CHRISTUS ST. JOHN HOSPITAL

HISTORY AND PHYSICAL

PATIENT NAME: ARMATTA,BETH
DOB/AGE/SEX: 10/26/1962 / 46 Y / F
PATIENT TYPE: ADM IN

ADMIT/SERVICE DATE: 07/10/09
DISCHARGE DATE:
REPORT NUMBER: 0710-0186

CHIEF COMPLAINT:
Hallucinations.

HISTORY OF PRESENT ILLNESS:
This is a 46 year-old female who is a poor historian and her husband does not seem to know all the details although he was somewhat helpful.

Apparently the patient had surgery on her foot back in May of 2009. She was given a course of antibiotics. She had a lot of nausea and maybe one episode of vomiting three days ago and she came to the emergency room and she was given Cipro and Flagyl and Phenergan to use as needed. The patient came back to the emergency room the next day because of hallucinations. The husband doesn't seem to be knowledgeable on when this started. It could be only two days but it could be longer. She denies any headaches. No double vision. She does have some nystagmus.

REVIEW OF SYSTEMS:
She is having tremors. She has no more nausea, no diarrhea. No fever or chills. She is still oriented even though she has decreased memory. She has no focal weakness of arms or legs. She had no melena. No dysuria, no hematuria. No dysphagia. No weight loss.

PAST MEDICAL HISTORY:
1. Hepatitis C with liver cirrhosis. She failed previous treatment with Interferon and Ribavirin in Austin. The husband thinks that liver biopsy done a few years ago did not show cirrhosis.
2. Cholecystectomy. Appendectomy.
3. Hypertension.

SOCIAL HISTORY:
She is a previous smoker who smoked 10 years but she quit 14 years ago. She says she has two drinks of alcohol per day. It was hard to pin her down on what she drinks.

FAMILY HISTORY:
Her father died at 67 of a heart attack. Her mother had multiple medical problems including hypertension.

ALLERGIES:None.

MEDICATIONS:
Cardizem; Flagyl; Ciprofloxacin; Vicodin; Phenergan as needed.

PHYSICAL EXAMINATION:
GENERAL: The patient had some tremors and she even had a little bit of spasticity and clonus in the left leg. She was oriented but decreased memory. She had occasional nystagmus. She had some visible exophthalmos.

HEENT EXAM as above in addition to no lymph nodes, no jugulovenous distention.
LUNGS are clear.
HEART regular.
ABDOMEN soft, nontender.
EXTREMITIES: The legs had no edema. The left foot had a dried up incision with a scab which means that it had some drainage recently.
SKIN had a few bruises.
NEURO: She had no focal motor weakness.

LABORATORY AND X-RAY DATA:
CT scan of the head was negative.

White blood cell count 6000. Hematocrit 38. Platelets 121. Drug screen was positive for cannabinoids and opiates. Potassium 3.1. BUN 6, creatinine 1.0. AST was 560 on July 6. It is down to 170 today. ALT 225 down to 115. Ammonia was 42. The bilirubin actually was 1 on July 6. It is up to 1.8 today. Alkaline phosphatase 133. Lipase 327.

IMPRESSION:
Hallucinations that are probably related to multiple risk factors including her alcohol drinking, marijuana, medications like Phenergan, Cipro and Codeine and possible contribution from liver cirrhosis. A genuine schizophrenia could be causing the psychosis also but would be diagnosed with exclusion.

PLAN:
I agree with Dr. Schneider that hepatic encephalopathy is not the main problem but we can continue Lactulose.
We need to stop all sedatives except Librium if needed for agitation since she may go into withdrawal. I will check her thyroid function and cortisol levels.
If the hallucinations persist I will try Zyprexa.
Neurology consultation.
If she is still having hallucinations upon discharge, I could let her go on Zyprexa and see Psychiatry as outpatient.
The patient's a patient of Dr. Dolle. I could not reach Dr. Christine Le to see if she would be able to be attending but I will ask her tomorrow and she can take over the case.

_____
Alfred S Maksoud, MD

AM/pq3/000344719/1315735 D: 07/10/2009 8:07 P T: 07/10/2009 10:26 P
cc: Donna S Dolle, MD
N. Christine Le, MD
Alfred S Maksoud, MD
Franz Emil Schneider, MD
Signed By

CHRISTUS ST. JOHN HOSPITAL

CONSULTATION

PATIENT NAME: ARMATTA,BETH
DOB/AGE/SEX: 10/26/1962 / 46 Y / F
PATIENT TYPE: ADM IN

ADMIT/SERVICE DATE: 07/10/09
DISCHARGE DATE:
REPORT NUMBER: 0712-0035

DATE OF CONSULTATION: 07/11/2009

CONSULTING PHYSICIAN: Leanne Burnett, MD

REFERRING PHYSICIAN: Alfred Maksoud, M.D.

REASON FOR CONSULTATION: Altered mental status. Questionable abnormal reflexes.

HISTORY OF PRESENT ILLNESS: The patient is a 46-year-old lady with a history of hepatitis C and chronic liver failure, with failed response with interferon and ribavirin. The patient continues to drink to some degree. The patient was admitted with altered mental status and a question of hepatic encephalopathy. CPKs have been found to be increased, and she has been being followed by Cardiology, with echocardiogram ordered. The patient has been very agitated in the hospital, and she has been receiving various medications. Librium was started, as was Zyprexa, and we are trying to hold some of her more sedating medications. She has had significant hypoxemia with question of pulmonary edema and bilateral infiltrates on chest x-ray, and there may be a question of aspiration pneumonia.

PAST MEDICAL HISTORY/MEDICAL ILLNESSES: As per history of present illness.

SOCIAL HISTORY: She has smoked in the past. She drinks alcohol, currently "socially."

FAMILY HISTORY: Positive for coronary artery disease.

HOME MEDICATIONS:
1. Diltiazem.
2. Metronidazole.
3. Cipro.
4. Vicodin.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

NEUROLOGIC EXAMINATION:
VITAL SIGNS: Temperature 98.7. Blood pressure 121/81. Heart rate 92. Respiratory rate 33.
MENTAL STATUS/SPEECH: The patient is alert. She is oriented to name and indicates she is in St. Christopher's hospital, but knows the month and the date, and the patient recalled three out of three objects immediately and two out of three at five minutes. She could spell "world" forward and backward correctly. She is very tremulous -- otherwise, speech is clear and fluent.
CRANIAL NERVES: I not tested. II through XII reveal pupils equal, round, and reactive to light. Extraocular movements intact. She may have slight nystagmus at end-gaze. Facial sensation and symmetry are normal. Tongue midline. Sternocleidomastoid and trapezius strength is normal.

MOTOR: Muscle tone is normal. She has relatively normal muscle bulk. Strength is 5/5 throughout. She has diffuse tremulousness.
DEEP TENDON REFLEXES: 1 to 2+ in the upper extremities, 1+ at the knees, and zero at the ankles. Toes are downgoing. There is no clonus.
SENSORY: Sensation is intact to light touch. Vibration sense is borderline to intact.
CEREBELLAR: Finger-to-nose-finger testing is intact, although, again, severe tremor is noted.
GAIT: Deferred.

STUDY RESULTS: Blood work today shows sodium 141, potassium 3.0, chloride 105, carbon dioxide (CO2) 20, BUN 7.2, creatinine 1.2, and glucose 209. Total bilirubin 1.7. Direct bilirubin 0.9. SGOT 141, SGPT 96. Albumin 3.2. Alkaline phosphatase 144. Hepatitis panel is positive only for hepatitis C. INR is 1.15. Ammonia level is 46.3, which is mildly elevated. Arterial blood gases performed this morning show pH 7.4, pCO2 35.6, pO2 45.9, and oxygen saturation 81.2%. CPK 240. Troponin 4.68.

CT of the head is negative.

TSH and T4 have been ordered and are pending.

IMPRESSION: This is a 46-year-old lady with altered mental status and delirium. She has had hallucinations in the hospital. I suspect this is multifactorial. She may have an underlying Wernicke's encephalopathy from alcohol with delirium related to medications. While her ammonia level alone is probably not responsible, it certainly may be a contributing factor.

RECOMMENDATIONS: I agree with holding as many of the medications that could be sedating or could alter her mental status as possible. The patient is currently on Zyprexa and Librium. Will check B12 and await TSH and T4. Will follow with you.

_____
Leanne Burnett, MD

LB/pq2/000344861/1315899 D: 07/11/2009 9:20 P T: 07/12/2009 12:18 P
cc: Leanne Burnett, MD
Alfred S Maksoud, MD
Signed By

CHRISTUS ST. JOHN HOSPITAL

CONSULTATION

PATIENT NAME: ARMATTA,BETH
DOB/AGE/SEX: 10/26/1962 / 46 Y / F
PATIENT TYPE: ADM IN

ADMIT/SERVICE DATE: 07/10/09
DISCHARGE DATE:
REPORT NUMBER: 0711-0043

DATE OF CONSULTATION: 07/11/2009

CONSULTING PHYSICIAN: Rajinder Bhalla, MD, FACC

REASON FOR REFERRAL:
Elevated troponins.

HISTORY OF PRESENT ILLNESS:
The patient is a 46 year-old Caucasian lady who has been evaluated by me in the remote past during her hospital admission in November of 2007.

She was currently admitted to Dr. Maksoud's service with symptom complex of confusion and apparent diagnosis of possible hepatic encephalopathy. Patient has chronic liver disease and Hepatitis C with failed therapy in the past with Interferon and Ribavirin. She continues to drink currently although it is difficult to get detailed chronological account of her medical problems.

I was called in this morning because a routine troponin done revealed a level of 4.68 consistent with myocardial injury. She also had elevated CPK and CPK MB along with CPK index.

From the cardiovascular standpoint, she has history of hypertension. No other details are available at this point. She does not have a documented history of myocardial infarction or known valvular disease or diagnosed congestive heart failure.

The rest of the medical history is noncontributory.

REVIEW OF SYSTEMS:
Is unremarkable.
Direct questioning reveals no significant respiratory distress or chest pain. No documented dysrhythmias in the intensive care unit.

SOCIAL HISTORY:
She is an ex-smoker, does drink at present. Denies history of drug use.

FAMILY HISTORY:
Is positive for coronary disease in father.

CURRENT MEDICATIONS:
Current medications have been reviewed.

Since admission the patient has been evaluated by Franz E. Schneider, MD from GI and therapy for suspected hepatic encephalopathy has been instituted.

Since her transfer to Intensive Care Unit she has been initiated on therapy with Lovenox with presumptive diagnosis of acute myocardial injury of non-ST segment elevation type.

PHYSICAL EXAMINATION:
GENERAL: Well-built obese lady who is arousable. Does not appear to be in any significant respiratory distress.
VITAL SIGNS: Pulse rate is about 88. Blood pressure is 118/70. Respiratory rate is about 20.
HEENT EXAM reveals normal carotid upstroke. Normal jugular venous pressure. No thyromegaly. No lymphadenopathy.
CARDIOVASCULAR Exam reveals normal precordium. Apical impulse is normal. No palpable heave or thrill. S1, S2 normal. No gallops are auscultated. No definite murmurs are heard.
CHEST: Clear to auscultation and percussion.
ABDOMEN: Obese abdomen without evidence of fluid, organomegaly or masses. Bowel sounds are normal.
CENTRAL NERVOUS SYSTEM: She has mild tremor with no other focal deficit.

ASSESSMENT:
1. Altered mental status, possible hepatic encephalopathy.
2. Chronic liver disease.
3. History of hypertension.
4. Elevated enzymes with no significant ST elevation on EKG.

RECOMMENDATIONS:At this point I would continue to monitor patient in the intensive care unit and monitor he with serial enzymes. I would advise evaluation with an echocardiogram and continuation of her current medications.

Thank you very much for allowing me to participate in the care of this patient. I do appreciate your confidence.

Sincerely,

_____
Rajinder Bhalla, MD, FACC

RB/pq3/000344762/1315780 D: 07/11/2009 10:00 A T: 07/11/2009 1:05 P
cc: Rajinder Bhalla, MD, FACC
Alfred S Maksoud, MD
Signed By

CHRISTUS ST. JOHN HOSPITAL

CONSULTATION

PATIENT NAME: ARMATTA,BETH
DOB/AGE/SEX: 10/26/1962 / 46 Y / F
PATIENT TYPE: ADM IN

ADMIT/SERVICE DATE: 07/10/09
DISCHARGE DATE:
REPORT NUMBER: 0710-0119

DATE OF CONSULTATION: 07/10/2009

CONSULTING PHYSICIAN: Franz Emil Schneider, MD

REFERRING PHYSICIAN: Alfred Maksoud, M.D.

REASON FOR CONSULTATION: Confusion. Liver disease.

HISTORY OF PRESENT ILLNESS: First, I would like to thank Dr. Maksoud for allowing me to see this patient. Briefly, the patient is a pleasant 46-year-old female with a past medical history apparently significant for hepatitis C, status post failed treatment with interferon and ribavirin, appendectomy, and cholecystectomy, who was brought to the emergency room by her husband, apparently because of confusion.

The husband claims that the patient apparently had a foot infection and actually was seen by Janice Teer, M.D., her primary care physician, and recently was placed on some antibiotics. Last evening, according to the husband, she apparently was having hallucinations and speaking to persons who were not in the room; therefore, he eventually brought her to the hospital. There is apparently no reported history of fever, nausea, vomiting, or diarrhea. Because of her previous history of hepatitis C, a diagnosis of possible encephalopathy has been made; therefore, a Gastroenterology consult was requested.

RISK FACTORS FOR LIVER DISEASE: The patient used to use drugs. She claims that the last time she used drugs was in the 80s. She describes alcohol consumption as "social." She does have multiple tattoos and apparently had a blood transfusion when she was 15 years old.

PAST MEDICAL HISTORY: Hepatitis C was apparently diagnosed several years ago. According to her and her husband, she was treated in Austin with a combination of interferon and ribavirin. She underwent treatment for 52 weeks, which apparently was unsuccessful. She did have a liver biopsy, which, according to her and her husband, did not reveal cirrhosis.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: The patient is married. She claims she does drink socially. She does not smoke.

REVIEW OF SYSTEMS: CONSTITUTIONAL: Denies fever or chills. CARDIAC: Denies chest pain. PULMONARY: Denies any wheezing. The rest of the review of systems is as in the history of present illness.

ALLERGIES: NO APPARENT DRUG ALLERGY.

PHYSICAL EXAMINATION:

VITAL SIGNS: All within normal limits.
GENERAL: A pleasant, middle-aged female, anxious and in no acute distress.
HEAD, EARS, EYES, NOSE AND THROAT: Unremarkable. She appeared to be anicteric.
NECK: Supple.
LUNGS: Clear.
HEART: Regular rate and rhythm.
ABDOMEN: Soft and appeared to be slightly distended. There was no obvious ascites and no obvious hepatosplenomegaly. Bowel sounds appeared to be normal. There was very minimal epigastric discomfort.
RECTUM: Exam deferred.
NEUROLOGIC: She was alert and oriented x3. She did have some tremor.

LABORATORY DATA: ON ADMISSION: White blood cell count 6000, hemoglobin 13, hematocrit 38, MCV 102, and platelet count 121. Differential showed a left shift. Electrolytes showed a potassium of 3.1, BUN 6.3, creatinine 1, and total bilirubin 1.8. AST 170, ALT 115. Alkaline phosphatase 133. Lipase 327. Ammonia 42.6. PT 15, INR 1.15.

Urinalysis showed no evidence of pyuria.

Abdominal ultrasound showed a fatty liver, status post cholecystectomy; common bile duct was 7 millimeters.

ASSESSMENT: A middle-aged female with history of hepatitis C, apparently with no significant end-stage liver disease, admitted with an episode of hallucinations and confusion. The patient does have some disproportionate numbers in her liver panel, particularly with a higher AST than ALT, as well as hyperbilirubinemia. I suspect that she is probably minimizing the amount of alcohol that she drinks, and we may actually be noticing some of her confusion related to withdrawal. A drug screen will also be important to do to see if there is any other issue that could cause this confusion. Certainly, I do not think that there is significant or advanced liver disease to advocate hepatic encephalopathy as a cause of her confusion.

PLAN:
1. For now, I do agree with lactulose, though I think we need to look for other causes of confusion.
2. I will proceed with a CT scan of her head.
3. Full-liquid diet.
4. Empiric proton pump inhibitors, and if she continues to complain of epigastric pain, then upper endoscopy may be necessary.
5. Will follow with you

Franz Emil Schneider, MD

FES/pq2/000344661/1315671 D: 07/10/2009 4:26 P T: 07/10/2009 4:46 P
cc: Alfred S Maksoud, MD
Franz Emil Schneider, MD

*Janice Teer, M.D.
Signed By <Electronically signed by FRANZ E SCHNEIDER, MD> 07/13/09 1120

ATTENDING PHYSICIAN: MAKSOUD,ALFRED S MD
DICTATED BY: SCHNEIDER,FRANZ E MD
LOC./ROOM NUMBER: AN.ICU/AN.ICU05
PATIENT NAME: ARMATTA,BETH
ACCOUNT NUMBER: AN0710182095
MR NUMBER: MN00497388

CHRISTUS ST. JOHN HOSPITAL
18300 St.John Drive
Nassau Bay, Tx 77058
281-333-8866

DIAGNOSTIC IMAGING REPORT

	Signed
Patient Name: ARMATTA,BETH **10/26/1962 / 46 Y / F**	**MR #: MN00497388** **Acct #: AN0710182095**
Exam Date:**07/10/09**	Exam: **0710-0055 US/ABDOMEN LIMITED**
Ord. Dx:	Report # : **RAD 0710-0123**
Requisition # : **09-0080787**	

Exam: 09-0080787 - US ABDOMEN LIMITED

CLINICAL INFORMATION: Elevated liver function studies

FINDINGS: Real time images were obtained. Permanent images were obtained for the patient record. There is a history of cholecystectomy.

The liver is of increased echogenicity keeping with fatty infiltrate. No evidence of biliary dilatation seen. The common bile duct measures 7 mm in keeping with history of cholecystectomy.

IMPRESSION:

Fatty liver

Status post cholecystectomy in the past

Dictated by: **MICHAEL SHER, MD**
Electronically signed by: **MICHAEL SHER, MD 07/10/09 1011**
Transcribed by: SXQ
D: 07/10/09 1006
T: 07/10/09 1007

ONLY PERTINENT FINDINGS AND MEASUREMENTS ARE MENTIONED. ALL FINDINGS NOT MENTIONED ARE CONSIDERED NORMAL FOR AGE OR INSIGNIFICANT.

Cc: KAALE,ROBERT L MD;	
Ordering Phys: **KAALE,ROBERT L MD**	Admit Service Date: **07/10/09** Discharge Service Date:
Patient Status: **REG ER**	Patient Loc: **AN.EDMAIN**

CHRISTUS ST. JOHN HOSPITAL
18300 St. John Drive
NASSAU BAY, TX 77058

281-333-5503

Patient Name: ARMATTA,BETH
10/26/1962 / 46 Y / F
Exam Date
07/11/09

MR #: MN00497388
Acct #: AN0710182095
Exam:
0711-0010 CARD/ECHO,TT w/2DMM, flow / doppler

Exam CPT:
93306

Report # :
CPND 0712-0004
Requisition # :
09-0026249

CONSULTING RajinderKBhallaMD
ATTENDING AlfredSMaksoud
ADMITTING AlfredSMaksoud

DIAGNOSES SUPPORTING MEDICAL NECESSITY:
410.71 Non-Q MI Subendocardial-Initial

PROCEDURE INFORMATION:
- The study was performed at the bedside.

- Limited acoustic window availability.

Cardiac anatomy:

LEFT VENTRICLE:
Left ventricular size was normal. Overall left ventricular systolic function was moderately decreased. LV function is moderately reduced with LVEF 35 - 40%. There appeared to be moderate hypokinesis of the apical anteroseptal wall. Left ventricular wall thickness was at the upper limits of normal. Doppler interpretation(s): There was a normal transmitral flow pattern.

Cc: BHALLA,RAJINDER K MD; MAKSOUD,ALFRED S MD; SCHNEIDER,FRANZ E MD;
Ordering Phys: **BHALLA,RAJINDER K MD**

Admit Service Date: **07/10/09**
Discharge Service Date:
Patient Status: **ADM IN**
Patient Loc.: **AN.ICU AN.ICU05-1**

AORTIC VALVE:
The aortic valve was trileaflet. Aortic valve thickness was normal. Doppler interpretation(s): There was no evidence for aortic valve stenosis. There was no significant aortic valvular regurgitation.

MITRAL VALVE:
Mitral valve structure was normal. There was normal mitral valve leaflet excursion. Doppler interpretation(s): There was no evidence for mitral stenosis. There was mild mitral valvular regurgitation.

LEFT ATRIUM:
Left atrial size was within the limits of normal when indexed for body surface area.

RIGHT VENTRICLE:
Right ventricular size was normal. Right ventricular systolic function was normal. Right ventricular wall thickness was normal.

TRICUSPID VALVE:
The tricuspid valve structure was normal. Tricuspid leaflet excursion was normal. Doppler interpretation(s): There was no evidence for tricuspid stenosis. There was trivial tricuspid valvular regurgitation.

RIGHT ATRIUM:
Right atrial size was normal.

SYSTEMIC VEINS:
The inferior vena cava was normal.

PERICARDIUM:
There was no pericardial effusion. The pericardium was normal in appearance.

Measurement tables:

2D measurements

LEFT VENTRICLE			NORMAL
LVID ed (chordal)	45.4	mm	40-48 mm
LVID es (chordal)	38.8	mm	27-35 mm
FS (chordal)	14	%	>29%
IVS ed	9.9	mm	7-10 mm
IVS es	10.4	mm	--

Cc: BHALLA,RAJINDER K MD; MAKSOUD,ALFRED S MD; SCHNEIDER,FRANZ E MD;
Ordering Phys: **BHALLA,RAJINDER K MD**

Admit Service Date: **07/10/09**
Discharge Service Date:
Patient Status: **ADM IN**
Patient Loc.: **AN.ICU AN.ICU05-1**

LVPW ed	10.9	mm	7-10 mm
LVPW es	12	mm	--
M-mode measurements			
AORTIC VALVE			NORMAL
AV cusp	16	mm	15-26 mm
AORTA			NORMAL
AoD (root)	27	mm	<37 mm
MITRAL VALVE			NORMAL
MV excursion	16	mm	--
MV E-septal sep.	7	mm	--
MV E-F slope	14.39	cm/sec	--
LEFT ATRIUM			NORMAL
LAD	40	mm	<37 mm
LAD index (A-P)	2.2	cm/m^2	<2.2 cm/m^2
Doppler measurements			
LVOT, AV, AORTA			NORMAL
LVOT diameter	1.7	cm	--
LVOT VTI	21	cm	--
Stroke volume (LVOT)	48	ml	--
Mean AV velocity	83.99	cm/sec	--
Peak AV velocity	107.15	cm/sec	--
AV VTI	19.3	cm	--
Mean AV gradient	3.1	mmHg	--
Peak AV gradient	5	mmHg	--
AV obstruct index (VTI)	1.09		--
AV area (VTI)	2.47	cm^2	--
AV area index (VTI)	1.34	cm^2/m^2	--
AV area (Vmax)	2.38	cm^2	--
AV area index (Vmax)	1.29	cm^2/m^2	--
MITRAL VALVE			NORMAL
Peak E velocity	93.4	cm/sec	--
Peak A velocity	77.6	cm/sec	--
MV peak E/A .	1.2		--
MV deceleration time	106	msec	150-230 msec
Peak gradient	3	mmHg	--
MR Vmax	3.49	m/s	--
MR maxPG	48.76	mmHg	--
RVOT, PV, PA			NORMAL
PV acceleration time	74	msec	--
TRICUSPID VALVE			NORMAL
Estimated RV systolic pressure	23	mmHg	<30 mmHg
TR Vmax	1.83	m/s	--

Cc: BHALLA,RAJINDER K MD; MAKSOUD,ALFRED S MD; SCHNEIDER,FRANZ E MD;
Ordering Phys: **BHALLA,RAJINDER K MD**

Admit Service Date: **07/10/09**
Discharge Service Date:
Patient Status: **ADM IN**
Patient Loc.: **AN.ICU AN.ICU05-1**

TR maxPG	13.46	mmHg	--

Study Conclusions:

SUMMARY:
- Overall left ventricular systolic function was moderately decreased. LV function is moderately reduced with LVEF 35 - 40%. There appeared to be moderate hypokinesis of the apical anteroseptal wall. Left ventricular wall thickness was at the upper limits of normal.
- Estimated aortic valve area (by VTI) was 2.47 cm^2.
- There was mild mitral valvular regurgitation.

All images and data generated for this procedure were personally reviewed by me.

Prepared and Electronically Authenticated

Rajinder K Bhalla MD
Confirmed July 12, 2009 10:26:59

Cc: BHALLA,RAJINDER K MD; MAKSOUD,ALFRED S MD; SCHNEIDER,FRANZ E MD;
Ordering Phys: **BHALLA,RAJINDER K MD**

Admit Service Date: **07/10/09**
Discharge Service Date:
Patient Status: **ADM IN**
Patient Loc.: **AN.ICU AN.ICU05-1**

CHRISTUS ST. JOHN HOSPITAL
18300 St.John Drive
Nassau Bay, Tx 77058
281-333-8866

DIAGNOSTIC IMAGING REPORT

Signed

Patient Name: ARMATTA,BETH **10/26/1962 / 46 Y / F**	**MR #: MN00497388** **Acct #: AN0710182095**
Exam Date:**07/11/09**	Exam: **0711-0127 DX/CHEST 1 VIEW** **0711-0145 DX/CHEST 2 VIEWS**
Ord. Dx: **PNEUMONIA/**	Report # : **RAD 0712-0090**
Requisition # : **09-0081280, 09-0081300**	

Exam: 09-0081280,09-0081300 - DX CHEST 1 VIEW,CHEST 2 VIEWS

History : Shortness of breath and chest pain:

The heart size appears within normal limits. There is consolidation of both lung bases consistent with pneumonia moderately severe degree. No other significant findings are noted.

Impression: Consolidation at the bases consistent with pneumonia developing since 11/11/2007.

Chest AP portable dated 07/11/2009 time on the film 2337 hours history: Check catheter placement

The heart size is within normal limits. Bibasilar consolidation remains. A PICC catheter inserted through the right side curls in the area of the superior vena cava its tip pointing cranially.

Impression: Catheter projects in the area superior vena cava tip pointing cranially

Dictated by: **JOHN C GILLESPIE, MD**

ONLY PERTINENT FINDINGS AND MEASUREMENTS ARE MENTIONED. ALL FINDINGS NOT MENTIONED ARE CONSIDERED NORMAL FOR AGE OR INSIGNIFICANT.

Cc: BHALLA,RAJINDER K MD; BURNETT,LEANNE MD; MAKSOUD,ALFRED S MD; SCHNEIDER,FRANZ E MD;	
Ordering Phys: **MAKSOUD,ALFRED S MD**	Admit Service Date: **07/10/09** Discharge Service Date:
Patient Status: **ADM IN**	Patient Loc: **AN.ICU AN.ICU05-1**

Patient Name: **ARMATTA,BETH** **MR:** **MN00497388** **Acct:** **AN0710182095**

Electronically signed by: **JOHN C GILLESPIE, MD 07/12/09 1101**
Transcribed by: SXQ
D: 07/12/09 1055
T: 07/12/09 1057

ONLY PERTINENT FINDINGS AND MEASUREMENTS ARE MENTIONED. ALL FINDINGS NOT MENTIONED ARE CONSIDERED NORMAL FOR AGE OR INSIGNIFICANT.

Cc: BHALLA,RAJINDER K MD; BURNETT,LEANNE MD; MAKSOUD,ALFRED S MD; SCHNEIDER,FRANZ E MD;	
Ordering Phys: **MAKSOUD,ALFRED S MD**	Admit Service Date: **07/10/09** Discharge Service Date:
Patient Status: **ADM IN**	Patient Loc: **AN.ICU AN.ICU05-1**

CHRISTUS ST. JOHN HOSPITAL
18300 St.John Drive
Nassau Bay, Tx 77058
281-333-8866

DIAGNOSTIC IMAGING REPORT

Signed

Patient Name: ARMATTA,BETH **10/26/1962 / 46 Y / F**	**MR #: MN00497388** **Acct #: AN0710182095**
Exam Date:**07/12/09**	Exam: **0712-0014 DX/CHEST 2 VIEWS**
Ord. Dx:	Report # : **RAD 0712-0091**
Requisition # : **09-0081332**	

Exam: 09-0081332 - DX CHEST 2 VIEWS

History: Check line placement: Time on the film 0115 hours, July 12, 2009

Compared to the earlier film demonstrates since previous the PICC catheter has been repositioned. The tip of the catheter projects the superior vena cava pointing toward the right atrium. Bilateral parenchymal lung consolidation remains

Dictated by: **JOHN C GILLESPIE, MD**
Electronically signed by: **JOHN C GILLESPIE, MD 07/12/09 1102**
Transcribed by: SXQ
D: 07/12/09 1058
T: 07/12/09 1058

ONLY PERTINENT FINDINGS AND MEASUREMENTS ARE MENTIONED. ALL FINDINGS NOT MENTIONED ARE CONSIDERED NORMAL FOR AGE OR INSIGNIFICANT.

Cc: BHALLA,RAJINDER K MD; BURNETT,LEANNE MD; MAKSOUD,ALFRED S MD; SCHNEIDER,FRANZ E MD;	
Ordering Phys: **MAKSOUD,ALFRED S MD**	Admit Service Date: **07/10/09** Discharge Service Date:
Patient Status: **ADM IN**	Patient Loc: **AN.ICU AN.ICU05-1**

CHRISTUS ST. JOHN HOSPITAL
18300 St.John Drive
Nassau Bay, Tx 77058
281-333-8866

DIAGNOSTIC IMAGING REPORT

	Signed
Patient Name: ARMATTA,BETH **10/26/1962 / 46 Y / F**	**MR #: MN00497388** **Acct #: AN0710182095**
Exam Date:**07/13/09**	Exam: **0713-0016 DX/CHEST 1 VIEW**
Ord. Dx:	Report # : **RAD 0713-0023**
Requisition # : **09-0081659**	

Exam: 09-0081659 - DX CHEST 1 VIEW

Compared to previous from 07/12/2009

Heart size appears normal. A PICC catheter projects its tip in the superior vena cava. There has been some improvement in the consolidation at both lung bases since yesterday.

Impression:
1. PICC catheter projects with its tip in the superior vena cava well above the right atrium.
2. Improving basilar consolidation

Dictated by: **JOHN C GILLESPIE, MD**
Electronically signed by: **JOHN C GILLESPIE, MD 07/13/09 0842**
Transcribed by: SXQ
D: 07/13/09 0838
T: 07/13/09 0839

ONLY PERTINENT FINDINGS AND MEASUREMENTS ARE MENTIONED. ALL FINDINGS NOT MENTIONED ARE CONSIDERED NORMAL FOR AGE OR INSIGNIFICANT.

Cc: BHALLA,RAJINDER K MD; BURNETT,LEANNE MD; MAKSOUD,ALFRED S MD; SCHNEIDER,FRANZ E MD;	
Ordering Phys: **MAKSOUD,ALFRED S MD**	Admit Service Date: **07/10/09** Discharge Service Date:
Patient Status: **ADM IN**	Patient Loc: **AN.ICU AN.ICU05-1**

CHRISTUS ST. JOHN HOSPITAL
18300 St. John Drive
NASSAU BAY, TX 77058

281-333-5503

Patient Name: ARMATTA,BETH
10/26/1962 / 46 Y / F
Exam Date
07/13/09

MR #: MN00497388
Acct #: AN0710182095
Exam:
0713-0015 NI/VENOUS DUPLEX BILATERAL

Exam CPT:
93970

Report # :
CPND 0714-0013
Requisition # :
09-0026506

CONSULTING RajinderKBhallaMD
ATTENDING AlfredSMaksoud
ADMITTING AlfredSMaksoud

HISTORY AND INDICATIONS:

INDICATIONS:
Evaluation for suspected deep vein thrombosis.

HISTORY:
Patient suffered MI on 07/09/2009.
Cardiac history: Known coronary artery disease.
Risk factors and comorbidity: Hypertension. History of cigarette smoking, patient quit.

PROCEDURE INFORMATION:

PROCEDURE PERFORMED:
Complete duplex study with imaging and spectral analysis was performed on both lower extremity venous systems. [CPT 93970]

PROCEDURE DETAIL:
This was an inpatient procedure.

Cc: BHALLA,RAJINDER K MD; BURNETT,LEANNE MD; MAKSOUD,ALFRED S MD; SCHNEIDER,FRANZ E MD;
Ordering Phys: **MAKSOUD,ALFRED S MD**

Admit Service Date: **07/10/09**
Discharge Service Date:
Patient Status: **ADM IN**
Patient Loc.: **AN.3MEDSUR AN.315-1**

RIGHT DUPLEX DATA
Greater saphenous
Patency/occlusion: Patent
Flow pattern: --
Spontaneity: --
B-mode compressibility: Complete
Augmentation: --
Common femoral
Patency/occlusion: Patent
Flow pattern: Phasic
Spontaneity: Yes
B-mode compressibility: Complete
Augmentation: Present
Superficial femoral
Patency/occlusion: Patent
Flow pattern: Phasic
Spontaneity: Yes
B-mode compressibility: Complete
Augmentation: Present
Deep femoral
Patency/occlusion: Patent
Flow pattern: Phasic
Spontaneity: Yes
B-mode compressibility: Complete
Augmentation: Present
Popliteal
Patency/occlusion: Patent
Flow pattern: Phasic
Spontaneity: Yes
B-mode compressibility: Complete
Augmentation: Present
Posterior tibial
Patency/occlusion: Patent
Flow pattern: --
Spontaneity: --
B-mode compressibility: Complete
Augmentation: Present

LEFT DUPLEX DATA
Greater saphenous
Patency/occlusion: Patent
Flow pattern: --

Cc: BHALLA,RAJINDER K MD; BURNETT,LEANNE MD; MAKSOUD,ALFRED S MD; SCHNEIDER,FRANZ E MD;
Ordering Phys: **MAKSOUD,ALFRED S MD**

Admit Service Date: **07/10/09**
Discharge Service Date:
Patient Status: **ADM IN**
Patient Loc.: **AN.3MEDSUR AN.315-1**

Spontaneity: --
B-mode compressibility: Complete
Augmentation: --
Common femoral
Patency/occlusion: Patent
Flow pattern: Phasic
Spontaneity: Yes
B-mode compressibility: Complete
Augmentation: Present
Superficial femoral
Patency/occlusion: Patent
Flow pattern: Phasic
Spontaneity: Yes
B-mode compressibility: Complete
Augmentation: Present
Deep femoral
Patency/occlusion: Patent
Flow pattern: Phasic
Spontaneity: Yes
B-mode compressibility: Complete
Augmentation: Present
Popliteal
Patency/occlusion: Patent
Flow pattern: Phasic
Spontaneity: Yes
B-mode compressibility: Complete
Augmentation: Present
Posterior tibial
Patency/occlusion: Patent
Flow pattern: --
Spontaneity: --
B-mode compressibility: Complete
Augmentation: Present

There was no evidence of deep vein thrombosis of the left lower extremity veins.

SUMMARY:
- There was no evidence of deep vein thrombosis of the left lower extremity veins.

Cc: BHALLA,RAJINDER K MD; BURNETT,LEANNE MD; MAKSOUD,ALFRED S MD; SCHNEIDER,FRANZ E MD;
Ordering Phys: **MAKSOUD,ALFRED S MD**

Admit Service Date: **07/10/09**
Discharge Service Date:
Patient Status: **ADM IN**
Patient Loc.: **AN.3MEDSUR AN.315-1**

All images and data generated for this procedure were personally reviewed by me.

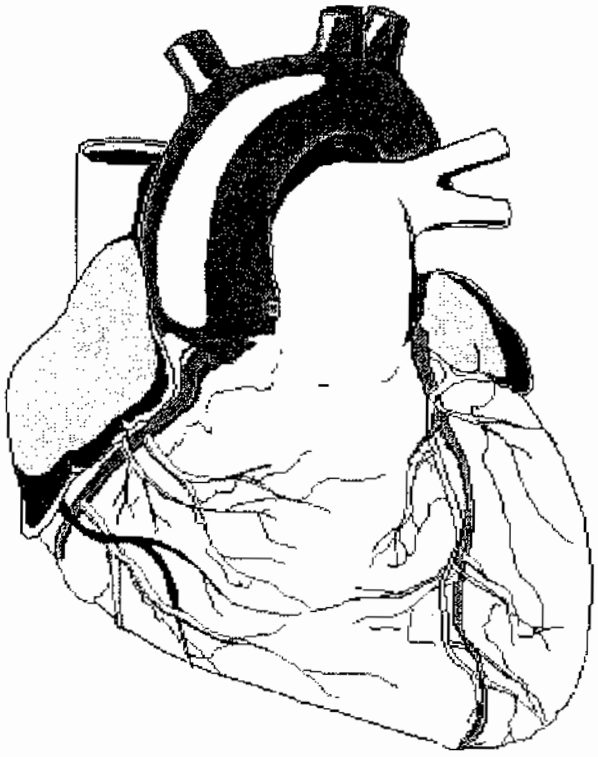
Prepared and Electronically Authenticated

Gordon H Martin MD
Confirmed 14-Jul-2009 16:18:47

Cc: BHALLA,RAJINDER K MD; BURNETT,LEANNE MD; MAKSOUD,ALFRED S MD; SCHNEIDER,FRANZ E MD;
Ordering Phys: **MAKSOUD,ALFRED S MD**

Admit Service Date: **07/10/09**
Discharge Service Date:
Patient Status: **ADM IN**
Patient Loc.: **AN.3MEDSUR AN.315-1**

Cardiac Catheterization Report



Christus St. John

at
18300 St. John Drive
Nassau Bay, TX. 77085

General

Patient Information:

Patient:	BETH ARMATTA	**DOB:**	10/26/1962	**Sex:**	F
SSN:	005-48-3753	**Age:**	46 Years	**Room No:**	AN.315

Case Information:

Mrn:	MN00497388	**Admit Date:**	07/10/2009	**Hospital No.:**	0
Date of Procedure:	07/15/2009	**Time:**	08:00	**Disc No:**	0
Case No:	09-254	**Scheduled Time:**	12:45	**Frame/Side No:**	
Protocol No:	CATH09-260	**Financial No.:**	AN0710182095	**Lab No:**	1
				Patient Status:	elective
Physician:	Robert Farrell				

Procedures:

Sheath Insertion Fem Art (right)
Coronary Angiogram RCA
LV Gram External
Sheath Removal Fem Art (right)
Catheter insertion
Coronary Angiogram LCA
Procedure Done

****

Staff

Referring Physician:

Assisting Physician(s):

Scrub:	Danek..RTR, John	**X-ray:**	McGrath RT R, Brandon
Record:	Crawford..CVT, Robert	**Other:**	Stone..RN, Wanda
Circulating:	Smith..RN, Scott		

Chronological Log (Military Time)

08:00 JL 4, 6, Cordis.
08:00 PIGTAIL 145, 6, Cordis.
08:00 Avanti Sheath 11cm, 6, Cordis.
08:00 LEFT HEART KIT, , Merit.
08:00 QUICK-COMBO PADS, , Medtronic.
08:00 SYRINGE 150 ML, 150 ML, Mallinckro.
08:00 J WIRE, .035 X 145, Merit.
08:00 JR 4, 6, Cordis
08:01 Lab values recorded.
08:13 ALL MEDICATION ON STERILE FIELD AND TABLE LABELED.
08:17 Patient Arrival Time (Pt. in proc room)
08:19 History record created.
08:19 The pt. arrived to the cath lab with a 5Fr. PICC in the right upper arm.

08:20 Confirmed correct patient and procedure verbally with patient, patient name and ID band. Consent for procedure signed on chart.
08:20 Consent signed and verified
08:23 BP 111/83 HR 99 SpO2 98.0 Resp BPM 11 loc 1
08:25 Initial Case assessment performed.
08:25 Recorded in Condition 1: 12 Lead.
08:26 BP 96/70 HR 97 SpO2 98.0 Resp BPM 36 loc 1
08:29 Bilateral groins prepped and draped in sterile fashion.
08:30 Patient Prepped Time (Ready for stick)
08:31 BP 114/85 HR 98 SpO2 100.0 Resp BPM 8 loc 1
08:33 Pressure channel 1 calibrated to 0 mmHg.
08:34 MD arrived
08:34 Risk/benefits/alternative options of procedure AND anesthesia discussed with patient and/or guardian by physician.
08:34 Patient and/or Guardian agree to proceed.
08:34 Previous Anesthesia Experience: Yes with no problems
08:34 Pre-Sedation Re-Evaluation Completed by Physician: Yes
08:36 American Society of Anesthesiologist (A.S.A.) Classification: II - Mild Systemic Disease
08:37 BP 116/81 HR 98 SpO2 100.0 Resp BPM 18 loc 1
08:38 "Time Out" performed. Correct patient, procedure and site verified by physician and cath lab staff.
08:39 1 mg VERSED via Peripheral IV by Smith..RN, Scott for sedation.
08:40 Case start
08:40 20 mL 1% XYLOCAINE via Subcutaneous R GROIN by Farrell, Robert local.
08:42 BP 118/80 HR 96 SpO2 100.0 Resp BPM 53 loc 1
08:42 In the Fem Art (right) a Avanti Sheath 11cm, 6, Cordis was inserted and advanced.
08:43 A JR 4, 6, Cordis was advanced over a J WIRE, .035 X 145, Merit.
08:44 RCA angiogram performed.
08:44 Recorded in Condition 1: AO.
08:45 Catheter was removed w/o difficulty
08:45 A JL 4, 6, Cordis was advanced over a J WIRE, .035 X 145, Merit.
08:46 LCA angiogram performed.
08:47 BP 117/80 HR 94 SpO2 100.0 Resp BPM 26 loc 1
08:48 Catheter was removed w/o difficulty
08:49 A PIGTAIL 145, 6, Cordis was advanced over a J WIRE, .035 X 145, Merit.
08:50 Recorded in Condition 1: LV.
08:50 Recorded in Condition 1: LVp.
08:50 Left Ventriculargram done using 10 mL/s for 40 mL at a psi of 750.
08:51 Recorded in Condition 1: P/B.
08:51 Catheter was removed w/o difficulty
08:52 BP 120/86 HR 99 SpO2 99.0 Resp BPM 23 loc 1
08:52 Case end
08:53 D-Stat, , Vasc. Solu
08:53 A Left Heart Cath was done using 5 units of Service.
08:53 The Fem Art (right) Avanti Sheath 11cm, 6, Cordis sheath was removed and hemostasis achieved using manual pressure.
08:54 End Case record created.
08:55 Final Case assessment performed.
08:55 Post-op instructions given; patient acknowledges understanding of instructions.
08:55 Post Procedure Status: Stable
08:57 BP 119/83 HR 96 SpO2 99.0 Resp BPM 26 loc 1
09:02 Report Given To: 3rd floor RN
09:02 BP 117/84 HR 96 SpO2 98.0 Resp BPM 24 loc 1
09:04 Dressing Applied. No bleeding or hematoma noted at this time
09:04 Patient transfered to: Room 315 on the 3rd floor.

ENDCASE
A total of 200 mL's of Isovue-370 was used. 115 mL's of contrast was administered to the patient leaving 85 mL's wasted.
1.4 minutes total fluoro time.
Patient received 100 mL's total IV fluids.
Pressure held for 20 minutes. Sheaths pulled by Danek..RTR, John.
Patient transferred to Telemetry Bed.
Interventional outcome was

Equipment

Mfg.	Description	Size	Barcode
Cordis	JL 4	6	+H739534620TXX
Cordis	PIGTAIL 145	6	+H739534652SXX
Cordis	Avanti Sheath 11cm	6	504606X
Merit	LEFT HEART KIT		+H656K0905251XX
Medtronic	QUICK-COMBO PADS		3010188-011
Mallinckro	SYRINGE 150 ML	150 ML	(01) 0 0746190 00045 0
Merit	J WIRE	.035 X 145	0000000000000000
Cordis	JR 4	6	+H739534621TXX
Vasc. Solu	D-Stat		0086688

Medications

In Lab	07/15/2009 08:39	VERSED	1.000 mg	
In Lab	07/15/2009 08:40	1% XYLOCAINE	20.000 mL	R GROIN

Lab Data

Hematology

Hgb:	12.0	(12-16 14-18)
Hct:	36.0	(37-47 42-55)
RBC:	3.4	(4.2-6.2 million/mL)
WBC:	6.4	(4.8-10.8 k/cumm)
Plat:	161.0	(in thousands)

Electrolytes

Na:	138	(138-146 MEQ/L)
K:	3.4	(3.8-5.1 MEQ/L)
Cl:	106	(101-111 MEQ/L)
CO2:	25	(24-30 MEQ/L)

Enzymes

CPK:		(37-289 U/L)
MB:		(0)
LDH:		(89-161 U/L)
SGOT:		(5-35 U/L)
SGPT:		(7-56 U/L)

Coagulation

Pre:		PT:	15.0	(10.8-13.8 sec)
Post:		PTT:	30.2	(21.6-27.9 sec)
INR:	1.2	Triponin:		(0.4-2.3 ng/ml)

Other Chemistries

BUN:	11	(8-20 MG/DL)
Creat:	0.7	(0.5-1.7MG/DL)
Glu:	100	(60-110mg/dl)

Patient History

Patient is a female weighing 155.0 pounds and is 5 feet, 8 inches tall.
Family Hx of CAD, Hypertension, Hep. C, poss. Altered mental Status was noted.
Patient is allergic to NKA.

On Going Assessments

L.O.C. – 1. Alert
L.O.C. – 2. Occasionally drowsy; Easy to arouse
L.O.C. – 3. Frequently drowsy; Easy to arouse
L.O.C. – 4 Sleep; Easy to arouse
L.O.C. – 5 Somnolent; Difficult to arouse

Date	Time	BP	HR	SpO2	Resp.	Temp.	ACT	Comments
07/15/2009	08:23	111/83	99	98	11	--	--	loc 1
07/15/2009	08:26	96/70	97	98	36	--	--	loc 1
07/15/2009	08:31	114/85	98	100	8	--	--	loc 1
07/15/2009	08:37	116/81	98	100	18	--	--	loc 1
07/15/2009	08:42	118/80	96	100	53	--	--	loc 1
07/15/2009	08:47	117/80	94	100	26	--	--	loc 1
07/15/2009	08:52	120/86	99	99	23	--	--	loc 1
07/15/2009	08:57	119/83	96	99	26	--	--	loc 1
07/15/2009	09:02	117/84	96	98	24	--	--	loc 1

PAR Scores

Status	Activity	Resp.	Circ.	L.O.C.	Color	Total
Pre Administration	2	2	2	2	2	10
Post Administration	2	2	2	2	2	10

Initial Assessments

Respiratory comment:

Rate 14 BPM
SpO2 97 percent
O2 2 LPM

TV: PEEP: IMV: PS: FIO2: Alarms: NONE

Ventilator Type:
Short of Breath
ET: None

Neurological Comment: Pupils 2+
Neuro. State: Alert OX3: X MAE: X

Pre Op:

Cardiovascular

HR: 98 Rhythm: Sinus BP: 111 / 83

Skin: Warm X Dry X Cool Clammy Cold Diaphoretic

Color: Normal Edema: None Chest Pain (0-10): 0 ACT: 0.0

Pulses:	Dors Ped.	Post Tib.	Femoral	Brachial	Radial
Right	1	1			
Left	1	1			

Lower Ext.	Right	Left
Temp:	0.0	0.0
Color:	Normal	Normal

Final Assessments

Respiratory comment:

Rate	14	BPM	TV:		IMV:	FIO2:	
SpO2	99	percent	PEEP:		PS:		
O2	2	LPM				Alarms:	NONE

Ventilator Type:

Short of Breath | ET: None

Neurological Comment: Pupils 2+

Neuro. State: Alert | OX3: X | MAE: X

Pre Op:

Cardiovascular

HR: 98 Rhythm: Sinus BP: 120 / 86

Skin: Warm X | Dry X | Cool | Clammy | Cold | Diaphoretic

Color: Normal | Edema: None | Chest Pain (0-10): 0 | ACT: 0.0

Pulses:	Dors Ped.	Post Tib.	Femoral	Brachial	Radial
Right	1	1			
Left	1	1			

Lower Ext.	Right	Left
Temp:	0.0	0.0
Color:	Normal	Normal

Hemodynamics/Calculations

Condition 1:

Height: 68.0 in. 172.7 cm. Weight: 155.0 lbs. 70.4 kg. BSA: 1.84

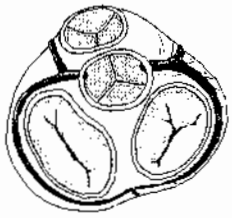
	Pressure	Rate	dPdT	Avg. SaO2	Time
RA:					
RV:					
PA:					
PCW:					
AO:	112/73/91	94			08:44
LV:	121/12/28	97			08:50
AOp:					
LVp:	114/7/21	98			08:50
PBa:	125/58/86	100			08:51
PBv:	153/-10/82	98	2540		08:51
UD1:					
UD2:					

Calculations done with: Fick

Valves	Flow	Area	Index	Peak	Mean
Tricuspid:			0.00		
Mitral:			0.00		
Aortic:			0.00	28.00	
Pulmonic:			0.00		
Other:					

Oxygen Values

Consumption: ml/min
Capacity: ml/L
Hemoglobin value: gm/dL



	HR	CO	CI	PVR	SVR	TSR	SWI	SV	SVI
Fick:									
Thermo:									
Angio:									

CARDIAC CATH LAB

ROOM TIME

STOP		*OUT-PT*	*In*
START	*08:00*	*STATUS*	*Scheduled*
MONITORED BY:		**LAB # 1**	**Dr. Robert Farrell**
CIRCULATED BY:			

CODE	DESCRIPTION	CPT

CARDIAC CATH LAB

CATH #: 09-254

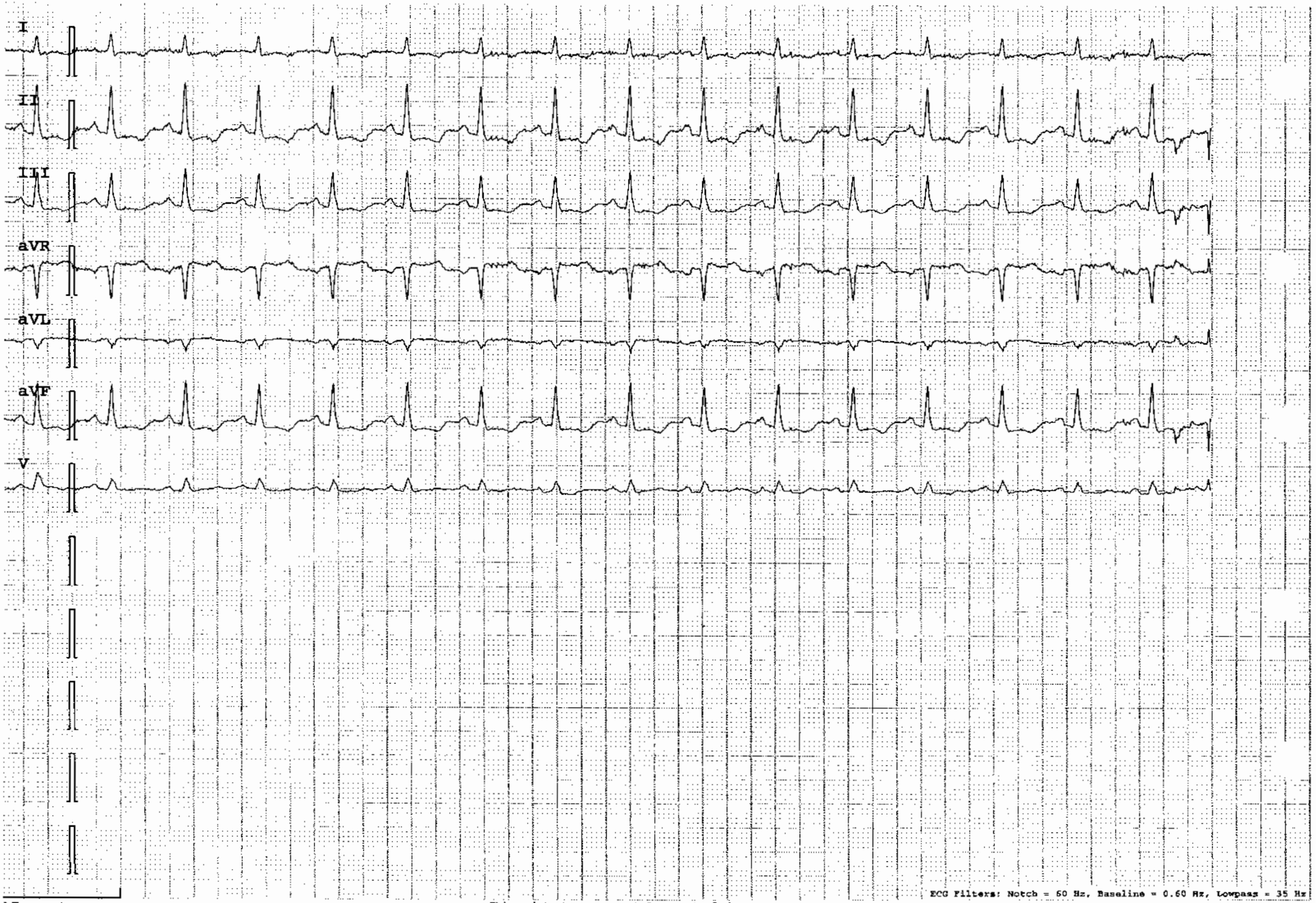
COMPLETED BY: _____

QTY	CODE	DESCRIPTION
1	0009480	AVANTI 6F SHEATH
1	0016398	150 ML INJECTOR SYRINGE
1	0026902	Quick Combo Pads
1	0030772	6 FR JL 4 DX
1	0030779	6 FR PGTL 145 DX
1	0081344	LEFT HEART KIT
1	0086500	6FR JR 4 INFIN DX
1	0086688	D-Stat
1	N/C	J WIRE

ARMATTA, BETH
Cath Date: 07/15/2009

MRN: MN00497388
CASE #: 09-254

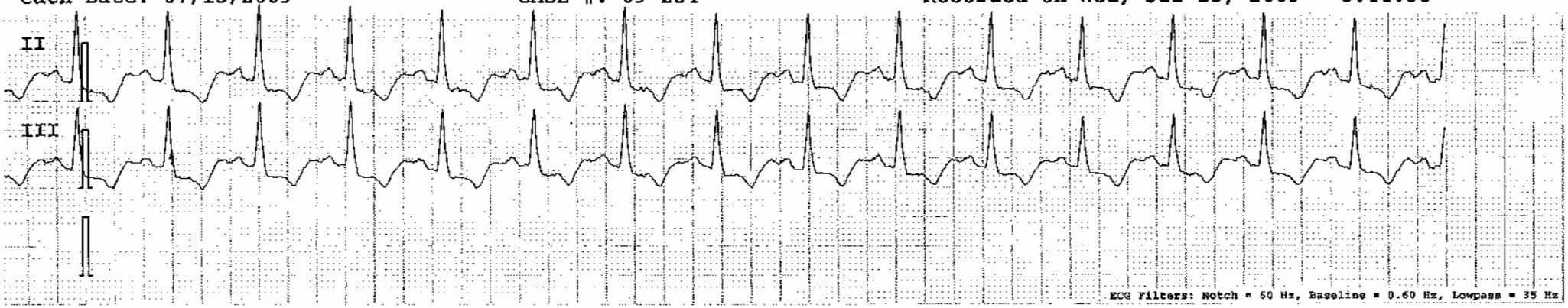
Condition 1:
Recorded on Wed, Jul 15, 2009 - 8:25:11



25 mm/sec.

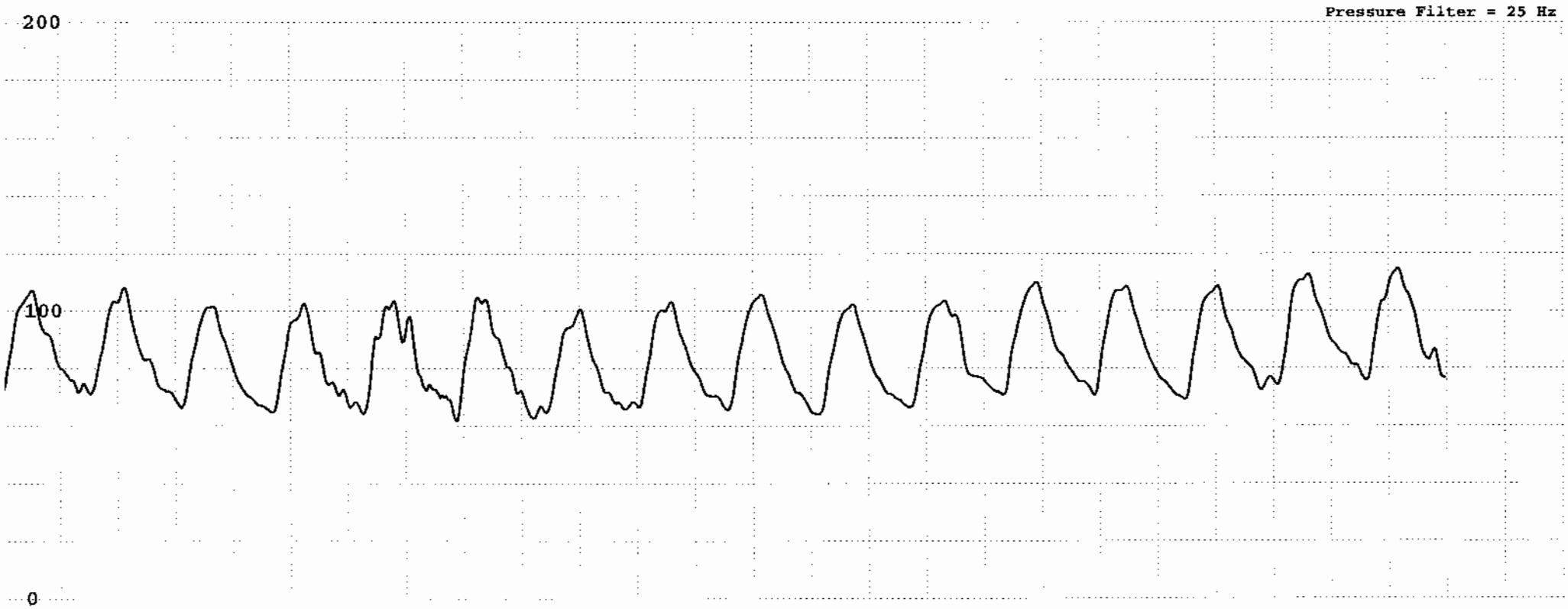
ECG Filters: Notch = 60 Hz, Baseline = 0.60 Hz, Lowpass = 35 Hz

ARMATTA, BETH
MRN: MN00497388
Condition 1:
Cath Date: 07/15/2009
CASE #: 09-254
Recorded on Wed, Jul 15, 2009 - 8:44:38



HR: 94

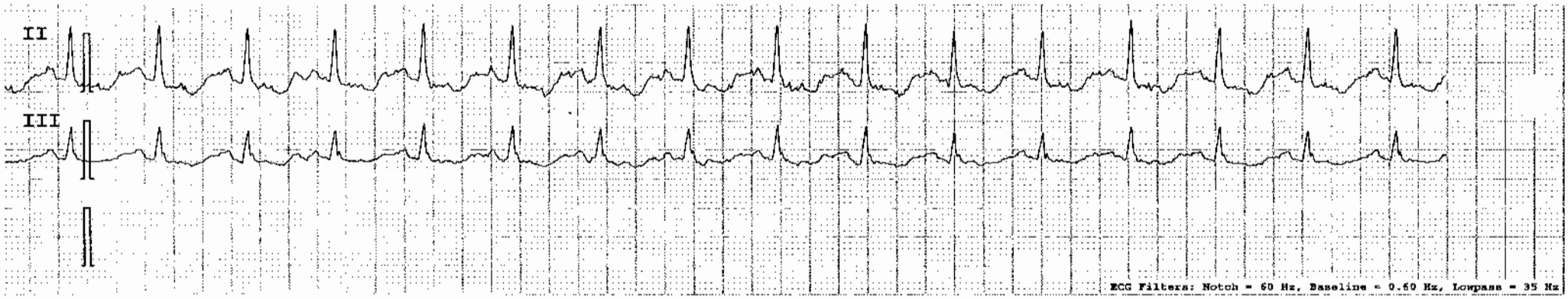
AO s/d/m
112/73/91



25 mm/sec.

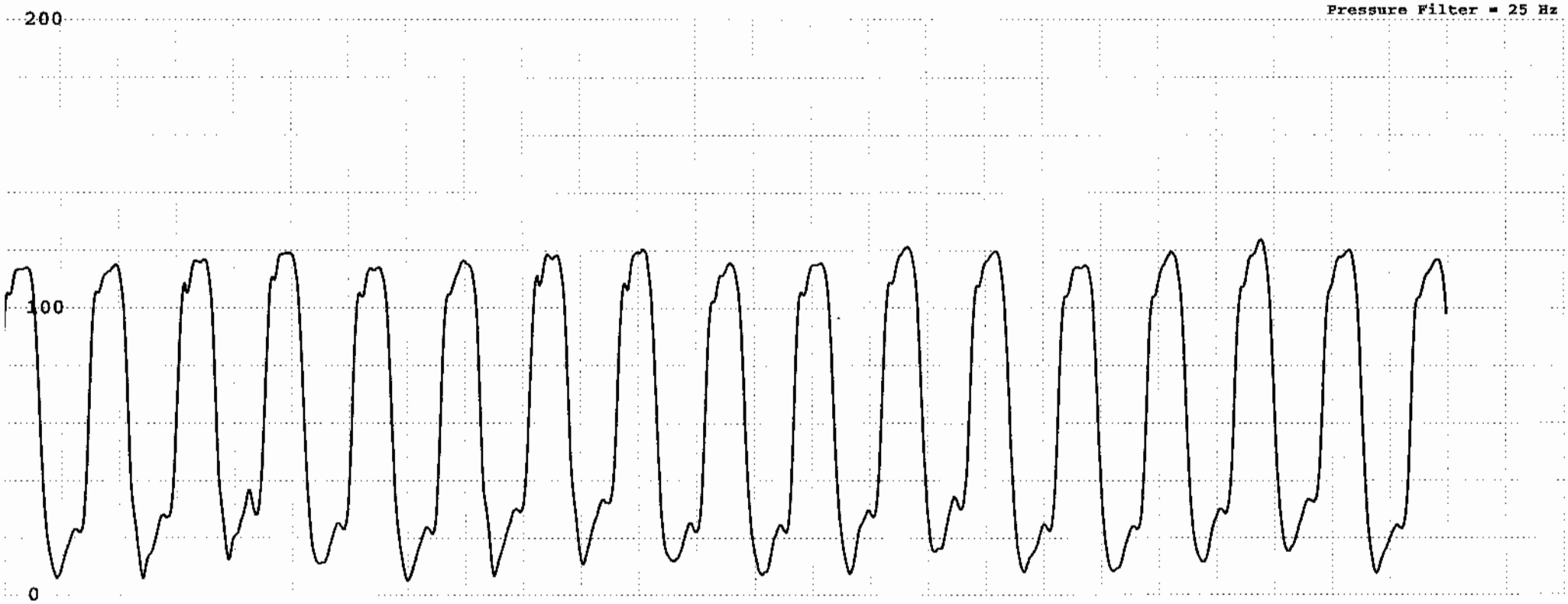
This printout was generated as part of the case report.

ARMATTA, BETH
MRN: MN00497388
Condition 1:
Cath Date: 07/15/2009
CASE #: 09-254
Recorded on Wed, Jul 15, 2009 - 8:50:04



HR: 97

LV s/d/edp
121/12/28



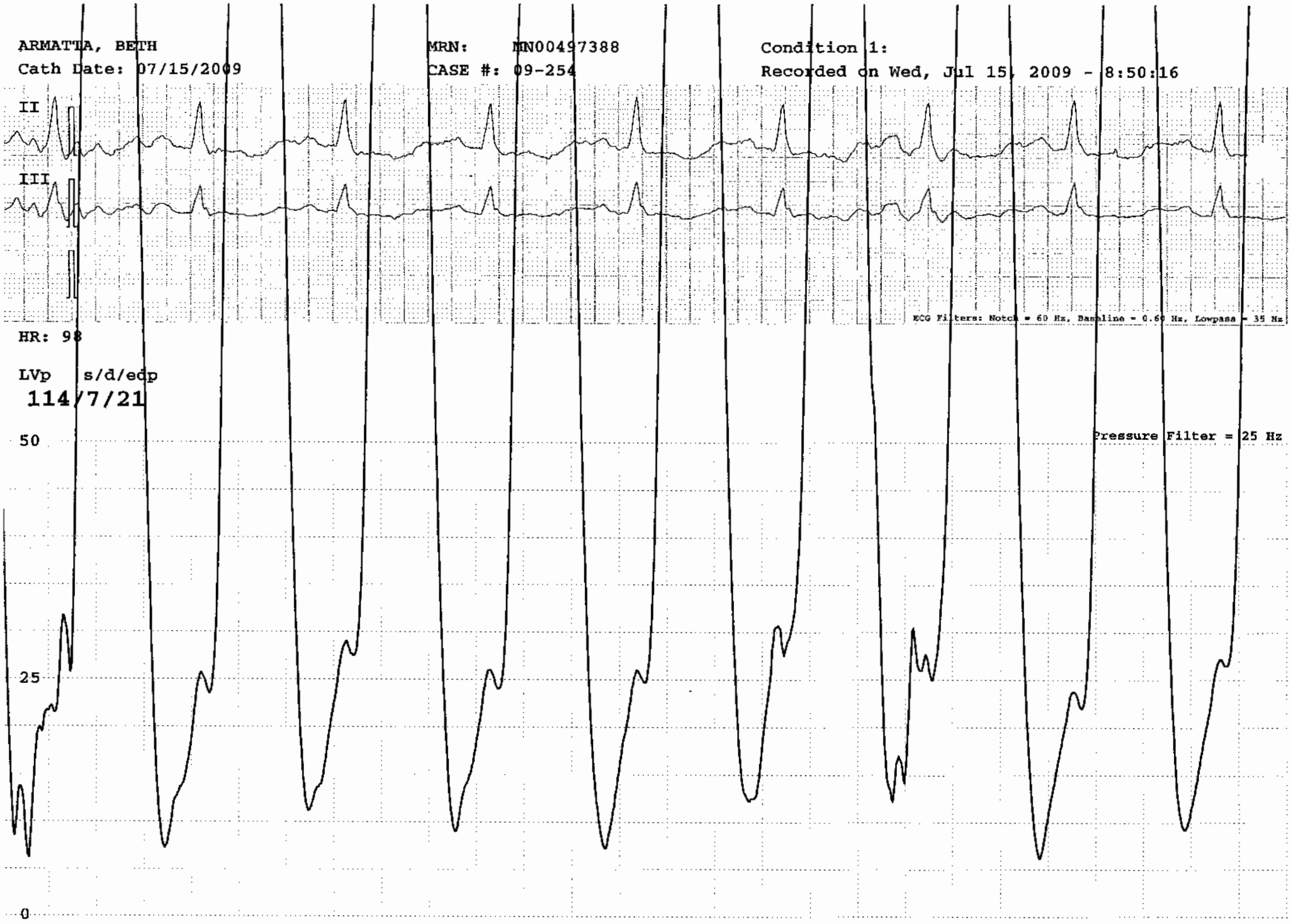
25 mm/sec.

This printout was generated as part of the case report.

ARMATTA, BETH
Cath Date: 07/15/2009

MRN: MN00497388
CASE #: 09-254

Condition 1:
Recorded on Wed, Jul 15, 2009 - 8:50:16



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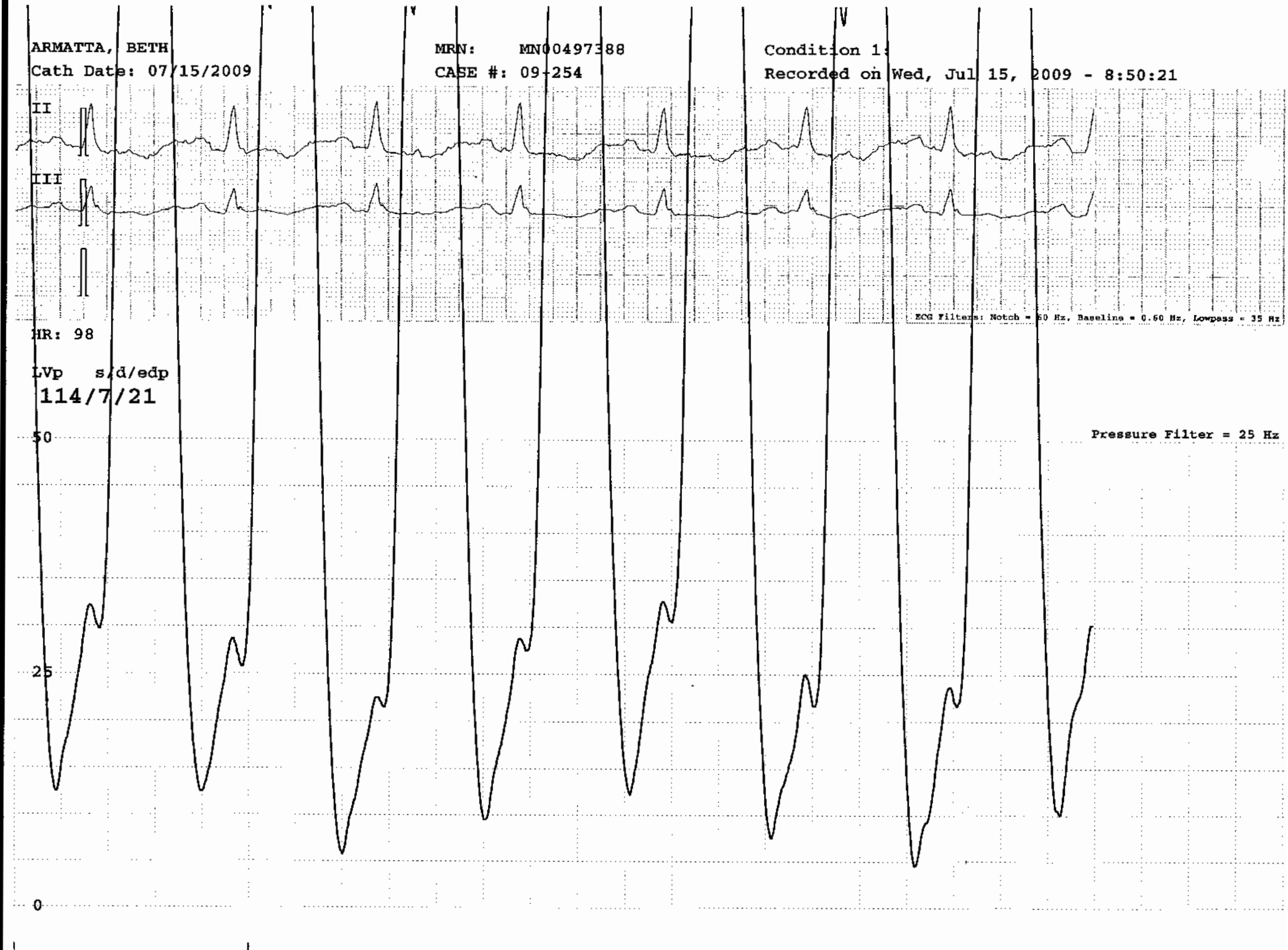
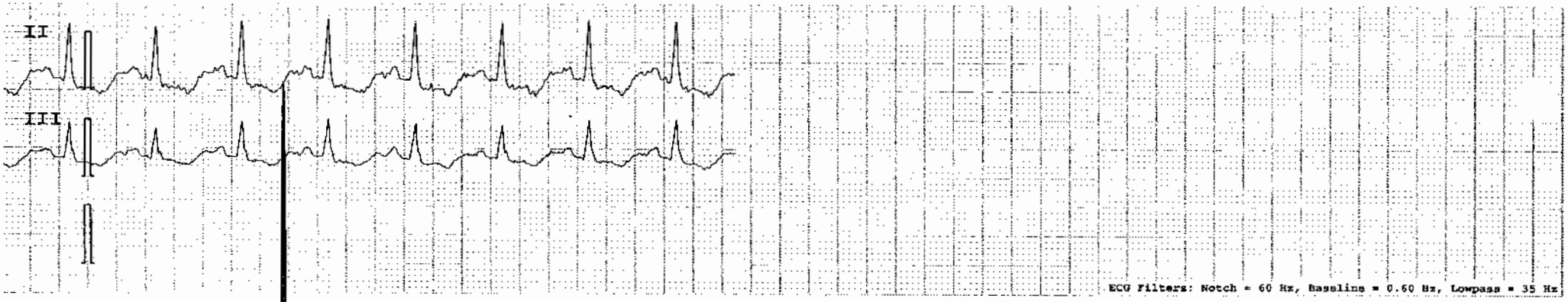


This printout was generated as part of the case report.

ARMATTA, BETH
Cath Date: 07/15/2009

MRN: MN00497388
CASE #: 09-254

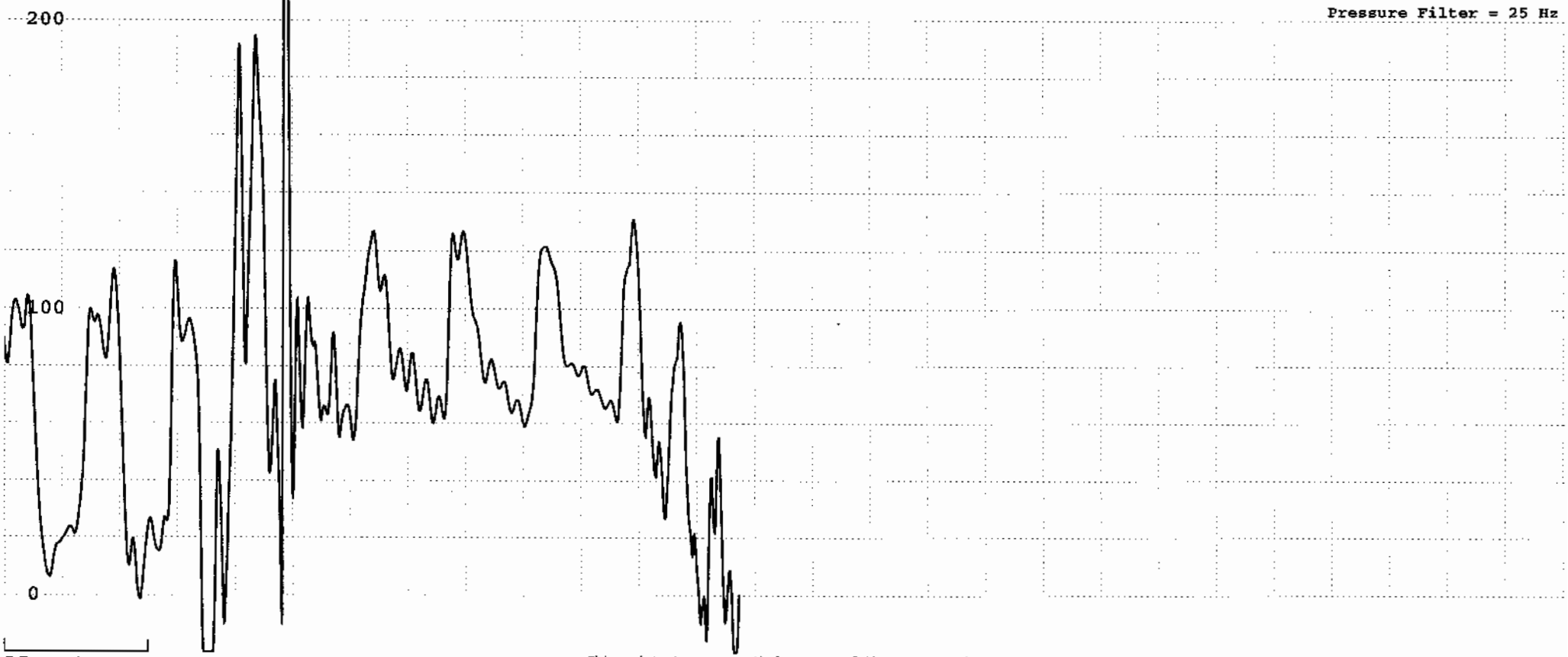
Condition 1:
Recorded on Wed, Jul 15, 2009 - 8:51:25



HR: 100

PBV s/d/edp
153/-10/82

PBA s/d/m
125/58/86



This printout was generated as part of the case report.

CHRISTUS ST. JOHN Hospital

Reorder #55236

CARDIAC CATH LAB

PROCEDURAL FINDINGS AND RECOMMENDATIONS

Procedures Performed:

✓ Left Heart Catheterization with
- ✓ Coronary Angiography and
- ___ Left Ventriculogram
- ___ Right Heart Catheterization ___ With Cardiac Outputs

Date: July 15, 2009
Operator: Dr. Farrell

Findings:

Left Main: nl
LAD: nl
Diagonal branch: nl
Circumflex: nl
Obtuse marginal: nl
Right coronary: 50%
Posterior descending: nl
Posterior lateral: nl
Ramus intermediate: ___

SVG ___
SVG ___
SVG ___
LIMA ___

LV wall motion: apical D/K
Estimated LVEF: 40 - 45%

Aortic Valve: ___
Mitral Valve: 2+ MR

Right Heart Pressures:

PCW: ___
PA: ___
RV: ___
RA: ___

Oxygen Saturations:

PA sat: ___
AO sat: ___

Cardiac Outputs:

TD: ___ ___
___ ___
Fick: ___

Left Heart Pressures:

AO: ___
LV: LVEDP ~ 25

Recommendations:

___ Medical Management
___ Interventional therapy
___ Surgical re-vascularization

Physician's Signature

Addressograph

MN00497388 AN0710182095 MED
ARMATTA, BETH
07/10/09 F 10/26/1962 46
MAKSOUD, ALFRED S MD
AN.315-1

ARMATTA, BETH **ID:497388** **11-JUL-2009 01:19:53** **CHRISTUS ST. JOHN**

26-OCT-1962 (46 yr)
Female Caucasian

Loc:1

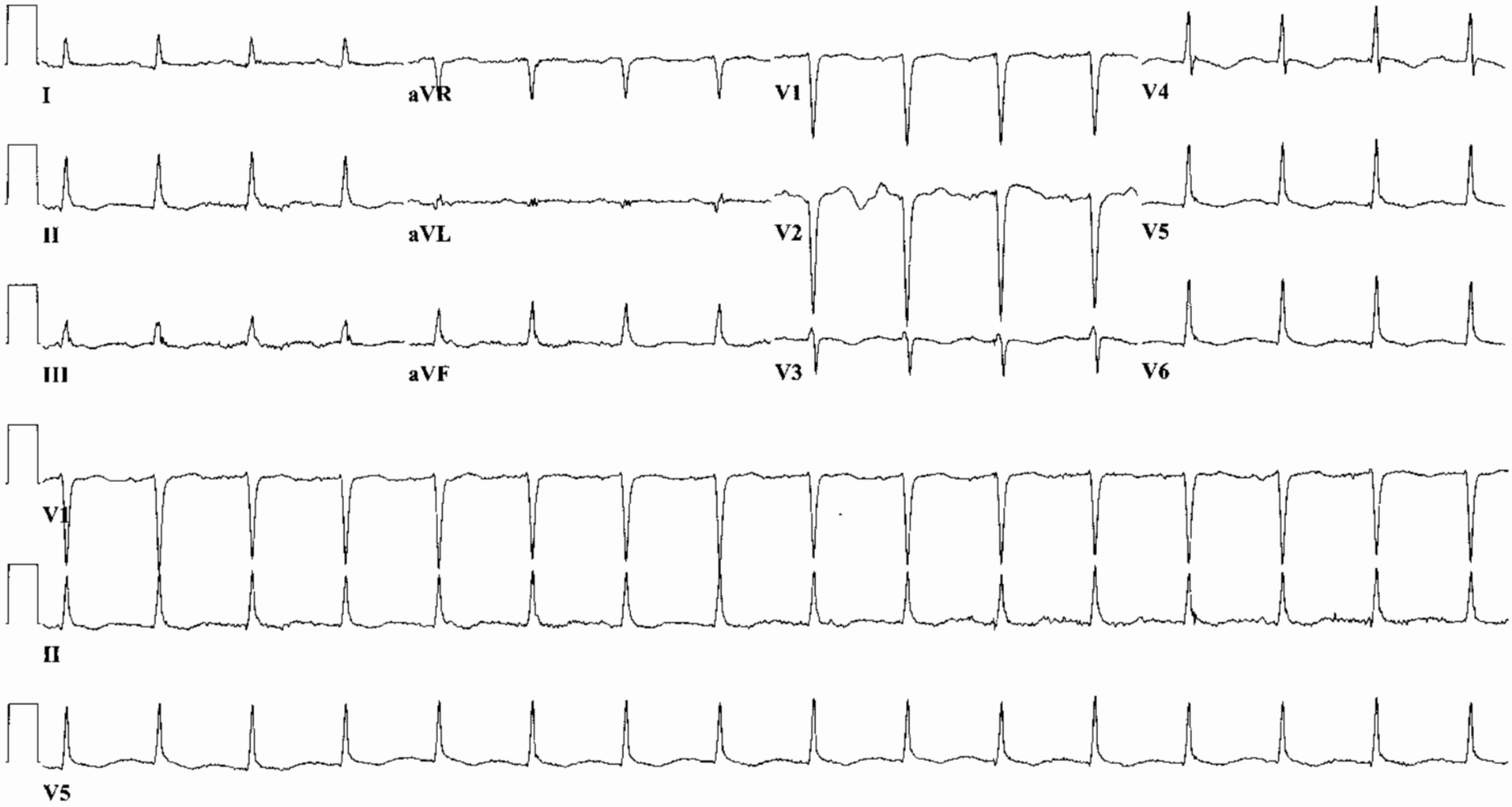
Vent. rate	94	BPM
PR interval	166	ms
QRS duration	110	ms
QT/QTc	412/515	ms
P-R-T axes	-3 58	-10

Normal sinus rhythm
Nonspecific ST and T wave abnormality
Prolonged QT
Abnormal ECG
Confirmed by BHALLA, MD, RAJINDER K (6200), editor CHESSON, JOYCE (6001) on 13-Jul-2009 11:15:06

Technician: MSG

Referred by: A MAKSOUD

Confirmed By: RAJINDER K BHALLA, MD



25mm/s 10mm/mV 150Hz 005E 12SL 237 CID: 3

SID: 710182095 EID:6001 EDT: 11:15 13-JUL-2009 ORDER:

CHRISTUS ST. JOHN HOSPITAL

DISCHARGE SUMMARY

PATIENT NAME: ARMATTA,BETH
DOB/AGE/SEX: 10/26/1962 / 46 Y / F
PATIENT TYPE: DIS IN

ADMIT/SERVICE DATE: 07/10/09
DISCHARGE DATE: 07/16/09
REPORT NUMBER: 0716-0210

REASON FOR ADMISSION:Altered mental state.

DISCHARGE DIAGNOSES:
Acute mental status change.
Acute encephalopathy.
Acute myocardial infarction.
Congestive heart failure.
Coronary disease.
Hepatitis C.
Chronic liver disease.
Hypertension.
History of alcohol use.

CONSULTANTS:Dr. Bhalla.

PROCEDURES PERFORMED:Coronary angiography.

DISPOSITION:Discharged home. Improved.

DISCHARGE MEDICATIONS:Lisinopril.
Toprol.
Lasix.
Potassium.
Aspirin.
Stop previous medications.
DIET:Low salt, low cholesterol.

ACTIVITY:Rest a home and advance as tolerated.
FOLLOW-UP:With Dr. Bhalla in two weeks. Follow-up with Dr. Dayal in two to three weeks.

HOSPITAL COURSE:Please see admission note, consult note and procedure note for details. The patient was admitted with altered mental state, confusion. Her condition worsened. Respiratory distress developed. Her breathing was poor. She was transferred to ICU. Cardiac enzymes were positive. Her cardiorespiratory status and mental status, central nervous system status all progressively improved.

She underwent hearth catheterization which showed a 50-percent right coronary artery lesion and typical hypokinesia. Medical management was opted. She was feeling much better one day post heart catheterization. She is being discharged home in much improved and stable condition with new prescription per Dr. Bhalla. Follow-up was strongly recommended as well as dietary and activity restrictions.

ATTENDING PHYSICIAN: MAKSOUD,ALFRED S MD
DICTATED BY: IYER,NIRANJAN G MD
LOC./ROOM NUMBER: AN.3MEDSUR/AN.315

PATIENT NAME: ARMATTA,BETH
ACCOUNT NUMBER: AN0710182095
MR NUMBER: MN00497388

DIAGNOSTIC DATA:Multiple lab work that are described in the chart, as well as CT and neural imaging.

CONDITION ON DISCHARGE:
Good.

Niranjan G Iyer, MD

NGI/pq5/000346107/1316871/1316871 D: 07/16/2009 1:44 P T: 07/16/2009 9:17 P
cc: Gauri Dayal, MD
Niranjan G Iyer, MD
Jack W Janoe, MD
Alfred S Maksoud, MD
Signed By

ATTENDING PHYSICIAN: MAKSOUD,ALFRED S MD
DICTATED BY: IYER,NIRANJAN G MD
LOC./ROOM NUMBER: AN.3MEDSUR/AN.315

PATIENT NAME: ARMATTA,BETH
ACCOUNT NUMBER: AN0710182095
MR NUMBER: MN00497388

CHRISTUS Hospital - St. John
18300 St. John Drive
NASSAU BAY, TEXAS 77058

***** FINAL DISCHARGE SUMMARY REPORT - INPATIENT ****

Name: ARMATTA,BETH **Age/Sex:** 46/F **Attend Dr:** MAKSOUD,ALFRED S MD
Acct#: AN0710182095 **Unit#:** MN00497388 **Status:** DIS IN **Location:** AN.3MEDSUR AN.315-1
Reg: 07/10/09 **Disch:** 07/16/09

********** GENERAL CHEMISTRY **********

Date	7/15/09		7/14/09		7/13/09			
Time	0445		0400		0435		Reference	Units
Sodium	140		138		140		(134-146)	mmol/L
Potassium	3.8		*3.4*	*L*	3.7		(3.6-5.2)	mmol/L
Chloride	*109*	*H*	106		*109*	*H*	(99-108)	mmol/L
CO2	25		25		22		(21-33)	mmol/L
BUN	9.5		11.1		17.3		(7.0-18.0)	mg/dl
Creatinine	0.7		0.7		0.7		(0.6-1.3)	mg/dL
Est GFR	> 90.0(a)		> 90.0(a)		> 90.0(a)			mL/min
Glucose	*110*	*H*	*100*	*H*	*121*	*H*	(65-99)	mg/dL
Calcium	*8.2*	*L*	8.4		*8.1*	*L*	(8.4-10.2)	mg/dL
Phosphorus	2.8		*2.2*	*L*	3.2		(2.5-4.9)	mg/dl
Magnesium	1.8		*1.5*	*L*	2.0		(1.8-2.4)	mg/dl
Bili Total	0.8		1.0		1.1		(0.2-1.2)	mg/dL
AST/SGOT	*159*	*H*	*100*	*H*	*70*	*H*	(15-37)	I/U
ALT/SGPT	*69*	*H*	57		53		(30-65)	U/L
TP	*6.1*	*L*	*6.2*	*L*	6.4		(6.3-8.2)	g/dL
Albumin	*2.3*	*L*	*2.4*	*L*	*2.5*	*L*	(3.5-5.0)	g/dL
ALKP	97		95		104		(50-136)	U/L

Date	7/12/09		----------7/11/09----------				
Time	0415		2100		0210		Reference	Units
Sodium	140		140		141		(134-146)	mmol/L
Potassium	4.7		3.8		*3.0*	*L*	(3.6-5.2)	mmol/L
Chloride	*111*	*H*	106		105		(99-108)	mmol/L

NOTES: (a) Estimated Glomerular Filtration Rate (GFR) has equal predictive value to Creatinine Clearance as suggested by the National Kidney Foundation; applies to 17 years of age and older.

STAGES OF CHRONIC KIDNEY DISEASE

1. Kidney damage with normal to increased GFR.	>=90
2. Kidney damage with mild or decreased GFR.	60-89
3. Moderately decreased GFR.	30-59
4. Severely decreased GFR.	15-29
5. Kidney failure or dialysis patients.	<15

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***** FINAL DISCHARGE SUMMARY REPORT - INPATIENT ****

Patient: ARMATTA,BETH **#**AN0710182095 **(Continued)**

********** GENERAL CHEMISTRY (continued) **********

Date	7/12/09		----------7/11/09----------					
Time	0415		2100		0210		Reference	Units
CO2	23		22		*20*	*L*	(21-33)	mmol/L
BUN	13.4		10.8		7.2		(7.0-18.0)	mg/dl
Creatinine	1.0		0.9		1.2		(0.6-1.3)	mg/dL
Est GFR	63.4(b)		71.6(b)		51.4(b)			mL/min
Glucose	*144*	*H*	*162*	*H*	*209*	*H*	(65-99)	mg/dL
Calcium	*8.0*	*L*	*8.1*	*L*	8.8		(8.4-10.2)	mg/dL
Phosphorus	*1.8*	*L*	2.9				(2.5-4.9)	mg/dl
Magnesium	2.4	D	**0.9(c)**	**CL**			(1.8-2.4)	mg/dl
Bili Total	1.2				*1.7*	*H*	(0.2-1.2)	mg/dL
Bili Direct					*0.9*	*H*	(0.0-0.3)	mg/dL
AST/SGOT	*96*	*H*			*141*	*H*	(15-37)	I/U
ALT/SGPT	65				*96*	*H*	(30-65)	U/L
TP	6.6				7.5		(6.3-8.2)	g/dL
Albumin	*2.7*	*L*			*3.2*	*L*	(3.5-5.0)	g/dL
ALKP	114				*144*	*H*	(50-136)	U/L
Amylase					26		(25-115)	U/L
Lipase					251		(23-300)	U/L
Vitamin B12	368						(239-931)	pg/ml
Ammonia					*46.3*	*H*	(11.0-32.0)	umol/L
HAVIGM					Negative		(NEGATIVE)	
HBsAg					Negative		(NEGATIVE)	
Hep B Core IgM					Negative		(NEGATIVE)	

NOTES: (b) Estimated Glomerular Filtration Rate (GFR) has equal predictive value to Creatinine Clearance as suggested by the National Kidney Foundation; applies to 17 years of age and older.

STAGES OF CHRONIC KIDNEY DISEASE

1. Kidney damage with normal to increased GFR.	>=90
2. Kidney damage with mild or decreased GFR.	60-89
3. Moderately decreased GFR.	30-59
4. Severely decreased GFR.	15-29
5. Kidney failure or dialysis patients.	<15

(c) Result verified by repeat analysis on same specimen.
Critical value called to MIKE IN ICU at 2229 on 07/11/09 by TXRICKE.
Result read-back successful.

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***** FINAL DISCHARGE SUMMARY REPORT - INPATIENT ****

Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

********** GENERAL CHEMISTRY (continued) **********

Date	7/12/09	----------7/11/09----------			
Time	0415	2100	0210	Reference	Units
Hep C Ab			*(A) AH*	(NEGATIVE)	

(A) Positive AH
See also (d), (e)

Date	7/10/09			
Time	0925		Reference	Units
Sodium	138		(134-146)	mmol/L
Potassium	*3.1*	*L*	(3.6-5.2)	mmol/L
Chloride	102		(99-108)	mmol/L
CO2	26		(21-33)	mmol/L
BUN	*6.3*	*L*	(7.0-18.0)	mg/dl
Creatinine	1.0		(0.6-1.3)	mg/dL
Est GFR	63.4(f)			mL/min
Glucose	*149*	*H*	(65-99)	mg/dL
Calcium	9.4		(8.4-10.2)	mg/dL
Bili Total	*1.8*	*H*	(0.2-1.2)	mg/dL
AST/SGOT	*170*	*H*	(15-37)	I/U
ALT/SGPT	*115*	*H*	(30-65)	U/L

NOTES:
(d) Result verified by repeat analysis on same specimen.
(d) Critical value called to CINDY, ICU at 0451 on 07/11/09 by
(d) JEN00063.
(d) Result read-back successful.
(e) A negative test result does not exclude the possibility of recent exposure to or infection with Hepatitis Virus. Follow CDC recommendations for supplemental testing of positive samples.
(f) Estimated Glomerular Filtration Rate (GFR) has equal predictive value to Creatinine Clearance as suggested by the National Kidney Foundation; applies to 17 years of age and older.

STAGES OF CHRONIC KIDNEY DISEASE

1. Kidney damage with normal to increased GFR.	>=90
2. Kidney damage with mild or decreased GFR.	60-89
3. Moderately decreased GFR.	30-59
4. Severely decreased GFR.	15-29
5. Kidney failure or dialysis patients.	<15

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***** FINAL DISCHARGE SUMMARY REPORT - INPATIENT ****

Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

********** GENERAL CHEMISTRY (continued) **********

Date	7/10/09			
Time	0925		Reference	Units
TP	7.7		(6.3-8.2)	g/dL
Albumin	3.7		(3.5-5.0)	g/dL
ALKP	133		(50-136)	U/L
Lipase	*327*	*H*	(23-300)	U/L
Ammonia	*42.6*	*H*	(11.0-32.0)	umol/L
Ethanol	< 10.0(g)		(0.0-10.0)	mg/dl

********** CARDIAC MARKERS **********

Date	7/13/09		7/12/09		7/11/09			
Time	0435		1104		1830		Reference	Units
BNP, Triage	*388.0*	*H*	*434.0*	*H*			(0-99)	pg/mL
CK					123		(30-135)	U/L
CKMB					3.3		(0.0-3.6)	ng/ml
CKMB Index					2.7		(0.0-3.5)	%
CKMBCK-I					LOWMB(h)			
Troponin I					**2.23(i)**	**CH**	(0.00-0.5)	ng/ml

Date	----------7/11/09----------					
Time	1300		0210		Reference	Units
CK	*136*	*H*	*240*	*H*	(30-135)	U/L
CKMB	*4.9*	*H*	*10.4*	*H*	(0.0-3.6)	ng/ml
CKMB Index	*3.6*	*H*	*4.3*	*H*	(0.0-3.5)	%

NOTES: (g) **BLOOD ALCOHOL PERFORMED FOR MEDICAL PURPOSES ONLY**
(h) CKMB <3.7 ng/ml, Negative for Myocardial injury.
(i) Result verified by repeat analysis on same specimen.
Critical value called to GONESH IN ICU at 1924 on 07/11/09
by TXRICKE.
Result read-back successful.
See also (j)
(j) Consistent with Myocardial injury >1.50 ng/ml

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***** FINAL DISCHARGE SUMMARY REPORT - INPATIENT ****

Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

********** CARDIAC MARKERS (continued) **********

Date	----------7/11/09----------			
Time	1300	0210	Reference	Units
CKMBCK-I	(B)	(C)		

(B) POSITIVE
See also (k)
(C) POSITIVE
See also (k)

Troponin I		**4.68(l) CH**	(0.0-0.5)	ng/ml
Troponin I	**2.64(n) CH**		(0.00-0.5)	ng/ml

NOTES: (k) CKMB is > or = 3.7 ng/ml and CKMB INDEX is > or = 3.6%.
Result is Positive for Myocardial injury. Correlate with Troponin I and clinical EKG findings.

(l) Result verified by repeat analysis on same specimen.
Critical value called to MIKE, ICU at 0324 on 07/11/09 by JEN00063. INITIAL RESULT OF <0.04 DUE TO SHORT SAMPLE BY ANALYZER. RESULTS VERIFIED BY REPEAT ANALYSIS ON BOTH ANALYZERS.
Result read-back successful.
--- 07/11/09 0326 ---
Troponin I previously reported as: 4.68 CH ng/ml
Result verified by repeat analysis on same specimen.
Critical value called to MIKE, ICU at 0324 on 07/11/09 by JEN00063.
Result read-back successful.
See also (m)

(m) Consistent with Myocardial injury >1.50 ng/ml

(n) Result verified by repeat analysis on same specimen.
Critical value called to RACHEL,ICU at 1409 on 07/11/09 by PAT00099.
Result read-back successful.
See also (m)

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***** FINAL DISCHARGE SUMMARY REPORT - INPATIENT ****

Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

********** BLOOD GAS ANALYSIS **********

	Date 7/11/09 Time 0158		Reference	Units
FIO2	100			%
pH	7.40		(7.35-7.45)	
PCO2	*34.6*	*L*	(35-45)	mmHg
PO2	**45.9(o)**	**CL**	(80-100)	mmHG
HCO3	*21*	*L*	(22-26)	mmol/L
BE	-2.8(p)			mmol/L
O2SAT	*81.2*	*L*	(96-97)	%

********** DRUGS OF ABUSE **********

	Date 7/10/09 Time 1030		Reference	Units
Amphetamine	Negative		(NEG)	
Barbiturate Urn	Negative		(NEG)	
Benzodiaz Urn	Negative		(NEG)	
Ecstacy Urine	Negative		(NEG)	
Cocaine	Negative		(NEG)	
Opiates	*(D)*	*AH*	(NEG)	

(D) Positive Unconfirmed AH
See also (q)

Phencyclidine	Negative		(NEG)

NOTES: (o) Result verified by repeat analysis on same specimen.
Critical value called to DEBBIE, ICU at 0225 on 07/11/09 by JEN00063.
Result read-back successful.
(p) Reference Range: -2.0 to +2.0
(q) Critical value called to KATHY IN 3MED at 1903 on 07/10/09
(q) by EXLEE02.
(q) Result read-back successful.

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***** FINAL DISCHARGE SUMMARY REPORT - INPATIENT ****

Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

********** DRUGS OF ABUSE (continued) **********

Date	7/10/09		
Time	1030	Reference	Units
Cannabinoids	*(E) AH*	(NEG)	

(E) Positive Unconfirmed AH
See also (r), (s)

********** HEMATOLOGY **********

Date	7/15/09		7/14/09		7/13/09			
Time	0445		0400		0435		Reference	Units
WBC	4.88		6.38		8.23		(4.00-10.80	thou/cm
RBC	*3.37*	*L*	*3.39*	*L*	*3.47*	*L*	(3.8-5.0)	mill/cm
Hgb	11.8		12.0		12.4		(11.0-15.8)	g/dL
Hct	35.7		36.0		37.3		(33.0-47.4)	%
MCV	*105.9*	*H*	*106.2*	*H*	*107.5*	*H*	(82-99)	fl
MCH	*35.0*	*H*	*35.4*	*H*	*35.7*	*H*	(27-33)	pg
MCHC	33.1		33.3		33.2		(31.0-36.0)	g/dL
RDW	14.4		14.5		14.8		(12-15)	%
Plt	163		161		155		(150-450)	thou/cm

NOTES: (r) Critical value called to KATHY IN 3MED at 1910 on 07/10/09
(r) by EXLEE02.
(r) Result read-back successful.
(s) (NOTE) DRUG CUTOFF LEVELS

DRUG CATEGORY	CUTOFF LEVELS
AMPHETAMINE/METHAMPHETAMINE	1000 ng/ml
OPIATES	300 ng/ml
THC(CANNABINOIDS)	50 ng/ml
PCP(PHENCYCLIDINE)	25 ng/ml
BENZODIAZEPINE	300 ng/ml
BARBITURATES	300 ng/ml
ECSTASY	500 ng/ml

MEDICAL PURPOSES ONLY!
POSITIVES NOT CONFIRMED; WITH THE EXCEPTION OF ECSTASY AND
PCP WHICH POSITIVES ARE SENT FOR CONFIRMATION.

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Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

********** HEMATOLOGY (continued) **********

Date	7/15/09		7/14/09		7/13/09		Reference	Units
Time	0445		0400		0435			
Manual Diff?	Yes		Yes		Yes		(N)	
Neutrophils	39		37		48		(36-70)	%
NEUTS#	*1.9*	*L*	*2.4*	*L*	4.0		(2.9-18.6)	thou/cm
Lymphocytes	46		46		36		(24-54)	%
Monocytes	*15*	*H*	*16*	*H*	*15*	*H*	(0-10)	%
Eosinophils					1		(0-5)	%
Basophils			1				(0-2)	%
Nucleated RBC					*1*	*H*	(0-0)	/100 WB
Plt Estimate	ADEQUATE		ADEQUATE		DECREASED			
RBC Morph	ABNORMAL		ABNORMAL		ABNORMAL			
Macrocytosis	FEW		FEW		FEW			
Poly	RARE		RARE		RARE			
Stomatocytes			FEW		FEW			

Date	7/12/09		7/10/09		Reference	Units
Time	0415		0925			
WBC	10.46		6.23		(4.00-10.80	thou/cm
RBC	3.83		*3.70*	*L*	(3.8-5.0)	mill/cm
Hgb	13.3		13.2		(11.0-15.8)	g/dL
Hct	40.4		38.0		(33.0-47.4)	%
MCV	*105.5*	*H*	*102.7*	*H*	(82-99)	fl
MCH	*34.7*	*H*	*35.7*	*H*	(27-33)	pg
MCHC	32.9		34.7		(31.0-36.0)	g/dL
RDW	14.4		13.0		(12-15)	%
Plt	165		*121*	*L*	(150-450)	thou/cm
Neut%			63.0		(36-70)	%
Lymph%			*22.2*	*L*	(24-54)	%
Mon%			14.6		(10-18)	%
Eos%			0.0		(0-5)	%
Baso%			0.2		(0-2)	%
Neut#			3.9		(1.8-8.2)	thou/cm
Lymph#			1.4		(0.8-5.0)	thou/cm
Mon#			*0.9*	*H*	(0.0-0.8)	thou/cm
Eos#			0.0		(0.0-0.6)	thou/cm
Baso#			0.0		(0.0-0.2)	thou/cm
Manual Diff?	Yes		(F)		(N)	

(F) AUTO DIFFERENTIAL

Neutrophils	61	(36-70)	%

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Patient: ARMATTA,BETH **#**AN0710182095 **(Continued)**

********** HEMATOLOGY (continued) **********

Date	7/12/09		7/10/09			
Time	0415		0925		Reference	Units
NEUTS#	6.4				(2.9-18.6)	thou/cm
Lymphocytes	26				(24-54)	%
Monocytes	*13*	*H*			(0-10)	%
Plt Estimate	ADEQUATE					
RBC Morph	ABNORMAL					
Macrocytosis	FEW					
Poly	RARE					

********** COAGULATION STUDIES **********

Date	7/11/09		7/10/09			
Time	0210		0925		Reference	Units
PT	*15.0*	*H*	*15.0*	*H*	(12.1-14.6)	SECS
INR	*1.15(t)*	*H*	*1.15(t)*	*H*	(0.80-1.11)	
PTT	30.2		32.2		(26.0-36.4)	SECS

NOTES: (t) INR NOTE:

The INR is only applicable for patients on stabilized oral anticoagulant therapy: 2.0-3.0. Patients with mechanical heart valves: 2.5-3.5

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Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

********** URINALYSIS **********

	Date 7/10/09 Time 1030		Reference	Units
UR Color	YELLOW		(YELLOW)	
UR Appearance	CLEAR		(CLEAR)	
UR pH	6.5		(4.5-8.0)	
UR SG	<= 1.005		(1.005-1.030)	
UR Protein	*TRACE*	*AH*	(NEGATIVE)	mg/dl
UR Glucose	NEGATIVE		(NEGATIVE)	mg/dl
UR Ketone	NEGATIVE		(NEGATIVE)	mg/dl
UR Occult Blood	NEGATIVE		(NEGATIVE)	
UR Nitrites	NEGATIVE		(NEGATIVE)	
UR Bilirubin	SMALL		(NEGATIVE)	
Ictotest	Negative		(NEGATIVE)	
UR Urobilinogen	0.2		(0.2-1.0)	EU/dl
UR Leuk Esteras	NEGATIVE		(NEGATIVE)	
UR RBC	0-3		(0-3)	/HPF
UR WBC	0-3		(0-2)	/HPF
UR Epithelial	Few			/LPF
UR Bacteria	Rare		(NS)	/HPF

********** SEROLOGY **********

	Date 7/11/09 Time 0210	Reference	Units
HAVIGM	Negative	(NEGATIVE)	
HBsAg	Negative	(NEGATIVE)	
Hep B Core IgM	Negative	(NEGATIVE)	

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***** FINAL DISCHARGE SUMMARY REPORT - INPATIENT ****

Patient: ARMATTA,BETH **#**AN0710182095 **(Continued)**

********** SEROLOGY (continued) **********

	Date	7/11/09		
	Time	0210	Reference	Units
Hep C Ab	*(G) AH*		(NEGATIVE)	

(G) Positive AH
See also (u), (v)

********** REFERENCE LAB TESTS **********

	Date	7/11/09		
	Time	0210	Reference	Units
Ceruloplasmin		20(w)	(17-54)	mg/dL

NOTES: (u) Result verified by repeat analysis on same specimen.
(u) Critical value called to CINDY, ICU at 0451 on 07/11/09 by
(u) JEN00063.
(u) Result read-back successful.
(v) A negative test result does not exclude the possibility of recent exposure to or infection with Hepatitis Virus. Follow CDC recommendations for supplemental testing of positive samples.
(w) Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Edward R. Ashwood, MD - Lab. Director
See also (@x)
(@x) Test performed at: Associated Regional & University Pathologists, Inc.
500 Chipeta Way Salt Lake City, UT 84108

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Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

********** REFERENCE LAB TESTS (continued) **********

Date	7/11/09			
Time	0210		Reference	Units
ANA Abs IgG Screen	(y)		(None Detected	
F-Actin Ab, IgG	3(aa)		(())	Units
Hep C RNA Quant PCR Interp	*Detected(@z)*	*AH*	(Not Detected)	

NOTES: (y) None Detected
If Anti-Nuclear Antibodies (ANA) is NONE DETECTED, the Extractable Nuclear Antigen Antibodies (RNP, Smith, SSA, and SSB) and Double Stranded DNA (dsDNA) Antibody, IgG will not be performed.
TEST INFORMATION: Anti-Nuclear Ab (ANA), IgG
ANA specimens are screened using an ELISA assay. All specimens that screen positive or equivocal are confirmed using HEp-2 cells, and if positive, the titer and pattern will be reported.
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Edward R. Ashwood, MD - Lab. Director
See also (@z)

(@z) Test performed at: Associated Regional & University Pathologists, Inc.
500 Chipeta Way Salt Lake City, UT 84108

(aa) If F-Actin (Smooth Muscle) Antibody, IgG is negative, the Smooth Muscle Antibody titer by IFA is not performed.
REFERENCE INTERVAL: F-Actin Antibody, IgG
19 Units or less ..... Negative
20 - 30 Units ..... Weak Positive-Suggest repeat testing in two to three weeks with fresh specimen.
. 31 Units or greater..... Positive-Suggestive of autoimmune hepatitis or chronic active hepatitis.
F-actin antibodies have been shown to have greater sensitivity and specificity for autoimmune liver disease than anti-smooth muscle antibodies.
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Edward R. Ashwood, MD - Lab. Director
See also (@z)

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Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

********** REFERENCE LAB TESTS (continued) **********

Date / Time	7/11/09 0210	Reference	Units
Hep C RNA Quant	7.1(ab)	(())	log IU
Hep C RNA Qual PCR	Not Done(ad)	(())	

NOTES: (ab) <><>VIRAL LOAD RESULT FOR HCV RNA IS 12,800,000 IU/ML<><>
THE LOG 10 VALUE OF HCV RNA IS 7.1
TEST INFORMATION: Hepatitis C Virus RNA Quantitative
Real-Time PCR(log IU/mL)
The quantitative range of this assay is 2.3 log IU/mL and
greater. Results between 1.9 and 2.3 log IU/mL
(75 to 200 IU/mL) will be reported as "HCV RNA detected
below the limit of quantitation."
An interpretation of "Not Detected" does not rule out the
presence of PCR inhibitors in the patient specimen or
hepatitis C virus RNA concentrations below the level of
detection of the assay. Care should be taken when
interpreting any single viral load determination.
This assay should not be used for blood donor screening,
associated re-entry protocols, or for screening Human
Cell, Tissues and Cellular Tissue-Based Products (HCT/P).
Analyte Specific Reagents (ASR) are used in many
laboratory tests necessary for standard medical care and
generally do not require U.S. Food and Drug Administration
approval. This test was developed and its performance
characteristics determined by ARUP Laboratories, Inc.
It has not been approved by the U.S. Food and Drug
Administration. This test should not be regarded as
investigational or for research use.
See also (@ac)

(@ac)Test performed at: Associated Regional & University Pathologists, Inc.
500 Chipeta Way Salt Lake City, UT 84108

(ad) The Hepatitis C (RNA) Quantitative test has a result
greater than or equal to 1.9 log (75 IU/mL); therefore,
the Hepatitis C (RNA) Qualitative test was not performed.
Result of "Not Done" has been reported.
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Edward R. Ashwood, MD - Lab. Director
See also (@ac)

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Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

********** REFERENCE LAB TESTS (continued) **********

Date / Time	7/11/09 0210		Reference	Units
Alpha Fetalprot, Tumor Marker *50(ae)*		*AH*	(0-15)	ng/mL

NOTES: (ae) TEST INFORMATION: AFP (Tumor Marker)
The Roche Modular E170 AFP method was used. Results obtained with different assay methods or kits cannot be used interchangeably. AFP is a valuable aid in the management of nonseminomatous testicular cancer patients when used in conjunction with information available from the clinical evaluation and other diagnostic procedures. Increased serum AFP concentrations have also been observed in ataxia telangiectasia, hereditary tyrosinemia, primary hepatocellular carcinoma, teratocarcinoma, gastrointestinal tract cancers with and without liver metastases, and in benign hepatic conditions such as acute viral hepatitis, chronic active hepatitis, and cirrhosis. This result cannot be interpreted as absolute evidence of the presence or absence of malignant disease. The result is not interpretable in pregnant females.
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Edward R. Ashwood, MD - Lab. Director
See also (@af)
(@af)Test performed at: Associated Regional & University Pathologists, Inc.
500 Chipeta Way Salt Lake City, UT 84108

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Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

********** MICROBIOLOGY SPECIMEN SUMMARY **********

Col Date	Time	Specimen #	Source	Sp Desc	P/F	Organisms ...
07/13/09	0435	09:BC0005330S	Blood	Cath/Picc	F	<none>
07/13/09	0435	09:BC0005331R	Blood	Periph Stk	F	<none>

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***** FINAL DISCHARGE SUMMARY REPORT - INPATIENT ****

Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

* MICROBIOLOGY CULTURES *

Collection Date: 07/13/09

Specimen: 09:BC0005330S **Collected:** 07/13/09-0435 **Status:** COMP **Req#:** 00701414
Received: 07/13/09-0457 **Source:** Blood **Sp Desc:** Cath/Picc
Subm Dr: MAKSOUD,ALFRED S MD

Ordered: Cult Blood
Comments: Is the patient on antibiotics? Yes
Name of Antimicrobial(s): LEVAQUIN

Procedure	Result	Site
CULTURE RESULT:	OBSERVED IN GRAM OF AERO BOTTLE DATE OF 071409 GRAM POSITIVE COCCI IN CLUSTERS 1 OF 2 SETS DRAWN THAT DAY - POSITIVE. RN TO NTFY DR. CALLED TO RHONDA LOCATED AT 3MED 0800 071409 ISOL FROM THE AER BOTTLE ON DATE 071509 COAG NEG STAPH PROBABLE CONTAMINANT, NOTIFY LAB IF FURTHER WORKUP DESIRED. * NO GROWTH IN ANAEROBIC BLOOD CULTURE BOTTLE AFTER 5 DAYS.	

Specimen: 09:BC0005331R **Collected:** 07/13/09-0435 **Status:** COMP **Req#:** 00701415
Received: 07/13/09-0457 **Source:** Blood **Sp Desc:** Periph Stk
Subm Dr: MAKSOUD,ALFRED S MD

Ordered: Cult Blood
Comments: Is the patient on antibiotics? Yes
Name of Antimicrobial(s): LEVAQUIN

Procedure	Result	Site
	No growth after 5 days	

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Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

Collection Date: 07/13/09

Specimen: 09:BC0005330S **Collected:** 07/13/09-0435 **Status:** COMP **Req#:** 00701414
Received: 07/13/09-0457 **Source:** Blood **Sp Desc:** Cath/Picc
Subm Dr: MAKSOUD,ALFRED S MD

Ordered: Cult Blood
Comments: Is the patient on antibiotics? Yes
Name of Antimicrobial(s): LEVAQUIN

Procedure	Result	Site
	see below for results.	

Specimen: 09:BC0005331R **Collected:** 07/13/09-0435 **Status:** COMP **Req#:** 00701415
Received: 07/13/09-0457 **Source:** Blood **Sp Desc:** Periph Stk
Subm Dr: MAKSOUD,ALFRED S MD

Ordered: Cult Blood
Comments: Is the patient on antibiotics? Yes
Name of Antimicrobial(s): LEVAQUIN

Procedure	Result	Site
	Test not performed	

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Patient: ARMATTA,BETH #AN0710182095 **(Continued)**

********** BLOOD BANK **********

COLLECTED: Jul 15, 2009 4:45am

Blood Type | A Pos

COLLECTED: Jul 15, 2009 4:45am

Antibody Screen | NEGATIVE

********** CANCELLED SPECIMENS **********

0711:C00009T CAN, Coll: 07/11/09-0500 Recd: - (R#00700111) SCHNEIDER,FRANZ E MD
Ordered: Hepatic Panel, Amylase, Lipase, Acute Hep Panel
Comment: COMBINED REQ'S
0711:C00119T CAN, Coll: 07/11/09-0924 Recd: 07/11/09-0931 (R#00700274) MAKSOUD,ALFRED S M
Ordered: CKMB + CK, Troponin I
Comment: NOT ENOUGH SAMPLE TO PERFORM THE TEST. HARD STICK PATIENT.
0715:C00035R CAN, Coll: 07/15/09-0500 Recd: - (R#00703097) SCHNEIDER,FRANZ E MD
Ordered: Basic Panel, Magnesium
Comment: DUPLICATE ORDERS

** END OF REPORT ** ;;

497388

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification

Printed Name: Bein Armair Date of Birth: 10/26/62

Address: [illegible] Kemah, TX 77565

Social Security #: 005-96-3353 Telephone: (832) 655-4969

Information To Be Released – Covering the Periods of Health Care

From (date) 7/10/09 to (date) 7/16/09

Please check type of information to be released:

☒ Clinically Pertinent Information	☐ Diagnosis & treatment codes	☒ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☒ Laboratory test results	☒ X-ray reports	☐ X-ray films / images
☐ Complete billing record	☐ Itemized bill	☐
☐ Other, (specify)		

Purpose of Request
☒ Treatment or consultation
☒ At the request of the patient
☐ Billing or claims payment
☐ Other specify:

Who and Where to Send / Release Information
Name:
Address:

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse and treatment I have been afforded the opportunity to sign a specific authorization.

Initial One: **Yes**_____ **No**_____ **Not Applicable** X

I understand if my medical or billing records contain information in reference to HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment I have been afforded the opportunity to sign a specific authorization.

Initial One: **Yes** _____ **No** _____ **Not Applicable**_____

Paid check $ 24.00 # 1464

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at CHRISTUS St. John Hospital. Unless revoked, this authorization will expire on the following date or event _____ or 180 days from the date of signature.

58 HH 7/28/09

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize CHRISTUS St. John Hospital to release the protected health information specified above.

Signature: [signature] Date: 7/28/09 Time: 9:00pm

Authority to Sign if not patient: _____

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** _____

Verified by: [signature] TXLIC

CHRISTUS. ST. JOHN Hospital

WHITE: Medical Record YELLOW: Patient Form # 0044420 cat#71540 Revised: 03/09

HealthPort.

CHRISTUS
ST JOHN

PATIENT FEE SCHEDULE

The fee schedule for Christus St John and HealthPort is as follows:

1-10 pages FREE)
.50 per page (10+)
Plus postage actual

This fee schedule is in accordance to HEALTH AND SAFETY CODE, CHAPTER 241.

I, the undersigned, understand that there will be a fee involved to obtain my records. I hereby agree that I have been informed of such fees by signing below.

X Beth Armatke

PLEASE NOTE THAT RECORDS ARE NOT MAILED UNTIL PAYMENT IS RECEIVED. ONCE YOU HAVE RECEIVED AN INVOICE YOU MAY MAIL IT IN OR USE A CREDIT CARD. FOR CREDIT CARD PAYMENTS PLEASE CONTACT 800-367-1500.

Charge applies if records are taken with you, otherwise, if we fax to your Doctor there is no Charge.