

124-5

G2C0251A1

JAN 19 1993

31

1. CASE NO. 930104CCN0580			2. INVESTIGATOR'S ID 9 0 0 3			3. OFFICE CODE 8 3 0			<b>EPIDEMIOLOGIC INVESTIGATION REPORT</b>		
4. DATE OF ACCIDENT YR: 9 2 MO: 1 2 DAY: 2 4			5. DATE INVESTIGATION INITIATED YR: 9 2 MO: 1 2 DAY: 3 1								

6. SYNOPSIS OF ACCIDENT OR COMPLAINT This investigation was initiated in response to a report from a 37 Y.O. consumer that she had 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 12/24/92. The victim was hospitalized overnight and treated for the symptoms of chemical pneumonia.

7. LOCATION (Home, school, etc.) Home		8. CITY Green Bay		9. STATE WI	
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10A. FIRST PRODUCT Fabric protection treatment		11A. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS Wilson's Suede and Leather, Inc., Minneapolis, MN. "Wilson's Leather Protector" (5 oz.)	
10B. SECOND PRODUCT leather jacket		11B. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS Same as above-	

12. AGE OF VICTIM 0 3 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		17. RESPONDENT(S) (Mother, Friend) Victim		18. TYPE INVESTIGATION ON SITE: 1, TELEPHONE: 2, OTHER: 3 2		19. TIME SPENT Tr: 0.0 0 3 0	
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20. ATTACHMENTS copy of original complaint		21. CASE SOURCE complainant		22. REVIEWED BY 8 1 3 0		YR: 9 3 MO: 0 1 DAY: 1 3	
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23. PERMISSION TO DISCLOSE NAMES (NON-BESS CASES ONLY)  
 CPSC MAY DISCLOSE MY NAME  CPSC MAY NOT DISCLOSE MY NAME

24. NARRATIVE (See Instructions on Other Side)  
See attached narrative.

25. REGIONAL OFFICE DIRECTOR REVIEW DATE

MFR/PRVLR NOTIFIED 6/10/93  
~~\_\_\_\_\_~~ No Comments made  
~~\_\_\_\_\_~~ Comments attached  
~~\_\_\_\_\_~~ Exclusions/Revisions  
~~\_\_\_\_\_~~ Firm has not requested further action

G2C0251A1

(USE OTHER SIDE AND ADDITIONAL SHEETS IF NECESSARY)

930104CCN0580

**SUMMARY:**

This investigation was conducted in response to a 37 year old female consumer's complaint that she experienced severe respiratory distress after being exposed to the fumes from an aerosol fabric protection product she was using to treat a newly purchased leather jacket on 12/24/92. The victim was hospitalized overnight and treated for the symptoms of chemical pneumonia.

**PRE-INCIDENT:**

During a telephone interview conducted on 12/31/92, the complainant reported that she had purchased a 3 quarter length black leather jacket from a "Wilson's Suede and Leather Products" retail store, located at 1009-A Port Plaza Mall, Green Bay, Wisconsin 54304 at approximately 2:00 p.m. on 12/24/92.

As she was purchasing this coat, the unidentified female store clerk suggested that it would be important to treat the new jacket with a fabric protection product to avoid damage from dirt or moisture. The clerk suggested that the complainant purchase "Wilson's Leather Protector" an aerosol product sold at the store in 5 ounce containers.

The complainant did purchase one 5 ounce can of the spray. She was told by the clerk to spray 1/2 the contents of the can onto the coat initially, let it dry for at least 30 minutes, and then repeat the process. The clerk also verbally warned the complainant to treat the coat in a well ventilated area.

**INCIDENT:**

Later that same day, 12/24/92 at approximately 8:00 P.M., The complainant sprayed the leather protector product onto the coat as she had been instructed. She did this in her home's unfinished, open basement, which she felt was large enough a space to allow the fumes from the products to dissipate; she did not open any of the basement windows or provide any further ventilation.

The complainant felt that the initial spraying procedure took approximately 15 minutes. At approximately 9:30 p.m. that evening, she returned to the basement and sprayed the remaining 1/2 can of "Wilson's Leather Protector" onto the coat. She did not find the fumes from the product to be particularly harsh or toxic.

Later, at approximately 10:20 p.m., the complainant was lying on her couch upstairs watching television, when she began experiencing difficulty breathing, coughing episodes, and the feeling that she might vomit. She stated that her "lungs felt heavy", and she began experiencing fever and chills.

#### POST INCIDENT:

At 12:29 a.m. on 12/25/92 the complainant's condition was worsening, and an ambulance was summoned to transport her to nearby St. Mary's hospital in Green Bay, Wisconsin for treatment. She was admitted to the hospital, and was diagnosed as suffering from chemical pneumonia. She received chest x-rays, IV chemical treatment, and was placed on oxygen to relieve her symptoms of respiratory distress.

Complainant was released at 11:00 a.m. on 12/25/92, and was to continue taking the prescription medication "Predesone".

"Authorization for Release of Medical Records" forms were sent to the complainant by mail on 1/4/93. When the forms are completed, the complainant's medical records will be obtained by this investigator and forwarded as an addendum to this report.

#### 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.

930104CCN0580

(3)

**PRODUCT IDENTIFICATION:**

Product: "Wilson's Leather Protector" fabric protection treatment; 5 ounce aerosol container, container described as being black with red and white lettering. SKU 18996003.

**MANUFACTURER:**

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

**ATTACHMENTS:**

Exhibit A - Copy of the original consumer complaint.

CONSUMER PRODUCT INCIDENT REPORT

1. NAME OF RESPONDENT Barbara A. Yaeger		2. TELEPHONE NO. (Home) (Work) (414) 499-6143 (Home)	
3. STREET ADDRESS 800 Stonybrook Lane		4. CITY STATE ZIP CODE Green Bay, WI. 54304	
5. DESCRIBE ACCIDENT SITUATION OR HAZARD, INCLUDING DATA ON INJURIES. (Use second page if necessary.) Respondent was spraying her newly purchased leather jacket with an aerosol fabric protection treatment; she began experiencing severe respiratory distress after several minutes exposure to the fumes. Victim's condition continued to deteriorate, and she was transported by ambulance to a local hospital for emergency treatment. She was diagnosed as suffering from chemical pneumonia; she was released the following day.			
6. DATE OF INCIDENT(S) 12/24/92	7. IF INJURY OR NEAR MISS, OBTAIN AGE <u>37</u> SEX <u>female</u> AND DESCRIBE INJURY <u>chemical pneumonia</u>	8. IF VICTIM DIFFERENT FROM RESPONDENT, PROVIDE NAME _____ RELATIONSHIP _____	
9. DESCRIPTION OF PRODUCT aerosol fabric protection treatment		10. BRAND NAME Wilson's Leather Protector	
11. MANUFACTURER/DISTRIBUTOR NAME, ADDRESS & PHONE Wilson Suede and Leather, Inc. Minneapolis, MN.		12. MODEL, SERIAL NO.'S 5 ounce can	
		13. DEALER'S NAME ADDRESS & PHONE Wilson's Suede and Leather Port Plaza Shopping Center Green Bay, WI. 54304	
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>12/24/92</u> USED _____ DATE PURCHASED _____ AGE <u>hours</u>	
		16. DOES PRODUCT HAVE WARNING LABELS? IF SO, NOTE: <u>vapors may be harmful.</u>	
17. HAVE YOU CONTACTED THE MANUFACTURER? YES _____ NO <u>X</u> IF NOT, DO YOU PLAN TO CONTACT THEM? YES _____ NO _____ OTHER _____		18. IS THE PRODUCT STILL AVAILABLE? YES _____ NO <u>X</u> IF NOT, ITS DISPOSITION _____	
19. MAY WE USE YOUR NAME WITH THIS REPORT? YES <u>X</u> NO _____			
FOR ADMINISTRATION USE			
20. DATE RECEIVED 12/31/92		21. RECEIVED BY (Name & Office) Dennis R. Blasius, MKX-RP	
22. FOLLOWUP ACTION <u>Conduct EPI</u>		23. DOCUMENT NO. <u>G2C0251</u>	
		24. PRODUCT CODE(S) <u>0952</u>	
25. DISTRIBUTION <u>D: EPOS; cc: CEM, Jacobson; cc: FOCK</u>		26. ENDSER'S NAME & TITLE <u>Amber, SDE</u>	

U.S. CONSUMER PRODUCT SAFETY COMMISSION

0952  
1646

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.

Debra A. Jaeger  
(Signature)

1/5/93  
(Date)

FEB 26 1993

IDI# 930104CCN0580

Addendum to original report:

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

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

Dennis R. Blasius  
Milwaukee Resident Post

Exhibit "B"

12/31/92

IOI# 930104CCN0580

U.S. CONSUMER PRODUCT SAFETY COMMISSION

FEB 26 1993

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO WHOM IT MAY CONCERN:

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

( the case of BARBARA A. YAEGER Name

SELF Relationship to you )

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

1/5/93  
(Date)

Barbara A. Yaeger  
(Signature)

Henry J. Yaeger  
(Witness)

**U.S. CONSUMER PRODUCT SAFETY**

TO I # 930104 CCN0580

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

930104 CCN0580

January 7, 1993

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

Att: Medical Records Dept.:

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

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

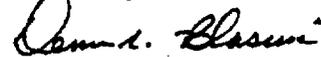
U.S. Consumer Product Safety Commission  
Milwaukee Resident Post  
310 W. Wisconsin Avenue  
Box 244  
Milwaukee, WI. 53203

Att: Investigator Dennis Blasius

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

Thank you for your prompt response.

Sincerely,



Dennis R. Blasius  
Investigator



**United States Government  
Consumer Product Safety  
Commission**

**DENNIS R. BLASIUS**  
Investigator

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

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

C  
P  
S  
C

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

ST MARYS MEDICAL CENTER GREEN BAY  
(QBP#P)

=====

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

===== ADMISSION/DISCHARGE  
RECORD

REF CLINIC: CITY:  
CLK: DJW  
ADDR: 800 STONEY BROOK LA  
GREEN BAY WI 54304-  
PHONE: 414-499-6143 CO: BRN  
PREV NAME: SCHROEDER  
DOB: 08/06/55 MS: M

SSN: 398586783 F/C: 70  
RELIGION: LUTH  
CHURCH: PILGRIM  
PARISH CODE: LD16

EMPLOYER: FREEDOM SCHOOLS  
OCCUPATION: TEACHER

ER CONTACT I: JERRY  
PHONE: 414-499-6143 REL: HU  
WORK: 414-499-3131

ACCIDENT DATE:  
CAUSE:  
HOW ADMITTED: SQUAD

ER CONTACT II:  
PHONE:  
WORK:  
REL:

ADM DX: INHALATION PNEUMONITIS CHEMICAL PNEUMONIA  
LTR NOTE:

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

DISCHARGE DATE AND TIME:

*12.25.92  
-H*

EXPIRED DATE AND TIME:

AUTOPSY? YES NO

PRINCIPLE DIAGNOSIS:

*acute bacterial pneumonia  
& bronchopneumonia*

SECONDARY DIAGNOSIS:

*506.0  
506.3  
E 862.1  
93.94*

COMPLICATIONS:

PROCEDURES:

*medical*

*EC  
ABG*

-----, MD  
ATTENDING PHYSICIAN

*[Signature]*

*116*



**St. Mary's  
Hospital**  
Medical Center

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

1. **INFORMED CONSENT FOR MEDICAL TREATMENT**

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

2. **INSPECTION OF HEALTH CARE RECORDS**

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

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

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

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

4. **ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT AGREEMENT**

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

5. **PATIENT VALUABLES**

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

\_\_\_\_\_ PT WILL KEEP VALUABLES \_\_\_\_\_ DEPOSITED IN HOSPITAL SAFE

\_\_\_\_\_ GIVEN TO RELATIVE: \_\_\_\_\_  
(Name)

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

\_\_\_\_\_  
(Patient's Signature)

*John L. Young*  
\_\_\_\_\_  
(Person legally authorized to sign on patient's behalf and their relationship to the patient)

*DW* \_\_\_\_\_ *12-25-92*  
(Witness) (Date)

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

**CHIEF COMPLAINT:**

Cough, shortness of breath, and trouble breathing.

**HISTORY OF PRESENT ILLNESS:**

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

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

**PAST MEDICAL HISTORY:**

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

**FAMILY HISTORY:**

Noncontributory except as outlined above.

**SOCIAL HISTORY:**

Noncontributory except as outlined above.

**REVIEW OF SYSTEMS:**

Noncontributory except as outlined above.

**PHYSICAL EXAMINATION:**

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

Yaeger, Barbara  
#302579  
Page 2  
Dr. Tibbetts

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

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

**INITIAL IMPRESSION:**

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

**DISPOSITION:**

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

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



MEDRC-2583  
12/26/92 03:00

ST MARYS MEDICAL CENTER GREEN BAY  
(QAFPRG)

PAGE 001

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YAEGER, BARBARA A	F 37 DISCH	MEDICAL	=====
M.R.#: 0302579	ADM MD: TIBBETTS J. J. MD	3N-8	TEST RESULTS SUMMARY
ACCT#: 5589023	ATT MD: TIBBETTS J. J. MD	318	=====
ADM: 12/25/92 00:50		RACE:W	
DOB: 08/06/55	REF MD: TIBBETTS J. J. MD		

=====

REFERRING CLINIC:	REF MD ADDR:
CONSULTANTS:	

=====

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

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

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BLOOD COUNTS

TEST	12/25	02:10		RANGE/UNITS
WBC	25.1	H*		3.0-10.5 K/UL
RBC	4.67	*		3.7-5.2 MIL/UL
HGB	12.4	*		11.8-15.8 GM/DL
HCT	37.4	*		35-46 %
MCV	81.0	*		80-98 CU U
MCH	26.8	L*		27-34 UUG
MCHC	33.2	*		32-36 %
RDW	38.3	*		35-47 CU U
MPV	10.1	*		CU U
PLT CT	403	*		140-440 K/UL
BAND	11	*		%
NEUT	78	*		%
LYMPH	5	*		%
MONO	6	*		%
TECH HEM	LK	*		
TECH DIFF	LK	*		



MEDRC-2599

ST MARYS MEDICAL CENTER GREEN BAY  
(QAXPRG)

12/26/92 03:01

PAGE 001

\*\*\*\*\*  
YAEGER, BARBARA A F 37  
MR#: 0302579 ACCT#: 3589023  
SERV: MEDI 3N-3 318  
MD: FIBBETTS J. J. MD ADM: 12/25/92  
DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA  
\*\*\*\*\*

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\* \* \* \* \*  
\* \* \* \* \*  
\* \* \* \* \*  
\* \* \* \* \*

DISCHARGE REPORT

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

NEW ORDERS ENTERED FOR THE DAY:

12/25/92 01:04

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

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

12/25/92 01:04

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

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

12/25/92 01:57

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

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

12/25/92 03:30

- 5. ACTIVITIES, UP, AS TOL, (TAB).
- 6. DIET: GENERAL, (TAB).
- 7. RESPIRATORY THERAPY NASAL CANNULA.  
O2 FLOW AT 4 LPM--TO KEEP O2 SAT > 95%, (TAB).
- 8. RESPIRATORY THERAPY OXYGEN SAT % PULSE OXIMETER, CONTINUOUS  
SAT% MONITOR, (TAB).
- 9. RESPIRATORY THERAPY UPDRAFT NEBULIZER.  
ALBUTEROL --Q 3-4 PRN, OTHER--WHEEZING, (TAB).
- 10. PREDNISON 20MG TAB, #1, PO, BID 8-17 MEALS --(GIVE WITH FOOD),  
(12/25/92 0800-..), (TAB).
- 11. IV LINE #1- START D5/.9% NS 1000ML, RATE:125ML/H, CONT TIL DC'D  
, (TAB).
- 12. TYLENOL ACETAMINOPHEN 325MG TAB, #2, PO, Q4H PRN--FOR PO TEMP >  
101, (TAB).

ENTERED BY: KLAWITTER LINDA NUR PHONE ORDER

CONTINUED

12/26/92 03:01

(QAXPRG)

PAGE 002

YAEGER, BARBARA A

F 37

MR#: 0302679

ACCT#: 3589023

SERV: MEDI

3N-S 318

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

DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA

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### ###
* * * * *
* * F * *
* * F * *
### * * ###

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DISCHARGE REPORT

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

ENTERED FOR: TIBBETTS J. J. MD

**SIGNED**

SIGNATURE:-----

12/25/92 10:32

13. DISCHARGE PATIENT TODAY.

TO: HOME, (T)..

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

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

ENTERED BY: MORELLO DIANE

NUR

WRITTEN ORDER

ENTERED FOR: TILKENS T. N. DPM

12/25/92 10:43

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

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

ENTERED BY: MORELLO DIANE

NUR

ADJUSTING ORDERS

12/25/92 10:44

18. (DELETE) DISCHARGE PATIENT TODAY.

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

ENTERED BY: MORELLO DIANE

NUR

ADJUSTING ORDERS

CONTINUED

12/26/92 03:01

(QAXPRG)

PAGE 003

YAEGER, BARBARA A

F 37

MR#: 0302579

ACCT#: 5589023

SERV: MEDI

3N-S 318

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

DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA

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

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

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DISCHARGE REPORT

12/25/92 10:46

19. DISCHARGE PATIENT TODAY.

TO: HOME, (TAB).

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

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

ENTERED BY: MORELLO DIANE

NUR

WRITTEN ORDER

ENTERED FOR: TIBBETTS J. J. MD

-----  
THERE WERE NO ORDERS HELD TODAY

-----  
NO ORDERS WERE COUNTERSIGNED TODAY

-----  
--COMPLETED ORDERS FOR THE DAY--

COMPLETED BY: ADAMS KIM

RT KS

01:42 12/25/92

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

-----  
COMPLETED BY: WAUTERS, SHEREE RTRES SWA

12:02 12/25/92

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

-----  
LASTPAGE





DATE TIME	PHYSICIAN'S ORDERS
12/25	May discharge (1) send - inhaled - may or equivalent to her
	(2) send Prednisone (20mg 100 TID c food)
	(3) send Rx's of inhaled
	5 Malt
	Dr Morells new 3 weeks on

DATE TIME	PROGRESS RECORD
	Note progress of case, physical findings, complications, change in diagnosis, condition on discharge, instructions to patient.
	RESPIRATORY CARE DEPT. OBJECTIVES
DATE 12-25-92	PT. HAS BEEN STARTED ON:
	O <sub>2</sub> per cann. @ 4lpm; cont. oxim. Updraft O <sub>2</sub>
	PLEASE INDICATE OBJECTIVES FOR THERAPY <sup>40 prn for wheezing</sup>
<input type="checkbox"/>	IMPROVE ALVEOLAR VENTILATION
<input type="checkbox"/>	IMPROVE ARTERIAL OXYGENATION
<input type="checkbox"/>	PREVENT/TREAT ATELECTASIS
<input type="checkbox"/>	IMPROVE/PROMOTE, COUGH/SPUTUM PRODUCTION
<input type="checkbox"/>	TREAT PULMONARY EDEMA/CONGESTION
<input type="checkbox"/>	REDUCE/REVERSE BRONCHOSPASM
<input type="checkbox"/>	IMPROVE RESPIRATORY FUNCTION
<input type="checkbox"/>	TRAIN IN USE OF HOME THERAPY/EQUIPMENT
<input type="checkbox"/>	ALLEVIATE RESP. DISTRESS <input type="checkbox"/> OTHER _____
	PHYSICIAN SIG. <i>[Signature]</i>
	RESP. CARE DEPT. OXIMETRY DONE
DATE: 12-25-92	TIME: 0300
SAT % PRE O <sub>2</sub>	
SAT % POST	100% LPM O <sub>2</sub> = 4lpm
COMMENT:	
TECH:	Burns
12/25	may discharge (1) send inhaled (2) prednisone 10mg TID (3) call for follow up today & report chest x & CBC - + follow assessment Rx 1/2 - 1/2
	5 Malt
	Dr Morells new 3 weeks on



**CLINICAL PROFILE**

DATE 12/25/92

NIGHT

DAY

EVENING

DIET	NIGHT			DAY			EVENING		
	BREAKFAST	LUNCH	SUPPER	BREAKFAST	LUNCH	SUPPER	BREAKFAST	LUNCH	SUPPER
	G F P	G F P	G F P	G F P	G F P	G F P	G F P	G F P	G F P
	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Feed			<input checked="" type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Feed			<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Feed		
HYGIENE	Bath <input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete			Bath <input checked="" type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete			Bath <input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete		
	<input type="checkbox"/> Shave <input type="checkbox"/> Tub <input type="checkbox"/> Shower			<input type="checkbox"/> Shave <input type="checkbox"/> Tub <input checked="" type="checkbox"/> Shower			<input type="checkbox"/> Shave <input type="checkbox"/> Tub <input type="checkbox"/> Shower		
	Mouth Care _____			Mouth Care <u>self</u>			Mouth Care _____		
	Skin Care _____			Skin Care <u>self</u>			Skin Care _____		
	<input type="checkbox"/> Peri Care <input type="checkbox"/> Shampoo			<input checked="" type="checkbox"/> Peri Care <u>self</u> <input type="checkbox"/> Shampoo			<input type="checkbox"/> Peri Care <input type="checkbox"/> Shampoo		
ACTIVITY	Sleep <input type="checkbox"/> Good <input checked="" type="checkbox"/> Poor <input type="checkbox"/> Intervals			Sleep <input type="checkbox"/> Good <input type="checkbox"/> Poor <input checked="" type="checkbox"/> Intervals			Sleep <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Intervals		
	<input checked="" type="checkbox"/> Bedrest Turn <u>self</u>			<input checked="" type="checkbox"/> Bedrest Turn <u>self</u>			<input type="checkbox"/> Bedrest Turn _____		
	CDB <u>enc</u> Suction _____			CDB <u>enc</u> Suction _____			CDB _____ Suction _____		
	<input checked="" type="checkbox"/> BRP <input type="checkbox"/> Commode <input type="checkbox"/> Elev. Toilet			<input type="checkbox"/> BRP <input type="checkbox"/> Commode <input type="checkbox"/> Elev. Toilet			<input type="checkbox"/> BRP <input type="checkbox"/> Commode <input type="checkbox"/> Elev. Toilet		
	Assist _____ <input type="checkbox"/> Urinal <input type="checkbox"/> Bedpan			Assist <u>self</u> <input type="checkbox"/> Urinal <input type="checkbox"/> Bedpan			Assist _____ <input type="checkbox"/> Urinal <input type="checkbox"/> Bedpan		
Up in Chair	<input type="checkbox"/> Self <input type="checkbox"/> Hoyer			<input checked="" type="checkbox"/> Self <input type="checkbox"/> Hoyer			<input type="checkbox"/> Self <input type="checkbox"/> Hoyer		
	With help (1, 2, 3)			With help (1, 2, 3)			With help (1, 2, 3)		
Chair	Length of time _____			Length of time <u>PRN</u>			Length of time _____		
	Tolerance G F P			Tolerance <u>G</u> F P			Tolerance G F P		
Up in Hall	<input type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2)			<input checked="" type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2)			<input type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2)		
	Tolerance G F P			Tolerance <u>G</u> F P			Tolerance G F P		
	Distance _____			Distance <u>to Shower</u>			Distance _____		
	<input type="checkbox"/> Linen Change # _____ <input type="checkbox"/> Complex Linen			<input type="checkbox"/> Linen Change # _____ <input type="checkbox"/> Complex Linen			<input type="checkbox"/> Linen Change # _____ <input type="checkbox"/> Complex Linen		
SAFETY	<input checked="" type="checkbox"/> Call Bell in Reach <input type="checkbox"/> Side Rails <u>2/2</u>			<input checked="" type="checkbox"/> Call Bell in Reach <input type="checkbox"/> Side Rails <u>2/2</u>			<input type="checkbox"/> Call Bell in Reach <input type="checkbox"/> Side Rails _____		
	<input type="checkbox"/> Vest Restraint <input checked="" type="checkbox"/> Bed Low Position			<input type="checkbox"/> Vest Restraint <input checked="" type="checkbox"/> Bed Low Position			<input type="checkbox"/> Vest Restraint <input type="checkbox"/> Bed Low Position		
	Restrains <input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> All			Restrains <input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> All			Restrains <input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> All		
	<input type="checkbox"/> Soft <input type="checkbox"/> Leather <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> CMT			<input type="checkbox"/> Soft <input type="checkbox"/> Leather <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> CMT			<input type="checkbox"/> Soft <input type="checkbox"/> Leather <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> CMT		
	<input type="checkbox"/> Bed Check System			<input type="checkbox"/> Bed Check System			<input type="checkbox"/> Bed Check System		
	<input type="checkbox"/> Isolation Type _____			<input type="checkbox"/> Isolation Type _____			<input type="checkbox"/> Isolation Type _____		
EQUIP / PREVENTION	Elastic Hose <input type="checkbox"/> Knee <input type="checkbox"/> Thigh			Elastic Hose <input type="checkbox"/> Knee <input type="checkbox"/> Thigh			Elastic Hose <input type="checkbox"/> Knee <input type="checkbox"/> Thigh		
	<input type="checkbox"/> Pneumatic Stockings			<input type="checkbox"/> Pneumatic Stockings			<input type="checkbox"/> Pneumatic Stockings		
	<input type="checkbox"/> Air Mattress <input type="checkbox"/> Egg Crate			<input type="checkbox"/> Air Mattress <input type="checkbox"/> Egg Crate			<input type="checkbox"/> Air Mattress <input type="checkbox"/> Egg Crate		
	<input type="checkbox"/> Therapeutic Bed _____			<input type="checkbox"/> Therapeutic Bed _____			<input type="checkbox"/> Therapeutic Bed _____		
	<input type="checkbox"/> Aqua K _____ <input type="checkbox"/> Sitz			<input type="checkbox"/> Aqua K _____ <input type="checkbox"/> Sitz			<input type="checkbox"/> Aqua K _____ <input type="checkbox"/> Sitz		
	<input type="checkbox"/> Ice _____			<input type="checkbox"/> Ice _____			<input type="checkbox"/> Ice _____		
	<input type="checkbox"/> Room Deodorizer <input type="checkbox"/> Trapeze			<input type="checkbox"/> Room Deodorizer <input type="checkbox"/> Trapeze			<input type="checkbox"/> Room Deodorizer <input type="checkbox"/> Trapeze		
MISC.	BM _____			BM <u>0</u>			BM _____		
	<input type="checkbox"/> 1:1 Nrsgr _____ hours			<input type="checkbox"/> 1:1 Nrsgr _____ hours			<input type="checkbox"/> 1:1 Nrsgr _____ hours		
	<u>02 sat monitor</u>			<u>Emotional Support (1:1)</u>					
				<u>Completed but needs doctor</u>					
	Care Plan - Review Initials <u>AD</u>			Care Plan - Review Initials <u>KP</u>			Care Plan - Review Initials _____		
	Initials - Responsible RN <u>AD</u>			Initials - Responsible RN <u>KP</u>			Initials - Responsible RN _____		
	Initials - Care Provider <u>AD</u>			Initials - Care Provider <u>KP</u>			Initials - Care Provider _____		

DATE \_\_\_\_\_

NIGHT

DAY

EVENING

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

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

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

INITIALS & SIGNATURES

<i>KP</i>			
<i>RP</i>			

### VITAL SIGNS RECORD

DATE	12-25			12-26			12-27			12-28			12-30								
TIME	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8
WRITE IN																					
104°																					
103°																					
102°																					
101°																					
100°																					
99°																					
98°																					
97°																					
WRITE IN																					
TEMPERATURE	100	99	98																		
PULSE	100	112	100																		
RESPIRATIONS	24	24	16																		
	AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM	
BP	12	136/76	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
	8	110/70	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
WEIGHT																					

MEDRC-2600

ST MARYS MEDICAL CENTER GREEN BAY  
(QAXPRG)

12/26/92 03:01

PAGE 001

=====
YAEGER, BARBARA A F 37
MR#: 0302379 ACCT#: 5589023
SERV: MEDI 3N-S 318
MD: TIBBETTS J. J. MD ADM: 12/25/92
DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA
=====

XXXX XXXX
X X X X X
XXXX X XXXX
X X X
X X

DISCHARGE REPORT

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

ALLERGIES:

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

LKAO
LKAO
LKAO

VITAL SIGNS:

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

MEDICATIONS:

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

PLUEMER KELLY RN
PEHLKE KAROLYN RN

OTHER PATIENT DATA:

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

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

CONTINUED

12/26/92 03:01 (QAXPRG)

PAGE 002

\*\*\*\*\*  
YAEGER, BARBARA A F 37  
MR#: 0302679 ACCT#: 5589023  
SERV: MEDI SN-S 318  
MD: FIBBETTS J. J. MD ADM: 12/25/92  
DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA  
\*\*\*\*\*

####  
\* \* \* \* \*  
#### \* \* \* \* \*  
\* \* \* \* \*  
\* \* \* \* \*

DISCHARGE REPORT

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

RESPIRATORY THERAPY NOTES:

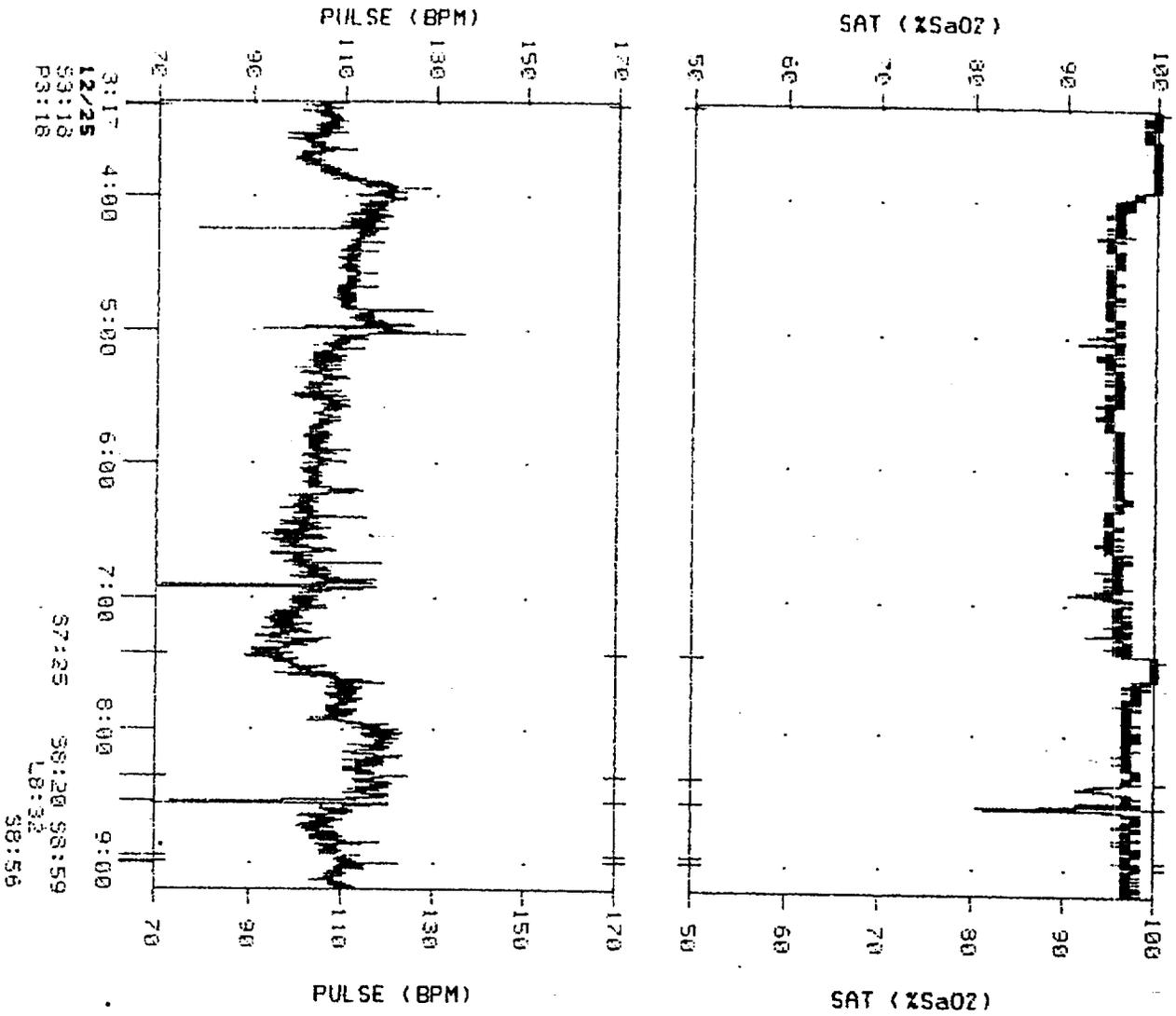
12/25 01:10	UPDRAFT NEBULIZER ALBUTEROL 0.083% IN 2.5ML NS....FIO2: OXYGEN. HEART RATE 112BPM BEFORE TX. HEART RATE 120BPM AFTER TX. COUGH STRONG HARSH NON-PROD BREATH SOUNDS DIMIN THROUGHOUT BEFORE TRT WITH- NO CHANGE AFTER TRT	IBAD
	COMMENTS:--PEAK FLOWS 200 LPM BEFORE TRT. 340 LPM AFTER TRT.	IBAD
12/25 03:15	O2 SETUP O2 HUM BOTTLE O2 VIA CANNULA SET UP O2 ON O2 FLOW AT 4LPM PULSE OX DAILY PULSE OX ELECTRODE OXIMETER ON ON O2 FLOW 4LPM	IBAD IBAD IBAD IBAD IBAD
12/25 03:45	UPDRAFT NEBULIZER ALBUTEROL 0.083% IN 2.5ML NS....FIO2: OXYGEN. HEART RATE 100BPM BEFORE TX. HEART RATE 110BPM AFTER TX. COUGH STRONG NON-PROD BREATH SOUNDS DIMIN THROUGHOUT BEFORE TRT WITH- NO CHANGE AFTER TRT	IBAD IBAD
12/25 07:15	UPDRAFT NEBULIZER ALBUTEROL 0.083% IN 2.5ML NS....FIO2: OXYGEN PEAK FLOW BEFORE 240LPM, PEAK FLOW AFTER 300LPM. HEART RATE 92BPM BEFORE TX. HEART RATE 100BPM AFTER TX. BRLATH SOUNDS: CLEAR AND DIMIN THROUGHOUT BEFORE TRT WITH- INCREASED AIR EXCHANGE AFTER TRT. COUGH SPONTANEOUS NON-PROD	IBAD JSAF
12/25 09:00	O2 DAILY O2 OFF PULSE OX DAILY	JSAF JSAF
12/25 10:15	UPDRAFT NEBULIZER TRT- NOT GIVEN. REASON: PT REFUSED. REASON: NOT NECESSARY	JSAF
12/25 11:30	OXIMETER HRS 8 OXIMETER NOTE: , OXIMETER OFF ,, DC'D PER ORDER	KMA SWAC
		SWAC

LASTPAGE

\*\*\*\*\*



PATIENT TREND GRAPH by NELLCOR



12/25  
59:18  
P3:18

57:25  
58:20  
58:32  
58:56



PATIENT CARE PLAN

PNEUMONIA

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

Date/Initial

DISCHARGE PLANS

Home  No Assistance  Assistance

Skilled Nursing Facility:

Rehabilitation Facility:

Other:

Signature/Initial

(Primary Nurse)

1. K.P. Tibbets J. J.
2. K.P. Tibbets J. J.
3. K.P. Tibbets J. J.
4. K.P. Tibbets J. J.

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

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

YAEGER, BARBARA A 3N-S  
 MR#:D302579 ADM:12/25/92 318  
 TIBBETTS J. J. MD 37 REL:LUTH  
 AC#:5589023 DOB:08/06/55 FC:7C

Expected Outcome	Nursing Intervention	Date Resolved/Initial
	because weakness & fatigue may be prolonged after pneumonia.	
	4. Notify physician if experiencing fever, chills, dyspnea, hemoptysis, or other signs of recurring pneumonia.	
	5. Encourage annual influenza or pneumococcal vaccines for those at greatest risk:	
	a. adults age 65 or older	
	b. adults with underlying chronic lung or cardiopulmonary disease.	
	c. adults with splenic dysfunction or other conditions associated with immunosuppression.	



# BROWN COUNTY PARAMEDIC REPORT

DATE: 12, 25, 92

SERVICE: GBFD

ID #: 168

STATION: 6

UNIT: R-6-B RUN #: 210880

Patient Name: BARBERA A. <del>YAEGER</del>		Requested By: Pt. / 911	Name: J STAUBER EMT #: 506 C HADZIMA 1276 S WOLFORD 38288	Milage:	Military Time
Patient Address: 800 STONY BROOK	City: GREEN BAY	Phone #:	DOB: 8, 06, 55	End: 10-76 00:30	Call Rec. 00:30
Loc. of Pickup: 800 STONY BROOK	Municipality: GREEN BAY	Age: 37	Doctor: TIBBETTS	Begin: 10-23 00:30	10-76 00:40
LOC: <input checked="" type="radio"/> Alert <input type="radio"/> Verbal <input type="radio"/> Pain <input type="radio"/> Unresp. <input type="radio"/> PNB	Weight: 130 #	Sex: M <input checked="" type="radio"/> F		Total: 10-7 00:40	10-8 00:50
Chief Complaint (Mech. of Injury): DYSPNOEA AFTER EXPOSURE TO AN AEROSOL LEATHER PROTECTOR, TOTAL EXPOSURE TIME 1/2 -> 3/4 HOURS.			ALLERGIES: NKA		

Home Meds. (Dosage, #/Day): NONE

Last Medical History: HEART MURMUR

Physical Assessment: ALERT ORIENTED X3. SKIN NORMAL X3. 90% HEAVY SENSATION @ LOWER CHEST WHICH INCREASES WITH INSPIRATION. RELIEF FROM PAIN & RESP. DISTRESS @ O<sub>2</sub> ADMIN. LUNGS SOUND CLEAR THROUGHOUT. @ JVA, PERIAL EDEMA.

Treatment Rendered (O<sub>2</sub>, Long Bd., Splints...): A<sub>1</sub>, O<sub>2</sub>, VITALS, TRANSPORT

Wil. Arrest?: Y/N Time Down?: \_\_\_\_\_ Prior CPR?: Y/N How Long?: \_\_\_\_\_ min. By Whom?: \_\_\_\_\_ CPR Adeq?: Y/N

TIME / EMT #	00:36	EMT #	:	EMT #								
ATROPINE	0.5 1.0		0.5 1.0		0.5 1.0		0.5 1.0		0.5 1.0		0.5 1.0	
50W												
EPINEPHRINE	0.5 1.0		0.5 1.0		0.5 1.0		0.5 1.0		0.5 1.0		0.5 1.0	
ASIX												
LECO BOLUS	50 75 100		50 75 100		50 75 100		50 75 100		50 75 100		50 75 100	
LEDO DRIP	2 3 4		2 3 4		2 3 4		2 3 4		2 3 4		2 3 4	
MORPHINE												
VARCAN												
VITROGLYCERIN	0.4		0.4		0.4		0.4		0.4		0.4	
12KG RHYTHM												
PERFUSION?	Y N		Y N		Y N		Y N		Y N		Y N	
BLOOD PRESSURE	124, 78		/		/		/		/		/	
PULSE	114 P		P		P		P		P		P	
RESPIRATIONS	24 R		R		R		R		R		R	
DEFIB JOULES	200 300 M		200 300 M		200 300 M		200 300 M		200 300 M		200 300 M	
OTHER DRUG/PROCEDURE	O <sub>2</sub> @ 10L NON-REBREATHER MASK.											
PUPILS	NORMAL											

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

COMMENTS:

ETA (Without Further Orders, Including Loading Time): \_\_\_\_\_ Min. NO TRANSPORT RELEASE SIGNED: Y/N

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

EMT In Charge: \_\_\_\_\_ Chart Review?: Y/N Page \_\_\_\_\_ of \_\_\_\_\_ Destination: St. V.  St. M.  Bellin  Other \_\_\_\_\_

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

PATIENT PROGRESS NOTES

Date	Time	Focus	D A R	D=Data	A=Action	R=Response
12/25	0315	Admission Note	D	37 yr. old female admitted from ER C/P SOB, nausea, chills & cough after using Wilson leather spray. Lungs are clear but diminished di. C/P SOB & turning ice dry cough. O2 on @ 4 l/min. O2 sat 100%. C/P nausea & turning abdomen soft & bowel sounds. Pt. pale. Skin warm & dry. Temp 100.8. IV site - asymptomatic. ——— K. Plummer		
	0345	comfort Airway clearance	D A D A	C/P headache Tylenol 4gr. given C/P tightness in chest. RT called to give treatment		
	0400	Resp	R	O2 off O2 sat 97%. SOB ↑. Slightly dyspneic @ rest. ——— K. Plummer		
	0500	Comfort Temp Resp	D D D	Denies further headache. Temp 99.8. "I'm breathing better." Able to rest. SOB ↑. ——— K. Plummer		
2-25-92	0915	Assessment	D:	Pt. is Alert & oriented x3. Skin pale, warm & dry. Lungs clear but diminished. No SOB at rest. Denies cough. O2 remains off. Abd. soft, nontender. BS x4. Denies nausea, headache or chills. No edema noted. IV site patent & asept. K. Plummer		
	1110	Discharge	A:	IV d/d. O2 stat monitor d/d. Discharge into general discharge per family. ——— K. Plummer		

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

**NURSING ADMISSION INTERVIEW**

Admission Date <i>12/25</i>	Time <i>0315</i>	Vital Signs			Orientation to Room	
Admitted Per <i>cart</i>	Room <i>318</i>	T <i>100.8</i>	P <i>100</i>	R <i>24</i>	Instructions in use of siderails	<i>L</i>
Admitted From <i>ER</i>	Accompanied By <i>ER Nurse</i>	SpO2 <i>138/76</i>	Ht. Wt.		Bed Operation	<i>L</i>
Admitting Dr. <i>Tibbetts</i>	Family Dr. <i>Tibbetts</i>	Stated/Actual	Stated/Actual		Nurse Call System	<i>L</i>
		Last Chest X-ray				
		<i>ER</i>				

**MEDICATIONS CURRENTLY TAKING**

(PRESCRIPTION AND OVER-THE-COUNTER)

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

Brought In: \_\_\_\_\_ Location Now: \_\_\_\_\_

**ALLERGY OR SENSITIVITY**

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

**NURSING HX ASSESSMENT**

RN or LPN Signature \_\_\_\_\_

**HEALTH PERCEPTION — HEALTH MANAGEMENT**

Chief Complaint/Reason for Admission:

*2000 spray w/leather spray*  
*2200 spray again*  
*2030 cough*  
*2230 - Nausea, SOB uncontrollable cough - Chills*

### HEALTH HISTORY

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

### NSG DIAGNOSIS

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

### NUTRITIONAL METABOLIC PATTERN

Special Diet <input checked="" type="checkbox"/>	Difficulty Swallowing <input checked="" type="checkbox"/>
Food Intolerances <input checked="" type="checkbox"/>	Handicaps related to eating <input checked="" type="checkbox"/>
Family Hx Diabetes - grandmother	Dentures: Upper Lower Bridge
Fad Diets <input checked="" type="checkbox"/>	Dentures Brought In <input checked="" type="checkbox"/>
Appetite good	Last Dental Exam:
M. loss or gain <input checked="" type="checkbox"/>	Oral mucous membranes/gums (color, moisture lesions)
Vausea/Vomiting <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> lesions
24hr recall of food/fluid:	
- fruit cup - bran muffin coffee green peas	Skin (color, temp, turgor, lesions, dryness, ecchymosis, other)
hungered - marked plethoric	pale (warm)
Alcoholic Beverages	<input checked="" type="checkbox"/> dry
occ	

### NSG DIAGNOSIS

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

### ELIMINATION PATTERN

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

### NSG DIAGNOSIS

Bowel Elimination Altered  
 Constipation  
 Diarrhea  
 Incontinence  
 Urinary Elimination Altered  
 Incontinence  
 Retention

### ACTIVITY EXERCISE

Self Care <input checked="" type="checkbox"/>	Assist of One	Leisure Activities
Requires use of Equipment/Devices		
		Smoking (duration, # pks/day) <input checked="" type="checkbox"/>
Gait/Falls Hx <input checked="" type="checkbox"/>		Smoking regulations explained <input checked="" type="checkbox"/>
Paralysis/Weakness <input checked="" type="checkbox"/>		Family Hx Heart or Lung Disease <i>lung - grand father</i>
Amputation/Prosthesis		
		Pulse Rate <i>100</i> Rhythm <i>regular</i>
Respiratory Rate <i>24</i>	Rhythm <i>regular</i>	Strength <i>strong</i>
Depth <i>normal</i>		Palpitations <input checked="" type="checkbox"/>
Cough <i>yes</i>	Sputum <input checked="" type="checkbox"/>	Chest Pains <i>yes slight</i>
Orthpnea <input checked="" type="checkbox"/>		Edema <input checked="" type="checkbox"/>
Dyspnea <i>yes</i>		Cyanosis <input checked="" type="checkbox"/>
Wheezing <input checked="" type="checkbox"/>		
Breath Sounds <i>clear but</i>		
Other		

### NSG DIAGNOSIS

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

### SLEEP REST PATTERN

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

### NSG DIAGNOSIS

- Sleep Pattern Disturbance

### COGNITIVE PERCEPTUAL PATTERN

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

### NSG DIAGNOSIS

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

**SEXUALITY REPRODUCTIVE PATTERN**

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

**NSG DIAGNOSIS**

Sexual Dysfunction  
Sexuality Patterns Altered  
Rape-Trauma Syndrome

**SELF PERCEPTION SELF CONCEPT**

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

**NSG DIAGNOSIS**

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

**ROLE RELATIONSHIPS COPING**

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

**NSG DIAGNOSIS**

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

**VALUE BELIEF PATTERN**

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

**NSG DIAGNOSIS**

Spiritual Distress



RISK OF FALL

CHECK CRITERIA WHICH APPLY

Date: \_\_\_\_\_ Time: \_\_\_\_\_

GENERAL - Each check = 2 points  
\_\_\_\_\_ History of prior falls

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

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

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

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

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

\_\_\_\_\_ DRESSING \_\_\_\_\_ AMBULATING \_\_\_\_\_ BATH \_\_\_\_\_ TO BR WITH ASSISTANCE

TOTAL POINTS: \_\_\_\_\_

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

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

Applied \_\_\_\_\_

Not applied: \_\_\_\_\_ Reasons: \_\_\_\_\_

Signature: \_\_\_\_\_

**DISCHARGE INSTRUCTIONS**

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

1. Your next appointment with Dr. Tibbets is \_\_\_\_\_

2. Activity/Care Instructions:

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

3. Diet: as tolerated

4. Medications:

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

5. Patient has:

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

I, the undersigned have read and understand the above.

[Signature] RN      12-25-92      [Signature]  
 Signature of Discharge Nurse      Date      Signature of Patient      Date



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

**HISTORY OF PRESENT ILLNESS:**

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

**PHYSICAL EXAMINATION:**

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

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

Neck: Supple.

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

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

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

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

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

**IMPRESSION:**

Acute chemical pneumonitis with bronchospasm, rule out lipoid pneumonia.

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

FEB 26 1993

IDI# 930104CCN0580

952/1646

Addendum to original report:

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

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

Dennis R. Blasius  
Milwaukee Resident Post

~~Product Code~~

EXHIBIT - 10

DOT# 9301140000000000

U.S. CONSUMER PRODUCT SAFETY COMMISSION

FEB 26 1993

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO WHOM IT MAY CONCERN:

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

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

( the case of BARBARA A. YAEGER  
Name

SELF  
Relationship to you

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

1/5/93  
(Date)

Barbara A. Yaeger  
(Signature)

Jerry J. Yaeger  
(Witness)



U.S. CONSUMER PRODUCT SAFETY

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

930104 CCN0580

January 7, 1993

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

Att: Medical Records Dept.:

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

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

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

Att: Investigator Dennis Blasius

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

Thank you for your prompt response.

Sincerely,

Dennis R. Blasius  
Investigator



United States Government  
Consumer Product Safety  
Commission

DENNIS R. BLASIUS  
Investigator

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

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

C  
P  
S  
C

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

ST MARYS MEDICAL CENTER GREEN BAY  
(QBPF\$P)

=====

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

=====

*AD*

\*\*\*\*\*  
\*\*\*\*\*  
\*\*\*\*\*  
\*\*\*\*\*  
\*\*\*\*\*

REF CLINIC: CITY: ADMISSION/DISCHARGE RECORD

CLK: DJW  
ADDR: 800 STONEY BROOK LA  
GREEN BAY WI 54304-  
PHONE: 414-499-6143 CO: BRN  
PREV NAME: SCHROEDER  
DOB: 08/06/55 MS: M

SSN: 398586783 F/C: 70  
RELIGION: LUTH  
CHURCH: PILGRIM  
PARISH CODE: LD16

EMPLOYER: FREEDOM SCHOOLS  
OCCUPATION: TEACHER

ER CONTACT I: JERRY  
PHONE: 414-499-6143 REL: HU  
WORK: 414-499-3131

ACCIDENT DATE:  
CAUSE:  
HOW ADMITTED: SQUAD

ER CONTACT II:  
PHONE:  
WORK: REL:

ADM DX: INHALATION PNEUMONITIS CHEMICAL PNEUMONIA  
LTR NOTE:

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

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

AUTOPSY? YES NO

PRINCIPLE DIAGNOSIS: *Acute bacterial pneumonia & bronchospas*

SECONDARY DIAGNOSIS:

COMPLICATIONS:

PROCEDURES: *medical*

*5-2-93  
5-16-93  
E-2621  
93.94*

*[Signature]*

-----, MD  
AT TENDING PHYSICIAN

*FR  
ABG*

*110*



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

## 1. INFORMED CONSENT FOR MEDICAL TREATMENT

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

## 2. INSPECTION OF HEALTH CARE RECORDS

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

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

## 3. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

4. ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT AGREEMENT

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

5. PATIENT VALUABLES

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

\_\_\_\_\_ PT WILL KEEP VALUABLES \_\_\_\_\_ DEPOSITED IN HOSPITAL SAFE

\_\_\_\_\_ GIVEN TO RELATIVE: \_\_\_\_\_  
(Name)

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

\_\_\_\_\_  
(Patient's Signature)

*Angela L. Young*  
\_\_\_\_\_  
(Person legally authorized to sign on patient's behalf and their relationship to the patient)

*DW*  
\_\_\_\_\_  
(Witness) *12-25-98*  
\_\_\_\_\_  
(Date)

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

**CHIEF COMPLAINT:**

Cough, shortness of breath, and trouble breathing.

**HISTORY OF PRESENT ILLNESS:**

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

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

**PAST MEDICAL HISTORY:**

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

**FAMILY HISTORY:**

Noncontributory except as outlined above.

**SOCIAL HISTORY:**

Noncontributory except as outlined above.

**REVIEW OF SYSTEMS:**

Noncontributory except as outlined above.

**PHYSICAL EXAMINATION:**

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

Yaeger, Barbara  
#302579  
Page 2  
Dr. Tibbetts

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

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

**INITIAL IMPRESSION:**

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

**DISPOSITION:**

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

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

10-21  
**CONSUMER PRODUCT INCIDENT REPORT**

1. NAME OF RESPONDENT  
 Siponda Washington

2. TELEPHONE NO. (Home) (Work)  
 (510) 814-0287

3. STREET ADDRESS  
 1509 Morton St, Apt. E

4. CITY STATE ZIP CODE  
 Alameda CA 94501

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

6. DATE OF INCIDENT(S)  
 ~12-15-92

7. IF INJURY OR NEAR MISS, OBTAIN AGE 30 SEX F AND DESCRIBE INJURY skin inflammation, blotches on leg.

8. IF VICTIM DIFFERENT FROM RESPONDENT, PROVIDE NAME La-Van Washington (9 years old) RELATIONSHIP son (headaches)

9. DESCRIPTION OF PRODUCT  
 leather protection spray

10. BRAND NAME  
 Wilson's Suede and Leather

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

12. MODEL, SERIAL NO.'S  
 ? 91492 (printed on bottom of can)

13. DEALER'S NAME, ADDRESS & PHONE  
 Wilson's Suede and Leather  
 Market St.  
 SF. CA

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

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

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

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

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

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

**FOR ADMINISTRATION USE**

20. DATE RECEIVED  
 2-23-93

21. RECEIVED BY (Name & Office)  
 LP / SFRO

22. DOCUMENT NO.  
 F320240

23. FOLLOW-UP ACTION  
 None

24. PRODUCT CODE(S)

25. DISTRIBUTION  
 C: EPAS cc: SFRO

26. ENDORSER'S NAME & TITLE  
 JFD Jay.

RADLG-1728  
12/26/92 09:54

ST MARYS-MEDICAL CENTER GREEN BAY  
(QAIPRR)

PAGE 001

=====

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

=====

PRELIMINARY  
RADIOLOGY  
RESULTS

=====

REQ#: I-360-002

=====

REFERRING CLINIC:  
CONSULTANTS:

=====

REF MD ADDR:

DX: INHALATION PNEUMONITISCHEMICAL PNEUMONIA

ORDER: CHEST, PA & LAT (ROUTINE)    2.01

=====

PRELIMINARY REPORT

FILE #: 206-693

DATE OF EXAM: 12/25/92

CHEST WITH LATERAL:

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

IMPRESSION:

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

CW

  
-----  
HF

LASTPAGE

FINAL COPY  
**CALL REPORT**

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=====
YAESER, BARBARA A          F 37 DISCH MEDICAL
M.R.#: 0302579    ADM MD: TIBBETTS J. J. MD    3N-3
ACCT#: 5589023    ATT MD: TIBBETTS J. J. MD    318
ADM: 12/25/92 00:50
DOB: 08/06/55     REF MD: TIBBETTS J. J. MD
=====

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REFERRING CLINIC:
CONSULTANTS:
REF MD ADDR:

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REPORT PERIOD: 00:50 12/25/92 - 00:00 12/26/92
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* = NEW RESULT  H = HIGH RESULT  L = LOW RESULT
O = ORIGINAL RESULT  M = MODIFIED RESULT
=====

```

BLOOD COUNTS

TEST	12/25	02:10		RANGE/UNITS
WBC	25.1		H*	3.0-10.5 K/UL
RBC	4.67		*	3.7-5.2 MIL/UL
HGB	12.4		*	11.8-15.8 GM/DL
HCT	37.4		*	35-46 %
MCV	81.0		*	80-98 CU U
MCH	26.8		L*	27-34 UUG
MCHC	33.2		*	32-36 %
RDW	38.3		*	35-47 CU U
MPV	10.1		*	CU U
PLT CT	403		*	140-440 K/UL
BAND	11		*	%
NEUT	78		*	%
LYMPH	5		*	%
MONO	6		*	%
TECH HEM	LK		*	%
TECH DIFF	LK		*	%



=====
YAEGER, BARBARA A F 37
MR#: 0302579 ACCT#: 3589023
SERV: MEDI 3N-S 318
MD: FIBBETS J. J. MD ADM: 12/25/92
DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA
=====

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\* \* \* \* \*
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DISCHARGE REPORT

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

NEW ORDERS ENTERED FOR THE DAY:

12/25/92 01:04

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

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

12/25/92 01:04

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

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

12/25/92 01:57

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

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

12/25/92 03:30

- 5. ACTIVITIES, UP, AS TOL, (TAB).
6. DIET: GENERAL, (TAB).
7. RESPIRATORY THERAPY NASAL CANNULA.
O2 FLOW AT 4 LPM--TO KEEP O2 SAT > 95%, (TAB).
8. RESPIRATORY THERAPY OXYGEN SAT % PULSE OXIMETER, CONTINUOUS
SAT% MONITOR, (TAB).
9. RESPIRATORY THERAPY UPDRAFT NEBULIZER.
ALBUTEROL --Q 3-4 PRN, OTHER--WHEEZING, (TAB).
10. PREDNISONE 20MG TAB, #1, PO, BID 8-17 MEALS --(GIVE WITH FOOD),
(12/26/92 0800-..), (TAB).
11. IV LINE #1- START D5/.9% NS 100UML, RATE:125ML/H, CONT TIL DC'D
, (TAB).
12. TYLENOL ACETAMINOPHEN 325MG TAB, #2, PO, Q4H PRN--FOR PO TEMP >
101, (TAB).

ENTERED BY: KLAWITTER LINDA NUR FROM ORDER

CONTINUED

12/26/92 03:01

(QAXPRG)

PAGE 002

YAEGER, BARBARA A

F 37

MR#: 0302579

ACCT#: 3589023

SERV: MEDI

3N-8 318

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

DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA

ENR	ENR	ENR
Y	X	X
U	X	X
F	X	X
ENR	X	ENR

DISCHARGE REPORT

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

ENTERED FOR: TIBBETTS J. J. MD

**SIGNED**

SIGNATURE:-----

12/25/92 10:32

13. DISCHARGE PATIENT TODAY.

TO: HOME, (T) ..

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

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

ENTERED BY: MORELLO DIANE

NUR

WRITTEN ORDER

ENTERED FOR: TILKENS T. N. DPM

12/25/92 10:43

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

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

ENTERED BY: MORELLO DIANE

NUR

ADJUSTING ORDERS

12/25/92 10:44

18. (DELETE) DISCHARGE PATIENT TODAY.

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

ENTERED BY: MORELLO DIANE

NUR

ADJUSTING ORDERS

CONTINUED

12/26/92 08:01 (QAXPRG)

PAGE 000

\*\*\*\*\*  
YAEGER, BARBARA A F 37  
MR#: 0302579 ACCT#: 5589023  
SERV: MEDI 3N-S 318  
MD: TIBBETTS J. J. MD ADM: 12/25/92  
DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA  
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\* \* \* \* \*  
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DISCHARGE REPORT

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

12/25/92 10:46

- 19. DISCHARGE PATIENT TODAY.  
TO: HOME, (TAB).
  - 20. MAXAIR PIRBUYEROL ACETATE INHALER AEROSOL 25.6 GM TAKE HOME, 1 CONTAINER, TWO INHALATIONS EVERY 4 TO 6 HOURS IF NEEDED--  
WHEEZING, (TAB).
  - 21. PREDNISONE 10MG TAB, TAKE HOME, #10 , TAKE 2 TABLETS THREE TIMES A DAY--WITH FOOD, (TAB).
- ENTERED BY: MORELLO DIANE. NUR WRITTEN ORDER  
ENTERED FOR: TIBBETTS J. J. MD

-----  
THERE WERE NO ORDERS HELD TODAY  
-----

NO ORDERS WERE COUNTERSIGNED TODAY  
-----

-----  
--COMPLETED ORDERS FOR THE DAY--  
-----

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

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

COMPLETED BY: WAUTERS, SHREE ATRES SWA  
12:02 12/25/92

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

LASTPAGE







**CLINICAL PROFILE**

NIGHT

DATE 12/25/92

DAY

-02

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

EVENING

DIET	BREAKFAST	LUNCH	SUPPER
	G F P	G F P	G F P
	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Feed		
HYGIENE	Bath	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete <input type="checkbox"/> Shave <input type="checkbox"/> Tub <input type="checkbox"/> Shower	
	Mouth Care	_____	
	Skin Care	_____	
ACTIVITY	Sleep	<input type="checkbox"/> Good <input checked="" type="checkbox"/> Poor <input type="checkbox"/> Intervals	
	Bedrest Turn	self	
	CDB	enc Suction	
SAFETY	BRP	<input type="checkbox"/> Commode <input type="checkbox"/> Elev. Toilet <input type="checkbox"/> Assist <input type="checkbox"/> Urinal <input type="checkbox"/> Bedpan	
	Up In Chair	<input type="checkbox"/> Self <input type="checkbox"/> Hoyer With help (1, 2, 3) Length of time _____ Tolerance G F P	
	Up In Hall	<input type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2) Tolerance G F P Distance _____	
EQUIP / PREVENTION	Call Bell in Reach	Side Rails <u>2/2</u>	
	Vest Restraint	<input checked="" type="checkbox"/> Bed Low Position	
	Restraints	<input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> All <input type="checkbox"/> Soft <input type="checkbox"/> Leather <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> CMT	
MISC.	Elastic Hose	<input type="checkbox"/> Knee <input type="checkbox"/> Thigh	
	Pneumatic Stockings	_____	
	Air Mattress	<input type="checkbox"/> Egg Crate	
Care Plan - Review Initials <u>AB</u> Initials - Responsible RN <u>AB</u> Initials - Care Provider <u>AB</u>			

DIET	BREAKFAST	LUNCH	SUPPER
	G F P	G F P	G F P
	<input checked="" type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Feed		
HYGIENE	Bath	<input checked="" type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete <input type="checkbox"/> Shave <input type="checkbox"/> Tub <input checked="" type="checkbox"/> Shower	
	Mouth Care	self	
	Skin Care	self	
ACTIVITY	Sleep	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input checked="" type="checkbox"/> Intervals	
	Bedrest Turn	self	
	CDB	enc Suction	
SAFETY	BRP	<input type="checkbox"/> Commode <input type="checkbox"/> Elev. Toilet <input checked="" type="checkbox"/> Assist self <input type="checkbox"/> Urinal <input type="checkbox"/> Bedpan	
	Up In Chair	<input checked="" type="checkbox"/> Self <input type="checkbox"/> Hoyer With help (1, 2, 3) Length of time <u>PRN</u> Tolerance <u>G</u> F P	
	Up In Hall	<input checked="" type="checkbox"/> Self <input type="checkbox"/> Assist (1, 2) Tolerance <u>G</u> F P Distance <u>to Shower</u>	
EQUIP / PREVENTION	Call Bell in Reach	Side Rails <u>2/2</u>	
	Vest Restraint	<input type="checkbox"/> Bed Low Position	
	Restraints	<input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> All <input type="checkbox"/> Soft <input type="checkbox"/> Leather <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> CMT	
MISC.	Elastic Hose	<input type="checkbox"/> Knee <input type="checkbox"/> Thigh	
	Pneumatic Stockings	_____	
	Air Mattress	<input type="checkbox"/> Egg Crate	
Care Plan - Review Initials <u>KP</u> Initials - Responsible RN <u>KP</u> Initials - Care Provider <u>KP</u>			

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

DATE \_\_\_\_\_

NIGHT

DAY

EVENING

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

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

DIET	BREAKFAST	LUNCH	SUPPER
	G F P	G F P	G F P
	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Feed		
HYGIENE	Bath	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Complete <input type="checkbox"/> Shave <input type="checkbox"/> Tub <input type="checkbox"/> Shower	
	Mouth Care	_____	
	Skin Care	_____	
ACTIVITY	Sleep	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Intervals <input type="checkbox"/> Bedrest Turn _____	
	CDB	_____ Suction _____	
	Assist	<input type="checkbox"/> BRP <input type="checkbox"/> Commode <input type="checkbox"/> Elev. Toilet <input type="checkbox"/> Urinal <input type="checkbox"/> Bedpan	
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	Room Deodorizer	<input type="checkbox"/> Trapeze	
MISC.	BM	_____	
	1:1 Nrsng	_____ hours	
	Care Plan - Review Initials	_____	
	Initials - Responsible RN	_____	
	Initials - Care Provider	_____	

INITIALS & SIGNATURES

KP <i>[Signature]</i>					
KP <i>[Signature]</i>					

### VITAL SIGNS RECORD

DATE	12-25			12-26			12-27			12-28			12-30								
TIME	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8
WRITE IN ↗																					
104°																					
103°																					
102°																					
101°																					
100°																					
99°																					
98°																					
97°																					
WRITE IN ↘																					
TEMPERATURE	100.4	99.8	99.7																		
PULSE	100	102	100																		
RESPIRATIONS	20	24	16																		
	AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM	
BP	12	138/70	12	12	12		12	12		12	12		12	12		12	12		12	12	
	4	4		4	4		4	4		4	4		4	4		4	4		4	4	
	8	110/70	8	8	8		8	8		8	8		8	8		8	8		8	8	
WEIGHT																					

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YAEGER, BARBARA A F 37  
MR#: 0302379 ACCT#: 5589023  
SERV: MEDI 3N-S 318  
MD: TIBBETTS J. J. MD ADM: 12/25/92  
DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA

DISCHARGE REPORT

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

ALLERGIES:

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

VITAL SIGNS:

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

MEDICATIONS:

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

OTHER PATIENT DATA:

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

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

CONTINUED

12/26/92 08:01

(QAXPRG)

PAGE 002

YAEGER, BARBARA A

F 37

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MR#: 0302679

ACCT#: 5589023

SERV: MEDI

SN-S 318

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

DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA

DISCHARGE REPORT

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

RESPIRATORY THERAPY NOTES:

12/25 01:10 UPDRAFT NEBULIZER IBAD  
 ALBUTEROL 0.083% IN 2.5ML NS....FIO2: OXYGEN.  
 HEART RATE 112BPM BEFORE TX. HEART  
 RATE 120BPM AFTER TX. COUGH STRONG  
 HARSH NON-PROD BREATH SOUNDS DIMIN  
 THROUGHOUT BEFORE TRT WITH- NO CHANGE  
 AFTER TRT IBAD  
 COMMENTS:--PEAK FLOWS 200 LPM BEFORE TRT. 340  
 LPM AFTER TRT. IBAD

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

12/25 03:45 UPDRAFT NEBULIZER IBAD  
 ALBUTEROL 0.083% IN 2.5ML NS....FIO2: OXYGEN.  
 HEART RATE 100BPM BEFORE TX. HEART  
 RATE 110BPM AFTER TX. COUGH STRONG  
 NON-PROD BREATH SOUNDS DIMIN  
 THROUGHOUT BEFORE TRT WITH- NO CHANGE  
 AFTER TRT IBAD

12/25 07:15 UPDRAFT NEBULIZER JSAF  
 ALBUTEROL 0.083% IN 2.5ML NS....FIO2: OXYGEN  
 PEAK FLOW BEFORE 230LPM, PEAK FLOW  
 AFTER 300LPM. HEART RATE 92BPM  
 BEFORE TX. HEART RATE 100BPM AFTER  
 TX. BREATH SOUNDS: CLEAR AND DIMIN  
 THROUGHOUT BEFORE TRT WITH-  
 INCREASED AIR EXCHANGE AFTER TRT.  
 COUGH SPONTANEOUS NON-PROD JSAF

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

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

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

LASTPAGE



PATIENT TREND GRAPH by NELLCOR

