



PATIENT CARE PLAN

PNEUMONIA

YAEGER, BARBARA A 3N-S
 MR#: 0302579 ADM: 12/25/92 318
 TIBBETTS, J. J. MD 37 REL: LUTP
 AC#: 5589023 DOB: 08/06/55 FC: 7T

Date/Initial

DISCHARGE PLANS
 Home No Assistance Assistance

Signature/Initial

Primary Nurse

1) Skilled Nursing Facility: _____
 2) Rehabilitation Facility: _____
 3) _____
 4) _____

122104000000
 Part 2 of the Epidemiologic Report

Onset Date Initial	Nursing Diagnosis	Expected Outcome	Nursing Intervention	Date Resolved/Initial
12/25/92	1) Ineffective airway clearance R/T accumulation of tracheobronchial secretions	Airway will remain patent. Pt demonstrates expectoration of secretions. Clear airway on auscultation.	1) Encourage coughing and deep breathing. Assist in splinting chest if needed. 2) Assess & document respirations every 4 hr & prn. 3) Elevate HOB & change patient's position every 2 hrs to promote pulmonary drainage. 4) Encourage fluid intake to liquefy secretions further and aid in expectoration. 5) Provide frequent oral care after expectoration. Pt preferences are: <i>Hot + Ice</i> 6) Teach necessity of raising secretions and expectoration versus swallowing. Document patient instruction	12-25-92 KP
12/25/92	2. Impaired gas exchange R/T dyspnea and lung consolidation	Regular respiratory rate, acyanotic. Accessory muscle use is limited or not used. SOB is decreased or does not exist.	1) Auscultate breath sounds every shift & prn. 2) Assess and document respiratory rate, depth, use of accessory muscles, & pursed lip breathing. 3) Check VS every 4 hr & prn. Note patient's color & check for circumoral or nailbed	12-25-92 KP

Onset Date Initial	Nursing Diagnosis	Expected Outcome	Nursing Intervention	Date Resolved/Initial
			<p><u>Cyanosis.</u></p> <p>4) Elevate HOB up to 30° to promote chest expansion.</p> <p>5) Change position every hr. NOTE: If pneumonia is unilateral, position with unaffected side down to improve arterial oxygenation by increasing blood flow to well oxygenated regions of lung.</p> <p>6) Reduce anxiety & exertion by explaining procedures, place necessary items within easy reach and minimize verbalizations.</p>	<p>12-25-92 KR</p>
1/2/95	<p>3. Alteration in comfort R/T <input checked="" type="checkbox"/> Pleuritic pain <input checked="" type="checkbox"/> fever <input checked="" type="checkbox"/> coughing</p>	<p>Relief of pain. Able to cough up secretions</p>	<p>1) Assess and document location, intensity (0 - 10 scale) of pain.</p> <p>2) Assess & document response to analgesics within 1 - 2 hours of administration.</p> <p>3) Teach ways to minimize pain, such as splinting chest & sitting upright when coughing.</p> <p>4) Change damp linen/gown prn.</p> <p>5) Encourage modified bedrest when pt is febrile.</p> <p><i>Shirley Pennington</i></p>	<p>12-25-92 KR</p>
	<p>4. Knowledge deficit R/T disease transmission & etiology</p>	<p>pt. & family will verbalize understanding of disease process, treatment, & prevention</p>	<p>1. Advise to maintain natural resistance with good nutrition, adequate fluid intake & rest.</p> <p>2. Avoid chilling & contact with people with upper respiratory infections.</p> <p>3. Encourage gradual increase in activity</p>	

YAEGER, BARBARA A 3N-9
MR#: 0302579 ADM: 12/25/92 318
TIBBETTS J. J. MD 37 REL: LUTH
AC#: 5589023 DOB: 08/06/55 FC: 7C

PATIENT PROGRESS NOTES

Date	Time	Focus	D A R	D=Data	A=Action	R=Response
12/25	0315	Admission Note	D	37 yr. old female admitted from ER C/O SOB, nausea, chills & cough after using Wilson leather spray. Lungs clear but diminished. C/O SOB & turning off dry cough. O2 on @ 4 l/min. O2 sat 100%. C/O nausea & turning abdomen soft & bowel sounds. (10/10) pale skin warm & dry. Temp 100.8. IV site - asymptomatic. — K. Plummer R		
	0345	comfort diaphragm clearance	D A D A	C/O headache Tympanic Tsp. given C/O tightness in chest RT called to give treatment		
	0400	Resp	R	O2 sat 97%. DOB ↑. Slightly dyspneic @ rest. — K. Plummer R		
	0500	Comfort Temp Resp	D D D	Desires further headache. Temp 99.8. "I'm breathing better" Able to rest. DOB ↑. — K. Plummer R		
12-25-92	0915	Assessment	D:	Pt. is Alert + oriented x3. Skin pale, warm + dry. Lungs clear but diminished. No SOB at rest. Desires cough. O2 remains off. Abd. soft, nontender. BS x4. Desires nausea, headache or chills. No edema noted. IV site patent + asep. K. Plummer R		
	1110	Discharge	A:	IV dr'd. O2 stat monitor dr'd. Discharge instr given. Discharge per fam. — J. Peltier R		

YAEGER, BARBARA A 3N-3
MR#: 0302579 ADM: 12/25/92 318
TIBBETTS J. J. MD 37 REL: LL
AC#: 5589023 DOB: 08/06/55 FC:

NURSING ADMISSION INTERVIEW

Admission Date <i>12/25</i>	Time <i>0315</i>	Vital Signs			Orientation to Room	
Admitted Per <i>car</i>	Room <i>318</i>	T <i>103.8</i>	P <i>100</i>	R <i>24</i>	Instructions in use of siderails <i>L</i>	
Admitted From <i>ER</i>	Accompanied By <i>ER Nurse</i>	Right <i>BP</i>	Left <i>138/76</i>		Bed Operation <i>L</i>	
Admitting Dr. <i>Tibbetts</i>	Family Dr. <i>Tibbetts</i>	Stated/Actual		Stated/Actual		Nurse Call System <i>L</i>
		Last Chest X-ray <i>ER</i>				

MEDICATIONS CURRENTLY TAKING

(PRESCRIPTION AND OVER-THE-COUNTER)

Medication & Dose	Frequency	Last Dose	Medication & Dose	Frequency	Last Dose
<i>Q</i>					

Brought In:

Location Now:

ALLERGY OR SENSITIVITY

Item	Yes	No	List and State Reaction
Drug		<input checked="" type="checkbox"/>	
Food	<input checked="" type="checkbox"/>		<i>nectarines</i>
Other	<input checked="" type="checkbox"/>		<i>ragweed, pollen</i>

NURSING HX ASSESSMENT

RN or LPN Signature _____

HEALTH PERCEPTION — HEALTH MANAGEMENT

Chief Complaint/Reason for Admission:

2000 spray Wilson leather spray
2200 spray again

2030 cough
2230 - Daxson SOB uncontrollable cough - Child

HEALTH HISTORY

Previous Hospitalization/Chronic Conditions/Injuries/Last Physical Examination

8 yrs ago - Fibro cysts
 2 yrs ago - Fibro cysts
 Slight heart murmur

Anesthesia Hx: (malignant Hyperthermia)

Transfusion Hx: (Previous Transfusions/Reactions, Including Febrile Reactions)

NSG DIAGNOSIS

- Health Maintenance Alteratic
- Noncompliance
- Infection Potential for
- Injury Potential For:
 - Poisoning
 - Suffocation
 - Trauma

NUTRITIONAL METABOLIC PATTERN

Special Diet <input checked="" type="checkbox"/>	Difficulty Swallowing <input checked="" type="checkbox"/>
Food Intolerances <input checked="" type="checkbox"/>	Handicaps related to eating <input checked="" type="checkbox"/>
Family Hx Diabetes - Grandmother	Dentures: Upper <input type="checkbox"/> Lower <input type="checkbox"/> Bridge <input type="checkbox"/>
Fad Diets <input checked="" type="checkbox"/>	Dentures Brought In <input checked="" type="checkbox"/>
Appetite good	Last Dental Exam:
Wt. loss or gain <input checked="" type="checkbox"/>	Oral mucous membranes/gums (color, moisture lesions)
Nausea/Vomiting	<input checked="" type="checkbox"/> Residual
24hr recall of food/fluid: - fruit cup - Dean Muffin Coffee green beans unsalted - marshmallows	Skin (color, temp, turgor, lesions, dryness, ecchymosis, other)
Alcoholic Beverages occ	Pale / Warm & Dry

NSG DIAGNOSIS

- Swallowing Impaired
- Nutrition Altered
 - More than Body Require
 - Less than Body Require
- Oral Mucous Memb. Alteratio
- Ineffective Thermoregulation
- Hypothermia
- Hyperthermia
- Tissue Integrity Impaired
- Skin Integrity Impaired

ELIMINATION PATTERN

Bowel	Bladder
Unusual Bowel Pattern 9 Day	Urinary Frequency <input checked="" type="checkbox"/> - Burning <input checked="" type="checkbox"/>
LBM - 12/23 Melena <input checked="" type="checkbox"/>	Incontinence <input checked="" type="checkbox"/> Nocturia <input type="checkbox"/>
Diarrhea/Constipation <input checked="" type="checkbox"/>	Hematuria <input checked="" type="checkbox"/>
Laxatives <input checked="" type="checkbox"/>	Unusual Discharge <input checked="" type="checkbox"/>
Incontinent <input checked="" type="checkbox"/>	Other
Eruptions <input checked="" type="checkbox"/>	Family Hx Kidney Disease or Ca.
Excessive flatus <input checked="" type="checkbox"/>	Grandmother - kidney disease
Abdomen soft	
Bowel Sounds BS x 4	

NSG DIAGNOSIS

- Bowel Elimination Altered
- Constipation
- Diarrhea
- Incontinence
- Urinary Elimination Altered
- Incontinence
- Retention

ACTIVITY EXERCISE

Self Care <input checked="" type="checkbox"/> Assist of One	Leisure Activities
Requires use of Equipment/Devices	
Gait/Falls Hx <input checked="" type="checkbox"/>	Smoking (duration, # pks/day) <input checked="" type="checkbox"/>
Paralysis/Weakness <input checked="" type="checkbox"/>	Smoking regulations explained <input checked="" type="checkbox"/>
	Family Hx Heart or Lung Disease <i>lung - grand father</i>
Amputation/Prosthesis	
Respiratory Rate <i>24</i> Rhythm <i>regular</i>	Pulse Rate <i>107</i> Rhythm <i>regular</i>
Depth <i>normal</i>	Strength <i>strong</i>
Cough <i>yes</i> Sputum <i>0</i>	Palpitations <input checked="" type="checkbox"/>
Orthopnea <input checked="" type="checkbox"/>	Chest Pains <i>yes slight</i>
Dyspnea <i>yes</i>	Edema <input checked="" type="checkbox"/>
Wheezing <input checked="" type="checkbox"/>	Cyanosis <input checked="" type="checkbox"/>
Breath Sounds <i>clear but w</i>	
Other	

NSG DIAGNOSIS

- Activity Intolerance
- Impaired Physical Mobility
- Self-Care Deficit
- Feeding
- Bathing/Hygiene
- Dressing/Grooming
- Toileting
- Injury Potential
- Home Mainten. Manage
- Impaired
- Cardiac Output Decreased
- Airway Clearance Ineffectiv
- Breathing Pattern Ineffectiv
- ~~Gas Exchange Impaired~~
- Fluid Volume
- Excess
- Deficit
- Tissue Perfusion Altered
- (specify)

SLEEP REST PATTERN

Hours/Night - <i>7-8 hrs</i>	Sleep onset problems <i>@ 1/5</i>
Feel rested for daily activities after sleep	Dreams/Nightmares <input checked="" type="checkbox"/>
Sleep Aids (pillows, meds, foods) <i>yes</i>	Early Awakening <input checked="" type="checkbox"/>

NSG DIAGNOSIS

- Sleep Pattern Disturbance

COGNITIVE PERCEPTUAL PATTERN

Orientation <i>X3</i>	Eye Drops <input checked="" type="checkbox"/>
Pupil Reaction	Family Hx Glaucoma <i>- father</i>
Headaches <input checked="" type="checkbox"/> Fainting <input checked="" type="checkbox"/>	Hearing Impaired <input checked="" type="checkbox"/>
Seizures <input checked="" type="checkbox"/>	Hearing Aid <input checked="" type="checkbox"/>
Numbness/tingling <input checked="" type="checkbox"/>	Grasps Ideas <i>well</i>
Hand Grasps <i>equal/strong</i>	Voice/Speech Pattern <i>- clear</i>
Visual Impairment <input checked="" type="checkbox"/>	Attention Span <i>good</i>
Glasses <input checked="" type="checkbox"/> Contacts <input checked="" type="checkbox"/>	Easiest way for you to learn
Glasses or contacts brought in with pt. <input checked="" type="checkbox"/>	
Discomfort/Pain	
Pain Management	
Other	

NSG DIAGNOSIS

- Sensory Perceptual Alteration:
- Visual
- Auditory
- Kinesthetic
- Taste
- Tactile
- Olfactory
- Unilateral Neglect
- Thought Processes Altered
- Knowledge Deficit
- Comfort Altered
- Chronic Pain
- Pain

SEXUALITY REPRODUCTIVE PATTERN

LMP - 2 wks	Duration 5 days	Breast Self Exam
Character	Any Changes/Problems in Sexual Relations (if appropriate)	
Discomfort - yes	Discharge	
Contraceptives		
Last pelvic exam/pap smear - last summer		
Other		

NSG DIAGNOSIS

Sexual Dysfunction
Sexuality Patterns Altered
Rape-Trauma Syndrome

SELF PERCEPTION SELF CONCEPT

Changes in way feel about self or body since illness	Grooming hygiene
	good
Most important aspects of your life are?	Nervous/Relaxed relaxed

NSG DIAGNOSIS

Self Concept Disturbance
Body Image
Self Esteem
Personal Identity
Anxiety
Hopelessness
Powerlessness

ROLE RELATIONSHIPS COPING

Occupation School teacher	Interaction with Family/Friends
Live Alone/with Others husband/kids	Family depends on you for things?
Who's most helpful in talking things over (Significant other)	
What helps you most when you feel afraid or need help?	Family concerns regarding hospitalization?
Other	

NSG DIAGNOSIS

Coping Ineffective
Individual
Family
Social Isolation (Rejection)
Social Interaction Impaired
Family Process Alteration
Parenting Alteration
Fear
Grieving
Violence Potential

VALUE BELIEF PATTERN

Do you belong to a particular religion / faith group? - Catholic
If yes, which church?
Is your faith an important source of strength for you?
How can I help in carrying out your faith? would you like a visit from your pastor or hospital chaplain? (Explain Pastoral Care Services and how to obtain)
Do you have a living will/power of attorney on file? If so, where?
Values/Disposition
Person Supplying Information Patient
Dr. Notified at Time R.N. Signature K. Bluswick

NSG DIAGNOSIS

Spiritual Distress

RISK OF FALLS ASSESSMENT

CHECK CRITERIA WHICH APPLY

Date: 12/25 Time: 0400

GENERAL - Each check = 2 points
History of prior falls

PHYSICAL - Each check = 1 point

- Age over 70 years
Dizziness
Unsteady Gait
Fatigue
Weakness
Impaired Vision
Incontinence

MENTAL STATUS - Each check = 2 points

- Confused/Disoriented
Impaired Memory

MEDICATIONS - Each check = 1 point

- Diuretic
Psychotropic
Anti Hypertensive
Sedative
Narcotic
Tranquilizer
Laxative

MEDICAL DIAGNOSIS - Each check = 1 point

- CVA
Diabetes
Parkinsonism
Amputee
Seizure Disorder
Arthritis
Alzheimer's
CHF
Other

FUNCTIONAL: I.D. = INDEPENDENT = 0 POINTS
P.A. = PARTIAL ASSISTANCE = 1 POINT
T.A. = TOTAL ASSISTANCE = 2 POINTS

6 DRESSING 1 AMBULATING 0 BATH 7 TO BE WITH ASSISTANCE

TOTAL POINTS: 2

ADD POINTS - IF TOTAL IS SEVEN (7) OR MORE ASSIGN TO RISK/FALL PROGRAM

If patient is at risk of falling and does not comply with or understand instructions to call for assistance, use the bed check patient monitor system.

Applied

Not applied: Reason: alert

oriented

Signature: R. Plummer MD

CHECK CRITERIA WHICH APPLY

Date: 12/27 Time: 0400

Reassessment after 48 hours.

GENERAL - Each check = 2 points

- History of prior falls
Hospital stay of five days or more anticipated

PHYSICAL - Each check = 1 point

- Age over 70 years
Dizziness
Unsteady Gait
Fatigue
Weakness
Impaired Vision
Incontinence

MENTAL STATUS - Each check = 2 points

- Confused/Disoriented
Impaired Memory

MEDICATIONS - Each check = 1 point

- Diuretic
Psychotropic
Anti Hypertensive
Sedative
Narcotic
Tranquilizer
Laxative

MEDICAL DIAGNOSIS - Each check = 1 point

- CVA
Diabetes
Parkinsonism
Amputee
Seizure Disorder
Arthritis
Alzheimer's
CHF
Other

FUNCTIONAL: I.D. = INDEPENDENT = 0 POINTS
P.A. = PARTIAL ASSISTANCE = 1 POINT
T.A. = TOTAL ASSISTANCE = 2 POINTS

DRESSING AMBULATING BATH TO BE WITH ASSISTANCE

TOTAL POINTS:

ADD POINTS - IF TOTAL IS SEVEN (7) OR MORE ASSIGN TO RISK/FALL PROGRAM

If patient is at risk of falling and does not comply with or understand instructions to call for assistance, use the bed check patient monitor system.

Applied

Not Applied: Reason:

Signature:

Reassessment after one week.

RISK OF FALL

CHECK CRITERIA WHICH APPLY

Date: _____ Time: _____

GENERAL - Each check = 2 points
_____ History of prior falls

PHYSICAL - Each check = 1 point
_____ Age over 70 years
_____ Dizziness
_____ Unsteady Gait
_____ Fatigue
_____ Weakness
_____ Impaired Vision
_____ Incontinence

MENTAL STATUS - Each check = 2 points
_____ Confused/Disoriented
_____ Impaired Memory

MEDICATIONS - Each check = 1 point
_____ Diuretic
_____ Psychotropic
_____ Anti Hypertensive
_____ Sedative
_____ Narcotic
_____ Tranquilizer
_____ Laxative

MEDICAL DIAGNOSIS - Each check = 1 point
_____ CVA
_____ Diabetes
_____ Parkinsonism
_____ Amputee
_____ Seizure Disorder
_____ Arthritis
_____ Alzheimer's
_____ CHF
_____ Other

FUNCTIONAL: I.D. = INDEPENDENT = 0 POINTS
P.A. = PARTIAL ASSISTANCE = 1 POINT
T.A. = TOTAL ASSISTANCE = 2 POINTS

_____ DRESSING _____ MOBILIZING _____ BATH _____ TO BR WITH ASSISTANCE

TOTAL POINTS: _____

ADD POINTS - IF TOTAL IS SEVEN (7) OR MORE ASSIGN TO RISK/FALL PROGRAM

If patient is at risk of falling and does not comply with or understand instructions to call for assistance, use the bed check patient monitor system.

Applied _____

Not applied: _____ Reason: _____

Signature: _____

DISCHARGE INSTRUCTIONS

YAEGER, BARBARA A 3N-3
 MR#:0302579 ADM:12/25/92 318
 TIBBETTS J. J. MD 37 REL:LL
 AC#:5589023 DOB:08/06/55 FC:

1. Your next appointment with Dr. Tibbets is _____

2. Activity/Care Instructions:

Emergency Room 12/26/92 for CBC, Chest X-Ray.

3. Diet: as tolerated

4. Medications:

Name	Dose	Time you should take it
<u>MAXAIR Inhaler</u>	<u>2 PUFFS</u>	<u>EVERY 4 to 6 hours if needed for wheezing.</u>
<u>prednisone</u>	<u>10mg</u>	<u>TAKE 2 TABLETS Three times A day - with food</u>

5. Patient has:

Discharge medications	Meds from home	All personal belongings
yes <input checked="" type="checkbox"/> no <input type="checkbox"/>	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	yes <input checked="" type="checkbox"/> no <input type="checkbox"/>

I, the undersigned have read and understand the above.

<u>[Signature]</u>	<u>12-25-92</u>	<u>[Signature]</u>	
Signature of Discharge Nurse	Date	Signature of Patient	Date

Green Bay, WI
 REGER, BARBARA A F 37 SERV:EMERGENCY
 I.R.#: 0302379 ADM MO: EMERG
 OCC#A: 3589023 ATT MO: -PATUN, D L MD
 DN: 12/25/92 RACE: W
 OO: 50 REF MD: TIBBETTS J. J. MD

CLINIC: CITY:
 DR: 800 STONEY BROOK LA SSN: 398586783 F/O: 70
 GREEN BAY WI 54304- RELIGION: LUTH LO16
 HOME: 414-499-6143 CHURCH: PILGRIM
 ER CONTACT I: JERRY
 REV NAME: SCHROEDER PHONE: 414-499-6143 REL: HU
 OB: 08/06/35 MS: M WORK: 414-499-3131
 EMPLOYER: VANBOXTEL FORD ER CONTACT II:
 OCCUPATION: TEACHER PHONE:
 INCIDENT DATE: WORK:
 REL:

ADMITTED: SQUAD
 DX: CHEMICAL REACTION

POLICE NOTIFIED HERE
 CORONER NOTIFIED HERE

PHYSICIAN NOTIFIED ANSWERING SERVICE AT HOME RESPONSE ARRIVAL IN THE EMERGENCY CENTER

TETANUS TOXOID /
 CURRENT MEDS none
 ALLERGIES NKDA
 MD EXAM Start

PHYSICIAN'S EXAMINER'S NOTES
 TEMP 100.4 T P 112 R 28 B.P 158/80
 0147 Taken to room 3 per SMT RS. @ 10:50pm/mask
 removed to check vitals. @ 11:00pm, patient
 due @ states she was using Wilson's leather
 protector @ 3pm for 15' and at 9:30pm for 15'
 states she began a slight cough @ 9:30pm
 and developed rhin to lower @ 10pm. Starts
 coughs was a deep inspiration. Rake pour
 AMB. lump & bases bilaterally. cont.
 0148 rna/allergies
 used Wilson's leather protector spray 2 2013
 cont. @ Jennifer hills HA and a...
 0059 @ @ stem inc.
 0103 @ states she feels better @ 10:30
 0200 @ set 9:30 RA. @ 2100 set 10:00 4:30pm/nc
 @ 10:00 @ 12:50 @ 12:50 @ 12:50 @ 12:50
 being stuck kit, 186ampin. St. pepper @ 0150 @
 @ 48 report called to 3rd Floor.

DIAGNOSIS Acute Chemical Pneumonitis = RAD
 TREATMENT Admits - Dr. Tibbets

INSTRUCTIONS X-RAY AND EKG READINGS ARE PRELIMINARY UNTIL LATER REVIEWED. INSTRUCTION SHEET GIVEN

FOLLOW UP WITH DR CONDITION UPON DISCHARGE CONDITION SATISFACTORY FAIR POOR CRITICAL

DISABILITY DURATION

Admit 318 12/25/92 0300 K. K... ATTENDING PHYSICIAN

Yaeger, Barbara
#302579
12-25-92
Dr. Paton

HISTORY OF PRESENT ILLNESS:

This is a 37-year-old woman who presents with complaint of acute dyspnea after spraying a coat with Wilson's Leather Protector aerosol. This is a hydrocarbon-based spray for garment protection. The patient is a nonsmoker. She relates no prior history of bronchospasm. She occasionally has extrinsic allergies. She has no medications and has no preceding infectious symptoms. In fact, the patient's husband, who was briefly exposed to the basement where she was spraying this agent had similar symptoms and so did another youngster.

PHYSICAL EXAMINATION:

Temperature is 100.4 tympanic, 100.8 orally, pulse 112, respirations 28, blood pressure 158/80. The patient appeared ill and was quite uncomfortable. She did volunteer symptoms of bifrontal headache as well as some chills and myalgias in addition to her dyspnea.

HEENT: Her conjunctiva are trace injected without chemosis. ENT examination shows hyperemia and is otherwise normal. There is no stridor or angioedema.

Neck: Supple.

Lungs: She has scattered rhonchi with end-expiratory wheezes on chest auscultation. The wheezing resolved significantly after an Albuterol updraft, however, the rhonchi persisted and a few crackles and mild rales developed later in her ER course. Pulse oximeter was in the low to mid-90s on room air on arrival and with four liters nasal cannula it went up to 99%.

Heart: Tones were regular without rubs or gallops. There was no ectopy.

Abdomen: Soft. There was no peritoneal signs. Bowel sounds are active.

Extremities: She had no peripheral clubbing, cyanosis, or edema.

Chest x-ray was compatible with pneumonitis though the patient was much more comfortable with oxygen administration. She clearly was too ill to be treated as an outpatient. An IV of D5 normal Saline was initiated and a Solu-Medrol bolus given. Her baseline CBC had a white count of 25.1. Hemoglobin is 12.4, platelets are adequate. She had 78% neutrophils, 11% bands. An initial blood gas had a pH of 7.46, PCO2 of 29, PO2 of 34 and a bicarb of 21. This clearly was not arterial and will be repeated. The patient's saturations were again 99% on four liters. She was discussed with Dr. J. Tibbetts and admitted.

IMPRESSION:

Acute chemical pneumonitis with bronchospasm, rule out lipid pneumonia.

DP:ct
D: 12-25-92
T: 12-26-92



SERVICE: GBFD

ID. #: 168

STATION: 6

UNIT: R-6-B RUN #: 210880

Patient Name: BARBERA A. ~~YAEGER~~
 Patient Address: 800 STONY BROOK, GREEN BAY
 City: GREEN BAY Zip:
 Loc. of Pickup: 800 STONY BROOK
 Municipality: GREEN BAY

Requested By: Pt. / 911
 Phone #:
 DOB: 8, 06, 55
 Age: 37 Doctor: TIBBETTS

Name: J STAUGER EMT #: 506
 C HADZIMA 1276
 S WOLFORD 38288
 GBFD E-6
 W REON J MILLER
 J JENSEN, A JENSEN

Milage:
 Military Time:
 Call Rec. 00:3
 End 10-76 00:3
 Begin 10-23 00:3
 Total 10-76 00:4
 10-7 00:4
 10-8 00:5
 ALLERGIES: NKA

LOC: Alert Verbal Pain Unresp. PNB
 Chief Complaint (Mech. of Injury): DYSPNOEA AFTER EXPOSURE TO AN AEROSOL LEADER PROTECTOR. TOTAL EXPOSURE TIME 1/2 -> 3/4 HOURS.
 Home Meds. (Dosage, #/Day): NONE

Past Medical History: HEART MURMUR

PT Assessment: ALERT ORIENTED X3. SKIN NORMAL X3. 1/2 HEAVY SENSATION @ LOWER CHEST WHICH INCREASES WITH INSPIRATION. RELIEF FROM PAIN & RESP. DISTRESS @ O2 ADMIN. LUNGS SOUND CLEAR THROUGHOUT. @ JVA, PERAL EDEMA.

Treatment Rendered (O2, Long Bd., Splints...): Hx, O2, VITALS, TRANSPORT

TIME / EMT #	00:36	EMT #	:	EMT #								
ATROPINE	0.5 1.0		0.5 1.0		0.5 1.0		0.5 1.0		0.5 1.0		0.5 1.0	
O ₂ W												
EPINEPHRINE	0.5 1.0		0.5 1.0		0.5 1.0		0.5 1.0		0.5 1.0		0.5 1.0	
LASIX												
LIDO BOLUS	50 75 100		50 75 100		50 75 100		50 75 100		50 75 100		50 75 100	
LIDO DRIP	2 3 4		2 3 4		2 3 4		2 3 4		2 3 4		2 3 4	
MORPHINE												
NARCAN												
VITROGLYCERIN	0.4		0.4		0.4		0.4		0.4		0.4	
EKG RHYTHM												
PERFUSION?	Y N		Y N		Y N		Y N		Y N		Y N	
BLOOD PRESSURE	124, 78		/		/		/		/		/	
PULSE	114 P		P		P		P		P		P	
RESPIRATIONS	24 R		R		R		R		R		R	
DEFIB JOULES	200 300 M		200 300 M		200 300 M		200 300 M		200 300 M		200 300 M	
OTHER DRUG/PROCEDURE	O ₂ @ 10L NON-REBREATHING MASK.											
PUPILS	NORMAL											

IV Attempts: IV Started?: Y/N By #: Time: Intubated By #: Timer: ET# EG

COMMENTS:
 TA (Without further Orders, Including Loading Time): Min. NO TRANSPORT RELEASE SIGNED: Y/N
 signed: [Signature] EMT #: 506 TIME: 00:58 E. R. Physician: ARON
 EMT In Charge: Chart Review?: Y/N Page of Destination: St. V. St. M. Bellin Other
 08/88 MJM ORIGINAL - Hospital Copy

FEB 26 1993

IDI# 930104CCN0580

Ø952/1646

Addendum to original report:

On this date, Tuesday, 2-16-93 the Milwaukee Resident Post received copies of the medical records pertaining to the treatment of the victim in this complaint.

Attached as Exhibit "B" is a copy of the "Authorization for Medical Records Disclosure" form signed by the victim. Exhibit "C" is the original "Authorization for Release of Name" form signed by the victim, authorizing release of her name in conjunction with this incident. Exhibit "D" are the medical records. This investigation is now completed.

Dennis R. Blasius
Milwaukee Resident Post

Product Code

Exhib - 10

101# 93...

U.S. CONSUMER PRODUCT SAFETY COMMISSION

FEB 26 1993

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO WHOM IT MAY CONCERN:

You are hereby authorized to furnish the United States Consumer Product Safety Commission

all information and copies of any and all records you may have pertaining to (my case)

(the case of BARBARA A. YAEGER
Name

SELF
Relationship to you

including, but not limited to, medical history, physical reports, laboratory reports and pathological slides, and X-ray reports and films.

1/5/93
(Date)

Barbara A. Yaeger
(Signature)

Jerry J. Yaeger
(Witness)

U.S. CONSUMER PRODUCT SAFETY COMMISSION

AUTHORIZATION FOR RELEASE OF NAME

Thank you for assisting us in collecting information on a potential product safety problem. The Consumer Product Safety Commission depends on concerned people to share product safety information with us. We maintain a record of this information, and use it to assist us in identifying and resolving product safety problems.

We routinely forward this information to manufacturers and private labelers to inform them of the involvement of their product in an accident situation. We also give the information to others requesting information about specific products. Manufacturers need the individual's name so that they can obtain additional information on the product or accident situation.

Would you please indicate on the bottom of this page whether you will allow us to disclose your name. If you request that your name remain confidential, we will of course, honor that request. After you have indicated your preference, please sign your name and date the document on the lines provided.

You are hereby authorized to disclose my name and address with the information collected on this case.

My identity is to remain confidential.

(Signature)

(Date)

U.S. CONSUMER PRODUCT SAFETY

Midwestern Regional Office
230 South Dearborn Street
Suite 2944
Chicago, Illinois 60604
(312) 353-8260

930104 ccN0580

January 7, 1993

St. Mary's Hospital
1726 Shawano Avenue
Green Bay, WI. 54303

Att: Medical Records Dept.:

Our Agency is investigating reports of consumers having ill effects from the apparent use of fabric protection treatments. On December 24, 1992 Barbara A. Yaeger, f/w, D.O.B. 8/06/55 was treated at your hospital's emergency room and subsequently admitted to the hospital after using such a product.

Enclosed is a signed medical records release form. Please send a complete copy of this patient's medical records to the following office:

U.S. Consumer Product Safety Commission
Milwaukee Resident Post
310 W. Wisconsin Avenue
Box 244
Milwaukee, WI. 53203

Att: Investigator Dennis Blasius

The U.S. Consumer Product Safety Commission is an investigative agency of the federal government; please send an invoice for payment with the requested records, and it will be immediately honored. If this is not satisfactory, please call our office immediately at (414) 297-1468 so that other arrangements can be made.

Thank you for your prompt response.

Sincerely,

Dennis R. Blasius
Investigator



United States Government
Consumer Product Safety
Commission

DENNIS R. BLASIUS
Investigator

Milwaukee Resident Post
310 W. Wisconsin Ave.
Post Box 244
Milwaukee, WI 53203
(414) 297-1468

Chicago Regional Office
230 S. Dearborn St.
Room 2944
Chicago, IL 60604
(312) 353-8260

C
P
S
C

3N-S - 1179
12/25/92 03:06

ST MARYS MEDICAL CENTER GREEN BAY
(GBP:PF)

YAEGER, BARBARA A F 37 SERV: MEDICAL
M.R.#: 0302579 ADM MD: TIBBETTS J. J. M 3N-S
ACCT#: 5589023 ATT MD: TIBBETTS J. J. M 318
ADM: 12/25/92 RACE: W
00:50 REF MD: TIBBETTS J. J. M

11

REF CLINIC: CITY: ADMISSION/DISCHARGE RECORD

CLK: DJW
ADDR: 800 STONEY BROOK LA
GREEN BAY WI 54304- SSN: 398586783 F/C: 70
PHONE: 414-499-6143 CO: BRN RELIGION: LUTH
PREV NAME: SCHROEDER CHURCH: PILGRIM
DOB: 08/06/55 MS: M PARISH CODE: LD16

EMPLOYER: FREEDOM SCHOOLS ER CONTACT I: JERRY
OCCUPATION: TEACHER PHONE: 414-499-6143 REL: HU
WORK: 414-499-3131
ACCIDENT DATE: ER CONTACT II:
CAUSE: PHONE: REL:
HOW ADMITTED: SQUAD WORK:

ADM DX: INHALATION PNEUMONITIS CHEMICAL PNEUMONIA
LTR NOTE:

=====PHYSICIAN'S REPORT=====

DISCHARGE DATE AND TIME: *12-25-92*

EXPIRED DATE AND TIME: *-H*

AUTOPSY? YES NO

PRINCIPLE DIAGNOSIS: *Acute bacterial pneumonia & bronchopneumonia*

SECONDARY DIAGNOSIS:

COMPLICATIONS:

PROCEDURES: *medical*

12/25/92
11:30 AM
12/25/92

FR ABC

[Signature]

-----, MD
ATTENDING PHYSICIAN



St. Mary's
Hospital
Medical Center

YAEGER, BARBARA A
MR#:0302579 ADM:12/25/92 EMERG
-PATON, D L MD 37 REL:LUTH
AC#:5589023 DOB:08/06/55 FC:70

1. **INFORMED CONSENT FOR MEDICAL TREATMENT**

I understand that I have a health problem which requires diagnosis and treatment. I voluntarily consent to such diagnostic procedures, medical care and/or emergency treatment ordered by the physician providing services to me which, in his or her opinion, are necessary to treat my health problem. I realize that the physician(s) attending me in the hospital direct my care and are responsible for discussing with me the nature of the care and treatment I will receive. I recognize that the physician(s) providing services to me in the hospital are independent contractors and not employees or agents of the hospital. I understand that the hospital is not liable for any act or omission when following the instructions of such physicians. No guarantees have been made to me as to the results of examinations or treatments provided to me in the hospital.

2. **INSPECTION OF HEALTH CARE RECORDS**

Upon submitting a statement of informed consent to release of confidential medical information, you or a person authorized by you may:

- a. Inspect your health care records in the medical record department during regular business hours 8:30AM - 4:30PM/Weekdays) with 24 hour advance notification.
- b. Receive a copy of your health care records upon payment of reasonable costs.
- c. Receive a copy of your x-ray reports or have your x-rays referred to another health care facility of your choice upon payment of reasonable costs.

3. **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I authorize St. Mary's Hospital Medical Center to disclose diagnostic and treatment information to any person or corporation which is liable under a contract to the hospital or to me or a family member or my employer for all or part of the hospital's charge in rendering care including, but not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, my employer or any public agency. I understand that should any additional information or copies of the record be required, I will be provided a consent form to authorize such release unless such release is required/permitted by State statute. If I am a member of a health insurance plan that requires approval of my hospitalization, the information released may also include the diagnosis, treatment plan and status of my condition, whether it be in writing or verbally, to determine the need for admission and/or continued stay.

4. ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT AGREEMENT

I authorize payment directly to St. Mary's Hospital Medical Center and to attending physicians and specialists all benefits otherwise payable to me for this hospital stay. If the insurance company or companies does not make payment within 60 days of discharge or pays less than the amount allowed, I will make immediate payment of the balance due on this account. I understand that I am financially responsible to the hospital for any charges not covered by my insurance. I agree that in consideration of the services to be rendered to me, I am responsible to pay the account of the hospital in full.

5. PATIENT VALUABLES

I understand that the hospital maintains a safe for storage of patient valuables such as money, jewelry, documents or other articles of value during hospitalization. I agree that the hospital does not assume liability for any loss or damage to valuables not deposited in the safe.

_____ PT WILL KEEP VALUABLES _____ DEPOSITED IN HOSPITAL SAFE

_____ GIVEN TO RELATIVE: _____
(Name)

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ THE FOREGOING AND IS COMPETENT TO EXECUTE IT OR AUTHORIZED TO EXECUTE IT ON THE BEHALF OF THE PATIENT.

(Patient's Signature)

Janet L. Young

(Person legally authorized to sign on patient's behalf and their relationship to the patient)

DW _____ *12-25-96*
(Witness) (Date)

Yaeger, Barbara
#302579
12/25/92
1 Day
Dr. Tibbetts

CHIEF COMPLAINT:

Cough, shortness of breath, and trouble breathing.

HISTORY OF PRESENT ILLNESS:

This patient is a 37-year-old white married female, gravida 2, para 2, AB 0 who has been in essentially good health until the day of admission. The patient was spraying a new leather jacket with a product known as Wilson's Leather Protector which is in an aerosol can containing no fluorocarbons but apparently containing, per label, petroleum distillates. No caution warning or specific use other than holding the can eight inches from the product are included on the can or reportedly on the cap or associated with other use other than the salesclerk having told Barb to use this in a ventilated area. She sprayed the jacket at approximately 8:30 last evening, 12/24. Subsequent to this, she felt a little fullness in her throat but no other symptoms. She gave a second spraying approximately an hour to 1 1/2 hours later and subsequently felt progressive fullness and tightness in the throat, cough, shortness of breath, and wheezing. This progressed over the next several hours to the point the patient was unable to breath in any comfortable fashion, and she was brought to the ER for assessment. She was seen and evaluated by ER personnel with shortness of breath, blood gases showing an O2 sat of 70 on room, pH was 7.46, PCO2 29, total CO2 22, PO2 34, and base HCO3 was 21. All of these values, of course, are quite markedly abnormal with a markedly diminished O2 sat and PO2. She was treated in the ER with updraft and oxygen. Labs and x-ray were obtained. She was subsequently admitted to the floor for further assessment and treatment which included updraft with Albuterol and oxygen per nasal cannula as well as oral Prednisone. She did receive Solu-Medrol IV in the ER.

The patient has no history of intrinsic asthma though she does have hay fever and some seasonal allergies which are typified by nasal congestion, burning eyes, but no pulmonary symptoms. She does have a brother and a nephew both of whom have asthma. She takes an occasional Bromfed but is otherwise been in good health with the exception of a recent right maxillary frontal sinusitis which has responded to Ceclor. She did have an episode of some subscleral spontaneous hemorrhage O.D. approximately two weeks ago and this has completely resolved.

PAST MEDICAL HISTORY:

Unremarkable except as outlined above. The patient is on no medications other than occasional Bromfed as noted. She has no drug allergies.

FAMILY HISTORY:

Noncontributory except as outlined above.

SOCIAL HISTORY:

Noncontributory except as outlined above.

REVIEW OF SYSTEMS:

Noncontributory except as outlined above.

PHYSICAL EXAMINATION:

Approximately seven hours after admission reveals a well-developed, well-nourished, slightly pale-appearing 37-year-old white female who is in no acute distress. Vital signs are as per nurse's notes. Skin is warm and moist. Lymphatics: Unremarkable.

Yaeger, Barbara
#302579
Page 2
Dr. Tibbetts

HEENT: Within normal limits. Pupils are equal and reactive to light and accommodation. Extraocular motion is full. Disks and grounds are normal. Ears are unremarkable. Mouth and throat is unremarkable.
Neck: Supple, freely movable. Thyroid is normal. No cervical bruits are heard.
Chest: The cage is symmetrical with good excursion.
Lungs: Clear to auscultation and percussion. There are no rales, rhonchi, or wheezes noted on pulmonary exam at this time.
Heart: Normal sinus rhythm without thrill or murmur.
Breasts: Reveal some generalized fiber nodularity. The patient is premenstrual. They are tender. She has increased findings on the left vs the right. No discrete nodules are palpable.
Abdomen: Soft and supple. Bowel sounds are normoactive. No masses, megaly, or tenderness is noted.
Back and Extremities: Unremarkable.
Neurologic: Physiologic.
Pelvic: Deferred.

Review of patient's chest x-ray shows no significant abnormality although slight infiltrate in the left base may be present.

INITIAL IMPRESSION:

Acute bronchospasm with reactive asthma secondary to undetermined chemical exposure from the product noted above. Rule out progressive chemical pneumonitis.

DISPOSITION:

The patient will be allowed to ambulate. She is anxious to be discharged as this is Christmas Day and spend time with her family. This judgement will be based upon her ability to function. She does have some discomfort with sitting upright with some mid substernal discomfort with positional change and deep breathing. Consideration of continuing outpatient treatment with an Alupent inhaler and Prednisone 10 mg tablets 2 t.i.d. with food will be entertained. If she is to be discharged, she will be seen in 24 hours at which time she will be clinically re-evaluated as well as have both a CBC and a chest x-ray. This disposition is yet to be determined based on the patient's clinical state.

JT:pg
D: 12/25/92
T: 12/25/92

MAR 2 1993

CONSUMER PRODUCT INCIDENT REPORT

1. NAME OF RESPONDENT Siponda Washington TELEPHONE NO. (Home) (510) 814-0287 (Work) _____

3. STREET ADDRESS 1509 Morton St, Apt. E 4. CITY Alameda STATE CA ZIP CODE 94501

5. DESCRIBE ACCIDENT SITUATION OR HAZARD, INCLUDING DATA ON INJURIES. (Use second page if necessary.)
 After spraying leather jacket with Wilson's Suede and Leather protection spray, Siponda Washin developed inflammations to the skin and blotches on the leg. She went to the emergency room and her doctor prescribed anti-biotics, ^{she also uses} Cocoa oil skin lotion. Her son also kept getting headaches. The manufacturer called to advise her to get rid of the can and to send the coat to the cleaners.

6. DATE OF INCIDENT(S) ~12-15-92 7. IF INJURY OR NEAR MISS, OBTAIN AGE 30 SEX F AND DESCRIBE INJURY skin inflammation, blotches on leg. 8. IF VICTIM DIFFERENT FROM RESPONDENT, PROVIDE NAME La. Van Washington (9 years old) RELATIONSHIP Son (headaches)

9. DESCRIPTION OF PRODUCT leather protection spray 10. BRAND NAME Wilson's Suede and Leather

11. MANUFACTURER/DISTRIBUTOR NAME, ADDRESS & PHONE
 main hdqtrs:
Wilson's Suede and Leather
400 Highway, 169 South, Ste. 600
Minneapolis, MN 55426
(612) 541-3309 or [couldn't read last 3 digits] phone digit

12. MODEL, SERIAL NO.'S ? 91492 (printed on bottom of can)
 13. DEALER'S NAME, ADDRESS & PHONE
Wilson's Suede and Leather
Market St.
SF. CA

14. WAS THE PRODUCT DAMAGED, REPAIRED OR MODIFIED?
 YES _____ NO IF YES, BEFORE OR AFTER THE INCIDENT? _____
 Describe _____

15. PRODUCT PURCHASED NEW USED _____
 DATE PURCHASED Dec. 1, 92 AGE _____

16. DOES PRODUCT HAVE WARNING LABELS?
 IF SO, NOTE: avoid breathing vapor or spray mist. avoid contact with skin or eyes. keep away from heat

17. HAVE YOU CONTACTED THE MANUFACTURER?
 YES NO _____ IF NOT, DO YOU PLAN TO CONTACT THEM? YES _____ NO _____ OTHER _____

18. IS THE PRODUCT STILL AVAILABLE?
 YES NO _____ IF NOT, ITS DISPOSITION _____

19. MAY WE USE YOUR NAME WITH THIS REPORT?
 YES NO _____

FOR ADMINISTRATION USE

20. DATE RECEIVED 2-23-93 21. RECEIVED BY (Name & Office) LP / SFRO 22. DOCUMENT NO. F320240

23. FOLLOW-UP ACTION None 24. PRODUCT CODE(S) _____

25. DISTRIBUTION C. [unclear] cc SFRO 26. ENDORSER'S NAME & TITLE [unclear] [unclear]

RADLG-1728
12/26/92 09:54

ST MARYS MEDICAL CENTER GREEN BAY
(QAIPRR)

PAGE 001

YAEGER, BARBARA A	F 37 DISCH MEDICAL	PRELIMINARY
M.R.#: 0302579	ADM MD: TIBBETTS J. J. MD	RADIOLOGY
ACCT#: 5589023	ATT MD: TIBBETTS J. J. MD	RESULTS
ADM: 12/25/92 00:50	RACE: W	REG#: I-360-002
DOB: 08/06/55	REF MD: TIBBETTS J. J. MD	

REFERRING CLINIC: REF MD ADDR:
CONSULTANTS:

DX: INHALATION PNEUMONITISCHEMICAL PNEUMONIA

ORDER: CHEST, PA & LAT (ROUTINE) 2.01

PRELIMINARY REPORT

FILE #: 206-693

DATE OF EXAM: 12/25/92

CHEST WITH LATERAL:

THERE IS INCREASED INTERSTITIAL MARKINGS AT BOTH BASES LEFT GREATER THAN RIGHT. THERE IS NO EVIDENCE OF PLEURAL EFFUSION OR PNEUMOTHORAX. THE CARDIAC AND MEDIASTINAL SILHOUETTES ALSO ARE WITHIN NORMAL LIMITS.

IMPRESSION:

INCREASED INTERSTITIAL MARKINGS AT THE BASES LEFT GREATER THAN RIGHT PROBABLY INFLAMMATORY IN ETIOLOGY.

CW



HF

LASTPAGE

FINAL COPY

CALL REPORT

FAGER, BARBARA A F 37 DISCH MEDICAL *****
M.R.#: 0302579 ADM MD: TIBBETTS J. J. MD 3N-3 TEST RESULTS SUMMARY
ACCT#: 5589023 ATT MD: TIBBETTS J. J. MD 318 *****
ADM: 12/25/92 00:50 RACE:W
DOB: 03/06/35 REF MD: TIBBETTS J. J. MD

REFERRING CLINIC: REF MD ADDR:
CONSULTANTS:

REPORT PERIOD: 00:50 12/25/92 - 00:00 12/26/92

* = NEW RESULT H = HIGH RESULT L = LOW RESULT
O = ORIGINAL RESULT M = MODIFIED RESULT

BLOOD COUNTS

TEST	12/25	02:10	RANGE/UNITS
WBC	25.1	H*	3.0-10.5 K/UL
RBC	4.67	*	3.7-5.2 MIL/UL
HGB	12.4	*	11.8-15.8 GM/DL
HCT	37.4	*	35-46 %
MCV	81.0	*	80-98 CU U
MCH	24.8	L*	27-34 UUG
MCHC	33.2	*	32-36 %
RDW	38.3	*	35-47 CU U
MFV	10.1	*	CU U
PLT CT	403	*	140-440 K/UL
BAND	11	*	%
NEUT	78	*	%
LYMPH	5	*	%
MONO	6	*	%
TECH HEM	LK	*	
TECH DIFF	LK	*	

JAEGER, BARBARA A F 37
MR#: 0802579 ACD#: 3889023
SERV: MEDI SN-S 318
MD: FISBERTS, J. J. MD ADM: 12/25/92
DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA

STAT * * * * *
* * * * *
* * * * *
* * * * *

DISCHARGE REPORT

SUMMARY: 12/25 00:00 TO 00:00 12/26

NEW ORDERS ENTERED FOR THE DAY:

12/25/92 01:04

- 1. RESPIRATORY THERAPY UPDRAFT NEBULIZER.
ALBUTEROL: STAT, (531).

ENTERED BY: HERBERT KRISTIN RNNUR WRITTEN ORDER
ENTERED FOR: -PATON, D L MD

12/25/92 01:04

- 2. X-RAY: CHEST, PA & LAT (ROUTINE) SCHEDULING: STAT, ED ROOM 03,
(531).

ENTERED BY: HERBERT KRISTIN RNNUR WRITTEN ORDER
ENTERED FOR: -PATON, D L MD

12/25/92 01:57

- 3. BLOOD GASES/PATIENT ON OXYGEN: LITER 4L, STAT, (531).
- 4. CBC, STAT, (531).

ENTERED BY: HERBERT KRISTIN RNNUR WRITTEN ORDER
ENTERED FOR: -PATON, D L MD

12/25/92 03:30

- 5. ACTIVITIES, UP, AS TOL, (TAB).
- 6. DIET: GENERAL, (TAB).
- 7. RESPIRATORY THERAPY NASAL CANNULA.
O2 FLOW AT 4 LPM--TO KEEP O2 SAT > 95%, (TAB).
- 8. RESPIRATORY THERAPY OXYGEN SAT % PULSE OXIMETER, CONTINUOUS
SAT% MONITOR, (TAB).
- 9. RESPIRATORY THERAPY UPDRAFT NEBULIZER.
ALBUTEROL --Q 3-4 PRN, OTHER--WHEEZING, (TAB).
- 10. PREDNISONE 20MG TAB, #1, PO, BID 8-17 MEALS --(GIVE WITH FOOD),
(12/25/92 0800-..), (TAB).
- 11. IV LINE #1- START D57.9% NS 100UML, RATE:125ML/H, CONT TIL DO'D
, (TAB).
- 12. TYLENOL ACETAMINOPHEN 325MG TAB, #2, PO, Q4H PRN--FOR PO TEMP >
101, (TAB).

ENTERED BY: KRAWITZER LINDA NUR PHONE ORDER

CONTINUED

12/26/92 08:01

(QAKFRG)

PAGE 001

FAEGEN, BARBARA A

F 07

MR#: 080277

ADCT#: 0889023

SERV: MEDI

SN-S 018

MD: TIBBETS J. J. MD ADM: 12/25/92

DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA

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

DISCHARGE REPORT

SUMMARY: 12/25 00:00 TO 00:00 12/26

ENTERED FOR: TIBBETS J. J. MD

SIGNED

SIGNATURE:-----

12/25/92 10:32

13. DISCHARGE PATIENT TODAY.

TO: HOME, (T)...

14. MAXAIR PIRBUTEROL ACETATE INHALER AEROSOL 25.6 GM TAKE HOME, 1 CONTAINER, TWO INHALATIONS EVERY 4 TO 6 HOURS IF NEEDED-- WHEEZING, (T)...

15. PREDNISONE 10MG TAB, TAKE HOME, #10, TAKE 2 TABLETS THREE TIMES A DAY--WITH FOOD, (T)...

ENTERED BY: MORELLO DIANE

NRN

WRITTEN ORDER

ENTERED FOR: TICKENS T. N. DRN

12/25/92 10:43

16. (DELETE) MAXAIR PIRBUTEROL ACETATE INHALER AEROSOL 25.6 GM TAKE HOME, 1 CONTAINER, TWO INHALATIONS EVERY 4 TO 6 HOURS IF NEEDED-- WHEEZING, (T)...: WRONG DOCTOR

17. (DELETE) PREDNISONE 10MG TAB, TAKE HOME, #10, TAKE 2 TABLETS THREE TIMES A DAY--WITH FOOD, (T)...: WRONG DOCTOR

ENTERED BY: MORELLO DIANE

NRN

ADJUSTING ORDERS

12/25/92 10:44

18. (DELETE) DISCHARGE PATIENT TODAY.

TO: HOME, (T)...: WRONG DOCTOR

ENTERED BY: MORELLO DIANE

NRN

ADJUSTING ORDERS

CONTINUED

12/26/92 08:01

(QAXPRG)

PAGE 000

YAEGER, BARBARA A F 37
MR#: 0302379 ACCT#: 5589013
SERV: MEDI SN-S 318
RD: TIBBETTS J. J. MD ADM: 12/25/92
DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA

SDI SDI SDI
X X X X X
X X X X X
X X X X X
SDI SDI SDI SDI

DISCHARGE REPORT

SUMMARY: 12/25 00:00 TO 00:00 12/26

12/25/92 10:46

- 19. DISCHARGE PATIENT TODAY.
TO: HOME, (TAB).
- 20. MAXAIR FIBROTROL ACETATE INHALER AEROSOL 25.6 GM TAKE HOME, 1
CONTAINER, TWO INHALATIONS EVERY 4 TO 6 HOURS IF NEEDED--
WHEEZING, (TAB).
- 21. PREDNISONE 10MG TAB, TAKE HOME, #10, TAKE 2 TABLETS THREE
TIMES A DAY--WITH FOOD, (TAB).

ENTERED BY: MORELLO DIANE NUR WRITTEN ORDER
ENTERED FOR: TIBBETTS J. J. MD

THERE WERE NO ORDERS HELD TODAY

NO ORDERS WERE COUNTERSIGNED TODAY

--COMPLETED ORDERS FOR THE DAY--

COMPLETED BY: ADAMS KIM RT KS
01:42 12/25/92

(ORD COMPLETE) RESPIRATORY THERAPY UPDRAFT NEBULIZER,
ALBUTEROL: 3AT, (531).

COMPLETED BY: WALTERS, SHARRE ARES BWA
12:02 12/25/92

(ORD COMPLETE) RESPIRATORY THERAPY NASAL CANNULA,
O2 FLOW AT 4 LPM--TO KEEP O2 SAT > 95%, (TAB).
(ORD COMPLETE) RESPIRATORY THERAPY OXYGEN SAT % PULSE OXIMETER,
CONTINUOUS SAT% MONITOR, (TAB).
(ORD COMPLETE) RESPIRATORY THERAPY UPDRAFT NEBULIZER,
ALBUTEROL --3 3-4 PRN, OTHER--WHEEZING, (TAB).

LASTPAGE

CLINICAL PROFILE

NIGHT

DATE 12/25/92

DAY

-02
YAEGER, BARBARA A SN: 0
MR#: 0302579 ADM: 12/25/92 318
TIBBETTS J. J. MD 37 REL: LHM
AC#: 5589023 DOB: 08/06/55 FC: 1

EVENING

DIET	BREAKFAST	LUNCH	SUPPER	
	G F P	G F P	G F P	
	<input type="checkbox"/> Self	<input type="checkbox"/> Assist	<input type="checkbox"/> Feed	
HYGIENE	Bath	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete	<input type="checkbox"/> Shave <input type="checkbox"/> Tub <input type="checkbox"/> Shower	
	Mouth Care			
	Skin Care			
	Peri Care	<input type="checkbox"/> Shampoo		
	Sleep	<input type="checkbox"/> Good <input checked="" type="checkbox"/> Poor <input type="checkbox"/> Intervals		
ACTIVITY	Bedrest Turn	<u>self</u>		
	CDB	<u>enc</u>	Suction	
	BRP	<input type="checkbox"/> Commode <input type="checkbox"/> Sev. Toilet		
	Assist	<input type="checkbox"/> Unnal <input type="checkbox"/> Bedpan		
	Up In	<input type="checkbox"/> Self <input type="checkbox"/> Hoyer		
	Chair	With help (1, 2, 3)	Length of time	Tolerance G F P
	Up In	<input type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2)		
	Hall	Tolerance G F P	Distance	
	Linen Change #	<input type="checkbox"/> Complex Linen		
	SAFETY	Call Bell in Reach	Side Rails <u>2/2</u>	
Vest Restraint		<input checked="" type="checkbox"/> Bed Low Position		
Restraints		<input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> All		
Soft <input type="checkbox"/> Leather		<input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> CMT		
Bed Check System		<input type="checkbox"/> Isolation Type		
EQUIP / PREVENTION	Elastic Hose	<input type="checkbox"/> Knee <input type="checkbox"/> Thigh		
	Pneumatic Stockings			
	Air Mattress	<input type="checkbox"/> Egg Crate		
	Therapeutic Bed			
	Aqua K	<input type="checkbox"/> Sitz		
	Ice			
	Room Deodorizer	<input type="checkbox"/> Trapeze		
MISC.	BM			
	1:1 Nrsng	hours		
	Assat monitor			
	Care Plan - Review Initials	<u>AD</u>		
	Initials - Responsible RN	<u>AD</u>		

DIET	BREAKFAST	LUNCH	SUPPER	
	G F P	G F P	G F P	
	<input checked="" type="checkbox"/> Self	<input type="checkbox"/> Assist	<input type="checkbox"/> Feed	
HYGIENE	Bath	<input checked="" type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete	<input type="checkbox"/> Shave <input type="checkbox"/> Tub <input checked="" type="checkbox"/> Shower	
	Mouth Care	<u>self</u>		
	Skin Care	<u>self</u>		
	Peri Care	<u>self</u>		
	Sleep	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input checked="" type="checkbox"/> Intervals		
ACTIVITY	Bedrest Turn	<u>self</u>		
	CDB	<u>enc</u>	Suction	
	BRP	<input type="checkbox"/> Commode <input type="checkbox"/> Sev. Toilet		
	Assist	<u>self</u> <input type="checkbox"/> Unnal <input type="checkbox"/> Bedpan		
	Up In	<input checked="" type="checkbox"/> Self <input type="checkbox"/> Hoyer		
	Chair	With help (1, 2, 3)	Length of time	Tolerance <u>PRN</u> G F P
	Up In	<input checked="" type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2)		
	Hall	Tolerance <u>G</u> F P	Distance <u>to Shower</u>	
	Linen Change #	<input type="checkbox"/> Complex Linen		
	SAFETY	Call Bell in Reach	Side Rails <u>2/2</u>	
Vest Restraint		<input checked="" type="checkbox"/> Bed Low Position		
Restraints		<input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> All		
Soft <input type="checkbox"/> Leather		<input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> CMT		
Bed Check System		<input type="checkbox"/> Isolation Type		
EQUIP / PREVENTION	Elastic Hose	<input type="checkbox"/> Knee <input type="checkbox"/> Thigh		
	Pneumatic Stockings			
	Air Mattress	<input type="checkbox"/> Egg Crate		
	Therapeutic Bed			
	Aqua K	<input type="checkbox"/> Sitz		
	Ice			
	Room Deodorizer	<input type="checkbox"/> Trapeze		
MISC.	BM	<u>0</u>		
	1:1 Nrsng	hours		
	Emotional support	<u>Completed but needs deuter</u>		
	Care Plan - Review Initials	<u>KP</u>		
	Initials - Responsible RN	<u>KP</u>		

DIET	BREAKFAST	LUNCH	SUPPER	
	G F P	G F P	G F P	
	<input type="checkbox"/> Self	<input type="checkbox"/> Assist	<input type="checkbox"/> Feed	
HYGIENE	Bath	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete	<input type="checkbox"/> Shave <input type="checkbox"/> Tub <input type="checkbox"/> Shower	
	Mouth Care			
	Skin Care			
	Peri Care	<input type="checkbox"/> Shampoo		
	Sleep	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Intervals		
ACTIVITY	Bedrest Turn			
	CDB			
	BRP	<input type="checkbox"/> Commode <input type="checkbox"/> Sev. Toilet		
	Assist	<input type="checkbox"/> Unnal <input type="checkbox"/> Bedpan		
	Up In	<input type="checkbox"/> Self <input type="checkbox"/> Hoyer		
	Chair	With help (1, 2, 3)	Length of time	Tolerance G F P
	Up In	<input type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2)		
	Hall	Tolerance G F P	Distance	
	Linen Change #	<input type="checkbox"/> Complex Linen		
	SAFETY	Call Bell in Reach	Side Rails	
Vest Restraint		<input type="checkbox"/> Bed Low Position		
Restraints		<input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> All		
Soft <input type="checkbox"/> Leather		<input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> CMT		
Bed Check System		<input type="checkbox"/> Isolation Type		
EQUIP / PREVENTION	Elastic Hose	<input type="checkbox"/> Knee <input type="checkbox"/> Thigh		
	Pneumatic Stockings			
	Air Mattress	<input type="checkbox"/> Egg Crate		
	Therapeutic Bed			
	Aqua K	<input type="checkbox"/> Sitz		
	Ice			
	Room Deodorizer	<input type="checkbox"/> Trapeze		
MISC.	BM			
	1:1 Nrsng	hours		
	Care Plan - Review Initials			
	Initials - Responsible RN			
	Initials - Care Provider			

DATE _____ DAY _____

NIGHT

DAY

EVENING

DIET	BREAKFAST	LUNCH	SUPPER
	G F P	G F P	G F P
	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Feed		
HYGIENE	Bath	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete <input type="checkbox"/> Shave <input type="checkbox"/> Tub <input type="checkbox"/> Shower	
	Mouth Care	_____	
	Skin Care	_____	
ACTIVITY	<input type="checkbox"/> Peri Care <input type="checkbox"/> Shampoo		
	Sleep	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Intervals	
	<input type="checkbox"/> Bedrest Turn _____		
	CDB _____ Suction _____		
	<input type="checkbox"/> BRP <input type="checkbox"/> Commode <input type="checkbox"/> Elev. Toilet		
	Assist _____ <input type="checkbox"/> Urinal <input type="checkbox"/> Bedpan		
	Up In Chair	<input type="checkbox"/> Self <input type="checkbox"/> Hoyer With help (1, 2, 3) Length of time _____ Tolerance G F P	
	Up In Hall	<input type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2.) Tolerance G F P Distance _____	
	<input type="checkbox"/> Linen Change # _____ <input type="checkbox"/> Complex Linen		
	SAFETY	<input type="checkbox"/> Call Bell in Reach Side Rails _____	
<input type="checkbox"/> Vest Restraint <input type="checkbox"/> Bed Low Position			
Restraints		<input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> All <input type="checkbox"/> Soft <input type="checkbox"/> Leather <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> CMT	
<input type="checkbox"/> Bed Check System			
<input type="checkbox"/> Isolation Type _____			
EQUIP / PREVENTION	Elastic Hose	<input type="checkbox"/> Knee <input type="checkbox"/> Thigh	
	<input type="checkbox"/> Pneumatic Stockings		
	<input type="checkbox"/> Air Mattress <input type="checkbox"/> Egg Crate		
	<input type="checkbox"/> Therapeutic Bed _____		
	<input type="checkbox"/> Aqua K _____ <input type="checkbox"/> Sitz		
	<input type="checkbox"/> Ice _____		
	<input type="checkbox"/> Room Deodorizer <input type="checkbox"/> Trapeze		
MISC.	<input type="checkbox"/> BM _____		
	<input type="checkbox"/> 1:1 Nrsng _____ hours		
	Care Plan - Review Initials		
Initials - Responsible RN			
Initials - Care Provider			

DIET	BREAKFAST	LUNCH	SUPPER
	G F P	G F P	G F P
	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Feed		
HYGIENE	Bath	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete <input type="checkbox"/> Shave <input type="checkbox"/> Tub <input type="checkbox"/> Shower	
	Mouth Care	_____	
	Skin Care	_____	
ACTIVITY	<input type="checkbox"/> Peri Care <input type="checkbox"/> Shampoo		
	Sleep	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Intervals	
	<input type="checkbox"/> Bedrest Turn _____		
	CDB _____ Suction _____		
	<input type="checkbox"/> BRP <input type="checkbox"/> Commode <input type="checkbox"/> Elev. Toilet		
	Assist _____ <input type="checkbox"/> Urinal <input type="checkbox"/> Bedpan		
	Up In Chair	<input type="checkbox"/> Self <input type="checkbox"/> Hoyer With help (1, 2, 3) Length of time _____ Tolerance G F P	
	Up In Hall	<input type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2.) Tolerance G F P Distance _____	
	<input type="checkbox"/> Linen Change # _____ <input type="checkbox"/> Complex Linen		
	SAFETY	<input type="checkbox"/> Call Bell in Reach Side Rails _____	
<input type="checkbox"/> Vest Restraint <input type="checkbox"/> Bed Low Position			
Restraints		<input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> All <input type="checkbox"/> Soft <input type="checkbox"/> Leather <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> CMT	
<input type="checkbox"/> Bed Check System			
<input type="checkbox"/> Isolation Type _____			
EQUIP / PREVENTION	Elastic Hose	<input type="checkbox"/> Knee <input type="checkbox"/> Thigh	
	<input type="checkbox"/> Pneumatic Stockings		
	<input type="checkbox"/> Air Mattress <input type="checkbox"/> Egg Crate		
	<input type="checkbox"/> Therapeutic Bed _____		
	<input type="checkbox"/> Aqua K _____ <input type="checkbox"/> Sitz		
	<input type="checkbox"/> Ice _____		
	<input type="checkbox"/> Room Deodorizer <input type="checkbox"/> Trapeze		
MISC.	<input type="checkbox"/> BM _____		
	<input type="checkbox"/> 1:1 Nrsng _____ hours		
	Care Plan - Review Initials		
Initials - Responsible RN			
Initials - Care Provider			

DIET	BREAKFAST	LUNCH	SUPPER
	G F P	G F P	G F P
	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Feed		
HYGIENE	Bath	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete <input type="checkbox"/> Shave <input type="checkbox"/> Tub <input type="checkbox"/> Shower	
	Mouth Care	_____	
	Skin Care	_____	
ACTIVITY	<input type="checkbox"/> Peri Care <input type="checkbox"/> Shampoo		
	Sleep	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Intervals	
	<input type="checkbox"/> Bedrest Turn _____		
	CDB _____ Suction _____		
	<input type="checkbox"/> BRP <input type="checkbox"/> Commode <input type="checkbox"/> Elev. Toilet		
	Assist _____ <input type="checkbox"/> Urinal <input type="checkbox"/> Bedpan		
	Up In Chair	<input type="checkbox"/> Self <input type="checkbox"/> Hoyer With help (1, 2, 3) Length of time _____ Tolerance G F P	
	Up In Hall	<input type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2.) Tolerance G F P Distance _____	
	<input type="checkbox"/> Linen Change # _____ <input type="checkbox"/> Complex Linen		
	SAFETY	<input type="checkbox"/> Call Bell in Reach Side Rails _____	
<input type="checkbox"/> Vest Restraint <input type="checkbox"/> Bed Low Position			
Restraints		<input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> All <input type="checkbox"/> Soft <input type="checkbox"/> Leather <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> CMT	
<input type="checkbox"/> Bed Check System			
<input type="checkbox"/> Isolation Type _____			
EQUIP / PREVENTION	Elastic Hose	<input type="checkbox"/> Knee <input type="checkbox"/> Thigh	
	<input type="checkbox"/> Pneumatic Stockings		
	<input type="checkbox"/> Air Mattress <input type="checkbox"/> Egg Crate		
	<input type="checkbox"/> Therapeutic Bed _____		
	<input type="checkbox"/> Aqua K _____ <input type="checkbox"/> Sitz		
	<input type="checkbox"/> Ice _____		
	<input type="checkbox"/> Room Deodorizer <input type="checkbox"/> Trapeze		
MISC.	<input type="checkbox"/> BM _____		
	<input type="checkbox"/> 1:1 Nrsng _____ hours		
	Care Plan - Review Initials		
Initials - Responsible RN			
Initials - Care Provider			

INITIALS & SIGNATURES

KP [Signature]			
KP [Signature]			

VITAL SIGNS RECORD

DATE	12-25			12-26			12-27			12-28			12-30								
TIME	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8
WRITE IN																					
104°																					
103°																					
102°																					
101°																					
100°																					
99°																					
98°																					
97°																					
WRITE IN																					
TEMPERATURE	99.7																				
PULSE	102																				
RESPIRATIONS	24																				
	AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM	
BP	12	134/70	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
	8	110/70	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
WEIGHT																					

MEDRC-2600 ST MARYS MEDICAL CENTER GREEN BAY
12/26/92 08:01 (QAXPRG)

PAGE 001

YAEGER, BARBARA A F 37
MR#: 0802579 ALOC#: 5589013
SERV: MEDI ON-S 018
MD: FIBBETTS J. J. MD ADM: 12/25/92
DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA

DATE: 12/25/92
TIME: 08:00
BY: J. J. FIBBETTS
REASON: PNEUMONIA

DISCHARGE REPORT

SUMMARY: 12/25 08:00 TO 08:00 12/26

ALLERGIES:

MED ALLERGY: NONE KNOWN
DIET ALLERGY:--NECTARINES
OTHER ALLERGY:--RAGWEED, POLLEN

LRAD
LRAD
LRAD

VITAL SIGNS:

	T-AX	T-O	T-R	P-R	P-A	R	BP	
12/25 03:15		100.8		100		24	138/76	LRAD
12/25 08:00	98.2			100		16	110/70	LRAD DM DM

MEDICATIONS:

TYLENOL ACETAMINOPHEN 325MG TAB,
12/25 03:50 #2, PO GIV GIVEN FOR HEADACHE
PREDNISONE 20MG TAB,
12/25 08:00 #1, PO GIV

FULLMER KELLY RN
FERRE KE MAROLYN RN

OTHER PATIENT DATA:

12/25 03:15	ADM T-O 100.8	LRAD
	ADM P-R 100	LRAD
	ADM RESP 24	LRAD
	ADM B/P 138/76 LT ARM	LRAD
12/25 11:10	PT DISCHARGED BY WHEELCHAIR	KOAE
	DISCHARGED TO HOME	KOAE
	ACCOMPANIED BY SPOUSE	KOAE
	WITH ALL PERSONAL BELONGINGS	KOAE
	WITH PRESCRIPTIONS	KOAE
	WITH TAKE HOME MEDS	KOAE
	WITH DISCHARGE INSTRUCTIONS	KOAE
	ESCORTED BY HOSPITAL PERSONNEL, RN	KOAE
	RETURN TO CLINIC/MD OFFICE--E.R. ON SAT AM	KOAE
	APPARENT EMOTIONAL STATUS: STABLE	KOAE

DISCHARGED, 018, 70: 12/25/92, 12/25/92 11:00....11:00

CONTINUED

12/26/92 08:01 (QAXPRG)

PAGE 002

YAEGER, BARBARA A F 37
MR#: 0302579 AOC#: 5539023
SERV: MEDI SN-S 318
MD: FIBBETTS J. J. MD ADM: 12/25/92
DX: INHALATION PNEUMONITIS(CHEMICAL PNEUMONIA)

CLINIC 5 17
W 8 12
PHYSICIAN 8 10
N 8 8
T 8 8

DISCHARGE REPORT

SUMMARY: 12/25 00:00 TO 00:00 12/26

RESPIRATORY THERAPY NOTES:

12/25 01:10 UPDRAFT NEBULIZER IBAD
ALBUTEROL 0.088% IN 2.5ML NS....FIO2: OXYGEN.
HEART RATE 112BPM BEFORE TX. HEART
RATE 108BPM AFTER TX. COUGH STRONG
HARSH NON-PROD BREATH SOUNDS DIMIN
THROUGHOUT BEFORE TRT WITH- NO CHANGE
AFTER TRT IBAD
COMMENTS:--PEAK FLOWS 200 LPM BEFORE TRT. 140
LPM AFTER TRT. IBAD

12/25 03:15 O2 SETUP IBAD
O2 HUM BOTTLE IBAD
O2 VIA CANNULA SET UP O2 ON O2 FLOW AT 4LPM IBAD
PULSE OX DAILY IBAD
PULSE OX ELECTRODE OXIMETER ON ON O2 FLOW 4LPM IBAD

12/25 03:45 UPDRAFT NEBULIZER IBAD
ALBUTEROL 0.088% IN 2.5ML NS....FIO2: OXYGEN.
HEART RATE 100BPM BEFORE TX. HEART
RATE 110BPM AFTER TX. COUGH STRONG
NON-PROD BREATH SOUNDS DIMIN
THROUGHOUT BEFORE TRT WITH- NO CHANGE
AFTER TRT IBAD

12/25 07:15 UPDRAFT NEBULIZER IBAD
ALBUTEROL 0.088% IN 2.5ML NS....FIO2: OXYGEN
PEAK FLOW BEFORE 290LPM, PEAK FLOW
AFTER 300LPM. HEART RATE 92BPM
BEFORE TX. HEART RATE 108BPM AFTER
TX. BREATH SOUNDS: CLEAR AND DIMIN
THROUGHOUT BEFORE TRT WITH-
INCREASED AIR EXCHANGE AFTER TRT. IBAD
COUGH SPONTANEOUS NON-PROD IBAD

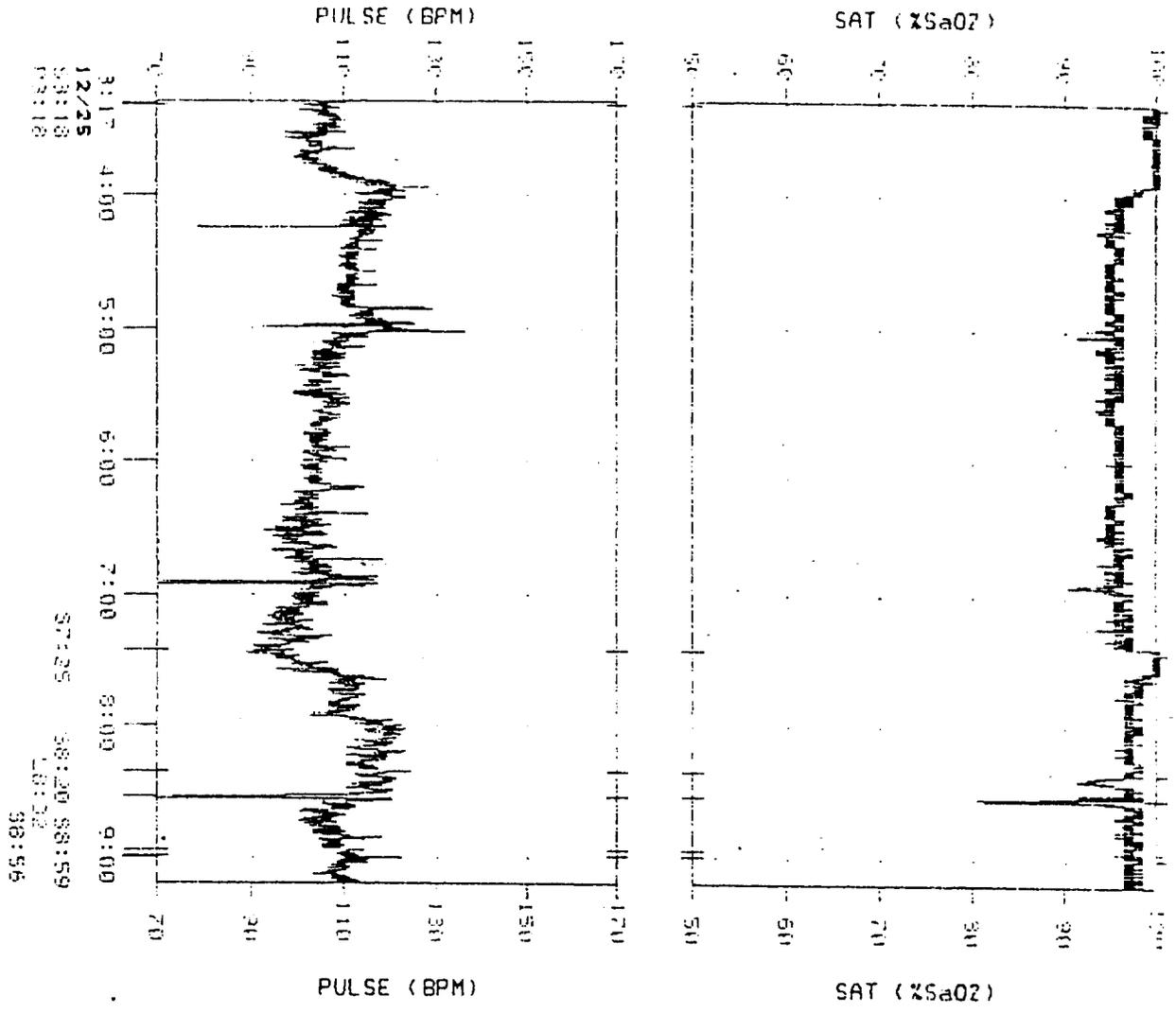
12/25 09:00 O2 DAILY O2 OFF IBAD
PULSE OX DAILY IBAD

12/25 10:15 UPDRAFT NEBULIZER TRT- NOT GIVEN. REASON: PT
REFUSED. REASON: NOT NECESSARY KMA

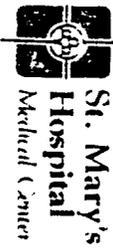
12/25 11:30 OXIMETER HRS 8 SWAC
OXIMETER NOTE: , OXIMETER OFF , , DC'D PER ORDER SWAC

LASTPAGE

PATIENT TREND GRAPH by NELLCOR



12/25
58:18
58:18
58:18
57:25
58:20 58:59
58:56



PATIENT CARE PLAN

PNEUMONIA

YAEGER, BARBARA A
 MR#: 0302579 ADM: 12/25/92 318
 TIBBETTS, J. J. MD 37 REL: LITF
 AC#: 5589023 DOB: 08/06/55 FC: 7F

Date/Initial

DISCHARGE PLANS
 Home No Assistance Assistance

Skilled Nursing Facility

Rehabilitation Facility

Other

Signature/Initial

(Primary Nurse)

1) RP Tibbets
 2) RP Tibbets
 3) RP Tibbets
 4) _____
 5) _____
 6) _____
 7) _____

Onset Date Initial	Nursing Diagnosis	Expected Outcome	Nursing Intervention	Date Resolved/Initial
12/25	1) Ineffective airway clearance R/T accumulation of tracheobronchial secretions	Airway will remain patent. Pt demonstrates expectoration of secretions. Clear airway on auscultation.	1) Encourage coughing and deep breathing. Assist in splinting chest if needed. 2) Assess & document respirations every 4 hr & prn. 3) Elevate HOB & change patient's position every 2 hrs to promote pulmonary drainage. 4) Encourage fluid intake to liquefy secretions further and aid in expectorations Pt preferences are: <u>H&O + C&C</u> 5) Provide frequent oral care after expectoration 6) Teach necessity of raising secretions and expectoration versus swallowing. Document patient instruction	12-25-92 KP
12/25	2. Impaired gas exchange R/T dyspnea and lung consolidation	Regular respiratory rate, acyanotic. Accessory muscle use is limited or not used. SOB is decreased or does not exist.	1) Auscultate breath sounds every shift & prn. 2) Assess and document respiratory rate, depth, use of accessory muscles, & pursed lip breathing. 3) Check VS every 4 hr & prn. Note patient's color & check for circumoral or nailbed	12-25-92 KP

Onset Date Initial	Nursing Diagnosis	Expected Outcome	Nursing Intervention	Date Resolved/Initial
1/2/25	3. Alteration in comfort R/T (x) pleuritic pain (x) fever (x) coughing	Relief of pain. Able to cough up secretions	1) Assess and document location, intensity (0 - 10 scale) of pain. 2) Assess & document response to analgesics within 1 - 2 hours of administration. 3) Teach ways to minimize pain, such as splinting chest & sitting upright when coughing. 4) Change damp linen/gown/prn. 5) Encourage modified bedrest when pt is febrile.	12-25-92 KPN
	4. Knowledge deficit R/T disease transmission & etiology	pt. & family will verbalize understanding of disease process, treatment, & prevention	1. Advise to maintain natural resistance with good nutrition, adequate fluid intake & rest. 2. Avoid chilling & contact with people with upper respiratory infections. 3. Encourage gradual increase in activity	

6 Blank pages with 12/2/25

YAEGER, BARBARA A 3N-5
MR#: 0302579 ADM: 12/25/92 318
TIBBETTS J. J. MD 37 REL: LUTH
AC#: 5589023 DOB: 08/06/55 FC: 7C

PATIENT PROGRESS NOTES

Date	Time	Focus	D A R	D-Data	A=Action	R=Response
12/25	0315	Admission Note	D	37 yr. old female admitted from ER C/O SOB, nausea, chills & cough after using Wilson leather spray. Lungs are clear but diminished. C/O SOB & turning off dry cough. O2 on @ 4 liters O2 sat 100% C/O nausea & turning abdomen soft & bowel sounds. Bilateral skin irritation clear. Temp 100.8. IV site asymptomatic. ——— K Plummer		
	0345	comfort airway clearance	D A D A	C/O headache Nasal congestion C/O tightness in chest		
	0400	Resp	R	O2 off O2 sat 97% SOB ↑ slight		
	0500	Comfort Temp Resp	D D D	Denies further headache Temp 99.2 "I'm breathing better"		
12-25-92	0915	Assessment	D	Pt. is Alert + oriented x3. Skin pale, warm + dry. Lungs clear but diminished. No SOB at rest. Denies cough. O2 remains off. Abd. soft, nontender 35x4. Denies nausea, headache or chills. No edema noted. IV site patent + asep. K. Pink		
	1110	Discharge	A	IV d/c'd. O2 stat monitor d/c'd. Discharge instructions given. Discharged per family. ——— J. K. ?		



YAEGER, BARBARA A SN-6
MR#: 0302579 ADM: 12/25/92 318
TIBBETTS J. J. MD 37 REL: LL
AC#: 5599023 DOB: 08/06/55 FC:

NURSING ADMISSION INTERVIEW

Admission Date <i>12/25</i>	Time <i>0315</i>	Vital Signs			Orientation to Room	
Admitted Per <i>car</i>	Room <i>318</i>	T <i>100.8</i>	P <i>100</i>	R <i>24</i>	Instructions in use of siderails <i>L</i>	
Admitted From <i>ER</i>	Accompanied By <i>ER Nurse</i>	Right <i>138/76</i>	BP	Left	Bed Operation <i>L</i>	
Admitting Dr. <i>Tibbetts</i>	Family Dr. <i>Tibbetts</i>	Ht.	Wt.	Stated/Actual	Stated/Actual	Nurse Call System <i>L</i>
		Last Chest X-ray <i>ER</i>				

MEDICATIONS CURRENTLY TAKING (PRESCRIPTION AND OVER-THE-COUNTER)

Medication & Dose	Frequency	Last Dose	Medication & Dose	Frequency	Last Dose
<i>2</i>					

Brought In: _____ Location Now: _____

ALLERGY OR SENSITIVITY

Item	Yes	No	List and State Reaction
Drug		<input checked="" type="checkbox"/>	
Food	<input checked="" type="checkbox"/>		<i>nectarines</i>
Other	<input checked="" type="checkbox"/>		<i>ragweed, pollen</i>

NURSING HX ASSESSMENT

RN or LPN Signature _____

HEALTH PERCEPTION - HEALTH MANAGEMENT

Chief Complaint/Reason for Admission:
2000 spray Wilson leather spray
2200 spray again

2030 cough
2230 - Bawson 55B uncontrollable cough - Child

HEALTH HISTORY

Previous Hospitalization/Chronic Conditions/Injuries/Last Physical Examination
 8 yrs ago - Fibro cysts
 2 yrs ago - Fibro cysts
 Slight heart murmur
 Anesthesia Hx: (malignant Hyperthermia)
 Transfusion Hx: (Previous Transfusions/Reactions, Including Febrile Reactions)

NSG DIAGNOSIS

- Health Maintenance Alteratic
- Noncompliance
- Infection Potential for
- Injury Potential For:
 - Poisoning
 - Suffocation
 - Trauma

NUTRITIONAL METABOLIC PATTERN

Special Diet <input checked="" type="checkbox"/>	Difficulty Swallowing <input checked="" type="checkbox"/>
Food Intolerances <input checked="" type="checkbox"/>	Handicaps related to eating <input checked="" type="checkbox"/>
Family Hx Diabetes - Grandmother	Dentures: Upper Lower Bridge
Fad Diets <input checked="" type="checkbox"/>	Dentures Brought In <input checked="" type="checkbox"/>
Appetite good	Last Dental Exam:
Wt. loss or gain <input checked="" type="checkbox"/>	Oral mucous membranes/gums (color, moisture lesions)
Nausea/Vomiting	<input checked="" type="checkbox"/> Present
24hr recall of food/fluid: - fruit cup - Bran Muffin Coffee green beans - turkey salad - Mashed potatoes	Skin (color, temp, turgor, lesions, dryness, ecchymosis, other)
Alcoholic Beverages occ	pale (warm) <input checked="" type="checkbox"/> dry

NSG DIAGNOSIS

- Swallowing Impaired
- Nutrition Altered
 - More than Body Require
 - Less than Body Require
- Oral Mucous Memb. Alteratio
- Ineffective Thermoregulation:
 - Hypothermia
 - Hyperthermia
- Tissue Integrity Impaired
- Skin Integrity Impaired

ELIMINATION PATTERN

Bowel		Bladder	
Unusual Bowel Pattern 9 Day	Urinary Frequency <input checked="" type="checkbox"/>	Burning <input checked="" type="checkbox"/>	
LBM - 12/23	Incontinence <input checked="" type="checkbox"/>	Nocturia <input checked="" type="checkbox"/>	
Diarrhea/Constipation <input checked="" type="checkbox"/>	Hematuria <input checked="" type="checkbox"/>		
Laxatives <input checked="" type="checkbox"/>	Unusual Discharge <input checked="" type="checkbox"/>		
Incontinent <input checked="" type="checkbox"/>	Other		
Eructations <input checked="" type="checkbox"/>			
Excessive flatus <input checked="" type="checkbox"/>	Family Hx Kidney Disease or Ca.		
Abdomen soft	grandmother - kidney disease		
Bowel Sounds BS x 4			

NSG DIAGNOSIS

- Bowel Elimination Altered
 - Constipation
 - Diarrhea
 - Incontinence
- Urinary Elimination Altered
 - Incontinence
 - Retention

ACTIVITY EXERCISE

Self Care <input checked="" type="checkbox"/> Assist of One	Leisure Activities
Requires use of Equipment/Devices	
Gait/Falls Hx <input checked="" type="checkbox"/>	Smoking (duration, # pks/day) <input checked="" type="checkbox"/>
Paralysis/Weakness <input checked="" type="checkbox"/>	Smoking regulations explained <input checked="" type="checkbox"/>
	Family Hx Heart or Lung Disease <i>lung - grand father</i>
Amputation/Prosthesis	
Respiratory Rate <i>14</i> Rhythm <i>regular</i>	Pulse Rate <i>100</i> Rhythm <i>regular</i>
Depth <i>normal</i>	Strength <i>strong</i>
Cough <i>yes</i> Sputum <input checked="" type="checkbox"/>	Palpitations <input checked="" type="checkbox"/>
Orthpnea <input checked="" type="checkbox"/>	Chest Pains <i>yes slight</i>
Dyspnea <i>yes</i>	Edema <input checked="" type="checkbox"/>
Wheezing <input checked="" type="checkbox"/>	Cyanosis <input checked="" type="checkbox"/>
Breath Sounds <i>clear but</i>	
Other	

NSG DIAGNOSIS

- Activity Intolerance
- Impaired Physical Mobility
- Self-Care Deficit
- Feeding
- Bathing/Hygiene
- Dressing/Grooming
- Toileting
- Injury Potential
- Home Mainten. Management Impaired
- Cardiac Output Decreased
- Airway Clearance Ineffective
- Breathing Pattern Ineffective
- Gas Exchange Impaired
- Fluid Volume Excess
- Deficit
- Tissue Perfusion Altered (specify)

SLEEP REST PATTERN

Hours/Night - <i>7.5 hrs</i>	Sleep onset problems <i>2-3</i>
Feel rested for daily activities after sleep	Dreams/Nightmares <input checked="" type="checkbox"/>
Sleep Aids (pillows, mats, foods) <i>yes</i>	Early Awakening <input checked="" type="checkbox"/>

NSG DIAGNOSIS

- Sleep Pattern Disturbance

COGNITIVE PERCEPTUAL PATTERN

Orientation <i>X3</i>	Eye Drops <input checked="" type="checkbox"/>
Pupil Reaction	Family Hx Glaucoma <i>father</i>
Headaches <input checked="" type="checkbox"/> Fainting <input checked="" type="checkbox"/>	Hearing Impaired <input checked="" type="checkbox"/>
Seizures <input checked="" type="checkbox"/>	Hearing Aid <input checked="" type="checkbox"/>
Numbness/tingling <input checked="" type="checkbox"/>	Grasps Ideas <i>well</i>
Hand Grasps <i>equal/strong</i>	Voice/Speech Pattern <i>clear</i>
Visual Impairment <input checked="" type="checkbox"/>	Attention Span <i>good</i>
Glasses <input checked="" type="checkbox"/> Contacts <input checked="" type="checkbox"/>	Easiest way for you to learn
Glasses or contacts brought in with pt. <input checked="" type="checkbox"/>	
Discomfort/Pain	
Pain Management	
Other	

NSG DIAGNOSIS

- Sensory Perceptual Alteration
- Visual
- Auditory
- Kinesthetic
- Taste
- Tactile
- Olfactory
- Unilateral Neglect
- Thought Processes Altered
- Knowledge Deficit
- Comfort Altered
- Chronic Pain
- Pain

SEXUALITY REPRODUCTIVE PATTERN

LMP - 2 weeks	Duration 5 days	Breast Self Exam
Character	Any Changes/Problems in Sexual Relations (if appropriate)	
Discomfort - yes	Discharge	
Contraceptives		
Last pelvic exam/pap smear - last summer		
Other		

NSG DIAGNOSIS

Sexual Dysfunction
Sexuality Patterns Altered
Rape-Trauma Syndrome

SELF PERCEPTION SELF CONCEPT

Changes in way feel about self or body since illness	Grooming hygiene
	good
Most important aspects of your life are?	Nervous/Relaxed relaxed

NSG DIAGNOSIS

Self Concept Disturbance
Body Image
Self Esteem
Personal Identity
Anxiety
Hopelessness
Powerlessness

ROLE RELATIONSHIPS COPING

Occupation School teacher	Interaction with Family/Friends
Live Alone/with Others	
husbands / kids	Family depends on you for things?
Who's most helpful in talking things over (Significant other)	
What helps you most when you feel afraid or need help?	Family concerns regarding hospitalization?
Other	

NSG DIAGNOSIS

Coping Ineffective
Individual
Family
Social Isolation (Rejection)
Social Interaction Impaired
Family Process Alteration
Parenting Alteration
Fear
Grieving
Violence Potential

VALUE BELIEF PATTERN

Do you belong to a particular religion / faith group? - Catholicism
If yes, which church?
Is your faith an important source of strength for you?
How can I help in carrying out your faith? would you like a visit from your pastor or hospital chaplain? (Explain Pastoral Care Services and how to obtain) yes
Do you have a living will / power of attorney on file? If so, where?
Valuables/Disposition
Person Supplying Information Patient
Dr. Notified at Time R.N. Signature K. Plummer

NSG DIAGNOSIS

Spiritual Distress

RISK OF FALLS ASSESSMENT

CHECK CRITERIA WHICH APPLY

Date: 12/25 Time: 0400

GENERAL - Each check = 2 points
History of prior falls

PHYSICAL - Each check = 1 point
Age over 70 years
Dizziness
Unsteady Gait
Fatigue
Weakness
Impaired Vision
Incontinence

MENTAL STATUS - Each check = 2 points
Confused/Disoriented
Impaired Memory

MEDICATIONS - Each check = 1 point
Diuretic
Psychotropic
Anti Hypertensive
Sedative
Narcotic
Tranquillizer
Laxative

MEDICAL DIAGNOSIS - Each check = 1 point
CVA
Diabetes
Parkinsonism
Amputee
Seizure Disorder
Arthritis
Alzheimer's
CHF
Other

FUNCTIONAL: IED - INDEPENDENT = 0 POINTS
P.A. - PARTIAL ASSISTANCE = 1 POINT
T.A. - TOTAL ASSISTANCE = 2 POINTS

6 DRESSING 1 MANIPULATING 0 BATH 1 TO BR WITH ASSISTANCE

TOTAL POINTS: 2

ADD POINTS - IF TOTAL IS SEVEN (7) OR MORE ASSIGN TO RISK/FALL PROGRAM

If patient is at risk of falling and does not comply with or understand instructions to call for assistance, use the bed check patient monitor system.

Applied

Not applied: Reason: alert

Signature: R. Plummer MD

CHECK CRITERIA WHICH APPLY

Date: 12/27 Time: 0400

Reassessment after 48 hours.

GENERAL - Each check = 2 points
History of prior falls
Hospital stay of five days or more anticipated

PHYSICAL - Each check = 1 point
Age over 70 years
Dizziness
Unsteady Gait
Fatigue
Weakness
Impaired Vision
Incontinence

MENTAL STATUS - Each check = 2 points
Confused/Disoriented
Impaired Memory

MEDICATIONS - Each check = 1 point
Diuretic
Psychotropic
Anti Hypertensive
Sedative
Narcotic
Tranquillizer
Laxative

MEDICAL DIAGNOSIS - Each check = 1 point
CVA
Diabetes
Parkinsonism
Amputee
Seizure Disorder
Arthritis
Alzheimer's
CHF
Other

FUNCTIONAL: IED - INDEPENDENT = 0 POINTS
P.A. - PARTIAL ASSISTANCE = 1 POINT
T.A. - TOTAL ASSISTANCE = 2 POINTS

DRESSING MANIPULATING BATH TO BR WITH ASSISTANCE

TOTAL POINTS:

ADD POINTS - IF TOTAL IS SEVEN (7) OR MORE ASSIGN TO RISK/FALL PROGRAM

If patient is at risk of falling and does not comply with or understand instructions to call for assistance, use the bed check patient monitor system.

Applied

Not Applied: Reason:

Signature:
Reassessment after one week.

RISK OF FALL

CHECK CRITERIA WHICH APPLY

Date: _____ Time: _____

GENERAL - Each check = 2 points
_____ History of prior falls

PHYSICAL - Each check = 1 point
_____ Age over 70 years
_____ Dizziness
_____ Unsteady Gait
_____ Fatigue
_____ Weakness
_____ Impaired Vision
_____ Incontinence

MENTAL STATUS - Each check = 2 points
_____ Confused/Disoriented
_____ Impaired Memory

MEDICATIONS - Each check = 1 point
_____ Diuretic
_____ Psychotropic
_____ Anti Hypertensive
_____ Sedative
_____ Narcotic
_____ Tranquilizer
_____ Laxative

MEDICAL DIAGNOSIS - Each check = 1 point
_____ CVA
_____ Diabetes
_____ Parkinsonism
_____ Amputee
_____ Seizure Disorder
_____ Arthritis
_____ Alzheimer's
_____ CHF
_____ Other

FUNCTIONAL: I.D. = INDEPENDENT = 0 POINTS
P.A. = PARTIAL ASSISTANCE = 1 POINT
T.A. = TOTAL ASSISTANCE = 2 POINTS

_____ DRESSING _____ AMBULATING _____ BATH _____ TO BR WITH ASSISTANCE

TOTAL POINTS: _____

ADD POINTS - IF TOTAL IS SEVEN (7) OR MORE ASSIGN TO RISK/FALL PROGRAM

If patient is at risk of falling and does not comply with or understand instructions to call for assistance, use the bed check patient monitor system.

Applied _____

Not applied: _____ Reason: _____

Signature: _____

DISCHARGE INSTRUCTIONS

YAEGER, BARBARA A 3N-3
 MR#:0302579 ADM:12/25/92 318
 TIBBETTS J. J. MD 37 REL:LL
 AC#:5589023 DOB:08/06/55 PC:

1. Your next appointment with Dr. Tibbets is _____

2. Activity/Care Instructions:

Emergency room 12/26/92 for CBC, Chest X-Ray.

3. Diet: as tolerated

4. Medications:

Name	Dose	Time you should take it
<u>MAXAIR Inhaler</u>	<u>2 puffs</u>	<u>Every 4 to 6 hours if needed for wheezing.</u>
<u>prednisone</u>	<u>10mg</u>	<u>TAKE 2 TABLETS Three times A day - with food</u>

5. Patient has:

Discharge medications
 yes no

Meds from home
 yes no

All personal belongings
 yes no

I, the undersigned have read and understand the above.

K. Penke RN
 Signature of Discharge Nurse

12-25-92
 Date

Barbara A. Jaeger
 Signature of Patient

Date

HOSPITAL: Green Bay 12/28/92 08:31 (QBN\$3P)
 MR. BARBARA A F 37 SERV: EMERGENCY
 ID: 0802374 ADM NO: EMERG
 ID: 389023 APT NO: PATUN, D L MD
 12/28/92 RACE: W
 DOB: 00:50 REF NO: VIBBETTS J. J. MD

CLINIC: CITY:
 DR: DJW SSN: 398586788 AGE: 70
 ADDR: 800 STONEY BROOK LA GREEN BAY WI 54304-
 HOME: 414-499-6143 RELIGION: CATH LC16
 REV NAME: SCHROEDER ER CONTACT I: JERRY
 LE: 08/06/53 SEX: M PHONE: 414-499-6143 REL: HU
 EMPLOYER: VANBOXICE FORD WORK: 414-499-3131
 OCCUPATION: TEACHER ER CONTACT II:
 INCIDENT DATE: PHONE: REL:
 WORK:

ADMITTED: SQUAD
 DX: CHEMICAL REACTION
 POLICE NOTIFIED - HERE
 CORONER NOTIFIED - HERE

PHYSICIAN NOTIFIED ANSWERING SERVICE AT HOME RESPONSE ARRIVAL IN THE EMERGENCY CENTER

TEMP 100.4 T P 112 R 28 B.P 158/80

PHYSICIAN'S NOTES
 0147 Tolon to room 3 per smt rs. @ 10:30pm/mash
 @ 10:30pm to check vitals @ 11:00pm @ 11:30pm et
 @ 12:00pm she was using Wilson's leather
 protector @ 3pm for 15' and at 9:30pm for 15'
 states she began a slight cough @ 9:30pm
 et developed mild to severe @ 10pm. Starts
 @ 10:30pm was a deep inspiration. Ribs pain
 @ 11:00pm. lungs & bases bilaterally. cont.

TETANUS TOXOID /
 CURRENT MEOS none
 ALLERGIES DKDA
 MD EXAM Start

0148 report called to 3rd Floor.
 0149 Wilson's leather protector spray 2.5oz
 cont. @ 10:30pm chills HA et nausea.
 0150 @ 11:00pm she feels better @ 11:30pm
 0151 @ 12:00pm she feels better @ 12:30pm
 0152 @ 1:00pm she feels better @ 1:30pm
 0153 @ 2:00pm she feels better @ 2:30pm
 0154 @ 3:00pm she feels better @ 3:30pm
 0155 @ 4:00pm she feels better @ 4:30pm
 0156 @ 5:00pm she feels better @ 5:30pm
 0157 @ 6:00pm she feels better @ 6:30pm
 0158 @ 7:00pm she feels better @ 7:30pm
 0159 @ 8:00pm she feels better @ 8:30pm
 0160 @ 9:00pm she feels better @ 9:30pm
 0161 @ 10:00pm she feels better @ 10:30pm
 0162 @ 11:00pm she feels better @ 11:30pm
 0163 @ 12:00pm she feels better @ 12:30pm
 0164 @ 1:00pm she feels better @ 1:30pm
 0165 @ 2:00pm she feels better @ 2:30pm
 0166 @ 3:00pm she feels better @ 3:30pm
 0167 @ 4:00pm she feels better @ 4:30pm
 0168 @ 5:00pm she feels better @ 5:30pm
 0169 @ 6:00pm she feels better @ 6:30pm
 0170 @ 7:00pm she feels better @ 7:30pm
 0171 @ 8:00pm she feels better @ 8:30pm
 0172 @ 9:00pm she feels better @ 9:30pm
 0173 @ 10:00pm she feels better @ 10:30pm
 0174 @ 11:00pm she feels better @ 11:30pm
 0175 @ 12:00pm she feels better @ 12:30pm

DIAGNOSIS Acute Chemical Pneumonitis = RAD

TREATMENT Admits - Dr. J. Vibbetts

X-RAY AND EKG READINGS ARE PRELIMINARY UNTIL LATER REVIEWED. INSTRUCTION SHEET GIVEN

FOLLOW UP WITH DR. CONDITION UPON DISCHARGE. CONDITION SATISFACTORY FAIR POOR CRITICAL

DISPOSITION Admit 318 DATE 12/28/92 TIME 0300 REFERRED TO K. Hebert RN ATTENDING PHYSICIAN

Yaeger, Barbara
#302579
12-25-92
Dr. Paton

HISTORY OF PRESENT ILLNESS:

This is a 37-year-old woman who presents with complaint of acute dyspnea after spraying a coat with Wilson's Leather Protector aerosol. This is a hydrocarbon-based spray for garment protection. The patient is a nonsmoker. She relates no prior history of bronchospasm. She occasionally has extrinsic allergies. She has no medications and has no preceding infectious symptoms. In fact, the patient's husband, who was briefly exposed to the basement where she was spraying this agent had similar symptoms and so did another youngster.

PHYSICAL EXAMINATION:

Temperature is 100.4 tympanic, 100.8 orally, pulse 112, respirations 28, blood pressure 158/80. The patient appeared ill and was quite uncomfortable. She did volunteer symptoms of bifrontal headache as well as some chills and myalgias in addition to her dyspnea.

HEENT: Her conjunctiva are trace injected without chemosis. ENT examination shows hyperemia and is otherwise normal. There is no stridor or angioedema.

Neck: Supple.

Lungs: She has scattered rhonchi with end-expiratory wheezes on chest auscultation. The wheezing resolved significantly after an Albuterol updraft, however, the rhonchi persisted and a few crackles and mild rales developed later in her ER course. Pulse oximeter was in the low to mid-90s on room air on arrival and with four liters nasal cannula it went up to 99%.

Heart: Tones were regular without rubs or gallops. There was no ectopy.

Abdomen: Soft. There was no peritoneal signs. Bowel sounds are active.

Extremities: She had no peripheral clubbing, cyanosis, or edema.

Chest x-ray was compatible with pneumonitis though the patient was much more comfortable with oxygen administration. She clearly was too ill to be treated as an outpatient. An IV of D5 normal Saline was initiated and a Solu-Medrol bolus given. Her baseline CBC had a white count of 25.1. Hemoglobin is 12.4, platelets are adequate. She had 78% neutrophils, 11% bands. An initial blood gas had a pH of 7.46, PCO2 of 29, PO2 of 34 and a bicarb of 21. This clearly was not arterial and will be repeated. The patient's saturations were again 99% on four liters. She was discussed with Dr. J. Tibbetts and admitted.

IMPRESSION:

Acute chemical pneumonitis with bronchospasm, rule out lipid pneumonia.

DP:ct
D: 12-25-92
T: 12-26-92

8
mf
Lubinski, Rottier, Reed & Klass, S.C.
LAWYERS

200 EAST WISCONSIN STREET, P.O. BOX 67
SEYMOUR, WI 54165-0067

2004/10/31
C335056

Richard Lubinski
Kenneth F. Rottier
Robert Lubinski
Ann Lubinski Reed
Mary Lubinski Klass

AREA CODE (414)

Seymour 833-2356
Pulaski 822-3115
Appleton 735-0834

Vernon Lubinski

Telecopier 833-2358

MAR 22 1993

March 11, 1993

Mr. Todd Stevenson
Freedom of Information Officer
Consumer Product Safety Commission
Office of the Secretary
5401 Westbard Ave.
Bethesda, MD 20207

(h)

0952

K15

0952

RE: Wilson's Leather Protector
[REDACTED]

Dear Mr. Stevenson:

Please be advised that this office has been retained by [REDACTED] and [REDACTED] on behalf of their minor child, [REDACTED], regarding their exposure to Wilson's Leather Spray and consequential injury on December 27, 1992.

MAIL
C/S
YI

I am hereby requesting photocopies of your investigation information regarding Wilson's Leather Spray under the Freedom of Information Act.

I am especially concerned regarding the identification of the substance contained in the spray which caused the medical complications, the long-term affects of the exposure and the knowledge of Wilson's regarding the hazard.

Thank you for your anticipated cooperation.

Sincerely yours,

LUBINSKI, ROTTIER, REED & KLASS, S.C.

Ann Reed

MFRA/PRVLR NOTIFIED

- No comments made
- Comments attached
- Excisions/Revisions
- Firm has not requested further notice

AR:kl

Encs.

ar\rodefDAN.L1

5303144

7/7/95
SAP

U.S. CONSUMER PRODUCT SAFETY COMMISSION

AUTHORIZATION FOR RELEASE OF NAME

Thank you for assisting us in collecting information on a potential product safety problem. The Consumer Product Safety Commission depends on concerned people to share product safety information with us. We maintain a record of this information, and use it to assist us in identifying and resolving product safety problems.

We routinely forward this information to manufacturers and private labelers to inform them of the involvement of their product in an accident situation. We also give the information to others requesting information about specific products. Manufacturers need the individual's name so that they can obtain additional information on the product or accident situation.

Would you please indicate on the bottom of this page whether you will allow us to disclose your name. If you request that your name remain confidential, we will of course, honor that request. After you have indicated your preference, please sign your name and date the document on the lines provided.

You are hereby authorized to disclose my name and address with the information collected on this case.

My identity is to remain confidential.


(Signature)

12-29-92
(Date)

EXHIBIT D

12147172

TQI#921229CCN0544

U.S. CONSUMER PRODUCT SAFETY COMMISSION

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO WHOM IT MAY CONCERN:

You are hereby authorized to furnish the United States Consumer Product Safety Commission all information and copies of any and all records you may have pertaining to (my case)

(the case of

[Redacted Name]

Name

Relationship to you

including, but not limited to, medical history, physical reports, laboratory reports and pathological slides, and X-ray reports and films.

12-29-92

(Date)

[Redacted Signature]

[Handwritten Signature]

(Witness)

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO WHOM IT MAY CONCERN:

You are hereby authorized to furnish the United States Consumer Product Safety Commission

all information and copies of any and all records you may have pertaining to (my case)

(the case of

[Redacted Name]

Name

my daughter

Relationship to you

including, but not limited to, medical history, physical reports, laboratory reports and

pathological slides, and X-ray reports and films.

12-29-92

(Date)

[Redacted Signature]

(Signature)

Dem. A. Blasin

(Witness)

U. S. CONSUMER PRODUCT

Exhib A G

12/29/92

SAMPLE COLLECTI

IDI# 921229CCN0544

1. Flag	2. Date Collected 12/29/92	3. Sample type & number <input checked="" type="checkbox"/> Physical R-830-4407 <input type="checkbox"/> Documentary
4a. Product name fabric treatment product	4b. Model Wilson's 5oz.	4c. NEISS 0952
5. Assignment ref. 921229CCN0544		
6. Complete for import samples	7. MIS 32672	8. Hours: a. Activity 2.0 b. Travel 0.0
a. Port of Entry		9a. Home RO
b. Entry # & date		9b. Collecting RO
c. Country of Origin		
d. HSUSA code		
e. Customs Contact		
10. Sample Cost \$0. -	11. Invoice value of lot retail value approx. \$5.00	12. Size of lot one available from consumer
13. Manufacturer/Importer Wilson's Suede and Leather Inc. Minneapolis, MN.	14. Shipper/Foreign Mfr. Wilson's Suede & Leather Port Plaza Mall A-1009 Port Plaza Mall Green Bay, WI. 54301	15. Dealer/Import Broker [REDACTED] Gillett, WI. 54124
ID #	ID#	ID#
16. Supporting documents attached:		
a. Invoice # & date: N/A	b. Date Shipped:	
c. Shipping record # & date:		
d. Affidavit signer's name, title & date:		
17. Product Identification:		
Sample consists of one 5 ounce aerosol can of "Wilson's Leather Protector." Can is black in color with red and white lettering, SKU #18996003. Date coding stamp on container bottom states "Cl 2." Front labeling describes product as "making suede and leather stain and water resistant, keeps dirt on the surface for easy wipe-off;" container further lists various warning and usage instructions.		
18. Reason for collection & analysis needed: FHSX <input checked="" type="checkbox"/> CPSA <input type="checkbox"/> FFA <input type="checkbox"/> PPPA <input type="checkbox"/> RSA <input type="checkbox"/>		
F/U to IDI# 921229CCN0544 (10 Y.O. and 19 Y.O. suffered respiratory distress after using the product); content and labeling analysis.		
19. Summary of Field Screening:		
None		
20. Sample Size, Method of Collection:		
Sample consists of one unused can as described in #17 above. This can was one of a two can set packaged together in a black cardboard display container. Sample was obtained from consumer at her residence on 12/29/92; it remained in my possession and in the locked CPSC office until shipment to the Sample Custodian on 12/31/92. Sample		
21. Identification on sample "R-830-4407 DRB 12/29/92"	22. Identification on seal "R-830-4407 Dennis R. Blasius 12/31/92"	
23a. Sample delivered to Sample Custodian via P.P. MKE	23b. Date 12/31/92	24. Orig. report/records sent to FOCR
25. Laboratory/Office: ESEL <input type="checkbox"/> HSHL <input checked="" type="checkbox"/> CERM <input type="checkbox"/> CECA <input type="checkbox"/> OTHER <input type="checkbox"/>		
26. Remarks was shipped in a cardboard box which was sealed and identified as under #22 above; sample itself was tagged and identified as described in #21 above. Sample was mailed via P.P.MKE to the Sample Custodian on 12/31/92, to be forwarded to HSHL for further analysis. Sample collection receipt, copy of original assignment attached.		
27. Related Samples R-830-4408		
28a. Collector's name, title & employee # Dennis R. Blasius, Investigator, #9003	28b. Collector's signature & date <i>Dennis R. Blasius</i> 12/31/92	
29a. Reviewer's name, title & employee #	29b. Reviewer's signature & date	

CONSUMER PRODUCT INC

Exhibit H

12/27/92

FOI # 92122900NCS44

1. NAME OF RESPONDENT [REDACTED]		2. TELEPHONE NO. (Home) (Work) [REDACTED] (Home)	
3. STREET ADDRESS [REDACTED]		4. CITY STATE ZIP CODE Gillett, WI. 54124	
6. DESCRIBE ACCIDENT SITUATION OR HAZARD, INCLUDING DATA ON INJURIES. (Use second page if necessary.) Respondent's two daughters, ages 19 and 10, were in the basement of their home treating a new leather coat with an aerosol leather protector product. After several minutes of exposure to the product's fumes both individuals began experiencing severe respiratory distress, including difficulty breathing, coughing, and tightness in their chests. Both victims were transported to a local hospital, where they were treated and released.			
6. DATE OF INCIDENT(S) 12/27/92	7. IF INJURY OR NEAR MISS, OBTAIN AGE 19 SEX Female AND DESCRIBE INJURY respiratory distress	8. IF VICTIM DIFFERENT FROM RESPONDENT, PROVIDE NAME RELATIONSHIP daughters	
9. DESCRIPTION OF PRODUCT aerosol spray leather protector		10. BRAND NAME Wilson's Leather Protector	
11. MANUFACTURER/DISTRIBUTOR NAME, ADDRESS & PHONE Wilson's Leather Company Minneapolis, MN.		12. MODEL, SERIAL NO.'S 5oz. and 7oz. cans	
		13. DEALER'S NAME, ADDRESS & PHONE Wilson's Leather Products Port Plaza Shopping Center Greenbay, WI.	
14. WAS THE PRODUCT DAMAGED, REPAIRED OR MODIFIED? YES NO <input checked="" type="checkbox"/> IF YES, BEFORE OR AFTER THE INCIDENT? Describe		15. PRODUCT PURCHASED NEW <input checked="" type="checkbox"/> USED DATE PURCHASED 12/27/92 AGE one day	
		16. DOES PRODUCT HAVE WARNING LABELS? IF SO, NOTE:	
17. HAVE YOU CONTACTED THE MANUFACTURER? YES <input checked="" type="checkbox"/> NO IF NOT, DO YOU PLAN TO CONTACT THEM? YES NO OTHER	18. IS THE PRODUCT STILL AVAILABLE? YES <input checked="" type="checkbox"/> NO IF NOT, ITS DISPOSITION	19. MAY WE USE YOUR NAME WITH THIS REPORT? YES <input checked="" type="checkbox"/> NO	
FOR ADMINISTRATION USE			
20. DATE RECEIVED 12/28/92	21. RECEIVED BY (Name & Office) Dennis R. Blasius, MKE-RP	22. DOCUMENT NO. 62 0137	
23. FOLLOW-UP ACTION Conduct ITI 92122900N0544		24. PRODUCT CODE(S) 0952	
25. DISTRIBUTION O: EPDS; cc (ERM, Jacobson) cc: EP		26. ENCLASER'S NAME & TITLE [Signature] JPS	

U.S. CONSUMER PRODUCT SAFETY COMMISSION

1. AREA OFFICE ADDRESS

CPSC - MILWAUKEE RESIDENT POST
310 W. WISCONSIN AVE.
MILWAUKEE, WI 53203

2. NAME OF INDIVIDUAL

3. TITLE OF INDIVIDUAL

4. DATE

Self

12/29/92

5. FIRM NAME

6. SAMPLE NUMBER

7. NUMBER AND STREET

8. CITY AND STATE (Include Zip Code)

Gillett, WI 54124

9. SAMPLE NUMBERS AND OTHER POSITIVE IDENTIFICATION

The following samples were collected by the Consumer Product Safety Commission pursuant to Section 27(f) of the Consumer Product Safety Act (15 U.S.C. 2076(f) and/or Section 11(b) of the Federal Hazardous Substances Act (15 U.S.C. 1270(b) and/or Sections 5(c) and (d) of the Flammable Fabrics Act (15 U.S.C. 1194(c) and (d) and/or Section 704(c) of the Federal Food Drug and Cosmetic Act (21 U.S.C. 374(c)) [Authority for sample collections made in connection with the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.)], and receipt for said samples is hereby acknowledged. Sections cited are quoted on the reverse side of this form.

1 - ONE 5oz. CAN OF "WILSON'S LEATHER PROTECTOR"
PURCHASED TO # 0018996003.

10. SAMPLES

11. SAMPLES WERE

12. COLLECTOR

a. AMOUNT RECEIVED FOR SAMPLE

PURCHASED

a. NAME (Print or type)

DENNIS R. BLASINS

b. SIGNATURE

BORROWED (To be returned)

b. SIGNATURE

Dennis R. Blasinski

Section 27(f) of the Consumer Product Safety Act (15 U.S.C. 2075(f)) is quoted below:

(f) For purposes of carrying out this Act, the Commission may purchase any consumer product and it may require any manufacturer, distributor, or retailer of a consumer product to sell the product to the Commission at manufacturer's, distributor's, or retailer's cost.

Section 11(b) of the Federal Hazardous Substances Act (15 U.S.C. 1270(b)) is quoted below:

(b) For purposes of enforcement of this Act, officers or employees duly designated by the Secretary, upon presenting appropriate credentials and a written notice to the owner, operator, or agent in charge, are authorized (1) to enter, at reasonable times, any factory, warehouse, or establishment in which hazardous substances are manufactured, processed, packed, or held for introduction into interstate commerce or are held after such introduction, or to enter any vehicle being used to transport or hold such hazardous substances in interstate commerce; (2) to inspect, at reasonable times and within reasonable limits and in a reasonable manner, such factory, warehouse, establishment, or vehicle, and all pertinent equipment, finished and unfinished materials, and labeling therein; and (3) to obtain samples of such materials or packages thereof, or of such labeling. A separate notice shall be given for each such inspection, but a notice shall not be required for each entry made during the period covered by the inspection. Each such inspection shall be commenced and completed with reasonable promptness.

NOTE: The term "Secretary" in the Federal Hazardous Substances Act section should be substituted by the term "Consumer Product Safety Commission".

Sections 5(c) and (d) of the Flammable Fabrics Act (15 U.S.C. 1194(c) and (d)) is quoted below:

(c) The Commission is authorized and directed to prescribe such rules and regulations, including provisions for maintenance of records relating to fabrics, related materials, and products, as may be necessary and proper for administration and enforcement of this Act. The violation of such rules and regulations shall be unlawful and shall be an unfair method of competition and an unfair and deceptive act or practice, in commerce, under the Federal Trade Commission Act.

(d) The Commission is authorized to-

(1) cause inspections, analyses, tests, and examinations to be made of any product, fabric or related material which it has reason to believe falls within the prohibitions of this Act; and

(2) cooperate on matters related to the purposes of this Act with any department or agency of the Government; with any State or territory or with the District of Columbia or the Commonwealth of Puerto Rico; or with any department, agency, or political subdivision thereof; or with any person.

Section 704(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 374(c)). [(Authority for Sample Collections made in connection with the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.)] is quoted below:

(c) If the officer or employee making any such inspection of a factory, warehouse, or other establishment has obtained any sample in the course of the inspection, upon completion of the inspection and prior to leaving the premises he shall give to the owner, operator, or agent in charge a receipt describing the samples obtained.

NOTE: The term "Commission" meaning the "Federal Trade Commission" in the Flammable Fabrics Act section should be substituted by the term "Consumer Product Safety Commission".

B18 TC 21

1

CONSUMER PRODUCT INCIDENT REPORT

JAN 25 1993

1. NAME OF RESPONDENT S. H. Wong, Gilmore	2. TELEPHONE NO. (Home) (Work) 602/936-4743 / 225-0732
3. STREET ADDRESS 2710 N. 89th Dr.	4. CITY STATE ZIP CODE Phoenix, AZ 85037

5. DESCRIBE ACCIDENT SITUATION OR HAZARD, INCLUDING DATA ON INJURIES. (Use second page if necessary.)
 The victim used the leather protector spray on her new leather jacket. Within 20 min. she began experiencing shortness of breath. Victim began coughing up blood & went to a physician. They found out that she was only able to use 1/4-1/2 of her lung capacity. She was given medication.

6. DATE OF INCIDENT(S) 12-23-92 9 P.M.	7. IF INJURY OR NEAR MISS, OBTAIN AGE <u>26</u> SEX <u>Female</u> AND DESCRIBE INJURY <u>damage to lungs</u>	8. IF VICTIM DIFFERENT FROM RESPONDENT, PROVIDE NAME _____ RELATIONSHIP _____
--	--	---

9. DESCRIPTION OF PRODUCT a spray to protect leather	10. BRAND NAME Wilson's Leather Protector
---	--

11. MANUFACTURER/DISTRIBUTOR NAME, ADDRESS & PHONE Wilson's The Leather Experts Munnepetiz, MN	12. MODEL, SERIAL NO.'S 5 oz. aerosol can	13. DEALER'S NAME, ADDRESS & PHONE Wilson's Suede & Leather Paradise Valley mall Phoenix, AZ
---	--	---

14. WAS THE PRODUCT DAMAGED, REPAIRED OR MODIFIED? YES _____ NO <input checked="" type="checkbox"/> IF YES, BEFORE OR AFTER THE INCIDENT? Describe _____	15. PRODUCT PURCHASED NEW <input checked="" type="checkbox"/> USED _____ DATE PURCHASED <u>around 12-23-92</u> AGE <u>new</u>	16. DOES PRODUCT HAVE WARNING LABELS? IF SO, NOTE: _____
--	--	---

17. HAVE YOU CONTACTED THE MANUFACTURER? YES <input checked="" type="checkbox"/> NO _____ IF NOT, DO YOU PLAN TO CONTACT THEM? YES _____ NO _____ OTHER _____	18. IS THE PRODUCT STILL AVAILABLE? YES <input checked="" type="checkbox"/> NO _____ IF NOT, ITS DISPOSITION _____	19. MAY WE USE YOUR NAME WITH THIS REPORT? <input checked="" type="checkbox"/> NO _____ YES <input checked="" type="checkbox"/> NO _____ No comments made Comments attached Excisions/Revisions <input checked="" type="checkbox"/> Firm has not request further notice
---	--	--

FOR ADMINISTRATION USE

20. DATE RECEIVED 12-29-92	21. RECEIVED BY (Name & Office) Zanne E. W... 101/TMR # 930113HWE 4015	22. DOCUMENT NO. 522/917 RTP F314014
23. FOLLOW-UP ACTION CAT 10 CHNNO1	24. PRODUCT CODE(S) 6952	

25. DISTRIBUTION	28. ENDORSER'S NAME & TITLE I-13
------------------	-------------------------------------

APR 21 1993

8

If you have any changes, additions, or comments you wish to make concerning your attached report, please make them in the space below.

I confirm that the information in the attached report (including any changes, additions, or comments I have made) is accurate to the best of my knowledge and belief.

Luong Thi Blou 4-28-93
Signature Date

I request that you do not release my name.

You may release my name to the manufacturer but I request that you not release it to the general public.

You may release my name to the manufacturer and to the public.

ISSUE 18
F314014
Ø952



(7)

5-11-93

Guelzow & Senteney, Ltd.

Trial Lawyers

703 Fifth Avenue ♦ P. O. Box 1243 ♦ Eau Claire, Wisconsin 54702
Telephone 715-834-0608 ♦ Fax 715-834-4043 ♦ 1-800-383-4200

C325048

February 15, 1993

Todd Stevenson
F.O.I.A. for C.P.S.C.
5401 Westbard Ave., Rm. 412
Washington D.C. 20207

0952

MAR 9 1993

RE: ~~Wilson Leather Protectant~~
Client's Name: ~~██████████~~

Dear Mr. Stevenson:

This letter is written pursuant to the Consumer Product Safety Commission - National Injury Information Clearinghouse's referral. This letter should be construed as a written request in accordance with the Freedom of Information Act. Please advise the undersigned of any forms available for future Freedom of Information Act requests.

We represent a 22 year old who has spent several weeks in coma after being hospitalized in early January 1993. She has been diagnosed with Adult Respiratory Distress Syndrome, kidney failure, and liver failure with no medical explanation available. Wilson's Leather Protectant has not been discharged as a possible cause for our client's health condition.

My understanding is Wilson voluntarily recalled their Leather Protectant in late December 1992. Therefore, please provide the undersigned with the following information on Wilson Leather Protectant and its subsequent recall: first, the number and demographics of complaints, the number and demographics of confirmed cases, and the signs & symptoms exhibited in these cases. Secondly, who is conducting investigations and the scope of these investigations.

5303025

Leather Protectant
C216

MRP/FVLER NOTIFIED	
No comments made	3/17
Comments attached	
Excisions/Revisions	
Firm has not requested further notice	

7/7/95

Thomas Kent Guelzow* ♦ George H. Senteney ♦ Robin A. Nelson

*Certified Trial Advocate: National Board of Trial Advocacy

Todd Stevenson
Page 2
February 15, 1993

Also, please advise the undersigned at 1-800-383-4200 with the volume of this request and whether a personal independent review would be beneficial. Arrangements can be made at this time for any costs associated with this request. We are more than willing to provide any information with others who are in similar circumstances.

Our client, and her family appreciate your cooperation with us.

Sincerely,

GUELZOW & SENTENEY, LTD.



Gwen Janell Anderson,
Paralegal

JUN 3 1993

CONSUMER PRODUCT INCIDENT REPORT

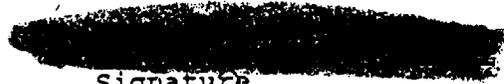
1. NAME OF RESPONDENT [REDACTED]		2. TELEPHONE NO. (Home) (Work) [REDACTED] —	
3. STREET ADDRESS [REDACTED]		4. CITY STATE ZIP CODE Superior WI 54880	
5. DESCRIBE ACCIDENT SITUATION OR HAZARD, INCLUDING DATA ON INJURIES. (Use second page if necessary.) Around the middle of November of 1992 I used a can of Wilson's leather spray on a coat, gloves and a book bag. Shortly after use I became weak and achy. On December 10 of '92 I went to a doctor, he prescribed pain pills. Those however, did not work. On December 25, 1992 I came down with a high temperature and again was given an antibiotic. Then, on January 4, 1993 I was admitted to the hospital because my lungs had filled up and I had a shortness of breath. Overall, my symptoms included a high temperature, adult respiratory distress syndrome, multi-organ failure and body aches & weakness.			
6. DATE OF INCIDENT(S) Mid-Nov '92	7. IF INJURY OR NEAR MISS, OBTAIN AGE 22 SEX F AND DESCRIBE INJURY See above	8. IF VICTIM DIFFERENT FROM RESPONDENT, PROVIDE NAME RELATIONSHIP	
9. DESCRIPTION OF PRODUCT Leather protectant spray (7 ounce can)		10. BRAND NAME Wilson's	
11. MANUFACTURER/DISTRIBUTOR NAME, ADDRESS & PHONE Wilson's Minneapolis, MN 55426		12. MODEL SERIAL NO.'S Lot # 7892 SKU# 18996003	
		13. DEALER'S NAME, ADDRESS & PHONE Wilson's Leather (715) 832-5616 Oakwood Mall 4800 Golf Road Space #330 Evel Claire, WI 54701	
14. WAS THE PRODUCT DAMAGED, REPAIRED OR MODIFIED? YES NO <input checked="" type="checkbox"/> IF YES, BEFORE OR AFTER THE INCIDENT? Describe		15. PRODUCT PURCHASED NEW <input checked="" type="checkbox"/> USED DATE PURCHASED Mid-Nov '92 AGE	
		16. DOES PRODUCT HAVE WARNING LABELS? IF SO, NOTE:	
17. HAVE YOU CONTACTED THE MANUFACTURER? YES NO <input checked="" type="checkbox"/> IF NOT, DO YOU PLAN TO CONTACT THEM? YES NO OTHER Depends on course of illness	18. IS THE PRODUCT STILL AVAILABLE? YES <input checked="" type="checkbox"/> NO IF NOT, ITS DISPOSITION	19. MAY WE USE YOUR NAME WITH THIS REPORT? YES <input checked="" type="checkbox"/> NO	
FOR ADMINISTRATION USE			
20. DATE RECEIVED	21. RECEIVED BY (Name & Office)		22. DOCUMENT NO.
23. FOLLOW-UP ACTION			24. PRODUCT CODE(S)
25. DISTRIBUTION		26. ENDORSER'S NAME & TITLE	

31

11/14 3 1993

If you have any changes, additions, or comments you wish to make concerning your attached report, please make them in the space below.

I confirm that the information in the attached report (including any changes, additions, or comments I have made) is accurate to the best of my knowledge and belief.



Signature

6-28-93

Date

I request that you do not release my name.

You may release my name to the manufacturer but I request that you not release it to the general public.

You may release my name to the manufacturer and to the public.

ISSUE 24
C325648
0952