

G2C0136.A1

1993

10 JAN 1993

31

1. CASE NO. 921229CCN0543		2. INVESTIGATOR'S ID 9 0 0 3		3. OFFICE CODE 8 3 0		<b>EPIDEMIOLOGIC INVESTIGATION REPORT</b>
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
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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.)
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10B. SECOND PRODUCT aerosol container leather jacket	11B. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS Same as above.
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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
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16. BODY PART all parts 8 5	17. RESPONDENT(S) (Mother, Friend) Victim 1	18. TYPE INVESTIGATION ON SITE 1 TELEPHONE 2 OTHER 3 1	19. TIME SPENT Tr: 0.0 0 5 0
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20. ATTACHMENTS multiple 9	21. CASE SOURCE State Health Dept. 0 2	22. REVIEWED BY 8 1 3 0 9 3 0 1 12
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23. PERMISSION TO DISCLOSE NAMES  
(NON-NEISS 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

6/10/93  
 [unclear]  
 [unclear]  
 JSC [unclear]  
 [unclear]

G2C0136 A1

(USE OTHER SIDE AND ADDITIONAL SHEETS IF NECESSARY)

921229CCN0543

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 then 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 CPCS 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 "Cl 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.

U.S. CONSUMER PRODUCT SAFETY COMMISSION

1. AREA: Exhibit "B"  
 cpsc IOI# 921229 ccn 0543  
 12/29/92

2. NAME OF INDIVIDUAL: *Kris J. Garbrecht*  
 3. TITLE OF INDIVIDUAL: *Self*  
 4. DATE: *12/29/92*

5. FIRM NAME: \_\_\_\_\_  
 6. SAMPLE NUMBER: \_\_\_\_\_

7. NUMBER AND STREET: *3843 Hwy C*  
 8. CITY AND STATE (Include Zip Code): *OCONTO FALLS, WI 53151*

9. SAMPLES COLLECTED (Describe fully. List lot, serial, model numbers and other positive identification)  
 The following samples were collected by the Consumer Product Safety Commission pursuant to Section 27(f) of the Consumer Product Safety Act (15 U.S.C. 2078(f)) and/or Section 11(b) of the Federal Hazardous Substances Act (15 U.S.C. 1270(b)) and/or Sections 5(c) and (d) of the Flammable Fabrics Act (15 U.S.C. 1194(c) and (d)) and/or Section 704(c) of the Federal Food Drug and Cosmetic Act (21 U.S.C. 374(c)) [Authority for sample collections made in connection with the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.)], and receipt for said samples is hereby acknowledged. Sections cited are quoted on the reverse side of this form.

*2 - 5oz cans of Wilson's leather protector  
 sent by Federal Express  
 by Federal Express*

10. SAMPLES  
 a. AMOUNT RECEIVED FOR SAMPLE: *\$10.00 (cash/check)*  
 b. SIGNATURE (Person from whom sample received): *Kris J. Garbrecht*

11. SAMPLES WERE  
 PURCHASED  
 BORROWED (To be returned)

12. COLLECTOR  
 a. NAME (Print or type): *Dennis P. Blasius*  
 b. SIGNATURE: *Dennis P. Blasius*

SAMPLE COLLECTIC

IQI # 921229CCN0543

1. Flag		2. Date Collected 12/29/92		Sample type & number <input checked="" type="checkbox"/> Physical R-830-4408 <input type="checkbox"/> Documentary	
4a. Product name fabric treatment product		4b. Model Wilson's 5oz.		4c. NEISS 0952	
				5. Assignment ref. 921229CCN0543	
6. Complete for import samples		7. MIS 32672		8. Hours: a. Activity 2.0 b. Travel 0.0	
a. Port of Entry				9a. Home RO	
b. Entry # & date				9b. Collecting RO	
c. Country of Origin				FOCR	
d. HSUSA code				FOCR	
e. Customs Contact					
10. Sample Cost \$10.00 (C)		11. Invoice value of lot retail value approx. \$10.00		12. Size of lot two available from consumer	
13. Manufacturer/Importer Wilson's Suede and Leather Inc. Minneapolis, MN.		14. Shipper/Foreign Mfr. Wilson's Suede & Leather Port Plaza Mall A-1009 Port Plaza Mall Green Bay, WI. 54301		15. Dealer/Import Broker Kris Garbrecht 3843 Hwy C. Oconto Falls, WI. 54154	
ID #		ID #		ID #	
16. Supporting documents attached:					
a. Invoice # & date: N/A		b. Date Shipped:			
c. Shipping record # & date:					
d. Affidavit signer's name, title & date:					
17. Product Identification:					
Sample consists of two 5 ounce aerosol can of "Wilson's Leather Protector." Can is black in color with red and white lettering, SKU #18996003. Date coding stamp on container bottom states C1292. Front labeling describes product as "making suede and leather stain and water resistant, keeps dirt on the surface for easy wipe-off;" container further lists various warning and usage instructions.					
18. Reason for collection & analysis needed: FHSA <input checked="" type="checkbox"/> CPSC <input type="checkbox"/> FFA <input type="checkbox"/> PPPA <input type="checkbox"/> RSA <input type="checkbox"/>					
F/U to IDI# 921229CCN0543. 17 year old female suffered respiratory distress after using the product); content and labeling analysis.					
19. Summary of Field Screening:					
None					
20. Sample Size, Method of Collection:					
Sample consists of two unused can as described in #17 above. Two cans - packaged together in a black cardboard display container. Sample was obtained from consumer at her residence on 12/29/92; it remained in my possession and in the locked CPSC office until shipment to the Sample Custodian on 12/31/92. Sample					
21. Identification on sample "R-830-4408 DRB 12/29/92"		22. Identification on seal "R-830-4408 Dennis R. Blasius 12/31/92"			
23a. Sample delivered to Sample Custodian via P.P. MKE		23b. Date 12/31/92		24. Orig. report/records sent to FOCR	
25. Laboratory/Office: ESEL <input type="checkbox"/> HSHL <input checked="" type="checkbox"/> CERM <input type="checkbox"/> CECA <input type="checkbox"/> OTHER <input type="checkbox"/>					
26. Remarks was shipped in a cardboard box which was sealed and identified as under #22 above; sample itself was tagged and identified as described in #21 above. Sample was mailed via P.P.MKE to the Sample Custodian on 12/31/92, to be forwarded to HSHL for further analysis. Sample collection receipt, copy of original assignment attached.					
27. Related Samples R-830-4407					
28a. Collector's name, title & employee # Dennis R. Blasius, Investigator, #9003		28b. Collector's signature & date <i>Dennis R. Blasius</i> 12/31/92			
29a. Reviewer's name, title & employee #		29b. Reviewer's signature & date			

Exhibit "D"

12/29/92

FOI # 921229CCN0543

CONSUMER PRODUCT INCIDENT REPORT

1. NAME OF RESPONDENT Kris Garbrecht		2. TELEPHONE NO. (Home) (Work) (414) 846-2316 (Home)	
3. STREET ADDRESS 3843 Hwy. C		4. CITY STATE ZIP CODE Oconto Falls, WI. 54154	
5. DESCRIBE ACCIDENT SITUATION OR HAZARD, INCLUDING DATA ON INJURIES. (Use second page if necessary.) Respondent's girlfriend was applying an aerosol leather protector treatment to her newly purchased leather jacket; victim began experiencing severe respiratory distress after several minutes exposure to the product's fumes. Victim was immediately transported to a nearby hospital for treatment, and remains hospitalized to date.			
6. DATE OF INCIDENT(S) 12/27/92	7. IF INJURY OR NEAR MISS, OBTAIN AGE _____ SEX female AND DESCRIBE INJURY respiratory distress	8. IF VICTIM DIFFERENT FROM RESPONDENT, PROVIDE NAME _____ RELATIONSHIP girlfriend	
9. DESCRIPTION OF PRODUCT Aerosol spray leather protector		10. BRAND NAME Wilson's Leather Protector	
11. MANUFACTURER/DISTRIBUTOR NAME, ADDRESS & PHONE Wilson Leather Company Minneapolis, MN.		12. MODEL, SERIAL NO.'S 5oz. can	
		13. DEALER'S NAME, ADDRESS & PHONE Wilson's Leather Products Port Plaza Shopping Center Greenbay, WI.	
14. WAS THE PRODUCT DAMAGED, REPAIRED OR MODIFIED? YES _____ NO <input checked="" type="checkbox"/> IF YES, BEFORE OR AFTER THE INCIDENT? Describe _____		15. PRODUCT PURCHASED NEW <input checked="" type="checkbox"/> USED _____ DATE PURCHASED 12/27/92 AGE one day	
		16. DOES PRODUCT HAVE WARNING LABELS? IF SO, NOTE: _____	
17. HAVE YOU CONTACTED THE MANUFACTURER? YES _____ NO <input checked="" type="checkbox"/> IF NOT, DO YOU PLAN TO CONTACT THEM? YES <input checked="" type="checkbox"/> 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 _____	
<b>FOR ADMINISTRATION USE</b>			
20. DATE RECEIVED 12/28/92	21. RECEIVED BY (Name & Office) Dennis R. Blasius, MKE-RP		22. DOCUMENT NO. <b>92 C 0136</b>
23. FOLLOW-UP ACTION Conduct FOI 921229CCN0543			24. PRODUCT CODE(S) 0952
25. CONTRIBUTION G: EPVS; cc CERH, Jacobson; cc: EF		26. ENDORSER'S NAME & TITLE <i>[Signature]</i> SPT	

Exhibit "A"  
IDI# 921229CCN0543

Photos of the enclosed  
porch area where this  
incident occurred.

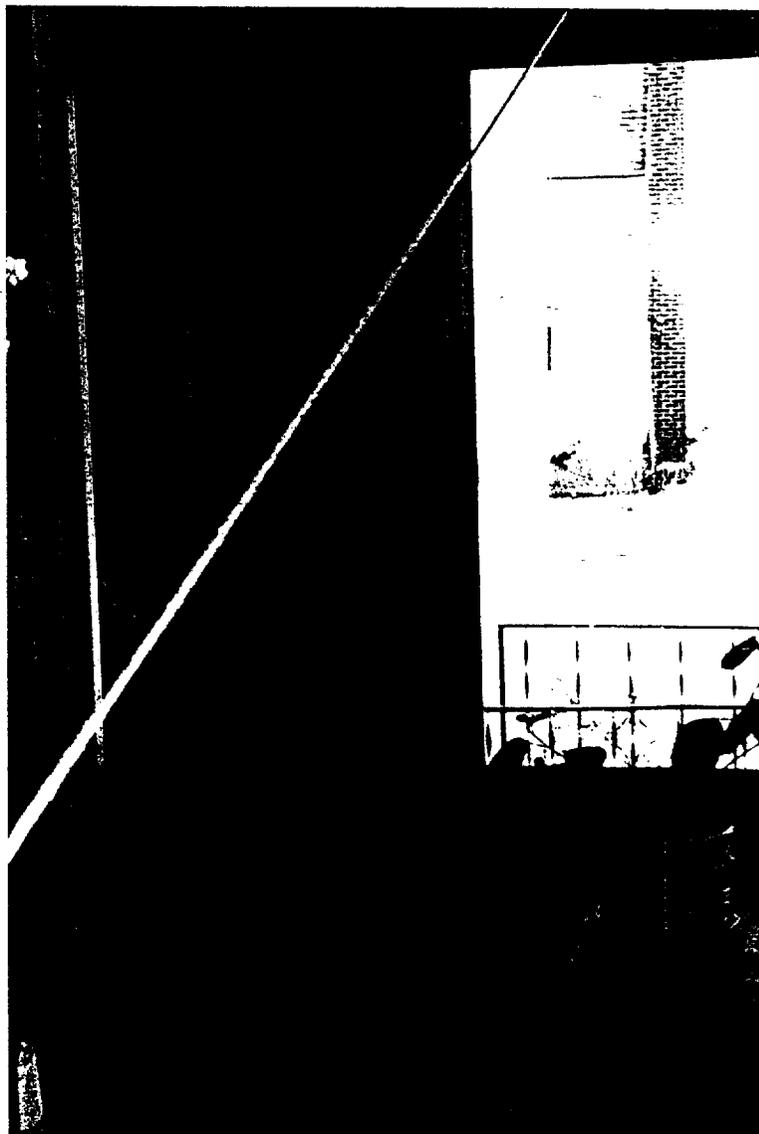


Exhibit "A"

IDI# 921229CCN0543

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



Exhibit "A"  
IDI# 921229CCN0543



Photos of the open window providing some outside ventilation (left), and a front view of the suspect product as purchased by the consumer.

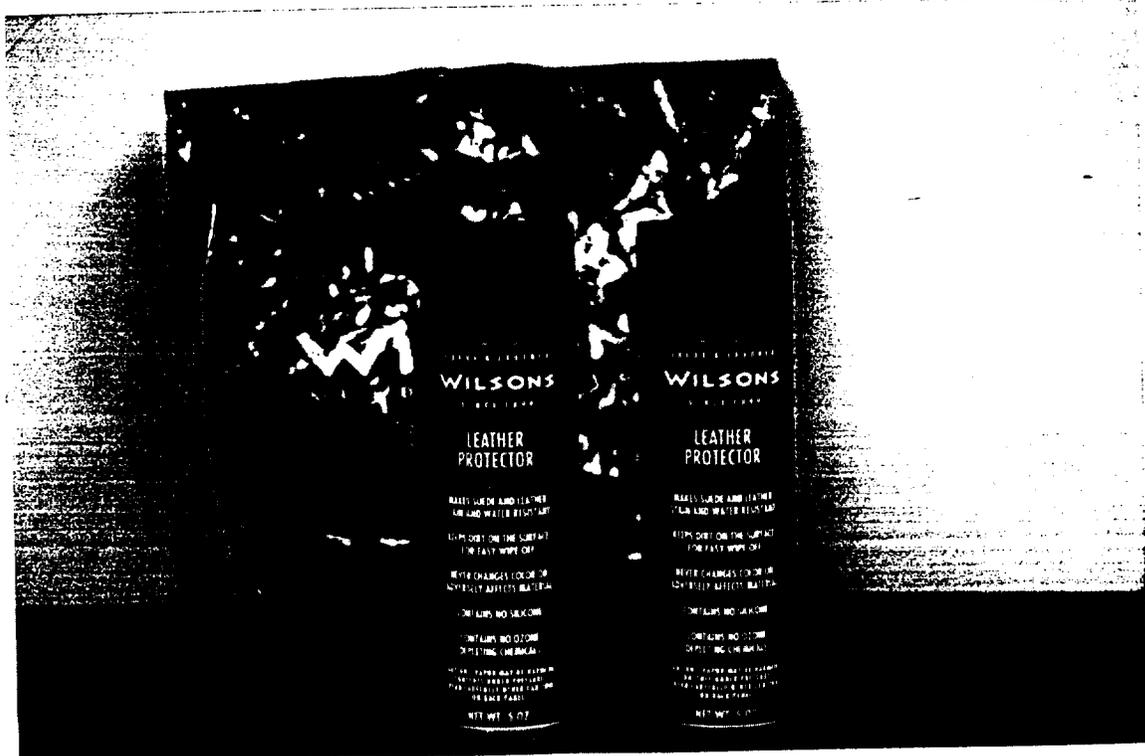
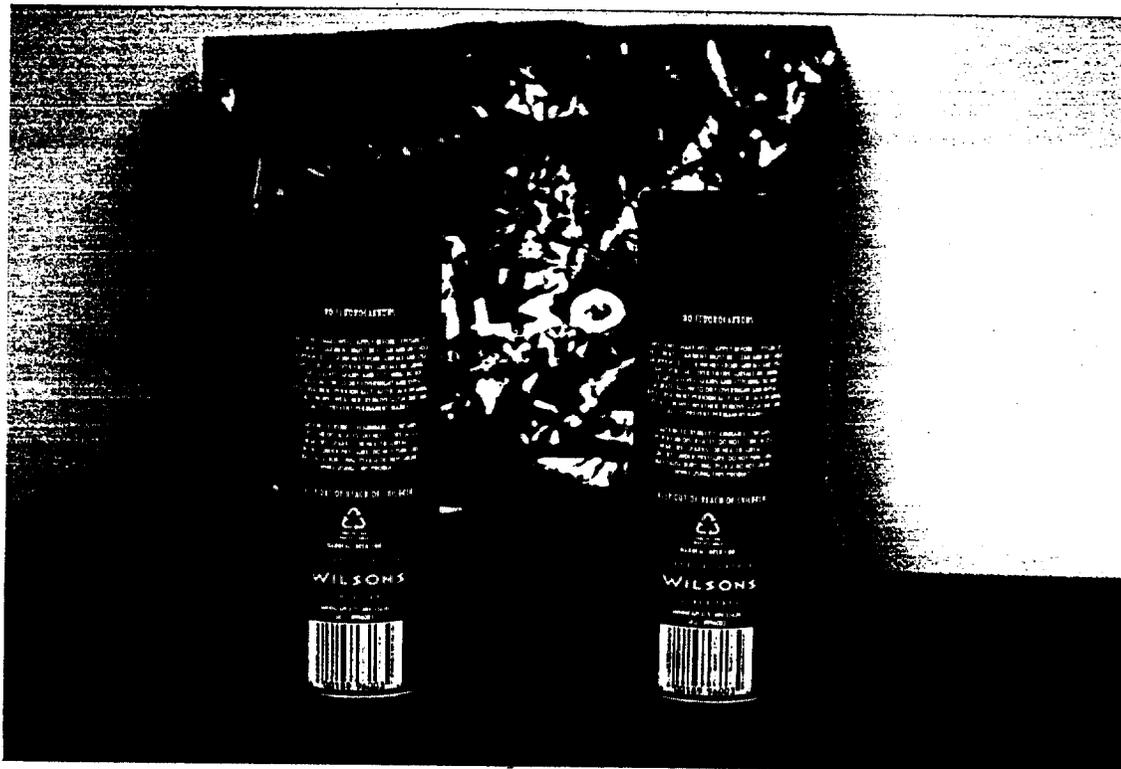


Exhibit "A"  
IDI# 921229CCN0543

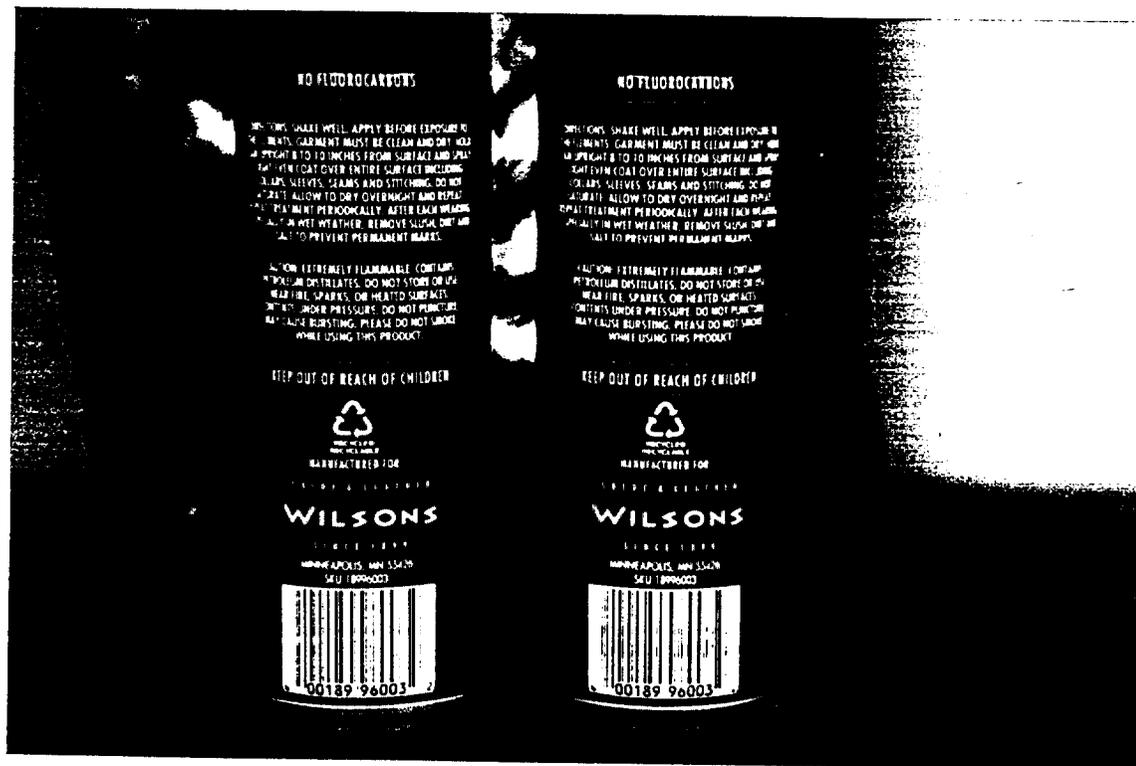


Date coding marking on bottom of containers (C1292.)

*NEGATIVES*



Photos of the labeling on the back panel of the aerosol container.



4G2C0137

13 JAN 1993

J1

1. CASE NO. 921229CCN0544			2. INVESTIGATOR'S ID 9 0 0 3				3. OFFICE CODE 8 3 0		
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						

# EPIDEMIOLOGIC INVESTIGATION REPORT

6. SYNOPSIS OF ACCIDENT OR COMPLAINT This investigation was initiated in response to a report that two sisters, ages 10 and 19, experienced severe respiratory distress after being exposed to the fumes from an aerosol fabric protection product they were treating a new leather jacket with in their basement. Both victims were treated and released at a local hospital emergency room.

7. LOCATION (Home, school, etc.) home		8. CITY 1 0 Gillett	9. STATE WI W I
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10A. FIRST PRODUCT fabric treatment product 0 9 5 2		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 Aerosol Container 1133		11B. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS Same as above.	

12. AGE OF VICTIM 0 1 9	13. SEX (Use numerical code) MALE - 1 FEMALE - 2 UNKNOWN - 3 2	14. DISPOSITION treated at E.R. and released 1	15. INJURY DIAGNOSIS chemical pneumonia 7 1
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16. BODY PART all parts 8 5	17. RESPONDENT(S) (Mother, Friend) victim 1	18. TYPE INVESTIGATION ON SITE 1 TELEPHONE 2 OTHER 3 1	19. TIME SPENT Tr: 8.0 0 7 0
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20. ATTACHMENTS multiple 9	21. CASE SOURCE State Health Dept. 0 2	22. REVIEWED BY 8 1 3 0 9 2 0 1 0 8
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23. PERMISSION TO DISCLOSE NAMES (NON-HESS 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
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6/10/93  
 X  
 250  
 X

G2C0137

(USE OTHER SIDE AND ADDITIONAL SHEETS IF NECESSARY)

921229CCN0544

SUMMARY:

This investigation was conducted in response to a report that two sister, ages ten and nineteen, experienced severe respiratory distress after treating a new leather coat with an aerosol fabric protection product. Both victims were treated at a local hospital emergency room and released.

PRE-INCIDENT:

On Sunday 12/27/92, at approximately 3:30 p.m. the nineteen year old female complainant purchased a new black leather waist length jacket from the "Wilson's Suede and Leather Products" retail store located at A-1009 Port Plaza Mall, located in Green Bay, Wis. 54301, phone # 414-432-3121.

The complainant was assisted in making this purchase by a female clerk named Darla, last name unknown, who is believed to be a store manager. The store manager suggested to the complainant that it would be important to treat the new jacket with a fabric protection product to avoid damage to the coat from dirt or moisture. The clerk suggested that the complainant purchase "Wilson's Leather Protector", which is an aerosol product sold at the store in 5 oz. aerosol cans. This aerosol fabric protector is sold in a two can cardboard display packaged, described as a "Leather Care Starter Set". The two container set retails for approximately \$10.00.

The complainant agreed to purchased the fabric protector product. She was told by the manager that the entire contents of a five ounce can of the product should be sprayed on the coat before it was worn, and that the coat should be retreated every six months afterwards by spraying an additional one-half container of the five ounce size can onto the coat. The clerk provided no further direction as to how the fabric protector should be applied, and provided no cautionary warning that the product's fumes might be hazardous.

INCIDENT:

Later that same day, 12/27/92, at approximately 6:30 p.m., the nineteen year old complainant sprayed the entire content of a five ounce aerosol can of Wilson's Leather Protector onto her new jacket. This jacket was treated in the basement area of the family's twostory single family residence. The basement is unfinished, though a portion of the basement area is used by the complainant's ten year old sister as a playroom. The area where the coat was treated is described as being approximately 16ft. long x 14ft. wide x 8ft. high, and is adjacent to the home's gas forced air furnace. There are several windows in the basement of the home, however none of the windows were opened during the time period that this incident occurred.

The spraying of the jacket took approximately five to ten minutes. The complainant stated that she read the instruction and warning labeling on the aerosol can before starting to use the product. She noted that the labeling stated that "Vapors may be harmful", and "Please do not smoke while using this product". The complainant felt that the open basement area was large enough to preclude her from having any problems with the product's fumes, so she sprayed the can's entire five ounce contents on the coat in one application. She did not find the fumes particularly offensive or overpowering, and noticed no adverse physical effects while using the product. Photographs attached to the end of this report as exhibit "A" depict the complainant reenacting the manner in which she sprayed the coat.

The complainant's ten year old sister was playing approximately twelve feet from where the coat was being treated. At one point the ten year old was asked by the complainant to assist in holding the jacket open during the spraying procedure; the ten year old did so for approximately one minute. A photograph of this procedure, reenacted by the sisters, is also contained in Exhibit "A".

Approximately fifteen to twenty minutes after finishing the leather protector treatment of the jacket, the ten year old daughter complained to her mother that she was having difficulty breathing. The ten year old complained that she had a burning sensation in her lungs if she took a deep breath, and that "it feels like somebody is sitting on my chest". The ten year old laid down on the living room couch to rest, at which time the nineteen year old complainant came downstairs from her bedroom also complaining to her mother that she felt like she could not breath. The nineteen year old could only take short, shallow breathes, and she began coughing uncontrollably, feeling like she needed to vomited. The nineteen year old also complained of the same burning sensation in her lungs.

#### POST-INCIDENT:

The girl's mother suspected that the victims were having some reaction to the fabric protector; she immediately called the local poison control center but was told that the "Wilson's Leather Protector" product was not listed in their files, and that she should immediately take both girls to a local hospital for emergency treatment of their symptoms. The victims' mother drove the girls to the near by Oconto Falls Community Memorial Hospital, 855 S. Main Street, Oconto Falls, Wi. 54154, where they both received emergency treatment from Dr. Wallace. Both girls were giving oxygen tests, chest x-rays, and were found to be suffering from symptoms usually associated with chemical pneumonia. The symptoms begin to subside, and the two victims were released from the hospital approximately two hours after admittance. As of the

date of this investigator's interviews with the victims, 12/29/92, both victims complained only of a lingering cough and no further symptoms.

Attached the end to this report as Exhibits "B-E", are "Authorization for Release of Name" and "Authorization for Medical Records Disclosure" forms sign by the victims. The victims did not wish their identities revealed, except as necessary to interact with other investigative government agencies.

SAMPLES COLLECTED:

Of the two five ounce cans of "Wilson's Leather Protector" fabric protection product purchased by the consumer, they had one full unused container remaining. The other used container had been given to a local Television Station. The remaining container was collected by this investigator as a CPSC sample, sample number R-8304407, and forwarded to HSHL for further analysis.

A copy of the sample collection receipt issued to the consumer is attached as Exhibit "F". A copy of the sample collection receipt is attached as Exhibit "G".

APPLICABLE STANDARDS:

The hazardous substances labeling requirements detailed in 16CFR1500 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; five ounce aerosol container, container-described as being black with red and white lettering. SKU number 18996003. Date coding ink print on bottom of container is apparently incomplete, states "C1--2".

MANUFACTURER: Wilson's Suede and Leather, Inc., Minneapolis, Mn.

ATTACHMENTS:

Exhibit A - Photographs of the product use reenactment as well as photographs of the product container itself.

Exhibit B - Authorization for release of name forms signed by

Michelle Rodefer.

Exhibit C - Authorization for release of name form signed by the parent of Lindsey Rodefer, a Juvenile.

Exhibit D - Authorization for Medical Records disclosure form signed by Michelle Rodefer.

Exhibit E - Authorization for Medical Records disclosure form signed by the mother of Lindsey Rodefer.

Exhibit F - Copy of the Sample Collection Receipt issued to Linda Rodefer for the sample of "Wilson's Leather Protector" obtained as a sample.

Exhibit G - Copy of the Sample Report, sample number R-830-4407.

Exhibit H - Copy of the original Consumer Product Incident Report, dated 12/28/92.

Medical Records pertaining to both victim's hospital treatment were requested on 1/4/93, and that information will be forwarded as a addendum to this report when it is received by the Milwaukee Resident Post.

Exhibit "D"

12/29/92

IQI#921229CCN0544

U.S. CONSUMER PRODUCT SAFETY COMMISSION

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO WHOM IT MAY CONCERN:

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

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

( the case of Michelle Prodezis  
Name

Relationship to you

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

12-29-92  
(Date)

Michelle Prodezis  
(Signature)

One Blasi  
(Witness)

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO WHOM IT MAY CONCERN:

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

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

( the case of Lindsey Rae Rodefer )  
Name

my daughter )  
Relationship to you

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

12-29-92  
(Date)

Linda Rodefer  
(Signature)

Demetri Blain  
(Witness)

U.S. CONSUMER PRODUCT SAFETY COMMISSION

1. AREA FOI# 92/229 DCW 0544  
Cpsc -  
310 W. WISCONSIN AVE.  
MILWAUKEE, WI 53203

2. NAME OF INDIVIDUAL  
LINA RODEFER

3. TITLE OF INDIVIDUAL  
Self

4. DATE  
12/29/92

5. FIRM NAME

6. SAMPLE NUMBER

7. NUMBER AND STREET  
5574 DULANSTOWN ROAD

8. CITY AND STATE (Include Zip Code)  
GILLET W.I. 53124

9. SAMPLES COLLECTED (Describe fully, List lot, serial, model numbers and other positive identification)

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

1 - ONE 552 CAN OF 'Wilson + Leather protector'  
PROWOT TO # 00189-96003

10. SAMPLES  
a. AMOUNT RECEIVED FOR SAMPLE  
b. SIGNATURE (Person from whom sample received)  
Lina Rodefer

11. SAMPLES WERE  
 PURCHASED  
 BORROWED (To be returned)

12. COLLECTOR  
a. NAME (Print or type)  
DENNIS R. BLASIUS  
b. SIGNATURE  
D. Blaus

U. S. CONSUMER PRODUCT

Exhibit "G"

12/24/92

SAMPLE COLLECTI

TOI# 921229CCN0544

1. Flag		2. Date Collected 12/29/92		3. Sample type & number <input checked="" type="checkbox"/> Physical R-830-4407 <input type="checkbox"/> Documentary	
4a. Product name fabric treatment product		4b. Model Wilson's 5oz.		4c. NEISS 0952	
5. Assignment ref. 921229CCN0544		6. Complete for import samples		7. MIS 32672	
a. Port of Entry		b. Entry # & date		8. Hours: a. Activity 2.0 b. Travel 0.0	
c. Country of Origin		d. HSUSA code		9a. Home RO	
e. Customs Contact		10. Sample Cost \$0.		9b. Collecting RO	
11. Invoice value of lot retail value approx. \$5.00		12. Size of lot one available from consumer		13. Manufacturer/Importer Wilson's Suede and Leather Inc. Minneapolis, MN.	
14. Shipper/Foreign Mfr. Wilson's Suede & Leather Port Plaza Mall A-1009 Port Plaza Mall Green Bay, WI. 54301		15. Dealer/Import Broker Linda Rodefer 5574 Degantown Road Gillett, WI. 54124		16. Supporting documents attached: a. Invoice # & date: N/A b. Date Shipped: c. Shipping record # & date: d. Affidavit signer's name, title & date:	
17. Product Identification: Sample consists of one 5 ounce aerosol can of "Wilson's Leather Protector." Can is black in color with red and white lettering, SKU #18996003. Date coding stamp on container bottom states "Cl 2." Front labeling describes product as "making suede and leather stain and water resistant, keeps dirt on the surface for easy wipe-off;" container further lists various warning and usage instructions.		18. Reason for collection & analysis needed: FHSA <input checked="" type="checkbox"/> CPSC <input type="checkbox"/> FFA <input type="checkbox"/> PPPA <input type="checkbox"/> RSA <input type="checkbox"/> F/U to IDI# 921229CCN0544 (10 Y.O. and 19 Y.O. suffered respiratory distress after using the product); content and labeling analysis.		19. Summary of Field Screening: None	
20. Sample Size, Method of Collection: Sample consists of one unused can as described in #17 above. This can was one of a two can set packaged together in a black cardboard display container. Sample was obtained from consumer at her residence on 12/29/92; it remained in my possession and in the locked CPSC office until shipment to the Sample Custodian on 12/31/92. Sample		21. Identification on sample "R-830-4407 DRB 12/29/92"		22. Identification on seal "R-830-4407 Dennis R. Blasius 12/31/92"	
23a. Sample delivered to Sample Custodian via P.P. MKE		23b. Date 12/31/92		24. Orig. report/records sent to FOCR	
25. Laboratory/Office: ESEL <input type="checkbox"/> HSHL <input checked="" type="checkbox"/> CERM <input type="checkbox"/> CECA <input type="checkbox"/> OTHER <input type="checkbox"/>		26. Remarks was shipped in a cardboard box which was sealed and identified as under #22 above; sample itself was tagged and identified as described in #21 above. Sample was mailed via P.P.MKE to the Sample Custodian on 12/31/92, to be forwarded to HSHL for further analysis. Sample collection receipt, copy of original assignment attached.		27. Related Samples R-830-4408	
28a. Collector's name, title & employee # Dennis R. Blasius, Investigator, #9003		28b. Collector's signature & date <i>Dennis R. Blasius</i> 12/31/92		29a. Reviewer's name, title & employee #	
29b. Reviewer's signature & date		Distribution: Orig <input type="checkbox"/> Lab <input type="checkbox"/> Fiscal <input type="checkbox"/> Data <input type="checkbox"/> Hdqtr <input type="checkbox"/> Other <input type="checkbox"/>		CPSC Form 166 (Rev. 9/91)	

CONSUMER PRODUCT INC

Exhibit "H"

12/27/92

FOI # 921229CCN0544

1. NAME OF RESPONDENT Linda Rodefer		2. TELEPHONE NO. (Home) (Work) (414) 855-6225 (Home)	
3. STREET ADDRESS 5574 Degantown Road		4. CITY STATE ZIP CODE Gillett, WI. 54124	
5. DESCRIBE ACCIDENT SITUATION OR HAZARD, INCLUDING DATA ON INJURIES. (Use second page if necessary.)  Respondent's two daughters, ages 19 and 10, were in the basement of their home treating a new leather coat with an aerosol leather protector product. After several minutes of exposure to the product's fumes both individuals began experiencing severe respiratory distress, including difficulty breathing, coughing, and tightness in their chests. Both victims were transported to a local hospital, where they were treated and released.			
6. DATE OF INCIDENT(S) 12/27/92	7. IF INJURY OR NEAR MISS, OBTAIN AGE <u>19</u> SEX <u>Female</u> AND DESCRIBE INJURY <u>respiratory distress</u>	8. IF VICTIM DIFFERENT FROM RESPONDENT, PROVIDE NAME _____ RELATIONSHIP <u>daughters</u>	
9. DESCRIPTION OF PRODUCT aerosol spray leather protector		10. BRAND NAME Wilson's Leather Protector	
11. MANUFACTURER/DISTRIBUTOR NAME, ADDRESS & PHONE Wilson's Leather Company Minneapolis, MN.		12. MODEL SERIAL NO.'S 5oz. and 7oz. cans	
		13. DEALER'S NAME, ADDRESS & PHONE Wilson's Leather Products Port Plaza Shopping Center Greenbay, WI.	
14. WAS THE PRODUCT DAMAGED, REPAIRED OR MODIFIED? YES _____ NO <u>X</u> IF YES, BEFORE OR AFTER THE INCIDENT? Describe _____		15. PRODUCT PURCHASED NEW <u>X</u> USED _____ DATE PURCHASED <u>12/27/92</u> AGE <u>one day</u>	
		16. DOES PRODUCT HAVE WARNING LABELS? IF SO, NOTE: _____	
17. HAVE YOU CONTACTED THE MANUFACTURER? YES <u>X</u> NO _____ IF NOT, DO YOU PLAN TO CONTACT THEM? YES _____ NO _____ OTHER _____	18. IS THE PRODUCT STILL AVAILABLE? YES <u>X</u> NO _____ IF NOT, ITS DISPOSITION _____	19. MAY WE USE YOUR NAME WITH THIS REPORT? YES <u>X</u> NO _____	
<b>FOR ADMINISTRATION USE</b>			
20. DATE RECEIVED 12/28/92	21. RECEIVED BY (Name & Office) Dennis R. Blasius, MKE-BP	22. DOCUMENT NO. <b>62 C. 0137</b>	
23. FOLLOW-UP ACTION <i>Conduct MRI 921229CCN0544</i>		24. PRODUCT CODE(S) <i>0952</i>	
25. DISTRIBUTION <i>Q: EPDS; cc (EARM, Jacobson) cc: EP</i>		26. ENCLOSED'S NAME & TITLE <i>[Signature] DPST</i>	

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.

Linda Rodefer  
(Signature)  
(for 10%0 daughter unosey)

12-29-92  
(Date)

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.

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

My identity is to remain confidential.

Michel Rodenas  
(Signature)

12-29-92  
(Date)

Exhibit "A"

IDI# 921229CCN0544

**NO FLUOROCARBONS**

**DIRECTIONS:** SHAKE WELL. APPLY BEFORE EXPOSURE TO THE ELEMENTS. GARMENT MUST BE CLEAN AND DRY AND HUNG 8 TO 10 INCHES FROM SURFACE AND SPRAY LIGHT EVEN COAT OVER ENTIRE SURFACE INCLUDING COLLARS, SLEEVES, SEAMS AND STITCHING. DO NOT SATURATE. ALLOW TO DRY OVERNIGHT AND REPEAT TREATMENT PERIODICALLY. AFTER EACH WASHING, ESPECIALLY IN WET WEATHER, REMOVE SALT AND SOAP 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 SMOKING WHILE USING THIS PRODUCT.

**KEEP OUT OF REACH OF CHILDREN**



MANUFACTURED FOR

**WILSONS**

SINCE 1899

MINNEAPOLIS, MN 55426

SKU 18996003



Additional photos of the instruction and warning labeling on the product container.

SALE 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 SMOKING WHILE USING THIS PRODUCT.

**KEEP OUT OF REACH OF CHILDREN**



MANUFACTURED FOR

**WILSONS**

SINCE 1899

MINNEAPOLIS, MN 55426

SKU 18996003



00189 96003

Exhibit "A"

IDI# 921229CCN0544

Photos of the suspect product.

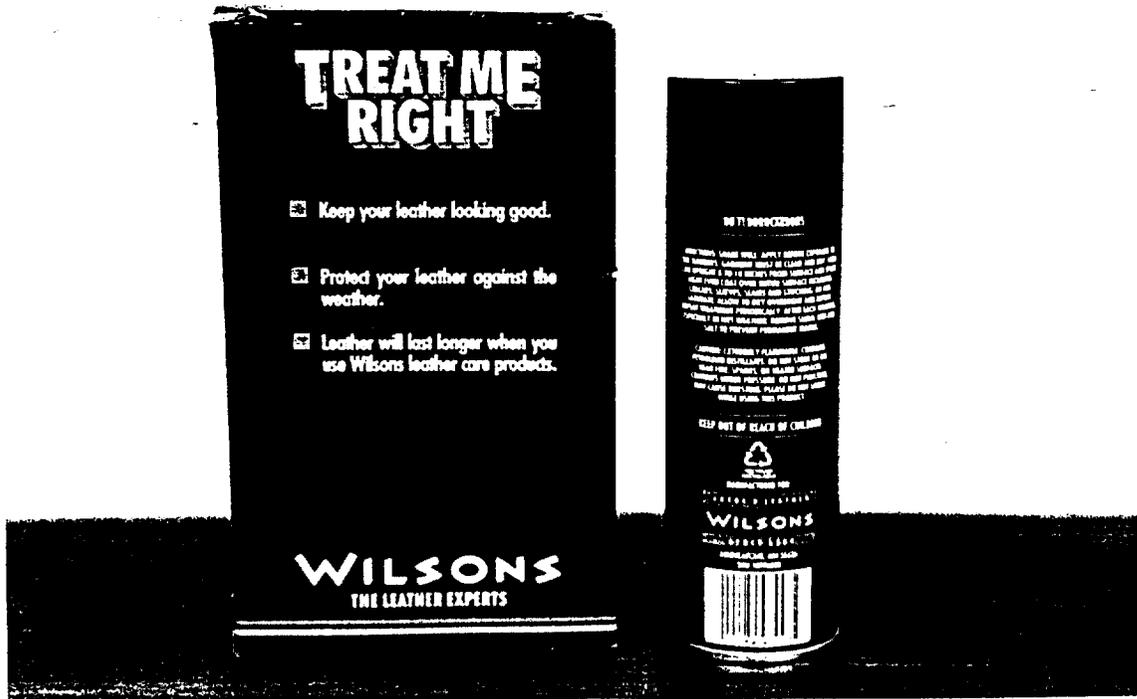
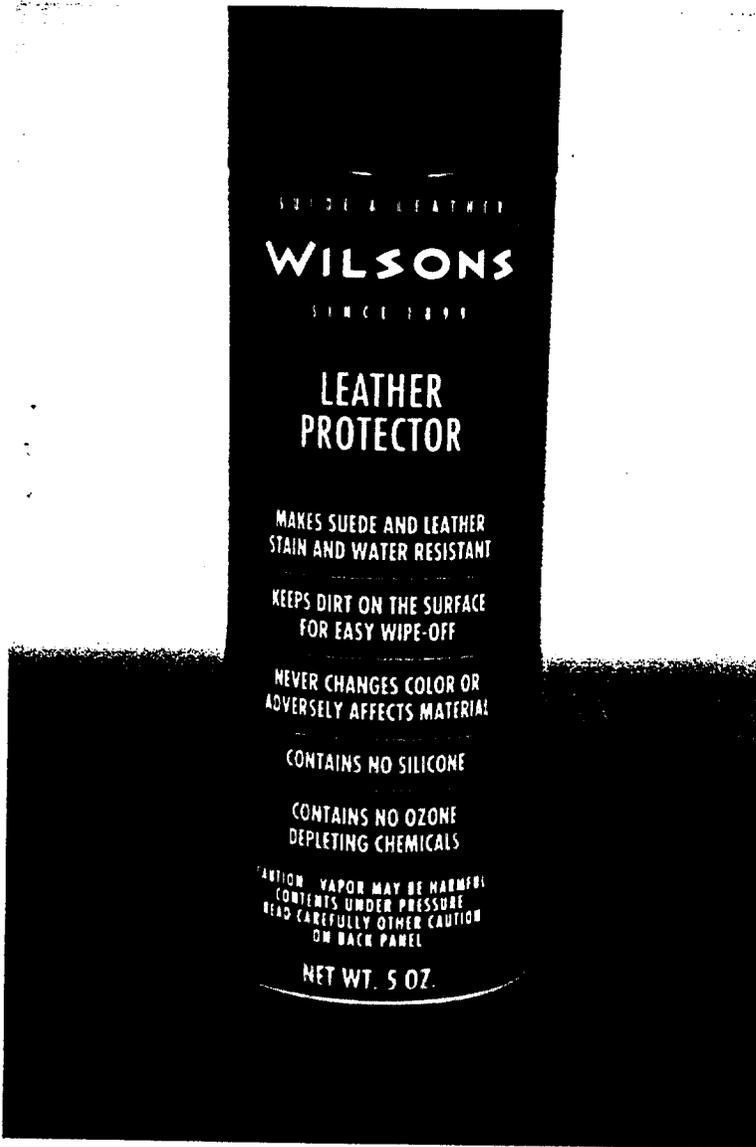


Exhibit "A"

IDI# 921229CCN0544

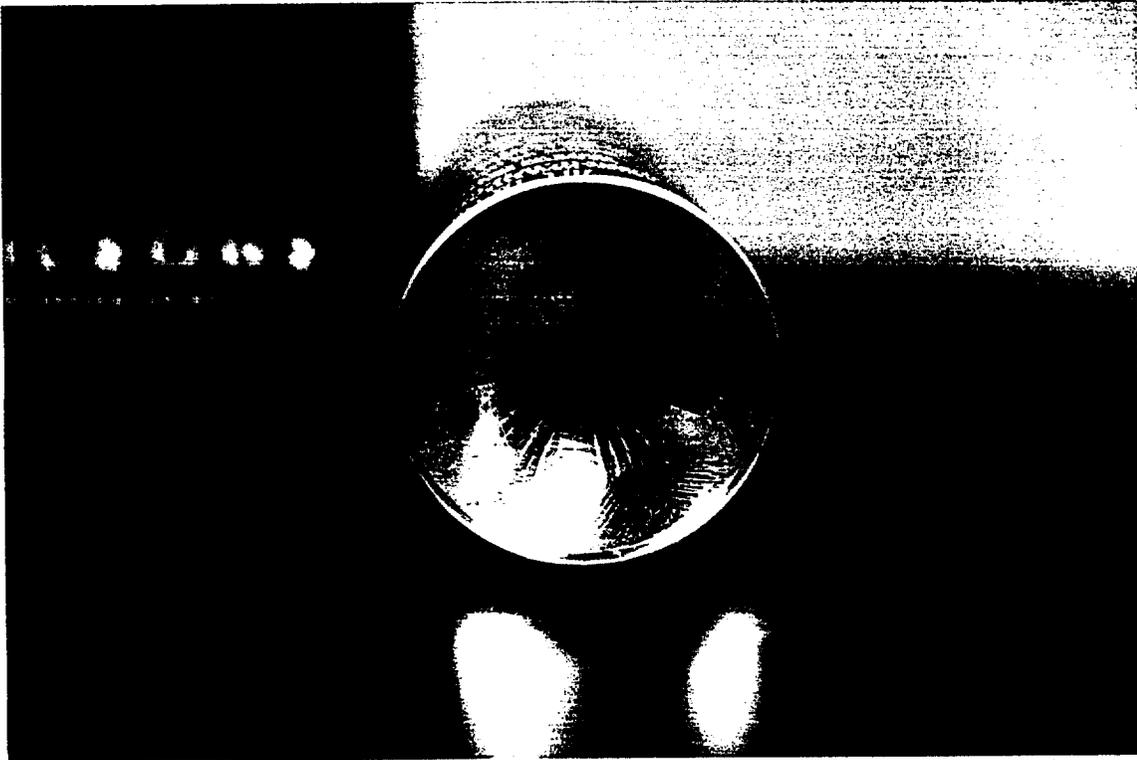


Photos of complainant re-enacting her use of the suspect product.



Exhibit "A"

IDI# 921229CCN0544



Date coding information on the bottom of the container; states "Cl..2"

NEGATIVES

Exhibit "A"

IDI# 921229CCN0544



Above: Complainant and her sister re-enacting their use of the fabric protector product.

Below: Photo of the product in question, as purchased by the consumer.



MAR 4 1993

31

G310081

1. CASE NO. 930111CCN0667		2. INVESTIGATOR'S ID 8 1 1 1		3. OFFICE CODE 8 3 0		<b>EPIDEMIOLOGIC INVESTIGATION REPORT</b>
4. DATE OF ACCIDENT YR MO DAY 9 2 1 2 2 5		5. DATE INVESTIGATION INITIATED YR MO DAY 9 3 0 1 2 8				

6. SYNOPSIS OF ACCIDENT OR COMPLAINT On 12-25-92 at approximately 0830 hours, a 43 year old male and his 17 year old son suffered chemical pneumonia after entering a room in which a leather protector had been applied to a coat. Both were treated and released at a local emergency room.

7. LOCATION (Home, school, etc.) Home (Niece's bedroom)	8. CITY Raleigh	9. STATE Tennessee
--	--------------------	-----------------------

10A. FIRST PRODUCT Leather protector	11A. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS Wilson's, Minneapolis, Mn. 55426
---	---

10B. SECOND PRODUCT n/a	11B. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS n/a
----------------------------	--

12. AGE OF VICTIM 0 4 3	13. SEX (Use numerical code) MALE - 1 FEMALE - 2 UNKNOWN - 3 1	14. DISPOSITION T & R 1	15. INJURY DIAGNOSIS Chemical pneumonia (vapor inhalation) 6 8
----------------------------	--	-------------------------------	--

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

20. ATTACHMENTS Multi	21. CASE SOURCE Newspaper	22. REVIEWED BY 8007	YR MO DAY 9 3 0 2 2 4
--------------------------	------------------------------	-------------------------	--------------------------

23. PERMISSION TO DISCLOSE NAMES (NON-NEISS CASES ONLY)	CPSC MAY DISCLOSE MY NAME <input checked="" type="checkbox"/>	CPSC MAY NOT DISCLOSE MY NAME <input type="checkbox"/>
--	---	--

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

Narrative begins on page 2.

APPROVED FOR USE THROUGH 5/31/94 OMB NO. 3041-0029

6/10/93

X

X

G310081

U.S. CONSUMER PRODUCT SAFETY COMMISSION

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO WHOM IT MAY CONCERN:

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

( the case of Donald Adams (self), Carey Adams (son)  
Name

Relationship to you

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

1/30/93  
(Date)

Donald Leon Adams  
(Signature)

Janice L. Mitchell  
(Witness)

930111CCN0667

Pre-Accident:

The victim, a 43 year old male, lives with his wife and 17 year old son in a one-story single family dwelling located in a blue-collar working class suburban community near Memphis, Tennessee.

The victim, a letter carrier with the U.S. Postal Service, said prior to this incident, he had not missed a day from work due to sickness in over 10 years. He said he has been in excellent health, and was not on any medication prior to this incident. He said he smokes cigarettes, averaging close to two packs per day, and has done so for some time.

He explained that the day of the incident was Christmas Day. He, his wife, and son went to his sister's home for Christmas breakfast, as their custom had been for several years. He said they arrived there at approximately 0730 hours. After greeting family and friends who were there, he said he went into one of the bedrooms, which had been designated as the "smoking area" to smoke a cigarette. Time was approximately 0745 hours. He then returned to the living room and kitchen area and ate breakfast. The family then began opening gifts.

The victim said his niece received a new waist length leather coat for Christmas from her boyfriend, who was there. The coat was in a garment bag. When she opened the garment bag, the first thing that fell out was a can of leather protector spray which came with the coat. He said she showed the coat to everyone, then took it to her bedroom (which was the room designated as the smoking area).

Unknown to the others, the niece's boyfriend proceeded to spray the leather coat with the 5 oz. leather protector spray in the niece's bedroom, as it hung on the outside of the closet door.

The victim said he went back to the designated smoking area and smoked another cigarette around 0830 hours.

Accident:

The victim said he noticed a peculiar smell in the room when he went to smoke a second cigarette, but assumed it was caused by stale cigarette smoke. After leaving the room, he said he felt a pain in his chest, and began coughing violently.

Post-Accident:

The victim said he and his family left his sister's house around 0900 hours. His wife said by the time they arrived home, both her husband and her son felt so ill, they immediately went to bed. She said they were complaining of shortness of breath,

930111CCN0667

coughing, chest pain, fever, and chills. She said she telephoned her sister-in-law and found out her niece and nephew were also experiencing similar symptoms. After talking about what was occurring, they both realized the only unusual occurrence was that the niece's boyfriend had sprayed her new leather coat in the same room that had been designated as the "smoking area."

The wife said she decided to telephone the poison control center for advice. She was told to take her husband and son to a local hospital emergency room for treatment.

She said they arrived at the hospital around 1245 hours. Their temperatures was at 102 degrees F. Both her husband and son were examined by physicians and diagnosed as experiencing chemical pneumonia. They were treated, prescribed medication, and released.

The victim said he continued feeling very ill until he began taking the medication. He remained at home recovering for three (3) days. He said his son was home recovering for 4 days, although he continued to cough for the next 10-14 days.

The victim said while he was being treated by the hospital emergency room staff, at least two physicians and one nurse questioned him on whether he had intentionally inhaled a chemical for drug abuse purposes. He said such questions were insulting and contributed to the discomfort he was experiencing.

The victim's wife said several of the family members became ill after being in the designated smoking room on Christmas Day, however, not all of them sought medical treatment. She said she subsequently contacted the local newspaper and reported her family's reaction to the leather protector spray, and found out that individuals nationwide had sustained similar illnesses.

The victim's niece who owned the leather coat was visited and she stated she also became ill and was treated at the local hospital emergency room. She said her boyfriend, however, did not become ill.

She said he purchased the leather coat and spray leather protector from a store in the Oakcourt Mall in Memphis, Tn. She said since the incident, he has subsequently purchased a second container of leather protector for her coat, however, it was a different size (7 oz.) and contained different label statements. She provided the original container for my examination and permitted me to photograph it, however, refused to permit CPSC to collect it as a sample due to possible litigation.

The room designated as the smoking area in which the spray protector was used was examined and noted to consist of approximately an 11'x12' area containing furnishings such as a waterbed, two dressers, and a storage bin (a diagram was drawn and is attached). The victim's niece stated the leather coat was hanging on the outer frame of the closet at the time the leather protector spray was applied, and left at the same location to dry. She said the room temperature was set at 73 degrees F. The window for the room was closed. There was no ventilation.

930111CCN0667

Product Information:

Product

Leather protector, product in black metal spray can, 5 oz. size, labeled in part: **\*\*WILSONS LEATHER PROTECTOR\*\***  
CAUTION: VAPOR MAY BE HARMFUL. CONTENTS UNDER PRESSURE. READ CAREFULLY OTHER CAUTION ON BACK PANEL. NET WT. 5 OZ. **\*\*WILSONS MINNEAPOLIS, MN 55426\*\***.

Manufacturer/Distributor

Wilson's  
Minneapolis, Ms. 55426

Product Code

"292" stamped on bottom of can

Standards Information:

Product is subject to 16 CFR Part 1500 under the Federal Hazardous Substances Act.

Attachments:

1. Photographs
2. Authorization to Release Name
3. Medical Records Disclosure
4. Medical Records
5. Poison Control Records
6. Diagram of room
7. Assignment

PATIENT NAME: ER23798234  
 ADAMS DONALD L 43 WMM 1620533-001  
 UNIT NUMBER: 1620533-001  
 REFERRING PHYSICIAN: NO REFER. DR.  
 ACCOUNT NUMBER: E-334422  
 PERSONAL PHYSICIAN: NONE  
 EMER. AM. CHG. 46  
 M & S SUPPLIES: [blank]  
 PHYSICIAN FEE: 00  
 OTHER CHARGES: [blank]  
 AMOUNT PAID: [blank]

IF ACCIDENT: INDUSTRIAL  MVA  OTHER   
 DATE: [blank] TIME: [blank] LOCATION: [blank]  
 POLICE NOTIFIED: [blank] AM: [blank] PM: [blank] FAMILY NOTIFIED: [blank]  
 MERG. DR. [blank] HOUSE STAFF: [blank] ADMITTING PHYSICIAN (INITIAL LAST): [blank]  
 DR. M. CARR

ALLERGIES: NKDA  
 BROUGHT BY: PRIVATE VEHICLE  
 A.M.B. NO.: [blank]  
 INS. 1: EG INS. 2: P INS. 3: [blank]

CHIEF COMPLAINT: DIFF BREATHING/INHALED CHEMICALS

HISTORY & PHYSICAL: 43yo male presented with difficulty breathing - 1/2 hr @ home 2 other family members present. Some of heavy exposure to paint fumes and some time but had chest pain cough. NB. Neck rigidity. High cheeks both been. Cough -> RUC relief.

DATE IN	12-25-92	TIME	1245
DATE OUT	12/25/92	TIME	1430
VITAL SIGNS			
TIME	B/P	T	P
1255	128/80	101°	116
1415	128/68	101°	112

CBC	WBC	15.1
HGB		
DIFF		
NA	K	
CL	CO <sub>2</sub>	
BUN	GLU	
UA		

DISCHARGE IMPRESSION: Pneumonia  
 ORDERS: CBC, BxT-CXR -> RUC relief  
 ABG's  
 Ergth  
 No-Tuss

DATE OF LAST TETANUS: [blank]  
 CURRENT MEDICATIONS: None  
 APR BAND ON: [blank]  
 SIDERAILS UP:

ADMISSION NOTES: Ambul to room #7: @ family in room - spraying Lestrin coat. NB  
 43yo white male pt ambul to room # @ 90: diff breathing + coughs + temp. - denies being sick - or having drug use. pt does smoke 1 pk/day. 2 tylenol po for temp 1305 (MMA).  
 PHYSICIAN COMMUNICATION: [blank]

PHYSICIAN COMMUNICATION: [blank]

INSTRUCTIONS TO PATIENT: 1) Bedrest etc 2) Medication 3) Return for any problems to Dr. Veyser

TURN OR SEE DR. [blank]  
 IMMEDIATELY IF WORSENS. OR IF NO BETTER IN [blank] HOURS.  GOOD  SATISFACTORY  SERIOUS  CRITICAL  
 ROOM # [blank]

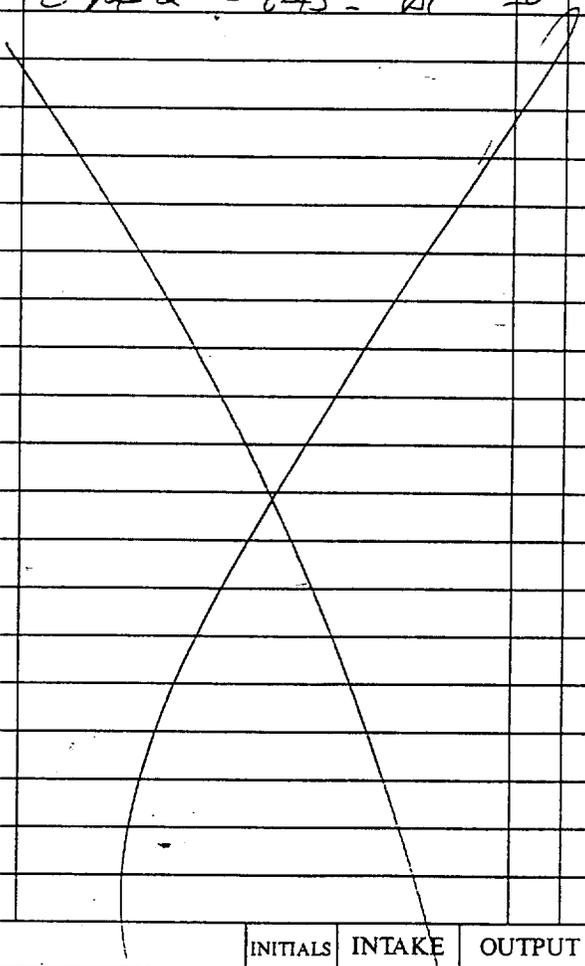


We Know What A Miracle You Are

ER 23798234 01620533-001  
ADAMS, DONALD L 2 043  
DR. D NONE 001723  
1780 WARNER AVE  
MEMPHIS TN 12/25/92

EMERGENCY DEPARTMENT ROOM NUMBER 7

TIME	BP	H	T	P	R	MEDICATION, TREATMENTS EQUIPMENT, & LABORATORY	OBSERVATIONS	I	O
1310							2 Call, wants to hold on Tandy & do CBC / eye. Mr		
						Lab work drawn by LIT no result. Mr.			
1410	109/68	101°	112	24		med c-epo tylenol per order CXR done	Mr. good BS vital. No comp. dry cough & deep breath Mr.		
1420							Dr. Carr in to examine pt. AP		
1430							Discharged ambulatory c-epo 2 1/2 PAS - AP D		



SIGNATURE	INITIALS	SIGNATURE	INITIALS	INTAKE	OUTPUT
<i>[Signature]</i>	MR	Beverly Petrean RN	BP		

**LABORATORY REPORT**

Know What A Miracle You Are

UNIT NUMBER  
 1620533

WARD TIME DATE  
 3EDM 17:30 12/25/92

PAGE  
 1

PATIENT NAME PATIENT NO. ROOM NO. AGE SEX DOCTOR'S NAME  
 ADAMS, DONALD L 1620533 43Y M NONE, DR

DATE	TIME	TEST NAME	ABNORMAL	RESULTS NORMAL	MISC.	UNITS
12/25/92	13:10	ARTERIAL BLOOD GAS				
AN: F80938		ARTERIAL PH		7.35-7.45		PH UNITS
		ARTERIAL PCO2		35-45		MMHG
		ARTERIAL PO2	76	85-95		MMHG
		ART O2 SATURATION		94-98		%
		ART BASE DEFICIT		0-2.5		MMOL/L
		ARTERIAL HCO3	22	23-28		MMOL/L
		AIR				O2
		PUNCTURE SITE				
		TIME PRESSURE HELD				MINUTES
		ALLEN TEST PERFORMED				
12/25/92	13:10	COMPLETE BLOOD CNT & DIF				
AN: F80939		WBC	15.1	5.0-10.0		THOUS/MM3
		RBC		4.60-6.70		MLN/MM3
		HEMOGLOBIN		14.0-18.0		GM/DL
		HEMATOCRIT		42.0-52.0		%
		MCV BLOOD		80.0-100.0		FL
		MCH BLOOD	30.0	27.0-31.0		PG
		MCHC BLOOD		32.0-36.0		%
		PLATELET COUNT		150-400		THOUS/MM3
		RDW		11.5-14.5		%
		MPV	7.0	7.4-10.4		FL
		DIFFERENTIAL				
		SLIDE NO.				
		SEG NEUTROPHIL		50-70		%
		LYMPHOCYTE	14	20-40		%
		BAND NEUTROPHIL	10	0-5		%
		MONOCYTES		1-6		%
		EOSINOPHILS		1-5		%
		CELL MORPHOLOGY				
		WBC DIFFERENTIAL		ESSENTIALLY NORMAL		

*DR*

X-RAY PROFESSIONAL SERVICES BY:  
MEMPHIS RADIOLOGICAL PROFESSIONAL CORP.

DEPARTMENT OF RADIOLOGY

C S N

23798234 01620533 16-72-75 North Radiology

ER ✓

ADAMS, DONALD L.

Age 43 WM

ER PHYSICIAN

12-25-92 CHEST PA AND LATERAL: Heart size is normal.  
Minimal chronic appearing densities are noted in the right  
upper lobe. No active infiltrate is seen.

Roy Kulp M.D./cv ✓  
Printed: 12/26/92 10:38

STATEMENT MEMPHIS RADIOLOGICAL PROFESSIONAL CORPORATION					
FOR: 1211 Union Ave., Suite 350 P.O. Box 42047 Memphis, TN 38174-2047 Tax ID No. 62-0859738					
Tel: (901) 725-1623					
ACCOUNT NUMBER	PATIENT NAME	DESCRIPTION	FACILITY WHERE SERVICES RENDERED	DATE	AMOUNT
12759795	MR. ...	... HEALTH BENEFIT ...	...	12/29/95	...
If you have remitted within the last 10 days, please disregard this statement.					
STATEMENT DATE	DIAGNOSIS CODE	LOCATION	TOTAL CHARGES	AMOUNT PAID	BALANCE DUE
12/29/95	...	...	...	...	...

ACCOUNT NUMBER	AMOUNT DUE
12759795	...
<b>Detach &amp; Return with Payment</b>	
PATIENT NAME	STATEMENT DATE
<b>PHYSICIANS</b> HOLLIS H. HALFORD, JR. WILLIAM E. LONG JOHN M. DOBSON JERRY W. GRISE JON C. JENKINS ROBERT L. COCKROFT ROBERT E. LASTER, JR. EDWARD H. MABRY, JR. JAMES W. BOALS ROY KULP, JR. ALVIN J. WEBER, III DAVIS D. MOSER BRIXY R. SHELTON WILLIAM E. ROUITT, JR. RICHARD G. BATES FRANK D. PARKS ROBERT R. YARBROUGH TOMMY S. FOWLER HOLLIS H. HALFORD, III MARK W. WEATHERLY R. MICHAEL FLEMING JAMES R. MITCHUM M. TERESA BROOKS MICHAEL A. LEMMI DALE E. HANSEN, JR. LINDA K. COX	
<b>RADIOLOGISTS FOR:</b> METHODIST CENTRAL HOSPITAL METHODIST NORTH HOSPITAL METHODIST SOUTH HOSPITAL GERMAN TOWN COMMUNITY HOSPITAL (METHODIST EAST) EASTWOOD HOSPITAL	
<b>REMIT PAYMENT TO:</b> MEMPHIS RADIOLOGICAL, P.C. RESPONSIBLE PARTY INFORMATION	



ER 23748234  
ADAMS, DONALD L  
DR. D NONE  
1780 WARNER AVE  
MEMPHIS TN  
H -3

01620533-001  
2 043  
001723  
12/25/92  
E-354422-8

PATIENT AFTERCARE SHEET

**METHODIST**  
THE METHODIST HOSPITALS OF MEMPHIS

*We Know What A Miracle You Are*

PATIENT AFTERCARE SHEET

The treatment you received in the Emergency Dept. is an emergency treatment only. It is your responsibility to see your physician for follow-up and continuing care. You must make any appointments and necessary arrangements yourself and take this form with you to your doctor.

GENERAL INSTRUCTIONS:

- No weight bearing.
- Elevate affected extremity as much as possible for \_\_\_\_\_ days.
- Ice pack to affected area intermittently for \_\_\_\_\_ days.
- Watch for excessive swelling, numbness, or bluish coloration of fingers or toes.
- You have been referred to Dr. \_\_\_\_\_ for follow-up care. Make an appointment to see your physician in \_\_\_\_\_ days.
- An x-ray was performed and a preliminary interpretation was made. The final report will be made by the Radiologist. If any significant changes are made, you will be notified at the telephone number you listed.
- Rewrap ace bandage if too tight or loose. Rewrap at least once daily.
- The prescription you received contains a substance that may make you drowsy. Do not drive or drink alcohol while taking this medication.
- The prescription you received contains a substance that tends to upset your stomach. Do not take medication on an empty stomach.
- A laboratory test requiring several days for completion was performed. The results will be forwarded to your doctor.
- You may be excused from work or school for \_\_\_\_\_ (not to exceed 24 hours). For time beyond this period, approval must be obtained from your private physician or company physician.
- You may return to work or school today.

INSTRUCTIONS FOR CARE FOR SUTURES:

- (1) Make an appointment to see your doctor on \_\_\_\_\_
- (2) Keep stitches clean & dry.
- (3) Watch for infection. See your doctor if redness, swelling, or drainage develops.
- (4) If you return to ER for suture removal, you must bring this form and come between the hours of 6:00 a.m. and 11:00 a.m.

INSTRUCTIONS FOR CARE FOLLOWING HEAD INJURY:

- (1) Eat lightly for twenty-four hours. No sedatives or alcoholic drinks.
- (2) Awake patient every two (2) hours for the next twelve (12) hours.
- (3) If any of the following symptoms occur, contact your doctor immediately. If you are unable to reach your physician, return to the Emergency Department for assistance.
  - A. Inability to arouse or awaken patient.
  - B. Inability to move arms and legs equally.
  - C. Vomiting, convulsions, mental confusion, restlessness, double vision, blurred vision, drainage of blood or clear liquid from nose or ears.
  - D. Severe headache unrelieved by medication.

2 Prescriptions received

0 Medication received in ER

DISCHARGE IMPRESSION Pneumonitis

OTHER INSTRUCTIONS:

Meds as directed. Bedrest x 24 hrs. Return for any problems. See Dr. Verzosa Monday.

If you are not much improved in \_\_\_\_\_ hours or, if you become worse at any time, contact your physician right away. If unable to reach your physician, return to the emergency department.

I understand these instructions and accept them:

X Donald Leon Adams

INSTRUCTED Car

Dr. B. P. tree

Nurse 12/25/92

Date

12/25/92

**MEDICAL RECORDS**

**PART I GENERAL CONDITIONS OF EMERGENCY MEDICAL TREATMENT - CONSENT TO TREATMENT**

Each patient in the hospital is admitted under the care of his/her attending physician or dentist. Physicians and dentists of the medical staff are not employees of the hospital.

- A. **MEDICAL AND SURGICAL CONSENT:** The undersigned consents to any examination (X-ray or otherwise) including but not limited to laboratory procedures, medications, infusions, transfusions of blood and blood products, anesthesia, surgical procedures or treatments (including the placement of prosthesis within a patient's body), photograph and/or other services rendered the patient by members of the medical staff, their representatives and/or associates, and hospital employees, under the instructions of the physician or dentist. The undersigned also consents to observations of surgical, diagnostic, or other procedures by medical personnel in training or by other appropriate persons permitted by the attending physician or dentist and allowed by hospital or departmental policy.
- B. **TISSUE DISPOSAL:** Should my hospital stay involve the removal of any tissue or parts of my body, including fetus or afterbirth, they may be retained or disposed of by the hospital.
- C. **PERSONAL VALUABLES:** It is understood that the hospital maintains a safe for money and valuables, and that the hospital will not be responsible for loss or damage to any money or property of the patient or others unless delivered to or deposited with the hospital for safekeeping and a written safekeeping receipt issued by the hospital therefor.
- D. **MEDICAL INFORMATION RECEIVED:** The patient, if in a condition to receive it, and if not, the undersigned representative of the patient, acknowledges that he/she has been informed concerning the need for hospital services, the purpose of the patient entering the hospital, and the planned examinations, procedures, and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained.

**PART II. RELEASE OF INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL AGREEMENT**

A. **RELEASE OF INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS:** The hospital, my physician or physicians, or Memphis Radiologists, P.C. may disclose all or any part of the record of the patient to any person or organization which is or may be liable for or responsible for payment of all or part of the hospital's charges, including, but not limited to, insurance companies, medical or hospital service companies, workmen's compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on behalf of the patient directly to the said physicians, radiologists, and hospitals and any of their appropriate agents or divisions.

B. **FINANCIAL AGREEMENT:** The undersigned SEVERALLY agree, whether signing as a patient or otherwise, that in consideration of the services rendered to patient, payment of the account is guaranteed by the undersigned in accordance with the regular rates and terms of the hospital, being payable to the hospital in Memphis, Tennessee. While any insurance or other protection related to the hospital account may be hereby assigned to and payable directly to the hospital, the undersigned clearly understands that the obligation to pay the hospital bill is primarily on the patient and the undersigned, and while insurance received by the hospital will be applied to the patient's account, any part of the account not so paid by insurance is nevertheless owing and payable. In case of default of payment, and if this account should be placed in the hands of a Collector or an Attorney for collection, all collection fees, attorney fees, (which shall equal one-third of any balance due), cost and other expenses will be paid by the undersigned. Notice of dishonor, demand and protest is waived. I further agree that due to the high cost of billing and refunding small amounts, the hospital will not bill or refund underpayments or overpayments of less than two dollars (\$2.00) on final balances, except on a request of the responsible party.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ THE FOREGOING, HAS RECEIVED A COPY HEREOF, IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT, AND THE FOREGOING CONDITIONS OF ADMISSION ARE ACCEPTED.

If patient is unable to execute above form (because of some disability, such as being a minor, non compos mentis, unconscious, or other disability which inhibits or precludes that patient's ability to legally sign) explain the patient's disability (tell chief complaint and diagnosis):

Patient's Signature (or Representative) for Consent to Treatment and Release of Information: Donald Leon Adams DATE 12-25-92 TIME \_\_\_\_\_

Responsible Policyholder(s)'s Signature for Insurance Assignment: (1) Donald Leon Adams DATE \_\_\_\_\_ TIME \_\_\_\_\_

(2) Donald Leon Adams DATE \_\_\_\_\_ TIME \_\_\_\_\_

All Financially Responsible Individuals: (2) Shirley Nelson DATE 12/25/92 TIME \_\_\_\_\_

I have read and/or explained the above information and all parts of this form outlining all stated conditions to the patient or the patient's responsible representative and the patient/-responsible party appears to fully understand these conditions as stated.

SIGNATURE OF ADMISSION PERSONNEL OR AUTHORIZED HOSPITAL REPRESENTATIVE

CAT.	UNIT NUMBER	ADM/SERVICE DATE	T/A PERF RECD	PHYSICIAN NAME AND NUMBER		ADMIT/REG TIME	ACCOUNT NUMBER				
ER	1620533-001	12/25/92	P	1723 NONE DR		2:47	23798234				
PATIENT NAME			NICKNAME	MC/SSN #	DATE OF BIRTH	AGE	MS	RS	GEO CODE	CL INI	
ADAMS DONALD L			L	410-86-1396	12/05/1949	48	M	UM	1	S	
RELIGION			CHURCH			HOME PHONE					
0 OTHER			NO PREF			901-353-3332					
PATIENT ADDRESS - LINE 1				PATIENT ADDRESS - LINE 2							
1780 WARNER AVE				MEMPHIS TN 381271335							
EMPLOYER			EMPLOYER'S ADDRESS			LENGTH SERVICE					
US POSTAL SERVICE			UNK MEMPHIS TN 00000			00					
OCCUPATION			EMPLOYER'S PHONE	PREV. ADM. DATE	PREVIOUS ADMISSION NAME						
LETTER CARRIER			999-999-9999	00/00/00	23798234						
PERSON TO NOTIFY IN EMERGENCY/NEAREST RELATIVE			PHONE NUMBER	RELATIONSHIP	ADDRESS						
ADAMS DORACE			901-357-4619	FATHER	00000						
COMMENTS:			PATIENT IN ANY HOSPITAL LAST 60 DAYS (WHERE)								
RESPONSIBLE PARTY			MC/SSN #	RELATIONSHIP	RP UNIT #	OWN/RENT	PHONE NUMBER				
ADAMS DONALD L			410-86-1396	SELF	1620533		901-353-3332				
ADDRESS - LINE 1			YEARS	ADDRESS - LINE 2	RP ACCT. NUMBER	PHONE NUMBER (BUSI)					
1780 WARNER AVE				MEMPHIS TN 38127	E-354422-8	999-999-99					
OCCUPATION:			EMPLOYER'S NAME			LENG SER					
LETTER CARRIER			UNK								
US POSTAL SERVICE			MEMPHIS TN 00000								
NATL ASSOC OF LETTER CARR			NATL ASSOC OF LETTER CAR			ADAMS DONALD					
INSURANCE CARRIER			GROUP POLICYHOLDER	SUBSCRIBER	CITY		STATE		ZIP		
EFFECTIVE DATE			POLICY NUMBER		410-86-1396		0000		8525		
00/00/00			410-86-1396	P.O. BOX 9668	SCOTTSDALE AZ						
INSURANCE CARRIER			GROUP POLICYHOLDER	SUBSCRIBER	CITY		STATE		ZIP		
EFFECTIVE DATE			POLICY NUMBER	ADDRESS/STREET							
00/00/00											

PLEASE DO NOT STAPLE IN THIS AREA

SEND TO PATIENT\*\*\*\*\* 0500  
 PLEASE FORWARD THIS CLAIM TO YOUR INDIVIDUAL INSURANCE CARRIER\*\*\*THANK YOU\*

93011100N0667  
 attachment 4

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA ACTP# 0040781 ARC534 P CO 02 HEALTH INSURANCE CLAIM FORM 5078A

1. MEDICARE  MEDICAID  CHAMPUS  CHAMPVA  GROUP HEALTH PLAN (SSN or ID)  FECA BLK LUNG (SSN)  OTHER  (X/D)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) **410861396**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **ADAMS DONALD L**

3. PATIENT'S BIRTH DATE MM DD YY **12 05 49** SEX  M  F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) **ADAMS DONALD**

5. PATIENT'S ADDRESS (No., Street) **1780 WARNER DR**

6. PATIENT RELATIONSHIP TO INSURED Self  Spouse  Child  Other

7. INSURED'S ADDRESS (No., Street) **1780 WARNER DR**

CITY **MEMPHIS** STATE **TN**

8. PATIENT STATUS Single  Married  Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO: Employed  Full-Time Student  Part-Time Student

11. INSURED'S POLICY GROUP OR FECA NUMBER **322**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE ON FILE **12/28/92** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) **12 25 92**

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE **Methodist North Dr. Carr Room Emergency**

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?  YES  NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **466 0**

2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

A	B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From MM DD YY To MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
12 28 92	3	1	99203	1	92 00	1				
12 28 92	3	4	71020	1	58 00	1				
12 28 92	3	5	36415	1	5 00	1				
12 28 92	A	5	80019	1	32 00	1				
12 28 92	3	5	85024	1	25 00	1				

24. FEDERAL TAX I.D. NUMBER **621468260** SSN EIN   X

25. PATIENT'S ACCOUNT NO. **01843119C**

26. ACCEPT ASSIGNMENT? (For govt. claims, see back)  YES  NO **L.A.**

27. TOTAL CHARGE \$ **212 00**

28. AMOUNT PAID \$ **212 00**

29. BALANCE DUE \$ **0 212 00**

30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) **SAMUEL T. VERZOSA, M.D. 00000**

31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) **Paid receipt enclosed**

32. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # **BARTLETT-RALEIGH INTERNAL MED 5134 STAGE RD SUITE 300 MEMPHIS, TN 38134**

33. PIN# \_\_\_\_\_ GRP# \_\_\_\_\_



2577-12/93  
HERE C ADAMS

9301110010667  
attachment 4

5782042

HC/VISA 285858  
BARTLETT / RALEIGH  
INTERNAL MEDICINE PC  
MPHS TN

PURCHASER SIGN HERE  
*Shere C. Adams*  
Cardholder acknowledges receipt of goods and/or services in the amount of the Total shown hereon and agrees to perform the obligations set forth in the Cardholder's agreement with the Issuer.

QUAN.	CLASS	DESCRIPTION	PRICE	AMOUNT
		Donald Adams # 4078		212.00
		Carey Adams #4064		187.00
DATE: 12/28/92 AUTHORIZATION: 038784			SUB TOTAL	
REFERENCE NO: 0060			TAX	
SALES SLIP			TOTAL: 399.00	

CUSTOMER COPY

IMPORTANT: RETAIN THIS COPY FOR YOUR RECORDS

**Receipt** Date 12/28 1992 No. 478880

RECEIVED FROM R Adams \$399.00

special charges DOLLARS

FOR RENT  FOR

FROM Credit card TO STV

ACCOUNT	# <u>4078</u>	<input type="checkbox"/> cash
PAYMENT	# <u>4064</u>	<input checked="" type="checkbox"/> check
BALANCE DUE	# <u>4064</u>	<input type="checkbox"/> money order

BY Cmassey

DC 1182

4078  
4064

Copy of receipt from  
Bartlett-Raleigh Internal Med  
Samuel T. Verzara, M.D.  
901 371-0200

Their Health Insurance Claim Form shows that they  
accept Assignment.  
We paid their bills, and we request  
reimbursement to us.  
*Shere Adams*

# NALC Health Benefit Plan

20547 Waverly Court, Ashburn, Virginia 22093  
(703) 729-4677

## AIM FORM FOR UNASSIGNED BILLS

(Benefits will be paid to member)

### STATEMENT OF MEMBER

Complete in full and use separate form for each patient and each calendar year

CHECK BOX IF CHANGE OF ADDRESS

1. MEMBER INFORMATION	2. PATIENT INFORMATION
SOCIAL SECURITY NUMBER 410-86-1396	
EMPLOYMENT STATUS: ACTIVE <input checked="" type="checkbox"/> ANNUITANT <input type="checkbox"/> SURVIVOR ANNUITANT <input type="checkbox"/>	PATIENT CODE <b>A</b>
NAME <u>Donald L. Adams</u>	NAME <u>Donald L. Adams</u>
ADDRESS <u>1780 Warner Dr</u>	DATE OF BIRTH <u>12-05-49</u>
CITY <u>Memphis</u> STATE <u>TN</u> ZIP <u>38127</u>	RELATIONSHIP TO MEMBER <u>Self</u>
TELEPHONE (DAYTIME) <u>901 353-3332</u>	MARITAL STATUS MARRIED <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/>

Are charges related to or covered by: YES NO If yes, give:

3. Workers' Compensation   Date of accident, diagnosis and compensation claim # 1/1

4. Accidental Injury   Date, place and diagnosis 12/25/92 Exposure to Wilson's Leather Protector, Had difficulty breathing 102° chills, cough  
 Is claim covered by no-fault auto insurance? YES  NO  Third party liability (subrogation)? YES  NO   
 If yes, insurance company's name and address Wilson's Claim Management, 400 S. Hwy 169, Minneapolis, Mn. 55428 spoke w/ Nancy Gjer 612 541-3566 Collect

5. Medicare   Medicare Identification Number \_\_\_\_\_  
 Effective date: Part A \_\_\_\_\_ Part B \_\_\_\_\_

6. Other group medical / dental coverage   If yes, is insurance issued through active employment? YES  NO   
 Is this an HMO policy? YES  NO   
 Name of person to whom issued \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Name of organization or employer through which obtained \_\_\_\_\_  
 HOSPITAL OR MEDICAL INSURANCE: Name and address of other insurance company \_\_\_\_\_  
 Effective date \_\_\_\_\_ Cancellation date \_\_\_\_\_  
 Policy # \_\_\_\_\_ Self Only  Family   
 Name and address of other insurance company \_\_\_\_\_  
 DENTAL INSURANCE: \_\_\_\_\_  
 Effective date \_\_\_\_\_ Cancellation date \_\_\_\_\_  
 Policy # \_\_\_\_\_ Self Only  Family

I authorize any holder of medical or other related information to release to NALC Health Benefit Plan any information in regard to myself or my family necessary for processing this or any related claim.

Donald L. Adams 1-18-93 Donald L. Adams 1-18-93  
Member's signature Date Patient's signature (parent, if minor) Date

I certify that the above information is correct, that the enclosed expenses were incurred for the named patient, and that I am a member in good standing of NALC.

Donald L. Adams 1-18-93  
Member's signature Date

**WARNING:** Any intentional false statement or willful misrepresentation relative to this claim is a violation of the law punishable by a fine, imprisonment or both. (18 U.S.C. Section 1341 and Title 5 U.S.C.)

CONTROL NUMBER	SHEET	REF. NUMBER
----------------	-------	-------------

# CLAIM FORM FOR UNASSIGNED BILLS

**NOTE:** When filing claims for doctor, laboratory, x-ray, durable medical equipment, etc. expenses, attach fully itemized bills. Be sure the diagnosis, date and description of service, patient's name and charge for each service is indicated on all bills. Enter total at bottom.  
The Plan will accept any claim form which provides the same information.  
If another insurance company is primary on this claim, their explanation of payment form must be included for each bill submitted.

**PRESCRIPTION DRUGS AND MEDICINES** Use ONLY for prescription drugs and medicines. List each prescription on a separate line and complete each column. ATTACH DRUG BILLS SHOWING INFORMATION LISTED BELOW.

DATE OF PURCHASE	RX NUMBER	NAME OF DRUG	PRESCRIBING PHYSICIAN	DIAGNOSIS (ILLNESS TREATED)	CHARGES
12-25-92	Methodist Hosp North ER		Carr	Pneumonitis 13567	\$ 46 00
				Hemogram	51 00
				Blood Gas	80 00
				Uenipuncture	4 50
				Uenipuncture	4 50
				Chest PA & Lateral	65 50
12-25-92	Memphis Radiological		Carr	786.01	31 00
12-28-92			S.T. Verzasa	O.U. 99203	92 00
				chest X-ray 71020	58 00
				Uenipuncture 36415	5 00
				SMAC 80019	32 00
				CBC 85024	25 00
12-25-92	C523135	Erythromycin	Carr	Pneumonitis 13567	8 39
12-25-92	C523136	Notuss Liquid	Carr	" "	12 09

**Walgreens The Pharmacy America Trusts**  
2924 COVINGTON PIKE PH. 382-9237  
MEMPHIS TN

**PATIENT** DONALD L ADAMS  
1780 WARNER  
N MEMPHIS TN 383-3332

**RX NO.** C523135 **DR.** CARR  
**MEDICATION** ERYTHROMYCIN 250MG TABS  
ABBOTT-ROBBS\*00074-6343-53

**QTY** 40 **REFILL** CALLRPH **TMO/** HRR  
**DATE** 12/25/92 \$ 8.39 EUA

**Walgreens The Pharmacy America Trusts**  
2924 COVINGTON PIKE PH. 382-9237  
MEMPHIS TN

**PATIENT** DONALD L ADAMS  
1780 WARNER  
N MEMPHIS TN 383-3332

**RX NO.** C523136 **DR.** CARR  
**MEDICATION** NOTUSS LIQUID  
S-U 43985-0621-14

**QTY** 150 **REFILL** CALLRPH **TMO/** DUR  
**DATE** 12/25/92 \$ 12.09 ERHA

TOTAL DRUGS \$ 20 48  
TOTAL ALL OTHER CHARGES \$ 494 50  
TOTAL \$ 514 98



PATIENT NAME: ER23798245  
 AGE: 17 RS MS  
 UNIT NUMBER: 471187-002  
 REFERRING PHYSICIAN: NO REFER. DR.  
 ACCOUNT NUMBER: E-30442  
 PERSONAL PHYSICIAN: DONALD  
 EMER. RM. CHG. 40  
 M & S SUPPLIES  
 PHYSICIAN FEE  
 DATE: TIME: LOCATION:  
 POLICE NOTIFIED TIME: AM FAMILY NOTIFIED PM  
 OTHER CHARGES: AMOUNT PAID:

ADMITTING PHYSICIAN (INITIAL LAST):  
 BROUGHT BY: PRIVATE VEHICLE  
 AMB. NO.:  
 PATIENT PHONE:  
 DATE IN: 12-25-92  
 DATE OUT: 12-25-92  
 INS. 1: EG  
 INS. 2: P  
 INS. 3:

CHIEF COMPLAINT: DIFF BREATHING/INHALED CHEMICAL  
 HISTORY & PHYSICAL:  
 1730 presents: cough, difficulty breathing  
 He has been in an enclosed space where  
 leather shoes have been used. Has fallen & is  
 an asthmatic & allergic to...  
 12/25/92  
 Meds: 102  
 Neds: 102  
 High? - cough & heavy - cough & deep breath  
 CxR - infiltrated

VITAL SIGNS			
TIME	B/P	T	P
1300	120/70	102	2/110

LABORATORY TESTS:  
 CBC: WBC 18.6  
 HGB:  
 DIFF:  
 NA:  
 CL:  
 BUN:  
 UA:  
 490

PHYSICIAN IMPRESSION:  
 Bronchitis - early pneumonia? Chem  
 CxR, CBC/BP

DATE OF LAST TETANUS: NA  
 CURRENT MEDICATIONS:  
 See pg 2  
 N/A

NOTES:  
 See pg 2 N/A - 2 Parker R

ARM BAND ON:   
 SIDERAILS UP:   
 PAGED AT: HOME OFFICE EXCHANGE

DISCHARGE INSTRUCTIONS:  
 1) Follow up with Dr. [Name] @ Methodist  
 2) Meds as directed  
 3) Return if you get worse  
 SEE DR. [Name] IMMEDIATELY IF WORSENS, OR IF NO BETTER IN \_\_\_\_\_ HOURS.  
 CONDITION ON DISCHARGE / TRANSFER:  GOOD  SATISFACTORY  SERIOUS  CRITICAL

ER 23798245 00471187-002  
 ADAMS, DONALD C 2 017  
 DR. ST VERZOSA 001942  
 1780 WARNER AVE  
 MEMPHIS TN 12/25/92



We Know What A Miracle You Are

EMERGENCY DEPARTMENT ROOM NUMBER 5

TIME	BP	T	P	R	MEDICATIONS, TREATMENTS, EQUIPMENT, & LABORATORY	OBSERVATIONS	I	O
1300	130/10	102	116	24	Allergies - <del>ph</del> meds - Eskalith CR 450 bid Pmt Smokes - 1ppd	17 y w/m amb to ER ± difficulty breathing dizziness, cough, general malaise ± being? exposed to leather protectant. Pt states was smoking in @ small room where @ leather coat had just been treated ± protectant. On arrival pt ± chills, on attempt to take deep inspiration coughs. Bilateral air exchange essentially normal (2P)		
1315					Labwork drawn per LLT			
1340						To ER from Xray ambulatory RP		
1355						Pt. moved to ER #5 so he can lie down. RP		
1415		102			Tylenol ii po.			
1435						Discharged amb ± parents. Mother given PAS, Rx ± verbalized understanding of instructions by mother		

SIGNATURE	INITIALS	SIGNATURE	INITIALS	INTAKE	OUTPUT
Leann Parker RN	LP	Beverly Petrus RN	BP		

**LABORATORY REPORT**

Know What A Miracle You Are

UNIT NUMBER  
**471187**

WARD TIME DATE  
**3EDN 17:30 12/25/92**

PAGE  
**1**

PATIENT NAME PATIENT NO. ROOM NO. AGE SEX DOCTOR'S NAME

**ADAMS, DONALD C 471187 3EDN 17:30 12/25/92**

DATE	TIME	TEST NAME	ABNORMAL	RESULTS NORMAL	MISC	UNITS
12/25/92	13:45	ARTERIAL BLOOD GAS				
		ARTERIAL PH		7.41		PH UNITS
		ARTERIAL PCO2		35		MMHG
		ARTERIAL PO2	82	85-95		MMHG
		ART. O2 SATURATION		96.0		%
		AET BASE DEFICIT		1.7		MMOL/L
		ARTERIAL pH	22	7.35-7.45		UNITS
		AIP		PM AVE		
		RIGHT RADIAL				
		COMPLETE BLOOD CNT - DU	18.6			
		RBC		5.10		MM3
		HEMATOCRIT		15.0		%
		HEMATOCRIT		45.0		%
		MCH BLOOD		29.6		PG
		MCH BLOOD		30.7		PG
		MCHC BLOOD		35.4		GM/DL
		PLAQUET COUNT		347		MM3
		EDW		10.0		MM3
		MPV		0.0		FML
		DIFFERENTIAL				
		SLIDE NO.		30		
		SEG NEUTROPHIL	80			%
		LYMPHYTE	4			%
		BAND NEUTROPHIL	10			%
		MONOCYTES				%
		RBC MORPHOLOGY				
		FEW DISPLASIA BASOPHILIC RBC				
		FEW MICROCYTES				

9K

PATIENT NAME PATIENT NO. ROOM NO. AGE SEX DOCTOR'S NAME

X-RAY PROFESSIONAL SERVICES BY:  
MEMPHIS RADIOLOGICAL PROFESSIONAL CORP

MENT OF RADIOLOGY

C S N

23798245 00471187 16-72-74 North Radiology ER ✓

ADAMS, DONALD C. Age 17 WM

Sam T. Verzosa M.D.

12-25-92 CHEST, TWO VIEWS: Heart size is normal. There are prominent interstitial markings noted throughout both lung fields present, and the possibility of an interstitial pneumonitis cannot be excluded from this examination. No discrete focal infiltrate is seen.

Roy Kulp M.D./cv  
Printed: 12/26/92 09:46

cc: Sam T. Verzosa M.D.  
FAX # 3719317

STATEMENT					MEMPHIS RADIOLOGICAL PROFESSIONAL CORPORATION	
FOR: 1211 Union Ave., Suite 350 P.O. Box 42047 Memphis, TN 38174-2047 Tax ID No. 62-0689738						
ACCOUNT NUMBER	PATIENT NAME		FACILITY WHERE SERVICES RENDERED			
2379245	DONALD L ADAMS		MEMPHIS HPTN			
DATE	DESCRIPTION		AMOUNT			
12/28/92 12/29/92	Chest - Top & Lateral COPPERHEAD JHS FILED/HALO HEAD 7H BENEFIT P PLEASE LOCATE YOUR ACCOUNT NUMBER ON THE UPPER LEFT CORNER OF THE STATEMENT BEFORE CALLING.		31.00			
STATEMENT DATE	DIAGNOSIS CODE	LOCATION	TOTAL CHARGES	AMOUNT PAID	BALANCE DUE	
01/14/93	506.01	2P	31.00	0.00	31.00	

If you have remitted within the last 10 days, please disregard this statement.

ACCOUNT NUMBER	AMOUNT DUE
2379245	31.00
<input checked="" type="checkbox"/> <b>Detach &amp; Return with Payment</b>	
PATIENT NAME	STATEMENT DATE
DONALD L ADAMS	01/14/93

PHYSICIANS	
HOLLIS H. HALFORD, JR.	WILLIAM E. ROUNTT, JR.
WILLIAM E. LONG	RICHARD G. BATES
JOHN M. DOBSON	FRANK D. PARKS
JERRY W. GRISE	ROBERT R. YARBROUGH
JON C. JENKINS	TOMMY S. FOWLER
ROBERT L. COCKROFT	HOLLIS H. HALFORD, III
ROBERT E. LASTER, JR.	MARK W. WEATHERLY
EDWARD H. MABRY, JR.	R. MICHAEL FLEMING
JAMES W. BOALS	JAMES R. MITCHELL
ROY KULP, JR.	M. TERESA BROOKS
ALVIN J. WEBER, III	MICHAEL A. LEMMI
DAVIS D. MOSER	DALE E. HANSEN, JR.
BRIXY R. SHELTON	LINDA K. COX

RADIOLOGISTS FOR:	
METHODIST CENTRAL HOSPITAL	GERMANTOWN COMMUNITY HOSPITAL
METHODIST NORTH HOSPITAL	(METHODIST EAST)
METHODIST SOUTH HOSPITAL	EASTWOOD HOSPITAL

REMIT PAYMENT TO:	
MEMPHIS RADIOLOGICAL, P.C.	
RESPONSIBLE PARTY INFORMATION	
2379245	DONALD L ADAMS (P)
1780	MEMPHIS HPTN
MEMPHIS TN 38104-1338	

PATIENT AFTERCARE SHEET

**METHODIST**

*We Know What A Miracle You Are*

PATIENT AFTERCARE SHEET

The treatment you received in the Emergency Dept. is an emergency treatment only. It is your responsibility to see your physician for follow-up and continuing care. You must make any appointments and necessary arrangements yourself and take this form with you to your doctor.

ER 23798245  
ADAMS, DONALD C  
DR. ST VERZOSA  
1780 WARNER AVE  
MEMPHIS  
GENERAL INSTRUCTIONS

00471187-002  
2 017  
001942  
12/25/92  
E-354423-A

- \_\_\_\_\_ No weight bearing.
- \_\_\_\_\_ Elevate affected extremity as much as possible for \_\_\_\_\_ days.
- \_\_\_\_\_ Ice pack to affected area intermittently for \_\_\_\_\_ days.
- \_\_\_\_\_ Watch for excessive swelling, numbness, or bluish coloration of fingers or toes.
- \_\_\_\_\_ You have been referred to Dr. \_\_\_\_\_ for follow-up care. Make an appointment to see your physician in \_\_\_\_\_ days.
- \_\_\_\_\_ An x-ray was performed and a preliminary interpretation was made. The final report will be made by the Radiologist. If any significant changes are made, you will be notified at the telephone number you listed.
- \_\_\_\_\_ Rewrap ace bandage if too tight or loose. Rewrap at least once daily.
- \_\_\_\_\_ The prescription you received contains a substance that may make you drowsy. Do not drive or drink alcohol while taking this medication.
- \_\_\_\_\_ The prescription you received contains a substance that tends to upset your stomach. Do not take medication on an empty stomach.
- \_\_\_\_\_ A laboratory test requiring several days for completion was performed. The results will be forwarded to your doctor.
- \_\_\_\_\_ You may be excused from work or school for \_\_\_\_\_ (not to exceed 24 hours). For time beyond this period, approval must be obtained from your private physician or company physician.
- \_\_\_\_\_ You may return to work or school today.

INSTRUCTIONS FOR CARE FOR SUTURES:

- \_\_\_\_\_ (1) Make an appointment to see your doctor on \_\_\_\_\_.
- \_\_\_\_\_ (2) Keep stitches clean & dry.
- \_\_\_\_\_ (3) Watch for infection. See your doctor if redness, swelling, or drainage develops.
- \_\_\_\_\_ (4) If you return to ER for suture removal, you must bring this form and come between the hours of 6:00 a.m. and 11:00 a.m.

INSTRUCTIONS FOR CARE FOLLOWING HEAD INJURY:

- \_\_\_\_\_ (1) Eat lightly for twenty-four hours. No sedatives or alcoholic drinks.
- \_\_\_\_\_ (2) Awake patient every two (2) hours for the next twelve (12) hours.
- \_\_\_\_\_ (3) If any of the following symptoms occur, contact your doctor immediately. If you are unable to reach your physician, return to the Emergency Department for assistance.
  - A. Inability to arouse or awaken patient.
  - B. Inability to move arms and legs equally.
  - C. Vomiting, convulsions, mental confusion, restlessness, double vision, blurred vision, drainage of blood or clear liquid from nose or ears.
  - D. Severe headache unrelieved by medication.

② Prescriptions received

\_\_\_\_\_ Medication received in ER

DISCHARGE IMPRESSION Bronchitis /

OTHER INSTRUCTIONS: Tylenol q 4° for temp / mcds as directed  
Return if you get worse / Follow-up with Dr.  
Verzosa Monday am

\_\_\_\_\_ If you are not much improved in \_\_\_\_\_ hours or, if you become worse at any time, contact your physician right away. If unable to reach your physician, return to the emergency department.

I understand these instructions and accept them: X Donald Adams

PLEASE DO NOT STAPLE IN THIS AREA

930111CCN0667  
attachment 4

SEND TO PATIENT\*\*\*\*\*  
PLEASE FORWARD THIS CLAIM TO  
YOUR INDIVIDUAL INSURANCE  
CARRIER\*\*\*THANK YOU\*

0500

CARRIER

PICA ACP# 0040641 ARC534 P CO 02 HEALTH INSURANCE CLAIM FORM 5064A

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/>		GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>	FECA BLK LUNG (SSN) <input type="checkbox"/>	OTHER <input checked="" type="checkbox"/>	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>410861396</b>
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>ADAMS DONALD Co</b>			3. PATIENT'S BIRTH DATE (MM DD YY) SEX <b>12 8 14 75 M</b> <input checked="" type="checkbox"/> <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>ADAMS DONALD L</b>
5. PATIENT'S ADDRESS (No., Street) <b>1780 WARNER DR</b>			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> <input checked="" type="checkbox"/> spouse <input type="checkbox"/> Child <input checked="" type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) <b>1780 WARNER DR</b>
CITY <b>MEMPHIS</b>		STATE <b>TN</b>	8. PATIENT STATUS Single <input type="checkbox"/> <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY <b>MEMPHIS</b>
ZIP CODE <b>38127</b>	TELEPHONE (Include Area Code) <b>(901) 353-3332</b>		Employed <input type="checkbox"/> Full-Time Student <input checked="" type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE <b>38127</b>
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER <b>322</b>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX <b>12 05 49 M</b> <input checked="" type="checkbox"/> <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>Wilson Spray</i>		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>SEND TO PATIENT*****NALC*****</b>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes return to and complete item 9 a-d.</i>	

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  
**SIGNATURE ON FILE**

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  
**SIGNATURE ON FILE**

SIGNED \_\_\_\_\_

14. DATE OF CURRENT: (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) <b>12 25 92</b>	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY <b>12-26-92</b>
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE <b>Methodist Hosp North Emergency Room</b>	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? S CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **466 0**

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

A		B	C	D		E	F		G	H	I	J	K
DATE(S) OF SERVICE From To		Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE	S CHARGES	DAYS OR UNITS	EPST/ Family Plan	EMG	COB	RESERVED FOR LOCAL USE	
12	28	92	3	1	99203	1	92 00	1					
12	28	92	3	4	71020	1	58 00	1					
12	28	92	3	5	36415	1	5 00	1					
12	28	92	A	5	80019	1	32 00	1					

5. FEDERAL TAX I.D. NUMBER <b>621468260</b>	SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. <b>01842517C</b>	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE <b>\$ 187 00</b>	29. AMOUNT PAID <b>\$ 187 00</b>	30. BALANCE DUE <b>\$ 0 00</b>
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>SAMUEL T. VERZOSA, M.D.</b>		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) <b>Methodist Hosp North Emergency Room</b>		33. PHYSICIAN'S, SUPPLIER'S, OR FACILITY'S ADDRESS, ZIP CODE & PHONE # <b>901 371-3020 BARTLETT-RALEIGH INTERNAL MED 5134 STAGE RD SUITE 300 MEMPHIS, TN 38134</b>		
SIGNED <b>1/11/93</b> DATE		PIN# _____ GRP# _____				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

# NALC Health Benefit Plan

20547 Waverly Court, Ashburn, Virginia 22093  
(703) 729-4677

## CLAIM FORM FOR UNASSIGNED BILLS

(Benefits will be paid to member)

### STATEMENT OF MEMBER

Complete in full and use separate form for each patient and each calendar year

CHECK BOX IF CHANGE OF ADDRESS

<p><b>1. MEMBER INFORMATION</b></p> <p>SOCIAL SECURITY NUMBER  <div style="border: 1px solid black; padding: 2px; display: inline-block;">4</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">1</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">0</div> <span style="font-size: 20px; margin: 0 5px;">-</span> <div style="border: 1px solid black; padding: 2px; display: inline-block;">8</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">6</div> <span style="font-size: 20px; margin: 0 5px;">-</span> <div style="border: 1px solid black; padding: 2px; display: inline-block;">1</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">3</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">9</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">6</div> </p> <p>EMPLOYMENT STATUS: ACTIVE <input checked="" type="checkbox"/> ANNUITANT <input type="checkbox"/> SURVIVOR ANNUITANT <input type="checkbox"/></p> <p>NAME <u>Donald L. Adams</u></p> <p>ADDRESS <u>1780 Warner Dr.</u></p> <p>CITY <u>Memphis</u> STATE <u>TN</u> ZIP <u>38127</u></p> <p>TELEPHONE (DAYTIME) <u>901 353-3332</u></p>	<p><b>2. PATIENT INFORMATION</b></p> <p>PATIENT CODE <span style="border: 1px solid black; padding: 2px; display: inline-block;">C</span></p> <p>NAME <u>Donald Carey Adams</u></p> <p>DATE OF BIRTH <u>08-14-75</u></p> <p>RELATIONSHIP TO MEMBER <u>Son</u></p> <p>MARITAL STATUS: MARRIED <input type="checkbox"/> SINGLE <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>
--	--

Are charges related to or covered by: YES NO If yes, give:

3. Workers' Compensation   Date of accident, diagnosis and compensation claim # 1/1/

4. Accidental Injury   Date, place and diagnosis 12/25/92 Exposure to Wilson's Leather Protector. Had difficulty breathing 102° fever, chills, coughing.  
 Is claim covered by no-fault auto insurance? YES  NO  Third party liability (subrogation)? YES  NO   
 If yes, insurance company's name and address Wilson's Claim Management  
400 S. Hwy 169, Minneapolis, MN 55428 / Spoke with Nancy Gjjerde  
612 541-3561  
Collected

5. Medicare   Medicare Identification Number \_\_\_\_\_  
 Effective date: Part A \_\_\_\_/\_\_\_\_/\_\_\_\_ Part B \_\_\_\_/\_\_\_\_/\_\_\_\_

6. Other group medical / dental coverage   If yes, is insurance issued through active employment? YES  NO   
 Is this an HMO policy? YES  NO   
 Name of person to whom issued \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Name of organization or employer through which obtained \_\_\_\_\_  
 HOSPITAL OR MEDICAL INSURANCE: Name and address of other insurance company \_\_\_\_\_  
 Effective date \_\_\_\_/\_\_\_\_/\_\_\_\_ Cancellation date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Policy # \_\_\_\_\_ Self Only  Family   
 Name and address of other insurance company \_\_\_\_\_  
 DENTAL INSURANCE: Name and address of other insurance company \_\_\_\_\_  
 Effective date \_\_\_\_/\_\_\_\_/\_\_\_\_ Cancellation date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Policy # \_\_\_\_\_ Self Only  Family

I authorize any holder of medical or other related information to release to NALC Health Benefit Plan any information in regard to myself or my family necessary for processing this or any related claim.

Donald L. Adams 1-18-93 Donald C. Adams 1-18-93  
 Member's signature Date Patient's signature (parent, if minor) Date

I certify that the above information is correct, that the enclosed expenses were incurred for the named patient, and that I am a member in good standing of NALC.

Donald L. Adams 1-18-93  
 Member's signature Date

**WARNING:** Any intentional false statement or willful misrepresentation relative to this claim is a violation of the law punishable by a fine, imprisonment or both. (18 U.S.C. Section 1341 and Title 5 U.S.C.)

CONTROL NUMBER	DATE	REF. NUMBER

# CLAIM FORM FOR UNASSIGNED BILLS

930111CCN0667  
attachment 4

**NOTE:** When filing claims for doctor, laboratory, x-ray, durable medical equipment, etc. expenses, attach fully itemized bills. Be sure the diagnosis, date and description of service, patient's name and charge for each service is indicated on all bills. Enter total at bottom.

The Plan will accept any claim form which provides the same information.

If another insurance company is primary on this claim, their explanation of payment form must be included for each bill submitted.

## PRESCRIPTION DRUGS AND MEDICINES

Use ONLY for prescription drugs and medicines. List each prescription on a separate line and complete each column. ATTACH DRUG BILLS SHOWING INFORMATION LISTED BELOW.

DATE OF PURCHASE	RX NUMBER	NAME OF DRUG	PRESCRIBING PHYSICIAN	DIAGNOSIS (ILLNESS TREATED)	CHARGES
12-25-92		Methodist North Hosp. E.R.	Carr	13567 Bronchitis/early pneumonia	\$ 46.00
S				Hemogram 682	51.00
				Blood Gas/Art 783	80.00
				Venipuncture 27883	4.50
				Venipuncture 27883	4.50
				Chest PA-lateral 89	65.50
		Mchs Radiological Prog Corp		786.01	31.00
12-28-92			Samuel T Verzosa	99203 office visit	92.00
}				71020 chest x-ray	58.00
				36415 venipuncture	5.00
				80019 SMAC	32.00
12-25-92	C523133	Erythromycin	Carr	Bronchitis/early pneumonia	8.39
12-25-92	C523134	Notuss liquid	Carr	" " " "	12.09

Assessment assessed  
Paid by

**Walgreens The Pharmacy America Trusts**  
 2926 COVINGTON PIK. PH. 382-9237  
 MEMPHIS TN

**PATIENT** DONALD C ADAMS  
 1760 WARNER DR  
 MEMPHIS TN 383-3332

**RX NO.** C523133 DR. CARR  
**MEDICATION** ERYTHROMYCIN 250MG TABS  
 ABBOTT-ROSS\*00074-6346-53

**QTY** 40 REFILL CALLRPH \*  
**DATE** 12/25/92 \$ 9.39 EUA HRR

**Walgreens The Pharmacy America Trusts**  
 2926 COVINGTON PIK. PH. 382-9237  
 MEMPHIS TN

**PATIENT** DONALD C ADAMS  
 1760 WARNER DR  
 MEMPHIS TN 383-3332

**RX NO.** C523134 DR. CARR  
**MEDICATION** NOTUSS LIQUID  
 S-U 05985-0521-16

**QTY** 150 REFILL CALLRPH \*  
**DATE** 12/25/92 \$ 12.09 BEMA HRR

TOTAL DRUGS \$	20 48
TOTAL ALL OTHER CHARGES \$	469 50
<b>TOTAL \$</b>	<b>489 98</b>

3960 NEW COVINGTON PIKE  
MEMPHIS TN 38128

DONALD L ADAMS  
1780 WARNER AVE  
MEMPHIS TN 38127-1335

INSURANCE PENDING:  
NATIONAL ASSOC LETTER CAR

METHODIST NORTH  
MAIL TO: MAKE CHECKS F.O. BOX 1000, DEPT. 97  
PAYABLE AND MEMPHIS TN 38148 - 0097

AMOUNT  
ENCLOSED

ACCOUNT NO.	PATIENT NAME	ADMISSION DATE	DISCHARGE DATE	STATEMENT DATE	AMOUNT DUE	DUE DATE
ER23798245	DONALD C ADAMS	12/25/92	12/25/92	01/06/93	0.00	

**▲ PLEASE DETACH UPPER PORTION AND RETURN WITH PAYMENT ▲**

METHODIST NORTH

PAGE 1 OF 1

THIS IS A STATEMENT OF YOUR ACCOUNT. RETAIN THIS PORTION FOR YOUR RECORDS.  
CHARGES OR PAYMENTS RECEIVED AFTER THE STATEMENT DATE WILL APPEAR ON YOUR NEXT STATEMENT.

ACCOUNT NO.	PATIENT NAME	ADMISSION DATE	DISCHARGE DATE	STATEMENT DATE	AMOUNT DUE	DUE DATE
ER23798245	DONALD C ADAMS	12/25/92	12/25/92	01/06/93	0.00	

DATE	HOSPITAL CODE	DESCRIPTION	AMOUNT
122592	13567	EMERGENCY RM LEVEL II	
122592	682	HEMOGRAM	46.00
122592	783	BLOOD GAS/ART	51.00
122592	27883	VENIPUNCTURE	80.00
122592	27883	VENIPUNCTURE	4.50
122592	89	CHEST PA & LATERAL	4.50
122992	6168	NATIONAL ASSOC LETTER CAR	65.50
			0.00

FOR INFORMATION REGARDING YOUR ACCOUNT, PLEASE CALL  
PATIENT ACCOUNTING@ 726-8375 (MON-FRI 9:00AM-4:00PM).

TOTAL	251.50
ESTIMATED INSURANCE (SEE REVERSE)	251.50
PLEASE PAY THIS AMOUNT	0.00

MEDICAL RECORDS

PART I GENERAL CONDITIONS OF EMERGENCY MEDICAL TREATMENT - CONSENT TO TREATMENT

Each patient in the hospital is admitted under the care of his/her attending physician or dentist. Physicians and dentists of the medical staff are not employees of the hospital.

- A. **MEDICAL AND SURGICAL CONSENT:** The undersigned consents to any examination (X-ray or otherwise) including but not limited to laboratory procedures, medications, infusions, transfusions of blood and blood products, anesthesia, surgical procedures or treatments (including the placement of prosthesis within a patient's body), photograph and/or other services rendered the patient by members of the medical staff, their representatives and/or associates, and hospital employees, under the instructions of the physician or dentist. The undersigned also consents to observations of surgical, diagnostic, or other procedures by medical personnel in training or by other appropriate persons permitted by the attending physician or dentist and allowed by hospital or departmental policy.
- B. **TISSUE DISPOSAL:** Should my hospital stay involve the removal of any tissue or parts of my body, including fetus or afterbirth, they may be retained or disposed of by the hospital.
- C. **PERSONAL VALUABLES:** It is understood that the hospital maintains a safe for money and valuables, and that the hospital will not be responsible for loss or damage to any money or property of the patient or others delivered to or deposited with the hospital for safekeeping and a written safekeeping receipt issued by the hospital therefor.
- D. **MEDICAL INFORMATION RECEIVED:** The patient, if in a condition to receive it, and if not, the undersigned representative of the patient, acknowledges that he/she has been informed concerning the need for hospital services, the purpose of the patient entering the hospital, and the planned examinations, procedures, and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained.

PART II. RELEASE OF INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL AGREEMENT

A. **RELEASE OF INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS:** The hospital, my physician or physicians, or Memphis Radiologists, P.C. may disclose all or any part of the record of the patient to any person or organization which is or may be liable for or responsible for payment of all or part of the hospital's charges, including, but not limited to, insurance companies, medical or hospital service companies, workmen's compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on behalf of the patient directly to the said physicians, radiologists, and hospitals and any of their appropriate agents or divisions.

B. **FINANCIAL AGREEMENT:** The undersigned SEVERALLY agree, whether signing as a patient or otherwise, that in consideration of the services rendered to patient, payment of the account is guaranteed by the undersigned in accordance with the regular rates and terms of the hospital, being payable to the hospital in Memphis, Tennessee. While any insurance or other protection related to the hospital account may be hereby assigned to and payable directly to the hospital, the undersigned clearly understands that the obligation to pay the hospital bill is primarily on the patient and the undersigned, and while insurance received by the hospital will be applied to the patient's account, any part of the account not so paid by insurance is nevertheless owing and payable. In case of default of payment, and if this account should be placed in the hands of a Collector or an Attorney for collection, all collection fees, attorney fees, (which shall equal one-third of any balance due), cost and other expenses will be paid by the undersigned. Notice of dishonor, demand and protest is waived. I further agree that due to the high cost of billing and refunding small amounts, the hospital will not bill or refund underpayments or overpayments of less than two dollars (\$2.00) on final balances, except on a request of the responsible party.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ THE FOREGOING, HAS RECEIVED A COPY HEREOF, IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT, AND THE FOREGOING CONDITIONS OF ADMISSION ARE ACCEPTED.  
If patient is unable to execute above form (because of some disability, such as being a minor, non compos mentis, unconscious, or other disability which inhibits or precludes that patient's ability to legally sign) explain the patient's disability (tell chief complaint and diagnosis):

Patient's Signature (or Representative) for Consent to Treatment and Release of Information: X Donald Lee Adams  
Responsible Policyholder(s)'s Signature for Insurance Assignment: (1) X Donald Lee Adams DATE 12-25-92 TIME \_\_\_\_\_  
(2) X Donald Lee Adams DATE \_\_\_\_\_ TIME \_\_\_\_\_  
All Financially Responsible Individuals: X Donald Lee Adams DATE 12-25-92 TIME \_\_\_\_\_  
I have read and/or explained the above information and all parts of this form outlining all stated conditions to the patient or the patient's responsible representative and the patient/- responsible party appears to fully understand these conditions as stated.

UNIT NUMBER 471.187-002	ADM/SERVICE DATE 12/25/92	T/A P	T/A PERF RECTD	PHYSICIAN NAME AND NUMBER 1942 VERZOSA NICKNAME SAM		ADMIT/REG. TIME T 12:51	ACCOUNT NUMBER 3-A 23798245					
PATIENT NAME ADAMS	DONALD	CAREY	MC/SSN # 000-00-0000	DATE OF BIRTH 08/14/1975	AGE 17	MS S	RS UM	GEO CODE 1	CLERK INITIA SJK	HOME PHONE 901-358-8332		
PATIENT ADDRESS - LINE 1 30 WARNER AVE				PATIENT ADDRESS - LINE 2 MEMPHIS TN 381271335				EMPLOYER'S ADDRESS UNK MEMPHIS TN 00000				
EMPLOYER'S PHONE 999-999-9999				PREV. ADM. DATE 00/00/00	PREVIOUS ADMISSION NAME 23798245							
PHONE NUMBER 901-357-4619				RELATIONSHIP GRANDFATH	ADDRESS 00000							
PATIENT IN ANY HOSPITAL LAST 60 DAYS, (WHERE)												
RESIDENT PARTY ADAMS				MC/SSN # L 410-86-1396	RELATIONSHIP FATHER	RP UNIT # 1620533	OWN/RENT	PHONE NUMBER 901-358-8333				
ADDRESS - LINE 1 30 WARNER AVE				ADDRESS - LINE 2 MEMPHIS TN 38127				RP ACCT. NUMBER E-354423-A	PHONE NUMBER (BUSINESS) 999-999-999			
EMPLOYER'S NAME LETTER CARRIER				EMPLOYER'S ADDRESS UNK MEMPHIS TN 00000								
POSTAL SERVICE ASSOC OF LETTER CARR				NATL ASSOC OF LETTER CAR				SUBSCRIBER ADAMS DONALD				
GROUP NUMBER 004708				POLICY NUMBER 410-86-1396				P.O. BOX 9668				
GROUP POLICYHOLDER				SUBSCRIBER ADAMS DONALD				CITY SCOTTSDALE AZ				
GROUP NUMBER				POLICY NUMBER				STATE 00000				
GROUP POLICYHOLDER				SUBSCRIBER				INS. CO. 85252				
ADDRESS/STREET				CITY				STATE AZ				
CITY				STATE				ZIP CO.				

14621801

# AAPCC COOPERATIVE POISON CENTER REPORT 930111CCN0667 attachment 5

DATE: 12-25-92 TIME: 11:58

See # 14621802

CALL TYPE (T) (one only)	Victim (V) (one only)	Exposure Type (E) (one only)	REASON (R) (one only)			
			Accidental	Intentional	Adverse Reaction	Unknown
1. Exposure 2. Drug Information 3. Poison Information 4. Medical/Other	1. Human 2. Animal	1. Acute 2. Chronic 3. Unknown	1. General 2. Occupational 3. Environmental 4. Misuse 5. Unknown	6. Suicidal 7. Misuse 8. Abuse 9. Unknown	10. Drug 11. Food 12. Other	13. Unknown Reason

**PATIENT DATA**  
 Name: Donald Adams  
 Telephone no.: ( )  
 Address: \_\_\_\_\_  
 Zip: \_\_\_\_\_  
 Age: 43  mo.  yr. Weight: 170  lbs.  kg.  
 Sex:  Male  Female  Unknown

**CALLER DATA**  
 Name: Irene Adams  MD  RN  
 RPh  OHP  
 Relationship to patient:  Self  Father  Other wife  
 Mother  
 Telephone no.: (901) 353-3332  
 Address: \_\_\_\_\_  Memphis  
 Zip: \_\_\_\_\_ County: \_\_\_\_\_

Pertinent Medical History:  Healthy  No chronic meds  No known allergies  
 Check here if patient is pregnant  Medical history unknown  
 PMD name & no.: \_\_\_\_\_

**Site of Caller**  Residence  Site of Exposure  
 Workplace   
 Health Care Facility   
 School   
 Other   
 Unknown

**SUBSTANCE DATA**  
 Substance: Leather Protector  
 Amount: inhaled fumes  
 Ingredients: Petroleum Distillates per Label Manufacturer: Wilson  
794-6567  
308-9095  
 Time of/Since exposure: 1° PTC  
 Route of Exposure:  Ingestion  Inhalation/Nasal  Ocular  Dermal  Bite/Sting  Parenteral  Unknown  Other \_\_\_\_\_

**HISTORY, ASSESSMENT, SYMPTOMS & CALCULATIONS**  
 History (witnessed? amount verified? other products/victims?)  No other products suspected  
~~to Room~~ Caller's son & husband were in room that coat was sprayed & above pdt. They went in p spraying was over. The room also was used for smoking cigarettes. She is unsure how long they were in the room. Possibly exposed for 10-15". Has SES below desires txt mgf.  
 Subjective complaints/objective findings  No symptoms at this time  
Coughing, gagging  
ough if breathes real deep, cold (chills)  
 Assessment (symptoms expected? rationale?)  
 Initial assessment (choose one)  
 Asymptomatic  
 Symptomatic, related ↑ risk of  
 Symptomatic, unrelated  
Due to symptomatology 3°  
p exposure → Refer to HCF..

MANAGEMENT PLAN, FOLLOW-UP NOTES AND OUTCOME: (Time & date each entry)

Code:

DATE/TIME

Treatment suggested: HCF

Symptoms to monitor:

coughing, choking, tachypnea, dyspnea, CNS excitation/depression, N/V/D, Abd pain.

Follow-up schedule: 2-4

45 Caller's sister calls: desires to know which HCF/ER sister went to. Told sister decision was left to Ms. Adams. Rec. nearest HCF/ER. SRH

58 Ans. Machine SRH

3 Ans. Machine. SRH

10 Spoke c Kerry. states feel a little bit better, but not the much better. Then spoke c Irene. went to Methodist North. Both husband & son received CXR. & given scripts for No-Tuss PRN & Erythro. Husband had pneumonitis & son had bronchitis. Assigned bed Res & f/u c MD (specialist on Monday). SRH

192 34 Spoke c Donald. States chest hurts a little bit but is feeling much better. Kerry today is more active & feels better today. f/u Monday. SRH P MD's appt.

Going to MD @ 3pm &

3 Ans Machine &

MULTANTS/RESOURCES USED:

- Medical director \_\_\_\_\_
- Texts \_\_\_\_\_
- Other consultant \_\_\_\_\_
- Other \_\_\_\_\_

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ED BY: SRH / PM

FORM

12(2)



AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION  
VIA TELEPHONE

TO: Peter A. Chyka, Pharm.D.  
Executive Director  
Southern Poison Center, Inc.  
848 Adams Avenue  
Memphis, TN 38103

You are hereby authorized to release to the US Consumer Product  
Safety Commission, Tennessee Agent: Janice Mitchell to  
investigate incident.

the case data that involved the following person: Kerry Adams  
Donald Adams  
12/23 Irene Adams

My relationship to the above person is checked below

- Mother                       Father                       Legal guardian  
 Self                               Other, please describe wife of Donald Adams  
mother of Kerry Adams

Verbal authorization given by telephone on the following date:

Signed Lynette Y. Zylstra

Date 1/21/93 1830

For Poison Center Use
Date received _____
Case no. _____

14621802

AAPCC COOPERATIVE POISON CENTER REPORT 930111CCN0667 attachment 5

DATE: 12-25-92 TIME: 11:58

CALL TYPE (T) (one only)	Victim (V) (one only)	Exposure Type (E) (one only)	REASON (R) (o)			
			Accidental	Intentional	Adverse Reaction	Unknown
1. Exposure 2. Drug Information 3. Poison Information 4. Medical/Other	1. Human 2. Animal	1. Acute 2. Chronic 3. Unknown	1. General 2. Occupational 3. Environmental 4. Misuse 5. Unknown	6. Suicidal 7. Misuse 8. Abuse 9. Unknown	10. Drug 11. Food 12. Other	13. Unknown Reason

See # 14621801

**PATIENT DATA**  
 Name: Kemy Adams  
 Telephone no.: ( )  
 Address:  
 Age: 17  mo.  yr. Weight: 180  lbs.  kg.  
 Sex:  Male  Female  Unknown

**CALLER DATA**  
 Name: Irene Adams  MD  RN  RPh  OHP  
 Relationship to patient:  Self  Father  Mother  Other  
 Telephone no.: (901) 353-3332  
 Address:  
 Memphis

**Pertinent Medical History:**  Healthy  No chronic meds  No known allergies  
 Respiratory Problems - Breathing Machine  
 Meds: Lithium  
 Check here if patient is pregnant  Medical history unknown

**Site of Caller**  Residence  Workplace  Health Care Facility  School  Other  Unknown  
**Site of Exposure**

**SUBSTANCE DATA**  
 Substance: Leather Protector  
 Amount: inhaled fumes  
 Ingredients: Petroleum Distillates > paraffin  
 Manufacturer: 744-6567 308-9095  
 Date of/Since exposure: 1<sup>o</sup> PTC  
 Route of Exposure:  Ingestion  Inhalation/Nasal  Ocular  Dermal  Bite/Sting  Parenteral  Unknown  Other

**HISTORY, ASSESSMENT, SYMPTOMS & CALCULATIONS**  
 History (witnessed? amount verified? other products/victims?)  No other products suspected

See # 14621802

Subjective complaints/objective findings  No symptoms at this time

Coughing, gagging  
can only take shallow breaths, lungs feel real cold

Assessment (symptoms expected? rationale?)  
Initial assessment (choose one)

- Asymptomatic
- Symptomatic, related
- Symptomatic, unrelated
- Symptomatic, unknown if related

↑ risk of aspiration pneumonia

Due to symptoms 3<sup>o</sup> p exposure  
Refer to HCF for evaluation.

Code:

MANAGEMENT PLAN, FOLLOW-UP NOTES AND OUTCOME: (Time & date each entry)

DATE/TIME

Treatment suggested: HCF

Symptoms to monitor:

Coughing, Choking, tachypnea, dyspnea, CNS excitation/Depression, N/V/D, Abd pain

Follow-up schedule: 2-4°

1:45 Caller's sister calls SPC.; desires to know which HCF/ER sister went to. Told sister decision was left to us. Adam: Rec Newcastle HCF/ER. SRA

1:58 Ans. Machine. SRA

1:53 Ans. Machine. SRA

1:40 Spoke Kerry States feel a little bit better, but not that much better. Then spoke Irene. Went to Methodist North. Both Husband & son went to ER. Were CXR'd & given scripts of NoTuss PRN & Erythromycin. Husband had pneumonitis; son was dx'd bronchitis. Assigned bed rest & F/u @ MD on Monday. SRA

1:34 Spoke Donald. States chest hurts a little bit but is feeling much better. Kerry today is more active & feels better today. F/u Monday after MD's appt. SRA

1:31 Going to MD @ 3pm

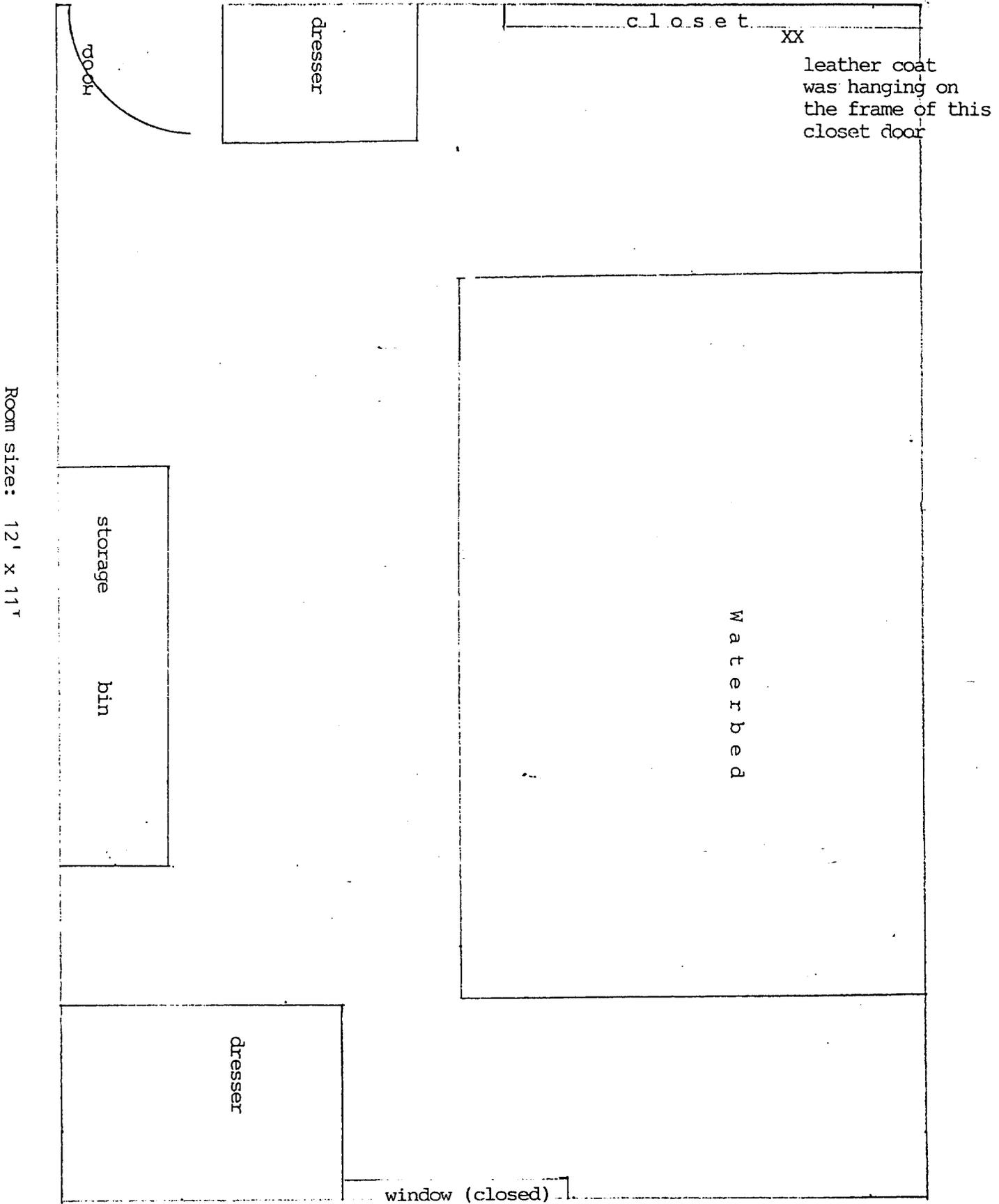
1:33 Ans Machine

CONSULTANTS/RESOURCES USED:

- Medical director \_\_\_\_\_
- Other consultant \_\_\_\_\_
- Texts \_\_\_\_\_
- Other \_\_\_\_\_
- Poicindex®



Diagram of Bedroom (where leather protector was sprayed)



**MAGNOLIA**  
CLIPPING SERVICE  
JACKSON, MS (601) 956-4221  
TUSCALOOSA, AL (205) 758-8610

COMMERCIAL APPEAL  
Memphis, Tennessee  
DAILY

G31 0081

IOI 930111CCN0667

DEC-30-92

## Exposure to spray <sup>506</sup>leaves 27 people ill

By Jon Hamilton  
The Commercial Appeal

Several members of a Memphis-area family were among dozens of people nationwide who fell ill over the holidays after exposure to a spray-on leather protector, poison control officials said Tuesday.

Irene Adams, 41, of Frayser said her husband, her son and a niece were treated in the emergency room at Methodist Hospital North on Christmas Day after spending time in a room where a leather coat had been sprayed with the product. "They couldn't breathe when they came out of the room," she said.

On Monday, Wilsons Suede and Leather Co. in St. Louis Park, Minn., recalled 270,000 cans of leather protector spray from 600 stores it operates, including several in Memphis.

The Southern Poison Control Center in Memphis has confirmed three local reports of exposure to the spray, said Dr. Peter Chyka, executive director of the center. Through Sunday there were 27 confirmed reports of illness linked to the spray, he said, adding that the number is likely to rise as more poison

centers submit information.

No consumer has died.

Poison control centers in at least six states have received hundreds of calls since Christmas from people reporting coughing, nausea, shortness of breath and other flu-like symptoms after exposure to the product. Wilsons said the problem seems to be a petroleum-based substance in new five-ounce cans of its leather protectant.

Chyka said the spray irritates the lining of the lungs, causing the symptoms.

Carey Adams, 17, said he realized something was wrong about 25 minutes after he left a room in which the product had been used to waterproof a leather coat given as a Christmas gift.

"My lungs started hurting," he said. "It kept getting worse and worse." Adams said his father and others who had been in the room also began coughing. He and his father are better, he said, though they still cough and are congested.

Chyka said people who think they have been exposed to the spray or have questions should call the center at 528-6408. Wilsons is encouraging consumers who purchased the spray to return it for a full refund.

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U.S. CONSUMER PRODUCT SAFETY COMMISSION

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AUTHORIZATION FOR RELEASE OF NAME

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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.

Donald Leon Adams  
(Signature)

1-30-93  
(Date)



Photo #1: This photo shows the front panel of the 5 oz. leather protector which was used to spray a leather coat on Christmas morning, the day of the incident.

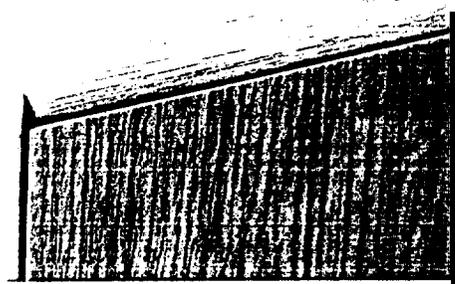


Photo #2: The leather protector was sprayed in a small bedroom which was being used as the "smoking room" for the family members who smoked. Both a 43 year old father and his 17 year old son became ill shortly after entering the room.



930111CCN0667  
attachment #1

Photo #3: This photo shows the markings on the bottom of the 5 oz. spray can which states "292."

