STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
DIVISION OF INVESTIGATION
Health Quality Investigation Unit
Sacramento Field Office
2535 Capitol Oaks Drive, Suite 220
Sacramento, CA 95833
Phone: (916) 263-2585 - Fax: (916) 263-2591

July 1, 2014

Raymond Craig, M.D.
2422 Broadway Blvd.
Carmichael, CA 95864

Re: Harold Wilson, M.D. Case No. 02-2013-654321

Dear Dr. Craig:

Thank you for agreeing to review and evaluate the treatment rendered by the above-named physician. The following materials are enclosed for your review:

Draft investigation report with the following attachments:

1. Original complaint and investigation from the Department of Social Services
2. Copy of partial records for Mr. Fussell from Dr. Wilson's office
3. Copy of autopsy findings
4. Transcript of interview

For further information regarding expert opinions, please review the Expert Reviewer Guidelines available on our website: http://www.mbc.ca.gov/enforcement/expert_reviewer/. Please also review the enclosed detailed instructions regarding the preparation of your report. Prepare your written opinion according to the recommended report format.

The guidelines and instructions ask you to summarize the care provided. **For each medical issue you identify, state the standard of care that applies, analyze whether the care provided represents a departure from the standard of care, and set forth your conclusion using the appoved terminologies (no departure, simple departure, extreme departure, and/or lack of knowledge).**

Please remember to provide your current Curriculum Vitae along with the written opinion.
Please complete the enclosed Expert Reviewer Program Statement of Services (pink billing form) and submit to me for review and approval. Please allow six to eight weeks for payment processing.

Unless previously discussed, you have agreed to complete your review within the next 30 days. In addition, you have agreed to notify me **immediately prior to exceeding 10 hours of case review**. When you have completed your review, please contact me. If you have any questions, please do not hesitate to call.

Sincerely,

Anne Stefani
Investigator

Enclosures

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
Sacramento District Office

2535 Capitol Oaks Drive, Suite 220
Sacramento, CA 94833
916-263-2585

INVESTIGATION REPORT

Case No: 02-2013-654321
Priority/Complex: R/No
Investigator: Stefani, #200

Subject Information

Name:	**WILSON, HARROLD, M.D.**
Aliases:	**None**
Residence Address:	**1224 Wisteria Lane** **Sacramento, CA 94831**
Residence Phone:	**On File**
Cellular Phone:	**On File**
Email:	**NONE**
Business Name:	**Wilson Care Medical Center**
Business Address:	**6311 Freeport Blvd., Suite 400** **Sacramento, CA 94531**
Business Phone:	**916-680-1200**
Description:	**Male; White; 6'2"; 175 lbs; brown eyes; brown hair**
Date of Birth:	**01-16-55**
CDL:	**On File**
CII/FBI:	**None**
SSN:	**On File**
Profession:	**Physician and Surgeon** **License No. W22149**
License Term:	**Issue: 06-25-80** **Expires: 12-31-14**
DEA Registration:	**BS 9877877 Issued: 6-5-81 Expires: 2-18-13 Schedules II-V**
Board Certified:	**No**
Outpatient Surgery Center:	N/A
Other:	**None**
Billing Code:	**03573**

Investigative Costs:
Primary Case No.:

Charges

Case Synopsis

Investigation Narrative

On 5-15-10, a complaint was received at the Medical Board's Central Complaint Unit (CCU) from the Department of Social Services (DSS) **(ATTACHMENT #1)**. The DSS conducted an investigation into one of their licensees after their client, Mr. Daniel Fussell, died while under their care. Fussell allegedly fell on the steps within the facility where he lived on 5-31-09 and reported the fall to staff at the facility. He was seen by Dr. Wilson on 6-1-09. Dr. Wilson diagnosed a "contusion of skin," "falling episode," and "BIPOLAR." Dr. Wilson's treatment plan was "observation neuro." The patient was to see Dr. Wilson in a month, or as necessary. Fussell complained of pain to the facility staff on 6-4-09 but was not seen by a doctor. On 6-6-09, Fussell was found unresponsive on the bathroom floor of the facility. He had been there from 45 minutes to an hour. Emergency Services pronounced him dead at the facility. An autopsy found he died from blunt force thoracic injuries which caused a right hemothorax.

The complaint included responses Dr. Wilson answered to DSS investigators' questions regarding Fussell's injuries. Dr. Wilson did not remember any injuries other than a bruise on his leg from the fall. Dr. Wilson said a rib injury may not cause bruising and a rib injury could have caused Fussell to die. When asked, "What is blunt force thoracic injury?" Dr. Wilson answered, "any momentum contact to chest suddenly (as opposed to sharp")."

A copy of Dr. Wilson's chart note dated 6-1-09 for Fussell was included. Dr. Wilson's history indicated, "fell and bruise his left leg otherwise status quo."

A copy of the autopsy findings for the County of Contra Costa was included **(ATTACHMENT #3)**. The findings indicate:

1. Fractures of multiple right ribs
2. Large right subpleural hematoma (500 cc)
3. Right hemothorax (2500 ml)
4. Secondary atelectasis of right lung
5. Contusion of left parietal scalp
6. Deep contusion of right chest wall
7. Deep contusion of right hip and flank
8. Recent contusion of left hip
9. Contusions of extremities; healing and recent
10. Splenomegaly (510 grams), congestive
11. Chronic hepatitis with early fibrosis

12. Glomerulonephrosclerosis, with acute tubular necrosis (shock kidney)
13. Multinodular goiter with right upper pole papillary carcinoma (3 cm mass), incidental
14. Degenerative arthritis of spine, severe
15. Pitting dependent edema of lower legs, with chronic venous statis skin changes
16. Obesity (BMI – 36.8)

CAUSE OF DEATH: Right hemothorax
DUE TO: Blunt force thoracic injuries

OTHER SIGNIFICANT CONDITIONS: Developmentally disabled, anemia, hypertension.

On 6-30-10, this case was assigned to me.

On 7-13-10, I spoke to Don Gilbert, the attorney handling Fussell's family's lawsuit against Dr. Wilson. He told me the family would provide releases and a death certificate. Gilbert said Fussell was not mentally deficient and could communicate. While he did have mental problems, he would often go home for Thanksgiving and other occasions. Fussell was not incompetent and could fill out forms, for example. On the same date, I sent authorizations to release records to Fussell's next-of-kin.

On 07-22-10, I received the signed releases, a death certificate and full autopsy report **(ATTACHMENT #4).** I noted that the death certificate showed Fussell had attended "some college" regarding his educational level.

On 7-22-10, I personally served Dr. Wilson's office with a copy of the release, a copy of B&P Code section 2225.5, a certification form, and a letter requesting the records of Fussell. I completed a declaration of service form **(ATTACHMENT #5).**

On 8-4-10, I received a telephone call from attorney Timothy Sullivan who told me he is now representing Dr. Wilson.

On 8-5-10, I received certified records, consisting of 125 pages, for Fussell, from Dr. Wilson's office **(ATTACHMENT #6).** The chart note prepared by Dr. Wilson dated 6-1-09 shows the history as being: "fell and bruise left leg otherwise status quo." There is no record of an examination of Fussell's right side where he reported to the medical assistant that it hurt.

On 8-30-10, I interviewed Daniel and Virgina Fussell, the parents of Daniel Jr.. Virginia Fussell is a registered nurse. She said Daniel was first diagnosed with epilepsy when he had a grand mal seizure in the bathroom when he was 15-years-old. Until his seizures were controlled, he had 2-3 per week. The medications brought the seizures down to a petit mal type where he would just "space out for little while." Heat would bring on grand mal seizures.

While he was diagnosed much later as Bi Polar, Virginia never saw any behavior which would indicate that problem. He was also later diagnosed as schizophrenic by a psychiatrist he saw one time. Virginia said he never exhibited any signs of that diagnosis, either. Virginia asked her son what he told the psychiatrist, and her son said, "I told the doctor I see dead soldiers." She asked

her son why he would say that and he didn't know. That is how he received that diagnosis. He was put on Geodon at a fairly high dose to address those diagnoses. She felt he did not need that medication and when asked if she would administer if he came to live with her, she truthfully told Alta Regional that she would not, as she felt the diagnoses were incorrect and he had never needed that medication and was quite functional when not taking it at all. The Geodon was reduced several years later to a lower dose. He had problems with hypertension and obesity, but did try to walk and exercise.

She said Daniel had an IQ of 62. He was a slow learner but did graduate from high school. He was in special education classes, but he was treated the same as his two siblings at home and had to do chores, just as they did. He tried college later but was unsuccessful with his classes. He was able to do simple math, he could cook, do the dishes, laundry and could use a telephone. He was able to live independently in his own apartment as long as she handled his finances. She would take him shopping for food, household items and clothes. He was very trusting and naïve and would spend all his money without thinking of saving it for bills or rent. He trusted anyone and was friends with anyone he met. He was able to read the newspaper and could comprehend what he read. He knew his left and ride sides. He was able to write letters. He was able to ride public transportation.

Virginia said Daniel lived at home until he was about 18 ½ years old. He then went into group homes and his affairs were administered by Alta Regional. He lived in approximately 3 group homes during that time, until his brother got out of the Army when Daniel was 25 years old. The two brothers lived in an apartment for 1 ½ to 2 years and then Daniel got his own apartment. Daniel ended up having an altercation with a neighbor and his parents thought it would be good to get him out of the apartment.

He lived at Madison Residential Care Facility for about 4-5 years. Virginia described Madison's as being a one story house with a converted garage in a neighborhood that wasn't very good. The garage had a very small bedroom built into the interior of the garage. It was just wide enough for a twin bed to fit in its width. They had to walk up 2-3 concrete steps to enter the living room from the garage bedroom. There were no safety hand rails on the steps. The garage didn't have any heat or air conditioning to her knowledge. When Daniel showed her his room, she could not believe they put him in a garage.

Of the 6 or so residents at Madison's, Daniel was the most alert and functional. She said she was told that Daniel fell on the garage stairs either Saturday or Sunday while going up the steps to use the bathroom. He saw Dr. Wilson on Monday after his fall. The Fussells were not told of Daniel's fall, or that he was hurt. They were not notified of anything until the coroner called to tell them of his death. They never knew that Daniel was seeing Dr. Wilson and were never notified Daniel had changed doctors to see Dr. Wilson.

Daniel did not have access to a telephone at Madison's. He had to ask permission to make a phone call and could only call if allowed.

The Fussells said Daniel would certainly be able to converse with Dr. Wilson and would have been able to tell Dr. Wilson what happened, what hurt, and where. Virginia said the broken ribs must have hurt terribly and should have been readily apparent with a good physical exam.

On 9-14-10, I interviewed Dr. Wilson at the Sacramento District Office. He was represented by his attorney, Timothy Sullivan. Also present for the interview was District Medical Consultant Vincent Barnett, M.D. The interview was recorded **(PROPERTY #1)** and subsequently transcribed **(ATTACHMENT #7).**

Dr. Wilson's attorney terminated the interview without discussing Fussell's care. Sullivan said Dr. Wilson would be providing a written care summary through his office. (Note: this was never provided).

Accurint was checked and there was no information. Sacramento County Superior Court civil index was checked and CAS was checked for historical information.

Evidence List

Evidence is maintained at the Sacramento District Office.

Attachments

Property

Witness List

Signatures

Prepared by: _____ Date: _____
Anne Stefani, Investigator

Approved by: _____ Date: _____
Mark Laurents, Supervising Investigator

Approved by: _____ Date: _____
Robert Harris, Deputy Attorney General

ATTACHMENT #1

CDSS
JOHN A. WAGNER
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
Sierra-Cascade Adult Care Licensing office
770 E. Shaw, Suite 330, Fresno, CA 93710
559-243-8080 www.ccld.ca.gov

ARNOLD SCHWARZENEGGER
GOVERNOR

May 6, 2010

Medical Board of California
Central Complaint Unit
2005 Evergreen Street, Suite 1200
Sacramento, California 95815

Dear Medical Board:

My name is Patrick and I am the Regional Manager for the Sierra-Cascade Adult Care Licensing Office of the Community Care Licensing Division with the California Department of Social Services. We are responsible for the licensing and monitoring of Community Residential Care in the State of California. We have completed an investigation of one of our licensees for lack of observation of two of their clients and substantiated the allegations. In the course of the investigation, we obtained medical reports for two developmentally disabled adults who were the subjects of the allegations. This letter and attachments, will outline our concerns with the care they received from Dr. of Care Medical Center located at ve, Suite Sacramento, California 95831.

The two clients names: Daniel l (DOB 2/9/65)). They were seen by Dr. on 6/1/09.

Daniel was seen for a fall he sustained on the day prior (5/31/09). Dr. s treatment plan was observation. Mr. passed away on 6/7/09; cause of death- right Hemothorax due to blunt force trauma.

Attached for your review are the following:
1. Licensing reports issued to the licensee substantiating their lack of observation of the two clients.
2. Dr. s medical reports
3. Sacramento County coroner's report for Daniel
4. A Question and Answer for Dr. on the two client's injuries.

Please review the attached documents and determine if any further action is necessary.

If you have any questions, you may contact me at 559-243-

Sincerely,

PATRICK
Regional Manager

I wish to complain about the individual named below. I understand that the Medical Board does not assist citizens seeking return of their money or other personal remedies. I am, however, submitting this information so that it may be determined whether disciplinary action against this practitioner's license should be considered.

Check one:

☑ **Physician (M.D.)** ☐ **Podiatrist (DPM)** ☐ **Physician Assistant (PA)** ☐ **Registered Dispensing Optician (RDO)** ☐ **Midwife** ☐ **Unlicensed Provider**

COMPLAINT REGISTERED AGAINST **Please Print or Type**

Name: _____
(Last Name) (First Name) (M.I.)

Office/Facility Name: Care Medical Center **License No.** (If known): _____

Street Address: [redacted] D SACRAMENTO CA 95831
(Address) (City) (State) (Zip Code)

Phone Number: (916) _____

Has the patient been examined/treated by another professional for this same condition?

☐ **No** ☐ **Yes** **If yes, provide name and address on the Authorization for Release of Medical Information**

Reason for Treatment: _____

Date(s) of Treatment: 6/1/09

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
2009 JUL 13 P 2:13

DETAILS OF COMPLAINT

(Attach additional sheets if necessary)

On 6/1/09, Dr. saw 2 developmentally disabled patients in care in residential community living:
1. D. F was seen for a fall, the treatment plan was to observe- on 6/7/09 Mr. F was pronounced dead due to Blunt Force Thoracic Injuries;
2. C. was seen for a fall- treatment plan was a ct head scan. On 6/3/09 Mr. ' required emergency surgery to correct a dislocated shoulder

Attached are the following:
1. Final reports issued to the above two individuals state licensed residential homes
2. Dr. s medical reports for each
3. Question and Answer for the state investigators by Dr, ' for the above two individuals.
4. D. I's Sacramento County Coroner autopsy findings

MEDICAL BOARD OF CALIFORNIA
CONSUMER COMPLAINT FORM

PERSON REGISTERING THE COMPLAINT

Please Print or Type

☑ Mr. ☐ Ms.
Name: S (Last Name) Patrick (First Name) (M.I.)

Mailing Address: 770 E. Shaw, Suite 330

Fresno, California 93710
(City) (State) (Zip)

Phone Number: (559) 243-
(Daytime Number) (Evening Number) (Cell phone/E-mail address)

☐ Mr. ☐ Ms.
Patient Name: (Last Name) (First Name) (M.I.)

Patient Date of Birth: **Your Relationship to Patient:**

NATURE OF COMPLAINT

Please check the box which best describes the nature of your complaint and provide details on the next page

☑ **Substandard Care** (e.g., Misdiagnosis, Negligent Treatment, Delay in Treatment, etc.)

☐ **Prescribing Issues** (e.g., excessive/under prescribing, Internet)

☐ **Unlicensed Provider orAiding/Abetting unlicensed practice**

☐ **Sexual Misconduct**

☐ **Physician/Provider Impairment** (e.g., Drug, Alcohol, Mental, Physical)

☐ **Unprofessional Conduct** (e.g., Breach of Confidence, Record Alteration, Fraud, Misleading Advertising, Arrest or conviction)

☐ **Office Practice** (e.g., Failure to Provide Medical Records to Patient, Failure to Sign Death Certificate, Patient Abandonment)

Other

Notice: The information included on the complaint form is requested per Section 2220 of the Business and Professions Code. Except for the name of the physician, all information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. Provide as much information as possible in connection with the complaint. The information on the complaint form will be used in part to determine whether a violation of State Law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies, including the Attorney General's Office.

INVESTIGATIONS BRANCH
INVESTIGATIVE FIELD REPORT

Case #	ND2309	Facility Name	Care Facility	Field Report #	8

Contact Type		Suspect		Victim	x	Witness		Complainant		Collateral Agencies		Other

Name	Dr.	DOB		CDL		SSN	
Address	Care Medical Center, , Sacramento, CA 95831						
Home #		Work #	(916)	Cell #			
Comments	Primary care physician						

On 10/9/09, I faxed Dr. questions regarding Daniel . I asked Dr. if he remembered any other injuries or complaints from Daniel when he saw Daniel on 6/1/09. Dr. replied no. I told Dr. that Daniel complained about his ribs hurting on 6/4/09 and Daniel was not taken to the doctor. I asked Dr. would the caregiver see any bruising caused by a rib injury. Dr. replied not necessarily. I asked Dr. if Daniel was taken to the doctor on 6/4/09, would Daniel's death have been prevented. Dr. replied possibly. See **Attachment # 8.**

Investigator		Badge#	22	Supervisor	

Questions for Dr.

Client Daniel **(DOB 2/9/65 and DOD 6/6/09)**

Dr. _ _ saw Daniel on 6/1/09 regarding a fall and bruise on his left leg. Remember any other injuries or complaints from Daniel?

No

On 6/4/09, Daniel complained of his ribs hurting. Daniel was not taken to the doctor. The Caretaker did not see any bruising. Does a rib injury have bruising?

not necessary

If Daniel was taken to the doctor, could/would Daniel's death have been prevented?

possible

Would a rib injury cause Daniel to die?

Possible

What is blunt force thoracic injury?

any momentum contact to chest suddenly (as opposed to "sharp")

Control Number 23-
STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

COMPLAINT INVESTIGATION REPORT (Cont)

CCLD Regional Office, 770 E. SHAW AV,STE 330 MS29-02
FRESNO, CA 93710

FACILITY NAME: [redacted] CARE FACILITY **FACILITY NUMBER:** 3
DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 03/18/2010

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
Type A 04/01/2010 **Section Cited** 85075.4(a)&(c)	OBSERVATION OF THE CLIENT - Facility failed to bring observed changes, including ongoing complaints of pain to the attention of client #1's physician or authorized representative. Facility also failed to inform Regional Center when he again complained of pain in the same area that he reported pain from his fall on 5/31/09.	Licensee shall develop a written plan in which all falls or injuries are documented and reported to client physicians and follow up information on client status documented and reported to interested parties. Written plan required by the Plan of Correction date indicated.
Type A 04/01/2010 **Section Cited** 80061(b)	REPORTING REQUIREMENTS - Facility failed to report a fall or injury of client #1 on 5/31/09 in which medical treatment was sought on 6/1/09.	Licensee shall forward all incident reports regarding this incident and client #1 and all other incidents with all clients not yet reported to Licensing by the Plan of Correction date indicated.

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

SUPERVISOR'S NAME: Richard T **TELEPHONE:** (209)

LICENSING EVALUATOR NAME: Tamara Je **TELEPHONE:** (916)

LICENSING EVALUATOR SIGNATURE:

DATE: 03/18/2010

I acknowledge receipt of this form and understand my appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:

Licensee refuse to sign document

DATE: 03/18/2010

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

COMPLAINT INVESTIGATION REPORT (Cont)

CCLD Regional Office, 770 E. SHAW AV,STE 330 MS29-02
FRESNO, CA 93710

This is an official report of an unannounced visit/investigation of a complaint received in our office on **06/23/2009** and conducted by Evaluator Tamara

COMPLAINT CONTROL NUMBER: 23-

FACILITY NAME:		TY	**FACILITY NUMBER:**	
ADMINISTRATOR:			**FACILITY TYPE:**	735
ADDRESS:			**TELEPHONE:**	(916) 42-
CITY:	SACRAMENTO	**STATE:**	**ZIP CODE:**	95822
CAPACITY:	6	**CENSUS:** 0	**DATE:**	03/18/2010
		UNANNOUNCED	**TIME VISIT BEGAN:**	02:00 PM
MET WITH:	Rebecca		**TIME COMPLETED:**	03:00 PM

ALLEGATION(S):

Record Keeping - client #1's fall was not reported

Lack of Supervision - facility failed to observe the client and follow-up with the physician as he continued to complain of ongoing pain.

INVESTIGATION FINDINGS:

LPA is delivering these findings at Licensee's other home Licensed by this Licensee as the facility licensed at the above address is no longer operating. This is a revision to the amended report issued at the facility on 2/24/10. This revision documents the investigation of the death of client #1 on 6/6/09 and shall clarify appropriate citations. Investiations Branch for Community Care Licensing has conducted an investigation of the death of client #1 and finds the following:

Client #1 reported a fall on the steps within the facility to facility staff on 5/31/09. The allegation states that the facility failed to report client #1's fall to Licensing. Because the facility failed to report client #1's fall, allegation is substantiated and citation issued.

Client #1 again complained of pain on 6/4/09. Staff asked client if he wanted to go to the doctor and he replied "no" but the facility staff did not pursue questioning of the client, check the client for injuries, seek medical advice or care, or report the new complaints to the client's physician or responsible party. Because the facility failed to observe the client and follow up with the physician, the allegation is substantiated and citation issued.

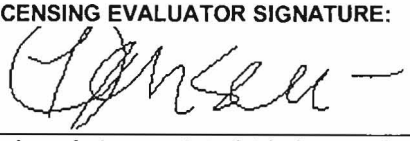
On 6/6/09 at approximately 10 am, the client was discovered unresponsive on the floor of the facility bathroom where he had been for 45 minutes to an hour. Emergency Services were summoned but he was pronounced deceased at the facility. Per the corner's report, the cause of death was "Right Hemothorax, Blunt Force Thoracic Injuries."

Substantiated **Estimated Days of Completion:**

SUPERVISOR'S NAME: Richard **TELEPHONE:** (209) 941-

LICENSING EVALUATOR NAME: Tamara **TELEPHONE:** (916) 708

LICENSING EVALUATOR SIGNATURE:



DATE: 03/18/2010

I acknowledge receipt of this form and understand my appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:

Licensee refuse to sign document

DATE: 03/18/2010

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

COMPLAINT INVESTIGATION REPORT

CCLD Regional Office, 770 E. SHAW AV,STE 330 MS29-02
FRESNO, CA 93710

This is an official report of an unannounced visit/investigation of a complaint received in our office on **06/23/2009** and conducted by Evaluator Tamara

COMPLAINT CONTROL NUMBER: 23-

FACILITY NAME:			**FACILITY NUMBER:**	
ADMINISTRATOR:			**FACILITY TYPE:**	735
ADDRESS:			**TELEPHONE:**	(916) 424-
CITY:	SACRAMENTO	**STATE:**	**ZIP CODE:**	95822
CAPACITY:	6	**CENSUS:** 0	**DATE:**	03/18/2010
		UNANNOUNCED	**TIME VISIT BEGAN:**	02:00 PM
MET WITH:	Rebecca		**TIME COMPLETED:**	03:00 PM

ALLEGATION(S):

1 Personal Rights - client was not afforded medical treatment following a fall at the facility

INVESTIGATION FINDINGS:

LPA is delivering these findings at Licensee's other home Licensed by this Licensee as the facility licensed at the above address is no longer operating.

This is a revision to the amended report issued at the facility on 2/24/10. This revision documents the investigation of the death of client #1 on 6/6/09 and shall clarify appropriate citations. Investiations Branch for Community Care Licensing has conducted an investigation of the death of client #1 and finds the following:

Client #1 reported a fall on the steps within the facility to facility staff on 5/31/09. The allegation states that the client was not afforded medical care following that fall. Based on the medical reports, client #1 was seen by his physician on 6/1/09 where the physician did not identify any injury to the client. There were no medication changes issued and no need for follow-up care following client's fall.

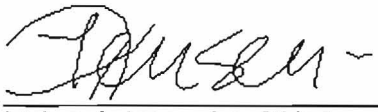
Allegation of violation of personal rights is unfounded at this time.

Unfounded **Estimated Days of Completion:**

SUPERVISOR'S NAME: Richard **TELEPHONE:** (209) 941-

LICENSING EVALUATOR NAME: Tamara **TELEPHONE:** (916) 708-

LICENSING EVALUATOR SIGNATURE:



DATE: 03/18/2010

I acknowledge receipt of this form and understand my appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:

Licensee refuse to sign document **DATE:** 03/18/2010

This report must be available at Child Care and Group Home facilities for public review for 3 years.

ATTACHMENT #2

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY: ARE FACILITY | TELEPHONE: 916-424-

ADDRESS: STREET: | CITY: SACRAMENTO, CA

LICENSEE'S NAME: REE A AND C S M | TELEPHONE: 916-912 | FACILITY LICENSE NUMBER:

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME: DANIEL | TELEPHONE: 916-424

ADDRESS: NUMBER: 6794 | STREET: SACRAMENTO. | CITY: | SOCIAL SECURITY NUMBER:

NEXT OF KIN: MOTHER | PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: | LENGTH OF TIME UNDER YOUR CARE:

AGE: 43 | HEIGHT: 5'9" | SEX: MALE | WEIGHT: 205 | IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☒ YES ☐ NO

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☒ INACTIVE ☐ NONE | DATE OF LAST TB TEST: 11/20/2008

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ YES ☒ NO If YES, list below:

TREATMENT/MEDICATION:
B) ☐ YES ☐ NO If YES, list below:

ALLERGIES
C) ☐ YES ☒ NO If YES, list below:

TREATMENT/MEDICATION:
D) ☐ YES ☐ NO If YES, list below:

Ambulatory status of client/resident: ☒ Ambulatory ☐ Nonambulatory

Health and Safety Code Section 13131 provides: "Nonambulatory persons" means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. The determination of ambulatory or nonambulatory status of persons with developmental disabilities shall be made by the Director of Social Services or his or her designated representative, in consultation with the Director of Developmental Services or his or her designated representative. The determination of ambulatory or nonambulatory status of all other disabled persons placed after January 1, 1984, who are not developmentally disabled shall be made by the Director of Social Services, or his or her designated representative.

I. PHYSICAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR | COMMENTS:

	YES	NO (Check One)	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment				
2. Visual impairment				
3. Wears dentures				
4. Special diet				
5. Substance abuse problem				
6. Bowel impairment				
7. Bladder impairment				
8. Motor impairment				
9. Requires continuous bed care				

II. MENTAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR | COMMENTS:

	NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: ☐ YES ☐ NO | COMMENTS:

	YES	NO (Check One)	COMMENTS:
1. Able to care for all personal needs			
2. Can administer and store own medications			
3. Needs constant medical supervision			
4. Currently taking prescribed medications			
5. Bathes self			
6. Dresses self			
7. Feeds self			
8. Cares for his/her own toilet needs			
9. Able to leave facility unassisted			
10. Able to ambulate without assistance			
11. Able to manage own cash resources			

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Others *(specify condition)*	

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1.	4.	7.
2.	5.	8.
3.	6.	9.

PHYSICIAN'S NAME AND ADDRESS: | TELEPHONE: | DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)

I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE | ADDRESS: | DATE:

: med ctr inc.

MEDICAL REPORT/SLP

NAME';I DANIEL 2 9 65M/MC

TODAY DATE;6 1 09
HISTORY; fell and bruise his left leg
otherwise status quo

GENERAL CONDITION STABLE.

PAST HISTORY; LIPIDEMIA/BIPOLAR/MR

PERSONAL HISTORY; NO USE OF SMOKING,ILLICIT DRUG
FAMILY HX;NP
CURRENT RX; GEODON80MG/PERPHENAZINE 8MG LIPITOR 10MG POTASIUM TOPAMAX100MG
DRUG ALLERGY;N

review of organ system;(DITTO
LAB;
PHYSICAL EXAM;BP 120/78 RR 24/M PR 80/M WT 257
HENT;NP
CHEST/COR/ABDOMEN;2/6 MURMUR
NEURO;NO FOCAL NEUROLOGICAL DEFICIT.
ORTHO;NP
MENTAL; OUT TOUCH
ABDOMEN;N
DIAGNOSIS;contussion of skin
falling episode
BIPOLAR
ASCVD/MR
LIPIDEMIA-
TREATMENT PLAN; observation neuro
RX;maintain same for now

rtc/1 month or prn

W. M.D.

MEDICALCENTER, INC

NAME: F ,DANIEL DATE: JUN 0 1 2009 ALLERGY: NKDA

BP: 132/76 WT 235 HT: 5'9 P: 82 R: 20 T: 100.3 MEDS: refer to list

CC: fell and right side hurts MA: L TRANS BY: AGE:

HP:

1. ABDOMEN PAIN	[ ]	
2. COUGH	[ ]	
3. CHEST PAIN	[ ]	
4. DIARRHEA	[ ]	
5. DIZZINESS	[ ]	
6. FATIGUE	[ ]	
7. HEADACHE	[ ]	
8. LOWER BACK PAIN	[ ]	
9. PAIN	[ ]	
10. SHORT OF BREATH	[ ]	
11. SKIN RASH	[ ]	

Instructed as Critical
( ) Need follow care plan
Instructed to call
( ) If problem persists
Follow Up Visit
( ) day ( ) week ( ) month
( ) Pt education discuss?
Ed InformationGiven
Cholesterol ( ) diabetes
Diet ( ) Exercise
Smoke ( ) Obesity
Family Planning ( ) STD's
Hypertension
Medications
Prenatal Care
Self Breast Exam

PAST:

PERSONAL/ SOCIAL
SMOKE
DRUG/ALCOHOL
WORK

FAMILY HISTORY

CANCER	[ ]	
DIABETES MALLEUS	[ ]	
HTN	[ ]	
ARTHRITIS	[ ]	

ROS: INCLUDING THE FOLLOWING CIRCLE (IF PRESENT)

PUL: COUGH, SOB, EX DYSPNEA
CV: CHEST PAIN, FLUTTER
GI: CONSTIPATION, DIARRHEA, DYSPHAGI
GU: DYSUREA FREQUENT URINE, IRRIGATRED M.C
NM: WEAKNESS, NUMBNESS, TREMOR
CONS: FEVER, CHILL, FATIGUE
HEMO: BLEEDING, BRUISING
MENTAL: DEPRESSION, FORGETFUL
SKIN: RASH, ULIC R.

PHYSICAL EXAM: (INCLUDING THE FOLLOWING BUT NOT LIMITED) N ABN

HEENT:	PUPILS ERLA: TYMP INTACT, CLEAR
	NASO- OROPHARYNX NO RED/EDMA
	NO CAROTIO BRUITR
LUNGS:	CLEAR BS. NO RALES. NO RHONCHI
HEART:	NRRR: NO MURMUR
ABC:	WNL; (+)
PELV:	VAG OS UT ADEN
EXT:	EDEMA VARICOSE
SKIN:	RASH ULCER MASS
MENTAL:	CLEAR CONF HALU
NEURO:	(+) FOAC DEF SEN MOT REF

ASSESSMENT:
1.
2.
3.

PLAN:
1.
2.
3.

ORDER
BMO
CHEM
CHOL
COLON
COLP
EAR WASH
EGD
EKG
EMG-NCV
GLU
GLUOMETER
HGB
HOLT
IMM/PPO
IV
MAMMO/BREAST
PAPS
PATHO
PEAK FLOW
PULSE OX
RADIO
RAPID STREP TEST
SPIRO
SP REFER
US

TIME SPENT: 15 30 60

PROVIDERS SIGNATURE: JUN 0 1 2009

RK DRIVE, STE
SACRAMENTO, CA 95831

PROGRESS NOTE

NAME: , Daniel DATE: APR 27 2009 ALLERGY: ∅

BP: 122/74 WT: 240 HT: 59" P: 86 R: 24 T: 99.8 MEDS: See List

CC: Check on B/L Ear Infection MA: TRANS BY: AGE:

HP:

1. ABDOMEN PAIN	[ ]
2. COUGH	[ ]
3. CHEST PAIN	[ ]
4. DIARRHEA	[ ]
5. DIZZINESS	[ ]
6. FATIGUE	[ ]
7. HEADACHE	[ ]
8. LOWER BACK PAIN	[ ]
9. PAIN	[ ]
10. SHORT OF BREATH	[ ]
11. SKIN RASH	[ ]

PAST:

PERSONAL/ SOCIAL
SMOKE
DRUG/ALCOHOL
WORK

FAMILY HISTORY

CANCER	[ ]
DIABETES MALLEUS	[ ]
HTN	[ ]
ARTHRITIS	[ ]

ROS: INCLUDING THE FOLLOWING CIRCLE (IF PRESENT)

PUL: COUGH, SOB, EX DYSPNEA
CV: CHEST PAIN, FLUTTER
GI: CONSTIPATION, DIARRHEA, DYSPHAGI
GU: DYSUREA FREQUENT URINE, IRRIGATRED M.C
NM: WEAKNESS, NUMBNESS, TREMOR
CONS: FEVER, CHILL, FATIGUE
HEMO: BLEEDING, BRUISING
MENTAL: DEPRESSION, FORGETFUL
SKIN: RASH, ULIC R.

PHYSICAL EXAM: (INCLUDING THE FOLLOWING BUT NOT LIMITED) N ABN

HEENT:	PUPILS ERLA: TYMP INTACT, CLEAR
	NASO- OROPHARYNX NO RED/EDMA
	NO CAROTIO BRUITR
LUNGS:	CLEAR BS, NO RALES, NO RHONCHI
HEART:	NRRR: NO MURMUR
ABC:	WNL: (+)
PELV:	VAG OS UT ADEN
EXT:	EDEMA VARICOSE
SKIN:	RASH ULCER MASS
MENTAL:	CLEAR CONF HALU
NEURO:	(+) FOAC DEF SEN MOT REF

ASSESSMENT:
1.
2
3.

PLAN:
1.
2.
3.

TIME SPENT: 15 30 60

PROVIDERS SIGNATURE:

Instructed as Critical
( ) Need follow care plan
Instructed to call
( ) If problem persists
Follow Up Visit
( ) day ( ) week ( ) month
( ) Pt education discuss?
Ed InformationGiven
Cholesterol ( ) diabetes
Diet ( ) Exercise
Smoke ( )Obesity
Family Planning ( ) STD's
Hypertension
Medications
Prenatal Care
Self Breast Exam

ORDER
BMO
CHEM
CHOL
COLON
COLP
EAR WASH
EGD
EKG
EMG-NCV
GLU
GLUOMETER
HGB
HOLT
IMM/PPO
IV
MAMMO/BREAST
PAPS
PATHO
PEAK FLOW
PULSE OX
RADIO
RAPID STREP TEST
SPIRO
SP REFER
US

med ctr inc.

MEDICAL REPORT/SLP

NAME'_ DANIEL 2 9 65M/MC

TODAY DATE;3 25 09
HISTORY; all time somnolance

GENERAL CONDITION STABLE.

PAST HISTORY; LIPIDEMIA/BIPOLAR/MR

PERSONAL HISTORY; NO USE OF SMOKING,ILLICIT DRUG
FAMILY HX;NP
CURRENT RX; GEODON80MG/PERPHENAZINE 8MG LIPITOR 10MG POTASIUM TOPAMAX100MG
DRUG ALLERGY;N

review of organ system;(DITTO
LAB;
PHYSICAL EXAM;BP 120/78 RR 24/M PR 80/M WT 257
HENT;NP
CHEST/COR/ABDOMEN;2/6 MURMUR
NEURO;NO FOCAL NEUROLOGICAL DEFICIT.
ORTHO;NP
MENTAL; OUT TOUCH
ABDOMEN;N
DIAGNOSIS;RESVING EAR INFECTION
_____ BIPOLAR
ASCVD/MR
LIPIDEMIA-
TREATMENT PLAN; sleep study
RX;maintain same for now

rtc/1 month or prn

M.D.

PROGRESS NOTE

NAME: DANIEL DATE: MAR 25 2009 ALLERGY: NKDA

BP: 138/88 WT: 246 HT: 5.9" P: 88 R: 16 T: MEDS: ALLOPURINOL 300mg

CC: check up MA: TRANS BY: AGE:

HP:

1. ABDOMEN PAIN	[ ]	
2. COUGH	[ ]	
3. CHEST PAIN	[ ]	
4. DIARRHEA	[ ]	
5. DIZZINESS	[ ]	
6. FATIGUE	[ ]	
7. HEADACHE	[ ]	
8. LOWER BACK PAIN	[ ]	
9. PAIN	[ ]	
10 SHORT OF BREATH	[ ]	
11. SKIN RASH	[ ]	

PAST:

PERSONAL/ SOCIAL
SMOKE
DRUG/ALCOHOL
WORK

FAMILY HISTORY

CANCER	[ ]	
DIABETES MALLEUS	[ ]	
HTN	[ ]	
ARTHRITIS	[ ]	

ROS: INCLUDING THE FOLLOWING CIRCLE (IF PRESENT)

PUL: COUGH, SOB, EX DYSPNEA
CV: CHEST PAIN, FLUTTER
GI: CONSTIPATION, DIARRHEA, DYSPHAGI
GU: DYSUREA FREQUENT URINE, IRRIGATRED M.C
NM: WEAKNESS, NUMBNESS, TREMOR
CONS: FEVER, CHILL, FATIGUE
HEMO: BLEEDING, BRUISING
MENTAL: DEPRESSION, FORGETFUL
SKIN: RASH, ULIC R.

PHYSICAL EXAM: (INCLUDING THE FOLLOWING BUT NOT LIMITED) N ABN

HEENT:	PUPILS ERLA: TYMP INTACT, CLEAR
	NASO- OROPHARYNX NO RED/EDMA
	NO CAROTIO BRUITR
LUNGS:	CLEAR BS, NO RALES, NO RHONCHI
HEART:	NRRR: NO MURMUR
ABC:	WNL; (-)
PELV:	VAG OS UT ADEN
EXT:	EDEMA VARICOSE
SKIN:	RASH ULCER MASS
MENTAL:	CLEAR CONF HALU
NEURO:	(+) FOAC DEF SEN MOT REF

ASSESSMENT:
1.
2.
3.

PLAN:
1.
2.
3.

TIME SPENT: 15 30 60

PROVIDERS SIGNATURE:

Instructed as Critical
( ) Need follow care plan
Instructed to call
( ) If problem persists
Follow Up Visit
( ) day ( ) week ( ) month
( ) Pt education discuss?
Ed InformationGiven
Cholesterol ( ) diabetes
Diet ( ) Exercise
Smoke ( )Obesity
Family Planning ( ) STD's
Hypertension
Medications
Prenatal Care
Self Breast Exam

ORDER
BMO
CHEM
CHOL
COLON
COLP
EAR WASH
EGD
EKG
EMG-NCV
GLU
GLUOMETER
HGB
HOLT
IMM/PPO
IV
MAMMO/BREAST
PAPS
PATHO
PEAK FLOW
PULSE OX
RADIO
RAPID STREP TEST
SPIRO
SP REFER
US

RAMÓN M.D.
EVARD, SUITE 202
SACRAMENTO, CALIFORNIA 95841
TELEPHONE FAX (

DEA REG. NO. / LIC. NO

NAME Dan AGE

ADDRESS DATE 2/4/09

℞ Please evaluate for sleep apnea

RSa

REFILL ____ TIMES ____ M.D.

PROGRESS NOTE

NAME Daniel DATE: FEB 25 2009 ALLERGY: NKDA

BP: 127/81 WT: 216 HT: P: 77 R: T: MEDS:

CC: Sleep test / problem sleeping MA: TRANS BY: AGE:

HP:

1. ABDOMEN PAIN	[ ]
2. COUGH	[ ]
3. CHEST PAIN	[ ]
4. DIARRHEA	[ ]
5. DIZZINESS	[ ]
6. FATIGUE	[ ]
7. HEADACHE	[ ]
8. LOWER BACK PAIN	[ ]
9. PAIN	[ ]
10. SHORT OF BREATH	[ ]
11. SKIN RASH	[ ]

PAST:

PERSONAL/ SOCIAL
SMOKE
DRUG/ALCOHOL
WORK

FAMILY HISTORY

CANCER	[ ]
DIABETES MALLEUS	[ ]
HTN	[ ]
ARTHRITIS	[ ]

ROS: INCLUDING THE FOLLOWING CIRCLE (IF PRESENT)

PUL: COUGH, SOB, EX DYSPNEA
CV: CHEST PAIN. FLUTTER
GI: CONSTIPATION, DIARRHEA, DYSPHAGI
GU: DYSUREA FREQUENT URINE. IRRIGATRED M.C
NM: WEAKNESS, NUMBNESS, TREMOR
CONS: FEVER, CHILL, FATIGUE
HEMO: BLEEDING, BRUISING
MENTAL: DEPRESSION, FORGETFUL
SKIN: RASH, ULIC R.

PHYSICAL EXAM: (INCLUDING THE FOLLOWING BUT NOT LIMITED) N ABN

HEENT:	PUPILS ERLA: TYMP INTACT, CLEAR
	NASO- OROPHARYNX NO RED/EDMA
	NO CAROTIO BRUITR
LUNGS:	CLEAR BS. NO RALES. NO RHONCHI
HEART:	NRRR: NO MURMUR
ABC:	WNL; (+)
PELV:	VAG OS UT ADEN
EXT:	EDEMA VARICOSE
SKIN:	RASH ULCER MASS
MENTAL:	CLEAR CONF HALU
NEURO:	(+) FOAC DEF SEN MOT REF

ASSESSMENT:
1.
2.
3.

PLAN:
1.
2.
3.

TIME SPENT: 15 30 60

PROVIDERS SIGNATURE:

Instructed as Critical
( ) Need follow care plan
Instructed to call
( ) If problem persists
Follow Up Visit
( ) day ( ) week ( ) month
( ) Pt education discuss?
Ed InformationGiven
Cholesterol ( ) diabetes
Diet ( ) Exercise
Smoke ( )Obesity
Family Planning ( ) STD's
Hypertension
Medications
Prenatal Care
Self Breast Exam

ORDER
BMO
CHEM
CHOL
COLON
COLP
EAR WASH
EGD
EKG
EMG-NCV
GLU
GLUOMETER
HGB
HOLT
IMM/PPO
IV
MAMMO/BREAST
PAPS
PATHO
PEAK FLOW
PULSE OX
RADIO
RAPID STREP TEST
SPIRO
SP REFER
US

, ctr inc.

MEDICAL REPORT/SLP
==========
NAME' DANIEL 2 9 65M/MC

TODAY DATE;12 24 08
HISTORY; NO MORE EAR COMPLIANT
DOING WELL IN GENERAL
PAST HISTORY; LIPIDEMIA/BIPOLAR/MR

PERSONAL HISTORY; NO USE OF SMOKING,ILLICIT DRUG
FAMILY HX;NP
CURRENT RX; GEODON80MG/PERPHENAZINE 8MG LIPITOR 10MG POTASIUM TOPAMAX100MG
DRUG ALLERGY;N

review of organ system;(DITTO
LAB;
PHYSICAL EXAM;BP 120/78 RR 24/M PR 80/M WT 257
HENT;NP
CHEST/COR/ABDOMEN;2/6 MURMUR
NEURO;NO FOCAL NEUROLOGICAL DEFICIT.
ORTHO;NP
MENTAL; OUT TOUCH
ABDOMEN;N
DIAGNOSIS;RESVING EAR INFECTION
BIPOLAR
ASCVD/MR
LIPIDEMIA-
TREATMENT PLAN;
RX;N

rtc/1 month or prn

M.D.

med ctr inc.

MEDICAL REPORT/SLP
==========
NAME 'DANIEL 2 9 65M/MC

TODAY DATE;12 24 08
HISTORY; NO MORE EAR COMPLIANT
DOING WELL IN GENERAL
PAST HISTORY; LIPIDEMIA/BIPOLAR/MR

PERSONAL HISTORY; NO USE OF SMOKING,ILLICIT DRUG
FAMILY HX;NP
CURRENT RX; GEODON80MG/PERPHENAZINE 8MG LIPITOR 10MG POTASIUM TOPAMAX100MG
DRUG ALLERGY;N

review of organ system;(DITTO
LAB;
PHYSICAL EXAM;BP 120/78 RR 24/M PR 80/M WT 257
HENT;NP
CHEST/COR/ABDOMEN;2/6 MURMUR
NEURO;NO FOCAL NEUROLOGICAL DEFICIT.
ORTHO;NP
MENTAL; OUT TOUCH
ABDOMEN;N
DIAGNOSIS;RESVING EAR INFECTION
_____ BIPOLAR
ASCVD/MR
LIPIDEMIA-
TREATMENT PLAN;
RX;N

rtc/1 month or prn

.D.

med ctr inc.

MEDICAL REPORT/SLP

NAM ANIEL 2 9 65M/MC

TODAY DATE;12 17 08
HISTORY; ears pain and drainage
other condititon stationary

PAST HISTORY; LIPIDEMIA/BIPOLAR/MR

PERSONAL HISTORY; NO USE OF SMOKING,ILLICIT DRUG
FAMILY HX;NP
CURRENT RX; GEODON80MG/PERPHENAZINE 8MG LIPITOR 10MG POTASIUM TOPAMAX100MG
DRUG ALLERGY;N

review of organ system;(DITTO
LAB;
PHYSICAL EXAM;BP 120/78 RR 24/M PR 80/M WT 257
HENT;red and drain ext ears
CHEST/COR/ABDOMEN;2/6 MURMUR
NEURO;NO FOCAL NEUROLOGICAL DEFICIT.
ORTHO;NP
MENTAL; OUT TOUCH
ABDOMEN;N
DIAGNOSIS;om
BIPOLAR
ASCVD/MR
LIPIDEMIA-
TREATMENT PLAN; amoxil/cortisporin
rtc/1 month or prn

PROGRESS NOTE

NAME Daniel DATE: 12/17/08 ALLERGY: Ø

BP 148/77 WT 284 HT 59 P: 76 R: 20 T: 95.8P MEDS: Ø

CC: F/u for ear infection. MA: TRANS BY: AGE: 42

HP:

1. ABDOMEN PAIN	[ ]
2. COUGH	[ ]
3. CHEST PAIN	[ ]
4. DIARRHEA	[ ]
5. DIZZINESS	[ ]
6. FATIGUE	[ ]
7. HEADACHE	[ ]
8. LOWER BACK PAIN	[ ]
9. PAIN	[ ]
10. SHORT OF BREATH	[ ]
11. SKIN RASH	[ ]

Instructed as Critical
( ) Need follow care plan
Instructed to call
( ) If problem persists
Follow Up Visit
( ) day ( ) week ( ) month
( ) Pt education discuss?
Ed InformationGiven
Cholesterol ( ) diabetes
Diet ( ) Exercise
Smoke ( )Obesity
Family Planning ( ) STD's
Hypertension
Medications
Prenatal Care
Self Breast Exam

PAST:

PERSONAL/ SOCIAL
SMOKE
DRUG/ALCOHOL
WORK

FAMILY HISTORY

CANCER	[ ]
DIABETES MALLEUS	[ ]
HTN	[ ]
ARTHRITIS	[ ]

ROS: INCLUDING THE FOLLOWING CIRCLE (IF PRESENT)

PUL: COUGH, SOB, EX DYSPNEA
CV: CHEST PAIN, FLUTTER
GI: CONSTIPATION, DIARRHEA, DYSPHAGI
GU: DYSUREA FREQUENT URINE, IRRIGATRED M.C
NM: WEAKNESS, NUMBNESS, TREMOR
CONS: FEVER, CHILL, FATIGUE
HEMO: BLEEDING, BRUISING
MENTAL: DEPRESSION, FORGETFUL
SKIN: RASH, ULIC R.

PHYSICAL EXAM: (INCLUDING THE FOLLOWING BUT NOT LIMITED) N ABN

HEENT:	PUPILS ERLA: TYMP INTACT. CLEAR
	NASO- OROPHARYNX NO RED/EDMA
	NO CAROTIO BRUITR
LUNGS:	CLEAR BS, NO RALES, NO RHONCHI
HEART:	NRRR: NO MURMUR
ABC:	WNL: (+)
PELV:	VAG OS UT ADEN
EXT:	EDEMA VARICOSE
SKIN:	RASH ULCER MASS
MENTAL:	CLEAR CONF HALU
NEURO:	(+) FOAC DEF SEN MOT REF

ASSESSMENT:
1.
2.
3.

PLAN:
1.
2.
3.

ORDER
BMO
CHEM
CHOL
COLON
COLP
EAR WASH
EGD
EKG
EMG-NCV
GLU
GLUOMETER
HGB
HOLT
IMM/PPO
IV
MAMMO/BREAST
PAPS
PATHO
PEAK FLOW
PULSE OX
RADIO
RAPID STREP TEST
SPIRO
SP REFER
US

TIME SPENT: 15 30 60

PROVIDERS SIGNATURE:

PROGRESS NOTE

NAME: ,Daniel DATE: DEC 17 2008 ALLERGY: 0

BP: 120, 80 WT: 25 HT: 6'2 P: 100 R: 28 T: MEDS: Same meds prescribed. ear drops

CC: Pt for ear infection & sign off on med sheet of ear infection cleared up MA: TRANS BY: AGE:

HP:

1. ABDOMEN PAIN	[ ]	*no bleeding or fluid w/ ear infection
2. COUGH	[ ]	
3. CHEST PAIN	[ ]	
4. DIARRHEA	[ ]	
5. DIZZINESS	[ ]	DC/ discontinued med sheet.
6. FATIGUE	[ ]	
7. HEADACHE	[ ]	
8. LOWER BACK PAIN	[ ]	
9. PAIN	[ ]	
10. SHORT OF BREATH	[ ]	
11. SKIN RASH	[ ]	

PAST:

PERSONAL/ SOCIAL

SMOKE
DRUG/ALCOHOL
WORK

FAMILY HISTORY

CANCER	[ ]
DIABETES MALLEUS	[ ]
HTN	[ ]
ARTHRITIS	[ ]

ROS: INCLUDING THE FOLLOWING CIRCLE (IF PRESENT)

PUL: COUGH, SOB, EX DYSPNEA
CV: CHEST PAIN, FLUTTER
GI: CONSTIPATION, DIARRHEA, DYSPHAGI
GU: DYSUREA FREQUENT URINE, IRRIGATRED M.C
NM: WEAKNESS, NUMBNESS, TREMOR
CONS: FEVER, CHILL, FATIGUE
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SKIN: RASH, ULIC R.

PHYSICAL EXAM: (INCLUDING THE FOLLOWING BUT NOT LIMITED) N ABN

HEENT:	PUPILS ERLA: TYMP INTACT, CLEAR
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PELV:	VAG OS UT ADEN
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MENTAL:	CLEAR CONF HALU
NEURO:	(+) FOAC DEF SEN MOT REF

ASSESSMENT:
1.
2.
3.

PLAN:
1.
2.
3.

TIME SPENT: 15 30 60

PROVIDERS SIGNATURE:

Instructed as Critical
( ) Need follow care plan
Instructed to call
( ) If problem persists
Follow Up Visit
( ) day ( ) week ( ) month
( ) Pt education discuss?
Ed InformationGiven
Cholesterol ( ) diabetes
Diet ( ) Exercise
Smoke ( )Obesity
Family Planning ( ) STD's
Hypertension
Medications
Prenatal Care
Self Breast Exam

ORDER
BMO
CHEM
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COLP
EAR WASH
EGD
EKG
EMG-NCV
GLU
GLUOMETER
HGB
HOLT
IMM/PPO
IV
MAMMO/BREAST
PAPS
PATHO
PEAK FLOW
PULSE OX
RADIO
RAPID STREP TEST
SPIRO
SP REFER
US

med ctr inc.

MEDICAL CONSULTATION REPORT/SLP

NAME DANIEL 2 9 65M/MC

TODAY DATE;11 19 08
HISTORY; ear drainges and bleeding for one week
congestion and soar throt
PAST HISTORY; LIPIDEMIA/BIPOLAR/MR

PERSONAL HISTORY; NO USE OF SMOKING,ILLICIT DRUG
FAMILY HX;NP
CURRENT RX; GEODON80MG/PERPHENAZINE 8MG LIPITOR 10MG POTASIUM TOPAMAX100MG
DRUG ALLERGY;N

*review of organ system;(POSITIVE DENOTED WITH *)*
*pulm;*cough/sob*
cv;chest pain/palpitation
*nm;tingle,numb/weak/pain/dizzy/headache**
gi;nausea/vomiting/diarhea/constipation*/loss of appetite*
*gu;urgency/painful urin*e/incont*
endo;thirsty/frequent urine/
others;loss vision/loss hearing/rash/itch/fatigue/loss weight

LAB;UA ;RBCS
PHYSICAL EXAM;BP 120/78 RR 24/M PR 80/M WT 257
HENT;NP
CHEST/COR/ABDOMEN;2/6 MURMUR
NEURO;NO FOCAL NEUROLOGICAL DEFICIT.
ORTHO;NP
MENTAL; OUT TOUCH
ABDOMEN;N
DIAGNOSIS;url and otitis external
BIPOLAR
ASCVD/MR
LIPIDEMIA-
TREATMENT PLAN;
RX;cortisporin otics/amoxil 500mg tid

rtc/1 month or prn

M.D.

PROGRESS NOTE

NAME: Daniel DATE: NOV 2 0 2008 ALLERGY: Ø

BP 122/78 WT: ~~205~~ 203 HT: 5'3" P: 84 R: 24 T: MEDS:

CC: TB reading MA: TRANS BY: AGE:

HP:

1. ABDOMEN PAIN	[ ]	
2. COUGH	[ ]	
3. CHEST PAIN	[ ]	
4. DIARRHEA	[ ]	
5. DIZZINESS	[ ]	
6. FATIGUE	[ ]	
7. HEADACHE	[ ]	
8. LOWER BACK PAIN	[ ]	
9. PAIN	[ ]	
10. SHORT OF BREATH	[ ]	
11. SKIN RASH	[ ]	

Instructed as Critical
( ) Need follow care plan
Instructed to call
( ) If problem persists
Follow Up Visit
( ) day ( ) week ( ) month
( ) Pt education discuss?
Ed InformationGiven
Cholesterol ( ) diabetes
Diet ( ) Exercise
Smoke ( )Obesity
Family Planning ( ) STD's
Hypertension
Medications
Prenatal Care
Self Breast Exam

PAST:

PERSONAL/ SOCIAL
SMOKE
DRUG/ALCOHOL
WORK

FAMILY HISTORY

CANCER	[ ]	
DIABETES MALLEUS	[ ]	
HTN	[ ]	
ARTHRITIS	[ ]	

ROS: INCLUDING THE FOLLOWING CIRCLE (IF PRESENT)

PUL: COUGH, SOB, EX DYSPNEA
CV: CHEST PAIN. FLUTTER
GI: CONSTIPATION, DIARRHEA, DYSPHAGI
GU: DYSUREA FREQUENT URINE, IRRIGATRED M.C
NM: WEAKNESS, NUMBNESS, TREMOR
CONS: FEVER, CHILL, FATIGUE
HEMO: BLEEDING, BRUISING
MENTAL: DEPRESSION, FORGETFUL
SKIN: RASH, ULIC R.

PHYSICAL EXAM: (INCLUDING THE FOLLOWING BUT NOT LIMITED) N ABN

HEENT:	PUPILS ERLA: TYMP INTACT, CLEAR
	NASO- OROPHARYNX NO RED/EDMA
	NO CAROTIO BRUITR
LUNGS:	CLEAR BS, NO RALES, NO RHONCHI
HEART:	NRRR: NO MURMUR
ABC:	WNL; (+)
PELV:	VAG OS UT ADEN
EXT:	EDEMA VARICOSE
SKIN:	RASH ULCER MASS
MENTAL:	CLEAR CONF HALU
NEURO:	(+) FOAC DEF SEN MOT REF

ASSESSMENT:
1.
2.
3.

PLAN:
1.
2.
3.

ORDER
BMQ
CHEM
CHOL
COLON
COLP
EAR WASH
EGD
EKG
EMG-NCV
GLU
GLUOMETER
HGB
HOLT
IMM/PPO
IV
MAMMO/BREAST
PAPS
PATHO
PEAK FLOW
PULSE OX
RADIO
RAPID STREP TEST
SPIRO
SP REFER
US

TIME SPENT: 15 30 60

PROVIDERS SIGNATURE:

MEDICAL CENTER

NAME: , Daniel DATE: NOV 20 2008

WEIGHT: 205 HEIGHT: 5'9 TEMP: _____ P: 74 R: 16

BP 128/78 ALLERGIES: _____

COMPLAIN: Check up, blood was comming out of his left ear, Flu Shot

TIME: _____ MA: B.S

MEDICATIONS:

CHIEF COMPLAINT:

PMH:

WOMAN ONLY

LMP: _____

GRAVIDA: _____

LAST PAP: _____

LAST MAMMO: _____

SOC HX: TABACCO: YES OR NO PPD ETOH

FH:

REVIW OF SYSTEM TIME SPENT: _____ 15 ____ 30 ____ 60

PROVIDERS'S SIGNATURE:

ned ctr inc.

MEDICAL CONSULTATION REPORT/SLP

NAME DANIEL 2 9 65M/MC

TODAY DATE;7 14 08
HISTORY; THE PT is here to establish as primary care.(GROUP HOME)
ON SEIZURE AND SYCHIAC MEDICATION ,WELL CONTROLLED
PAST HISTORY; LIPIDEMIA/BIPOLAR/MR

PERSONAL HISTORY; NO USE OF SMOKING,ILLICIT DRUG
FAMILY HX;NP
CURRENT RX; GEODON80MG/PERPHENAZINE 8MG LIPITOR 10MG POTASIUM TOPAMAX100MG
DRUG ALLERGY;N

*review of organ system;(POSITIVE DENOTED WITH *)*
*pulm;*cough/sob*
cv;chest pain/palpitation
*nm;tingle,numb/weak/pain/dizzy/headache**
gi;nausea/vomiting/diarhea/constipation*/loss of appetite*
*gu;urgency/palnful urin*e/incont*
endo;thirsty/frequent urine/
others;loss vision/loss hearing/rash/itch/fatigue/loss weight

LAB;UA ;RBCS
PHYSICAL EXAM;BP 120/78 RR 24/M PR 80/M WT 257
HENT;NP
CHEST/COR/ABDOMEN;2/6 MURMUR
NEURO;NO FOCAL NEUROLOGICAL DEFICIT.
ORTHO;NP
MENTAL; OUT TOUCH
ABDOMEN;N
DIAGNOSIS; BIPOLAR
ASCVD/MR
LIPIDEMIA
TREATMENT PLAN;
RX;KEEP SAME UNTIL REVIEWED NEXT

rtc/1 month or prn

M.D.

MEDICAL CENTER

NAME: T. DANIEL DATE JUL 14 2008

WEIGHT: 257 HEIGHT: 6'2" TEMP: _____ P: 80 R: 18

B/P 120/80 ALLERGIES: 0

COMPLAIN: prescription refill + change of physician

TIME: _____ MA: _____

MEDICATIONS:

CHIEF COMPLAINT:

PMH:

WOMAN ONLY

LMP: _____

GRAVIDA: _____

LAST PAP: _____

LAST MAMMO: _____

SOC HX: TABACCO: YES OR NO PPD ETOH

FH:

REVIW OF SYSTEM TIME SPENT: _____ 15 ____ 30 ____ 60

PROVIDERS'S SIGNATURE:

MEDICAL CENTER

Name DANIEL D Date of Birth 2/9/65 Sex (M) F
First Middle Init.

DO YOU HAVE ANY MEDICATION ALLERGIES? YES ☐ NO ☑ If so, to what?

Current Medical Problems: Swelling of both legs, incontinence, obesity
Medications NOT FILLED AS REQUIRED BY PREVIOUS PHYSIAN.

Have you ever been hospitalized? If so, explain (include dates)

Major illnesses (include dates) MILD MR, BIPOLAR DISORDER

Current Medications: SNEE LOST SIMVASTATIN(10MG) PERPHENAZINE (8MG)
GEODON(80 MG) ✓POTASSIUM CL (8MEQ)
TOPAMAX(100MG)

Have you ever had surgeries? (include dates)

Have you ever had a blood transfusion? Y☐ / N☐ If so, when? When was your last physical? 10/1/07

Who is your regular family doctor? Dr. /DrG (women only) Who is your OB/GYN doctor

When was your last tetanus shot? last PPD shot (test for TB) 10/1/07 Was it positive? Y☐ / N☒

Do you smoke? Y☐ / N☒ If yes, how many packs a day? ____ how many years? ____ ≤2x Do you drink? Y☐ / N☐ How much?

If you have had any of the following conditions, please circle:

ANEMIA	ARTHRITIS	ASTHMA	BLADDER INFECTION	CANCER
CHEST PAIN	DIABETES	DIZZINESS	EMPHYSEMA	DEPRESSION
MENTAL PROBLEMS	EYE DISORDER	GENITAL HERPES	GONORRHEA	KIDNEY DISEASE
HEADACHE	HEART PROBLEMS	HEPATITIS	HIGH BLOOD PRESSURE	LIVER DISEASE
DIFFICULTY SLEEPING	MIGRAINES	LUNG DISEASE	NAUSEA	PNEUMONIA
SEIZURES	STOMACH PROBLEMS	STROKE	SYPHILLIS	THYROID PROBLEMS
VARICOSE VEINS	VENEREAL WARTS	ANXIETY	BLOOD IN STOOL	WEIGHT LOSS

Do any of your family members have serious illnesses? (provide age, illness, and relationship)

Where were you born? CALIF. What is your occupation? N/A

WOMEN ONLY: When was your last PAP smear? ___/___/___ Was it normal? Y☐ / N☐. Have you had a Mammogram? Y☐ / N☐

Have you had any abnormal vaginal bleeding, discharge, or itching? If so explain

Age when menses began? ____ years old. Are your periods regular? Y☐ / N☐ How many days per cycle? ____ are they painful? Y☐ / N☐

How long does your flow last? ____ days. When was your last period? ___/___/___

How many pregnancies____ live childbirths____ abortions____ miscarriages____ have you had?

If you are on birth control, which type? Pill (brand)____, IUD, Condom, diaphragm, rhythm, Depo Provera, Tubal ligation

If needed, do you consent to a pelvic exam? Y☐ / N☐

If you have other areas of concern you think we should know, please explain below:

Today's date 1/4/08 Form completed by

Immunization Record and History

P/	(Middle Initial) Daniel	NUMBER
BIR...	☐ Male ☐ Female	KNOWN REACTIONS TO VACCINES/ALLERGIES	PRACTICE NAME/ADDRESS

VACCINES FOR CHILDREN (VFC) ELIGIBILITY (check one)

☐ CHDP/Medi-Cal eligible ☐ No health insurance ☐ American Indian/ Alaskan Native ☐ (Only federally qualified and rural health centers) Health insurance does not cover IZs ☐ Not eligible

If a combination vaccine (e.g., DTaP+IPV+HepB or HepB+Hib) is used, record dose in each section.

VACCINE Circle one	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINIS-TERED BY	SITE** VIS I.D.†	VACCINE	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINIS-TERED BY	SITE** VIS I.D.†
HepB 1				IM	Pneumo Conj 1				IM
HepB 2				IM	Pneumo Conj 2				IM
HepB 3				IM	Pneumo Conj 3				IM
HepB				IM	Pneumo Conj 4				IM
Rotavirus 1				oral	IPV 1				IM or SC
Rotavirus 2				oral	IPV 2				IM or SC
Rotavirus 3				oral	IPV 3				IM or SC
DTaP/DT/Td/ Tdap 1				IM	IPV 4				IM or SC
DTaP/DT/Td/ Tdap 2				IM	MMR 1				SC
DTaP/DT/Td/ Tdap 3				IM	MMR 2				SC
DTaP/DT/Td/ Tdap 4				IM	Varicella 1				SC
DTaP/DT/Td/ Tdap 5				IM	Varicella 2				SC
Td/Tdap (boosters over)				IM	HepA 1				IM
HIB 1				IM	HepA 2				IM
HIB 2				IM					
HIB 3				IM					
HIB 4				IM					

TB SKIN TESTS

DATE GIVEN	TYPE	DATE READ	IMPRESSION
11/19/2008	☒ Mantoux ☐ Other	11/21/2008	☒ Negative ☐ Positive (mm 0)
	☐ Mantoux ☐ Other		☐ Negative ☐ Positive (mm)
	☐ Mantoux ☐ Other		☐ Negative ☐ Positive (mm)

* Date Given is the date you gave the patient the Vaccine Information Statement (VIS) and you administered the vaccine.

** Site: Abbreviations are LD = left deltoid or left outer upper arm; LT = left thigh; RD = right deltoid or right outer upper arm; RT = right thigh. Proper route indicated by italics: IM = intramuscular; SC = subcutaneous.

§ MCV4 is given IM and MPSV4 is given SC.

† VIS = Vaccine Information Statement. Each VIS has an issue date in the lower corner. Record the VIS issue date here. The VIS should be given to the patient/parent before each dose of vaccine is administered. Each VIS can be downloaded from www.cdc.gov/nip/publications/VIS.

Note: If you are recording a vaccine given elsewhere, record date dose was given, write in elsewhere or transcribed, and/or name of provider.

Immunization Record and History, continued

If a combination vaccine (e.g., DTaP+IPV+HepB or HepB+Hib) is used, record dose in each section.

VACCINE	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINIS-TERED BY	SITE** / VIS I.D.†	VACCINE Circle one	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINIS-TERED BY	SITE** / VIS I.D.†
TIV/LAIV (Flu)	11/19/08		[illegible]	IM/Nasal [illegible]	HPV 1 (for girls only)				IM
TIV/LAIV (Flu)				IM/Nasal	HPV 2 (for girls only)				IM
TIV/LAIV (Flu)				IM/Nasal	HPV 3 (for girls only)				IM
TIV/LAIV (Flu)				IM/Nasal	MCV4/ MPSV4[1] (meningococcal)				IM or SC
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal	Tdap/Td				IM
TIV/LAIV (Flu)				IM/Nasal	Tdap/Td				IM
TIV/LAIV (Flu)				IM/Nasal	Tdap/Td				IM
TIV/LAIV (Flu)				IM/Nasal	Tdap/Td				IM
TIV/LAIV (Flu)				IM/Nasal	Tdap/Td				IM
TIV/LAIV (Flu)				IM/Nasal	Tdap/Td				IM
TIV/LAIV (Flu)				IM/Nasal	Tdap/Td				IM
TIV/LAIV (Flu)				IM/Nasal	Tdap/Td				IM
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

LITY:	TELEPHONE:
_3 CARE FACILITY	916-424

ADDRESS NUMBER	STREET	CITY
		SACRAMENTO, CA

LICENSEE'S NAME:	TELEPHONE:	FACILITY LICENSE NUMBER:
RE AND CH	916-[illegible]	[illegible]

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME:	TELEPHONE:
DANIELF L JR	916-424-

NUMBER	STREET	CITY	SOCIAL SECURITY NUMBER:
		SACRAMENTO.	

NEXT OF KIN:	PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:
MOTHER	

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: | LENGTH OF TIME UNDER YOUR CARE:

AGE:	HEIGHT:	SEX:	WEIGHT:	IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE?
43	5'9"	MALE	205	☒ YES ☐ NO

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☒ INACTIVE ☐ NONE | DATE OF LAST TB TEST: 11/20/2008

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ YES ☒ NO If YES, list below:

TREATMENT/MEDICATION:
B) ☐ YES ☐ NO If YES, list below:

ALLERGIES
C) ☐ YES ☒ NO If YES, list below:

TREATMENT/MEDICATION:
D) ☐ YES ☐ NO If YES, list below:

Ambulatory status of client/resident: ☒ Ambulatory ☐ Nonambulatory

Health and Safety Code Section 13131 provides: "Nonambulatory persons" means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. The determination of ambulatory or nonambulatory status of persons with developmental disabilities shall be made by the Director of Social Services or his or her designated representative, in consultation with the Director of Developmental Services or his or her designated representative. The determination of ambulatory or nonambulatory status of all other disabled persons placed after January 1, 1984, who are not developmentally disabled shall be made by the Director of Social Services, or his or her designated representative.

I. PHYSICAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR

	YES NO (Check One)	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment			
2. Visual impairment			
3. Wears dentures			
4. Special diet			
5 Substance abuse problem			
6. Bowel impairment			
7. Bladder impairment			
8. Motor impairment			
9. Requires continuous bed care			

II. MENTAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR

	NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: ☐ YES ☐ NO

	YES NO (Check One)	COMMENTS:
1. Able to care for all personal needs		
2. Can administer and store own medications		
3. Needs constant medical supervision		
4. Currently taking prescribed medications		
5. Bathes self		
6 Dresses self		
7. Feeds self		
8. Cares for his/her own toilet needs		
9. Able to leave facility unassisted		
10. Able to ambulate without assistance		
11. Able to manage own cash resources		

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Others *(specify condition)*	

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

PHYSICIAN'S NAME AND ADDRESS: | TELEPHONE: | DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)

I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE | ADDRESS: | DATE:

COUNTY OF SACRAMENTO
CORONER'S OFFICE

4800 Broadway, Suite 100
Sacramento, California 95820-1530

(916) 874-9320
FAX (916) 874-9257

Gregory P. Wyatt
Coroner

Edward E. Smith
Assistant Coroner

Kim Burson
Assistant Coroner

Daniel Baker
Administrative Services Officer

Mark Super
Chief Forensic Pathologist

July 25, 2009

To: Dr. Office
Attn: Medical Records
Phone: 916-
Fax: 916-

Patient: Daniel
Date of Birth: 02/09/1965
Date of Death: 06/06/2009

Re: Request for records

To Whom It May Concern:

In lieu of a subpoena for inquest, as authorized by Section 27498 of the Government Code, State of California, it is requested that you grant access to any books, medical records, documents, prescription orders, or other things under your control concerning the decedent's physical condition, which in the opinion of this office, are necessary as a further aid in determining the circumstances, manner and cause of death.

NOTE: The coroner's office is exempt from HIPAA (Health Insurance Portability and Accountability Act). The information necessary to complete the Certificate of Birth and Certificate of Death is required by California State law (Health and Safety Code Sections 102425 and 102875 respectively). The Privacy rule permits covered entities to disclose PHI (Protected Health Information), without authorization, to public health authorities or other entities that are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This includes the reporting of disease or injury and reporting of vital event records, such as births and deaths (Reference 45 Code of Federal Regulations (CFR) Section 164.512).

Thank you for your time and assistance,

Jennifer Deputy Coroner

* Please fax our office all medical records [redacted]. Please be sure to include all office notes regarding his 06/01/09 visit for complaint of pain. These records may include office notes, Discharge Summaries, H&P's, imaging results and lab results. These records are needed in order to assist this office in our death investigation. Please fax [redacted] so very much!

SHIELD Healthcare
Shield Advantage™

50 YEARS OF EXCELLENCE 1957-2007

FAX Cover Sheet

Date: April 15, 2009 Pages: 1 (including cover sheet)

To: Name: J L. From: Name: Ya

Dept: RCF

Fax# : 916-395-8364 Phone: 800-782-9374 FAX: 800-748-0713

RE: , JR DANIEL,

X Urgent ☐ For Review ☐ Please Comment ☑ Please Reply

Message: The above clients are requesting incontinent supplies. We need a primary diagnosis of what is causing the incontinence. We need this information to processes the orders. Thank you.

, JR DANIEL 2/09/65

Diagnosis: 1) urgent urine incontence
2) irritable urinary bladder
3) neurogenic bladder.

Shield Healthcare
Corporate Office
27911 Franklin Pkwy.
Valencia, CA 91355

www.shieldhealthcare.com

FAXED 04/15/09

MEDICATION LIST

	PROBLEMS AND	MEDICATION LIST	
NAME	DANIEL	RTC: RETUTN TO CLINIC	
ACCT #		LAB : LABORATORY ORDERED	
		OMR: OBTAIN MEDICAL RECORD PROCEEDED	
DATE	PROBLEMS	RX	RTX/LAB/OMR
DEC [illegible] 08			
DEC 08 2008	called pt. appt sched.	2/17/@10 am WW	
DEC 17 2008			
FEB 25 2009			
MAR 25 2009			
APR 27 2009			
JUN 01 2009			

	PROBLEMS AND	MEDICATION LIST	
NAME		RTC: RETUTN TO CLINIC	
ACCT #		LAB : LABORATORY ORDERED	
		OMR: OBTAIN MEDICAL RECORD PROCEEDED	
DATE	PROBLEMS	RX	RTX/LAB/OMR
NOV 19 2008			
		Cortisporin	
NOV 21 2008			

MR0178

REPORT STATUS FINAL REPRINT

QUEST DIAGNOSTICS INCORPORATED

PATIENT
DANIEL

DOB: 55 AGE: 43
GENDER: M FASTING: U

PHYSICIAN
STUART G DPM

SPECIMEN INFORMATION
SPECIMEN:
REQUISITION:

ID:
PHONE: 916- 9

CLIENT INFORMATION
42 1001
STUART DPM
9 A
SACRAMENTO, CA

916-

COLLECTED: NG
RECEIVED: 08/28/08 18:00
REPORTED: 09/11/09 15:58

COMMENTS: The original copy of this report was printed on: 09/01/08 at 15:00

No collection date received. We have used the date the specimen was received by Quest Diagnostics as the collection date. If this is incorrect, please contact us at 800-952-5691 (Option 1 - Client Services).

Test Name	In Range	Out of Range	Reference Range	Lab
CULTURE, AEROBIC				
STATUS	FINAL			SC
SOURCE	OTHER			SC
SITE	R GREAT TOE			SC
CULTURE				SC

1) LIGHT GROWTH PROTEUS MIRABILIS
2) HEAVY GROWTH STAPHYLOCOCCUS AUREUS

(S-SENSITIVE I-INTERMEDIATE R-RESISTANT)
All MIC values are in mcg/mL

SENSITIVITY:	ORG 1	ORG 2	
AMIKACIN	S <=16		SC
AMOX/K CLAV	S <=8/4	S <=4/2	SC
AMP/SULBACTAM	S <=8/4		SC
AMPICILLIN	S <=2		SC
AZTREONAM	S <=8		SC
CEFAZOLIN	S <=8	S <=2	SC
CEFEPIME	S <=8		SC
CEFOTAXIME	S <=8		SC
CEFTAZIDIME	S <=2		SC
CEFTRIAXONE	S <=8		SC
CEFUROXIME	S <=4		SC
CEPHALOTHIN	S <=8		SC
CIPROFLOXACIN	I 2	S <=1	SC
CLINDAMYCIN		S <=0.25	SC
ERYTHROMYCIN		S <=0.5	SC
GENTAMICIN	S <=1	S <=1	SC
IMIPENEM	S <=4		SC
LEVOFLOXACIN	S <=2	S <=2	SC

Page 1 - Continued on Page 2

PATIENT INFORMATION
DANIEL

REPORT STATUS FINAL REPRINT

QUEST DIAGNOSTICS INCORPORATED

ORDERING PHYSICIAN
G DPM

DOB: 9 3 AGE: 43
COLLECTED: NG GENDER: M FASTING: U
REPORTED: 09/11/09 15:58 ID:

Test Name	In Range	Out of Range	Reference Range	Lab
LINEZOLID	S 2			SC

(S-SENSITIVE I-INTERMEDIATE R-RESISTANT)
All MIC values are in mcg/mL

SENSITIVITY:	ORG 1	ORG 2		
OXACILLIN		S <=0.25		SC
PENICILLIN		R 8		SC
PIP/TAZO	S <=16			SC
PIPERACILLIN	S <=8			SC
RIFAMPIN		S <=1		SC
SYNERCID		S <=0.25		SC
TETRACYCLINE	R >8	S <=4		SC
TICAR/K CLAV	S <=16			SC
TOBRAMYCIN	S 2			SC
TRIMETH/SULFA	S <=2/38	S <=2/38		SC
VANCOMYCIN		S <=2		SC

PERFORMING LABORATORY INFORMATION

SC Quest Diagnostics, 3714 Northgate Boulevard, Sacramento, CA 95834
Laboratory Director: Gordon L. Phone: (800) CLIA: C5D0C

RAM... ...A, M.D.
JITE 202
...AMENTO, CALIFORNIA 95841
TELEPHONE (916) ...AX (916)

DEA REG. NO. A... LIC. NO.

NAME Dan AGE

ADDRESS DATE 2/4/09

℞
Please evaluate
for sleep apnea

REFILL ____ TIMES ____ M.D.

WESTCLIFF
MEDICAL LABORATORIES, INC.

LABORATORY REPORT

SRCEC: 17667
[illegible] CENTER
1540 [illegible] E
WEST SACRAMENTO CA 95691

PATIENT: , DANIEL D
DOB: AGE: 44Y SEX: M
PT. PHONE: 916 424 0000
REF. DR , M.D.
MRN/OTHER#

REQ#: R0[illegible]
ADVANTAGE#: 33466/8
COLLECTED: 02/27/09 09:03
REPORTED: 03/02/09 08:00

TEST	LOW	RESULT	HIGH	NORMAL RANGE	
GENERAL CHEMISTRY					
Glucose[1]		90[2]		65-99	mg/dL
BUN		8		8-24	mg/dL
Creatinine		0.6		0.6-1.4	mg/dL
eGFR - Non African American		>60.0[3]			
eGFR - African American		>60.0			
BUN/Creatinine Ratio		13		6-25	
Sodium		138		131-150	mEq/L
Potassium		3.5		3.5-5.5	mEq/L
Chloride		105		95-108	mEq/L
Calcium		9.3		8.5-10.6	mg/dL
Total Protein		6.8		6.0-8.5	g/dL
Albumin		3.8		3.5-5.0	g/dL
Globulin (Calc)		3.0		1.8-3.8	g/dL
A/G Ratio (Calc)		1.3		1.1-2.5	
Bilirubin, Total		0.4		0.1-1.4	mg/dL
Alkaline Phosphatase		84		30-130	IU/L
AST/SGOT		18		0-48	u/L
ALT/SGPT		20		0-52	u/L
Osmolality-Serum (Calc)		284		278-305	mOsm/kg
Ionized Calcium (Calc)		4.2		3.9-4.7	mg/dL
Bicarbonate (CO2)		23		21-31	mEq/L
Cholesterol[4]	121 L			140-200	mg/dL
Triglycerides		104		10-150	mg/dL
HDL	30 L[5]			40-80	mg/dL
LDL (Calc)		70		57-100	mg/dL
VLDL (Calc)		20.8		6.0-35.0	
Cholesterol/HDL Ratio		4.0[6]			
LDL/HDL Ratio		2.3		0.5-3.0	Ratio

[1] Fasting

[2] American Diabetes Association Guidelines can be found at www.westcliffiabs.com

[3] Chronic Kidney Disease is based on < 60 mL/min/1.73 m2 or kidney damage for at least three months. Kidney failure is based on < 15 mL/min/1.73 m2. Additional information can be found at www.westcliffiabs.com

[4] Fasting

[5] HDL of males greater than 45 mg/dL and females greater than 40 mg/dL have less than average incidence of coronary arterial sclerosis.

[6] Reference Range
Male: < 5.0
Female: < 4.4

	PATIENT: ...)ANIEL D	
...DICAL CENTER	DOB: (.GE: 44Y SEX: M	REQ#:
...AL AVE	PT. PHO... ...9	ADVANTAGE#
	REF. DR... ...JNG, M.D.	COLLECTED: 02/2.../0... ...:03
WEST SACRAMENTO CA 95691	MRN/OTHER#	REPORTED: 03/02/09 08:00

TEST	LOW	RESULT	HIGH	NORMAL RANGE	
TSH, 3rd Generation		1.247		0.350-5.500	uIU/mL
Free T4		1.03		0.80-1.80	ng/dL

HEMATOLOGY-COAGULATION-IMMUNOHEMATOLOGY

TEST	LOW	RESULT	HIGH	NORMAL RANGE	
WBC		10.6		4.0-11.0	thou/uL
RBC		4.84		4.20-5.80	mill/uL
Hemoglobin		15.0		14.0-18.0	g/dL
Hematocrit		44.8		40.0-52.0	%
MCV		93		80.0-100.0	fL
MCH		31.0		27.0-35.0	pg
MCHC		33.5		31.0-37.0	g/dL
RDW		13.5		11.5-14.5	%
Platelet Count		222		150-450	thou/uL

Quest Diagnostics

Medical Center (110897) ,MD

Sacramento, CA 95833

2. 25. 09

Form: CSRP110897-,MD

INFORMATION MUST BE PROVIDED OR ACCOUNT WILL BE BILLED - *Please Print Clearly*

PATIENT'S LAST NAME	FIRST NAME Daniel			
SEX	DOB /	PATIENT ID #/CHART #	DATE COLLECTED Required	TIME COLLECTED
PATIENT'S PHONE #	ORDERING PROVIDER	SUPERVISING PHYSICIAN Medi-Cal Requirement		
ROOM/LOCATION	CC: or Clinical Comments			

☐ **STAT** (Additional Charge) ☐ PHONE ( )______ ☐ FAX ( )______

URINE VOL. 24 HR | FASTING ☒ | RANDOM ☐ | TIME OF LAST DOSE ☐ AM ☐ PM

For any patient of any payor (including Medicare and Medi-Cal) that has a medical necessity requirement, you should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

BILL TO: ☐ OUR ACCOUNT ☐ PATIENT ☐ WC ☐ HMO/IPA ☐ MEDICARE A ☐ MEDICARE B ☐ MEDI-CAL ☐ INSURANCE ☐ CHDP ☐ FPACT

COMPLETE FOR ALL BILLING TYPES

RESPONSIBLE PARTY (Please Print)

ADDRESS

CITY/STATE/ZIP

COPY OF INSURANCE – HMO/IPA CARD REQUIRED

PRIMARY INSURANCE COMPANY - HMO/IPA HEALTH PLAN

ADDRESS (Street/City/State/Zip)

CERTIFICATE # | GROUP #

MEDI-CAL/MEDICARE # | MEDI-CAL ISSUE DATE | STATE

ICD-9 CODE(S) FOR DIAGNOSIS, SYMPTOM OR COMPLAINT (MUST BE PROVIDED) SHADED TESTS REQUIRE MEDICAL NECESSITY (ICD-9) CODE IF BILLED TO MEDICARE. SEE PAGE 3 FOR ADVANCE BENEFICIARY NOTICE

ICD-9 CODE(S) OR S CODE(S): 272.4 | 244.9 | V4.00 | 285.9

FOR ADDITIONAL TESTS PLEASE REFER TO THE DIRECTORY OF SERVICES

Panels — Any profile/panel component may be ordered separately

Code	Panel	Spec Req
30009	☐ Electrolyte Panel ✓	SST
3228	☐ Hepatic Function Panel ✓	SST
3012	☐ Basic Metabolic Panel ✓	SST
3565	☐ Renal Function Panel ✓	SST
3481	☒ Comprehensive Metabolic Panel ✓	SST
3057	☒ Lipid Panel ✓ ICD9	SST
48000	☐ Obstetric Panel w/reflex ✓ #	PNK, SST, L
42785	☐ Acute Hepatitis Panel w/reflex ✓ # ICD9	SST

Tests

Code	Test		Spec Req
50203	☐ ABO Group & Rh (O)		PNK
30065	☐ Albumin		SST
30115	☐ Alkaline Phosphatase		SST
30110	☐ ALT (SGPT)		SST
39345	☐ Amylase		SST
55910	☐ ANA w/reflex to titer #		SST
50202	☐ Antibody Screen w/reflex to ID #		PNK
30086	☐ AST (SGOT)		SST
30095	☐ Bilirubin, Direct		SST
30090	☐ Bilirubin, Total		SST
30045	☐ Calcium		SST
30020	☐ Carbon Dioxide (CO2)		SST
46000	☐ Cardio CRP		SST
4012	☒ CBC Hemogram, (Hgb, Hct, RBC, Indices, WBC, PLT)	ICD9	LAV
35010	☐ CBC w/Platelets & Diff (Hgb, Hct, RBC, WBC, PLT, Diff)	ICD9	LAV
30015	☐ Chloride (CL)		SST
30120	☐ Cholesterol, Total	ICD9	SST
39375	☐ CK, Total		SST
30030	☐ Creatinine, Serum		SST
50100	☐ ESR - Westergren		LAV
42960	☐ Estradiol (E2)		SST
42000	☐ Ferritin	ICD9	SST
43370	☐ Folic Acid, Serum		SST
42980	☐ Follicle Stimulating Hormone (FSH)		SST
39050	☐ Glucose, Fasting	ICD9	SST
39135	☐ Glucose, Gestational Screen		GRY
39157	☐ Glycohemoglobin, A1C	ICD9	LAV
46695	☐ H. Pylori, IgG		SST
42940	☐ HCG, Serum (Preg), Qual		SST
42950	☐ HCG, Serum, Quant	ICD9	SST
42956	☐ HCG Serum Quant, Gestational	ICD9	SST
39405	☐ HDL Cholesterol	ICD9	SST
35004	☐ Hematocrit	ICD9	LAV
35003	☐ Hemoglobin	ICD9	LAV
42710	☐ Hepatitis A Antibody, IgM		RED
42740	☐ Hepatitis B Core Antibody, IgM		RED
42720	☐ Hepatitis B Surface Ag (w/reflex confirm #)	ICD9	SST
42800	☐ Hepatitis C Antibody		SST
55803	☐ HIV Antibody, Elisa/Reflex WB #	ICD9	RED
42990	☐ Luteinizing Hormone (LH)		SST
70090	☐ OCC BLD, Feces-Guaiac X____ †	ICD9	CD
70099	☐ OCC BLD, Fecest IMMUNOCHEM, INSURE®	ICD9	CD
30050	☐ Phosphorus		SST
30010	☐ Potassium (K)		SST
43230	☐ Prolactin		SST
30060	☐ Protein, Total (TP)		SST
42920	☐ PSA, Total †	ICD9	SST
50051	☐ PT (Protime) w/INR	ICD9	B
50063	☐ PTT (Activated)	ICD9	B
56960	☐ Rheumatoid Factor		SST
64001	☐ RPR/Reflex TPPA #		SST
55010	☐ Rubella Ab, IgG		SST
30005	☐ Sodium (Na)		SST
34005	☐ T3 Uptake	ICD9	SST
42545	☒ T4 Free	ICD9	SST
34010	☐ Thyroxine, T4 Total	ICD9	SST
30133	☐ TIBC w/Iron	ICD9	SST
30125	☐ Triglycerides	ICD9	SST
42500	☒ TSH, 3rd Generation	ICD9	SST
30026	☐ Urea Nitrogen (BUN)		SST
30055	☐ Uric Acid		SST
37054	☐ Urinalysis No Microscopic		UAT
37051	☐ Urinalysis w/Microscopic		UAT
2050	☐ Urinalysis, Complete w/Microscopic Culture and sensitivity if indicated #		UAT, UTC
37052	☐ Urinalysis/Reflex Microscopic #		UAT
43360	☐ Vitamin B12		SST

Microbiology — Source:

Code	Test	Spec Req
70060	☐ Chlamydia DNA Probe	GP
45845	☐ Chlamydia trachomatis DNA, SDA	BDS, BDU
70065	☐ GC DNA Probe	GP
46855	☐ Neisseria gonorrhoeae DNA, SDA	BDS, BDU
70061	☐ Chlamydia/GC DNA Probe Screen #	GP
46865	☐ Chlamydia/N. gonorrhoeae DNA, SDA	BDS, BDU
70295	☐ Culture, Blood #	
70260	☐ Culture, Group B Strep #	BC
70290	☐ Culture, Genital #	BC
21665	☐ Culture, Herpes #	CH,V
70300	☐ Culture, Miscellaneous #	BC
70340	☐ Culture, Sputum/Gram Stain #	SC
70280	☐ Culture, Stool (Campy/Sal/Shig/Yers) #	CB
70275	☐ Culture, Campylobacter #	CB
70277	☐ Culture, Salmonella/Shigella #	CB
70270	☐ Culture, Throat #	BC
70265	☐ Culture, Throat, Strep Group A #	BC
70297	☐ Culture, Urine #	UTC
70120	☐ Ova & Parasites x____ # w/stain	SAF
70155	☐ Rapid Strep, Group A	PS

CUSTOM PANELS & TESTS - *Please Mark Desired Panel(s)/Test Number(s)* ✓ (See back for Panel comp.) # Reflex Testing/ID/Sensitivities performed at an additional charge.

A24

3714 Northgate Blvd., Sacramento, CA 95834 (916) 927-9900 • (800) 952-5691 • (916) 929-7600 automated
Medical Director and Pathologist - Gerald E. Simon, M.D.

SRPR110897-2/09

† MEDICARE MAY DENY DUE TO FREQUENCY PARAMETERS
MEDICARE REQUIRES SPECIFIC ICD-9 FOR ', ICD9 and/or SHADED TESTS

MR0184

Prescriber Authorization Required

Date/Time Sent: 05/04/2009 14:17:46

DANIEL
Rx #1
Sender:

Attn: Dr.

From: 1 CARE PHARMACY

RANCHO CORDOVA, CA 95670
Phone: 916
Fax: 916 106
Dr.

CADWAY
SACRAMENTO, CA 95817
Phone: 916-45[illegible]
Fax: 916-45[illegible]

** PLEASE RESPOND TO THE FOLLOWING MESSAGE REGARDING THE PRESCRIPTION BELOW **

WE HAVE RECEIVED A REQUEST FOR YOUR PATIENT BELOW TO FILL THE FOLLOWING PRESCRIPTION. PLEASE SIGN BELOW TO AUTHORIZE US RELEASING THIS MEDICATION SINCE IT WAS NOT SENT TO US BY YOUR AGENT AND THEY ARE UNABLE TO PROVIDE THE ORIGINAL HARD COPY OF THE PRESCRIPTION. WE ARE ALSO ASKING FOR ADDITIONAL REFILLS IF IT IS A MAINTENANCE MEDICATION.

NUMBER OF REFILLS REQUESTED: 6

NUMBER OF REFILLS AUTHORIZED: [10]

Patient: DANIEL
DOB: 02/09/1965
Medical Records #:

Facility: [illegible]7177)
8794 [illegible] WAY
SACRAMENTO [illegible] 95822
Phone: 916-4[illegible]

Medication: OMEPRAZOLE 20MG CAPSULE
Directions: TAKE 1 CAP ORALLY EVERY DAY

Date Requested: 05/04/2009
Last Filled: 04/18/2009
Quantity: 30
Days Supply: 30
Rx Number:

The items marked above have NO REFILLS AND WILL NOT BE DISPENSED NEXT WEEK.

X 10

MD Signature or Authorized Agent:

Unless otherwise indicated, your signature authorizes the number of refills requested.

PLEASE FAX BACK TO: 916- 3

FAXED May 11/2007

Prescriber Authorization Required

DANIEL
Rx:
Sender: E S

Date/Time Sent: 05/04/2009 14:17:45

Attn: Dr. E.
RANCHO CORDOVA CA 95670
Phone: 916-
Fax: 91 5
DEA#

From: S TERM CARE PHARMACY
SACRAMENTO, CA 95817
Phone: 916-
Fax: 916-

** PLEASE RESPOND TO THE FOLLOWING MESSAGE REGARDING THE PRESCRIPTION BELOW **

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NUMBER OF REFILLS REQUESTED: 6

NUMBER OF REFILLS AUTHORIZED: [ ]

Patient: DANIEL
DOB: 0
Medical Records #:

Facility: MON RF #1 (7177)
6794 Y
SACRAMENTO CA 95822
Phone: 916-424

Medication: OMEPRAZOLE 20MG CAPSULE
Directions: TAKE 1 CAP ORALLY EVERY DAY

The items marked above have NO REFILLS AND WILL NOT BE DISPENSED NEXT WEEK.

Date Requested: 05/04/2009
Last Filled: 04/18/2009
Quantity: 30
Days Supply: 30
Rx Number: 1

MD Signature or Authorized Agent: _____
Unless otherwise indicated, your signature authorizes the number of refills requested.

PLEASE FAX BACK TO: 916-

SHIELD HEALTHCARE
27911 FRANKLIN PKWY
VALENCIA, CA 91355
(800) 458-7718 FAX (661)294-6636

MEDICAL PRESCRIPTION

PATIENT: JR DANIEL CONTROL NO:
ADDRESS:
SACRAMENTO CA 95822 3955

AUTHORIZATION PERIOD: 04/21/09 TO 04/21/10
DOB: ACCT #:
PROG: FAIR
DIAGNOSIS: 344.61 NEUROGENIC BLDR:CAUDA EQUINA S
788.31 URINARY, URGE INCONTINENCE

MEDICAL SUPPLY ORDER

QUANTITY/MONTH		ITEM	DOSAGE/FREQUENCY OF USE
18	OZ	CREAM	UP TO 18 OZ PER MONTH
32	OZ	WASH	UP TO 32 OZ PER MONTH
120		BRIEF	UP TO 120 PER MONTH
120		PREVAIL UNDERPAD	UP TO 120 PER MONTH
1		WATERPROOF SHEETING	UP TO 1 PER MONTH

PHYSICIAN'S VERIFICATION

I HAVE REVIEWED MY PATIENT'S MEDICAL RECORDS AND THE ITEMS REQUESTED ABOVE. I VERIFY THAT THIS PATIENT'S MEDICAL CONDITION REQUIRES THE PRODUCTS DESCRIBED AND THE USAGE QUANTITIES ARE MEDICALLY NECESSARY FOR THE PATIENT. I WILL MAINTAIN A COPY OF THIS PRESCRIPTION IN THE PATIENT'S FILE TO MEET CARRIER DOCUMENTATION REQUIREMENTS.

PHYSICIAN'S SIGNATURE _____ DATE: APR 27 2009
VERBAL ORDER RECEIVED FROM: MEL AT PHYSICIAN'S OFFICE: 4/21/
BY: E

FAXED

DR. PHONE: 916
NPI #:
SACRAMENTO 3662 DR.MEDI-CAL PROV #:
440

Prescriber Authorization Required

DANIEL
Rx R1
Sender

Date/Time Sent: 03/20/2009 12:12:51

Attn: Dr. \ From: ERM CARE PHARMACY

SACRAMENTO, CA 95817
Phone: 916-[illegible]2
Fax: 916

DEA#:

** PLEASE RESPOND TO THE FOLLOWING MESSAGE REGARDING THE PRESCRIPTION BELOW **

WE HAVE RECEIVED A REQUEST FOR YOUR PATIENT BELOW TO FILL THE FOLLOWING PRESCRIPTION. PLEASE SIGN BELOW TO AUTHORIZE US RELEASING THIS MEDICATION SINCE IT WAS NOT SENT TO US BY YOUR AGENT AND THEY ARE UNABLE TO PROVIDE THE ORIGINAL HARD COPY OF THE PRESCRIPTION. WE ARE ALSO ASKING FOR ADDITIONAL REFILLS IF IT IS A MAINTENANCE MEDICATION.

NUMBER OF REFILLS REQUESTED: 12

NUMBER OF REFILLS AUTHORIZED: [ ]

Patient: DANIEL
DOB:
Medical Records #:

Facility
SACRAMENTO, CA
Phone

Medication: OMEPRAZOLE 20MG CAPSULE
Directions: TAKE 1 CAP ORALLY EVERY DAY

Date Requested: 03/20/2009
Last Filled: 03/04/2009
Quantity: 30
Days Supply: 30
Rx Number.

The items marked above have NO REFILLS AND WILL NOT BE DISPENSED NEXT WEEK.

x 1 refill allowed.

4-13-9

MD Signature or Authorized Agent: _____

Unless otherwise indicated, your signature authorizes the number of refills requested.

PLEASE FAX BACK TO: 916

RE FAXED 04/11/09

DEA [redacted] CA Lic # [redacted]

[redacted]
[redacted] SUITE D
CORDOVA, CA 95670
(916) 368 [redacted] Fax: (916) 638

Name Daniel Age

Address [redacted] 10

SECURITY FEATURES ON BACK Date 12-17-08

℞

Incontinence Supply x 1

(Dx: mixed type incontinence)

NRX050225547688

☐ Label

Refil____times PRN NR

Do Not Substitute ☐

M.D.

To ensure brand name dispensing check and initial box.

Prescriber Authorization Required

C

DANIEL
Rx: R164
Sender: HI

Date/Time Sent: 03/09/2009 10:09:52

Attn: Dr.
7275
SACRAMENTO, CA 95823
Phone: 916-4
Fax: 9
DEA#:

From: ERM CARE PHARMACY
SACRAMENTO, CA 3817
Phone: 916-
Fax: 916-

** PLEASE RESPOND TO THE FOLLOWING MESSAGE REGARDING THE PRESCRIPTION BELOW **

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NUMBER OF REFILLS REQUESTED: 6
NUMBER OF REFILLS AUTHORIZED: [6]

Patient: DANIE I)
DOB: C
Medical Records #:

Facility: 77)
SACRAMENTO, CA
Phone: 916-

Medication: ALLOPURINOL 300MG TAB
Directions: TAKE 1 TAB ORALLY EVERY DAY

Date Requested: 03/09/2009
Last Filled: 02/12/2009
Quantity: 28 30
Days Supply: 28 30
Rx Number:

MD Signature or Authorized Agent: _____

Unless otherwise indicated, your signature authorizes the number of refills requested.

PLEASE FAX BACK TO: 916-

FAXED 3/16/09

Prescriber Authorization Required

C

DANIEL
Rx
Sender: K

Date/Time Sent: 03/09/2009 10:10:26

Attn: Dr.
7275 4
SACRAMENTO CA 95823
Phone: 916-4
Fax: 91
DEA#

From: PHARMACY
SACRAMENTO
Phone: 916-4
Fax: 916

** PLEASE RESPOND TO THE FOLLOWING MESSAGE REGARDING THE PRESCRIPTION BELOW **

WE HAVE RECEIVED A REQUEST FOR YOUR PATIENT BELOW TO FILL THE FOLLOWING PRESCRIPTION. PLEASE SIGN BELOW TO AUTHORIZE US RELEASING THIS MEDICATION SINCE IT WAS NOT SENT TO US BY YOUR AGENT AND THEY ARE UNABLE TO PROVIDE THE ORIGINAL HARD COPY OF THE PRESCRIPTION. WE ARE ALSO ASKING FOR ADDITIONAL REFILLS IF IT IS A MAINTENANCE MEDICATION.

NUMBER OF REFILLS REQUESTED: 6
NUMBER OF REFILLS AUTHORIZED: [6]

Patient: DANIEL)
DOB:
Medical Records #:

Facility (#1 (7177)
Phone: 916-424

Medication: HYDROCHLOROTHIAZIDE 25MG TAB
Directions: TAKE 1 TAB ORALLY EVERY DAY

Date Requested: 03/09/2009
Last Filled: 02/12/2009
Quantity: 28 30
Days Supply: 28
Rx Number:

MD Signature or Authorized Agent: _____
Unless otherwise indicated, your signature authorizes the number of refills requested.

PLEASE FAX BACK TO: 916-452

FAXED 3/16 TKG

Prescriber Authorization Required

C

DANIE
Rx: F
Sender:

Date/Time Sent: 03/09/2009 10:10:08

Attn: Dr.
7275 4
SACRAMENTO, CA 95820
Phone: 916-
Fax: 916-
DEA#:

From: M
SACRAME
Phone: 916
Fax: 916

** PLEASE RESPOND TO THE FOLLOWING MESSAGE REGARDING THE PRESCRIPTION BELOW **

WE HAVE RECEIVED A REQUEST FOR YOUR PATIENT BELOW TO FILL THE FOLLOWING PRESCRIPTION. PLEASE SIGN BELOW TO AUTHORIZE US RELEASING THIS MEDICATION SINCE IT WAS NOT SENT TO US BY YOUR AGENT AND THEY ARE UNABLE TO PROVIDE THE ORIGINAL HARD COPY OF THE PRESCRIPTION. WE ARE ALSO ASKING FOR ADDITIONAL REFILLS IF IT IS A MAINTENANCE MEDICATION.

NUMBER OF REFILLS REQUESTED: 6

NUMBER OF REFILLS AUTHORIZED: [6]

Patient: DANIEL (1)
DOB: (
Medical Records #

Facility:)
6794
SACRAMENTO, CA 95822
Phone: 916-424

Medication: ASPIRIN EC 81MG TAB
Directions: TAKE 1 TAB ORALLY EVERY DAY

Date Requested: 03/09/2009
Last Filled: 02/12/2009
Quantity: 28 30
Days Supply: 28 30
Rx Number:

MD Signature or Authorized Agent: _____

Unless otherwise indicated, your signature authorizes the number of refills requested.

PLEASE FAX BACK TO: 916

#1 STOCK NUMBER

FAXED 3/16/09

Confidentiality Notice- Health information is personal and sensitive information related to a person's health care. You, the recipient are required to maintain this information in safe, secure, and confidential manner. Redisclosure without appropriate authorization is prohibited unless otherwise permitted or required by law. If you have received this transmission in error, please notify us by telephone immediately so that we can arrange for its return to us. Thank you for your cooperation.

02/25/2009 03:42

Prescriber Authorization Required

C

DANIEL
Rx. R161
Sende

Date/Time Sent: 02/09/2009 3:19:35

Attn: Dr
7275 [illegible]204
SACRAMENTO CA 95823
Phone: 916
Fax: 916
DEA#:

From: [illegible]RE PHARMACY
SACRAMENTO
Phone: 916
Fax: 916-

Pt out

** PLEASE RESPOND TO THE FOLLOWING MESSAGE REGARDING THE PRESCRIPTION BELOW **

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NUMBER OF REFILLS REQUESTED: 6
NUMBER OF REFILLS AUTHORIZED: [2]

Urgent

Patient: DANIEL [illegible]
DOB:
Medical Records #:

Facility: [illegible]CARE #1 (7177)
SACRAMENTO, C
Phone: 916-424

Medication: OMEPRAZOLE 20MG CAPSULE
Directions: TAKE 1 CAP ORALLY EVERY DAY

Date Requested: 02/09/2009
Last Filled: 01/15/2009
Quantity: ~~28~~ 30
Days Supply: ~~28~~ 30
Rx Number: [illegible]

MD Signature or Authorized Agent: _____
Unless otherwise indicated, your signature authorizes the number of refills requested.

PLEASE FAX BACK TO: 916

3.2.09

02/25/2009 03:42

Prescriber Authorization Required

C

DANIEL
Rx: R16
Sender: HEATHER

Date/Time Sent: 02/09/2009 9:19:48

Attn: Dr.
7275 E204
SACRAMENTO CA 95823
Phone: 916-4
Fax 916-4
DEA#: B

From: PHARMACY
SACRAMENTO,
Phone: 916
Fax: 916-

Pt Out

** PLEASE RESPOND TO THE FOLLOWING MESSAGE REGARDING THE PRESCRIPTION BELOW **

WE HAVE RECEIVED A REQUEST FOR YOUR PATIENT BELOW TO FILL THE FOLLOWING PRESCRIPTION. PLEASE SIGN BELOW TO AUTHORIZE US RELEASING THIS MEDICATION SINCE IT WAS NOT SENT TO US BY YOUR AGENT AND THEY ARE UNABLE TO PROVIDE THE ORIGINAL HARD COPY OF THE PRESCRIPTION. WE ARE ALSO ASKING FOR ADDITIONAL REFILLS IF IT IS A MAINTENANCE MEDICATION.

NUMBER OF REFILLS REQUESTED: 6
NUMBER OF REFILLS AUTHORIZED: 12

Urgent

Patient: DANIEL (1)
DOB:
Medical Records #:

Facility
SACRAMENTO
Phone: 916-42

Medication: PHENYTOIN ER 100MG CAP
Directions: TAKE 1 CAP ORALLY AT BEDTIME

Date Requested: 02/09/2009
Last Filled: 01/15/2009
Quantity: ~~28~~ 30
Days Supply: ~~28~~ 30
Rx Number:

MD Signature or Authorized Agent: _____
Unless otherwise indicated, your signature authorizes the number of refills requested.

PLEASE FAX BACK TO: 916-

FAXED 3.2.09

6569343

Attn.

- [ ] KUNCHO D. LIC. #
- [x] RC M.D. LIC. #
- [ ] MARILYN FNP LIC. #
- [ ] JO LIC. #

Health Center

Name Daniel Age

Address Date 5/22/08

℞

(1) ~~Pottey~~ Pull up diapers # ~~60~~ 60 change b.i.d.

(2) Disposable Bed pads # 60 up to 2/day

Bowel Bladder incontinence

Refill PRN Times

DO NOT SUBSTITUTE ☐

R.

DEL ICS, INC.

PATIENT INFO

[illegible] CARE MEDICAL [illegible] CENTER

PATIENT INFORMATION

NAME: [illegible] DANIEL [illegible]
LAST FIRST MIDDLE

DO YOU HAVE ANY ALLERGIES? Y (N) IF YES, TO WHAT? _____

PARENT'S NAME (IF A MINOR PATIENT) _____

ADDRESS [illegible] VV I SACTO. CA [illegible]
NUMBER STREET CITY STATE ZIP

HOME ☎ (916) 424 [illegible] WORK ☎ ( ) N/A

DATE OF BIRTH [illegible]
Month Day Year

AGE 44 SEX (M) F

SOCIAL SECURITY NUMBER 548 [illegible]

MARITAL STATUS: Married/Divorced / Widowed

EMERGENCY CONTACT Rebecca – (Res. Care Provider) ☎ (916) [illegible]

FRIEND OR RELATIVE NOT LIVING WITH YOU Virginia (mother) ☎ (530) 742-

EMPLOYER: N/A OCCUPATION: _____

PRIMARY LANGUAGE: ENGLISH

INSURANCE COMPANY MEDICARE/CAL NAME OF INSURED _____

GROUP NUMBER _____ ID NUMBER [illegible]

ASSIGNMENT AND RELEASE: I hereby authorize that my insurance benefits be paid directly to my physician. I assume full responsibility for any and all non-covered services. I also authorize the physician or designated representative to release any information required to process this claim. I also consent to treatment and agree to hold the VALLEY CARE MEDICAL CENTER free from any claims, demands or suits for damages arising from any injury/complications, save for negligence, that may result from the treatment.

_____ Signature of patient or authorized guardian
_____ Relationship to patient
_____ Date

WHO REFERRED YOU TO THIS OFFICE? Rebecca [illegible]

PREVIOUS PHYSICIAN: _____

ADVANCE DIRECTIVE
Living Will _____
Health Care Proxy _____
Durable Power of Attorney
For health care _____
Refused _____
Other _____

I GIVE PERMISSION TO THE VT CARE MEDICAL CENTER TO
LEAVE MESSAGES WITH _____
OR ON MY ANSWERING [illegible] MACHINE YES/ NO

[illegible] 7-14-08
PATIENT'S SIGNATURE DATE

MEDICAL CENTER, INC.
7248 [illegible] 3
Sacramento, C
Tel.: (916) 3[illegible] Fax. (916)

PAIN MANAGEMENT CONTRACT

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this agreement, is essential to the trust and confidence necessary in a doctor-patient relationship and that my doctor undertakes to treat me based on this agreement.

In understand that if I break this agreement, my doctor will stop prescribing these pain-Control medicines.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of pain, the effect of pain on my daily life, and how well the medicine is helping to relieve pain.

I will not use any illegal controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescription for pain medicine will be only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use [illegible] PHARMACY [illegible] Pharmacy located at [illegible] Tel #: 916- [illegible] for filling prescriptions for all of my pain medicine. (ATTN) [illegible]

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this State's Board of Pharmacy in the investigation of any possible misuse, sale, or other diversion of my pain medicine I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to wave any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into this 14 day of July, 20 08.

Patient's Printed Name: DANIEL JR Signature: [signature]

HIPAA Notice of Privacy Practices

CARE MEDICAL CENTER

7275 ramento, CA 95823	ıva. CA 95670	Sacramento, CA 95815
Telephone Number: (916)	Telephone Number: (916)	Telephone Number: (916

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. " Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present or future physical, mental health or condition and related health services.

Uses and Disclosure of Protected Health Information. Your Protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination and management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information may be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan, to obtain approval for the hospital admission.

Health care Operation: We may use or disclose as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations **without your authorization**. These situations include (Public Health Issues as Required By Law): Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosure. Under the law, we must make the disclosure and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights. Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information may not be disclosed to family members nor friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interests to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Health care Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Office Manager of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 14, 2003.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Office Manager in person or call (916) 428-3788

Signature below is only an acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: Signature: Date:

HIPAA Notice of Privacy Practices

CENTER

03

Sacramento CA 95831

916-

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Signature below is only an acknowledgment that you have received this Notice of our Privacy Practices:

Print Name [redacted] Signature [redacted] Date [redacted]

MEDICAL CENTER -

PATIENT REGISTRATION FORM

Patient Name: Daniel M. DOB: 0

Patient Address: Wdy Soc. Ca.
Address *City* *ST* *Zip*

Home Phone (916) 424 - Other Phone:

Social Security: 572 - Work Phone:

Primary Language Spoken: Eng Referral Source:

Emergency Contact Information: R (Tony) Phone: (916)

Friend or Relative not living with you: Phone:

Marital Status: (S) M D W Other: Patient's Sex: (M) F Student: FT PT N/A

Work Status: Full Time Part Time Unemployed Retired: / /
Date

Employer:

Employer Address:

Guarantor Name: DOB: / /

Guarantor Address:
Address *City* *ST* *Zip*

Home Phone: Work:

Employer: SS#:

Employer Address:

Authorization

I hereby authorize " dical Center" and its authorized personnel to release any medical or other information to my insurance carrier, in order to process any and all claims. I also authorize payment of medical benefits to the physician or supplier for services rendered. I understand that I am responsible for any deductibles, co-payments, or co-insurance amounts not paid by my insurance carrier and for all non-covered services. I understand that " edical Center" does not participate with the California State Medi-Cal Program.

Daniel 11-19-08
Patient Signature Date

I GIVE PERMISSION TO WCMC, INC. TO LEAVE MESSAGES WITH ______
OR ON MY ANSWERING MACHINE - YES NO

______
Patient Signature Date

ADVANCE DIRECTIVE:
___ Living Will
___ Health Care Proxy
___ Durable Power of Attorney for Health Care

Refused on: ______
Date

Patient's Initial's: ______

ATTACHMENT #3

CERTIFICATION OF VITAL RECORD

SACRAMENTO COUNTY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF DEATH

STATE OF CALIFORNIA

STATE FILE NUMBER: 320(

LOCAL REGISTRATION NUMBER:

DECEDENT'S PERSONAL DATA

1. NAME OF DECEDENT — FIRST (Given)	2. MIDDLE	3. LAST (Family)
DANIEL		

3a. AKA/ALIAS (FIRST, MIDDLE, LAST)	4. DATE OF BIRTH (mm/dd/yyyy)	5. AGE Yrs.	Days	Hours	Minutes	6. SEX
DANIEL JR	5	44				M

7. BIRTHPLACE (STATE/FOREIGN COUNTRY)	8. IF UNDER 1 YEAR OR UNDER 1 DAY — AGE — UNDER	9. EVER IN U.S. ARMED FORCES?	10. MARITAL STATUS AT THE TIME OF DEATH	11. DATE OF DEATH (mm/dd/yyyy)	12. HOUR OF DEATH (24 hour)
CA	572	YES [ ] X NO [ ] UNK	NEVER MARRIED	06/06/2009	1011

13. EDUCATION — Mark the box for highest degree or level of school completed at time of death	14. WAS DECEDENT OF HISPANIC, LATINO, OR SPANISH ORIGIN? (If yes, see worksheet on back)	15. DECEDENT'S RACE — If more than one race is indicated, see worksheet on back
SOME COLLEGE	YES [ ] X NO	CAUCASIAN

16. USUAL OCCUPATION — Type of work done during most of working life. DO NOT USE RETIRED	17. KIND OF BUSINESS OR INDUSTRY	18. YEARS IN OCCUPATION
NEVER WORKED	DISABLED	

USUAL RESIDENCE

19. DECEDENT'S USUAL RESIDENCE (Street and Number)	20. INSIDE CITY LIMITS?	21. CITY	22. COUNTY	23. ZIP CODE	24. YEARS IN COUNTY	25. STATE/FOREIGN COUNTRY
6794 [illegible] WAY		SACRAMENTO	SACRAMENTO	95822	10	CA

INFORMANT

26. INFORMANT'S NAME — Relationship	27. MAILING ADDRESS (Street and Number or Rural Route, City or Town, State, ZIP)
VIRGINIA FF L, MOTHER	40 AVE, OL ST, CA

SPOUSE AND PARENT INFORMATION

28. NAME OF SURVIVING SPOUSE — FIRST	28a. MIDDLE	28b. LAST (Married Name)

29. NAME OF FATHER — FIRST	29a. MIDDLE	29b. LAST	29c. BIRTH STATE
DANIEL		FI SR	CA

30. NAME OF MOTHER — FIRST	30a. MIDDLE	30b. LAST (Maiden)	30c. BIRTH STATE
VIRGINIA		ME	CA

FUNERAL DIRECTOR/LOCAL REGISTRAR

31. DISPOSITION DATE (mm/dd/yyyy)	32. PLACE OF DISPOSITION	
0	4900 (	SIE [illegible] RIAL PARK OLI [illegible] 161

33. TYPE OF DISPOSITION(S)	34. SIGNATURE OF EMBALMER	34a. LICENSE NUMBER
CR/BU	NOT EMBALMED	

35. NAME OF FUNERAL ESTABLISHMENT	36. LICENSE NUMBER	37. SIGNATURE OF LOCAL REGISTRAR	37a. DATE (mm/dd/yyyy)
EW MORTUARY	FD1365	GLE [illegible]	06/10/2009

PLACE OF DEATH

38. PLACE OF DEATH	38a. IF HOSPITAL, SPECIFY ONE	38b. IF OTHER THAN HOSPITAL, SPECIFY ONE
RESIDENCE - OWN	IP [ ] ER [ ] DOA [ ]	Hospice [ ] Nursing Home/LTC [ ] X Residence [ ] Other [ ]

39. COUNTY	39a. FACILITY	39b. IF NOT AT FACILITY, WHERE FOUND (Street and number or location)	39c. CITY
SACRAMENTO	6794	F WAY	SACRAMENTO

CAUSE OF DEATH

40. CAUSE OF DEATH — Enter the chain of events — diseases, injuries, or complications — that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

		Time Interval between Onset and Death	40b. DEATH REPORTED TO MEDICAL EXAMINER?
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	(a) RIGHT HEMOTHORAX	(a) DAYS	X YES [ ] NO
Sequentially list conditions, if any, leading to cause on line a. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	(b) BLUNT FORCE THORACIC INJURIES	(b) DAYS	[ ] YES X NO
	(c)	(c)	40c. AUTOPSY PERFORMED? X YES [ ] NO
	(d)	(d)	40d. USED IN DETERMINING CAUSE? X YES [ ] NO

41. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 40:
DEVELOPMENTALLY DISABLED; ANEMIA; HTN

42. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 40? (If yes, list type of operation and date): NO

43. IF FEMALE, WAS DECEDENT PREGNANT WITHIN THE PAST YEAR? [ ] YES [ ] NO [ ] UNK

PHYSICIAN'S CERTIFICATION

44. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.

Decedent Attended Since	Decedent Last Seen Alive	45. SIGNATURE AND TITLE OF CERTIFIER	45a. LICENSE NUMBER	45b. DATE (mm/dd/yyyy)
(a) mm/dd/yyyy	(b) mm/dd/yyyy			

46. TYPE/ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE

CORONER'S USE ONLY

47. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.

MANNER OF DEATH: [ ] Natural X Accident [ ] Homicide [ ] Suicide [ ] Pending Investigation [ ] Could not be determined

48. INJURED AT WORK?	49. INJURY DATE (mm/dd/yyyy)	50. HOUR (24 hour)
[ ] YES X NO [ ] UNK	05/31/2009	0400

51. PLACE OF INJURY (e.g., home, construction site, restaurant, wooded area, etc.)
RESIDENCE - OWN

52. DESCRIBE HOW INJURY OCCURRED (Describe activity of decedent at time of injury)
THE DECEDENT SUFFERED AN UNWITNESSED FALL AT HOME

53. LOCATION OF INJURY (Street and Number, or location, and City, and ZIP)
6794 WAY, SACRAMENTO, CA 95822

54. SIGNATURE OF CORONER	55. DATE (mm/dd/yyyy)	56. TYPE/NAME AND TITLE OF DEPUTY CORONER
EDWARD	06/08/2009	EDWARD DEPUTY CORONER

STATE (REGISTRAR)	A	B	C	D	E	FAX AUTH.#	CENSUS TRACT
						01000100123852	

CERTIFIED COPY OF VITAL RECORDS

STATE OF CALIFORNIA
COUNTY OF SACRAMENTO } SS

00101

This is a true and exact reproduction of the document officially registered and placed on file with SACRAMENTO COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES.

DATE ISSUED June 18, 2009

LOCAL REGISTRAR

This copy not valid unless prepared on engraved border displaying date and signature of Registrar

SACRAMENTO COUNTY
CORONER
FINAL REPORT OF INVESTIGATION

Gregory P. Wyatt
CORONER

CLASSIFICATION	1Final Classification: ACCIDENT	2 Case No.: 09-	3 Deputy Assigned: JENNIFER	4a Date of Death: 06/06/2009	4b Found?: No	
DECEDENT PERSONAL DATA	5 Name First: DANIEL	6 Name Middle:	7 Name Last: F	8a Time of Death: 10:11	8b Fnd/Est/Unk: DECLARED	
	9 Sex: MALE	10 Race: CAUCASIAN	11 Date of Birth:	12 Age: 44 YEARS	13 Marital Status: NEVER MARRIED	
RESIDENCE	14 Usual Address: Y					
	15 City: SACRAMENTO	16 County: SACRAMENTO	16a State: CA	17 Zip Code:		
IDENTIFICATION	18 Remains identified by or how identified: J IDENTIFICATION CARD					
RELATIVES	19 Name: DANIEL & VIRGINIA	20 Relation: (PARENTS)				
PLACE OF DEATH	21 Place of Death: RESIDENCE - OWN					
	22 Street Address: --					
	23 City: SACRAMENTO	24 County: SACRAMENTO	25 Zip:			
REMAINS	26 Death Reported By: CAPT. (SACRAMENTO CITY FIRE)	27 Removed To Coroner: Yes	28 Type of Medical Examination: FULL AUTOPSY			
CAUSE OF DEATH	29 Cause: RIGHT HEMOTHORAX					
	due to: BLUNT FORCE THORACIC INJURIES					
	due to:					
	due to:					
OTHER SIGNIFICANT CONDITIONS	30 DEVELOPMENTALLY DISABLED, ANEMIA, HTN					
INJURY INFORMATION	31 Manner of Death: ACCIDENT	32 Place of Injury: RESIDENCE - OWN	33 At Work?: No	34a Date of Injury: 05/31/2009	34b Fnd/Est/Unk:	
	35 Address or Location: NAY			36a Time of Injury: 04:00	36b Fnd/Est/Unk:	
	37 City: SACRAMENTO	38 County: SACRAMENTO			39 Zip Code: 95822	
	40 Describe how injury occurred: THE DECEDENT SUFFERED AN UNWITNESSED FALL AT HOME.					
CASE SUMMARY	*As required by Government Code, Section 27491, an inquiry was made into the death of the subject of this report. It was determined by an investigation that an autopsy would be necessary to establish the cause of death. An autopsy was performed and revealed the above cause of death. Based on the known circumstances and cause of death, the manner of death is accident.*					

Deputy Jennifer JENNIFER Date 01/15/2010

County Of Sacramento

Department of Coroner
4800 Broadway, Suite 100
Sacramento, CA 95820-1530

Gregory P. Wyatt
Coroner

☒ Autopsy ☐ External Examination

NAME: DANIEL **CASE NO.** 09-

POSTMORTEM DATE: 06/07/09 **TIME:** 09:15

INVESTIGATOR: J.

DATE OF DEATH: 06/06/09 **TIME:** 10:11

AGE: 44 **SEX:** Male **Ht:** 67" **Wt:** 235 lbs.

RACE/ ETHNICITY: White

AUTOPSY FINDINGS:

1. Fractures of multiple right ribs.
2. Large right subpleural hematoma (500 cc).
3. Right hemothorax (2500 ml).
4. Secondary atelectasis of right lung.
5. Contusion of left parietal scalp.
6. Deep contusion of right chest wall.
7. Large healing contusions of right hip and flank.
8. Recent contusion of left hip.
9. Contusions of extremities, healing and recent.
10. Splenomegaly (510 grams), congestive.
11. Chronic hepatitis with early fibrosis.
12. Glomerulonephrosclerosis, with acute tubular necrosis (shock kidney).
13. Multinodular goiter with right upper pole papillary carcinoma (3 cm mass), incidental.
14. Degenerative arthritis of spine, severe.
15. Pitting dependent edema of lower legs, with chronic venous stasis skin changes.
16. Obesity (BMI = 36.8).

CAUSE OF DEATH: Right hemothorax.
DUE TO: Blunt force thoracic injuries.

OTHER SIGNIFICANT CONDITIONS: Developmentally disabled, anemia, hypertension.

Mark A. M.D.
Chief Forensic Pathologist 1-2-10

.../sjr
D: 06/07/09
T: 06/08/09

AUTOPSY ASSISTANTS:
J. Rus

WITNESSES:
None.

IDENTIFICATION:
The body is identified by a Coroner's ID tag attached to the left great toe, labeled with the subject's name and case number.

EVIDENCE OF MEDICAL INTERVENTION:
EKG pads are distributed about the anterior torso.

EXTERNAL EXAMINATION

The unclothed, unembalmed body is that of a normally developed, obese white male who appears consistent with the reported age of 44 years. The body measures 67 inches long and weighs 235 pounds, as received. Rigor mortis is fully developed in the cold body, able to be overcome with moderate effort in the jaw and arms. Lividity is posterior, except over pressure points. The entire head is intensely congested, extending onto the tops of the shoulders.

The scalp hair is brown with a few admixed strands of gray, wavy and averages approximately 8cm long. The hair is unkempt. Facial hair consists of a light growth of brown and gray whiskers. The irides are brown and the corneas are filmy. The sclerae and conjunctivae are congested. No scleral hemorrhages or conjunctival petechiae. Both pupils are widely dilated. No periorbital cutaneous petechiae. The ears, nose and mouth are free of foreign material or abnormal secretion. The nasal skeleton and facial bones are palpably intact. The lips are uninjured. The teeth are natural and in fair condition, with periodontal disease and remotely missing upper canines. There is a prominent overbite.

The neck is stable and symmetric.

The chest is stable and symmetric. No palpable subcutaneous emphysema. The abdomen is protuberant and soft. There is a palpable and reducible small umbilical hernia. Dried brown feces is smeared about the lower mid-abdomen. On the right upper abdomen is an ovoid 3 cm yellow-green healing ecchympsis. There is a shallow abdominal panniculus covered by skin that is clean, dry and not discolored. Over the left iliac crest is a faint 5 cm red-purple contusion. The external genitalia are those of an uncircumcised adult male with bilaterally descended testes. However, the penis appears small.

The extremities are symmetric, without angularity or deformity. The fingernails are uninjured, extending to the fingertips. No clubbing of the digits. Over the dorsal PIP joint of the right little finger is a 0.5 cm crusted abrasion. On the back of the right hand are three ovoid contusions. One is a 4 cm red-blue deep contusion and two are more superficial ovoid red-purple contusions, averaging 1 cm in greatest dimension. On the ulnar right wrist is 4 x 2.5 cm red-purple contusion. On the ulnar right forearm is a 14 cm long thin faint longitudinal remote scar. On the medial right upper arm is a faint 1 cm red-blue contusion. On the lateral right upper arm is a horizontal 3 cm long, remote scar. On the back of the left hand is a faint 1 cm red-brown contusion. Over the left biceps is a faint 1 cm red-purple contusion. There is a faint postmortem pressure mark on the top of the left shoulder. There is pitting edema of the lower extremities to the level of the knees. Dried smeared brown feces stains both anterior thighs. Pale brown discoloration associated with thickening of the skin and loss of hair involves both lower legs and feet, consistent with chronic venous stasis changes. Over the right hip is a large, irregularly shaped, 17 x 11 cm, mottled red-

purple and yellow-green healing ecchymosis with slight swelling. The right second toe is ecchymotic and focally abraded. On the anterior and lateral left lower leg are several faint red-blue contusions that average 1.5 cm. A large amount of soft dried brown feces stains the posterior thighs, left greater than right.

The posterior torso and anus are unremarkable, except for a large amount of soft brown feces on the perianal skin. Also, on the lower right flank at the waistline is a 6 x 2.5 cm faint yellow-green and red-purple healing contusion.

INTERNAL EXAMINATION

HEAD:

The scalp is reflected after making the usual intermastoid incision, and reveals a 7.5 x 5.5 cm subcutaneous and subgaleal contusion over the left parietal skull. The calvarium is intact. No epidural or subdural hemorrhage. The brain weighs 1330 grams and is of the usual configuration covered by congested, but glistening and transparent leptomeninges with clear cerebrospinal fluid. The vessels at the base of the brain pursue their usual anatomic courses and are patent throughout, without significant atherosclerosis, thrombosis or aneurysms. No evidence of coning or herniation. There is symmetry of the cerebral and cerebellar hemispheres noted on serial coronal sectioning in the fresh state. Recent or remote traumatic lesions or other abnormalities are not seen. The ventricular system is symmetric and free of blood. No lesions are seen in the mid-brain, brain stem or cerebellum. The bones at the base of the skull are without evidence of fracture. The atlanto-occipital membrane is intact.

NECK:

The hyoid bone and laryngeal cartilages are intact with immobile joints. The larynx and trachea are unobstructed and lined by pink-tan mucosa. No laryngeal mucosal edema. No anterior cervical soft tissue hemorrhage. The cervical spine is intact. No anterior prevertebral fascia hemorrhage. The back of the neck is dissected revealing no superficial or deep paracervical soft tissue hemorrhage.

BODY CAVITIES:

The body cavities are entered in the usual manner. Testing for free air in the pleural cavities is negative. However, the right lung is severely compressed by a large accumulation of liquid blood in the right chest cavity that measures 2500 ml. There is also a large right subpleural hematoma, 22 cm in greatest dimension, 5.5 cm thick, consisting of red-brown clot that involves the posterolateral right chest wall and compresses the right lung. The other cavities are free of excess or abnormal fluid accumulations. All cavities are free of adhesions, except for localized right upper lobe pleural adhesions. The organs are in their usual anatomic locations. The right lung is collapsed, while the left lung is expanded. Serosal surfaces are generally smooth, glistening and wet.

CARDIOVASCULAR SYSTEM:

The heart weighs 380 grams and is of the usual configuration covered by a smooth glistening epicardium. No epicardial petechiae. Serial sections show firm red-brown fibrillar myocardium without recent or remote infarcts. The heart walls are not thickened. The endocardium is thin and translucent. The heart valves are normally formed, pliable and intact. No vegetations. The coronary ostia are in their usual locations and are patent. The coronary circulation is left dominant. The coronary arteries exhibit minimal atherosclerosis and patent throughout, without thrombosis. The aorta is intact and exhibits mild fatty streak formation. No complicated plaques or aneurysms. The vena cava and pulmonary arteries are free of antemortem thrombus. The heart and great vessels contain thin fluid blood.

RESPIRATORY SYSTEM:
The lung weights are: right - 280 grams, left - 430 grams. The pleural surfaces are smooth and glistening and the lungs exhibit the usual lobation with mild anthracotic pigmentation. The right lung is severely atelectatic, with sections showing red-brown cut surfaces that ooze a moderate amount of watery serosanguineous fluid. The left lung is relatively more expanded and congested, and oozes a moderate-marked amount of frothy serosanguineous fluid. Both lungs are free of focal intrapulmonary lesions. Specifically, there are no right pleural contusions or lacerations. No areas of gross pneumonic consolidation in either lung. The tracheobronchial tree is unobstructed and without mass lesions.

LIVER AND PANCREAS:
The liver weighs 1600 grams and is covered by a smooth intact capsular surface with sharp anterior margins. Sections show slightly softened cut surfaces that exhibit a prominent "nutmeg" pattern of centrilobular congestion that is somewhat mottled in intensity. No focal intraparenchymal lesions. I can easily pass my thumb through 2 cm thick sections. The gallbladder contains approximately 20 ml of thin green bile and the gallbladder mucosa is unremarkable. The bile passages appear patent. No stones. No portal lymphadenopathy. The pancreas is free of fat necrosis, fibrosis or hemorrhages.

GASTROINTESTINAL SYSTEM:
The tongue is without evident injury. The pharynx is unobstructed. The esophagus is intact and lined by unremarkable gray-tan mucosa. The stomach is empty. The gastric mucosa is intact and pale pink-tan. No gastric ulcers or masses. The duodenum and remainder of the small and large bowels are without evident mucosal abnormality. The colon contains abundant, soft and mushy, green-brown feces and is free of blood. The appendix is present.

SPLEEN AND LYMPH NODES:
The spleen weighs 510 grams and is covered by an intact blue-gray capsule. Sections show softened red-brown parenchyma with prominent white pulp. No enlargement of mediastinal, lung hilar, mesenteric or para-aortic lymph nodes.

ENDOCRINE SYSTEM:
The thyroid gland is diffusely enlarged and weighs 55 grams. No surrounding adhesions. Incising the right lobe reveals a discrete, pale pink-tan, firm mass, 3 cm in greatest dimension. However, there are other nodules of various sizes in both lobes, including a 3.8 cm mass in the left lower pole that measures 3.8 cm in greatest dimension and has slightly softened red-brown cut surfaces with focal cystic change. Many of the other nodules have cystic change. No discrete fibrosis. The adrenal glands are free of cortical masses or medullary hemorrhages. The pituitary gland is unremarkable.

UROGENITAL SYSTEM:
The kidneys are of similar size and shape. The kidney weights are: Right – 190 grams. Left – 180 grams. The capsules strip with ease to reveal finely granular cortical surfaces, with mottled congestion alternating with areas of pallor. Both kidneys are somewhat softened. Sections show uniform cortical thickness with slight patchy blurring of the cortico-medullary junctions. The calices, pelves and ureters are unremarkable. The bladder is empty. The bladder mucosa is unremarkable. The prostate gland measures 4.7 cm in greatest dimension and is somewhat boggy, but free of discrete masses.

MUSCULOSKELETAL SYSTEM:
There is a large deep soft tissue contusion over the right anterolateral chest wall without accumulated blood. The right scapula is intact. However, there are multiple fractures of right-sided ribs, including the right 4th through 7th costal cartilages, anteriorly; the 3rd through 5th ribs,

anterolaterally; and the 3rd through 8th ribs, posteriorly. The pleura over the right chest is thickened and dark red-purple. There is a large right subpleural hematoma, as described above. Removal of the hematoma reveals slight displacement of the lower right posterior rib fractures, only one of which grossly perforates the pleura. No left rib fractures or sternal fractures. No visible or palpable fractures of the vertebral column, pelvis or long bones of the extremities. The vertebral column exhibits kyphosis and severe osteophytic lipping of the thoracolumbar spine, with chronic compression fractures of mid-thoracic vertebrae. The abdominal fat averages 5 cm in thickness.

TOXICOLOGY:
Samples of central and peripheral blood and vitreous humor are retained.

HISTOLOGY:
Sections of the right upper pole thyroid mass, left lower pole thyroid mass, liver and kidney are submitted.

PHOTOGRAPHS:
Digital photographs are obtained of some internal findings.

X-RAYS:
None.

EVIDENCE:
None.

MICROSCOPIC DESCRIPTION:
Right thyroid mass: Papillary carcinoma.
Left thyroid mass: Benign adenomatous nodule.
Liver: Centrilobular pattern of sinusoidal congestion without significant hepatocellular necrosis. Mild autolysis. Mild-moderate chronic portal inflammation. Portal fibrosis appears mildly increased.
Kidney: Autolysis. Evidence of ATN. Glomerulonephrosclerosis, mild.

I .3/slr
D: 06/07/09
T: 06/08/09
End: 11:00

ATTACHMENT #4

TRANSCRIPT OF INTERVIEW

HARROLD WILSON, M.D.

Medical Board of California
Sacramento District Office

September 14, 2010

APPEARANCES:

ANNE STEFANI, INVESTIGATOR
DR. BARNETT, DISTRICT MEDICAL CONWILSONLTANT
HARROLD WILSON, M.D.
MR. SULLIVAN, ATTORNEY AT LAW

Case Number: 02-2013-654321

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SACRAMENTO, CALIFORNIA, SEPTEMBER 14, 2010

MS. STEFANI: Today's date is September 14, 2010. It's approximately 9:15 in the morning. My name is Anne Stefani and I'm an investigator for the Medical Board of California. This interview is regarding case number 02-2013-654321. Can everyone state their name for the tape recording?

MR. SULLIVAN: Timothy Sullivan representing

DR. WILSON: Harrold Wilson.

DR. BARNETT: Vincent Barnett, District Medical Consultant.

MS. STEFANI: Okay. So what we're going to begin with, Dr. Wilson, is getting some background information from you and then we'll discuss the care you provided to Daniel Fussell. I already got your driver's license information. And your current address is at 1224 Wisteria Lane, Sacramento, California?

DR. WILSON: Correct.

MS. STEFANI: That's your home address. And your work address is 6311 Freeport Blvd., Suite 400, Sacramento, California?

DR. WILSON: Yeah.

MS. STEFANI: And your home phone is 916-937-1901?

DR. WILSON: Yes.

MS. STEFANI: And your cell is 916-300-6255?

DR. WILSON: Yes.

MS. STEFANI: And in going through your CV, it looks like you completed your medical degree in 1965 at the University of St. Louis in St. Louis, Missouri?

DR. WILSON: Yes.

MS. STEFANI: And where did you get your training here in the United States? Where did you do your internship and residency?

DR. WILSON: The first two years was internal medicine with a University Medical School affiliate hospital in Trenton, New Jersey, called St. Francis Hospital.

MS. STEFANI: Okay.

DR. BARNETT: Is that in your CV here?

MS. STEFANI: Yeah. It looks like it's just -- on the first page at the bottom. So you were there from 1974 through 1976?

DR. WILSON: (Indiscernible)

MS. STEFANI: Okay.

DR. BARNETT: Yeah. Hahnemann here is spelled wrong. It's -- it's Hahnemann Medical School.

DR. WILSON: Hahnemann --

DR. BARNETT: That's the wrong spelling of Hahnemann.

DR. WILSON: It's in Pittsburgh --

DR. BARNETT: It's in Philadelphia area. It's the wrong spelling, so you might want to correct that. It's H-a-h.

DR. WILSON: Okay.

MS. STEFANI: Okay. Then --

DR. WILSON: Then after that two years, I took another two years in medical oncology fellowship.

MS. STEFANI: Uh-huh.

DR. WILSON: That's in Rhode Island with Brown University.

MS. STEFANI: Okay. And then where did you go after that?

DR. WILSON: After I finished my fellowship, then I went to practice medicine.

MS. STEFANI: I see. So then it looks like you went into solo practice in Rhode Island, is that --

DR. WILSON: No. That's when I got out of fellowship training.

MS. STEFANI: Okay.

DR. WILSON: I was practice there (indiscernible).

DR. BARNETT: What kind of practice was that? General medicine or oncology?

DR. WILSON: Oncology initially and a few years later, I mixed oncology and general internal medicine.

MS. STEFANI: And so then you -- it looks like for

a year or so, you went -- you were the medical director of -- like a drug treatment center?

DR. WILSON: I also was the director of the detox center in Rhode Island.

MR. SULLIVAN: In Rhode Island?

DR. WILSON: In Rhode Island.

MS. STEFANI: Okay. And then you came to Sacramento, it looks like.

DR. WILSON: Yeah. I decided to move to west.

MS. STEFANI: Okay. What brought you here?

DR. WILSON: Well, kids all grown up and I missed the good weather.

MS. STEFANI: I see. Was there anything else that brought you here?

DR. WILSON: Well, then it's just want a change.

MS. STEFANI: I see. That was in 1993. And since the time that you've worked here in California, you've been just a general medicine type of a practice?

DR. WILSON: Yeah. I practice general internal medicine also.

MS. STEFANI: So you're licensed to practice in California. What about other states?

DR. WILSON: I have Massachusetts. I have Philadelphia -- I mean Pennsylvania. I have Rhode Island.

MS. STEFANI: Okay. Are you current in those

states or --

MR. SULLIVAN: Do you keep them up, Doctor, or do you let them expire?

MS. STEFANI: Are they --

DR. WILSON: Well, they expired on the basis of no payment.

MS. STEFANI: Okay. So they're all expired.

DR. WILSON: Yeah. I can renew them if I clear up the payment.

DR. BARNETT: Which one was that that you did not pay a renewal fee and --

DR. WILSON: All the -- the states since I'm not planning to go back to practice.

DR. BARNETT: Pennsylvania and Rhode Island --

DR. WILSON: Pennsylvania and Rhode Island and Massachusetts.

DR. BARNETT: So all of them expired --

DR. WILSON: Right.

DR. BARNETT: -- because you didn't pay.

DR. WILSON: I didn't pay, yeah.

DR. BARNETT: For the renewal fee.

MS. STEFANI: Now weren't you also licensed in New York?

DR. WILSON: I have a license in New York too before.

MS. STEFANI: Uh-huh.

DR. WILSON: And then I got a disciplinary action in North Island (ph) and that is cleared up, but in reciprocating, my lawyer asked me if I wanted to take care of the New York license or not --- if I didn't want to go there, that I could just surrender my license.

MS. STEFANI: Um-hmm.

DR. WILSON: So I surrendered it back to New York State.

DR. BARNETT: It was a surrender and not a revocation?

DR. WILSON: Surrender.

DR. BARNETT: It wasn't revoked first before you surrendered it?

DR. WILSON: It wasn't revoked. It's just because I had an action in Rhode Island and in reciprocal discipline they -- the Rhode -- New York State said you have to clear up your license whenever they require and I was not planning go back to practice in New York. So I just surrendered the license back to them.

MR. SULLIVAN: You must have the records, so --

MS. STEFANI: Yeah. I know that we took action when you came -- when you were disciplined also. We put you on probation for I think five years.

MR. SULLIVAN: Right.

MS. STEFANI: Yeah.

MR. SULLIVAN: Dr. Wilson has successfully completed probation now.

MS. STEFANI: Right.

MR. SULLIVAN: And that's really old. What -- he's been off probation for what, ten years?

MS. STEFANI: Yeah. What happened in Rhode Island?

MR. SULLIVAN: Why is this relevant?

MS. STEFANI: I was just --

MR. SULLIVAN: Do you remember what happened in Rhode Island?

MS. STEFANI: Actually --

DR. WILSON: Oh, there was a case in the hospital where -- where a patient (indiscernible) -- and I checked on the patient, so I admitted him to the hospital. That was over the weekend. So then we called a surgeon, the back surgeon, to evaluate Monday or whatever my order said. The patient need to be evaluated by -- by a surgeon and for whatever reason the surgeon didn't come during the weekend, but came the Saturday and that patient -- after evaluation, the surgeon decided to do surgery.

So the patient had this problem and the surgery was done and the patient then slowly recovered and for some reason the patient sued the hospital, the attending doctor,

all the other doctors, and I was included because I was the primary care. But finally that case was settled between the -- the patient, the patient's lawyer, and the hospital.

MR. SULLIVAN: But I think your question was you wanted to know he was disciplined in Rhode Island?

MS. STEFANI: Yeah. That sounds like --

MR. SULLIVAN: Was it that case?

DR. WILSON: Yes, that's the case.

MS. STEFANI: Oh, okay.

DR. BARNETT: That was the case, yeah.

MS. STEFANI: Yeah. Now, it looks like they have you here as revoked in -- they revoked your license in New York. Maybe that was just because you didn't respond to the charges?

MR. SULLIVAN: Probably.

DR. BARNETT: So there was a malpractice case in that Rhode Island case?

DR. WILSON: Right. And this is the hospital and the hospital settled with the -- the patient.

DR. BARNETT: You were not personally sued?

DR. WILSON: No.

DR. BARNETT: Who were the defendants?

DR. WILSON: The hospital, like I said, the attending doctor, yeah, I was included as a defendant.

MS. STEFANI: Okay. Have you been sued at all?

DR. BARNETT: We need go back and look at the CV.

MS. STEFANI: Yeah, go ahead.

DR. BARNETT: The two of you might want to clean this up.

MR. SULLIVAN: Yeah, we will. We will.

DR. BARNETT: There's a lot of errors in this CV, you know, spelling and other stuff. (Indiscernible) would not look good if I see this if you, you know, submit it to me, this CV obviously does not look good. I mean the spellings are incorrect.

MR. SULLIVAN: Yeah. Normally the primary care docs don't have to use a CV, so -- and I didn't go over it carefully and check it for spelling.

MS. STEFANI: Yeah.

MR. SULLIVAN: The thing is it tells where he went to school and what training he --

DR. BARNETT: Okay. Well let me ask a question about your credential here. You said here board certified is medical oncology; is that correct?

DR. WILSON: I'm not certified. I didn't take exam (indiscernible). I'm qualified.

DR. BARNETT: You didn't specify here -- if I read this, it would appear that you are certified by American Board of Medical Oncology.

MR. SULLIVAN: Board eligible it says.

DR. BARNETT: That's American Board of Medicine. The next sentence, American Board of Medical Oncology. When you state that, it implies you are board certified.

MR. SULLIVAN: Well, I don't read it that way, Dr. Barnett.

DR. BARNETT: Oh, I do.

MR. SULLIVAN: Okay.

DR. BARNETT: I mean that's not factual.

MR. SULLIVAN: Okay.

MS. STEFANI: You're not board certified in any --

MR. SULLIVAN: No, he's not.

DR. WILSON: No.

MS. STEFANI: Okay.

MR. SULLIVAN: He's just board eligible.

DR. BARNETT: Have you taken any exams at all?

DR. WILSON: No. Not with the oncology.

DR. BARNETT: How about medicine, have you taken an exam?

DR. WILSON: Medicine, I remember it was way, way back, I took it once, but I -- I might be mistaken. I don't know because I don't recall I ever took the exam.

DR. BARNETT: Okay. All right. So -- okay. So you're not certified in any boards.

DR. WILSON: No, not --

DR. BARNETT: Okay. How about this publication, Book of Prevention of Cancer. Do you have a copy of this book? I'm just kind of curious.

DR. WILSON: Yeah. Actually I need to -- to bring in the book --

DR. BARNETT: Okay. All right.

MS. STEFANI: Okay. With regards to being sued, how many times have you been sued?

MR. SULLIVAN: That -- that case in --

DR. BARNETT: Rhode Island? Okay.

DR. WILSON: -- that's one.

DR. WILSON: And then this case.

MR. SULLIVAN: Just -- this is the only other malpractice case you've --

DR. WILSON: Yeah.

MR. SULLIVAN: -- ever had?

DR. WILSON: Yeah --

MR. SULLIVAN: So you got two. One in Rhode Island and one here.

MS. STEFANI: Okay. And aside from the civil case, any other legal problems that you have?

DR. WILSON: No.

MS. STEFANI: Have you ever been arrested or convicted of a crime?

DR. WILSON: No.

MS. STEFANI: Describe your use of alcohol.

DR. WILSON: I don't drink.

MS. STEFANI: Are you taking any prescription medications?

DR. WILSON: I take atenolol for high blood pressure.

MS. STEFANI: Anything else?

DR. WILSON: No, not right now.

MS. STEFANI: How would you describe your health?

DR. WILSON: It's good. It's okay.

MS. STEFANI: Great. Now, maybe you can tell us a little bit about -- well, maybe want to ask him about his practice --

DR. BARNETT: Yeah. I'd like to -- so (indiscernible) you trained out there in medical oncology and that's, you know, way back then. I'm just interested in your work history in California. So you came out here the first time around and what was your first job?

DR. WILSON: Well, my first job was working together with Dr. Chan.

DR. BARNETT: Okay. Was it a group?

DR. WILSON: It's a medical group. It was just using his office. He had the general care clinic.

DR. BARNETT: Where is this located now?

DR. WILSON: It's 33939 Fruitridge Avenue.

DR. BARNETT: Was he a friend of yours and did he invite you to use his office?

DR. WILSON: Yes. But he invited me to join that -- that practice site.

DR. BARNETT: It was just an informal arrangement back then?

DR. WILSON: Informal.

DR. BARNETT: Informal arrangement. It wasn't a partnership?

DR. WILSON: No, no partnership at all.

DR. BARNETT: Okay. What kind of practice was that?

DR. WILSON: General practice.

DR. BARNETT: General. General internal medicine?

DR. WILSON: Yes.

DR. BARNETT: Okay. All right. How many years were you with them?

DR. WILSON: Less than a year.

DR. BARNETT: Okay. So after that what happened next?

DR. WILSON: Then I decided to take a job at the county.

DR. BARNETT: County Medical Clinic?

DR. WILSON: Sacramento County Clinic.

DR. BARNETT: Okay. Is that in your CV?

DR. WILSON: Well, yeah.

DR. BARNETT: Sacramento County, that's 1994-1995. What was your work there? What were your duties at the county health clinic?

DR. WILSON: Well, it's also general practice.

DR. BARNETT: Okay. So after that from 1995, you --

DR. WILSON: I set up my own practice.

DR. BARNETT: Was it a single -- solo?

DR. WILSON: Yeah.

DR. BARNETT: And how long were you doing that as a solo?

DR. WILSON: That was for a couple years.

DR. BARNETT: Couple of years. And your practice was still general medicine?

DR. WILSON: Still general medicine.

DR. BARNETT: Okay. So after that, did you join a group?

DR. WILSON: No, I never joined a group. I --

MR. SULLIVAN: You were with Dr. Price though for a while.

DR. WILSON: Oh -- Right. Well, on Zinfandel -- when I set out at the Zinfandel, that's (indiscernible). That was for a couple years. Then I set up the Wilson Care Medical Center.

DR. BARNETT: The Wilson Care was your group. So you were the one who organized that?

DR. WILSON: Yeah. I organized it. I have a couple of doctors that include an M.D. and a P.A.

DR. BARNETT: Okay. So -- okay. So that was incorporated --

DR. WILSON: Incorporated.

DR. BARNETT: Okay. So what kind of practice do you have at Wilson Care?

DR. WILSON: Wilson Care is general practice.

DR. BARNETT: General practice also? And you're the sole practitioner or you had another --

MR. SULLIVAN: He had another doctor.

MS. STEFANI: And a P.A.

DR. BARNETT: A P.A.? And a nurse; okay. And that's where you're practicing right now?

DR. WILSON: I still carry the Wilson Care medical practice, but I no longer have any associates. It's just myself.

MS. STEFANI: When did that change?

DR. WILSON: Well, that happened because the Wilson Care incorporated got audited by Medi-Cal and they -- then they (indiscernible) there they're holding my Medi-Cal number, so I cannot see Medi-Cal patients.

DR. BARNETT: So -- I'm sorry. What happened to

the Medi-Cal thing? You were --

MR. SULLIVAN: He was audited by Medi-Cal.

MS. STEFANI: And when did this happen?

DR. WILSON: That was in year 2004.

MR. SULLIVAN: We've been interviewed on that already.

DR. BARNETT: And just kind of -- in general just tell us what it is because --

DR. WILSON: Well, that's why the Wilson Care was changed from a group into now a solo practice because then the Medi-Cal patients comprised at least 80 percent of my practice.

DR. BARNETT: So you were audited. So they took action against you -- Medi-Cal did.

DR. WILSON: Yeah --

MR. SULLIVAN: -- and he's got an appeal pending.

DR. BARNETT: What was the outcome of the audit that led to you being --

MR. SULLIVAN: I can tell you very simply because I represented him. He was doing colonoscopies -- a lot of colonoscopies -- and he wasn't using anesthesia routinely and they -- and some doctor in the Medi-Cal program said that was below the standard of care. We got an expert from the University of California, chief of gastroenterology there, and he said you don't need -- routinely give people

Versed or any other -- you know, any other anesthetic agent.

DR. BARNETT: Um-hmm.

MR. SULLIVAN: If you know what you're doing with the colonoscopy, it's not necessary. And so they closed that. Then they were doing echoes -- echocardiograms.

DR. BARNETT: Um-hmm.

MR. SULLIVAN: And the Medi-Cal had a rule that nobody knew about. We never could find it that you could not bill for echocardiograms unless you had a six-month training program devoted entirely to echocardiograms.

So they did -- they take a sample -- I don't know if you're familiar with this, Dr. Barnett, but they take a sample of your claims and then they extrapolate.

DR. BARNETT: Well, actually there really -- there is actually a requirement for you to be able to do cardiac echo set forth by the American Society of Echocardiography. There's a minimum training requirement. If you haven't fulfilled that, you're not qualified to read an echocardiogram.

So I mean that's -- I'm just telling you that -- that is actually --

MR. SULLIVAN: But that's not the -- in any event --

DR. BARNETT: Okay.

MR. SULLIVAN: -- so the thing is still in

litigation. What happened was that he left -- there was a big fight in his medical group --

MS. STEFANI: Now, do you have any hospital privileges?

DR. WILSON: No, I don't -- I don't go the hospital to treat patients.

MS. STEFANI: Have you had hospital privileges in this area?

DR. WILSON: Not in this area.

DR. BARNETT: Have you ever applied for any hospital privileges?

DR. WILSON: No. Actually when I first come here, I wanted to practice but there were no openings in the oncology group. The group did not accept any new members. So I just --

DR. BARNETT: So when you applied for privileges, that's the response you had that --

MR. SULLIVAN: No. I think he meant he tried to get a job with a group and they weren't taking anybody.

DR. BARNETT: Okay. She was asking about hospital privileges.

MR. SULLIVAN: Yeah, I know.

MS. STEFANI: So you're saying that if you'd gotten in that group then you would have applied for

hospital privileges?

DR. WILSON: Yeah.

DR. BARNETT: Okay. So you never had any privileges in California.

DR. WILSON: No.

DR. BARNETT: And your group practice dissolved?

MR. SULLIVAN: He got thrown out essentially.

DR. WILSON: Yeah.

DR. BARNETT: Was this because of Medi-Cal restriction or --

DR. WILSON: Well, because I cannot see patient; right?

MR. SULLIVAN: Yeah, I think so.

DR. BARNETT: He was not bringing in more money for them.

MS. STEFANI: About how many patients do you see a day now?

DR. WILSON: Oh, 30 to 40.

MS. STEFANI: Oh, you have quite a busy practice still.

DR. WILSON: I love work.

MS. STEFANI: Even without the Medi-Cal.

MR. SULLIVAN: Dr. Wilson started a second family. He has young children. He essentially --

DR. WILSON: Oh, yeah.

MR. SULLIVAN: -- can never stop working.

MS. STEFANI: Oh, gosh.

MR. SULLIVAN: Six and nine, Doctor? Are they six and nine?

DR. WILSON: Six and nine, yeah.

DR. BARNETT: I think we're done with the background stuff --

MS. STEFANI: Yeah.

DR. BARNETT: When you see a new patient, do you go through an initial reevaluation of what the medical problems are and then plan for what you're going to do? What's your normal protocol for new patients?

DR. WILSON: When I have a new patient, I sit down face to face with patient, and they will say blah, blah, blah, blah. But actual their initial presentation, what their problem is, what they want to say to me, and then I start systematically asking history. Personal history, family history, social history, job history, history of smoking, alcohol, drug, everything, allergy history. Those are standard -- uniform. Every single new patient no matter what kind of insurance or if they're cash pay. Every one goes through this thorough screening --

DR. BARNETT: Okay. So you take this -- you take it yourself.

DR. WILSON: I obtain it myself. Oh, I have to

add patients also fill out a patient information form.

DR. BARNETT: Okay. Did you -- when you make a diagnosis of Bipolar Disorder do you -- is it your practice to consult with a psychiatrist to do an evaluation to confirm your diagnosis and, you know, assist and help you with choices of medications? What's your practice for those psychiatric patients?

DR. WILSON: It would depend on the mental illness to what degree. Physical psychiatry or mental disorder, we can handle at the primary care --

DR. BARNETT: (Indiscernible)

DR. WILSON: Yeah.

DR. BARNETT: Without referral; okay.

DR. WILSON: Yeah.

DR. BARNETT: Now, let's talk about patient Daniel Fussell.

MR. SULLIVAN: The big issue on Fussell is that he saw -- had a normal exam and then five days later shows up --

DR. WILSON: Yeah.

MR. SULLIVAN: -- having

MS. STEFANI: Yes, we're going to go over that visit very closely.

MR. SULLIVAN: Can we take a break.

MS. STEFANI: Sure. Ten minutes?

Off the record

MS. STEFANI: Now, we're back on the record.

DR. BARNETT: We can go ahead with patient Fussell.

MS. VANDERVEEN: Okay. Mr. Sullivan has returned.

MR. SULLIVAN: We're terminating the interview at this time and I will respond in writing regarding patient Fussell.

MS. VANDERVEEN: Okay.

(Off record)

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