[redacted] 1-Rpt #135888246-ORT-ER-1/13/2013

DOCUMENT (1)

Nurse's Notes

John T. Mather Memorial Hospital

Name: [redacted]
Age: 90 years Sex: Female DOB: 05[redacted]
Arrival Date: 01/13/2013 Time: 21:28
Bed: XT22
Diagnosis: Thoracic Spine Sprain; Bruised ribs

MRN: 000000794138
Account#: 000135888246
Private MD: Lin, Matthew

Presentation:

01/13 21:28 Method of Arrival: Walk-In. jg

21:32 Presenting complaint: Patient states: Daughter in law states that she found pt on the floor last night at approx 11:30 pm. It was noted pt had scrape on her right mid back with pain in the rib area. (-) head injury, neck pain, lower back pain, LOC, vomiting, nausea. Acuity: ESI - 3. Method of arrival: In a wheelchair. mt

21:41 Acuity: Level 3. mt

Triage Assessment:

21:40 **General:** Appears well developed, well groomed, well nourished. **Pain:** Patient reports pain. Complains of pain in right mid lateral back Intensity currently is 2 out of 10 on a pain scale. mt

Historical:

- **Allergies:** PENICILLINS; SULFA (SULFONAMIDES); Demerol;
- **Home Meds:**
  1. Miralax Oral
  2. Keppra Oral
  3. Vicodin Oral as needed
  4. Lopressor Oral
  5. calcitriol Oral
  6. citrate of magn as needed
  7. Remeron Oral
  8. Vitamin D Oral
  9. vitamin b12
  10. Valium Oral as needed
  11. Amitiza Oral
  12. Prednisone Oral
  13. levothyroxine Oral
- **PMHx:** Hyperlipidemia; Hypothyroidism; Pseudo gout; DVT; Depression; Meningioma on Right; TIA; CAD; Seizures; constipation; renal insufficiency; Hypertension; hyperparathyroidism; Dementia; Hyperlipidemia
- **PSHx:** Appendectomy; Carpal Tunnel Repair; Cataract Surgery; finger surgery; Hysterectomy
- **Immunization history::** Seasonal flu vaccine; Flu vaccine is up to date. Last tetanus immunization: unknown Pneumococcal vaccine status is unknown..
- : Patient has a Health Care Proxy. Name of Health Care Proxy: [redacted] Health Care Proxy's phone number: [redacted]. Patient does not have DNR..
- **Family history::** denies family history of similar symptoms recently,.
- **Social history::** The patient lives with family,.
- **Bariatric Surgery::** No..
- **The history from nurses notes was reviewed:** and I agree with what is documented..

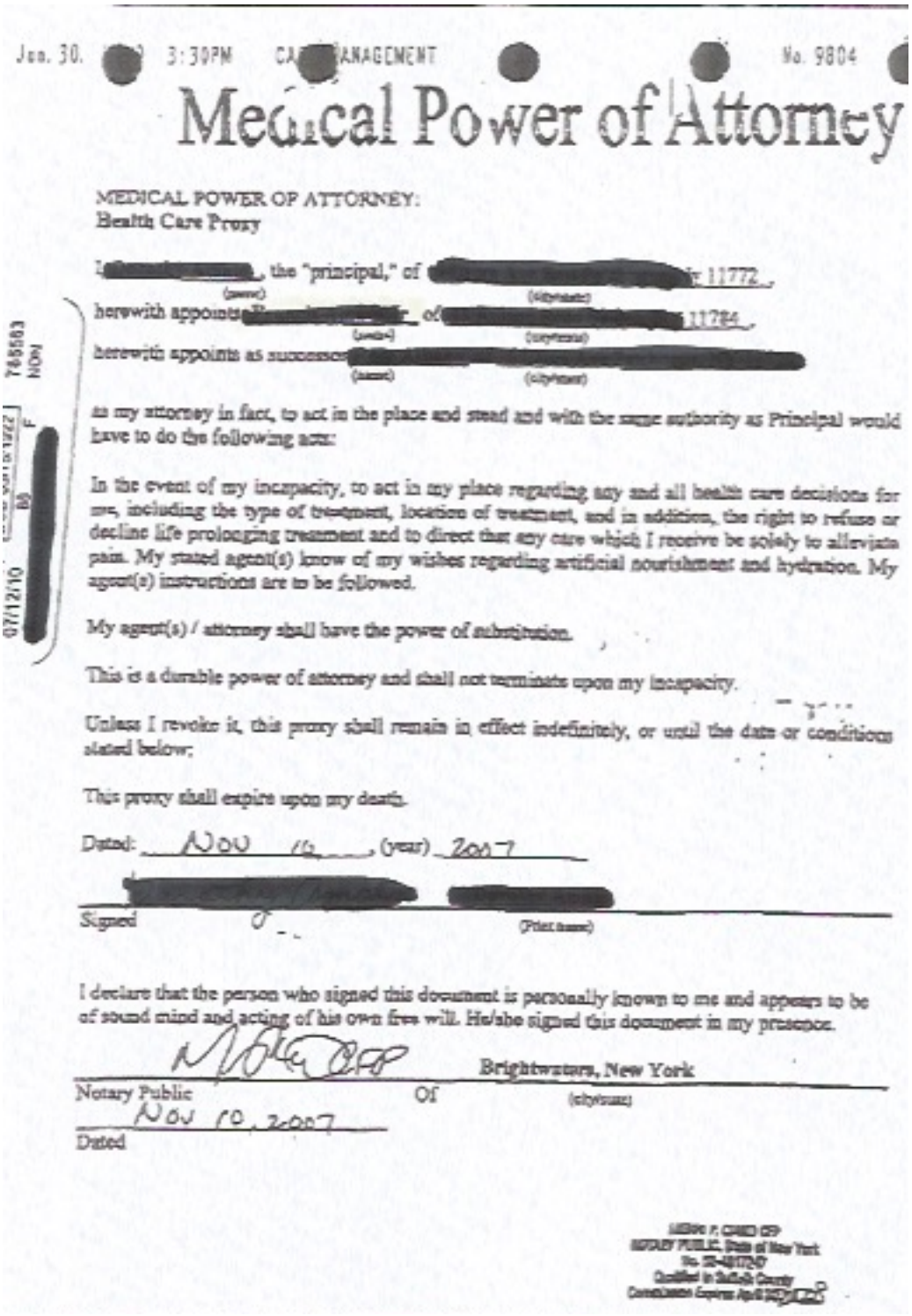
Screening:

23:48 **Abuse screen:** kac
No signs of abuse.
Nutritional screening:
No deficits noted.

Print Time: 1/15/2013 14:18:28

*** CHART COMPLETE ***

My mothers original HCP as documented by Mather Hospital on 1/13/13 and 1/14/13.



Jan. 30. [redacted] 3:39PM CA[redacted]ANAGEMENT No. 9804

Medical Power of Attorney

MEDICAL POWER OF ATTORNEY:
Health Care Proxy

I [redacted], the "principal," of [redacted] r 11772,
(name) (city/state)

herewith appoints [redacted] of [redacted] 11784,
(name) (city/state)

herewith appoints as successor [redacted]
(name) (city/state)

as my attorney in fact, to act in the place and stead and with the same authority as Principal would have to do the following acts:

In the event of my incapacity, to act in my place regarding any and all health care decisions for me, including the type of treatment, location of treatment, and in addition, the right to refuse or decline life prolonging treatment and to direct that any care which I receive be solely to alleviate pain. My stated agent(s) know of my wishes regarding artificial nourishment and hydration. My agent(s) instructions are to be followed.

My agent(s) / attorney shall have the power of substitution.

This is a durable power of attorney and shall not terminate upon my incapacity.

Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below:

This proxy shall expire upon my death.

Dated: Nov 10, (year) 2007

[redacted]
Signed (Print name)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his own free will. He/she signed this document in my presence.

Notary Public Brightwaters, New York
Of (city/state)

Nov 10, 2007
Dated

[redacted]
NOTARY PUBLIC, State of New York
No. [redacted]
Qualified in Suffolk County
Commission Expires [redacted]

Mather Hospital requesting my signature for my mother after I provided a copy of her Health Care Proxy on 1/13/13.

[redacted] T-Enc #135888246-ODT-ER-1/13/2013

Discharge Instructions for: Dorothy Amato

DISCHARGE INSTRUCTIONS	FORMS
Thoracic Strain RICE, with Fields	Medication Reconciliation
FOLLOW UP INSTRUCTIONS	**PRESCRIPTIONS**
Private Physician When: 2 - 3 days Reason: Recheck today's complaints	Vicodin 5-500 mg Oral Tablet Take 1 tablet(s) by ORAL route every 6 hours as needed; Quantity: 20 tablet(s)

TESTS AND PROCEDURES

Labs
None

Rad
Ribs 1 Side Xr Rt, CHEST XRAY, Thoracic Spine Xr, Cervical Spine Complete

Procedures
None

Other
None

SPECIAL NOTES

Please take tylenol over the counter as directed for pain.

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any). I acknowledge that failure to follow-up with the above doctors as directed will release the emergency department physicians of any responsibility for any adverse outcome or worsening of my condition. I also understand that my signature authorizes John T. Mather Memorial Hospital to release all or any part of my medical record (including, if applicable, information pertaining to AIDS/HIV testing, mental health records, and drug/alcohol treatment) to the referred physician(s) listed above.

D[redacted]
MRN # 000000794138
ACCT # 000135888246

ED Physician or Nurse

Date 1/13/13

Chart Copy

Health Care Proxy that was sent to me.

[redacted] MR# 794138

(5) **Your Identification** *(please print)*

Your Name [redacted]

Your Signature [redacted] Date [redacted]

Your Address [redacted] DR Bldg [redacted] Port Jefferson NY 11777

(6) **Optional: Organ and/or Tissue Donation**

I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)

[redacted] 794138 02/09/2013

[redacted] DR BLG [redacted] DIMOS

PORT JEFFERSON NY 11777

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues [redacted]

☐ Limitations [redacted]

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature [redacted] Date [redacted]

(7) **Statement by Witnesses** *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date 1/31/13 Date 1/20/13

Name of Witness 1 *(print)* [redacted] Name of Witness 2 *(print)* [redacted]

Signature [redacted] Signature [redacted]

Address [redacted] Address [redacted]

Middle Island NY 11953 Babylon NY

State of New York
Department of Health

1450 2/02

Health Care Proxy

(1) I, Dorothy [redacted]

hereby appoint [redacted] Joanne Sapio

(name, home address and telephone number)

[redacted] Parade Drive Bldg [redacted]

Port Jefferson, NY 11777 [redacted]

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) **Optional: Alternate Agent**

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint [redacted] Rose Albano

(name, home address and telephone number)

[redacted] Pinnacle Drive Bldg [redacted]

Port Jefferson, NY 11777 631 [redacted] 3145

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: N/A

(4) **Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: DNR order to be in place

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydrat

135968569 794138 01/30/2013

[redacted] P

05/15/[redacted] S. [redacted]

[redacted] DR BLG [redacted]

PORT JEFFERSON NY 11777

A closer look at the witness signature dates stated to be 1/30/13 and 1/31/13.

1/31/13

7) **Statement by Witnesses** (*Witnesses must be 18*
agent or alternate.)

I declare that the person who signed this documen
sound mind and acting of his or her own free will.
her) this document in my presence.

Date 1/31/13

Below 1/30/13?

years of age or older and cannot be the health care

t is personally known to me and appears to be of
He or she signed (or asked another to sign for him or

Date 1/30/13