



series of frauds in the Estates and Trusts of Simon and Shirley Bernstein and this is a case of extra-ordinary and exceptional circumstances of statewide and public importance as it relates to the conduct of Fiduciaries and attorneys in Estate and Trust matters and for the detriment to proper beneficiaries and the rule of law in the State of Florida.

5. The Order of the Court below is both a fraud upon the Court and by the Court amounting to a fraudulent and criminal theft and conversion of substantial assets where no proper compliance with the Statutory requirements under Florida law for proper Accountings by Fiduciaries and attorneys has occurred.
6. Appellant has already exposed direct criminal frauds, including Proven and Admitted Fraud Upon the Court by Court Appointed Officers/Lawyers and Fiduciaries in the related cases in the Lower Tribunal including but not limited to admitted criminal conduct of six counts of forgery and fraudulent notarizations on Estate and Trust documents by one Kimberly Moran, notary public and employee at the now defunct law firm of Tescher & Spallina, PA and further criminal conduct in the creation and dissemination of a Fraudulent Shirley Bernstein Trust that changed beneficiaries fraudulently and has been admitted to by Fiduciary and attorney (acting as counsel on Ted Bernstein's behalf as Fiduciary) Robert Spallina, Esq. although such admissions by Spallina have not been prosecuted criminally at this time to the best of Appellant's knowledge, despite Spallina's

admitting such felony criminal acts as a witness in a December 15, 2015 hearing before the lower court.

7. Appellant has further provided and shown prima facie proof of further direct false conduct and fraudulent pleadings by attorney Alan Rose both in the lower tribunal and before this Court, the 4th DCA, although this Court has yet to fulfill legal obligations under law to address the frauds and misconduct and Appellant again respectfully pleads this Court to comply with such Court obligations and further obligations under the Statewide Court Fraud policy<sup>1</sup>, FL Attorney Conduct Code, Judicial Canon and Law to report and regulate Fraud, Waste and Abuse of Court Resources by Court Officers and Court Appointed Officers under its jurisdiction.
8. While proper and full Discovery has never occurred or been complied with in the related cases despite multiple requests by Appellant, nonetheless the volume of documents and records in the related cases that Appellant must continually review to check and cross-check and verify and re-verify due to continuing and ongoing frauds including but not limited to documentary frauds exceeds over 10,000 ( ten-thousand ) pages.
9. The Order on Appeal herein is further defective for the lack and absence of any proper due process hearings and/or evidentiary hearings and further being

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<sup>1</sup> September 27, 2012 Office of the State Court Administrator - State Court Systems Fraud Policy {  
HYPERLINK

"<http://iviewit.tv/Simon%20and%20Shirley%20Estate/20120927%20Florida%20State%20Courts%20System%20Fraud%20on%20the%20Court%20Policy%20Procedure.pdf>" \h }

conducted by a now retired Judge of the lower Court who should have mandatorily disqualified and is further the product of actions by fiduciaries and counsels who should have been removed and disqualified for their involvement in Fraud Upon the Court and more.

10. Appellant has further been addressing true “life threatening” medical issues (See Exhibit 1 - Medical Records) during the relevant time that this Appeal became due and was under express Medical instructions by a licensed Florida Doctor to avoid stress during the timeframe of October 2016 through December 2016 and yet has been forced to address repeated “sharp practices” by counsel, fraudulent pleadings, and coordinated abusive motion practice despite the fact that proper adjudication of the Estates and Trusts herein would have provided funds for proper Counsel for Appellant and the minor children herein who have been repeatedly denied counsel in the various cases and where prior counsel retained by Appellant either were “bullied” off the case by misconduct of the parties herein or turned out to have conflicts and be working with some of the parties herein.
11. Appellant has upcoming medical appointments relating to the same medical conditions in January of 2017.
12. Appellant incorporates and attached by reference herein a list of the various motions and pleadings and related Documents and transcripts and records that Appellant has had to address during the relevant timeframes for this Appeal and

pre-dating the Order starting on or around June of 2016 up through November of 2016 and does not include those motions and filings for December of 2016 nor those pre-dating June 16, of 2016.

13. Said list is incorporated herein to further demonstrate Appellant's good faith in requesting an extension herein and to show due diligence in prosecuting all of the various cases to date. It is noted that such list contains Hyperlinks so the Court or parties may review the involved motion, pleading or filing etc., all fully incorporated by reference in entirety herein. See, List below:

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[20160711 MOTION FOR ONE DAY EXTENSION INITIAL BRIEF FILING 4THDCA and Draft Brief ECF STAMPED COPY.pdf](#)

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}

WHEREFORE, it is respectfully prayed for an Order granting an Extension of time to submit the Initial brief herein of 45 days from today's date but no less than at least 30 days from today's date and for such other and further relief as to this Court may seem just and proper.

Respectfully submitted,

Dated January 9, 2017

**/s/ Eliot Ivan Bernstein**

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**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that a copy of the within has been served upon all parties on the attached Service List by E-Mail Electronic Transmission, Court ECF on this 9th day of January, 2017.

**/s/ Eliot Ivan Bernstein**

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<p>Gary R. Shendell, Esq.  Kenneth S. Pollock, Esq.  Shendell &amp; Pollock, P.L.  2700 N. Military Trail,  Suite 150  Boca Raton, FL 33431  (561)241-2323 - Telephone (561)241-2330-Facsimile  Email: gary@shendellpollock.com  ken@shendellpollock.com  estella@shendellpollock.com  britt@shendellpollock.com  grs@shendellpollock.com</p>	<p>Counter Defendant  Robert Spallina, Esq.  Donald Tescher, Esq.  Tescher &amp; Spallina  925 South Federal Hwy., Suite 500  Boca Raton, Florida 33432</p>
<p>Brian M. O'Connell, Esq.  Joielle A. Foglietta, Esq.  Ciklin Lubitz Martens &amp; O'Connell  515 N. Flagler Dr., 20th Floor  West Palm Beach, FL 33401  561-832-5900-Telephone  561-833-4209 - Facsimile  Email: boconnell@ciklinlubitz.com;  ifoglietta@ciklinlubitz.com;  service@ciklinlubitz.com;  slobdell@ciklinliibitz.com</p>	<p>Counter Defendant  John J. Pankauski, Esq.  Pankauski Law Firm PLLC  120 South Olive Avenue  7th Floor  West Palm Beach, FL 33401  courtfilings@pankauskilawfirm.com  john@pankauskilawfirm.com</p>
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<p>Theodore Stuart Bernstein  880 Berkeley  Boca Raton, FL 33487</p>	<p>Counter Defendant  TESCHER &amp; SPALLINA, P.A..  Wells Fargo Plaza</p>

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Estate of Simon Bernstein	Counter Defendant

<p>Brian M O'Connell Pa  515 N Flagler Drive  West Palm Beach, FL 33401  boconnell@ciklinlubitz.com</p>	<p>Steven Lessne, Esq.  Gray Robinson, PA  225 NE Mizner Blvd #500  Boca Raton, FL 33432  steven.lessne@gray-robinson.com</p>
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<p>ADR &amp; MEDIATIONS SERVICES, LLC  Diana Lewis  2765 Tecumseh Drive  West Palm Beach, FL 33409  (561) 758-3017 Telephone  Email: dzlewis@aol.com  (Fla. Bar No. 351350)</p>	



**EXHIBIT 1 - MEDICAL RECORDS - VASOVAGAL**

WEST PALM BEACH NEUROLOGY, P.A.  
JAMAL A. HALIM, M.D.  
WELLINGTON RESERVE  
1035 SOUTH STATE ROAD 7, SUITE 214  
WELLINGTON, FL 33414-6137

(561) 422-1006 TEL.

(561) 422-1078 FAX

BATCH # MDI16012603027791054

DEA # \_\_\_\_\_

LIC. # ME85753

NAME Eliot Bernstein DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

TAMPER-RESISTANT SECURITY FEATURES LISTED ON BACK OF SCRIPT

Rx

11/7/16

Patient should avoid  
all types of stress  
till  
his ENT Evaluation  
on Dec 15, 16

Label

Refill NR 1 2 3 4 5

(Signature)

In order for the brand name product to be dispensed, the prescriber must write 'Medically Necessary' on the front of this prescription.



002934

6ANE0302779

## MEDISCRIPTS – TAMPER-RESISTANT SECURITY FEATURES

### STANDARD FEATURES:

- ✓ SAFETY-BLUE ERASE-RESISTANT BACKGROUND
- ✓ "ILLEGAL" PANTOGRAPH
- ✓ REFILL INDICATOR
- ✓ SERIALIZATION
- ✓ ARTIFICIAL WATERMARK ON BACK
- ✓ MICROPRINTING

### ADDITIONAL FEATURES (where applicable):

- ✓ QUANTITY CHECK-OFF BOXES (optional in some states)
- ✓ UNIQUE TRACKING IDENTIFICATION NUMBER (FL)
- ✓ THERMOCHROMIC APPROVED STATE SEAL (WA)

WEST PALM BEACH NEUROLOGY, P.A.  
JAMAL A. HALIM, M.D.  
WELLINGTON RESERVE  
1035 SOUTH STATE ROAD 7, SUITE 214  
WELLINGTON, FL 33414-6137

(561) 422-1006 TEL.  
(561) 422-1078 FAX  
BATCH # MD116012603027791054

DEA # \_\_\_\_\_  
LIC. # ME85753

NAME Glenn Bernstein DOB \_\_\_\_\_  
ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

TAMPER-RESISTANT SECURITY FEATURES LISTED ON BACK OF SCRIPT

**R**

10/24/16

Patient should avoid  
all type of stren over  
the next 2 wks pending  
GN7 / swallowing  
evaluation for recurrent  
syncope

Label  
Refill NR 1 2 3 4 5

(Signature)

In order for the brand name product to be dispensed, the prescriber must write 'Medically Necessary' on the front of this prescription.

002750

6ANE0302779

Patient: Bernstein, Eliot  
MD ED: Cohen, Terry M.D.

DI Printed: 9/6/2016 1248  
RN Eval: Karen F R.N.  
RN Dispo: \_\_\_\_\_

**AFTERCARE INSTRUCTIONS**

We are pleased to have been able to provide you with emergency care. Please review these instructions when you return home in order to better understand your diagnosis and the necessary further treatment and precautions related to your condition. Your diagnoses and prescribed medications today are:

----- This page is not a prescription. -----

Dx 1: Fx L rib, closed  
Rx 1: Percocet Tablets 325mg,5mg (acetaminophen,oxycodone)  
1 tablet by mouth every 6 hrs as needed for pain

Orders performed during ED visit
Order
XR RIBS UNILATERAL LEFT

Procedures performed during ED visit
Procedure

**Follow Up Info**

Follow-up 1: Dr. Esener  
\_\_\_\_\_

F/U MD Ph: \_\_\_\_\_  
F/U MD Fax: \_\_\_\_\_

Specialty: \_\_\_\_\_

Follow-up 1 Date: As needed

Msg F/U MD: \_\_\_\_\_

**EKGs and X-Rays:** If you had an EKG or X-Ray today, it will be formally reviewed by a specialist tomorrow. If there is any change from today's Emergency Department reading, you will be notified.

**IMPORTANT NOTICE TO ALL PATIENTS:** The examination and treatment you have received in our Emergency Department have been rendered on an emergency basis only and will not substitute for definitive and ongoing evaluation and medical care. If you have an assigned physician, or physician of record, it is essential that you make arrangements for follow-up care with that physician as instructed. If you do not currently have a physician locally, please contact our Health Navigator at 561-955-4714 and they will assist you with scheduling an appointment. Report any new or remaining problems to your physician at your scheduled appointment, because it is impossible to recognize and treat all elements of injury or disease in a single Emergency Department visit. *Significant changes or worsening in your condition may require more immediate attention. The Emergency Department is always open and available if this becomes necessary.*

**General Information on BROKEN RIBS**

The ribs are long, thin bones that curve around each side of the chest. There are twelve ribs on each side. Any firm blow to the chest can break a rib(s). Most of the time this results from sports injuries, falls or motor vehicle accidents. Medically speaking, the words "broken", "cracked" and "fractured" all mean the same thing.

What are the symptoms?

Ordinarily there is a sharp pain in the chest, usually in the area of the broken rib(s). The pain is often worse with bending,



Emergency Department  
800 Meadows Road  
Boca Raton, FL 33486  
(561) 955-4425

Patient: Bernstein, Eliot  
Pt Acct: 1625001096  
Med Rcd: 000446213  
DI Printed: 9/6/2016 1248

lifting, deep breathing or any strenuous activity.

What can be done?

Simple rib fractures usually heal on their own within TWO TO SIX WEEKS. Splinting and other therapies used in the past have proven not to be helpful and are generally not recommended.

What are the risks?

Rib fractures usually heal completely and produce no serious medical problems. There are, however, some risks:

1. Because of the pain, many people with broken ribs avoid breathing deeply. Persistent, shallow breathing increases the risk of developing pneumonia.
2. A severe blow to the chest sometimes damages the lungs, heart, liver or spleen. This damage can be serious and is occasionally even life-threatening.

#### INSTRUCTIONS

- 1) Acetaminophen (Tylenol) or ibuprofen (Advil) will help ease the pain. **WARNING:** Do not take these drugs if you are allergic to them. Do not take these drugs if you are already taking a prescription pain medication that contains acetaminophen or ibuprofen.
- 2) Every two or three hours, while you are awake, take several deep breaths and cough. This will help keep your lungs well expanded. You can challenge yourself to take deep breaths by trying to blow up a balloon, or blow to knock down an empty paper cup. You should continue this routine until the pain is gone (usually two to six weeks).
- 3) Except for deep breathing, avoid any strenuous activity that makes your pain worse.
- 4) **SEEK IMMEDIATE MEDICAL ATTENTION** if you develop difficulty breathing, pain in the belly, vomiting, severe chest pain, persistent dizziness, cough up blood, pass out or if your condition worsens in any other way.



Emergency Department  
800 Meadows Road  
Boca Raton, FL 33486  
(561) 955-4425

Meds Review Printed: 9/6/2016 1248  
Patient: Bernstein, Eliot  
DOB: 9/30/1963  
Age: 52yr  
Pt Acct: 1625001096  
Med Rcrd: 000446213

1625001096

Medication Reconciliation

**MEDICATION RECONCILIATION (Discharge)**

MD ED: Cohen, Terry M.D.

PA: \_\_\_\_\_

Local P Esener

Triage: Fettner, Karen R.N.

RN Eval: Karen F R.N.

PMD Ph: \_\_\_\_\_

Allergies		
Allergic Substance	Reaction	Severity
NKDA		

Home Meds (Discharge Reconciliation)		
Arrival Medication	Instructions	Modified Medication
Lisinopril <unknown dose>	NO CHANGE - keep taking & ask your physician	

The table above shows the home medication(s) you are currently taking; information which was provided to the Emergency Department.

Read the last column (MD Review) for further medication instructions.

The list below shows any prescription(s) provided to you upon discharge from the Emergency Department.

**Prescription / Rx**

Rx 1: Percocet Tablets 325mg,5mg (acetaminophen,oxycodone)

1 tablet by mouth every 6 hrs as needed for pain

\*2060149564\*





BOCA RATON REGIONAL HOSPITAL  
Eliot Bernstein DOB:09/30/1963  
Patient:Bernstein, Eliot  
Mailing Address:2753 Nw 34Th Street  
City:Boca Raton  
State:FL Zip:33434  
Home Ph:(561)245-8588

EMERGENCY REPORT  
ACCT:1625001096 MRN:000446213

Arrival:9/6/2016 1132  
Registration Time:9/6/2016 1134  
Disposition:Home  
Condition at Disp:Stable  
Time Left ED:9/6/2016 1254

Mode of Arrival:Personal Transport  
Dispo Summary Printed:9/6/2016 1248  
Mode of Departure:Ambulatory  
Accompanied By:wife  
Diagnostic Eval:9/6/2016 1141  
Admit Decision:

Chief Cmplnt:Possible Broken Rib Per Pt  
Triage Impressi:Pain, Local  
Acuity:4 Pt weight:93 kg (205 lbs)  
Precautions:  
Ebola Exposure?No  
Travel Outside No

=====  
Allergies  
=====

Allergic Substance	Reaction	Severity
--------------------	----------	----------

NKDA  
=====

=====  
Home Medications (MDM)  
=====

Arrival Medication	Last Dose
--------------------	-----------

Lisinopril <unknown dose>  
=====

=====  
Past Medical History (Problem List)  
=====

Condition	Confirmed By
Kidney stone	Fettner, Karen R.N.
Diverticulitis	Fettner, Karen R.N.
HTN - Hypertension	Fettner, Karen R.N.
Multiple trauma	Fettner, Karen R.N.
Vasovagal syncope	Fettner, Karen R.N.
Cerebral hemorrhage after vasovagal syncope	Fettner, Karen R.N.

=====  
Past Surgical History (Procedures)  
=====

Procedure	Confirmed By
Lithotripsy	Fettner, Karen R.N.
Cystoscopy	Fettner, Karen R.N.
Reconstructive surgery face and neck, sp trauma	Fettner, Karen R.N.
Dental implants	Fettner, Karen R.N.
Tracheotomy	Fettner, Karen R.N.

## Meds Given-ED(If Blank-See Orders/Notes)

Medication	Dose	Route/SitRate	Start/GiEnd	Entered By
No Entries				

## Orders ED Record (MDM)

Order	Providers	Sched D/In	Prog	Comp	D/T
XR RIBS UNILATERAL LEFT	316-Cohen, Terry M.D.; same	9/6/201 6 1204	9/6/201 6 1218	9/6/201 6 1242	

## Clinical Alerts

Description	Origin	Result	Alert Text	Reason to CoDate T	User Name
No Entries					

## Vital Signs (MDM)

Sys Dia	PulResp	SAT O2	DelTemp	(Route	Pain	Scale	Taken at	User Name	
136	82	77	16	97% RA	97.7	oral	10/10	9/6/2016	Fettner, Karen R.N.
				F		Standard	1153		

## Input Output

Fluid Type	Intake	Output	I/O Time
No Entries			

## calls

Name	Requested By	Call 1	Returned
No Entries			

MD ED:Cohen, Terry M.D.  
PA:  
Triage Full:Fettner, Karen R.N.  
RN Eval Full:Fettner, Karen R.N.  
RN Dispo:Fettner, Karen R.N.

MD ED ID:316  
PA ID:  
Triage ID:32560  
RN Eval ID32560  
RN Dispo I

## EMS/PMD

LocalEsener

PMD Ph:

## RN Notes

Fettner, Karen R.N. Created: 9/6/2016 1154 Last Entry: 1200

>>>> HPI:  
Pain - Onset 16hrs prior to arrival. Occurred in left middle chest.  
(?)injury. Associated Symptoms:, pain left chest to touch or breathing.  
>>>> PMH List (See PMH Table) PSH List (See PSH Table)  
>>>> TRIAGE DATA:  
Travel outside US (<= Click to view/enter)  
Ebola Exposure (<= Click to view/enter)  
Last Tetanus: less than 10yrs.  
Pneumonia Vaccine: Potential candidate (> 5 years).  
Influenza Vaccine: Potential candidate.  
LMP: Not applicable.  
Safety of Living Environment: Safe  
>>>> SH: (+)smokes, patient advised on smoking cessation, drinks socially,  
no drugs  
>>>> PREHOSPITAL CARE: Took one of his wife's Vicodin last pm.  
>>>> TRIAGE INTERVENTION: ED physician notified.

-----  
Fettner, Karen R.N. Created: 9/6/2016 1154 Last Entry: 1205  
-----

Nurse Note: 9/6/2016 1137  
ASSESSMENT CARE CENTER - Adult  
Patient's wife at bedside.  
Cohen, Terry M.D. at the bedside 9/6/2016 1201  
>>>> PHYSICAL EXAM: Pt reports while taking a drink and coughing about 16  
hrs prior to arrival he passed out. Pt reports his 17 yo son was w/ him,  
caught him and lowered him to the ground. Pt reports his 17 yo son then  
"pounded" on the left side of his chest and he "woke right up."  
GENERAL APPEARANCE: alert, cooperative.  
PAIN: pain scale: 10/10 Standard.  
location: left middle chest  
quality: sharp.  
aggravating factors: activity.  
alleviating factors: rest.  
MENTAL STATUS: speech clear, oriented x 3, normal affect, responds  
appropriately to questions.  
SKIN: warm, dry, good color, (-)cyanosis, no rash, no ulcers.  
Nutritional Screening: normal nutrition  
>>>> COMMUNICATION DEFICIT: None Identified.  
Learning Aids Needed: (+)none, ( )Signer, ( )Interpreter.  
Educational Needs: patient and wife needs information on (+)current  
illness, ( )medications, ( )equipment, ( )home care, ( )activity, ( )diet,  
( )community resources.  
>>>> SH: Support system: lives w family or significant other  
Suspected Violence: none  
Referrals Reporting: none  
Patient verbalizes suicidal or homicidal ideations: no suicidal  
homicidal ideations  
>>>> JHFRAT FALL RISK Assessment  
If patient has any of the following KNOWN conditions, select it and  
apply Fall Risk interventions as indicated. If any of these KNOWN fall  
risks are selected, do NOT continue with the Fall Risk Score Calculation.  
If there are NO KNOWN fall risks, choose the option for NO KNOWN fall  
risks and proceed with the Fall Risk calculation.  
Fall Risk Status NO KNOWN Fall Risk  
Age: \_\_\_\_\_ 0=Less than 60 years  
Fall History: \_\_\_\_\_ 0=No fall 6 months prior to admit  
Elimination bowel urine: \_\_\_\_\_ 0=No incontinence

Medications: \_\_\_\_\_ 0=No high fall risk drugs  
Equipment: \_\_\_\_\_ 0=None present

Pg 4

Mobility: \_\_\_\_\_ 0=No mobility issues  
Cognition: \_\_\_\_\_ 4=Lack of understanding of one's physical  
and cognitive limitations

JHFRAT Total Score:, Low Risk(less than 6) Green.

>>>> Fall Prevention Interventions:

(+)bed in lowest position (L-M-H), (+)bedside rails up times 2,  
(+)educated patient how to use call bell call bell within reach,  
(+)educated patient and or family about preventing falls.

-----  
Fettner, Karen R.N. Created: 9/6/2016 1221 Last Entry: 1221  
-----

Nurse Note:

RADIOLOGY Transport - Patient transported without RN accompanying to XRay  
Plain films via walking escorted by radiology technologist.

-----  
Fettner, Karen R.N. Created: 9/6/2016 1253 Last Entry: 1254  
-----

Nurse Note:

DSP DISCHARGE with Prescription(s) - Plan of care discussed with patient  
and wife. Patient discharged with printed instructions. Prescriptions  
given to patient. Reviewed prescribed medications with patient;  
including potential interactions with other substances. (-)Adverse Drug  
Reactions (ADR) during this ED visit: if ADR see details in RN Notes.  
Patient encouraged to follow-up with PMD or clinic. Patient verbalized  
understanding and ability to comply. Medical Driving Restrictions: none.  
Patient is stable and condition is now unchanged. Extended stay less  
than 4hours.

Time of Departure - 9/6/2016 1254 to home

=====Other Notes=====

=====MD/PA Notes=====

-----  
Sarwary, Sophia (Scribe) Created: 9/6/2016 1158 Last Entry: 1158  
-----

MD Note:

ATTENDING NOTE (Scribe) - I, Sarwary, Sophia (Scribe), am scribing for,  
and in the presence of, Cohen, Terry M.D..

-----  
Sarwary, Sophia (Scribe) Created: 9/6/2016 1158 Last Entry: 1208  
Cohen, Terry M.D. First Entry: 9/6/2016 1251 Last Entry: 1253  
-----

PHYSICIAN H P (Medical)

(+)Nursing Notes Reviewed Travel outside US (<= Click to view/enter) Ebola  
Exposure (<= Click to view/enter)

Physician/PA Evaluation Time: 9/6/2016 1141

>>>> HPI:

Patient with h/o vaso vagal syncopal episodes with coughing spells c/o L  
sided rib pain. Last night, patient had a syncopal episode during a  
coughing spell and was caught by his son who laid him on the floor. Son  
immediately started to perform CPR, heard a loud pop and patient woke up  
almost immediately. Patient denies head trauma, dizziness, headache,  
visual change, speech change, nausea, vomiting, chest pain, SOB,  
diaphoresis, fever or chills. Has been worked up extensively for these  
syncopal episodes which are associated with coughing spells and they have

been dx'd as vasovagal. This episode was typical.  
Sx began after CPR.

Pg 5

breathing out, breathing in, laying, movement worsens Sx.  
standing still improves Sx.  
Previous Episodes: prior hx of similar problem.  
Additional HPI Information: none  
>>>> ROS: no fever, (-)chills, (-)LOC, (-)headache, (-)visual changes,  
(-)sore throat, no cough, (-)SOB, (-)chest wall pain,  
(-)chest pain, (-)nausea, (-)vomiting, (-)myalgias, (-)rash, (-)dysuria,  
in addition to the systems reviewed, all other systems reviewed are  
negative.  
PREHOSPITAL CARE:  
>>>> PMH List (PMH Table Reviewed) PSH List (PSH Table Reviewed)  
(+)Medical Records Reviewed  
>>>> FH: (-)DM, (-)HTN, (-)CAD.  
>>>> SH: no tobacco, no alcohol, no drugs.  
>>>> PHYSICAL EXAM:  
VITAL SIGNS: reviewed as documented.  
GENERAL APPEARANCE: well nourished, alert, cooperative, no acute distress,  
no discomfort.  
MENTAL STATUS: speech clear, oriented X 3, normal affect, responds  
appropriately to questions.  
NEURO: CNS normal as tested, motor intact, sensory intact.  
FACE: no tenderness on the face.  
EYES: PERRL, EOMI, conjunctiva clear.  
NOSE: no nasal discharge.  
MOUTH: (-)decreased moisture.  
THROAT: no tonsillar inflammation, no airway obstruction.  
NECK: supple, no neck tenderness, (-)thyromegaly.  
BACK: no CVAT, no back tenderness.  
CHEST WALL: exquisite point tenderness L anterolateral lower ribs which  
exactly reproduces his pain  
HEART: normal rate, normal rhythm, normal S1, normal S2, no murmur, no  
rub.  
LUNGS: no wheezing, no rales, no rhonchi, (-)accessory muscle use, good  
air exchange bilateral.  
ABDOMEN: (-)ascites, normal BS, soft, no abd tenderness, (-)guarding,  
(-)rebound, no organomegaly, no abd masses.  
EXTREMITIES: good pulses in all extremities, no extremity tenderness, no  
edema.  
SKIN: warm, dry, good color, no rash.  
>>>> DIFFERENTIAL Dx: Including but not limited to; chest wall contusion,  
rib fracture, intercostal strain

-----  
Sarwary, Sophia (Scribe) Created: 9/6/2016 1245 Last Entry: 1246  
Cohen, Terry M.D. First Entry: 9/6/2016 1250 Last Entry: 1251  
-----

MD Note:

I have counseled the patient regarding their ( )labs, (+)radiological  
exams, ( )EKG, (+)diagnosis. Although no fx seen on x-ray, he clinically  
has one. Will treat accordingly.  
DISCUSSION - Discussed diagnosis and condition of patient with patient.  
DISCHARGE with Prescription(s) - Plan of care discussed and questions  
answered. The patient was discharged with verbal and printed  
instructions. Prescription(s) were given and prescribed medications were  
reviewed, including potential interactions with other substances. The  
importance of outpatient follow up was emphasized and should be followed  
as noted in the discharge instructions. The understanding of the  
instructions and ability to comply was verbalized. The condition at

discharge is stable. Instructions to return to the emergency department for worsening symptoms.

Pg 6

-----  
Sarwary, Sophia (Scribe) Created: 9/6/2016 1246 Last Entry: 1246  
-----

MD Note:  
//////////////////////////////// Author: wellsoft Interface ////////////////////////////////// 9/6/2016  
12:42pm //////////////////////////////////  
Patient: BERNSTEIN, ELIOT ; Date/Time: 9/6/2016 1217 ; 1016697767  
----- HXR RIBS LT UNILAT -----  
EXAM START: 9/6/2016 1216  
EXAM STOP: 9/6/2016 1218  
Left RIBS, 3 views  
Clinical history- Trauma  
Findings- Multiple views of the left ribs were obtained. There is no evidence of fracture or bone destruction.  
IMPRESSION-  
Negative left ribs.  
-Authenticated and electronically signed by- Jonathan Shapir, M.D.  
Electronically signed- 9/6/2016 12-40 PM

Read By- JONATHAN SHAPIR M.D.  
Released Date Time- 09/06/16 1241  
READ BY: JONATHAN SHAPIR M.D.  
RELEASED BY: JONATHAN SHAPIR M.D.

-----  
Cohen, Terry M.D. Created: 9/6/2016 1247 Last Entry: 1247  
-----

Results Reviewed by ED Physician:  
XR RIBS UNILATERAL LEFT

-----  
Cohen, Terry M.D. Created: 9/6/2016 1248 Last Entry: 1248  
-----

MD Note:  
ATTENDING NOTE (Scribe attestation) - I, Cohen, Terry M.D., personally performed the services described in this documentation, as scribed by Sarwary, Sophia (Scribe) in my presence, and it is both accurate and complete.

-----  
Cohen, Terry M.D. Created: 9/11/2016 0920 Last Entry: 0921  
-----

MD Note:  
Addendum: The ROS should include the following (+): cough, chest wall pain

=====Results=====

===== Dx/Instr =====  
Dx 1:Fx L rib, closed  
Follow-up 1:Dr. Esener  
Follow-up 1 Date:As needed

=====

Patient BelongiNone

Belongings locaSent\_home

===== Prescription / Rx =====  
RX 1:Percocet Tablets 325mg,5mg (acetaminophen,oxycodone)  
Dose/Conc:

Freq/Rte:1 tablet by mouth every 6 hrs as needed for pain  
Disp:#24 (twenty four) ta Refill:zero

Pg 7

====work/School Excuse====  
==== Signatures =====  
MD Sgntr:Cohen, Terry M.D. 9/6/2016 1248  
RN Sgntr:Fettner, Karen R.N. 9/6/2016 1254  
Triage Sgntr:Fettner, Karen R.N. 9/6/2016 1206  
=== (C) 2009 wellsoft, Elsevier ===== THIS IS THE LAST PAGE ===

DELRAY MEDICAL CENTER  
5352 Linton Boulevard  
Delray Beach, FL 33484

Name: BERNSTEIN, ELIOT TR  
MRN: 000188764  
ACCT: 012940564

RICHARD H KIM, MD  
ADM: 06/04/2013

Consultation

---

DATE OF CONSULTATION: 06/04/2013

CHIEF COMPLAINT: Syncope.

HISTORY OF PRESENT ILLNESS: The patient is a 49-year-old gentleman who was at dinner at a friend's house. His wife apparently told a joke. He began laughing and then coughing. He then thinks he passed out. He apparently had urinary incontinence. He fell and hit his head on a marble floor. He sustained a subarachnoid hemorrhage. He also complains of chest discomfort now. Cardiology consultation is requested.

ALLERGIES: IODINE which has apparently caused anaphylaxis in the past.

PAST MEDICAL HISTORY: Borderline hypertension. No history of diabetes, myocardial infarction, CVA. He does have hyperlipidemia. He is now vegetarian.

FAMILY HISTORY: Mother and father both have had myocardial infarction at a premature age.

PAST SURGICAL HISTORY: Facial reconstruction, lower extremity surgery secondary to trauma in his late teens.

SOCIAL HISTORY: Still smokes 3 cigarettes a day, used to smoke 40, social alcohol.

REVIEW OF SYSTEMS:

CONSTITUTIONAL: No fevers, chills or sweats.

VISION: No double vision, blurry vision or cataracts.

HEENT: No hearing loss or tinnitus.

LUNGS: No wheezing, cough or hemoptysis.

GASTROINTESTINAL: No nausea or vomiting.

GENITOURINARY: No hematuria or dysuria.

CENTRAL NERVOUS SYSTEM: No strokes or seizures.

ENDOCRINE: No diabetes or thyroid.

HEMATOLOGIC: No anemia or leukemia.

CARDIOVASCULAR: No chest pain or pressure, but he does complain his chest pain as described above.

PHYSICAL EXAMINATION:

GENERAL: Pleasant, well-developed, well-nourished gentleman, in no acute distress.

VITAL SIGNS: 98.4, 69, 144/75.

---

Work Type: Consultation  
T001

Work Type Code: CON  
Page: 1

DATE 07/18/2013

PRINTED BY: MariaGeribon

441335 m/r: Parli, Geribon



DELRAY MEDICAL CENTER  
5352 Linton Boulevard  
Delray Beach, FL 33484

Name: BERNSTEIN, ELIOT TR  
MRN: 000188764  
ACCT: 012940564

RICHARD H KIM, MD  
ADM: 06/04/2013

Consultation

---

HEENT: Anicteric sclerae. Mucous membranes are moist.  
NECK: Supple, no jugular venous distention, no carotid bruits.  
CARDIAC: Regular rate and rhythm.  
LUNGS: Lung fields are clear to auscultation.  
ABDOMEN: Soft, nontender.  
EXTREMITIES: No clubbing, cyanosis or edema. His left chest wall is clearly extremely tender to palpation.

ASSESSMENT:

1. Atypical musculoskeletal chest discomfort.
2. Syncope.
3. Subarachnoid hemorrhage.
4. Family history of \_\_\_\_\_ heart disease.
4. Tobacco abuse.
5. Hypertension
5. Borderline hyperlipidemia.

PLAN: Check echo color Doppler study when he can tolerate pain on his left chest. This is clearly not cardiac pain, but musculoskeletal. Syncope is probably vagal posttussive. Monitor on tele. We will be happy to follow this patient with you.

---

Richard H. Kim, MD

TR:RHK/HN  
DD:06/04/2013 13:12 EDT  
DT:06/04/2013 20:03 EDT  
Dictation ID: 9462482/Confirmation #: 3900064  
R:

Authenticated by RICHARD H KIM MD [1397] on 06/07/2013 at 13:03:19

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Work Type: Consultation  
T001

Work Type Code: CON  
Page: 2

DATE 07/18/2013

PRINTED BY: MariaGeribon

PRINTED BY: maria.geribon

RADIOLOGY REPORT  
5352 LINTON BOULEVARD  
AREA CODE (561) 495-3170

DELRAY BEACH, FL

DELRAY MEDICAL CENTER

PT NAME: BERNSTEIN, ELIOT I

DOB: 09/30/1963

LOCATION: ER -

ACCT. # 012940564

DR. ROYCRAFT, EDWARD L

MR # 000188764

ORDER # 714438281

06/04/2013

CT HEAD OR BRAIN W/O CONT

Abbrv: CTHD1

INDICATION: Trauma

A CT scan of the brain was performed from the base of the skull through the vertex without intravenous contrast.

No prior images are available for comparison.

The ventricles and CSF spaces appear normal. This addendum is made of a cavum the cecum, normal anatomic variant. There is no mass or mass effect present. Small amount of subarachnoid blood is seen within sulci within the a right temporal lobe in right sylvian fissure. Brain parenchyma is normal in attenuation. There is no evidence of acute infarct or intracranial hemorrhage. The mastoid air cells, paranasal sinuses and orbits appear normal.

IMPRESSION:

1. Small amount of subarachnoid blood within sulci right temporal lobe and right sylvian fissure likely posttraumatic
2. No midline shift or mass effect.
3. No evidence of infarct or hydrocephalus.

Edward Roycraft, MD was notified of critical results at 12:27 a.m. on June 4, 2013

\*\*\* Final \*\*\*

Dictated By: THAME, CRAIG (06/04/2013 00:26)

Signed By: THAME, CRAIG (06/04/2013 00:28)

DATE 07/18/2013

PRINTED BY: MariaGeribon

CRITICAL RESULTS

DELRAY MEDICAL CENTER

RADIOLOGY REPORT  
5352 LINTON BOULEVARD  
AREA CODE (561) 495-3170

DELRAY BEACH, FL

PT NAME: BERNSTEIN, ELIOT TR I

DOB: 09/30/1963

LOCATION: TI 0282-A

ACCT. # 012940564

DR. ROYCRAFT, EDWARD L

MR # 000188764

ORDER # 714438281

06/04/2013

CT HEAD OR BRAIN W/O CONT

Abbrv: CTHD1

ADDENDUM:

Trauma over read:

Quality assurance review of the head and cervical spine CT examinations was performed and is in agreement with the initial interpretation of mild right-sided subarachnoid hemorrhage. The cervical spine is intact, as reported.

Final assessment: No discrepancy.

\*\*\* Addendum \*\*\*

Dictated By: MARTELLO, RICHARD (06/04/2013 10:55)

Signed By: MARTELLO, RICHARD (06/04/2013 10:57)

=====

INDICATION: Trauma

A CT scan of the brain was performed from the base of the skull through the vertex without intravenous contrast.

No prior images are available for comparison.

The ventricles and CSF spaces appear normal. This addendum is made of a cavum the cecum, normal anatomic variant. There is no mass or mass effect present. Small amount of subarachnoid blood is seen within sulci within the a right temporal lobe in right sylvian fissure. Brain parenchyma is normal in attenuation. There is no evidence of acute infarct or intracranial hemorrhage. The mastoid air cells, paranasal sinuses and orbits appear normal.

IMPRESSION:

1. Small amount of subarachnoid blood within sulci right temporal lobe and right sylvian fissure likely posttraumatic
2. No midline shift or mass effect.
3. No evidence of infarct or hydrocephalus.

Edward Roycraft, MD was notified of critical results at 12:27 a.m. on June 4, 2013

\*\*\* Final \*\*\*

Dictated By: THAME, CRAIG (06/04/2013 00:26)

DATE 07/18/2013

PRINTED BY: MariaGeribon

Reliable By: [unclear]

DELRAY MEDICAL CENTER

RADIOLOGY REPORT  
5352 LINTON BOULEVARD  
AREA CODE (561) 495-3170

DELRAY BEACH, FL

PT NAME: BERNSTEIN, ELIOT TR I

DOB: 09/30/1963

LOCATION: TI 0282-A

ACCT. # 012940564

DR. ROYCRAFT, EDWARD L

MR # 000188764

ORDER # 714438281

06/04/2013

CT HEAD OR BRAIN W/O CONT

Abbrv: CTHD1

Signed By: THAME, CRAIG (06/04/2013 00:28)

DATE 07/18/2013

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DELRAY MEDICAL CENTER

RADIOLOGY REPORT  
5352 LINTON BOULEVARD  
AREA CODE (561) 495-3170

DELRAY BEACH, FL

PT NAME: BERNSTEIN, ELIOT TR I

DOB: 09/30/1963

LOCATION: TI 0282-A

ACCT. # 012940564

DR. PACKER, EVAN

MR # 000188764

ORDER # 714507263

06/04/2013

MRA HEAD W/O CONTRAST

Abbrv: MRAHD1

MRA brain without gadolinium

HISTORY: Subarachnoid hemorrhage

FINDINGS: Study performed utilizing 3-D MIPS. The circle of Willis appears normal with no occlusion or stenosis. No aneurysm or AVM identified. Specifically in the region of the right MCA trifurcation there is no aneurysm identified. No AVM. In the posterior circulation there is robust intracranial vertebral sterile flow with a normal basilar artery. The right posterior vertebral artery is supplied by the large posterior communicating artery from the right ICA.

IMPRESSION: Normal study

\*\*\* Final \*\*\*

Dictated By: ROBERTSON, STEPHEN (06/04/2013 16:24)

Signed By: ROBERTSON, STEPHEN (06/04/2013 16:26)

DATE 07/18/2013

PRINTED BY: MariaGeribon

DELRAY MEDICAL CENTER

RADIOLOGY REPORT  
5352 LINTON BOULEVARD  
AREA CODE (561) 495-3170

DELRAY BEACH, FL

PT NAME: BERNSTEIN, ELIOT TR I

DOB: 09/30/1963

LOCATION: TI 0282-A

ACCT. # 012940564

DR. STAFF, PHYSICIAN NOT ON

MR # 000188764

ORDER # 714820363

06/05/2013

CT HEAD OR BRAIN W/O CONT

Abbrv: CTHD1

BERNSTEIN, ELIOT TR I

INDICATION: Evaluate brain.

CT scan of the brain was performed from the base of the skull through the vertex without intravenous contrast.

Comparison is made to prior exam dated June 4, 2013 crit

Previously identified subarachnoid blood within sulci of the right temporal lobe and right sylvian fissure has significantly decreased. No new area of hemorrhage is present. There is no midline shift the there is no mass effect present. No parenchymal hematoma is seen. Incidental note is made of a cavum septum pellucida. Brain parenchyma normal in attenuation. Mastoid air cells, paranasal sinuses and orbits are normal.

IMPRESSION:

1. Decrease in volume of subarachnoid blood within the sulci of the right temporal lobe and right sylvian fissure.
2. No midline shift or mass effect.

\*\*\* Final \*\*\*

Dictated By: THAME, CRAIG (06/05/2013 05:39)

Signed By: THAME, CRAIG (06/05/2013 05:43)

DATE 07/18/2013

PRINTED BY: MariaGeribon

7/10/13  
16:11:53

DELRAY MEDICAL CENTER  
5352 LINTON BLVD. DELRAY BEACH FL 33484  
ADMISSION RECORD-F01

PATIENT NO: 012940564 ADMIT DT/TIME: 6/04/13 02:10 M/R NO: 000188764  
NS/RM/BED/ACM: TI 282 A 17 RESISTANT ORG:  
DISCH DT/TIME: 6/05/13 13:30 BY: ARAS  
PATIENT NAME: BERNSTEIN, ELIOT TR T TITLE:  
MAILING ADDR: 2753 NW 34TH ST SOCIAL SECURITY: 361622566  
CITY/STATE: BOCA RATON FL 33434 3459 PHONE: (561) 245-8588  
PHYSICAL ADR: 2753 NW 34TH ST NPP: 2.0 DATE: 12/08/03  
CITY/STATE: BOCA RATON FL 33434 3459 PHONE: (561) 245-8588  
OCCUPATION: UNKNOWN LANGUAGE: EN FC: 80  
POB: ADMT PHYS: 1173- RODRIGUEZ EUGENIO HSV: 37  
DOB: 9/30/1963 ADMT PHYS PHONE: (561) 330-4695 RLG: PAR:  
AGE: 49 Y RACE: WHI ATTEND PHYS: 1173- RODRIGUEZ EUGENIO MS: S  
SEX: M REF PHY: 1173-RODRIGUEZ EUGENIO PHN: 561 330-4695 SMK: N  
PCP PHY: - PHN: VAL: PT: 1  
ETHNICITY:NON FLAG: FATHER'S DOB: MOTHER'S DOB:

EMER CONTACT: CANDICE BERNSTEIN REL: SPOUSE  
ADDRESS: 72753 NW 34TH ST PHONE: (561) 245-8588  
CITY/STATE: BOCA RATON FL 33434 1111  
NEAREST REL: REL:  
ADDRESS: PHONE: ( )  
CITY/STATE: RESEARCH ID:

GUARANTOR: BERNSTEIN, ELIOT I REL: SELF  
ADDRESS 1: 2753 NW 34TH ST PHONE: (561) 245-8588  
ADDRESS 2: SOCIAL SECURITY: 361622566  
CTY/STE/ZIP: BOCA RATON FL 33434 3459 OCC: AF:  
PAYOR NAME 1: BCBS-FL INS. PLAN ID: 07033 SRV/TYPE: ALLIP  
PLAN NAME: BC FL PPO/ADVANTAGE 65/PPC/BLEU CHO IPA:  
BILL C/O NAME: BC FL PPC AUTH #: 10251606  
BILL ADDRESS: P.O. BOX 1798 CERT-SSN-HIC-ID#: QCB6046973501  
CTY/STE/CNTRY: JACKSONVILLE FL 32231 0014 BILL PHONE: (800) 275-2583  
BILLING NAME: GP #: 509415  
INSURED: BERNSTEIN, ELIOT I SEX/REL: M SELF  
EMPLOYER: MSP: TRACKING#:  
ADDRESS: EMP PHONE: ( ) 000-0000  
CITY/STATE: 00000 0000 ESC: 1  
PAYOR NAME 2: INS. PLAN ID:  
PLAN NAME:  
BILL C/O NAME: CERT-SSN-HIC-ID#:  
BILL ADDRESS: AUTH #:  
CTY/STE/CNTRY: BILL PHONE: ( ) 000-0000  
BILLING NAME: GP #:  
INSURED: SEX/REL:  
EMPLOYER: TRACKING#:  
ADDRESS: EMP PHONE: ( ) 000-0000  
CITY/STATE: ESC:

SPAN CODE: PRIOR VISIT: 6/09/13  
FROM/TO DATE: PRIOR HOSPITAL:  
CONDITION CD CONDITION CD OCCURRENCE CD/DATE OCCURRENCE CD/DATE  
P7 05 6/03/13  
11 6/03/13

CHIEF COMPLAINT DESCRIPTION: ADMIT DIAGNOSIS CODE: 780.2  
SAH  
COMMENTS: ER ADMIT TO TICU  
1ST ORIGINAL-CHART COPY 2-PHYSICIAN COPY 3-MEDICAL RECS. COPY 4-UTIL. REV.

DATE 07/18/2013  
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