

00-1121-CD

Lillian Kanary vs Penn Traffic Company

00

00-1121-CD  
LILLIAN J. KANARY -vs- THE PENN TRAFFIC COMPANY

IN THE COURT OF COMMON PLEAS OF  
CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

NO. 00-<sup>6</sup> - C.D.

LILLIAN J. KANARY,

Plaintiff

VS.

THE PENN TRAFFIC COMPANY,

Defendant

COMPLAINT

**FILED**

SEP 11 2000 Atty Mohney pd \$ 80.00  
SAC M124211cc Sherry  
William A. Shaw  
Prothonotary 1cc a/c  
H

LAW OFFICES

**BLAKLEY, JONES & MOHNEY**

90 BEAVER DRIVE - BOX 6  
DUBOIS, PA 15801

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

(1) LILLIAN J. KANARY, : NO. 00-1124-C.D.  
Plaintiff : TYPE OF CASE: CIVIL  
VS. : TYPE OF PLEADING: COMPLAINT  
(3) THE PENN TRAFFIC COMPANY, : FILED ON BEHALF OF: PLAINTIFF  
Defendant : COUNSEL OF RECORD:  
: CHRISTOPHER E. MOHNEY, ESQUIRE  
: SUPREME COURT NO.: 63494  
: BLAKLEY, JONES & MOHNEY  
: 90 BEAVER DRIVE, BOX 6  
: DU BOIS, PA 15801  
: (814) 371-2730

**FILED**

SEP 11 2000

William A. Shaw  
Prothonotary

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY, : NO. 00 - - C.D.  
: Plaintiff :  
: VS. :  
: THE PENN TRAFFIC COMPANY, :  
: Defendant :

**NOTICE TO DEFEND**

You have been sued in Court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this Complaint is served, by entering a written appearance personally or by attorney and filing in writing with the Court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so, the case may proceed without you and an order may be entered against you by the Court without further notice for any money claimed in the Complaint requested by the Plaintiff. You may lose money or property or other rights important to you.

**YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF  
YOU DO NOT HAVE A LAWYER OR CANNOT AFFORD ONE, GO TO OR TELEPHONE  
THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL  
HELP.**

Court Administrator  
Clearfield County Courthouse  
Second & Market Streets  
Clearfield, Pennsylvania 16830  
(814) 765-2641 Ext. 50-51

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY, : NO. 00 - - C.D.  
: Plaintiff :  
VS. :  
: THE PENN TRAFFIC COMPANY, :  
: Defendant :

**COMPLAINT**

AND NOW, comes the Plaintiff, **LILLIAN J. KANARY**, by her attorneys, **BLAKLEY, JONES & MOHNEY**, who files the within Complaint against the above-captioned Defendant and in support thereof avers the following:

1. Plaintiff **LILLIAN J. KANARY** is an adult individual residing at 103 Cordella Avenue, Toronto, Ontario M6N258.
2. Defendant **THE PENN TRAFFIC COMPANY** is a Delaware corporation qualified to do business in the Commonwealth of Pennsylvania as of June 5, 1992, with a mailing address in the care of CT Corporation System, 1635 Market Street, Philadelphia, Pennsylvania 19103.
3. **THE PENN TRAFFIC COMPANY** is the owner and operator of BiLo No. 231, DuBois, Pennsylvania, with a place of business at Sandy Plaza, DuBois, Clearfield County, Pennsylvania 15801.
4. At all times relevant to this cause of action of Plaintiff, BiLo No. 231 was a supermarket open to the public.

5. On or about January 2, 1999, Plaintiff was a customer at Defendant's BiLo Supermarket, No. 231, located in the Sandy Plaza in DuBois, Pennsylvania.

6. While seated on the bench within the supermarket, Plaintiff was caused to be struck on the head with an industrial-size mop resultant of the negligence, carelessness, recklessness and wrongful acts of an employee of Defendant who was then mopping the floor.

7. The negligence, carelessness, recklessness and wrongful acts of Defendant, its agents, servants and/or employees consisted of one or more of the following particulars:

(a) failing to post warning signs in the immediate area of the floor mopping to notify customers of the dangerous condition;

(b) failing to use reasonable prudence in the supervision of its employees;

(c) failing to use reasonable prudence in the mopping of its floors; and

(d) Such other acts or omissions by Defendant constituting negligence which may be ascertained during the course of discovery or at the trial of this case.

8. As a direct and proximate result of the negligence, carelessness and/or recklessness of Defendant, its agents, servants and/or employees, Plaintiff has suffered and will suffer in the future, great pain, suffering and inconvenience generally and in the following particulars:

(a) Skull contusion with mild concussion;

(b) Neck and left shoulder pain;

(c) Strain of cervical spine;

(d) Post-Concussive Syndrome with headaches;

(e) Cervical Myofascitis; and

(f) Embarrassment, humiliation, hindrance and/or loss of life's enjoyment and

pleasures and daily activities, loss of well being.

9. As a direct and proximate result of the negligence, carelessness and/or recklessness of Defendant, its agents, servants and/or employees, Plaintiff has incurred and will incur future substantial expenses for medical treatment and therapy in an amount not yet ascertained.

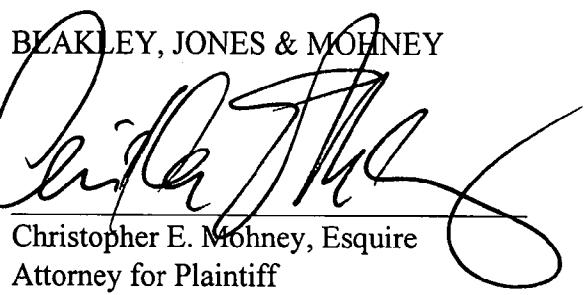
10. The Defendant, its agents, servants and/or employees remain liable for the injuries sustained by Plaintiff as a direct, proximate, natural, foreseeable and probable consequence of the negligence, carelessness and/or reckless actions, errors and/or omissions of the Defendant, its agents, servants and/or employees for those reasons set forth more fully herein.

WHEREFORE, Plaintiff, **LILLIAN J. KANARY**, respectfully demands judgment against Defendant, **THE PENN TRAFFIC COMPANY**, for compensatory damages in an amount not in excess of \$20,000.00, plus costs, interest and such other relief as the Court deems just.

Respectfully submitted,

BLAKLEY, JONES & MOHNEY

BY:

  
Christopher E. Mohney, Esquire  
Attorney for Plaintiff

**VERIFICATION**

I, **LILLIAN J. KANARY**, being duly authorized to make this verification, have read the foregoing Complaint. The statements therein are correct to the best of my personal knowledge or information and belief.

This statement and verification is made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn fabrication to authorities, which provides that if I make knowingly false averments I may be subject to criminal penalties.

Date:

Aug 16, 2000

Lillian J. Kanary

**LILLIAN J. KANARY**

CHRISTOPHER E. MOHNEY

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

KANARY, LILLIAN J.

VS

THE PENN TRAFFIC COMPANY

00-1121-CD

COMPLAINT

SHERIFF RETURNS

NOW SEPTEMBER 13, 2000 AT 10:53 AM DST SERVED THE WITHIN  
COMPLAINT ON THE PENN TRAFFIC COMPANY, DEFENDANT AT  
EMPLOYMENT BILO SUPERMARKET, SANDY PLAZA, DUBOIS, CLEARFIELD  
COUNTY, PENNSYLVANIA BY HANDING TO DEAN TRINLA, ASST.  
MANAGER A TRUE AND ATTESTED COPY OF THE ORIGINAL COMPLAINT  
AND MADE KNOWN TO HIM THE CONTENTS THEREOF.

SERVED BY: MCINTOSH/MARSHALL

28.21 SHFF. HAWKINS PAID BY: ATTY.

10.00 SURCHARGE PAID BY: ATTY.

SWORN TO BEFORE ME THIS

25th DAY OF September 2000

William A. Shaw

WILLIAM A. SHAW  
Prothonotary  
My Commission Expires  
1st Monday in Jan. 2002  
Clearfield Co., Clearfield, PA.

SO ANSWERS,

*Chester A Hawkins*  
*by Marilyn Harr*

CHESTER A. HAWKINS  
SHERIFF

FILED

*REC'D*  
SEP 25 2000

William A. Shaw  
Prothonotary

**IN THE COURT OF COMMON PLEAS CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION**

LILLIAN J. KANARY,

No. 00 - 1121 - C.D.

Plaintiff,

vs.

THE PENN TRAFFIC COMPANY,

Filed on behalf of:  
The Penn Traffic Company, Defendant

Defendant.

Counsel of Record for this Party:  
John W. Bruni, Esquire  
PA I.D. #63892

Pietragallo, Bosick & Gordon  
38<sup>th</sup> Floor  
One Oxford Centre  
Pittsburgh, PA 15219  
(412) 263-2000

**FILED**

OCT 26 2000

William A. Shaw  
Prothonotary

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY,

Plaintiff,

No. 00 - 1121 CD

vs.

THE PENN TRAFFIC COMPANY,

Defendant.

**PRAECIPE FOR APPEARANCE**

TO: Prothonotary

Kindly enter the appearance of John W. Bruni, Esquire and Pietragallo, Bosick & Gordon  
as counsel of record on behalf of The Penn Traffic Company, in the above captioned action.

Respectfully submitted,

PIETRAGALLO, BOSICK & GORDON

by

  
John W. Bruni, Esquire

*Counsel for Defendant, The Penn Traffic Company*  
PA I.D. #63892

PIETRAGALLO, BOSICK & GORDON  
Firm #834  
One Oxford Centre, 38<sup>th</sup> Floor  
Pittsburgh, PA 15219  
(412) 263-2000

**FILED**

OCT 26 2000

CO 1:30 NO C  
William A. Shaw  
Prothonotary  
FAT

IN THE COURT OF COMMON PLEAS CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY,

No. 00 - 1121 - C.D.

Plaintiff,

vs.

THE PENN TRAFFIC COMPANY,

Defendant.

*ANSWER and NEW MATTER*

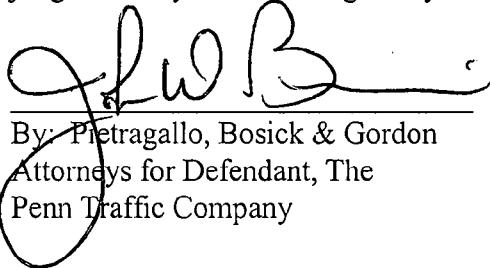
Filed on behalf of:  
The Penn Traffic Company, Defendant

Counsel of Record for this Party:  
John W. Bruni, Esquire

NOTICE TO PLEAD

To: Lillian J. Kanary

You are hereby notified to file a written response to the enclosed Answer and New matter within twenty (20) days or a judgment may be entered against you.

  
By: Pietragallo, Bosick & Gordon  
Attorneys for Defendant, The  
Penn Traffic Company

PA I.D. #63892

Pietragallo, Bosick & Gordon  
38<sup>th</sup> Floor  
One Oxford Centre  
Pittsburgh, PA 15219  
(412) 263-2000

**FILED**

NOV 27 2000

William A. Shaw  
Prothonotary

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY,

Plaintiff,

No. 00 - 1121 CD

vs.

THE PENN TRAFFIC COMPANY,

Defendant.

**ANSWER and NEW MATTER**

AND NOW, comes the defendant, The Penn Traffic Company, by and through its attorneys, Pietragallo, Bosick & Gordon and files the within Answer and New Matter to the plaintiff's Complaint and states as follows:

1. After reasonable investigation, the defendant is without knowledge or information sufficient to form a belief as to the truth or falsity of the averments set forth in Paragraph 1 of the plaintiff's Complaint and, therefore, the same are denied and strict proof thereof is demanded at time of trial.
2. The averments of Paragraph 2 of the plaintiff's Complaint are admitted.
3. The averments of Paragraph 3 of the plaintiff's Complaint are admitted.
4. The averments of Paragraph 4 of the plaintiff's Complaint are admitted.
5. Defendant is without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations set forth in Paragraph 5 of the plaintiff's Complaint and therefore, the allegations are denied and strict proof thereof is demanded at time of trial.
6. The averments of Paragraph 6 of the plaintiff's Complaint set forth conclusions of law to which no response is required. To the extent that response is deemed necessary, it is denied

that defendant or any of its employees acted with negligence, carelessness, recklessness or conducted any wrongful acts in regard to its treatment of the plaintiff while she was a customer of the defendant supermarket on January 2, 1999.

7. The averments of Paragraph 7 and its subparagraphs set forth conclusions of law to which no response is required. To the extent that a response is deemed necessary, defendant avers that it was not negligent, careless or reckless and, to the extent that a response is deemed further necessary, the averments are deemed denied pursuant to Pa. R.C.P. 1029(e).

8. Defendant is without information sufficient to form a belief as to the truth or falsity of the allegations set forth in Paragraph 8 of the plaintiff's Complaint and, therefore, the same are denied and strict proof thereof is demanded at time of trial.

9. The averments of Paragraph 9 of the plaintiff's Complaint set forth conclusions of law to which no response is required. To the extent that a response is deemed necessary, the averments are deemed denied pursuant to Pa. R.C.P. 1029(e). By way of further response, defendant is without information sufficient to form a belief as to the truth or falsity regarding any expense for medical treatment and therapy plaintiff may have incurred and therefore, the same are denied.

10. Paragraph 10 of the plaintiff's Complaint contains conclusions of law to which no response is required. To the extent that a response is deemed necessary, the averments are deemed denied pursuant to Pa. R.C.P. 1029(e). By way of further answer, all remaining averments including, but not limited to those of causation, reckless, carelessness and negligence by or on behalf of the defendant are specifically denied as stated or implied and it is specifically denied that defendant committed or had committed on its behalf any legally, culpable act or omission including, but not limited to those set forth in plaintiff's Complaint.

WHEREFORE, defendant demands that the Complaint of the plaintiff against it be dismissed and judgment be entered in favor of said defendant, together with interest and cost.

JURY TRIAL DEMANDED

**NEW MATTER**

Defendant, The Penn Traffic Company, pursuant to Pa. R.C.P. 1030, hereby interposes New Matter and states as follows:

11. Plaintiffs claims are barred, limited and/or diminished by the Pennsylvania Comparative Negligence Act and the comparative and contributory negligence of the plaintiff, Lillian Kanary.

12. At all times material hereto, the plaintiff was contributorily/comparatively negligent by failing to exercise adequate, reasonable and legally sufficient care and caution for her own safety by, inter alia, failing to properly and adequately observe the work being performed around her; failing to see and avoid any allegedly dangerous conditions; negligently and carelessly placing herself in a position of claimed unreasonable danger and peril; negligently, carelessly and recklessly disregarding her own safety and exerting a level of care for her own safety and well-being below that required of a reasonable person under the circumstances under the law of the Commonwealth of Pennsylvania.

13. The plaintiff's Complaint fails to show the breach of any alleged duty by the defendant.

14. The plaintiff's Complaint fails to state any legally, culpable act or omission by, or on behalf of the defendant which proximately caused or was a substantial factor in bringing about the plaintiff's claim to injuries, damages and losses.

15. Plaintiff has failed to state a cause of action against the defendant.

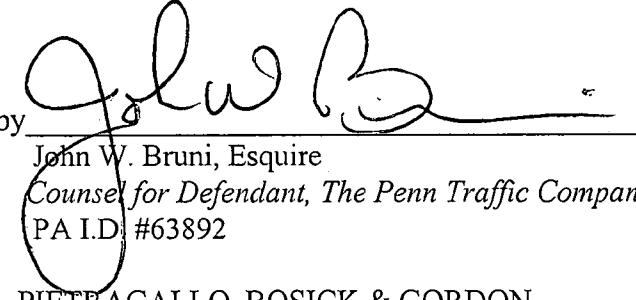
16. Plaintiff has failed to properly mitigate her claim of damages.
17. If the plaintiff suffered any injury, damage or loss, which is specifically denied, they were or may have been caused, by pre-existing or subsequently occurring falls, accidents, traumas, causes, factors, conditions, diseases and/or disease processes which serve to bar, limit and/or diminish all or part of the plaintiff's claims herein.

WHEREFORE, the defendant demands that the Complaint of the plaintiff against it be dismissed and that judgment be entered in favor of the defendant, together with costs of suit.

JURY TRIAL DEMANDED

Respectfully submitted,

PIETRAGALLO, BOSICK & GORDON

by   
John W. Bruni, Esquire  
Counsel for Defendant, *The Penn Traffic Company*  
PA I.D. #63892

PIETRAGALLO, BOSICK & GORDON  
Firm #834  
One Oxford Centre, 38<sup>th</sup> Floor  
Pittsburgh, PA 15219  
(412) 263-2000

VERIFICATION

I, Tabitha May, on behalf of The Penn Traffic Company, hereby verifies that I have read the foregoing Answer and New Matter and that it is true and correct to the best of my knowledge, information and belief. To the extent that the contents of the pleading are that of counsel, verifier has relied upon counsel in making this verification. This verification is made subject to the penalties of 18 Pa.C.S.A. §4904 relating to unsworn falsification to authorities.

THE PENN TRAFFIC COMPANY

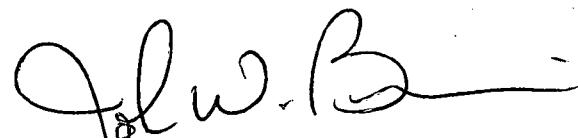
Date: 10/31/00

By: Tabitha A. May

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing **ANSWER and NEW MATTER** was served by United States First Class, postage pre-paid mail this 22nd day of November, 2000, upon:

Christopher E. Mohney, Esquire  
*Attorney for Plaintiff*  
Blakely, Jones & Mohney  
90 Beaver Drive, Box 6  
DuBois, PA 15801

  
John W. Bruni, Esquire  
*Counsel for Defendant, The Penn Traffic Company*

**FILED**

NOV 27 2000  
13/100  
William A. Shaw  
Prothonotary

LAW OFFICES

**CHRISTOPHER E. MOHNEY**

90 BEAVER DRIVE - SUITE 111B

DUBOIS, PA 15801

(814) 375-1044

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY, : No. 2000-01121-C.D.  
Plaintiff, : Type of Pleading: PRAECIPE  
vs. : TO MARK SETTLED, DISCONTINUED  
THE PENN TRAFFIC COMPANY, : AND ENDED  
Defendant, : Filed on Behalf of: PLAINTIFF  
: LILLIAN J. KANARY  
: Counsel of Record:  
: CHRISTOPHER E. MOHNEY, ESQUIRE  
: Supreme Court No. 63494  
: 90 BEAVER DRIVE  
: SUITE 111B  
: DUBOIS, PA 15801  
: (814) 375-1044

FILED *bk*  
0 11:39 SA *copy to CA*  
DEC 17 2004

William A. Shaw  
Prothonotary

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY,

Plaintiff,

vs.

No. 2000-01121-C.D.

THE PENN TRAFFIC COMPANY,

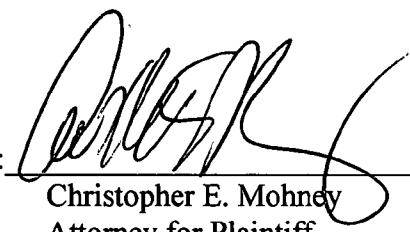
Defendant.

**PRAECIPE TO MARK SETTLED, DISCONTINUED AND ENDED**

TO: PROTHONOTARY OF CLEARFIELD COUNTY

Kindly mark the above captioned case settled, discontinued and ended.

BY:

  
Christopher E. Mohney  
Attorney for Plaintiff

**IN THE COURT OF COMMON PLEAS OF  
CLEARFIELD COUNTY, PENNSYLVANIA**

**CIVIL DIVISION**

**Lillian J Kanary**

**Vs.** **No. 2000-01121-CD**  
**The Penn Traffic Company**

**CERTIFICATE OF DISCONTINUATION**

Commonwealth of PA  
County of Clearfield

I, William A. Shaw, Prothonotary of the Court of Common Pleas in and for the County and Commonwealth aforesaid do hereby certify that the above case was on December 17 2004, marked:

Discontinued, Settled and Ended

Record costs in the sum of \$138.21 have been paid in full by Attorney Mohney.

IN WITNESS WHEREOF, I have hereunto affixed my hand and seal of this Court at Clearfield, Clearfield County, Pennsylvania this 17th day of December A.D. 2004.

---

William A. Shaw, Prothonotary

IN THE COURT OF COMMON PLEAS OF  
CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION  
NO. 00 - 1121 - C.D.

LILLIAN J. KANARY,

Plaintiff

VS.

THE PENN TRAFFIC COMPANY,

Defendant

REPLY TO NEW MATTER

LAW OFFICES

**BLAKLEY, JONES & MOHNEY**

90 BEAVER DRIVE - BOX 6  
DUBOIS, PA 15801

**FILED**

DEC 14 2000

William A. Shaw  
Prothonotary

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY, : NO. 00 - 1121 - C.D.  
Plaintiff : TYPE OF CASE: CIVIL  
VS. : TYPE OF PLEADING: REPLY TO  
THE PENN TRAFFIC COMPANY, : NEW MATTER  
Defendant : FILED ON BEHALF OF: PLAINTIFF  
: COUNSEL OF RECORD:  
: CHRISTOPHER E. MOHNEY, ESQUIRE  
: SUPREME COURT NO.: 63494  
: BLAKLEY, JONES & MOHNEY  
: 90 BEAVER DRIVE, BOX 6  
: DU BOIS, PA 15801  
: (814) 371-2730

**FILED**

DEC 14 2000  
m/1:38/mr  
William A. Shaw  
Prothonotary  
No. C/C

*EAS*

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY, : NO. 00 - 1121 - C.D.  
: Plaintiff :  
VS. :  
: THE PENN TRAFFIC COMPANY, :  
: Defendant :

**REPLY TO NEW MATTER**

AND NOW, comes the Plaintiff, **LILLIAN J. KANARY**, by her attorneys, **BLAKLEY, JONES & MOHNEY**, who files the within Reply to New Matter and in support thereof avers the following:

11. Paragraph 11 of Defendant's New Matter is a legal conclusion to which no answer is required, the same being deemed to be denied.
12. Paragraph 12 of Defendant's New Matter is a legal conclusion to which no answer is required, the same being deemed to be denied.
13. Paragraph 13 of Defendant's New Matter is a legal conclusion to which no answer is required, the same being deemed to be denied. By way of further response, paragraph 13 of Defendant's New Matter is more properly raised by Preliminary Objection, which Defendant has waived by not so doing.
14. Paragraph 14 of Defendant's New Matter is a legal conclusion to which no answer is required, the same being deemed to be denied. By way of further response, paragraph 14 of

Defendant's New Matter is more properly raised by Preliminary Objection, which Defendant has waived by not so doing.

15. Paragraph 15 of Defendant's New Matter is a legal conclusion to which no answer is required, the same being deemed to be denied. By way of further response, paragraph 16 of Defendant's New Matter is more properly raised by Preliminary Objection, which Defendant has waived by not so doing.

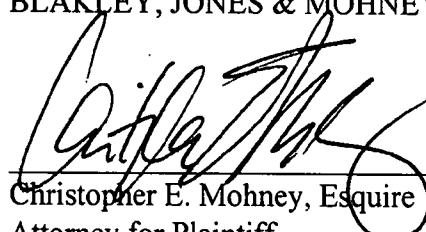
16. Paragraph 16 of Defendant's New Matter is a legal conclusion to which no answer is required, the same being deemed to be denied.

17. Paragraph 17 of Defendant's New Matter is a legal conclusion to which no answer is required, the same being deemed to be denied.

Respectfully submitted,

BLAKLEY, JONES & MOHNEY

BY:

  
Christopher E. Mohney, Esquire  
Attorney for Plaintiff

**VERIFICATION**

I, **LILLIAN J. KANARY**, being duly authorized to make this verification, have read the foregoing Reply to New Matter. The statements therein are correct to the best of my personal knowledge or information and belief.

This statement and verification is made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn fabrication to authorities, which provides that if I make knowingly false averments I may be subject to criminal penalties.

Date: Dec 3<sup>rd</sup> 2000

Lillian Kanary,  
**LILLIAN J. KANARY**

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY, : NO. 00 - 1121 - C.D.  
Plaintiff :  
VS. :  
THE PENN TRAFFIC COMPANY, :  
Defendant :  
:

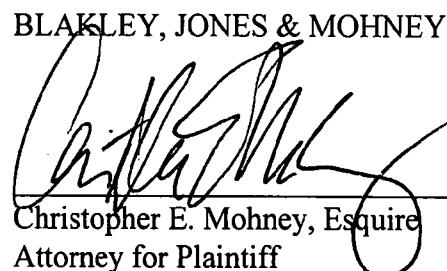
**CERTIFICATE OF SERVICE**

The undersigned hereby certifies that a true and correct copy of the within Reply to New Matter was served on the following person by regular United States mail, postage prepaid, on this 13 day of December, 2000:

John W. Bruni, Esquire  
Pietragallo Bosick & Gordon  
Attorneys at Law  
The Thirty-Eighth Floor  
One Oxford Centre  
Pittsburgh, PA 15219  
Attorney for Defendant

BLAKLEY, JONES & MOHNEY

BY:

  
Christopher E. Mohney, Esquire  
Attorney for Plaintiff  
PA I.D. 63494  
90 Beaver Drive, Box 6  
Du Bois, PA 15801  
(814) 371-2730

LAW OFFICES  
**BLAKLEY, JONES & MOHNEY**  
90 BEAVER DRIVE - BOX 6  
DUBOIS, PA 15801

CERTIFIED COPY

---

ATTORNEY FOR

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY, : NO. 00 - 1121 - C.D.  
Plaintiff : TYPE OF CASE: CIVIL  
VS. : TYPE OF PLEADING: CERTIFICATE  
THE PENN TRAFFIC COMPANY, : OF SERVICE  
Defendant : FILED ON BEHALF OF: PLAINTIFF  
: COUNSEL OF RECORD:  
: CHRISTOPHER E. MOHNEY, ESQUIRE  
: SUPREME COURT NO.: 63494  
: BLAKLEY, JONES & MOHNEY  
: 90 BEAVER DRIVE, BOX 6  
: DU BOIS, PA 15801  
: (814) 371-2730

**FILED**

APR 16 2001

William A. Shaw  
Prothonotary

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY, : NO. 00 - 1121 - C.D.  
: Plaintiff  
VS. :  
: THE PENN TRAFFIC COMPANY, :  
: Defendant

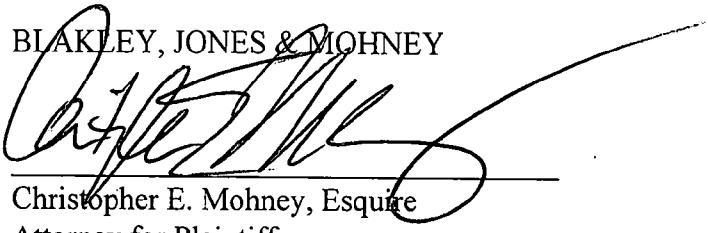
**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of Plaintiff's First Set of Interrogatories and Request for Production of Documents Directed to Defendant The Penn Traffic Company has been served upon the following individual by regular United States mail, postage prepaid, on this 12<sup>th</sup> day of April, 2001:

Brian S. Kane, Esquire  
Pietragallo Bosick & Gordon  
Attorneys at Law  
The Thirty-eighth Floor  
One Oxford Centre  
Pittsburgh, PA 15219  
Attorney for Defendant  
The Penn Traffic Company

BY:

BLAKLEY, JONES & MOHNEY

  
Christopher E. Mohney, Esquire  
Attorney for Plaintiff  
90 Beaver Drive, Box 6  
Du Bois, PA 15801  
(814) 371-2730

FILED

APR 16 2001  
M 1101 nocc  
William A. Shaw  
Prothonotary  
*E. K.*

IN THE COURT OF COMMON PLEAS CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY,

No. 00 - 1121 - C.D.

Plaintiff,

vs.

THE PENN TRAFFIC COMPANY,

**SUBSTITUTION OF APPEARANCE**

Filed on behalf of:  
The Penn Traffic Company, Defendant

Defendant.

Counsel of Record for this Party:

Brian S. Kane, Esquire  
PA I.D. #65715

Pietragallo, Bosick & Gordon  
38<sup>th</sup> Floor  
One Oxford Centre  
Pittsburgh, PA 15219  
(412) 263-2000

**FILED**

JAN 11 2001

William A. Shaw  
Prothonotary

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY,

Plaintiff,

No. 00 - 1121 CD

vs.

THE PENN TRAFFIC COMPANY,

Defendant.

**SUBSTITUTION OF APPEARANCE**

TO: PROTHONOTARY OF CLEARFIELD COUNTY:

Kindly withdraw my appearance on behalf of Penn Traffic Company

Respectfully submitted,

By: John W. Bruni / BSL  
John W. Bruni

**PRAECIPE FOR APPEARANCE**

Kindly enter the appearance of Brian S. Kane as counsel of record on behalf of The  
Penn Traffic Company, in the above captioned action.

Respectfully submitted,

By: B. S. Kane  
Brian S. Kane

**CERTIFICATE OF SERVICE**

I, Brian S. Kane, Esquire, hereby certify that a true and correct copy of the **Substitution of Appearance** has been forwarded to all counsel of record this 8th day of January, 2000, by United States First Class Mail, Postage Prepaid.

Christopher E. Mohney, Esquire  
Blakley, Jones & Mohney  
90 Beaver Drive, Box 6  
Du Bois, PA 15801



---

Brian S. Kane, Esquire

FILED

JAN 11 2001  
17 1:24 PM  
William A. Shaw NOCC  
Prothonotary  
EJ

**COURT OF COMMON PLEAS OF ~~CLEARFIELD~~ JEFFERSON COUNTY  
CIVIL TRIAL LISTING**

CERTIFICATE OF READINESS		TO THE PROTHONOTARY	
(To be executed by Trial Counsel Only)		May 15, 2001 DATE PRESENTED	
CASE NUMBER 00-1121-C.D. Date Complaint filed: September 11, 2000	TYPE TRIAL REQUESTED ( ) Jury ( ) Non-jury (X) Arbitration	ESTIMATED TRIAL TIME 1 DAYS	

PLAINTIFF(S)

LILLIAN J. KANARY ( )

DEFENDANT(S)

THE PENN TRAFFIC COMPANY ( )

ADDITIONAL DEFENDANT(S)

N/A

Check Block  
if a Minor  
is a Party  
to the Case

( )

JURY DEMAND FILED BY:

DATE JURY DEMAND FILED:

N/A

N/A

AMOUNT AT ISSUE

CONSOLIDATION

DATE CONSOLIDATION ORDERED

Not Greater Than  
\$ 20,000.00

( ) Yes (X) No

*Not Greater Than  
\$ 20,000.00*

*(X) Yes ( ) No*

PLEASE PLACE THE ABOVE CAPTIONED CASE ON THE TRIAL LIST.

I certify that all discovery in the case has been completed; all necessary parties and witnesses are available; serious settlement negotiations have been conducted; the case is ready in all respects for trial, and a copy of this Certificate has been served upon all counsel of record and upon all parties of record who are not represented by counsel.

**FILED**

**MAY 16 2001**

**William A. Shaw  
Prothonotary**

**COUNSEL WHO WILL ACTUALLY TRY THE CASE**

FOR THE PLAINTIFF Christopher E. Mohney, Esquire	TELEPHONE NUMBER (814) 371-2730
FOR THE DEFENDANT Brian S. Kane, Esquire	TELEPHONE NUMBER (412) 263-4380
FOR ADDITIONAL DEFENDANT N/A	TELEPHONE NUMBER

FILED

MAY 16 2001  
MAY 13, 2001 Mohney  
William A. Shaw  
Prothonotary  
P 2 400.00

Copy CA  
[initials]



OFFICE OF COURT ADMINISTRATOR  
FORTY-SIXTH JUDICIAL DISTRICT OF PENNSYLVANIA

CLEARFIELD COUNTY COURTHOUSE  
230 EAST MARKET STREET, SUITE 228  
CLEARFIELD, PENNSYLVANIA 16830

DAVID S. MEHOLICK  
COURT ADMINISTRATOR

PHONE: (814) 765-2641  
FAX: 1-814-765-8089 7L-49

MARCY KELLEY  
DEPUTY COURT ADMINISTRATOR

June 1, 2001

Christopher E. Mohney, Esquire  
Blakley, Jones & Mohney  
90 Beaver Drive, Box 6  
DuBois, PA 15801

Brian S. Kane, Esquire  
Pietragallo, Bosick & Gordon  
The 38<sup>th</sup> Floor, One Oxford Center  
Pittsburgh, PA 15219

RE: LILLIAN J. KANARY  
vs.  
THE PENEN TRAFFIC COMPANY  
No. 00-1121-CD

Dear Counsel:

The above case is scheduled for Arbitration Hearing to be held Tuesday, August 7, 2001 at 9:00 A.M. The following have been appointed to the Board of Arbitrators:

Kim C. Kesner, Esquire,  
Andrew P. Gates, Esquire  
David J. Hopkins, Esquire  
Warren B. Mikesell, II, Esquire  
Frederick M. Neiswender, Esquire

If you wish to strike an Arbitrator, you must notify the undersigned within seven (7) days from the date of this letter the name you wish stricken from the list.

Very truly yours,  
*Marcy Kelley*  
Marcy Kelley  
Deputy Court Administrator

FILED

JUN 11 2001

William A. Shaw  
Prothonotary



OFFICE OF COURT ADMINISTRATOR  
FORTY-SIXTH JUDICIAL DISTRICT OF PENNSYLVANIA

CLEARFIELD COUNTY COURTHOUSE  
230 EAST MARKET STREET, SUITE 228  
CLEARFIELD, PENNSYLVANIA 16830

DAVID S. MEHOLICK  
COURT ADMINISTRATOR

PHONE: (814) 765-2641  
FAX: 1-814-765-6000 7449

MARCY KELLEY  
DEPUTY COURT ADMINISTRATOR

June 11, 2001

Christopher E. Mohney, Esquire  
Blakley, Jones & Mohney  
90 Beaver Drive, Box 6  
DuBois, PA 15801

Brian S. Kane, Esquire  
Pietragallo, Bosick & Gordon  
The 38<sup>th</sup> Floor, One Oxford Center  
Pittsburgh, PA 15219

RE: LILLIAN J. KANARY  
vs.  
THE PENEN TRAFFIC COMPANY  
No. 00-1121-CD

Dear Counsel:

The above case is scheduled for Arbitration Hearing to be held Tuesday, August 7, 2001 at 9:00 A.M. The following have been appointed as Arbitrators:

Kim C. Kesner, Esquire, Chairman  
David J. Hopkins, Esquire  
Warren B. Mikesell,II, Esquire

Pursuant to Local Rule 1306A, you must submit your Pre-Trial Statement seven (7) days prior to the scheduled Arbitration. The original should be forwarded to the Court Administrator's Office and copies to opposing counsel and the Board of Arbitrators. For your convenience, a Pre-Trial (Arbitration) Memorandum Instruction Form is enclosed as well as a copy of said Local Rule of Court.

Very truly yours,  
*Marcy Kelley*  
Marcy Kelley  
Deputy Court Administrator

cc: Kim C. Kesner, Esquire  
David J. Hopkins, Esquire  
Warren B. Mikesell,II, Esquire

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY  
PENNSYLVANIA

Lillian J. Kanary

Vs.

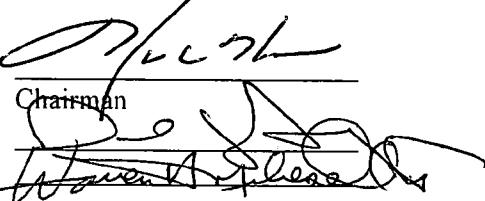
The Penn Traffic Company

No. 2000-01121-CD

**OATH OR AFFIRMATION OF ARBITRATORS**

Now, this 7th day of August, 2001, we the undersigned, having been appointed arbitrators in the above case do hereby swear, or affirm, that we will hear the evidence and allegations of the parties and justly and equitably try all matters in variance submitted to us, determine the matters in controversy, make an award, and transmit the same to the Prothonotary within twenty (20) days of the date of hearing of the same.

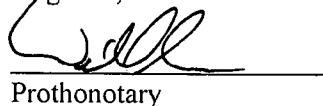
Kim C. Kesner, Esq.

  
Chairman

David J. Hopkins, Esq.

Warren B. Mikesell, II, Esq.

Sworn to and subscribed before me this  
August 7, 2001

  
Prothonotary

**AWARD OF ARBITRATORS**

Now, this 7 day of Aug, 2001, we the undersigned arbitrators appointed in this case, after being duly sworn, and having heard the evidence and allegations of the parties, do award and find as follows:

for the Plaintiff in the sum of

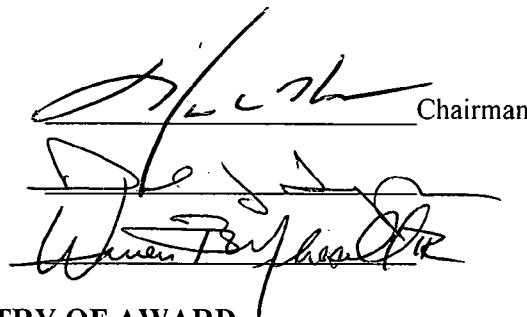
\$17,500 plus taxable costs.

**FILED**

AUG 07 2001

William A. Shaw  
Prothonotary

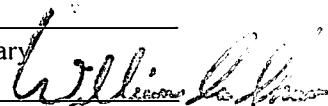
(Continue if needed on reverse.)

  
Chairman

**ENTRY OF AWARD**

Now, this 7th day of August, 2001, I hereby certify that the above award was entered of record this date in the proper dockets and notice by mail of the return and entry of said award duly given to the parties or their attorneys.

**WITNESS MY HAND AND THE SEAL OF THE COURT**

Prothonotary  
By 

**FILED** Notice to Atty Kane  
Off. of the  
AUG 17 2001 Notice to Atty Mohney  
SAC  
William A. Shaw  
Prothonotary

COPY

Lillian J. Kanary

Vs.

The Penn Traffic Company

IN THE COURT OF COMMON PLEAS  
OF CLEARFIELD COUNTY  
No. 2000-01121-CD

NOTICE OF AWARD

TO: CHRISTOPHER E. MOHNEY

You are herewith notified that the Arbitrators appointed in the above case have filed their award in this office on August 7, 2001 and have awarded:

For the Plaintiff in the sum of \$17,500.00 plus taxable costs.

William A. Shaw  
Prothonotary  
By \_\_\_\_\_

August 7, 2001

Date

In the event of an Appeal from Award of Arbitration within thirty (30) days of date of award.

**COPY**

Lillian J. Kanary

Vs.

The Penn Traffic Company

IN THE COURT OF COMMON PLEAS  
OF CLEARFIELD COUNTY  
No. 2000-01121-CD

**NOTICE OF AWARD**

TO: BRIAN S. KANE

You are herewith notified that the Arbitrators appointed in the above case have filed their award in this office on August 7, 2001 and have awarded:

For the Plaintiff in the sum of \$17,500.00 plus taxable costs.

William A. Shaw  
Prothonotary  
By \_\_\_\_\_

August 7, 2001

Date

In the event of an Appeal from Award of Arbitration within thirty (30) days of date of award.

PIETRAGALLO BOSICK & GORDON  
ATTORNEYS AT LAW

THE THIRTY-EIGHTH FLOOR  
ONE OXFORD CENTRE  
PITTSBURGH, PENNSYLVANIA 15219

TELEPHONE NO.: 412-263-2000  
FACSIMILE NO.: 412-261-5295

Brian S. Kane  
PT 42913

Direct Dial No.: (412) 263-4380  
E-mail: bsk@pbandg.com

July 30, 2001

Arb 8-7-01

VIA FEDERAL EXPRESS  
David S. Meholic  
Court Administrator  
Clearfield County Courthouse  
230 East Market Street  
Suite 228  
Clearfield, PA 16830

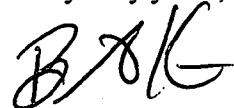
*Re: Lillian J. Kanary vs. Penn Traffic Company- No. 00-1121-CD (Clearfield  
County)*

Dear Mr. Meholic:

Enclosed for filing is Defendant's Pre-Trial Statement relative to the aforementioned matter. Kindly time-stamp the enclosed extra cover sheet, and return it to our office in the pre-addressed stamped envelope provided.

Thank you for your cooperation.

Very truly yours,



Brian S. Kane

BSK/  
Enclosures

cc: Christopher E. Mohney, Esquire (via Federal Express)  
Kim C. Kesner, Esquire via Federal Express  
David J. Hopkins, Esquire via Federal Express  
Warren B. Mikesell, II, Esquire via Federal Express

RECEIVED

JUL 31 2001

COURT ADMINISTRATOR'S  
OFFICE

IN THE COURT OF COMMON PLEAS CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY,

No. 00 - 1121 - C.D.

Plaintiff,

**DEFENDANT'S PRE-TRIAL  
STATEMENT**

vs.

THE PENN TRAFFIC COMPANY,

Filed on behalf of:  
The Penn Traffic Company, Defendant

Defendant.

Counsel of Record for this Party:

Brian S. Kane, Esquire  
PA I.D. #65715

Pietragallo, Bosick & Gordon  
38<sup>th</sup> Floor  
One Oxford Centre  
Pittsburgh, PA 15219  
(412) 263-2000

**RECEIVED**

JUL 31 2001

COURT ADMINISTRATOR'S  
OFFICE

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY,

Plaintiff,

No. 00 - 1121 CD

vs.

THE PENN TRAFFIC COMPANY,

Defendant.

**DEFENDANT'S PRE-TRIAL STATEMENT**

AND NOW come the Defendant, The Penn Traffic Company, by and through its counsel, Pietragallo, Bosick & Gordon, and Brian S. Kane, Esquire, and files the following Pre-Trial Statement:

**I. Statement of the Case**

Plaintiff, Lillian J. Kanary, initiated this action, seeking to recover for injuries allegedly sustained on January 2, 1999, at Bilo Supermarket, in DuBois, Pennsylvania.

Plaintiff contends that on January 2, 1999, she was struck on the head by a mop as the result of the negligence, carelessness, recklessness and wrongful acts of an employee of Defendant, who was mopping the floor. As a result of the incident, Plaintiff has alleged that she suffered from head and neck injuries.

Defendant contends that all times material and relevant hereto, it acted in a reasonable and non-negligent manner. Further, Plaintiff asserts that it is not reasonable that the injuries claimed by Plaintiff could have been caused by the equipment involved in the

accident. Further, it is asserted that Plaintiff's injuries, and the extent of those injuries, arise from superceding or pre-existing causes.

Defendant has offered \$4,000 to settle this claim. Plaintiff's demand is \$10,000.

## **II. Witnesses**

1. Lillian Kanary  
103 Cordella Avenue  
Toronto, Ontario, M6N258
2. Gloria Olewnick  
c/o Bilo #231  
Sandy Plaza  
R.D. #3, Box 70-A  
DuBois, Pennsylvania 15801
3. Tim New  
c/o Penn Traffic  
7667 Perry Highway  
Cresson, PA 16630
4. Josephine Summerville  
(Address unknown)
5. Shawn Bradford  
c/o Penn Traffic  
7667 Perry Highway  
Cresson, PA 16630

Defendant may call as witnesses during the trial of this matter any and all persons identified in the Pre-Trial Statement filed on behalf of any party to this action.

Defendant also reserves the right to call as a witness any person identified in any deposition, answer to interrogatory or document produced during the course of discovery.

Defendant also reserves the right to call as a witness any person to present rebuttal or impeachment of evidence.

Defendant may call as a witness during the trial of this matter any party or agent, servant, employee or representative of any party to this matter.

Defendant may call any healthcare provider, medical practitioner, chiropractor or nurse who provided healthcare to the plaintiff either prior to or subsequent to the accident identified in Plaintiff's Complaint.

Defendant may call on the issue of damages any and all healthcare providers, medical practitioners, nurses, physical therapists or chiropractors identified in any medical bill, statement or record of the plaintiff.

### **III. Exhibits**

Defendant may introduce at the time of trial any of the following exhibits:

1. Any and all medical records of DuBois Regional Medical Center outlining treatment to the Plaintiff;
2. Any and all medical records of DuBois Radiologists I outlining treatment to the Plaintiff;
3. Any and all medical records of DuBois EMS Ambulance outlining treatment to the Plaintiff;
4. Any and all medical records of Dr. Jane Howell outlining treatment to the Plaintiff;
5. Any and all records of L&G BodyCare, Inc. relative to the Plaintiff;
6. Any and all radiographic studies relative to Plaintiff, including, but not limited to, x-rays and CT scans;
7. A prototype of the subject "industrial-size mop";

8. January 2, 1999 Customer and Public Report of Accident;
9. Any and all invoices regarding medical treatment rendered to the Plaintiff, as a result of the alleged injuries of January 2, 1999, including, but not limited to, DuBois Regional Medical Center, DuBois Radiologists I, DuBois EMS Ambulance, Dr. Jane Howell, and L&G Body Care, Inc.
10. Any and all receipts for cab fare submitted by Plaintiff;

Defendant reserves the right to use as an exhibit any document, item or tangible thing identified as a potential exhibit in the Pre-Trial Statement filed on behalf of any party in this action.

Defendant also reserves the right to utilize demonstrative exhibits as aids at the time of trial.

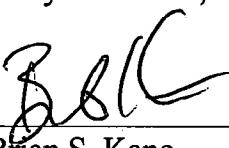
Defendant also reserves the right to use as an exhibit any document item or tangible thing identified or produced in any deposition, answer to interrogatory or document produced during this course of discovery.

Defendant also reserves the right to utilize any medical record, report, bill, statement or other medical documents evidencing or relating to treatment provided to the plaintiff both prior to and subsequent to the subject accident.

**Reservation of Rights**

Defendant reserves the right to amend, alter, change or modify this Pre-Trial Statement at any time, up to, and including, the time of trial.

Respectfully submitted,

By: 

Brian S. Kane  
Counsel for Defendant, The Penn  
Traffic Company

**CERTIFICATE OF SERVICE**

I, Brian S. Kane, Esquire, hereby certify that a true and correct copy of the Defendant's Pre-Trial Statement has been forwarded to all counsel of record this 30th day of July, 2001, by United States First Class Mail, Postage Prepaid.

Christopher E. Mohney, Esquire  
Blakley, Jones & Mohney  
90 Beaver Drive, Box 6  
Du Bois, PA 15801

Kim C. Kesner, Esquire  
Attorney At Law  
23 North Second Street  
Clearfield, PA 16830

David J. Hopkins, Esquire  
The Hopkins Law Firm  
900 Beaver Drive  
DuBois, PA 15801

Warren B. Mikesell, II, Esquire  
Attorney at Law  
115 East Locust Street  
Clearfield, PA 16830

David S. Meholick  
Court Administrator  
Clearfield County Courthouse  
230 East Market Street  
Suite 228  
Clearfield, PA 16830

  
\_\_\_\_\_  
Brian S. Kane, Esquire

NAME AND ADDRESS KANARY,LILLIAN 103 CORDELLA AVENUE  TORONTO CA 000 00			REGISTRATION DATE 01/02/99	TIME 19	ORG DNR 446977	MED REC NO 9900200146	BILLING NO	
CITY COUNTY OC			AGE 68Y	BIRTH DATE 01/12/30	METHOD ARRIVAL 4 AMBULANCE	SEX F	RACE 1	M.S. M
TELEPHONE NO. EMPLOYER, ADDRESS; OCCUPATION, PHONE  HOMEMAKER			RELIGION CATHOLIC	P.T. ER	FIN.CL. SP	ADMIT BY DEH	ICD-9-CM/CPT4 CODES	
PT/PT REPRESENTATIVE STATES SYMPTOMS OR ACCIDENT - HOW, WHERE, WHEN INDUSTRIAL MOP FELL ON HEAD PASSE			STAFF ALERT 375-8888 Friends @ TL					
PERSON TO NOTIFY IN CASE OF EMERGENCY NOT GIVEN			RELATIONSHIP OTHER					
NAME AND ADDRESS KANARY,LILLIAN SELF 103 CORDELLA AVENUE TORONTO CA 000 00			TELEPHONE HOMEMAKER SOC.SEC.# 445-42-6692	REL	EMPLOYER NAME AND ADDRESS			
INSURANCE COMPANY			PLAN	POLICY HOLDER	REL	POLICY #	GROUP #	
E.R. PHYSICIAN SETH,SATISH K SHILAJA, P		FAMILY PHYSICIAN NO,DOCTOR GIVEN		REFERRING PHYSICIAN NO,DOCTOR GIVEN				

## AUTHORIZATION FOR EMERGENCY, OUTPATIENT, OR SHORT PROCEDURES UNIT TREATMENT

Lillian \_\_\_\_\_ (or \_\_\_\_\_)  
 or \_\_\_\_\_, voluntarily authorize and consent to diagnostic procedures, examinations, and/or medical care as prescribed by, or deemed necessary in the judgement of Dr. Seeth for  
 Emergency Treatment       Outpatient Services       Short Procedures Unit Services.

understand that this consent does not include operations or any non-routine procedures or treatment, and that the risks and alternatives for such procedures or treatment, which a reasonable patient would consider significant to a decision whether or not to undergo such treatment or procedures, will be explained to me by my treating physician or another physician designated by him.

I certify that no guarantees have been made to me as to the results of treatments or examinations in the Medical Center.

This form has been explained to me and I certify that I understand its contents.

Verbal explanation, Lillian, Seeth, 1/2-98  
 Signature of Patient      Relationship      Date/Time  
Dorothy Horne  
 Witness

Patient is unable to consent for the following reason: \_\_\_\_\_

Signature of Patient Representative      Relationship      Date/Time  
 Witness      Witness

## RELEASE FROM RESPONSIBILITY FOR DISCHARGE

I am leaving (or taking \_\_\_\_\_) from the DuBois Regional Medical Center against the advice of my physician. I have been informed of the risks involved in this decision. I hereby release the DuBois Regional Medical Center, its staff, and my physician from all responsibility for any ill effects which may result from this action.

Signature of Patient      Relationship      Date/Time  
 Witness      Witness

Time: 1:50  Emergent  Urgent  NonurgentCONDITION ON ARRIVAL:  Poor  Fair  Satisfactory  DOACHIEF COMPLAINT: *Was being struck on the head with a mop at 6:19 Short LOC but did not stump over*

VITAL SIGNS Temp 97.6 Pulse 110 Resp 22 SpO2 100% O2 Sat WT

ALLERGIES: *Tylenol, Codeine*CURRENT MEDS:  See attached list *Propantheline Muscle Relaxant for pain Resperon Lorazepam*IMMUNIZATIONS:  DNA  UP TO DATE LAST TT/TD:VISUAL ACUITY  OD  OS  OU  CORRECTED  UNCORRECTEDPT. PREGNANT?  DNA  YES  NO  UNSURE  Hysterectomy  TUBAL LIGATIONTRIAGE TO  Registration  Room Triage Nurse:Primary Nurse: *Tracy Smith RA*

CHECK THE REQUESTED STUDIES			
<input type="checkbox"/> CBC	<input type="checkbox"/> Cardiac enzymes	<input type="checkbox"/> Magnesium	<input type="checkbox"/> GC
<input type="checkbox"/> Lymes	<input type="checkbox"/> CKMB	<input type="checkbox"/> UA	<input type="checkbox"/> C&S
<input type="checkbox"/> BUN	<input type="checkbox"/> CPK, Trip, Myo	<input type="checkbox"/> UC	<input type="checkbox"/> Wet Mount
<input type="checkbox"/> Creatinine	<input type="checkbox"/> Troponin I	<input type="checkbox"/> RSS	<input type="checkbox"/> RSV
<input type="checkbox"/> Blood Sugar	<input type="checkbox"/> Myoglobin	<input type="checkbox"/> Throat C&S	<input type="checkbox"/> Triage Drug Screen
<input type="checkbox"/> Amylase	<input type="checkbox"/> Digoxin level	<input type="checkbox"/> Blood C&S	<input type="checkbox"/> Coma Panel
<input type="checkbox"/> PT/PTT	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Type and Screen	<input type="checkbox"/>
<input type="checkbox"/> Basic Met Prof.	<input type="checkbox"/> Monospot	<input type="checkbox"/> Type and Cross	<input type="checkbox"/>
<input type="checkbox"/> Hepatic Prof.	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Type and Cross	<input type="checkbox"/>
<input type="checkbox"/> Compre profile	<input type="checkbox"/> ETOH	<input type="checkbox"/> Chlamydia	<input type="checkbox"/>

EKG	<input type="checkbox"/> EKG: Provisional Reading <i>MS</i>	<input type="checkbox"/> Repeat
CARDIO	<input type="checkbox"/> ABG <input type="checkbox"/> on O2 <input type="checkbox"/> on Room Air	<input type="checkbox"/> Repeat <input type="checkbox"/> Repeat
<input type="checkbox"/> Proventil	<input type="checkbox"/> Proventil <input type="checkbox"/> Atrovent	<input type="checkbox"/> Repeat <input type="checkbox"/> Repeat
<input type="checkbox"/> Vaponephrine	<input type="checkbox"/> Vaponephrine <input type="checkbox"/> Other	<input type="checkbox"/> Repeat <input type="checkbox"/> Repeat
<input type="checkbox"/> Other	<input type="checkbox"/> Other <input type="checkbox"/> Peak Flows	<input type="checkbox"/> Repeat <input type="checkbox"/> Repeat
RESPIRATORY	<input type="checkbox"/> Chest <input type="checkbox"/> Portable Chest <input type="checkbox"/> Port Lat C Spine <i>MS</i>	<input type="checkbox"/> Enhanced <input type="checkbox"/> Unenhanced
<input type="checkbox"/> Spine	<input type="checkbox"/> Spine <input type="checkbox"/> LS Spine <input type="checkbox"/> ABD Series	<input type="checkbox"/> Enhanced <input type="checkbox"/> Unenhanced
<input type="checkbox"/> + L	<input type="checkbox"/> LS Spine <input type="checkbox"/> ABD Series	<input type="checkbox"/> Enhanced <input type="checkbox"/> Unenhanced

EXAM TIME: 2:15

## PHYSICIAN REPORT

Dictated

DX *Skull Contusion, m/s Concussion*  
*Neck Strain, L/S Shoulder Strain*  
*Left C-S pain / Cr - Headache*

## DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS

Condition On Discharge:  Satisfactory  Fair  Poor Time: *3:40* WITH: *Leave* Admitted Room No:  Physician Notified/Time:  Sent Home  Return to work  Deceased  TransferredNOTIFIED:  
 Relative  Police  
 Coroner  Poison CenterFor follow-up care please see:  Personal physician  Occupational medicine  ER if worse or not improvingFOLLOW INSTRUCTIONS ON  HEAD INJURY  CULTURE  STREP SCREEN  LAB TEST  X-RAY/EKG'S  SPRAINS, STRAINS AND CONTUSIONS  NOSEBLEEDS  U.R.I. WOUND CARE AND BURN CARE  GASTROENTERITIS AND/OR ABDOMINAL PAIN  ALLERGY INJ.  URINARY INFECTIONS  CARE OF CHILD AND FEVER  
 ANIMAL BITES  CASTS  EYE CARE  TETANUS INJECTION  MEDICATION ALERT  MEDICATION USEOTHER INSTRUCTION: *1. Rest for 24 to 48 Hours - then activity as tolerated**2. Aspirin for pain if needed**3. Sleep in a position of comfort**4. See family physician for blood pressure**5. Recheck in 24 hr if needed refer to doctor**6. Drowsiness**7. Drowsiness**8. Drowsiness**9. Drowsiness**10. Drowsiness**11. Drowsiness**12. Drowsiness**13. Drowsiness**14. Drowsiness**15. Drowsiness**16. Drowsiness**17. Drowsiness**18. Drowsiness**19. Drowsiness**20. Drowsiness**21. Drowsiness**22. Drowsiness**23. Drowsiness**24. Drowsiness**25. Drowsiness**26. Drowsiness**27. Drowsiness**28. Drowsiness**29. Drowsiness**30. Drowsiness**31. Drowsiness**32. Drowsiness**33. Drowsiness**34. Drowsiness**35. Drowsiness**36. Drowsiness**37. Drowsiness**38. Drowsiness**39. Drowsiness**40. Drowsiness**41. Drowsiness**42. Drowsiness**43. Drowsiness**44. Drowsiness**45. Drowsiness**46. Drowsiness**47. Drowsiness**48. Drowsiness**49. Drowsiness**50. Drowsiness**51. Drowsiness**52. Drowsiness**53. Drowsiness**54. Drowsiness**55. Drowsiness**56. Drowsiness**57. Drowsiness**58. Drowsiness**59. Drowsiness**60. Drowsiness**61. Drowsiness**62. Drowsiness**63. Drowsiness**64. Drowsiness**65. Drowsiness**66. Drowsiness**67. Drowsiness**68. Drowsiness**69. Drowsiness**70. Drowsiness**71. Drowsiness**72. Drowsiness**73. Drowsiness**74. Drowsiness**75. Drowsiness**76. Drowsiness**77. Drowsiness**78. Drowsiness**79. Drowsiness**80. Drowsiness**81. Drowsiness**82. Drowsiness**83. Drowsiness**84. Drowsiness**85. Drowsiness**86. Drowsiness**87. Drowsiness**88. Drowsiness**89. Drowsiness**90. Drowsiness**91. Drowsiness**92. Drowsiness**93. Drowsiness**94. Drowsiness**95. Drowsiness**96. Drowsiness**97. Drowsiness**98. Drowsiness**99. Drowsiness**100. Drowsiness**101. Drowsiness**102. Drowsiness**103. Drowsiness**104. Drowsiness**105. Drowsiness**106. Drowsiness**107. Drowsiness**108. Drowsiness**109. Drowsiness**110. Drowsiness**111. Drowsiness**112. Drowsiness**113. Drowsiness**114. Drowsiness**115. Drowsiness**116. Drowsiness**117. Drowsiness**118. Drowsiness**119. Drowsiness**120. Drowsiness**121. Drowsiness**122. Drowsiness**123. Drowsiness**124. Drowsiness**125. Drowsiness**126. Drowsiness**127. Drowsiness**128. Drowsiness**129. Drowsiness**130. Drowsiness**131. Drowsiness**132. Drowsiness**133. Drowsiness**134. Drowsiness**135. Drowsiness**136. Drowsiness**137. Drowsiness**138. Drowsiness**139. Drowsiness**140. Drowsiness**141. Drowsiness**142. Drowsiness**143. Drowsiness**144. Drowsiness**145. Drowsiness**146. Drowsiness**147. Drowsiness**148. Drowsiness**149. Drowsiness**150. Drowsiness**151. Drowsiness**152. Drowsiness**153. Drowsiness**154. Drowsiness**155. Drowsiness**156. Drowsiness**157. Drowsiness**158. Drowsiness**159. Drowsiness**160. Drowsiness**161. Drowsiness**162. Drowsiness**163. Drowsiness**164. Drowsiness**165. Drowsiness**166. Drowsiness**167. Drowsiness**168. Drowsiness**169. Drowsiness**170. Drowsiness**171. Drowsiness**172. Drowsiness**173. Drowsiness**174. Drowsiness**175. Drowsiness**176. Drowsiness**177. Drowsiness**178. Drowsiness**179. Drowsiness**180. Drowsiness**181. Drowsiness**182. Drowsiness**183. Drowsiness**184. Drowsiness**185. Drowsiness**186. Drowsiness**187. Drowsiness**188. Drowsiness**189. Drowsiness**190. Drowsiness**191. Drowsiness**192. Drowsiness**193. Drowsiness**194. Drowsiness**195. Drowsiness**196. Drowsiness**197. Drowsiness**198. Drowsiness**199. Drowsiness**200. Drowsiness**201. Drowsiness**202. Drowsiness**203. Drowsiness*

TIME: 146

Mode of Arrival	Arrived with	Self Care
<input checked="" type="checkbox"/> Ambulance <input type="checkbox"/> W.C. <input type="checkbox"/> Ambulatory <input type="checkbox"/> Carried Gait <input type="checkbox"/> Steady <input type="checkbox"/> Unsteady	<input type="checkbox"/> Self <input type="checkbox"/> Police <input type="checkbox"/> Parent <input checked="" type="checkbox"/> Friend <input type="checkbox"/> Spouse <input type="checkbox"/> Delegate <input type="checkbox"/> Family <input type="checkbox"/>	<input checked="" type="checkbox"/> Independent <input type="checkbox"/> Total Assist <input type="checkbox"/> Partial Assist <input type="checkbox"/> Child

Safety Measures	Environmental
<input checked="" type="checkbox"/> Siderails up <input type="checkbox"/> Family at bedside <input checked="" type="checkbox"/> Call Bell <input type="checkbox"/> Security present	Lives with: <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse Language barrier <input type="checkbox"/> Translator

Trauma/Accidents	<input type="checkbox"/> DNA
<input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Seat Belt on <input type="checkbox"/> Air bag deployed Type: <input type="checkbox"/> Car <input type="checkbox"/> Truck <input type="checkbox"/> Motorcycle <input type="checkbox"/> Bicycle <input type="checkbox"/> Impact: <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Rollover <input type="checkbox"/> Side <input type="checkbox"/> Helmet <input type="checkbox"/> Protective Clothing Time of incident: _____ Extrication needed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Fall (____ feet) <input type="checkbox"/> GSW <input type="checkbox"/> Assault <input type="checkbox"/> Other _____	

Prehospital Care / Treatment	<input type="checkbox"/> DNA
<input checked="" type="checkbox"/> ALSB <input checked="" type="checkbox"/> C1D <input checked="" type="checkbox"/> Stiff collar <input checked="" type="checkbox"/> IV of # at in <input type="checkbox"/> IV of # at in <input type="checkbox"/> Accuchek _____ <input type="checkbox"/> Meds: _____ <input type="checkbox"/> Splints _____ <input type="checkbox"/> 0, <input type="checkbox"/> NC <input type="checkbox"/> Simple <input type="checkbox"/> Non-Rebreather Airway: <input type="checkbox"/> Oral <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> ETT _____ <input type="checkbox"/> EOA	

PMH:	<input type="checkbox"/> DNA
<input type="checkbox"/> NONE <input type="checkbox"/> Unable to obtain <input type="checkbox"/> CHF <input type="checkbox"/> MI <input type="checkbox"/> Cardiac Cath <input checked="" type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma/COPD <input type="checkbox"/> Seizures <input type="checkbox"/> Cancer <input type="checkbox"/> Stroke <input type="checkbox"/> Dementia <input type="checkbox"/> Mental Illness <input type="checkbox"/> Ulcers <input type="checkbox"/> GI Bleed <input type="checkbox"/> Renal Disease <input checked="" type="checkbox"/> Anxiety Attack _____	

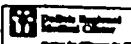
Alcohol use: \_\_\_\_\_  
Tobacco use: \_\_\_\_\_  
Caffeine use: \_\_\_\_\_

Psychosocial			
Overall appearance:	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Frail	<input type="checkbox"/> Alert <input type="checkbox"/> Anxious	<input type="checkbox"/> Obese
Mood/affect:	<input type="checkbox"/> Cooperative <input type="checkbox"/> Blunted/flat	<input type="checkbox"/> Age appropriate <input type="checkbox"/> Combative	<input type="checkbox"/> Crying <input type="checkbox"/> Lethargic
Ideations:	<input type="checkbox"/> Unresponsive <input type="checkbox"/> Uncooperative	<input type="checkbox"/> Confused	<input type="checkbox"/> Confused
Cardio Pulmonary <input type="checkbox"/> DNA			
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Location:			
Radiation:			
Onset/Duration:			
Pain Scale (0-10)			
Character:			
<input type="checkbox"/> Dyspnea			
<input type="checkbox"/> Syncope			
<input type="checkbox"/> Diaphoresis			
Dinemapp on: <input type="checkbox"/>			
CARDIAC MONITOR <input type="checkbox"/>			
Rhythm _____			
Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No			
Neurological <input type="checkbox"/> DNA			
Patient Status			
Loss of Consciousness	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Witnessed			
Unwitnessed			
Nausea			
Vomiting			
Visual disturbance			
<input type="checkbox"/> Appropriate verbal responses			
<input type="checkbox"/> Appropriate motor responses			
<input type="checkbox"/>			
Circulation			
Color:	<input checked="" type="checkbox"/> Pink <input type="checkbox"/> Pale	<input type="checkbox"/> Mottled <input type="checkbox"/> Cyanotic	<input type="checkbox"/> Ashen <input type="checkbox"/> Jaundice
	<input type="checkbox"/> Sallow <input type="checkbox"/>		
Condition:	<input checked="" type="checkbox"/> Warm <input type="checkbox"/> Dry	<input type="checkbox"/> Cool <input type="checkbox"/> Moist	<input type="checkbox"/> Hot <input type="checkbox"/> Cold
Pulses: Right	Left	<input type="checkbox"/> DNA	
Radial <input type="checkbox"/>	<input type="checkbox"/>		
Normal <input type="checkbox"/>	<input type="checkbox"/>		
Thready <input type="checkbox"/>	<input type="checkbox"/>		
Bounding <input type="checkbox"/>	<input type="checkbox"/>		
Absent <input type="checkbox"/>	<input type="checkbox"/>		
Pedal <input type="checkbox"/>	<input type="checkbox"/>		
Normal <input type="checkbox"/>	<input type="checkbox"/>		
Thready <input type="checkbox"/>	<input type="checkbox"/>		
Bounding <input type="checkbox"/>	<input type="checkbox"/>		
Absent <input type="checkbox"/>	<input type="checkbox"/>		
Capillary refill: _____ seconds			
Bleeding controlled <input type="checkbox"/> Yes <input type="checkbox"/> No			
Extremity movement			
Hand grasps			
<input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal _____			
<input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak _____			
Leg movement			
<input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal _____			
<input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak _____			

Signature: *Dailey Smith, DO*

446977 68Y ER  
KANARY, LILLIAN  
SETH, SATISH K

01/02/99  
045-42-1452 9500200146  
CR CRVEN



Pain:

 DNALocation: Side of headDescription: Sore from bump on head

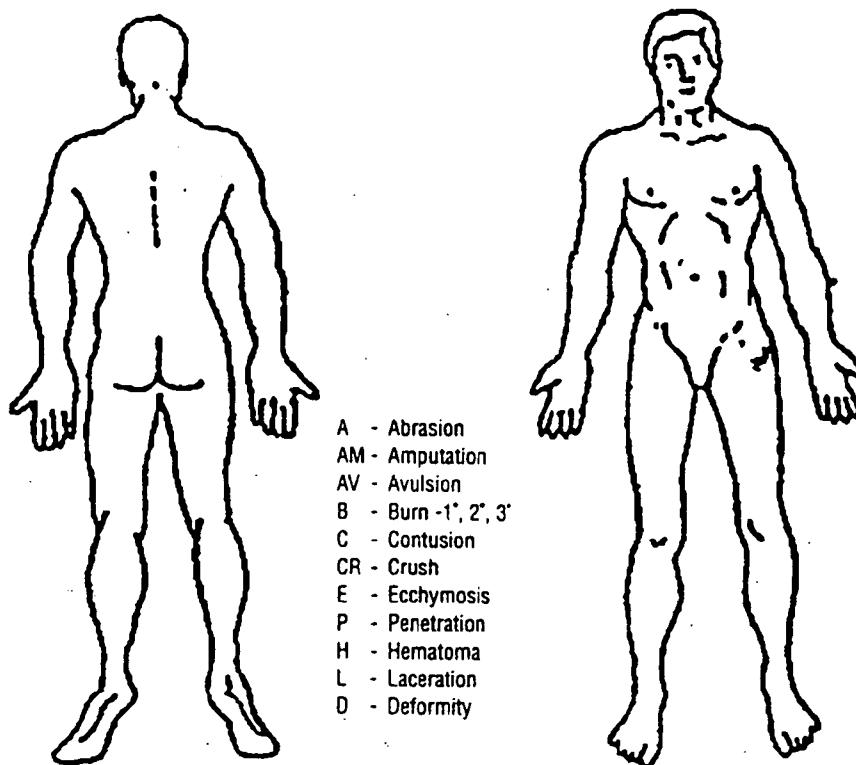
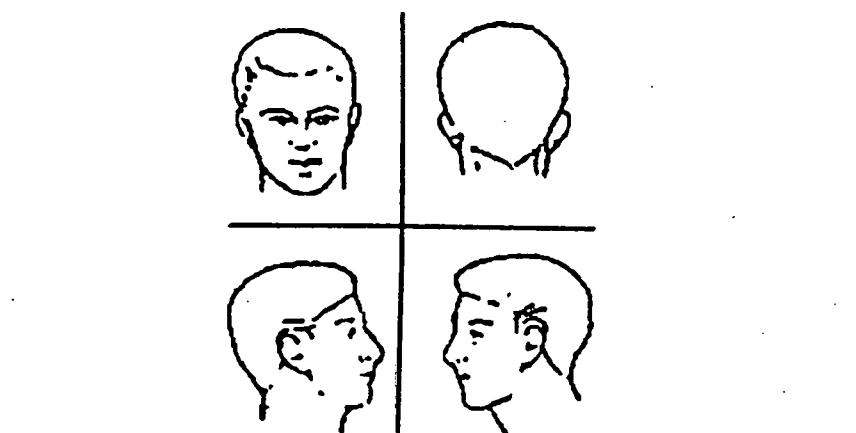
Pain Scale (0-10) \_\_\_\_\_

## Musculoskeletal Injury/Wounds

 DNAMechanism of injury: A mop handle fell out of a bucket, struck my parent on the side of headTime of injury: 1/1/99Injured at: Bilo Bilo

Type of injury:

Laceration       Avulsion  
 Abrasion       Burn  
 Puncture Wound       Contusion

Site of injury: head See body diagram

446977 68Y ER

XANARY, LILLIAN

SETH, SATISH K

01/12/30

445-42-6692

22-20 SCR CIVEN

01/02/99

9900200146

ENT

 DNA

EYES	OD	OS	EARS	AD	AS	NOSE/THROAT
Red	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Epistaxis
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Drainage	<input type="checkbox"/>	<input type="checkbox"/>	Rhinorrhea
Matted	<input type="checkbox"/>	<input type="checkbox"/>	Decreased	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
Burning/pain	<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Dysphagia
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Other:			Other:
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>				
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>				
Flashing light	<input type="checkbox"/>	<input type="checkbox"/>				
Floater	<input type="checkbox"/>	<input type="checkbox"/>				
Foreign body	<input type="checkbox"/>	<input type="checkbox"/>				

Onset of symptoms: \_\_\_\_\_

## GI/GU/GYN

 DNA

## Abdomen:

Soft       Distended  
 Guarding       Rigid

## Tenderness:

None       LUQ  
 RUQ       LLQ  
 RLQ       Epigastric

## Bowel Sounds:

Present  
 Diminished  
 Hyperactive  
 None  
 Last BM \_\_\_\_\_

## GI:

Nausea       Dry heaves  
 Vomiting       Diarrhea  
 Rectal Bleed \_\_\_\_\_

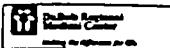
## GU:

Voids without difficulty  
 Flank pain R L  
 Dysuria  
 Urgency  
 Hematuria  
 Frequency  
 Foley  
 Other \_\_\_\_\_

## GYN:

Fetal tones \_\_\_\_\_  
 Vaginal bleeding  
 Vaginal discharge  
 History of ectopic  
 Para \_\_\_\_\_ Gravida \_\_\_\_\_  
 Ab \_\_\_\_\_  
 Onset of symptoms: \_\_\_\_\_

Signature: NS



## **Emergency Department Record**

1 of 7

446977 68  
KANARY, LILLIAN  
SETH. SATISH K  
21165

68Y ER

ER

**ACCUCKEK**

HEMOCCULT

01/02/99  
9900200146  
CP 11 EN

9900200146

9900200146

**Code: R = Relief**

P = Partial Belief

**N = N<sub>0</sub> e<sup>0.117t</sup>**

THE JOURNAL OF CLIMATE

Time	Intervention	Type/Site	Comments	Initials
	Wound Care:			
	Cleansed:			
	Steri Strips			
	Dressing			
2:00	<i>inc pack to forearm</i>			
	Musculoskeletal			
	Splint			
	Ace			
	Immobilizer			
	Sling			
	Crutches/Walker			
	Immobilizations Removed			
	GI			
	NG/Lavage			
	Enema			
	GU			
	Catheter			
	Other:			

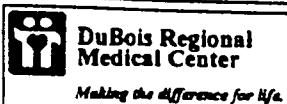
**Signature:** \_\_\_\_\_

Initials:

**Signature:**

100-15





Making the difference for life.

6 of 7

Emergency Department Record

446977 68Y ER  
 KANARY, LILLIAN  
 SETH, SATISH K  
 01/12/30 F 01/02/99  
 445-14-8632 9909200146  
 DR. DOCTOR CIVEN

### PATIENT PROBLEM LIST

Patient needs identified as: (Number to Prioritize) (Minimum of 1 need to be identified)

Knowledge deficit: _____	Alteration in body temperature: _____
Alteration in Comfort: <i>Hord pain</i>	Individual ineffective coping: _____
Alteration in fluid volume: _____	Risk of infection _____
Alteration in Oxygenation: _____	Impaired tissue integrity: _____
Decreased Cardiac Output: _____	Other: _____

(See Chart and nurses notes for interventions and response.)

### SCREENING CRITERIA

Patient Home Phone Number/Room #: \_\_\_\_\_

Suspected Abuse: Adult/Child: <input checked="" type="checkbox"/> No Identified Needs <input type="checkbox"/> Unusual/suspicious marks (i.e. burns, bruises, welts, lacerations, punctures) <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Domestic Violence: Patient verbalizes need for assistance. <b>FOLLOW DRMC POLICY (PR-1, PR-1.2, PR-1.3),</b>	Initial visit: date: _____ Time: _____ Signature: _____ Follow-up: <input type="checkbox"/> None <input type="checkbox"/> See Progress Note
Discharge Planning: <input checked="" type="checkbox"/> No Identified Needs <input type="checkbox"/> Additional supportive services needed upon d/c (med. equip., Home Health). <input type="checkbox"/> INITIAL Placement assistance needed before discharge. <input type="checkbox"/> Financial assistance required to follow treatment. <input type="checkbox"/> Patient has an Advanced Directive but did not bring in a copy, follow up needed.	Initial visit: date: _____ Time: _____ Signature: _____ Follow-up: <input type="checkbox"/> None <input type="checkbox"/> See Progress Note
Pastoral Care: <input checked="" type="checkbox"/> No Identified Needs <input type="checkbox"/> Terminal Illness; <input type="checkbox"/> Recent Loss of Significant Other; <input type="checkbox"/> Request for Pastoral Care	Initial visit: date: _____ Time: _____ Signature: _____ Follow-up: <input type="checkbox"/> None <input type="checkbox"/> See Progress Note
If any of the above are indicated, PLEASE FAX THIS FORM TO THE SOCIAL WORK/ <b>PASTORAL CARE AREA #3488</b>	

### KEY/CODES

Glasgow Coma Score		Adult	Child	Infant	Pupils: D = Dilated S = Small M = Medium L = Large Pupil reaction: + = Brisk S = Sluggish O = No reaction			
Eyes Open	Spontaneous	4	4	4	Cardiac Rhythms: NSR - Normal Sinus Rhythm AF - Atrial Fib HB - Heart block SB - Sinus Brady SR - Sinus Rhythm ST - Sinus Tachycardia J - Junctional H - Heart block PVC - Premature Ventricular Complex PAC - Premature Atrial Complex VT - Ventricular tachy VF - Ventricular fib SVT - Supraventricular tachy PA - Pacemaker			
	To Voice/Speech	3	3	3				
	To pain	2	2	2				
	No response	1	1	1				
Best Verbal Response	Oriented	5	5		Hand Grasp and Leg Movement: Strong - S Sensation Intact - SI Weak - W Paresthesia - P Equal = Unequal <input checked="" type="checkbox"/> BP D = See dinemapp			
	Coos, babbles, smiles			5				
	Confused	4	4					
	Irritable, crying			4				
	Inappropriate words	3	3					
	Cries, Screams to pain			3				
	Incomprehensible sounds	2	2					
	Moans, grunts			2				
	None/No response	1	1	1				
Best Motor Response	Obeys Commands	6	6		Medication code R = Relief P = Partial Relief N = No relief O = No adverse effects Pain scale 0 - 10			
	Spontaneous			6				
	Localizes to Pain	5	5					
	Withdraws from touch			5				
	Normal flexion	4	4					
	Withdraws from pain			4				
	Abnormal flexion - decorticate	3	3	3				
	Abnormal extension - decerebrate	2	2	2				
	No response	1	1	1				

Signature: *Sherry Smith*

DUBOIS REGIONAL MEDICAL CENTER  
DUBOIS, PENNSYLVANIA

EMERGENCY ROOM

Date: 1/2/99 Time: 2 p.m.

Patient Name: KANARY, LILLIAN

9900200146 - 000446977

HISTORY-OF PRESENT ILLNESS: This is a 68 year old female brought to our Department by ambulance for evaluation of injuries sustained at BiLo Supermarket a short time ago. This 68 year old female states that she was accidentally struck in the head by a industrial sized mop. The patient states that she was sitting by a person who was going to use the mop. Evidently the person using the mop lost control of the mop and bucket that it was in and according to the patient's friend who witnessed this, she states that the mop struck her friend in the right side of her head causing resultant pain. There was also a short period of loss of consciousness. The patient was brought to our Department fully immobilized in a long spine board with cervical immobilization device in place complaining of pain to the right side of her head, her neck, and her left shoulder. She is here for evaluation of this problem.

PAST MEDICAL HISTORY: Positive for hypertension and anxiety attacks.

MEDICATIONS: Ativan, a muscle relaxant for right knee pain and Premarin.

ALLERGIES: TYLENOL AND CODEINE.

PHYSICAL EXAMINATION: GENERAL: Alert, cooperative oriented 68 year old white female who appears to be no acute physical distress. VITAL SIGNS: Temperature 97.6. Her initial blood pressure was 218/111 with a pulse rate 110 and irregular. Blood pressure has since come down to a more acceptable level at 177/88, however, it is still elevated and as mentioned earlier this patient does have a history of hypertension, however, she is not taking any medication at this time for her high blood pressure. Initial part of Mrs. Kanary's physical examination was carried out while she was fully immobilized in a long spine board with a cervical immobilization device. Lateral X rays of the C-spine were taken before I had an opportunity to examine this lady and I could not see any fracture, dislocation although she does have significant degenerative joint disease present. During the examination again, she is alert, cooperative oriented. HEENT: Head is normocephalic. There is tenderness to the right parietal skull. I cannot feel any deformities and I cannot see any hematomas or contusion or abraded areas. Ears appear normal. There is no bleeding present. It is negative for hemotympanum. Eyes, Pupils equal, round and reactive to light and accommodation. Extraocular muscles intact. Face, there is no facial paresis or paralysis present. There is no facial pain. there is no ecchymosis or edema to the face. HEART: Rapid rate, irregular rhythm. There appears to be sinus rhythm with PACs, left ventricle ectopy was noted. Low grade murmur present. LUNGS: clear. Patient is not short of breath. The remaining of the cervical spine X rays were done and they showed degenerative joint disease with no fracture or dislocations. In addition to that, an un-enhanced CAT scan of the head was also done and it was normal. When the patient returns from our Radiology Department, we then removed the rigid collar and her neck was tender to palpation. There was also tenderness to palpation to her left shoulder and left arm, however, no deformities were present. Range of motion was full but painful. Her back was not injured. There is no tenderness to the thoracic spine or lumbar spine with palpation.

DIAGNOSIS:

1. Skull contusion with mild concussion.
2. Neck and left shoulder pain, probably secondary to skull contusion.

EMERGENCY ROOM REPORT  
DUBOIS REGIONAL MEDICAL CENTER  
DUBOIS, PENNSYLVANIA  
KANARY, LILLIAN  
Page 2

9900200146 - 000446977

Patient was discharged from our Department with aforementioned diagnoses and the following instructions:

1. Aspirin for pain.
2. Rest for 24 to 48 hours. Then engage in activities as tolerated.
3. Sleep in a position of comfort. May be feel better sleeping in a semi-sitting position.
4. See your family physician when you get back home and have your blood pressure reevaluated. You may need to be put on medication for this.
5. Return to our Emergency Room if necessary.

D: 01/02/1999 3:26 P  
T: 01/04/1999 8:56 P PFS/cw  
DOCUMENT NO: 62570  
Job/Tape ID: 006121

  
P.F. Shilala, D.O.

DUBoIS REGIONAL MEDICAL CENTER  
10 Hospital Ave, DuBois, PA 5801

KANARY, LILLIAN  
103 CORDELLA AVENUE  
TORONTA  
CA 000 00  
Date 01/02/99 Time: 1442

\*ER Unit # 000446977  
Age 68Y Acct # D9900200146

SETH, SATISH K

NO, DOCTOR GIVEN

Chk-in #	Order	Exam	
318476	0002	43023	XR-SPINE SINGLE VIEW Ord Diag: HIT WITH A MOP
318478	0004	43003	XR-CERVICAL SPINE MIN 4 Ord Diag: HIT WITH MOP

CERVICAL SPINE - CROSS-TABLE LATERAL AND AP, LATERAL, BOTH OBLIQUE  
AND OPEN-MOUTH VIEWS:

Marked degenerative changes are seen in the distal cervical spine with slight narrowing of C4-5 disc space. Degenerative changes are seen in the facet joints also in the mid and distal cervical spine. No fracture or dislocation is noted.

IMPRESSION: OSTEOARTHRITIS DISTAL CERVICAL SPINE.  
NO FRACTURE SEEN.

/READ BY/ G. ALI SHAH,  
/Released By/ G. ALI SHAH,

01/04/99 0834  
JAH

Complete      \*\* Portable \*\*

DUBOIS REGIONAL MEDICAL CENTER  
Hospital Ave, DuBois, PA 5801

KANARY, LILLIAN  
103 CORDELLA AVENUE  
TORONTO

CA 000 00

\*ER

Unit # 000446977

Age 68Y

Acct # D9900200146

Date 01/02/99 Time: 1508

SETH, SATISH K

NO, DOCTOR GIVEN

Chk-in # Order

318477 0003

Exam

72724

CT-HEAD UNENHANCED

Ord Diag: HIT IN HEAD BY INDUST. MOP

CT SCAN OF HEAD:

Axial images of the head were obtained without intravenous contrast enhancement.

Intra- and extraventricular CSF spaces are normal. No intracranial bleeding or fresh infarct is seen. No space occupying lesion is noted. There is no midline shift present.

IMPRESSION: NORMAL UNENHANCED CT SCAN OF HEAD.

/READ BY/ G. ALI SHAH,  
/Released By/ G. ALI SHAH,

01/04/99 0834  
JAH

Complete

68 years Female NADAN, WILLIAM

DuBois Regional Medical Center  
Dept: ER-5

Oper: DT

Doctor

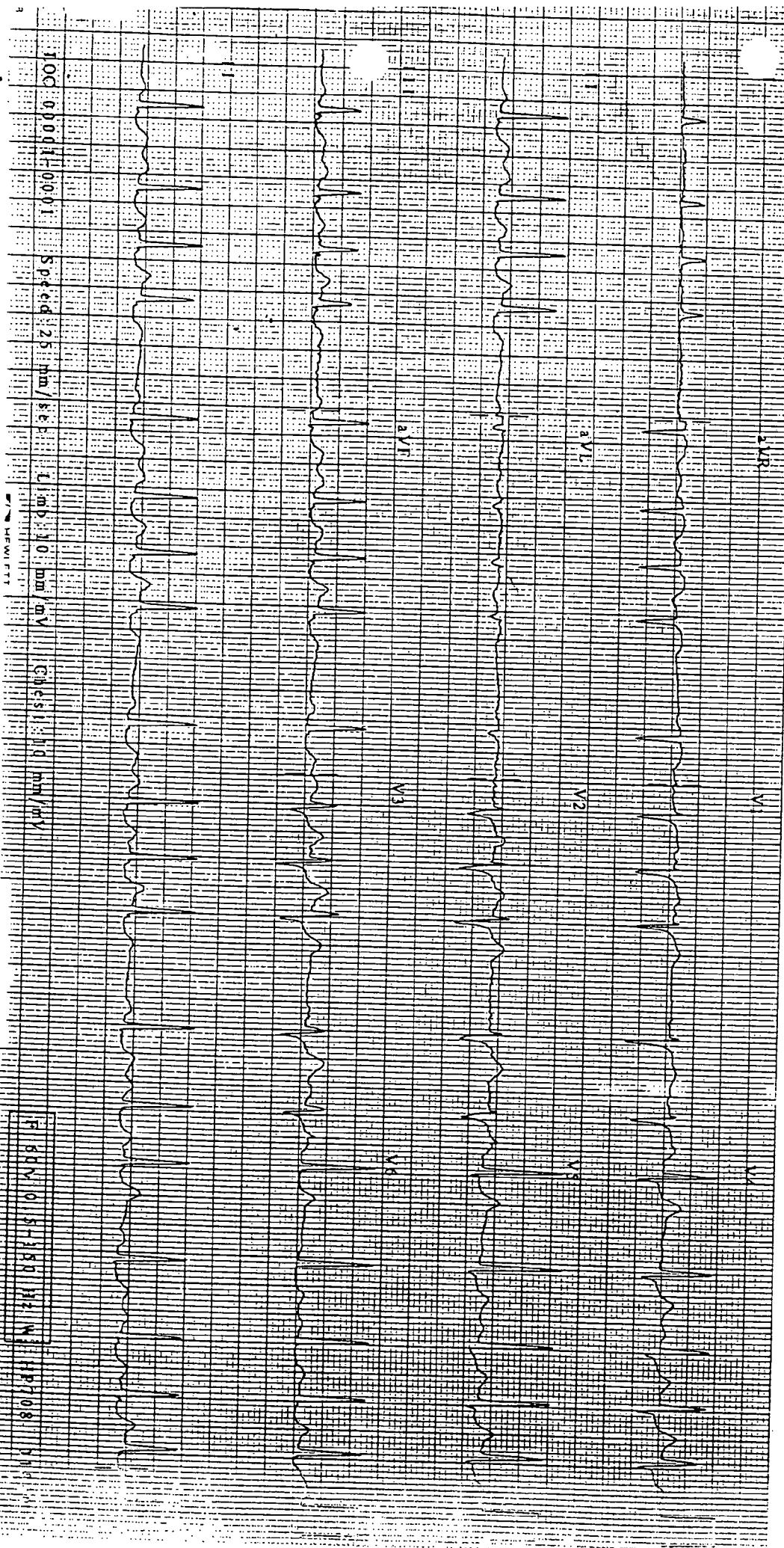
Rate 111 Sinus tachycardia, rate 111  
PR 167 Multiple atrial premature complexes  
ORS 87 Non-specific ST depression  
OT 306  
QTc 416

--AXIS--

P 86  
ORS 72  
T 61

7 Dampfing

- ABNORMAL ECG -



D'HOIS REGIONAL MEDICAL CENT

BP	157/112	14:26
MAP	(137)	██████████
BPM	125	♦
BP	205/ 95	14:15
MAP	(135)	██████████████████
BPM	125	♦
BP	220/111	14:05
*MAP	(144)	██████████████████
BPM	108	♦
BP	201/121	13:55
*MAP	(154)	██████████████████
BPM	111	♦
BP	218/111	13:54
*MAP	(144)	██████████████████
BPM	110	♦
mmHg&BPM	20 50 100 150 200	

MOVE STRIP OF TAPE  
D ATTACH SECOND REPORT

PATIENT'S NAME

PHYSICIAN'S NAME

PROCEDURE

DATE

COMMENTS

SETH, SATHISH K  
01/12/30  
445-42-6692 F 01/02  
NO, DOCTOR GIVEN 99002001

CRITIKON DINAMAP 1846 SX/P VERSION 089

446-7 68Y ER

KANARY, LILLIAN  
SETH, SATISH K

## E.R. AFTER CARE INSTRUCTIONS TO THE PATIENT

 HEAD INJURIES

Although no evidence of serious injury was found at this time, contact your physician or return to the Emergency Department if any of the following conditions occur:

1. Loss of consciousness
2. Nausea and/or vomiting associated with a headache. (Persistent vomiting).
3. Unusual sleepiness or difficulty in arousing. (Awaken the patient from sleep every 2-3 hours during the next 24 hours).
4. One pupil (dark area) of the eye much larger than the other. Unequal pupils (one large - one small).
5. Weakness, numbness, or paralysis of the arms or legs.
6. Double or blurred vision.
7. Persistent dizziness.
8. Increasing confusion, drowsiness or irritability.
9. Convulsions (jerking and spells)
10. Irregular or labored breathing.
11. Drainage of blood or clear fluid from the ears or nose.
12. Stiffness of neck.
13. Continued or worsening headache unrelieved by medication prescribed only by the doctor.
14. Trouble with speech or swallowing.

Limit activities for 24 hours. Diet as tolerated.

 NOSE BLEEDS

1. Don't blow your nose for 24 hrs.
2. Rest
3. No strenuous activity for 24 hrs.
4. Medication as advised.
5. If nose begins to bleed apply direct pressure by pinching nostrils together continuously for 10 minutes.

 LAB TESTS

The results of all your lab tests are not immediately available. If the results are abnormal or require a change in care, the Emergency Department will notify you. If you do not hear from us within one week, call the Emergency Department at 375-3470.

 CULTURES

The results of your culture are reviewed by the Emergency Department. If your culture is abnormal and a medication adjustment needs to be made, you will be contacted by the Emergency Department. A minimum of 48 hours is required for the results.

 STREP SCREEN

All strep screens are reviewed by the Emergency Department. You will be notified by phone if your strep screen is positive and/or if any medication adjustments need to be made. A minimum of 48 hours is required for test results.

 X-RAY'S/EKG'S

Your X-RAY/EKG has been read on a preliminary basis by the Emergency Department physician. Final consultation and review by the radiologist/cardiothoracic will be made. You will be notified by phone if his interpretation differs and given follow-up instructions.

 DIAGNOSTIC TEST RESULTS

If you have not been notified within 24 to 48 hours or your condition is not improving, please call the Emergency Department at 375-3470 for further instructions.

 SPRAINS, STRAINS, AND CONTUSIONS

1. Elevate and application of ice to injured extremity to reduce pain and swelling for 48 hours.
2. After 48 hours apply moist heat to the affected area 4 times a day for 20-35 minutes.
3. Rest the affected area as much as possible for the first 24 hours.
4. Activity as directed below by the physician.

 U.R.I.

1. Encourage clear liquids.
2. Rest
3. Tylenol for fever and achiness.
4. Medications as advised.
5. If no improvement in 2-3 days follow-up with your family physician.

 TETANUS INJECTION

1. Injection site may become red, warm, and swollen.
2. Use ice to the site 20 minutes 4 times the first day.
3. Use heat to the site 20 minutes 4 times for the next 2-3 days.
4. Report reaction larger than silver dollar to your physician, or if pain persists.
5. Tylenol or aspirin for pain or fever.

 WOUND AND BURN CARE

1. Keep wound clean and dry.
2. If your dressing becomes wet or dirty, reapply a sterile dressing unless advised otherwise by the physician.
3. If any difficulties develop (i.e. wound becomes red, swollen, hot, more painful, or begins to drain) report to the Emergency Department or contact your family physician.
4. Keep your wound elevated if possible to reduce pain and swelling.
5. Should bleeding occur, apply pressure firmly over the bandage and elevate the area for ten (10) minutes. Return to the Emergency Department immediately for re-evaluation if bleeding does not stop.
6. Return for suture removal as instructed below to minimize scar formation. After 48 hours, remove original bandage and apply a clean one. Clean daily thereafter. Cleanse as instructed by the physician. Use only medications prescribed by the physician.

 GASTROENTERITIS AND/OR ABDOMINAL PAIN

1. You should take only ice chips by-mouth for 4-6 hours to rest your stomach. (Give 1 ounce of clear fluids every hour for infants.)
2. After 4-6 hours, start to take clear liquids (i.e. Jello, water, Kool-Aid, Gatorade, tea, flat Coke or gingerale, or Pedialyte (available in drugstores). Take clear liquids for 24 hours.
3. If no vomiting occurs, progress from the clear liquid diet to a full liquid diet (i.e. soups, cream of wheat, cornstarch puddings, soft cooked eggs and sherbet). Then to a B.R.A.T. diet (Bananas, Rice, Applesauce and Toast). Slowly progress to a regular diet. Avoid fatty or spicy foods, milk and milk products for 5-6 days.

4. Do not take an enema or laxative unless ordered by the doctor.
5. Take medications only as prescribed by the doctor.
6. Return to the Emergency Department or call your family doctor for any of the following:
  - a) persistent vomiting/diarrhea for 24 hours with or without signs of dehydration (lips/mouth very dry, decreased urine output, no tears).
  - b) pain persists or worsens
  - c) fever
  - d) blood in stools or urine
  - e) listless/or lethargic behavior

## DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS

		Condition On Discharge:	Satisfactory	Fair	Poor	Time: <i>3/4</i>	WITH:
<input type="checkbox"/> Admitted	<input type="checkbox"/> Physician	<input type="checkbox"/> Agent	<input type="checkbox"/> Return to work	<input type="checkbox"/> Deceased	<input type="checkbox"/> Transferred		<input type="checkbox"/> self <input type="checkbox"/> family <input checked="" type="checkbox"/> other
Room No:	Notified/Time:	<input type="checkbox"/> Home					<input type="checkbox"/> Relative <input type="checkbox"/> Police
For follow-up care please see: <input type="checkbox"/> Personal physician <input type="checkbox"/> Occupational medicine <input type="checkbox"/> ER if worse or not improving							<input type="checkbox"/> Coroner <input type="checkbox"/> Poison Center

FOLLOW INSTRUCTIONS ON		<input type="checkbox"/> HEAD INJURY <input type="checkbox"/> CULTURE <input type="checkbox"/> STREP SCREEN <input type="checkbox"/> LAB TEST <input type="checkbox"/> X-RAY/EKG'S <input type="checkbox"/> SPRAINS, STRAINS AND CONTUSIONS <input type="checkbox"/> NOSEBLEEDS <input type="checkbox"/> U.R.I.
		<input type="checkbox"/> WOUND CARE AND BURN CARE <input type="checkbox"/> GASTROENTERITIS AND/OR ABDOMINAL PAIN <input type="checkbox"/> ALLERGY INJ. <input type="checkbox"/> URINARY INFECTIONS <input type="checkbox"/> CARE OF CHILD AND FEVER
		<input type="checkbox"/> ANIMAL BITES <input type="checkbox"/> CASTS <input type="checkbox"/> EYE CARE <input type="checkbox"/> TETANUS INJECTION <input type="checkbox"/> MEDICATION ALERT <input type="checkbox"/> MEDICATION USE

OTHER INSTRUCTION: <i>Get a 14-16 oz glass when a day as tolerated</i>	
<input type="checkbox"/> No Work or School	Date: <i>6/1/98</i>
<input type="checkbox"/> No Physical Education	<input type="checkbox"/> Until Released by Physician
Method of Validating Knowledge: <input type="checkbox"/> Verbalization <input type="checkbox"/> Return Demo <input type="checkbox"/> Other: <i>Handwritten signature</i>	

PATIENT / RESPONSIBLE PARTY	NURSE'S SIGNATURE: <i>Handwritten signature</i>	PHYSICIAN'S SIGNATURE: <i>Handwritten signature</i>
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I hereby acknowledge receipt of these instructions, have read them and understand them. I further understand that I have had emergency treatment and that I may be released before all of my medical conditions/test results are known or treated. I will arrange for follow-up care. DuBois Regional Medical Center-DuBois, PA 15801

<p>P A T I E N T</p> <p>NAMIC ADDRESS KANARY, LILLIAN 103 CORDELLA AVENUE TORONTO CA 000 00 TELEPHONE NO. (416)763-5787 S.S. NO. 445-42-6692 EMPLOYER, ADDRESS, OCCUPATION, PHONE</p>										REGISTRATION DATE 01/04/99	TIME 14:40	ORG DNR	MED. REC. NO. 446977	BILLING NO. 9900400261
										AGE 68Y	BIRTH DATE 01/12/30	METHOD ARRIVAL 2 WALK IN	SEX F	RACE 1
<p>COUNTY OC</p> <p>RELIGION CATHOLIC</p>										P.T. ER	FIN. CL. CI	ADMIT BY CAC		
										ICD-9-CM/CPT4 CODES				
<p>HOMEMAKER</p> <p>PT/PT REPRESENTATIVE STATES SYMPTOMS OR ACCIDENT - HOW, WHERE, WHEN INJ 0102 HEADACHE NECK PAIN</p> <p>PERSON TO NOTIFY IN CASE OF EMERGENCY</p> <p>SUMMERTON, JOSEPHINE H 552 T L</p>										<p>STAFF ALERT</p>				
<p>NAME AND ADDRESS KANARY, LILLIAN SELF 103 CORDELLA AVENUE TORONTO CA 000 00</p>										<p>RELATIONSHIP OTHER</p>				
<p>TELEPHONE (416)763-5787 HOMEMAKER SOC. SEC. # 445-42-6692</p>										<p>REL EMPLOYER NAME AND ADDRESS</p>				
<p>INSURANCE COMPANY MANULIFE FINANCIAL</p>		PLAN 300001	<p>POLICY HOLDER KANARY, LILLIAN</p>		REL 1	<p>POLICY # 9131361132WP</p>		GROUP # 999999						
<p>E.R. PHYSICIAN RASHWAN, AHMED S Shahina</p>		<p>FAMILY PHYSICIAN NO. DOCTOR GIVEN</p>		<p>REFERRING PHYSICIAN NO. FAMILY DOCTOR</p>		<p>7-110</p>								

**AUTHORIZATION FOR EMERGENCY, OUTPATIENT, OR SHORT PROCEDURES UNIT TREATMENT**

I, Lillian (or )  
for Self ), voluntarily authorize and consent to diagnostic procedures,  
examinations, and/or medical care as prescribed by, or deemed necessary in the judgement of Dr. Bashwan for  
 Emergency Treatment       Outpatient Services       Short Procedures Unit Services.

I understand that this consent does not include operations or any non-routine procedures or treatment, and that the risks and alternatives for such procedures or treatment, which a reasonable patient would consider significant to a decision whether or not to undergo such treatment or procedures, will be explained to me by my treating physician or another physician designated by him.

I certify that no guarantees have been made to me as to the results of treatments or examinations in the Martin A. C.

This form has been explained to me and I certify that I understand its contents.

~~Signature of Patient~~

1 Se  
Relationship

Date/Time

88

Patient is unable to consent for the following reason:

**Signature of Patient Representative:**

### Relationship

Witness

— 1 —

**RELEASE FROM RESPONSIBILITY FOR DISCHARGE**

I am leaving (or taking \_\_\_\_\_ from) the DuBois Regional Medical Center against the advice of my physician. I have been informed of the risks involved in this decision. I hereby release the DuBois Regional Medical Center, its staff, and my physician from all responsibility for any ill effects which may result from this action.

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**Signature of Patient**

### Relationships

**Date/Time**

THE BOSTONIAN

Witness

Dubois Regional Medical Center Make the difference for life		EMERGENCY DEPARTMENT RECORD		Page 1 of 7	
Time: <u>235</u>	<input type="checkbox"/> Emergent	<input type="checkbox"/> Urgent	<input checked="" type="checkbox"/> Nonurgent		
CONDITION ON ARRIVAL:		<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Satisfactory	<input type="checkbox"/> DOA
CHIEF COMPLAINT: <u>Go neck pain has</u> <u>had pain since 1/2/99</u> <u>which may start of on</u> <u>(L) side of head</u>					
VITAL SIGNS	Temp <u>98.4</u>	Pulse <u>98</u>	Resp <u>18</u>	BP <u>190/94</u>	O <sub>2</sub> Sat <u>94</u>
ALLERGIES:	<u>Tylenol</u> <u>Cadence</u>				
CURRENT MEDS:	<input type="checkbox"/> See attached list <u>Prevacid</u> <u>Locerapezine</u> <u>Tranxene</u> <u>relaxant</u> <u>ASA</u>				
IMMUNIZATIONS:	<input type="checkbox"/> DNA <input type="checkbox"/> UP TO DATE LAST TT/TD: _____				
VISUAL ACUITY	OD <u>20/20</u>	OS <u>20/20</u>	OU <u>20/20</u>	<input type="checkbox"/> CORRECTED <input type="checkbox"/> UNCORRECTED	
PT. PREGNANT?	<input type="checkbox"/> DNA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNSURE	<input type="checkbox"/> HYSTERECTOMY <input type="checkbox"/> TUBAL LIGATION
LMP	<u>1/24/99</u>				
TRIAGE TO	<input type="checkbox"/> Registration <input type="checkbox"/> Room		Triage Nurse: <u>Naomi Hunter</u>		
Primary Nurse:	<u>Naomi Hunter</u>				

446977 68Y ER  
BANNAY, ILLIAN  
PUSHWAN, AHMED S  
01/12/30 01/04/29  
445-42-5692 9900400268  
446977 68Y ER  
PUSHWAN, AHMED S  
01/12/30 01/04/29  
445-42-5692 9900400268

Lillian Kanarski

#### **CHECK THE REQUESTED STUDIES**

<input type="checkbox"/> CBC	<input type="checkbox"/> Cardiac enzymes	<input type="checkbox"/> Magnesium	<input type="checkbox"/> GC
<input type="checkbox"/> Lytes	<input type="checkbox"/> CKMB	<input type="checkbox"/> UA	<input type="checkbox"/> C&S
<input type="checkbox"/> BUN	<input type="checkbox"/> CPK, Trip, Myo	<input type="checkbox"/> UC	<input type="checkbox"/> Wet Mount
<input type="checkbox"/> Creatinine	<input type="checkbox"/> Troponin I	<input type="checkbox"/> RSS	<input type="checkbox"/> RSV
<input type="checkbox"/> Blood Sugar	<input type="checkbox"/> Myoglobin	<input type="checkbox"/> Throat C&S	<input type="checkbox"/> Triage Drug Screen
<input type="checkbox"/> Amylase	<input type="checkbox"/> Digoxin level	<input type="checkbox"/> Blood C&S	<input type="checkbox"/> Coma Panel
<input type="checkbox"/> PT/PTT	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Type and Screen	<input type="checkbox"/>
<input type="checkbox"/> Basic Met Prof.	<input type="checkbox"/> Monospot	<input type="checkbox"/> Type and Cross	<input type="checkbox"/>
<input type="checkbox"/> Hepatic Prof.	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Type and Cross	<input type="checkbox"/>
<input type="checkbox"/> Complete profile	<input type="checkbox"/> ETOH	<input type="checkbox"/> Chlamydia	<input type="checkbox"/>

~~EKG~~ Provisional Reading:  
O Repeat

<input type="checkbox"/> ABG	<input type="checkbox"/> on O <sub>2</sub>	<input type="checkbox"/> on Room Air	<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat
<input type="checkbox"/> Proventil			<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat
<input type="checkbox"/> Proventil	<input type="checkbox"/> Atrovent	<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat
<input type="checkbox"/> Vaponephrine			<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat
<input type="checkbox"/> Other			<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat
<input type="checkbox"/> Peak Flows	<input type="checkbox"/>			
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/> CT		
<input type="checkbox"/> Portable Chest	<input type="checkbox"/>	<input type="checkbox"/> Enhanced		
<input type="checkbox"/> Port Lat C Spine	<input type="checkbox"/>	<input type="checkbox"/> Unenhanced		
<input type="checkbox"/> C Spine	<input type="checkbox"/>			
<input type="checkbox"/> LS Spine	<input type="checkbox"/>			
<input type="checkbox"/> ABD Series	<input type="checkbox"/>			

## PHYSICIAN REPORT

EXAM TIME: 3:40 PM

## **DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS**

DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS		Condition On Discharge:	Satisfactory <input checked="" type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Time: <u>5/40</u>	WITH: <input type="checkbox"/> self <input type="checkbox"/> family <input checked="" type="checkbox"/> other
<input type="checkbox"/> Admitted Room No:	<input type="checkbox"/> Physician Notified/Time:	<input checked="" type="checkbox"/> Sent Home	<input type="checkbox"/> Return to work	<input type="checkbox"/> Deceased	<input type="checkbox"/> Transferred	NOTIFIED: <input type="checkbox"/> Relative <input type="checkbox"/> Police <input type="checkbox"/> Coroner <input type="checkbox"/> Poison Center	
For follow-up care please see: <input checked="" type="checkbox"/> Personal physician <input type="checkbox"/> Occupational medicine <input type="checkbox"/> If worse or not improving							
FOLLOW INSTRUCTIONS ON <u>5/40</u>							

For follow-up care please see:  personal physician  Occupational medicine  If worse or not improving

**FOLLOW INSTRUCTIONS ON**

HEAD INJURY  CULTURE  STREP SCREEN  LAB TEST  X-RAY/EKG'S.  SPRAINS, STRAINS AND CONTUSIONS  NOSEBLEEDS  U.R.I.  
 WOUND CARE AND BURN CARE  GASTROENTERITIS AND/OR ABDOMINAL PAIN  ALLERGY INJ.  URINARY INFECTIONS  CARE OF CHILD AND FEVER  
 ANIMAL BITES  CASTS  EYE CARE  TETANUS INJECTION  MEDICATION ALERT  MEDICATION USE

**OTHER INSTRUCTION:**

① Sip Colloidal as needed - would use for  
- 7-10 days & no longer ② Continue  
meds as needed ③ Recheck if needed

No Work or School      Date: \_\_\_\_\_  
 No Physical Education       Until Released by Physician  
 Light Work Only

- 7-10 days, 4 to longer @ Continue  
meds as needed @ Recheck if needed

### Method of Validating Knowledge: **Verbalization**

## 8. Patterns

**PATIENT/  
RESPONSIBLE PARTY**

Lillian Kanare

**NURSE'S  
SIGNATURE**

**PHYSICIAN'S  
SIGNATURE**

I hereby acknowledge receipt of these instructions, have read them and understand them. I further understand that I have had emergency treatment and that I may be released before all of my medical conditions/test results are known or treated. I will arrange for follow-up care. DuBois Regional Medical Center-DuBois, PA 15801

DUBOIS REGIONAL MEDICAL CENTER  
DUBOIS, PENNSYLVANIA

EMERGENCY ROOM

Date: 01/04/98 Time: 3:40 p.m.

Patient Name: KANARY, LILLIAN

9900400268 - 000446977

CHIEF COMPLAINT: This is a 68-year-old female who presents to our department for further evaluation of neck and head pain.

HISTORY OF PRESENT ILLNESS: The patient was seen here several days ago after she was accidentally struck in the head by a mop at one of our Bi-Low supermarkets. X-rays of the cervical spine were negative and an unenhanced CAT scan of the head was done at that time and it was also negative. She continues to have pain to the head, neck, and left shoulder. She is here for evaluation of this continuing pain.

MEDICATIONS: Her current meds include Premarin, Ativan, and a muscle relaxant. She has been taking Aspirin for current injuries, however, states that she cannot take or tolerate the Aspirin because she is experiencing some tinnitus.

ALLERGIES: SHE IS ALLERGIC TO TYLENOL AND CODEINE.

PHYSICAL EXAMINATION

VITAL SIGNS: Temperature 98.6, pulse 98, respiratory rate of 18, blood pressure 190/94.

GENERAL: Alert, cooperative, oriented, 68-year-old white female in no acute physical distress.

HEENT: Her head is normocephalic. There is tenderness on palpation to the right parietal scalp area. She has a small hematoma to the right parietal scalp with no contused or abraded areas that are obvious at this time. Neck - There is tenderness on palpation of the upper cervical spine and paracervical areas. There is pain to the left shoulder area with palpation and movement. However, the patient does exhibit full range of motion to the left shoulder. HEART: The heart shows a slightly irregular rhythm, normal rate, and no adventitious sounds noted. Ears appear normal. There is no evidence of injury. That is, there is no ecchymosis or hemotympanum or bleeding seen. The nose is non-swollen, nontender, and no bleeding is noted. The oropharynx is not injured.

EMERGENCY ROOM COURSE: An EKG was done today and it shows a sinus rhythm with an occasional PVC. No additional x-rays were done.

DIAGNOSIS: Recheck skull contusion and sprain/strain of cervical spine.

DISPOSITION: The patient was given a soft collar and discharged with the following instructions.

- 1) Soft collar as needed. I told the patient to use it only for seven to ten days, no longer.
- 2) Continue her meds as prescribed.
- 3) Recheck if needed.

D: 01/04/1999 5:17 P

T: 01/05/1999 2:28 P PFS/bc

DOCUMENT NO: 62699

Job/Tape ID: 006592

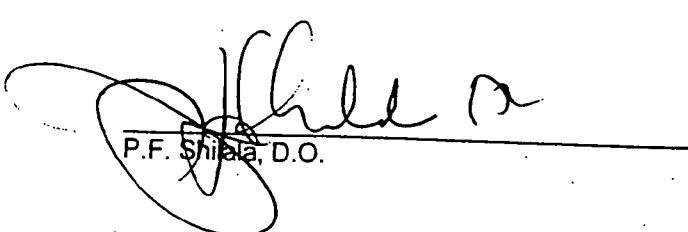
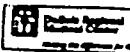
  
P.F. Shihla, D.O.

Chart Copy

Patient Regional Medical Center		Emergency Department Record		Page 2 of 7
TIME: 07:15 pm				
Mode of Arrival		Arrived with		Self Care
<input type="checkbox"/> Ambulance <input type="checkbox"/> W.C. <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Carried Gait <input type="checkbox"/> Steady <input type="checkbox"/> Unsteady	<input type="checkbox"/> Self <input type="checkbox"/> Police <input type="checkbox"/> Parent <input checked="" type="checkbox"/> Friend <input type="checkbox"/> Spouse <input type="checkbox"/> Delegate <input type="checkbox"/> Family <input type="checkbox"/>	<input checked="" type="checkbox"/> Independent <input type="checkbox"/> Total Assist <input type="checkbox"/> Partial Assist <input type="checkbox"/> Child		
Safety Measures		Environmental		
<input checked="" type="checkbox"/> Siderails up <input type="checkbox"/> Family at bedside <input checked="" type="checkbox"/> Call Bell <input type="checkbox"/> Security present		Lives with: <input type="checkbox"/> Self <input type="checkbox"/> Spouse  Language barrier <input type="checkbox"/> Translator <u>friend</u>		
Psychosocial				
Overall appearance: <input checked="" type="checkbox"/> Normal Mood/affect: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Cooperative <input type="checkbox"/> Age appropriate <input type="checkbox"/> Unresponsive <input type="checkbox"/> Crying <input type="checkbox"/> Lethargic <input type="checkbox"/> Blunted/flat <input type="checkbox"/> Confused <input type="checkbox"/> Combative <input type="checkbox"/> Uncooperative				
Trauma/Accidents				
<input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Seat Belt on <input type="checkbox"/> Air bag deployed Type: <input type="checkbox"/> Car <input type="checkbox"/> Truck <input type="checkbox"/> Motorcycle Impact: <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Rollover <input type="checkbox"/> Side <input type="checkbox"/> Helmet <input type="checkbox"/> Protective Clothing Time of incident: _____ Extrication needed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Fall (____ feet) <input type="checkbox"/> GSW <input type="checkbox"/> Assault <input type="checkbox"/> Other _____				
Cardio Pulmonary				
<input type="checkbox"/> DNA <b>Airway</b> <input checked="" type="checkbox"/> Clear/Patent <input type="checkbox"/> Adjuncts _____  <b>Breathing</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Dyspneic <input type="checkbox"/> Grunting <input type="checkbox"/> Stridor <input type="checkbox"/> Nasal flaring <input type="checkbox"/> Retractions <input type="checkbox"/> Accessory muscles <input type="checkbox"/> Absent <input type="checkbox"/> Other _____ Cough: <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Non productive Breath Sounds: <input type="checkbox"/> Not assessed / DNA <input type="checkbox"/> Right <input checked="" type="checkbox"/> Left <input checked="" type="checkbox"/> Clear <input checked="" type="checkbox"/> Rales/crackles <input type="checkbox"/> Rhonchi/Coarse <input type="checkbox"/> Wheeze <input type="checkbox"/> Diminished <input type="checkbox"/> Absent <input type="checkbox"/> Tracheal Deviation <input type="checkbox"/> JVD  <input type="checkbox"/> Oxygen: _____ LPM <input type="checkbox"/> Time <input type="checkbox"/> NC <input type="checkbox"/> Simple face <input type="checkbox"/> Nonrebreather <input type="checkbox"/> Tube <input type="checkbox"/> Humidified <input type="checkbox"/> Ventilator Pulse Oximeter on at _____ % <input type="checkbox"/> DNA <b>Circulation</b> Color: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Pale <input type="checkbox"/> Mottled <input type="checkbox"/> Cyanotic <input type="checkbox"/> Ashen <input type="checkbox"/> Jaundice <input type="checkbox"/> Sallow <input type="checkbox"/> Condition: <input checked="" type="checkbox"/> Warm <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Cool <input type="checkbox"/> Moist <input type="checkbox"/> Hot <input type="checkbox"/> Cold  Pulses: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> DNA <input type="checkbox"/> Radial <input type="checkbox"/> <input checked="" type="checkbox"/> Normal <input checked="" type="checkbox"/> <input type="checkbox"/> Thready <input type="checkbox"/> <input type="checkbox"/> Bounding <input type="checkbox"/> <input type="checkbox"/> Absent <input type="checkbox"/> Pedal <input type="checkbox"/> <input type="checkbox"/> Normal <input type="checkbox"/> <input type="checkbox"/> Thready <input type="checkbox"/> <input type="checkbox"/> Bounding <input type="checkbox"/> <input type="checkbox"/> Absent <input type="checkbox"/> Capillary refill: <u>12 sec</u> seconds Bleeding controlled <input type="checkbox"/> Yes <input type="checkbox"/> No				
Neurological				
<input type="checkbox"/> DNA <b>Patient Status</b> Loss of Consciousness <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Witnessed <input type="checkbox"/> Duration _____ <input type="checkbox"/> Unwitnessed <input type="checkbox"/> Incontinence _____ <input type="checkbox"/> Nausea <input checked="" type="checkbox"/> Headache <input type="checkbox"/> Vomiting <input type="checkbox"/> Post ictal _____ <input checked="" type="checkbox"/> Visual disturbance <input checked="" type="checkbox"/> Appropriate verbal responses <input checked="" type="checkbox"/> Appropriate motor responses <input checked="" type="checkbox"/> Loss of appetite				
Pupils				
<input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal _____ <input checked="" type="checkbox"/> Reactive <input type="checkbox"/> Non reactive _____ <input type="checkbox"/> Dilated & Fixed <input checked="" type="checkbox"/> EOMI <input type="checkbox"/> Other <u>dry eyes</u>				
Extremity movement				
Hand grasps <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal _____ <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak Leg movement <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal _____ <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak				
Alcohol use: _____ Tobacco use: _____ Caffeine use: _____				



Pain

DNA

Location: \_\_\_\_\_

Description: \_\_\_\_\_

Pain Scale (0-10) \_\_\_\_\_

## Musculoskeletal Injury/Wounds

DNA

Mechanism of injury: \_\_\_\_\_

Time of injury: \_\_\_\_\_

Injured at: \_\_\_\_\_

Type of injury:

Laceration       Avulsion  
 Abrasion       Burn  
 Puncture Wound       \_\_\_\_\_

Site of injury: \_\_\_\_\_

 See body diagram

EENT

DNA

EYES

Red       OD       OS  
 Tearing       Drainage  
 Matted       Decreased  
 Burning/pain       Hearing  
 Itching       Other: \_\_\_\_\_  
 Blurred vision       \_\_\_\_\_  
 Loss of vision       \_\_\_\_\_  
 Flashing light       \_\_\_\_\_  
 Floaters       \_\_\_\_\_  
 Foreign body       \_\_\_\_\_

EARS

AD

AS

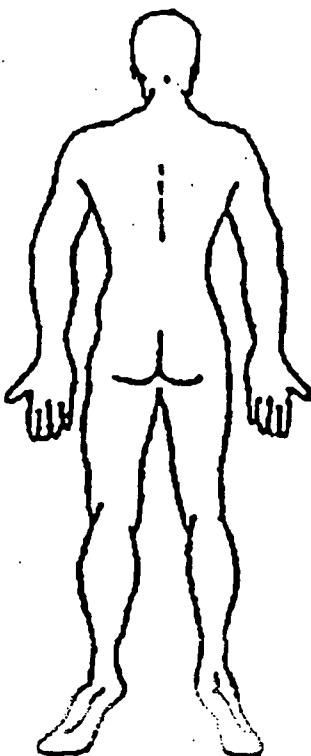
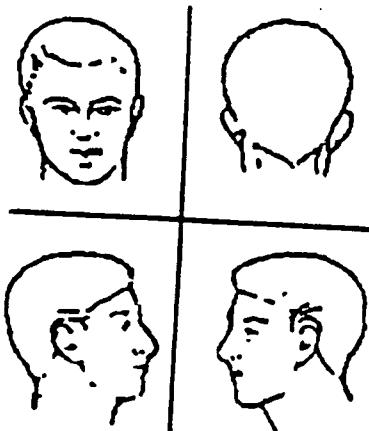
NOSE/THROAT

DNA

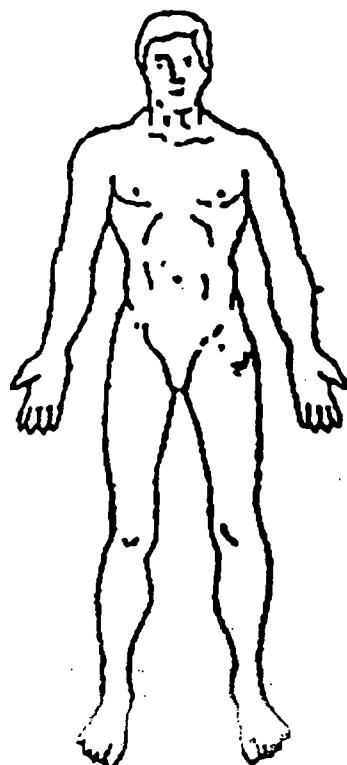
 Epistaxis Rhinorrhea Sore throat Dysphagia

Other: \_\_\_\_\_

Onset of symptoms: \_\_\_\_\_



A - Abrasion  
 AM - Amputation  
 AV - Avulsion  
 B - Burn -1', 2', 3'  
 C - Contusion  
 CR - Crush  
 E - Ecchymosis  
 P - Penetration  
 H - Hematoma  
 L - Laceration  
 D - Deformity



## GI/GU/GYN

DNA

Abdomen:

Soft       Distended  
 Guarding       Rigid

Tenderness:

none       LUQ  
 RUQ       LLQ  
 RLQ       Epigastric

Bowel Sounds:

Present  
 Diminished  
 Hyperactive  
 None  
 Last BM \_\_\_\_\_

GI:

Nausea       Dry heaves  
 Vomiting \_\_\_\_\_  
 Diarrhea \_\_\_\_\_  
 Rectal Bleed \_\_\_\_\_

GU:

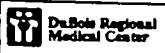
Voids without difficulty  
 Flank pain R L  
 Dysuria  
 Urgency  
 Hematuria  
 Frequency  
 Foley  
 Other \_\_\_\_\_

GYN:

Fetal tones \_\_\_\_\_  
 Vaginal bleeding  
 Vaginal discharge  
 History of ectopic  
 Para \_\_\_\_\_ Gravida \_\_\_\_\_  
 Ab \_\_\_\_\_

Onset of symptoms: \_\_\_\_\_

Signature: \_\_\_\_\_



446977 68Y ER  
KANARY, LILLIAN  
RASHWAN, AHMED S  
C1/12/30 F 01/04/99  
445-42-6652 9900400268  
NO. 1 FAMILY DOCTOR

## NOTES



68 years Female KANTRY LILLIAN

DuBois Regional Medical Center

Dept: ER4

Oper: BD

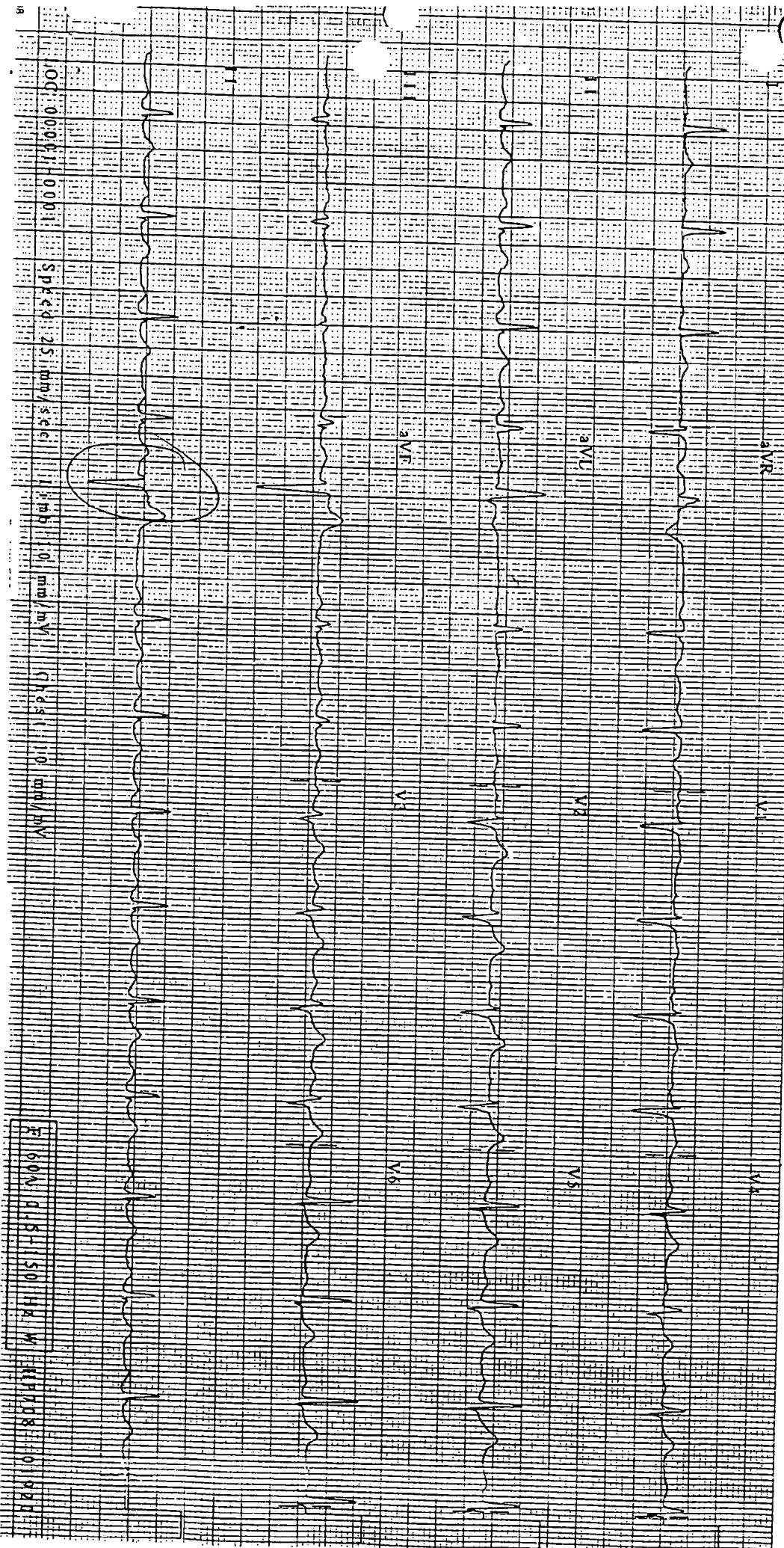
268

Rate 87 . Sinus rhythm, rate 87  
PR 178 . Ventricular premature complex  
ORS 92  
OT 346  
OTc 416

Doctor  
RASHWAN

--AXIS--  
P 68  
QRS 23  
T 43  
  
- ABNORMAL ECG -

PL



DuBois Radiologists I  
 PO Box 1106  
 23 Beaver Drive  
 DuBois, PA 15801  
 814-371-1784

FOR X RAY INTERPRETATION

**\*\*NOTICE OF DELINQUENT ACCOUNT\*\***  
 THIS ACCOUNT IS SERIOUSLY OVERDUE.  
 PROMPT PAYMENT WILL AVOID FURTHER  
 ACTION.

Account No.	Amount Due
kanalii-00	174.00
Date	Amount Enclosed
05/20/99	

Lillian Kanary  
 103 Cordella Avenue  
 Toronto, ON 0000000000

Remit Payment To: DuBois Radiologists

IF ANY QUESTIONS CALL (814) 371-1784

Kanary, Lillian

PAYMENT DUE UPON RECEIPT !!

Please remove and return this portion with your payment

Date	Dr.	Procedure Code	Description	Diagnosis	Chrgs/Credits	Item Balance
01/02/99	3	72050	CERVICAL SPINE MINIMUM 4 Plan Payment: X NO INSURANCE INFO RECEIVED	95909	41.00 0.00	41.00
04/01/99			CT HEAD WO	85400	133.00	133.00
**IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH YOUR CORRECT INSURANCE INFORMATION. PLEASE DO SO AS SOON AS POSSIBLE; OR YOU CAN BE HELD RESPONSIBLE FOR THIS BALANCE. **						
<b>**NOTICE OF DELINQUENT ACCOUNT**</b> THIS ACCOUNT IS SERIOUSLY OVERDUE. PROMPT PAYMENT WILL AVOID FURTHER ACTION.						
OUR CHARGES ARE BILLED SEPARATE FROM HOSPITAL.						
DuBois Radiologists I PO Box 1106 23 Beaver Drive DuBois, PA 15801 Tax Id: 25-1715230						
0001 Phone: 814-371-1784						

Patient Name: Lillian Kanary		PLEASE RETAIN THIS PORTION OF STATEMENT FOR YOUR RECORDS				PAY THIS AMOUNT →		174.00
Account Analysis		Total	Current	30+60	61+90	91+120	120+*	PATIENT BALANCE AMOUNT DUE
Insurance Balance		0.00	0.00	0.00	0.00	0.00	0.00	0.00
Patient Balance		174.00	0.00	174.00	0.00	0.00	0.00	0.00

174.00

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

APPROVED OMB-0938-0038

CONTACT US WITH YOUR INSURANCE INFORMATION IMMEDIATELY!!

HEALTH INSURANCE CLAIM FORM																			
PICA <input type="checkbox"/>																			
1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP	FECA	OTHER	1a. INSURED'S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)											
<input type="checkbox"/> (Medicare #)	<input type="checkbox"/> (Medicaid #)	<input type="checkbox"/> (Sponsor's SSN)	<input type="checkbox"/> (VA File #)	HEALTH PLAN (SSN or ID)	BLK LUNG (SSN)	<input checked="" type="checkbox"/> (ID)	6202822338420003												
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)													
Kanary Lillian				MM DD YY		Kanary Lillian													
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)											
103 Cordella Avenue				Self <input checked="" type="checkbox"/>	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>	Other <input type="checkbox"/>	103 Cordella Avenue											
CITY		STATE		8. PATIENT STATUS				CITY		STATE									
Toronto		CD		Single <input type="checkbox"/>	Married <input checked="" type="checkbox"/>	Other <input type="checkbox"/>		Toronto		CD									
ZIP CODE		TELEPHONE (Include Area Code)		Employed <input type="checkbox"/>	Full-Time <input type="checkbox"/>	Part-Time <input type="checkbox"/>	Student <input type="checkbox"/>	ZIP CODE		TELEPHONE (INCLUDE AREA CODE)									
000000000		(416) 763-5787						000000000		(416) 763-5787									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER											
Lillian Kanary				a. EMPLOYMENT? (CURRENT OR PREVIOUS)															
a. OTHER INSURED'S POLICY OR GROUP NUMBER				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	a. INSURED'S DATE OF BIRTH				SEX									
9131361132WP						MM DD YY	01 12 1930	M <input type="checkbox"/>	F <input type="checkbox"/>										
b. OTHER INSURED'S DATE OF BIRTH				b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME													
MM DD YY				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO														
M <input type="checkbox"/> F <input type="checkbox"/>				c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME													
c. EMPLOYER'S NAME OR SCHOOL NAME				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO														
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
X				*****				<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, return to and complete item 9 a-d.									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																			
Signature On File 071499																			
SIGNED _____ DATE _____																			
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR MM DD YY <input type="checkbox"/> INJURY (Accident) OR PREGNANCY(LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Satish K Sethi MD				17a. I.D. NUMBER OF REFERRING PHYSICIAN				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. RESERVED FOR LOCAL USE																			
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ 0.00																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 95909 95909 3. E9179 2. 85400 4. _____																			
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
23. PRIOR AUTHORIZATION NUMBER																			
24. A				B	C	D	E	F	G	H	I	J	K						
DATE(S) OF SERVICE From MM DD YY To MM DD YY				Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE						
1	1	1	1	1	1	1	1	1	1	1	1	1							
2	01 02 99		2	4	72050 26		1 3	41 00	1										
3	01 02 99		2	4	70450 26		2 3	133 00	1										
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back)				28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE			
25-1715230				kanali332921				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				\$ 174 00		\$ 0 00		\$ 174 00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) DuBois Reg Medical Ctr DuBois, PA 15801 DU390086				33. PHYSICIAN'S SUPPLIER'S BILLING NAME & PHONE # DuBois Radiologists Inc. PO Box 1106 DuBois PA 15801 PA 15801 PIN# 25-1715230 GPP# 25-1715230			
SIGNED 25-1715230 DATE 071499																			

## DUBOIS EMS AMBULANCE SERVICE, INC.

P.O. BOX 187

DUBOIS, PA 15801

(814) 375-1185 (Business)  
(814) 371-3456 (Emergency)Federal ID #  
25-1513894

"YOUR AMBULANCE SERVICE FOR LIFE"

TO:

LILLIAN KANARY  
103 CORDELLA AVENUE  
TORONTO CANADA CA 00000

## STATEMENT

DATE:	03/28/00
ACCT. #:	PAT-003125
BALANCE FORWARD:	695.25
LATE FEE:	0.00
BALANCE DUE:	695.25

REF #	TRIP #	CODE	DATE	DESCRIPTION	AMOUNT	BALANCE
000681447	0990008		01/02/99	KANARY, LILLIAN		
000681447	0990008	1C	01/21/99	FIRST BILL COMMERCIAL	675.25	675.25
000683395	0990008	SG	03/23/99	STATEMENT GENERATED	0.00	675.25
000685912	0990008	SG	06/18/99	STATEMENT GENERATED	0.00	675.25
000687060	0990008	SG	08/16/99	STATEMENT GENERATED	0.00	675.25
000689120	0990008	SG	10/26/99	STATEMENT GENERATED	0.00	675.25
000691198	0990008	SG	01/19/00	STATEMENT GENERATED	0.00	675.25
000681987	0990008A		02/05/99	KANARY, LILLIAN		
000681987	0990008A	1P	02/05/99	FIRST BILL PATIENT	20.00	695.25
000683396	0990008A	SG	03/23/99	STATEMENT GENERATED	0.00	695.25
000685913	0990008A	SG	06/18/99	STATEMENT GENERATED	0.00	695.25
000687061	0990008A	SG	08/16/99	STATEMENT GENERATED	0.00	695.25
000689121	0990008A	SG	10/26/99	STATEMENT GENERATED	0.00	695.25
000691199	0990008A	SG	01/19/00	STATEMENT GENERATED	0.00	695.25
THIS ACCOUNT HAS BEEN PROCESSED TO COLLECTIONS. A 20% CHARGE HAS BEEN ADDED.					PLEASE PAY	695.25
COMMENTS:						
PAGE #:						

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

BI LO MARK  
SANDY PLAZA

APPROVED OMB-0938-0008

DUBOIS PA 15801

XXX PICA

HEALTH INSURANCE CLAIM FORM

PICA XXX

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER <b>9131B61132</b>	(FOR PROGRAM IN ITEM 1)				
<input type="checkbox"/> (Medicare #)	<input type="checkbox"/> (Medicaid #)	<input type="checkbox"/> (Sponsor's SSN)	<input type="checkbox"/> (VA File #)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM : DD : YY		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>KANARY, LILLIAN</b>					
5. PATIENT'S ADDRESS (No., Street) <b>103 CORDELLA AVENUE</b>				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) <b>103 CORDELLA AVENUE</b>						
CITY <b>TORONTO CANADA</b>		STATE <b>CA</b>	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		CITY <b>TORONTO CANADA</b>		STATE <b>CA</b>					
ZIP CODE <b>00000</b>	TELEPHONE (Include Area Code) <b>( )</b>				ZIP CODE <b>00000</b>	TELEPHONE (INCLUDE AREA CODE) <b>( )</b>						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:  a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												
<b>SIGNATURE ON FILE</b>					<b>01/02/99</b>							
SIGNED		DATE										
14. DATE OF CURRENT: MM : DD : YY <b>01 : 02 : 99</b> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM : DD : YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM : DD : YY TO MM : DD : YY						
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE <b>STAFF DOCTOR</b>				17a. I.D. NUMBER OF REFERRING PHYSICIAN <b>0TH000</b>		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM : DD : YY TO MM : DD : YY						
19. RESERVED FOR LOCAL USE												
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) <b>354-HEAD INJURY</b>												
3. _____												
2. HIT IN HEAD WITH MOP												
24. A From MM DD YY To MM DD YY		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS   MODIFIER		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 02 99 01 02 99		41	9	AO370 SH		1	500.00	01				
01 02 99 01 02 99		41	9	AO390 SH		1	23.25	003				
01 02 99 01 02 99		41	9	AO422 SH		1	42.00	01				
01 02 99 01 02 99		41	9	Z0224 SH		1	85.00	01				
01 02 99 01 02 99		41	9	AO398 SH		1	25.00	01				
25. FEDERAL TAX I.D. NUMBER <b>25-1513934</b>		SSN EIN <input type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. <b>0990008</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE <b>\$ 675.25</b>	29. AMOUNT PAID <b>\$ 0.00</b>	30. BALANCE DUE <b>\$ 675.25</b>			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof.) <b>PATRICK J. WILLIAMS</b> OWNER		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (Other than home or office) <b>BI LO MARKET</b> <b>DUBOIS REGIONAL MED CTR D</b>		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE PHONE # <b>DUBOIS EMS AMBULANCE SVC</b> <b>P.O. BOX 187 103 W. WASHINGTON</b> <b>DUBOIS, PA 15801</b>								
SIGNED		DATE <b>01/21/99</b>		PIN# <b>207241 814-371-3456</b>								

DR. JANE HOWELL  
98 Guestville Ave., Toronto, Ontario M6N 4N6  
Z(416)763-1171 Fax (416)763-0573

May 18,1999

Blakley, Jones & Mohney,  
90 Beaver Drive,  
Box 6,  
DuBois, Pennsylvania 15801

Dear Mr. Mohney,

**Re: Lillian KANARY**  
**Date of Accident: 1/2/99**

I, Jane Howell am a duly qualified medical practitioner, licensed to practice in Ontario. I am a graduate of the University of Toronto Faculty of Medicine and am certified by the College of Family Physicians of Canada in Family Medicine.

Mrs Kanary first came to see me regarding the above accident on February 1, 1999. She informed me that whilst shopping in a DuBois grocery store in Pittsburgh, Pennsylvania she was injured. Apparently, an employee of the store who Mrs. Kanary said was affected by Down's Syndrome, hit Mrs. Kanary over her head with an industrial mop. Mrs. Kanary stated she lost consciousness for about three minutes. An ambulance was called and she was taken to the local hospital where she was admitted to the Intensive Care Unit for one day. Apparently a CT scan and x-rays were taken. I have tried to obtain copies of the hospital records but they have never arrived at my office.

Continued.....

LILLIAN KANARY

She was discharged after a day but Mrs. Kanary had to return the following day because of severe headaches.

When I saw Mrs. Kanary on February 1<sup>st</sup> she was complaining of headaches and neck pain and stiffness. On examination there was soft tissue swelling over the right occipital region of her head. There was no evidence of previous lacerations. She had tenderness over the paracervical and trapezii muscles of her neck and upper shoulders respectively with limitation in lateral neck rotation. My diagnoses was post concussive syndrome with headaches and cervical myofascitis . I referred her for physiotherapy and massage therapy. I prescribed Demerol 50mg because of the severity of her headaches and Bromazepam 3mg as needed for her nerves to help her relax.

She had been attending therapy twice weekly when I reviewed her on April 7,1999. She felt she was making slow progress with reduction in the amount of pain she was experiencing.

Continued.....

LILLIAN KANARY

However, she was finding herself becoming quite paranoid and scared to go out to shop. She was fearful something might fall on her. She was depending on her friends Margaret and Tom Hollywell to do her shopping. She had had to cease her social activities such as line dancing and swimming because of her anxieties about venturing outside of her home. I felt she was suffering from post traumatic stress/depression and prescribed an antidepressant, Zoloft 50mg daily.

I last assessed Mrs. Kanary on May 12,1999. She was continuing to attend massage therapy twice weekly for her neck and back. She was still experiencing headaches for which she was taking Advil (Ibuprofen). She was also doing exercises at home for her neck and back. She complained of ongoing pain in the left side of her neck and across the left shoulder and also back soreness. Examination revealed tenderness over the left trapezius and left lateral cervical muscles. There was decreased lateral rotation of her neck more so to the left side than her right, and limited internal rotation of her left shoulder. Her back exhibited diminished forward flexion.

Continued.....

(4)

LILLIAN KANARY

In summary, Mrs. Kanary continues to suffer both physical and emotional sequelae from the accident of January 2, 1999. She has neck and back myofascial pain, headaches and post traumatic anxiety and depressive syndrome. Her prognosis is quite good. With time and continued therapy, I anticipate she will recover fully from these disabilities over the next few months.

Sincerely,



Dr. J.C. Howell

JCH:bc

Account enclosed

DR. JANE HOW L  
FOR APPOINTMENT PHONE 63-1171  
98 GUESTVILLE AVENUE, TORONTO, ONTARIO M6N 4N6

November 1.....19 99

Blakley, Jones & Mohney,.....  
Attorneys & Counselors at Law,  
90 Beaver Drive, Box 6,.....  
Du Bois, Pennsylvania 15801

TO PROFESSIONAL SERVICES \$ 225.00  
RE Lillian KANARY Date of Accident 1/2/99  
We would appreciate hearing from you with regard  
to this account. RECEIVED PAYMENT

PER .....

(RECEIPTS WILL BE SENT ONLY ON REQUEST)



# L&G Bodycare Inc.

1172 Weston Road, Upper Level, Weston, M6M 4P4, Ont. 241-091

Blakley Jones and Mohney  
Attorneys and Counselors at Law  
90 Beaver Dr., Box 6  
Du Bois Pennsylvania 15801

Toronto, June 22, 99

Dear Mr. Christopher Mohney:

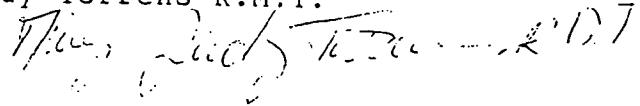
Mrs. Lillian J. Kanary, has been under our personal care for massage therapy as prescribed by her Dr. Jane Howell from February 15, 99, onwards.

Examination

Feb. 15/99	\$30.00	May 3/99	\$40.00
Treatment	\$40.00	" 6/99	\$40.00
Feb 22/99	\$40.00	" 10/99	\$40.00
" 18/99	\$40.00	" 13/99	\$40.00
" 25/99	\$40.00	" 17/99	\$40.00
March 1/99	\$40.00	" 20/99	\$40.00
" 4/99	\$40.00	" 24/99	\$40.00
" 8/99	\$40.00	" 27/99	\$40.00
" 11/99	\$40.00	" /#/99	\$40.00
" 15/99	\$40.00	June 4th	\$40.00
" 18/99	\$40.00	" 7/99	\$40.00
" 22/99	\$40.00	" 10/99	\$40.00
" 25/99	\$40.00		
" 29	\$40.00		
		Total to date	\$1,390.00
April 1/99	\$40.00		
" 5/99	\$40.00		
" 8/99	\$40.00		
" 12/99	\$40.00		
" 15/99	\$40.00		
" 19/99	\$40.00		
" 22/99	\$40.00		
" 26/99	\$40.00		
" 29/00	\$40.00		

with thanks yours truly

Mary Judy Torrens R.M.T.



L&G Bodycare Inc.

1172 Weston Road, Upper Level, Toronto, Ont. M6M 4P4

# CUSTOMER AND PUBLIC REPORT OF ACCIDENT

STORE # 231  
STORE NAME Big 5

Date of Report 1-2-99  
Telephone # 371-1017

1. NAME OF INJURED PERSON Lilian Kanar  
Home address 552 Treasure Lake Telephone #   
City Gordels Toronto Ontario State  Zip Code
2. Name of Companion, if Any: Josephine Somerville  
Address  City  State
3. Customer or Patrons Present Who Witnessed Loss:  
Address  Phone #
4. Employee Witnesses: ( Also complete employee report attached )  
Name and Department   
Address  Phone #
5. Date of Accident 1-2-99 Time 1:10 AM/PM AM
6. Exact Location of Accident By exit Door
7. Describe any conditions that may have contributed to loss  
use of Damp Map
8. Nature of Injury Blow to head, resulting in Dizziness, Light headed
9. Where Taken? Name of Dr. or Hospital St. Dubois Hospital  
Injured Persons Attitude confused
10. Name and Address of Manufacturer or Supplier of Product or  
Machine involved in Accident if any
11. Did you Witness Accident? No 12. If not, who informed  
you of Accident? Marc  
Address  Phone
13. Did you inspect Location immediately after Accident? Yes
14. Exact Time AM/PM 15. No. of Photos Taken
16. Was Location Clean? 17. Dry? 18. Any Puddles
19. Any Foreign Substances or Obstructions? If yes, describe
20. Type of Floor
21. Was injured Person Wearing Glasses?
22. What type of Shoes  23. Carrying any Objects

RECEIVED JAN 05 1999

Page 1 of 4

## EMPLOYEE'S REPORT

31. Name GLORIA OLEVINICK 32. Address \_\_\_\_\_  
33. How soon after accident did you inspect location? immediately  
34. Location Clean? yes 35. Dry? Damp 36. Puddles? no  
37. What did you observe as a contributing factor misplacement  
of mop

40. Customer wearing glasses? No 41. Carrying Bundles? No  
42. Type and condition of Shoes Good  
43. Where were you when accident occurred? near storage room  
44. Did you see accident? yes 45. If so, describe fully  
WENT TO PUT SHOVEL IN STORAGE ROOM  
MOP HANDLE FELL OVER IT IT HIT IT IN THE HEAD

46. Customer's comments and attitude \_\_\_\_\_

\* If Question Not Applicable, Answer N/A

Signature of Employee Gloria Olevnick

## MAINTENANCE REPORT

(To be completed if injured person slipped and fell)

46. Name \_\_\_\_\_ 47. Address \_\_\_\_\_  
48. Are you responsible for maintaining accident location? \_\_\_\_\_  
49. If so, describe your time schedule for cleaning location \_\_\_\_\_  
50. Time last cleaned \_\_\_\_\_

51. Floor product used \_\_\_\_\_  
52. When, before accident, did you last inspect location? \_\_\_\_\_  
53. Describe its condition \_\_\_\_\_  
54. When did you first inspect location after accident? \_\_\_\_\_  
55. Describe its condition \_\_\_\_\_  
56. Was location clean? \_\_\_\_\_ 57. Dry? \_\_\_\_\_  
58. Defects? \_\_\_\_\_  
59. Remarks? \_\_\_\_\_

Signature of Employee \_\_\_\_\_

Manager's Signature \_\_\_\_\_

Name of Person Completing this Report \_\_\_\_\_

Date \_\_\_\_\_

CUSTOMER ACCIDENT DESCRIPTION  
(TO BE FILLED OUT BY CUSTOMER)

How Did Injury Occur: Setting on the Bench, mug fell  
over & hit her on the head

Customer Name: ( Please Print ) Lilian Kanary  
Customer Address Cardella Toronto, Ontario Canada  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone# ( ) - 514-5200  
Customer Signature Lillian Kanary  
Date 1-2-99  
Store Location 231 Duhaie

**DR. JANE HOWELL**  
FOR APPOINTMENT PHONE 763-1171  
98 GUESTVILLE AVENUE, TORONTO, ONTARIO M6N 4N6

July 7 ..... 19.99

The Penn Traffic Company,  
P.O. box 4737, .....  
1200 State Fair boulevard, .....  
Syracuse, New York, 12331-4737  
Attn: Stephanie Rozyezko .....

TO PROFESSIONAL SERVICES \$ 50.00 .....  
Re: Lillian KANARY 103 Cordella Ave., Toronto M6N 2J8  
RE: Incident at BILo #231, Dubois, Pennsylvania  
RECEIVED PAYMENT  
We would appreciate hearing from you with regard to  
this account.

PER .....

(RECEIPTS WILL BE SENT ONLY ON REQUEST)

**DR. JANE DWELL**  
FOR APPOINTMENT PHONE 763-1171  
98 GUESTVILLE AVENUE, TORONTO, ONTARIO M6N 4N6

February 1..... 19 99

The Penn. Traffic Company, . . . . .  
P.O. Box 4737,  
1200 State Fair Boulevard, . . . . .  
Syracuse, New York, 13221-4737  
Att: Stephanie Rozyczko . . . . .

TO PROFESSIONAL SERVICES \$..... 50.00  
RE: Medical Services- Lillian KANARY  
Incident BiLo # 231  
RECEIVED PAYMENT

**RECEIVED PAYMENT**

PER. . . . .

(RECEIPTS WILL BE SENT ONLY ON REQUEST)





Dubois Regional Medical Center

P.O. Box 447 - DuBois, PA 15801-0447  
(8 375-4200  
FEDERAL NO. 25-1490707

## DETAIL STATEMENT

TYPE OF BILL:	DATE OF BILL:	PAGE NO.:
A2-ER	01/06/99	1

PATIENT NAME		PATIENT NUMBER		SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
LILLIAN KANARY		99002-00146		F	69Y	01/02/99	01/02/99		
INSURANCE COMPANY NAME		GROUP NUMBER		POLICY NUMBER			PAYMENT AMOUNT		
300001 BI-LO		999999		445426692					
300001 CAA CENTRAL ONTARIO		999999		6202822338420003					
300001 MANULIFE FINANCIAL		999999		9131361132WP					
GUARANTOR NAME AND ADDRESS	LILLIAN KANARY 103 CORDELLA AVENUE TORONTO CD 000 00								
	<input type="checkbox"/>		CARD NO. _____						
<input type="checkbox"/>		EXPIRATION DATE _____							
<input type="checkbox"/>		SIGNATURE _____							
PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT									

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE							
DATE	ITEM NO.	DESCRIPTION	CLM. CODE	ORDER NO.	Q.TY	UNIT PRICE	TOTAL CHARGES
01/02/99	94035	0.9% NSS 500 7983-03	258	8	1	20.00	20.00
01/02/99	94375	VENT PRIM PIGGYBACK VENO 11522	258	7	1	9.00	9.00
		TOTAL PHARMACY					29.00
01/02/99	95052	ICE BAG	270	11	1	6.00	6.00
01/02/99	95946	20GA CATHLON PLASTIC	270	9	2	2.00	4.00
01/02/99	96652	NASAL CANNULA	270	12	1	2.00	2.00
01/02/99	96877	NON-REBREATHING OXYGEN MASK	270	10	1	3.00	3.00
		TOTAL SUPPLIES					15.00
01/02/99	43003	CERVICAL, MIN 4	320	4	1	158.00	158.00
01/02/99	43023	SPINE, SINGLE VIEW	320	2	1	97.00	97.00
01/02/99	49012	BEDSIDE/OR RADIOGRAPHY	320	2	1	0.00	0.00
		TOTAL RADIOLOGY					255.00
01/02/99	72724	CT HEAD, NO CONTRAST	351	3	1	484.00	484.00
01/02/99	72813	ZZ-CT OUTSIDE REGULAR HOURS	352	3	1	0.00	0.00
01/02/99	72817	CT - EACH ADDITIONAL FILM	351	3	1	16.00	16.00
		TOTAL CT SCAN					500.00
01/02/99	16212	EMRGNCY DEP VIS E/M EX MOD CMPLX	450	13	1	150.00	150.00
		TOTAL EMERGENCY ROOM					150.00
01/02/99	34900	EKG	730	5	1	68.00	68.00
		TOTAL EKG					68.00
01/02/99	1612	PC EMRGNCY DEP VIS E/M EX MOD CO	450	13	1	125.00	125.00
01/02/99	517	PC EKG GERHART	730	6	1	26.00	26.00
		TOTAL pro fee misc code(not use ub92)					151.00
		TOTAL CHARGES					1,168.00

PATIENT NUMBER:

MEMORANDUM TO PARENT  
... OF THE CHILD

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

**TOTAL AMOUNT  
DUE**

**CONTINUED**

AND CORRESPONDENCE.

**PAYMENTS** may be taken to the East or West registration areas or to the Business Office located at 207 Hospital Avenue.



## DuBois Regional Medical Center

P.O. Box 447 - DuBois, PA 15801-0447  
(814) 75-4200  
FEDERAL I.D. NO. 25-1490707

## DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL	PAGE NO.
A2-ER	01/06/99	2

PATIENT NAME		PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
LILLIAN KANARY		99002-00146	F	69Y	01/02/99	01/02/99	
INSURANCE COMPANY NAME		GROUP NUMBER	POLICY NUMBER				
300001 BI-LO 300001 CAA CENTRAL ONTARIO 300001 MANULIFE FINANCIAL		999999 999999 999999	445426692 6202822338420003 9131361132WP				
GUARANTOR NAME AND ADDRESS		<input type="checkbox"/> CARD NO. _____ <input type="checkbox"/> EXPIRATION DATE _____ <input type="checkbox"/> SIGNATURE _____					
DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO.	Q.TY	UNIT PRICE	TOTAL CHARGES
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PATIENT NUMBER
99002-00146

PLEASE REFER TO PATIENT  
NUMBER ON ALL INQUIRIES  
AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT  
DUE

1,168.00

PAYMENTS may be taken to the East or West registration  
areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS

DRMC Financial Maintain Claims by Account Processor

Account	Name	FC	Type	Admit	Disch	Balance	Loc
D99002-00146	KANARY, LILLIAN	CI	ER	01/02/99	01/02/99	\$1168.00	AR
1 Code	2 Description	3 Last Edit date					
1	PATIENT WAS INJURED	01/02/99 02:51pm					
4 Created By	5 Creation Date	6 Edit Text?	7 Security				
HOOVER.DOROTHY E	01/02/99		1				

at the bi lo market ssnady plaza when an industrial mop fell over and hit her on the side of head she passed out cam in by ambulance  
i didnt know about the billing

Press NL--

next(/) or previous screen(/P) [/]

DRMC Financial Maintai , Claims by Account Processor

Fr: **01/30/99 08:50 am**

• Account	Name	FC Type	Admit	Disch	Balance	Loc
<b>D99004-00268</b>	<b>KANARY, LILLIAN</b>	<b>CI</b>	<b>ER 01/04/99</b>	<b>01/04/99</b>	<b>\$289.00</b>	<b>AR</b>
1 Code	2 Description	3 Last Edit date				
1	PT HIT ON HEAD WITH BROOM AT	01/04/99 02:50pm				
4 Created By	5 Creation Date	6 Edit Text?	7 Security			
CUNNINGHAM, CARLA A	01/04/99					1

BiLo. Does not have drivers license with her.

Press NL--

next(/) or previous screen(/P) [/]

DUBOIS REG MED CTR

O BOX 447

DUBOIS PA 15801

2141-371-2200

FED. TAX NO.		6 STATEMENT COVERS PERIOD		7 C		3 PATIENT CONTROL NO.			4 TYPE OF BILL		
		FROM	THROUGH			8 N-C.D.	9 C.D.	10 L.R.D.	11	7900100248	124

125-1 190707 010499 010499 000 0000 000 000

13 PATIENT ADDRESS

ANARY, LILLIAN

BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
11211930	F	M	010499	14	2	1	16	01	000145977									
DE OCCURRENCE DATE				34 OCCURRENCE CODE	35 DATE			36 CODE		OCCURRENCE SPAN FROM	THROUGH	37	A	B	C			

KANARY, LILLIAN  
03 CORDELLA AVENUE

ORONTO	CD 00000	39 CODE	40 VALUE CODES AMOUNT	41 CODE	42 VALUE CODES AMOUNT
		a			
		b			
		c			
		d			

REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
270	SUPPLIES				1500		
450	EMRGNCY DEP VIS E/M EX L	99282		1	13000		
730	EKG	93005		1.	9400		
001 TOTAL CHARGES 28900							

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
BI-LO MANULIFE FINANCIAL		Y	Y			
		Y	Y			

57 INSURED'S NAME	58 P.R.E.L	59 CERT. SSN - HIC - ID NO.	60	61 GROUP NAME	62 INSURANCE GROUP NO.
KANARY, LILLIAN	01	445426692		BILO	999999
KANARY, LILLIAN	01	9131361132WP		PROVINCIAL H.E.A	

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
	3		
	3		

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
V5889	4279								V5889		

79 P.C. 80 PRINCIPAL PROCEDURE CODE	81 DATE	82 OTHER PROCEDURE CODE	83 DATE	84 OTHER PROCEDURE CODE	85 DATE

86 REMARKS BI-LO	87 OTHER PHYS. ID

88 OTHER PHYS. ID	89 OTHER PHYS. ID
90 PROVIDER REPRESENTATIVE	91 DATE
X PAKER, JANE L	042999



DUBOIS REGIONAL MEDICAL CENTER  
P.O. Box 447 - DuBois, PA 15801-0447  
(812) 775-4200  
FEDERAL I.D. NO. 25-1490707

DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL
A2-ER	01/08/99

PAGE NO.
1

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
LILLIAN KANARY	99004-00268	F	69Y	01/04/99	01/04/99	
INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER				
300001 BI-LO 300001 MANULIFE FINANCIAL	999999 999999	445426692 9131361132WP				

GUARANTOR NAME AND ADDRESS	LILLIAN KANARY 103 CORDELLA AVENUE TORONTO CD 000 00	<input type="checkbox"/>		CARD NO.		
		<input type="checkbox"/>		EXPIRATION DATE		
		<input type="checkbox"/>		SIGNATURE	PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE	

DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO.	QTY	UNIT PRICE	TOTAL CHARGES
01/04/99	95052	ICE BAG	270	4	1	6.00	6.00
01/04/99	96027	CERVICAL COLLAR MED LONG TOTAL SUPPLIES	270	5	1	9.00	9.00
							15.00
01/04/99	16211	EMRGNCY DEP VIS E/M EX LOW COMPL TOTAL EMERGENCY ROOM	450	6	1	110.00	110.00
01/04/99	34900	EKG TOTAL EKG	730	2	1	68.00	68.00
01/04/99	1611	PC EMRGNCY DEP VIS E/M EX LOW CM	450	6	1	70.00	70.00
01/04/99	520	PC EKG PATHAK TOTAL pro fee misc code(not use ub92)	730	3	1	26.00	26.00
							96.00
		TOTAL CHARGES					289.00
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PATIENT NUMBER	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	289.00
99004-00268			

PLEASE REFER TO PATIENT  
NUMBER ON ALL INQUIRIES  
AND CORRESPONDENCE.

PAYMENTS may be taken to the East or West registration  
areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS

**RECEIPT / CAB FARE**

Amount \$4.02 Date 04-12-99  
From 1174 Weston  
To 103 Corolla  
Cab No. 2457 Driver J

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date 26-4-99  
From 1172 Weston  
To 103 Corolla  
Cab No. 83 Driver J

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount \$4.00 Date 1-3-99  
From 103 Corolla  
To 1172 Weston Rd.  
Cab No. 2033 Driver R

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date Feb 22 99  
From 103 Corolla Ave  
To 1172 Weston Rd.  
Cab No. 2748 Driver R

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date 11/21/99  
From 103 Corolla Ave  
To 1172 Weston Rd.  
Cab No. 1190 Driver J

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date 18/6/99  
From 103 Corolla Ave  
To 1172 Weston Rd.  
Cab No. 31 Driver D-SR

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount \$4.00 Date Mar. 29, 99  
From 1172 Weston Rd.  
To 103 Corolla Av.  
Cab No. 92 Driver ADS

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date 26.3.99  
From 1172 Weston  
To 103 Corolla  
Cab No. 110 Driver J

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date APR 12 99  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 2782 Driver J  
 N.C. Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 84.00 Date May 06 99  
 From 103 Cordella Ave  
 To Weston Rd  
 Cab No. 981 Driver S.S.  
 N.C. Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 11 - 22 Date 15 - 3 - 99  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 98 Driver J  
 N.C. Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date April 15/99  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 8 Driver Deel  
 N.C. Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date Feb 28 99  
 From 1172 Weston Rd  
 To 103 Cordella Ave  
 Cab No. 2748 Driver J  
 N.C. Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 54.00 Date 23-02-99  
 From 103 Cordella Ave  
 To 1171 Weston Rd  
 Cab No. 492 Driver VS  
 N.C. Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date 15-3-99  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 1140 Driver J  
 N.C. Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date 18/3/99  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 613 Driver J  
 N.C. Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date May 3/99  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 1143 Driver J  
 N.C. Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date 18-3-99  
 From 1272 Weston Rd  
 To 103 Cordella Ave  
 Cab No. 52 Driver J  
 N.C. Thanks for your Business

**RECEIPT FOR B FARE**

Amount 4-00 Date 6- MAY 99  
 From 1172 Weston Rd.  
 To Cordelia  
 Cab No. 79 Driver H-Su

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date 13/05/99  
 From 103 Cordelia Ave.  
 To 1172 Weston Rd.  
 Cab No. 604 Driver J

Thanks for your Business

*Cord*

**RECEIPT FOR CAB FARE**

Amount \$4.00 Date 5-3-99  
 From 1172 Weston Rd  
 To 103 Cordelia Ave.  
 Cab No. 2098 Driver CJ

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date Mar. 5 99  
 From 103 Cordelia Ave.  
 To 1172 Weston Rd.  
 Cab No. 897 Driver J

PD Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4-00 Date May 17/83  
 From 103 Cordelia Ave.  
 To 1172 Weston Rd.  
 Cab No. 3802 Driver J

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date 10-12-99  
 From 103 Cordelia  
 To 1172 Weston Rd  
 Cab No. 390 Driver J

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount \$4.00 Date 05-03-99  
 From 103 Cordelia Ave.  
 To 1172 Weston Rd.  
 Cab No. 2751 Driver Paki

PD Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4-00 Date 10/05/99  
 From 103 Cordelia  
 To 1172 Weston Rd  
 Cab No. 721 Driver J

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date MAR 15/99  
 From 1172 Weston  
 To Cordelia  
 Cab No. 161 Driver J

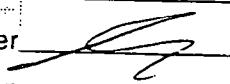
NG Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date 20-4-99  
 From 103 Cordelia Ave.  
 To 1172 Weston Rd.  
 Cab No. 1897 Driver J

Thanks for your Business

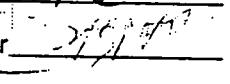
**RECEIPT FOR CAB FARE**

Amount 41 Date APR 29/99  
 From 103 Cordella Ave  
 To 1172 Weston Rd.  
 Cab No. 16 Driver   
*Thanks for your Business*

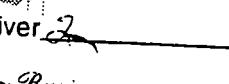
**RECEIPT**

Date 17/5/99  
 Cab No. 2857 Amount \$ 4.00  
 Driver's Name \_\_\_\_\_  
 From: 103 Cordella Ave  
 To: 1172 Weston Rd.  
 (★) NOTE: - AMOUNT SHOWN ABOVE INCLUDES G.S.T.  
 Driver is a Dependent Contractor, any G. S. T. Input  
 Credit may be claimed as 'NOTIONAL' or applied to  
 DRIVER'S Registration Number, not Diamond Taxi.  
 Driver GST Number: (If Available) \_\_\_\_\_

**RECEIPT FOR CAB FARE**

Amount 4-00 Date 15/4/99  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 108 Driver   
*Thanks for your Business*

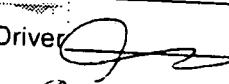
**RECEIPT FOR CAB FARE**

Amount 400 Date April 8/99  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 1190 Driver   
*Thanks for your Business*

**RECEIPT FOR CAB FARE**

Amount 4-00 Date 5 APR 99  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 16-0 Driver   
*Thanks for your Business*

**RECEIPT FOR CAB FARE**

Amount 4-00 Date 6/10/99  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 2372 Driver   
*Thanks for your Business*

**RECEIPT FOR CAB FARE**

Amount 8400 Date Apr 20/99  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 721 Driver   
*Thanks for your Business*

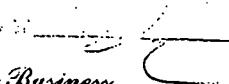
**RECEIPT FOR CAB FARE**

Amount 4.00 Date 25/2/00  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 60 Driver   
*Thanks for your Business*

**RECEIPT FOR CAB FARE**

Amount 4-00 Date 13/05/99  
 From 1172 Weston Rd.  
 To 103 Cordella Ave  
 Cab No. 14 Driver   
*Thanks for your Business*

**RECEIPT FOR CAB FARE**

Amount 4-00 Date May 4/99  
 From 103 Cordella Ave  
 To 1172 Weston Rd  
 Cab No. 277 Driver   
*Thanks for your Business*

**RECEIPT FOR CAB FARE**

Amount \$4- Date 10/6/99  
 From 103 Cordella Ave  
 To 1172 Weston Rd.  
 Cab No. 99 Driver John

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 8.00 Date 14/85/99  
 From 140 LANDSEURN AVE.  
 To 103 Cordella Ave  
 Cab No. 721 Driver John

Thanks for your Business  
 Mr. Jane Howell.

**RECEIPT FOR CAB FARE**

Amount \$4- Date 22/3/99  
 From 103 Cordella  
 To 1172 Weston Rd.  
 Cab No. 99 Driver John

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount \$9.00 Date MAY 14/99  
 From 103 Cordella Ave  
 To 940 Lawrence  
 Cab No. 64 Driver John

Thanks for your Business  
 Dr. Jane Howell.

**RECEIPT FOR CAB FARE**

Amount \$4.00 Date June 10/99  
 From 1172 Weston Rd.  
 To 103 cordella  
 Cab No. 2940 Driver KANG

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 5.00 Date April 29/99  
 From 2089 Lawrence  
 To 2100 Lawrence  
 Cab No. 1706 Driver D.J.

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date March 26/99  
 From 103 Cordella  
 To 1172 Weston Rd.  
 Cab No. 135 Driver D.J.

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date 29 April 10  
 From 103 Cordella Ave  
 To 1172 Weston Rd.  
 Cab No. 1706 Driver D.J.

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount 4.00 Date 29-3-99  
 From 103 Cordella  
 To 1172 Weston Rd.

Thanks for your Business

**RECEIPT FOR CAB FARE**

Amount \$4.00 Date 25-02-99  
 From 1172 Weston Rd.  
 To 103 Cordella Ave

**BLAKLEY, JONES & MOHNEY**

*Attorneys and Counselors at Law*

*90 Beaver Drive, Box 6*

*Du Bois, Pennsylvania 15801*

July 26, 2001

**Telephone (814) 371-2730**

**Fax (814) 375-1082**

**Benjamin S. Blakley, III**

**Christopher E. Mohney**

Marcy Kelley  
Deputy Court Administrator  
Office of the Court Administrator  
Clearfield County Courthouse  
1 North Second Street  
Clearfield, PA 16830

**RE: Lillian J. Kanary vs. The Penn Traffic Company  
No. 00-1121-C.D.**

Dear Ms. Kelley:

Please file the enclosed Pre-Arbitration Statement on behalf of Lillian J. Kanary. The Arbitration is scheduled for Tuesday, August 7, 2001, at 9:00 a.m.

By copy of this correspondence, I am sending all the arbitrators and opposing counsel a true and correct copy of the enclosed.

Sincerely yours,

BLAKLEY, JONES & MOHNEY

Christopher E. Mohney, Esquire

CEM:djf

Enclosures

copy to: Brian S. Kane, Esquire (w/enc.)  
David J. Hopkins, Esquire (w/enc.)  
Kim C. Kesner, Esquire (w/enc.)  
Warren B. Mikesell, II, Esquire (w/enc.)

**RECEIVED**

**JUL 30 2001**

**COURT ADMINISTRATOR'S  
OFFICE**



IN THE COURT OF COMMON PLEAS OF  
CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION  
No. 00-1121-C.D.

LILLIAN J. KANARY,

Plaintiff

vs.

THE PENN TRAFFIC COMPANY,

Defendant

PRE-ARBITRATION STATEMENT

LAW OFFICES

**BLAKLEY, JONES & MOHNEY**  
90 BEAVER DRIVE - BOX 6  
DUBOIS, PA 15801

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY, : NO. 00 - 1121 - C.D.  
Plaintiff : TYPE OF CASE: CIVIL  
VS. : TYPE OF PLEADING:  
THE PENN TRAFFIC COMPANY, : PRE-ARBITRATION STATEMENT  
Defendant : FILED ON BEHALF OF: PLAINTIFF  
: COUNSEL OF RECORD:  
: CHRISTOPHER E. MOHNEY, ESQUIRE  
: SUPREME COURT NO.: 63494  
: BLAKLEY, JONES & MOHNEY  
: 90 BEAVER DRIVE, BOX 6  
: DU BOIS, PA 15801  
: (814) 371-2730

RECEIVED

JUL 30 2001

COURT ADMINISTRATOR'S  
OFFICE

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY,	:	NO. 00 - 1121 - C.D.
	:	
Plaintiff	:	
	:	
VS.	:	
	:	
THE PENN TRAFFIC COMPANY,	:	
	:	
Defendant	:	

**PRE-ARBITRATION STATEMENT**

AND NOW, comes the Plaintiff, **LILLIAN J. KANARY**, by her attorneys, **BLAKLEY, JONES & MOHNEY**, who files the within Pre-Arbitration Statement and in support thereof avers the following:

**I. BRIEF STATEMENT OF THE CASE**

Plaintiff Lillian J. Kanary is a 71-year-old resident of Toronto, Canada. Over the Christmas and New Year holiday period in 1999, she was visiting friends in Du Bois, Pennsylvania. On January 2, 1999, Mrs. Kanary accompanied her friends to the BiLo Supermarket located in Sandy Township, Pennsylvania. BiLo is owned by The Penn Traffic Company, the named Defendant in this lawsuit.

Immediately before the accident, Mrs. Kanary was sitting on a bench in the BiLo Market. An employee of BiLo was mopping the floor near the bench where Mrs. Kanary was sitting. The mop was one of the large industrial-type mops, commonly utilized by supermarkets and other places of business for mopping large floors. The mop was left unattended for a moment and fell over and

hit Mrs. Kanary on the side of the head. She never saw it coming.

Mrs. Kanary fell to the floor and was taken to the Du Bois Regional Medical Center via ambulance. She was experiencing pain of the shoulder, neck and head. X-rays were taken, an unenhanced CAT-Scan was done and all, thankfully, were negative. She was diagnosed with a skull contusion and a mild concussion, with some neck and left shoulder pain. She was discharged, instructed to take aspirin for pain and rest for twenty-eight (28) to forty-eight (48) hours.

Mrs. Kanary had to report back to the emergency room two (2) days later, as she was still experiencing discomfort. Her skull contusion was re-examined, and she was given a soft collar and discharged.

Because of her discomfort caused by the injuries sustained in the accident, Mrs. Kanary was forced to delay return to Canada. Upon her return to Canada, she consulted with her personal physician, Dr. Jane Howell. She initiated massage therapy. She still experiences some pain and discomfort. The ordeal was very upsetting for Mrs. Kanary, having caused her significant embarrassment and resultant anxiety.

## II. APPLICABLE CASES OR STATUTES

In Pennsylvania, there are four elements to establishing a successful cause of action for negligence. They are: 1. A duty recognized by law; 2. A failure to conform to that duty; 3. The causation between the breach of duty and resulting injury; and 4. Damages resulting from the injury. Rankin v. Southeastern PA Transportation Authority, 606 A2d 536 (1992). The causation element can also be explained as "proximate cause." Brown v. Philadelphia College of Osteopathic Medicine, 760 A2d 863 (PaSuper 2000).

Business invitees are owed the highest duty of care and the possessor is under an affirmative duty to protect the invitee, not only against dangers, but also against those which it could discover with reasonable care. Latch v. Reburn, 281 A2d 673 (PaSuper. 1971).

### III. WITNESSES

1. Lillian J. Kanary
2. Josie Sommerville
3. Raymond Sommerville
4. Jerry Pregel

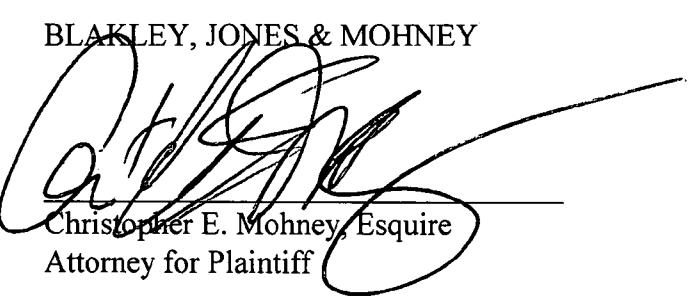
### IV. STATEMENT OF DAMAGES AND COPIES OF THOSE BILLS WHICH THE PARTY INTENDS TO OFFER

Mrs. Kanary suffered injuries to her head, neck and shoulder. Attached are copies of the medical bills which Plaintiff intends to offer, as well as the medical records that Mrs. Kanary intends to offer. These medical records, reports and bills were presented to opposing counsel under letter dated June 20, 2001, in compliance with Pennsylvania Rule of Civil Procedure 1305 and Clearfield County Local Rule 1306. No objection to the reasonableness of the charges have been presented from opposing counsel, and the medical records and reports are admissible in this Arbitration pursuant to Pennsylvania Rule of Civil Procedure 1305.

Respectfully submitted,

BLAKLEY, JONES & MOHNEY

BY:

  
Christopher E. Mohney, Esquire  
Attorney for Plaintiff

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA  
CIVIL DIVISION

LILLIAN J. KANARY, : NO. 00 - 1121 - C.D.  
: Plaintiff :  
VS. :  
: THE PENN TRAFFIC COMPANY, :  
: Defendant :  
:

**CERTIFICATE OF SERVICE**

The undersigned hereby certifies that a true and correct copy of the within Pre-Arbitration Statement of Plaintiff was served on the following persons by regular United States mail, postage prepaid, on this 26 day of July, 2001:

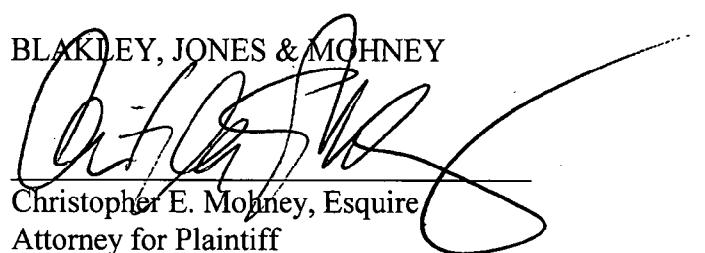
Brian S. Kane, Esquire  
Pietragallo Bosick & Gordon  
Attorneys at Law  
The Thirty-Eighth Floor  
One Oxford Centre  
Pittsburgh, PA 15219  
Attorney for Defendant

David J. Hopkins, Esquire  
The Hopkins Law Firm  
900 Beaver Drive  
Du Bois, PA 15801  
Arbitrator

Kim C. Kesner, Esquire  
Sughrue & Kesner  
23 North Second Street  
Clearfield, PA 16830  
Arbitrator

Warren B. Mikesell, II, Esquire  
115 East Locust Street  
Clearfield, PA 16830  
Arbitrator

BY:

BLAKLEY, JONES & MOHNEY  
  
Christopher E. Mohney, Esquire  
Attorney for Plaintiff  
PA I.D. 63494  
90 Beaver Drive, Box 6  
Du Bois, PA 15801  
(814) 371-2730

**BLAKLEY, JONES & MOHNEY**

*Attorneys and Counselors at Law*

*90 Beaver Drive, Box 6*

*Du Bois, Pennsylvania 15801*

June 20, 2001

**Telephone (814) 371-2730**

**Fax (814) 375-1082**

**Benjamin S. Blakley, III**

**Christopher E. Mohney**

Brian S. Kane, Esquire  
Pietragallo Bosick & Gordon  
Attorneys at Law  
The Thirty-Eighth Floor  
One Oxford Centre  
Pittsburgh, PA 15219

**RE: Lillian J. Kanary vs. Penn Traffic Company  
No. 00-1121-C.D. (Clearfield County)**

Dear Mr. Kane:

Pursuant to Pennsylvania Rule of Civil Procedure 1305 and Clearfield County Local Rule 1306, enclosed are the medical records and reports and bills that we intend to enter into evidence at the Arbitration scheduled for August 10, 2001.

Sincerely,

**BLAKLEY, JONES & MOHNEY**



Christopher E. Mohney, Esquire

CEM:kdm

Enclosures



**DR. JANE HOWELL**  
FOR APPOINTMENT PHONE 763-1171  
98 GUESTVILLE AVENUE, TORONTO, ONTARIO M6N 4N6

November 1..... 19. 99

Blakley, Jones & Mohney,  
Attorneys & Counselors at Law,  
90 Beaver Drive, Box 6,  
Du Bois, Pennsylvania 15801

TO PROFESSIONAL SERVICES \$ 225.00  
RE Lillian KANARY Date of Accident 1/2/99  
We would appreciate hearing from you with regard  
to this account. RECEIVED PAYMENT

PER.....

(RECEIPTS WILL BE SENT ONLY ON REQUEST)

**DuBois Regional Medical Center**

P.O. Box 447 - DuBois, PA 15801-0447,  
(814) 375-4200  
FEDERAL I.D. NO. 25-1490707

**DETAIL STATEMENT**

TYPE OF BILL	DATE OF BILL
D1-ER	01/08/99

PAGE NO. 1

PATIENT NAME		PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
ILLIAN KANARY		99004-00268	F	70Y	01/04/99	01/04/99		
INSURANCE COMPANY NAME		GROUP NUMBER	POLICY NUMBER					
300001 BI-LO 300001 MANULIFE FINANCIAL		999999 999999	445426692 9131361132WP				<b>PAYMENT AMOUNT</b>	
GUARANTOR NAME AND ADDRESS	ILLIAN KANARY 103 CORDELLA AVENUE TORONTO CD 000 00							
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>							
	CARD NO. _____ EXPIRATION DATE _____ SIGNATURE _____							
PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE								
DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO.	QTY	UNIT PRICE	TOTAL CHARGES	
		270 SUPPLIES 450 EMERGENCY ROOM 730 EKG 998 pro fee misc code(not use ub92)					15.00 110.00 68.00 96.00	
		TOTAL CHARGES					289.00	
		TOTAL PAYMENTS/ADJUSTMENTS					0.00	
PATIENT NUMBER		PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY					TOTAL AMOUNT DUE	289.00
99004-00268								

PLEASE REFER TO PATIENT  
NUMBER ON ALL INQUIRIES  
AND CORRESPONDENCE.

PAYMENTS may be taken to the East or West registration  
areas or to the Business Office located at 207 Hospital Avenue.

PLEASE RETAIN FOR YOUR RECORDS



## DuBois Regional Medical Center

P.O. Box 447 - DuBois, PA 15801-0447,  
(814) 375-4200  
FEDERAL I.D. NO. 25-1490707

## DETAIL STATEMENT

TYPE OF BILL	DATE OF BILL
D1-ER	01/06/99

PAGE NO.
1

PATIENT NAME		PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
LILLIAN KANARY		99002-00146	F	70Y	01/02/99	01/02/99	
INSURANCE COMPANY NAME		GROUP NUMBER	POLICY NUMBER				
300001 BI-LO 300001 CAA CENTRAL ONTARIO 300001 MANULIFE FINANCIAL		999999 999999 999999	445426692 6202822338420003 9131361132WP			PAYMENT AMOUNT	
GUARANTOR NAME AND ADDRESS	LILLIAN KANARY 103 CORDELLA AVENUE TORONTO CD 000 00						
<input type="checkbox"/> CARD NO. _____ <input type="checkbox"/> EXPIRATION DATE _____ <input type="checkbox"/> SIGNATURE _____ <small>PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE</small>							

DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO.	Q.TY	UNIT PRICE	TOTAL CHARGES
		250 PHARMACY					29.00
		270 SUPPLIES					15.00
		320 RADIOLOGY					255.00
		350 CT SCAN					500.00
		450 EMERGENCY ROOM					150.00
		730 EKG					68.00
		998 pro fee misc code(not use ub92)					151.00
		TOTAL CHARGES					1,168.00
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

Please contact me regarding  
the balance due.

Thanks  
Barbara  
814-375-4207

PATIENT NUMBER
99002-00146

PLEASE REFER TO PATIENT  
NUMBER ON ALL INQUIRIES  
AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT  
DUE 1,168.00

PAYMENTS may be taken to the East or West registration  
areas or to the Business Office located at 207 Hospital Avenue.



# L&G Bodycare Inc.

1172 Weston Road, Upper Level, Weston, M6M 4P4, Ont. 241-0914

Toronto, June 22, 99

Blakley Jones and Mohney  
Attorneys and Councelors at Law  
90 Beaver Dr., Box 6  
Du Bois Pennsylvania 15801

Dear Mr. Christopher Mohney:

Mrs. Lillian J. Kanary, has been under our personal care for massage therapy as prescribed by her Dr. Jane Howell from February 15, 99, onwards.

Examination

Feb. 15/99	\$30.00	May 3/99	\$40.00
Treatment	\$40.00	" 6/99	\$40.00
Feb 22/99	\$40.00	" 10/99	\$40.00
" 18/99	\$40.00	" 13/99	\$40.00
" 25/99	\$40.00	" 17/99	\$40.00
		" 20/99	\$40.00
March 1/99	\$40.00	" 24/99	\$40.00
" 4/99	\$40.00	" 27/99	\$40.00
" 8/99	\$40.00	" /#99	\$40.00
" 11/99	\$40.00		
" 15/99	\$40.00	June 4th	\$40.00
" 18/99	\$40.00	" 7/99	\$40.00
" 22/99	\$40.00	" 10/99	\$40.00
" 25/99	\$40.00		
" 29	\$40.00		
		Total to date	\$1,390.00
April 1/99	\$40.00		
" 5/99	\$40.00		
" 8/99	\$40.00		
" 12/99	\$40.00		
" 15/99	\$40.00		
" 19/99	\$40.00		
" 22/99	\$40.00		
" 26/99	\$40.00		
" 29/00	\$40.00		

with thanks yours truly

Mary Judy Torrens R.M.T.

L&G Bodycare Inc.

1172 Weston Road, Upper Level, Toronto, Ont. M6M 4P4

Judy Torrens R.M.T.  
Registered Massage Therapist

Appointments  
(416) 242-7825

DuBois Radiologists I  
 PO Box 1106  
 23 Beaver Drive  
 DuBois, PA 15801  
 814-371-1784

FOR X RAY INTERPRETATION

**\*\*NOTICE OF DELINQUENT ACCOUNT\*\***  
 THIS ACCOUNT IS SERIOUSLY OVERDUE.  
 PROMPT PAYMENT WILL AVOID FURTHER  
 ACTION.

Account No.	Amount Due
kanalli-00	174.00
Date	Amount Enclosed
05/20/99	

Lillian Kanary  
 103 Cordelia Avenue  
 Toronto, ON 000000000

Remit Payment To: DuBois Radiologists I

IF ANY QUESTIONS CALL (814) 371-1784

Kanary, Lillian

PAYMENT DUE UPON RECEIPT !!

Please remove and return this portion with your payment

Date	Dr.	Procedure Code	Description	Diagnosis	Chrgs./Credits	Item Balance
01/02/99	3	72050	CERVICAL SPINE MINIMUM 4	95909	41.00	41.00
04/01/99			Plan Payments: X		0.00	
01/02/99	3	70450	NO INSURANCE INFO RECEIVED CT HEAD WO	85400	133.00	133.00
<b>**IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH YOUR CORRECT INSURANCE INFORMATION. PLEASE DO SO AS SOON AS POSSIBLE; OR YOU CAN BE HELD RESPONSIBLE FOR THIS BALANCE. **</b>						
<b>**NOTICE OF DELINQUENT ACCOUNT**</b> <b>THIS ACCOUNT IS SERIOUSLY OVERDUE. PROMPT PAYMENT WILL AVOID FURTHER ACTION.</b>						
<b>OUR CHARGES ARE BILLED SEPARATE FROM HOSPITAL!</b>						
DuBois Radiologists I PO Box 1106 23 Beaver Drive DuBois, PA 15801 0001 Phone: 814-371-1784						
Tax Id: 25-1715230						

Patient Name:	PLEASE RETAIN THIS PORTION OF STATEMENT FOR YOUR RECORDS					PAY THIS AMOUNT →	174.00
Account Analysis	Total	Current	30 - 60	61 - 90	91 - 120	120 +	PATIENT BALANCE AMOUNT DUE
Insurance Balance	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Patient Balance	174.00	0.00	174.00	0.00	0.00	0.00	0.00
Account Balance	174.00						

## DUBOIS EMS AMBULANCE SERVICE, INC.

P.O. BOX 187

DUBOIS, PA 15801

(814) 375-1185 (Business)  
(814) 371-3456 (Emergency)Federal ID #  
25-1513894

## STATEMENT

DATE:	05/02/00
ACCT. #:	PAT-003125
BALANCE FORWARD:	695.25
LATE FEE:	0.00
BALANCE DUE:	695.25

"YOUR AMBULANCE SERVICE FOR LIFE"

TO:

LILLIAN KANARY  
103 CORDELLA AVENUE  
TORONTO CANADA CA 00000

Are you still  
handling this  
account.

REF #	TRIP #	CODE	DATE	DESCRIPTION	AMOUNT	BALANCE
000681447	0990008	1C	01/02/99	KANARY, LILLIAN		
	0990008		01/21/99	FIRST BILL COMMERCIAL	675.25	675.25
000683395	0990008	SG	03/23/99	STATEMENT GENERATED	0.00	675.25
000685912	0990008	SG	06/18/99	STATEMENT GENERATED	0.00	675.25
000687060	0990008	SG	08/16/99	STATEMENT GENERATED	0.00	675.25
000689120	0990008	SG	10/26/99	STATEMENT GENERATED	0.00	675.25
000691198	0990008	SG	01/19/00	STATEMENT GENERATED	0.00	675.25
000692984	0990008	SG	03/28/00	STATEMENT GENERATED	0.00	675.25
	0990008A		02/05/99	KANARY, LILLIAN		
000681987	0990008A	1P	02/05/99	FIRST BILL PATIENT	20.00	695.25
000683396	0990008A	SG	03/23/99	STATEMENT GENERATED	0.00	695.25
000685913	0990008A	SG	06/18/99	STATEMENT GENERATED	0.00	695.25
000687061	0990008A	SG	08/16/99	STATEMENT GENERATED	0.00	695.25
000689121	0990008A	SG	10/26/99	STATEMENT GENERATED	0.00	695.25
000691199	0990008A	SG	01/19/00	STATEMENT GENERATED	0.00	695.25
000692985	0990008A	SG	03/28/00	STATEMENT GENERATED	0.00	695.25
COMMENTS:						PLEASE PAY
PAGE #:						695.25

446977 68Y ER  
KANARY, LILLIAN  
SETH, SATISH K

E.R. AFTER CARE INSTRUCTIONS TO THE PATIENT

**HEAD INJURIES**

Although no evidence of serious injury was found at this time, contact your physician or return to the Emergency Department if any of the following conditions occur:

1. Loss of consciousness
2. Nausea and/or vomiting associated with a headache. (Persistent vomiting).
3. Unusual sleepiness or difficulty in arousing. (Awaken the patient from sleep every 2-3 hours during the next 24 hours).
4. One pupil (dark area) of the eye much larger than the other. Unequal pupils (one large - one small).
5. Weakness, numbness, or paralysis of the arms or legs.
6. Double or blurred vision.
7. Persistent dizziness.
8. Increasing confusion, drowsiness or irritability.
9. Convulsions (jerking and spells)
10. Irregular or labored breathing.
11. Drainage of blood or clear fluid from the ears or nose
12. Stiffness of neck.
13. Continued or worsening headache unrelieved by medication prescribed only by the doctor.
14. Trouble with speech or swallowing.

Limit activities for 24 hours. Diet as tolerated.

**NOSE BLEEDS**

1. Don't blow your nose for 24 hrs.
2. Rest
3. No strenuous activity for 24 hrs.
4. Medication as advised.
5. If nose begins to bleed apply direct pressure by pinching nostrils together continuously for 10 minutes.

**LAB TESTS**

The results of all your lab tests are not immediately available. If the results are abnormal or require a change in care, the Emergency Department will notify you. If you do not hear from us within one week, call the Emergency Department at 375-3470.

**CULTURES**

The results of your culture are reviewed by the Emergency Department. If your culture is abnormal and a medication adjustment needs to be made, you will be contacted by the Emergency Department. A minimum of 48 hours is required for the results.

**STREP SCREEN**

All strep screens are reviewed by the Emergency Department. You will be notified by phone if your strep screen is positive and/or if any medication adjustments need to be made. A minimum of 48 hours is required for test results.

**X-RAY'S/EKG'S**

Your X-RAY/EKG has been read on a preliminary basis by the Emergency Department physician. Final consultation and review by the radiologist/cardiothoracic will be made. You will be notified by phone if his interpretation differs and given follow-up instructions.

**DIAGNOSTIC TEST RESULTS**

If you have not been notified within 24 to 48 hours or your condition is not improving, please call the Emergency Department at 375-3470 for further instructions.

**SPRAINS, STRAINS, AND CONTUSIONS**

1. Elevate and application of ice to injured extremity to reduce pain and swelling for 48 hours.
2. After 48 hours apply moist heat to the affected area 4 times a day for 20-35 minutes.
3. Rest the affected area as much as possible for the first 24 hours.
4. Activity as directed below by the physician.

**U.R.I.**

1. Encourage clear liquids.
2. Rest
3. Tylenol for fever and achiness.
4. Medications as advised.
5. If no improvement in 2-3 days follow-up with your family physician.

**TETANUS INJECTION**

1. Injection site may become red, warm, and swollen.
2. Use ice to the site 20 minutes 4 times the first day.
3. Use heat to the site 20 minutes 4 times for the next 2-3 days.
4. Report reaction larger than silver dollar to your physician, or if pain persists.
5. Tylenol or aspirin for pain or fever.

**WOUND AND BURN CARE**

1. Keep wound clean and dry.
2. If your dressing becomes wet or dirty, reapply a sterile dressing unless advised otherwise by the physician.
3. If any difficulties develop (i.e. wound becomes red, swollen, hot, more painful, or begins to drain) report to the Emergency Department or contact your family physician.
4. Keep your wound elevated if possible to reduce pain and swelling.
5. Should bleeding occur, apply pressure firmly over the bandage and elevate the area for ten (10) minutes. Return to the Emergency Department immediately for re-evaluation if bleeding does not stop.
6. Return for suture removal as instructed below to minimize scar formation. After 48 hours, remove original bandage and apply a clean one. Clean daily thereafter. Cleanse as instructed by the physician. Use only medications prescribed by the physician.

**GASTROENTERITIS AND/OR ABDOMINAL PAIN**

1. You should take only ice chips by mouth for 4-6 hours to rest your stomach. (Give 1 ounce of clear fluids every hour for infants.)
2. After 4-6 hours, start to take clear liquids (i.e. Jello, water, Kool-Aid, Gatorade, tea, flat Coke or gingerale, or Pedialyte (available in drugstores). Take clear liquids for 24 hours.
3. If no vomiting occurs, progress from the clear liquid diet to a full liquid diet (i.e. soups, cream of wheat, cornstarch puddings, soft cooked eggs and sherbet). Then to a B.R.A.T. diet (Bananas, Rice, Applesauce and Toast). Slowly progress to a regular diet. Avoid fatty or spicy foods, milk and milk products for 5-6 days.
4. Do not take an enema or laxative unless ordered by the doctor.
5. Take medications only as prescribed by the doctor.
6. Return to the Emergency Department or call your family doctor for any of the following:
  - a) persistent vomiting/diarrhea for 24 hours with or without signs of dehydration (lips/mouth very dry, decreased urine output, no tears).
  - b) pain persists or worsens.
  - c) fever
  - d) blood in stools or urine
  - e) listless/or lethargic behavior

DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS		Condition On Discharge:	Satisfactory	Fair	Poor	Time: <i>3:45</i>	WITH: <input type="checkbox"/> self <input type="checkbox"/> family <input checked="" type="checkbox"/> other
<input type="checkbox"/> Admitted Room No:	<input type="checkbox"/> Physician Notified/Time:	<input type="checkbox"/> Agent Home	<input type="checkbox"/> Return to work	<input type="checkbox"/> Deceased	<input type="checkbox"/> Transferred	NOTIFIED: <input type="checkbox"/> Relative <input type="checkbox"/> Police <input type="checkbox"/> Coroner <input type="checkbox"/> Poison Center	
For follow-up care please see: <input type="checkbox"/> Personal physician <input type="checkbox"/> Occupational medicine <input type="checkbox"/> ER if worse or not improving							

FOLLOW INSTRUCTIONS ON  HEAD INJURY  CULTURE  STREP SCREEN  LAB TEST  X-RAY/EKG'S  SPRAINS, STRAINS AND CONTUSIONS  NOSEBLEEDS  U.R.I.  
 WOUND CARE AND BURN CARE  GASTROENTERITIS AND/OR ABDOMINAL PAIN  ALLERGY INJ.  URINARY INFECTIONS  CARE OF CHILD AND FEVER  
 ANIMAL BITES  CASTS  EYE CARE  TETANUS INJECTION  MEDICATION ALERT  MEDICATION USE

OTHER INSTRUCTION: *Rest for 24 to 48 hours after arriving as tolerated*

No Work or School Date: *2/21/2010*  
 No Physical Education  Until Released by Physician  
 Light Work Only

Method of Validating Knowledge:  Verbalization  Return Demo  Other: *Signature*

PATIENT/  
RESPONSIBLE PARTY: *Signature*

NURSE'S  
SIGNATURE: *Signature*

PHYSICIAN'S  
SIGNATURE: *Signature*

I hereby acknowledge receipt of these instructions, have read them and understand them. I further understand that I have had emergency treatment and that I may be released before all of my medical conditions/test results are known or treated. I will arrange for follow-up care. DuBois Regional Medical Center-DuBois, PA 15801

46977 68Y ER  
 CANARY, LILLIAN  
 RASHWAN, AHMED S  
 01/12/30 01/04/99  
 9900400268

E.R. AFTER CARE INSTRUCTIONS TO THE PATIENT

HEAD INJURIES

Although no evidence of serious injury was found at this time, contact your physician or return to the Emergency Department if any of the following conditions occur:

1. Loss of consciousness
2. Nausea and/or vomiting associated with a headache. (Persistent vomiting).
3. Unusual sleepiness or difficulty in arousing. (Awaken the patient from sleep every 2-3 hours during the next 24 hours).
4. One pupil (dark area) of the eye much larger than the other. Unequal pupils (one large - one small).
5. Weakness, numbness, or paralysis of the arms or legs.
6. Double or blurred vision.
7. Persistent dizziness.
8. Increasing confusion, drowsiness or irritability.
9. Convulsions (jerking and spells).
10. Irregular or labored breathing.
11. Drainage of blood or clear fluid from the ears or nose.
12. Stiffness of neck.
13. Continued or worsening headache unrelieved by medication prescribed only by the doctor.
14. Trouble with speech or swallowing.

Limit activities for 24 hours. Diet as tolerated.

LAB TESTS

The results of all your lab tests are not immediately available. If the results are abnormal or require a change in care, the Emergency Department will notify you. If you do not hear from us within one week, call the Emergency Department at 375-3470.

CULTURES

The results of your culture are reviewed by the Emergency Department. If your culture is abnormal and a medication adjustment needs to be made, you will be contacted by the Emergency Department. A minimum of 48 hours is required for the results.

STREP SCREEN

All strep screens are reviewed by the Emergency Department. You will be notified by phone if your strep screen is positive and/or if any medication adjustments need to be made. A minimum of 48 hours is required for test results.

X-RAY'S/EKG'S

Your X-RAY/EKG has been read on a preliminary basis by the Emergency Department physician. Final consultation and review by the radiologist/cardiothoracic will be made. You will be notified by phone if his interpretation differs and given follow-up instructions.

DIAGNOSTIC TEST RESULTS

If you have not been notified within 24 to 48 hours or your condition is not improving, please call the Emergency Department at 375-3470 for further instructions.

SPRAINS, STRAINS, AND CONTUSIONS

1. Elevate and application of ice to injured extremity to reduce pain and swelling for 48 hours.
2. After 48 hours apply moist heat to the affected area 4 times a day for 20-35 minutes.
3. Rest the affected area as much as possible for the first 24 hours.
4. Activity as directed below by the physician.

U.R.I.

1. Encourage clear liquids.
2. Rest
3. Tylenol for fever and achiness.
4. Medications as advised.
5. If no improvement in 2-3 days follow-up with your family physician.

TETANUS INJECTION

1. Injection site may become red, warm, and swollen.
2. Use ice to the site 20 minutes 4 times the first day.
3. Use heat to the site 20 minutes 4 times for the next 2-3 days.
4. Report reaction larger than silver dollar to your physician, or if pain persists.
5. Tylenol or aspirin for pain or fever.

WOUND AND BURN CARE

1. Keep wound clean and dry.
2. If your dressing becomes wet or dirty, reapply a sterile dressing unless advised otherwise by the physician.
3. If any difficulties develop (i.e. wound becomes red, swollen, hot, more painful, or begins to drain) report to the Emergency Department or contact your family physician.
4. Keep your wound elevated if possible to reduce pain and swelling.
5. Should bleeding occur, apply pressure firmly over the bandage and elevate the area for ten (10) minutes. Return to the Emergency Department immediately for re-evaluation if bleeding does not stop.
6. Return for suture removal as instructed below to minimize scar formation. After 48 hours, remove original bandage and apply a clean one. Clean daily thereafter. Cleanse as instructed by the physician. Use only medications prescribed by the physician.

GASTROENTERITIS AND/OR ABDOMINAL PAIN

1. You should take only ice chips by mouth for 4-6 hours to rest your stomach. (Give 1 ounce of clear fluids every hour for infants.)
2. After 4-6 hours, start to take clear liquids (i.e. Jello, water, Kool-Aid, Gatorade, tea, flat Coke or gingerale, or Pedialyte (available in drugstores). Take clear liquids for 24 hours.
3. If no vomiting occurs, progress from the clear liquid diet to a full liquid diet (i.e. soups, cream of wheat, cornstarch puddings, soft cooked eggs and sherbet). Then to a B.R.A.T. diet (Bananas, Rice, Applesauce and Toast). Slowly progress to a regular diet. Avoid fatty or spicy foods, milk and milk products for 5-6 days.
4. Do not take an enema or laxative unless ordered by the doctor.
5. Take medications only as prescribed by the doctor.
6. Return to the Emergency Department or call your family doctor for any of the following:
  - a) persistent vomiting/diarrhea for 24 hours with or without signs of dehydration (lips/mouth very dry, decreased urine output, no tears).
  - b) pain persists or worsens
  - c) fever
  - d) blood in stools or urine
  - e) listless or lethargic behavior

DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS		Condition On Discharge:	Satisfactory	Fair	Poor	Time:	WITH:
<input type="checkbox"/> Admitted Room No:	<input type="checkbox"/> Physician Notified/Time:	<input type="checkbox"/> Sent Home	<input type="checkbox"/> Return to work	<input type="checkbox"/> Deceased	<input type="checkbox"/> Transferred	1/15	<input type="checkbox"/> self <input type="checkbox"/> family <input type="checkbox"/> other

For follow-up care please see:  Personal physician  Occupational medicine  ER if worse or not improving

FOLLOW INSTRUCTIONS ON  HEAD INJURY  CULTURE  STREP SCREEN  LAB TEST  X-RAY/EKG'S  SPRAINS, STRAINS AND CONTUSIONS  NOSEBLEEDS  U.R.I.  WOUND CARE AND BURN CARE  GASTROENTERITIS AND/OR ABDOMINAL PAIN  ALLERGY INJ.  URINARY INFECTIONS  CARE OF CHILD AND FEVER  ANIMAL BITES  CASTS  EYE CARE  TETANUS INJECTION  MEDICATION ALERT  MEDICATION USE

OTHER INSTRUCTION:

*Off color as needed - would use for 7-10 days & no longer & continue meds as needed & kickled if needed*

Method of Validating Knowledge:  Verbalization  Return Demo  Other:

PATIENT/ RESPONSIBLE PARTY *Lillian Canary*

NURSE'S SIGNATURE *John W. Weller*

PHYSICIAN'S SIGNATURE *John W. Weller*

I hereby acknowledge receipt of these instructions, have read them and understand them. I further understand that I have had emergency treatment and that I may be released before all of my medical conditions/test results are known or treated. I will arrange for follow-up care. DuBois Regional Medical Center-DuBois, PA 15801

## DUBOIS REGIONAL MEDICAL CENTER

## **MEDICAL RECORDS**

Seen in FB part 48 hrs?

Mon Jan 6 14:40:39 EST 1989

PATIENT	NAME AND ADDRESS <b>KANARY, LILLIAN 103 CORDELLA AVENUE</b>				REGISTRATION DATE <b>01/04/99</b>	TIME <b>14:40</b>	ORG DNR	ADMISSION NO. <b>446977</b>	BILLING NO. <b>9900400268</b>	
	<b>TORONTO</b>		CA 000 00	COUNTY OC	AGE <b>68Y</b>	BIRTH DATE <b>01/12/30</b>	METHOD ARRIVAL <b>2 WALK IN</b>	SEX <b>F</b>	RACE <b>1</b>	M.S. <b>M</b>
	TELEPHONE NO. <b>(416)763-5787</b> S.S. NO. <b>445-42-6692</b> EMPLOYER, ADDRESS, OCCUPATION, PHONE				RELIGION <b>CATHOLIC</b>		P.T. <b>ER</b>	FIN.CL. <b>CI</b>	ADMIT BY <b>CAC</b>	
	<b>HOMEMAKER</b>				ICD-9-CM/CPT4 CODES					
	PT/PT REPRESENTATIVE STATES SYMPTOMS OR ACCIDENT - HOW, WHERE, WHEN <b>INJ 0102 HEADACHE NECK PAIN</b>						STAFF ALERT			
	PERSON TO NOTIFY IN CASE OF EMERGENCY <b>SUMMerville, JOSEPHINE M 552 T L</b>						RELATIONSHIP <b>OTHER</b>			
NAME AND ADDRESS <b>KANARY, LILLIAN SELF 103 CORDELLA AVENUE TORONTO CA 000 00</b>				TELEPHONE <b>(416)763-5787 HOMEMAKER SOC.SEC.# 445-42-6692</b>	REL	EMPLOYER NAME AND ADDRESS				
INSURANCE COMPANY <b>MANULIFE FINANCIAL</b>		PLAN <b>300001</b>	POLICY HOLDER <b>KANARY, LILLIAN</b>		REL <b>1</b>	POLICY # <b>9131361132WP</b>	GROUP # <b>999999</b>	<i>7-110</i>		
	E.R. PHYSICIAN <b>RASHWAN, AHMED S SHITALA, P.</b>	FAMILY PHYSICIAN <b>NO. DOCTOR GIVEN</b>		REFERRING PHYSICIAN <b>NO. FAMILY DOCTOR</b>						

**AUTHORIZATION FOR EMERGENCY, OUTPATIENT, OR SHORT PROCEDURES UNIT TREATMENT**

I, Lillian (or ), for Self, voluntarily authorize and consent to diagnostic procedures, examinations, and/or medical care as prescribed by, or deemed necessary in the judgement of Dr. Brashaw, for  Emergency Treatment  Outpatient Services  Short Procedures Unit Services.

I understand that this consent does not include operations or any non-routine procedures or treatment, and that the risks and alternatives for such procedures or treatment, which a reasonable patient would consider significant to a decision whether or not to undergo such treatment or procedures, will be explained to me by my treating physician or another physician designated by him.

I certify that no guarantees have been made to me as to the results of treatments or examinations in the Medical Center.

This form has been explained to me and I certify that I understand its contents

~~Signature of Patient~~

### Relationship

1111111111  
Beta/Time

Witness

NOTE: This report is strictly Confidential and is for the information only of the person to whom it is addressed. No responsibility can be accepted if it comes into the hands of any other person, INCLUDING THE PATIENT.

Patient is unable to consent for the following reason:

---

**Signature of Patient Representative**

## Relationship

/    /    Date/Time

---

**Witness**

Witness

**RELEASE FROM RESPONSIBILITY FOR DISCHARGE**

I am leaving (or taking \_\_\_\_\_ from) the DuBois Regional Medical Center against the advice of my physician. I have been informed of the risks involved in this decision. I hereby release the DuBois Regional Medical Center, its staff, and my physician from all responsibility for any ill effects which may result from this action.

---

**Signature of Patient**

### **Relationship**

---

**Date/Time**

---

**Witness**

---

## Witness



DUBOIS REGIONAL MEDICAL CENTER  
DUBOIS, PENNSYLVANIA

**EMERGENCY ROOM**

Date: 01/04/98 Time: 3:40 p.m.

Patient Name: KANARY, LILLIAN

9900400268 - 000446977

**CHIEF COMPLAINT:** This is a 68-year-old female who presents to our department for further evaluation of neck and head pain.

**HISTORY OF PRESENT ILLNESS:** The patient was seen here several days ago after she was accidentally struck in the head by a mop at one of our Bi-Low supermarkets. X-rays of the cervical spine were negative and an unenhanced CAT scan of the head was done at that time and it was also negative. She continues to have pain to the head, neck, and left shoulder. She is here for evaluation of this continuing pain.

**MEDICATIONS:** Her current meds include Premarin, Ativan, and a muscle relaxant. She has been taking Aspirin for current injuries, however, states that she cannot take or tolerate the Aspirin because she is experiencing some tinnitus.

**ALLERGIES:** SHE IS ALLERGIC TO TYLENOL AND CODEINE.

**PHYSICAL EXAMINATION**

**VITAL SIGNS:** Temperature 98.6, pulse 98, respiratory rate of 18, blood pressure 190/94.

**GENERAL:** Alert, cooperative, oriented, 68-year-old white female in no acute physical distress.

**HEENT:** Her head is normocephalic. There is tenderness on palpation to the right parietal scalp area. She has a small hematoma to the right parietal scalp with no contused or abraded areas that are obvious at this time. Neck - There is tenderness on palpation of the upper cervical spine and paracervical areas. There is pain to the left shoulder area with palpation and movement. However, the patient does exhibit full range of motion to the left shoulder. **HEART:** The heart shows a slightly irregular rhythm, normal rate, and no adventitious sounds noted. Ears appear normal. There is no evidence of injury. That is, there is no ecchymosis or hemotympanum or bleeding seen. The nose is non-swollen, nontender, and no bleeding is noted. The oropharynx is not injured.

**EMERGENCY ROOM COURSE:** An EKG was done today and it shows a sinus rhythm with an occasional PVC. No additional x-rays were done.

**DIAGNOSIS:** Recheck skull contusion and sprain/strain of cervical spine.

**DISPOSITION:** The patient was given a soft collar and discharged with the following instructions.

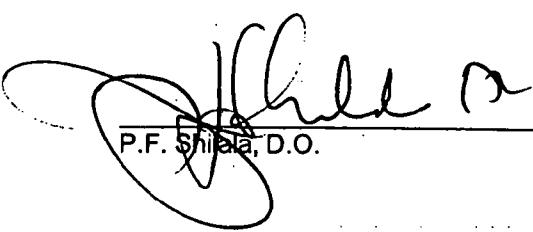
- 1) Soft collar as needed. I told the patient to use it only for seven to ten days, no longer.
- 2) Continue her meds as prescribed.
- 3) Recheck if needed.

D: 01/04/1999 5:17 P

T: 01/05/1999 2:28 P PFS/bc

DOCUMENT NO: 62699

Job/Tape ID: 006592

  
P.F. Shihala, D.O.

TIME: 3:15 pm

Mode of Arrival	Arrived with	Sell Care
<input type="checkbox"/> Ambulance <input type="checkbox"/> W.C. <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Carried <b>Gait</b> <input type="checkbox"/> Steady <input type="checkbox"/> Unsteady	<input type="checkbox"/> Self <input type="checkbox"/> Police <input type="checkbox"/> Parent <input checked="" type="checkbox"/> Friend <input type="checkbox"/> Spouse <input type="checkbox"/> Delegate <input type="checkbox"/> Family <input type="checkbox"/> _____	<input checked="" type="checkbox"/> Independent <input type="checkbox"/> Total Assist <input type="checkbox"/> Partial Assist <input type="checkbox"/> Child

Safety Measures	Environmental
<input checked="" type="checkbox"/> Siderails up <input type="checkbox"/> Family at bedside <input checked="" type="checkbox"/> Call Bell <input type="checkbox"/> Security present	Lives with: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> <u>Daughter</u> Language barrier <input type="checkbox"/> <u>friend</u> Translator

Trauma/Accidents				<input checked="" type="checkbox"/> DNA	Airway
<input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Seat Belt on <input type="checkbox"/> Air bag deployed				<input checked="" type="checkbox"/> Clear/Patent <input type="checkbox"/> Adjuncts _____	
Type:	<input type="checkbox"/> Car	<input type="checkbox"/> Truck	<input type="checkbox"/> Motorcycle	Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Dyspneic <input type="checkbox"/> Stridor <input type="checkbox"/> Nasal flaring <input type="checkbox"/> Accessory muscles <input type="checkbox"/> Other _____	
	<input type="checkbox"/> Bicycle	<input type="checkbox"/> _____			
Impact:	<input type="checkbox"/> Front	<input type="checkbox"/> Back	<input type="checkbox"/> Rollover	<input type="checkbox"/> Side	
<input type="checkbox"/> Helmet		<input type="checkbox"/> Protective Clothing		Cough: <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive Breath Sounds: <input type="checkbox"/> Not assessed / DNA	
Time of incident: _____					
Extrication needed		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sx: _____	
<input type="checkbox"/> Fall (_____ feet)		<input type="checkbox"/> GSW			
<input type="checkbox"/> Assault		<input type="checkbox"/> Other _____			

Prehospital Care / Treatment		<input checked="" type="checkbox"/> DNA
<input type="checkbox"/> LSB <input type="checkbox"/> CID <input type="checkbox"/> Stiff collar <input type="checkbox"/> IV of _____ # _____ at _____ in _____ <input type="checkbox"/> IV of _____ # _____ at _____ in _____ <input type="checkbox"/> Accuchek _____ <input type="checkbox"/> Meds: _____  <input type="checkbox"/> Splints <input type="checkbox"/> _____ O <sub>2</sub> <input type="checkbox"/> NC <input type="checkbox"/> Simple <input type="checkbox"/> Non-Rebreather Airway: <input type="checkbox"/> Oral <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> ETT _____ <input type="checkbox"/> EOA		
		<b>Right</b>  <input type="checkbox"/> Clear <input type="checkbox"/> Rales/crackles <input type="checkbox"/> Rhonchi/Coarse <input type="checkbox"/> Wheeze <input type="checkbox"/> Diminished <input type="checkbox"/> Absent <input type="checkbox"/> Tracheal Deviation <input type="checkbox"/> JVD
<b>Oxygen:</b> _____ LPM <input type="checkbox"/> NC <input type="checkbox"/> Simple face <input type="checkbox"/> Tube <input type="checkbox"/> Humidified		

PMH:	<input type="checkbox"/> DNA	Pulse Oximeter on at _____
<input type="checkbox"/> NONE <input type="checkbox"/> CHF <input type="checkbox"/> MI <input type="checkbox"/> Cardiac Cath <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma/COPD <input type="checkbox"/> Seizures <input type="checkbox"/> Cancer	<input type="checkbox"/> Unable to obtain <b>Surgeries:</b> <input type="checkbox"/> Angioplasty <input type="checkbox"/> CABG <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Appendectomy <input checked="" type="checkbox"/> <u>Home Surgery</u>	<b>Circulation</b> Color: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Mottled <input type="checkbox"/> Ashen <input type="checkbox"/> Sallow Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Hot

<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Dementia	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Ulcers	<input type="checkbox"/> GI Bleed	<input type="checkbox"/> Renal Disease	<input type="checkbox"/> <i>Handwriting</i>		
							<b>Pulses:</b>	<b>Right</b>	<b>Left</b>
							<b>Radial</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
							<b>Normal</b>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
							<b>Thready</b>	<input type="checkbox"/>	<input type="checkbox"/>
							<b>Bounding</b>	<input type="checkbox"/>	<input type="checkbox"/>
							<b>Absent</b>	<input type="checkbox"/>	<input type="checkbox"/>
							<b>Pedal</b>	<input type="checkbox"/>	<input type="checkbox"/>
							<b>Normal</b>	<input type="checkbox"/>	<input type="checkbox"/>

Alcohol use: \_\_\_\_\_ Normal   
Tobacco use: \_\_\_\_\_ Thready   
Caffeine use: \_\_\_\_\_ Bounding   
Capillary refill: \_\_\_\_\_ Absent   
Bleeding controlled

446977 GAY ER  
KANARY, LILLIAN  
RAJSHWAR, ANHED S  
G-17-13 / 01/04/93  
445-22-4437 9900400268  
12. JULY 2010 R

Psychosocial			
Overall appearance:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Frail	<input type="checkbox"/> Obese
Mood/affect:	<input checked="" type="checkbox"/> Alert	<input type="checkbox"/> Anxious	<input type="checkbox"/> Crying
	<input checked="" type="checkbox"/> Cooperative	<input type="checkbox"/> Blunted/flat	<input type="checkbox"/> Lethargic
	<input type="checkbox"/> Age appropriate	<input type="checkbox"/> Combative	<input type="checkbox"/> Confused
	<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Uncooperative	
Ideations:			

		Cardio Pulmonary		<input checked="" type="checkbox"/> DNA
		Chest pain		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Location:		
		Radiation:		
		Onset/Duration:		
		Pain Scale (0-10)		
		Character:		
		<input type="checkbox"/> Non productive		
Left		<input type="checkbox"/> Dyspnea		
		<input type="checkbox"/> Syncope		
		<input type="checkbox"/> Diaphoresis		
		Dinemapp on:		<input type="checkbox"/>
		CARDIAC MONITOR		<input type="checkbox"/>
		Rhythm:		
		Pacemaker		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Neurological		<input type="checkbox"/> DNA
		Patient Status		
		Loss of Consciousness		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		<input type="checkbox"/> Witnessed		
		<input type="checkbox"/> Unwitnessed		
		<input type="checkbox"/> Nausea		
		<input type="checkbox"/> Vomiting		
Time		Duration		
Nonrebreather		<input type="checkbox"/> Incontinence		
Ventilator		<input checked="" type="checkbox"/> Headache		
		<input type="checkbox"/> Post op		

<input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Jaundice  <input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Cold	<p>% <input type="text"/></p> <p><input type="checkbox"/> Vomiting <input type="checkbox"/> Post icteric</p> <p><input type="checkbox"/> Visual disturbance <input type="checkbox"/></p> <p><input checked="" type="checkbox"/> Appropriate verbal responses <input type="checkbox"/></p> <p><input checked="" type="checkbox"/> Appropriate motor responses <input type="checkbox"/></p> <p><del><input checked="" type="checkbox"/> Loss of appetite</del></p> <p><b>Pupils</b></p> <p><input checked="" type="checkbox"/> Equal <input type="checkbox"/></p> <p><input type="checkbox"/> Unequal <input type="checkbox"/></p> <p><input checked="" type="checkbox"/> Reactive <input type="checkbox"/></p> <p><input type="checkbox"/> Non reactive <input type="checkbox"/></p> <p><input checked="" type="checkbox"/> Dilated &amp; Fixed <input type="checkbox"/></p> <p><input checked="" type="checkbox"/> EOMI <input type="checkbox"/></p> <p><input type="checkbox"/> Other <input type="checkbox"/> <i>(eg stupor)</i></p> <p><b>Extremity movement:</b></p> <p><b>Hand grasps</b></p> <p><input checked="" type="checkbox"/> Equal <input type="checkbox"/></p> <p><input type="checkbox"/> Unequal <input type="checkbox"/></p> <p><input checked="" type="checkbox"/> Strong <input type="checkbox"/></p> <p><input type="checkbox"/> Weak <input type="checkbox"/></p> <p><b>Leg movement</b></p> <p><input checked="" type="checkbox"/> Equal <input type="checkbox"/></p> <p><input type="checkbox"/> Unequal <input type="checkbox"/></p> <p><input checked="" type="checkbox"/> Strong <input type="checkbox"/></p> <p><input type="checkbox"/> Weak <input type="checkbox"/></p>
--	---

Signature: 

Pain

Location:

Description:

Pain Scale (0-10)

Musculoskeletal Injury/Wounds

Mechanism of injury:

Time of injury:

Injured at:

Type of injury:

Laceration       Avulsion  
 Abrasion       Burn  
 Puncture Wound       \_\_\_\_\_

Site of injury:

 See body diagram

DNA

446977 68Y ER

KANARY, LILLIAN

PASHWAN, AHMED S

01/12/99 31/04/99

446977 9900400268

GURU FAMILY DOCTOR

EENT

EYES

OD

OS

EARS

AD

AS

NOSE/THROAT

Red

 Epistaxis

Tearing

 Rhinorrhea

Matted

 Sore throat

Burning/pain

 Dysphagia

Itching

 Other: \_\_\_\_\_

Blurred vision

 Other: \_\_\_\_\_

Loss of vision

 Other: \_\_\_\_\_

Flashing light

 Other: \_\_\_\_\_

Floaters

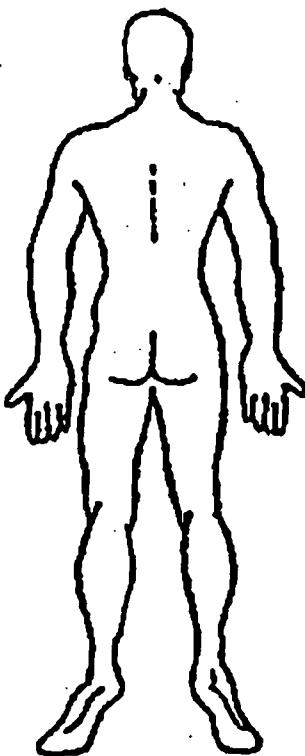
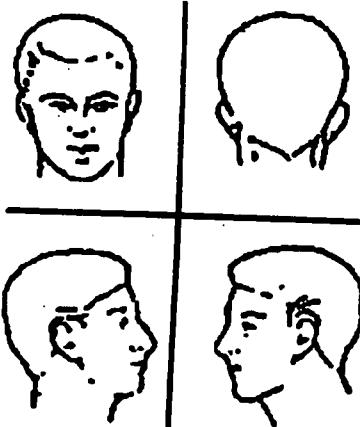
 Other: \_\_\_\_\_

Foreign body

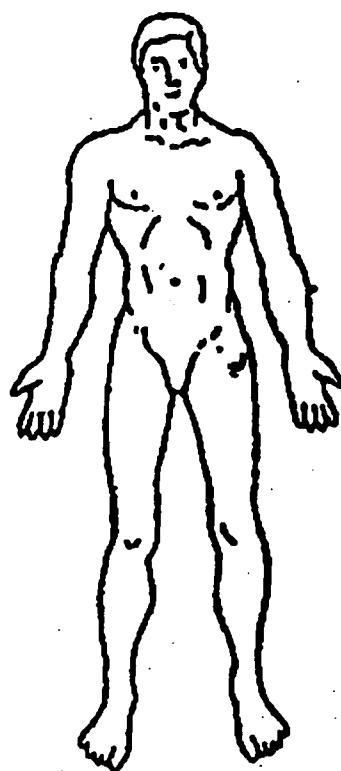
 Other: \_\_\_\_\_

Onset of symptoms:

DNA



A - Abrasion  
 AM - Amputation  
 AV - Avulsion  
 B - Burn -1', 2', 3'  
 C - Contusion  
 CR - Crush  
 E - Ecchymosis  
 P - Penetration  
 H - Hematoma  
 L - Laceration  
 D - Deformity



GI/GU/GYN

Abdomen:

Soft       Distended  
 Guarding       Rigid

Tenderness:

none       LUQ  
 RUQ       LLQ  
 RLQ       Epigastric

Bowel Sounds:

Present  
 Diminished  
 Hyperactive  
 None

Last BM

GI:

Nausea       Dry heaves  
 Vomiting       \_\_\_\_\_  
 Diarrhea       \_\_\_\_\_  
 Rectal Bleed       \_\_\_\_\_

GU:

Voids without difficulty  
 Flank pain R L  
 Dysuria  
 Urgency  
 Hematuria  
 Frequency  
 Foley  
 Other

GYN:

Fetal tones        
 Vaginal bleeding  
 Vaginal discharge  
 History of ectopic

Para \_\_\_\_\_ Gravida \_\_\_\_\_

Ab

Onset of symptoms:

Signature: \_\_\_\_\_



**See Key/Codes on Page 6**

446977 68Y ER  
KANARY, LILLIAN  
RASHMAN, AHMED S  
C: 12/30 F 01/04/99  
445-42-5652 9900400268  
NO FAMILY DOCTOR

## NOTES



446977

01/04/1999 16:02:13  
68 years Female

KANARY LILLIAN

DuBois Regional Medical Center

Dept: ER4

Oper: BD

Doctor

RASHWAN

268

• Sinus rhythm, rate 87

• Ventricular premature complex

Rate 87  
PR 178  
QRS 92  
QT 346  
QTc 416

--AXIS--

P 68

QRS 23

T 43

- ABNORMAL ECG -

Q

aVR

V1

V4

aVL

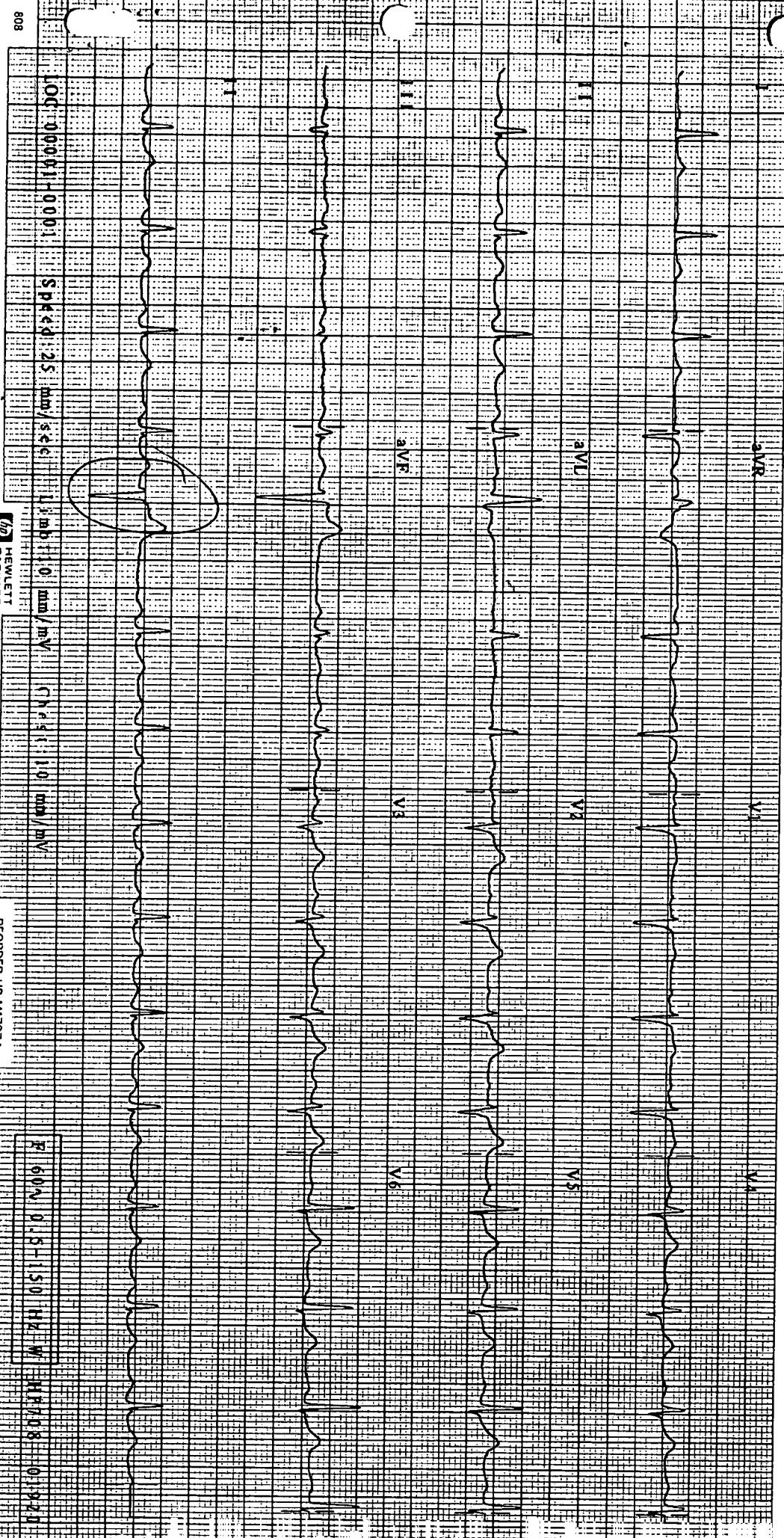
V2

V5

aVF

V3

V6



PATIENT	NAME AND ADDRESS KANARY, LILLIAN 103 CORDELLA AVENUE			REGISTRATION DATE 01/02/99	TIME 14:19	ORG DNR	MED. REC. NO. 446977	BILLING NO. 9900200146	
	TORONTO	CA 000 00	COUNTY OC	AGE 68Y	BIRTH DATE 01/12/30	METHOD ARRIVAL 4 AMBULANCE	SEX F	RACE 1	M.S. M
	TELEPHONE NO. EMPLOYER, ADDRESS, OCCUPATION, PHONE			RELIGION CATHOLIC			P.T. ER	FIN.CL. SP	ADMIT BY DEH
	PT/PT REPRESENTATIVE STATES SYMPTOMS OR ACCIDENT - HOW, WHERE, WHEN INDUSTRIAL MOP FELL ON HEAD PASSE					STAFF ALERT 375-8888 Friends @ TL			
	PERSON TO NOTIFY IN CASE OF EMERGENCY NOT GIVEN					RELATIONSHIP OTHER			
	NAME AND ADDRESS KANARY, LILLIAN SELF 103 CORDELLA AVENUE TORONTO CA 000 00			TELEPHONE HOMEMAKER SOC.SEC.# 445-42-6692	REL	EMPLOYER NAME AND ADDRESS			
	INSURANCE COMPANY			PLAN	POLICY HOLDER	REL	POLICY #		
	E.R. PHYSICIAN BETH, SATISH K. SHILAIK, P.			FAMILY PHYSICIAN NO, DOCTOR GIVEN	REFERRING PHYSICIAN NO, DOCTOR GIVEN	end is for the	group #		
	This record is strictly Confidential to whom it is addressed. No responsibility can be accepted if it is made available to any other person, INCLUDING THE PATIENT.								

## AUTHORIZATION FOR EMERGENCY, OUTPATIENT, OR SHORT PROCEDURES UNIT TREATMENT

I, Lillian (or Self) for Self, voluntarily authorize and consent to diagnostic procedures, examinations, and/or medical care as prescribed by, or deemed necessary in the judgement of Dr. Self for Emergency Treatment Outpatient Services Short Procedures Unit Services.

I understand that this consent does not include operations or any non-routine procedures or treatment, and that the risks and alternatives for such procedures or treatment, which a reasonable patient would consider significant to a decision whether or not to undergo such treatment or procedures, will be explained to me by my treating physician or another physician designated by him.

I certify that no guarantees have been made to me as to the results of treatments or examinations in the Medical Center.

This form has been explained to me and I certify that I understand its contents.

Verbal signature  
Signature of Patient

Self  
Relationship

1-2-98  
Date/Time

Wit  
Witness

Patient is unable to consent for the following reason: \_\_\_\_\_

Signature of Patient Representative

Relationship

Date/Time

Witness

Witness

## RELEASE FROM RESPONSIBILITY FOR DISCHARGE

I am leaving (or taking \_\_\_\_\_ from) the DuBois Regional Medical Center against the advice of my physician. I have been informed of the risks involved in this decision. I hereby release the DuBois Regional Medical Center, its staff, and my physician from all responsibility for any ill effects which may result from this action.

Signature of Patient

Relationship

Date/Time

Witness

Witness

Time: 1450  Emergent  Urgent  Nonurgent

CONDITION ON ARRIVAL:  Poor  Fair  Satisfactory  DOA

CHIEF COMPLAINT: Was being struck on the head with a mop at 6:10. Short LOC but did not bump over

VITAL SIGNS Temp 97.6 Pulse 110 Resp 22 RR 18 O<sub>2</sub> Sat 100 WT 119

ALLERGIES: Tylenol, cologne

CURRENT MEDS:  See attached list  
Promazine  
Muscle Relaxant for knee  
Roxiphen Lorazepam

IMMUNIZATIONS:  DNA  UP TO DATE LAST TT/TD:

VISUAL ACUITY  OD  OS  OU  CORRECTED  
 DNA  UNCORRECTED

PT. PREGNANT?  DNA  YES  NO  UNSURE  HYSTERECTOMY  
 LMP  TUBAL LIGATION

TRIAGE TO  Registration  Room Triage Nurse:

Primary Nurse: Brandy Smith RA

446977 887 ER

XANART, LILLIAN

SETH, SATISH K

611410

01/08/98

9800200148

148

CHECK THE REQUESTED STUDIES

<input type="checkbox"/> CBC	<input type="checkbox"/> Cardiac enzymes	<input type="checkbox"/> Magnesium	<input type="checkbox"/> GC
<input type="checkbox"/> Lytes	<input type="checkbox"/> CKMB	<input type="checkbox"/> UA	<input type="checkbox"/> C&S
<input type="checkbox"/> BUN	<input type="checkbox"/> CPK, Trip, Myo	<input type="checkbox"/> UC	<input type="checkbox"/> Wet Mount
<input type="checkbox"/> Creatinine	<input type="checkbox"/> Troponin I	<input type="checkbox"/> RSS	<input type="checkbox"/> RSV
<input type="checkbox"/> Blood Sugar	<input type="checkbox"/> Myoglobin	<input type="checkbox"/> Throat C&S	<input type="checkbox"/> Triage Drug Screen
<input type="checkbox"/> Amylase	<input type="checkbox"/> Digoxin level	<input type="checkbox"/> Blood C&S	<input type="checkbox"/> Coma Panel
<input type="checkbox"/> PT/PTT	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Type and Screen	<input type="checkbox"/>
<input type="checkbox"/> Basic Met Prof.	<input type="checkbox"/> Monospot	<input type="checkbox"/> Type and Cross	<input type="checkbox"/>
<input type="checkbox"/> Hepatic Prof.	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Type and Cross	<input type="checkbox"/>
<input type="checkbox"/> Compre profile	<input type="checkbox"/> ETOH	<input type="checkbox"/> Chlamydia	<input type="checkbox"/>

ECG: Provisional Reading MS

Repeat

<input type="checkbox"/> ABG	<input type="checkbox"/> on O <sub>2</sub>	<input type="checkbox"/> on Room Air	<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat
<input type="checkbox"/> Proventil	<input type="checkbox"/> Atrovent	<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat
<input type="checkbox"/> Proventil	<input type="checkbox"/> Atrovent	<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat
<input type="checkbox"/> Vaponephrine	<input type="checkbox"/>	<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat	<input type="checkbox"/> Repeat
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/> Peak Flows	<input type="checkbox"/>	<input type="checkbox"/> Repeat
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head
<input type="checkbox"/> Portable Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Enhanced
<input type="checkbox"/> Port Lat C Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Unenhanced
<input type="checkbox"/> L-S Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ABD Series	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

X SP RAY A T L ACT Head MS

PHYSICIAN REPORT

EXAM TIME: 1450

Dictated

DX Skull Contusion concussion  
Neck Spine EEG Skull Spine  
EEG Spine CT - Head Spine

ORDERS IC - Spine / CT - Head

Ortho

Ortho</p

TIME: 145

Mode of Arrival	Arrived with	Self Care
<input checked="" type="checkbox"/> Ambulance <input type="checkbox"/> W.C. <input type="checkbox"/> Ambulatory <input type="checkbox"/> Carried Gait <input type="checkbox"/> Steady <input type="checkbox"/> Unsteady	<input type="checkbox"/> Self <input type="checkbox"/> Police <input type="checkbox"/> Parent <input type="checkbox"/> Friend <input type="checkbox"/> Spouse <input type="checkbox"/> Delegate <input type="checkbox"/> Family <input type="checkbox"/> _____	<input type="checkbox"/> Independent <input checked="" type="checkbox"/> Total Assist <input type="checkbox"/> Partial Assist <input type="checkbox"/> Child

Safety Measures	Environmental	Psychosocial
<input checked="" type="checkbox"/> Siderails up <input type="checkbox"/> Family at bedside <input checked="" type="checkbox"/> Call Bell <input type="checkbox"/> Security present	Lives with: <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse Language barrier <input type="checkbox"/> Translator	Overall appearance: <input type="checkbox"/> Normal <input type="checkbox"/> Frail Mood/affect: <input type="checkbox"/> Alert <input type="checkbox"/> Anxious <input type="checkbox"/> Cooperative <input type="checkbox"/> Blunted/flat <input type="checkbox"/> Age appropriate <input type="checkbox"/> Combative <input type="checkbox"/> Unresponsive <input type="checkbox"/> Confused <input type="checkbox"/> Uncooperative

Trauma/Accidents	<input type="checkbox"/> DNA	Airway	<input type="checkbox"/> DNA
<input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Seat Belt on <input type="checkbox"/> Air bag deployed	<input checked="" type="checkbox"/> Clear/Patent <input type="checkbox"/> Adjuncts _____		
Type: <input type="checkbox"/> Car <input type="checkbox"/> Truck <input type="checkbox"/> Motorcycle <input type="checkbox"/> Bicycle <input type="checkbox"/> _____	Breathing		
Impact: <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Rollover <input type="checkbox"/> Side	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Dyspneic <input type="checkbox"/> Grunting <input type="checkbox"/> Stridor <input type="checkbox"/> Nasal flaring <input type="checkbox"/> Retractions <input type="checkbox"/> Accessory muscles <input type="checkbox"/> Absent <input type="checkbox"/> Other _____		
<input type="checkbox"/> Helmet <input type="checkbox"/> Protective Clothing	Cough: <input type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Non productive		
Time of incident: _____	Breath Sounds:		
Extrication needed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Fall (_____ feet) <input type="checkbox"/> GSW <input type="checkbox"/> Assault <input type="checkbox"/> Other _____	<input type="checkbox"/> Not assessed / DNA		

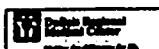
Prehospital Care / Treatment	<input type="checkbox"/> DNA
<input checked="" type="checkbox"/> LSB <input checked="" type="checkbox"/> CID <input checked="" type="checkbox"/> Stiff collar	
<input checked="" type="checkbox"/> IV of _____ # _____ at _____ in _____	
<input type="checkbox"/> IV of _____ # _____ at _____ in _____	
<input type="checkbox"/> Accuchek _____	
<input type="checkbox"/> Meds: _____	
<input type="checkbox"/> Splints _____	
O <sub>2</sub> <input type="checkbox"/> NC <input type="checkbox"/> Simple <input type="checkbox"/> Non-Rebreather	
Airway: <input type="checkbox"/> Oral <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> ETT _____ <input type="checkbox"/> EOA	

PMH:	<input type="checkbox"/> DNA
<input type="checkbox"/> NONE <input type="checkbox"/> Unable to obtain	
<input type="checkbox"/> CHF	
<input type="checkbox"/> MI	
<input type="checkbox"/> Cardiac Cath	
<input checked="" type="checkbox"/> Hypertension	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Asthma/COPD	
<input type="checkbox"/> Seizures	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Dementia	
<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Ulcers	
<input type="checkbox"/> GI Bleed	
<input type="checkbox"/> Renal Disease	
<input checked="" type="checkbox"/> Anxiety Attack	
Alcohol use: _____	
Tobacco use: _____	
Caffeine use: _____	

Airway	Cardio Pulmonary
<input checked="" type="checkbox"/> Clear/Patent <input type="checkbox"/> Adjuncts _____	Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing	Location: _____
<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Dyspneic <input type="checkbox"/> Grunting <input type="checkbox"/> Stridor <input type="checkbox"/> Nasal flaring <input type="checkbox"/> Retractions <input type="checkbox"/> Accessory muscles <input type="checkbox"/> Absent <input type="checkbox"/> Other _____	Radiation: _____
Cough: <input type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Non productive	Onset/Duration: _____
Breath Sounds:	Pain Scale (0-10) _____
<input type="checkbox"/> Not assessed / DNA	Character: _____
Right	<input type="checkbox"/> Dyspnea <input type="checkbox"/> Syncope <input type="checkbox"/> Diaphoresis
<input checked="" type="checkbox"/> Clear <input type="checkbox"/> Rales/crackles <input type="checkbox"/> _____ <input type="checkbox"/> Rhonchi/Coarse <input type="checkbox"/> _____ <input type="checkbox"/> Wheeze <input type="checkbox"/> _____ <input type="checkbox"/> Diminished <input type="checkbox"/> _____ <input type="checkbox"/> Absent <input type="checkbox"/> _____ <input type="checkbox"/> Tracheal Deviation <input type="checkbox"/> _____ <input type="checkbox"/> JVD <input type="checkbox"/> _____	Left <input type="checkbox"/> _____
Oxygen: <input checked="" type="checkbox"/> LPM <input type="checkbox"/> Time _____	Dinemapp on: <input type="checkbox"/>
<input checked="" type="checkbox"/> NC <input type="checkbox"/> Simple face <input type="checkbox"/> Nonrebreather <input type="checkbox"/> Tube <input type="checkbox"/> Humidified <input type="checkbox"/> Ventilator	CARDIAC MONITOR <input type="checkbox"/> Rhythm _____ Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No
Pulse Oximeter on at _____ %	Neurological <input type="checkbox"/> DNA
Circulation	Patient Status
Color: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Pale <input type="checkbox"/> Mottled <input type="checkbox"/> Cyanotic <input type="checkbox"/> Ashen <input type="checkbox"/> Jaundice <input type="checkbox"/> Sallow <input type="checkbox"/> _____	Loss of Consciousness <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Witnessed <input type="checkbox"/> Duration _____ <input type="checkbox"/> Unwitnessed <input type="checkbox"/> Incontinence <input type="checkbox"/> Nausea <input type="checkbox"/> Headache <input type="checkbox"/> Vomiting <input type="checkbox"/> Post ictal <input type="checkbox"/> Visual disturbance _____
Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Dry <input checked="" type="checkbox"/> Cool <input type="checkbox"/> Moist <input checked="" type="checkbox"/> Hot <input type="checkbox"/> Cold	Appropriate verbal responses <input type="checkbox"/> Appropriate motor responses <input type="checkbox"/>
Pulses: Right <input type="checkbox"/> DNA Radial <input type="checkbox"/> <input type="checkbox"/> Normal <input type="checkbox"/> <input type="checkbox"/> Thready <input type="checkbox"/> <input type="checkbox"/> Bounding <input type="checkbox"/> <input type="checkbox"/> Absent <input type="checkbox"/> <input type="checkbox"/> Pedal <input type="checkbox"/> <input type="checkbox"/> Normal <input type="checkbox"/> <input type="checkbox"/> Thready <input type="checkbox"/> <input type="checkbox"/> Bounding <input type="checkbox"/> <input type="checkbox"/> Absent <input type="checkbox"/> <input type="checkbox"/>	Pupils <input checked="" type="checkbox"/> Equal <input type="checkbox"/> _____ <input type="checkbox"/> Unequal <input type="checkbox"/> _____ <input checked="" type="checkbox"/> Reactive <input type="checkbox"/> _____ <input type="checkbox"/> Non reactive <input type="checkbox"/> _____ <input type="checkbox"/> Dilated & Fixed <input type="checkbox"/> _____ <input checked="" type="checkbox"/> EOMI <input type="checkbox"/> _____ <input type="checkbox"/> Other _____
Capillary refill: _____ seconds	Extremity movement
Bleeding controlled <input type="checkbox"/> Yes <input type="checkbox"/> No	Hand grasps <input checked="" type="checkbox"/> Equal <input type="checkbox"/> _____ <input type="checkbox"/> Unequal <input type="checkbox"/> _____ <input checked="" type="checkbox"/> Strong <input type="checkbox"/> _____ <input type="checkbox"/> Weak <input type="checkbox"/> _____
Leg movement <input checked="" type="checkbox"/> Equal <input type="checkbox"/> _____ <input type="checkbox"/> Unequal <input type="checkbox"/> _____ <input checked="" type="checkbox"/> Strong <input type="checkbox"/> _____ <input type="checkbox"/> Weak <input type="checkbox"/> _____	

Signature: DeeDee Smith, RN

446977 68Y ER  
KANARY, LILLIAN  
SETH, SATISH K  
01/12/30 01/02/99  
445-42-1652 9500200146  
122 ECR Given



Pain

 DNALocation: Side of headDescription: Sore from bump on head

Pain Scale (0-10)

Musculoskeletal Injury/Wounds

 DNAMechanism of injury: A snap handle fell out of a buckle from my parent on the side of headTime of injury: 2/1/99Injured at: B.10 D.Bois

Type of injury:

Laceration       Avulsion  
 Abrasion       Burn  
 Puncture Wound       Contusion

Site of injury: head See body diagram

EENT

 DNA

EYES

OD

OS

EARS

AD

AS

NOSE/THROAT

Red  
 Tearing  
 Matted  
 Burning/pain  
 Itching  
 Blurred vision  
 Loss of vision  
 Flashing light  
 Floaters  
 Foreign body







DuBois Regional Medical Center

Making the difference for life.

88  
Emergency Department Record

6 of 7

446977 68Y ER

KANARY, LILLIAN  
SETH, SATISH KC1/12/30 F 01/02/99  
445-42-6632 9909200146  
+ P. DOCTOR GIVEN

## PATIENT PROBLEM LIST

Patient needs identified as: (Number to Prioritize) (Minimum of 1 need to be identified)

Knowledge deficit: _____	Alteration in body temperature: _____
Alteration in Comfort: <u>Head pain</u>	Individual ineffective coping: _____
Alteration in fluid volume: _____	Risk of infection _____
Alteration in Oxygenation: _____	Impaired tissue integrity: _____
Decreased Cardiac Output: _____	Other: _____

(See Chart and nurses notes for interventions and response.)

## SCREENING CRITERIA

Patient Home Phone Number/Room #: \_\_\_\_\_

<b>Suspected Abuse: Adult/Child:</b> <input checked="" type="checkbox"/> No Identified Needs <input type="checkbox"/> Unusual/suspicious marks (i.e. burns, bruises, welts, lacerations, punctures) <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Domestic Violence: Patient verbalizes need for assistance. <b>FOLLOW DRMC POLICY (PR-1, PR-1.2, PR-1.3),</b>	Initial visit: date: _____ Time: _____ Signature: _____ Follow-up: <input type="checkbox"/> None <input checked="" type="checkbox"/> See Progress Note
<b>Discharge Planning:</b> <input checked="" type="checkbox"/> No Identified Needs <input type="checkbox"/> Additional supportive services needed upon d/c (med. equip., Home Health). <input type="checkbox"/> INITIAL Placement assistance needed before discharge. <input type="checkbox"/> Financial assistance required to follow treatment. <input type="checkbox"/> Patient has an Advanced Directive but did not bring in a copy, follow up needed.	Initial visit: date: _____ Time: _____ Signature: _____ Follow-up: <input type="checkbox"/> None <input checked="" type="checkbox"/> See Progress Note
<b>Pastoral Care:</b> <input checked="" type="checkbox"/> No Identified Needs <input type="checkbox"/> Terminal Illness; <input type="checkbox"/> Recent Loss of Significant Other; <input type="checkbox"/> Request for Pastoral Care <b>If any of the above are indicated, PLEASE FAX THIS FORM TO THE SOCIAL WORK/ PASTORAL CARE AREA #3488</b>	Initial visit: date: _____ Time: _____ Signature: _____ Follow-up: <input type="checkbox"/> None <input checked="" type="checkbox"/> See Progress Note

## KEY/CODES

Glasgow Coma Score		Adult	Child	Infant	Pupils: D = Dilated S = Small M = Medium L = Large	Pupil reaction: + = Brisk S = Sluggish O = No reaction	Cardic Rhythms:	Hand Grasp and Leg Movement:
Eyes Open	Spontaneous	4	4	4			NSR - Normal Sinus Rhythm	Strong - S Sensation Intact - SI
	To Voice/Speech	3	3	3			AF - Atrial Fib	Weak - W Paresthesia - P
	To pain	2	2	2			HB - Heart block	Equal =
	No response	1	1	1			SB - Sinus Brady	Unequal <input checked="" type="checkbox"/>
Best Verbal Response	Oriented	5	5				SR - Sinus Rhythm	BP
	Coos, blabbles, smiles			5			ST - Sinus Tachycardia	D = See dinemapp
	Confused	4	4				J - Junctional	
	Irritable, crying			4			H - Heart block	
	Inappropriate words	3	3				PVC - Premature Ventricular Complex	
	Cries, Screams to pain			3			PAC - Premature Atrial Complex	
	Incomprehensible sounds	2	2				VT - Ventricular tachy	
	Moans, grunts			2			VF - Ventricular fib	
	None/No response	1	1	1			SVT - Supraventricular tachy	
Best Motor Response	Obeys Commands	6	6				PA - Pacemaker	
	Spontaneous			6				
	Localizes to Pain	5	5					
	Withdraws from touch			5				
	Normal flexion	4	4					
	Withdraws from pain			4				
	Abnormal flexion - decorticate	3	3	3				
	Abnormal extension - decerebrate	2	2	2				
	No reponse	1	1	1				

Pain scale 0 - 10

Signature:

*Sherry Smith*

DUBOIS REGIONAL MEDICAL CENTER  
DUBOIS, PENNSYLVANIA

**EMERGENCY ROOM**

Date: 1/2/99 Time: 2 p.m.

Patient Name: KANARY, LILLIAN

9900200146 - 000446977

**HISTORY OF PRESENT ILLNESS:** This is a 68 year old female brought to our Department by ambulance for evaluation of injuries sustained at BiLo Supermarket a short time ago. This 68 year old female states that she was accidentally struck in the head by a industrial sized mop. The patient states that she was sitting by a person who was going to use the mop. Evidently the person using the mop lost control of the mop and bucket that it was in and according to the patient's friend who witnessed this, she states that the mop struck her friend in the right side of her head causing resultant pain. There was also a short period of loss of consciousness. The patient was brought to our Department fully immobilized in a long spine board with cervical immobilization device in place complaining of pain to the right side of her head, her neck, and her left shoulder. She is here for evaluation of this problem.

**PAST MEDICAL HISTORY:** Positive for hypertension and anxiety attacks.

**MEDICATIONS:** Ativan, a muscle relaxant for right knee pain and Premarin.

**ALLERGIES:** TYLENOL AND CODEINE.

**PHYSICAL EXAMINATION: GENERAL:** Alert, cooperative oriented 68 year old white female who appears to be no acute physical distress. **VITAL SIGNS:** Temperature 97.6. Her initial blood pressure was 218/111 with a pulse rate 110 and irregular. Blood pressure has since come down to a more acceptable level at 177/88, however, it is still elevated and as mentioned earlier this patient does have a history of hypertension, however, she is not taking any medication at this time for her high blood pressure. Initial part of Mrs. Kanary's physical examination was carried out while she was fully immobilized in a long spine board with a cervical immobilization device. Lateral X rays of the C-spine were taken before I had an opportunity to examine this lady and I could not see any fracture, dislocation although she does have significant degenerative joint disease present. During the examination again, she is alert, cooperative oriented. **HEENT:** Head is normocephalic. There is tenderness to the right parietal skull. I cannot feel any deformities and I cannot see any hematomas or contusion or abraded areas. Ears appear normal. There is no bleeding present. It is negative for hemotympanum. Eyes, Pupils equal, round and reactive to light and accommodation. Extraocular muscles intact. Face, there is no facial paresis or paralysis present. There is no facial pain. There is no ecchymosis or edema to the face. **HEART:** Rapid rate, irregular rhythm. There appears to be sinus rhythm with PACs, left ventricle ectopy was noted. Low grade murmur present. **LUNGS:** clear. Patient is not short of breath. The remaining of the cervical spine X rays were done and they showed degenerative joint disease with no fracture or dislocations. In addition to that, an un-enhanced CAT scan of the head was also done and it was normal. When the patient returns from our Radiology Department, we then removed the rigid collar and her neck was tender to palpation. There was also tenderness to palpation to her left shoulder and left arm, however, no deformities were present. Range of motion was full but painful. Her back was not injured. There is no tenderness to the thoracic spine or lumbar spine with palpation.

**DIAGNOSIS:**

1. Skull contusion with mild concussion.
2. Neck and left shoulder pain, probably secondary to skull contusion.

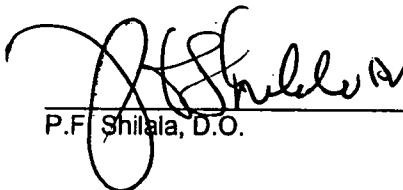
EMERGENCY ROOM REPORT  
DUBOIS REGIONAL MEDICAL CENTER  
DUBOIS, PENNSYLVANIA  
KANARY, LILLIAN  
Page 2

9900200146 - 000446977

Patient was discharged from our Department with aforementioned diagnoses and the following instructions:

1. Aspirin for pain.
2. Rest for 24 to 48 hours. Then engage in activities as tolerated.
3. Sleep in a position of comfort. May be feel better sleeping in a semi-sitting position.
4. See your family physician when you get back home and have your blood pressure reevaluated. You may need to be put on medication for this.
5. Return to our Emergency Room if necessary.

D: 01/02/1999 3:26 P  
T: 01/04/1999 8:56 P PFS/cw  
DOCUMENT NO: 62570  
Job/Tape ID: 006121



P.F. Shilala, D.O.

DUBOIS REGIONAL MEDICAL CENTER  
100 Hospital Ave, DuBois, PA 15801

KANARY, LILLIAN  
103 CORDELLA AVENUE  
TORONTO

CA 000 00

\*ER

Unit # 000446977

Age 68Y

Acct # D9900200146

Date 01/02/99 Time: 1442

SETH, SATISH K

NO, DOCTOR GIVEN

Chk-in #	Order	Exam	
318476	0002	43023	XR-SPINE SINGLE VIEW Ord Diag: HIT WITH A MOP
318478	0004	43003	XR-CERVICAL SPINE MIN 4 Ord Diag: HIT WITH MOP

CERVICAL SPINE - CROSS-TABLE LATERAL AND AP, LATERAL, BOTH OBLIQUE  
AND OPEN-MOUTH VIEWS:

Marked degenerative changes are seen in the distal cervical spine with slight narrowing of C4-5 disc space. Degenerative changes are seen in the facet joints also in the mid and distal cervical spine. No fracture or dislocation is noted.

IMPRESSION: OSTEOARTHRITIS DISTAL CERVICAL SPINE.  
NO FRACTURE SEEN.

/READ BY/ G. ALI SHAH,  
/Released By/ G. ALI SHAH,

01/04/99 0834  
JAH

Complete

\*\* Portable \*\*

DUBOIS REGIONAL MEDICAL CENTER  
100 Hospital Ave, DuBois, PA 15801

KANARY, LILLIAN \*ER Unit # 000446977  
103 CORDELLA AVENUE CA 000 00 Age 68Y Acct # D9900200146  
TORONTA

Date 01/02/99 Time: 1508

SETH, SATISH K NO, DOCTOR GIVEN

Chk-in # Order Exam  
318477 0003 72724 CT-HEAD UNENHANCED  
Ord Diag: HIT IN HEAD BY INDUST. MOP

CT SCAN OF HEAD:

Axial images of the head were obtained without intravenous contrast enhancement.

Intra- and extraventricular CSF spaces are normal. No intracranial bleeding or fresh infarct is seen. No space occupying lesion is noted. There is no midline shift present.

IMPRESSION: NORMAL UNENHANCED CT SCAN OF HEAD.

/READ BY/ G. ALI SHAH,  
/Released By/ G. ALI SHAH,

01/04/99 0834  
JAH

Complete

6694000

01/02/1999 14:10:43  
68 years Female

KANARY, LILLIAN

DuBois Regional Medical Center  
Dept: ER-5

Oper: DT

Rate 111 Sinus tachycardia, rate 111  
PR 167 : Multiple atrial premature

QRSD 87 . Nonspecific ST depression

QT 306

QTc 416

318

— 13 —

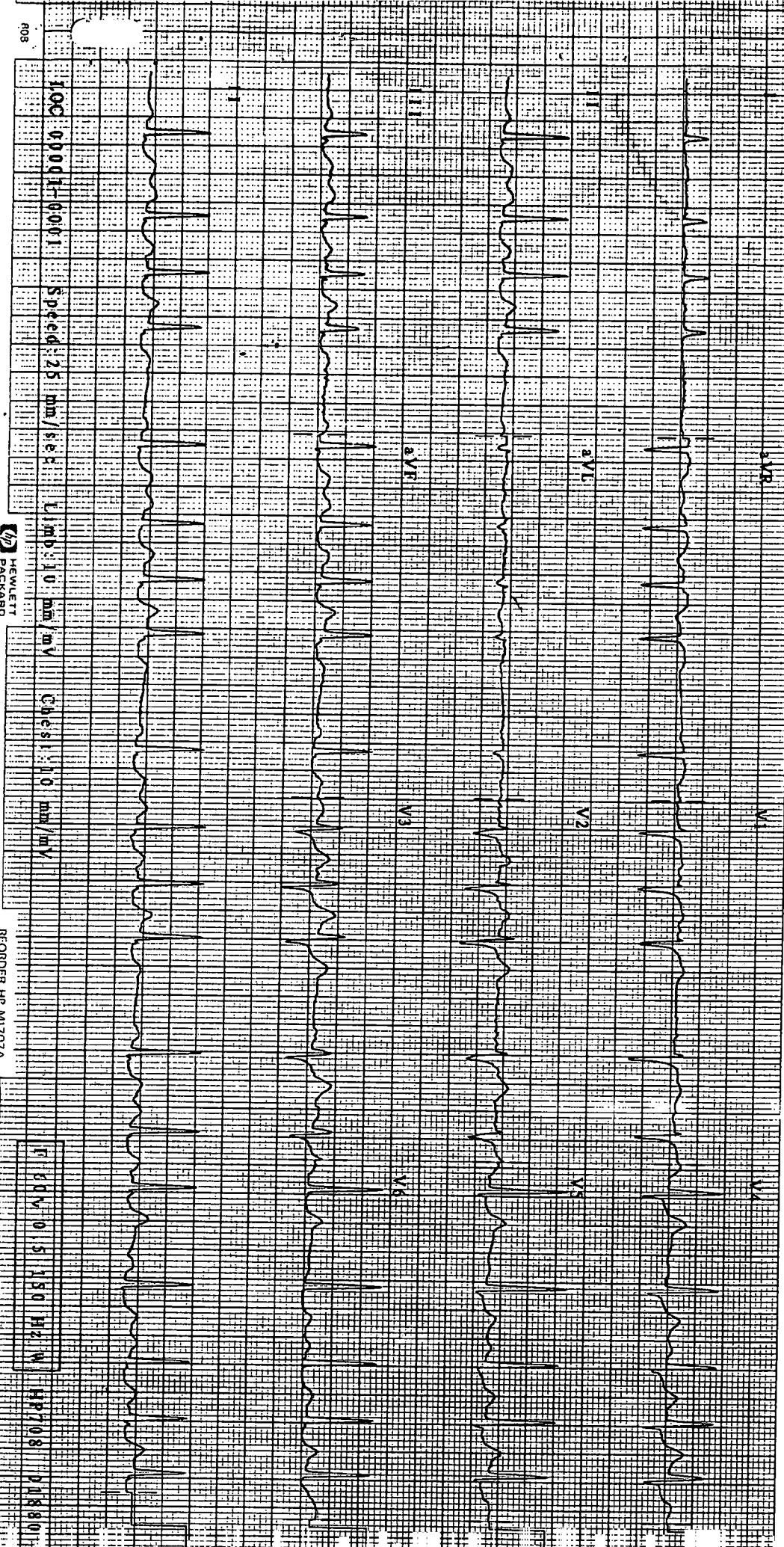
ORS 7280

T  
-61

T  
61

- ABNORMAL ECG

• [www.ams.org/amsmta/2010-11/2010-11.html](http://www.ams.org/amsmta/2010-11/2010-11.html)



HEWLETT  
PAKET

REORDERING MOTIONS

DUBOIS REGIONAL MEDICAL CENTER

BP 157/112 14:26  
MAP (137)   
bPM 125  
  
BP 205/ 95 14:15  
MAP (135)   
bPM 125  
  
BP 220/111 14:05  
\*MAP (144)   
bPM 108  
  
BP 201/121 13:55  
\*MAP (154)   
bPM 111  
  
BP 218/111 13:54  
\*MAP (144)   
bPM 110  
  
mmHg&bPM 20 50 100 150 200

MOVE STRIP OF TAPE  
D ATTACH SECOND REPORT

PATIENT'S NAME

PHYSICIAN'S NAME

PROCEDURE

DATE

COMMENTS

SETH, SATHISH X  
01/12/30 445-42-6692 NO, DOCTOR GIVEN  
F 01/02 99002001

CRITIKON DINAMAP 1846 SX/P VERSION 089

**DR. JANE HOWELL  
98 Guestville Ave., Toronto, Ontario M6N 4N6  
Z(416)763-1171 Fax (416)763-0573**

**May 18, 1999**

**Blakley, Jones & Mohney,  
90 Beaver Drive,  
Box 6,  
DuBois, Pennsylvania 15801**

**Dear Mr. Mchney,**

**Re: Lillian KANARY  
Date of Accident: 1/2/99**

**I, Jane Howell am a duly qualified medical practitioner, licensed to practice in Ontario. I am a graduate of the University of Toronto Faculty of Medicine and am certified by the College of Family Physicians of Canada in Family Medicine.**

**Mrs Kanary first came to see me regarding the above accident on February 1, 1999. She informed me that whilst shopping in a DuBois grocery store in Pittsburgh, Pennsylvania she was injured. Apparently, an employee of the store who Mrs. Kanary said was affected by Down's Syndrome, hit Mrs. Kanary over her head with an industrial mop. Mrs. Kanary stated she lost consciousness for about three minutes. An ambulance was called and she was taken to the local hospital where she was admitted to the Intensive Care Unit for one day. Apparently a CT scan and x-rays were taken. I have tried to obtain copies of the hospital records but they have never arrived at my office.**

**Continued.....**

LILLIAN KANARY

**She was discharged after a day but Mrs. Kanary had to return the following day because of severe headaches.**

**When I saw Mrs. Kanary on February 1<sup>st</sup> she was complaining of headaches and neck pain and stiffness. On examination there was soft tissue swelling over the right occipital region of her head. There was no evidence of previous lacerations. She had tenderness over the paracervical and trapezii muscles of her neck and upper shoulders respectively with limitation in lateral neck rotation. My diagnoses was post concussive syndrome with headaches and cervical myofascitis . I referred her for physiotherapy and massage therapy. I prescribed Demerol 50mg because of the severity of her headaches and Bromazepam 3mg as needed for her nerves to help her relax.**

**She had been attending therapy twice weekly when I reviewed her on April 7,1999. She felt she was making slow progress with reduction in the amount of pain she was experiencing.**

**Continued.....**

LILLIAN KANARY

However, she was finding herself becoming quite paranoid and scared to go out to shop. She was fearful something might fall on her. She was depending on her friends Margaret and Tom Hollywell to do her shopping. She had had to cease her social activities such as line dancing and swimming because of her anxieties about venturing outside of her home. I felt she was suffering from post traumatic stress/depression and prescribed an antidepressant, Zoloft 50mg daily.

I last assessed Mrs. Kanary on May 12,1999. She was continuing to attend massage therapy twice weekly for her neck and back. She was still experiencing headaches for which she was taking Advil (Ibuprofen). She was also doing exercises at home for her neck and back. She complained of ongoing pain in the left side of her neck and across the left shoulder and also back soreness. Examination revealed tenderness over the left trapezius and left lateral cervical muscles. There was decreased lateral rotation of her neck more so to the left side than her right, and limited internal rotation of her left shoulder. Her back exhibited diminished forward flexion.

Continued.....

(4)

**LILLIAN KANARY**

**In summary, Mrs. Kanary continues to suffer both physical and emotional sequelae from the accident of January 2,1999. She has neck and back myofascial pain, headaches and post-traumatic anxiety and depressive syndrome. Her prognosis is quite good. With time and continued therapy, I anticipate she will recover fully from these disabilities over the next few months.**

**Sincerely,**



**Dr. J.C. Howell**

**JCH:bc**

**Account enclosed**