HILL,BRIAN D
MM7805836274 PRE ER MM.ER
11/19/17 0850 UNKNOWN.UNKNOWN
DOB:05/26/90 27 M MR# MM00370912
Sovah Health - Martinsville

Sovah Health Martinsville

320 Hospital Drive
Martinsville, VA 24112
276-666-7237

11/9/67
97
98%
18

Emergency Department Instructions for: **Hill, Brian D**

Arrival Date: **Sunday, November 19, 2017**

Thank you for choosing **Sovah Health Martinsville** for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: Ekuban-Gordon, Edna, MD

Diagnosis: Head Laceration/ Open wound of head; Hyperglycemia, unspecified

DISCHARGE INSTRUCTIONS	FORMS
Head Injury, Adult Facial Laceration Hyperglycemia, Easy-to-Read Stitches, Staples, or Adhesive Wound Closure, Easy-to-Read	Medication Reconciliation
FOLLOW UP INSTRUCTIONS	**PRESCRIPTIONS**
Private Physician When: 2 - 3 days; Reason: Wound Recheck	None
SPECIAL NOTES	
None	

Suicide National Hotline: 1-800-273-8255 (800-273-TALK)

If you received a narcotic or sedative medication during your Emergency Department stay you should not drive, drink alcohol or operate heavy machinery for the next 8 hours as this medication can cause drowsiness, dizziness, and decrease your response time to events.

I hereby acknowledge that I have received a copy of my transition care record and understand the above instructions and prescriptions.

Brian D. Hill

Brian Hill
MRN # MM00370912

Bell Thornton, RN

ED Physician or Nurse
11/19/2017 12:14

X-RAYS and LAB TESTS:
If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you

had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:
If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

TESTS AND PROCEDURES

Labs
CMP, Complete Blood Count W/auto Diff, Thyroid Stimulating Hormone, POC GLU, POC GLU

Rad
CT Head w/o Contrast, Chest 1 View - Portable

Procedures
Blood Sugar, 12 Lead EKG, Laceration

Other
Seizure precautions, Accucheck, Cardiac Monitor, Apply to Pt, Pulse ox continuous, Oxygen at 2 L/NC, IV saline lock, EKG ED, Laceration repair set up

Chart Copy

EMERGENCY DEPARTMENT RECORD
Nurse's Notes
Sovah Health Martinsville
Name: Brian Hill
Age: 27 yrs
Sex: Male
DOB: 05/26/1990
MRN: MM00370912
Arrival Date: 11/19/2017
Time: 08:51
Account#: MM7805836274
Bed ER 6
Private MD:
Diagnosis: Head Laceration/ Open wound of head;Hyperglycemia, unspecified

Presentation:
11/19
09:08 Presenting complaint: Patient states: had a seizure this morning due to low blood sugar, laceration to head per pt, bleeding controlled. Airway is patent with good air movement. The patient is breathing without difficulty. The patient is pink,warm and dry. Heart rate is within normal limits. Patient is alert and oriented to person, place and time, Patient is moving all extremities appropriately. ll
11/19
09:08 Acuity: Urgent (3) ll

Historical:
- Allergies: Ranitidine;
- Home Meds:
1. Unable to Obtain
- PMHx: OCD; autism; Diabetes - IDDM;
- Sepsis Screening:: Sepsis screening negative at this time.
- Social history:: Tobacco Status: The patient states he/she has never used tobacco. The patient's primary language is English. The patient's preferred language is English.
- Family history:: Reviewed and not pertinent.
- Exposure Risk/Travel Screening:: Patient has not been out of the country in last 30 days. Have you been in contact with anyone who is ill that has traveled outside of the country in the last 30 days? No.
- Suicide Screening:: Have you recently had thoughts about hurting yourself or others? No.
- Tuberculosis screening:: No symptoms or risk factors identified.

Screening:
11/19
09:41 Fall Risk: Total Points: Med. Risk (25-44);. Abuse Screen: Patient verbally denies physical, verbal and emotional abuse/neglect. There are no cultural/spiritual considerations for care for this patient. mkk

Assessment:
11/19

09:38 Complains of pain in face Pain does not radiate. Pain currently is 7 mkk

out of 10 on a pain scale. The level of pain that is acceptable is 0 out of 10 on a pain scale. General: Appears in no apparent distress, comfortable, well developed, well nourished, well groomed, Behavior is appropriate for age, cooperative, pleasant. Neuro: Reports headache. Neuro: Reports seizure due to low blood sugar. EENT: Denies. Cardiovascular: Denies. Respiratory: Denies. GI: Denies. GU: Denies. Derm: Denies. Musculoskeletal: Denies. Injury Description: Laceration sustained to face is clean, 0.5 to 2.5 cm long, not bleeding, was sustained 4-6 hours ago.

11/19
09:38 Method Of Arrival: EMS mkk

Vital Signs:

11/19
09:08 BP 131 / 76; Pulse 118; Resp 20; Temp 98.2; Pulse Ox 97% ; Weight 91.63 kg; Height 5 ft. 10 in. (177.80 cm); ll

11/19
09:46 mkk

11/19
10:59 BP 124 / 73; Pulse 93; Resp 18; Pulse Ox 100% on R/A; mkk

11/19
12:57 BP 119 / 67; Pulse 97; Resp 19; Pulse Ox 98% on R/A; pt3

11/19
09:08 Body Mass Index 28.98 (91.63 kg, 177.80 cm) ll

11/19
09:46 patient has OCD and had to do his "routines" prior to coming, has been about 4 hours since injury occured mkk

Glasgow Coma Score:

11/19
12:16 Eye Response: spontaneous(4). Verbal Response: oriented(5). Motor Response: obeys commands(6). Total: 15. eeg

ED Course:

11/19
08:51 Patient arrived in ED. knm

11/19
09:09 Rapid Initial Assessment completed. ll

11/19
09:27 Ekuban-Gordon, Edna, MD is Attending Physician. eeg

11/19
09:41 Patient has correct armband on for positive identification. Placed in gown. Bed in low position. Call light in reach. Side rails up X2. Adult with patient. Seizure precautions initiated. NIBP on. Pulse ox on. mkk

11/19
09:41 No physician assisted procedures were completed. mkk

11/19
10:01 Inserted saline lock: 20 gauge right arm blood drawn from IV and sent to lab per order. mkk

11/19
10:08 EKG Done By ED Tech 10:06 Reviewed by Physician Edna Ekuban-Gordon MD.bh

11/19
10:40 Critical Lab Value: Patient Name verified: Brian Hill, Patient DOB ll

Verified May 26, 1990 Critical value glucose 459reported read back to reporting lab personnel, and reported to Dr. Edna Ekuban-Gordon MD.
11/19
10:59 Assist provider with laceration repair Set up tray. mkk
11/19
11:53 Troncoso, Priscilla, RN is Primary Nurse. pt3

Administered Medications:
11/19
10:59 Drug: NS 0.9% 1000 ml Route: IV; Rate: 999 mL/hr; Site: right arm; mkk
11/19
12:59 Follow up: Response: No adverse reaction; IV Status: Completed infusion pt3
11/19
11:02 Drug: NovoLIN R 7 units {Co-Signature: mkk (Michaela Karet RN).} Route: IVP; Site: right arm; ll
11/19
12:58 Follow up: Response: No adverse reaction pt3

Point of Care Testing:
Blood Glucose:
11/19
09:40 Glucose Value: 489; mkk
11/19
09:43 Glucose Value: 435; mkk
11/19
09:40 test repeated mkk
Ranges:

Output:
11/19
11:28 Urine: 600ml (Voided); Total: 600ml. dab

Outcome:
11/19
12:14 Discharge ordered by Provider. eeg
11/19
12:57 Discharged to home ambulatory, with family. pt3
12:57 Instructions given to patient, parent, Instructed on discharge instructions. follow up and referral plans. . Patient and/or family voiced understanding of instructions using teach back method.
12:57 The patients' shirt, pants, shoes, socks and underwear were sent with the patient.
12:57 Discharge Assessment: Patient
12:57 Discharge Assessment: Patient has no functional deficits.
12:57 Discontinued IV lock intact, bleeding controlled, pressure dressing applied, No redness/swelling at site.
11/19
13:24 Patient left the ED. jkp

Signatures:
Harrison, Rindi, RN RN ll
Ekuban-Gordon, Edna, MD MD eeg

EMERGENCY DEPARTMENT RECORD
Physician Documentation
Sovah Health Martinsville
Name: Brian Hill
Age: 27 yrs
Sex: Male
DOB: 05/26/1990
MRN: MM00370912
Arrival Date: 11/19/2017
Time: 08:51
Account#: MM7805836274
Bed ER 6
Private MD:
ED Physician Ekuban-Gordon, Edna
HPI:
11/19
11:49 This 27 yrs old White Male presents to ER via EMS with complaints of Fall Injury. eeg
11/19
11:49 Onset: The symptoms/episode began/occurred today. Associated injuries: The patient sustained injury to the head. Associated signs and symptoms: Loss of consciousness: the patient experienced no loss of consciousness. Severity of symptoms: in the emergency department the symptoms are unchanged. Pain Management: Patient denies pain. The patient has experienced similar episodes in the past, a few times. The patient has not recently seen a physician. Family report history of low blood sugar, general low will have seizure episode when the blood sugar is low. Blood sugar was obtained by mom at 20 repeat 40 was subsequently given some oral glucose and brought here for further evaluation. Patient denies any headache palpitation no neck pain and stiffness. Admits to feeling like himself.. eeg

Historical:
- Allergies: Ranitidine;
- Home Meds:
1. Unable to Obtain
- PMHx: OCD; autism; Diabetes - IDDM;
- Sepsis Screening:: Sepsis screening negative at this time.
- Social history:: Tobacco Status: The patient states he/she has never used tobacco. The patient's primary language is English. The patient's preferred language is English.
- Family history:: Reviewed and not pertinent.
- Exposure Risk/Travel Screening:: Patient has not been out of the country in last 30 days. Have you been in contact with anyone who is ill that has traveled outside of the country in the last 30 days? No.
- Suicide Screening:: Have you recently had thoughts about hurting yourself or others? No.
- Tuberculosis screening:: No symptoms or risk factors identified.
- The history from nurses notes was reviewed: and I agree with what is documented up to this point.

ROS:

11/19
11:52 Eyes: Negative for injury, pain, redness, and discharge, ENT: eeg
Negative for injury, pain, and discharge, Neck: Negative for injury, pain, and swelling, Cardiovascular: Negative for chest pain, palpitations, and edema, Respiratory: Negative for shortness of breath, cough, wheezing, and pleuritic chest pain, Abdomen/GI: Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation, Back: Negative for injury and pain, MS/Extremity: Negative for injury and deformity. All other systems are negative, except as documented below. Skin: Positive for laceration(s), of the face. Neuro: Negative for dizziness, headache, weakness. Psych: Negative for depression, alcohol dependence, homicidal ideation, suicide gesture.

Exam:
11/19
11:53 Eyes: Pupils equal round and reactive to light, extra-ocular motions eeg intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema. ENT: Nares patent. No nasal discharge, no septal abnormalities noted. Tympanic membranes are normal and external auditory canals are clear. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membrane moist Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Chest/axilla: Normal chest wall appearance and motion. Nontender with no deformity. No lesions are appreciated. Cardiovascular: Regular rate and rhythm with a normal S1 and S2. ,no jvd No pulse deficits. Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring. Abdomen/GI: Soft, non-tender, with normal bowel sounds. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout. Back: No spinal tenderness. No costovertebral tenderness. Full range of motion. MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion. Neuro: Awake and alert, GCS 15, oriented to person, place, time, and situation. Cranial nerves II-XII grossly intact. Motor strength 5/5 in all extremities. Sensory grossly intact. Cerebellar exam normal. Normal gait., slow, but appropriate Psych: Awake, alert, with orientation to person, place and time. Behavior, mood, and affect are within normal limits.
11:53 Constitutional: The patient appears alert, awake, non-diaphoretic.
11:53 Head/face: Noted is a laceration(s), that is linear, 3 cm(s).
11:53 Musculoskeletal/extremity: Extremities: all appear grossly normal, with no appreciated pain with palpation, ROM: intact in all extremities, Circulation is intact in all extremities. Sensation intact.
11:53 Psych: Behavior/mood is cooperative.

Vital Signs:
11/19

RUN DATE:11/23/17

DISCHARGE SUMMARY FOR MEDICAL RECORDS FOR LABORATORY

Patient: HILL,BRIAN D #MM7805836274 **(Continued)**

**********CHEMISTRY**********

Date / Time	11/19/17 1007			Reference	Units
BUN	7			(5-25)	MG/DL
CREATININE	1.01			(0.90-1.30)	MG/DL
eGFR NON-AA	102(A)				
eGFR AA	118(B)				
SODIUM	131 L			(135-145)	MMOL/L
POTASSIUM	4.4			(3.5-5.0)	MMOL/L
CHLORIDE	96 L			(98-109)	MMOL/L
CO2	26			(20-30)	MMOL/L
ANION GAP	9.0			(1-10)	
GLUCOSE	459(C) *H			(65-100)	MG/DL
CALCIUM	9.0			(8.5-10.3)	MG/DL
TOTAL PROTEIN	7.8			(6.0-8.0)	G/DL
ALBUMIN	4.3			(3.2-5.5)	G/DL
AG	1.2			(1.2-1.7)	RATIO
GLOBULIN	3.5			(2.5-3.9)	G/DL
T BILI	0.50			(0.20-1.00)	MG/DL
SGOT/AST	27			(10-42)	IU/L
SGPT/ALT	21			(10-60)	IU/L
ALK PHOS	74			(42-121)	IU/L
TSH	1.29			(0.34-5.60)	uIU/ML

(A) Non-African American

(B) African American.
eGFR UNITS: ml/min/1.73m2.
*eGFR >= 60 = Normal GFR or mild decrease in GFR
*eGFR 30-59 = Moderate decrease in GFR (Stage 3 CKD)
*eGFR 15-29 = Severe decrease in GFR (Stage 4 CKD)
*eGFR <15 = End-stage kidney failure (Stage 5 CKD)

The equation has not been validated in patients >70 YRS OLD.

(C) CRITICAL RESULTS CALLED ON 11/19/17
AT 1035 TO: RINDY LAPRADE/RB/CALLED X 2 SNCE 1035
BY: CLIFTON,LYDIA C

Patient: HILL,BRIAN D **Age/Sex:** 27/M **Acct#**MM7805836274 **Unit#**MM00370912

SOVAH HEALTH - MARTINSVILLE
RADIOLOGY DEPT
320 HOSPTIAL DR
MARTINSVILLE, VA 24112
PHONE #: 276-666-7223
FAX #: 276-666-7591

Name: HILL,BRIAN D
Phys: EKUBAN-GORDON,EDNA MD
DOB: 05/26/1990 Age: 27 Sex: M
Acct: MM7805836274 Loc: MM.ER
Exam Date: 11/19/2017 Status: DEP ER
Radiology No:
Unit No: MM00370912

EXAMS:
000898111 CHEST 1 VIEW - PORTABLE

EXAM REASON:
Chest Tightness

PORTABLE CHEST

HISTORY: Seizure.

COMPARISON: 11/10/2015

FINDINGS: The heart size and configuration are within normal limits for age and portable technique. The lungs are clear. There is no evidence of pleural effusions or pneumothorax. No acute bony abnormality.

IMPRESSION: No evidence of acute cardiopulmonary disease.

** Electronically Signed by MAROON B KHOURY on 11/19/2017 at 1424 **
Reported by: DR. MAROON B KHOURY
Signed by: KHOURY,MAROON B

CC: EDNA EKUBAN-GORDON MD

Technologist: KYLEA ANN KEATTS
Transcribed Date/Time: 11/19/2017 (1146)
Transcriptionist: MMTRSPSB
Orig Print D/T: S: 11/19/2017 (1424)
BATCH NO: N/A

PAGE 1 Signed Report

HILL, BRIAN ID: 000370912 19-Nov-2017 10:06:44 Memorial Hospital of Martinsville

27years
Male Caucasian

Vent. rate 105 bpm
PR interval 158 ms
QRS duration 92 ms
QT/QTc 328/433 ms
P-R-T axes 64 64 52

Sinus tachycardia
Possible Left atrial enlargement
Borderline ECG

Time: 1007
Bed 6

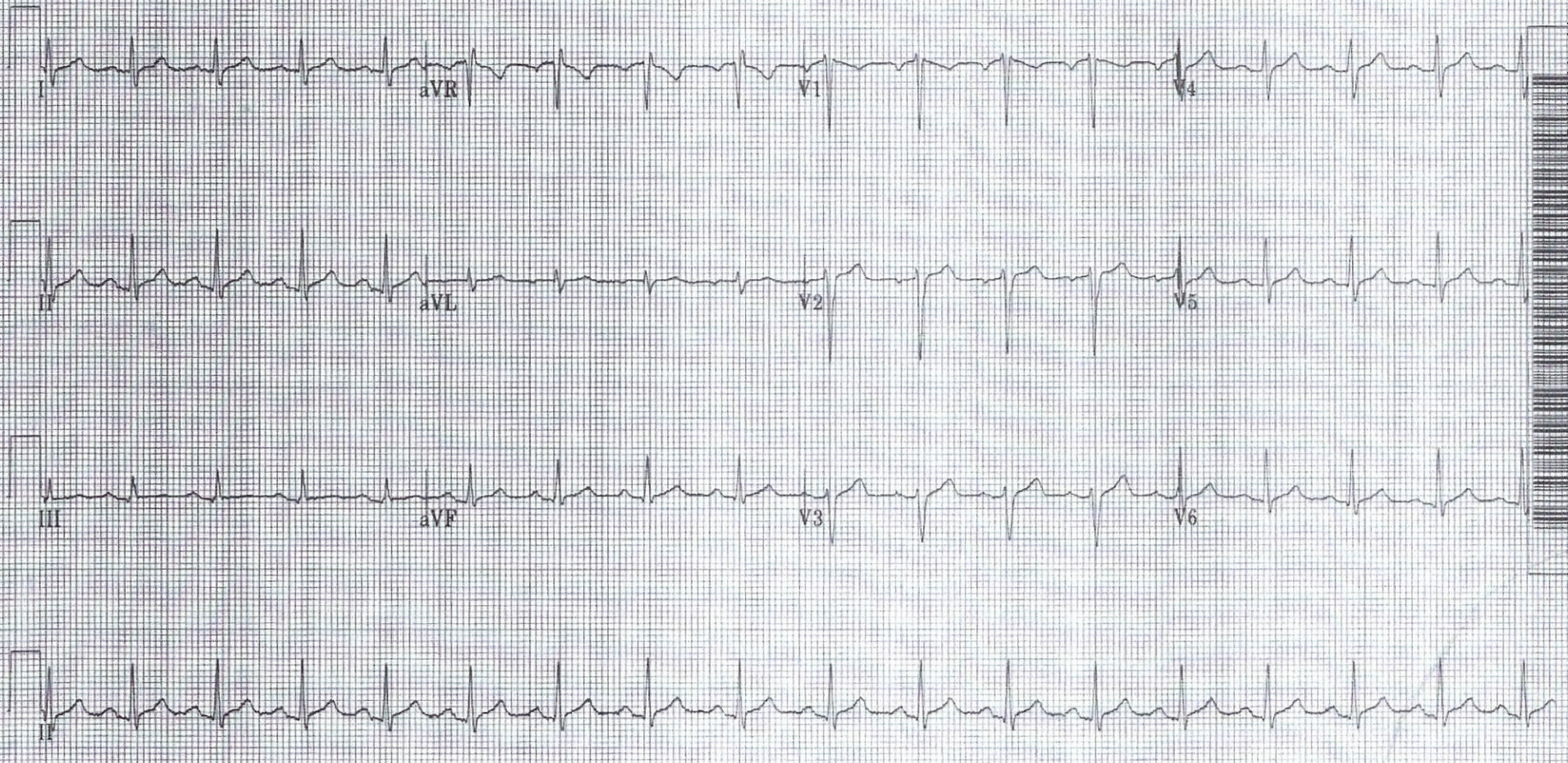
Room: 6
Loc: 15

T HILL,BRIAN D
MM7805836274 PRE ER MM.ER
11/19/17 0850 UNKNOWN,UNKNOWN
DOB:05/26/90 27 M MR# MM00370912
Sovah Health - Martinsville

Visit: MM7805836274
Secondary ID: MM216937
Referred by: EKUBAN-GORDON, EDNA

Order no.: 211490013
Unconfirmed

CHEST PAIN:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 010B 12SL™v241 HD

P/N 2009828-024 | GE Healthcare | PRINTED IN U.S.A.

EKG Scanned Page 1/1 MM00370912 MM7805836274 SOVAH Health - Martinsville Job 12468 (07/02/2019 14:03) -- Page 35 Doc# 12

SOVAH HEALTH - MARTINSVILLE
320 HOSPITAL DRIVE - P.O. BOX 4788
MARTINSVILLE, VA 24112 (276)666-7360
CLIA NO. 49D0231853 RT CLIA NO. 4D0661287

RUN DATE:11/23/17

DISCHARGE SUMMARY FOR MEDICAL RECORDS FOR LABORATORY

CMAX: MM00370912~MM7805836274~LABDATA~20171123~LABDISMM1001869144~COCMMH~COCVAE~LAB.COCMMH~

PATIENT: HILL,BRIAN D		**ACCT #:** MM7805836274	**LOC:** MM.ER	**U #:** MM00370912	
		AGE/SX: 27/M	**ROOM:**	**REG:** 11/19/17	
REG DR: EKUBAN-GORDON,EDNA MD		**DOB:** 05/26/90	**BED:**	**DIS:**	
		STATUS: DEP ER	**TLOC:**		

**********POINT OF CARE**********

Date	11/19/17			
Time	1006	0943	Reference	Units
POC GLU	429 H	435 H	(65-100)	MG/DL

**********HEMATOLOGY**********

Date	11/19/17		
Time	1007	Reference	Units
WBC	11.6 H	(4.5-11.0)	K/UL
RBC	5.32	(4.50-5.90)	M/UL
HGB	15.8	(14.0-17.5)	G/DL
HCT	46.0	(35.0-49.0)	%
MCV	86.5	(80-96)	UM3
MCH	29.7	(27-32)	PG
MCHC	34.3	(32-37)	G/DL
RDW	13.1	(11.5-14.5)	%
RDW-SD	41.1	(35.1-43.9)	fl
PLT	241	(140-440)	K/UL
MPV	10.8 H	(7.4-10.4)	fl
SEGS %	84 H	(37-80)	%
SEG ABSOLUTE	9.77 H	(1.5-6.8)	K/UL
LYMPH %	10	(10-50)	%
LYMPH ABSOLUTE	1.10	(1.0-4.0)	K/UL
MONO %	6	(0-12)	%
MONO ABSOLUTE	0.64	(0.2-1.0)	K/UL
EOS %	0	(0-7)	%
EOS ABSOLUTE	0.05	(0.0-0.5)	K/UL
BASO %	0	(0-2)	%
BASO ABSOLUTE	0.04	(0.0-0.2)	K/UL
IG %	0.3		%
IG ABSOLUTE	0.0	(0.0-0.1)	

09:08 BP 131 / 76; Pulse 118; Resp 20; Temp 98.2; Pulse Ox 97% ; Weight 91.63 kg; Height 5 ft. 10 in. (177.80 cm); — ll

11/19
09:46 — mkk

11/19
10:59 BP 124 / 73; Pulse 93; Resp 18; Pulse Ox 100% on R/A; — mkk

11/19
12:57 BP 119 / 67; Pulse 97; Resp 19; Pulse Ox 98% on R/A; — pt3

11/19
09:08 Body Mass Index 28.98 (91.63 kg, 177.80 cm) — ll

11/19
09:46 patient has OCD and had to do his "routines" prior to coming, has been about 4 hours since injury occured — mkk

Glasgow Coma Score:

11/19
12:16 Eye Response: spontaneous(4). Verbal Response: oriented(5). Motor Response: obeys commands(6). Total: 15. — eeg

Laceration:

11/19
12:11 Wound Repair of 3cm (1.2in) subcutaneous laceration to forehead. Linear shaped.. No foreign body noted. Distal neuro/vascular/tendon intact. Anesthesia: Wound infiltrated with 3 mls of 1% lidocaine w/ Epi. Wound prep: Simple cleansing with betadine. Skin closed with 6 1-0 Prolene using Staple gun. Dressed with pressure dressing. Patient tolerated well. — eeg

MDM:

11/19
09:27 MSE Initiated by Provider. — eeg

11/19
12:12 Differential diagnosis: abrasion, closed head injury, concussion, contusion, dislocation, fracture, laceration, multiple trauma, sprain, Substance abuse. Data reviewed: vital signs, nurses notes, lab test result(s), radiologic studies. Data interpreted: Cardiac monitor: Normal rate. Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, radiology results, the need for outpatient follow up, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home. Response to treatment: the patient's symptoms have markedly improved after treatment. — eeg

11/19
09:46 Order name: POC GLU; Complete Time: 09:57 — EDMS

11/19
09:56 Order name: CMP; Complete Time: 10:53 — eeg

11/19
09:56 Order name: Complete Blood Count W/auto Diff; Complete Time: 10:53 — eeg

11/19
09:56 Order name: Thyroid Stimulating Hormone; Complete Time: 10:53 — eeg

11/19

11/19/17 12:14 Discharged to Home. Impression: Head Laceration/ Open wound of head, Hyperglycemia, unspecified.
- Condition is Stable.
- Discharge Instructions: Head Injury, Adult, Facial Laceration, Hyperglycemia, Easy-to-Read, Stitches, Staples, or Adhesive Wound Closure, Easy-to-Read.

- Medication Reconciliation form.
- Follow up: Private Physician; When: 2 - 3 days; Reason: Wound Recheck.
- Problem is new.
- Symptoms have improved.

Order Results:
Lab Order: POC GLU; SPEC'M 11/19/17 09:46
Test: POC GLU; Value: 435; Range: 65-100; Abnormal: Above high normal; Units: MG/DL; Status: F; Updated: 11/19 09:46
Lab Order: CMP; SPEC'M 11/19/17 10:11
Test: SODIUM; Value: 131; Range: 135-145; Abnormal: Below low normal; Units: MMOL/L; Status: F; Updated: 11/19 10:24
Test: POTASSIUM; Value: 4.4; Range: 3.5-5.0; Abnormal: ; Units: MMOL/L; Status: F; Updated: 11/19 10:24
Test: CHLORIDE; Value: 96; Range: 98-109; Abnormal: Below low normal; Units: MMOL/L; Status: F; Updated: 11/19 10:24
Test: CARBON DIOXIDE; Value: 26; Range: 20-30; Abnormal: ; Units: MMOL/L; Status: F; Updated: 11/19 10:24
Test: ANION GAP; Value: 9.0; Range: 1-10; Abnormal: ; Status: F; Updated: 11/19 10:24
Test: CALCIUM; Value: 9.0; Range: 8.5-10.3; Abnormal: ; Units: MG/DL; Status: F; Updated: 11/19 10:24
Test: BLOOD UREA NITROGEN; Value: 7; Range: 5-25; Abnormal: ; Units: MG/DL; Status: F; Updated: 11/19 10:34
Test: CREATININE; Value: 1.01; Range: 0.90-1.30; Abnormal: ; Units: MG/DL; Status: F; Updated: 11/19 10:34
Test: GLOMERULAR FILTRATION RATE; Value: 102; Abnormal: ; Status: F; Updated: 11/19 10:34
Test Note: 11/19 10:34 T nbsp;; Non-African American
Test: GLOMERULAR FILTRATION RATE-AA; Value: 118; Abnormal: ; Status: F; Updated: 11/19 10:34
Test Note: 11/19 10:34 T nbsp;; African American. eGFR UNITS: ml/min/1.73m2. *eGFR >= 60 = Normal GFR or mild decrease in GFR *eGFR 30-59 = Moderate decrease in GFR (Stage 3 CKD) *eGFR 15-29 = Severe decrease in GFR (Stage 4 CKD) *eGFR <15 = End-stage kidney failure (Stage 5 CKD) The equation has not been validated in patients >70 YRS OLD.
Test: TOTAL PROTEIN; Value: 7.8; Range: 6.0-8.0; Abnormal: ; Units: G/DL; Status: F; Updated: 11/19 10:34

Test: ALBUMIN; Value: 4.3; Range: 3.2-5.5; Abnormal: ; Units: G/DL; Status: F; Updated: 11/19 10:34
Test: ALB/GLOB RATIO; Value: 1.2; Range: 1.2-1.7; Abnormal: ; Units: RATIO; Status: F; Updated: 11/19 10:34
Test: GLOBULIN; Value: 3.5; Range: 2.5-3.9; Abnormal: ; Units: G/DL;

Status: F; Updated: 11/19 10:34
Test: BILIRUBIN, TOTAL; Value: 0.50; Range: 0.20-1.00; Abnormal: ;
Units: MG/DL; Status: F; Updated: 11/19 10:34
Test: SGOT/AST; Value: 27; Range: 10-42; Abnormal: ; Units: IU/L;
Status: F; Updated: 11/19 10:34
Test: SGPT/ALT; Value: 21; Range: 10-60; Abnormal: ; Units: IU/L;
Status: F; Updated: 11/19 10:34
Test: ALKALINE PHOSPHATASE; Value: 74; Range: 42-121; Abnormal: ;
Units: IU/L; Status: F; Updated: 11/19 10:34
Test: GLUCOSE, SERUM; Value: 459; Range: 65-100; Abnormal: Above
upper panic limits; Units: MG/DL; Status: F; Updated: 11/19 10:39
Test Note: 11/19 10:39 T nbsp;; CRITICAL RESULTS CALLED ON 11/19/17 AT
1035 TO: RINDY LAPRADE/RB/CALLED X 2 SNCE 1035 BY: CLIFTON,LYDIA C
Lab Order: Complete Blood Count W/auto Diff; SPEC'M 11/19/17 10:11
Test: WHITE BLOOD CELL; Value: 11.6; Range: 4.5-11.0; Abnormal: Above
high normal; Units: K/UL; Status: F; Updated: 11/19 10:18
Test: RED BLOOD CELL; Value: 5.32; Range: 4.50-5.90; Abnormal: ;
Units: M/UL; Status: F; Updated: 11/19 10:18
Test: HEMOGLOBIN; Value: 15.8; Range: 14.0-17.5; Abnormal: ; Units:
G/DL; Status: F; Updated: 11/19 10:18
Test: HEMATOCRIT; Value: 46.0; Range: 35.0-49.0; Abnormal: ; Units:
%; Status: F; Updated: 11/19 10:18
Test: MEAN CELL VOLUME; Value: 86.5; Range: 80-96; Abnormal: ; Units:
UM3; Status: F; Updated: 11/19 10:18
Test: MCH; Value: 29.7; Range: 27-32; Abnormal: ; Units: PG; Status:
F; Updated: 11/19 10:18
Test: MCHC; Value: 34.3; Range: 32-37; Abnormal: ; Units: G/DL;
Status: F; Updated: 11/19 10:18
Test: RELL CELL DISTRIBUTION WIDTH; Value: 13.1; Range: 11.5-14.5;
Abnormal: ; Units: %; Status: F; Updated: 11/19 10:18
Test: RDW STANDARD DEVIATION; Value: 41.1; Range: 35.1-43.9;
Abnormal: ; Units: fl; Status: F; Updated: 11/19 10:18
Test: PLATELETS; Value: 241; Range: 140-440; Abnormal: ; Units: K/UL;
Status: F; Updated: 11/19 10:18
Test: MEAN PLATELET VOLUME; Value: 10.8; Range: 7.4-10.4; Abnormal:
Above high normal; Units: fl; Status: F; Updated: 11/19 10:18
Test: SEGMENTED NEUTROPHIL PERCENT; Value: 84; Range: 37-80;
Abnormal: Above high normal; Units: %; Status: F; Updated: 11/19 10:18
Test: SEGMENTED NEUTROPHIL ABSOLUTE; Value: 9.77; Range: 1.5-6.8;
Abnormal: Above high normal; Units: K/UL; Status: F; Updated: 11/19
10:18
Test: LYMPHOCYTE PERCENT; Value: 10; Range: 10-50; Abnormal: ; Units:
%; Status: F; Updated: 11/19 10:18
Test: LYMPHOCYTES ABSOLUTE; Value: 1.10; Range: 1.0-4.0; Abnormal: ;
Units: K/UL; Status: F; Updated: 11/19 10:18
Test: MONOCYTE PERCENT; Value: 6; Range: 0-12; Abnormal: ; Units: %;
Status: F; Updated: 11/19 10:18
Test: MONOCYTE ABSOLUTE COUNT; Value: 0.64; Range: 0.2-1.0; Abnormal:

; Units: K/UL; Status: F; Updated: 11/19 10:18
Test: EOSINOPHIL PERCENT; Value: 0; Range: 0-7; Abnormal: ; Units: %;
Status: F; Updated: 11/19 10:18
Test: EOSINOPHIL ABSOLUTE; Value: 0.05; Range: 0.0-0.5; Abnormal: ;
Units: K/UL; Status: F; Updated: 11/19 10:18
Test: BASOPHIL PERCENT; Value: 0; Range: 0-2; Abnormal: ; Units: %;

Status: F; Updated: 11/19 10:18
Test: BASOPHIL ABSOLUTE; Value: 0.04; Range: 0.0-0.2; Abnormal: ;
Units: K/UL; Status: F; Updated: 11/19 10:18
Test: IMMATURE GRANS PERCENT; Value: 0.3; Abnormal: ; Units: %;
Status: F; Updated: 11/19 10:18
Test: IMMATURE GRANS ABSOLUTE; Value: 0.0; Range: 0.0-0.1; Abnormal:
; Status: F; Updated: 11/19 10:18
Lab Order: Thyroid Stimulating Hormone; SPEC'M 11/19/17 10:11
Test: THYROID STIMULATING HORMONE; Value: 1.29; Range: 0.34-5.60;
Abnormal: ; Units: uIU/ML; Status: F; Updated: 11/19 10:48
Lab Order: POC GLU; SPEC'M 11/19/17 10:13
Test: POC GLU; Value: 429; Range: 65-100; Abnormal: Above high
normal; Units: MG/DL; Status: F; Updated: 11/19 10:13

Radiology Order: Chest 1 View - Portable
Test: Chest 1 View - Portable
SOVAH HEALTH - MARTINSVILLE Name: HILL,BRIAN D ; RADIOLOGY DEPT Phys:
EKUBAN-GORDON,EDNA MD ; 320 HOSPTIAL DR DOB: 05/26/1990 Age: 27 Sex:
M ; MARTINSVILLE, VA 24112 Acct: MM7805836274 Loc: MM.ER ; PHONE #:
276-666-7223 Exam Date: 11/19/2017 Status: DEP ER ; FAX #:
276-666-7591 Radiology No: ; Unit No: MM00370912 ; EXAMS: EXAM
REASON: ; 000898111 CHEST 1 VIEW - PORTABLE Chest Tightness ;
PORTABLE CHEST ; HISTORY: Seizure. ; COMPARISON: 11/10/2015 ;
FINDINGS: The heart size and configuration are within normal limits ;
for age and portable technique. The lungs are clear. There is no ;
evidence of pleural effusions or pneumothorax. No acute bony ;
abnormality. ; IMPRESSION: No evidence of acute cardiopulmonary
disease. ; ** Electronically Signed by MAROON B KHOURY on 11/19/2017
at 1424 ** ; Reported by: DR. MAROON B KHOURY ; Signed by:
KHOURY,MAROON B ; ; CC: EDNA EKUBAN-GORDON MD ; ; Technologist: KYLEA
ANN KEATTS ; Transcribed Date/Time: 11/19/2017 (1146) ;
Transcriptionist: MMTRSPSB ; Orig Print D/T: S: 11/19/2017 (1424) ;
Reprint D/T: 11/19/2017 (1424) BATCH NO: N/A ;
Radiology Order: CT Head w/o Contrast
Test: CT Head w/o Contrast
SOVAH HEALTH - MARTINSVILLE Name: HILL,BRIAN D ; RADIOLOGY DEPT Phys:
EKUBAN-GORDON,EDNA MD ; 320 HOSPTIAL DR DOB: 05/26/1990 Age: 27 Sex:
M ; MARTINSVILLE, VA 24112 Acct: MM7805836274 Loc: MM.ER ; PHONE #:
276-666-7223 Exam Date: 11/19/2017 Status: DEP ER ; FAX #:
276-666-7591 Radiology No: ; Unit No: MM00370912 ; EXAMS: EXAM
REASON: ; 000898114 CT HEAD W/O CONTRAST ; UNENHANCED HEAD CT ;
HISTORY: Head injury. ; COMPARISON: 11/10/2015 ; TECHNIQUE: This CT
examination was performed using one or more of the ; following dose
reduction techniques: automated exposure control, ; adjustment of the
MA and/or KV according to patient size, and/or use ; of iterative
reconstruction techniques. ; Axial CT images were obtained through
the brain without the use of ; intravenous contrast. ; FINDINGS:

There is no evidence of acute infarct, intracranial ; hemorrhage, or
mass effect. Ventricles and sulci are normal for the ; patient's age.
Calvarium is intact. Visualized portions of the ; paranasal sinuses
and orbits are normal. ; IMPRESSION: Negative for acute intracranial
process. ; ** Electronically Signed by MAROON B KHOURY on 11/19/2017
at 1424 ** ; Reported by: DR. MAROON B KHOURY ; Signed by:
KHOURY,MAROON B ; ; CC: EDNA EKUBAN-GORDON MD ; ; Technologist:

HILL,BRIAN D
MM7805836274 PRE ER MM.ER
11/19/17 0850 UNKNOWN,UNKNOWN
DOB:05/26/90 27 M MR# MM00370912
Sovah Health - Martinsville

Sovah Health Martinsville

320 Hospital Drive
Martinsville, VA 24112
276-666-7237

11/9/67
97
98%
18

Emergency Department Instructions for: **Hill, Brian D**

Arrival Date: **Sunday, November 19, 2017**

Thank you for choosing **Sovah Health Martinsville** for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: Ekuban-Gordon, Edna, MD

Diagnosis: Head Laceration/ Open wound of head; Hyperglycemia, unspecified

DISCHARGE INSTRUCTIONS	FORMS
Head Injury, Adult Facial Laceration Hyperglycemia, Easy-to-Read Stitches, Staples, or Adhesive Wound Closure, Easy-to-Read	Medication Reconciliation
FOLLOW UP INSTRUCTIONS	**PRESCRIPTIONS**
Private Physician When: 2 - 3 days; Reason: Wound Recheck	None
SPECIAL NOTES	
None	

Suicide National Hotline: 1-800-273-8255 (800-273-TALK)

If you received a narcotic or sedative medication during your Emergency Department stay you should not drive, drink alcohol or operate heavy machinery for the next 8 hours as this medication can cause drowsiness, dizziness, and decrease your response time to events.

I hereby acknowledge that I have received a copy of my transition care record and understand the above instructions and prescriptions.

Brian D. Hill

Brian Hill
MRN # MM00370912

Bell Thornton, RN

ED Physician or Nurse
11/19/2017 12:14

X-RAYS and LAB TESTS:
If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you

had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:
If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

TESTS AND PROCEDURES

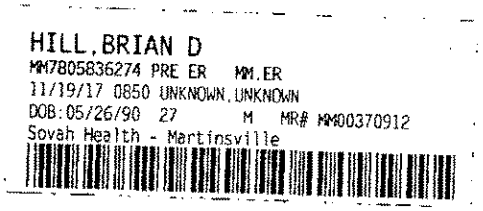
Labs
CMP, Complete Blood Count W/auto Diff, Thyroid Stimulating Hormone, POC GLU, POC GLU

Rad
CT Head w/o Contrast, Chest 1 View - Portable

Procedures
Blood Sugar, 12 Lead EKG, Laceration

Other
Seizure precautions, Accucheck, Cardiac Monitor, Apply to Pt, Pulse ox continuous, Oxygen at 2 L/NC, IV saline lock, EKG ED, Laceration repair set up

Chart Copy



EMERGENCY DEPARTMENT RECORD
Nurse's Notes
Sovah Health Martinsville
Name: Brian Hill
Age: 27 yrs
Sex: Male
DOB: 05/26/1990
MRN: MM00370912
Arrival Date: 11/19/2017
Time: 08:51
Account#: MM7805836274
Bed ER 6
Private MD:
Diagnosis: Head Laceration/ Open wound of head;Hyperglycemia, unspecified

Presentation:
11/19
09:08 Presenting complaint: Patient states: had a seizure this morning due to low blood sugar, laceration to head per pt, bleeding controlled. Airway is patent with good air movement. The patient is breathing without difficulty. The patient is pink,warm and dry. Heart rate is within normal limits. Patient is alert and oriented to person, place and time, Patient is moving all extremities appropriately. ll
11/19
09:08 Acuity: Urgent (3) ll

Historical:
- Allergies: Ranitidine;
- Home Meds:
1. Unable to Obtain
- PMHx: OCD; autism; Diabetes - IDDM;
- Sepsis Screening:: Sepsis screening negative at this time.
- Social history:: Tobacco Status: The patient states he/she has never used tobacco. The patient's primary language is English. The patient's preferred language is English.
- Family history:: Reviewed and not pertinent.
- Exposure Risk/Travel Screening:: Patient has not been out of the country in last 30 days. Have you been in contact with anyone who is ill that has traveled outside of the country in the last 30 days? No.
- Suicide Screening:: Have you recently had thoughts about hurting yourself or others? No.
- Tuberculosis screening:: No symptoms or risk factors identified.

Screening:
11/19
09:41 Fall Risk: Total Points: Med. Risk (25-44);. Abuse Screen: Patient verbally denies physical, verbal and emotional abuse/neglect. There are no cultural/spiritual considerations for care for this patient. mkk

Assessment:
11/19

09:38 Complains of pain in face Pain does not radiate. Pain currently is 7 mkk

out of 10 on a pain scale. The level of pain that is acceptable is 0 out of 10 on a pain scale. General: Appears in no apparent distress, comfortable, well developed, well nourished, well groomed, Behavior is appropriate for age, cooperative, pleasant. Neuro: Reports headache. Neuro: Reports seizure due to low blood sugar. EENT: Denies. Cardiovascular: Denies. Respiratory: Denies. GI: Denies. GU: Denies. Derm: Denies. Musculoskeletal: Denies. Injury Description: Laceration sustained to face is clean, 0.5 to 2.5 cm long, not bleeding, was sustained 4-6 hours ago.

11/19
09:38 Method Of Arrival: EMS mkk

Vital Signs:
11/19
09:08 BP 131 / 76; Pulse 118; Resp 20; Temp 98.2; Pulse Ox 97% ; Weight 91.63 kg; Height 5 ft. 10 in. (177.80 cm); ll
11/19
09:46 mkk
11/19
10:59 BP 124 / 73; Pulse 93; Resp 18; Pulse Ox 100% on R/A; mkk
11/19
12:57 BP 119 / 67; Pulse 97; Resp 19; Pulse Ox 98% on R/A; pt3
11/19
09:08 Body Mass Index 28.98 (91.63 kg, 177.80 cm) ll
11/19
09:46 patient has OCD and had to do his "routines" prior to coming, has been about 4 hours since injury occured mkk

Glasgow Coma Score:
11/19
12:16 Eye Response: spontaneous(4). Verbal Response: oriented(5). Motor Response: obeys commands(6). Total: 15. eeg

ED Course:
11/19
08:51 Patient arrived in ED. knm
11/19
09:09 Rapid Initial Assessment completed. ll
11/19
09:27 Ekuban-Gordon, Edna, MD is Attending Physician. eeg
11/19
09:41 Patient has correct armband on for positive identification. Placed in gown. Bed in low position. Call light in reach. Side rails up X2. Adult with patient. Seizure precautions initiated. NIBP on. Pulse ox on. mkk
11/19
09:41 No physician assisted procedures were completed. mkk
11/19
10:01 Inserted saline lock: 20 gauge right arm blood drawn from IV and sent to lab per order. mkk
11/19
10:08 EKG Done By ED Tech 10:06 Reviewed by Physician Edna Ekuban-Gordon MD.bh

11/19
10:40 Critical Lab Value: Patient Name verified: Brian Hill, Patient DOB ll

Verified May 26, 1990 Critical value glucose 459reported read back to reporting lab personnel, and reported to Dr. Edna Ekuban-Gordon MD.
11/19
10:59 Assist provider with laceration repair Set up tray. mkk
11/19
11:53 Troncoso, Priscilla, RN is Primary Nurse. pt3

Administered Medications:
11/19
10:59 Drug: NS 0.9% 1000 ml Route: IV; Rate: 999 mL/hr; Site: right arm; mkk
11/19
12:59 Follow up: Response: No adverse reaction; IV Status: Completed infusion pt3
11/19
11:02 Drug: NovoLIN R 7 units {Co-Signature: mkk (Michaela Karet RN).} ll
Route: IVP; Site: right arm;
11/19
12:58 Follow up: Response: No adverse reaction pt3

Point of Care Testing:
Blood Glucose:
11/19
09:40 Glucose Value: 489; mkk
11/19
09:43 Glucose Value: 435; mkk
11/19
09:40 test repeated mkk
Ranges:

Output:
11/19
11:28 Urine: 600ml (Voided); Total: 600ml. dab

Outcome:
11/19
12:14 Discharge ordered by Provider. eeg
11/19
12:57 Discharged to home ambulatory, with family. pt3
12:57 Instructions given to patient, parent, Instructed on discharge instructions. follow up and referral plans. . Patient and/or family voiced understanding of instructions using teach back method.
12:57 The patients' shirt, pants, shoes, socks and underwear were sent with the patient.
12:57 Discharge Assessment: Patient
12:57 Discharge Assessment: Patient has no functional deficits.
12:57 Discontinued IV lock intact, bleeding controlled, pressure dressing applied, No redness/swelling at site.
11/19
13:24 Patient left the ED. jkp

Signatures:
Harrison, Rindi, RN RN ll
Ekuban-Gordon, Edna, MD MD eeg

EMERGENCY DEPARTMENT RECORD
Physician Documentation
Sovah Health Martinsville
Name: Brian Hill
Age: 27 yrs
Sex: Male
DOB: 05/26/1990
MRN: MM00370912
Arrival Date: 11/19/2017
Time: 08:51
Account#: MM7805836274
Bed ER 6
Private MD:
ED Physician Ekuban-Gordon, Edna
HPI:
11/19
11:49 This 27 yrs old White Male presents to ER via EMS with complaints of Fall Injury. eeg
11/19
11:49 Onset: The symptoms/episode began/occurred today. Associated injuries: The patient sustained injury to the head. Associated signs and symptoms: Loss of consciousness: the patient experienced no loss of consciousness. Severity of symptoms: in the emergency department the symptoms are unchanged. Pain Management: Patient denies pain. The patient has experienced similar episodes in the past, a few times. The patient has not recently seen a physician. Family report history of low blood sugar, general low will have seizure episode when the blood sugar is low. Blood sugar was obtained by mom at 20 repeat 40 was subsequently given some oral glucose and brought here for further evaluation. Patient denies any headache palpitation no neck pain and stiffness. Admits to feeling like himself.. eeg

Historical:
- Allergies: Ranitidine;
- Home Meds:
1. Unable to Obtain
- PMHx: OCD; autism; Diabetes - IDDM;
- Sepsis Screening:: Sepsis screening negative at this time.
- Social history:: Tobacco Status: The patient states he/she has never used tobacco. The patient's primary language is English. The patient's preferred language is English.
- Family history:: Reviewed and not pertinent.
- Exposure Risk/Travel Screening:: Patient has not been out of the country in last 30 days. Have you been in contact with anyone who is ill that has traveled outside of the country in the last 30 days? No.
- Suicide Screening:: Have you recently had thoughts about hurting yourself or others? No.
- Tuberculosis screening:: No symptoms or risk factors identified.
- The history from nurses notes was reviewed: and I agree with what is documented up to this point.

ROS:

11/19
11:52 Eyes: Negative for injury, pain, redness, and discharge, ENT: eeg
Negative for injury, pain, and discharge, Neck: Negative for injury, pain, and swelling, Cardiovascular: Negative for chest pain, palpitations, and edema, Respiratory: Negative for shortness of breath, cough, wheezing, and pleuritic chest pain, Abdomen/GI: Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation, Back: Negative for injury and pain, MS/Extremity: Negative for injury and deformity. All other systems are negative, except as documented below. Skin: Positive for laceration(s), of the face. Neuro: Negative for dizziness, headache, weakness. Psych: Negative for depression, alcohol dependence, homicidal ideation, suicide gesture.

Exam:
11/19
11:53 Eyes: Pupils equal round and reactive to light, extra-ocular motions eeg intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema. ENT: Nares patent. No nasal discharge, no septal abnormalities noted. Tympanic membranes are normal and external auditory canals are clear. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membrane moist Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Chest/axilla: Normal chest wall appearance and motion. Nontender with no deformity. No lesions are appreciated. Cardiovascular: Regular rate and rhythm with a normal S1 and S2. ,no jvd No pulse deficits. Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring. Abdomen/GI: Soft, non-tender, with normal bowel sounds. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout. Back: No spinal tenderness. No costovertebral tenderness. Full range of motion. MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion. Neuro: Awake and alert, GCS 15, oriented to person, place, time, and situation. Cranial nerves II-XII grossly intact. Motor strength 5/5 in all extremities. Sensory grossly intact. Cerebellar exam normal. Normal gait., slow, but appropriate Psych: Awake, alert, with orientation to person, place and time. Behavior, mood, and affect are within normal limits.
11:53 Constitutional: The patient appears alert, awake, non-diaphoretic.
11:53 Head/face: Noted is a laceration(s), that is linear, 3 cm(s).
11:53 Musculoskeletal/extremity: Extremities: all appear grossly normal, with no appreciated pain with palpation, ROM: intact in all extremities, Circulation is intact in all extremities. Sensation intact.
11:53 Psych: Behavior/mood is cooperative.

Vital Signs:
11/19

RUN DATE:11/23/17

DISCHARGE SUMMARY FOR MEDICAL RECORDS FOR LABORATORY

Patient: HILL,BRIAN D #MM7805836274 **(Continued)**

**********CHEMISTRY**********

	Date / Time		Reference	Units
	11/19/17 1007			
BUN	7		(5-25)	MG/DL
CREATININE	1.01		(0.90-1.30)	MG/DL
eGFR NON-AA	102(A)			
eGFR AA	118(B)			
SODIUM	131 L		(135-145)	MMOL/L
POTASSIUM	4.4		(3.5-5.0)	MMOL/L
CHLORIDE	96 L		(98-109)	MMOL/L
CO2	26		(20-30)	MMOL/L
ANION GAP	9.0		(1-10)	
GLUCOSE	459(C) *H		(65-100)	MG/DL
CALCIUM	9.0		(8.5-10.3)	MG/DL
TOTAL PROTEIN	7.8		(6.0-8.0)	G/DL
ALBUMIN	4.3		(3.2-5.5)	G/DL
AG	1.2		(1.2-1.7)	RATIO
GLOBULIN	3.5		(2.5-3.9)	G/DL
T BILI	0.50		(0.20-1.00)	MG/DL
SGOT/AST	27		(10-42)	IU/L
SGPT/ALT	21		(10-60)	IU/L
ALK PHOS	74		(42-121)	IU/L
TSH	1.29		(0.34-5.60)	uIU/ML

(A) Non-African American

(B) African American.
eGFR UNITS: ml/min/1.73m2.
*eGFR >= 60 = Normal GFR or mild decrease in GFR
*eGFR 30-59 = Moderate decrease in GFR (Stage 3 CKD)
*eGFR 15-29 = Severe decrease in GFR (Stage 4 CKD)
*eGFR <15 = End-stage kidney failure (Stage 5 CKD)

The equation has not been validated in patients >70 YRS OLD.

(C) CRITICAL RESULTS CALLED ON 11/19/17
AT 1035 TO: RINDY LAPRADE/RB/CALLED X 2 SNCE 1035
BY: CLIFTON,LYDIA C

Patient: HILL,BRIAN D **Age/Sex:** 27/M **Acct#**MM7805836274 **Unit#**MM00370912

SOVAH HEALTH - MARTINSVILLE
RADIOLOGY DEPT
320 HOSPTIAL DR
MARTINSVILLE, VA 24112
PHONE #: 276-666-7223
FAX #: 276-666-7591

Name: HILL,BRIAN D
Phys: EKUBAN-GORDON,EDNA MD
DOB: 05/26/1990 Age: 27 Sex: M
Acct: MM7805836274 Loc: MM.ER
Exam Date: 11/19/2017 Status: DEP ER
Radiology No:
Unit No: MM00370912

EXAMS:
000898111 CHEST 1 VIEW - PORTABLE

EXAM REASON:
Chest Tightness

PORTABLE CHEST

HISTORY: Seizure.

COMPARISON: 11/10/2015

FINDINGS: The heart size and configuration are within normal limits for age and portable technique. The lungs are clear. There is no evidence of pleural effusions or pneumothorax. No acute bony abnormality.

IMPRESSION: No evidence of acute cardiopulmonary disease.

** Electronically Signed by MAROON B KHOURY on 11/19/2017 at 1424 **
Reported by: DR. MAROON B KHOURY
Signed by: KHOURY,MAROON B

CC: EDNA EKUBAN-GORDON MD

Technologist: KYLEA ANN KEATTS
Transcribed Date/Time: 11/19/2017 (1146)
Transcriptionist: MMTRSPSB
Orig Print D/T: S: 11/19/2017 (1424)
BATCH NO: N/A

PAGE 1 Signed Report

HILL, BRIAN ID: 000370912 19-Nov-2017 10:06:44 Memorial Hospital of Martinsville

27years
Male Caucasian

Room: 6
Loc: 15

Vent. rate	105 bpm
PR interval	158 ms
QRS duration	92 ms
QT/QTc	328/433 ms
P-R-T axes	64 64 52

Sinus tachycardia
Possible Left atrial enlargement
Borderline ECG

(007)
Bed 6

T HILL,BRIAN D
MM7805836274 PRE ER MM.ER
11/19/17 0850 UNKNOWN,UNKNOWN
DOB:05/26/90 27 M MR# MM0037091Z
Sovah Health - Martinsville

Visit: MM7805836274
Secondary ID: MM216937
Referred by: EKUBAN-GORDON, EDNA

Order no.: 211090013
Unconfirmed

CHEST PAIN

I aVR V1 V4
II aVL V2 V5
III aVF V3 V6
II

100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 010B 12SL™v241 HD

P/N 2009828-024

SOVAH HEALTH - MARTINSVILLE
320 HOSPITAL DRIVE - P.O. BOX 4788
MARTINSVILLE, VA 24112 (276)666-7360
CLIA NO. 49D0231853 RT CLIA NO. 4D0661287

RUN DATE:11/23/17

DISCHARGE SUMMARY FOR MEDICAL RECORDS FOR LABORATORY

CMAX: MM00370912~MM7805836274~LABDATA~20171123~LABDISMM1001869144~COCMMH~COCVAE~LAB.COCMMH~

PATIENT: HILL,BRIAN D		**ACCT #:** MM7805836274	**LOC:** MM.ER	**U #:** MM00370912
		AGE/SX: 27/M	**ROOM:**	**REG:** 11/19/17
REG DR: EKUBAN-GORDON,EDNA MD		**DOB:** 05/26/90	**BED:**	**DIS:**
		STATUS: DEP ER	**TLOC:**	

**********POINT OF CARE**********

Date	----------11/19/17----------			
Time	1006	0943	Reference	Units
POC GLU	429 H	435 H	(65-100)	MG/DL

**********HEMATOLOGY**********

Date	11/19/17		
Time	1007	Reference	Units
WBC	11.6 H	(4.5-11.0)	K/UL
RBC	5.32	(4.50-5.90)	M/UL
HGB	15.8	(14.0-17.5)	G/DL
HCT	46.0	(35.0-49.0)	%
MCV	86.5	(80-96)	UM3
MCH	29.7	(27-32)	PG
MCHC	34.3	(32-37)	G/DL
RDW	13.1	(11.5-14.5)	%
RDW-SD	41.1	(35.1-43.9)	fl
PLT	241	(140-440)	K/UL
MPV	10.8 H	(7.4-10.4)	fl
SEGS %	84 H	(37-80)	%
SEG ABSOLUTE	9.77 H	(1.5-6.8)	K/UL
LYMPH %	10	(10-50)	%
LYMPH ABSOLUTE	1.10	(1.0-4.0)	K/UL
MONO %	6	(0-12)	%
MONO ABSOLUTE	0.64	(0.2-1.0)	K/UL
EOS %	0	(0-7)	%
EOS ABSOLUTE	0.05	(0.0-0.5)	K/UL
BASO %	0	(0-2)	%
BASO ABSOLUTE	0.04	(0.0-0.2)	K/UL
IG %	0.3		%
IG ABSOLUTE	0.0	(0.0-0.1)	

09:08 BP 131 / 76; Pulse 118; Resp 20; Temp 98.2; Pulse Ox 97% ; Weight 91.63 kg; Height 5 ft. 10 in. (177.80 cm); — ll

11/19
09:46 — mkk

11/19
10:59 BP 124 / 73; Pulse 93; Resp 18; Pulse Ox 100% on R/A; — mkk

11/19
12:57 BP 119 / 67; Pulse 97; Resp 19; Pulse Ox 98% on R/A; — pt3

11/19
09:08 Body Mass Index 28.98 (91.63 kg, 177.80 cm) — ll

11/19
09:46 patient has OCD and had to do his "routines" prior to coming, has been about 4 hours since injury occured — mkk

Glasgow Coma Score:

11/19
12:16 Eye Response: spontaneous(4). Verbal Response: oriented(5). Motor Response: obeys commands(6). Total: 15. — eeg

Laceration:

11/19
12:11 Wound Repair of 3cm (1.2in) subcutaneous laceration to forehead. Linear shaped.. No foreign body noted. Distal neuro/vascular/tendon intact. Anesthesia: Wound infiltrated with 3 mls of 1% lidocaine w/ Epi. Wound prep: Simple cleansing with betadine. Skin closed with 6 1-0 Prolene using Staple gun. Dressed with pressure dressing. Patient tolerated well. — eeg

MDM:

11/19
09:27 MSE Initiated by Provider. — eeg

11/19
12:12 Differential diagnosis: abrasion, closed head injury, concussion, contusion, dislocation, fracture, laceration, multiple trauma, sprain, Substance abuse. Data reviewed: vital signs, nurses notes, lab test result(s), radiologic studies. Data interpreted: Cardiac monitor: Normal rate. Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, radiology results, the need for outpatient follow up, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home. Response to treatment: the patient's symptoms have markedly improved after treatment. — eeg

11/19
09:46 Order name: POC GLU; Complete Time: 09:57 — EDMS

11/19
09:56 Order name: CMP; Complete Time: 10:53 — eeg

11/19
09:56 Order name: Complete Blood Count W/auto Diff; Complete Time: 10:53 — eeg

11/19
09:56 Order name: Thyroid Stimulating Hormone; Complete Time: 10:53 — eeg

11/19

11/19/17 12:14 Discharged to Home. Impression: Head Laceration/ Open wound of head, Hyperglycemia, unspecified.
- Condition is Stable.
- Discharge Instructions: Head Injury, Adult, Facial Laceration, Hyperglycemia, Easy-to-Read, Stitches, Staples, or Adhesive Wound Closure, Easy-to-Read.

- Medication Reconciliation form.
- Follow up: Private Physician; When: 2 - 3 days; Reason: Wound Recheck.
- Problem is new.
- Symptoms have improved.

Order Results:
Lab Order: POC GLU; SPEC'M 11/19/17 09:46
Test: POC GLU; Value: 435; Range: 65-100; Abnormal: Above high normal; Units: MG/DL; Status: F; Updated: 11/19 09:46
Lab Order: CMP; SPEC'M 11/19/17 10:11
Test: SODIUM; Value: 131; Range: 135-145; Abnormal: Below low normal; Units: MMOL/L; Status: F; Updated: 11/19 10:24
Test: POTASSIUM; Value: 4.4; Range: 3.5-5.0; Abnormal: ; Units: MMOL/L; Status: F; Updated: 11/19 10:24
Test: CHLORIDE; Value: 96; Range: 98-109; Abnormal: Below low normal; Units: MMOL/L; Status: F; Updated: 11/19 10:24
Test: CARBON DIOXIDE; Value: 26; Range: 20-30; Abnormal: ; Units: MMOL/L; Status: F; Updated: 11/19 10:24
Test: ANION GAP; Value: 9.0; Range: 1-10; Abnormal: ; Status: F; Updated: 11/19 10:24
Test: CALCIUM; Value: 9.0; Range: 8.5-10.3; Abnormal: ; Units: MG/DL; Status: F; Updated: 11/19 10:24
Test: BLOOD UREA NITROGEN; Value: 7; Range: 5-25; Abnormal: ; Units: MG/DL; Status: F; Updated: 11/19 10:34
Test: CREATININE; Value: 1.01; Range: 0.90-1.30; Abnormal: ; Units: MG/DL; Status: F; Updated: 11/19 10:34
Test: GLOMERULAR FILTRATION RATE; Value: 102; Abnormal: ; Status: F; Updated: 11/19 10:34
Test Note: 11/19 10:34 T nbsp;; Non-African American
Test: GLOMERULAR FILTRATION RATE-AA; Value: 118; Abnormal: ; Status: F; Updated: 11/19 10:34
Test Note: 11/19 10:34 T nbsp;; African American. eGFR UNITS: ml/min/1.73m2. *eGFR >= 60 = Normal GFR or mild decrease in GFR *eGFR 30-59 = Moderate decrease in GFR (Stage 3 CKD) *eGFR 15-29 = Severe decrease in GFR (Stage 4 CKD) *eGFR <15 = End-stage kidney failure (Stage 5 CKD) The equation has not been validated in patients >70 YRS OLD.
Test: TOTAL PROTEIN; Value: 7.8; Range: 6.0-8.0; Abnormal: ; Units: G/DL; Status: F; Updated: 11/19 10:34

Test: ALBUMIN; Value: 4.3; Range: 3.2-5.5; Abnormal: ; Units: G/DL; Status: F; Updated: 11/19 10:34
Test: ALB/GLOB RATIO; Value: 1.2; Range: 1.2-1.7; Abnormal: ; Units: RATIO; Status: F; Updated: 11/19 10:34
Test: GLOBULIN; Value: 3.5; Range: 2.5-3.9; Abnormal: ; Units: G/DL;

Status: F; Updated: 11/19 10:34
Test: BILIRUBIN, TOTAL; Value: 0.50; Range: 0.20-1.00; Abnormal: ;
Units: MG/DL; Status: F; Updated: 11/19 10:34
Test: SGOT/AST; Value: 27; Range: 10-42; Abnormal: ; Units: IU/L;
Status: F; Updated: 11/19 10:34
Test: SGPT/ALT; Value: 21; Range: 10-60; Abnormal: ; Units: IU/L;
Status: F; Updated: 11/19 10:34
Test: ALKALINE PHOSPHATASE; Value: 74; Range: 42-121; Abnormal: ;
Units: IU/L; Status: F; Updated: 11/19 10:34
Test: GLUCOSE, SERUM; Value: 459; Range: 65-100; Abnormal: Above
upper panic limits; Units: MG/DL; Status: F; Updated: 11/19 10:39
Test Note: 11/19 10:39 T nbsp;; CRITICAL RESULTS CALLED ON 11/19/17 AT
1035 TO: RINDY LAPRADE/RB/CALLED X 2 SNCE 1035 BY: CLIFTON,LYDIA C
Lab Order: Complete Blood Count W/auto Diff; SPEC'M 11/19/17 10:11
Test: WHITE BLOOD CELL; Value: 11.6; Range: 4.5-11.0; Abnormal: Above
high normal; Units: K/UL; Status: F; Updated: 11/19 10:18
Test: RED BLOOD CELL; Value: 5.32; Range: 4.50-5.90; Abnormal: ;
Units: M/UL; Status: F; Updated: 11/19 10:18
Test: HEMOGLOBIN; Value: 15.8; Range: 14.0-17.5; Abnormal: ; Units:
G/DL; Status: F; Updated: 11/19 10:18
Test: HEMATOCRIT; Value: 46.0; Range: 35.0-49.0; Abnormal: ; Units:
%; Status: F; Updated: 11/19 10:18
Test: MEAN CELL VOLUME; Value: 86.5; Range: 80-96; Abnormal: ; Units:
UM3; Status: F; Updated: 11/19 10:18
Test: MCH; Value: 29.7; Range: 27-32; Abnormal: ; Units: PG; Status:
F; Updated: 11/19 10:18
Test: MCHC; Value: 34.3; Range: 32-37; Abnormal: ; Units: G/DL;
Status: F; Updated: 11/19 10:18
Test: RELL CELL DISTRIBUTION WIDTH; Value: 13.1; Range: 11.5-14.5;
Abnormal: ; Units: %; Status: F; Updated: 11/19 10:18
Test: RDW STANDARD DEVIATION; Value: 41.1; Range: 35.1-43.9;
Abnormal: ; Units: fl; Status: F; Updated: 11/19 10:18
Test: PLATELETS; Value: 241; Range: 140-440; Abnormal: ; Units: K/UL;
Status: F; Updated: 11/19 10:18
Test: MEAN PLATELET VOLUME; Value: 10.8; Range: 7.4-10.4; Abnormal:
Above high normal; Units: fl; Status: F; Updated: 11/19 10:18
Test: SEGMENTED NEUTROPHIL PERCENT; Value: 84; Range: 37-80;
Abnormal: Above high normal; Units: %; Status: F; Updated: 11/19 10:18
Test: SEGMENTED NEUTROPHIL ABSOLUTE; Value: 9.77; Range: 1.5-6.8;
Abnormal: Above high normal; Units: K/UL; Status: F; Updated: 11/19
10:18
Test: LYMPHOCYTE PERCENT; Value: 10; Range: 10-50; Abnormal: ; Units:
%; Status: F; Updated: 11/19 10:18
Test: LYMPHOCYTES ABSOLUTE; Value: 1.10; Range: 1.0-4.0; Abnormal: ;
Units: K/UL; Status: F; Updated: 11/19 10:18
Test: MONOCYTE PERCENT; Value: 6; Range: 0-12; Abnormal: ; Units: %;
Status: F; Updated: 11/19 10:18
Test: MONOCYTE ABSOLUTE COUNT; Value: 0.64; Range: 0.2-1.0; Abnormal:

; Units: K/UL; Status: F; Updated: 11/19 10:18
Test: EOSINOPHIL PERCENT; Value: 0; Range: 0-7; Abnormal: ; Units: %;
Status: F; Updated: 11/19 10:18
Test: EOSINOPHIL ABSOLUTE; Value: 0.05; Range: 0.0-0.5; Abnormal: ;
Units: K/UL; Status: F; Updated: 11/19 10:18
Test: BASOPHIL PERCENT; Value: 0; Range: 0-2; Abnormal: ; Units: %;

Status: F; Updated: 11/19 10:18
Test: BASOPHIL ABSOLUTE; Value: 0.04; Range: 0.0-0.2; Abnormal: ;
Units: K/UL; Status: F; Updated: 11/19 10:18
Test: IMMATURE GRANS PERCENT; Value: 0.3; Abnormal: ; Units: %;
Status: F; Updated: 11/19 10:18
Test: IMMATURE GRANS ABSOLUTE; Value: 0.0; Range: 0.0-0.1; Abnormal:
; Status: F; Updated: 11/19 10:18
Lab Order: Thyroid Stimulating Hormone; SPEC'M 11/19/17 10:11
Test: THYROID STIMULATING HORMONE; Value: 1.29; Range: 0.34-5.60;
Abnormal: ; Units: uIU/ML; Status: F; Updated: 11/19 10:48
Lab Order: POC GLU; SPEC'M 11/19/17 10:13
Test: POC GLU; Value: 429; Range: 65-100; Abnormal: Above high
normal; Units: MG/DL; Status: F; Updated: 11/19 10:13

Radiology Order: Chest 1 View - Portable
Test: Chest 1 View - Portable
SOVAH HEALTH - MARTINSVILLE Name: HILL,BRIAN D ; RADIOLOGY DEPT Phys:
EKUBAN-GORDON,EDNA MD ; 320 HOSPTIAL DR DOB: 05/26/1990 Age: 27 Sex:
M ; MARTINSVILLE, VA 24112 Acct: MM7805836274 Loc: MM.ER ; PHONE #:
276-666-7223 Exam Date: 11/19/2017 Status: DEP ER ; FAX #:
276-666-7591 Radiology No: ; Unit No: MM00370912 ; EXAMS: EXAM
REASON: ; 000898111 CHEST 1 VIEW - PORTABLE Chest Tightness ;
PORTABLE CHEST ; HISTORY: Seizure. ; COMPARISON: 11/10/2015 ;
FINDINGS: The heart size and configuration are within normal limits ;
for age and portable technique. The lungs are clear. There is no ;
evidence of pleural effusions or pneumothorax. No acute bony ;
abnormality. ; IMPRESSION: No evidence of acute cardiopulmonary
disease. ; ** Electronically Signed by MAROON B KHOURY on 11/19/2017
at 1424 ** ; Reported by: DR. MAROON B KHOURY ; Signed by:
KHOURY,MAROON B ; ; CC: EDNA EKUBAN-GORDON MD ; ; Technologist: KYLEA
ANN KEATTS ; Transcribed Date/Time: 11/19/2017 (1146) ;
Transcriptionist: MMTRSPSB ; Orig Print D/T: S: 11/19/2017 (1424) ;
Reprint D/T: 11/19/2017 (1424) BATCH NO: N/A ;
Radiology Order: CT Head w/o Contrast
Test: CT Head w/o Contrast
SOVAH HEALTH - MARTINSVILLE Name: HILL,BRIAN D ; RADIOLOGY DEPT Phys:
EKUBAN-GORDON,EDNA MD ; 320 HOSPTIAL DR DOB: 05/26/1990 Age: 27 Sex:
M ; MARTINSVILLE, VA 24112 Acct: MM7805836274 Loc: MM.ER ; PHONE #:
276-666-7223 Exam Date: 11/19/2017 Status: DEP ER ; FAX #:
276-666-7591 Radiology No: ; Unit No: MM00370912 ; EXAMS: EXAM
REASON: ; 000898114 CT HEAD W/O CONTRAST ; UNENHANCED HEAD CT ;
HISTORY: Head injury. ; COMPARISON: 11/10/2015 ; TECHNIQUE: This CT
examination was performed using one or more of the ; following dose
reduction techniques: automated exposure control, ; adjustment of the
MA and/or KV according to patient size, and/or use ; of iterative
reconstruction techniques. ; Axial CT images were obtained through
the brain without the use of ; intravenous contrast. ; FINDINGS:

There is no evidence of acute infarct, intracranial ; hemorrhage, or
mass effect. Ventricles and sulci are normal for the ; patient's age.
Calvarium is intact. Visualized portions of the ; paranasal sinuses
and orbits are normal. ; IMPRESSION: Negative for acute intracranial
process. ; ** Electronically Signed by MAROON B KHOURY on 11/19/2017
at 1424 ** ; Reported by: DR. MAROON B KHOURY ; Signed by:
KHOURY,MAROON B ; ; CC: EDNA EKUBAN-GORDON MD ; ; Technologist: