



St. Mary's
Hospital
Medical Center

CLINICAL PROFILE

DATE 12/25/92

-02
YAEGER, BARBARA A 3N-9
MR#: 0302579 ADM: 12/25/92 318
REL: LUTH
AC#: 5589023 DOB: 08/06/55 FC: 7C

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	Sleep	<input type="checkbox"/> Good <input checked="" type="checkbox"/> Poor <input type="checkbox"/> Intervals	
	Bedrest Turn	<u>self</u>	
	CDB	<u>enc</u> Suction	
SAFETY	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
EQUIP / PREVENTION	Up in Hall	<input type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2)	Tolerance G F P Distance _____
	Linen Change #	<input type="checkbox"/> Complex Linen	
	Call Bell in Reach	Side Rails <u>2/2</u>	
MISC.	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		
Care Plan - Review Initials <u>AD</u>			
Initials - Responsible RN <u>AD</u>			
Initials - Care Provider <u>AD</u>			

DIET	BREAKFAST	LUNCH	SUPPER
	G F P	G F P	G F P
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	Mouth Care	<u>self</u>	
	Skin Care	<u>self</u>	
ACTIVITY	Sleep	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input checked="" type="checkbox"/> Intervals	
	Bedrest Turn	<u>self</u>	
	CDB	<u>enc</u> Suction	
SAFETY	BRP	<input type="checkbox"/> Commode <input type="checkbox"/> Elev. Toilet	
	Assist	<input checked="" type="checkbox"/> Urinal <input type="checkbox"/> Bedpan	
	Up in Chair	<input checked="" type="checkbox"/> Self <input type="checkbox"/> Hoyer	With help (1, 2, 3) Length of time <u>PRN</u> Tolerance <input checked="" type="checkbox"/> G <input type="checkbox"/> F <input type="checkbox"/> P
EQUIP / PREVENTION	Up in Hall	<input checked="" type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2)	Tolerance <input checked="" type="checkbox"/> G <input type="checkbox"/> F <input type="checkbox"/> P Distance <u>to Shower</u>
	Linen Change #	<input type="checkbox"/> Complex Linen	
	Call Bell in Reach	Side Rails <u>2/2</u>	
MISC.	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		
Care Plan - Review Initials <u>KP</u>			
Initials - Responsible RN <u>KP</u>			
Initials - Care Provider <u>KP</u>			

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	Bedrest Turn		
	CDB		
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MISC.	Restraints	<input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> All	
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	Bed Check System		
Care Plan - Review Initials _____			
Initials - Responsible RN _____			
Initials - Care Provider _____			

DATE _____ DAY _____

NIGHT

DAY

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	G F P	G F P	G F P
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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	
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	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		
	Therapeutic Bed	_____	
	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 Nrg _____ hours		
	Care Plan - Review Initials		
	Initials - Responsible RN		
	Initials - Care Provider		

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<input type="checkbox"/> Bed Check System			
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EQUIP / PREVENTION	Elastic Hose	<input type="checkbox"/> Knee <input type="checkbox"/> Thigh	
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	Therapeutic Bed	_____	
	Aqua K	_____ <input type="checkbox"/> Sitz	
	<input type="checkbox"/> Ice _____		
	<input type="checkbox"/> Room Deodorizer <input type="checkbox"/> Trapeze		
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	Initials - Responsible RN		
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	Therapeutic Bed	_____	
	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 Nrg _____ hours		
	Care Plan - Review Initials		
	Initials - Responsible RN		
	Initials - Care Provider		

INITIALS & SIGNATURES

<i>KPKP</i>			
<i>RP & Lehler RN</i>			

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	100 ⁸	99 ⁸	98 ⁸																		
PULSE	150	112	100																		
RESPIRATIONS	24	24	16																		
	AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM	
BP	12	13 ⁴ / ₁₀	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	
	8	110 ¹ / ₇₀	8	8	8		8	8		8	8		8	8		8	8		8	8	
WEIGHT																					

=====

YAEGER, BARBARA A F 37
MR#: 0302579 ACCT#: 5589023
SERV: MEDI SN-S 318
MD: [REDACTED] ADM: 12/25/92
DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA
=====

DISCHARGE REPORT

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

ALLERGIES:

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

LKAO
LKAO
LKAO

VITAL SIGNS:

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

PLUEMER KELLY RN
PERLKE KAROLYN RN

OTHER PATIENT DATA:

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

DISCHARGED, 318, 70: 12/25/92, 12/25/92 11:00....11:00

CONTINUED

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12/26/92 03:01

(QAXPRG)

PAGE 002

YAEGER, BARBARA A

F 37

MR#: 0302579

ACCT#: 5589023

SERV: MEDI

3N-S

318

MD:

ADM: 12/25/92

DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA

=====

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

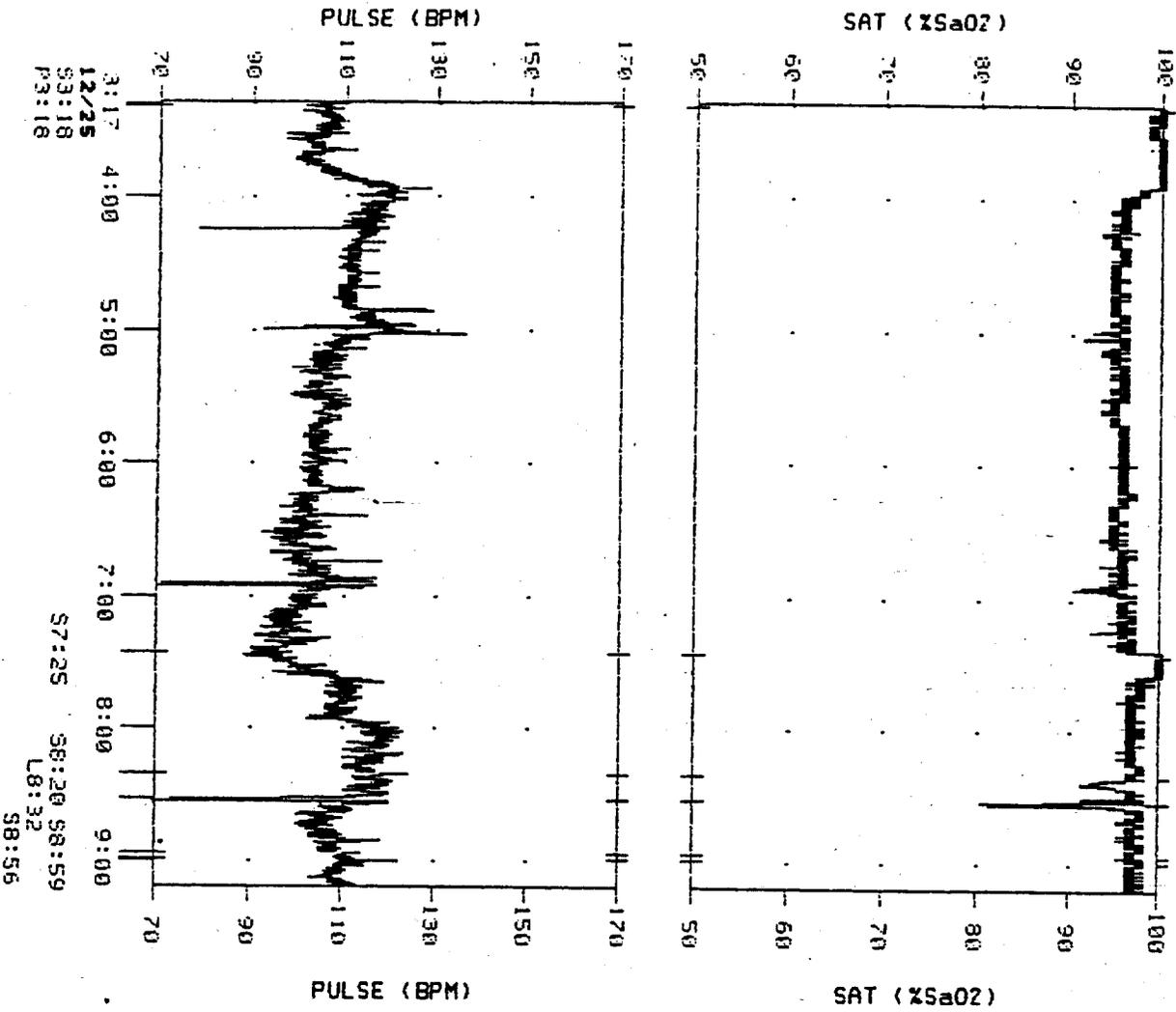
DISCHARGE REPORT

RESPIRATORY THERAPY NOTES:

12/25 01:10	UPDRAFT NEBULIZER ALBUTEROL 0.083% IN 2.5ML NS....FIO2: OXYGEN. HEART RATE 112BPM BEFORE TX. HEART RATE 120BPM AFTER TX. COUGH STRONG HARSH NON-PROD BREATH SOUNDS DIMIN THROUGHOUT BEFORE TRT WITH- NO CHANGE AFTER TRT	IBAD IBAD
	COMMENTS:--PEAK FLOWS 200 LPM BEFORE TRT. 340 LPM AFTER TRT.	IBAD
12/25 03:15	O2 SETUP O2 HUM BOTTLE O2 VIA CANNULA SET UP O2 ON O2 FLOW AT 4LPM PULSE OX DAILY PULSE OX ELECTRODE OXIMETER ON ON O2 FLOW 4LPM	IBAD IBAD IBAD IBAD IBAD
12/25 03:45	UPDRAFT NEBULIZER ALBUTEROL 0.083% 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 IBAD
12/25 07:15	UPDRAFT NEBULIZER ALBUTEROL 0.083% IN 2.5ML NS....FIO2: OXYGEN PEAK FLOW BEFORE 240LPM; PEAK FLOW AFTER 300LPM. HEART RATE 92BPM BEFORE TX. HEART RATE 100BPM AFTER TX. BREATH SOUNDS: CLEAR AND DIMIN THROUGHOUT BEFORE TRT WITH- INCREASED AIR EXCHANGE AFTER TRT. COUGH SPONTANEOUS NON-PROD	IBAD JSAF JSAF
12/25 09:00	O2 DAILY O2 OFF PULSE OX DAILY	JSAF JSAF JSAF
12/25 10:15	UPDRAFT NEBULIZER TRT- NOT GIVEN. REASON: PT REFUSED. REASON: NOT NECESSARY	KMA
12/25 11:30	OXIMETER HRS 8 OXIMETER NOTE: , OXIMETER OFF ,, DC'D PER ORDER	SWAC SWAC

LASTPAGE

PATIENT TREND GRAPH by NELLCOR





PATIENT CARE PLAN

PNEUMONIA

Date/Time

YAEGER, BARBARA A
 MR#: 0302572 ADM: 12/25/92 318
 AC#: 5589023 DOB: 08/06/55 REL: LUT- FC: 7C
 3N-S

DISCHARGE PLANS

Home No Assistance Assistance

Skilled Nursing Facility:

Rehabilitation Facility:

Other:

Signature/Initial

Primary Nurse

1. *[Signature]*
 2. *[Signature]*
 3. *[Signature]*
 4. _____
 5. _____
 6. _____
 7. _____

Onset Date	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 expectoration. 5) Provide frequent oral care after expectoration. Pt preferences are: <i>AG + CCo</i> 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 <input checked="" type="checkbox"/> Pleuritic pain <input checked="" type="checkbox"/> fever <input checked="" type="checkbox"/> coughing	Relief of pain. Able to cough up secretions	<ol style="list-style-type: none"> 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. <p><i>Sharon Pennington</i></p>	12:25-92 RP
	4. Knowledge deficit R/T disease transmission & etiology	Pr. & family will verbalize understanding of disease process, treatment, & prevention	<ol style="list-style-type: none"> 1. Advise to maintain natural resistance with good nutrition, adequate fluid intake & rest. 2. Avoid chilling & contact with people. 3. Encourage gradual increase in activity. 	

YAEGER, BARBARA A 3N-S
MR#: 0302579 ADM: 12/25/92 318
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 ltr. O2 sat 100%. C/O nausea & turning abdomen soft & bowel sounds. (P) pale. Skin warm & dry. Temp 100.8. IV site asymptomatic. ——— K Plummer		
	0345	comfort	D	C/O headache		
		airway clearance	A	Tylenol 500 mg given		
			D	C/O tightness in chest		
			A	RT called to give treatment		K Plummer
	0400	Resp	R	O2 off O2 sat 97%. SOB ↑. Slightly dyspneic @ rest. ——— K Plummer		
	0500	Comfort	D	Desires further headache.		
		Temp	D	Temp is 99.8.		
		Resp	D	"I'm breathing better" Able to rest. SOB ↓. ——— K Plummer		
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. BS x4. Denies nausea, headache or chills. No edema noted. IV site patent + asept. N. Pehlke		
	1110	Discharge	A:	IV d/c'd. O2 stat monitor d/c'd. Discharge instructions given. Discharged per family. ——— N. Pehlke		



St. Mary's
Hospital
Green Bay, WI

YAEGER, BARBARA A 3N-8
MR#: 0302579 ADM: 12/25/92 318
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 For <i>chest</i>	Room <i>318</i>	T <i>100.8</i>	P <i>100</i>	R <i>24</i>	Instructions in use of siderails	<input checked="" type="checkbox"/>
Admitted From <i>ER</i>	Accompanied by <i>ER Nurse</i>	<i>138/76</i>			Bed Operation	<input checked="" type="checkbox"/>
Admitting Dr. <i>[Redacted]</i>	Family Dr. <i>[Redacted]</i>	Last Chest X-ray <i>ER</i>			Nurse Call System	<input checked="" type="checkbox"/>

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 Wiskol leather spray
2200 spray again

2030 cough
2230 - Bausen SOB uncontrollable cough - Chills

HEALTH HISTORY

Previous Hospitalization/Chronic Conditions/Injuries/Last Physical Examination
8 yrs ago - Fibro cysts
8 yrs ago - Fibro cysts
Slight heart murmur
Anesthesia Hx: (malignant Hyperthermia)
Transfusion Hx: (Previous Transfusions/Reactions, including Febrile Reactions) <input checked="" type="checkbox"/>

NSG DIAGNOSIS

- Health Maintenance Alteration
- 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"/> lesions
24hr recall of food/fluid: - fruit cup - bread muffin coffee green tea 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. Alteration
 - 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 flatulence <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		Smoking (duration, # pks/day) <input checked="" type="checkbox"/>
Paralysis/Weakness		Smoking regulations explained <input checked="" type="checkbox"/>
Amputation/Prosthesis		Family Hx Heart or Lung Disease <i>lung - grandfather</i>
Respiratory Rate <i>24</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"/>
On... <i>yes</i>		Chest Pains <i>yes slight</i>
Dyspnea <i>yes</i>		Edema <input checked="" type="checkbox"/>
Wheezing <i>yes</i>		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>7-8 hrs</i>	Sleep onset problems <i>no</i>
Feel rested for daily activities after sleep	Dreams/Nightmares <i>no</i>
Sleep Aids (pillows, meds, foods) <i>yes</i>	Early Awakening <i>no</i>

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

SEXUALITY REPRODUCTIVE PATTERN

LMP - <i>2 weeks</i>	Duration <i>5 days</i>	Breast Self Exam
Character	Any Changes/Problems in Sexual Relations (if appropriate)	
Discomfort - <i>yes</i>	Discharge	
Contraceptives		
Last pelvic exam/pap smear - <i>last summer</i>		
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
	<i>good</i>
Most important aspects of your life are?	Nervous/Relaxed <i>relaxed</i>

NSG DIAGNOSIS

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

ROLE RELATIONSHIPS COPING

Occupation <i>school teacher</i>	Interaction with Family/Friends
Live Alone/with Others	
<i>husbands / kids</i>	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? - <i>Catholic</i>
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? <i>yes</i> (Explain Pastoral Care Services and how to obtain)
Do you have a living will / power of attorney on file? If so, where?
Valuables/Disposition <i>Patent</i>
Person Supplying Information <i>Patent</i>
Dr. Notified at Time R.N. Signature <i>K Plummer RN</i>

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

DRESSING 1 AMBULATING 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

oriented

Signature: [Signature]

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: 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:

Reassess 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: IED = 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 marker system.

Applied _____

Not applied: _____ Reason: _____

Signature: _____

DISCHARGE INSTRUCTIONS

YAEGER, BARBARA A 3N-E
 MR#: 0302579 ADM: 12/25/92 318
 [REDACTED] 37 REL: LL
 AC#: 5589023 DOB: 08/06/55 FC:

1. Your next appointment with [REDACTED] is _____
2. Activity/Care Instructions:

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

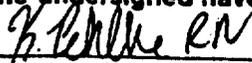
3. Diet: as tolerated

4. Medications:

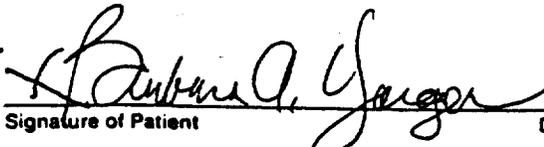
Name	Dose	Time you should take it
MAXAIR Inhaler	2 puffs	Every 4 to 6 hours if needed for wheezing.
prednisone	10mg	TAKE 2 TABLETS Three times A day - with food

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.


 Signature of Discharge Nurse

12-25-92
 Date


 Signature of Patient

Date

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.

EENT: 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 24. 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



BROWN COUNTY PARAMEDIC REPORT

DATE: 12, 25, 92

SERVICE: GRFD

ID. #: 168

STATION: 6

UNIT: R-6-B RUN #: 210880

Patient Name: <u>BARBERA A. YAEGER</u>		Requested By: <u>PT. / 911</u>	Name: <u>J SAUGER</u> EMT #: <u>506</u>	Mileage:	Military Time
Patient Address: <u>800 STONY BROOK, GREEN BAY</u>		Phone #:	EMT: <u>C MADZIMA</u> <u>1276</u>	End	Call Rec. <u>00:30</u>
Loc. of Pickup: <u>800 STONY BROOK</u>		DOB: <u>8.06.55</u>	<u>S WOLFORD</u> <u>38288</u>	Begin	10-76 <u>00:35</u>
Municipality: <u>GREEN BAY</u>		Age: <u>37</u> Doct: <u>[REDACTED]</u>	<u>GRFD E-6</u>	Total	10-23 <u>00:35</u>
LOC: <input checked="" type="radio"/> Alert Verbal Pain Unresp. PNB		Weight: <u>130#</u> Sex: <u>M</u>		10-76 <u>00:44</u>	
Chief Complaint (Mech. of Injury): <u>MYSAEA AFTER EXPOSURE TO AN AEROSOL LEADER PROTECTOR, TOTAL EXPOSURE TIME 1/2 -> 3/4 HOURS.</u>		ALLERGIES: <u>NKA</u>		10-7 <u>00:48</u>	
Home Meds. (Dosage, #/Day): <u>NONE</u>				10-8 <u>00:59</u>	

Past Medical History: HEART MURMUR

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

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. @ JNA, PERAL EDEMA.

TIME / EMT #	EMT #	:	EMT #	:	EMT #	:	EMT #	:	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
LIDO DRIP	2	3	4	2	3	4	2	3	4	2	3	4
MORPHINE												
NA:												
NITROGLYCERIN	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	1	1	1	1	1	1	1	1	1	1
PULSE	114	P	P	P	P	P	P	P	P	P	P	P
RESPIRATIONS	24	R	R	R	R	R	R	R	R	R	R	R
DEFIB JOULES	200	300	M	200	300	M	200	300	M	200	300	M
OTHER DRUG/PROCEDURE	<u>O₂ @ 10L</u> <u>NON-REBREATHER MASK.</u>											
PUPILS	<u>NORMAL</u>											

IV Attempts: _____ IV Started?: Y/N By #: _____ Time: _____ Intubated By #: _____ Time: _____ ET# _____ EGTA _____

COMMENTS: _____

ETA (Without further orders, including Loading Time): _____ Min. NO TRANSPORT RELEASE SIGNED: Y/N

Signed: [Signature] EMT #: 506 TIME: 00:58 E. R. Physician: ALTON

*EMT in Charge: _____ Chart Review?: Y/N Page _____ of _____ Destination: St. V. St. M. Bellin Other _____

08/88 MJM ORIGINAL - Hospital Coop #3

369

FIELD ACTIVITY COVERSHEET

1. REGION/STATE FOCR	2. OPERATION (Check One) <input type="checkbox"/> Inspection <input type="checkbox"/> Establishment Visit <input type="checkbox"/> Telephone Contact <input checked="" type="checkbox"/> Investigation <input type="checkbox"/> Other _____	3. DATE 1-4-93 4. NUMBER (For RO Use) 921230CCN0563
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5. ESTABLISHMENT Name <u>Wilson's Suede and Leather, Inc.</u> Address <u>400 HWY 169 South</u> City <u>Minneapolis</u> State <u>MN</u> Zip _____ Telephone No. _____
--

6. RELATED FIRM <input type="checkbox"/> Parent <input type="checkbox"/> Headquarters <input type="checkbox"/> Subsidiary <input type="checkbox"/> Other _____ Name _____ City _____ State _____
--

7. PRODUCTS COVERED <u>Wilson's Leather Protector</u> _____ _____	8. OTHER CONSUMER PRODUCTS _____ _____
---	---

9. ESTABLISHMENT TYPE <input type="checkbox"/> Manufacturer <input type="checkbox"/> Importer <input type="checkbox"/> Wholesaler <input type="checkbox"/> Own Label Distributor <input type="checkbox"/> Retailer <input type="checkbox"/> Repackager <input type="checkbox"/> Other _____	10. ANNUAL PRODUCTION Product Covered \$ _____ Units _____ Other Products \$ _____ Units _____
--	---

11. I.S. BUSINESS % Received _____ % Shipped _____	12. SAMPLES COLLECTED _____	13. MIS CODE _____	14. HOURS Activity _____ Travel _____
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15. REASON FOR ACTIVITY (Assignment Reference) _____
--

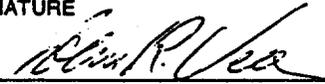
16. ANNOUNCED <input type="checkbox"/> Rationale for Announced Inspection UNANNOUNCED <input type="checkbox"/>

17 EMPLOYEE'S NAME _____	TITLE _____	SIGNATURE _____
------------------------------------	-----------------------	---------------------------

18. (X) ENDORSEMENT	<input type="checkbox"/> REMARKS	<input type="checkbox"/> SUMMARY	<input type="checkbox"/> OTHER _____
----------------------------	----------------------------------	----------------------------------	--------------------------------------

A 25 year old woman suffered respiratory distress after using Wilson's Leather Protector, 5 oz. can, to spray a leather coat and boots. The victim saw a doctor and was diagnosed as having a reaction to a chemical irritant.

F/U: Refer to Compliance.

19. REVIEWER'S NAME John R. Vece	TITLE S.P.S.I.	SIGNATURE 
--	--------------------------	---

20. REVIEW DATE 1-14-93	21. DISTRIBUTION O: EPDS; cc: CERM, C. Jacobson; (c: EF; cc: FOCR.
-----------------------------------	--

8F

EPIDEMIOLOGIC INVESTIGATION REPORT

1. CASE NO. 921230CCN0563			2. INVESTIGATOR'S ID 8 1 5 6			3. OFFICE CODE 8 3 0		
4. DATE OF ACCIDENT YR MO DAY 92 1 2 2 7			5. DATE INVESTIGATION INITIATED YR MO DAY 9 3 0 1 0 4					

6. SYNOPSIS OF ACCIDENT OR COMPLAINT The 25 yr. old female complainant used an aerosol container of leather protector on a leather coat and pair of boots inside her home. She said about an hr. later she experienced SOB, tightness in chest, coughing spells and other respiratory distress. Her 6 yr. old son also experienced some respiratory problems. She visited a medical clinic was treated for reaction to chemical irritant. She has recovered from this incident.

7. LOCATION (Home, school, etc.) Home	8. CITY 1 0 White Bear Lake	9. STATE Minnesota	M N
--	------------------------------------	-----------------------	-------

10A. FIRST PRODUCT Aerosol Leather Protector	0 9 5 2	11A. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS 5 Oz. SKU# 18996003 "C129" Wilsons-The Leather Experts, 400 Hiwy# 169 So; Mpls, MN.
---	---------------	---

10B. SECOND PRODUCT None	0 0 0 0	11B. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS N/A
-----------------------------	---------------	--

12. AGE OF VICTIM 0 2 5	13. SEX (Use numerical code) MALE - 1 FEMALE - 2 UNKNOWN - 3 2	14. DISPOSITION T & R 1	15. INJURY DIAGNOSIS Chemical Irrit. 6 8
--------------------------------	--	-------------------------------	--

16. BODY PART APB 8 5	17. RESPONDENT(S) (Mother, Friend) Complainant, Doctor 1	18. TYPE INVESTIGATION ON SITE 1 TELEPHONE 2 OTHER 3 1	19. TIME SPENT 0 9 0 1 hr. avg
-------------------------------	--	--	--

20. ATTACHMENTS Product Label, MD Rept, Etc. 9	21. CASE SOURCE Complaint 0 7	22. REVIEWED BY 8/30 9/30/94
--	---------------------------------------	------------------------------------

23. PERMISSION TO DISCLOSE NAMES (NON-NEISS CASES ONLY)
 CPSC MAY DISCLOSE MY NAME XX
 CPSC MAY NOT DISCLOSE MY NAME

24. NARRATIVE (See Instructions on Other Side) SEE ATTACHED	25. REGIONAL OFFICE DIRECTOR REVIEW DATE
--	---

~~NOTIFY~~ LBR NOTIFIED
 ___ No comments made
 ___ Comments attached
 ___ Excisions/Revisions
 Firm has not requested further notice
 6/28/94 JHP

(USE OTHER SIDE AND ADDITIONAL SHEETS IF NECESSARY)

921230CCN0563

SUMMARY:

The complainant said she received a new leather jacket on 12/24/92. When the jacket was purchased they also bought a 5 ounce aerosol can of leather protector from the same store. This is a product you spray on the coat to help protect it from dirt and moisture.

She said several days later on 12/27/92 she decided to apply the leather protector to her coat. She added that her husband had a pair of leather boots so she decided that she would apply the protector product to both products.

She was in a split level home and on the upper level where the kitchen, dining room and living room all adjoined. She said that the house was closed up as it was winter in Minnesota and guessed that the outside temperature was probably in the teens. She sprayed both her jacket and the boots and guessed it took about 15 minutes and she used up about half of the contents of the 5 ounce aerosol container. While she was applying the spray her son (6 years old) and a sister-in-law were in an adjoining room on the same level. Her husband was not present.

She said about an hour later she experienced shortness of breath, tightness in her chest, sporadic coughing spells, and a sore throat. An hour later her 6 year old son developed a sporadic cough, neck pain and a sore throat. She said to a lesser degree her sister in law developed a cough. She said she's a non-smoker with some minor history of asthma-like conditions. She said she's allergic to cats and dogs. She said these conditions occurred many years ago and she's not under medical attention for her asthma. She said she just avoids going to homes where there are dogs and cats which has eliminated that problem. None of the other family members have any history of respiratory problems.

She visited a medical clinic on the following day and was diagnosed as having a reaction to a chemical irritant. She was given an inhaler for her cough spasms when needed (See Attachment 3). She and the other family members had recovered from their respiratory problems at the time of my investigation. She added that her husband who was not present when the product was being used did not experience any of the respiratory problems experienced by the other family members.

She said she did contact the distributor of the product about her experience with the leather protector. She was told by someone in customer service that the office has been receiving a number of calls regarding their 5 ounce container of aerosol leather and suede protector. She was told by the firm that she should see her physician and if her physician had any questions as to the ingredients within the product they should contact them. She was told that they could return the product at any of their retail stores in the Twin Cities, Minnesota area.

STANDARDS ADHERENCE:

There is no information available on the product's container in respect to adhering to any voluntary or mandatory safety standards.

SAMPLES COLLECTED:

As requested by FOIC (Vece) I collected the partially used 5 ounce aerosol container of "Wilson" Leather Protector from the complainant. This product was sampled, identified and sent to HSAM under Sample R-030-4206.

PRODUCT IDENTIFICATION:

Product involved in this incident is a 5 ounce aerosol container of suede and leather protector. Examination of the label reveals the following information:

"Suede and Leather Protector ***Wilson's ***Caution: Vapor may be harmful. ***Net Weight - 5 ounces. ***No Fluorocarbons. ***Caution: Extremely flammable. Contains petroleum distillates. ***Keep Out Of Reach Of Children*** ***Manufactured for Wilson's*** Minneapolis, Minnesota 55426 SKU-18996003 ***C 129***".

Product was purchased on 12/24/92 from:

Wilson's
Lakewood Mall
St. Paul, Minnesota

921230CCN0563

(3)

Product is manufactured for:

Wilson's The Leather Experts
400 Hwy 169 South
Minneapolis, Minnesota 55426

ATTACHMENTS:

1. Copy of Product Label
2. Copy of CR R-830-4206
3. Medical Records

921230 CCN0548

1

WILSONS

LEATHER
PROTECTOR

MAKES SUEDE AND LEATHER
STAIN AND WATER RESISTANT

KEEPS DIRT ON THE SURFACE
FOR EASY WIPE-OFF

NEVER CHANGES COLOR OR
ADVERSELY AFFECTS MATERIAL

CONTAINS NO SILICONE

CONTAINS NO OZONE
DEPLETING CHEMICALS

CAUTION: VAPOR MAY BE HARMFUL.
CONTENTS UNDER PRESSURE.
READ CAREFULLY OTHER CAUTION
ON BACK PANEL.

NET WT. 5 OZ.

Q21230CCN0868

#1

NO. FLUOROCARBONS

INSTRUCTIONS: SHAKE WELL. APPLY BEFORE EXPOSURE TO
STAINING. GARMENT MUST BE CLEAN AND DRY. HOLD
UPRIGHT 8 TO 10 INCHES FROM SURFACE AND SPRAY
EVEN COAT OVER ENTIRE SURFACE INCLUDING
COLLARS, SLEEVES, SEAMS AND STITCHING. DO NOT
HEAT. ALLOW TO DRY OVERNIGHT AND REPEAT
TREATMENT PERIODICALLY. AFTER EACH WASH
ESPECIALLY IN WET WEATHER, REMOVE SLUSH, DIRT AND
SALT TO PREVENT PERMANENT MARKS.

CAUTION: EXTREMELY FLAMMABLE. CONTAINS
PETROLEUM DISTILLATES. DO NOT STORE OR USE
NEAR FIRE, SPARKS, OR HEATED SURFACES.
CONTENTS UNDER PRESSURE. DO NOT PUNCTURE.
MAY CAUSE BURSTING. PLEASE DO NOT SMOKE
WHILE USING THIS PRODUCT.

KEEP OUT OF REACH OF CHILDREN



MANUFACTURED FOR:

WILSONS

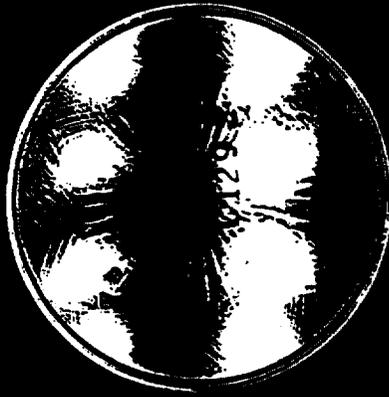
MINNEAPOLIS, MN 55426

18996001



00189 96003 2

~~9212306620568~~
9212306620568
#1



U. S. CONSUMER PRODUCT SAFETY COMMISSION

SAMPLE COLLECTION REPORT

1. Flag		2. Date Collected 1-4-93		3. Sample type & number <input checked="" type="checkbox"/> Physical R-830-4206 <input type="checkbox"/> Documentary	
4a. Product name Aerosol Container of Leather/ Suede Protector		4b. Model 5 Oz. Can SKU 18996003		4c. NEISS 0952	
5. Assignment ref. IDI# 921230CCN0568		6. Complete for import samples		7. MIS 33672	
a. Port of Entry		b. Entry # & date		8. Hours: a. Activity 4 b. Travel 1	
c. Country of Origin		d. HSUSA code		9a. Home RO FOCR	
e. Customs Contact				9b. Collecting RO MSP-RP	
10. Sample Cost \$5.00 cash		11. Invoice value of lot \$.00		12. Size of lot 1 Can	
13. Manufacturer/Importer Distributor Wilsons 400 Hiwy# 169 So., St#600-- Mpls, MN. 55426 ID #		14. Shipper/Foreign Mfr. Retail Store Wilsons Maplewood Mall St. Paul, MN. 55109 ID#		15. Consumer Consumer Michele Huston 3580 Dell Court White Bear Lake, MN. 55110 ID#	
16. Supporting documents attached: None					
a. Invoice # & date:			b. Date Shipped:		
c. Shipping record # & date:					
d. Affidavit signer's name, title & date:					
17. Product Identification: METAL AEROSOL CONTAINER OF LEATHER PROTECTOR/Labeled in part, "SUEDE & LEATHER WILSONS *** LEATHER PROTECTOR *** CAUTION: VAPOR MAY BE HARMFUL *** NET WT. 5 OZ. ***NO FLUOROCARBONS *** CAUTION: EXTREMELY FLAMMABLE. CONTAINS PETROLEUM DISTILLATES ***KEEP OUT OF REACH OF CHILDREN *** MANUFACTURED FOR: WILSONS *** MINNEAPOLIS, MN 55426 SKU 189960003 ***C129***".					
18. Reason for collection & analysis needed: FHSA XX CPSA FFA PPPA RSA Sample collected as F/U to IDI#921230CCN5668 regarding complainant's reaction to aerosol product after use. Assign from FOCR (Vece).					
19. Summary of Field Screening: None					
20. Sample Size, Method of Collection: The above consumers partially used can of the aerosol product was collected as requested by FOCR (Vece). The unit was identified, placed in a paper bag, sealed and prepared for shipment to HSHL for evaluation.					
21. Identification on sample "R-830-4206 1-4-93 JRB"		22. Identification on seal "R-830-4206 1-4-93 Jerome R. Boog"			
23a. Sample delivered to U.S. Mail; St. Paul, MN.		23b. Date 1-5-93		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 The consumer used the above product of her new leather coat and a pair of boots. Used for about 15 minutes inside home. Four later she experienced SOB, tightness in chest, coughing and respiratory distress. Four later her son (6 yrs) began coughing, neck pain and sore throat. Family has recovered.					
27. Related Samples None					
28a. Collector's name, title & employee # Jerome R. Boog, Investigator 8156			28b. Collector's signature & date <i>Jerome R. Boog</i> 1-5-93		
29a. Reviewer's name, title & employee # John R. Vece, Supv.			29b. Reviewer's signature & date		

CONSUMER PRODUCT SAFETY COMMISSION
FEDERAL COURTS BUILDING, RM. 128
316 N. ROBERT STREET
ST. PAUL, MINNESOTA 55101

Ren Huston

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO:

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) Michelle T. Huston
(NAME)

Myself
(RELATIONSHIP TO YOU)

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

The approximate date of hospitalization was 12-28-92 and/or
the nature of treatment received was Chemical spray
Reaction

The reason for the request is that this agency is conducting an investigation of the incident affecting the above named individual. The records will be included in a report which will be used for official purposes only.

I understand that I may revoke this authorization at any time. The expiration date of this request is 1-31-93.

1-4-93
(DATE)

Michelle T. Huston
(SIGNATURE)
Jerome R. Boyer
(WITNESS)

921230CCN0568

3

01/06/93 09:48 FAX 612 777 7839

NO ST PAUL MED C

001

Page No. 3

NORTH ST. PAUL MEDICAL CENTER
2579 East Seventh Avenue
North St. Paul, MN 55109

Allergies _____

X-Ray No. 31993

Harold R. Broman, M.D.
Thomas P. Haas, M.D.

William R. Schroeder, M.D.
Edward M. Dennison, M.D.

Name Huston, Michelle

Date of Birth 7/17/67

Address _____

Head of Family same

Sex F S M W

Telephone Number _____

Atten: Jerry Boog

MONDAY	DEC 28 1992	(B) COUGH x 2 days	
1-5765	SOB	POSS. REACTION f/leather	
	SPRAY clo. HA.	neck ache, SOB.	
	1997	BLP	
<p>MUSUN, Michelle 12-28-92 (dict 12-28-92/typed 12-29-92)</p> <p>S: Pt sprayed a new leather coat with Protector spray, Leather protector spray from Wilson's. Evidentially this was a new chemical spray to protect her coat and has caused some irritations in other people. She says that she has developed a reaction from the spray. Developed a headache and a neck ache, felt tightness in her chest and has been coughing. Her only medication is MZ's. She has had one previous history of an asthmatic bronchitis when she was exposed to a cat and dog, required hospitalization years ago. She has never had any other history of asthma.</p> <p>O: Her vit's are clear. Pharynx is clear. Lungs are clear. There is no wheezing, rales or respiratory distress.</p> <p>A: Chemical irritant.</p> <p>Z: Pt was advised to avoid contact with the leather coat that has been sprayed. She is given a <u>Marol</u> inhaler to use for the spray and she is to take the spray back to Wilson's and not use it again.</p>			

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.

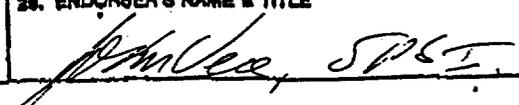


My identity is to remain confidential.

Michelle J. Houston
(Signature)

1-4-93
(Date)

CONSUMER PRODUCT INCIDENT REPORT

1. NAME OF RESPONDENT Michelle Huston		2. TELEPHONE NO. (Home) (Work) (612) 779-1929 690-1751	
3. STREET ADDRESS 3580 Dell Court North		4. CITY STATE ZIP CODE White Bear Lake, MN 55110	
5. DESCRIBE ACCIDENT SITUATION OR HAZARD, INCLUDING DATA ON INJURIES. (Use second page if necessary.) The respondent reported that she and two other people at this residence experienced respiratory illness after this product was used by her to treat a pair of boots and a leather coat. The product was sprayed on these garments in a large open area of the home. The spraying was done in about 15 minutes and used up about 1/2 of the 5 oz. can. An hour later the respondent experienced shortness of breath, tightness in chest and coughing spells. An hour after this happened her 6 year old son began coughing and experienced neck pain and sore throat. The respondent's sister-in-law was visiting and she also experienced coughing spells. The respondent saw her doctor, but she is still running a temp. (99°-100°F) has a headache and neckache, feels lethargic and continues to cough.			
6. DATE OF INCIDENT(S) 12-27-92	7. IF INJURY OR NEAR MISS, OBTAIN AGE 25 SEX F AND DESCRIBE INJURY respiratory illness	8. IF VICTIM DIFFERENT FROM RESPONDENT, PROVIDE NAME RELATIONSHIP	
9. DESCRIPTION OF PRODUCT Aerosol leather protector (5 oz. can)		10. BRAND NAME Wilson's Leather Protector	
11. MANUFACTURER/DISTRIBUTOR NAME, ADDRESS & PHONE Wilson's- The Leather Experts 400 Hiway 169 South Mpls, MN 55426		12. MODEL, SERIAL NO.'S UPC SKU 18996003 On bottom C129	
		13. DEALER'S NAME, ADDRESS & PHONE Wilson's Maplewood Mall St. Paul, MN	
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 12-24-92 AGE	
		16. DOES PRODUCT HAVE WARNING LABELS? Yes IF SO, NOTE: Caution Vapor May Be Harmful Caution: EXT. Flammable, Contains Pet. Dist.	
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) Carolyn A. Schultz, MSP-RP	
23. FOLLOW-UP ACTION Conduct IDI 921230CCN0563		22. DOCUMENT NO.  C 0163	
		24. PRODUCT CODE(S) ? 0952	
25. DISTRIBUTION C EPDS; cc: CEI, Successor, cc: EV		26. ENDORSER'S NAME & TITLE  SP5	

FIELD ACTIVITY COVERSHEET

1. REGION/STATE FOCR	2. OPERATION (Check One) <input type="checkbox"/> Inspection <input type="checkbox"/> Establishment Visit <input type="checkbox"/> Telephone Contact <input checked="" type="checkbox"/> Investigation <input type="checkbox"/> Other _____	3. DATE 12-29-92 <hr/> 4. NUMBER (For RO Use) 921229CCN0543
------------------------------------	---	--

5. ESTABLISHMENT	Name <u>Wilson's Suede and Leather Inc.</u> Address _____ City <u>Minneapolis</u> State <u>MN</u> Zip _____ Telephone No. _____		
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6. RELATED FIRM	<input type="checkbox"/> Parent <input type="checkbox"/> Headquarters <input type="checkbox"/> Subsidiary <input type="checkbox"/> Other _____ Name _____ City _____ State _____		
------------------------	---	--	--

7. PRODUCTS COVERED <u>Wilson's Leather Protector</u> _____ _____	8. OTHER CONSUMER PRODUCTS _____ _____
---	---

9. ESTABLISHMENT TYPE <input type="checkbox"/> Manufacturer <input type="checkbox"/> Importer <input type="checkbox"/> Wholesaler <input type="checkbox"/> Own Label Distributor <input type="checkbox"/> Retailer <input type="checkbox"/> Repackager <input type="checkbox"/> Other _____	10. ANNUAL PRODUCTION Product Covered \$ _____ Units _____ Other Products \$ _____ Units _____
--	---

11. I.S. BUSINESS % Received _____ % Shipped _____	12. SAMPLES COLLECTED _____	13. MIS CODE _____	14. HOURS Activity _____ Travel _____
---	---------------------------------------	------------------------------	--

15. REASON FOR ACTIVITY (Assignment Reference) _____
--

16. ANNOUNCED <input type="checkbox"/> Rationale for Announced Inspection UNANNOUNCED <input type="checkbox"/>

17. EMPLOYEE'S NAME _____	TITLE _____	SIGNATURE _____
-------------------------------------	-----------------------	---------------------------

18. (X) ENDORSEMENT	<input type="checkbox"/> REMARKS	<input type="checkbox"/> SUMMARY	<input type="checkbox"/> OTHER _____
----------------------------	----------------------------------	----------------------------------	--------------------------------------

A 17 yr. old suffered severe respiratory distress after using Wilson's Leather Protector to treat 2 new leather coats. The product was sprayed on the coats in an enclosed porch. The victim was taken to a local hospital and was diagnosed as suffering from chemical pneumonia.

F/U: Refer to Compliance.

19. REVIEWER'S NAME John R. Vece	TITLE S.P.S.I.	SIGNATURE <i>John R. Vece</i>
--	--------------------------	---

20. REVIEW DATE 1-12-92	21. DISTRIBUTION O: EPDS; cc: CERM, C. Jacobson; cc: EF; cc: FOCR.
-----------------------------------	--

1. CASE NO. 921229CCN0543			2. INVESTIGATOR'S ID 9 0 0 3			3. OFFICE CODE 8 3 0			EPIDEMIOLOGIC INVESTIGATION REPORT
4. DATE OF ACCIDENT YR MO DAY 9 2 1 2 2 7			5. DATE INVESTIGATION INITIATED YR MO DAY 9 2 1 2 2 9						

6. SYNOPSIS OF ACCIDENT OR COMPLAINT: This investigation was conducted in response to a consumer's complaint that a 17 Y.O. female experienced severe respiratory distress after being exposed to the fumes from an aerosol fabric protection product being used to treat a new leather jacket on 12/27/92. The victim was hospitalized overnight and treated for the symptoms of chemical pneumonia.

7. LOCATION (Home, school, etc.) Home		8. CITY Oconto Falls		9. STATE WI	
--	--	-------------------------	--	----------------	--

10A. FIRST PRODUCT Fabric protection treatment product		11A. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS Wilson's Suede and Leather, Inc., Minneapolis, MN. "Wilson's Leather Protector(5 oz.)"	
10B. SECOND PRODUCT leather jacket		11B. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS Same as above.	

12. AGE OF VICTIM 0 1 7		13. SEX (Use numerical code) MALE :1 FEMALE :2 UNKNOWN :3 2		14. DISPOSITION treated and transferred for hospitalization 3		15. INJURY DIAGNOSIS chemical pneumonia 7 1	
----------------------------	--	---	--	---	--	---	--

16. BODY PART all parts		17. RESPONDENT(S) (Mother, Friend) Victim		18. TYPE INVESTIGATION ON SITE 1 TELEPHONE 2 OTHER 3 1		19. TIME SPENT Tr:0.0 0 5 0	
----------------------------	--	--	--	--	--	--------------------------------	--

20. ATTACHMENTS multiple		21. CASE SOURCE State Health Dept.		22. REVIEWED BY 8 1 3 0 YR MO DAY 9 3 0 1 1 2			
-----------------------------	--	---------------------------------------	--	--	--	--	--

23. PERMISSION TO DISCLOSE NAMES (NON-BESS CASES ONLY)
 CPSC MAY DISCLOSE MY NAME CPSC MAY NOT DISCLOSE MY NAME

24. NARRATIVE (See instructions on Other Side) See attached narrative.		25. REGIONAL OFFICE DIRECTOR REVIEW DATE	
---	--	---	--

PR/ELR NOTIFIED
 No comments made
 Comments attached
 256 Excisions/Revisions
 Firm has not requested further notice
[Signature]

SUMMARY:

This investigation was conducted in response to a report that a 17 year old female experienced severe respiratory distress after being exposed to the fumes from an aerosol fabric protection product that she was using to treat a new leather jacket on 12/27/92. The victim was hospitalized overnight and treated for the symptoms of chemical pneumonia.

PRE-INCIDENT:

On Sunday, 12/27/92 at approximately 12:30 P.M. the complainant and her boyfriend each purchased a new waist-length brown suede leather jacket from the "Wilson's Suede and Leather Products," retail store located at A-1009 Port Plaza Mall in Green Bay, WI 54301.

As the complainant was purchasing her coat, the store clerk suggested that it would be important to treat the new jackets with a fabric protection product to avoid damage from dirt or moisture. The clerk suggested that the complainant and her boyfriend purchase "Wilson's Leather Protector," an aerosol product sold at the store in 5 ounce cans. The aerosol protector is sold in a two can package, described as a "Leather Care Starter Kit."

The complainant and her boyfriend agreed to purchase four cans of the above described product. They were told by the clerk that they should spray 1/2 the contents of a 5 ounce can on each jacket, then wait 30 minutes and spray another 1/2 can on each coat again.

(Each coat then has been treated with an entire 5 ounce can.) The clerk further suggested that each coat be treated again every 2 months by spraying an additional 1/2 can onto each coat, and, if the coats were subjected to rain or dirt, to spray them again immediately after such exposure.

The complainant paid \$19.96 for four 5 ounce containers of the Wilson's Leather Protector product.

The store clerk, whose name is unknown, is described as having short brown hair, and being 20-25 years of age. This clerk provided no further instructions to the complainant and her boyfriend as to how the product should be applied to the coats, and he did not suggest that the product's fumes might be hazardous.

INCIDENT:

Later that same day, 12/27/92 at approximately 3:00 P.M., the 17 year old female complainant and 21 year old boyfriend hung each coat on a hanger and suspended the hanger from a clothesline in the attached and enclosed front porch of the family's farm house. The 17 year old complainant did the actual spraying of the fabric protector product, though her boyfriend was present in the porch for part of the time. The complainant sprayed 1/2 the contents of a 5 ounce can onto each jacket as she had been directed, and estimated that this activity took her less than 5 minutes. Both complainants then left the porch where the spraying had taken place until 30 minutes had elapsed at which time the 17 year old female then re-entered the porch and sprayed 1/2 the contents of a second can of the fabric protector onto each coat. She estimated this activity again took her approximately 5 minutes. The complainant's boyfriend was not present during this second application.

Photographs depicting the complainant's reenactment of the manner in which she used the fabric protection product are attached to the end of this report as exhibit "A".

The complainant stated that before using the fabric protector product, she did read the instruction labels on the can, and noted the warning "Vapor's May Be Harmful." She felt that the unheated, enclosed porch was large enough a space to allow the vapors to dissipate, and she left one of the porch's, crank-out style windows open approximately 6 inches to assist in further ventilating the fumes. The porch area is 26 feet long by 6 feet wide by 7 feet high. The porch has two pedestrian doors that provide excess to the main living areas of the house; both doors were kept closed, except to enter and exit the porch during the spraying periods.

Approximately 20 minutes after treating the coats for the second time, the 17 year old complainant noticed that she could not take deep breaths, and felt like she could not catch her breath. It hurt her to breath, and she experienced a burning sensation in her lungs. The complainant also began coughing uncontrollably, and felt slightly dizzy. The complainant's boyfriend suffered no ill symptoms.

POST INCIDENT:

The complainant's condition continued to deteriorate, and she was later transported to nearby Community Memorial Hospital in Oconto Falls, Wisconsin for emergency treatment. She was diagnosed as suffering from chemical pneumonia, and was admitted to the hospital for treatment. Chest x-rays showed clouding in her lungs, and she received chemical and oxygen therapy. The complainant was released from the hospital late the following day, 12/28/92.

As the female complainant is a juvenile living apart from her parents, she was asked to obtain a parent's signature on the "Authorization for Release of Name" and "Authorization for Medical Records Disclosure" forms, and then return the completed forms to the CPSC Milwaukee Resident Post. When these authorizations are received, the medical records will be obtained and forwarded as an addendum to this report.

SAMPLES COLLECTED:

The complainant still had two full 5 ounce cans of the "Wilson's Leather Protector" product remaining. These containers were purchased from the complainant as a CPSC sample, sample no. R-830-4408, and were later forwarded to HSHL for further analysis.

A copy of the sample collection receipt issued to the consumer is attached to the end of this report as exhibit "B". A copy of the sample collection report is attached as exhibit "C".

APPLICABLE STANDARDS:

The hazardous substances labeling requirements detailed in 16 CFR 1500 may apply to this product; the adequacy of the present warning labeling could not be evaluated as the product's actual content ingredients are not known at this time.

PRODUCT IDENTIFICATION:

Product: "Wilson's Leather Protector" fabric protection treatment; 5 ounce aerosol container, described as black in color with red and white lettering. SKU no. 18996003. Date coding ink printing on the bottom of the container is apparently smudged and incomplete states "C1 2".

Manufacturer: Wilson's Suede and Leather, Inc.
Minneapolis, Minnesota.

ATTACHMENTS:

- Exhibit "A" Photographs depicting the complainant's reenactment of her use of the product in question.
- "B" Copy of the sample collection receipt issued to the complainant on 12/29/92.
- "C" Copy of sample collection report number R-830-4408.
- "D" Copy of the original consumer complaint.

Exhibit "A"

IDI# 921229CCN0543

Photos of victim re-enacting
the manner in which she used
the product.

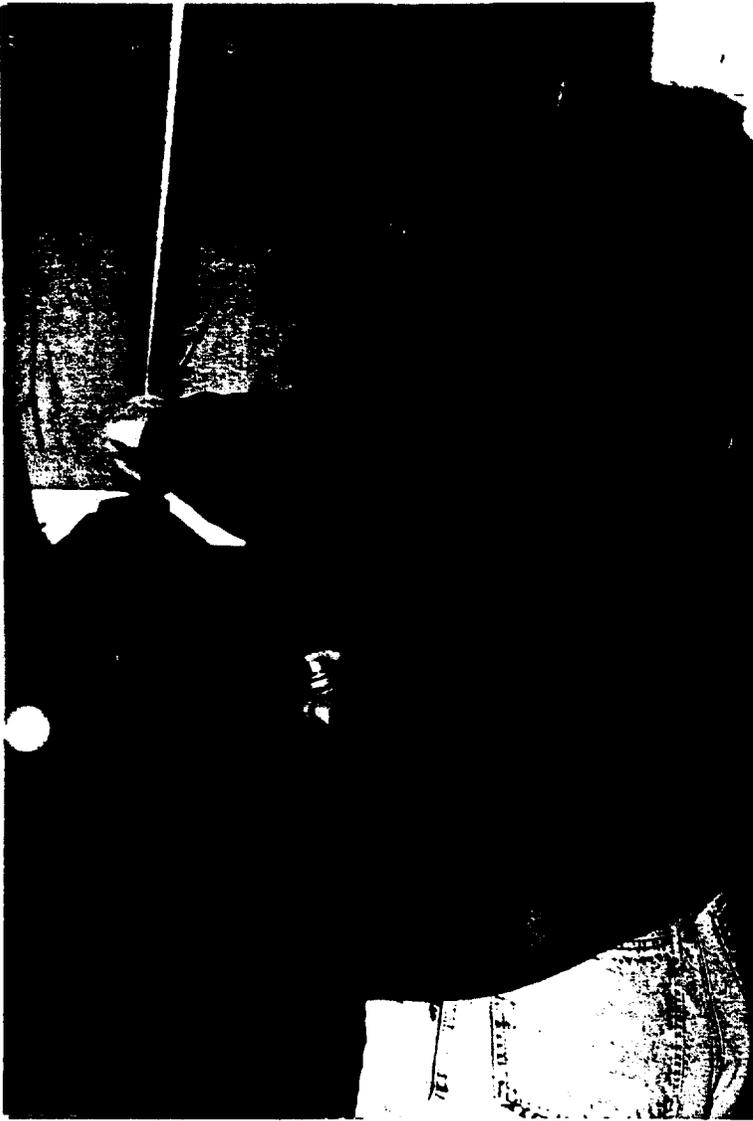
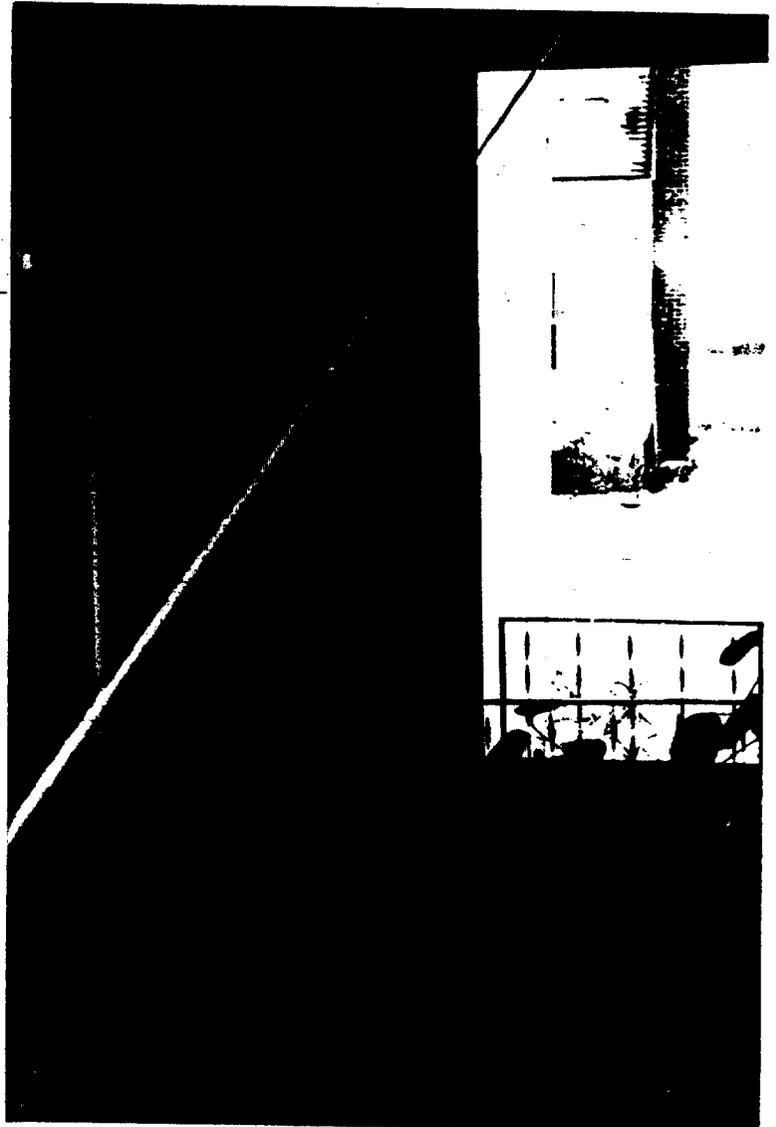


Exhibit "A"
IDI# 921229CCN0543

Photos of the enclosed
porch area where this
incident occurred.





8883711 12/26/92 5546 314
 CCCCEN, STACIE L. G6/13/75
 F/17

DATE	TIME	ORDERS	PHYSICIAN	NURSE
12-27-92	1345	↑ O ₂ to 4l/m - T.O.	[Redacted] P. Nealey 1948	[Redacted] 12-26-92
12/28/92		① after lunch ↓ O ₂ to 2l/m ② Notify me in O ₂ Sat is < 90%	[Redacted]	[Redacted]
		RT called	[Redacted]	[Redacted]
12/28/92	1325	① D/c O ₂ & pulse oximetry	[Redacted]	[Redacted]
12/28/92		Depostat lozenges prn may discharge A/TN with Dr. Baker by Thursday to Dr. Mice/Baker	[Redacted]	[Redacted]

CONFIDENTIAL INFORMATION
 COMMUNITY MEMORIAL HOSPITAL - Oconto Falls
 WAS AUTHORIZED TO RELEASE THIS REPORT
 ONLY FOR THE INFORMATION ONLY TO WHOM
 IT WAS REQUESTED. IT CAN NOT FURTHER BE
 REPRODUCED OR TRANSMITTED IN ANY MANNER WITHOUT THE
 EXPRESS WRITTEN AUTHORIZATION.



COMMUNITY MEMORIAL HOSPITAL
855 South Main Street Oconto Falls, Wisconsin 54154

13 77 92
8330711 12/26/92 5545 314
COOPER, STACIE L. C6/13/75
F/17

PRN MEDICATION RECORD

Allergic To: Penicillin

Ord Date	Exp. Date Time	MEDICATION - DOSAGE - MISC.	Record response within 1 hour using 0-10 scale. 0 = No pain 10 = Max. amount of pain.						*See Nurses Notes A=Asleep D=Dozing										
			Date	Time	Dose	Site	Init	Response											
12/26		Lydrenal tablet 9 4h pm Headache	12/26	9:00	100	PO	PR	7.5											
12/27		Tussi Organidin DM 2 tab po q 4h Cough Pen	12/27	10:10	100	PO	PR	0											
12/28		Cepostat lozenges PRN																	

CONFIDENTIAL INFORMATION
COMMUNITY MEMORIAL HOSPITAL - Oconto Falls
WAS AUTHORIZED TO RELEASE THIS REPORT
IT IS FOR THE INFORMATION ONLY TO WHOM
IT IS ADDRESSED. IT CAN NOT FURTHER BE
RELEASED TO ANY PARTY WITHOUT THE
PATIENT'S AUTHORIZATION

Room 314 Name Cooper Stacie MD Initial RP

ADMISSION NURSING ASSESSMENT

8888711 12/26/92 5848 314
 COCFMAN, STACIE L. 06/13/75
 #117

Chief Complaint: (onset of symptoms, location, severity, how relieved, patient's idea of cause and effect).

Inhaled. some spray for leather-proofing -

Medications	Dose/Freq.	Last Taken
<u>A.C.P.</u>		<u>12-26-92 -</u>

Medication brought to hospital. Yes/No NO Sent home / sent to pharmacy

Who helps you with your medications? No one

Do you follow your medication schedule? Yes/No NO If no, why not?

CIRCULATION:

COLOR - Pink
 Flashes Pale
 Mottled
 Cyanotic
 Jaundiced

PULSES - RT LT
 Radial ✓ ✓
 Pedal ✓ ✓
 Carotid ✓ ✓

EDEMA - Yes
 No
 Location
 Severity

JVD Yes
 No

APICAL PULSE Rate 120
 Regular / Irregular
 Normal / Distant

CONFIDENTIAL INFORMATION
 COMMUNITY MEMORIAL HOSPITAL - Oconto Falls

WAS AUTHORIZED TO RELEASE THIS REPORT.
 IT IS FOR THE INFORMATION OF THE PATIENT'S HOME
 IT IS ADDRESSED. IT CAN NOT FURTHER BE
 RELEASED TO ANY PARTY WITHOUT THE
 PATIENT'S AUTHORIZATION.

Comments:

VENTILATION

RESPIRATORY PATTERN
 Regular, easy
 Irregular
 Dyspneic w/exertion
Dyspneic at rest
 Specify

BREATH SOUNDS
Clear
 Equal
 Crackles
 Wheezes
 Specify
 Decreased

COUGH
Yes
 No
Non-productive
 Productive
 Specify

TOBACCO USE
 Smoking quit 7/20/92 pk/day
 Chewing NO

Comments: Inhaled fumes from leather water proofing spray

NUTRITION/HYDRATION:

Teeth
 No teeth
 Dentures/Partials
 Feeding Tube
 Type
 Date inserted

APPETITE -
Good
 Fair
 Poor
 Increased thirst
 Home diet: 1400 - w/ reduction -

HYDRATION -
 Poor skin turgor
Good skin turgor
 Dry mucous membranes
Moist mucous membranes

Nausea
 Vomiting
 Bleeding
Able to swallow
Able to chew
 Recent weight change -
 Specify

ALCOHOL INTAKE
 Amount NO except last night
 Type

Comments:

ELIMINATION/REPRODUCTIVE:

BLADDER -
~~Continent~~
 Incontinent
 Retention
 Frequency
 Burning
 Dribbling
 Nocturia

FOLEY CATHETER -
 Type _____
 Size _____
 Date inserted

OSTOMY -
 Type _____
 Appliance _____
 Routine

BOWEL -
 Continent
 Incontinent
 Constipation
 Diarrhea
 Bleeding
 Last BM _____
 Normal Routine _____
 Laxative _____

ABDOMEN -
~~Soft~~
 Firm
 Distended
 Pain

BOWEL SOUNDS -
~~Normal~~
 Hypoactive
 Hyperactive
 Absent

FEMALE -
 Lat pap smear 8 mo ago
 Last mammogram never
 Birth Control Pills Yes/No
 Vaginal discharge Yes/No

MALE -
 Prostate problems Yes/No
 Penile discharge Yes/No

Comments: _____

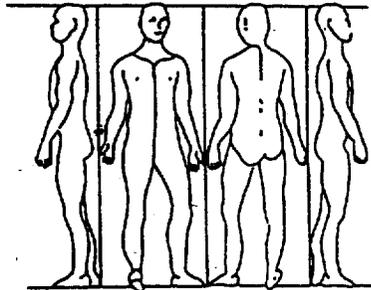
SKIN INTEGUMENTARY:

SKIN TEMPERATURE -
 Cool
~~Warm~~
 Hot

Mark any cuts: abrasions, decubiti, rash, and bruises on chart:
 Describe _____

SKIN MOISTURE -
~~Dry~~
 Normal
 Diaphoretic

RASH
~~Absent~~
 Generalized
 Localized



ABILITY:

~~Normal~~
 Pain with movement
 Limited ROM
 arm left/right
 leg left/right
 hip left/right
 neck left/right

GAIT -
 Steady
~~Unsteady~~

AIDS
 Wheelchair
 Walker
 Cane
 Crutches
 Braces

EXTREMITY STRENGTH -
 Unequal
~~Equal~~
 Amputation - specify _____

Prosthesis Yes/No _____
 Specify (if weak) _____

Comments: Feels dizzy & head pained

SENSORY:

VISION -
~~Adequate~~
 Poor
 Blind
 Cataracts
 Glaucoma
~~read~~
~~to write~~

leg was blurred first

HEARING -
~~Adequate~~
 Poor
 Deaf
 Aid R/L

PUPILS
~~Equal~~
~~Reactive~~
 Specify _____

4mm -

SPEECH
~~Clear~~
 Slurred
 Unable
 Language Barrier

SLEEP SCHEDULE
 Bedtime _____
 Wake up Time 10:30
sep prep @ night & day

Comments: _____

PSYCHOSOCIAL:

MENTAL STATUS
~~Alert~~
 Arouses easily
 Lethargic
 Comatose
~~Oriented~~
 Disoriented
 Confused

BEHAVIOR -
 Wanders
~~Cooperative~~
 Combative
 Forgetful
 Other

CONFIDENTIAL INFORMATION
 COMMUNITY MEMORIAL SPECIAL SERVICES CENTER INTO FALLS
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 PATIENT'S AUTHORIZATION.

Comments: _____

EDUCATION/TEACHING NEEDS:

Tests _____
 Procedures _____
 Disease _____
 Medications _____
 Self-Care _____
 Pre-op _____
 Post-op _____
 Diet _____
 Other _____

IDENTIFIED FOCUS AREA(S):

alt. air exchange EIT
petroleum distillate Inhalation
 Signature J. Berginski R.N.
 Date 12-24-92 Time 2230

PATIENT INFORMATION

8888711 12/26/92 5548 314
 CCCPMAN, STACIE L. 06/13/75
 F/17

Date: 12-26-92 Time: 2040 I.D. Band On
 Admitted from: ER Via Car
 Information obtained from: pt. Relationship _____

EMERGENCY INFORMATION:

Notify: Melvin Crozman - Father Phone No. 546-8308
 Spokesperson for family Same Phone No. _____
 Legal guardian Yes/No If yes, Name _____ Phone No. _____
 Do you wish to restrict visitors or phone calls? Yes / No

HISTORY OF ALLERGIES Yes / No

Drug _____	Describe Reaction _____
Food _____	_____
Other (tape, soaps, etc.) _____	_____

VITAL SIGNS:

Temp 101.8 Oral/rectal/axillary BP RT 146/80 LT 142/80
 Pulse 120 Regular/irregular Height 5'10 1/2 Actual / Stated
 Respirations 32 Easy/distressed Weight 197 Bed / Standing

Indicate: Current Problem (C) Past Problem (P) Family Hx of (F)

Include date of onset for current problems.

- | | | | |
|--------------------------|-------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>father</u>
Diabetic |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> Cardiac - |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> Seizures - |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> Hypertension <u>Last med 24 '92</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> Kidney - |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> Hepatitis/Liver Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> Bleeding Disorders |

C P F **EMERGENCY INFORMATION**
 COMMUNITY MEMBER **Emotional** Gconto Falls
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 PATIENT'S AUTHORIZATION.
 Breathing Problems
 Cancer
 Infections, Specify _____
 Other _____

Past Surgeries/App. Date

Other Hospitalizations/App. Date (for major illness only)
Mena-
Shrap threat
child birth
bronchitis -

Previous Blood Transfusion Yes/No Reaction Yes/No If yes, when NA

LIFESTYLE:

Private home / Nursing Home / Apartment:

Live alone / with family / significant other

Self care / needs assistance:

Public or Home Health Yes / No *comes for son*

Bath Preference: tub, shower, -AM, evening, right before bed

Who helps you at home? No one

Who relies on you at home? Son - Grandmother taking care of them

What church do you belong to? - Home - Catholic

Orientation to Unit	Yes	No	Personal Possessions	With Pt	Sent home with
Nurse call	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Dentures: Upper	NA	
Bed control	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lower		
Side rail policy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Partial		
Activity limitations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hearing Aid	NA	
Smoking Policy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Glasses/Contacts	NO	
TV/Radio	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Cane/walker/wheelchair	NO	
Phone	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Money (Amt. _____)	-	
Visiting Hours	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Other _____	-	
Meals	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Jewelry (describe)		
			<i>2 rings -</i>		

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 PATIENT'S AUTHORIZATION.

Signature: _____

Reviewed by: _____

Bozynski

RN



COMMUNITY MEMORIAL HOSPITAL
 855 South Main Street
 Oconto Falls, Wisconsin 54154
 414/846-3444

8888711 12/26/92 5548 314
 COOPERMAN, STACIE L. 06/13/75
 F/17

ADVANCED DIRECTIVES DATA

- (Circle)
- A. Do you have a Living Will? (If after 1-92 a copy is OK) Y N
1. Does CMH have an original copy? Y / N
2. Family / friend will deliver? Y / N
3. Document presently accepted? Y / N
- B. Do you have a Durable Power of Attorney for healthcare? Y N
1. Does CMH have a copy of this? Y / N
2. Family / friend will deliver? Y / N
3. Document presently accepted? Y / N
- C. Information booklet presented? Y N
- D. Do you want more information? Y N
- E. The above information was obtained from: (circle)
- Patient / Family / Old Chart / Other _____

COMMENTS: _____

~~CONFIDENTIAL INFORMATION~~

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 PATIENT'S AUTHORIZATION.

Signature J. Bognardi

NURSING CARE PLAN GENERAL

88887111 12/26/92 5548 314
COOPMAN, STACIE L. 06/13/75
F/17

401

Date Implemented: 12-26-92
EOM - Expected Outcome Met
NURSING DIAGNOSIS/
FOCUS

Thyroid

Thyroid good
exchange w/ substitution
of thyroid - potassium
disturbance
abnormal physical
mobility 1/3 approx.

EXPECTED OUTCOME

1. All muscle strength in 4 and 5 fingers. SLOD 80
 2. Ref. are within normal limits. less than 30 mm. by discharge 12/26/92
 3. All the quantity in within normal limits for pt. 70% on ROM 12/26/92
 4. Tolerated activity. 12/26/92
 5. SOB. 12/26/92
- 50% values are within normal limits by discharge 12/26/92

REVIEW DATE INITIALS

12/26/92

NURSING INTERVENTIONS

1. monitor v.s. 4x daily
2. State of 6% as ordered. assess specimens
3. monitor pulse oximetry & shift water balance & shift
4. monitor lab reports notify
5. monitor for changes in mental status.
6. encourage oral fluids
7. encourage rest periods
8. achieve med for 6%.

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CMH
Nursing Service
Oct. 1986

PATIENT CARE
DAILY FLOW SHEET

6888711 12/26/92 5548 314
COOPMAN, STACIE L. 06/13/75
F/17

DATE:	12 AM - 8 AM	8 AM - 4 PM	4 PM - 12 AM
NUTRITION	Diet Type		<i>gen</i>
	Food Taken Per	Self ___ Assist ___ Fed ___	Self <input checked="" type="checkbox"/> Assist ___ Fed ___
	Amount Eaten	All ___ % ___ % ___ 0	All ___ % ___ % ___ 0
	Supplements		<i>Sanclurin Skin milk</i>
ACTIVITY	Type/Distance Rehab Stage Toleration		<i>bedrest 1A</i>
	Repositioned		<i>Self</i>
	Sleeping		
ELIMINATION	Stool - BM		<i>φ</i>
	Enema - Type Results		<i>φ</i>
	Urine - Voided		<i>φ</i>
	Foley Cath Care		<i>φ</i>
PAIN	Type/Location - Intervention - - Response -	CONFIDENTIAL INFORMATION COMMUNITY MEMORIAL HOSPITAL - Oconto Falls WAS AUTHORIZED TO RELEASE THIS REPORT. IT IS FOR THE INFORMATION ONLY TO WHOM IT IS ADDRESSED. IT CAN NOT FURTHER BE RELEASED TO ANY PARTY WITHOUT THE PATIENT'S AUTHORIZATION.	<i>21m. No 8/10 pain SOB 2. exertion 1A</i>
IV	Site Appearance Rate		<i>NA</i>

Initial	Signature/Title	Initial	Signature/Title	Initial	Signature/Title

DATE:		12 AM - 8 AM	3 AM - 4 PM	4 PM - 12 AM	
HYGIENE	Bath - Type				
	Oral Care				
	Back Care				
	Peri Care				
	Shave/Shampoo				
	Foot Care/Ted Hose				
SAFETY	Side Rails			22 nd - up x 2	
	Call Light in Reach			OK JA	
	Isolation/Type			NA	
WOUND	Type/Location Appearance/Drng			NA	
	Dressing Change				
	Treatment				
TUBES	Type			NA	
	Irrigations				
MENTAL STATUS				22 nd alert JA	
RESPIRATORY	Lung Sounds			22 nd Rung CTA.	
	Cough/Results			SOB - elevation	
	O ₂ Therapy			O ₂ - 6L NC - 10.	
	Suctioning				
ABDOMEN	Bowel Sounds			22 nd -	
	Soft/Firm			abd. soft. no tendr	
	Flat/Distended			BS present JA	
	Tenderness				
SKIN CIRCULATION	Warm/Dry	<p align="center">CONFIDENTIAL INFORMATION COMMUNITY MEMORIAL HOSPITAL - Oconto Falls WAS AUTHORIZED TO RELEASE THIS REPORT. IT IS FOR THE INFORMATION ONLY TO WHOM IT IS ADDRESSED. IT CAN NOT FURTHER BE RELEASED TO ANY PARTY WITHOUT THE PATIENT'S AUTHORIZATION.</p>			22 nd -
	Cool/Moist				Skin w/d.
	Skin Color/Nail Color				color pale - pink
	Cmts. of Extremities				No perip edema JA
	Pulses				
	Edema				
OTHER					

PATIENT CARE
DAILY FLOW SHEET

8888711 12/26/92 5548 314
COOPMAN, STACIE L. 06/13/75
F/17

DATE: 12/27/92		12 AM - 8 AM	8 AM - 4 PM	4 PM - 12 AM
NUTRITION	Diet Type	Gen	General	General
	Food Taken Per	Self <input checked="" type="checkbox"/> Assist <input type="checkbox"/> Fed <input type="checkbox"/>	Self <input checked="" type="checkbox"/> Assist <input type="checkbox"/> Fed <input type="checkbox"/>	Self <input checked="" type="checkbox"/> Assist <input type="checkbox"/> Fed <input type="checkbox"/>
	Amount Eaten	All <input type="checkbox"/> % <input type="checkbox"/> % <input checked="" type="checkbox"/> 0	All <input checked="" type="checkbox"/> % <input type="checkbox"/> % <input type="checkbox"/> 0	All <input checked="" type="checkbox"/> % <input type="checkbox"/> % <input type="checkbox"/> 0
	Supplements	apple juice 0030		chicken broth juice
ACTIVITY	Type/Distance	BAP assist	9 to 10:30 assist 9:45 - 7:50 - 7:50 - RR 48	1600 to bathroom by self S.O. to activity
	Rehab Stage			
	Toleration	NOBS felt tired out yet this Am - B		
	Repositioned	Self	Self	Self
Sleeping	0115 - 0240 - 0350 - 0530			
ELIMINATION	Stool - BM	0		0
	Enema - Type			
	Results			
	Urine - Voided	x 1	x 1	✓
Foley Cath Care			NA	
PAIN	Type/Location	0005 tylenol somewhat effective for H/A	8:30 c/o upper across chest - 2 inspirations	c/o discomfort in nose from n.e. repositioned
	- Intervention - - Response -	'Wants to deep breathe' PEARL 400m - B	Several swabs Crush med p 5 effective @ 11:00	
IV	Site Appearance			
	Rate			

CONFIDENTIAL INFORMATION

Initial Signature/Title

COMMUNITY MEMORIAL HOSPITAL - Ontario Falls
VASSAR DRUG STORE
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Initial Signature/Title

DATE: 12 AM - 8 AM 3 AM - 4 PM 4 PM - 12 AM

HYGIENE	Bath - Type		Completed - assist	
	Oral Care		Self	Self 7B
	Back Care		Done	
	Peri Care		Self	
	Shave/Shampoo			
	Foot Care/Ted Hose			

SAFETY	Side Rails	↑↑ / AS	↑↓	Call 7B 2100
	Call Light in Reach	11-7 ✓ AS	7-3 ✓	7B 7B 7B
	Isolation/Type			NA

MO.	Type/Location Appearance/Drng			NA
	Dressing Change			
	Treatment			

TUBES	Type			NA
	Irrigations			

MENTAL STATUS: Alert & oriented ⁵ Alert - Oriented ⁵ Alert ⁵

SPIRATORY	Lung Sounds	CTA SOB activity	Basal CTA - 4 exp	1600 Lung CTA -
	Cough/Results	O ₂ @ 6 L/nc PS	Basal P50% Relatively dry	Activity bring in enough
	O ₂ Therapy		crackles	Moderate for same
	Suctioning		O ₂ 20/nc	O ₂ 4L NC

ABDOMEN	Bowel Sounds	Present	1 hr soft	1600 soft
	Soft/Firm	Soft AS	non-tender	Non-tender
	Flat/Distended		BS ⊕	BS present 20%
	Tenderness	non-tender		

SKIN CIRCULATION	Warm/Dry	cool ✓	pink	1600
	Cool/Moist		warm/dry	skin w/d
	Skin Color/Nail Color	pale AS	no bed pink	color pink
	Cmts. of Extremities		MTS AS	No pty edema 20%
	Pulses			
	Edema			

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PATIENT CARE
DAILY FLOW SHEET

828 8711 12/26/92 5548 314
CCC MAN, STACIE L. 06/13/75
F/17

DATE: 12-28-92		12 AM - 8 AM	8 AM - 4 PM	4 PM - 12 AM
NUTRITION	Diet Type	Reg.	Regular	
	Food Taken Per	Self <input checked="" type="checkbox"/> Assist <input type="checkbox"/> Fed <input type="checkbox"/>	Self <input checked="" type="checkbox"/> Assist <input type="checkbox"/> Fed <input type="checkbox"/>	Self <input checked="" type="checkbox"/> Assist <input type="checkbox"/> Fed <input type="checkbox"/>
	Amount Eaten	All <u>3/4</u> % <input type="checkbox"/> % <input type="checkbox"/> 0	All <input checked="" type="checkbox"/> % <input type="checkbox"/> % <input type="checkbox"/> 0	All <input checked="" type="checkbox"/> % <input type="checkbox"/> % <input type="checkbox"/> 0
	Supplements		vitare 240	
ACTIVITY	Type/Distance	0001 - Awakened for vitals check - SS	0730 - ad lib - little SOB & restlessness	1600 - ad lib SS
	Rehab Stage	0400 - Awakened for vitals. P to BR to void		
	Toleration	Cough syrup given for cough. Habley cough brought on by activity		
	Repositioned	Self - SS	Self - CS	Self
Sleeping	SS SS SS SS SS 0100 0200 0300 0500 0600		SS	
ELIMINATION	Stool - BM	0	CS	0
	Enema - Type	NA	—	—
	Urine - Voided	g.s. x one	brads 3 Clo CS	go yellow
	Foley Cath Care	NA	—	NA
PAIN	Type/Location	0001 - Comfortable at this time - SS	0955 - dry Habley cough cough syrup given 1115 Tylenol II po for cough headache 1500 cough syrup 1/2 tsp open for coughs	1600 - Denies pain SS
	- Intervention - - Response -	0400 - no lumbar back pain. Rcvr catch on bed raised. SS		
IV	Site Appearance	NA	NP	NP
	Rate	SS	NP	NP

CONFIDENTIAL INFORMATION

Initial	Signature/Title	Initial	Signature/Title	Initial	Signature/Title
	COMMUNITY MEMORIAL HOSPITAL - OMAHA, NE			SS	COMMUNITY
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COMMUNITY MEMORIAL HOSPITAL
855 South Main Street
Oconto Falls, Wisconsin 54154
414/846-3444

8888711 12/26/92 5548 314
COOPMAN, STACIE L. 06/13/75
F/17

NURSING PROGRESS NOTES

Date/Time	Focus	D=Data	A=Action	R=Response	
12-26-92 2040	admission	D 17 y. old female admitted from ER. per chart - a petroleum distillate inhalation this afternoon - a low. See Nursing assessment.	P O ₂ on 6L N.C. Pulse oximetry 94% Instructed on Skewing resp. Tends to hyper ventilate. P- SOB & exertion.		
12-26-92	Nourishment	2200 D requesting something to eat - states "I didn't eat tonight"	P 1/2 sandwich, carton milk & Ice Cream given - P ate Ice Cream - only picked @ sandwich - 1/2 banana.		
12/26/92 2315	Comfort	P No headache - requests pain med. P. P. pain relieved of same - Tymol tablet for relief of same - 1/2 Tylenol.			
12/27/92	Resp	P Pt. SOB steadily absent - Dx P - SOB D - dry cough P P activities RR: 48 shallow "helping" breaths - a bit P bed 3 void - 2 tabs on P reassurance offered care to slow deep breaths P let legs hold P Pulse monitored, AD to hold N/C (extension/tubers on to allow freedom & movement P) RR: 48 continuous - lungs CTR & base D/T & lungs excursion			

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cat

830

act/resp

DATE:		12 AM - 8 AM	8 AM - 4 PM	4 PM - 12 AM
HYGIENE	Bath - Type	/	0945 C3	1715 Discharged SO
	Oral Care			
	Back Care			
	Peri Care			
	Shave/Shampoo			
	Foot Care/Ted Hose			
SAFETY	Side Rails	M 0001-0730-SS	0730 1 ↑ C3	1600 ↑ X1 SO
	Call Light in Reach	CYS 0001-0730-SS	0730 V 00	V SO
	Isolation/Type	NA	n/a	
JND	Type/Location Appearance/Drng	NA	/	NA
	Dressing Change			
	Treatment			
TUBES	Type	NA	/	NA
	Irrigations			
MENTAL STATUS		Alert, oriented x3	955 alert oriented x3	1000 A+O x3 SO
RESPIRATORY	Lung Sounds	CTA all fields Dry, hacky cough 1/2 activity. O2-4L.	955 CTA all fields decreased dry hacky cough. 2/4	1600 - Lungs ↓ throughout SE SOB c act NP cough SO
	Cough/Results			
	O2 Therapy			
	Suctioning			
ABDOMEN	Bowel Sounds	abd. soft, non-tender = normal Bowel sounds ss	955 1/3 all quadrants soft nontender	1600 Abd soft & tender (+) SO SO
	Soft/Firm			
	Flat/Distended			
	Tenderness			
SKIN CIRCULATION	Warm/Dry	W+D = no peripheral edema SS.	955 - warm dry color pale no peripheral clonus.	1600 - Skin pale pink w/d CMTS adig PP & Idema SO
	Cool/Moist			
	Skin Color/Nail Color			
	Cmts. of Extremities			
	Pulses			
	Edema			
OTHER	<p style="text-align: center;">CONFIDENTIAL INFORMATION COMMUNITY MEMORIAL HOSPITAL - Oconto Falls WAS AUTHORIZED TO RELEASE THIS REPORT. FOR THE INFORMATION ONLY TO WHOM IS ADDRESSED. IT CAN NOT FURTHER BE BASED TO ANY PARTY WITHOUT THE AUTHORIZATION.</p>			



COMMUNITY MEMORIAL HOSPITAL
 855 South Main Street Oconto Falls, Wisconsin 54154
 414/846-3444

8333711 12/26/92 5545 314
 COOPMAN, STACIE L. C6/13/75
 F/17

NURSING PROGRESS NOTES

Date/Time	Focus	D=Data	A=Action	R=Response
12-27-92	Comfort mdd	D - On ausc & inspection Acrtes r/l chest & Spleen no crackles		
9:30		R) asleep		
1400	Resp.	R Resp. rate 16-22. Color pink. O ₂ remains at 2L per nasal cannula. Ate 1/2 of lunch. C/o mucus in lungs. C/o headache, itchy throat. 1) Naproxen 300mg p Tid. (Nursing D. Nelson MD)		
19:00	Comfort	1) Glaxoheadache tylenol tab 7 given for same. Resting in bed = O ₂ on State. Headache was relieved. Color pink - Resp 20-24 Requesting extra fluids. Both and juice. Request granted. States she has some pain across chest at times but not like before. - Brian LPN.		
12-28-92	1445 Discharge	D. Remains SOB = slight exertion. ^{me} had Ca decreased = has dry occ. cough. Keeps SOB. Lunges decreased thruout lower lobes. Kept O ₂ on this shift 14th @ rest & = activity. A Green cough med thro AM. O ₂ decreased thruout shift. O ₂ sat 92% 1434 Remains a little SOB = exertion thro p noon. Takes her rest breaks, remains delet oriented. Cleets LPN		
	1600 Discharge	D - Lunges ↓ d. C/o feeling SOB = act "The air catches in my lungs" Denies pain. Resp rate 20/min O ₂ sat 90% = frequent non prod cough. Skin pale pink w/d. "I'm afraid to go home" A - Dr Price here to see pt. Informed of above.		
	17:15 Discharge	R - Pt ↑ to above. Condition unchanged Tol act well. Discharge instructions completed. Discharged via w/c accompanied by boyfriend ^{R.D.} Amurica		

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 PATIENT'S AUTHORIZATION.

NURSING DISCHARGE SUMMARY

DATE: 12/28/92 TIME: 1715 MODE: w/c

ACCOMPANIED BY: boy friend

MEDS FROM HOME SENT: — BELONGINGS/VALUABLES SENT: ✓

DISCHARGE CONDITION: Lungs decreased. O2 saturation 90%. Infrequent non-productive cough. Slightly short of breath with activity. Alert & oriented.

PATIENT INSTRUCTIONS

1) DIET: Regular 2) ACTIVITY LIMITATIONS: As tolerated

3) SPECIAL INSTRUCTIONS: —

4) MEDICATIONS: Cepaxstat lozenges as needed for sore throat

CONFIDENTIAL INFORMATION

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PATIENT'S AUTHORIZATION.

VERBAL INSTRUCTION: ✓

5) FOLLOW UP CARE: APPT: DATE — TIME — PHYSICIAN —

6) REFERRALS: —

7) COMMENTS: Follow up with Dr Culver by Thursday 12/31/92
Call Emergency Room if any problems breathing
846-3444

I AUTHORIZE MEDICATIONS SENT HOME WITH ME FROM COMMUNITY MEMORIAL HOSPITAL TO BE IN NON-SAFETY CONTAINERS. I HAVE READ AND UNDERSTAND CONTENTS OF DISCHARGE SUMMARY
DATE: 12/28/92

PATIENT: Stacie Copman NURSE: Samurawa R

RESPONSIBLE PARTY: — RELATIONSHIP: —

Respiratory Therapy Department

888871-12/26/92 5548 314
 CCEPMAN, STACIE L. 06/13/75
 F/17

Dx: toxic fume inhalation
 Rx: 1. O₂ @ 6lpm
 2. _____
 Goals: _____

DATE	THERAPY & FREQUENCY MEDICATIONS	PULSE R	COUGH EFFORT	SPUTUM	AUSCULTATION	ANTERIOR or POSTERIOR
12-26 92	I.S. _____ IPPB _____ HUM. _____ CANNULA <u>X</u> MASK _____ CPT _____ MA-1 _____ TENT _____ Hand Neb. _____ Other _____ O2 Meter _____ MEDS _____	Before	None	Color	1. Clear 2. Rhonchi 3. Rales 4. Wheeze 5. _____	99
		After	Mod	Amount		
TIME			Strong	Density	P.F. Pred. _____	
2100	Ear Oximetry _____ On O ₂ <u>6lpm</u> Off O ₂ _____				Pre: _____ Post: _____	SIGNATURE _____
12-27 92	I.S. _____ IPPB _____ HUM. _____ CANNULA <u>X</u> MASK _____ CPT _____ MA-1 _____ TENT _____ Hand Neb. _____ Other _____ O2 Meter <u>10.6</u> MEDS _____	Before	None	Color	1. Clear 2. Rhonchi 3. Rales 4. Wheeze 5. _____	99
		After	Mod	Amount		
TIME			Strong	Density	P.F. Pred. _____	
700	Ear Oximetry <u>100%</u> On O ₂ <u>6lpm</u> Off O ₂ _____				Pre: _____ Post: _____	SIGNATURE _____
12-27 92	I.S. _____ IPPB _____ HUM. _____ CANNULA <u>X</u> MASK _____ CPT _____ MA-1 _____ TENT _____ Hand Neb. _____ Other _____ O2 Meter _____ MEDS _____	Before	None	Color	1. Clear 2. Rhonchi 3. Rales 4. Wheeze 5. _____	99
		After	Mod	Amount		
TIME			Strong	Density	P.F. Pred. _____	
1600	Ear Oximetry <u>94%</u> On O ₂ <u>4lpm</u> Off O ₂ _____				Pre: _____ Post: _____	SIGNATURE _____
12-28 92	I.S. _____ IPPB _____ HUM. _____ CANNULA <u>X</u> MASK _____ CPT _____ MA-1 _____ TENT _____ Hand Neb. _____ Other _____ O2 Meter _____ MEDS _____	Before	None	Color	1. Clear 2. Rhonchi 3. Rales 4. Wheeze 5. _____	99
		After	Mod	Amount		
TIME			Strong	Density	P.F. Pred. _____	
0700	Ear Oximetry <u>94%</u> On O ₂ <u>4lpm</u> Off O ₂ _____				Pre: _____ Post: _____	SIGNATURE _____
12-28 92	I.S. _____ IPPB _____ HUM. _____ CANNULA <u>X</u> MASK _____ CPT _____ MA-1 _____ TENT _____ Hand Neb. _____ Other _____ O2 Meter _____ MEDS _____	Before	None	Color	1. Clear 2. Rhonchi 3. Rales 4. Wheeze 5. _____	99
		After	Mod	Amount		
TIME			Strong	Density	P.F. Pred. _____	
0755	Ear Oximetry <u>94%</u> On O ₂ <u>4lpm</u> Off O ₂ _____				Pre: _____ Post: _____	SIGNATURE _____
12-28 92	I.S. _____ IPPB _____ HUM. _____ CANNULA <u>X</u> MASK _____ CPT _____ MA-1 _____ TENT _____ Hand Neb. _____ Other _____ O2 Meter _____ MEDS _____	Before	None	Color	1. Clear 2. Rhonchi 3. Rales 4. Wheeze 5. _____	99
		After	Mod	Amount		
TIME			Strong	Density	P.F. Pred. _____	
1400	Ear Oximetry <u>90%</u> On O ₂ _____ Off O ₂ _____				Pre: _____ Post: _____	SIGNATURE _____

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10' x 6' 2 1/2"
like slightly 93%
7 10" then 95%
7 25"
like slightly on
from the x 50"
93%



LABORATORY REPORTS

PATIENT

Coopman
NO. *314*

12-27-92 16:30
SAO₂ 89 %
RATE 106 BPM
NELLCOR N-10
PULSE OXIMETER

PATIENT

Coopman
NO. *314*

12-27-92 16:30
SAT BPM
00:30 88% 100
01:00 87% 109
* 01:12 87% 112

* MIN SAT: 87%
AT 16:31:52

NELLCOR N-10
PULSE OXIMETER

12-27-92 07:51
SAO₂ 100 %
RATE 93 BPM
NELLCOR N-10
PULSE OXIMETER

Coopman
NO. *314*

12-27-92 01:30
SAO₂ 95 %
RATE 111 BPM
NELLCOR N-10
PULSE OXIMETER

12-26-92 22:24
SAO₂ 94 %
RATE 126 BPM
NELLCOR N-10
PULSE OXIMETER

88887111212
CCOPMAN, STACI

PATIENT

Coopman
NO. *314* *X26"*
21

12-28-92 14:00
SAO₂ 98 %
RATE 94 BPM
NELLCOR N-10
PULSE OXIMETER

314 *21*
12-28-92 *13:28*
SAO₂ 95 % *X26"*
RATE 90 BPM
NELLCOR N-10
PULSE OXIMETER

NO.

10/28/92 21 X 20"
12-28-92 *13:06*
SAO₂ 93 %
RATE 91 BPM
NELLCOR N-10
PULSE OXIMETER

NO. V

314 *41*
12-28-92 08:22
SAO₂ 94 %
RATE 90 BPM
NELLCOR N-10
PULSE OXIMETER

NO.

O₂-4L
12-28-92 *11:10*
SAO₂ 97 %
RATE 87 BPM
NELLCOR N-10
PULSE OXIMETER

12-27-92 17:15

SAT BPM
00:30 98% 90

* MIN SAT: 98%
AT 17:16:59

NELLCOR N-10
PULSE OXIMETER

(Paste 3rd report here and succeeding ones on above lines)

(Paste 2nd report on this line)

(Paste 1st report on this line)

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COMMUNITY MEMORIAL HOSPITAL

COOPMAN, STACIE L.
AGE/SEX: 17Y /F
0314-A
MEDICAL RECORDS COPY

INPATIENT

ADM: 122692
DCH: 122892

CHEMISTRY

===== ARTERIAL BLOOD GAS ANALY =====			REFERENCE
COLLECTED	12/26 20:10	12/27 07:30	7.350-7.450
pH	7.390	7.338 L	35.0-45.0 mmHG
pCO2	34.9 L	47.1 H	85.0-100.0 mmHG
pO2	41.4 L	119.5 H	95.0-100.0 %
O2 SAT.	75.8 L	98.2	16.0-24.0 meq/l
HCO3	20.4	24.5 H	2.5
BASE EXCESS	-2.5	-1.4	
FI02	.21	6 LPM	

12/26 20:10 DRAWN FROM RT. RADIAL ARTERY
12/27 07:30 DRAWN FROM RT. RADIAL ARTERY

P. HEALY CRTT
P. HEALY CRTT

*** END OF PATIENT'S REPORT ***

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COOPMAN, STACIE L.



COMMUNITY MEMORIAL HOSPITAL
855 S. Main St.
Oconto Falls, WI 54154

DATE PRINTED:
888871 DEC 31, 1992 15:40
PATIENT NUMBER

COMMUNITY MEMORIAL HOSPITAL

OCONTO FALLS, WISCONSIN

DEPARTMENT OF RADIOLOGY

PATIENT'S NAME Coopman, Stacie X-RAY NO. 30652

ROOM NO. Adm CASE NO. _____ AGE 17 DATE 12-26-92

PART TO BE X-RAYED PA and Lat Chest

CLINICAL DIAGNOSIS: cough

REFERRED BY [REDACTED] M.D.

RADIOGRAPHIC OR FLUOROSCOPIC FINDINGS

Coopman, Stacie

CHEST PA AND LATERAL 12/26/92:

The patient has taken only very shallow inspiration. The heart size appears normal on the lateral view. There is prominence of the bronchovascular markings, but this is probably all related to the poor inspiration.

CONCLUSION: (1) Expiratory chest.

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[REDACTED]
BY 12/28/92

RADIOLOGIST M.D.

COMMUNITY MEMORIAL HOSPITAL

OCONTO FALLS, WISCONSIN

DEPARTMENT OF RADIOLOGY

PATIENT'S NAME Coopman, Stacie X-RAY NO. 30652

ROOM NO. 314 CASE NO. _____ AGE 17 DATE 12-27-92

PART TO BE X-RAYED Portable Chest 0815 hrs

CLINICAL DIAGNOSIS: Cough, SOB

REFERRER [REDACTED] M.D.

**RADIOGRAPHIC OR
FLUOROSCOPIC FINDINGS**

Coopman, Stacie

AP PORTABLE CHEST 12/27/92:

The patient has taken a slightly better inspiration. The heart still appears somewhat prominent but again this may just be related to poor inspiration as there is no pulmonary congestion. The lung fields again appear clear allowing for the poor inspiration.

CONCLUSION: (1) Poor inspiration.

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[REDACTED]
[REDACTED]

RADIOLOGIST M.D.

