77

STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Medical Associates of Brevard — Name of office
655 S. Apollo Blvd. — Street Address
Melbourne — City
32901 — Zip Code
Brevard — County
(321) 751-2707 — Telephone
Peter S. Dougan, MD — Name of Physician or Licensee Reporting
DOUGAN
OSR #1027 / ME 79594 — License Number & office registration number, if applicable
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted] — Patient's Address
[redacted] — Age
[redacted] — Gender
☐ Medicaid ☑ Medicare
15871 — Patient Identification Number
7/19/2016 — Date of Office Visit
Diagnosis
Bilateral Angio — Purpose of Office Visit
ICD-9 Code for description of incident
II — Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

7/19/2016. — Incident Date/and Time
Location of Incident:
☑ Operating Room ☐ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

During the case it was identified that the sheath had become separated in the mid portion and was lodged from the proximal SFA to the common iliac on the right. Access was lost during removal attempt. All other wires devices and the proximal portion of the sheath were removed at that time. Patient remained hemodynamically stable and Holmes Regional was notified that we required an OR for foreign body retrieval. EMS was contacted for transport.

10

STATE OF FLORIDA DOH Consumer Services
Rick Scott, Governor

SEP 1 2 2016

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Atlantic Surgery Center of Jacksonville Beach
Name of office

1361 13th Avenue South #130
Street Address

Jacksonville Beach | 32250 | Duval
City | Zip Code | County

904-249-2580
Telephone

Scott J. Trimas, M.D.
Name of Physician or Licensee Reporting

ME56523/OSR 434
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted]
Patient's Address

39035
Patient Identification Number

Aging face
Diagnosis

[redacted] | Female | ⊙ | ⊙
Age | Gender | Medicaid | Medicare

9/6/2016
Date of Office Visit

Facial surgery
Purpose of Office Visit

E849.0
ICD-9 Code for description of incident

III
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

9/6/2016 - 13:51
Incident Date and Time

Location of Incident:
⊙ Operating Room ⊙ Recovery Room
⊙ Other Patient's home

Note: If the incident involved a death, was the medical examiner notified? ⊙ Yes ⊙ No
Was an autopsy performed? ⊙ Yes ⊙ No

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

[redacted] y/o female patient with no contraindications or known allergies underwent an uneventful mini-facelift procedure on the morning of September 6, 2016. She was ASA Class II Mallampati Class 3.

Procedure started 08:22 hours and was completed at 10:45 hours. Anesthesia ended at 10:55 hours. Patient's post-operative course was uneventful. She was stable, alert, oriented, and voided prior to discharge.

Patient remained at the office surgery center until 11:55 a.m. She was evaluated by surgeon and anesthesiologist and discharged when they felt she met criteria for discharge. There were no issues with her post-operative course in recovery.

After arriving home, the patient's friend contacted the practice with complaint of patient having difficulty breathing. She was directed to call EMS.

There was a brief delay in EMS arrival at the residence because of its remoteness. When they arrived, patient was unresponsive and they could not establish an airway. Resuscitation was attempted without success.

Patient was taken to the emergency room of Baptist Hospital - Nassau. Upon arrival at the emergency department, patient was unresponsive and pronounced in the emergency room.

[redacted]

4

DOH Consumer Services
JAN 2 6 2017

STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

LIFELINE VASCULAR ACCESS CENTER
Name of office

337 S NORTHLAKE BLVD STE 1002
Street Address

ALTAMONTE SPRINGS 32701 SEMINOLE
City Zip Code County

407-260-1679
Telephone

MATTHEW SOLIS RT(R) / DR PAUL DREYER M.D.
Name of Physician or Licensee Reporting

CRT 71880 / ME 116056
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted] M ☐ ☒
Age Gender Medicaid Medicare

Patient's Address

11-30-16
Date of Office Visit

24206714 1
Patient Identification Number

THROMBECTOMY
Purpose of Office Visit

N18.6, T82.898A
Diagnosis

75710, 36147, 36870, 36215, 35476, 75978
ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

11-30-16 1251
Incident Date and Time

Location of Incident:
☐ Operating Room ☐ Recovery Room
☒ Other PROCEDURE Room

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

DURING THROMBECTOMY, EXTRAVASATION WAS NOTED BY THE PHYSICIAN. AFTER DEPLOYMENT OF STENT, BALLOON WAS RE-INSERTED TO SEAT STENT WHICH RESULTED IN STENT MIGRATION. STENT LOCATION COULD NOT BE CONFIRMED THROUGH FLUOROSCOPY. DR DREYER REQUESTED EMS BE ACTIVATED AT 1308. PT WAS TRANSFERRED TO FLORIDA HOSPITAL ORLANDO VIA AMBULANCE. PT REMAINED ALERT AND ORIENTED x 3 DURING PROCEDURE AND TRANSPORT TO HOSPITAL.

20162015T - 161

STATE OF FLORIDA
Rick Scott, Governor

DOH Consumer Services

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

OCT 2 8 2016

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

American Access Care
Name of office

6766 W. Sunrise Blvd. Suite 100
Street Address

Plantation 33313 Broward
City Zip Code County

954 583-8472
Telephone

Naveen Goel
Name of Physician or Licensee Reporting

N/A
License Number & office registration number, if applicable

6766 W. Sunrise Blvd. Suite 100
Patient's address for Physician or Licensee Reporting
Plantation, FL 33313

II. PATIENT INFORMATION

[redacted]
Patient's Name

[redacted]
Patient's Address

MR # 3662229
Patient Identification Number

ESRD N18.6
Diagnosis

[redacted] M ☒ Preferred Care Partners ☐ Medicaid ☐ Medicare
Age Gender

10.19.16
Date of Office Visit

Need For catheter change
Purpose of Office Visit

Acute Bronchospasm - J98.01
ICD-9 Code for description of incident

(I) (No sedation)
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

10.19.16 1125 AM
Incident Date and Time

Location of Incident:
☒ Operating Room 3 ☐ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No (N/A)
Was an autopsy performed? ☐ Yes ☐ No (N/A)

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

See attached

Florida HEALTH

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Surgical Specialists of Ocala
Name of office

1920 SW 20th PL, #100
Street Address

Ocala 34471 Marion
City Zip Code County

352-237-1212
Telephone

Cathy Duncan RN
Name of Physician or Licensee Reporting

OSR 11163
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted]
Patient's Address

34204
Patient Identification Number

PVD
Diagnosis

DOB [redacted] male ☐ ☐
Age Gender Medicaid Medicare

10/28/11
Date of Office Visit

Lower extremity Angiogram
Purpose of Office Visit

Abdominal pain R10.9
ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

10/28/11 1300
Incident Date and Time

Location of Incident:
☐ Operating Room ☒ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

Remived patient from cath lab with complaint of RUQ abdominal pain; firmness noted above RFA cath site + manual pressure applied + straight cathed patient + 850cc clear-yellow urine output. Patient continued to complain of pain upon palpation of RUQ of abdomen and became hypotensive. Administered 250cc NS IV Fluid Bolus + placed patient in trendelenburg position. Blood pressure normalized but patient continued to complain of RUQ abdominal pain on palpation and firmness increased. Dr. Chandra transferred patient to mrmc for CT of abdomen and observation.

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)
443.9		Hem.

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

NA

D) Outcome of Incident (Please check)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient.
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.
- ☒ Any condition that required the transfer of the patient to a hospital.

Outcome of transfer – e.g., death, brain damage, observation only CT + observation
Name of facility to which patient was transferred: Munroe Regional medical Center

- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure.

** if it resulted in:
- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function.
- ☐ Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Dr. Ravi Chandra ME 59502
Cathy Duncan RN RN 9214426
Kim McKenzie RN RN 9316251e
Jessica Richardson RN RN 9277914

F) List witnesses, including license numbers if licensed, and locating information if not listed above

NA

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

retroperitoneal hematoma

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Manual pressure applied, pain medication, fluid bolus, trendelenburg, & transferred patient to hospital for CT of abdomen and observation.

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DOH Consumer Services

STATE OF FLORIDA
Rick Scott, Governor

MAR 15 2017

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Vascular Interventional + Vein Associates
Name of office

2215 Nebraska Ave, Ste 3D
Street Address

Ft. Pierce; 34950; St Lucie Cty
City; Zip Code; County

772-801-2108
Telephone

Pranay T. Ramdev, MD
Name of Physician or Licensee Reporting

ME 87031; OBS # 1155
License Number & office registration number, if applicable

see below
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Identification Number

I70.213
Diagnosis

[redacted]; [redacted]; ☐ Medicaid ☑ Medicare
Age; Gender

11-8-16
Date of Office Visit

Right femoral access; left leg atherectomy
Purpose of Office Visit

4442.3 / I72.4 (ICD-10)
ICD-9 Code for description of incident

II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

11/8/2016, 5:00pm (1700)
Incident Date and Time

Location of Incident:
☑ Operating Room ☑ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

Patient underwent successful left leg atherectomy via right femoral groin access. Due to slightly elevated blood pressure during the procedure, The patient was treated effectively with medication. Sheath was pulled at end of procedure and manual pressure was held. Hemostasis was obtained. A small right groin hematoma was noted. Patient was transferred to recovery in stable condition. The hematoma became larger, MD was immediately notified, pressure was further held and ultrasound performed. Orders were given by MD to transfer patient to the hospital for further evaluation. Patient was alert, oriented, and vital signs stable upon transfer.

STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Intervasc @ Bay Radiology
Name of office

527 N. Palo Alto Ave
Street Address

Panama City | 32401 | Bay
City | Zip Code | County

850-873-3990
Telephone

Kunal Jani, MD
Name of Physician or Licensee Reporting

ME 118740 / OSR #1664
License Number & office registration number, if applicable

[redacted]
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted] | M | ☐ Medicaid ☒ Medicare
Age | Gender

[redacted]
Patient's Address

11-9-16
Date of Office Visit

MR# 136119
Patient Identification Number

Liver Chemoembolization
Purpose of Office Visit

Liver Cancer
Diagnosis

ICD 10 - C22.8 / C15.8 / K76.89
ICD-9 Code for description of incident

II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

11/9/16 @ 0910
Incident Date and Time

Location of Incident:
☒ Operating Room ☐ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

See attached typed narrative

B) ~~ICD-9-CM Codes~~ ICD 10

C22.8 / C15.8 / K76.89

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

C) **List any equipment used if directly involved in the incident**
(Use additional sheets as necessary for complete response)
N/A

D) **Outcome of Incident** (Please check)

☐ Death	☐ Surgical procedure performed on the wrong site **
☐ Brain Damage	☐ Wrong surgical procedure performed **
☐ Spinal Damage	☐ Surgical repair of injuries or damage from a planned surgical procedure.
☐ Surgical procedure performed on the wrong patient.	** if it resulted in:
☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.	☐ Death ☐ Brain Damage ☐ Spinal Damage ☐ Permanent disfigurement not to include the incision scar ☐ Fracture or dislocation of bones or joints ☐ Limitation of neurological, physical, or sensory function. ☐ Any condition that required the transfer of the patient to a hospital.
☒ Any condition that required the transfer of the patient to a hospital.	
Outcome of transfer – e.g., death, brain damage, observation only:	
Name of facility to which patient was transferred: BMC Sacred Heart	

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Kunal Jani, MD - ME 118740 - MD performing procedure
Blake Jolly RT(R) - CRT 55788 - Direct Patient Care
Kacey Carter RN - RN 9399117 - Direct patient care
Shanna Forehand, RN/CRN - RN9179305

F) List witnesses, including license numbers if licensed, and locating information if not listed above
Candice Rhodes, RVT ARDMS # 133723

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)
N/A

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)
N/A

V. [signature] ME 118740
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

11/9/16 1430
DATE REPORT COMPLETED TIME REPORT COMPLETED

November 9, 2016

Attachment to Physician Office Adverse Incident Form

RE: [redacted] DOB: [redacted]

DX: Malignant neoplasm of liver

Procedure performed: Liver Chemoembolization

Pt brought to procedure room via ambulation and placed on table in the supine position at 0829. Pt draped and prepped in sterile fashion. Time out and pause for the cause conducted at 0848. Procedure started at 0849. 0907 chemo agent started via Dr. Jani. Pt tolerated well until 0909 when he stated he needed to urinate. Urinal placed and pt urinated. 0910 pt started complaining that he could not breathe and his face was red. His O2 dropped and ambu bag was placed on pt and procedure stopped. Narcan 0.4 mg and Romazion 0.2 mg were given IV at 0910. Pulse was still felt and pt was in sinus tachycardia. Pt continued with assisted breathing. 0914 pt stopped breathing, pulse was lost, sinus bradycardia at 56 BPR. CPR started at this time and EMS called. 1 ampule of Atropine was given at 0914 and CPR continued. 1 ampule of Epinephrine was given at 0917 and oral airway was established. Pulse felt at 0918 but lost again at 0919. 1 ampule of Epinephrine given and suction performed at 0919. EMS arrived at 0920 and faint pulse was felt. 0921 pulse lost and CPR started. 1 ampule of Epinephrine given at 0921. 0922 pt was successfully intubated by EMS. Pulse was back and pt arousable at 0922. Sheath left in place, Right groin and dressed with tegaderm by Dr. Jani. 0930 EMS switched IV fluids to their bag and left with pt via stretcher to BMC ER.

Kacey Carter, RN

2016285181 167

STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

DOH Consumer Services
NOV 2 8 2016

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

New Life Plastic Surgery
Name of office

8400 SW 8th St.
Street Address

Miami 33144 Miami-Dade
City Zip Code County

305-501-5020
Telephone

Enrique Hanabergh Jr
Name of Physician or Licensee Reporting

ME 104210
License Number & office registration number, if applicable

[redacted]
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted] F
Age Gender ☐ Medicaid ☐ Medicare

Patient's Address

11/16/2016
Date of Office Visit

5497
Patient Identification Number

Trunk Liposuction & Fat Graft to Butt
Purpose of Office Visit

Shortness of Breath
Diagnosis

R06.02
ICD-9 Code for description of incident

III
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

11/16/2016
Incident Date and Time

Location of Incident:
☐ Operating Room ☒ Recovery Room
☐ Other_____

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

Unventful trunk liposuction with fat graft to butt. ~~Upon~~ It was stable throughout the case. She was extubated without incident and transfered to Recovery. While in recovery she was complaining of dyspnea and became very anxious. O2 Sat on room air were 92-93% and on NRM 99%. Rescue was called to transfer to hospital for work up, possible pulmonary embolus.

ICD-10

B) ICD-9-CM Codes

E65	I26.99	I26.99
Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

None

D) Outcome of Incident (Please check)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient.
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.
- ☑ Any condition that required the transfer of the patient to a hospital.

Outcome of transfer -- e.g., death, brain damage, observation only

Name of facility to which patient was transferred: Kendall Regional

- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure.

** if it resulted in:
- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function.
- ☐ Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Eduardo Lorenzo MD	ME95110
Zury Fojo RN	RN9377516
Mirka Morales RN	RN9381238

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)
Post operative anxiety. Upon arrival to hospital pt's VSS with O2 Sat 99% on NC. Pulmonary embolus found very small and according to hospital not large enough to cause sympto

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)
We will continue to use SCD's + compression stockings

20162874662

STATE OF FLORIDA
Rick Scott, Governor

DOH Consumer Services
DEC 0 1 2016

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Florida medical Pain Management
Name of office

8139 SR 54
Street Address

New Port Richey | 34655 | Pasco
City | Zip Code | County

727-484-6999
Telephone

Matthew Hellman, MD
Name of Physician or Licensee Reporting

ME127431
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted] | Male
Age | Gender

☐ Medicaid ☐ Medicare

[redacted]
Patient's Address

11/15/2016
Date of Office Visit

19980
Patient Identification Number

Stellate Ganglion Block
Purpose of Office Visit

Complex Regional Pain Syndrome
Diagnosis

6879
ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

11/15/2016 07:40 PM
Incident Date and Time

Location of Incident:
☐ Operating Room ☐ Recovery Room
☒ Other Home after discharge

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

Please See Attachment

B) ICD-9-CM Codes

64510 - stellate ganglion block	E879	729.92 Hematoma
Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

fluoroscopy machine, 25 gauge 3.5 inch spinal needle, omnipaque dye

D) Outcome of Incident (Please check)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient.
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.
- ☒ Any condition that required the transfer of the patient to a hospital.

Outcome of transfer – e.g., death, brain damage, observation only: tracheostomy, evacuation of hematoma

Name of facility to which patient was transferred: Morton Plant Hospital Clearwater.

- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure.

** if it resulted in:
- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function.
- ☐ Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

CRNA - Henry Schloegl
Radiological Technician - Kristin Wessel RT
Circulator - Sidney Halfhill -
Recovery Room Nurse - Beth Snavely RN

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Please see attachment.

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Please see attachment

V. Matthew Keller M.D. — ME127431

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT — **LICENSE NUMBER**

11/28/2016

M[redacted] underwent right stellate ganglion block (SGB) on 11/15/16 for CRPS. Patient underwent diagnostic right SGB on 10/18/2016 without any complications. As the diagnostic procedure did alleviate his CRPS pain, I did a therapeutic SGB block on 11/15/2016 using a 25G 3 1/2 inch needle under fluoroscopy with mild sedation with CRNA present. We confirmed the placement of the needle with contrast dye (Omnipaque) which showed needle placement was along the sympathetic chain and was not intra-vascular. Also, upon aspiration, it was negative for heme. After the patient had good result from the SGB , I subsequently transferred the patient to the recovery room in stable condition. The patient denied any shortness of breath, neurological or vascular complication in the recovery room. Patient was alert and oriented times three following the procedure at all times and I visited the recovery room multiple times to assess his condition and the extent of his response to the sympathetic block. Prior to discharge, I visited the patient again in the recovery room and the patient had no complications at no time did the patient have a problem with swallowing and was provided with a soft drink by a registered nurse in the recovery room with no difficulty in swallowing. The patient was asked to contact me if he developed any complications. I told him that I would follow him the next day to assess his response to the SGB.

I was notified that night at approximately at 7:40 PM by my associate, Dr. Kazi Hassan, regarding [redacted] since he received a phone call from the ER physician Dr. Osborn at Morton Plant North Bay Emergency Department. Dr. Osborn, the attending physician, had contacted Dr. Hassan regarding a complication (respiratory distress) associated with the (SGB) interventional procedure. Immediately, I contacted Dr. Osborn, who explained that Mr. [redacted] arrived at the ER with difficulty swallowing and respiratory distress and he found that it was prudent to intubate the patient to prevent further complication. After arriving at North Bay Emergency Department, I spoke to Dr. Osborn as well as the family members for an additional 45 minutes and reassured the family that I would continue to follow up on the care and condition of Mr. [redacted] following his transfer and that I agreed with Dr. Osborn and his decision to protect his airway.

As reported to myself by his family and Dr. Osborn, he was asymptomatic for almost three hours post-procedure and he was breathing on his own with difficulty breathing as well as swallowing upon his arrival to the Emergency Department. After assessment, the decision was made to secure his airway via intubation and subsequently transferred to Morton Plant Hospital in Clearwater for further care as he developed hematoma which was causing deviation of his trachea.

Upon his arrival to Morton Plant Hospital in Clearwater, a CT angiogram was performed which revealed a cervical hematoma without active bleeding. The patient was maintained in the ICU and a repeat scan was performed several days later which did not show a reduction in the size of the hematoma. Therefore, the ENT specialist made the decision to place a tracheostomy due to the hematoma as he believed the hematoma would resolve on its own. Since the

201700128-62

FLORIDA DEPARTMENT OF HEALTH

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

Consumer Services
JAN 04 2017

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

The Woman's Group — Name of office
3000 Medical Park DR STE 300 — Street Address
Tampa — City; 33613 — Zip Code; Hillsborough — County
813-769-2778 — Telephone
Marc Kaufman ME 55165 — Name of Physician or Licensee Reporting
OSR 735 — License Number & office registration number, if applicable
3000 Medical Park DR Suite 300 Tampa, Fl 33613 — Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted] — Patient Name
[redacted] — Age
Female — Gender
☐ Medicaid ☐ Medicare
[redacted] — Patient's Address
12/16/2016 — Date of Office Visit
7926 — Patient Identification Number
in office D+C/polypectomy — Purpose of Office Visit
626.9/N93.9 and 621.0/N84.0 — Diagnosis ICD-9
6 — Code for description of incident
II — Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

12/16/16 11:00 AM — Incident Date and Time

Location of Incident:
☐ Operating Room ☒ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

Healthy [redacted] Female for in office D+C/polypectomy with anesthesia. Pt had anesthesia (propofol/fentanyl/[illegible]/[illegible]) for D+C. During procedure, pt had episode of bradycardia upon entering uterine cavity treated with atropine 0.4mg IV. Also had obstructed airway treated with nasopharyngeal airway. [illegible] BP/SaO2 were stable throughout + HR increased after atropine. Procedure finished + patient had delayed awakening in O.R for 25 mins. After 25 minutes, pt opened her eyes + was transported to PACU. Her VS in PACU were stable but patient despite opening her eyes was noncommunicative + could not follow commands. Her VS were stable. She was given Romazicon 0.2mg IV x2 to reverse preop valium with no effect. After 20 mins of unchanging mental status, Ambulance was called + pt was transported to [illegible]

cont.

On arrival to ER, pt had blood work + head CT which was normal and pt gradually woke up to the pre-op level + pt was discharged home ~~after~~ 2 hrs in ER stable.
Diagnosis delayed anesthesia emergence

B) ICD-9-CM Codes 49320 N840

58558 D+C/Polypectomy 99812 Delayed Anesthesia Emergency Ø

Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

BP / SaO_2 / EKG / Oxygen Cylinder / Nasal Cannula / Nasopharyngeal Airway ETCO2 Monitor

D) Outcome of Incident (Please check)

☐ Death	☐ Surgical procedure performed on the wrong site **
☐ Brain Damage	☐ Wrong surgical procedure performed **
☐ Spinal Damage	☐ Surgical repair of injuries or damage from a planned surgical procedure:
☐ Surgical procedure performed on the wrong patient.	** if it resulted in:
☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.	☐ Death ☐ Brain Damage ☐ Spinal Damage ☐ Permanent disfigurement not to include the incision scar ☐ Fracture or dislocation of bones or joints ☐ Limitation of neurological, physical, or sensory function. ☐ Any condition that required the transfer of the patient to a hospital.
☒ Any condition that required the transfer of the patient to a hospital.	
Outcome of transfer – e.g., death, brain damage, observation only	
Name of facility to which patient was transferred: Florida Hospital	

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Dr Marc Kaufman-anesthesiologist ME 55165 5041 W. Cypress St Tampa, Fl 33607
Dr Robert Barrero-surgeon ME 92113 3000 Medical Parkway #300 Tampa Fl 33613
Cathy Maples RN-PACU nurse RN1151192 3402 W. Tacon ST Tampa Fl 33629

F) List witnesses, including license numbers if licensed, and locating information if not listed above

Adrienne Rodriguez 3000 Medical Park dr Suite 300 Tampa Fl 33613
Tiffany Cornell " " " " " " " " " "

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Delayed anesthesia emergence

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

No Corrective action needed

V.

Marc Kaufman MD — SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
ME55165 — LICENSE NUMBER
12/16/16 — DATE REPORT COMPLETED
5PM — TIME REPORT COMPLETED

STATE OF FLORIDA 20170029 5
Rick Scott, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

Consumer Services
JAN 05 2017

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Mark Lamet MD PA
Name of office

1150 N. 35th Ave #405
Street Address

Hollywood 33021 Broward
City Zip Code County

954-961-7771
Telephone

Name of Physician or Licensee Reporting

0513871 OSR#193
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted] F ☐ ☐
Age Gender Medicaid Medicare

[redacted]
Patient's Address

12/29/16
Date of Office Visit

Patient Identification Number 0000025350

Colonoscopy
Purpose of Office Visit

Diagnosis 286.010

536.533A
ICD-9 Code for description of incident

II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

12/29/16
Incident Date and Time

Location of Incident:
☒ Operating Room ☐ Recovery Room
☐ Other_____

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

During colonoscopy, there was concern for colon perforation. Decision was made to abort the procedure at that time. After patient awoke from sedation, she was informed of findings. Patients family was then contacted. Patient was sent to the Emergency Department where she underwent CT imaging which revealed findings consistent with colon perforation. Patient went for laparoscopic surgery that evening and is currently recovering satisfactorily in hospital.

B) ICD-9-CM Codes

45378	N/A	536.533A
Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**

C) **List any equipment used if directly involved in the incident**
(Use additional sheets as necessary for complete response)

D) **Outcome of Incident** (Please check)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient.
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.
- ☒ Any condition that required the transfer of the patient to a hospital.

Outcome of transfer – e.g., death, brain damage, observation only _____
Name of facility to which patient was transferred: _____

- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure.

** if it resulted in:
- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function.
- ☐ Any condition that required the transfer of the patient to a hospital.

E) **List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

Ari Lamet D.O. – 051387
Paul Alabaster, CRNA – ARNP92940745
Belinda Del Toro RN – RN 9429405
Joanne Rumbaoa LPN – PN 522537
Codian Dixon LPN – PN 5218355

F) **List witnesses, including license numbers if licensed, and locating information if not listed above**

See Above

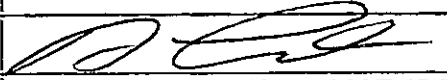
IV. ANALYSIS AND CORRECTIVE ACTION

A) **Analysis (apparent cause) of this incident** (Use additional sheets as necessary for complete response)

N/A

B) **Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

N/A

V. 

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT — LICENSE NUMBER: 051387

1/3/2017 — DATE REPORT COMPLETED

10:00 AM — TIME REPORT COMPLETED

HEALTH

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Vascular and Spine Institute
Name of office

7887 N. Kendall Dr #210
Street Address

Miami 33156 Miami Dade
City Zip Code County

305 598-1555
Telephone

Osmany DeAngelo D.O.
Name of Physician or Licensee Reporting

OSR 718
License Number & office registration number, if applicable

Same as above
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient's Address

[redacted] F
Age Gender ☐ Medicaid ☑ Medicare

#19617
Patient Identification Number

10-11-16
Date of Office Visit

End Stage renal disease
Diagnosis

Venogram
Purpose of Office Visit

T50.905A
ICD-9 Code for description of incident

level I
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

10-11-16 2:30pm
Incident Date and Time

Location of Incident:
☑ Operating Room ☐ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

See impression section in report attached (pg 2)

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

none

D) Outcome of Incident (Please check)

☐ Death	☐ Surgical procedure performed on the wrong site **
☐ Brain Damage	☐ Wrong surgical procedure performed **
☐ Spinal Damage	☐ Surgical repair of injuries or damage from a planned surgical procedure.
☐ Surgical procedure performed on the wrong patient.	** if it resulted in: ☐ Death ☐ Brain Damage ☐ Spinal Damage ☐ Permanent disfigurement not to include the incision scar ☐ Fracture or dislocation of bones or joints ☐ Limitation of neurological, physical, or sensory function. ☐ Any condition that required the transfer of the patient to a hospital.
☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.	
☑ Any condition that required the transfer of the patient to a hospital.	
Outcome of transfer – e.g., death, brain damage, observation only patient admitted Name of facility to which patient was transferred: South Miami Hospital	

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Osmany DeArrejo, DO (OS9245)
Nathaly Betancourt, RN (RN5209103)
Robert Alvarez, RT (CRT 58699)
Claudia Perez (MA)

F) List witnesses, including license numbers if licensed, and locating information if not listed above

same as above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

allergic reaction to iodinated contrast

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

none necessary

V. [signature] OS9245
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

10/25/16 2:21 pm
DATE REPORT COMPLETED TIME REPORT COMPLETED

Patient: [redacted]
Date of Birth:
Referring Physician: Luis Garcia Mayol MD
Procedure: Bilateral Upper Extremity Venography
Date of Service: 10/11/2016

CLINICAL HISTORY: The patient is a [redacted]-year-old female with history of end-stage renal disease on dialysis referred for venogram of the bilateral upper extremities. The patient has a right upper extremity HERO catheter which is nonfunctioning. The patient will be referred for possible access revision. The patient and her daughter communicated to us that she had been allergic to iodine in the past but has recently undergone a CT examination with contrast without an allergic reaction after steroid preparation. The patient was given a steroid preparation prior to this exam and has taken all the medication as prescribed.

OPERATOR: Osmany DeAngelo, D.O.

PROCEDURE SUMMARY:

1. Cannulation the right and left upper extremity
2. Bilateral upper extremity venograms with S&I

INFORMED CONSENT:

The procedure was done after obtaining informed consent. Complications including an inability to repair the access and vessel rupture, both of which could necessitate surgery, were reviewed with the patient

The patient was brought into the angiography suite and placed on the angiography table in supine position. A timeout was performed prior to the start of the procedure in order to confirm patient identity and procedure location.

A peripheral vein of the right upper extremity was accessed utilizing a micropuncture needle. A 018 wire was introduced through the needle and needle was removed. A 5 French catheter was then placed over the wire and the wire was removed. A venogram of the right upper extremity was performed utilizing IV contrast material.

A peripheral vein of the left upper extremity was accessed utilizing a micropuncture needle. A 018 wire was introduced through the needle and needle was removed. A 5 French catheter was then placed over the wire and the wire was removed. A venogram of the left upper extremity was performed utilizing IV contrast material

FINDINGS:

RIGHT ARM

Distal forearm cephalic: 0.9mm diameter
Cephalic vein at elbow:1.0 mm diameter
Basilic vein at elbow: 1.6 mm diameter

[redacted]

LEFT ARM

Distal forearm cephalic: 0.9mm diameter
Cephalic vein at elbow:1.0 mm diameter
Basilic vein at elbow: 1.6 mm diameter

The right and left subclavian vein, brachiocephalic vein appear occluded with collaterals extending throughout the neck and chest.

IMPRESSION:

The patient has very small veins and occlusion of the bilateral central veins as described above. The HERO catheter was identified in the right internal jugular vein.

Shortly after the last injection of contrast for total 15 mL of iodine the patient underwent a seizure most likely secondary to an allergic reaction despite steroid preparation per protocol. The patient was immediately given 120 mg of Solu-Medrol and 50 mg of Benadryl. The patient was also given O2 via mask at 6 L/m. After approximately 10 minutes the patient began to respond to verbal inquiries. There was no cardiac or respiratory arrest. Rescue was called and the patient was taken to South Miami Baptist Hospital as a precaution.

Electronically Signed by Dr. DeAngelo

Osmany DeAngelo, D.O.
Vascular/Interventional Specialist
Vascular and Spine Institute

Clinical Assistant Professor of Endovascular
Surgery and Interventional Radiology
NOVA Southeastern University

PATIENT'S NAME/PERM & LOCAL ADDRESS/SS#/PHONE

[redacted] SS# [redacted] AGE: [redacted] VIP:

[redacted] APT [redacted] FL [redacted]

PERM ADD PHONE: [redacted] LOCAL ADD PHONE:

EMPLOYER
RETIRED
NONE
UNKNOWN FL 00000
PH# 000 000-0000

Ins: MEDICARE OP 204 (1) SIMPLYHLTH MD HMO NC 063 (2) ( )

PRIMARY CONTACT NAME/ADDRESS/PHONE

[redacted] , [redacted] CHILD

PH# [redacted]

EMPLOYER
UNKOWN
NONE
UNKNOWN FL 00000

ACCIDENT DATE/TIME ACC IND PREBY ADMBY EMRCXP

COMMENTS PCP PIMENTEL, ELEONOR 305 445-0700 REVBY

ADM PHYSICIAN 305 661-4611
008888 MISC, ER DOCTOR

ATN PHYSICIAN 305 661-4611
008888 MISC, ER DOCTOR

CHIEF COMPLAINT
SEIZURE

Estimated Patient Responsibility Amount:
Based on the insurance information provided by you and verified by your insurance carrier, the estimated out-of-pocket responsibility is $ UNK . Estimates are based on our contract (if any) with, and the benefits provided by your insurance company and the average charges for the test(s)/procedure(s) scheduled. Your final bill may be higher, depending on the actual services rendered.

Basado en la información sobre el seguro brindada por usted y verificada por su proveedor de seguro, la responsabilidad del estimado a pagar de su bolsillo es $ UNK . Los estimados están basados en nuestro contrato (si lo hubiera) con, y los beneficios provistos por su compañía de seguro y los cargos promedio por el/los examen(es)/procedimiento(s) programados. Su factura final puede ser más alta, dependiendo de los servicios actuales brindados.

Baptist Health Rep. Initials/Iniciales

CONSENT TO TREATMENT

I consent to all medical and surgical procedures and treatment, including but not limited to surgery, medical treatment, radiological examination, laboratory procedures and/or inpatient or outpatient services performed or rendered and anesthesia and/or medications that may be administered by or under the specific or general instructions of my or my child's physician(s) or surgeon(s) during this hospitalization or outpatient visit. In addition, I agree to abide by facility regulations designed to enhance the care and safety of patients and I consent to the appropriate disposal of any specimen or other bodily materials removed during the course of my or my child's treatment.

CONSENTIMIENTO PARA TRATAMIENTO

Yo consiento a todos los procedimientos médicos y quirúrgicos y tratamiento, incluyendo pero no limitados a cirugía, tratamiento médico, examen radiológico, procedimientos de laboratorio y/o servicios como paciente hospitalizado o ambulatorio realizados o brindados, y anestesia y/o medicamentos que pudieran administrarse por o bajo las instrucciones específicas o generales del/de los médico(s) o cirujano(s) míos o de mi hijo durante esta hospitalización o visita ambulatoria. Además, yo acepto cumplir con los reglamentos del establecimiento establecidos para mejorar la atención y seguridad de los pacientes y consiento a que se deseche de forma apropiada cualquier espécimen u otros materiales corporales extraídos durante el curso del tratamiento mío, o de mijo.

NOTICE OF PRIVACY PRACTICES AND RELEASE OF INFORMATION

I acknowledge that I was provided with a copy of the Baptist Health Notice of Privacy Practices describing how Baptist Health may use and disclose my health information under the federal law. Provided that Baptist Health continues its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purposes and activities permitted under the federal privacy law, which are described in the Baptist Health Notice of Privacy Practices.

AVISO DE PRÁCTICAS DE PRIVACIDAD Y DIVULGACION DE INFORMACIÓN

Yo declaro que se me dio una copia del Aviso de Prácticas de Privacidad de Baptist Health describiendo cómo Baptist Health podría usar o divulgar mi información de salud bajo la ley federal. Siempre que Baptist Health continúe su esfuerzo de buena fe de cumplir con los requisitos de la ley de privacidad federal, por la presente consiento al uso y divulgación de mi información de salud con los propósitos y actividades permitidos bajo la ley de privacidad federal, que están descritas en el Aviso de Prácticas de Privacidad de Baptist Health.

Baptist Health Rep. Initials/Iniciales

User ID: EMRCXP LC EMR1
Date: 10/11/2016 Time 16:25

MEDICAL EDUCATION
I understand and acknowledge that this facility is a teaching facility, and that my medical treatment may be observed and/or aided by residents, medical students, or other students in the course of their training as health care professionals.
EDUCACION MEDICA
Yo entiando y declaro que este centro es un centro de educacion medica, y que mi tratamiento medico pudiera ser observado o ayudado por residentes, estudiantes medicos, u otro estudiante en el curso de su entrenamiento medico.

ADVANCE DIRECTIVES INFORMATION -- INPATIENTS I acknowledge that should I be admitted, I will receive written information concerning my individual rights under Florida law to make decisions concerning my medical/health care. I understand that I have the right to execute an Advance Directive and will be provided the opportunity to do so. I understand that I am not required to execute an advance directive as a condition of receiving care at this hospital. I also acknowledge and understand that the terms of my advance directive, should I choose to execute one, will be followed by this hospital to the extent required or allowable by law.
INFORMACIÓN SOBRE DIRECTRICES ANTICIPADAS (Solamente para pacientes adultos hospitalizados) Yo declaro que si se me ingresa, recibiré información por escrito sobre mis derechos individuales bajo las leyes de la Florida para tomar decisiones sobre mi atención médica/salud. Yo comprendo que tengo el derecho de ejecutar una Directriz Anticipada y que se me dará la oportunidad de hacerlo. Comprendo que no se me obliga a ejecutar una directriz anticipada como una condición para recibir atención en este hospital. Yo también reconozco y comprendo que los términos de mi directriz anticipada -de escoger ejecutar una- serán seguidos por este hospital hasta donde la ley lo requiera o permita.
ADVANCE DIRECTIVES INFORMATION -- OUTPATIENTS
Based on the nature of outpatient services, where a patient's stay is short term and doesn't allow sufficient time for a physician to determine if the conditions of the living will have been met, as permitted by Florida Law, full care within the capabilities of the facility will be provided. If the patient insists that he/she wants resuscitative measures withheld, any treatment, test or procedure will be cancelled. Patients will be instructed to notify their physician, with the exception of any treatment test or procedure requiring the physician's presence; in these cases the referring physician will be notified by the facility and the reason(s) for cancellation documented in the medical record.
INFORMATION SOBRE DIRECTRICES ANTICIPADAS -- PACIENTES EXTERNO
Conforme a la naturaleza de los servicios ambulatorios, en los que la brevedad de la estancia del paciente no permite que un médico tenga tiempo suficiente para determinar si se han cumplido las estipulaciones del Testamento Vital, de acuerdo con lo permitido por la legislación del estado de Florida, se brindará atención completa según las capacidades del centro. Si el paciente insiste en que no desea la implementación de medidas de resucitación, se suspenderá todo tratamiento, prueba o procedimiento. Al paciente se le indicará que notifique a su médico, con excepción de cualquier tratamiento, prueba o procedimiento que requiera la presencia del médico. En tales casos, se notificará al médico remitente y los motivos de la cancelación se documentarán en la historia clínica.

INDEPENDENT PRACTITIONERS
I recognize that physicians, surgeons and allied health professionals providing medical services to me or my child as a patient of this facility are private practicing physicians/professionals and not employees or agents of this facility. These private physicians/professionals include, without limitation, radiologists, anesthesiologists, pathologists, emergency room physicians, ICU physicians, neonatologists and all other physicians/professionals called in consultation.
PRACTICANTES INDEPENDIENTES
Yo reconozco que los médicos cirujanos y profesionales aliados de la salud que brindan servicios médicos a mi, o a mi hijo, como paciente de este establecimiento, son médicos/profesionales en prácticas privadas y no empleados o agentes de este establecimiento. Estos médicos/profesionales privados incluyen, sin limitación, radiólogos, anestesiólogos, patólogos, médicos del salón de emergencia, médicos de ICU, neonatólogos y todos los otros médicos/profesionales que se llamen en consulta.

CONSENT TO PHOTOGRAPH
I authorize the facility and its affiliates to take pictures of my or my child's medical or surgical procedure(s) and condition(s) and to include such photos in my medical records.
CONSENTIMIENTO PARA FOTOGRAFIAR
Yo autorizo al centro y sus afiliados a tomar fotos de las condiciones y procedimientos médicos o quirúrgicos míos o de mi hijo e incluir tales fotos en mi record medico.

RECEIVED AS IS

ASSIGNMENT OF INSURANCE BENEFITS AND APPOINTMENT AUTHORIZED REPRESENTATIVE

I authorize payment of Medicare, Medicaid or other insurance benefits otherwise payable to me for the services provided that are deemed necessary by my or my child's physician(s), directly to this facility and its affiliates, attending and consulting physicians and allied health professionals. Where MEDICARE AND MEDICAID BENEFITS are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct, and request that these payments of authorized benefits be made directly to this facility and its affiliates, attending and consulting physicians and allied health professionals on my behalf. For coverage or benefits under my ERISA (a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry) health benefits plan (the "plan"), if applicable, I appoint the licensed and legal owner of this facility to act on my behalf. I further authorize this facility, as my authorized representative, to receive any and all information that is provided to me, and to act for me in providing information to my Plan that relates to any claims for coverage or benefits under the plan. I agree to execute such documents as shall be appropriate and authorize this facility and its affiliates to share my medical record and/or any information contained therein, including, without limitation, laboratory procedure results (such as HIV test results), with Medicare, Medicaid or any other applicable insurance benefits provider to further the purposes of the foregoing.

ASIGNACION DE BENEFICIOS DE SEGURO Y NOMBRAMIENTO DE UN REPRESENTATE AUTORIZADO

Yo autorizo el pago a Medicare, Medicaid u otros beneficios de seguro de otra forma pagaderos a mi por los servicios provistos que consideren necesarios mi medico(s) or el/los de mi hijo, directamente a este centro y sus afiliados, medicos tratantes y en consultas y profesionales aliados de salud. Donde apliquen BENEFICIOUS DE MEDICARE Y MEDICAID, yo certifico que la information brindada por mi al aplicar para pago bajo el Titulo XVIII or XIX de la ley del Seguro Social es correcta, y solicito que estos pagos de los beneficios autorizados se hagan directamente a este establecimiento y sus afiliados; medico tratante o en consulta, y profesionales aliados de salud de parte mia. Para cobertura o beneficios bajo my ERISA (una ley federal que establece estandares minimos para la mayoria de los planes de pension y salud voluntairamente establecidos en la industria privada) plan de beneficios de salud (el "Plan") si aplicara. Yo nombro al dueno licenciado y legal de este establecimito para que actue en my nombre. Yo tambien autorizo a este establecimiento, como mi representative autorizado, para recibir cualquiera y toda la information que se me brined, y para actuar en my nombre al dar a mi Plan informacion relacionada a cualquier reclamo para cobertura o beneficious bajo este Plan. Yo acuerdo ejecutar tales documentos segun sea apropiado apropiado y autorizo a esta instalación médica y sus afiliadas a compartir mi historia clínica y/o cualquier información contenida en la misma, incluyendo, a título enunciativo pero no limitativo, resultados de procedimientos de laboratorio (tales como resultados de pruebas de VIH), con Medicare, Medicaid o cualquier otro proveedor de beneficios de seguro correspondientepara mejorar los propositos de lo anterior.

GUARANTEE OF PAYMENT

I guarantee payment of any and all charges incurred, which are not covered or allowable by my insurance, or Medicare, if any, to this facility and its affiliates, attending and consulting physicians and allied health professionals. This includes any denial of payment due to lack of medical necessity or pre-certification/authorization (as may be determined by a review organization), lack of affiliation with an HMO or any other constraint imposed as a condition of my insurance coverage. It is further agreed that if this account is referred for collection, I will pay the costs of collection including litigation costs and reasonable trial and appellate attorney's fees. An itemized bill is available from Patient Financial Services. I understand and acknowledge that the bill I will receive from this facility may not include charges for the services provided at this facility by attending and consulting physicians and allied health professionals. I may be billed separately by these individuals, who may or may not be contracted providers with my insurance company (if insured), and understand it is my responsibility to pay for those.

GUARANTIA DE PAGO

Yo garantizo el pago de cualquiera y todos los cargos incurridos, que no estén cubiertos o permitidos por mi seguro, o Medicare, si lo hubiera, a este establecimiento y sus afiliados, médicos tratantes y en consulta y profesionales aliados de salud. Esto incluye cualquier negativa de pago debido a falta de necesidad médica o pre-certificación/autorización (según pudiera determinarlo una organización de revisión), falta de afiliación con un HMO o cualquiera otra restricción impuesta como condición para mi cobertura de seguro. Además, acuerdo que si esta cuenta se refiere a cobro, yo pagaré los costos de cobro incluyendo los costos de la querella y honorarios razonables del abogado de la corte y apelación. Hay disponible una factura desglosada de los Servicios Financieros del Paciente.

Entiendo y reconozco que la factura que recibiré de parte de esta instalación pudiera no incluir los cargos por concepto de los servicios prestados, en esta instalación, por los médicos tratantes y consultores y por otros profesionales de la salud asociados. Es posible que sea facturado aparte por dichos individuos, quienes pueden ser o no ser proveedores bajo contrato con mi aseguradora (si estuviera asegurado), y entiendo que soy responsable de pagar dichos servicios por separado.

RECEIVED AS IS

THIRD PARTY COMMUNICATIONS

I hereby consent to and authorize this facility and its affiliates as well as any third parties acting on their behalf or for their benefit and any successors, assigns, affiliates, or agents, including without limitation any debt collectors, to make calls to, send text messages to, communicate with me and/or contact me at any telephone number or e-mail address associated with my account(s), including, without limitation, any telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service, or any service for which I am charged for the call, whether such number or e-mail address was provided by me in the past, present or future or whether obtained by any other method whatsoever. I agree that methods of contact many include using pre-recorded or artificial voice message and/or an automatic telephone dialing system. This consent and authorization shall be construed as broadly as possible under 47 U.S.C.A section 227.

COMUNICACIONES CON TERCEROS

Por la presente consiento y autorizo a este centro y sus afiliados así como a cualquier tercero actuando en su nombre o para su beneficio y cualquier sucesor, asignado, afiliado o agente, incluyendo sin limitaciones a cualquier cobrador de deudas, a hacer llamadas, enviar mensajes de texto, comunicarse conmigo y/o contactarme a cualquier número de teléfono o dirección de correo electrónico asociado con mi(s) cuenta(s), incluyendo, y sin limitaciones, a cualquier número de teléfono asignado a servicios de localización (pagers), servicios de teléfono celular, servicios de radio móvil especializado u otros proveedor de servicios de radio común, o cualquier servicio por el cual se me cobre por la llamada, lo mismo si tal número o dirección de correo electrónico lo brindé yo en el pasado, presente o futuro o si fue obtenido mediante absolutamente cualquier otro método. Estoy de acuerdo que los métodos de comunicación pueden incluir usar un mensaje pre-grabado o de voz artificial y/o un sistema que marca el teléfono automáticamente. Este consentimiento y autorización se interpretará tan ampliamente como sea posible bajo el 48 U.S.C.A. sección 227.

PERSONAL VALUABLES

I acknowledge that this facility does not accept responsibility for any personal property. I understand that this facility advises patients to send any valuables home or to inquire about securing valuables, if this service is available in the treatment setting. I accept the risk of loss or damage to any of my or my child's personal property.

OBJETOS PERSONALES DE VALOR

Yo reconozco que este centro no acepta responsabilidad por ninguna propiedad personal. Comprendo que este centro aconseja a los pacientes que envíen a casa sus artículos de valor o pregunten sobre como, resguardar sus objetos de valor, si este servicio esta disponible en el lugar del tratamiento. Yo acepto el riesgo de pérdica o daño de cualquier propiedad personal mía, o de mi hijo.

EMAIL COMMUNICATIONS

By providing an e-mail address above, I will be able to access the Baptist Health patient portal to obtain information about the services I received at this facility. I consent to the use of that e-mail by this facility and its affiliates to communicate with me and to send me information related to the services provided by the facilities and/or their affiliates, and other related reasons. However, e-mail will not be used to communicate clinical information about my condition, care, or treatment unless I separately consent to use e-mail for that purpose. I understand that this facility and/or its affiliates and their employees, medical staff and agents may use, save, and have access to e-mails that are sent from or to me for those and any legally permitted purposes. I also understand that e-mails may include personal information about me, that the information included may be accessed by any individual who has access to the e-mail address I have provided, and that it is my responsibility to safeguard access to that information. (Note: Any e-mail address provided by a parent for communication on behalf of a patient who is their minor child will no longer be used by Baptist Health after the date that child becomes an adult).

COMUNICACIONES POR CORREO ELECTRÓNICO

Al brindar la dirección de correo electrónico que aparece arriba, yo podré tener acceso al portal de pacientes de Baptist Health y obtener información sobre los servicios que he recibido en este centro. Yo consiento al uso de ese correo electrónico por parte de este centro y sus afiliados para comunicarse conmigo y enviarme información relacionada con los servicios brindados por los centros y/o sus afiliados, y otras razones relacionadas. Sin embargo, el correo electrónico no se utilizará para comunicar información clínica sobre mi condición, atención o tratamiento a menos que yo por separado consienta al uso del correo electrónico con ese propósito. Comprendo que este centro y/o sus afiliados y sus empleados, personal médico y agentes pueden usar, guardar y tener acceso a los correos electrónicos que yo envíe o se me envíen para cualquier propósito permitido legalmente. También comprendo que los correos electrónicos pueden incluir información personal sobre mí, mi condición, o servicios brindados por el centro o sus afiliados, que a la información incluida pudiera tener acceso cualquier individuo que tenga acceso a la dirección de correo electrónico que yo brindé, y que es mi responsabilidad.

Margie Somarriba

PRINT NAME/NOMBRE(EN LETRA DE MOLDE)

Margie

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE/
FIRMA DEL PACIENTE O DEL REPRESENTANTE

SELF

PERSONAL REPRESENTATIVE'S AUTHORITY TO
ACT/RELACION DE AUTORIDAD DEL REPRESENTANTE.

10/11/16 1625

DATE/FECHA TIME/HORA

RECEIVED AS IS

User ID: EMRCXP LC EMR1
Date: 10/11/2016 Time 16:25

Patient: [redacted]
MRN: 000001387800 EAD: 005139471 Acct#: [redacted]
DOB: [redacted]
Sex: F Age: [redacted]
PCP: PIMENTEL, ELEONOR,
ATN/REF: GONZALEZ-ROJAS, YANEICY,
Chief Complaint: seizure

Time Seen: 15:23 Oct 11 2016; initial patient contact, initial documentation.
Arrived- By ambulance. Historian- patient and family.
Attending Note: Documentation assistance provided by scribe (Alyssa Anteen). Information recorded by the scribe was done at my direction (Dr. Campbell). Information recorded by the scribe has been reviewed and validated by me (Dr. Campbell).

HISTORY OF PRESENT ILLNESS

Chief Complaint: SINGLE SEIZURE. This occurred today. Unknown when patient was last known well. The patient has recovered. Seizure was not witnessed. Had a single isolated seizure. Post-ictally has had weakness. No injuries noted.

Did not recently change anticonvulsant medication or miss recent dose of anticonvulsant. No recent sleep deprivation or alcohol recently. [redacted] y F presents with a single seizure episode that occurred today while having an Iodine injection for a scan at a spine center. She was premedicated with Prednisone and Benadryl due to a Iodine allergy. Per son, she was being evaluated for possible blood clots (her lungs are clean, per son from her last CT scan) and her graft not working. Pt is on dialysis M,W,F and only had about 45 minutes of dialysis yesterday, and she usually receives about 4 hours of dialysis.

Similar symptoms previously: Once. (Per son, she had one prior seizure episode in the past and he states that it occurred "a long time ago.").

Recent medical care: The patient was seen recently in a clinic. (For a scan to evaluate her blood clots and her graft not working.).

REVIEW OF SYSTEMS

No chills, fever, double vision, eye irritation or ear pain. No hearing loss, epistaxis, runny nose, sore throat or cough. No difficulty breathing, diarrhea, nausea, vomiting or hematuria. No joint pain, neck pain, laceration, skin lesions or headache. No difficulty with urination or swelling. The patient has had abdominal pain (chronic). She had seizure activity. All systems otherwise negative, except as recorded above.

PAST HISTORY

(Per son, she has a hx of chronic abdominal pain). Hypertension. Anemia. Hypothyroidism. Renal failure; on dialysis. Lupus.

Surgeries: Appendectomy. Cholecystectomy. Had hysterectomy. Lung surgery.
Allergies:

SOCIAL HISTORY

Never smoker. No alcohol use or drug use.

ADDITIONAL NOTES

The nursing notes have been reviewed.

PHYSICAL EXAM

Vital Signs: 10/11/2016 15:19 BP: 158/124. HR: 93. RR: 33. O2 saturation: 93%. Temp: 97.6 F. Have been reviewed and appear to be correct.
Appearance: Alert. No acute distress.
Eyes: Pupils equal, round and reactive to light.
ENT: Normal ENT inspection. Moist mucous membranes. Pharynx normal.
Neck: Normal inspection. Neck supple.
CVS: Normal heart rate and rhythm. Heart sounds normal.
Respiratory: Respiratory distress.
Abdomen: Soft and nontender.
Back: Normal inspection.
Skin: Skin warm and dry. Normal skin color.
Extremities: Extremities exhibit normal ROM. No lower extremity edema.
Neuro: Alert. Oriented X 3. Cranial nerves normal (as tested). No cerebellar findings. No motor deficit.

LABS, X-RAYS, AND EKG

EKG: EKG time: (15:28 Oct 11 2016). Tachycardia (110). Normal P waves. Normal QRS complex. Non-specific ST segment / T wave abnormalities in lead V1, V2 and V3. The study has been interpreted contemporaneously by me. The study has been independently viewed by me.
Laboratory Tests: Laboratory tests have been ordered, with results reviewed and considered in the medical decision making process.

BUN: (COLL: 10/11/2016 17:52) (MsgRcvd 10/11/2016 18:43) Final results

This order is a replacement of the rejected order with accession number 2651621360.

Test	**Result**	**Flag**	**Units**	**(Reference)**
BUN	51	H	mg/dL	(8-23)

CO2: (COLL: 10/11/2016 17:52) (MsgRcvd 10/11/2016 18:43) Final results

This order is a replacement of the rejected order with accession number 2651621360.

Test	**Result**	**Flag**	**Units**	**(Reference)**
CO2 (Bicarbonate)	21		mmol/L	(21-32)
Anion Gap	14			(2-15)

POTASSIUM: (COLL: 10/11/2016 17:52) (MsgRcvd 10/11/2016 18:43) Final results

This order is a replacement of the rejected order with accession number 2651621360.

Test	**Result**	**Flag**	**Units**	**(Reference)**
Potassium	6.6	HC	mmol/L	(3.5-5.1)

Called to and read back by:
rn yoleny pereda at 1840 10/11/15/vp

TROPONIN I: (COLL: 10/11/2016 17:52) (MsgRcvd 10/11/2016 18:43) Final results

This order is a replacement of the rejected order with accession number 2651621360.

Test	**Result**	**Flag**	**Units**	**(Reference)**
Troponin I	0.35	H	ng/mL	(0.00-0.05)

CHLORIDE: (COLL: 10/11/2016 17:52) (MsgRcvd 10/11/2016 18:43) Final results

This order is a replacement of the rejected order with accession number 2851621360.

Test	**Result**	**Flag**	**Units**	**(Reference)**
Chloride	100		mmol/L	(98-107)

CREATININE: (COLL: 10/11/2016 17:52) (MsgRcvd 10/11/2016 18:43) Final results

This order is a replacement of the rejected order with accession number 2851621360.

Test	**Result**	**Flag**	**Units**	**(Reference)**
Creatinine	6.44	H	mg/dL	(0.60-1.30)
BUN/Creat Ratio	7.9	L	ratio	(12.0-20.0)

SODIUM: (COLL: 10/11/2016 17:52) (MsgRcvd 10/11/2016 18:43) Final results

This order is a replacement of the rejected order with accession number 2851621360.

Test	**Result**	**Flag**	**Units**	**(Reference)**
Sodium	135	L	mmol/L	(136-145)

GLUCOSE (RANDOM): (COLL: 10/11/2016 17:52) (MsgRcvd 10/11/2016 18:43) Final results

This order is a replacement of the rejected order with accession number 2851621360.

Test	**Result**	**Flag**	**Units**	**(Reference)**
Glucose, Random	117		mg/dL	(80-126)

BRAIN CT W/O CONTRAST : (COLL: 10/11/2016 17:20) (MsgRcvd 10/11/2016 17:33) New Order

Exam
CT 7895GDT
ORDERED BY: DAMION RIRCHARD CAMPBELL, M.D.READ BY: LORNA WILLIAMS ON: Oct 11 2016 5:31P***FINAL RESULT***ADMITTING DIAGNOSIS: SEIZUREPROCEDURE: SCT 7895 BRAIN CT WO CONAcc #: 20351885 Date: Oct 11 2016 CPT: 70450PROCEDURE: BRAIN CT WO CONCLINICAL INDICATION:SEIZURE AND HEADACHE TODAYCOMPARISON:01/24/2016 CT brainTECHNIQUE:Noncontrast axial images through the brain were obtained. Radiation dosereduction techniques used for this exam include: Iterative ReconstructionTechnique and/or adjustments of the mA/kV according to patient size.DISCUSSION:The ventricles are midline and nondilated. Hemorrhage or acuteextra-axial fluid collection is not seen.Generalized cortical and central atrophy is seen stable when compared tothe prior examination. Decreased attenuation is seen within theperiventricular white matter suggesting mild small vessel ischemicchanges, stable from prior exam.No acute parenchymal attenuation abnormalities are identified. Nodefinite area of acute infarction is seen.The visualized osseous structures are intact.IMPRESSION:No acute intracranial findings.READ BY: LORNA WILLIAMS ON: Oct 11 2016 5:31P***FINAL RESULT***

CBC WITH DIFF - BHSF: (COLL: 10/11/2016 16:20) (MsgRcvd 10/11/2016 17:11) Final results

Test	**Result**	**Flag**	**Units**	**(Reference)**
WBC	15.75	H	K/uL	(3.40-11.00)
RBC	4.30		M/uL	(3.80-5.20)
Hgb	13.6		g/dL	(12.0-15.0)
Hct	43.0		%	(35.0-45.0)
MCV	100.0		fL	(80.0-100.0)
MCH	31.6		pg	(26.0-35.0)
MCHC	31.6	L	g/dL	(32.0-36.0)
RDW CV	17.5	H	%	(11.5-14.5)
Plt Ct	106	L	K/uL	(130-360)
MPV	9.9		fL	(7.7-13.2)
Diff.Type	AUTO			
% Neutrophils	90.9	H	%	(40.0-70.0)
% Lymphocytes	6.0	L	%	(17.0-45.0)
% Monocytes	1.8	L	%	(3.0-12.0)
% Eosinophils	0.1		%	(0.0-7.0)
% Basophils	0.1		%	(0.0-1.0)
% Imm. Gran.	1.1	H	%	(0.0-0.4)
Metanyelocytes, Myelocytes, and Promyelocytes only				
Abs Neutrophils	14.31	H	K/uL	(1.10-8.00)
Abs Lymphocytes	0.95		K/uL	(0.60-3.10)
Abs Monocytes	0.29		K/uL	(0.00-0.36)
Abs Eosinophils	0.01		K/uL	(0.00-0.36)
Abs Basophils	0.01		K/uL	(0.00-0.08)
Abs Imm. Gran.	0.18	H	K/uL	(0.00-0.03)

Test	**Result**	**Flag**	**Units**	**(Reference)**
PT	18.1	H	Seconds	(11.1-15.5)
INR	1.5	H		(0.8 1.2)

Interpretive Comment:
2.0 - 3.0 Therapeutic
2.5 - 3.5 Mechanical Heart Valve

Estimated Glomerular Filtration Rate: (COLL: 10/11/2016 16:20) (MsgRcvd 10/11/2016 16:48)
Final results

Test	**Result**	**Flag**	**Units**	**(Reference)**
Est.Glom.Filtr.Rate	Result:		mL/min/1.73sq.m	
Estimated GFR if African American	= 8Estimated GFR if non - African American = 7			

Note: The estimated glomerular filtration rate (eGFR) is
calculated using the simplified 4 variable MDRD formula.
An eGFR value above 60 mL/min/1.73 sq. meters is simply reported as
>60 mL/min/1.73 sq. meters and not as an exact number.
It is important to recognize that this prediction equation has
many limitations and may not be valid in the following conditions
or situations: rapidly changing renal function, ages <18 and >70 years,
pregnancy, exceptional dietary
practice (vegetarian, creatine supplements), any extremes of body size,
any changes of muscle mass (amputation, muscle wasting, malnutrition,
paraplegia, quadriplegia,diseases of skeletal muscle) and prior to
dosaging drugs excreted by the kidney.
In these clinical conditions, clinical judgement is necessary
and a twenty-four hour urine collection may be considered.

AKI Risk FAILURE
Staging for Acute Kidney Injury (AKI) based on modified RIFLE
classification, AKI Network stages and the Kidney Disease Improving
Global Outcomes (KDIGO) Guidelines.
RIFLE?Risk Injury Failure Loss End stage
Baseline SCr - 0.797506 Collected: ########
Recommendation: (To be used only for monitoring patient clinical status)
Notify the attending/managing physician
Acute Kidney Injury is defined as the presence of any of the following:
1. Increase in serum creatinine by >=0.3 mg/dL (>=26.5 micromol/L) within
48 hours; or
2. Increase in serum creatinine by >=1.5 times baseline, which is known or
presumed to have occurred within the prior seven days; or
3. Urine volume <0.5 mL/kg/h for six hours
RISK
Stage 1 - Increase in serum creatinine to 1.5 to 1.9 times baseline, or
increase in serum creatinine by >=0.3 mg/dL (>=26.5 micromol/L), or
reduction in urine output to <0.5 mL/kg per hour for 6 to 12 hours.
INJURY
Stage 2 - Increase in serum creatinine to 2.0 to 2.9 times baseline, or
reduction

SCAN - BHSF (WAM): (COLL: 10/11/2016 16:20) (MsgRcvd 10/11/2016 17:11) Final results

Test	**Result**	**Flag**	**Units**	**(Reference)**
RBC Morph.	REVIEWED			

The previous value of "no value" was changed
by IF on 10/11/16 17:11 to "REVIEWED"

Platelet Morphology NORMAL
The previous value of "no value" was changed
by IF on 10/11/16 17:11 to "NORMAL"

CHEST SINGLE VIEW XR: (COLL: 10/11/2016 16:00) (MsgRcvd 10/11/2016 15:23) New Order

hernia. The cardiopericardial silhcuette is within normallinits.There is no consolidation. No pleural effusions are present. The bonesare unremarkable for age.IMPRESSION:There is no acute cardiopulmonary disease.Large hiatal hernia.Dialysis catheter as above.READ BY: LOUIS P FREEMAN ON: Oct 11 2016 4:21D***FINAL RESULT***

Pulse Oximetry: 10/11/2016 15:19 O2 saturation: 93%. (FIO2 - room air). Interpretation: normal.

PROGRESS AND PROCEDURES

Course of Care: 15:24 10/11/16. Call placed to Respiratory for a Duoneb breathing treatment.

15:31 Oct 11 2016. Trandate 20 mg IV, Solumedrol 125 mg IV, Pepcid 20 mg IV, and Benadryl 25 mg IVP ordered.

15:32 Oct 11 2016. Chest XR ordered.

15:32 Oct 11 2016. UA, troponin, glucose, PT, PTT, and labs ordered.

17:20 Oct 11 2016. Brain CT ordered.

19:05 Oct 11 2016. Ecotrin, Dextrose, Humulin, Sodium Bicarb, Calcium Gluconate ordered due to high potassium level (6.6).

19:25 10/11/16. Case discussed with Dr. Sanjar who accepts the patient for admission.

Critical care performed (40 minutes). Time is exclusive of separately billable procedures. Time includes: direct patient care, patient reassessment, interpretation of data (laboratory data and chest xrays), review of patient's medical records, medical consultation and documentation of patient care- see progress notes.

Patient and family counseled in person several times regarding the patient's stable condition, diagnosis and need for additional testing. Concerns were addressed. Old medical records reviewed. Patient has had multiple ED visits.

Disposition orders written.

CLINICAL IMPRESSION

Generalized seizure.
Acute myocardial infarction with elevated markers and no ST elevation (NSTEMI).
Chronic renal failure- end stage disease.
Hyperkalemia.
malfunctioning dialysis graft.

(Electronically signed by Campbell, Damion R, M.D. 030114 10/18/2016 1:30)

[redacted]

Patient: [redacted]
MRN: 000001387800 EAD: 005139471 Acct#: [redacted]
DOB: [redacted]
Sex: F Age: [redacted]
PCP: PIMENTEL, ELEONOR,
ATN/REF: GONZALEZ-ROJAS, YANEICY,
Chief Complaint: seizure

TRIAGE

Triage time: 15:15 10/11/2016. Acuity: LEVEL 1.
Chief Complaint: (Seizure / allergic reaction).
Alert. No acute distress.

SEPSIS SCREEN: NEGATIVE. Infection suspected/documented. Heart rate greater than 90. Temperature not greater than 38.3 degrees C (101 degrees F). Respiratory rate not greater than 20. --15:30 (10/11/16) Herrera, Barbara, R.N.

15:19 10/11/16. BP: 158/124. HR: 93. RR: 33. O2 saturation: 93%. Temp: 97.6 F. Pain level now deferred. --15:30 (10/11/16) Herrera, Barbara, R.N.
Weight: 55.3 kg. Height/Length: 56 inches. BMI: 27.3. --15:17 (10/11/16) Herrera, Barbara, R.N.

Medications

Aspirin Oral (Tablet 81 mg) 1 tablet, daily .
CloNIDine HCl Oral 0.1 mg, 2x a day.
Dexilant Oral 30 mg, at bedtime.
Dialyvite 3000 Oral, daily , last dose unk.
Dicyclomine HCl Oral 20 mg, 2x a day.
Folic Acid Oral 1 mg, daily. --19:29 (10/11/16) Pereda, Yeleny, R.N.
Isoniazid Oral (Tablet 300 mg), daily.
Medications reviewed with patient and obtained from dialysis center list.
PAROxetine HCl Oral (Tablet 40 mg) 1 tablet, daily .
Plaquenil Oral (Tablet 200 mg) 1 tablet, daily .
Proteinex Oral 15ml , daily, last dose unk.
Renvela Oral (Tablet 800 mg) 2 tablets, 3x a day with meal. --19:29 (10/11/16) Pereda, Yeleny, R.N.

Allergies

Amoxicillin.
Dilantin.
Iodine.
Sulfa Antibiotics. --15:30 (10/11/16) Herrera, Barbara, R.N.

History

[redacted]

bedside. Pt noted c a redness via neck and partial face area / swelling. No active seizure activity.). No fever or cough.

Treatment PTA:
Took Benadryl. Symptoms did not improve after treatment. See EMS report. Finger stick glucose performed (FR # 86).

PAST MEDICAL HX: Dialysis shunt. (Hypertension. Seizures. Renal failure; on dialysis- M-W-D. Lupus. Anemia. Hypothyroidism.).
SOCIAL HX: Never smoker. Alcohol use. (SBIRt NO).

NUTRITIONAL RISK ASSESSMENT: The nutritional risk assessment revealed no deficiencies.

LEARNING NEEDS ASSESSMENT: The learning needs assessment revealed no barriers.

FALL RISK ASSESSMENT: Fall risk assessment completed. Risk factors identified include patient age greater than 65 years.

FUNCTIONAL ASSESSMENT: Functional assessment performed: uses wheelchair and walker.

SKIN INTEGRITY ASSESSMENT: Skin integrity risk assessment completed. No skin integrity risk identified. --15:30 (10/11/16) Herrera, Barbara, R.N.

PROBLEMS:
Arthritis.
Hypothyroidism.
Anemia.
DVT - Deep Venous Thrombosis.
Seizure.
Renal Failure.
Coronary Artery Disease.
Cholelithiasis.
Biliary Colic.
Hypertension.
Systemic Lupus Erythematosus. --19:30 (10/11/16) Pereda, Yeleny, R.N.

ADDITIONAL SURGERIES:
Appendectomy.
Cholecystectomy.
Hysterectomy.
Lung Surgery.
Oophorectomy. --19:30 (10/11/16) Pereda, Yeleny, R.N.

Interventions
Allergy band on patient. To room. --15:30 (10/11/16) Herrera, Barbara, R.N.

15:00 10/11/2016 Site #1 started prior to arrival by transferring facility via IV in the right hand with an 20g angiocath. --15:26 (10/11/16) Herrera, Barbara, R.N.

HEENT: No facial asymmetry noted. Mucous membranes are pink.
RESPIRATORY: Chest nontender. Breath sounds within normal limits.
CVS: Capillary refill less than 2 seconds. Pulses within normal limits.
GI / GU: Abdomen soft and nontender and normal bowel sounds.
SKIN: Skin intact. Skin is warm and dry. Normal skin turgor. --15:34 (10/11/16) Pereda, Yeleny, R.N.

EXTREMITIES: (dialysis shunt of left femoral noted). --15:35 (10/11/16) Pereda, Yeleny, R.N.

NURSING PROGRESS NOTES

15:20. Cardiac rhythm: sinus tachycardia; (109). Oxygen administered by nasal cannula at 2 liters. Cardiac monitor, pulse oximeter and NIBP monitor placed on patient; cardiac monitor- Lead II; monitor alarms on. Patient gowned. Head of bed elevated. Reassurance given to the patient and patient's family. Two patient identifiers checked. Call light placed in reach. Side rails up x 2. Bed placed in lowest position. Brakes of bed on. Patient ready for evaluation- ED physician notified. (EDP- Dr. Campbell.). --15:31 (10/11/16) Herrera, Barbara, R.N.

15:25. (Respiratory called for breathing tx). --15:31 (10/11/16) Herrera, Barbara, R.N.

15:28 10/11/16. EKG time: (15:28 Oct 11 2016). EKG was ordered, performed by a tech and shown to the ED physician. --16:33 (10/11/16) Pereda, Yeleny, R.N.

15:36 10/11/16 respiratory at bedside for tx. --15:36 (10/11/16) Pereda, Yeleny, R.N.

15:45 10/11/16. Seizure precautions maintained: side rails up x2 and padded, suction, O2 and family at bedside, patient in view of nurse's station and call bell in reach. --16:39 (10/11/16) Pereda, Yeleny, R.N.

15:48 10/11/2016 PEPCID IVP 20 mg given over 2 minute(s) via site #1 per protocol. Allergies verified and confirmed 5 rights. IV patency established. IV site checked: no pain, redness, or swelling. IV flushed thoroughly pre- and post-medication administration. IVP given by RN. --15:55 (10/11/16) Pereda, Yeleny, R.N.

15:50 10/11/2016 BENADRYL (DiphenhydrAMINE HCl) IVP 25 mg given over 2 minute(s) via site #1 per protocol. Allergies verified, confirmed 5 rights and sedative warning given to the patient. IV patency established. IV site checked: no pain, redness, or swelling. IV flushed thoroughly pre- and post-medication administration. IVP given by RN. --15:56 (10/11/16) Pereda, Yeleny, R.N.

15:52 10/11/2016 SOLU-MEDROL IVP 125 mg given over 2 minute(s) via site #1 per protocol. Allergies verified and confirmed 5 rights. IV patency established. IV site checked: no pain, redness, or swelling. IV flushed thoroughly pre- and post-medication administration. IVP given by RN. --15:56 (10/11/16) Pereda, Yeleny, R.N.

15:57 Oct 11 2016as per edp dr. campbell will hold trandate due to bp of 140/86. --15:57 (10/11/16) Pereda, Yeleny, R.N.

15:56 10/11/16 chest xray tech at bedside. --16:29 (10/11/16) Pereda, Yeleny, R.N.

16:30 10/11/16. Patient and family informed about reason for wait. Patient waiting for CT to be done. --16:30 (10/11/16) Pereda, Yeleny, R.N.

17:06 10/11/16.
GENERAL / NEURO / PSYCH: Appears in no acute distress. Patient transported to CT by stretcher with tech. --17:06 (10/11/16) Pereda, Yeleny, R.N.

17:20 10/11/16. Patient returned from CT by stretcher with tech. --17:20 (10/11/16) Pereda, Yeleny, R.N.

17:31 10/11/16. The patient is calm and resting quietly.
RESPIRATORY: No respiratory distress.
SKIN: Skin is warm and dry. Skin color within normal limits. --17:31 (10/11/16) Pereda, Yeleny, R.N.

18:18 10/11/16. BP: 107/64. HR: 91. RR: 18. O2 saturation: 100%. Pain level now 0/10. --18:18 (10/11/16) Pereda, Yeleny, R.N.

18:18 10/11/16. The patient reports no complaints and she is calm and resting quietly.
RESPIRATORY: No respiratory distress.
CVS: Denies chest pain.
SKIN: Skin is warm and dry. Skin color within normal limits. --18:18 (10/11/16) Pereda, Yeleny, R.N.

18:48 10/11/16. K: 6.6. Critical value read back. Verified lab result and patient ID. ED physician notifed of critical value (Dr. Campbell). --18:48 (10/11/16) Pereda, Yeleny, R.N.

18:50 Oct 11 2016 as per pt, pt does not produce urine EDP made aware. --18:58 (10/11/16) Pereda, Yeleny, R.N.

19:15 10/11/16. Care transferred and report given (jazmine). --19:27 (10/11/16) Pereda, Yeleny, R.N.

19:47 10/11/16. (DR. SANJAR TO SEE PT. PER DR. SANJAR, SHE SPOKE WITH NEPHROLOGIST AND PER NEPHROLOGIST, PT. IS TO BE MEDICATED FIRST FOR HYPERKALEMIA AND POTASSIUM LEVEL REPEATED. NEPHROLOGIST TO BE MADE AWARE IF CRITICAL POTASSIUM LEVEL PERSISTS.). --19:51 (10/11/16) Roses, Marta, R.N.

19:50 10/11/16. (DR. SANJAR AT BEDSIDE FOR PT ADMISSION AND GAVE THE OK TO ACCESS DIALYSIS U-DALL TO LEFT THIGH.). --20:07 (10/11/16) Atiles, Jasmine, R.N.

19:51 10/11/2016 Site #2 accessed indwelling dialysis catheter in the left femoral using a non-coring needle-less system following sterile technique; 1 attempt. Good blood return noted. Site prepped with alcohol. Proximal port flushed with 5 mL saline. --20:08 (10/11/16) Atiles, Jasmine, R.N.

19:53 10/11/16. BP: 111/63. HR: 91. RR: 20. O2 saturation: 100%. Pain level now 0/10. --20:09 (10/11/16) Atiles, Jasmine, R.N.

19:54 10/11/16. Finger stick glucose: 85; performed by nurse. --20:09 (10/11/16) Atiles, Jasmine, R.N.

19:55 10/11/2016 DEXTROSE 50%-WATER (Electrolyte-A in Dextrose) IVP 25 gm given via site #2 Allergies verified and confirmed 5 rights. IV patency established. IV site checked: no pain, redness, or swelling. IV flushed thoroughly pre- and post-medication administration. IVP given by RN. --20:10 (10/11/16) Atiles, Jasmine, R.N.

[redacted]

19:57 10/11/2016 SODIUM BICARBONATE IVP 50 meq given via site #2 Allergies verified and confirmed 5 rights. IV patency established. IV site checked: no pain, redness, or swelling. IV flushed thoroughly pre- and post-medication administration. IVP given by RN. --20:12 (10/11/16) Atiles, Jasmine, R.N.

20:00 10/11/2016 Started 1 gm of CALCIUM GLUCONATE IVPB in bag #1 100 mL; at over 15 minute(s) via site #2 via IV pump. Allergies verified and confirmed 5 rights. IV flushed thoroughly pre- and post-medication administration. --20:13 (10/11/16) Atiles, Jasmine, R.N.

20:01 10/11/2016 KAYEXALATE PO Oral Suspension 30 gm given. Allergies verified and confirmed 5 rights. --20:13 (10/11/16) Atiles, Jasmine, R.N.

20:03 10/11/2016 ECOTRIN * PO 243 MG VERIFIED 5 PT RIGHTS AND ALLERGIES. --20:14 (10/11/16) Atiles, Jasmine, R.N.

20:15 10/11/2016 CALCIUM GLUCONATE IVPB Discontinued: bag #1 completed upon admission. Total amount infused: 100 mL. IV patency established. IV site checked: no pain, redness, or swelling. IV flushed thoroughly. --20:49 (10/11/16) Atiles, Jasmine, R.N.

20:21 10/11/16. (ATTEMPTED TO GIVE REPORT HOWEVER PT IS NOW GOING TO BE PLACED IN 4 PAV NOT 7 PAV.). --20:21 (10/11/16) Atiles, Jasmine, R.N.

DISPOSITION / DISCHARGE

19:25 10/11/16. (ADMIT: GONZALEZ ROJAS IMPT, TELE DX: ACUTE SEIZURE). --20:16 (10/11/16) Atiles, Jasmine, R.N.

20:48 10/11/16. Condition at departure: stable. The goals identified in the patient's plan of care were met. Fall risk assessment completed per protocol. Admitted to Telemetry. Transported via stretcher by nurse and transport team with monitor and IV. Report was given to a nurse via a phone call. Report included patient's care, treatment, medications, reviewed medication reconcilliation, and condition (including any recent changes or anticipated changes). All questions were answered. Report was acknowledged and care was transferred. (MARTINE). Bed obtained and ready (414).

FALL RISK ASSESSMENT: Fall risk assessment completed. No fall risk identified. --20:48 (10/11/16) Atiles, Jasmine, R.N.

~~21:00 10/11/16. (111/63. HR: 91. RR: 20. O2 saturation: 100%. Pain level now 0/10.). --21:05 (10/11/16) Atiles, Jasmine, R.N.~~ Correction --21:05 (10/11/16) Atiles, Jasmine, R.N.

21:00 10/11/16. BP: 112/66. HR: 89. RR: 18. O2 saturation: 99%. Pain level now 0/10. --21:05 (10/11/16) Atiles, Jasmine, R.N.

Departure time: 21:05 10/11/2016. --21:05 (10/11/16) Atiles, Jasmine, R.N.

Locked/Released at 10/11/2016 21:06 by Atiles, Jasmine, R.N.

DISCHARGE SUMMARY

PATIENT NAME: [redacted]
MEDICAL RECORD NUMBER: 000001387800
ACCOUNT NUMBER: [redacted]
DATE OF ADMISSION: 10/11/2016
DATE OF DISCHARGE: 10/16/2016
PHYSICIAN: ARIEL MOSES, MD
SERVICE: EDA

CHIEF COMPLAINT: A [redacted]-year-old woman with a history of ESRD who was admitted initially with reported seizures during a procedure and then had a lower GI bleed. Please see H and P for further details.

HOSPITAL COURSE BY PROBLEM:

1. Reported seizures. The patient was admitted after having what seemed to be an episode of altered mental status or seizures while undergoing a contrast study with iodine and left groin catheter. Neurology was consulted and she is followed by Dr. Garcia-Mayol in the outpatient setting. She was started initially on IV Keppra. An EEG was done, which showed no clear significant abnormalities in the awake and drowsy states. She also had a brain CT on admission, which showed no acute intracranial findings. Neurology is following, Dr. Ardila, most likely the altered mental status, given negative EEG, was secondary to metabolic disturbances, again secondary to not being able to take dialysis and noncompliance with diet. No need for AED as per neurology and they will followup as an outpatient.
2. Lower GI bleed. The patient did have an episode of a GI bleed with bright red blood per rectum. On October 12, 2016, she underwent an initial bleeding scan, which did not show any evidence of an active GI bleed. Following this, however, she did have several episodes of small amounts of bright red blood per rectum. She underwent a colonoscopy on October 14, 2016, by Dr. Brand, which showed extensive diverticulosis and internal hemorrhoids. On the day of discharge, the patient's CBC and hemoglobin have been stable without any recurrent episodes of GI bleed. She will follow up outpatient as needed.
3. Troponinemia. The patient did have an episode of troponinemia with a troponin of 0.38 at its peak and an echocardiogram which showed a normal ejection fraction with moderate tricuspid regurgitation on EKG with nonspecific changes. Most likely, all of this was secondary to the underlying disease process, including ESRD, SLE and the lower GI bleed, so there was no further intervention by Cardiology, who was consulted. The consultant being Dr. Schroeder.
4. ESRD. The patient was continued on dialysis and followed by Dr. Garcia-Mayol while in the hospital.

DISCHARGE MEDICATIONS:

1. Aspirin 81 daily.
2. Atenolol 12.5 b.i.d.
3. Dexilant 60 mg daily.
4. Plaquenil 200 daily.
5. Hydroxyzine 25 nightly.
6. Labetalol 100 b.i.d.
7. Nexium 40 mg daily.
8. Paroxetine 40 mg daily.
9. Prednisone 5 mg daily.
10. Sensipar 30 mg daily.

DISPOSITION: The patient will be discharged home today with regular PCP, nephrology and hemodialysis followup. She will also followup with neurology on an outpatient basis.

AM/MedQ
D: 10/16/2016 14:39:36
T: 10/16/2016 18:22:49
Job #: 585046/717048120

Ariel Moses, MD 177352

cc: Barry E Brand, MD

Eric R Schroeder, MD

ADMIT NOTE/HISTORY & PHYSICAL

PATIENT NAME: [redacted]
MEDICAL RECORD NUMBER: 000001387800
ACCOUNT NUMBER: [redacted]
DATE OF ADMISSION: 10/11/2016
PHYSICIAN: TINA SANJAR, MD
ROOM/SERVICE: SE09AA/EMR

CHIEF COMPLAINT: Reported seizures during procedure.

HISTORY OF PRESENT ILLNESS: This is a [redacted]-year-old end-stage vasculopath female with underlying history of end-stage renal disease, who is on hemodialysis via left groin tunneled catheter, with underlying history of lupus, who presents to South Miami Hospital because of what was witnessed seizure during a CT contrast study to evaluate her catheter in her left groin. The patient is a dialysis patient Monday, Wednesday and Friday. She is followed by Dr. Garcia-Mayol in the outpatient setting. She was seeing Dr. Osmany DeAngelo of vascular Surgery, today, to re-evaluate possible sites of dialysis access because she is unable to access any upper extremity vessels due to multiple clots, therefore, she was undergoing a contrast study with iodine in her left groin catheter access site and she does have an allergy to iodine. She, therefore, was taking premedications and she had a similar procedure about a month ago and took premedications at that time and did fine with it, but she was hospitalized at that time. This time, she was doing the premedications outside of the hospital and regardless the procedure in the hospitalization went well, but apparently today during the course of the iodine CT study she had tongue numbness, lost her memory and has yet to go back to her complete baseline, although she is improved. She also was witnessed to have some convulsions. She did not lose continence and she was, therefore, sent to the emergency room for evaluation. Of her 3-hour session to 4-hour session of dialysis, she only received 45 minutes, today, from what I understand, because she had multiple problems with her last dialysis session. She has had problems with her fistula for some time. She did experience a seizure, which was last witnessed, August 17, 2016, when she had surgery as well. She is usually hospitalized at Kendall Medical Regional Hospital and Mercy Hospital University of Miami. She has not recently had any change in her anticonvulsant medications. She has not missed a recent dose of anticonvulsants given her history of seizures. There has been no change in her sleep habits or alcohol ingestion. She was getting premedicated with prednisone and Benadryl due to her iodine allergy.

REVIEW OF SYSTEMS:
No fever, chills, double vision, changes in diarrhea, hematuria, etc.

[redacted]

ALLERGIES:
1. **Amoxicillin.**
2. **Dilantin.**
3. **Iodine.**
4. **Sulfa antibiotics.**

SOCIAL HISTORY: No smoking. No alcohol. No drugs.

FAMILY HISTORY: Reviewed. Essentially noncontributory at this point.

PHYSICAL EXAMINATION:
VITAL SIGNS: At the time of my evaluation, blood pressure is 158/124, heart rate 93, respiratory rate 33, O2 saturation is 93% laying flat in bed. Temperature is 97.6.
GENERAL: She is normocephalic, atraumatic. Extraocular movements are intact. She is alert and oriented to her name.
NECK: Supple.
HEART: Regular rate and rhythm. S1, S2, with no rubs or gallops appreciated. There is a murmur appreciated.
LUNGS: Clear to auscultation, anteriorly.
ABDOMEN: Benign, with positive bowel sounds. Nontender, nondistended.
EXTREMITIES: With diminished pulses throughout.

LABORATORY DATA: At the time of presentation are notable for WBC count of 15.75, potassium of 6.6 and troponin 0.35.

IMAGING DATA: CT of the brain was unremarkable.

Chest x-ray was unremarkable.

ASSESSMENT AND PLAN:
1. Presumed acute seizure episode. Start on Keppra IV. Continue home medications for seizures. Neurology consultation.
2. Electrolyte imbalances, specifically hyperkalemia. Insulin with dextrose, DuoNeb, Kayexalate, calcium and sodium bicarb, all to be administered, if not via any type of access we will administer via tunneled dialysis catheter in the left groin. Repeat the potassium level after these are administered, if not may require dialysis.
3. Mildly elevated troponins, likely in the setting of renal disease and vasculopathy. Obtain 2D echocardiogram. Place on telemetry.

TS/MedQ
D: 10/11/2016 20:04:16
T: 10/11/2016 20:40:04
Job #: 497950/716518027

TINA SANJAR, MD 106310

cc: Osmany DeAngelo, DO

Eleonor Pimentel, MD

Luis Garcia-Mayol, MD

10/12/2016 19:13:02

CONSULTATION REPORT

PATIENT NAME: [redacted]
MEDICAL RECORD NUMBER: 000001387800
ACCOUNT NUMBER: [redacted]
DATE OF ADMISSION: 10/11/2016
DATE OF CONSULTATION: 10/12/2016
CONSULTING PHYSICIAN: ALBERTO PINZON ARDILA, MD
SPECIALTY: NEUROLOGY
REFERRING PHYSICIAN:
ROOM/SERVICE: 041401/EDA

CHIEF COMPLAINT: Seizure.

HISTORY OF PRESENT ILLNESS: This is a pleasant [redacted]-year-old woman with a longstanding history of systemic lupus erythematosus. The patient has a kidney disease with end-stage renal disease on hemodialysis. The patient was having a CT to verify fistula access and during the CT, patient had a seizure. The patient has no memory of the event, but she knows that she had a seizure. She reports that she used to have seizures in the past and she took medications in the past for seizures, but she has not had a seizure for many years. She was off medications for several years as well. The patient does not know the reason exactly why she had seizures before or if they were provoked in the past. The patient is back to baseline, slightly confused, but in general the patient can cooperate with exam.

REVIEW OF SYSTEMS:
CONSTITUTIONAL: As per HPI.
HEAD, EARS, EYES, NOSE AND THROAT: Negative.
CARDIAC: Negative.
PULMONARY: Negative.
GI: As per HPI.
GU: As per HPI. The patient reported that she has also some blood in stool.
NEURO: As per HPI.
PSYCHIATRIC: Negative.
HEME/LYMPH: Negative.
ALLERGIES/IMMUNOLOGIC: Negative.

PAST MEDICAL HISTORY: She has hypertension, hypothyroidism and as per HPI.

PAST SURGICAL HISTORY: Appendectomy, cholecystectomy, hysterectomy, lung surgery and bilateral cataract surgery.

[redacted]

Dialyvite, dicyclomine, folic acid, _____, paroxetine, Plaquenil, Protonix, _____.

ALLERGIES: Recorded allergies to amoxicillin, Dilantin, iodine and sulfa antibiotics.

FAMILY HISTORY: Reviewed, no findings that contribute to this point in history.

PHYSICAL EXAMINATION:
GENERAL: Patient is found awake, in no distress.
VITAL SIGNS: Blood pressure 105/87, heart rate 92, respiratory rate 18, temperature 98.4.
HEAD: Normocephalic.
CARDIAC: Appears rhythmic.
EXTREMITIES: Patient has a fistula and she has some areas of ecchymoses.
NEUROLOGIC: Patient is awake, patient is oriented to place, hospital. Patient is oriented in time, although she has difficulties telling me the exact year. Patient has some mild decreased attention, concentration but speech and language are normal. Fund of knowledge is susceptible.
CRANIAL NERVES: 2: Pupils are reactive to light but they are surgical. Her visual fields are full. 3, 4 and 6: Extraocular movements are intact. 5: Facial sensation symmetric. 7: Face is symmetric. 8: Hearing is grossly preserved. 9: Patient elevates palate adequately. 11: The patient elevates shoulders adequately. 12: Tongue is central.
MOTOR STRENGTH: Patient is 5/5 throughout. Tone and bulk within normal limits. Reflexes are 1-2+, symmetric in upper, lower extremities. Toes are downgoing.
SENSATION: Patient reports symmetric sensation at this point in time.
COORDINATION: There is no ataxia.
GAIT: Deferred as patient is undergoing an echocardiogram.

DATA REVIEW: CBC: White blood cell count initially 15.75, currently 12.36, platelet count currently 70. Chemistry: PT 18.1, INR 1.5. The chemistry showed initially a potassium of 6.6, a BUN of 51, a creatinine of 6.4. Troponin is slightly elevated at 0.35 on the setting of renal failure.

The patient had a brain head CT that showed no acute intracranial findings, just periventricular white matter, chronic small-vessel disease, stable from prior exams.

ASSESSMENT: This is a [redacted]-year-old woman who presented with what appears to be a seizure. It could be a provoked event due to significant metabolic disturbances. Additionally I noticed that at admission, patient had a severely elevated blood pressure in the 150s/110s. Patient could have encephalopathy at this point in time, slightly or mild. She has had history of seizures in the past, but there is no clear intracranial findings that could give us an idea of why she is having seizures. The patient has systemic lupus erythematosus that has been associated with seizures as well and she is also on multiple medications that can have seizures. Additionally, patient was having a CT with contrast and could have been a reaction to contrast in the setting of all the metabolic disturbances all combined.

CONSULTATION REPORT

PATIENT NAME: [redacted]
MEDICAL RECORD NUMBER: 000001387800
ACCOUNT NUMBER: [redacted]
DATE OF ADMISSION: 10/11/2016
DATE OF CONSULTATION: 10/12/2016
CONSULTING PHYSICIAN: LUIS GARCIA-MAYOL, MD
SPECIALTY: NEPHROLOGY
REFERRING PHYSICIAN:
ROOM/SERVICE: 041401/EDA

HISTORY OF PRESENT ILLNESS: Patient is a [redacted]-year-old female with history of being poor compliant on dialytic therapy who has been with clotted vascular access and while patient has _____ vascular access, patient had what seems to be a seizure activity. No nausea, vomiting, diarrhea. Seizure was not witnessed, but patient had been detected to be with elevated potassium since patient was eating bananas during the week not following instruction about diet as well. No nausea, vomiting, diarrhea, _____ Patient claimed that she was premedicated with prednisone and Benadryl therapy prior to having the procedure this weekend and patient had been noted to be having also lidocaine injection as well. Patient upon arrival to the hospital was detected to be with elevated potassium since patient was eating a lot of bananas during the week.

PAST MEDICAL HISTORY: History of systemic lupus erythematosus, hypertension, anemia, hypothyroidism, secondary hypoparathyroidism, chronic kidney disease stage 5, lupus.

SURGICAL HISTORY: Appendectomy, cholecystectomy, hysterectomy, lung surgery, history of graft creation and catheterization in view of severe peripheral vascular disease.

SOCIAL HISTORY: No alcohol, drugs, or smoking.

FAMILY HISTORY: No family history of systemic diseases

ALLERGY: To amoxicillin, Dilantin, iodine and sulfa, according to patient.

MEDICATIONS: Patient had been taking: Aspirin, _____ Dexilant, _____ folic acid, paroxetine, Plaquenil, Protonix, and Renvela.

REVIEW OF SYSTEMS:
GENERAL: Malaise and weakness.

GI: No change in bowel habits, diarrhea, melena, hematochezia.
GENITOURINARY: No dysuria, polyuria, nocturia or hematuria. Patient is oliguric since patient is on dialysis.
MUSCULOSKELETAL: Essentially negative.
NEUROLOGICAL: No tremor, no seizure.

PHYSICAL EXAMINATION:
GENERAL: Alert, oriented. No respiratory distress. Claims to have no seizures in the past.
VITAL SIGNS: Blood pressure 113/73, pulse 97.
SKIN: No discharge, erythema or jaundice.
HEENT: No discharge, erythema or jaundice.
NECK: No jugular venous distention or tracheal deviation. No thyroid enlargement.
LUNGS: Bilaterally scattered atelectatic changes and rhonchi.
HEART: Regular rate. No pericardial effusion. No gallop.
ABDOMEN: Soft, depressible. No mass palpable.
EXTREMITIES: Symmetric. No cyanosis. No deformity.
NEUROLOGIC: Decreased DTRs.

Patient with a femoral catheter for dialytic therapy since patient has obstructed, in the upper extremities and subclavian system, vascular access.

LABORATORY VALUES: Value hemoglobin 11.2, hematocrit of 35.0, platelet count of 70,000. Potassium is 5.6 upon arrival potassium _____ 6.6, CO2 of 19, BUN 53, creatinine of 7.2, calcium of 7.2.

ASSESSMENT: Patient, at this moment, being a case of having chronic kidney disease stage 5, very poor compliance who had a lot of banana's this week and now having hypercapnic state. Patient, at this moment, is going to admitted to dialysis this morning after being treated for hyperkalemia. Patient, at this moment, potassium has been under control. Currently, patient being educated to be more compliant with diet and medication and compliant with dialysis treatment not ingesting hyperkalemic foods. At this moment, patient will need to continue dialysis in the left lower extremity femoral catheter since patient has exhausted upper extremity vascular access sites due to decreased circulatory status in the subclavian system. _____ follow the course of the care of your patient.

DIAGNOSTIC IMPRESSIONS: At this moment:
1. Chronic kidney disease stage 5.
2. Systemic lupus erythematosus.
3. _____.
4. Hyperkalemia.
5. Peripheral vascular disease.

CONSULTATION REPORT

PATIENT NAME: [redacted]
MEDICAL RECORD NUMBER: 000001387800
ACCOUNT NUMBER: [redacted]
DATE OF ADMISSION: 10/11/2016
DATE OF CONSULTATION: 10/12/2016
CONSULTING PHYSICIAN: NEIL E ROSENKRANZ, MD
SPECIALTY: GASTROENTEROLOGY
REFERRING PHYSICIAN: TINA SANJAR, MD
ROOM/SERVICE: 041401/EDA

DATE OF BIRTH: 11/13/1942.

CHIEF COMPLAINT: Rectal bleed.

HISTORY OF PRESENT ILLNESS: The patient is a [redacted]-year-old woman referred through the courtesy of Dr. Sanjar for a gastrointestinal consultation. She has multiple medical problems including end-stage renal disease on hemodialysis as well as systemic lupus erythematosus, hypertension, and hypothyroidism. She has had problems with vascular access for dialysis graft placement and was undergoing a CT scan administered with contrast prior to admission with the patient subsequently developing a seizure presumed due to a contrast allergy. She subsequently was sent to the South Miami Hospital Emergency Room for evaluation and admitted. She states that for the past 3 days she has been having rectal bleeding consisting of bright red blood per rectum on the paper and in the bowl with no clots present. This was preceded by 3 days of constipation and associated straining, currently having normally formed stools. She has had no abdominal or anal pain, nausea, vomiting, abdominal distention, or other related symptoms. She takes aspirin chronically, but denies additional anticoagulants. She states her last colonoscopy was performed approximately 8 years ago which was unremarkable, having no history of additional GI pathology. Hemoglobin and hematocrit are currently stable at 11.2 and 35.0.

PAST MEDICAL HISTORY: Pertinent for appendectomy, cholecystectomy, hysterectomy, pulmonary surgery, hypertension, hypothyroidism, and end-stage renal disease on hemodialysis as well as lupus.

MEDICATION: Prior to admission have been reviewed. They are well documented in the patient's chart.

ALLERGIES: She states allergies to amoxicillin, Dilantin, iodine, and sulfa.

CONSULTATION REPORT

PATIENT NAME: [redacted]
MEDICAL RECORD NUMBER: 000001387800
ACCOUNT NUMBER: [redacted]
DATE OF ADMISSION: 10/11/2016
DATE OF CONSULTATION: 10/13/2016
CONSULTING PHYSICIAN: ERIC R SCHROEDER, MD
SPECIALTY: CARDIOVASCULAR DISEASE
REFERRING PHYSICIAN: TINA SANJAR, MD
ROOM/SERVICE: 041401/EDA

REASON FOR CONSULTATION: Abnormal troponin.

HISTORY OF PRESENT ILLNESS: This is a [redacted]-year-old woman with end-stage renal disease, who was having a seizure during a procedure for her dialysis access. Cardiac enzymes were checked which were mildly abnormal. She has no history of cardiac disease. She denies any chest pain. She says she has chronic shortness of breath.

PAST MEDICAL HISTORY: Chronic abdominal pain, hypertension, anemia, hypothyroidism, end stage renal disease on hemodialysis and lupus.

PAST SURGICAL HISTORY: Appendectomy, cholecystectomy, hysterectomy, lung surgery and AV graft in the right upper extremity which is not functioning.

ALLERGIES: Iodine, Dilantin, amoxicillin, sulfa.

SOCIAL HISTORY: She denies smoking. No alcohol or drug abuse.

FAMILY HISTORY: Reviewed and noncontributory.

CURRENT MEDICATIONS:
1. Atarax 25 mg p.o. bedtime.
2. Claritin 10 mg p.o. daily.
3. Aspirin 81 mg p.o. daily.
4. Keppra 500 mg p.o. twice daily.
5. Pantoprazole 40 mg p.o. twice daily.
6. Paxil 40 mg p.o. daily.
7. Plaquenil 200 mg p.o. once daily.

setting of end-stage renal disease and no clinical symptoms of heart disease and has no angina. No further workup is advisable at this time.

Thank you for this consultation and allowing me to assist you in her care.

ERS/MedQ
D: 10/13/2016 10:37:08
T: 10/13/2016 11:06:49
Job #: 501080/716710455

ERIC R SCHROEDER, MD 75440

1

OPERATIVE REPORT

PATIENT NAME: [redacted]
MEDICAL RECORD NUMBER: 000001387800
ACCOUNT NUMBER: [redacted]
DATE OF ADMISSION: 10/11/2016
DATE OF OPERATION: 10/14/2016
SURGEON: BARRY E BRAND, MD
ASSISTANT SURGEON:
ROOM/SERVICE: SSUR04/EDA

PROCEDURES PERFORMED: Patient was colonoscoped with the Olympus video endoscope, sedated by Anesthesia.

INDICATIONS FOR PROCEDURE: Lower GI bleed. Prior to sedating the patient, the procedure of colonoscopy, including indications, alternatives, risks, complications, the risks of perforation, bleeding, missed lesion, and death were explained to the patient.

DESCRIPTION OF PROCEDURE: The colonoscope was easily inserted through the rectum to the cecum. We identified the ileocecal valve by seeing the valve itself, seeing the light in the right lower quadrant identifying the appendiceal orifice. Patient had a lot of liquid in her colon, but that was suctioned out. The scope was slowly and carefully withdrawn. The patient had extensive diverticulosis. There was no active bleeding. There were no blood clots. There was no blood present in the colon. There was no evidence of masses, ulcerations, or bleeding. In the rectum, I retroflexed the scope. The patient had grade 2 internal hemorrhoids. The remainder of the colon appeared normal.

IMPRESSION:
1. Extensive diverticulosis.
2. Internal hemorrhoids.

BEB/MedQ
D: 10/14/2016 10:16:19
T: 10/14/2016 10:35:59
Job #: 581334/716851383

1

BARRY E BRAND, MD 5249

PATIENT NAME: [redacted]
ACCOUNT NUMBER:
SURGEON: BARRY E BRAND, MD

OPERATIVE REPORT

DISCHARGE REPORT
HEMATOLOGY

COMPLETE BLOOD COUNT (CBC)

Collected	10/16/16 05:41	10/15/16 19:37	10/14/16 02:21	10/13/16 05:26	10/13/16 02:23	Reference Range	Units
Hgb	10.5 L	10.2 L	10.5 L	10.5 L	11.0 L	12.0-15.0	g/dL
Hct	33.4 L	32.5 L	33.6 L	32.7 L	34.2 L	35.0-45.0	%
WBC	5.75	6.03	7.55	6.72	6.28	3.40-11.00	K/uL
Plt Ct	81 L	78 L	69 L	77 L	85 L	130-360	K/uL
RBC	3.35 L	3.28 L	3.36 L	3.33 L	3.49 L	3.80-5.20	M/uL
MCV	99.7	99.1	100.0	98.2	98.0	80.0-100.0	fL
MCH	31.3	31.1	31.3	31.5	31.5	26.0-35.0	pg
MCHC	31.4 L	31.4 L	31.3 L	32.1	32.2	32.0-36.0	g/dL
RDW CV	17.0 H	17.0 H	17.3 H	17.3 H	17.3 H	11.5-14.5	%
MPV	10.2	10.4	11.2	10.4	9.4	7.7-13.2	fL
Diff.Type			AUTO	AUTO	AUTO		
% Neutrophils			68.5	72.5 H	76.7 H	40.0-70.0	%
% Imm. Gran.			0.5 H[1]	0.9 H[1]	0.5 H[1]	0.0-0.4	%
% Lymphocytes			18.9	17.6	14.3 L	17.0-45.0	%
% Monocytes			11.5	8.2	8.0	3.0-12.0	%
% Eosinophils			0.5	0.7	0.5	0.0-7.0	%
% Basophils			0.1	0.1	0.0	0.0-1.0	%
Abs Neutrophils			5.16	4.87	4.82	1.10-8.00	K/uL
Abs Lymphocytes			1.43	1.18	0.90	0.60-3.10	K/uL
Abs Monocytes			0.87 H	0.55 H	0.50 H	0.00-0.36	K/uL
Abs Eosinophils			0.04	0.05	0.03	0.00-0.36	K/uL
Abs Basophils			0.01	0.01	0.00	0.00-0.08	K/uL
Abs Imm. Gran.			0.04 H	0.06 H	0.03	0.00-0.03	K/uL

Collected	10/12/16 18:35	10/12/16 04:25[2]	10/11/16 16:20	Reference Range	Units
Hgb	10.5 L	11.2 L	13.6	12.0-15.0	g/dL
Hct	33.4 L	35.0	43.0	35.0-45.0	%
WBC		12.36 H	15.75 H	3.40-11.00	K/uL
Plt Ct		70 L	106 L	130-360	K/uL
RBC		3.54 L	4.30	3.80-5.20	M/uL
MCV		98.9	100.0	80.0-100.0	fL
MCH		31.6	31.6	26.0-35.0	pg
MCHC		32.0	31.6 L	32.0-36.0	g/dL
RDW CV		17.5 H	17.5 H	11.5-14.5	%
MPV		10.7	9.9	7.7-13.2	fL
Diff.Type			AUTO		
% Neutrophils			90.9 H	40.0-70.0	%
% Imm. Gran.			1.1 H[1]	0.0-0.4	%
% Lymphocytes			6.0 L	17.0-45.0	%
% Monocytes			1.8 L	3.0-12.0	%
% Eosinophils			0.1	0.0-7.0	%
% Basophils			0.1	0.0-1.0	%
Abs Neutrophils			14.31 H	1.10-8.00	K/uL
Abs Lymphocytes			0.95	0.60-3.10	K/uL
Abs Monocytes			0.29	0.00-0.36	K/uL
Abs Eosinophils			0.01	0.00-0.36	K/uL
Abs Basophils			0.01	0.00-0.08	K/uL
Abs Imm. Gran.			0.18 H	0.00-0.03	K/uL

[1]Metamyelocytes, Myelocytes, and Promyelocytes only
[2]This order is a replacement of the rejected order with accession number 2851622370.

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct#: [redacted]
DOB: [redacted] Age [redacted] Sex: F
Name: [redacted]

DISCHARGE REPORT

Collected	10/12/16 18:35	10/12/16 04:25[2]	10/11/16 16:20	Reference Range	Units
RBC Morph.			REVIEWED[3]		
Platelet Morphology			NORMAL[4]		

COAGULATION

ROUTINE COAGULATION

Collected	10/13/16 15:19	10/11/16 16:20	Reference Range	Units
PT	16.1 H	18.1 H	11.1-15.5	Seconds
INR	1.3 H[5]	1.5 H[5]	0.8-1.2	
APTT		32.7	21.8-39.0	Seconds

[5]Interpretive Comment:
2.0 - 3.0 Therapeutic
2.5 - 3.5 Mechanical Heart Valve

SPECIAL COAGULATION

[3]The previous value of "no value" was changed by IF on 10/11/16 17:11 to "REVIEWED"

[4]The previous value of "no value" was changed by IF on 10/11/16 17:11 to "NORMAL"

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct#: [redacted]
DOB: [redacted] Age [redacted] Sex: F
Name: [redacted]

DISCHARGE REPORT

	Collected	Reference Range	Units
	10/13/16 15:19		
HIT-Optical Density	0.217[6]	0.000-0.399	Optical Density
HIT Interpretation	Negative	Negative	

CHEMISTRY

ROUTINE CHEMISTRY

[6]This assay should be used as a screening test. It should not be relied upon exclusively to establish, or rule out, a diagnosis of Heparin Induced Thrombocytopenia (HIT).
The results should be used in conjunction with clinical findings and other serological tests.

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct#: [redacted]
DOB: [redacted] Age [redacted] Sex: F
Name: [redacted]

DISCHARGE REPORT

Collected	10/14/16 02:21	10/13/16 05:26	10/13/16 02:23	10/12/16 21:35[7]	10/12/16 04:25[8]	Reference Range	Units
Sodium	141	140	140		140	136-145	mmol/L
Potassium	4.8	3.6	3.4 L		5.6 H	3.5-5.1	mmol/L
Chloride	105	102	102		103	98-107	mmol/L
CO2 (Bicarbonate)	23	24	25		19 L	21-32	mmol/L
Anion Gap	13	14	13		18 H	2-15	
Glucose, Random	90	76 L	81		96	80-126	mg/dL
BUN	27 H	23	22		53 H	8-23	mg/dL
Creatinine	5.80 H	4.44 H	3.99 H		7.28 H	0.60-1.30	mg/dL
BUN/Creat Ratio	4.7 L	5.2 L	5.5 L		7.3 L	12.0-20.0	ratio
Est.Glom.Filtr.Rate	Result:[9]	Result:[10]	Result:[11]				mL/min/1.73sq.m

[7]Patient not available
[8]This order is a replacement of the rejected order with accession number 2851621562.
[9]Estimated GFR if African American = 9
Estimated GFR if non - African American = 7

Note: The estimated glomerular filtration rate (eGFR) is calculated using the simplified 4 variable MDRD formula.
An eGFR value above 60 mL/min/1.73 sq. meters is simply reported as **>60 mL/min/1.73 sq. meters** and not as an exact number.
It is important to recognize that this prediction equation has many limitations and may not be valid in the following conditions or situations: *rapidly changing renal function, ages <18 and >70 years, pregnancy, exceptional dietary practice (vegetarian, creatine supplements), any extremes of body size, any changes of muscle mass (amputation, muscle wasting, malnutrition, paraplegia, quadriplegia, diseases of skeletal muscle) and prior to dosaging drugs excreted by the kidney.*
In these clinical conditions, clinical judgement is necessary and a twenty-four hour urine collection may be considered.

[10]Estimated GFR if African American = 12
Estimated GFR if non - African American = 10

Note: The estimated glomerular filtration rate (eGFR) is calculated using the simplified 4 variable MDRD formula.
An eGFR value above 60 mL/min/1.73 sq. meters is simply reported as **>60 mL/min/1.73 sq. meters** and not as an exact number.
It is important to recognize that this prediction equation has many limitations and may not be valid in the following conditions or situations: *rapidly changing renal function, ages <18 and >70 years, pregnancy, exceptional dietary practice (vegetarian, creatine supplements), any extremes of body size, any changes of muscle mass (amputation, muscle wasting, malnutrition, paraplegia, quadriplegia, diseases of skeletal muscle) and prior to dosaging drugs excreted by the kidney.*
In these clinical conditions, clinical judgement is necessary and a twenty-four hour urine collection may be considered.

[11]Estimated GFR if African American = 13
Estimated GFR if non - African American = 11

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct#: [redacted]
DOB: [redacted] Age [redacted] Sex: F
Name: [redacted]

Account: [redacted]
Patient Name: [redacted]

DISCHARGE REPORT

Collection Date	Specimen	Test Name	Reason
10/17/16 02:00	Blood	CBC - BHSF (WAM)	Unspecified
10/17/16 02:00	Blood	BASIC METABOLIC PANEL (BMP)	Unspecified
10/13/16 07:56	Blood	ALBUMIN-BLOOD	Duplicate Order
10/13/16 06:00	Blood	CBC - BHSF (WAM)	Duplicate Order
10/13/16 06:00	Blood	BASIC METABOLIC PANEL (BMP)	Duplicate Order
10/12/16 04:00	Blood	CBC - BHSF (WAM)	Redraw requested by RN/floor
10/12/16 04:00	Blood	BASIC METABOLIC PANEL (BMP)	A Lab Employee Cancelled this Order
10/11/16 21:05	Blood	POTASSIUM (BLOOD)	Duplicate Order
10/11/16 19:25	Blood	TROPONIN I	Duplicate Order
10/11/16 15:32	Urine	URINALYSIS WITH CULTURE REFLEX	Cancelled by the Lab after 3 days
10/11/16 15:32[20]	Blood	TROPONIN I	Hemolyzed specimen/to be re-drawn
10/11/16 15:32[21]	Blood	SODIUM (SERUM)	Hemolyzed specimen/to be re-drawn
10/11/16 15:32[22]	Blood	POTASSIUM (BLOOD)	Hemolyzed specimen/to be re-drawn
10/11/16 15:32[23]	Blood	GLUCOSE (RANDOM)	Hemolyzed specimen/to be re-drawn
10/11/16 15:32[24]	Blood	CREATININE (BLOOD)	Hemolyzed specimen/to be re-drawn
10/11/16 15:32[25]	Blood	CO2 (BICARBONATE)	Hemolyzed specimen/to be re-drawn
10/11/16 15:32[26]	Blood	CHLORIDE (BLOOD)	Hemolyzed specimen/to be

20
called to glenda

21
called to glenda

22
called to glenda

23
called to glenda

24
called to glenda

25
called to glenda

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct#: [redacted]
DOB: [redacted] Sex: F
Name: [redacted]

Report Printed On: 10/17/16 08:42

DISCHARGE REPORT

Collection Date	Specimen	Test Name	Reason
10/11/16 15:32[27]	Blood	BUN	re-drawn Hemolyzed specimen/to be re-drawn

[26]
called to glenda

[27]
called to glenda

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct#: [redacted]
DOB: [redacted] Age [redacted] Sex: F
Name: [redacted]

[redacted]

Account [redacted]
Patient Name: [redacted]

DISCHARGE REPORT
HEMATOLOGY

COMPLETE BLOOD COUNT (CBC)

Collected	10/16/16 05:41	10/15/16 19:37	10/14/16 02:21	10/13/16 05:26	10/13/16 02:23	Reference Range	Units
Hgb	10.5 L	10.2 L	10.5 L	10.5 L	11.0 L	12.0-15.0	g/dL
Hct	33.4 L	32.5 L	33.6 L	32.7 L	34.2 L	35.0-45.0	%
WBC	5.75	6.03	7.55	6.72	6.28	3.40-11.00	K/uL
Plt Ct	81 L	78 L	89 L	77 L	65 L	130-360	K/uL
RBC	3.35 L	3.28 L	3.36 L	3.33 L	3.49 L	3.80-5.20	M/uL
MCV	99.7	99.1	100.0	98.2	98.0	80.0-100.0	fL
MCH	31.3	31.1	31.3	31.5	31.5	26.0-35.0	pg
MCHC	31.4 L	31.4 L	31.3 L	32.1	32.2	32.0-36.0	g/dL
RDW CV	17.0 H	17.0 H	17.3 H	17.3 H	17.3 H	11.5-14.5	%
MPV	10.2	10.4	11.2	10.4	9.4	7.7-13.2	fL
Diff.Type			AUTO	AUTO	AUTO		
% Neutrophils			68.5	72.5 H	76.7 H	40.0-70.0	%
% Imm. Gran.			0.5 H[1]	0.9 H[1]	0.5 H[1]	0.0-0.4	%
% Lymphocytes			18.9	17.6	14.3 L	17.0-45.0	%
% Monocytes			11.5	8.2	8.0	3.0-12.0	%
% Eosinophils			0.5	0.7	0.5	0.0-7.0	%
% Basophils			0.1	0.1	0.0	0.0-1.0	%
Abs Neutrophils			5.16	4.87	4.82	1.10-8.00	K/uL
Abs Lymphocytes			1.43	1.18	0.90	0.60-3.10	K/uL
Abs Monocytes			0.87 H	0.55 H	0.50 H	0.00-0.36	K/uL
Abs Eosinophils			0.04	0.05	0.03	0.00-0.36	K/uL
Abs Basophils			0.01	0.01	0.00	0.00-0.08	K/uL
Abs Imm. Gran.			0.04 H	0.06 H	0.03	0.00-0.03	K/uL

Collected	10/12/16 18:35	10/12/16 04:25[2]	10/11/16 16:20	Reference Range	Units
Hgb	10.5 L	11.2 L	13.6	12.0-15.0	g/dL
Hct	33.4 L	35.0	43.0	35.0-45.0	%
WBC		12.36 H	15.75 H	3.40-11.00	K/uL
Plt Ct		70 L	106 L	130-360	K/uL
RBC		3.54 L	4.30	3.80-5.20	M/uL
MCV		98.9	100.0	80.0-100.0	fL
MCH		31.6	31.6	26.0-35.0	pg
MCHC		32.0	31.6 L	32.0-36.0	g/dL
RDW CV		17.5 H	17.5 H	11.5-14.5	%
MPV		10.7	9.9	7.7-13.2	fL
Diff.Type			AUTO		
% Neutrophils			90.9 H	40.0-70.0	%
% Imm. Gran.			1.1 H[1]	0.0-0.4	%
% Lymphocytes			6.0 L	17.0-45.0	%
% Monocytes			1.8 L	3.0-12.0	%
% Eosinophils			0.1	0.0-7.0	%
% Basophils			0.1	0.0-1.0	%
Abs Neutrophils			14.31 H	1.10-8.00	K/uL
Abs Lymphocytes			0.95	0.60-3.10	K/uL
Abs Monocytes			0.29	0.00-0.36	K/uL
Abs Eosinophils			0.01	0.00-0.36	K/uL
Abs Basophils			0.01	0.00-0.08	K/uL
Abs Imm. Gran.			0.18 H	0.00-0.03	K/uL

[1]Metamyelocytes, Myelocytes, and Promyelocytes only
[2]This order is a replacement of the rejected order with accession number 2851622370.

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct# [redacted]
DOB [redacted] Sex: F
Name: [redacted]

DISCHARGE REPORT

				Reference Range	Units
Collected	10/12/16 18:35	10/12/16 04:25[3]	10/11/16 16:20		
RBC Morph.			REVIEWED[3]		
Platelet Morphology			NORMAL[4]		

COAGULATION

ROUTINE COAGULATION

			Reference Range	Units
Collected	10/13/16 15:19	10/11/16 16:20		
PT	16.1 H	18.1 H	11.1-15.5	Seconds
INR	1.3 H[5]	1.5 H[5]	0.8-1.2	
APTT		32.7	21.8-39.0	Seconds

[5]Interpretive Comment:
2.0 - 3.0 Therapeutic
2.5 - 3.5 Mechanical Heart Valve

SPECIAL COAGULATION

[3]The previous value of "no value" was changed by IF on 10/11/16 17:11 to "REVIEWED"

[4]The previous value of "no value" was changed by IF on 10/11/16 17:11 to "NORMAL"

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct# [redacted]
DOB: [redacted] Age [redacted] Sex: F
Name: [redacted]

DISCHARGE REPORT

	Collected	Reference Range	Units
	10/13/16 15:19		
HIT-Optical Density	0.217[6]	0.000-0.399	Optical Density
HIT Interpretation	Negative	Negative	

CHEMISTRY

ROUTINE CHEMISTRY

[6]This assay should be used as a screening test. It should not be relied upon exclusively to establish, or rule out, a diagnosis of Heparin Induced Thrombocytopenia (HIT).
The results should be used in conjunction with clinical findings and other serological tests.

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct#: [redacted]
DOB: [redacted] Age [redacted] Sex: F
Name: [redacted]

DISCHARGE REPORT

Collected	10/14/16 02:21	10/13/16 05:26	10/13/16 02:23	10/12/16 21:35[7]	10/12/16 04:25[8]	Reference Range	Units
Sodium	141	140	140		140	136-145	mmol/L
Potassium	4.8	3.8	3.4 L		5.6 H	3.5-5.1	mmol/L
Chloride	105	102	102		103	98-107	mmol/L
CO2 (Bicarbonate)	23	24	25		19 L	21-32	mmol/L
Anion Gap	13	14	13		18 H	2-15	
Glucose, Random	90	76 L	81		96	80-126	mg/dL
BUN	27 H	23	22		53 H	8-23	mg/dL
Creatinine	5.80 H	4.44 H	3.99 H		7.28 H	0.60-1.30	mg/dL
BUN/Creat Ratio	4.7 L	5.2 L	5.5 L		7.3 L	12.0-20.0	ratio
Est.Glom.Filtr.Rate	Result:[9]	Result:[10]	Result:[11]				mL/min/1.73sq.m

[7]Patient not available
[8]This order is a replacement of the rejected order with accession number 2851621562.
[9]Estimated GFR if African American = 9
Estimated GFR if non - African American = 7

==========

Note: The estimated glomerular filtration rate (eGFR) is calculated using the simplified 4 variable MDRD formula.
An eGFR value above 60 mL/min/1.73 sq. meters is simply reported as >60 mL/min/1.73 sq. meters and not as an exact number.
It is important to recognize that this prediction equation has many limitations and may not be valid in the following conditions or situations: *rapidly changing renal function, ages <18 and >70 years, pregnancy, exceptional dietary practice (vegetarian, creatine supplements), any extremes of body size, any changes of muscle mass (amputation, muscle wasting, malnutrition, paraplegia, quadriplegia, diseases of skeletal muscle) and prior to dosaging drugs excreted by the kidney.*
In these clinical conditions, clinical judgement is necessary and a twenty-four hour urine collection may be considered.
[10]Estimated GFR if African American = 12
Estimated GFR if non - African American = 10

==========

Note: The estimated glomerular filtration rate (eGFR) is calculated using the simplified 4 variable MDRD formula.
An eGFR value above 60 mL/min/1.73 sq. meters is simply reported as >60 mL/min/1.73 sq. meters and not as an exact number.
It is important to recognize that this prediction equation has many limitations and may not be valid in the following conditions or situations: *rapidly changing renal function, ages <18 and >70 years, pregnancy, exceptional dietary practice (vegetarian, creatine supplements), any extremes of body size, any changes of muscle mass (amputation, muscle wasting, malnutrition, paraplegia, quadriplegia, diseases of skeletal muscle) and prior to dosaging drugs excreted by the kidney.*
In these clinical conditions, clinical judgement is necessary and a twenty-four hour urine collection may be considered.
[11]Estimated GFR if African American = 13
Estimated GFR if non - African American = 11

==========

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct# [redacted]
DOB: [redacted] Sex: F
Name: [redacted]

DISCHARGE REPORT

Collected	10/14/16 02:21	10/13/16 05:26	10/13/16 02:23	10/12/16 21:35[7]	10/12/16 04:25[8]	Reference Range	Units
AKI Risk	FAILURE[12]	FAILURE[12]	FAILURE[12]				
Calcium	6.6 L[13]	7.2 L[13]	7.2 L[13]		7.7 L[13]	8.5-10.1	mg/dL
Phosphorus			2.9			2.5-4.9	mg/dL

Note: The estimated glomerular filtration rate (eGFR) is calculated using the simplified 4 variable MDRD formula. An eGFR value above 60 mL/min/1.73 sq. meters is simply reported as **>60 mL/min/1.73 sq. meters** and not as an exact number. It is important to recognize that this prediction equation has many limitations and may not be valid in the following conditions or situations: *rapidly changing renal function, ages <18 and >70 years, pregnancy, exceptional dietary practice (vegetarian, creatine supplements), any extremes of body size, any changes of muscle mass (amputation, muscle wasting, malnutrition, paraplegia, quadriplegia, diseases of skeletal muscle) and prior to dosaging drugs excreted by the kidney.* In these clinical conditions, clinical judgement is necessary and a twenty-four hour urine collection may be considered.

[12]Staging for Acute Kidney Injury (AKI) based on modified RIFLE classification, AKI Network stages and the Kidney Disease Improving Global Outcomes (KDIGO) Guidelines.
RIFLE--Risk Injury Failure Loss End stage

Baseline SCr = 0.797506 Collected: ########

Recommendation: (To be used only for monitoring patient clinical status)
Notify the attending/managing physician

Acute Kidney Injury is defined as the presence of any of the following:
1. Increase in serum creatinine by >=0.3 mg/dL (>=26.5 micromol/L) within 48 hours; or
2. Increase in serum creatinine by >=1.5 times baseline, which is known or presumed to have occurred within the prior seven days; or
3. Urine volume <0.5 mL/kg/h for six hours

RISK
Stage 1 - Increase in serum creatinine to 1.5 to 1.9 times baseline, or increase in serum creatinine by >=0.3 mg/dL (>=26.5 micromol/L), or reduction in urine output to <0.5 mL/kg per hour for 6 to 12 hours.

INJURY
Stage 2 - Increase in serum creatinine to 2.0 to 2.9 times baseline, or reduction in urine output to <0.5 mL/kg per hour for >=12 hours.

FAILURE
Stage 3 - Increase in serum creatinine to 3.0 times baseline, or increase in serum creatinine to >=4.0 mg/dL (>=353.6 micromol/L), or reduction in urine output to <0.3 mL/kg per hour for >=24 hours, or anuria for >=12 hours, or the initiation of renal replacement therapy, or, in patients <18 years, decrease in eGFR to <35 mL/min per 1.73 m2

[13]Reference Range for premature infants: 8.2-11.0 mg/dL

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct#: [redacted]
DOB: [redacted] Age [redacted] Sex: F
Name: [redacted]

DISCHARGE REPORT

Collected	10/14/16 02:21	10/13/16 05:26	10/13/16 02:23	10/12/16 21:35[7]	10/12/16 04:25[8]	Reference Range	Units
Protein, Total	6.4		6.7	6.1 L		6.4-8.2	g/dL
Albumin	3.5		3.6	3.5		3.4-5.0	g/dL
Globulin	2.9		3.1	2.6		2.3-3.9	g/dL
Alb/Glob Ratio	1.2		1.2	1.3		1.1-2.5	ratio
ALT (SGPT)	20		23	19		16-65	U/L
AST (SGOT)	19		24	18		8-37	U/L
AST/ALT Ratio	1.0		1.0	1.0			ratio
Alkaline Phos.	138 H		145 H	133		50-136	U/L
Bilirubin, Total	0.5		0.5	0.4		0.2-2.0	mg/dL
Bilirubin, Direct	0.2		0.2	0.2		0.0-0.2	mg/dL
Bilirubin, Indirect	0.3		0.3	0.2 L		0.3-1.9	mg/dL
CK				49		26-308	U/L
Troponin I				0.20 H[14]		0.00-0.05	ng/mL

Collected	10/12/16 01:35	10/11/16 21:32	10/11/16 17:52[15]	10/11/16 16:20	Reference Range	Units
Sodium			135 L		136-145	mmol/L
Potassium		6.3 HC[16]	6.6 HC[17]		3.5-5.1	mmol/L
Chloride			100		98-107	mmol/L
CO2 (Bicarbonate)			21		21-32	mmol/L
Anion Gap			14		2-15	
Glucose, Random			117		80-126	mg/dL
BUN			51 H		8-23	mg/dL
Creatinine			6.44 H		0.60-1.30	mg/dL
BUN/Creat Ratio			7.9 L		12.0-20.0	ratio
Est.Glom.Fltr.Rate	Result:[18]			Result:[18]		mL/min/1.73sq.m

[14]Interpretive Comments:
Negative: <0.05 ng/mL
Indeterminate: 0.06-0.50 ng/mL
Suggests AMI: >0.50 ng/mL
Correlation with clinical findings and ECG changes is recommended.
[15]This order is a replacement of the rejected order with accession number 2851621360.
[16]Called to and read back by:
rn martine aurales at 2200 10/11/16/vp

[17]Called to and read back by:
rn yeleny pereda at 1840 10/11/16/vp

[18]Estimated GFR If African American = 7
Estimated GFR if non - African American = 6

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.
Note: The estimated glomerular filtration rate (eGFR) is calculated using the simplified 4 variable MDRD formula.
An eGFR value above 60 mL/min/1.73 sq. meters is simply reported as >60 mL/min/1.73 sq. meters and not as an exact number.
It is important to recognize that this prediction equation has many limitations and may not be valid in the following conditions or situations: *rapidly changing renal function, ages <18 and >70 years, pregnancy, exceptional dietary practice (vegetarian, creatine supplements), any extremes of body size, any changes of muscle mass (amputation, muscle wasting, malnutrition,*

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct#: [redacted]
DOB: [redacted] Age [redacted] Sex: F
Name: [redacted]

DISCHARGE REPORT

Collected	10/12/16 01:35	10/11/16 21:32	10/11/16 17:52[15]	10/11/16 16:20	Reference Range	Units
AKI Risk	FAILURE[12]			FAILURE[2]		
Troponin I	0.38 H[14]		0.35 H[14]		0.00-0.05	ng/mL

POINT OF CARE

Collected	10/11/16 19:50	Reference Range	Units
Glucose-POC	85	80-126	mg/dL

SEROLOGY

HEPATITIS TESTING

Collected	10/14/16 15:40	Reference Range	Units
Hep B Surface Ag	NonReact	NonReact	
Hep A Ab (IgM)	NonReact	NonReact	
Hep C Ab	NonReact	NonReact	
Hep B Core Ab (IgM)	NonReact	NonReact	

CANCELED TESTS

paraplegia, quadriplegia, diseases of skeletal muscle) and prior to dosaging drugs excreted by the kidney.
In these clinical conditions, clinical judgement is necessary and a twenty-four hour urine collection may be considered.
[15]Estimated GFR if African American = 8
Estimated GFR if non - African American = 7

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.
.
Note: The estimated glomerular filtration rate (eGFR) is calculated using the simplified 4 variable MDRD formula.
An eGFR value above 60 mL/min/1.73 sq. meters is simply reported as >60 mL/min/1.73 sq. meters and not as an exact number.
It is important to recognize that this prediction equation has many limitations and may not be valid in the following conditions or situations: *rapidly changing renal function, ages <18 and >70 years, pregnancy, exceptional dietary practice (vegetarian, creatine supplements), any extremes of body size, any changes of muscle mass (amputation, muscle wasting, malnutrition, paraplegia, quadriplegia, diseases of skeletal muscle) and prior to dosaging drugs excreted by the kidney.*
In these clinical conditions, clinical judgement is necessary and a twenty-four hour urine collection may be considered.

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct#: [redacted]
DOB: [redacted] Age [redacted] Sex: F
Name: [redacted]

Account [redacted]
Patient Name: [redacted]

DISCHARGE REPORT

Collection Date	Specimen	Test Name	Reason
10/17/16 02:00	Blood	CBC - BHSF (WAM)	Unspecified
10/17/16 02:00	Blood	BASIC METABOLIC PANEL (BMP)	Unspecified
10/13/16 07:56	Blood	ALBUMIN-BLOOD	Duplicate Order
10/13/16 06:00	Blood	CBC - BHSF (WAM)	Duplicate Order
10/13/16 06:00	Blood	BASIC METABOLIC PANEL (BMP)	Duplicate Order
10/12/16 04:00	Blood	CBC - BHSF (WAM)	Redraw requested by RN/floor
10/12/16 04:00	Blood	BASIC METABOLIC PANEL (BMP)	A Lab Employee Cancelled this Order
10/11/16 21:05	Blood	POTASSIUM (BLOOD)	Duplicate Order
10/11/16 19:25	Blood	TROPONIN I	Duplicate Order
10/11/16 15:32	Urine	URINALYSIS WITH CULTURE REFLEX	Cancelled by the Lab after 3 days
10/11/16 15:32[20]	Blood	TROPONIN I	Hemolyzed specimen/to be re-drawn
10/11/16 15:32[21]	Blood	SODIUM (SERUM)	Hemolyzed specimen/to be re-drawn
10/11/16 15:32[22]	Blood	POTASSIUM (BLOOD)	Hemolyzed specimen/to be re-drawn
10/11/16 15:32[23]	Blood	GLUCOSE (RANDOM)	Hemolyzed specimen/to be re-drawn
10/11/16 15:32[24]	Blood	CREATININE (BLOOD)	Hemolyzed specimen/to be re-drawn
10/11/16 15:32[25]	Blood	CO2 (BICARBONATE)	Hemolyzed specimen/to be re-drawn
10/11/16 15:32[26]	Blood	CHLORIDE (BLOOD)	Hemolyzed specimen/to be

20
called to glenda

21
called to glenda

22
called to glenda

23
called to glenda

24
called to glenda

25
called to glenda

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct#: [redacted]
DOB: [redacted] Sex: F
Name: [redacted]

Report Printed On: 10/17/16 09:02

DISCHARGE REPORT

Collection Date	Specimen	Test Name	Reason
10/11/16 15:32[27]	Blood	BUN	re-drawn Hemolyzed specimen/to be re-drawn

---

[26] called to glenda

[27] called to glenda

Location: S4PAV 0414 01
Physician: Gonzalez-Rojas, Yane
MR#: 1387800S Acct#: [redacted]
DOB: [redacted] Age [redacted] Sex: F
Name: [redacted]

DISCHARGE REPORT

[redacted]

(786) 662-4000

Patient Information

Account Number	Last Name	Middle	First Name
[redacted]	[redacted]		[redacted]

Medical Record Number	Room	DOB	Gender
000001387800	0414	[redacted]	F

Sample Demographics

Analyse Date & Time	Drawn Date & Time	Sample Site	Device ID
10/12/2016 11:24	10/12/2016 11:20	L Brachial	36326
Mode	**Flow**	**Sample Type**	**Operator ID**
NC/LPM	3.00	Arterial	Lozano
Vent Mode		**Allen Test**	**Notified To**
		NA	
Respiratory Rate	**PEEP**	**Lidocaine**	**Read Back By**
		Yes	
Tidal Volume	**PS**	**Reviewed By (TODO)**	**Notified By**
	Order #	**Notified Time**	
	00118		

Sample Results

pH	7.401		[7.350-7.450]	ctHb	11.1L	g/dL	[12.0-18.0]
pCO2	37.0	mmHg	[35.0-45.0]	sO2	96.5	%	[92.0-99.0]
pO2	94.0	mmHg	[80.0-100.0]	FO2Hb	95.9	%	
HCO3act	22.5	mmol/L	[22.0-26.0]	FCOHb	0.3	%	[0.0-3.0]
BE(B)	-2.0	mmol/L		FMetHb	0.3	%	[0.0-1.5]
pH(T)				FHHb	3.5	%	
pO2(T)							
pCO2(T)							
Temp							
FIO2	32.0	%					
NA							
K							
Ca							
Cl							
Glucose							
Lactate							

REPORT OF RADIOLOGIC CONSULTATION

Patient Name: [redacted]
Patient Class: EMERGENCY **Priority:** STAT **Order No:** 90009
DOB: [redacted] **Age:** [redacted] **Sex:** F **Corp ID:** 000005139471
Adm No: [redacted] **Adm Date:** 10/11/2016 **Time:** 3:12PM
Rad / MR No: 1387800 **Pt NS/Room:** SEDM-SE09AA **Ph#:** (305) 265-8136
Ordered By: DAMION RIRCHARD CAMPBELL, M.D. 030114 **Phone:** (786) 662-0455 **Fax:** () -
Referred By: ER DOCTOR MISC 008888 **Phone:** (786) 596-6556 **Fax:** () -

***** Final Report *****

ADMITTING DIAGNOSIS:

PROCEDURE: SXR 7101 CHEST SINGLE VIEW XR
Acc #: 20351884 **Date: Oct 11 2016** **CPT: 71010**

PROCEDURE:
CHEST SINGLE VIEW XR

CLINICAL INDICATION:
SEIZURE

COMPARISON:
Chest x-ray 07/18/2014

TECHNIQUE:
Single view chest radiography.

DISCUSSION:
There is a dialysis catheter with the tip into the right ventricle. There is an IVC central line with the tip into the right atrium. There is a large hiatal hernia. The cardiopericardial silhouette is within normal limits.
There is no consolidation. No pleural effusions are present. The bones are unremarkable for age.

Transcribed by: On: Oct 11 2016 4:21P

Read by: LOUIS P FREEMAN, MD On: Oct 11 2016 4:23P
Signed Electronically by: LOUIS P FREEMAN, M.D. On: Oct 11 2016 4:21P

{read_info2}
{psgn_dr_addend} {psgn_dr_addend2}

REPORT OF RADIOLOGIC CONSULTATION

Patient Name: [redacted]
Patient Class: EMERGENCY | **Priority:** STAT | **Order No:** 90009
DOB: [redacted] | **Age:** [redacted] **Sex:** F | **Corp ID:** 000005139471
Adm No: [redacted] | **Adm Date:** 10/11/2016 | **Time:** 3:12PM
Rad / MR No: 1387800 | **Pt NS/Room:** SEDM-SE09AA | **Ph#:** (305) 265-8136
Ordered By: DAMION RIRCHARD CAMPBELL, M.D. 030114 **Phone:** (786) 662-0455 **Fax:** () -
Referred By: ER DOCTOR MISC 008888 **Phone:** (786) 596-6556 **Fax:** () -

IMPRESSION:
There is no acute cardiopulmonary disease.
Large hiatal hernia.
Dialysis catheter as above.

Transcribed by: On: Oct 11 2016 4:21P

Read by: LOUIS P FREEMAN, MD On: Oct 11 2016 4:23P
Signed Electronically by: LOUIS P FREEMAN, M.D. On: Oct 11 2016 4:21P

{read_Info2}
{psgn_dr_addend}
{psgn_dr_addend2}

REPORT OF RADIOLOGIC CONSULTATION

Patient Name: [redacted]
Patient Class: EMERGENCY | **Priority:** STAT | **Order No:** 90010
DOB: [redacted] | **Age:** [redacted] **Sex:** F | **Corp ID:** 000005139471
Adm No: [redacted] | **Adm Date:** 10/11/2016 | **Time:** 3:12PM
Rad / MR No: 1387800 | **Pt NS/Room:** SEDM-SE09AA | **Ph#:** (305) 265-8136
Ordered By: DAMION RIRCHARD CAMPBELL, M.D. 030114 **Phone:** (786) 662-0455 **Fax:** () -
Referred By: ER DOCTOR MISC 008888 **Phone:** (786) 596-6556 **Fax:** () -

***** Final Report *****

ADMITTING DIAGNOSIS: SEIZURE

PROCEDURE: SCT 7895 BRAIN CT WO CON
Acc #: 20351885 **Date: Oct 11 2016** **CPT: 70450**

PROCEDURE: BRAIN CT WO CON

CLINICAL INDICATION:
SEIZURE AND HEADACHE TODAY

COMPARISON:
01/24/2016 CT brain

TECHNIQUE:
Noncontrast axial images through the brain were obtained. Radiation dose reduction techniques used for this exam include: Iterative Reconstruction Technique and/or adjustments of the mA/kV according to patient size.

DISCUSSION:
The ventricles are midline and nondilated. Hemorrhage or acute extra-axial fluid collection is not seen.

Generalized cortical and central atrophy is seen stable when compared to the prior examination.

Transcribed by: On: Oct 11 2016 5:31P

Read by: LORNA WILLIAMS, MD On: Oct 11 2016 5:33P
Signed Electronically by: LORNA WILLIAMS, M.D. On: Oct 11 2016 5:31P

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{psgn_dr_addend}
{psgn_dr_addend2}

REPORT OF RADIOLOGIC CONSULTATION

Patient Name: [redacted]
Patient Class: EMERGENCY **Priority:** STAT **Order No:** 90010
DOB: [redacted] **Age:** [redacted] **Sex:** F **Corp ID:** 000005139471
Adm No: [redacted] **Adm Date:** 10/11/2016 **Time:** 3:12PM
Rad / MR No: 1387800 **Pt NS/Room:** SEDM-SE09AA **Ph#:** (305) 265-8136
Ordered By: DAMION RIRCHARD CAMPBELL, M.D. 030114 **Phone:** (786) 662-0455 **Fax:** () -
Referred By: ER DOCTOR MISC 008888 **Phone:** (786) 596-6556 **Fax:** () -

Decreased attenuation is seen within the periventricular white matter suggesting mild small vessel ischemic changes, stable from prior exam.

No acute parenchymal attenuation abnormalities are identified. No definite area of acute infarction is seen.

The visualized osseous structures are intact.

IMPRESSION:
No acute intracranial findings.

Transcribed by: On: Oct 11 2016 5:31P

Read by: LORNA WILLIAMS, MD On: Oct 11 2016 5:33P
Signed Electronically by: LORNA WILLIAMS, M.D. On: Oct 11 2016 5:31P

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{psgn_dr_addend}
{psgn_dr_addend2}

REPORT OF RADIOLOGIC CONSULTATION

Patient Name: [redacted]
Patient Class: INPATIENT **Priority:** STAT **Order No:** 90012
DOB: [redacted] **Age:** [redacted] **Sex:** F **Corp ID:** 000005139471
Adm No: [redacted] **Adm Date:** 10/11/2016 **Time:** 7:25PM
Rad / MR No: 1387800 **Pt NS/Room:** 4PAV-041401 **Ph#:** (305) 265-8136
Ordered By: NEIL E ROSENKRANZ, M.D. 013243 **Phone:** (305) 273-7319 **Fax:** (305) 662-9515
Referred By: YANEICY GONZALEZ-ROJAS,M.D. 167692 **Phone:** (786) 662-5465 **Fax:** () -

***** Final Report *****

ADMITTING DIAGNOSIS: ACUTE SEIZURE

PROCEDURE: SNM 7898 G. I. BLEEDING SCAN
Acc #: 20355178 Date: Oct 12 2016 CPT: 78278

The following medications were administered for today's exam:
TC99M RBC ULTRATAG UP TO 30MCI Quantity: 1

PROCEDURE: G. I. BLEEDING SCAN

CLINICAL INDICATION:
RECTAL BLEED

COMPARISON:
None.

TECHNIQUE:
Following the administration of 25 mCi of Tc-99m UltraTAG labeled red blood cells, a dynamic GI bleeding study is performed for 60 minutes post injection. Delayed imaging was also obtained.

DISCUSSION:
There is no evidence of active GI bleeding identified in the first hour dynamic acquisition as well as delayed images. Patient was injected via superficial vein of the anterior left chest wall, leading to flow through the epigastric veins and eventually into the iliac veins rather than through the left subclavian
Transcribed by: On: Oct 13 2016 7:53A

Read by: JUAN CARLOS BATLLE, MD On: Oct 12 2016 9:30P
Signed Electronically by: LAWRENCE F ELGARRESTA, M.D. On: Oct 13 2016 7:53A

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{psgn_dr_addend} {psgn_dr_addend2}

REPORT OF RADIOLOGIC CONSULTATION

Patient Name: [redacted]
Patient Class: INPATIENT | **Priority:** STAT | **Order No:** 90012
DOB: [redacted] | **Age:** [redacted] **Sex:** F | **Corp ID:** 000005139471
Adm No: [redacted] | **Adm Date:** 10/11/2016 | **Time:** 7:25PM
Rad / MR No: 1387800 | **Pt NS/Room:** 4PAV-041401 | **Ph#:** (305) 265-8136
Ordered By: NEIL E ROSENKRANZ, M.D. 013243 | **Phone:** (305) 273-7319 | **Fax:** (305) 662-9515
Referred By: YANEICY GONZALEZ-ROJAS,M.D. 167692 | **Phone:** (786) 662-5465 | **Fax:** () -

veln.

IMPRESSION:
No evidence of active GI bleed.

FINAL SUB-SPECIALITY REPORT read by Lawrence Elgarresta M.D. 10/13/2016 7:53 AM.

PROCEDURE: G. I. BLEEDING SCAN

CLINICAL INDICATION:
RECTAL BLEED GI BLEEDING

COMPARISON:
None.

TECHNIQUE:
Following the administration of 25 mCi of Tc-99m UltraTAG labeled red blood cells, a GI bleeding study is performed.

Transcribed by: On: Oct 13 2016 7:53A

Read by: JUAN CARLOS BATLLE, MD On: Oct 12 2016 9:30P
Signed Electronically by: LAWRENCE F ELGARRESTA, M.D. On: Oct 13 2016 7:53A

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{psgn_dr_addend}
{psgn_dr_addend2}

REPORT OF RADIOLOGIC CONSULTATION

Patient Name: [redacted]
Patient Class: INPATIENT | **Priority:** STAT | **Order No:** 90012
DOB: [redacted] | **Age:** [redacted] **Sex:** F | **Corp ID:** 000005139471
Adm No: [redacted] | **Adm Date:** 10/11/2016 | **Time:** 7:25PM
Rad / MR No: 1387800 | **Pt NS/Room:** 4PAV-041401 | **Ph#:** (305) 265-8136
Ordered By: NEIL E ROSENKRANZ, M.D. 013243 | **Phone:** (305) 273-7319 **Fax:** (305) 662-9515
Referred By: YANEICY GONZALEZ-ROJAS,M.D. 167692 | **Phone:** (786) 662-5465 **Fax:** () -

DISCUSSION:
There is no evidence of active GI bleeding identified in the first hour of dynamic acquisition as well as delayed images. Extensive varices are evident.

IMPRESSION:
No evidence of active GI bleed.

Transcribed by: On: Oct 13 2016 7:53A

Read by: JUAN CARLOS BATLLE, MD On: Oct 12 2016 9:30P
Signed Electronically by: LAWRENCE F ELGARRESTA, M.D. On: Oct 13 2016 7:53A

{read_info2}
{psgn_dr_addend}
{psgn_dr_addend2}

Vascular Institute
SOUTH MIAMI HOSPITAL

Miami FL 33143
(786) 662-8432

Transthoracic Echocardiogram Report

Name: [redacted]
CI #: 5139471
Age: [redacted]
DOB: [redacted]
Referring Physician: GONZALEZ-ROJAS, YANEICY
Patient Status: Inpatient
Patient Location: ::4PAV:0414:01

Study Date: 10/12/2016 08:58 AM
MRN #: 1387800
Ordering Physician: SANJAR, TINA
Accession#: 20352767
Account #[redacted]
Gender: Female

Performed By: Robert S Sukhoo, RCS
Reason For Study: CORONARY ARTERY DISEASE
History: CAD
Height: 54 in Weight: 121 lb BSA: 1.4 m^2 BP: 121/65 mmHg HR: 80

Procedure

A complete two-dimensional transthoracic echocardiogram was performed (2D, M-mode, spectral and color flow Doppler).

M-Mode/2D Measurements (Female)

IVSd: 0.73 cm (0.6-1.0 cm)

LVPWd: 0.60 cm (0.6-1.0 cm)

LVIDs: 2.7 cm (2.2-3.5 cm)

LA dimension: 2.7 cm (2.7-3.8 cm)

LA ESV Index (BP): 15.0 ml/m^2 (16-34 ml/m2)

LVIDd: 3.6 cm (3.8-5.2 cm)

LVIDd/BSA: 2.6 (2.3-3.1 cm/m2)

LVIDs/BSA: 1.9 (1.3-2.1 cm/m2)

Ao root diam: 2.6 cm (< 4.0 cm)

MMode/2D Measurements and Calculations

LA ESV Index (A2C): 7.1 ml/m^2

LA ESV Index (A4C): 27.1 ml/m^2

Doppler Measurements and Calculations

MV E max vel: 100.0 cm/sec

MV A max vel: 129.0 cm/sec

MV E/A: 0.78

MV dec time: 0.10 sec

TV E max vel: 68.6 cm/sec

PV vel max: 51.3 cm/sec

PV max PG.: 1.1 mmHg

TR max vel: 248.0 cm/sec

TR max PG: 25.0 mmHg

RVSP(TR): 30.0 mmHg

RAP systole: 5.0 mmHg

Lat Peak E' Vel: 6.9 cm/sec

AV Dim Index: 0.75

Lat E/E': 14.5

DISCUSSION:

Left Ventricle
The left ventricular size, shape and wall thickness are normal. Left ventricular systolic function is normal. Ejection fraction is within normal limits estimated at equal to greater than 55 percent. No regional wall motion abnormalities noted. Normal diastolic function parameters.

Left Atrium
Normal left atrial size and appearance.

Right Ventricle
The right ventricular size, shape, and wall thickness are normal. The right ventricular systolic function is normal. pacer noted in right heart

Right Atrium
Normal right atrial size and appearance.

Aortic Valve
There is mild aortic sclerosis. There was no aortic regurgitation noted. No valvular aortic stenosis noted.

Aorta
The aortic root is normal in appearance and dimension.

Mitral Valve
There appears to be mild mitral annular calcification. There is no significant mitral regurgitation noted. There is no mitral valve stenosis noted. There is no evidence of mitral valve prolapse.

Tricuspid Valve
The tricuspid valve appears to be normal in structure and function. Estimated right ventricular systolic pressure is within normal limits for age. Moderate tricuspid regurgitation. There is no tricuspid valve stenosis noted.

Pericardium and Pleural
There is no significant pericardial effusion noted. The pericardium appears normal.

IMPRESSION:
Ejection fraction is within normal limits estimated at equal to greater than 55 percent.
pacer noted in right heart
Moderate tricuspid regurgitation.
Estimated right ventricular systolic pressure is within normal limits for age.

Reading Physician: Electronically signed by: **MATTHEW E SNOW** on 10/12/2016 12:44 PM

ELECTROENCEPHALOGRAM REPORT

PATIENT NAME: [redacted]
MEDICAL RECORD NUMBER: 000001387800
ACCOUNT NUMBER: [redacted]
DATE OF STUDY: 10/12/2016
PHYSICIAN: ALBERTO PINZON ARDILA, MD
REFERRING PHYSICIAN:
DOB: [redacted]
EEG #:
ROOM: 041401

READING PHYSICIAN: Dr. Pinzon Ardila, MD.

TECHNICAL INFORMATION: Electrode type: Disk.
Electrode placement: 10/20 international system.
Equipment: XLTEK with video.
Number of channels: 22.

DESCRIPTION OF THE RECORD: The background rhythm revealed an 8-9 Hz posterior rhythm with faster frequencies anteriorly that attenuated with eye opening. During drowsiness, slower frequencies were observed. There were some intermixed shifting slower frequencies bilaterally. There were no clear epileptiform discharges.

IMPRESSION: There were no clear significant abnormalities in this EEG study in the awake and drowsy states. Clinical correlation is recommended.

AP/McdQ
D: 10/15/2016 10:43:33
T: 10/15/2016 18:12:07
Job #: 583579/716971693

ALBERTO PINZON ARDILA, MD 114660

PATIENT NAME: [redacted]
MEDICAL RECORD NUMBER: 000001387800
ACCOUNT NUMBER: [redacted]
PHYSICIAN: ALBERTO PINZON ARDILA, MD

ELECTROENCEPHALOGRAM REPORT

2016079000 151

DOH Consumer Services

JAN 2 8 2018

STATE OF FLORIDA
Rick Scott, Governor

FLORIDA DEPARTMENT OF HEALTH

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Spectrum Aesthetics
Name of office

51 SW 42nd Ave
Street Address

miami 33134 Dade
City Zip Code County

305.514.0318
Telephone

Dr Mel Ortega
Name of Physician or Licensee Reporting

OSR 920
License Number & office registration number, if applicable

51
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted]
Patient's Address

[redacted] ☐ ☐
Age Gender Medicaid Medicare

756 7439
Patient Identification Number

1/13/16
Date of Office Visit

Liposuction with fat transfer
Purpose of Office Visit

Diagnosis

ICD-9 Code for description of incident

11
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

1/13/16
Incident Date and Time

Location of Incident:
☐ Operating Room ☑ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

Patient [redacted] underwent liposuction/fat transfer to buttocks (areas treated abdomen - arms). Procedure completed satisfactorily with stable vitals throughout procedure. Extubated and transfered to PACU. Approximately 20 minutes after transfer, called to PACU due to patient being reported to be in distress with hypotension. ACLS protocols initiated including establishing airway, assisted ventilation; chest compressions, call for EMS-911 and administration of standard resuscitative drugs and defibrillation. EMS arrived and continued resuscitative measures including defibrillation/cardioversion for VTach. Pulse and BP with sinus tach achieved. Patient transported to UM Hospital ER for further evaluation and treatment.

B) ICD-9-CM Codes

86.83	E879.8	998.89
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

n/a

D) Outcome of Incident (Please check)

☐ Death	☐ Surgical procedure performed on the wrong site **
☐ Brain Damage	☐ Wrong surgical procedure performed **
☐ Spinal Damage	☐ Surgical repair of injuries or damage from a planned surgical procedure.
☐ Surgical procedure performed on the wrong patient.	** If it resulted in:
☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.	☐ Death ☐ Brain Damage ☐ Spinal Damage ☐ Permanent disfigurement not to include the incision scar ☐ Fracture or dislocation of bones or joints ☐ Limitation of neurological, physical, or sensory function. ☐ Any condition that required the transfer of the patient to a hospital.
☒ Any condition that required the transfer of the patient to a hospital.	
Outcome of transfer – e.g., death, brain damage, observation only Observation Name of facility to which patient was transferred: ~~Jac~~ University of Miami Hospital Jackson Memorial Hospital	

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Dr. Mel Ortega ME 65154
Carlos Faeitas - Anesthesiologist - ARNP - 9279188
Isabel Fuentes - RN - 9333991

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Unable to specify apparent cause as I did not witness any precipitating event.

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	ME 65154 LICENSE NUMBER
1/25/16 DATE REPORT COMPLETED	5:22 pm TIME REPORT COMPLETED

STATE OF FLORIDA
Rick Scott, Governor

Florida HEALTH

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

South Florida Center for Cosmetic Surgery
Name of office

915 Middle River Drive
Street Address

Ft. Lauderdale 33304 Broward
City Zip Code County

954-565-7575
Telephone

Dr John Pinella, MD
Name of Physician or Licensee Reporting

ME 39119 OSR #491
License Number & office registration number, if applicable

Same as above
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted]
Patient's Address

[redacted] [redacted] ☐ ☐ N/A
Age Gender Medicaid Medicare

D77259
Patient Identification Number

1/19/16
Date of Office Visit

Abdominal Laxity
Diagnosis

elective cosmetic surgery
Purpose of Office Visit

458.9 Hypotension
ICD-9 Code for description of incident

3C
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

1/19/16 @ 6:30pm
Incident Date and Time

Location of Incident:
☐ Operating Room ☒ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No N/A
Was an autopsy performed? ☐ Yes ☐ No N/A

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

See attached

Patient was discharged on 1/20/16 in stable condition and had a follow-up visit with Dr. Pinella on 1/25/16 Patient is healing well.

B) ICD-9-CM Codes

Hypotensive in PACU	Hypotension	none
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

Abdominoplasty set , Liposuction Cannula

D) Outcome of Incident (Please check)

☐ Death	☐ Surgical procedure performed on the wrong site **
☐ Brain Damage	☐ Wrong surgical procedure performed **
☐ Spinal Damage	☐ Surgical repair of injuries or damage from a planned surgical procedure.
☐ Surgical procedure performed on the wrong patient;	** if it resulted in:
☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.	☐ Death ☐ Brain Damage ☐ Spinal Damage ☐ Permanent disfigurement not to include the incision scar ☐ Fracture or dislocation of bones or joints ☐ Limitation of neurological, physical, or sensory function. ☐ Any condition that required the transfer of the patient to a hospital.
☒ Any condition that required the transfer of the patient to a hospital.	
Outcome of transfer – e.g., death, brain damage, observation only	
Name of facility to which patient was transferred: Holy Cross Hospital	

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Dr John Pinella ME 39619 Surgeon Jacqueline Ells. RN 3242212
Dr Jason White ME 858164 Anesthesiologist - Recovery Room RN
Gabriel Diaz - 1st Asst 11-142 - Surg Asst
Adriana Veins , MA

F) List witnesses, including license numbers if licensed, and locating information if not listed above

same as above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

See attached

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

See attached

V. John Pinella ME 39619
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

1/28/14 1000
DATE REPORT COMPLETED TIME REPORT COMPLETED

Department of health
Board of Medicine
4952 bald Cypress way
Tallahassee, Fl 32399

January 26, 2016

To Whom It May Concern:

Patient [redacted] came into my office on 1/9/16 for a cosmetic surgery procedure of abdominoplasty with 1000 cc of suction assisted lipectomy of the flanks . After an H& P the patient was found to be a [redacted] with an unremarkable medical history. The patient arrived on 1/19/16 for [redacted] scheduled procedure and the surgery was performed in a routine fashion and was uneventful.

The patient was stable throughout the procedure but [redacted] BP was 90/60 for an extended period of time in the PACU , fluids were given and [redacted] was monitored. Upon my recommendation [redacted] was transferred to Holy Cross hospital for hypotension and observation. [redacted] was admitted and given 1 liter of blood. I saw the patient in the hospital on 1/20/16 and [redacted] was seen in my office on 1/25/16 for [redacted] 1 week follow-up. [redacted] is doing well and is scheduled for [redacted] two-week follow-up in my office on 2/8/16.

Please call my office for further information.

Regards,

John Pinella, M.D.

20160895? 115

DOH Consumer Services
FEB 12 2016

STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Mark Lamet MD PA
Name of office

1150 N. 35th Avenue #445
Street Address

Hollywood 33021 Broward
City Zip Code County

954-961-7771
Telephone

Mark Lamet MD
Name of Physician or Licensee Reporting

ME0037518 OR# 193
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted]
Patient's Address

Patient Identification Number

Diagnosis

[redacted]
Age Gender

☐ Medicaid ☐ Medicare

02/01/16
Date of Office Visit

Colonoscopy
Purpose of Office Visit

K91.89
~~ICD-9~~ Code for description of incident
ICD-10

II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2/2/16
Incident Date and Time

Location of Incident:
☐ Operating Room ☐ Recovery Room
☒ Other Broward General

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

Patient underwent Colonoscopy on 2/1/16 – Large (6-7 cm) polyp removed from Cecum.
On 2/2/16 Pt c/o abd Pain + small amount of Rectal Bleeding Went to Broward General ER where noted to have Fever w/ mild Leukocytosis. Imaging Studies → no perforation.
Pt being treated Conservatively for Trans-mural burn from Cautery w/ IV antibiotics + Clear liquid diet. [redacted] is convalescing in the hospital

B) ICD-9-CM Codes

45384	N/A	K 91.89
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury ~~(ICD-9~~ Codes 800-999.9) ICD-10

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient.
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.
- ☒ Any condition that required the transfer of the patient to a hospital.

Outcome of transfer – e.g., death, brain damage, observation only _____
Name of facility to which patient was transferred: _____

- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure.

** if it resulted in:
- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function.
- ☐ Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Mark Lamet MD - ME 037518

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

None

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

V.

[signature]	037518
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	LICENSE NUMBER
2/3/16	11 AM
DATE REPORT COMPLETED	TIME REPORT COMPLETED

20160958

STATE OF FLORIDA
Rick Scott, Governor

DOH Consumer Services

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

FEB 2 3 2016

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Renalus Vascular Access Center
Name of office

925 mar walt Dr. Suite 2
Street Address

Fort Walton Beach 32547 Okaloosa
City Zip Code County

850-804-4005
Telephone

Dr. Douglas Bunting
Name of Physician or Licensee Reporting

ME114135
License Number & office registration number, if applicable

[redacted]
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient's Address

[redacted] Age 2/9/16 Gender ☐ Medicaid ☑ Medicare

45548-0
Patient Identification Number

Date of Office Visit

I5R0
Diagnosis

fistulogram/Angioplasty
Purpose of Office Visit

585.6
ICD-9 Code for description of incident

II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2/9/16 at 0913
Incident Date and Time

Location of Incident:
☑ Operating Room ☐ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

Patient presented to facility for scheduled fistulogram. Patient's heart rate pre procedure was 84. Patient taken to procedure room and placed supine on procedure bed. Patient's heart rate 102. Patient denied chest pain, shortness of breath or dizziness. Physician informed. During procedure patient's heart rate 118. Physician informed. Patient denied chest pain, shortness of breath or dizziness. After procedure, patient placed in sitting position on side of bed. Patient's heart rate 133. Patient denied chest pain, shortness of breath or dizziness. Physician notified. Verbal order to provide PO fluids and monitor received. PO fluid provided.

Patient's heart rate remained at 133. Physician notified. Verbal order to contact EMS for transport to Emergency Department received. EMS evaluated patient. Patient left facility via EMS transport.

B) ICD-9-CM Codes

585.6

Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

☐ Death	☐ Surgical procedure performed on the wrong site **
☐ Brain Damage	☐ Wrong surgical procedure performed **
☐ Spinal Damage	☐ Surgical repair of injuries or damage from a planned surgical procedure.
☐ Surgical procedure performed on the wrong patient.	** if it resulted in: ☐ Death ☐ Brain Damage ☐ Spinal Damage ☐ Permanent disfigurement not to include the incision scar ☐ Fracture or dislocation of bones or joints ☐ Limitation of neurological, physical, or sensory function. ☐ Any condition that required the transfer of the patient to a hospital.
☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.	
☐ Any condition that required the transfer of the patient to a hospital.	
Outcome of transfer – e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred: _____	

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Dr. Douglas Bunting ME 114135
Layan Smith, RN RN 9325235
Jeff Mcaney, RT CRT 87001
Barbara Caliman

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)
Patient has history of irregular heart rate, with history of tachycardia

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)
Continue to follow policy and procedure.

V. _____ ME 114135
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT **LICENSE NUMBER**

2/9/16 1500
DATE REPORT COMPLETED **TIME REPORT COMPLETED**

OPERATIVE REPORT

PATIENT: [redacted]

DATE: 02/09/2016

PREOPERATIVE DIAGNOSIS:

POSTOPERATIVE DIAGNOSIS: Same.

OPERATION PERFORMED: Corset platysmaplasty, high SMAS facelift.

SURGEON: Harold Bafitis, D.O., MPH, FACOS, FACS

PROCEDURE: This [redacted]-year-old patient well known to us has come in with the above complaints. The patient full well understands the nature of surgery, the fact that there are complications inherent with this, and he read his patient consultation worksheet in detail, and not only that but had all the complications reviewed with him by me and the staff. He signed the consent knowingly, and the staff went over all the particular issues inherent with his surgery. The patient understands that there will be some degree of autologous fat grafting with facial rejuvenation, and this may impose some undue amount of swelling and/or potential resorption problems that may need further fat and/or other filler injections at a later time. No guarantee was made or implied as to the final result, and we did state that there may be prolonged swelling and that the area of the most significant relapse would be around the mouth and jowls as the patient animates. No improvement should be expected for the perioral area, as this is something that should be addressed in a separate procedure. The patient was counseled several times preoperatively, and we jointly agreed on rhitidectomy as the operative course. The patient was prepared in the usual manner and obtained medical clearance for his surgery.

We saw the patient in the holding area and marked him appropriately for the procedure. We explained to him again our plan as to where we would place fat, where we would harvest fat. We went over any further questions and elaborated on potential complications. He was cleared by Anesthesia.

The patient was given 1 g of Ancef and 10 mg of Decadron and then taken to the operating theater. He was placed in the supine position. His arms were minimally abducted, supinated, and padded, and he was induced under mild IV sedation. We then prepared the head and neck by prepping it with 1% Betadine

Continued

solution and applying sterile drapes. We went ahead and infiltrated the entire neck area and the right side of the face with local anesthetic. We used a mixture of 0.5% Marcaine with 1:200,000 epinephrine and 1% Xylocaine with 1:100,000 epinephrine on the incisional areas in the submental area and along the pretragal area and posterior auricular area and in the occipitomastoid zone. We also infiltrated the incisional areas of the flap areas with 0.5% Xylocaine with 1:200,000 epinephrine. We infiltrated the remainder of the flap with a tumescent solution of epinephrine, saline, and 1% lidocaine.

Please note that we went forward and prepared our fat for any fat grafting, and prior to working on the submental area and pretragal areas, we went forward and judiciously placed fat in appropriate zones utilizing filtered prepared fat in 1 cc syringes. Please see separate operative report for this.

Once autologous fat filling was done and after adequate time for hemostasis and anesthesia to take effect, we went forward and approached the submental area. We approached the submental area, made an incision in a natural skin crease, and raised a preplatysmal flap. Undermining ensued down to the thyroid cartilage, and we were able to visualize the platysma without incident. We then gently removed any preplatysmal fat with direct trimming and open liposuction. All bleeding points were controlled by directed electrocautery. We created a plane in the subplatysmal zone; and with gentle dissection, we removed the subplatysmal fat accordingly. If needed with pronounced digastric musculature and obtuse cervicomental angle, we performed anterior digastric resection. We then performed a corset platysmoplasty utilizing 3-0 PDS as well as 3-0 and 4-0 Vicryl Plus sutures. The platysma was cut about 2-3 cm on either side of the midline at the distal end of our corset. We then packed the submental incision utilizing Betadine soaked sponges. With this being done, we then went forward to the right side of the face.

We approached the right side of the face and raised an occipitomastoid flap and cheek/neck flap in the usual manner. Our incision went along the anterior hairline. Care was given to not damage any hair follicles. The patient had undermining in the subcutaneous plane to the area of the midcheek as drawn before surgery. All bleeding points again were controlled by directed electrocautery. We raised a SMAS flap in the cheek, undermined the flap to the pivot point and then to the area of the midcheek and inferiorly about 4.5 to 5 cm where we were under the platysma

Continued

as well. With this being done, we placed traction on this SMAS flap to effect an upward lift. We created a small transposition flap and tacked this about the area just beneath the tragus with 3-0 Vicryl Plus suture. We then were able to provide upward traction on our SMAS flap, roll it on itself to create a contour fill of the malar and zygomatic zone and literally create a more volumized cheek. Please note, we also released the retaining ligaments that anchored the depressed cheek fat. By rolling the SMAS and contouring it superiorly, we utilized buried sutures of 3-0 Vicryl Plus suture. We also approximated the SMAS to the pretragal parotid fascia utilizing interrupted sutures of 3-0 Vicryl Plus. We then went ahead and affected traction to the posterior border of the platysma muscle to complete our chin/neck work and corset platysmaplasty. As stated, we had dissected in the midline of the neck, cutting the platysma for about 3-4 cm in the low anterior cervical area to allow more traction. The anchoring sutures were again 3-0 Vicryl Plus sutures as well as on the lateral platysma 2-0 PDS sutures.

With this being done, irrigation ensued with bacitracin and saline. We then trimmed any excessive fat below the mandible directly and as needed with open liposculpture. All bleeding points were controlled. A TLS drain was placed, brought out through a separate stab wound in the hairline superior to the occipitomastoid incision, and secured with interrupted 3-0 Vicryl Plus suture. We then went ahead and placed appropriate traction on our skin flaps and draped them accordingly into a more natural vector, often different than the vector of the SMAS pull. Sutures secured at key tension points above the ear and in the occipitomastoid zone utilizing 3-0 Vicryl Plus suture. Flaps were trimmed accordingly, preserving hair follicles as needed, and we closed all incisions at the hairline with 3-0 Monocryl as well as 5-0 plain gut suture. The occipitomastoid area was closed again with 3-0 Monocryl, 3-0 Vicryl Plus suture, as well as 3-0 running chromic (3-0 chromic) suture. We trimmed the flaps around the ear and tailored the earlobes appropriately and closed them with interrupted 4-0 Monocryl in the deep areas as well as 5-0 nylon on the skin as well as 5-0 plain gut suture. The patient had a small posterior auricular area left open for drainage.

We then applied Bactroban Ointment to all suture lines as well as a small amount of nitro paste to decrease venous engorgement. We held pressure on this area with ABDs and then infused the contralateral side.

Continued

An exact similar procedure was done on the contralateral side as we did on the right side, and we then were able to close not only the submental area but the left side of the face. The submental incision was closed with 4-0 Monocryl as well as 5-0 plain gut suture. Bactroban, Xeroform, and Telfa were placed on all incisions and nitro paste on the occipitomastoid area.

As stated, final dressings included bacitracin and saline cleansing of all the skin, Bactroban on the suture lines, cut-to-fit Xeroform dressings, as well as Telfa, sterile cotton padding with mineral oil. The drains were placed on suction tubes. We then placed Kerlix fluffs, Kerlix wrap, and Kling dressings as well as silk tape. The patient was given 10 mg of Decadron at the close of the procedure and will be monitored and given more antibiotic as needed.

The patient was taken to the post-anesthetic room in satisfactory condition. He was able to move all muscles of facial expression without any deficit. He will be followed closely and will be discharged with appropriate pain medication and antibiotics, and will be monitored by our RN.

Harold Bafitis, D.O., MPH, FACOS, FACS
D:02/25/2016 T:02/25/2016
(dictated but not read)

HB/lkr

OPERATIVE REPORT

PATIENT: [redacted]

DATE: 02/09/2016

PREOPERATIVE DIAGNOSIS: Redundant lower lid with lateral canthal laxity.

POSTOPERATIVE DIAGNOSIS: Same.

OPERATION PERFORMED: Lower lid pinch blepharoplasty with orbicularis tightening.

SURGEON: Harold Bafitis, D.O., MPH, FACOS, FACS

PROCEDURE: This [redacted]-year-old patient presented to us with the above-mentioned issues. We explained to him that although he did not have any lower lid fat, he did have skin laxity and redundant skin. He would be a candidate for a skin pinch only blepharoplasty with orbicularis suspension and release of the orbitomalar ligament.

We went forward, marked the patient accordingly, and he was given preop 2 mg of Ativan. The patient was taken to the operating theater where he had an IV started, and he was given another 1 mg of Ativan IV. After adequate time for relaxation, the lower lid was blocked with 1% Xylocaine with 1:100,000 epinephrine as well 0.5% Marcaine with 1:200,000 epinephrine. After adequate time for hemostasis to take place, we then also blocked the upper lid area in a natural skin crease. We made the marks for our skin pinch at approximately 5 mm beneath the lash line, angling downward at the lateral cantus. We utilized two Brown-Adson forceps to pinch the skin and then went forward and excised a strip of skin only. We cauterized any minimal bleeding along the orbicularis. At that point, we were able to dissect laterally down through the orbicularis. We had no bleeding, and we were able to bluntly dissect down and then introduced a periosteal elevator. We were able to easily sweep and release orbitomalar ligament lateral to medial. We tented the skin, and with no issue noted, we were able to then grab the orbicularis muscle and do a lateral canthopexy in terms of tightening the orbicularis muscle and retinacular suspension going up to the orbital rim in the superior lid and utilizing 4-0 Vicryl suture. With that being done, excellent contour was appreciated. We closed the lower lid with interrupted 6-0 plain gut sutures and 5-0 plain gut sutures, and the same was done with the upper lid incision. We cleansed the area with bacitracin

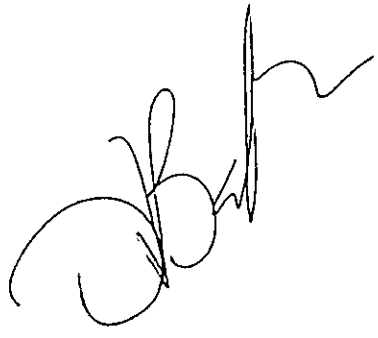
Continued

and saline. We applied an ice pack and went to the contralateral eye and did a similar procedure.

TobraDex drops were placed in the eye prior and postprocedure and TobraDex ointment on the incision line. The patient will have cool ice packs placed and placed in the semi-Fowler position. The patient was given preop antibiotics and will be sent home in the care of a guardian with postop antibiotics, ice packs, and local wound care instructions with TobraDex ointment.

Harold Bafitis, D.O., MPH, FACOS, FACS
D:02/25/2016 T:02/25/2016
(dictated but not read)

HB/lkr



OPERATIVE REPORT

PATIENT: [redacted]

DATE: 02/09/2016

SURGEON: Harold Bafitis, D.O., MPH, FACOS, FACS

PREOPERATIVE DIAGNOSIS: Dermatochalasis and fat herniation of the lower lids.

POSTOPERATIVE DIAGNOSIS: Dermatochalasis and fat herniation of the lower lids.

PROCEDURE: Lower lid transconjunctival blepharoplasty.

INDICATIONS FOR SURGERY: This [redacted]-year-old patient presented to our office with the above-mentioned complaints. The patient states that there is a chronic tired look in the lower lids. The patient was diagnosed as having obvious dermatochalasis with significant fat herniation of the lower lids. We determined together that a transconjunctival lower lid blepharoplasty would be appropriate. We went over the presurgical workup together and our patient consultation worksheet was gone over several times. The patient understood the nature of the procedure and all potential complications.

DESCRIPTION OF PROCEDURE: On the day of surgery, the patient was seen in the holding area and was marked appropriately. An IV was started and the patient was given a gram of Ancef and 10 mg of Decadron. The patient was taken to the operating theater where a mild intravenous sedation was given. Monitoring devices were secured and a standard 1% Betadine prep was affected to the head and neck areas.

Attention was now given towards performing bilateral lower lid transconjunctival blepharoplasty. We injected each lower lid area with a mixture of 0.5% Xylocaine with 1:200,000 epinephrine and 0.5% Marcaine with 1:200,000 epinephrine. We also placed some of the mixture in the lower palpebral conjunctival sack. We placed a cool saline pack on the left eye and approached the right initially. Tetracaine drops were placed in the right eye and a corneal shield protector was placed that was saturated on its inside with Maxitrol ointment. After an appropriate amount of time lapsed for hemostasis and anesthesia, attention was given to the job at hand.

Continued

Attention was now given towards the left eye where an exact similar procedure was done, keeping the right eye in view for contour and symmetry. Again, we used Frost sutures of 6-0 silk as we did on the right eye.

At the end of the procedure, the patient was gently awakened, was able to visualize very nicely through both eyes, and we then placed Steri-Strips along the lower lid periocular area to act as supporting mechanisms to prevent ectropion and help with edema.

Another 10 mg of Decadron was given for swelling and at that point, our final dressings were placed.

The patient had the head elevated. The patient's vital signs were checked and found to be in excellent order, and the patient was taken to the postanesthesia care unit in satisfactory condition. Cool iced saline packs were then placed on the patient's eyes. The patient will be monitored closely. The patient will be discharged with appropriate pain pills, antibiotics, and strict instructions on ointments to be placed in the eyes. The patient will subsequently be discharged to the care of a selected guardian.

Harold Bafitis, D.O., MPH, FACOS, FACS
D:02/25/2016 T:02/25/2016
(dictated but not read)

HB/dst/imi

OPERATIVE REPORT

PATIENT: [redacted]

DATE: 02/09/2016

PREOPERATIVE DIAGNOSIS: Microgenia.

POSTOPERATIVE DIAGNOSIS: Microgenia.

OPERATION PERFORMED: Placement of anatomic chin implant shaved down to medium.

SURGEON: Harold Bafitis, D.O., MPH, FACOS, FACS

ROUTE: Intraoral/Extraoral

INDICATIONS FOR PROCEDURE: This [redacted]-year-old patient presented to us with complaints relating to the fact that he had microgenia as noted above. The patient states that it is interfering with his profile and overall esthetic balance. On clinical assessment we found in fact that the patient does have evidence of hypogenia with significant imbalance in terms of facial proportions.

The patient understands full well that we will be able to correct this to some degree and in fact, if he wants further correction (greater than 6-8 millimeters), he will have to go with a sliding osteotomy-type procedure. The patient does not desire this procedure at this point and is full well aware of the procedure, all potential complications, including infection, hematoma, seroma, rejection of the implant, as well as malposition and problems with paresthesias around the chin and lip, as well as mental nerve problems, be they temporary or permanent. The patient signed the consent knowingly and is ready to undergo the procedure.

DESCRIPTION OF PROCEDURE: We saw the patient the day of surgery and marked him appropriately in terms of anatomic guidelines. The anterior mandibular ligaments were marked, as well as the symphysis and pogonion. An IV was started, and *he was given one gram of Ancef, 10 of Decadron and taken to the operating theater.

With this being done, the patient was induced under general endotracheal anesthesia. He was properly positioned and padded, and the area was prepped

Continued

With this being done the procedure was through, and the patient was given another 10 of Decadron. The patient tolerated the procedure well and was taken to the post anesthetic room in satisfactory condition.

ADDENDUM: Please note that after essentially almost completely closing the left side of the cheek/neck lift, the patient had an issue with bradycardia that progressed into asystole and pulseless rhythm. This has been documented. CPR began, and we redraped the flap putting a moist Betadine soaked lap over the area. Once we were at Palm Beach Gardens Hospital and the patient had come back and was intubated and had good rhythm and oxygenation, in the emergency department, we went forward and completed the cutaneous closure. We already had placed a drain, and we were essentially just closing the wounds in the pretragal area and occipitomastoid area. This was done in the usual manner with the same sutures as on the contralateral side. The patient had standard dressings placed and was transferred to ICU. Please review the subsequent notes on this patient from this point on.

Harold Bafitis, D.O., MPH, FACOS, FACS
D:02/25/2016 T:02/25/2016
(dictated but not read)

HB/im/imi

PLASTIC SURGERY INSTITUTE
OF THE PALM BEACHES, INC.

HAROLD BAFITIS, D.O., M.PH., F.A.C.O.S., F.A.C.S.†
Board Certified in Plastic and Reconstructive Surgery †
Board Certified in General Surgery

February 10, 2016

My name is Lisa Perez. I am a registered nurse first assistant. I work at the Plastic Surgery Institute of the Palm Beaches, which is an AAAHC accredited surgery center.

On 02/09/2016, we were performing a facelift on a [redacted]-year-old male. When we were closing the last second side of the face, our anesthetist noticed that the patient's heart rate was bradycardic and continuing to descend. We stopped the surgery to help the anesthetist. A mask was applied for air. Then when no response, we noted the monitors were showing asystole. We continued to check for pulses in carotid, femoral, pedal, all places that we could assess. When we found we could not get any pulses, we applied the AED and did as instructed . When it said no shock required, we once again felt for pulses and began CPR. A total of three doses of epinephrine were given and one dose ofD50. Upon that, CPR was continued. The ET tube was in place and ventilating, and that is approximately when the medics arrived, and they took over.

Lisa Perez RNFA

Lisa Perez, RNFA

PALM BEACH GARDENS/JUPITER: *4601 Military Trail • Suite 208 • Jupiter • Florida • 33458 • OFFICE (561) 795-3787 • FAX (561) 798-0003*
WELLINGTON CENTER: *1447 Medical Park Blvd.• Suite 107 • Wellington • Florida • 33414 • OFFICE (561) 422-1117*
www.drbafitis.com

Member

† Certified by the American Osteopathic Board of Surgery, Plastic Surgery • General Surgery • Fellow, American College of Osteopathic Surgeons
† Fellow, American College of Surgeons • † Fellow, American Academy of Cosmetic Surgeons

OPERATIVE REPORT

PATIENT: [redacted]

DATE: 02/09/2016

PREOPERATIVE DIAGNOSIS: Laxity of lower lid with hypertrophic redundant orbicularis muscle.

POSTOPERATIVE DIAGNOSIS: Same.

OPERATION PERFORMED: Lateral retinacular suspension utilizing upper and lower lid lateral incisions.

SURGEON: Harold Bafitis, D.O., MPH, FACOS, FACS

PROCEDURE: This [redacted]-year-old patient presented with the above-mentioned components of facial aging. You may refer to separate operative reports or to the patient notes for complete analysis of facial aging and planned corrective procedures. As far as the lower lid laxity and orbicularis hypertrophy, our plan would be to go forward and perform a lateral retinacular suspension via the technique of Fagien.

The patient had undergone appropriate counseling for all facial aging corrective procedures to be performed on the above-mentioned day and was aware that further work may be needed as a result of the lateral retinacular suspension. The patient was totally aware of the fact that there still may be some laxity of the lower lid which may occur over time and would in fact need further corrective measures. Our plan was to incorporate this procedure as a support mechanism for the lower lid as well as a tightening and lifting of the redundant orbicularis muscle.

As the patient was premedicated according to standard protocol, preoperative antibiotics and 10 mg of Decadron were given. The patient had been sedated in the usual manner (please see separate operative reports as necessary).

We approached this suspension by either utilizing the lateral upper blepharoplasty incision or making a small lateral incision in the upper lid. We would also be making a lateral incision 2-3 mm beneath the lash line on the lower lid extending in a natural skin contour line. If, in fact, we needed to do further work on the orbicularis, we would extend the incision in the lower lid as necessary nasally. Our

Continued

20160918

DOH Consumer Services

MAR 0 1 2016

179

STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Vascular Specialists of Central Florida
Name of office

80 W Michigan St
Street Address

Orlando 32806 Orange
City Zip Code County

407 648 4523
Telephone

ADAM LEVITT
Name of Physician or Licensee Reporting

ME91525
License Number & office registration number, if applicable

[redacted]
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted] M ☐ Medicaid ☒ Medicare
Age Gender

[redacted]
Patient's Address

2-16-2016
Date of Office Visit

40482
Patient Identification Number

Angiography
Purpose of Office Visit

170.25
Diagnosis

ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2-16-2016 2010
Incident Date and Time

Location of Incident:
☐ Operating Room ☒ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☒ No
Was an autopsy performed? ☐ Yes ☒ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

See Attached

DESCRIPTION OF CIRCUMSTANCES OF THE INCIDENT
2/16/2016

Patient: [redacted]
DOB: [redacted]
Acct # 40482

Patient came to the endovascular lab on 2/16/2016 for an angiography of the left lower extremity with possible intervention When the patient was ready for discharge at 2010, he exhibited orthostatic blood pressures. Vital signs were stable at laying and sitting, but when he stood up, his blood pressure would drop to 70/40, heart rate increased to 120s, and patient became light headed and dizzy. Patient was rested back in bed and a bolus of fluids were given. No signs of hematoma. Dr. Levitt was notified and orders to transfer the patient to the emergency room were given. 911 was called at 2015 and the paramedics arrived at 2020, patient left facility at 2030 and transferred to Orlando Regional Medical Center.

Erika D Johannsen, RN-BSN

Vascular Specialists of Central Florida

80 W. Michigan Street

Orlando, FL 32806

407.648.4323, ext 131

ejohannsen@arteryandvein.com

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**
I70.25	E95.1	?

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

☐ Death	☐ Surgical procedure performed on the wrong site **
☐ Brain Damage	☐ Wrong surgical procedure performed **
☐ Spinal Damage	☐ Surgical repair of injuries or damage from a planned surgical procedure.
☐ Surgical procedure performed on the wrong patient.	** if it resulted in: ☐ Death ☐ Brain Damage ☐ Spinal Damage ☐ Permanent disfigurement not to include the incision scar ☐ Fracture or dislocation of bones or joints ☐ Limitation of neurological, physical, or sensory function. ☐ Any condition that required the transfer of the patient to a hospital.
☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.	
☒ Any condition that required the transfer of the patient to a hospital.	
Outcome of transfer – e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred: _____	

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

- DR. Adam LEWIS = ME91525
- ERIKA JOHANNSON, RN = RN9211502
- JAMIE RODRIGUEZ, RN = RN2122252

F) List witnesses, including license numbers if licensed, and locating information if not listed above

Ø

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Unknown why patient's BP ↓ & HR ↑ with standing - This is why patient was transferred to ORMC for monitoring.

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Proactive Action taken & Patient was sent to hospital for Cardiac monitoring

V. X _____ ME91525

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT — LICENSE NUMBER

2-17-2016 — DATE REPORT COMPLETED

1600 — TIME REPORT COMPLETED

20161 0020

DOH Consumer Services

STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

American Access Care
Name of office

6766 West Sunrise Blvd. suite 100
Street Address

Plantation | 33313 | Broward
City | Zip Code | County

954-583-8472
Telephone

Naveen Goel
Name of Physician or Licensee Reporting

License Number & office registration number, if applicable

6766 W. Sunrise Blvd suite 100
Patient's address for Physician or Licensee Reporting
Plantation FL 33313

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted] | M | ☐ Medicaid ☐ Medicare
Age | Gender

[redacted]
Patient's Address

2-22-16
Date of Office Visit

3600405
Patient Identification Number

Evaluation of Dialysis Access
Purpose of Office Visit

ESRD - N18.6
Diagnosis

T80
ICD-9 Code for description of incident

Respiratory distress

II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2-22-16 0921
Incident Date and Time

Location of Incident:
☒ Operating Room 3 ☐ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☒ No
Was an autopsy performed? ☐ Yes ☒ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

See Attached

B) ICD-9-CM Codes

J80.

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)
Angioplasty - 35476	unknown	Respiratory distress

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

N/A

D) Outcome of Incident (Please check)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient.
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.
- ☒ Any condition that required the transfer of the patient to a hospital.

Outcome of transfer – e.g., death, brain damage, observation only DIC Hone 2/23/16

Name of facility to which patient was transferred: West Side Regional Medical Center Admit - 2/22/16

- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure.

** if it resulted in:
- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function.
- ☐ Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Naveen Goel MD ME 97536
Amit Kamra MD ME 115193
Dupuy-Muse, LYNN RN RN 2212132
Earle, Maurlene RT CRT 54011

F) List witnesses, including license numbers if licensed, and locating information if not listed above

Colondres, Yahaira RN RN 9249085

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Cause is unknown, however, continue to follow PtP provided by FMC ACLS trained RN to monitor patient during all procedures to ensure appropriate actions can be taken immediately during any change in patient's status.

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Interventional RN was proactive in reporting to LIP the changes that took place in patients condition thus leading to the immediate response to help ensure a positive outcome.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	LICENSE NUMBER
2-23-16	1600
DATE REPORT COMPLETED	TIME REPORT COMPLETED

ME 97536

20161085 4

STATE OF FLORIDA
Rick Scott, Governor

DOH Consumer Servi

MAR 11 2016

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Vascular + Spine Institute
Name of office

7887 N. Kendall Dr #210
Street Address

Miami 33156 Miami Dade
City Zip Code County

305 598-1555
Telephone

Oscar Sosa, M.D.
Name of Physician or Licensee Reporting

OSR 718
License Number & office registration number, if applicable

~~Patient's address for Physician or Licensee Reporting~~

II. PATIENT INFORMATION

[redacted]
Patient's Address

#137756
Patient Identification Number

I43.9 + R09.89
Diagnosis

[redacted] M
Age 72 Gender

☐ Medicaid ☑ Medicare

2-22-16
Date of Office Visit

angiogram
Purpose of Office Visit

ICD-9 Code for description of incident

Level II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2-22-16 10:06 am
Incident Date and Time

Location of Incident:
☑ Operating Room ☐ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

See attached report

B) ICD-9-CM Codes

N/A	unknown	none
Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

no equipment used

D) Outcome of Incident (Please check)

☐ Death	☐ Surgical procedure performed on the wrong site **
☐ Brain Damage	☐ Wrong surgical procedure performed **
☐ Spinal Damage	☐ Surgical repair of injuries or damage from a planned surgical procedure.
☐ Surgical procedure performed on the wrong patient.	** if it resulted in: ☐ Death ☐ Brain Damage ☐ Spinal Damage ☐ Permanent disfigurement not to include the incision scar ☐ Fracture or dislocation of bones or joints ☐ Limitation of neurological, physical, or sensory function. ☐ Any condition that required the transfer of the patient to a hospital.
☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.	
☑ Any condition that required the transfer of the patient to a hospital.	
Outcome of transfer – e.g., death, brain damage, observation only patient admitted Name of facility to which patient was transferred: Baptist Hospital	

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Oscar Sosa, M.D. (ME80319); Eva Ramos, RN (RN9248026); Guillermo Grado, RN (RN916385D); Nathaly Betancourt, RN (RN5209403); Robert Alvarez, R.T. (RT58699); Claudia Alvarez (TechASSH); Marisa Rodriguez, ARNP (ARNP9288105)

F) List witnesses, including license numbers if licensed, and locating information if not listed above

same as above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

see attached report

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

see attached report

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	ME80319 LICENSE NUMBER
3-4-16 DATE REPORT COMPLETED	2:20pm TIME REPORT COMPLETED

VASCULAR
AND SPINE
INSTITUTE

7887 N. Kendall Drive
Suite 210
Miami, Florida 33156
305 | 598 | 1555 tel
305 | 598 | 1155 fax
www.vascularandspine.com

Patient: [redacted]
Date of Birth:
Referring Physician: **Nelson Garcia-Morales, M.D.**
Date of Service: **02/22/2016**

Incident Report by Physician

Patient History and Incident Report:

[redacted] is a very pleasant [redacted] who is well-known to the Vascular and Spine Institute having previously undergone treatment for documented superficial venous reflux disease in 2014. He recently presented for evaluation of suspected arterial insufficiency. He does have a medical history which is complicated by known diabetes mellitus, coronary artery disease, peripheral arterial disease, hypertension, hyperlipidemia, hypothyroidism and benign prostatic hypertrophy. He has undergone prior coronary artery bypass graft surgery as well as prior lower extremity arterial interventions although the exact nature of the prior interventions is somewhat uncertain by patient history. He has suffered from lower extremity ulcerations in the past with multiple toe amputations in both lower extremities.

Recent arterial noninvasive evaluation revealed diminished ankle-brachial indices bilaterally measuring 0.65 on the right and 0.57 on the left at rest. This represented a significant worsening when compared with a prior arterial noninvasive evaluation from July 13, 2015 where the ankle-brachial indices were 0.88 on the right and 0.85 on the left at rest. The patient was having difficulty walking although it was difficult to determine the source of his difficulties given his multiple underlying issues including his severe diabetes. However, given the findings on the arterial noninvasive evaluation as well as the significant areas of stenosis visualized by arterial Duplex imaging, [redacted] was scheduled for arteriography with possible endovascular reconstruction.

[redacted] presented to our office early this morning and was evaluated by me at approximately 8:30 AM. At that time, he was awake and alert. He was responding appropriately to all of my questions and appeared to be stable overall. We did feel that he was a candidate for the arteriogram with possible endovascular reconstruction. Appropriate consent was obtained from the patient and his wife.

The patient was placed on the angiography table and we began prepping and draping the groin regions for the arteriogram. The patient was connected to the appropriate monitoring systems including EKG and pulse oximetry evaluations. While the patient was being prepped, he was given 1 mg of Versed and 50 μg of Fentanyl intravenously. The patient immediately developed respiratory distress and stopped breathing. This was noted by the operating room personnel almost immediately after the infusion of the intravenous moderate sedation. We immediately called a code in the office and began our evaluation. We were unable to document a palpable radial, femoral or carotid pulse although this was somewhat difficult to determine given the patient's overall body habitus. When we confirmed the lack of a palpable pulse, we did begin CPR and bag mask ventilation. The patient was given reversal agents for the intravenous moderate sedation and eventually did receive 2 rounds of epinephrine intravenously. After approximately 3–4 minutes of CPR, we did note a palpable radial pulse and the patient was breathing spontaneously. However, he did remain unresponsive.

20161060 187

STATE OF FLORIDA
Rick Scott, Governor

DOH Consumer Services

DOH Consumer Service

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

MAR 0 9 2016

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Surgery Center of Broward
Name of office

4300 N. University Dr. #200
Street Address

Lauderhill | 33351 | Broward
City | Zip Code | County

954.749.3040
Telephone

Harold M. Bass, MD
Name of Physician or Licensee Reporting

ME 16754 OSR 026
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted]
Patient's Address

[redacted] ☐ ☐
Age Gender Medicaid Medicare

330/786
Patient Identification Number

February 23, 2016
Date of Office Visit

Gynecomastia
Diagnosis

Surgery
Purpose of Office Visit

ICD-9 Code for description of incident

Level III
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

February 23, 2016 17:35
Incident Date and Time

Location of Incident:
☐ Operating Room ☒ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

See attached.

B) *ICD-9-CM Codes*

Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

☐ Death	☐ Surgical procedure performed on the wrong site **
☐ Brain Damage	☐ Wrong surgical procedure performed **
☐ Spinal Damage	☐ Surgical repair of injuries or damage from a planned surgical procedure.
☐ Surgical procedure performed on the wrong patient.	** if it resulted in: ☐ Death ☐ Brain Damage ☐ Spinal Damage ☐ Permanent disfigurement not to include the incision scar ☐ Fracture or dislocation of bones or joints ☐ Limitation of neurological, physical, or sensory function. ☐ Any condition that required the transfer of the patient to a hospital.
☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.	
☒ Any condition that required the transfer of the patient to a hospital.	
Outcome of transfer – e.g., death, brain damage, observation only: observation Name of facility to which patient was transferred: Coral Springs Medical Center	

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Harold M. Bass, MD Surgeon
Tiffany Becker, MD Recovery Nurse
Derek Tarr, MD Anesthesiologist

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

V.

[signature] ME167544
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

March 7, 2016 12:46 pm
DATE REPORT COMPLETED TIME REPORT COMPLETED

Narrative

2/23/2016

Pt presented to the Surgery Center of Broward for a Gynecomastia. Procedure was successfully performed by Dr. Harold M. Bass. Pt was received in PACU at 11:05 am by Tiffany Becker, RN.

At 11:48 am, pt had developed a Hematoma and was taken back into the OR for evacuation of Hematoma. At 13:20 pt was received back into PACU. Dr. Derek Tartt (anesthesiologist), ordered orthostatic blood pressure at discharge. Pt was positive for orthostatic hypotension.

Dr. Bass was notified, and pt was transferred to Coral Springs Medical Center.

2/24/2016

After subsequent follow-ups of pt at CSMC, patient disclosed that [redacted] had been rectally bleeding for several weeks. This [redacted] stated has happened on and off for about four years. Pt had not disclosed or revealed this information previously. Also, post-op surgery, patient also disclosed a history of vertigo. Again pt had not disclosed this information prior to surgery, during the interview with the surgeon, anesthesia, or at pre-operative history and physical.

3/07/2016

Pt has been seen for post-op evaluations on 2/26/2016 and 3/04/2016. pt is healing as expected. Pt is currently seeing a gi doctor and is planning a colonoscopy to address rectal bleeding.

20161048 52

STATE OF FLORIDA

FLORIDA DEPARTMENT OF HEALTH

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

DOH Consumer Serv

MAR 0 8 2016

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Vascular & Interventional Pavilion — Name of office
1881 W. Kennedy Blvd — Street / Address
Tampa — City
33606 — Zip Code
Hillsborough — County
813.573.3030 — Telephone
Dr. Obinna Nwobi — Name of Physician or Licensee Reporting
OSR #979 — License Number & office registration number, if applicable
1881 W. Kennedy Blvd — Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted] — Patient Name
[redacted] — Patient's Address
Age — [redacted]
Gende — Medicaid ☐ Medicare ☑
Date — 02-25-2016 — of Office Visit
15373 — Patient Identification Number
Purpose — Vascular procedure — of Office Visit
PAD - I 73.9 — Diagnosis ICD-9 10
K (06.1 — Code for description of incident
Level — of Surgery (II) or (III)

III. INCIDENT INFORMATION

02/25/2016 — Incident Date and Time

Location of Incident:
☐ Operating Room ☑ Recovery Room
☐ Other_____

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No N/A
Was an autopsy performed? ☐ Yes ☐ No

A). Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

Post angiogram procedure, patient recovered & incident from 1456 until 1655 (VSS no hematoma) when we ↑ HOB to 60° (BP 89/51). At this time we lowered pt. to supine position - BP ↑ to 124/62. Each time nurse elevated HOB, BP dropped to 70-88/48-58. IV had been d/c'd. Made 2 unsuccessful attempts to restart IV so Venous Sheath inserted by Dr. Nwobi. 1 STAT Checked - Hgb was 9.9 (was 12.9 preop). Dr. Suresh palpated RLQ hematoma - painful on deep palpation. Rt. C/o SOB. O2 initiated via nonrebreather @ 4L/min. IV fluids infused wide open. Pt. transported to hospital c EMS.

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)
AORTOGRAM 75630 (POSTOP)	unknown	Retroperitoneal hematoma K66.1

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

☐ Death	☐ Surgical procedure performed on the wrong site **
☐ Brain Damage	☐ Wrong surgical procedure performed **
☐ Spinal Damage	☐ Surgical repair of injuries or damage from a planned surgical procedure.
☐ Surgical procedure performed on the wrong patient.	
☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.	** if it resulted in: ☐ Death ☐ Brain Damage ☐ Spinal Damage ☐ Permanent disfigurement not to include the incision scar ☐ Fracture or dislocation of bones or joints ☐ Limitation of neurological, physical, or sensory function. ☐ Any condition that required the transfer of the patient to a hospital.
☐ Any condition that required the transfer of the patient to a hospital.	
Outcome of transfer – e.g., death, brain damage, observation only Blood transfusion Name of facility to which patient was transferred: Memorial Hospital of Tampa	

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Lindsay Schoen RN RN 9356622
SANDY NORTON RN RN 9379678
Dr. Nwobi ME 106633
Dr. Suresh ME 118812

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)
Possible perforation of vessel during angiogram procedure, creating retroperitoneal bleed. Not noted on Xray

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)
Patient transferred to hospital, then OR by Dr. Nwobi to explore and ICU observation.

V. Sandra J Norton RN. RN 9379678
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

2/26/2016 1323
DATE REPORT COMPLETED TIME REPORT COMPLETED

20160673

STATE OF FLORIDA
Rick Scott, Governor

DOH Consumer Services

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

DOH Consumer Services

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

MAR 09 2016

I. OFFICE INFORMATION

Vascular Access Center of Jacksonville
Name of office

6820 Southpoint Pkwy Suite 1
Street Address

Jacksonville 32216 Duval
City Zip Code County

904-296-4106
Telephone

Dr Erin Moore
Name of Physician or Licensee Reporting

ME 101863
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient N

[redacted] [redacted]
Age Gender

☐ Medicaid ☐ Medicare

Patient's Address

3/1/16
Date of Office Visit

572490
Patient Identification Number

Arteriogram
Purpose of Office Visit

PAD
Diagnosis

ICD-9 Code for description of incident

II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

3/1/16 950
Incident Date and Time

Location of Incident:
☒ Operating Room ☐ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

See Attached Sheet

Description of incident (type here): After informed consent was obtained the Left groin was prepped in a sterile fashion and the Left Common Femoral artery was accessed using a micro-puncture set under ultrasound guidance. A 6Fr SOS catheter was placed in the aorta and aortogram performed. The catheter was then brought back to the level of the bifurcation and bilateral pelvic obliques were performed. Right lower extremity run-off was then completed showing the above mentioned findings. Systemic heparin was given and a 6Fr 45cm Pinnacle Sheath was advanced to the right common iliac level. Selective catheterization of the Right Superficial Femoral artery was performed with wire advancement. 7x59 Omnilink Elite Stent was placed in the distal external iliac with an 8x57 EV3 Everflex stent in the proximal external iliac. Extravasation was noted from the mid-proximal external iliac and the sheath was immediately upsized to an 8Fr to allow for placement of a 7x100 Viabahn Stent graft. Good result was noted at all the treated sites with rapid flow into the leg and no further extravasation seen. Catheters and wires were withdrawn to the aortic bifurcation. 25 mg of protamine was given for heparin reversal and a Star-Close closure device was used with removal of the sheath.

0830-Baseline vital signs were BP-118/74, HR-80, RR-16, O2-99%, T-97.4, Pain-0,HCT-34, Hgb-11.6. Procedure start time was at 0920, procedure ended at 0958. StarClose closure device inserted into left groin, and site secured with a sterile 4x4 and tegaderm. 0950 after extravasation was noted, pt began complaining of nausea so 4mg Zofran given IV. 0953 VS noted of BP 74/40 HR 57 Resp 16, O2 99% fluid bolus of 500mg started, 0954 0.5mg Atropine given IV. 0958 VS noted of 97/53, HR 76 R 16, O2 96%. Post procedure, 1020 pt take to recovery without complaints of pain BP was still 80s/60s physician made aware. 1035 pt complaining of 9/10 pain in abdomen, morphine 2mg given. Pt remained in pain with continued pain meds and BP remained between low 100s down to mid 80s. 1230As patient reached [redacted] time for groin procautions, [redacted] was slightly elevated in which [redacted] pressure dropped to 76/50, physician decided to send patient to ER to have CT of abdomen to rule out bleeding. Dr. Moore initiated physician to physician report to the attending ER physician at Baptist Medical Center Downtown of Jacksonville. Dr. Moore's PA was scheduled to meet the patient in the ER. Patient transferred via EMS BMC-Downtown at 1300 V/S BP 88/52, HR 80, R 16, O2 96%. Patient A&Ox3 aware of why [redacted] was going to hospital family following EMS.

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident:
(Use additional sheets as necessary for complete response)
Bare metal stent / drug coated stent.

D) Outcome of Incident (Please check)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient.
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.
- ☒ Any condition that required the transfer of the patient to a hospital.

Outcome of transfer – e.g., death, brain damage, observation only: At SNF home in 2 days
Name of facility to which patient was transferred: Baptist Health

- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure.

** if it resulted in:
- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function.
- ☐ Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.
Dr Erin Moore MD ME101863
Tracy Rimmer RN 9323041
Rachel Lowe RT ART376509/CRT63259
Perry Curree RT ART257371/CRT20176

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)
Patients will be closely monitored & sent to higher level of care when needed.

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)
Sent to hospital for precautionary CT to ensure no bleeding in Abdomen

STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Plastic Surgery Institute of the Palm Beaches
Name of office

46-01 Military Trl. Suite 208
Street Address

Palm Beach 33458 Palm Beach
City Zip Code County

Jupiter, Florida 33458
Telephone

HARUN BAFTS D.O. FACS, FACS
Name of Physician or Licensee Reporting

561-775-3787
License Number & office registration number, if applicable

AAAHC certified
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted]
Patient's Address

[redacted] male
Age Gender ☐ Medicaid ☐ Medicare

Patient Identification Number

Date of Office Visit

Diagnosis

Purpose of Office Visit

ICD-9 Code for description of incident

Level II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

Incident Date and Time

Location of Incident:
☒ Operating Room ☐ Recovery Room
☐ Other

Note: If the incident ~~involved a death, was the medical examiner notified?~~ ☐ Yes ☐ No
~~Was an~~ autopsy performed? ☐ Yes ☐ No N/A

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

- see attached narratives

- pt. survived NO deficits - home and under Internal medicine care - follow-up

- post op visits normal.

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)
Surgical - Face Lift	UNKNOWN	NONE

C) List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete response) see sheets of narrative

D) Outcome of Incident (Please check)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient.
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.
- ☒ Any condition that required the transfer of the patient to a hospital.

Outcome of transfer – e.g., death, brain damage, observation only

Name of facility to which patient was transferred: Palm Beach Gardens Hospital

- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure.

** if it resulted in:
- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function.
- ☐ Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers

Dr Babini - OS 5647
Gary Bennett CRNA - 188276A
Lisa Perez B.S.N. RNFA - RN 1904772
Rhonda Jenkins CST - 58451

F) List witnesses, including license numbers if licensed, and locating information if not listed above

Dr. M. Terisky Florida M.D. License # ME124064

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

- see attached sheets -

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

see attached sheets

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	LICENSE NUMBER
Dr Babini / Babini's	OS 5647 (letter S)
DATE REPORT COMPLETED	TIME REPORT COMPLETED
2/13/16	

PLASTIC SURGERY INSTITUTE
OF THE PALM BEACHES, INC.

HAROLD BAFITIS, D.O., M.P.H., F.A.C.O.S., F.A.C.S.†
Board Certified in Plastic and Reconstructive Surgery †
Board Certified in General Surgery

February 10, 2016

My name is George Bennett. I am a CRNA. I work at the Plastic Surgery Institute of the Palm Beaches, which is an AAAHC accredited surgery center.

[redacted]-year-old having a cheek and neck lift, chin implant, liposuction of bilateral posterior hip rolls and chest, with a 20 mL fat transfer to the face by Dr. Harold Bafitis at the Plastic Surgery Institute of the Palm Beaches on 02/09/2016 at approximately 0800 hours. Rhonda Jenkins, certified first assistant and certified OR technician was present. Lisa Perez, RNFA, was present. Robert Krieger, fourth year medical student was present as well as our guest Dr. A.Terskiy,ER physician..

Patient [redacted] was questioned and identified, chart reviewed, moved to OR suite, connected to pulse oximeter, EKG, and blood pressure monitor. Nasal cannula attached to the patient delivering 3 L of oxygen per minute. A baseline blood pressure was taken. A 22 Angiocath was placed in the dorsum of the right hand infusing well. The patient was sedated with propofol, Versed, ketamine, and oxygen. Decadron 10 mg given at this time IV along with 4 mg of Zofran for nausea and fentanyl 50 mcg also given during the first hour of surgery. Subsequent doses of fentanyl were given throughout the procedure totalling 150 mcg. Propofol was given in a continuous infusion, rate approximately 100 mcg/kg/minute throughout the procedure. After loss of lid reflex, the prep was started. Insertion of Foley catheter was underway and draping was completed. Nasal cannula was replaced at this time with a nasal trumpet & in-line oxygen continuously.

Surgery began at 0820. The patient responding appropriately throughout the procedure. At 1643 hours, pulse oximeter decreases to 87%, and patient's respirations sounded laborious. Initial elevation of the chin and extension of the head and neck. Saturations continue to fall. Immediately told Dr. Bafitis to terminate surgery, and I ventilated by mask 100% oxygen. Nasal cannula switched out to #4 LMA, cuff inflated with air, good chest excursions. Decreased heart rate was noted at this time. Atropine 0.4 mg given IV push. At 1646, no heart rate noted on EKG. Leads were checked and intact. CPR begun by Lisa Perez, RNFA.

Continued

Dr. A. Terskiy who was in the OR as an observer this day is a board certified ER physician and ordered us to give epinephrine 1 mL push and to connect the AED monitor defibrillator. LMA was replaced at this time by a 7.5 endotracheal tube, one attempt, cuff up, secured at 21 cm to the lip. Saturation improves after intubation. CPR continues. BP cuff recording, pulse oximeter recording, all in the 80s. Nine-one-one notified by Dr. Bafitis himself. CPR done in two-minute intervals with additional epinephrine given each time totally 3mg. Each time pulses taken and CPR resumed for lack of pulses and no rhythm on monitor.

EMT arrives quickly between second and third dose of epinephrine. Prepared syringe of D50 ordered by Dr. Terskiy. Report given to EMT on arrival. Two more subsequent doses of epinephrine given while the EMTs were preparing to depart for Palm Beach Gardens Hospital. The patient turned and placed on transport table, secured. Lucas Thump device in place of CPR was initiated.

George Bennett, CRNA

PLASTIC SURGERY INSTITUTE
OF THE PALM BEACHES, INC.

HAROLD BAFITIS, D.O., M.PH., F.A.C.O.S., F.A.C.S.†
Board Certified in Plastic and Reconstructive Surgery †
Board Certified in General Surgery

February 10, 2016

My name is Ronda Jenkins. I work at the Plastic Surgery Institute of the Palm Beaches which is an AAAHC accredited surgery center. My position here is certified surgical technician.

On 02/09/2016, we were performing a surgery on a [redacted]-year-old male. We were performing a fat transfer to the face, lower blepharoplasty, chin implant, cheek and neck lift. When Dr. Bafitis was about to start closing the second side of the face for the cheek and neck lift, the anesthesia machine beeped as George was watching, and the monitoring said that the patient started to go into a bradycardia situation. Everyone was made aware of it. We all paid attention to Anesthesia to see what our next move was. We started checking pulses. Pulses were checked. We could not find a pulse. We got out the AED, applied the AED stickers in the appropriate spots. Everything started to move pretty fast at that point. The AED was fired, and it said to clear the patient, don't touch. It said no shock needed. Begin compressions. The chest compressions were begun, and as they were doing that, we also were drawing up epinephrine. Epinephrine was given, and compressions were done by multiple people. The paramedics were called at one point by Dr. Bafitis while we were all busy doing chest compressions. O2 was continually pushed with an Ambu bag. We also were able to establish an airway in the very beginning with an LMA. Pulses were checked three or four times throughout the whole events. Also, the AED was tried three times to the best of my knowledge and each time said no shock needed and to begin chest compressions again.

Once the medics showed up, the chest compressions were taken over by them, and they took over the situation.

Ronda Jenkins, CST

PALM BEACH GARDENS/JUPITER: *4601 Military Trail • Suite 208 • Jupiter • Florida • 33458 • OFFICE (561) 795-3787 • FAX (561) 798-0003*
WELLINGTON CENTER: *1447 Medical Park Blvd.• Suite 107 • Wellington • Florida • 33414 • OFFICE (561) 422-1117*
www.drbafitis.com
Member
† Certified by the American Osteopathic Board of Surgery, Plastic Surgery • General Surgery • Fellow, American College of Osteopathic Surgeons
† Fellow, American College of Surgeons • † Fellow, American Academy of Cosmetic Surgeons

PLASTIC SURGERY INSTITUTE
OF THE PALM BEACHES, INC.

HAROLD BAFITIS, D.O., M.PH., F.A.C.O.S., F.A.C.S.†
Board Certified in Plastic and Reconstructive Surgery †
Board Certified in General Surgery

February 10, 2016

To Whom It May Concern:

Please note this is Dr. Harold Bafitis, Medical Director of the Plastic Surgery Institute of the Palm Beaches. I am giving a summary of an incident that occurred in our surgery center which is AAAHC approved on 02/09/2016. Please note the details have been laboriously chronicled and will be sent separately in regard to our nurse anesthetist, our scrub technician, and registered nurse first assistant. The disposition of this case is delineated in all the detailed summaries.

WHAT IS SIGNIFICANT TO NOTE IS THAT THE PATIENT HAS MADE A COMPLETE RECOVERY WITH NO NEUROLOGICAL DEFICITS, NO MOTOR OR COGNITIVE DEFICITS, HAS BEEN DISCHARGED AND SENT HOME TO A LOCAL COLLEAGUE MD, AND IS SCHEDULED TO GO BACK TO PENSACOLA, FLORIDA, THIS THURSDAY, FEBRUARY 25, 2016.

The patient is healing well from his procedures, has some minimal extra swelling along the sternocleidomastoid which is resolving, and overall by the grace of God has done well. He has had a medical recorder device placed subcutaneously and will be monitored by Cardiology at Palm Beach Gardens Hospital under Gabriel Brewer, MD. He has been given no extra medications and is progressing well.

SUMMARY:
The patient is a [redacted]-year-old physician assistant and military reserve airman living in Pensacola, Florida. He came down to Palm Beach County for cheek and neck lifting, chin implant, and minimal liposuction of the chest and hip rolls (less than 300 cc total). The patient was medically cleared and had appropriate laboratory work beforehand. He had clearance per our anesthesia staff and undertook the procedure under IV sedation and nasal airway on the morning of 02/09/2016. Please note that the patient progressed well, and we have a detailed tracing per our anesthesia machine of his saturation and heart rate throughout the procedure. As we were closing the remainder cheek/neck side (left side), the patient went into a bradyarrhythmia, was given atropine, and progressed into full asystole. The patient then had a mask placed and then subsequently an LMA,

Continued

and cardiac compressions began once we confirmed there was no pulse. Compressions persisted and then we changed his LMA to an endotracheal tube. In the presence of our staff was a visiting physician, Dr. Alex Teirsky, who is a board certified emergency room doctor. She was asked to assist in the resuscitation, and she did without hesitation. She provided an extra hand to our team. We also had a fourth year medical student, Bert Krieger, who assisted in resuscitation and was on rotation with me. He is scheduled to begin a surgical residency in Toledo, Ohio, in July 2016.

After approximately 12 minutes of resuscitation, I called 911 explaining the situation to them and explaining that I would contact the emergency department at Palm Beach Gardens Hospital whom my surgery center is affiliated with. This 911 call was responded to quickly, and my front office staff progressed downstairs to allow easy access and transport to the paramedics into the surgery center which is located on the second floor. I called the emergency department at Palm Beach Gardens Hospital and also called Cardiology, Dr. Brewer and Pulmonary, Dr. Fuquay and ascertained a time when he would accompany the patient to the emergency department.

The paramedics came into the office, assessed the situation, and then hooked the patient up to a Lucas automatic device. The patient left the surgery center with the paramedics. I along with student doctor Krieger accompanied him in the ambulance to the hospital. Please note that the Lucas device continued to function in the ambulance, and I provided calibrated breathing through an Ambu bag. Approximately 3 minutes into the ambulance ride to the hospital, the Lucas device stopped, reading a cardiac rhythm, and several seconds after the cardiac rhythm was confirmed, the patient's own breathing started.

Upon arrival to the emergency department of Palm Beach Gardens Hospital, an entire team was waiting for us where they transferred the patient into a room, stabilized him, and obtained appropriate blood work. The patient had already

Continued

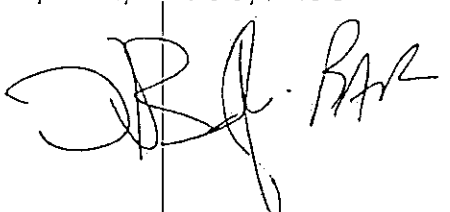
had a Foley placed during the procedure and was intubated. At that point, I also consulted Dr. Waterman's group for nephrology. The patient was breathing on his own and had a good rhythm and was assessed by EKG in the emergency department.

I and my registered nurse first assistant (RNFA, Lisa Perez) then proceeded to finish closing the delayed closure of the facial flap after irrigating copiously with bacitracin, saline, and 1% Betadine in the emergency department after getting appropriate equipment and a sterile field set up via the surgery department of Palm Beach Gardens Hospital. The drains worked, and a head wrap was placed, and care was then given over to the subspecialties. It was recommended by Pulmonary that he would be placed in a hypothermic coma and that this would protect the brain. Throughout the sewing of the flap, the patient was starting to move his hand and respond to minimal pain on punctures from the suture.

The patient progressed well and was transferred to ICU where in 24 hours, the hypothermic coma was slowly removed, and he began to wake up and have full function. As stated above, no neurological deficits have been noted, and this has been documented by the neurologist who works for the hospital who came to see the patient as well.

At this point, the patient is doing well, has been walking and eating, and came into the office with his colleague caretaker MD and had ultrasound to his neck. He will be discharged home this Thursday, 02/25/2016, to the care of his wife who is also a physician assistant. Complete communication has been given to him and his family members as well as between me and the subspecialty. This is an exceptional situation that ended well, and I congratulate the excellent care and systematic treatment following the standard protocols instituted by the Plastic Surgery Institute of the Palm Beaches and staff training.

Harold Bafitis, D.O., MPH, FACOS, FACS



201612391 151

DOH Consumer Servic

APR 0 6 2016

STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

The Vascular Group of Naples.
Name of office

2450 Goodlette Rd. N. Suite 102.
Street Address

Naples 34103 Collier
City Zip Code County

239-643-8794.
Telephone

Dr Zamora
Name of Physician or Licensee Reporting

ME12801
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient's Address

[redacted] Age Gender ☐ Medicaid ☒ Medicare

305612.
Patient Identification Number

Date of Office Visit 3/8/16

Severe Peripheral Vascular Disease with Claudication.
Diagnosis

Purpose of Office Visit
Left Lower Extremity Aortogram

ICD-9 Code for description of incident
R41.0

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

3/8/16
Incident Date and Time

Location of Incident:
☐ Operating Room ☒ Recovery Room
☐ Other N/A.

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☒ No
Was an autopsy performed? ☐ Yes ☒ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

During [redacted] postoperative recovery, patient had mild confusion and agitation. [redacted] was hemodynamically stable and comfortable. Due to [redacted] mental status change, it was decided it would be in patient's best interest to be transferred to hospital

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**
I70.222	N/A	R41.0

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

N/A.

D) Outcome of Incident (Please check)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient.
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.
- ☒ Any condition that required the transfer of the patient to a hospital.

Outcome of transfer – e.g., death, brain damage, observation only: Observation Only.
Name of facility to which patient was transferred: NCH North Naples.

- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure.

** if it resulted in:
- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function.
- ☐ Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Kim Free RN. Lic 9233781.
Warly Gonzalez Moreno RN. Lic. 9419240.
Alvaro Zamora MD. ME 12801

F) List witnesses, including license numbers if licensed, and locating information if not listed above

N/A

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Sedatives administered.

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Transferred to hospital.

20161793

STATE OF FLORIDA
Rick Scott, Governor

DOH Consumer Services

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

MAR 2 8 2016

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Vascular Specialists of Central Florida — Name of office
80 W Michigan St — Street Address
Orlando — City
32806 — Zip Code
Orange — County
407.648.4328 — Telephone
DR. ADAM LEVITT — Name of Physician or Licensee Reporting
ME0091525 — License Number & office registration number, if applicable
80 W Michigan St. — Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted] — Patient Name
[redacted] — Patient's Address
4117 — Patient Identification Number
Intermittent claudication — Diagnosis
173.9

[redacted] — Age
Male — Gender
☐ Medicaid ☐ Medicare
3-9-16 — Date of Office Visit
Angiography w/ LLE runoff possible pta/stent intervention — Purpose of Office Visit
ICD-9 Code for description of incident
II — Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

3-9-16 @ 1156 — Incident Date and Time

Location of Incident:
☒ Operating Room ☐ Recovery Room
☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

SEE ATTACHED →