Apr 12, 2011 BLD/TC

Pt called regarding smoking cessation group April 13, left message.

Apr 29, 2011 BLD/KLF

COMPLAINTS: Cough, green phlegm, painful muscles. Swelling of hands and feet. Last menstrual period 3 months ago. New fabulous job. With good benefits etc. Her depression has disappeared.
EXAMINATION: WT: 251 lbs. HT: 5'7 3/4". Head and neck: Throat is normal. Lymph: Enlarged anterior cervical nodes. Chest: Expiratory rhonchi. Abdomen: Overweight.
DIAGNOSIS: 1. Rule out menopause. 2. Asthmatic bronchitis. 3. Obesity.
TREATMENT: Blood tests. Chest X-ray. 2-hr glucose tolerance test.

Apr 29, 2011 BLD/KLF

Start: Qvar 2 inhalations bid
Start: Ventodisk Disk/Diskhaler 2 puffs qid
Start: Z-Pak (Zithromax) for 5 days
Start: Zytram XL 200 mg 1 daily for pain to feet and low back

May 12, 2011 BLD/TC

Canadian Medical Laboratories Lab Data

HEMOGLOBIN	142	115 - 165
HEMATOCRIT	0.419	0.37 - 0.47
WBC COUNT	6.1	4.0 - 11.0
RBC COUNT	4.53	3.80 - 5.80
MCV	92.4	80 - 97
MCH	31.3	27.0 - 32.0
MCHC	339	320 - 360
RDW	14.1	11.0 - 14.5
PLATELET COUNT	341	150 - 400
ABSOLUTE: NEUTROS	3.6	2.0 - 7.5
(A) LYMPH	1.9	1.1 - 3.3
(A) MONO	0.4	0 - 0.8
(A) EOS	0.1	0 - 0.5
(A) BASO	0	0 - 0.2
hs-CRP	1.4	

CUT POINTS FOR CARDIAC RISK ASSESSMENT ARE:
LOW RISK LEVEL <1.0 MG/L
AVERAGE RISK LEVEL 1.0 - 3.0 MG/L
HIGH RISK LEVEL >3.0 MG/L
VALUES >8.0 MG/L INDICATE INFLAMMATORY CONDITIONS AND MAY NOT PREDICT CARDIAC RISK
.

CREATININE	65	60 - 115
eGFR	85	
	**** ****	****

For patients of African descent, the reported eGFR must be multiplied by a correction factor of 1.21.

	**** ****	****
SODIUM	138	135 - 146
POTASSIUM	4.4	3.5 - 5.2
CHLORIDE	106	95 - 108
CALCIUM	2.26	2.15 - 2.60
ALT	14	4 - 43
CK	174	BELOW 170
HEMOGLOBIN A1C	0.061	0.04 - 0.06

***
HbA1C is best performed every 3 months in unstable diabetics and every 6 months in stable ones. More frequent testing is meaningless.

GLUCOSE CHALLENGE 75 gm		
GLUCOSE FASTING	5.2	3.3 - 6.0
GLUCOSE 2 HR	8.5	3.3 - 7.7

7.8-11.0 MMOL/L = IMPAIRED GLUCOSE TOLERANCE.

CHOLESTEROL	5.22	TARGET<5.20
TRIGLYCERIDES	3.30	TARGET <1.71
HDL CHOLESTEROL	0.94	TARGET>1.29
LDL CHOLESTEROL	2.78	See Targets
CHOL/HDL RATIO	5.55	See Targets

If Clinically	Target

determined risk is:	for LDL-C	
Low	reduce by 50%	
Moderate or High	<2.0 or reduce by 50%	

...as per 2009 Canadian Guidelines
NOTE
Serum lipids should be measured no more often than every six months after diet or medication adjustment or annually for routine screen.

TSH	1.15	0.30 - 5.60

***
TSH is the single initial test of thyroid function. It should be performed only on symptomatic patients or pregnant, post partum and post menopausal women.

FSH SERUM	7.2	

FSH (Female Ref.Range) IU/L
==========
Mid-Follicular : 3.9 - 8.8
Mid-Cycle Peak : 4.5 - 22.5
Mid-Luteal : 1.8 - 5.1
Post Menopausal : 16.7 - 113.6

URINALYSIS, ROUTINE:		
APPEARANCE	CLEAR	
COLOUR	YELLOW	
PH	5.5	5.0 - 9.0
PROTEIN	NEGATIVE	NEGATIVE
GLUCOSE	NEGATIVE	NEGATIVE
KETONE	NEGATIVE	NEGATIVE
BLOOD	NEGATIVE	NEGATIVE
NITRITE	NEGATIVE	NEGATIVE
LEUKOCYTE ESTERASE	NEGATIVE	NEGATIVE
SPECIFIC GRAVITY	1.020	

May 12, 2011 Chest X-Ray BLD/KKD

Received: Jun 7, 2011
St. Joseph's Hospital

GR-CHEST PA/LAT ADULT

Comparison is made to previous chest radiographs from April 28, 2009.

Cardiac, mediastinal and hilar contours are normal. Lungs and pleural spaces are clear of active disease. Visualized osseous structures are intact.

IMPRESSION:

No acute intrathoracic radiographic abnormalities are seen.

- DR EHSAN ARMED HAIDER

May 20, 2011 BLD/KLF

PHONE CONVERSATION
COMPLAINTS: the pt is swelling. She is concerned about edema.
TREATMENT: I did advise her that she has pre-diabetes and abnormal lipid profile. She will come in to see the dietician.
Inconvenient for patient to come to office.

May 20, 2011 BLD/KLF

Start: hydrochlorothiazide 25 mg 1 daily

May 27, 2011 BLD/MMW

Nutrition - 46 yr old female with predm, low HDL, obesity (BMI>35), reporting risk of hypoglycemi with infrequent meals, often skipping meals due to busy work schedule (2 jobs).

NUTRITION CONCERNS
1. excess caloric intake resulting in wgt gain as evident by BMI> target, and low activity level reported
2. retaining water (legs, hands) due to high salt diet, limited activity

3. dehydrated as reported by dietary intake, concentrated urine
4. at risk of dm with low activity, obesity, and A1c -0.061, low HDL chol

ACTION
Nutrition assessment- lifestyle challenges (work, family, husband cooking with high salt carribean meals), dietary intake , activity, med hx, meds.
Education- nutrition therapy to improve glycemic control, reduce risk of diabetes by promoting weight loss and daily activity.

Provided Diabetic Food guide and Potassium rich foods handout.

GOAL SETTING
1. will add 3 fruits each day (to boost potassium, prevent hypo)
2. will add small meals every 4 hrs
3. will have 2 water bottles by 2 pm

FOLLOWUP 1 mth with RD with food records
Michele MacDonald Werstuck, RD, MSc., CDE.

DIETARY INTAKE
B- coffee, 1 cream, poached egg//
L- sandwich

May 27, 2011 BLD/KLF

COMPLAINTS: Problems with her abdomen. She is getting hot flashes. Periods have not returned.
EXAMINATION: Pelvic sonogram.
DIAGNOSIS:
TREATMENT: Probiotic. Acidopholus. She saw Michelle for extensive counselling. Advised to watch weight and to lose weight to prevent Type II diabetes.

Jun 5, 2011 Ultrasound Abdomen BLD/KLF

Received: Jun 23, 2011
St. Joseph's Hospital
ULTRASOUND OF THE ABDOMEN

Clinical Indication: History of TCC

Previous examination: Ultrasound September 2005

The liver is normal in size and echotexture. No focal lesions seen.

The gallbladder contains no stones.

The intra and extra hepatic bile ducts are normal, not dilated.

The pancreas is grossly normal with no focal lesions.

Both kidneys are normal in size with preserved cortex. No stones or hydronephrosis is noted. The right kidney measures 11.4 cm, the left kidney measures 11.0 cm. Simple cortical cysts seen in the right kidney.

The spleen is normal in size with a normal echotexture.

The Aorta and IVC are unremarkable.

Urinary bladder only partially filled difficult to assess for details.

Enlarged 70 ml prostate probably post TURP.
Bilateral UV Jets seen.

No ascites or free fluid is noted.

IMPRESSION: Unremarkable, urinary bladder not assessable being only partially filled.

- DR ANDU CORET

Sep 28, 2011 Obstetrics & Gynecology BLD/KKD

Dr. Small
Received: Feb 26, 2012
Dear Leo:

I met this 48-year-old single sterilized mother of one on the 28th of September, 2011 because of dysfunctional bleeding and ovarian cysts. This patient had her, last menstrual period that was "normal" in January of this year. She was then amenorrheic until August. She saw you because of that in the spring and an ultrasound scan was undertaken. An incidental finding of multiple small cysts of her ovaries were noted as well as a relatively thick endometrium. Prior to January of this year she had a regular predictable and "perfect" menstrual cycle. She had bleeding in August of this year which lasted for six weeks, and stopped, and then restarted. Some of the days were extremely heavy to the point where she was even considering going to Emergency. She is working 70 hours per week both as a staffing specialist for Human Resources and at McDonald's. She is trying to care for her one child although I note that that child is 28 years of age.

She takes Ventolin. She smokes several cigarettes per day. She is allergic to Penicillin and peanuts.

She has not had any menopausal symptoms through this. Her weight has "rocketed" in the past nine months - no cause has been identified. She weighed 249 lb today.

She was examined and her blood pressure was 120/80. Her abdominal examination revealed moderate obesity. She had an appearance of query PCOS. A Pap was done. I have done an endometrial biopsy. My impression is that of anovulatory dysfunctional uterine bleeding with physiologic ovarian cyst formation.

My plan is to check her CBC, ferritin, prolactin, FSH, TSH, give her Provera 10 mg two p.o. daily for ten days to induce a withdrawal bleed, Cyklokapron in case she has heavy bleeding, repeat her ultrasound scan and follow up visit. I have encouraged her to use iron. Information regarding the potential use of a Mirena was provided at her visit today. I will see her back.

Yours sincerely,

D. Small, M.D., F.R.C.SC.

Sep 29, 2011 DynaCare Laboratories (HL7) Lab Data BLD/TC

Sep 29, 2011

```
Collection Date
Result Copy To: Di Paolo, Bruno L
Ordering Physician: SMALL, D.R.
HISTOLOGY
    ---------
    TISSUE (SITE): Endometrium
    SUMMARY OF HISTORY: DUB.
    LMP Sept 23.
    GROSS:         SCO multiple fragments of grey-tan and hemorrhagic
    tissue measuring 1.5cm in aggregate size EIT.
    DIAGNOSIS:     PROLIFERATIVE ENDOMETRIUM.
    NO EVIDENCE OF HYPERPLASIA/MALIGNANCY.
    Pathologist: DR. D. DAYA  M.D., F.R.C.P.(C)
    (signature on file)
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Oct 28, 2011 Obstetrics & Gynecology BLD/KKD

Dr. Small
Received: Dec 15, 2011
Dear Leo:

This patient was seen in follow up on the 28th of October. Her endometrial biopsy showed proliferative endometrium, Pap smear was negative and gonadotropin levels within a normal range as well as her prolactin and her hemoglobin and ferritin are well preserved.

Her pelvic ultrasound scanning shows multiple small cysts in both ovaries. 11cr hormonal profile is not really consistent with PCOS although the ultrasound appearance is suggestive. I think she is experiencing anovulatory dysfunctional bleeding, and I am not sure it is critical to label it with a specific diagnosis. I do think she would benefit from cyclic Provera for cycle regulation. She declines a Mirena - she has used an IUD in the past and has had problems with its use. She will take Provera 10 mg for the first ten days of each month for the next six months. I will have her back at that point with a repeat ultrasound scan to see if her cysts have changed and

assess the response to cyclic progestin.

Yours sincerely,

D. Small, M.D., F.R.C.S.C.

Oct 28, 2011 Ultrasound Pelvis BLD/KKD

Received: Dec 22, 2011
DIAGNOSTIC ULTRASOUND CLINIC
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

St. Joseph's Hospital

OG-PELVIC & TRANSVAGPANEL

Indication: Followup ovarian cyst.

Findings:

Both transvaginal and transabdominal images were obtained. The uterus anteverted and measures 108 x 48 x 63 mm. There is a lower uterine segment subserosal fibroid measuring 48 x 20 x 22 mm. The endometrium measures 11 mm.

The right ovary measures 35 x 22 x 35 mm and contains multiple small cysts with the largest measuring 17 x 14 x 15 mm. There are no solid components are internal septations. There is no increased vascular flow.

The left ovary is measures a total of 88 x 34 x 41 mm and contains an 3 simple cysts measuring 20 mm, 21 mm, and 32 mm respectively. There are no internal septations, solid components, or increased vascular flow.

There is no free fluid in the pelvis.

Impression:

There are bilateral ovarian cysts, which appear unchanged from the previous ultrasound.

- DR NIRUPAMA GANGAM

Dec 20, 2011 BLD/KLF

COMPLAINTS: Cough, wheezing.
EXAMINATION: Head and neck: Normal. Lymph: Normal. Chest: Expiratory rhonchi. Hebberden's nodes left hand.
DIAGNOSIS: Asthmatic bronchitis. OA.
TREATMENT: Wax bath both hands. Ventolin. Flovent 250 mg bid.

Dec 20, 2011 BLD/KLF

Start: Z-Pak (Zithromax) for 5 days
Start: Flovent 250 mg bid

Dec 30, 2011 BLD/KKD

COMPLAINTS: continuing cough, shortness of breath and wheezing. Her phlegm is still green, we will review her x-ray.
EXAMINATION: head and neck: normal. Lymph: normal. Chest: expiratory rhonchi.
DIAGNOSIS: Asthmatic bronchitis.
TREATMENT: Prednisone.

Dec 30, 2011 BLD/KKD

Start: prednisone 50 mg 1 daily for 10 days
Start: Avelox 400 mg 1 daily for 7 days

Jan 14, 2012 BLD/KKD

COMPLAINTS: the patient continues to cough and has phlegm. She is getting better. She did take 10 days of prednisone.
EXAMINATION: Head and neck: normal. Lymph; Normal. Chest: expiratory rhonchi.
DIAGNOSIS:
TREATMENT: Chest x-ray PA and lateral. Blood tests. Still off work. See on Monday morning. Advised to goto

ER if she feels short of breath or gets a fever.

Accession Number LA42057
Requisition Date Jan 16, 2012
Collection Date Jan 16, 2012
Ordering Physician: Di Paolo, Bruno L

HEMOGLOBIN	149	115 - 165
HEMATOCRIT	0.427	0.37 - 0.47
WBC COUNT	6.4	4.0 - 11.0
RBC COUNT	4.60	3.80 - 5.80
MCV	93.0	80 - 97
MCH	32.3	27.0 - 32.0
MCHC	348	320 - 360
RDW	12.9	11.0 - 14.5
PLATELET COUNT	286	150 - 400
ABSOLUTE: NEUTROS	4.1	2.0 - 7.5
(A) LYMPH	1.8	1.1 - 3.3
(A) MONO	0.4	0.0 - 0.8
(A) EOS	0.1	0.0 - 0.5
(A) BASO	0.0	0.0 - 0.2
GLUCOSE FASTING-SER	5.6	3.3 - 6.0
CREATININE	68	60 - 115
eGFR	80	

**** **** ****

For patients of African descent, the reported eGFR must be multiplied by a correction factor of 1.21.

**** **** ****

SODIUM	138	135 - 146
POTASSIUM	4.8	3.5 - 5.2
CHLORIDE	105	95 - 108
ALT	11	4 - 43
CK	91	BELOW 170
HEMOGLOBIN A1C	0.063	0.040- 0.060

***

HbA1C is best performed every 3 months in unstable diabetics and every 6 months in stable ones. More frequent testing is meaningless.

CHOLESTEROL	5.56	TARGET<5.20
TRIGLYCERIDES	4.01	TARGET <1.71
HDL CHOLESTEROL	0.92	TARGET>1.29
LDL CHOLESTEROL	2.82	See Targets
CHOL/HDL RATIO	6.04	See Targets

If Clinically determined risk is:	Target for LDL-C
Low	reduce by 50%
Moderate or High	<2.0 or reduce by 50%

...as per 2009 Canadian Guidelines

NOTE
Serum lipids should be measured no more often than every six months after diet or medication adjustment or annually for routine screen.

URINALYSIS, ROUTINE:		
APPEARANCE	CLEAR	
COLOUR	YELLOW	
PH	5.5	5.0 - 9.0
PROTEIN	NEGATIVE	NEGATIVE
GLUCOSE	NEGATIVE	NEGATIVE
KETONE	NEGATIVE	NEGATIVE
BLOOD	NEGATIVE	NEGATIVE
NITRITE	NEGATIVE	NEGATIVE
LEUKOCYTE ESTERASE	NEGATIVE	NEGATIVE
SPECIFIC GRAVITY	1.018	

Jan 16, 2012 ECG BLD/KLF

Jan 16, 2012 Chest X-Ray BLD/KKD

Received: Mar 3, 2012
CHARLTON X-RAY AND ULTRASOUND

CHEST PA, LL:

INDICATION: Pneumonia?

No previous.

Unremarkable heart and mediastinum.

The lung fields are clear. No infiltrate, effusion or vascular redistribution is seen.

Unremarkable bones.

OPINION: No evidence of pneumonia.

A. Coret, MD CPSO

Jan 18, 2012 Respirology BLD/KKD

Dr. McIvor
Received: Mar 2, 2012
Dear Dr. DiPaolo:

I was pleased to see this 47 year old female who has had problems with her breathing since the week before Christmas. She is a smoker of a few cigarettes a day. She does have a 13 pack/year smoking history, smoking one pack every two to three days, but was off them for a number of years. She works two jobs, fill time headhunter in Etobicoke and also part time at McDonalds. She said she has been sick since the week before Christmas with an upper respiratory tract infection, and some tightness in her chest. She has been on two 1 pack antibiotics and another antibiotic but she is unsure of the name. She is allergic to Penicillin. Jnitially she had some cough with green sputum, now this is yellow. She feels a little bit dizzy and lightheaded. She has been using her Ventolin on a regular basis and Flovent 2SOmg/2 inhalations twice a day. She has no other regular drugs, tablets, pills or medications.

As well as being allergic to Penicillin, she has anaphylaxis to nuts and is known to be allergic to cats, although at the present time she has three cats at home which are her daughters.

There is a lifelong history of asthma in herself but there is no other family history of asthma or allergies.

She does have a drug plan.

On examination today there was no anaemia, cyanosis or jaundice. No finger clubbing or adenopathy. Her ears, nose and throat are clear. Her chest is clear. Her abdomen is soft.

There is no peripheral oedeina. Her height is 165cm, her weight however is 114kg, giving her a 13W of 42.

A recent chest x-ray on the 16' of January was unremarkable. There was no evidence of pneumonia.

Spirometry today is normal. Her FEV1 is 95%. There is no evidence of significant air flow obstruction.

I have advised her to take over the counter decongestants or saline irrigation for her nose. I do not believe she needs any further antibiotics. I do feel that she would be better on Symbicort 200/2 inhalations twice a day, rather than Flovent 250 which I have asked her to stop.

I see no indication why she could not return to work. I have arranged a follow up appointment to see her in one month's time, with repeat spirometry.

Yours sincerely,

R.. Andrew McIvor, MD, MSc, FEW?

Jan 27, 2012 BLD/KKD

COMPLAINTS: continues to cough and wheeze. She saw Dr. McIvor. The patient feels very fatigued. She has problems sleeping at night. Part of this is the actue infection. Part may be related to the Cortisone that this patient was on at a fairly heavy dose for 15 days.
EXAMINATION: head and necK: normal. Lymph: normal. Chest: occasional expiratory rhonchi.
DIAGNOSIS: asthma.
TREATMENT: Continue. RTW Feb. 8/12.

Mar 15, 2012 BLD/KLF

COMPLAINTS: Redeveloped a cough with SOB and also sinus problems.
EXAMINATION: Head and neck: Slightly tender sinuses. Lymph: Normal. Chest: Expiratory rhonchi.
DIAGNOSIS: Asthmatic bronchitis. Bronchospasm. ?GERD. Sinusitis.
TREATMENT: Upper GI series.

Mar 15, 2012 BLD/KLF

Start: Hydrasense Nasal Care
Start: Z-Pak (Zithromax) for 5 days
Start: Tecta 40 mg bid

Mar 27, 2012 Misc. Diagnostic Test BLD/KKD

St. Joseph's Hospital

FL-ESO. STOM & DUO. (A.C.)

Apr 20, 2012 BLD/KLF

COMPLAINTS: The pt has GERD. Severe reflux.
EXAMINATION:
DIAGNOSIS:
TREATMENT: Take the Tecta indefinitely.

May 11, 2012 BLD/KKD

COMPLAINTS: released from her job. She is very down, she is having problems sleeping at night. Developed brown spots on her face. She has eczema on her legs.
EXAMINATION:
DIAGNOSIS: brown spots, anxiety state, reflux, bronchospasm.
TREATMENT: ALso, the patient is suffering from tension headaches and cervical strain. Massage therapy. Dermetics.

May 11, 2012 BLD/KKD

Discontinue: Ativan 1 mg. qhs
Discontinue: Zytram XL 200 mg 1 daily for pain to feet and low back
Discontinue: Ventodisk Disk/Diskhaler 2 puffs qid
Discontinue: Qvar 2 inhalations bid
Discontinue: hydrochlorothiazide 25 mg 1 daily
Discontinue: Flovent 250 mg bid
Discontinue: Hydrasense Nasal Care
Discontinue: Tecta 40 mg bid
Start: Ativan 1 mg. qhs
Start: Ventodisk Disk/Diskhaler 2 puffs qid
Start: Flovent 250 mg bid
Start: Tecta 40 mg bid
Start: EpiPen

May 18, 2012 Ultrasound Pelvis BLD/KKD

St. Joseph's Hospital

May 18, 2012 Obstetrics & Gynecology BLD/KLF

Received: Sep 6, 2012

ST. JOSEPH'S HOSPITAL MCMASTER UNIVERSITY
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

May 18, 2012

This patient is a 47-year-old patient, being followed up with respect to menstrual dysfunction and ovarian cysts. I had seen her on two occasions last iäll, at which time she was felt to have physiologic ovarian cyst activity and anovulatory dysfunctional uterine bleeding. Endometrial sampling and Pap smear was negative. She was treated with Provera 20 mg for ten days each day subsequently to induce a withdrawal bleed. Her gonadotropin levels at that time were still within normal limits.

The ovarian cysts had been imaged several times and did not appear to he significantly changed, and their appearances were not suspicious. I am at a bit of a loss to explain things since then. She has not had withdrawal bleeds despite being compliant with Provera therapy. However, her endometrium on ultrasound scanning today is thick at 15 mm. In addition, the ovarian cysts previously noted are persisting, and perhaps even slightly larger such that her right ovary is now 6 ciii in maximal diameter and the left is almost 10 cm. This is somewhat larger then noted in late October, 2011. 1 have asked her to do an LII, FSH, estradiol, progesterone, CA 125 and I will have her back. 1 don't have the formal report on her ultrasound at this point either, and I will be interested to see what they say. I suggested to her that we may be having to consider surgical investigation, more to do with her ovarian cysts then the uterus, but at the time of dictation we have no formal plan. I will let you know.

Yours sincerely,
D. Small, M.D., F.R.C.S.C.

May 29, 2012 Obstetrics & Gynecology BLD/KKD

Received: Aug 28, 2012

ST. JOSEPH'S HOSPITAL MCMASTER UNIVERSITY
DEPARTMENT OF OBSTETRICS & GYNECOLOGY
D.RJ. SMALL, MD, FRCSC ML LOOSLEY-
MILLMAN, MD, PhD, FRCSC

May 29, 2012

I saw this patient in follow up on the 29' of May, 2012. Her LI-I and FSH as well as estrogen levels suggest that she is premenopausal. She has a thick endometrium still, but is not having withdrawal bleeds with the cyclic Provera. This is all a bit odd.

In addition her ultrasound scan shows progressive, very gradual enlargement of hi lateral benign appearing ovarian cysts. Her CA 125 is completely normal. She has some physical stigmata suggestive of I)COS, and ultrasound somewhat reminiscent thereof, but her ovaries are slightly larger then one might normally see with this condition. I have emailed one of my colleagues who is a reproductive endocrinologist to see if they see PCOS follicles as big as this, and I am waiting for that response. In the interim I talked to Suzanne about next steps. She is completely asymptomatic at the present time. Her risk of malignancy index is low. I don't think we are dealing with anything sinister, although the size of the ovaries does concern me somewhat.

She is going to continue her cyclic Provera through the summer. I have set aside some operating time in September such that if these cysts are persisting, we would probably undertake a D&C and laparoscopy to see what we are dealing with. I don't really want to jump into a TAII 1350 scenario at this point in her life unless we are compelled to. I am going to have her back about a month prior to this tentative booking with an ultrasound scan to see if there is interval change.

I have also ordered an androgen profile while we are waiting.

Suzanne will call me in the interim if she has any unmanageable bleeding or other symptoms.

Yours sincerely,

D. Small, M.D., F.RC.S.C.

Aug 29, 2012 Misc. Diagnostic Test BLD/KKD

St. Joseph's Hospital

Aug 29, 2012 Obstetrics & Gynecology BLD/KLF

Received: Oct 30, 2012

St. Joseph's Healthcare, Hamilton
St JOSEPH'S HOSPITAL MCMASTER UNIVERSITY
DEPARTMENT OF OBSTETRICS & GYNECOLOGY
D.RJ. SMALL, MD, FRCSC
August 29, 2012

I saw Suzanne in follow up on the 29th of August, 2012, in conjunction with an ultrasound scan. This patient continues to have ultrasound evidence of bilateral ovarian cysts. These continue to be present, with ultrasound scanning today showing enlargement of both ovaries although reduction in size compared to tier last ultrasound. Both ovaries contain multiple small cysts. I think that this is a variant of PCOS. I have discussed this case with Dr. Kaniis and we have tried to send her ultrasound images for Megan to review but unfortunately we had trouble. The appearance is not entirely typical, however, but the patient does have some physical stigmata consistent with this including hirsutism and acanthosis. She continues to have very minimal withdrawal bleeding with cyclic Provera but continues to have a relatively thick endometrium of 12 to 15 mm as well.

The plan is to do a diagnostic laparoscopy, hysteroscopy and dilatation and curettage. I would like to ensure we are not dealing with anything more serious with her ovaries, and I would like to have a thorough sampling of her endometrial lining in view of her possible PCOS condition and thick endomctrial lining. She realizes that if there is something more serious going on that further surgery might be necessary for definitive management and that this is mainly a "fact finding" mission.

Surgery is scheduled for October 1", 2012 at noon. Consent was obtained. I will see her after surgery to discuss what follow up is necessary.

Yours sincerely,
Small, M.D., F.R.C.S.C.

Oct 1, 2012 Other Consultant BLD/KKD

Dr. Small

Received: Nov 15, 2012

St. Joseph's Healthcare, Hamilton
Operative Report - Chariton Campus

SURGEON(S): D. Small, MD
ASSISTANT(S):
ANESTHETIST:
ANESTHESIA: General.

PREOPERATIVE DIAGNOSIS: 1. Abnormal uterine bleeding.
2. Ovarian cyst (etiology NYD).
POSTOPERATIVE DIAGNOSIS: Same, await pathology.
OPERATION: D AND C, HYSTEROSCOPY AND LAPAROSCOPY, BIOPSY OF PERITONEUM AND BIOPSY OF OVARIES.

PROCEDURE: A surgical pause was undertaken. The patient was allergic to penicillin. Clindamycin was administered. General anesthetic was administered with endotracheal intubation.

The patient was prepped and draped in lithotomy. Her arms were left out. Her bladder was drained.

Her uterus was sounded to 12 cm. Diagnostic hysteroscopy was undertaken. The cavity looked slightly "lush". It appeared that she had a midline septum in the uterine cavity. This may have been accounting for her endometrial thickness on ultrasound scanning.

The cervix dilated to a 9 Hegar with no resistance. Curettage was undertaken and curettings have been submitted.

There was no obvious polyp noted.

She had a previous laparoscopy incision from the site of her tubal sterilization. We elected to make a midline incision within the umbilical cleft as the abdominal wall was a bit thinner there. A 5 mm incision was made. Marcaine 0.5% was infiltrated prior to the incision. The Veress needle was passed. With the first pass, the inflation pressure seemed a bit high and so a second introduction was undertaken at which point appropriate inflation pressures were noted. We elected to increase the inflation to 20 mmHg in view of the patient's body habitus to try and make it easier to get the primary trocar in. Once that pressure had been achieved, a primary trocar was placed without incident. A 5 mm laparoscope was introduced. Careful inspection of the entry site was undertaken with no evident trauma. There was a bit of subcutaneous emphysema which I think indicates the first introduction was preperitoneal.

The liver was normal. The diaphragms were normal. There was no ascites. The stomach was slightly distended but normal. The omentum was normal. The uterus was bulky. It was anteverted. There was bilateral multiple small ovarian cysts noted on both ovaries. These were rather unusual. On the left ovary there was a vascular excrescence which I think was a hemorrhagic corpus luteum cyst. The ovaries were completely mobile. Tubes were normal. There was evidence of previous sterilization. There was a Filshie clip attached on the right tube and separate on the left tube in the anterior cul-de-sac. There was one vesicle of smooth walled clear fluid on the bladder. I introduced a suprapubic port and a left lateral port under direct visualization, both 5 mm. We removed the bladder peritoneum vesicle and also removed one of the vesicular growths on the ovary. I think it is a cyst adenofibroma of the ovary rather than any ovarian malignancy - it did not have a characteristic appearance of a malignancy but was certainly not characteristic of PCOS either. I did not want to upstage her if she had malignancy, but I felt that we needed to establish a diagnosis to help us plan the need for future surgery, including any urgency.

The two areas that had been removed were gingerly cauterized and there was really no bleeding. We had done washings as well with the irrigation apparatus.

At this point, I did not think there was more that we could do without further consent of the patient.

The trocars were removed under direct visualization. Gas was expelled. All counts were correct at this point. The abdominal incisions were closed with subcuticular 3-0 Vicryl suture. Specimens including washings, biopsies, and curettings have been submitted for histology.
The patient was awakened, extubated, and transported to recovery in good condition.

David Small, MD

Oct 1, 2012 BLD/KKD

St. Joseph's Hospital - Pathology

Oct 1, 2012 Pathology BLD/KKD

Oct 3, 2012 Misc. X-Ray BLD/KKD

St. Joseph's Hospital
Abdomen and Chest

Oct 3, 2012 Obstetrics & Gynecology BLD/KKD

Dr. Ramanna
Received: Nov 26, 2012
St. Joseph's Healthcare, Hamilton
Consultation - Chariton Campus

GYNECOLOGY CONSULTATION

47-year-old G4, TI A3, Li postoperative day #2 from a diagnostic laparoscopy, peritoneal washings, ovarian cyst biopsy and bladder biopsy.

PAST OBSTETRICAL HISTORY:
1. 1982 to 1990: Three therapeutic abortions.
2. 1993: Spontaneous vaginal delivery of a term live female. No complications.

ALLERGIES:
Penicillin.

MEDICATIONS:
1. Tecta.
2. Ventolin.
3. Flovent.

PAST MEDICAL HISTORY:
1. Asthma.
2. GERD with hiatal hernia.
3. Hypoglycemia.

PAST SURGICAL HISTORY:

Three diagnostic laparoscopies; two of which were remote and the last of which was on October 1st.

PAST GYNECOLOGICAL HISTORY:
The patients last Pap was this year and was normal. She has never had an abnormal Pap. She has no history of STIs. She does have a history of ovarian cysts both currently and when she was in her early twenties. The patient smokes five to six cigarettes per day. She does not drink any alcohol or use any other drugs.

HISTORY OF PRESENTING ILLNESS:
Suzanne was seeing Dr. Small for suspicious cyst noted on ultrasound. She stated that she was tried on various medications, however does not remember which. She had a diagnostic laparoscopy on Monday. She states that since she woke up from the laparoscopy, she has been having a stabbing constant pain in her right lower quadrant. She also describes having retrosternal chest pain that feels like something sitting on her chest. The pain worsens with a deep breath and worsens with lying down. She also is complaining of a sore throat and a nonproductive cough. She states that the pain in her chest is a constant pressure. She has not passed gas since the procedure and has not had any bowel movements. She states that she is burping but having no nausea or vomiting. She is quite lightheaded. She has some pain with urinating. There is no hematuria. She states that she has had a fever at home at 38. There are no chills.

PHYSICAL EXAMINATION:
On examination, vital signs are stable with a temperature of 36, heart rate 79, respiratory rate 16, blood pressure 149/102, and oxygen saturation 100% on room air.

Respiratory examination was significant for an inspiratory wheeze. Abdominal examination reveals a soft abdomen that was tender in the right lower quadrant. There were no peritoneal signs. Cardiovascular examination was unremarkable.

INVESTIGATIONS:
Investigations revealed a normal CBC with a hemoglobin of 135, WBC count 10.3, platelet count 269. Electrolytes were grossly normal.

EKG showed normal sinus rhythm.

CK 132, troponins less than 0.01.

Chest x-ray normal.

Abdominal x-ray showed no free air and no air fluid levels. There was a significant amount of fecal loading.

IMPRESSION AND PLAN:
This is a 47-year-old G4, Ti, A3, LI postoperative day #2 from diagnostic laparoscopy who is complaining of increasing abdominal pain that is in the right lower quadrant and sharp, chest heaviness and shortness of breath. All of her investigations are normal apart from an abdominal x-ray showing a significant amount of fecal loading. Unfortunately, this patient left AMA before we were able to reassess her.
Thank you very much for allowing us to participate in the care of this patient.

Gillian Dharmai, MD, Resident FOR
Raj Ramanna, MD

Oct 17, 2012 Obstetrics & Gynecology BLD/KKD

Dr. Small

Received: Nov 28, 2012

Dear Dr. DiPaolo:

This patient was seen with her friend accompanying her on the 7,h of October, 2012 in follow up of her laparoscopy. She has rather unusual looking ovaries. These do not appear to be typical "polycystic" ovaries, They were a bit worrisome but didn't really have the appearance of a malignancy. Ovarian biopsy showed a simple benign serous cyst. Her washings showed tight clusters of atypical cells of undetermine origin. I-Icr peritoneal biopsy was negative. I wonder if this is a cystadenofibroma?

I think the bottom line is that she should probably have both of her ovaries removed for complete histologic evaluation. That being the case, a hysterectomy will he undertaken concurrently. I have explained this to Suzanne and she understands the rationale and agrees. She is aware that she will experience a surgical menopause. We have briefly talked about hormone replacement therapy and we will address that issue postoperatively. The risks of surgery including bleeding, infection or damage to surrounding structures was part of the informed consent process undertaken today. Surgery is planned for November 26", 2012.

Trusting this is helpful

Yours sincerely,

D. Small, M.D., F.R.C.S.C.

Nov 26, 2012 BLD/mvs

St. Joseph's healthcare
Dr. Small - Operative Report

Nov 26, 2012 BLD/mvs

St. Joseph's Hospital
Dr. Salama - Surgical Pathology Report

Nov 29, 2012 Misc. X-Ray BLD/KKD

St. Joseph's Hospital
Chest and Abdomen

Nov 30, 2012 Pathology BLD/KLF

DR. ABDEL-MESIH

Dec 4, 2012 BLD/KLF

PHONE CONVERSATION

COMPLAINTS: The pt was just released from hospital. She was on Dilaudid. She had a total hysterectomy and followed by complications of infection.
TREATMENT: Dr. Small is going to have an operation on his shoulder.
Inconvenient for patient to come to office. If not better, call office or go to ER.

Dec 4, 2012 Obstetrics & Gynecology BLD/KKD

Dr. Small

Dec 6, 2012 DynaCare Laboratories (HL7) Lab Data (Updated) BLD/TC

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Accession Number                    50-53221256
Collection Date                     Dec 6, 2012 0:00AM
Result Copy To: Di Paolo, Bruno L
Ordering Physician: SMALL, D.R.


OTHER CULTURE
    ---------
    SOURCE:     INCISIONAL
    MICROSCOPY: No WBC
    Few Gram positive cocci
    CULTURE: (1)A heavy growth of  Enterococcus
    (2)A moderate growth of Staphylococcus epidermidis
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Dec 12, 2012 Obstetrics & Gynecology BLD/KKD

Dr. Small

Dec 20, 2012 BLD/KKD

PHONE CONVERSATION

COMPLAINTS: the patient has had a hysterectomy on November 26th. She developed a seroma.She is on Clindamycin. The medication is now finished, the discharge has increased. Further, she has developed a cough with phlegm. She has a history of asthma and sinustiis.
TREATMENT: Z-Pak. Yogurt daily.
Inconvenient for patient to come to office. If not better, call office or go to ER.

Dec 20, 2012 BLD/KKD

Start: Z-Pak (Zithromax) for 5 days
Start: clindamycin hydrochloride 300 mg qid for 10 days

Dec 27, 2012 Obstetrics & Gynecology BLD/KKD

Dr. Small

Jan 10, 2013 Misc. Diagnostic Imaging BLD/di

St. Joseph's Hospital

GR - 2-3 V V & Chest 1 V Panel

Jan 10, 2013 BLD/KKD

Consultation Report - Dr. Small
Obstetrics and Gynecology

Jan 16, 2013 BLD/JW

COMPLAINTS: Had a c in November 2012. Dr. Small did the procedure. He is now away on a sick leave. The pt is apparently had a hit on her head while she was being transferred although she is not sure about that. She now is experiencing headaches, dizziness, difficulty with word formulation. Memory problems. Visual problems. She is feeling sad. Dr. Small wanted to start her on estrogen medication, Estrace 1 mg. The pt is not comfortable with this because of possibility of CA of the breast.
EXAMINATION: BP: 120/80. Her general colour is reasonable. Eyes: Perla.
DIAGNOSIS: Rule out acute brain injury.
TREATMENT: MRI of head. Dr. Rathbone. Blood tests. Pt was also given Stemitil 5 mg tid. Hopefully they will have this at the pharmacy. She is not doing well with Diclectin and not well with Gravol.

Jan 16, 2013 BLD/KLF

Start: Stemetil Tablets 5 mg tid

Jan 23, 2013 Obstetrics & Gynecology BLD/KKD

Dr. Small

Jan 29, 2013 Misc. MRI Scan BLD/KLF

Feb 4, 2013 BLD/KLF

PHONE CONVERSATION
COMPLAINTS: The pt is to come in to see Jeff, the pharmacist for her medications. She was unable to get the MRI. She suffered from clausterphobia.
TREATMENT: Send to General Hospital. Bigger machine with sedation. Being referred to Acquired Brain Injury clinic. She has partial dysfunction of the left eye. Headaches. She also stutters after the concussion. Inconvenient for patient to come to office. If not better, call office or go to ER.

Feb 12, 2013 MRI Scan Head BLD/KKD

Hamilton General Hospital

Feb 20, 2013 Obstetrics & Gynecology BLD/KKD

Dr. Small
Received: Mar 20, 2013
Dear Dr. DiPaolo:

Suzanne was seen in follow tip today. She seems to be in much better spirits today. She was even showing evidence of humour. She still complains of persistent headache, unsteadiness and stuttering when excited as well as memory problems but overall she looks better today. I understand she had an MR I of the head completed last week at the Hamilton General Hospital and the results are pending. She is hoping following this that she will have a quick appointment with Dr. Rathbone from neurology.

With regards to the wound infection, CCAC is still seeing her and packing the site. They have told her that the overall dimensions are now decreasing. I understand she has had one set back with a repeat infection. This was apparently diagnosed by the CCAC nurse, she had a refill on her Clindamycin prescription and so she was started with the Clindamycin on her own advice.

When I examined the site today the abdomen is soft and non-tender. There was no evidence of erythema or purulent drainage. I have advised her if they feel the site is becoming infected again that she return to our clinic, 1 would recommend taking a swab of the site. It is possible that whatever is growing in there is not susceptible to the Clindamycin.

Occupational therapy have recommended that she gret abdominal binders as well as a heating pad and cane to help with mobility as well as her abdominal and back pain that she still suffers from following the surgery. A prescription was given was all of those. We will see her back in the clinic in one month's time to reassess her wound healing.

Thank you for involving us. We will continue to keep you apprised.

Yours sincerely,

Lauren Smith, M.D., F.R.C.S.C., Locum for
D. Small. M.D.. F.R.C.S.C.

Feb 21, 2013 DynaCare Laboratories (HL7) Lab Data BLD/KKD

Accession Number 64-54473922
Collection Date Feb 21, 2013 11:15AM
Ordering Physician: Di Paolo, Bruno L

GLUCOSE SERUM FASTING	6.5 (H)	3.6	- 6.00
3.6 - 6.0 NORMAL FASTING GLUCOSE			
6.1 - 6.9 IMPAIRED FASTING GLUCOSE			
>6.9 PROVISIONAL DIAGNOSIS OF DIABETES MELLITUS			
CREATININE			
CREATININE	62	50	- 100.00
eGFR	89	60	- 99999.98
Result considered normal unless there is other evidence of kidney damage e.g. proteinuria, or patient is at high risk for chronic kidney disease.			
For African Americans, the reported eGFR should be multiplied by a factor of 1.21 and re-interpreted accordingly.			
CHOLESTEROL	6.97 (H)	<=5.19	
TRIGLYCERIDES	3.51 (H)	<=2.29	
HDL CHOLESTEROL	1.31	1.3	- 99999.00
LDL CHOLESTEROL CALC.	4.05		
TC/HDL-C RATIO			
TC/HDL-C RATIO	5.3		

Risk Categories should be determined using Reynolds or Framingham Risk scores:

10 year CVD Risk	Initiation of Therapy	Treatment Targets
High >=20%	Consider in all patients	LDL-C: < 2.00 mmol/L or >= 50 % decrease Apo B <0.80 g/L
Moderate 10% - 19%	LDL-C > 3.50 mmol/L or TC/HDL-C ratio > 5.0 or hs-CRP > 2.0 mg/L*	LDL-C: < 2.00 mmol/L or >= 50 % decrease Apo B <0.80 g/L
Low <10%	LDL-C >=5.00 mmol/L	LDL-C: >= 50% decrease

* Consider treatment when hs-CRP is >2.0 mg/L, in men >50y or in women >60y of age, irrespective of LDL-C level.
Updated guidelines, effective April 18, 2011, as per the Can J Cardiol Vol 25 (10 October): 2009; 567 - 579.

VITAMIN B12	223	>221	
DEFICIENCY:		< 148	pmol/L
INSUFFICIENCY: 148 - 220 pmol/L			
SUFFICIENCY: > 220 pmol/L			
60% OF SYMPTOMATIC PATIENTS HAVE A HEMATOLOGIC OR NEUROLOGIC RESPONSE TO B12 SUPPLEMENTATION AT A LEVEL <148 pmol/L			
FERRITIN	95	31	- 300.00
<12 Iron deficient			
12 - 30 Depleted iron stores			
31 - 79 Reduced iron stores			
80 - 300 Normal iron stores			
>300 Likely iron overload			
SODIUM	139	135	- 145.00
POTASSIUM	4.5	3.3	- 5.1
ALKALINE PHOSPHATASE	72	35	- 122.00
ALT	23	<=35.99	
TSH	2.54	0.35	- 5.00

PLEASE NOTE UPDATE TO REFERENCE INTERVAL EFFECTIVE APRIL 16,2012.

HEMOGLOBIN	145	115 - 155.000
HEMATOCRIT	0.43	0.33 - 0.450
RBC	4.74	3.6 - 5.010
RBC INDICES: MCV	90	80 - 99.000
MCH	31	27 - 32.000
MCHC	338	320 - 360.000
RDW	13.6	11.5 - 15.500
WBC	6.1	4 - 11.000
PLATELETS	302	145 - 400.000
MPV	7.3 (L)	7.4 - 11.300
DIFFERENTIAL WBC'S		
NEUTROPHILS	3.36	1.80 - 7.00
LYMPHOCYTES	2.20	1.00 - 3.20
MONOCYTES	0.37	0.00 - 0.80
EOSINOPHILS	0.12	0.00 - 0.40
BASOPHILS	0.00	0.00 - 0.20
URINALYSIS CHEMICAL		
GLUCOSE	NEG	NEG
BILIRUBIN	NEG	NEG
KETONES	NEG	NEG
S.G.	1.028	1.005- 1.030
BLOOD	NEG	NEG
pH	5.5	5 - 8.000
PROTEIN	NEG	<=NEG
UBG	3.2	<32.999
NITRITE	NEG	NEG
LEUKOCYTE	SMALL (A)	NEG

BLD/KKD

Feb 27, 2013

St. Joseph's HOspital
Neuroophthalmology Clinic - Dr. Rodriguez

yb

Feb 28, 2013

MRI booked by BLD and Dr from HGH. Pt. cancelled St. Joseph's because of illness but then had MRI done at HGH by specialist

BLD/KLF

Feb 28, 2013

PHONE CONVERSATION

COMPLAINTS: Apparently an appt for Suzanne Young was sent to another patient's house. This pt called her. She will go and retrieve the appt.
TREATMENT: Let her know that her appt was stuck to the other appt for Mr. Putignano. She agreed that this could be destroyed.
Inconvenient for patient to come to office. If not better, call office or go to ER.

BLD/KLF

Mar 4, 2013

PHONE CONVERSATION

COMPLAINTS: Spoke to Dr. Rathbone's secretary again. I advised her that I would send the MRI. I also informed her that I had spoken to Dr. Rodriguez's office and they did not have a diagnosis as far as the secretary knew. She has an appt on March 7, 2013 to have further testing.
TREATMENT:
Inconvenient for patient to come to office. If not better, call office or go to ER.

BLD/KLF

Mar 4, 2013

PHONE CONVERSATION

COMPLAINTS: N/A.
TREATMENT:
Inconvenient for patient to come to office. If not better, call office or go to ER.

BLD/KKD

Mar 5, 2013

Consultation Report - Dr. Jiaravuthisan
Dermatology

BLD/TC

Misc. Diagnostic Test

Mar 7, 2013

St. Joseph's Hosptital
Neuro-Visual Evoked Response

Mar 14, 2013 BLD/KLF

PHONE CONVERSATION

COMPLAINTS: Developed infection in foot. Using Naproxen 500 mg bid. Painful surgery after she had her hysterectomy.
TREATMENT: She will be examined on March 18, 2013.
Inconvenient for patient to come to office. If not better, call office or go to ER.

Mar 14, 2013 BLD/KLF

Start: clindamycin hydrochloride 300 mg qid for 10 days
Start: naproxen 500 mg bid

Mar 18, 2013 JW

Pharmacy note
- pt failed to show for appt
Jeff Wong, RPh

Mar 19, 2013 Obstetrics & Gynecology KKD

Dr. Small
Received: Apr 10, 2013
Dear Leo:

I saw Suzanne on the 19111 of March, 2013 in follow up. This patient had a TAH and BSO on November 26", 2012. Her hospital course was complicated by having a small bruise on her occiput after her surgery, which she awake with after the operation. The cause of that was not determined from the hospital record. She subsequently had some loss of hair in the area. She has had some unusual neurological symptoms that have been persisting since all of this happened, and I am not sure I can understand the relationship between the small bruise on her occiput and the subsequent neurological symptomatology.

In addition to that she had a postoperative incisional infection. The good news here is that's now healed up completely and her incision looks quite nice. She is still a bit tender there and I have encouraged her to do some active massage of the area to break down any scar tissue.
Her head is back to normal - her hair has grown in and you really cannot see any evidence of any kind of trauma area. She had an MRI since I last saw her which was normal. She is seeing Dr. Rathbone, a neurologist, in the near future. She has also seen a neuro-ophthalmologist, Dr. Rodriguez, but I don't have his report.

I think that there is a family meeting with Suzanne arranged by the hospital because of her concerns around the query head in that she experienced postoperatively. However, this is relayed to me through Suzanne and the hospital has not contacted me to have me participate in that discussion. That whole issue is more related to nursing and anesthesia then the actual surgical course.

I do want to talk to Suzanne in more detail about long-tern estrogen replacement therapy in view of her relatively young age for surgical menopause. However, I am not sure that this is the right time to embark on that discussion, until we have a better sense of what's going on with her current neurological issues. To that end, I have asked her to return to the office once those issues have been sorted out and we will have a discussion about that issue.

This has certainly been a challenging situation for Suzanne through all of this and I have tried to be supportive throughout her course. I will continue to follow her with you.

Yours sincerely,

D. Small, M.D., F.R.C.S.C.

Mar 21, 2013 KKD

Consultation Report - Dr. Rathbone
Neurology

Apr 8, 2013 JW

Pharmacy note
- referral for discussion of opioids. On pain meds for ongoing abdo pain from hysterectomy and oophorectomy in Nov 2012, head pain due to ? unexplained trauma during surgery (as per pt)
- pt meeting with hospital board today to discuss unexplained injury
- finds pain to be improved by about 50% with opioids. Depending on activities, pain meds may be providing 25-100% pain reduction. Taking 5 tablets per day on average. Opioids providing benefit for QOL and ability to perform iADLs, but benefit wanes after 4 hours approx.

Opioid Medication Treatment Agreement

I understand that I am receiving opioid medication from Dr. to treat my pain condition.
I agree to the following:

1. I will not seek opioid medications from another physician. Only Dr. will prescribe opioids for me.
2. I will not take opioid medications in larger amounts or more frequently than is prescribed by Dr. .
3. I will not give or sell my medication to anyone else, including family members; nor will I accept any opioid medication from anyone else.
4. I will not use over-the-counter opioid medications such as 222's and Tylenol No. 1.
5. I understand that if my prescription runs out early for any reason (for example, if I lose the medications, or take more than prescribed), Dr. will not prescribe extra medications for me; I will have to wait until the next prescription is due.
6. I will fill my prescriptions at one pharmacy of my choice; pharmacy name: SDM on Plains Rd in Burlington
7. I will store my medication in a secured location.

I understand that if I break these conditions, Dr. may choose to cease writing opioid prescriptions for me.

Sincerely,

Suzanne Young

P: Provoked by activity, photophobia. Relieved by dark rooms and rest
Q: constant, sharp pain in abdo, and dull pain in head
R: no
S: 5-7/10 avg
T: Every day, constant

Current meds (as per pt, did not bring in): Tecta 40mg BID, Naproxen 500mg BID, Ventolin uses every day for asthma, Flovent 2 puffs BID, Soflax 100mg BID, Stemetil 10mg TID
No constipation, nausea and dizziness present likely d/t headaches vs. pain meds. No abherrent behaviours noted.

A: Pain in abdomen and head on Dilaudid
P: 1) Opioid treatment agreement discussed and entered into EMR
2) Urine drug screen monthly, req given
3) Continue with Dilaudid 150 tabs every 30 days. Reduce opioid use as possible, discussed concerns with tolerance, dependence of long-term use. Pt agreeble to plan and wants to cut down
4) F/U with Firestone clinic for asthma
Discussed with Dr. DiPaolo
Jeff Wong, RPh

Apr 8, 2013 BLD/JW

Change To: Stemetil Tablets 10 mg tid
Start: Dilaudid 4mg tablets. Take 1 tablet every 4 hours when needed. Quantity: Total 450 tablets. Please dispense 150 tablets every 1 month.

Apr 25, 2013 Otolaryngology (ENT) BLD/KKD

Dr. Robertson
Received: May 13, 2013
Dear Dr. Rathbone:

This 48-year-old woman was seen today for otologic review. She presented with complaints of dizziness. She says her circumstances developed November 26, 2012 after having abdominal hysterectomy surgery. The circumstances apparently are unclear at this time. She had the surgery at St. Joseph's Hospital. She awoke with a concussion. She had a swelling at the back of her head. She was noting a headache, dizziness, nausea and vomiting. She was noted to have a right occipital contusion. She subsequently developed photophobia, blurred vision, sound sensitivity, memory issues, concentration difficulty, sleep problems and fatigue. She has had neurologic assessment suggesting these symptoms to be compatible with a post concussion syndrome. She developed some visual loss and has since seen Dr. Rodriguez from rieuro-ophthalmology. Visual field testing showed a bilateral superior arcuate defect with thinning of the temporal pen-papillary nerve fiber layer. An MRI scan of the head on February 12 was apparently unremarkable. The vertigo that she had was fairly intense for the first 6 weeks. She was aware of head motion intolerance and positional triggering. The latter aspect appears to have improved but she still persists with head motion intolerance, chronic dizziness and dysequilibrium. She is aware of occasional tinnitus but no concerns of hearing loss, hyperacusis, otorrhea, otalgia, or facial palsy. She does not wear hearing aids. There is no history of otologic surgery.

She indicated her general health prior to this was otherwise satisfactory. She does have some issues with asthma, bronchitis and hypoglycemia. Her medications include Ventolin, Flovent, Tecta, Dilaudid, Prochlorperazine, Soflax, Naproxen and Lorazepam. She indicated no drug allergies.

On examination today, the ears were debrided. The tympanic membranes appeared satisfactory with no atelectasis, perforation, serous effusions, or cholesteatoma. Sinonasal endoscopy was unremarkable. The mouth, pharynx, and neck appeared clear.

A neuro otologic assessment with infra red video oculography identified no spontaneous or gaze nystagmus. Dix-Hallpike testing as well as positional testing appeared negative. She did note head motion intolerance as well as nausea throughout the assessment. Low velocity VOR responses were hypoactive to the right with a left being post head shaking nystagmus. Head impulse testing appeared negative bilaterally. Oculomotor function as well as nystagmus suppression appeared intact. Romberg, tandem Romberg and stance on one leg postural control testing was abnormal with an eyes closed performance restricted to no more than 4, 4, and 2 seconds respectively. Dynamic visual acuity testing was reduced to 0.22 Log Mar.
An audiogram was normal. Auditory evoked response studies appeared normal.

At the present time, her assessment indicates changes consistent with an uncompensated right peripheral

vestibulopathy. Some of her initial history may support benign positional vertigo but there is no active cupulolithiasis nor canalolithiasis for intervention at this time. Given the pattern of vestibular loss that she demonstrates, she may benefit with a trial of vestibular physiotherapy and balance retraining to help foster vestibular compensation, mitigate her dizziness, and help improve vestibular recovery. All of this was discussed with her today. We will provide her with information on the vestibular physiotherapy program. I will leave it to her timing and discretion to pursue. For now I don't think any further vestibular testing would significantly advance her management. Thank you for the opportunity to participate in her care.

Yours sincerely,

Dr. D. Robertson, M.D., F.R,C,S.C.

May 13, 2013 BLD/KKD

Consultation Report - Dr. Rathbone
Neurology

May 30, 2013 Misc. Consultant Report BLD/KKD

Dr. Rodriguez
Received: Jul 25, 2013
St. Joseph's Healthcare, Hamilton
Clinic Note - King Campus

NEUROPHTHALMOLOGY CLINIC

FOLLOWUP NOTE

This patient was initially seen on February 27, 2013. At that time, she was found to have decreased visual acuity. Visual field testing did show some defects. Optical coherence tomography showed thinning of the nerve fiber layer.

Since her last visit, she feels her vision is about the same. She still has problems reading and finds it frustrating. She complains of severe headaches and nausea. She was seen by Dr. Robertson who found evidence of right vestibulopathy.

On examination, visual acuity without correction is 20/40 OD and 20/70 05. There is no pinhole improvement in either eye. Pupils are equal and reactive to light with no relative afferent pupillary defect. Slit lamp examination is unremarkable OU. Intraocular pressure is 10 mm of mercury OU. Fundoscopy reveals distinct margins of both optic discs. There is no obvious pallor. Maculae within normal limits. Ocular motility is full. Eye movements make her dizzy.

Visual evoked potentials were normal bilaterally.

New Humphrey 24-2 Visual Field Test completed today shows a small superonasal defect in the right eye. Both eyes look certainly better than the previous visual field test completed in February 2013.

IMPRESSION: Visual fields seem better. Her vision remains about the same. I am going to review her again in a followup in six months.

Yours sincerely,

Amadeo Raul Rodriguez, MD

Jun 4, 2013 BLD/KLF

PHONE CONVERSATION
COMPLAINTS: Still off work. Still under treatment. Still not able to return to work.
TREATMENT:
Inconvenient for patient to come to office. If not better, call office or go to ER.

Jun 7, 2013 Misc. Ultrasound BLD/KKD

St. Joseph's Hospital
Extremities

Sep 3, 2013 BLD/KKD

COMPLAINTS: the patient continues with headaches. She has problems with balance. She also has difficulty

producing words. She has been to Dr. Rathbone and has seen a number of other specialist. She is getting some special rehab at home to help her with her balance and she is going to St. Peters for speech therapy. Her unemployment ran out. She is on Ontario Works. The patient breaks out in a rash, hives, when she has wheat products or dairy products. The patient has a cough. She went to a walk-in clinic. They didn't give her anything. She has green phlegm. She also stopped smoking for 1 year. In-grown big toenail.
EXAMINATION:
DIAGNOSIS:
TREATMENT: Dr. Bailey.

Sep 11, 2013 BLD/KLF

COMPLAINTS: Being sent for speech therapy and also there will be some therapy with someone going to her home. She continues with headaches and some photophobia today. Chest is feeling well. She uses even less inhalers. Also going to a sleep clinic.
EXAMINATION:
DIAGNOSIS:
TREATMENT: Totally disabled from any occupation at this time.

St. Joseph's Hospital
50 CHARLTON AVENUE EAST
HAMILTON, ONTARIO L8N 4A6
(905) 522-1155

RADIOLOGY
Ext. 36009

UNIT NO.0000372533 ODP

Patient Name YOUNG,SUZANNE MARIE
695 PLAINS RD E

BURLINGTON, ON L7T2E8
ONTARIO HEALTH NO. 6427-959-512 YW
DOB: 64/10/11 SEX F

EXAM DATE 13/06/07 0937 Check-in No. 3752915 Account # 56403233

ORDERED BY	KUMBHARE,DINESH	Fax# (905)777-9399
ATTENDING PHYS.	KUMBHARE,DINESH	Fax# (905)777-9399
FAMILY PHYS.	DIPAOLO,BRUNO L	Fax# (905)575-9896
REFERRING PHYS.	RATHBONE,MICHEL P	Fax# 905-383-3958

Chk-in #	Exam
3752915	US-EXTREMITIES-PER LIMB*L

TARGETED ULTRASOUND POSTERIOR NECK

INDICATION: 48-year-old female with headache after concussion in November 2012 with large contusion of the upper cervical spine. Bilateral occipital neuralgia. Assess for hematoma. Assess occipital nerves.

COMPARISON: None.

FINDINGS:

No hematoma is demonstrated. No mass or cyst.
The occipital nerves were too small to be accurately assessed by ultrasound.

- DR SRINIVASAN HARISH
Reading Physician- DR SRINIVASAN HARISH
Releasing Physician- DR SRINIVASAN HARISH
Released Date Time- 13/06/09 1030
Reading Resident- DR KATAYOUN RICHARD

THE ULTRASOUND FACILITY OF ST. JOSEPH'S HEALTHCARE HAMILTON IS ACCREDITED BY THE AMERICAN INSTITUTE OF ULTRASOUND IN MEDICINE (AIUM)

COMPLETE

DIAGNOSTIC IMAGING

McMaster University

St. Joseph's Healthcare Hamilton

Hamilton Health Sciences

Combined Neurology - Physiatry Clinic

Dr. Michel Rathbone
Department of Medicine - Division of Neurology
McMaster University - JH
Hamilton, ON L8S 4K1
Telephone: (905) 574-8630
FAX: (905) 383-3958

Dr. Dinesh Kumbhare
Physical Medicine Rehabilitation
240 James Street South, Hamilton, Ontario, L8P 3B3
Telephone: (905) 777-9389
FAX: (905) 777-9399

Monday, May 13, 2013

Dr. Bruno Di Paolo
Address: 77 Markland Hamilton L8P 2J8
Phone: (905) 575-5173
Fax: (905) 575-9896
Re: Young, Suzanne
OHIP: 6427 959 512 YW
Address: 101-695 Plains Rd E Burlington
Phone: (905) 333-2744
DOB: 1964-10-11

Dear Dr. Di Paolo,

Thank you for asking me to see this 49 year-old right-handed woman in neurological consultation today. Thank you for your referral note.

Problem:
Post concussion syndrome

Problem description:
Ms. Young was seen for a follow-up today, accompanied by her sister. Her last appointment was March 21, 2013. She had a total abdominal hysterectomy on November 26, 2012 and woke up with a contusion over her left occipital region after the surgery. She developed headache, vertigo, nausea and vomiting, blurred vision, photophobia, cognitive difficulties, sleep problems, fatigue, and mood changes. These symptoms did not improve since last appointment.

She reported her headache is constant, sharp, around the entire top of the head, to the neck and behind the eyes. Her headache is affected by weather changes and humidity as well as light and emotions and is associated with nausea. She states that nothing has provides relief.

Dr. Robertson, neurotologist, saw her on April 25, 2013 and indicated uncompensated right vestibulopathy. She is anxious about her financial situation as she does not have money for the therapy sessions referred to her by Dr. Robertson.

Brain MRI on February 12, 2012 was unremarkable.

Previous medical and surgical history:
- Total abdominal hysterectomy
- Bronchial asthmatic
- Hypoglycemic

Allergies:
- Penicillin
- All nuts

Current medications:
- Ventolin 100mcg, four times a day
- Flovent 125mcg, twice a day
- Soflax 100mg, three times a day
- Tecta 40mg, twice a day
- Lorazepam 1mg, once a day
- Dilaudid 4mg, six times a day
- Prochloroperazine 10mg, three times a day

Discontinued:
- Naproxen
- Ativan

Other specialists:
Dr. Rodriguez

Family history:
- Crohn's disease, mother
- Colitis, mother
- Cancer, father
- Heart disease, father
- Triple bypass surgery, father
- Cancer, both sides

Social history:
Ms. Young is currently single with 1 child who is generally healthy. She has been off work due to surgery. She works as an executive administrator.

Physical examination:
Neurological examination within normal limits except for bilateral greater and lesser occipital neuralgia. She is emotionally labile.

Problem formulation:
Ms. Young developed multiple symptoms after surgery in November. Unfortunately, her symptoms did not improve over time. Regarding the persistent headache, her current medications, especially high dose Dilaudid, could have caused rebound headaches.

I suggest you, Dr. Di Paolo, to adjust her pain medications. We prescribed Cymbalta for her depressed mood and pain.

Regarding her occipital neuralgia, injection treatment is probably the best option. An ultrasound was ordered by Dr. Kumbhare in preparation for the injection. She will be seen again after the test.

Further investigations:
Ultrasound of upper cervical spine, especially for occipital nerves.

Treatment:
- Cymbalta 30mg, once a day

Follow up:
We will follow-up with Ms. Young in the Combined Neuro-Physiatry Clinic. An appointment is currently pending.

With best wishes,
Yours sincerely,

Joy Deng, Neurology Fellow, dictating for:

Michel P. Rathbone

Michel P. Rathbone, M.B., Ch.B., PhD., FRCP (C)
Professor, Department of Medicine (Neurology, Neuroscience and Neuropharmacology)
McMaster University

Dinesh Kumbhare
FRCPC, PhysMed & Rehab - St.Joseph's Hospital

CC: Rodriguez, Amadeo R. - 905-573-4858

McMaster University

Dr. Michel P. Rathbone, M.B., Ch.B., PhD., FRCP (C)
Neurology, Neuroscience and Neuropharmacology
Department of Medicine - Division of Neurology
McMaster University - JH
1280 Main Street West
Hamilton, ON L8S 4K1

Phone: (905) 574-8630
Fax: (905) 383-3958
e-mail: mrathbon@mcmaster.ca

Thursday, March 21, 2013

Dr. Bruno Di Paolo
Address: 77 Markland Hamilton L8P 2J8
Phone: (905) 575-5173
Fax: (905) 575-9896

Re: Young, Suzanne
OHIP: 6427 959 512 YW
Address: 101-695 Plains Rd E Burlington
Phone: (905) 333-2744
DOB: 1964-10-11

Dear Dr. Di Paolo,

Thank you for asking me to see this 49 year-old right-handed woman in neurological consultation today. Thank you for your referral note.

Problem:
Post concussion syndrome

Problem description:
Ms. Young was accompanied by her sister today. She had a major surgery of total abdominal hysterectomy at St. Joseph's on November 26, 2012. When she woke up from the surgery she had severe headache, dizziness, nausea with vomiting. She reported that there was a big contusion over her right occipital region. Later she developed blurred vision, photophobia, sensitivity to high pitch sounds and smells, short term memory and concentration difficulties, sleep problems, fatigue, and mood changes. These symptoms were not improving over time. Brain MRI on February 12, 2013 was unremarkable.

Currently, she has constant headache over occipital region radiating up to frontal area, sharp stabbing and pressure in quality and 5-6/10 in severity most the time. Light or noise exacerbates it. She has constant dizziness with nausea, occasionally associated with spinning sensation without head position change. Her sleep is poor that she cannot sleep continuously for more than 1 hour at night. She repeats herself all the time and does not remember what she has talked about or read. She is irritable, anxious, depressed without suicidal ideas. Her sister confirmed these symptoms after the surgery.

Dr. Rodriguez saw her on February 27, 2013 for her blurred vision. Visual field test showed bilateral superior more than inferior arcuate defects and OCT showed thinning of the temporal peripapillary nerve fiber layer OU. Visual evoked potential was set up. Dr. Rodriguez will review her again in followup appointment.

5

Previous medical and surgical history:
- Total abdominal hysterectomy
- Bronchial asthmatic
- Hypoglycemic
- Hyatus hernia

Current medications:
- Ventolin, qid
- Flovent 250mg, bid
- Soflax, 2 tablets bid
- Tecta, bid
- Naproxen, bid
- Ativan, prn
- Dilaudid, prn
- Prochloroperazine, tid for nausea

Family history:
- Chrones disease, mother
- Colitis, mother
- Cancer, father
- Heart disease, father
- Triple bypass surgery, father
- Cancer, both sides

Social history:
Ms. Young is currently single with 1 child who is generally healthy. She has been off work due to surgery. She works as an executive administrator.

Physical examination:
On neurological examination, significant features were:

- CNs 2-12 grossly normal, no nystagmus, but eyes following examiner's finger triggered dizziness and nausea
- Strength 5/5 through out
- DTRs symmetric
- Plantar response flexor bilaterally
- Finger-to-nose normal
- Cannot stand without support due to dizziness
- Right side greater and lesser occipital neuralgia

Problem formulation:
Ms. Young developed multiple symptoms similar to post concussion syndrome after having surgery in November 2012. She has experienced ongoing symptoms without much improvement over time. She is currently under the care of Dr. Rodriguez regarding her blurry vision. As for her dizziness, I will refer her to Neurotologist Dr. Robertson to examine her inner ear and exclude any vestibular abnormality. Due to her cognitive difficulties and mood changes, I will refer her to Dr. Unsal for a neuropsychological assessment. Examination revealed right-sided greater and lesser occipital neuralgia, so she will be seen again in the Neuro-Physiatry Combined Clinic with Dr. Kumbhare to further manage her headache.

Further consultations:
- Dr. Unsal for a neuropsychological assessment
- Dr. Robertson for a neurotological evaluation

Follow up:
I will follow-up with Ms. Young on May 18, 2013 at 3:00pm in the Combined Neuro-Physiatry Clinic.

With best wishes,
Yours sincerely,

Joy Deng, Neurology Fellow, dictating for:

Michel P. Rathbone

Michel P. Rathbone, M.B., Ch.B., PhD., FRCP (C)
Professor, Department of Medicine (Neurology, Neuroscience and Neuropharmacology)
McMaster University

CC: Rodriguez, Amadeo R. - 905-573-4858

St. Joseph's Healthcare, Hamilton
St. Joseph's Hospital
50 Charlton Avenue East
Hamilton, Ontario L8N 4A6

(905) 522-1155

EDS - Ext. 36082

UNIT NO.0000372533 *ODM

Patient Name YOUNG,SUZANNE MARIE
695 PLAINS RD E

BURLINGTON, ON L7T2E8
ONTARIO HEALTH NO. 6427-959-512 YW
DOB: 64/10/11 SEX F

EXAM DATE 13/03/07 1030 Check-in No. 3681191 Account # 56261486

ORDERED BY	RODRIGUEZ,AMADEO RAUL	Fax# 905-573-4858
ATTENDING PHYS.	RODRIGUEZ,AMADEO RAUL	Fax# 905-573-4858
FAMILY PHYS.	DIPAOLO,BRUNO L	Fax# (905)575-9896
REFERRING PHYS.		Fax#

Chk-in #	Exam
3681191	NEURO-VISUAL EVOKED RESPONSE

EVP REPORT

CLINICAL HISTORY: Visual acuity loss.

VISUAL EVOKED RESPONSES: Stimulating both eyes with pattern reversal stimuli produces a P100 at 98.0 msec on the right and 99.4 msec on the left. Amplitude is 8.5 on the right and 8.8 on the left.

CONCLUSION: This is a normal study.

Susan Goodwin, MD

DICTATED BUT NOT READ
This document will be reviewed by the attending physician/staff, as per Hospital Policy 009-MED, and any corrections will be forwarded.

D. D/T: 03/08/2013 12:56:45,SG
T. D/T: 03/11/2013 09:17:34,bc
Doc #: 1533971
Job #: 924178

c.c.: Amadeo Raul Rodriguez, MD
Susan Goodwin, MD
Bruno Dipaolo, MD

COMPLETE

CARDIOLOGY/NEUROLOGY DIAGNOSTICS

dermetics
Dr. Michael Jiaravuthisan, MD, FRCPC
3305 Harvester Road, Unit 8 & 9, Burlington, ON L7N 3N2 Tel: 905.336.9624 Fax: 905.336.9625
March 05, 2013

Dr. B. DiPaolo
755 Concession Street
Ste. 200
Hamilton ON L8V 1C4

Dear Dr. DiPaolo:

RE: **Suzanne Marie Young**
DOB: October 11, 1964

Thank you for referring this pleasant 48 year old woman for assessment of multiple brown pigmented lesion on the face. She states over 1 year ago she developed this brown area on the left cheek that increased in size. This since decreased in size and is asymptomatic.

The patient has no personal history of skin cancer.
The patient has no family history of skin cancer.

Medical History:
Anemia
Hysterectomy
Ovarian cancer

Medications:
Ventolin
Flovent
Tecta
Naproxen
Hydromorphone
Ativan
Epi pen

Allergies:
Penicillin
Nuts

Physical Examination:
Upper cheeks, peri-orbital region = Poorly-defined, faint brown macules/patches with regular borders = Melasma

Lateral forehead region = Small barely visible papules; no scarring = Mild non scarring acne

Antecubital fossa = Poorly-defined, erythematous, scaly papules = Mild eczema

Diagnosis:
As above

Plan/Suggestions:
The natural history of these problems was discussed along with treatment options.

For melasma:

Since the condition is benign, no treatment is required. It can sometimes be associated with OCP use, sun exposure and pregnancy.

The patient has agreed to use 1% hydrocortisone powder + 4% hydroquinone powder in 0.025% tretinoin cream BID M = 100g, R = 6x.

Side effects discussed include but are not limited to allergy, irritation, photosensitivity, lightening of normal skin, telangiectasia, atrophy and exogenous ochronosis.

If there is no improvement after 6 weeks, the patient has been instructed to stop using the medication.

For prevention and possible worsening of the condition, I have asked the patient to use a sunblock of at least SPF 30, especially after applying the above lightening agent.

For eczema:
The natural history of this problem was discussed, along with treatment options.

The importance of frequent moisturization, especially after wetting the skin, was emphasized. The patient should also avoid all scented products, wool clothing as well as fabric softeners. A cool mist humidifier should be use in the bedroom during drier months.

For the affected areas on the body (not face or genitals), the patient has agreed to use Betaderm 0.05% cream BID prn M = 100g, R = 3x.

Side effects of topical steroids discussed include but are not limited to atrophy, telangiectasia, striae and dyspigmentation.

For her acne:
She will use Tactuo gel qhs prn M = 1, R = 10x.

Side effects of these topical anti-acne therapies have been discussed including but not limited to bleaching of clothes, temporary worsening of acne, as well as erythema, xerosis and pruritus. Appropriate use has been discussed including volume of use and the need to avoid the peri-orbital region and neck.

Since the conditions are quite mild, I will discharge the patient back to your care but would be happy to see them back in consultation for any further concerns.

Thank you for allowing me to share in the care of your patient.

Warmest regards,

Dr. Michael Jlaravuthisan, MD, FRCPC
Dermatologist

St. Joseph's Healthcare, Hamilton
King Street Campus
2757 King Street East
Hamilton, Ontario L8G 5E4

Date Format is MM/DD/YYYY

Patient Name: YOUNG, SUZANNE M
DOB: 10/11/1964
Admission Date: 02/27/2013
Discharge Date:
Dictated By: AMADEO RAUL RODRIGUEZ
Dictating For:
Attending Provider: AMADEO RODRIGUEZ

MRN: 372533
Account #: 56258980

Patient Type/Svc: EYE/EMS
Location: EYC
Visit Date: 02/27/2013

Clinic Note - King Campus

NEUROOPHTHALMOLOGY CLINIC

I have been asked to see this patient by Dr. Bahoshy, Optometrist. She has been found to have a recent decline in her best corrected visual acuity. According to Dr. Bahoshy's note the patient had a best corrected visual acuity of 20/20 in the right eye and 20/25 in the left eye in May 2012. The patient has noticed worsening of her visual acuity since November 26, 2012. That day she underwent a hysterectomy and salpingo-oophorectomy at St. Joseph's Hospital. She tells me she woke with a severe headache and there was swelling in the back of her head. She was nauseated and dizzy. She was in bed for two days after surgery and around that time she noticed blurry vision in both eyes, more in the left. She tells me she got glasses before that day, but they do not seem to work now. She says she had a "concussion." She does not know how it happened, but says that the swelling in the back of her head was not there when she in, but it was there when she woke up from surgery. Her sister Theresa, who accompanied her today, says she went missing in the hospital after surgery from recovery to the room.

Otherwise she has a history of asthma and eczema. She is currently on:
1. Ventolin.
2. Flovent.
3. Naproxen.
4. Tecta.
5. Ativan as needed.
6. Hydromorphone as needed.

She is allergic to MORPHINE.

EXAMINATION: Visual acuity without correction is 20/50 OD and 20/70 OS. There is no pinhole improvement with either eye. Color vision is 11/16 OD and 6/16 OS. Pupils are equal and reactive to light with no relative afferent pupillary defect. Slit-lamp examination is unremarkable OU. Intraocular pressure is 17 mmHg OD and 19 mmHg OS. Dilated funduscopic exam reveals distinct margins of both optic discs. No obvious pallor or edema. Cup-to-disc ratio 0.2 OU. Macula, blood vessels, and peripheral retina within normal limits. Ocular motility seems full. However, the patient became nauseated during the ocular motor exam.

INVESTIGATIONS: Humphrey 24-2 visual field test completed today shows bilateral superior more than inferior arcuate defects. Given the glaucomatous appearance of those visual field defects, an optical coherence tomography of the optic nerves was obtained. It showed thinning of the temporal peripapillary nerve fiber layer OU (OS more than OD).

In summary, this 48-year-old woman has been complaining of decreased visual acuity since November 2012. The details around the onset of her symptoms are not completely clear to me. She tells me she had an MRI at the Hamilton General Hospital, but I could not find the report. I would really appreciate if Dr. Dipaolo could send me a copy of the report. In addition, she did have a visual field test in the past with an optometrist and the patient will try to get a copy for comparison. I am going to obtain visual evoked potentials. Finally, she already has an appointment to see Dr. Rathbone, Neurologist, for evaluation of her ongoing symptoms. I am going to review her again in followup to see how she evolves.

Yours sincerely,

Amadeo Raul Rodriguez, MD

DICTATED BUT NOT READ

This document will be reviewed by the attending physician/staff, as per Hospital Policy 009-MED, and any corrections will be forwarded.

D.D/T: 02/27/2013 12:37:37,AR; T.D/T: 03/05/2013 14:17:59,th
Doc #: 1531574; Job #: 919619

c.c.: Amadeo Raul Rodriguez, MD
Bruno Dipaolo, MD
Michel Rathbone, MD
Louis Bahoshy, OD

HAMILTON HEALTH SCIENCES – DIAGNOSTIC SERVICES REPORT
HAMILTON GENERAL HOSPITAL (905) 527-4322 ext. 46906
237 BARTON STREET EAST, HAMILTON, ON. L8L 2X2

YOUNG,SUZANNE MARIE Sex: F Age:48 DOB:11/10/1964
Unit #: 1109244
Acct #: GX024579/12
Location: GO-DS-MR
Exam Date: 12/02/13

Requisition #: 13-0046118

Order Num Category/Procedure
1202-0059 MRI/MR HEAD SERIES W/O GAD W/3D **Report Status: Signed**

MR head.

Blurry vision, dizziness.

Multiple acquisition sequences were obtained.

FINDINGS: The structures of the midline are located centrally. There is no hydrocephalus. The gray-white matter distribution is well-preserved. No signs of areas of recent intracranial hemorrhage are seen. There are no acute infarcts. The cerebellar tonsils are at level of the foramen magnum. Incidental note is made of a pineal cyst, which measures 6.9 x 14.4 mm in its largest dimension

Opinion: Unremarkable MRI of the brain. No signs of intracranial tumor lesions or recent ischemic infarcts are seen. The gray-white matter distribution is preserved.

Dictated by: R. Larrazabal, MD
Dictated for: Ramiro A. Larrazabal MD
Signed by: Ramiro A. Larrazabal MD
Date Signed: 13/02/13 1204

CC: Di Paolo,Bruno Livio
Report #: 1302-0587
mne.: DIPA

Bruno Livio Di Paolo
200-755 Concession Street
Hamilton, ON L8V 1C4

Ordering Physician's copy

St. Joseph's Hospital
50 CHARLTON AVENUE EAST
HAMILTON, ONTARIO L8N 4A6
(905) 522-1155

RADIOLOGY
Ext. 36009

UNIT NO.0000372533 *ODP

Patient Name YOUNG,SUZANNE MARIE
695 PLAINS RD E

BURLINGTON, ON L7T2E8
ONTARIO HEALTH NO. 6427-959-512 YW
DOB: 64/10/11 SEX F

EXAM DATE 13/01/29 0705 Check-in No. 3644768 Account # 56209409

ORDERED BY	DIPAOLO,BRUNO L	Fax# (905)575-9896
ATTENDING PHYS.	DIPAOLO,BRUNO L	Fax# (905)575-9896
FAMILY PHYS.	DIPAOLO,BRUNO L	Fax# (905)575-9896
REFERRING PHYS.		Fax#

Chk-in #	Exam
3644768	MR-MINOR ASSESSMENT

MRI MINOR ASSESSMENT.

The patient was booked for an MRI, but was unable to tolerate the examination due to claustrophobia. The patient is interested in re-booking. The patient has been notified to contact their referring physician to obtain a prescription for oral sedation. Once the patient has received this, they can contact our booking office for rescheduling of their MRI appointment. No images were obtained.

- DR NARRY MUHN
Reading Physician- DR NARRY MUHN
Releasing Physician- DR NARRY MUHN
Released Date Time- 13/01/29 0824

THE MRI FACILITY OF ST. JOSEPH'S HEALTHCARE HAMILTON IS ACCREDITED BY THE AMERICAN COLLEGE OF RADIOLOGY

COMPLETE

St. Joseph's Healthcare Hamilton

ST. JOSEPH'S HOSPITAL MCMASTER UNIVERSITY
DEPARTMENT OF OBSTETRICS & GYNECOLOGY
ST. JOSEPH'S HOSPITAL
301 James Street South
4th Floor - Fontbonne Building
Hamilton, Ontario Canada L8P 3B6

D.R.J. SMALL, MD, FRCSC
Tel: (905) 572-1122
Fax: (905) 572-7373

M.E. LOOSLEY-MILLMAN, MD, PhD, FRCSC
Tel: (905) 572-1117
Fax: (905) 572-7373

January 23, 2013

Dr. B.L. DiPaolo,
755 Concession Street,
Hamilton, ON

Dear Dr. DiPaolo: re: **YOUNG, Suzanne Marie #3821**

Suzanne was seen in follow up today regarding her complicated postoperative course. As you are aware from previous correspondence, she has struggled with the wound infection that continues to require packing from CCAC. Her postoperative course has also been complicated by chronic nausea and headaches which she associates with a bruise and bump obtained on her occiput during her hospital stay.

Suzanne unfortunately is still feeling no better and all of her concerns are largely related to the bruise on her occiput. She summarized these symptoms for me today and they include difficulty with her balance, nausea particularly associated with head movements, chronic daily unremitting headaches as well as blurred vision. She tells me that she has seen an optometrist in regards to this latter symptom and he did not feel it was related to her prescription. In addition to this, her family have noticed difficulties regarding short term memory and stuttering when excited, which is new for her.

I had previously recommended that Suzanne contact yourself to discuss these symptoms further and she tells me she did do this. You were able to arrange for an MRI of her head in short order. I understand she also has a referral pending with Dr. Rathbone from neurology. I am hoping that the consultation as well as the MRI might help to shed light on what's going on with regards to the symptoms she is having.

With regards to her wound, Suzanne continues to see CCAC for packing. They tell her that the site is improving and there is no evidence of infection at this time. She has completed her most recent course of antibiotics. She still complains of abdominal pain but admits it is likely secondary to her poor muscle tone. She is unable to start the physiotherapy ordered secondary to her neurologic problems.

On examination today there were no signs of infection. She has only a small less then 1 cm diameter area still requiring packing. There is no erythema at the site and no malodourous discharge. At her request, I have given her a refill on the Demerol. She feels it is the only thing helping her with regards to her headaches. I am reluctant to continue this prescription in the long-term and I am hoping that her consultation with the neurologist may help shed light. She has accepted a follow up appointment to our clinic in two weeks' time. We will continue to keep you apprised.

Thank you for involving us.

Yours sincerely,
Lauren Smith, M.D., F.R.C.S.C., Locum for

D. Small, M.D., F.R.C.S.C.
LS:lmw
Dictated but not read

St. Joseph's Hospital
50 CHARLTON AVENUE EAST
HAMILTON, ONTARIO L8N 4A6
(905) 522-1155

RADIOLOGY
Ext. 36009

UNIT NO.0000372533 ODR

Patient Name YOUNG,SUZANNE MARIE
695 PLAINS RD E

BURLINGTON, ON L7T2E8
ONTARIO HEALTH NO. 6427-959-512 YW
DOB: 64/10/11 SEX F

EXAM DATE 13/01/10 1452 Check-in No. 3633234 Account # 56189403

ORDERED BY	SMALL,DAVID R	Fax# 905-572-7373
ATTENDING PHYS.	SMALL,DAVID R	Fax# 905-572-7373
FAMILY PHYS.	DIPAOLO,BRUNO L	Fax# (905)575-9896
REFERRING PHYS.		Fax#

Chk-in #	Exam
3633234	GR-ABD 2-3 V & CHEST 1 V PANEL

GR-ABDOMEN 3 VIEWS + CHEST 1 PANE

INDICATIONS: 6WKS POST-OP WITH WOUND INFECTION ONGOING ABDO PAIN ? CONSTIPATION

Comparison: November 29, 2012

Findings: Heart and mediastinum are within normal limits. Lung aeration is normal. Pleural spaces are clear. No aggressive bony changes. No free intra-abdominal air. No evidence of bowel obstruction. No fecal loading. No concerning calcifications.

Summary: No acute abnormality. No interval change.

- DR JUDITH CORET-SIMON
Reading Physician- DR JUDITH CORET-SIMON
Releasing Physician- DR JUDITH CORET-SIMON
Released Date Time- 13/01/10 1554

COMPLETE

This report was generated through Powerscribe

DIAGNOSTIC IMAGING

St. Joseph's Healthcare Hamilton

ST. JOSEPH'S HOSPITAL MCMASTER UNIVERSITY
DEPARTMENT OF OBSTETRICS & GYNECOLOGY
ST. JOSEPH'S HOSPITAL
301 James Street South
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M.E. LOOSLEY-MILLMAN, MD, PhD, FRCSC
Tel: (905) 572-1117
Fax: (905) 572-7373

December 27, 2012

Dr. B.L. DiPaolo,
755 Concession Street,
Hamilton, ON

Dear Dr. DiPaolo: re: **YOUNG, Suzanne Marie #**

Suzanne was seen in follow up today for an assessment of her incision. As you are aware, she underwent a total abdominal hysterectomy and bilateral salpingo-oophorectomy on November 26th, 2012. Her postoperative course has been complicated by a wound infection. She is still having pain at the site of the incision. There is an area that continues to drain and CCAC is doing dressing changes and packing. She does occasionally get some purulent discharge from the site but overall feels that the discharge is serous in nature. She most recently was treated with Clindamycin for ten days. She was given a second course but elected not to start until she had this appointment with us. She does still complain of some vaginal bleeding and feels now it is quite malodourous. Others have noticed.

On examination today her incision is actually healing quite well. She does have an area that continues to drain but it is now less then 1 cm in length. The discharge I noted today was only serous. No evidence of purulent discharge. There is also no erythema, heat, or other signs of cellulitis or infection. On speculum examination I saw no evidence of vaginal bleeding or malodourous discharge. I tried to reassure Suzanne today.

Suzanne also continues to complain of persistent headaches and nausea. She tells me that upon waking from her surgery she had a large bump on her head. She feels she sustained the injury while in hospital. I am unclear of the exact source and will discuss this with Dr. Small as he apparently is aware of the situation. Her complaint today surrounds the fact that the site where she previously had the bump on her head she noticed the other day when showering that this is now a bald spot. When she showed me the site on her head, she does have a circular area where there is no hair. It is starting to regrow but there is a definite bald spot. Apparently Dr. Small had previously offered her a consultation to neurology and she would now like to accept this. I will discuss this with him and do have her permission to do so.

From our point of view, I did try to reassure Suzanne that her wound infection is getting better. I have refilled her prescription for Hydromorphone today as she is unable to take Advil secondary to asthma. CCAC will continue to pack the incision. I will see her back in the clinic again in two weeks' time for her six week postoperative visit.

Thank you for involving us in her care. We will continue to keep you apprised.

Yours sincerely,
Lauren Smith, M.D., F.R.C.S.C., Locum for

D. Small, M.D., F.R.C.S.C.

LS:lmw
Dictated but not read

St. Joseph's Healthcare
Hamilton

ST. JOSEPH'S HOSPITAL MCMASTER UNIVERSITY
DEPARTMENT OF OBSTETRICS & GYNECOLOGY
ST. JOSEPH'S HOSPITAL
301 James Street South
4th Floor - Fontbonne Building
Hamilton, Ontario Canada L8P 3B6

D.R.J. SMALL, MD, FRCSC
Tel: (905) 572-1122
Fax: (905) 572-7373

M.E. LOOSLEY-MILLMAN, MD, PhD, FRCSC
Tel: (905) 572-1117
Fax: (905) 572-7373

December 12, 2012

Dr. B.L. DiPaolo,
755 Concession Street,
Hamilton, ON

Dear Leo: Re: **YOUNG, Suzanne #3821**

I saw Suzanne on the 12th of December. Her incision is markedly less red, less tender, and less firm. She is not draining very much serous fluid from the midline seroma. I have removed her packing and repacked it today. I was able to put in about 7 cm of packing. Home Care are seeing her daily. She is still suffering from a lot of nausea. She is having normal bowel movements. Her bowel sounds are normal and her abdomen is soft. Unfortunately her medication plan does not cover Ondenestron which she was using in hospital and was working. I have given her a prescription for Diclectin to see if that helps. She has three more days of antibiotics and I think when she is finished that it should help. She is still having some neck pain. I don't think it is justifying a CT scan which she has requested. As you are aware, I think from prior correspondence, Suzanne had a small raised area on her occiput postoperatively of uncertain etiology. We have discussed this with the anesthetist, nursing staff and recovery room staff and really don't know how this occurred. She relates it to her surgery and is upset that it happened. I am not able to provide a rational explanation for it. At any rate, there is nothing left to feel now and she still has some neck pain but I have suggested some massage therapy, a heating pad and ensuring that she has a comfortable bed and pillow.

I will have her back again in a couple of weeks to reassess her incision.

Yours sincerely,

D. Small, M.D., F.R.C.S.C.

DS:lmw
Dictated but not read

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM
ST. JOSEPH'S HOSPITAL - SERVICE OF ANATOMICAL PATHOLOGY

50 Charlton Avenue E. Hamilton, Ontario L8N 4A6
(905) 521-6012

Run Date: 30/11/12

Bruno Livio Di Paolo
200-755 Concession Street
Hamilton,ON
L8V 1C4

CYTOPATHOLOGY REPORT

Specimen No.: 12:CJ5577
Name: YOUNG,SUZANNE MARIE
Sex: F **Age:** 48 **D.O.B.:** 11/10/64
Patient's Home Phone: (905)333-2744

Procedure Date: 26/11/12 **Status:** SOUT
Date Received: 27/11/12 **Time:** 1136
Status: ADM IN **Location:** JI-7MS
Account #: J0011612512
Medical Record #: J000372533
Health Card #: 6427959512-YW
Requesting Physician: Small,David Richard Joh

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Di Paolo,Bruno Livio
Small,David Richard Johnson

SOURCE OF SPECIMEN
PERITONEAL WASH

SPECIMEN DESCRIPTION
10 mL of bloody, red specimen received.

CLINICAL HISTORY
Ovarian cyst.

DIAGNOSIS
Rare cluster of atypical cells of undetermined origin in a background of mesothelial cells and histiocytes. Please note that there are additional specimens on this patient, 12:SJ17444.

Preliminary Electronically Authenticated WEN-YU LEE (Cytotech) 28/11/12

Final Electronically Signed Dr. A. Abdel-Mesih (PATHOLOGIST) 29/11/12

** END OF REPORT ** CYTOPATHOLOGY REPORT
Date fields on this report in the format DD/MM/YY

St. Joseph's Hospital
50 CHARLTON AVENUE EAST
HAMILTON, ONTARIO L8N 4A6
(905) 522-1155

RADIOLOGY
Ext. 36009

UNIT NO.0000372533 7MS-G702-02

Patient Name YOUNG,SUZANNE MARIE
695 PLAINS RD E

BURLINGTON, ON L7T2E8
ONTARIO HEALTH NO. 6427-959-512 YW
DOB: 64/10/11 SEX F

EXAM DATE 12/11/29 1115 Check-in No. 3601904 Account # 11612512

ORDERED BY	SMALL,DAVID R	Fax# 905-572-7373
ATTENDING PHYS.	SMALL,DAVID R	Fax# 905-572-7373
FAMILY PHYS.	DIPAOLO,BRUNO L	Fax# 905-575-9896
REFERRING PHYS.		Fax#

Chk-in #	Exam
3601904	GR-ABD 2-3 V & CHEST 1 V PANEL

Chest:

Normal examination.

Abdomen:

No free intraperitoneal air. No surgical clips and no radiopaque calculus.

Bowel gas pattern is unremarkable.

Incidental note of degenerative disc and facet disease at L4-L5.

Summary:

No abnormality in the chest or abdomen.

- DR DAVID WOODS
Reading Physician- DR DAVID WOODS
Releasing Physician- DR DAVID WOODS
Released Date Time- 12/11/29 1424

COMPLETE

This report was generated through Powerscribe

DIAGNOSTIC IMAGING

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM
ST. JOSEPH'S HOSPITAL - SERVICE OF ANATOMICAL PATHOLOGY

50 Charlton Avenue E. Hamilton, Ontario L8N 4A6
(905) 521-6012

Run Date: 30/11/12

Bruno Livio Di Paolo
200-755 Concession Street
Hamilton,ON
L8V 1C4

SURGICAL PATHOLOGY REPORT

Specimen No.: 12:SJ17444
Name: YOUNG,SUZANNE MARIE
Sex: F **Age:** 48 **D.O.B.:** 11/10/64
Patient's Home Phone: (905)333-2744

Procedure Date: 26/11/12 **Status:** SOUT
Date Received: 26/11/12 **Time:** 1256
Status: ADM IN **Location:** JI-7MS
Account #: J0011612512
Medical Record #: J000372533
Health Card #: 6427959512-YW
Requesting Physician: Small,David Richard Joh

COPIES TO
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Di Paolo,Bruno Livio
Small,David Richard Johnson

SOURCE OF SPECIMEN
A. Fallopian tube - Left and ovary
B. Uterus and Cervix - Right fallopian tube and ovary and fibroid

CLINICAL HISTORY
Ovarian cyst

FROZEN SECTION
BENIGN SMALL SIMPLE EPITHELIAL CYSTS

Pathologist: Dr. S. Salama

GROSS DESCRIPTION
The patient demographics and specimen identification on the requisition correspond to that on the specimen container.

A. The specimen consists of a fallopian tube with attached ovary together weighing 40 gm. The fallopian tube measures 5 cm. in length x 0.7 cm. diameter and at one end there is a metal clip. There are two paratubal cysts present each 1 cm. in diameter. The attached ovary has multiple multilocular cysts on the outer and inner surface. These measure up to 2 cm. in diameter and are filled with clear fluid. Also present is a corpus luteum. A section from the cyst were submitted for frozen section and now submitted in block 1.

Further representative sections are submitted as follows;

Block 2 fallopian tube and fimbriated end.

** CONTINUED ON NEXT PAGE ** **ANATOMIC PATHOLOGY REPORT**
Date fields on this report in the format DD/MM/YY

Run Date: 30/11/12

Specimen No.: 12:SJ17444 Name: YOUNG,SUZANNE MARIE

GROSS DESCRIPTION (Continued)

Block 3 fallopian tube with peritubal cyst.
Block 4-7 ovary with cyst.

B. The specimen consists of a uterus with attached cervix weighing 216 gm. and measuring 13 x 8 x 5 cm. On the anterior serosal surface there is a serosal nodule 0.5 cm. in diameter present. The ectocervix measures 4.8 x 4.5 cm. and has a round os 1 x 0.5 cm. The endocervical canal measures 5.5 cm. in length. The endometrial cavity is lined by tan endometrium 0.5 cm. in thickness. The myometrium measures 3 cm. in thickness and there are some small intramural nodules up to 0.3 cm. and some adenomyosis.

Representative sections are submitted as follows;

Block 1 serosal nodule.
Block 2 anterior cervix.
Block 3 posterior cervix.
Block 4,5 anterior uterus.
Block 6-8 posterior uterus.

Also included in the specimen container is a nodular portion of pink tan tissue weighing 12 gm. and measuring 3.5 x 2.5 x 2.2 cm. Cut section has a white whorled appearance. Representative section submitted in blocks 9 and 10.

Also included in the specimen container is a fallopian tube with attached cystic ovary weighing 43 gm. The fallopian tube measures 7 cm. in length x 0.5 cm. diameter and there are multiple peritubal cysts present measuring up to 3 cm. and two fimbrial-like adhesions 2 x 0.2 cm. and 3 x 0.5 cm. The attached multicystic ovary measures 5 x 4.5 x 3.5 cm. Cut section reveals multiple clear fluid filled cysts with smooth inner linings. Representative sections from the fallopian tube are submitted in blocks 11 and 12 and representative sections from the cystic ovary in blocks 13-16.

Grossed By: BROWNE,LEANNE
Transcribed: *ALMEIDAA*

DIAGNOSIS

A. Left Fallopian Tube And Ovary:
- Multiple serous cysts or cystadenomas of the ovary.
- Focal fibrous serosal adhesions of the ovarian surface.
- Unremarkable fallopian tube.

B. Uterus And Cervix, Right Fallopian Tube And Ovary, Fibroid:
- Small leiomyomata uteri/fibroids.
- Focal adenomyosis of the uterine wall.

** CONTINUED ON NEXT PAGE ** ANATOMIC PATHOLOGY REPORT
Date fields on this report in the format DD/MM/YY

Run Date: 30/11/12

Specimen No.: 12:SJ17444 Name: YOUNG,SUZANNE MARIE

GROSS DESCRIPTION (Continued)

Block 3 fallopian tube with peritubal cyst.
Block 4-7 ovary with cyst.

B. The specimen consists of a uterus with attached cervix weighing 216 gm. and measuring 13 x 8 x 5 cm. On the anterior serosal surface there is a serosal nodule 0.5 cm. in diameter present. The ectocervix measures 4.8 x 4.5 cm. and has a round os 1 x 0.5 cm. The endocervical canal measures 5.5 cm. in length. The endometrial cavity is lined by tan endometrium 0.5 cm. in thickness. The myometrium measures 3 cm. in thickness and there are some small intramural nodules up to 0.3 cm. and some adenomyosis.

Representative sections are submitted as follows;

Block 1 serosal nodule.
Block 2 anterior cervix.
Block 3 posterior cervix.
Block 4,5 anterior uterus.
Block 6-8 posterior uterus.

Also included in the specimen container is a nodular portion of pink tan tissue weighing 12 gm. and measuring 3.5 x 2.5 x 2.2 cm. Cut section has a white whorled appearance. Representative section submitted in blocks 9 and 10.

Also included in the specimen container is a fallopian tube with attached cystic ovary weighing 43 gm. The fallopian tube measures 7 cm. in length x 0.5 cm. diameter and there are multiple peritubal cysts present measuring up to 3 cm. and two fimbrial-like adhesions 2 x 0.2 cm. and 3 x 0.5 cm. The attached multicystic ovary measures 5 x 4.5 x 3.5 cm. Cut section reveals multiple clear fluid filled cysts with smooth inner linings. Representative sections from the fallopian tube are submitted in blocks 11 and 12 and representative sections from the cystic ovary in blocks 13-16.

Grossed By: BROWNE,LEANNE
Transcribed: *ALMEIDAA*

DIAGNOSIS

A. Left Fallopian Tube And Ovary:
- Multiple serous cysts or cystadenomas of the ovary.
- Focal fibrous serosal adhesions of the ovarian surface.
- Unremarkable fallopian tube.

B. Uterus And Cervix, Right Fallopian Tube And Ovary, Fibroid:
- Small leiomyomata uteri/fibroids.
- Focal adenomyosis of the uterine wall.

** CONTINUED ON NEXT PAGE ** **ANATOMIC PATHOLOGY REPORT**
Date fields on this report in the format DD/MM/YY

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM
ST. JOSEPH'S HOSPITAL - SERVICE OF ANATOMICAL PATHOLOGY
50 Charlton Avenue E. Hamilton, Ontario L8N 4A6
(905) 521-6012

Run Date: 30/11/12

Specimen No.: 12:SJ17444 Name: YOUNG,SUZANNE MARIE

DIAGNOSIS

(Continued)

- Benign secretory endometrium.
- Mild chronic cervicitis.
- Unremarkable fallopian tube with simple paratubal Hydatid.
- Multiple serous cysts or cystadenomas of the ovary.

SS/aa

Preliminary Electronically Signed Dr. S. Salama (Pathologist) 29/11/12

Final Electronically Signed Dr. S. Salama (Pathologist) 29/11/12

** END OF REPORT ** ANATOMIC PATHOLOGY REPORT
Date fields on this report in the format DD/MM/YY

St. Joseph's Healthcare, Hamilton
Charlton Campus
50 Charlton Avenue East
Hamilton, Ontario L8N 4A6

Date Format is MM/DD/YYYY

Patient Name: YOUNG, SUZANNE M
DOB: 10/11/1964
Admission Date: 11/26/2012
Discharge Date:
Dictated By: DAVID R SMALL
Dictating For:
Attending Physician: DAVID SMALL

MRN: 372533
Account # : 11612512
Patient Type/Svc: I/P/GYN
Location: 7MS
Room / Bed: G702/02
Procedure Date: 11/26/2012

Operative Report - Charlton Campus

SURGEON(S): Dr. D. Small
ASSISTANT(S):
ANESTHETIST: Dr. F. Baxter
ANESTHESIA: General

PREOPERATIVE DIAGNOSIS: Bilateral ovarian cysts.
POSTOPERATIVE DIAGNOSIS: Same.
OPERATION: TOTAL ABDOMINAL HYSTERECTOMY AND BILATERAL SALPINGO-OOPHORECTOMY.

PROCEDURE: Surgical pause was undertaken. Prophylactic antibiotics were administered as well as thromboprophylaxis. General anesthesia was administered by Dr. Baxter with endotracheal intubation.

The patient's body mass index was 41.

Her pannus was retracted cephalad and a Pfannenstiel incision made above her skin fold. This was opened transversely using cautery, cauterizing bleeding points when encountered. Fascia was then freed up from the rectus muscle, opened transversely, and the rectus was then divided and the parietal peritoneum was opened. Peritoneal washings were taken and submitted for cytology. The patient had palpably normal upper abdomen. She was placed in Trendelenburg. A deep Balfour retractor was placed. The bowel was packed with a moist sponge.

The ovaries had bilateral cysts on them, multiple. There were probably 20-30 in all, rather unusual in appearance. The patient had requested photographs and this was undertaken.

We decided to remove her ovaries separately and submit one for frozen section as we proceeded with the rest of the surgery. We started on the left side. The round ligament was opened. The broad ligament was then skeletonized and a hole was placed in the broad ligament to isolate the infundibulopelvic ligament. This was then clamped, cut and doubly ligated. The ureter was well below where we were operating. We then amputated the specimen from the uterus with a clamp medially and submitted this for frozen section. This ultimately came back benign sometime later.

We then removed the right adnexa in a similar fashion, although on the right side we first secured the uteroovarian pedicle and then isolated, clamped, cut and doubly ligated the infundibulopelvic. Again, ureter on the right was identified well below where we were operating.

Note is made of the fact that exposure throughout the procedure was exceedingly difficult due to the patient's body mass index.

The vesicouterine fold was then incised. There was a large fibroid on the left side of the uterus at the level of the isthmus. This made things a little bit more difficult to see. We made sure the bladder was reflected as inferiorly as we could, and then secured the uterine artery below the fibroid. On the right side, the anatomy was normal. The uterine arteries were secured. In order to aid in visualization of the cervix, we elected to remove the fibroid separately. An incision was made along the length of the fibroid and it was shelled out from the surrounding cervical stroma.

We then pushed the bladder further down. The cervix was quite long - probably about 6 cm in length. We took multiple bites on either side and still were not at the level of the vagina. We then circumscribed the cervix using cautery to enter the anterior and posterior fornices of the vagina. We then shelled out the cervix from the vagina. The vault apex was then closed with interrupted figure-of-eight sutures.

There were a couple of bleeding areas on the right uterosacral ligament which were then oversewn. We thought that we had good hemostasis at that point, but after removal of the pack, we reinspected things and there was some bleeding from the left uterine pedicle. This was clamped again and the pedicle was oversewn.

At that point, there did not appear to be any bleeding.

The pelvis was lavaged with warm water again and reinspected with no bleeding noted.

Again, exposure and visualization was quite challenging. The bladder was falling into the surgical space despite the deep Balfour and retraction and the bowel posteriorly was likewise obscuring things. Nevertheless, we were happy with hemostasis at this point.

We then rechecked the infundibulopelvic pedicles bilaterally and they were dry.

Ureters were palpably normal.

The packs and retractor was removed. The bowel was tucked into the pelvis. Parietal peritoneum was closed with 0 Vicryl suture. #1 Vicryl was used for fascia. Interrupted 3-0 plain was used for fat and subcuticular 3-0 Vicryl for skin. All counts were correct. The patient was stable through the course of the procedure. She was awakened, extubated and transported to Recovery in good condition.

David Small, MD

St. Joseph's Hospital
50 CHARLTON AVENUE EAST
HAMILTON, ONTARIO L8N 4A6
(905) 522-1155

RADIOLOGY
Ext. 36009

JR

UNIT NO.0000372533 *EMD

Patient Name YOUNG,SUZANNE MARIE
695 PLAINS RD E

BURLINGTON, ON L7T2E8
ONTARIO HEALTH NO. 6427-959-512 YW
DOB: 64/10/11 SEX F

EXAM DATE 12/10/03 1948 Check-in No. 3554731 Account # 56049549

ORDERED BY	RAMANNA,RAJ	Fax# 905-972-0913
ATTENDING PHYS.	RAMANNA,RAJ	Fax# 905-972-0913
FAMILY PHYS.	DIPAOLO,BRUNO L	Fax# 905-575-9896
REFERRING PHYS.		Fax#

Chk-in #	Exam
3554731	GR-ABDOMEN 3 VIEWS & CHEST 2 PANE

GR-ABDOMEN 3 VIEWS \T\ CHEST 2 PANEL

Indication: r/o RLQ pain pt in waiting room

Comparison to November 2001.

The heart lungs and mediastinum are normal.

No acute abnormalities.

- DR SRIHARSHA ATHREYA
Reading Physician- DR SRIHARSHA ATHREYA
Releasing Physician- DR SRIHARSHA ATHREYA
Released Date Time- 12/10/04 0900

COMPLETE

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DIAGNOSTIC IMAGING

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM
ST. JOSEPH'S HOSPITAL - SERVICE OF ANATOMICAL PATHOLOGY

50 Charlton Avenue E. Hamilton, Ontario L8N 4A6
(905) 521-6012

Run Date: 04/10/12

Bruno Livio Di Paolo
200-755 Concession Street
Hamilton,ON
L8V 1C4

CYTOPATHOLOGY REPORT

Specimen No.: 12:CJ4588
Name: YOUNG,SUZANNE MARIE
Sex: F **Age:** 47 **D.O.B.:** 11/10/64
Patient's Home Phone: (905)333-2744

Procedure Date: 01/10/12 **Status:** SOUT
Date Received: 02/10/12 **Time:** 1142
Status: DEP CLI **Location:** JO-DSU
Account #: J0056019978
Medical Record #: J000372533
Health Card #: 6427959512-YW
Requesting Physician: Small,David Richard Joh

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Di Paolo,Bruno Livio
Small,David Richard Johnson

SOURCE OF SPECIMEN
PERITONEAL WASH

SPECIMEN DESCRIPTION
25 mL of colorless, clear specimen received.

DIAGNOSIS
Very cellular specimen.
Tight clusters of atypical cells of undetermined origin. Also noted are mesothelial cells, histiocytes, glandular cells and mixed inflammatory cells.
Please note that there are additional specimens on this patient, 12:SJ14347.

Preliminary Electronically Authenticated Paula Windle (Cytotech) 03/10/12

Final Electronically Signed Dr. I. El-Shinnawy (PATHOLOGIST) 03/10/12

** END OF REPORT ** **CYTOPATHOLOGY REPORT**
Date fields on this report in the format DD/MM/YY

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM
ST. JOSEPH'S HOSPITAL - SERVICE OF ANATOMICAL PATHOLOGY

50 Charlton Avenue E. Hamilton, Ontario L8N 4A6
(905) 521-6012

9

Run Date: 03/10/12

Bruno Livio Di Paolo
200-755 Concession Street
Hamilton,ON
L8V 1C4

SURGICAL PATHOLOGY REPORT

Specimen No.: 12:SJ14347	**Procedure Date:** 01/10/12 **Status:** SOUT
	Date Received: 01/10/12 **Time:** 1404
Name: YOUNG,SUZANNE MARIE	**Status:** DEP CLI **Location:** JO-DSU
	Account #: J0056019978
Sex: F **Age:** 47 **D.O.B.:** 11/10/64	**Medical Record #:** J000372533
	Health Card #: 5427959512-YW
Patient's Home Phone: (905)333-2744	**Requesting Physician:** Small,David Richard Joh

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Small,David Richard Johnson

SOURCE OF SPECIMEN
A. Urinary bladder - Biopsy peritoneum
B. Ovary - Biopsy right
C. Endometrium - Curettings

CLINICAL HISTORY
Ovarian cysts

GROSS DESCRIPTION
The patient demographics and specimen identification on the requisition correspond to that on the specimen container.

A. The specimen consists of a fragment of pink tan tissue 0.5 x 0.3 x 0.2 cm. All submitted.

B. The specimen consists of a portion of white cyst wall 1 x 1 x 0.1 cm. Bisected and all submitted.

C. The specimen consists of multiple polypoid portions of pink tan and hemorrhagic tissue together measuring 3 x 3 x 0.5 cm. All submitted in two blocks.

Grossed By: BROWNE,LEANNE
Transcribed: *ALMEIDAA*

** CONTINUED ON NEXT PAGE ** **ANATOMIC PATHOLOGY REPORT**
Date fields on this report in the format DD/MM/YY

121202 (REV 97 - 1)

CML - Charlton Avenue East, Hamilton

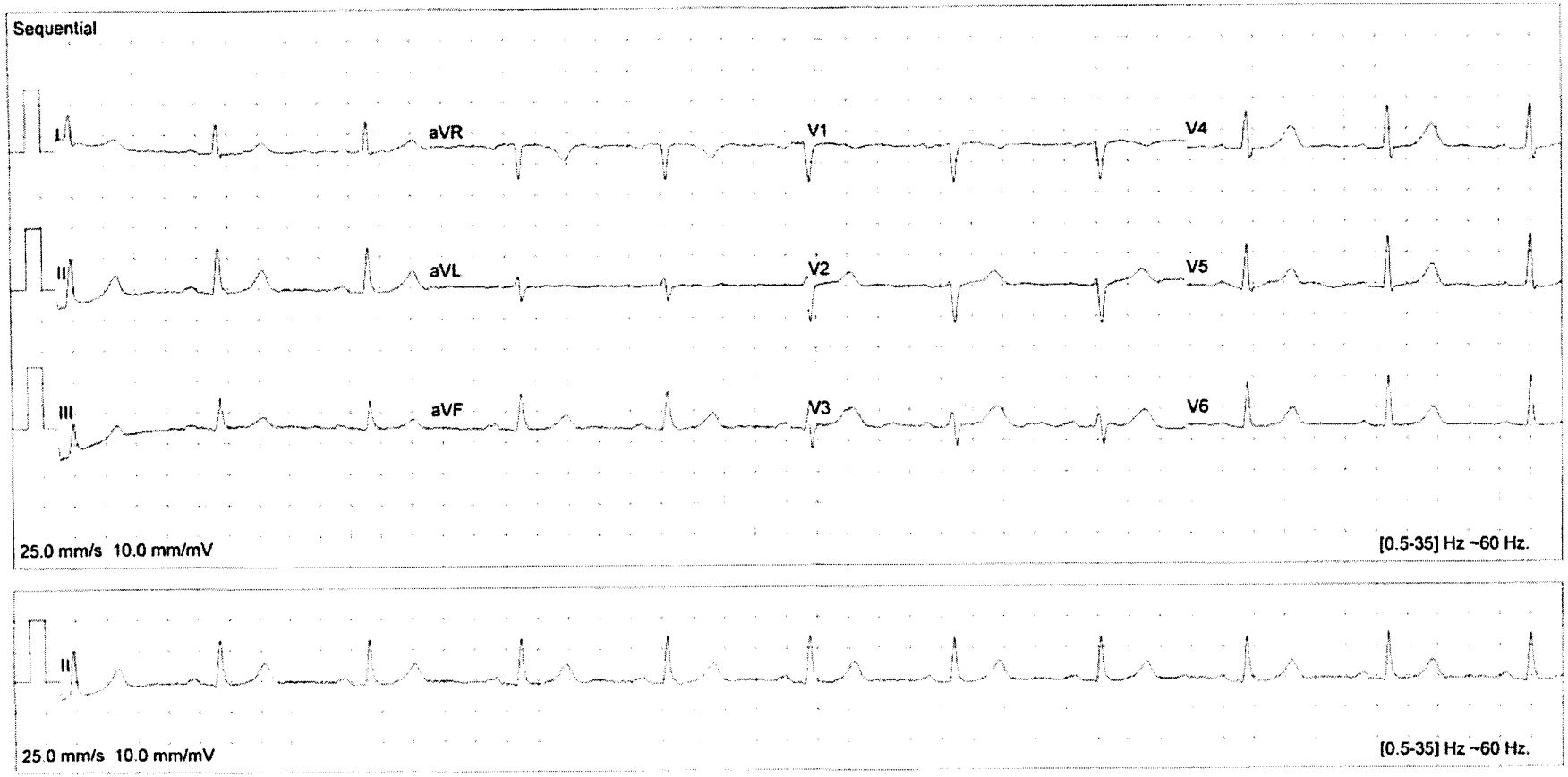
Name:	YOUNG, SUZANNE
Number:	6427959512
Gender:	Female
Birthdate:	1964/10/11 47 years
P / PR:	110 ms / 183 ms
QRS:	89 ms
QT / QTc / QTd:	420 ms / 427 ms / -
P/QRS/T axis:	46° / 65° / 72°
Heartrate:	64 bpm

Recorded:	2012/01/16 10:28:26 AM
Recorded by:	Student, Student
Referring physician:	1334540 DR. B. LEO DI PAOLO, 755 CON
Ordering physician:	
Attending physician:	
Location:	CML - 25 CHARLTON AVENUE EAST, HA
Comment:	LA42025 R#1484S#200-755 concession sthamiltonl8v1c4meds nonecheck upkd... 1334540 DR. B. LEO DI PAOLO R#1484 S# 755 CONCESSION STREETHAMILTON, ON L8V1C4

Confirmed interpretation edited at 2012/01/17 2:00:41 PM by Sullivan, B
sinus rhythm

Normal ECG

Dr.B.Sullivan, Cardiologist



Sykes Assistance Services Corporation

THAS Services Call Documentation/Services THAS Documentation de l'appel

Today: 08/20/2013

Patient Name:	SUZANNE YOUNG	**Call Date:**	08/20/2013 18:34:PM
Gender:	Female	**Client:**	THAS
DOB:	10/11/1964	**Caller Name:**	
Age:	48 Y 10 M 9 D	**Relationship To Patient:**	Self
Return Phone Number:	(905) 333-2744 (Home)	**Return Phone Number:**	Unavailable
Address:	101-695 PLAINS RD E	**Understands Health Info/Service Referral?:**	
City/Province/Zip:	BURLINGTON ON L7T 2E8	**Data Transfer Consent:**	Yes
Language:	English		
PCP:	Di Paolo, Bruno		

Patient Medical History

Condition/Procedure	Treatment	Comment
Nov 2012 - concussion		
asthma		
hypoglycemia		
hiatus hernia		

Nurse Assessment

What is the nature of the call?	---Illness
Is this for an anonymous patient record?	---No
Reason for call:	---headache
Onset	---48hrs
to walk in clinic approx 6.5hrs ago, advised that it could be meningitis, advised to go to ED if symptoms worsened	
Location:	---head
Characteristics/Severity:	---chronic pain at back of head since concussion headache at forehead x 24hrs, constant increasing pain that is 9/10, 'pressure', 'head feels like it is bleeding inside, gets worse at night intermittent nausea (more than chronic nausea since concussion)
Other symptoms	---swollen R neck gland x 48hrs that is mild to moderately swollen at present, tender to the touch, pain is now radiating down towards shoulders, hurts to lift arms intermittent chills x 24hrs

NOTICE OF DISCHARGE

from

St. Joseph's Healthcare, Hamilton - St. Joseph's Hospital

Date Format is YY/MM/DD

Attention Dr:	DIPAOLO,BRUNO L		
Patient Name:	YOUNG,SUZANNE MARIE		
Attending Physician:	SMALL,DAVID R	Station:	7MS G702-02
Admit Dt/Tm:	12/11/26 08:28	Discharge Dt/Tm:	12/12/01 13:20
Visit #:	1-1612512	Unit #:	0000372533

This notice is being sent to you as the Family Physician of YOUNG,SUZANNE MARIE

We would like to inform you that your patient was discharged on 12/12/01 13:20

If you have any questions, please contact the Health Records Department at Ext.33822

St. Joseph's Healthcare Hamilton

DISCHARGE SUMMARY

PATIENT: YOUNG,SUZANNE MARIE			TITLE: MS	RESP. FOR PAYMENT:	
ADDRESS: 695 PLAINS RD E 101 BURLINGTON ON L7T 2E8		BIRTH DATE: 1964/10/11	AGE: 48Y	SEX: F	RES. CODE: 1021
		TELEPHONE: (905)333-2744	MARITAL STATUS: S SINGLE		LANGUAGE: ENG
IN EMERGENCY NOTIFY: YOUNG,CARI-ANN		RELATIONSHIP: DAUGHTER	HOME PHONE: (905)741-2697	WORK PHONE:	EXT.
HEALTH NO.: 6427-959-512	VERSION: YW	EXP.: 16/10/11	MEDICAL RECORD #: J 0000372533		
DENOMINATION: CRC	PLACE OF WORSHIP: ST. PATRICK'S				☐ SAC/RITUAL
PHYSICIAN MOST RESPONSIBLE: D R SMALL	PHONE: (905)572-1122	FAX: 905-572-7373	ACCOUNT NUMBER: J1-1612512		ADMIT DATE/TIME: 12/11/26 08:28
FAMILY: DIPAOLO,BRUNO L	PHONE: (905)575-2888	FAX: 905-575-9896	SERVICE: GYN	PT TYPE: I/P	EXPECTED DATE OF DISCHARGE: 12/11/27
REFERRING:	PHONE:	FAX: 905-575-9896	PREFERRED ACCOMMODATION: 1 WARD		DISCHARGE DATE: DEC. 1/12

ADMITTING COMPLAINT: OTHER GYNECOLOGICAL DIAGNOSES

PREVIOUS VISIT INFO: EMD 12/10/03 OBG 12/08/29 DSU 12/10/01

MOST RESPONSIBLE DIAGNOSES(Diagnoses most responsible for length of stay):

Ovarian cysts bilateral

PRE-ADMIT COMORDIBITY (Diagnoses coexisting on admission which have a significant influence on length of stay):

anemia, Hg

morbid obesity (BMI 41).

POST-ADMIT COMORBIDITY/ADVERSE DRUG REACTIONS (Diagnoses arising after admission which have a significant influence on length of stay):

PROCEDURES/INVESTIGATIONS/COURSE IN HOSPITAL:

Total abdominal hysterectomy, bilateral salpingo oophorectomy

DISCHARGE PLAN AND FOLLOW-UP

Dr Small 6 week.

MEDICATIONS ON DISCHARGE

☐ Please see attached copy of Discharge Prescription Form

SIGNATURE OF RESIDENT OR INTERN

SIGNATURE OF MOST RESPONSIBLE PHYSICIAN

RECORD: Checked by _____ Coded by _____ ☐ Dictated Discharge Date: _____

PD3595 Rev March 2012

☐ Fax to Family Doctor

HEALTH RECORDS COPY

Latest 01.18.13

Dr. Rodriguez,

DR. LOUIS P. BAHOSHY
OPTOMETRIST
110-15 Mountain Avenue South, Health Sciences Building
Stoney Creek, Ontario L8G 2V6
Phone: 905-662-8863 Fax: 905-662-4401

PATIENT: NAME: Suzane Young D.O.B. 10/11/1964
ADDRESS: 695 Plains Rd E Apt. 101 OHIP: 6427 959 512 YW
Burlington ON L7T 2E8
PHONE: (905) 333-2744 WORK:
FAMILY DOCTOR: Dr. Bruno DiPaolo

His/~~Her~~ appointment with us : Jan 17, 2013

Reason for Referral
~~**DIAGNOSIS:**~~ - Recent decline in BCVA following head injury

HISTORY: - Patient reporting a decline in her vision and a constant headache following a head injury sustained on Nov 26/12.

CURRENT GLASSES AND VISION:

REFRACTION:
OD +0.50 -0.50 x 030 +2.00 20/40
OS -0.25 -2.00 x 130 20/60

OBSERVATIONS:
ONH cupping OD: OS:
IOPS: OD: 18 mmHg OS: 18 mmHg

Previous visit with us was May 11/12 with BCVA OD 20/20 OS 20/25 - possible meridional amblyopia.

I am referring Suzane to your care for assessment + management as necessary of her condition.

Thank you for seeing this patient.

Sincerely,

Louis P. Bahoshy, B.Sc., O.D

CC: - Dr. Bruno Dipaolo

NOTICE OF ADMISSION

from

St. Joseph's Healthcare, Hamilton - St. Joseph's Hospital

Date Format is YY/MM/DD

Attention Dr:	DIPAOLO,BRUNO L		
Patient Name:	YOUNG,SUZANNE MARIE		
Attending Physician:	D R SMALL	Station:	DSU DSU-13
Admit Dt/Tm:	12/11/26 08:28	Discharge Dt/Tm:	
Visit #:	1-1612512	Unit #:	0000372533

This notice is being sent to you as the Family Physician of YOUNG,SUZANNE MARIE

We would like to inform you that your patient was admitted on 12/11/26 08:28

If you have any questions, please contact the Health Records Department at Ext.33822

REPORT DATE
15/11/12

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

St. Joseph's Hospital
50 Charlton Ave. E., Hamilton, Ontario, L8N 4A6
(905) 522-4941

Di Paolo,Bruno Livio
200-755 Concession Street
Hamilton ON
L8V 1C4
905-575-2888

Copies To: Small,David Richard Johns

Patient's Name: YOUNG,SUZANNE MARIE
Unit Number : J000372533
Patient's Home Phone: (905)333-2744
Family Doctor : Di Paolo,Bruno Livio

DOB: 11/10/64 **Sex:** F **HIN:** 6427959512
Account Number: J0056105944 **Location:** JO-PAT

Specimen Report Status: COMPLETE
Specimen: 1411:C00806R **Collected:** 14/11/12 - 0745
Submitted by: Small,David Richard Johnson
Received: 14/11/12 - 0905

Ordered: L, CREAT, UREA
Comments: OR NOV 26

Test	Result	Flag	Reference
	*** CLINICAL CHEMISTRY ***		
> UREA	5.4		3.0-6.5 mmol/L
> CREATININE	65		50-100 umol/L
> SODIUM	138		135-145 mmol/L
> POTASSIUM	3.4	L	3.5-5.0 mmol/L
> CHLORIDE	102		98-107 mmol/L
> TOTAL CO2	23		22-30 mmol/L
> AC GAP	13		5-17 mmol/L

Specimen Report Status: COMPLETE
Specimen: 1411:C00809R **Collected:** 14/11/12 - 0745
Submitted by: Small,David Richard Johnson
Received: 14/11/12 - 0905

Ordered: CA125
Comments: OR NOV 26

Test	Result	Flag	Reference	
	*** MISCELLANEOUS CHEMISTRY TESTS ****			
> CA125	17		<= 35 U/mL	HEN

Specimen Report Status: COMPLETE
Specimen: 1411:H00550R **Collected:** 14/11/12 - 0745
Submitted by: Small,David Richard Johnson
Received: 14/11/12 - 0905

Ordered: CBC
Comments: OR NOV 26

Test	Result	Flag	Reference
	*** COMPLETE BLOOD COUNT ***		
> LKCS	6.8		4.0-11.0 X10 9/L
> ERCS	4.34		3.8-5.8 x10 12/L
> **HB**	137		115-165 g/L

HEN - PERFORMED AT JURAVINSKI HOSPITAL AND CANCER CENTRE 711 Concession St.,
Hamilton On, L8V 1C3 905-527-4322 ext 42055

$ Symbol following a result indicates test was referred out - Address available upon request
> Symbol prefixing the test name indicates a new result for this reporting
Date fields on this report in the format DD/MM/YY

** CONTINUED ON NEXT PAGE **

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

St. Joseph's Hospital
50 Charlton Ave. E., Hamilton, Ontario, L8N 4A6
(905) 522-4941

Patient's Name: YOUNG,SUZANNE MARIE **HIN:** 6427959512 **Acct#:** J0056105944
Report Doctor : Di Paolo,Bruno Livio (Continued)

Specimen: 1411:H00550R **Collected:** 14/11/12 - 0745 (Continued)

Test	Result	Flag	Reference
	*** COMPLETE BLOOD COUNT *** (Continued)		
> **HCT**	0.399		0.370-0.470
> MCV	92.0		82-99 fL
> MCH	31.5		27-32 pg
> MCHC	342		300-350 g/L
> RDW	13.2		11.5-15.0 %
> **PLT**	300		150-400 x10 9/L
> MPV	7.5		7.4-10.4 fL
AUTO DIFF			
> ABSOLUTE NEUTS	4.1		2.0-7.5 x10 9/L
> ABSOLUTE LYMPHS	2.1		1.5-4.0 x10 9/L
> ABSOLUTE MONOS	0.4		0.2-0.8 x10 9/L
> ABSOLUTE EOS	0.1		0.0-0.4 x10 9/L
> ABSOLUTE BASOS	0.0		0.0-0.1 x10 9/L
> SMEAR EXAMINE	Blood film not made		

Specimen Report Status: COMPLETE **Submitted by:** Small,David Richard Johnson
Specimen: 1411:BB00061R **Collected:** 14/11/12 - 0745 **Received:** 14/11/12 - 0941

Ordered: GROUP & SCREEN, ABO & RH CONF.
Comments: OR NOV 26
PRE-OP SPECIMEN? YES
OR Date 12/11/26
OR Time 10.30
Trans Last 3 Months? NO
Pregnant Now? No
Preg last 3 months? NO

Test	Results
	*** TRANSFUSION MEDICINE ***
> GS EXPIRY	NOV 29
GROUP & SCREEN	
> ABO GROUP & RH	O NEG
> AB SCREEN INTERPRETATION	Negative

$ Symbol following a result indicates test was referred out - Address available upon request
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** END OF REPORT **

PART 4 (BLUE STRIPE) - EMERGENCY PHYSICIAN

PART 3 (YELLOW STRIPE) - EMERGENCY

PART 2 (RED STRIPE) - FAMILY PHYSICIAN

ST. JOSEPH'S HOSPITAL, 50 Charlton Ave. E., Hamilton, Ontario L8N 4A6

EMERGENCY RECORD

DSU 12/10/01
OBG 12/08/29
OPC 12/05/18

DATE AND TIME OF VISIT: 12/10/03 18:37
UNIT NUMBER: J 0000372533
ACCOUNT NUMBER: 5-6049549

PATIENT NAME AND ADDRESS: YOUNG,SUZANNE MARIE
695 PLAINS RD E 101
BURLINGTON ON L7T 2E8

DATE OF BIRTH: 1964/10/11
AGE: 47Y
SEX: F
RELIGION: CRC
LANGUAGE: ENG
HOME PHONE: (905)333-2744
BUSINESS PHONE: (905)681-7744

NEXT OF KIN: YOUNG,CARI-ANN
RELATIONSHIP: DAUGH
HOME PHONE: (905)741-2697
BUSINESS PHONE:

CONTACT 2:

ONTARIO HEALTH NO.: NONE,WISHED
EXP.: YW
NAME AS ON CARD: YOUNG,SUZANNE MARIE
S.I.N.: 481-332-690
FIN. CLASS.: OH

OTHER INSURANCE: 6427-959-512
PATIENT'S EMPLOYER:
DATE OF ACC.:
CLAIM NO.:

PRESENTING PROBLEM: DIRECT CONSULT

[redacted]

MOST RESP. PHYS.: R RAMANNA
PHONE: (905)972-0911
PHYS. NO.: 7382

FAMILY PHYS.:
PHONE: (905)575-2888
PHYS. NO.: 630

CLERK: AMB
TRANSFERRED FROM: DIPAOLO,BRUNO

Arrival Time	Triage Time	NAME	Tetanus Required: ☐ Yes ☐ No	T	P	R	BP	WT
	1437							

Presenting Complaint:

Cap Refill | O_2 Sat

Triage Assessment:

AFFIX TRIAGE LABEL HERE

Past Medical Hx:

Medications:

Allergies:

Triage R/A (See Nursing Record): ☐

Initial Intervention: ☐ Cleanse ☐ Dressing ☐ Splint ☐ Other [ ] ☐ Ice ☐ Elevation

RN

PHYSICIAN ASSESSMENT

PLACEMENT TIME | ASSESSMENT TIME

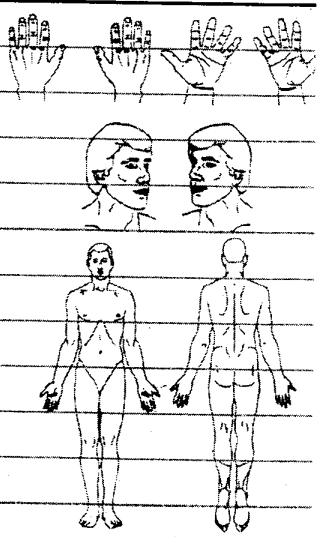

CHART READY FOR REASSESSMENT TIME

REASSESSMENT TIME

INITIAL DIAGNOSIS | SEEN BY DOCTOR ☐ STAFF ☐ RESIDENT ☐ INTERN ☐ C.C. TIME : | E.R. PHYSICIAN

TREATMENT

	INIT.		INIT.

☐ Td 0.5 ml IM

DISCHARGE DIAGNOSIS | CONSULTATION NAME/SERV. | TIME CALLED | ANSWERED | ARRIVED

PROCEDURE

DISPOSITION

[redacted]

127005G (REV. 05-2007)

☐ RECORD CHECKED BEFORE FILING_____INIT.

EMERGENCY RECOR

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

St. Joseph's Hospital
50 Charlton Ave. E., Hamilton, Ontario, L8N 4A6
(905) 522-4941

Patient's Name: YOUNG,SUZANNE MARIE HIN: 6427959512 Acct#: J0056049549
Report Doctor : Di Paolo,Bruno Livio (Continued)

Specimen: 0310:H02132U Collected: 03/10/12 - 2040 (Continued)

Test	Result	Flag	Reference
	*** COMPLETE BLOOD COUNT *** (Continued)		
> MCH	33.1	H	27-32 pg
> MCHC	358	H	300-350 g/L
> RDW	14.4		11.5-15.0 %
> **PLT**	269		150-400 x10 9/L
> MPV	7.1	L	7.4-10.4 fL
AUTO DIFF			
> ABSOLUTE NEUTS	6.8		2.0-7.5 x10 9/L
> ABSOLUTE LYMPHS	2.8		1.5-4.0 x10 9/L
> ABSOLUTE MONOS	0.6		0.2-0.8 x10 9/L
> ABSOLUTE EOS	0.1		0.0-0.4 x10 9/L
> ABSOLUTE BASOS	0.1		0.0-0.1 x10 9/L
> SMEAR EXAMINE	Blood film not made		

$ Symbol following a result indicates test was referred out - Address available upon request
> Symbol prefixing the test name indicates a new result for this reporting
Date fields on this report in the format DD/MM/YY

** END OF REPORT **

1a.

REPORT DATE
04/10/12

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

St. Joseph's Hospital
50 Charlton Ave. E., Hamilton, Ontario, L8N 4A6
(905) 522-4941

Di Paolo,Bruno Livio
200-755 Concession Street
Hamilton ON
L8V 1C4
905-575-2888

Copies To: Ramanna,Raj

Patient's Name: YOUNG,SUZANNE MARIE **DOB:** 11/10/64 **Sex:** F **HIN:** 6427959512
Unit Number : J000372533 **Account Number:** J0056049549 **Location:** JO-EMR
Patient's Home Phone: (905)333-2744
Family Doctor : Di Paolo,Bruno Livio

Specimen Report Status: COMPLETE **Submitted by:** Ramanna,Raj
Specimen: 0310:C04185U **Collected:** 03/10/12 - 2040 **Received:** 03/10/12 - 2052

Ordered: L, CREAT, CK, UREA

Test	Result	Flag	Reference
	*** CLINICAL CHEMISTRY ***		
> UREA	5.3		3.0-6.5 mmol/L
> CREATININE	73		50-100 umol/L
> SODIUM	140		135-145 mmol/L
> POTASSIUM	3.6		3.5-5.0 mmol/L
> CHLORIDE	103		98-107 mmol/L
> TOTAL CO2	28		22-30 mmol/L
> AC GAP	9		5-17 mmol/L
> CK	132		< 150 U/L

Specimen Report Status: COMPLETE **Submitted by:** Ramanna,Raj
Specimen: 0310:C04186U **Collected:** 03/10/12 - 2040 **Received:** 03/10/12 - 2052

Ordered: TROP T

Test	Result	Flag	Reference
	*** CLINICAL CHEMISTRY ***		
> TROPONIN T	< 0.01		<=0.04 ug/L
	<=0.04 ug/L No evidence of myocardial necrosis		
	> 0.04 ug/L Evidence of myocardial necrosis		

Specimen Report Status: COMPLETE **Submitted by:** Ramanna,Raj
Specimen: 0310:H02132U **Collected:** 03/10/12 - 2040 **Received:** 03/10/12 - 2052

Ordered: CBC

Test	Result	Flag	Reference
	*** COMPLETE BLOOD COUNT ***		
> LKCS	10.3		4.0-11.0 X10 9/L
> ERCS	4.08		3.8-5.8 x10 12/L
> **HB**	135		115-165 g/L
> **HCT**	0.377		0.370-0.470
> MCV	92.5		82-99 fL

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Date fields on this report in the format DD/MM/YY

** CONTINUED ON NEXT PAGE **

REPORT DATE
02/10/12

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

St. Joseph's Hospital
50 Charlton Ave. E., Hamilton, Ontario, L8N 4A6
(905) 522-4941

Di Paolo,Bruno Livio
200-755 Concession Street
Hamilton ON
L8V 1C4
905-575-2888

Copies To: Small,David Richard Johns

Patient's Name: YOUNG,SUZANNE MARIE
Unit Number : J000372533
Patient's Home Phone: (905)333-2744
Family Doctor : Di Paolo,Bruno Livio

DOB: 11/10/64 **Sex:** F **HIN:** 6427959512
Account Number: J0056019978 **Location:** JO-DSU

Specimen Report Status: COMPLETE
Specimen: 0110:PC00412R **Collected:** 01/10/12 - 1058
Submitted by: Small,David Richard Johnson
Received: 01/10/12 - 1854

Ordered: GLUCOSE POCT

Test	Result	Flag	Reference	
	*** CLINICAL CHEMISTRY ***			
> GLUCOSE POCT	5.2		mmol/L	ML

ML - PERFORMED AT HAMILTON GENERAL, 237 BARTON ST E, HAMILTON, ON L8L 2X2
905-527-4322 ext 46360

$ Symbol following a result indicates test was referred out - Address available upon request
> Symbol prefixing the test name indicates a new result for this reporting
Date fields on this report in the format DD/MM/YY

** END OF REPORT **

REPORT DATE
24/09/12

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

St. Joseph's Hospital
50 Charlton Ave. E., Hamilton, Ontario, L8N 4A6
(905) 522-4941

Di Paolo,Bruno Livio
200-755 Concession Street
Hamilton ON
L8V 1C4
905-575-2888

Copies To: Small,David Richard Johns

Patient's Name: YOUNG,SUZANNE MARIE **DOB:** 11/10/64 **Sex:** F **HIN:** 6427959512
Unit Number : J000372533 **Account Number:** J0056019978 **Location:** JO-PAT
Patient's Home Phone: (905)333-2744
Family Doctor : Di Paolo,Bruno Livio

Specimen Report Status: COMPLETE **Submitted by:** Small,David Richard Johnson
Specimen: 1709:C00303R **Collected:** 17/09/12 - 0955 **Received:** 17/09/12 - 1033

Ordered: GLUR, L, CREAT, UREA, ANDRO, TESTO
Comments: OR OCT 1

Test	Result	Flag	Reference	
	*** ENDOCRINOLOGY ***			
> ANDROSTENEDIONE	4.4		2.5-10.5 nmol/L	ML
	Post Menopausal Female: 1.5-6.5 nmol/L			

ML - PERFORMED AT HAMILTON GENERAL, 237 BARTON ST E, HAMILTON, ON L8L 2X2
905-527-4322 ext 46360

$ Symbol following a result indicates test was referred out - Address available upon request
> Symbol prefixing the test name indicates a new result for this reporting
Date fields on this report in the format DD/MM/YY

** END OF REPORT **

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

St. Joseph's Hospital
50 Charlton Ave. E., Hamilton, Ontario, L8N 4A6
(905) 522-4941

Patient's Name: YOUNG,SUZANNE MARIE **HIN:** 6427959512 **Acct#:** J0056019978
Report Doctor : Di Paolo,Bruno Livio (Continued)

Specimen Report Status: COMPLETE
Specimen: 1709:C00305R **Collected:** 17/09/12 - 0955
Submitted by: Small,David Richard Johnson
Received: 17/09/12 - 1033

Ordered: PROLACTIN
Comments: OR OCT 1

Test	Result	Flag	Reference	
	*** ENDOCRINOLOGY ***			
> PROLACTIN	5.0		< 24.0 ug/L	CMH

Specimen Report Status: COMPLETE
Specimen: 1709:H00231R **Collected:** 17/09/12 - 0955
Submitted by: Small,David Richard Johnson
Received: 17/09/12 - 1033

Ordered: CBC
Comments: OR OCT 1

Test	Result	Flag	Reference
	*** COMPLETE BLOOD COUNT ***		
> LKCS	11.7	*H*	4.0-11.0 X10 9/L
> ERCS	4.64		3.8-5.8 x10 12/L
> **HB**	146		115-165 g/L
> **HCT**	0.430		0.370-0.470
> MCV	92.8		82-99 fL
> MCH	31.5		27-32 pg
> MCHC	340		300-350 g/L
> RDW	13.6		11.5-15.0 %
> **PLT**	312		150-400 x10 9/L
> MPV	7.2	*L*	7.4-10.4 fL
AUTO DIFF			
> ABSOLUTE NEUTS	9.0	*H*	2.0-7.5 x10 9/L
> ABSOLUTE LYMPHS	2.1		1.5-4.0 x10 9/L
> ABSOLUTE MONOS	0.5		0.2-0.8 x10 9/L
> ABSOLUTE EOS	0.1		0.0-0.4 x10 9/L
> ABSOLUTE BASOS	0.0		0.0-0.1 x10 9/L
> SMEAR EXAMINE	Blood film not made		

CMH - PERFORMED AT MCMASTER MEDICAL CENTRE, 1200 MAIN ST W, HAMILTON, ON L8N 3Z5
905-521-2100 ext 75022

$ Symbol following a result indicates test was referred out - Address available upon request
> Symbol prefixing the test name indicates a new result for this reporting
Date fields on this report in the format DD/MM/YY

** END OF REPORT **

REPORT DATE
18/09/12

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

St. Joseph's Hospital
50 Charlton Ave. E., Hamilton, Ontario, L8N 4A6
(905) 522-4941

Di Paolo,Bruno Livio
200-755 Concession Street
Hamilton ON
L8V 1C4
905-575-2888

Copies To: Small,David Richard Johns

Patient's Name: YOUNG,SUZANNE MARIE
Unit Number : J000372533
Patient's Home Phone: (905)333-2744
Family Doctor : Di Paolo,Bruno Livio

DOB: 11/10/64 **Sex:** F **HIN:** 6427959512
Account Number: J0056019978 **Location:** JO-PAT

Specimen Report Status: INCOMPLETE
Specimen: 1709:C00303R **Collected:** 17/09/12 - 0955
Submitted by: Small,David Richard Johnson
Received: 17/09/12 - 1033

Ordered: GLUR, L, CREAT, UREA, ANDRO, TESTO
Comments: OR OCT 1

Test	Result	Flag	Reference
	*** CLINICAL CHEMISTRY ***		
> GLUCOSE RANDOM	6.5		3.8-11.0 mmol/L
	Please Note: New Reference Interval Effective June 20, 2012.		
> UREA	4.8		3.0-6.5 mmol/L
> CREATININE	79		50-100 umol/L
> SODIUM	139		135-145 mmol/L
> POTASSIUM	3.8		3.5-5.0 mmol/L
> CHLORIDE	102		98-107 mmol/L
> TOTAL CO2	27		22-30 mmol/L
> AC GAP	10		5-17 mmol/L
	*** ENDOCRINOLOGY ***		
ANDROSTENEDIONE	PENDING		
> TESTOSTERONE	0.7		SEE COMMENT nmol/L ML
	Female: Ovulating: less than or equal to 2.5 nmol/L		
	Post menopausal: less than or equal to 1.5 nmol/L		
	Pre-Pubertal Reference Interval:		
	Infant to onset of puberty < 1 nmol/L.		
	Progressive increase in Testosterone levels during puberty.		

Specimen Report Status: COMPLETE
Specimen: 1709:C00304R **Collected:** 17/09/12 - 0955
Submitted by: Small,David Richard Johnson
Received: 17/09/12 - 1033

Ordered: BETA-hCG
Comments: OR OCT 1

Test	Result	Flag	Reference
	*** ENDOCRINOLOGY ***		
> BETA-hCG	< 1		SEE COMMENT IU/L
	Healthy non-pregnant and pre-menopausal women: < or = 1 IU/L		
	Healthy Post Menopausal women: < or = 7 IU/L		
	Males: < 2 IU/L		

ML - PERFORMED AT HAMILTON GENERAL, 237 BARTON ST E, HAMILTON, ON L8L 2X2
905-527-4322 ext 46360

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Date fields on this report in the format DD/MM/YY

** CONTINUED ON NEXT PAGE **

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

St. Joseph's Hospital
50 Charlton Ave. E., Hamilton, Ontario, L8N 4A6
(905) 522-4941

Di Paolo,Bruno Livio
200-755 Concession Street
Hamilton ON
L8V 1C4
905-575-2888

Copies To: Small,David Richard Johns

Patient's Name: YOUNG,SUZANNE MARIE **DOB:** 11/10/64 **Sex:** F **HIN:** 6427959512
Unit Number : J000372533 **Account Number:** J0055850350 **Location:** JO-OOUJ
Patient's Home Phone: (905)333-2744
Family Doctor : Di Paolo,Bruno Livio

Specimen Report Status: COMPLETE **Submitted by:** Small,David Richard Johnson
Specimen: 1805:C02398R **Collected:** 18/05/12 - 1135 **Received:** 18/05/12 - 1220

Ordered: PROG, ESTRADIOL, FSH, LH, CA125

Test	Result	Flag	Reference	
		*** ENDOCRINOLOGY ***		
> ESTRADIOL	1513		pmol/L	CMH
	REFERENCE RANGE FEMALE:		*FOLLICULAR.....45-610 pmol/L*	
			LUTEAL.....160-770 pmol/L	
			PEAK.....315-1830 pmol/L	
			POST MENOPAUSAL < 200 pmol/L	
> FSH	3.5		SEE COMMENT IU/L	CMH
	Female	*Reference range (IU/L)*		
	Prepubertal	*0 - 5.0*		
	Pubertal	*0.3 - 10.0*		
	Follicular	*3.5 - 12.5*		
	Mid-cycle	*4.7 - 21.5*		
	Luteal	*1.7 - 7.7*		
	Postmenopausal	*25.8 - 134.8*		
> LH	8.2		SEE COMMENT IU/L	CMH
	Female	*Reference range (IU/L)*		
	Prepubertal	*0 - 1.0*		
	Pubertal	*0.4 - 12.0*		
	Follicular	*2.4 - 12.6*		
	Mid-cycle	*14.0 - 95.6*		
	Luteal	*1.0 - 11.4*		
	Postmenopausal	*7.7 - 58.5*		
> PROGESTERONE	1.0		SEE COMMENT nmol/L	CMH
	Female PROGESTERONE reference interval varies with menstrual cycle.			
	Follicular phase : 0.6 - 4.7 nmol/L			
	Luteal phase : 5.3 - 86.0 nmol/L			
		*** MISCELLANEOUS CHEMISTRY TESTS ****		
> CA125	17		<= 35 U/mL	HEN

CMH - PERFORMED AT MCMASTER MEDICAL CENTRE, 1200 MAIN ST W, HAMILTON, ON L8N 3Z5
905-521-2100 ext 75022
HEN - PERFORMED AT JURAVINSKI HOSPITAL AND CANCER CENTRE 711 Concession St.,
Hamilton On, L8V 1C3 905-527-4322 ext 42055

$ Symbol following a result indicates test was referred out - Address available upon request
> Symbol prefixing the test name indicates a new result for this reporting
Date fields on this report in the format DD/MM/YY

** END OF REPORT **

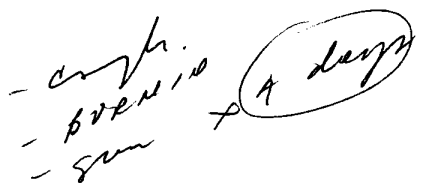
HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

St. Joseph's Hospital
50 Charlton Ave. E., Hamilton, Ontario, L8N 4A6
(905) 522-4941

Patient's Name: YOUNG,SUZANNE MARIE **HIN:** 6427959512 **Acct#:** J0055513788 (Continued)
Report Doctor : Di Paolo,Bruno Livio

Specimen: 2809:H01730R **Collected:** 28/09/11 - 1415 (Continued)

Test	Result	Flag	Reference
	*** COMPLETE BLOOD COUNT *** (Continued)		
> ABSOLUTE NEUTS	5.5		2.0-7.5 x10 9/L
> ABSOLUTE LYMPHS	2.1		1.5-4.0 x10 9/L
> ABSOLUTE MONOS	0.4		0.2-0.8 x10 9/L
> ABSOLUTE EOS	0.1		0.0-0.4 x10 9/L
> ABSOLUTE BASOS	0.0		0.0-0.1 x10 9/L



$ Symbol following a result indicates test was referred out - Address available upon request
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** END OF REPORT **

REPORT DATE
29/09/11

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

St. Joseph's Hospital
50 Charlton Ave. E., Hamilton, Ontario, L8N 4A6
(905) 522-4941

Di Paolo,Bruno Livio
200-755 Concession Street
Hamilton ON
L8V 1C4
905-575-2888

Copies To: Small,David Richard Johns

Patient's Name: YOUNG,SUZANNE MARIE **DOB:** 11/10/64 **Sex:** F **HIN:** 6427959512
Unit Number : J000372533 **Account Number:** J0055513788 **Location:** JO-OOUJ
Patient's Home Phone: (905)333-2744
Family Doctor : Di Paolo,Bruno Livio

Specimen Report Status: COMPLETE **Submitted by:** Small,David Richard Johnson
Specimen: 2809:C02874R **Collected:** 28/09/11 - 1415 **Received:** 28/09/11 - 1444

Ordered: GLUR, FER, TSH

Test	Result	Flag	Reference
	*** CLINICAL CHEMISTRY ***		
> GLUCOSE RANDOM	4.7		< 11.1 mmol/L
> FERRITIN	74		ug/L
	Reference Intervals:		
	< 23 ug/L Probably Iron Deficient		
	24-50 ug/L Possibly Iron Deficient		
	51-140 ug/L Probably Not Iron Deficient		
	141-400 ug/L Not Iron Deficient		
	> 400 ug/L Possible Iron Overload		
	*** ENDOCRINOLOGY ***		
> TSH	1.5		0.30-4.2 mU/L

Specimen Report Status: COMPLETE **Submitted by:** Small,David Richard Johnson
Specimen: 2809:H01730R **Collected:** 28/09/11 - 1415 **Received:** 28/09/11 - 1444

Ordered: CBC

Test	Result	Flag	Reference
	*** COMPLETE BLOOD COUNT ***		
> LKCS	8.1		4.0-11.0 X10 9/L
> ERCS	4.21		3.8-5.8 x10 12/L
> **HB**	136		115-165 g/L
> **HCT**	0.389		0.370-0.470
> MCV	92.4		82-99 fL
> MCH	32.3	*H*	27-32 pg
> MCHC	350		300-350 g/L
> RDW	13.7		11.5-15.0 %
> **PLT**	294		150-400 x10 9/L
> MPV	7.4		7.4-10.4 fL
> RELATIVE NEUTS	0.68		
> RELATIVE LYMPHS	0.26		
> RELATIVE MONOS	0.05		
> RELATIVE EOS	0.01		
> RELATIVE BASOS	0.00		

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** CONTINUED ON NEXT PAGE **

REPORT DATE
30/09/11

HAMILTON REGIONAL LABORATORY MEDICINE PROGRAM

St. Joseph's Hospital
50 Charlton Ave. E., Hamilton, Ontario, L8N 4A6
(905) 522-4941

Di Paolo,Bruno Livio
200-755 Concession Street
Hamilton ON
L8V 1C4
905-575-2888

Copies To: Small,David Richard Johns

Patient's Name: YOUNG,SUZANNE MARIE
Unit Number : J000372533
Patient's Home Phone: (905)333-2744
Family Doctor : Di Paolo,Bruno Livio

DOB: 11/10/64 **Sex:** F **HIN:** 6427959512
Account Number: J0055513788 **Location:** J0-00UJ

Specimen Report Status: COMPLETE
Specimen: 2809:C02872R **Collected:** 28/09/11 - 1415
Submitted by: Small,David Richard Johnson
Received: 28/09/11 - 1444

Ordered: FSH, LH, PROLACTIN

Test	Result	Flag	Reference	
	*** ENDOCRINOLOGY ***			
> FSH	9.2		SEE COMMENT IU/L	CMH
	Female		*Reference range (IU/L)*	
	Prepubertal		*0 - 5.0*	
	Pubertal		*0.3 - 10.0*	
	Follicular		*3.5 - 12.5*	
	Mid-cycle		*4.7 - 21.5*	
	Luteal		*1.7 - 7.7*	
	Postmenopausal		*25.8 - 134.8*	
> LH	3.3		SEE COMMENT IU/L	CMH
	Female		*Reference range (IU/L)*	
	Prepubertal		*0 - 1.0*	
	Pubertal		*0.4 - 12.0*	
	Follicular		*2.4 - 12.6*	
	Mid-cycle		*14.0 - 95.6*	
	Luteal		*1.0 - 11.4*	
	Postmenopausal		*7.7 - 58.5*	
> PROLACTIN	2		< 24 ug/L	CMH

CMH - PERFORMED AT MCMASTER MEDICAL CENTRE, 1200 MAIN ST W, HAMILTON, ON L8N 3Z5
905-521-2100 ext 75022

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** END OF REPORT **

Joseph Brant Memorial EDM *LIVE*
Registration Discharge Summary

Patient: YOUNG,SUZANNE MARIE
ED Provider: AZIZ,S.
Family Doctor: DIPAULO,B-HAMILTON

Age/Sex: 46/F
DOB: 11/10/1964
Mne: DIPAU

Acct No: ER012119/11
Unit No: J00477141
HCN: 6427959512-VG

ED Physician: AZIZ,S.
Nurse:

Arrival Date/Time: 03/07/11 - 0928
Triage Date/Time: 03/07/11 - 0929

Stated Complaint: RIGHT EYE SWELLING
Chief Complaint: Eye Redness or Discharge 501 **CTAS:** 4
Discharge Diagnosis: RT EYE SWELLING

DISCHARGE DISPOSITION

1014 Melany M Podrebarac, RN
***Disposition>** Home
***Date:** 03/07/11
***Time:#** 1014

TRIAGE ENTRY/EDN

0929 Karen Poulsen, RN
Report: NOTICED SOME FACIAL SWELLING YESTERDAY. TODAY WOKE WITH RIGHT EYE SWOLLEN SHUT - BATHED IT TO OPEN IT. C/O PAIN ALONG THE BRIDGE OF HER NOSE ALONG WITH EYE PAIN. RIGHT EYE REMAINS QUITE SWOLLEN

TRIAGE ASSESSMENT

0929 Karen Poulsen, RN
MVC? No
Airway/Breathing> Within defined limits
Circulation> Within defined limits
Neurological> Within defined limits

TRIAGE VITAL SIGNS

0929 Karen Poulsen, RN
Temperature:# 36.5; **Pulse:#** 73; **Respiratory rate:#** 20; **Systolic:#** 133; **Diastolic:#** 83; **Oxygen saturation:#** 97; ***Pain score>** 2

DISCHARGE INSTRUCTIONS

1014 Melany M Podrebarac, RN
Instructions> Follow up with family MD, Return to ED as needed
Other instructions/Rx: RX GIVEN FOR CIPRO AND TORADOL
Instructions given and reviewed with> Patient

Dr. .

This record is current at date/time of printing.
Final/Complete record is EDM Patient Audit Trail.

Joseph Brant Memorial Hospital
Department of Laboratory Medicine
1230 North Shore Boulevard,
Burlington, Ontario, Canada L7S 1W7
Tel: (905)336-4122 Fax: (905)336-4138

Physician
DIPAULO,B-HAMILTON

Patient: YOUNG,SUZANNE MARIE
Unique #: J477141
DOB: October 11, 1964 **Age:** 46/F
Location: E **Room:**
Encounter: ER002799/11
Most Responsible Dr:
Family Dr:
Admitting Dr:
Associated Dr:
Attending ED MD: AZIZ,S.
Registered: April 23, 2011

Specimen # 11:M0020733R COMP
Ordered: 23/04/11-2103 **Collected:** 23/04/11-2230
Source: Random ur
Comment: Isolation > Routine Practice (None)
Ordering Dr: AZIZ,S.
Received: 23/04/11-2342
Other Dr(s): DIPAULO,B-HAMILTON
Specimen Description:

Procedure	Result	Verified
	Routine Microbiology	
> Urine Culture Final		25/04/11-0854
10-100x10^6 CFU/L mixed urinary contaminants		

YOUNG,SUZANNE MARIE J477141
> = New Activity,* = Critical Results, H = High or L = Low Results, # = Delta Results

End of Report