

01/08/93 07:33 301 504 0358  
SENT BY: CDC:NCEH:EHHE:LPPB ; 1- 8-93 ; 8:16PM :

Western Region 005/005  
(404) 488-7335- 301 504 0358: # 1 / 4

**CENTERS FOR DISEASE CONTROL FACSIMILE TRANSMISSION**

DATE 1-5

TO: Chuck Jacobson

CPSC

PHONE: \_\_\_\_\_

FAX: 301-504-0359

FROM: **DR. RUTH ETZEL**  
Chief, Air Pollution and Respiratory Health Branch  
Division of Environmental Hazards and Health Effects  
National Center for Environmental Health  
Centers for Disease Control  
Mailstop F39  
4770 Buford Highway, N.E.  
Atlanta, GA 30341-3724

Phone: 404-488-7320

FAX: 404-488-7335/7310

Subject: draft of MMWR

Pages to follow: 3



January 8, 1983 / Vol. 41 / Nos. 52 & 53

# M M W R

*Second Proof*

MORBIDITY AND MORTALITY WEEKLY REPORT

## Epidemiologic Notes and Reports

### **Respiratory Illness Linked to Use of Aerosol Leather Conditioner — Oregon, December 1982**

Early on December 27, 1982, the Oregon Poison Control Center (OPCC) notified the Oregon Health Division (OHD) of 13 persons in one household who became ill following the use of an aerosol leather conditioner. This report was similar to calls received on December 26, which alerted the OPCC to a possible cluster of reports related to the product. Late on December 27, the product producer issued a voluntary recall of this product. Following the public announcement of the recall, as of December 31, the number of preliminary reports to the OHD and the OPCC of illness associated with the spray increased to 400 and involved approximately 650 persons. This report summarizes the preliminary investigation of this problem by the OHD.

Although the cluster of reports was recognized by the OPCC on December 27, a subsequent review of telephone logs identified calls on December 23 and on December 26 involving a total of 29 persons in six households who reported illness associated with the spray. Among persons who reported seeking medical attention, symptoms reportedly began within a few minutes to several hours (range: 2 minutes to 3 hours) after using the spray to apply conditioner to leather products. Manifestations of the illness most commonly reported included prolonged cough, shortness of breath, and chest pain (described as burning or squeezing). Persons who contacted the OPCC complained of headache, malaise, and fever as high as 102 F (39 C). At least three persons exhibited signs of pulmonary infiltrates based on radiographic examination; one person was admitted to a hospital with a diagnosis of adult respiratory distress syndrome. At least four other persons were admitted to hospitals for observation or treatment. For most persons, the symptoms appeared to resolve in less than 24 hours.

Following the prompt voluntary recall, by December 31, approximately 275,000 of a possible 350,000 cans of leather protector were removed from stores and distribution channels. The cans are not marked with specific lot identifiers. The OHD and CDC

01/08/93 09:23 AM  
01/08/93 07:48 301 504 0358  
SENT BY: CDC:NCEH:EHHE:LPPB 1- 5-83 : 6:17PM :

Western Region 003/004  
(404) 488-7335 301 504 0358: # 3/ 4

688

MMWR

January 8, 1993

### **Aerosol Leather Conditioner — Continued**

are conducting epidemiologic investigations and research studies to further define the association between illness and use of this product.

*Reported by: M. Emilstein, MD, Oregon Health Sciences University's Poison Control Center; W. Keene, PhD, D. Fleming, MD, State Epidemiologist, Health Div, Oregon Dept of Human Resources, Air Pollution and Respiratory Health Sr, Div of Environmental Hazards and Health Effects, National Center for Environmental Health; Div of Field Epidemiology, Epidemiology Program Office, CDC.*

**Editorial Note:** Preliminary information indicates the outbreak is associated with the use of Wilson's Leather Protector distributed nationally by Wilson's, the Leather Experts, headquartered in Minneapolis. Leather Protector is sold nationally at more than 550 stores owned by Wilson's; the stores are operated under several names. Typically, one or two applications of the protector are intended to be applied to new leather garments. Preliminary information suggests that some persons who experienced symptoms had used the product indoors or in other areas with limited ventilation. The new product was distributed to Wilson's stores in late November 1992; however, stores did not sell the new product until the old product supply was exhausted. Sales of the product in Oregon began during December 20-25, 1992.

From December 27 through December 31, 1992, following publicity and contact by the OHD and CDC, poison centers in at least 17 other states reported persons who experienced spray-associated symptoms; poison centers in California received at least 70 such reports; Washington, 40; and Colorado, 35. Reports were also received from Georgia, Idaho, Maine, Massachusetts, Minnesota, New Hampshire, New York, Ohio, Pennsylvania, Utah, Vermont, Virginia, West Virginia, and Wisconsin.

The product is packaged in 5-ounce black aerosol cans with red and white lettering. The cans are a new formulation of Wilson's Leather Protector that had previously been sold in a 7-ounce can. The new formulation is made exclusively for Wilson's. The major product changes involved a shift from carbon dioxide to propane as the propellant and from 1-1-1 trichloroethane to isooctane as the solvent. The 5-ounce can of leather protector spray contains 1.2% FC-3237, a proprietary solution of a fluorosilyl polymer.

The most commonly reported symptoms suggest an acute chemical pneumonitis (1) or a hypersensitivity pneumonitis (2). Some patients have had symptoms consistent with inhalation fevers such as polymer-fume fever (e.g., chest tightness, headache, shivering, fever, weakness, and shortness of breath). This syndrome is caused by inhalation of fumes containing pyrolytic products released when fluoropolymers are heated to high temperatures. In most cases, patients with polymer-fume fever have been cigarette smokers (3,4). However, it is also possible that an unknown contaminant in the leather spray may be causing this illness.

Persons should be warned against using Wilson's Leather Protector. In addition, any spray containing polymers or solvents should only be used in areas where there is adequate ventilation.

A provisional case definition used by the OHD includes the onset of any pulmonary symptom (i.e., chest pain, shortness of breath, and nonproductive cough) 8 hours or less after exposure and either radiographic evidence of pulmonary infiltrates or at least two pulmonary symptoms and at least one pulmonary symptom lasting 12 hours or more. CDC has requested that state health departments report cases to CDC using a standardized case report form available from CDC's Air Pollution and Respiratory

Vol. 41 / No. 52 & 53

MMWR

867

*Aerosol Leather Conditioner—Continued*

for Environmental Health, telephone (404) 485-7320. Further consumer information regarding this product is available from the Consumer Product Safety Commission, telephone 800 628-2772.

**References**

1. Wae OF, Healy KM, Sheppard G, Tong TG. Chest pain and hypoxemia from inhalation of a trichloroethane aerosol product. *J Toxicol Clin Toxicol* 1983;20:333-41.
2. Fink JN. Hypersensitivity pneumonitis. In: Epier GR, ed. *Clinics in chest medicine: occupational lung diseases*. Philadelphia: W. B. Saunders 1982.
3. Lewis CE, Kirby GR. An epidemic of polymer fume fever. *J Am Med Assn* 1966;191:274-8.
4. Albrecht WN, Bryant CJ. Polymer fume fever associated with smoking and use of a mold-release spray containing polytetrafluoroethylene. *J Occup Med* 1987;29:517-8.

Current Trends

**Air Pollution Information Activities at State and Local Agencies — United States, 1992**

Because air pollution is a pervasive environmental health problem in the United States, one of the national health objectives for the year 2000 is to increase from 49.7% to 85.0% the proportion of persons who live in counties that have not exceeded any air quality standard during the previous 12 months (7). Public support for air pollution control efforts is critical if the national health objective is to be achieved. To characterize public health information activities related to air pollution, in 1992, the State and Territorial Air Pollution Program Administrators (STAPPA) and the Association of Local Air Pollution Control Officials (ALAPCO), with the assistance of CDC, conducted a survey of state and local air pollution control agencies. This report summarizes the findings of that survey.

In July 1992, a questionnaire was mailed to 228 state, territorial, and local air pollution control agencies. Agencies that did not respond were contacted by telephone. The questionnaire sought information on attainment of National Ambient Air Quality Standards, publication of an air quality index (e.g., the Pollutant Standards Index [PSI]<sup>1</sup>), issuance of forecasts or warnings, communication with outside health officials, distribution of educational materials, and evaluation of health information and on air pollution issues of greatest concern to the community. Of the 88 STAPPA agencies, 48 (57%) responded to the questionnaire; of the 170 ALAPCO agencies, 149 (88%) responded (overall response rate: 82%). Together, responding agencies represented 48 states, the District of Columbia, and the Virgin Islands. No agency was represented more than once.

Of the 197 respondents, 124 (63%) represented jurisdictions that had exceeded one or more National Ambient Air Quality Standards during the preceding 3 years. State and local agencies that represented such areas were more likely to calculate the PSI—

<sup>1</sup>The PSI converts the daily measured concentrations of five major pollutants (ozone, carbon monoxide, particulate matter, nitrogen dioxide, and sulfur dioxide) into a number on a scale of 0-500. The index value of 100 corresponds to the National Ambient Air Quality Standard for that pollutant. Intervals on the PSI scale are associated with descriptive terms (e.g., "good" [0-50], "moderate" [50-100], or "unhealthy" [100-500]).

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U.S. CONSUMER PRODUCT SAFETY COMMISSION

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AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

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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 Huong Thi Gilmore  
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.

1-31-93  
(Date)

Huong Thi Gilmore  
(Signature)

Jennil E. Wearst  
(Witness)

E/F

### FIELD ACTIVITY COVERSHEET

1. REGION/STATE  FOCR	2. OPERATION (Check One) <input type="checkbox"/> Inspection <input type="checkbox"/> Telephone Contact <input type="checkbox"/> Other <input checked="" type="checkbox"/> Establishment Visit <input checked="" type="checkbox"/> Investigation	3. DATE
		4. NUMBER (For RO Use) 930111CCN0667

5. ESTABLISHMENT  
 Name Wilson's  
 Address \_\_\_\_\_  
 City Minneapolis State Mn. Zip 55426 Telephone No. \_\_\_\_\_

6. RELATED FIRM Name \_\_\_\_\_  
 Parent  Headquarters  Subsidiary  Other  
 City \_\_\_\_\_ State \_\_\_\_\_

7. PRODUCTS COVERED  
Leather Protector Spray

8. OTHER CONSUMER PRODUCTS  
 \_\_\_\_\_  
 \_\_\_\_\_

9. ESTABLISHMENT TYPE  
 Manufacturer  Importer  
 Wholesaler  Own Label Distributor  
 Retailer  Repackager  
 Other \_\_\_\_\_

10. ANNUAL PRODUCTION  
 Product Covered \$ \_\_\_\_\_ Units \_\_\_\_\_  
 Other Products \$ \_\_\_\_\_ Units \_\_\_\_\_

11. L.S. BUSINESS  
 % Received \_\_\_\_\_  
 % Shipped \_\_\_\_\_

12. SAMPLES COLLECTED

13. MIS CODE  
33672

14. HOURS  
 Activity 12.0  
 Travel 4.0

15. REASON FOR ACTIVITY (Assignment Reference)  
Workplan assignment.

16. ANNOUNCED  Rationale for Announced Inspection  
 UNANNOUNCED

17. EMPLOYEE'S NAME Janice L. Mitchell, 8111	TITLE Investigator	SIGNATURE <i>J Mitchell</i>
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18. ( ) ENDORSEMENT ( ) REMARKS ( ) SUMMARY ( ) OTHER

A 43 year old male and his 17 year old son suffered adverse respiratory problems after being exposed to chemical fumes resulting from the use of an aerosol-type "leather protector" product. Both victims were treated at a hospital emergency room and released. Some residual symptoms, to include coughing, continued for 10-14 days.

The "leather protector" involved in this incident, manufactured by Wilson's, has been implicated in other similar incidents.

F/U: Refer to FOCR Compliance.

19. REVIEWER'S NAME William E. Gentry, #8007	TITLE S.P.S.I.	SIGNATURE <i>W E Gentry</i>
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20. REVIEW DATE 2/24/93 21. DISTRIBUTION  
 O: EPDS, C: [redacted] FOCR(COMP), CECA, CERM, CS: BG, RF, NSH-RP

282

# EPIDEMIOLOGIC INVESTIGATION REPORT

1. CASE NO. 930111CCN0667		2. INVESTIGATOR'S ID 8 1 1 1		3. OFFICE CODE 8 3 0	
4. DATE OF ACCIDENT YR MO DAY 9 2 1 2 2 5		5. DATE INVESTIGATION INITIATED YR MO DAY 9 3 0 1 2 8			
6. SYNOPSIS OF ACCIDENT OR COMPLAINT On 12-25-92 at approximately 0830 hours, a 43 year old male and his 17 year old son suffered chemical pneumonia after entering a room in which a leather protector had been applied to a coat. Both were treated and released at a local emergency room.					
7. LOCATION (Home, school, etc.) Home (Niece's bedroom)		8. CITY Raleigh		9. STATE Tennessee T N	
10A. FIRST PRODUCT Leather protector 0 9 5 2		11A. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS Wilson's Leather Protector, 5 oz. Wilson's, Minneapolis, Mn. 55426			
10B. SECOND PRODUCT n/a		11B. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS n/a			
12. AGE OF VICTIM 0 4 3		13. SEX (Use numerical code) MALE -1 FEMALE -2 UNKNOWN -3 1		14. DISPOSITION T & R 1	
15. INJURY DIAGNOSIS Chemical pneumonia (vapor inhalation) 6 8		16. BODY PART All 8 5		17. RESPONDENT(S) (Mother, Friend) Victim 1	
18. TYPE INVESTIGATION ON SITE 1 TELEPHONE 2 OTHER 3 1		19. TIME SPENT 1 2 0		20. ATTACHMENTS Multi 9	
21. CASE SOURCE Newspaper 0 5		22. REVIEWED BY 8007 530 2 2 4			
23. PERMISSION TO DISCLOSE NAMES (NON-HESS CASES ONLY) CPSC MAY DISCLOSE MY NAME <input checked="" type="checkbox"/> X CPSC MAY NOT DISCLOSE MY NAME <input type="checkbox"/>		24. NARRATIVE (See instructions on Other Side)			
		25. REGIONAL OFFICE DIRECTOR REVIEW DATE			

Narrative begins on page 2.

MFR/PRV/BR NOTIFIED  
 No comments made  
 Comments attached  
 2562  Excisions/Revisions  
 Firm has not requested further notice  
 6/28/94  
*[Signature]*

(USE OTHER SIDE AND ADDITIONAL SHEETS IF NECESSARY)

930111CCN0667

Pre-Accident

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

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

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

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

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

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

Accident

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

Post-Accident

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

930111CCN0667

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

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

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

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

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

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

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

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

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

901.

930111CCN0667

Product Information:

Product

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

Manufacturer/Distributor

Wilson's  
Minneapolis, Ms. 55426

Product Code

"292" stamped on bottom of can

Standards Information:

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

Attachments:

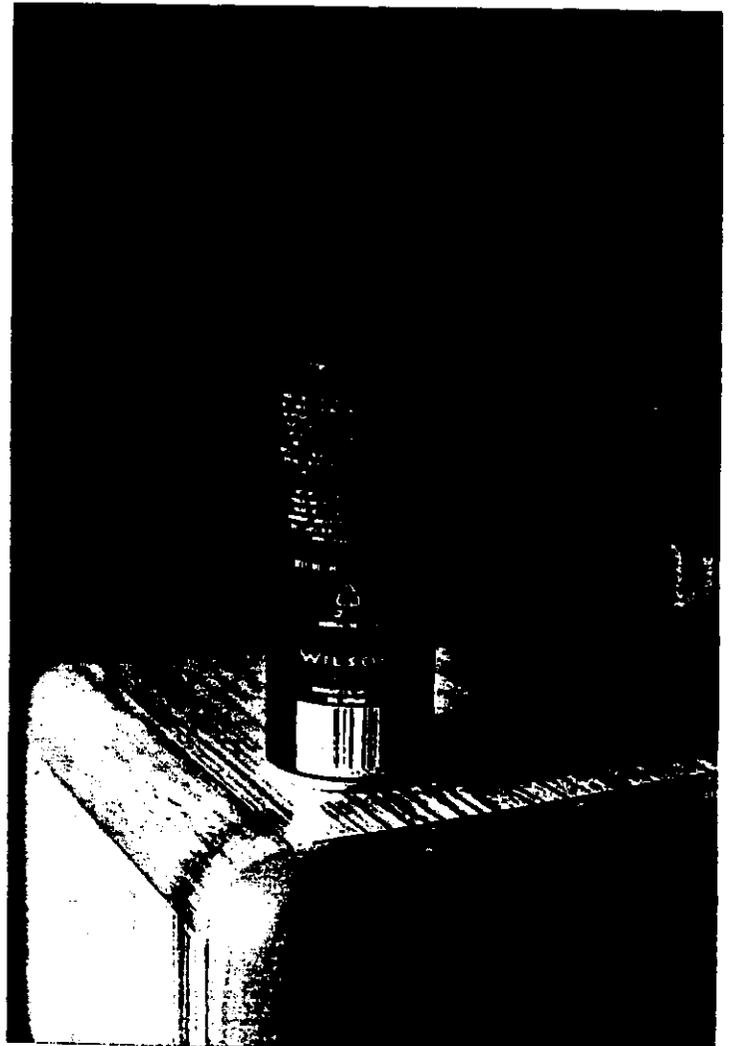
1. Photographs
2. Authorization to Release Name
3. Medical Records Disclosure
4. Medical Records
5. Poison Control Records
6. Diagram of room
7. Assignment

930111CCN0667  
attachment #1



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

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



930111CCN0667  
attachment #1

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



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U.S. CONSUMER PRODUCT SAFETY COMMISSION

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AUTHORIZATION FOR RELEASE OF NAME

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

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

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

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

My identity is to remain confidential.

Donald Leon Adams  
(Signature)

1-30-93  
(Date)

U.S. CONSUMER PRODUCT SAFETY COMMISSION

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO WHOM IT MAY CONCERN:

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

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

Relationship to you

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

1/30/93  
(Date)

Ronald L. Adams  
(Signature)

Janice L. Mitchell  
(Witness)

METHODIST

MEDICAL RECORDS

930111000667  
attachment 4

ITEM NO. 1  
FAC 10/9

PATIENT NAME ER23798234  
 ADAMS DONALD L 43 JMM 1620588-001  
 REFERRING PHYSICIAN 000000 NO REFER. DR.  
 ACCOUNT NUMBER E-35442

PERSONAL PHYSICIAN NONE  
 EMER. RM. CHG. 40  
 M & S SUPPLIES  
 PHYSICIAN FEE 00  
 OTHER CHARGES  
 AMOUNT PAID

DATE TIME LOCATION POLICE NOTIFIED TIME AM PM FAMILY NOTIFIED  
 2-25-92 11:24  
 DATE OUT 2/25/92 1:43  
 ADMITTING PHYSICIAN (INITIAL LAST)

ALLERGIES NKDA  
 BROUGHT BY PRIVATE VEHICLE  
 AMB. NO. MS. 1 EG MS. 2 P

CHEF COMPLAINT DIFF BREATHING/INHALED CHEMICALS

HISTORY & PHYSICAL  
 43yo M presented with difficulty breathing - 14 hrs  
 @ home 2 other people involved Present Small  
 box of heavy cardboard & leather bound card  
 some other heavy cardboard pieces  
 Bedroom  
 heavy sheets both been  
 used -> R. useful

TIME	S/P	T	F
1255	100	101	116
1415	100	101	112

CBC	WBC
	15.1
HGB	
DIFF	
NA	K
CL	CO2
BUN	GLU
UA	

IMPRESSION: Pneumonia

ORDERS: ACC, 7-04K -> R. useful  
 ABG's  
 Ergin  
 No-Tuss

DATE OF LAST TETANUS  
 CURRENT MEDICATIONS: none  
 AFM BAND ON  
 SERIALS

NURSES NOTES: Ambul to room # 7: c family in Am. sleeping with in coat. Note  
 (340) white male pt ambul to room # 7 @ 9:0: diff breathing + coughs +  
 7 temp. - during being sick - or having sleep longer in class. pt does  
 small 1pk/day. 2 tylenol po for temp 1305 (10/10/92)

ATTENDING M.D. CALLED HOME OFFICE EXCHANGE PAGED AT  
 PHYSICIAN COMMUNICATION

DISPOSITION AND INSTRUCTION TO PATIENT: 1) Bedrest etc. 2) Medication 3) Return for any problems Dr. Vengren

RETURN OR SEE DR. IMMEDIATELY IF WORSENS, OR IF NO BETTER IN \_\_\_\_\_ HOURS  
 CONDITION ON DISCHARGE / TRANSFER:  GOOD  SATISFACTORY  SERIOUS  CRITICAL  
 ATTENDING PHYSICIAN'S SIGNATURE: [Signature]

ER 23798234 01620533-001

ADAMS, DONALD L 2 043  
001723

1780 WARNER AVE  
MEMPHIS TN 38103

EMERGENCY DEPARTMENT ROOM NUMBER 7

12/25/98

TIME	L	H	-3	T	P	R	MEDICATIONS EQUIPMENT, & LABORATORY	OBSERVATIONS	I	O
1310								Dr. Call wants to hold on to Tuprel & do CBC / Upr. Mr.		
							Lab work drawn by LIT no result. Mr.			
1410	109	68	101	8	112	24	med c-epo topical per order CNR done	Mr. good BS vital. No compl. by car. E. deep Mr. Mr.		
1420								<del>in to examine pt. BP</del>		
1430								Discharged ambulatory c-epo 2 to PAS. BP 10		

SIGNATURE

*[Signature]*

INITIALS

MP

SIGNATURE

*[Signature]*

INITIALS

BP

INTAKE

OUTPUT

**LABORATORY REPORT**

930111CND667  
attachment 4

ARLES R. HANCOCK, M.D.  
DIRECTOR OF LABORATORY  
CENTRAL 1211 UNION AVE.  
SOUTH 1238 WESLEY  
NORTH 382 NEWINGTON

We Know What A Miracle You Are.

PATIENT NO. **1620533**      ROOM NO. **3E/DN**      AGE **17**      SEX **30**      DATE **12/25/92**      PAGE **1**

PATIENT NAME **ADAMS, DONALD L**      PATIENT NO. **1620533**      ROOM NO. **3E/DN**      AGE **17**      SEX **30**      DOCTOR'S NAME **[REDACTED]**

DATE	TIME	TEST NAME	ABNORMAL	RESULTS	UNITS
12/25/92	13:10	ARTERIAL BLOOD GAS			
		ARTERIAL PH		7.35-7.45	PH UNITS
		ARTERIAL PCO2		35-45	MMHG
		ARTERIAL PO2	76	85-95	MMHG
		ART O2 SATURATION		94-98	
		ART BASE DEFICIT		0-2.5	MMOL/L
		ARTERIAL HCO3	32	23-28	MMOL/L
		AIR PUNCTURE SITE			112
		TIME PRESSURE HOLD			
		ALLEN TEST PERFORMED			MINUTES
12/25/92	13:10	COMPLETE BLOOD CNT & DIF			
		WBC	15.0	5.0-10.0	THOUS/MM3
		RBC		4.50-5.70	MILL/MM3
		HEMOCRITIN		34.0-38.0	GM/100
		HEMATOCRITIC		42.0-52.0	
		MCH BLOOD		80.0-100.0	PG
		MCH BLOOD	30.0	27.0-31.0	PG
		MCHC BLOOD		32.0-36.0	
		PLATELET COUNT		150-400	THOUS/MM3
		RDS		11.5-14.5	
		MPV	7.0	7.4-10.4	FL
		DIFFERENTIAL			
		SLIDE NO.			
		SEG NEUTROPHIL		50-70	
		LYMPHOCYTE	14	20-40	
		BAND NEUTROPHIL	13	0-5	
		MONOCYTES			
		EOSINOPHILS			
		CELL MORPHOLOGY			
				ESSENTIALLY NORMAL	

*qr*

PATIENT NAME **ADAMS, DONALD L**      PATIENT NO. **1620533**      ROOM NO. **3E/DN**      AGE **17**      SEX **30**      DOCTOR'S NAME **[REDACTED]**



STATEMENT MEMPHIS RADIOLOGICAL PROFESSIONAL CORPORATION  
 FOR: 1211 Union Ave, Suite 350 P.O. Box 42047 Memphis, TN 38174-2047  
 Tel: (901) 725-1823 Fax: (901) 725-1823

ACCOUNT NUMBER	PATIENT NAME	FACILITY WHERE SERVICES RENDERED	DATE	DESCRIPTION	AMOUNT
123456789	JOHN D. DOBSON	MEMPHIS RADIOLOGICAL PROFESSIONAL CORPORATION	01/15/88	FLUOROGRAPHY - CHEST (2 VIEWS) - STAT (REF: 123456789)	11.00
If you have remitted within the last 10 days, please disregard this statement.					
STATEMENT DATE	DIAGNOSIS CODE	LOCATION	TOTAL CHARGES	AMOUNT PAID	BALANCE DUE
01/15/88	01	ST	11.00	11.00	00.00

ACCOUNT NUMBER	AMOUNT DUE
123456789	11.00
<input type="checkbox"/> Detach & Return with Payment	
PATIENT NAME	STATEMENT DATE
JOHN D. DOBSON	01/15/88
<b>PHYSICIANS</b> HOLLIS H. HALFORD, JR. WILLIAM E. LONG JOHN M. DOBSON JERRY W. GRISSE JON C. JENKINS ROBERT L. COOGRIFT ROBERT E. LASTER, JR. EDWARD H. MABRY, JR. JAMES W. BOALS ROY KULP, JR. ALVIN J. WEBER, III DAVIS D. MOSEN BRUXEY R. SHELTON RADIOLOGISTS FOR: METHODIST CENTRAL HOSPITAL, GREENBAY COMMUNITY HOSPITAL, METHODIST NORTH HOSPITAL, (METHODIST EAST) METHODIST SOUTH HOSPITAL, EASTWOOD HOSPITAL	
REMIT PAYMENT TO: MEMPHIS RADIOLOGICAL, P.C. RESPONSIBLE PARTY INFORMATION	

ER 23798234  
ADAMS, DONALD L  
1780 WARNER AVE  
MEMPHIS TN  
H -3

0162-533-001  
PATIENT AFTERCARE SHEET  
2 043  
001723

**METHODIST**  
We Advise What A Facility You Are

**PATIENT AFTERCARE SHEET**

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

**GENERAL INSTRUCTIONS:**

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

**INSTRUCTIONS FOR CARE FOR SUTURES:**

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

**INSTRUCTIONS FOR CARE FOLLOWING HEAD INJURY:**

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

2 Prescriptions received

Medication received in ER

**DISCHARGE IMPRESSION**

*Pneumonia*

**OTHER INSTRUCTIONS:**

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

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

I understand these instructions and accept them:

*X Donald Leon Adams*

INSTRUCTED

Dr. *A. Petre*

Nurse

Date

*12/25/92*

MEDICAL RECORDS

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

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

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

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

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

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

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

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

Patient's Signature (or Representative) for Consent to Treatment and Release of Information: Donald Lee Adams DATE 12-25-92 TIME 10:45

Responsible Policyholder's Signature for Insurance Assignment: Donald Lee Adams DATE 12-25-92 TIME 10:45

All Financially Responsible Individuals: Donald Lee Adams DATE 12-25-92 TIME 10:45

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

SIGNATURE OF ADMISSION PERSONNEL OR AUTHORIZED HOSPITAL REPRESENTATIVE: Shirley Nelson

CAT.	UNIT NUMBER	ADM/SERVICE DATE	T/A PER	T/A RECD	PHYSICIAN NAME AND NUMBER	ADMIT/REG. TIME	ACCOUNT NUMBER			
ER	1620533-001	12/25/92	P			2:47	2379823			
PATIENT NAME		NICKNAME		MC/SSN #	DATE OF BIRTH	AGE	MS	RB	QD CODE	LENG SERV
ADAMS		DONALD L		410-86-1396	12/05/1949	43	M	WM	1	S
PATIENT ADDRESS - LINE 1		PATIENT ADDRESS - LINE 2		CHURCH		HOME PHONE				
1780 WARNER AVE		MEMPHIS TN 381271335		NO PREF		901-353-3332				
EMPLOYER		EMPLOYER'S ADDRESS		EMPLOYER'S PHONE	PREV. ADM. DATE	PREVIOUS ADMISSION NAME				
US POSTAL SERVICE		- UNK		999-999-9999	00/00/00	23798234				
OCCUPATION		PERSON TO NOTIFY IN EMERGENCY/NEAREST RELATIVE		PHONE NUMBER	RELATIONSHIP	ADDRESS				
LETTER CARRIER		ADAMS DORACE		901-357-4619	FATHER	00000				
COMMENTS:		RESPONSIBLE PARTY		MC/SSN #	RELATIONSHIP	RP UNIT #	DWR/REG	PHONE NUMBER		
		ADAMS DONALD L		410-86-1396	SELF	1620533		901-353-3		
PATIENT ADDRESS - LINE 1		ADDRESS - LINE 2		YEARS	ADDRESS - LINE 2	RP ACCT. NUMBER	PHONE NUMBER (BL)			
1780 WARNER AVE		MEMPHIS TN 38127				E-354422-8	999-999-5			
OCCUPATION		EMPLOYER'S NAME		ADDRESS		PHONE NUMBER				
LETTER CARRIER		US POSTAL SERVICE		MEMPHIS TN 00000		00000				
INSURANCE CARRIER		GROUP POLICYHOLDER		GROUP POLICYHOLDER	ADDRESS/STREET	CITY	STATE			
NATL ASSOC OF LETTER CARR		NATL ASSOC OF LETTER CARR		410-86-1396	P.O. BOX 9668	SCOTTSDALE AZ	852			
EFFECTIVE DATE		GROUP NUMBER		POLICY NUMBER	ADDRESS/STREET	CITY	STATE			
00/00/00		004708		410-86-1396						
INSURANCE CARRIER		GROUP NUMBER		POLICY NUMBER	ADDRESS/STREET	CITY	STATE			
00/00/00										

930111CCN0667  
attachment 4

PLEASE  
DO NOT  
STAPLE  
IN-THIS  
AREA

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

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

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN)		1a. INSURED'S I.C. NUMBER (FOR PROGRAM IN ITEM 1) <b>410861396</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>ADAMS DONALD L.</b>		3. PATIENT'S BIRTH DATE MM DD YY SEX <b>12 05 49 M X F</b>	
5. PATIENT'S ADDRESS (No., Street) <b>1780 WARNER DR</b>		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE <b>MEMPHIS TN</b>		7. INSURED'S ADDRESS (No., Street) <b>1780 WARNER DR</b>	
ZIP CODE TELEPHONE (Include Area Code) <b>38127 (901 353-3332)</b>		CITY STATE <b>MEMPHIS TN</b>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (w. Lab Spray)	
c. EMPLOYER'S NAME OR SCHOOL NAME <b>U.S. Postal Service</b>		11. INSURED'S POLICY GROUP OR FECA NUMBER <b>322</b>	
d. INSURANCE PLAN NAME OR PROGRAM NAME <b>SEND TO PATIENT*****</b>		a. INSURED'S DATE OF BIRTH MM DD YY SEX <b>12 05 49 M X F</b>	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.		b. EMPLOYER'S NAME OR SCHOOL NAME <b>U.S. Postal Service</b>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. <b>SIGNATURE ON FILE 12/28/92</b>		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>NALC</b>	
SIGNED DATE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
14. DATE OF CURRENT ILLNESS, First Symptom, OR INJURY, Accident, OR PREGNANCY, LMP <b>12 25 92</b>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>SIGNATURE ON FILE</b>	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		SIGNED	
16. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE <b>Methodist North Emergency Room</b>		17. I.D. NUMBER OF REFERRING PHYSICIAN	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE ITEMS 1, 2, 3 OR 4 TO ITEMS 24E BY LINE <b>466 0</b>		22. MEDICAID RESUBMISSION CODE ORIGINAL REF #	
23. PRIOR AUTHORIZATION NUMBER		23. PRIOR AUTHORIZATION NUMBER	

24. DATE OF SERVICE From MM DD YY To MM DD YY	25. Place of Service	26. Type of Service	27. PROCEDURES, SERVICES, OR SUPPLIES (CPT, HCPCS, I, MODIFIER)	28. DIAGNOSIS CODE	29. \$ CHARGES	30. DAYS (EPSDT OR Family Plan)	31. EMG	32. COB	33. RESERVED FOR LOCAL USE
12 28 92	3	1	99203	1	92 00	1			
12 28 92	3	4	71020	1	58 00	1			
12 28 92	3	5	36415	1	5 00	1			
12 28 92	A	5	80019	1	32 00	1			
12 28 92	3	5	85024	1	25 00	1			

25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <b>Yes</b>		28. TOTAL CHARGE <b>212 00</b>		29. AMOUNT PAID <b>212 00</b>		30. BALANCE DUE <b>0 00</b>	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) <b>Fair receipt enclosed</b>		33. PHYSICIAN'S, SUPPLIER'S, AND/OR FACILITY'S ADDRESS, ZIP CODE & PHONE # <b>BARTLETT-RALEIGH INTERNAL MED 5134 STAGE RD SUITE 300 MEMPHIS, TN 38134</b>							
SIGNED <b>1/11/93</b> DATE		PINA		GRPK							

230-0118 (12/94) (OCR) 2 PL

PATIENT NAME ER23798234 AGE 43 RS MS UNIT NUMBER 1620333-001 REFERRING PHYSICIAN 000000  
ADAMS DONALD L 43 MMH NO REFER. DR. E-354422-8

PERSONAL PHYSICIAN NONE EMER. RM. CHG. M & S SUPPLIES PHYSICIAN FEE OTHER CHARGES AMOUNT PAID

IF ACCIDENT: INDUSTRIAL  POLICE NOTIFIED TIME  AM FAMILY NOTIFIED DATE IN 1-1-91 7411  
 MVA  OTHER  PM

MERG. DR. HOUSE STAFF ADMITTING PHYSICIAN (INITIAL LAST) DATE OUT

ALLERGIES NKDA BROUGHT BY PRIVATE VEHICLE AMB. NO. INS. 1 EG INS. 2 P INS. 3

CHIEF COMPLAINT DIFF BREATHING/INHALED CHEMICALS PATIENT PHONE

Table with 4 columns: INS. 1, INS. 2, INS. 3, and an unlabeled column. The table is mostly empty with some faint markings.

Table with 2 columns: CBC, WBC, HGB, H, DIFF, NA, K, CL, CO2, BUN, GLU, UA. The table is mostly empty with some faint markings.

Table with 2 columns: DISCHARGE IMPRESSION and an unlabeled column. The table is mostly empty with some faint markings.

DISPOSITION AND INSTRUCTION TO PATIENT  SEND COPY OF CHART WITH PATIENT  DONE

RETURN OR SEE DR. IMMEDIATELY IF WORSENS, OR IF NO BETTER IN \_\_\_\_\_ HOURS.  GOOD  SATISFACTORY  SERIOUS  CRITICAL ROOM #

(NURSE'S SIGNATURE) (HOUSE STAFF PHYSICIAN'S SIGNATURE) (M.E.R.G. PHYSICIAN'S SIGNATURE) (ATTENDING PHYSICIAN'S SIGNATURE)

23176-12/93  
HEIDI C ADAMS

93011100N0667  
attachment 4

5782042

MC/VISA 285H58  
BARTLETT / RALEIGH  
INTERNAL MEDICINE PC  
MPNS TN

PURCHASER SIGN HERE

*Sharon C. Adams*  
Cardholder acknowledges receipt of goods and/or services for the amount of the Total shown hereon and agrees to perform the obligations set forth in the Cardholder's agreement with the issuer.

SALES SLIP U.S. Pat. 4,403,783

QUAN.	CLASS	DESCRIPTION	PRICE	AMOUNT
		Donald Adams # 4078		212.00
		Carey Adams #4064		187.00
DATE: 12/28/92 AUTHORIZATION: 008784			SUB TOTAL	
REFERENCE NO: 0060			TAX	
SALES SLIP				TOTAL: 399.00

CUSTOMER COPY

IMPORTANT: RETAIN THIS COPY FOR YOUR RECORDS

**Receipt** Date 12/28 1992 No. 479880

RECEIVED FROM R Adams \$399.00

FOR RENT office charges DOLLARS

FOR credit card TO STV

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

BY Cmassey OCT183

Copy of receipt from  
Bartlett-Raleigh Internal Med

Their Health Insurance Claim Form shows that they accept Assignment.

We paid their bills, and we request reimbursement to us.

*Sharon Adams*

# NALC Health Benefit Plan

20547 Waverly Court, Ashburn, Virginia 22093  
(703) 729-4877

## CLAIM FORM FOR UNASSIGNED BILLS

(Benefits will be paid to member)

### STATEMENT OF MEMBER

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

CHECK BOX IF CHANGE OF ADDRESS

1. MEMBER INFORMATION		2. PATIENT INFORMATION	
SOCIAL SECURITY NUMBER 4110-816-1396		PATIENT CODE <u>A</u>	
EMPLOYMENT STATUS: ACTIVE <input checked="" type="checkbox"/> ANNUITANT <input type="checkbox"/> SURVIVOR ANNUITANT <input type="checkbox"/>		NAME <u>Donald L Adams</u>	
NAME <u>Donald L Adams</u>		DATE OF BIRTH <u>12-05-49</u>	
ADDRESS <u>1780 Warner Dr</u>		RELATIONSHIP TO MEMBER <u>Self</u>	
CITY <u>Memphis</u> STATE <u>TN</u> ZIP <u>38127</u>		MARITAL STATUS MARRIED <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
TELEPHONE (DAYTIME) <u>901 353-3332</u>			

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

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

4. Accidental Injury   Date, place and diagnosis The bedroom of my niece Leslie Ma 12/25/92 Exposure to Wilson's Leather Protector, had difficulty breathing 102° achills, cough  
 Is claim covered by no-fault auto insurance? YES  NO  Third party liability (subrogation)? YES  NO  ?  
 If yes, insurance company's name and address Wilson's Claim Management, 400 S Hwy 169, Minneapolis, Ma. 55428 Spoke w Nancy Gjo 612 541-35 Collect

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

6. Other group medical / dental coverage   If yes, is insurance issued through active employment? YES  NO   
 Is this an HMO policy? YES  NO

Name of person to whom issued \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Name of organization or employer through which obtained \_\_\_\_\_  
 HOSPITAL OR MEDICAL INSURANCE: Name and address of other insurance company \_\_\_\_\_  
 Effective date \_\_\_\_\_ Cancellation date \_\_\_\_\_  
 Policy # \_\_\_\_\_ Self Only  Family  U.S. Consumer Product Safety Con 1-800 638-2776 1 tape # 162 on Wilson's Leat. Protector

DENTAL INSURANCE: Name and address of other insurance company \_\_\_\_\_  
 Effective date \_\_\_\_\_ Cancellation date \_\_\_\_\_  
 Policy # \_\_\_\_\_ Self Only  Family

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

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

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

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

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

CONTROL NUMBER	SHEET	REF NUMBER

### CLAIM FORM FOR UNASSIGNED BILLS

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

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

DATE OF PURCHASE	RX NUMBER	NAME OF DRUG	PRESCRIBING PHYSICIAN	DIAGNOSIS (ILLNESS TREATED)	CHARGES
12-25-92	Methodist Hosp North ER	[REDACTED]	[REDACTED]	Pneumonia 13567	\$ 46.05
				Hemogram	51.00
				Blood Gas	80.00
				Venipuncture	4.50
				venipuncture	4.50
				Chest Abnormal	65.50
12-25-92	Memphis Radilogical	[REDACTED]	[REDACTED]	786.01	31.00
12-28-92		[REDACTED]	[REDACTED]	O.V. 99203	92.00
				chest X-ray 71020	58.00
				venipuncture 36415	5.00
				SMA/C 80019	32.00
				CBC 85024	25.00
12-25-92	C523135	Erythromycin	[REDACTED]	Pneumonia 13567	8.39
12-25-92	C523136	Notusce liquid	[REDACTED]	" "	12.09

**Walgreens The Pharmacy America Trusts**  
 2325 COVINGTON BLVD PH 382-9237  
 MEMPHIS TN  
**PATIENT** DONALD L ADAMS  
 1750 WARNER  
 MEMPHIS TN 38114-2332  
**RX NO.** C523135 DR. [REDACTED]  
**MEDICATION** ERYTHROMYCIN 250MG TABS  
 APR 011-4085\*00074-6996-39  
 QTY 60 REFILL CALLAPH TAB/ HRX  
 DATE 12/25/92 6.99 EUR

**Walgreens The Pharmacy America Trusts**  
 2325 COVINGTON BLVD PH 382-9237  
 MEMPHIS TN  
**PATIENT** DONALD L ADAMS  
 1750 WARNER  
 MEMPHIS TN 38114-2332  
**RX NO.** C523136 DR. GARR  
**MEDICATION** NOTUSCE LIQUID  
 5 FL 4085-0681-16  
 QTY 15 REFILL CALLAPH TAB/ HRX  
 DATE 12/25/92 12.09 EUR

TOTAL DRUGS \$ 20.48  
 TOTAL ALL OTHER CHARGES \$ 494.50  
 TOTAL \$ 514.98

**METHODIST**  
THE METHODIST HOSPITAL  
We Honor When A Miracle You, Inc.  
3960 NEW  
MEMPHIS

COVINGTON P 4056  
TN 38128-0000

INSURANCE PENDING:

|||||  
DONALD L ADAMS  
1780 WARNER AVE  
MEMPHIS TN 38127-1335

NATL ASSOC OF LETTER CARR

METHODIST HOSPITAL  
P.O. BOX 1000, DEPT. 97  
MEMPHIS TN 38148-0097

ER23798234 DONALD L ADAMS 12/25/92 12/25/92 12/29/92 251.50 01/23/93

▲ PLEASE DETACH UPPER PORTION AND RETURN WITH PAYMENT ▲

PAGE 1 OF 1

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

ER23798234 DONALD L ADAMS 12/25/92 12/25/92 12/29/92 251.50 01/23/93

12/25/92	000089	CHEST PA & LATERAL	65.50
12/25/92	000682	HEMOGRAM	51.00
12/25/92	000783	BLOOD GAS/ART	80.00
12/25/92	013567	EMERGENCY RM LEVEL II	46.00
12/25/92	027883	VENIPUNCTURE	4.50
12/25/92	027883	VENIPUNCTURE	-4.50

IF YOU HAVE ANY QUESTIONS, PLEASE CALL  
PATIENT ACCOUNTING @ 726-8375 (MON-FRI 9:00AM - 4:00PM)  
OR VISIT US AT 1211 UNION AVE, SUITE 500. PLEASE KEEP THIS  
STATEMENT FOR YOUR RECORDS. INSURANCES, IF SHOWN ABOVE,  
HAVE BEEN BILLED. YOUR AMOUNT DUE AND DUE DATE ARE ALSO  
SHOWN ABOVE. THANK YOU FOR ALLOWING US TO SERVE YOU.

TOTAL	251.50
	.00
	251.50

**METHODIST**  
THE METHODIST HOSPITAL

We Honor When A Miracle You, Inc.

WE  
ACCEPT



SEE REVERSE

304

PATIENT NAME ER23798245 ADAMS DONALD C 17 MMS 471187-002 REFERRING PHYSICIAN 000000 NO REFER. DR. DOCUMENT NUMBER ER 23798 E-35442

PERSONAL PHYSICIAN [REDACTED] EMER. PMA CHG. 40 M & S SUPPLIES PHYSICIAN FEE 80 OTHER CHARGES AMOUNT PAID

ACCIDENT INDUSTRIAL DATE TIME LOCATION POLICE NOTIFIED TIME AM FAMILY NOTIFIED PM DATE IN 12-25-72 125

MERG. DR. HOUSE STAFF ADMITTING PHYSICIAN (INITIAL LAST) DATE OUT 12-25-72 1430

ALLERGIES NKDA PRIVATE VEHICLE BROUGHT BY AMB. NO. INR. 1 EG INR. 2 P INR. 3

CHIEF COMPLAINT DIFF BREATHING/INHALED CHEMICAL PATIENT PHONE VITAL SIGNS

HISTORY & PHYSICAL 1730 present - cough - difficulty breathing. It has been an acute episode since then. He has been coughing since. Has fallen 6' onto concrete floor - 12/25/72. No trauma. No chest pain. No hemoptysis. No sputum. No fever. No chills. No night sweats. No weight loss. No anorexia. No fatigue. No weakness. No dizziness. No headache. No chest pain. No palpitations. No syncope. No fainting. No seizures. No incontinence. No sexual dysfunction. No menstrual changes. No pregnancy. No lactation. No menopause. No osteoporosis. No osteoarthritis. No rheumatoid arthritis. No gout. No diabetes. No hypertension. No heart disease. No lung disease. No kidney disease. No liver disease. No thyroid disease. No endocrine disease. No autoimmune disease. No cancer. No infection. No trauma. No surgery. No hospitalization. No ICU. No ventilator. No intubation. No tracheostomy. No dialysis. No chemotherapy. No radiation. No immunosuppression. No organ transplant. No genetic testing. No genetic counseling. No genetic diagnosis. No genetic carrier testing. No genetic prenatal testing. No genetic newborn testing. No genetic forensic testing. No genetic gene therapy. No genetic gene editing. No genetic gene silencing. No genetic gene overexpression. No genetic gene underexpression. No genetic gene knockout. No genetic gene knockin. No genetic gene replacement. No genetic gene correction. No genetic gene deletion. No genetic gene insertion. No genetic gene amplification. No genetic gene downregulation. No genetic gene upregulation. No genetic gene silencing. No genetic gene overexpression. No genetic gene knockout. No genetic gene knockin. No genetic gene replacement. No genetic gene correction. No genetic gene deletion. No genetic gene insertion. No genetic gene amplification. No genetic gene downregulation. No genetic gene upregulation.

Need Druggable  
magn? - 1/2 hr @ home - cough - deep breath  
cough - intermittent

CBC WBC 18.6

HGB

DIFF

490

NA K

CL CO2

BUN GLU

UA

DATE OF LAST TETANUS NA

CURRENT MEDICATIONS: See pg 2 N/A

APR BAND ON SIDERAILS I

ATTENDING M.D. CALLED HOME OFFICE EXCHANGE PAGED AT AM CONSULT M.D. CALLED HOME OFFICE EXCHANGE PAGED AT

PHYSICIAN COMMUNICATION

DISPOSITION AND INSTRUCTION TO PATIENT: 1) General get further @ Meds order 2) Return for get

CONDITION ON DISCHARGE / TRANSFER: GOOD SATISFACTORY SERIOUS CRITICAL

RETURN OR SEE DR. IMMEDIATELY IF WORSENS, OR IF NO BETTER IN \_\_\_\_\_ HOURS

HOUSE STAFF PHYSICIAN'S SIGNATURE MERG PHYSICIAN'S SIGNATURE ATTENDING PHYSICIAN'S SIGNATURE

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

**METHODIST**  
MEMPHIS HEALTH SYSTEMS

We Know What A Miracle You Are

EMERGENCY DEPARTMENT ROOM NUMBER 5

TIME	BP	T	P	R	MEDICATIONS, TREATMENTS EQUIPMENT & LABORATORY	OBSERVATIONS	I	O
1300	130/100	102	116	24	Allergies - <del>✓</del> meds - Eskalith CR 40 bid Pmt Smokes - 1ppd	17 y w/m amb to ER ± c/o difficulty breathing dizziness, cough, general malaise & being exposed to leather protectant. Pt states was smoking in @ small room where @ leather coat had just been treated & protectant. On arrival pt ± chills, on attempt to take deep inspiration coughs. Bilateral air exchange essentially normal (BP)		
1315					Labwork drawn per LLT			
1340						To ± from X-ray ambulatory BP		
1355						Pt. moved to GR #5 so he can lie down. BP		
1415		102			Tylenol ii po			
1435						Discharged amb ± parents Mother given PAS, Rx ± verbalized understanding of instructions by mother		

SIGNATURE	INITIALS	SIGNATURE	INITIALS	INTAKE	OUTPUT
Lisa Parker RN	LP	Beverly Peter RN	BP		

930111CCN0667  
attachment 4

CHARLES R. HANCOCK  
DIRECTOR OF LABORATORY  
SOUTH MED WBLBY  
NORTH MED CCYNG

**METHODIST**  
THE MEMORIAL HOSPITAL OF MEMPHIS

1265 UNION AVE.  
MEMPHIS, TN 38104  
(901) 726-7175

### LABORATORY REPORT

CENTRAL  
WEST LUNCH AVE.

SOUTH  
MED WBLBY

PAGE

We Know What A Miracle You Are

471187

3EDR 17:30 12/25/92

1

PATIENT NAME: ADAMS, DUHARD C      PATIENT NO.: 471187      ROOM NO.:      AGE:      SEX:      DOCTOR'S NAME:

DATE	TIME	TEST NAME	ABNORMAL	RESULTS NORMAL	MISC	UNITS
		GENERAL CHEMISTRY		7.43		
		ALBUMIN		25		
		BUN	82	96.4		
		CREATININE	22	1.7		
		GLUCOSE		PM AVE		
		RIGHT RADIAL				
		COMPLETE BLOOD COUNT	18.6	5.13		
		HEMATOCRIT		15.0		
		HEMATOCRIT		45.0		
		HEMATOCRIT		35.0		
		HEMATOCRIT		30.7		
		HEMATOCRIT		35.4		
		HEMATOCRIT		34.7		
		HEMATOCRIT		10.9		
		HEMATOCRIT		0.0		
		DIFFERENTIAL		0.0		
		NEUTROPHILS	80			
		LYMPHOCYTES	4			
		MONOCYTES	10			
		PLATELETS		5		
		PERIPHERAL BLOOD SMEAR				
		FEW MICROCYTES				

PATIENT NAME: ADAMS, DUHARD C      PATIENT NO.: 471187      ROOM NO.:      AGE:      SEX:      DOCTOR'S NAME:      307

X-RAY PROFESSIONAL SERVICES BY:  
MEMPHIS RADIOLOGICAL PROFESSIONAL CORP

MENT OF RADIOLOGY

C    S    N

23798245   00471187   16-72-74   North Radiology   ER ✓

ADAMS, DONALD C.

Age 17 WM

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

[REDACTED] (cv) K  
Printed: 12/26/92 09:46

cc: [REDACTED]  
FAX # 3719317

STATEMENT MEMPHIS RADIOLOGICAL PROFESSIONAL CORPORATION  
 1211 Union Ave., Suite 350 P.O. Box 42047 Memphis, TN 38174-2047 Tel: (901) 725-1623  
 Fax: (901) 725-1623

ACCOUNT NUMBER	PATIENT NAME	FACILITY WHERE SERVICES RENDERED	AMOUNT
12/29/92	12/29/92	12/29/92	33.00
PLEASE LOCATE YOUR ACCOUNT NUMBER ON THE UPPER LEFT CORNER OF THE STATEMENT BEFORE CALLING.			
01/14/93	01/14/93	01/14/93	31.00
If you have remitted within the last 10 days, please disregard this statement.			
STATEMENT DATE	DIAGNOSIS CODE	LOCATION	TOTAL CHARGES
01/14/93	740.01	99	31.00
			AMOUNT PAID
			0.00
			AMOUNT DUE
			31.00

ACCOUNT NUMBER	AMOUNT DUE
12/29/92	31.00
Detach & Return with Payment	
STATEMENT DATE	PATIENT NAME
01/14/93	

**PHYSICIANS**

HOLLIS H. HALFORD, JR.  
 WILLIAM E. LONG  
 JOHN M. DOBSON  
 JERRY W. GRIBBE  
 JON C. JENNINS  
 ROBERT L. COCKROFT  
 ROBERT E. LASTER, JR.  
 EDWARD H. MARRY, JR.  
 JAMES W. BONLS  
 ROY KILP, SR.  
 ALVIN J. WEBER, III  
 DAVIS D. MOSSER  
 BRUCE R. SHELTON

**RADIOLOGISTS FOR:**

METHODIST CENTRAL HOSPITAL, GERMANTOWN COMMUNITY HOSPITAL  
 METHODIST NORTH HOSPITAL, METHODIST EAST  
 METHODIST NORTH HOSPITAL, EASTWOOD HOSPITAL

REMIT PAYMENT TO:  
 MEMPHIS RADIOLOGICAL, P.C.  
 RESPONSIBLE PARTY INFORMATION

23758245  
 DONALD L. ADAMS, JR.  
 1780 BERNARD AVE.  
 MEMPHIS TN 38107-1035

PATIENT AFTERCARE SHEET

**METHODIST**

*We Show What A Doctor You Are*

PATIENT AFTERCARE SHEET

ER 23798245

00471187-002

ADAMS, DONALD C

2 017

1780 WARNER AVE

001942

MEMPHIS, TN  
GENERAL INSTRUCTIONS:

12/25/92

E-354423-A

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

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

INSTRUCTIONS FOR CARE FOR SUTURES:

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

INSTRUCTIONS FOR CARE FOLLOWING HEAD INJURY:

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

② Prescriptions received

\_\_\_ Medication received in ER

DISCHARGE IMPRESSION

Bronchitis /

OTHER INSTRUCTIONS:

Tylenol q 4<sup>o</sup> for temp / meds as directed

Return if you get worse / Follow up with Dr.

Monday am

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

I understand these instructions and accept them:

X Donald Adams

INSTRUCTED

Nurse Date

12/25/92

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

930111CCN0667  
attachment 4

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA ACTP# 0040641 ARC534 P CO 0 HEALTH INSURANCE CLAIM FORM 506#

1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		CHAMPUS (Sponsor's SSN)		CHAMPVA (VA File #)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (X)		12. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																																																									
														410861396																																																									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE (MM DD YY)						4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																											
ADAMS DONALD C						10 8 14 75 M X F						ADAMS DONALD L																																																											
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED						7. INSURED'S ADDRESS (No., Street)																																																											
1780 WARNER DR						Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input checked="" type="checkbox"/> Other <input type="checkbox"/>						1780 WARNER DR																																																											
CITY				STATE				8. PATIENT STATUS				CITY				STATE																																																							
MEMPHIS				TN				Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>				MEMPHIS				TN																																																							
ZIP CODE				TELEPHONE (include Area Code)				Employed <input checked="" type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/>				ZIP CODE				TELEPHONE (INCLUDE AREA CODE)																																																							
38127				(901) 353-3332				Student <input type="checkbox"/>				38127				(901) 353-3332																																																							
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:						11. INSURED'S POLICY GROUP OR FECA NUMBER																																																											
						a. EMPLOYMENT? (CURRENT OR PREVIOUS)						a. INSURED'S DATE OF BIRTH (MM DD YY) SEX																																																											
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						12 05 49 M X																																																											
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX						b. AUTO ACCIDENT? PLACE (State)						d. EMPLOYER'S NAME OR SCHOOL NAME																																																											
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																																																	
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME																																																											
						Wilson spray						SEND TO PATIENT*****																																																											
c. INSURANCE PLAN NAME OR PROGRAM NAME						10c. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN?																																																											
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d																																																											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																											
SIGNATURE ON FILE												SIGNATURE ON FILE																																																											
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY/LMP												15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE																																																											
12 25 92																																																																							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE												17a. I.D. NUMBER OF REFERRING PHYSICIAN																																																											
Methodist Hosp North Emergency Room																																																																							
19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												20. OUTSIDE LAB? CHARGES																																																											
FROM 12-26-92 TO												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)												22. MEDICARD RESUBMISSION CODE ORIGINAL REF NO																																																											
466 0																																																																							
24. A B C D E												F G H I J K																																																											
DATE(S) OF SERVICE To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT-NCPS I MODIFIER				DIAGNOSIS CODE		CHARGES		DAYS EPSU OR Family Units Paid		EING		COR		RESERVED FOR LOCAL USE																																																			
MM DD YY MM DD		YY		YY		CPT-NCPS I MODIFIER				CODE		\$		UNITS																																																									
12 28 92		3		1		99203				1		92 00		1																																																									
12 28 92		3		0		71020				1		58 00		1																																																									
12 28 92		3		5		36415				1		5 00		1																																																									
12 28 92		A		5		80019				1		32 00		1																																																									
25. FEDERAL TAX I.D. NUMBER SSN EIN												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? (For govt. claims, see back)												28. TOTAL CHARGE												29. AMOUNT PAID												30. BALANCE DUE											
621468260												01842517C												NO												\$ 187 00												\$ 187 00												\$ 0 00											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)												33. PHYSICIAN'S ORDER #												33. PHYSICIAN'S ADDRESS, ZIP CODE																																			
												Bartlett-Raleigh Internal Med												901 371-0200												5134 STAGE RD SUITE 300																																			
												Memphis, TN 38134																								MEMPHIS, TN 38134																																			
SIGNED 1/11/93 DATE												PIN#												GRP#																																															

# NALC Health Benefit Plan

20547 Waverly Court, Ashburn, Virginia 22093  
(703) 729-4577

## CLAIM FORM FOR UNASSIGNED BILLS (Benefits will be paid to member)

### STATEMENT OF MEMBER

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

CHECK BOX IF CHANGE OF ADDRESS

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

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

- Workers' Compensation   Date of accident, diagnosis and compensation claim # 1/1
- Accidental Injury   Date, place and diagnosis 12/25/92 Exposure to Wilson's Leather Protector. Had difficulty breathing 102° fever, chills, coughing  
 Is claim covered by no-fault auto insurance? YES  NO  Third party liability (subrogation)? YES  NO ? The bedroom spray cushion looks like
- Medicare   Medicare Identification Number 400 S Hwy 169, Minneapolis, MN 55428 / Spouse with Nancy Gjerde  
 Effective date: Part A 1/1 Part B 1/1 612  
 If yes, is insurance issued through active employment? YES  NO  541-2561  
 Is this an HMO policy? YES  NO  Collected
- Other group medical / dental coverage   Name of person to whom issued \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Name of organization or employer through which obtained \_\_\_\_\_  
 HOSPITAL OR MEDICAL INSURANCE: Name and address of other insurance company \_\_\_\_\_ U.S. Consumer Product Safety  
 Effective date \_\_\_\_\_ Cancellation date \_\_\_\_\_ 1-800-638-277  
 Policy # \_\_\_\_\_ Self Only  Family  Tape # 162  
 DENTAL INSURANCE: Name and address of other insurance company \_\_\_\_\_ on Wilson's Leather Protector  
 Effective date \_\_\_\_\_ Cancellation date \_\_\_\_\_  
 Policy # \_\_\_\_\_ Self Only  Family

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

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

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

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

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

CONTROL NUMBER	REF. NUMBER

### CLAIM FORM FOR UNASSIGNED BILLS

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

**PRESCRIPTION DRUGS AND MEDICINES**

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

DATE OF PURCHASE	RX NUMBER	NAME OF DRUG	PRESCRIBING PHYSICIAN	DIAGNOSIS (ILLNESS TREATED)	CHARGES
12-25-92	Methodist North Hoga	E.R.	[Redacted]	13567 Bronchitic/early pneumonia	\$ 46.00
S	S			Hemogram 682	51.00
				Blood Gas/Art 783	80.00
				Ureapuncture 27882	4.50
				Ureapuncture 27883	4.50
				Chest PA lateral 89	65.50
		Mchs. Radiologic Prac Care		786.01	31.00
12-28-92			Samuel T Verzosa	99203 office visit	92.00
}				71030 chest x-ray	58.00
				36415 Ureapuncture	5.00
				80019 SMAC	32.00
12-25-92	C523133	Erythromycin	[Redacted]	Bronchitic/early pneumonia	8.39
12-25-92	C523134	Naturec Liquid	[Redacted]	" " " "	12.09

Assessment accepted

Paid by

**Walgreens The Pharmacy America Trusts**  
2926 COVINGTON PIK. MEMPHIS TN 382-9227  
**PATIENT:** DONALD C ADAMS  
1780 BARNER DR. MEMPHIS TN 382-6382  
**RX NO.:** C523133 DR. [Redacted]  
**MEDICATION:** ERYTHROMYCIN 250MG TABS ABBOTT-ROSS \*00074-6344-33  
**QTY:** 40 REFILL CALLAPH TMO/ HRA  
**DATE:** 12/25/92 \$ 8.39 EUA

**Walgreens The Pharmacy America Trusts**  
2926 COVINGTON PIK. MEMPHIS TN 382-9227  
**PATIENT:** DONALD C ADAMS  
1780 BARNER DR. MEMPHIS TN 382-6382  
**RX NO.:** C523134 DR. [Redacted]  
**MEDICATION:** NATUREC LIQUID [Redacted] \*5923-0521-16  
**QTY:** 100 REFILL CALLAPH TMO/ DRK  
**DATE:** 12/25/92 \$ 12.09 BONA

TOTAL DRUGS \$ 20.48  
 TOTAL ALL OTHER CHARGES \$ 469.50  
 TOTAL \$ 490.00

**METHODIST**  
THE METHODIST HOSPITALS

*We Know What A Miracle You Are*

METHODIST NORTH

930111000667  
attachment 4

3960 NEW COVINGTON PIKE  
MEMPHIS TN 38128

DONALD L ADAMS  
1790 WARNER AVE  
MEMPHIS TN 38127-1335

INSURANCE PENDING:  
NATIONAL ASSOC LETTER CAR

METHODIST NORTH  
MAKE CHECKS P.O. BOX 1300, DEPT. 97  
PAYABLE AND MEMPHIS TN 38148 - 0097  
MAIL TO:

AMOUNT  
ENCLOSED

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

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

PAGE 1 OF

METHODIST NORTH

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

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

DATE	HOSPITAL CODE	DESCRIPTION	AMOUNT
122592	13567	EMERGENCY RM LEVEL II	46.00
122592	682	HEMOGRAM	51.00
122592	783	BLOOD GAS/ART	80.00
122592	27883	VENIPUNCTURE	4.50
122592	27883	VENIPUNCTURE	4.50
122592	85	CHEST PA & LATERAL	55.50
122592	6168	NATIONAL ASSOC LETTER CAR	0.00

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

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

METHODIST

**MEDICAL RECORDS**

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

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

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

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

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

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

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

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

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

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

All Financially Responsible Individuals: (2) X Donald James Adams DATE 12/25/92 TIME \_\_\_\_\_

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

SIGNATURE OF ADMISSION PERSONNEL OR AUTHORIZED HOSPITAL REPRESENTATIVE: [Signature]

CAT. ER	UNIT NUMBER 471187-002	ADM/SERVICE DATE 12/25/92	T/A PREV REC'D P	PHYSICIAN NAME AND NUMBER	ADMIT/REG. TIME 2:51	ACCOUNT NUMBER 23798245
PATIENT NAME ADAMS	DONALD CAREY	MC/SSN # 000-00-0000	DATE OF BIRTH 08/14/1975	AGE 17	MS 5	RS UM
REF N	CHURCH NO PREF	HOME PHONE 901-353-3332				
PATIENT ADDRESS - LINE 1 1780 WARNER AVE		PATIENT ADDRESS - LINE 2 MEMPHIS TN 381271335		LENGTH OF SERVICE 00		
EMPLOYER STUDENT	EMPLOYER'S ADDRESS UNK	MEMPHIS TN 00000	EMPLOYER'S PHONE 999-999-9999	PREV. ADM. DATE 00/00/00	PREVIOUS ADMISSION NAME 23798245	
OCCUPATION STUDENT	PERSON TO NOTIFY IN EMERGENCY/NEAREST RELATIVE ADAMS DORACE	PHONE NUMBER 901-357-4619	RELATIONSHIP GRANDFATH	ADDRESS	00000	
COMMENTS:			PATIENT IN ANY HOSPITAL LAST 60 DAYS (WHERE)			
RESPONSIBLE PARTY ADAMS DONALD		MC/SSN # L 410-86-1396	RELATIONSHIP FATHER	RP UNIT # 1620533	OWN/RENT	PHONE NUMBER 901-353-33
ADDRESS - LINE 1 1780 WARNER AVE		YEARS	ADDRESS - LINE 2 MEMPHIS TN 38127	RP ACCT. NUMBER E-354423-A	PHONE NUMBER (BUSI) 999-999-99	
OCCUPATION: US POSTAL SERVICE	EMPLOYER'S NAME: NATL ASSOC OF LETTER CARR	ADDRESS: MEMPHIS TN 00000	LENGTH SERV			
INSURANCE CARRIER EFFECTIVE DATE 00/00/00	GROUP POLICYHOLDER GROUP NUMBER 004708	POLICY NUMBER 410-86-1396	ADDRESS/STREET P.O. BOX 9668	CITY SCOTTSDALE	STATE AZ	ZIP 8525
INSURANCE CARRIER EFFECTIVE DATE 00/00/00	GROUP POLICYHOLDER GROUP NUMBER	POLICY NUMBER	ADDRESS/STREET	CITY	STATE	ZIP
INSURANCE CARRIER	GROUP POLICYHOLDER	SUBSCRIBER	315			

14621801

AAPCC COOPERATIVE POISON CENTER REPORT #30111CCN0667 attachment 5

DATE: 12-25-98 TIME: 11:58

See # 14621802

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

PATIENT DATA  
 Name: Donald Adams  
 Telephone no.: ( )  
 Address: \_\_\_\_\_  
 Zip: \_\_\_\_\_

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

Age: 43  mo.  yr. Weight: 170  lbs.  kg.  
 Sex:  Male  Female  Unknown  
 Present Medical History:  Healthy  No chronic meds  No known allergies

Zip: \_\_\_\_\_ County: \_\_\_\_\_  
 Site of Caller:  Residence  Workplace  Health Care Facility  School  Other  Unknown

Check here if patient is pregnant   Medical history unknown  
 PMD name & no.: \_\_\_\_\_

SUBSTANCE DATA  
 Substance: Leather Protector  
 Amount: inhaled fumes  
 Ingredients: Petroleum Distillates } per Label  
 Manufacturer: Wilson  
 794 6567  
 308 4095  
 Time of/Since exposure: 1° PTC  
 Route of Exposure:  Ingestion  Inhalation/Nasal  Ocular  Dermal  Bite/Sting  Parenteral  Unknown  Other

HISTORY, ASSESSMENT, SYMPTOMS & CALCULATIONS  
 History (witnessed? amount verified? other products/victims?)  No other products suspected  
~~to Room~~ Caller's son & husband were in room that coat was sprayed & above pdt. They went in p spraying was over. The room also was used for smoking cigarettes. She is unsure how long they were in the room. Possibly exposed for 10-15". Has SxS below desires fxt ingt.  
 Subjective complaints/objective findings  No symptoms at this time  
 Coughing, gagging  
 cough if breathes real deep, cold (chills)  
 Assessment (symptoms expected? rationale?)  
 Initial assessment (choose one)  
 Asymptomatic  
 Symptomatic, related  $\uparrow$  risk of asymptomatic  
 Symptomatic, unrelated  
 Symptomatic, unknown related  
 Due to symptomatology 3°  
 p exposure  $\rightarrow$  Refer to HCF for evaluation  
 3/6

Treatment  
Facility:

Code:

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

DATE/TIME

Treatment suggested: HCF

Symptoms to monitor:

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

Follow-up schedule: 2-4<sup>o</sup>

12:45 Caller's sister calls: desires to know which HCF/ER  
SISTER went to. TOLD SISTER decision was left to  
Ms. Adams. Rec. Request HCF/ER. ~~ERH~~

13:58 Ans. Machine ~~ERH~~

4:53 Ans. Machine. ~~ERH~~

16:40 Spoke to Kerry. states feel a little bit better, but not as  
much better. Then spoke to Irene. Went to Methodist  
North. Both husband & son received CXR. & given  
Scripts for No-Tuss PRN & Erythro. Husband has  
pneumonitis & Son had bronchitis. Assigned bed re  
& Fluc MD (specialist on Monday). ~~ERH~~

2/26/92

09:34 Spoke to Donald. States chest hurts a little bit but  
is feeling much better. Kerry today is more  
active & feels better today. ~~ERH~~  
r/u Monday. ~~ERH~~  
P MD's appt.

2/28/92

14:31 Going to MD @ 3pm x

16:33 Ans Machine x

CONSULTANTS/RESOURCES USED:

- Medical director \_\_\_\_\_
- Other consultant \_\_\_\_\_
- Taxis \_\_\_\_\_
- Other \_\_\_\_\_ ~~Reindex~~



**AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION  
VIA TELEPHONE**

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

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

the case data that involved the following person: Kerry Adams  
Dorend Adams  
12/23 Ill. Adams

My relationship to the above person is checked below

- Mother
- Self
- Father
- Other, please describe 1 child of Dorend Adams  
mother of Kerry Adams
- Legal guardian

Verbal authorization given by telephone on the following date: -

Signed Lynette X 3/4/93

Date 1/21/93 1030

For Poison Center Use	
Date received	_____
Case no.	_____

14621802

AAPCC COOPERATIVE POISON CENTER REPORT 930111CCN0667 attachment 5

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

See # 14621801

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

PATIENT DATA  
 Name: Kemy Adams  
 Telephone no.: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Zip: \_\_\_\_\_  
 Age: 17  mo.  yr. Weight: 180  lbs.  kg.  
 Sex:  Male  Female  Unknown

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

Patient Medical History:  Healthy  No chronic meds  No known allergies  
Respiratory Problems - Breathing Machine  
Meds: Lithium  
 Check here if patient is pregnant   Medical history unknown  
 PMD name & no.: \_\_\_\_\_

Site of Caller  Residence   
 Workplace   
 Health Care Facility   
 School   
 Other   
 Unknown

SUBSTANCE DATA  
 Substance: Leather Protector  
 Amount: inhaled fumes  
 Ingredients: Petroleum Distillates / paraffin Manufacturer: 794-6567  
308-9091  
 Time of/Since exposure: 1<sup>o</sup> PTC  
 Route of Exposure:  Ingestion  Inhalation/Nasal  Ocular  Dermal  Bite/Sting  Parenteral  Unknown  Other

HISTORY, ASSESSMENT, SYMPTOMS & CALCULATIONS  
 History (witnessed? amount verified? other products/victims?)  No other products suspected  
 See # 14621802

Subjective complaints/objective findings  No symptoms at this time  
Coughing, gagging  
can can only take shallow breaths, lungs feel real cold  
 Assessment (symptoms expected? rationale?)  
 Initial assessment (choose one)  
 Asymptomatic  
 Symptomatic, related ↑ risk of aspiration  
 Symptomatic, unrelated  
Due to symptoms 3<sup>o</sup> p exposure  
Refer to HCF for evaluation

Treatment  
Facility: \_\_\_\_\_

Code: \_\_\_\_\_

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

DATE/TIME

Treatment suggested: HCF

Symptoms to monitor:

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

Follow-up schedule: 2-4°

12:45 Caller's sister calls SPC.; desires to know which HCF/ER  
sister went to. TOLD SISTER decision was left to us. Advise  
Rec Newcastle HCF/ER. SRH

13:58 Ans. Machine. SRH

14:53 Ans. Machine. SRH

16:40 Spoke Kerry States feel a little bit better, but not  
that much better. Then spoke Irene. Went to  
Methodist North. Both Husband & son went to ER.  
were CXR'd & given scripts of NoTuss PRN  
Erythromycin. Husband had pneumonitis. son was  
dx'd bronchitis. Assigned bed rest & F/u & MD  
on Monday. SRH

12/26/92  
09:34 Spoke Donald. States chest hurts a little bit but is  
feeling much better. Kerry today is more active &  
feels better today. F/u Monday after MD's appt.

2/25/92  
14:31 Going to MD @ 3pm

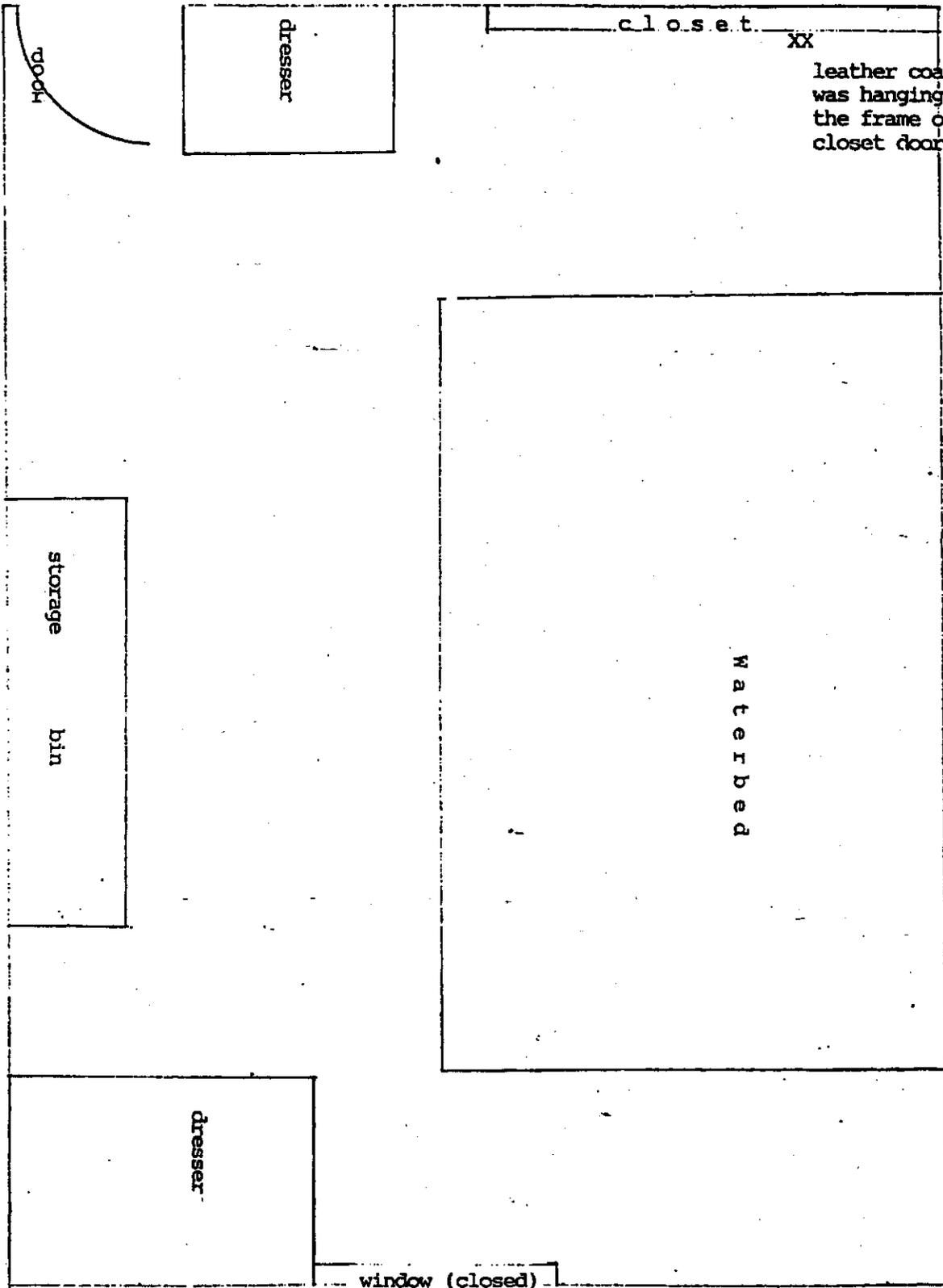
16:33 Ans Machine  
CONSULTANTS/RESOURCES USED:

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

— Poisindex®



Diagram of Bedroom (where leather protector was sprayed)



Not to scale

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

COMMERCIAL APPEAL  
Memphis, Tennessee  
DAILY

G31 0081

IOI 930111CCN0667

DEC-30-92

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

By Jon Hamilton  
The Commercial Appeal

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

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

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

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

centers submit information.

No consumer has died.

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

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

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

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

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

### FIELD ACTIVITY COVERSHEET

1. REGION/STATE  FOCR	2. OPERATION (Check One) <input type="checkbox"/> Inspection <input type="checkbox"/> Establishment Visit <input type="checkbox"/> Telephone Contact <input checked="" type="checkbox"/> Investigation <input type="checkbox"/> Other _____	3. DATE  12-31-92
		4. NUMBER (For RO Use) 930104CCN0580

5. ESTABLISHMENT			
Name <u>Wilson's Suede and Leather Inc.</u>			
Address _____			
City <u>Minneapolis</u>	State <u>MN</u>	Zip _____	Telephone No. _____

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

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

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

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

15. REASON FOR ACTIVITY (Assignment Reference)
--

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

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

18. <input checked="" type="checkbox"/> ENDORSEMENT <input type="checkbox"/> REMARKS <input type="checkbox"/> SUMMARY <input type="checkbox"/> OTHER _____
<p>A 37 yr. old woman suffered severe respiratory distress after spraying Wilson's Leather Protector on a leather coat. She was hospitalized and diagnosed as suffering from chemical pneumonia.</p> <p>F/U: Refer to Compliance.</p>

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

20. REVIEW DATE 1-13-93	21. DISTRIBUTION O: EPDS; cc: CERM, C. Jacobson; cc: EF; cc: FOCR.
----------------------------	---

EF

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 MO DAY 9 2 1 2 2 4			5. DATE INVESTIGATION INITIATED YR MO DAY 9 2 1 2 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			
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.			15. INJURY DIAGNOSIS chemical pneumonia		
16. BODY PART all parts			17. RESPONDENT(S) (Mother, Friend) Victim			18. TYPE INVESTIGATION ON SITE 1 TELEPHONE 2 OTHER 3			19. TIME SPENT Tr: 0:0 0 3 0		
20. ATTACHMENTS copy of original complaint			21. CASE SOURCE complainant			22. REVIEWED BY 8 1 3 0			YR MO DAY 9 3 0 1 1 3		
23. PERMISSION TO DISCLOSE NAMES (NON-EMERGENCY CASES ONLY) CPSC MAY DISCLOSE MY NAME <input type="checkbox"/> CPSC MAY NOT DISCLOSE MY NAME <input checked="" type="checkbox"/>											
24. NARRATIVE (See instructions on Other Side) See attached narrative.						25. REGIONAL OFFICE DIRECTOR REVIEW DATE					
(USE OTHER SIDE AND ADDITIONAL SHEETS IF NECESSARY)											

MFR/PRVLER NOTIFIED  
 No comments made  
 Comments attached  
 Excisions/Revisions  
 Firm has not requested further notice

201

930104CCM0580

**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.

Exhibit "A"

1-04-93

WIS # 930104CCN 0580

CONSUMER PRODUCT INCIDENT REPORT

1. NAME OF RESPONDENT [REDACTED]		2. TELEPHONE NO. (Home) [REDACTED] (Work) [REDACTED] (Home) [REDACTED]	
3. STREET ADDRESS [REDACTED]		4. CITY Green Bay, WI.	STATE AND ZIP CODE 54304

5. DESCRIBE ACCIDENT SITUATION OR HAZARD, INCLUDING DATA ON INJURIES. (Use several pages 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 12/24/92	7. IF INJURY ON LIMB, STATE 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, VENDOR, BATCH 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 Fort 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>12/26/92</u> USED <u>NEW</u> DATE PURCHASED _____ AGE <u>hours</u>
	16. DOES PRODUCT HAVE WARNING LABEL? IF SO, NOTE: <u>YEARS</u> may be harmful.

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 B. Blasius, MKI-EP	22. DOCUMENT NO. <del>626</del> G2C0251

23. FOLLOWUP ACTION Conduct ITOI 930104CCN 0580	24. PRODUCT CODE(S) 0952
--	-----------------------------

25. DISTRIBUTION D: EPOS; cc: CENM, Jacobson; cc: FOCK	26. REPORTER'S NAME & TITLE [Signature] SPT
---	--

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

*file:*

*Wilson Suede &  
Leather*

*EF*

U.S. CONSUMER PRODUCT SAFETY COMMISSION

AUTHORIZATION FOR RELEASE OF NAME

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

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

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

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

My identity is to remain confidential.

Debra A. Yager  
(Signature)

1/5/93  
(Date)

Exhibit "B"

12/3/92

IOI# 930124CCN0580

U.S. CONSUMER PRODUCT SAFETY COMMISSION

**AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE**

**TO WHOM IT MAY CONCERN:**

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

( the case of 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)

James J. Yaeger  
(Witness)

Exhibit "D"

12/3/92

U.S. CONSUMER PRODUCT SAFETY

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

TO I # 930104 CCN0580

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. Yeager, 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.  
Rm. 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





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

YAEGER, BARBARA A  
MR#:0302579 ADM:12/25/92 EMERG  
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)

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

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

Yaeger, Barbara  
#302579  
12/25/92  
1 Day

**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

**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.

**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

RADLG-1728  
12/26/92 09:54

ST MARYS MEDICAL CENTER GREEN BAY  
(GAIARR)

PAGE 001

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

=====

REFERRING CLINIC:	REF MD ADDR:
CONSULTANTS:	

DX: INHALATION PNEUMONITISCHEMICAL PNEUMONIA

ORDER: CHEST, PA & LAT (ROUTINE) 2.01

PRELIMINARY REPORT

FILE #: 206-693

DATE OF EXAM: 12/25/92

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

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

CW

  
-----  
HF

LASTPAGE

FINAL COPY

**CALL REPORT**

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: [REDACTED]	3N-3 TEST RESULTS SUMMARY
ACCT#: 5589023	ATT MD: [REDACTED]	318
ADM: 12/25/92 00:50		RACE:W
DOB: 08/06/55	REF MD: [REDACTED]	

=====

REFERRING CLINIC: REF MD ADDR:  
CONSULTANTS:

=====

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

=====

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

=====

BLOOD COUNTS

TEST	12/25		RANGE/UNITS
WBC	25.1	H*	3.0-10.5 K/UL
RBC	4.62	*	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
AND	11	*	%
NEUT	78	*	%
LYMPH	5	*	%
MONO	6	*	%
TECH HEM	LK	*	
TECH DIFF	LK	*	

=====

YAEGER, BARBARA A

0302579

HEMATOLOGY/COAGULATION (ON (2)

12/26/92 03:00

(QA/PRG)

PAGE 002

=====

YAEGER, BARBARA A F 37 DISCH. MEDICAL =====

M.R.#: 0302579 ADM MD: [REDACTED] MD 3N-S TEST RESULTS SUMMARY

ACCT#: 5589023 ATT MD: [REDACTED] 318 =====

ADM: 12/25/92 00:50 RACE: W

DOB: 08/06/55 REF MD: [REDACTED]

=====

REFERRING CLINIC: REF MD ADDR:

CONSULTANTS:

=====

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

=====

\* = NEW RESULT H = HIGH RESULT L = LOW RESULT

O = ORIGINAL RESULT M = MODIFIED RESULT

=====

ARTERIAL BLOOD GASES

TEST	12/25 02:10		RANGE/UNITS
PH	7.46	H*	7.35-7.45 UNITS
PCO2	29	L*	35-45 MM HG
TCO2	22	L*	23-27 MMOL/L
PO 2	34	L*	80-90 MM HG
O2 SAT	70	L*	96-100 %
HCO3	21	L*	22-26 MEQ/L
BASE	-1.2	*	-2-+2
PT ON	(A)	*	
DRAWN	02:15	*	
TECH	LK	*	
COMMENT	(B)	*	

\*(A) ROOM AIR

\*(B) MIXED VENOUS SAMPLE

=====

YAEGER, BARBARA A 0302579 CHEMISTRY (3)

=====

MEDRC-2599

ST MARYS MEDICAL CENTER GREEN BAY

12/26/92 09:01

(QAXPRG)

PAGE 001

YAEGER, BARBARA A

F 37

MR#: 0302579

ACCT#: 3589023

SERV: MEDI

SN-S

318

MD: ADM: 12/25/92

DX: INHALATION PNEUMONITIS/CHEMICAL PNEUMONIA

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

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

DISCHARGE REPORT

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. PREDNISONE 20MG TAB, #1, PO, BID 8-17 MEALS --(GIVE WITH FOOD),  
(12/25/92 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 PHONE ORDER

CONTINUED

YAEGER, BARBARA A

0302579

DISCHARGE R. RT 30

343

12/26/92 03:01

(QAXPRG)

PAGE 003

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YAEGEN, BARBARA A F 37
MR#: 0302679 ACCT#: 3589023
SERV: MEDI 3M-S 318
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

ENTERED FOR

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

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YAEGER, BARBARA A F 37
MR#: 0302579 AOC#: 5589033
SERV: MEDI 3N-S 318
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 PIRBUTEROL 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

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

NO ORDERS WERE COUNTERSIGNED TODAY
-----

--COMPLETED ORDERS FOR THE DAY--

COMPLETED BY: ADAMS KIM R1 KS
01:42 12/25/92

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

COMPLETED BY: WAUTERS, SHEREE NRES 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).

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LASTPAGE

=====
YAEGER, BARBARA A

0302579

DISCHARGE R. RT 10

211



