Kern Medical
1700 Mt. Vernon Ave.
Bakersfield, CA 93306

7018 0680 0000 1375 1102

U.S. POSTAGE PITNEY

$ 008.
OCT 15

10-22-18 1333

Joseph William Baker
500 Westover Dr. #4444
Sanford NC 27330

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Joseph WilliamBaker
500 Westover Dr. #4444
Sanford NC 27330.

9590 9402 3988 8079 9312 30

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ Agent
☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☒ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Mail
☐ Mail Restricted Delivery
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

KERN MEDICAL
1700 MOUNT VERNON AVE
BAKERSFIELD, CA 93306

Request made to/by: ☒ Health Information Services
Medical Legal
Phone (661) 326-2591
Fax (661) 326-2593
☐ **Correctional Medicine**
Phone (661) 391-7913
Fax (661) 391-7386

AUTHORIZATION FOR USE AND / OR DISCLOSUREOF PROTECTED HEALTH INFORMATION

(Not To Be Used For The Release of Psychotherapy Notes***)***

Patient Name Baker, Joseph, William (Last, First, Middle)
MR #/ACCT # 1270166
Address 500 Westover Dr. #4444
Date of Birth June 19th 1965
City/State/Zip Code Sanford, NC 27330
SS# [redacted]
Telephone Number 262-806-8031
Mother's Maiden Name/Other Name:
Date of Request Wednesday, Sept 26th, 2018

I authorize KERN MEDICAL to release information to:
Name of Provider Organization/Person : Self- Joseph William Baker
Address: 500 Westover Dr. #4444
Phone Number: 262-806-8031 Fax Number:

I authorize KERN MEDICAL to obtain information from:
Provider Name/Organization: Kern Medical Center
Address: 1700 Mount Vernon Ave; Bakersfield, CA 93306
Phone Number: Fax Number:

Purpose of Request for Information: ☒ Healthcare ☐ Insurance Coverage ☐ Personal
☒ Other: Evidence of Police officer Richard S. Davis Jr. Attempting Murder by stomping on my Head and neck 3 times

Information to be Released: ***(Check all applicable boxes and/initial selection as required.)***

JB (Initial) All my health information pertaining to any medical history, physical condition and treatment received. Or, only the following records or types of health information and/or only on the specified date(s):
Date(s) of Treatment: September 28th 2009 Type of Treatment: Emergency Dept.
(Inpatient, Emergency Dept, Outpatient, Other)

- ☒ Discharge Summary
- ☒ History & Physical
- ☒ Operative Report
- ☒ Consultation
- ☒ Emergency Room Records
- ☐ Pathology Report
- ☒ Laboratory Reports
- ☒ Radiology Reports
- ☒ EKG Reports
- ☒ Physician Orders
- ☒ Medication Records
- ☒ Nursing Notes
- ☒ Radiology Film

JB (Initial) Other: Name of Nurses & Supervisor of Working that time who denied me water as I Begged 35 times. She said "Well if you hadn't knocked over a police officer."

JB (Initial) Records of treatment for psychiatric or mental health illness.

_____ (Initial) HIV test results or records of the diagnosis or treatment for HIV, HIV-related illness, AIDS, or AIDS-related.

Name: BAKER,JOSEPH W
DOB: 06/19/65 Age: 44Y Sex: M
Unit#: K0001270166
ACCT#: K0927100500
Location: DIS - ERJ

Ord Phys: GLENN,KELLY
Adm Phys: AMIN,MANISH
Con Phys:

Chk-in #	Order	Exam		
1361000	0001	70450	CT BRAIN W/O CONTRAST	09/28/09 0810

NON-CONTRAST HEAD: September 28, 2009

CLINICAL INDICATION: R/O bleed.

Contiguous transaxial images of the head were obtained without intravenous contrast.

FINDINGS: There is a comminuted fracture of the right zygomatic arch. No air fluid level seen in the paranasal sinuses or in the mastoid air cells. There is no intracranial bleed or extraaxial collection or midline shift.

IMPRESSION:
Comminuted fracture of the right zygomatic arch. No intracranial bleed or midline shift.

D: September 28, 2009/ds

T: 09/29/09 1005

Transcriptionist- DEBBIE STANSBURY, Medical Secretary/Transcriptionist
Reading Radiologist- SUDHA CHALLA M.D., Radiologist
Releasing Radiologist- SUDHA CHALLA M.D., Radiologist
Released Date Time- 09/29/09 1649

KERN MEDICAL CENTER
1830 FLOWER STREET
BAKERSFIELD, CA 93305-1497
(661)326-2520

DEPARTMENT OF RADIOLOGY

GLENN,KELLY

Name: BAKER,JOSEPH W
DOB: 06/19/65 Age: 44Y Sex: M
Unit#: K0001270166
ACCT#: K0927100500
Location: DIS - ERJ

Ord Phys: GLENN,KELLY
Adm Phys: AMIN,MANISH
Con Phys:

Chk-in #	Order	Exam		
1361001	0002	73590	XR TIBIA/FIBULA 2 V*R	09/28/09 0811

RIGHT LOWER EXTREMITY: 09/28/09

CLINICAL INDICATION: Rule out fracture.

Frontal, lateral views of the right tibia and fibula. No fracture or dislocation seen.

IMPRESSION:
No fracture or dislocation seen.

D: 09/28/09 cmt

T: 09/29/09 1136

Transcriptionist- COLLEEN TAYLOR, Medical Secretary/Transcriptionist
Reading Radiologist- SUDHA CHALLA M.D., Radiologist
Releasing Radiologist- SUDHA CHALLA M.D., Radiologist
Released Date Time- 09/30/09 1450

KERN MEDICAL CENTER
1830 FLOWER STREET
BAKERSFIELD, CA 93305-1497
(661)326-2520

DEPARTMENT OF RADIOLOGY

GLENN,KELLY

KERN MEDICAL CENTER
Owned And Operated by the County of Kern
Bakersfield, CA 93305

ACCT # 0927100500
PATIENT BAKER,JOSEPH W
ADMIT DATE: 09/28/09

MEDREC# 0001270166
DOB: 06/19/65

ADVANCE DIRECTIVE DETERMINATION FORM

Section A – Registration Staff to Complete:

1. **Does the patient have an Advance Directive/Psychiatric Advance Directive?**
   - ☐ Yes-copy present
   - ☐ Yes – provided on previous admission. *Date:* _____
   - ☐ Yes-copy not available – *See Section B #4*
   - ☒ No
2. ☐ **Patient was given:** ☐ **Consent Giver was provided the following information:**
   - Patient Rights Information Booklet
   - Your Right to Make Decisions About Medical Treatment

   ☒ Patient refused information
   ☐ Patient unable to receive information due to condition (emergency treatment; confusion; or unresponsive state)
   ☐ Other: _____
3. **Does the patient wish assistance to create an Advance Directive?**
   ☐ No ☐ Yes (refer Inpatients to Social Services for assistance/Outpatients Resource List Provided)

Registration Staff completing the above
Referral Sent By: _____ Date/Time: _____
Registration Staff Signature: _____ Date/Time: 9/28/09

Section B – Inpatient Nursing Staff to Complete: (Complete This Section if patient has an Advance Directive/Psychiatric Advance Directive)

1. **Is copy of Advance Directive with patient/registration packet?**
   ☐ Yes, copy placed in chart by: _____
2. ☐ **Copy from previous admission requested from Medical Records and placed in chart**
3. **The following reminder contacts or phone calls were made to obtain the copy of Advance Directive:**
   Record Follow-Up Attempts Below to Obtain Advance Directive: (at least 2 additional contacts, 24 hours apart)*

Date	Time	Person Contacted	Signature of KMC Staff

4. **Not available, patient states intent as follows:** _____
5. ☐ **Current Advance Directive validated with patient:**
   ☐ No changes requested
   ☐ Changes requested. _____, Physician notified.
   Date: _____ Time: _____
6. ☐ **Level of Care order form completed.**

_____ _____
RN Signature/HIS # *Date/Time*

Section C – Social Services: (Complete if Referral is Requested)

1. **Social Worker consultation completed by:** _____
   Date/Time: _____
   ☐ Advance Directive placed in chart
   ☐ RN and Physician notified Date/Time: _____

Section D – Revocation of Advance Directive:

1. **Patient revocation of Advance Directive communicated to:** _____ Date/Time: _____
   ☐ Patient's wishes documented in Progress Notes
   Signed: _____ (*Physician*) Date/Time: _____

KERN MEDICAL CENTER
OWNED AND OPERATED BY THE COUNTY OF KERN
BAKERSFIELD, CA 93306

ACCT#0928000125 MEDREC 0001270166
BAKER,JOSEPH W
SUR DATE: 10/07/09 DOB: 06/19/65 SEX M

OUTPATIENT CHART REVIEW

Check appropriate clinic:
Family Practice [ ] Gen. Medicine [ ]
Orthopedic [ ] Pediatric [ ] Gyn [ ]
New OB [ ] Surgery [ ]
Other_____

DATE

------- CLINIC APPOINTMENT NOT KEPT -------

RETURN TO CLINIC (check one of the following): FAD [ ] PRN [ ]

NOT KEPT LETTER SENT YES [ ] NO [ ]

WAS A RETURN APPOINTMENT CARD SENT? NO [ ] YES [ ] DATE_____

RETURN TO CLINIC ON:_____
(Date/time of appointment)

NURSE/CLERK NAME: KJ8903

DATE

Plastics

------- CHART CHECK / SCREENING ----------

NO Show

PHYSICIAN _____
(Signature) (Date)

KMC 580 8997 511 (2/09)
Stock # 14-1810

OUTPATIENT CHART REVIEW

Owner: Outpatient Clinics
Approved by Medical Record Committee 10/28/03

KERN MEDICAL CENTER
Owned And Operated by the County of Kern
Bakersfield, CA 93305

ACCT # 0927100500
PATIENT BAKER,JOSEPH W
ADMIT DATE: 09/28/09

MEDREC# 0001270166
DOB: 06/19/65

CONDITIONS OF ADMISSION

CONSENT TO MEDICAL AND SURGICAL PROCEDURES

The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures, anesthesia, or hospital services rendered the patient under the general and special instructions of the patient's physician or surgeon.

NURSING CARE

This hospital provides only general nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that the patient is not provided with such additional care.

RELEASE OF INFORMATION

The hospital will obtain the patient's consent and his/her written authorization to release information, except in those instances when the hospital is permitted or required by law to release such information. The law provides that the consent of the patient be obtained so that the hospital may use or disclose patient information to provide medical treatment to the patient, to the extent necessary for health care operations, and to determine liability for payment or to obtain reimbursement. By signing below, the patient acknowledges his/her consent, or if you are the patient's legal representative, you consent on the patient's behalf. Disclosure may be made to any person or entity that may be liable for any of the hospital's charges. Health care operations may be performed by the hospital, or its authorized agents, who will also have a binding obligation to maintain the confidentiality of the patient information. Special permission may be required to release this information, or other limitations on release may apply, if the patient is treated for alcohol, drug abuse, or HIV or AIDS, or if the patient receives certain mental-health related services.

PERSONAL VALUABLES

It is understood and agreed that the hospital maintains a fireproof safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, or other articles of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property, which is deposited with the hospital for safekeeping, is limited by statute to five hundred dollars ($500), unless a written receipt for a greater amount has been obtained from the hospital by the patient.

PHOTOGRAPHY FOR PATIENT TREATMENT OR HEALTH CARE OPERATIONS

I consent to the taking of photographs of my medical or surgical condition or treatment, and the use of the photographs, for purposes of my diagnosis or treatment or for the hospital's operations, including peer review and education or training programs conducted by the hospital.

PHOTOGRAPHY OF NEWBORNS

I consent to the taking of photographs of my newborn child or children for possible purchase by me.

KERN MEDICAL CENTER
Owned & Operated by County of Kern
Bakersfield, CA

ACCT# 0927100500 MEDREC 0001270166
ACCT# BAKER,JOSEPH W
PATIEN ERJ DATE: 09/28/09 DOB: 06/19/65 SEX M

B //
//
of 1

CONSULTATION – FOCUSED

ATTENDING PHYSICIAN + SERVICE REQUESTING CONSULTATION: _____

CONSULTATION TO: Plastics

REASON FOR CONSULTATION: Zygomatic fracture

Physician Signature and HIS # _____ Date _____ Time _____

Physician Name + Pager # (Print) _____

HISTORY/PHYSICAL EXAM: Pt ~~underwent~~ is 44 yo CM inmate, hit with baton in jail this AM at 3 am. Pt c/o mild pain + edema.

PE: HEENT - Mildly TTP over (R) zygoma. (+) ecchymosis below eye, (+) abrasions to (R) face.

LABORATORY: ~~X~~ N/A

X-RAY: ☐ N/A ☐ normal ☒ abnormal:
specify: CT - (R) zygoma fracture

EKG: ☐ N/A ☐ normal ☐ abnormal:
specify: _____

MEDICATIONS: ☒ none
☐ see medication reconciliation form

ALLERGIES: ~~☒~~ NO ☒ YES; describe Morphine - hypotension

IMPRESSION + PLAN: 44 y/o CM c (R) zygoma fracture.
(R) zygomaticomaxillary fx ⇒ See in clinic 1 wk
Out pt reduction if desired.

Physician Signature and HIS # 4545 Date 9/28/09 Time 1400

Physician Name (Print) Chris Stalker

☒ I reviewed the consultation, examined the patient and I agree with the assessment and plan.
This has been discussed with the resident.

9.28

Attending Physician Signature and HIS # ☐ same as above

Attending Physician Name + Pager (Print) ☐ same as above

KERN MEDICAL CENTER
Owned & Operated by County of Kern
Bakersfield, CA

EMERGENCY DEPARTMENT COMPREHENSIVE TRIAGE SHEET

ACCT#0927100500 MEDREC 0001270166
BAKER,JOSEPH W
ERJ DATE: 09/28/09 DOB: 06/19/65 SEXM

Date: 9/28/09 Time: 0405

CHECK ALL BOXES THAT APPLY

AIRWAY
- ☑ Clear
- ☐ Obstructed

BREATHING
- ☑ Unlabored
- ☐ Labored
- ☐ Nasal Flaring
- ☐ Expiratory Grunting
- ☐ Retractions
- ☐ Audible Wheezes
- ☐ Stridor
- ☐ Accessory Muscle Use

CIRCULATION
- ☐ Normal
- ☐ Capillary Refill over 3 Seconds
- ☐ Pulse – Radial Pulse Palpable
- ☐ Pulse – Irregular tachycardia refuses to allow me to palpate his pulses

NEURO
- ☐ Alert and Oriented times 4
- ☐ Confused
- ☐ Altered Mental Status
- ☐ Unconscious
- ☐ Agitated
- ☐ Pupils PERRLA

PAIN: PQRST pneumonic:

Provokes_____
- ☐ No

Palliates_____
- ☐ No

Quality ☐ Sharp ☐ Dull ☐ Heavy
☐ Pressure ☐ Aching ☐ Burning
☐ Tight ☐ Cramping
☐ Throbbing

Region_____ Refuses to answer

Radiates_____

Severity Scale:
0 1 2 3 4 5 6 7 8 9 10
Mild Mod Severe

Timing:
Onset_____

Duration_____

ASSESS ONLY FOLLOWING AREAS WHICH ARE SPECIF. TO CHIEF COMPLAINT

SKIN
- ☐ Warm
- ☐ Cool
- ☐ Hot
- ☐ Normal Skin Color
- ☐ Pale
- ☐ Ashen
- ☐ Flushed
- ☐ Mottled
- ☐ Jaundiced
- ☐ Cyanotic
- ☐ Normal Turgor
- ☐ Tenting
- ☐ Diaphoretic
- ☐ Laceration/Avulsion

Describe further in comments:
- ☐ Abrasions
- ☐ Rash

See description in Comments

☐ **FINGERSTICK GLUCOSE**
_____mg/dl

HEAD Peds/Infants only
- ☐ Normal
- ☐ Bulging
- ☐ Sunken
- ☐ Flat

CHEST
- ☐ Lung Sounds Normal
- ☐ Lung Sounds Abnormal

See description in Comments:

HEART
- ☐ Normal
- ☐ Braydcardic
- ☐ Tachycardia
- ☐ Irregular Rhythm

ABD
- ☐ Soft, bowel sounds present
- ☐ Non-Tender
- ☐ Abnormal

See description in Comments:

GU
- ☐ Normal
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ LMP _____
- ☐ Gravida_____ Para_____
- ☐ Urine HCG ☐ positive ☐ negative

COMPLAINT

UPPER EXT:
- ☐ Normal
- ☐ Deformity

"See description in Comments"
- ☐ Abnormal Neuro Status

"See description in Comments"

LOWER EXT:
- ☐ Normal
- ☐ Deformity

See description in Comments
- ☐ Abnormal Neuro Status

See description in Comments

****

PSYCH:
- ☐ Danger to self
- ☐ Danger to others
- ☐ Gravely disabled
- ☐ 5150
- ☐ Implement Appropriate Observation Leve

See description in Comments

****

Victims of Abuse Questions.

Do you feel safe in your home?
Yes ☐ No☐

Have you ever been harmed or threatene by someone you live with or are close to?
Yes ☐ No ☐

Is any one misusing your money, food, clothing, housing, and denying your medi care?
Yes ☐ No ☐

Staff assessment: Any signs of physical abuse?
Yes ☐ No ☐

Comments:_____

RN Signature: Marderosian M3050

KMC 580 8997 2149 (01/08) Owner: Emergency Dept. Approved by Medical Records Committee 01/08 Index Code: EDN

Kern Medical Center
Emergency Department Triage

Name: Joseph Baker Date: 9/28/09

Check in Time: 0400 Triage Time: 0400

Age: 44 DOB: 6/19/65 Gender: Male Female

Private MD: None

Called: Yes No

Language: ENGLISH SPANISH OTHER Interpreter:

Barriers to Learning: Specify None

Patient Label

ACCT#0927100500 MEDREC 0001270166
BAKER,JOSEPH W
ERJ DATE: 09/28/09 DOB: 06/19/65 SEX M

Brought in By: EMS Police
Juvenile Hall Family Self
How Arrived
Walk Auto Carried WC

Chief Complaint: Medical Clearance for jail

Subjective History:

Current Medications (INCLUDE OTC/HERBALS) Refuses to answer

See Medication Reconciliation Form

Street Drugs Yes No Type Refuses to answer ETOH Yes No How much per day? Refuses to Answer

Vitals Signs: BP L / R: 111/82 HR 145 RR 18 Temp Refused O2 Sat 98% RA O2

2nd BP L / R: / Comments:

ALLERGIES: Refuses to answer NKA

Explain symptoms:

Allergic to Meds: Yes No Food Yes No Latex Yes No

PMH: HTN Asthma Diabetes
Cardiac Pacemaker COPD
Cancer GI GU Renal Seizures
Arthritis Drug/ETOH Psych Coccidioidomycosis
Surgeries None Refuses to answer

Smoking Yes No
Packs Per Day
Smoking Cessation Education

Last Tetanus: Less than 5yrs Greater than 5yrs

Immunizations: Refuses to answer UTD NO UNK

Communicable Disease Exposure: Chicken Pox STD HIV

Cough more than 3 Weeks Night Sweats Tires Easily

Fever/Chills Hemoptysis

Domestic Violence Suspected
Yes No

If Yes: Significant Other Present
Yes No

Suspected Sexual Assault
Yes No

Weight: (Kg) Height: Weight Loss of Lbs over Wks

Advanced Protocols: CAP AMI CHF
Specify
Protocol Order Sheet Attached YES NO

Triage Acuity: 1 Resuscitative 2 Emergent 3 Urgent 4 Less than Urgent 5 Routine

TRIAGE DISPOSITION: MAIN ED FAST TRACK EPAC

TRIAGE RN: Marderosian RN M5050 TRANSLATOR:

No Answer Time Time Time

KERN MEDICAL CENTER
1830 Flower Street
Bakersfield, CA 93305

ACCT # 0927100500
PATIENT BAKER,JOSEPH W
ADMIT DATE: 09/28/09

MEDREC# 0001270166
DOB: 06/19/65

EMERGENCY: Nursing Initial/ Continuing Assessment Form

Date: 9/28/09

Allergies: ☒ No ☐ Yes , Identify & Describe Reaction: _____

Pediatric:
All patients under the age of 14 years:
Height:_____ Weight:_____
If patient is under the age of 2 years, include
Head Circumference:_____

Pain Assessment:
☐ No ☒ Yes , If yes describe below:

Pregnant:
☐ No ☐ Yes ☐ Unk ☒ NA
LMP:_____

Tetanus:
☐ UTD ☐ NUTD ☒ UNK

Immunizations:
☒ UTD ☐ NUTD ☐ UNK

Nursing Initial/ Continuing Reassessment

NEUROLOGICAL

Oriented X3
Behavior appropriate
Speech clear, appropriate

Time:	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
Initials:	JH		JH																					

0750

A&O X4, denies LOC

CARDIOVASCULAR

HR Reg.
Extrem. warm, pink

Time:	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
Initials:	JH		JH																					

Multiple area ecchymosis

RESPIRATORY

Resp. quiet & reg. rates/depth
Nailbeds, membranes pink

Time:	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
Initials:	JH		JH																					

Even, equal, non-labored

PAIN

Absence of

Time:	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
Initials:	JH		JH																					

B/L knees + (L) thigh 6/10 ↑ c movement

GASTRONTESTINAL

Tol diet w/o nausea/vomiting
BM within usual pattern/consistency
Normal appetite/chewing
Swallows w/out difficulty
No Bleeding

Time:	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
Initials:	JH		JH																					

Soft, flat

KERN MEDICAL CENTER
1830 Flower Street
Bakersfield, CA 93305

ACCT # **0927100500**
PATIENT BAKER,JOSEPH W
ADMIT DATE: 09/28/09

MEDREC# **0001270166**
DOB: **06/19/65**

EMERGENCY MEDICINE RECORD
TEACHING PHYSICIAN ADDENDUM

HISTORY AND PHYSICAL

I have personally seen, evaluated and participated in this patient's services and find this patient's history and physical examination to be consistent with that documented by Dr. Glenn

Brief history is as follows: 44yoM c/o Head, face, neck, legs ∓ altercation c law enforcement

On exam, I find as follows:

CONSTIT / VITALS	☑ nl	☐ abn
HEENT	☐ nl	☒ abn (R) facial swelling/ecchymosis, (R) upper lip hematoma
RESP	☑ nl	☐ abn
CVS	☑ nl	☐ abn
GI/GU	☑ nl	☐ abn
NEURO/PSYCH	☐ nl	☒ abn guarded historian
MUSC/SKEL	☐ nl	☒ abn (L) thigh ecchymosis/hematoma
OTHER	☐ nl	☐ abn (R) shin - 2cm lac

MEDICAL DECISION MAKING

☒ I personally interpreted the EKGs, diagnostic x-rays and laboratory studies documented by the resident.
DIAGNOSTIC TESTS REVIEWED
- ☐ LAB
- ☒ X-RAY (R) tib/fib; CT Head
- ☐ EKG
- ☐ OTHER

☐ I personally supervised the following medical treatment documented by the resident.

☐ I personally participated in the decision making and was present for, and supervised the following procedures:

PROCEDURES:

☐ CPR AND ACLS	☐ LUMBAR PUNCTURE	☐ FX or DISLOC REDUC.
☐ INTUBATION	☐ CENTRAL LINE	☐ SPLINT / CAST
☐ CRITICAL CARE ____ Mins	☐ DPL	☐ LACER. REPAIR / WOUND CARE
☐ CONSCIOUS SEDATION	☐ ARTHRO / PARA / THORACENTESIS	☐ DIGITAL / HEMATOMA BLOCK
☐ CHEST TUBE	☐ BURSA / JOINT / TRIG-POINT INJ.	☐ OTHER

Procedure note

☒ I agree with and participated in determining the final impression, treatment and disposition documented by the resident. See resident's note for det

Patient ☐ Admitted Diagnosis (R) Zygoma Fx, multiple facial/ext contusions (R) shin lac

☐ I revised the resident's clinical impression(s) and or care plan as follows:

Faculty Physician:

☒ Dr Dong 1398 ☐ Dr Heer 1165 ☐ Dr Michaelson 9702 ☐ Dr McPheeters 1257 ☐ Dr Purcell 006 ☐ Dr. Amin 7147
☐ Dr.Schmidt 416 ☐ Dr.Azimian 7470 ☐ Dr Sverchek 395 ☐ Dr Tobias 1368 ☐ Dr. Walsh 7451 ☐ Dr. Winter 7312

KERN MEDICAL CENTER
Owned And Operated by the County of Kern
Bakersfield, CA 93305

ACCT # **0927100500**
PATIENT **BAKER,JOSEPH W**
ADMIT DATE: **09/28/09**

MEDREC# **0001270166**
DOB: **06/19/65**

EMERGENCY AFTERCARE INSTRUCTIONS

The examination and treatment which you received has been rendered on an emergency basis only, and is not intended to be substituted for complete medical care. It is important that you follow-up with your clinic or private physician and report any new or remaining problem to him or her.

☐ **WOUND CARE:**
__ Keep wound covered until rechecked
__ If dressings get wet or dirty you should:
__ change them
__ call your MD or the ER
__ Leave wound open to the air
__ You may wash the wound after ____ days
__ Return for wound recheck in ____ days
__ Sutures to be removed in ____ days
__ Limit movement of the affected part
__ Elevate the injured part higher than your heart, to decrease swelling and improve healing for ____ hours
__ Cool packs to the area to prevent swelling and pain for ____ hours

DESPITE THE GREATEST CARE, ANYWOUND CAN BE INFECTED. RETURN IMMEDIATELY OR SEE YOUR DOCTOR IF SIGNS OF REDNESS, SWELLING, PUS, OR RED STREAKS OCCUR, OR IF THE WOUND FEELS MORE SORE INSTEAD OF LESS SORE AS THE DAYS GO BY.

☐ **HEAD INJURY:**
REPORT TO YOUR DOCTOR OR RETURN HERE IMMEDIATELY IF ANY OF THE SIGNS LISTED BELOW OCCUR, EVEN IF SEVERALWEEKS AFTER THE INJURY.
__ Persistent vomiting, stiff neck or fever
__ Severe, persistent or worsening headache
__ Confusion or unusual drowsiness
__ Convulsions or unconsciousness
__ Pupils are unequal (one larger than the other)
__ Stumbling or other problems with normal use of arms or legs or other areas of numbness
__ Blood or clear fluid from ears or nose
__ Clear liquid diet for the first 24 hours
__ Awake every ____ hours for the first 24 hours to make sure that patient is arousable and to check the above signs

☐ **BACK AND NECK INJURIES:**
__ Read the included Back or Neck injury material
__ Return if severe pain down arms or legs or weakness or numbness of arms or legs develops
__ Bed rest as much as possible on a firm mattress until you are improved, or for ____ days
__ Avoid any lifting or positions that cause pain for at leasl ____ days

☐ **DISPOSITION:**
__ You may return to work
__ You may not return to work until _____
__ You may return to light work:
__ immediately
__ on _____
__ No school until _____
__ No physical education until _____
__ You were given: __ Tetanus __ dt
__ DPT

☐ **SPRAINS OR FRACTURE CARE:**
__ Elevate the injured part for ____ hours to lessen swelling and pain
__ Do not put weight on the injured part
__ Ice packs (cool) to area for hours to decrease the swelling and pain
__ If you have an elastic bandage, rewrap it if tight or too loose
__ If you have a cast, keep dry at all times
__ Wait 48 hours for the cast to become strong before you put pressure or weight on the cast
__ Wiggle toes and fingers to prevent swelling in the injured part, this should be done often if it does not cause pain
__ If the injured part swells in any way or gets cold, blue, numb, or pain increases markedly, have it checked promptly
__ Follow whatever other instructions you have been given by the cast clinic

☐ **RESPIRATORY INFECTIONS:**
__ Treat fever if present with Tylenol® (see fever below)
__ Drink lots of fluids
__ Use vaporizer (cool)
__ Call MD or return if you have difficulty breathing
__ Take the prescriptions you have been given

☐ **FEVER:**
__ Dress in light clothes (don't bundle up)
__ Treat temperature if greater than ____ with Tylenol® _____ every four hours
__ If fever persists, patient should be placed in bath tub with lukewarm water. Massage the back and legs. DO NOT leave the patient unattended in the bath tub.
__ Call MD if temperature (greater than 102°) persists, in spite of treatment listed, or if a seizure occurs

☐ **VOMITING:**
__ Clear liquid diet but in frequent small amounts only
__ Watch for signs of dehydration (see below)
__ Call your doctor if you notice blood in the vomitus

☐ **DIARRHEA:**
__ Clear liquid diet
__ If not vomiting and keeps clear liquids down you may try fresh ripe bananas that have been mashed. Also dried toast may be tried.
__ Call the MD if you see blood in the diarrhea
__ Watch for signs of dehydration (see below)

☐ **DEHYDRATION:** Signs to look for:
__ Decreased urine flow
__ Very sleepy, hard to wake up
__ Dizziness when standing up
__ Very dry mouth
__ No tears seen when patient cries

☐ **OTHER INSTRUCTION SHEETS**

__ ENGLISH __ SPANISH

__ Anemia
__ Angina/Heart Diseases
__ Baby Care
__ Bronchitis/Asthma
__ Burns
__ Chest Injury
__ Chicken Pox
__ Clear Liquid
__ Congestion in infants
__ Constipation in infants
__ Croup
__ D & C
__ Diabetes
__ Ear Infections
__ Epididymitis
__ Febrile Seizures
__ Gallbladder Disease
__ Gastritis
__ Gonorrhea
__ Hypertension
__ Kidney Stones
__ PID
__ Pneumonia
__ Pregnancy
__ Pyelonephritis
__ Sinusitis
__ Syphilis
__ Threat Abort
__ Urethritis
__ UTI
__ Vaginitis
__ Other _____

ER RECHECK: medically clear to jail

OTHER INSTRUCTIONS (INCLUDING PRESCRIPTIONS, DIAGNOSIS, LAB AND X-RAY) transverse arch fracture
Meds as ordered
follow up ~~for~~ in one week

Patient Education
☐ Learning needs/abilities assessed
Specify: _____
☐ Barriers to learning
Specify: _____

I have received as well as demonstrated my understanding of the discharge instructions given.

Patient Signature: 1059 Date and Time: 1750 9/28/09

Exit Interviewer: J. Rapke RN #88335 Physician Signature: 9780

AN C:\MYFILES\MEDFORMS\Alan\Emerg_Aft.Car 9/6/00

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KERN MEDICAL CENTER
Owned And Operated by the County of Kern
Bakersfield, CA 93305

EMERGENCY MEDICINE RECORD

ACCOUNT NO.	DATE ARRIVED	TIME	ARRIVAL MODE	PT CLASS	LOCATION	MEDICAL RECORD NO.
0927100500	09/28/09	04:26	BAKERSFIELD POLICE		ERM	0001270166

PATIENT

PATIENT NAME: BAKER,JOSEPH W — BIRTHDATE: 06/19/65 — AGE: 44Y — SEX: M
STREET ADDRESS: GENERAL DELIVERY — CITY: BAKERSFIELD — STATE: CA — ZIP: 99999
PHONE — SOC. SEC. NO: [redacted] — MARITAL STATUS: S — FINANCIAL CLASS: J COUNTY CORRECTIONA
INS. POL NO — POL NO — POL NO.
IN EMERGENCY NOTIFY: NO,ONE — HOME PHONE — BUSINESS PHONE

ACCIDENT	ACCIDENT TYPE	DATE OF ACCIDENT	TIME	PLACE	POLICE NOTIFIED ☐ YES ☐ NO
				0400 4	

CHIEF COMPLAINT/ PROBLEM: MEDICAL CLEARANCE
LANGUAGE: ENG ENGLISH

OBJECTIVE FINDINGS: See Triage Note 100 10/82, 18, 115 98?

TIME OF FIRST SYMPTONS	PRIMARY CARE PHYICIAN	TIME RECEIVED TO TxAREA:	TIME SEEN BY M.D
		0400	0500

PRIMARY CARE HOME: None (111)111-1111

CHIEF COMPLAINT: Head pain

☐ VITAL SIGNS REVIEWED FROM TRIAGE
☐ NURSING NOTES REVIEWED
☐ EMS NOTES REVIEWED
CHECK BOX(/) FOR NORMAL, CIRCLE POSITIVES, SLASH NEGATIVES, NOTE FINDINGS

ALLERGIES: none see nurse's notes

HISTORIAN: Patient/Friend/Family/EMS
HX LIMITED BY: Acuity/ALOC/Intoxication
ARRIVED BY: EMS/Walk-in/Wheelchair

HISTORY OF PRESENT ILLNESS

Sb Altercation
Police N 0500
c/o pain to face
Bil

ONSET gradual/ sudden/ insidious
TIMING constant/ intermittent
DURATION _____mins/ _____hrs/ _____days
QUALITY aching/ burning/ cramping/ pressure/ sharp/ stabbing/ squeezing/ tearing
SEVERITY mild/ moderate/ severe
CONTEXT

ASSOC. SIGNS/SXS ☐ none

MODIFYING FACTORS ☐ nothing

LOCATION/RADIATION

MEDICAL RECORDS REVIEWED from KMC/ outside facility
☐ DATES_____ FINDINGS _____

RECENT PRIOR AND SIMILAR EPISODES ☐ NONE
WORK UP:
DIAGNOSIS:
TREATMENT:

REVIEW OF SYSTEMS

Face/Head
Bil Pain

☐ CONSTITUTIONAL: fever / chills / wt loss / weakness
☐ EYE: blurred or double vision/ pain/ photophobia
☐ ENT: congestion/ epistaxis/ pain. Discharge
☐ CVS: chest pain / palpitations/ orthopnea/ edema/ DOE
☐ RESP: cough/ dyspnea/ sputum/ wheezing/ hemoptysis
☐ GI: pain/ heartburn/ melena/ distension/ vomiting/ nausea/ diarrhea
☐ GU: dysuria/ urgency/ hesitation/ hematuria/ discharge/ bleeding
☐ MUSKEL: pain_____/ swelling/ stiffness/ weakness
☐ SKIN: rash/ discolorations/ jaundice/ pruritus
☐ NEURO: headache/ LOC/ numbness/ confusion/ memory loss
☐ HEME/ENDO: bruising/ bleeding/ polyuria/ polydipsia/ adenopathy
☐ ALLER/IMMUNE: rash/ itching/ swelling
☐ PSYCH: anxiety/ depression/ sleep disturbance/ mood changes
☑ ALL OTHER SYSTEMS REVIEWED AND ARE NEGATIVE

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

PMH: _____unknown
CAD/ HTN/ CHF/ MI/ IDDM/ NIDDM
COPD/ ASTHMA/ CVA/ PUD/ GERD
BILIARY DZ/ PANCREATITIS/ CRF
RENAL STONES/ HEPATITIS
Denies

FAMILY HX: ____ none ____unknown
DM/ CAD/ HTN/ CA/ CVA

SURGICAL HX: _____none

IMMUNIZATIONS UTD: ____Y ____N

GYN HX: G___P___TAB__SAB___
LMP____/____/____

MEDS: ___none___ see nurses notes
Denies

SOCIAL HX:
Tobacco —
Etoh —
Drugs —

KERN MEDICAL CENTER
1830 Flower Street
Bakersfield, CA 93305

ACCT # **0927100500** MEDREC# **0001270166**
PATIENT BAKER,JOSEPH W
ADMIT DATE: 09/28/09 Comminuted DOB: **06/19/65**
R Zygomatic Arch Fx

CHECK BOX✓ FOR NORMALS, CIRCLE POSITIVES, SLASH NEGATIVES, NOTE FINDINGS

PHYSICAL EXAM — Only use chart areas that are clinically indicated

GEN: Distress___ no / mild / mod / severe Hydration___ nl / dehydrated
☐ VS reviewed from nurses notes: ___ nl ___ abn YALE___
☐ P. OX:___% on RA / ___ ☐ nl ☐ hypoxic
☐ Exam limited by: urgency of pt's condition or altered mental status
☐ Alert and O x 3 Nutrition status:___ nl / cachectic / obese
Orthostatic vitals: ←:__________ ↑ :__________

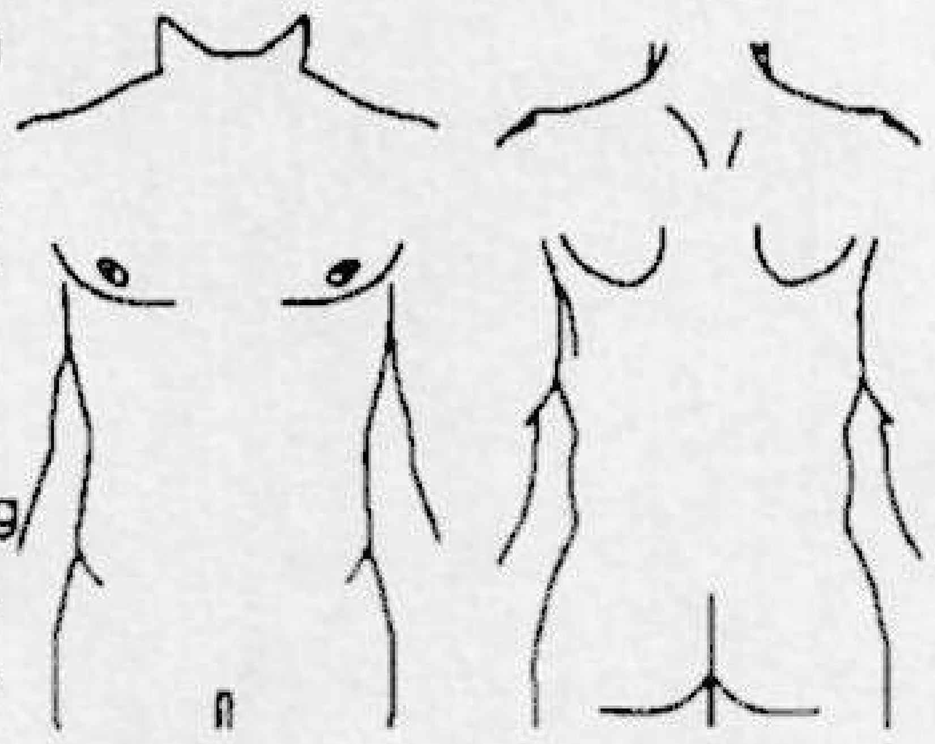
EYE: R lip through line
☒ PERRLA ☐ Lids, Sclerae, Conj, Cornea ☐ Fundi ☐ EOM's intact
Multiple large R facial
ecchymosis

ENT:
☒ Nasal Exam ☐ Canals, Hearing, TM's ☒ Tonsils, Pharynx

NECK:
☒ No JVD ☐ Trachea ☐ No Meningeal Signs ☒ Thyroid nl
multiple contusions

CV:
☒ RRR ☐ No abn sounds, murmurs ☐ No edema
Pulses ☐ Carotid nl ☐ Abd Aorta nl ☐ Femoral nl ☐ Periph. nl

RESP:
☒ Effort ☐ Chest Wall Palpation
☒ Lungs clear ☐ Bilat BS



GI/ABD/BACK:
☒ Soft, NT w/o masses ☐ BS nl
☒ Liver/Spleen nl ☐ no CVAT
☐ Rectal nl HEME :☐ pos ☐ neg

GU:
MALE: ☐ Ext Gent nl ☐ Testes nl ☐ Prostate nl
FEMALE: ☐ Ext Gent. ☐ Cx nl
☐ No vaginal discharge
☐ Uterus nl size, Non-tender
☐ Adnexa nl ☐ No CMT

NEURO:
☒ Cr Nerves intact ☐ DTR'S equal ☒ Motor intact ☐ No abn reflexes
☒ Sensation intact ☐ O x 3

PSYCH: **SAD SCORE:** ___ **MME:** ___
☐ Insight/judgement ☐ Recent/Remote Memory ☐ Social Support
☐ Halluc/Delusion ☐ Mood/Affect ☐ Suicidal/Homicidal Ideation

SKIN: ☒ Warm, Dry, Well hydrated ☐ No Rash ☐ No Nodules

MUSC-SKEL EXTREMITIES ☒ Strength & Tone ☐ Joints w/o effusion or tenderness
☐ nl ROM ☐ nl Digits/ Nails BACK ☐ nl gait ☐ nl ROM ☐ nl SLR
Hematoma (R) thigh
LAC (R) shin

MEDICAL DECISION MAKING
DIAGNOSTIC CONSIDERATIONS: #

DIAGNOSTIC TESTS: ✔ if ordered and normal, circle and note abnormals
LAB
CBC ☐ nl ☐ nl except: **BMP** ☐ nl ☐ nl except:
WBC______ Na___ CL___ GLU___ BUN___
H/H______ K___ CO2___ AG___ CR___
SEGS___ BANDS___ LYMP___ PLATE___

UA ☐ nl ☐ nl except: **uHCG** ☐ neg ☐ pos Quant ______
WBC___ RBC___ BACT___ **uTox** ☐ neg ☐ pos ______
DIP______ **PT / PTT** ___ **LFT's** ______
CARDIAC ENZ: ☐ nl ☐ abn ______ **LIP/AMYL** ______
MISC ______

EKG
☐ Read by ED MD ☐ Compared to ______ unchanged / changed
☐ NSR ☐ nl intervals ☐ nl QRS ☐ nl ST-T waves ______
Impression: ______

MONITOR/RHYTHM STRIP
☐ NSR ☐ ectopy ______

ABG
on RA / ___ L via NC / MASK / ET pH___ pCO2___ PO2___ HCO___
Interpreted by ED MD as NL / Hypoxic / Hypercarbic / Resp Acid / Met Acid

X-RAYS
☐ Read by ED MD
☐ CXR 2V / 1V ☐ nl ☐ Abn______
☐ Abd Series ☐ nl ☐ Abn______
☐ Ext______ ☐ nl ☐ Abn______
☐ ______ ☐ nl ☐ Abn______

TREATMENT / ED COURSE
☐ O2 via NC / MASK / ETT ☐ Critical Care:___ mins
☐ IV Fluids ______
☐ IV Meds ______
☐ Pain Meds ______
☐ Foley ☐ NG tube ☐ Charcoal ☐ HHN x___ with Proventil / Atrovent

RESPONSE TO TREATMENT / RE-EXAM: Decl w/ analgesics
Time: 1930 same/better/worse
Time:___ same/better/worse

PROCEDURES BY ED MD: ☐ CIRCLE AND DESCRIBE
ACLS CENTRAL LINE CARDIOVERT INTUBATION THROMBOLYSIS
EXT PACER CHEST TUBE NGT FOLEY LP SLIT LAMP CON-SED
EPISTAXIS-CON IVP DYE DIGITAL BLOCK FRACT / DISLOC REDUC SPLINT
LACERATION: ☐ WOUND PREP ☐ IRRIGATED & DEBRIDED ☐ LOCAL ANESTH INJECTED
☐ ___ LAYERS CLOSED ☐ LENGTH ______ cm
☐ Risk, Benefits & Alternatives Discussed with Patient
~~[illegible]~~ Stapled with difficulty
Cleansed sterile fashion

CLINICAL IMPRESSION(S) (1) Comminuted R Zygomatic Arch Fx
(2) multiple contusions

CONSULTATIONS: ☐ IM / FP TIME___ ☐ SURG TIME___
☐ PEDS TIME___ ☐ OB/GYN TIME___
DISPOSITION: ___ Home ___ Admit ICU / Tele / OR / Med / Surg / Ped / ObGyn / Trauma
___ Transferred to:______ Time:______
FOLLOWUP: ___ PMD / KMC:______ In___ days / prn / as sched
CONDITION: ☒ Stable ☐ Unstable ☐ Expired ☐ AMA
DISCH INSTR: ☒ written ☐ handout ☐ Diag & Tx discussed w/ Pt / Consult/PMD
DICTATION: ☐ YES ☐ NO **TRAUMA PT:** ☐ YES ☒ NO
RX given: ______
PLAN: Staple out 7 days
SIG [signature] Res-MD-DO / PA / NP

I agree with and participated in determining the final impression, treatment, and disposition documented by the resident. See Facility Teaching Addendum for further details.

SIG [signature] Faculty MD/DO Review
JONG 1388

1620 3 Jail OH

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KERN MEDICAL CENTER
Owned And Operated by the County of Kern
Bakersfield, CA 93305

ACCT # **0927100500** MEDREC# **0001270166**
PATIENT **BAKER,JOSEPH W**

ADMIT DATE: 09/28/09 ADMIT TIME: 04:26 DOB: **06/19/65**

DO NOT write this	What you should write	DO NOT write this	What you should write
U	Unit	gtt	Drop or drip (IV infusions)
IU	International unit	cc	ml or mL
µg	Microgram or mcg	T3	Tylenol with Codeine 30 mg
QD,QOD,QID	Daily, every other day, four times daily	$MgSO_4$	Magnesium sulfate
AS,AD,AU	Left ear, right ear, both ears	MS, MSO_4	Morphine Sulfate
OS,OD,OU	Left eye, right eye, both eyes	1.0 (zero after decimal)	1 mg
TIW or tiw	Three times a week	.1 (no zero before decimal)	0.1 mg
SS	Sliding scale		

DATE AND TIME

9/28/09 ~~CT~~ Head R/O Bleed
0807 X ~~RAY~~ (R) ft BFB R/O fx
[signature]
G780

noted 9/28/09 0810 [signature] RN M8835

9/28/09 discharge Home
1450
[signature]
G780

noted 9/28/09 ~~1525~~ [signature] M8835

PHYSICIAN'S ORDER FORM

medforms\8.2\mt\physorder 1185 SG 12/01/2005

1270166

CLINIC REFERRAL

ACCT#0927100500 MEDREC 0001270166
BAKER,JOSEPH W
ERJ DATE: 09/28/09 DOB: 06/19/65 SEXM

Patients Name _____
Medical Record #_____Phone#_____

Clinic Service Request:

___Gold Surgery	___Ortho	___Medicine Clinic
___Red Surgery	___Plastics	___Med Specialty
___Trauma Surgery	___Urology	___Hospital Discharge
___Neurosurgery	___Eye	___Family Practice
___ENT	___OB/GYN	___Physical Therapy

FAX TO PLASTICS - Cerri

When is the appointment needed? ONE WEEK

Diagnosis (R) Comminuted 3/4 [illegible] c Acet Fx.

Consulting Physician 9/28 Glenn / Doug

Pre-clinic x-rays ordered _____

Pre-clinic labs ordered _____

Financial class Pretrial BK# 1870482

FAXED

Form completed by _____ Date _____

Appt 10/7/09 @ 1:00pm

Please fax referral and a copy of the ED face sheets to 326-2793

Call 326-2800 for Appt

PRINTED BY: m8903
DATE 9/29/2009

9/29 Appt confirmed w/Gail from CRF

CLINIC REFERRAL

ACCT#0927100500 MEDREC 0001270166
BAKER,JOSEPH W
ERJ DATE: 09/28/09 DOB: 06/19/65 SEXM

Patients Name _____
Medical Record #_____Phone#_____

Clinic Service Request:

___Gold Surgery	___Ortho	___Medicine Clinic
___Red Surgery	___Plastics	___Med Specialty
___Trauma Surgery	___Urology	___Hospital Discharge
___Neurosurgery	___Eye	___Family Practice
___ENT	___OB/GYN	___Physical Therapy

From PLASTICS - Ceresi

When is the appointment needed? ONE WEEK

Diagnosis (R) Comminuted 3/4 Joint c Arch Fx.

Consulting Physician Ceresi / Davis

Pre-clinic x-rays ordered_____

Pre-clinic labs ordered_____

Financial class_____

Form completed by_____Date_____ FAXED

Please fax referral and a copy of the ED face sheets to 326-2793

Call 326-2800 for Appt.

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Joseph William Baker
500 Westover Dr. #4444
Sanford NC 27330.

9590 9402 3988 8079 9312 30

2. Article Number *(Transfer from service label)*

7018 0680 0000 1375 1102

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

☐ Agent
☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type

☐ Adult Signature
☐ Adult Signature Restricted Delivery
☒ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Mail
☐ Mail Restricted Delivery
500)

☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

USPS TRACKING #

9590 9402 3988 8079 9312 30

First-Class Mail
Postage & Fees Paid
USPS
Permit No. G-10

United States Postal Service

• Sender: Please print your name, address, and ZIP+4® in this box•

Kern Medical
1700 Mt. Vernon Ave.
Bakersfield, CA 93306

1270160.