TAB # 7

BREVARD COUNTY SHERIFF'S OFFICE
TITUSVILLE, FLORIDA 32780
PROPERTY RECEIPT

NOTICE: PROPERTY SEIZED AS EVIDENCE: UNLESS TURNED OVER TO APPROPRIATE COURT WILL BE DISPOSED OF 60 DAYS FROM ACQUITTAL/DISMISSAL DATE OF CASE, UNLESS CLAIMED BY OWNER. FOUND, ABANDONED OR SAFEKEEPING PROPERTY, UNLESS CLAIMED BY OWNER, WILL BE DISPOSED OF 90 DAYS AFTER RECEIPT BY THIS OFFICER.

MO.	DAY	YEAR	TIME:	ADDRESS FROM WHERE PROPERTY TAKEN:	PRECINCT	CR NUMBER
12	11	18	1130	860 Camp Rd, Cocoa, FL	WP	18-00434257

☐ FOUND PROPERTY ☐ EF-EVIDENCE FELONY ☐ CONFISCATED ☑ PROPERTY OF DECEASED ☐ FORFEITURE
☐ RECOVERED STOLEN ☐ EM-EVIDENCE MISD ☐ TO BE DESTROYED ☒ SAFEKEEPING

☐ INJUNCTION#: _____ ☐ OTHER: _____
☐ ITEMS MAY BE RELEASED TO OWNER LIST ITEMS TO RELEASE/DISPOSED OF: _____

☐ BCSO CSU LAB SUBMISSION ☐ LFP LATENT FINGERPRINT PROCESSING
☐ FDLE LAB SUBMITTAL ☐ PBT PRESUMPTIVE BLOOD TESTING
☐ DNA SWAB ☐ SNR SERIAL NUMBER RESTORATION
☐ (CHECK BOX(ES) OF ITEM(S) TO BE TRANSFERRED)
ITEMS PROCESSED MAY BE RETURNED TO ☐ OWNER ☐ DISPOSED OF AFTER BCSO PROCESSING

EVIDENCE USE ONLY
BIN LOCATION(S)

☐ DRUG CASES ☐ PRESUMPTIVE TEST ☐ ARREST MADE ☐ JUVENILE
☐ ITEMS CHECKED THROUGH NCIC/FCIC ☐ CRIMINAL HISTORY CHECK COMPLETED BY ID#

NAME	ADDRESS:	PHONE:
☐ ARR/ ☐ COMP/ ☐ VICT/ ☐ SUSP/ ☐ OWNER:		
☐ ARR/ ☒ COMP/ ☐ VICT/ ☐ SUSP/ ☒ OWNER: Vitani, Amy	ADDRESS: 860 Camp Rd. Cocoa, FL	PHONE:

CASE AGENT/DEPUTY: Agent J. Straight 442

ITEM	QUANTITY:	PROPERTY DESCRIPTION (MAKE, MODEL, BRAND, TYPE, SIZE, COLOR, CALIBER, ETC.)	SERIAL #/V.I.N.	☑
1 GM	1	Packet Inmate Gregory Edwards medical records from the BCDC Medical facility		☐

Voiding to follow

IMPOUNDING DEPUTY/AGENT SIGNATURE ID NO./DIVISION: 442
PRINT NAME OF IMPOUNDING DEPUTY / AGENT: Agent J. Straight

SIGNATURE FROM WHOM PROPERTY TAKEN:
PRINT NAME OF PERSON FROM WHOM PROPERTY TAKEN: Amy Vitani - Health Services Administrator

FIREARMS/CURRENCY ONLY

FIREARM RENDERED SAFE BY:	WITNESSED BY:
CURRENCY INVENTORIED BY:	WITNESSED BY:

TRANSFER OF CUSTODY

IVED BY/ID#:		REASON:		TIME:		MO/DAY/YEAR:	
RECEIVED BY/ID#:		REASON:		TIME:		MO/DAY/YEAR:	

PROPERTY RECEIPT DISTRIBUTION
ORIGINAL Remains with Property/CANARY-Investigating Officer/PINK-To Person from Whom Property Seized

PAGE ________ OF ________

BREVARD COUNTY SHERIFF'S OFFICE
TITUSVILLE, FLORIDA 32780
PROPERTY RECEIPT

NOTICE: PROPERTY SEIZED AS EVIDENCE: UNLESS TURNED OVER TO APPROPRIATE COURT WILL BE DISPOSED OF 60 DAYS FROM ACQUITTAL/DISMISSAL DATE OF CASE, UNLESS CLAIMED BY OWNER. FOUND, ABANDONED OR SAFEKEEPING PROPERTY, UNLESS CLAIMED BY OWNER, WILL BE DISPOSED OF 90 DAYS AFTER RECEIPT BY THIS OFFICER.

MO.	DAY	YEAR	TIME:	ADDRESS FROM WHERE PROPERTY TAKEN:	PRECINCT	CR NUMBER
12	11	13	1130	[illegible]	[illegible]	13-00[illegible]

☐ FOUND PROPERTY ☐ EF-EVIDENCE FELONY ☐ CONFISCATED ☒ PROPERTY OF DECEASED ☐ FORFEITURE
☐ RECOVERED STOLEN ☐ EM-EVIDENCE MISD ☐ TO BE DESTROYED ☐ SAFEKEEPING

☐ INJUNCTION#: ________ ☐ OTHER: ________
☐ ITEMS MAY BE RELEASED TO OWNER LIST ITEMS TO RELEASE/DISPOSED OF: ________

☐ BCSO CSU LAB SUBMISSION ☐ LFP LATENT FINGERPRINT PROCESSING
☐ FDLE LAB SUBMITTAL ☐ PBT PRESUMPTIVE BLOOD TESTING
☐ DNA SWAB ☐ SNR SERIAL NUMBER RESTORATION
☐ (CHECK BOX(ES) OF ITEM(S) TO BE TRANSFERRED)
ITEMS PROCESSED MAY BE RETURNED TO ☐ OWNER ☐ DISPOSED OF AFTER BCSO PROCESSING

EVIDENCE USE ONLY
BIN LOCATION(S)

☐ DRUG CASES ☐ PRESUMPTIVE TEST ☐ ARREST MADE ☐ JUVENILE
☐ ITEMS CHECKED THROUGH NCIC/FCIC ☐ CRIMINAL HISTORY CHECK COMPLETED BY ID#

NAME	ADDRESS:	PHONE:
☐ ARR / ☐ COMP / ☐ VICT / ☐ SUSP / ☐ OWNER:		
☐ ARR / ☒ COMP / ☐ VICT / ☐ SUSP / ☒ OWNER: [illegible]	[illegible]	

CASE AGENT/DEPUTY: [illegible] J. [illegible] 442

ITEM	QUANTITY:	PROPERTY DESCRIPTION (MAKE, MODEL, BRAND, TYPE, SIZE, COLOR, CALIBER, ETC.)	SERIAL #/V.I.N.	☑
[illegible]	1	[illegible]		☐
		[illegible]		☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐

IMPOUNDING DEPUTY/AGENT SIGNATURE ID NO./DIVISION: [illegible] 442
SIGNATURE FROM WHOM PROPERTY TAKEN: [illegible]
PRINT NAME OF IMPOUNDING DEPUTY / AGENT: [illegible]
PRINT NAME OF PERSON FROM WHOM PROPERTY TAKEN: [illegible]

FIREARMS/CURRENCY ONLY

FIREARM RENDERED SAFE BY:	WITNESSED BY:
CURRENCY INVENTORIED BY:	WITNESSED BY:

TRANSFER OF CUSTODY

[RECEI]VED BY/ID#:		REASON:		TIME:		MO/DAY/YEAR:	
RECEIVED BY/ID#:		REASON:		TIME:		MO/DAY/YEAR:	

PROPERTY RECEIPT DISTRIBUTION
ORIGINAL Remains with Property/CANARY-Investigating Officer/PINK-To Person from Whom Property Seized

IMPORTANT INFORMATION REGARDING THE ENCLOSED MEDICAL RECORDS

CONFIDENTIAL MEDICAL INFORMATION ENCLOSED TO BE REVIEWED BY AUTHORIZED PERSONS ONLY!!!

The enclosed health information was produced by medical records personnel of Armor Correctional Health Services/ Brevard County Sheriff's Office Detention Center.

These reproduction copies have been made from the medical unit's original records. The confidentiality of these records is protected by federal state laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

These medical records contain sensitive information that cannot be released without patient authorization, therefore if you have received these records in error or have any further questions regarding these records you can contact our office at (321) 690-1500 ext: 51618.

THANK YOU. IT IS OUR PLEASURE TO TRY TO ASSIST YOU.

MEDICAL RECORDS DEPARTMENT

Armor Correctional Health Services, Inc.

INMATE HEALTH RECORD ACKNOWLEDGEMENT FORM

Health Record Copy To: BSCO Major Crimes

The attached documents are not intended to represent the full and complete medical record. The recipient acknowledges that this record is not complete until all lab reports, physicians' notes, nursing notes or other information is included. Until then the information contained herein should not be relied upon as a full and complete medical record for this patient.

This is a copy of the medical documents available at this time.

Armor Medical Records Representative | 12/10/18 Date | 1:30 pm Time

Attach original to copy of record. Keep copy with original health record.

Gregory Lloyd Edwards

#2018-00018862

Sex: Male
DOB: 09/23/1980 (Age 38)
Height: 5ft 11in
SSN: 148824843
Agency: FL0050000
Location: Hospital : Hospital
JMS ID: 4782869
Allergies:
NKMA

Reports
Full Patient History

Full Patient History

Name: Edwards, Gregory Lloyd

DOB: 09-23-1980

Sex: Male

SSN: 148824843

JMS ID: 4782869

Race: Black or African American

Location: Hospital : Hospital

Allergies: NKMA

Intake Screening Forms

(No Records)

Medical Forms

(No Records)

Release Forms

(No Records)

Exam Forms

Booking Number	Form Name	Form Item	Item Response	Interviewer	Interview Date
2018-00018862	Urgent Care Assessment (PT-037)	How was patient transported to examination area?	Treated at the scene	Nadeau, Debora	12-09-2018 2:59 pm

2018-00018862	Urgent Care Assessment (PT-037)	Type of Urgent Situation:	Acute Medical Condition (e.g. loss of consciousness, seizure, etc.)	Nadeau, Debora	12-09-2018 2:59 pm
2018-00018862	Urgent Care Assessment (PT-037)	Details of Event/Injury/Condition:	PT WAS BEING COMBATIVE AND WAS MACED AND TASED BY SECURITY AND 4 POINTED IN CHAIR, UNABLE TO APPROACH FOR VITALS AT THAT TIME, PT HOLLERING	Nadeau, Debora	12-09-2018 2:59 pm
2018-00018862	Urgent Care Assessment (PT-037)	Condition of patient at initial presentation:	Alert and Oriented	Nadeau, Debora	12-09-2018 2:59 pm
2018-00018862	Urgent Care Assessment (PT-037)	Vital Signs:	NOT ABLE TO APPROACH FOR VITALS	Nadeau, Debora	12-09-2018 2:59 pm
2018-00018862	Urgent Care Assessment (PT-037)	Physical findings: Note: Attach pictures when appropriate	PT STOPPED HOLLERING APROX 1430 AND WAS SLUMPED OVER WHEN SECURITY APPROACHED, PT WAS UNRESPONSIVE, APPLIED OXYGEN VIA MASK AND PTS CHEST WAS MOVING AND WAS BLINKING BUT NOT RESPONSIVE TO VERBAL COMMANDS. 02 AT 98%, PULSE 64,	Nadeau, Debora	12-09-2018 2:59 pm
2018-00018862	Urgent Care Assessment (PT-037)	Treatment provided:	PT WAS TRANSPORTED TO MEDICAL VIA CHAIR FOR FURTHER EVALUATION BY CHARGE NURSE	Nadeau, Debora	12-09-2018 2:59 pm
2018-00018862	Urgent Care Assessment (PT-037)	Was HCP notified?	No (NOT AT THIS TIME)	Nadeau, Debora	12-09-2018 2:59 pm
2018-00018862	Urgent Care Assessment (PT-037)	Orders received:	NOT AT THIS TIME	Nadeau, Debora	12-09-2018 2:59 pm
2018-00018862	Urgent Care Assessment (PT-037)	How was patient transported to examination area?	Other (specify) (restraint chair)	Robinson, Ayana	12-09-2018 4:04 pm
2018-00018862	Urgent Care Assessment (PT-037)	Details of Event/Injury/Condition:	in medical at time of a page of "all available to booking". Nurse Jones and I went STAT to booking. Upon arrival, inmate was seen in restraint chair facing cells with bil wrist and bil ankles restrained, shaking head and spitting because inmate had on spit mask. this writer did not see inmates face.	Robinson, Ayana	12-09-2018 4:04 pm
2018-00018862	Urgent Care Assessment (PT-037)	Condition of patient at initial presentation:	Confused or Disoriented	Robinson, Ayana	12-09-2018 4:04 pm
2018-00018862	Urgent Care Assessment (PT-037)	Vital Signs:	unable to obtain at this time	Robinson, Ayana	12-09-2018 4:04 pm
2018-00018862	Urgent Care Assessment (PT-037)	Physical findings: Note: Attach pictures when appropriate	inmate uncooperative, trying to get out of restraint chair, spitting into spit mask.	Robinson, Ayana	12-09-2018 4:04 pm
2018-00018862	Urgent Care Assessment (PT-037)	Disposition:	Other (specify) (inmate was in restraint chair in booking.)	Robinson, Ayana	12-09-2018 4:04 pm
2018-00018862	Urgent Care Assessment (PT-037)	How was patient transported to examination area?	Other (specify) (in restraint chair)	Jones, Yolanda	12-09-2018 4:06 pm
2018-00018862	Urgent Care Assessment (PT-037)	Details of Event/Injury/Condition:	Page went out to have all available to booking. Myself and nurse Robinson walked down to give help in situation. Upon arriving in booking patient was in restraint chair with bilateral restraints to ankles and wrist, spit mask on facing towards back entrance to booking. Patient noted to be moving head. I didn't see his face and at time didn't hear him being aggressive just moving head.Patient was placed in holding cell. We returned to medical.	Jones, Yolanda	12-09-2018 4:06 pm
2018-00018862	Urgent Care Assessment (PT-037)	Condition of patient at initial presentation:	Confused or Disoriented	Jones, Yolanda	12-09-2018 4:06 pm
		Vital Signs:	Was unable to obtain vitals at that time.		

2018-00018862	Urgent Care Assessment (PT-037)			Jones, Yolanda	12-09-2018 4:06 pm
2018-00018862	Urgent Care Assessment (PT-037)	Disposition:	Other (specify) (patient was placed in holding cell.)	Jones, Yolanda	12-09-2018 4:06 pm
2018-00018862	Urgent Care Assessment (PT-037)	How was patient transported to examination area?	Other (specify) (Restraint chair)	Fried, Ashley	12-09-2018 4:26 pm
2018-00018862	Urgent Care Assessment (PT-037)	Type of Urgent Situation:	Acute Medical Condition (e.g. loss of consciousness, seizure, etc.)	Fried, Ashley	12-09-2018 4:26 pm
2018-00018862	Urgent Care Assessment (PT-037)	Details of Event/Injury/Condition:	Inmate was brought to medical at 1439 in restraint chair with O2 mask on at 15L. Inmate was unresponsive with very shallow breathing. This nurse performed a sternal rub without any response from the Inmate. This nurse instructed that 911 needed to be called now, and that we needed a sergeant to call 911 now. Sargent Zimmerman was already in the room. At 1439 this nurse instructed Nurse Robinson LPN to obtain VS as this nurse was going to begin the paperwork for the hospital transportation. This nurse heard Nurse Jones LPN state he is not breathing and that CPR needed to be initiated. The officers stated that Inmate was in a restraint chair. This nurse and Nurse Jones LPN both stated that he needs to be removed out of the restraint chair so that CPR could be initiated. This nurse grabbed the back board from the stretcher as Inmate was being released from the restraint chair. This nurse went back to the crash cart and grabbed the ambu bag. Nurse Jones began chest compressions at 1440 as this nurse was hooking up the ambu bag to 15L of O2. Nurse Jones LPN continued with chest compressions while this nurse continued with breathes with the ambu bag. At 1440 Nurse Robinson grabbed the AED and pulse ox. Nurse Jones then applied AED to Inmate. Chest compressions were then continues by Sargent Zimmerman. This nurse continues with breaths via ambu bag with 15L O2. This nurse then instructed Nurse Jones LPN to get a blood sugar on Inmate. At 1441 blood sugar was 95. Nurse Jones LPN then took over giving breaths at 1442 as this Nurse administered Narcan via right nare. Inmate continues to be unresponsive. Chest compressions rotated between Sargent Zimmerman, Corporal Wright, and Deputy Turco. EMS arrived in medical at 1450 and took over care of inmate.	Fried, Ashley	12-09-2018 4:26 pm
2018-00018862	Urgent Care Assessment (PT-037)	Condition of patient at initial presentation:	Unresponsive	Fried, Ashley	12-09-2018 4:26 pm
2018-00018862	Urgent Care Assessment (PT-037)	Vital Signs:	*[blank]*	Fried, Ashley	12-09-2018 4:26 pm
2018-00018862	Urgent Care Assessment (PT-037)	Physical findings: Note: Attach pictures when appropriate	Inmate was brought to medical at 1439 in restraint chair with O2 mask on at 15L. Inmate was unresponsive with very shallow breathing. This nurse performed a sternal rub without any response from the Inmate.	Fried, Ashley	12-09-2018 4:26 pm
2018-00018862	Urgent Care Assessment (PT-037)	Treatment provided:	CPR O2 15L via non-rebreather then via ambu bag narcan AED accu check	Fried, Ashley	12-09-2018 4:26 pm
2018-00018862	Urgent Care Assessment (PT-037)	Was HCP notified?	Yes (HCP Name and Time) (Dr. Gilete 1452)	Fried, Ashley	12-09-2018 4:26 pm
2018-00018862	Urgent Care Assessment (PT-037)	Disposition:	Transfer to emergency department	Fried, Ashley	12-09-2018 4:26 pm
2018-00018862	Urgent Care Assessment (PT-037)	Condition at discharge:	Poor	Fried, Ashley	12-09-2018 4:26 pm

2018-00018862	Urgent Care Assessment (PT-037)	How was patient transported to examination area?	Stretcher	Abdelhady, Hany	12-09-2018 4:28 pm
2018-00018862	Urgent Care Assessment (PT-037)	Type of Urgent Situation:	Acute Medical Condition (e.g. loss of consciousness, seizure, etc.)	Abdelhady, Hany	12-09-2018 4:28 pm
2018-00018862	Urgent Care Assessment (PT-037)	Details of Event/Injury/Condition:	The inmate was transferred unconscious, unresponsive from booking to infirmary at 14:39 and oxygen mask was on his face providing oxygen. Vital signs were unable to be identified and the nurse transferred him from the stretcher to the floor where CPR started and nurse Robinson provided oxygen while nurse Ashly called 911 and gave him chest rub, and narcane injection.CPR was continued by SRG:Zimmerman,and CPL:Wright till 1504when 911 arrived and continued CPR and provided interosseous fluid infusion. The inmate was transferred to the hospital under the care of rescue team.	Abdelhady, Hany	12-09-2018 4:28 pm
2018-00018862	Urgent Care Assessment (PT-037)	Condition of patient at initial presentation:	Unresponsive	Abdelhady, Hany	12-09-2018 4:28 pm
2018-00018862	Urgent Care Assessment (PT-037)	Vital Signs:	*[blank]*	Abdelhady, Hany	12-09-2018 4:28 pm
2018-00018862	Urgent Care Assessment (PT-037)	Treatment provided:	Oxygen was provided via facial mask, Antidote Narcane was injected, and CPR was provided by SRG:Zimmerman,and CPL:Wright, and CPR was also provided by the rescue team 911,and transferring to the hospital by the rescue team was provided too.	Abdelhady, Hany	12-09-2018 4:28 pm
2018-00018862	Urgent Care Assessment (PT-037)	Was HCP notified?	Yes (HCP Name and Time)	Abdelhady, Hany	12-09-2018 4:28 pm
2018-00018862	Urgent Care Assessment (PT-037)	Orders received:	Rescue team transferred the inmate to the hospital to continue his care as he had asystole and the hospital has more abilities than our place.	Abdelhady, Hany	12-09-2018 4:28 pm
2018-00018862	Urgent Care Assessment (PT-037)	Disposition:	Transfer to emergency department	Abdelhady, Hany	12-09-2018 4:28 pm
2018-00018862	Urgent Care Assessment (PT-037)	Follow-up:	As needed	Abdelhady, Hany	12-09-2018 4:28 pm
2018-00018862	Urgent Care Assessment (PT-037)	Condition at discharge:	Poor	Abdelhady, Hany	12-09-2018 4:28 pm
2018-00018862	Urgent Care Assessment (PT-037)	Armor: PT-037 (Rev 04/2013) 5/6/2015 CB	the inmate was transferred with cardiac activity by rescue team to the hospital for continuation of care.	Abdelhady, Hany	12-09-2018 4:28 pm
2018-00018862	Urgent Care Assessment (PT-037)	How was patient transported to examination area?	Other (specify) (restraint chair)	Robinson, Ayana	12-09-2018 4:35 pm
2018-00018862	Urgent Care Assessment (PT-037)	Type of Urgent Situation:	Acute Medical Condition (e.g. loss of consciousness, seizure, etc.)	Robinson, Ayana	12-09-2018 4:35 pm
2018-00018862	Urgent Care Assessment (PT-037)	Details of Event/Injury/Condition:	a page for a stretcher to booking at approximately 1430, nurse Jones and I responded STAT with stretcher. Deputy Hartley and Cpl Mustafa met us at medical door with stretcher. upon arrival to booking, inmate was in holding cell with several security and booking nurse surrounding him. inmate was in restraint chair with bilateral ankle and wrist restraints and nonrebreather oxygen mask applied, unresponsive with shallow breaths. inmate was brought to medical while in restraint chair by security. upon arriving to medical at 1439, inmate still unresponsive. Charge nurse Fried attempted a sternum rub and instructed this nurse to get vitals, in which unsuccessful. Charge Nurse called to Sgt. Zimmerman to initiate 911 at approximately 1440. Charge Nurse instructed deputy Hartley and Sgt.	Robinson, Ayana	12-09-2018 4:35 pm

			Zimmerman to release inmate from restraint chair so medical could initiate CPR. Once inmate on backboard, Nurse Jones initiated chest compressions. this writer grabbed AED and pulse ox at same time Charge Nurse Ashley attached ambu bag to oxygen. Chest compressions continued between medical and security. Charge nurse Ashley instructed this writer grab Narcan from crash cart, in which she applied. inmate still unresponsive, no reading from pulse ox. Chest compression continued, until EMS arrived approx. 1450.		
2018-00018862	Urgent Care Assessment (PT-037)	Condition of patient at initial presentation:	Unresponsive	Robinson, Ayana	12-09-2018 4:35 pm
2018-00018862	Urgent Care Assessment (PT-037)	Vital Signs:	unable to obtained	Robinson, Ayana	12-09-2018 4:35 pm
2018-00018862	Urgent Care Assessment (PT-037)	Physical findings: Note: Attach pictures when appropriate	a page for a stretcher to booking at approximately , nurse Jones and I responded STAT with stretcher. Deputy Hartley and Cpl Mustafa met us at medical door with stretcher. upon arrival to booking, inmate was in holding cell with several security and booking nurse surrounding him. inmate was in restraint chair with bilateral ankle and wrist restraints and nonrebreather oxygen mask applied, unresponsive with shallow breaths. inmate was brought to medical while in restraint chair by security. upon arriving to medical at 1439, inmate still unresponsive. Charge nurse Fried attempted a sternum rub and instructed this nurse to get vitals, in which unsuccessful. Charge Nurse called to Sgt. Zimmerman to initiate 911 at approximately 1440. Charge Nurse instructed deputy Hartley and Sgt. Zimmerman to release inmate from restraint chair so medical could initiate CPR.	Robinson, Ayana	12-09-2018 4:35 pm
2018-00018862	Urgent Care Assessment (PT-037)	Disposition:	Infirmary medical housing	Robinson, Ayana	12-09-2018 4:35 pm
2018-00018862	Urgent Care Assessment (PT-037)	How was patient transported to examination area?	Other (specify) (Restraint chair)	Jones, Yolanda	12-09-2018 4:37 pm
2018-00018862	Urgent Care Assessment (PT-037)	Details of Event/Injury/Condition:	Call given to have stretcher brought to booking. Nurse Robinson and myself went back to booking with stretcher. Accompanied by Corpal Mustafa and deputy Hartley. Upon arriving in medical patient was in restraint chair with bilateral ankles and wrist restrained and O2 being administered via rebreather mask. Booking nurse in cell with patient. Patient noted to be unresponsive and very shallow breaths. Patient was brought to medical in restraint chair by Sgt. Zimmerman and deputy Hartley with O2. Patient noted to have more shallow breaths when entering medical. Charge nurse Fried told nurse Robinson to try and obtain vitals. Charge nurse Fried attempted sternal rub and immediately demanded that a Sgt be here so that patient could be taking to the hospital. There was a Sgt already here. . Then asked that he be taken out of the restraint chair so that CPR can be started and preformed. Sgt Zimmerman and deputy Hartley released patient and he was placed on back board and I began chest compressions while Charge Fried started breaths with ambu bag. Nurse Robinson was told to get AED and Pulse ox. AED pads applied to patient by me, While Sgt Zimmerman continued chest compressions. Charge Fried instructed me to get patients glucose reading. BS is 95. Note was not able to be completed due to Major and Lt demanding that I get out of chart.	Jones, Yolanda	12-09-2018 4:37 pm
2018-00018862	Urgent Care Assessment (PT-037)	Vital Signs:	*[blank]*	Jones, Yolanda	12-09-2018 4:37 pm
2018-00018862	Urgent Care Assessment (PT-037)	How was patient transported to examination area?	Other (specify)	Jones, Yolanda	12-09-2018 8:45 pm

2018-00018862	Urgent Care Assessment (PT-037)	Type of Urgent Situation:	Acute Medical Condition (e.g. loss of consciousness, seizure, etc.)	Jones, Yolanda	12-09-2018 8:45 pm
2018-00018862	Urgent Care Assessment (PT-037)	Details of Event/Injury/Condition:	Continuance of previous noted that I wasn't able to finish. After checking patients glucose, Charge nurse asked nurse Robinson to grab narcan from the crash cart. Narcan administered by charge nurse in right nare, without any response noted. Chest compressions continued by Sgt Zimmerman, deputy Turco and Cpl Wright rotating out while I provided breaths with Ambu bag. Noted raised area over his right eye and some bruising to his face(minimal), he also had abrasion to right wrist. EMS arrived and took over care of the Patient.	Jones, Yolanda	12-09-2018 8:45 pm
2018-00018862	Urgent Care Assessment (PT-037)	Condition of patient at initial presentation:	Unresponsive	Jones, Yolanda	12-09-2018 8:45 pm
2018-00018862	Urgent Care Assessment (PT-037)	Vital Signs:	*[blank]*	Jones, Yolanda	12-09-2018 8:45 pm
2018-00018862	Urgent Care Assessment (PT-037)	Disposition:	Transfer to emergency department	Jones, Yolanda	12-09-2018 8:45 pm
2018-00018862	Urgent Care Assessment (PT-037)	Condition at discharge:	Poor	Jones, Yolanda	12-09-2018 8:45 pm

Patient History Forms

(No Records)

Subjective Interview Form

(No Records)

Patient Request Forms

(No Records)

Education Forms

(No Records)

Custom Flows

Booking Number	Form Name	Form Item	Item Response	Interviewer	Interview Date
2018-00018862	Security Restraint Log	Type of Restraint:	Chair	Nadeau, Debora	12-09-2018 3:01 pm
2018-00018862	Security Restraint Log	Behavior:	Agitated	Nadeau, Debora	12-09-2018 3:01 pm
2018-00018862	Security Restraint Log	CMS (Circulation, Motion, Sensation)	Intact	Nadeau, Debora	12-09-2018 3:01 pm
2018-00018862	Security Restraint Log	Respiratory Status	Unlabored	Nadeau, Debora	12-09-2018 3:01 pm
2018-00018862	Security Restraint Log	Notes:	LATE ENTRY OCURRED AT 1400. UNABLE TO TAKE VITALS WHEN PLACED IN CHAIR DUE TO PT BEING COMBATIVE	Nadeau, Debora	12-09-2018 3:01 pm

Medications

(No Records)

MAR (Medication Administration Record)

(No Records)

Tasks

Appointment Scheduled Date	12-09-2018
Appointment Created Date	12-09-2018 4:26 pm
Appointment Description	Inmate was brought to medical at 1439 in restraint chair with O2 mask on at 15L. Inmate was unresponsive with very shallow breathing. This nurse performed a sternal rub without any response from the Inmate. This nurse instructed that 911 needed to be called now, and that we needed a sergeant to call 911 now. Sargent Zimmerman was already in the room. At 1439 this nurse instructed Nurse Robinson LPN to obtain VS as this nurse was going to begin the paperwork for the hospital transportation. This nurse heard Nurse Jones LPN state he is not breathing and that CPR needed to be initiated. The officers stated that Inmate was in a restraint chair. This nurse and Nurse Jones LPN both stated that he needs to be removed out of the restraint chair so that CPR could be initiated. This nurse grabbed the back board from the stretcher as Inmate was being released from the restraint chair. This nurse went back to the crash cart and grabbed the ambu bag. Nurse Jones began chest compressions at 1440 as this nurse was hooking up the ambu bag to 15L of O2. Nurse Jones LPN continued with chest compressions while this nurse continued with breathes with the ambu bag. At 1440 Nurse Robinson grabbed the AED and pulse ox. Nurse Jones then applied AED to Inmate. Chest compressions were then continues by Sargent Zimmerman. This nurse continues with breaths via ambu bag with 15L O2. This nurse then instructed Nurse Jones LPN to get a blood sugar on Inmate. At 1441 blood sugar was 95. Nurse Jones LPN then took over giving breaths at 1442 as this Nurse administered Narcan via right nare. Inmate continues to be unresponsive. Chest compressions rotated between Sargent Zimmerman, Corporal Wright, and Deputy Turco. EMS arrived in medical at 1450 and took over care of inmate.

Appointment Category	Urgent Referral
Priority (1=High, 5=Low)	1
Current Status	Open
Requested by Patient?	No
Appointment Set By	Fried, Ashley
Appointment Last Modified By	Fried, Ashley
Last Modified Date and Time	12-09-2018 4:26 pm
Appointment Completed By	N/A
Completed Date and Time	N/A
Appointment Change Note	*[blank]*
Change Note Type	*[blank]*
Change Note Date	*[blank]*
Change Note By	,

Appointment Scheduled Date	12-09-2018
Appointment Created Date	12-09-2018 4:28 pm
Appointment Description	The inmate was transferred unconscious, unresponsive from booking to infirmary at 14:39 and oxygen mask was on his face providing oxygen. Vital signs were unable to be identified and the nurse transferred him from the stretcher to the floor where CPR started and nurse Robinson provided oxygen while nurse Ashly called 911 and gave him chest rub, and narcane injection.CPR was continued by SRG:Zimmerman,and CPL:Wright till 1504when 911 arrived and continued CPR and provided interosseous fluid infusion. The inmate was transferred to the hospital under the care of rescue team.
Appointment Category	Urgent Referral
Priority (1=High, 5=Low)	1
Current Status	Open
Requested by Patient?	No
Appointment Set By	Abdelhady, Hany
Appointment Last Modified By	Abdelhady, Hany
Last Modified Date and Time	12-09-2018 4:28 pm
Appointment Completed By	N/A

Completed Date and Time	N/A
Appointment Change Note	*[blank]*
Change Note Type	*[blank]*
Change Note Date	*[blank]*
Change Note By	,

Appointment Scheduled Date	12-09-2018
Appointment Created Date	12-09-2018 8:45 pm
Appointment Description	Continuance of previous noted that I wasn't able to finish. After checking patients glucose, Charge nurse asked nurse Robinson to grab narcan from the crash cart. Narcan administered by charge nurse in right nare, without any response noted. Chest compressions continued by Sgt Zimmerman, deputy Turco and Cpl Wright rotating out while I provided breaths with Ambu bag. Noted raised area over his right eye and some bruising to his face(minimal), he also had abrasion to right wrist. EMS arrived and took over care of the Patient.
Appointment Category	Urgent Referral
Priority (1=High, 5=Low)	1
Current Status	Open
Requested by Patient?	No
Appointment Set By	Jones, Yolanda
Appointment Last Modified By	Jones, Yolanda
Last Modified Date and Time	12-09-2018 8:45 pm
Appointment Completed By	N/A
Completed Date and Time	N/A
Appointment Change Note	*[blank]*
Change Note Type	*[blank]*
Change Note Date	*[blank]*
Change Note By	,

Appointment Scheduled Date	12-09-2018
Appointment Created Date	12-09-2018 8:45 pm
Appointment Description	Continuance of previous noted that I wasn't able to finish. After checking patients glucose, Charge nurse asked nurse Robinson to grab narcan from the crash cart. Narcan administered by charge nurse in right nare, without any response noted. Chest compressions continued by Sgt Zimmerman, deputy Turco and Cpl Wright rotating out while I provided breaths with Ambu bag. Noted raised area over his right eye and some bruising to his face(minimal), he also had abrasion to right wrist. EMS arrived and took over care of the Patient.
Appointment Category	Urgent Referral

Priority (1=High, 5=Low)	3
Current Status	Open
Requested by Patient?	No
Appointment Set By	Jones, Yolanda
Appointment Last Modified By	Jones, Yolanda
Last Modified Date and Time	12-09-2018 8:45 pm
Appointment Completed By	N/A
Completed Date and Time	N/A
Appointment Change Note	*[blank]*
Change Note Type	*[blank]*
Change Note Date	*[blank]*
Change Note By	,

Appointment Scheduled Date	12-09-2018
Appointment Created Date	12-09-2018 4:28 pm
Appointment Description	The inmate was transferred unconscious, unresponsive from booking to infirmary at 14:39 and oxygen mask was on his face providing oxygen. Vital signs were unable to be identified and the nurse transferred him from the stretcher to the floor where CPR started and nurse Robinson provided oxygen while nurse Ashly called 911 and gave him chest rub, and narcane injection.CPR was continued by SRG:Zimmerman,and CPL:Wright till 1504when 911 arrived and continued CPR and provided interosseous fluid infusion. The inmate was transferred to the hospital under the care of rescue team.
Appointment Category	Urgent Referral
Priority (1=High, 5=Low)	3
Current Status	Open
Requested by Patient?	No
Appointment Set By	Abdelhady, Hany
Appointment Last Modified By	Abdelhady, Hany
Last Modified Date and Time	12-09-2018 4:28 pm
Appointment Completed By	N/A
Completed Date and Time	N/A
Appointment Change Note	*[blank]*
Change Note Type	*[blank]*

Change Note Date	*[blank]*
Change Note By	,

Appointment Scheduled Date	12-09-2018
Appointment Created Date	12-09-2018 4:26 pm
Appointment Description	Inmate was brought to medical at 1439 in restraint chair with O2 mask on at 15L. Inmate was unresponsive with very shallow breathing. This nurse performed a sternal rub without any response from the Inmate. This nurse instructed that 911 needed to be called now, and that we needed a sergeant to call 911 now. Sargent Zimmerman was already in the room. At 1439 this nurse instructed Nurse Robinson LPN to obtain VS as this nurse was going to begin the paperwork for the hospital transportation. This nurse heard Nurse Jones LPN state he is not breathing and that CPR needed to be initiated. The officers stated that Inmate was in a restraint chair. This nurse and Nurse Jones LPN both stated that he needs to be removed out of the restraint chair so that CPR could be initiated. This nurse grabbed the back board from the stretcher as Inmate was being released from the restraint chair. This nurse went back to the crash cart and grabbed the ambu bag. Nurse Jones began chest compressions at 1440 as this nurse was hooking up the ambu bag to 15L of O2. Nurse Jones LPN continued with chest compressions while this nurse continued with breathes with the ambu bag. At 1440 Nurse Robinson grabbed the AED and pulse ox. Nurse Jones then applied AED to Inmate. Chest compressions were then continues by Sargent Zimmerman. This nurse continues with breaths via ambu bag with 15L O2. This nurse then instructed Nurse Jones LPN to get a blood sugar on Inmate. At 1441 blood sugar was 95. Nurse Jones LPN then took over giving breaths at 1442 as this Nurse administered Narcan via right nare. Inmate continues to be unresponsive. Chest compressions rotated between Sargent Zimmerman, Corporal Wright, and Deputy Turco. EMS arrived in medical at 1450 and took over care of inmate.
Appointment Category	Urgent Referral
Priority (1=High, 5=Low)	3
Current Status	Open
Requested by Patient?	No
Appointment Set By	Fried, Ashley
Appointment Last Modified By	Fried, Ashley
Last Modified Date and Time	12-09-2018 4:26 pm
Appointment Completed By	N/A
Completed Date and Time	N/A
Appointment Change Note	*[blank]*
Change Note Type	*[blank]*
Change Note Date	*[blank]*
Change Note By	,

Chart Notes

Note Date	Note Text	Note By	Note Access	Note Type
12-09-2018 3:37 pm	PT WAS BROUGHT IN TO BOOKING APROX 1330 AND PLACED IN HOLDING CELL TO BE PROCESSED, PT WAS BANGING ON WINDOW AND APPEARED AGITATED. MY CONTACT WITH PT WAS WHEN PT BECAME COMBATIVE WITH SECURITY AND WAS PLACED IN RESTRAINT CHAIR AFTER BEING MACED AND TASED, PT WAS HOLLERING AND TRYING TO GET LOOSE FROM CHAIR, WAS UNABLE TO OBTAIN VITALS AT THIS TIME. APPROX 1430 PT STOPPED HOLLERING AND WAS OBSERVED BY SECURITY SLUMPED AND UNRESPONSIVE. PT WAS UNRESPONSIVE TO VERBAL STIMULI, NURSE APPLIED OXYGEN VIA MASK AND PT RESPONDED BY BLINKING AND CHEST WAS OBSERVED RISING TO BREATHS, PULSE WAS AT 64 BEATS PER MINUTE AND 02 WAS AT 98%. PT WAS THEN TRANSFERRED TO MEDICAL VIA CHAIR WITH OXYGEN TO CHARGE NURSE FOR FURTHER EVALUATION.	Nadeau, Debora	Medical Staff	Misc. Note

Problems

(No Records)

Vital Signs

Date of Reading	12-09-2018 8:45 pm
Date Entered	12-09-2018 8:45 pm
Blood Pressure Sitting	/
Blood Pressure Standing	*[blank]*
Pulse Sitting	*[blank]*
Pulse Standing	*[blank]*
Respiration	*[blank]*
Temperature	*[blank]*
Weight	*[blank]*
SPO2	*[blank]*
Notes	*[blank]*

Date of Reading	12-09-2018 4:37 pm
Date Entered	12-09-2018 4:37 pm
Blood Pressure Sitting	/
Blood Pressure Standing	*[blank]*
Pulse Sitting	*[blank]*
Pulse Standing	*[blank]*
Respiration	*[blank]*
Temperature	*[blank]*
Weight	*[blank]*
SPO2	*[blank]*
Notes	*[blank]*

Date of Reading	12-09-2018 4:35 pm
Date Entered	12-09-2018 4:35 pm
Blood Pressure Sitting	/
Blood Pressure Standing	*[blank]*
Pulse Sitting	*[blank]*
Pulse Standing	*[blank]*
Respiration	*[blank]*
Temperature	*[blank]*
Weight	*[blank]*
SPO2	*[blank]*
Notes	unable to obtained

Date of Reading	12-09-2018 4:28 pm
Date Entered	12-09-2018 4:28 pm
Blood Pressure Sitting	/
Blood Pressure Standing	*[blank]*
Pulse Sitting	*[blank]*
Pulse Standing	*[blank]*
Respiration	*[blank]*
Temperature	*[blank]*
Weight	*[blank]*
SPO2	*[blank]*
Notes	*[blank]*

Date of Reading	12-09-2018 4:26 pm
Date Entered	12-09-2018 4:26 pm
Blood Pressure Sitting	/
Blood Pressure Standing	*[blank]*
Pulse Sitting	*[blank]*
Pulse Standing	*[blank]*
Respiration	*[blank]*
Temperature	*[blank]*
Weight	*[blank]*
SPO2	*[blank]*
Notes	*[blank]*

Date of Reading	12-09-2018 4:06 pm
Date Entered	12-09-2018 4:06 pm
Blood Pressure Sitting	/
Blood Pressure Standing	*[blank]*
Pulse Sitting	*[blank]*
Pulse Standing	*[blank]*
Respiration	*[blank]*
Temperature	*[blank]*

Weight	*[blank]*
SPO2	*[blank]*
Notes	Was unable to obtain vitals at that time.

Date of Reading	12-09-2018 4:04 pm
Date Entered	12-09-2018 4:04 pm
Blood Pressure Sitting	/
Blood Pressure Standing	*[blank]*
Pulse Sitting	*[blank]*
Pulse Standing	*[blank]*
Respiration	*[blank]*
Temperature	*[blank]*
Weight	*[blank]*
SPO2	*[blank]*
Notes	unable to obtain at this time

Date of Reading	12-09-2018 2:59 pm
Date Entered	12-09-2018 2:59 pm
Blood Pressure Sitting	/
Blood Pressure Standing	*[blank]*
Pulse Sitting	*[blank]*
Pulse Standing	*[blank]*
Respiration	*[blank]*
Temperature	*[blank]*
Weight	*[blank]*
SPO2	*[blank]*
Notes	NOT ABLE TO APPROACH FOR VITALS

Blood Glucose Levels

(No Records)

Medical Sick Calls

(No Records)

Dental Sick Calls

(No Records)

Mental Health Sick Calls

(No Records)

Alerts

(No Records)

Lab Results

(No Records)

Radiology Results

(No Records)

Smoking Notes

(No Records)

Incident Summary Report

Incident ID	12090000	A435
Incident Time	12/9/2018 15:42:11	
Serial Number:	04310653	12090000.stm
Model Number:	00009395	
Responder ID		
Patient ID:		
Social Security Number:		
Date of Birth:		
Age:	0	
Sex:		
Race:		
Patient Name:		
Address:		

Telephone Numbers:

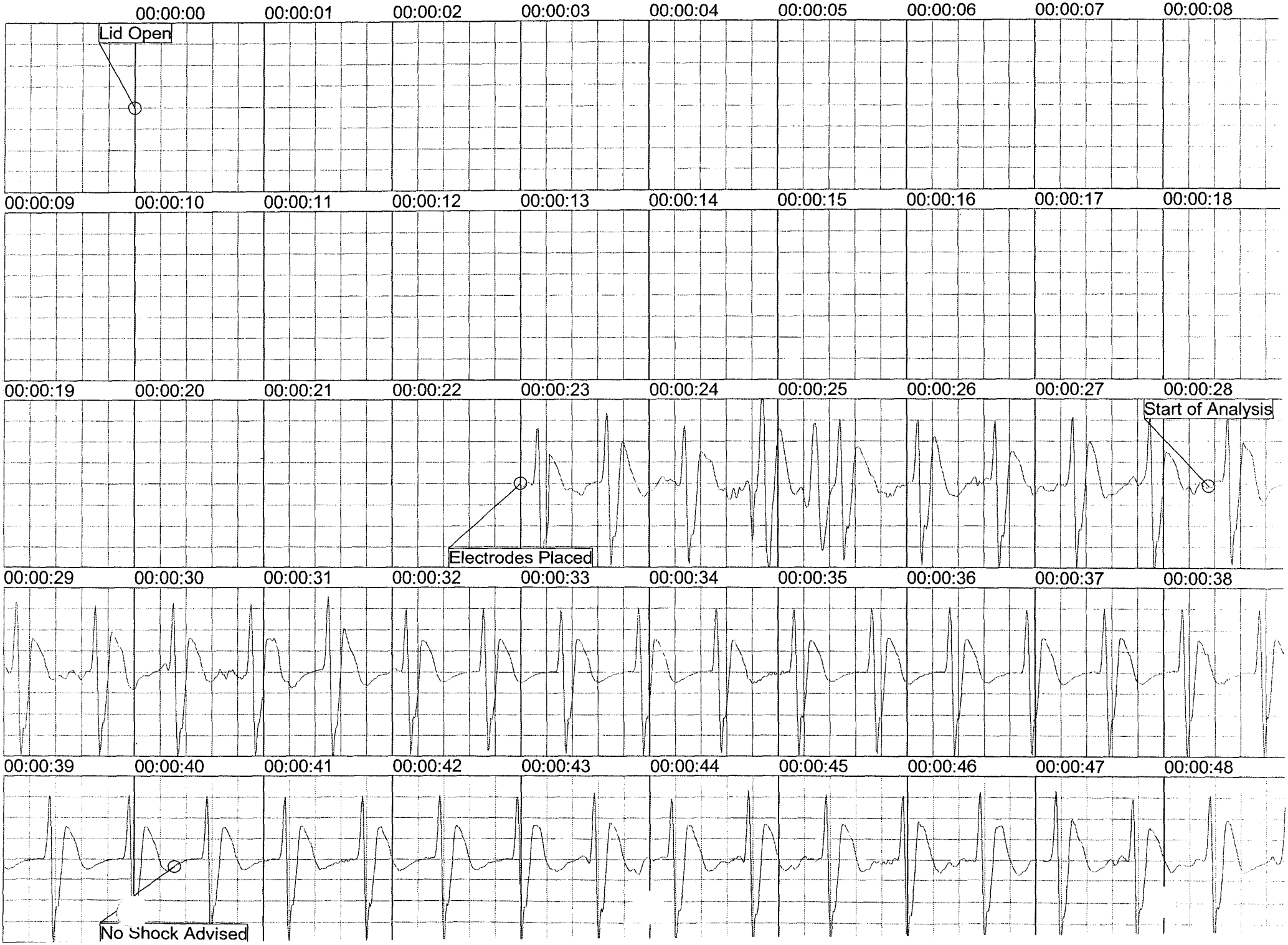
Event List Summary Report
Model Number: 00009395, Serial Number: 04310653

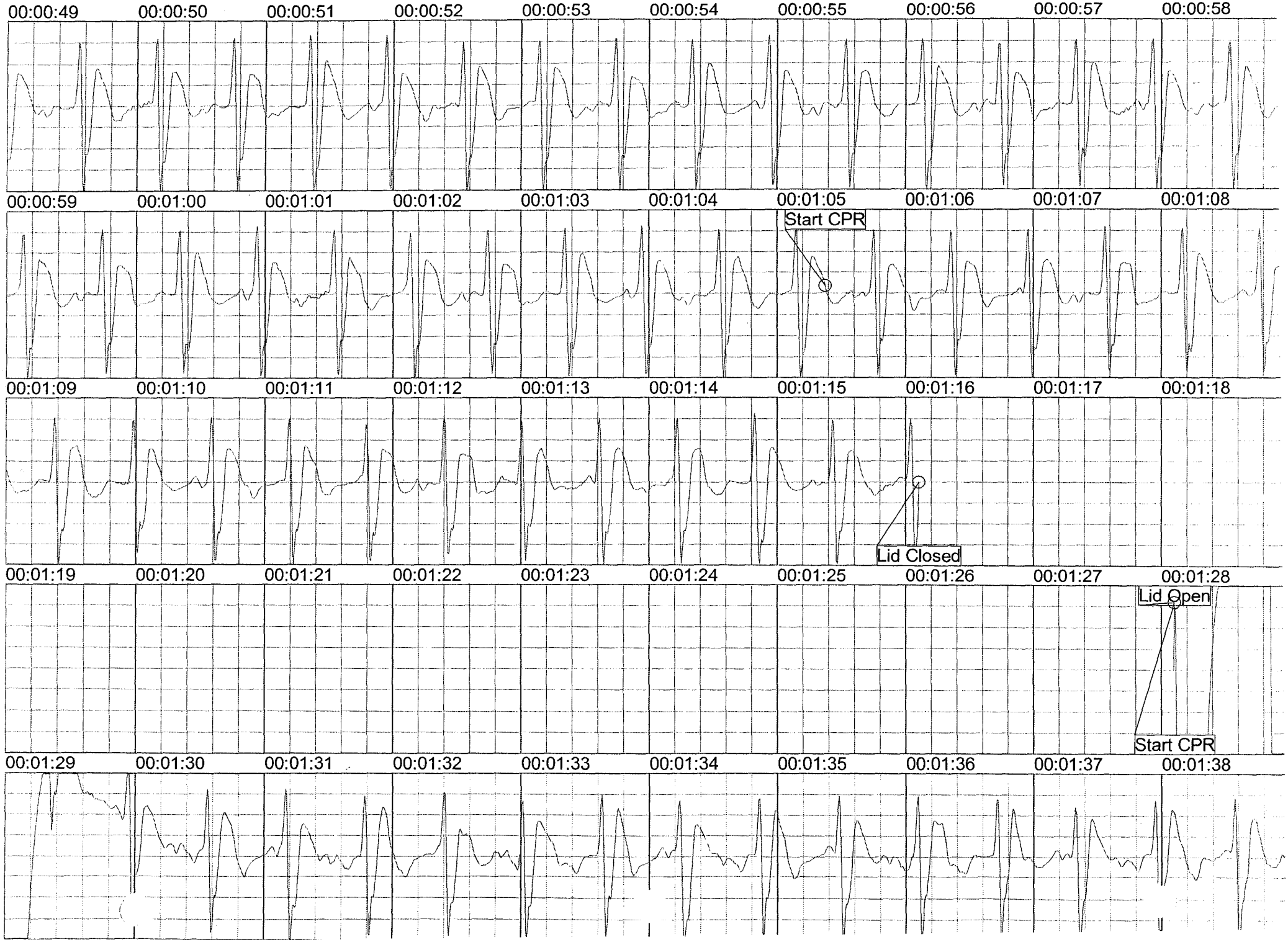
Event	Actual Time	Elapsed Time	Comments
Lid Open	15:42:11	00:00:00	
Electrodes Placed	15:42:34	00:00:23	
Start of Analysis	15:42:39	00:00:28	Analysis #0
No Shock Advised	15:42:51	00:00:40	
Start CPR	15:43:16	00:01:05	
Lid Closed	15:43:27	00:01:16	
Lid Open	15:43:39	00:01:28	
Start CPR	15:43:39	00:01:28	
End CPR	15:45:40	00:03:29	
Start of Analysis	15:45:47	00:03:36	Analysis #1
No Shock Advised	15:45:59	00:03:48	
Start CPR	15:46:24	00:04:13	
End CPR	15:48:51	00:06:40	
Start of Analysis	15:48:58	00:06:47	Analysis #2
No Shock Advised	15:49:10	00:06:59	
Start CPR	15:49:20	00:07:09	
End CPR	15:51:47	00:09:36	
Start of Analysis	15:51:54	00:09:43	Analysis #3
No Shock Advised	15:52:05	00:09:54	
Start CPR	15:52:16	00:10:05	

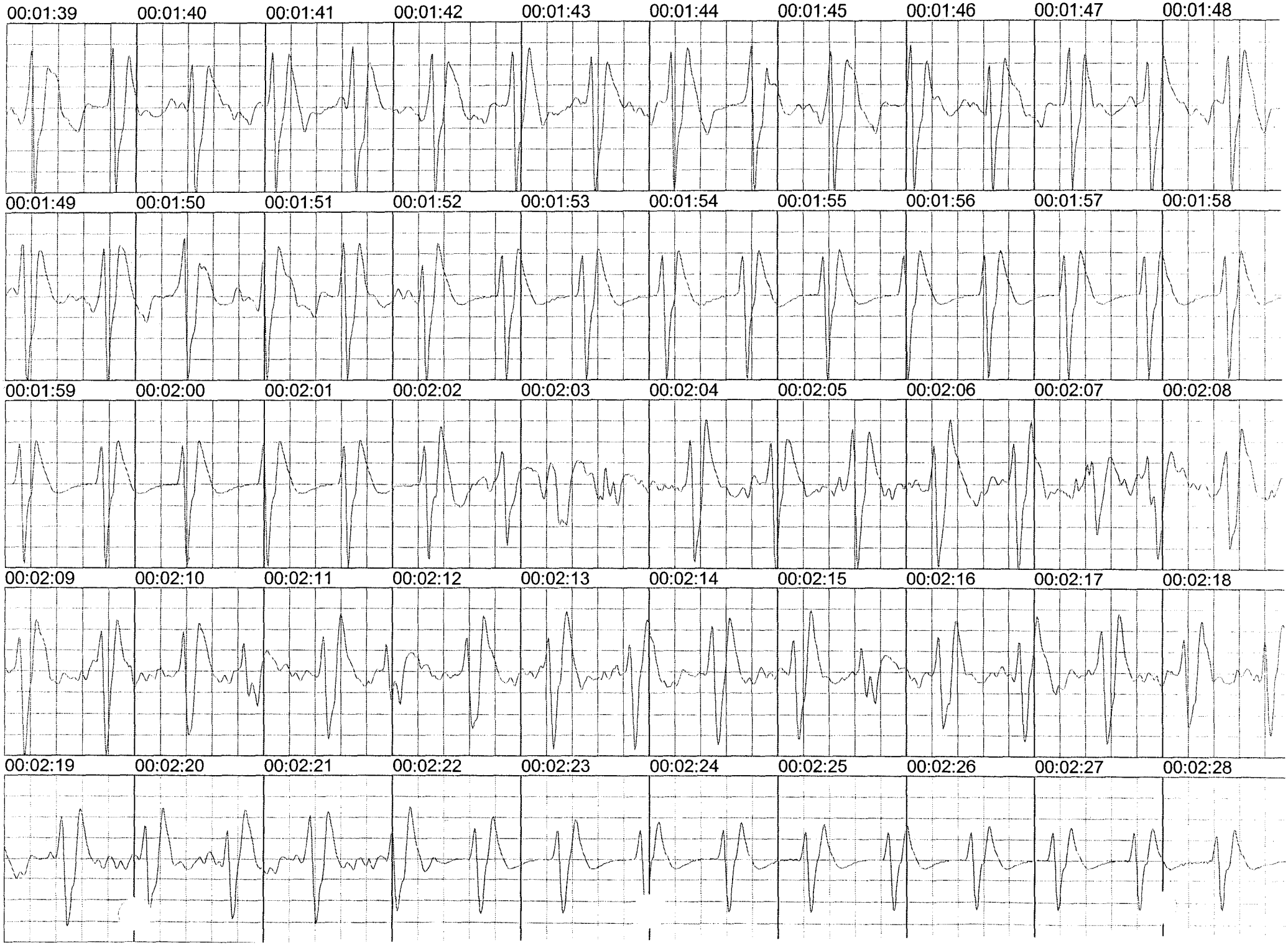
Lid Closed	15:52:36	00:10:25

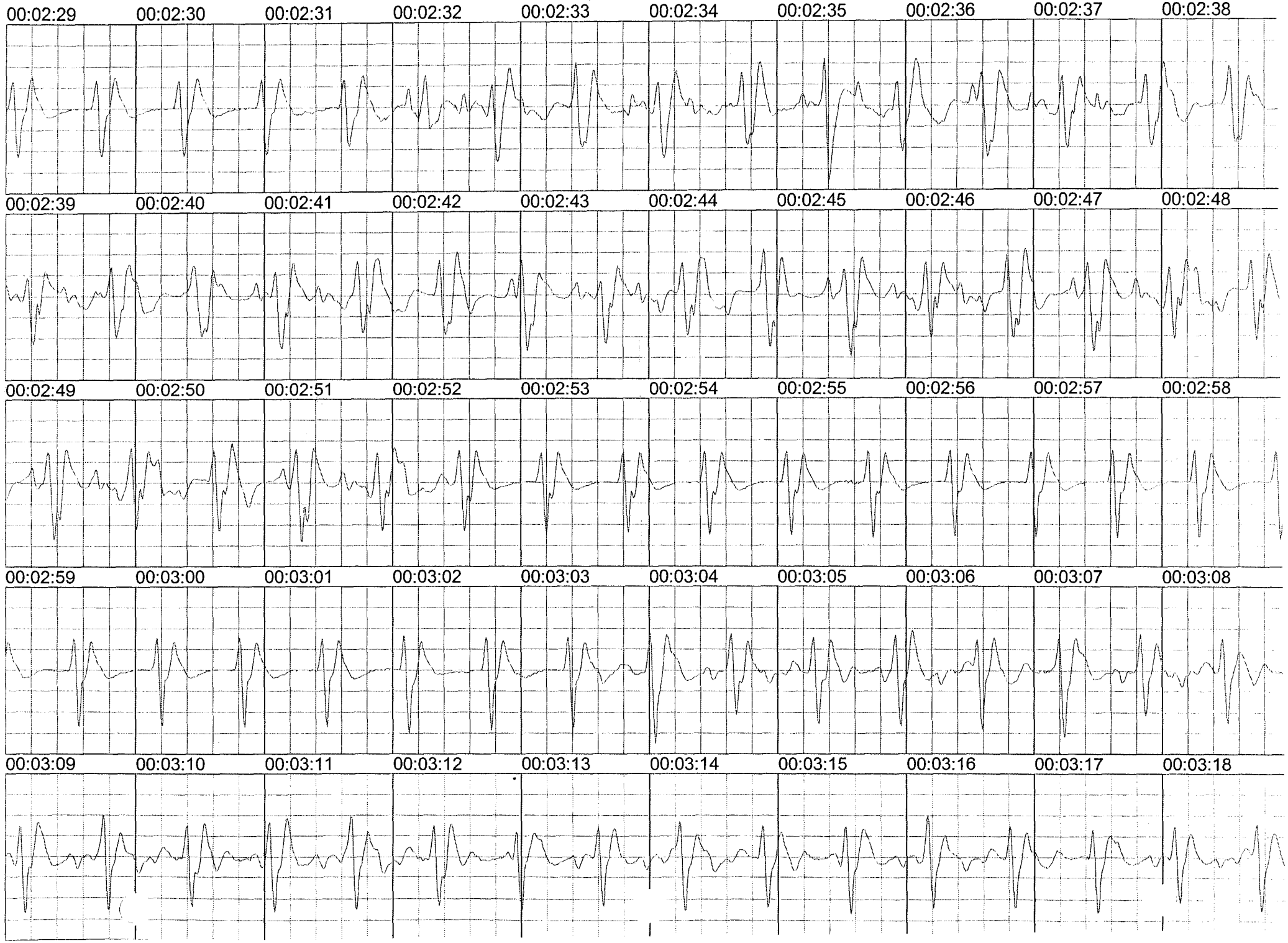
AED Operating Parameters
Model Number: 00009395, Serial Number: 04310653

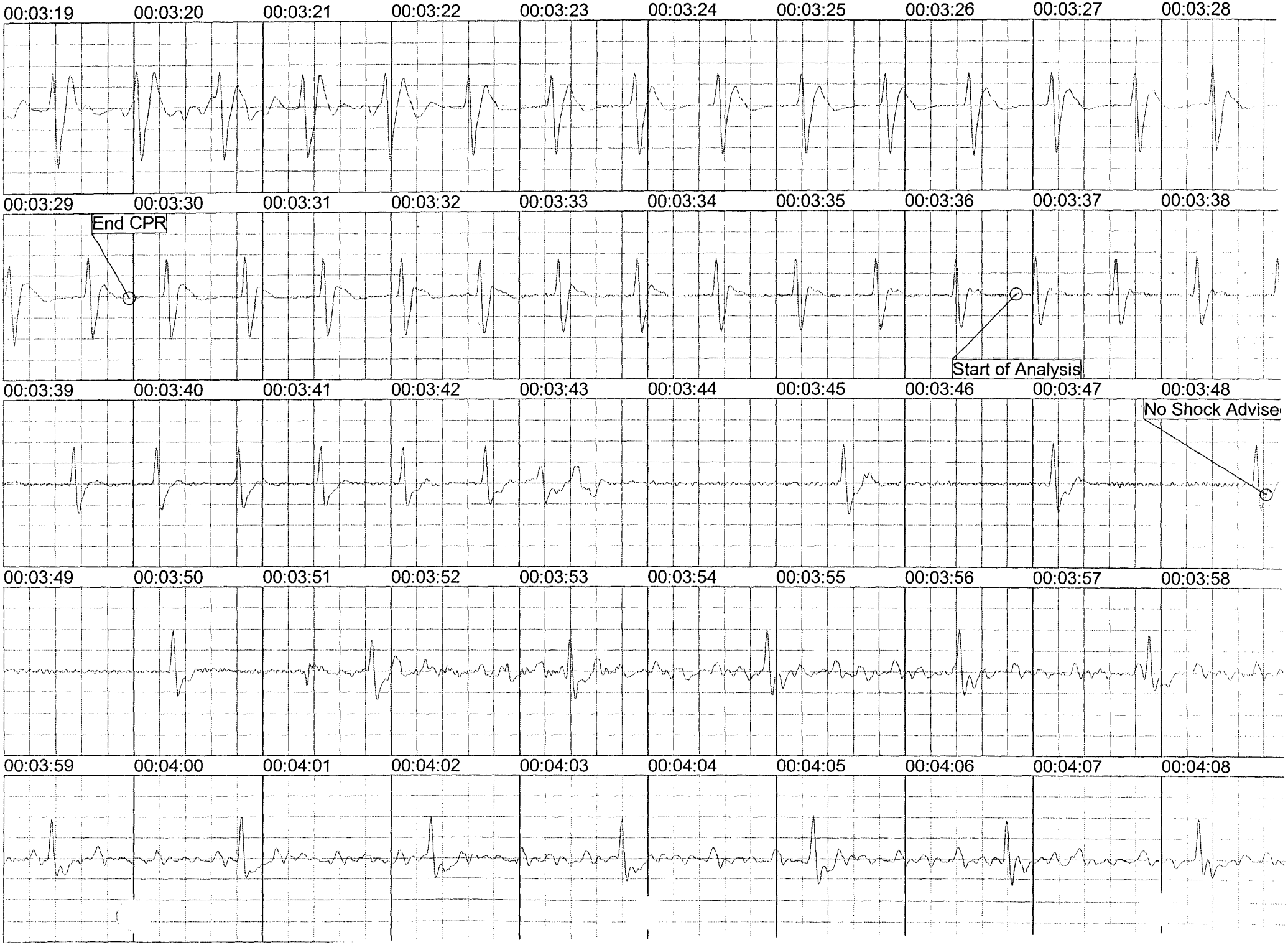
Serial Number:	04310653
Model Number:	00009395
Code Version:	A435
Continue CPR prompt:	Press (Enhanced)
CPR Time:	135 seconds
Daylight Saving Time:	Enabled
Electrode Test:	Enabled
Energy Protocol:	200VE 300VE 300VE
Maximum Shocks per Rescue:	99
Same Energy After Conversion:	Enabled
SVT Rate:	No Therapy for SVT
VF/VT Rate:	160
Initial Prompt:	Call 911
Prompt Sound Volume:	Normal
User defined Identification:	

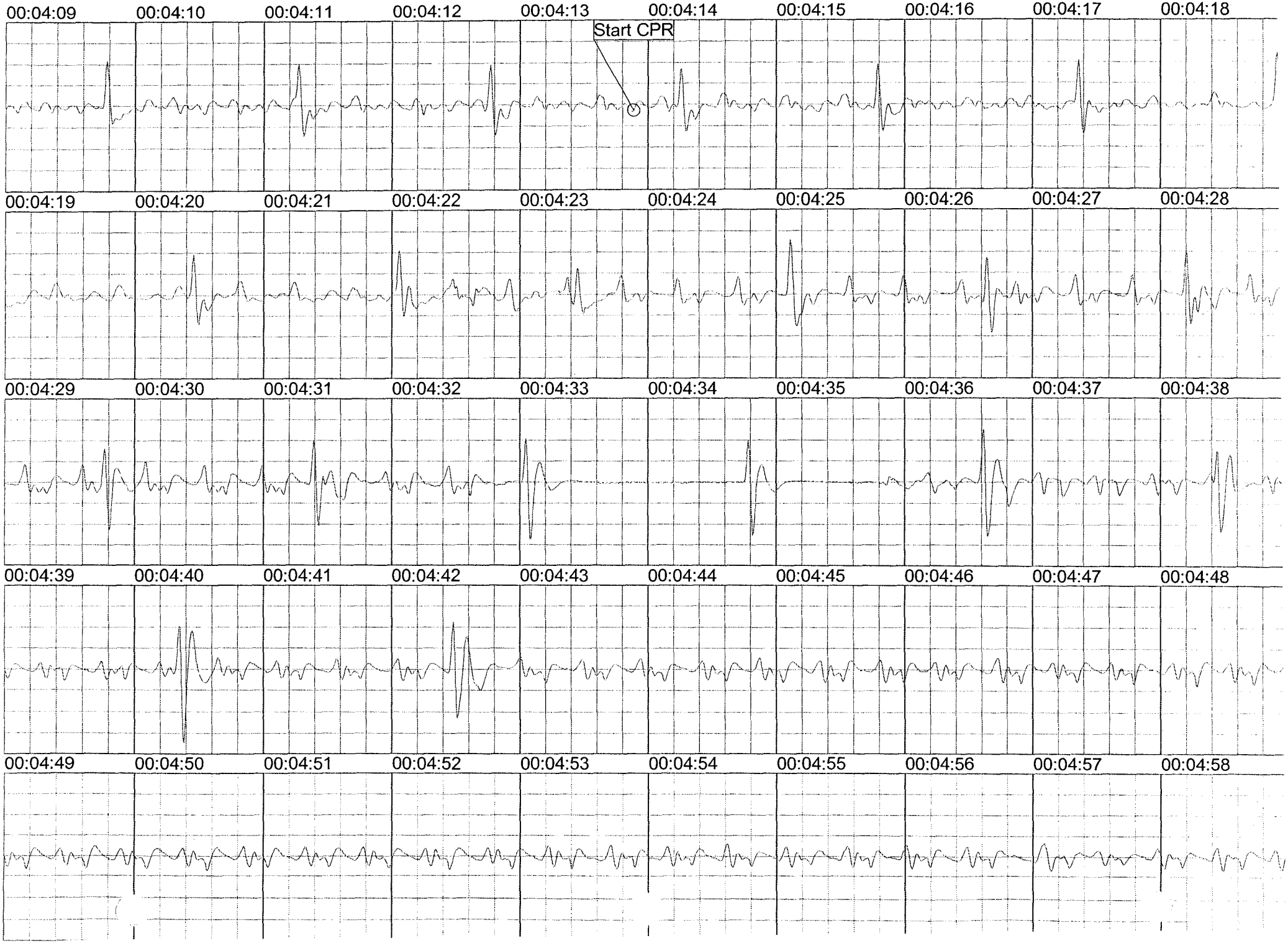

00:00:00
00:00:01
00:00:02
00:00:03
00:00:04
00:00:05
00:00:06
00:00:07
00:00:08
Lid Open
00:00:09
00:00:10
00:00:11
00:00:12
00:00:13
00:00:14
00:00:15
00:00:16
00:00:17
00:00:18
00:00:19
00:00:20
00:00:21
00:00:22
00:00:23
00:00:24
00:00:25
00:00:26
00:00:27
00:00:28
Start of Analysis
Electrodes Placed
00:00:29
00:00:30
00:00:31
00:00:32
00:00:33
00:00:34
00:00:35
00:00:36
00:00:37
00:00:38
00:00:39
00:00:40
00:00:41
00:00:42
00:00:43
00:00:44
00:00:45
00:00:46
00:00:47
00:00:48
No Shock Advised

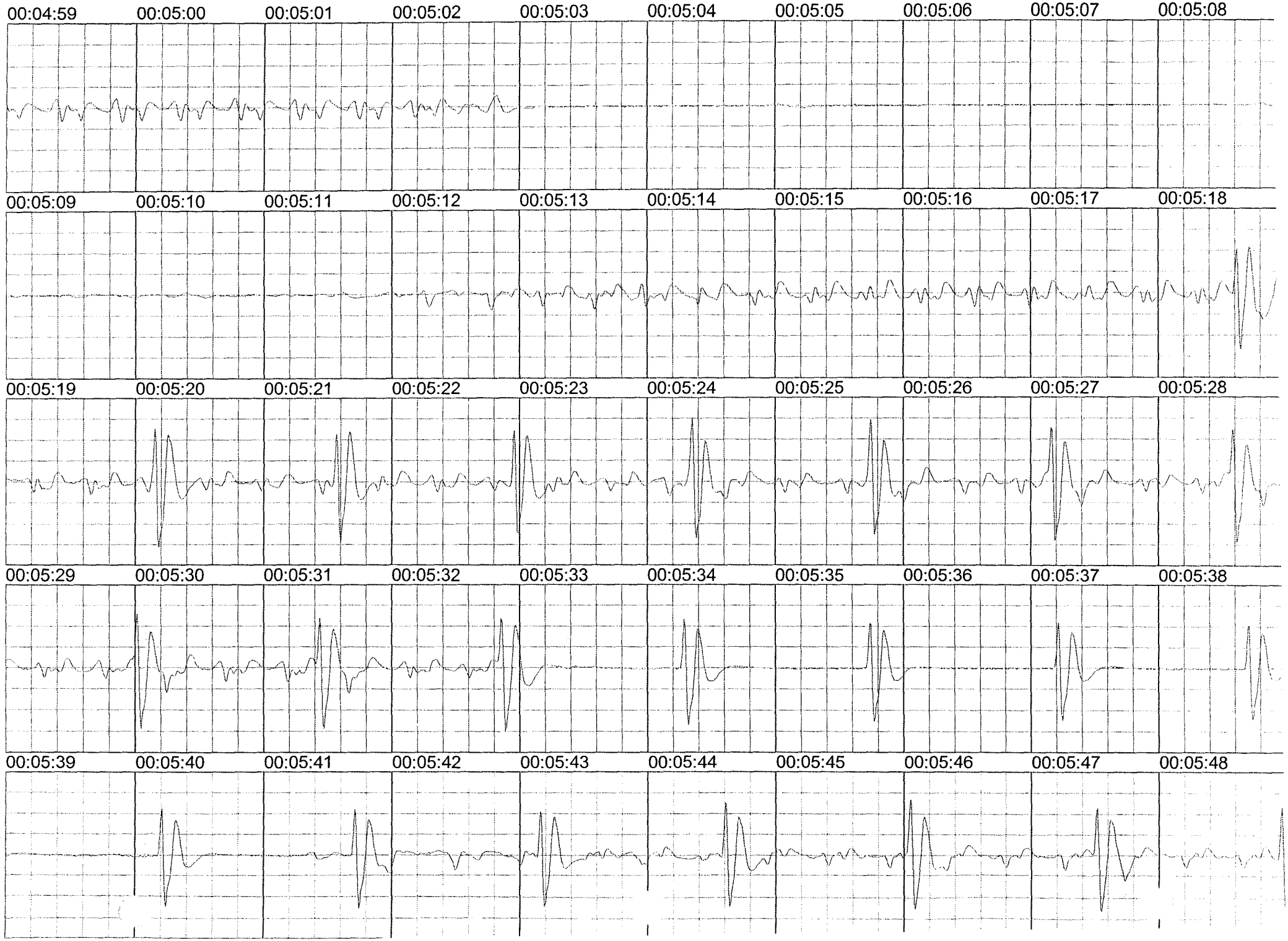

00:00:49
00:00:50
00:00:51
00:00:52
00:00:53
00:00:54
00:00:55
00:00:56
00:00:57
00:00:58
00:00:59
00:01:00
00:01:01
00:01:02
00:01:03
00:01:04
00:01:05
00:01:06
00:01:07
00:01:08
Start CPR
00:01:09
00:01:10
00:01:11
00:01:12
00:01:13
00:01:14
00:01:15
00:01:16
00:01:17
00:01:18
Lid Closed
00:01:19
00:01:20
00:01:21
00:01:22
00:01:23
00:01:24
00:01:25
00:01:26
00:01:27
00:01:28
Lid Open
Start CPR
00:01:29
00:01:30
00:01:31
00:01:32
00:01:33
00:01:34
00:01:35
00:01:36
00:01:37
00:01:38

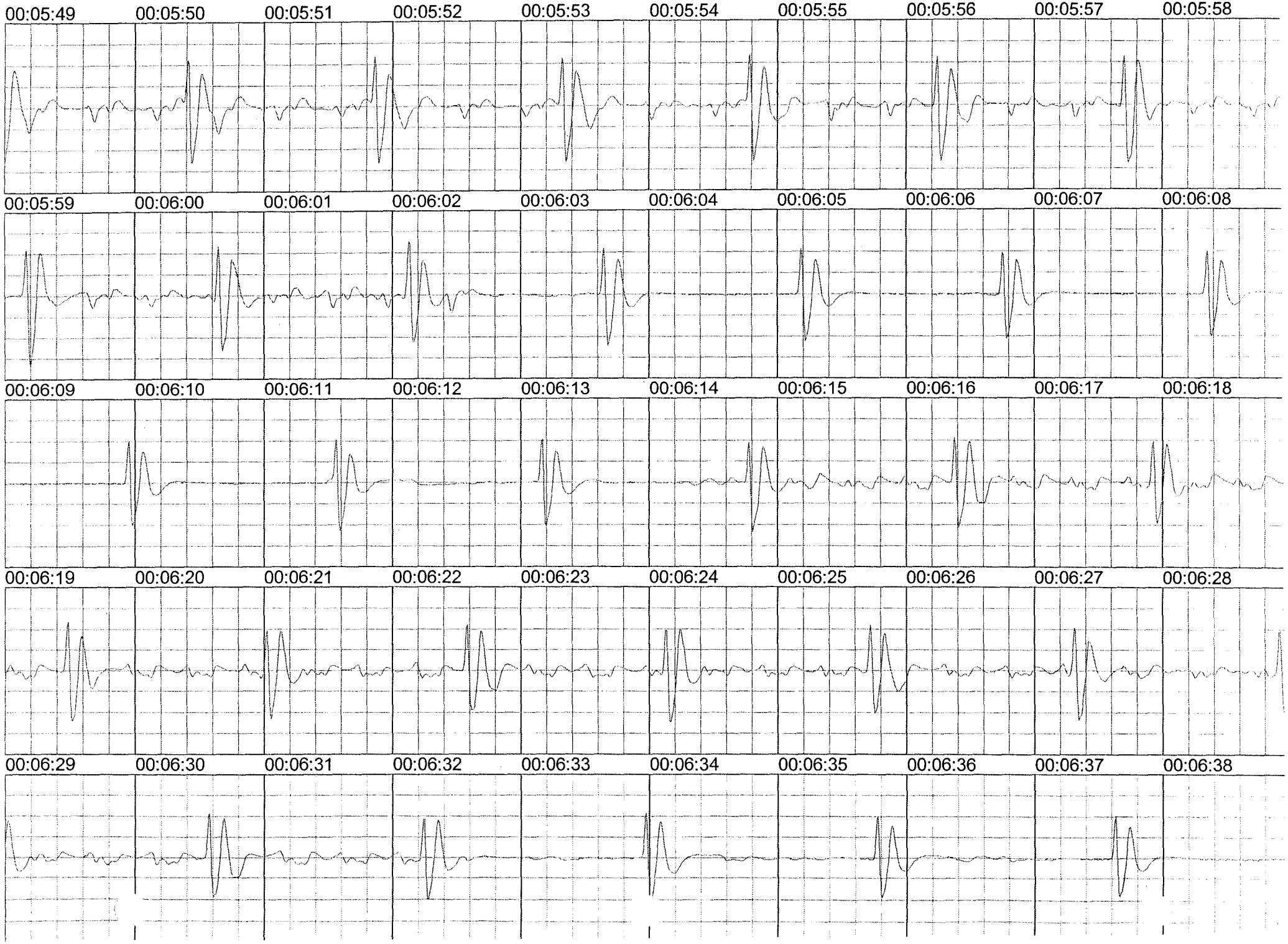

00:01:39
00:01:40
00:01:41
00:01:42
00:01:43
00:01:44
00:01:45
00:01:46
00:01:47
00:01:48
00:01:49
00:01:50
00:01:51
00:01:52
00:01:53
00:01:54
00:01:55
00:01:56
00:01:57
00:01:58
00:01:59
00:02:00
00:02:01
00:02:02
00:02:03
00:02:04
00:02:05
00:02:06
00:02:07
00:02:08
00:02:09
00:02:10
00:02:11
00:02:12
00:02:13
00:02:14
00:02:15
00:02:16
00:02:17
00:02:18
00:02:19
00:02:20
00:02:21
00:02:22
00:02:23
00:02:24
00:02:25
00:02:26
00:02:27
00:02:28

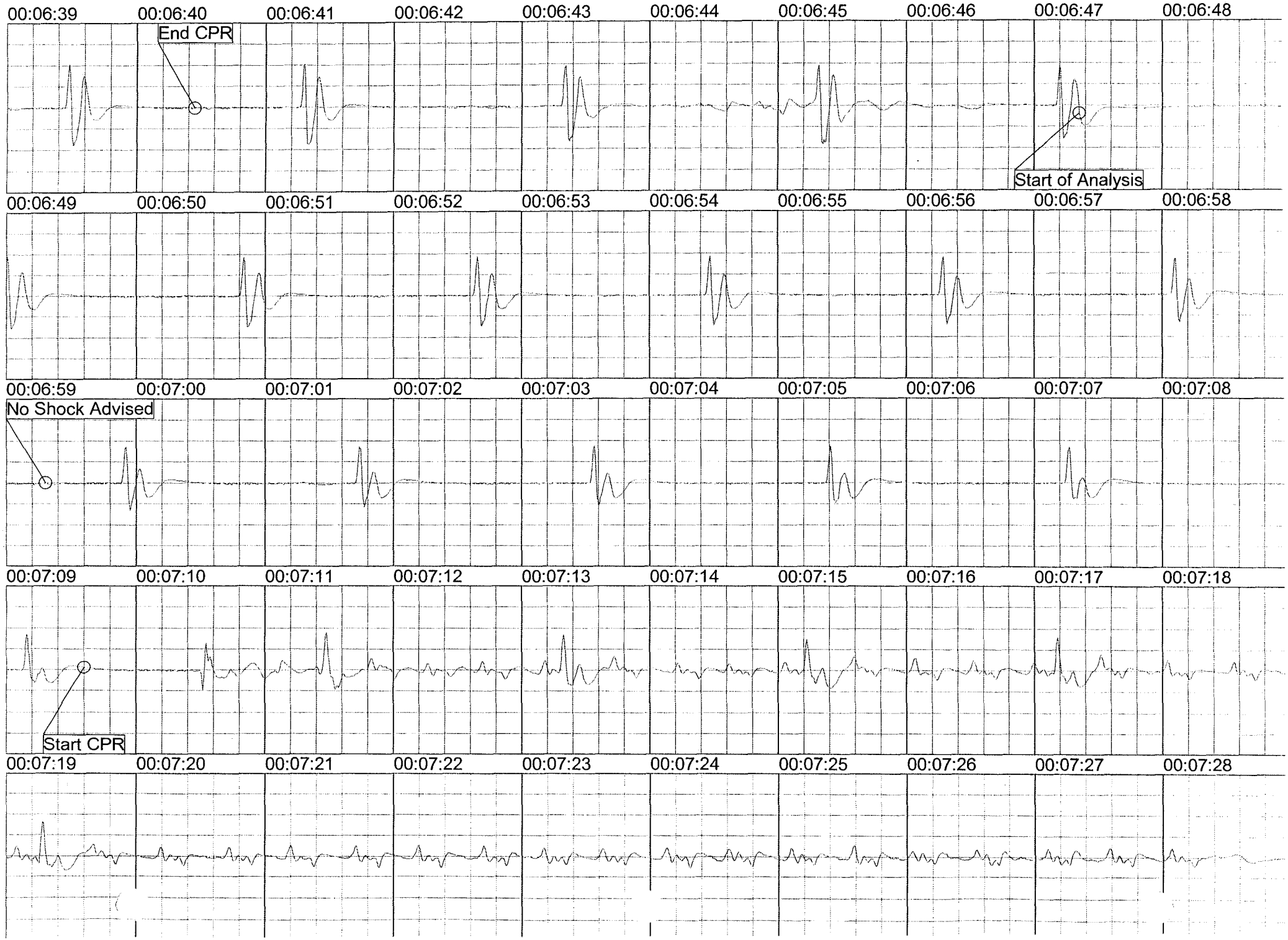

00:02:29
00:02:30
00:02:31
00:02:32
00:02:33
00:02:34
00:02:35
00:02:36
00:02:37
00:02:38
00:02:39
00:02:40
00:02:41
00:02:42
00:02:43
00:02:44
00:02:45
00:02:46
00:02:47
00:02:48
00:02:49
00:02:50
00:02:51
00:02:52
00:02:53
00:02:54
00:02:55
00:02:56
00:02:57
00:02:58
00:02:59
00:03:00
00:03:01
00:03:02
00:03:03
00:03:04
00:03:05
00:03:06
00:03:07
00:03:08
00:03:09
00:03:10
00:03:11
00:03:12
00:03:13
00:03:14
00:03:15
00:03:16
00:03:17
00:03:18

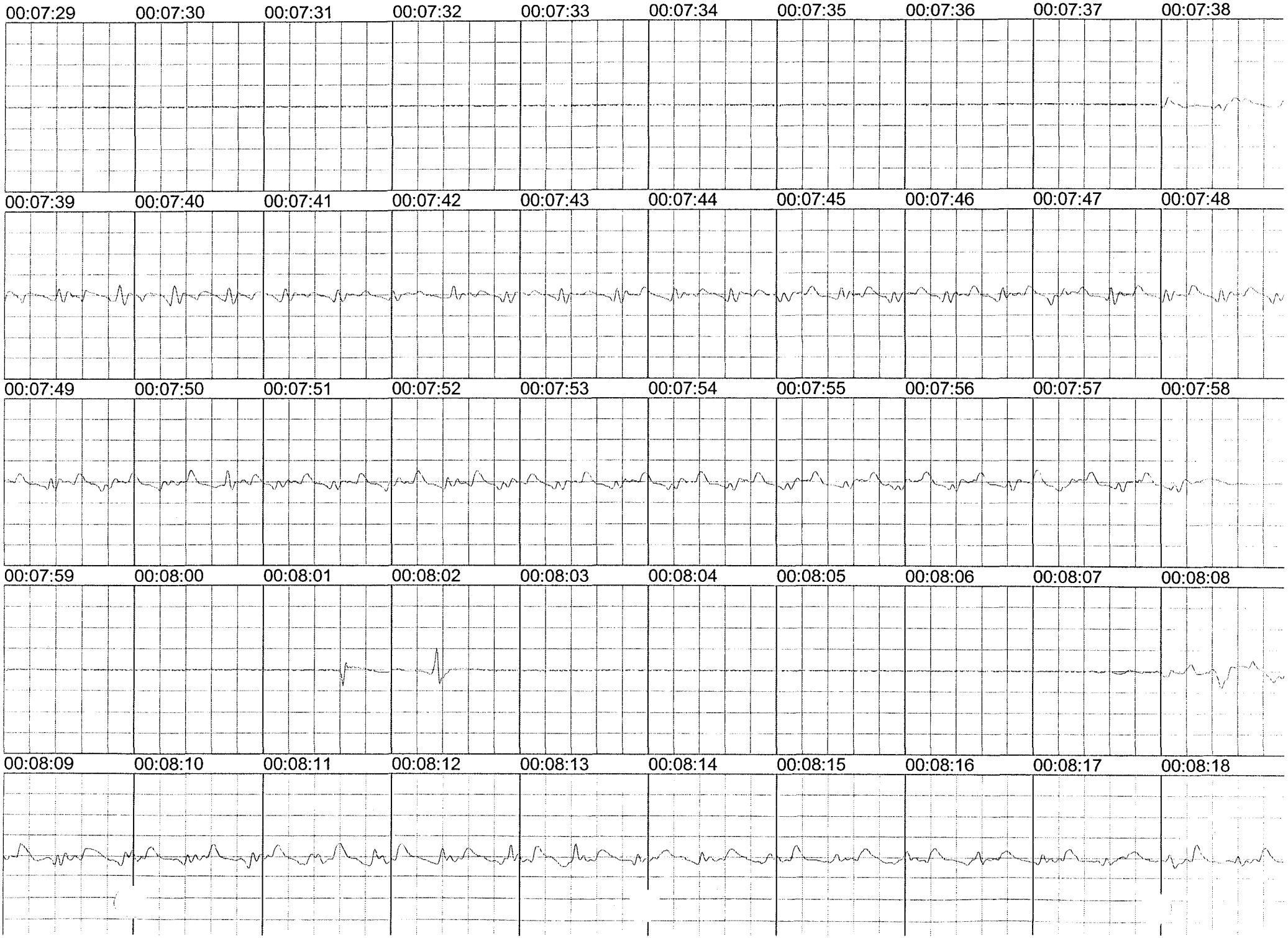

00:03:19
00:03:20
00:03:21
00:03:22
00:03:23
00:03:24
00:03:25
00:03:26
00:03:27
00:03:28
00:03:29
00:03:30
End CPR
00:03:31
00:03:32
00:03:33
00:03:34
00:03:35
00:03:36
00:03:37
00:03:38
Start of Analysis
00:03:39
00:03:40
00:03:41
00:03:42
00:03:43
00:03:44
00:03:45
00:03:46
00:03:47
00:03:48
No Shock Advise
00:03:49
00:03:50
00:03:51
00:03:52
00:03:53
00:03:54
00:03:55
00:03:56
00:03:57
00:03:58
00:03:59
00:04:00
00:04:01
00:04:02
00:04:03
00:04:04
00:04:05
00:04:06
00:04:07
00:04:08

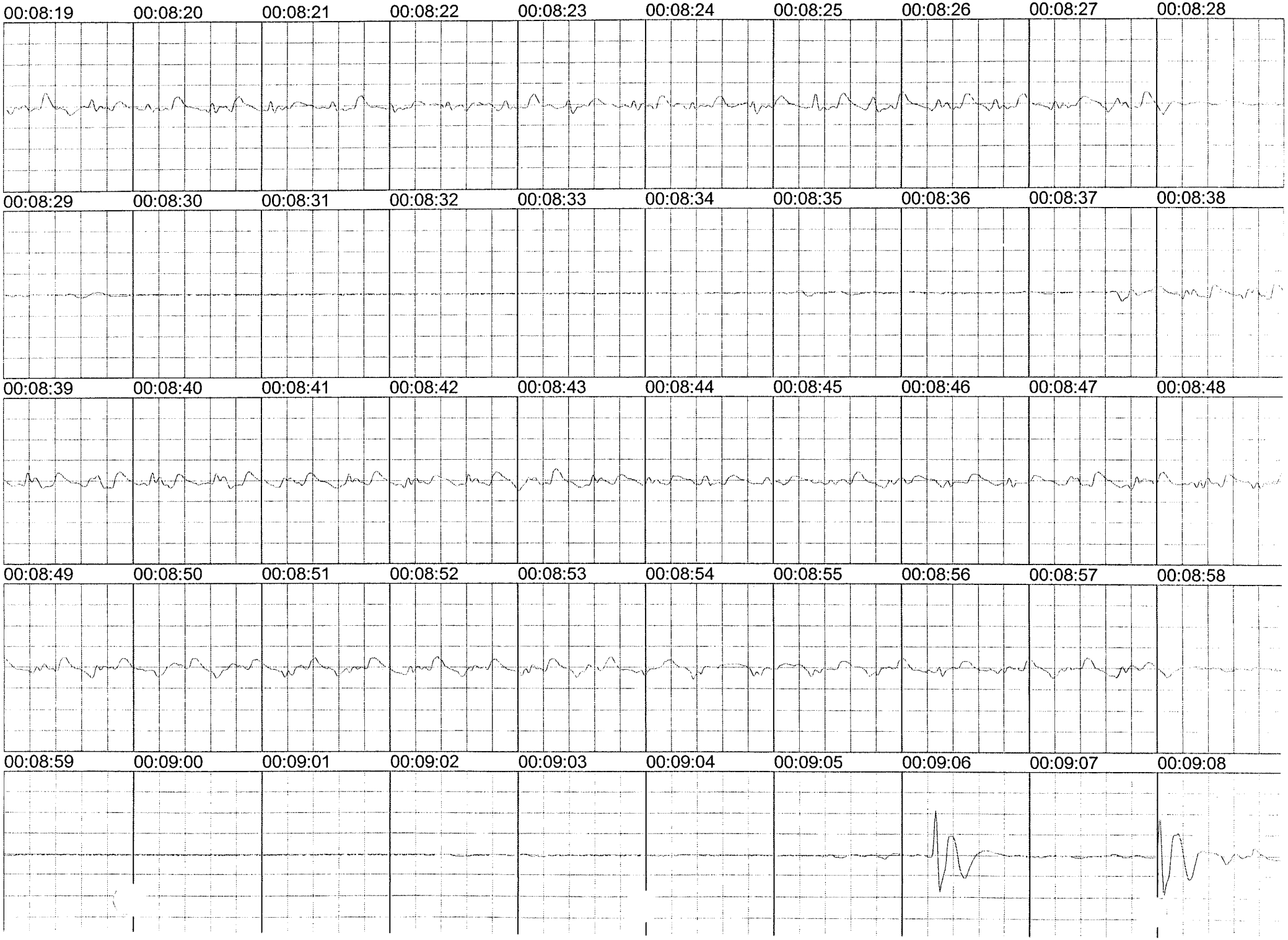

00:04:09
00:04:10
00:04:11
00:04:12
00:04:13
Start CPR
00:04:14
00:04:15
00:04:16
00:04:17
00:04:18
00:04:19
00:04:20
00:04:21
00:04:22
00:04:23
00:04:24
00:04:25
00:04:26
00:04:27
00:04:28
00:04:29
00:04:30
00:04:31
00:04:32
00:04:33
00:04:34
00:04:35
00:04:36
00:04:37
00:04:38
00:04:39
00:04:40
00:04:41
00:04:42
00:04:43
00:04:44
00:04:45
00:04:46
00:04:47
00:04:48
00:04:49
00:04:50
00:04:51
00:04:52
00:04:53
00:04:54
00:04:55
00:04:56
00:04:57
00:04:58

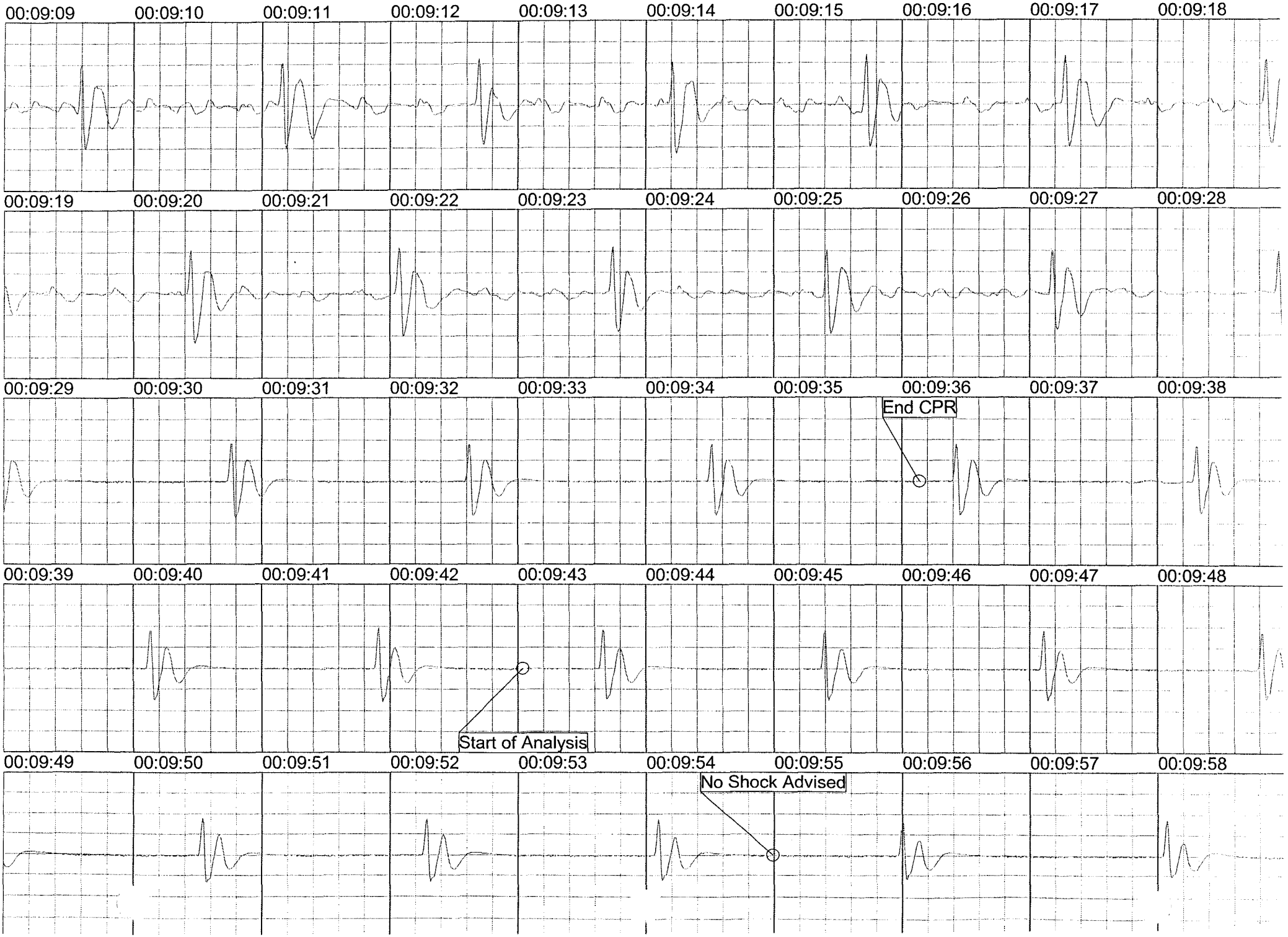

00:04:59
00:05:00
00:05:01
00:05:02
00:05:03
00:05:04
00:05:05
00:05:06
00:05:07
00:05:08
00:05:09
00:05:10
00:05:11
00:05:12
00:05:13
00:05:14
00:05:15
00:05:16
00:05:17
00:05:18
00:05:19
00:05:20
00:05:21
00:05:22
00:05:23
00:05:24
00:05:25
00:05:26
00:05:27
00:05:28
00:05:29
00:05:30
00:05:31
00:05:32
00:05:33
00:05:34
00:05:35
00:05:36
00:05:37
00:05:38
00:05:39
00:05:40
00:05:41
00:05:42
00:05:43
00:05:44
00:05:45
00:05:46
00:05:47
00:05:48

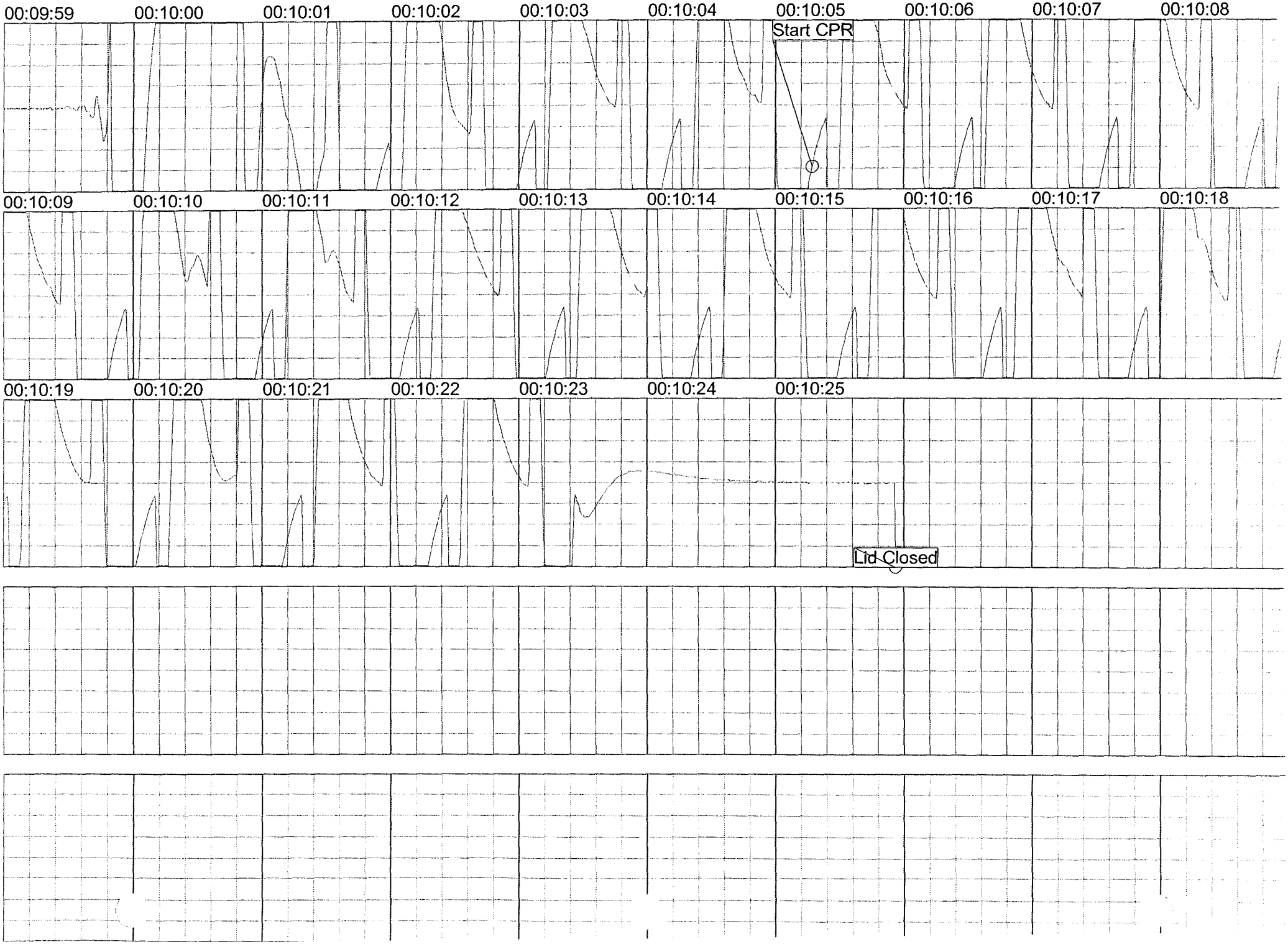

00:05:49
00:05:50
00:05:51
00:05:52
00:05:53
00:05:54
00:05:55
00:05:56
00:05:57
00:05:58
00:05:59
00:06:00
00:06:01
00:06:02
00:06:03
00:06:04
00:06:05
00:06:06
00:06:07
00:06:08
00:06:09
00:06:10
00:06:11
00:06:12
00:06:13
00:06:14
00:06:15
00:06:16
00:06:17
00:06:18
00:06:19
00:06:20
00:06:21
00:06:22
00:06:23
00:06:24
00:06:25
00:06:26
00:06:27
00:06:28
00:06:29
00:06:30
00:06:31
00:06:32
00:06:33
00:06:34
00:06:35
00:06:36
00:06:37
00:06:38


00:06:39
00:06:40
End CPR
00:06:41
00:06:42
00:06:43
00:06:44
00:06:45
00:06:46
00:06:47
Start of Analysis
00:06:48
00:06:49
00:06:50
00:06:51
00:06:52
00:06:53
00:06:54
00:06:55
00:06:56
00:06:57
00:06:58
00:06:59
No Shock Advised
00:07:00
00:07:01
00:07:02
00:07:03
00:07:04
00:07:05
00:07:06
00:07:07
00:07:08
00:07:09
00:07:10
00:07:11
00:07:12
00:07:13
00:07:14
00:07:15
00:07:16
00:07:17
00:07:18
Start CPR
00:07:19
00:07:20
00:07:21
00:07:22
00:07:23
00:07:24
00:07:25
00:07:26
00:07:27
00:07:28


00:07:29
00:07:30
00:07:31
00:07:32
00:07:33
00:07:34
00:07:35
00:07:36
00:07:37
00:07:38
00:07:39
00:07:40
00:07:41
00:07:42
00:07:43
00:07:44
00:07:45
00:07:46
00:07:47
00:07:48
00:07:49
00:07:50
00:07:51
00:07:52
00:07:53
00:07:54
00:07:55
00:07:56
00:07:57
00:07:58
00:07:59
00:08:00
00:08:01
00:08:02
00:08:03
00:08:04
00:08:05
00:08:06
00:08:07
00:08:08
00:08:09
00:08:10
00:08:11
00:08:12
00:08:13
00:08:14
00:08:15
00:08:16
00:08:17
00:08:18


00:08:19
00:08:20
00:08:21
00:08:22
00:08:23
00:08:24
00:08:25
00:08:26
00:08:27
00:08:28
00:08:29
00:08:30
00:08:31
00:08:32
00:08:33
00:08:34
00:08:35
00:08:36
00:08:37
00:08:38
00:08:39
00:08:40
00:08:41
00:08:42
00:08:43
00:08:44
00:08:45
00:08:46
00:08:47
00:08:48
00:08:49
00:08:50
00:08:51
00:08:52
00:08:53
00:08:54
00:08:55
00:08:56
00:08:57
00:08:58
00:08:59
00:09:00
00:09:01
00:09:02
00:09:03
00:09:04
00:09:05
00:09:06
00:09:07
00:09:08


00:09:09
00:09:10
00:09:11
00:09:12
00:09:13
00:09:14
00:09:15
00:09:16
00:09:17
00:09:18
00:09:19
00:09:20
00:09:21
00:09:22
00:09:23
00:09:24
00:09:25
00:09:26
00:09:27
00:09:28
00:09:29
00:09:30
00:09:31
00:09:32
00:09:33
00:09:34
00:09:35
00:09:36
End CPR
00:09:37
00:09:38
00:09:39
00:09:40
00:09:41
00:09:42
00:09:43
00:09:44
00:09:45
00:09:46
00:09:47
00:09:48
Start of Analysis
00:09:49
00:09:50
00:09:51
00:09:52
00:09:53
00:09:54
No Shock Advised
00:09:55
00:09:56
00:09:57
00:09:58


00:09:59
00:10:00
00:10:01
00:10:02
00:10:03
00:10:04
00:10:05
Start CPR
00:10:06
00:10:07
00:10:08
00:10:09
00:10:10
00:10:11
00:10:12
00:10:13
00:10:14
00:10:15
00:10:16
00:10:17
00:10:18
00:10:19
00:10:20
00:10:21
00:10:22
00:10:23
00:10:24
00:10:25
Lid Closed

Progress Notes

STANDARD TITLE: PSYCHIATRY NOTE
DATE OF NOTE: APR 17, 2018@15:28 ENTRY DATE: APR 17, 2018@15:29:01
AUTHOR: MALONEY, MARTIN EXP COSIGNER:
URGENCY: STATUS: COMPLETED

PSYCHIATRY NOTE (Established Patient)

Patient Identification: Patient is a 37 year old, MALE with a diagnosis of psychosis; alcohol abuse; PTSD; cannabis abuse.

Chief Complaint: Med Mgt

History of Presenting Problem
-not on medication on 'advice of urologist'
-medications/antipsychotics were causing retrograde ejaculation.
-taking only Trazodone 4 days per week.
-pain: 2/10
-last use of alcohol: 'none in six months'
-smoking: 1/2 ppd
-coffee: 1 cup daily
-sleep: 8-9 hours per night
-using Trazodone only when needed.
-occas. nightmares.
-no longer wishes to take medications.
-denied AH/VH

PSYCHIATRIC ROS AND ASSOCIATED SYMPTOMS:
MOOD:
Euthymic

SLEEP:
8-9 : Hours/Day;

INTEREST:
No complaints
GUILT/WORTHLESSNESS:
Denies
ENERGY:
Good
CONCENTRATION:
No complaints
APPETITE:
Stable
Weight: Stable
PSYCHOMOTOR:
No retardation or agitation
SEXUAL INTEREST:

Progress Notes

No complaints

TRAUMA-RELATED SYMPTOMS:
Avoidance of distressing memories, thoughts, feelings about trauma

Active problems - Computerized Problem List is the source for the following:

1. Psychosis (SCT 69322001) Schizoaffective Disorder, provisional
2. Degenerative joint disease of ankle AND/OR foot
3. Tinea pedis
4. Onychomycosis
5. Callus
6. Nondependent alcohol abuse
7. Cannabis abuse
8. Chronic post-traumatic stress disorder
9. Migraine
10. Smoker

TODAY'S VITAL SIGNS (Most recent as entered in VISTA):

Date	Vital	Measurement	Qualifiers
04/17/2018 15:17	Temp F (C)	97.8 (36.6)	
" "	Pulse	55	
" "	Respir	18	
" "	BP	110/70	
" "	Ht in (cm)	71 (180.34)	
" "	Wt lbs (kg)[BMI]	195.5 (88.68)[27]	
" "	Pain	3	
" "	POx (L/Mn)(%)	98	

Pertinent Past Medical, Family Medical, Social History:
No change(s)

Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	CHOLECALCIFEROL (VIT D3) 1,000UNIT TAB TAKE ONE TABLET BY MOUTH EVERY DAY	ACTIVE
2)	CLINDAMYCIN P04 1% TOP SWAB USE ONE SWAB ON SKIN EVERY TWELVE HOURS	ACTIVE
3)	CYANOCOBALAMIN 1000MCG TAB TAKE ONE TABLET BY MOUTH EVERY DAY (VITAMIN B-12)	ACTIVE
4)	IBUPROFEN 400MG TAB TAKE ONE TABLET BY MOUTH EVERY EIGHT HOURS AS NEEDED FOR PAIN, TAKE WITH FOOD	ACTIVE
5)	MULTIVITAMIN CAP/TAB TAKE 1 CAPSULE/TABLET BY MOUTH EVERY DAY	ACTIVE

Progress Notes

Printed On Jan 15, 2019

Pending Outpatient Medications	Status
1) TRAZODONE HCL 100MG TAB TAKE ONE TABLET BY MOUTH AT BEDTIME FOR SLEEP.	PENDING

6 Total Medications

Reviewed the following Labs with patient:
Allergies: Patient has answered NKA

Pain assessment: 2;

Substances and other addictions (Quantity/last use):
Current alcohol use? No
Illicit drug use including synthetic cannabinoids (bath salts, spice, K2): No
Nicotine: Yes
Caffeine: Yes

SUICIDE RISK SCREEN:
1. Risk Factors: Chronic psychiatric/medical conditions

2. Protective Factors: Positive social supports (marriage, children, stable environment), Positive personal traits (resiliency, help seeking), Optimistic outlook, Ongoing mental health care relationships with good treatment engagement

3. Are you having thoughts today about killing yourself? No
4. Do you have a plan to kill yourself? No
5. Do you have the means to carry out the plan? NA
6. Risk level: Low (no suicide specific actions are needed)

Rationale for risk level: denied si/hi
future focused
forward looking

HOMICIDE RISK:
Homicidal/violence history/risk: No

SCREENINGS ADMINISTERED:
No testing done

MENTAL STATUS EXAM
Appearance: alert
Motor Activity: calm
Interpersonal: cooperative

Progress Notes

Speech: normal rate/volume
Mood: euthymic
Affect: broad
Attention: normal
Concentration: normal
Memory: Recent: normal
Remote: normal
Thought Process: normal linear and goal oriented, logical
Thought Content: no auditory or visual hallucinations, no delusional thoughts
Judgment: fair
Insight: fair
Orientation to: person, place, situation, date

DIAGNOSIS:
Mental Health Diagnoses and Relevant Medical Conditions:
PTSD
Schizoaffective Disorder
Alcohol Use Disorder

Significant Psychosocial and Contextual Factors:
CASE FORMULATION AND RESPONSE TO TREATMENT:
37 year old client who has not taken medication other than Trazodone in the past 30 - 60 days. Denied si/hi. Future focused and forward looking. Denied ah/vh.
Future focused. Feels he is doing better
since stopped
use of alcohol in October.

Goals: Not met; patient stated goals as identified in plan of care/recovery.

PLAN:
Return in 3 month(s)

Medications to continue: Trazodone

Medications to stop:
Medications to change or add:
Referrals to:

MEDICATION RECONCILIATION: Medication reconciliation was done. Written medication list was given and reviewed with patient/family/caregiver. It was stated the list was accurate; no discrepancies found. Importance of managing medication was discussed with patient/family/caregiver.

Therapeutic technique/approach involved a veteran centered approach which includes rapport building, exploration of triggers for anger and depressive symptoms, empathic listening and recovery planning/management.

Progress Notes

Treatment provided: Supportive

Time Spent: 30 minutes
The patient has been involved in the development of this plan of care and concurs with such and consents to treatment: Yes
Education provided on: illness management, firearm safety, coping strategies, lifestyle changes
Patient understands treatment purpose, risk, benefits, effects and was , provided the opportunity to ask questions, Patient verbalized understanding by using the Teach Back Method.

/es/ MARTIN MALONEY, DO
STAFF PSYCHIATRIST
Signed: 04/17/2018 15:34

LOCAL TITLE: NURSING SPECIALTY CLINIC NOTE
STANDARD TITLE: NURSING OUTPATIENT NOTE
DATE OF NOTE: APR 17, 2018@15:21 ENTRY DATE: APR 17, 2018@15:21:45
AUTHOR: STAFFORD, MARCY E EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Scheduled Visit
Patient's identity actively confirmed by two identifiers:
Full Name, Complete date of birth

Reason for Visit: Visit with Dr Maloney.
Today's vitals:

Date	Vital	Measurement	Qualifiers
04/17/2018 15:17	Temp F (C)	97.8 (36.6)	
" "	Pulse	55	
" "	Respir	18	
" "	BP	110/70	
" "	Ht in (cm)	71 (180.34)	
" "	Wt lbs (kg)[BMI]	195.5 (88.68)[27]	
" "	Pain	3	
" "	POx (L/Mn)(%)	98	

Allergy list is current and correct. Patient denies change of allergy.
Medication Review:
Medication list was reviewed with the patient. Stated it was accurate; no changes needed.

Mental Status Screen
Status: Alert and oriented x3

Abuse and Neglect Screen
1. Are you or anyone in your home being hurt, hit, threatened

Progress Notes

Printed On Jan 15, 2019

(including financial exploitation), frightened or neglected?
No
2. Signs and symptoms of abuse and neglect observed?
No
Suicidal/Homicidal Screen:

Are you having thoughts today about killing/harming yourself or others?
No

Within the past 30 days, has the Veteran attempted suicide or engaged in any gesture or action that could be thought of as self-directed violence?
No
If yes, specify:

Within the past 12 months, has the Veteran attempted suicide or engaged in any gesture or action that could be thought of as self-directed violence?
No
If yes, specify:
Outside Providers Screen
Are you seeing any doctors outside of this VA?
No.
Previous learning needs barriers and health literacy questions have been reviewed. There are no changes at this time.

EDUCATION and/or ADDITIONAL EDUCATION:
Patient and/or family was educated on the following topics:
Topic: Follow up Treatment Education

Education Information:
Patient was educated.
Recipient was motivated to learn.
Recipient was ready to learn.
No barriers to learning identified.

Educational Evaluation:
Recipient had complete understanding/demonstration.

Clinical Reminder Information
Homelessness/Food Insecurity Screen:
In the past 2 months, have you been living in stable housing that you own, rent, or stay in as part of a household? Yes - Living in stable housing.

Progress Notes

Printed On Jan 15, 2019

DATE OF NOTE: JUN 28, 2018@11:30 ENTRY DATE: JUN 28, 2018@11:30:17
AUTHOR: CRUZ, ANDREA C EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Individual Session

Veteran Identification: Patient's Full Name and Full SSN verified

Veteran arrived on time for the scheduled psychotherapy appointment this date June 28, 2018. The medical record was reviewed.

DATA:
Veteran reported: Veteran reports he is doing well overall, has been working the yard which keeps him physically active and offers good psychological distraction. He denies any alcohol use since Oct 2017; did go on short vacation and had craving to drink, but did not do so. He admits struggled with Memorial Day "a bit", would normally be "drunk" on this day, thinks this is the first year he hasn't been. Veteran reaffirms that "I can't drink." He has some anxiety about upcoming hurricane season, which was a trigger last year with high anxiety; couple has plan in place that wife and children will go up North and veteran will stay in the home; he does worry about drinking while being alone. Couple is 4 months pregnant, will be having a gender reveal party this weekend, veteran is very excited. Veteran stopped taking his medications other than trazadone, felt that it was affecting his fertility.

SCREENINGS ADMINISTERED: testing was reviewed with the veteran during session

PHQ9 (Depression): 3 score indicative of mild depression
(RANGES: 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-19 Moderately severe; 20-27 Severe)

GAD7 (Anxiety): 4 score indicative of mild anxiety
(RANGES: 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-21 Severe)

Intervention Provided: Supportive, behavioral
We continue to discuss warning signs that PTSD is worsening identified i.e., increased anxiety that is unmanageable, paranoid thinking, delusions or auditory hallucinations, drinking---discuss importance of notifying his providers if these start to occur early on. We discussed how he managed his cravings, was able to think through of the consequences based on past experiences, what he would lose e.g., his family, hospitalization. Discussed needing to plan ahead for when hurricane season does occur and how to stay connected to family and not drink. Processed Memorial Day, new ritual of taking care of himself that day vs. going to memorial sites which was too emotional for him

Discussed tx planning, veteran is open to a group therapy, open to attending PTSD Skills Group 2nd and 4th Wed of the month 2:30-4:00pm on 7/11/18.

Goal(s) addressed in session: mood management

Progress Notes

Education Provided: Psychotherapeutic

Understanding demonstrated using "teach-back" method.

ASSESSMENT:

SUICIDE RISK SCREEN:
1. Risk Factors:
chronic psychiatric/medical conditions

2. Protective Factors:
positive social supports (marriage, children, stable environment), positive personal traits (resiliency, help seeking), optimistic outlook, future goals, ongoing mental health care relationships with good treatment engagement, effective clinical care

3. Are you having thoughts today about killing yourself? No

4. Do you have a plan to kill yourself? No

5. Do you have the means to carry out the plan? yes, has weapons in the home

Rationale for risk level: Patient denied SI; has supportive family, amenable to therapy

6. Risk level: Low (no suicide specific actions are needed)

HOMICIDE RISK:
Homicidal/violence history/risk: No

Safety Risk: None

Reporting required? No

Pain: 2
Pain 4 or greater: no
Location: both knees
Veteran receiving treatment for pain: ibuprofen PRN

MENTAL STATUS:
Orientation: x4
Appearance: appears stated age, dressed appropriately for weather, adequate hygiene, well nourished, appeared sleepy
Social Interaction: cooperative, slightly guarded
Communication Barriers: none
Ambulation: unaided
Attention: focused
Psychomotor: calm
Memory: Veteran reports problems with short-term memory

Progress Notes

Speech: normal rate an dtone
Cognition: logical, goal-directed, spontaneous
Thought Content: hx of paranoid ideation
Psychosis: hypervigilance, hx of more severe paranoid ideation
Judgment: fair
Insight: fair
Impulse Control: fair, hx of binge drinking, acting out
Mood: anxious
Affect: restricted

DIAGNOSIS: PTSD; alcohol use disorder-binge drinking; medical problems

INTEGRATED SUMMARY/CASE FORMULATION: Veteran is 37 y.o married African American male 100%SC for PTSD with recent hospitalization. Veteran with chronic sxs of anxiety, hypervigilance, paranoid thoughts, recent hospitalization.

Time spent providing psychotherapy was 30 minutes.

PLAN OF CARE

Veteran's stated goals as identified in plan of care/recovery:

1. decrease anxiety (i.e., veteran will identify and challenged maladaptive thoughts at least 50% of the time)
   Progress toward goal: moderate
   Veteran response to care or treatment: generalized anxiety, using yardwork as physical and psychological coping; denies paranoia or delusions lately

2. abstain from alcohol (i.e., identify cravings and develop relapse prevention)
   Progress towards goals: as expected
   Veteran response to care or treatment: denies any alcohol use since Oct 2017

Return to Clinic: 8/8/18 at 11:00lm first available. Veteran is aware of how to contact the clinic and/or walk-in and use of Crisis Hotline

Out-of-session practice assignment? Yes, structured self-care, monitoring warning signs of acute illness

/es/ ANDREA C. CRUZ, PSY.D
STAFF PSYCHOLOGIST
Signed: 06/28/2018 11:44

Receipt Acknowledged By:
06/29/2018 07:19 /es/ MARTIN MALONEY, DO
STAFF PSYCHIATRIST

LOCAL TITLE: MH PSYCHIATRY NOTE

PATIENT NAME AND ADDRESS (Mechanical Imprinting, If ava
EDWARDS, GREGORY LLOYD
029 GARDENWOOD CIRCLE
GRANT VALKARIA, FLORIDA 32949

VISTA Electronic Medical Documentation
Printed at ORLANDO VAMC

Progress Notes

Printed On Jan 15, 2019

LOCAL TITLE: MH PSYCHOLOGY NOTE
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: SEP 14, 2018@10:02 ENTRY DATE: SEP 14, 2018@10:03:07
AUTHOR: CRUZ, ANDREA C EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** MH PSYCHOLOGY NOTE Has ADDENDA ***

Individual Session

Veteran Identification: Patient's Full Name and Full SSN verified

Veteran arrived on time for the scheduled psychotherapy appointment this date September 14, 2018. The medical record was reviewed.

DATA:
Veteran reported: Veteran last seen on 6/28/18 feels that he is sleeping "too much", but upon questioning only sleeping appx 7 hours and what he is more frustrated by is late bedtime and late morning waking. Admits spends several hours on his phone before bed "watching news, conspiracy theory stuff" and won't fall sleep until 3am He received noticed from the VA regarding his warrant last year, will stop his benefits if he does not present court papers stating he is on probation. Son will be born in Dec 2018, couple is excited, wife is doing well. He is staying busy with home projects, goes to the gym Denies any alcohol intake, denies cravings at this time.

SCREENINGS ADMINISTERED: testing was reviewed with the veteran during session

PHQ9 (Depression): 2 score indicative of mild depression
(RANGES: 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-19 Moderately severe; 20-27 Severe)

GAD7 (Anxiety): 1 score indicative of mild anxiety
(RANGES: 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-21 Severe)

Intervention Provided: Supportive, behavioral
Discussed is preferred sleep cycle, going to bed appx 11-12 midninght and waking by 8am Educated on sleep hygiene, importance of stopping electronic use 1 hour before bed, reading book or magazine instead; spending time outdoors between 8-11am to reset cirdadiam rhythms. Discussed also have weekly goals to keep him focused and to reinforce sense of accomplishment and control. Discussed monitoring sxs, including alcohol cravings; reminded ways to contac the clinic, receive help is needed in between sessions.

Goal(s) addressed in session: mood management

Education Provided: Psychotherapeutic

Understanding demonstrated using "teach-back" method.

Progress Notes

Printed On Jan 15, 2019

ASSESSMENT:

SUICIDE RISK SCREEN:
1. Risk Factors:
chronic psychiatric/medical conditions

2. Protective Factors:
positive social supports (marriage, children, stable environment), positive personal traits (resiliency, help seeking), optimistic outlook, future goals, ongoing mental health care relationships with good treatment engagement, effective clinical care

3. Are you having thoughts today about killing yourself? No

4. Do you have a plan to kill yourself? No

5. Do you have the means to carry out the plan? yes, has weapons in the home

Rationale for risk level: Patient denied SI; has supportive family, amenable to therapy

6. Risk level: Low (no suicide specific actions are needed)

HOMICIDE RISK:
Homicidal/violence history/risk: No

Safety Risk: None

Reporting required? No

Pain: 2
Pain 4 or greater: no
Location: both knees
Veteran receiving treatment for pain: ibuprofen PRN

MENTAL STATUS:
Orientation: x4
Appearance: appears stated age, dressed appropriately for weather, adequate hygiene, well nourished, appeared sleepy
Social Interaction: cooperative, slightly guarded
Communication Barriers: none
Ambulation: unaided
Attention: focused
Psychomotor: calm
Memory: Veteran reports problems with short-term memory
Speech: normal rate an dtone
Cognition: logical, goal-directed, spontaneous
Thought Content: hx of paranoid ideation
Psychosis: hypervigilance, hx of more severe paranoid ideation

Progress Notes

Judgment: fair
Insight: fair
Impulse Control: fair, hx of binge drinking, acting out
Mood: slightly anxious
Affect: restricted

DIAGNOSIS: PTSD; alcohol use disorder-binge drinking; medical problems

INTEGRATED SUMMARY/CASE FORMULATION: Veteran is 37 y.o married African American male 100%SC for PTSD with recent hospitalization. Veteran with chronic sxs of anxiety, hypervigilance, paranoid thoughts, recent hospitalization.

Time spent providing psychotherapy was 30 minutes.

PLAN OF CARE

Veteran's stated goals as identified in plan of care/recovery:

1. decrease anxiety (i.e., veteran will identify and challenged maladaptive thoughts at least 50% of the time)
   Progress toward goal: as expected
   Veteran response to care or treatment: denies overwhelming anxiety

2. abstain from alcohol (i.e., identify cravings and develop relapse prevention)
   Progress towards goals: as expected
   Veteran response to care or treatment: denies any alcohol use since Oct 2017

Return to Clinic: Nov 2018; Veteran is aware of how to contact the clinic and/or walk-in and use of Crisis Hotline

Out-of-session practice assignment? Yes, structured self-care, monitoring warning signs of acute illness

Clinical Reminder Information
  Tobacco Use Screen:
    Patient reports they currently use tobacco products.
      Patient states they use or used the following forms of tobacco: cigarettes
      Handout provided and reviewed with patient:
        a. Benefits and reasons to be tobacco free
        b. Strategies for quitting
        c. Identify situations/triggers that would encourage tobacco use
        d. Develop skills and establish a plan to handle triggers/situations

Progress Notes

e. Use of nicotine replacement therapy and/or behavior change support
f. Strategies to address nicotine withdrawal symptoms
g. Strategies to address tobacco cravings

Cessation Class Referral Offered:
Patient states they do not wish to quit using tobacco products at this time. Offer of a tobacco cessation class was declined by the patient at this encounter.

Cessation Medications Offered:
Veteran declined medication offered at this encounter.

/es/ ANDREA C. CRUZ, PSY.D
STAFF PSYCHOLOGIST
Signed: 09/14/2018 10:36

09/14/2018 ADDENDUM STATUS: COMPLETED
Clinical Reminder Information
Depression Screening:
PHQ-2+I9
PHQ-2+I9 Depression Screening Score: 0
The score on this administration is 0, which indicates a negative screen on the Depression Scale over the past two weeks.

PHQ-2+I9 Suicide Screening Score: 1
The results of this administration revealed suicidal ideation over the last 2 weeks, which indicates a POSITIVE primary screen for Risk of Suicide.

Over the past two weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things
Not at all

2. Feeling down, depressed, or hopeless
Not at all

3. Thoughts that you would be better off dead or of hurting yourself in some way
Several days

/es/ ANDREA C. CRUZ, PSY.D
STAFF PSYCHOLOGIST
Signed: 09/14/2018 10:37

LOCAL TITLE: MH PSYCHIATRY NOTE

Progress Notes

discussed with patient/family/caregiver.

/es/ JUDITH MINAYA, M D.
STAFF PHYSICIAN, PRIMARY CARE
Signed: 11/19/2018 13:05

LOCAL TITLE: MH PSYCHOLOGY NOTE
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: NOV 09, 2018@10:31 ENTRY DATE: NOV 09, 2018@10:31:31
AUTHOR: CRUZ, ANDREA C EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Individual Session

Veteran Identification: Patient's Full Name and Full SSN verified

Veteran arrived on time for the scheduled psychotherapy appointment this date November 9, 2018. The medical record was reviewed.

DATA:
Veteran reported: Veteran reports doing well overall, mood has been stable, denies paranoid ideation or feeling depressed, denies alcohol cravings. Veteran is celebrating 1 year sobriety this month, has been attending a weekly Recovery Group at his church the entire year and has found it very helpful. He is keeping busy with taking care of 1-2 acre property and taking 19 month old daughter to school 3x/wk, goes to gym on those days, denies excessive hypervigilance in that environment "it's during the day, it's quieter, I see the same ppl so that helps." He does report feeling "tired" wanting to sleep, despite sleeping "10pm-6am" most nights; also napping during the day. Veteran will have nightmares "about them taking be back to war" appx 1x/wk and will use trazadone PRN. Has PCP appt coming up, will address fatigue concerns. Looking forward to birth of son in December.

SCREENINGS ADMINISTERED: testing was reviewed with the veteran during session

PHQ9 (Depression): 3 score indicative of mild depression
(RANGES: 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-19 Moderately severe; 20-27 Severe)

GAD7 (Anxiety): 2 score indicative of mild anxiety
(RANGES: 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-21 Severe)

Intervention Provided: Supportive, behavioral
Reviewed symptoms, reports mood stability, no alcohol intake; staying active and optimistic. Encouraged him to ask PCP about bloodwork to rule out medical reasons for fatigue. We also discussed monitoring depressive symptoms as excessive sleeping can be a warning sign.

Goal(s) addressed in session: mood management

Progress Notes

Education Provided: Psychotherapeutic

Understanding demonstrated using "teach-back" method.

ASSESSMENT:

SUICIDE RISK SCREEN:
1. Risk Factors:
chronic psychiatric/medical conditions

2. Protective Factors:
positive social supports (marriage, children, stable environment), positive personal traits (resiliency, help seeking), optimistic outlook, future goals, ongoing mental health care relationships with good treatment engagement, effective clinical care

3. Are you having thoughts today about killing yourself? No

4. Do you have a plan to kill yourself? No

5. Do you have the means to carry out the plan? yes, has weapons in the home

Rationale for risk level: Patient denied SI; has supportive family, amenable to therapy

6. Risk level: Low (no suicide specific actions are needed)

HOMICIDE RISK:
Homicidal/violence history/risk: No

Safety Risk: None

Reporting required? No

Pain: 2
Pain 4 or greater: no
Location: both knees
Veteran receiving treatment for pain: ibuprofen PRN

MENTAL STATUS:
Orientation: x4
Appearance: appears stated age, dressed appropriately for weather, adequate hygiene, well nourished, appeared sleepy
Social Interaction: cooperative, slightly guarded
Communication Barriers: none
Ambulation: unaided
Attention: focused
Psychomotor: calm
Memory: Veteran reports problems with short-term memory

Progress Notes

Speech: normal rate an dtone
Cognition: logical, goal-directed, spontaneous
Thought Content: hx of paranoid ideation
Psychosis: hypervigilance, hx of more severe paranoid ideation
Judgment: fair
Insight: fair
Impulse Control: fair, hx of binge drinking, acting out
Mood: euthymic
Affect: restricted

DIAGNOSIS: PTSD; alcohol use disorder, sustained full remission ; medical problems

INTEGRATED SUMMARY/CASE FORMULATION: Veteran is 38 y.o married African American male 100%SC for PTSD with recent hospitalization. Veteran with chronic sxs of anxiety, hypervigilance, paranoid thoughts, recent hospitalization. Veteran has shown stability in the past year with efforts in his sobriety, focusing on family.

Time spent providing psychotherapy was 30 minutes.

PLAN OF CARE

Veteran's stated goals as identified in plan of care/recovery:

1. decrease anxiety (i.e., veteran will identify and challenged maladaptive thoughts at least 50% of the time)
   Progress toward goal: as expected
   Veteran response to care or treatment: denies overwhelming anxiety

2. abstain from alcohol (i.e., identify cravings and develop relapse prevention)
   Progress towards goals: as expected
   Veteran response to care or treatment: denies any alcohol use since Oct 2017

Return to Clinic: Jan 2019; Veteran is aware of how to contact the clinic and/or walk-in and use of Crisis Hotline

Out-of-session practice assignment? Yes, structured self-care, monitoring warning signs of acute illness

/es/ ANDREA C. CRUZ, PSY.D
STAFF PSYCHOLOGIST
Signed: 11/09/2018 10:55

Receipt Acknowledged By:
11/13/2018 07:07 /es/ MARTIN MALONEY, DO
STAFF PSYCHIATRIST

EDWARDS

Progress Notes

Printed On Jan 15, 2019

LOCAL TITLE: AMBULATORY CARE NOTE
STANDARD TITLE: PRIMARY CARE E & M NOTE
DATE OF NOTE: NOV 19, 2018@12:57 ENTRY DATE: NOV 19, 2018@12:57:43
AUTHOR: MINAYA,JUDITH S EXP COSIGNER:
URGENCY: STATUS: COMPLETED

****
SUBJECTIVE
****

CHIEF COMPLAINT: annual

HPI:
^38yr old male h/o TBI, PTSD, Left knee pain,
migraines, smoker 1/2 ppd, comes to clinic for routine care.
Denies chest pain, palpitations, headache, abdominal pain.

Patient h/o Rehab in Portland, OR (ETOH).
Patient discharged after 24days on 11/12/17.

Patient's wife is pregnant, due on 12/24/18.
Patient c/o ED.
ROS: see HPI
****

PAST MEDICAL/SURGICAL HISTORY:
Active problems - Computerized Problem List is the source for the following:

1. Psychosis (SCT 69322001) Schizoaffective Disorder, provisional
2. Degenerative joint disease of ankle AND/OR foot
3. Tinea pedis
4. Onychomycosis
5. Callus
6. Nondependent alcohol abuse
7. Cannabis abuse
8. Chronic post-traumatic stress disorder
9. Migraine
10. Smoker

ALLERIGES: Patient has answered NKA

FAMILY/SOCIAL HISTORY
no change from last H&P with me

MEDICATIONS:
Med list reviewed and reconciled with patient
Active Outpatient Medications (including Supplies):

TRAZODONE HCL 100MG TAB TAKE ONE TABLET BY MOUTH AT ACTIVE

Progress Notes

BEDTIME FOR SLEEP.

No Active Remote Medications for this patient

****
OBJECTIVE
****

VITAL SIGNS:
BP: 135/82 (11/19/2018 12:53)
P : 73 (11/19/2018 12:53)
R : 18 (11/19/2018 12:53)
T : 96.9 F [36.1 C] (11/19/2018 12:53)
W 204.3 lb [92.9 kg] (11/19/2018 12:53)
BMI: 28.6

GENERAL: no distress, non-toxic
NECK: no JVD, no LA
LUNGS: clear to auscultation bilaterally
HEART: RRR, no murmurs
ABD: soft, non-tender, non-distended, positive bowel sounds
EXTR: no cyanosis, clubbing, or edema

Labs reviewed with pt
Medication list reconciled

****
ASSESSMENT AND PLAN:
****

1. smoker; advised to stop
2. ED, will try Viagra prn
3. h/o psychosis; alcohol abuse; PTSD; cannabis abuse; stable; f/up by MH.

RTC if worse or no better. Risks/benefits/alternatives discussed.
The patient expressed understanding and acknowledged personal responsibility for care, compliance and follow-up.

****
DISPOSITION: ANNUAL
****

*****COMPLETED REMINDERS***** (If blank, none completed/required today)

Clinical Reminder Information
Medication Reconciliation:
Medication reconciliation was done. Medication list was reviewed with patient/family/caregiver. Discrepancies were found and/or new medications were prescribed at today's visit; list was updated. Written list given to patient. Importance of managing medication was

TAB # 8