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

11/7/16

Rx

Patient should avoid all types of steroids 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.

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WELLINGTON, FL 33414-6137

(561) 422-1006 TEL.
(561) 422-1078 FAX
DEA # _____
LIC. # ME85753

BATCH # MDI16012603027791054

NAME Clint Bernstein DOB _____

ADDRESS _____ DATE _____

TAMPER-RESISTANT SECURITY FEATURES LISTED ON BACK OF SCRIPT

℞ 10/24/16

Patient should avoid all type of straw over the next 2 wks pending GI / small bowel 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

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

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

Patient: Bernstein, Eliot
DI Printed: 9/6/2016 1248
MD ED: Cohen, Terry M.D.
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,

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

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.

 THIS IS THE LAST PAGE

BOCA RATON REGIONAL HOSPITAL
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 Accnt: 1625001096
Med Rcrd: 000446213

Medication Reconciliation

1625001096

MEDICATION RECONCILIATION (Discharge)

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

Local P Esener
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

Health Information Management Department
634 Glades Road
Boca Raton, FL 33431
Phone Number: 561-955-4072

BERNSTEIN, CANDICE
2753 NW 34TH STREET
BOCA RATON, FL 33434

RELEASE OF INFORMATION INVOICE

For Producing Copies of Medical Records for:

Patient Name:	MRN:	Invoice Date:	Invoice Number:
BERNSTEIN, ELIOT	000446213	Monday, January 09, 2017	185226

Number of Pages: 8

Billing Tier: PATIENT **Billing Tier Pages:** 8 **Subtotal:** $8.00

Payment ($8.00) Cash

Adjust/Payment Total: ($8.00)

Balance Due: $0.00

----------*PLEASE RETURN LOWER PORTION WITH PAYMENT*----------

Boca Raton Regional Hospital
Health Information Department
634 Glades Road
Boca Raton, FL 33431
Phone Number: 561-955-4072

Requester: BERNSTEIN, CANDICE

Balance Due: $0.00

Patient Name:	MRN:	Invoice Date:	Invoice Number:
BERNSTEIN, ELIOT	000446213	Monday, January 09, 2017	185226

BOCA RATON REGIONAL HOSPITAL — EMERGENCY REPORT

Eliot Bernstein DOB:09/30/1963 ACCT:1625001096 MRN:000446213
Patient:Bernstein, Eliot
Mailing Address:2753 Nw 34Th Street
City:Boca Raton
State:FL Zip:33434
Home Ph:(561)245-8588

Arrival:9/6/2016 1132 — Mode of Arrival:Personal Transport
Registration Time:9/6/2016 1134 — Dispo Summary Printed:9/6/2016 1248
Disposition:Home — Mode of Departure:Ambulatory
Condition at DispStable — Accompanied By:wife
Diagnostic Eval9/6/2016 1141
Time Left ED:9/6/2016 1254 — Admit Decision:

Chief Cmplnt:Possible Broken Rib Per Pt
Triage ImpressiPain, 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 hemmorhage 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 Co	Date TU	User Name
No Entries						

Vital Signs (MDM)

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

	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. MD ED ID:316
PA: PA ID:
Triage Full:Fettner, Karen R.N. Triage ID:32560
RN Eval Full:Fettner, Karen R.N. RN Eval ID32560
RN Dispo:Fettner, Karen R.N. RN Dispo I

EMS/PMD

LocalEsener PMD Ph:

RN Notes

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

ADULT TRIAGE 9/6/2016 1136

>>>> 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

Mobility:_____ 0=No mobility issues
Cognition:_____ 4=Lack of understanding of one's physicial 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.

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 tonsilar 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.

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 SHAPIRM.D.
RELEASED BY: JONATHAN SHAPIRM.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

==========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
 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.

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

DATE 07/18/2013
PRINTED BY: MariaGaribon

DELRAY MEDICAL CENTER

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

DELRAY BEACH, FL

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

RADIOLOGY REPORT

DELRAY MEDICAL CENTER 5352 LINTON BOULEVARD DELRAY BEACH, FL
AREA CODE (561) 495-3170

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

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

PRINTED BY: MariaGeribon

RADIOLOGY REPORT

DELRAY MEDICAL CENTER | 5352 LINTON BOULEVARD | DELRAY BEACH, FL

AREA CODE (561) 495-3170

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

RADIOLOGY REPORT

DELRAY MEDICAL CENTER 5352 LINTON BOULEVARD DELRAY BEACH, FL
AREA CODE (561) 495-3170

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 DELRAY MEDICAL CENTER ADMISSION
16:11:53 5352 LINTON BLVD. DELRAY BEACH FL 33484 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 RELT: 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/BLUE 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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