FORM B10 (Official Form 10) 4009284

UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

PROOF OF CLAIM
Chapter 11

In Re Kmart Corporation, et al. | **Case Numbers 02-02462 through 02-02499**

Your claim is scheduled as follows
Class
UNSECURED NON PRIORITY
Amount
CONTINGENT, DISPUTED, UNLIQUIDATED

Name of Debtor. (see attached for complete list of debtors) Kmart Corporation
Kmart of Greenwood #7058

Case Number: 02-02474

NOTE: This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A request for payment of an administrative expense may be filed pursuant to 11 U.S.C. § 503.

Name of Creditor (The person or other entity to whom the debtor owes money or property)

MOORE, EARTHY
C/O WATSON LAW FIRM & [redacted] 11 3314081
MARVIN WATSON
333 MAIN STREET
PO DRAWER 799
GREENWOOD, SC 29648

- ☐ Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars
- ☐ Check box if you have never received any notices from the bankruptcy court in this case
- ☐ Check box if the address differs from the address on the envelope sent to you by the court

10099980

This Space is for Court Use Only

If address differs from above, please complete the following:
Creditor Name
Address
City/St/Zip
Telephone # 864-229-2569

Account or other number by which creditor identifies debtor.

Check here if this claim ☐ replaces ☐ amends a previously filed claim, dated 7/16/01

1 Basis for Claim
- ☐ Goods sold
- ☐ Services performed
- ☐ Money loaned
- ☑ Personal injury/wrongful death
- ☐ Taxes
- ☐ Other

- ☐ Retiree benefits as defined in 11 U.S.C. §1114(a)
- ☐ Wages, salaries, and compensation (fill out below)
  Your SS # _____
  Unpaid compensation for services performed from _____ (date) to _____ (date)

2. Date debt was incurred: Injured - 02/02/01

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $ 7,500.00
If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below
☐ Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Secured Claim.
☐ Check this box if your claim is secured by collateral (including a right of setoff)
Brief Description of Collateral
☐ Real Estate ☐ Motor Vehicle ☐ Other _____
Value of Collateral: $ _____
Amount of arrearage and other charges at time case filed included in secured claim, if any $ _____

6. Unsecured Priority Claim.
☐ Check this box if you have an unsecured priority claim
Amount entitled to priority $ _____
Specify the priority of the claim
- ☐ Wages, salaries, or commissions (up to $4,650), earned within 90 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(3)
- ☐ Contributions to an employee benefit plan - 11 U.S.C. §507(a)(4)
- ☐ Up to $ 2,100 of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(6)
- ☐ Alimony, maintenance, or support owed to a spouse, former spouse, or child - 11 U.S.C. § 507(a)(7)
- ☐ Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8)
- ☐ Other – Specify applicable paragraph of 11 U.S.C. § 507(a)(__)

7. Credits: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.

8. Supporting Documents: Attach copies of supporting documents, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary.

9. Date-Stamped Copy: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

This Space is for Court Use Only

RECEIVED
TRUMBULL SERVICES COMPANY
APR 22 2002
BANKRUPTCY
4/22/02
#10045 ck.

Date 4/18/02

Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any)

Penalty for presenting fraudulent claim Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571

STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENWOOD)

IN THE MAGISTRATE'S COURT

Earthy Moore
P O Box 1463
Greenwood SC 29648

Plaintiff(s),

vs.

Kmart of Greenwood #7058
54 By Pass 72 NW
Greenwood SC 29649

Defendant(s).

COMPLAINT
CASE NO.:

I, Earthy Moore, the Plaintiff in this civil action do make the following claims:

1. I believe that the Defendant, Kmart of Greenwood #7058 is a corporation doing business in Greenwood County at 54 By Pass 72 NW, Greenwood SC 29649.

2. I make this complaint on the following:

On or about February 5, 2001, while leaving the check-out counter in the Kmart store in Greenwood, South Carolina, I slipped and fell on some spilt paint in the aisle of the check-out counter. The paint had been spilt by another customer, who was present at the scene and this customer had reported the spilled paint to an employee of Kmart. This employee failed to clean up or properly warn customers and other employees of the store.

3. I believe, because of the above information, that I am entitled to and do request a judgment for $7,500.00 as below requested:

Piedmont Health Group	$200.25
Upper Savannah Radiology	$92.00
Upper Savannah Radiology	$112.00
Self Memorial Hospital	$170.00

Self Memorial Hospital	$358.65
Total Medical	**$932.90**
Pain and Suffering	$6,567.10
Total	**$7,500.00**

including any costs resulting in this action.

I state under penalty of perjury that the above is correct and truthful.

Earthy M. Moore

Earthy Moore, Plaintiff

07 - 13 - , 2001

Marvin R. Watson
Attorney for Plaintiff
333 Main Street
P O Drawer 799
Greenwood SC 29648
(864) 229-2569

SELF MEMORIAL HOSPITAL
P.O. BOX 48305
JACKSONVILLE,FL 32247-8305

105#113
Return Service Requested
12146-21648

PATIENT NAME
EARTHY MOORE

ACCOUNT NUMBER
0760*0033397667

STATEMENT DATE
03-30-01

Place of Service: SELF MEMORIAL HOSPITAL
GFS01*0760*0033397667 105#113

AMOUNT DUE
170.00

AMOUNT PAID

EARTHY MOORE
PO BOX 1463
GREENWOOD SC 29648-1463

SELF MEMORIAL HOSPITAL
PO BOX 75878
CHARLOTTE,NC 282755878

13868000000000003339766732600017000 16

PLEASE DETACH AND RETURN TOP PORTION WITH PAYMENT

DATE	DOCTOR	CODE	DESCRIPTION	AMOUNT
02-05-01	WAYNE S MOUNTS, PA	99283	EMERGENCY DEPARTMENT VISIT	170.00

ACCOUNT NUMBER
0033397667

DATE OF STATEMENT
03-30-01

PAYMENTS AFTER THIS DATE WILL APPEAR ON YOUR NEXT STATEMENT

BALANCE

AMOUNT DUE
170.00

PATIENT NAME
EARTHY MOORE

MAKE CHECKS PAYABLE TO:
SELF MEMORIAL HOSPITAL

THIS ACCOUNT IS
PAST DUE
IMMEDIATE PAYMENT IS REQUESTED

BILLING QUESTIONS:LOCAL (800)-877-7564
OUT OF AREA: 1(800)-877-7564 CUSTOMER SERVICE
MON-FRI 8:00 AM THRU 5:45 PM EST

Tax Id 57-0331865

Place of service: SELF MEMORIAL HOSPITAL
Diagnosis: 959.3

SELF MEMORIAL HOSPITAL
PO BOX 75878
CHARLOTTE,NC 282755878
(800)-877-7564

SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

PATIENT NAME	ACCOUNT NUMBER	ADMIT DATE	DISCHARGE DT	STATEMENT DT	P/T
EARTHY MOORE	01036-00376	02/05/01	02/05/01	02/15/01	ED

BILLING STATEMENT

PLEASE REMIT TO
Self Memorial Hospital
1325 Spring Street
Greenwood, SC 29646

PLEASE VERIFY THE INSURANCE INFORMATION AND POLICY NUMBER ABOVE

PAY THIS AMOUNT 358.65

EARTHY MOORE
PO BOX 1463
GREENWOOD SC 29646-0000

☐ CHECK ENCLOSED
☐ VISA ☐ MASTERCARD ☐ AMEX
CARD HOLDER'S NAME
CARD NUMBER
EXPIRATION DATE
SIGNATURE

PLEASE FILL OUT TOP PORTION OF THIS STATEMENT AND INCLUDE IT WITH YOUR PAYMENT

Rev Cd	Description	Total
259	DRGS/OTHER	4.10
272	MED/SURG - STERILE SUPPLIES	1.80
320	DX X-RAY	232.05
450	EMERG ROOM	120.70
	TOTAL CHARGES	358.65
	TOTAL PAYMENTS/ADJUSTMENTS	0.00

The account balance shown below is for services provided by Self Memorial Hospital. Payment in full is required within 30 days. If you need to discuss payment arrangements, please contact us at (864)227-4120 Monday thru Friday 8:30am - 5:00pm.

PATIENT NAME EARTHY MOORE
PATIENT ACCOUNT NUMBER **01036-00376**

SELF MEMORIAL HOSPITAL
1325 SPRING STREET
GREENWOOD, SC 29646
(864)227-4111

TOTAL CHARGES	358.65
TOTAL PAYMENTS AND ADJUSTMENTS	0.00
PLEASE PAY THIS AMOUNT	358.65

Emerge y Care Center Registratior Form

SELF MEMORIAL HOSPITAL
1325 Spring Street
Greenwood, S.C. 29646

BS 1.30

Problem

PATIENT INFO

ACCOUNT#	ROOM/BED	I C	ADMIT DATE/TIME	ADM BY	PATIENT TYPE	UNIT #/MPI #
01036-00376	-	6	02/05/01 1340	DB	ED	000087958

PATIENT NAME AND ADDRESS	BIRTHDATE	AGE	RACE	SEX	M S	Arrived By
MOORE,EARTHY PO BOX 1463 GREENWOOD SC 29646-0000	05/15/53	47Y	2	F	D	WALK

COUNTY	MOTHER'S NAME
GREENWOOD	
PREV ADMIT DATE	FATHER'S NAME
01/30/99	

PHONE	SSN	PREV ADMIT NAME	
(864)943-0940	247-11-2562	MOORE,EARTHY	

GUARANTOR

GUARANTOR NAME AND ADDRESS	RELATIONSHIP	GUARANTOR'S EMPLOYER NAME AND ADDRESS
MOORE,EARTHY PO BOX 1463 GREENWOOD SC 29646-0000	SELF	CCC

PHONE	SS #	PHONE	OCCUPATION
(864)943-0940	247-11-2562		

RELATIVE

RELATIVE #1 NAME AND ADDRESS	RELATIVE #2 NAME
TUTTES,JUANITA	

RELATIONSHIP	PHONE	WORK PHONE	RELATIONSHIP	PHONE	WORK PHONE
SIBLING	(864)443-2724				

INSURANCE

	INSURANCE NAME	COMPANY #	GROUP NAME	POLICY NUMBER
1				
	INSURED		RELATIONSHIP	
2				
3				

MED

PROVISIONAL DIAG	ADMITTING PHYSICIAN/ATTENDING PHYSICIAN
FALL INJURY	VAUGHN,KENNETH W /

FINAL DIAGNOSIS:	CODE NUMBER	PHYS No
	719.43	
	924.11	
	723.11	
	E885.9	
	E849.6	
COMPLICATIONS:		
OPERATIONS.		

HOSPITAL INFECTIONS:

CONSULTANT(S)

I, THE UNDERSIGNED ATTENDING PHYSICIAN, CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE DIAGNOSIS TREATMENT AND WRITTEN ORDERS OF THIS PATIENT HAVE BEEN COMPLETELY AND PROMPTLY RECORDED

DISCHARGED ALIVE ☐ DIED: UNDER 48 HRS. ☐ OVER 48 HRS. ☐

AUTOPSY YES ☐ NO ☐

BY _____ DATE _____

35

CONDITIONS OF ADMISSION OR TREATMENT

The following are the conditions for admission or treatment at SELF MEMORIAL HOSPITAL for_____
(patient name)

GENERAL DUTY NURSING The hospital provides only general duty nursing care Under this system nurses are called to the bedside of the patient by a signal system. If the patient is in such condition as to need continuous or special family duty care, such must be arranged by the patient or legal representative. The hospital is not responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care

I have received a copy of the Hospital's Smoking Policy. As a condition of admission, I agree not to smoke within the Hospital, and if there is a basis for believing that I have violated this agreement, I authorize the Hospital to search my room and any articles within the room If any smoking materials are found, I authorize the Hospital to remove them.

MEDICAL AND SURGICAL CONSENT. The patient's care is under the direction of the attending physician and the Hospital is not responsible for any act or omission of the physician. The undersigned consents to any x-ray examination, laboratory procedure, anesthesia, medical or surgical treatment or hospital services rendered the patient under the general and special instructions of the physician. The undersigned recognizes that most medical staff members furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, and the like are indendent contractors and not employees or agents of agents of the hospital

I CONSENT to appropriate tests for the presence of infection, such as, but not limited to infection by the hepatitis B virus or human immunodeficiency virus, if deemed necessary for the protection of others, and I authorize the withdrawal of blood or other body fluids for this purpose.

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS I/We hereby guarantee payment of all charges incurred for the account of the patient and hereby assign to the hospital benefits any hospital benefits, major benefits, pip benefits, sick benefits or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient unless we pay account in full upon discharge If eligible for Medicare, I request Medicare services, I request that this authorization apply to the period_____ to _____.

ASSIGNMENT OF PHYSICIAN BENEFITS In the event that I, the patient, in addition to the hospital benefits, am entitled to physicians' benefits of any type whatsoever arising out of a policy of insurance insuring me or any other liability to me, I hereby assign said benefits to any physician rendering care or treatment during this stay or outpatient visits, to be applied to my physician's bill

FINANCIAL AGREEMENT The undersigned agrees whether he signs as agent or as patient that in consideration of the services to be rendered to that patient, he hereby individually obligates himself to pay the account of the Hospital in accrdance with the regular rates and terms of the Hospital. Should the account not be paid when due, the undersigned shall pay Hospital reasonable attorney's fees and collection expenses All delinquent accounts may bear interest at the legal rate.
I do hereby appoint the Hospital as my lawful attorney to act in my behalf to collect the above mentioned claims and to give full and final receipt for me for all amounts so collected, and to endorse for me any checks made payable to me for benefits or claims collected under the above agreements. In the event insurance benefits exceed the actual amount of charges for this period of hospitalization, I hereby authorize and direct the Hospital to apply any overpayment that I may otherwise be entitled to, to any account that may exist at the Hospital for myself, my spouse, or my children or any other account for which I am responsible

RELEASE OF MEDICAL INFORMATION I hereby authorize the Hospital to furnish from medical records compiled during the admission any information requested by the Insurance Co., it's designated agent, or liable third parties to include Medicare and Medicaid whose benefits have been assigned for purposes of benefit payment. During my hospitalization at the Hospital, I authorize my treating physicians to direct copies of my medical records to other physicians as they deem necessary for continuity of care while an inpatient, and further authorize the transfer of copies of my medical records of any health care facility to which I am transferred

MEDICARE PATIENTS· If Medicare, I request that payment of authorized medicare benefits be made on my behalf I certify that the information given by me in applying for payment under, Title XVII of the Social Security Act is correct and that information supplied is also correct Has the patient been admitted to any hospital or nursing home within the past 60 days?_____ If yes, name of hospital or nursing home_____ Was patient transferred from another acute-care hospital?_____Was patient discharged from this hospital within past 30 days?_____

PERSONAL VALUABLES The Hospital is not responsible for personal property retained in the patient's room and will not be responsible for any personal property of the patient unless it is accepted for safekeeping by the Hospital and receipts are issued therefore

Date	Witness	Patient or Authorized Rep	Relationship to Pt
2/5/01	D.S.	Dorothy Moore	
Date	Witness	Insured (if other than Patient)	Relationship to Pt

RELEASE FROM RESPONSIBILITY FOR DISCHARGE This certifies that I, _____ a patient of Self Memorial Hospital, am leaving against the advice of the attending Physician and the Hospital administration I acknowledge that I have been informed to the risk involved and hereby released the attending Physician and the Hospital from all responsibility for any ill effects which may result from such leaving

Witness	Signed
Witness	Date

02 501

Self Memorial Hospital

N-217

PHYSICIAN ORDERS AND WORKSHEET

376 QED

PI 0000067958

SHORT FORM

SURGERY DATE-

ADDRESSOGRAPH

PHYSICIAN ASSESSMENT Time

CC:

PMHx: DM HTN CAD COPD PUD CA CVA

Allergy:

Surg: APPY GB TONS HYST BTL

FHx: DM HTN CAD COPD PUD CA CVA

Soc: EtOH smoke

Meds:

ROS: CONST GI ENDO

HEENT GU NEURO

RESP MS PSYCH

CV HEME SKIN

Exam

Reassessment / Time

PERTINENT RESULTS

LABS

X-RAY

ECG

CONSULTS

Name				
Called				
Arrive				

Time	ADDITIONAL ORDERS / MEDICATIONS	Time	Initials
	Motrin 1 Cong PO [illegible]		
1549	® elbow x-ray	1539	

Time PHYSICIAN ORDERS Time

- ☐ Old Records
- ☐ FSBS
- ☐ CBC ☐ hemogram
- ☐ Basic metabolic profile
- ☐ Comp metab profile
- ☐ Liver profile
- ☐ Amylase ☐ Lipase
- ☐ PT ☐ PTT
- ☐ CKI ☐ w/ Troponin
- ☐ Cardiac Labs
- ☐ Trauma Labs
- ☐ Blood culture X
- ☐ Drug levels
- ☐ UA void / cath
- ☐ Urine culture
- ☐ UCG ☐ hCG
- ☐ Urine drug screen
- ☐ GC/Chlamydia
- ☐ wet prep
- ☐ CXR ☐ Port
- ☐ C-spine ☐ Port
- ☐ Pelvis ☐ Port
- ☐ Abd Series
- ☐ IVP
- ☐ CT
- ☐ U/S
- 1445 ☒ Xrays ® knee ® wrist
- ☐ ECG
- ☐ ABG
- ☐ Monitor ☐ Pulse Ox
- ☐ IV
- ☐ O_2 @ lpm via
- ☐ Trauma Alert called @
- ☐ Pathway. AMI – ROMI - Asthma - CVA

DIAGNOSIS/PROCEDURES

1. ® wrist pain cannot R/O
2. occult navicular Fx
3. ® elbow contusion
4. ® knee contusion
5.

Signature [signature] ☐Dictated

Signature [signature] ☐Dictated

DISPOSITION Cond: Improved/Stable/Unstable Time

☒ D/C ☐ Admit/Obs Dr. Trans – Walkout

INSTRUCTIONS rest ice to areas of soreness 20 min QID

Follow-up with your MD, 1 week recheck wrist

Return to work/school 2/8/01

Return to ED if worse or no better in

Prescriptions Relafen Lortab

☐ Last Visit ☐ Old Records ☐ WC	**CLASSIFICATION:** I II III

Date: 2/3/01 Time: 1333 Sex: ☐ M ☒ F

Name: Moore Earthy DOB: 5/15/53

Age: 47 Weight 160 Act /Est /Lbs /Kgs Ht /Length 5'4 Head Circum (<13 mos)

SSN·

Arrival: ☒ Amb ☐ W/C ☐ Carry ☐ Stretcher ☐ Police ______ ☒ Private Auto ☐ Ambulance – Unit # ______

MVA: Seatbelt Y / N ☐ Driver ☐ Passenger: FS / BS ☐ Ambulatory at scene LOC Y / N Duration ______ Accompanied By ______

V.S.: Oral Rectal T 99.8, P 82 Reg Irreg, R 20, B/P Right 184/95 Left ______ sit lying stand Pulse Ox ____ % on ____ L/M O2 via ____

Allergies: ☐ Not Available
☐ Meds ______
☐ Food ______
☒ NKA ☐ Latex, tape, dye, etc
PMD: ☐ None Williams

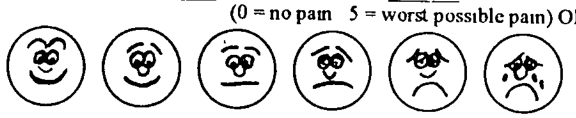
Medications: ☐ Not Available
None

Immunizations: ☐ Unknown ☐ UTD ______ in last 3 wks Y / N ______ **LNMP:** ______

Chief Complaint: stated by (Per) Patient shopping K-mart, stepped in a trail of blue paint, fallen on Rt side - Rt arm & elbow c/o pain & bruise Rt wrist, Rt knee pain, and numbness Rt hand, Lt hand. No obvious deform

PRIOR TREATMENT

PAIN ASSESSMENT: Pain Rating 0 – 5 ______
(0 = no pain 5 = worst possible pain) OR



0 1 2 3 4 5

Face 0 = Very happy because she/he doesn't hurt at all
Face 1 = Hurts just a little bit
Face 2 = Hurts a little more
Face 3 = Hurts even more
Face 4 = Hurts a whole lot
Face 5 = Hurts as much as you can imagine, although you don't have to be crying.

PAST HISTORY: ☐ Not Available ☐ Ulcer ☐ CA ☐ Smoker ______ PPD x ______ yrs ☐ Surgery/Other. ☐ N/A ☐ Seizures ☐ Arthritis ☐ MI/CHF ☐ Psych ☐ Stroke ☐ Angina ☐ Liver Disease ☐ DM ☐ Alcohol / Frequency. ______ ☐ Abuse ☐ GI Problems ☐ GYN Problems ☐ Hypo/Hypertension ☐ Bleeding/Clotting ☐ GU Problems Disorder ☐ Asthma/COPD ☐ Fainting/ Dizzy spells

INFECTION CONTROL PRECAUTIONS ☐ N/A
Sus. TB ☐ Cough > 3 wks ☐ Unexplained Wt Loss ☐ Fever/Night Sweats ☐ Hemoptysis ☐ +HIV with new pneumonia ☐ Current Active TB
Sus Measles· ☐ Maculopapular Rash With Fever, URI and/or Conjunctivitis
Sus Varicella. ☐ Vesicular Rash With Itching or Pain
Sus Meningitis: ☐ HA With Nuchal Rigidity That Is Suggestive Of Meningitis
☐ **Respiratory Isolation Initiated Related To Signs/Symptoms** (Surgical Mask On Patient/Tissue & Emesis Basin Given/Private Room with Sign) TIME INITIALS

PROTOCOL ORDERS: TIME ______ INITIALS ______ ☐ FSBS ______ mg/dl ☐ UA ☐ UA Preg. ☐ X-Ray Type ______
☐ Visual Acuity OD ____ OS ____ OU ____ ☐ INT ☐ P Oximetry ☐ C Monitor ☐ ______ L/MO2 via ______
☐ C-Collar ☐ Splint ☐ Ice/Elevate ☐ Dressing ☐ Icepack ☐ Eye Patch ☐ Other

TRIAGE ASSESSMENT 1406 TIME COMPLETED 1414 INITIALS BL
TREATMENT AREA Room # 22 Time 1410 (Via Amb) / Stretcher / Wheelchair / Carry) Pt Requests (MD)
(MD) Notified Posted Int ☒ ID Band On Examining Physician McDermott Time

MEDICATIONS

TIME	MEDICATION	DOSE	ROUTE	SITE	EFFECT	INITIALS
	dt / Manf Lot #	0.5ml	IM			
1448	motrin	600	po			BL

IV SITE / FLUIDS

TIME START	IV #	IV # of attempts	GAUGE	SITE	FLUIDS/ MEDICATIONS	BAG #	AMOUNT	RATE	PUMP	TIME DC'D	AMOUNT INFUSED	INITIAL
			ga				cc	cc/hr	Y / N		cc	
			ga				cc	cc/hr	Y / N		cc	
			ga				cc	cc/hr	Y / N		cc	
			ga				cc	cc/hr	Y / N		cc	

010-6-00376 QED
MOORE, EARTHY
ADDRESSOGRAPH
F 05/15/1953 MPI 000087958
ER SHORT FORM
SURGERY DATE-

EMERGENCY CARE CENTER (ECC)
NON-EMERGENT PATIENT CARE FLOWSHEET

SELF MEMORIAL HOSPITAL N-520 A 9/13/2000

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CONDITIONS OF ADMISSION OR TREATMENT

The following are the conditions for admission or treatment at SELF MEMORIAL HOSPITAL for _____
(patient name)

GENERAL DUTY NURSING. The hospital provides only general duty nursing care. Under this system nurses are called to the bedside of the patient by a signal system. If the patient is in such condition as to need continuous or special family duty care, such must be arranged by the patient or legal representative. The hospital is not responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care

I have received a copy of the Hospital's Smoking Policy. As a condition of admission, I agree not to smoke within the Hospital, and if there is a basis for believing that I have violated this agreement, I authorize the Hospital to search my room and any articles within the room If any smoking materials are found, I authorize the Hospital to remove them

MEDICAL AND SURGICAL CONSENT. The patient's care is under the direction of the attending physician and the Hospital is not responsible for any act or omission of the physician The undersigned consents to any x-ray examination, laboratory procedure, anesthesia, medical or surgical treatment or hospital services rendered the patient under the general and special instructions of the physician The undersigned recognizes that most medical staff members furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, and the like are indendent contractors and not employees or agents of agents of the hospital

I CONSENT to appropriate tests for the presence of infection, such as, but not limited to infection by the hepatitis B virus or human immunodeficiency virus, if deemed necessary for the protection of others, and I authorize the withdrawal of blood or other body fluids for this purpose

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS I/We hereby guarantee payment of all charges incurred for the account of the patient and hereby assign to the hospital benefits any hospital benefits, major benefits, pip benefits, sick benefits or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient unless we pay account in full upon discharge. If eligible for Medicare, I request Medicare services, I request that this authorization apply to the period _____ to _____.

ASSIGNMENT OF PHYSICIAN BENEFITS In the event that I, the patient, in addition to the hospital benefits, am entitled to physicians' benefits of any type whatsoever arising out of a policy of insurance insuring me or any other liability to me, I hereby assign said benefits to any physician rendering care or treatment during this stay or outpatient visits, to be applied to my physician's bill

FINANCIAL AGREEMENT The undersigned agrees whether he signs as agent or as patient that in consideration of the services to be rendered to that patient, he hereby individually obligates himself to pay the account of the Hospital in accrdance with the regular rates and terms of the Hospital Should the account not be paid when due, the undersigned shall pay Hospital reasonable attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate
I do hereby appoint the Hospital as my lawful attorney to act in my behalf to collect the above mentioned claims and to give full and final receipt for me for all amounts so collected, and to endorse for me any checks made payable to me for benefits or claims collected under the above agreements. In the event insurance benefits exceed the actual amount of charges for this period of hospitalization, I hereby authorize and direct the Hospital to apply any overpayment that I may otherwise be entitled to, to any account that may exist at the Hospital for myself, my spouse, or my children or any other account for which I am responsible

RELEASE OF MEDICAL INFORMATION I hereby authorize the Hospital to furnish from medical records compiled during the admission any information requested by the Insurance Co , it's designated agent, or liable third parties to include Medicare and Medicaid whose benefits have been assigned for purposes of benefit payment During my hospitalization at the Hospital, I authorize my treating physicians to direct copies of my medical records to other physicians as they deem necessary for continuity of care while an inpatient, and further authorize the transfer of copies of my medical records of any health care facility to which I am transferred

MEDICARE PATIENTS· If Medicare, I request that payment of authorized medicare benefits be made on my behalf I certify that the information given by me in applying for payment under, Title XVII of the Social Security Act is correct and that information supplied is also correct Has the patient been admitted to any hospital or nursing home within the past 60 days?_____ If yes, name of hospital or nursing home_____ Was patient transferred from another acute-care hospital?_____Was patient discharged from this hospital within past 30 days?_____

PERSONAL VALUABLES. The Hospital is not responsible for personal property retained in the patient's room and will not be responsible for any personal property of the patient unless it is accepted for safekeeping by the Hospital and receipts are issued therefore.

Date	Witness	Patient or Authorized Rep	Relationship to Pt
2/5/01	D.S.	Dorothy Moore	
Date	Witness	Insured (if other than Patient)	Relationship to Pt

RELEASE FROM RESPONSIBILITY FOR DISCHARGE This certifies that I, _____ a patient of Self Memorial Hospital, am leaving against the advice of the attending Physician and the Hospital administration I acknowledge that I have been informed to the risk involved and hereby released the attending Physician and the Hospital from all responsibility for any ill effects which may result from such leaving

Witness	Signed
Witness	Date

32. 301 L

Self Memorial Hospital

N-217

PHYSICIAN ORDERS AND WORKSHEET

376 QED

PT 0000067956

ADDRESSOGRAPH

PHYSICIAN ASSESSMENT Time

CC:

PMHx: DM HTN CAD COPD PUD CA CVA | Allergy:

Surg: APPY GB TONS HYST BTL

FHx: DM HTN CAD COPD PUD CA CVA

Soc: EtOH smoke | Meds:

ROS: CONST GI ENDO
HEENT GU NEURO
RESP MS PSYCH
CV HEME SKIN

Exam

Reassessment / Time

PERTINENT RESULTS

LABS

X-RAY

ECG

CONSULTS

Name				
Called				
Arrive				

Time	ADDITIONAL ORDERS / MEDICATIONS	Time	Initials
	Mother in lobby PC [illegible]		
1549	AP (L) elbow x-ray	1539	

Time PHYSICIAN ORDERS Time

- ☐ Old Records
- ☐ FSBS
- ☐ CBC ☐ hemogram
- ☐ Basic metabolic profile
- ☐ Comp metab profile
- ☐ Liver profile
- ☐ Amylase ☐ Lipase
- ☐ PT ☐ PTT
- ☐ CKI ☐ w/ Troponin
- ☐ Cardiac Labs
- ☐ Trauma Labs
- ☐ Blood culture X
- ☐ Drug levels
- ☐ UA void / cath
- ☐ Urine culture
- ☐ UCG ☐ hCG
- ☐ Urine drug screen
- ☐ GC/Chlamydia
- ☐ wet prep
- ☐ CXR ☐ Port
- ☐ C-spine ☐ Port
- ☐ Pelvis ☐ Port
- ☐ Abd Series
- ☐ IVP
- ☐ CT
- ☐ U/S
- 1445 ☒ Xrays (R) knee (R) wrist
- ☐ ECG
- ☐ ABG
- ☐ Monitor ☐ Pulse Ox
- ☐ IV
- ☐ O_2 @ lpm via
- ☐ Trauma Alert called @
- ☐ Pathway. AMI – ROMI - Asthma - CVA

DIAGNOSIS/PROCEDURES

1. (R) wrist pain cannot R/O
2. occult navicular Fx
3. (R) elbow contusion
4. (R) knee contusion
5.

Signature [signature] ☐Dictated

Signature [signature] ☐Dictated

DISPOSITION Cond: Improved/Stable/Unstable Time

☒ D/C ☐ Admit/Obs Dr. Trans – Walkout

INSTRUCTIONS: rest ice to areas of soreness 20 min QID

Follow-up with your MD 1 week recheck wrist

Return to work/school 2/8/01

Return to ED if worse or no better in

Prescriptions Relafen Lortab

[redacted]

CLASSIFICATION:	I	II	III

SSN

Date: 2/3/01 **Time:** 1335 **Sex:** ☐ M ☒ F

Name: Moore Earthy **DOB:** 5/15/53

☐ Last Visit ☐ Old Records ☐ WC

Age: 47 **Weight** 160 Act /Est /Lbs /Kgs
Ht /Length 5'4 Head Circum (<13 mos) ____

Arrival: ☒ Amb ☐ W/C ☐ Carry ☐ Stretcher ☐ Police ____
☒ Private Auto ☐ Ambulance – Unit # ____

MVA: Seatbelt Y / N ☐ Driver ☐ Passenger FS / BS
☐ Ambulatory at scene
LOC Y / N Duration ____
Accompanied By ____

V.S.: Oral / Rectal T 99.8, P 82 Reg / Irreg, R 20, B/P Right 181/95 sit / lying / stand, Left ____
Pulse Ox ____ % on ____ L/M O2 via ____

Allergies: ☐ Not Available
☐ Meds. ____
☐ Food ____
☒ NKA ☐ Latex, tape, dye, etc.

PMD: ☐ None Wi Hary

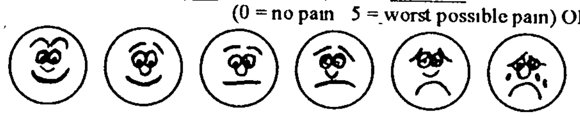
Medications: ☐ Not Available
None

Immunizations: ☐ Unknown ☐ UTD ____ in last 3 wks Y / N ____ **LNMP:** ____

Chief Complaint: stated by (Pt) Patient shopping K-mart stepped in a tray of blue paint fell on Rt side - Rt arm to elbow c/o pain Rt wrist Rt knee pain and dizziness Rt hand Lt hand No obvious deformity

PRIOR TREATMENT

PAIN ASSESSMENT: Pain Rating 0 – 5 ____
(0 = no pain 5 = worst possible pain) OR


0 1 2 3 4 5

Face 0 = Very happy because she/he doesn't hurt at all
Face 1 = Hurts just a little bit
Face 2 = Hurts a little more
Face 3 = Hurts even more
Face 4 = Hurts a whole lot
Face 5 = Hurts as much as you can imagine, although you don't have to be crying.

PAST HISTORY: ☐ Not Available ☐ N/A ☐ MI/CHF ☐ Angina ☐ Abuse ☐ Hypo/Hypertension ☐ Asthma/COPD
☐ Ulcer ☐ Seizures ☐ Psych ☐ Liver Disease ☐ GI Problems ☐ Bleeding/Clotting ☐ Fainting/Dizzy spells
☐ CA ☐ Arthritis ☐ Stroke ☐ DM ☐ GYN Problems ☐ GU Problems Disorder
☐ Smoker ____ PPD x ____ yrs ☐ Alcohol / Frequency ____
☐ Surgery/Other.

INFECTION CONTROL PRECAUTIONS ☐ N/A
Sus TB ☐ Cough > 3 wks ☐ Unexplained Wt Loss ☐ Fever/Night Sweats ☐ Hemoptysis ☐ +HIV with new pneumonia ☐ Current Active TB
Sus Measles ☐ Maculopapular Rash With Fever, URI and/or Conjunctivitis
Sus Varicella ☐ Vesicular Rash With Itching or Pain
Sus. Meningitis ☐ HA With Nuchal Rigidity That Is Suggestive Of Meningitis

☐ **Respiratory Isolation Initiated Related To Signs/Symptoms** (Surgical Mask On Patient/Tissue & Emesis Basin Given/Private Room with Sign)
TIME ____ INITIALS ____

PROTOCOL ORDERS: TIME ____ INITIALS ____ ☐ FSBS ____ mg/dl ☐ UA ☐ UA Preg ☐ X-Ray Type ____
☐ Visual Acuity OD ____ OS ____ OU ____ ☐ INT ☐ P Oximetry ☐ C Monitor ☐ ____ L/MO2 via ____
☐ C-Collar ☐ Splint ☐ Ice/Elevate ☐ Dressing ☐ Icepack ☐ Eye Patch ☐ Other

TRIAGE ASSESSMENT 1406 **TIME COMPLETED** 1407 **INITIALS** BL

TREATMENT AREA Room # 27 Time 1410 (Via Amb) / Stretcher / Wheelchair / Carry) Pt Requests (MD)
(MD) Notified ____ Posted ____ Int ____ ☒ ID Band On Examining Physician M Cuerstor Time ____

MEDICATIONS

TIME	MEDICATION	DOSE	ROUTE	SITE	EFFECT	INITIALS
	dt / Manf Lot #	0.5ml	IM			
1448	motrin	600	po			CK

IV SITE / FLUIDS

TIME START	IV #	IV # of attempts	GAUGE	SITE	FLUIDS/ MEDICATIONS	BAG #	AMOUNT	RATE	PUMP	TIME DC'D	AMOUNT INFUSED	INITIAL
			ga				cc	cc/hr	Y / N		cc	
			ga				cc	cc/hr	Y / N		cc	
			ga				cc	cc/hr	Y / N		cc	
			ga				cc	cc/hr	Y / N		cc	

010-6-00376 QED
MOORE, EARTHY
ADDRESSOGRAPH
F 05/15/1953 MPI 000087958
ER SHORT FORM
SURGERY DATE-

EMERGENCY CARE CENTER (ECC)
NON-EMERGENT PATIENT CARE FLOWSHEET

SELF MEMORIAL HOSPITAL N-520 A 9/13/2000

TIME	NOTES	INITIALS
1525	Back from X-ray	[illegible]
1555	To X-ray for Elbow	[illegible]
1625	Back from X-ray	
	[illegible]	[illegible]

DISCHARGE ASSESSMENT: Review above information, assess patient, document changes.

V.S.: BP 154/70 P 80 R 18 T ______ ☐ Unchanged From Initial Assessment ☐ Assessment Changes:

Left alert ambulatory Ace in place Rt elbow [illegible] to car

Signature [signature] Date 2/05/01 Time 1655

DISPOSITION

TIME OF DISCHARGE		CONDITION	INSTRUCTIONS	SIGNATURE / TITLE	INITIALS
VIA ☑ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance ☐ Carried ☐ ______	Transfer To ☐ Transfer/Transport Protocol ☐ ______	☑ Stable ☐ Unstable ☐ Unchanged ☐ Morgue ☐ LWT ☐ LBTC ☐ AMA	☐ See Instruction Sheet ☑ Verbal / Written Instructions Given To/By [signature] ☑ Prescriptions/Drug Info Given ☐ N/A	[signature]	[illegible]

I have received my discharge instructions including how to take/give medications and potential food/drug interactions (if any).

Signature (Patient/SO/Parent) X [signature] Staff Initial [illegible]

N- 520 B 9/13/2000

TIME SEEN: 1424 ROOM: 28 __ EMS arrival
HISTORIAN: __patient __spouse __paramedics
__HX / __EXAM LIMITED BY:

HPI chief complaint: Fall Injury to (R) wrist elbow knee

occurred:
- just PTA 1300
- __today
- __yesterday
- ____ days PTA

where:
- __home __school
- __neighbor's __city park
- __work __street
- Kmart

context:
- __tripped / slipped / lost balance __alleged assault
- __became dizzy / fainted __bicycle (helmet? Y N)
- Fell from (standing position / from height)

Slipped on Spilled Paint @ Kmart by checkout stand

location of pain/injuries:
head face mouth
neck chest abdomen
back upper mid- lower
radiating to R / L thigh / leg

–right–		–left–	
shldr	hip	shldr	hip
arm	thigh	arm	thigh
elbow	knee	elbow	knee
f-arm	leg	f-arm	leg
wrist	ankle	wrist	ankle
hand	foot	hand	foot

severity of pain:
mild
moderate
severe

associated symptoms:
- __lost consciousness / dazed
  - duration:
  - remembers: impact coming to hospital
- __seizure

ROS ☐all systems neg excpt as markd
- __loss feeling/power arms/legs
- __headache
- __double vision / hearing loss
- __trouble breathing / chest pain
- __nausea / vomiting
- __loss of bladder function
- __skin laceration
- __recent fever / illness

SOCIAL HISTORY __recent ETOH __smoker __drug abuse

PAST HISTORY negative
GB, ASTHMA, FIBROIDS D&C.
Truck Driver

Meds- __none / __see nurses note
Allergies- __NKDA / __see nurses note

01035-00329 QED
LINDLE, MARGARET
07/09/1960 MPI 000048582
ER SHORT FORM
SURGERY DATE-

01036-00376 QED
MOORE, EARTHY
F 05/15/1953 MPI 000087958
ER SHORT FORM
SURGERY DATE-

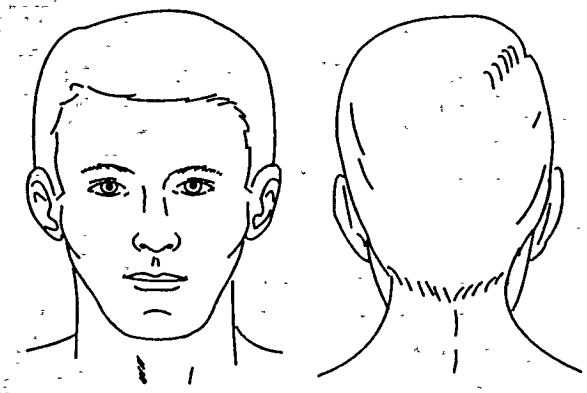
19 **Fall** (5)

☑Nurses note reviewed ☐Tetanus immun. UTD ☑Vital signs reviewed

PHYSICAL EXAM __Alert __Lethargic __Anxious
Distress- __NAD __mild __moderate __severe
Other- __c-collar (PTA / in ED) __back-board __IV __splint

HEAD
- __no evidence of trauma
- __see diagram
- __Battle's sign / Raccoon Eyes

NECK
- __non-tender
- __painless ROM
- __trachea midline
- __see diagram
- __vertebral point-tenderness
- __muscle spasm / decreased ROM
- __pain on movement of neck



EYES
- __PERRL
- __EOMI
- __unequal pupils R-____mm L-____mm
- __EOM entrapment / palsy
- __subconjunctival hemorrhage

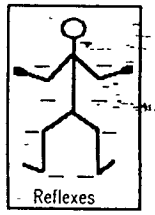
ENT
- __nml external inspection
- __no dental injury
- __hemotympanum
- __TM obscured by wax
- __clotted nasal blood
- __dental injury / malocclusion

RESP & CVS
- __chest non-tender
- __breath sounds nml
- __heart sounds nml
- __see diagram (on reverse)
- __decreased breath sounds
- __wheezing / rales
- __splinting / paradoxical movements

ABDOMEN
- __non-tender
- __no organomegaly
- __see diagram (on reverse)
- __tenderness / guarding / rebound
- __mass / organomegaly

GENITAL / RECTAL
- __nml genital exam
- __nml vaginal exam
- __nml rectal exam
- __heme negative stool
- __perineal hematoma
- __blood at urethral meatus
- __decreased rectal tone

NEURO / PSYCH
- __oriented x3
- __mood & affect
- __CN'S nml as tested
- __sensation & motor nml
- __confusion / disorientation
- __EOM palsy / anisocoria
- __facial asymmetry
- __unsteady / ataxic gait
- __sensory / motor deficit



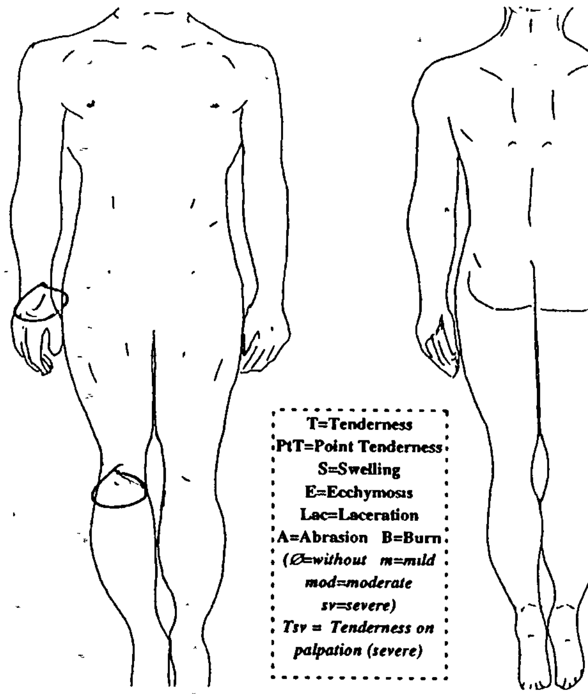
EMERGENCY PHYSICIAN RECORD
Emergency Care Center
Self Memorial Hospital

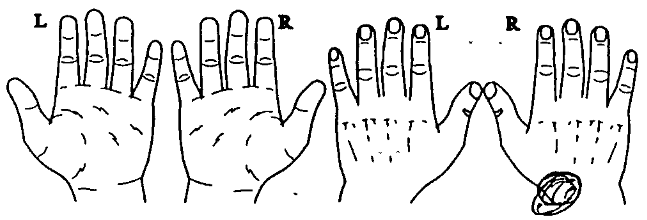
SKIN
__intact (checked) — __see diagram
__warm, dry (checked) — __crepitus / diaphoresis

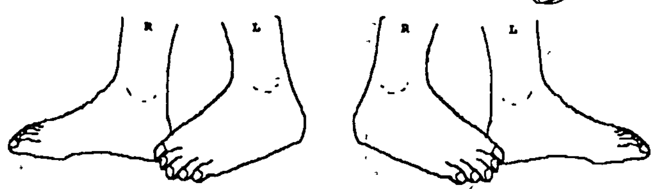
BACK
__no CVA tenderness (checked) — __see diagram
__no vertebral tenderness — __vertebral point-tenderness
__CVA tenderness
__muscle spasm / limited ROM

EXTREMITIES
__atraumatic — __see diagram (circled)
__pelvis stable — __bony point-tenderness (circled)
__hips non-tender — __painful / unable to bear weight (painful circled)
__no pedal edema — __pulse deficit
__nml ROM

Joint Exam:
__limited ROM / ligaments laxity / joint effusion







PROGRESS:
Thumb spica splint
(R) wrist
2° snuff box tenderness
fall on outstretched
(R) wrist

XRAYS ☐Interp. by me ☐Reviewed by me ☒Discsd w/radiologist

C-Spine *D-Spine* *LS-Spine*
__nml / NAD — __reversal / straightening of cerv. lordosis
__no fracture — __DJD / spondylosis / spurring
__nml alignment
__soft tissues nml

CXR
__nml / NAD — __rib fracture
__no infiltrates — __infiltrate / atelectasis
__nml heart size
__nml mediastinum

OTHER ☐See separate report
(R) wrist (R) elbow (R) knee
all negative Øfx ØFB/ØDisloc

__Discussed with Dr.
will see patient in: office / ED / hospital
__Counseled patient / family regarding:
lab results diagnosis need for follow-up
__Rx given __Admit orders written
__CRIT CARE- *30-74 min* *75-104 min* ____ *min*
__Prior records ordered
__Additional history from:
family caretaker paramedics

CLINICAL IMPRESSION: *Fall* (circled)

contusion (circled)		**sprain / strain**
head	wrist (circled) (R) / L	neck dorsal lumbar
face	hand R / L	
chest	hip R / L	
abdomen	thigh R / L	**concussion**
back	knee (circled) (R) / L	*with LOC* *w/o LOC*
shoulder R / L	leg R / L	
arm R / L	ankle R / L	
elbow (circled) (R) / L	foot R / L	**laceration**
forearm R / L		

Wound Description/Repair
length____**cm** **location**____
__superficial __SQ __muscle __linear __^stellate __^irregular
__clean __contaminated *moderately / *heavily*
distal NVT: __neuro & vascular status intact __no tendon injury
anesthesia: __local __digital block ____cc
__lidoc 1% 2% epi / bicarb __marcaine .25% .5% __LET
prep:
__Hibiclens / Betadine / H2O2 — __^debrided / undermined **extensively*
__irrigated / washed w/saline **extensively* — __foreign material removed *minimal moderate ^extensive*
__explored
repair: *Wound closed with:* *wound adhesive / steri-strips*
SKIN- #____ ____-0 nylon / prolene / staples / ethilon
*SUBCU-. #____ ____-0 vicryl / chromic
*may indicate intermediate repair ^may indicate intermediate or complex repair

x [signature] NP / PA x ____ MD
Resident
x [signature] MD
Attending

(T) 1635

Fall - 19

Patient Department:	ECC
Patient Diagnosis:	FALL INJURY, FALL INJURY
Patient Ht/Wt:	Unknown
Active Allergies:	Not Documented

*** NEW Order for RAD ***

Requisition Count: **1 of 1**

Order #	Order Description	Freq	Priority	Qty	Order Start	Order Stop
00004	XR ELBOW RIGHT COMPLETE	STAT	2	1	02/05/01 15:39	

Order Detail
1. **Ordering Diagnosis: FALL INJURY**
2. **Method of Transportation: NSG UNIT TO CALL**

Order Comments: **28 5714**

Ordered by	Entered by	Entered date
MD VAUGHN, KENNETH W	1USTC (US/ POWELL, LINDA B	02/05/01 15:39

Scheduled for: **02/05/01 15:39**

Requisition #: **229308**

Session #: **545502**

Occurrence #: **2697490 PCM**

Placer #: **2697489 PCM**

******* INSTANT BILL *******

ACCT: 509047 DATE: 05/10/01

PIEDMONT HEALTH GROUP, LLC
103 LITTLE MOUNTAIN RD
NINETY SIX, SC 29666

LAST PAYMENT		YTD PAY
03/13/01	$45.00	$170.00

OFFICE PH:864-543-3515 HOME PH:864-943-0940 BUSINESS PH:800-524-1101
SSN:247-11-7562

PAT NAME	APPOINTMENT
EK EARTHY M. MOORE	

EARTHY M. MOORE
PO BOX 1463
GREENWOOD, SC 29648

DIAGNOSIS

1-924.5 CONTUSION
2-719.43 WRIST PAIN
3-465.9 UPPER RESPIRATORY INFECT.
4-472.0 RHINITIS

HCH DOCTOR	SSN#	TAX ID	MEDICAID	PROVIDER
13 OLIVER THOMAS WILLARD	247806582	571040510	084161	571040510002

DATE	DR	PAT	DIAG	TCODE	MOD	DESCRIPTION	CHARGE	CREDIT	BALANCE
02/07/01	13	EK	12	99213		EST. EXPANDED OFFI	53.00		53.00
02/07/01	13	EK		1		CASH PAYMENT		45.00	8.00
** APPLIES TO CHARGES ON:02/07/01									
02/07/01- 02/07/01	13	EK		109C		PAYMENT DISCOUNT		8.00	0.00
02/12/01	13	EK	32	99213		EST. EXPANDED OFFI	53.00		53.00
02/12/01	13	EK		1		CASH PAYMENT		45.00	8.00
** APPLIES TO CHARGES ON:02/12/01									
02/12/01- 02/12/01	13	EK		109C		PAYMENT DISCOUNT		8.00	0.00
02/19/01	13	EK	2	99212		ESTABLISHED FOCUSE	41.25		41.25
02/19/01	13	EK		1		CASH PAYMENT		35.00	6.25
** APPLIES TO CHARGES ON:02/19/01									
02/19/01- 02/13/01	13	EK		109C		PAYMENT DISCOUNT		6.25	0.00
03/13/01	13	EK	4	99213		EST. EXPANDED OFFI	53.00		53.00
03/19/01	13	EK		1		CASH PAYMENT		45.00	8.00
** APPLIES TO CHARGES ON:03/19/01									
03/19/01- 03/19/01	13	EK		109C		PAYMENT DISCOUNT		8.00	0.00

TOTAL: $0.00

MESSAGES

* The Balance shown may not be the entire Account Balance.
It only reflects the transactions listed on this statement.

not related

Earthy Moore
DOB: 05/15/53
09/05/00

Last period was about 3 weeks ago. Has had some discharge since then, a little bit of irritation. Intermittently she's had some adnexal discomfort. On exam B/P 130/88. Wt up 8 lbs at 180. She is AF. There is vaginal erythema, thin discharge. Did not see any vesicles but she had tenderness on insertion of the speculum Milder tenderness in the adnexal areas bilaterally & only slightly tender on manipulation. Wet prep revealed clue cells, large number of bacteria, & yeast. Will treat with Diflucan 150 qd x 2 & Flagyl 500 mg bid for 7 days. She is due a PE & plans to get in for that in the near future.

Oliver T. Willard, MD

Earthy Moore
DOB: 05/15/53
02/07/01

Here for injuries. She was in K-Mart on Monday, 2 days ago, around 1:00 PM. Slipped on some paint that had spilled from a paint can out onto the floor. Fell. Was not sure of the mechanism of injury, how she landed & such, but had discomfort in her right wrist, right elbow, & right knee primarily. She went to the ER where she understands a hairline fracture was seen in her wrist. She was placed in a splint & is here today for F/U. She was given some Hydrocodone & Relafen, taking the Hydrocodone as a night time item. Still is a little sore in her buttocks area & the right knee. Right forearm is uncomfortable when she presses grips with her right hand. Still is wearing her splint. Her work involves fairly heavy activity driving a truck & handling equipment & such. Got copies of her x-ray reports from the hospital revealing no evidence of fracture of any of these sites. There was slight scalloping along the mid lateral border of the navicular but it was thought to represent normal variance. For the most part she seems to be gradually mending. Mild discomfort in the right knee but no effusion. Flexes & extends without pain. Is able to weight bear. The thumb immobilized in the splint, moves her fingers well. I think it would be wise for her to forgo the heavy activity her work involves for now. Gave her an excuse for being out of work this week. Will re-eval next week. Talked to her about the potential need for repeating x-rays or even bone scan to find navicular injuries which can be subtle. See how things look when she returns.

Oliver T. Willard, MD

PHONE MESSAGE Illness ☐ Injury ☐ Refill ☐ Test Results ☐ URGENT ☐

Patient Name: Earthe Moore
Caller: S
Date of Birth: 5-15-53
Doctor: W
Date: 2/14/01
Home Phone: 993-0946
Work or Other Phone:
Times Available or Call By:
Pharmacy: CVS-Bypass

Message: What else can she do for her wrist, in alot of pain

Reply: Send for bone scan of wrist R/O Fx then see
ACN/10 #15 ī T/Ø
1) 11:35
to CVS/BP

Name & Time: WA 11:22
Message Taken

Doctor Action

has this been called yet?
I just got pharamacy

Nurse Completion

Earthy Moore
DOB: 05/15/53
02/12/01

Here for a couple of items. One, she has developed a head cold or head congestion at least with some drainage. Not much in the way of bitter taste to this, not discolored, mostly clear thus far rhinorrhea. No fever with it. A little bit of cough associated with it. On exam B/P 134/88. Wt 180. AF. No real tenderness over the frontal or maxillary sinuses. Pharynx does not appear to be inflamed Place her on some Allegra for this. F/U if she gets any worse. Meanwhile on her injuries she feels much better in terms of the right wrist. Splint was removed today. She has a little bit of tenderness along the extensor tendon mechanism from the thumb into the forearm but is able to oppose thumb to fingers. Has grip with mild discomfort. Has some stiffness in the wrist & thumb that I think will be better served by allowing ROM at this point. Don't think she is ready to return to handling an 18 wheeler just yet. Will let her stay out this week. Will check next week & probably give clearance to return to work If her tenderness is persistent may need to consider occult fracture.

Oliver T. Willard, MD

Earthy Moore
DOB: 05/15/53
02/19/01

Here for pain right wrist. She has cont to make progress with her wrist. Feels more comfortable wearing a little bit of ACE wrap around it for support. Has improved to the point that she can lift overhand & palm up & palm down reasonably well though there is some discomfort along the anterior aspect of the wrist near the radial side. Bone scan was performed last week finding no evidence of occult fracture. That is on a telephone report, hard copy is not back yet. She is anxious to get back to work. B/P is up a few points today but she thinks it is because of the stress of injury & being out. She believes that she can handle her job at this time. She is advised that the Darvocet N 100 can cause positive urine drug test, will be watchful of that & F/U if this isn't working out to return to her job. Otherwise see her back in about 4 weeks for recheck.

Oliver T. Willard, MD

Earthy Moore
~~DOB: 05~~/15/53
03/19/01

Here for several items. Has had some head congestion of late, believe the pollen may be a provocative factor for her. She drives up & down the seaboard as a long distance trucker from still ice bound north back to the south where it is sometimes warmer. That may be stirring up a bit as well. She has taken some Tylenol Sinus this morning & pressure is up a little from what she normally runs at 140/96 & that might be relevant. Nose a little bit congested but chest is clear. Weight is stable. She is AF. Will treat that with some Flonase & Allegra plain. Samples & Rx for both given. Might want to check her pressure in a month & see how that is running. Meantime right wrist & knee both feel much better. She had a fair amount of pain with her right wrist for the first week back on the road but now is almost pain free. Similarly the right knee was painful for a bit but it is better. She has good grip strength & no tenderness about the wrist now or the knee that I could find. Pleased with how those have healed up, hope she cont to do well. She observed that she doesn't heal as quickly now as in the past.

TRC 3 23 01

Oliver T. Willard, MD

UPPER SAVANNAH R[illegible]OLOGY ASSOC

PO BOX 1207
GREENWOOD SC 29648

FORWARDING SERVICE REQUESTED

STATEMENT

PATIENT NAME	
EARTHY MOORE	
ACCOUNT NUMBER	STATEMENT DATE
103600376	04-06-01
AMOUNT DUE	AMOUNT PAID
92.00	

MAKE CHECKS PAYABLE TO:

103600376
EARTHY MOORE
PO BOX 1463
GREENWOOD, SC 29646

UPPER SAVANNAH RADIOLOGY ASSOC
PO BOX 1207
GREENWOOD SC 29648

THIS IS FOR THE RADIOLOGIST SERVICES @ SELF MEMORIAL HOSPITAL

PLEASE DETACH AND RETURN THIS PORTION WITH PAYMENT

DATE	CPT	PL	TYPE	DESCRIPTION	DIAGNOSIS	UNITS	AMOUNT
02-05-01	73080	23	4	ELBOW COMPLETE MIN 3 VWS	718.82	1	32.00
04-05-01				APPLIED TO DEDUCTIBLE Amt 32.00			
02-05-01	73564	23	4	KNEE COMP W/OBL	718.86	1	32.00
04-05-01				APPLIED TO DEDUCTIBLE Amt 32.00			
02-05-01	73110	23	4	WRIST COMPLETE	718.83	1	28.00
04-05-01				APPLIED TO DEDUCTIBLE Amt 28.00			
02-20-01				STATEMENT MAILED			
02-27-01				SUBMITTED TO YOUR INS CO			
				COMCAR INDUSTRIES			

PATIENT NAME	ACCOUNT NUMBER	STATEMENT DATE	AMOUNT DUE
EARTHY MOORE	103600376	04-06-01	92.00

PROMPT PAYMENT ON YOUR ACCOUNT IS APPRECIATED!

UPPER SAVANNAH RADIOLOGY ASSOC

Fed Tax Id# 57-0610627
Referred by VAUGHN KENNETH W

BILLING QUESTIONS, PLEASE CALL 864-943-2170 9:00 AM TO 4:00 PM

SELF MEMORIAL HOSPITAL
Greenwood, S.C.

DEPARTMENT OF RADIOLOGY

Patient Name: MOORE,EARTHY
Unit Number: A000087958
Check-in Date: 02/05/01 1520
Location: DIS - ED

Account # 0103600376 BD: 05/15/53 Age: 47Y Sex: F

Ordering Physician MOUNTS,WAYNE S Admit Phys:VAUGHN,KENNETH W

MOUNTS,WAYNE S
718B MONTAGUE AVENUE
GREENWOOD SC 29649-0000

VAUGHN,KENNETH W
718B MONTAGUE AVENUE
GREENWOOD SC 29646

Chk-in #	Order	Exam	
116633	0002	68989	XR WRIST RIGHT COMPLETE

Ord Diag: PT FELL

RIGHT WRIST 02-05-01

Indication: Injury evaluation.

No fracture or dislocation is identified. Slight scalloping alone the mid lateral border of the navicular bone is felt to represent the normal neck region and there is no evidence of an acute angulation to suggest a fracture.

Impression: No evidence of fracture.

Read By: ROGER F BLEY M.D.
Released By: JOHN W MCALHANY JR M.D.

02/05/01 2109
JPS

FINAL DUPLICATE

SELF MEMORIAL HOSPITAL
Greenwood, S.C.

DEPARTMENT OF RADIOLOGY

Patient Name: MOORE,EARTHY
Unit Number: A000087958
Check-in Date: 02/05/01 1604
Location: DIS - ED

Account # 0103600376 BD: 05/15/53 Age: 47Y Sex: F

Ordering Physician *VAUGHN,KENNETH W* *Admit Phys:VAUGHN,KENNETH W*

VAUGHN,KENNETH W
718B MONTAGUE AVENUE
GREENWOOD SC 29646-0000

VAUGHN,KENNETH W
718B MONTAGUE AVENUE
GREENWOOD SC 29646

Chk-in #	Order	Exam	
116662	0003	68862	XR ELBOW RIGHT COMPLETE

Ord Diag: FALL INJURY

Right elbow 02-05-01

INDICATION: Fall injury.

No fracture or dislocation is identified. There is no abnormal fat pad seen.

Impression: Normal elbow.

Read By: ROGER F BLEY M.D.
Released By: JOHN W MCALHANY JR M.D.

02/05/01 2109
JPS

FINAL DUPLICATE

SELF MEMORIAL HOSPITAL
Greenwood, S.C.

DEPARTMENT OF RADIOLOGY

Patient Name: MOORE,EARTHY
Unit Number: A000087958
Check-in Date: 02/05/01 1520
Location: DIS - ED

Account # 0103600376 BD: 05/15/53 Age: 47Y Sex: F

Ordering Physician MOUNTS,WAYNE S Admit Phys: VAUGHN,KENNETH W

MOUNTS,WAYNE S
718B MONTAGUE AVENUE
GREENWOOD SC 29649-0000

VAUGHN,KENNETH W
718B MONTAGUE AVENUE
GREENWOOD SC 29646

Chk-in #	Order	Exam	
116630	0001	68924	XR KNEE RIGHT COMPLETE

Ord Diag: PT FELL

RIGHT KNEE 02-05-01

Indication: Injury evaluation.

Normal knee.

Read By: ROGER F BLEY M.D.
Released By: JOHN W MCALHANY JR M.D.

02/05/01 2109
JPS

FINAL DUPLICATE

UPPER SAVANNAH R. OLOGY ASSOC

PO BOX 1207
GREENWOOD SC 29648

FORWARDING SERVICE REQUESTED

TATEMENT

PATIENT NAME	
EARTHY MOORE	
ACCOUNT NUMBER	STATEMENT DATE
104700105	04-17-01
AMOUNT DUE	AMOUNT PAID
62.46	

MAKE CHECKS PAYABLE TO:

104700105
EARTHY MOORE
PO BOX 1463
GREENWOOD, SC 29646

UPPER SAVANNAH RADIOLOGY ASSOC
PO BOX 1207
GREENWOOD SC 29648

THIS IS FOR THE RADIOLOGIST SERVICES @ SELF MEMORIAL HOSPITAL

PLEASE DETACH AND RETURN THIS PORTION WITH PAYMENT

DATE	CPT	PL	TYPE	DESCRIPTION	DIAGNOSIS	UNITS	AMOUNT
02-16-01	78300	22	4	BONE IMAGING LIMITED	V71.9	1	112.00
04-16-01				INSURANCE PAYMENT			-49.54
				COMCAR INDUSTRIES			
04-16-01				APPLIED TO DEDUCTIBLE Amt 50.07			
04-16-01				APPLIED TO CO-INS Amt 12.39			
02-28-01				SUBMITTED TO YOUR INS CO			
				COMCAR INDUSRTIES			
04-14-01				INSURANCE REFILED			
				COMCAR INDUSRTIES			
04-14-01				PRI INS FILED - NO PAYMT REC'D			

PATIENT NAME	ACCOUNT NUMBER	STATEMENT DATE	AMOUNT DUE
EARTHY MOORE	104700105	04-17-01	62.46

UPPER SAVANNAH RADIOLOGY ASSOC

Fed Tax Id# 57-0610627
Referred by WILLARD OLIVER T

BILLING QUESTIONS, PLEASE CALL 864-943-2170 9:00 AM TO 4:00 PM

SELF MEMORIAL HOSPITAL
Greenwood, S.C.

DEPARTMENT OF RADIOLOGY

Patient Name: MOORE,EARTHY Check-in Date: 02/16/01 1000
Unit Number: A000087958 Location: DIS - OP

Account # 0104700105 BD: 05/15/53 Age: 47Y Sex: F

Ordering Physician WILLARD,OLIVER T Admit Phys:WILLARD,OLIVER T

WILLARD,OLIVER T 110 LINER DRIVE	WILLARD,OLIVER T 110 LINER DRIVE
GREENWOOD SC 29646	GREENWOOD SC 29646

Chk-in #	Order	Exam	
119625	0001	71010	NM BONE SCAN LIMITED

Ord Diag: R/O FX RT WRIST

LIMITED BONE SCAN OF THE HANDS AND WRISTS 2/16/01

Indication: Painful right wrist with history of trauma - evaluate for occult fracture.

The patient was injected with 20 mCi. of 99m Technetium Osteolite intravenously. Images of the hands and wrists were obtained in anterior, posterior and lateral projections.

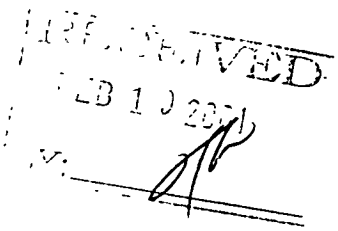
Bone activity in both hands and wrists is normal. There is no focal abnormal activity to suggest the presence of an occult fracture.

IMPRESSION:

No evidence of occult fracture.

Read By: CHARLES F COLBY M.D.
Released By: WILLIAM C KITCHENS JR M.D.

02/16/01 2201
AH



FINAL

SELF MEMORIAL HOSPITAL
Greenwood, S.C.

DEPARTMENT OF RADIOLOGY

Patient Name: MOORE,EARTHY
Unit Number: A000087958
Check-in Date: 02/16/01 1000
Location: DIS - OP

Account # C104700105 BD: 05/15/53 Age: 47Y Sex: F

Ordering Physician: WILLARD,OLIVER T Admit Phys:WILLARD,OLIVER T

WILLARD,OLIVER T
110 LINER DRIVE
GREENWOOD SC 29646

WILLARD,OLIVER T
110 LINER DRIVE
GREENWOOD SC 29646

Chk-in #	Order	Exam	
119625	0001	71010	NM BONE SCAN LIMITED

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IMPRESSION:

No evidence of occult fracture.

Read By: CHARLES F COLBY M.D.
Released By: WILLIAM C KITCHENS JR M.D.

02/16/01 2201
AH

FINAL DUPLICATE