------------|------------------------------------------------|
| Side Rails Up               | <input checked="" type="checkbox"/>            |
| Alarms On/Audible           | <input checked="" type="checkbox"/>            |
| Warm Blankets               | <input type="checkbox"/>                       |
| Warming Device              | <input type="checkbox"/>                       |
| Cold Pack                   | <input type="checkbox"/>                       |
| Elevation                   | <input type="checkbox"/>                       |
| Sequential                  | <input type="checkbox"/>                       |
| TEDS                        | <input type="checkbox"/>                       |
| Turning                     | <input checked="" type="checkbox"/>            |
| Deep Breathing and Coughing | <input checked="" type="checkbox"/> encouraged |
| MiniVeb                     | <input type="checkbox"/>                       |

|                                    |                          |
|------------------------------------|--------------------------|
| Patient Identified as Fall Risk    | <input type="checkbox"/> |
| Safety Belt Applied                | <input type="checkbox"/> |
| Patient Wearing Fall Risk Bracelet | <input type="checkbox"/> |
| PCA                                | <input type="checkbox"/> |
| Epidural                           | <input type="checkbox"/> |
| X-Ray                              | <input type="checkbox"/> |
| EKG                                | <input type="checkbox"/> |
| Other                              | <input type="checkbox"/> |
| Other                              | <input type="checkbox"/> |

#### DISCHARGE EVALUATION

|                                                    |                                                                     |
|----------------------------------------------------|---------------------------------------------------------------------|
| Awake/Arousable                                    | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Respirations Full/Regular                          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Dressings                                          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Drains Patent & Secured                            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Vital Signs Stable                                 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Post-Op Orders Reviewed                            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Patient's pain was managed and medicated as needed | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| IV Site(s)                                         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Last Narcotic Given                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Discharge RN                                       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |

|                        |                                               |         |      |
|------------------------|-----------------------------------------------|---------|------|
| O2 Therapy             | <input checked="" type="checkbox"/> from PACU | O2 SAT  | 100% |
| Report Given to:       |                                               |         |      |
| Pain Level @ discharge |                                               |         |      |
| Comments:              |                                               |         |      |
| Discharge to           | Home                                          | Time    | 1740 |
| Via                    | W/                                            | Monitor |      |
| Discharge MD           |                                               | Time    |      |

Mercy Philadelphia Hospital  
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PACU FLOWSHEET

BENTON, ALONZO  
DOB: 11/12/1958 58Y M  
Adm: 09/20/2017  
Acc: PA1304861964 MR#: M000301370



# PROGRESS DOCUMENTATION

11030 pt WTB JSS c/o pain to  
left shoulder (+) color movement  
and sensation distal to site  
of surgery is

(P1M0A10)

25 mm/sec

Sep 17 16:10

Patient Admitted

APHEA 0:26

INTERRUPTED

71 bpm

0 /min

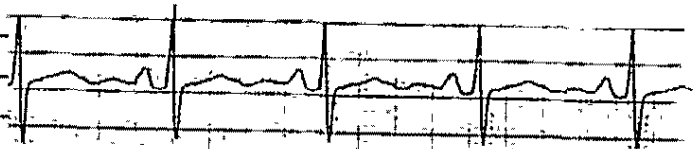
2 99 %

se 68 bpm

2.0

II 1 mV 0.5-40 Hz Non-Paced

ABP (Not available)



PR: 16  
QES: 08  
PT: 40

Nurse's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

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PACU FLOWSHEET

BENTON, ALONZO

DOB: 11/12/1958 58Y M

Adm: 09/20/2017

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**Mercy Health System**

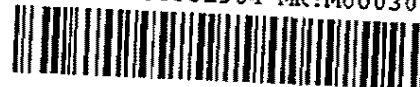
A member of Catholic Health East

- ☐ MERCY FITZGERALD HOSPITAL  
☐ MERCY HOSPITAL OF PHILADELPHIA  
☐ MERCY SUBURBAN HOSPITAL

POOR QUALITY ORIGINAL

**OUTPATIENT MEDICATION  
 RECONCILIATION AND  
 DISCHARGE INSTRUCTIONS FORM**

BENTON, ALONZO  
 DOB: 11/12/1958 58 M  
 ADM: 09/20/17  
 ACC: PA1304861964 MR: M000301370



|                                                                                                                                                 |                                                                           |                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-------------|--|
| <b>Allergies (Food and Med)</b><br>Contrast<br>Dye<br>Hing                                                                                      | <b>Reaction/Side Effects</b>                                              | <b>Latex sensitive?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Allergic to dyes?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Allergic to iodine?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown | <b>Discharged To:</b><br><input type="checkbox"/> Home<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Trans.<br><input type="checkbox"/> Other<br><b>Via:</b><br><input type="checkbox"/> W/C<br><input type="checkbox"/> Amb | <b>Discharge Instructions:</b><br>1. You should go home and rest quietly for the next 12-24 hours.<br>2. The sedation you received today will be acting in your body for the next 24 hours, so you might feel a little dizzy, sleepy, or light headed.<br>3. Because the sedation is in your system for the next 24 hours, you should be careful of your activities.<br>• Do <u>not</u> smoke alone.<br>• Do <u>not</u> drive a car, operate machinery or power tools.<br>• Do <u>not</u> drink any alcoholic beverages.<br>Do change position slowly.<br>4. You may return to a regular diet starting with liquids such as soup and crackers and work up to solid foods.<br>5. You may have some pain or discomfort. A prescription for pain may be given to you by the doctor. Should be taken as directed. If the pain does not improve notify your doctor.<br>6. If you have any questions contact your doctor.<br>7. If you can not reach your doctor, you should return to the Emergency Department, 215-748-9400. The Physician there will contact your doctor.<br>8. Physical Activities Permitted: y/n<br>• Bath/shower <input checked="" type="checkbox"/><br>• Climb stairs <input checked="" type="checkbox"/><br>• Driving <input checked="" type="checkbox"/><br>• Lifting <input checked="" type="checkbox"/><br>• Resume sexual activities <input checked="" type="checkbox"/><br>9. Follow-up:<br>Appointment <u>Dr. Miller</u><br>Call Doctor for appointment <input checked="" type="checkbox"/><br>Return to work or school <input checked="" type="checkbox"/> |                              |             |  |
| <b>List all medicines taken at home:</b><br>(Prescriptions, over the counter, herbals, patches, inhalers, eye drops & supplements)<br>Drug Name | <b>Use laymen's terms</b> (oral, inject, Daily, twice a day, bedtime etc) |                                                                                                                                                                                                                                                                                                                                   | <b>Last dose</b>                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Discharge Initial ONE</b> |             |  |
|                                                                                                                                                 | <b>Dose</b>                                                               | <b>Route</b>                                                                                                                                                                                                                                                                                                                      | <b>Frequency</b>                                                                                                                                                                                                                               | <b>Date</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Time</b>                  | <b>Cont</b> |  |
| lorazepam                                                                                                                                       | 25                                                                        | PO                                                                                                                                                                                                                                                                                                                                | PRN                                                                                                                                                                                                                                            | 9/13/17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 11 AM                        |             |  |
| gabapentin                                                                                                                                      | 20                                                                        | PO                                                                                                                                                                                                                                                                                                                                | PRN                                                                                                                                                                                                                                            | 9/13/17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | AN                           |             |  |
| gabapentin                                                                                                                                      | 75                                                                        | PO                                                                                                                                                                                                                                                                                                                                | PRN                                                                                                                                                                                                                                            | 9/13/17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | AN                           |             |  |
| <p>Percocet 5/325 1002 up to 3 times<br/>         The office Rx was just filled &amp; should be used<br/>         NO use left per x 1 month</p> |                                                                           |                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |             |  |
| <input checked="" type="checkbox"/> I have reviewed the patient's medications and reconciled.                                                   |                                                                           |                                                                                                                                                                                                                                                                                                                                   | I, the outpatient physician have reviewed your medications on this visit. All medications continued will remain managed by the prescribing doctor.                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |             |  |
| Date: _____ Time: _____ Physician's signature: <u>Miller</u>                                                                                    |                                                                           |                                                                                                                                                                                                                                                                                                                                   | Physician Signature: <u>9/20/17</u>                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |             |  |
| <b>NEW MEDS OR CHANGES IN MEDS FOR DISCHARGE</b>                                                                                                |                                                                           |                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |             |  |
| Use Laymen's Terms (daily, twice a day, at bedtime etc)                                                                                         |                                                                           |                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |             |  |
| <u>gabapentin</u>                                                                                                                               |                                                                           |                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |             |  |
| <b>Other Instructions:</b><br><u>Keep thing in place for 1 month</u><br><u>Apply ice to area 3 times/day for 15 minutes</u>                     |                                                                           |                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |             |  |
| I, _____ have had the instructions discussed with me, understand them, and have no further questions at this time.                              |                                                                           |                                                                                                                                                                                                                                                                                                                                   | Date/Time: <u>9/20/17</u>                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |             |  |
| Patient Signature: <u>[Signature]</u> Family Member: _____                                                                                      |                                                                           |                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |             |  |
| Nurse's Signature: <u>[Signature]</u> Physician: <u>Miller</u>                                                                                  |                                                                           |                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |             |  |

# CONSENT FOR HOSPITAL TREATMENT AND SERVICES

PATIENT NAME: BENTON, ALONZO

- I have presented myself for treatment and/or admission on 9/20/17 (date). I consent to routine medical care and treatment, including diagnostic procedures and blood tests, and to such emergency or additional care as may be deemed necessary, which will be provided by the Hospital and by my Attending Physician, his/her assistants and/or designees. The use of telemedicine technology may be included in the diagnostic process of my care.
- I understand that, except for emergency situations, this consent does not include operations and non-routine procedures or treatment. I may be asked to consent to such operations and procedures after the risks and alternatives have been explained to me by my Attending Physician or by another physician.
- I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in the Hospital.
- I realize that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law. If such treatments or procedures are my reason for hospitalization, refusal may result in discharge.
- I hereby authorize the Hospital to photograph my face for purposes of identification and camera monitoring as indicated. In addition, I authorize the Hospital to take photographs for clinical purposes as part of the diagnostic/treatment documentation process.
- In the event that the results of my diagnostic studies or procedures indicate the need for further coordination of care, the hospital's patient care coordinator may be notified of my results, as deemed appropriate, so as to assist me with further diagnostic and/or treatment options.
- I consent to the release of such information from my medical records as may be required by my health insurance company for the processing of claims for hospital or medical benefits, except for records containing mental health, drug and alcohol information. In these cases a separate written consent will be required. I consent to release medical information to any medical care provider for the purpose of continuity of care/discharge planning. I consent to the use of my medical information for research when federal law allows such use without my specific consent.
- I understand the Hospital will not be liable for loss of or damage to any money or personal property.
- I hereby assign to the Hospital payment of all hospital and insurance benefits otherwise payable to me or for my benefit in connection with my treatment and/or hospitalization.
- In consideration of the care and services to be furnished to me, I undertake and promise to pay for these services (to the extent that the charges are not covered by any insurance benefits) in accordance with Hospital terms and usual and customary charges.
- The professional services of physicians are billed separately from the hospital bill, such as the departments of Anesthesia, Pathology, Emergency, Radiology, Neurology, Cardiology, and Physician Medicine.
- (Managed Care Patients Only) A law was passed in Pennsylvania in 1998 called "Act 68" or the "Quality Health Care Accountability and Protection Act." This law allows you to give the Hospital consent to seek payment from your health insurance company for health care you received for the Hospital if your health insurance company (a) denies payment; (b) limits the scope of services; (c) only pays for a shorter stay in the hospital; or (d) only pays for an alternative service than the one you received. When a hospital seeks payment from a health insurance company it is called a "grievance". I hereby give consent to the Hospital (and/or its designee) to file a grievance on my behalf, including requesting an appeal of any decision by my health insurance company. If the Hospital files a grievance for me, all costs related to the grievance will be paid by the Hospital. I also understand and agree that (1) I will not file a grievance with my health insurance company unless I withdraw my consent in writing; (2) I have the right to rescind this consent at any time during the grievance process; and (3) my consent will be automatically rescinded if the Hospital does not file a grievance.
- (Medicare Patients Only) - Certification, Authorization to Release Information, and Payment Requests. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize the release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I will either assign any such benefits to be paid directly to the Hospital or to the physician or organization furnishing the services or authorize the Hospital or such physician or organization to submit a claim to Medicare on my behalf, for payment.
- I understand that Hospital, including their business associates, may contact me by telephone at any telephone number I have provided or that is associated with my record, including cell phone numbers, which could result in charges to me. Hospital may also contact me by sending text messages or e-mails, using the contact information provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I am the patient or the person authorized to give consent for the patient. My signature certifies that I have read and understood this consent and that any questions have been answered to my satisfaction.

Signature of Patient [Signature] Date/Time 9/16/17 11:55 PM Witness to Signature [Signature] Date/Time 9/15/17 11:55 AM

If Patient is a minor or incompetent/unable to give consent

Signature of Person authorized to give consent \_\_\_\_\_ Date/Time \_\_\_\_\_ Address \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Witness \_\_\_\_\_ Date/Time \_\_\_\_\_

Patient Rights and Responsibilities ☒ I have received the Patient Rights and Responsibilities form (40M)

## Hospital Directory

The hospital directory contains your name, room number and general condition. It can be used to direct visitors, flower deliveries and phone callers to you. ☐ I want to be included in the directory ☒ I do not want to be included in the directory

Patient's Email Address: \_\_\_\_\_

## Notice of Privacy Practices

The Notice of Privacy Practices explains how your Protected Health Information (medical and demographic information about you) may be used or disclosed. ☐ I have received the Notice of Privacy Practices.

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it: \_\_\_\_\_

 Mercy Philadelphia Hospital  
A member of Mercy Health System

CONSENT FOR HOSPITAL TREATMENT AND SERVICES

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 09/20/17  
ACC: PA1304861964 MR: M000301370

MERCY HEALTH SYSTEM  
CONSENT TO SURGICAL/DIAGNOSTIC/THERAPEUTIC PROCEDURES

PATIENT: Alonzo Benton

DATE: 9/12/17 TIME: 2:15 p AM/PM

A. EXPLANATION: (To be filled in by physician. Cross out any paragraphs that do not apply.)

1. I authorized Dr. Meller, and his/her assistants or associates to perform upon me the following surgical/diagnostic or therapeutic procedure ("procedure"):

(List specific nature of procedure to be performed)

Open Reduction and internal fixation of distal clavicle fracture

2. Dr. Meller has explained to me and I understand the nature and purpose of the procedure. I also understand the following:

- a. That there are some risks and there can be complications associated with this procedure, including but not necessarily limited to:

Wound Healing Delay, Infection, loosening

- b. Alternatives to the proposed procedure, including doing nothing, and their risks have been explained to me.

3. I have been told that, in addition to the risks set forth in Item 2(a) above, there are other risks, such as severe loss of blood, infection, heart stoppage, etc., associated with any surgical procedure. I am also aware that the practice of medicine and surgery is not an exact science, that there is no certainty that the described benefits will be achieved and I acknowledge that no guarantees or assurances have been made to me concerning the outcome.
4. I have had sufficient opportunity to discuss my condition and treatment with Dr. Meller and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge to consent to the proposed procedure, and I consent voluntarily and freely.
5. I understand that my doctor will be assisted by other health professionals of Mercy Health System, and such others as my doctor considers necessary in my care.
6. I understand that unforeseen conditions may arise or be revealed during the course of the procedure which may require an extension of the procedure, the performance of procedures in addition to or different from those now contemplated or termination of the procedure. In such a situation, I authorize my doctor and his/her assistants to change or terminate the procedure and/or to perform such procedures as are deemed necessary and desirable in the exercise of their professional judgment.
7. There are no limitations on my consent except the following: (If none, so state) None
8. I permit Mercy Health System to use any tissue samples (biopsies) of my body taken during the procedure for microscopic examination and for scientific teaching purposes except as noted here:
9. I consent to the examination, photographic study and disposal of any bodily tissues or parts which may be removed during the course of my procedure.

BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 09/20/17  
ACC: PA1304861964 MR: M000301370



A Healthcare Ministry of the Sisters of Mercy

- ☐ Mercy Fitzgerald Hospital  
☒ Mercy Hospital of Philadelphia  
☐ Mercy Community Hospital

CONSENT TO  
SURGICAL/DIAGNOSTIC/THERAPEUTIC  
PROCEDURES

B. **STATEMENT OF CONSENT:** I hereby certify that I have read and fully understand the above consent statement which has been preceded by an explanation by my physician, that I understand the explanation, and that all blanks or statements requiring insertion or completion were filled in before I signed this consent and that all questions have been answered to my satisfaction.

Alexis Benton  
Signature of Patient

Date: 9-12-17

\_\_\_\_\_  
Witness to Signature of Patient

If Patient is a minor or incompetent to give consent:

\_\_\_\_\_  
Signature of Person authorized to give consent

\_\_\_\_\_  
Relationship to Patient

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness

C. **PHYSICIAN CERTIFICATION:** I have personally explained the above information to the patient. (or the patient's representative if the patient is incompetent to consent.)

Heather Ann Keller  
Physician

Date: 9/12/17

PROCEDURE: NOTE \_\_\_\_\_

PROCEDURE: \_\_\_\_\_

REASON FOR PROCEDURE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

DESCRIPTION OF PROCEDURE: \_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ent

I acknowledge that my doctor has explained to me that I will have an operation, treatment, or procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments, and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that I would experience much less pain, discomfort, or anxiety during my planned operation or procedure.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my anesthesia, procedure, or treatment. Although rare, severe and unexpected complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack, cardiac arrest, or death. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified as they may apply to a specific type of anesthesia.

I understand that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor will do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthetic technique which involves the use of local anesthetics may not succeed completely and therefore, another technique may have to be used, including general anesthesia. Furthermore, I understand that while I am receiving anesthesia, conditions may develop which require modifying or extending this consent. I therefore authorize modifications or extension of this consent that professional judgment indicates to be necessary under the circumstances.

|                                                                                        |                  |                                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> General Anesthesia                                 | Expected Results | Total unconscious state, possible placement of breathing tube into throat or wind pipe                                                                                                                                                                                                                                 |
|                                                                                        | Techniques       | Drug injected into the bloodstream, breathed into the lungs, or by other routes                                                                                                                                                                                                                                        |
|                                                                                        | Risks            | Mouth, throat, or jaw pain, hoarseness, injury to mouth, gums, lips, or teeth, awareness under anesthesia, injury to blood vessels or nerves, aspiration of stomach contents into lungs, pneumonia, nausea and vomiting, muscle soreness, injury to the eyes                                                           |
| <input type="checkbox"/> Spinal or Epidural Anesthesia or Analgesia with IV sedation   | Expected Results | Temporarily decreased or total loss of feeling and/or movement to lower part of the body                                                                                                                                                                                                                               |
|                                                                                        | Techniques       | Drug injected through a needle/catheter placed either directly into the spinal fluid (spinal) or immediately outside this space (epidural)                                                                                                                                                                             |
|                                                                                        | Risks            | Headache, backache, infection, persistent weakness or numbness, decreased blood pressure, residual pain, injury to blood vessels or nerves, unexpected high level of spinal anesthetic block (causing upper body weakness or numbness), local anesthetic toxicity causing sudden drop in blood pressure or convulsions |
| <input type="checkbox"/> Nerve Block Anesthesia or Analgesia with IV sedation          | Expected Results | Temporary loss of feeling and/or movement of a specific limb or area                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Axillary block                                                | Techniques       | Drug injected near nerves, providing loss of sensation to the area of the operation                                                                                                                                                                                                                                    |
| <input type="checkbox"/> Interscalene block                                            | Risks            | Infection, convulsions, persistent weakness or numbness, residual pain, soreness at injection site, injury to blood vessels or nerves, local anesthetic toxicity causing sudden drop in blood pressure or convulsions                                                                                                  |
| <input type="checkbox"/> Femoral nerve block                                           |                  |                                                                                                                                                                                                                                                                                                                        |
| <input type="checkbox"/> IV-regional (Bier block)                                      |                  |                                                                                                                                                                                                                                                                                                                        |
| <input type="checkbox"/> Other:                                                        |                  |                                                                                                                                                                                                                                                                                                                        |
| <input type="checkbox"/> Monitored Anesthesia Care (local anesthesia with IV sedation) | Expected Results | Reduced anxiety and pain, partial or total amnesia                                                                                                                                                                                                                                                                     |
|                                                                                        | Techniques       | Drug injected into the bloodstream, breathed into the lungs, or by other routes producing a semi-conscious state                                                                                                                                                                                                       |
|                                                                                        | Risks            | An unconscious state, depressed breathing                                                                                                                                                                                                                                                                              |

I certify that I have, to the best of my ability, told the anesthesiologist obtaining consent of all major illnesses I have had, of all past anesthetics I have received and any complications of these anesthetics known to me, of any drug allergies I have, and of all medications I have recently taken, including aspirin, over-the-counter medications, pain medications, herbal supplements, and recreational street drugs. I have also responded truthfully to any additional questions asked by the anesthesiologist.

I understand that my anesthesia care will be given to me by or under the supervision of an attending anesthesiologist. Knowing that Mercy Philadelphia Hospital is a teaching institution, I understand that along with my anesthesiologist and certified registered nurse anesthetist, other medical center personnel, such as student anesthetists, interns, residents, and other trainees, may be involved in my anesthesia care.

If I am pregnant, I understand that elective surgery should be postponed until after the baby is born. Although fetal complications of anesthesia during pregnancy are very rare, the risks to my baby include, but are not limited to, birth defects, premature labor, permanent brain damage and death of my newborn.

I have listened to Dr. V. Naef CRNA/Anesthesiologist explain the type(s) of anesthesia/analgesia I may receive, its benefits, and common foreseeable risks and consequences, as well as those of its alternatives, and now accept his or her recommendation with the EXCEPTION of (check one):

Type of Anesthesia refused \_\_\_\_\_ ☒ No exception to anesthetic recommendations

By signing this consent form, I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives, and expected results of the chosen anesthetic(s), and that I have had ample opportunity to ask questions and consider my decision. I agree to the above provisions, and hereby consent to the administration of the above checked anesthesia services for my operation, treatment, or procedure. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by the Anesthesiologist.

Signature of Patient Alonzo Benton

Signature of Patient's Guardian or POA \_\_\_\_\_

Date/Time 9/20/17 1230

Relationship to Patient \_\_\_\_\_

PHYSICIAN/CRNA CERTIFICATION: I have personally explained the above information to the patient, or the patient's representative if the patient is incompetent to consent.

Physician/CRNA Dr. V. Naef

Date/Time 9/20/17 1230

CONSENT TO ANESTHESIA



BENTON, ALONZO  
DOB: 11/12/1958 58 M  
ADM: 09/20/17  
ACC: PA1304861964 MR: M000301370



DATE: 09/26/17 @ 1253      Mercy Philadelphia Hospital ABS \*LIVE\*      PAGE 1  
USER: COQUINN      ATTESTATION STATEMENT

NAME: BENTON, ALONZO      ACCT #: PA1304861964

ADM DATE: 09/20/17      UNIT #: M000301370  
ATTEND PHYS: MELLER, MENACHEM M, MD      SEX: M  
DIS DATE: 09/20/17      AGE: 58  
DISCH DISP: HOME, SELF-CARE      DOB: 11/12/1958  
LOS: 1      FIN CLASS: MCRMNG  
PT CLASS: SDC      ABS STATUS: FINAL

DIAGNOSES:  
ADMIT: S42.032A      DISP FX OF LATERAL END OF LEFT CLAVICLE, INIT FOR CLOS FX      POA?  
PRINC: S42.032A      DISP FX OF LATERAL END OF LEFT CLAVICLE, INIT FOR CLOS FX  
SECOND: W18.39XA      OTHER FALL ON SAME LEVEL, INITIAL ENCOUNTER  
K21.9      GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS  
I10      ESSENTIAL (PRIMARY) HYPERTENSION  
Z85.46      PERSONAL HISTORY OF MALIGNANT NEOPLASM OF PROSTATE  
Z87.891      PERSONAL HISTORY OF NICOTINE DEPENDENCE  
Z01.810      ENCOUNTER FOR PREPROCEDURAL CARDIOVASCULAR EXAMINATION

OPERATIONS:  
09/20/17 0PSB04Z      REPOSITION LEFT CLAVICLE WITH INT FIX, OPEN APPROACH      B1

CPTS:  
09/20/17 23515      TREAT CLAVICLE FRACTURE

DRG:  
STATUS      \$ REIMB      MIN-LOS      MAX-LOS      STD-LOS      GRP VERS      GRP FC  
34      MCRMNG

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

DATE: \_\_\_\_\_

DATE: 10/13/17 @ 0142  
USER: MT

Mercy Philadelphia Hospital AOM \*LIVE\*  
Ambulatory Prescriptions and Procedures

PAGE 1

|                                         |                                            |
|-----------------------------------------|--------------------------------------------|
| Patient Name: BENTON, ALONZO            | Admission/Registration Date: 09/20/17      |
| Unit Number: M000301370                 | Discharge Date: 09/20/17                   |
| Account Number: PA1304861964            | Admitting Physican:                        |
| Date of Birth: 11/12/1958 Age/Sex: 58 M | Attending Physican: MELLER, MENACHEM M. MD |

Preferred Pharmacy: \*Do Not ePrescribe - PRINT , PA  
Phone: Fax:  
Mail Order: LTC: Specialty: 24Hrs: eRx: EPCS:

#### Prescriptions

Claritin (Loratadine) 10 Mg Capsule  
10 MG ORAL DAILY 30 Days  
Rx# 0000000004 Days: 30 Refills: 0 CAPSULE  
Entered Date: Oct 21, 2015 Compound Med: No  
Ordering Provider: MOHASA01 Location: PH6NW  
Diagnosis:

Losartan Potassium (Losartan Potassium) 50 Mg Tablet  
50 MG ORAL DAILY 30 Days  
Rx# 0000001916 Days: 30 Refills: 0  
Entered Date: Oct 23, 2015 Compound Med: No  
Ordering Provider: BABAFA Location: PH6NW  
Diagnosis:

Pantoprazole Sodium (Pantoprazole Sodium) 20 Mg Tablet.dr  
40 MG ORAL DAILY , #30 TABLET.DR  
Rx# 0000001918 Qty: 30 Refills: 0 TABLET  
Entered Date: Oct 23, 2015 Compound Med: No  
Ordering Provider: BABAFA Location: PH6NW  
Diagnosis:

#### Referrals

Gastroenterology Ref  
In 7 Days  
To Practice:  
To Provider: Danilewitz, Mervyn, Md  
Referral Authorization Date:  
Referral Expiration Date:  
Referral Type:  
Diagnosis:  
# OF VISITS: Active Babar, Fatima, Md

# EXHIBIT D

# MRCP

MEDICAL REHABILITATION CENTERS OF PENNSYLVANIA

For Physical Medicine

Department of Physical Medicine  
Morton L. Silverman, M.D., ABIM  
Lynn Yang, M.D. FAAPMR  
Francis V. Cavolo, M.D., Ph.D., FCP  
Bruce J. Barris, M.D., ABIM  
Alexander J. Ricciuti, M.D., Ph.D.

April 23, 2018

Michael Tinari, Esquire  
1500 John F. Kennedy Boulevard  
Suite 1910  
Philadelphia, Pa 19102

RE: Alonzo Benton  
Date of Accident: 08/29/2017

Dear Mr. Tinari:

I had the pleasure seeing your client, Alonzo Benton, in the office for an initial evaluation on 04/20/2018. As you know, this is a 60-year-old, right-handed gentleman, who slipped and fell on the train track on 08/29/2017. He fell onto his left shoulder. Since that time he has been having left shoulder pain and increased low back pain. He reports being in a motor vehicle accident over 10 years ago, had low back pain, was diagnosed with a disc herniation and is on Disability. His pain was an 8/10 to 9/10 and an after this fall it is now a 10/10. Prior to the fall he was taking Percocet 5/325 mg tablets for his pain, and after the fall he is now taking oxycodone 10 mg tablets.

He describes ongoing low back pain with numbness in both his legs right greater than left and sees a pain management doctor, Dr. Framble Kozara and he also finds that it is difficult for him to get out of bed. After the fall he went to the ER at Mercy Hospital, had x-rays done showing a left distal clavicle fracture. He was given a sling and referred to orthopedics. He followed up with Dr. Metrum, who recommended surgery, which Mr. Benton underwent one week after the fall which did not help his pain. He reports that the plate started coming through his skin, and he had a second surgery a couple weeks later to have the

---

**MRCP Walnut Street**

1608 Walnut Street, 4th Floor, Philadelphia, PA 19103 215.545.5630 Fax 215.545.5678

**MRCP Northeast**  
2311 Cottman Avenue  
Philadelphia, PA 19149  
215.331.3414  
Fax 215.331.9363

**MRCP Broomall**  
419 Lawrence Road  
Broomall, PA 19008  
610.353.2800  
Fax 610.353.5963

**MRCP Plymouth**  
580 W. Germantown Pike, Ste. 106  
Plymouth Meeting, PA 19462  
610.628.3110  
Fax 610.628.9116

**MRCP Lower Bucks**  
1111 Street Road, Ste. 104  
Southampton, PA 18966  
215.675.4466  
Fax 215.675.3711

**MRCP West Chester**  
1103 Paoli Pike  
West Chester, PA 19380  
610.692.8885  
Fax 610.692.9881

**MRCP South Phila.**  
330 W. Oregon Avenue  
Philadelphia, PA 19148  
215.952.8717  
Fax 215.952.8710

RE: Alonzo Benton  
April 23, 2018  
Page 2

hardware removed.

His ongoing left shoulder pain is off and on, worse when he wakes up in the morning and it feels stiff and stuck. He also notices pain with movement and he describes it as a pulling pain. He is unable to sleep on his left side. He reports when he sleeps on his left side, his left side "falls asleep." He reports weakness in the left arm and he tries not to use his left arm. His low back pain is a 10/10, constant crampy pain with difficulty transferring from a sit-to-stand position. He has off-and-on radiation into the right greater than left leg. He denies any tripping or falling, but does report loss of balance and denies any bowel or bladder symptoms.

REVIEW OF SYSTEMS: As above, benign or noncontributory.

Past Medical/Surgical History: Right herniorrhaphy, left hernia, hypertension, GERD, prostate cancer.

MEDICATIONS: Losartan, clonidine, omeprazole.

ALLERGIES: Contrast dye.

FAMILY HISTORY: Heart disease, cancer, hypertension, diabetes.

SOCIAL HISTORY: He reports being on SSD.

Medical Records Available for Review Include:

1. Mercy Philadelphia Hospital Emergency record dated 08/29/2017 including an x-ray of the left shoulder showing a distal clavicle comminuted fracture

I routinely rely on medical records and special studies to help formulate my opinions.

PHYSICAL EXAMINATION: On physical examination, there is a 5 inch scar in the left anterior shoulder which is healed, and distally there is some decreased sensation to light touch along the scar. He has limited range of motion in the left shoulder with flexion to 20 degrees, extension to

RE: Alonzo Benton  
April 23, 2018  
Page 3

50 degrees, external rotation to 20 degrees, internal rotation to 0 degrees, abduction to 20 degrees, and adduction to 0 degrees. He has 2/5 motor strength in the left deltoid, and 4/5 motor strength throughout the rest of the left upper extremity. He has decreased lumbar range of motion with flexion to 15 degrees, extension to 0 degrees, rotation to 10 degrees bilaterally and lateral bending to 10 degrees bilaterally. He has 4/5 to 4+/5 motor strength in the left lower extremity, and 4/5 motor strength in the right lower extremity.

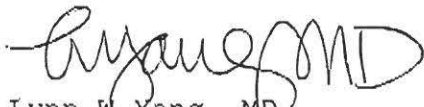
IMPRESSION: Based on the history and physical the following diagnoses are a direct result of the injury Mr. Benton sustained on 08/29/2017 to a reasonable degree of medical certainty:

1. Right distal clavicle fracture status post ORIF status post hardware removal with persistent pain.
2. Aggravation of previous low back pain and leg symptoms.

Mr. Benton's current symptoms are a direct result of his 08/29/2017 slip and fall. As he continues to have symptoms almost 8 months after his injury, I opine that his prognosis for a full recovery is guarded. My opinions are made with a reasonable degree of medical certainty.

Thank you for allowing me to help in the care of your client. If I can be of any further assistance, please do not hesitate to contact me.

Sincerely,



Lynn W. Yang, MD  
Board Certified in Physical Medicine and Rehabilitation  
mts/1737142

# **EXHIBIT E**









# **EXHIBIT F**

EQUIAN  
P.O. Box 34060  
Louisville, Kentucky 40232-4060

FEDERAL TAX ID: 27-0083277  
TELEPHONE NUMBER: (855) 891-5877  
PAGE 1 OF 4

### CONSOLIDATED STATEMENT OF BENEFITS

PATIENT'S NAME: ALONZO BENTON  
DATE OF INJURY: 8/29/2017  
SERVICE PERIOD: 8/29/2017-5/8/2019  
EVENT NUMBER: 12578837-12521972

**Subject to change.**

**Instructions:**

- If remitting payment, make checks payable to: Equian.
- **Write the patient's name, ALONZO BENTON, and event number, 12578837-12521972, on the check.**

| Provider of Service        | Diagnosis Code                | Claim Number     |                   |
|----------------------------|-------------------------------|------------------|-------------------|
| Date of Service            | Procedure Code(s)             | Billed Amt.      | Provided Benefits |
| <b>COMPLEXCARE SOLUTIO</b> | <b>M54.5 LOW BACK PAIN</b>    | <b>909332718</b> |                   |
| 5/14/2018                  | 99343 HOME VISIT, NEW         | \$0.00           | \$0.00            |
| <b>MERCY CATHOLIC MEDI</b> | <b>M25.412 EFFUSION, LEFT</b> | <b>725219691</b> |                   |
| 8/29/2017                  | A9270 NON-COVERED ITEM        | \$3.40           | \$0.00            |
| 8/29/2017                  | 73030 X-RAY EXAM SHOUL        | \$652.00         | \$0.00            |
| 8/29/2017                  | 99283 EMERGENCY DEPT V        | \$899.00         | \$153.31          |
|                            | <b>S42.032A DISP FX OF LA</b> | <b>726330483</b> |                   |
| 9/12/2017                  | 73200 CT UPPER EXTREMI        | \$1685.00        | \$0.00            |
|                            | <b>S42.032A DISP FX OF LA</b> | <b>729502652</b> |                   |
| 9/15/2017                  | 36415 ROUTINE VENIPUNC        | \$17.00          | \$0.00            |
| 9/15/2017                  | 82310 ASSAY CALCIUM           | \$84.00          | \$0.00            |
| 9/15/2017                  | 82040 ASSAY SERUM ALBU        | \$84.00          | \$0.00            |
| 9/15/2017                  | 84100 ASSAY PHOSPHORUS        | \$104.00         | \$0.00            |
| 9/15/2017                  | 83735 ASSAY MAGNESIUM         | \$114.00         | \$0.00            |
| 9/15/2017                  | 85027 COMPLETE CBC, AU        | \$194.00         | \$0.00            |
| 9/15/2017                  | 84134 ASSAY PREALBUMIN        | \$271.00         | \$0.00            |
| 9/15/2017                  | 82728 ASSAY FERRITIN          | \$293.00         | \$0.00            |
| 9/15/2017                  | 87641 MR-STAPH, DNA, A        | \$395.00         | \$0.00            |
| 9/15/2017                  | 82306 ASSAY VITAMIN D         | \$483.00         | \$0.00            |
| 9/15/2017                  | 82652 ASSAY DIHYDROXYV        | \$663.00         | \$0.00            |
| 9/15/2017                  | 93005 ELECTROCARDIOGRA        | \$691.00         | \$0.00            |
| 9/15/2017                  | 83970 ASSAY PARATHORMO        | \$696.00         | \$0.00            |
|                            | <b>M81.0 AGE-RELATED OSTE</b> | <b>726507296</b> |                   |
| 9/15/2017                  | 77080 DXA BONE DENSITY        | \$485.00         | \$127.05          |
|                            | <b>S42.032A DISP FX OF LA</b> | <b>729502652</b> |                   |
| 9/20/2017                  | 710 RECOVERY ROOM             | \$3150.00        | \$0.00            |
| 9/20/2017                  | 370 ANESTHESIA                | \$9115.00        | \$0.00            |
| 9/20/2017                  | C1713 ANCHOR/SCREW BON        | \$16778.06       | \$0.00            |
| 9/20/2017                  | 23515 TREAT CLAVICLE F        | \$21694.00       | \$5688.71         |
| 9/20/2017                  | 76000 FLUOROSCOPE EXAM        | \$386.00         | \$0.00            |
| 9/20/2017                  | J2710 NEOSTIGMINE METH        | \$247.25         | \$0.00            |
| 9/20/2017                  | 250 PHARMACY                  | \$252.00         | \$0.00            |
| 9/20/2017                  | 250 PHARMACY                  | \$168.25         | \$0.00            |
| 9/20/2017                  | J1170 HYDROMORPHONE IN        | \$19.00          | \$0.00            |
| 9/20/2017                  | J3010 FENTANYL CITRATE        | \$5.00           | \$0.00            |

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### CONSOLIDATED STATEMENT OF BENEFITS

PATIENT'S NAME: ALONZO BENTON  
DATE OF INJURY: 8/29/2017  
SERVICE PERIOD: 8/29/2017-5/8/2019  
EVENT NUMBER: 12578837-12521972

Subject to change.

#### Instructions:

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| Provider of Service        | Diagnosis Code                | Claim Number     |                   |
|----------------------------|-------------------------------|------------------|-------------------|
| Date of Service            | Procedure Code(s)             | Billed Amt.      | Provided Benefits |
| 9/20/2017                  | J2250 INJECT MIDAZOLAM        | \$5.00           | \$0.00            |
| 9/20/2017                  | A9270 NON-COVERED ITEM        | \$6.80           | \$0.00            |
| 9/20/2017                  | J2704                         | \$8.50           | \$0.00            |
| 9/20/2017                  | 250 PHARMACY                  | \$10.25          | \$0.00            |
| 9/20/2017                  | J1885 KETOROLAC TROMET        | \$12.50          | \$0.00            |
| 9/20/2017                  | J1170 HYDROMORPHONE IN        | \$14.00          | \$0.00            |
|                            | <b>T84.84XA PAIN DUE TO I</b> | <b>730107004</b> |                   |
| 10/12/2017                 | J2250 INJECT MIDAZOLAM        | \$2.50           | \$0.00            |
| 10/12/2017                 | J3010 FENTANYL CITRATE        | \$5.00           | \$0.00            |
| 10/12/2017                 | J2405 ONDANSETRON HCL         | \$5.00           | \$0.00            |
| 10/12/2017                 | A9270 NON-COVERED ITEM        | \$6.80           | \$0.00            |
| 10/12/2017                 | J2704 Inj, propofol, 1        | \$8.50           | \$0.00            |
| 10/12/2017                 | J1170 HYDROMORPHONE IN        | \$9.25           | \$0.00            |
| 10/12/2017                 | J1170 HYDROMORPHONE IN        | \$9.50           | \$0.00            |
| 10/12/2017                 | J1885 KETOROLAC TROMET        | \$12.50          | \$0.00            |
| 10/12/2017                 | J1580 GARAMYCIN GENTAM        | \$75.00          | \$0.00            |
| 10/12/2017                 | 87070 CULTURE, BACTERI        | \$218.00         | \$0.00            |
| 10/12/2017                 | 88300 SURGICAL PATH, G        | \$225.00         | \$0.00            |
| 10/12/2017                 | 87075 CULTR BACTERIA,         | \$226.00         | \$0.00            |
| 10/12/2017                 | 87186 MICROBE SUSCEPTI        | \$260.00         | \$0.00            |
| 10/12/2017                 | 87641 MR-STAPH, DNA, A        | \$395.00         | \$0.00            |
| 10/12/2017                 | 88304 TISSUE EXAM BY P        | \$636.00         | \$0.00            |
| 10/12/2017                 | 73030 X-RAY EXAM SHOUL        | \$652.00         | \$0.00            |
| 10/12/2017                 | 370 ANESTHESIA                | \$5751.00        | \$0.00            |
| 10/12/2017                 | 710 RECOVERY ROOM             | \$6300.00        | \$0.00            |
| 10/12/2017                 | 20680 REMOVE SUPPORT I        | \$8522.00        | \$2225.82         |
| 10/13/2017                 | 87077 CULTURE AEROBIC         | \$145.00         | \$0.00            |
| 10/15/2017                 | 87077 CULTURE AEROBIC         | \$145.00         | \$0.00            |
| <b>MERCY DIAGNOSTIC IM</b> | <b>S42.032D DISP FX OF LA</b> | <b>726806243</b> |                   |
| 9/12/2017                  | 73200 CT UPPER EXTREMI        | \$200.00         | \$0.00            |
|                            | <b>S42.032A DISP FX OF LA</b> | <b>730120619</b> |                   |
| 10/12/2017                 | 73030 X-RAY EXAM SHOUL        | \$35.00          | \$0.00            |
| <b>MERCY MANAGEMENT OF</b> | <b>S42.032A DISP FX OF LA</b> | <b>725619409</b> |                   |
| 9/8/2017                   | 99202 OFFICE/OUTPATIEN        | \$158.00         | \$56.52           |
|                            | <b>S42.032A DISP FX OF LA</b> | <b>727127779</b> |                   |

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### CONSOLIDATED STATEMENT OF BENEFITS

PATIENT'S NAME: ALONZO BENTON  
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#### Instructions:

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| Date of Service            | Procedure Code(s)             | Billed Amt.                 | Provided Benefits |
| 9/20/2017                  | 23515 TREAT CLAVICLE F        | \$1364.00                   | \$0.00            |
|                            | <b>S42.032A DISP FX OF LA</b> | <b>730728996</b>            |                   |
| 9/20/2017                  | 23515 TREAT CLAVICLE F        | \$1364.00                   | \$900.02          |
|                            | <b>T84.498D MECH COMPL OF</b> | <b>730000768</b>            |                   |
| 10/12/2017                 | 88300 SURGICAL PATH, G        | \$27.00                     | \$0.00            |
| 10/12/2017                 | 88304 TISSUE EXAM BY P        | \$54.00                     | \$11.70           |
|                            | <b>T84.84XA PAIN DUE TO I</b> | <b>731430227</b>            |                   |
| 10/12/2017                 | 20680 REMOVE SUPPORT I        | \$938.00                    | \$492.89          |
| <b>MERCY MANAGEMENT OF</b> | <b>Z01.810 ENCOUNTER FOR</b>  | <b>802200359</b>            |                   |
| 9/15/2017                  | 93010 ELECTROCARDIOGRA        | \$33.00                     | \$0.00            |
| <b>NORTHSTAR ANESTHESI</b> | <b>S42.002B FRACTURE OF U</b> | <b>727704126</b>            |                   |
| 9/20/2017                  | 00450 ANESTH SURGERY O        | \$2296.00                   | \$0.00            |
| 9/20/2017                  | 00450 ANESTH SURGERY O        | \$2296.00                   | \$278.11          |
|                            | <b>Z47.2 ENCOUNTER FOR RE</b> | <b>729919478</b>            |                   |
| 10/12/2017                 | 00450 ANESTH SURGERY O        | \$1650.00                   | \$0.00            |
| 10/12/2017                 | 00450 ANESTH SURGERY O        | \$1650.00                   | \$96.28           |
|                            | <b>Z47.2 ENCOUNTER FOR RE</b> | <b>729919482</b>            |                   |
| 10/12/2017                 | 00450 ANESTH SURGERY O        | \$1640.00                   | \$0.00            |
| 10/12/2017                 | 00450 ANESTH SURGERY O        | \$1640.00                   | \$96.28           |
| <b>PENN PRESBYTERIAN M</b> | <b>M50.20 OTHER CERVICAL</b>  | <b>725044646</b>            |                   |
| 8/29/2017                  | G0480                         | \$237.00                    | \$50.86           |
| 8/29/2017                  | 80307                         | \$851.00                    | \$182.64          |
| <b>RITE AID PHARMACY 2</b> |                               | <b>RX172584152792132999</b> |                   |
| 9/15/2017                  | 47781019601 OXYCODONE         | \$164.24                    | \$9.87            |
| <b>RITE AID PHARMACY 4</b> | <b>00003925 NSAID ANALGES</b> | <b>RX172416324350212999</b> |                   |
| 8/29/2017                  | 68462019001 NAPROXEN 5        | \$25.90                     | \$1.16            |
|                            |                               | <b>RX172416342336145999</b> |                   |
| 8/29/2017                  | 47781019601 OXYCODONE         | \$13.68                     | \$1.25            |
| <b>RITECHOICE PHARMACY</b> | <b>00003664 ANALGESIC NAR</b> | <b>RX172428318340120999</b> |                   |
| 8/31/2017                  | 60951060270 ENDOCET 5-        | \$205.30                    | \$17.84           |
|                            | <b>00003664 ANALGESIC NAR</b> | <b>RX172728304080116999</b> |                   |
| 9/30/2017                  | 60951060270 ENDOCET 5-        | \$205.30                    | \$14.54           |
|                            | <b>00003664 ANALGESIC NAR</b> | <b>RX173003649567173999</b> |                   |
| 10/27/2017                 | 60951060270 ENDOCET 5-        | \$153.97                    | \$11.33           |
|                            | <b>00000583 ANALGESIC NAR</b> | <b>RX190703647305134999</b> |                   |

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|--------------------------------------------|-------------------------------|--------------------------------|-------------------|
| Date of Service                            | Procedure Code(s)             | Billed Amt.                    | Provided Benefits |
| 3/11/2019                                  | 10702005601 OXYCODONE         | \$93.75                        | \$27.31           |
|                                            | <b>00000583 ANALGESIC NAR</b> | <b>RX190978299714199999</b>    |                   |
| 4/8/2019                                   | 10702005601 OXYCODONE         | \$93.75                        | \$27.31           |
|                                            | <b>00000583 ANALGESIC NAR</b> | <b>RX191283803717083998</b>    |                   |
| 5/8/2019                                   | 10702005601 OXYCODONE         | \$93.75                        | \$13.96           |
| <b>UNIVERSITY OF PENN</b>                  | <b>M50.20 OTHER CERVICAL</b>  | <b>724701873</b>               |                   |
| 8/30/2017                                  | 99214 OFFICE/OUTPATIEN        | \$260.00                       | \$108.00          |
|                                            | <b>M50.20 OTHER CERVICAL</b>  | <b>734933370</b>               |                   |
| 12/12/2017                                 | 99214 OFFICE/OUTPATIEN        | \$260.00                       | \$108.00          |
|                                            | <b>M50.20 OTHER CERVICAL</b>  | <b>805011657</b>               |                   |
| 2/15/2018                                  | 99214 OFFICE/OUTPATIEN        | \$260.00                       | \$108.73          |
|                                            | <b>M50.20 OTHER CERVICAL</b>  | <b>810703377</b>               |                   |
| 4/12/2018                                  | 99214 OFFICE/OUTPATIEN        | \$260.00                       | \$108.73          |
|                                            | <b>M50.20 OTHER CERVICAL</b>  | <b>819902575</b>               |                   |
| 7/13/2018                                  | 99214 OFFICE/OUTPATIEN        | \$260.00                       | \$108.73          |
|                                            | <b>M50.20 OTHER CERVICAL</b>  | <b>825718119</b>               |                   |
| 9/12/2018                                  | 99214 OFFICE/OUTPATIEN        | \$260.00                       | \$108.73          |
|                                            | <b>M54.5 LOW BACK PAIN</b>    | <b>831930701</b>               |                   |
| 11/13/2018                                 | 99214 OFFICE/OUTPATIEN        | \$260.00                       | \$108.73          |
|                                            | <b>M50.20 OTHER CERVICAL</b>  | <b>901604676</b>               |                   |
| 1/11/2019                                  | 99214 OFFICE/OUTPATIEN        | \$260.00                       | \$0.00            |
|                                            | <b>M50.20 OTHER CERVICAL</b>  | <b>907312290</b>               |                   |
| 3/11/2019                                  | 99214 OFFICE/OUTPATIEN        | \$260.00                       | \$84.69           |
|                                            | <b>M54.5 LOW BACK PAIN</b>    | <b>913103837</b>               |                   |
| 5/8/2019                                   | 99214 OFFICE/OUTPATIEN        | \$260.00                       | \$115.31          |
| <b>Total Billed Charges \$103,376.70</b>   |                               | <b>Amount Received \$0.00</b>  |                   |
| <b>Total Benefits Provided \$11,444.41</b> |                               | <b>Balance Due \$11,444.41</b> |                   |