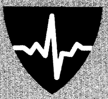

Southern Health Partners
Your Partner In Affordable Inmate Healthcare

December 6, 2016

Brian Hill
310 Forest Street
Apt 2
Martinsville, VA 24112

Re: Medical Records

Mr. Hill,

Enclosed please find the medical records you requested from the Orange County Jail. Let me know if I can further assist.

Sincerely,

Brooke Shirley

Brooke Shirley
Risk Management Assistant

MEDICAL SUMMARY OF FEDERAL PRISONER/ ALIEN IN TRANSIT
U.S. Department of Justice

TB Clearance ☑ Yes ☐ No

1) PPD Completed: 6-9-14 Date
Results: Ø mm

2) CXR Completed: ____ Date
Results:

3) Health Authority Clearance:
Sign ____ Date

Note: Dates listed above must be within one year of this transfer.

I. PRISONER/ALIEN

Name: Hill Brian

Prisoner/Alien Reg. #:

D.O.B. 3-26-94

Departed From:

Date Departed: 9-30-14

Destination:

Reason for Transfer:

District Name:

District #:

Date in Custody:

II. CURRENT MEDICAL PROBLEMS

1. DM
2.
3.
4.
5.
6.

Medication	Dose	Route	Medication Required For Care En Route Instructions For Use (Include proper time for Administering)	Stop
Prozac	20mg	PO	QD x 90days	12-29-14
			CBGs QID ac meals & HS & cover	10-4-14
			c CHC coverage x 90 days.	
70/30	20units	SQ	AC meals x 90 days	10-4-14
70/30	4units	SQ	QHS x 90days	10-4-14

Additional Comments:

III. SPECIAL NEEDS AFFECTING TRANSPORTATION

Is prisoner medically able to travel by BUS, VAN or CAR? ☑ Yes ☐ No If no, Why not?

Is prisoner medically able to travel by airplane? ☑ Yes ☐ No If no, Why not?

Is prisoner medically able to stay overnight at another facility en route to destination? ☑ Yes ☐ No If no, Why not?

Is there any medical reason for restricting the length of time prisoner can be in travel status? ☐ Yes ☑ No If yes, state reason:

Does prisoner require any medical equipment while in transport status? ☐ Yes ☑ No If yes, What equipment?

Sign & Print Name- Certifying Health Authority: [signature] LPN

Phone Number: 336-641-2856

Date Signed: 9-30-14

Yellow (original) - Upon Transfer

Form USM-553
Est. 6/98

...CAL SUMMARY OF F...ERAL PRISONER/ ALIEN IN TR...SIT
...Department of Justice

TB Clearance ☒ Yes ☐ No

1) PPD Completed: 6-9-14 Date

Results: 0mm

2) CXR Completed: ______ Date

Results: ______

3) Health Authority Clearance: Rosetta Smith LPN

Sign 11/6/14 Date

Note: Dates listed above must be within one year of this transfer.

I. PRISONER/ALIEN

Name: Hill, Brian

Prisoner/Alien Reg. #:

D.O.B: 3-26-94

Departed From: Orange County Jail

Date Departed: 11-7-14

Destination:

Reason for Transfer: FED

Dist. Name:

Dist. #:

Date in Custody:

II. Current Medical Problems

1. DM
2.
3.
4.
5.
6.

			Medication Required For Care En Route	
Medication	**Dose**	**Route**	**Instructions For Use** (Include proper time for Administering)	**Stop**
Prozac 20mg	20mg	by mouth	one by mouth every morning	
Metformin 1000mg	1000mg	by mouth	one by mouth twice a day	
Novolin N 100	30units	SQ	inject 30units SQ every Morning	
Novolin N 100	20units	SQ	inject 20units SQ every evening	
Novolin R 100	Per Sliding Scale	SQ	inject SQ twice daily per sliding scale	
Accucheck BID with			151-200= 3units	
Regular Ins. Sliding			201-250= 6units	
Scale Coverage*			251-300= 9units	
			301-350= 12units	
			351-400= 14units	
			>400 call MD	

Additional Comments:

III. SPECIAL NEEDS AFFECTING TRANSPORTATION

Is prisoner medically able to travel by BUS, VAN or CAR? ☒ Yes ☐ No If no, Why not?

Is prisoner medically able to travel by airplane? ☒ Yes ☐ No If no, Why not?

Is prisoner medically able to stay overnight at another facility en route to destination? ☒ Yes ☐ No If no, Why not?

Is there any medical reason for restricting the length of time prisoner can be in travel status? ☐ Yes ☒ No If yes, state reason:

Does prisoner require any medical equipment while in transport status? ☐ Yes ☒ No If yes, What equipment?

Sign & Print Name- Certifying Health Authority: Rosetta Smith LPN

Rosetta Smith LPN

Phone Number: (919) 245-2946

Date Signed: 11-6-14

Yellow (original) - Upon Transfer

Form USM-553

Southern Health Partners

Inmate Name:

DOB or ID#: Hill, Brian 5/24/90

Allergies: Geodon

Start at top and write Subsequent orders below

Date of Physician's Order	
1 10-1-14 Noted 10-1-14	Regular insulin Sliding Scale BID x 90 days 151-200=3u 301-350=12u 201-250=6u 351-400=14u 251-300=9u >400 call MD/UA Prozac 20mg Po q AM x 90 days -Dr. Davis/M. Kitchens LPN 10/1/14 MK
2 10-10-14 Noted 10-10-14	CTM 4mg Po BID x 5 days -Dr. Davis/M. Kitchens LPN 10/14/14
3 10-14-14 Noted 10-14-14	Guaifenesin 200mg (2) po BID x 5 days -Dr. Davis/M. Kitchens LPN 10/14/14
4 10/21/14 noted 10.22-14	metformin 500 po BID x 90 day Hg A1c in 3 month Davis
5 10/28/14 noted 10/29/14 (8)	D/C metformin metformin 1000 po BID x 90 day Davis
6	D/C NPH insulin NPH 30 units SQ @ am and 25 units SQ @ pm cont regular insulin SS Davis

Southern Health Partners
Your Partner in Affordable Inmate Healthcare

Inmate Name: ______
DOB or ID#: Hill, Brian 5/26/90
Allergies: NKDA

Start at top and write
Subsequent orders below

Date of Physician's Order:	
1 5-14-14 Noted 5-14-14	① Ziprasidone 20 mg Cap Po q Hs x 90 days ② insulin ® SQ 7 units TID x 90 days ③ NPH insulin 30u SQ q Am x 90 days ④ NPH 18 units SQ q Pm x 90 days ⑤ Prozac 20mg PO q Am x 14 days (then)
2	⑥ Prozac 40 mg PO q Am x 90 days Dr Davis / Kay [illegible] RN [signature] 5/26/14
3 5/26/14	Base line EKG in one month [signature]
4 5-26-14 Noted 5-26-14	CTM 4mg PO BID x 14 days Dr Davis / Kay [illegible] RN [signature] 5/27/14
5 5/27/14 Noted 5/28/14	[illegible] SS insulin reg to start @ BS greater than 200 [signature]
6 regular 9-30-14	NPH insulin 30 unit SQ @ Am NPH insulin 20 unit SQ @ pm SS insulin 14 units now cover c̄ SS insulin BID

[signature] Davis

ORANGE CO JAIL
HILL, BRIAN DAVID
REPORT DATE : 11/14

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
NOVOLIN N 100 UNITS/ML VI INJECT (30) UNITS SUB-Q EVERY MORNING AND (20) UNITS IN THE EVENING x90 days 10-1-14	10/01/15 AM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	PM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
NOVOLIN R 100 UNITS/ML VI INJECT SUB-Q TWICE DAILY PER SLIDING SCALE 151-200 = 3u 201-250 = 6u	10/01/15 AM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	AMT	1	2	[illegible]	[illegible]	[illegible]	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
251-300 = 9u 301-350 = 12u 351-400 = 14u >400 call MD 10-1-14	PM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	AMT	1	2	3	12	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Prozac 20mg PO q AM x 90 days 10-1-14	AM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
metformin 500mg PO BID x 90 days 10-22-14 (D/C)	AM	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	PM	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
HgA1C in 3 months 10-22-14		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Metformin 1000mg PO BID x90 days 10/28/14	AM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	PM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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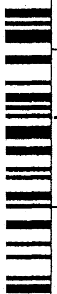
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31



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CHARTING FOR 11/01/14 THROUGH 11/30/14 PAGE 1 OF 1

Physician: DAVIS, ARTHUR
Telephone No.:
Medical Record No.:
Alt. Physician:
Alt. Telephone:
Allergies: GEODON
Rehabilitative Potential:
Diagnosis:

Medicaid Number: | Medicare Number: | Complete Entries Checked By: B. Carther | Title: RN | Date: 10/28/14

RESIDENT: HILL, BRIAN DAVID | D.O.B. 05/26/1990 | Sex: | Room #: J | Patient Code: HILLBRIAB | Admission Date: 10/01/14

Southern Health Partners
Your Partner in Affordable Inmate Healthcare

BLOOD SUGAR FLOW SHEET

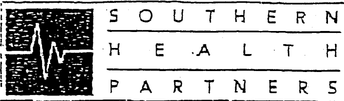
Inmate's Name: Hill, Brian   Site: 7212 Orange Co Jail

I.D.#/S.S.#: ______ DOB: 5/26/90   Physician: DAVIS

Physician Order/Instructions: BSFS √ BID 30u NPH q AM 20u NPH q PM   Have M.D. review findings upon next on-site visit

BLOOD SUGAR INFO: Blood sugar tests check for conditions such as hypoglycemia (low blood sugar), pre-diabetes, and diabetes. Common tests include a fasting blood sugar which is no eating or drinking for at least 8 hours prior to testing. Blood Sugar tests less than 110 is considered normal. Follow physician orders/instructions for BS numbers which are higher or lower than normal. ***If insulin is given due to high numbers, or intervention is used for low numbers, then recheck BS within 30 minutes and document appropriately.***

DATE	TIME	BLOOD SUGAR	AMOUNT INSULIN GIVEN	INITIAL	DATE	TIME	BLOOD SUGAR	AMOUNT INSULIN GIVEN	INITIAL
10/22/14	0800	373	30u NPH 14u R	BC	10/31/14	5p	218	6u Reg 20u NPH	[illegible]
10/22/14	1700	402	20u NPH 14u R	BC	11/1/14	930A	369	14u Reg 30u NPH	[illegible]
10/23/14	0800	398	30u NPH 14u R	[illegible]	11/1/14	330p	138	20u NPH	[illegible]
10/23/14	1600	248	20u NPH 6u R	[illegible]	11/2/14	9A	382	30u NPH 14u Reg	[illegible]
10/24/14	0900	364	30u NPH 14u Reg	TB	11/2/14	3:30 pm	105	20u NPH	[illegible]
10/24/14	1800	286	20u NPH 9u R	SL	11/4/14	8:15 Am	368	30u NPH 14u Reg	JP
10/25/14	[illegible]	340	30u NP	LS	~~11/4/14~~			11/4/14	JP
10/25/14	1730	328	20u NPH 9u R	LS	11/4/14	5pm	331	20u NPH 14u Reg	JP
10/26/14	0715	328	30u NPH 12u R	HW	11/5/14	9:30	400	30u NPH 14u Reg	[illegible]
10/26/14	1730	400	20 NPH 14u R	HW	11/5/14	5p	336	20u NPH 12u Reg	[illegible]
10/27/14	0800	284	30 NPH 9u R	BC	11/6/14	8:40 A	216	6u Reg 30u NPH	[illegible]
10/27/14	1800	245	20u NPH 6u R	BC	11/6/14	5p	227	6u Reg 20u NPH	[illegible]
10/28/14	0800	294	30u NPH 9u R	BC	IM released				
10/28/14	1700	295	20 NPH 9u R	[illegible]				11/ /	
10/28/14									
10/29/14	0730	375	30u NPH 14u R	SL					
10/29/14	1730	345	20u NPH 14u R	SL					
10/30/14	0730	272	30u NPH 9u R	JP					
10/30/14	5:05 pm	351	20u NPH 14u R	JP					
10/31/14	0900	287	30u NPH 9u Reg	[illegible]					



BLOOD SUGAR FLOW SHEET

Inmate's Name: Hill, Brian Site: 7212 Orange Co. Jail

I.D.#/S.S.#: DOB: 5-26 90 Physician: Davis

Physician Order/Instructions: BSFs ✓ BID, 30uNPHqAM 20uNPHqPM c̄ SSI coverage >200 Have M.D. review findings

DATE	TIME	BLOOD SUGAR	AMOUNT INSULIN GIVEN	INITIAL	DATE	TIME	BLOOD SUGAR	AMOUNT INSULIN GIVEN	INITIAL
10-1-14	0800	471	30u NPH 14u RSS	MK	10-10-14	1600	225	20u NPH 6u RSS	MK
10-1-14	1030	372	∅	MK	10-11-14	8am	395	30u NPH 14u R	MK
10-1-14	12p	300	∅	MK	10-11-14	5p	149	20u NPH	MK
10-1-14	1600	274	20u NPH 9u R	MK	10-12-14	8a	338	30u NPH 12u RSS	MK
10-2-14	0730	359	30u NPH 14u R	MK	10-12-14	1430	59	glucose tab crackers	MK
10-2-14	12p	108	∅	MK	10-12-14	1700	179	20u NPH 3u R	MK
10-2-14	1730	180	20u NPH 3u Rss	MK	10/13/14	8a	447	30u NPH 14u Reg	BC
10-3-14	0730	417	30u NPH 14u R	BC	10/13/14	4p	379	20u NPH 14u Reg	BC
10-3-14	400pm	278	20u NPH 9u R	BC	10-14-14	8a	236	30u NPH 6u R	MK
10/4/14	0730	381	30u NPH 14u R	SL	10-14-14	1700	375	20u NPH 14u RSS	MK
10/4/14	1145	52	sandwich glucose tabs	SL	10/14/14				
10/4/14	1745	333	12u R 20u NPH	SL	10-15-14	0730	350	30u NPH 12u R	MK
10/5/14	0730	278	9u R 30u NPH	SL	10-15-14	1730	300	20u NPH 9u R	MK
10/5/14	1730	257	9u R 20u NPH	[illegible]	10-16-14	0800	347	30u NPH 14u R	BC
10/6/14	0800	183	3u Reg 30u NPH	BC	10-16-14	1700	391	20u NPH 14u R	BC
10/6/14	5:41pm	366	14u Reg 20u NPH	BC	10-17-14	0800	325	30u NPH 12u R	BC
10/7/14	0800	225	6u Reg 30u NPH	BC	10-17-14	1700	84	20u NPH	BC
10/7/14	600pm	272	9u Reg 20u NPH	BC	10/18/14	0730	212	30u NPH	SL
10-8-14	0800	310	30u NPH 12u RSS	MK	10/18/14	1630	331	12u R 20u NPH	SL
10-8-14	1500	52	glucose tab crackers	MK	10/19/14	0730	376	30u NPH 14u R	SL
10-8-14	1730	323	20u NPH 12u RSS	MK	10/19/14	1730	409	20u NPH 14u R	SL
10/9/14	0800	341	30u NPH 12u Reg	BC	10/20/14	0800	283	30u NPH 9u R	BC
10/9/14	400pm	367	20u NPH 14u Reg	BC	10/20/14	1730	440	20u NPH 14u R	BC
10-10-14	8am	336	30u NPH 12u RSS	MK	10/21/14	0800	272	30u NPH 9u R	BC
10-10-14	11am	75	∅	MK	10/21/14	1700	347	20u NPH 12u R	BC

Southern Health Partners, Inc. CONFIDENTIAL MEDICAL INFORMATION

SHP Form 12/06

PROGRESS NOTES

Date/Time	Inmate's Name: Brian Hill D.O.B.: 5/26/90 Allergies: Geodon
10/30/14 7:00pm FED	PSYCH NOTE: Pt. seen 1:1. Stated "basically things way a lot better." Cheerful mood & affect. Explained he was moved to a smaller pod due to another inmate bullying. Denied H/SI/SIB urges or mental health problems. Eating 100% meals, sleeping 8-10 hrs. day. Grooming & hygiene are adequate. Sentencing is next week Friday. & hopes for time served & "supervised release". Talk some about hopefulness of his case. Logical, linear speech w/o signs of delusional themes. No attending/responding to internal stimuli & denies. Tolerating medication well w/no side effects. F-up: 3 weeks PSC
11/7/14 0800	IM released - Fed. B. Cartner RN

m Health Partners, Inc.
DENTIAL MEDICAL INFORMATION

Please print legibly.

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR
Prozac 20mg po q Am x 90 days. (10-1-14)	Am
NPH insulin 30u sq q Am x 90 days. (10-1-14)	Am
NPH insulin 20units sq q Pm x 90 days. (10-1-14)	Pm
Reg insulin sliding scale To start BS > 200, BID 151-200=3u 201-250=6u	Am AMT
251-300=9u 301-350=12u 351-400=14u >400 Call MD	Pm AMT
CTM 4mg po BID x 7 days. (10-10-14)	Am Pm
Guaifenesin 200mg (2) po BID x 5 days (10-14-14)	Am Pm
Metformin 500mg po BID x 90 days. 10-22-14	AM PM
HG A1C in 3 months 10-22-14	

STOCK # 506461

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FORM A55, A76, A81

50_276617

REV. 9/12

CHARTING FOR 10-1-14 THROUGH 10-30-14

Physician Davis

Alt. Physician

Telephone No.

Alt. Telephone

Medical Record No.

Allergies Geodon

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: M. Kitchens Title: LPN Date: 10-7-14

RESIDENT Hill, Brian

D.O.B. 5-26-90

Sex M

Room # Small

Patient Code

Admission Date

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Metformin 1000mg PO BID x90days																																
	Am	~~1~~	~~2~~	~~3~~	~~4~~	~~5~~	~~6~~	~~7~~	~~8~~	~~9~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	~~23~~	~~24~~	~~25~~	~~26~~	~~27~~	~~28~~ →	[illegible]	[illegible]	[illegible]
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	PM	~~1~~	~~2~~	~~3~~	~~4~~	~~5~~	~~6~~	~~7~~	~~8~~	~~9~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	~~23~~	~~24~~	~~25~~	~~26~~	~~27~~	~~28~~ →	8 [illegible]	[illegible]	[illegible]
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FORM A55, A76, A81

50_276617

REV 9/12

HARTING FOR: 10/29/14 THROUGH: 10/31/14

hysician: Davis

Telephone No.:

Medical Record No.:

lt. Physician:

Alt. Telephone:

llergies: Geodon

Rehabilitative Potential:

iagnosis:

Medicaid Number	Medicare Number	Complete Entries Checked By: [signature]	Title: LPN	Date: 10/29/14

RESIDENT	Hill, Brian	D.O.B.	Sex M	Room # B	Patient Code	Admission Date

Report Status: Final

HILL, BRIAN

Patient Information	Specimen Information	Client Information
HILL, BRIAN **DOB: 05/26/1990** **AGE: 24** Gender: M Fasting: N Phone: NG Patient ID: NG	Specimen: AL714555B Requisition: 8763591 Collected: 10/16/2014 / 09:00 EDT Received: 10/18/2014 / 08:21 EDT Reported: 10/20/2014 / 12:51 EDT	Client #: 97508677 MAIL992 DOSHI, VASZNT SHP-ORANGE COUNTY JAIL 125 COURT ST HILLSBOROUGH, NC 27278-2510

Test Name	In Range	Out Of Range	Reference Range	Lab
HEMOGLOBIN A1c		8.8 H	<5.7 % of total Hgb	AT

According to ADA guidelines, hemoglobin A1c <7.0% represents optimal control in non-pregnant diabetic patients. Different metrics may apply to specific patient populations. Standards of Medical Care in Diabetes-2013. Diabetes Care. 2013;36:s11-s66

For the purpose of screening for the presence of diabetes

<5.7%	Consistent with the absence of diabetes
5.7-6.4%	Consistent with increased risk for diabetes (prediabetes)
>or=6.5%	Consistent with diabetes

This assay result is consistent with diabetes mellitus.

Currently, no consensus exists for use of hemoglobin A1c for diagnosis of diabetes for children.

PERFORMING SITE:

AT QUEST DIAGNOSTICS-ATLANTA, 1777 MONTREAL CIRCLE, TUCKER, GA 30084-6802 Laboratory Director: WILLIAM M MILLER, MD, CLIA: 11D0255931

10/21/17

DA ((

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Southern Health Partners, Inc.
Clinical Pathways / Patient Clinical Data Form

Southern Health Partners
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UPPER RESPIRATORY SYMPTOMS

Instructions: Upon patient's complaint(s), please complete the form in its entirety. Refer to the Treatment Guidelines Manual for further implementation, or feel free to contact your site physician for orders as needed. The completed form should be placed in the medical chart for future reference and/or review by the site physician.

Patient's Name: Hill, Brian DOB 5-26-90

Onset of Symptoms 1 week Duration ongoing
Runny nose? Yes___ No ✓ Nasal Congestion? Yes ✓ No___ Drainage? Yes ✓ No___
Cough Present? Yes ✓ No___ Dry? Yes___ No ✓ Productive? Yes ✓ No___
Secretions? Clear___ Green___ (Yellow) ✓ Brown___ With Blood N (Thick) or Thin?
Coughing up secretions frequently? Yes ✓ No___ Certain times of the day? When___
Earache N Sore Throat reported Facial Pain___ Headache Y Neck Pain N
Describe the pain___
Level of Pain (1-10)___ Is there pain when leaning forward?___
Shortness of Breath N Sweats N Drainage in throat Y
Have you had this problem before yes If YES, what was the cause and how was it treated? antibiotics or cough suppresant
Are you taking any medications___
Any allergies Geodon
Further comments___

CLINICAL DATA: B/P 100/70 Pulse 72 RESP 16 Temp 98.0 98%
Skin: Warm ✓ Dry ✓ Hot___ Cool___ Clammy___ Moist___
Color: Race appropriate ✓ Pale___ Flushed___ Jaundice___ Ashen___
Respirations: Non-labored ✓ Labored___ Orthopnea___
Lung sounds: (R) clear ✓ Wheezing___ Crackles___ Ronchi___
(L) clear ✓ Wheezing___ Crackles___ Ronchi___
Pain upon palpation of sinuses? Y Location___
Throat reddened N Tonsils swollen N
Exudate noted NO (if yes) Describe___
Glands swollen N Tender Y (if yes) Location___
Pain with neck movement N
Can coughing be reproduced with deep breath___
If sputum specimen available, describe Agree with above?___

TREATMENT PLAN: Fever___ Nasal Congestion___ Cough ✓
Follow tx protocol___
If no, describe plan___

Ø Temp
Ø swollen glands
Ø drainage / Redness noted

Physician's Order: Guaifenesin 200mg (2) po BID x 5 days
Inmate advised to alert staff of changes and/or improvement: Yes ✓ No___
Patient education information supplied and/or discussed? Yes ✓ No___

Medical Signature: M. Kitchens LPN Date: 10-14-14

[signature] 10/14/1[illegible]

MEDICAL HISTORY

Problems	Yes	No	Problems	Yes	No	Problems	Yes	No
Balance/Dizziness			Stomach Pain		✓	Gonorrhea		✓
Blackouts			Heartburn	✓		Syphilis		✓
DT's/Withdrawal		✓	Ulcer		✓	Muscle Problem		✓
Headaches			Nausea/Vomiting	✓		Joint Problem		✓
Seizures		✓	Gall Bladder		✓	Arthritis		✓
Nervous Disorder		✓	Liver		✓	FOR FEMALES ONLY:		
Asthma		✓	Hepatitis		✓	Regular Menstrual Period		
Hay Fever		✓	Diabetes	✓		Irregular Menstrual Period		
Pneumonia		✓	Kidney Disease		✓	# of days Menstrual Period	Male	
Tuberculosis		✓	Bladder Infection		✓	LMP		
Heart		✓	Trouble Voiding		✓	Gravida/Para		
Hypertension		✓	Pediculi (lice)		✓	Last Pap		
Anemia /Blood		✓				Contraception		

Height	Weight	Pulse	BP	Temp	Resp	O2 Sat
5' 10"	150	70	100/62	96.9	14	98

MEDICAL STAFF PHYSICAL ASSESSMENT – Ask Patient if any problem areas:

Area/Type	ASSESSMENT NOTES	Area/Type	ASSESSMENT NOTES
Skin: Color, Condition, Turgor, Recent Inj.	Good skin turgor w/D race appropriate	Chest (Breasts): Configuration, Auscultation, Respirations, Cough/Sputum	= Rise/fall bilateral Normal Resp Ø cough
Head: Glasses, Pupils, Sclera, Conjunctiva, Vision	prescribed glasses good vision moist conjunctiva	Heart: Auscultation, Radial pulses, Apical pulse, Rhythm	~~= Rise~~ Normal rate rythm strong pulses
Neuro: Pupils, EOM, Orientation	Perla Eom	Extremities: Pulses, Edema, Joints	+ Rom + Pulses x4
Ears: Appearance, Canals, Hearing	Ø drainage clear	Spine	Ø Curvature
Mouth: Teeth/Gums, Dentures, Plates, Throat, Tongue, Tonsils	moist mucosa Ø swelling	Abdomen: Shape, Palpation, Hernia, Bowel sounds	Soft/Non tender
Nose	Ø drainage	Genital/Urinary:	No problems reported
Neck: Veins, Mobility, Thyroid, Carotids, Lymph nodes	– JVD Ø Swollen Lymph.		

LABORATORY TESTS

	Date & Initial	Results
TB Screening Done?	Clear - See	Fed Log
VDRL / RPR	N/A	
Pregnancy Test?	Male	
HGB A1C?	Ordered	BG = 395
Drug Levels Drawn: ex. Lithium/Dilantin	N/A	

MENTAL HEALTH OBSERVATION

	N	A/Comment
General appearance (motor behavior, mannerisms):		good well mannered, Calm
Affect (mood)		Calm
Content of thought		good
History of suicide; present thoughts of suicide		No

PATIENT REFERRAL BASED ON INFO (circle that apply): MD DENTIST (MENTAL HEALTH)

CHRONIC CARE: Based on H&P, is patient to be added to Chronic Care List: Y or (N)

Initial here after patient has been added to Chronic Care listing:________

Physical Examiner's Signature: M. Kitchen LPN Date: 10-11-14

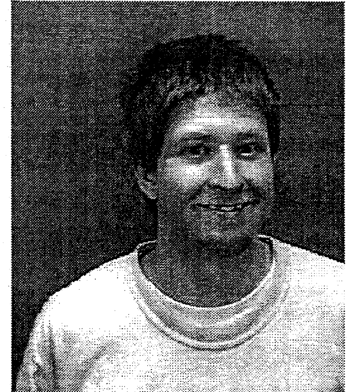
Physician's Signature: [signature] Date: 10/14/14

User: LTHOMPSON, | ORANGE COUNTY SHERIFF`S OFF | 09/30/2014 18:58

BOOKING REPORT

Booking #		Status
47532		Active

Date/Time	Cell Location
09/30/2014 18:40	OCJ, OLD JAIL, SM HOLDING, 2
Booking Officer: THOMPSON, L. C. (7280)	Name ID: 238306
Fingerprint Officer: (0)	Prior Bookings: None, 46284
Search Officer: HINKLE, J. W. (9251)	
Fingerprint	Security: FED
Property Bins: GL 124	



INMATE INFORMATION

Name	Local ID	
HILL, BRIAN DAVID		
Address: 916 CHALMERS ST MARTINSVILLE, VA 24112	Race: W Hair: BLO	Sex: M Eye: BLU

DOB	Age	Height	Weight
05/26/1990	24	6'00	153

SSN	Marital Status	Time Lived In Area
000-00-0000	Single, 0 Dependents	0 Yr

Local ID	SID	FBI #	

Juvenile	Country of Birth	Citizenship
	United States Of America	United States Of America

Employer	Religion
Employer Address	Employer Phone #: n/a
Attorney: Federal Public Defender	Attorney Phone #: 919-828-4620
AKA	
Alerts	

CHARGES

Case ID	Date Arrested	Officer	Agency	Charge	UCR	Charge: Type	Status	Bond: Amount	Status	Type
	09/30/2014	Fredricks	USM	HOLD FOR FED	99AA	F	FEDE		TRAN	NOBD

NOTES

USM#29947-057

(+) Screen

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Southern Health Partners, Inc.
Clinical Pathways / Patient Clinical Data Form

UPPER RESPIRATORY SYMPTOMS

Instructions: Upon patient's complaint(s), please complete the form in its entirety. Refer to the Treatment Guidelines Manual for further implementation, or feel free to contact your site physician for orders as needed. The completed form should be placed in the medical chart for future reference and/or review by the site physician.

Patient's Name: Hill, ~~Briand~~ Brian DOB 5-26-90

Onset of Symptoms 3 days Duration Ongoing
Runny nose? Yes ✓ No ___ Nasal Congestion? Yes ✓ No ___ Drainage? Yes ✓ No ___
Cough Present? Yes ✓ No ___ Dry? Yes ✓ No ___ Productive? Yes ___ No ___
Secretions? Clear ___ Green ___ Yellow ___ Brown ___ With Blood ___ Thick or (Thin?)
Coughing up secretions frequently? Yes ___ No ___ Certain times of the day? When ___
Earache N Sore Throat ✓ Facial Pain N Headache Y Neck Pain N
Describe the pain ___
Level of Pain (1-10) ___ Is there pain when leaning forward? ___
Shortness of Breath N Sweats ___ Drainage in throat N
Have you had this problem before Y If YES, what was the cause and how was it treated? Cold, antibiotics
Are you taking any medications yes. prozac 20mg
Any allergies Geodon
Further comments Low Bp Both arms, Pale No diaphresis

CLINICAL DATA: B/P 88/60 Pulse 88 RESP 14 Temp 95.6 99%
Skin: Warm ✓ Dry ✓ Hot ___ Cool ___ Clammy ___ Moist ___
Color: Race appropriate ✓ Pale ___ Flushed ___ Jaundice ___ Ashen ___
Respirations: Non-labored ✓ Labored ___ Orthopnea ___
Lung sounds: (R) clear ✓ Wheezing ___ Crackles ___ Ronchi ___ ∅ N/V
(L) clear ✓ Wheezing ___ Crackles ___ Ronchi ___
Pain upon palpation of sinuses? ___ Location ___
Throat reddened N Tonsils swollen N
Exudate noted None (if yes) Describe ___
Glands swollen N Tender ___ (if yes) Location ___
Pain with neck movement No
Can coughing be reproduced with deep breath ___
If sputum specimen available, describe Agree with above? ___
BG=75

TREATMENT PLAN: Fever ___ Nasal Congestion ✓ Cough ___
Follow tx protocol ✓
If no, describe plan encourage fluids
will monitor VS
Physician's Order: CTM 4mg Po BID x 5 days
Inmate advised to alert staff of changes and/or improvement: Yes ✓ No ___
Patient education information supplied and/or discussed? Yes ✓ No ___

Medical Signature: M. Kitchens LPN Date: 10-10-14

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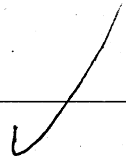


INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 10/09/2014 Pod/Location: Old Jail Cell: SM/HC ID# 238306

Inmate's Full Name: Brian David Hill

Complaint/Problem: I have had coughing throat is sore, a lot of mucas in my throat, sometimes my nose wants to run.

How long have you had this problem? A few days

Inmate's Signature: Brian David Hill Brian D. Hill Date: Oct. 9, 2014

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

TO BE COMPLETED BY MEDICAL STAFF:

- ☐ *See Clinical Pathway for Documentation/Response*
- ☐ *See Physician Order for Response to this Sick Call*
- ☐ *See Progress Note for Response to this Sick Call*
- ☐ *See Below for Response to this Sick Call*

Nurse's Signature/Date: M. Kitchens LPN

Rec'd 10-10

Document Patient's Vital Signs: Temp____ Resp____ Pulse____ B/P____

Instructions/Assessment: Document your findings, Inmate's responses/actions

See Pathways – Upper Resp

- ☑ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
- ☐ Follow-Up Required? If checked, date to be seen again____
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit (MK)

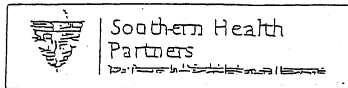
Date Seen by Medical: 10-10-14 Seen by: M. Kitchens LPN

Place original form in patient's medical record. SHP Form 12/06/Updated 6/2009

PROGRESS NOTES

Date/Time	Inmate's Name: Hill, Brian D.O.B. 5-26-90 Allergies: Geodon
10-8-14	Called to Small Hold By officer - inmate stated he felt
1500	like Bs was low - BG✓ = 52 - gave ① glucose tab and
	pack of peanut butter crackers, Evening meal will be served
	@ 3:30 pm, will recheck after meal - m. Kitchens LPN
10-10-14	Seen in medical for S/C - C/o sore throat, Nasal
11am	Congestion. No Redness noted ∅ Swelling, Lungs Clear
	No temp 95.6°F, inmate Pale, C/o dizziness blurred
	vision, checked BG = 75, Bp✓ 88/60 Both arms
	encouraged fluid ↑, gave water - no c/o nausea/vomiting
	or sweating at this time. Called MD alerted to Low Bp
	MD verbalized to encourage fluid ↑ and monitor Bp q hr
	if inmate c/o N/V may need to send to ER - m. Kitchens LPN
1pm	Re-check Bp 90/62 - has good color in face
	no c/o dizziness. inmate stated feeling better, continue
	to give fluids, will recheck in pm - m. kitchens LPN
1900	Gave fluids throughout the day - Re-checked Bp @ 1830
	98/66 - good cap refill / good coloring in face - No c/o
	N/V or dizziness tonight - m. Kitchens LPN
10-11-14	physical done today - will order Hg/A1C to be done
8am	this week. Bp✓ 100/62 - continue encouraging fluids
	inmate agree's, started CTM for allergies - m. kitchens LPN
10-12-14	IM moved to G-cell - Checked Bp today 100/66 encouraged
	IM to continue w/ fluid replacement - He agreed. Good cap-refill
	and coloring in face - No c/o N/V or dizziness - m. Kitchens LPN
1430	Called to G-cell - IM reported ↓ BG BSFS✓ = 59 - gave
	glucose tab and crackers will recheck in 1 hour - m. Kitchens LPN
~~10/15/14~~	~~PSYCH NOTE: Seen [illegible]~~
6:45pm	
10/16/14	IM to medical for Lab draw (HgA1C).
0900	called Quest @ 0945 for pick-up.
	B. Carthen, RN

Please print legibly.



MEDICAL STAFF RECEIVING SCREENING FORM

LAST NAME	FIRST NAME	MIDDLE	BOOKING DATE	SCREENING DATE	TIME AM/PM
Hill	Brian		9-30-14	10-1-14	1030am

PREVIOUS INCARCERATIONS:	SEX	SOCIAL SECURITY NO.	DOB
OCJ 5/2014	M		5-26-90

CURRENT INSURANCE COVERAGES? CURRENTLY UNDER PHYSICIAN'S CARE FOR CHRONIC CONDITION:

VISUAL / MEDICAL OBSERVATION: *(Explain all "Yes" Answers)* Circle Y or N:	YES	NO
Is inmate unconscious or showing visible signs of illness, injury, bleeding, pain, or other symptoms suggesting the need for immediate emergency medical referral? If yes:	Y	(N)
Are there any visible signs of fever, jaundice, skin lesions, rash, or infection: cuts, bruises, or minor injuries; needle marks, body vermin? If yes:	Y	(N)
Does the inmate exhibit any signs that suggest the risk of suicide, assault, or abnormal behavior? If yes:	Y	(N)
Does the inmate appear to be under the influence of, or withdrawing from drugs or alcohol? If yes:	Y	(N)
Is the inmate's mobility restricted in any way due to deformity, cast, injury, etc. If yes:	Y	(N)
ASK THE INMATE THESE QUESTIONS: *(Explain all "Yes" answers)*		
Have you had or been treated for: (circle as appropriate) asthma, diabetes, epilepsy, heart condition, high blood pressure, mental health problems, seizures, ulcers, or other conditions? Other: DMI, Autism, OCD	(Y)	N
Have you taken or are you taking any medication(s) prescribed for you by a physician? If yes: NPH, ®SS Prozac	(Y)	N
Are you allergic to any medications, foods, plants, etc.? If yes: Geodon,	(Y)	N
Have you fainted or had a head injury within the last 72 hours? If yes:	Y	(N)
Do you have or have you been exposed to AIDS, hepatitis, TB, VD, or other communicable disease? For TB, ask if he/she has had night sweats; had weight loss recently; persistent coughing. If yes: TB Cleared See Fed Log	(Y)	N
Have you been hospitalized by a physician or psychiatrist within the last year? If yes: Martinsville Mem Hosp Dec 2013 mental Health	(Y)	N
Have you ever considered or attempted suicide? If yes:	Y	(N)
Do you have a painful dental condition? If yes:	Y	(N)
Are you on a specific diet prescribed by a physician? If yes:	Y	(N)
Do you use drugs? How often? Last time? What kind? How much?	Y	(N)
Do you use alcohol? How often? Last time? What kind? How much?	Y	(N)
Females: LMP Date:______ Are you pregnant, recently delivered or aborted; on birth control pills; having abdominal pain or discharge? If yes:	Y	(N)

DOCUMENT VITAL SIGNS:

Respiration:	O2 Sat	Pulse:	Temperature:	Blood Pressure:	Weight:
14	98	88	98.6	110/78	~~153~~ 140

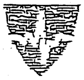
PPD IMPLANTED? __Y__ OR __N__ HAVE ALL CONCERNS FROM OFFICER INTAKE AND ABOVE ANSWERS BEEN EXPLAINED ABOVE?

REMARKS: BG= 471@ 0800 30u NPH 14u ®SS
BG= 372@ 10:30

I have answered all questions truthfully, I have been told and shown how to obtain medical services and advised on how to obtain medication upon release. I hereby give my consent for professional services to be provided to me by and through Southern Health Partners, Inc. Further, I release Southern Health Partners, Inc., its staff, the County, the Sheriff, Jailer, and his/her staff from all responsibility and I assume personal responsibility for the conditions that may occur as a result of my not requesting services and/or refusing treatment as prescribed by the medical staff of the facility and/or outside consultation services.

Inmate's Signature: Brian D. Hill Date: 10/1/14

Interviewer's Signature and Title: M. Kitchens LPN Date: 10-1-14



Southern Health Partners
Your Partner In Affordable Inmate Healthcare

PATIENT'S CONSENT FOR TREATMENT

The undersigned, being in the custody of the County Jail, hereby authorize and request that all medical records and/or information, wherever located, including any hospital or medical doctor or any other place where medical records may be located, be released to the County Jail medical department for use by the medical department regarding any treatment to be reviewed while in custody. I understand I will provide this information to the medical department.

I further authorize the County Jail medical department to evaluate and treat any condition that I may have or develop while in the custody of the County Jail. My signature below provides consent for medical photographs to be made of me. I understand that the photographs and information may be used in my medical record for the purposes of documentation and/or treatment. I acknowledge no guarantee or assurance has been made as to the desired result that may be obtained.

I have been made aware of how to request medical services while incarcerated, and am aware I have the right to refuse treatment. I may be required to sign a Refusal of Treatment form should I refuse medical treatments and/or medications.

I release Southern Health Partners, Inc., its staff, the County, the Sheriff (where applicable), his/her staff from all responsibility and I assume personal responsibility for the conditions that may occur as a result of my not requesting services and/or refusing treatment as prescribed by the medical staff of the facility and/or outside consultation services.

Patient's Signature: Brian D. Hill Date: 10/1/14

Printed Name: Brian Hill Patient's DOB: 5-26-90

Witness: ______________________ (Officer Signature)

Note: This completed form must be given to the medical department for inclusion in the inmate's confidential medical file.

SHP Form 12/06; Updated January 2014

MEDICAL SUMMARY OF FEDERAL PRISONER/ ALIEN IN TRANSIT

U.S. Department of Justice

TB Clearance ☑ Yes ☐ No

1) PPD Completed: 2-9-14 Date

Results: 0 mm

2) CXR Completed: / Date

Results: /

3) Health Authority Clearance: ____

Sign Date

Note: Dates listed above must be within one year of this transfer.

I. PRISONER/ALIEN

Name: Hill, Brian David

Prisoner/Alien Reg. #:

D.O.B: 5-26-90

Departed From:

Date Departed:

Destination:

Reason for Transfer:

Dist. Name:

Dist. #

Date in Custody:

II. Current Medical Problems

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Medication	Dose	Route	Medication Required For Care En Route Instructions For Use (Include proper time for Administering)	Stop

Additional Comments:

III. SPECIAL NEEDS AFFECTING TRANSPORTATION

Is prisoner medically able to travel by BUS, VAN or CAR? ☒ Yes ☐ No If no, Why not?

Is prisoner medically able to travel by airplane? ☒ Yes ☐ No If no, Why not?

Is prisoner medically able to stay overnight at another facility en route to destination? ☒ Yes ☐ No If no, Why not?

Is there any medical reason for restricting the length of time prisoner can be in travel status? ☐ Yes ☒ No If yes, state reason:

Does prisoner require any medical equipment while in transport status? ☐ Yes ☒ No If yes, What equipment?

Sign & Print Name- Certifying Health Authority: M. Kitchens LPN Orange Co. Jail

Phone Number: 919-245-2946

Date Signed: 5-14-14

SOUTHERN HEALTH PARTNERS

BLOOD SUGAR FLOW SHEET

Inmate's Name: Hill, Brian D Site: OCJ

I.D.#/S.S.#: ________ DOB: 5-26-90 Physician: Davis

Physician Order/Instructions: BSFs / TID Have M.D. review findings

DATE	TIME	BLOOD SUGAR	AMOUNT INSULIN GIVEN	INITIAL	DATE	TIME	BLOOD SUGAR	AMOUNT INSULIN GIVEN	INITIAL
5-14-14	1730	269	7u Reg 18u NPH	MK	5-23-14	11am	153	7uR	MK
5-15-14	0900	397	7u Reg 30u NPH	MK	5-23-14	1800	164	7uR 18u NPH	MK
5-15-14	12p	272	7uR	MK	5-24-14	06:30	108	30 NPH 7 R	KD
5-15-14	1800	300	7u Reg 18u NPH	MK	5-24-14	11:30	165	7 Reg	KD
5-16-14	08:15	219	7u Reg 30 NPH	KD	5-24-14	5:00	201	18 NPH 7 Reg	KD
5-16-14	12:30	167	7uR	KD	5-25-14	0730	440	7uR 30u NPH	MK
5-16-14					5-25-14	11a	331	7uR	MK
5/17/14	0810	237	13uR 30u NPH	SL	5-25-14	1630	108	7uR 18u NPH	MK
5/17/14	1130	65	7uR	SL	5-26-14	06:30	153	7u R 30 NPH	K
5/17/14	1800	382	21u R 18u NPH	SL	5-26-14	11:00	81	hold till lunch 7u R	KD
5/18/14	0800	295	16uR 30u NPH	SL	5-26-14	15:30	344	18 NPH 7 R	KD
5/18/14	1130	56	7uR	SL	5-27-14	06:45	161	30 NPH 7 Reg	KD
5/18/14	1700	100	7uR 18u NPH	SL	5-27-14	11:00	189	7 Reg	KD
5/19/14	07:00	253	30 NPH 7 R	KD	5-27-14	15:30	153	18 NPH R	KD
5/19/14	11:30	200	7R	KD	5-28-14	0730	159	7uR 30u NPH	MK
5/19/14	16:30	165	18 NPH 7 units	KD	5-28-14	11am	215	7uR	MK
5/20/14	0830	277	30 NPH 7u Reg	MK	5-28-14	1900	330	7uR 18u NPH	MK
5-20-14	12p	288	7u Reg	MK	5-29-14	0730	277	30 NPH 7uR	MK
5-21-14	0830	178	30u NPH 7uR	MK	5-29-14	11am	104	∅	MK
5-21-14	11a	336	7uR	MK	5-29-14	1430	108	∅	MK
5-21-14	1700	166	7uR 18u NPH	MK	5-29-14	4P	230	7uR	MK
5-22-14	6:30	148	30 NPH 7 R	KD	5-29-14	1900	336	7uR 18u NPH	MK
5-22-14	11:30	127	7unR	KD	5-30-14	6:30	397	30 NPH 14 R	KD
5-22-14	5pm	165	7R 18 NPH	KD	5-30-14	11:30	157	7unR	KD
5-23-14	0800	255	7uR 30u NPH	MK	5-30-14	01:30 pm	74	—	KD

5-30-14 17:30 157 — 18 NPH 7u Reg

Southern Health Partners, Inc. CONFIDENTIAL MEDICAL INFORMATION

SHP Form 12/06

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Reg insulin SS to																																
start @ BS greater		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
than 200.		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
151-200=3u		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
201-250=6u																																
251-300=9u		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
301-350=12u		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
351-400=14u																																
>400 call MD		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

STOCK # 506461

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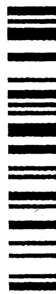

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FORM A55, A76, A81

50_273229

REV. 9/12

HARTING FOR 5-1-14 THROUGH 5-31-14

hysician Davis

t. Physician

Telephone No.

Alt. Telephone

Medical Record No.

lergies NKDA

Rehabilitative Potential

iagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: M. Kitchens Title: LPN Date 5-28-14

RESIDENT Hill, Brian

D.O.B. 5-26-90

Sex M

Room #

Patient Code

Admission Date

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Ziprasidone 20mg Cap PO q̄ HS x 90 days. (5-14-14)	PM																															
Insulin Reg 7units SQ TID x 90 days. (5-14-14)	Am Noon PM																															
NPH 30units SQ q̄ AM x 90 days. (5-14-14)	Am																															
NPH 18units SQ q̄ PM x 90 days. (5-14-14)	PM																															
Prozac 20mg PO q AM x 14days then 5-16-14	AM																															
Prozac 40mg PO q̄ Am x 90days 5-16-14	AM																															
EKG in 1 month 5-21-14																																
CTM 4mg PO BID x 14 days 5-26-14	AM PM																															
Hg. A1c ordered. (5-28-14)																																

CHARTING FOR 5-1-14 THROUGH 5-31-14

Physician: Davis

Alt. Physician:

Telephone No.:

Alt. Telephone:

Medical Record No.:

Allergies: NKDA

Rehabilitative Potential:

Diagnosis:

Medicaid Number:

Medicare Number:

Complete Entries Checked By: M. Kitchens Title: LPN Date: 5-14-14

RESIDENT: Hill, Brian

D.O.B.: 5-26-90

Sex: M

Room #:

Patient Code:

Admission Date:

STOCK # 506461
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FORM A55, A76, A81
50_273229
REV. 9/12

MEDICAL SUMMARY OF FEDERAL PRISONER/ ALIEN IN TRANSIT

U.S. Department of Justice

TB Clearance ☑ Yes ☐ No

1) PPD Completed: 6-9-14 (Date)

Results: ∅ MM

2) CXR Completed: ______ (Date)

Results:

3) Health Authority Clearance:

Sign ______ Date

Note: Dates listed above must be within one year of this transfer.

I. PRISONER/ALIEN

Name: Hill Brian

Prisoner/Alien Reg. #:

D.O.B. 5 26 94

Departed From:

Date Departed: 9 30 14

Destination:

Reason for Transfer:

District Name:

District #

Date in Custody:

II. CURRENT MEDICAL PROBLEMS

1. DM
2.
3.
4.
5.
6.

Medication	Dose	Route	Medication Required For Care En Route Instructions For Use (Include proper time for Administering)	Stop
Prozac	20mg	PO	[illegible] x 90 days	12 29 14
			CBG's BID AC meals & HS [illegible]	10 4 14
			[illegible] coverage x 90 days.	
70/30	30 units	SQ	AC meals x 90 days	10 4 14
70/30	4 units	SQ	4 HS x 90 days	10 4 14

Additional Comments:

III. SPECIAL NEEDS AFFECTING TRANSPORTATION

Is prisoner medically able to travel by BUS, VAN or CAR? ☑ Yes ☐ No If no, Why not?

Is prisoner medically able to travel by airplane? ☑ Yes ☐ No If no, Why not?

Is prisoner medically able to stay overnight at another facility en route to destination? ☑ Yes ☐ No If no, Why not?

Is there any medical reason for restricting the length of time prisoner can be in travel status? ☐ Yes ☑ No If yes, state reason:

Does prisoner require any medical equipment while in transport status? ☐ Yes ☑ No If yes, What equipment?

Sign & Print Name- Certifying Health Authority: [illegible signature]

Phone Number: 556 641 2856

Date Signed: 9 30 14

Form USM-553
Est. 6/98

Blue - Medical File at Jail

PROGRESS NOTES

Date/Time	Inmate's Name: Hill, Brian D.O.B. 3/26/94 Allergies: NKDA
800pm 9/30/14	Dr came and wrote orders for NPH and S/S insulin. Also a 1 time order of 14u regular for high Blood sugar. I/m told officer upon booking that blood sugar high. I checked BS and it read High. Dr wrote above orders. — B. Carther RN —
815pm 9/30/14	gave 14u regular insulin — B. Carther —
10-1-14 0820	BG=471 → 30u NPH 14u Ⓡ SS Per MD order Re-checked @ 10:30 BG=372 — M. Kitchens LPN —
10-1-14 6:30pm IN SMALL HOLDING	PSYCH NOTE: Pt. seen 1:1. Relayed legal difficulties & getting a new attorney. Meds started & denied any side effects of them - These were the same as @ Guilford County. Relayed having some anxiety about his case, "but I'm definitely not suicidal (smiles)." Eating 100% meals & sleeping 8 hrs. daily. No signs of psychosis @ this time w/ logical & linear speech, delusional themes absent. Denied having any difficulties in his cell. Grooming & hygiene good. Has no significant difficulties in presentation & smiling often. F-up: 2 weeks
10/15/14 7:00pm	PSYCH NOTE: Pt. seen 1:1. Tolerating medications w/ no side effects. Moved out of holding cell 3 days ago "it's pretty good." Denies any M.H. concerns other than some mild issues w/ other inmate of taunting that he reported to officers today. Veg. signs good. No signs of psychosis, mania, depression or anxiety in sx report or presentation. Denied HI/SI. Grooming/hygiene good. Family support is good & pt. cheerful in session - receptive to CBT - 2 weeks

HILL, BRIAN DAVID
W / M 05/26/1990 FED
BK# 47532 ID# 238306

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Prozac 40mg PO q̄ Am x 90 days	Am	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
5-16-14		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
CTM 4mg PO BID x 14 days	Am	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	Stop			12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
5-26-14	Pm	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
FSBS TID	Am	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Noon	[illegible]	[illegible]	[illegible]	(4)	[illegible]	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	PM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
NPH Insulin 30units SQ q̄ Am x 90 days	Am	[illegible]	2	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
5-14-14		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
NPH 18units SQ q̄ Pm x 90 days		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
5-14-14	PM	[illegible]	2	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Reg Insulin Reg 7units If < 200 TID x 90 days	AM	1	2	[illegible]	(4)	[illegible]	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Noo	1	2	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
5-14-14	PM	1	2	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Reg Insulin (SS) > 200 BG	Am	[illegible]	2	3	4	5	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
151-200 = 3un; 201-250 = 6un; 251-300 = 9un		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
301-350 = 12un; 351-400 = 14un	noon	[illegible]	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
> 400 call MD	Pm	[illegible]	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
EKG in 1 month		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
5-21-14		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Hg A1C ordered		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
5-28-14		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

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STOCK # 506461

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FORM A55, A76, A81

50_273229

REV. 9/12

CHARTING FOR 6-1-14 THROUGH 6-30-14

Physician: Days

Telephone No.

Medical Record No.

Alt. Physician

Alt. Telephone

Allergies: NKDA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: Kay Durham Title: RN Date: 6-1-14

RESIDENT: Hill, Brian

D.O.B. 5/26/90

Sex: M

Room #: holding

Patient Code

Admission Date

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Ziprasidone 20mg cap																																
① po q̄ Hs x 90days		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
(5-14-14)	PM	1	2	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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HARTING FOR 6-1-14 THROUGH 6-30-14

hysician Davis

Telephone No.

Medical Record No.

lt. Physician

Alt. Telephone

llergies NKDA

Rehabilitative Potential

iagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: M. Kitchens Title: LPN Date: 6-3-14

RESIDENT Hill, Brian

D.O.B. 5-26-90 Sex M Room # SM Hold Patient Code Admission Date

STOCK # 506461

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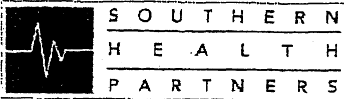
FORM A55, A76, A81

50_273229

REV. 9/12



BLOOD SUGAR FLOW SHEET

Inmate's Name: Hill, Brian   Site: OCJ

I.D.#/S.S.#: BSFS ✓ TID   DOB: 5-26-90   Physician: Davis

Physician Order/Instructions: ______   Have M.D. review findings

DATE	TIME	BLOOD SUGAR	AMOUNT INSULIN GIVEN	INITIAL	DATE	TIME	BLOOD SUGAR	AMOUNT INSULIN GIVEN	INITIAL
6-1-14	06:30	331	30 NPH 12 R	KD	6-8-14	11a	112	Ø	MK
6-1-14	11:30	259	9 Reg	KD	6-8-14	1800	213	18u NPH 7u R	MK
6-1-14	4:30pm	225	18 NPH 6 reg	KD	6-9-14	06:15	279	30 NPH 9 R	KD
6-2-14	06:20	336	30 NPH 12 Reg	KD	6-9-14	11:30	198	7 R	KD
6-2-14	11:35	252	9 Reg	KD	6-10-14				
6-2-14	6:30pm	256	18 NPH 9 Reg	KD					
6-3-14	0730	140	7u R 30u NPH	MK					
6-3-14	1130a	197	7u R	MK					
6-3-14	1830	269	7u R 18u NPH	MK					
6-4-14	0730	in court		MK					
6-4-14	12p	in court		MK					
6-4-14	3P	429	30u NPH 14u R	MK					
6-4-14	1730	288	7u R 18u NPH	MK					
6-5-14	0630	22	Ø	KD					
6-5-14	07:30	316	30 NPH 12 R	KD					
6-5-14	11:30	91	7 Reg	KD					
6-5-14	4:30	176	Ø	KD					
6-6-14	6:30	344	12u R 30u NPH	MK					
6-6-14	11am	136	7u R	MK					
6-6-14	1630	127	Ø	MK					
6-6-14	1900	289	7u R 18u NPH	MK					
6-7-14	0630	214	30 NPH 6 R	KD					
6-7-14	1130	186	7 R	KD					
6-7-14	4:30pm	256	18 NPH 9 R	KD					
6-8-14	0730	353	30u NPH 12u R SS	MK					

Southern Health Partners, Inc.   **CONFIDENTIAL MEDICAL INFORMATION**

SHP Form 12/06

Southern Health Partners
Your Partner in Affordable Inmate Healthcare

SHP Form 12/2013

ADMISSION DATA / HISTORY AND PHYSICAL FORM

Medical Staff: Review Intake Screening Information prior to completing this form. ***Check when done***: ✓
The following information is to be completed by the medical staff upon interview with Patient:

Exam Date	5-23-14	Patient Name (Last, First, Middle Initial	Brian Hill		
Booking Date	5-14-14	Birthdate:	5-26-14	Soc. Sec. #	unknown
Marital Status	S	Religion:		Education Level:	Race: W
Read/Write English: (YES) NO	Sex: (MALE) FEMALE		Previous Incarcerations (Facility/Date)		

MEDICAL HISTORY

Emergency Contact Info (Name/Relationship:			
Phone No		Family Phys Name	Dr. Surinder
Health Ins. Info:		Family Phys City/State:	Martinsville, VA
Past Hospitalizations:			
Last Tetanus:	unknown	Immunizations Current:	yes
Any Allergies:	NKDA	Current Medications:	
Name current medical conditions/diagnoses you have: DMI, Autistic, GERD, OCD			

MENTAL HEALTH EVALUATION

Any Mental Health Hospitalizations (if yes, where/when):	2013-12, Martinsville. Mem
Any prior counseling/outpatient Mental Health Tx? (if yes, where/when)	yes
Have you ever attempted Suicide: How/When?	Dec 2013
Have you recently considered committing suicide?	yes Dec 2013
Do people consider you a violent person?	No
Have you ever been arrested for a violent crime/sexual offense? Specify	yes
Do you drink alcohol? If yes, what kind, how much, how often:	No
Do you smoke? If yes, how much, how often:	No
Do you use drugs? If yes, what kind; how much; how often?	No

I will/have answered all questions truthfully. I have been told and shown how to obtain medical services and advised on how to obtain medication upon release. I hereby give my consent for professional services to be provided to me by and through Southern Health Partners, Inc. Further, I release Southern Health Partners, Inc., its staff, the County, the Sheriff, Jailer, and his/her staff from all responsibility and I assume personal responsibility for conditions that may occur as a result of my not requesting services and/or refusing treatment as prescribed by the medical staff of the facility and/or outside consultation services.

Inmate's Signature: Brian D. Hill Date: 5-23-14

Interviewer's Signature: M. Kitchens LPN Date: 5-23-14

Witness: (if physical is refused): ____________ Date ________

MEDICAL HISTORY

Problems	Yes	No	Problems	Yes	No	Problems	Yes	No
Balance/Dizziness		✓	Stomach Pain			Gonorrhea		✓
Blackouts		✓	Heartburn		✓	Syphilis		✓
DTs/Withdrawal		✓	Ulcer			Muscle Problem		✓
Headaches		✓	Nausea/Vomiting		✓	Joint Problem		✓
Seizures	✓		Gall Bladder		✓	Arthritis		✓
Nervous Disorder		✓	Liver		✓	**FOR FEMALES ONLY:**		
Asthma		✓	Hepatitis		✓	Regular Menstrual Period		
Hay Fever		✓	Diabetes	✓		Irregular Menstrual Period		
Pneumonia		✓	Kidney Disease		✓	# of days Menstrual Period	Male	
Tuberculosis		✓	Bladder Infection		✓	LMP		
Heart		✓	Trouble Voiding		✓	Gravida/Para		
Hypertension		✓	Pediculi (lice)		✓	Last Pap		
Anemia /Blood		✓				Contraception		

Height	Weight	Pulse	BP	Temp	Resp	O2 Sat
6'	170	88	106/84	98.3	16	97

MEDICAL STAFF PHYSICAL ASSESSMENT – Ask Patient if any problem areas:

Area/Type	ASSESSMENT NOTES	Area/Type	ASSESSMENT NOTES
Skin: Color, Condition, Turgor, Recent Inj.	W/D race appropriate good turgor	Chest (Breasts): Configuration, Auscultation, Respirations, Cough/Sputum	= Rise/Fall Normal Resp Ø cough
Head: Glasses, Pupils, Sclera, Conjunctiva, Vision	Corrective lenses moist conjunctiva good vision	Heart: Auscultation, Radial pulses, Apical pulse, Rhythm	Normal rate/Rhythym + strong pulses
Neuro: Pupils, EOM, Orientation	Perla. Good Eom	Extremities: Pulses, Edema, Joints	+ Rom + pulses
Ears: Appearance, Canals, Hearing	Clear Ø drainage	Spine	Ø Curvature
Mouth: Teeth/Gums, Dentures, Plates, Throat, Tongue, Tonsils	moist mucosa No dental problems reported Ø swelling	Abdomen: Shape, Palpation, Hernia, Bowel sounds	Soft/Non'tender + Bowel sounds
Nose	Clear Ø drainage	Genital/Urinary:	No Problems reported
Neck: Veins, Mobility, Thyroid, Carotids, Lymph nodes	– JVD + Rom – swelling		

LABORATORY TESTS

	Date & Initial	Results
TB Screening Done?	TB Clear	See Fed Log
VDRL / RPR		
Pregnancy Test?	Male	N/A
HGB A1C?	ordered	
Drug Levels Drawn: ex. Lithium/Dilantin	N/A	

MENTAL HEALTH OBSERVATION

	(N)	A/Comment
General appearance (motor behavior, mannerisms):		Good well Groomed
Affect (mood)		Calm
Content of thought		Somewhat organized
History of suicide; present thoughts of suicide		Not Presently

PATIENT REFERRAL BASED ON INFO (circle that apply): MD DENTIST (MENTAL HEALTH)

CHRONIC CARE: Based on H&P, is patient to be added to Chronic Care List: (Y) or N

Initial here after patient has been added to Chronic Care listing: MK

Physical Examiner's Signature: M. Kitchens LPN Date: 5-23-14

Physician's Signature: 5/27/14 [illegible] Date:

BUTNER FCC BUT - X04-01[illegible]
OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 275[illegible]
902437-BUX Owens, Thomas MD 03/19/14
HILL, BRIAN 29947-057
Take one capsule by mouth at bedtime ***pill line***
Consent form on file * **writ*

Ziprasidone 20 MG Cap UD
(0) Refills 05/13/14 MF Refill Until: 09/15/14
#7 Don't Confiscate Before: 08/11/14

May Cause Drowsiness. Use Care When Operating A Vehicle, Vessel, Or Dangerous Machinery.

Take With Food

CAUTION: Do Not Take With Alcohol Or Nonprescription Drugs Without Consulting Your Doctor.

Do Not Take Other Medicines Without Checking With Your Doctor Or Pharmacist.

BUTN[illegible] FCC BUT - X04-010L
OLD N. C[illegible]OLINA HWY 75 - BUTNER, North Carolina 27509
902437-BUX Owens, Thomas MD 03/19/14
HILL, BRIAN 29947-057
Take one capsule by mouth at bedtime ***pill line***
Consent form on file * **writ*

Ziprasidone 20 MG Cap UD
(0) Refills 05/13/14 MF Refill Until: 09/15/14
#7 Don't Confiscate Before: 08/11/14

Ord. Date HILL, BRIAN Owens, Thomas
03/19/14 29947-057 MF X04 (0) Refills
Exp. Date **Take one capsule by mouth at bedtime**
09/15/14 *****pill line*** *Consent form on file ***
#7 ****writ****
902437-BUX Ziprasidone 20 MG Cap UD

HILL, BRIAN
29947-057
BUT - X04-010L
03/19/14

Ord. Date HILL, BRIAN Owens, Thomas MD
03/19/14 29947-057 MF X04 (0) Refills
Exp. Date **Take one capsule by mouth at bedtime**
09/15/14 *****pill line*** *Consent form on file ***
#7 ****writ****
902437-BUX Ziprasidone 20 MG Cap UD

Ziprasidone 20 MG Cap UD **902437-BUX**

GENERIC NAME: ZIPRASIDONE (zi-PRAS-i-done)

COMMON USES: This medicine is an antipsychotic used to treat mental and emotional disorders such as schizophrenia. It is also used alone or with other medicines (eg, lithium, valproate) to treat bipolar disorder (manic-depression). It may also be used to treat conditions as determined by your doctor.

BEFORE USING THIS MEDICINE: WARNING: This medicine is an antipsychotic. It may increase the risk of death when used to treat mental problems caused by dementia in elderly patients. Most of the deaths were linked to heart problems or infection. This medicine is not approved to treat mental problems caused by dementia. Talk with your doctor or pharmacist for more information. Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. DO NOT TAKE THIS MEDICINE if you are also taking astemizole, cisapride, dofetilide, droperidol, halofantrine, levomethadyl, a macrolide immunosuppressive (eg, tacrolimus), mefloquine, methadone, nilotinib, pentamidine, certain phenothiazines (eg, thioridazine), pimozide, probucol, procainamide, quinidine, certain quinolone antibiotics (eg, moxifloxacin), a serotonin receptor antagonist antiemetic (eg, dolasetron), sotalol, sparfloxacin, terfenadine, or tetrabenazine. QTc prolongation can infrequently result in serious, rarely fatal, irregular heartbeats. Consult your doctor or pharmacist for details. Ask for instructions about whether you need to stop any other QTc-prolonging medicines you may be using in order to minimize the risk of this effect. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking arsenic, bepridil, carbamazepine, chloroquine, class III antiarrhythmics (eg, amiodarone), domperidone, haloperidol, IA and IC antiarrhythmics (eg, flecainide, procainamide, propafenone), ketoconazole, kinase inhibitors (eg, lapatinib), macrolides and ketolides (eg, azithromycin, erythromycin), maprotiline, streptogramins (eg, mitomycin, pristinamycin), or tramadol. Inform your doctor of any other medical conditions including a history of heart problems (eg, heart failure, slow or irregular heartbeat), low blood potassium or magnesium levels, low blood volume, low white blood cell counts, a drug-induced movement disorder, kidney or liver problems, stroke, heart attack, low blood pressure, seizures, difficulty swallowing, neuroleptic malignant syndrome (NMS), Alzheimer disease, dementia, or suicidal thoughts or actions; a personal or family history of diabetes; high blood prolactin levels or a history of certain types of cancer (eg, breast, pancreas, pituitary), or if you are at risk for breast cancer; allergies; pregnancy; or breast-feeding. Tell your doctor if you are dehydrated, drink alcohol, or will be exposed to high temperatures; or if you have any problem with fainting or dizziness. USE OF THIS MEDICINE IS NOT RECOMMENDED if you have a history of QT prolongation, irregular heartbeat, recent heart attack, or severe heart failure. Use of this medicine in children is not recommended. Discuss with your doctor the risks and benefits of giving this medicine to your child. Contact your doctor or pharmacist if you have any questions or concerns about using this medicine.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. This medicine comes with a patient information leaflet. Ask your doctor, nurse, or pharmacist any questions that you may have about this medicine. SWALLOW WHOLE. Do not break, crush, or chew before swallowing. TAKE THIS MEDICINE with food. STORE THIS MEDICINE at 77 degrees F (25 degrees C), in a tightly-closed container, away from heat, moisture, and light. Brief storage between 59 and 86 degrees F (15 and 30 degrees C) is permitted. KEEP THIS MEDICINE out of the reach of children and away from pets. Take this medicine regularly to receive the most benefit from it. Taking this medicine at the same time each day will help you to remember. IT MAY TAKE SEVERAL WEEKS for you to notice the benefits of this medicine. CONTINUE TO TAKE THIS MEDICINE even if you feel well. Do not miss any doses. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: DO NOT TAKE THIS MEDICINE if you have had an allergic reaction to it or are allergic to any ingredient in this product. Do not stop using this medicine without checking with your doctor. KEEP ALL DOCTOR AND LABORATORY APPOINTMENTS while you are using this medicine. THIS MEDICINE MAY CAUSE DROWSINESS, DIZZINESS, lightheadedness, or fainting. To prevent them, sit up or stand slowly, especially in the morning. Also, sit or lie down at the first sign of these effects. Do not drive, operate machinery, or do anything else that could be dangerous until you know how you react to this medicine. DO NOT DRINK ALCOHOL while you are taking this medicine. THIS MEDICINE WILL ADD TO THE EFFECTS of alcohol and other depressants. DO NOT BECOME OVERHEATED in hot weather or during exercise or other activities since risk of heatstroke may be increased. THIS MEDICINE MAY INCREASE YOUR RISK OF DEVELOPING DIABETES or increase blood sugar levels. High blood sugar levels can cause serious problems if left untreated. THIS MEDICINE MAY LOWER THE ABILITY OF YOUR BODY TO FIGHT INFECTION. Tell your doctor if you notice signs of infection like fever, sore throat, rash, or chills. SEROTONIN SYNDROME and NEUROLEPTIC MALIGNANT SYNDROME (NMS) are possibly fatal syndromes that can be caused by this medicine. Your risk may be greater if you take this medicine with certain other medicines (eg, "triptans", MAOIs, antipsychotics). Symptoms may include blood pressure changes; agitation; confusion; hallucinations; other mental or mood changes; coma; fever; fast or irregular heartbeat; tremor; excessive sweating; rigid muscles; and nausea, vomiting, or diarrhea. SOME PATIENTS WHO TAKE THIS MEDICINE MAY DEVELOP MUSCLE MOVEMENTS that they cannot control. This is more likely to happen in elderly patients. Tell your doctor at once if you have muscle problems with your arms; legs; or your tongue, face, mouth, or jaw (eg, tongue sticking out, puffing of cheeks, mouth puckering, chewing movements) while taking this medicine. THIS MEDICINE MAY RARELY CAUSE A PROLONGED, PAINFUL ERECTION. If this is not treated right away, it could lead to permanent sexual problems such as impotence. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. CAUTION IS ADVISED when using this medicine in the elderly because they may be more sensitive to the effects of this medicine. FOR WOMEN: IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. Using this medicine during the third trimester may result in uncontrolled muscle movements or withdrawal symptoms in the newborn. Discuss any questions or concerns with your doctor. IT IS UNKNOWN IF THIS MEDICINE IS EXCRETED in breast milk. DO NOT BREAST-FEED while taking this medicine. DIABETICS: THIS MEDICINE MAY AFFECT YOUR BLOOD SUGAR. Check blood sugar levels closely and ask your doctor before adjusting the dose of your diabetes medicine.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS that may occur while taking this medicine include anxiety; constipation; diarrhea; dizziness; drowsiness; dry mouth; feeling unusually

BUTNER FCC BUT - X04-01
OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 275
906274-BUX Sichel, Lawrence MD 03/27/14
HILL, BRIAN 29947-057

30 units of nph insulin subcutaneously each morning ***pill line* only **writ****

Insulin NPH (10 ML) 100 UNITS/ML INJ
(0) Refills 05/13/14 MF Refill Until: 09/23/14
#10 Don't Confiscate Before: 08/11/14

Check With Your Doctor Or Pharmacist Before Drinking Alcoholic Beverages While Using

Roll Gently Between Hands To Mix Before

Store Using Directions Provided. Throw Away Any Medicine That Remains ____ Days After First

Read The Patient Information Leaflet That Came With This Medicine

BUTN FCC BUT - X04-010L
OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 27509
906274-BUX Sichel, Lawrence MD 03/27/14
HILL, BRIAN 29947-057

30 units of nph insulin subcutaneously each morning ***pill line* only **writ****

Insulin NPH (10 ML) 100 UNITS/ML INJ
(0) Refills 05/13/14 MF Refill Until: 09/23/14
#10 Don't Confiscate Before: 08/11/14

Ord. Date 03/27/14 HILL, BRIAN 29947-057 MF X04 Sichel, Lawrence (0) Refills
Exp. Date 09/23/14 **30 units of nph insulin subcutaneously each morning ***pill line*** only **writ****
#10
906274-BUX Insulin NPH (10 ML) 100 UNITS/ML INJ

HILL, BRIAN
29947-057
BUT - X04-010L
03/27/14

Ord. Date 03/27/14 HILL, BRIAN 29947-057 MF X04 Sichel, Lawrence (0) Refills
Exp. Date 09/23/14 **30 units of nph insulin subcutaneously each morning ***pill line*** only **writ****
#10
906274-BUX Insulin NPH (10 ML) 100 UNITS/ML INJ

Insulin NPH (10 ML) 100 UNITS/ML INJ **906274-BUX**

GENERIC NAME: INSULIN (IN-su-lin)

COMMON USES: This medicine is a hormone used to treat diabetes.

BEFORE USING THIS MEDICINE: Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking dexfenfluramine, fenfluramine, a monoamine oxidase inhibitor (MAOI), salicylates, oral medicines for diabetes, or a beta-blocker such as propranolol. DO NOT START OR STOP ANY MEDICINE without doctor or pharmacist approval. Inform your doctor of any other medical conditions, allergies, pregnancy, or breast-feeding. USE OF THIS MEDICINE IS NOT RECOMMENDED during any episode of low blood sugar. Contact your doctor or pharmacist if you have any questions or concerns about using this medicine.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. AN EXTRA PATIENT LEAFLET is available with this medicine. Talk to your pharmacist if you have questions about this information. A HEALTH CARE PROVIDER will teach you how to use this medicine. Be sure you understand how to use this medicine. Follow the procedures you are taught when you use a dose. Contact your health care provider if you have any questions. Check with your doctor about how you should use this medicine with regard to meals. CAREFULLY ROTATE the vial as directed before each injection. This will ensure that the contents are evenly mixed. This insulin should look uniformly cloudy or milky. DO NOT USE THIS MEDICINE if it contains particles or clumps, is discolored, or if the vial is cracked or damaged. IF YOU ARE MIXING THIS MEDICINE WITH ANOTHER INSULIN, draw the other insulin into the syringe first. Inject the dose immediately after mixing, as directed by your doctor. Do NOT use this medicine in an insulin pump. USE THE PROPER TECHNIQUE taught to you by your doctor. Inject deep under the skin, NOT into muscle or a vein. Injection sites within an injection area (abdomen, thigh, upper arm) must be rotated from one injection to the next. THIS MEDICINE BEGINS LOWERING BLOOD SUGAR within 30 to 90 minutes after an injection. The peak effect occurs within 4 to 12 hours after a dose. The effect may last for up to 24 hours. BE SURE YOU HAVE PURCHASED THE CORRECT INSULIN. Insulin comes in a variety of containers including vials, cartridges, and pens. Make sure that you understand how to properly measure and prepare your dose. If you have any questions about measuring or preparing your dose, contact your doctor, nurse, or pharmacist for information. STORE NEW (UNOPENED) vials in the refrigerator between 36 and 46 degrees F (2 and 8 degrees C). Do not freeze. Certain brands of this medicine may be stored at room temperature, below 77 degrees F (25 degrees C) for up to 6 weeks (42 days), if refrigeration is not possible. Check with your pharmacist to see if your brand can be stored at room temperature. Keep this medicine in the carton to protect from light. STORE USED (OPEN) VIALS as directed in the extra patient leaflet or by your health care provider. Check with your pharmacist to see how long unrefrigerated or opened vials may be used. STORE THIS MEDICINE away from heat and light. If this medicine has been frozen or overheated, throw it away. Do not leave this medicine in a car on a warm or sunny day. Do not use this medicine after the expiration date stamped on the label. If this medicine has been mixed with other medicines, you may need to store it differently. Ask your pharmacist if you have questions about how to properly store or when to discard your insulin. KEEP THIS PRODUCT, as well as syringes and needles, out of the reach of children and away from pets. It is very important to follow your insulin regimen exactly. DO NOT MISS any doses of insulin. Ask your doctor for specific instructions to follow in case you should ever miss a dose of insulin.

CAUTIONS: ALWAYS CHECK THE APPEARANCE OF YOUR INSULIN. If you notice anything unusual or if you see solid particles or clumps, discard the insulin and begin using a new container of insulin. KEEP ALL DOCTOR AND LABORATORY APPOINTMENTS while you are using this medicine. Laboratory and/or medical tests such as fasting blood glucose levels or HBA1C levels may be done to monitor your progress or to check for side effects. DO NOT DRIVE, OPERATE MACHINERY, OR DO ANYTHING ELSE THAT COULD BE DANGEROUS until you know how you react to this medicine. DO NOT DRINK ALCOHOL without discussing with your doctor. INJECT EACH DOSE OF INSULIN in a different area to prevent skin irritation. AN INSULIN REACTION resulting from low blood sugar levels or hypoglycemia may occur if you take too much insulin, skip a meal, or exercise too much. Signs of hypoglycemia include increased heartbeat, headache, chills, sweating, tremor, increased hunger, changes in vision, nervousness, weakness, dizziness, drowsiness, or fainting. It is a good habit to carry glucose tablets or gel to treat low blood sugar. If you do not have a reliable source of glucose available, eat a quick source of sugar such as table sugar, honey, candy, or drink a glass of orange juice or non-diet soda to quickly raise your blood sugar level. TELL YOUR DOCTOR IMMEDIATELY about the reaction. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. This includes medicine containing aspirin or other salicylates. FOR WOMEN: IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. IT IS UNKNOWN IF THIS MEDICINE IS EXCRETED in breast milk. If you are or will be breast-feeding, check with your doctor to discuss the benefits and risks to your baby.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS that may occur while using this medicine include redness, swelling, or itching at the injection site. If they continue or are bothersome, check with your doctor. CHECK WITH YOUR DOCTOR AS SOON AS POSSIBLE if you experience signs of low or high blood sugar. Signs of low blood sugar include increased heartbeat, headache, chills, sweating, tremor, increased hunger, changes in vision, nervousness, weakness, dizziness, drowsiness, or fainting. IF SEIZURES OR LOSS OF CONSCIOUSNESS OCCUR, obtain emergency medical care immediately. Signs of high blood sugar include thirst, increased urination, confusion, drowsiness, flushing, rapid breathing, or fruity breath odor. AN ALLERGIC REACTION to this medicine is unlikely, but seek immediate medical attention if it occurs. Symptoms of an allergic reaction include rash, itching, swelling, dizziness, or trouble breathing. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist. This is not a complete list of all side effects that may occur. If you have questions about side effects, contact your healthcare provider. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

OVERDOSE: If overdose is suspected, contact your local poison control center or emergency room immediately. Symptoms of overdose may include increased heartbeat, headache.

BUTNER FCC BUT - X04-01(

OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 2750..

906273-BUX Sichel, Lawrence MD 03/27/14

HILL, BRIAN 29947-057

18 units of nph insulin subcutaneously each evening ***pill line* only **writ****

Insulin NPH (10 ML) 100 UNITS/ML INJ

(0) Refills 05/13/14 MF Refill Until: 09/23/14

#10 Don't Confiscate Before: 08/11/14

Check With Your Doctor Or Pharmacist Before Drinking Alcoholic Beverages While Using

Roll Gently Between Hands To Mix Before

Store Using Directions Provided. Throw Away Any Medicine That Remains ____ Days After First

Read The Patient Information Leaflet That Came With This Medicine

BUTN ;CC BUT - X04-010L

OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 27509

906273-BUX Sichel, Lawrence MD 03/27/14

HILL, BRIAN 29947-057

18 units of nph insulin subcutaneously each evening ***pill line* only **writ****

Insulin NPH (10 ML) 100 UNITS/ML INJ

(0) Refills 05/13/14 MF Refill Until: 09/23/14

#10 Don't Confiscate Before: 08/11/14

Ord. Date HILL, BRIAN Sichel, Lawrence

03/27/14 29947-057 MF X04 (0) Refills

Exp. Date **18 units of nph insulin subcutaneously**

09/23/14 **each evening ***pill line*** only **writ****

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906273-BUX Insulin NPH (10 ML) 100 UNITS/ML INJ

HILL, BRIAN

29947-057

BUT - X04-010L

03/27/14

Ord. Date HILL, BRIAN Sichel, Lawrence

03/27/14 29947-057 MF X04 (0) Refills

Exp. Date **18 units of nph insulin subcutaneously**

09/23/14 **each evening ***pill line*** only **writ****

#10

906273-BUX Insulin NPH (10 ML) 100 UNITS/ML INJ

Insulin NPH (10 ML) 100 UNITS/ML INJ **906273-BUX**

GENERIC NAME: INSULIN (IN-su-lin)

COMMON USES: This medicine is a hormone used to treat diabetes.

BEFORE USING THIS MEDICINE: Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking dexfenfluramine, fenfluramine, a monoamine oxidase inhibitor (MAOI), salicylates, oral medicines for diabetes, or a beta-blocker such as propranolol. DO NOT START OR STOP ANY MEDICINE without doctor or pharmacist approval. Inform your doctor of any other medical conditions, allergies, pregnancy, or breast-feeding. USE OF THIS MEDICINE IS NOT RECOMMENDED during any episode of low blood sugar. Contact your doctor or pharmacist if you have any questions or concerns about using this medicine.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. AN EXTRA PATIENT LEAFLET is available with this medicine. Talk to your pharmacist if you have questions about this information. A HEALTH CARE PROVIDER will teach you how to use this medicine. Be sure you understand how to use this medicine. Follow the procedures you are taught when you use a dose. Contact your health care provider if you have any questions. Check with your doctor about how you should use this medicine with regard to meals. CAREFULLY ROTATE the vial as directed before each injection. This will ensure that the contents are evenly mixed. This insulin should look uniformly cloudy or milky. DO NOT USE THIS MEDICINE if it contains particles or clumps, is discolored, or if the vial is cracked or damaged. IF YOU ARE MIXING THIS MEDICINE WITH ANOTHER INSULIN, draw the other insulin into the syringe first. Inject the dose immediately after mixing, as directed by your doctor. Do NOT use this medicine in an insulin pump. USE THE PROPER TECHNIQUE taught to you by your doctor. Inject deep under the skin, NOT into muscle or a vein. Injection sites within an injection area (abdomen, thigh, upper arm) must be rotated from one injection to the next. THIS MEDICINE BEGINS LOWERING BLOOD SUGAR within 30 to 90 minutes after an injection. The peak effect occurs within 4 to 12 hours after a dose. The effect may last for up to 24 hours. BE SURE YOU HAVE PURCHASED THE CORRECT INSULIN. Insulin comes in a variety of containers including vials, cartridges, and pens. Make sure that you understand how to properly measure and prepare your dose. If you have any questions about measuring or preparing your dose, contact your doctor, nurse, or pharmacist for information. STORE NEW (UNOPENED) vials in the refrigerator between 36 and 46 degrees F (2 and 8 degrees C). Do not freeze. Certain brands of this medicine may be stored at room temperature, below 77 degrees F (25 degrees C) for up to 6 weeks (42 days), if refrigeration is not possible. Check with your pharmacist to see if your brand can be stored at room temperature. Keep this medicine in the carton to protect from light. STORE USED (OPEN) VIALS as directed in the extra patient leaflet or by your health care provider. Check with your pharmacist to see how long unrefrigerated or opened vials may be used. STORE THIS MEDICINE away from heat and light. If this medicine has been frozen or overheated, throw it away. Do not leave this medicine in a car on a warm or sunny day. Do not use this medicine after the expiration date stamped on the label. If this medicine has been mixed with other medicines, you may need to store it differently. Ask your pharmacist if you have questions about how to properly store or when to discard your insulin. KEEP THIS PRODUCT, as well as syringes and needles, out of the reach of children and away from pets. It is very important to follow your insulin regimen exactly. DO NOT MISS any doses of insulin. Ask your doctor for specific instructions to follow in case you should ever miss a dose of insulin.

CAUTIONS: ALWAYS CHECK THE APPEARANCE OF YOUR INSULIN. If you notice anything unusual or if you see solid particles or clumps, discard the insulin and begin using a new container of insulin. KEEP ALL DOCTOR AND LABORATORY APPOINTMENTS while you are using this medicine. Laboratory and/or medical tests such as fasting blood glucose levels or HBA1C levels may be done to monitor your progress or to check for side effects. DO NOT DRIVE, OPERATE MACHINERY, OR DO ANYTHING ELSE THAT COULD BE DANGEROUS until you know how you react to this medicine. DO NOT DRINK ALCOHOL without discussing with your doctor. INJECT EACH DOSE OF INSULIN in a different area to prevent skin irritation. AN INSULIN REACTION resulting from low blood sugar levels or hypoglycemia may occur if you take too much insulin, skip a meal, or exercise too much. Signs of hypoglycemia include increased heartbeat, headache, chills, sweating, tremor, increased hunger, changes in vision, nervousness, weakness, dizziness, drowsiness, or fainting. It is a good habit to carry glucose tablets or gel to treat low blood sugar. If you do not have a reliable source of glucose available, eat a quick source of sugar such as table sugar, honey, candy, or drink a glass of orange juice or non-diet soda to quickly raise your blood sugar level. TELL YOUR DOCTOR IMMEDIATELY about the reaction. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. This includes medicine containing aspirin or other salicylates. FOR WOMEN: IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. IT IS UNKNOWN IF THIS MEDICINE IS EXCRETED in breast milk. If you are or will be breast-feeding, check with your doctor to discuss the benefits and risks to your baby.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS that may occur while using this medicine include redness, swelling, or itching at the injection site. If they continue or are bothersome, check with your doctor. CHECK WITH YOUR DOCTOR AS SOON AS POSSIBLE if you experience signs of low or high blood sugar. Signs of low blood sugar include increased heartbeat, headache, chills, sweating, tremor, increased hunger, changes in vision, nervousness, weakness, dizziness, drowsiness, or fainting. IF SEIZURES OR LOSS OF CONSCIOUSNESS OCCUR, obtain emergency medical care immediately. Signs of high blood sugar include thirst, increased urination, confusion, drowsiness, flushing, rapid breathing, or fruity breath odor. AN ALLERGIC REACTION to this medicine is unlikely, but seek immediate medical attention if it occurs. Symptoms of an allergic reaction include rash, itching, swelling, dizziness, or trouble breathing. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist. This is not a complete list of all side effects that may occur. If you have questions about side effects, contact your healthcare provider. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

OVERDOSE: If overdose is suspected, contact your local poison control center or emergency room immediately. Symptoms of overdose may include increased heartbeat, headache

BUTNER FCC BUT - X04-01[illegible]
OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 27509
889649-BUX Sichel, Lawrence MD 02/12/14
HILL, BRIAN 29947-057

Inject 7 units of regular insulin subcutaneously three times a day ***pill line* **writ****

Insulin Reg (10 ML) 100 UNITS/ML Inj
(0) Refills 05/13/14 MF Refill Until: 08/11/14
#10 Don't Confiscate Before: 08/11/14

Check With Your Doctor Or Pharmacist Before Drinking Alcoholic Beverages While Using

Store Using Directions Provided. Throw Away Any Medicine That Remains ____ Days After First

Take Or Use This Medicine Exactly As Directed. Do Not Skip Doses Or Discontinue Unless Directed By Your Doctor.

BUTN[illegible]CC BUT - X04-010L
OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 27509
889649-BUX Sichel, Lawrence MD 02/12/14
HILL, BRIAN 29947-057

Inject 7 units of regular insulin subcutaneously three times a day ***pill line* **writ****

Insulin Reg (10 ML) 100 UNITS/ML Inj
(0) Refills 05/13/14 MF Refill Until: 08/11/14
#10 Don't Confiscate Before: 08/11/14

Ord. Date HILL, BRIAN Sichel, Lawrence
02/12/14 29947-057 MF X04 (0) Refills
Exp. Date **Inject 7 units of regular insulin**
08/11/14 **subcutaneously three times a day ***pill**
#10 **line*** **writ****
889649-BUX Insulin Reg (10 ML) 100 UNITS/ML Inj

HILL, BRIAN
29947-057
BUT - X04-010L
02/12/14

Ord. Date HILL, BRIAN Sichel, Lawrence
02/12/14 29947-057 MF X04 (0) Refills
Exp. Date **Inject 7 units of regular insulin**
08/11/14 **subcutaneously three times a day ***pill**
#10 **line*** **writ****
889649-BUX Insulin Reg (10 ML) 100 UNITS/ML Inj

Insulin Reg (10 ML) 100 UNITS/ML Inj **889649-BUX**

GENERIC NAME: INSULIN (IN-su-lin)

COMMON USES: This medicine is a fast-acting form of the hormone insulin used for treating diabetes mellitus.

BEFORE USING THIS MEDICINE: Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking angiotensin-converting enzyme (ACE) inhibitors (eg, enalapril), atypical antipsychotics (eg, olanzapine), beta-blockers (eg, propranolol), clonidine, corticosteroids (eg, prednisone), danazol, disopyramide, diuretics (eg, furosemide, hydrochlorothiazide), estrogen, fenfluramine, fibrates (eg, clofibrate, gemfibrozil), fluoxetine, guanethidine, hormonal contraceptives (eg, birth control pills), isoniazid, lithium, monoamine oxidase inhibitors (MAOIs) (eg, phenelzine), niacin, oral medicines for diabetes (eg, glipizide, metformin, nateglinide), pentamidine, phenothiazines (eg, chlorpromazine), pramlintide, progesterones (eg, medroxyprogesterone), propoxyphene, reserpine, salicylates (eg, aspirin), somatostatin analogs (eg, octreotide), somatropin, sulfonamide antibiotics (eg, sulfamethoxazole), sympathomimetics (eg, albuterol, epinephrine, terbutaline), or thyroid hormones (eg, levothyroxine). DO NOT START OR STOP ANY MEDICINE without doctor or pharmacist approval. Inform your doctor of any other medical conditions, including kidney or liver problems; nerve problems; adrenal, pituitary, or thyroid problems; eye problems caused by diabetes; diabetic ketoacidosis; high blood sodium levels; low blood potassium levels; allergies; pregnancy; or breast-feeding. Tell your doctor if you drink alcoholic beverages, if you smoke, or if you use 3 or more insulin injections per day. Tell your doctor if you are fasting or you do not eat regularly, if you are on a low-salt (sodium) diet, or if you have had or will be having heart surgery. USE OF THIS MEDICINE IS NOT RECOMMENDED during any episode of low blood sugar. Contact your doctor or pharmacist if you have any questions or concerns about using this medicine.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. AN ADDITIONAL PATIENT INFORMATION LEAFLET is available with this medicine. Read it carefully. USE THIS MEDICINE within 30 minutes before a meal, as directed by your doctor. IF YOU WILL BE USING THIS MEDICINE AT HOME, a health care provider will teach you how to use it. Be sure you understand how to use it. Follow the procedures you are taught when you use a dose. Ask your doctor, nurse, or pharmacist any questions that you may have about this medicine or about giving injections. THIS MEDICINE SHOULD BE CLEAR AND COLORLESS. Do not use this medicine if it contains particles; is cloudy, thickened, or discolored; or if the vial is cracked or damaged. USE THE PROPER TECHNIQUE taught to you by your doctor. Inject deep under the skin, NOT into a vein or muscle. Injection sites within an injection area (abdomen, buttocks, thigh, upper arm) must be rotated from one injection to the next. DO NOT MIX THIS MEDICINE WITH ANOTHER INSULIN unless your doctor tells you to. If you are mixing this medicine with another insulin, draw this medicine into the syringe first. Inject the dose immediately after mixing as directed by your doctor. CERTAIN BRANDS OF THIS MEDICINE should not be used in an insulin pump unless your doctor tells you otherwise. If you will be using an insulin pump, check with your doctor or pharmacist to see if your brand may be used in a pump. If you are using an insulin pump, do NOT dilute this medicine or mix it with any other type of insulin. THIS MEDICINE BEGINS LOWERING BLOOD SUGAR within 30 minutes after an injection. The effect usually lasts from 4 to 12 hours. STORE NEW (UNOPENED) VIALS in the refrigerator, between 36 and 46 degrees F (2 and 8 degrees C). Do NOT freeze or use this medicine if it has been frozen. Certain brands of this medicine may be stored at room temperature below 77 degrees F (25 degrees C) for up to 6 weeks (42 days), if refrigeration is not possible. Check with your pharmacist to see if your brand can be stored at room temperature. Keep this medicine in the carton to protect from light. STORE USED (OPENED) VIALS as directed in the extra patient leaflet or by your health care provider. Check with your pharmacist to see how long unrefrigerated or opened vials may be used. Store away from heat and light. If this medicine has been frozen or overheated, throw it away. Do not leave in a car on a warm or sunny day. Do not use this medicine after the expiration date stamped on the label. If you are using this medicine in an insulin pump, or if this medicine has been mixed with other medicines, ask your doctor, pharmacist, or other health care provider how to store this medicine. KEEP THIS PRODUCT, as well as syringes and needles, out of the reach of children and away from pets. It is very important to follow your insulin regimen exactly. DO NOT MISS any doses. Ask your doctor for specific instructions to follow in case you should ever miss a dose of insulin.

CAUTIONS: DO NOT TAKE THIS MEDICINE if you are allergic to any ingredient in this medicine. DO NOT EXCEED THE RECOMMENDED DOSE, use this medicine more often than prescribed, or change the type or dose of insulin you are using without checking with your doctor. Lab tests may be performed to monitor your progress or to check for side effects. KEEP ALL DOCTOR AND LABORATORY APPOINTMENTS. BEFORE YOU HAVE ANY MEDICAL OR DENTAL TREATMENTS, emergency care, or surgery, tell the doctor or dentist that you are taking this medicine. DROWSINESS, DIZZINESS, LIGHT-HEADEDNESS, OR BLURRED VISION MAY OCCUR while you use this medicine. These effects may be worse if you take it with alcohol or certain medicines. Use this medicine with caution. Do not drive or perform other potentially unsafe tasks until you know how you react to it. DO NOT DRINK ALCOHOL without discussing with your doctor. ANY CHANGE OF INSULIN should be made cautiously and only under medical supervision. Changes in purity, strength, brand (manufacturer), type (regular, NPH, lente), species (beef, pork, beef-pork, human), and/or method of manufacture may require a change in dose. ILLNESS, ESPECIALLY WITH NAUSEA AND VOMITING, may cause your insulin requirements to change. Even if you are not eating, you still require insulin. You and your doctor should establish a sick-day plan to use in case of illness. When you are sick, test your blood/urine frequently and call your doctor as instructed. AN INSULIN REACTION resulting from low blood sugar levels (hypoglycemia) may occur if you take too much insulin, skip a meal, or exercise too much. Signs of hypoglycemia include increased heartbeat, headache, chills, sweating, tremor, increased hunger, changes in vision, nervousness, weakness, dizziness, drowsiness, or fainting. It is a good habit to carry glucose tablets or gel to treat low blood sugar. If you do not have a reliable source of glucose available, eat a quick source of sugar such as table sugar, honey, candy, or drink a glass of orange juice or non-diet soda to quickly raise your blood sugar level. TELL YOUR DOCTOR IMMEDIATELY about the reaction. DEVELOPING A FEVER OR INFECTION, eating significantly more than prescribed, or missing your dose of insulin may cause high blood sugar (hyperglycemia). High blood sugar may make you feel confused, drowsy, or thirsty. It can also make you flush, breathe faster, or have a fruit-like breath odor. If these symptoms occur, tell you doctor right away. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, [illegible]

BUTNER FCC BUT - X04-01
OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 27509
902218-BUX Sielicki, Stanislaw MLP 03/18/14
HILL, BRIAN 29947-057
Chew 1 tablet as needed for low blood glucose **writ**

Glucose 4 GM Tab
(0) Refills 05/13/14 MF Refill Until: 09/14/14
#10 Don't Confiscate Before: 08/11/14

Carry Or Wear Medical Identification Stating You Are Taking This Medicine

Chew Tablets Before Swallowing

BUTN... FCC BUT - X04-010L
OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 27509
902218-BUX Sielicki, Stanislaw MLP 03/18/14
HILL, BRIAN 29947-057
Chew 1 tablet as needed for low blood glucose **writ**

Glucose 4 GM Tab
(0) Refills 05/13/14 MF Refill Until: 09/14/14
#10 Don't Confiscate Before: 08/11/14

Ord. Date 03/18/14 HILL, BRIAN 29947-057 MF X04 Sielicki, Stanislaw (0) Refills
Exp. Date 09/14/14 **Chew 1 tablet as needed for low blood glucose **writ****
#10
902218-BUX Glucose 4 GM Tab

HILL, BRIAN
29947-057
BUT - X04-010L
03/18/14

Ord. Date 03/18/14 HILL, BRIAN 29947-057 MF X04 Sielicki, Stanislaw (0) Refills
Exp. Date 09/14/14 **Chew 1 tablet as needed for low blood glucose **writ****
#10
902218-BUX Glucose 4 GM Tab

Glucose 4 GM Tab **902218-BUX**

GENERIC NAME: GLUCOSE (GLOO-kose)

COMMON USES: This medicine is a monosaccharide used to treat low blood sugar or insulin reactions.

BEFORE USING THIS MEDICINE: INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. Inform your doctor of any other medical conditions, allergies, pregnancy, or breast-feeding.

HOW TO USE THIS MEDICINE: Use this medicine exactly as directed on the package, unless instructed differently by your doctor. CHEW THOROUGHLY before swallowing. If your reaction continues, you may repeat the dose in 10 minutes. Also you may repeat the dose as needed for additional insulin reaction episodes that may occur with longer acting insulin. STORE THIS MEDICINE at room temperature, away from heat and light.

CAUTIONS: IF YOUR SYMPTOMS DO NOT IMPROVE within 20 minutes or if they become worse, check with your doctor. Notify your doctor about low blood sugar or insulin reaction episodes. DO NOT GIVE THIS MEDICINE to anyone who is unconscious.

POSSIBLE SIDE EFFECTS: NO COMMON SIDE EFFECTS HAVE BEEN REPORTED with the proper use of this medicine. If you notice any unusual effects, contact your doctor, nurse, or pharmacist. This is not a complete list of all side effects that may occur. If you have questions about side effects, contact your healthcare provider. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

OVERDOSE: If overdose is suspected, contact your local poison control center or emergency room immediately.

ADDITIONAL INFORMATION: CHECK THE EXPIRATION DATE on this medicine regularly. Replace it so you always have a non-expired product available. DO NOT SHARE THIS MEDICINE with others for whom it was not prescribed. DO NOT USE THIS MEDICINE for other health conditions. KEEP THIS MEDICINE out of the reach of children.

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Issue Date: May 7, 2014

This information should not be used to decide whether or not to take this medicine or any other medicine. Only your health care provider has the knowledge and training to decide which medicines are right for you. This information does not endorse any medicine as safe, effective, or approved for treating any patient or health condition. This is only a brief summary of general information about this medicine. It does NOT include all information about the possible uses, directions, warnings, precautions,

BUTNER FCC BUT - X04-01(

OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 27509

893333-BUX Owens, Thomas MD 02/24/14

HILL, BRIAN 29947-057

Take one capsule by mouth (20 mg) by mouth each morning x 14 days ***pill line* only *Consent form on file *---Take two capsules (40 mg) by mouth each morning ***pill line*** only *Consent form on file * **writ****

FLUoxetine 20 MG Cap UD

(0) Refills 05/13/14 MF Refill Until: 08/17/14

#14 **1 of 1** Don't Confiscate Before: 08/11/14

May Cause Drowsiness. Taking Alone Or With Alcohol May Lessen Your Ability To Operate A Vehicle, Vessel, Or Perform Hazardous Tasks.

Warning: Do Not Use If You Are Breastfeeding. Consult Your Doctor Or Pharmacist.

Do Not Take Other Medicines Without Checking With Your Doctor Or Pharmacist.

Read The Medication Guide That Comes With This Medicine.

BUTNE... FCC BUT - X04-010L

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HILL, BRIAN 29947-057

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FLUoxetine 20 MG Cap UD

(0) Refills 05/13/14 MF Refill Until: 08/17/14

#14 **1 of 1** Don't Confiscate Before: 08/11/14

Ord. Date HILL, BRIAN Owens, Thomas

02/24/14 29947-057 MF X04 (0) Refills

Exp. Date **Take one capsule by mouth (20 mg) by mouth each morning x 14 days ***pill line*** only *Consent form on file * **writ****

08/17/14

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893333-BUX FLUoxetine 20 MG Cap UD

HILL, BRIAN

29947-057

BUT - X04-010L

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Exp. Date **Take two capsules (40 mg) by mouth each morning ***pill line*** only *Consent form on file * **writ****

08/17/14

#14

893333-BUX FLUoxetine 20 MG Cap UD

FLUoxetine 20 MG Cap UD **893333-BUX**

GENERIC NAME: FLUOXETINE (floo-OX-e-teen)

COMMON USES: This medicine is a selective serotonin reuptake inhibitor (SSRI) used for treating depression or obsessive-compulsive disorder (OCD) in adults and children. It is used to treat bulimia nervosa and panic disorder in adults. It may also be used for other conditions as determined by your doctor.

BEFORE USING THIS MEDICINE: WARNING: Antidepressants may increase the risk of suicidal thoughts or actions in children, teenagers, and young adults. However, depression and certain other mental problems may also increase the risk of suicide. Talk with the patient's doctor to be sure that the benefits of using this medicine outweigh the risks. Family and caregivers must closely watch patients who take this medicine. It is important to keep in close contact with the patient's doctor. Tell the doctor right away if the patient has symptoms like worsened depression, suicidal thoughts, or changes in behavior. Discuss any questions with the patient's doctor. THIS MEDICINE IS NOT APPROVED FOR USE IN ALL CHILDREN. If this medicine is prescribed for your child, talk with the doctor to be sure that this medicine is right for your child. Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. DO NOT TAKE THIS MEDICINE if you are taking or have taken linezolid, a monoamine oxidase inhibitor (MAOI) (eg, phenelzine, selegiline), or St. John's wort within the last 14 days. DO NOT TAKE THIS MEDICINE IF you are taking a fenfluramine derivative (eg, dexfenfluramine), nefazodone, pimozide, a serotonin norepinephrine reuptake inhibitor (SNRI) (eg, venlafaxine), another SSRI (eg, paroxetine), sibutramine, thioridazine, or tryptophan. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking anorexiants (eg, phentermine), buspirone, fentanyl, lithium, meperidine, metoclopramide, rasagiline, serotonin 5-HT1 receptor agonists (eg, sumatriptan), trazodone, anticoagulants (eg, warfarin), aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs) (eg, ibuprofen, intranasal ketorolac), diuretics (eg, furosemide, hydrochlorothiazide), tramadol, HIV protease inhibitors (eg, ritonavir), cyproheptadine, aripiprazole, benzodiazepines (eg, alprazolam), beta-blockers (eg, propranolol), bupropion, carbamazepine, clozapine, digoxin, flecainide, haloperidol, hydantoins (eg, phenytoin), iloperidone, norepinephrine reuptake inhibitors (eg, atomoxetine), phenothiazines (eg, chlorpromazine), propafenone, risperidone, tamoxifen, tetrabenazine, tricyclic antidepressants (eg, amitriptyline), vinblastine, or methylene blue. DO NOT START OR STOP any medicine without doctor or pharmacist approval. Inform your doctor of any other medical conditions, including if you have a history of seizures, stroke, heart problems, high blood pressure, liver problems, kidney problems, bleeding problems, diabetes, narrow-angle glaucoma or risk for narrow-angle glaucoma, allergies, pregnancy, or breast-feeding. Tell your doctor if you or a family member has a history of bipolar disorder (manic-depression), other mental or mood problems, suicidal thoughts or attempts, or alcohol or substance abuse. Tell your doctor if you are dehydrated, have low blood sodium levels, drink alcohol, or if you will be having electroconvulsive therapy (ECT). Contact your doctor or pharmacist if you have any questions or concerns about using this medicine.

HOW TO USE THIS MEDICINE: Follow the directions for taking this medicine provided by your doctor. This medicine comes with a MEDICATION GUIDE approved by the U.S. Food and Drug Administration. Read it carefully each time you refill this medicine. Ask your doctor, nurse, or pharmacist any questions that you may have about this medicine. TAKE THIS MEDICINE with or without food. STORE THIS MEDICINE at room temperature, between 59 and 86 degrees F (15 and 30 degrees C) away from heat, moisture, and light. Do not store in the bathroom. KEEP THIS MEDICINE out of the reach of children and away from pets. Other brands of medicine that contain the same ingredient (fluoxetine) are available. These other brands may be used to treat premenstrual dysphoric disorder (PMDD) or to treat depression in patients with bipolar disorder. DO NOT TAKE THIS MEDICINE if you are taking any other medicine that contains fluoxetine. Discuss any questions or concerns with your doctor. Taking this medicine at the same time each day will help you remember to take it. Continue to take this medicine even if you feel well. Do not miss any doses. DO NOT SUDDENLY STOP TAKING THIS MEDICINE without checking with your doctor. Side effects may occur. They may include mental or mood changes, numbness or tingling of the skin, dizziness, confusion, headache, trouble sleeping, or unusual tiredness. You will be closely monitored when you start this medicine and whenever a change in dose is made. IF YOU MISS A DOSE of this medicine, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: DO NOT USE THIS MEDICINE IF you are allergic to any ingredient in this medicine. THIS MEDICINE MAY CAUSE DROWSINESS OR DIZZINESS. It may also cause you to not be able to make decisions, think clearly, or react quickly. DO NOT DRIVE OR PERFORM OTHER POSSIBLY UNSAFE TASKS until you know how you react to this medicine. DO NOT DRINK ALCOHOL while you are using this medicine. Check with your doctor before you use medicines that may cause drowsiness (eg, sleep aids, muscle relaxers) while you are using this medicine; it may add to their effects. Ask your pharmacist if you have questions about which medicines may cause drowsiness. Do NOT take more than the recommended dose, change your dose, or take this medicine for longer than prescribed without checking with your doctor. SEROTONIN SYNDROME is a possibly fatal syndrome that can be caused by this medicine. Your risk may be greater if you take this medicine with certain other medicines (eg, "triptans", MAOIs). Symptoms may include agitation; confusion; hallucinations; coma; fever; fast or irregular heartbeat; tremor; excessive sweating; and nausea, vomiting, or diarrhea. Contact your doctor at once if you have any of these symptoms. IF YOUR DOCTOR TELLS YOU TO STOP TAKING THIS MEDICINE, you will need to wait at least 5 weeks before beginning to take certain other medicines (eg, MAOIs, nefazodone, thioridazine). Ask your doctor when you should start to take your new medicines after you have stopped taking this medicine. LOW BLOOD SODIUM LEVELS MAY occur from treatment with this medicine. In severe cases, this can be deadly. Call your doctor right away if you have confusion, decreased coordination, fainting, hallucinations, headache, memory problems, mental or mood changes, seizures, sluggishness, trouble concentrating, or weakness. THIS MEDICINE MAY RARELY CAUSE a prolonged, painful erection. This could happen even when you are not having sex. If this is not treated right away, it could lead to permanent sexual problems such as impotence. Contact your doctor right away if this happens. BEFORE YOU BEGIN TAKING ANY NEW MEDICINES, either prescription or over-the-counter, check with your doctor or pharmacist. Use this medicine with caution in the ELDERLY; they may be more sensitive to its effects. Caution is advised when using this medicine in CHILDREN; they may be more sensitive to its effects, especially increased risk of suicidal thoughts or actions. This medicine may cause weight changes. CHILDREN and teenagers may need regular weight and growth checks while they take this medicine. FOR WOMEN: THIS MEDICINE MAY CAUSE HARM to the fetus. If you become pregnant, contact your doctor.

PROGRESS NOTES

Date/Time	Inmate's Name: Hill Brian D.O.B.: 5/24/90 Allergies: NKDA
6-5-14 0630	During med pass Hill wouldn't get up to get his meds. I checked his BG and it was 22. I gave a glucose tab and 8oz Orange juice. Got I/m up to drink and eat will recheck in 30 minutes. His BG was 316 on recheck at 715 Kay [illegible]
6-5-14 ~~0715~~	
6-5-14	Gave NPH 30 + 12 (units) R Insulin on recheck Kay [illegible]
6-5-14	12:00 I/m has been pacing back + forth in the cell due to court yesterday. Yelling out at times

Southern Health Partners, Inc.
CONFIDENTIAL MEDICAL INFORMATION

Please print legibly.

ATTN: ALL PERSONELL URGENT!
Thank You

Southern Health Partners
Your Partner In Affordable Inmate Healthcare

INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 05-25-14 Pod/Location: Old Jail Cell: SM ID# 238306

Inmate's Full Name: Brian David

Complaint/Problem: I think my blood sugar low. I need something with sugar as soon as possible. Even peanut butter would do.

How long have you had this problem? Happened now

Inmate's Signature: Brian D. Hill Date: May 25, 2014

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

TO BE COMPLETED BY MEDICAL STAFF:

- ☐ *See Clinical Pathway for Documentation/Response*
- ☐ *See Physician Order for Response to this Sick Call*
- ☐ *See Progress Note for Response to this Sick Call*
- ☑ *See Below for Response to this Sick Call*

Rcvd 5-26

Nurse's Signature/Date: M. Kitchens LPN

Document Patient's Vital Signs: Temp______ Resp______ Pulse______ B/P______

Instructions/Assessment: Document your findings, Inmate's responses/actions

Given : Juice / glucose tab for low BG level
Rechecked BS = 185 @ 10:30pm 5/25/14, informed staff
to give glucose tab if I/m reports low Blood sugar
again – let him check BS FCV He is able to do it.

- ☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
- ☐ Follow-Up Required? If checked, date to be seen again______
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 5-26-14 Seen by: M. Kitchens LPN

Place original form in patient's medical record. SHP Form 12/06/Updated 6/2009

Southern Health Partners
Your Partner in Affordable Inmate Healthcare

FAX TRANSMITTAL

Confidential Transmission by SHP

FAX TO: Kim Fax #: 1-866-279-0307

FROM: Kay Foch RN Jail Medical Unit

From Site Name: Orange County City/State

From Site Phone #: 919-245-2946 From Site Fax #: 919-644-3382

DATE: 5-27-14 PAGES: 3, includes cover page
(if you have not received all of the pages, please contact me immediately)

☑ For Your Information ☐ Needs Immediate Response/Action ☐ Please call me

Message(s):
He came from Butner FCC facility with these medications.

The information transmitted is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use of, or taking of any action in reliance upon, this information by persons or entities other than the intended recipient is prohibited.

BUTNER FCC BUT - X04-01(
OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 27509
893333-BUX Owens, Thomas MD 02/24/14
HILL, BRIAN 29947-057
Take one capsule by mouth (20 mg) by mouth each morning x 14 days ***pill line* only *Consent form on file *---Take two capsules (40 mg) by mouth each morning ***pill line*** only *Consent form on file * **writ****

FLUoxetine 20 MG Cap UD
(0) Refills 05/13/14 MF Refill Until: 08/17/14
#14 **1 of 1** Don't Confiscate Before: 08/11/14

May Cause Drowsiness. Taking Alone Or With Alcohol May Lessen Your Ability To Operate A Vehicle, Vessel, Or Perform Hazardous Tasks.

Warning: Do Not Use If You Are Breastfeeding. Consult Your Doctor Or Pharmacist.

Do Not Take Other Medicines Without Checking With Your Doctor Or Pharmacist.

Read The Medication Guide That Comes With This Medicine.

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893333-BUX FLUoxetine 20 MG Cap UD

FLUoxetine 20 MG Cap UD **893333-BUX**

GENERIC NAME: FLUOXETINE (floo-OX-e-teen)

COMMON USES: This medicine is a selective serotonin reuptake inhibitor (SSRI) used for treating depression or obsessive-compulsive disorder (OCD) in adults and children. It is used to treat bulimia nervosa and panic disorder in adults. It may also be used for other conditions as determined by your doctor.

BEFORE USING THIS MEDICINE: WARNING: Antidepressants may increase the risk of suicidal thoughts or actions in children, teenagers, and young adults. However, depression and certain other mental problems may also increase the risk of suicide. Talk with the patient's doctor to be sure that the benefits of using this medicine outweigh the risks. Family and caregivers must closely watch patients who take this medicine. It is important to keep in close contact with the patient's doctor. Tell the doctor right away if the patient has symptoms like worsened depression, suicidal thoughts, or changes in behavior. Discuss any questions with the patient's doctor. THIS MEDICINE IS NOT APPROVED FOR USE IN ALL CHILDREN. If this medicine is prescribed for your child, talk with the doctor to be sure that this medicine is right for your child. Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. DO NOT TAKE THIS MEDICINE if you are taking or have taken linezolid, a monoamine oxidase inhibitor (MAOI) (eg, phenelzine, selegiline), or St. John's wort within the last 14 days. DO NOT TAKE THIS MEDICINE IF you are taking a fenfluramine derivative (eg, dexfenfluramine), nefazodone, pimozide, a serotonin norepinephrine reuptake inhibitor (SNRI) (eg, venlafaxine), another SSRI (eg, paroxetine), sibutramine, thioridazine, or tryptophan. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking anorexiants (eg, phentermine), buspirone, fentanyl, lithium, meperidine, metoclopramide, rasagiline, serotonin 5-HT1 receptor agonists (eg, sumatriptan), trazodone, anticoagulants (eg, warfarin), aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs) (eg, ibuprofen, intranasal ketorolac), diuretics (eg, furosemide, hydrochlorothiazide), tramadol, HIV protease inhibitors (eg, ritonavir), cyproheptadine, aripiprazole, benzodiazepines (eg, alprazolam), beta-blockers (eg, propranolol), bupropion, carbamazepine, clozapine, digoxin, flecainide, haloperidol, hydantoins (eg, phenytoin), iloperidone, norepinephrine reuptake inhibitors (eg, atomoxetine), phenothiazines (eg, chlorpromazine), propafenone, risperidone, tamoxifen, tetrabenazine, tricyclic antidepressants (eg, amitriptyline), vinblastine, or methylene blue. DO NOT START OR STOP any medicine without doctor or pharmacist approval. Inform your doctor of any other medical conditions, including if you have a history of seizures, stroke, heart problems, high blood pressure, liver problems, kidney problems, bleeding problems, diabetes, narrow-angle glaucoma or risk for narrow-angle glaucoma, allergies, pregnancy, or breast-feeding. Tell your doctor if you or a family member has a history of bipolar disorder (manic-depression), other mental or mood problems, suicidal thoughts or attempts, or alcohol or substance abuse. Tell your doctor if you are dehydrated, have low blood sodium levels, drink alcohol, or if you will be having electroconvulsive therapy (ECT). Contact your doctor or pharmacist if you have any questions or concerns about using this medicine.

HOW TO USE THIS MEDICINE: Follow the directions for taking this medicine provided by your doctor. This medicine comes with a MEDICATION GUIDE approved by the U.S. Food and Drug Administration. Read it carefully each time you refill this medicine. Ask your doctor, nurse, or pharmacist any questions that you may have about this medicine. TAKE THIS MEDICINE with or without food. STORE THIS MEDICINE at room temperature, between 59 and 86 degrees F (15 and 30 degrees C) away from heat, moisture, and light. Do not store in the bathroom. KEEP THIS MEDICINE out of the reach of children and away from pets. Other brands of medicine that contain the same ingredient (fluoxetine) are available. These other brands may be used to treat premenstrual dysphoric disorder (PMDD) or to treat depression in patients with bipolar disorder. DO NOT TAKE THIS MEDICINE if you are taking any other medicine that contains fluoxetine. Discuss any questions or concerns with your doctor. Taking this medicine at the same time each day will help you remember to take it. Continue to take this medicine even if you feel well. Do not miss any doses. DO NOT SUDDENLY STOP TAKING THIS MEDICINE without checking with your doctor. Side effects may occur. They may include mental or mood changes, numbness or tingling of the skin, dizziness, confusion, headache, trouble sleeping, or unusual tiredness. You will be closely monitored when you start this medicine and whenever a change in dose is made. IF YOU MISS A DOSE of this medicine, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: DO NOT USE THIS MEDICINE IF you are allergic to any ingredient in this medicine. THIS MEDICINE MAY CAUSE DROWSINESS OR DIZZINESS. It may also cause you to not be able to make decisions, think clearly, or react quickly. DO NOT DRIVE OR PERFORM OTHER POSSIBLY UNSAFE TASKS until you know how you react to this medicine. DO NOT DRINK ALCOHOL while you are using this medicine. Check with your doctor before you use medicines that may cause drowsiness (eg, sleep aids, muscle relaxers) while you are using this medicine; it may add to their effects. Ask your pharmacist if you have questions about which medicines may cause drowsiness. Do NOT take more than the recommended dose, change your dose, or take this medicine for longer than prescribed without checking with your doctor. SEROTONIN SYNDROME is a possibly fatal syndrome that can be caused by this medicine. Your risk may be greater if you take this medicine with certain other medicines (eg, "triptans", MAOIs). Symptoms may include agitation; confusion; hallucinations; coma; fever; fast or irregular heartbeat; tremor; excessive sweating; and nausea, vomiting, or diarrhea. Contact your doctor at once if you have any of these symptoms. IF YOUR DOCTOR TELLS YOU TO STOP TAKING THIS MEDICINE, you will need to wait at least 5 weeks before beginning to take certain other medicines (eg, MAOIs, nefazodone, thioridazine). Ask your doctor when you should start to take your new medicines after you have stopped taking this medicine. LOW BLOOD SODIUM LEVELS MAY occur from treatment with this medicine. In severe cases, this can be deadly. Call your doctor right away if you have confusion, decreased coordination, fainting, hallucinations, headache, memory problems, mental or mood changes, seizures, sluggishness, trouble concentrating, or weakness. THIS MEDICINE MAY RARELY CAUSE a prolonged, painful erection. This could happen even when you are not having sex. If this is not treated right away, it could lead to permanent sexual problems such as impotence. Contact your doctor right away if this happens. BEFORE YOU BEGIN TAKING ANY NEW MEDICINES, either prescription or over-the-counter, check with your doctor or pharmacist. Use this medicine with caution in the ELDERLY; they may be more sensitive to its effects. Caution is advised when using this medicine in CHILDREN; they may be more sensitive to its effects, especially increased risk of suicidal thoughts or actions. This medicine may cause weight changes. CHILDREN and teenagers may need regular weight and growth checks while they take this medicine. FOR WOMEN: THIS MEDICINE MAY CAUSE HARM [illegible]

BUTNER FCC BUT - X04-01
OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 275
902437-BUX Owens, Thomas MD 03/19/14
HILL, BRIAN 29947-057

Take one capsule by mouth at bedtime ***pill line* *Consent form on file * **writ****

Ziprasidone 20 MG Cap UD
(0) Refills 05/13/14 MF Refill Until: 09/15/14
#7 Don't Confiscate Before: 08/11/14

May Cause Drowsiness. Use Care When Operating A Vehicle, Vessel, Or Dangerous Machinery.

Take With Food

CAUTION: Do Not Take With Alcohol Or Nonprescription Drugs Without Consulting Your Doctor.

Do Not Take Other Medicines Without Checking With Your Doctor Or Pharmacist.

Ord. Date 03/19/14 HILL, BRIAN 29947-057 MF X04 Owens, Thomas (0) Refills
Exp. Date 09/15/14 **Take one capsule by mouth at bedtime ***pill line*** *Consent form on file * **writ****
#7
902437-BUX Ziprasidone 20 MG Cap UD

HILL, BRIAN
29947-057
BUT - X04-010L
03/19/14

BUTN FC BUT - X04-010L
OLD N. CAROLINA HWY 75 - BUTNER, North Carolina 27509
902437-BUX Owens, Thomas MD 03/19/14
HILL, BRIAN 29947-057

Take one capsule by mouth at bedtime ***pill line* *Consent form on file * **writ****

Ziprasidone 20 MG Cap UD
(0) Refills 05/13/14 MF Refill Until: 09/15/14
#7 Don't Confiscate Before: 08/11/14

Ord. Date 03/19/14 HILL, BRIAN 29947-057 MF X04 Owens, Thomas MD (0) Refills
Exp. Date 09/15/14 **Take one capsule by mouth at bedtime ***pill line*** *Consent form on file * **writ****
#7
902437-BUX Ziprasidone 20 MG Cap UD

Ziprasidone 20 MG Cap UD **902437-BUX**

GENERIC NAME: ZIPRASIDONE (zi-PRAS-i-done)

COMMON USES: This medicine is an antipsychotic used to treat mental and emotional disorders such as schizophrenia. It is also used alone or with other medicines (eg, lithium, valproate) to treat bipolar disorder (manic-depression). It may also be used to treat conditions as determined by your doctor.

BEFORE USING THIS MEDICINE: WARNING: This medicine is an antipsychotic. It may increase the risk of death when used to treat mental problems caused by dementia in elderly patients. Most of the deaths were linked to heart problems or infection. This medicine is not approved to treat mental problems caused by dementia. Talk with your doctor or pharmacist for more information. Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. DO NOT TAKE THIS MEDICINE if you are also taking astemizole, cisapride, dofetilide, droperidol, halofantrine, levomethadyl, a macrolide immunosuppressive (eg, tacrolimus), mefloquine, methadone, nilotinib, pentamidine, certain phenothiazines (eg, thioridazine), pimozide, probucol, procainamide, quinidine, certain quinolone antibiotics (eg, moxifloxacin), a serotonin receptor antagonist antiemetic (eg, dolasetron), sotalol, sparfloxacin, terfenadine, or tetrabenazine. QTc prolongation can infrequently result in serious, rarely fatal, irregular heartbeats. Consult your doctor or pharmacist for details. Ask for instructions about whether you need to stop any other QTc-prolonging medicines you may be using in order to minimize the risk of this effect. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking arsenic, bepridil, carbamazepine, chloroquine, class III antiarrhythmics (eg, amiodarone), domperidone, haloperidol, IA and IC antiarrhythmics (eg, flecainide, procainamide, propafenone), ketoconazole, kinase inhibitors (eg, lapatinib), macrolides and ketolides (eg, azithromycin, erythromycin), maprotiline, streptogramins (eg, mitomycin, pristinamycin), or tramadol. Inform your doctor of any other medical conditions including a history of heart problems (eg, heart failure, slow or irregular heartbeat), low blood potassium or magnesium levels, low blood volume, low white blood cell counts, a drug-induced movement disorder, kidney or liver problems, stroke, heart attack, low blood pressure, seizures, difficulty swallowing, neuroleptic malignant syndrome (NMS), Alzheimer disease, dementia, or suicidal thoughts or actions; a personal or family history of diabetes; high blood prolactin levels or a history of certain types of cancer (eg, breast, pancreas, pituitary), or if you are at risk for breast cancer; allergies; pregnancy; or breast-feeding. Tell your doctor if you are dehydrated, drink alcohol, or will be exposed to high temperatures; or if you have any problem with fainting or dizziness. USE OF THIS MEDICINE IS NOT RECOMMENDED if you have a history of QT prolongation, irregular heartbeat, recent heart attack, or severe heart failure. Use of this medicine in children is not recommended. Discuss with your doctor the risks and benefits of giving this medicine to your child. Contact your doctor or pharmacist if you have any questions or concerns about using this medicine.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. This medicine comes with a patient information leaflet. Ask your doctor, nurse, or pharmacist any questions that you may have about this medicine. SWALLOW WHOLE. Do not break, crush, or chew before swallowing. TAKE THIS MEDICINE with food. STORE THIS MEDICINE at 77 degrees F (25 degrees C), in a tightly-closed container, away from heat, moisture, and light. Brief storage between 59 and 86 degrees F (15 and 30 degrees C) is permitted. KEEP THIS MEDICINE out of the reach of children and away from pets. Take this medicine regularly to receive the most benefit from it. Taking this medicine at the same time each day will help you to remember. IT MAY TAKE SEVERAL WEEKS for you to notice the benefits of this medicine. CONTINUE TO TAKE THIS MEDICINE even if you feel well. Do not miss any doses. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: DO NOT TAKE THIS MEDICINE if you have had an allergic reaction to it or are allergic to any ingredient in this product. Do not stop using this medicine without checking with your doctor. KEEP ALL DOCTOR AND LABORATORY APPOINTMENTS while you are using this medicine. THIS MEDICINE MAY CAUSE DROWSINESS, DIZZINESS, lightheadedness, or fainting. To prevent them, sit up or stand slowly, especially in the morning. Also, sit or lie down at the first sign of these effects. Do not drive, operate machinery, or do anything else that could be dangerous until you know how you react to this medicine. DO NOT DRINK ALCOHOL while you are taking this medicine. THIS MEDICINE WILL ADD TO THE EFFECTS of alcohol and other depressants. DO NOT BECOME OVERHEATED in hot weather or during exercise or other activities since risk of heatstroke may be increased. THIS MEDICINE MAY INCREASE YOUR RISK OF DEVELOPING DIABETES or increase blood sugar levels. High blood sugar levels can cause serious problems if left untreated. THIS MEDICINE MAY LOWER THE ABILITY OF YOUR BODY TO FIGHT INFECTION. Tell your doctor if you notice signs of infection like fever, sore throat, rash, or chills. SEROTONIN SYNDROME and NEUROLEPTIC MALIGNANT SYNDROME (NMS) are possibly fatal syndromes that can be caused by this medicine. Your risk may be greater if you take this medicine with certain other medicines (eg, "triptans", MAOIs, antipsychotics). Symptoms may include blood pressure changes; agitation; confusion; hallucinations; other mental or mood changes; coma; fever; fast or irregular heartbeat; tremor; excessive sweating; rigid muscles; and nausea, vomiting, or diarrhea. SOME PATIENTS WHO TAKE THIS MEDICINE MAY DEVELOP MUSCLE MOVEMENTS that they cannot control. This is more likely to happen in elderly patients. Tell your doctor at once if you have muscle problems with your arms; legs; or your tongue, face, mouth, or jaw (eg, tongue sticking out, puffing of cheeks, mouth puckering, chewing movements) while taking this medicine. THIS MEDICINE MAY RARELY CAUSE A PROLONGED, PAINFUL ERECTION. If this is not treated right away, it could lead to permanent sexual problems such as impotence. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. CAUTION IS ADVISED when using this medicine in the elderly because they may be more sensitive to the effects of this medicine. FOR WOMEN: IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. Using this medicine during the third trimester may result in uncontrolled muscle movements or withdrawal symptoms in the newborn. Discuss any questions or concerns with your doctor. IT IS UNKNOWN IF THIS MEDICINE IS EXCRETED in breast milk. DO NOT BREAST-FEED while taking this medicine. DIABETICS: THIS MEDICINE MAY AFFECT YOUR BLOOD SUGAR. Check blood sugar levels closely and ask your doctor before adjusting the dose of your diabetes medicine.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS that may occur while taking this medicine include anxiety; constipation; diarrhea; dizziness; drowsiness; dry mouth; feeling unusually

Southern Health Partners
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INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 05-26-2014 Pod/Location: Orange County Jail Old Jail Cell: SM ID# 238306

Inmate's Full Name: Brian David Hill

Complaint/Problem: I realize after the incident last night that I have a problem. I like to have counseling sessions with your psychologist to help me with issues, as I don't want to ever do this again. Thank You!

How long have you had this problem? Months

Inmate's Signature: ____________ Date: ____________

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

TO BE COMPLETED BY MEDICAL STAFF:

- ☐ *See Clinical Pathway for Documentation/Response*
- ☐ *See Physician Order for Response to this Sick Call*
- ☐ *See Progress Note for Response to this Sick Call*
- ☐ *See Below for Response to this Sick Call*

Nurse's Signature/Date: Kay [signature]

****

Document Patient's Vital Signs: Temp________ Resp________ Pulse________ B/P____________

Instructions/Assessment: Document your findings; Inmate's responses/actions

Talked with I/m in cell. I put him on the Mental Health list

- ☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
- ☐ Follow-Up Required? If checked, date to be seen again____________
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Date (Not) Seen by Medical: 5-26-14 Seen by: Kay [signature] RN

Place original form in patient's medical record. SHP Form 12/06/Updated 6/2009

Southern Health Partners, Inc.
Clinical Pathways / Patient Clinical Data Form

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UPPER RESPIRATORY SYMPTOMS

Instructions: Upon patient's complaint(s), please complete the form in its entirety. Refer to the Treatment Guidelines Manual for further implementation, or feel free to contact your site physician for orders as needed. The completed form should be placed in the medical chart for future reference and/or review by the site physician.

Patient's Name: Hill Brian DOB 5/26/90

Onset of Symptoms months Duration all the time
Runny nose? Yes____ No ✓ Nasal Congestion? Yes ✓ No____ Drainage? Yes____ No ✓
Cough Present? Yes____ No ✓ Dry? Yes ✓ No____ Productive? Yes____ No ✓
Secretions? Clear Ø Green Ø Yellow Ø Brown Ø With Blood Ø Thick or Thin?
Coughing up secretions frequently? Yes____ No____ Certain times of the day? When —
Earache — Sore Throat — Facial Pain — Headache — Neck Pain —
Describe the pain stuffy nose
Level of Pain (1-10) — Is there pain when leaning forward? no pain stuffy nose
Shortness of Breath no Sweats no Drainage in throat mucus in throat
Have you had this problem before yes If YES, what was the cause and how was it treated? a long time
Are you taking any medications yes
Any allergies no
Further comments____

CLINICAL DATA: B/P 128/76 Pulse 93 RESP 12 Temp 98.4
Skin: Warm ✓ Dry ✓ Hot____ Cool____ Clammy____ Moist____
Color: Race appropriate ✓ Pale — Flushed — Jaundice — Ashen —
Respirations: Non-labored ✓ Labored____ Orthopnea____
Lung sounds: (R) clear ✓ Wheezing____ Crackles____ Ronchi____
(L) clear ✓ Wheezing____ Crackles____ Ronchi____
Pain upon palpation of sinuses? "a little" Location forehead
Throat reddened no Tonsils swollen no
Exudate noted no (if yes) Describe —
Glands swollen no Tender no (if yes) Location —
Pain with neck movement no
Can coughing be reproduced with deep breath no
If sputum specimen available, describe Agree with above? Ø

TREATMENT PLAN: Fever no Nasal Congestion stuffy Cough no
Follow tx protocol____
If no, describe plan CTM x 14 days PO BID

Physician's Order:____
Inmate advised to alert staff of changes and/or improvement: Yes ✓ No____
Patient education information supplied and/or discussed? Yes____ No____

Medical Signature: Kay [signature] RN Date: 5-26-14

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INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 05-25-2014 Pod/Location: Orange Co. Jail Old Jail Cell: SM ID# 238306

Inmate's Full Name: Brian David Hill

Complaint/Problem: I have a snoring/muccas problem. I snore so loud I annoy other inmates. Anything I can do to snore less loudly and clear the muccas from my throat would be great.

How long have you had this problem? Months

Inmate's Signature: Brian D. Hill Date: May, 25 2014

****

TO BE COMPLETED BY MEDICAL STAFF:

- ☐ *See Clinical Pathway for Documentation/Response*
- ☐ *See Physician Order for Response to this Sick Call*
- ☑ *See Progress Note for Response to this Sick Call*
- ☐ *See Below for Response to this Sick Call*

Nurse's Signature/Date: Kay [signature]

****

Document Patient's Vital Signs: Temp 98.4 Resp 12 Pulse 93 B/P 128/76

Instructions/Assessment: Document your findings, Inmate's responses/actions

I/m said nose is stuffy – tender "a little" on palpation of forehead
CTM 4mg PO BID x 14 days

- ☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
- ☐ Follow-Up Required? If checked, date to be seen again__________
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 5-26-14 Seen by: Kay [signature]

Place original form in patient's medical record. SHP Form 12/06/Updated 6/2009

USMS PRISONERS - PRIOR AUTHORIZATION QUESTIONNAIRE – Atypical Antipsychotics

Detention Facility Name & Code: Orange Co. 7212	*Date:* 5/25/14
Physician Last Name: Davis	*Physician First Name:* Arthur
Detention Facility Phone: 919-245-2946	*Detention Facility Fax:* 919-644-3382
USMS Prisoner: Hill, Brian David *ID#* 29947057	*DOB* 5-26-90

FAILURE TO COMPLETE THIS FORM MAY RESULT IN A DELAY IN PA PROCESSING

Drug Name

Geodon (Ziprasidone) 20 **MG**	**Zyprexa (Olanzapine)** ______ **MG**	**Seroquel (Quetiapine)** ______ **MG**
Invega (Paliperidone) ______ **MG**	**Latuda (Lurasidone)** ______ **MG**	**Saphris (Asenapine)** ______ **MG**

Diagnosis: ______________________

Please circle the appropriate answer for each question.

1.	Has the patient tried and failed Risperidone? (If the answer to this question is no, no further questions required.)	Y (N)
2.	Is the patient currently taking the prescribed medication with evidence of improvement?	(Y) N
	[If the answer to this question is yes, then no further questions are required.]	
3.	Has the patient demonstrated inadequate treatment response to Risperidone (any dosage form) after a trial of at least 30 days? [If the answer to this question is yes, no further questions required.]	Y N
4.	Has the patient experienced and adverse event with or does the patient have a documented contraindication to Risperidone (any dosage form) that would prohibit a 30 day trial?	Y N

☐ Check box if drug requested is a result of a court-ordered evaluation at the Federal Bureau of Prisons (FBOP). Please attach records from BOP directing use of the requested medication when you submit this Prior Authorization.

Comments: Came from Butner on this Medication

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date Martin Kitchen LPN - 5/25/14

CVS Caremark **Toll Free PH # 877-233-9820**	**CVS Caremark** **Toll Free Fax # 855-291-1938**

*****DISCLOSURE STATEMENT*****

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USMS PRISONERS - PRIOR AUTHORIZATION QUESTIONNAIRE –SSRI

Detention Facility Name & Code: Orange Co. 7212 **Date:** 5/25/14
Physician Last Name: Davis, Arthur **Physician First Name:** Arthur
Detention Facility Phone: 919-245-2946 **Detention Facility Fax:** 919-644-3382
USMS Prisoner: Hill, Brian David **ID#** 29947-057 **DOB** 5-26-90

****FAILURE TO COMPLETE THIS FORM MAY RESULT IN A DELAY IN PA PROCESSING****

Drug Name (select from list of drugs shown)

Prozac (Fluoxetine) 20 MG Zoloft (Sertraline) _____ MG Lexapro (Escitalopram) _____ MG
Paxil (Paroxetine) _____ MG Luvox (Fluvoxamine) _____ MG

Diagnosis:

anxiety, Depression

Please circle the appropriate answer for each question.

	Question	Answer
1.	Is the patient taking a monoamine oxidase inhibitor (MAOI)? (e.g. Phenelzine, Selegiline, Tranylcypromine)	Y (N)
2.	Does the patient have the diagnosis of Major depressive disorder (MDD)? [If the answer to this question is no, then skip to question 4.]	Y (N)
3.	Has the patient had at least a one month trial and an inadequate treatment response with at least one of the following options - A selective serotonin reuptake inhibitor (SSRI) (e.g., Citalopram) - Bupropion, Trazadone, Mirtazapine - Tricyclic antidepressant (e.g. Amitriptyline, Nortriptyline) - SNRI (e.g. Venlafaxine) [No further questions are required]	Y N
4.	Does the patient have the diagnosis of generalized anxiety disorder (GAD)	(Y) N

☐ Check box if drug requested is a result of a court-ordered evaluation at the Federal Bureau of Prisons (FBOP). Please attach records from BOP directing use of the requested medication when you submit this Prior Authorization.

Comments: Inmate Came to our facility from Butner on prozac 20mg every a.m. for 14 days then increase to 40mg every a.m.

I affirm that the information given on this form is true and accurate as of this date.

Martin Kitchens LPN - Orange Co. Jail

Prescriber (Or Authorized) Signature and Date

CVS Caremark **Toll Free PH # 877-233-9820**	**CVS Caremark** **Toll Free Fax # 855-291-1938**

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Sending Confirm

Date : MAY-25-2014 SUN 11:47
Name :
Tel. :

Phone	:	918552911938
Pages	:	2/2
Start Time	:	05-25 11:46
Elapsed Time	:	00'55"
Mode	:	ECM
Result	:	Ok

Southern Health P[illegible]ers
[illegible] in Affordable Inmate Healthcare

Clinical Pathways / Patient Clinical Data Form

Use for (circle): **BRUISES CONTUSIONS ABRASIONS LACERATIONS (BLISTERS) (BUNIONS) CORNS CALLOUSES SKIN LESION(S)**

Instructions: Upon patient's complaint(s), please complete the form in its entirety. Check YES answers. Uncheck is considered a NO answer. Refer to the Treatment Guidelines Manual for further implementation, or feel free to contact your site physician for orders as needed. The completed form should be placed in the medical chart for future reference and/or review by the site physician.

Patient's Name: Hill, David DOB 5/26/90

When did this occur a few Days
How did this happen Rubbed blister on left great toe from Sandels
Location of injury Left Great toe
Level of pain (1/10)____ Constant____ Intermittent____
Does pain increase with movement Y Any numbness N tenderness N Swelling N
Bruising N Color of bruising____ Size of area____ Shape____
Bleeding N Where____ Blisters____ where____
Any chronic conditions or bleeding tendencies DMI (if yes) Describe____
Are you taking any medications Yes Any allergies NKDA
Last Tetanus Shot____ Further comments____

CLINICAL DATA: B/P____ Pulse 96 RESP 14 Temp 98.3 98%
Sizes of bruise if present N Any crepitus at areas of tenderness____
Any guarding N (if yes) Describe____
Any limit to range of motion N
If Bleeding present, Arterial N Venous N Controlled N New Wound N Old Wound N
Size of laceration/abrasion Small blister Will closure require MD N
Does injury correspond with history given Y If no, why____
Blisters/Feet: Shoes fit Y Wearing socks No Shoes in good condition Y
Blisters/Hands: Wearing gloves____ Chemical exposure____ Redness Y Itching____
Swelling____ Drainage N Open wounds N Closed wounds____ Fluid filled____
Clusters____ Bleeding____
TREATMENT PLAN: Follow tx protocol ✓ Tetanus given____ If Bleeding is uncontrolled, or signs of shock, call 911.
If not following tx protocol, describe plan____
Placed on Wound Care flowsheet for monitoring/recheck N if no, why blister will bandage/give socks

IM advised to alert staff of changes: Yes ✓ Patient education information supplied/discussed? Yes ✓

Physician's Order: antibiotic ointment, bandaid x 3 days

Medical Staff Signature: M. Kitchens LPN Date: 5-20-14

Physician/Provider initials as confirmation of review of form info [initials] 5/20/14

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INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 05-19-2014 Pod/Location: Old Jail Cell: SM ID# 238306

Inmate's Full Name: Brian David Hill

Complaint/Problem: My foot has a small injury. As a diabetic I am suppose to be careful with my feet as I heal more slowly. I ask that it be treated. It's a small red sore.

How long have you had this problem? A few days

Inmate's Signature: Brian David Hill / Brian D. Hill Date: May 19 2014

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

TO BE COMPLETED BY MEDICAL STAFF:

- ☑ *See Clinical Pathway for Documentation/Response*
- ☐ *See Physician Order for Response to this Sick Call*
- ☐ *See Progress Note for Response to this Sick Call*
- ☑ *See Below for Response to this Sick Call*

Rcvd 5-20

Nurse's Signature/Date: M. Kitchens LPN

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

Document Patient's Vital Signs: Temp________ Resp________ Pulse________ B/P______________

Instructions/Assessment: Document your findings, Inmate's responses/actions

See Pathways Blisters

- ☑ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
- ☐ Follow-Up Required? If checked, date to be seen again______________
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 5-20-14 Seen by: M. Kitchens LPN

Place original form in patient's medical record.

Southern Health Partners
Your Partner In Affordable Inmate Healthcare

<back for details>

INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 05-19-14 Pod/Location: Old Jail Cell: 5M ID# 238306

Inmate's Full Name: Brian David Hill

Complaint/Problem: I haven't had my A1C blood hemoglobin level checked since February for my type 1 brittle diabetes. I ask for doing bloodwork for a lab test to be done. I also ask that I get a copy of the medical record of lab results.

How long have you had this problem? 3 Months

Inmate's Signature: Brian D. Hill Date: May 19, 2014

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

TO BE COMPLETED BY MEDICAL STAFF:

- ☐ See Clinical Pathway for Documentation/Response
- ☐ See Physician Order for Response to this Sick Call
- ☐ See Progress Note for Response to this Sick Call
- ☑ See Below for Response to this Sick Call

Rcvd 5-20

Nurse's Signature/Date: M. Kitchens LPN

Document Patient's Vital Signs: Temp______ Resp______ Pulse______ B/P__________

Instructions/Assessment: Document your findings, Inmate's responses/actions

Dr. To Review Chart

- ☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
- ☐ Follow-Up Required? If checked, date to be seen again__________
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 5-20-14 Seen by: M. Kitchens LPN

Place original form in patient's medical record. SHP Form 12/06/Updated 6/2009

PROGRESS NOTES

Date/Time	Inmate's Name: Hill, Brian D.O.B.: 5/26/90 Allergies:
5/17/14 0900	IM seen for S/C regarding insulin timing. Spoke c̄ Lt regarding IM concerns & mental status. IM trays to be held until insulin is checked TID. Detention & IM agrees to plan. [illegible signature]

PROGRESS NOTES

Date/Time	Inmate's Name: Brian Hill D.O.B.: 5/26/90 Allergies: NKDA
5/16/14	PSYCH ASSESS: 23-y-o, Cau male seen due to (+)
[illegible]	responses on [illegible] screen. Seen individually w/
	officer outside door. Was informed on limits
	of confidentiality & consented by signing form.
	Hx: Pt. jailed 12/13 & FEDERAL prisoner.
	Denied substance abuse or treatment.
	MH tx began at age 8 for "something in
	school" w/ difficulty in temper tantrums w/
	dx "Mild Autism, OCD, a lot of anxiety."
	Taking meds. "Never" @ psychiatric hospital,
	later stated @ age 13 to Baptist hospital
	for "temper tantrums & put on Prozac, it worked
	to an extent. I had to work on not being
	angry." One time in December 2013 w/ arrest
	pending he developed plan to cut throat/
	neck but no suicide attempts. Present:
	Mood "pretty much okay," affect cheerful.
	Tolerating meds w/o side effects. Denied M.H.
	difficulties or getting along in cell. No signs
	of psychosis, mania, depression & anxiety in
	presentation. Some concerns of legal situation
	as he "pretty much fired my public defender."
	MSE = Alert, attentive, Ox4 w/ normal speech
	absent of delusional themes - childish tones.
	Eating & sleeping well. Good eye contact.
	Denied HI/SI convincingly. Insight fair,
	judgment fair, impulse control good. Memory
	intact. Dx: OCD, Autism. F-up: PRN MH tx
	& pt. aware of procedure to obtain tx in
	future via blue sick call form — [signature]

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INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 05-~~13~~ 16-14 Pod/Location: Old Jail Cell: S/M ID# 238308

Inmate's Full Name: Brian David Hill

Complaint/Problem: The reason my blood sugar is high is because of getting my insulin shot 1-2 hours after each meal I had ate. My body processes sugar and starches fast so need to <back>

How long have you had this problem? Since I was booked into Orange Co. Jail.

Inmate's Signature:________ Date:________

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

TO BE COMPLETED BY MEDICAL STAFF:

- ☐ See Clinical Pathway for Documentation/Response
- ☐ See Physician Order for Response to this Sick Call
- ☐ See Progress Note for Response to this Sick Call
- ☐ See Below for Response to this Sick Call

Nurse's Signature/Date: ________

Document Patient's Vital Signs: Temp____ Resp____ Pulse____ B/P____

Instructions/Assessment: Document your findings, Inmate's responses/actions________

See NN

- ☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
- ☐ Follow-Up Required? If checked, date to be seen again________
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical:________ Seen by:________

Place original form in patient's medical record.

SHP Form 12/06/Updated 6/2009

Confidentiality – Mental Health

There are limits to the information about you that your mental health provider can keep confidential. Sometimes the law, safety or institutional security requires mental health providers to disclose your information to others. It is very important that those seeking mental health services carefully read and understand these limits of confidentiality. The following is a list of the sorts of circumstances under which mental health staff will be required to make appropriate reports to non-medical or non-mental health personnel:

1) An individual plans to take harmful, dangerous, or criminal action against another individual or against him/herself. This means if we believe you are a danger to yourself or to someone else, we have to take steps and notify the proper authorities of that danger.

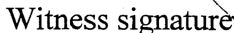
2) Incidents of suspected child abuse or neglect.

3) Incidents of "dependent adult" or elderly physical abuse or neglect.

4) Information that an individual is a threat to the security and orderly operation of any correctional facility. This means that if you tell us about drug trafficking, sexual activity, plans to escape, riot, work stoppage, hostage taking, inappropriate relationships with staff, or any other significant prohibited behavior (major infractions involving safety or institutional security), we will report this to the proper institutional authorities.

5) If your mental illness requires that you be transferred to another facility for treatment.

I, the undersigned, have read (or had read to me) this statement and fully understand the limits of my confidentiality.



Brian D. Hill

Inmate signature

5/16/14

Date

Witness signature

5/16/14

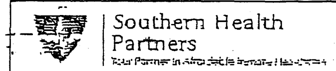
Date

Inmate name: BriAN Hill

Inmate birth date: 5-26-90

Location: Orange County Jail

SHP Form 3/2013



MEDICAL STAFF RECEIVING SCREENING FORM

LAST NAME	FIRST NAME	MIDDLE	BOOKING DATE	SCREENING DATE	TIME AM/PM
Hill	Brian	D	5-14-14	5-15-14	1745

PREVIOUS INCARCERATIONS: Butner Fed Prison SEX: M SOCIAL SECURITY NO.: DOB: 5-26-90

CURRENT INSURANCE COVERAGES? CURRENTLY UNDER PHYSICIAN'S CARE FOR CHRONIC CONDITION:

VISUAL / MEDICAL OBSERVATION: *(Explain all "Yes" Answers)* Circle Y or N:	YES	NO
Is inmate unconscious or showing visible signs of illness, injury, bleeding, pain, or other symptoms suggesting the need for immediate emergency medical referral? If yes:	Y	(N)
Are there any visible signs of fever, jaundice, skin lesions, rash, or infection: cuts, bruises, or minor injuries; needle marks, body vermin? If yes:	Y	(N)
Does the inmate exhibit any signs that suggest the risk of suicide, assault, or abnormal behavior? If yes:	Y	(N)
Does the inmate appear to be under the influence of, or withdrawing from drugs or alcohol? If yes:	Y	(N)
Is the inmate's mobility restricted in any way due to deformity, cast, injury, etc. If yes:	Y	(N)
ASK THE INMATE THESE QUESTIONS: *(Explain all "Yes" answers)*		
Have you had or been treated for: (circle as appropriate) asthma, diabetes, epilepsy, heart condition, high blood pressure, mental health problems, seizures, ulcers, or other conditions? Other: DMI, Autistic, Acid Reflux, OCD	(Y)	N
Have you taken or are you taking any medication(s) prescribed for you by a physician? If yes: insulin (R) SS, NPH, Prozac	(Y)	N
Are you allergic to any medications, foods, plants, etc.? If yes: Geodon,	(Y)	N
Have you fainted or had a head injury within the last 72 hours? If yes:	Y	(N)
Do you have or have you been exposed to AIDS, hepatitis, TB, VD, or other communicable disease? For TB, ask if he/she has had night sweats; had weight loss recently; persistent coughing. If yes: TB Cleared See Fed Log	Y	(N)
Have you been hospitalized by a physician or psychiatrist within the last year? If yes: Martinsville Memorial Hosp Dec 2013 Mental eval	(Y)	N
Have you ever considered or attempted suicide? If yes:	Y	(N)
Do you have a painful dental condition? If yes:	Y	(N)
Are you on a specific diet prescribed by a physician? If yes:	Y	(N)
Do you use drugs? How often? Last time? What kind? How much?	Y	(N)
Do you use alcohol? How often? Last time? What kind? How much?	Y	(N)
Females: LMP Date:______ Are you pregnant, recently delivered or aborted; on birth control pills; having abdominal pain or discharge? If yes: Male	Y	(N)

DOCUMENT VITAL SIGNS:

Respiration:	O2 Sat:	Pulse:	Temperature:	Blood Pressure:	Weight:
16	99	76	98.4	116/74	170

PPD IMPLANTED? Y OR (N) HAVE ALL CONCERNS FROM OFFICER INTAKE AND ABOVE ANSWERS BEEN EXPLAINED ABOVE?

REMARKS: PPD clear – See Fed Log
BG=300

I have answered all questions truthfully. I have been told and shown how to obtain medical services and advised on how to obtain medication upon release. I hereby give my consent for professional services to be provided to me by and through Southern Health Partners, Inc. Further, I release Southern Health Partners, Inc., its staff, the County, the Sheriff, Jailer, and his/her staff from all responsibility and I assume personal responsibility for the conditions that may occur as a result of my not requesting services and/or refusing treatment as prescribed by the medical staff of the facility and/or outside consultation services.

Inmate's Signature: Brian David Hill Date: 5-15-14

Interviewer's Signature and Title: M. Kitchen CPN Date: 5-15-14

Bureau of Prisons
Health Services
Inmate Study Complete

Reg #: 29947-057 **Inmate Name:** HILL, BRIAN DAVID

SENSITIVE BUT UNCLASSIFIED – This information is confidential and must be appropriately safeguarded.

Transfer To: Study Complete Transfer Date: 05/05/2014

Health Problems

Type	Health Problem	Status
Chronic	Autistic disorder	Current
	By his self-report and nothing in MSE suggested otherwise.	
Chronic	Obsessive-compulsive personality disorder	Current
	Perhaps frank OCD though difficult to distinguish b/t PD vs OCD.	
Chronic	Diabetes mellitus, type I (juvenile type)	Current
Temporary/Acute	Delusional disorder	Current
	In the wake of autism, difficult to assess presence of psychosis but he endorses irrational belief of a conspiracy against him. He brought these beliefs up only when prompted and did not volunteer them on his own which is consistent with paranoia delusions.	
Temporary/Acute	Health examination of defined subpopulations	Current

Medications: All medications to be continued until evaluated by a physician unless otherwise indicated. Bolded drugs required for transport.

FLUoxetine 20 MG Cap UD Exp: 08/17/2014 SIG: Take one capsule by mouth (20 mg) by mouth each morning x 14 days ***pill line* only *Consent form on file *---Take two capsules (40 mg) by mouth each morning ***pill line*** only *Consent form on file ***

Glucose 4 GM Tab Exp: 09/14/2014 SIG: Chew 1 tablet as needed for low blood glucose

Insulin Reg (10 ML) 100 UNITS/ML Inj Exp: 08/11/2014 SIG: Inject 7 units of regular insulin subcutaneously three times a day ***pill line***

Insulin Reg (10 ML) 100 UNITS/ML Inj Exp: 05/12/2014 SIG: Sliding scale twice daily : BG 150-199=1 unit; 200-249=2 units; 250-299=3 units; 300-349=4 units; 350-399=5 units; >400=6 units and call MD

Insulin NPH (10 ML) 100 UNITS/ML INJ Exp: 09/23/2014 SIG: 18 units of nph insulin subcutaneously each evening ***pill line* only**

Insulin NPH (10 ML) 100 UNITS/ML INJ Exp: 09/23/2014 SIG: 30 units of nph insulin subcutaneously each morning ***pill line* only**

Ziprasidone 20 MG Cap UD Exp: 09/15/2014 SIG: Take one capsule by mouth at bedtime ***pill line* *Consent form on file ***

OTCs: Listing of all known OTCs this inmate is currently taking.

None

Pending Appointments

Date	Time	Activity	Provider
05/02/2014	12:54	Exit Summary	MLP 02
05/15/2014	00:00	Sick Call/Triage	MLP 02
06/10/2014	08:30	Chronic Care Visit	MLP 02
02/09/2015	00:00	PPD Administration	Nurse
03/30/2015	00:00	Diabetic Foot Screen	Phys Therapist 01
04/15/2014	15:08	Psychology Encounter	Graney, Dawn PhD

Pending Non-Medication Orders:

Order	Order Date	Frequency	Duration	Details
Blood Glucose	04/03/2014	BID	90 days	

TB Clearance:

Last PPD Date: 02/09/2014
Last Chest X-Ray Date:
TB Treatment:
TB Follow-up Recommended: No

Induration: 0mm
Results:
Sx free for 30 days: Yes

SENSITIVE BUT UNCLASSIFIED – This information is confidential and must be appropriately safeguarded.

Sickle Cell:

Sickle Cell Trait/Disease: No

Limitations/Restrictions/Diets:

Cell: lower bunk --- 12/12/2014
Cleared for Food Service: Yes
No Ladders --- 12/12/2014
LAN Comments: Care level 2

Comments:

Allergies

No Known Allergies

Devices / Equipment

Shoe inserts

Alternate Institutional Shoes

Shoe inserts

Travel:

Direct Travel: No
Travel Restrictions: None

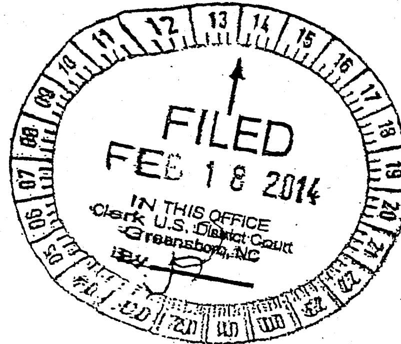
UNIVERSAL PRECAUTIONS OBSERVED WHEN TRANSPORTING ANY INMATE:

Transfer From Institution: BUTNER MED FCI Phone Number: 9195754541
Address 1: OLD NC HWY 75
Address 2:
City/State/Zip: BUTNER, North Carolina 27509

Name/Title of Person Completing Form: Sielicki, Stanislaw MLP Date: 05/02/2014

Inmate Name: HILL, BRIAN DAVID Reg #: 29947-057 DOB: 05/26/1990 Sex: M

U.S. Department of Justice
Federal Bureau of Prisons
Federal Correctional Complex
Federal Correctional Institution
P. O. Box 1000
Butner, North Carolina 27509



February 11, 2014

The Honorable Catherine C. Eagles
United States District Court
Middle District of North Carolina
324 West Market Street
Greensboro, NC 27401-2544

RE: HILL, Brian David
REGISTER NUMBER: 29947-057
DOCKET NUMBER: 1:13-CR-435-1

Dear Judge Eagles:

The above referenced individual was admitted to the Federal Correctional Institution, Butner, North Carolina, on February 7, 2014, pursuant to the provisions of Title 18, United States Code, Sections 4241(b) and 4242 (a). Currently, the evaluator is conducting interviews and psychological testing with Mr. Hill, which are necessary to complete his evaluation. In order to complete extensive psychological testing, I respectfully request the evaluation period start on the date of his arrival at this institution and be extended for thirty days. If this request is granted, the evaluation period will end on April 22, 2014. Staff will complete the evaluation as soon as possible after that date and notify the U.S. Marshals Service and the Clerk of Court when the evaluation is completed. If you concur, please complete the bottom section of this request and return by fax machine to Tracy Taylor, Health Systems Specialist, at (919) 575-2015, and to Antonia Loyd, Supervisory Inmate Systems Specialist, at (919) 575-2003.

Thank you in advance for your assistance in this matter. If you need additional information, please contact me at (919) 575-4541.

Respectfully,

Charles Ratledge
Warden

X The above requested extension of time is hereby granted

[ ] The above requested extension of time is not hereby granted

Signature: ______________________ DATE: 2/18/14
U.S. District Judge Catherine C. Eagles