Patient Allergy Report

Name: **YOUNG,SUZANNE MARIE**
Unit #: **1109244**
HIN: **6427959512-YW**
Address: **U101-695 PLAINS RD E**

Account #: **GX024579/12**
DOB: **19641011** Sex: **F**
Family Doctor: **Di Paolo,Bruno Livio**

City: **BURLINGTON** Prov: **ON** Postal: **L7T 2E8** Home phone: **905-333-2744**

Run Date: 20130213 Run Time: 0340

Coded Allergy or Adverse Reaction for Interaction Checks

Allergy Type	Severity	Date of Last Edit	Verified Status	Patient Reaction

Uncoded Allergy or Adverse Reaction

Uncoded Allergy Type	Severity	Date of Last Edit	Patient Reaction

***** END OF REPORT *****

Patient Allergy Report

Name: **YOUNG,SUZANNE MARIE**
Unit #: **1109244**
HIN: **6427959512-YW**
Address: **U101-695 PLAINS RD E**

Account #: **GF004030/13**
DOB: **19641011** Sex: **F**
Family Doctor: **Di Paolo,Bruno Livio**

City: **BURLINGTON** Prov: **ON** Postal: **L7T 2E8** Home phone: **905-333-2744**

Run Date: 20130814 Run Time: 0339

Coded Allergy or Adverse Reaction for Interaction Checks

Allergy Type	Severity	Date of Last Edit	Verified Status	Patient Reaction
PEANUT OIL. (NUTS (INCLUDES PEANUTS))				
Allergy	Unknown	13/08/20	Not Verified	ANAPHYLAXIS
Penicillins				
Allergy	Unknown	13/08/20	Not Verified	ANAPHYLAXIS

Uncoded Allergy or Adverse Reaction

Uncoded Allergy Type	Severity	Date of Last Edit	Patient Reaction

***** END OF REPORT *****

Patient Allergy Report

Name: **YOUNG,SUZANNE MARIE**
Unit #: **1109244**
HIN: **6427959512-YW**
Address: **U101-695 PLAINS RD E**

Account #: **GF004029/13**
DOB: **19641011** Sex: **F**
Family Doctor: **Di Paolo,Bruno Livio**

City: **BURLINGTON** Prov: **ON** Postal: **L7T 2E8** Home phone: **905-333-2744**

Run Date: 20130814 Run Time: 0339

Coded Allergy or Adverse Reaction for Interaction Checks

Allergy Type	Severity	Date of Last Edit	Verified Status	Patient Reaction
PEANUT OIL. (NUTS (INCLUDES PEANUTS))				
Allergy	Unknown	13/08/20	Not Verified	ANAPHYLAXIS
Penicillins				
Allergy	Unknown	13/08/20	Not Verified	ANAPHYLAXIS

Uncoded Allergy or Adverse Reaction

Uncoded Allergy Type	Severity	Date of Last Edit	Patient Reaction

***** END OF REPORT *****

Patient Allergy Report

Name: **YOUNG,SUZANNE MARIE**
Unit #: **1109244**
HIN: **6427959512-YW**
Address: **U101-695 PLAINS RD E**

Account #: **GD006770/13**
DOB: **19641011** Sex: **F**
Family Doctor: **Di Paolo,Bruno Livio**

City: **BURLINGTON** Prov: **ON** Postal: **L7T 2E8** Home phone: **905-333-2744**

Run Date: 20130912 Run Time: 0339

Coded Allergy or Adverse Reaction for Interaction Checks

Allergy Type	Severity	Date of Last Edit	Verified Status	Patient Reaction
PEANUT OIL. (NUTS (INCLUDES PEANUTS))				
Allergy	Unknown	13/08/20	Not Verified	ANAPHYLAXIS
Penicillins				
Allergy	Unknown	13/08/20	Not Verified	ANAPHYLAXIS

Uncoded Allergy or Adverse Reaction

Uncoded Allergy Type	Severity	Date of Last Edit	Patient Reaction

***** END OF REPORT *****

Psychological Services
General Site – Regional Rehabilitation Centre
300 Wellington Street North
Hamilton, Ontario, Canada
L8L 0A4

Phone No (905) 521-2100, Ext 40983
Fax No (905) 577-8231

Psychologist
A Unsal, Ph D , C Psych

Psychometrists
E Pastirik, B A
T Cebrat, M A

September 12, 2013

Neuropsychological Assessment

Name:	Suzanne **YOUNG**
ID#:	1109244
Date of Birth:	October 11, 1964
Date of Assessment:	August 13, 2013
Age at Testing:	48 years
Education:	Business Administration Diploma + Some University Courses
Occupation:	Unemployed (Formerly in Human Resources)
Referred By:	Dr Rathbone, Neurologist
Examined By:	Ayse Unsal, Ph D , C Psych & Ellen Pastirik, B A

Patient Account # GF00400/13

Background

Reason for Referral

Ms Young was referred for a neuropsychological assessment to determine her neurocognitive and emotional profile in light of reported cognitive difficulties and mood changes after surgery in November 2012

Consent

Ms Suzanne Young consented to undertake a neuropsychological examination to respond to Dr Rathbone's referral question The content and process of a neuropsychological examination were discussed briefly, namely the administration of a clinical interview, standardized psychological and neuropsychological tests (listed in Appendix A), and review of background documentation (listed in Appendix B) The flow of information was also discussed the report summarizing the results to be placed on the hospital medical chart, and copies to those identified at the end of the report with the information otherwise remaining confidential and requiring a signed consent for release Limits of confidentiality were also discussed, in particular the requirement to inform if it is judged that there may be a significant likelihood of harm to themselves or another person, and the requirement for the psychologist to comply with any court orders

History of Presenting Problem

According to Dr Rathbone's Consultation Note (March 21, 2013), Ms Young reportedly had severe headache, dizziness, nausea with vomiting and a big contusion over her right occipital region following a total abdominal hysterectomy on November 26, 2012 Later, she developed blurred vision (for which she is under the care of Dr Rodriguez) , photophobia, sensitivity to high pitched sounds and smells, short term memory and concentration difficulties, sleep problems, fatigue and mood changes These symptoms did not reportedly show improvement over time She reported that her headache is constant, sharp, around the entire top of the head, to the neck and behind the eyes, affected by weather changes and humidity, bright light and emotional state and is associated with nausea Results of an MRI (February 12, 2013) were reported to be unremarkable Ms Young was seen by Dr Robertson, neurotologist and he reportedly indicated uncompensated right vestibulopathy and although he referred her for therapy sessions, she has limited financial resources A neurological examination completed on May 13, 2013 was reportedly within normal limits except for bilateral greater and lesser occipital neuralgia Dr Rathbone reported her multiple symptoms to be similar to Post-Concussion Syndrome

Currently, Ms Young reports that she becomes easily agitated (for which she tries to meditate to decrease anxiety), irritable (particularly in situations where there is a lot of noise or bright lights) and she has problems with concentration There are times where she experiences racing thoughts Previously an avid reader, Ms Young is having vision problems that impede her Ms Young reports waking up with panic attacks, nightmares and that she tends to toss and turn throughout the night She is reportedly always tired

Psychiatric History

Ms Young indicated that she had been abused as a child, however, she preferred not to elaborate She has not undergone psychotherapy

Medical History

In addition to the above, Ms Young is hypoglycemic and has diagnoses of hiatus hernia and bronchial asthma Her hysterectomy in November 2012 was reportedly performed as a result of a discovery of Stage 1 cancer There is a family history of Crohn's disease and colitis (mother), cancer (both sides) and heart disease (father)

Current medications include Ventolin (qid), Flovent (250 mg/bid), Soflax (2 tablets/bid), Tecta (bid), Cymbalta (30 mg/od), Dilaudid (prn) and Prochloroperazine (tid for nausea)

Psychosocial History

Ms Young is preparing to move in with her and her daughter's fiancé in November She completed a two-year Business Administration Diploma at college and has taken some university courses She was working in Human Resources, however, she was laid off due to company restructuring in May 2012 Ms. Young's vocational history also includes private investigation for eight years in the 1980s and she was a singer in a band Ms Young plays games on the computer (e.g cribbage, chess and other puzzle-type activities), sometimes online with others Although she has never reportedly had hobbies, she used to enjoy playing

pool in a league, however, balance difficulties interfere with her ability to engage in it currently Until recently, Ms Young supported herself with U I benefits, and she has been looking for a job

TEST RESULTS

Behavioural Observations

Ms Young presented to her appointment promptly and unaccompanied She had driven herself to the clinic Unfortunately, due to a variety of administrative errors, she was left in the waiting room for one hour and was understandably very upset as a result She indicated that her initial anxiety and nervousness became escalated as she waited, and she tended to respond to questions or conversation in an abrupt manner initially Over time, she became more at ease, jovial and personable Ms Young used a cane when walking During testing, Ms Young intermittently used one of the two pairs of glasses (prescription and readers) she had brought with her She was asked to confirm she could see stimulus items that were presented visually Ms Young rated her headache to be six (on a ten-point scale of increasing intensity)

Sensory-Perceptual and Motor Skills

Ms Young is right handed Simple motor speed fell in the high average range bilaterally Fine motor dexterity and grip strength were average bilaterally There was not consistent expected right hand advantage

Ms Young made no errors on bilateral tactile stimulation Her performance was in the impaired range on bilateral visual and auditory stimulation, with errors lateralized entirely to the left She was able to correctly identify stimuli at eye level, however, she was unable to identify stimuli below eye level or consistently above eye level

Attention, Concentration and Processing Speed

Ms Young's ability to attend to basic auditory information fell in the Low Average range (21st percentile) Her performance on a sub-test requiring her to complete mental arithmetic calculations was better (50th percentile) than on one where she repeated or manipulated digit strings (9th percentile) Ms Young's ability to attend to and work with visual information (i e block tapping) was Average (50th percentile)

On visuomotor tests designed to tap processing speed, Ms Young's performance was slowed (4th percentile) On another test, where she was required to quickly connect numeric information, her score fell in the average range

Intellectual Functioning

Ms Young's overall intellectual function fell in the low Average range (13th percentile) compared with her age-matched Canadian peers There was a significant discrepancy between her overall well learned verbal abilities and those more visuoperceptual in nature A discrepancy of the measured difference occurs in 18 3% of the general population, however, and is therefore not an overly uncommon occurrence.

Verbal Functioning

Ms Young's overall well learned verbal abilities fell in the Low Average range (16th percentile) A relative weakness was verbal abstract reasoning, which fell in the Borderline range (2nd percentile) Expressive vocabulary and fund of information scores were Average (25th to 50th percentile)

Verbal fluency, or the ability to quickly generate unique words according to a beginning letter fell in the low average range When the cue was a category, her score was average

Visual Spatial/Visual Motor Functioning

Ms Young's overall visuoperceptual reasoning fell in the Average range (45th percentile) Her ability to complete patterns and quickly replicate block designs and analyze puzzles and their components was Average (37th to 50th percentile)

Ms Young's ability to copy a complex figure was average Her approach to the task was organized and sequential

Memory and Learning

Ms Young's ability to incidentally recall and draw a complex figure she had copied thirty minutes earlier was average

When information was presented verbally, Ms Young demonstrated an adequate ability to learn a list of words (average) She had difficulty encoding them for later recall (borderline range) Additional structure was not helpful When information was contextual in nature, that is, where she was required to re-tell short stories she had heard one time, Ms Young's immediate and delayed recall scores fell in the High Average range (84th percentile)

Integrative Cognitive Functions

On a challenging test requiring an individual to adjust her strategy in light of changing external contingencies, Ms. Young completed all of the required categories with an average number of errors

On a timed visuomotor test requiring her to quickly shift cognitive set between alternating types of well known stimuli, Ms Young's score fell in the average range

EMOTIONAL FUNCTION

Ms Young's responses on screening measures of mood (Beck Depression Inventory – II and Beck Anxiety Inventory) were suggestive of mild difficulties (e g loss of confidence and ability to concentrate and an inability to relax, dizziness and heart pounding) When compared with others with chronic pain, she reports an average level of impact on her life

In terms of everyday function, Ms Young reports mild difficulty with working memory (e g problems with multi-tasking) and more problems with apathy (e g getting started on an activity) and executive function (e g getting stuck on certain ideas, mixing up sequences) than she did prior to her surgery

SUMMARY OF TEST RESULTS

RELATIVE STRENGTHS

(1) Visuoperceptual Reasoning (Average)
(2) Incidental Visual Memory (Average)
(3) Executive Function – Novel Problem Solving & Complex Attention (Average)

RELATIVE WEAKNESSES

(1) Variable Attention (Affecting Processing Speed Score Ranging from Borderline to Average)
(2) Verbal Abstract Reasoning (Borderline)
(3) Visual Perception on Bilateral Stimulation (Left Sided Errors Made Above and Below Eye Level)

SUMMARY AND CONCLUSIONS

Ms Young had a total abdominal hysterectomy on November 26, 2012 and reportedly had a severe headache, dizziness, nausea with vomiting and a big contusion over her right occipital region when she woke up from surgery Later, she developed blurred vision (for which she is under the care of Dr Rodriguez) , photophobia, sensitivity to high pitched sounds and smells, short term memory and concentration difficulties, sleep problems (including nightmares and panic attacks) , fatigue, mood changes (e g agitation, racing thoughts) and a constant headache Results of an MRI (February 12, 2013) were reported to be unremarkable Ms Young was seen by Dr Robertson, neurotologist and he reportedly indicated uncompensated right vestibulopathy and although he referred her for therapy sessions, she has limited financial resources A neurological examination completed on May 13, 2013 was reportedly within normal limits except for bilateral greater and lesser occipital neuralgia Dr Rathbone reported her multiple symptoms to be similar to Post-Concussion Syndrome Ms Young is in the process of looking for a job, having been supported until recently by Employment Insurance

Ms Young demonstrated variability in her attention during testing, which could be secondary to headache (which she rated to be 6 on a 10-point scale during her testing appointment), chronic sleep problems and subsequent fatigue, or a combination of these factors, that seemed to affect processing speed and focus Verbal abilities, including verbal list learning appear to be reduced Self-report questionnaires revealed mild to moderate levels of anxious and depressive symptomatology The profile, overall, is likely associated with post-concussion syndrome, with additional psychological factors and sleep difficulty impacting her performance

It is our understanding that Ms Young has been referred to the Acquired Brain Injury Program (HHS) for Outreach Services and that she is followed in the Combined Neuro-Physiatry Clinic for management of headaches

Suzanne YOUNG
ID # 1109244
Date September 12, 2013
Patient Account # GF004030/13

Recommendations:

1 Referral to physiotherapy in the community (through the ABI Program) that could include vestibular therapy (further to Dr Robertson's recommendation), as she currently has financial limitations

2 Ms Young would benefit from an increase in structure in her day, to include physical exercise (provided it is not contraindicated by her family physician), socializing and continuation with playing games on the computer (for mental stimulation) A review of sleep hygiene and avoiding overstimulation before retiring in the evening is advisable

3 Relaxation training to assist with sleep and anxious rumination

4 At this time, Ms Young is not likely able to work competitively in a manner to support herself

5 Followup neuropsychological assessment in one year

These results and recommendations were communicated in a feedback session on September 11, 2013

Thank you for your referral If you have any questions, do not hesitate to contact us in Psychology Services at (905) 521-2100, Ext 40983

Ellén Pastirik, B A
Psychometrist

Ayse Unsal, Ph D , C Psych
Psychologist

o Medical Records
cc Dr Rathbone, Neurologist
Dr Bruno DiPaolo, Family Physician
ABI Program (S Bedard, CIC)
Psychology File

Note: Raw data from tests are kept in files held by Psychology Services

Appendix A – Tests Administered

Wechsler Adult Intelligence Scale - Fourth Edition (WAIS-IV)
Wechsler Memory Scale – IV (WMS-IV) – Logical Memory
Wechsler Memory Scale – III (WMS-III) – Spatial span
Brief Visuospatial Memory Test – Revised (BVMT-R) – Form 1
California Verbal Learning Test – Second Edition (CVLT-II)
Trail Making Tests (A & B)
Verbal Fluency (FAS and Animal Naming)
Rey Osterrieth Figure
Finger Tapping Test
Grooved Pegboard
Wisconsin Card Sorting Test (WCST)
Reitan-Klove Sensory Perceptual Examination

Self-Report Measures Completed by Ms. Young

Beck Anxiety Inventory
Beck Depression Inventory-II
Behavior Rating Inventory of Executive Function – Adult
Pain Disability Inventory
Frontal Systems Behavior Scale

Appendix B – Background Documentation

Request for Consultation Note	Dr Rathbone – March 21, 2013
Consultation Reports	Dr Rathbone – May 13, 2013 & March 21, 2013

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.:

Medical Records

HAMILTON HEALTH SCIENCES ☐ GENERAL CAMPUS ☐ HENDERSON CAMPUS ☐ McMASTER UNIVERSITY MEDICAL CENTRE

PART 3 (GREEN) - FAMILY PHYSICIAN · PART 2 (YELLOW) - ACCOUNTING · PART 1 (WHITE) - HEALTH RECORDS · DISTRIBUTION:

REGISTRATION

REGISTER NUMBER	ADMISSION DATE	TIME	PATIENT ID. NUMBER	SURNAME / GIVEN NAME(S)
GE002630/03	30/04/03	1830	1109244	YOUNG, SUZANNE MARIE

MODE OF ARRIVAL: WALKED
PREVIOUS TREATMENT: ☐ E.R. ☐ O.P.D. ☐ IN-PATIENT
STREET ADDRESS (INC. APT. NO.): 14 WEBBER AVE.
RELIGION:
PERSON TO BE NOTIFIED: YOUNG, DEBORAH — TELEPHONE: 905 521-0735 — RELATIONSHIP: SIS
CITY: HAMILTON — PROVINCE: ON — POSTAL CODE: L8N 1W3
ADDRESS: 14 WEBBER AVE.
NOTIFIED BY / AT / HRS.
TELEPHONE: 905 521-0735 — BIRTHDATE: 11/10/64 — AGE: 38 — SEX: F — RESPONSIBILITY FOR PAYMENT: HER
ATTENDING DOCTOR IN EMERGENCY: GILL, RAJINDER S.
TIME CALLED / ANSWERED / ARRIVED
HEALTH NUMBER: 6427959512-XF
FAM./REF. PHYSICIAN: ~~TAYLOR, J. GRANT~~ DR. BRUNO DIPAULO — 905-521-1226
CURRENT DRUGS: Ventolin, Atrovent, Flovent
PRESENTING COMPLAINT: TWISTED KNEE
ALLERGIES / MEDICAL ALERT:
ALLERGY? Y Penicillin
MEDIC ALERT? Y, Asthma, hypoglycemia
If Yes, see ALLERGY/ALERT RECORD
TRIAGE: LESS-URGENT

NURSING

PLACEMENT	VITAL SIGNS	TEMP.	PULSE	RESP.	B.P.	WEIGHT	LAST TET. TOX.	TIME	TAKEN BY
Waiting		36.3	80	16	116/65	kg.		1945	K. Cornell RN

Pt states "stepped wrong" & injured knee 1 week ago. Mod. swelling & difficulty ambulating [signature] R.N. 2100 (TIME) HRS.

PHYSICIAN ASSESSMENT

22:05 (TIME) HRS.

ID - 38 y/o employment agency - on feet all day → not today cc - L knee twisted
HPI - Weds/Thurs - ~~c~~ dog (large) - fell forward ? what area trauma
- knee sore immediately - swelling — felt weak before hit ground
- moist heat → ½ hr on + ½ hr off - kept elevated - got worse
- hurts all time regardless of pos'n - 10/10 TODAY
Ø painkillers

Meds: Ventolin, Serevent, Flovent
Allergies: Penicillin
PMHx: Asthma, ? Hypoglycemia
Fam. Hx: DVT (father)

O/E ~~[illegible]~~ Ø erythema Ø ms atrophy Ø deformity
Ø skin Δ
- ~~[illegible]~~ positive bulge sign (effusion)
- tenderness on palpation of med jt line (tib plateau) + med collateral lig
Ø pain on lat - pain of popliteal fossa — taken in one pos'n too long
- ~~[illegible]~~ ROM

SEEN BY DR. Sam Herman CLINICAL CLERK ☐ HOUSE STAFF ☐ CLERK (NAME) (TIME) HRS.

ORDERS / RESULTS — INVESTIGATION / TREATMENT

1. ~~[illegible]~~ knee Tensor
2. Crutches
3. Tylenol No. 2, 2 tabs po q4h prn @ 2215
4.
5.
6.
7.
8.
9.
10.
11.

FINAL DIAGNOSIS: MCL Ligament Sprain

INITIAL CONSULTATION - NAME/SERV. | TIME CALLED | ANSWERED | ARRIVED

DISPOSITION

DISPOSITION TO: Home
DATE: 30/4/03 — TIME: 2205
FOLLOW-UP ADVICE TO PATIENT:
☐ CRUTCH ☐ SUTURE ☐ CAST ☐ HEAD INJURY ☐ FEVER ☐ TET. TOX. EXPLAINED ☐ FB COMPLETED
NURSE'S NAME (PRINTED & SIGNATURE): [signature]
PHYSICIAN-IN-EMERGENCY (PRINTED & SIGNATURE): [signature] Con
☐ ADDITIONAL INFORMATION ATTACHED

EMERGENCY RECORD — **HEALTH RECORDS COPY**

☐ RECORD CHECKED FOR SIGNATURES BEFORE FILING

HAMILTON CIVIC HOSPITALS

ALLERGY/MEDICAL ALERT RECORD

INFO FROM: P - Patient, F - Family, PH - Pharmacy, O - Other, C - Chart, N - Nurtition, MP - Med Profile, (Del) - Deleted

HEALTH RECORDS COPY

YOUNG.SUZANNE MARIE
1109244 11/10/64 38 F
GE002630/03 ER-MUS/SKE
TAYLOR.J.GRANT

CURRENT DATE & TIME: 30/04/03 - 2001

DATE (ORIGINAL)	SUBSTANCE	TYPE OF REACTION/ DELETION	YEAR OF REACTION	INFO FROM	REVIEWED BY:	ENTERED BY:
05/05/01	PENICILLIN			P		

COMMENTS ON BACK OF FORM

MEDICAL ALERT (1 - 4)	REVIEW BY:	ENTER BY:	MEDICAL ALERT (5 - 8)	REVIEW BY:	ENTER BY:
Asthma					
Diabetes					

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

GE 002630/03

Severe Acute Respiratory Syndrome (SARS) SCREENING TOOL
For All Ontario Healthcare Settings

Visitor ☐ Patient ☐ OP ☐ Staff ☐ ED* ☐ INPT*

*send form with patient

SECTION A:

1. Have you had unprotected contact with a person with SARS in the last 10 days? ☑ No ☐ Yes → **Quarantine applies, notify Public Health**

OR

2. In the last ten days have you been to a health care facility that is closed due to SARS? **OR**

3. Are you under quarantine, or have you been contacted by public health and put on home isolation?

SECTION B:

Have you been to China, Hong Kong, Vietnam, Singapore or Taiwan in the last 10 days? ☑ No ☐ Yes

SECTION C: Are you experiencing any of the following symptoms? ☑ No ☐ Yes

- Myalgia (muscle aches) **OR**
- Malaise (severe tiredness or unwell) **OR**
- Severe headache (worse than usual) **OR**
- Cough (onset within 7 days) **OR**
- Shortness of Breath (worse than what is normal for you) **OR**
- Feeling feverish, or have had a fever in the last 24 hours

SECTION D: Please record the temperature if answer to C is yes.

Temperature		°C (Is the temperature above 38°C?) ☑ No ☐ Yes

☑ **PASS**

✔ If the response is NO to all Sections A through C, then the person passes.

✔ If the response is YES to only Section B, then the person passes.

Provide education materials about SARS if the answer to Section B is YES.

☐ **FAIL** X All persons who do not Pass automatically "FAIL" and **must** be assessed by the secondary screener.

I certify the above information to be correct. (Please print)

Interviewee Name: YOUNG (Last Name) SUZANNE (First Name) Signature: Suzanne Young

Home Phone Number 905-528-0735

Date: April 3/03 Interviewer Name: C. Henderson Signature:

☐ MUMC ☑ General ☐ Henderson ☐ Chedoke ☐ St.Joseph'sHospital ☐ CAHS ☐ CMHS ☐ CLS ☐ HRCC ☐ Other

Directives for FAIL:

PATIENT **Entry?** ☐ **Yes** ☐ **No** **RN Signature**_____

If **YES** in Section **A only**:

1. **EMERGENCY DEPARTMENT PATIENT**:
   - Apply regular surgical mask to patient
   - Isolate
   - Contact Infection Control

2. **ALL OTHER PATIENTS:**
   - Record patient oral temperature ____
   - Apply regular surgical mask to pt.
   - Hold pt. and contact Infection Control
   - Contact Hospital Clinic \ Physician's Office \ Admitting as appropriate

If **YES** in Section **A & C or A & D or A, C & D:**
- Apply regular surgical mask to patient
- Escort patient with form to Emergency Department Triage
- Emergency Department to isolate and contact Infection Control

If **YES** in Section **B & C or B & D or B, C & D:**
- Apply regular surgical mask to patient
- Escort patient with form to Emergency Department Triage
- Emergency Department to isolate and contact Infection Control

If **YES** to Section **C & D or D only:**
- RN to assess re appropriate disposition (i.e. to scheduled appointment or Emergency Department Triage)

STAFF **Entry?** ☐ **Yes** ☐ **No** **RN Signature**_____

If **YES** in Section **A Only**
- Apply regular surgical mask; refuse entry to hospital and send home with instructions to quarantine themselves.
- Screener to notify Employee Health Services and Infection Control
- Screener to notify home unit \ department
- Forward form to Employee Health Services

If **YES** in Section **A & C or A & D or A, C & D:**
- Apply regular surgical mask to staff member
- Escort staff member with form to Emergency Department Triage
- Emergency Department to isolate, contact Infection Control and notify Home Unit

If **YES** in Section **B & C or B & D or B,C & D:**
- Apply regular surgical mask to staff member
- Escort staff member with form to Emergency Department Triage
- Emergency Department to isolate, contact Infection Control and notify Home Unit

If **YES** in Section **C & D or D only:**
- Send home
- Instruct staff member to contact Employee Health Services or Family Physician
- Screener to notify home unit \ department
- Forward form to Employee Health Services

VISITOR **Entry?** ☐ **Yes** ☐ **No** **RN Signature**_____

If **YES** in Section **A only:**
- Apply regular surgical mask; refuse entry to hospital and instruct visitor to quarantine themselves
- Screener to notify Infection Control

If **YES** in Section **A & C or A & D or A, C & D:**
- Apply regular surgical mask to visitor
- Escort visitor with form to Emergency Department Triage
- Emergency Department to isolate and contact Infection Control

If **YES** in Section **B & C or B & D or B, C & D:**
- Apply regular surgical mask to visitor
- Escort visitor with form to Emergency Department Triage
- Emergency Department to isolate and contact Infection Control

If **YES** in Section **C &D or D only:**
- Refuse entry to hospital
- Instruct visitor to contact Telehealth or Family Physician

714005 (2000-03)

Dr. B. De Paula

Hamilton Health Sciences

Suzanne . Young
6427 959512 XF
DOB 1964-10-11
14 Webber, ave
Hamilton On L8N1W3

EMERGENCY TRIAGE RECORD

Arrival: Date (yyyy/mm/dd) 03/04/30 Time 1830 (hh:mm)

Patient's Name ______ Age 38

Accompanied by: ☐ Relative ______ ☐ Police Badge Number ______

☐ Other ______ **Restrained:** ☐ Yes ☐ No

Presenting Complaint: Twisted knee.

Mode of Arrival: ☐ Ambulance ☑ Other Car. **RN Signature** (if different than below) ______

Referral: ☐ MD Referral ☐ Orders **With Patient on Arrival:** ☐ Advanced Directives ☐ Other ______ ☐ Referral letter ☐ Xrays ☐ Lab Results

Transferred from: ☐ Residence ☐ Nursing Home ☐ Other ______

Triage Assessment: Time: Knee injury 1 week ago – thought she stepped wrong – Some swelling around patella. [illegible] ambulating – [illegible]

~~DV Screening Yes ☐ No ☐~~

If no, why? ______

Pain Scale: 0 (no pain).. 1 .. 2 .. 3 .. 4 .. 5 .. 6 .. 7 .. 8 .. 9 .. 10(worst)

Faces Pain Rating Scale: 0.. 1 .. 2 .. 3 .. 4 .. 5

Past Medical History:

Medication: ☑ Yes ☐ No Ventolin, Atrovent, Flovent.

Allergies: ☑ Yes ☐ No ☐ Unknown **If Yes** - identify Penicillin

Medical Alerts: ☑ Yes ☐ No ☐ Unknown **If Yes** - identify asthmatic, hypoglycemic

Tetanus Status: ☐ N/A ☐ Up to date Date of Last Tetanus (yyyy//mm/dd) ______ ☐ No ☐ Unknown

Triage Interventions: ☐ Cleansed ☐ Dressing ☐ Elevation ☐ Ice ☐ Splint ☐ Other ______

☐ Medical Directive ______ Initiated at ______

Triage Level: (circle) I - Resuscitation II - Emergent III - Urgent **(IV - Less Urgent)** V - Non Urgent

Initial Vital Signs:

Time	Temp	Pulse/ Heart Rate	Resp Rate	BP Left	BP Right	O_2 Sat	Cap Refill	Initial
1945	36.3	80	16	116/65			sec	K

see Clinical Observation Record ☐

Pediatrics

Last Oral Intake Time	Last Oral Intake Amount	Last Urine Output Time	Last Urine Output Amount	Cap Refill	Weight (dressed)	Initial
				sec		

Immunization up to date: ☐ Yes ☐ No ☐ Unknown **Contact with Communicable Disease:** ☐ Yes ☐ No ☐ Unknown

Patient Waiting Room: ☑ Yes ☐ No **Triage Nurse Signature:** K. [illegible] RN

Patient Transferred to: Exam **Report Given to:** ______ at ______ . Initial ______

If Triage Level I or II - Doctor: ______ **notified at:** ______ . Initial ______

Reassessment

Time: ______________ hh/mm• ______________________________

____

____

Pain Scale: 0 (no pain).. 1 .. 2 .. 3 .. 4 .. 5 .. 6 .. 7 .. 8 .. 9 .. 10 (worst)

Faces Pain Rating Scale: 0.. 1 .. 2 .. 3 .. 4 .. 5

Vital Signs:

Time	Temp	Pulse/ Heart Rate	Resp Rate	BP Left	BP Right	O_2 Sat	Cap Refill
							sec

see Clinical Observation Record ☐

RN Signature: ______________________

Reassessment

Time: ______________ hh/mm• ______________________________

____

____

Pain Scale: 0 (no pain).. 1 .. 2 .. 3 .. 4 .. 5 .. 6 .. 7 .. 8 .. 9 .. 10 (worst)

Faces Pain Rating Scale: 0.. 1 .. 2 .. 3 .. 4 .. 5

Vital Signs:

Time	Temp	Pulse/ Heart Rate	Resp Rate	BP Left	BP Right	O_2 Sat	Cap Refill
							sec

see Clinical Observation Record ☐

RN Signature: ______________________

Reassessment

Time: ______________ hh/mm• ______________________________

____

____

Pain Scale: 0 (no pain).. 1 .. 2 .. 3 .. 4 .. 5 .. 6 .. 7 .. 8 .. 9 .. 10 (worst)

Faces Pain Rating Scale: 0.. 1 .. 2 .. 3 .. 4 .. 5

Vital Signs:

Time	Temp	Pulse/ Heart Rate	Resp Rate	BP Left	BP Right	O_2 Sat	Cap Refill
							sec

see Clinical Observation Record ☐

RN Signature: ______________________

Initials	Printed Name	Signature & Designation	Initials	Printed Name	Signature & Designation

HAMILTON HEALTH SCIENCES CORPORATION

☒ GENERAL CAMPUS ☐ HENDERSON CAMPUS

REGISTRATION

REGISTER NUMBER	ADMISSION DATE	TIME	PATIENT ID. NUMBER	SURNAME / GIVEN NAME(S)
GE014268/01	06/08/01	0916	1109244	YOUNG, SUZANNE MARIE

MODE OF ARRIVAL: WALKED
PREVIOUS TREATMENT: ☐ E.R. ☐ O.P.D. ☐ IN-PATIENT
STREET ADDRESS (INC. APT. NO.): 14 WEBBER AVE.
RELIGION:

PERSON TO BE NOTIFIED: YOUNG, DEBORAH — TELEPHONE: 521-0735 — RELATIONSHIP: SIS
CITY: HAMILTON — PROVINCE: ON — POSTAL CODE: L8N 1W3

ADDRESS: 14 WEBBER AVE. — NOTIFIED BY — AT — HRS.
TELEPHONE: 521-0735 905 — BIRTHDATE: 11/10/64 — AGE: 36 — SEX: F — RESPONSIBILITY FOR PAYMENT: HSC

ATTENDING DOCTOR IN EMERGENCY: ROSS, CHRISTOPHER — TIME CALLED — ANSWERED — ARRIVED
HEALTH NUMBER: 6427959512-XF

FAM./REF. PHYSICIAN: TAYLOR, J.GRANT 521-1226

CURRENT DRUGS: Ventolin prn. Atrovent / Tigan Serevent ? 9pm Flovent 250mg ? Zantac 150mg bd. ? pm

PRESENTING COMPLAINT: INFECTED INSECT
ALLERGIES / MEDICAL ALERT: ALLERGY? Y ~~N~~ MEDIC ALERT? Y ~~N~~ If Yes, see ALLERGY/ALERT RECORD

LESS-URGENT

NURSING

PLACEMENT: [illegible] — VITAL SIGNS: TEMP. 36.4 — PULSE 76 — RESP. 20 — B.P. 126/87 — WEIGHT — kg. — LAST TET. TOX. — TIME 2130 — TAKEN BY [illegible]

Pt states returned for IV antibiotics and reassessment of insect bite on [illegible].

______ R.N. ______ HRS. (TIME)

PHYSICIAN ASSESSMENT

0950 HRS. (TIME) [illegible]
[illegible]
[illegible] IV [illegible] infected
insect bite [illegible]
[illegible]
[illegible]
[illegible]
[illegible]

[illegible]
[illegible]
[illegible]
[illegible]
[illegible]

ORDERS / RESULTS — INVESTIGATION TREATMENT

1. see Med profile
2.
3. [illegible] po clindamycin
4. [illegible]
5.
6.

SEEN BY DR. ☐ HOUSE STAFF ☐ CLERK (NAME) AT (TIME) HRS.

7.
8. IV lock D/C
9. site + cannula [illegible]
10. intact [illegible]
11.

FINAL DIAGNOSIS: Cellulitis - Resolving

INITIAL CONSULTATION - NAME/SERV. — TIME CALLED — ANSWERED — ARRIVED

DISPOSITION: H
FOLLOW-UP ADVICE TO PATIENT:
DATE: 6 8 01 — TIME: 0950

☐ CRUTCH
☐ SUTURE
☐ CAST
☐ HEAD INJURY
☐ FEVER
☐ TET. TOX. EXPLAINED
☐ FB COMPLETED

NURSE'S NAME (PRINTED & SIGNATURE): Linda Jefferies Jefferies
PHYSICIAN IN EMERGENCY (PRINTED & SIGNATURE): [signature] (Ross)

☒ ADDITIONAL INFORMATION ATTACHED

EMERGENCY RECORD **HEALTH RECORDS COPY**

☒ RECORD CHECKED FOR SIGNATURES BEFORE FILING

DISTRIBUTION: PART 1 (WHITE) - HEALTH RECORDS PART 2 (YELLOW) - ACCOUNTING PART 3 (GREEN) - FAMILY PHYSICIAN

NB

HAMILTON HEALTH SCIENCES CORPORATION

☒ GENERAL CAMPUS ☐ HENDERSON CAMPUS

REGISTRATION

REGISTER NUMBER	ADMISSION DATE	TIME	PATIENT ID. NUMBER	SURNAME / GIVEN NAME(S)
GE014223/01	05/08/01	2122	1109244	YOUNG, SUZANNE MARIE

MODE OF ARRIVAL: WALKED
PREVIOUS TREATMENT: ☐ E.R. ☐ O.P.D. ☐ IN-PATIENT Yes
STREET ADDRESS: 14 WEBBER AVE.
RELIGION:

PERSON TO BE NOTIFIED: YOUNG, DEBORAH — TELEPHONE: 521-0735 — RELATIONSHIP: SIS
CITY: HAMILTON — PROVINCE: ON — POSTAL CODE: L8N 1W3

ADDRESS: 14 WEBBER AVE.
NOTIFIED BY / AT / HRS.:
TELEPHONE: 521-0735 905
BIRTHDATE: 11/10/64 — AGE: 36 — SEX: F — RESPONSIBILITY FOR PAYMENT: HSC

ATTENDING DOCTOR IN EMERGENCY: WORSTER, ANDREW
TIME CALLED / ANSWERED / ARRIVED:
HEALTH NUMBER: 6427959512-XF

FAM./REF. PHYSICIAN: TAYLOR, J. GRANT 521-1226
CURRENT DRUGS: Ventolin, Zantac, Beclofarte, Serevent, Atrovent

PRESENTING COMPLAINT: ?INFECTION LT Neck
ALLERGIES / MEDICAL ALERT: ALLERGY? Y MEDIC ALERT? Y If Yes, see ALLERGY/ALERT RECORD
TRIAGE: LESS-URGENT

NURSING

PLACEMENT	VITAL SIGNS TEMP.	PULSE	RESP.	B.P.	WEIGHT	LAST TET. TOX.	TIME	TAKEN BY
Clark 2	36 oral	76	18	135/89 (R) SaO2=99%		<5yrs	2135	

Returned @2122hrs for repeat IV Clindamycin. (doses to be given unclear on order sheet) C/O ↑ pain & Toradol script unfilled as NE when given earlier. - outlined insect bite to (L) side neck with pen. ∅ drainage. Swelling [illegible] 2135 HRS. (TIME)

PHYSICIAN ASSESSMENT

___ HRS. (TIME) surrounding redness - extends up into neck.

LWBS

ORDERS / RESULTS

1 V/O per Dr. Worster [illegible]
2 (1) Administer Maxeran 10mg IV q15min x2 - GIVEN #1 @2235
3 then give 30mg IV Toradol x 1 dose #2 @ 2255 [illegible]
4 refused.
5 LAMA
6

SEEN BY DR. ___ ☐ HOUSE STAFF ☐ CLERK (NAME) ___ AT ___ HRS. (TIME)

10
11

FINAL DIAGNOSIS:
INITIAL CONSULTATION - NAME/SERV. / TIME CALLED / ANSWERED / ARRIVED

DISPOSITION

DISPOSITION TO: LWBS
FOLLOW-UP ADVICE TO PATIENT:
DATE: 6 08 01 — TIME: 0915
NURSE'S NAME (PRINTED & SIGNATURE): Jefferies
PHYSICIAN-IN-EMERGENCY (PRINTED & SIGNATURE):

☐ CRUTCH ☐ SUTURE ☐ CAST ☐ HEAD INJURY ☐ FEVER ☐ TET. TOX. EXPLAINED ☐ F6 COMPLETED

☐ ADDITIONAL INFORMATION ATTACHED — EMERGENCY RECORD — HEALTH RECORDS COPY — ☐ RECORD CHECKED FOR SIGNATURES BEFORE FILING

DISTRIBUTION: PART 1 (WHITE) - HEALTH RECORDS; PART 2 (YELLOW) - ACCOUNTING; PART 3 (GREEN) - FAMILY PHYSICIAN

✓ NB

HAMILTON HEALTH SCIENCES CORPORATION ☑ GENERAL CAMPUS ☐ HENDERSON CAMPUS

REGISTER NUMBER: GE014144/01
ADMISSION DATE: 05/08/01
TIME: 0227
PATIENT ID. NUMBER: 1109244
SURNAME / GIVEN NAME(S): YOUNG, SUZANNE MARIE

MODE OF ARRIVAL: WALKED
PREVIOUS TREATMENT: Yes ☐ O.P.D. ☐ INPATIENT
STREET ADDRESS: 14 WEBBER AVE.
RELIGION:

PERSON TO BE NOTIFIED: YOUNG, DEBORAH
TELEPHONE: 521-0735
RELATIONSHIP: SIS
CITY: HAMILTON
PROVINCE: ON
POSTAL CODE: L8N 1W3

ADDRESS: 14 WEBBER AVE.
NOTIFIED BY / AT / HRS.
TELEPHONE: 521-0735 905
BIRTHDATE: 11/10/64
AGE: 36
SEX: F
RESPONSIBILITY FOR PAYMENT: HSC

ATTENDING DOCTOR IN EMERGENCY: SIMPSON, DIANE L.
TIME CALLED / ANSWERED / ARRIVED
HEALTH NUMBER: 6427959512-XF

FAM./REF. PHYSICIAN: TAYLOR, J. GRANT 521-122[illegible]
CURRENT DRUGS: [illegible]

PRESENTING COMPLAINT: ?INSECT BITE LT shoulder
ALLERGIES / MEDICAL ALERT: ALLERGY? Y MEDIC ALERT? Y
TRIAGE: LESS-URGENT Yes. see ALLERGY/ALERT RECORD

NURSING

PLACEMENT: [illegible] VITAL SIGNS: TEMP. [illegible] PULSE 78 RESP. 16 B.P. [illegible] WEIGHT kg. LAST TET. TOX. TIME TAKEN BY

[illegible]

PHYSICIAN ASSESSMENT

(TIME) HRS.

36 yo F c ? insect bite (L) shoulder
mild swelling erythema.
Tender ++ (L) lateral neck ? lymph gland
Migraine

ORDERS / RESULTS

1. CBC
2. IV N/S 1 litre over 1 hr.
3. Clindamycin 600 mg IV
4. Maxeran 10 mg IV
Tyl#3 ii po

SEEN BY DR. ☐ HOUSE STAFF ☐ CLERK (NAME) AT (TIME) HRS.

(0615) Pt states headache ø better
30 Toradol IV
given Toradol 30mg IV vo Dr. Simpson
BP 127/84 HR 65

FINAL DIAGNOSIS: ? Infection (L) neck

INITIAL CONSULTATION - NAME/SERV. | TIME CALLED | ANSWERED | ARRIVED

DISPOSITION TO: HOME
FOLLOW-UP ADVICE TO PATIENT:
DATE: 5/09/01 TIME: [illegible] Signed out @2120 to Reregister for RIA

☐ CRUTCH ☐ SUTURE ☐ CAST ☐ HEAD INJURY ☐ FEVER ☐ TET. TOX. EXPLAINED ☐ FB COMPLETED

NURSE'S NAME (PRINTED & SIGNATURE): [signature]
PHYSICIAN-IN-EMERGENCY (PRINTED & SIGNATURE): Simpson

☐ ADDITIONAL INFORMATION ATTACHED

EMERGENCY RECORD **HEALTH RECORDS COPY**

☑ RECORD CHECKED FOR SIGNATURES BEFORE FILING

PART 3 (GREEN) - FAMILY PHYSICIAN
PART 2 (YELLOW) - ACCOUNTING
PART 1 (WHITE) - HEALTH RECORDS
DISTRIBUTION:

HAMILTON HEALTH SCIENCES CORPORATION

☑ GENERAL CAMPUS ☐ HENDERSON CAMPUS

REGISTRATION

REGISTER NUMBER	ADMISSION DATE	TIME	PATIENT ID. NUMBER	PATIENT
GE004073/01	06/05/01	1830	1109244	YOUNG, SUZANNE

MODE OF ARRIVAL: WALKED

PREVIOUS TREATMENT: ☐ E.R. ☐ O.P.D. ☐ IN-PATIENT

Address: 14 WEBBER AVE

PERSON TO BE NOTIFIED: YOUNG, DEBORAH — TELEPHONE: 521 0735 — RELATIONSHIP: SIS

CITY: HAMILTON — ON — L8N 1W3

ADDRESS: 14 WEBBER AVE

NOTIFIED BY / AT HRS.

TELEPHONE: 521 0735 905 — BIRTHDATE: 11/10/64 — 36 — F — HSC

ATTENDING DOCTOR IN EMERGENCY: SELLENS, CATHY

TIME CALLED / ANSWERED / ARRIVED

HEALTH NUMBER: 6427959512-XF

FAM./REF. PHYSICIAN: TAYLOR, J. GRANT 521-1226

CURRENT DRUGS -

PRESENTING COMPLAINT: RECHECK RT FORE

ALLERGIES / MEDICAL ALERT: ALLERGY? Y
MEDIC ALERT? Y
If Yes, see ALLERGY/ALERT RECORD

TRIAGE: URGENT

NURSING

PLACEMENT	VITAL SIGNS	TEMP.	PULSE	RESP.	B.P.	WEIGHT	LAST TET. TOX.	TIME	TAKEN BY
CX Clair						kg.			

asked to return post radiologists report from x-ray as Mayo1

McComb McCOMB R.N. 1635 HRS. (TIME)

PHYSICIAN ASSESSMENT

____ HRS. (TIME)

Asked to return because of xray finding by radiologist.

Patient ⊘ tender @ elbow

⊘ bony pain

Meds Tyl #3

Pt with elbow & back pain.

ORDERS / RESULTS

1. Elbow xray MD - 1846
2. → (N)
3.
4.
5.
6.

SEEN BY DR. ☐ HOUSE STAFF ☐ CLERK (NAME) AT ____ HRS. (TIME)

7.
8.
9.
10.
11.

FINAL DIAGNOSIS: Normal Exam

INITIAL CONSULTATION - NAME/SERV. | TIME CALLED | ANSWERED | ARRIVED

DISPOSITION

DISPOSITION TO: Home by MD

DATE: D 6 M 5 Y 01 — TIME: 1920

FOLLOW-UP ADVICE TO PATIENT:

☐ CRUTCH ☐ SUTURE ☐ CAST ☐ HEAD INJURY ☐ FEVER ☐ TET. TOX. EXPLAINED ☐ F8 COMPLETED

NURSE'S NAME (PRINTED & SIGNATURE): Bluzowski Blurawski

PHYSICIAN-IN-EMERGENCY (PRINTED & SIGNATURE): C Sellens Sellens

☐ ADDITIONAL INFORMATION ATTACHED — EMERGENCY RECORD — HEALTH RECORDS COPY — ☑ RECORD CHECKED FOR SIGNATURES BEFORE FILING

DISTRIBUTION: PART 1 (WHITE) - HEALTH RECORDS; PART 2 (YELLOW) - ACCOUNTING; PART 3 (GREEN) - FAMILY PHYSICIAN

HAMILTON HEALTH SCIENCES CORPORATION

☑ GENERAL CAMPUS ☐ HENDERSON CAMPUS

REGISTRATION

REGISTER NUMBER: GE003987/01
ADMISSION DATE: 05/05/01
TIME: 2313
PATIENT ID. NUMBER: 1109244
NAME: YOUNG, SUZANNE

MODE OF ARRIVAL: WALKED
PREVIOUS TREATMENT: ☐ E.R. ☐ O.P.D. ☐ IN-PATIENT
ADDRESS: 14 WEBBER AVE
CITY: HAMILTON
PROVINCE: ON
POSTAL CODE: L8N 1W3

PERSON TO BE NOTIFIED: YOUNG, DEBORAH
TELEPHONE: 521 0735
RELATIONSHIP: SIS
ADDRESS: 14 WEBBER AVE
NOTIFIED BY / AT / HRS.
TELEPHONE: 521 0735 905
BIRTHDATE: 11/10/64
AGE: 36
SEX: F
HER

ATTENDING DOCTOR IN EMERGENCY: SIMPSON, DIANE L.
TIME CALLED / ANSWERED / ARRIVED
HEALTH NUMBER: 6427959512-XF

FAM./REF. PHYSICIAN: TAYLOR, J. GRANT 521-1226
CURRENT DRUGS: Ventolin, Atrovent, Flovent, Serevent

PRESENTING COMPLAINT: FALL-CP T@0130
ALLERGIES / MEDICAL ALERT: ALLERGY? Y/N; MEDIC ALERT? Y; If Yes, see ALLERGY/ALERT RECORD
TRIAGE: LESS-URGENT

NURSING

PLACEMENT: Exam 6
VITAL SIGNS: TEMP. / PULSE 88 / RESP. 20 / B.P. 131/83 / O2 sat 98% / TIME 2355 / TAKEN BY [illegible]

Fell forward braced self c Rt arm @ 0130 today. Pain worse today than last. Tender Rt shoulder, wrist and across front of chest. [signature] R.N. 2355 HRS.

PHYSICIAN ASSESSMENT

(TIME) HRS.

Fall 24 hrs ago onto (R) hand + arm. This am woke c pain (R) shoulder, upper chest + forearm

++ tender forearm.
(N) ROM wrist + shoulder
Tender ant. Rotator cuff

ORDERS / RESULTS — INVESTIGATION / TREATMENT

1. Called 2320.
2. TORADOL 30 mg im [illegible] @ 0055 (...)
3. Xray (R) forearm
4.
5. Tylenol #3 II po
6. Rx Ibuprofen

SEEN BY DR. ☐ HOUSE STAFF ☐ CLERK (NAME) AT (TIME) HRS.

FINAL DIAGNOSIS: Strain (R) Shoulder Sprain (R) wrist

INITIAL CONSULTATION - NAME/SERV. / TIME CALLED / ANSWERED / ARRIVED

DISPOSITION

DISPOSITION: D/C
DATE: 05/05/01
TIME: 0330
FOLLOW-UP ADVICE TO PATIENT: Ice, rest. Rotate thru ROM. F/U c F.D. ? physio

☐ CRUTCH ☐ SUTURE ☐ CAST ☐ HEAD INJURY ☐ FEVER ☐ TET. TOX. EXPLAINED ☐ CONSULTED

NURSE'S NAME (PRINTED & SIGNATURE): [signature] (Daley)
PHYSICIAN-IN-EMERGENCY (PRINTED & SIGNATURE): [signature] Simpson

☐ ADDITIONAL INFORMATION ATTACHED — EMERGENCY RECORD — HEALTH RECORDS COPY — ☐ RECORD CHECKED FOR SIGNATURES BEFORE FILING

DISTRIBUTION: PART 1 (WHITE) - HEALTH RECORDS; PART 2 (YELLOW) - ACCOUNTING; PART 3 (GREEN) - FAMILY PHYSICIAN

HAMILTON CIVIC HOSPITALS

ALLERGY/MEDICAL ALERT RECORD

INFO FROM: P - Patient O - Other
F - Family C - Chart
PH - Pharmacy N - Nurtition
(Del) - Deleted MP - Med Profile

HEALTH RECORDS COPY

YOUNG,SUZANNE MARIE
1109244 11/10/64 36 F
GE014268/01 ER-MED
TAYLOR,J.GRANT

CURRENT DATE & TIME: 06/08/01 - 0923

DATE (ORIGINAL)	SUBSTANCE	TYPE OF REACTION/ DELETION	YEAR OF REACTION	INFO FROM	REVIEWED BY:	ENTERED BY:
05/05/01	PENICILLIN			P		

COMMENTS ON BACK OF FORM

MEDICAL ALERT (1 - 4)	REVIEW BY:	ENTER BY:	MEDICAL ALERT (5 - 8)	REVIEW BY:	ENTER BY:
Asthma					

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

05/06/01 PATIENT REGISTRATION PAGE 1

- HAMILTON GENERAL CAMPUS -
DEPARTMENT OF LABORATORY MEDICINE
237 Barton Street East, Hamilton, Ontario, L8L 2X2
(905) 527-4322 ext. 46360

Account Number: GE0146144/01 Patient's Name: YOUNG,SUZANNE MARIE
Discharge Loc : ER-SKIN HIN: 6427953512 DOB: 11/10/64 Sex: F Unit #: 1109244
Attending Dr. : Family Dr.: TAYLOR,J.GRANT

Specimen Report Status: COMPLETE Submitted by: SIMPSON,DIANE L.
Specimen: 0508:H091760 Collected: 05/03/01 - 0335 Received: 05/03/01 - 0502

Ordered: CBC

Test	Result	Flag	Reference
	*** COMPLETE BLOOD COUNT ***		
> **WBC**	9.0		4.0-11.0 X10 9/L
> EOS	4.59		3.8-5.8 x1012/L
> **HGB**	146		115-165 g/L
> **HCT**	0.429		0.370-0.470
MCV	93.3		82-99 fL
> MCH	31.7		27-32 pg
> MCHC	340		300-350 g/L
> RDW	13.6		11.5-16.0
> **PLT**	369		150-400 x10 9/L
> MPV	7.3		fL
> RELATIVE LYMPHS	0.22		
> RELATIVE MONOS	0.05		
> RELATIVE GRANS	0.68		
> RELATIVE EOS	0.04		
> RELATIVE BASOS	0.01		
> ABSOLUTE LYMPHS	2.0		1.5-4.0 x10 9/L
> ABSOLUTE MONOS	0.5		0.2-0.8 x10 9/L
> ABSOLUTE GRANS	6.1		2.0-7.5 x10 9/L
> ABSOLUTE EOS	0.30		0.04-0.40 x10 9/L
> ABSOLUTE BASOS	0.10		0.02-0.10 x10 9/L
FLAGGED DIFF	NO		

Please note reference interval changes, effective March 5, 2001
F 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

** END OF REPORT **

HAMILTON CIVIC HOSPITALS

ALLERGY/MEDICAL ALERT RECORD

INFO FROM: P - Patient O - Other
F - Family C - Chart
PH - Pharmacy N - Nurtition
(Del) - Deleted MP - Med Profile

HEALTH RECORDS COPY

YOUNG,SUZANNE MARIE
1109244 11/10/64 36 F
GE014223/01 ER-MED
TAYLOR,J.GRANT

CURRENT DATE & TIME: 05/08/01 - 2122

DATE (ORIGINAL)	SUBSTANCE	TYPE OF REACTION/ DELETION	YEAR OF REACTION	INFO FROM	REVIEWED BY:	ENTERED BY:
05/05/01	PENICILLIN			P		

COMMENTS ON BACK OF FORM

MEDICAL ALERT (1 - 4)	REVIEW BY:	ENTER BY:	MEDICAL ALERT (5 - 8)	REVIEW BY:	ENTER BY:
Asthma					

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

712192 (1999-02)

HAMILTON HEALTH SCIENCES CORPORATION

INTERDISCIPLINARY PATIENT CARE NOTES

YOUNG, SUZANNE MARIE
#1109244 F 36
6427959512-XF GE014144/01

TAYLOR, J.GRAN
WEBBER AVE. HAMILT
DC. 1735 905 L8N 1W3
11/10/64

DATE (yyyy/mm/dd) TIME AND ISSUE	PATIENT CARE NOTES
Aug 5 01 @2120:	BP- 135/89 (R). HR= 76bpm. Sao2=99%. Temp=36° oral.
	Patient was re-registered to then be R/A by ERP.
	c/o migraine - Toradol NE. ∴ did not fill Rx/pt. IV Site
	benign. ——— Thibaudeau Rn.
2230 (N)	Pt waiting to leave at this time. Explained that she is free to leave against medical advice. Decided to stay but unhappy that she has not yet been assessed by a doctor. Explained that she is to receive her abx first and that she is in the line up waiting to be seen. ——— MacAulay Rn
2305 (N)	Pt stated that she is leaving without being seen. She is "very tired and doesn't know what is going on". Explained that the ED is very busy and that she must wait to be seen as the others do. Pt IV locked off at pt request. Explained to pt that she should return at 0530 for another dose of Clindamycin - Q8h. Pt stated "will see about that". I explained that if she did not wish to comply that is her decision but that we cannot help her medically if she did not wish to receive treatment as ordered. Pt said she'll get here when I get here + walked out. ——— MacAulay Rn.
Aug 6/01 0530 (N)	Pt due back at this time. Has not yet arrived for antibiotic treatment MacAulay Rn

HAMILTON CIVIC HOSPITALS

ALLERGY/MEDICAL ALERT RECORD

INFO FROM: P - Patient O - Other
F - Family C - Chart
PH - Pharmacy N - Nurtition
(Del) - Deleted MP - Med Profile

HEALTH RECORDS COPY

YOUNG.SUZANNE MARIE
1109244 11/10/64 36 F
GE014144/01 ER-SKIN
TAYLOR.J.GRANT

CURRENT DATE & TIME: 05/08/01 - 0227

DATE (ORIGINAL)	SUBSTANCE	TYPE OF REACTION/ DELETION	YEAR OF REACTION	INFO FROM	REVIEWED BY:	ENTERED BY:
05/05/01	PENICILLIN			P	RG	

COMMENTS ON BACK OF FORM

MEDICAL ALERT (1 - 4)	REVIEW BY:	ENTER BY:	MEDICAL ALERT (5 - 8)	REVIEW BY:	ENTER BY:
Asthma	RG				

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
[signature]	RG				

25 Aug 01

HAMILTON CIVIC HOSPITALS

☑ Hamilton General Division ☐ Henderson General Division

YOUNG, SUZANNE MARIE
U1109244 F 36
6427959512-XF GE014144/01

TAYLOR, J. GRAN
14 WEBBER AVE. HAMIL
521-0735 905 L8N 1W3
11/10/64

PATIENT LEAVE OF ABSENCE FROM HOSPITAL

This is to certify that the above named person is leaving the Hamilton Civic Hospitals temporarily and at his/her own request and with permission of his/her attending physician. The hospital is hereby released from all responsibility for the above named patient while away from the hospital. The time of the above named patient's return should be checked with the charge nurse prior to his/her departure.

Patients may remain out for 2 nights. Any patient who have not returned to the ward by midnight of the 2nd night will be automatically discharged.

Out				Expected Return		Actual Return		
Date	Time	Patient/Guardian Signature	Destination	Date	Time	Staff Witness	Date	Time
01/08/05	0805	Suzanne Young	Home	01/08/05	1200	[illegible]		1205
11	1320	Suzanne Young	H	11	2000	[illegible]	Aug 5/01	1320
Aug 5/01	1320		Home	Aug 6	0520	[illegible]	6/8/01	0915

FORM 003845 8/89

PATIENT LEAVE OF ABSENCE

HAMILTON HEALTH SCIENCES CORPORATION
GENERAL AND HENDERSON CAMPUSES
MEDICATION PROFILE

SHEET ______ of ______

WEIGHT

ALLERGIES
Penicillin.

DIAGNOSIS
? Infection (L) neck.

RECOPIED BY:

CHECKED BY:

YOUNG, SUZANNE MARIE
U1109244 F 36
642793951 2-XF GED14144/01
TAYLOR, J. GRAH
14 WEBBER AVE. HAMILT
521-0735 905 L0H 1H3
11/10/64

ADDRESSOGRAPH

COPIED BY DATE	COPIED BY INITIALS	TO BE GIVEN DATE	TO BE GIVEN TIME	SINGLE ORDER MEDICATIONS: MEDICATION	DOSE	ROUTE	GIVEN: INITIALS	GIVEN: TIME	GIVEN: REASON/EFFECT
01/08/05	CC	08/05	1200	Clindamycin	600mg	IV	1215	CC	
				THEN P/A.					
01/08/05	CC	08/05	1325	Toradol	30mg	IV	1300	CC	

INIT	SIGNATURE (CATEGORY)	INIT	SIGNATURE (CATEGORY)
CC	C Wanier		
CC	Cheteancorth		
LJ	L Jeffries		

FORM 008560 (REV. 1999-06)

SCHEDULED MEDICATIONS

(PRN MEDICATIONS ON REVERSE)

MEDICATION	FREQUENCY	01/08/05 TIME	INIT	01/08/06 TIME	INIT	DATE (YYYY/MM/DD) TIME	INIT	DATE (YYYY/MM/DD) TIME	INIT	DATE (YYYY/MM/DD) TIME	INIT	DATE (YYYY/MM/DD) TIME	INIT	DATE (YYYY/MM/DD) TIME	INIT	DATE (YYYY/MM/DD) TIME	INIT
START DATE 01/08/05 · LAST REORDER DATE (YYYY/MM/DD) · STOP DATE (YYYY/MM/DD)	Q8hrs																
Clindamycin 600mg IV	1 2 3 (4) 5 6	4:30 [illegible]															
	7 8 9 10 11 (12)	2100	[illegible]	0830	[illegible]												
	13 14 15 16 17 18																
	19 (20) 21 22 23 24																
TRANSCRIBED · CHECK																	
START DATE (YYYY/MM/DD) · LAST REORDER DATE (YYYY/MM/DD) · STOP DATE (YYYY/MM/DD)																	
	1 2 3 4 5 6																
	7 8 9 10 11 12																
	13 14 15 16 17 18																
	19 20 21 22 23 24																
TRANSCRIBED · CHECK																	
START DATE (YYYY/MM/DD) · LAST REORDER DATE (YYYY/MM/DD) · STOP DATE (YYYY/MM/DD)																	
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19 20 21 22 23 24

TRANSCRIBED		CHECK
START DATE (YYYY / MM / DD)	LAST REORDER DATE (YYYY / MM / DD)	STOP DATE (YYYY / MM / DD)

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TRANSCRIBED		CHECK
START DATE (YYYY / MM / DD)	LAST REORDER DATE (YYYY / MM / DD)	STOP DATE (YYYY / MM / DD)

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START DATE (YYYY / MM / DD)	LAST REORDER DATE (YYYY / MM / DD)	STOP DATE (YYYY / MM / DD)

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TRANSCRIBED		CHECK
START DATE (YYYY / MM / DD)	LAST REORDER DATE (YYYY / MM / DD)	STOP DATE (YYYY / MM / DD)

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19	20	21	22	23	24

TRANSCRIBED		CHECK
START DATE (YYYY / MM / DD)	LAST REORDER DATE (YYYY / MM / DD)	STOP DATE (YYYY / MM / DD)

1	2	3	4	5	6
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24

TRANSCRIBED	CHECK

ROOM NUMBER ______________

PATIENT'S NAME Young, Suzanne, Marie

ROOM NO. PATIENT'S NAME

EFFECT CODE (EFF)
E - EFFECTIVE
NE - NOT EFFECTIVE (MUST DOCUMENT)

PRN MEDICATIONS ONLY

PRN Page 1 of ______

MEDICATION			DATE (YYYY/MM/DD)				DATE (YYYY/MM/DD)				DATE (YYYY/MM/DD)				DATE (YYYY/MM/DD)				DATE (YYYY/MM/DD)				DATE (YYYY/MM/DD)				DATE (YYYY/MM/DD)				DATE (YYYY/MM/DD)			
START DATE (YYYY / MM / DD)	LAST REORDER DATE (YYYY / MM / DD)	STOP DATE (YYYY / MM / DD)	TIME	DOS	SITE	INIT EFF	TIME	DOS	SITE	INIT EFF	TIME	DOS	SITE	INIT EFF	TIME	DOS	SITE	INIT EFF	TIME	DOS	SITE	INIT EFF	TIME	DOS	SITE	INIT EFF	TIME	DOS	SITE	INIT EFF	TIME	DOS	SITE	INIT EFF
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715500 (2000-06)

HAMILTON HEALTH SCIENCES
C O R P O R A T I O N

YOUNG,SUZANNE
!1109244 06/05/2001 0242 (35)
DUE*RIGHT FOREARM 2 VIEWS

DIAGNOSTIC RESULTS FOLLOW UP FORM

☑ General Campus ☑ Radiology Stat Report ☐ Other _____
☐ MUMC Campus ☐ Radiology Discrepant X-ray
☐ Henderson Campus ☐ Microbiology Verbal Report from _____

Patient's Name Young, Suzanne Test or Exam Date 6/5/01 (yyyy/mm/dd)

Patient Identification Number 1109244

TEST OR EXAM DONE: Right forearm 2V

DIAGNOSIS:
2. Possible undisplaced fx
at radial neck.
Suggest elbow views

Completed By: Printed Name: Signature Date (yyyy/mm/dd)

ACTION:
May 6/01 1600 - tried to call pt - no answer
~~DR~~ asked charge nurse to call pt back for further
May 6/01 - 1720 - Pt to return to ER, X-ray
~~technologist~~

Completed By: Printed Name: 6/5/01 12:30 Signature Date (yyyy/mm/dd)
REPORTING DATE: (yyyy/mm/dd) **TIME:** (hh:mm) **REPORTED BY:** DR. DORIS

REPORT GIVEN TO: (Emergency Physician)
BY: (Charge Nurse) **DATE:** (yyyy/mm/dd) **TIME:** (hh:mm)

COPY DISTRIBUTION: PART 1 (WHITE) - CHART PART 2 (CANARY) - X-RAY PART 3 (PINK) REFERRING DEPARTMENT

HAMILTON CIVIC HOSPITALS

ALLERGY/MEDICAL ALERT RECORD

INFO FROM: P - Patient O - Other
F - Family C - Chart
PH - Pharmacy N - Nurtition
(De)) - Deleted MP - Med Profile

HEALTH RECORDS COPY

YOUNG.SUZANNE
1109244 11/10/64 36 F
GE004073/01 ER-MUS/SKE
TAYLOR.J.GRANT

CURRENT DATE & TIME: 06/05/01 - 1836

DATE (ORIGINAL)	SUBSTANCE	TYPE OF REACTION/ DELETION	YEAR OF REACTION	INFO FROM	REVIEWED BY:	ENTERED BY:
05/05/01	PENICILLIN			P		

COMMENTS ON BACK OF FORM

MEDICAL ALERT (1 - 4)	REVIEW BY:	ENTER BY:	MEDICAL ALERT (5 - 8)	REVIEW BY:	ENTER BY:
Asthma					

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

HAMILTON CIVIC HOSPITALS

ALLERGY/MEDICAL ALERT RECORD

INFO FROM: P - Patient O - Other
F - Family C - Chart
PH - Pharmacy N - Nurtition
(Del) - Deleted MP - Med Profile

HEALTH RECORDS COPY

YOUNG,SUZANNE
1109244 11/10/64 36 F
GE003987/01 ER-MED
TAYLOR,J.GRANT

CURRENT DATE & TIME: 05/05/01 - 2319

DATE (ORIGINAL)	SUBSTANCE	TYPE OF REACTION/ DELETION	YEAR OF REACTION	INFO FROM	REVIEWED BY:	ENTERED BY:
05/05/01	PENICILLIN			P	MD	

COMMENTS ON BACK OF FORM

MEDICAL ALERT (1 - 4)	REVIEW BY:	ENTER BY:	MEDICAL ALERT (5 - 8)	REVIEW BY:	ENTER BY:
Asthma	RD				

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
RDaley,Rn	RA				