

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 2 - C.D.

LILLIAN J. KANARY,

Plaintiff

VS.

THE PENN TRAFFIC COMPANY,

Defendant

COMPLAINT

FILED

SEP 11 2000
M 12 42 1 cc Shaw
William A. Shaw
Prothonotary
cc atty
attn Motney rd \$ 80.00

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

(13) LILLIAN J. KANARY,

Plaintiff

VS.

(13) THE PENN TRAFFIC COMPANY,

Defendant

: NO. 00 -1121 - C.D.

: TYPE OF CASE: CIVIL

: TYPE OF PLEADING: COMPLAINT

: 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

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 M6N2S8.

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.

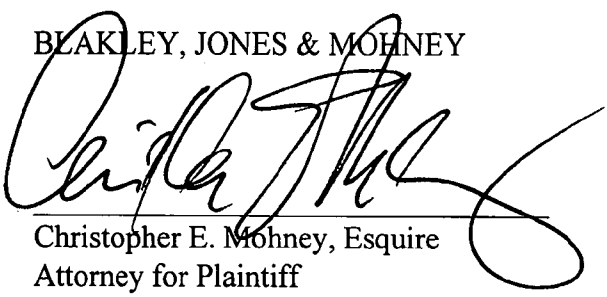
10. The Defendant, its agents, servants and/or employees remain liable for the injuries sustained by Plaintiff as a direct, proximate, natural, foreseeable and probable consequence of the negligence, carelessness and/or reckless actions, errors and/or omissions of the Defendant, its agents, servants 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 16th, 2000

Lillian J. Kanary
LILLIAN J. KANARY

CHRISTOPHER E. MOHNEY

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

KANARY, LILLIAN J.

00-1121-CD

VS

THE PENN TRAFFIC COMPANY

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 Harris

CHESTER A. HAWKINS
SHERIFF

FILED

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.

PRAECIPE FOR APPEARANCE

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
38th 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

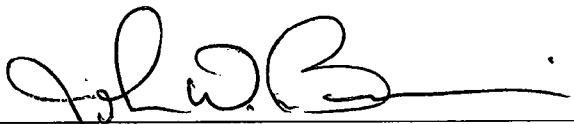
TO: Prothonotary

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, 38th Floor

Pittsburgh, PA 15219

(412) 263-2000

FILED

OCT 26 2000

William A. Shaw
Prothonotary

WAS

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

LILLIAN J. KANARY,

No. 00 - 1121 - C.D.

Plaintiff,

ANSWER and NEW MATTER

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

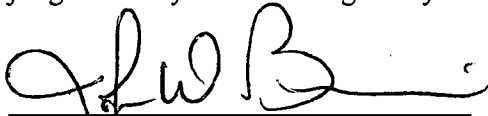
NOTICE TO PLEAD

PA I.D. #63892

To: Lillian J. Canary

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.

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



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

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, 38th 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

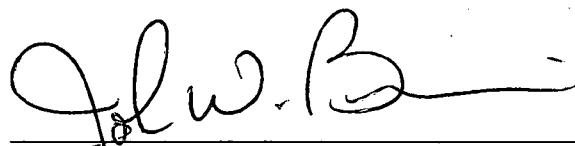
Date: 10/31/00

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. Mohny, Esquire
Attorney for Plaintiff
Blakely, Jones & Mohny
90 Beaver Drive, Box 6
DuBois, PA 15801

A handwritten signature in black ink, appearing to read "J.W. Bruni", written over a horizontal line.

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

FILED

NOV 27 2000

11/5/00
William A. Shaw
Prothonotary

			<p>LAW OFFICES CHRISTOPHER E. MOHNEY 90 BEAVER DRIVE - SUITE 111B DUBOIS, PA 15801 (814) 375-1044</p>
--	--	--	--

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

LILLIAN J. KANARY,

Plaintiff,

vs.

THE PENN TRAFFIC COMPANY,

Defendant.

No. 2000-01121-C.D.

Type of Pleading: PRAECIPE
TO MARK SETTLED, DISCONTINUED
AND ENDED

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 ^{6K}

*copy to CA
11:39 AM Cent. atty*

DEC 17 2004

William A. Shaw
Prothonotary

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

LILLIAN J. KANARY,

Plaintiff,

vs.

THE PENN TRAFFIC COMPANY,

Defendant.

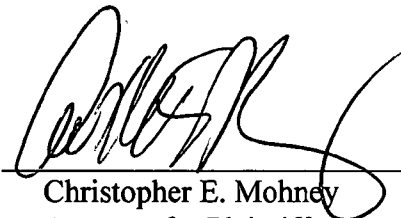
No. 2000-01121-C.D.

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. Mohnhey
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,

Plaintiff

VS.

THE PENN TRAFFIC COMPANY,

Defendant

: NO. 00 - 1121 - C.D.

:
: TYPE OF CASE: CIVIL

:
: TYPE OF PLEADING: REPLY TO
: NEW MATTER

:
: 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/ms
William A. Shaw
Prothonotary

NO C/L

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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.

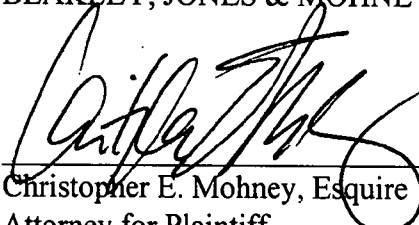
16. Paragraph 16 of Defendant's New Matter is a legal conclusion to which no answer is required, the same being deemed to be denied.

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. Mohny, 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 3rd 2000

Lillian Kanary,
LILLIAN J. KANARY

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

LILLIAN J. KANARY,

Plaintiff

VS.

THE PENN TRAFFIC COMPANY,

Defendant

NO. 00 - 1121 - C.D.

CERTIFICATE OF SERVICE

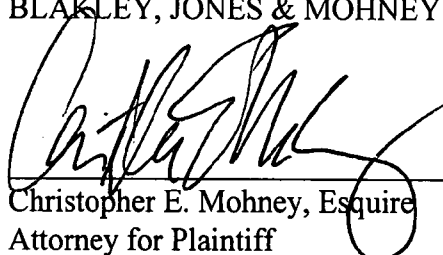
The undersigned hereby certifies that a true and correct copy of the within Reply to New Matter was served on the following person by regular United States mail, postage prepaid, on this

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,

Plaintiff

VS.

THE PENN TRAFFIC COMPANY,

Defendant

NO. 00 - 1121 - C.D.

TYPE OF CASE: CIVIL

TYPE OF PLEADING: CERTIFICATE
OF SERVICE

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,

Plaintiff

VS.

THE PENN TRAFFIC COMPANY,

Defendant

NO. 00 - 1121 - C.D.

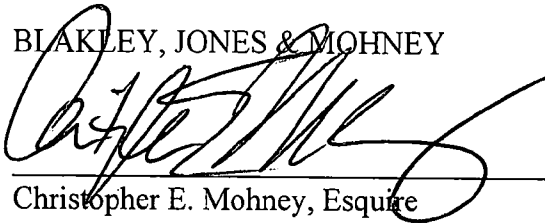
CERTIFICATE OF SERVICE

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 12th 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

BLAKLEY, JONES & MOHNEY

BY:


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

FILED

APR 10 2001

M/110/mcc

William A. Shaw

Prothonotary

~~2/10~~

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

LILLIAN J. KANARY,

No. 00 - 1121 - C.D.

Plaintiff,

SUBSTITUTION OF APPEARANCE

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

38th 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 / BSLC
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: Brian 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. Mohny, Esquire
Blakley, Jones & Mohny
90 Beaver Drive, Box 6
Du Bois, PA 15801

A handwritten signature in black ink, appearing to read "Brian S. Kane", written over a horizontal line.

Brian S. Kane, Esquire

FILED

JAN 11 2001

William A. Shaw
Prothonotary

11:44 AM
1/11/01

W.A. Shaw

**CLEARFIELD
JERAMERSON COUNTY**
COURT OF COMMON PLEAS OF
CIVIL TRIAL LISTING

CERTIFICATE OF READINESS (To be executed by Trial Counsel Only)		TO THE PROTHONOTARY 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:

N/A

DATE JURY DEMAND FILED:

N/A

AMOUNT AT ISSUE

CONSOLIDATION

DATE CONSOLIDATION ORDERED

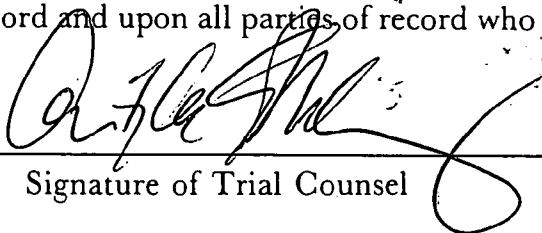
Not Greater Than
\$ 20,000.00

() Yes (X) No

N/A

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.


Signature of Trial Counsel

FILED

MAY 16 2001

William A. Shaw
Prothonotary

COUNSEL WHO WILL ACTUALLY TRY THE CASE

FOR THE PLAINTIFF Christopher E. Mohny, 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
M 3:12 PM
William A. Shaw
Prothonotary

Indivny
p 2 \$20.00
Copy CA E
KED



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-~~8000~~ 7649

MARCY KELLEY
DEPUTY COURT ADMINISTRATOR

June 1, 2001

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

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

RE: LILLIAN J. KANARY

vs.

THE PENEN TRAFFIC COMPANY
No. 00-1121-CD

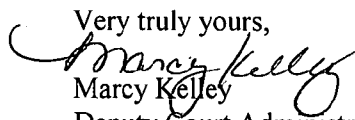
Dear Counsel:

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
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. Mohny, Esquire
Blakley, Jones & Mohny
90 Beaver Drive, Box 6
DuBois, PA 15801

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

RE: LILLIAN J. KANARY

vs.

THE PENEN TRAFFIC COMPANY
No. 00-1121-CD

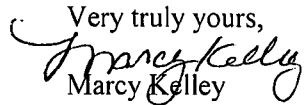
Dear Counsel:

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
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.

David J. Hopkins, Esq.

Warren B. Mikesell, II, Esq.

Chairman

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 Lane

011-2001

AUG 07 2001

Notice to Atty Cheney

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

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

Arb 8-7-01

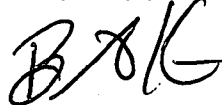
Re: Lillian J. Kanary vs. Penn Traffic Company- No. 00-1121-CD (Clearfield County)

Dear Mr. Meholick:

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. Mohny, 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,

Plaintiff,

vs.

THE PENN TRAFFIC COMPANY,

Defendant.

No. 00 - 1121 - C.D.

**DEFENDANT'S PRE-TRIAL
STATEMENT**

Filed on behalf of:
The Penn Traffic Company, Defendant

Counsel of Record for this Party:

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

Pietragallo, Bosick & Gordon
38th 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, M6N2S8
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. Mohny, Esquire
Blakley, Jones & Mohny
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

Sat Jan 2 14:20:00 EST 1999

PATIENT	NAME AND ADDRESS KANARY, LILLIAN 103 CORDELLA AVENUE TORONTO CA 000 00		COUNTY OC	REGISTRATION DATE 01/02/99	TIME 19	ORG DNR	MED. REC. NO. 446977	BILLING NO. 9900200146
	TELEPHONE NO.		S.S. NO. 445-42-6692	AGE 68Y	BIRTH DATE 01/12/30	METHOD ARRIVAL 4 AMBULANCE	SEX F	RACE 1
	EMPLOYER, ADDRESS, OCCUPATION, PHONE			RELIGION CATHOLIC	P.T. ER	FIN. CL. SP	ADMIT BY DEH	
	HOMEMAKER			ICD-9-CM/CPT4 CODES				
PARTY	PT/PT REPRESENTATIVE STATES SYMPTOMS OR ACCIDENT - HOW, WHERE, WHEN INDUSTRIAL MOP FELL ON HEAD PASSE							
	PERSON TO NOTIFY IN CASE OF EMERGENCY NOT GIVEN							
	STAFF ALERT 375-8888 Friends @ TL							
	RELATIONSHIP OTHER							
INS	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 BETH SATHI K. SHILATA, P.		FAMILY PHYSICIAN NO, DOCTOR GIVEN	REFERRING PHYSICIAN NO, DOCTOR GIVEN				
	AUTHORIZATION FOR EMERGENCY, OUTPATIENT, OR SHORT PROCEDURES UNIT TREATMENT							

Lillian (or Seth)
or Seth, voluntarily authorize and consent to diagnostic procedures, examinations, and/or medical care as prescribed by, or deemed necessary in the judgement of Dr. Seth 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

Date/Time

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: 1:35 ☐ Emergent ☒ Urgent ☐ Nonurgent

CONDITION ON ARRIVAL: ☐ Poor ☐ Fair ☒ Satisfactory ☐ DOA

CHIEF COMPLAINT: *He being struck on the head with a mop at 6:15 Short LOC but did not slump over*

VITAL SIGNS: Temp 97.6 Pulse 110 Resp 22 SpO2 98% O2 Sat 100% WT 118

ALLERGIES: *Tylenol, Codeine*

CURRENT MEDS: ☐ See attached list
Protonix, Muscle Relaxant for @ knee, Rocephin, Lorazepam

IMMUNIZATIONS: ☒ DNA ☐ UP TO DATE LAST TT/TD: _____

VISUAL ACUITY: OD / OS / OU ☐ CORRECTED ☐ UNCORRECTED

PT. PREGNANT? ☒ DNA ☐ YES ☐ NO ☐ UNSURE ☐ HYSTERECTOMY ☐ TUBAL LIGATION

TRIAGE TO: ☐ Registration ☐ Room Triage Nurse: _____

Primary Nurse: *Theresa Smith RN*

PHYSICIAN REPORT

EXAM TIME: 2:15 Dictated: *[Signature]*

[Blank lines for physician report]

*Skull Contusion - midline (crossed)
Neck Swollen - at C5
C-spine / C6 - Head Immobilized*

DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS

Condition On Discharge: ☒ Satisfactory ☐ Fair ☐ Poor Time: 3:40 WITH: ☒ self ☐ family ☐ other

☐ Admitted Room No: _____ ☐ Physician Notified/Time: _____ ☒ Sent Home ☐ Return to work ☐ Deceased ☐ Transferred

For follow-up care please see: ☐ Personal physician ☐ Occupational medicine ☐ ER if worse or not improving NOTIFIED: ☐ Relative ☐ Police ☐ Coroner ☐ Poison Center

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 - then activity as tolerated
Aspirin for pain if needed
Sleep in a position of comfort
See family physician for all other blood pressure
Recheck in ER if needed (refer to med)*

☐ No Work or School Date: _____ ☐ No Physical Education ☐ Until Released by Physician ☐ Light Work Only

Method of Validating Knowledge: ☒ Verbalization ☐ Return Demo ☐ Other: _____

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

TIME: 145

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

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

Trauma/Accidents ☐ DNA

☐ Driver ☐ Passenger ☐ Front ☐ Back

☐ Seat Belt on ☐ Air bag deployed

Type: ☐ Car ☐ Truck ☐ Motorcycle

☐ Bicycle ☐ _____

Impact: ☐ Front ☐ Back

☐ Rollover ☐ Side

☐ Helmet ☐ Protective Clothing

Time of incident: _____

Extraction needed ☐ Yes ☐ No

☐ Fall (____ feet) ☐ GSW

☐ Assault ☐ Other _____

Prehospital Care / Treatment ☐ DNA

☒ LSB ☒ CID ☒ Stiff collar

☒ IV of _____ # _____ at _____ in _____

☐ IV of _____ # _____ at _____ in _____

☐ Accucheck _____

☐ Meds: _____

☐ Splints _____

O₂ ☐ NC ☐ Simple ☐ Non-Rebreather

Airway: ☐ Oral ☐ Nasopharyngeal

☐ ETT _____ ☐ EOA

PMH: ☐ DNA

☐ NONE ☐ Unable to obtain

☐ CHF

☐ MI

☐ Cardiac Cath

☒ Hypertension

☐ Diabetes

☐ Asthma/COPD

☐ Seizures

☐ Cancer

☐ Stroke

☐ Dementia

☐ Mental illness

☐ Ulcers

☐ GI Bleed

☐ Renal Disease

☒ Anxiety Attack

Surgeries:

☐ Angioplasty

☐ CABG

☐ Hysterectomy

☐ Appendectomy

☒ Knee

Alcohol use: _____

Tobacco use: _____

Caffeine use: _____

Airway

☒ Clear/Patent

☐ Adjuncts _____

Breathing

☒ Normal ☐ Dyspneic ☐ Grunting

☐ Stridor ☐ Nasal flaring ☐ Retractions

☐ Accessory muscles ☐ Absent

☐ Other _____

Cough: ☐ No ☐ Productive ☐ Non productive

Breath Sounds: _____

☐ Not assessed / DNA

Right	Left
<input checked="" type="checkbox"/> Clear	<input checked="" type="checkbox"/> Clear
<input type="checkbox"/> Rales/crackles	<input type="checkbox"/> Rales/crackles
<input type="checkbox"/> Rhonchi/Coarse	<input type="checkbox"/> Rhonchi/Coarse
<input type="checkbox"/> Wheeze	<input type="checkbox"/> Wheeze
<input type="checkbox"/> Diminished	<input type="checkbox"/> Diminished
<input type="checkbox"/> Absent	<input type="checkbox"/> Absent
<input type="checkbox"/> Tracheal Deviation	<input type="checkbox"/> Tracheal Deviation
<input type="checkbox"/> JVD	<input type="checkbox"/> JVD

Oxygen: 2 LPM _____ Time _____

☒ NC ☐ Simple face ☐ Nonrebreather

☐ Tube ☐ Humidified ☐ Ventilator

Pulse Oximeter on at _____ %

Circulation

Color: ☒ Pink ☐ Pale

☐ Mottled ☐ Cyanotic

☐ Ashen ☐ Jaundice

☐ Sallow ☐ _____

Condition: ☒ Warm ☐ Dry

☒ Cool ☐ Moist

☐ Hot ☐ Cold

Pulses: Right Left ☐ DNA

Radial ☐ ☐

Normal ☐ ☐

Thready ☐ ☐

Bounding ☐ ☐

Absent ☐ ☐

Pedal ☐ ☐

Normal ☐ ☐

Thready ☐ ☐

Bounding ☐ ☐

Absent ☐ ☐

Capillary refill: _____ seconds

Bleeding controlled ☐ Yes ☐ No

446977 68Y ER
KANARY, LILLIAN
SETH, SATISH K
01/12/30
01/02/99
9500200146

Psychosocial

Overall appearance: ☒ Normal ☐ Frail ☐ Obese

Mood/affect: ☒ Alert ☐ Anxious ☐ Crying

☐ Cooperative ☐ Blunted/flat ☐ Lethargic

☐ Age appropriate ☐ Combative ☐ Confused

☐ Unresponsive ☐ Uncooperative

Ideations: _____

Cardio Pulmonary ☒ DNA

Chest pain ☐ Yes ☐ No

Location: _____

Radiation: _____

Onset/Duration: _____

Pain Scale (0-10) _____

Character: _____

☐ Dyspnea

☐ Syncope

☐ Diaphoresis

Dinemap on: ☐

CARDIAC MONITOR ☐

Rhythm _____

Pacemaker ☐ Yes ☐ No

Neurological ☐ DNA

Patient Status

Loss of Consciousness ☒ Yes ☐ No

☒ Witnessed ☐ Duration _____

☐ Unwitnessed ☐ Incontinence

☐ Nausea ☐ Headache

☐ Vomiting ☐ Post ictal

☐ Visual disturbance

☒ Appropriate verbal responses

☒ Appropriate motor responses

Pupils

☒ Equal

☐ Unequal

☒ Reactive

☐ Non reactive

☐ Dilated & Fixed

☒ EOMI

☐ Other _____

Extremity movement

Hand grasps

☒ Equal

☐ Unequal

☒ Strong

☐ Weak

Leg movement

☒ Equal

☐ Unequal

☒ Strong

☐ Weak

Signature: Nancy Smith, MD

Pain ☐ DNA

Location: Base of head
 Description: Small bump on head
 Pain Scale (0-10): _____

Musculoskeletal Injury/Wounds ☐ DNA

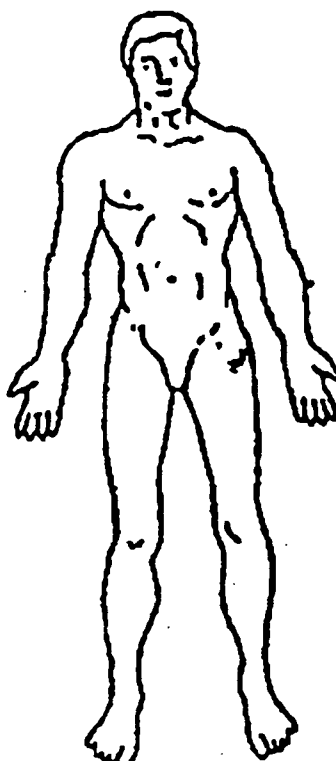
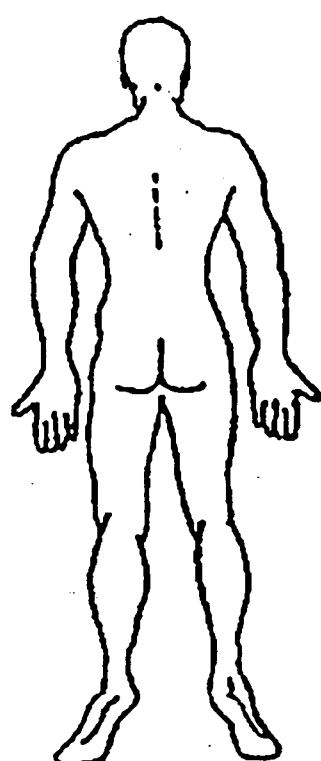
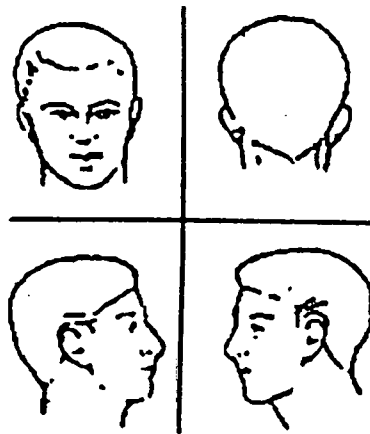
Mechanism of injury: A lamp handle fell on it
A bucket of water fell on it
on the side of head
 Time of injury: 2:13 PM
 Injured at: Belo Dubois
 Type of injury:
☐ Laceration ☐ Avulsion
☐ Abrasion ☐ Burn
☐ Puncture Wound ☐ Contusion
 Site of injury: head
☐ See body diagram

446977 68Y ER
 KANARY, LILLIAN
 SETH, SATISH K
 01/12/30 F 01/02/99
 445-42-6692 9900200146
 0000 FOR GIVEN

EENT ☐ DNA

EYES	OD	OS	EARS	AD	AS	NOSE/THROAT
Red	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Epistaxis
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rhinorrhea
Matted	<input type="checkbox"/>	<input type="checkbox"/>	Decreased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sore throat
Burning/pain	<input type="checkbox"/>	<input type="checkbox"/>	Hearing			<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: _____



- 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: AS

CP : EN

N

Signature: _____ Initials: _____ Signature: _____ Initials: NS



Emergency Department Record

5 of 7

See Key/Codes on Page 6

KANARY, LILLIAN

SETH, SATISH K

21/12/30

1

01/02/99

445-42-6532

9900200146

[illegible]

NOTES

Time	NOTES	Initials
1 ⁴⁵ / ₁₀ p	To ER on L5B to C10 and C Collar Pt % pain to (R) side head (L) side of neck and (D) arm Pt was at Bilo Market when a mop fell from a bucket and the mop handle struck patient on (R) side of head. Pt was assisted to office where she started to "shake" as she was explaining details of mop accident. "Industrial strength" Manager states patient lost train of thought Pt yelled out "hold me" Pt had LOC. Was caught by Bld Manager. Did not fall. Awoke to ask "Where am I" Passed out "3 or more times per manager	
2 ⁰⁰ / ₁₀ p	A awake alert orient x3 PEARL 20MT Strong equal hand grips leg lifts Glasgow 15 Neckplate removed placed in patients pocket	NS
2 ¹⁵ / ₁₀ p	Orthopedic C spine done	NS
2 ⁴⁰ / ₁₀ p	To Xray - To have CT	NS
3 ⁰⁰ / ₁₀ p	Returns from Xray Glasgow 15	NS
3 ¹⁵ / ₁₀ p	A/c & friends Dr Shilala talks to pt and friends	NS

Signature: _____ Initials: NS

Signature:

Initials: ALS

Signature:

Initials:



**DuBois Regional
Medical Center**

Making the difference for life.

6 of 7

Emergency Department Record

446977 68Y ER

KAMARY, LILLIAN

SETH, SATISH K

01/12/30 F

01/02/99

445-44-6032

9909200146

ADULT FOR GIVEN

PATIENT PROBLEM LIST

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

<input type="checkbox"/> Knowledge deficit: _____ <input checked="" type="checkbox"/> Alteration in Comfort: <u>Head pain</u> <input type="checkbox"/> Alteration in fluid volume: _____ <input type="checkbox"/> Alteration in Oxygenation: _____ <input type="checkbox"/> Decreased Cardiac Output: _____ (See Chart and nurses notes for interventions and response.)	<input type="checkbox"/> Alteration in body temperature: _____ <input type="checkbox"/> Individual ineffective coping: _____ <input type="checkbox"/> Risk of infection _____ <input type="checkbox"/> Impaired tissue integrity: _____ <input type="checkbox"/> Other: _____
---	---

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. FOLLOW DRMC POLICY (PR-1, PR-1.2, PR-1.3),	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 If any of the above are indicated, PLEASE FAX THIS FORM TO THE SOCIAL WORK/ PASTORAL CARE AREA #3488	Initial visit: date: _____ Time: _____ Signature: _____ Follow-up: <input type="checkbox"/> None <input 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
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 ⊕ BP D = See dinemapp
	Coos, blabbles, 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 N = No relief R = Relief P = Partial 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: Nancy 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.

Chart Copy

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, P. 15801

KANARY, LILLIAN
103 CORDELLA AVENUE
TORONTA

CA 000 00

*ER
Age 68Y

Unit # 000446977
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. *Y*

01/04/99 0834
JAH

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

Complete

** Portable **

DUBOIS REGIONAL MEDICAL CENT
Hospital Ave, DuBois, PA 15801

KANARY, LILLIAN
103 CORDELLA AVENUE
TORONTO

CA 000 00

*ER

Age 68Y

Unit # 000446977

Acct # D9900200146

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.

01/04/99 0834
JAH

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

Complete

146

68 years Female

ABNORMAL ECG

DuBois Regional Medical Center
Dept: ER-5

Oper: DT

Rate 111 Sinus tachycardia, rate 111
PR 167 Multiple atrial premature complexes
QRSD 87 Nonspecific ST depression
QT 306
QTc 416

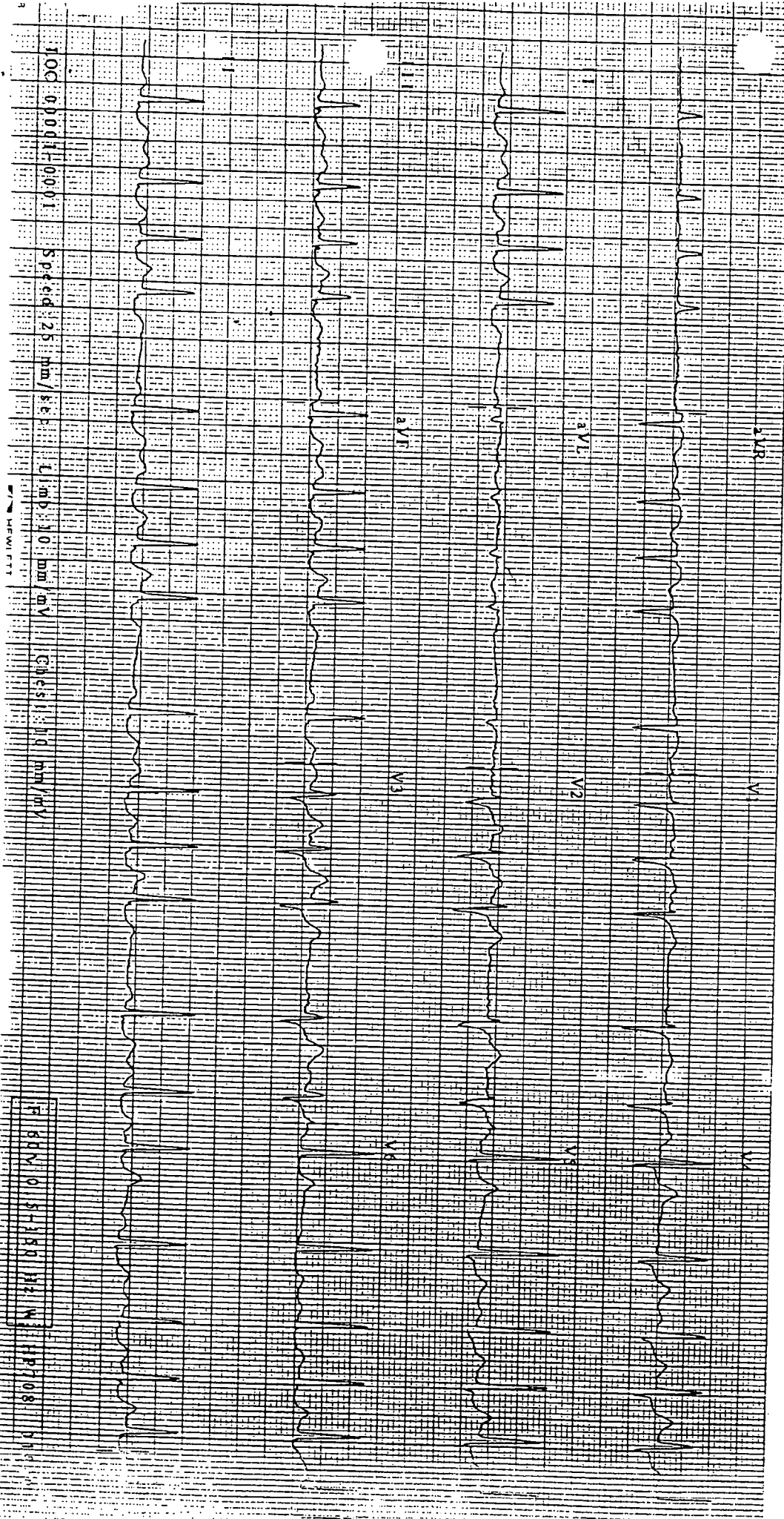
7/20/88

Doctor

--AXIS--
P 86
QRS 72
T 61

- ABNORMAL ECG -

[Signature]



F 60V 0.5-1.50 Hz W 100 Hz 708

CHICAGO 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

SITH, WILLIAM
 01/12/30
 445-42-6692 F 01/02/
 NO. DOCTOR GIVEN 99002001

CRITIKON DINAMAP 1846 SX/P VERSION 089

LABORATORY REPORT

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 (jerkings 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/cardiologist 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: 3:14 WITH: ☐ self ☐ family ☐ other

☐ Admitted Room No: ☐ Physician Notified/Time: ☒ Sent Home ☐ Return to work ☐ Deceased ☐ Transferred

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: Rest for 24 to 48 hours - then as tolerated

☐ No Work or School Date: ☐ Until Released by Physician ☐ Light Work Only

Method of Validating Knowledge: ☒ Verbalization ☐ Return Demo ☐ Other:

PATIENT/RESPONSIBLE PARTY: 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

Seen in ER past 48 hrs? ☐ Mon Jan 4 14:40:39 EST 1999

P A T I E N T	NAME AND ADDRESS KANARY, LILLIAN 103 CORDELLA AVENUE TORONTO CA 000 00			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			
				RELIGION CATHOLIC				P.T. ER		FIN. CL. CI		M.S. M			
	TELEPHONE NO. (416)763-5787 S.S. NO. 445-42-6692 EMPLOYER, ADDRESS, OCCUPATION, PHONE HOMEMAKER											ADMIT BY CAC			
P A T I E N T	PT/PT REPRESENTATIVE STATES SYMPTOMS OR ACCIDENT - HOW, WHERE, WHEN INJ 0102 HEADACHE NECK PAIN														
	PERSON TO NOTIFY IN CASE OF EMERGENCY SUMMERVILLE, JOSEPHINE H 552 T L DUBOIS PA(814)375-8888 D														
	RELATIONSHIP OTHER														
	STAFF ALERT														
P A T I E N T	NAME AND ADDRESS KANARY, LILLIAN SELF 103 CORDELLA AVENUE TORONTO CA 000 00														
	TELEPHONE (416)763-5787 HOMEMAKER SOC. SEC. # 445-42-6692														
	REL. EMPLOYER NAME AND ADDRESS														
P A T I E N T	INSURANCE COMPANY MANULIFE FINANCIAL			PLAN 300001		POLICY HOLDER KANARY, LILLIAN			REL 1		POLICY # 9131361132WP			GROUP # 999999	
P A T I E N T	E.R. PHYSICIAN RASHWAN, AHMED G			FAMILY PHYSICIAN NO, DOCTOR GIVEN			REFERRING PHYSICIAN NO, FAMILY DOCTOR								
	SHUJATA, P.														

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. Rashwan 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 Lillian Kanary Relationship SELF Date/Time 1/4/99 14:40 PM
 Witness Carol Cuy

Patient is unable to consent for the following reason: _____

Signature of Patient Representative _____ Relationship _____ Date/Time _____
 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 _____

Time: 2:38 ☐ Emergent ☐ Urgent ☒ Nonurgent

CONDITION ON ARRIVAL: ☐ Poor ☐ Fair ☒ Satisfactory ☐ DOA

CHIEF COMPLAINT: 40 neck pain has had pain since 1/2/99 when was struck pt on (R) side of head

VITAL SIGNS: Temp 98.2 Pulse 95 Resp 18 190/194 O₂ Sat WT

ALLERGIES: Tylenol Codeine

CURRENT MEDS: ☐ See attached list
Painkillers
Lorazepam / anxiety
Muscle relaxant
ASA

IMMUNIZATIONS: ☒ DNA ☐ UP TO DATE LAST TT/DT:

VISUAL ACUITY: OD OS OU ☐ CORRECTED ☐ UNCORRECTED

PT. PREGNANT? ☒ DNA ☐ YES ☐ NO ☐ UNSURE ☐ HYSTERECTOMY ☐ TUBAL LIGATION

TRIAGE TO: ☐ Registration ☐ Room Triage Nurse: Nurse Smith

Primary Nurse: Nurse Smith

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"/>

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

PHYSICIAN REPORT

EXAM TIME: 3:40 pm Dictated

Diagnosis: Soft Neck Pain / Spine - C-Spine

DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS

Condition On Discharge: Satisfactory Fair Poor Time: 4:40 WITH: self family other

☐ Admitted Room No: ☐ Physician Notified/Time: ☒ Sent Home ☐ Return to work ☐ Deceased ☐ Transferred

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

NOTIFIED: ☐ Relative ☐ Police ☐ Coroner ☐ Poison Center

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 Soft collar as needed - would use for 7-10 days & to longer @ Continues meds as needed 2 Ice pack 3 Rubbed if needed

☐ No Work or School Date: ☐ Until Released by Physician ☐ Light Work Only

Method of Validating Knowledge: ☒ Verbalization ☐ Return Demo ☐ Other:

PATIENT/RESPONSIBLE PARTY: Lillian Kanary NURSE'S SIGNATURE: E. Smith PHYSICIAN'S SIGNATURE: J. Smith

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

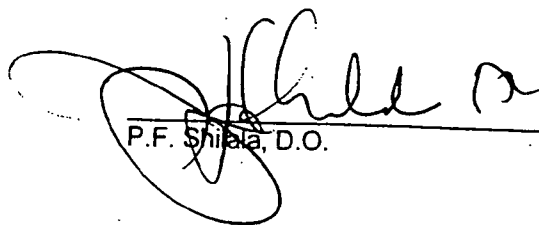
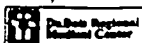

P.F. Shiela, D.O.

Chart Copy



Emergency Department Record

Page 2 of 7

TIME: 7:15 PM

446977

68Y

ER

KANARY, LILLIAN

RASHMAN, AHMED S

01/04/99

9900400268

FAMILY DOCTOR

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

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

Overall appearance	Mood/affect	Psychosocial
<input checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Alert	<input type="checkbox"/> Frail
<input type="checkbox"/> Alert	<input type="checkbox"/> Cooperative	<input type="checkbox"/> Anxious
<input type="checkbox"/> Age appropriate	<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Blunted/flat
		<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
<input type="checkbox"/> Bicycle
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 _____

Airway
<input checked="" type="checkbox"/> Clear/Patent
<input type="checkbox"/> Adjuncts _____
Breathing
<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
Right <input checked="" 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
Left <input checked="" 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

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"/> Dyspnea
<input type="checkbox"/> Syncope
<input type="checkbox"/> Diaphoresis
Dinemap on: <input type="checkbox"/>
CARDIAC MONITOR <input type="checkbox"/>
Rhythm _____
Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No

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"/> Accucheck _____
<input type="checkbox"/> Meds: _____
<input type="checkbox"/> Splints _____
O ₂ : <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

Oxygen
_____ LPM _____ 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 _____ %

PMH:
<input checked="" 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 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"/> <u>Heart Failure</u>

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
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

Neurological
<input checked="" type="checkbox"/> DNA
Patient Status
Loss of Consciousness <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Witnessed <input type="checkbox"/> Duration _____
Unwitnessed <input type="checkbox"/> Incontinence
Nausea <input checked="" type="checkbox"/> Headache
Vomiting <input type="checkbox"/> Post ictal
Visual disturbance
<input checked="" type="checkbox"/> Appropriate verbal responses
<input checked="" type="checkbox"/> Appropriate motor responses
<input checked="" type="checkbox"/> <u>Loss of appetite</u>

Pulses
Right <input type="checkbox"/> Left <input type="checkbox"/> DNA
Radial <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Thready <input type="checkbox"/> Bounding <input type="checkbox"/> Absent
Pedal <input type="checkbox"/> Normal <input type="checkbox"/> Thready <input type="checkbox"/> Bounding <input type="checkbox"/> Absent
Capillary refill: <u>2 sec</u> seconds
Bleeding controlled <input type="checkbox"/> Yes <input type="checkbox"/> No

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>(Dysphagia)</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: _____

Signature: Enriquez, R. L.

Emergency Department Record 3 of 7

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 ☐ _____

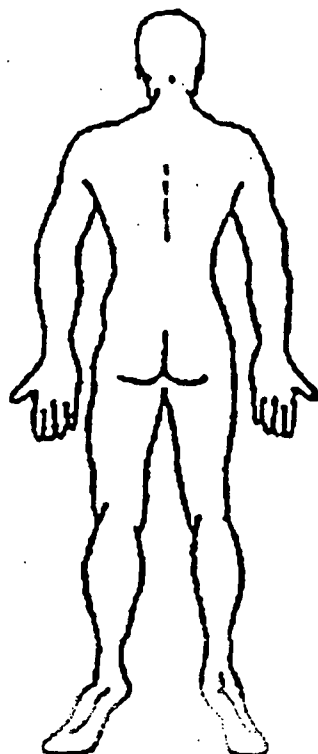
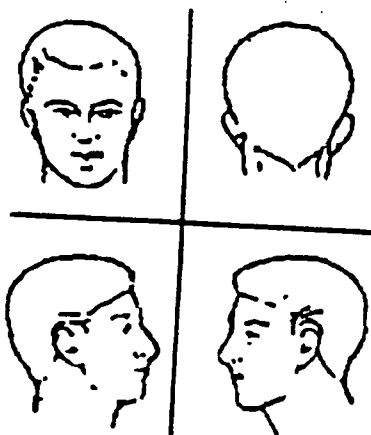
Site of injury: _____
☐ See body diagram _____

446977 68Y ER
 KANARY, LILLIAN
 PASHWAN, AHMED S
 01/12/99 01/04/99
 005-42-4192 9900400268
 FAMILY DOCTOR

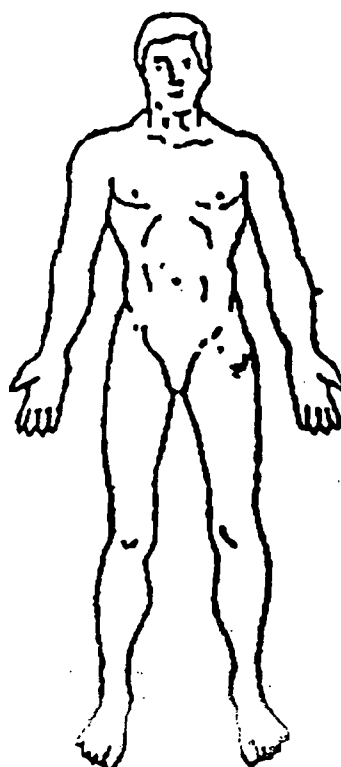
EENT ☒ DNA

EYES	OD	OS	EARS	AD	AS	NOSE/THROAT
Red	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Epistaxis
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rhinorrhea
Matted	<input type="checkbox"/>	<input type="checkbox"/>	Decreased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sore throat
Burning/pain	<input type="checkbox"/>	<input type="checkbox"/>	Hearing			<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"/>				
Floaters	<input type="checkbox"/>	<input type="checkbox"/>				
Foreign body	<input type="checkbox"/>	<input type="checkbox"/>				

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
01/12/30 01/04/99
445-42-5052 9900400268
NON-FAMILY DOCTOR

See Key/Codes on Page 6

[illegible]

NOTES

Time	Notes	Initials
3:15p	Admitted seen 11/2/99 for skull contusion & mild concussion, neck strain & @ shoulder Pain & being hit on head accidentally & not per pt returning today. C6 cervical spine pain, pain @ parietal area @ arm, shoulder pain @ arm pain requesting cervical collar and ice bag for continued pain & pt taking ASA (unable to take Tylenol). muscle relaxant. Full ROM of cervical spine. S. Nuchal rigidity. (+) nausea or vomiting (-) dizziness, (-) blurred vision. (+) loss of appetite. Moves all extremities actively.	EA
4:20p	pm Cervical collar, ice bag applied	EA.
4:30p	pm DR @ bedside, pt for discharge. Written instructions explained & copy received. Both pt & friend verbalize understanding of instructions	EA



**DuBois Regional
Medical Center**

Making the difference for life.

6 of 7

Emergency Department Record

446977

68Y

ER

KANARY, LILLIAN

RASHWAN, AHMED S

01/12/30

445-42-0672

01/04/98

9700400468

PATIENT PROBLEM LIST

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

<input type="checkbox"/> Knowledge deficit: _____ <input checked="" type="checkbox"/> Alteration in Comfort: <u>head, neck pain</u> <input type="checkbox"/> Alteration in fluid volume: _____ <input type="checkbox"/> Alteration in Oxygenation: _____ <input type="checkbox"/> Decreased Cardiac Output: _____ (See Chart and nurses notes for interventions and response.)	<input type="checkbox"/> Alteration in body temperature: _____ <input type="checkbox"/> Individual ineffective coping: _____ <input type="checkbox"/> Risk of infection _____ <input type="checkbox"/> Impaired tissue integrity: _____ <input type="checkbox"/> Other: _____
---	---

SCREENING CRITERIA

Patient Home Phone Number/Room #: _____

Suspected Abuse: Adult/Child:

- ☒ No Identified Needs
- ☐ Unusual/suspicious marks (i.e. burns, bruises, welts, lacerations, punctures)
- ☐ Sexual abuse
- ☐ Domestic Violence: Patient verbalizes need for assistance.

FOLLOW DRMC POLICY (PR-1, PR-1.2, PR-1.3).

Initial visit: date: _____

Time: _____

Signature: _____

Follow-up: ☐ None

☐ See Progress Note

Discharge Planning:

- ☒ No Identified Needs
- ☐ Additional supportive services needed upon d/c (med. equip., Home Health).
- ☐ INITIAL Placement assistance needed before discharge.
- ☐ Financial assistance required to follow treatment.
- ☐ Patient has an Advanced Directive but did not bring in a copy, follow up needed.

Initial visit: date: _____

Time: _____

Signature: _____

Follow-up: ☐ None

☐ See Progress Note

Pastoral Care:

- ☒ No Identified Needs
- ☐ Terminal Illness;
- ☐ Recent Loss of Significant Other;
- ☐ Request for Pastoral Care

If any of the above are indicated, PLEASE FAX THIS FORM TO THE SOCIAL WORK/
PASTORAL CARE AREA #3488

Initial visit: date: _____

Time: _____

Signature: _____

Follow-up: ☐ None

☐ See Progress Note

KEY/CODES

Glasgow Coma Score		Adult	Child	Infant
Eyes Open	Spontaneous	4	4	4
	To Voice/Speech	3	3	3
	To pain	2	2	2
	No response	1	1	1
Best Verbal Response	Oriented	5	5	
	Coos, blabbles, 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
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

Pupils: D = Dilated S = Small M = Medium L = Large

Pupil reaction: + = Brisk S = Sluggish O = No reaction

Cardiac Rhythms:

NSR - Normal Sinus Rhythm HB - Heart block

AF - Atrial Fib 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

Hand Grasp and Leg Movement:

Strong - S Sensation Intact - SI

Weak - W Paresthesia - P

Equal = Unequal (X)

BP

D = See dinemapp

Medication code

R = Relief P = Partial Relief N = No relief

O = No adverse effects

Pain scale 0 - 10

Signature: Evelyn A. King RN

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
kanali-00	174.00
Date	Amount Enclosed
05/20/99	

Lillian Kanary
103 Cordella Avenue

Toronto, CD 000000000

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	95909	41.00	41.00
04/01/99			Plan Payment: X		0.00	
			NO INSURANCE INFO RECEIVED			
01/02/99	3	70450	CT HEAD WO	85400	133.00	133.00
<p>**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. **</p>						
<p>**NOTICE OF DELINQUENT ACCOUNT** THIS ACCOUNT IS SERIOUSLY OVERDUE. PROMPT PAYMENT WILL AVOID FURTHER ACTION.</p>						
<p>OUR CHARGES ARE BILLED SEPARATE FROM HOSPITAL!</p>						
<p>Tax Id: 25-1715230</p>			<p>DuBois Radiologists I PO Box 1106 23 Beaver Drive DuBois, PA 15801</p>		<p>0001 Phone: 814-371-1784</p>	

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		
Patient Balance	174.00	0.00	174.00	0.00	0.00	0.00		
Account Balance	174.00							

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0078

Y
CONTACT US WITH YOUR INSURANCE
INFORMATION IMMEDIATELY!!

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 6202822338420003	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Kanary Lillian		3. PATIENT'S BIRTH DATE MM DD YY 01 12 1930 SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M	
5. PATIENT'S ADDRESS (No., Street) 103 Cordella Avenue		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) 103 Cordella Avenue		8. INSURED'S NAME (Last Name, First Name, Middle Initial) Kanary Lillian	
CITY Toronto STATE CD		CITY Toronto STATE CD	
ZIP CODE 000000000 TELEPHONE (Include Area Code) (416) 763-5787		ZIP CODE 000000000 TELEPHONE (INCLUDE AREA CODE) (416) 763-5787	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Lillian Kanary		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	
a. OTHER INSURED'S POLICY OR GROUP NUMBER 9131361132WP		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY 01 12 1930 SEX <input type="checkbox"/> M <input type="checkbox"/> F		a. INSURED'S DATE OF BIRTH MM DD YY 01 12 1930 SEX <input type="checkbox"/> M <input type="checkbox"/> F	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME X		c. INSURANCE PLAN NAME OR PROGRAM NAME	
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		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signature On File	
SIGNED _____ DATE _____		SIGNED _____	
14. DATE OF CURRENT: MM DD YY 01 12 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Satish K Seth M D		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES 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. L		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A DATE(S) OF SERVICE To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE	
25. FEDERAL TAX I.D. NUMBER SSN EIN 25-1715230		26. PATIENT'S ACCOUNT NO. kanali332921 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$ 174 00 29. AMOUNT PAID \$ 0 00 30. BALANCE DUE \$ 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.) G Shah MD	
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 AND PHONE # DuBois Radiologists Inc. PO Box 1106 DuBois PA 15801	
SIGNED 25-1715230 DATE 071499		PIN# 25-1715230	

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: 03/28/00

ACCT. #: PAT-003125

BALANCE FORWARD: 695.25

LATE FEE: 0.00

BALANCE DUE: 695.25

TO:

LILLIAN KANARY
103 CORDELLA AVENUE
TORONTO CANADA CA 00000

REF #	TRIP #	CODE	DATE	DESCRIPTION	AMOUNT	BALANCE
	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
	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 #: 1

PLEASE
DO NOT
STAPLE
IN THIS
AREA

BI LO MARK
SANDY PLAZA

DUBOIS PA 15801

APPROVED OMB-0938-0008

XXX PICA

HEALTH INSURANCE CLAIM FORM

PICA XXX

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 9131B61132	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) KANARY, LILLIAN		3. PATIENT'S BIRTH DATE MM DD YY 01 12 1930M SEX F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 103 CORDELLA AVENUE CITY TORONTO CANADA STATE CA ZIP CODE 00000 TELEPHONE (Include Area Code) ()		4. INSURED'S NAME (Last Name, First Name, Middle Initial) KANARY, LILLIAN	
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) 103 CORDELLA AVENUE CITY TORONTO CANADA STATE CA ZIP CODE 00000 TELEPHONE (INCLUDE AREA CODE) ()	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
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 benefit is either to myself or to the party who accepts assignment below. SIGNATURE ON FILE SIGNED _____ DATE 01/02/99		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED _____	
14. DATE OF CURRENT: MM DD YY 01 02 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE STAFF DOCTOR		17a. I.D. NUMBER OF REFERRING PHYSICIAN 0TH000	
19. RESERVED FOR LOCAL USE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. 854-HEAD INJURY 2. HIT IN HEAD WITH MOP		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A DATE(S) OF SERVICE From To MM DD YY 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 A0370 SH 1 500 00 01			
01 02 99 01 02 99 41 9 A0390 SH 1 23 25 003			
01 02 99 01 02 99 41 9 A0422 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 A0398 SH 1 25 00 01			
25. FEDERAL TAX I.D. NUMBER SSN EIN 25-1513994 <input type="checkbox"/> 26. PATIENT'S ACCOUNT NO. 0990008 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 675 25 29. AMOUNT PAID \$ 0 00 30. BALANCE DUE \$ 675 25	
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.) PAPERER J. WILLIAM OWNER SIGNED _____ DATE 01/21/99		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) BI LO MARK DUBOIS REGIONAL MED CTR D 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE DUBOIS EMS AMBULANCE SVC P.O. BOX 187 103 W. WASHINGTON DUBOIS, PA 15801 PIN# 207241 814-571-3456	

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

May 18, 1999

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

Dear Mr. Mohny,

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 1st 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 763-1171
98 GUESTVILLE AVENUE, TORONTO, ONTARIO M6N 4N6

November 1 19 99

Blakley, Jones & Mohnney,
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

Toronto, June 22, 99

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

Dear Mr. Christopher Mohny:

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
Treatment \$40.00
Feb 22/99 \$40.00
" 18/99 \$40.00
" 25/99 \$40.00

March 1/99 \$40.00
" 4/99 \$40.00
" 8/99 \$40.00
" 11/99 \$40.00
" 15/99 \$40.00
" 18/99 \$40.00
" 22/99 \$40.00
" 25/99 \$40.00
" 29 \$40.00

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

May 3/99 \$40.00
" 6/99 \$40.00
" 10/99 \$40.00
" 13/99 \$40.00
" 17/99 \$40.00
" 20/99 \$40.00
" 24/99 \$40.00
" 27/99 \$40.00
" /#/99 \$40.00

June 4th \$40.00
" 7/99 \$40.00
" 10/99 \$40.00

Total to date \$1,390.00

with thanks yours truly

Mary Judy Torrens R.M.T.

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 Date of Report 1-2-99
STORE NAME Bingo Telephone # 371-1017

1. NAME OF INJURED PERSON Lillian Kanary
Home address 552 Treasure Lake Telephone # _____
City Orleans 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
6. Exact Location of Accident By ~~entrance~~ 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 San 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 OLEWICK 32. Address _____
33. How soon after accident did you inspect location? immediately
34. Location Clean? yes 35. Dry? comp 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 HIT IT IN HEAD
46. Customer's comments and attitude _____

* If Question Not Applicable, Answer N/A

Signature of Employee Gloria Olewick

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, map Fell
over & hit her on the head

Customer Name: (Please Print) Lilian Kanary
Customer Address Cardella Toronto, Ontario CANADA
City _____ State _____ Zip Code _____
Telephone# () - _____
Customer Signature Lilian Kanary
Date 1-2-99
Store Location 231 Duhaiss

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 s. 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

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
RE: Medical Services- Lillian KANARY
Incident BiLo # 231

\$..... 50.00

RECEIVED PAYMENT

PER

(RECEIPTS WILL BE SENT ONLY ON REQUEST)

002 041



DuBois Regional Medical Center

P.O. Box 447 - DuBois, PA 15801-0447

(P 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 REMITTANCE							

DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO.	QTY	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 CMLX	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	PLEASE REFER TO PATIENT	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	CONTINUED
99C02-00146	PLEASE RETURN TO PATIENT	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		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 REMITTANCE							

DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO.	QTY	UNIT PRICE	TOTAL CHARGES
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PATIENT NUMBER	PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	1,168.00
99002-00146				

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
1 Code	2 Description	3 Last Edit date		\$1168.00 AR	
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 ssady 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

Account	Name	Fr:	pr 30, 1999 08:50 am
D99004-00268	KANARY, LILLIAN	FC Type Admit	Disch
1 Code	2 Description	CI: ER 01/04/99 01/04/99	Balance Loc
1	PT HIT ON HEAD WITH BROOM AT	3 Last Edit date	\$289.00 AR
+ Created By		01/04/99 02:50pm	
CUNNINGHAM, CARLA A	5 Creation Date	6 Edit Text?	7 Security
	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

UBOIS

PA 15801

PATIENT NAME 3141 371-2300

FED. TAX NO.

6 STATEMENT COVERS PERIOD
FROM THROUGH

7 C

8 N.C.D.

9 C.I.D.

10 L.R.D.

11

3 PATIENT CONTROL NO.

4 TYPE
OF BILL

131

13 PATIENT ADDRESS

KANARY, LILLIAN

103 CORDELLA AVENUE

TORONTO

CD 00000

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

1121930

F

M

010499

14

2

1

15

01

000446977

DE OCCURRENCE DATE

34 CODE

OCCURRENCE DATE

36 CODE

OCCURRENCE SPAN

FROM

THROUGH

37

A

B

C

KANARY, LILLIAN

03 CORDELLA AVENUE

TORONTO

CD 00000

4161 763-5797

REV. CD. 43 DESCRIPTION

44 HCPCS / RATES

45 SERV. DATE

46 SERV. UNITS

47 TOTAL CHARGES

48 NON-COVERED CHARGES

49

270 SUPPLIES

450 EMRGNCY DEP VIS E/M EX L

730 EKG

99282

93005

1

1.

1500

13000

7400

001 TOTAL CHARGES

28900

5 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

DUE FROM PATIENT

8 INSURED'S NAME

59 REL.

60 CERT. - SSN - HIC - ID NO.

61 GROUP NAME

62 INSURANCE GROUP NO.

KANARY, LILLIAN

01

445426692

BILO

999999

KANARY, LILLIAN

01

9131361132WP

PROVINCIAL HEA

3 TREATMENT AUTHORIZATION CODES

64 ESC

65 EMPLOYER NAME

66 EMPLOYER LOCATION

3

3

7 PRIN. DIAG. CD.

58 CODE

70 CODE

OTHER DIAG. CODES

72 CODE

74 CODE

76 ADM. DIAG. CD.

77 E-CODE

78

V5889 4279

80

PRINCIPAL PROCEDURE

CODE

DATE

81

OTHER PROCEDURE

CODE

DATE

7

OTHER PROCEDURE

CODE

DATE

OTHER PROCEDURE

CODE

DATE

82 ATTENDING PHYS. ID

WENGER

83 OTHER PHYS. ID

OTHER PHYS. ID

14 REMARKS BI-LO

85 PROVIDER REPRESENTATIVE

86 DATE

XBAKER, JANE L

042999

**DuBois Regional Medical Center**

P.O. Box 447 - DuBois, PA 15801-0447

(814) 775-4200

FEDERAL NO. 25-1490707

**DETAIL
STATEMENT**

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

PAGE NO.
1

PATIENT NAME LILLIAN KANARY		PATIENT NUMBER 99004-00268	SEX F	AGE 69Y	ADMISSION DATE 01/04/99	DISCHARGE DATE 01/04/99	DAYS
INSURANCE COMPANY NAME 300001 BI-LO 300001 MANULIFE FINANCIAL		GROUP NUMBER 999999 999999	POLICY NUMBER 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 _____ <small>PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE</small>					

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	270	5	1	9.00	9.00
		TOTAL SUPPLIES					15.00
01/04/99	16211	EMRGNCY DEP VIS E/M EX LOW COMPL	450	6	1	110.00	110.00
		TOTAL EMERGENCY ROOM					110.00
01/04/99	34900	EKG	730	2	1	68.00	68.00
		TOTAL EKG					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	730	3	1	26.00	26.00
		TOTAL pro fee misc code(not use ub92					96.00
		TOTAL CHARGES					289.00
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PATIENT NUMBER
99004-00268

PLEASE REFER TO PATIENT
NUMBER ON ALL INQUIRIES
AND CORRESPONDENCE.

PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY

TOTAL AMOUNT DUE	289.00
------------------	--------

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

RECEIPT / CAB FARE

Amount \$4.00 Date 04-2-99
From 1174 Weston
To 103 Cordella
Cab No. 2497 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date 26-4-99
From 1172 Weston
To 103 Cordella
Cab No. 88 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE

Amount \$4.00 Date 1-3-99
From 103 Cordella
To 1172 Weston Rd.
Cab No. 2033 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date Feb 22-99
From 103 Cordella Ave
To 1172 Weston Rd.
Cab No. 2748 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date 11-02-11-92-99
From 103 Cordella Ave
To 1172 Weston Rd.
Cab No. 1190 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date 18 Feb. 92
From 103 Cordella Ave
To 1172 Weston Rd.
Cab No. 31 Driver D-S/R

Thanks for your Business

RECEIPT FOR CAB FARE

Amount \$4.00 Date Mar. 29, 99
From 1179 Weston Rd.
To 103 Cordella Av.
Cab No. 92 Driver AD [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date 26-3-99
From 1171 Weston
To 103 Cordella
Cab No. 40 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE

Amount \$4.00 Date MAR. 12/99
 From 103 Cordilla Ave
 To 1172 Weston Rd
 Cab No. 2782 Driver [Signature]
 NJ Govt Thanks for your Business

RECEIPT FOR CAB FARE

Amount \$4.00 Date May 06/99
 From 103 Cordilla Ave
 To Weston Rd
 Cab No. 981 Driver S.S.
 Thanks for your Business

RECEIPT FOR CAB FARE

Amount 11-22 Date 15-3-99
 From 103 Cordilla Ave
 To 1172 Weston Rd
 Cab No. 98 Driver [Signature]
 Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4-00 Date April 15/99
 From 103 Cordilla Ave
 To 1172 Weston Rd
 Cab No. 8 Driver Deed
 Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date Feb 22-99
 From 1172 Weston Rd
 To 103 Cordilla Ave
 Cab No. 2748 Driver [Signature]
 Thanks for your Business

RECEIPT FOR CAB FARE

Amount \$4.00 Date 25-02-99
 From 103 Cordilla Ave
 To 1171 Weston Rd
 Cab No. 492 Driver [Signature]
 Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4-00 Date 15-3-99
 From 103 Cordilla Ave
 To 1172 Weston Rd
 Cab No. 1140 Driver [Signature]
 Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date Apr 26/99
 From 103 Cordilla Ave
 To 1172 Weston Rd
 Cab No. 653 Driver [Signature]
 Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date May 3/99
 From 103 Cordilla Ave
 To 1172 Weston Rd
 Cab No. 1198 Driver [Signature]
 Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date 18-3-99
 From 1272 Weston Rd
 To 103 Cordilla Ave
 Cab No. 52 Driver [Signature]
 Thanks for your Business

RECEIPT FOR B FARE

Amount 4.00 Date 6-MAR-99
 From 1172 Western Rd.
 To Cardella
 Cab No. 77 Driver H-Sn

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date 13/05/99
 From 103 Cardella Ave.
 To 1172 Western Rd.
 Cab No. 604 Driver h

Thanks for your Business

Good

RECEIPT FOR CAB FARE

Amount 4.00 Date 5-3-99
 From 1172 Western Rd
 To 103 Cardella Ave.
 Cab No. 2078 Driver Cg3

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date MAR. 5 '99
 From 103 Cardella Ave.
 To 1172 Western Rd.
 Cab No. 1897 Driver Sen

Thanks for your Business

PD

RECEIPT FOR CAB FARE

Amount 4.00 Date May 17/99
 From 103 Cardella Ave.
 To 1172 Western Rd.
 Cab No. 3802 Driver h

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date May 17/99
 From 103 Cardella
 To 1172 Western Rd.
 Cab No. 390 Driver h

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date 05-03-99
 From 103 Cardella Ave.
 To 1172 Western Ave.
 Cab No. 2751 Driver Nati

Thanks for your Business

N.G.

RECEIPT FOR CAB FARE

Amount 4.00 Date 10/05/99
 From 103 Cardella Ave.
 To 1172 Western
 Cab No. 721 Driver h

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date MAR 15/99
 From 1172 Western
 To Cardella
 Cab No. 101 Driver h

Thanks for your Business

N.G.

RECEIPT FOR CAB FARE

Amount 4.00 Date 20-4-99
 From 103 Cardella Ave.
 To 1172 Western Rd.
 Cab No. 1892 Driver h

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 [Signature]

Thanks for your Business

RECEIPT

Date 17/5/96

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 Tax.
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. 1108 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date April 8/99
From 103 Cordella Ave
To 1172 Weston Rd
Cab No. 1190 Driver 2

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date 5 APR 99
From 103 Cordella Ave
To 1172 Weston
Cab No. 1600 Driver [Signature]

Thanks for your Business

may RECEIPT FOR CAB FARE

Amount 4.00 Date 6 10 /99
From 103 Cordella Ave
To 1172 Weston Rd
Cab No. 2372 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 8.400 Date April 29/99
From 103 Cordella Ave.
To 1172 Weston Rd
Cab No. 721 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE

Amount 4.00 Date 25 2/98
From 103 Cordella Ave.
To 1172 Weston Rd.
Cab No. 60 Driver [Signature]

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. 1172 Driver [Signature]

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. 1172 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE
Amount 84- Date 10/6/99
From 103 Cordella Ave
To 1172 Weston Rd.
Cab No. 99 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE
Amount 8.00 Date 14/85/99
From 140 LANDSDOWN AVE.
To 103 CORDILLA AVE
Cab No. 721 Driver [Signature]

Thanks for your Business
Mr. Jane Howell.

RECEIPT FOR CAB FARE
Amount 84- Date 22/3/99
From 103 Cordella Ave
To 1172 Weston Rd.
Cab No. 99 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE
Amount \$9.00 Date MAY 14, 99
From 103 CORDILLA AVE
To 940 LANDSDOWN
Cab No. 64 Driver [Signature]

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 Ave
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 [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE
Amount 4.00 Date March 26/99
From 103 Cordella Ave
To 1172 Weston Rd
Cab No. 135 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE
Amount 4.00 Date 29 April 99
From 103 Cordella Ave
To 1172 Weston Rd
Cab No. 1706 Driver [Signature]

Thanks for your Business

RECEIPT FOR CAB FARE
Amount 4.00 Date 29-3-99
From 103 Cordella Ave
To 1172 Weston Rd

Thanks for your Business

RECEIPT FOR CAB FARE
Amount \$4.00 Date 25-03-99
From 1172 Weston Rd
To 103 Cordella Ave

Thanks for your Business

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.

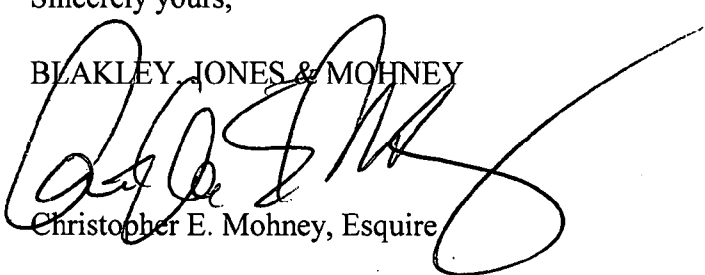
Dear Ms. Kelley:

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,

Plaintiff

VS.

THE PENN TRAFFIC COMPANY,

Defendant

NO. 00 - 1121 - C.D.

TYPE OF CASE: CIVIL

TYPE OF PLEADING:
PRE-ARBITRATION STATEMENT

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. Canary
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. Canary 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. Canary 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. Mohny, Esquire
Attorney for Plaintiff

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

LILLIAN J. KANARY,

Plaintiff

VS.

THE PENN TRAFFIC COMPANY,

Defendant

NO. 00 - 1121 - C.D.

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

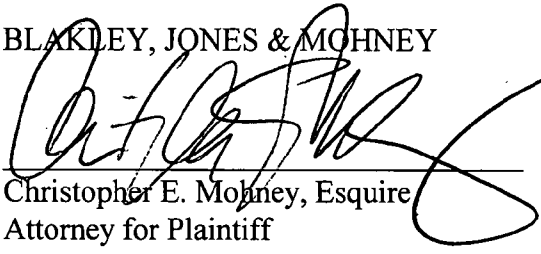
David J. Hopkins, Esquire
The Hopkins Law Firm
900 Beaver Drive
Du Bois, PA 15801
Arbitrator

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

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

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 & Mohny,
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	PAGE NO.
D1-ER	01/08/99	1

PATIENT NAME		PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
LILLIAN KANARY		99004-00268	F	70Y	01/04/99	01/04/99	
INSURANCE COMPANY NAME		GROUP NUMBER		POLICY NUMBER			
300001 BI-LO		999999		445426692			
300001 MANULIFE FINANCIAL		999999		9131361132WP			
						PAYMENT AMOUNT	
GUARANTOR NAME AND ADDRESS	LILLIAN KANARY			<input type="checkbox"/>	CARD NO. _____		
	103 CORDELLA AVENUE			<input type="checkbox"/>	EXPIRATION DATE _____		
	TORONTO CD 000 00			<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
		270 SUPPLIES					15.00
		450 EMERGENCY ROOM					110.00
		730 EKG					68.00
		998 pro fee misc code(not use ub92					96.00
		TOTAL CHARGES					289.00
		TOTAL PAYMENTS/ADJUSTMENTS					0.00

PATIENT NUMBER	PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.	PAYMENT TO DUBOIS REGIONAL MEDICAL CENTER ONLY	TOTAL AMOUNT DUE	289.00
99004-00268		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	PAGE NO.
D1-ER	01/06/99	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	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 REMITTANCE						

DATE	ITEM NO.	DESCRIPTION	CLM CODE	ORDER NO.	QTY	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
<i>Please contact me regarding the balance due.</i>							
<i>Thanks</i>							
<i>Barbara</i>							
<i>814-375-4207</i>							

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



L&G Bodycare Inc.

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

Toronto, June 22, 99

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

Dear Mr. Christopher Mohny:

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
Treatment \$40.00
Feb 22/99 \$40.00
" 18/99 \$40.00
" 25/99 \$40.00

March 1/99 \$40.00
" 4/99 \$40.00
" 8/99 \$40.00
" 11/99 \$40.00
" 15/99 \$40.00
" 18/99 \$40.00
" 22/99 \$40.00
" 25/99 \$40.00
" 29 \$40.00

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

May 3/99 \$40.00
" 6/99 \$40.00
" 10/99 \$40.00
" 13/99 \$40.00
" 17/99 \$40.00
" 20/99 \$40.00
" 24/99 \$40.00
" 27/99 \$40.00
" /#/99 \$40.00

June 4th \$40.00
" 7/99 \$40.00
" 10/99 \$40.00

Total to date \$1,390.00

with thanks yours truly

Mary Judy Torrens R.M.T.

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
kanali-00	174.00
Date	Amount Enclosed
05/20/99	

Lillian Kanary
103 Cordella Avenue

Toronto, CD 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	
			NO INSURANCE INFO RECEIVED			
01/02/99	3	70450	CT HEAD WO	85400	133.00	133.00
<p>**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. **</p>						
<p>**NOTICE OF DELINQUENT ACCOUNT** THIS ACCOUNT IS SERIOUSLY OVERDUE. PROMPT PAYMENT WILL AVOID FURTHER ACTION.</p>						
<p>OUR CHARGES ARE BILLED SEPARATE FROM HOSPITAL!</p>						
<p>Tax Id: 25-1715230</p>			<p>DuBois Radiologists I PO Box 1106 23 Beaver Drive DuBois, PA 15801</p>		<p>0001 Phone: 814-371-1784</p>	

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		
Patient Balance	174.00	0.00	174.00	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
	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
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	695.25
PAGE #:					PAY	

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/cardiologist 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 aches.
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 checked="" type="checkbox"/> Sent Home	<input checked="" type="checkbox"/> Return to work	<input type="checkbox"/> Deceased	<input type="checkbox"/> Transferred	3:48	<input type="checkbox"/> self <input type="checkbox"/> family <input checked="" type="checkbox"/> other
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		NOTIFIED: <input type="checkbox"/> Relative <input type="checkbox"/> Police <input type="checkbox"/> Coroner <input type="checkbox"/> Poison Center					
FOLLOW INSTRUCTIONS ON <input checked="" 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 checked="" 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: <u>Rest for 24 to 48 hours - then a walk as tolerated</u>							
<input type="checkbox"/> No Work or School <input type="checkbox"/> No Physical Education <input type="checkbox"/> Light Work Only		Date: <u>2-11-99</u> <input type="checkbox"/> Until Released by Physician					
Method of Validating Knowledge: <input checked="" type="checkbox"/> Verbalization <input type="checkbox"/> Return Demo <input type="checkbox"/> Other:							
PATIENT/RESPONSIBLE PARTY: <u>[Signature]</u>		NURSE'S SIGNATURE: <u>[Signature]</u>		PHYSICIAN'S SIGNATURE: <u>[Signature]</u>			
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							

446977 68Y ER
KANARY, 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.

☐ 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/cardiologist 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: 1/2	WITH: <input type="checkbox"/> self <input type="checkbox"/> family <input 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"/> ER if worse or not improving							
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: <u>① Soft collar as needed - would use for 7-10 days & no longer @ continued needs as needed ③ checked if needed</u>							
<input type="checkbox"/> No Work or School <input type="checkbox"/> No Physical Education <input type="checkbox"/> Light Work Only		Date: <u>7-10 days & no longer @ continued needs as needed ③ checked if needed</u>					
Method of Validating Knowledge: <input checked="" type="checkbox"/> Verbalization <input type="checkbox"/> Return Demo <input type="checkbox"/> Other:							
PATIENT/ RESPONSIBLE PARTY <u>Lillian Kanary</u>		NURSE'S SIGNATURE <u>[Signature]</u>		PHYSICIAN'S SIGNATURE <u>[Signature]</u>			
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							

PATIENT	NAME AND ADDRESS KANARY, LILLIAN 103 CORDELLA AVENUE TORONTO CA 000 00		REGISTRATION DATE 01/04/99		TIME 14:40	ORG DNR	MED. REC. NO. 446977	BILLING NO. 9900400268			
	COUNTY OC		AGE 68Y	BIRTH DATE 01/12/30		METHOD ARRIVAL 2 WALK IN		SEX F	RACE 1	M.S. M	
	TELEPHONE NO. (416)763-5787 S.S. NO. 445-42-6692		RELIGION CATHOLIC		P.T. ER		FIN. CL. CI	ADMIT BY CAC			
	EMPLOYER, ADDRESS, OCCUPATION, PHONE HOMEMAKER		ICD-9-CM/CPT4 CODES								
PHYSICIAN	PT/PT REPRESENTATIVE STATES SYMPTOMS OR ACCIDENT - HOW, WHERE, WHEN INJ 0102 HEADACHE NECK PAIN										STAFF ALERT
	PERSON TO NOTIFY IN CASE OF EMERGENCY SUMMERVILLE, JOSEPHINE H 552 T L DUBOIS PA (814) 375-8888 O										RELATIONSHIP OTHER
	NAME AND ADDRESS KANARY, LILLIAN SELF 103 CORDELLA AVENUE TORONTO CA 000 00		TELEPHONE (416)763-5787 HOMEMAKER SOC. SEC. # 445-42-6692		REL 1		EMPLOYER NAME AND ADDRESS				
	INSURANCE COMPANY MANULIFE FINANCIAL		PLAN 300001	POLICY HOLDER KANARY, LILLIAN		POLICY # 9131361132WP		GROUP # 999999		7-110	
INS	E.R. PHYSICIAN RASHWAN AHMED G SHILIA, P		FAMILY PHYSICIAN NO, DOCTOR GIVEN		REFERRING PHYSICIAN NO, FAMILY DOCTOR						

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. Rashwan 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

Date/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 is made available to 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 SELF 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: 2:35 ☐ Emergent ☐ Urgent ☒ Nonurgent

CONDITION ON ARRIVAL: ☐ Poor ☐ Fair ☒ Satisfactory ☐ DOA

CHIEF COMPLAINT: no neck pain, has had pain since 11/2/99 when mop struck it on (R) side of head

VITAL SIGNS: Temp 98.4 Pulse 98 Resp 18 BP 190/94 O₂ Sat 94 WT

ALLERGIES: Tylenol
Cadexa

CURRENT MEDS: ☐ See attached list
Prozac
lorazepam anxiety
Musc relaxant
ASA

IMMUNIZATIONS: ☒ DNA ☐ UP TO DATE LAST TT/TD:

VISUAL ACUITY: OD NA OS NA OU NA ☐ CORRECTED ☐ UNCORRECTED

PT. PREGNANT? ☒ DNA ☐ YES ☐ NO ☐ UNSURE ☐ HYSTERECTOMY ☐ TUBAL LIGATION

TRIAGE TO: ☐ Registration ☐ Room Room Triage Nurse: Nancy Smith

Primary Nurse: Lillian Kanary

PHYSICIAN REPORT

EXAM TIME: 3:40 PM

St. Richard's Skull Center / Spine - C-Spine

DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS

☐ Admitted Room No: ☐ Physician Notified/Time: Condition On Discharge: ☒ Satisfactory ☐ Fair ☐ Poor Time: 4:40 PM WITH: ☐ self ☐ family ☒ other

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. Soft collar as needed - would use for 7-10 days & to longer @ continue meds as needed @ Richard's needed

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

Method of Validating Knowledge: ☒ Verbalization ☐ Return Demo ☐ Other:

PATIENT/RESPONSIBLE PARTY: Lillian Kanary NURSE'S SIGNATURE: Evelyn H. H. H. PHYSICIAN'S SIGNATURE: St. Richard's

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

446977 68Y ER
KANARY, LILLIAN
POSMAN, ANNE S
01/12/00 01/04/99
445-42-6692 9900400268
DO NOT WRITE

Lillian Kanary

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: ☐ Repeat

<input type="checkbox"/> ABG <input type="checkbox"/> on O ₂ <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 Atrovent	<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"/>
<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"/>
<input type="checkbox"/> LS Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ABD Series	<input type="checkbox"/>	<input type="checkbox"/>

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

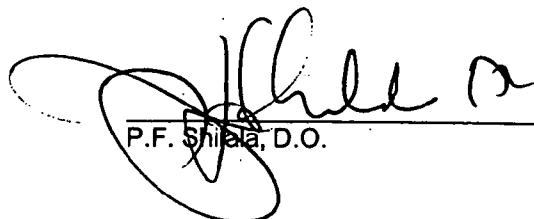
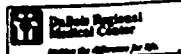

P.F. Shih, D.O.

Chart Copy



TIME: 7:15 PM

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

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

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	

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
<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
Fall (____ feet) <input type="checkbox"/> GSW
<input type="checkbox"/> Assault <input type="checkbox"/> Other _____

Airway
<input checked="" type="checkbox"/> Clear/Patent
<input type="checkbox"/> Adjuncts _____
Breathing
<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

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"/> Dyspnea
<input type="checkbox"/> Syncope
<input type="checkbox"/> Diaphoresis
Dinemap on: <input type="checkbox"/> _____

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"/> Accucheck _____
<input type="checkbox"/> Meds: _____
<input type="checkbox"/> Splints _____
O ₂ <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

Oxygen
Right
<input checked="" 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
Left
<input checked="" 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

Neurological
<input checked="" type="checkbox"/> DNA
Patient Status
Loss of Consciousness <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Duration _____
<input type="checkbox"/> Witnessed
<input type="checkbox"/> Unwitnessed
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Visual disturbance
<input checked="" type="checkbox"/> Appropriate verbal responses
<input checked="" type="checkbox"/> Appropriate motor responses

PMH:
<input checked="" 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 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"/> _____
Alcohol use: _____
Tobacco use: _____
Caffeine use: _____

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 checked="" 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 checked="" type="checkbox"/> <input 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"/> <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: 2 seconds
Bleeding controlled <input type="checkbox"/> Yes <input type="checkbox"/> No

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 (Dysphagia)
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: _____

Emergency Department Record 3 of 7

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 ☐ _____

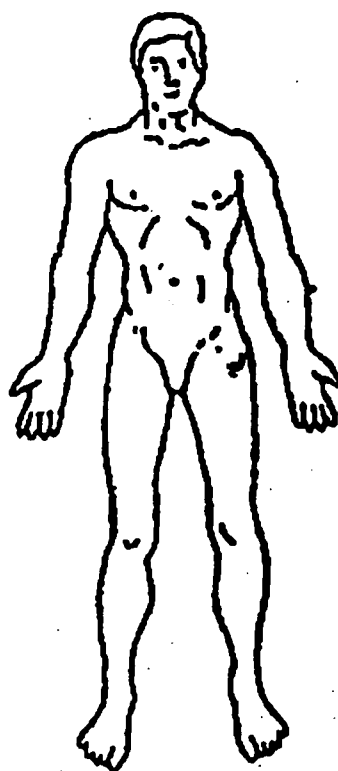
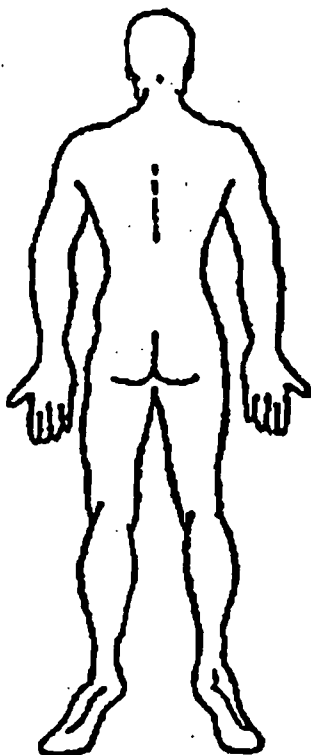
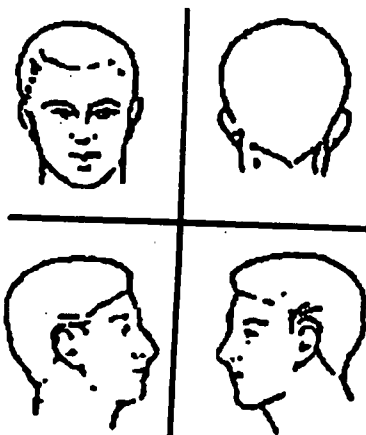
Site of injury: _____
☐ See body diagram _____

446977 68Y ER
 KANARY, LILLIAN
 PASHWAN, AHMED S
 01/12/99 01/04/99
 445-42-6092 9900400268
 FAMILY DOCTOR

EENT ☒ DNA

	OD	OS	EARS	AD	AS	NOSE/THROAT
EYES						
Red	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Epistaxis
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rhinorrhea
Matted	<input type="checkbox"/>	<input type="checkbox"/>	Decreased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sore throat
Burning/pain	<input type="checkbox"/>	<input type="checkbox"/>	Hearing			<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"/>				
Floaters	<input type="checkbox"/>	<input type="checkbox"/>				
Foreign body	<input type="checkbox"/>	<input type="checkbox"/>				

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: _____

See Key/Codes on Page 6

446977 68Y ER
KANARY, LILLIAN
RASHWAN, AHMED S
01/12/30 01/04/99
445-42-5022 9900400268
NON-FAMILY DOCTOR

[illegible]

NOTES

Time		Initials
3:15p	<p>Thoroughly seen 1/2/99 for skull contusion & mild concussion, neck strain & @ shoulder pain. Pt being hit on head accidentally & map per pt. returning today. No cervical spine pain, pain @ parietal area @ arm, shoulder pain @ arm pain requesting cervical collar and ice bag for continued pain. Pt taking ASA (unable to take Tylenol). muscle relaxant. Full ROM of cervical spine. S. nuchal rigidity. (+) nausea or vomiting (-) dizziness (-) blurred vision. (+) loss of appetite. Moves all extremities actively.</p>	EA
4:20p	<p>Cervical collar, ice bag applied</p>	EA.
4:30p	<p>DR. Shalala @ bedside, pt for discharge. Written instructions explained & copy received. Both pt & friend verbalize understanding of instructions</p>	EA.

$C \cap A \subset B \cap A$



**DuBois Regional
Medical Center**
Making the difference for life.

6 of 7

Emergency Department Record

446977 68Y ER

KANARY, LILLIAN

RASHMAN, AHMED S

01/12/30 F

01/04/98

445-42-2672

9700-00168

PATIENT PROBLEM LIST

Patient needs identified as: (Number to Prioritize (1-5) sum of 1 need to be identified)

- ☒ Knowledge deficit: _____
- ☒ Alteration in Comfort: head, neck pain
- ___ Alteration in fluid volume: _____
- ___ Alteration in Oxygenation: _____
- ___ Decreased Cardiac Output: _____

- ___ Alteration in body temperature: _____
- ___ Individual ineffective coping: _____
- ___ Risk of infection: _____
- ___ Impaired tissue integrity: _____
- ___ Other: _____

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

SCREENING CRITERIA

Patient Home Phone Number/Room #: _____

Suspected Abuse: Adult/Child:

- ☒ No Identified Needs
- ☐ Unusual/suspicious marks (i.e. burns, bruises, welts, lacerations, punctures)
- ☐ Sexual abuse
- ☐ Domestic Violence: Patient verbalizes need for assistance.

FOLLOW DRMC POLICY (PR-1, PR-1.2, PR-1.3).

Initial visit: date: _____
Time: _____
Signature: _____
Follow-up: ☐ None
☐ See Progress Note

Discharge Planning:

- ☒ No Identified Needs
- ☐ Additional supportive services needed upon d/c (med. equip., Home Health).
- ☐ INITIAL Placement assistance needed before discharge.
- ☐ Financial assistance required to follow treatment.
- ☐ Patient has an Advanced Directive but did not bring in a copy, follow up needed.

Initial visit: date: _____
Time: _____
Signature: _____
Follow-up: ☐ None
☐ See Progress Note

Pastoral Care:

- ☒ No Identified Needs
- ☐ Terminal Illness;
- ☐ Recent Loss of Significant Other;
- ☐ Request for Pastoral Care

If any of the above are indicated, PLEASE FAX THIS FORM TO THE SOCIAL WORK/
PASTORAL CARE AREA #3488

Initial visit: date: _____
Time: _____
Signature: _____
Follow-up: ☐ None
☐ 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			
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 ≠ BP D = See dinemapp			
	Coos, blabbles, 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: Evelyn A. King RN

446977

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

KANARY LILLIAN

DuBois Regional Medical Center
Dept: ER4

Oper: BD

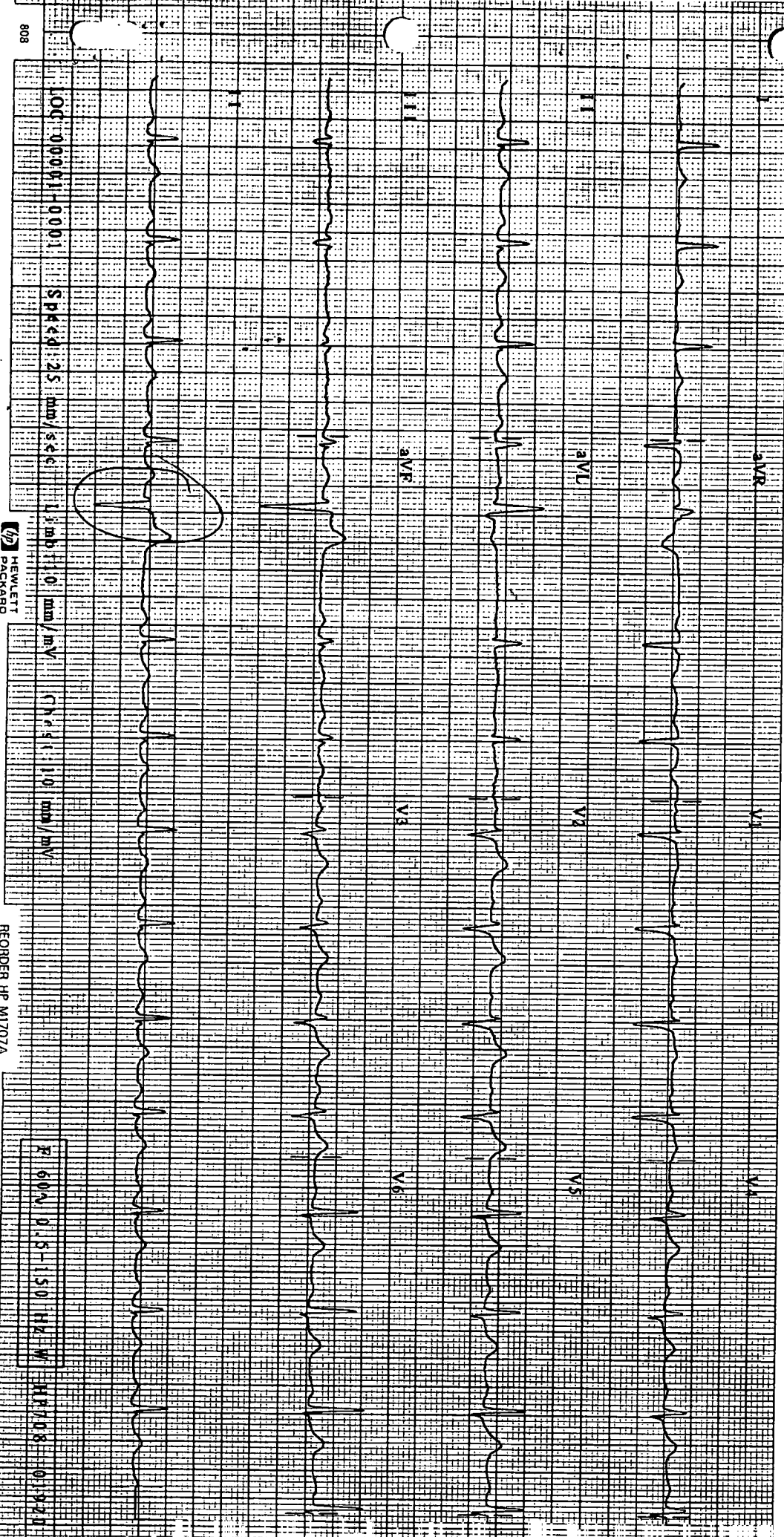
268

Rate 87 Sinus rhythm, rate 87
PR 178 Ventricular premature complex
QRSD 92
QT 346
QTc 416

Doctor
RASHWAN

--AXIS--
P 68
QRS 23
T 43

- ABNORMAL ECG -



2-6692. This report is strictly Confidential and is for the REL. POLICY use only of the person 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 _____)
for Seth), voluntarily authorize and consent to diagnostic procedures,
examinations, and/or medical care as prescribed by, or deemed necessary in the judgement of Dr. Seth for
☒ Emergency Treatment ☐ Outpatient Services ☐ Short Procedures Unit Services.

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

Verbal patient consent

Signature of Patient: Nancy Smith Relationship: Self Date/Time: 1-2-98

Witness: Nancy Hoover

Signature of Patient Representative Relationship Date/Time

Witness

Witness

Signature of Patient	Relationship	Date/Time
Witness	Witness	

Time: 1:55 ☐ Emergent ☒ Urgent ☐ Nonurgent

CONDITION ON ARRIVAL: ☐ Poor ☐ Fair ☒ Satisfactory ☐ DOA

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

VITAL SIGNS: Temp 97 Pulse 110 Resp 22 218 O₂ Sat 118 WT 118

ALLERGIES: Tylenol
Cocaine

CURRENT MEDS: ☐ See attached list
Promarin
Muscle Relaxant for @ knee
Roxapron Lorazepam

IMMUNIZATIONS: ☒ DNA ☐ UP TO DATE LAST TT/DT: _____

VISUAL ACUITY: OD / OS / OU / ☐ CORRECTED ☐ UNCORRECTED

PT. PREGNANT? ☒ DNA ☐ YES ☐ NO ☐ UNSURE ☐ HYSTERECTOMY ☐ TUBAL LIGATION

TRIAGE TO: ☐ Registration ☐ Room Triage Nurse: _____

Primary Nurse: Chaucer Smith RN

PHYSICIAN REPORT

EXAM TIME: 1:55

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"/>

☒ EKG: Provisional Reading MS
☐ Repeat

☐ ABG ☐ on O₂ ☐ on Room Air
☐ Proventil ☐ Repeat ☐ Repeat
☐ Proventil ☐ Atrovent ☐ Repeat ☐ Repeat
☐ Vaponephrine ☐ Repeat ☐ Repeat
☐ Other ☐ Repeat ☐ Repeat
☐ Peak Flows ☐

☐ Chest ☐
☐ Portable Chest ☐
☐ Port Lat C Spine ☐
☐ C Spine ☐
☐ LS Spine ☐
☐ ABD Series ☐

☒ CT Head MS
☐ Enhanced
☒ Unenhanced

Dictated: X

DIAGNOSIS

Skull Contusion - mild Concussion
Neck Strain & Shoulder Strain
C-Spine / C6 - Head Uninjured

DISPOSITION OF PATIENT AND PATIENT INSTRUCTIONS

Condition On Discharge: ☒ Satisfactory ☐ Fair ☐ Poor Time: 3:40 WITH: ☐ self ☐ family ☒ other

☐ Admitted Room No: _____ ☐ Physician Notified/Time: _____ ☒ Sent Home ☐ Return to work ☐ Deceased ☐ Transferred

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: Rest for 24 to 48 Hours - when activity is tolerated
Aspirin for pain if needed

☐ No Work or School Date: _____ ☐ No Physical Education ☐ Until Released by Physician ☐ Light Work Only

Method of Validating Knowledge: ☒ Verbalization ☐ Return Demo ☐ Other: _____

PATIENT RESPONSIBLE: William L. Smith NURSE'S SIGNATURE: Chaucer Smith RN PHYSICIAN'S SIGNATURE: John Doe

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

TIME: 146

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

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

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

Trauma/Accidents ☐ DNA

☐ Driver ☐ Passenger ☐ Front ☐ Back

☐ Seat Belt on ☐ Air bag deployed

Type: ☐ Car ☐ Truck ☐ Motorcycle

☐ Bicycle ☐ _____

Impact: ☐ Front ☐ Back

☐ Rollover ☐ Side

☐ Helmet ☐ Protective Clothing

Time of incident: _____

Extrication needed ☐ Yes ☐ No

☐ Fall (____ feet) ☐ GSW

☐ Assault ☐ Other _____

Prehospital Care / Treatment ☐ DNA

☒ LSB ☒ CID ☒ Stiff collar

☒ IV of _____ # _____ at _____ in _____

☐ IV of _____ # _____ at _____ in _____

☐ Accucheck _____

☐ Meds: _____

☐ Splints _____

☐ O₂ ☐ NC ☐ Simple ☐ Non-Rebreather

Airway: ☐ Oral ☐ Nasopharyngeal

☐ ETT _____ ☐ EOA

PMH: ☐ DNA

☐ NONE ☐ Unable to obtain

☐ CHF

☐ MI

☐ Cardiac Cath

☒ Hypertension

☐ Diabetes

☐ Asthma/COPD

☐ Seizures

☐ Cancer

☐ Stroke

☐ Dementia

☐ Mental Illness

☐ Ulcers

☐ GI Bleed

☐ Renal Disease

☒ Anxiety Attack

Surgeries:

☐ Angioplasty

☐ CABG

☐ Hysterectomy

☐ Appendectomy

☒ Knee

Alcohol use: _____

Tobacco use: _____

Caffeine use: _____

Airway

☒ Clear/Patent

☐ Adjuncts _____

Breathing

☒ Normal ☐ Dyspneic ☐ Grunting

☐ Stridor ☐ Nasal flaring ☐ Retractions

☐ Accessory muscles ☐ Absent

☐ Other _____

Cough: ☐ No ☐ Productive ☐ Non productive

Breath Sounds:

☐ Not assessed / DNA

Right	Left
<input checked="" type="checkbox"/> Clear	<input checked="" type="checkbox"/> Clear
<input type="checkbox"/> Rales/crackles	<input type="checkbox"/> Rales/crackles
<input type="checkbox"/> Rhonchi/Coarse	<input type="checkbox"/> Rhonchi/Coarse
<input type="checkbox"/> Wheeze	<input type="checkbox"/> Wheeze
<input type="checkbox"/> Diminished	<input type="checkbox"/> Diminished
<input type="checkbox"/> Absent	<input type="checkbox"/> Absent
<input type="checkbox"/> Tracheal Deviation	<input type="checkbox"/> Tracheal Deviation
<input type="checkbox"/> JVD	<input type="checkbox"/> JVD

Oxygen: 2 LPM _____ Time _____

☒ NC ☐ Simple face ☐ Nonrebreather

☐ Tube ☐ Humidified ☐ Ventilator

Pulse Oximeter on at _____ %

Circulation

Color: ☒ Pink ☐ Pale

☐ Mottled ☐ Cyanotic

☐ Ashen ☐ Jaundice

☐ Sallow ☐ _____

Condition: ☒ Warm ☐ Dry

☒ Cool ☐ Moist

☐ Hot ☐ Cold

Pulses: Right Left ☐ DNA

Radial ☐ ☐

Normal ☐ ☐

Thready ☐ ☐

Bounding ☐ ☐

Absent ☐ ☐

Pedal ☐ ☐

Normal ☐ ☐

Thready ☐ ☐

Bounding ☐ ☐

Absent ☐ ☐

Capillary refill: _____ seconds

Bleeding controlled ☐ Yes ☐ No

Psychosocial

Overall appearance: ☒ Normal ☐ Frail ☐ Obese

Mood/affect: ☒ Alert ☐ Anxious ☐ Crying

☐ Cooperative ☐ Blunted/flat ☐ Lethargic

☐ Age appropriate ☐ Combative ☐ Confused

☐ Unresponsive ☐ Uncooperative

Ideations: _____

Cardio Pulmonary ☒ DNA

Chest pain ☐ Yes ☐ No

Location: _____

Radiation: _____

Onset/Duration: _____

Pain Scale (0-10) _____

Character: _____

☐ Dyspnea

☐ Syncope

☐ Diaphoresis

Dinemap on: ☐

CARDIAC MONITOR ☐

Rhythm _____

Pacemaker ☐ Yes ☐ No

Neurological ☐ DNA

Patient Status

Loss of Consciousness ☒ Yes ☐ No

☒ Witnessed ☐ Unwitnessed

☐ Nausea

☐ Vomiting

☐ Visual disturbance

☐ Appropriate verbal responses

☐ Appropriate motor responses

Pupils

☒ Equal

☐ Unequal

☒ Reactive

☐ Non reactive

☐ Dilated & Fixed

☒ EQMI

☐ Other _____

Extremity movement

Hand grasps

☒ Equal

☐ Unequal

☒ Strong

☐ Weak

Leg movement

☒ Equal

☐ Unequal

☒ Strong

☐ Weak

Pain ☐ DNA

Location: Back of head
 Description: Soft foam bump on head
 Pain Scale (0-10): _____

Musculoskeletal Injury/Wounds ☐ DNA

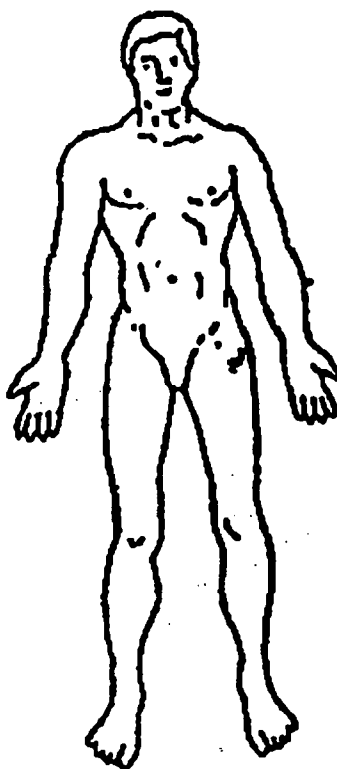
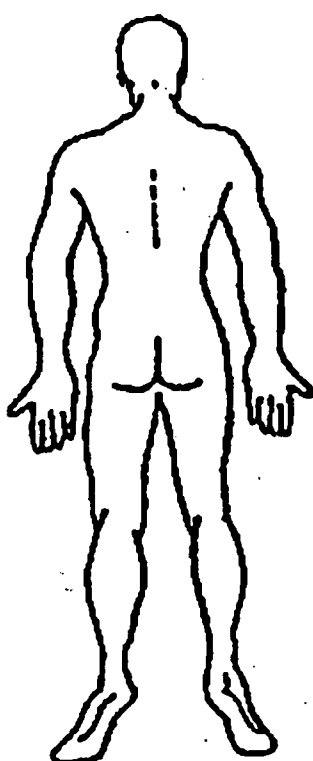
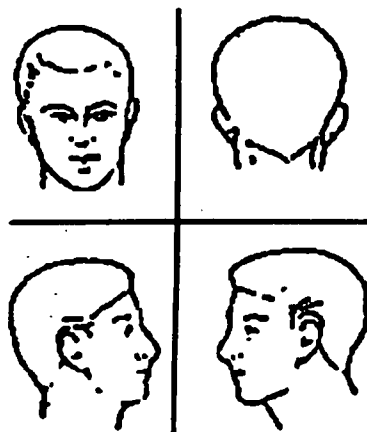
Mechanism of injury: A mop handle fell out of a bucket striking patient on side of head
 Time of injury: 2/1/99
 Injured at: B. to D. Bois
 Type of injury:
☐ Laceration ☐ Avulsion
☐ Abrasion ☐ Burn
☐ Puncture Wound ☐ Contusion
 Site of injury: head
☐ See body diagram

446977 68Y ER
 KANARY, LILLIAN
 SETH, SATISH K
 01/12/30 F 01/02/99
 445-42-6692 9900200146
 40.00 TOR GIVEN

EENT ☐ DNA

EYES	OD	OS	EARS	AD	AS	NOSE/THROAT
Red	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Epistaxis
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rhinorrhea
Matted	<input type="checkbox"/>	<input type="checkbox"/>	Decreased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sore throat
Burning/pain	<input type="checkbox"/>	<input type="checkbox"/>	Hearing			<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"/>				
Floaters	<input type="checkbox"/>	<input type="checkbox"/>				
Foreign body	<input type="checkbox"/>	<input type="checkbox"/>				

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: NS



Duke University Medical Center
making the difference for you

4 of 7

HEMOCCULT

Time: _____

Results: _____ **Initials:** _____

Time	Intervention	Type/Site	Comments	Initials
	Wound Care:			
	Cleansed			
	Steri Strips			
	Dressing			
2:00 p	ice pack to forehead			US
	Musculoskeletal			
	Splint			
	Ace			
	Immobilizer			
	Sling			
	Crutches/Walker			
3:00 p	Returns C Collar off			US
2:30 p	Immobilizations Removed		C Collar left on	US
	GI			
	NG/Lavage			
	Enema			
	GU			
	Catheter			
	Other:			

Signature: _____ Initials: _____ Signature: _____ Initials: NS



**DuBois Regional
Medical Center**

Making the difference for life.

6 of 7

EE
Emergency Department Record

446977 68Y ER

KANARY, LILLIAN
SETH, SATISH K

01/12/30 F

01/02/99

445-42-6232

9900200146

AD. DOCTOR GIVEN

PATIENT PROBLEM LIST

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

___ Knowledge deficit: _____
 / Alteration in Comfort: Head pain
 ___ Alteration in fluid volume: _____
 ___ Alteration in Oxygenation: _____
 ___ Decreased Cardiac Output: _____
 (See Chart and nurses notes for interventions and response.)

___ Alteration in body temperature: _____
 ___ Individual ineffective coping: _____
 ___ Risk of infection _____
 ___ Impaired tissue integrity: _____
 ___ Other: _____

SCREENING CRITERIA

Patient Home Phone Number/Room #: _____

Suspected Abuse: Adult/Child:

- ☐ Unusual/suspicious marks (i.e. burns, bruises, welts, lacerations, punctures)
☐ Sexual abuse
☐ Domestic Violence: Patient verbalizes need for assistance.

FOLLOW DRMC POLICY (PR-1, PR-1.2, PR-1.3),

☒ No Identified Needs

Initial visit: date: _____

Time: _____

Signature: _____

Follow-up: ☐ None

☐ See Progress Note

Discharge Planning:

- ☐ Additional supportive services needed upon d/c (med. equip., Home Health).
☐ INITIAL Placement assistance needed before discharge.
☐ Financial assistance required to follow treatment.
☐ Patient has an Advanced Directive but did not bring in a copy, follow up needed.

☒ No Identified Needs

Initial visit: date: _____

Time: _____

Signature: _____

Follow-up: ☐ None

☐ See Progress Note

Pastoral Care:

- ☐ Terminal Illness;
☐ Recent Loss of Significant Other;
☐ Request for Pastoral Care

**If any of the above are indicated, PLEASE FAX THIS FORM TO THE SOCIAL WORK/
 PASTORAL CARE AREA #3488**

☒ No Identified Needs

Initial visit: date: _____

Time: _____

Signature: _____

Follow-up: ☐ None

☐ 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			
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 ⊕ BP D = See dinemapp			
	Coos, blabbles, 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 N = No relief R = Relief P = Partial 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 reponse	1	1	1					

Signature: Nancy 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
TORONTA

CA 000 00

*ER

Age 68Y

Unit # 000446977

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. *Y*

/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
103 CORDELLA AVENUE
TORONTA

CA 000 00

*ER

Age 68Y

Unit # 000446977

Acct # D9900200146

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

146: 00046977

01/02/1999 14:10:43 KANARY, LILLIAN
68 years Female

DuBois Regional Medical Center
Dept: ER-5

Operator: DT

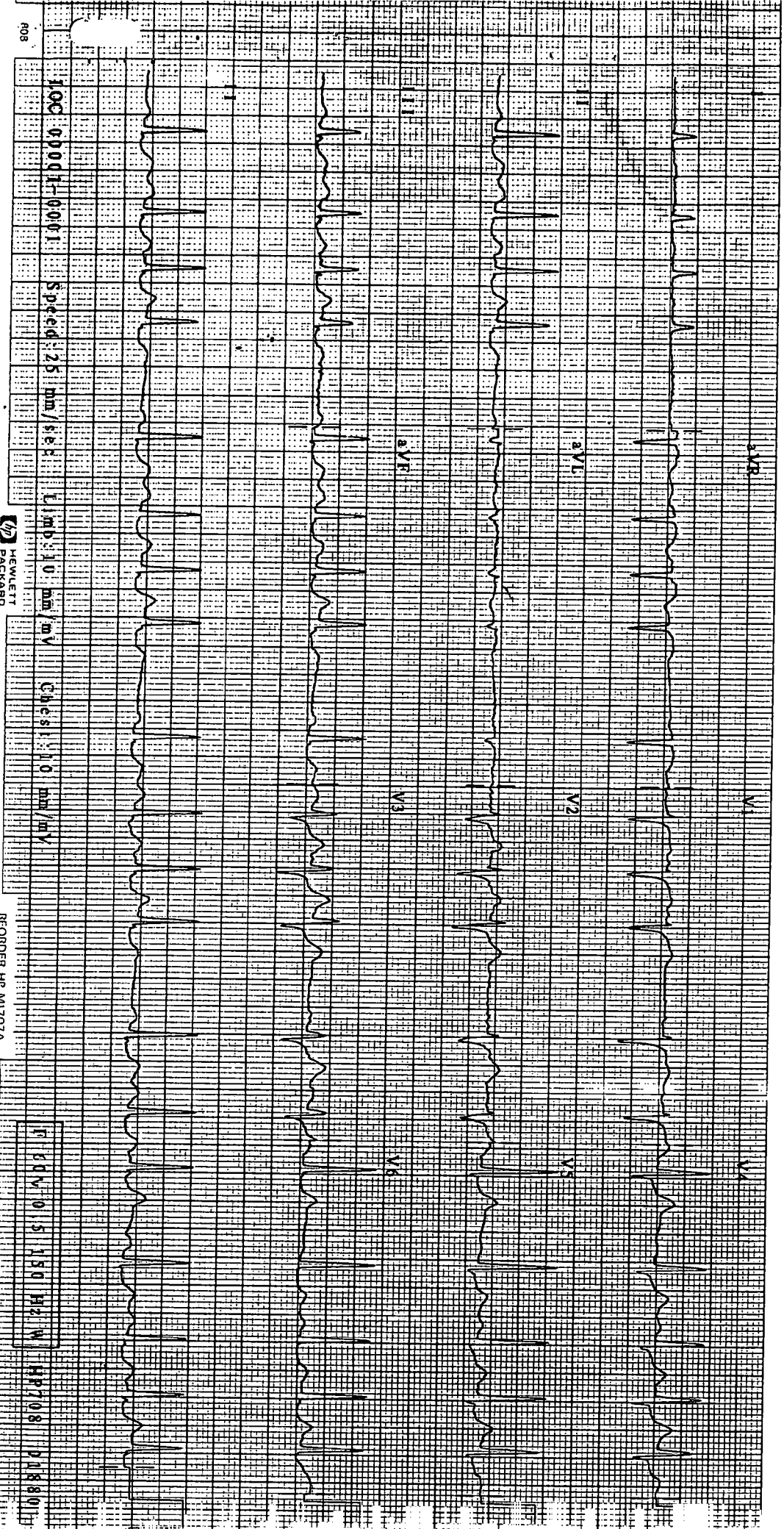
Doctor

Rate 111
PR 167
QRSD 87
QT 306
QTc 416
Sinus tachycardia, rate 111
Multiple atrial premature complexes
Nonspecific ST depression
? Digoxin

--AXIS--
P 86
QRS 72
T 61

- ABNORMAL ECG -

[Signature]



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, WILLIAM

01/12/30

445-42-6692

NO, DOCTOR GIVEN

F

01/02/

99002001

CRITIKON DINAMAP 1846 SX/P VERSION 089

LABORATORY REPORT

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

May 18,1999

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

Dear Mr. Mohny,

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.....

(2)

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 1st 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.....

(3)

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,

A handwritten signature in black ink, appearing to read "J.C. Howell", written in a cursive style.

Dr. J.C. Howell

JCH:bc

Account enclosed