EXHIBIT NO. 1F
PAGE: 1 OF 22

FAX TRANSMITTAL

NORTHSHORE ALLERGY & IMMUNOLOGY, LLC
Richard J. Guillot, MD
355 Lakeview Court
Covington, LA 70433
PHONE: (985) 892-3122
FAX: (985) 892-3394

Date: 8/8/17

Pages Including Cover Sheet:

Attention: children & family Services

From:

Fax Number: 1866 4442216

Regarding: Bodin, Jeffrey 5/22/97

EXHIBIT NO. 1F
PAGE: 2 OF 22

Practice name, Street address: 804 Heavens Dr. ... [illegible] / Practice name Ordering physician: Carl Hordowitz ... 47047
Telephone (985) 792-4022 Fax (985) 792-4027

Patient name: Bodin, Jeffrey Date of birth: 5/22/97 Patient number: ___
Testing Technician: [illegible]
Last use of antihistamine (or other med affecting response to histamine): ___ days medication ___
Testing Date (s) and Time: Percutaneous 1/8/10 11:60 AM PM Intradermal _/_/___ AM PM

General information about skin test protocol

1. Percutaneous reported as: Allergen: Testing concentration: Extract company (*see below)
   Location: back ✓ arm Device: multi test
2. Intradermal: 0.__ ml injected, Location: arm Testing concentration: 1:___ w/v or BAU or AU/ml, PNU
3. Results Longest diameter (*Left in this example*) or longest diameter and orthogonal diameter (*Right in this example*) of wheal (W) and erythema (flare) (F) measured in millimeters at 15 minutes.
   Blank in results column indicates test was not performed, 0=negative

19 Allergens, B Mosquito

* Extract manufacturer abbreviations: G=Greer, AL= Allergy Labs (Oklahoma), AE=ALK Abello, AD=ALK (Denmark), H=Hollister-Stier, AG=Antigen, N=Nelco, AM=Allermed

Allergen	Percutaneous wheal	flare (mm)	Intradermal wheal	flare (mm)	Allergen	Percutaneous wheal	flare (mm)	Intradermal wheal	flare (mm)
A					E				
8 Positive Control	9				8 Negative Control	—			
7 Cocklebur	—				7 Red Mulberry	—			
6 Ragweed Mix	—				6 Red Maple	—			
5 Pecan Tree	—				5 American Elm	—			
4 Va. Live Oak ✓ X	7				4 Box Elder ✓ X	7			
3 Bahia Grass ✓ X	7				3 Red/River Birch	—			
2 Timothy Grass *	—				2 Red/River Ash	—			
1 Negative Control	—				1 Ligustrum (Privet)	—			
B					F				
8 Negative Control	—				8 Negative Control	—			
7 Mixed Feathers	—				7 Cedar, Red	—			
6 Cottonwood, Eastern	—				6 American Beech	—			
5 Cockroach	—				5 Black Willow	—			
4 D. Pterony ✓ XX	13	+			4 Sycamore, Am./East	—			
3 D. Farinae ✓ XX	13	+			3 Sweet Gum	—			
2 Cat Hair	—				2 White Poplar	—			
1 Dog	—				1 Loblolly Pine	—			
C					G				
8 Negative Control	—				8 Negative Control	—			
7 Red Top Grass *	—				7 Pigweed Mix	—			
6 Perenial Rye Grass *	7				6 Marsh Elder ✓ X	5			
5 Kentucky Blue Grass * ✓ X	7	+			5 Lamb's Quarter	—			
4 Meadow Fescue *	—				4 Hemp, West/Water ✓ X	5			
3 Orchard Grass *	—				3 Dock, Yellow/Curly ✓ X	5			
2 Johnson Grass	—				2 Olive ✓ X	5			
1 Bermuda Grass ✓ X	7				1 Hackberry	—			
D					H				
8 Negative Control	—				8 Negative Control	—			
7 Epicoccum	—				7 Sage Mix	—			
6 Alternaria ✓ XX	7				6 Russian Thistle ✓ X	5			
5 Fusarium ✓ XX	7				5 Kochia				
4 Helminthosp ✓ XX	7				4 Cypress, Bald ✓ X	5			
3 Hormodendrum	—				3 Wormwood				
2 Penicillium ✓ XX	7				2 Sorrel, Red/Sheep ✓ X	5			
1 Aspergillus ✓ XX	7				1 English Plantain	—			

✓ B Mosquito

Street address 804 [illegible] City [illegible] State [illegible] Zip 7047[illegible]
Telephone (985) 793-4022 Fax (985) 793-407[illegible]

EXHIBIT NO. 1F
PAGE: 3 OF 22

Patient name: Bodin, Jeffrey Date of birth: 5/22/97 Patient number: ______
Testing Technician: [illegible]
Last use of antihistamine (or other drug affecting response to histamine): ___ days medication ______
Testing Date (s) and Time: Percutaneous 1/18/10 11:20 (AM) PM Intradermal _/_/___ AM PM

General information about skin test protocol

1. Percutaneous reported as: Allergen: Testing concentration: Extract company (* see below)
   Location: back ✓ arm ___ Device: multi-test
2. Intradermal: 0.__ ml injected, Location: arm Testing concentration: 1:___ w/v or BAU or AU/ml, PNU
3. Results Longest diameter (*Left in this example*) or longest diameter and orthogonal diameter (*Right in this example*) of wheal (W) and erythema (flare) (F) measured in millimeters at 15 minutes
   Blank in results columns indicates test was not performed, 0=negative

* Extract manufacturer abbreviations: G=Greer, AL= Allergy Labs (Oklahoma), AK=ALK Abello, AI=ALK (Denmark), H=Hollister-Stier, AG=Antigen, N=Nelco, AM=Allermed

Allergen	Percutaneous wheal	Percutaneous flare (mm)	Intradermal wheal	Intradermal flare (mm)	Allergen	Percutaneous wheal	Percutaneous flare (mm)	Intradermal wheal	Intradermal flare (mm)
A					E				
8 Positive Control	9				8 Negative Control	–			
7 Cocklebur	–				7 Red Mulberry	–			
6 Ragweed Mix	–				6 Red Maple	–			
5 Pecan Tree	–				5 American Elm	–			
4 Va. Live Oak	7				4 Box Elder	7			
3 Bahia Grass	7				3 Red/River Birch	–			
2 Timothy Grass	–				2 Red/River Ash	–			
1 Negative Control	–				1 Ligustrum (Privet)	–			
B					F				
8 Negative Control	–				8 Negative Control	–			
7 Mixed Feathers	–				7 Cedar, Red	–			
6 Cottonwood, Eastern	–				6 American Beech	–			
5 Cockroach	–				5 Black Willow	–			
4 D. Pterony	13+	+			4 Sycamore, Am./East	–			
3 D. Farinae	13+	+			3 Sweet Gum	–			
2 Cat Hair	–				2 White Poplar	–			
1 Dog	–				1 Loblolly Pine	–			
C					G				
8 Negative Control	–				8 Negative Control	–			
7 Red Top Grass	–				7 Pigweed Mix	–			
6 Perenial Rye Grass	7				6 Marsh Elder	5			
5 Kentucky Blue Grass	7	+			5 Lamb's Quarter	–			
4 Meadow Fescue	–				4 Hemp, West/Water	5			
3 Orchard Grass	–				3 Dock, Yellow/Curly	5			
2 Johnson Grass	–				2 Olive	5			
1 Bermuda Grass	7				1 Hackberry	–			
D					H				
8 Negative Control	–				8 Negative Control	–			
7 Epicoccum	–				7 Sage Mix	–			
6 Alternaria	7				6 Russian Thistle	5			
5 Fusarium	7				5 Kochia	–			
4 Helminthosp	7				4 Cypress, Bald	5			
3 Hormodendrum	–				3 Wormwood	–			
2 Penicillium	7				2 Sorrel, Red/Sheep	5			
1 Aspergillus	7				1 English Plantain	–			

(+) DM, molds, pollen (grass, tree & weed) allergy
[signature]

EXHIBIT NO. 1F
PAGE: 4 OF 22

Ochsner
ALLERGY DEPARTMENT

BODIN, JEFFREY
2592229 05/22/1997 M
HASSETT, CATHRYN C
VISIT:04/22/2009

Inhalant Allergen Skin Test Results
Tested to included ones

Date: 4/22/09	Wheal	Flare	Grade	Doctor: Hassett	Wheal	Flare	Grade
1. Cat Pelt 10,000 BAU/ml			0	31. Bahia (Gramineae)			0
2. Cockroach, Mixed			0	32. Bermuda (Gramineae) 10,000 BAU/ml			0
3. Dog Epithelium			0	33. Johnson (Gramineae)			0
4. Dust Mite (D.f.)10,000 AU/ml			>4	34. Timothy (Gramineae) 10,000 BAU/ml			0
5. Dust Mite (D.p.)10,000 AU/ml			>4				
				35. Acremonium (Cephalosporium)			
6. Ash, White (Oleaceae)				36. Alternaria alternata			0
7. Birch, Mixed (Betulaceae)			0	37. Aspergillus fumigatus			0
8. Box Elder (Aceraceae)				38. Botrytis cinerea			
9. Cedar, Red (Cupressaceae)			0	39. Candida albicans			
10. Cottonwood, Eastern (Salicaceae)				40. Chaetomium globosum			
11. Cypress, Bald (Cupressaceae)				41. Cladosporium cladosporioides			0
12. Elm, American (Ulmaceae)			0	42. Curvularia spp. (Epicoccum)			
13. Hackberry (Ulmaceae)				43. Epicoccum nigrum			
14. Maple, Red (Aceraceae)				44. Fusarium spp.			
15. Mulberry, Red (Moraceae)				45. Glycladium (Greer Laboratory 1:20)			
16. Oak, Mixed (Fagaceae)			0	46. Helminthosporium (Drechslera-type)			0
17. Pecan (Juglandaceae)			0	47. Mucor spp.			
18. Pine, White (Pinaceae)				48. Neurospora spp.			
19. Sweetgum (Hamamelidaceae)				49. Nigrospora spp.			
20. Sycamore, American (Platanaceae)				50. Penicillium, Mixed			
21. Walnut, Black (Juglandaceae)				51. Phoma herbarum			
22. Willow, Black (Salicaceae)			0	52. Pullularia pullulans			
				53. Rhizopus spp.			
23. Lambs Quarters (Chenopodiaceae)			0	54. Rhopalomyia rubra			
24. Marsh Elder, Rough (Compositae)				55. Smuts, Mixed			
25. Mugwort (Compositae)				56. Stemphylium spp.			
26. Pigweed, Rough (Amaranthaceae)			0	57. Trichoderma (Greer Laboratory 1:20)			
27. Plantain, English (Plantaginaceae)				58. Trichophyton mentagrophytes			
28. Ragweed, Mixed (Compositae)			0				
29. Russian Thistle (Chenopodiaceae)				59. Saline			0
30. Sorrel/Dock, Mixed (Polygonaceae)			0	60. Histamine			4

Grade: Misc .0 No Reaction
1+ Erythema only
2+ 3mm wheal w/ <21mm erythema
3+ 3mm wheal w/ >21mm erythema
4+ Wheal w/ pseudopods
>4+ Very large wheal w/pseudopods

Form No. 00237 (12/29/08) Cary Center

All extracts are from ALK-Abello and are glycerinated (1:20 w/v) unless otherwise specified.

Physician Signature / Print Name / Date Cathryn A Hassett MD

RD 7/13/10

EXHIBIT NO. 1F
PAGE: 5 OF 22

Ochsner
ALLERGY DEPARTMENT

BODIN, JEFFREY
2592229 05/22/1997 M
HASSETT, CATHRYN C
VISIT: 11/16/2009

Food Allergen Skin Test Results

Date: 11/16/09	Wheal	Flare	Grade	Doctor: [illegible]	Wheal	Flare	Grade
DAIRY PRODUCTS				**SEEDS**			
1. Milk			0	29. Mustard			
POULTRY PRODUCTS				30. Sesame			0
2. Chicken			0	31. Sunflower			
3. Egg			0	**FRUITS**			
4. Turkey			0	32. Apple			1
MEATS				33. Apricot			
5. Beef			0	34. Banana			
6. Lamb				35. Cantaloupe			
7. Pork			0	36. Peach			
FISH/SHELLFISH				37. Pineapple			
8. Clam				38. Strawberry			0
9. Crab			0	39. Tomato			
10. Flounder				40. Watermelon			
11. Lobster				**CITRUS FRUITS**			
12. Oyster				41. Grapefruit			0
13. Salmon			3	42. Lemon			0
14. Shrimp			0	43. Orange			0
15. Tuna				**VEGETABLES**			
NUTS & LEGUMES				44. Beans (String)			0
16. Almond				45. Broccoli			0
17. Brazil Nut				46. Carrots			0
18. Cashew				47. Celery			0
19. Coconut				48. Garlic			0
20. Hazelnut (Filbert)				49. Mushroom			0
21. Peanut			0	50. Onion			0
22. Pecan				51. Peas (Green)			0
23. Walnut (English)				52. Potatoes (Sweet)			
GRAINS				53. Potatoes (White)			0
24. Corn			0	54. Soybean			0
25. Oat			0	55. Spinach			
26. Rice			0	**OTHER**			
27. Rye			0	56. Cinnamon			
28. Wheat			0	57. Cacao			0
				58. Coffee			
				CONTROLS			
				59. Saline			0
				60. Histamine			3
				MISCELLANEOUS			

Rating	Prick
Negative	No Reaction
1+	Erythema only
2+	Erythema, w/wheal ≤ 3 mm
3+	Erythema, w/wheal > 3 mm
4+	Erythema, wheal w/pseudopods

All extracts are from ALK-Abello and are glycerinated (1:20 weight/volume) unless otherwise specified.

Physician Signature / Print Name / Date [signature]

[signature] 7/15/20

Ochsner
ALLERGY DEPARTMENT

BODIN, JEFFREY
2592229 05/22/1997 M
HASSETT, CATHRYN C
VISIT:04/22/2009

Inhalant Allergen Skin Test Results
tested to cancled ones

Date: 4/22/09	Wheal	Flare	Grade	Doctor: Hassett	Wheal	Flare	Grade
UNCATEGORIZED							
1. Cat Pelt 10,000 BAU/ml			0	21. Bahia (Gramineae)			0
2. Cockroach, Mixed			0	22. Bermuda (Gramineae) 10,000 BAU/ml			0
3. Dog Epithelium			0	23. Johnson (Gramineae)			0
4. Dust Mite (D.f)10,000 AU/ml			>4	24. Timothy (Gramineae) 100,000 BAU/ml			0
5. Dust Mite (D.p)10,000 AU/ml			>4	**MOLD**			
TREES				35. *Acremonium* (Cephalosporium)			
6. Ash, White (Oleaceae)				36. *Alternaria alternata*			0
7. Birch, Mixed (Betulaceae)			0	37. *Aspergillus fumigatus*			0
8. Box Elder (Aceraceae)				38. *Botrytis cinerea*			
9. Cedar, Red (Cupressaceae)			0	39. *Candida albicans*			
10. Cottonwood, Eastern (Salicaceae)				40. *Chaetomium globosum*			
11. Cypress, Bald (Cupressaceae)				41. *Cladosporium cladosporioides*			0
12. Elm, American (Ulmaceae)			0	42. *Curvularia spp.* (Sporaria)			
13. Hackberry (Ulmaceae)				43. *Epicoccum nigrum*			
14. Maple, Red (Aceraceae)				44. *Fusarium spp.*			
15. Mulberry, Red (Moraceae)				45. *Gliocladium* (Grass Laboratory 1:20)			
16. Oak, Mixed (Fagaceae)			0	46. *Helminthosporium* (Drechslera-type)			0
17. Pecan (Juglandaceae)			0	47. *Mucor spp.*			
18. Pine, White (Pinaceae)				48. *Neurospora spp.*			
19. Sweetgum (Hamamelidaceae)				49. *Nigrospora spp.*			
20. Sycamore, American (Platanaceae)				50. *Penicillium, Mixed*			
21. Walnut, Black (Juglandaceae)				51. *Phoma herbarum*			
22. Willow, Black (Salicaceae)			0	52. *Pullularia pullulans*			
WEEDS				53. *Rhizopus spp.*			
23. Lambs Quarters (Chenopodiaceae)			0	54. *Rhodotorula rubra*			
24. Marsh Elder, Rough (Compositae)				55. Smuts, Mixed			
25. Mugwort (Compositae)				56. *Stemphylium spp.*			
26. Pigweed, Rough (Amaranthaceae)			0	57. *Trichoderma* (Grass Laboratory 1:20)			
27. Plantain, English (Plantaginaceae)				58. *Trichophyton mentagrophytes*			
28. Ragweed, Mixed (Compositae)			0	**CONTROLS**			
29. Russian Thistle (Chenopodiaceae)				59. Saline			0
30. Sorrell/Dock, Mixed (Polygonaceae)			0	60. Histamine			3+

Grade: Misc 0 No Reaction
1+ Erythema only
2+ 3mm wheal w/ <21mm erythema
3+ 3mm wheal w/ >21mm erythema
4+ Wheal w/ pseudopods
> 4+ Very large wheal w/pseudopods

Form No. 00237 [12/2/2008] Copy Center

All extracts are from ALK-Abello and are glycerinated (1:20 w/v) unless otherwise specified.

Physician Signature / Print Name / Date Cathryn Hassett

Ochsner
ALLERGY DEPARTMENT

BODIN, JEFFREY
2592229 05/22/1997 M
HASSETT, CATHRYN C
VISIT:11/16/2009

Food Allergen Skin Test Results

Date: 11/16/09	Wheal	Flare	Grade	Doctor: Hassett	Wheal	Flare	Grade
DAIRY PRODUCTS				**SEEDS**			
1. Milk			0	29. Mustard			
POULTRY PRODUCTS				30. Sesame			0
2. Chicken			0	31. Sunflower			
3. Egg			0	**FRUITS**			
4. Turkey			0	32. Apple	—		/
MEATS				33. Apricot			
5. Beef			0	34. Banana			
6. Lamb				35. Cantaloupe			
7. Pork			0	36. Peach			
FISH & SHELLFISH				37. Pineapple			
8. Clam				38. Strawberry			0
9. Crab			0	39. Tomato			
10. Flounder				40. Watermelon			
11. Lobster				**CITRUS FRUITS**			
12. Oyster				41. Grapefruit			0
13. Salmon			3	42. Lemon			0
14. Shrimp			0	43. Orange			0
15. Tuna				**VEGETABLES**			
NUTS & LEGUMES				44. Beans (String)			0
16. Almond				45. Broccoli			0
17. Brazil Nut				46. Carrots			0
18. Cashew				47. Celery			0
19. Coconut				48. Garlic			0
20. Hazelnut (Filbert)				49. Mushroom			0
21. Peanut			0	50. Onion			0
22. Pecan				51. Peas (Green)			0
23. Walnut (English)				52. Potatoes (Sweet)			
GRAINS				53. Potatoes (White)			0
24. Corn			0	54. Soybean			0
25. Oat			0	55. Spinach			
26. Rice			0	**OTHER**			
27. Rye			0	56. Cinnamon			G
28. Wheat			0	57. Cacao			
				58. Coffee			
				CONTROLS			
				59. Saline			0
				60. Histamine			3
				MISCELLANEOUS			

Rating	Prick
Negative	No Reaction
1+	Erythema only
2+	Erythema, w/wheal ≤ 3 mm
3+	Erythema, w/wheal > 3 mm
4+	Erythema, wheal w/pseudopods

Form No. D0236 (1/20/2009) Copy: Coder/Ochsner

All extracts are from ALK-Abello and are glycerinated (1:20 weight/volume) unless otherwise specified.

Physician Signature / Print Name / Date Cathryn Hassett

EXHIBIT NO. 1F
PAGE: 8 OF 22

Report printed:04/02/15,0927 Page 1

DOCTOR'S COPY

PATIENT: [illegible] ACCT #: [illegible] LOC: [illegible] U #: [illegible]
AGE/SX: 17/M ROOM: REG: 03/26/15
REG DR: Guillot,Richard J MD DOB: 05/22/97 BED: DIS:
STATUS: DEP CLI TLOC:

SPEC #: 0326:LV:S00019R **COLL:** 03/26/15-1411 **STATUS:** COMP **REQ #:** 02502096
RECD: 03/26/15-1411 **SUBM DR:** Guillot,Richard J MD

ENTERED: 03/26/15-1412 **DR:** **OTHR DR:**

ORDERED: PNEUMO AB IGG

-----SEROLOGY-----

	Test	Low	Normal	High	Flag	Reference	Site
	PNEUMO AB IGG						
>	PNEUMO 1 IGG		27.4 7U/			>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 3 IGG		1.4			>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 4 IGG		11.9 72x			>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 8 IGG		0.4		L	>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 9N IGG		2.1 + 2x			>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 12F IGG		0.2		L	>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 14 IGG		2.8 +			>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 19F IGG		3.4 +			>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 23F IGG		>31.8 +			>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 26 IGG		9.0 +			>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 51 IGG		>29.3 +			>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 56 IGG		14.4 +			>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 57 IGG		>39.4 +			>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 68 IGG		14.5 +			>1.3 ug/mL	LC 04/01/15-1616

This test was developed and its performance characteristics determined by Viracor-IBT Laboratories. It has not been cleared or approved by the U.S. Food and Drug Administration.
Performed At: NEWXW Viracor IBT Laboratories Inc
1001 NW Technology Drive Lees Summit, MO 640865603
[illegible]

LC LABCORP L#17131140 M#17301445
Test performed at LabCorp, Birmingham, AL unless otherwise noted in result

Good Responder to Pneumovax
12/1/15

Date:4/1/2015 Time:6:41:41 PM

EXHIBIT NO. 1F
PAGE: 9 OF 22

Report printed:04/01/15,1841 Page 1 DOCTOR'S COPY

PATIENT: BODIN, JEFFREY T ACCT #: F00041519535 LOC: F LAB U #: F0007231
AGE/SX: 17/M ROOM: REG: 03/26/15
REG DR: Guillot,Richard J MD DOB: 05/22/97 BED: DIS:
STATUS: DEP CLI TLOC:

SPEC #: 0326:LV:S00019R COLL: 03/26/15-1411 STATUS: COMP REQ #: 02502096
RECD: 03/26/15-1411 SUBM DR: Guillot,Richard J MD

ENTERED: 03/26/15-1412 DR: OTHR DR:

ORDERED: PNEUMO AB IGG

-----SEROLOGY-----

Test	Low	Normal	High	Flag	Reference	Site
PNEUMO AB IGG						
> PNEUMO 1 IGG		27.4			>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 3 IGG		1.4			>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 4 IGG		11.9			>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 8 IGG		0.4		L	>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 9N IGG		2.1			>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 12F IGG		0.2		L	>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 14 IGG		2.8			>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 19F IGG		3.4			>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 23F IGG		>31.8			>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 26 IGG		9.0			>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 51 IGG		>29.3			>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 56 IGG		14.4			>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 57 IGG		>39.4			>1.3 ug/mL	LC 04/01/15-1616
> PNEUMO 68 IGG		14.5			>1.3 ug/mL	LC 04/01/15-1616

**This test was developed and its performance characteristics determined by Viracor-IBT Laboratories. It has not been cleared or approved by the U.S. Food and Drug Administration.*
Performed At: NEWXW Viracor IBT Laboratories Inc
1001 NW Technology Drive Lees Summit, MO 640865603
Altrich Michelle L PhD Ph:8558248477

*LC - LABCORP L#17131140 M#17381445
Test performed at LabCorp, Birmingham, AL unless otherwise noted in result

Report printed:04/01/15,1658

DOCTOR'S COPY

PATIENT: [illegible] ACCT #: [illegible] LOC: [illegible] D.#: [illegible]
AGE/SEX: 17/M ROOM: REG: 03/26/15
REQ DR: Guillot,Richard J MD DOB: 05/22/97 BED: DIS:
STATUS: BED CLT TLOC:

SPEC #: 0326:LV:S00019R COLL: 03/26/15-1411 STATUS: COMP REQ #: 02502096
RECD: 03/26/15-1411 SUBM DR: Guillot,Richard J MD

ENTERED: 03/26/15-1412 DR: OTHR DR:

ORDERED: PNEUMO AB IGG

	Test	Low	Normal	High	Flag	Reference	Lab
			-----SEROLOGY-----				
	PNEUMO AB IGG						
>	PNEUMO 1 IGG	27.4				>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 3 IGG	1.4				>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 4 IGG	11.9				>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 5 IGG	0.4		L		>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 9N IGG	2.1				>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 12F IGG	0.2		L		>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 14 IGG	2.8				>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 19F IGG	3.4				>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 23F IGG	>31.8				>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 26 IGG	9.0				>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 51 IGG	>29.3				>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 56 IGG	14.4				>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 57 IGG	>39.4				>1.3 ug/mL	LC 04/01/15-1616
>	PNEUMO 68 IGG	14.5				>1.3 ug/mL	LC 04/01/15-1616

*This test was developed and its performance characteristics determined by Viracor-IBT Laboratories. It has not been cleared or approved by the U.S. Food and Drug Administration.
Performed At: NEWXW Viracor IBT Laboratories Inc
1001 NW Technology Drive Lees Summit, MO 640865603
Altrich Michelle L PhD Ph:8558248477

*LC - LADCORP L#17131140 M#17301445
Test performed at LabCorp, Birmingham, AL unless otherwise noted in result

NORTHSHORE ALLERGY & IMMUNOLOGY, LLC
355 Lakeview Court
Covington, LA 70433
Office (985) 892-3122
Fax (985) 892-3394

Name: Bodin, Jeffrey
DOB: 5/22/97

DR. RICHARD GUILLOT'S ORDERS:

Post Pneumococcal Antibodies 14 serotypes

Diagnosis: 279.3

Physician signature: Richard Guillot MD

PLEASE FAX RESULTS TO (985) 892-3394

Date:1/22/2015 Time:6:04:39 PM

EXHIBIT NO: 1F
PAGE: 12 OF 22

Lakeview Regional Medical Center, Covington, Louisiana
CLIA ID 19D1021830
Pamela Bartholomew, M.D. Jeremy Henderson, M.D.

PATIENT: **BODIN, JEFFREY T** ACCT #: F00041386523 LOC: F.LAB U #: F000723116
DOB: 05/22/97 AGE/SX: 17/M ROOM: REG: 01/15/15
REG DR: Guillot, Richard J MD STATUS: DEP CLI BED: DIS:
Dr Phone: (985)892-3122 or

SPEC #: 0115:LV:S00024R **COLL:** 01/15/15-1542 **STATUS:** COMP **REQ #:** 02469672
RECD: 01/15/15-1542 **SUBM DR:** Guillot, Richard J MD

ENTERED: 01/15/15-1547 **OTHR DR:** Casey, Sherri MD
ORDERED: PNEUMO AB IGG

Test	Result	Flag	Reference	Site / Verified
PNEUMO AB IGG				
> PNEUMO 1 IGG	0.5	L	>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 3 IGG	0.9	L	>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 4 IGG	1.8		>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 8 IGG	0.2	L	>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 9N IGG	<0.1	L	>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 12F IGG	0.2	L	>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 14 IGG	0.8	L	>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 19F IGG	0.9	L	>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 23F IGG	0.6	L	>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 26 IGG	<0.1	L	>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 51 IGG	0.8	L	>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 56 IGG	1.2	L	>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 57 IGG	1.2	L	>1.3 ug/mL	LC 01/22/15-1810
> PNEUMO 68 IGG	0.1	L	>1.3 ug/mL	LC 01/22/15-1810

** This test was developed and its performance characteristics determined by Viracor-IBT Laboratories. It has not been cleared or approved by the FDA.*
Performed At: NEWXW Viracor IBT Laboratories Inc
1001 NW Technology Drive Lees Summit, MO 640865603
Altrich Michelle L PhD Ph:8558248477

mother aware 2/2/15

Y/4t

Baseline Non Responder

LC - LABCORP L#17131140 M#17381445
Test performed at LabCorp, Birmingham, AL unless otherwise noted in result

Need Pneumovax 13 or Prevnar 13 then repeat labs ~4-6 weeks

Pamela Bartholomew, M.D. CLIA # 19D0048415
** END OF REPORT **

1/26/15

OAS 87 9918

Date: 1/20/2015 Time: 3:42:49 PM

EXHIBIT NO. 1F
PAGE: 13 OF 22

Report printed: 01/20/15,1548 Page 1

DOCTOR'S COPY

PATIENT: BODIN, JEFFREY T ACCT #: F00041386522 LOC: F LAB U #: F0007281
AGE/SX: 17/M ROOM: REG: 01/15/15
REG DR: Guillot, Richard J MD DOB: 05/22/97 BED: DIS:
STATUS: DEP CLI TLOC:

SPEC #: 0115:LV:C00171R COLL: 01/15/15-1542 STATUS: COMP REQ #: 02469672
RECD: 01/15/15-1542 SUBM DR: Guillot, Richard J MD

ENTERED: 01/15/15-1547 DR: OTHR DR:

ORDERED: IGG SUBCLASSES

Test	Low	Normal	High	Flag	Reference	Site
-----CHEMISTRY-----						
IGG SUBCLASSES						
> IGG QUANT		867			549-1584 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 1		542			422-1292 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 2		226			117-747 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 3		33		L	41-129 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 4		212			1-291 mg/dL	LC 01/20/15-0914

Results verified by repeat testing
Performed At: MB LabCorp Birmingham
1801 First Avenue South Birmingham, AL 352331935
Elgin John MD Ph:2055813500
Performed At: BN LabCorp Burlington
1447 York Court Burlington, NC 272153361
Hancock William F MD Ph:8007624344

*LC - LABCORP L#17131140 M#17381445
Test performed at LabCorp, Birmingham, AL unless otherwise noted in result.

√ pneumococcal Ab's

RJDMD

Report printed:01/20/15,1548 Page 2

DOCTOR'S COPY

PATIENT: BODIN,JEFFREY T ACCT #: F00041386322 LOC: F.LAB U #: F0007221
AGE/SX: [illegible] ROOM: REG: [illegible]
REG DR: Guillot,Richard J MD DOB: [illegible] BED: DIS:
STATUS: DEP CLI TLOC:

SPEC #: 0115:LV:S00025R	**COLL:** 01/15/15-1542	**STATUS:** COMP	**REQ #:** 02469672
	RECD: 01/15/15-1542	**SUBM DR:** Guillet,Richard J MD	
ENTERED: 01/15/15-1547	**DR:**	**OTHR DR:**	
ORDERED: TETANUS AB			

Test	Low	Normal	High	Flag	Reference	Site
		----SEROLOGY-----				
> TETANUS AB IGG		0.40			<0.10 IU/mL	LC
					01/20/15-1217	

Protective

Interpretation:
Non-Protective <0.10
Protective >=0.10

Results for this test are for research purposes only by the assay's manufacturer. The performance characteristics of this product have not been established. Results should not be used as a diagnostic procedure without confirmation of the diagnosis by another medically established diagnostic product or procedure.
Performed At: BN LabCorp Burlington
1447 York Court Burlington, NC 272153361
Hancock William F MD Ph:8007624344

*LC - LABCORP L#17131140 M#17381445
Test performed at LabCorp, Birmingham, AL unless otherwise noted in result

EXHIBIT NO. 1F
PAGE: 15 OF 22

Report printed:01/20/15,1234 Page 1

DOCTOR'S COPY

PATIENT: BODIN,JEFFREY L ACCT #: F000413B6523 LOC: F,LAB U #: T0007231
AGE/SX: 17/M ROOM: REG: 01/15/15
REG DR: Guillot,Richard J MD DOB: 05/22/97 BED: DIS:
STATUS: DEP CLI TLOC:

SPEC #: 0115:LV:S00025R COLL: 01/15/15-1542 STATUS: COMP REQ #: 02469672
RECD: 01/15/15-1542 SUBM DR: Guillot,Richard J MD

ENTERED: 01/15/15-1547 DR: OTHR DR:

ORDERED: TETANUS AB

Test	Low	Normal	High	Flag	Reference	Site
		-----SEROLOGY-----				
> TETANUS AB IGG		0.40			<0.10 IU/mL	LC 01/20/15-1217

Interpretation:
Non-Protective <0.10
Protective >=0.10

Results for this test are for research purposes only by the assay's manufacturer. The performance characteristics of this product have not been established. Results should not be used as a diagnostic procedure without confirmation of the diagnosis by another medically established diagnostic product or procedure.
Performed At: BN LabCorp Burlington
1447 York Court Burlington, NC 272153361
Hancock William F MD Ph:8007624344

*LC - LABCORP L#17131140 M#17381445
Test performed at LabCorp, Birmingham, AL unless otherwise noted in result

EXHIBIT NO. 1F
PAGE: 16 OF 22

Report printed: 01/20/15,0919 Page 1

DOCTOR'S COPY

PATIENT: BODIN,JEFFREY T ACCT #: F00041386522 LOC: F LAB U #: F00072?21
AGE/SX: 17/M ROOM: REG: 01/15/15
REG DR: Guillot,Richard J MD DOB: 05/22/97 BED: DIS:
STATUS: DEP CLI TLOC:

SPEC #: 0115:LV:C00171R COLL: 01/15/15-1542 STATUS: COMP REQ #: 02469672
RECD: 01/15/15-1542 SUBM DR: Guillot,Richard J MD

ENTERED: 01/15/15-1547 DR: OTHR DR:

ORDERED: IGG SUBCLASSES

Test	Low Normal	High	Flag Reference	Site
	-----CHEMISTRY-----			
IGG SUBCLASSES				
> IGG QUANT	867		549-1584 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 1	542		422-1292 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 2	226		117-747 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 3	33	L	41-129 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 4	212		1-291 mg/dL	LC 01/20/15-0914

Results verified by repeat testing
Performed At: MB LabCorp Birmingham
1801 First Avenue South Birmingham, AL 352331935
Elgin John MD Ph:2055813500
Performed At: BN LabCorp Burlington
1447 York Court Burlington, NC 272153361
Hancock William F MD Ph:8007624344

*LC - LABCORP L#17131140 M#17381445
Test performed at LabCorp, Birmingham, AL unless otherwise noted in result

Lakeview Regional Medical Center, Covington, Louisiana
CLIA ID 19D1021830
Pamela Bartholomew, M.D. Jeremy Henderson, M.D.

PATIENT: **BODIN,JEFFREY T** ACCT #: F00041386523 LOC: F.LAB U #: F000723116
DOB: 05/22/97 AGE/SX: 17/M ROOM: REG: 01/15/15
REG DR: Guillot,Richard J MD STATUS: DEP CLI BED: DIS:
Dr Phone: (985)892-3122 or

SPEC #: 0115:LV:C00171R **COLL:** 01/15/15-1542 **STATUS:** COMP **REQ #:** 02469672
RECD: 01/15/15-1542 **SUBM DR:** Guillot,Richard J MD

ENTERED: 01/15/15-1547 **OTHR DR:** Casey,Sherri MD
ORDERED: IGG SUBCLASSES

Test	Result	Flag	Reference	Site Verified
IGG SUBCLASSES				
> IGG QUANT	867		549-1584 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 1	542		422-1292 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 2	226		117-747 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 3	33	L	41-129 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 4	212		1-291 mg/dL	LC 01/20/15-0914

Results verified by repeat testing
Performed At: MB LabCorp Birmingham
1801 First Avenue South Birmingham, AL 352331935
Elgin John MD Ph:2055813500
Performed At: BN LabCorp Burlington
1447 York Court Burlington, NC 272153361
Hancock William F MD Ph:8007624344

LC - LABCORP L#17131140 M#17381445
Test performed at LabCorp, Birmingham, AL unless otherwise noted in result

Pamela Bartholomew, M.D. CLIA # 19D0048415
** END OF REPORT **

EXHIBIT NO. 1F
PAGE: 18 OF 22

Lakeview Regional Medical Center, Covington, Louisiana
CLIA ID 19D1021830
Pamela Bartholomew, M.D. Jeremy Henderson, M.D.

PATIENT: **BODIN,JEFFREY T** ACCT #: F00041386523 LOC: F.LAB U #: F000723116
DOB: 05/22/97 AGE/SX: 17/M ROOM: REG: 01/15/15
REG DR: Guillot,Richard J MD STATUS: REG CLI BED: DIS:
Dr Phone: (985)892-3122 or

SPEC #: 0115:LV:C00170R **COLL:** 01/15/15-1542 **STATUS:** COMP **REQ #:** 02469672
RECD: 01/15/15-1542 **SUBM DR:** Guillot,Richard J MD

ENTERED: 01/15/15-1547 **OTHR DR:** Casey,Sherri MD
ORDERED: IGG, IGM, IGE

Test	Result	Flag	Reference	Site Verified
> IGG	831		510-1275 MG/DL	LV 01/15/15-1655
> IGM	36.0		35.5-251.3 MG/DL	LV 01/15/15-1655
> IGE	20.0		0-158 IU/L	LV 01/15/15-1655

SPEC #: 0115:LV:C00171R **COLL:** 01/15/15-1542 **STATUS:** RECD **REQ #:** 02469672
RECD: 01/15/15-1542 **SUBM DR:** Guillot,Richard J MD

ENTERED: 01/15/15-1547 **OTHR DR:** Casey,Sherri MD
ORDERED: IGG SUBCLASSES

Test	Result	Flag	Reference	Site Verified
IGG SUBCLASSES	SENT TO LABCORP RESULTS IN TWO DAYS			

LV - LAKEVIEW REGIONAL MEDICAL CTR
LAKEVIEW LABORATORY
COVINGTON, LA, 70433
PAMELA BARTHOLOMEW M MD

Pamela Bartholomew, M.D. CLIA # 19D0048415

** CONTINUED ON NEXT PAGE **

EXHIBIT NO. 1F
PAGE: 19 OF 22

SPEC #: 0115:LV:S00024R | PATIENT: BODEN, JEFFREY T #P06041-86523 (Continued)

SPEC #: 0115:LV:S00024R COLL: 01/15/15-1542 STATUS: RECD REQ #: 02469672
RECD: 01/15/15-1542 SUBM DR: Guillot,Richard J MD

ENTERED: 01/15/15-1547 OTHR DR: Casey,Sherri MD
ORDERED: PNEUMO AB IGG

Test	Result	Flag	Reference	Site Verified
PNEUMO AB IGG	SENT TO LABCORP			

SPEC #: 0115:LV:S00025R COLL: 01/15/15-1542 STATUS: RECD REQ #: 02469672
RECD: 01/15/15-1542 SUBM DR: Guillot,Richard J MD

ENTERED: 01/15/15-1547 OTHR DR: Casey,Sherri MD
ORDERED: TETANUS AB

Test	Result	Flag	Reference	Site Verified
TETANUS AB	PENDING			

Pamela Bartholomew, M.D. CLIA # 19D0048415

** END OF REPORT **

Report printed: 01/16/15,08 Page 1

DOCTOR'S COPY

PATIENT: BODIN, JEFFREY T. ACCT #: F00041286523 LOC: F.LAB U #: F0007231
AGE/SX: 17/M ROOM: REG: 01/15/15
REG DR: Guillot, Richard J MD DOB: 05/22/97 BED: DIS:
STATUS: DEP CLI TLOC:

SPEC #: 0115:LV:C00170R COLL: 01/15/15-1542 STATUS: COMP REQ #: 02469672
RECD: 01/15/15-1542 SUBM DR: Guillot, Richard J MD

ENTERED: 01/15/15-1547 DR: OTHR DR:

ORDERED: IGG, IGM, IGE

Test	Low	Normal	High	Flag	Reference	Sit
		-----CHEMISTRY-----				
> IGG		831			510-1275 MG/DL	01/15/15-1655
> IGM		36.0			35.5-251.3 MG/DL	01/15/15-1655
> IGE		20.0			0-158 IU/L	01/15/15-1655

Report printed: 01/15/15,1701 Page 1

DOCTOR'S COPY

PATIENT: [illegible], JEFFREY T	ACCT #: F0004[illegible]	LOC: F LAB	U #: F000[illegible]
	AGE/SX: 17/M	ROOM:	REG: 01/15/15
REG DR: Guillot, Richard J MD	DOB: 05/22/97	BED:	DIS:
	STATUS: REG CLI	TLOC:	

SPEC #: 0115:LV:C00170R COLL: 01/15/15-1542 STATUS: COMP REQ #: 02469672
RECD: 01/15/15-1542 SUBM DR: Guillot, Richard J MD

ENTERED: 01/15/15-1547 DR: OTHR DR:

ORDERED: IGG, IGM, IGE

Test	Low	Normal	High	Flag	Reference	Site
		-----CHEMISTRY-----				
> IGG		831			510-1275 MG/DL	01/15/15-1655
> IGM		36.0			35.5 251.3 MG/DL	01/15/15-1655
> IGE		20.0			0-158 IU/L	01/15/15-1655

↑ IgG subclasses (P)
Tetanus) Ab's (P)
Pneumococcal

[signature]
1/15/15

Report printed:01/15/15,1703

Lakeview Regional Medical Center
95 E. Fairway Drive, Covington, LA 70433
ph. 985-867-4041 fax. 985-867-4039
CLIA # 19D0048415
Medical Director: Pamela Bartholomew, M.D.

PATIENT: BODIN, JEFFREY T   ACCT #: F00041386523 LOC: F.LAB   U #: F0007221
AGE/SX: 17/M   ROOM: REG: 01/15/15
REG DR: Guillot,Richard J MD   DOB: 05/22/97   BED: DIS:
STATUS: REG CLI   TLOC:

SPEC #: 0115:LV:C00170R   COLL: 01/15/15-1542   STATUS: COMP   REQ #: 02469672
RECD: 01/15/15-1542   SUBM DR: Guillot,Richard J MD

ENTERED: 01/15/15-1547   OTHR DR: Casey,Sherri MD
ORDERED: IGG, IGM, IGE

Test	Low	Normal	High	Flag Reference	Site
		-----CHEMISTRY-----			
> IGG		831		510-1275 MG/DL 01/15/15-1655	
> IGM		36.0		35.5-251.3 MG/DL 01/15/15-1655	
> IGE		20.0		0-158 IU/L 01/15/15-1655	

NAI, LLC
Northshore Allergy & Immunology

Richard J. Guillot, M.D.
ABAI, FAAAAI, FACAAI

Patient's Name Jeffrey Bodin Drug/Food Allergies

DATE REVIEWED AND INITIAL CHANGES

MEDICATION	DOSE	FREQ		10/22/12	11/27/13	1/9/15			
Veramyst	[illegible]	[illegible]		✓					
Mucinex				prn	prn	prn			
Zyrtec		prn		[illegible]	prn	prn			
Benadryl		prn		prn	prn	prn			
Prozac	10mg	qd		—	—	—			
Neutrogena AD	[illegible]			✓	✓	✓			
(2 or 3 days/week)									
Allegra				prn	prn	✓			
Singulair	10mg	qd			✓	✓			
Phenobarbital						✓			
Butalbital/Acetam/Caff						✓			
Gabapentin						✓			
Methylphenidate	20mg					✓			
Pataday eye drops		prn				prn			

Update medication record at each visit when patient is seeing Dr. Guillot

INJECTION RECORDS

DATE	NAME	TYPE OF INJECTION
1/27/15	Kenalog 60mg / 1½cc to (R) hip Lot# 1/8/2015	90@% [illegible] 4/8/65

EXHIBIT NO. 2F
PAGE: 3 OF 18

NORTHSHORE ALLERGY & IMMUNOLOGY, LLC

Richard J. Guillot, MD
355 Lakeview Court
Covington, LA 70433
Office: (985) 892-3122
Fax: (985) 892-3394

REQUEST and CONSENT to MEDICAL PROCEDURES

Date: 1/27/15 Time: 12:00 AM / PM

Please Print Clearly When Completing This Section:

1. My diagnosis/conditions are:
   [✓] Allergic Rhinitis [ ] Allergic Reaction
   [ ] Allergic Asthma [✓] Acute Sinusitis
   [ ] Acute Bronchitis [ ] Other _____
2. My recommended procedures are:
   [✓] Kenalog 60 mg [ ] Celestone ____ mg
3. My procedure has been explained by R. Guillot, MD
4. My procedure will be performed/supervised by R.G. (RN)
5. My risks include: bleeding, bruising, infection, soft tissue atrophy (scarring or "dimple in butt"), hypopigmentation, pain, failure of response, need for recurrent treatment, hypersensitivity, increased risk of osteoporosis or other bone conditions (fractures, avascular necrosis or hip or other bones, etc.) with multiple steroid injections.
6. I understand the approximate location of my procedure will be in the gluteal muscles (buttocks or hip area).
7. I have read all of the above and understand the risks. I have been given the chance to ask any questions. I understand the answers and have no other questions. I consent to the following procedures listed in #2 above (initial) JRB.
   Exceptions (to be completed by Provider ONLY): _____

I understand the office will work with me in filing charges with my insurance carrier. I will be responsible for payment of charges not covered by my insurance.

Jeffrey Bodin
Patient Name (please print)

Jeffrey Bodin
Patient/Authorized Representative Signature

1/27/15
Date

Witness

Date

(90) 1/8/2015:90@6 Exp 4/8/15

NORTHSHORE ALLERGY & IMMUNOLOGY, LLC

INFLUENZA VACCINE CONSENT FORM

Please answer the following questions and information below:

1.	Have you ever had a flu shot before?	Yes	or	(No)
2.	Are you allergic to eggs?	Yes	or	(No)
3.	Are you currently taking an antibiotic for infection?	Yes	or	(No)
4.	Do you feel ill today or do you have a fever?	Yes	or	(No)
5.	If you are female, are you pregnant?	Yes	or	(No)
6.	If you are female, are you nursing?	Yes	or	(No)
7.	Have you ever had Guillain-Barre Syndrome (temporary severe muscle weakness) after receiving flu vaccine?	Yes	or	(No)
8.	Any allergy to Thimerosol or Latex?	Yes	or	(No)
9.	Have you had a recent immunization? Name ______ Date ______	Yes	or	(No)
10.	Have you had a bad reaction to a flu shot in the past?	Yes	or	(No)

I hereby certify that the foregoing history is true and complete to the best of my knowledge and request the influenza vaccine. Further, I authorize Northshore Allergy & Immunology, LLC (NAI) to release the fact that I have received a flu shot to my employer. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me.

I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where and why my confidential health information may be used or shared. I acknowledge that NAI, the physician, nurses and other NAI staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern NAI's operations and responsibilities.

Information about person to receive vaccine (please print)

Last Name Babin First Jeffrey MI T

Address 520 Beau Chene Dr

City Mandeville State LA Zip 70471

Birth date 5/22/97 Age 18

Signature of Patient/Authorized Representative [signature]

Relationship if other than patient ______

For Clinic Use: Influenza

DATE VACCINATED: 10/6/15

MANUFACTURER & LOT NUMBER: 151530l

EXPIRATION DATE: 5/2016

SITE OF INJECTION: R / (L) DELTOID ROUTE: IM

SIGNATURE OF VACCINE ADMINISTRATOR: H.J., APN

NORTHSHORE ALLERGY & IMMUNOLOGY, LLC

INFLUENZA VACCINE CONSENT FORM

Please answer the following questions and information below:

1.	Have you ever had a flu shot before?	(Yes)	or	No
2.	Are you allergic to eggs?	Yes	or	(No)
3.	Are you currently taking an antibiotic for infection?	Yes	or	(No)
4.	Do you feel ill today or do you have a fever?	Yes	or	(No)
5.	If you are female, are you pregnant?	~~Yes~~	~~or~~	~~No~~
6.	If you are female, are you nursing?	~~Yes~~	~~or~~	~~No~~
7.	Have you ever had Guillain-Barre Syndrome (temporary severe muscle weakness) after receiving flu vaccine?	Yes	or	(No)
8.	Any allergy to Thimerosol or Latex?	Yes	or	(No)
9.	Have you had a recent immunization? Name _____ Date _____	Yes	or	(No)
10.	Have you had a bad reaction to a flu shot in the past?	Yes	or	(No)

I hereby certify that the foregoing history is true and complete to the best of my knowledge and request the influenza vaccine. Further, I authorize Northshore Allergy & Immunology, LLC (NAI) to release the fact that I have received a flu shot to my employer. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me.

I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where and why my confidential health information may be used or shared. I acknowledge that NAI, the physician, nurses and other NAI staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern NAI's operations and responsibilities.

Information about person to receive vaccine (please print)

Last Name Bodin First Tiffany MI T.

Address 528 Beau Chene Drive

City Mandeville State LA Zip 70471

Birth date 5/22/1997 Age 17

Signature of Patient/Authorized Representative Tyrude A. Bod

Relationship if other than patient mother

For Clinic Use: Influenza

DATE VACCINATED: _____

MANUFACTURER & LOT NUMBER: Novartis 13102D1

EXPIRATION DATE: 5/2014

SITE OF INJECTION: R / L DELTOID ROUTE: IM

SIGNATURE OF VACCINE ADMINISTRATOR: _____

Northshore Allergy & Immunology, LLC

PROGRESS NOTE

NAME: Boston, Jeffrey

1/20/15

Skin testing: here for full ST + possible reformulation or add new 3RD vaccine. C/O ↑ Nasal/sinus congestion, PND, sneezing, pressure ⊕ yellow-greenish nasal D/c. Has had ↑ RTI's over the past year ē multiple ATBx's (≥4) ✶ for sinusitis ON, & 4 steroid injections. Labs ordered for Immune deficiency W/u. still ō migraine HA's recurring often.

ROS/ HEENT: Ears TMs clear (B) Bare Serythema
Nose - hyperemic nasal mucosa ē edematous turbinates ō yellow-greenish D/c
Throat ⊕ PND (mild)
Sinuses ⊕ maxillary + frontal tenderness on percussion
Neck: Supple, FROM, Ø adenopathy
CV RRR ō M/G
Chest: CTA (B)

Tetanus 0.40 (Protective)
IgG3 - 33 mg/dl (41-129)
All other were Pneumococcal Ab's (B)

Impr: 1) Acute Sinusitis
2) PAR, PND, AC
3) r/o recurrent/frequent RTI's ē low IgG3, Immunodeficiency, Unspec
4) Migraine HA's

Plan: 1) Needs Pneumovax or Prevnar 13, then ✓ post Ab's in 4-6 weeks, ? IVIG or SQ Ig
2) Continue present meds
{ (L) + (R) allergy vaccines q 2-4 weeks
3) Add new 3RD (L) q weekly per protocol.
4) Rx 4-6 weeks, Zmax 500mg [illegible]

[signature]

Northshore Allergy & Immunology, LLC

PROGRESS NOTE

Walking Pneumonia [illegible]
CVG < 7 ATBx's over past yr (sinusitis, OM) steroid shots x4

NAME: Boden, Jeffrey

1/7/15 wgt 101 hgt 5' 7½"

Annual

- as always doing OK c̄ allergy shots q 2-4 weeks (mostly q 1-2 weeks b/c ↑AR sx's past q 2 weeks). No problems c̄ local rxns. ↑RTI's over the past year (tx'd by Peds (Dr Sherri Casey)) ~7 ATBx's over past year for sinusitis + OM episodes, 4 steroid injections by Dr Casey over past year. ⊕ h/o walking pneumonia @ 4 yrs. Still needs frequent daily allergy meds. No problems c̄ GERD or BB Sx's. ⊕ h/o melanoma resection of Ⓛ ankle + lymph node resection (3/08), s/p Interferon therapy. Continues c̄ frequent/recurrent migraine HA's

PE: HEENT: Ears TM's clear Ⓑ Eyes ∅ erythema
Nose - pale, mild turbinate edema
Throat ⊕ PND (mild)
Sinuses NT
Neck: Supple, FROM ∅ adenopathy or nuchal rigidity
CV: RRR s̄ m/G
Chest: CTA Ⓑ

Imp: 1) PAR
2) h/o recurrent/frequent RTI's - R/O Immunodeficiency, unspec
3) PND
4) AC
5) Migraine HA'S

Plan: 1) Continue present meds
2) Needs repeat ST (A→H), ? foods; ? reformulate or new 3RD
3) Labs: IgA, E, M, G (total), IgG 1-4, Tetanus + Pneumococcal Ab's
4) F/u in [illegible] weeks for ST

R Drullett, MD

Northshore Allergy & Immunology, LLC

PROGRESS NOTE

Singulair - Helpful

NAME: Boden, Jeffrey

11/27/13 Wgt: 110 lbs 5 1/2

Annual

as above; feeling well overall from AR standpoint. Allergy shots q 2-4 weeks s problem; Patient & mother (Linda) feel like allergy injections have been, and are, Helpful! Improved QOL, No RTI's or need for ATBx's over past year. Non-nasal ICS (doesn't like); uses allegra or zyrtec q daily. ↓ migraine HA's c less AR Sxs. No GI issues recently.

PE: NAD; Ears (R) EAC c cerumen impaction; (L) TM clear
Eyes - mild conjunctival erythema
Nose - pale, mod edematous turbinates
Throat (+) PND (mild)
Airway NP
Neck: Supple, FROM, (-) nuchal rigidity or adenopathy
CV: RRR s M/G
Chest: CTA (B)

Impr 1) PAR, AC } much improved c IT
2) PND
3) Migraine HA's
4) GB (stable)
5) (R) EAC Cerumen Impaction

Plan 1) Pataday eye gtts 0.2% 1-2 gtt(s) in eyes qd
2) Continue other meds
allergy injections q 2-4 weeks
3) Epi (v) yearly (summer prn)
Refer to Ped or ENT for cerumen removal

[signature], MD

Northshore Allergy & Immunology

PROGRESS NOTE

NAME: Boden, Jeffrey

10/22/12 wgt: 110 hgt: 5'5½"

Annual

– as always doing very well overall c̄ Ivx Injections (2) q 4 weeks – s̄ problems. No local rxns. Using less meds. No RI's or need for ATBx's over the past year. No recent HA's – much improved c̄ Ivx. Past few days c̄ sore throat, PND, No Fx; other family members ill too

PE: HEENT Ears TM's clear (B)
Nose pale nonedematous turbinates
Throat ⊕ PND, mild erythema, ∅ exudate
Sinuses NT
Neck: supple, ∅ adenopathy
CV: RRR
Chest CTA (B)

Imp: 1) PAR
2) PND
3) Migraine HA's
4) BB (stable)

} much improved c̄ Ivx

Plan: 1) Continue present meds
2) If sore throat sxs worsen, begin Z-Pak x 5d
3) Continue allergy injections q 6 – 4 weeks
4) F/u @ yearly (sooner prn)

[signature] MD

NAI – 1

Northshore Allergy & Immunology

PROGRESS NOTE

NAME: Bodin, Jeffrey

11/8/11 9D#

- annual visit
- Shots @ maintenance
- Ø sinus infection
- Mucinex
- Allegra
- Ø nasal spray ↗ is better
- Some ⊕ PND + headache

- [illegible] doing much better overall on allergy vaccine q weekly. Some local rxns (both arms) last few weeks. Otherwise no problem c injections. Not ill over the past year! No RTI's or need for ATBx's. Fewer migraine HA's as well. Only using Mucinex & Allegra.

PE: HEENT: [illegible] edematous turbinates
Throat - mild PND
Sinuses NT
Neck: supple, Ø adenopathy
CV: RRR
Chest: CTA (B)

Impression: 1) PAR } improved c Dx!
2) PND
3) Migraine HA's (stable, improved)
4) Eosinophilic Gastroenteritis / Colitis
5) H/o Malignant Melanoma ⓡ Ankle, 1 excision & S/P Interferon Tx

Plan: 1) Continue present meds (try to wean off to prn)
allergy injections q 1-2 weeks

NAI-1 [illegible]

PROGRESS NOTE

NAME: Bodin, Jeffrey

11/8/10

- here for skin testing
- Ø antihistamines X 7days
- [illegible] here for full ST. Continues allergy injections from Ochsner ([illegible]); no problems c shots; no [illegible]. No change in AR Sx. No recent [illegible] or need for Ab Rx since last OV (7/29/10). Still c occasional migraine HA.

PE: HEENT Unchanged
Neck
CV
Chest

Imp 1) PAR
2.) PND
3.) Migraine HA
4.) Eosinophilic Gastroenteritis / Colitis
5.) h/o Malignant Melanoma (R ankle), + excision + S/P Interferon Tx

Plan 1.) ST A → H
2.) Continue present meds
3.) Reformulate new vaccine p today's ST
4.) RTC @ 3rd vial

[signature] MD

7/29/10

PROGRESS NOTE

NAME: Jeffrey Bodin

C/o ear feels like it has fluid in both of them. Mom states will be flying out on Saturday and would like them checked.

— as above; past few days c̄ c/o (B) ear fluid, like some fluid stuck in ears, some popping of ears, some nasal congestion + PND. Feeling better today. Only uses Veramyst prior leaving in 2 days for Canada

PEx: HEENT: Ears TMs clear (B) Ø effusion or bulging or retraction

Nose – pale edematous turbinates

Throat (+) PND

Skin: NT

Neck supple — CKRRR

Chest: CTA (B)

Imp: 1) PAR

2) ETD

3) Migraine HA's

4) Eosinophilic Gastroenteritis / Colitis

5) h/o Malignant Melanoma (L) ankle), + excision + s/p Interferon Tx

Plan: 1) Use Veramyst daily

2) Afrin nasal spray + Sudafed pre-flight + prn

3) Continue all other Tx

c̄ Allergy shots weekly @ Ochsner

4) F/u prn

R. Baillot, MD

NAI, LLC
Northshore Allergy & Immunology, LLC

ALLERGY QUESTIONNAIRE

Richard J. Guillot, M.D.
804 Heavens Dr. Ste. 203
Mandeville, LA 70471
Office (985) 792-4022
Fax (985) 792-4007

Please complete this form and bring it with you on your first visit

NAME Jeffrey Bodin.

Address 528 Beauchene Dr. Age 13

Telephone (home) 845-0969 Referred by Dr. Sherri Casey & Alison Statton

Symptoms:

Please check all current symptoms

[ ] Sneezing	[ ] Itching of the throat	[ ] Rash
[ ] Watery eyes	[ ] Frequent clearing of throat	[X] Headache
[ ] Runny nose	[ ] Shortness of breath	[ ] Sinus infection
[✓] Post nasal drip	[ ] Coughing	[ ] Nausea
[ ] Blocked nose	[ ] Wheezing	[ ] Diarrhea
[ ] Itching of the nose	[ ] Swelling of the eyelids	[ ] Stomach cramps
[ ] Itching of the eyes	[ ] Swelling of the lips	
[ ] Itching of the ears	[ ] Swelling of the body	

Please answer these questions as they apply to the symptoms which you have checked:

When did these symptoms first occur? ?

How often and when do the symptoms occur?

Is there any seasonal variation in your symptoms, and if so, when are they worse? maybe

Is there a particular time of day or night when the symptoms are worse? morning ?

Is there anything that you have identified which can cause symptoms or make them worse? Change in pressure in weather ?

What medications help to control your allergic symptoms? (Please list them here) mucinex, motrin, zyrtec, benadryl ?

Medical History:

Have you ever had:

[ ] Hay fever	[ ] Asthma	[X] Ear infections
[ ] Croup	[ ] Hives	[ ] Pneumonia
[ ] Bronchitis	[X] Sinus infections	[ ] Sensitivity to insect stings

(over)

Have you ever had allergy tests? [ ] NO [X] YES (if yes, when)

Have you ever had allergy shots? [ ] NO [X] YES (if yes, when)

Food History

Are you aware of any foods that may cause you symptoms? [X] NO [ ] YES (if yes, list food and type of reaction)

Drug History

Have you ever had any reactions to any drug? [X] NO [ ] YES (if yes, list drug and type of reaction)

Family History

Do any of these members of your family have allergies and /or asthma?

[X] Mother allergies [X] Grandparent(s) allergies [ ] Brother(s)
[ ] Father [ ] Aunt(s) or Uncle(s) [ ] Sister(s)

Home Environment

How long have you lived at your current residence? 13 years

Has your residence ever had water or flood damage? [ ] Yes [X] No

Does your house have:

[X] Central air conditioning [ ] A basement [ ] Electric heat
[ ] Window A/C units [ ] Electrostatic air cleaner
[X] Attic Fan [X] Gas heat

Does your bedroom have:

[X] Carpeting [X] Ceiling fan
[X] Plastic mattress cover [X] Venetian (mini) blinds
[ ] Stuffed animals [ ] Potted plants

Circle the type of pillow you sleep on: Feather Foam Fiberfill (Hollofil) Other

w/allergy protectors

Do you have a :

[X] Cats [ ] Bird
[ ] Dog [ ] Other animals(if yes, what?)

Does being around your pet aggravate your allergic symptoms? [X] NO [ ] YES

Are the pets inside in the house, outside the house or both?

Do you or any household member smoke ? [ ] Yes [X] No

Occupation _____

If patient is an infant or child, is he or she in day care? [ ] Yes [X] No

Is there anything else that might be important for the doctor to know ?

Jeffry has a history of cancer (malignant melanoma, stage III) Had two surgeries and treatment for this in 2008. He remains clear / free of cancer but returns to MD Anderson every 6 mos. for follow-up apts. and scans. Also, sees Dr. Pouw, endocrinologist,

EXHIBIT NO. 2F
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Northshore Allergy & Immunology
Physician: Richard J. Gould(?), MD

PT NAME: Budin, Jeffrey AGE: 13 DATE: 7/12/10
REFERRED BY: DATE OF BIRTH: 5/22/97

REASON FOR VISIT:

- allergy shots @ Ochsner; 13 y.o. young man (WM)
- ō long h/o PAR; started [illegible] 3 weeks ago @ Ochsner, ⊕ h/o recurrent URIs (ATBx's for OM + sinusitis ~3-4x/yr). No h/o recurrent or chronic chest sx/ & asthma, ∅ nebulizer, ∅ pneumonia. ⊕ AR sx: nasal/sinus congestion, sinus HAs, ear pressure (BT). ⊕ h/o Melanoma excision dx'd age 10, ō 2 operations for resection + lymph node dissection ⊕ leg ō subsequent interferon (IV x 20 days then SubQ, but had to D/C early 2° to seizures + tics).

Pulse Ox:

PMHx: as above
[illegible] ⊕ AR (mother + father)

PHYSICAL EXAM BP PULSE TEMP O2 Sat: WEIGHT 73#

T.B. skin test ☐ yes ☐ no Results: ______
Pneumovax ☐ yes ☐ no Date: ______ Flu shot ☒ yes ☐ no Date: Aug 2009
H1N1 Aug 2009

MEDICAL ILLNESSES	SURGICAL PROCEDURES	MEDICATIONS
Malignant Melanoma 3/08 (age 10)	- 2 Surgeries on leg for melanoma	- Prozac 10mg
⊕ OM episodes	- tonsils	- Veramyst
BT	- adenoids	Neutrogena AQ daily (6 days/week)
AR	- tubes (PET's)	Mucinex
Migraine HAs	- appendectomy	Zyrtec or Benadryl } prn

ALLERGIES: NKDA, NKFA, ⊕ Mosquito (S) (large local rxn)
(↑ GI upset ō multiple ATBx's)

PT NAME: DATE:

Occupational History: Student	General (pos/abn): weight change, malaise, fever/chills, night sweats, loud snoring, hypersomnolence — Ø fever/chills, sweats [illegible], somewhat [illegible], Neutrogena
Exercise habits: N/C	Neurologic: headache, syncope, dizziness, seizures — Ø Migraine HAs; seizures → [illegible] Interferon [illegible]
Dietary habits: N/C	
Educational level (indicate highest level): 7th grade; ___ years college; ___ professional	Skin: rashes/lesions — N/C
Tobacco ☐ yes ☒ no — Ø in house	Eyes: vision — WNL
Alcohol ☐ yes ☒ no	Ears: hearing — WNL
Drug use ☐ yes ☒ no	Noses/Sinuses: rhinitis, sinus pain — Ø PND, [illegible]
Travel/pets: 2 cats	Throat: hoarseness, dysphagia, choking, pain — Ø PND
Family History: ✓ single ___ married ___ divorced ___ widowed ___ separated	Cardiac: chest pain, PND, orthopnea, palpitations, pedal edema — Ø chest Sxs
Children: Ø	
Father: ☑ living ☐ deceased; Illnesses: allergies	GI: nausea/vomiting, pain, bowel habits, hematemesis, rectal bleeding — NR (Ø Ø Ø Ø Ø [illegible])
Mother: ☑ living ☐ deceased; Illnesses: allergies	
Siblings: sister - Ø allergies	GU: hematuria, dysuria, nocturia — N/C
	GYN: LMP __/__/__ menopause ___
Yes: Asthma ☐; Allergies ☑; COPD ☐; Tuberculosis ☐; Diabetes ☐; Hypertension ☐; Heart disease ☐; Cancer ☐	Musculoskeletal: pain, pedal edema, varicosities, back pain — N/C
	Hemopoetic: bruising, bleeding — N/C

NAME: Jeffrey Bodin DATE: 7/12/10

General	NAD, AA Ox3	**Heart** rhythm sounds murmurs PMI clicks rubs	RRR s m/G
Skin rash lesions	∅ lesions noted		
HEENT eyes pupils ears nasal mucosa sinuses oral mucosa throat dentures	PERRLA, EOMI; ⊕ allergic shiners; TMs clear; pale, edematous turbinates; ⊕ PND/cobblestoning; N/A (sinuses); NTA (dentures)	**Abdomen** liver spleen masses tenderness distention inguinal nodes	Deferred
NECK trachea thyroid cervical nodes	Supple, FROM ∅ adenopathy	**Genital / Rectal** masses other	
CHEST pa diameter kyphosis br. sounds crackles wheezes axillary nodes	CTA(B)	**Extremities** edema clubbing tenderness cord / Homan's	∅ C, C, or E
		Neurologic mental status strength gait reflexes	Grossly Intact
X-rays			
Pulmonary function tests			

Findings: 1) PAR
2) ETD
3) Migraine HA's
4) Eosinophilic Gastroenteritis / Colitis (only ⊕ STt salmon, apple)
5) h/o Malignant Melanoma (⊕ ankle) s/ excision, s/p Interferon

Plan: 1) Review records from Ochsner, need ST results + allergy vaccine formula
2) Continue present meds + allergy shots (@ Ochsner until allergy vaccine can be obtained from Ochsner)

Return to clinic prn

Letter to: Dr. Sherri Casey

Refer to:

Orders:

Sleep study			
MSLT			
CPAP titration			
Home O2 LPM			
Concentrator LPM			
Portable O2 LPM			
Nebulizer: Atrovent			
Albuterol			
Chest x-ray			
CT Chest Contrast			
No Contrast			
CT Sinus No Contrast			
Barium Swallow			
CBC		ESR	
BMP		CMP	
Liver Profile		PT / PTT	
Magnesium		Calcium	
Rheumatoid Factor			
PPT			

Return Appt. Recall

CN

Richard J. Grillot 7/12/10
M.D. SIGNATURE

FAX TRANSMITTAL

NORTHSHORE ALLERGY & IMMUNOLOGY, LLC
Richard J. Guillot, MD
355 Lakeview Court
Covington, LA 70433
PHONE: (985) 892-3122
FAX: (985) 892-3394

Date: 8/8/17

Pages Including Cover Sheet:

Attention: children & family Services

From:

Fax Number: 1866 4442216

Regarding: Bodin, Jeffrey 5/22/97

EXHIBIT NO. 3F
PAGE: 1 OF 14

FAX TRANSMITTAL

NORTHSHORE ALLERGY & IMMUNOLOGY, LLC
Richard J. Guillot, MD
355 Lakeview Court
Covington, LA 70433
PHONE: (985) 892-3122
FAX: (985) 892-3394

Date: 8/8/17

Pages Including Cover Sheet:

Attention: children & family Services

From:

Fax Number: 1866 444 2216

Regarding: Bodin, Jeffrey 5/22/97

NAI, LLC Richard J. Gui[illegible] [illegible]D
355 Lakeview Court
Covington, LA 70433
Ofc: (985) 892-3122
Fax: (985) 892-3394

79G

Patient Name: Boden, Jeffrey
Date of Birth: 5/22/97
Dx:
Dx:
Phone #:

The following allergen vaccines have been issued for treatment:
Vaccine 1: (L) CrDmm2T3G2W2 Expiration Date: 2/3/16
Vaccine 2: Expiration Date:
Vaccine 3: Expiration Date:
Vaccine 4: Expiration Date:

Give injection in intervals of twice a week for "Silver Vials" and thereafter once a week following dosages below.

Vial	#7	#6	#5	#4	#3	#2	#1	
Color Top	SILVER	SILVER	SILVER	GREEN	BLUE	YELLOW	RED	
Concentration	(1:1,000,000)	(1:100,000)	(1:10,000)	(1:1,000)	(1:100)	(1:10)	(1:1)	
Dosages	0.025	0.025	.0.025	0.025	0.025	0.025	0.025	
	0.05	0.05	0.05	0.05	0.05	0.05	0.05	
	0.10	0.10	0.10	0.10	0.10	0.10	0.10	
	0.20	0.20	0.20	0.20	0.20	0.20	0.20	Maintenance dose
	0.30	0.30	0.30	0.30	0.30	0.30		
	0.40	0.40	0.40	0.40	0.40	0.40		

Comments:

Date	VACCINE 1: (L) CrDmm2T3G2W2				VACCINE 2:				VACCINE 3:				PEFR	Initial of person giving injection
mm/dd/yy	Vial#	amt.	ARM L or R	grade of local reaction	Vial#	amt.	ARM L or R	grade of local reaction	Vial#	amt.	ARM L or R	grade of local reaction		
2/11/15	#6	0.025	O											
3/4/15	#6	0.05	O											[illegible]
3/9/16	#6	0.10	O											[illegible]
3/12/15	#6	0.10	O											[illegible]
3/31/15	#6	0.20	O											[illegible]
4/16/15	#6	0.30	O											[illegible]
4/21/15	#6	0.40	O											[illegible]
5/7/15	#5	0.025	O											[illegible]
5/11/15	#5	0.05	O											[illegible]
5/18/15	#5	0.10	O											[illegible]
6/1/15	#5	0.20	O											[illegible]
6/17/15	#5	0.30	O											[illegible]
6/24/15	#5	0.40	O											[illegible]
7/13/15	#4	0.025	O											[illegible]
7/28/15	#4	0.05	O											[illegible]
8/5/15	#4	0.10	O											[illegible]
8/10/15	#4	0.20	O											[illegible]
8/17/15	#4	0.30	O											[illegible]
8/24/15	#4	0.40	O											[illegible]
9/13/15	#3	.025	O											[illegible]
9/14/15	#3	0.05	O											[illegible]
9/21/15	#3	0.10	O											[illegible]
9/28/15	#3	0.20	O											[illegible]
10/[illegible]/15	#3	0.30	[illegible]											

NAI, LLC **Richard J. Guillot MD**
355 Lakeview Court
Covington, LA 70433
Ofc: (985) 892-3122
Fax: (985) 892-3394

Patient Name: ____________________
Date of Birth: ____________________
Dx: ____________________
Dx: ____________________
Phone # ____________________

The following allergen vaccines have been issued for treatment:

Vaccine 1: ____________________ Expiration Date: ____________________
Vaccine 2: ____________________ Expiration Date: ____________________
Vaccine 3: ____________________ Expiration Date: ____________________
Vaccine 4: ____________________ Expiration Date: ____________________

Give injection in intervals of twice a week for "Silver Vials" and thereafter once a week following dosages below.

Vial	#7	#6	#5	#4	#3	#2	#1
Color Top	SILVER	SILVER	SILVER	GREEN	BLUE	YELLOW	RED
Concentration	(1:1,000,000)	(1:100,000)	(1:10,000)	(1:1,000)	(1:100)	(1:10)	(1:1)
Dosages	0.025	0.025	0.025	0.025	0.025	0.025	0.025
	0.05	0.05	0.05	0.05	0.05	0.05	0.05
	0.10	0.10	0.10	0.10	0.10	0.10	0.10
	0.20	0.20	0.20	0.20	0.20	0.20	0.20 Maintenance dose
	0.30	0.30	0.30	0.30	0.30	0.30	
	0.40	0.40	0.40	0.40	0.40	0.40	

Comments: ____________________

Date mm/dd/yy	VACCINE 1: Vial#	VACCINE 1: amt.	VACCINE 1: ARM L or R	VACCINE 1: grade of local reaction	VACCINE 2: Vial#	VACCINE 2: amt.	VACCINE 2: ARM L or R	VACCINE 2: grade of local reaction	VACCINE 3: Vial#	VACCINE 3: amt.	VACCINE 3: ARM L or R	VACCINE 3: grade of local reaction	PEFR	Initial of person giving injection
1/3/15	#7	0.025	(L)											[illegible]
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EXHIBIT NO. 3F
PAGE: 4 OF 14

NAI, LLC Richard J. Guil[illegible] D
355 Lakeview [illegible]
Covington, LA 70433
Ofc: (985) 892-3122
Fax: (985) 892-3394

805

Patient Name: Baden [illegible]
Date of Birth: 5/22/91
Dx: Mosquito - T63.481A
Dx:
Phone #

The following allergen vaccines have been issued for treatment:

Vaccine 1:	(2) DMMT	Expiration Date:	2/3/16
Vaccine 2:	(2) GW mosq	Expiration Date:	2/3/16
Vaccine 3:		Expiration Date:	
Vaccine 4:		Expiration Date:	

Give injection in intervals of twice a week for "Silver Vials" and thereafter once a week following dosages below.

Vial	#7	#6	#5	#4	#3	#2	#1
Color Top	SILVER	SILVER	SILVER	GREEN	BLUE	YELLOW	RED
Concentration	(1:1,000,000)	(1:100,000)	(1:10,000)	(1:1,000)	(1:100)	(1:10)	(1:1)
Dosages	0.025	0.025	0.025	0.025	0.025	0.025	0.025 —
	0.05	0.05	0.05	0.05	0.05	0.05	0.05
	0.10	0.10	0.10	0.10	0.10	0.10	0.10
	0.20	0.20	0.20	0.20	0.20	0.20	0.20 Maintenance dose
	0.30	0.30	0.30	0.30	0.30	0.30	0.25 maintenance dose
	0.40	0.40	0.40	0.40	0.40	0.40	

Comments:

Date	VACCINE 1: (2) DMMT				VACCINE 2: (2) GW Mosq				VACCINE 3:				PEFR	Initial of person giving injection
mm/dd/yy	Vial#	amt.	ARM L or R	grade of local reaction	Vial#	amt.	ARM L or R	grade of local reaction	Vial#	amt.	ARM L or R	grade of local reaction		
2/11/15	#1	0.025	L		#1	0.025	R							
3/4/15	#1	0.05	L		#1	0.05	R							
3/19/15	#1	0.10	L		#1	0.10	R							
3/26/15	#1	0.20	L		#1	0.20	R							
4/2/15	#1	0.20	L		#1	0.20	R							
4/10/15	#1	0.20	L		#1	0.20	R							
4/21/15	#1	0.20	L		#1	0.20	R							
5/7/15	#1	0.20	L		#1	0.20	R							
5/11/15	#1	0.20	L		#1	0.20	R							
5/18/15	#1	0.20	L		#1	0.20	R							
6/1/15	#1	0.20	L		#1	0.20	R							
6/17/15	#1	0.20	L		#1	0.20	R							
6/24/15	#1	0.20	L		#1	0.20	R							
7/1/15	#1	0.20	L		#1	0.20	R							
7/8/15	#1	0.20	L		#1	0.20	R							
7/22/15	#1	0.20	L		#1	0.20	R							
8/5/15	#1	0.20	L		#1	0.20	R							
8/12/15	#1	0.20	L		#1	0.20	R							
8/19/15	#1	0.20	L		#1	0.20	R							
8/26/15	#1	0.20	L		#1	0.20	R							
9/9/15	#1	0.20	L		#1	0.20	R							
9/16/15	#1	0.20	L		#1	0.20	R							
9/23/15	#1	0.25	L		#1	0.25	R							
9/30/15	#1	0.25	L		#1	0.25	R							
10/7/15	#1	0.25	L		#1	0.25	R							

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NAI, LLC **Richard J. Guillot**
355 Lakeview Cou...
Covington, LA 70433
Ofc: (985) 892-3122
Fax: (985) 892-3394

Patient Name: ______________
Date of Birth: ______________
Dx: ______________
Dx: ______________
Phone # ______________

The following allergen vaccines have been issued for treatment:

Vaccine 1: ______________ Expiration Date: ______________
Vaccine 2: ______________ Expiration Date: ______________
Vaccine 3: ______________ Expiration Date: ______________
Vaccine 4: ______________ Expiration Date: ______________

Give injection in intervals of twice a week for "Silver Vials" and thereafter once a week following dosages below.

Vial	#7	#6	#5	#4	#3	#2	#1
Color Top	SILVER	SILVER	SILVER	GREEN	BLUE	YELLOW	RED
Concentration	(1:1,000,000)	(1:100,000)	(1:10,000)	(1:1,000)	(1:100)	(1:10)	(1:1)
Dosages	0.025	0.025	0.025	0.025	0.025	0.025	0.025
	0.05	0.05	0.05	0.05	0.05	0.05	0.05
	0.10	0.10	0.10	0.10	0.10	0.10	0.10
	0.20	0.20	0.20	0.20	0.20	0.20	0.20 Maintenance dose
	0.30	0.30	0.30	0.30	0.30	0.30	
	0.40	0.40	0.40	0.40	0.40	0.40	

Comments: ______________

Date	VACCINE 1:				VACCINE 2:				VACCINE 3:				PEFR	Initial of person giving injection
mm/dd/yy	Vial#	amt.	ARM L or R	grade of local reaction	Vial#	amt.	ARM L or R	grade of local reaction	Vial#	amt.	ARM L or R	grade of local reaction		
11/13/15	#1	0.20	(L)		#1	0.20	(L)							[illegible]
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EXHIBIT NO. 3F
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NAI, LLC Richard J. Guillo[illegible] D
355 Lakeview Cour[illegible]
Covington, LA 70433
Ofc: (985) 892-3122
Fax: (985) 892-3394

Patient Name: [illegible] Baden [illegible]
Date of Birth: 5/22/91
Dx:
Dx:
Phone #

The following allergen vaccines have been issued for treatment:

Vaccine 1: (C) DM mt — Expiration Date: 2/3/16
Vaccine 2: (R) GW mosq. — Expiration Date: 2/3/16
Vaccine 3: — Expiration Date:
Vaccine 4: — Expiration Date:

83B

Give injection in intervals of twice a week for "Silver Vials" and thereafter once a week following dosages below.

Vial	#7	#6	#5	#4	#3	#2	#1
Color Top	SILVER	SILVER	SILVER	GREEN	BLUE	YELLOW	RED
Concentration	(1:1,000,000)	(1:100,000)	(1:10,000)	(1:1,000)	(1:100)	(1:10)	(1:1)
Dosages	0.025	0.025	0.025	0.025	0.025	0.025	0.025
	0.05	0.05	0.05	0.05	0.05	0.05	0.05
	0.10	0.10	0.10	0.10	0.10	0.10	0.10
	0.20	0.20	0.20	0.20	0.20	0.20	0.20 Maintenance dose
	0.30	0.30	0.30	0.30	0.30	0.30	0.25 Maintenance dose
	0.40	0.40	0.40	0.40	0.40	0.40	

Comments:

Date mm/dd/yy	VACCINE 1: (C) DM mt Vial#	amt.	ARM L or R	grade of local reaction	VACCINE 2: (R) GW mosq Vial#	amt.	ARM L or R	grade of local reaction	VACCINE 3: Vial#	amt.	ARM L or R	grade of local reaction	PEFR	Initial of person giving injection
2/11/15	#1	0.025	(L)		#1	0.025	(R)							
2/18/15	#1	0.05	(L)		#1	0.05	(R)							
2/24/15	#1	0.10	(L)		#1	0.10	(R)							
3/4/15	#1	0.20	(L)		#1	0.20	(R)							
3/11/15	#1	0.20	(L)		#1	0.20	(R)							
3/18/15	#1	0.20	(L)		#1	0.20	(R)							
3/25/15	#1	0.20	(L)		#1	0.20	(R)							
4/1/15	#1	0.20	(L)		#1	0.20	(R)							
4/8/15	#1	0.20	(L)		#1	0.20	(R)							
4/15/15	#1	0.20	(L)		#1	0.20	(R)							
4/22/15	#1	0.20	(L)		#1	0.20	(R)							
4/29/15	#1	0.20	(L)		#1	0.20	(R)							
5/6/15	#1	0.20	(L)		#1	0.20	(R)							
5/13/15	#1	0.20	(L)		#1	0.20	(R)							
5/20/15	#1	0.20	(L)		#1	0.20	(R)							
5/27/15	#1	0.20	(L)		#1	0.20	(R)							
6/3/15	#1	0.20	(L)		#1	0.20	(R)							
6/10/15	#1	0.20	(L)		#1	0.20	(R)							
6/17/15	#1	0.20	(L)		#1	0.20	(R)							
6/24/15	#1	0.20	(L)		#1	0.20	(R)							
7/1/15	#1	0.20	(L)		#1	0.20	(R)							
7/8/15	#1	0.20	(L)		#1	0.20	(R)							
7/15/15	#1	0.20	(L)		#1	0.20	(R)							
7/22/15	#1	0.20	(L)		#1	0.20	(R)							
7/29/15	#1	0.20	(L)		#1	0.20	(R)							
8/5/15	#1	0.20	(L)		#1	0.20	(R)							
8/12/15	#1	0.20	(L)		#1	0.20	(R)							
8/19/15	#1	0.20	(L)		#1	0.20	(R)							
8/26/15	#1	0.20	(L)		#1	0.20	(R)							
9/2/15	#1	0.20	(L)		#1	0.20	(R)							
9/9/15	#1	0.20	(L)		#1	0.20	(R)							
9/16/15	#1	0.20	(L)		#1	0.20	(R)							
/ /														
/ /														
/ /														
/ /														

NAI, LLC Richard J. Guilly[illegible]
355 Lakeview C[illegible]
Covington, LA 70433
Ofc: (985) 892-3122
Fax: (985) 892-3394

Patient Name: Bodin [illegible]
Date of Birth: 5/22/97
Dx:
Dx:
Phone #

83C

The following allergen vaccines have been issued for treatment:

Vaccine 1: (D) Cr Dm m2 T3 G2 W2 Expiration Date: 2/3/16
Vaccine 2: Expiration Date:
Vaccine 3: Expiration Date:
Vaccine 4: Expiration Date:

Give injection in intervals of twice a week for "Silver Vials" and thereafter once a week following dosages below.

Vial	#7	#6	#5	#4	#3	#2	#1
Color Top	SILVER	SILVER	SILVER	GREEN	BLUE	YELLOW	RED
Concentration	(1:1,000,000)	(1:100,000)	(1:10,000)	(1:1,000)	(1:100)	(1:10)	(1:1)
Dosages	0.025	0.025	0.025	0.025	0.025	0.025	0.025
	0.05	0.05	0.05	0.05	0.05	0.05	0.05
	0.10	0.10	0.10	0.10	0.10	0.10	0.10
	0.20	0.20	0.20	0.20	0.20	0.20	0.20 Maintenance dose
	0.30	0.30	0.30	0.30	0.30	0.30	
	0.40	0.40	0.40	0.40	0.40	0.40	

Comments:

Date	VACCINE 1: (D) Cr Dm m2 T3 G2 W2				VACCINE 2:				VACCINE 3:				PEFR	Initial of person giving injection
mm/dd/yy	Vial#	amt.	ARM L or R	grade of local reaction	Vial#	amt.	ARM L or R	grade of local reaction	Vial#	amt.	ARM L or R	grade of local reaction		
2/11/15	#6	0.025	O											
3/4/15	#6	0.05	O											[illegible]
3/19/15	#6	0.10	O											[illegible]
3/24/15	#6	0.10	O											[illegible]
3/31/15	#6	0.20	O											[illegible]
4/16/15	#6	0.30	O											[illegible]
4/21/15	#6	0.40	O											[illegible]
5/7/15	#5	0.025	O											[illegible]
5/11/15	#5	0.05	O											[illegible]
5/18/15	#5	0.10	O											[illegible]
6/1/15	#5	0.20	O											[illegible]
6/17/15	#5	0.30	O											[illegible]
6/24/15	#5	0.40	O											[illegible]
7/13/15	#4	0.025	O											[illegible]
7/20/15	#4	0.05	O											[illegible]
8/5/15	#4	0.10	O											[illegible]
8/10/15	#4	0.20	O											[illegible]
8/17/15	#4	0.30	O											[illegible]
8/24/15	#4	0.40	O											[illegible]
9/8/15	#3	0.025	O											[illegible]
9/14/15	#3	0.05	O											[illegible]
/ /														
/ /														
/ /														
/ /														

Richard J. Guillot, MD
Northshore Allergy & Immunology, LLC
355 Lakeview Court, Covington, LA 70433
Office: (985) 892-3122 Fax: (985) 892-3394

Patient Name: Boden, Jeffrey Date of Birth: 5 22 97
Testing Technician: Hawkins, LPN
Last use of antihistamine (or other med affecting response to histamine): >5 days
Medication Zyrtec, Benadryl, Pataday
Testing Date and Time: 1 12 2018 3:50 AM PM

General Information about skin test protocol:
1. Percutaneous reported as: Allergen: Testing concentration MTT-PC X= new
   Location: back ✓ arm ____ Device: ____________
2. Intradermal: 0.____ ml injected, Location: arm Testing concentration: 1:____ w/v or BAU or AU/ml, PNU
3. Results Longest diameter (Left in this example) or longest diameter and orthogonal diameter (Right in this example) of wheal and erythema (flare) measured in millimeters at 15 minutes

Blank in results column indicates test was not performed, 0 = negative

	Allergen	Percutaneous wheal (mm)	Percutaneous flare (mm)	Intradermal wheal (mm)	Intradermal flare (mm)		Allergen	Percutaneous wheal (mm)	Percutaneous flare (mm)	Intradermal wheal (mm)	Intradermal flare (mm)
A						E					
8	Positive Control	7				8	Negative Control	—			
7	Cocklebur	—				7	Red Mulberry	—			
6	Ragweed Mix	—				6	Red Maple	—			
5	Pecan Tree ✓X	7	X .15			5	American Elm	—			
4	Va. Live Oak ✓X	7	.15			4	Box Elder ✓X	7	.15		
3	Bahia Grass	—				3	River Birch	—			
2	Timothy Grass	—				2	White Ash	—			
1	Negative Control	—				1	Ligustrum (Privet)	—			
B						F					
8	Negative Control	—				8	Negative Control	—			
7	Mixed Feathers	—				7	Cedar, Red	—			
6	Cottonwood, Eastern X	7	X .15			6	American Beech	—			
5	Cockroach ✓X	7	X .15			5	Black Willow	—			
4	D. Pterony ✓X	11	.20			4	Sycamore, Am./East	—			
3	D. Farinae ✓X	9	.20			3	Sweet Gum	—			
2	Cat Hair	—				2	White Poplar	—			
1	Dog	—				1	Loblolly Pine	—			
C						G					
8	Negative Control	—				8	Negative Control	—			
7	Red Top Grass ✓X	7	.15			7	Pigweed Mix				
6	Perennial Rye Grass	—				6	Marsh Elder	—			
5	Kentucky Blue Grass X	7	.15			5	Lamb's Quarter ✓X	7	X .15		
4	Meadow Fescue	—				4	Hemp, West/Water X	7	.15		
3	Orchard Grass	—				3	Cypress, Bald	—			
2	Johnson Grass	—				2	Olive	—			
1	Bermuda Grass	—				1	Hackberry	—			
D						H					
8	Negative Control	—				8	Negative Control	—			
7	Epicoccum	—				7	Sage Mix				
6	Alternaria ✓X	7	.15			6	Russian Thistle				
5	Fusarium	—				5	Kochia				
4	Helminthosp	—				4	Dock, Yellow/Curly				
3	Hormodendrum	—				3	Mugwort				
2	Penicillium ✓X	7	0.15			2	Sorrel, Red/Sheep				
1	Aspergillius ✓X	7	.16			1	English Plantain				

* CR DM, mold pollen (grass, tree, weed) allergy

RJG MD

EXHIBIT NO. 3F
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NAI, LLC Richard J. Guillot, M.D.
804 Heavens Dr. Suite 203
Mandeville La. 70471
Office 985 792 4022 Fax 985 792 4007

Patient's Name: Bodin, Jeffrey
Date of Birth: 5/22/57
Dx: Allergic Rhinitis
Dx:
Phone #:

The following allergen vaccines have been issued for treatment

Vaccine 1: (L) Dm MT — Expiration date: 12/5/14
Vaccine 2: (R) G W mosq — Expiration date: 12/5/14
Vaccine 3: — Expiration date:
Vaccine 4: — Expiration date:

Give injections in intervals of twice a week for "Silver Vials" and thereafter once a week following dosages below.

Vial	#7	#6	#5	#4	#3	#2	#1
Color Top	SILVER	SILVER	SILVER	GREEN	BLUE	YELLOW	RED
Concentration	(1:1,000,000)	(1:100,000)	(1:10,000)	(1:1,000)	(1:100)	(1:10)	Maintenance Concentrate
Dosages	0.025	0.025	0.025	0.025	0.025	0.025	0.025
	0.05	0.05	0.05	0.05	0.05	0.05	0.05
	0.10	0.10	0.10	0.10	0.10	0.10	0.10
	0.20	0.20	0.20	0.20	0.20	0.20	0.20 Maintenance dose
	0.30	0.30	0.30	0.30	0.30	0.30	
	0.40	0.40	0.40	0.40	0.40	0.40	

Comments: Begin @ Vials #1 (red, 1:1) @ 0.025 mL and proceed as directed to Maintenance dose (#1, 1:1 red) @ 0.20 mL

DATE mm/dd/yy	VACCINE 1: (L) Dm MT Vial #	mL	ARM L or R	grams of local reaction	VACCINE 2: (R) G Wmosq Vial #	mL	ARM L or R	grams of local reaction	VACCINE 3: Vial #	mL	ARM L or R	grams of local reaction	PEFR	Signature of person giving injection
1/2/14	#1	0.025 (L)			#1	0.025 (R)								
1/20/14	#1	0.05 (L)			#1	0.05 (R)								
1/5/14	#1	0.10 (L)			#1	0.10 (R)								
1/19/14	#1	0.20 (L)			#1	0.20 (R)								
1/26/14	#1	0.10			#1	0.10 (R)								
2/2/14	#1	0.20 (L)			#1	0.20 (R)								
2/9/14	#1	0.20 (L)			#1	0.20 (R)								
2/16/14	#1	0.20 (L)			#1	0.20 (R)								
2/23/14	#1	0.20 (L)			#1	0.20 (R)								
3/2/14	#1	0.20 (L)			#1	0.20 (R)								
3/9/14	#1	0.20 (L)			#1	0.20 (R)								
3/16/14	#1	0.20 (L)			#1	0.20 (R)								
3/23/14	#1	0.20 (L)			#1	0.20 (R)								
3/30/14	#1	0.20 (L)			#1	0.20 (R)								
4/6/14	#1	0.20 (L)			#1	0.20 (R)								
4/13/14	#1	0.20 (L)			#1	0.20 (R)								
4/20/14	#1	0.20 (L)			#1	0.20 (R)								
4/27/14	#1	0.20 (L)			#1	0.20 (R)								
5/4/14	#1	0.20 (L)			#1	0.20 (R)								
5/11/14	#1	0.20 (L)			#1	0.20 (R)								
5/18/14	#1	0.20 (L)			#1	0.20 (R)								
5/25/14	#1	0.20 (L)			#1	0.20 (R)								
6/1/14	#1	0.20 (L)			#1	0.20 (R)								
6/8/14	#1	0.20 (L)			#1	0.20 (R)								
6/15/14	#1	0.20 (L)			#1	0.20 (R)								
6/22/14	#1	0.20 (L)			#1	0.20 (R)								
6/29/14	#1	0.20 (L)			#1	0.20 (R)								
7/6/14	#1	0.20 (L)			#1	0.20 (R)								
7/13/14	#1	0.20 (L)			#1	0.20 (R)								
7/20/14	#1	0.20 (L)			#1	0.20 (R)								
7/27/14	#1	0.20 (L)			#1	0.20 (R)								
8/3/14	#1	0.20 (L)			#1	0.20 (R)								
8/10/14	#1	0.20 (L)			#1	0.20 (R)								
8/17/14	#1	0.20 (L)			#1	0.20 (R)								
8/24/14	#1	0.20 (L)			#1	0.20 (R)								
8/31/14	#1	0.20 (L)			#1	0.20 (R)								
9/7/14	#1	0.20 (L)			#1	0.20 (R)								
9/14/14	#1	0.20 (L)			#1	0.20 (R)								
9/21/14	#1	0.20 (L)			#1	0.20 (R)								
9/28/14	#1	0.20 (L)			#1	0.20 (R)								
10/5/14	#1	0.20 (L)			#1	0.20 (R)								
10/12/14	#1	0.20 (L)			#1	0.20 (R)								
10/19/14	#1	0.20 (L)			#1	0.20 (R)								
10/26/14	#1	0.20 (L)			#1	0.20 (R)								
11/2/14	#1	0.20 (L)			#1	0.20 (R)								
11/9/14	#1	0.20 (L)			#1	0.20 (R)								
11/16/14	#1	0.20 (L)			#1	0.20 (R)								
11/23/14	#1	0.20 (L)			#1	0.20 (R)								
11/30/14	#1	0.20 (L)			#1	0.20 (R)								
12/7/14	#1	0.20 (L)			#1	0.20 (R)								
12/14/14	#1	0.20 (L)			#1	0.20 (R)								
12/21/14	#1	0.20 (L)			#1	0.20 (R)								
12/28/14	#1	0.20 (L)			#1	0.20 (R)								
1/4/15	#1	0.20 (L)			#1	0.20 (R)								
1/11/15	#1	0.20 (L)			#1	0.20 (R)								
1/18/15	#1	0.20 (L)			#1	0.20 (R)								
1/25/15	#1	0.20 (L)			#1	0.20 (R)								
2/1/15	#1	0.20 (L)			#1	0.20 (R)								
2/8/15	#1	0.20 (L)			#1	0.20 (R)								
2/15/15	#1	0.20 (L)			#1	0.20 (R)								

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Richard J. Guillot, MD
Northshore Allergy & Immunology, LLC
355 Lakeview Court, Covington, LA 70433
Office: (985) 892-3122 Fax: (985) 892-3394

Patient Name: Boden Jeffrey Date of Birth: 5 22 97
Testing Technician: Abernons, LPN
Last use of antihistamine (or other med affecting response to histamine): >5 days
Medication Zyrtec, Benadryl, Pataday
Testing Date and Time: 1/20/18 3:00 AM PM (circled)

General Information about skin test protocol:
1. Percutaneous reported as: Allergen: Testing concentration MTII-PC X= new
   Location: back ✓ arm ____ Device: ____
2. Intradermal: 0.____ ml injected, Location: arm Testing concentration: 1:____ w/v or BAU or AU/ml, PNU
3. Results Longest diameter (Left in this example) or longest diameter and orthogonal diameter (Right in this example) of wheal and erythema (flare) measured in millimeters at 15 minutes

Blank in results column indicates test was not performed, 0 = negative

	Allergen	Percutaneous wheal (mm)	Percutaneous flare (mm)	Intradermal wheal (mm)	Intradermal flare (mm)		Allergen	Percutaneous wheal (mm)	Percutaneous flare (mm)	Intradermal wheal (mm)	Intradermal flare (mm)
A						E					
8	Positive Control	7				8	Negative Control	—			
7	Cocklebur	—				7	Red Mulberry	—			
6	Ragweed Mix	—				6	Red Maple	—			
5	Pecan Tree	7	X			5	American Elm	—			
4	Va. Live Oak	7				4	Box Elder	7			
3	Bahia Grass	—				3	River Birch	—			
2	Timothy Grass	—				2	White Ash	—			
1	Negative Control	—				1	Ligustrum (Privet)	—			
B						F					
8	Negative Control	—				8	Negative Control	—			
7	Mixed Feathers	—				7	Cedar, Red	—			
6	Cottonwood, Eastern	7	X			6	American Beech	—			
5	Cockroach	7	X			5	Black Willow	—			
4	D. Pterony	11				4	Sycamore, Am./East	—			
3	D. Farinae	9				3	Sweet Gum	—			
2	Cat Hair	—				2	White Poplar	—			
1	Dog	—				1	Loblolly Pine	—			
C						G					
8	Negative Control	—				8	Negative Control	—			
7	Red Top Grass	7				7	Pigweed Mix	—			
6	Perennial Rye Grass	—				6	Marsh Elder	—			
5	Kentucky Blue Grass	7				5	Lamb's Quarter	7	X		
4	Meadow Fescue	—				4	Hemp, West/Water	7			
3	Orchard Grass	—				3	Cypress, Bald	—			
2	Johnson Grass	—				2	Olive	—			
1	Bermuda Grass	—				1	Hackberry	—			
D						H					
8	Negative Control	—				8	Negative Control	—			
7	Epicoccum	—				7	Sage Mix				
6	Alternaria	7				6	Russian Thistle				
5	Fusarium	—				5	Kochia				
4	Helminthosp	—				4	Dock, Yellow/Curly				
3	Hormodendrum	—				3	Mugwort				
2	Penicillium	7				2	Sorrel, Red/Sheep				
1	Aspergillius	7				1	English Plantain				

*CR, DM, molds pollen (grass, tree, weed) allergy

[signature] MD

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Annual maintenance Rob'd

NAI, LLC Richard J. Guillot, M.D.
804 Heavens Dr. Suite 203
Mandeville La. 70471
Office 985 792-4022 Fax 985 792-4007

Patient's Name: Boolin, Jeffrey
Date of Birth: 5/22/97
Dx: Allergic Rhinitis
Dx:
Phone #

The following allergen vaccines have been issued for treatment

Vaccine 1: (L) Dm MT — Expiration date: 11/1/13
Vaccine 2: (R) G W mesq — Expiration date: 11/1/13
Vaccine 3: — Expiration date:
Vaccine 4: — Expiration date:

Give injections in intervals of twice a week for "Silver Vials" and thereafter once a week following dosages below.

Vial	#7	#6	#5	#4	#3	#2	#1
Color Top	SILVER	SILVER	SILVER	GREEN	BLUE	YELLOW	RED
Concentration	(1:1,000,000)	(1:100,000)	(1:10,000)	(1:1,000)	(1:100)	(1:10)	Maintenance Concentrate
Dosages	0.025	0.025	0.025	0.025	0.025	0.025	0.025
	0.05	0.05	0.05	0.05	0.05	0.05	0.05
	0.10	0.10	0.10	0.10	0.10	0.10	0.10
	0.20	0.20	0.20	0.20	0.20	0.20	0.20 Maintenance dose
	0.30	0.30	0.30	0.30	0.30	0.30	
	0.40	0.40	0.40	0.40	0.40	0.40	

Comments: Begin @ Vials #1 (red, 1:1) @ 0.025 mL and proceed per protocol 2 weekly to maintence dose (#1, 1:1 red) @ 0.02 mL

DATE	VACCINE 1: (L) Dm MT				VACCINE 2: (R) G W mesq				VACCINE 3:				PEFR	Signature of person giving injection
mm/dd/yy	Vial #	amt.	ARM L or R	grade of local reaction	Vial #	amt.	ARM L or R	grade of local reaction	Vial #	amt.	ARM L or R	grade of local reaction		
1 19 13	#1	0.025	(L)		#1	0.025	(R)							
1 24 13	#1	0.05	(L)		#1	0.05	(R)							
3 1 13	#1	0.05	(L)		#1	0.05	(R)							
4 1 13	#1	0.10	(L)		#1	0.10	(R)							
4 12 13	#1	0.20	(L)		#1	0.20	(R)							
5 1 13	#1	0.20	(L)		#1	0.20	(R)							
6 5 13	#1	0.20	(L)		#1	0.20	(R)							
6 20 13	#1	0.20	(L)		#1	0.20	(R)							
9 10 13	#1	0.20	(L)		#1	0.20	(R)							
10 23 13	#1	0.20	(L)		#1	0.20	(R)							
11 21 13	#1	0.20	(L)		#1	0.20	(R)							

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* Annual Maintenance left

NAI, LLC Rick J. Guillot, M.D.
804 Heavens Dr. Suite 203
Mandeville, LA 70471
Office 985 792 4022 Fax 985 792 4007

Patient's Name: Bodin, Jeffrey
Date of Birth: 5/22/95 Phone: 845-096
Dx: Allergic Rhinitis
Dx: _____

The following allergen vaccines have been issued for treatment
Vaccine 1: (L) DmMT Exp. Date: 11/9/12 Vaccine 2: (R) GMosq Exp. Date: 11/9/12
Vaccine 3: _____ Exp. Date: _____ Vaccine 4: _____ Exp. Date: _____

Give injections in intervals of twice a week for "Silver Vials" and thereafter once a week following dosages below

Vial	#7	#6	#5	#4	#3	#2	#1
Color Top	SILVER	SILVER	SILVER	GREEN	BLUE	YELLOW	RED
Concentration	(1:1,000,000)	(1:100,000)	(1:10,000)	(1:1000)	(1:100)	(1:10)	maintenance concentra
Dosages	0.025	0.025	0.025	0.025	0.025	0.025	0.025
	0.05	0.05	0.05	0.05	0.05	0.05	0.05
	0.10	0.10	0.10	0.10	0.10	0.10	0.10
	0.20	0.20	0.20	0.20	0.20	0.20	0.20 maintenance
	0.30	0.30	0.30	0.30	0.30	0.30	
	0.40	0.40	0.40	0.40	0.40	0.40	

Comments: Begin @ Vial #1 [red, 1:1) @ 0.025ml + proceed q week To maintance Dose (#1, 1:1, red) @ 0.20ml then q

DATE mm/dd/yy	VACCINE 1: (L) DmMT Vial #	arm:	ARM L or R	grade of local reaction	VACCINE 2: (R) GMosq Vial #	arm:	ARM L or R	grade of local reaction	VACCINE 3 Vial #	arm:	ARM L or R	grade of local reaction	Signature of person giving injection
11/17/11	#1	0.025	L		#1	0.025	R						
11/22/11	#1	0.05	L		#1	0.05	R						
12/6/11	#1	0.10	L		#1	0.10	R						
12/28/11	#1	0.20	L		#1	0.20	R						
1/4/12	#1	0.20	L		#1	0.20	R						
1/11/12	#1	0.20	L		#1	0.20	R						
1/19/12	#1	0.20	L		#1	0.20	R						
2/2/12	#1	0.20	L		#1	0.20	R						
3/8/12	#1	0.20	L		#1	0.20	R						
3/22/12	#1	0.20	L		#1	0.20	R						
4/12/12	#1	0.20	L		#1	0.20	R						
4/25/12	#1	0.20	L		#1	0.20	R						
6/4/12	#1	0.20	L		#1	0.20	R						
6/21/12	#1	0.20	L		#1	0.20	R						
9/17/12	#1	0.20	L		#1	0.20	R						
7/26/12	#1	0.20	L		#1	0.20	R						
9/7/12	#1	0.025	L		#1	0.025	R						
10/2/12	#1	0.025	L		#1	0.025	R						

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NAI, LLC

Richard J. Guillot, M.D.
804 Heavens Dr. Suite 203
Mandeville La 70471
Office 985 792 4022 Fax 985 792 4007

49A

Patient's Name: Bodin, Jeffrey
Date of Birth: 5/22/97
Dx: Allergic Rhinitis
Dr:
Phone #:

The following allergen vaccines have been issued for treatment
Vaccine 1: (L) Dm MT
Vaccine 2: (R) GW Mosq Expiration date: 11/11/11
Vaccine 3: Expiration date: 11/11/11
Vaccine 4: Expiration date:
Expiration date:

Give injections in intervals of twice a week for "Silver Vials" and thereafter once a week following dosages below.

Vial	#7	#6	#5	#4	#3	#2	#1
Color Top	SILVER	SILVER	SILVER	GREEN	BLUE	YELLOW	RED
Concentration	(1:1,000,000)	(1:100,000)	(1:10,000)	(1:1,000)	(1:100)	(1:10)	Maintenance Concentrate
Dosages	0.025	0.025	0.025	0.025	0.025	0.025	0.025
	0.05	0.05	0.05	0.05	0.05	0.05	0.05
	0.10	0.10	0.10	0.10	0.10	0.10	0.10
	0.20	0.20	0.20	0.20	0.20	0.20	0.20 Maintenance dose
	0.30	0.30	0.30	0.30	0.30	0.30	
	0.40	0.40	0.40	0.40	0.40	0.40	

Date: Begin @ Vial #6 (silver #2 (1:100,000 dilution) 2x's/week per standard protocol, after maintenance dose (Red, #1 @ 0.20) then q weekly.

DATE mm/dd/yy	VACCINE 1 (L) Dm MT Vial #	ml	ARM L or R	grade of local reaction	VACCINE 2 (R) GW Mosq Vial #	ml	ARM L or R	grade of local reaction	VACCINE 3 Vial #	ml	ARM L or R	grade of local reaction	PEFR
11/16/10	#6	0.025	L		#6	0.025	R						
11/20/10	#6	0.05	L		#6	0.05	R						
12/2/10	#6	.10	L		#6	0.05	R						
12/7/10	#6	0.20	L		#6	.10	R						
12/9/10	#6	0.30	L		#6	0.20	R						
12/15/10	#6	0.40	L		#6	0.30	R						
12/16/10	#5	0.025	L		#6	0.40	R						
12/28/10	#5	0.05	L		#5	0.025	R						
1/4/11	#5	0.10	L		#5	0.05	R						
1/19/11	#5	0.20	L		#5	0.10	R						
1/26/11	#5	0.30	L		#5	0.20	R						
1/27/11	#5	0.40	L		#5	0.30	R						
1/31/11	#4	0.025	L		#5	0.40	R						
2/3/11	#4	0.05	L		#4	0.025	R						
2/8/11	#4	0.10	L		#4	0.05	R						
2/15/11	#4	0.20	L		#4	0.10	R						
2/17/11	#4	0.20	L		#4	0.20	R						
2/28/11	#4	0.30	L		#4	0.20	R						
3/14/11	#4	0.40	L		#4	0.30	R						
3/24/11	#3	0.025	L		#4	0.40	R						
4/6/11	#3	0.05	L		#3	0.025	R						
4/14/11	#3	0.10	L		#3	0.05	R						
4/18/11	#3	0.20	L		#3	0.10	R						

EXHIBIT NO. 3F
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NAI, LLC
Richard J. Guillot, M.D.
804 Heavens Dr. Suite 203
Mandeville La. 70471
Office 985 792 4022 Fax 985 792 4607

Patient's Name:
Date of Birth:
Dx: Allergic Rhinitis
Dx:
Phone #

The following allergen vaccines have been issued for treatment

Vaccine 1: Expiration date:
Vaccine 2: Expiration date:
Vaccine 3: Expiration date:
Vaccine 4: Expiration date:

Give injections in intervals of twice a week for "Silver Vials" and thereafter one a week following dosage below:

Vial Color Key Concentration Dosages	#7 SILVER (1:1,000,000)	#6 SILVER (1:100,000)	#5 SILVER (1:10,000)	#4 GREEN	#3 BLUE	#2 YELLOW	#1 RED
	0.02	0.02	0.025				0.025 Maintenance Concen.
	0.05	0.05	0.05				0.05
	0.10	0.10	0.10				0.10
	0.20	0.20	0.20				0.20 Maintenance
	0.30	0.30	0.30				
	0.40	0.40	0.40				

DATE mm/dd/yy	VACCINE 1 Vial #	cc	APM L or R	Time of local reaction	VACCINE 2 Vial #	cc	APM L or R	Time of local reaction	VACCINE 3 Vial #	cc	APM L or R	Time of local reaction	Pain
5/2/11	#3	0.30	L		#3	0.30	R						
5/16/11	#3	0.40	L		#3	0.40	R						
5/24/11	#2	0.025	L		#2	0.025	R						
6/21/11	#2	0.05	L		#2	0.05	R						
7/11/11	#2	0.10	L		#2	0.10	R						
7/20/11	#2	0.20	L		#2	0.20	R						
7/28/11	#2	0.30	L		#2	0.30	R						
8/3/11	#2	0.40	L		#2	0.40	R						
8/10/11	#1	0.025	L		#1	0.025	R						
8/17/11	#1	0.05	L		#1	0.05	R						
8/31/11	#1	0.10	L		#1	0.10	R						
9/8/11	#1	0.20	L		#1	0.20	R						
9/15/11	#1	0.20	L		#1	0.20	R						
9/29/11	#1	0.20	L		#1	0.20	R						
10/6/11	#1	0.20	L		#1	0.20	R						
10/19/11	#1	0.20	L		#1	0.20	R						
11/3/11	#1	0.10	L		#1	0.10	R						
11/8/11	#1	0.20	L		#1	0.20	R						
/ /													
/ /													
/ /													
/ /													

Health Information Technology (HIT) Medical Report

NOTE: The following displays data transmitted to the SSA from the health IT partner using standards-based computer transactions and is reformatted to assist with navigating through the clinical details of the record. Known duplicative information will be struck-through (e.g. ~~sample~~).

Summarization of Episode Note
Continuity of Care Document

Received From: Ochsner Health System

Creation Date:	Date Range Requested:	Type of Request:
08/07/2017	07/01/2015 - 08/07/2017	User Triggered

JEFFREY T BODIN
SSN: 436-95-8926 **DOB:** 05/22/1997 **Sex:** Male

Partner Medical Record Demographics:
Name: Jeffrey Bodin **DOB:** 05/22/1997 **Sex:** Male

Table of Contents

PROB LIST

Problems List

Problem [Code]	Occurrences	First Date	Last Date	Associated Types	Last Prognosis Value	Last Prognosis Date
Anxiety [48694002] **Anxiety disorder, unspecified [F41.9]** **Anxiety state NOS [300.00]** **Anxiety [38413]**	1	08/15/2016	-	Problem		
Bilateral headache [162301005] **Headache [R51]** **Headache [784.0]** **Bilateral headache [355282]**	1	12/05/2013	-	Problem		
Depressive disorder [35489007] **Major depressive disorder, single episode, unspecified [F32.9]** **Depressive disorder NEC [311]** **Depression [41696]**	1	08/15/2016	-	Problem		
Hypersomnia [77692006] **Hypersomnia, unspecified [G47.10]** **Hypersomnia NOS [780.54]** **Hypersomnolence [46878]**	1	06/15/2016	-	Problem		
Seizure disorder [128613002] **Epilepsy, unspecified, not intractable, without status epilepticus [G40.909]** **Epilep NOS w/o intr epil [345.90]** **Seizure disorder [54347]**	1	07/07/2014	-	Problem		

Narrative Text

Problem	Noted Date
Depression	08/15/2016
Anxiety	08/15/2016
Hypersomnolence	06/15/2016
Seizure disorder	07/07/2014
Bilateral headache	12/05/2013

ENC

Encounters

Date	Type	Specialty	Care Team	Description
10/06/2016	Hospital Encounter		Africk, Diane K., MD	**JEFFERSON HIGHWAY HOSPITAL 10/06/2016**
				Bilateral headache
09/19/2016	Telephone		Taylor, Denise M., RN	

JEFFERSON HIGHWAY CLINICS 09/19/2016

Telephone Encounter - Taylor, Denise M., RN - 09/19/2016 11:47 AM CDT

----- Message from Cheryl Riley sent at 9/19/2016 10:37 AM CDT -----
Contact: Mom Linda 985-264-5277
Mom Linda 985-264-5277----------requesting a return call to reschedule pt **MRI**

Telephone Encounter - Taylor, Denise M., RN - 09/19/2016 11:48 AM CDT

Spoke to mother and **mri** rescheduled to 10/6/2016

09/06/2016	Telephone		Taylor, Denise M., RN	

JEFFERSON HIGHWAY CLINICS 09/06/2016

Telephone Encounter - Taylor, Denise M., RN - 09/06/2016 9:33 AM CDT

----- Message from Trenee A Scott sent at 9/2/2016 4:39 PM CDT -----
Contact: Mom Linda 985-264-5277
Mom Linda 985-264-5277----calling to check the status on Pt orders... No other message please advise...

Telephone Encounter - Taylor, Denise M., RN - 09/06/2016 9:34 AM CDT

Patient had head **ct** performed; **results** normal. Mother is requesting **MRI** order. Please advise; thank you.

Telephone Encounter - Africk, Diane K., MD - 09/06/2016 6:38 PM CDT

Mri ordered. Diane africk 9/6/16 6:44 pm

Telephone Encounter - Taylor, Denise M., RN - 09/07/2016 1:33 PM CDT

Spoke to mother; **MRI** scheduled and appt reminder mailed to address on file.

08/25/2016	Telephone		Taylor, Denise M., RN	

JEFFERSON HIGHWAY CLINICS 08/25/2016

Telephone Encounter - Taylor, Denise M., RN - 08/25/2016 11:37 AM CDT

----- Message from Marlene Derocha sent at 8/25/2016 10:05 AM CDT -----
Contact: mom 985-264-5277
Mom wanted to notify dr africk that South West General Hospital, in San Antonio, TX will be faxing **results** for **Ct scan** today

Date	Type	Specialty	Care Team	Description
	----per mom no **MRI** was done ----mom would like to request **MRI** with constrast Telephone Encounter - Taylor, Denise M., RN - 08/25/2016 11:37 AM CDT **Results** received: **ct** head/brain and chest xray. Scanned and copy in your inbox.			
08/15/2016	Office Visit		Africk, Diane K., MD	Hypersomnolence (Primary Dx); Bilateral headache; Seizure disorder; **Depression**; **Anxiety**

JEFFERSON HIGHWAY CLINICS
08/15/2016

Progress Notes - Africk, Diane K., MD - 08/15/2016 4:27 PM CDT

Jeffrey Bodin is a 19-year-old male who initially saw me on 12/05/2013. Jeffrey returns today with his mother. Jeffrey carries the **diagnoses** of headaches, narcolepsy, status post interferon for **malignant** melanoma, **depression**, **anxiety**.

Please see my original **consultation** of 12/05/2013 for headache descriptions and full history.

I have not seen Jeffrey since 11/09/2015. He stopped seeing Dr. Lysenko with a tentative **diagnosis** of narcolepsy. I have spoken to his pediatrician, Dr. Terral. Both of us had concerns about the amount of Adderall that Jeffrey was taking.

So today is a whole different story. First, I was with Jeffrey and his mother. Then I was with Jeffrey alone. Then, I was with his mother alone.

Jeffrey gave me permission to speak to his mother. He has also given me permission to speak to Mr. Nelson at 985-264-2127 and Dr. Balachandran at MD Anderson.

I am told that Jeffrey has been diagnosed at MD Anderson with narcolepsy. I am told he has been prescribed Xyrem. When I am alone with Jeffrey, he tells me he needs to be on the Adderall. He does not want to try the Xyrem. The Adderall made it possible for him to have a life. He has no life. He is unable to go to college. He is unable to do any of the things he wants to do.

Jeffrey is telling me at great length about the tension in the family. He tells me that the family is no longer going to counseling together.

Mom tells me that it has been a very difficult year. Jeffrey had a seizure in Houston in the spring. He had a syncopal event. The family has taken away his Adderall. Mom says it has been very hard for everyone to understand about Jeffrey's choices and illnesses.

Jeffrey's blood pressure today is 132/91. He has had elevated blood pressures in the past. His pulse rate is 71 per minute. His respiratory rate is 22 per minute. His weight is 49.4 kg (less than the 5th percentile; stable since the last time he was here, but decreased from when he was 16 years old and was on the chart at 52.5 kg). Height is 172.1 cm (25th percentile).

Jeffrey is an alert, attentive young man. He is manipulative. He is sad. He agrees that he has **depression**. Mom says he can sleep 20 hours a day. Jeffrey says the same thing.

Jeffrey says he does not have friends. He never had friends. Even though we talked about his friends, he did not have them. It is hard to know the left from the right at this point.

I do know that Jeffrey is a very troubled young man. I do know that the family is in a state of turmoil at this time. I have spoken to both Jeffrey and his

mother about family counseling. I have spoken to Jeffrey about trying Xyrem. I am opposed to Adderall at this time. We may need an addiction specialist to help us as well.

I was with Jeffrey and his mother for an hour. Greater than 50% of the time was spent counseling.

A copy of this **consultation** will be sent to Dr. Terral.

DKA/HN dd: 08/15/2016 14:28:16 (CDT) td: 08/16/2016 06:28:27 (CDT) Doc ID #1895405 Job ID #008825

CC: William Terral MD

08/09/2016 Telephone Taylor, Denise M., RN

JEFFERSON HIGHWAY CLINICS
08/09/2016

Telephone Encounter - Taylor, Denise M., RN - 08/09/2016 9:31 AM CDT

----- Message from Danesha Thornton sent at 8/9/2016 9:18 AM CDT -----
Contact: pt mom #985-264-5277
Mom returning call

Telephone Encounter - Taylor, Denise M., RN - 08/09/2016 9:31 AM CDT

Spoke to mother; adult appt scheduled 8/15/2016

08/09/2016 Telephone Taylor, Denise M., RN

JEFFERSON HIGHWAY CLINICS
08/09/2016

Telephone Encounter - Taylor, Denise M., RN - 08/09/2016 9:15 AM CDT

----- Message from Trenee A Scott sent at 8/9/2016 8:57 AM CDT -----
Contact: Mom Linda 985-264-5277
Mom Linda 985-264-5277----would like to schedule Pt a f/u.. I Could not schedule the apmt..the patient is an adult.. No other message please advise....

Telephone Encounter - Taylor, Denise M., RN - 08/09/2016 9:15 AM CDT

Attempted to contact mother to schedule adult appt for patient. Message left for mother to return call

06/15/2016 Telephone Lysenko, Liudmila, MD
06/13/2016 Telephone Lysenko, Liudmila, MD

BAPTIST CLINICS
06/13/2016

Telephone Encounter - Bush, Barbara, MA - 06/13/2016 4:26 PM CDT

----- Message from Karen Hogans sent at 6/13/2016 3:54 PM CDT -----
Contact: Mother
Pt's mother called and stated that she was returning a call from the office. Please call her at 985-264-5277

Telephone Encounter - Bush, Barbara, MA - 06/13/2016 4:26 PM CDT

FYI The patient mother was advised of message dated on 5/18/2016.the patient mother would like to advise our clinic the patient will no longer be a patient. She will not be returning to New Orleans so an order to repeat the sleep study is no longer needed.

Telephone Encounter - Lysenko, Liudmila, MD - 06/15/2016 4:37 PM CDT

I will remove the **diagnosis** of "narcolespy" and addend the sleep study reports in Epic

The following communication will be sent to the patient by certified mail:

Department of Sleep Medicine

Dear Jeffry,

Your PMD Dr. Terrel made me aware that he was concerned about potential psychological side effects of high dose of Adderall that made him decrease the dose– that was one of the reasons I wanted to see you for the follow up in the sleep clinic.

Another concern was that after looking closer into your daytime sleep study history, I found that the lab **result** which was pending at the time of your sleep study interpretation – urine drug test (UDGS) was presumptively positive for barbiturates on the day of your study. The term "presumptive" means that the test is not designed to give a 100% guarantee that barbiturate itself was in your system, and it could have been a cross reaction with some other medication.

But nevertheless, the recommendation is to repeat PSG/MSLT (overnight followed by the daytime sleep study) with UDGS to reestablish the **diagnosis** of "narcolepsy without cataplexy". For now I have to change the **diagnosis** on the sleep study report in our system to "**diagnosis** of central hypersomnia cannot be reliably established in the presence of presumptively positive urine drug test".

Please feel free to contact me on My Ochsner or over the phone if you would like to discuss this matter in more details.

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Best regards, and thanks for choosing Ochsner.

Liudmila Lysenko, MD

This communication was also sent to Dr Terrell (office number 985-893-2581) and Dr. Africk

05/18/2016 Telephone Lysenko, Liudmila, MD

JEFFERSON HIGHWAY CLINICS 05/18/2016

Telephone Encounter - Lysenko, Liudmila, MD - 05/18/2016 4:36 PM CDT

I went back to UDGS and noticed that on the night of PSLT barbiturates were presumptively positive.

After today's discussion with his pediatrician, Dr. Terrel, I would like to repeat MSLT making sure there is no substance potentially clouding the picture.

05/18/2016 Telephone Lysenko, Liudmila, MD

JEFFERSON HIGHWAY CLINICS 05/18/2016

Telephone Encounter - Glass, Latasha R., MA - 05/18/2016 12:11 PM CDT

----- Message from Hillary Franklin sent at 5/17/2016 3:37 PM CDT -----
Contact: Dr. William Terral
Dr. Terral states he would like to speak with someone today if possible regarding the pt. Dr. Terral asks that the whoever calls him back has the pt's chart available. Please call Dr. Terral.

Dr. William Terral
985-259-1234

Telephone Encounter - Lysenko, Liudmila, MD - 05/18/2016 12:38 PM CDT

Jeffry's primary physician, Dr. William Terrel expressed the concern, that Jeffrey may not be using Adderall appropriately.

He was reported to be out of school for months and being unable to carry on a coherent conversation.

Apparently, Jeffrey states that he has not been sleeping well at all.

I'm concerned that late Adderall doses may be playing a role.

I have recommended to stop short acting Adderall and continue long acting dosing in the morning.

Latasha,
Please schedule Jeffrey for the follow up in the clinic with me when available.
Thanks!

Telephone Encounter - Glass, Latasha R., MA - 05/18/2016 4:15 PM CDT

Pt has f/u appt scheduled

05/18/2016 Telephone Lysenko, Liudmila, MD

JEFFERSON HIGHWAY CLINICS
05/18/2016

Telephone Encounter - Glass, Latasha R., MA - 05/18/2016 11:12 AM CDT

----- Message from Hillary Franklin sent at 5/17/2016 3:37 PM CDT -----
Contact: Dr. William Terral
Dr. Terral states he would like to speak with someone today if possible regarding the pt. Dr. Terral asks that the whoever calls him back has the pt's chart available. Please call Dr. Terral.

Dr. William Terral
985-259-1234

Telephone Encounter - Glass, Latasha R., MA - 05/18/2016 11:12 AM CDT

----- Message from Hillary Franklin sent at 5/18/2016 9:12 AM CDT -----
Contact: Marleen with Dr. Terral's Office
Marleen states that Dr. Terral would like to speak with Dr. Lysenko regarding the pt. Please call Dr. Terral.

Marleen with Dr. Terral's Office
985-893-2581

Dr. William Terral
985-259-1234

03/28/2016 Telephone Africk, Diane K., MD

02/15/2016 Refill Africk, Diane K., MD

JEFFERSON HIGHWAY CLINICS
02/15/2016

Telephone Encounter - Washington, Tavian L., MA - 02/16/2016 3:32 PM CST

Mom Linda called requesting a refill for butalbital-acetaminophen-caffeine 50-325-40 mg (FIORICET, ESGIC) 50-325-40 mg per tablet. Mom stated that the pharmacy sent over a refill request. Informed mom that the refill request was not received from the pharmacy. Further informed mom that the pt needs to be seen, mom scheduled appt for 3/28. Mom confirmed appt date and time.

Telephone Encounter - Washington, Tavian L., MA - 02/16/2016 3:53 PM CST

Spoke to mom Linda. Informed mom that the pt's prescription has been sent over to the pharmacy.

01/27/2016 Telephone Lysenko, Liudmila, MD

BAPTIST CLINICS
01/27/2016

Telephone Encounter - Bush, Barbara, MA - 01/27/2016 11:33 AM CST

----- Message from Virginia Calvin sent at 1/27/2016 10:18 AM CST -----
Contact: pt's mother Linda
Pt's mother called requesting a call. She has specific days pt would like to come to see Dr. Lysenko. I tried to accommodate

Date	Type	Specialty	Care Team	Description

but wasn't successful. Pl give pt a call at your earliest convenience. Thanks!

Pt: Jeffery Bodin (mrn# 2592229)
Caller: Linda Bodin / Mother
Ph# 985-264-5277

Telephone Encounter - Bush, Barbara, MA - 01/27/2016 11:33 AM CST

I spoke with the patient mother she stated she wanted to reschedule the patient in April. Appointment scheduled as requested.

12/21/2015	Office Visit		Lysenko, Liudmila, MD	Primary narcolepsy with cataplexy (Primary Dx); Primary narcolepsy without cataplexy

JEFFERSON HIGHWAY CLINICS
12/21/2015

Progress Notes - Lysenko, Liudmila, MD - 12/21/2015 1:50 PM CST

Formatting of this note may be different from the original.

Jeffrey Bodin was seen at the request of No ref. provider found for sleep evaluation.

10/29/2014: INITIAL HISTORY OF PRESENT ILLNESS: Jeffrey Bodin is a 18 y.o. male is here to be evaluated for a sleep disorder. He is accompanied by his mother Linda.

CHIEF COMPLAINT:

The patient's complaints include non refreshing sleep, fatigue and sleeepiness since 6 years ago when he was treated for melanoma with IV and SQ Interferons.
His symptoms remained stable over 6 years. He would sometimes fall asleep at school.
Was born prematurely - born at 7 weeks - had some infant sleep apnea back then.
He was developing fine and had no problem with his sleep till 6 years back.
He denied snoring, witnessed breathing pauses, gasping for air in sleep and interrupted sleep.
he denies cataplexy, sleep paralysis, **hallucinations**, palpitations, tremors, **anxiety**.

Denies dry mouth and sore throat
Denies nasal congestion
Report morning headaches - different from usual migrains which start later. Gets them daily
Denies interrupted sleep
Denies frequent leg movements
Denies symptoms concerning for parasomnia

The ESS (Epworth Sleepiness Score) taken on initial visit is 15 /24

He denied trouble falling asleep and staying asleep.

He was recently started on Tranxene -> Restoril by his neurologist. Denies any improvement in fatigue/sleepiness so far.

He is taking Gabapentin for Neuropathy, daily Fioricet for headaches. States that those medications do not make him sleepy.

The patient had tonsillectomy in the past

INTERVAL HISTORY:

03/02/2015 The patient has not presented any new complaints since the previous visit. He is coming with both parents to discuss sleep study, which was positive for OSA (AHI 10.3) and MSLT stronly suggestive of Narcolepsy.
He is currently taking Ritalin for ADD - 40 mg Ritalin LA in the morning - feels sleepy again at noon. He states that lower doses were not effective. States that Ritalin is not aggravating his headaches. he denies cataplexy, sleep paralysis, **hallucinations**, headaches, palpitations, tremors, **anxiety**, or rash. ESS 10/24 today (on Ritalin).

04/01/2015: Jeffrey tried Concerta 36 mg with ER Ritalin in the afternoon - he did not feel a sufficient control of his sleepiness. His pediatrician's husband who is a sleep specialist prescribed Modafinil 200 mg - > further increased to 200 mg BID. He is no longer taking Concerta 36 or Ritalin. He states that Modafinil was inferior to Methylphenidate in its ability to control his daytime sleepiness. ESS 11/24. States that on Modafinil he was falling asleep at school on many occasions. Out of treatment regiments tried to this point Ritalin 40 mg seemed to work the best, but effect only lasted for two hours. He tried APAP, but could not tolerate it. He would like to defer treatment for now. HR and BP remain normal on today's visit.

05/04/2015: Jeffrey is taking 40 mg Adderall XR at 6 AM and 40 mg Adderall XR at 3-4 Pm when he comes from school to be able to do the homework. States that does not affect his sleep latency/continuity.
VS are normal today. Denied any change in his appetite, thought process, palpitations, change in headache pattern on his current high Adderall dose. Reports residual sleepiness at the end of school day. Topamax was recently D/C due to side effects. Still suffers from daily headaches. Taking a nap at 12-1 at school or 4-5 at home - naps are refreshing.

06/08/2015: Jeffrey is generally satisfied with the control of daytime sleepiness. Further improvement on Adderall 40 mg at 7:30-8 and 40 mg at 3 PM (was 5 PM at school) and sometimes 20 mg at noon. Denied palpitations, jitteriness and changes in his appetite. EKG 5/15 showed NSR, but with indication of right atrial enlargement. He is taking naps instead of second dose so far.

07/14/2015: Reports improved sleepiness and improved migraines with more consistent Adderall schedule. Denied Anorexia, mood changes, palpitations. ESS 12/24 tioday.
He would like additional 20 mg to avoid taking a nap at school. BP is slightly increased for his age since Adderall was increased. Had a cardiologist cleared him for Adderral use.

09/02/2015: He suffers simus infection. Reports longstanding allergies - using Mucinex pill year round. ESS 12/24. Tolerates Adderall well.Sometimes would skip the second dose and take a nap. Taking 20-90 min at school (dozing off during boring classes). SBP remained at 110-120's mm Hg as per patient.

12/21/2015: Tolerates Adderall 40 mg XR BID and 20 mg IR BID. He is concerned with his ability to go to be able to keep up with classes in college next year. Interested in partial disability. No weight loss, denied side effects. Migraine is at bay with daily Butalbital. Seizures on Elavil and too groggy on high dose Topamax. He is planning to switch to adult Neurology.

SLEEP ROUTINE 12/21/2015 :

Bed partner:
Time to bed: !2:30 AM
Sleep onset latency: 10 min
Disruptions or awakenings: 0 - even without meds
Time to fall back into sleep:
Wakeup time: 5:40-6 AM
Perceived sleep quality: 0
Perceived total sleep time: 7-8 hours.
Daytime naps: 1-2 daily - during and after school 1-2 hrs (6 hrs after school) ->up till 12
Weekend sleep routine: 12 -till 8
Exercise routine: yes - cross country

PREVIOUS SLEEP STUDIES:

PSG 2/2/15: Significant Obstructive sleep apnea (OSA) with AHI (apnea hypopnea Index) of 0.9 and SaO2 of 91 (weight 218 lbs).
MSLT 2/315: Mean Sleep Latency - 1.5 min. 4 SOREMS out of 4 naps. Suggestive of narcolepsy in appropriate clinical setting.

Using My Ochsner: No

PAST MEDICAL HISTORY:
Active Ambulatory Problems
Diagnosis Date Noted
• Bilateral headache 12/05/2013
• Seizure disorder 07/07/2014
• Narcolepsy 06/03/2015

Resolved Ambulatory Problems
Diagnosis Date Noted
• No Resolved Ambulatory Problems

Past Medical History
Diagnosis Date
• Allergy
• Migraine headache
• Sinusitis
• Otitis media
• Hay fever

PAST SURGICAL HISTORY:
Past Surgical History
Procedure Laterality Date
• Tonsillectomy
• Adenoidectomy
• Tympanostomy tube placement
• Appendectomy

FAMILY HISTORY:
No family history on file.

SOCIAL HISTORY:
Tobacco:
History
Smoking status
• Never Smoker
Smokeless tobacco
• Never Used

alcohol use:
History
Alcohol Use: Not on file

Occupation: High scool junior. Very good student.

ALLERGIES: No Known Allergies

CURRENT MEDICATIONS:
Current Outpatient Prescriptions
Medication Sig Dispense Refill
• butalbital-acetaminophen-caffeine 50-325-40 mg (FIORICET, ESGIC) 50-325-40 mg per tablet 2 po prn headache; may repeat in 4 hours 90 tablet 3
• dextroamphetamine-amphetamine (ADDERALL XR) 20 MG 24 hr capsule 2 po q am and 2 po q afternoon

Do not refill till 6/30 120 capsule 0
• dextroamphetamine-amphetamine (ADDERALL) 20 mg tablet 1 pill PO BID PRN sleepiness 60 tablet 0
• diphenhydrAMINE (BENADRYL) 12.5 mg chewable tablet Take 12.5 mg by mouth 4 (four) times daily as needed.
• DYMISTA 137-50 mcg/spray Spry
• guaifenesin (MUCINEX) 600 mg 12 hr tablet Take 1,200 mg by mouth 2 (two) times daily.
• montelukast (SINGULAIR) 10 mg tablet
• naproxen (EC NAPROSYN) 500 MG EC tablet 500 mg once daily.
• PATADAY 0.2 % Drop
• pseudoephedrine (SUDAFED) 120 mg 12 hr tablet Take 120 mg by mouth every 12 (twelve) hours.

No current facility-administered medications for this visit.

REVIEW OF SYSTEMS:
Sleep related symptoms as per HPI

denies weight gain
Denies dyspnea
Denies palpitations
Denies acid reflux

Denies polyuria
Denies mood diturbance
Denies anemia
Reports muscle pain

Reports migraines and nerve damage post interferon treatment.

PHYSICAL EXAM:
BP 131/88 mmHg | Pulse 115 | Ht 5' 7.5" (1.715 m) | Wt 46.72 kg (103 lb) | BMI 15.88 kg/m2
GENERAL: Normal development, well groomed.
HEENT:
HEENT: Conjunctivae are non-erythematous; Pupils equal, round, and reactive to light; Nose is symmetrical; Nasal mucosa is pink and moist; Septum is midline; Inferior turbinates are normal; Nasal airflow is normal; Posterior pharynx is pink; Modified Mallampati:"I; Posterior palate is low; Tonsils absent; Uvula is elongated;Tongue is enlarged; Dentition is fair; No TMJ tenderness; Jaw opening and protrusion without click and without discomfort.
NECK: Supple. Neck circumference is 13.2 inches. No thyromegaly. No palpable nodes.
SKIN: On face and neck: No abrasions, no rashes, no lesions. No subcutaneous nodules are palpable.
RESPIRATORY: Chest is clear to auscultation. Normal chest expansion and non-labored breathing at rest.
CARDIOVASCULAR: Normal S1, S2. No murmurs, gallops or rubs. No carotid bruits bilaterally. No edema. No clubbing. No cyanosis.
NEURO: Oriented to time, place and person. Normal attention span and concentration. **Gait** normal.
PSYCH: Affect is full. Mood is normal
MUSCULOSKELETAL: Moves 4 extremities. **Gait** normal.

ASSESSMENT:

1. Narcolepsy without cataplexy. He denies cataplexy, sleep paralysis, **hallucinations**, palpitations, tremors, **anxiety**. Previously tried Ritalin - 40 mg worked best, but effect lasted long enough, Concerta (insufficinet effect on 36 mg + IR Ritalin), Modafinil 200 mg BID (felt no effect). Jeffrey seems to have a high tolerance to stimulant medications. Residual sleepiness on 40 mg Adderall XR BID and 20 mg Adderall IR. He is known to have high medication tolerance. No side effects reported, except his BP increased from 114/70 towards 129-130/79 when he was switched from Concerta to Adderall and as Adderall dose was increased. Increased Adderall dose was apparently helpful in migraine control.

2. OSA - moderate by pediatric criteria, mild by adult criteria. He denied snoring, witnessed breathing pauses, gasping for air in sleep and interrupted sleep. He does get morning headache which is different from his usual migrains. He did not find benefit from 1 week APAP use..

PLAN:

1. Continue Adderall XR 40 mg BID
2. Continue Adderall IR from 20 mg to 40 mg for the end of Day as needed (can substitute with a nap).
3. Side effects were again explained in detail (psychosis, mood swings, increased HR and BP (he was recommended to monitor BP and HR at home in the morning and in the evening and keep a log, anorexia). He was recommended to monitor BP at home.
5. If he continues to be sleepy, will consider a trial of Xyrem

Follow up in MD.

11/09/2015 Office Visit — Africk, Diane K., MD — Bilateral headache (Primary Dx)

JEFFERSON HIGHWAY CLINICS
11/09/2015

Progress Notes - Africk, Diane K., MD - 11/09/2015 12:19 PM CST

Jeffrey Bodin is an 18-1/2-year-old male who initially saw me on 12/05/2013. Jeffrey returns today with his mother. Jeffrey carries the **diagnoses** of headaches, narcolepsy and status post interferon for **malignant** melanoma.

Please see my original **consultation** of 12/05/2013 for headache descriptions, birth history, hospitalizations and surgeries, **review of systems**, immunizations, medications, developmental history, endocrine history, social history, family history and dietary history.

Jeffrey was late today because he had a severe migraine. It was hard for him to get up.

Jeffrey tells me he is doing good. Mother does not agree. However, Jeffrey is telling me more than once that he is doing well.

Jeffrey would like some papers filled out for college. They have to do with accommodation secondary to his recurrent headaches and exhaustion associated with narcolepsy.

Jeffrey is currently on Adderall 40 mg one p.o. t.i.d. He is also on butalbital two p.o. b.i.d.

Jeffrey has been on amitriptyline, Neurontin, Topamax and verapamil for his headaches in the past. They have all been unsuccessful.

On neurologic examination today, I do not have any vitals. Jeffrey is off and about. He looks well. He is running the show in the room. Mother is not sure what she go on the forms; Jeffrey is very much in control today.

Jeffrey has no ataxia. He has no dysmetria. He has no nystagmus. Extraocular movements are full and conjugate.

I was with Jeffrey and his mother for 45 minutes. Greater than 50% of the time was spent counseling. Jeffrey is an 18-year-old male with a history of **malignant** melanoma, status post interferon. He has a history of intractable headaches and narcolepsy without cataplexy. Dr. Lysenko has Jeffrey on his Adderall. I will continue him on butalbital.

I would like to see Jeffrey back in three months or sooner if there are problems.

DKA/IN dd: 11/09/2015 12:37:32 (CST) td: 11/10/2015 09:22:39 (CST) Doc ID #1748957 Job ID #1637643

CC: Sherri Casey MD

11/09/2015 Telephone Lysenko, Liudmila, MD

JEFFERSON HIGHWAY CLINICS
11/09/2015

Telephone Encounter - Glass, Latasha R., MA - 11/09/2015 1:21 PM CST

----- Message from Hillary Franklin sent at 11/9/2015 1:07 PM CST -----
Contact: Linda Bodin (Mother)
Pt's mother states she just wanted to let Dr. Lysenko know that she would be faxing over paperwork that needed to be filled out for the pt's school. Pt's mother states the pt is applying to LSU and needs disability paperwork filled out.

Linda Bodin (Mother)
985-264-5277

BODIN,JEFFREY [2592229]

Telephone Encounter - Glass, Latasha R., MA - 11/09/2015 1:21 PM CST

I checked the fax for the form it was not received at this time.

10/26/2015 Telephone Lysenko, Liudmila, MD

JEFFERSON HIGHWAY CLINICS
10/26/2015

Telephone Encounter - Glass, Latasha R., MA - 10/26/2015 9:25 AM CDT

----- Message from Angela Powell sent at 10/26/2015 9:19 AM CDT -----

Date	Type	Specialty	Care Team	Description

Contact: pt's mother Linda 985-264-5277
Pt's mother stated she is waiting for referral for migranes. She states no one called her. Please call Linda 985-246-5277

Telephone Encounter - Glass, Latasha R., MA - 10/26/2015 9:25 AM CDT

Please advise thanks

Telephone Encounter - Lysenko, Liudmila, MD - 10/27/2015 9:49 AM CDT

I thought they are seeing pediatric neurologist (Dr. Afric). What kind of referral did they mean? Please clarify.

Telephone Encounter - Glass, Latasha R., MA - 10/27/2015 10:28 AM CDT

Called patient mother Ms Linda to inform that Jeffrey has an appt scheduled with Dr Africk for neuro.

10/16/2015 Telephone Lysenko, Liudmila, MD

BAPTIST CLINICS
10/16/2015

Telephone Encounter - C., Whalen Sara, MA - 10/16/2015 11:40 AM CDT

----- Message from Leneshia Hills sent at 10/16/2015 10:36 AM CDT -----
Contact: Linda Bodin (Mother) 985-264-5277
Linda Bodin (Mother) will like a call in reference to the referral for a migraine specialist that was spoke in previous appt. Pls call to advise, Thanks!

BODIN,JEFFREY [2592229]

Linda Bodin (Mother) 985-264-5277

Telephone Encounter - C., Whalen Sara, MA - 10/16/2015 11:40 AM CDT

Mrs. Bodin states she can't remember the name of the provider Dr. Lysenko was recommending Jeffrey see for headache. She also scheduled a visit for him to see Dr. Lysenko in Kenner.

10/13/2015 Refill Africk, Diane K., MD
10/05/2015 Telephone Valteau, Christine A, LPN

JEFFERSON HIGHWAY CLINICS
10/05/2015

Telephone Encounter - Valteau, Christine A, LPN - 10/05/2015 8:57 AM CDT

----- Message from Debra Armstead sent at 10/5/2015 7:44 AM CDT -----
Contact: Mom Linda 985-264-5277
Mom states she's calling about the new rule for prescription drugs that need **diagnosis** when you send the script to the pharmacy.She have questions re: this matter.

Telephone Encounter - Valteau, Christine A, LPN - 10/05/2015 8:57 AM CDT

Spoke with mom regarding **diagnosis** code for medication. Butalbital.

09/24/2015 Telephone Lysenko, Liudmila, MD

BAPTIST CLINICS
09/24/2015

Telephone Encounter - Bush, Barbara, MA - 09/24/2015 4:19 PM CDT

Patient prescription for Adderall XR was approved through the insurance. Per insurance the rx was filled on 9/2/2015.Information faxed to Walgreen's. I spoke with Janice L. @ 4:10.

09/02/2015 Office Visit Lysenko, Liudmila, MD Narcolepsy (Primary Dx)

JEFFERSON HIGHWAY CLINICS
09/02/2015

Progress Notes - Lysenko, Liudmila, MD - 09/02/2015 9:26 AM CDT

Formatting of this note may be different from the original.

Jeffrey Bodin was seen at the request of No ref. provider found for sleep evaluation.

10/29/2014: INITIAL HISTORY OF PRESENT ILLNESS: Jeffrey Bodin is a 18 y.o. male is here to be evaluated for a sleep disorder. He is accompanied by his mother Linda.

CHIEF COMPLAINT:

The patient's complaints include non refreshing sleep, fatigue and sleeepiness since 6 years ago when he was treated for melanoma with IV and SQ Interferons.
His symptoms remained stable over 6 years. He would sometimes fall asleep at school.
Was born prematurely - born at 7 weeks - had some infant sleep apnea back then.
He was developing fine and had no problem with his sleep till 6 years back.
He denied snoring, witnessed breathing pauses, gasping for air in sleep and interrupted sleep.
he denies cataplexy, sleep paralysis, **hallucinations**, palpitations, tremors, **anxiety**.

Denies dry mouth and sore throat
Denies nasal congestion
Report morning headaches - different from usual migrains which start later. Gets them daily
Denies interrupted sleep
Denies frequent leg movements
Denies symptoms concerning for parasomnia

The ESS (Epworth Sleepiness Score) taken on initial visit is 15 /24

He denied trouble falling asleep and staying asleep.

He was recently started on Tranxene -> Restoril by his neurologist. Denies any improvement in fatigue/sleepiness so far.

He is taking Gabapentin for Neuropathy, daily Fioricet for headaches. States that those medications do not make him sleepy.

The patient had tonsillectomy in the past

INTERVAL HISTORY:

03/02/2015 The patient has not presented any new complaints since the previous visit. He is coming with both parents to discuss sleep study, which was positive for OSA (AHI 10.3) and MSLT stronly suggestive of Narcolepsy.
He is currently taking Ritalin for ADD - 40 mg Ritalin LA in the morning - feels sleepy again at noon. He states that lower doses were not effective. States that Ritalin is not aggravating his headaches. he denies cataplexy, sleep paralysis, **hallucinations**, headaches, palpitations, tremors, **anxiety**, or rash. ESS 10/24 today (on Ritalin).

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05/04/2015: Jeffrey is taking 40 mg Adderall XR at 6 AM and 40 mg Adderall XR at 3-4 Pm when he comes from school to be able to do the homework. States that does not affect his sleep latency/continuity.
VS are normal today. Denied any change in his appetite, thought process, palpitations, change in headache pattern on his current high Adderall dose. Reports residual sleepiness at the end of school day. Topamax was recently D/C due to side effects. Still suffers from daily headaches. Taking a nap at 12-1 at school or 4-5 at home - naps are refreshing.

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07/14/2015: Reports improved sleepiness and improved migraines with more consistent Adderall schedule. Denied Anorexia,

mood changes, palpitations. ESS 12/24 tioday.
He would like additional 20 mg to avoid taking a nap at school. BP is slightly increased for his age since Adderall was increased. Had a cardiologist cleared him for Adderral use.

09/02/2015: He suffers simus infection. Reports longstanding allergies - using Mucinex pill year round. ESS 12/24. Tolerates Adderall well.Sometimes would skip the second dose and take a nap. Taking 20-90 min at school (dozing off during boring classes). SBP remained at 110-120's mm Hg as per patient.

SLEEP ROUTINE 09/02/2015 :

Bed partner:
Time to bed: !2:30 AM
Sleep onset latency: 10 min
Disruptions or awakenings: 0 - even without meds
Time to fall back into sleep:
Wakeup time: 5:40-6 AM
Perceived sleep quality: 0
Perceived total sleep time: 7-8 hours.
Daytime naps: 1-2 daily - during and after school 1-2 hrs (6 hrs after school) ->up till 12
Weekend sleep routine: 12 -till 8
Exercise routine: yes - cross country

PREVIOUS SLEEP STUDIES:

PSG 2/2/15: Significant Obstructive sleep apnea (OSA) with AHI (apnea hypopnea Index) of 0.9 and SaO2 of 91 (weight 218 lbs).
MSLT 2/315: Mean Sleep Latency - 1.5 min. 4 SOREMS out of 4 naps. Suggestive of narcolepsy in appropriate clinical setting.

Using My Ochsner: No

PAST MEDICAL HISTORY:
Active Ambulatory Problems
Diagnosis Date Noted
• Headache 12/05/2013
• Seizure disorder 07/07/2014
• Narcolepsy 06/03/2015

Resolved Ambulatory Problems
Diagnosis Date Noted
• No Resolved Ambulatory Problems

Past Medical History
Diagnosis Date
• Allergy
• Migraine headache
• Sinusitis
• Otitis media
• Hay fever

PAST SURGICAL HISTORY:
Past Surgical History
Procedure Laterality Date
• Tonsillectomy
• Adenoidectomy
• Tympanostomy tube placement
• Appendectomy

FAMILY HISTORY:
History reviewed. No pertinent family history.

SOCIAL HISTORY:
Tobacco:

History
Smoking status
• Never Smoker
Smokeless tobacco
• Never Used

alcohol use:
History
Alcohol Use: Not on file

Occupation: High scool junior. Very good student.

ALLERGIES: No Known Allergies

CURRENT MEDICATIONS:
Current Outpatient Prescriptions
Medication Sig Dispense Refill
• butalbital-acetaminophen-caffeine 50-325-40 mg (FIORICET, ESGIC) 50-325-40 mg per tablet 2 po prn headache; may be repeated in 4 hours 90 tablet 2
• dextroamphetamine-amphetamine (ADDERALL XR) 20 MG 24 hr capsule 2 po q am and 2 po q afternoon

Do not refill till 6/30 120 capsule 0
• dextroamphetamine-amphetamine (ADDERALL) 20 mg tablet 1 pill PO BID PRN sleepiness 60 tablet 0
• diphenhydrAMINE (BENADRYL) 12.5 mg chewable tablet Take 12.5 mg by mouth 4 (four) times daily as needed.
• DYMISTA 137-50 mcg/spray Spry
• guaifenesin (MUCINEX) 600 mg 12 hr tablet Take 1,200 mg by mouth 2 (two) times daily.
• montelukast 4 MG chewable tablet Take 4 mg by mouth every evening.
• naproxen (EC NAPROSYN) 500 MG EC tablet 500 mg once daily.
• PATADAY 0.2 % Drop
• pseudoephedrine (SUDAFED) 120 mg 12 hr tablet Take 120 mg by mouth every 12 (twelve) hours.

No current facility-administered medications for this visit.

REVIEW OF SYSTEMS:
Sleep related symptoms as per HPI

denies weight gain
Denies dyspnea
Denies palpitations
Denies acid reflux
Denies polyuria
Denies mood diturbance
Denies anemia
Reports muscle pain

Reports migraines and nerve damage post interferon treatment.

PHYSICAL EXAM:
BP 135/79 mmHg | Pulse 88 | Ht 5' 7" (1.702 m) | Wt 48.5 kg (106 lb 14.8 oz) | BMI 16.74 kg/m2
GENERAL: Normal development, well groomed.
HEENT:
HEENT: Conjunctivae are non-erythematous; Pupils equal, round, and reactive to light; Nose is symmetrical; Nasal mucosa is pink and moist; Septum is midline; Inferior turbinates are normal; Nasal airflow is normal; Posterior pharynx is pink; Modified Mallampati:"I; Posterior palate is low; Tonsils absent; Uvula is elongated;Tongue is enlarged; Dentition is fair; No TMJ tenderness; Jaw opening and protrusion without click and without discomfort.
NECK: Supple. Neck circumference is 13.2 inches. No thyromegaly. No palpable nodes.
SKIN: On face and neck: No abrasions, no rashes, no lesions. No subcutaneous nodules are palpable.
RESPIRATORY: Chest is clear to auscultation. Normal chest expansion and non-labored breathing at rest.
CARDIOVASCULAR: Normal S1, S2. No murmurs, gallops or rubs. No carotid bruits bilaterally. No edema. No clubbing. No cyanosis.
NEURO: Oriented to time, place and person. Normal attention span and concentration. **Gait** normal.
PSYCH: Affect is full. Mood is normal
MUSCULOSKELETAL: Moves 4 extremities. **Gait** normal.

ASSESSMENT:

1. Narcolepsy without cataplexy. He denies cataplexy, sleep paralysis, **hallucinations**, palpitations, tremors, **anxiety**. Previously tried Ritalin - 40 mg worked best, but effect lasted long enough, Concerta (insufficinet effect on 36 mg + IR Ritalin), Modafinil 200 mg BID (felt no effect). Jeffrey seems to have a high tolerance to stimulant medications. Residual sleepiness on 40 mg Adderall XR BID and 20 mg Adderall IR. He is known to have high medication tolerance. No side effects reported, except his BP increased from 114/70 towards 129-130/79 when he was switched from Concerta to Adderall and as Adderall dose was increased. Increased Adderall dose was apparently helpful in migraine control.
2. OSA - moderate by pediatric criteria, mild by adult criteria. He denied snoring, witnessed breathing pauses, gasping for air in sleep and interrupted sleep. He does get morning headache which is different from his usual migrains. He did not find benefit from 1 week APAP use..

PLAN:

1. Continue Adderall XR 40 mg BID
2. Continue Adderall IR from 20 mg to 40 mg for the end of Day as needed (can substitute with a nap).
3. Side effects were again explained in detail (psychosis, mood swings, increased HR and BP (he was recommended to monitor BP and HR at home in the morning and in the evening and keep a log, anorexia). He was recommended to monitor BP at home.
5. If he continues to be sleepy, will consider a trial of Xyrem

Follow up in 1 month with MD.

08/24/2015 Telephone Lysenko, Liudmila, MD

JEFFERSON HIGHWAY CLINICS
08/24/2015

Telephone Encounter - Glass, Latasha R., MA - 08/24/2015 3:23 PM CDT

----- Message from Angela Powell sent at 8/24/2015 2:35 PM CDT -----
Contact: pt
Pt's mother is calling regarding the Adderral that her son is on. Has questions regarding the effects of the medication. Please call 985-264-5277

Telephone Encounter - Glass, Latasha R., MA - 08/24/2015 3:23 PM CDT

Spoke with patient mother she was checking to see if Dr Lysenko think it is best for patient to seek a pych phy to prescribe meds for patient **anxiety**
patient is going through a lot of stress the beginning of this school year and she think he need to see a pych. Informed Dr Lysenko and advised patient mother that Dr Lysenko does agree that patient should see pych

08/20/2015 Telephone Brandt, Victoria Z., NP

BAPTIST CLINICS
08/20/2015

Telephone Encounter - Brandt, Victoria Z., NP - 08/20/2015 6:39 PM CDT

Was returning her call. Will try again tomorrow (1839)

08/20/2015 Telephone Brandt, Victoria Z., NP

BAPTIST CLINICS
08/20/2015

Telephone Encounter - Glass, Latasha R., MA - 08/20/2015 11:13 AM CDT

----- Message from Hillary Franklin sent at 8/20/2015 10:11 AM CDT -----
Contact: Linda Bodin (Mother)
Pt's mom states she would like to speak with someone regarding some side effects the pt is experiencing with ADDERALL. Please call pt's mother.

Linda Bodin (Mother)
985-264-5277

Date	Type	Specialty	Care Team	Description
	BODIN,JEFFREY [2592229]			
08/12/2015	Office Visit		Africk, Diane K., MD	Headache (Primary Dx)

JEFFERSON HIGHWAY CLINICS
08/12/2015

Progress Notes - Africk, Diane K., MD - 08/12/2015 8:53 AM CDT

Jeffrey Bodin is an 18-year-old male who initially saw me on 12/05/2013. Jeffrey returns today with his mother. Jeffrey carries the **diagnoses** of headaches, narcolepsy and status post interferon for **malignant** melanoma.

Please see my original **consultation** of 12/05/2013, for headache descriptions, birth history, hospitalizations, surgeries, **review of systems**, immunizations, medications, developmental history, endocrine history, social history, family history and dietary history.

Jeffrey looks well today. He is in a tie and long sleeve shirt for school. However, when I mentioned that Jeffrey looks well, he tells me that he will have a headache shortly.

Jeffrey is currently on Adderall 40 mg p.o. t.i.d. He tells me it is better, but still not perfect. He wants to make sure he can stay on the butalbital.

Jeffery's blood pressure is 135/69. We discussed the issues with blood pressure and Dr. Lysenko's concerns. Jeffrey tells me that he has always noted he does not want to have to go on high blood pressure medicine and as long as he can wait until he is in his 30s, then it is okay. I discussed trading the complications of one medicine for another. Jeffrey said that he wanted to stay on the Adderall because it helps him.

Jeffrey has been on amitriptyline, Neurontin, Topamax and verapamil for his headaches in the past.

On neurologic examination today, Jeffery's weight is 106 pounds (an increase of 1 pound). His height is 5 feet 7 inches. Today's blood pressure is 135/69. The last time he was here, it was 134/73. He has not been taking it at home because he has not been able to get a machine calibrated appropriately. He says he does not have time to go to the pediatrician's office once a week to have it checked. Pulse rate is 67 per minute. Respiratory rate is 24 per minute.

Jeffrey is a thin, well-nourished young man. He looks well today. He is in a rush. He needs to get to class. He just wants to make sure that he can stay on his butalbital.

Jeffrey has no ataxia. He has no dysmetria. He has no nystagmus. Extraocular movements are full and conjugate.

I was with Jeffrey and his mother for 20 minutes. Greater than 50% of the time was spent in counseling. Jeffrey is an 18-year-old male child with a history of **malignant** melanoma status post interferon. He has a history of intractable headaches and narcolepsy without cataplexy.

I have left a message for Dr. Lysenko regarding Jeffery and his medications.

I told Jeffrey I would be glad to see him back between Thanksgiving and Christmas. He said he would like to come before Thanksgiving. Mother says they would like to come in January. Jeffrey said they would be coming in early November.

Copy of this **consultation** to be sent to Dr. Sherry Casey.

DKA/HN dd: 08/12/2015 09:00:18 (CDT) td: 08/12/2015 22:51:37 (CDT) Doc ID

#1708787 Job ID #1597563

CC: Sherry Casey M.D.

08/12/2015 Telephone — Brandt, Victoria Z., NP
08/12/2015 Telephone — Lysenko, Liudmila, MD

BAPTIST CLINICS
08/12/2015

Telephone Encounter - Glass, Latasha R., MA - 08/12/2015 10:33 AM CDT

----- Message from Virginia Calvin sent at 8/12/2015 8:51 AM CDT -----
Contact: Dr.Africk / pager# 477-7774
Pl give Dr.Africk a call back. Says, "her call pertains to a mutual patient."
Thanks!

Pt: Jeffery Bodin (mrn# 2592229)
Caller: Dr.D.Africk
Pager# 477-7774

Telephone Encounter - Glass, Latasha R., MA - 08/12/2015 10:33 AM CDT

Paged Dr Africk for concern in reference to patient.

07/14/2015 Office Visit — Lysenko, Liudmila, MD — Narcolepsy (Primary Dx)

BAPTIST CLINICS
07/14/2015

Progress Notes - Lysenko, Liudmila, MD - 07/14/2015 9:19 AM CDT

Formatting of this note may be different from the original.

Jeffrey Bodin was seen at the request of No ref. provider found for sleep evaluation.

10/29/2014: INITIAL HISTORY OF PRESENT ILLNESS: Jeffrey Bodin is a 18 y.o. male is here to be evaluated for a sleep disorder. He is accompanied by his mother Linda.

CHIEF COMPLAINT:

The patient's complaints include non refreshing sleep, fatigue and sleeepiness since 6 years ago when he was treated for melanoma with IV and SQ Interferons.
His symptoms remained stable over 6 years. He would sometimes fall asleep at school.
Was born prematurely - born at 7 weeks - had some infant sleep apnea back then.
He was developing fine and had no problem with his sleep till 6 years back.
He denied snoring, witnessed breathing pauses, gasping for air in sleep and interrupted sleep.
he denies cataplexy, sleep paralysis, **hallucinations**, palpitations, tremors, **anxiety**.

Denies dry mouth and sore throat
Denies nasal congestion
Report morning headaches - different from usual migrains which start later. Gets them daily
Denies interrupted sleep
Denies frequent leg movements
Denies symptoms concerning for parasomnia

The ESS (Epworth Sleepiness Score) taken on initial visit is 15 /24

He denied trouble falling asleep and staying asleep.

He was recently started on Tranxene -> Restoril by his neurologist. Denies any improvement in fatigue/sleepiness so far.

He is taking Gabapentin for Neuropathy, daily Fioricet for headaches. States that those medications do not make him sleepy.

The patient had tonsillectomy in the past

INTERVAL HISTORY:

03/02/2015 The patient has not presented any new complaints since the previous visit. He is coming with both parents to discuss sleep study, which was positive for OSA (AHI 10.3) and MSLT stronly suggestive of Narcolepsy.
He is currently taking Ritalin for ADD - 40 mg Ritalin LA in the morning - feels sleepy again at noon. He states that lower doses were not effective. States that Ritalin is not aggravating his headaches. he denies cataplexy, sleep paralysis, **hallucinations**, headaches, palpitations, tremors, **anxiety**, or rash. ESS 10/24 today (on Ritalin).

04/01/2015: Jeffrey tried Concerta 36 mg with ER Ritalin in the afternoon - he did not feel a sufficient control of his sleepiness. His pediatrician's husband who is a sleep specialist prescribed Modafinil 200 mg - > further increased to 200 mg BID. He is no longer taking Concerta 36 or Ritalin. He states that Modafinil was inferior to Methylphenidate in its ability to control his daytime sleepiness. ESS 11/24. States that on Modafinil he was falling asleep at school on many occasions. Out of treatment regiments tried to this point Ritalin 40 mg seemed to work the best, but effect only lasted for two hours. He tried APAP, but could not tolerate it. He would like to defer treatment for now. HR and BP remain normal on today's visit.

05/04/2015: Jeffrey is taking 40 mg Adderall XR at 6 AM and 40 mg Adderall XR at 3-4 Pm when he comes from school to be able to do the homework. States that does not affect his sleep latency/continuity.
VS are normal today. Denied any change in his appetite, thought process, palpitations, change in headache pattern on his current high Adderall dose. Reports residual sleepiness at the end of school day. Topamax was recently D/C due to side effects. Still suffers from daily headaches. Taking a nap at 12-1 at school or 4-5 at home - naps are refreshing.

06/08/2015: Jeffrey is generally satisfied with the control of daytime sleepiness. Further improvement on Adderall 40 mg at 7:30-8 and 40 mg at 3 PM (was 5 PM at school) and sometimes 20 mg at noon. Denied palpitations, jitteriness and changes in his appetite. EKG 5/15 showed NSR, but with indication of right atrial enlargement. He is taking naps instead of second dose so far.

07/14/2015: Reports improved sleepiness and improved migraines with more consistent Adderall schedule. Denied Anorexia, mood changes, palpitations. ESS 12/24 tioday.
He would like additional 20 mg to avoid taking a nap at school. BP is slightly increased for his age since Adderall was increased. Had a cardiologist cleared him for Adderral use.

SLEEP ROUTINE 07/14/2015 :

Bed partner:
Time to bed: 10:10-11 PM
Sleep onset latency: 10 min
Disruptions or awakenings: 0 - even without meds
Time to fall back into sleep:
Wakeup time: 5:45
Perceived sleep quality: 0
Perceived total sleep time: 7-8 hours.
Daytime naps: 1-2 daily - during and after school 1-2 hrs
Weekend sleep routine: 12 -till 8
Exercise routine: yes - cross country

PREVIOUS SLEEP STUDIES:

PSG 2/2/15: Significant Obstructive sleep apnea (OSA) with AHI (apnea hypopnea Index) of 0.9 and SaO2 of 91 (weight 218 lbs).
MSLT 2/315: Mean Sleep Latency - 1.5 min. 4 SOREMS out of 4 naps. Suggestive of narcolepsy in appropriate clinical setting.

Using My Ochsner: No

PAST MEDICAL HISTORY:
Active Ambulatory Problems
Diagnosis Date Noted
• Headache 12/05/2013
• Seizure disorder 07/07/2014
• Narcolepsy 06/03/2015

Resolved Ambulatory Problems

Diagnosis Date Noted
• No Resolved Ambulatory Problems

Past Medical History
Diagnosis Date
• Allergy
• Migraine headache
• Sinusitis
• Otitis media
• Hay fever

PAST SURGICAL HISTORY:
Past Surgical History
Procedure Laterality Date
• Tonsillectomy
• Adenoidectomy
• Tympanostomy tube placement
• Appendectomy

FAMILY HISTORY:
History reviewed. No pertinent family history.

SOCIAL HISTORY:
Tobacco:
History
Smoking status
• Never Smoker
Smokeless tobacco
• Never Used

alcohol use:
History
Alcohol Use: Not on file

Occupation: High scool junior. Very good student.

ALLERGIES: No Known Allergies

CURRENT MEDICATIONS:
Current Outpatient Prescriptions
Medication Sig Dispense Refill
• butalbital-acetaminophen-caffeine 50-325-40 mg (FIORICET, ESGIC) 50-325-40 mg per tablet 2 po prn headache; may be repeated in 4 hours 90 tablet 1
• dextroamphetamine-amphetamine (ADDERALL XR) 20 MG 24 hr capsule 2 po q am and 2 po q afternoon

Do not refill till 6/30 120 capsule 0
• dextroamphetamine-amphetamine (ADDERALL) 20 mg tablet 1 po q day

Do not refill till 6/30/15 30 tablet 0
• diphenhydrAMINE (BENADRYL) 12.5 mg chewable tablet Take 12.5 mg by mouth 4 (four) times daily as needed.
• DYMISTA 137-50 mcg/spray Spry
• guaifenesin (MUCINEX) 600 mg 12 hr tablet Take 1,200 mg by mouth 2 (two) times daily.
• montelukast 4 MG chewable tablet Take 4 mg by mouth every evening.
• naproxen (EC NAPROSYN) 500 MG EC tablet 500 mg once daily.
• PATADAY 0.2 % Drop
• pseudoephedrine (SUDAFED) 120 mg 12 hr tablet Take 120 mg by mouth every 12 (twelve) hours.

No current facility-administered medications for this visit.

REVIEW OF SYSTEMS:
Sleep related symptoms as per HPI

denies weight gain
Denies dyspnea
Denies palpitations
Denies acid reflux
Denies polyuria
Denies mood diturbance
Denies anemia
Reports muscle pain

Reports migraines and nerve damage post interferon treatment.

PHYSICAL EXAM:
BP 129/79 mmHg | Pulse 88 | Ht 5' 7" (1.702 m) | Wt 47.582 kg (104 lb 14.4 oz) | BMI 16.43 kg/m2
GENERAL: Normal development, well groomed.
HEENT:
HEENT: Conjunctivae are non-erythematous; Pupils equal, round, and reactive to light; Nose is symmetrical; Nasal mucosa is pink and moist; Septum is midline; Inferior turbinates are normal; Nasal airflow is normal; Posterior pharynx is pink; Modified Mallampati:"I; Posterior palate is low; Tonsils absent; Uvula is elongated;Tongue is enlarged; Dentition is fair; No TMJ tenderness; Jaw opening and protrusion without click and without discomfort.
NECK: Supple. Neck circumference is 13.2 inches. No thyromegaly. No palpable nodes.
SKIN: On face and neck: No abrasions, no rashes, no lesions. No subcutaneous nodules are palpable.
RESPIRATORY: Chest is clear to auscultation. Normal chest expansion and non-labored breathing at rest.
CARDIOVASCULAR: Normal S1, S2. No murmurs, gallops or rubs. No carotid bruits bilaterally. No edema. No clubbing. No cyanosis.
NEURO: Oriented to time, place and person. Normal attention span and concentration. **Gait** normal.
PSYCH: Affect is full. Mood is normal
MUSCULOSKELETAL: Moves 4 extremities. **Gait** normal.

ASSESSMENT:

1. Narcolepsy without cataplexy. He denies cataplexy, sleep paralysis, **hallucinations**, palpitations, tremors, **anxiety**. Previously tried Ritalin - 40 mg worked best, but effect lasted long enough, Concerta (insufficinet effect on 36 mg + IR Ritalin), Modafinil 200 mg BID (felt no effect). Jeffrey seems to have a high tolerance to stimulant medications. Residual sleepiness on 40 mg Adderall XR BID and 20 mg Adderall IR. He is known to have high medication tolerance. No side effects reported, except his BP increased from 114/70 towards 129-130/79 when he was switched from Concerta to Adderall and as Adderall dose was increased. Increased Adderall dose was apparently helpful in migraine control.
2. OSA - moderate by pediatric criteria, mild by adult criteria. He denied snoring, witnessed breathing pauses, gasping for air in sleep and interrupted sleep. He does get morning headache which is different from his usual migrains. He did not find benefit from 1 week APAP use..

PLAN:

1. Continue Adderall XR 40 mg BID
2. Will increase Adderall IR from 20 mg to 40 mg for the end of Day as needed (can substitute with a nap).
3. Side effects were again explained in detail (psychosis, mood swings, increased HR and BP (he was recommended to monitor BP and HR at home in the morning and in the evening and keep a log, anorexia). He was recommended to monitor BP at home.
5. If he continues to be sleepy, will consider a trial of Xyrem

Follow up in 1 month with MD.

07/07/2015 Office Visit Africk, Diane K., MD Headache (Primary Dx)

JEFFERSON HIGHWAY CLINICS
07/07/2015

Progress Notes - Africk, Diane K., MD - 07/07/2015 10:40 AM CDT

Jeffrey Bodin is an 18-year-old male who initially saw me on 12/05/2013.
Jeffrey returns today with his mother. Jeffrey carries the **diagnoses** of headaches, narcolepsy, status post interferon for **malignant** melanoma.

Please see my original **consultation** of 12/05/2013 for headache descriptions,

birth history, hospitalizations and surgeries, **review of systems**, immunizations, medications, developmental history, endocrine history, social history, family history and dietary history.

There are always many ongoing issues with Jeffrey. It is true as well today.

When I came in the room, the lights were out. Jeffrey did not take his Adderall this morning. He wanted to be able to sleep on the way here and back. He was not able to sleep on the way here.

The headaches are not better. However, Jeffrey does not want to try the zonisamide. What he wants is to increase the Adderall to 40 mg p.o. t.i.d. He feels consistency helps his migraines. I said I would have to check with Dr. Lysenko. I have never had anybody on 120 mg of Adderall every day.

Jeffrey had a good trip to Washington DC with the ROTC leadership team. He is running again.

At this time, Jeffrey is taking Adderall extended release 40 mg p.o. b.i.d. and Adderall short release 20 mg p.o. every day.

Jeffrey has been on amitriptyline, Neurontin, Topamax and verapamil for his headaches in the past.

On neurologic examination today, Jeffrey's weight is 105 pounds (an increase of 1 pound). His height is 5 feet 7 inches. His blood pressure is 134/73. His pulse rate is 75 per minute. His respiratory rate is 24 per minute.

Jeffrey is a thin, well-nourished young man. He does not look well today. He says it is because he did not take his Adderall.

Jeffrey has no ataxia. He has no dysmetria. He has no nystagmus. Extraocular movements are full and conjugate.

I was with Jeffrey and his mother for 35 minutes. Greater than 50% of the time was spent counseling. Jeffrey is an 18-year-old male with a history of intractable headaches; narcolepsy; status post interferon for **malignant** melanoma. Jeffrey would like me to increase his Adderall to 40 mg p.o. t.i.d. He has been cleared by Cardiology. I explained that I would like to speak to Dr. Lysenko.

The family is due to see Dr. Lysenko shortly.

I would like to see Jeffrey back in three months or sooner if there are problems.

A copy of this **consultation** will be sent to Dr. Casey and Dr. Lysenko.

DKA/IN dd: 07/07/2015 10:39:41 (CDT) td: 07/08/2015 08:39:36 (CDT) Doc ID #1691838 Job ID #1580670

CC: LIUDMILA LYSENKO MD
Sherry Casey M.D.

after 06/30/2015

LABS

Laboratory Results

Date	Test	
10/06/2016	**MRI Brain W WO Contrast**	
	Associated Procedure: MRI Brain W WO Contrast	
	Unknown	**Text:** MRI Brain W WO Contrast (10/06/2016 9:02 AM) **Specimen** **Performing Laboratory** OCHS TALK TECHNOLOGY **Impressions** Normal MRI of the brain with and without gadolinium Electronically signed by:JOSEPH HAJJAR MD Date: 10/06/16 Time:14:58 **Narrative** Pre-and post gadolinium (4 cc of Gadovist) images were obtained through the brain. Comparison is made to the previous examination performed 07/14/2014. The brain ventricles appear normal. There is no evidence of mass effect or midline shift. No abnormal extra-axial collections are seen. There is no evidence of restricted diffusion and there is no evidence of abnormal enhancement. Flow voids are seen in the expected locations of the carotid and vertebrobasilar systems. **Procedure Note** Interface, Rad Results In - 10/06/2016 2:58 PM CDT Pre-and post gadolinium (4 cc of Gadovist) images were obtained through the brain. Comparison is made to the previous examination performed 07/14/2014. The brain ventricles appear normal. There is no evidence of mass effect or midline shift. No abnormal extra-axial collections are seen. There is no evidence of restricted diffusion and there is no evidence of abnormal enhancement. Flow voids are seen in the expected locations of the carotid and vertebrobasilar systems. IMPRESSION: Normal MRI of the brain with and without gadolinium Electronically signed by:JOSEPH HAJJAR MD Date: 10/06/16 Time:14:58

Narrative Text

- ~~MRI Brain W WO Contrast (10/06/2016 9:02 AM)~~

~~Specimen~~ **~~Performing Laboratory~~**

~~OCHS TALK TECHNOLOGY~~

~~Impressions~~

~~Normal MRI of the brain with and without gadolinium~~

~~Electronically signed by:JOSEPH HAJJAR MD~~

~~Date: 10/06/16~~

~~Time:14:58~~

~~Narrative~~

~~Pre-and post gadolinium (4 cc of Gadovist) images were obtained through the brain. Comparison is made to the previous examination performed 07/14/2014. The brain ventricles appear normal. There is no evidence of mass effect or midline shift. No abnormal extra-axial collections are seen. There is no evidence of restricted diffusion and there is no evidence of abnormal enhancement. Flow voids are seen in the expected locations of the carotid and vertebrobasilar systems.~~

Interface, Rad Results In - 10/06/2016 2:58 PM CDT

Pre-and post gadolinium (4 cc of Gadovist) images were obtained through the brain. Comparison is made to the previous examination performed 07/14/2014. The brain ventricles appear normal. There is no evidence of mass effect or midline shift. No abnormal extra-axial collections are seen. There is no evidence of restricted diffusion and there is no evidence of abnormal enhancement. Flow voids are seen in the expected locations of the carotid and vertebrobasilar systems.

IMPRESSION:

Normal MRI of the brain with and without gadolinium

Electronically signed by:JOSEPH HAJJAR MD

Date: 10/06/16

Time:14:58

after 06/30/2015

VITALS

Vital Signs

Type	Date	Interpretation	Value	Ref Range
BP dias	08/15/2016		91 mm[Hg]	
BP sys	08/15/2016		132 mm[Hg]	
Bdy height	08/15/2016		172.1 cm	
Heart rate	08/15/2016		71 /min	
Weight	08/15/2016		49.4 kg	

Narrative Text

Vital Sign	Reading	Time Taken
Blood Pressure	132 / 91	08/15/2016 1:10 PM CDT
Pulse	71	08/15/2016 1:10 PM CDT
Temperature	-	-
Respiratory Rate	-	-
Oxygen Saturation	-	-
Inhaled Oxygen Concentration	-	-
Weight	49.4 kg (108 lb 14.5 oz)	08/15/2016 1:10 PM CDT
Height	172.1 cm (5' 7.76")	08/15/2016 1:10 PM CDT
Body Mass Index	16.68	08/15/2016 1:10 PM CDT

MEDS

Medication Information

Non-identified Provider

Date	Product	Indication	Status	Dose	Frequency	Quantity
02/16/2016	Butalbital-Acetaminophen-Caff 50-325-40 Mg Oral Tab		Inactive		Unknown	90
12/21/2015	Dextroamphetamine-Amphetamine 20 Mg Oral Cp24	Diagnosis interpretation	Active		Unknown	120
12/21/2015	Dextroamphetamine-Amphetamine 20 Mg Oral Tab	Diagnosis interpretation	Active		Unknown	60
11/09/2015	Butalbital-Acetaminophen-Caff 50-325-40 Mg Oral Tab		Inactive		Unknown	90
10/14/2015	Butalbital-Acetaminophen-Caff 50-325-40 Mg Oral Tab		Inactive		Unknown	90
10/06/2015	Montelukast 10 Mg Oral Tab		Active		Unknown	
09/02/2015	Dextroamphetamine-Amphetamine 20 Mg Oral Cp24	Diagnosis interpretation	Inactive		Unknown	120
09/02/2015	Dextroamphetamine-Amphetamine 20 Mg Oral Tab	Diagnosis interpretation	Inactive		Unknown	60
08/12/2015	Butalbital-Acetaminophen-Caff 50-325-40 Mg Oral Tab	Diagnosis interpretation	Inactive		Unknown	90
07/14/2015	Dextroamphetamine-Amphetamine 20 Mg Oral Cp24	Diagnosis interpretation	Inactive		Unknown	120
07/14/2015	Dextroamphetamine-Amphetamine 20 Mg Oral Tab	Diagnosis interpretation	Inactive		Unknown	60
07/14/2015	Dextroamphetamine-Amphetamine 20 Mg Oral Tab	Diagnosis interpretation	Inactive		Unknown	60
06/08/2015	Dextroamphetamine-Amphetamine 20 Mg Oral Tab	Diagnosis interpretation	Inactive		Unknown	30
06/08/2015	Dextroamphetamine-Amphetamine 20 Mg Oral Cp24	Diagnosis interpretation	Inactive		Unknown	120
06/03/2015	Zonisamide 25 Mg Oral Cap	Diagnosis interpretation	Inactive		Unknown	30
06/03/2015	Butalbital-Acetaminophen-Caff 50-325-40 Mg Oral Tab	Diagnosis interpretation	Inactive		Unknown	90
05/13/2015	Dymista 137-50 McG/Spray Nasl Spry		Active		Unknown	
05/09/2015	Pataday 0.2 % Opht Drop		Active		Unknown	
No Date Available	Guaifenesin 600 Mg Oral Tbsr		Active	1200 mg	Unknown	
No Date Available	Diphenhydramine Hcl 12.5 Mg Oral Chew		Active	12.5 mg	Unknown	
12/21/2015	Montelukast 4 Mg Oral Chew		Inactive	4 mg	Unknown	
No Date Available	Naproxen 500 Mg Oral Tbec		Active	500 mg	Unknown	
No Date Available	Pseudoephedrine Hcl 120 Mg Oral Tbsr		Active	120 mg	Unknown	

Narrative Text

Prescription	Sig.	Disp.	Refills	Start Date	End Date	Status
guaifenesin (MUCINEX) 600 mg 12 hr tablet	Take 1,200 mg by mouth 2 (two) times daily.					Active
diphenhydrAMINE (BENADRYL) 12.5 mg chewable tablet	Take 12.5 mg by mouth 4 (four) times daily as needed.					Active

Prescription	Sig.	Disp.	Refills	Start Date	End Date	Status
naproxen (EC NAPROSYN) 500 MG EC tablet	500 mg once daily.					Active
DYMISTA 137-50 mcg/spray Spry				05/13/2015		Active
PATADAY 0.2 % Drop				05/09/2015		Active
pseudoephedrine (SUDAFED) 120 mg 12 hr tablet	Take 120 mg by mouth every 12 (twelve) hours.					Active
montelukast (SINGULAIR) 10 mg tablet				10/06/2015		Active
dextroamphetamine-amphetamine (ADDERALL XR) 20 MG 24 hr capsule	2 po q am and 2 po q afternoon Do not refill till 6/30	120 capsule	0	12/21/2015		Active
Indications: Primary narcolepsy without cataplexy						
dextroamphetamine-amphetamine (ADDERALL) 20 mg tablet	1 pill PO BID PRN sleepiness	60 tablet	0	12/21/2015		Active
Indications: Primary narcolepsy without cataplexy						
montelukast 4 MG chewable tablet	Take 4 mg by mouth every evening.				12/21/2015	Discontinued
zonisamide (ZONEGRAN) 25 MG Cap	1 po q hs	30 capsule	1	06/03/2015	07/07/2015	Discontinued
Indications: Headache(784.0)						
butalbital-acetaminophen-caffeine 50-325-40 mg (FIORICET, ESGIC) 50-325-40 mg per tablet	2 po prn headache; may be repeated in 4 hours	90 tablet	1	06/03/2015	08/12/2015	Discontinued
Indications: Headache(784.0)						
dextroamphetamine-amphetamine (ADDERALL) 20 mg tablet	1 po q day Do not refill till 6/30/15	30 tablet	0	06/08/2015	07/14/2015	Discontinued
Indications: Narcolepsy						
dextroamphetamine-amphetamine (ADDERALL XR) 20 MG 24 hr capsule	2 po q am and 2 po q afternoon Do not refill till 6/30	120 capsule	0	06/08/2015	07/14/2015	Discontinued
Indications: Narcolepsy						
dextroamphetamine-amphetamine (ADDERALL XR) 20 MG 24 hr capsule	2 po q am and 2 po q afternoon Do not refill till 6/30	120 capsule	0	07/14/2015	09/02/2015	Discontinued
Indications: Narcolepsy						
dextroamphetamine-amphetamine (ADDERALL) 20 mg tablet	1 po q day Do not refill till 6/30/15	60 tablet	0	07/14/2015	07/14/2015	Discontinued
Indications: Narcolepsy						
dextroamphetamine-amphetamine (ADDERALL) 20 mg tablet	1 pill PO BID PRN sleepiness	60 tablet	0	07/14/2015	09/02/2015	Discontinued
Indications: Narcolepsy						

Prescription	Sig.	Disp.	Refills	Start Date	End Date	Status
butalbital-acetaminophen-caffeine 50-325-40 mg (FIORICET, ESGIC) 50-325-40 mg per tablet Indications: Headache(784.0)	2 po prn headache; may be repeated in 4 hours	90 tablet	2	08/12/2015	10/13/2015	Discontinued
dextroamphetamine-amphetamine (ADDERALL XR) 20 MG 24 hr capsule Indications: Narcolepsy	2 po q am and 2 po q afternoon Do not refill till 6/30	120 capsule	0	09/02/2015	12/21/2015	Discontinued
dextroamphetamine-amphetamine (ADDERALL) 20 mg tablet Indications: Narcolepsy	1 pill PO BID PRN sleepiness	60 tablet	0	09/02/2015	12/21/2015	Discontinued
butalbital-acetaminophen-caffeine 50-325-40 mg (FIORICET, ESGIC) 50-325-40 mg per tablet	TAKE TWO TABLETS BY MOUTH AS NEEDED FOR HEADACHE, MAY REPEAT IN 4 HOURS	90 tablet	0	10/14/2015	11/09/2015	Discontinued
butalbital-acetaminophen-caffeine 50-325-40 mg (FIORICET, ESGIC) 50-325-40 mg per tablet	2 po prn headache; may repeat in 4 hours	90 tablet	3	11/09/2015	02/15/2016	Discontinued
butalbital-acetaminophen-caffeine 50-325-40 mg (FIORICET, ESGIC) 50-325-40 mg per tablet	TAKE 2 TABLETS BY MOUTH AS NEEDED FOR HEADACHE. MAY REPEAT IN 4 HOURS	90 tablet	0	02/16/2016	08/15/2016	Discontinued

CARE PLAN

Plan of Care

Health Maintenance	Due Date	Last Done	Comments
Lipid Panel	**05/22/1997**		
HPV Vaccines (1 of 3 - Male 3 Dose Series)	**05/22/2008**		
TETANUS VACCINE	**05/22/2015**		
Influenza Vaccine	08/01/2017	11/25/2013	

PROV LIST

Healthcare Providers

Ochsner Health System and Its Subsidiaries and Affiliates (10/11/2013 - No Date Available)

Provider Name	Address	Telecom	MRN
Sherri Casey, MD	71107 HWY 21 SUITE 105 COVINGTON, LA 70433	tel:tel:+1-985-893-2580, tel:fax:+1-985-871-9418	2592229

MD Anderson Cancer Center

MAIN BUILDING
FACESHEET

BODIN,JEFFREY T
MRN: 0744652
DOB: 5/22/1997, Sex: M

Patient Information

Patient Name	Sex	DOB
Bodin, Jeffrey T	Male	5/22/1997

PCP and Center

Primary Care Provider	Phone	Center
Merrick I Ross, MD	713-792-6800	None

Patient Ethnicity & Race

Ethnic Group	Patient Race
Not Hispanic or Latino	White or Caucasian

Emergency Contacts

Contact Person (Rel.)	Home Phone	Work Phone	Mobile Phone
Bodin,Linda (Mother)	985-264-5277	--	--
Bodin,Mark (Father)	985-237-8363	--	--

Addendum Note by Beatriz Rozo, NP

Author: Beatriz Rozo, NP | Service: (none) | Author Type: Nurse Practitioner
Filed: 5/25/2016 6:03 PM | Encounter Date: 5/25/2016 | Status: Signed
Editor: Beatriz Rozo, NP (Nurse Practitioner)
Addended by: ROZO, BEATRIZ on: 5/25/2016 06:03 PM

Modules accepted: Orders

H&P by Diwaker Balachandran, MD

Author: Diwaker Balachandran, MD | Service: (none) | Author Type: Physician
Filed: 8/1/2016 11:59 AM | Encounter Date: 8/1/2016 | Status: Signed
Editor: Diwaker Balachandran, MD (Physician)

Sleep Consult Note

Patient: Jeffrey T Bodin **Age:** 19 y.o.
MRN: 0744652
Consult Date: August 1, 2016 **Consultant:** DAVE BALACHANDRAN, MD

Requesting Clinician/Service. : Merrick I Ross, MD

Reason for Consult. Evaluate for narcolepsy

HISTORY OF PRESENT ILLNESS:

This is a 19-year-old gentleman with an oncologic history as below. He is currently without active disease and is on surveillance.

1. History of 1.3 mm Clark's level 4 Spitzoid melanoma of the left ankle with

H&P by Diwaker Balachandran, MD (continued)

5 mitotic figures per millimeter squared.

2. Status post wide local excision along with sentinel biopsy positive for metastatic disease in the left inguinal region in March 2008.

3. Status post left inguinal lymph node dissection in April 2008.

4. Completion of 4 months interferon therapy. The patient discontinued secondary to toxicities.

The patient is referred to the sleep clinic for second opinion regarding narcolepsy.

The patient has had symptoms of narcolepsy he says since and his chemotherapy when he was about 11 years old. He states that he's always had extreme daytime sleepiness but fairly normal nocturnal sleep.

He states that he usually goes to bed between 12 AM and 2 AM. It takes him less than 5 minutes to fall asleep. He awakens between 10 AM and 12 PM and awakens unrefreshed. He'll stay up for 2-3 hours and then take another 2-3 hour nap and repeat this pattern until his bedtime.

The patient has been diagnosed with narcolepsy in the past. He had a PSG MSLT on 2/2/2015 at the os Schnur health system sleep Center. The telephone number for the sleep center is 504-842-4910.

The report reads as follows the patient slept a total of 401 minutes. N1 sleep was 5.4%. Slow wave sleep was 24.4%. An REM sleep was 21.2%.

The patient had mild OSA mostly hypotony is with no obstructive apneas. His AHI was 5.9. The REM AHI was 30.4. His oxygen nadir was 91%.

The test was followed by an MSLT with 4 naps at two-hour intervals. He fell asleep on 4 out of 4 naps. He had so rems on 4 out of 4 naps. Nap one latency was 3.3 minutes nap to latency was 1 minute nap 3 latency was 0.5 minutes and nap 4 latency was 2 minutes. The average sleep latency was 1.5 minutes. His urine drug screen on the morning of the test was negative.

The patient has clinical symptoms of sleep paralysis without hypnopompic or hypnagogic hallucinations. He says the sleep paralysis occurs daily. He denies any cataplexy.

He denies snoring he denies witnessed apneas other than during the sleep study.

He denies leg kicking in fact he states does he sleeps very still. He denies any restless legs. He just denies any symptoms of parasomnia such as sleepwalking or sleep talking.

The patient has a history of migraine headaches.

For his narcolepsy in the past, he has taken high doses of Adderall. The Adderall dose was 120 milligrams per day. When he was taking the Adderall and the patient said he had tremendously improved daytime wakefulness. He was able to make friends which he says he cannot do currently. The patient also try Provigil and Nuvigil without improvement. As far as I can tell he has not been on a REM suppressant therapy. Xyrem has been discussed with him by his sleep doctor in Louisiana.

The patient finished high school and is considering going to college soon.

The patient does not smoke does not drink alcohol or take any other recreational drugs.

Review of System.

Review of Systems
Constitutional: Negative for chills, diaphoresis, fatigue and fever.
HENT: Negative for nosebleeds and sore throat.
Eyes: Negative for photophobia.
Respiratory: Negative for apnea, cough, chest tightness, shortness of breath and wheezing.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for constipation, diarrhea, nausea and vomiting.
Endocrine: Negative for cold intolerance and heat intolerance.
Genitourinary: Negative for dysuria.
Musculoskeletal: Negative for arthralgias and myalgias.
Skin: Negative for rash.
Neurological: Negative for seizures and syncope.
Psychiatric/Behavioral: Negative for confusion.

Allergies.
No Known Allergies

Medications.
Current Medications
Not on File

Past Medical History.
No past medical history on file.

Past Surgical History.
No past surgical history on file.

Family Medical History.
No family history on file.

Social History.
History

Social History

H&P by Diwaker Balachandran, MD (continued)

- Marital status: Single
  Spouse name: N/A
- Number of children: N/A
- Years of education: N/A

Social History Main Topics

- Smoking status: Not on file
- Smokeless tobacco: Not on file
- Alcohol use: Not on file
- Drug use: Not on file
- Sexual activity: Not on file

Other Topics — Concern

- Not on file

Social History Narrative

Vital Signs:

Visit Vitals

- BP 133/73
- Pulse 73
- Temp 36.9 °C (98.4 °F)
- Resp 20
- Ht 168 cm (5' 6.14")
- Wt 50 kg (110 lb 3.7 oz)
- SpO2 100%
- BMI 17.72 kg/m2

Physical Exam.

GENERAL: This is a pleasant young man in no distress. The patient is awake and alert. The patient is able to talk in complete sentences.
HEENT: Pupils equal, round and reactive to light. Extraocular movements are intact. Nasal mucosa is normal without any epistaxis. Oropharyngeal aperture is clear without any exudates or thrush. Oropharyngeal aperture (Mallampati 1) is reduced. There are no tonsils present. These were removed when he was 4 years old.
NECK: Supple. There is no supraclavicular or cervical lymphadenopathy. No upper airway sounds or stridor. No jugular venous distention is noted.
CARDIAC: Regular rate and rhythm without any murmurs, gallops or rubs.
LUNGS: Clear to auscultation. No wheezing. No use of accessory muscles.
ABDOMEN: Soft, nontender, nondistended.
EXTREMITIES: No asymmetrical edema, 2+ pedal and radial pulses. No peripheral cyanosis.
MUSCULOSKELETAL: No joint deformities, no synovitis. Full range of motion throughout.
SKIN: No rash, lesions, or ulceration.
NEUROLOGIC: Alert and oriented x 3. No gross focal deficits.
PSYCHIATRIC: Pleasant affect. Adequate insight into disease process. Mood is appropriate.

Diagnostic Studies.

1. Pittsburgh sleep quality index score of 6

H&P by Diwaker Balachandran, MD (continued)

2. Epworth Sleepiness Scale 14.
3. STOP-BANG 3

Obstructive sleep apnea. This patient carries a diagnosis of mild sleep apnea. I reviewed his sleep study and his sleep apnea is mainly hyponeas. There is no evidence of central sleep apnea. We will be repeating the PSG as part of his PSG/MSLT.

I don't think obstructive sleep apnea is a major contributor to his daytime sleepiness compared to his narcolepsy. And unless it's very significant I would not advocate treatment of his obstructive sleep apnea at this time.

2. Narcolepsy: Based on his clinical symptoms of daytime sleepiness and sleep paralysis as well as his MSLT which is consistent with a diagnosis I believe the patient does have narcolepsy. The patient and his mother are concerned about the adequacy of the prior test and have asked for repeat testing to confirm the diagnosis. We will go ahead and order a PSG MSLT to reconfirm the diagnosis of narcolepsy.

We discussed therapeutic options including sodium oxybate therapy and other means of REM suppression. In addition we discussed alertness drugs including continuing the Adderall versus restarting Provigil individual if he does begin sodium oxybate therapy

Currently the patient is not on stimulant therapy due to his parents concern about the high-dose and side effects.

3. Headaches: The patient has a history of headaches that are thought to be related to migraines we discussed that treatment with desire and can also cause headaches. Before beginning any therapy the patient and perhaps myself communicate with his neurologist.

3.. Driving length: I discussed the dangers of drowsy driving with the patient.

4. Insomnia.
The patient does not have problems with sleep initiation or sleep maintenance.

5. Movement disorder.
My clinical suspicion for sleep-related movement disorder is low.

6. Sleep hygiene.
Sleep hygiene. Patient's sleep hygiene appears to be adequate. We discussed the importance of set sleep time and wake time. Patient's sleep environment appears to be optimized.

7. Disposition: The patient's mother's request a follow-up with telephone or electronically indication as much as possible.

The aforementioned impression and plan was discussed with the patient at length. All questions were answered. Follow up will be coordinated with other visits. The patient has our clinic number and my direct e-mail if needed.

Progress Notes by Diwaker Balachandran, MD

Author: Diwaker Balachandran, MD | Service: (none) | Author Type: Physician
Filed: 8/15/2016 1:16 PM | Encounter Date: 8/4/2016 | Status: Signed
Editor: Diwaker Balachandran, MD (Physician)

Procedures
MD Anderson Sleep Center
PO Box 301439, Unit 1284
Houston, TX 77030
Phone: 713-792-2352

Baseline Polysomnogram Report

I. PATIENT PROFILE:

Patient Name: Bodin, Jeffrey
Medical Record Number: 0744652
Age: 19 (years)
Sex: Male
Height: 168 cm Weight: 50.0 Kg
BMI: 17.7 kg/m2
Study Date: 8/4/2016
Referring Physician: Dr. Merrick, I. Ross

II. CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS:

The patient is referred for evaluation of hypersomnia and narcolepsy. An MSLT followed this PSG and is reported separately. Please see Dr. Balachandran's consultation for further details.

III. DIAGNOSIS* AND COMMENT:

Others
G47.1 Hypersomnia

The sleep study was performed using attended comprehensive polysomnography. This included recording electroencephalogram, electrooculograms, submentalis electromyogram, airflow, respiratory effort, oxygen saturation, anterior tibialis electromyogram, and heart rhythm. A standard montage was used. Recordings were scored manually according to American Academy of Sleep Medicine guidelines*.

The total recording time (TRT) from lights off to lights on was 526.7 minutes. Total sleep time (TST) for 408.0 minutes. This resulted in a sleep efficiency that was low (less than 85%) at 77.5%. Latency to persistent sleep was long (greater than 20 minutes) at 92.5 minutes, and latency to REM sleep was short (less than 60 minutes) at 1.5 minutes. A short REM sleep latency is seen in narcolepsy, but may also be due to prior REM-sleep deprivation or disruption as seen in patients with sleep apnea, depression, irregular sleep/wake schedule, or upon withdrawal of medications such as stimulants. The patient spent 45.0 minutes (11.0%) of TST in the supine position. Sleep architecture was characterized 8.8% in N1 sleep, 67.6% in N2 sleep, 3.1%

in N3 Sleep and 20.5% in REM sleep. The time of wake after sleep onset (WASO) was 26.5 minutes and the arousal index (AI) was 24.4 per hour.

There was no snoring without clinically significant sleep disordered breathing.

During the 408.0 minutes of TST, polysomnographic assessment revealed 0 episodes of apnea (0 obstructive, 0 central, 0 mixed) and 0 episodes of hypopnea. The Apnea Index (AI, apneas/hour of sleep) was 0, the Apnea & Hypopnea Index (AHI, apnea & hypopnea/hour of sleep) was 0, and the oxygen saturation nadir was 93.0%. Overall, the Respiratory Event Related Arousals (RERAs) index was 12.2, resulting in a Respiratory Disturbance Index (RDI) of 12.2.

This patient did not have significant leg movement activity during sleep evaluation Sleep study revealed 66 periodic leg movements (PLM), 13 of which were associated with arousal. PLM index was 9.7 and PLM arousal index was 1.9 events per hour of sleep.

The electrocardiogram demonstrated normal sinus rhythm.

There were no EEG abnormalities.

IV. TREATMENT PLAN RECOMMENDATIONS:

Sleep Disorder

Insomnia/Hypersomnia
Evaluation for other etiologies of hypersomnia with a multiple sleep latency test may be considered.

The patient should be scheduled for a post-evaluation consultation with the sleep clinic to discuss our findings and explain the available treatment options. If there are any questions regarding our examination, please feel free to contact our office for further elaboration or interpretation of our findings. Details concerning specific test scores and the results of sleep studies are available upon request.

Sincerely,
Diwakar Balachandran, MD
UT M. D. Anderson Sleep Center

*A hypopnea is scored if the peak signal excursions drop by greater than or equal to 30% of pre-event baseline using nasal pressure (diagnostic study), PAP device flow (titration study), or an alternative hypopnea sensor (diagnostic study). The duration of the greater than or equal to 30% drop in signal excursion is greater than or equal to 10 seconds and there is a greater than or equal to 4% oxygen desaturation from pre-event baseline.

Berry RB, Brooks R, Gamaldo CE, Harding SM, Marcus CL and Vaughn BV for the American Academy of Sleep Medicine. The AASM Manual for the Scoring of Sleep and Associated Events: Rules, Terminology and Technical Specifications, Version 2.0. www.aasmnet.org, Darien, Illinois: American Academy of Sleep Medicine, 2012.

Progress Notes by Diwaker Balachandran, MD (continued)

Progress Notes by Diwaker Balachandran, MD

Author: Diwaker Balachandran, MD | Service: (none) | Author Type: Physician
Filed: 8/15/2016 1:17 PM | Encounter Date: 8/5/2016 | Status: Signed
Editor: Diwaker Balachandran, MD (Physician)

Procedures
MD Anderson Sleep Center
PO Box 301439, Unit 1284
Houston, TX 77030
Phone: 713-792-2352

Multiple Sleep Latency Test Report

I. PATIENT PROFILE

Patient Name: Bodin, Jeffrey
Medical Record Number: 744652
Age: 19 (years)
Sex: Male
Height: 168 cm Weight: 50.0 Kg

BMI: 17.7 kg/m2
Study Date: 8/5/2016
Referring Physician: Dave Balachandran M.D., M.D.
Epworth Sleepiness Score (ESS): 14.0

II. DIAGNOSIS

Hypersomnia
347.00 Narcolepsy, Unspecified

III. PROCEDURE
The patient underwent a MSLT (multiple sleep latency test) according to the guidelines established by the American Academy of Sleep Medicine*. The patient was allowed to nap starting at two hours post awakening from the baseline study and subsequently at 2 hour intervals. During the baseline polysomnogram the sleep efficiency was 77/5%. There was no evidence of clinically significant sleep disordered breathing, nocturnal hypoxemia or movement disorders. The MSLT immediately followed the baseline study.

A total of four naps were performed. The patient slept during four of the four naps. The mean sleep latency (MSLT score) was 5.9 minutes. There were four sleep onset REM periods (SOREM) noted.

Progress Notes by Diwaker Balachandran, MD (continued)

The diagnosis of narcolepsy requires 2 SOREMs, and an MSLT score of less than 8 minutes (mean sleep latency). An MSLT score of less than 10 minutes with less than 2 SOREMs can be seen in idiopathic (CNS) hypersomnia, upper airway resistance syndrome, periodic limb movement disorder and sleep apnea.

IV. CONCLUSION

The clinical history is suggestive of hypersomnia, and the MSLT is consistent with narcolepsy.

V. RECOMMENDATIONS

Stimulant therapy is recommended for daytime sleepiness.

Possible pharmacologic therapies include fluoxetine, venlafaxine, sodium oxybate, clomipramine, viloxazine, imipramine.

Additionally, HLA testing for DQ antigens (DQB1*0602 and DQA1*0102), which are associated with narcolepsy, and HLA-Cw2, which is associated with familial idiopathic hypersomnia, may provide further information.
Strategically timed naps should be incorporated in the patient's daily schedule.

The patient will be seen for a post-evaluation consultation with sleep clinic to discuss our findings and to explain the available treatment options.

If there are any questions regarding our examination, please feel free to contact our office for further elaboration or interpretation of our findings. Details concerning specific test scores and the results of sleep studies are available upon request.

Sincerely,
Diwakar Balachandran, MD
UT M. D. Anderson Sleep Center

* The International Classification of Sleep Disorders: Diagnostic and Coding Manual. Diagnostic Classification Steering Committee, Thorpy MJ, Chairman. Rochester, Minnesota: American Sleep Disorders Association, 2005

Berry RB, Brooks R, Gamaldo CE, Harding SM, Marcus CL and Vaughn BV for the American Academy of Sleep Medicine. The AASM Manual for the Scoring of Sleep and Associated Events: Rules, Terminology and Technical Specifications, Version 2.0. www.aasmnet.org, Darien, Illinois: American Academy of Sleep Medicine, 2012

Littner MR et al. Practice Parameters for Clinical Use of the Multiple Sleep Latency Test and the Maintenance of Wakefulness Test- AASM Practice Paramenters. Sleep 2005: 28(1) 113-121

Progress Notes by Vivian C Esquivel, RN

Progress Notes by Vivian C Esquivel, RN (continued)

Author: Vivian C Esquivel, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/18/2016 4:24 PM | Encounter Date: 10/18/2016 | Status: Signed
Editor: Vivian C Esquivel, RN (Registered Nurse)

Nursing Note

Patient: Jeffrey T Bodin **Age:** 19 y.o.
MRN: 0744652 **Attending:**

Date of Visit: October 18, 2016

History of Present Illness:
Jeffrey T Bodin is a 19 y.o. male who presents with 10 hours leep at night time and sleep up 6 hours in the morning intermittently. Feels tired and fatigue.

Review of Systems

Physical Exam

H&P by Diwaker Balachandran, MD

Author: Diwaker Balachandran, MD | Service: (none) | Author Type: Physician
Filed: 10/18/2016 4:24 PM | Encounter Date: 10/18/2016 | Status: Signed
Editor: Diwaker Balachandran, MD (Physician)

This a follow-up note on the patient with narcolepsy.

719-year-old gentleman with a history of melanoma. He also has a history of narcolepsy which we studied via polysomnography and verified the diagnosis.

About one month ago we started him on ziram for a total of 4.5 grams nightly in 2 divided doses.

The patient states that he is absolutely had no improvement in his excessive daytime sleepiness since starting the ziram one month ago.

I'm also in contact with his mother via my chart says she thinks there is been some improvement in alertness.

The patient states that he goes to bed around 1 AM which is when he takes the first dose of Xyrem. He sets his alarm for about 4 AM 3 hours later and takes the second dose of Xyrem. He awakens between 8 AM and 1 PM. He stays up for 1-2 hours and then sleeps again for about 2-4 hours. In the may have wake periods every 3-4 hours until his bedtime once again. Her because of this he states that he has no social life and cannot make any friends and her stay in touch with anyone.

He states that he stays up for more than 1-2 hours that he starts having migraine headaches and needs to sleep at that point.

H&P by Diwaker Balachandran, MD (continued)

The patient states that in the past he has been on an phentermine such as at a row with better fact that at least allowed him to be awake enough to make friends.

Assessment and plan:

1. Narcolepsy: This patient has MSLT proven narcolepsy. We have recently started him on ziram at 4.5 grams nightly. The patient finds that it has had no improvement on his daytime sleepiness. He does not have cataplexy but he has not had cataplexy in the past.

We have a couple options for advancing treatment. Because his daytime symptoms of the ones that he cares about the most. I think we'll go ahead and start him on Nuvigil 250 milligrams at 9 AM. In addition to the Xyem that he is on.

We spent quite a bit of time talking about the Haverhill modification and how that without behavioral modification medical therapy is unlikely to be very successful. We discussed in's I stressed the importance of keeping a daytime schedule. I encouraged him to have an exercise plan and I encouraged him to make sure that he stays awake for as long as possible after the first dose of modafinil which would be best reinforced with a daily schedule. I told him to be very important to take his medications on a schedule and not to change the times of the doses and that he should again maintain a schedule in terms of meals and scheduled naps and times of wakefulness. The patient is concerned that if he stays up from 1-2 hours he may suffer migraines.

The patient feels that only and phentermine medications well help him in the long run. We did address this and stated that even those medications will be subject to tachyphylaxis and that they may not have the effect that he desires in the long run.

We discussed that we are using Nuvigil which she has tried in the past and found to be ineffective now in the setting of the ziram which I hope will make it more effective. Once again I stressed that without behavioral changes it is unlikely that he will have significant improvement with medications alone.

The patient's father was with him today also stressed with him that I like to see him every 3 months while he is on the scheduled medications.

I will communicate with Dr. Jarrell in Louisiana the patient's pediatrician about the conversation we had an about the new medication we started today.

I spent a total of 30 minutes with this patient which more than half was spent with face-to-face counseling and coordination of care.

Procedures (Outpatient) by Diwaker Balachandran, MD

Author: Diwaker Balachandran, MD | Service: (none) | Author Type: Physician
Filed: 3/1/2017 4:02 PM | Encounter Date: 1/31/2017 | Status: Signed
Editor: Diwaker Balachandran, MD (Physician)

This note is to document that I saw Mr. Jeffrey Bodin in clinic today along with his mother who accompanied

him.

He has narcolepsy without cataplexy. Since November he has been on increasing dose of Xyrem. The current doses 4.25 grams at bedtime and an additional 2.125 grams 2-3 hours later. The patient was on modafinil but he had nausea and discontinued it 2 weeks ago.

The patient says that his daytime sleepiness is not improved. He states that he gets up between 9 AM and 12 PM. Stays awake for 3-4 hours. Takes a nap for 2-3 hours. Stays up for a time and then goes to bed around 2 AM.

He is unable to have significant social interactions or attend school because of this.

I discussed the case with Dr. Terrel the patient's pediatrician and we decided on the following course of action.

1. We have asked him to keep a schedule as best as possible especially his wakeup time which is suggested be about 9 AM.
2. We asked him to obtain a light box 10,000 lux to be used for 20 minutes upon awakening to increase alertness.
3. We will start Nuvigil 250 milligrams by mouth daily upon awakening. I stress to the patient has a different side effect profile and different therapeutic index compared to Provigil.

4. I like to see this patient back in 3 months to assess the effects. We will be in touch with them on the phone and I will also be in touch with his pediatrician.

Disposition we'll see this patient back in 3 months.

END OF REPORT

Mail | BUL

#4973467

Department of Children & Family Services
Building a Stronger Louisiana

Disability Determinations Services
Economic Stability
Division of Programs
2150 WESTBANK EXPRESSWAY SUITE 131
HARVEY, LA 70058

(O) 800.256.2299
(F) 1-866-444-2216
www.dcfs.la.gov

John Bel Edwards, Governor
Marketa Garner Walters, Secretary

August 7, 2017

MD ANDERSON CANCER CENTER
MEDICAL RECORDS/CIOX
7007 BERTNER UNIT 1632
HOUSTON, TX 77030

Claimant: JEFFREY BODIN
CASE #: 1150892
DOB: 05/22/1997 XREF #:

Request for Evidence - Fax Coversheet/Invoice

We are the office that makes disability determinations for Social Security. JEFFREY BODIN is applying for or is receiving disability benefits due to the following conditions: narcolepsy, migraines, peripheral neuropathy, allergies.

We ask that you provide complete medical history on all conditions, not limited to those listed above, covering the period of **07/01/2015 to PRESENT**, to help us evaluate this claim.

SPECIAL INSTRUCTIONS:

RQID:LLA000B5WTU00 SITE:S77 DR:S
SSN:********* DOCTYPE:0001 RF:D CS:243a

***** Please return this fax/coversheet/invoice with your response.*****

We are authorized to pay $ 20.00 for information received within 30 days of this request. We will no longer research and reissue payment on invoices that are over 180 days from the date of request for records.

This information can be faxed toll free to our fax gateway at 1-866-444-2216 and will help us provide a quicker decision. Should you have any questions please contact A. BARTHELEMY at 504-361-6236 or 1-800-256-2299.

Please do not forward this letter if patient was seen by another doctor's office, clinic or hospital. Write new source name here: _____.

PLEASE INDICATE IF:

__Requested Evidence Attached
__No Evidence for Date Requested
__Chart not available through date
__No Patient Found
__Check here if you do not wish to be paid

040100127

QDD=N CAL=N **DMA Case: Y** Continued on next page
noakb/20MER/0026562 Auth#:20170807330008 Invoice No. MH5984

RECEIVED AUG 14 2017

Explanation for Request

This claim for disability benefits under the Social Security Act has been referred to this agency. We are requesting copies of your medical records or a narrative report to help in making a decision.

The information we are requesting will aid us in establishing the nature, severity, and duration of the alleged impairment(s). We need detailed information including medical history, clinical and laboratory findings, information on prescribed treatment and response to treatment, diagnosis, and prognosis.

We would also like to have a statement, based on your medical findings, of this individual's ability to perform work-related physical activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling. When there is a mental impairment, please include your opinion regarding understanding and memory, sustained concentration and persistence, social interaction, and adaptation.

If the individual is a child, we ask for a statement of the child's functional limitations such as any limitations in learning, motor functioning, performing self-care activities, communicating, socializing, and completing tasks. If the child is under age one, please report on responsiveness to stimuli.

An authorization to release the medical records and/or information is also enclosed. The Privacy Act of 1974 permits review of these records by the claimant and/or his representative.

Submitting Your Response Electronically Free Options

Help expedite this individual's decision by submitting his/her records to us electronically - free.

Records can be faxed to our toll-free secure servers. When faxing, page one of this request must be used as the fax coversheet.

If you have electronic records, you may be interested in uploading records to SSA's secure website. For information, contact our DDS Medical Relations Staff 504-361-6335 OR 1-800-256-2299.

Submitting Via US Post Office

If returning via US Postal Service, records must be forwarded to the address on the attached sheet.

Receiving Medical Request VIA SSA Secure Website or Fax

We are now able to submit our requests to you via SSA's Secure Website or Fax. If you are interested in receiving additional information please either

1) Complete the following before returning this letter:

Your Contact Name _____ & Phone Number _____ or

2) Call our Medical Relations staff at 504-361-6335 OR 1-800-256-2299.

Important Information

Would you be willing to perform consultative examinations on your own patients and/or other claimants applying for Social Security Disability benefits? If so, or if you would like additional information, please contact our Medical Relations Staff at AADDR

040200124

Form Approved
OMB No. 0960-0623

BODIN, JEFFREY T
436958926 05/22/1997

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*
Jeffrey T Bodin

SSN **436-95-6926** Birthday *(mm/dd/yy)* **05/22/97**

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records;* also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s)** ***including*****, and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

MD ANDERSON CANCER CENTER
HOUSTON, TX 77030

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶ *Electronically Signed By:* **Jeffrey T Bodin**

IF not signed by subject of disclosure, specify basis for authority to sig

☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
07/30/17	528 Beau Chene Dr		
Phone Number (with area code)	City	State	ZIP
985-264-1080	Mandeville	LA	70471

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶	IF needed, second witness sign here (e.g., if signed with "X" above) SIGN ▶
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Ciox Health
P.O. Box 409822
Atlanta, GA 30384-9822
Fed Tax ID 58 - 2659941
1-800-367-1500

CIOX HEALTH

INVOICE

Invoice #: 0224498179
Date: 8/17/2017
Customer #: 1298067

Ship to:	Bill to:	Records from:
DDS NEW ORLEANS LA S77 DDS NEW ORLEANS LA S77 2150 WESTBANK EXPY, SUITE 709 HARVEY, LA 70058	DDS NEW ORLEANS LA S77 DDS NEW ORLEANS LA S77 2150 WESTBANK EXPY, SUITE 709 HARVEY, LA 70058	UNIV OF TX M D ANDERSON CENTER 1155 PRESSLER BLVD UNIT 1209 HOUSTON, TX 77030

Requested By: DDS NEW ORLEANS LA S77
Patient Name: BODIN JEFFREY

INVOICE#: AA0000

Description	Quantity	Unit Price	Amount
Basic Fee			20.00
Retrieval Fee			0.00
Per Page Copy (Paper) 1	12	0.00	0.00
Subtotal			20.00
Sales Tax			0.00
Invoice Total			20.00
Balance Due			20.00

Pay your invoice online at https://paycioxhealth.com/pay/

Terms: Net 30 days

Please remit this amount : $ 20.00 (USD)

Ciox Health
P.O. Box 409822
Atlanta, GA 30384-9822
Fed Tax ID 58 - 2659941
1-800-367-1500

Invoice #: 0224498179

Check # _____

Payment Amount $_____

Get future medical records as soon as they are processed, by signing up for secure electronic delivery.
Register at: edelivery.cioxhealth.com

Please return stub with payment.
Please include invoice number on check.
To pay invoice online, please go to https://paycioxhealth.com/pay/ or call 800-367-1500.
Email questions to collections@cioxhealth.com.

EXHIBIT NO. 6F
PAGE: 1 OF 22

9011409027 Q 05/25/17 06:00 HEM C
BODIN, JEFFREY
DOB: 05/22/1997 020 Y M 0445573
LEBLANC DANA MD 015438

CHILDREN'S HOSPITAL

INTERIM VISIT FORM HEMATOLOGY/ ONCOLOGY CLINIC

PAGE 1 OF 4

NAME: Jeffrey Bodin AGE: 20y/o SEX: ☑M ☐F MEDICATIONS: See List

DIAGNOSIS: Melanoma ALLERGIES: ✓

☐ Oral Chemotherapy Administered at home as ordered: (initials)

CC: Here for follow-up for h/o metastatic melanoma.
HPI: Doing well overall – continues to follow c derm for skin exam. ∅ fever or fatigue

ROS:

General:
- Activity: ☑ Normal ☐ Abnormal:
- Appetite: ☑ Normal ☐ Abnormal:
- Fatigue: ☑ Normal ☐ Abnormal:
- Fever: ☑ Normal ☐ Abnormal
- Night Sweats: ☑ Normal ☐ Abnormal:
- Skin Rash: ☑ Normal ☐ Abnormal:
- Weight loss: ☑ Normal ☐ Abnormal:

Hem/Lymph Nodes: ☐ Bruises ☐ Petechiae ☐ Epistaxis
☐ Lymph Nodes: –
☐ Bleeding: GI: – GU: –

MS: – Bone/joint pain/swelling

ENT: – Sore throat – Mouth sores
– Nasal congestion – Rhinorrhea

Eyes: – Visual changes – Discharge
GI: – Abd pain – Nausea/vomiting
– Constipation – Diarrhea
Pulm: – Chest pain – Shortness of breath
– Asthma/wheezing – Cough
Cardiovasc: – Heart murmur
Neuro/Psych: – Seizures – Ataxia
– Weakness – Dev. Delay
Headache – Mood changes
GU: Menarch/LMP:
– UTI/kidney/bladder:
Derm: – Skin rash

PERFORMANCE SCORE:

DL
Initials/Date

Past, Family & Social History: ☑ Reviewed ☑ No changes ☐ New issues:

PHYSICAL EXAM: *General Appearance:* alert, NAD
PSYCH: *Mental Status & Mood:* appropriate

		NORMAL	ABNORMAL
HEENT:	**Eyes:**	☑ PERLA ☑ EOMs intact ☐ No jaundice noted	☐
	Ears:	☐ TMs clear bilaterally	☐
	Nose:	☐ Mucosa with normal appearance	☐ Rhinorrhea ☐ Bleeding ☐
	Oral Cavity:	☑ No labial or oral lesions **Pharynx:** ☐ clear **Tonsils:** ☐ normal	☐ ☐ ☐ Erythematous ☐ Exudate ☐ Enlarged
NECK:		☑ Supple ☑ No palpable Lymph nodes ☐ Thyroid not enlarged, non tender	☐ Lymph nodes: cervical: supraclavicular: others:

I reviewed the CC & HPI with parent/patient and team and concur with above.

Attending Physician's Signature	Date MM/DD/YY	Time 00:00 AM/PM
X Dana LeBlanc	5/25/17	3:45
Team Member's Signature	**Date MM/DD/YY**	**Time 00:00 AM/PM**
X	/ /	:

HEMONC/INTERIMCLINIC 1.20.15 Revised PDF 05.11.17

HEMATOLOGY/ONCOLOGY CLINIC CHART
Clinic Note

HEM0010

CHILDREN'S HOSPITAL

INTERIM VISIT FORM HEMATOLOGY/ ONCOLOGY CLINIC

PAGE 2 OF 4

9011409027 Q 05/25/17 06:00 HEM C
BODIN ,JEFFREY
DOB: 05/22/1997 020 Y M 0445573
LEBLANC DANA MD 015438

	NORMAL	ABNORMAL
CHEST/LUNGS:	☑ Symmetrical ☑ Well-ventilated bilateral ☐ Clear to auscultation	☐ ______
BREAST:	☐ Tanner ☐ No palpable masses	☐ Palpable mass:
HEART/CV:	☑ Regular rhythm ☑ No murmur ☑ Pulses 2+ & symm ☑ Cap refil 2 secs	☐ Murmur: ______ ☐ ______
ABD:	☑ Bowel sounds, non tender ☑ Liver spleen ☑ No palpable masses ☐ No hernia ☐ Perianal—no lesions	☐ ______ ☐ Liver: ______ ☐ Spleen: ______ ☐ Palpable mass: ______
GU:	☐ Tanner ☐ No rash ☐ No testicular swelling/mass ☐ No vulvar/vaginal lesions	☐ ______
MUSCULO SKELETAL:	☐ Full range of motion ☐ No edema/cyanosis/clubbing	☐ ______
SKIN:	☐ No rash ☐ Good turgor	☐ ______ ☐ ______
NEURO:	☐ Strength adeq/symm ☐ CNs 2-12 intact ☐ Gait normal ☐ DTRs symmetric	☐ ______ ☐ ______
Lymph nodes:	☑ No significant lymphadenopathy	☐ Palpable nodes: ______ ☐ axillary Ø ☐ inguinal Ø ☐ others Ø

☐ I examined the patient and concur with above exam.

ASSESSMENT/DECISION-MAKING:

Stage III melanoma (L ankle, metastatic to L inguinal nodes) treated c̄ interferon - off therapy since 10/08 (Dr. Herzog @ MD Anderson / Dr. Morales)
- seizure disorder post interferon - followed by neurology (Ochsner)

Ht:	
Wt:	
BSA:	
LAB RESULTS:	
WBC:	
Hgb/Hct:	
Plt:	
ANC:	
Retic:	
CMP:	

CLINIC PLAN:

1. Chemotherapy: a. ☐ If ANC greater than ______ and platelet count greater than ______.
   i. See chemo and antiemetics orders.
   ii. ______

Team Member's Signature	Date MM/DD/YY	Time 00:00 AM/PM
X	/ /	:
Attending Physician's Signature	**Date MM/DD/YY**	**Time 00:00 AM/PM**
X Dana LeBlanc	5/25/17	3 45

HEMONC/INTERIMCLINIC

HEMATOLOGY/ONCOLOGY CLINIC CHART
Clinic Note

HEM0010

9011409027 Q 05/25/17 06:00 HEM C
BODIN ,JEFFREY
DOB: 05/22/1997 020 Y M 0445573
LEBLANC DANA MD 015438

CHILDREN'S HOSPITAL

INTERIM VISIT FORM HEMATOLOGY/ ONCOLOGY CLINIC

PAGE 3 OF 4

CLINIC PLAN (continued):

2. Medications i. ______ ii. ______ iii. ______

3. Transfusions required (*See SS order*): ☐ PRBCs ☐ Platelets
4. Procedures performed: ☐ BMA/BX ☐ Lumbar puncture ☐ Lumbar puncture with Meds
5. Labs: ______
6. Radiological studies: CXR
   ☑ Results reviewed and discussed with radiologist
   ☑ Results reviewed and discussed with parents/patient ☑ Copy given → CXR clear
7. Admit to hospital / short stay (see orders) for: ______

☐ **I reviewed the assessment and plan with patient/parent and team and concur with the above**
☑ **Medications reconciled with Medication List**
☑ **I reviewed lab results with parent/patient** ☑ **Copy given**

8. Discussed with parents/patient about: sun safe practices, continue f/u c derm for routine skin exams.

DISCHARGE PLAN

1. Chemotherapy: i. Methotrexate ______ mg PO/IV/IM x 1 today
   ii. Continue 6MP ______ mg PO ______.
   iii. ______
2. Medications a. Pen Vee K ______ mg PO BID b. Folic acid 1 mg PO Q day
   c. PCP prophylaxis: ______
   d. Others: ______
3. Consults / referrals: 5/24/18 1245pm
4. Return to clinic: 1 yr ☑ MD visit ☐ Labs only ☐ Chemo only ☐ Admit ☐ Transfusion ☐ Other: ______

Physician orders for return visit.

☐ Labs: ☑ CBC D&P ☑ CMP ☐ BMP ☐ $Mg\&PO_4$ ☐ Retic ☐ Other: ______
☐ Home labs: ______
☑ Tests/studies: CXR - AP & lat.

☐ **PROCEDURES:** ☐ BMA/BX ☐ Lumbar puncture

5. **MEDICATION ORDERS FOR NEXT CLINIC VISIT** ☐ **EMLA** cream one application to IV site prior to needle stick
   ☐ **Synera** patch (one patch) to IV site prior to needle stick
6. **Heparin Flush:** Port-A-Cath ☐ 20 units heparin for intermittent heparinization ☐ 300 units heparin prior to removing needle
   Central line or PICC ☐ 20 units heparin for intermittent heparinization per lumen(s)
   Pheresis catheter ☐ 20 units heparin for intermittent heparinization per lumen(s) ☐ 100 units heparin daily per lumen(s)
7. Other: yearly exam c labs & CXR until 10 years off of therapy → then will refer to adult provider for yearly labs & exam

☐ **Fax to PCP**

Team Member's Signature	Date MM/DD/YY	Time 00:00 AM/PM
X	/ /	:
Attending Physician's Signature	**Date MM/DD/YY**	**Time 00:00 AM/PM**
X Dana LeBlanc	5/25/17	3 45

HEMONC/INTERIMCLINIC 1.09/15 Revised PDF DS 11x17

HEMATOLOGY/ONCOLOGY CLINIC CHART
Clinic Note

HEM0010

CHILDREN'S HOSPITAL

INTERIM VISIT FORM HEMATOLOGY/ ONCOLOGY CLINIC

PAGE 4 OF 4

9011409027 Q 05/25/17 06:00 HEM C
BODIN ,JEFFREY
DOB: 05/22/1997 020 Y M 0445573
LEBLANC DANA MD 015438

DX (Initials) I reviewed the assessment and plan with parents / patient and team members and cc

I spent ____ hours / 30 minutes

____ (Initials) I personally supervised the infusion of ________ (CHEMOTHERAPY/MEDICATION) for ____ hours / ____ minutes
☐ No complications ☐ complications: ________

____ (Initials) I personally supervised the transfusion of ________ for ____ hours / ____ minutes
☐ No complications ☐ complications:

☑ **MORE than 50 percent of my time was spent on educating, counseling caretaker about diagnosis, risks and treatment plans.** ________

☑ **READY TO BE SCANNED**

Attending Physician's Signature	Initials	Date MM/DD/YY	Time 00:00 AM/PM
X [signature]	DX	5/25/17	3:45

DISCHARGE INSTRUCTIONS: (CHECK ALL THAT APPLY)

☑ Return to clinic appointment given
☐ Verbalize understanding of follow up care
☐ Test times, NPO status and instructions given
☑ Verbalize understanding of medication(s) prescribed/administered
☑ Contact us for any fever greater than 100.4 degrees
☑ Contact us for any complications or concerns
☑ Parent/guardian instructed to carry a copy of the patient's current medications to share with their physicians and in the event of an emergency.
☑ Pain Score: 0 ☐ Visual Analog ☐ Cries ☑ Faces

PARENT'S INITIALS	NURSE'S INITIALS
X JB	X [initials]

Nurse's Signature	Initials	Date MM/DD/YY	Time 00:00 AM/PM
X [signature]	[initials]	5/25/17	1245pm

DATE	TIME	NOTES
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HEMONC/INTERIMCLINIC 09/15 Revised PDF1DS 11x17

HEMATOLOGY/ONCOLOGY CLINIC CHART
Clinic Note

HEM0010

9009008005 Q 05/30/16 06:00 H
BODIN ,JEFFREY
DOB: 05/22/1997 019 Y M 0445573
MORALES, JAIME MD 012294

CHILDREN'S HOSPITAL

INTERIM VISIT FORM HEMATOLOGY/ ONCOLOGY CLINIC

PAGE 1 OF 4

NAME: Jeffrey Bodin AGE: 19y SEX: ☒M ☐F MEDICATIONS: See List
DIAGNOSIS: melanoma ALLERGIES:
☐ Oral Chemotherapy ______ Administered at home as ordered: (Initials) ______

CC:
HPI: Doing well. No new skin lesions or reports of abnormal moles. Continue to F/u with Dermatology and Neurology

ROS:

General: Activity: ☒Normal ☐Abnormal: ______
Appetite: ☒Normal ☐Abnormal: ______
Fatigue: ☒Normal ☐Abnormal: ______
Fever: ☒Normal ☐Abnormal ______
Night Sweats: ☐Normal ☐Abnormal: ______
Skin Rash: ☐Normal ☐Abnormal: ______
Weight loss: ☐Normal ☐Abnormal: ______

Hem/Lymph Nodes: ☐ Bruises ☐ Petechiae ☐ Epistaxis
☐ Lymph Nodes: ______
☐ Bleeding: GI: ______ GU: ______

MS: ______ Bone/joint pain/swelling
ENT: ______ Sore throat ______ Mouth sores
______ Nasal congestion ______ Rhinorrhea

Eyes: ______ Visual changes ______ Discharge
GI: ______ Abd pain ______ Nausea/vomiting
______ Constipation ______ Diarrhea
Pulm: ______ Chest pain ______ Shortness of breath
______ Asthma/wheezing ______ Cough
Cardiovasc: ______ Heart murmur
Neuro/Psych: + Seizures → not seizure down ______ Ataxia
______ Weakness ______ Dev. Delay
______ Headache ______ Mood changes
GU: ______ Menarch/LMP: ______
______ UTI/kidney/bladder: ______
Derm: ______ Skin rash

PERFORMANCE SCORE: ______

TW
Initials/Date

Past, Family & Social History: ☒Reviewed ☐No changes ☐New issues: going to CSU next year for college

PHYSICAL EXAM: *General Appearance:* ______
PSYCH: *Mental Status & Mood:* ______

	NORMAL	ABNORMAL
HEENT: Eyes:	☒PERLA ☒EOMs intact ☒No Jaundice noted	☐
Ears:	☒TMs clear bilaterally	☐
Nose:	☒Mucosa with normal appearance	☐Rhinorrhea ______ ☐Bleeding ☐ ______
Oral Cavity:	☒No labial or oral lesions **Pharynx:** ☒clear **Tonsils:** ☒normal	☐ ☐ ☐Erythematous ☐Exudate ☐Enlarged
NECK:	☒Supple ☒No palpable Lymph nodes ☒Thyroid not enlarged, non tender	☐Lymph nodes: cervical: ______ supraclavicular: ______ others: ______

I reviewed the CC & HPI with parent/patient and team and concur with above.

Attending Physician's Signature	Date MM/DD/YY	Time 00:00 AM/PM
X [signature]	5/30/16	:
Team Member's Signature	**Date** MM/DD/YY	**Time** 00:00 AM/PM
X	/ /	:

HEMONC INTERIMCLINIC 10/15 Revised PDF LDS 11/16

HEMATOLOGY/ONCOLOGY CLINIC CHART
Clinic Note

HEM0010

CHILDREN'S HOSPITAL

INTERIM VISIT FORM HEMATOLOGY/ ONCOLOGY CLINIC

PAGE 2 OF 4

9009008005 Q 05/30/16 06:00 HEM J
BODIN ,JEFFREY
DOB: 05/22/1997 019 Y M 0445573
MORALES, JAIME MD 012294

	NORMAL	ABNORMAL
CHEST/LUNGS:	☑ Symmetrical ☑ Well-ventilated bilateral ☑ Clear to auscultation	❑
BREAST:	❑ Tanner ❑ No palpable masses	❑ Palpable mass:
HEART/CV:	☑ Regular rhythm ❑ No murmur ☑ Pulses ____ & symm ☑ Cap refil ____ secs	❑ Murmur: ❑
ABD:	☑ Bowel sounds, non tender ☑ Liver spleen ☑ No palpable masses ☑ No hernia ☑ Perianal—no lesions	❑ ❑ Liver: ❑ Spleen: ❑ Palpable mass:
GU:	☑ Tanner ❑ No rash ❑ No testicular swelling/mass ❑ No vulvar/vaginal lesions	❑ → post surgical scar (L) foot + (L) inguinal area intact
MUSCULO SKELETAL:	❑ Full range of motion ❑ No edema/cyanosis/clubbing	❑
SKIN:	☑ No rash ☑ Good turgor	❑ ❑
NEURO:	☑ Strength adeq/symm ☑ CNs 2-12 intact ☑ Gait normal ☑ DTRs symmetric	❑ ❑ No inguinal
Lymph nodes:	☑ No significant lymphadenopathy	❑ Palpable nodes: lymphadenopathies ❑ axillary ❑ inguinal ❑ others

❑ **I examined the patient and concur with above exam.**

ASSESSMENT/DECISION-MAKING:

- Stage III Melanoma
EOT therapy (Interferon) 10/08
- No evidence of recurrence

Ht:	
Wt:	
BSA:	
LAB RESULTS:	
WBC:	
Hgb/Hct:	
Plt:	
ANC:	
Retic:	
CMP:	

CLINIC PLAN:

1. Chemotherapy: a. ❑ If ANC greater than ____ and platelet count greater than ____,
   i. See chemo and antiemetics orders.
   ii. - Seizure disorder post Interferon followed by neurology

Team Member's Signature	Date MM/DD/YY	Time 00:00 AM/PM
X	/ /	:
Attending Physician's Signature	**Date** MM/DD/YY	**Time** 00:00 AM/PM
X [signature]	5/30/16	/ :

HEMONC/INTERIMCLINIC 1/09/15 Revised PDF EDS 11x17

HEMATOLOGY/ONCOLOGY CLINIC CHART
Clinic Note

HEM0010

INTERIM VISIT FORM HEMATOLOGY/ ONCOLOGY CLINIC

CHILDREN'S HOSPITAL

PAGE 3 OF 4

9009008005 Q 05/30/16 06:00 HEM
BODIN ,JEFFREY
DOB: 05/22/1997 019 Y M 0445573
MORALES, JAIME MD 012294

CLINIC PLAN (continued):

2. Medications i. ____ ii. ____ iii. ____
3. Transfusions required (*See SS order*): ☐ PRBCs ☐ Platelets
4. Procedures performed: ☐ BMA/BX ☐ Lumbar puncture ☐ Lumbar puncture with Meds
5. Labs: ____
6. Radiological studies: CX Ray - No evidence of disease
   ☐ Results reviewed and discussed with radiologist
   ☐ Results reviewed and discussed with parents/patient ☐ Copy given
7. Admit to hospital / short stay (see orders) for: ____

☐ **I reviewed the assessment and plan with patient/parent and team and concur with the above**
☐ **Medications reconciled with Medication List**
☐ **I reviewed lab results with parent/patient** ☐ **Copy given**

8. Discussed with parents/patient about: Sun safe practices. Follow up with dermatology for skin checks.

DISCHARGE PLAN

1. Chemotherapy: i. Methotrexate F/UP dermatology ____ mg PO/IV/IM x 1 today
   ii. Continue 6MP ____ mg PO ____
   iii.
2. Medications a. Pen Vee K ____ mg PO BID b. Folic acid 1 mg PO Q day
   c. PCP prophylaxis: P53 mutation test today
   d. Others: 4 week follow visit
3. Consults / referrals: 5/29/17 11AM
4. Return to clinic: 1 year ☐ MD visit ☐ Labs only ☐ Chemo only ☐ Admit ☐ Transfusion ☐ Other:____

Physician orders for return visit.

☐ Labs: ☒ CBC D&P ☒ CMP ☐ BMP ☐ Mg&PO$_4$ ☐ Retic ☐ Other:____
☐ Home labs: ____
☐ Tests/studies: Chest X Ray AP + lateral

☐ **PROCEDURES:** ☐ BMA/BX ☐ Lumbar puncture

5. **MEDICATION ORDERS FOR NEXT CLINIC VISIT** ☐ **EMLA** cream one application to IV site prior to needle stick
   ☐ **Synera** patch (one patch) to IV site prior to needle stick
6. **Heparin Flush:** Port-A-Cath ☐ 20 units heparin for intermittent heparinization ☐ 300 units heparin prior to removing needle
   Central line or PICC ☐ 20 units heparin for intermittent heparinization per lumen(s)
   Pheresis catheter ☐ 20 units heparin for intermittent heparinization per lumen(s) ☐ 100 units heparin daily per lumen(s)
7. Other: * Yearly exam with labs + chest X Ray until 10 years off therapy & then refer to adult provider for yearly exam and labs & X Ray unless clinically indicated yearly.

☐ **Fax to PCP**

Team Member's Signature	Date MM/DD/YY	Time 00:00 AM/PM
X	/ /	:
Attending Physician's Signature	**Date** MM/DD/YY	**Time** 00:00 AM/PM
X [signature]	5/30/16	:

HEMONC/INTERIMCLINIC 1.09'15 Revised PDF 1/DS 1/1'17

HEMATOLOGY/ONCOLOGY CLINIC CHART
Clinic Note

HEM0010

9009008005 Q 05/30/16 06:00 HEM J
BODIN ,JEFFREY
DOB: 05/22/1997 019 Y M 0445573
MORALES, JAIME MD 012294

CHILDREN'S HOSPITAL

INTERIM VISIT FORM HEMATOLOGY/ ONCOLOGY CLINIC

PAGE 4 OF 4

______ I reviewed the assessment and plan with parents / patient and team members and concur with the above.
Initials I spent _____ hours / _____ minutes

______ I personally supervised the infusion of ______ (CHEMOTHERAPY/MEDICATION) ______ for ___ hours / ___ minutes
Initials ❑ No complications ❑ complications: ______

______ I personally supervised the transfusion of ______ for ___ hours / ___ minutes
Initials ❑ No complications ❑ complications:

❑ **MORE than 50 percent of my time was spent on educating, counseling caretaker about diagnosis, risks and treatment plans.** ______

❑ **READY TO BE SCANNED**

Attending Physician's Signature	Initials	Date MM/DD/YY	Time 00:00 AM/PM
X		/ /	:

DISCHARGE INSTRUCTIONS: (CHECK ALL THAT APPLY)

❑ Return to clinic appointment given
❑ Verbalize understanding of follow up care
❑ Test times, NPO status and instructions given
❑ Verbalize understanding of medication(s) prescribed/administered
❑ Contact us for any fever greater than 100.4 degrees
❑ Contact us for any complications or concerns
❑ Parent/guardian instructed to carry a copy of the patient's current medications to share with their physicians and in the event of an emergency.
❑ Pain Score: ______ ❑ Visual Analog ❑ Cries ❑ Faces

PARENT'S INITIALS	NURSE'S INITIALS
X JB	X JW

(985) 264-1080

Nurse's Signature	Initials	Date MM/DD/YY	Time 00:00 AM/PM
X J Watkinson	JW	5/30/16	1:00 PM

DATE	TIME	NOTES
/ /	:	
/ /	:	
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HEMONC/INTERIMCLINIC 1/09/15 Revised PDF DS 11/17

HEMATOLOGY/ONCOLOGY CLINIC CHART
Clinic Note

HEM0010

EXHIBIT NO. 6F
PAGE: 9 OF 22

CHILDREN'S HOSPITAL

200 Henry Clay Avenue
New Orleans, Louisiana 70118
(504) 896-9490

CLINICAL LABORATORY REPORT

Patient: BODIN,JEFFREY
Patient ID (MR#): 0445573
Hospital Account #: 9009008005
DOB: 05/22/1997 Age: 19Y Sex: M
Location: HEM
Admit Date: 05/30/2016
Discharge Date:
Admitting Physician: MORALES,JAIME

M6623 COLL: 05/30/2016 06:00 REC: 05/30/2016 09:40 PHYS: MORALES,JAIME

MISC TEST	REQUEST CREDITED	
	HIS CANCEL	

M6624 COLL: 05/30/2016 12:07 REC: 05/30/2016 12:15 PHYS: MORALES,JAIME

COMP METABOLIC PANEL			
SPEC APPEAR	NO VIS HEMOLYS		
SODIUM	143	[134-144]	MMOL/L
POTASSIUM	4.2	[3.4-5.5]	MMOL/L
CHLORIDE	106	[98-107]	MMOL/L
CO2	30	[20-31]	MMOL/L
GLUCOSE	73	[65-110]	MG/DL
BUN	8	[7-21]	MG/DL
CREATININE	0.8	[0.2-1.4]	MG/DL
eGFR,AFRICAN AMERICA			
	>60		
eGFR,NON-AFR AMERICA			
	>60		
CALCIUM	8.9	[8.5-10.4]	MG/DL
TOTAL PROTEIN	7.6	[6.5-8.0]	GM/DL
ALBUMIN	4.5	[3.0-4.8]	GM/DL
BILIRUBIN TOTAL	0.4	[0.2-1.3]	MG/DL
AST	8	[8-53]	U/L
ALKALINE PHOS	91	[39-253]	U/L
ALT	22	[7-56]	U/L
CBC			
WBC	5.62	[3.70-11.70]	10exp3/UL
RBC	5.31	[4.50-5.90]	10exp6/UL
HGB	16.2	[13.5-17.5]	GM/DL
HCT	H 46.9	[35.0-46.0]	%
MCV	88.3	[75.0-97.0]	FL
MCH	30.5	[24.0-32.0]	PG
MCHC	34.5	[31.0-35.0]	GM/DL
PLATELETS	317	[135-450]	10exp3/UL
RDW-SD	36.5	[35.1-46.3]	FL
RDW-CV	L 11.4	[11.5-15.4]	%
MPV	9.8	[8.6-12.4]	FL
ABS NRBC	0.00	[0]	10exp3/UL
NRBC	0.0	[0]	/100 WBC

CONTINUED

EXHIBIT NO. 6F
PAGE: 10 OF 22

CHILDREN'S
HOSPITAL

200 Henry Clay Avenue
New Orleans, Louisiana 70118
(504) 896-9490

CLINICAL LABORATORY REPORT

Patient: BODIN,JEFFREY
Patient ID (MR#): 0445573
Hospital Account #: 9009008005
DOB: 05/22/1997 Age: 19Y Sex: M
Location: HEM
Admit Date: 05/30/2016
Discharge Date:
Admitting Physician: MORALES,JAIME

M6624 COLL: 05/30/2016 12:07 REC: 05/30/2016 12:15 PHYS: MORALES,JAIME

DIFFERENTIAL

DIFFERENTIAL		AUTOMATED		
ABS NEUTROPHIL		2.73	[1.80-8.00]	10exp3/UL
ABS LYMPHOCYTE		2.25	[1.20-5.20]	10exp3/UL
ABS MONOCYTE		0.53	[0.23-0.65]	10exp3/UL
ABS EOSINOPHIL		0.03	[0.00-0.39]	10exp3/UL
ABS BASOPHIL	H	0.07	[0]	10exp3/UL
NEUTROPHILS		49		%
LYMPHOCYTES		40		%
MONOCYTES		9		%
EOSINOPHILS		1		%
BASOPHILS		1		%

END OF REPORT

EXHIBIT NO. 6F
PAGE: 11 OF 22

ARUP LABORATORIES | **www.aruplab.com**
500 Chipeta Way, Salt Lake City, Utah 84108-1221
phone: (801) 583-2787, toll free: (800) 522-2787
Jerry W. Hussong, MD, Director of Laboratories

Patient Report | **FINAL**

BODIN,JEFFREY PID#: 0445573
M6959 BODIN,JEFFREY
L28123282 HEM 19Y M 05/22/1997
MISCTS
BODIN,JEFFREY L28123282 1207
L28123282 MORALES,JAIME 05/30/2016
MISCTS-BLOOD-P53 GENE MUTATION ANALYSIS SEND MISCTS M6959 MISC

6/19/16 MBK

Patient: BODIN, JEFFREY

DOB:	5/22/1997
Gender:	Male
Patient Identifiers:	1ARUP0001883892, 0445573
Visit Number (FIN):	L28123282
Collection Date:	5/30/2016 12:07

P53 Mutation Analysis, Plasma-Based (Leumeta)

ARUP test code 2013484

P53 Mutation Analysis, Leumeta — See Note

Performed at: Quest Diagnostics, 33608 Ortega Hwy, San Juan Capistrano, CA 92675

P53 Exon 4 Mutation Analysis — See Note

Performed at: Quest Diagnostics, 33608 Ortega Hwy, San Juan Capistrano, CA 92675

P53 Exon 5 Mutation Analysis — See Note

Performed at: Quest Diagnostics, 33608 Ortega Hwy, San Juan Capistrano, CA 92675

P53 Exon 6 Mutation Analysis — See Note

Performed at: Quest Diagnostics, 33608 Ortega Hwy, San Juan Capistrano, CA 92675

P53 Exon 7 Mutation Analysis — See Note

Performed at: Quest Diagnostics, 33608 Ortega Hwy, San Juan Capistrano, CA 92675

P53 Exon 8 Mutation Analysis — See Note

Performed at: Quest Diagnostics, 33608 Ortega Hwy, San Juan Capistrano, CA 92675

P53 Exon 9 Mutation Analysis — See Note

Performed at: Quest Diagnostics, 33608 Ortega Hwy, San Juan Capistrano, CA 92675

P53 Mutation Analysis, Interpretation — See Note

TEST	RESULT	UNITS	REFERENCE RANGE
P53 Mutations, Leumeta			
Specimen Type:	BLOOD		
PARAFFIN BLOCK NUMBER:	NOT GIVEN		
P53 Mutations, Leumeta	NEGATIVE		NEGATIVE
Interpretation	SEE BELOW		

This result was reviewed and interpreted by K.A. Lynch, M.D.

H – high L – low * – abnormal C – critical

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EXHIBIT NO. 6F
PAGE: 12 OF 22

ARUP LABORATORIES | www.aruplab.com
500 Chipeta Way, Salt Lake City, Utah 84108-1221
phone: (801) 583-2787, toll free: (800) 522-2787
Jerry W. Hussong, MD, Director of Laboratories

Patient Report | **FINAL**

Based on sequence analysis, no mutations were detected in the p53 gene exons 4-9.

Mutations in p53 tumor suppressor gene occur in greater than 50% of adult human cancers. The p53 gene mutations usually correlate with poor outcome and early recurrence in cancer. Testing was performed on P53 exon 4-9 which account for >90% mutations in p53 gene. We cannot rule out the possibilities of mutation in other sites of the gene.

The total nucleic acid was extracted from patient's plasma, PB/BM cells or paraffin embedded tissues. PCR reactions are performed to amplify exon 4-9 of p53 gene. The PCR products are then purified and sequenced in both forward and reverse directions. All mutations, deletions and insertions detected in the P53 exons 4-9 will be reported.

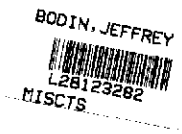
This assay does not detect large deletions in the p53 gene. For (17p-) please refer to FISH assay. The sensitivity of this sequencing assay is 20% of mutant cell in the background of normal cells.

This test was developed and its performance characteristics have been determined by Quest Diagnostics Nichols Institute, San Juan Capistrano. It has not been cleared or approved by FDA. This assay has been validated pursuant to the CLIA regulations and is used for clinical purposes.
Performed at: Quest Diagnostics, 33608 Ortega Hwy, San Juan Capistrano, CA 92675

VERIFIED/REPORTED DATES

Procedure	Accession	Collected	Received	Verified/Reported
P53 Mutation Analysis, Leumeta	16-151-400225	5/30/2016 12:07	6/2/2016 09:51	6/18/2016 15:44
P53 Exon 4 Mutation Analysis	16-151-400225	5/30/2016 12:07	6/2/2016 09:51	6/18/2016 15:44
P53 Exon 5 Mutation Analysis	16-151-400225	5/30/2016 12:07	6/2/2016 09:51	6/18/2016 15:44
P53 Exon 6 Mutation Analysis	16-151-400225	5/30/2016 12:07	6/2/2016 09:51	6/18/2016 15:44
P53 Exon 7 Mutation Analysis	16-151-400225	5/30/2016 12:07	6/2/2016 09:51	6/18/2016 15:44
P53 Exon 8 Mutation Analysis	16-151-400225	5/30/2016 12:07	6/2/2016 09:51	6/18/2016 15:44
P53 Exon 9 Mutation Analysis	16-151-400225	5/30/2016 12:07	6/2/2016 09:51	6/18/2016 15:44
P53 Mutation Analysis, Interpretation	16-151-400225	5/30/2016 12:07	6/2/2016 09:51	6/18/2016 15:44

END OF CHART



H – high L – low * – abnormal C – critical

ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

EXHIBIT NO. 6F
PAGE: 13 OF 22

CHILDREN'S HOSPITAL

Pt Name:	**BODIN, JEFFREY**	**MRN:**	0445573
DOB:	05/22/1997	**Acct No:**	9009008005
Age/Sex:	19Y/M	**Atn Dr:**	Morales, Jaime MD
Admit:	05/30/2016 06:00	**Discharge:**	

Label: Chest Ap And Lat Result ID: 21705783

Finding Abbr:	RAD29	**Finding Name:**	Chest Ap And Lat
Obs DateTime:	05/30/2016 11:58	**Result DateTime:**	05/30/2016 12:06
Result:		**Reading Dr:**	CONGENI, JANE

CHEST AP AND LAT :

.
. Lungs are symmetrically aerated and are clear. Heart size and pulmonary vascularity are
. within normal limits. Aortic arch is left-sided. No bony abnormalities are present.
.
. IMPRESSION: NORMAL CHEST
.
.
. Electronically Signed By: JANE CONGENI
. Electronically Signed on: 30-MAY-2016 12:05:32

EXHIBIT NO. 6F
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9007276216 D 09/10/15 08:27 CLN
BODIN ,JEFFREY
DOB: 05/22/1997 018 Y M 0445573
PRASAD, PINKI MD 013706

CHILDREN'S HOSPITAL

LATE EFFECTS CLINIC VISIT

PAGE 1 OF 4

DATE: Jeffrey Bodin

ANNUAL HISTORY & PHYSICAL

Date: 9·10·15

PRIMARY DIAGNOSIS:	DIAGNOSIS DATE:	OFF THERAPY DATE:
Stage IIIA Melanoma of left ankle	03/2008	10/02/2008

INTERVAL MEDICAL HISTORY: migraines, narcolepsy, peripheral neuropathy, seizure syndrome
Dr. Sherri Lacey
last seizure last July

ER VISITS:
None

INTERVAL FAMILY/SOCIAL HISTORY:
No changes

INTERVAL SCHOOL HISTORY: senior in HS - St. Paul's
doing ok - @ IEP in place
very accommodating

INTERVAL IMMUNIZATION HISTORY:
UTD

CURRENT MEDICATIONS: Amerge ī caffeine, butalbital (migraines), OTC allergy

ALLERGIES:

REVIEW OF SYSTEMS:

GENERAL:
Activity ☑Normal ☐Abnormal:
Fatigue ☑Normal ☐Abnormal:
Night Sweats ☑None ☐Present:
Weight Loss ☑None ☐Present:
Appetite ☑Normal ☐Abnormal:
Fever ☐None ☑Present: 2½ weeks
Skin Rash ☐None ☐Present:

HEM/LYMPH NODES:
Bruises ☑None ☐Present:
Petechiae ☑None ☐Present:
GI:
Lymph Nodes
Bleeding ☑None ☐Present:
GU:

MS:
Bone/Joint Pain/Swelling ☐None ☐Present:

ENT:
Sore Throat ☐None ☐Present
Nasal Congestion ☐None ☑Present: seasonal allergies
Mouth sores ☐None ☐Present:
Rhinorrhea ☐None ☑Present: seasonal allergies
receiving q week allergy shots

EYES:
Visual Changes ☑None ☐Present:
Eye discharge ☑None ☐Present:

GI:
Abdominal Pain ☑None ☐Present:
Constipation ☑None ☐Present:
Nausea/Vomiting ☑None ☐Present:
Diarrhea ☐None ☐Present:

PULM:
Chest Pain ☑None ☐Present:
Asthma/Wheezing ☑None ☐Present:
Shortness of breath ☐None ☐Present:
Cough ☑None ☐Present:

CARDIOVASC: Heart Murmur ☑None ☐Present:

NEURO/PSYCH: Seizures ☑None ☐Present: last seizure 1 year ~~while on amitryptline~~
Weakness ☐None ☐Present:
Mood Changes ☑None ☐Present:
☐ Peripheral neuropathy
Ataxia ☐None ☐Present:
Dev. delay ☑None ☐Present:
☐ Diagnosed w/ narcolepsy by neurologist at Oschner

GU: Menarch/LMP:
UTI/Kidney/Bladder:

DERM: Skin Rash:

HEMATOLOGY/ONCOLOGY
Late Effects Clinic Interim Visit

HEM0010

9007276216 D 09/10/15 08:27 CLN I
BODIN ,JEFFREY
DOB: 05/22/1997 018 Y M 0445573
PRASAD, PINKI MD 013706

CHILDREN'S HOSPITAL

LATE EFFECTS CLINIC VISIT

PAGE 2 OF 4

DATE: 9.10.15

PHYSICAL EXAMINATION:

VS:					
HR: 93	Temp: 97.9	Wt: 47kg	SA:	HC:	
RR: 18	BP: 130/69	Ht: 171.2	Performance:	BMI: 16	

PHYSICAL EXAM: *General Appearance:* thin appearing male, NAD

PSYCH: *Mental Status & Mood:*

	NORMAL	ABNORMAL
HEENT: Eyes:	☑ PERLA ☑ EOMs intact ☑ No jaundice noted	☐
Ears:	☑ TMs clear bilaterally	☐
Nose:	☑ Mucosa with normal appearance	☐ Rhinorrhea ☐ Bleeding ☐
Oral Cavity:	☐ No oral lesions **Pharynx:** ☑ clear **Tonsils:** ☑ normal	☐ ☐ ☐ Erythematous ☐ Exudate ☐ Enlarged
NECK:	☑ Supple ☑ No palpable Lymph node ☑ Thyroid not enlarged, Non tender	☐ Lymph node: Cervical: Supraclavicular: Others:
CHEST/LUNGS:	☑ Symmetrical ☑ Well-ventilated bilateral ☑ Clear to auscultation	☐
BREAST:	☐ Tanner ____ ☐ No palpable masses	☐ Palpable mass:
HEART/CV:	☑ Regular rhythm ☑ No murmur ☑ Pulses 2+ & symm ☑ Cap refil <3 secs	☐ Murmur present: ☐ ☑ NYHA class: I ✓ II ___ III ___ IV ___
ABD:	☑ Bowel sounds present, Non tender ☑ Liver/spleen ☑ No palpable masses ☑ No hernia ☑ Perianal—no lesions	☐ ☐ Liver: ☐ Spleen: ☐ Palpable mass:
GU:	☐ Tanner ____ ☐ No rash ☐ No testicular swelling/mass ☐ No vulvar/vaginal lesions } deferred	☐
MUSCULO SKELETAL:	☑ Full ROM ☑ No edema/cyanosis/clubbing	☐
SKIN:	☑ No rash ☑ Good turgor	☐ ☐
NEURO:	☑ Strength adeq/symm ☑ CNs 2-12 intact ☑ Gait normal ☑ DTRs symmetric	☐ ☐

9007276216 D 09/10/15 08:23 CLN
BODIN ,JEFFREY
DOB: 05/22/1997 018 Y M 0445573
PRASAD, PINKI MD 013706

CHILDREN'S HOSPITAL

LATE EFFECTS CLINIC VISIT
PAGE 3 OF 4

DATE: 9.10.15

ASSESSMENT:

18 yr. old with history of metastatic stage IIIA melanoma of left ankle
- treated with interferon, completed therapy in 10/2008
- multiple issues c̄ allergy and sinus issues
- Hx of seizure D/O
- Hx of narcolepsy

☐ Anthracyclines ________ Last Echo_____ Next Echo in _____ years
☐ Alkylating Agent ☐ Bleomycin _________ Last PFT's _________
☐ Lab results reviewed

PLAN:

☐ Diagnostics:

■ Education:
Binder with health links given ☑ Yes ☐ No
Treatment summary given ☑ Yes ☐ No
■ Assessed by Social Worker

☐ Referrals:

☐ Immunizations:
☐ Flu shot ☐ Other:
☐ Gardasil – received already

☐ Return Visit: Jan. 2016
■ Primary oncologist Dr. Jaime Morales ■ Late Effects Clinic: prn

DIAGNOSTIC EVALUATION (labs, radiology, diagnostics): 172.9

TO BE DONE AT NEXT VISIT:

Labs:
☑ CBC & diff #1 } 9/10/15
☑ CMP #2 } 9/10/15
☐ Mg & PO4
☐ Lipid Panel

☐ FSH
☐ LH
☐ Anti-mullerian hormone
☐ IgG, IgA, IgM, IgE #3 – Done 9/10/15

☐ Other:

Radiology:
☐ Dexa scan

Diagnostics:
☐ Echo/EKG (with strain)
☐ PFT's

☐ Other:

Referral:

☑ **MORE than 50 percent of my time was spent on educating, counseling caretaker about diagnosis, risks and treatment plans.**

☑ **READY TO BE SCANNED**

Physician's Signature	Date MM/DD/YY	Time 00:00 am/pm
X [signature] vnoM	9 / 10 / 15	10:30 AM

LSU Health Sciences Center
NEW ORLEANS

CHILDREN'S HOSPITAL

SUMMARY OF CANCER TREATMENT

Demographics		
Name: Jeffrey Bodin	Sex: Male	Date of Birth: 05/22/1997
PCP:		

Cancer Diagnosis		
Diagnosis: Melanoma of left ankle	Sites involved/stage: Stage IIIA/T2aN2a	
Date of Diagnosis: 03/2008	Age at Diagnosis: 10yrs. 9 months	Date Therapy Completed: 10/02/2008
Relapse(s):		

Treatment Center : MD Anderson Cancer Center; LSUHSC, Children's Hospital New Orleans, 200 Henry Clay Avenue, New Orleans, LA 70118 Primary Oncologist: Dr. Cynthia Herzog (MD Anderson Cancer Center) Dr. Jaime Morales (Children's Hospital of New Orleans) Surgeon: MD Anderson Cancer Center Radiation Oncologist: n/a Transplant Physician: n/a Long Term Follow-Up: Dr. Pinki Prasad (504) 896-9740	Medical Record #: MD Anderson 074-46-52 CHNOLA: 0445573
Family History Cancer:	Other Family History:

CANCER TREATMENT SUMMARY

Protocol/Treatment: On Study: NO

Chemotherapy

Drug Name	Route	Selected Cumulative Dose (units or mg/m²) when Applicable
Interferon alpha 2B	IV	400 million units/m2
Interferon alpha 2B	SQ	155 million units/m2

Surgery

Surgery	Date	Surgeon
Primary excision of melanoma on left ankle with sentinel node mapping	03/15/2008	MD Anderson Cancer Center
Appendectomy	05/13/2008	MD Anderson Cancer Center
PICC Line Insertion	06/09/2008	Children's Hospital of New Orleans

Radiation: n/a

Transplant: n/a

Treatment Complications/Late Effects

Problem	Status
Neurologic: Seizures while on interferon	
Neurologic: Peripheral neuropathy	

Treatment Summary

LSU Health Sciences Center
NEW ORLEANS

CHILDREN'S HOSPITAL

Potential Late Effects		
Potential Late Effect	**Exposure**	**Screening Recommendations**
Any Cancer History		Annual Physical Exam with PCP Annual Cancer Screening by age Regular exercise Avoid cigarette smoking, excess alcohol consumption or illicit drugs Eat a well balanced, low fat diet
Any Cancer History	Biologics Interferon Alpha 2B	Insufficient information currently available regarding late effects of biological agents
Dental Problems	Any chemotherapy exposure	Regular Dental Exams
General Recommendations:		
Immunizations	Any cancer experience	Recommend annual Flu shot Recommend (HPV vaccination or Gardasil) series
Summary prepared by: Pinki Prasad, MD, MPH		**Date prepared:** 01/15/2015

EXHIBIT NO. 6F
PAGE: 19 OF 22

CHILDREN'S HOSPITAL

200 Henry Clay Avenue
New Orleans, Louisiana 70118
(504) 896-9490

CLINICAL LABORATORY REPORT

Patient: BODIN,JEFFREY
Patient ID (MR#): 0445573
Hospital Account #: 9007276216
DOB: 05/22/1997 Age: 18Y Sex: M
Location: CLN
Admit Date: 09/10/2015
Discharge Date:
Admitting Physician: PRASAD,PINKI

H3748 COLL: 09/10/2015 10:50 REC: 09/10/2015 10:52 PHYS: PRASAD,PINKI

COMP METABOLIC PANEL

SPEC APPEAR		NO VIS HEMOLYS	
SODIUM		142	[134-144] MMOL/L
POTASSIUM		3.8	[3.4-5.5] MMOL/L
CHLORIDE		106	[98-107] MMOL/L
CO2		31	[20-31] MMOL/L
GLUCOSE	L	56	[65-110] MG/DL
BUN		10	[7-21] MG/DL
CREATININE		0.6	[0.1-1.4] MG/DL
eGFR,AFRICAN AMERICA		>60	
eGFR,NON-AFR AMERICA		>60	
CALCIUM	L	8.4	[8.5-10.4] MG/DL
TOTAL PROTEIN		8.0	[6.5-8.0] GM/DL
ALBUMIN		4.3	[3.0-4.8] GM/DL
BILIRUBIN TOTAL		0.2	[0.2-1.3] MG/DL
AST		16	[8-53] U/L
ALKALINE PHOS		99	[39-253] U/L
ALT		31	[7-56] U/L

CBC

WBC		5.65	[3.70-11.70] 10exp3/UL
RBC		5.26	[4.50-5.90] 10exp6/UL
HGB		16.0	[13.5-17.5] GM/DL
HCT	H	46.4	[35.0-46.0] %
MCV		88.2	[75.0-97.0] FL
MCH		30.4	[24.0-32.0] PG
MCHC		34.5	[31.0-35.0] GM/DL
PLATELETS		370	[135-450] 10exp3/UL
RDW-SD		36.3	[35.1-46.3] FL
RDW-CV	L	11.4	[11.5-15.4] %
MPV		9.4	[8.6-12.4] FL
ABS NRBC		0.00	[0] 10exp3/UL
NRBC		0.0	[0] /100 WBC

DIFFERENTIAL

SEGS	47	%
LYMPHOCYTES	37	%
MONOCYTES	10	%
EOSINOPHILS	1	%
BASOPHILS	2	%
ATYPICAL LYMPHS	3	%

CONTINUED

EXHIBIT NO. 6F
PAGE: 20 OF 22

CHILDREN'S
HOSPITAL

200 Henry Clay Avenue
New Orleans, Louisiana 70118
(504) 896-9490

CLINICAL LABORATORY REPORT

Patient: BODIN,JEFFREY
Patient ID (MR#): 0445573
Hospital Account #: 9007276216
DOB: 05/22/1997 Age: 18Y Sex: M
Location: CLN
Admit Date: 09/10/2015
Discharge Date:
Admitting Physician: PRASAD,PINKI

H3748 COLL: 09/10/2015 10:50 REC: 09/10/2015 10:52 PHYS: PRASAD,PINKI

DIFFERENTIAL	(CONTINUED)			
ABS NEUTROPHIL		2.65	[1.80-8.00]	10exp3/UL
ABS LYMPHOCYTE		2.26	[1.20-5.20]	10exp3/UL
ABS MONOCYTE		0.57	[0.23-0.65]	10exp3/UL
ABS EOSINOPHIL		0.06	[0.00-0.39]	10exp3/UL
ABS BASOPHIL	H	0.11	[0]	10exp3/UL
DIFFERENTIAL		MANUAL		
PLT ESTIMATE		NORMAL		
RBC MORPHOLOGY		NORMAL		
IGGAME				
IGG		698	[510-1275]	MG/DL
IGA	L	68.4	[70.6-315.4]	MG/DL
IGM	L	31.6	[35.5-251.3]	MG/DL
IGE		42.1	[0-158]	IU/ML

END OF REPORT

Department of Children & Family Services
Building a Stronger Louisiana

Disability Determinations Services
Economic Stability
Division of Programs
2150 WESTBANK EXPRESSWAY SUITE 131
HARVEY, LA 70058

(O) 800.256.2299
(F) 1-866-444-2216
www.dcfs.la.gov

John Bel Edwards, Governor
Marketa Garner Walters, Secretary

August 7, 2017

CHILDRENS HOSPITAL (CLINIC)
MEDICAL RECORDS/MRO
200 HENRY CLAY AVE
NEW ORLEANS, LA 70118

Claimant: JEFFREY BODIN
CASE #: 1150892
DOB: 05/22/1997 XREF #:

MRO
AUG 11 2017

445573
H/O

Request for Evidence - Fax Coversheet/Invoice

We are the office that makes disability determinations for Social Security. JEFFREY BODIN is applying for or is receiving disability benefits due to the following conditions: narcolepsy, migraines, peripheral neuropathy, allergies.

We ask that you provide complete medical history on all conditions, not limited to those listed above, covering the period of **07/01/2015 to PRESENT**, to help us evaluate this claim.

SPECIAL INSTRUCTIONS:

RQID:LLA000B5WUC00 SITE:S77 DR:S
SSN:********* DOCTYPE:0001 RF:D CS:7b8b

***** Please return this fax/coversheet/invoice with your response.*****

We are authorized to pay $ 20.00 for information received within 30 days of this request. We will no longer research and reissue payment on invoices that are over 180 days from the date of request for records.

This information can be faxed toll free to our fax gateway at 1-866-444-2216 and will help us provide a quicker decision. Should you have any questions please contact A. BARTHELEMY at 504-361-6236 or 1-800-256-2299.

Please do not forward this letter if patient was seen by another doctor's office, clinic or hospital. Write new source name here: _____.

PLEASE INDICATE IF:

__Requested Evidence Attached
__No Evidence for Date Requested
__Chart not available through date
__No Patient Found
__Check here if you do not wish to be paid

040100025 2

QDD=N CAL=N **DMA Case: Y** Continued on next page
noakb/20MER/0046453 Auth#:20170807330016 Invoice No. MH5992

MRO
1000 Madison Avenue, Suite 100
Norristown, PA 19403

Invoice
18080575
August 14, 2017

Phone: (610) 994-7500
Fax: (610) 962-8421

Claims Adjudicator
S77 LA DDS
P.O. Box 8907
London, KY 40742-9807

On 8/11/2017 the following healthcare provider received your request for copies of medical records:

CHACC-Hematology/Oncology
200 Henry Clay Avenue, Suite 4109
New Orleans, LA 70118

You requested records for: JEFFREY BODIN

This is your invoice for providing the copies of the medical records.

Your Reference ID:
MH5992

MRO Request ID: 18080575

MRO Online Tracking Number: CHNO46PBC5B8A

You can track and pay for your request online at:
www.roilog.com

Fees

Search and Retrieval Fee:	$20.00
Number of Pages:	20
Tier 1:	$0.00
Tier 2:	$0.00
Tier 3:	$0.00
Media pages/materials:	0
Media Fee:	$0.00
Certification Fee:	$0.00
Adjustments:	$0.00
Postage:	$0.00
Sales Tax:	$0.00
TOTAL:	$20.00
Paid at Facility:	($0.00)
Paid to MRO:	($0.00)
BALANCE DUE:	$20.00

PAYMENT

You may pay this invoice online at:
www.roilog.com

You can send a check to:
MRO
P.O. Box 6410,
Southeastern, PA 19398-6410
MRO Tax ID (EIN): 01-0661910

Please write the Invoice # on the check or return this invoice with the payment.

By paying this invoice, you are representing that you: have reviewed, understood, and approved the charges; have agreed to pay them; and have agreed to the following terms. Any dispute relating to the charges in this invoice must be presented before paying this invoice. Any dispute not so presented is waived. Presentation of a dispute must be made by telephone (610) 994-7500. Upon presentation of a dispute, your payment of the invoice will be noted as made under protest pending resolution of the dispute presented. All disputes regarding the charges in this invoice, whether presented by you or by MRO, must be resolved by arbitration under the Federal Arbitration Act through one or more neutral arbitrators before the American Arbitration Association (AAA). Your dispute will be resolved by the arbitrators, and not by a judge or a jury. Class arbitrations are not permitted. Disputes must be brought only in the claimant's individual capacity and not as a representative or member of a class. An arbitrator may not consolidate your dispute with the dispute of anyone else nor preside over any form of class proceeding. Upon request by you at the time a dispute is presented, MRO will pay the AAA fee for arbitration of your dispute.

Please contact MRO at (610) 994-7500 for any questions regarding this invoice.
MRO is the medical copy request processor for:
CHACC-Hematology/Oncology.

EXHIBIT NO. 7F
PAGE: 1 OF 15

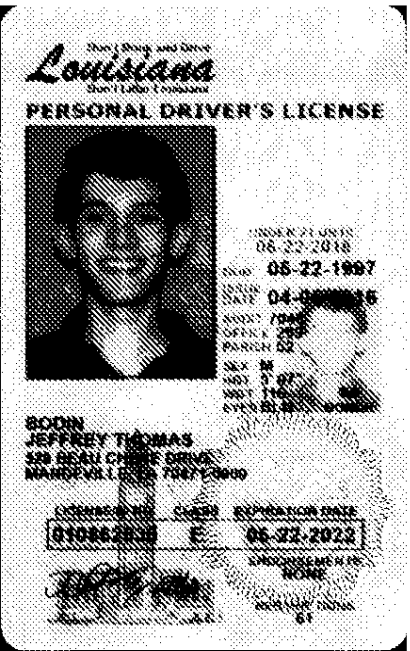


EXHIBIT NO. 7F
PAGE: 2 OF 15

SLENT

Jason Guillot, MD James Connolly, MD Jordan Cruz, FNP-C JJ Martinez, AuD
1420 North Causeway Blvd. Mandeville, LA 70471
Phone 985-327-5905 Fax 205-623-1080

PATIENT INFORMATION & CONSENTS **DATE:** 6/27/17

Name: Jeffrey Bodin **Date of Birth:** 5/22/97

Gender: (Male) Female **SS#:** 436-95-8926 **Marital Status:** (S) M D W

Address: 528 Bean Chene Dr Mandeville LA
Street Address Apt # City State Zip Code

Billing Address: _____
Street Address Apt # City State Zip Code

Home#: 985-845-0969 **Cell#:** 985-264-1080 **Other#:** _____

Email: jeffreybodin7130@gmail.com **Parent/Guardian's Name** Linda Bodin

Emergency Contact: Linda Bodin **Relationship:** Mom **Contact#:** 985-264-5277

Referring MD: _____ **Primary MD:** Dr. Terral

Pharmacy: Walgreens Mandeville 985-674-2551
Name Street City Phone Number

Referred by? MD/Hospital _____ Google Facebook Self Referral Other _____

GOVERNMENT REQUIRED QUESTIONS

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian
☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unreported/Declined to Report

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unreported/Decline to Report

Language Preference: ☐ English ☐ Spanish ☐ **Other** _____

Employment Status: ☐ Employed ☐ Not Employed ☐ Retired **Occupation:** _____

INSURANCE INFORMATION

If information provided below is incorrect or incomplete you will be financially responsible for all charges rendered.
Patient must bring insurance card and driver's license to appointments.

Primary Insurance: BCBS **Secondary Insurance:** _____

Member ID #: _____ **Member ID #:** _____

Relationship of Patient to Insured
☐ Self ☐ Spouse ☑ Parent ☐ Other
(Complete below if patient is not policy holder)

Name: Mark N. Bodin
DOB: 9/12/62 **Phone:** 985-237-8363

SS#: _____

Relationship of Patient to Insured
☐ Self ☐ Spouse ☐ Parent ☐ Other
(Complete below if patient is not policy holder)

Name: _____
DOB: _____ **Phone:** _____

SS#: _____

*New patient information and consent forms **must** be completed & returned prior to your appointment.*
If unable to return in advance, patient must arrive at least 15 minutes early.

EXHIBIT NO. 7F
PAGE: 3 OF 15

SLENT

Jason Guillot, MD James Connolly, MD Jordan Cruz, FNP-C JJ Martinez, AuD
1420 N. Causeway Blvd. Mandeville, LA 70471
Phone: 985-327-5905 Fax: 205-623-1080

MEDICAL RECORDS REQUEST
REQUEST FOR PROTECTED HEALTH INFORMATION (PHI)

Patient: Joffrey Bodin **Date of Birth:** 5/22/97

This request will expire on the following date _____ or in the event of _____.
If date or event is not indicated, authorization will expire on January 1st the next calendar year.

I hereby request a copy of the sections of my medical record as indicated below to be forwarded to SLENT at fax number 205-623-1080.

- [x] History and Physical Exam and Progress Notes
- [x] Audiology: Hearing Test / Balance Study / ABR / Etc.
- [x] Consultation Reports
- [x] Hospital Operative/Discharge Summary
- [x] Lab/Pathology Results
- [x] Radiology Reports: CT / MRI / X-Ray / Ultrasound/ Etc.
- [x] Sleep Study Results / Compliance Downloads
- [ ] Other _____

Signature: Joffrey Bodin **Date:** 6/27/17
Patient or Legal Guardian

Please include this request as a coversheet when returning records.

Faxed To: _____ **Fax Number:** _____ **Date:** _____

From: _____ **Phone Number:** 985-327-5905 **Ext:** _____ **Date:** _____
Practice Representative

Warning: *This message is intended only for the person listed above. The attached information is confidential and considered privileged by law. If the reader of this fax is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you are not the intended recipient, please notify us and shred this information. Thank you for your cooperation.*

SLENT

Patient: Jeffrey Bodin
please print name

Check the appropriate boxes for symptoms you are *currently* experiencing.

Eyes
☐ Pain ☐ Dry ☐ Watery/Itchy ☐ Vision loss ☐ Blurring/Double vision ☐ Discharge

Ear, Nose, Throat
☐ Ear Pain ☐ Hearing loss ☐ Ringing ☐ Dizzy ☐ Stuffy Nose ☐ Runny Nose
☐ Hoarseness ☐ Sore throat ☐ Trouble swallowing

Cardiovascular
☐ Chest Pain ☐ Palpitations ☐ Fainting ☐ Shortness of breath with activity
☐ Shortness of breath while resting ☐ Swelling in legs

Respiratory
☐ Cough ☐ Shortness of breath ☐ Excessive sputum ☐ Coughing up blood ☐ Wheezing

Gastrointestinal
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation

Genitourinary
☐ Pain urinating ☐ Waking up to urinate ☐ Blood in urine ☐ Discharge
☐ Trouble starting ☐ Trouble stopping ☐ Genital sores

Musculoskeletal
☐ Back pain ☐ Joint pain ☐ Joint swelling ☐ Muscle cramps ☐ Muscle weakness ☐ Stiffness

Skin
☐ Scarring ☐ Eczema ☐ Rashes ☐ Skin cancer ☐ Suspicious lesions

Neurologic
☐ Paralysis ☐ Focal loss of sensation ☐ Blackouts ☐ Seizures
☐ Restless legs ☐ Insomnia ☐ Sleep Apnea ☐ Snoring

Psychiatric
☐ Depression ☐ Anxiety ☐ Memory loss ☐ Mental disturbance ☐ Suicidal
☐ Hallucinations ☐ Paranoia

Endocrine
☐ Cold intolerance ☐ Heat intolerance ☐ Always thirsty ☐ Always hungry

HemeLymphatic
☐ Abnormal bruising ☐ Abnormal bleeding ☐ Enlarged lymph nodes
☐ Tender lymph nodes ☐ Frequent illnesses

Allergic/Immune
☐ Ocular allergies ☑ Nasal allergies ☐ Allergic dermatitis ☐ Recurring infections
☐ HIV exposure ☐ Immuno-compromised

Signature: Jeffrey Bodin **Date:** 6/27/17
Patient or Legal Guardian

EXHIBIT NO. 7F
PAGE: 5 OF 15

Office Use Only
Area: _____ Age: ____
Insurance: _____

ENT

Patient: _____
please print name

Primary Care Physician: Dr. Terral **Pharmacy:** Walgreens Mandeville 985-674-5577

Reason for today's visit: Narcolepsy

List daily medications and dosage: Adderal 30mg 3x Daily

Allergies? N/A

Prior surgeries? Surgery related to cancer

MEDICAL HISORY

Patient - please check the appropriate boxes below for any conditions you are *currently* experiencing.

		FAMILY HISTORY	
Condition	**Patient**	**Mother**	**Father**
Allergic rhinitis			
Anxiety			
Asthma			
Heart Condition*			
Lung Disease*			
Diabetes			
Hearing Loss			
Heartburn/Reflux			
High Blood Pressure			X
Sleep Apnea			X
Snoring			X
Kidney Failure			
Sinusitis		X	
Stroke			
Smoking			
Anemia			
Depression			
Heart Attack			
Hypothyroidism	✓		
Migraine	✓		
Cancer* ↑			
Other malignant melanoma			

**specify condition*

☐ Family history unknown

Previous Radiation
☐ Yes ☑ No

Prior Chemotherapy
☐ Yes ☑ No

Smoking Status
☑ Never

Current Smoker
☐ Yes ☐ No
Number of cigarettes/day: _____
How many years? _____

Former Smoker
☐ Yes ☐ No
Number of cigarettes /day: _____
How many years? _____
Quit Date: _____

Do you drink alcohol?
☐ Yes ☐ No
☐ Beer ☐ Wine ☐ Liquor
Number of drinks: _____
☐ daily ☐ weekly ☐ monthly ☐ yearly

Have you ever used illegal or IV drugs?
☐ Yes ☑ No
Type: _____

SLENT

Patient: Jeffrey Bodin
please print name

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* at any time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Signature: Jeffrey Bodin **Date:** 6/27/17
Patient or Legal Guardian

ASSIGNMENT OF BENEFIT AGREEMENT

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to South Louisiana Ear, Nose, Throat & Facial Plastics (SLENT) for medical or surgical services or items rendered to me or my dependent by SLENT. Should my insurance carrier deny SLENT, I understand that I am financially responsible for the charges. I authorize SLENT to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

Signature: Jeffrey Bodin **Date:** 6/27/17
Patient or Legal Guardian

NOTICE OF IN-OFFICE PROCEDURE BILLING & FINANCIAL RESPONSIBILITY POLICY

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to the office visit charge. We are aware that some insurance carriers are classifying these procedures as "Surgery" and apply the charges to a higher co-pay or deductible amount. The result may be insurance payment for an office visit but not the procedure. In such cases, payment for the procedure will be due from the patient. Be assured we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care.

Examples of in-office procedures include:

- Flexible Laryngoscopy: This procedure involves passing a long thin flexible fiber-optic scope through the nasal cavity and into the throat. The fiber-optic scope enables the physician to visualize areas of the throat not seen using the laryngeal mirrors.
- Nasal endoscopy: This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.
- Nasal endoscopy with debridement or biopsy: This is the same procedure as above with removal of crusting or tissue.

Please speak with our nurse or clinical assistant if you have any questions.

Signature: Jeffrey Bodin **Date:** 6/27/17
Patient or Legal Guardian

SLENT

Patient: Jeffrey Bolin
please print name

NOTICE OF FORM REQUEST POLICY

It is the goal of our practice to accommodate form completion request as timely as possible.

Work and School Excuses should be requested at time of visit. Due to HIPPA regulations we are not allowed to fax excuses to work or school. Forms not requested at time of visit **must** be picked up at the office.

Medical Records

- Medical release forms are included in our new patient packet and on our website. Completion of the forms allows us to request your records from other healthcare providers.
- A copy of your office visit at our clinic will be automatically sent to other healthcare providers you identify.
- A signed release is required if you are requesting transfer of care to another provider. Depending on the number of documents a processing fee may apply.

FMLA/Disability/Supplemental Insurance Forms

- Blank forms will not be accepted. Personal information must be completed.
- Turnaround time is usually 7 business days.
- Forms are completed for those accounts in good standing. Outstanding balances need to be paid prior to forms being filled out.
- A $25 fee due when forms are completed.
- Forms will be mailed only if pre-addressed envelope is provided and fee is paid in advance.

Signature: Jeffrey Bolin **Date:** 6/27/17
Patient or Legal Guardian

CANCELLATION AND NO-SHOW POLICY

OFFICE VISITS
We understand there are times when appointments must be missed due to emergencies or family and work obligations. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. **If an appointment is not cancelled at least 24 hours in advanced you will be charged a twenty-five dollar ($25) fee; this will not be covered by your insurance company.** Additionally three last minute cancellations or no-shows within a 12 month period may result in discharge from the practice.

SURGERY & OFFICE PROCEDURES
Due to the block of time reserved, the coordination among our practice, outside facilities, and your insurance provider, last minute cancellations causes problems and added expenses for the office. **If surgery is not cancelled at least 10 days in advance you will be charged a one hundred dollar ($100) fee; this is not covered by your insurance company.**

Signature: Jeffrey Bolin **Date:** 6/27/17
Patient or Legal Guardian

Practice Use Only
I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so because _____

Practice Representative Signature: _____ **Date:** _____

Progress Notes

Procedures
MD Anderson Sleep Center
PO Box 301439, Unit 1284
Houston, TX 77030
Phone: 713-792-2352

Multiple Sleep Latency Test Report

I. PATIENT PROFILE

Patient Name: Bodin, Jeffrey
Medical Record Number: 744652
Age: 19 (years)
Sex: Male
Height: 168 cm Weight: 50.0 Kg

BMI: 17.7 kg/m2
Study Date: 8/5/2016
Referring Physician: Dave Balachandran M.D., M.D.
Epworth Sleepiness Score (ESS): 14.0

II. DIAGNOSIS

Hypersomnia
347.00 Narcolepsy, Unspecified

III. PROCEDURE
The patient underwent a MSLT (multiple sleep latency test) according to the guidelines established by the American Academy of Sleep Medicine*. The patient was allowed to nap starting at two hours post awakening from the baseline study and subsequently at 2 hour intervals. During the baseline polysomnogram the sleep efficiency was 77/5%. There was no evidence of clinically significant sleep disordered breathing, nocturnal hypoxemia or movement disorders. The MSLT immediately followed the baseline study.

A total of four naps were performed. The patient slept during four of the four naps. The mean sleep latency (MSLT score) was 5.9 minutes. There were four sleep onset REM periods (SOREM) noted.

The diagnosis of narcolepsy requires 2 SOREMs, and an MSLT score of less than 8 minutes (mean sleep latency). An MSLT score of less than 10 minutes with less than 2 SOREMs can be seen in idiopathic (CNS) hypersomnia, upper airway resistance syndrome, periodic limb movement disorder and sleep apnea.

IV. CONCLUSION
The clinical history is suggestive of hypersomnia, and the MSLT is consistent with narcolepsy.

V. RECOMMENDATIONS

Stimulant therapy is recommended for daytime sleepiness.

Possible pharmacologic therapies include fluoxetine, venlafaxine, sodium oxybate, clomipramine, viloxazine, imipramine.

Additionally, HLA testing for DQ antigens (DQB1*0602 and DQA1*0102), which are associated with narcolepsy, and HLA-Cw2, which is associated with familial idiopathic hypersomnia, may provide further information.
Strategically timed naps should be incorporated in the patient's daily schedule.

The patient will be seen for a post-evaluation consultation with sleep clinic to discuss our findings and to explain the available treatment options.

If there are any questions regarding our examination, please feel free to contact our office for further elaboration or interpretation of our findings. Details concerning specific test scores and the results of sleep studies are available upon request.

Sincerely,
Diwakar Balachandran, MD
UT M. D. Anderson Sleep Center

* The International Classification of Sleep Disorders: Diagnostic and Coding Manual. Diagnostic Classification Steering Committee, Thorpy MJ, Chairman. Rochester, Minnesota: American Sleep Disorders Association, 2005

Berry RB, Brooks R, Gamaldo CE, Harding SM, Marcus CL and Vaughn BV for the American Academy of Sleep Medicine. The AASM Manual for the Scoring of Sleep and Associated Events: Rules, Terminology and Technical Specifications, Version 2.0. www.aasmnet.org, Darien, Illinois: American Academy of Sleep Medicine, 2012

Littner MR et al. Practice Parameters for Clinical Use of the Multiple Sleep Latency Test and the Maintenance of Wakefulness Test- AASM Practice Paramenters. Sleep 2005: 28(1) 113-121

Electronically signed by Dave Balachandran, MD at 8/15/2016 1:17 PM

Procedure visit on 8/5/2016

Ochsner Health System
Sleep Center
Tel: 504 842-4910

Baseline PSG/MSLT REPORT

Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

Patient Name: Bodin, Jeffery			**Hospital #:**	83000256150
Sex:	Male	**Study Date:**	2/2/2015	
D.O.B.:	5/22/1997	**Clinic #:**	2592229	
Age:	17	**Referring Physician:**	Liudmila Lysenko, MD	
Height:	67.0 in	**Referring Physician #**	2478	
Weight:	107.0 lbs	**Sleep Specialist:**	L. Lysenko, MD	
B.M.I.:	16.8	**Sleep Specialist #**	2478	
Hypopnea rule:	AASM1A	**Scoring Tech:**	A.Becnel,RPSGT	
Total AHI:	10.3	**Recording Tech:**	Leanett Sandifer, RRT	
Lowest O2 sat:	91.0%	**Recording Location:**	Ochsner Baptist	

Sleep architecture: This is a baseline polysomnogram. At light's out, the patient fell asleep in 3.5 minutes and slept for 94.4% of the time. Total sleep time (TST) was 401.5 minutes. 5.4% of TST was in Stage N1 sleep, 24.4% TST in slow wave sleep, and 21.2% TST in REM sleep. The REM latency was 69.0 minutes. Sleep architecture was mildly disrupted due to underlying sleep apnea.

Respiratory: Mild snoring was present. There was mild, yet significant OSA (obstructive sleep apnea) based on AHI (apnea hypopnea index) criteria. The overall AHI was 10.3 with an oxygen nadir of 91.0%. The supine AHI was 5.9 and the REM AHI was 30.4. The patient did not qualify for a split night study due to an insufficient number of events in the first half of the study.

Motor movement / Parasomnia: There were no significant limb movements of sleep noted. The total limb movement index was 0.0 (0.0with arousal).

Cardiac: Cardiac rhythm monitoring revealed a normal sinus rhythm ..

Patient perception: On a post-sleep study questionnaire, the patient indicated that sleep was "worse" in the lab than compared to home.

MSLT: Next day, for the MSLT 4 naps were recorded at 2 hour intervals, for approximately 20 minutes duration each, starting at a lights out time of 7:35 AM AM for Nap 1. She fell asleep on 4/4 naps and developed sleep onset REM periods (SOREMPs) on 4/4 naps. The sleep onset latency for Naps 1 through 4 were 3:30 min, 1:00 min, 0:30 min, 2:00 min, respectively. The 4 nap-mean sleep latency was severily diminished at 1.5 minutes. The patient felt that she fell asleep on naps 1-4. Urine drug screen on the morning of the MSLT was negative.

IMPRESSION:

1. Severily diminished sleep onset latency of 1.5 minutes was noted on MSLT with 4/4 SOREMS (sleep onset REM periods). This is suggestive of narcolepsy in appropriate clinical context.

2. Mild, yet significant OSA (327.23) based on AHI criteria

RECOMMENDATION:

1. Clinical correlation is suggested.

Liudmila Lysenko, MD

Digitally signed by Liudmila Lysenko, MD
DN: cn=Liudmila Lysenko, MD, o, ou, email=llysen@ochsner.com, c=US
Date: 2015.02.10 13:18:33 -06'00'

Ochsner Health System
Sleep Center
Tel: 504 842-4910

Baseline PSG/MSLT REPORT

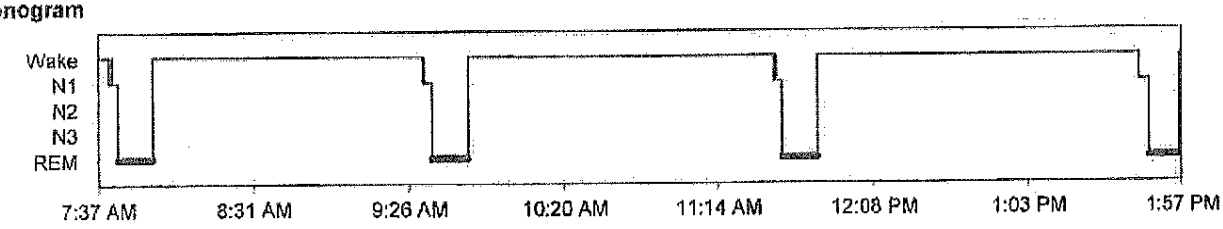
Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

MULTIPLE SLEEP LATENCY TEST:

Sleep Architecture	NAP 1	NAP 2	NAP 3	NAP 4	NAP 5	Mean Values
Analysis Start Time:	7:37:28 AM	9:29:58 AM	11:33:28 AM	1:40:28 PM	N/A	--
Analysis End Time:	7:55:58 AM	9:45:58 AM	11:48:58 AM	1:57:28 PM	N/A	--
Time In Bed*:	18:30	16:00	15:30	17:00	N/A	16:45
Total Sleep Time*:	14:30	15:00	14:30	14:30	N/A	14:38
Sleep Onset*:	03:30	01:00	00:30	02:00	N/A	01:45
REM Latency*:	03:30	03:00	03:00	03:30	N/A	03:15

* Time formats are in min:sec. Note: report will return default time = 20 min. for Sleep Onset, if no sleep occurs during nap.

Hypnogram



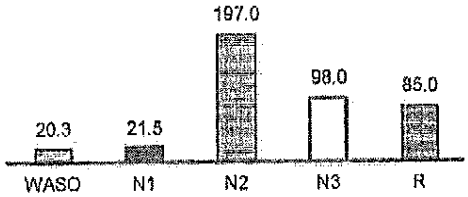
Ochsner Health System
Sleep Center
Tel: 504 842-4910

Baseline PSG/MSLT REPORT

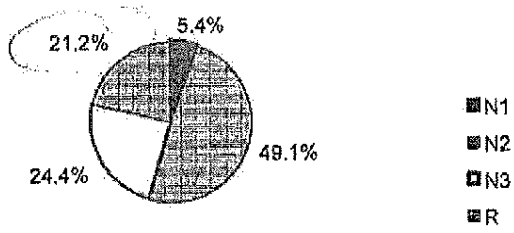
Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

Sleep Architecture	
Lights out clock time (hr:min):	10:44:13 PM
Lights on clock time (hr:min):	5:49:32 AM
Total Recording Time (TRT; in min.):	426.3
Sleep Period Time (SPT)*:	7:01:50
Total Sleep Time (TST; in min.):	401.5
Sleep Efficiency:	94.4%
Sleep latency (SL):	0:03:30
Total Stage Changes (after sleep onset):	101
Awakenings (after sleep onset):	22
WASO (min.):	20.3
REM Periods:	6
REM Latency*:	1:10:00
REM Latency (less Wake time)*:	1:09:00

* Time formats are in hrs:min:sec



Stage Distribution (in min.)



Sleep Stage (%TST)

Sleep Stage	Latency (min)
N1:	0.0
N2:	3.5
N3:	14.0
R:	70.0

Stage Latency = 0.0 denotes start of sleep.

Ochsner Health System
Sleep Center
Tel: 504 842-4910

Baseline PSG/MSLT REPORT

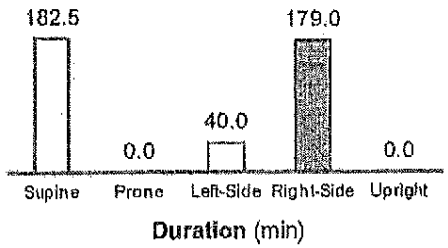
Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

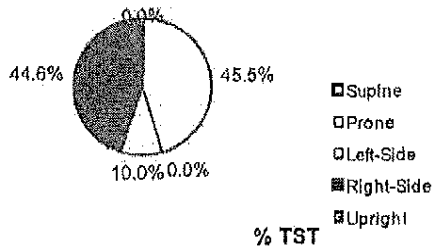
RESPIRATORY EVENTS	Cen. Apneas	Obs. Apneas	Mxd. Apneas	Hypopneas	Total Apneas	Apnea+ Hypopnea	RERA	All Resp. Events *
Count:	6	0	0	63	6	69	0	69
Index (events / hr.):	0.9	0.0	0.0	9.4	0.9	**10.3**	0.0	10.3
Mean Duration (sec.):	12.5	N/A	N/A	19.9	12.5	19.2	N/A	19.2
Longest Event (sec.):	14.4	N/A	N/A	44.7	14.4	44.7	N/A	44.7
REM Count:	3	0	0	40	3	43	0	43
Non-REM Count:	3	0	0	23	3	26	0	26
REM Index:	2.1	0.0	0.0	28.2	2.1	30.4	0.0	30.4
Non-REM Index:	0.6	0.0	0.0	4.4	0.6	4.9	0.0	4.9

* Note: Does not contain Cheyne Stokes Breathing, Hypoventilation, or Periodic Breathing.

RESPIRATORY EVENTS (by Body-Position)	Supine Sleep		Prone Sleep		Left-Side Sleep		Right-Side Sleep		Upright Sleep	
	Count	Index	Count	Index	Count	Index	Count	Index	Count	Index
Duration (hrs:min:sec):	3:02:30		0:00:00		0:40:00		2:59:00		0:00:00	
Obstructive Apneas:	0	0.0	N/A	N/A	0	0.0	0	0.0	N/A	N/A
Central Apneas:	1	0.3	N/A	N/A	1	1.5	4	1.3	N/A	N/A
Mixed Apneas:	0	0.0	N/A	N/A	0	0.0	0	0.0	N/A	N/A
Hypopneas:	17	5.6	N/A	N/A	2	3.0	44	14.7	N/A	N/A
RERAs:	0	0.0	N/A	N/A	0	0.0	0	0.0	N/A	N/A
Total*:	18	5.9	N/A	N/A	3	4.5	48	16.1	N/A	N/A

* Note: Does not contain Cheyne Stokes Breathing, Hypoventilation, or Periodic Breathing.





BODY-POSITION RESULTS

Ochsner Health System
Sleep Center
Tel: 504 842-4910

Baseline PSG/MSLT REPORT

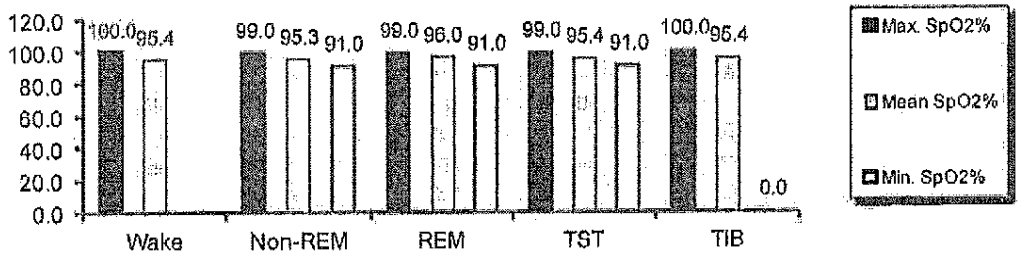
Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

AROUSALS	Resp. Count	Resp. Index	Spontaneous Count	Spontaneous Index*	Total Count	Total Index
Total Sleep Time:	49	7.3	60	9.0	109	16.3
Non-REM	17	3.2	28	5.3	45	8.5
REM:	32	22.6	32	22.6	64	45.2

* EEG Arousal activity not associated with Respiratory or PLM events.

LIMB MOVEMENTS (by sleep stage)	LM w/ Arousals Count	LM w/ Arousals Index	LM w/o Arousals Count	LM w/o Arousals Index	Total LMs Count	Total LMs Index	PLM Series Count	PLM Series Index
Total Sleep Time:	0	0.0	0	0.0	0	0.0	0	0.0
N1:	0	0.0	0	0.0	0	0.0	0	0.0
N2:	0	0.0	0	0.0	0	0.0	0	0.0
N3:	0	0.0	0	0.0	0	0.0	0	0.0
R:	0	0.0	0	0.0	0	0.0	0	0.0

OXYGEN DESATURATION EVENTS	Count	Index
Total Sleep Time:	56	8.4
Wake (after sleep onset):	0	0.0
Non-REM:	30	5.7
REM:	26	18.4



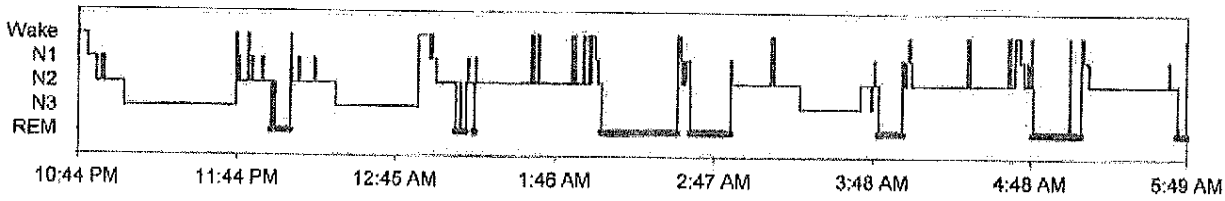
Oximetry Trend Graph

Ochsner Health System
Sleep Center
Tel: 504 842-4910

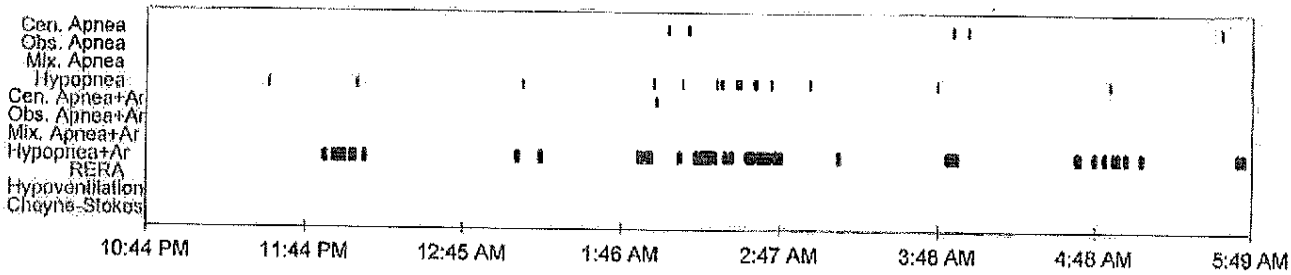
Baseline PSG/MSLT REPORT

Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

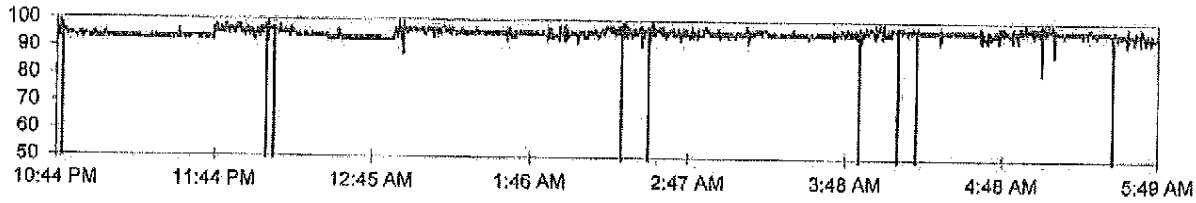
Hypnogram



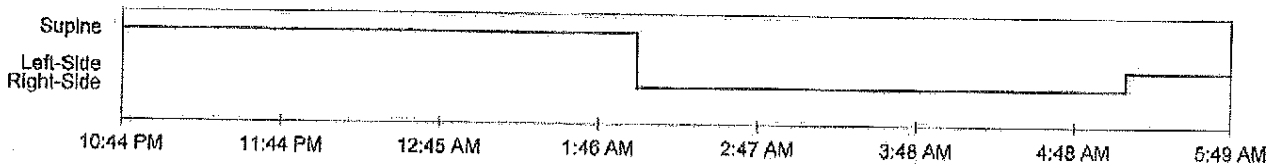
Respiratory Events



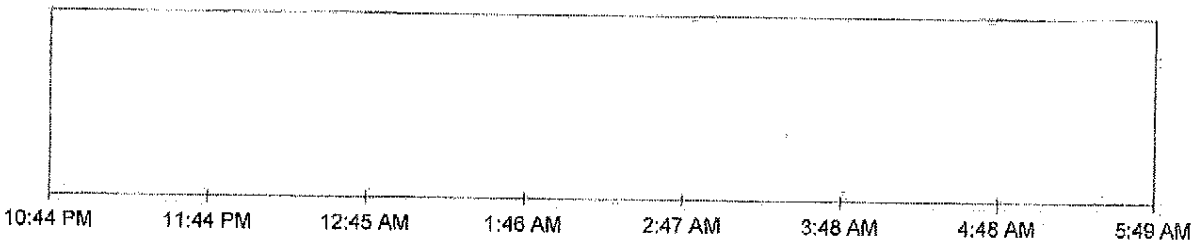
SpO2%



Body Position



Limb Movement Events



Visit Note - July 11, 2017

BODJE000 | Male | 06/22/1997 | (985) 204-1080 | BODJE000

Medical History
Reviewed on July 11, 2017 and no changes noted
Other: Melanoma, Narcolepsy

Surgical History
Reviewed on July 11, 2017 and no changes noted
Appendix (Appendectomy)
Skin Melanoma
Skin Skin Biopsy

Derm History
Reviewed on July 11 2017 and no changes noted.
Acne
Melanoma

Social History
Reviewed on July 11, 2017 and no changes noted.
None
Occupation
Place of Residence
Smoking status - Never smoker

Medications
Reviewed on July 11, 2017 and no changes noted
Adderall 30 mg Oral - tablet
Allegra Allergy
Singulair
Nasal spray

Allergies
Reviewed on July 11, 2017 and no changes noted.
No known drug allergies

ROS
A focused review of systems was performed including Allergic / Immunologic and Integumentary

No new skin lesion.

Family History
Family history, neoplasm of skin (situation)
- Father

Chief Complaint: Surveillance against skin cancer recurrences

HPI: This is a 20 year old male who comes in for a chief complaint of surveillance against skin cancer recurrences. His history is significant for melanoma located on the left lower extremity, malignant melanoma type, excised in 2008. This melanoma has been treated with: sentinel lymph node biopsy and wide local excision. He presents today for: skin cancer surveillance He is up to date on dental and ocular exams.

Exam:
An examination was performed including the scalp (including hair inspection), head (including face), inspection of conjunctivae and lids, neck, chest, abdomen, back, right upper extremity, left upper extremity, right lower extremity, left lower extremity, buttocks but not genitalia, and buttocks and groin but not genitalia.

Findings in the above examined areas were normal with the exception of the following exam descriptions below:

Impression/Plan:
1. **History of malignant melanoma**
   (Z85.820)
   Well healed scar with NER
   distributed on the left posterior ankle and body throughout.
   Associated diagnosis: Medical surveillance following completed treatment

   Plan: Counseling.
   I counseled the patient regarding the following.
   Skin Care Patients with a history of melanoma should wear sunblock and sun protective clothing.
   Expectations: Scars from excisional sites of melanoma should be monitored for any recurrences. Monthly self-skin checks should be performed to monitor for any moles that change in size, shape or color, itch burn or bleed.
   Contact Office if: Patient notices any new or changing moles, develops constitutional symptoms or develops new lesions within or around the previous melanoma scar.
   Well healed scar

   Plan: Reassurance.

   Plan: Treatment Regimen.
   Plan: Pt. To continue regular follow up appointment at Children's.

2. **Benign Appearing Nevi**
   (D22.5)
   Regular, symmetrical, evenly-colored brown macules
   distributed on the body throughout.

   Plan: Counseling.
   I counseled the patient regarding the following:
   Instructions: Monthly self-skin checks to monitor for any changes in moles are recommended.
   Expectations: Benign Nevi are pigmented nests of cells within the skin. No treatment is necessary.
   Contact Office If: Any moles change in size, shape or color, itch, burn or bleed.

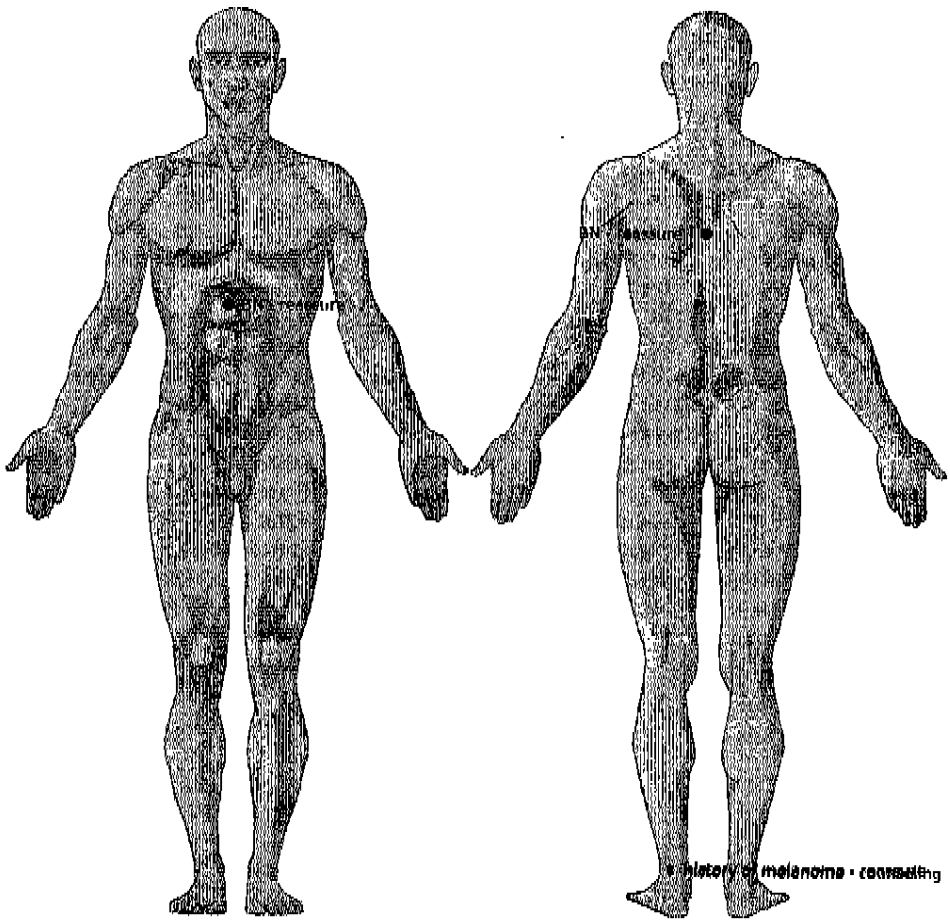
   Plan: Reassurance.

Follow up in 1 year for: Skin Cancer Surveillance - 15 minutes (DB ok)

Staff:

Rhonda Baldone, M.D. (Primary Provider) (Bill Under)

Robin Evans (scribe)



I, Robin Evans am scribing for, and in the presence of Rhonda Baldone M.D.

Electronically Signed By Robin Evans, 07/11/2017 09:49 AM CDT

I, Rhonda Baldone M.D., personally performed the services described in the documentation as scribed by Robin Evans in my presence, and confirm it is both accurate and complete.

Visit Note - July 11, 2017

Pat ID	Sex	DOB	Phone	Work
BODJE000	Male	05/22/1997	(985) 264-1000	BODJE000

Electronically Signed By: Rhonda Baldone, M.D., 07/11/2017 09:49 AM CDT

Department of Children & Family Services
Building a Stronger Louisiana

Disability Determinations Services
Economic Stability
Division of Programs
2150 WESTBANK EXPRESSWAY SUITE 131
HARVEY, LA 70058

(O) 800.256.2299
(F) 1-866-444-2216
www.dcfs.la.gov

John Bel Edwards, Governor
Marketa Garner Walters, Secretary

August 7, 2017

RHONDA BALDONE MD
MEDICAL RECORDS
150 LAKEVIEW CIR
COVINGTON, LA 70433

Claimant: JEFFREY BODIN
CASE #: 1150892
DOB: 05/22/1997 XREF #:

Request for Evidence - Fax Coversheet/Invoice

We are the office that makes disability determinations for Social Security. JEFFREY BODIN is applying for or is receiving disability benefits due to the following conditions: narcolepsy, migraines, peripheral neuropathy, allergies.

We ask that you provide complete medical history on all conditions, not limited to those listed above, covering the period of **07/01/2015 to PRESENT**, to help us evaluate this claim.

SPECIAL INSTRUCTIONS:

ok to send KB 8/10/17

RQID:LLA000B5WTW00 SITE:S77 DR:S
SSN:********* DOCTYPE:0001 RF:D CS:e188

***** Please return this fax/coversheet/invoice with your response.*****

We are authorized to pay $ 20.00 for information received within 30 days of this request. We will no longer research and reissue payment on invoices that are over 180 days from the date of request for records.

This information can be faxed toll free to our fax gateway at 1-866-444-2216 and will help us provide a quicker decision. Should you have any questions please contact A. BARTHELEMY at 504-361-6236 or 1-800-256-2299.

Please do not forward this letter if patient was seen by another doctor's office, clinic or hospital. Write new source name here: _____.

PLEASE INDICATE IF:

✓ Requested Evidence Attached
__ Chart not available through date
__ No Evidence for Date Requested
__ No Patient Found
__ Check here if you do not wish to be paid

04001002478

QDD=N CAL=N **DMA Case: Y** Continued on next page
noakb/20MER/0093340 Auth#:20170807330009 Invoice No. MH5985

Explanation for Request

This claim for disability benefits under the Social Security Act has been referred to this agency. We are requesting copies of your medical records or a narrative report to help in making a decision.

The information we are requesting will aid us in establishing the nature, severity, and duration of the alleged impairment(s). We need detailed information including medical history, clinical and laboratory findings, information on prescribed treatment and response to treatment, diagnosis, and prognosis.

We would also like to have a statement, based on your medical findings, of this individual's ability to perform work-related physical activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling. When there is a mental impairment, please include your opinion regarding understanding and memory, sustained concentration and persistence, social interaction, and adaptation.

If the individual is a child, we ask for a statement of the child's functional limitations such as any limitations in learning, motor functioning, performing self-care activities, communicating, socializing, and completing tasks. If the child is under age one, please report on responsiveness to stimuli.

An authorization to release the medical records and/or information is also enclosed. The Privacy Act of 1974 permits review of these records by the claimant and/or his representative.

Submitting Your Response Electronically Free Options

Help expedite this individual's decision by submitting his/her records to us electronically - free.

Records can be faxed to our toll-free secure servers. When faxing, page one of this request must be used as the fax coversheet.

If you have electronic records, you may be interested in uploading records to SSA's secure website. For information, contact our DDS Medical Relations Staff 504-361-6335 OR 1-800-256-2299.

Submitting Via US Post Office

If returning via US Postal Service, records must be forwarded to the address on the attached sheet.

Receiving Medical Request VIA SSA Secure Website or Fax

We are now able to submit our requests to you via SSA's Secure Website or Fax. If you are interested in receiving additional information please either

1) Complete the following before returning this letter:

Your Contact Name _____ & Phone Number _____ or

2) Call our Medical Relations staff at 504-361-6335 OR 1-800-256-2299.

Important Information

Would you be willing to perform consultative examinations on your own patients and/or other claimants applying for Social Security Disability benefits? If so, or if you would like additional information, please contact our Medical Relations Staff at AADDR

Form Approved OMB No 0960-0623

BODIN, JEFFREY T
436958926 05/22/1997

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*			
Jeffrey T Bodin			
SSN	436-95-8926	Birthday *(mm/dd/yy)*	05/22/97

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records;* also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

RHONDA BALDONE MD
COVINGTON, LA 70433

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility** for benefits, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶ *Electronically Signed By:* **Jeffrey T Bodin**

IF not signed by subject of disclosure, specify basis for authority to sig
☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
07/30/17	528 Beau Chene Dr		
Phone Number (with area code)	City	State	ZIP
985-264-1080	Mandeville	LA	70471

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶	IF needed, second witness sign here (e.g., if signed with "X" above) SIGN ▶
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

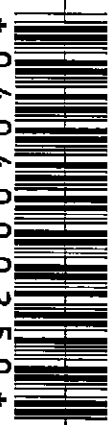
0403002048

DISABILITY DETERMINATION SERVICES - S77
PO Box 8909
London, Ky. 40742-8909

We are no longer sending the address label.

Please use this address to send your documents to the Scan Contractor.

Thank you.



Ciox Health
P.O. Box 409822
Atlanta, GA 30384-9822
Fed Tax ID 58 - 2659941
1-800-367-1500

CIOX HEALTH

INVOICE

Invoice #: 0224295353
Date: 8/14/2017
Customer #: 1298067

Ship to:	Bill to:	Records from:
DDS DDS NEW ORLEANS LA S77 2150 WESTBANK EXPY, SUITE 709 HARVEY, LA 70058	DDS DDS NEW ORLEANS LA S77 2150 WESTBANK EXPY, SUITE 709 HARVEY, LA 70058	CHILDRENS MEDICAL CENTER 71107 HIGHWAY 21 STE 1 COVINGTON, LA 70433

Requested By: DISABILITY DETERMINATIONS
Patient Name: BODIN JEFFREY

INVOICE#: MH5987

Description	Quantity	Unit Price	Amount
Basic Fee			20.00
Retrieval Fee			0.00
Per Page Copy (Paper) 1	18	0.00	0.00
Subtotal			20.00
Sales Tax			0.00
Invoice Total			20.00
Balance Due			20.00

Pay your invoice online at https://paycioxhealth.com/pay/

Terms: Net 30 days

Please remit this amount : $ 20.00 (USD)

Ciox Health
P.O. Box 409822
Atlanta, GA 30384-9822
Fed Tax ID 58 - 2659941
1-800-367-1500

Invoice #: **0224295353**

Check # _____

Payment Amount $_____

Get future medical records as soon as they are processed, by signing up for secure electronic delivery.
Register at: edelivery.cioxhealth.com

Please return stub with payment.

Please include invoice number on check.
To pay invoice online, please go to https://paycioxhealth.com/pay/ or call 800-367-1500.
Email questions to collections@cioxhealth.com.

EXHIBIT NO. 9F
PAGE: 3 OF 23

Date: 7/26/17 Acct# 22110 Ins Elig Ck: Oemyl 7/2/17

In With: self

Patient's Name: Jeffrey Bodin DOB: 5/22/97 Phone: 264-1080 pt

Medications:	Allergies:	HPI:
~~Xyrem~~ Adderall 30mg	NKDA	

Chief Complaint: rech & refill on Adderall 30mg i tid

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

SHx, FHx, PMHx, Work

LABS Today:

☐ Except as documented above all systems are negative.

PE:	BP:	Ht:	Wt:	HC:	P:	RR:	BMI:	Temp:
	126/84		106.4lb					

☑ NORMAL

☐ Constitutional
☐ HEENT
☐ CV
☐ Respiratory
☐ Chest
☐ GI
☐ GU
☐ Lymphatic
☐ MS
☐ Skin
☐ Neuro
☐ Psych

Meds: same
No Xyrem
Adderall 30 1 : 1
Off to LSU 2 classes
Math Biology
RTC 1 mo

In: Out: Signature: [signature]

Plan/Treatment:

8/10/2017 Clox | ROI | LADDS

Date: 7/5/17 Acct#: ______ Ins Elig Ck: ______

In With: self

Patient's Name: Jeffrey Bodin DOB: 5/22/97 Phone: 264-1080 pt

Medications:	Allergies:	HPI:
Xyzen Adderall 30mg	NKDA	Mom 264-8277

Chief Complaint: rech on meds - Adderall 30mg i tid

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

√ (L) ear ©

SHx, FHx, PMHx, Work

LABS Today:

☐ Except as documented above all systems are negative.

PE:	BP:	Ht:	Wt:	HC:	P:	RR:	BMI:	Temp:
			102.1lb ø shoes					

☑ NORMAL
☐ Constitutional
☐ HEENT
☐ CV
☐ Respiratory
☐ Chest
☐ GI
☐ GU
☐ Lymphatic
☐ MS
☐ Skin
☐ Neuro
☐ Psych

o/f Xyzen No replacement
Cont. Adderall 30 tid
RTC 3 m

In: Out: Signature: Tarl

Plan/Treatment:

Date: 6/15/17 Acct# 22110 Ins Elig Ck: 6/14/17

In With:

Patient's Name: Jeffrey Boden DOB: 5/22/97 Phone: 264-1080 pt

Medications:	Allergies:	HPI: Mom 264 5277
Xyzen Adderall		

Chief Complaint ① rech on Adderall 30mg i tid

Constitutional (fever) (wt loss) ② feet real red + puffy

HEENT

CV

Respiratory

GI

GU

MS

Skin/Breast

Neuro (HA)

Psych

Endo/Heme/Lymph

Allergic/Immunologic

SHx, FHx, PMHx, Work

LABS Today:

☐ Except as documented above all systems are negative.

PE:	BP:	Ht:	Wt:	HC:	P:	RR:	BMI:	Temp:
	110/60		103.4					

☑ NORMAL Ø shoes

☐ Constitutional

☐ HEENT

☐ CV

☐ Respiratory

☐ Chest

☐ GI

☐ GU

☐ Lymphatic

☐ MS

☐ Skin

☐ Neuro

☐ Psych

In: Out: Signature:

Plan/Treatment:

Date: 5/26/17 Acct# 22110 Ins Elig Ck: 5/24/17

In With: Self

Patient's Name: Jeffrey Bodin DOB: 5/22/97 Phone: 264-1080 pt

Medications:	Allergies:	HPI: Mom 264-5277
Adderall 30mg		

Chief Complaint: rech on meds Adderall 30 mg tid

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

SHx, FHx, PMHx, Work

LABS Today:

☐ Except as documented above all systems are negative.

PE:	BP:	Ht:	Wt:	HC:	P:	RR:	BMI:	Temp:
	128/68		100.2lb					

☑ NORMAL
☐ Constitutional
☐ HEENT
☐ CV
☐ Respiratory
☐ Chest
☐ GI
☐ GU
☐ Lymphatic
☐ MS
☐ Skin
☐ Neuro
☐ Psych

Cat - Xyzen 2X at Night
Adderall 30 mg tid
Keep Log of Activities while on Adderall

In: Out: Signature: [signature]

Plan/Treatment:

Date: 4/26/17 Acct# 22110 Ins Elig Ck: _____ In With: self

Patient's Name: Jeffrey Bodin DOB: 5/22/77 Phone: 264-1080

Medications:	Allergies:	HPI:
Adderall	NKA	

Chief Complaint: rech on meds
Adderall 20mg tid

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

SHx, FHx, PMHx, Work

LABS Today:

☐ Except as documented above all systems are negative.

PE: BP: 118/80 Ht: Wt: 102.2 lb HC: P: RR: BMI: Temp:

☑ NORMAL
☐ Constitutional
☐ HEENT
☐ CV
☐ Respiratory
☐ Chest
☐ GI
☐ GU
☐ Lymphatic
☐ MS
☐ Skin
☐ Neuro
☐ Psych

8 shoes

↑ to 25 t.i.d
(20+5)
RTC 2 wk.

In: Out: Signature:

Plan/Treatment:

Date: 4/12/17 Acct# 22110 Ins Elig Ck: 4/10/17

In With: self

Patient's Name: Jeffrey Bodin DOB: 5/22/97 Phone: 264-1080 pt

Medications: Adderall	Allergies: NKDA	HPI: mom 264-5277

Chief Complaint: reck on meds - Rx of Adderall 20 #60 i po BID - given on 4/3/17

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

SHx, FHx, PMHx, Work Lives c Parents + sister

LABS Today:

☐ Except as documented above all systems are negative.

PE:	BP:	Ht:	Wt:	HC:	P:	RR:	BMI:	Temp:
			99 lb Ø shoes					

☑ NORMAL
☐ Constitutional
☐ HEENT
☐ CV
☐ Respiratory
☐ Chest
☐ GI
☐ GU
☐ Lymphatic
☐ MS
☐ Skin
☐ Neuro
☐ Psych

↑ 20 mg t.i.d

RTC 2 wk

In: 8:40 A Out: Signature: [signature]

Plan/Treatment:

Date: 3/31/17 Acct# 22110 Ins Elig Ck: 3/29/17 JB

In With: self

Patient's Name: Jeffrey Bodin DOB: 5/22/97 Phone: 264-1080 pt

Medications: Adderall 20 mg
OTC allergy meds

Allergies: NKDA

HPI: mom 264-5277

Chief Complaint: tech on meds
Adderall 20mg

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

last 2½ hrs

SHx, FHx, PMHx, Work: lives home © Parents + sister

LABS Today:

☐ Except as documented above all systems are negative.

PE:	BP:	Ht:	Wt:	HC:	P:	RR:	BMI:	Temp:
			102.0 lb					

8 shoes

☑ NORMAL
☐ Constitutional
☐ HEENT
☐ CV
☐ Respiratory
☐ Chest
☐ GI
☐ GU
☐ Lymphatic
☐ MS
☐ Skin
☐ Neuro
☐ Psych

1 20 mg b.i.d now
C sleep midday

In: Out: Signature: JM

Plan/Treatment:

4/3/17 VO Adderall 20mg #60
Take 1 po BID pm WCTC

Date: 3/22/17 Acct# 22110 Ins Elig Ck: 3/15/17

In With: Mom - in waiting

Patient's Name: Jeffrey Bodin DOB: 5/22/97 Phone: 264-1080 pt

Medications:	Allergies:	HPI:
Adderall 15mg	NKDA	Mom 264-5277

Chief Complaint: rech on meds. Adderall 15mg

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

SHx, FHx, PMHx, Work

n Help

LABS Today:

☐ Except as documented above all systems are negative.

PE:	BP:	Ht:	Wt:	HC:	P:	RR:	BMI:	Temp:
	120/60		102.4					

- ☑ NORMAL
- ☐ Constitutional
- ☐ HEENT
- ☐ CV
- ☐ Respiratory
- ☐ Chest
- ☐ GI
- ☐ GU
- ☐ Lymphatic
- ☐ MS
- ☐ Skin
- ☐ Neuro
- ☐ Psych

t 2mg s/l

rtc 1 wk

In: Out: Signature:

Plan/Treatment:

Date: 3/15/17 Acct# 22110 Ins Elig Ck:

In With: mom in waiting Rm

Patient's Name: Jeffrey Bodin DOB: 5/22/97 Phone: 264-1080 pt

Medications:	Allergies:	HPI:
Adderall	NKDA	Mom 264-5277

Chief Complaint: ck on meds
taking Adderall 5mg
ii qd

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

better

SHx, FHx, PMHx, Work

LABS Today:

☐ Except as documented above all systems are negative.

PE:	BP:	Ht:	Wt:	HC:	P:	RR:	BMI:	Temp:
			103.4 lb ⊘ shoes					

☑ NORMAL

☐ Constitutional
☐ HEENT
☐ CV
☐ Respiratory
☐ Chest
☐ GI
☐ GU
☐ Lymphatic
☐ MS
☐ Skin
☐ Neuro
☐ Psych

↑ 15 mg qd

RTC 1 wk

In: Out: Signature: [signature]

Plan/Treatment:

Date: 3/8/17 Acct# 22110 Ins Elig Ck: _____

In With: Mom (in waiting room)

Patient's Name: Jeffrey Bodin DOB: 5/22/97 Phone: 264-1080 pt

Medications:	Allergies:	HPI: Mom 264-5277
Q	NKDA	

Chief Complaint: follow up stopped taking Modafinil last wk

Constitutional (fever) (wt loss) gained 2 lbs

HEENT

CV

Respiratory

GI

GU

MS

Skin/Breast

Neuro (HA)

Psych

Endo/Heme/Lymph

Allergic/Immunologic

SHx, FHx, PMHx, Work

LABS Today:

☐ Except as documented above all systems are negative.

PE:	BP:	Ht:	Wt:	HC:	P:	RR:	BMI:	Temp:
	92/64		102lb 8 shoes					

☑ NORMAL

☐ Constitutional
☐ HEENT
☐ CV
☐ Respiratory
☐ Chest
☐ GI
☐ GU
☐ Lymphatic
☐ MS
☐ Skin
☐ Neuro
☐ Psych

Start Adderall 5 mg x 2-3 d + 10 mg qd use 1 wk

In: Out: Signature:

Plan/Treatment:

Jeffrey Bodin 5/22/97 #22110

11/11/16 (2) followup ℞ in alone (Mom in waiting Rm)

Wt 100.4lb
Ø shoes

lost 7lbs - states has GI bug 2wks ago ℞

Meds.
Modafinil
(DrB)

NKDA

pt 264-1080

12/30/16 followup ℞ in alone (Mom in waiting Rm)

wt. 100.4lb
Ø shoes

off Modafinil x 5 d (Nausea)
Also ↓ neg d/c

Meds:
allergy meds
Modafinil

Will discuss c̄ Dr B.

NKDA

[illegible]

pt 2641080
Mom 264-5277

Jeffrey Bodin #22110 5/22/97

9/9/16 (2) follow up - in alone (Mom in waiting Rm)

wt 107.4 lb
Ø shoes

meds. Now on
Ø Xyrem 2.25 H.S.
then " 1 3 hr later

NKDA

Jeffery 985 264 1080

Rec. Daily physical and mental stimulation
pos attitude

Will stay w Xyrem ō
Dx unaltered.
rtc 2 wks

10/5/16 Recheck on meds in alone (mom in waiting room)

wt 107.4

NKDA

meds: Allegra

Jeffery 264-1080
pts cell

Fluzone® Quadrivalent NDC 49281-416-88
(L)UI690AB
(E)30JUN17

IM

(L) Delt

Jeffrey Bodin #22110 7/22/97

EXHIBIT NO. 9F
PAGE: 15 OF 23

6/22/16 Appears to be doing well
Jeffrey doesn't think so.
Will cont. planned weaning of
Adderall XR.
See calendar.
Rx 1 [illegible]

[illegible]

in alone
6/29/16 reck + refill on
Adderall XR
Wt 102lb ∅ shoes
B/P 102/58
See schedule

meds
Adderall XR

NKDA

264 1080
pt cell

7/13/16 ⑤ [illegible] Recheck
[illegible] in med in [illegible] self
wt 103.6
Adderall XR 15mg
bid x4d - pt only
had done only 1 day
NKDA
of meds given out.
Last dose was Sun 7/10
meds:
per pt — [illegible]
Adderall XR
Last 4 d Adderall
XR 5 mg bid x 4 d
#264-1080
Sleep study 8/2/16
Pt's cell
[illegible]

Bodin, Jeffrey 5/22/97 [illegible]

5/18/16 Recheck inc Mom

wt 103.6

Here to discuss problems c̄ Meds

NKDA

Plan:

Meds: Adderall 20mg ii po d #60
Adderall 20mg XR ii cap BID #120

264-1080

Pt's cell

Wean Adderall totally by mid July
Sleep study Aug.
Planning MD Anderson

6/15/16 rech on meds.

wt 103lb
Ø shoes
B/P 118/72

Meds:
Adderall XR 20mg ii po BID
Adderall 20mg ii po q PM

NKDA

pt 264-1080

⟨CBC 2/16⟩

sleep study - Jan/feb
bulb; fol
of 1-2 m.

Plan: d/c plan Adderall starting 6/19:
↓ XR by 5 mg q 4d
[illegible]

[illegible signature]

Jeffrey Bodin # 22110 5/22/97

4/18/16 Refilled Adderall XR 20mg #120
Take ii PO BID qu WCT - ø
Refilled Adderall 20mg #60
Take ii PO daily qu WCT @

Mom
264-5277

Lysenko - sleep study

Dr Conn - Pain
Botox

Sleep Study 4/11/16 cancelled

No show 3/16 Dr Afridi

12/21/15 last note Lysenko

XR 40 bid
IR 40 H.S

Imp: Anxiety

Dr Lysenko XR 40 bid

never should Adderall

Update Jeffrey Bodin # 32110 5/22/17

① DR Conn reviewed. — decreased Fioricet from 4 tabs to 3 tabs daily in a 24hr period. - F# 892-6857

② Eating habits - have become worse - ☹

③ not going to school daily - if goes only goes for 3 hrs. & always in class ☹

④ Taking Adderall - whenever throughout the day - ~~clear~~

3/11/16 ① here to discuss meds & other issues in clinic alone

Wt 103.8lb ② needs refill on
BP 118/78 Adderall XR 20mg #120
Take ii po BID on Pt

Meds
Fioricet
Adderall XR 20mg
Adderall 20 mg

Adderall 20mg #60
ii PO daily -

Fioricet 1 q 6 hrs prn tid #90
(see note above)

NKDA

Pt cell
785 2641080

③ had seizure on 2/26/16 - while on field trip to TX - Grand Mal - seen in ER - scans clear on Pt ☹

Fioricet 2 tabs plus 2 Adderall XR q AM

to see Dr Conn this monday 3/14 at 2:00

Jeffery Bodin #22110 5/22/97

#90

2/12/16 currently on Adderall XR 20mg
ī tid ——

Osborn
wt 103.8lb Adderall 20mg #60
B/P 102/64 ī - īī po daily ——

meds. needs refill on meds,
Adderall XR but also wants to
Adderall start weaning off meds
Dymista having sleep study in summer
Fioricet @ Stanford -

NKDA it took several months
before meds - really started
264-5277. helping ~~for~~ pt @

Dr Lysenko * pt does not take meds
orders ADD @ same time takes
meds for when ever throughout
Narco. the day *

40XR bid gets 4 hr max on
good day

9852641080
Jeffery cell

Rx Adderall 20 #60
" 20 XR 120

OK to speak ē any
of my physician's
that are treating
me
x Jeffery Bodin

[illegible], [illegible] 5/22/97 # [illegible]

2/1/[illegible] (S) [illegible]

wt 102.4 C/O Mom [illegible]
⊖ Shots CBC

[illegible]

CBC · Diarrhea xs 7 days / [illegible] xs 7 days
· Cramping in Stomach ; [illegible]
· Soft Stools [illegible] same [illegible] 2 wks ago

NKDA ⊖ [illegible]

Meds: O: Alert & Cooperative [illegible] /
Allegra Request [illegible] in room due
Singulair To migraine HA
Adderall EENT: sclera white, conj. pink ø d/c,
[illegible] B TMs clear, [illegible] d/c, pharynx pink, [illegible], mod.
Dymista [illegible] → clearly PND
Resp: Lungs CTA
CV: RRR ø murmur
264-5277 Abd: soft, nontender, ø HSM ⊕ BS x 4

A: Diarrhea

CBC nl

P: Stool for C+S, C diff, Giardia
O+P when available
RTC prn

[signature]
APRN

Department of Children & Family Services
Building a Stronger Louisiana

Disability Determinations Services
Economic Stability
Division of Programs
2150 WESTBANK EXPRESSWAY SUITE 131
HARVEY, LA 70058

(O) 800.256.2299
(F) 1-866-444-2216
www.dcfs.la.gov

John Bel Edwards, Governor
Marketa Garner Walters, Secretary

August 7, 2017

CHILDRENS MEDICAL CENTER
MEDICAL RECORDS/CIOX
71107 HIGHWAY 21
COVINGTON, LA 70433

Claimant: JEFFREY BODIN
CASE #: 1150892
DOB: 05/22/1997 XREF #:

Request for Evidence - Fax Coversheet/Invoice

We are the office that makes disability determinations for Social Security. JEFFREY BODIN is applying for or is receiving disability benefits due to the following conditions: narcolepsy, migraines, peripheral neuropathy, allergies.

We ask that you provide complete medical history on all conditions, not limited to those listed above, covering the period of **07/01/2015 to PRESENT**, to help us evaluate this claim.

SPECIAL INSTRUCTIONS:

RQID:LLA000B5WU000 SITE:S77 DR:S
SSN:********** DOCTYPE:0001 RF:D CS:7526

***** Please return this fax/coversheet/invoice with your response.*****

We are authorized to pay $ 20.00 for information received within 30 days of this request. We will no longer research and reissue payment on invoices that are over 180 days from the date of request for records.

This information can be faxed toll free to our fax gateway at 1-866-444-2216 and will help us provide a quicker decision. Should you have any questions please contact A. BARTHELEMY at 504-361-6236 or 1-800-256-2299.

Please do not forward this letter if patient was seen by another doctor's office, clinic or hospital. Write new source name here: _____.

PLEASE INDICATE IF:

__Requested Evidence Attached
__No Evidence for Date Requested
__Chart not available through date
__No Patient Found
__Check here if you do not wish to be paid

QDD=N CAL=N **DMA Case: Y** Continued on next page
noakb/20MER/0033978 Auth#:20170807330011 Invoice No. MH5987

8/10/2017
CIOX/ROI

Explanation for Request

This claim for disability benefits under the Social Security Act has been referred to this agency. We are requesting copies of your medical records or a narrative report to help in making a decision.

The information we are requesting will aid us in establishing the nature, severity, and duration of the alleged impairment(s). We need detailed information including medical history, clinical and laboratory findings, information on prescribed treatment and response to treatment, diagnosis, and prognosis.

We would also like to have a statement, based on your medical findings, of this individual`s ability to perform work-related physical activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling. When there is a mental impairment, please include your opinion regarding understanding and memory, sustained concentration and persistence, social interaction, and adaptation.

If the individual is a child, we ask for a statement of the child`s functional limitations such as any limitations in learning, motor functioning, performing self-care activities, communicating, socializing, and completing tasks. If the child is under age one, please report on responsiveness to stimuli.

An authorization to release the medical records and/or information is also enclosed. The Privacy Act of 1974 permits review of these records by the claimant and/or his representative.

Submitting Your Response Electronically Free Options

Help expedite this individual`s decision by submitting his/her records to us electronically - free.

Records can be faxed to our toll-free secure servers. When faxing, page one of this request must be used as the fax coversheet.

If you have electronic records, you may be interested in uploading records to SSA`s secure website. For information, contact our DDS Medical Relations Staff 504-361-6335 OR 1-800-256-2299.

Submitting Via US Post Office

If returning via US Postal Service, records must be forwarded to the address on the attached sheet.

Receiving Medical Request VIA SSA Secure Website or Fax

We are now able to submit our requests to you via SSA's Secure Website or Fax. If you are interested in receiving additional information please either

1) Complete the following before returning this letter:

Your Contact Name _____ & Phone Number _____ or

2) Call our Medical Relations staff at 504-361-6335 OR 1-800-256-2299.

Important Information

Would you be willing to perform consultative examinations on your own patients and/or other claimants applying for Social Security Disability benefits? If so, or if you would like additional information, please contact our Medical Relations Staff at AADDR

040200025O

Form Approved
OMB No. 0960-0623

BODIN, JEFFREY T
436958926 05/22/1997

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*
Jeffrey T Bodin

SSN **436-95-8926** | Birthday *(mm/dd/yy)* **05/22/97**

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW **

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s)** ***including*****, and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM
- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

CHILDRENS MEDICAL CENTER
COVINGTON, LA 70433

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶ *Electronically Signed By:* **Jeffrey T Bodin**

IF not signed by subject of disclosure, specify basis for authority to sig
☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
07/30/17	528 Beau Chene Dr		
Phone Number (with area code)	City	State	ZIP
985-264-1080	Mandeville	LA	70471

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶

Phone Number (or Address)

IF needed, second witness sign here (e.g., if signed with "X" above)
SIGN ▶

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

040300025O

EXHIBIT NO. 10F
PAGE: 1 OF 221

EDCS ROUTING FORM

FLAGS: Prototype Case

CLIENT SSN: **436-95-8926** CLIENT: **Jeffrey T Bodin**

N/H SSN(S): **436-95-8926 DI** EDCS CLAIM NUMBER(S): **253060770**

EDCS FOLDER NUMBER: **214713286** EDCS CASE NUMBER: **232127568**

KEYED EDCS FORMS: **SSA-3441 SSA-3367**

CASE LEVEL: **Hearing**

ROUTING: DATE: **10/26/2017**

FROM: **ST TAMMANY LA FO/1 D18**
SOCIAL SECURITY
64285 HIGHWAY 434
LACOMBE, LA 70445-5416

TO: **NEW ORLEANS OHAFO Y32**
SSA ODAR HEARING OFC
SUITE 1600
1515 POYDRAS ST
NEW ORLEANS, LA 70112

REMARKS: **MEDICALS TO BE SCANNED OVER 15 PAGES**

DOCUMENTS IN ELECTRONIC FOLDER:

Authorization for Source to Release Information to SSA (827)
Disability Report - Appeals (3441)
Disability Report - Field Office (3367)
DDS Disability Worksheet (WRKSHT)
Personal Decision Notice (PDN)
Disability Determination Explanation (DDE)
Disability Determination Transmittal (831)
Copy of Case Development Claimant Correspondence (CASDVLTR)
Copy of Case Development Claimant Correspondence (CASDVLTR)
Copy of Case Development Claimant Correspondence (CASDVLTR)
Medical Evidence of Record (MER)
Copy of Case Development Claimant Correspondence (CASDVLTR)
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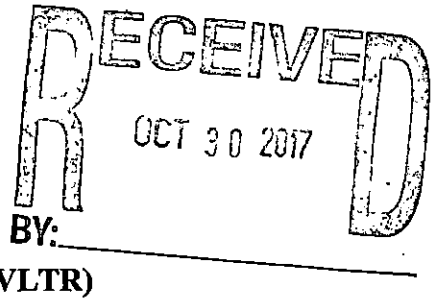

Medical Evidence of Record (MER)
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HIT MER (HITMER)
HIT Request (HITRQST)
Copy of Case Development Claimant Correspondence (CASDVLTR)
Copy of Evidence Request (CPYEVREQ)
Copy of Evidence Request (CPYEVREQ)
Copy of Evidence Request (CPYEVREQ)
Authorization for Source to Release Information to SSA (827)
Disability Report - Field Office (3367)
Disability Report - Adult (3368)

Social Security Administration

JEFFREY T BODIN
528 BEAU CHENE DR
MANDEVILLE LA 70471-1777

Date: September 18, 2017
Claim Number: XXX-XX-8926A

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

Date of Birth Information

The date of birth shown on our records is May 22, 1997.

Suspect Social Security Fraud?

Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

If You Have Questions

We invite you to visit our web site at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local office at 866-887-8997. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
64285 HIGHWAY 434
LACOMBE, LA 70445

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Social Security Administration

Proof of Identity

- Driver's License
- School ID
- Health Insurance Card/BlueCross BlueShield ID
- Voter's Registration Card
- Check Stub
- Birth Certificate

Jeffrey Thomas Bodin
436-95-8926
528 Bean Chant Dr
Mandeville, LA 70471
(985) 520-4713

Social Security Administration

JEFFREY T BODIN
528 BEAU CHENE DR
MANDEVILLE LA 70471-1777

Date: September 18, 2017
Claim Number: XXX-XX-8926A

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

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Social Security Administration

M. D. Anderson Cancer Center

Jeffreys # 744 652

Dr. Merrick Ross (713) 792-6800
mross@mdanderson.org (713) 563-9724

Lane Read, P.A. fax: (713) 745-3811 for Dr. Ross *
(713) 745-6858, fax (713) 792-0722 page operator
(713) 792-7090

Brian Rivers, P.A.
(713) 794-5618

Tamme Ford, RN

Agerico Palaypay
Scheduler
(713) 792-6800

Dr. C. Herzog (713) 745-0157
Child/Adolescent Center fax #(713) 745-5400 *

Dr Moore - psych. evaluation (713) 792-2454
Bernadette Taylor, test prater, etc
(page last when finished w/ Ross & Herzog)

(eye apt. every 3 months)

at&t

[Print] [Close]

From: "Ernest S Chiu" <eschiu@gmail.com>
To: "mljscomp@bellsouth.net" <mljscomp@bellsouth.net>, r106casey@mac.com
Cc: mross@mdanderson.org, cscott@mdanderson.org
Subject: *** NEW PATIENT - JEFFREY BODIN ***
Date: Tue, 18 Mar 2008 14:01:05 +0000

Merrick:

Ms Laura Bodin, Jeffrey's mother, is very interested in consultation/surgery next week if possible. Her cell phone number is 985-264-5277 or 985-845-0969.

We faxed the path report to 713-792-4689 yesterday.

If I can help in any way, let me know. Best wishes to all.

Ernie

--
Ernest S. Chiu, MD
Associate Professor of Surgery
Director of Plastic Surgical Research
Division of Plastic & Reconstructive Surgery
Tulane University Health Sciences Center
1430 Tulane Avenue, SL22
New Orleans, LA 70112
504-988-5500, Office
504-988-3740, Fascimile

Rick Casey
fax # (866) 228-8723

LSU Health Sciences Center NEW ORLEANS

1/15/2015

CHILDREN'S HOSPITAL

SUMMARY OF CANCER TREATMENT

Demographics		
Name: Jeffrey Bodin	Sex: Male	Date of Birth: 05/22/1997
PCP:		
Cancer Diagnosis		
Diagnosis: Melanoma of left ankle	Sites Involved/stage: Stage IIIA/T2aN2a	
Date of Diagnosis: 03/2008	Age at Diagnosis: 10yrs. 9 months	Date Therapy Completed: 10/02/2008
Relapse(s):		
Treatment Center : MD Anderson Cancer Center; LSUHSC, Children's Hospital New Orleans, 200 Henry Clay Avenue, New Orleans, LA 70118 Primary Oncologist: Dr. Cynthia Herzog (MD Anderson Cancer Center) Dr. Jaime Morales (Children's Hospital of New Orleans) Surgeon: MD Anderson Cancer Center Radiation Oncologist: n/a Transplant Physician: n/a Long Term Follow-Up: Dr. Pinki Prasad (504) 896-9740		Medical Record #: MD Anderson 074-46-52 CHNOLA: 0445573
Family History Cancer:	Other Family History:	

CANCER TREATMENT SUMMARY

Protocol/Treatment:	On Study: NO

Chemotherapy

Drug Name	Route	Selected Cumulative Dose (units or mg/m^2) when Applicable
Interferon alpha 2B	IV	400 million units/m2
Interferon alpha 2B	SQ	155 million units/m2

Surgery :

Surgery	Date	Surgeon
Primary excision of melanoma on left ankle with sentinel node mapping	03/15/2008	MD Anderson Cancer Center
Appendectomy	05/13/2008	MD Anderson Cancer Center
PICC Line Insertion	06/09/2008	Children's Hospital of New Orleans

Radiation: n/a

Transplant: n/a

Treatment Complications/Late Effects

Problem	Status
Neurologic: Seizures while on interferon	
Neurologic: Peripheral neuropathy	

LSU Health Sciences Center
NEW ORLEANS

CHILDREN'S HOSPITAL

Potential Late Effects		
Potential Late Effect	**Exposure**	**Screening Recommendations**
Any Cancer History		Annual Physical Exam with PCP Annual Cancer Screening by age Regular exercise Avoid cigarette smoking, excess alcohol consumption or illicit drugs Eat a well balanced, low fat diet
Any Cancer History	Biologics Interferon Alpha 2B	Insufficient information currently available regarding late effects of biological agents
Dental Problems	Any chemotherapy exposure	Regular Dental Exams
General Recommendations:		
Immunizations	Any cancer experience	Recommend annual Flu shot Recommend (HPV vaccination or Gardasil) series
Summary prepared by: Pinki Prasad, MD, MPH		**Date prepared:** 01/15/2015

Interferon Alfa
Intron A® (Interferon-alfa 2b)

Interferon alfa is a synthetic (man-made) protein. It is very similar to natural interferons, substances produced by cells in the body that help the immune system fight infections and certain cancer growths. Interferon alfa is used to treat AIDS-related Kaposi's sarcoma and certain types of hepatitis, leukemia, or other cancers. It is given intravenously (into a vein), subcutaneously (under the skin), or into the muscle several times weekly.

Special Instructions

Before you take this drug, tell your doctor if:

- You are pregnant or think you are pregnant, or if you are breastfeeding
- You have ever had any unusual reaction to interferon alfa or any other form of protein, or if you have an allergy to benzyl alcohol
- You have any sort of infection (especially chicken pox, herpes, or hepatitis), or any form of heart, liver, lung or kidney disease
- You have any type of immune system disorder, mental problems or history of seizures
- You have any type of blood or bleeding disorder, diabetes, or thyroid disease

Tell your doctor about any medications you are taking, including non-prescription medicines, nutritional supplements, vitamins, minerals, or herbal products.

Do not drink any alcohol beverages (beer, wine, liquor) or take any new medicines (such as antihistamines, pain relievers, sleeping medicine) while you are taking this medication, unless your doctor says it is okay.

Different brands of interferon can act differently in your body. Check with your pharmacist if your refills do not look like your original product.

Your nurse will teach you how to give yourself injections. Make sure to rotate the site of your alfa interferon injections. For further instructions on how to give yourself injections, ask your nurse for a copy of "Administration of a Subcutaneous Injection" and "Disposal Tips for Home Health Care."

Make sure your medication is clear and colorless. If your medicine becomes cloudy or changes color, do not use it. Do not shake the medicine container.

Store your medicine in a refrigerator until used. Protect it from light. Throw away any medication that has an expiration date that has passed. If you are given a powder form of

interferon alfa, you will be given bacteriostatic water to add to the powder for injection. After the water is added to the powder, the medicine must be used within one month.

Side Effects

- Fever
  - There is a possibility that you may develop a fever (100.4°F/38°C or higher) within 24 hours of receiving your injection, this is normal. *However, if you develop a fever 24 hours after the injection, please contact your nurse, immediately, because your fever will need to be investigated. A fever, after 24 hours of the injection, should not be considered related to the injection, but as a new concern.*
- Flu-like symptoms
  - Flu-like symptoms may begin around 4 hours after the injection. Symptoms include muscle, joint, or bone pain, headaches, fatigue, flushing of the skin (redness), and/or chills. Symptoms may decrease with time.
  - You may take acetaminophen (Tylenol®) to reduce your temperature. Should fever or chills continue, call your doctor **immediately**. Do not take any aspirin or other pain relievers such as ibuprofen (Advil® or Motrin®), Naproxen (Naprosyn® or Aleve®) unless your doctor says it is okay.
  - Giving our injection before bedtime may help decrease your experience of flu-like symptoms.
- Fatigue, lethargy, or sluggishness
  - You may feel sluggish or tire more easily while taking this medication. Tell your doctor or nurse if fatigue interferes with your daily activities.
- Nausea, vomiting, and/or appetite loss
  - Ask your doctor about medicines to relieve nausea.
  - Tell your doctor or nurse **immediately** if you experience severe nausea or vomiting and cannot keep food or water in your stomach.
  - Drink 8 to 12 eight-ounce glasses (2 to 3 liters) of non-alcoholic, non-caffeinated fluids each day to avoid becoming dehydrated.
  - Eat when you are hungry. Try eating several small meals or snacks throughout the day. Small meals are easier to handle than large meals and will help you get the nutrients your body needs.
  - For more information, please ask for a copy of "Keeping Nausea Under Control." For additional help in coping with nausea and/or appetite and weight loss, ask your doctor to make an appointment with a dietitian for you.
- Swelling at the site of injection
  - If swelling occurs, alternate the site you inject. Between treatments, put warm, moist towels on the swollen area several times a day.
- Taste changes
  - Some foods may taste different while you are taking this medicine. This is not permanent.

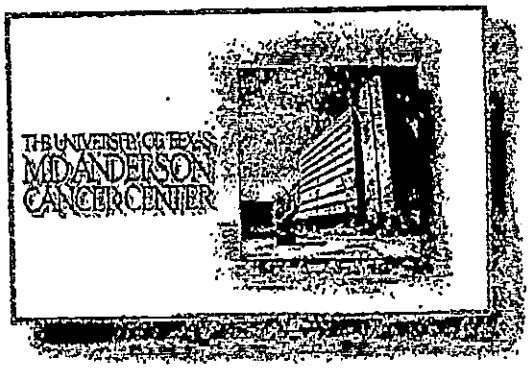
- Hair thinning
  - The hair on your head or on your entire body may thin.
- Diarrhea
  - You may take a non-prescription medication (e.g., Imodium® or Kaopectate®) to control diarrhea **only** if you do not have a fever.
  - Tell your doctor if you have diarrhea during or after your treatment.
  - Drink 8 to 12 eight-ounce glasses (2 to 3 liters) of non-alcoholic, non-caffeinated fluids each day to avoid becoming dehydrated.
  - If you experience severe diarrhea while taking this medicine at home (more than 4 loose bowel movements in one day or diarrhea at night), call your doctor or nurse. If it is after regular clinical hours, go to the emergency room.
- Low white blood cell count
  - Your chance of getting an infection may increase. Avoid contact with persons who have colds, flu, shingles, chicken pox, or any type of infection. Bathe daily and practice good mouth care. For more information, please ask for a copy of "Mouth Care for Chemotherapy Patients."
  - Go to the emergency room **immediately** if you have fever of 101°F (38.3°C) or higher, chills, sore throat and/or cough, lower back or side pain, or painful or difficult urination.
- Low platelet count
  - You may bruise and bleed more easily. Avoid cutting or injuring yourself. If you shave, always use an electric shaver. Do not take any aspirin or other pain relievers such as ibuprofen (Advil® or Motrin®) or Naproxen (Naprosyn® or Aleve®) unless your doctor says it is okay.
  - Tell your doctor or nurse **immediately** if you notice tiny red spots under your skin, bruising, or unusual bleeding (e.g., blood in urine or stools, black tarry stools). Go to the nearest emergency room if you cough up blood or if you have bleeding that will not stop.
- Low red blood cell count
  - You may tire easily or become short of breath. Take naps and rest often. Go to the nearest emergency room **immediately** if you have chest pain, sudden shortness of breath, or increased shortness of breath.
- Skin rash, itching
  - Tell your doctor or nurse about any rash, blisters, itching, redness, drying, or peeling of your skin. Ask your doctor about medicines to relieve itching. Over-the-counter antihistamines such as diphenhydramine (e.g., Benadryl®) may help to relieve the itching. A bath with mild soap, such as Dove®, Tone®, Basis®, Lubriderm Body Bar®, Lowila®, Oilatum®, or Emulave®, may be soothing.
- Neurological effects
  - If you take high doses of this medicine you may have neurological effects.
  - Tell your doctor or nurse if you have mood changes, depression, confusion, hallucinations, nervousness, difficulty sleeping, dizziness, drowsiness, clumsiness, difficulty walking, or restlessness.

- Tell your doctor or nurse if you are more sleepy or drowsy than usual. Do not drive or operate heavy machinery until you know how this medicine affects you. Do not drink alcoholic beverages (beer, wine, liquor) while you are taking this medicine.

Notify your doctor as soon as possible if you:

- Have trouble breathing or have chest pain
- Have numbness or tingling of the fingers, toes, or face
- Become very depressed or think about suicide
- Have yellowing of the eyes or skin
- Have changes in your vision
- Have a fast or irregular heartbeat
- Have severe stomach or low back pain
- Have bleeding with a bowel movement
- Start having seizures

These are the most common side effects; other side effects may occur and should be reported to your doctor. Do not change your dose or schedule unless you are told to do so by your doctor. Please report any problems to your doctor, nurse, or pharmacist.



- Date Tuesday, April 08, 2008
- To Mark Bodin
- Company
- Fax Number 504) 596-2861
- Total Number of Pages (4)

Four

Lane Read, MPAS, PA-C

Department of Surgical Oncology
1400 Holcombe Blvd, Box 301402, Unit 444
Houston, Texas 77230-1402

Telephone: 713-745-6858
Fax: 713-792-0722

NOTES:

Attached is pathology on Patient Jeffrey Bodin.

Please contact me if further information is needed.

Sincerely,

Lane Read, PA-C

Lane Read, PA-C for Merrick I Ross, MD

FAX TRANSMISSION

UT M.D. Anderson Cancer Center
Tamtron Print by 10964 at 4/8/2008 11:42:51 AM

744652 - BODIN, JEFFREY T 10yo M 05/22/1997 (135.0cm 28.9kg BSA: 1.04m² 03/26/08)

Accession:-S-08-017604
Specimen Date/Time: 03/26/2008

******* MODIFIED REPORT - REVIEW ADDENDUM SECTION *******

DIAGNOSIS

(A) LEFT INGUINAL SENTINEL LYMPH NODE #1, BLUE COUNT 1300:
METASTATIC MELANOMA TO ONE OF ONE LYMPH NODE (1/1)
2.7 X 1.6 MM (SUBCAPSULAR)
EXTRACAPSULAR EXTENSION NOT IDENTIFIED.

(B) LEFT INGUINAL SENTINEL LYMPH NODE #2, BLUE COUNT 2800:
One lymph node, see addendum report.

(C) LEFT INGUINAL SENTINEL LYMPH NODE #3, COUNT 5600, BLUE:
One lymph node, see addendum report.

(D) LEFT INGUINAL SENTINEL LYMPH NODE #4, LIGHT BLUE, COUNT 980:
One lymph node, see addendum report.

(E) WIDE EXCISION, LEFT ANKLE:
SKIN AND SUBCUTANEOUS TISSUE WITH SCAR, AND FOCAL INVASIVE MELANOMA.
CLARK LEVEL IV.
BRESLOW THICKNESS 1.40 MM
Margins of resection are free of melanoma.

(F) ADDITIONAL PROXIMAL TISSUE, LEFT ANKLE:
Skin and subcutaneous tissue, no melanoma is identified.

(G) ADDITIONAL DISTAL TISSUE, LEFT ANKLE:
Skin and subcutaneous tissue, no melanoma is identified.

(H) BIOPSY, LESION LEFT KNEE:
Verruca vulgaris.

(I) PUNCH BIOPSY, RIGHT FACE:
Scar. See addendum report after examination of step sections.

(J) LEFT POPLITEAL FOSSA SENTINEL LYMPH NODE #1, NOT BLUE, COUNT 1028:
One lymph node, see addendum report.

(K) LEFT POPLITEAL SENTINEL LYMPH NODE #2, NOT BLUE, COUNT 2200:
One lymph node, see addendum report.

VGP:ZZ/elk
DD: 3/28/08
3/28/2008 7:37 AM

GROSS DESCRIPTION

(A) LEFT INGUINAL SENTINEL LYMPH NODE #1, BLUE COUNT 1300 - A single possible lymph node measuring 1.8 cm in its greatest dimension. Sectioned and entirely submitted in cassette A. AM1/elk
(B) LEFT INGUINAL SENTINEL LYMPH NODE #2, BLUE COUNT 2800 - A single possible lymph node measuring 0.5 cm in its greatest dimension. Entirely submitted in cassette B. AM1/elk

744652 - BODIN, JEFFREY T 10yo M 05/22/1997 (135.0cm 28.9kg BSA: 1.04m² 03/26/08)
Accession: S-08-017604
Specimen Date/Time: 03/26/2008

(C) LEFT INGUINAL SENTINEL LYMPH NODE #3, COUNT 5600, BLUE - A single possible lymph node measuring 0.6 cm in its greatest dimension. Entirely submitted in cassette C. AM1/elk
(D) LEFT INGUINAL SENTINEL LYMPH NODE #4, LIGHT BLUE, COUNT 980 - A single possible lymph node measuring 0.5 cm in its greatest dimension. Entirely submitted in cassette D. AM1/elk
(E) WIDE EXCISION OF MELANOMA, LEFT ANKLE, SHORT PROXIMAL, LONG POSTERIOR - An ellipse of tan skin measuring 2.5 x 2.5 x 0.3 cm. Surgical margin is inked. The skin surface contains slightly elevated well demarcated, centrally ulcerated tan lesion measuring 0.6 x 0.4 cm and it is 1.1 cm away from the proximal surgical margin, 1.0 cm from the distal surgical margin, 1.0 cm from the posterior surgical margin and 1.1 cm from the anterior surgical margin. Entirely submitted.
INK CODE: Proximal - blue; distal - yellow. Entire specimen is submitted in sequential order from posterior toward the anterior aspect.
SECTION CODE: E1, posterior tip; E2, anterior tip; E3, E4, the rest of the skin. AM1/elk
(F) ADDITIONAL PROXIMAL TISSUE, LEFT ANKLE - A triangular shaped fragment of tan, grossly unremarkable skin measuring 1.2 x 1.0 cm. Representative sections submitted in cassette F. AM1/elk
(G) ADDITIONAL DISTAL TISSUE, LEFT ANKLE - A triangular shaped fragment of grossly unremarkable skin measuring 1.0 x 0.8 cm. Surgical margin is inked. Bisected and entirely submitted in cassette G. AM1/elk
(H) BIOPSY, LESION LEFT KNEE - A fragment of a tan, shaved unoriented skin measuring 0.6 x 0.4 cm. The skin surface contains a fairly well demarcated light gray elevated lesion measuring 0.3 x 0.3 cm grossly approach the surgical margin. The surgical margin is inked blue. Bisected and entirely submitted in cassette H. AM1/elk
(I) PUNCH BIOPSY, RIGHT FACE - A shallow skin punch biopsy measuring 0.4 x 0.4 cm. Surgical margin is inked blue. Entirely submitted in cassette I. AM1/elk
(J) LEFT POPLITEAL FOSSA SENTINEL LYMPH NODE #1, NOT BLUE, COUNT 1028 - A single possible lymph node measuring 0.8 cm in its greatest dimension. Entirely submitted in cassette J. AM1/elk
(K) LEFT POPLITEAL SENTINEL LYMPH NODE #2, NOT BLUE, COUNT 2200 - A single possible lymph node measuring 0.7 cm in its greatest dimension. Bisected and entirely submitted in cassette K. AM1/elk

CLINICAL HISTORY:

Melanoma.

SNOMED CODES

T-02840, T-02120, T-C4800, T-C4810, M-87203, M-80703, M-78060, M-72750
"Some tests reported here may have been developed and performance characteristics determined by UT MD Anderson Pathology and Laboratory Medicine. These tests have not been specifically cleared or approved by the U.S. Food and Drug Administration."
Entire report and diagnosis completed by: Victor Prieto MD Mar 28, 2008

744652 - BODIN, JEFFREY T 10yo M 05/22/1997 (135.0cm 28.9kg BSA: 1.04m² 03/26/08)
Accession: S-08-017604
Specimen Date/Time: 03/26/2008

ADDENDUM

This modified report is being issued to provide additional information/results for specimens A, B, C, D. J and K.

Addendum completed by Diwan, A. Hafeez MD.
Apr 01, 2008 at 11:22 AM

DIAGNOSIS

(A) Examination of additional tissue levels and an immunohistochemical study on paraffin sections with an anti-melanocytic cocktail (HMB-45, anti-MART 1 and anti-tyrosinase) confirms METASTATIC MELANOMA as previously indicated (1/1). In addition to the information already given, please note that there is an intraparenchymal component as well.

(B) Examination of additional tissue levels and an immunohistochemical study on paraffin sections with an anti-melanocytic cocktail (HMB-45, anti-MART 1 and anti-tyrosinase) fails to reveal metastatic melanoma.

(C) Examination of additional tissue levels and an immunohistochemical study on paraffin sections with an anti-melanocytic cocktail (HMB-45, anti-MART 1 and anti-tyrosinase) is positive for METASTATIC MELANOMA (1/1).

(D, J, K) Examination of additional tissue levels and an immunohistochemical study on paraffin sections with an anti-melanocytic cocktail (HMB-45, anti-MART 1 and anti-tyrosinase) fails to reveal metastatic melanoma

AHD:ZZ/elk
DD: 3/31/08
4/1/2008 11:26 AM

Entire report and diagnosis completed by: A. Hafeez Diwan MD Apr 01, 2008

-----END OF REPORT------

Division of Pathology and Laboratory Medicine
U.T.M.D. Anderson Cancer Center
1515 Holcombe Boulevard
Houston, Texas 77030

UT M.D. Anderson Cancer Center
Tamtron Print by 10964 at 5/1/2008 2:19:27 PM

744652 - BODIN, JEFFREY T 10yo M 05/22/1997 (135.0cm 28.0kg BSA: 1.02m² 04/23/08)

Accession: S-08-023559
Specimen Date/Time: 04/23/2008

DIAGNOSIS

(A) LEFT INGUINAL SUPERFICIAL LYMPH NODES:
Eight lymph nodes, no tumor present (0/8).
Skin and subcutaneous tissue with scar, granulation tissue and fat necrosis.
(B) LEFT CLOQUET LYMPH NODE:
One lymph node, no tumor present in frozen and permanent H&E sections (0/1).

DI:LP/elk
DD: 4/24/08
4/25/2008 8:37 AM

GROSS DESCRIPTION

(A) LEFT INGUINAL SUPERFICIAL LYMPH NODE - Received is a strip of white-tan skin with incision scar (6.0 x 1.1 cm) and underlying soft tissue (8.5 x 3.8 x 3.0 cm). Eight lymph nodes are identified ranging from 0.4 x 0.2 x 0.2 cm to 1.0 x 0.5 x 0.3 cm.
SECTION CODE: A1, skin and scar tissue; A2, four lymph nodes; A3, four lymph nodes. PX/amf
(B) LEFT CLOQUET NODE, RULE OUT METASTATIC MELANOMA - A tan possible lymph node (0.9 x 0.3 x 0.3 cm). Serially sectioned and entirely submitted for frozen section in FSB. DO/amf
Frozen section block is submitted for permanent sections. MJ/amf
*FS/DX: LYMPH NODE, NO TUMOR PRESENT. AR/amf

CLINICAL HISTORY

Melanoma.

SNOMED CODES

T-C4810, M-00110

"Some tests reported here may have been developed and performance characteristics determined by UT MD Anderson Pathology and Laboratory Medicine. These tests have not been specifically cleared or approved by the U.S. Food and Drug Administration."

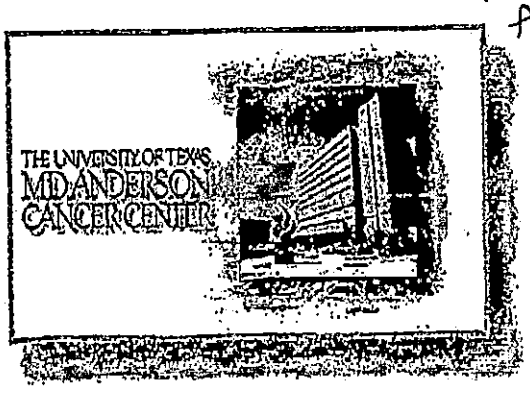
Entire report and diagnosis completed by: Doina Ivan MD Apr 25, 2008

------END OF REPORT------

Division of Pathology and Laboratory Medicine
U.T.M.D. Anderson Cancer Center
1515 Holcombe Boulevard
Houston, Texas 77030

phone 985 624 3470 fax #

646 888-2315 Jeanie



- **Date** Thursday, May 01, 2008
- **To** Mark Bodin
- **Company**
- **Fax Number** 504) 596-2861
- **Total Number of Pages** (2) Two

Re: Jeffrey Bodin

Lane Read, MPAS, PA-C

Department of Surgical Oncology
1400 Holcombe Blvd, Box 301402, Unit 444
Houston, Texas 77230-1402

Telephone: 713-745-6858
Fax: 713-792-0722

NOTES:

Mr Bodin,

attached is final Pathology on Jeffrey's last Surgery. Linda requested that I send this to you.

Lane Read, PA-C

FAX TRANSMISSION

5/8/2008

Re: BODIN, JEFFREY
Age: 10 Sex: M

1: LEFT INGUINAL SENTINAL LYMPH NODE, LEFT ANKLE, LEFT KNEE, RIGHT FACE, LEFT POPLITEAL, MD ANDERSON CANCER CENTER. S08-17604 (12 SLIDES) (jb)

Casey,Sherri
Sherri Casey, M.D.
71107 Highway 21, Sute 1
Covington, LA 70433
TEL: 985-871-9418
FAX: 985-893-2580

Dear Dr. Casey.

Dr. Alan Houghton has asked me to review the slides of Jeffrey Bodin's melanocytic tumor. Unfortunately, so far I have not received the slide of the initial biopsy. What I have been able to review is the re-excision of the melanocytic tumor from the left ankle. It shows a proliferation of plump fusiform melanocytes in nests and intersecting fascicles in the dermis in association with a scar. The lesion shows Spitzoid features, a nevoid growth pattern, but only limited "maturation". A rare mitotic figure is seen. The margins are benign. The left inguinal sentinel lymph node shows small clusters of melanocytes in the lymph node parenchyma and focally within fibrous tissue. These melanocytes are similar in appearance to the primary tumor cells, and need to be considered derivatives thereof.
Descriptively, one may summarize the findings as "atypical Spitzoid melanocytic proliferation with microscopic deposits in one sentinal lymph node". I acknowledge that on the one hand, the constellation of findings is compatible with a diagnosis of "melanoma with sentinel node micrometastasis". However, alternatively, one may also consider an "atypical Spitz nevus/tumor with lymph node involvement" (via mechanical transport) that is different in its biology from (conventional) metastatic melanoma.
I believe that Jeffrey's prognosis is likely more favorable than for a child with a "conventional" melanoma. I have seen a number of similar lesions and clinical scenarios which fortunately so far have not been associated with adverse outcome to the patient, but these are preliminary and anecdotal data.
Since I did not see the top part of the lesion, I cannot be more definitive at the current time. I would appreciate the opportunity to review the initial biopsy of the lesion, since its features may help diagnostically. In attempt to further classify the primary tumor, we have requested additional material to study the tumor for possible chromosomal aberrations. Once results from those studies are available, we will issue a final assessment of the lesion.

Sincerely,

Klaus J Busam, M.D.
Attending Pathologist

MH#: S08-18392

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street Covington, Louisiana 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Patient: BODIN, JEFFREY

Med. Rec. No.: (0000)0000-280719
Account No: 0376424008
DOB: 05/22/1997 *Age/Sex:* 10 YRS M
Physician: HEINTZ, LUDWIG C
Admit Date: 05/13/08 *Loc:* PED

Copy to: HEINTZ, LUDWIG C

Clinical Diagnosis:

Specimen Recd: 05/14/08

SURGICAL PATHOLOGY

Accession: ST-08-02269 Surgery: 05/13/08

SPECIMEN SOURCE:
Appendix

CLINICAL INFORMATION:
Appendicitis

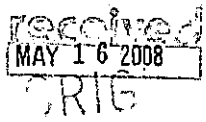
PROCEDURE: Appendectomy

GROSS DESCRIPTION:
Received in formalin is a vermiform appendix 5.5 x 1.0 cm. Attached is a small amount of epiploic fat. The serosa is covered by a thin tan dull fibrinous exudate through which prominent serosal vascular markings are seen. Gross perforation is not seen. Gross discoloration is not seen. The wall measures up to 2 - 3 mm thick. The mucosa is grossly edematous, the lumen is filled with a cheesy green material. Routine sections.

DLF:TTE

DIAGNOSIS:
Appendix coli: Acute suppurative appendicitis.

PATHOLOGIST COMMENT:
P88304



DLF:DLF:TTE By: Daniel L. Ferguson, M.D.
05/15/08 (Electronic Signature)

cc:

Printed: 05/15/08 1701 *Page:* 1 End of Chart

PREPRINTED DISCHARGE EDUCATION

☐ Congestive Heart Failure — Others: ☐
☐ Smoking Cessation — ☐
☐ Post-op — ☐

ACTIVITIES / RESTRICTIONS

☐ Gradual return to previous activities
☐ Rest/relaxation for _____ hours / days
☐ No driving motor vehicles, no operating machinery or making major decisions for 24 hours
☐ Avoid heavy lifting (_____ lbs) for _____ days
☐ Avoid climbing stairs for _____ days
☐ Avoid sexual activity for _____ days/weeks
☐ Avoid tub bath for _____ days/weeks
☐ May shower
☐ Equipment _____ ☐ Instructions given
_____ ☐ Instructions given
☐ Other:

WOUND CARE

☐ Keep incision clean and dry
☐ Keep dressing on and dry
☐ Remove dressing _____
☐ Ice pack to _____ for _____ hours/days
☐ Elevate _____ for _____ hours/days
☐ Avoid tampon/douching for _____ days/weeks
☐ IV site instructions given
☐ Other:

EMERGENCY

If you experience any serious problems and you are unable to contact your doctor; go to your nearest emergency department for help.

Call your doctor if:

* Fever of 101 or above
* Bright red bloody drainage
* Redness/tenderness at surgical site
* Coughing / vomiting blood
* Excessive nausea and vomiting
* Pain not relieved by medication
* Shortness of breath
* Difficulty urinating
* Chest Pain
* Rectal Bleeding
* Abdominal Pain
* Excessive swelling
* Any questions regarding instructions or medications
* Other:

DIET

☐ No dietary restrictions
☐ Progress to regular diet
☐ Other:
☐ Special diet ☐ Instructions given
☐ Drink plenty of fluids

Questions about your special diet? Call our Dietary Department (985) 898-4063.

FOLLOW-UP

Physician's Name:
☐ Appointment Date:
Physician's Name:
☐ Appointment Date:
☐ Referrals
☐ Community Resources
☐ Physician's phone number:
☐ Call office to schedule
☐ Physician's phone number:
☐ Call office to schedule
☐ Diagnostic studies scheduled

DISPOSITION

Discharged at _____ by Dr. _____ ☐ Home ☐ Against medical advice
☐ Home Health Agency ☐ Discharge Instructions sent to agency
Discharge per ☐ Wheelchair ☐ Stretcher ☐ Arms of adult ☐ Walking with assistance
Accompanied by _____ Transportation: ☐ Private vehicle ☐ Ambulance ☐ Transport Service
Patient / Significant other able to restate instructions ☐ Yes ☐ No If NO, why
Copy of instructions given to: _____ Patient/Significant other signature:
Nurse giving instructions: _____ Date: _____ Time:

St. Tammany PARISH HOSPITAL
Excellence In Healthcare... Close To Home

INPATIENT DISCHARGE INSTRUCTION SHEET

FORM NO. 65655-45709 (Rev. 6/04)

BODIN, JEFFREY MED
280719
M 05/22/1997 10 BC 376424008
HEINTZ, LUDWIG 05/13/08

PATIENT COPY

INPATIENT DISCHARGE INSTRUCTIONS: MEDICATIONS

PRINT ALL INFORMATION					TAKE MEDICATIONS AT THE FOLLOWING TIMES			
NEW RX	HOME MED.	MEDICATION(S)	DOSE	FREQUENCY (PER DAY)	ON AN EMPTY STOMACH	WITH MEALS	AT BEDTIME	REASON ORDERED
		[illegible]					[illegible]	
							[illegible]	
							[illegible]	
							[illegible]	
		[illegible]					[illegible]	
							[illegible]	

PATIENT COPY

St. Tammany PARISH HOSPITAL
World-class healthcare... Close to home.

Date: [illegible]

Nurse giving instructions: [illegible] RN

Patient/Significant other: [illegible]

_____ Printed/Verbal Instructions given on medications

BODIN, JEFFREY
M 05/22/1997 10 BC 376424008
HEINTZ, LUDWIG

MED
280719
05/13/08

FORM 45712 (Rev. 1/05)

FOR INFORMATION ON FILING A GRIEVANCE OR FOR ANY QUESTIONS ABOUT ANY OF THE RIGHTS LISTED BELOW, CONTACT GUEST SERVICES AT 898-4669 OR THE LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS AT (225) 342-6429.

AS A PATIENT, YOU HAVE THE RIGHT TO:

- **Access care and services** based upon need and according to the Hospital's mission and vision, admission policies and capability to provide needed services regardless of race, gender, religion, national origin, age, physical ability or financial status.
- **Receive considerate care** that respects psychosocial, spiritual, and cultural values.
- **Wear personal and religious or symbolic items** provided the items do not interfere with medical therapy or diagnostic procedures. Have a family member or representative of your choice and your physician notified of your admission.
- **Receive appropriate pain management** and information about pain relief measures. This includes having health professionals who respond quickly to reports of pain and staff who are committed to pain control.
- **Make informed decisions** about your care and any proposed procedure or treatment. This includes being informed of your health status, being involved in care planning and treatment, and being able to request or refuse treatments. This right is not a mechanism to demand medically unnecessary or inappropriate treatment or services.
- **Have an advance directive** concerning end of life care and treatment, for example a living will, or to designate a surrogate decision-maker with the expectation that Hospital staff and practitioners will honor the intent of the directive(s) to the extent permitted by law and Hospital policy.
- **Know the identity of the physician** who has primary responsibility for your care and the identity and professional status of individuals responsible for authorizing or performing procedures or treatments.
- **Be informed of outcomes of care**, including any unanticipated outcomes, and be informed if the Hospital proposes to engage in investigational, experimental, research or educational activity and have the right to refuse to participate in such activity.
- **Voice complaints or submit a written grievance** about the Hospital's care and services and receive a response to the complaint or grievance. *Submitting a complaint or grievance will not compromise your future access to care.*
- **Participate** in the consideration of the **ethical issues** that may arise in the course of your care.
  Expect personal privacy and be interviewed, examined and treated with reasonable visual and auditory privacy.
- **Receive care in a safe setting**; be free from all forms of abuse, neglect, or harassment; be free from restraints of any form that are not medically necessary; and be free from seclusion and restraints of any form imposed for behavior management unless clinically necessary.
- **Expect confidentiality of health information and clinical records;** have that information provided only to those involved in your care, to those monitoring its quality, or to those otherwise legally authorized to receive such information; and access information contained in your clinical record within a reasonable time frame.
- **Request and receive an itemized explanation of total charges** for services rendered by the Hospital regardless of the source of payment.

YOUR PATIENT RESPONSIBILITIES INCLUDE:

- Providing correct, accurate and complete information about your health.
- Following the treatment plan ordered by your physician, including working with your doctor(s) and nurse(s) to develop a pain management plan, helping measure your pain, and reporting any unrelieved pain.
- Considering the rights of other patients and Hospital personnel.
- Ensuring that the Hospital has a copy of your written advance directive (if you have one).
- Following Hospital rules and regulations that apply to patient conduct.
- Taking responsibility for your actions if you refuse treatment or do not follow instructions given by your physician.
- Making sure that the financial obligations of your health care are met as soon as possible.
- Asking questions when you do not understand what you have been told about your care.
- Contacting your nurse, physician, or other staff member if you perceive any safety risk relating to your environment or care.

If the patient is unable to exercise any of the rights set forth in this document, surrogates in the order provided by Louisiana statute may do so.

By signing this form, the patient (or his/her designated representative) acknowledges that he/she has been given a copy of patient rights and responsibilities for review.

Patient Signature: _____ **Date:** _____

Hospital Representative: _____ **Date:** _____

PATIENT RIGHTS AND RESPONSIBILITIES

St. Tammany PARISH HOSPITAL

MR 00019

BODIN, JEFFREY
376424008 05/13/08 MED
M 05/22/1997 10 C B 280719
HEINTZ, LUDWIG

sleep mask
Cat book (backpack)
-? Prozac
Change of clothes 4 Jeff
PJ's for Jeff
toothbrush for Jeff

me ← PJ top, underwear, Tylenol PM
makeup stuff

Chest XRAY

Children's Hospital

Patient Name	BODIN,JEFFREY	**Patient ID**	0445573
Birth Date	05/22/1997	**Sex**	M
Age	11 Year	**Exam Status**	APPROVED
Exam Procedure	CHEST - AP & LAT	**Modality**	CR
Study Time	09/15/2008 12:16:24	**Image Count**	2

Diagnostic Report(Radiologists : WARD, KENNETH)

A.P. LATERAL CHEST: There is no focal consolidation or atelectasis. The cardiovascular silhouette and mediastinal structures are within normal limits. The musculoskeletal structures are normal in appearance.
IMPRESSION: Normal chest.

THOMAS NICOTRI, JR., M.D., LLC
DERMATOPATHOLOGY SERVICES
P.O. Box 1713 Mandeville, LA 70470
1305 W Causeway Approach, Ste. 209 Mandeville, LA 70471
Reports/Lab: (504) 361-3757
Billing: (877) 626-0312

Name: Jeffrey Bodin
Address: 528 Beau Chene Drive
Mandeville,LA 70471

Number: N08-12618
Doctor: Dr. Rhonda Baldone
Clinic: Baldone
Clinic Number:
Social Security #:

Date of Biopsy: 12/01/2008
Date Received: 12/02/2008
Date Reported: 12/03/2008
Age: Sex: M
Date of Birth: 05/22/1997

BIOPSY SITE:
L LOWER ABDOMEN, 4 MM PUNCH

PATHOLOGY REPORT

CLINICAL DIAGNOSIS AND HISTORY:
3 mm dark brown papule
Atypical nevus - History of melanoma

GROSS EXAMINATION: Received is a 4 mm punch biopsy of skin extending to a depth of 0.4 cm. Entirely submitted. (fg)

MICROSCOPIC DESCRIPTION:
The skin is slightly elevated. In some areas the rete ridges are elongated. There is an increased number of melanocytes along the basal layer of the epidermis where they are distributed both diffusely and in nests. These nests are located not only at the tips of rete, but also along the sides of rete and between rete ridges. Within the dermis are orderly nests, cords and strands of nevus cells which tend to mature at the deeper aspect of the lesion. The junctional component of this nevus extends some distance lateral to the intradermal component and within this junctional component, occasional melanocytes exhibit cytologic atypia. There is stromal fibroplasia beneath this lateral area of involvement and a mild mononuclear cell infiltrate is present.

DIAGNOSIS:
SKIN, L LOWER ABDOMEN, 4 MM PUNCH
-Compound dysplastic nevus, mild atypia (Clark's nevus). 6K KB

Comment: Margins are clear in this plane of section.

Thomas Nicotri, Jr., MD
Thomas Nicotri, Jr., MD

PATIENT INFORMED
DATE: 12-4-08
BY: KB

ST TAMMANY PARISH HOSPITAL
1202 SOUTH TYLER STREET, COVINGTON, LA 70433

NAME:	BODIN, JEFFREY	PT PHONE:	985-845-0959
SEX:	M	DATE OF BIRTH:	05/22/1997
LOCATION:		AGE:	11Y
MR#:	28-07-19	DATE OF EXAM:	02/16/2009
PHYSICIAN:	SHERRI CASEY	ORD# / FC:	90002 / B
	71107 Hwy 21 Suite 1	ADM NO:	000377557483
	Covington, LA 70433	PT CLASS / TYPE:	O / P
	(985) 893-2580	ADM DATE:	02/16/2009

Final Report ACCESSION #: 1791895

Clinical History: 172.9 - SKIN MAL MELANOMA NOS

MRI BRAIN W/WO CONTRAST 02/16/2009 metastatic melanoma

RESULT: MRI of the brain

70553

Indication: Headaches, malignant melanoma, rule out metastases

Technique: Sequences performed included axial and sagittal T1 weighted, axial T2 weighted, axial FLAIR, axial proton density, and axial ADC and diffusion weighted images.

Findings:
There is no abnormal enhancement or focal brain parenchymal abnormality evident. Normal enhancement of the pituitary is incidentally noted. Diffusion images demonstrate no acute ischemia. The ventricles and sulci are not enlarged. There is no intracranial hemorrhage, mass or mass effect. The posterior fossa is unremarkable. There is no abnormality of the cerebellum, brainstem or cerebellopontine angles. The sella and optic chiasm are within normal limits. The paranasal sinuses and mastoid air cells are clear.

IMPRESSION:
1. No focal brain parenchymal abnormality or abnormal enhancement

---

Interpreting Physician: JOSEPH PERDIGAO M.D.
Transcribed by / Date: PSC on Feb 16 2009 3:23P
Approved Electronically by / Date: PERDIGAO M.D., JOSEPH Feb 16 2009 3:23P
Distribution: SHERRI CASEY
SHERRI CASEY

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 800.669.6625

SPECIMEN INFORMATION
SPECIMEN: HU111925F
REQUISITION: 0050069

COLLECTED: 03/06/2009 10:11 CT
RECEIVED: 03/06/2009 10:09 CT
REPORTED: 03/13/2009 06:37 CT

PATIENT INFORMATION
BODIN,JEFFREY T

DOB: 05/22/1997 AGE: 11
GENDER: M

ID: BODIN,JEFFREY
PHONE: 985.845.0969

REPORT STATUS FAX COPY

ORDERING PHYSICIAN
POUW,VICTOR VINCENT

CLIENT INFORMATION
L82333 MI99MI12
CHILDREN'S INT'L MED GROUP
1430 LINDBERG DR
SLIDELL, LA 70458-8056

COMMENTS: FASTING

Test Name	In Range	Out of Range	Reference Range	Lab
HELICOBACTER PYLORI ANTIBODIES (IGG,IGA,IGM)				
HELICOBACTER PYLORI ANTIBODY (IGG)				E2
H. PYLORI AB IGG	NEGATIVE		Reference Range: NEGATIVE	

H. pylori serology testing measures antibodies to H.pylori and is not recommended for the diagnosis of active infection. The American College of Gastroenterology and the American Gastroenterological Association recommend either the urea breath test (test code #14839X) or the fecal antigen test (test code# 34838X) for diagnosis and confirmation of eradication in cases of suspected or proven Helicobacter pylori infection.

HELICOBACTER PYLORI ANTIBODY (IGA)				E2
H. PYLORI AB IGA	NEGATIVE		Reference Range: NEGATIVE	
HELICOBACTER PYLORI ANTIBODY (IGM)				E2
H. PYLORI AB IGM	NEGATIVE		Reference Range: NEGATIVE	
FSH/LH, PEDIATRICS				
LH, PEDIATRICS	0.86		mIU/mL Reference Range: < OR = 6.64	E2

Male Reference Ranges for LH (Luteinizing Hormone), Pediatric:

Males:

3-7 years	< or = 0.26 mIU/mL
8-9 years	< or = 1.40 mIU/mL
10-11 years	< or = 6.64 mIU/mL
12-14 years	0.85-6.87 mIU/mL
15-17 years	0.90-7.82 mIU/mL

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED

COLLECTED: 03/06/2009 10:11 CT
REPORTED: 03/13/2009 06:37 CT

PATIENT INFORMATION
BODIN,JEFFREY T

DOB: 05/22/1997 AGE: 11
GENDER: M
ID: BODIN,JEFFREY

REPORT STATUS FAX COPY

ORDERING PHYSICIAN
POUW,VICTOR VINCENT

Test Name	In Range	Out of Range	Reference Range	Lab
18-20 years	0.95-8.44 mIU/mL			
Tanner Stage				
I	< or = 0.50 mIU/mL			
II	< or = 1.73 mIU/mL			
III	0.09-4.09 mIU/mL			
IV-V	0.18-10.43 mIU/mL			
FSH (FOLLICLE STIMULATING HORMONE), PEDIATRICS				EZ
FSH, PEDIATRICS	0.81		mIU/mL	

Reference Range:
EARLY PREPUBERTAL:
0.30-4.00

Male Pediatric Reference Ranges for FSH:

0-9 years/prepubertal*:	<3.00 mIU/mL
10-13 years/early pubertal:	0.30-4.00 mIU/mL
14-17 years:	0.40-7.40 mIU/mL

*FSH peaks (typically 3.00-6.00 mIU/mL for this assay) in male infants at 4 months of age, falling to prepubertal levels by 1 year of age. (Forest MG, Ducharme JR, Gonadotropic and gonadal hormones. Ch8, in: Bertrand et al, eds. Pediatric Endocrinology, 2nd Ed. Baltimore: Williams & Wilkins, 1993).

Test Name	In Range	Out of Range	Reference Range	Lab
COMPREHENSIVE METABOLIC PANEL W/EGFR				RGA
GLUCOSE	75		65-99 mg/dL FASTING REFERENCE INTERVAL	
UREA NITROGEN (BUN)	13		7-20 mg/dL	
CREATININE	0.67		0.50-1.30 mg/dL	
PATIENT IS <18 YEARS OLD. UNABLE TO CALCULATE EGFR.				
BUN/CREATININE RATIO	NOT APPLICABLE		6-22 (calc)	
BUN/CREATININE RATIO IS NOT REPORTED WHEN THE BUN AND CREATININE VALUES ARE WITHIN NORMAL LIMITS.				
SODIUM	138		135-146 mmol/L	
POTASSIUM		3.7 L	3.8-5.1 mmol/L	
CHLORIDE	104		98-110 mmol/L	
CARBON DIOXIDE	22		21-33 mmol/L	

 Page 2 - Continued on Page 3

Quest Diagnostics®

QUEST DIAGNOSTICS INCORPORATED

COLLECTED: 03/06/2009 10:11 CT
REPORTED: 03/13/2009 06:37 CT

PATIENT INFORMATION
BODIN,JEFFREY T

DOB: 05/22/1997 AGE: 11
GENDER: M
ID: BODIN,JEFFREY

REPORT STATUS FAX COPY

ORDERING PHYSICIAN
POUW,VICTOR VINCENT

Test Name	In Range	Out of Range	Reference Range	Lab
CALCIUM	9.7		8.9-10.4 mg/dL	
PROTEIN, TOTAL	7.4		6.3-8.2 g/dL	
ALBUMIN	5.1		3.6-5.1 g/dL	
GLOBULIN	2.3		2.1-3.5 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO		2.2 H	1.0-2.1 (calc)	
BILIRUBIN, TOTAL	0.3		0.2-1.1 mg/dL	
ALKALINE PHOSPHATASE	126		91-476 U/L	
AST	19		12-32 U/L	
ALT	10		8-30 U/L	
IGF-I	122		ng/mL	E2

Reference Range:
80-723

Pediatric Male Reference Ranges for IGF-I:

1-7 days	< or = 31 ng/mL
8-14 days	< or = 43 ng/mL
15 days-1 year	25-265 ng/mL
1-2 years	45-222 ng/mL
3-4 years	36-202 ng/mL
5-6 years	32-259 ng/mL
7-8 years	65-278 ng/mL
9-10 years	52-330 ng/mL
11-12 years	80-723 ng/mL
13-14 years	142-855 ng/mL
15-16 years	176-845 ng/mL
17-18 years	152-668 ng/mL

Tanner Stages (7-17 years)

Tanner I	59-296 ng/mL
Tanner II	56-432 ng/mL
Tanner III	135-778 ng/mL
Tanner IV	230-855 ng/mL
Tanner V	181-789 ng/mL

TESTOSTERONE, FREE AND TOTAL, LC/MS/MS	PENDING			
IGF BINDING PROTEIN 3 (IGFBP 3)	3.7		ng/L	E2

Reference Range:
2.4-8.4

Pediatric Reference Ranges (ng/L) for IGF Binding Protein-3 (IGFBP-3):

Age	Units

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED	PATIENT INFORMATION BODIN,JEFFREY T	REPORT STATUS FAX COPY
	DOB: 05/22/1997 AGE: 11	ORDERING PHYSICIAN POUW,VICTOR VINCENT
COLLECTED: 03/06/2009 10:11 CT REPORTED: 03/13/2009 06:37 CT	GENDER: M ID: BODIN,JEFFREY	

Test Name	In Range	Out of Range	Reference Range	Lab

1-7 days	<0.7
8-15 days	0.5-1.4
16 days-1 year	0.7-3.6
2 years	0.8-3.9
3 years	0.9-4.3
4 years	1.0-4.7
5 years	1.1-5.2
6 years	1.3-5.6
7 years	1.4-6.1
8 years	1.6-6.5
9 years	1.8-7.1
10 years	2.1-7.7
11 years	2.4-8.4
12 years	2.7-8.9
13 years	3.1-9.5
14 years	3.3-10.0
15 years	3.5-10.0
16 years	3.4-9.5
17 years	3.2-8.7

Male Reference Ranges (mg/L) for IGF Binding Protein-3 (IGFBP-3) by Pubertal (Tanner) Stage:

Males

Tanner I	1.4-5.2
Tanner II	2.3-6.3
Tanner III	3.1-8.9
Tanner IV	3.7-8.7
Tanner V	2.6-8.6

Test Name	In Range	Out of Range	Reference Range	Lab
T4, FREE	1.3		0.9-1.4 ng/dL	RGA
TSH, 3RD GENERATION	3.84		0.50-4.30 mIU/L	RGA

HARD COPY TO FOLLOW

PATIENT RESULTS CONTAINED IN A FACSIMILE OR ELECTRONIC MEDICAL REPORT ARE PROVIDED ONLY UPON THE REQUEST OF THE PHYSICIAN OR AUTHORIZED PERSON. FACSIMILE OR ELECTRONIC MEDICAL REPORTS THAT ARE CREATED BEFORE FINAL RESULTS ARE REPORTED ARE CONSIDERED TO BE INTERIM RESULTS ONLY AND ARE SUBJECT TO CHANGE BY THE LABORATORY.

 Page 4 - Continued on Page 5

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED

COLLECTED: 03/06/2009 10:11 CT
REPORTED: 03/13/2009 06:37 CT

PATIENT INFORMATION
BODIN, JEFFREY T

DOB: 05/22/1997 AGE: 11
GENDER: M
ID: BODIN, JEFFREY

REPORT STATUS FAX COPY

ORDERING PHYSICIAN
POUW, VICTOR VINCENT

PERFORMING LABORATORY INFORMATION

EZ QUEST DIAGNOSTICS/SJC, 33608 ORTEGA HWY, SAN JUAN CAPISTRANO, CA 92675
Laboratory Director: R.E. REITZ, MD, CLIA: 05D0643352

RGA QUEST DIAGNOSTICS HOUSTON, 5850 ROGERDALE ROAD, HOUSTON, TX 77072-1602
Laboratory Director: JOHN G BUCK, MD, CLIA: 45D0660150

Page 5 - Continued on Page 6

ST. TAMMANY PARISH HOSPITAL
Covington, Louisiana
Peds: (985) 871-5966

PHYSICIAN'S ORDERS
USE BALL POINT PEN ONLY!

ALLERGIES: NKDA

BSA: 1.06 m².

Height: 53.65" Weight: 30.2 kg.

DATE & TIME ORDERED 8/3/2009

Admit to Pediatrics #1 service Dr. Victor Pouw / Neuromuscular
for Growth Hormone Stimulation Test on:
Dx: Growth Failure (ICD-9. 783.43).
Cond: good
Diet: water only until test is finished.
then regular as tolerated
IV: saline lock for blood sampling

BODIN, Jeffrey
DOB: 5/22/'97
M.cell: (985) 264-5277.

FAXED

NOTED BY

DATE & TIME ORDERED

Clonidine: 0.15 mg PO x1 after baseline labs
Glucagon: 1.0 mg IM x1
Zofran 4 mg IV Q4hr PRN nausea/vomiting.
Baseline: Growth Hormone; IGF-1; Accuchek; Insulin
T=30' = " ; " ; "
T=60' = " ; " ; "
T=90' = " ; " ; " ; Insulin, Cortisol
T=120' = " ; " ; "

FAXED

NOTED BY

DATE & TIME ORDERED

T=180' = " ; " ; " ; Cortisol

May discharge to home at the end of the test if stable
Please notify Dr. Pouw (pager 504/464.2000) if problems.
F/U: Dr. Pouw 3-4 wks after test.

[signature]

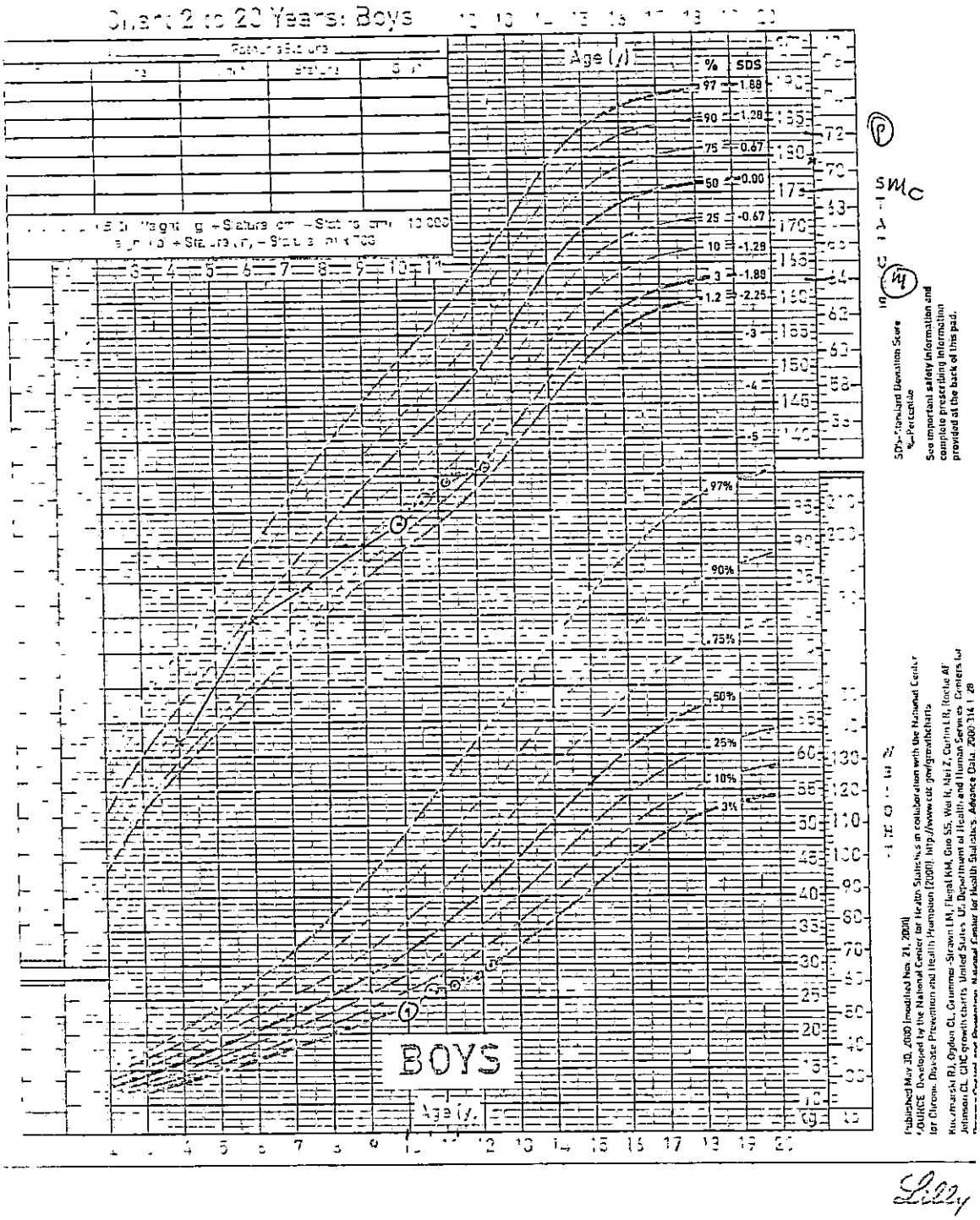
23 hrs observation.

FAXED

NOTED BY

Humatrope®
somatropin (rDNA origin)
for injection

Name: Jeffrey Bodin DOB: 5/22/1997



Published May 30, 2000 (modified Nov. 21, 2000)
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). http://www.cdc.gov/growthcharts
Kuczmarski RJ, Ogden CL, Guo SS, Grummer-Strawn LM, Flegal KM, Guo SS, Wei R, Mei Z, Curtin LR, Roche AF, Johnson CL. CDC growth charts: United States. US Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Health Statistics. Advance Data. 2000;314:1-28.

SDS=Standard Deviation Score
%=Percentile

See important safety information and complete prescribing information provided at the back of this pad.

EXHIBIT NO. 10F
PAGE: 36 OF 221

FOR INFORMATION ON FILING A GRIEVANCE OR FOR ANY QUESTIONS ABOUT ANY OF THE RIGHTS LISTED BELOW, CONTACT GUEST SERVICES AT 898-4669 OR THE LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS AT (225) 342-6429.

AS A PATIENT, YOU HAVE THE RIGHT TO:

- **Access care and services** based upon need and according to the Hospital's mission and vision, admission policies, and capability to provide needed services regardless of race, gender, religion, national origin, age, physical ability or financial status.
- **Receive considerate care** that respects psychosocial, spiritual, and cultural values.
- **Wear personal and religious or symbolic items** provided the items do not interfere with medical therapy or diagnostic procedures. Have a family member or representative of your choice and your physician notified of your admission.
- **Receive appropriate pain management** and information about pain relief measures. This includes having health professionals who respond quickly to reports of pain and staff who are committed to pain control.
- **Make informed decisions** about your care and any proposed procedure or treatment. This includes being informed of your health status, being involved in care planning and treatment, and being able to request or refuse treatments. This right is not a mechanism to demand medically unnecessary or inappropriate treatment or services.
- **Have an advance directive** concerning end of life care and treatment, for example a living will, or to designate a surrogate decision-maker with the expectation that Hospital staff and practitioners will honor the intent of the directive(s) to the extent permitted by law and Hospital policy.
- **Know the identity of the physician** who has primary responsibility for your care and the identity and professional status of individuals responsible for authorizing or performing procedures or treatments.
- **Be informed of outcomes of care,** including any unanticipated outcomes, and be informed if the Hospital proposes to engage in investigational, experimental, research or educational activity and have the right to refuse to participate in such activity.
- **Voice complaints or submit a written grievance** about the Hospital's care and services and receive a response to the complaint or grievance. *Submitting a complaint or grievance will not compromise your future access to care.*
- **Participate** in the consideration of the **ethical issues** that may arise in the course of your care.
  Expect personal privacy and be interviewed, examined and treated with reasonable visual and auditory privacy.
- **Receive care in a safe setting;** be free from all forms of abuse, neglect, or harassment; be free from restraints of any form that are not medically necessary; and be free from seclusion and restraints of any form imposed for behavior management unless clinically necessary.
- **Expect confidentiality of health information and clinical records;** have that information provided only to those involved in your care, to those monitoring its quality, or to those otherwise legally authorized to receive such information; and access information contained in your clinical record within a reasonable time frame.
- **Request and receive an itemized explanation of total charges** for services rendered by the Hospital regardless of the source of payment.

YOUR PATIENT RESPONSIBILITIES INCLUDE:

- Providing correct, accurate and complete information about your health.
- Following the treatment plan ordered by your physician, including working with your doctor(s) and nurse(s) to develop a pain management plan, helping measure your pain, and reporting any unrelieved pain.
- Considering the rights of other patients and Hospital personnel.
- Ensuring that the Hospital has a copy of your written advance directive (if you have one).
- Following Hospital rules and regulations that apply to patient conduct.
- Taking responsibility for your actions if you refuse treatment or do not follow instructions given by your physician.
- Making sure that the financial obligations of your health care are met as soon as possible.
- Asking questions when you do not understand what you have been told about your care.
- Contacting your nurse, physician, or other staff member if you perceive any safety risk relating to your environment or care.

If the patient is unable to exercise any of the rights set forth in this document, surrogates in the order provided by Louisiana statute may do so.

By signing this form, the patient (or his/her designated representative) acknowledges that he/she has been given a copy of patient rights and responsibilities for review.

Patient Signature: _____ **Date:** _____

Hospital Representative: _____ **Date:** _____

PATIENT RIGHTS AND RESPONSIBILITIES

St. Tammany PARISH HOSPITAL

BODIN JEFFREY
378286843 08/05/09 PED
M 05/22/1997 12 O B 280719
POUW, I.S. VICTOR

MR 00019

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result ["f"] indicates result has comment or value was truncated

Pt. Name: BODIN , JEFFREY
Pt ID: 2008006301
DOB: 05/22/1997
Adm DTime:
Nurs Sta:
Dx:
Alrg:

MRN: 280719
Acct No:
Age/Sex: 12Y/M
Atn Dr:
Rm/Bed:

Laboratory Results — Chemistry

	[redacted]	08/05/09 12:02	08/05/09 11:02	08/05/09 10:02	08/05/09 10:03	08/05/09 09:41	08/05/09 08:50
		0000921700710	0000921700687	0000921700625	0000921700595	0000921700563	0000921700434
Growth Hormone 0 Minutes 0.03-14.90 ng/mL							0.18 ["f"]
Growth Hormone, 30 Minutes	ng/mL					0.32 ["f"]	
Growth Hormone, 60 Minutes	ng/mL				7.92 ["f"]		
Growth Hormone, 90 Minutes	ng/mL			1.62 ["f"]			
Growth Hormone, 120 Minutes	ng/mL		8.45 ["f"]				
Growth Hormone Minutes	min	180					
Growth Hormone, Other Minutes	ng/mL	2.62 ["f"]					
Insulin-Like Growth Factor 1 108-558 ng/mL		139 ["f"]	139 ["f"]	144 ["f"]	139 ["f"]	150 ["f"]	153 ["f"]
Cortisol, Serum	ug/dL	28.0 ["f"]		9.0 ["f"]			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 12:02	Growth Hormone, Other Minutes	ng/mL

Result: 2.62

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result ["f"] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 12:02	Growth Hormone, Other Minutes	ng/mL

Comment: TEST INFORMATION: Growth Hormone, Other
Growth Hormone Stimulation tests should induce a peak of greater than 7 ng/mL in children and greater than 5 ng/mL in adults; lower values suggest growth hormone deficiency. For children, some experts consider values of 7-10 ng/mL equivocal and only peak values of greater than 10 ng/mL truly normal.
For suppression testing, normal subjects have growth hormone concentrations of less than 1 ng/mL within 2 hours of ingestion of a 75 or 100 gram glucose dose. Patients with acromegaly fail to show normal suppression.

Collected DT	Finding Name	Normal(s)
8/5/09 12:02	Insulin-Like Growth Factor I	108-558 ng/mL

Result: 139

Comment: Tanner Stage Reference Intervals

Tanner Stage	Female	Male
I	70-397 ng/mL	50-278 ng/mL
II	165-665 ng/mL	79-392 ng/mL
III	201-695 ng/mL	119-577 ng/mL
IV-V	160-609 ng/mL	184-580 ng/mL

Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
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Collected DT	Finding Name	Normal(s)
8/5/09 12:02	Cortisol, Serum	ug/dL

Result: 26.0

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
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Laboratory Results Report

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Pt. Name: BODIN , JEFFREY
Pt ID: 2008006301
DOB: 05/22/1997
Adm DTime:
Nurs Sta:
Dx:
Alrg:

MRN: 280719
Acct No:
Age/Sex: 12Y/M
Atn Dr:
Rm/Bed:

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 12:02	Cortisol, Serum	ug/dL

Comment: REFERENCE INTERVAL: Cortisol, Serum or Plasma
0800 hrs: 6-23 ug/dL
2000 hrs: 0-9 ug/dL
8 hrs post 1 mg dexamethasone given at midnight: 0-5 ug/dL
30-60 min post 25 units Cosyntropin I.V.: greater than 20 ug/dL
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 11:02	Growth Hormone, 120 Minutes	ng/mL

Result: 9.45

Comment: TEST INFORMATION: Growth Hormone 120 Minutes
Growth Hormone Stimulation tests s hould induce a peak of greater than 7 ng/mL in children and greater than 5 ng/mL in adults; lower values suggest growth hormone deficiency. For children, some experts consider values of 7-10 ng/mL equivocal and only peak values of greater than 10 ng/mL as truly normal.
For suppression testing, normal subjects have growth hormone concentrations of less than 1 ng/mL within 2 hours of ingestion of a 75 or 100 gram glucose dose. Patients with acromegaly fail to show normal suppression.
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Collected DT	Finding Name	Normal(s)
8/5/09 11:02	Insulin-Like Growth Factor I	109-558 ng/mL

Result: 138

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result ["f"] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 11:02	Insulin-Like Growth Factor I	108-558 ng/mL

Comment: Tanner Stage Reference Intervals

Tanner Stage	*Female*	*Male*
I	*70-397 ng/mL*	*50-278 ng/mL*
II	*165-665 ng/mL*	*79-392 ng/mL*
III	*201-695 ng/mL*	*119-577 ng/mL*
IV-V	*160-609 ng/mL*	*184-580 ng/mL*

Performed by ARUP Laboratories,
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www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 10:32	Growth Hormone, 90 Minutes	ng/mL

Result: 1.62

Comment: TEST INFORMATION: Growth Hormone 90 Minutes
Growth Hormone Stimulation tests sh ould induce a peak of greater than 7 ng/mL in children and greater than 5 ng/mL in adults; lower values suggest growth hormone deficiency. For children, some experts consider values of 7-10 ng/mL equivocal and only peak values of greater than 10 ng/mL as truly normal.
For suppression testing, normal subjects have growth hormone concentrations of less than 1 ng/mL within 2 hours of ingestion of a 75 or 100 gram glucose dose. Patients with acromegaly fail to show normal suppression.
Performed by ARUP Laboratories,
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Collected DT	Finding Name	Normal(s)
8/5/09 10:32	Insulin-Like Growth Factor I	108-558 ng/mL

Result: 144

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant M.D.

Laboratory Results Report

Legend: P indicates preliminary result ["f"] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008003301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 10:32	Insulin-Like Growth Factor I	106-358 ng/mL

Comment: Tanner Stage Reference Intervals

Tanner Stage	Female	Male
I	70-397 ng/mL	50-278 ng/mL
II	165-665 ng/mL	79-392 ng/mL
III	201-695 ng/mL	119-577 ng/mL
IV-V	160-609 ng/mL	194-580 ng/mL

Performed by ARUP Laboratories,
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www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 10:32	Cortisol, Serum	ug/dL

Result: 9.0

Comment: REFERENCE INTERVAL: Cortisol, Serum or Plasma
0800 hrs: 6-23 ug/dL
2000 hrs: 0-9 ug/dL
8 hrs post 1 mg dexamethasone given at midnight:0-5 ug/dL
30-60 min post 25 units Cosyntropin I.V.: greater than 20 ug/dL
Performed by ARUP Laboratories,
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Collected DT	Finding Name	Normal(s)
8/5/09 10:09	Growth Hormone, 60 Minutes	ng/mL

Result: 7.92

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Department of Pathology and Laboratory Services
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Laboratory Results Report

Legend: P indicates preliminary result ["f"] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
9/5/09 10:08	Growth Hormone, 60 Minutes	ng/mL

Comment: TEST INFORMATION: Growth Hormone 60 Minutes
Growth Hormone Stimulation tests should induce a peak of greater than 7 ng/mL in children and greater than 5 ng/mL in adults; lower values suggest growth hormone deficiency. For children, some experts consider values of 7-10 ng/mL equivocal and only peak values of greater than 10 ng/mL as truly normal.
For suppression testing, normal subjects have growth hormone concentrations of less than 1 ng/mL within 2 hours of ingestion of a 75 or 100 gram glucose dose. Patients with acromegaly fail to show normal suppression.
Performed by ARUP Laboratories,
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Collected DT	Finding Name	Normal(s)
9/5/09 10:08	Insulin-Like Growth Factor I	108-558 ng/mL

Result: 135

Comment: Tanner Stage Reference Intervals

Tanner Stage	Female	Male
I	70-397 ng/mL	50-278 ng/mL
II	165-665 ng/mL	79-392 ng/mL
III	201-695 ng/mL	119-577 ng/mL
IV-V	160-609 ng/mL	184-580 ng/mL

Performed by ARUP Laboratories,
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Collected DT	Finding Name	Normal(s)
9/5/09 9:41	Growth Hormone, 30 Minutes	ng/mL

Result: 0.32

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Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result [*i*] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2006006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 9:41	Growth Hormone, 30 Minutes	ng/mL

Comment: TEST INFORMATION: Growth Hormone 30 Minutes
Growth Hormone Stimulation tests sh ould induce a peak of greater than 7 ng/mL in children and greater than 5 ng/mL in adults; lower values suggest growth hormone deficiency. For children, some experts consider values of 7-10 ng/mL equivocal and only peak values of greater than 10 ng/mL as truly normal.
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Collected DT	Finding Name	Normal(s)
8/5/09 9:41	Insulin-Like Growth Factor I	106-358 ng/mL

Result: 180

Comment: Tanner Stage Reference Intervals

Tanner Stage	Female	Male
I	70-397 ng/mL	50-278 ng/mL
II	165-665 ng/mL	79-392 ng/mL
III	201-695 ng/mL	119-577 ng/mL
IV-V	160-609 ng/mL	184-580 ng/mL

Performed by ARUP Laboratories,
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www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 8:50	Growth Hormone, 0 Minutes	0.03-14.90 ng/mL

Result: 0.18

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Covington, LA 70433

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Laboratory Results Report

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Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 8:50	Growth Hormone, 0 Minutes	0.03-14.90 ng/mL

Comment: TEST INFORMATION: Growth Hormone 0 Minutes
Growth Hormone Stimulation tests sho uld induce a peak of greater than 7 ng/mL in children and greater than 5 ng/mL in adults; lower values suggest growth hormone deficiency. For children, some experts consider values of 7-10 ng/mL equivocal and only peak values of greater than 10 ng/mL as truly normal.
For suppression testing, normal subjects have growth hormone concentrations of less than 1 ng/mL within 2 hours of ingestion of a 75 or 100 gram glucose dose. Patients with acromegaly fail to show normal suppression.
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Collected DT	Finding Name	Normal(s)
8/5/09 8:50	Insulin-Like Growth Factor I	108-559 ng/mL

Result: 151

Comment: Tanner Stage Reference Intervals

Tanner Stage	Female	Male
I	70-397 ng/mL	50-278 ng/mL
II	165-665 ng/mL	79-392 ng/mL
III	201-695 ng/mL	119-577 ng/mL
IV-V	160-609 ng/mL	184-580 ng/mL

Performed by ARUP Laboratories,
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Laboratory Results — Chem Tox

Specimen ID	08/05/09 10:32	08/05/09 08:50
	0000921700625	0000921700434

EXHIBIT NO. 10F
PAGE: 45 OF 221

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Mervant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result ["*"] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Laboratory Results — Chem Tox

	[redacted]	08/05/09 10:32	08/05/09 08:50
		0000321709825	0000321730434
Insulin, Fasting	3-19 uIU/mL		5 ["*"]
Insulin, 90 Minutes	26-94 uIU/mL	41 ["*"]	

Comments and Long Results Section

Laboratory Results — Chem Tox

Collected DT	Finding Name	Normal(s)
8/5/09 10:32	Insulin, 90 Minutes	26-94 uIU/mL

Result: 41

Comment: TEST INFORMATION: Insulin 90 Minutes
This assay reacts on a nearly equimolar basis with the analogs insulin aspart, insulin glargine, and insulin lispro. The reference interval is based on a 75 g glucose challenge.
To convert to pmol/L, multiply uIU/mL by 6.0.
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Collected DT	Finding Name	Normal(s)
8/5/09 8:50	Insulin, Fasting	3-19 uIU/mL

Result: 5

ST. TAMMANY PARISH HOSPITAL
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Covington, LA 70433

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Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

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Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chem Tox

Collected DT	Finding Name	Normal(s)
8/5/09 8:50	Insulin, Fasting	3-19 uIU/mL

Comment: TEST INFORMATION: Insulin, Fasting
This assay reacts on a nearly equimolar basis with the analogs insulin aspart, insulin glargine, and insulin lispro.
To convert to pmol/L, multiply uIU/mL by 6.0.
Performed by ARUP Laboratories,
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www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

THOMAS NICOTRI, JR., M.D., LLC
DERMATOPATHOLOGY SERVICES
P.O. Box 1713 Mandeville, LA 70470
Reports/Lab: (504) 361-3757
Billing: (877) 626-0312

Name: Jeffrey Bodin
Address: 528 Beau Chene Drive
Mandeville,LA 70471

Number: N08-02365
Doctor: Dr. Rhonda Baldone
Clinic: Baldone
Clinic Number:
Social Security #:

Date of Biopsy: 03/06/2008
Date Received: 03/07/2008
Date Reported: 03/13/2008
Age: Sex: M
Date of Birth: 05/22/1997

BIOPSY SITE:
1. R CHEEK
2. L ANKLE

PATHOLOGY REPORT

CLINICAL DIAGNOSIS AND HISTORY:
1. 3 mm crusted pink papule
2. 7 mm pink crusted papule
Nevi; R/O atypia

GROSS EXAMINATION:
1. Received is a 0.3 cm shave biopsy of skin containing a 0.2 cm hyperpigmented papule. Entirely submitted.

2. Received is a 0.5 cm shave biopsy of skin containing a 0.5 cm hyperpigmetned crusted papule; bisected and entirely submitted.

MICROSCOPIC DESCRIPTION:
1. There is prominent scale crust with fibrin beneath the epidermis. There is a lymphohistiocytic inflammatory cell infiltrate. There are a few nests of melanocytic cells that stain with Melan-A in the dermis. An appropriate control is examined.

2. There are nests of melanocytic cells in the epidermis. The cells have oval to spindle-shaped nuclei. There are similar nests present throughout the dermis without evidence of maturation. There is no evidence of a host response. The cells have enlarged nuclei. There are scattered mitotic figures present at all levels of the dermis even to the base of the specimen. S100 and the repeat Melan-A stain revealed dense diffuse labeling. HMB45 only labels superficially. Ki-67 reveals a large number of cells throughout the proliferation. At least 1 out of 10 cells labels and in some areas there is even more significant labeling. Appropriate controls are examined.

DIAGNOSIS:
1. SKIN, R CHEEK
-Melanocytic proliferation in the dermis with inflammation and prominent scale crust. See note.

NOTE: I favor that this represents the superior portion of an irritated and inflamed dermal nevus. The base of the specimen is not present to evaluate for maturation. Therefore if the lesion is

Patient Name: Jeffrey Bodin Acct No. N08-02365

concerning clinically, an additional deeper biopsy might be considered.

2. SKIN, L ANKLE
-Malignant melanoma, amelanotic type.
-Breslow thickness at least 1.3 mm in thickness (the tumor extends to the base of the specimen).
-At least Clark's level IV.
-Absent host response.
-Non ulcerated.
-No evidence of regression.
-No convincing evidence of lymphovascular invasion. Six mitoses per 10/hpf.
-The tumor extends to the base of the specimen.

Case was reviewed by Dr. Paul Long who agrees with the diagnosis. The case will also be shown to Dr. Alun Wang and an additional report will follow.

Thomas Nicotri, Jr., MD
Thomas Nicotri, Jr., MD

PATIENT INFORMED
DATE: _____
BY: _____

Pathology Report

JEFFREY BODIN 744652

Procedure Name: Surgical Case

Procedure Date: 03/26/2008

Accession Number: S-08-017604

******* MODIFIED REPORT - REVIEW ADDENDUM SECTION *******

DIAGNOSIS

(A) LEFT INGUINAL SENTINEL LYMPH NODE #1, BLUE COUNT 1300
METASTATIC MELANOMA TO ONE OF ONE LYMPH NODE (1/1)
2.7 X 1.6 MM (SUBCAPSULAR)
EXTRACAPSULAR EXTENSION NOT IDENTIFIED.

(B) LEFT INGUINAL SENTINEL LYMPH NODE #2, BLUE COUNT 2800
One lymph node, see addendum report.

(C) LEFT INGUINAL SENTINEL LYMPH NODE #3, COUNT 5600, BLUE.
One lymph node, see addendum report.

(D) LEFT INGUINAL SENTINEL LYMPH NODE #4, LIGHT BLUE, COUNT 980
One lymph node, see addendum report

(E) WIDE EXCISION, LEFT ANKLE
SKIN AND SUBCUTANEOUS TISSUE WITH SCAR, AND FOCAL INVASIVE MELANOMA.
CLARK LEVEL IV
BRESLOW THICKNESS 1 40 MM
Margins of resection are free of melanoma

(F) ADDITIONAL PROXIMAL TISSUE, LEFT ANKLE
Skin and subcutaneous tissue no melanoma is identified.

(G) ADDITIONAL DISTAL TISSUE, LEFT ANKLE:
Skin and subcutaneous tissue, no melanoma is identified.

(H) BIOPSY, LESION LEFT KNEE.
Verruca vulgaris.

(I) PUNCH BIOPSY, RIGHT FACE.
Scar See addendum report after examination of step sections

(J) LEFT POPLITEAL FOSSA SENTINEL LYMPH NODE #1, NOT BLUE, COUNT 1028:
One lymph node see addendum report.

(K) LEFT POPLITEAL SENTINEL LYMPH NODE #2, NOT BLUE, COUNT 2200:
One lymph node see addendum report.

VGP:ZZ/ek
DD: 3/28/08
3/28/2008 7:37 AM

GROSS DESCRIPTION

(A) LEFT INGUINAL SENTINEL LYMPH NODE #1 BLUE COUNT 1300 - A single possible lymph node measuring 1.8 cm in its greatest dimension. Sectioned and entirely submitted in cassette A AM1/ek
(B) LEFT INGUINAL SENTINEL LYMPH NODE #2, BLUE COUNT 2800 - A single possible lymph node measuring 0.5 cm in its greatest dimension Entirely submitted in cassette B AM1/ek
(C) LEFT INGUINAL SENTINEL LYMPH NODE #3, COUNT 5600, BLUE - A single possible lymph node measuring 0.6 cm in its greatest dimension Entirely submitted in cassette C AM1/ek
(D) LEFT INGUINAL SENTINEL LYMPH NODE #4, LIGHT BLUE, COUNT 980 - A single possible lymph node measuring 0.5 cm in its greatest dimension Entirely submitted in cassette D AM1/ek
(E) WIDE EXCISION OF MELANOMA, LEFT ANKLE, SHORT PROXIMAL, LONG POSTERIOR - An ellipse of tan skin measuring 2.5 x

Pathology Report

JEFFREY BODIN 744652

2.5 x 0.3 cm. Surgical margin is inked. The skin surface contains slightly elevated well demarcated, centrally ulcerated tan lesion measuring 0.5 x 0.4 cm and it is 1.1 cm away from the proximal surgical margin, 1.0 cm from the distal surgical margin, 1.0 cm from the posterior surgical margin and 1.1 cm from the anterior surgical margin. Entirely submitted.

INK CODE: Proximal - blue; distal - yellow. Entire specimen is submitted in sequential order from posterior toward the anterior aspect.

SECTION CODE: E1, posterior tip; E2, anterior tip, E3, E4, the rest of the skin. AM1/elk

(F) ADDITIONAL PROXIMAL TISSUE, LEFT ANKLE - A triangular shaped fragment of tan, grossly unremarkable skin measuring 1.2 x 1.0 cm. Representative sections submitted in cassette F. AM1/elk

(G) ADDITIONAL DISTAL TISSUE, LEFT ANKLE - A triangular shaped fragment of grossly unremarkable skin measuring 1.0 x 0.8 cm. Surgical margin is inked. Bisected and entirely submitted in cassette G. AM1/elk

(H) BIOPSY, LESION LEFT KNEE - A fragment of a tan, shaved unoriented skin measuring 0.6 x 0.4 cm. The skin surface contains a fairly well demarcated light gray elevated lesion measuring 0.3 x 0.3 cm grossly approach the surgical margin. The surgical margin is inked blue. Bisected and entirely submitted in cassette H. AM1/elk

(I) PUNCH BIOPSY, RIGHT FACE - A shallow skin punch biopsy measuring 0.4 x 0.4 cm. Surgical margin is inked blue. Entirely submitted in cassette I. AM1/elk

(J) LEFT POPLITEAL FOSSA SENTINEL LYMPH NODE #1, NOT BLUE, COUNT 1028 - A single possible lymph node measuring 0.8 cm in its greatest dimension. Entirely submitted in cassette J. AM1/elk

(K) LEFT POPLITEAL SENTINEL LYMPH NODE #2, NOT BLUE, COUNT 2200 - A single possible lymph node measuring 0.7 cm in its greatest dimension. Bisected and entirely submitted in cassette K. AM1/elk

CLINICAL HISTORY

Melanoma.

SNOMED CODES

T-02840, T-02120, T-C4800, T-C4810, M-87203, M-80703, M-78060, M-72750

"Some tests reported here may have been developed and performance characteristics determined by UT MD Anderson Pathology and Laboratory Medicine. These tests have not been specifically cleared or approved by the U.S. Food and Drug Administration."

Entire report and diagnosis completed by: Victor Prieto MD Mar 28, 2008

ADDENDUM

This modified report is being issued to provide additional information/results for specimens A, B, C, D, J and K.

Addendum completed by Diwan, A. Hafeez MD
Apr 01, 2008 at 11:22 AM

DIAGNOSIS

(A) Examination of additional tissue levels and an immunohistochemical study on paraffin sections with an anti-melanocytic cocktail (HMB-45, anti-MART 1 and anti-tyrosinase) confirms METASTATIC MELANOMA as previously indicated (1/1). In addition to the information already given, please note that there is an intraparenchymal component as well.

(B) Examination of additional tissue levels and an immunohistochemical study on paraffin sections with an anti-melanocytic cocktail (HMB-45, anti-MART 1 and anti-tyrosinase) fails to reveal metastatic melanoma.

(C) Examination of additional tissue levels and an immunohistochemical study on paraffin sections with an anti-melanocytic cocktail (HMB-45, anti-MART 1 and anti-tyrosinase) is positive for METASTATIC MELANOMA (1/1).

(D, J, K) Examination of additional tissue levels and an immunohistochemical study on paraffin sections with an anti-melanocytic cocktail (HMB-45, anti-MART 1 and anti-tyrosinase) fails to reveal metastatic melanoma.

AHD:ZZ/elk
DD: 3/31/08
4/1/2008 11:26 AM

Entire report and diagnosis completed by: A. Hafeez Diwan MD Apr 01, 2008

Pathology Report

JEFFREY BODIN 744652

ADDENDUM #2

Addendum completed by Diwan, A. Hafeez MD.

This modified report is being issued to provide additional information/results for specimen I.

DIAGNOSIS

(I) Multiple deeper sections are examined. The diagnosis is:

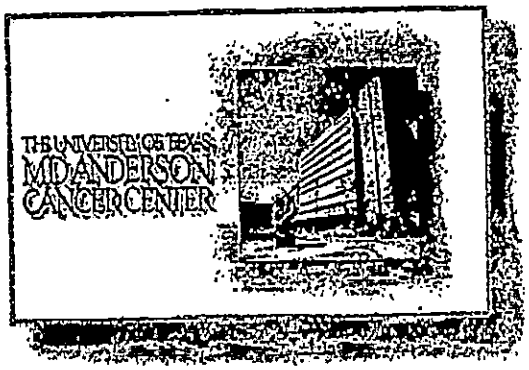
Scar and biopsy site changes with pseudoepitheliomatous hyperplasia. Tumor not identified.

Entire report and diagnosis completed by: A. Hafeez Diwan MD Apr 23, 2008

------END OF REPORT------

Division of Pathology and Laboratory Medicine
U.T.M.D. Anderson Cancer Center
1515 Holcombe Boulevard
Houston, Texas 77030

The display and printing format in this system may not match the formatting of the original laboratory report.



- Date Tuesday, April 08, 2008
- To Mark Bodin
- Company
- Fax Number 504) 596-2861
- Total Number of Pages (4)

Four

Lane Read, MPAS, PA-C

Department of Surgical Oncology
1400 Holcombe Blvd, Box 301402, Unit 444
Houston, Texas 77230-1402

Telephone: 713-745-6858
Fax: 713-792-0722

NOTES:

Attached is pathology on Patient Jeffrey Bodin.

Please contact me if further information is needed.

Sincerely,

Lane Read, PA-C

Lane Read, PA-C for Merrick I Ross, MD

FAX TRANSMISSION

UT M.D. Anderson Cancer Center
Tamtron Print by 10964 at 4/8/2008 11:42:51 AM

744652 - BODIN, JEFFREY T 10yo M 05/22/1997 (135.0cm 28.9kg BSA: 1.04m² 03/26/08)

Accession: S-08-017604
Specimen Date/Time: 03/26/2008

******* MODIFIED REPORT - REVIEW ADDENDUM SECTION *******

DIAGNOSIS:

(A) LEFT INGUINAL SENTINEL LYMPH NODE #1, BLUE COUNT 1300:
METASTATIC MELANOMA TO ONE OF ONE LYMPH NODE (1/1)
2.7 X 1.6 MM (SUBCAPSULAR)
EXTRACAPSULAR EXTENSION NOT IDENTIFIED.

(B) LEFT INGUINAL SENTINEL LYMPH NODE #2, BLUE COUNT 2800:
One lymph node, see addendum report.

(C) LEFT INGUINAL SENTINEL LYMPH NODE #3, COUNT 5600, BLUE:
One lymph node, see addendum report.

(D) LEFT INGUINAL SENTINEL LYMPH NODE #4, LIGHT BLUE, COUNT 980:
One lymph node, see addendum report.

(E) WIDE EXCISION, LEFT ANKLE:
SKIN AND SUBCUTANEOUS TISSUE WITH SCAR, AND FOCAL INVASIVE MELANOMA.
CLARK LEVEL IV.
BRESLOW THICKNESS 1.40 MM
Margins of resection are free of melanoma.

(F) ADDITIONAL PROXIMAL TISSUE, LEFT ANKLE:
Skin and subcutaneous tissue, no melanoma is identified.

(G) ADDITIONAL DISTAL TISSUE, LEFT ANKLE:
Skin and subcutaneous tissue, no melanoma is identified.

(H) BIOPSY, LESION LEFT KNEE:
Verruca vulgaris.

(I) PUNCH BIOPSY, RIGHT FACE:
Scar. See addendum report after examination of step sections.

(J) LEFT POPLITEAL FOSSA SENTINEL LYMPH NODE #1, NOT BLUE, COUNT 1028:
One lymph node, see addendum report.

(K) LEFT POPLITEAL SENTINEL LYMPH NODE #2, NOT BLUE, COUNT 2200:
One lymph node, see addendum report.

VGP:ZZ/elk
DD: 3/28/08
3/28/2008 7:37 AM

GROSS DESCRIPTION

(A) LEFT INGUINAL SENTINEL LYMPH NODE #1, BLUE COUNT 1300 - A single possible lymph node measuring 1.8 cm in its greatest dimension. Sectioned and entirely submitted in cassette A. AM1/elk
(B) LEFT INGUINAL SENTINEL LYMPH NODE #2, BLUE COUNT 2800 - A single possible lymph node measuring 0.5 cm in its greatest dimension. Entirely submitted in cassette B. AM1/elk

744552 - BODIN, JEFFREY T 10yo M 05/22/1997 (135.0cm 28.9kg BSA: 1.04m² 03/26/08)
Accession: S-08-017604
Specimen Date/Time: 03/26/2008

(C) LEFT INGUINAL SENTINEL LYMPH NODE #3, COUNT 5600, BLUE - A single possible lymph node measuring 0.6 cm in its greatest dimension. Entirely submitted in cassette C. AM1/elk
(D) LEFT INGUINAL SENTINEL LYMPH NODE #4, LIGHT BLUE, COUNT 980 - A single possible lymph node measuring 0.5 cm in its greatest dimension. Entirely submitted in cassette D. AM1/elk
(E) WIDE EXCISION OF MELANOMA, LEFT ANKLE, SHORT PROXIMAL, LONG POSTERIOR - An ellipse of tan skin measuring 2.5 x 2.5 x 0.3 cm. Surgical margin is inked. The skin surface contains slightly elevated well demarcated, centrally ulcerated tan lesion measuring 0.5 x 0.4 cm and it is 1.1 cm away from the proximal surgical margin, 1.0 cm from the distal surgical margin, 1.0 cm from the posterior surgical margin and 1.1 cm from the anterior surgical margin. Entirely submitted.

INK CODE: Proximal - blue; distal - yellow. Entire specimen is submitted in sequential order from posterior toward the anterior aspect.

SECTION CODE: E1, posterior tip; E2, anterior tip; E3, E4, the rest of the skin. AM1/elk
(F) ADDITIONAL PROXIMAL TISSUE, LEFT ANKLE - A triangular shaped fragment of tan, grossly unremarkable skin measuring 1.2 x 1.0 cm. Representative sections submitted in cassette F. AM1/elk
(G) ADDITIONAL DISTAL TISSUE, LEFT ANKLE - A triangular shaped fragment of grossly unremarkable skin measuring 1.0 x 0.8 cm. Surgical margin is inked. Bisected and entirely submitted in cassette G. AM1/elk
(H) BIOPSY, LESION LEFT KNEE - A fragment of a tan, shaved unoriented skin measuring 0.6 x 0.4 cm. The skin surface contains a fairly well demarcated light gray elevated lesion measuring 0.3 x 0.3 cm grossly approach the surgical margin. The surgical margin is inked blue. Bisected and entirely submitted in cassette H. AM1/elk
(I) PUNCH BIOPSY, RIGHT FACE - A shallow skin punch biopsy measuring 0.4 x 0.4 cm. Surgical margin is inked blue. Entirely submitted in cassette I. AM1/elk
(J) LEFT POPLITEAL FOSSA SENTINEL LYMPH NODE #1, NOT BLUE, COUNT 1028 - A single possible lymph node measuring 0.8 cm in its greatest dimension. Entirely submitted in cassette J. AM1/elk
(K) LEFT POPLITEAL SENTINEL LYMPH NODE #2, NOT BLUE, COUNT 2200 - A single possible lymph node measuring 0.7 cm in its greatest dimension. Bisected and entirely submitted in cassette K. AM1/elk

CLINICAL HISTORY:

Melanoma.

SNOMED CODES

T-02840, T-02120, T-C4800, T-C4810, M-87203, M-80703, M-78060, M-72750

"Some tests reported here may have been developed and performance characteristics determined by UT MD Anderson Pathology and Laboratory Medicine. These tests have not been specifically cleared or approved by the U.S. Food and Drug Administration."

Entire report and diagnosis completed by: Victor Prieto MD Mar 28, 2008

744652 - BODIN, JEFFREY T 10yo M 05/22/1997 (135.0cm 28.9kg BSA: 1.04m² 03/26/08)
Accession: S-08-017604
Specimen Date/Time: 03/26/2008

ADDENDUM

This modified report is being issued to provide additional information/results for specimens A, B, C, D, J and K.

Addendum completed by Diwan, A. Hafeez MD.
Apr 01, 2008 at 11:22 AM

DIAGNOSIS

(A) Examination of additional tissue levels and an immunohistochemical study on paraffin sections with an anti-melanocytic cocktail (HMB-45, anti-MART 1 and anti-tyrosinase) confirms METASTATIC MELANOMA as previously indicated (1/1). In addition to the information already given, please note that there is an intraparenchymal component as well.

(B) Examination of additional tissue levels and an immunohistochemical study on paraffin sections with an anti-melanocytic cocktail (HMB-45, anti-MART 1 and anti-tyrosinase) fails to reveal metastatic melanoma.

(C) Examination of additional tissue levels and an immunohistochemical study on paraffin sections with an anti-melanocytic cocktail (HMB-45, anti-MART 1 and anti-tyrosinase) is positive for METASTATIC MELANOMA (1/1).

(D, J, K) Examination of additional tissue levels and an immunohistochemical study on paraffin sections with an anti-melanocytic cocktail (HMB-45, anti-MART 1 and anti-tyrosinase) fails to reveal metastatic melanoma

AHD:ZZ/elk
DD: 3/31/08
4/1/2008 11:26 AM

Entire report and diagnosis completed by: A. Hafeez Diwan MD Apr 01, 2008

------END OF REPORT------

Division of Pathology and Laboratory Medicine
U.T.M.D. Anderson Cancer Center
1515 Holcombe Boulevard
Houston, Texas 77030

UT M.D. Anderson Cancer Center
Tamtron Print by 10964 at 5/1/2008 2:19:27 PM

744652 - BODIN, JEFFREY T 10yo M 05/22/1997 (135.0cm 28.0kg BSA: 1.02m² 04/23/08)

Accession: S-08-023559
Specimen Date/Time: 04/23/2008

DIAGNOSIS

(A) LEFT INGUINAL SUPERFICIAL LYMPH NODES:
Eight lymph nodes, no tumor present (0/8).
Skin and subcutaneous tissue with scar, granulation tissue and fat necrosis.
(B) LEFT CLOQUET LYMPH NODE:
One lymph node, no tumor present in frozen and permanent H&E sections (0/1).

DI:LP/elk
DD: 4/24/08
4/25/2008 6:37 AM

GROSS DESCRIPTION

(A) LEFT INGUINAL SUPERFICIAL LYMPH NODE - Received is a strip of white-tan skin with incision scar (6.0 x 1.1 cm) and underlying soft tissue (8.5 x 3.8 x 3.0 cm). Eight lymph nodes are identified ranging from 0.4 x 0.2 x 0.2 cm to 1.0 x 0.5 x 0.3 cm
SECTION CODE: A1, skin and scar tissue; A2, four lymph nodes; A3, four lymph nodes. PX/amf
(B) LEFT CLOQUET NODE, RULE OUT METASTATIC MELANOMA - A tan possible lymph node (0.9 x 0.3 x 0.3 cm). Serially sectioned and entirely submitted for frozen section in FSB. DO/amf
Frozen section block is submitted for permanent sections. MJ/amf
*FS/DX: LYMPH NODE, NO TUMOR PRESENT. AR/amf

CLINICAL HISTORY

Melanoma.

SNOMED CODES

T-C4810, M-00110

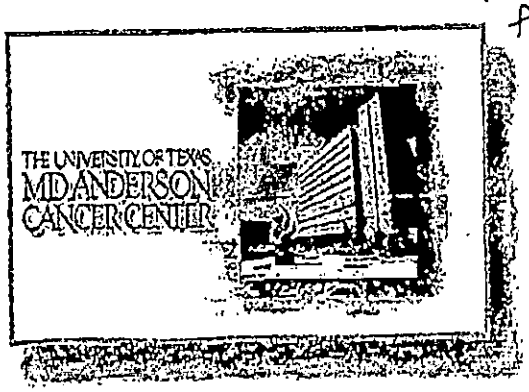
"Some tests reported here may have been developed and performance characteristics determined by UT MD Anderson Pathology and Laboratory Medicine. These tests have not been specifically cleared or approved by the U.S. Food and Drug Administration."
Entire report and diagnosis completed by: Doina Ivan MD Apr 25, 2008

------END OF REPORT------

Division of Pathology and Laboratory Medicine
U.T.M.D. Anderson Cancer Center
1515 Holcombe Boulevard
Houston, Texas 77030

phone 985 624 3470 fax

646 888-2315 Jeanie



- Date Thursday, May 01, 2008
- To Mark Bodin
- Company
- Fax Number 504) 596-2861
- Total Number of Pages (2) Two

Re: Jeffrey Bodin

Lane Read, MPAS, PA-C

Department of Surgical Oncology
1400 Holcombe Blvd, Box 301402, Unit 444
Houston, Texas 77230-1402

Telephone: 713-745-6858
Fax: 713-792-0722

NOTES:

Mr Bodin,

attached is final pathology on Jeffrey's last Surgery. Linda requested that I send this to you.

Lane Read, PA

FAX TRANSMISSION

5/8/2008

Re: BODIN, JEFFREY
Age: 10 Sex: M

1: LEFT INGUINAL SENTINAL LYMPH NODE, LEFT ANKLE, LEFT KNEE, RIGHT FACE, LEFT POPLITEAL, MD ANDERSON CANCER CENTER.
S08-17604 (12 SLIDES) (jb)

Casey,Sherri
Sherri Casey M D
71107 Highway 21, Suite 1
Covington, LA 70433
TEL. 985-871-9418
FAX. 985-893-2580

Dear Dr Casey

Dr. Alan Houghton has asked me to review the slides of Jeffrey Bodin's melanocytic tumor. Unfortunately, so far I have not received the slide of the initial biopsy. What I have been able to review is the re-excision of the melanocytic tumor from the left ankle. It shows a proliferation of plump fusiform melanocytes in nests and intersecting fascicles in the dermis in association with a scar. The lesion shows Spitzoid features, a nevoid growth pattern, but only limited "maturation". A rare mitotic figure is seen. The margins are benign. The left inguinal sentinel lymph node shows small clusters of melanocytes in the lymph node parenchyma and focally within fibrous tissue. These melanocytes are similar in appearance to the primary tumor cells, and need to be considered derivatives thereof.

Descriptively, one may summarize the findings as "atypical Spitzoid melanocytic proliferation with microscopic deposits in one sentinel lymph node". I acknowledge that on the one hand, the constellation of findings is compatible with a diagnosis of "melanoma with sentinel node micro metastasis". However, alternatively, one may also consider an "atypical Spitz nevus/tumor with lymph node involvement" (via mechanical transport) that is different in its biology from (conventional) metastatic melanoma. I believe that Jeffrey's prognosis is likely more favorable than for a child with a "conventional" melanoma. I have seen a number of similar lesions and clinical scenarios which fortunately so far have not been associated with adverse outcome to the patient but these are preliminary and anecdotal data.

Since I did not see the top part of the lesion, I cannot be more definitive at the current time. I would appreciate the opportunity to review the initial biopsy of the lesion, since its features may help diagnostically. In attempt to further classify the primary tumor we have requested additional material to study the tumor for possible chromosomal aberrations. Once results from those studies are available, we will issue a final assessment of the lesion.

Sincerely,

Klaus J Busam, M.D.
Attending Pathologist

MH# S08-18392

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street Covington, Louisiana 70433
Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Patient: BODIN, JEFFREY
Med. Rec. No.: (0000)0000-280719
Account No: 0376424008
DOB: 05/22/1997 *Age/Sex:* 10 YRS M
Physician: HEINTZ, LUDWIG C
Admit Date: 05/13/08 *Loc:* PED
Copy to: HEINTZ, LUDWIG C

Clinical Diagnosis:

Specimen Recd: 05/14/08

SURGICAL PATHOLOGY

Accession: ST-08-02269 Surgery: 05/13/08

SPECIMEN SOURCE:
Appendix

CLINICAL INFORMATION:
Appendicitis

PROCEDURE: Appendectomy

GROSS DESCRIPTION:
Received in formalin is a vermiform appendix 5.5 x 1.0 cm. Attached is a small amount of epiploic fat. The serosa is covered by a thin tan dull fibrinous exudate through which prominent serosal vascular markings are seen. Gross perforation is not seen. Gross discoloration is not seen. The wall measures up to 2 - 3 mm thick. The mucosa is grossly edematous, the lumen is filled with a cheesy green material. Routine sections.

DLF:TTE

DIAGNOSIS:
Appendix coli: Acute suppurative appendicitis.

PATHOLOGIST COMMENT:
P88304

Received
MAY 16 2008
RTE

DLF:DLF:TTE By: Daniel L. Ferguson, M.D.
05/15/08 (Electronic Signature)

cc:

PREPRINTED DISCHARGE EDUCATION

☐ Congestive Heart Failure — Others: ☐
☐ Smoking Cessation — ☐
☐ Post-op — ☐

ACTIVITIES / RESTRICTIONS

☐ Gradual return to previous activities
☐ Rest/relaxation for _____ hours / days
☐ No driving motor vehicles, no operating machinery or making major decisions for 24 hours
☐ Avoid heavy lifting (_____ lbs) for _____ days
☐ Avoid climbing stairs for _____ days
☐ Avoid sexual activity for _____ days/weeks
☐ Avoid tub bath for _____ days/weeks
☐ May shower
☐ Equipment _____ ☐ Instructions given
_____ ☐ Instructions given
☐ Other:

WOUND CARE

☐ Keep incision clean and dry
☐ Keep dressing on and dry
☐ Remove dressing
☐ Ice pack to _____ for _____ hours/days
☐ Elevate _____ for _____ hours/days
☐ Avoid tampon/douching for _____ days/weeks
☐ IV site instructions given
☐ Other:

EMERGENCY

If you experience any serious problems and you are unable to contact your doctor; go to your nearest emergency department for help.

Call your doctor if:

* Fever of 101 or above
* Bright red bloody drainage
* Redness/tenderness at surgical site
* Coughing / vomiting blood
* Excessive nausea and vomiting
* Pain not relieved by medication
* Shortness of breath
* Difficulty urinating
* Chest Pain
* Rectal Bleeding
* Abdominal Pain
* Excessive swelling
* Any questions regarding instructions or medications
* Other:

DIET

☐ No dietary restrictions
☐ Progress to regular diet
☐ Other:
☐ Special diet
☐ Drink plenty of fluids
☐ Instructions given

Questions about your special diet? Call our Dietary Department (985) 898-4063.

FOLLOW-UP

Physician's Name:
☐ Appointment Date:
Physician's Name:
☐ Appointment Date:
☐ Referrals
☐ Community Resources
☐ Physician's phone number:
☐ Call office to schedule
☐ Physician's phone number:
☐ Call office to schedule
☐ Diagnostic studies scheduled

DISPOSITION

Discharged at _____ by Dr. _____ ☐ Home ☐ Against medical advice
☐ Home Health Agency ☐ Discharge Instructions sent to agency
Discharge per ☐ Wheelchair ☐ Stretcher ☐ Arms of adult ☐ Walking with assistance
Accompanied by _____ Transportation: ☐ Private vehicle ☐ Ambulance ☐ Transport Service
Patient / Significant other able to restate instructions ☐ Yes ☐ No If NO, why
Copy of instructions given to: _____ Patient/Significant other signature: _____
Nurse giving instructions: _____ Date: _____ Time: _____

St. Tammany PARISH HOSPITAL
Excellence In Healthcare... Close To Home

INPATIENT DISCHARGE INSTRUCTION SHEET

FORM NO 65855-45703 (Rev 6/04)

BODIN ,JEFFREY MED
280719
M 05/22/1997 10 BC 376424008
HEINTZ, LUDWIG 05/13/08

PATIENT COPY

INPATIENT DISCHARGE INSTRUCTIONS: MEDICATIONS

PRINT ALL INFORMATION					TAKE MEDICATIONS AT THE FOLLOWING TIMES			
NEW RX	HOME MED.	MEDICATION(S)	DOSE	FREQUENCY (PER DAY)	ON AN EMPTY STOMACH	WITH MEALS	AT BEDTIME	REASON ORDERED

PATIENT COPY

St. Tammany PARISH HOSPITAL
World-class healthcare... Close to home

Date: _____

Nurse giving instructions: _____

Patient/Significant other: _____

_____Printed/Verbal Instructions given on medications

BODIN, JEFFREY
M 05/22/1997 10 BC 376424008
HEINTZ, LUDWIG
MED
280719
05/13/08

FORM 45712 (Rev 1/05)

FOR INFORMATION ON FILING A GRIEVANCE OR FOR ANY QUESTIONS ABOUT ANY OF THE RIGHTS LISTED BELOW, CONTACT GUEST SERVICES AT 898-4669 OR THE LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS AT (225) 342-6429.

AS A PATIENT, YOU HAVE THE RIGHT TO:

- **Access care and services** based upon need and according to the Hospital's mission and vision, admission policies, and capability to provide needed services regardless of race, gender, religion, national origin, age, physical ability or financial status.
- **Receive considerate care** that respects psychosocial, spiritual, and cultural values.
- **Wear personal and religious or symbolic items** provided the items do not interfere with medical therapy or diagnostic procedures. Have a family member or representative of your choice and your physician notified of your admission.
- **Receive appropriate pain management** and information about pain relief measures. This includes having health professionals who respond quickly to reports of pain and staff who are committed to pain control.
- **Make informed decisions** about your care and any proposed procedure or treatment. This includes being informed of your health status, being involved in care planning and treatment, and being able to request or refuse treatments. This right is not a mechanism to demand medically unnecessary or inappropriate treatment or services.
- **Have an advance directive** concerning end of life care and treatment, for example a living will, or to designate a surrogate decision-maker with the expectation that Hospital staff and practitioners will honor the intent of the directive(s) to the extent permitted by law and Hospital policy.
- **Know the identity of the physician** who has primary responsibility for your care and the identity and professional status of individuals responsible for authorizing or performing procedures or treatments.
- **Be informed of outcomes of care**, including any unanticipated outcomes, and be informed if the Hospital proposes to engage in investigational, experimental, research or educational activity and have the right to refuse to participate in such activity.
- **Voice complaints or submit a written grievance** about the Hospital's care and services and receive a response to the complaint or grievance. *Submitting a complaint or grievance will not compromise your future access to care.*
- **Participate** in the consideration of the **ethical issues** that may arise in the course of your care.
  Expect personal privacy and be interviewed, examined and treated with reasonable visual and auditory privacy.
- **Receive care in a safe setting;** be free from all forms of abuse, neglect, or harassment; be free from restraints of any form that are not medically necessary; and be free from seclusion and restraints of any form imposed for behavior management unless clinically necessary.
- **Expect confidentiality of health information and clinical records;** have that information provided only to those involved in your care, to those monitoring its quality, or to those otherwise legally authorized to receive such information, and access information contained in your clinical record within a reasonable time frame.
- **Request and receive an itemized explanation of total charges** for services rendered by the Hospital regardless of the source of payment.

YOUR PATIENT RESPONSIBILITIES INCLUDE:

- Providing correct, accurate and complete information about your health.
- Following the treatment plan ordered by your physician, including working with your doctor(s) and nurse(s) to develop a pain management plan, helping measure your pain, and reporting any unrelieved pain.
- Considering the rights of other patients and Hospital personnel.
- Ensuring that the Hospital has a copy of your written advance directive (if you have one).
- Following Hospital rules and regulations that apply to patient conduct.
- Taking responsibility for your actions if you refuse treatment or do not follow instructions given by your physician.
- Making sure that the financial obligations of your health care are met as soon as possible.
- Asking questions when you do not understand what you have been told about your care.
- Contacting your nurse, physician, or other staff member if you perceive any safety risk relating to your environment or care

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Patient Signature: _____ **Date:** _____

Hospital Representative: _____ **Date:** _____

PATIENT RIGHTS AND RESPONSIBILITIES

St. Tammany Parish Hospital

MP100019

BODIN,JEFFREY
376424008 05/13/08 MED
M 05/22/1997 10 C B 280719
HEINTZ,LUDWIG

sleep mask
cat book (backpack)
-? Prozac
change of clothes 4 Jeff
PJ's for Jeff
toothbrush for Jeff

me ← PJ top, underwear, Tylenol PM
makeup stuff

Chest XRAY

Children's Hospital

Patient Name	BODIN,JEFFREY	**Patient ID**	0445573
Birth Date	05/22/1997	**Sex**	M
Age	11 Year	**Exam Status**	APPROVED
Exam Procedure	CHEST - AP & LAT	**Modality**	CR
Study Time	09/15/2008 12:16:24	**Image Count**	2

Diagnostic Report(Radiologists : WARD, KENNETH)

A.P. LATERAL CHEST: There is no focal consolidation or atelectasis. The cardiovascular silhouette and mediastinal structures are within normal limits. The musculoskeletal structures are normal in appearance.
IMPRESSION: Normal chest.

THOMAS NICOTRI, JR., M.D., LLC
DERMATOPATHOLOGY SERVICES
P.O. Box 1713 Mandeville, LA 70470
1305 W Causeway Approach, Ste. 209 Mandeville, LA 70471
Reports/Lab: (504) 361-3757
Billing: (877) 626-0312

Name: Jeffrey Bodin
Address: 528 Beau Chene Drive
Mandeville,LA 70471

Number: N08-12618
Doctor: Dr. Rhonda Baldone
Clinic: Baldone
Clinic Number:
Social Security #:

Date of Biopsy: 12/01/2008
Date Received: 12/02/2008
Date Reported: 12/03/2008
Age: Sex: M
Date of Birth: 05/22/1997

BIOPSY SITE:
L LOWER ABDOMEN, 4 MM PUNCH

PATHOLOGY REPORT

CLINICAL DIAGNOSIS AND HISTORY:
3 mm dark brown papule
Atypical nevus - History of melanoma

GROSS EXAMINATION: Received is a 4 mm punch biopsy of skin extending to a depth of 0.4 cm. Entirely submitted. (fg)

MICROSCOPIC DESCRIPTION:
The skin is slightly elevated. In some areas the rete ridges are elongated. There is an increased number of melanocytes along the basal layer of the epidermis where they are distributed both diffusely and in nests. These nests are located not only at the tips of rete, but also along the sides of rete and between rete ridges. Within the dermis are orderly nests, cords and strands of nevus cells which tend to mature at the deeper aspect of the lesion. The junctional component of this nevus extends some distance lateral to the intradermal component and within this junctional component, occasional melanocytes exhibit cytologic atypia. There is stromal fibroplasia beneath this lateral area of involvement and a mild mononuclear cell infiltrate is present.

DIAGNOSIS:
SKIN, L LOWER ABDOMEN, 4 MM PUNCH
-Compound dysplastic nevus, mild atypia (Clark's nevus). GK KB

Comment: Margins are clear in this plane of section.

Thomas Nicotri, Jr., MD
Thomas Nicotri, Jr., MD

PATIENT INFORMED
DATE: 12-4-08
BY: KB

ST TAMMANY PARISH HOSPITAL
1202 SOUTH TYLER STREET COVINGTON, LA 70433

NAME:	BODIN, JEFFREY	PT PHONE:	985-845-0969
SEX:	M	DATE OF BIRTH:	05/22/1997
LOCATION:		AGE:	11Y
MR#:	28-07-19	DATE OF EXAM:	02/16/2009
PHYSICIAN:	SHERRI CASEY	ORD# / FC:	90002 / B
	71107 Hwy 21 Suite 1	ADM NO:	000377557483
	Covington, LA 70433	PT CLASS / TYPE:	O / P
	(985) 893-2580	ADM DATE:	02/16/2009

Final Report ACCESSION #: 1791895

Clinical History: 172.9 - SKIN MAL MELANOMA NOS

[redacted] metastatic melanoma

RESULT: MRI of the brain

70553

Indication: Headaches, malignant melanoma, rule out metastases

Technique: Sequences performed include axial and sagittal T1 weighted, axial T2 weighted, axial FLAIR, axial proton density, and axial ADC and diffusion weighted images.

Findings:
There is no abnormal enhancement or focal brain parenchymal abnormality evident. Normal enhancement of the pituitary is incidentally noted. Diffusion images demonstrate no acute ischemia. The ventricles and sulci are not enlarged. There is no intracranial hemorrhage, mass or mass effect. The posterior fossa is unremarkable. There is no abnormality of the cerebellum, brainstem or cerebellopontine angles. The sella and optic chiasm are within normal limits. The paranasal sinuses and mastoid air cells are clear.

IMPRESSION:
1. No focal brain parenchymal abnormality or abnormal enhancement

Interpreting Physician: JOSEPH PERDIGAO M.D.
Transcribed by / Date: PSC on Feb 16 2009 3:23P
Approved Electronically by / Date: PERDIGAO M.D., JOSEPH Feb 16 2009 3:23P
Distribution: SHERRI CASEY
SHERRI CASEY

Mar. 16. 2009 11:13AM   No. 7094   P. 1/5

Quest Diagnostics

PATIENT INFORMATION
BODIN,JEFFREY T

REPORT STATUS FAX COPY

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 800.669.6605

DOB: 05/22/1997 AGE: 11
GENDER: M

ORDERING PHYSICIAN
POUW,VICTOR VINCENT

SPECIMEN INFORMATION
SPECIMEN: HU111925F
REQUISITION: 0050069

ID: BODIN,JEFFREY
PHONE: 985.845.0969

CLIENT INFORMATION
L82333   MY99MT12
CHILDREN'S INT'L MED GROUP
1430 LINDBERG DR
SLIDELL, LA 70458-8056

COLLECTED: 03/06/2009 10:11 CT
RECEIVED: 03/06/2009 10:09 CT
REPORTED: 03/13/2009 06:37 CT

COMMENTS: FASTING

Test Name	In Range	Out of Range	Reference Range	Lab
HELICOBACTER PYLORI ANTIBODIES (IGG,IGA,IGM)				
HELICOBACTER PYLORI ANTIBODY (IGG)				E2
H. PYLORI AB IGG	NEGATIVE	Reference Range: NEGATIVE		

H. pylori serology testing measures antibodies to H.pylori and is not recommended for the diagnosis of active infection. The American College of Gastroenterology and the American Gastroenterological Association recommend either the urea breath test (test code #14839X) or the fecal antigen test (test code# 34838X) for diagnosis and confirmation of eradication in cases of suspected or proven Helicobacter pylori infection.

Test Name	In Range	Out of Range	Reference Range	Lab
HELICOBACTER PYLORI ANTIBODY (IGA)				E2
H. PYLORI AB IGA	NEGATIVE	Reference Range: NEGATIVE		
HELICOBACTER PYLORI ANTIBODY (IGM)				E2
H. PYLORI AB IGM	NEGATIVE	Reference Range: NEGATIVE		
FSH/LH, PEDIATRICS				
LH, PEDIATRICS	0.86	Reference Range: < OR = 6.64	mIU/mL	E2

Male Reference Ranges for LH (Luteinizing Hormone), Pediatric:

Males:

3-7 years	< or = 0.26 mIU/mL
8-9 years	< or = 1.40 mIU/mL
10-11 years	< or = 6.64 mIU/mL
12-14 years	0.85-6.87 mIU/mL
15-17 years	0.90-7.82 mIU/mL

Page 1 - Continued on Page 2

03/13/09 06:37 1/1

Quest Diagnostics®

QUEST DIAGNOSTICS INCORPORATED

COLLECTED: 03/06/2009 10:11 CT
REPORTED: 03/13/2009 06:37 CT

PATIENT INFORMATION
BODIN,JEFFREY T

DOB: 05/22/1997 AGE: 11
GENDER: M
ID: BODIN,JEFFREY

REPORT STATUS FAX COPY

ORDERING PHYSICIAN
POUW,VICTOR VINCENT

Test Name	In Range	Out of Range	Reference Range	Lab
18-20 years	0.95-8.44 mIU/mL			
Tanner Stage				
I	< or = 0.50 mIU/mL			
II	< or = 1.73 mIU/mL			
III	0.09-4.09 mIU/mL			
IV-V	0.18-10.43 mIU/mL			
FSH (FOLLICLE STIMULATING HORMONE), PEDIATRICS				EZ
FSH, PEDIATRICS	0.81		mIU/mL	
			Reference Range: EARLY PREPUBERTAL: 0.30-4.00	

Male Pediatric Reference Ranges for FSH:

0-9 years/prepubertal*:	<3.00 mIU/mL
10-13 years/early pubertal:	0.30-4.00 mIU/mL
14-17 years:	0.40-7.40 mIU/mL

*FSH peaks (typically 3.00-6.00 mIU/mL for this assay) in male infants at 4 months of age, falling to prepubertal levels by 1 year of age. (Forest MG, Ducharme JR, Conadotropic and gonadal hormones. Ch8, in: Bertrand et al, eds. Pediatric Endocrinology, 2nd Ed. Baltimore: Williams & Wilkins, 1993).

COMPREHENSIVE METABOLIC PANEL W/EGFR				RGA
GLUCOSE	75		65-99 mg/dL FASTING REFERENCE INTERVAL	
UREA NITROGEN (BUN)	13		7-20 mg/dL	
CREATININE	0.67		0.50-1.30 mg/dL	
PATIENT IS <18 YEARS OLD. UNABLE TO CALCULATE EGFR.				
BUN/CREATININE RATIO	NOT APPLICABLE		6-22 (calc)	
BUN/CREATININE RATIO IS NOT REPORTED WHEN THE BUN AND CREATININE VALUES ARE WITHIN NORMAL LIMITS.				
SODIUM	138		135-146 mmol/L	
POTASSIUM		3.7 L	3.8-5.1 mmol/L	
CHLORIDE	104		98-110 mmol/L	
CARBON DIOXIDE	22		21-33 mmol/L	

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED

PATIENT INFORMATION
BODIN, JEFFREY T

DOB: 05/22/1997 AGE: 11
GENDER: M
ID: BODIN, JEFFREY

REPORT STATUS FAX COPY

ORDERING PHYSICIAN
POUW, VICTOR VINCENT

COLLECTED: 03/06/2009 10:11 CT
REPORTED: 03/13/2009 06:37 CT

Test Name	In Range	Out of Range		Reference Range	Lab
CALCIUM	9.7			8.9-10.4 mg/dL	
PROTEIN, TOTAL	7.4			6.3-8.2 g/dL	
ALBUMIN	5.1			3.6-5.1 g/dL	
GLOBULIN	2.3			2.1-3.5 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO		2.2	H	1.0-2.1 (calc)	
BILIRUBIN, TOTAL	0.3			0.2-1.1 mg/dL	
ALKALINE PHOSPHATASE	126			91-476 U/L	
AST	19			12-32 U/L	
ALT	10			8-30 U/L	
IGF-I	122			ng/mL	EZ

Reference Range:
80-723

Pediatric Male Reference Ranges for IGF-I:

1-7 days	< or = 31 ng/mL
8-14 days	< or = 43 ng/mL
15 days-1 year	25-265 ng/mL
1-2 years	45-222 ng/mL
3-4 years	36-202 ng/mL
5-6 years	32-259 ng/mL
7-8 years	65-278 ng/mL
9-10 years	52-330 ng/mL
11-12 years	80-723 ng/mL
13-14 years	142-855 ng/mL
15-16 years	176-845 ng/mL
17-18 years	152-668 ng/mL

Tanner Stages (7-17 years)	
Tanner I	59-296 ng/mL
Tanner II	56-432 ng/mL
Tanner III	135-778 ng/mL
Tanner IV	230-855 ng/mL
Tanner V	181-789 ng/mL

Test Name	In Range	Out of Range	Reference Range	Lab
TESTOSTERONE, FREE AND TOTAL, LC/MS/MS		PENDING		
IGF BINDING PROTEIN 3 (IGFBP 3)	3.7		mg/L	EZ

Reference Range:
2.4-8.4

Pediatric Reference Ranges (mg/L) for IGF Binding Protein-3 (IGFBP-3):

Age Units

Page 3 - Continued on Page 4

03/13/09 06:37 0255753 3/7

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED

	PATIENT INFORMATION BODIN,JEFFREY T	REPORT STATUS FAX COPY
COLLECTED: 03/06/2009 10:11 CT REPORTED: 03/13/2009 06:37 CT	DOB: 05/22/1997 AGE: 11 GENDER: M ID: BODIN,JEFFREY	ORDERING PHYSICIAN POUW,VICTOR VINCENT

Test Name	In Range	Out of Range	Reference Range	Lab

1-7 days	<0.7
8-15 days	0.5-1.4
16 days-1 year	0.7-3.6
2 years	0.8-3.9
3 years	0.9-4.3
4 years	1.0-4.7
5 years	1.1-5.2
6 years	1.3-5.6
7 years	1.4-6.1
8 years	1.6-6.5
9 years	1.8-7.1
10 years	2.1-7.7
11 years	2.4-8.4
12 years	2.7-8.9
13 years	3.1-9.5
14 years	3.3-10.0
15 years	3.5-10.0
16 years	3.4-9.5
17 years	3.2-8.7

Male Reference Ranges (ng/L) for IGF Binding Protein-3 (IGFBP-3) by Pubertal (Tanner) Stage:

Males

Tanner I	1.4-5.2
Tanner II	2.3-6.3
Tanner III	3.1-8.9
Tanner IV	3.7-8.7
Tanner V	2.6-8.6

Test Name	In Range	Out of Range	Reference Range	Lab
T4, FREE	1.3		0.9-1.4 ng/dL	RGA
TSH, 3RD GENERATION	3.84		0.50-4.30 mIU/L	RGA

HARD COPY TO FOLLOW

PATIENT RESULTS CONTAINED IN A FACSIMILE OR ELECTRONIC MEDICAL REPORT ARE PROVIDED ONLY UPON THE REQUEST OF THE PHYSICIAN OR AUTHORIZED PERSON. FACSIMILE OR ELECTRONIC MEDICAL REPORTS THAT ARE CREATED BEFORE FINAL RESULTS ARE REPORTED ARE CONSIDERED TO BE INTERIM RESULTS ONLY AND ARE SUBJECT TO CHANGE BY THE LABORATORY.

 Page 4 - Continued on Page 5

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED

COLLECTED: 03/06/2009 10:11 CT
REPORTED: 03/13/2009 06:37 CT

PATIENT INFORMATION
BODIN,JEFFREY T

DOB: 05/22/1997 AGE: 11
GENDER: M
ID: BODIN,JEFFREY

REPORT STATUS FAX COPY

ORDERING PHYSICIAN
POUW,VICTOR VINCENT

PERFORMING LABORATORY INFORMATION

E2 QUEST DIAGNOSTICS/SJC, 33608 ORTEGA HWY, SAN JUAN CAPISTRANO, CA 92675
Laboratory Director: R.E. REITZ,MD, CLIA: 05D0643352

RGA QUEST DIAGNOSTICS HOUSTON, 5850 ROGERDALE ROAD, HOUSTON, TX 77072-1602
Laboratory Director: JOHN G BUCK,MD, CLIA: 45D0660150

ST. TAMMANY PARISH HOSPITAL
Covington, Louisiana
Peds: (985) 871-5966

PHYSICIAN'S ORDERS
USE BALL POINT PEN ONLY!

ALLERGIES: NKDA

BSA: 1.06 m².

Height: 53.65" Weight: 30.2kg

BODIN, Jeffrey
DOB. 5/22/'97
M.cell: (985) 264-5277.

DATE & TIME ORDERED 8/3/2009

Admit to Pediatrics at service Dr. Victor Pouw/Naremanelli
for "Growth Hormone Stimulation Test" on:
Dx: Growth Failure (ICD-9. 783.43)
Cond: good
Diet: water only until test is finished,
then regular as tolerated
IV: saline lock for blood sampling

NOTED BY

FAXED

DATE & TIME ORDERED

Meds: Clonidine: 0.15 mg PO x1 } after baseline labs
Glucagon: 1.0 mg IM x1
Zofran 4 mg IV Q4hr PRN nausea/vomiting.
Baseline: Growth Hormone; IGF-1; Accuchek; Insulin
① T=30' = " ; " ; "
② T=60' = " ; " ; "
③ T=90' = " ; " ; " ; Insulin, Cortisol
④ T=120' = " ; " ; "
⑤ T=180' = " ; " ; " ; Cortisol

NOTED BY

FAXED

DATE & TIME ORDERED

Discharge to home at the end of the test if stable
Please notify Dr. Pouw (page: 504/464-2000) if problems.
F/U: Dr. Pouw 3-4 wks after test.

[signature]

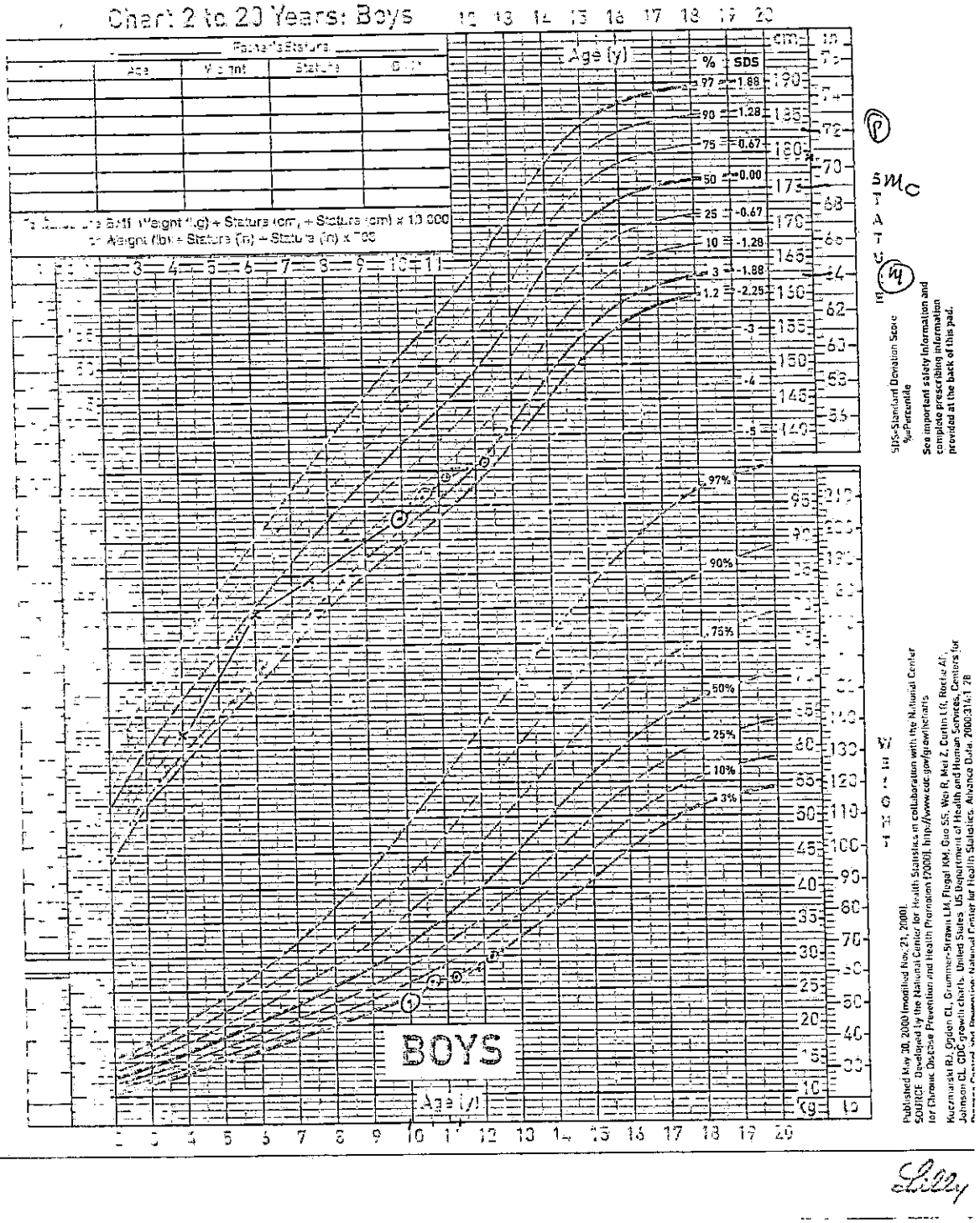
23 hr observation.

NOTED BY

FAXED

Humatrope®
somatropin (rDNA origin)
for injection

Name: Jeffrey Bodin ID#: DOB 5/22/1997



Lilly

FOR INFORMATION ON FILING A GRIEVANCE OR FOR ANY QUESTIONS ABOUT ANY OF THE RIGHTS LISTED BELOW, CONTACT GUEST SERVICES AT 898-4669 OR THE LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS AT (225) 342-6429.

AS A PATIENT, YOU HAVE THE RIGHT TO:

- **Access care and services** based upon need and according to the Hospital's mission and vision, admission policies, and capability to provide needed services regardless of race, gender, religion, national origin, age, physical ability or financial status.
- **Receive considerate care** that respects psychosocial, spiritual, and cultural values.
- **Wear personal and religious or symbolic items** provided the items do not interfere with medical therapy or diagnostic procedures. Have a family member or representative of your choice and your physician notified of your admission.
- **Receive appropriate pain management** and information about pain relief measures. This includes having health professionals who respond quickly to reports of pain and staff who are committed to pain control.
- **Make informed decisions** about your care and any proposed procedure or treatment. This includes being informed of your health status, being involved in care planning and treatment, and being able to request or refuse treatments. This right is not a mechanism to demand medically unnecessary or inappropriate treatment or services.
- **Have an advance directive** concerning end of life care and treatment, for example a living will, or to designate a surrogate decision-maker with the expectation that Hospital staff and practitioners will honor the intent of the directive(s) to the extent permitted by law and Hospital policy.
- **Know the identity of the physician** who has primary responsibility for your care and the identity and professional status of individuals responsible for authorizing or performing procedures or treatments.
- **Be informed of outcomes of care**, including any unanticipated outcomes, and be informed if the Hospital proposes to engage in investigational, experimental, research or educational activity and have the right to refuse to participate in such activity.
- **Voice complaints or submit a written grievance** about the Hospital's care and services and receive a response to the complaint or grievance. *Submitting a complaint or grievance will not compromise your future access to care.*
- **Participate** in the consideration of the **ethical issues** that may arise in the course of your care.
- **Expect personal privacy** and be interviewed, examined and treated with reasonable visual and auditory privacy.
- **Receive care in a safe setting;** be free from all forms of abuse, neglect, or harassment; be free from restraints of any form that are not medically necessary; and be free from seclusion and restraints of any form imposed for behavior management unless clinically necessary.
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- Following the treatment plan ordered by your physician, including working with your doctor(s) and nurse(s) to develop a pain management plan, helping measure your pain, and reporting any unrelieved pain.
- Considering the rights of other patients and Hospital personnel.
- Ensuring that the Hospital has a copy of your written advance directive (if you have one).
- Following Hospital rules and regulations that apply to patient conduct.
- Taking responsibility for your actions if you refuse treatment or do not follow instructions given by your physician.
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- Asking questions when you do not understand what you have been told about your care.
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Patient Signature: _____ **Date:** _____

Hospital Representative: _____ **Date:** _____

PATIENT RIGHTS AND RESPONSIBILITIES

St. Tammany Parish Hospital
Excellence in Healthcare Close To Home

BODIN, JEFFREY
378286843 08/05/09 PED
M 05/22/1997 12 O B 280719
POUW, I.S. VICTOR

MR 00019

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result ["f"] indicates result has comment or value was truncated

Pt. Name: BODIN , JEFFREY
Pt ID: 2008006301
DOB: 05/22/1997
Adm DTime:
Nurs Sta:
Dx:
Alrg:

MRN: 280719
Acct No:
Age/Sex: 12Y/M
Atn Dr:
Rm/Bed:

Laboratory Results — Chemistry

		08/05/09 12:02	08/05/09 11:02	08/05/09 10:32	08/05/09 10:08	08/05/09 09:41	08/05/09 08:50
		0000921700710	0000921700587	0000921700525	0000921700598	0000921700583	0000921700434
Growth Hormone, 0 Minutes	0.03-14.90 ng/mL						0.18 ["f"]
Growth Hormone, 30 Minutes	ng/mL					0.32 ["f"]	
Growth Hormone, 60 Minutes	ng/mL				7.92 ["f"]		
Growth Hormone, 90 Minutes	ng/mL			1.82 ["f"]			
Growth Hormone, 120 Minutes	ng/mL		9.46 ["f"]				
Growth Hormone Minutes	min	180					
Growth Hormone, Other Minutes	ng/mL	2.62 ["f"]					
Insulin-Like Growth Factor 1	106-558 ng/mL	139 ["f"]	138 ["f"]	144 ["f"]	139 ["f"]	152 ["f"]	153 ["f"]
Cortisol, Serum	ug/dL	28.0 ["f"]		9.0 ["f"]			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 12:02	Growth Hormone, Other Minutes	ng/mL

Result: 2.62

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result [*f*] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	**MRN:**	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 12:02	Growth Hormone, Other Minutes	ng/mL

Comment: TEST INFORMATION: Growth Hormone, Other
Growth Hormone Stimulation tests should induce a peak of greater than 7 ng/mL in children and greater than 5 ng/mL in adults; lower values suggest growth hormone deficiency. For children, some experts consider values of 7-10 ng/mL equivocal and only peak values of greater than 10 ng/mL truly normal.
For suppression testing, normal subjects have growth hormone concentrations of less than 1 ng/mL within 2 hours of ingestion of a 75 or 100 gram glucose dose. Patients with acromegaly fail to show normal suppression.

Collected DT	Finding Name	Normal(s)
8/5/09 12:02	Insulin-Like Growth Factor I	108-559 ng/mL

Result: 139

Comment: Tanner Stage Reference Intervals

Tanner Stage	Female	Male
I	70-397 ng/mL	50-278 ng/mL
II	165-665 ng/mL	79-392 ng/mL
III	201-695 ng/mL	119-577 ng/mL
IV-V	160-609 ng/mL	184-580 ng/mL

Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 12:02	Cortisol, Serum	ug/dL

Result: 28.0

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result [*f*] indicates result has comment or value was truncated

Pt. Name: BODIN , JEFFREY
Pt ID: 2008006301
DOB: 05/22/1997
Adm DTime:
Nurs Sta:
Dx:
Alrg:

MRN: 280719
Acct No:
Age/Sex: 12Y/M
Atn Dr:
Rm/Bed:

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 12:02	Cortisol, Serum	ug/dL

Comment: REFERENCE INTERVAL: Cortisol, Serum or Plasma
0800 hrs: 6-23 ug/dL
2000 hrs: 0-9 ug/dL
8 hrs post 1 mg dexamethasone given at midnight: 0-5 ug/dL
30-60 min post 25 units Cosyntropin I.V.: greater than 20 ug/dL
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 11:02	Growth Hormone, 120 Minutes	ng/mL

Result: 9.45

Comment: TEST INFORMATION: Growth Hormone 120 Minutes
Growth Hormone Stimulation tests s hould induce a peak of greater than 7 ng/mL in children and greater than 5 ng/mL in adults; lower values suggest growth hormone deficiency. For children, some experts consider values of 7-10 ng/mL equivocal and only peak values of greater than 10 ng/mL as truly normal.
For suppression testing, normal subjects have growth hormone concentrations of less than 1 ng/mL within 2 hours of ingestion of a 75 or 100 gram glucose dose. Patients with acromegaly fail to show normal suppression.
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 11:02	Insulin-like Growth Factor I	108-558 ng/mL

Result: 139

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result [*f*] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/3/09 11:02	Insulin-Like Growth Factor I	109-558 ng/mL

Comment: Tanner Stage Reference Intervals

Tanner Stage	Female	Male
I	70-397 ng/mL	50-278 ng/mL
II	155-665 ng/mL	79-392 ng/mL
III	201-695 ng/mL	119-577 ng/mL
IV-V	160-609 ng/mL	184-580 ng/mL

Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 10:32	Growth Hormone, 90 Minutes	ng/mL

Result: 1.62

Comment: TEST INFORMATION: Growth Hormone 90 Minutes
Growth Hormone Stimulation tests sh ould induce a peak of greater than 7 ng/mL in children and greater than 5 ng/mL in adults; lower values suggest growth hormone deficiency. For children, some experts consider values of 7-10 ng/mL equivocal and only peak values of greater than 10 ng/mL as truly normal.
For suppression testing, normal subjects have growth hormone concentrations of less than 1 ng/mL within 2 hours of ingestion of a 75 or 100 gram glucose dose. Patients with acromegaly fail to show normal suppression.
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 10:32	Insulin-Like Growth Factor I	109-558 ng/mL

Result: 144

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant M.D.

Laboratory Results Report

Legend: P indicates preliminary result [*f*] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 10:32	Insulin-Like Growth Factor I	106-353 ng/mL

Comment: Tanner Stage Reference Intervals

Tanner Stage	Female	Male
I	70-397 ng/mL	50-278 ng/mL
II	165-665 ng/mL	79-392 ng/mL
III	201-695 ng/mL	119-577 ng/mL
IV-V	160-609 ng/mL	184-580 ng/mL

Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 10:32	Cortisol, Serum	ug/dL

Result: 9.0

Comment: REFERENCE INTERVAL: Cortisol, Serum or Plasma
0800 hrs: 6-23 ug/dL
2000 hrs: 0-9 ug/dL
8 hrs post 1 mg dexamethasone given at midnight:0-5 ug/dL
30-60 min post 25 units Cosyntropin I.V.: greater than 20 ug/dL
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 10:08	Growth Hormone, 60 Minutes	ng/mL

Result: 7.92

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result ["T"] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 10:08	Growth Hormone, 60 Minutes	ng/mL

Comment: TEST INFORMATION: Growth Hormone 60 Minutes
Growth Hormone Stimulation tests sh ould induce a peak of greater than 7 ng/mL in children and greater than 5 ng/mL in adults; lower values suggest growth hormone deficiency. For children, some experts consider values of 7-10 ng/mL equivocal and only peak values of greater than 10 ng/mL as truly normal.
For suppression testing, normal subjects have growth hormone concentrations of less than 1 ng/mL within 2 hours of ingestion of a 75 or 100 gram glucose dose. Patients with acromegaly fail to show normal suppression.
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 10:08	Insulin-Like Growth Factor I	108-558 ng/mL

Result: 139

Comment: Tanner Stage Reference Intervals

Tanner Stage	Female	Male
I	70-397 ng/mL	50-278 ng/mL
II	165-665 ng/mL	79-392 ng/mL
III	201-695 ng/mL	119-577 ng/mL
IV-V	160-609 ng/mL	184-580 ng/mL

Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
9/5/09 9:41	Growth Hormone, 30 Minutes	ng/mL

Result: 0.32

ST. TAMMANY PARISH HOSPITAL
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Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result ["f"] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 9:41	Growth Hormone, 30 Minutes	ng/mL

Comment: TEST INFORMATION: Growth Hormone 30 Minutes
Growth Hormone Stimulation tests sh ould induce a peak of greater than 7 ng/mL in children and greater than 5 ng/mL in adults; lower values suggest growth hormone deficiency. For children, some experts consider values of 7-10 ng/mL equivocal and only peak values of greater than 10 ng/mL as truly normal.
For suppression testing, normal subjects have growth hormone concentrations of less than 1 ng/mL within 2 hours of ingestion of a 75 or 100 gram glucose dose. Patients with acromegaly fail to show normal suppression.
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 9:41	Insulin-Like Growth Factor I	106-858 ng/mL

Result: 180

Comment: Tanner Stage Reference Intervals

Tanner Stage	Female	Male
I	70-397 ng/mL	50-278 ng/mL
II	165-665 ng/mL	79-392 ng/mL
III	201-695 ng/mL	119-577 ng/mL
IV-V	160-609 ng/mL	184-580 ng/mL

Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 8:50	Growth Hormone, 0 Minutes	0.03-14.90 ng/mL

Result: 0.16

ST. TAMMANY PARISH HOSPITAL
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Department of Pathology and Laboratory Services
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Laboratory Results Report

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Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chemistry

Collected DT	Finding Name	Normal(s)
8/5/09 8:50	Growth Hormone, 0 Minutes	0.03-14.90 ng/mL

Comment: TEST INFORMATION: Growth Hormone 0 Minutes
Growth Hormone Stimulation tests sho uld induce a peak of greater than 7 ng/mL in children and greater than 5 ng/mL in adults; lower values suggest growth hormone deficiency. For children, some experts consider values of 7-10 ng/mL equivocal and only peak values of greater than 10 ng/mL as truly normal.
For suppression testing, normal subjects have growth hormone concentrations of less than 1 ng/mL within 2 hours of ingestion of a 75 or 100 gram glucose dose. Patients with acromegaly fail to show normal suppression.
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 8:50	Insulin-Like Growth Factor I	108-558 ng/mL

Result: 153

Comment: Tanner Stage Reference Intervals

Tanner Stage	Female	Male
I	70-397 ng/mL	50-278 ng/mL
II	165-665 ng/mL	79-392 ng/mL
III	201-695 ng/mL	119-577 ng/mL
IV-V	160-509 ng/mL	184-580 ng/mL

Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Laboratory Results — Chem Tox

	08/05/09 10:32	08/05/09 08:50
	0000921700625	0000921700434

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result ["F"] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Laboratory Results — Chem Tox

	[redacted]	08/05/09 10:32	08/05/09 08:50
		0000921700629	0000921700434
Insulin, Fasting	3-19 uIU/mL		5 ["F"]
Insulin, 90 Minutes	26-84 uIU/mL	41 ["F"]	

Comments and Long Results Section

Laboratory Results — Chem Tox

Collected DT	Finding Name	Normal(s)
8/5/09 10:32	Insulin, 90 Minutes	26-84 uIU/mL

Result: 41

Comment: TEST INFORMATION: Insulin 90 Minutes
This assay reacts on a nearly equimolar basis with the analogs insulin aspart, insulin glargine, and insulin lispro. The reference interval is based on a 75 g. glucose challenge.
To convert to pmol/L, multiply uIU/mL by 6.0.
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2767
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

Collected DT	Finding Name	Normal(s)
8/5/09 8:50	Insulin, Fasting	3-19 uIU/mL

Result: 5

ST. TAMMANY PARISH HOSPITAL
1202 S. Tyler Street
Covington, LA 70433

Department of Pathology and Laboratory Services
Medical Director: Dale J. Morvant, M.D.

Laboratory Results Report

Legend: P indicates preliminary result [*f*] indicates result has comment or value was truncated

Pt. Name:	BODIN , JEFFREY	MRN:	280719
Pt ID:	2008006301	Acct No:	
DOB:	05/22/1997	Age/Sex:	12Y/M
Adm DTime:		Atn Dr:	
Nurs Sta:		Rm/Bed:	
Dx:			
Alrg:			

Comments and Long Results Section

Laboratory Results — Chem Tex

Collected DT	Finding Name	Normal(s)
8/5/09 8:50	Insulin, Fasting	3-19 uIU/mL

Comment: TEST INFORMATION: Insulin, Fasting
This assay reacts on a nearly equimolar basis with the analogs insulin aspart, insulin glargine, and insulin lispro.
To convert to pmol/L, multiply uIU/mL by 6.0.
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director

ST. TAMMANY PARISH HOSPITAL

Covington, Louisiana
Peds: (985) 871-5966

PHYSICIAN'S ORDERS

USE BALL POINT PEN ONLY!

ALLERGIES: NKDA

BSA: 1.06 m²

Height: 53.65" Weight: 30.2kg

BODIN, Jeffrey
DOB: 5/22/'97
Mobile: (985) 264-5277

DATE & TIME ORDERED 8/3/2009

1/ Admit to Pediatrics */ service Dr. Vicki Powell / Neuroendocrine
for Growth Hormone Stimulation Test on.
2/ Dx: Growth Failure (ICD-9: 783.43)
3/ Cond: good
4/ Diet: water only until test is finished.
Then regular as tolerated
5/ IV: saline lock for blood sampling.

FAXED

NOTED BY

DATE & TIME ORDERED

6/ Meds: Clonidine: 0.15 mg PO x1 ; after baseline labs
Glucagon: 1.0 mg IM x1
Zofran 4 mg IV Q4hrs PRN nausea/vomiting.
7/ Labs: ① baseline: Growth Hormone; IGF1; Accucheck; Insulin
⑤ T=30' = " ; " ; "
③ T=60' = " ; " ; "
④ T=90' = " ; " ; " ; Insulin; Cortisol
⑤ T=120' = " ; " ; "
⑥ T=180' = " ; " ; " ; Cortisol

FAXED 8/3/09

FAXED

NOTED BY

DATE & TIME ORDERED

8/ May discharge home at the end of the test if stable
9/ Please notify Dr. Powell (page: 504/464-2000) if problems.
10/ F/U: Dr. Powell 3-4 wks after test.

Attn: Holly McNeese, RN
Melinda Cox, RNP

*/ 23hrs observation.

FAXED

NOTED BY

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED CLIENT SERVICE 800.669.6605	PATIENT INFORMATION BODIN,JEFFREY T DOB: 05/22/1997 AGE: 11 GENDER: M	REPORT STATUS FINAL REPRINT ORDERING PHYSICIAN POUW,VICTOR VINCENT
SPECIMEN INFORMATION SPECIMEN: HU111925F REQUISITION: 0050069	ID: BODIN,JEFFREY PHONE: 985.845.0969	CLIENT INFORMATION L82333 MT99MT12 CHILDREN'S INT'L MED GROUP 1430 LINDBERG DR SLIDELL, LA 70458-8056
COLLECTED: 03/06/2009 10:11 CT RECEIVED: 03/06/2009 10:09 CT REPORTED: 03/17/2009 06:53 CT		

COMMENTS: FASTING

Test Name	In Range	Out of Range	Reference Range	Lab
HELICOBACTER PYLORI ANTIBODIES (IGG,IGA,IGM)				
HELICOBACTER PYLORI ANTIBODY (IGG)				EZ
H. PYLORI AB IGG	NEGATIVE	Reference Range: NEGATIVE		

H. pylori serology testing measures antibodies to H.pylori and is not recommended for the diagnosis of active infection. The American College of Gastroenterology and the American Gastroenterological Association recommend either the urea breath test (test code #14839X) or the fecal antigen test (test code# 34838X) for diagnosis and confirmation of eradication in cases of suspected or proven Helicobacter pylori infection.

Test Name	In Range	Out of Range	Reference Range	Lab
HELICOBACTER PYLORI ANTIBODY (IGA)				EZ
H. PYLORI AB IGA	NEGATIVE	Reference Range: NEGATIVE		
HELICOBACTER PYLORI ANTIBODY (IGM)				EZ.
H. PYLORI AB IGM	NEGATIVE	Reference Range: NEGATIVE		
FSH/LH, PEDIATRICS				
LH, PEDIATRICS	0.86	Reference Range: < OR = 6.64	mIU/mL	EZ

Male Reference Ranges for LH (Luteinizing Hormone), Pediatric:

Males:

5-7 years	< or = 0.26 mIU/mL
8-9 years	< or = 1.40 mIU/mL
10-11 years	< or = 6.64 mIU/mL
12-14 years	0.85-6.87 mIU/mL
15-17 years	0.90-7.82 mIU/mL

Page 1 - Continued on Page 2

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED

COLLECTED: 03/06/2009 10:11 CT REPORTED: 03/17/2009 06:53 CT	PATIENT INFORMATION BODIN,JEFFREY T DOB: 05/22/1997 AGE: 11 GENDER: M ID: BODIN,JEFFREY	REPORT STATUS FINAL REPRINT ORDERING PHYSICIAN POUW,VICTOR VINCENT

Test Name	In Range	Out of Range	Reference Range	Lab
18-20 years	0.95-8.44 mIU/mL			
Tanner Stage				
I	< or = 0.50 mIU/mL			
II	< or = 1.73 mIU/mL			
III	0.09-4.09 mIU/mL			
IV-V	0.18-10.43 mIU/mL			
FSH (FOLLICLE STIMULATING HORMONE), PEDIATRICS				EZ
FSH, PEDIATRICS	0.81		mIU/mL Reference Range: EARLY PREPUBERTAL: 0.30-4.00	

Male Pediatric Reference Ranges for FSH:

0-9 years/prepubertal*:	<3.00 mIU/mL
10-13 years/early pubertal:	0.30-4.00 mIU/mL
14-17 years:	0.40-7.40 mIU/mL

*FSH peaks (typically 3.00-6.00 mIU/mL for this assay) in male infants at 4 months of age, falling to prepubertal levels by 1 year of age. (Forest MG, Ducharme JR, Gonadotropic and gonadal hormones. Ch8, in: Bertrand et al, eds. Pediatric Endocrinology, 2nd Ed. Baltimore: Williams & Wilkins, 1993).

Test Name	In Range	Out of Range	Reference Range	Lab
COMPREHENSIVE METABOLIC PANEL W/EGFR				RGA
GLUCOSE	75		65-99 mg/dL FASTING REFERENCE INTERVAL	
UREA NITROGEN (BUN)	13		7-20 mg/dL	
CREATININE	0.67		0.50-1.30 mg/dL	
PATIENT IS <18 YEARS OLD. UNABLE TO CALCULATE EGFR.				
BUN/CREATININE RATIO	NOT APPLICABLE		6-22 (calc)	
BUN/CREATININE RATIO IS NOT REPORTED WHEN THE BUN AND CREATININE VALUES ARE WITHIN NORMAL LIMITS.				
SODIUM	138		135-146 mmol/L	
POTASSIUM		3.7 L	3.8-5.1 mmol/L	
CHLORIDE	104		98-110 mmol/L	
CARBON DIOXIDE	22		21-33 mmol/L	

 Page 2 - Continued on Page 3

03/18/09 13:25 #2257546 2/4

Quest Diagnostics®

QUEST DIAGNOSTICS INCORPORATED

COLLECTED: 03/06/2009 10:11 CT
REPORTED: 03/17/2009 06:53 CT

PATIENT INFORMATION
BODIN,JEFFREY T

DOB: 05/22/1997 AGE: 11
GENDER: M
ID: BODIN,JEFFREY

REPORT STATUS FINAL REPRINT

ORDERING PHYSICIAN
POUW,VICTOR VINCENT

Test Name	In Range	Out of Range	Reference Range	Lab
CALCIUM	9.7		8.9-10.4 mg/dL	
PROTEIN, TOTAL	7.4		6.3-8.2 g/dL	
ALBUMIN	5.1		3.6-5.1 g/dL	
GLOBULIN	2.3		2.1-3.5 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO		2.2 H	1.0-2.1 (calc)	
BILIRUBIN, TOTAL	0.3		0.2-1.1 mg/dL	
ALKALINE PHOSPHATASE	126		91-476 U/L	
AST	19		12-32 U/L	
ALT	10		8-30 U/L	
IGF-I	122		ng/mL	EZ

Reference Range:
80-723

Pediatric Male Reference Ranges for IGF-I:

1-7 days	< or = 31 ng/mL
8-14 days	< or = 43 ng/mL
15 days-1 year	25-265 ng/mL
1-2 years	45-222 ng/mL
3-4 years	36-202 ng/mL
5-6 years	32-259 ng/mL
7-8 years	65-278 ng/mL
9-10 years	52-330 ng/mL
11-12 years	80-723 ng/mL
13-14 years	142-855 ng/mL
15-16 years	176-845 ng/mL
17-18 years	152-668 ng/mL

Tanner Stages (7-17 years)	
Tanner I	59-296 ng/mL
Tanner II	56-432 ng/mL
Tanner III	135-778 ng/mL
Tanner IV	230-855 ng/mL
Tanner V	181-789 ng/mL

TESTOSTERONE, FREE AND TOTAL, LC/MS/MS				EZ
TESTOSTERONE, TOTAL	3		ng/dL	

Reference Range:
260 OR LESS

RESULTS CONFIRMED BY REPEAT ANALYSIS.
Pediatric Reference Ranges for Testosterone, Total (Women and Children), LC/MS/MS (ng/dL):

Quest Diagnostics®

QUEST DIAGNOSTICS INCORPORATED

COLLECTED: 03/06/2009 10:11 CT
REPORTED: 03/17/2009 06:53 CT

PATIENT INFORMATION
BODIN,JEFFREY T

DOB: 05/22/1997 AGE: 11
GENDER: M
ID: BODIN,JEFFREY

REPORT STATUS FINAL REPRINT

ORDERING PHYSICIAN
POUW,VICTOR VINCENT

Test Name	In Range	Out of Range	Reference Range	Lab
Age	Males			
**Cord Blood:	17-61			
**1-10 days:	187 or less			
**1-3 months:	72-344			
**3-5 months:	201 or less			
**5-7 months:	59 or less			
**7-12 months:	16 or less			
1-5.9 years:	5 or less			
6-7.9 years:	25 or less			
8-10.9 years:	42 or less			
11-11.9 years:	260 or less			
12-13.9 years:	420 or less			
14-17.9 years:	1000 or less			

**Data from J Clin Invest 1974;53:819-828 and J Clin Endocrinol Metab 1973;36:1132-1142.

Pediatric Reference Ranges by Pubertal Stage for Testosterone, Total (Women and Children), LC/MS/MS (ng/dL):

Tanner Stage	Males
Stage I	5 or less
Stage II	167 or less
Stage III	21-719
Stage IV	25-912
Stage V	110-975

Total Testosterone was measured by LCMSMS. The LCMSMS method correlates well with our extraction/RIA method.

% FREE TESTOSTERONE	1.11		%	
			Reference Range: 0.53-3.33	

Pediatric Male Reference Ranges for Testosterone, Free-LCMSMS-Percent:

5-9.9 years	0.44-1.78
10-13.9 years	0.53-3.33
14-17.9 years	1.05-2.91

TESTOSTERONE, FREE	0.3	L	pg/mL	
			Reference Range: 0.7-52.0	

Pediatric Male Reference Ranges for Testosterone, Free-LCMSMS (pg/mL):

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED

COLLECTED: 03/06/2009 10:11 CT
REPORTED: 03/17/2009 06:53 CT

PATIENT INFORMATION
BODIN,JEFFREY T

DOB: 05/22/1997 AGE: 11
GENDER: M
ID: BODIN,JEFFREY

REPORT STATUS FINAL REPRINT

ORDERING PHYSICIAN
POUW,VICTOR VINCENT

Test Name	In Range	Out of Range	Reference Range	Lab
5-9.9 years	5.3 or less			
10-13.9 years	0.7-52.0			
14-17.9 years	18.0-111.0			
IGF BINDING PROTEIN 3 (IGFBP 3)	3.7		ng/L Reference Range: 2.4-8.4	EZ

Pediatric Reference Ranges (ng/L) for IGF Binding Protein-3 (IGFBP-3):

Age	Units
1-7 days	<0.7
8-15 days	0.5-1.4
16 days-1 year	0.7-3.6
2 years	0.8-3.9
3 years	0.9-4.3
4 years	1.0-4.7
5 years	1.1-5.2
6 years	1.3-5.6
7 years	1.4-6.1
8 years	1.6-6.5
9 years	1.8-7.1
10 years	2.1-7.7
11 years	2.4-8.4
12 years	2.7-8.9
13 years	3.1-9.5
14 years	3.3-10.0
15 years	3.5-10.0
16 years	3.4-9.5
17 years	3.2-8.7

Male Reference Ranges (ng/L) for IGF Binding Protein-3 (IGFBP-3) by Pubertal (Tanner) Stage:

Males

Tanner I	1.4-5.2
Tanner II	2.3-6.3
Tanner III	3.1-8.9
Tanner IV	3.7-8.7
Tanner V	2.6-8.6

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED

PATIENT INFORMATION
BODIN,JEFFREY T

DOB: 05/22/1997 AGE: 11
GENDER: M
ID: BODIN,JEFFREY

REPORT STATUS FINAL REPRINT

ORDERING PHYSICIAN
POUW,VICTOR VINCENT

COLLECTED: 03/06/2009 10:11 CT
REPORTED: 03/17/2009 06:53 CT

Test Name	In Range	Out of Range	Reference Range	Lab
T4, FREE	1.3		0.9-1.4 ng/dL	RGA
TSH, 3RD GENERATION	3.84		0.50-4.30 mIU/L	RGA

HARD COPY TO FOLLOW

PERFORMING LABORATORY INFORMATION
EZ QUEST DIAGNOSTICS/SJC, 33608 ORTEGA HWY, SAN JUAN CAPISTRANO, CA 92675
Laboratory Director: R.E. REITZ,MD, CLIA: 05D0643352

RGA QUEST DIAGNOSTICS HOUSTON, 5850 ROGERDALE ROAD, HOUSTON, TX 77072-1602
Laboratory Director: JOHN G BUCK,MD, CLIA: 45D0660150

Quest Diagnostics

PATIENT INFORMATION
BODIN,JEFFREY T

REPORT STATUS FINAL REPRINT

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 800.669.6605

DOB: 05/22/1997 AGE: 11
GENDER: M

ORDERING PHYSICIAN
POUW,VICTOR VINCENT

SPECIMEN INFORMATION
SPECIMEN: HU111925F
REQUISITION: 0050069

ID: BODIN,JEFFREY
PHONE: 985.845.0969

CLIENT INFORMATION
L82333 MT99MT12
CHILDREN'S INT'L MED GROUP
1430 LINDBERG DR
SLIDELL, LA 70458-8056

COLLECTED: 03/06/2009 10:11 CT
RECEIVED: 03/06/2009 10:09 CT
REPORTED: 03/17/2009 06:53 CT

COMMENTS: FASTING

Test Name	In Range	Out of Range	Reference Range	Lab
TEST AUTHORIZATION				RGA
TEST NAME:	HPYLORI ABS IGG/IGM/IGA			
TEST CODE:	20325			
CLIENT CONTACT:	STEFANIE D			

THE LABORATORY TESTING ON THIS PATIENT WAS VERBALLY REQUESTED OR CONFIRMED BY THE ORDERING PHYSICIAN OR HIS OR HER AUTHORIZED REPRESENTATIVE AFTER CONTACT WITH AN EMPLOYEE OF QUEST DIAGNOSTICS. FEDERAL REGULATIONS REQUIRE THAT WE MAINTAIN ON FILE WRITTEN AUTHORIZATION FOR ALL LABORATORY TESTING. ACCORDINGLY WE ARE ASKING THAT THE ORDERING PHYSICIAN OR HIS OR HER AUTHORIZED REPRESENTATIVE SIGN A COPY OF THIS REPORT AND PROMPTLY RETURN IT TO THE CLIENT SERVICE REPRESENTATIVE.

SIGNATURE:______________________________

* Reference footnote 1

PERFORMING LABORATORY INFORMATION
RGA QUEST DIAGNOSTICS HOUSTON, 5850 ROGERDALE ROAD, HOUSTON, TX 77072-1602
Laboratory Director: JOHN G BUCK,MD, CLIA: 45D0660150

Footnote 1
PLEASE FAX THIS SIGNED PAGE TO 713-877-7829 OR
RETURN IT VIA YOUR QUEST DIAGNOSTICS COURIER.

03/18/09 13:25

8·20·09

Lakeview Regional Medical Ctr.
95 EAST FAIRWAY DR.
COVINGTON, LA 70433

PHONE #: (985)867-4050
FAX #: (985)867-4051

Name: BODIN,JEFFREY
Phys: Pouw, In-Sian Victor V. MD
DOB: 05/22/1997 Age: 11 Sex: M
Acct: F00017205253 Loc: F.RAD
Exam Date: 03/04/2009 Status: REG CLI
Radiology No:
Unit No: F0000723116

EXAMS:
000634976 BONE AGE

CPT:
77072

Bone age

History: Growth failure

Findings:
Single AP radiograph of the left hand demonstrates a bone age which corresponds to a standard male of 11 years 6 months.

** Electronically Signed by M.D. MICHAEL HALL on 03/04/2009 at 1305 **
Reported and signed by: MICHAEL HALL, M.D.

Own: 11yr/age.

CC. Pouw, In-Sian Victor V. MD

Dictated Date/Time: 03/04/2009 (1304)
Technologist: LMM RT; UNKNOWN TECHNOLOGIST
Transcribed Date/Time: 03/04/2009 (1305)
Transcriptionist: RAD.VR
Electronic Signature Date/Time: 03/04/2009 (1305)
Orig Print D/T: S 03/04/2009 (1306)
BATCH NO: N/A

71107 Highway 21, Suite 1
Covington, LA 70433
Phone: (985)893-2580
Fax: (985)871-9418

CHILDREN'S MEDICAL CENTER
William L. Terral, M.D.
William C. Terral, M.D.
Sherri B. Casey, M.D.
John E. Williams, M.D.
Kristen Frentz Konney, FNP

Attn

To: Linda & Mark Bodin From: Dr Casey

Fax: (504) 596-2861 Pages: 4 (including cover)

Phone: Date: 9/2/09

Re: CC:

Jeffery Bodin DOB 5/22/97

Stool Results

SEP-02-2009 12:45 From:CHILDRENS MEDICAL 9858719418 To:504 5962861 P.2/4

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 800.669.6605

SPECIMEN INFORMATION
SPECIMEN: HU800247H
REQUISITION: 3645304

COLLECTED: 08/24/2009
RECEIVED: 08/24/2009 19:13 CT
REPORTED: 08/27/2009 11:51 CT

PATIENT INFORMATION
BODIN,JEFFERY

DOB: 05/22/1997 AGE: 12
GENDER: M FASTING: U

ID:
PHONE: 504.596.2826

REPORT STATUS FINAL

ORDERING PHYSICIAN
CASEY,SHERRI B

CLIENT INFORMATION
L34857 MT03MT03
CHILDRENS MEDICAL CENTER___FAX
71107 HIGHWAY 21
COVINGTON, LA 70433-7151

Test Name	In Range	Out of Range	Reference Range	Lab

==============================

CULTURE, CAMPYLOBACTER — NO

MICRO NUMBER: 90437739
TEST STATUS: FINAL
SPECIMEN SOURCE: STOOL
SPECIMEN COMMENTS: ADEQUATE
RESULT: NO ENTERIC CAMPYLOBACTER ISOLATED

==============================

CULTURE, SALMONELLA AND SHIGELLA — NO

MICRO NUMBER: 90437740
TEST STATUS: FINAL
SPECIMEN SOURCE: STOOL
SPECIMEN COMMENTS: ADEQUATE
RESULT: NO SALMONELLA OR SHIGELLA ISOLATED

PERFORMING LABORATORY INFORMATION
NO QUEST DIAGNOSTICS-NEW ORLEANS, 4648 I 10 SERVICE RD, METAIRIE, LA 70001
Laboratory Director: CAROL W SARTIN, CLIA: 19D0648716

called
l/m
8/27/09

BODIN,JEFFERY - HU800247H

Page 1 - End of Report

08/27/09 11:51

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 800.669.6605

SPECIMEN INFORMATION
SPECIMEN: HU881034H
REQUISITION: 3645320

COLLECTED: 08/25/2009
RECEIVED: 08/26/2009 03:27 CT
REPORTED: 08/26/2009 23:00 CT

PATIENT INFORMATION
BODIN, JEFFREY

DOB: 05/22/1997 AGE: 12
GENDER: M FASTING: U

ID:
PHONE:

REPORT STATUS FINAL

ORDERING PHYSICIAN
CASEY, SHERRI B

CLIENT INFORMATION
L34857 MT03MT03
CHILDRENS MEDICAL CENTER___FAX
71107 HIGHWAY 21
COVINGTON, LA 70433-7151

Test Name	In Range	Out of Range	Reference Range	Lab

==============================

OVA AND PARASITES, STOOL CONC AND PERM SMEAR RGA

MICRO NUMBER: 90442435
TEST STATUS: FINAL
SPECIMEN SOURCE: STOOL
SPECIMEN COMMENTS: ADEQUATE
CONCENTRATION 1: NO OVA OR PARASITES SEEN
TRICHROME 1: NO OVA OR PARASITES SEEN

PERFORMING LABORATORY INFORMATION
RGA QUEST DIAGNOSTICS HOUSTON, 5850 ROGERDALE ROAD, HOUSTON, TX 77072-1602
Laboratory Director: JOHN G BUCK, MD, CLIA: 4500660150

SEP-02-2009 12:46 From:CHILDRENS MEDICAL 9858719418 To:504 5962861 P.4/4

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 800.669.6605

PATIENT INFORMATION
BODIN,JEFFREY

DOB: 05/22/1997 AGE: 12
GENDER: M FASTING: U

ID:
PHONE: 504.596.2826

REPORT STATUS FINAL

ORDERING PHYSICIAN
CASEY,SHERRI B

CLIENT INFORMATION
L34857 MT03MT03
CHILDRENS MEDICAL CENTER__FAX
71107 HIGHWAY 21
COVINGTON, LA 70433-7151

SPECIMEN INFORMATION
SPECIMEN: HU856251H
REQUISITION: 4080868

COLLECTED: 08/24/2009
RECEIVED: 08/25/2009 02:37 CT
REPORTED: 08/25/2009 23:03 CT

Test Name	In Range	Out of Range	Reference Range	Lab

============================

GIARDIA AG, EIA, STOOL				RGA

MICRO NUMBER: 90439558
TEST STATUS: FINAL
SPECIMEN SOURCE: STOOL
SPECIMEN COMMENTS: ADEQUATE
RESULT 1: NOT DETECTED

PERFORMING LABORATORY INFORMATION
RGA QUEST DIAGNOSTICS HOUSTON, 5850 ROGERDALE ROAD, HOUSTON, TX 77072-1602
Laboratory Director: JOHN G BUCK,MD, CLIA: 45D0660150

Rec 8/26/09

BODIN,JEFFREY - HU856251H

Page 1 - End of Report

09/25/09 23 03 ... 1/1

Bodin Copy

744652
BODIN, JEFFREY

M.D. Anderson Cancer Center
DIAGNOSTIC IMAGING CONSULTATION

PATIENT: BODIN, JEFFREY
PATIENT CLASS: WMSB — PATIENT TYPE: O
DOB: 05/22/1997 — RM#: -
CITY/ST/COUNTRY: MANDEVILLE, LA UNITED STATES — LOCATION: 712
REQUESTING M.D.: MERRICK I. ROSS — ORDER NO: 90013
EXAMINATION: CT THORAX W/CONTRAST, on 09/16/2009

Comment [bd1]: BEGIN RESULT:
Comment [COMMENT2]: ACCESSION: (7939497)

FULL RESULT:
Examination: CT Thorax with contrast 09/16/2009.

Clinical History: Melanoma, restaging.

Comparison: 11/03/2009 and previous.

Technique: Contrast-enhanced images of the thorax at 2.5 mm intervals with sagittal and coronal reconstructions.

Findings: Normal-appearing thymic tissue is present in the anterior mediastinum. There is a stable 8 x 9 mm right hilar node. Several subcentimeter left axillary nodes, none enlarged by size criteria, are minimally larger compared with 03/11/2009. There is a stable minimal linear scar in the right middle lobe on image 79 of series 3. No pulmonary nodule is seen and there is no pleural effusion. There is no osseous lesion. A 4 mm subcutaneous nodule in the left chest wall is unchanged from prior studies dating back to 04/21/2008.

IMPRESSION:
No finding for pulmonary metastases. Multiple subcentimeter left axillary nodes, a few of which have increased in modestly in size since 03/11/2009.

Read by: NANCY FITZGERALD,M.D. on 09/17/2009 08:38
SIGNED BY: NANCY FITZGERALD,M.D. on 09/17/2009 14:38

Comment [COMMENT3]: READING DR: (011744) READING DATE: (09/17/2009 08:38) REVIEWING DR: () RELEASE RESULTS: (Y) CPT MODIFIER: (\) END VIEW:

D: 09/17/2009 08:38 T: 09/17/2009 08:50

Comment [COMMENT4]: END RESULT:

DIAGNOSTIC RADIOLOGY — CT THORAX W/CONTRAST

744652
BODIN, JEFFREY

M.D. Anderson Cancer Center
DIAGNOSTIC IMAGING CONSULTATION

PATIENT: **BODIN, JEFFREY**
PATIENT CLASS: WMSB — PATIENT TYPE: O
DOB: 05/22/1997 — RM#: -
CITY/ST/COUNTRY: MANDEVILLE, LA UNITED STATES — LOCATION: 712
REQUESTING M.D.: MERRICK I. ROSS — ORDER NO: 90013
EXAMINATION: **CT THORAX W/CONTRAST, on 09/16/2009**

DIAGNOSTIC RADIOLOGY

CT THORAX W/CONTRAST

744652
BODIN, JEFFREY

M.D. Anderson Cancer Center
DIAGNOSTIC IMAGING CONSULTATION

PATIENT:	BODIN, JEFFREY		
PATIENT CLASS:	WMSB	PATIENT TYPE:	O
DOB:	05/22/1997	RM#:	-
CITY/ST/COUNTRY:	MANDEVILLE, LA UNITED STATES	LOCATION:	712
REQUESTING M.D.:	MERRICK I. ROSS	ORDER NO:	90013
EXAMINATION:	CT, ABDOMEN W/CONTRAST, on 09/16/2009		

FULL RESULT:
Examination: CT of the Abdomen and Pelvis 09/16/2009

Clinical History: Malignant melanoma of the left ankle, left inguinal sentinel lymph node metastasis, post superficial femoral and suprainguinal lymph node dissection with rotational of sartorius flap on 04/23/2008.

Comparison: 03/11/2009 and previous.

Technique: Images of the abdomen and pelvis following oral and intravenous contrast at 2.5 mm intervals.

Findings: There is no new CT finding among the surgical staples and muscle flap of the left inguinal region. The largest lower left external iliac node on image 97 of series 4 measuring 6 x 13 mm has not progressed from prior studies. There is no retroperitoneal adenopathy.

The liver, gallbladder, pancreas, spleen, adrenal glands and kidneys are normal. There is no bladder wall thickening or pelvic ascites. Bowel loops are normal. Clustered small mesenteric nodes, the largest 13 x 7 mm in the ileocolic distribution, are a common finding for age. There is no osseous lesion.

IMPRESSION:
No finding for local recurrence or metastases.

Read by: NANCY FITZGERALD,M.D. on 09/17/2009 08:30
SIGNED BY: NANCY FITZGERALD,M.D. on 09/17/2009 14:38

D: 09/17/2009 08:30 T: 09/17/2009 08:41

744652
BODIN, JEFFREY

M.D. Anderson Cancer Center
DIAGNOSTIC IMAGING CONSULTATION

PATIENT: BODIN, JEFFREY
PATIENT CLASS: WMSB — PATIENT TYPE: O
DOB: 05/22/1997 — RM#: -
CITY/ST/COUNTRY: MANDEVILLE, LA UNITED STATES — LOCATION: 712
REQUESTING M.D.: MERRICK I. ROSS — ORDER NO: 90014
EXAMINATION: MRI BRAIN W&W/O CONTRAST, on 09/16/2009

Comment [bd1]: BEGIN RESULT.
Comment [COMMENT2]: ACCESSION: (7940349)

FULL RESULT:

Examination: Pre and Postcontrast MRI Scan of the Brain

Clinical History: Melanoma. Rule out metastasis to the brain.

Findings: There is no evidence of metastasis to the brain. The lateral ventricles are of normal size. There is no shift of midline structures.

Orbits, skull base and craniocervical junction appear normal.

IMPRESSION:

The study again demonstrates no evidence of metastasis to the brain, finding unchanged from 11/25/2008 MRI study.

Read by: A.J. KUMAR,M.D. on 09/16/2009 12:59
SIGNED BY: A.J. KUMAR,M.D. on 09/16/2009 15:55

Comment [COMMENT3]: READING DR: (000097) READING DATE: (09/16/2009 12:59) REVIEWING DR: () RELEASE RESULTS: (Y) CPT MODIFIER: (\) END VIEW:

D: 09/16/2009 12:59 T: 09/16/2009 13:07

Comment [COMMENT4]: END RESULT

DIAGNOSTIC RADIOLOGY — MRI BRAIN W&W/O CONTRAST

CHILDREN'S HOSPITAL

COMPREHENSIVE DISCHARGE SUMMARY

5500181549F 10/15/09 08:00
BODIN ,JEFFREY
05/22/1997 M 0445573 J 23H
BROWN RAYNORDA F. 000588

Admit Date: 10/15/09 Discharge Date: 10/16/09 Time: 1356

Status: ☒ Stable ☐ Other (explain) EGD

Vital Signs: T: 95.5 P: 119 R: 20 B/P: 110/70 Diagnosis: (Esophagogastroduodenoscopy)&colonoscopy

Activity: ☐ No Restrictions ☐ Other Light activity today with plenty of rest. Closely supervise activities today.

Pain: ☒ No ☐ Yes: Score (0-5) 0 Location: _____ Onset: _____ Duration: _____

HOME MEDICATIONS Name	Dose	Schedule	Time Last Dose Given	Home Instructions Given By	Prescriptions Given By
Resume Home Meds					
Carafate	800mg	2 times a day for 2 weeks	none	mb	mb
Zantac	100mg	2 times a day for 1 month	none	mb	mb

Discharge medications reconciled with Current Medication List(A3) and Medication Administration Record.

Diet: ☒ Oral ☐ Nasogastric Tube ☐ Gastrostomy Tube Bland foods today, avoid greasy, spicy or acidic foods.

Other Instructions (i.e. wound care, equipment, etc.)

Sore throat is normal for 24-48 hours. Call for temp over 101.5 any other problems.
Call GI office at (504) 896-9752 in 7 – 10 days for test results. Call for any questions or concerns.
Call for any bleeding from mouth or rectum, difficulty breathing, fever >101.5, or pain. Nausea or vomiting that does not improve x1

FOLLOW-UP

Name: Physician	Appointment Made: Date/Time	Call for Appointment: Phone No.	Reason
Dr. Brown	(504) 896-9534		
Call office as soon as possible to schedule an appointment to see Dr. Brown as instructed.			

Mode of Discharge: ☐ Ambulatory ☒ Wheelchair ☐ Stretcher ☐ Carried ☐ Other _____

☒ Copy of form to guardian ☐ Other Facility: _____

☒ FAX to Primary Care Physician Dr. Sherri Casey

☐ FAX to Home Health Agency _____

PARENT/GUARDIAN STATEMENT

I understand the above information.

Parent/Guardian Signature: Rhonda Bodin Relationship: mother

IN CASE OF PROBLEMS CALL Dr. Brown AT (PHONE NO.) (504) 896-9534

Form Distribution:
White-MR Chart
Canary-Patient/Parent

Children's Hospital (504) 899-9511
Short Stay Unit (504) 896-9803

Nurse Signature: MBeard RN

33-75015-9-D1
MR #312
10/1071 Revised
2NCR 1 PDF

1:30 - 15%

PLAN OF CARE **D1**

CHILDREN'S HOSPITAL

PATIENTS' RIGHTS AND RESPONSIBILITIES

5500181549 J F 0445573
BODIN ,JEFFREY 05/22/1997 M
BROWN RAYNORDA F. 000588 10/15/09 23H
08:00

YOUR RIGHTS:

1. Non-discriminatory treatment regardless of race, creed, sex, disability or national origin.
2. The right to give or refuse consent for certain medical and/or surgical procedures and treatments for your child within the limits of state law.
3. The right to appropriate assessment and management of pain.
4. The authority to seek appropriate care for your child, including additional consultations and second opinions.
5. Information concerning your child's condition that is current and easy to understand, and the right to know who each of your child's caregivers are.
6. Respect and dignity from all members of the hospital staff, as well as confidentiality and privacy concerning your child's care.
7. Access to religious counsel of your choice.
8. The right, if medically stable, to be transferred to another facility upon request after you have obtained an accepting physician at the other facility.
9. Clear discharge plans and instructions.
10. The right to formulate advance directives relative to your child's treatment and to have hospital personnel and practitioners who provide care in the hospital comply with those directives.
11. The right to be free from restraints and seclusion of any form used as a means of coercion, disciplinary convenience or retaliation by staff.
12. The right to receive care in a safe setting.

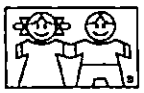
YOUR RESPONSIBILITIES:

1. To be available when medical staff needs to talk about your child's care and make important decisions.
2. To tell us how we can reach you when not at the hospital. Please leave a telephone number with your nurse.
3. To ask questions concerning your child's care.
4. To follow all hospital rules including:
   - Respect hospital and other patient's property.
   - Remain quiet.
   - Obey visiting hours.
   - Smoke only in designated areas.
   - Strictly obey the hospital's overnight policy.
5. To provide your own transportation to and from the hospital.
6. To obtain your own meals.
7. To pay the hospital bill if insurance or medical coverage is not applicable.

The Ethics Committee is an advisory committee which serves as a resource to deal with ethical questions related to health care and/or interprofessional relationships. All members of the hospital community including the patient and his/her family have access to the committee. To access the committee, call Social Services at extension 4367.

Children's Hospital is committed to providing quality healthcare. If you have a complaint or suggestion, please ask for the Department Director in the area where the problem occurred. Presenting a complaint will not adversely affect your child's care.

You may contact the Joint Commission on Accreditation of Healthcare Organizations by calling (800) 994-6610, or by fax at (630) 792-5636.



CHILDREN'S
HOSPITAL

Care Instructions

200 Henry Clay Avenue • New Orleans, Louisiana 70118 • 504/899-9511 • 1-800-299-9511 • www.chnola.org

SHORT STAY UNIT GUIDELINES

SMOKING

1. Because smoking is an acknowledged fire and health hazard, all patient care areas are non-smoking areas. Smoking is only permitted outside of the hospital. Smoking in bathrooms in NOT permitted.

SAFETY

2. It is of utmost importance that the side rails on cribs or beds are up at all times, unless you are in physical contact with your child. The bed should remain in the lowest position. This is important whether your child is awake or asleep.

3. If your child is less three years of age, he/she will be placed in a crib.

4. If parents must leave the hospital, it is recommended that you obtain someone to be with your child. If this in not possible, PLEASE NOTIFY YOUR NURSE that your are leaving, when you plan to return, and where you can be reached if needed. Do NOT leave prior to signing all consents - verify with your nurse that all consents have been properly signed. Whenever your leave the child's bedside, the side rails must all be up and the bed must be in the lowest position.

5. Do not allow any person that cannot be identified as a Children's Hospital employee to remove your child from your presence.

6. The hospital has identified certain factors that make your child at risk for abduction. These include unattended children, children being followed by the office of community services, custody issues and victims of violence. Please take the following precautions to prevent abductions. Notify your child's nurse before leaving him/her unattended. If your child has been identified at risk for abduction, do not allow him/her to leave the unit or your presence unless accompanied by a staff member.

DIET

7. Most of our patients may not have anything to eat or drink prior to their procedure. Ask your nurse for specific feeding instructions for your child.

8. After the procedure, dietary intake is limited. Please check with your nurse prior to allowing your child to eat or drink anything.

MEDICATIONS

9. If you have brought any medications from home, please give them to your nurse. Please do not administer any home medications to your child while in the hospital.

VISITATION

10. Visitation hours are from 6:00 a.m. until 6:00 p.m. Siblings of patients may visit but must be accompanied and supervised by an adult. We strongly discourage infants from visiting, as they are susceptible to catching infections. Only parents of patients or siblings over 18 years of age may stay overnight. Two parents may stay overnight in a private room and one parent in a semi-private room.

NED [03.04] Revised
CV184 - TF White Bond(DS)

GENERAL INFORMATION

11. If a room has an isolation sign on the door, please ask the nurse for instructions before entering. If your child has been placed in isolation, please ask visitors to check with the nurse for instructions before entering.

12. The call light is located in your room on the bed rails or by your hand held remote. To call for your nurse, please press the button with a picture of a nurse, the word nurse, or the letter N. Also located on this panel is the button for the television set. By continuing to press this button, the TV will come on, change channels, and click off.

13. The EMERGENCY LIGHT is located in the bathroom on the wall by the toilet. To activate, pull the cord.

14. If your child is connected to any type of monitor or equipment and it alarms, please call your nurse. Do NOT attempt to fix it yourself.

15. If you need to discuss a problem, please speak to your nurse, the change nurse, or the nurse manager on the unit so that the problem is addressed and corrected.

Thank you for your cooperation in helping us to make your child's stay as safe and comfortable as possible.

CHILDREN'S
HOSPITAL

Outpatient Safety at Children's Hospital

Our goal is to make your visit to Children's Hospital as comfortable as possible and pleasant as possible. Your child's safety is very important to us. We consider you a part of your child's health care team, and you can assist us in providing a safe environment for your child. If you have any questions or concerns, please let your child's nurse or physician know.

Actively participate in your child's health care plan:

- Speak up if you have concerns.
- Make sure you and your child understand the health care team's answers (it's OK to ask questions and expect answers you can understand).
- Talk to your physician about your child's health, and get as much information as you can about your child's illness, prescribed medications and/or treatments.
- When you receive written instructions from your physician or other health care provider be sure that you completely understand the instructions before leaving the hospital.
- Bring a friend or relative with you if this will help you ask questions and understand the answers.
- Ask your physician or nurse how you will receive test results.

Know your child's medications:

- Keep a list of your child's medications, and carry the list with you. Make sure to include Tylenol, ibuprofen, vitamins and herbals.
- Tell your physician, nurse and pharmacist about the medications your child is taking.
- Always carry an up-to-date list of your child's immunizations with you.
- Let your physician know if your child has any food, drug, tape or latex allergies.
- Read all medication labels, including warnings. Make sure the medication is what the physician prescribed and you know how and when to give it to your child.
- If the medications look different than expected, ask a member of the health care team.

If your child receives sedation:

- Before your child receives sedation medication, notify your physician or nurse if your child has a history of heart, kidney, liver and/or lung problems, including reactive airway diseases, asthma and bronchitis.
- Children receiving sedation may experience the effects of the medication for 12 to 24 hours. Your child may have impaired judgment and coordination. Please protect your child from falls, sharp objects or other potentially hazardous situations.
- Your child may be held securely or he or she may remain in bed with all bedrails on cribs or beds up. Keep the bed in the lowest position with the brakes secured. Ask a member of your child's health care team for assistance if necessary.
- Do not allow your child to walk around.
- Your child may have feeding restrictions. Check with your nurse regarding feeding instructions.
- Please notify a member of your child's health care team immediately if you have any questions or concerns.

Children's Hospital Laboratory
200 Henry Clay Avenue New Orleans, LA 70118
504-896-9489
Medical Director : Dr. Randall Craver

PID # - 0445573
GODIN,JEFFREY
Home Phone :
Gender : M DOB : 05/22/1997 Age : 12 Y
Physician :

PATHOLOGY

Surgical Pathology

Ord Phys : Raynorda F Brown
Collect Date/Time : 10/15/2009 10:27

FINAL DIAGNOSIS

S09-2134
#1 Duodenal biopsy: Moderate eosinophilia, lymphoid hyperplasia.
#2 Gastric antrum biopsy: Minimal chronic gastritis, mild eosinophilia, diffuse.
#3 Gastric body: Normal.
#4 Esophageal biopsy: Normal.
#5 Terminal ileum: Lymphoid hyperplasia, marked eosinophilia.
#6 Cecum/ascending colon: Marked eosinophilia, lymphoid hyperplasia.
#7 Transverse colon: Moderate eosinophilia, lymphoid hyperplasia.
#8 Sigmoid colon: Mild eosinophilia, lymphoid hyperplasia.
#9 Rectum: Lymphoid hyperplasia.
I.A.

Electronically Signed Out
10/10/15/2009 Randall D. Craver, M.D. - Pathologist

CLINICAL HISTORY

12 year old male, history of malignant melanoma with abdominal pain, taking Motrin.

SPECIMEN(S) RECEIVED
1. Duodenum, biopsy x7
2. Antrum, biopsy x2
3. Gastric body, biopsy x6
4. Esophagus, biopsy x2
5. Colon, biopsy terminal ileum x8
6. Cecum/ascend. bx x4
7. transverse Colon, biopsy x2
8. Sigmoid colon, biopsy x2
9. Rectum, biopsy x4

GROSS DESCRIPTION

Continued on next page

Children's Hospital Laboratory
200 Henry Clay Avenue New Orleans, LA 70118
504-896-9469
Medical Director : Dr. Randall Craver

PID # - 0445573
BODIN,JEFFREY
Home Phone :
Gender : M DOB : 05/22/1997 Age : 12 Y
Physician :

Continued from prior page: **Surgical Pathology**

Received in a container labeled with the patient' s name and:
#1
' Duodenum,' specimen consists of seven tan mucosal biopsies that range in size from 0.2 x 0.1 x 0.1 cm to 0.6 x 0.2 x 0.1 cm, entirely submitted in two cassettes.
#2
' Antrum,' specimen consists of two tan mucosal biopsies that measure 0.2 x 0.2 x 0.1 cm and 0.3 x 0.2 x 0.1 cm, entirely submitted in one cassette.
#3
' Gastric body,' specimen consists of three tan mucosal biopsies that range in size from 0.4 x 0.2 x 0.1 cm to 0.5 x 0.2 x 0.1 cm, entirely submitted in one cassette.
#4
' Esophagus,' specimen consists of two tan mucosal biopsies that each measure 0.4 x 0.2 x 0.1 cm, entirely submitted in one cassette.
#5
' Terminal ileum,' specimen consists of six tan mucosal biopsies that range in size from 0.2 x 0.2 x 0.1 cm to 0.6 x 0.2 x 0.1 cm, entirely submitted in two cassettes.
#6
' Cecum/ascending,' specimen consists of three tan mucosal biopsies range in size from 0.4 x 0.2 x 0.1 cm to 0.6 x 0.2 x 0.1 cm, entirely submitted in one cassette.
#7
' Transverse,' specimen consists of two tan mucosal biopsies that measure 0.3 x 0.2 x 0.1 cm and 0.7 x 0.2 x 0.1 cm, entirely submitted in one cassette.
#8
' Sigmoid,' specimen consists of two tan mucosal biopsies that measure 0.3 x 0.2 x 0.1 cm and 0.5 x 0.2 x 0.1 cm, entirely submitted in one cassette.
#9
' Rectum,' specimen consists of four tan mucosal biopsies that range in size from 0.1 x 0.1 x 0.1 cm and 0.6 x 0.3 x 0.1 cm, entirely submitted in one cassette.
CWN

Randall D. Craver, M.D. - Pathologist

MICROSCOPIC DESCRIPTION
#1
Specimen labeled duodenum consists of duodenal mucosa. The overall architecture

Continued on next page

Children's Hospital Laboratory
200 Henry Clay Avenue New Orleans, LA 70118
504-896-9489
Medical Director : Dr. Randall Craver

PID # - 0445573
BODIN,JEFFREY
Home Phone :
Gender : M DOB : 05/22/1997 Age 12 Y
Physician :

Continued from prior page: **Surgical Pathology**

is intact with long, thin, delicate villi and a villus crypt ratio of 3:1 Superficial epithelium is intact with a normal brush border and a normal complement of intraepithelial lymphocytes. The glands are normal. The lamina propria contains a normal complement of lymphocytes and plasma cells and up to 55 eosinophils per high powered field. No granulomata, telangiectasias, parasites, or metaplasia are identified. There are hyperplastic lymphoid aggregates complete with germinal centers.

#2
Specimen labeled gastric antrum consists of non-oxyntic gastric mucosa. The overall architecture is intact. Superficial epithelium is intact with no curved bacillary organisms identified. Helicobacter pylori immunostain is negative. Controls stain appropriately. Glands are normal. The lamina propria contains only a minimal number of lymphocytes superficially with up to 15 eosinophils per high powered field, diffusely distributed.

#3
Specimen labeled gastric body consists of oxyntic gastric mucosa. The overall architecture is intact. Superficial epithelium is intact. Glands contain chief and parietal cells. The lamina propria contains a normal.

#4
Specimen labeled esophagus consists of strips of non-keratinizing stratified squamous epithelium. Basal cells are limited to the basal layer. Subepithelial papillae rise halfway to the surface. There is no increased number of intraepithelial eosinophils or neutrophils.

#5
Specimen labeled consists of small intestinal mucosa biopsies. The overall architecture in some are distorted due to the hyperplastic lymphoid aggregates complete with germinal centers. Others are normal with a villus crypt ratio of 3:1. Villi outside the lymphoid aggregates are long, thin and delicate. Superficial epithelium is intact. Glands contain lymphocytic infiltrates, especially around the lymphoid aggregates. The lamina propria contains a normal complement of lymphocytes and plasma cells with an irregular distribution of eosinophils, numbering up to 120 per high powered field. No granulomata are identified.

#6 - 9
Specimens labeled cecum, transverse, sigmoid, and rectum consists of colonic mucosa. The overall architecture is intact. Superficial epithelium is intact.

Continued on next page

Children's Hospital Laboratory
200 Henry Clay Avenue New Orleans, LA 70118
504-896-9489
Medical Director Dr. Randall Craver

PID # - 0445573
BODIN,JEFFREY
Home Phone :
Gender : M DOB 05/22/1997 Age : 12 Y
Physician

Continued from prior page: **Surgical Pathology**

Glands contain a normal goblet cells, abut the muscularis mucosa, and show no abnormal branching or inflammatory infiltrates. The lamina propria contains a normal complement of lymphocytes and plasma cells, hyperplastic lymphoid aggregates complete with germinal centers, and up to 65, 40, 20, and 15 eosinophils per high powered field. No granulomata are identified.

No melanoma is encountered in any section or slide.
PREVIOUS REPORTS:
No previous reports in computer file.

End of Pathology report

PHONE CALL
FOR Carie / CFB DATE 11/5/9 TIME 10:00 A.M. P.M.
M Linda Bodin
OF Jeffrey Bodin
PHONE AREA CODE 985-264-5277 NUMBER EXTENSION
MESSAGE Path Report from Colonoscopy - Can you fax to 504. 596 2861
SIGNED
PHONED
RETURNED YOUR CALL
PLEASE CALL
WILL CALL AGAIN
CAME TO SEE YOU
WANTS TO SEE YOU
FORM 4003

Last Page

fax # for Morales
504 896 9758

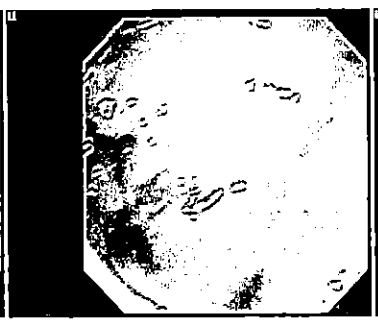
Was attached to back of Surgical Pathology
Report, by Dr. Brown. 10/15/08
Last page. Back of last page.
Dr. Morales's fax # circa 08.

Children's Hospital of New Orleans

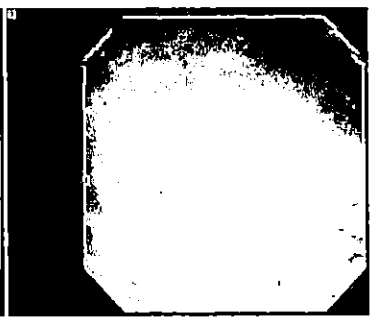
Colonoscopy Exam Images

Patient:	Jeffrey Bodin	**Attending Physician:**	Raynorda Brown M.D.
Patient ID:	MRN-0445573	**Referring Physician:**	
Exam Date:	10/15/2009		

perianal area, normal

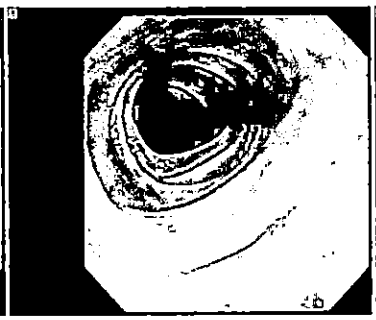


2-Normal-anus

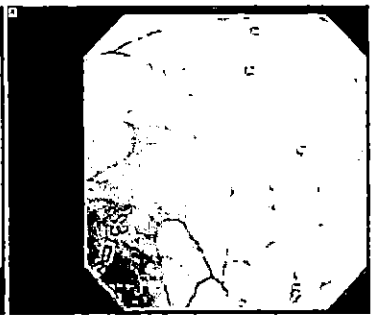


3-Normal-rectum

4-Normal-rectosigmoid junction



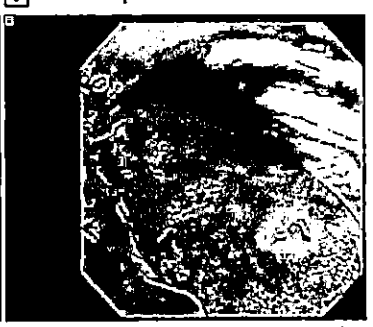
5-Normal-descending colon



6-Normal-hepatic flexure

7-Normal-proximal ascending colon

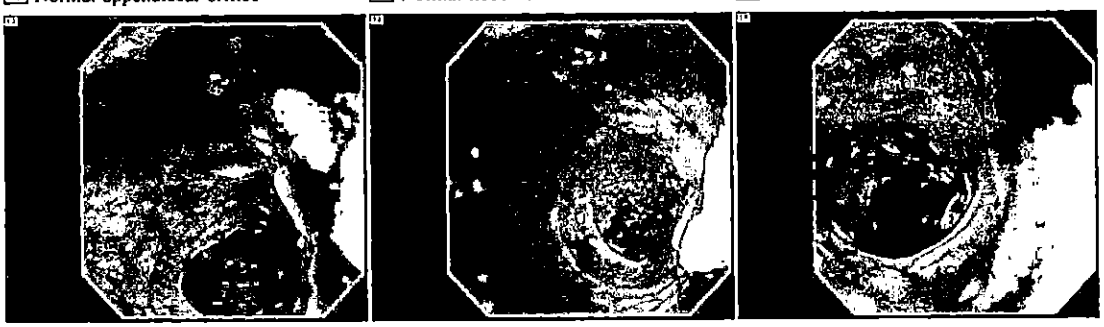
8-Normal-ileocecal valve



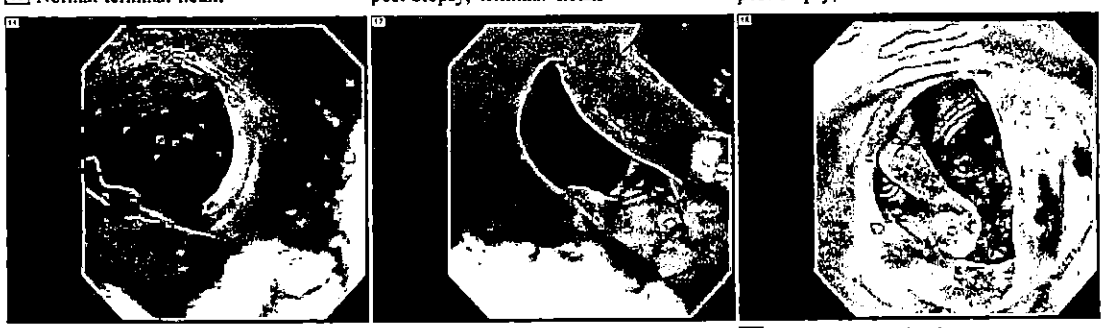
9-Normal-cecum

MRN-0445573 Patient Name: Bodin, Jeffrey

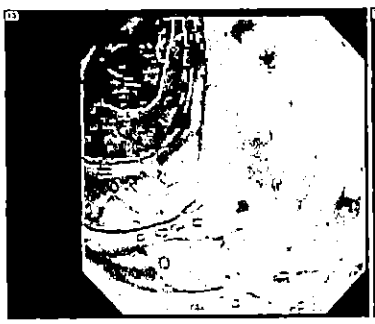
10-Normal-appendiceal orifice | 11-Normal-ileocecal valve | 12-Normal-terminal ileum



13-Normal-terminal ileum | post biopsy, terminal ileum | post biopsy, terminal ileum

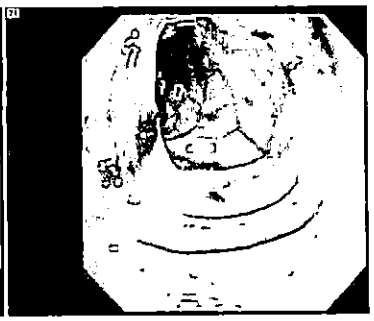


16-Normal-terminal ileum | 17-Normal-ileocecal valve | 18-Normal-ileocecal valve

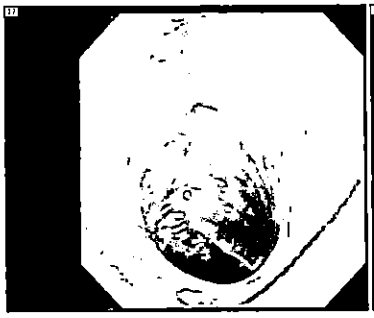


19-Normal-mid-ascending colon

20-Normal-proximal ascending colon



21-Normal-hepatic flexure

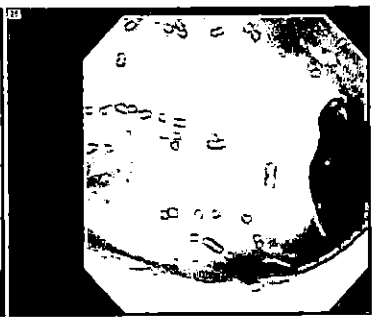


22-Normal-distal transverse colon

23-Normal-proximal descending colon

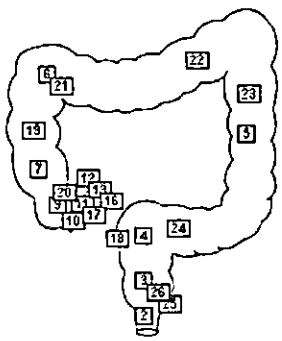
24-Normal-mid-sigmoid

25-Normal-rectum



26erythematous mucosa-colon-rectum

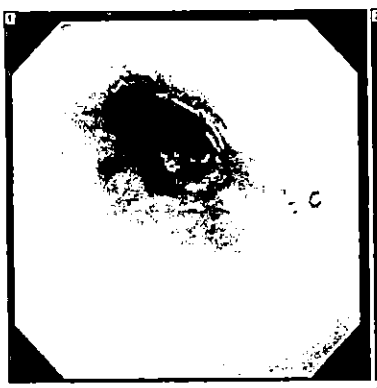
MRN-0445573 Patient Name: Bodin, Jeffrey



Children's Hospital of New Orleans

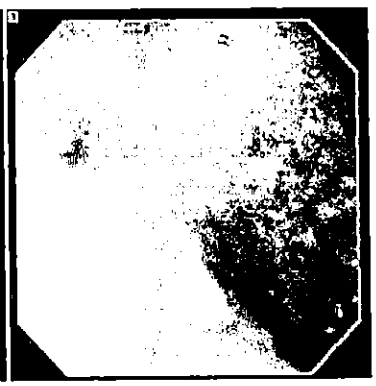
Esophagogastroduodenoscopy Exam Images

Patient:	Jeffrey Bodin	**Attending Physician:**	Raynorda Brown M.D.
Patient ID:	MRN-0445573	**Referring Physician:**	
Exam Date:	10/15/2009		

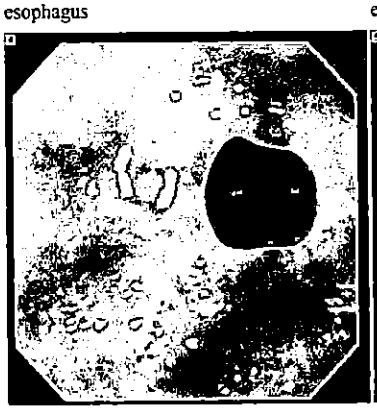


1 normal-esophagus-middle third of the esophagus

2 normal-esophagus-distal third of the esophagus

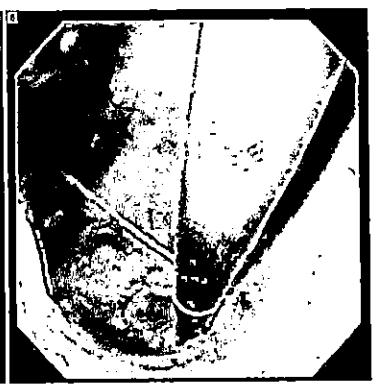


3 erosion-stomach-anterior wall of the antrum



erythematous mucosa-pylorus

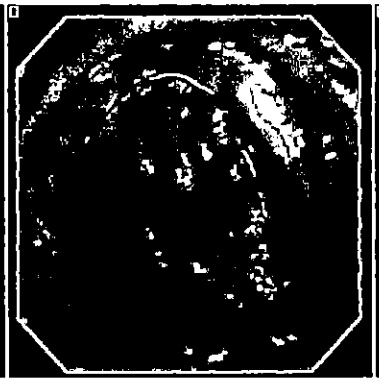
5 normal-stomach-cardia



6 erythematous mucosa-stomach-fundus

MRN-0445573 Patient Name: Bodin, Jeffrey

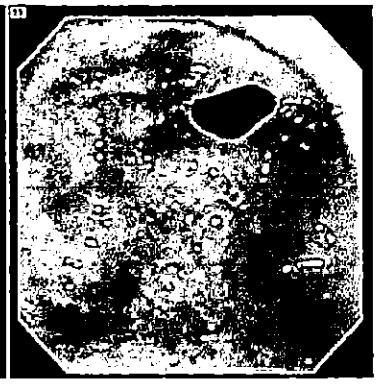
7 normal-duodenum-2nd portion of the duodenum



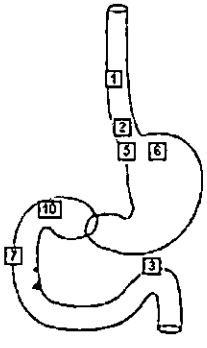
normal-duodenum-3rd portion of the duodenum

post biopsy, duodenum

10-distal bulb



erythematous mucosa-pylorus



Children's Hospital

Patient Name	BODIN,JEFFREY	**Patient ID**	0445573
Birth Date	05/22/1997	**Sex**	M
Age	12 Year	**Exam Status**	APPROVED
Exam Procedure	CHEST - AP & LAT	**Modality**	DX
Study Time	12/17/2009 11:30:08	**Image Count**	2

Diagnostic Report(Radiologists : ARCEMENT, CHRIS)

CHEST AP AND LAT :

Lungs are symmetrically aerated and are clear. Heart size and pulmonary vascularity are within normal limits. Aortic arch is left-sided. No bony abnormalities are present.

IMPRESSION: NORMAL CHEST

Ross

THOMAS NICOTRI, JR., M.D., LLC
DERMATOPATHOLOGY SERVICES
P.O. Box 1713 Mandeville, LA 70470
1305 W Causeway Approach, Ste. 209 Mandeville, LA 70471
Reports/Lab: (504) 361-3757
Billing: (877) 626-0312

Name: Jeffrey Bodin
Address: 528 Beau Chene Drive
Mandeville,LA 70471

Number: N10-0515
Doctor: Dr. Rhonda Baldone
Clinic: Baldone
Clinic Number:
Social Security #:

Date of Biopsy: 01/14/2010
Date Received: 01/15/2010
Date Reported: 01/22/2010
Age: Sex: M
Date of Birth: 05/22/1997

BIOPSY SITE:
L ANKLE, PUNCH

PATHOLOGY REPORT

CLINICAL DIAGNOSIS AND HISTORY:
Nevus near melanoma scar

GROSS EXAMINATION:Received is a 3 mm punch biopsy of skin extending to a depth of .4 cm. Entirely submitted. jr

MICROSCOPIC DESCRIPTION:
Many deeper sections were performed. There is a small but somewhat haphazard melanocytic proliferation of single unit and nested melanocytic cells in the epidermis with occasional upward migration of single unit cells above the basal layer of the epidermis. There are melanophages. HMB45 was done which labels the junctional melanocytic proliferation of single unit and nests in the lower epidermis with rare extension of cells above the basal layer. The positive control is positive; negative control, negative.

DIAGNOSIS:
SKIN, L ANKLE, PUNCH
-Atypical junctional nevus with moderate to severe architectureal atypia.

Comment: No convincing evidence of extension to the margins in these planes of section. Case reviewed by Dr. Alun Wang.

Thomas Nicotri, Jr., MD
Thomas Nicotri, Jr., MD

mother
PATIENT INFORMED
DATE: 1-28-10
BY: KB

ICD9(s): 216.9
CPT(s): 88305

Jeffrey Bodin
N10-0515

Date generated: 01/22/2010

THOMAS NICOTRI, JR., M.D., LLC
DERMATOPATHOLOGY SERVICES
P.O. Box 1713 Mandeville, LA 70470
1305 W Causeway Approach, Ste. 209 Mandeville, LA 70471
Reports/Lab: (504) 361-3757
Billing: (877) 626-0312

Name: Jeffrey Bodin
Address: 528 Beau Chene Drive
Mandeville,LA 70471

Number: N10-0990
Doctor: Dr. Rhonda Baldone
Clinic: Baldone
Clinic Number:
Social Security #:

Date of Biopsy: 01/28/2010
Date Received: 01/28/2010
Date Reported: 02/02/2010
Age: Sex: M
Date of Birth: 05/22/1997

BIOPSY SITE:
L INNER KNEE, PUNCH

PATHOLOGY REPORT

CLINICAL DIAGNOSIS AND HISTORY:
Nevus - R/O Atypia

GROSS EXAMINATION:Received is a 0.3 cm punch biopsy of skin extending to a depth of 0.4 cm. Entirely submitted.

MICROSCOPIC DESCRIPTION:
Histologic sections of skin show slight elongation of some of the rete. Along the basal layer are increased numbers of melanocytes which are arranged both singly and in small nests at the tips of some of the rete.

DIAGNOSIS:
SKIN, L INNER KNEE, PUNCH
-Melanocytic nevus, junctional type. OK RB

Thomas Nicotri, Jr., MD
Thomas Nicotri, Jr., MD

PATIENT INFORMED
DATE:_____
BY:_____

2-3-10
Lmom

ICD9(s): 216.9
CPT(s): 88305

Jeffrey Bodin
N10-0990

Date generated: 02/02/2010

THOMAS NICOTRI, JR., M.D., LLC
DERMATOPATHOLOGY SERVICES
P.O. Box 1713 Mandeville, LA 70470
1305 W Causeway Approach, Ste. 209 Mandeville, LA 70471
Reports/Lab: (504) 361-3757
Billing: (877) 626-0312

Name: Jeffrey Bodin
Address: 528 Beau Chene Drive
Mandeville,LA 70471

Number: N11-8967
Doctor: Dr. Rhonda Baldone
Clinic: Baldone
Clinic Number:
Social Security #:

Date of Biopsy: 08/25/2011
Date Received: 08/26/2011
Date Reported: 08/30/2011
Age: Sex: M
Date of Birth: 05/22/1997

BIOPSY SITE:
L GREAT TOE, SHAVE

PATHOLOGY REPORT

CLINICAL DIAGNOSIS AND HISTORY:
5 mm brown macule in a patient with history of MM
Nevus; R/O atypia

GROSS EXAMINATION: Received is a 0.7 cm shave biopsy of skin containing a 0.5 cm hyperpigmented irregular macule. Trisected and entirely submitted.

MICROSCOPIC DESCRIPTION:
There are nests of melanocytes in the epidermis. There is focal increased single unit melanocytes with an occasional cell above the basal layer of the epidermis. There is a rare mitotic figure present within a junctional nest of melanocytes.

DIAGNOSIS:
SKIN, L GREAT TOE, SHAVE
-Junctional nevus, mild architectural disorder on acral skin extending to the base of the specimen. See note.

NOTE: I would favor conservative re-excision of this lesion. The proliferation extends to the base of the specimen. Recurrence of this lesion would likely pose a histologic dilemma.

schedule excision

Thomas Nicotri, Jr., MD
Thomas Nicotri, Jr., MD

Lmom

PATIENT INFORMED
DATE: 9/6/11
BY: mandy

exc 9/7/11

CPT(s):

Jeffrey Bodin
N11-8967

Date generated: 08/30/2011

BALDONE·REINA
DERMATOLOGY
THE SKIN HEALTH CENTER

Rhonda R. Baldone, M.D.
Board Certified Dermatologist
Rachel S. Reina, M.D.
Board Certified Dermatologist

AFTER SURGERY CARE

1. The bandage on your surgical site can be removed 24 hours after your surgery. The wound should then be cleaned with hydrogen peroxide, Vaseline and covered with a bandage.
2. Clean wound with hydrogen peroxide once a day, and then apply the vaseline. Use Q-tips when cleaning. Remove all crust or scab formation. The ointment keeps the wound moist.
3. If you experience pain, take Tylenol or Acetaminophen Extra Strength. Do not take aspirin or ibuprofen because it increases the chance of bleeding.
4. If the site bleeds, apply continuous firm pressure for 20 minutes without peeking, timing the minutes with a clock. This will stop most bleeding. If it does not, apply continuous firm pressure with an ice pack. Once again, use a clock to time the 20 minutes. If there is bleeding still after 2 attempts then call the office.
5. Water can run over the surgical excision but do not soak the incision site because it will cause the stitches to pull out and allow bacteria to get in the wound. You should not swim or take baths.
6. If your incision is on your face or neck, avoid bending over. This may cause bleeding in the first 48 hours after surgery. The first night after surgery sleep with your head up on several pillows and avoid sleeping on the side of the surgical incision.
7. Dr. Baldone/Dr. Reina would like to remove your sutures. During your suture appointment the doctor will explain the pathology report. The sutures will be removed from 5 to 14 days after surgery, depending on the site.
8. If the lesion removed was malignant, (skin cancer), periodic exams are recommended at 3 months, 6 months, then yearly.
9. Rest with minimal exertion and activity is recommended for the first 24 hours after your surgery. Remember the better you care for yourself and your surgery wound, the better it will heal.
10. Leave ice on for 20 minutes every hour for 4 hours.

IN CASE OF AN EMERGENCY, CALL 985-892-3376 OR 985-898-1285 TO REACH DR. BALDONE or DR. REINA

Jeffrey Bodin
12/5/2013 2:30 PM Office Visit Description: **Male DOB: 5/22/1997**
MRN: 2592229 Provider: **Diane K. Africk, MD**
Department: **Nomc Pediatric Neurology**

Patient Information

Patient Name	Sex	DOB
Bodin, Jeffrey	Male	5/22/1997

Progress Notes by Diane K. Africk, MD at 12/5/2013 3:54 PM

Author: Diane K. Africk, MD Service: (none) Author Type: Physician
Filed: 12/9/2013 1:01 PM Note Time: 12/5/2013 3:54 PM Note Type: Progress Notes
Status: Signed Editor: Diane K. Africk, MD (Physician)
REFERRING PHYSICIAN: Sherri Casey, M.D.

Jeffrey Bodin is a 16-1/2-year-old male child who presents today for neurological consultation. The consultation is requested by Dr. Sherri Casey. A copy of this consultation will be sent to Dr. Sherri Casey. Jeffrey is here today with his mother. The consultation is regarding headaches.

Jeffrey tells me he has had migraine headaches for five years. He says maybe they are stress headaches. He has them five out of seven days a week. He says they started after he was treated with interferon for malignant melanoma.

The headaches are described as behind his eyes and at the forehead. They usually start after 12:00 noon. He does not vomit. They are exacerbated by light, noise and movement. He has no history of motion sickness. The headaches have a gradual onset. He takes Excedrin Migraine. If he takes it early, it helps. If he waits for the headache is bad, it would not help. Rest or sleep will help. Being in a dark room will help. He is able to watch TV when he has the headache.

The headache is described as a knife moving through his head or throbbing if he is not moving about.

Jeffrey feels that stress makes his headaches worse.

The headaches were so bad this year that he could not run cross country.

Jeffrey was born in Covington at Lakeview Hospital at 32 weeks' gestation. Mother had preeclampsia and emergency C-section was done. Jeffrey weighed 4 pounds 3 ounces. He stayed in the nursery for 11 days and then came home with machines for sleep apnea.

Hospitalizations and surgeries include PE tube placement with an adenoidectomy and tonsillectomy at four years of age due to recurrent otitis media. In 2008, a melanoma was diagnosed. He had two surgeries. The second involved lymph nodes. The melanoma was in his nodes. He had chemotherapy. He had interferon. He has now been cleared by MD Anderson and is not being followed there any

longer. He has had a number of recent MRIs of his head in view of his followup for his melanoma. He does return to Children's every year.

Review of systems is negative for any problems with his heart such as chest pain or anomalies; lungs such as pneumonia or asthma; digestion such as vomiting or diarrhea.

Jeffrey eats a full diet. He has had no recent weight loss. He is lactose intolerant.

Jeffrey is right-handed. He met his developmental milestones "on time."

Jeffrey's immunizations are up-to-date including his flu shot. Medications include Mucinex, Zyrtec, Singulair, Nutropin, Accutane and amoxicillin.

Jeffrey is followed by Dr. Pouw, Endocrinology. Jeffrey has no known drug allergies.

Jeffrey lives in Mandeville in a house with his mother, father and sister. They have three cats. He attends St. Paul's. He is in the 10th grade. He drives himself to school at 7:00 a.m. and comes home at 3:30 p.m. He does well. He used to run in cross country. As previously noted, he was unable to run this year. Bedtime is 10:00 p.m. He does sleep through the night.

Mother is 47 years old. She has a history of allergies. Jeffrey has allergies like mother and father. Mom is in good health. She is a homemaker and primary caretaker. Father is 51 years old. He is in good health. As previously noted, he has allergies. He also has high blood pressure. He is an attorney. Sister is 14 years old. She is in good health.

Jeffrey usually has breakfast about 6:00 a.m. It is usually cereal and coffee and fruit and water. He has a granola bar at 9:00 a.m.; 11:00 a.m. is lunch. He has a sandwich and water. Dinner is at 4:00 p.m. It is usually cooked people food. He does not eat anything after dinner or before bed.

Jeffrey has been having knee pain and joint pain. The thought was that he had Osgood-Schlatter. He has taken Aleve. However, his joints still have problems.

Jeffrey drinks about 64 ounces of water a day.

On neurologic examination today, Jeffrey's head circumference is 56.3 cm. His height is 170.2 cm. His weight is 51 kg. His blood pressure is 124/66. His pulse rate is 88 per minute. His respiratory rate is 20 per minute.

Jeffrey is a well-nourished, well-developed young man. He looks sad. However, he is very much a part of the conversation and answers my questions with great thought.

Cranial nerve exam reveals his pupils to be equal and reactive to light.

Extraocular movements are intact. His dics are sharp. I appreciate no facial asymmetry or weakness. He has a midline shoulder shrug, palate elevation and tongue thrust. He has no nuchal rigidity.

Jeffrey is a nail biter.

Deep tendon reflexes are 3+ in the lower extremities with downgoing toes and 2+ in the upper extremities.

Tone is within normal limits. Strength is 5/5.

Gait testing is intact to toe, heel and standard gaits. He can hop on each foot without difficulty. He can jump without difficulty. He can get up from the ground without using his hands.

Coordination testing reveals finger-to-finger and rapidly alternating movements to be intact. He has no tremor.

Sensory exam is intact to light touch and vibration. He attends to the tuning fork bilaterally.

I was with Jeffrey and his mother for 60 minutes. Greater than 50% of the time was spent counseling.

We have talked about small frequent meals including something to eat before bed; continuing to drink a minimum of 70 ounces of water a day and increase if he is hot; trying to get more sleep; he has had a recent visit to the eye doctor; counseling to help with his stress.

I am going to start Jeffrey on amitriptyline 10 mg p.o. at bedtime x1 week and then two p.o. at bedtime along with Maxalt 5 mg to be taken with the onset of the headache. Mom is going to call me after the family gets back from New York where they are spending Christmas.

Please send a copy of this consultation to Dr. Sherri Casey.

DKA/IN dd: 12/05/2013 16:02:49 (CST) td: 12/06/2013 01:07:35 (CST) Doc ID #1403734 Job ID #1293434

CC: Sherri Casey M.D.

Revision History

Jeffrey Bodin
7/2/2014 10:30 AM Office Visit
MRN: 2592229

Description: **Male DOB: 5/22/1997**
Provider: **Diane K. Africk, MD**
Department: **Nomc Pediatric Neurology**

Patient Information

Patient Name	Sex	DOB
Bodin, Jeffrey	Male	5/22/1997

Progress Notes by Diane K. Africk, MD at 7/2/2014 11:42 AM

Author: Diane K. Africk, MD | Service: (none) | Author Type: Physician
Filed: 7/9/2014 12:31 PM | Note Time: 7/2/2014 11:42 AM | Note Type: Progress Notes
Status: Signed | Editor: Diane K. Africk, MD (Physician)

Jeffrey Bodin is a 17-year-old male child who initially saw me on 12/05/2013. Jeffrey returns with his mother and sister. Jeffrey carries a diagnosis of headaches, status post interferon for malignant melanoma.

Please see my original consultation of 12/05/2013 for headache description, birth history, hospitalizations and surgeries, review of systems, immunizations, medications, developmental history, endocrine history, social history, family history and dietary history.

The first time I saw Jeffrey, he was having headaches at least 5 out of 7 days a week. That continues. Jeffrey says they started after he was treated with interferon for malignant melanoma.

The headaches are described as behind his eyes and at the forehead. They usually start after 12:00 noon. He does not vomit. They are exacerbated by light and noise and movement. He has no history of motion sickness. The headaches have a gradual onset.

Jeffrey is currently on amitriptyline 175 mg p.o. at bedtime. He also takes butalbital. He feels both of these medications help.

Jeffrey has finally started running again. Everyone seems happy about this. He does tell me that his knees are giving him some trouble, but that he is on naproxen.

Jeffrey is eating well. He is sleeping well.

Family went to Chicago for a week. Jeffrey did not have a good time. He likes to stay home.

On neurologic examination today, Jeffrey's weight is 108 pounds (a decrease of 2 pounds since he was here last). Height is 171 cm. His blood pressure is 123/73. Pulse rate is 90 per minute. His respiratory rate is 24 per minute.

Jeffrey is a thin, well-nourished young man. He looks sad again today. This is not a change. He is willing to talk with me. He is not willing to go to

counseling.

Jeffrey has no ataxia. He has no dysmetria. He has no nystagmus. Extraocular movements are full and conjugate. Discs are sharp.

I did have Jeffrey and his sister leave the room. I did speak to Jeffrey's mom.

I was with Jeffrey and his family for 25 minutes. Greater than 50% of the time was spent counselling. Jeffrey is a 17 year old male status post melanoma with interferon therapy. Jeffrey has headaches and depression associated with his illness. I wish Jeffrey would be seen by Psychiatry. Mother says he will not do that.
Mom does understand that Jeffrey does not want to go away to college. She understands that he wants to stay at home. Jeffrey and I have had a long talk about interferon and headaches.

I am going to up Jeffrey's amitriptyline to 200 mg p.o. at bedtime. Mother and I have discussed antidepressants and headaches and Jeffrey's depression.

Jeffrey is going to be a junior in high school this year. Mom does not want him to miss school. Therefore, he will return at either Thanksgiving or Christmas or sooner if there are problems.

Please send a copy to Dr. Casey.

DKA/IN dd: 07/02/2014 11:50:11 (CDT) td: 07/03/2014 05:22:24 (CDT) Doc ID #1510601 Job ID #1399930

CC: Sherri Casey M.D.

Revision History

Jeffrey Bodin
12/23/2014 10:30 AM Office Visit
MRN: 2592229

Description: **Male DOB: 5/22/1997**
Provider: **Diane K. Africk, MD**
Department: **Nomc Pediatric Neurology**

Patient Information

Patient Name	Sex	DOB
Bodin, Jeffrey	Male	5/22/1997

Progress Notes by Diane K. Africk, MD at 12/23/2014 11:51 AM

Author: Diane K. Africk, MD | Service: (none) | Author Type: Physician
Filed: 12/31/2014 9:28 AM | Note Time: 12/23/2014 11:51 AM | Note Type: Progress Notes
Status: Signed | Editor: Diane K. Africk, MD (Physician)

Jeffrey Bodin is a 17-1/2-year-old male who initially saw me on 12/05/2013. Jeffrey returns today with his mother. Jeffrey carries a diagnosis of headaches, status post interferon for malignant melanoma.

Please see my original consultation of 12/05/2013 for the headache description, birth history, hospitalizations and surgeries, review of systems, immunizations, medications, developmental history, endocrine history, social history, family history and dietary history.

There is always a lot going on with Jeffrey. Recently, he was ill with a vomiting virus. He is down to 105 pounds.

Jeffrey was also started on Ritalin long acting in the hopes of helping him stay awake in class. It is hard to tell whether it helps or not. Jeffrey says he can still fall asleep. Mother feels it is helping. We are going to go up to 20 per day.

The Remeron did not help. Jeffrey is still not sleeping at night. More importantly, the headaches are greater problem. He is not on a daily headache medication. I am going to start him on low-dose phenobarbital (0.25 mg per pound). He will take the butalbital as well.

The good news is the gabapentin has helped with his leg pain. He is on 300 mg p.o. b.i.d. We are gradually going to increase it to 600 mg p.o. b.i.d.

Jeffrey is scheduled for a sleep study in the first part of February.

Jeffrey hopes to get back to weightlifting and running on the track team.

On neurologic examination today, Jeffrey's weight is 105 pounds (a decrease of 2 pounds). His height is 5 feet 7 inches. His blood pressure is 130/85. His pulse rate is 90 per minute. His respiratory rate is 24 per minute.

Jeffrey is a thin, well-nourished young man. Today, he looks happy. The last few times prior to this, he looked sad. However, today, he appears happy. He speaks to me with enthusiasm.

Jeffrey has no ataxia. He has no dysmetria. He has no nystagmus.

I was with Jeffrey and his mother for 25 minutes. Greater than 50% of the time was spent counseling. Jeffrey is a 17-year-old male with a history of malignant melanoma, leg pain, headaches and depression. The discussion was about starting phenobarbital for headaches; increasing the gabapentin for the leg pain; giving an increased dose of Ritalin a try. I would like to see Jeffrey back in one month or sooner if there are problems.

A copy of this consultation will be sent to Dr. Casey.

DKA/IN dd: 12/23/2014 12:01:27 (CST) td: 12/24/2014 08:43:12 (CST) Doc ID #1600105 Job ID #1489147

CC: Sherri Casey M.D.

Revision History

Jeffrey Bodin
3/3/2015 1:00 PM Office Visit
MRN: 2592229

Description: **Male DOB: 5/22/1997**
Provider: **Diane K. Africk, MD**
Department: **Nomc Pediatric Neurology**

Patient Information

Patient Name	Sex	DOB
Bodin, Jeffrey	Male	5/22/1997

Progress Notes by Diane K. Africk, MD at 3/3/2015 3:03 PM

Author: Diane K. Africk, MD	Service: (none)	Author Type: Physician
Filed: 3/4/2015 10:27 AM	Note Time: 3/3/2015 3:03 PM	Note Type: Progress Notes
Status: Signed	Editor: Diane K. Africk, MD (Physician)	

Jeffrey Bodin is a 17-1/2-year-old male who initially saw me on 12/05/2013. Jeffrey returns today with his mother. Jeffrey carries a diagnosis of headaches, status post interferon for malignant melanoma.

Please see my original consultation of 12/05/2013 for the headache descriptions, birth history, hospitalizations and surgeries, review of systems, immunizations, medications, developmental history, endocrine history, social history, family history and dietary history.

There are always many issues with Jeffery.

Jeffrey is on Topamax right now. He takes 25 mg p.o. at bedtime. However, the bigger issue is narcolepsy. Jeffrey has been diagnosed with narcolepsy. He has also been diagnosed with obstructive sleep apnea. He has tried the ~~APAP~~ CPAP machine one night. He does not believe it will work.

Jeffrey has recently had his meds changed from Ritalin 40 mg to Concerta 36 mg p.o. q.a.m. and 10 mg p.o. q. noon. Mom says that he could only take less Ritalin until he gains weight. Now, not only is he not gaining weight, he has lost another pound. He was sick last week. He had a sinus infection two weeks ago. Then he got diarrhea. He had to miss two field trips.

We have tried gabapentin for leg pain. It did not help. We have tried phenobarbital for headaches. It did not help.

On neurologic examination today, Jeffrey's weight is 107 pounds (an increase of 3 pounds). His height is 5 feet 7 inches. His blood pressure is 94/56. His pulse rate is 82 per minute. Respiratory rate is 24 per minute.

Jeffrey is a thin, well-nourished young man. He looks pale.

Jeffrey has no ataxia. He has no dysmetria. He has no nystagmus. Extraocular movements are full and conjugate.

I was with Jeffrey and his mother for 45 minutes. Greater than 50% of the time was spent counseling. Jeffrey is a 17-year-old male with a history of malignant

melanoma, leg pain, headaches and depression. The discussion today was about narcolepsy and Jeffrey's overall health. I am going to increase Jeffrey's Topamax slowly to 50 mg p.o. b.i.d. He will continue with the Concerta and the Ritalin. I have given Jeffrey a note to take to school regarding increased time on standardized testing.

I would like to see Jeffrey back in the next two to three months or sooner if there are problems.

A copy of this consultation will be sent to Dr. Casey.

DKA/IN dd: 03/03/2015 15:11:58 (CST) td: 03/04/2015 07:20:35 (CST) Doc ID #1632526 Job ID #1521499

CC: Sherry Casey M.D.

Revision History

Jeffrey Bodin
6/3/2015 9:00 AM Office Visit
MRN: 2592229

Description: **Male DOB: 5/22/1997**
Provider: **Diane K. Africk, MD**
Department: **Nomc Pediatric Neurology**

Patient Information

Patient Name	Sex	DOB
Bodin, Jeffrey	Male	5/22/1997

Progress Notes by Diane K. Africk, MD at 6/3/2015 9:14 AM

Author: Diane K. Africk, MD	Service: (none)	Author Type: Physician
Filed: 6/4/2015 4:34 PM	Note Time: 6/3/2015 9:14 AM	Note Type: Progress Notes
Status: Signed	Editor: Diane K. Africk, MD (Physician)	

Jeffrey Bodin is an 18-year-old male who initially saw me on 12/05/2013. Jeffrey returns today with his mother. Jeffrey carries a diagnosis of headaches, narcolepsy, status post interferon for malignant melanoma.

Please see my original consultation of 12/05/2013 for the headache descriptions, birth history, hospitalizations and surgeries, review of systems, immunizations, medications, developmental history, endocrine history, social history, family history, and dietary history.

There are always many ongoing issues with Jeffrey. It is true as well today.

First of all, let me say that Jeffery looks wonderful. He has gained 7 pounds. He is working out again for the track team. He is going to be going to Washington on June 26 with ROTC leadership team.

Jeffrey is currently taking Adderall extended release 40 mg p.o. b.i.d. and Adderall short release 20 mg p.o. every day. He would like to go up to 40, 40 and 40. I said I would have to check with the sleep doctor.

The Topamax had helped for a while. However, once the Topamax was increased, Jeffrey said it made him foggy. He has stopped it in total. He likes better how he feels. However, the headaches have returned.

In the past, we have tried amitriptyline, Neurontin, Topamax, verapamil for the headaches.

On neurologic examination today, Jeffery's weight is 104 pounds. His height is 67.4 inches. His blood pressure is 126/82. His heart rate is 90 per minute. His respiratory rate is 24 per minute.

Jeffrey is a thin, well-nourished young man. He is in a good mood today. He is talkative. He has excited facial expressions.

Jeffrey has no ataxia. He has no dysmetria. He has no nystagmus. Extraocular movements are full and conjugate.

I was with Jeffrey and his mother for 35 minutes. Greater than 50% of the time was spent counseling. Jeffrey is an 18-year-old male child with a history of intractable headaches; narcolepsy; status post interferon for malignant melanoma. Jeffrey would like to try another medicine that will not interfere with his attention or concentration span for his headaches. He does feel the butalbital helps, but he would like to have less headaches. I would like to give low-dose zonisamide a try. Therefore, we will start a 25 mg p.o. at bedtime. I would like to see Jeffrey back in six weeks or sooner if there are problems.

/sc 060415 blank

DKA/IN dd: 06/03/2015 09:38:56 (CDT) td: 06/03/2015 18:20:32 (CDT) Doc ID #1676588 Job ID #1565465

CC: LIUDMILA LYSENKO MD
Sherry Casey M.D.

Revision History

Jeffrey Bodin
7/7/2015 9:00 AM Office Visit
MRN: 2592229

Description: **Male DOB: 5/22/1997**
Provider: **Diane K. Africk, MD**
Department: **Nomc Pediatric Neurology**

Patient Information

Patient Name	Sex	DOB
Bodin, Jeffrey	Male	5/22/1997

Progress Notes by Diane K. Africk, MD at 7/7/2015 10:40 AM

Author: Diane K. Africk, MD | Service: (none) | Author Type: Physician
Filed: 7/9/2015 1:54 PM | Note Time: 7/7/2015 10:40 AM | Note Type: Progress Notes
Status: Signed | Editor: Diane K. Africk, MD (Physician)

Jeffrey Bodin is an 18-year-old male who initially saw me on 12/05/2013. Jeffrey returns today with his mother. Jeffrey carries the diagnoses of headaches, narcolepsy, status post interferon for malignant melanoma.

Please see my original consultation of 12/05/2013 for headache descriptions, birth history, hospitalizations and surgeries, review of systems, immunizations, medications, developmental history, endocrine history, social history, family history and dietary history.

There are always many ongoing issues with Jeffrey. It is true as well today.

When I came in the room, the lights were out. Jeffrey did not take his Adderall this morning. He wanted to be able to sleep on the way here and back. He was not able to sleep on the way here.

The headaches are not better. However, Jeffrey does not want to try the zonisamide. What he wants is to increase the Adderall to 40 mg p.o. t.i.d. He feels consistency helps his migraines. I said I would have to check with Dr. Lysenko. I have never had anybody on 120 mg of Adderall every day.

Jeffrey had a good trip to Washington DC with the ROTC leadership team. He is running again.

At this time, Jeffrey is taking Adderall extended release 40 mg p.o. b.i.d. and Adderall short release 20 mg p.o. every day.

Jeffrey has been on amitriptyline, Neurontin, Topamax and verapamil for his headaches in the past.

On neurologic examination today, Jeffrey's weight is 105 pounds (an increase of 1 pound). His height is 5 feet 7 inches. His blood pressure is 134/73. His pulse rate is 75 per minute. His respiratory rate is 24 per minute.

Jeffrey is a thin, well-nourished young man. He does not look well today. He says it is because he did not take his Adderall.

Jeffrey has no ataxia. He has no dysmetria. He has no nystagmus. Extraocular movements are full and conjugate.

I was with Jeffrey and his mother for 35 minutes. Greater than 50% of the time was spent counseling. Jeffrey is an 18-year-old male with a history of intractable headaches; narcolepsy; status post interferon for malignant melanoma. Jeffrey would like me to increase his Adderall to 40 mg p.o. t.i.d. He has been cleared by Cardiology. I explained that I would like to speak to Dr. Lysenko.

The family is due to see Dr. Lysenko shortly.

I would like to see Jeffrey back in three months or sooner if there are problems.

A copy of this consultation will be sent to Dr. Casey and Dr. Lysenko.

DKA/IN dd: 07/07/2015 10:39:41 (CDT) td: 07/08/2015 08:39:36 (CDT) Doc ID #1691838 Job ID #1580670

CC: LIUDMILA LYSENKO MD
Sherry Casey M.D.

Revision History

Jeffrey Bodin
8/12/2015 8:30 AM Office Visit
MRN: 2592229

Description: **Male DOB: 5/22/1997**
Provider: **Diane K. Africk, MD**
Department: **Nomc Pediatric Neurology**

Patient Information

Patient Name	Sex	DOB
Bodin, Jeffrey	Male	5/22/1997

Progress Notes by Diane K. Africk, MD at 8/12/2015 8:53 AM

Author: Diane K. Africk, MD | Service: (none) | Author Type: Physician
Filed: 8/17/2015 6:48 PM | Note Time: 8/12/2015 8:53 AM | Note Type: Progress Notes
Status: Signed | Editor: Diane K. Africk, MD (Physician)

Jeffrey Bodin is an 18-year-old male who initially saw me on 12/05/2013. Jeffrey returns today with his mother. Jeffrey carries the diagnoses of headaches, narcolepsy and status post interferon for malignant melanoma.

Please see my original consultation of 12/05/2013, for headache descriptions, birth history, hospitalizations, surgeries, review of systems, immunizations, medications, developmental history, endocrine history, social history, family history and dietary history.

Jeffrey looks well today. He is in a tie and long sleeve shirt for school. However, when I mentioned that Jeffrey looks well, he tells me that he will have a headache shortly.

Jeffrey is currently on Adderall 40 mg p.o. t.i.d. He tells me it is better, but still not perfect. He wants to make sure he can stay on the butalbital.

Jeffery's blood pressure is 135/69. We discussed the issues with blood pressure and Dr. Lysenko's concerns. Jeffrey tells me that he has always noted he does not want to have to go on high blood pressure medicine and as long as he can wait until he is in his 30s, then it is okay. I discussed trading the complications of one medicine for another. Jeffrey said that he wanted to stay on the Adderall because it helps him.

Jeffrey has been on amitriptyline, Neurontin, Topamax and verapamil for his headaches in the past.

On neurologic examination today, Jeffery's weight is 106 pounds (an increase of 1 pound). His height is 5 feet 7 inches. Today's blood pressure is 135/69. The last time he was here, it was 134/73. He has not been taking it at home because he has not been able to get a machine calibrated appropriately. He says he does not have time to go to the pediatrician's office once a week to have it checked. Pulse rate is 67 per minute. Respiratory rate is 24 per minute.

Jeffrey is a thin, well-nourished young man. He looks well today. He is in a rush. He needs to get to class. He just wants to make sure that he can stay on his butalbital.

Jeffrey has no ataxia. He has no dysmetria. He has no nystagmus. Extraocular movements are full and conjugate.

I was with Jeffrey and his mother for 20 minutes. Greater than 50% of the time was spent in counseling. Jeffrey is an 18-year-old male child with a history of malignant melanoma status post interferon. He has a history of intractable headaches and narcolepsy without cataplexy.

I have left a message for Dr. Lysenko regarding Jeffery and his medications.

I told Jeffrey I would be glad to see him back between Thanksgiving and Christmas. He said he would like to come before Thanksgiving. Mother says they would like to come in January. Jeffrey said they would be coming in early November.

Copy of this consultation to be sent to Dr. Sherry Casey.

DKA/HN dd: 08/12/2015 09:00:18 (CDT) td: 08/12/2015 22:51:37 (CDT) Doc ID #1708787 Job ID #1597563

CC: Sherry Casey M.D.

Revision History

Re-Writeup 9/16/17
Old writeup approx Sep/Aug ~~16~~ 2016

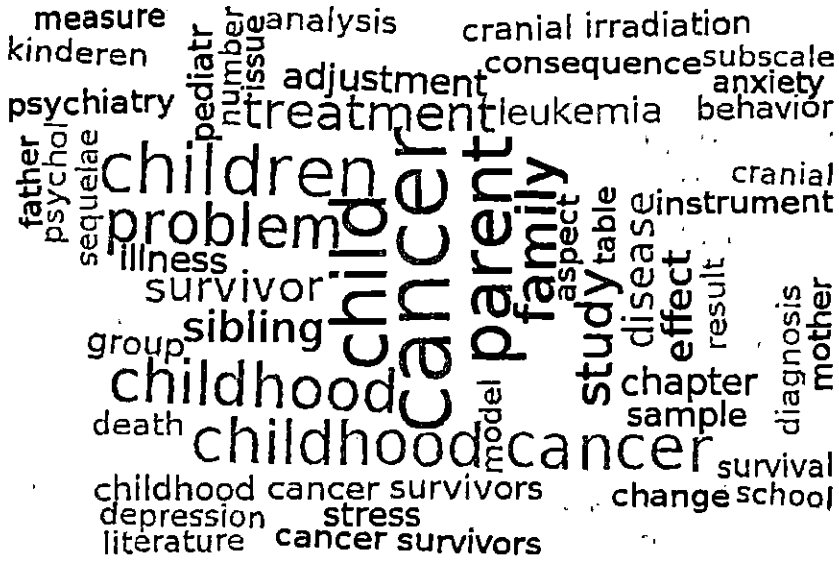
(copies)
Afreck's
notes

←

This was attached to the front of the ~~last~~ 1st pg of the last enclosed appt printout, Which was the 1st printout in the stack, Out of date ascending order.

My mother disorganized/printed many enclosed copies sideways, ~~Around~~ Spring 2016. Specifically 2/29/16. See my vitals printout ~~That~~ I printed out shortly before putting my medical records into ascending date order to scan into my school laptop, Lenovo. My mother had gone into my room taken slanted records in question and scanned them that way on purpose, To intentionally obfuscated the date printed by Dr. Diane Africk. She quote on quote wanted to, "Destroy my memory/memories."

- See my vitals printed surrounding above events in question.
- 2/29/16
- Right before setting into ascending date order ~~to~~ to scan into school laptop.



TREATMENT AFTER CANCER AND LATE EFFECTS

TACLE CLINIC

CHILDREN'S OF NEW ORLEANS

LSUSHC

LSU Health Sciences Center NEW ORLEANS

1/15/2015

CHILDREN'S HOSPITAL

SUMMARY OF CANCER TREATMENT

Demographics		
Name: Jeffrey Bodin	Sex: Male	Date of Birth: 05/22/1997
PCP:		
Cancer Diagnosis		
Diagnosis: Melanoma of left ankle	Sites involved/stage: Stage IIIA/T2aN2a	
Date of Diagnosis: 03/2008	Age at Diagnosis: 10yrs. 9 months	Date Therapy Completed: 10/02/2008
Relapse(s):		
Treatment Center : MD Anderson Cancer Center; LSUHSC, Children's Hospital New Orleans, 200 Henry Clay Avenue, New Orleans, LA 70118 Primary Oncologist: Dr. Cynthia Herzog (MD Anderson Cancer Center) Dr. Jaime Morales (Children's Hospital of New Orleans) Surgeon: MD Anderson Cancer Center Radiation Oncologist: n/a Transplant Physician: n/a Long Term Follow-Up: Dr. Pinki Prasad (504) 896-9740		Medical Record #: MD Anderson 074-46-52 CHNOLA: 0445573
Family History Cancer:	Other Family History:	

CANCER TREATMENT SUMMARY

Protocol/Treatment:	On Study: NO	
Chemotherapy		
Drug Name	Route	Selected Cumulative Dose (units or mg/m^2) when Applicable
Interferon alpha 2B	IV	400 million units/m2
Interferon alpha 2B	SQ	155 million units/m2
Surgery :		
Surgery	Date	Surgeon
Primary excision of melanoma on left ankle with sentinel node mapping	03/15/2008	MD Anderson Cancer Center
Appendectomy	05/13/2008	MD Anderson Cancer Center
PICC Line Insertion	06/09/2008	Children's Hospital of New Orleans
Radiation: n/a		
Transplant: n/a		
Treatment Complications/Late Effects		
Problem	Status	
Neurologic: Seizures while on interferon		
Neurologic: Peripheral neuropathy		

LSU Health Sciences Center NEW ORLEANS

CHILDREN'S HOSPITAL

Potential Late Effects		
Potential Late Effect	**Exposure**	**Screening Recommendations**
Any Cancer History		Annual Physical Exam with PCP Annual Cancer Screening by age Regular exercise Avoid cigarette smoking, excess alcohol consumption or illicit drugs Eat a well balanced, low fat diet
Any Cancer History	Biologics Interferon Alpha 2B	Insufficient information currently available regarding late effects of biological agents
Dental Problems	Any chemotherapy exposure	Regular Dental Exams
General Recommendations:		
Immunizations	Any cancer experience	Recommend annual Flu shot Recommend (HPV vaccination or Gardasil) series
Summary prepared by: Pinki Prasad, MD, MPH		**Date prepared:** 01/15/2015

Writeup on 9/17/17
Note the following is informational general handouts, etc.

I, Jeffrey Thomas Bodin, am and to my knowledge will always be a cancer patient. Not a survivor. As was noted by Dr. Pinki Prassad whenever she handed me the enclosed documentation. At my first, and as of writing only so far, long term follow up appointment. She stated as such that not all the information within the folder/binder, she handed me, "applied to me specifically."
It was just what they gave everyone in the clinic."
Just re-recording ~~that~~ this fact to note that I am still/always will be a cancer patient.

-9/17/17

Note: Appt in question 1/15/15.
Children's Hospital New Orleans
200 Henry Clay Avenue
New Orleans, LA 70118

Health Link

1/15/15

Healthy living after treatment of childhood cancer

CHILDREN'S ONCOLOGY GROUP

The world's childhood cancer experts

Introduction to Long-Term Follow-Up after Treatment for Childhood, Adolescent, or Young Adult Cancer

Congratulations! You have "graduated" to long-term follow-up. ***You can now think of yourself as a cancer survivor, not as a cancer patient!*** In long-term follow-up, the goal is to help you stay as healthy as possible—to stay well and to do well in school or at work.

Even though you are a cancer survivor, it is still important that you continue to have regular medical care. In some cases, your care may continue at the same hospital or clinic where you received your treatment, but you may be seen by different doctors and nurses in a special Long-Term Follow-Up Program. In other cases, you may receive care from a healthcare provider working in partnership with your treatment center, or from a provider who is closer to your home. No matter where you receive your care, it is important that you learn what you need to know about your treatment and the follow-up care that you need so that you can stay in the very best health possible.

Your cancer treatment summary

When you graduate to long-term follow-up, it is important that you get a record of the cancer treatment that you received. This record, known as a ***Summary of Cancer Treatment***, should contain the following information:

- Name of the **disease** that you had, the date when you were diagnosed, and the site/stage of the disease
  - Date(s) and description(s) of any relapses
  - Name, address, and phone number of hospital(s) or clinic(s) where you received your care
  - Name, address, and phone numbers of your cancer doctor (oncologist) and other health team members responsible for your care
  - Date that your cancer treatment was completed
- Names of all the **chemotherapy** medicines that you received and specific information about certain chemotherapy drugs as follows:
  - Total doses of anthracycline chemotherapy (such as doxorubicin or daunorubicin)
  - For cytarabine and methotrexate: How they were given (such as by mouth or into the vein), and if into the vein, whether you received "high dose" (1000 mg/m^2 or more in any single dose) or "standard dose" therapy
  - For carboplatin: Whether or not the dose was myeloablative (given during preparation for a bone marrow, cord blood, or stem cell transplant), and whether any carboplatin was given prior to one year of age.
  - Total doses of other chemotherapy agents and how they were given should be included, if available
- **Radiation** therapy summary, including
  - Part(s) of body that received radiation (radiation site or field)
  - Total radiation dose (including any boost doses) to each field
- Name and dates of any **surgeries** that you had
- Whether or not you received a **hematopoietic cell transplant** (bone marrow, cord blood, or stem cell transplant), and if so, whether or not you developed chronic Graft-versus-Host Disease (cGVHD)
- Names of any other **cancer treatment(s)** that you received (such as radioiodine therapy or bioimmunotherapy)

- Names and dates of **any significant complication(s)**, and treatments received for the complication(s)

Keep a copy of your cancer treatment summary in a safe place, and give a copy to each of your healthcare providers.

Your follow-up schedule

Most cancer survivors need long-term follow-up visits about once a year. During these visits, it is important to talk about your progress and check for problems that can happen after treatment for cancer. Talk with your healthcare provider about your individual situation and determine a schedule for the follow-up care that best meets your needs.

Between visits

Once you "graduate" to long-term follow-up care, you will usually need to identify a local healthcare provider that you can visit or call if you are injured or sick. Make an appointment for a check-up with this healthcare provider so that they can get to know you before an illness arises. If a problem comes up that may be related to your cancer treatment, your local healthcare provider can discuss this with your long-term follow-up team.

Late effects after treatment for childhood, adolescent, or young adult cancer

Problems that happen after treatment for cancer are known as "late effects." Fortunately, most long-term survivors don't have serious late effects, but it is important to catch any problems early. You may have already learned about some of the possible late effects that can happen after treatment for cancer. Some of the more common ones are reviewed here.

Growth

Treatment for cancer during childhood, especially radiation to the brain or spine, can sometimes slow or stunt growth. Yearly measurements help to predict whether you will reach a normal height. If you are "at risk" for being short as an adult, your healthcare provider may also recommend other specialized tests and treatments.

Heart

A small percentage of survivors treated with chest radiation or certain chemotherapy drugs known as "anthracyclines" (such as doxorubicin or daunomycin) have problems with the heart. This is most likely to happen in people who received higher doses of these medicines, and in those who received their treatment before their heart finished growing. Your healthcare provider may recommended tests to check your heart function, and may arrange for a cardiologist (heart specialist) to see you if the tests show any sign of these problems.

Fertility

Radiation to the pelvis and certain anticancer drugs can affect sexual development and reproduction. Some survivors may be at risk for delayed puberty, infertility (inability to have children), or early menopause. Check-ups and certain blood tests can help determine if you have any of these problems. These issues are important, and if you have any concerns, you should be sure to discuss them with your healthcare provider. If there is a problem, arrangements may be made for you to see a specialist.

Thyroid

Head or neck radiation can sometimes cause the thyroid gland to stop working properly. This gland helps regulate growth, weight, and the balance of body chemicals. Blood tests can be done to check thyroid hormone levels. Low thyroid levels are easily treated with oral medication.

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Second Cancers

Some chemotherapy drugs and radiation can increase the risk of a second (different) cancer. Some survivors may have genetic changes that put them at risk for second cancers. Tobacco, excessive sun exposure, and other chemicals and behaviors can also increase this risk. Talk with your healthcare provider about ways to lower your risk and to detect common cancers at an early stage.

School and Work

Problems with schoolwork or jobs can occur as a result of some types of cancer treatment. Psychologists can work with your local school system to make sure that any special needs are met. Also, financial assistance for education and job training may be available through government programs. Social workers can help to explain these programs.

Moving toward the future

Thinking about developing late effects after surviving cancer can be anxiety provoking. But it is quite possible that you will NOT develop any serious complications. And if you do, it is best to catch them early, so that you can begin treatment right away. So don't let anxiety get in the way of taking the very best care of your health.

Being treated for cancer at a young age is always a difficult experience. Having survived that experience, you have learned many things. Most likely, you are a stronger person than you were before you were diagnosed with cancer. As you move forward into your future, use those strengths to your advantage. Make healthy choices. Keep your follow-up appointments. And always remember that YOU are the most important member of your healthcare team!

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Additional health information for childhood cancer survivors is available at *www.survivorshipguidelines.org*

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Chronic Pain after Childhood Cancer

Pain is a common experience during cancer treatment, either from the cancer itself or from the treatment. Usually, after the treatment is finished, there is no more pain. For some people, however, pain continues to be a side effect of either the cancer or its treatment, even when the cancer is in remission and treatment has been completed. For cancer survivors, long-term pain may occur for a variety of reasons, such as damage to bones, joints, or nerves resulting from treatment with radiation, surgery, certain chemotherapy medications, or corticosteroids.

What is the difference between acute and chronic pain?

Acute pain is generally the result of illness (such as cancer), injury and/or surgery and is usually confined to a limited period of time. Acute pain has a biologic purpose, that is, it tells us that we are hurt or ill, so that we can protect ourselves.

Chronic pain lasts after the underlying illness or injury has resolved. Chronic pain is a problem because the longer the pain lasts, the more complicated it might become, particularly in the way it could affect a survivor's quality of life.

Pain is very complex

Healthcare providers used to think that the amount of pain a person had was directly related to the extent of physical damage to body tissue. Healthcare providers now know that the pain people feel is affected by many physical, emotional, and cognitive factors that are unique to each individual.

Recent studies involving new technology to study the brain are confirming that many processes are involved in chronic pain. The experience of pain is the result of a complex interchange of information from many different areas of the brain. These studies have also helped us to understand that pain can sometimes persist (even when the original injury has healed) due to changes in the way the body sends and receives pain signals.

Healthcare providers have learned that different people perceive pain in different ways. These differences can be seen in brain imaging studies as individuals rate their pain to the same source of pain, or "stimulus". That is, some people seem to be very sensitive, whereas others may report little pain even with the same stimulus. While you might be born with some of these differences, environmental factors tend to play an important role too. Factors such as age, sex, developmental level, family and cultural traditions, prior pain experience, and circumstances surrounding the injury all contribute toward how a cancer survivor might interpret, experience, and cope with pain.

Pain and Psychological Health

Psychological factors play a role in the amount of distress that is experienced, or how upsetting the pain might be to each individual. Furthermore, other factors, such as family or work environment, can also affect the ability to cope with pain.

In the case of chronic pain that lasts for months and years, it is possible for cancer survivors to become increasingly depressed if they don't have ways to cope with the pain in a healthy way. Survivors with pain may sometimes become frustrated and angry, especially if pain is preventing them from doing activities that they used to enjoy. If a survivor believes that pain controls his or her life, then they may begin to feel powerless, develop low self-esteem, and avoid taking on challenges and opportunities for growth. Pain can develop into a troublesome cycle. For example, a survivor might stop moving around and doing physical activities because they are afraid of triggering or worsening their pain, but the less active they are, the weaker their muscles become, which can then worsen the pain.

Sometimes, people begin to anticipate the physical sensations of pain in a fearful way. They may withdraw from social or community activities to avoid having to deal with pain in public situations, and they may increasingly iso-

late themselves. Depression, anxiety, and chronic stress may follow, which than can make the pain worse. This may also lead to physical changes in the body associated with stress, depression, and anxiety, which can lower the pain thresholds.

How is Pain Treated?

Fortunately, there are ways to manage and cope with chronic pain. Chronic pain can be treated with medicine, without medicine using behavioral treatments (such as relaxation or meditation), or by a combination of the two. Non-medicine treatments can be used along with medications to manage pain during all phases of cancer treatment. Studies of patients suffering from chronic pain show that training in pain-coping skills can help increase self-confidence and reduce distress from pain. Changes in how a person copes with pain and what they believe about their pain may also produce positive changes in behavior, such as increased exercise, improved pacing of activities, better compliance with medication, and increased participation in social activities.

Behavioral skills can be helpful in treating and coping with pain. Specific techniques include relaxation, meditation, guided imagery, distraction, and redirected thinking, as well as changing thoughts and beliefs about pain and what it means. Other effective approaches include support groups, massage, music, and counseling focused on pain management and behavioral modification.

Additional information about chronic pain is available on the following websites:

- ***www.americanpainsociety.org***
- ***www.painandhealth.org***

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Educational Issues Following Treatment for Childhood Cancer

Treatment for cancer during childhood or adolescence may affect educational progress due to prolonged absences or reduced energy levels that frequently occur during treatment. In addition, some types of cancer may require therapy to control or prevent spread of the disease to the brain and/or spinal cord (central nervous system). This therapy can sometimes affect memory and learning abilities. Parents and teachers should be aware of potential educational problems that may be related to cancer treatment so that children and teens at risk can be watched closely and given extra help if the need arises.

What increases the risk of educational problems?

Factors that may place children and teens at increased risk for difficulties in school include:

- Diagnosis of cancer at a very young age
- Numerous or prolonged school absences
- A history of learning problems before being diagnosed with cancer
- Cancer treatment that results in reduced energy levels
- Cancer treatment that affects hearing or vision
- Cancer treatment that results in physical disabilities
- Cancer therapy that includes treatment to the central nervous system (see below).

Are children and teens with certain types of cancer at higher risk of developing educational difficulties?

Yes, children and teens with the types of cancer listed below are more likely to have received treatments that may affect learning and memory. Since treatments for these types of cancer vary widely, not everyone who was treated for these cancers is at increased risk.

- Brain tumors
- Tumors involving the eye or ear
- Acute lymphoblastic leukemia (ALL)
- Non-Hodgkin's lymphoma (NHL)

What types of treatment place children and teens at higher risk for learning and memory problems?

- Methotrexate—if given in high doses intravenously (IV) or injected into the spinal fluid [intrathecal (IT) or intraommaya(IO)]
- Cytarabine—if given in high doses intravenously (IV)
- Surgery involving the brain
- Radiation to any of the following areas:
  - Brain (cranial)
  - Ear/infratemporal region (midfacial area behind the cheekbones)
  - Total body irradiation (TBI)
  - Cisplatin or carboplatin (may affect hearing)

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What testing is recommended?

Any young person who has had any of the above cancer treatments, or who is having difficulties in school, should undergo a specialized evaluation by a pediatric psychologist (neuropsychological testing) at the time of entry into long-term follow-up. This type of testing will measure IQ and school based skills, along with more detailed information about how the child processes and organizes information.

Even if the initial neuropsychological evaluation is normal, it is important for parents and teachers to remain watchful. Further neuropsychological evaluations may be necessary if the child or teen begins having trouble in school or develops any of the problems listed below. In addition, repeat testing is often recommended at times when academic challenges are more likely to occur, such as at entry into elementary school, middle school, high school, and during pre-college planning.

What learning problems may occur?

The brain is a very complex structure that continues to grow and develop throughout childhood and adolescence. Some problems may not become apparent until years after therapy is completed. Common problems areas include:

- Handwriting
- Spelling
- Reading
- Vocabulary
- Math
- Concentration
- Attention span
- Ability to complete tasks on time
- Memory
- Processing (ability to complete assignments that require multiple steps)
- Planning
- Organization
- Problem-solving
- Social skills

What can be done to help with learning problems?

If a problem is identified, special accommodations or services can be requested to help maximize the student's learning potential. The first step is usually to schedule a meeting with the school in order to develop a specialized educational plan. Examples of strategies that are often helpful for children and teens with educational problems related to cancer treatment include:

- Seating near the front of the classroom
- Minimizing the amount of written work required
- Use of tape-recorded textbooks and lectures
- Use of a computer keyboard instead of handwriting
- Use of a calculator for math

- Modification of test requirements (extra time, oral instead of written exams)
- Assignment of a classroom aide
- Extra help with math, spelling, reading, and organizational skills
- Access to an elevator
- Extra time for transition between classes
- Duplicate set of textbooks to keep at home

What laws protect the rights of students who have undergone treatment for cancer?

In the United States, there are three public laws that protect the rights of students with educational problems related to cancer treatment. These laws are:

The Rehabilitation Act of 1973 – Section 504

This legislation provides accommodations for students with a "physical or mental impairment which substantially limits one or more major life activities," or students who have "a record of such impairment", or who are "perceived as having such an impairment" (The Rehabilitation Act, 1973). Qualifying conditions include chronic illnesses such as cancer, as well as many other disabilities, including hearing problems, vision problems, learning disabilities, speech disorders, and orthopedic handicaps. All childhood cancer survivors in the United States are eligible for accommodations under this law, and all educational institutions receiving federal funding (including colleges and universities) are required to comply. Accommodations may include modifications in the curriculum (such as allowing the use of a calculator and extra time for assignments or test-taking) and the environment (such as seating near the front of the classroom or allowing extra time between classes).

The Individuals with Disabilities Education Act (IDEA)

The IDEA legislation (PL 105-17) requires that public schools provide "free and appropriate education in the least restrictive environment" for disabled students between the ages of 3 and 21 years of age. In order to qualify for special education services under IDEA, the student must meet qualifications under at least one disability outlined in the law - those that most commonly apply to students treated for cancer include "specific learning disability," "traumatic brain injury," or "other health impairment." In order to access services under the IDEA legislation, parents must initiate the process by requesting that the student be evaluated for an "Individualized Education Plan" or IEP. The student will then undergo an assessment process to determine what assistance is required. A conference is then held to discuss the results of the evaluation and, if the student qualifies, to determine an individualized plan to meet the identified specialized educational needs. Services available under the IDEA legislation include tutoring, specialized classroom placements (such as a resource room), psychological services, adaptive physical education, physical, occupational and speech/language therapy, and transportation services. All services and accommodations required by the student should be specified in the IEP (the written document describing the special education program). The IEP should be reviewed and updated on an annual basis to assure that it continues to meet the student's educational needs.

The Americans with Disabilities Act (ADA)

The ADA law (PL 101-336) protects against discrimination in employment, transportation, communication, government and public accommodations for people with disabilities. It guarantees equal access to public spaces, event, and opportunities and may be particularly helpful for students seeking higher education or employment.

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Where can I get more information?

Additional information is available from the Center for Parent Information and Resources (***www.parentcenterhub.org***).

American Childhood Cancer Organization, for the free publication: Educating the Child with Cancer, a Guide for Parents and Teachers (phone: 1-855-858-2226, ext. 101; website: ***www.acco.org***.)

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Emotional Issues after Childhood Cancer

The Cancer Experience

Diagnosis and Treatment

Diagnosis and treatment are difficult times for children with cancer and their families. During diagnosis, children have tests and procedures that are new, painful and often scary. For parents, it is the anxiety of waiting for the results of these tests and procedures that can be the worst part of this time. Learning the diagnosis can be a relief, especially when effective treatments are available. These treatments, though, can be unpleasant for children to have and upsetting for families to watch or give. Tests and procedures are repeated during treatment to find out if the treatment is helping or should be changed. Children with cancer and their parents are frequently at the hospital, sometimes away from other family, friends, home, work or school for long periods of time. Parents worry about whether or not their child's cancer will be cured, how to minimize their child's suffering, and how to make the most of life. Brothers and sisters also worry about, and are sometimes jealous of, the child with cancer. Childhood cancer survivors and their siblings can be concerned about their parents, and keep worries and feelings to themselves to try to protect their parents. As a result, children with cancer, their parents and their siblings can feel angry, lonely, sad and afraid during treatment. Periods of anxiety and depression can occur.

After Treatment Ends

For survivors and their families, the end of treatment can bring new feelings as they come to know the good (and sometimes not so good) outcomes of successful treatment. During treatment, people tend to be concerned with getting through the day-to-day. It is after treatment that people can begin to think about and come to terms with their experience. People can have a range of feelings after treatment ends, and the blend of feelings can be as unique as each person. Survivors and their families often fear that the original cancer will return. Regular testing for recurrent cancer or late effects, and even just talking about possible late effects can cause stressful feelings. The diagnosis of a late effect related to cancer treatment or a new health problem unrelated to childhood cancer can also be sources of distress. Anniversaries of cancer events, such as the date of diagnosis or end of treatment, and life changes such as school entry or the normalization of peer relationships can bring on feelings that include relief and happiness, sadness about the loss of a regular childhood, and guilt over having survived when others did not. Some survivors may feel vulnerable because of their cancer experience, and can be concerned about their health and act with caution. Parents of childhood cancer survivors very much want to protect all of their children from harm. These protective feelings can increase usual tensions between parents and teenagers over issues related to growing independence, especially in matters that can affect health. Other teens who have had cancer believe that, having survived cancer, they can do anything—and this makes them feel invincible. These feelings can lead some survivors to undertake difficult studies, work or hobbies. The same feelings can lead other survivors to take part in unhealthy or risky behaviors.

Some Reactions to the Stresses of Survivorship

For the most part, childhood cancer survivors and their family members respond well to the stresses of survivorship. Sometimes though, physical problems or other stresses related to childhood cancer and everyday life can sometimes lead to intensely distressing emotions that need medical attention. Some survivors, and their family members, can experience periods of high anxiety that may or may not be triggered by reminders of the upsetting aspects of treatment. They may develop three types of symptoms typically seen in people with posttraumatic stress disorder (PTSD), including (1) unwanted recall of unpleasant memories of cancer, (2) physical or emotional overreactions, and (3) going out of the way to avoid reminders of cancer. For the most part, childhood cancer survivors and their family members

do not develop all three types of symptoms and PTSD. Yet one or two of these symptoms can nonetheless get in the way of relationships, school, work and other key areas of daily life in survivorship.

Personal growth can be another reaction to the stresses of survivorship. After years of living with childhood cancer, some survivors and their family members may find that they have undergone meaningful and beneficial changes in themselves, their relationships with other people, and their values as a result of their experiences. It does not mean that these survivors would choose to have had cancer, but that they have been able to find some positive changes in their lives as a result of surviving that stressful experience. Experiencing these positive changes is sometimes referred to as posttraumatic growth.

Risk Factors

Several factors can affect the development of depression and anxiety with symptoms of posttraumatic stress after diagnosis and treatment of childhood cancer, including:

- Female gender
- Adolescent or young adult age
- Prior trauma
- Mental health or learning problems before childhood cancer
- Low levels of social support
- Parental history of depression, anxiety, or PTSD
- Cancer of the brain or spine (central nervous system [CNS])
- Cancer treatment to the CNS (radiation to head, chemotherapy into spinal fluid)
- Treatment with Hematopoietic Cell Transplant (bone marrow or stem cell transplant)

When to Seek Help

People with distress that (1) lasts two weeks or more, and/or (2) interferes with their ability to do key home, school or work tasks, should call their healthcare provider to discuss the need for a referral to a mental health professional. Because physical health problems can cause these same symptoms, a through check-up by your primary healthcare professional is recommended if they occur. Some possible signs that help is needed can include:

- Changes in appetite and weight
- Crying easily or being unable to cry
- Constant tiredness and low energy level
- Sleeping a lot
- Not sleeping well
- Feeling hopeless; thoughts of death, escape, suicide—Increased irritability
- Decreased interest in activities that had been pleasurable in the past
- Unwanted recall of painful aspects of cancer
- Feeling extremely fearful, upset or angry when thinking about cancer
- Physical reactions (rapid heart rate, shortness of breath, nausea) when thinking about cancer
- Avoiding health care visits
- Refusing to talk about cancer

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Share Your Concerns with Your Healthcare Provider

If you experience distress, discuss it with your primary health care provider or childhood cancer specialist. Your distress may be related to your cancer experience, worries about late effects, or other events in your life. In any case, there is treatment. Talking with others about your fears and worries is a first step in gaining control over them. In addition to receiving help from a health care provider, some people also find support through support groups, participation in activities at their place of worship, or their sense of spirituality. Support can help survivors and their families manage difficulties in useful ways.

Treatment Options

Treatments for depression, anxiety and posttraumatic stress symptoms include counseling in group or individual sessions and medication. Medication usually works in combination with some form of counseling. Mental health professionals (including mental health nurse practitioners, psychiatrists, psychologists, and social workers) provide treatment for depression and anxiety in a variety of community settings. Your primary healthcare provider can help you find a suitable mental health professional in your community.

Resources

Support is available to childhood cancer survivors and their families who have anxiety and depression after treatment. These are just a few of the many resources available:

American Cancer Society (*www.cancer.org*)
This site provides web-based support network, other programs and services, and stories of hope for cancer survivors and their families.

American Psychiatric Association (*www.healthyminds.org*)
This site provides guidelines for choosing a psychiatrist.

The Anxiety Disorders Association of America (*www.adaa.org*)
This site provides information that can help people with anxiety disorder find treatment and develop self-help skills.

American Childhood Cancer Organization (*www.acco.org*)
This site offers education, support, service, and advocacy for childhood cancer survivors, their families and the professionals who care for them.

Children's Oncology Group (*www.childrensoncologygroup.org*)
This site provides parents and families with information related to specific cancer type, treatment stage and age group as well as tips on navigating the health care system, getting and giving support, and maintaining a healthy lifestyle.

National Institute of Mental Health (*www.nimh.nih.gov*)
This site provides general information about anxiety or depression, available treatments, finding a mental health provider, and access to research reports and other relevant information. See these specific areas of the web site:

http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

http://www.nimh.nih.gov/health/topics/depression/index.shtml

Patient Centered Guides *http://childhoodcancerguides.org/sresource.html*
This site provides a list of follow-up clinics for childhood cancer survivors and articles related to psychosocial aspects of survivorship.

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Finding and Paying for Healthcare after Treatment for Childhood Cancer

As a childhood cancer survivor, it is important for you to have regular medical check-ups, since some of the treatments that you received may increase your risk for health problems as you get older. Sometimes it is difficult to find and pay for the medical care that you need. There are several things you can do to make sure you are getting the best possible care for your needs. Here are some suggestions.

If possible, find a long-term follow-up clinic. Many childhood cancer programs have long-term follow-up clinics. A directory of long-term follow-up clinics affiliated with Children's Oncology Group institutions can be found at this link: ***http://applications.childrensoncologygroup.org/Surveys/lateEffects/lateEffects.PublicSearch.asp.*** If you are still followed in a childhood cancer center, or if there is a childhood cancer center near where you live, contact that center to discuss your options for obtaining long-term follow-up care. Long-term follow-up clinics usually screen for late effects and educate survivors about ways to lower the risk of health problems after cancer. They are generally an excellent place to get a complete health evaluation, but are not usually designed to meet the everyday healthcare needs of survivors. Also, some long-term follow-up programs are only able to follow survivors until they reach adulthood, which may mean that they can see survivors only until they reach age 18 or 21. So, even if you are attending a long-term follow-up clinic, it is also important to find a primary healthcare provider who can take care of your general medical needs.

Choose a primary healthcare provider in your community. The best primary healthcare providers for adults are usually those who specialize in family practice or internal medicine. The chance of finding a primary healthcare provider who has experience taking care of childhood cancer survivors is low, due to the rarity of serious illnesses like cancer in children. However, it is important to look for a healthcare provider who is thorough, well-trained, and a good listener. Ask friends and family members to help you identify healthcare providers with these qualities who are practicing in your area. Make an appointment for a general check-up and discuss your past medical history and health risks during this visit. It is best to do this at a time when you are well, and not when you are being seen because of an illness.

Tell your healthcare provider about the Childhood Cancer Survivor Long-Term Follow-Up Guidelines, available on the Children's Oncology Group website at ***www.survivorshipguidelines.org.*** This comprehensive set of healthcare screening and management guidelines is designed for use by healthcare professionals who are providing ongoing medical follow-up for childhood cancer survivors.

Organize a medical team to provide your local care. Get advice from your childhood cancer doctor and your primary healthcare provider about who should be on your medical team. Your team should always include a primary healthcare provider and a dentist. Depending on your situation, you may also need to include other professionals that are important for your continued health, such as a physical therapist or psychologist. Your primary healthcare provider can help you select these individuals and provide referrals for their services.

Share your medical records with all the members of your medical team. Ask your hospital or clinic to send copies of your treatment records to all of your new healthcare providers. If possible, ask the doctor who treated your childhood cancer to provide you with a summary of your diagnosis and treatment, future health risks, and recommended screening. Keep a copy of the summary and important sections of your pediatric medical records in a personal medical file. Be sure that every new healthcare provider you see is aware of your medical history and any special health risks you may have because of your cancer treatment. If you need help in obtaining your medical records, *call the hospital, clinic, or medical center where you received your treatment.*

Health Link

Healthy living after treatment of childhood cancer

CHILDREN'S ONCOLOGY GROUP
The world's childhood cancer experts

Be a partner in the healthcare that you receive. To find out if you are getting adequate care, ask yourself the following questions:

- Do I know my cancer diagnosis and specific treatment I received?
- Do I know about the health problems that can occur after this treatment?
- Have I shared this information with my healthcare providers?
- Does my healthcare provider check periodically for health problems specifically related to my childhood cancer?
- Does my healthcare provider advise me about things I should or should not do to keep healthy after my treatment for childhood cancer?

Explore all resources for paying for healthcare. Healthcare is expensive and people who have had a serious illness often face many hurdles when trying to obtain adequate follow-up care. In the United States, insurance companies are now required to provide coverage for childhood cancer survivors, regardless of pre-existing medical conditions. The law also now provides the option of coverage under a parent's health insurance policy for young adults under age 26. More information about your rights and protections under the health care law (commonly known as the "Affordable Care Act"), is available at this link: ***https://www.healthcare.gov/how-does-the-health-care-law-protect-me/.*** If you aren't insured, you should seek assistance a local social service organization or your hospital social worker to identify your coverage options.

As a survivor of childhood cancer, you have already overcome many obstacles. The process of obtaining and paying for healthcare can sometimes seem discouraging, but it is worth the effort!!

Survivorship Healthcare Coverage Checklist

Define your current healthcare needs. Ask yourself:

- Do I mainly need a healthcare provider for general check-ups?
- Do I have chronic health problems that require frequent medical visits?
- Do I have problems that need periodic monitoring by specialists?
- Am I on expensive prescription medications?
- Do I require prosthetic or rehab services?

Explore all resources for healthcare coverage:

- Coverage through a parent's or spouse's policy
- Health insurance coverage offered by your college or employer
- State or federal public assistance programs that may substantially lower the cost of coverage
- Discounted or free healthcare through health department clinics or church-based programs
- Low cost or free prescription programs provided by some pharmaceutical companies for people with low incomes

If you are insured, get the facts about your policy.

- What services are covered?
- Does your plan offer a discounted prescription program?
- Are referrals to specialists controlled through a primary care physician?

Health Link

Healthy living after treatment of childhood cancer

CHILDREN'S ONCOLOGY GROUP
The world's childhood cancer experts

- Are limitations set on pre-existing medical conditions?
- Is coverage in effect only while the patient is a full-time student?
- Does coverage expire at certain age?

Ask for help in understanding current resources and locating new ones.

- Ask family members, friends, hospital or clinic insurance managers and insurance representatives to explain unclear details about insurance benefits.
- Call a clinic or hospital social worker to ask for help in finding state or community healthcare resources.
- Check out services offered by national nonprofit organizations (example, Lions Club for ocular prostheses).
- Be proactive in obtaining and maintaining health insurance coverage.
- Visit ***healthcare.gov*** to determine your options for insurance coverage and to determine whether you qualify for discounted or free coverage available to people with low income or disability.
- Avoid lapses in coverage. Plan for transitions in health insurance coverage that occur with college graduation, aging out of parental coverage, or job changes.

Be aware of the laws that help you keep insurance benefits. The following laws apply to survivors living in the United States:

- **ACA** (Affordable Care Act), the comprehensive health care reform law enacted in the United States on March 30, 2010, created a Health Insurance Marketplace and new rights and protections that make health insurance coverage fairer and easier to understand. More information is available at ***www.healthcare.gov.***
- **COBRA** (Consolidated Omnibus Budget Reconciliation Act) requires employers or larger businesses to make insurance available for a limited time to employees (and their dependents) who are fired or laid off.
- **HIPAA** (Health Insurance Portability and Accountability Act of 1996) allows people with pre-existing conditions to keep comprehensive insurance coverage when they are changing insurance plans or jobs. Under the new Health Care Law in the United States, HIPAA eligibility provides greater protections than are otherwise available under state law.

Be persistent when meeting obstacles. Try not to get overwhelmed.

- Complete and follow through with applications.
- Appeal denials with letters of support from your healthcare provider.
- Contact groups such as Candlelighters and the National Coalition of Cancer Survivors for more information about healthcare resources.
- Don't give up!

Recommended Resources

The **National Coalition of Cancer Survivors** is a patient-led advocacy organization for cancer survivors. Their booklet, "A Cancer Survivor's Almanac," lists hundreds of organizations and agencies that offer help regarding specific cancer-related issues, including finding affordable healthcare. The booklet is available on their website, ***www.canceradvocacy.org.*** Their phone number is (877) 622-7937.

Cancer Care, a nonprofit organization dedicated to providing emotional support, information, and practical help to people with cancer and their loved ones. They also offer assistance in helping people with a cancer history understand the provisions of the Affordable Care Act. 1-800-813- HOPE (4673). ***www.cancercare.org.***

Health Link

Healthy living after treatment of childhood cancer

CHILDREN'S ONCOLOGY GROUP

The world's childhood cancer experts

Written by: Melissa M. Hudson, MD, After Completion of Therapy (ACT) Clinic, St. Jude Children's Research Hospital, Memphis, TN; Sally Wiard, MSW, LCSW, Christus Santa Rosa Hospital, San Antonio, TX; and Allison Hester, RN, MSN, CPNP, Arkansas Children's Hospital, Little Rock, AR. Adapted from the CCSS Newsletter, Spring 2003, used with permission.

Reviewed by Leslie L. Robison, PhD; Kevin Oeffinger, MD; Peggy Kulm, RN, MA; Scott Hawkins, LMSW; and Octavio Zavala.

Additional health information for childhood cancer survivors is available at *www.survivorshipguidelines.org*

Note: Throughout this *Health Links* series, the term "childhood cancer" is used to designate pediatric cancers that may occur during childhood, adolescence, or young adulthood. Health Links are designed to provide health information for survivors of pediatric cancer, regardless of whether the cancer occurred during childhood, adolescence, or young adulthood.

1/15/15

Resources for Pediatric Cancer Survivors

The following organizations offer information and support to pediatric cancer survivors.

Foundations

Candlelighters Childhood Cancer Foundation

This national, non-profit organization educates, supports, serves and advocates for families of children with cancer, survivors of childhood cancer and the professionals who care for them.

CureSearch

CureSearch is the combined effort of the Children's Oncology Group (COG) and the National Childhood Cancer Foundation (NCCF), two organizations with the common goal of finding a cure for childhood cancer. Their site provides information and support for both those on treatment and those who are now survivors. The information is disease specific and is presented for patients, parents and families, and healthcare professionals.

Lance Armstrong Foundation

The foundation's site has information for patients living with and beyond cancer. Its focus is on advocacy, education, public health and research. Other features include survivor stories and information about the physical, emotional and practical aspects of survivorship.

National Brain Tumor Foundation

A good site specifically for survivors of pediatric brain tumors.

National societies

Beyond The Cure

Beyond the Cure is a program of The National Children's Cancer Society. It helps childhood cancer survivors integrate the cancer experience into their new life as survivors and successfully handle the challenges that may lie ahead of them. The site has information about late effects, particularly those relating to education, work, fertility and psychological issues. In the near future, this site will also allow one to enter information about diagnosis and treatment and create a personal profile of medical history and potential late effects that may be accessed by both the survivor and a caregiver (with the survivor's permission). It will also provide guidelines for healthy living.

The Leukemia and Lymphoma Society

The Society's mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and to improve the quality of life of patients and their families. Check out their Survivorship Education Series which includes webcasts, teleconferences and conferences for survivors, families and healthcare professionals.

American Cancer Society

This site provides support and information to cancer survivors. Here you'll find links to the ACS Cancer Survivors Network and other resources from the American Cancer Society, as well as links to outside organizations.

Financial resources

The SAMFund

The SAMFund is a unique non-profit organization created to assist young adult survivors of cancer with a successful transition into their post-treatment life, by providing financial support through the distribution of grants and scholarships.

Scholarships for Cancer Survivors

Visit our scholarship listings pages to learn more about the opportunities available to you.

11/15/15

VACCINE INFORMATION STATEMENT

HPV Vaccine Gardasil® (Human Papillomavirus)

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 What is HPV?

Genital **human papillomavirus (HPV)** is the most common sexually transmitted virus in the United States. More than half of sexually active men and women are infected with HPV at some time in their lives.

About 20 million Americans are currently infected, and about 6 million more get infected each year. HPV is usually spread through sexual contact.

Most HPV infections don't cause any symptoms, and go away on their own. But HPV can cause **cervical cancer** in women. Cervical cancer is the 2nd leading cause of cancer deaths among women around the world. In the United States, about 12,000 women get cervical cancer every year and about 4,000 are expected to die from it.

HPV is also associated with several less common cancers, such as vaginal and vulvar cancers in women, and anal and oropharyngeal (back of the throat, including base of tongue and tonsils) cancers in both men and women. HPV can also cause genital warts and warts in the throat.

There is no cure for HPV infection, but some of the problems it causes can be treated.

2 HPV vaccine: Why get vaccinated?

The HPV vaccine you are getting is one of two vaccines that can be given to prevent HPV. It may be given to both males and females.

This vaccine can prevent most cases of cervical cancer in females, if it is given before exposure to the virus. In addition, it can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.

Protection from HPV vaccine is expected to be long-lasting. But vaccination is not a substitute for cervical cancer screening. Women should still get regular Pap tests.

3 Who should get this HPV vaccine and when?

HPV vaccine is given as a 3-dose series

1st Dose	Now
2nd Dose	1 to 2 months after Dose 1
3rd Dose	6 months after Dose 1

Additional (booster) doses are not recommended.

Routine vaccination

- This HPV vaccine is recommended for girls and boys **11 or 12 years of age.** It *may* be given starting at age 9.

Why is HPV vaccine recommended at 11 or 12 years of age?
HPV infection is easily acquired, even with only one sex partner. That is why it is important to get HPV vaccine before any sexual contact takes place. Also, response to the vaccine is better at this age than at older ages.

Catch-up vaccination

This vaccine is recommended for the following people who have not completed the 3-dose series:

- Females 13 through 26 years of age.
- Males 13 through 21 years of age.

This vaccine *may* be given to men 22 through 26 years of age who have not completed the 3-dose series.

It is *recommended* for men through age 26 who have sex with men or whose immune system is weakened because of HIV infection, other illness, or medications.

HPV vaccine may be given at the same time as other vaccines.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Some people should not get HPV vaccine or should wait.

- Anyone who has ever had a life-threatening allergic reaction to any component of HPV vaccine, or to a previous dose of HPV vaccine, should not get the vaccine. Tell your doctor if the person getting vaccinated has any severe allergies, including an allergy to yeast.
- HPV vaccine is not recommended for pregnant women. However, receiving HPV vaccine when pregnant is not a reason to consider terminating the pregnancy. Women who are breast feeding may get the vaccine.
- People who are mildly ill when a dose of HPV vaccine is planned can still be vaccinated. People with a moderate or severe illness should wait until they are better.

5 What are the risks from this vaccine?

This HPV vaccine has been used in the U.S. and around the world for about six years and has been very safe.

However, any medicine could possibly cause a serious problem, such as a severe allergic reaction. The risk of any vaccine causing a serious injury, or death, is extremely small.

Life-threatening allergic reactions from vaccines are very rare. If they do occur, it would be within a few minutes to a few hours after the vaccination.

Several **mild to moderate** problems are known to occur with this HPV vaccine. These do not last long and go away on their own.

- Reactions in the arm where the shot was given:
  - Pain (about 8 people in 10)
  - Redness or swelling (about 1 person in 4)
- Fever:
  - Mild (100° F) (about 1 person in 10)
  - Moderate (102° F) (about 1 person in 65)
- Other problems:
  - Headache (about 1 person in 3)
- Fainting: Brief fainting spells and related symptoms (such as jerking movements) can happen after any medical procedure, including vaccination. Sitting or lying down for about 15 minutes after a vaccination can help prevent fainting and injuries caused by falls. Tell your doctor if the patient feels dizzy or light-headed, or has vision changes or ringing in the ears.

Like all vaccines, HPV vaccines will continue to be monitored for unusual or severe problems.

6 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS is only for reporting reactions. They do not give medical advice.

7 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation.**

8 How can I learn more?

- Ask your doctor.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement (Interim)

HPV Vaccine (Gardasil)

5/17/2013

42 U.S.C. § 300aa-26

Office Use Only

HPV

also known as *Human Papillomavirus*

As parents, you do everything you can to protect your children's health for now and for the future. Today, there is a strong weapon to prevent several types of cancer in our kids: the HPV vaccine.

HPV and Cancer

HPV is short for Human Papillomavirus, a common virus. In the United States each year, there are about 17,500 women and 9,300 men affected by HPV-related cancers. Many of these cancers **could be prevented with vaccination.** In both women and men, HPV can cause anal cancer and mouth/throat (oropharyngeal) cancer. It can also cause cancers of the cervix, vulva and vagina in women; and cancer of the penis in men.

For women, screening is available to detect most cases of cervical cancer with a Pap smear. Unfortunately, there is no routine screening for other HPV-related cancers for women or men, and these cancers can cause pain, suffering, or even death. **That is why a vaccine that prevents most of these types of cancers is so important.**

More about HPV

HPV is a virus passed from one person to another during skin-to-skin sexual contact, including vaginal, oral, and anal sex. HPV is most common in people in their late teens and early 20s. Almost all sexually active people will get HPV at some time in their lives, though most will never even know it.

Most of the time, the body naturally fights off HPV, before HPV causes any health problems. But in some cases, the body does not fight off HPV, and HPV can cause health problems, like cancer and genital warts. Genital warts are not a life-threatening disease, but they can cause emotional stress, and their treatment can be very uncomfortable. About 1 in 100 sexually active adults in the United States have genital warts at any given time.

HPV vaccination is recommended for preteen girls and boys at age 11 or 12 years

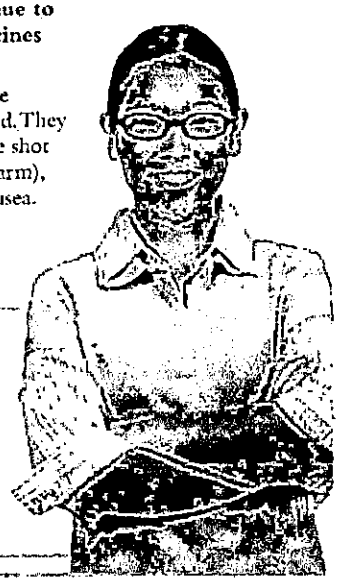
HPV vaccine is also recommended for girls ages 13 through 26 years and for boys ages 13 through 21 years, who have not yet been vaccinated. So if your son or daughter hasn't started or finished the HPV vaccine series—**it's not too late!** Talk to their doctor about getting it for them now.

Two vaccines—Cervarix and Gardasil—are available to prevent the HPV types that cause most cervical cancers and anal cancers. One of the HPV vaccines, Gardasil, also prevents vulvar and vaginal cancers in women and genital warts in both women and men. Only Gardasil has been tested and licensed for use in males. Both vaccines are given in a series of 3 shots over 6 months. The best way to remember to get your child all three shots is to make an appointment for the second and third shot before you leave the doctor's office after the first shot.

Is the HPV vaccine safe?

Yes. Both HPV vaccines were studied in tens of thousands of people around the world. More than 57 million doses have been distributed to date, and there have been no serious safety concerns. Vaccine safety continues to be monitored by CDC and the Food and Drug Administration (FDA). **These studies continue to show that HPV vaccines are safe.**

The most common side effects reported are mild. They include: pain where the shot was given (usually the arm), fever, dizziness, and nausea.



Why does my child need this now?

HPV vaccines offer the best protection to girls and boys who receive all three vaccine doses and have time to develop an immune response before they begin sexual activity with another person. This is not to say that your preteen is ready to have sex. In fact, it's just the opposite—it's important to get your child protected before you or your child have to think about this issue. The immune response to this vaccine is better in preteens, and this could mean better protection for your child.

DISTRIBUTED BY:

You may have heard that some kids faint when they get vaccinated. Fainting is common with preteens and teens for many medical procedures, not just the HPV shot. Be sure that your child eats something before going to get the vaccine. It's a good idea to have your child sit or lay down while getting any vaccine, and for 15 minutes afterwards, to prevent fainting and any injuries that could happen from fainting.

The HPV vaccine can safely be given at the same time as the other recommended vaccines, including the Tdap, meningococcal, and influenza vaccines. Learn more about all of the recommended preteen vaccines at **www.cdc.gov/vaccines/teens**

Help paying for vaccines

The Vaccines for Children (VFC) program provides vaccines for children ages 19 years and younger who are under-insured, not insured, Medicaid-eligible, or American Indian/Alaska Native. Learn more about the VFC program at **www.cdc.gov/Features/VFCprogram/**

Whether you have insurance, or your child is VFC-eligible, some doctors' offices may also charge a fee to give the vaccines.

Jacquelyn's story: "I was healthy—and got cervical cancer."

When I was in my late 20's and early 30's, in the years before my daughter was born, I had some abnormal Pap smears and had to have further testing. I was told I had the kind of HPV that can cause cancer and mild dysplasia.

For three more years, I had normal tests. But when I got my first Pap test after my son was born, they told me I needed a biopsy. The results came back as cancer, and my doctor sent me to an oncologist. Fortunately, the cancer was at an early stage. My lymph nodes were clear, and I didn't need radiation. But I did need to have a total hysterectomy.

My husband and I have been together for 15 years, and we were planning to have more children. We are so grateful for our two wonderful children, but we were hoping for more—which is not going to happen now.

The bottom line is they caught the cancer early, but the complications continue to impact my life and my family. For the next few years, I have to get pelvic exams and Pap smears every few months, the doctors measure tumor markers, and I have to have regular x-rays and ultrasounds, just in case. I have so many medical appointments that are taking time away from my family, my friends, and my job.

Worse, every time the phone rings, and I know it's my oncologist calling, I hold my breath until I get the results. I'm hopeful I can live a full and healthy life, but cancer is always in the back of my mind.

In a short period of time, I went from being healthy and planning more children to all of a sudden having a radical hysterectomy and trying to make sure I don't have cancer again. It's kind of overwhelming. And I am one of the lucky ones!

Ultimately I need to make sure I'm healthy and there for my children. I want to be around to see their children grow up.

I will do everything to keep my son and daughter from going through this. I will get them both the HPV vaccine as soon as they turn 11. I tell everyone—my friends, my family—to get their children the HPV vaccine series to protect them from this kind of cancer.

What about boys?

One HPV vaccine—Gardasil—is for boys too! This vaccine can help prevent boys from getting infected with the types of HPV that can cause cancers of the mouth/throat, penis and anus. The vaccine can also help prevent genital warts. HPV vaccination of males is also likely to benefit females by reducing the spread of HPV viruses.

Learn more about HPV and HPV vaccine at **www.cdc.gov/hpv**

For more information about the vaccines recommended for preteens and teens:
800-CDC-INFO *(800-232-4636)*
http://www.cdc.gov/vaccines/teens

Ochsner Health System
Sleep Center
Tel 504 842-4910

Baseline PSG/MSLT REPORT

Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

Patient Name: Bodin, Jeffery			Hospital #:	83000256150
Sex:	Male	Study Date:	2/2/2015	
D.O.B.:	5/22/1997	Clinic #:	2592229	
Age:	17	Referring Physician:	Liudmila Lysenko, MD	
Height:	67.0 in	Referring Physician #	2478	
Weight:	107.0 lbs	Sleep Specialist:	L. Lysenko, MD	
B.M.I.:	16.8	Sleep Specialist #	2478	
Hypopnea rule:	AASM1A	Scoring Tech:	A.Becnel,RPSGT	
Total AHI:	10.3	Recording Tech:	Leanett Sandifer, RRT	
Lowest O2 sat:	91.0%	Recording Location:	Ochsner Baptist	

Sleep architecture: This is a baseline polysomnogram. At light's out, the patient fell asleep in 3.5 minutes and slept for 94.4% of the time. Total sleep time (TST) was 401.5 minutes. 5.4% of TST was in Stage N1 sleep, 24.4% TST in slow wave sleep, and 21.2% TST in REM sleep. The REM latency was 69.0 minutes. Sleep architecture was mildly disrupted due to underlying sleep apnea.

Respiratory: Mild snoring was present. There was mild, yet significant OSA (obstructive sleep apnea) based on AHI (apnea hypopnea index) criteria. The overall AHI was 10.3 with an oxygen nadir of 91.0%. The supine AHI was 5.9 and the REM AHI was 30.4. The patient did not qualify for a split night study due to an insufficient number of events in the first half of the study.

Motor movement / Parasomnia: There were no significant limb movements of sleep noted. The total limb movement index was 0.0 (0.0with arousal).

Cardiac: Cardiac rhythm monitoring revealed a normal sinus rhythm ..

Patient perception: On a post-sleep study questionnaire, the patient indicated that sleep was "worse" in the lab than compared to home.

MSLT: Next day, for the MSLT 4 naps were recorded at 2 hour intervals, for approximately 20 minutes duration each, starting at a lights out time of 7:35 AM AM for Nap 1. She fell asleep on 4/4 naps and developed sleep onset REM periods (SOREMPs) on 4/4 naps. The sleep onset latency for Naps 1 through 4 were 3:30 min, 1;00 min, 0:30 min, 2:00 min, respectively. The 4 nap-mean sleep latency was severily diminished at 1.5 minutes. The patient felt that she fell asleep on naps 1-4. Urine drug screen on the morning of the MSLT was negative.

IMPRESSION:

1. Severily diminished sleep onset latency of 1.5 minutes was noted on MSLT with 4/4 SOREMS (sleep onset REM periods). This is suggestive of narcolepsy in appropriate clinical context.

2. Mild, yet significant OSA (327.23) based on AHI criteria

RECOMMENDATION:

1. Clinical correlation is suggested

Liudmila Lysenko, MD

Ochsner Health System
Sleep Center
Tel: 504 842-4910

Baseline PSG/MSLT REPORT

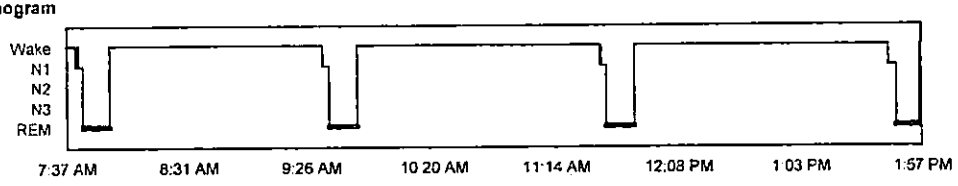
Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

MULTIPLE SLEEP LATENCY TEST:

Sleep Architecture	NAP 1	NAP 2	NAP 3	NAP 4	NAP 5	Mean Values
Analysis Start Time:	7:37:28 AM	9:29:58 AM	11:33:28 AM	1:40:28 PM	N/A	–
Analysis End Time:	7:55:58 AM	9:45:58 AM	11:48:58 AM	1:57:28 PM	N/A	–
Time in Bed*:	18:30	16:00	15:30	17:00	N/A	16:45
Total Sleep Time*:	14:30	15:00	14:30	14:30	N/A	14:38
Sleep Onset*:	03:30	01:00	00:30	02:00	N/A	01:45
REM Latency*:	03:30	03:00	03:00	03:30	N/A	03:15

* Time formats are in min:sec. Note: report will return default time = 20 min. for Sleep Onset, if no sleep occurs during nap.

Hypnogram



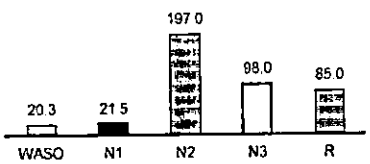
Ochsner Health System
Sleep Center
Tel: 504 842-4910

Baseline PSG/MSLT REPORT

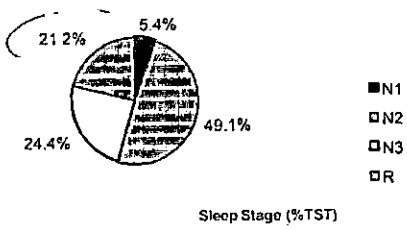
Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

Sleep Architecture	
Lights out clock time (hr:min):	10:44:13 PM
Lights on clock time (hr:min):	5:49:32 AM
Total Recording Time (TRT; in min.):	425.3
Sleep Period Time (SPT)*:	7:01:50
Total Sleep Time (TST; in min.):	401.5
Sleep Efficiency:	94.4%
Sleep latency (SL):	0:03:30
Total Stage Changes (after sleep onset):	101
Awakenings (after sleep onset):	22
WASO (min.):	20.3
REM Periods:	6
REM Latency*:	1:10:00
REM Latency (less Wake time)*:	1:09:00

* Time formats are in hrs:min:sec



Stage Distribution (in min.)



Sleep Stage (%TST)

Sleep Stage	Latency (min)
N1:	0.0
N2:	3.5
N3:	14.0
R:	70.0

Stage Latency = 0.0 denotes start of sleep.

Ochsner Health System
Sleep Center
Tel: 504 842-4910

Baseline PSG/MSLT REPORT

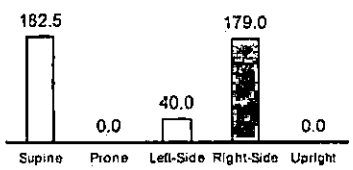
Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

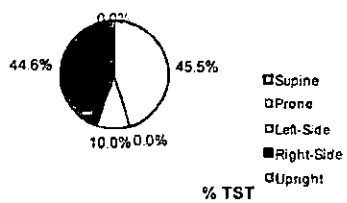
RESPIRATORY EVENTS	Cen. Apneas	Obs. Apneas	Mxd. Apneas	Hypopneas	Total Apneas	Apnea+ Hypopnea	RERA	All Resp. Events *
Count:	6	0	0	63	6	69	0	69
Index (events / hr.):	0.9	0.0	0.0	9.4	0.9	10.3	0.0	10.3
Mean Duration (sec.):	12.5	N/A	N/A	19.9	12.5	19.2	N/A	19.2
Longest Event (sec.):	14.4	N/A	N/A	44.7	14.4	44.7	N/A	44.7
REM Count:	3	0	0	40	3	43	0	43
Non-REM Count:	3	0	0	23	3	26	0	26
REM Index:	2.1	0.0	0.0	28.2	2.1	30.4	0.0	30.4
Non-REM Index:	0.6	0.0	0.0	4.4	0.6	4.9	0.0	4.9

* Note: Does not contain Cheyne Stokes Breathing, Hypoventilation, or Periodic Breathing.

RESPIRATORY EVENTS (by Body-Position)	Supine Sleep		Prone Sleep		Left-Side Sleep		Right-Side Sleep		Upright Sleep *	
	Count	Index	Count	Index	Count	Index	Count	Index	Count	Index
Duration (hrs:min:sec):	3:02:30		0:00:00		0:40:00		2:59:00		0:00:00	
Obstructive Apneas:	0	0.0	N/A	N/A	0	0.0	0	0.0	N/A	N/A
Central Apneas:	1	0.3	N/A	N/A	1	1.5	4	1.3	N/A	N/A
Mixed Apneas:	0	0.0	N/A	N/A	0	0.0	0	0.0	N/A	N/A
Hypopneas:	17	5.6	N/A	N/A	2	3.0	44	14.7	N/A	N/A
RERAs:	0	0.0	N/A	N/A	0	0.0	0	0.0	N/A	N/A
Total*:	18	5.9	N/A	N/A	3	4.5	48	16.1	N/A	N/A

* Note: Does not contain Cheyne Stokes Breathing, Hypoventilation, or Periodic Breathing.





BODY-POSITION RESULTS

Ochsner Health System
Sleep Center
Tel: 504 842-4910

Baseline PSG/MSLT REPORT

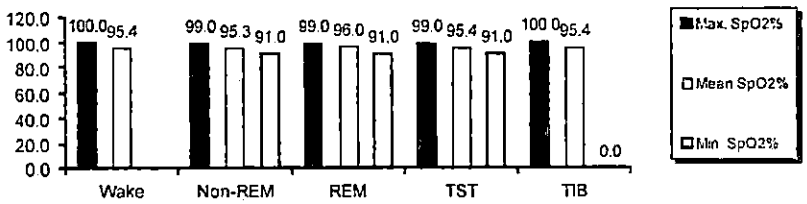
Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

AROUSALS	Resp. Count	Resp. Index	Spontaneous Count*	Spontaneous Index*	Total Count	Total Index
Total Sleep Time:	49	7.3	60	9.0	109	16.3
Non-REM	17	3.2	28	5.3	45	8.5
REM:	32	22.6	32	22.6	64	45.2

* EEG Arousal activity not associated with Respiratory or PLM events

LIMB MOVEMENTS (by sleep stage)	LM w/ Arousals Count	LM w/ Arousals Index	LM w/o Arousals Count	LM w/o Arousals Index	Total LMs Count	Total LMs Index	PLM Series Count	PLM Series Index
Total Sleep Time:	0	0.0	0	0.0	0	0.0	0	0.0
N1	0	0.0	0	0.0	0	0.0	0	0.0
N2:	0	0.0	0	0.0	0	0.0	0	0.0
N3:	0	0.0	0	0.0	0	0.0	0	0.0
R	0	0.0	0	0.0	0	0.0	0	0.0

OXYGEN DESATURATION EVENTS	Count	Index
Total Sleep Time:	56	8.4
Wake (after sleep onset):	0	0.0
Non-REM:	30	5.7
REM:	26	18.4



Oximetry Trend Graph

Ochsner Health System
Sleep Center
Tel: 504 842-4910

Baseline PSG/MSLT REPORT

Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

OXYGEN SATURATION	Wake	Non-REM	REM	TST	TIB
Max. SpO2%:	100.0	99.0	99.0	99.0	100.0
Mean SpO2%:	95.4	95.3	96.0	95.4	95.4
Min. SpO2%:		91.0	91.0	91.0	0.0
SpO2% <= 89% (min.)	0.2	0.0	0.0	0.0	0.2
		% Time in range			
90 – 100%:	97.4%	99.8%	99.0%	99.6%	99.5%
80 – 89%:	0.9%	0.0%	0.0%	0.0%	0.1%
70 – 79%:	0.0%	0.0%	0.0%	0.0%	0.0%
60 – 69%:	0.0%	0.0%	0.0%	0.0%	0.0%
50 – 59%:	0.0%	0.0%	0.0%	0.0%	0.0%
< 50%:	0.4%	0.0%	0.0%	0.0%	0.0%
% Artifact / Bad Data:	1.2%	0.2%	1.0%	0.4%	0.4%

HEART RATE RESULTS	Wake	Non-REM	REM	TST	TIB
Mean HR (bpm):	66.5	49.8	57.3	51.4	52.3
		% Time in range			
> 100 (bpm):	1.0%	0.0%	0.0%	0.0%	0.1%
90 – 100 (bpm):	1.9%	0.0%	0.0%	0.0%	0.1%
80 – 89 (bpm):	13.3%	0.3%	0.9%	0.4%	1.1%
70 – 79 (bpm):	26.4%	0.9%	7.8%	2.4%	3.7%
60 – 69 (bpm):	21.4%	3.6%	38.2%	10.9%	11.5%
50 – 59 (bpm):	24.7%	33.3%	25.8%	31.7%	31.3%
< 50 (bpm):	11.3%	61.9%	27.3%	54.6%	52.2%
% Artifact / Bad Data:	0.0%	0.0%	0.0%	0.0%	0.0%

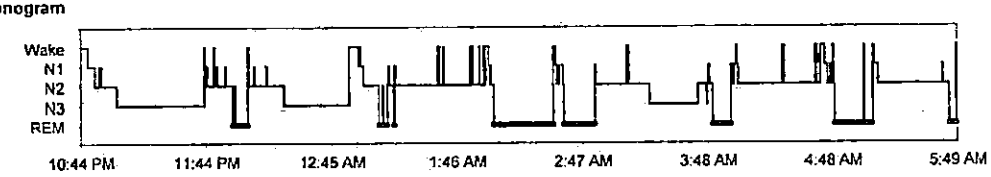
CARDIAC EVENTS	Brady.	Asystole	Tachy.	Narrow Complex Tachy.	Wide Complex Tachy.	Atrial Fibrillation	Accel.	Decel.
Count.	0	0	0	0	0	0	0	0
Shortest Event (min:sec):	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Longest Event (min:sec):	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sum Duration (min:sec):	0:00:00	0:00:00	0:00:00	0:00:00	0:00:00	0:00:00	0:00:00	0:00:00
Absolute Max. Rate (bpm):	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Absolute Min. Rate (bpm)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Ochsner Health System
Sleep Center
Tel: 504 842-4910

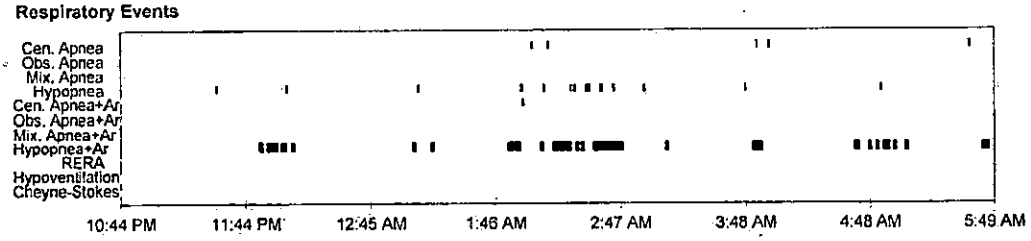
Baseline PSG/MSLT REPORT

Patient Name: Bodin, Jeffery Clinic #: 2592229 Date of Study: 2/2/2015

Hypnogram

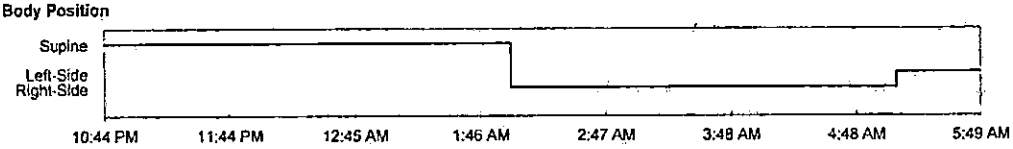


Respiratory Events

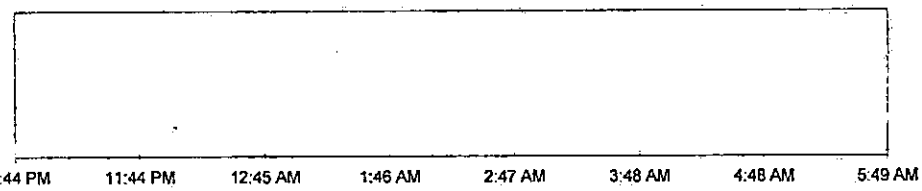


SpO2%

Body Position



Limb Movement Events



Was obtained in the first page of sleep study.

2/2/15 Sleep Study

2/11/15 – See Below 4/16/17

Lakeview Regional Medical Center, Covington, Louisiana
CLIA ID 19D1021830
Pamela Bartholomew, M.D. Jeremy Henderson, M.D.

PATIENT: BODIN,JEFFREY T ACCT #: F00041386523 LOC: F.LAB U #: F000723116
DOB: 05/22/97 AGE/SX: 17/M ROOM. REG: 01/15/15
REG DR: Guillot,Richard J MD STATUS· DEP CLI BED: DIS:
Dr Phone (985)892-3122 or

SPEC #: 0115:LV:S00024R COLL: 01/15/15-1542 STATUS: COMP REQ #: 02469672
RECD: 01/15/15-1542 SUBM DR: Guillot,Richard J MD

ENTERED: 01/15/15-1547 OTHR DR: Casey,Sherri MD
ORDERED: PNEUMO AB IGG

Test	Result	Flag	Reference	Verified	Site
PNEUMO AB IGG					
> PNEUMO 1 IGG	0.5	L	>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 3 IGG	0.9	L	>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 4 IGG	1.8		>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 8 IGG	0.2	L	>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 9N IGG	<0.1	L	>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 12F IGG	0.2	L	>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 14 IGG	0.8	L	>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 19F IGG	0.9	L	>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 23F IGG	0.6	L	>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 26 IGG	<0.1	L	>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 51 IGG	0.8	L	>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 56 IGG	1.2	L	>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 57 IGG	1.2	L	>1.3 ug/mL	01/22/15-1810	LC
> PNEUMO 68 IGG	0.1	L	>1.3 ug/mL	01/22/15-1810	LC

** This test was developed and its performance characteristics determined by Viracor-IBT Laboratories.It has not been cleared or approved by the FDA.*
Performed At: NEWXW Viracor IBT Laboratories Inc
1001 NW Technology Drive Lees Summit, MO 640865603
Altrich Michelle L PhD Ph:8558788477

Baseline — Non Responder

Need Pneumovax, recheck Pneumo 13 in 4–6 weeks

1/26/15

LC - LABCORP L#17131140 M#17381445
Test performed at LabCorp, Birmingham, AL unless otherwise noted in result

Pamela Bartholomew, M.D. CLIA # 19D0048415
** END OF REPORT **

Report printed:01/20/15,1548

Page 1

DOCTOR'S COPY

PATIENT: BODIN,JEFFREY T
ACCT #: F00041386523 LOC: F.LAB U #: F00072311
AGE/SX: 17/M ROOM: REG: 01/15/15
REG DR: Guillot,Richard J MD DOB: 05/22/97 BED: DIS:
RT&TIR: DEP CIT FLOOR:

SPEC #: 0115:LV:C00171R COLL: 01/15/15-1542 STATUS: COMP REQ #: 02469672
RECD: 01/15/15-1542 SUBM DR: Guillot,Richard J MD

ENTERED: 01/15/15-1547 DR: OTHR DR:

ORDERED: IGG SUBCLASSES

Test	Low	Normal	High	Flag	Reference	Site
		-----CHEMISTRY-----				
IGG SUBCLASSES						
> IGG QUANT	867				549-1584 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 1	549				422-1282 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 2	226				117-747 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 3	33			L	41-129 mg/dL	LC 01/20/15-0914
> IGG SUBCLASS 4	212				1-291 mg/dL	LC 01/20/15-0914

Results verified by repeat testing
Performed At: MB LabCorp Birmingham
1801 First Avenue South Birmingham, AL 352331935
Elgin John MD Ph:2055813500
Performed At: BN LabCorp Burlington
1447 York Court Burlington, NC 272153361
Hancock William F MD Ph:8007624344

*LC - LABCORP L#17131140 M#17381445
Test performed at LabCorp, Birmingham, AL unless otherwise noted in result

Pneumococcal IgG's

RGDML

Report printed:01/20/15,1548

DOCTOR'S COPY

PATIENT: BODIN,JEFFREY T — ACCT #: F00041386523 LOC: F.LAB — U #: P0007231
AGE/SEX: 17/M — ROOM: — REG: 01/15/15
REG DR: Guillet,Richard J MD — DOB: 09/22/97 — BED: — DIS:
STATUS: DEP CLI — TLOC:

SPEC #: 0115:LV:S00025R — COLL: 01/15/15-1542 — STATUS: COMP — REQ #: 02469672
RECD: 01/15/15-1542 — SUBM DR: Guillet,Richard J MD

ENTERED: 01/15/15-1547 — DR: — OTHR DR:

ORDERED: TETANUS AB

Test	Low	Normal	High	Flag	Reference	Sit
		-----SEROLOGY-----				
> TETANUS AB IGG		0.40			<0.10 IU/mL	LC 01/20/15-1217

Protective

Interpretation:
Non-Protective <0.10
Protective >=0.10

Results for this test are for research purposes only by the assay's manufacturer. The performance characteristics of this product have not been established. Results should not be used as a diagnostic procedure without confirmation of the diagnosis by another medically established diagnostic product or procedure.
Performed At: BN LabCorp Burlington
1447 York Court Burlington, NC 272152361
Hancock William F MD Ph:8007624344

>LC - LABCORP L#17131140 M#17381445
Test performed at LabCorp, Birmingham, AL unless otherwise noted in result

PNEUMOCOCCAL CONJUGATE VACCINE

WHAT YOU NEED TO KNOW

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis.

1 Pneumococcal disease

Infection with *Streptococcus pneumoniae* bacteria can make children very sick.

It causes blood infections, pneumonia, and meningitis, mostly in young children. (Meningitis is an infection of the covering of the brain.) Although pneumococcal meningitis is relatively rare (less than 1 case per 100,000 people each year), it is fatal in about 1 of 10 cases in children.

Pneumococcal meningitis can also lead to other health problems, including deafness and brain damage.

Before routine use of pneumococcal conjugate vaccine, pneumococcal infections caused:

- over 700 cases of meningitis,
- 13,000 blood infections,
- about 5 million ear infections, and
- about 200 deaths

annually in the United States in children under five.

Children younger than 2 years of age are at higher risk for serious disease than older children.

Pneumococcal bacteria are spread from person to person through close contact.

Pneumococcal infections may be hard to treat because some strains of the bacteria have become resistant to the drugs that are used to treat them. This makes prevention of pneumococcal infections through vaccination even more important.

2 Pneumococcal conjugate vaccine (PCV13)

There are more than 90 types of pneumococcal bacteria. The new pneumococcal conjugate vaccine (PCV13) protects against 13 of them. These bacteria types are responsible for most severe pneumococcal infections among children. PCV13 replaces a previous conjugate vaccine (PCV7), which protected against 7 pneumococcal types and has been in use since 2000. During that time severe pneumococcal disease dropped by nearly 80% among children under 5.

PCV13 may also prevent some cases of pneumonia and some ear infections. But pneumonia and ear infections have many causes, and PCV13 only works against the types of pneumococcal bacteria targeted by the vaccine.

PCV13 is given to infants and toddlers, to protect them when they are at greatest risk for serious diseases caused by pneumococcal bacteria.

In addition to receiving PCV13, older children with certain chronic illnesses may get a different vaccine called PPSV23. There is a separate Vaccine Information Statement for that vaccine.

3 Who should get PCV13, and when?

Infants and Children Under 2 Years of Age

PCV13 is recommended as a series of 4 doses, one dose at each of these ages: 2 months, 4 months, 6 months, and 12 through 15 months

Children who miss their shots at these ages should still get the vaccine. The number of doses and the intervals between doses will depend on the child's age. Ask your health care provider for details.

Children who have began their immunization series with PCV7 should complete the series with PCV13.

Older Children and Adolescents

- Healthy children between their 2nd and 5th birthdays who have not completed the PCV7 or PCV13 series before age 2 years should get 1 dose.

- Children between the 2nd and 6th birthdays with medical conditions such as:
  - sickle cell disease,
  - a damaged spleen or no spleen,
  - cochlear implants,
  - diabetes,
  - HIV/AIDS or other diseases that affect the immune system (such as cancer, or liver disease), or
  - chronic heart or lung disease,

  or who take medications that affect the immune system, such as immunosuppressive drugs or steroids, should get 1 dose of PCV 13 (if they received 3

doses of PCV7 or PCV13 before age 2 years), or 2 doses of PCV13 (if they have received 2 or fewer doses of PCV7 or PCV13).

A dose of PCV13 may be administered to children and adolescents 6 through 18 years of age who have certain medical conditions, even if they have previously received PCV7 or PPSV23.

Children who have completed the 4-dose series with PCV7: Healthy children who have not yet turned 5, and children with medical conditions who have not yet turned 6, should get one additional dose of PCV13.

Ask your health care provider if you have questions about any of these recommendations.

PCV13 may be given at the same time as other vaccines.

4 Some children should not get PCV13 or should wait

Children should not get PCV13 if they had a serious (life-threatening) allergic reaction to a previous dose of this vaccine, to PCV7, or to any vaccine containing diphtheria toxoid (for example, DTaP).

Children who are known to have a severe allergy to any component of PCV7 or PCV13 should not get PCV13. Tell your health care provider if your child has any severe allergies.

Children with minor illnesses, such as a cold, may be vaccinated. But children who are moderately or severely ill should usually wait until they recover before getting the vaccine.

5 What are the risks from PCV13?

Any medicine, including a vaccine, could possibly cause a serious problem, such as a severe allergic reaction. However, the risk of any vaccine causing serious harm, or death, is extremely small.

In studies, most reactions after PCV13 were mild. They were similar to reactions reported after PCV7, which has been in use since 2000. Reported reactions varied by dose and age, but on average:

- About half of children were drowsy after the shot, had a temporary loss of appetite, or had redness or tenderness where the shot was given.
- About 1 out of 3 had swelling where the shot was given.
- About 1 out of 3 had a mild fever, and about 1 in 20 had a higher fever (over 102.2°F).
- Up to about 8 out of 10 became fussy or irritable.

Life-threatening allergic reactions from vaccines are very rare. If they do occur, it would be within a few minutes to a few hours after the vaccination.

6 What if there is a severe reaction?

What should I look for?

Any unusual condition, such as a high fever or behavior changes. Signs of a severe allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- Call a doctor, or get the person to a doctor right away.
- Tell the doctor what happened, the date and time it happened, and when the vaccination was given.
- Ask your provider to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.
  Or you can file this report through the VAERS website at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS does not provide medical advice.

7 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) was created in 1986.

Persons who believe they may have been injured by a vaccine may file a claim with VICP by calling 1-800-338-2382 or visiting their website at www.hrsa.gov/vaccinecompensation.

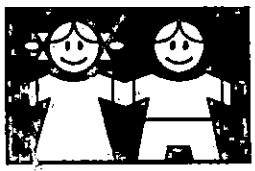
8 How can I learn more?

- Ask your provider. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC's website at www.cdc.gov/vaccines.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC

Vaccine Information Statement (Interim)
PCV13 **4/16/2010** 42 U.S.C. §300aa-26



CHILDREN'S HOSPITAL

CLINICAL GENETICS
Office: ACC Room 2308
Telephone: (504) 896-9254
Fax: (504) 896-3997
Appointments: (504) 896-9254

CLINICS:
NEW ORLEANS
Children's Hospital, ACC
200 Henry Clay Avenue
New Orleans, LA 70118

METAIRIE
Children's Hospital Metairie Center
3040 33rd Street, Metairie, LA 70001

BATON ROUGE
Children's Hospital Outpatient Clinic
720 Connell Park Lane
Baton Rouge, LA 70806

LAFAYETTE
Children's Hospital Outpatient Clinic
Burdin Riehl ACC of LGMC
1211 Coolidge Blvd., 2nd Floor
Lafayette, LA 70503

Lake Charles State Clinic
3236 Kirkman St.
Lake Charles, LA 70602
Appt: (337) 478-6020

Thibodaux State Clinic
2535 Veterans Blvd.
Thibodaux, LA 70301
Appt: (985) 447-0896

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Inborn Errors of Metabolism
Abnormal Newborn Screening
Down & Chromosomal Disorders
Neurofibromatosis
Craniofacial Anomalies
Hereditary Diseases
Genetic Counseling
Metabolic Nutrition Services

200 Henry Clay Avenue
New Orleans, Louisiana 70118
(504) 899-9511
www.chnola.org

DEPARTMENT OF GENETICS
Children's Hospital New Orleans

DIVISION OF GENETICS, DEPARTMENT OF PEDIATRICS
Louisiana State University Health Sciences Center

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May 11, 2015

Jaime Morales-Arias MD
Children's Hospital Hematology/Oncology
IN HOUSE – HAND DELIVER

Re: Bodin, Jeffrey
DOB: 5/22/97

Dear Dr. Morales-Arias:

Thank you very much for the referral of your patient, Jeffrey Bodin, who was seen along with his mother Linda in my Genetics Clinic at Children's Hospital on April 21, 2015.

As you know, Jeffrey is an almost 18-year-old white male referred by you because of a history of melanoma as he presents a stage III tumor over the left ankle with nodes in the left inguinal area. This is his major problem, but he recently was diagnosed with narcolepsy by Dr. Lysenko at Ochsner. He has a history of daily migraines and peripheral neuropathy diagnosed by Dr. Africk and attributed to the use of interferon. He also has bad allergies that are seasonal, being seen by Dr. Guillot on the Northshore. He also has had two episodes of seizures while being on interferon. I understand you referred him to see if we wanted to perform any other molecular testing besides the p53 or other that you are willing to request.

As this was our first evaluation, I tried to obtain a detailed family, prenatal, perinatal, and postnatal history, and we performed a detailed physical examination. Let me just summarize the positive antecedents and findings. Regarding the family history, I learned that the father Mark was 35 years old when Jeffrey was born. He is a lawyer. He only has high blood pressure. He has one brother who is 51 and one sister who is under 50. His mother has mydriasis and Jeffrey has the same problem, according to the information provided by the mother. Mark's mother and Jeffrey are seen by Dr. Marilu O'Byrne, the ophthalmologist across the lake.

Jeffrey's mother Linda was 31 years old at the time of delivery. She is a housewife. She has one sister who has two normal daughters, although

one has intellectual disability. Her mother died at age 54 of vaginal cancer. There is no consanguinity. The father is from Algiers and all his family is from Louisiana and the mother is from California.

Mom has had two pregnancies. The first one was with Jeffrey, the proband, and the second was with Stephanie, who is 15 years old and has a history of scoliosis. The pregnancy with Jeffrey was uneventful until the last one and a half months, when mom presented preeclampsia. For this reason, a C-section was performed. Jeffrey was born at 32 weeks gestational age with a birth weight of 4 pounds and 3 ounces or 1890 grams. The birth length, head circumference, and Apgar score were not recollected. Jeffrey at birth was in an incubator with oxygen and nasogastric tube for feeding for about one week. He was discharged after two weeks with a heart monitor, which was used for three months. He had some questionable sleep apnea.

Regarding postnatal history and growth, he has always had low growth, but at approximately age 9, this got worse. For that reason, he was seen by Dr. Pouw, the pediatric endocrinologist. Jeffrey discontinued his visits to Endocrinology because he developed cancer at age 10. Thereafter, he was seen by Dr. Pouw again, noticing that he was okay. At age 12, he had new testing by Dr. Pouw, showing low growth hormone. He did treat Jeffrey for four years with Nutropin. He stopped growing at age 17. From the developmental point of view, he had normal milestones. He is in the eleventh grade getting A's and B's and some honors. It was good to learn that he wants to be a doctor. His only surgeries were for a tonsillectomy and adenoidectomy at age 4 and appendectomy after the second surgery for melanoma.

On physical examination, his height was 170.4 cm, being on the 25th percentile. This corresponds to the 50th percentile for 15 years of age. His weight was 44.2 kg, being below the 5th percentile and corresponding to the 50th percentile for 13 years of age. He is certainly very thin and underweight. His head circumference measured 54.7 cm, being between the 2nd and 50th percentile. I noticed that he has prominent ears, but I was told that this is from the father. However, I had the opportunity to see some pictures of the whole family and to me the father seems to have normal ears. Jeffrey has a scar on the left inguinal area. He has redness of hands and feet. At the level of the elbows, he has prominent ulnas. In the hands, I noticed tendency to short fourth metacarpals, but this is seen in about 10% of the normal population. In the hands, I noticed normal proximal axial triradius and quite normal dermatoglyphics.

After my evaluation, I told Jeffrey and his mother that certainly with the history of melanoma, I do not think that it is related to any genetic syndrome. For that reason, I told them that you are certainly in the best position to request molecular testing. You can request the p53 as well as some other specific genes that may be of interest regarding the history of melanoma. I told Jeffrey and his mother that I was sorry that I could not help more. However, in the future, I would be happy to talk with them if necessary. Thanks again for allowing me to meet this very

Bodin, Jeffrey (MR # 2592229) 6/8/15

Bodin, Jeffrey #2592229 (CSN: 46819388) (18 y.o. M)

Results EKG 12-lead (Order 150498662)

Result Image Hyperlink

Show images for EKG 12-lead

EKG 12-lead

Status: Final result Visible to patient: Not Released Next appt: 07/07/2015 at 09:00 AM in Pediatric Neurology (Diane K Africk, MD) Dx: Tachycardia

Result Narrative

```
Test Reason : 785.0
Blood Pressure : ***/*** mmHG
Vent. Rate : 090 BPM     Atrial Rate : 090 BPM
   P-R Int : 148 ms          QRS Dur : 102 ms
    QT Int : 340 ms       P-R-T Axes : 081 058 075 degrees
   QTc Int : 415 ms

Normal sinus rhythm
Right atrial enlargement
Borderline Abnormal ECG
No previous ECGs available
Confirmed by OREJARENA MD, LEONARDO (193) on 5/30/2015 10:58:36 AM

Referred By: LIUDMILA LYSENKO            Confirmed By:LEONARDO OREJARENA MD
```

Specimen Collected: 05/25/15 6:33 AM | Last Resulted: 05/30/15 10:58 AM | Order Details Lab and Collection Details Routing Result History

Lab Collection Information

Collected: 5/25/2015 6:33 AM

Reviewed by List

Liudmila Lysenko, MD on 6/2/2015 5:04 PM

Encounter	Result Information	
View Encounter	Status: Final result (5/30/2015 10:58 AM)	Provider Status: Reviewed

PACS Images

Show images for EKG 12-lead

EKG 12-lead (OCW IDPatientID=002592229&Date=25-05-2015&Time=06%3a33%3a22%3a255&TestType=ECG&Site=1&OutputType=PDF&Ext=PDF) (Order 150498662)
Results

Status: **Final result** **5/30/2015 10:58 AM**

View SmartLink Info

EKG 12-LEAD (Order #150498662) on 5/25/15

EKG 12-lead [EKG1] (Order 150498662)
ECG
Order: 150498662

Rel By: **Hanna Matthews**
Authorizing: **Liudmila Lysenko, MD**

Date and Time: **5/25/2015 7:34 AM**
Department: **Nsmc Cardiology**

Print This Page | Close This Window

Name: Jeffrey Bodin | DOB: 5/22/1997 | MRN: 2592229 | PCP: Sherry Casey, MD

EKG 12-LEAD - Details

About This Test

Narrative

Test Reason : 785.0
Blood Pressure : ***/*** mmHG
Vent. Rate : 090 BPM Atrial Rate : 090 BPM
P-R Int : 148 ms QRS Dur : 102 ms
QT Int : 340 ms P-R-T Axes : 081 058 075 degrees
QTc Int : 415 ms

Normal sinus rhythm
Right atrial enlargement
Borderline Abnormal ECG
No previous ECGs available
Confirmed by OREJARENA MD, LEONARDO (193) on 5/30/2015 10:58:36 AM

Referred By: LIUDMILA LYSENKO Confirmed By:LEONARDO OREJARENA MD

Component Results

There is no component information for this result.

General Information

Collected:	05/25/2015 6:33 AM
Resulted:	05/30/2015 10:58 AM
Ordered By:	Liudmila Lysenko, MD
Result Status:	Final result

Print This Page | Close This Window

Name: Jeffrey Bodin | DOB: 5/22/1997 | MRN: 2592229 | PCP: Sherry Casey, MD

2D ECHO WITH COLOR FLOW DOPPLER - Details

About This Test

Narrative

TEST DESCRIPTION
Technical Quality: This is a technically good study.

Aorta: The aortic root is normal in size, measuring 2.3 cm at sinotubular junction.

Left Atrium: The left atrial volume index is normal, measuring 21.22 cc/m2.

Left Ventricle: The left ventricle is normal in size, with an end-diastolic diameter of 3.9 cm, and an end-systolic diameter of 2.4 cm. LV wall thickness is normal, with the septum and the posterior wall each measuring 0.9 cm across. Relative wall
thickness was increased at 0.46, and the LV mass index was 76.2 g/m2 consistent with concentric remodeling. Global left ventricular systolic function appears normal. Visually estimated ejection fraction is 60-65%. The LV Doppler derived stroke volume
equals 55.0 ccs.
The E/e'(lat) is 5, consistent with normal diastolic function.

Right Atrium: The right atrium is normal in size, measuring 3.2 cm in length and 3.4 cm in width in the apical view.

Right Ventricle: The right ventricle is normal in size. Global right ventricular systolic function appears normal. The estimated PA systolic pressure is 17 mmHg.

Aortic Valve: The peak gradient obtained across the aortic valve is 5.0 mmHg, with a mean gradient of 3.0 mmHg. Using a left ventricular outflow tract diameter of 1.9 cm, a left ventricular outflow tract velocity time integral of 19 cm, and a peak
instantaneous transvalvular velocity of m/s, the calculated aortic valve area is 2.5 cm2.

Mitral Valve: The pressure half time is 58.0 msec. The calculated mitral valve area is 3.79 cm2.

Tricuspid Valve: There is trivial tricuspid regurgitation.

IVC: IVC is normal in size and collapses > 50% with a sniff, suggesting normal right atrial pressure of 3 mmHg.

Intracavitary: There is no evidence of pericardial effusion, intracavity mass, thrombi, or vegetation.

CONCLUSIONS
1 - Concentric remodeling.
2 - Normal left ventricular systolic function (EF 60-65%).
3 - Normal left ventricular diastolic function.
4 - Normal right ventricular systolic function .
5 - Trivial tricuspid regurgitation.

This document has been electronically
SIGNED BY: Gerardo Aristimuno, MD On: 06/15/2015 11:18

Component Results

Component	Standard Range	Your Value
EF	55 - 65	65
Diastolic Dysfunction		No
Est. PA Systolic Pressure		17.29
Tricuspid Valve Regurgitation		TRIVIAL

General Information

Collected: 06/15/2015 7:00 AM
Resulted: 06/15/2015 8:33 PM
Ordered By: Michael D Lecce, MD
Result Status: Final result

Melanoma and Skin Center

Welcome JEFFREY BODIN

Date: 09/11/2015 11:24:17 AM

From: Butler, Tiffany
NNST/Herzog - Scheduling
Child and Adolescent Center

Subject: Re: referral

Message: Good morning,

I sent your message to Dr Herzog but she said we don't have a physician here who treats narcolepsy and he would need to see a specialist outside of MD Anderson.

Please let us know if you have any further questions

Thanks,
Tiffany RN

Date: 09/10/2015 6:06:59 PM

To: NNST/Herzog - Scheduling
Child and Adolescent Center

From: BODIN, JEFFREY

Jeffrey was recently diagnosed with narcolepsy. We would like to get a second opinion. Could you please provide a referral of a doctor at MD Anderson?
Thank you
Linda Bodin
Mother of Jeffrey Bodin
615-284-5277

Reply | Delete

Return to View Messages

myMDAnderson

Search | FAQ | Help | Contact Us | Logout

MD Anderson Cancer Center
Making Cancer History

Melanoma and Skin Center

Welcome JEFFREY BODIN

Read Message < Secure messaging < Home

Printer friendly version

Date: 09/11/2015 04:33:52 PM

From: Paulino, Charles
Dr. Ross - Clinical
Melanoma and Skin Center

Subject: Re: Request appointment

Message: Hello, I have forwarded the message to Rebecca Carpenter PA for Dr Ross She should be able to order a consult.

Thanks
Charles

Date: 09/10/2015 6:00:19 PM

To: Dr. Ross - Scheduling
Melanoma and Skin Center

From: BODIN, JEFFREY

Jeffrey was recently diagnosed with narcolepsy. We would like to get a second opinion with a board certified sleep study doctor at MD Anderson. Could you please provide us with a referral?
Thank you,
Linda Bodin
mother to Jeffrey
855-264-5277

Reply | Delete

Return to View Messages

Jeffrey Bodin (Male, born May. 22, 1997)

528 BEAU CHENE DR
MANDEVILLE, LA 70471

9852645277 (Mobile)
9852645277 (Home)
jeffreybodin713@gmail.com

Note from Ochsner Health System and its Subsidiaries and Affiliates
This document contains information that was shared with Jeffrey Bodin. It may not contain the entire record from Ochsner Health System and its Subsidiaries and Affiliates.

Allergies

Not on file

Current Medications

butalbital-acetaminophen-caffeine 50-325-40 mg (FIORICET, ESGIC) 50-325-40 mg per tablet (Started 11/9/2015)
2 po prn headache; may repeat in 4 hours

dextroamphetamine-amphetamine (ADDERALL XR) 20 MG 24 hr capsule (Started 9/2/2015)
2 po q am and 2 po q afternoondo not refill till 6/30

dextroamphetamine-amphetamine (ADDERALL) 20 mg tablet (Started 9/2/2015)
1 pill po bid prn sleepiness

diphenhydrAMINE (BENADRYL) 12.5 mg chewable tablet
Take 12.5 mg by mouth 4 (four) times daily as needed.

DYMISTA 137-50 mcg/spray Spry (Started 5/13/2015)

guaifenesin (MUCINEX) 600 mg 12 hr tablet
Take 1,200 mg by mouth 2 (two) times daily.

montelukast 4 MG chewable tablet
Take 4 mg by mouth every evening.

naproxen (EC NAPROSYN) 500 MG EC tablet
500 mg once daily.

PATADAY 0.2 % Drop (Started 5/9/2015)

pseudoephedrine (SUDAFED) 120 mg 12 hr tablet
Take 120 mg by mouth every 12 (twelve) hours.

Active Problems

Bilateral headache (Noted 12/5/2013)

Narcolepsy (Noted 6/3/2015)

Seizure disorder (Noted 7/7/2014)

Immunizations

Influenza Split (Given 11/25/2013)

Information not available to this user

Results

2D ECHO WITH COLOR FLOW DOPPLER - Final result (06/15/2015 7:00 AM CDT)

Component	Value	Range
EF	65	55-65
Diastolic Dysfunction	No	
Est. PA Systolic Pressure	17.29	
Tricuspid Valve Regurgitation	TRIVIAL	

Narrative

```
TEST DESCRIPTION:
Technical Quality: This is a technically good study.
```

Component	Value	Range
Basophil%	0.8	0.0-0.7 %
Differential Method	Automated	

SEDIMENTATION RATE, MANUAL - Final result (11/25/2013 4:37 PM CST)

Component	Value	Range
Sed Rate	6	0-10 mm/Hr

COMPREHENSIVE METABOLIC PANEL - Final result (11/25/2013 4:36 PM CST)

Component	Value	Range
Sodium	140	136-145 mmol/L
Potassium	4.4	3.5-5.1 mmol/L
Chloride	105	95-110 mmol/L
CO2	23	23-29 mmol/L
Glucose	88	70-110 mg/dL
BUN, Bld	14	5-18 mg/dL
Creatinine	0.7	0.5-1.4 mg/dL
Calcium	9.9	8.7-10.5 mg/dL
Total Protein	7.5	6.0-8.4 g/dL
Albumin	4.4	3.2-4.7 g/dL
Total Bilirubin	0.5	0.1-1.0 mg/dL
	Comment: For infants and newborns, interpretation of results should be based on gestational age, weight and in agreement with clinical observations. Premature Infant recommended reference ranges: Up to 24 hours.....<8.0 mg/dL Up to 48 hours.....<12.0 mg/dL 3-5 days.....<15.0 mg/dL 6-29 days.....<15.0 mg/dL	
Alkaline Phosphatase	143	52-171 U/L
AST	23	10-40 U/L
ALT	14	10-44 U/L
Anion Gap	12	8-16 mmol/L
eGFR if non African American	Comment: Calculation used to obtain the estimated glomerular filtration rate (eGFR) is the CKD-EPI equation. Since race is unknown in our information system, the eGFR values for African-American and Non-African-American patients are given for each creatinine result.	mL/min/1.73 m^2

CK - Final result (11/25/2013 4:36 PM CST)

Component	Value	Range
CPK	76	20-200 U/L

T4 FREE (T4, FREE) - Final result (11/25/2013 4:36 PM CST)

Component	Value	Range
Free T4	1.11	0.71-1.51 ng/dL

TSH - Final result (11/25/2013 4:36 PM CST)

Component	Value	Range
TSH	0.093	0.400-5.000 uIU/mL

If you take your Lucy record on a thumb drive to a different doctor, he or she might be able to use his computer to read the file electronically. Your downloaded, machine-readable Personal Health Summary document is in a format called "CDA." If your doctor has a computer that understands CDA, your information is a folder on your thumb drive called MachineReadable_XDMFormat. You might need to enter a password before your doctor can use this file.

BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association

P.O. Box 98029
Baton Rouge, Louisiana 70898-9029
Phone 225/295-3307
Fax 225/295-2054

HMO Louisiana, Inc.
A subsidiary of Blue Cross and Blue Shield of Louisiana, an independent licensee of the Blue Cross and Blue Shield Association

P.O. Box 98024
Baton Rouge, Louisiana 70898-9024
Phone 800/376-7741
Fax 225/295-2494

000264

0100169180002640201

February 02, 2016

JEFFREY BODIN
528 BEAU CHENE DRIVE
MANDEVILLE, LA 704711777

We have approved 1 service(s)/procedure(s) for JEFFREY BODIN, Contract # 200597860, with a primary service/procedure code of E0601 as agreed upon at the time of the authorization request. This service is approved for the following provider(s):

RICHARD CASEY
NORTHLAKE MEDICAL SUPPLY, INC.

For Dates of Service
01/29/2016 to 03/29/2016

Please refer to Certification Number: AA0715362

The certification process is based on medical necessity only and is not a guarantee of payment. Any additional services/procedures that have not been approved by Blue Cross and Blue Shield of Louisiana are subject to review for contractual limitations and/or exclusions. We recommend that you verify benefits for all certifications.

Should you require further information about contract eligibility or limitations of your contract benefits, contact Blue Cross and Blue Shield Customer Service or Provider Inquiry Unit at the toll free number printed on the subscriber ID card.

This is a reminder if the provider is not contracted with your network plan, then reduced benefits may be applied to your claim. Please visit BCBSLA.com or call the customer service number on the back of your ID card to inquire if your provider is in your network.

Care Management Department

(Member Copy)

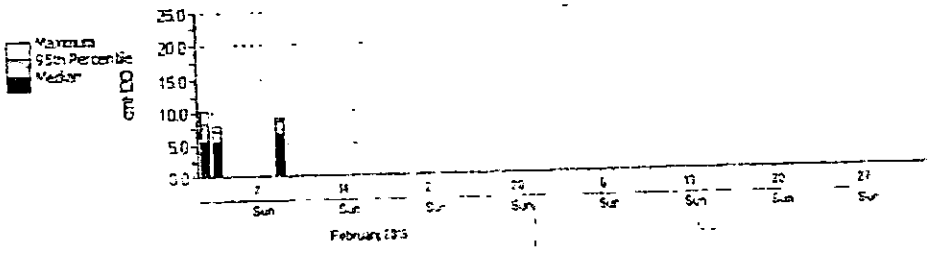
ResScan SOFTWARE

Name: JEFFREY BODIN
Patient ID
Reference ID
Date of Birth: 22 May 1957
Report prepared by: sleep on 2/15/2015 at 3:53 PM

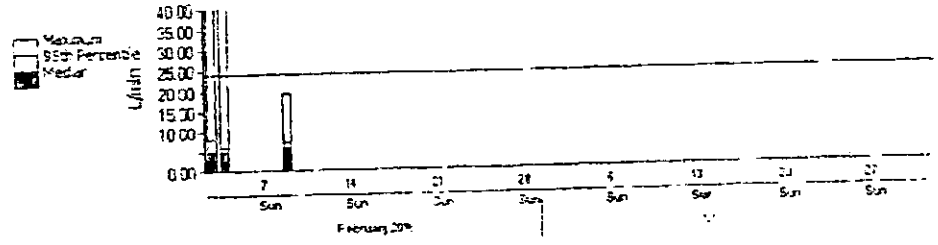
Summary Graphs

Serial No.: 20070439791
Product: S8 AutoSet Spirit

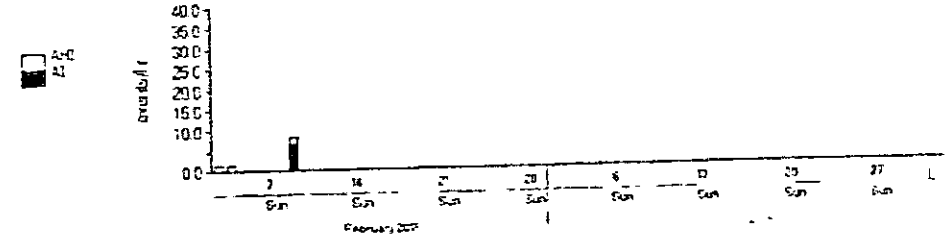
Pressure



Leak



AHI & AI



ResScan SOFTWARE

Name: JEFFREY BODIN
Patient ID:
Reference ID:
Date of Birth: 22 May 1997
Report prepared by: alison on 2/?/2016 at 3:55 PM

Statistics

Serial No.: 20070409791
Product: S8 AutoSet Spirit

2/3/2016 - 2/16/2016

Device Settings Therapy Mode: AutoSet	Minimum Pressure 5.0 cmH2O	Maximum Pressure 12.0 cmH2O
Pressure cmH2O Median 5.6	95th Percentile 6.4	Maximum 9.0
Leak - L/min Median 4.8	95th Percentile 7.2	Maximum 43.2
AHI & AI - events/hr Apnea Index 0.3 % Time in Apnea 0.1	Hypopnea Index 1.3	AHI 1.6
Total Usage Used Days >= 4 hrs 2 Days not used: 11 Median daily usage 5:04	Used Days < 4 hrs 1 Total days 14 Average daily usage 0.55	% Used Days >= 4 hrs 14 Total hours used 12.68

ACCT#- 8456 DR- AC LOC- OF
DOB: 05/22/1997
BODIN, JEFFREY T
CHRT#- (985) 845-0969
FC- B INS(BLU/ /) H/S- N

Premier Pain Center

(985) 809-1997

POST PROCEDURE INSTRUCTIONS

FEB 19 2016

M.D. ___________

Type of Procedure:
- ☐ Nerve Root Injection
- ☐ Medial Branch Block
- ☐ Other: ___________
- ☐ Radiofrequency
- ☐ Sacroiliac Joint Injection

ACTIVITY:
- ______ Regular Activity
- ______ Avoid Strenuous Activity Today
- ______ No Driving for 24 Hours
- ______ Other

Recommend Stationary Bike (inside) start 1 min at a time 3 days per week add one min per week

Medication received during stay:
☐ Robinul ☐ Pepcid ☐ Reglan ☐ Toradol
☐ Propofol ☐ Valium ☐ Versed ☐ Other ___________
☐ Marcaine, Omnipaque, Kenalog or Celestone - injected per physician

DIET:
- ______ Regular diet
- ______ Avoid hot liquids until normal sensation in throat returns
- ______ Other ___________

- Discontinue Fioricet slowly
- sphenopalatine injections ...
- Relpax for Rescue (Limit to 9 per month)
- Do not rec. running
- Rec. Botox in 3 weeks

MEDICATIONS:
- ______ Resume all previous medications
- ______ Do not use Aspirin for 3 days after procedure
- ______ Prescription for ___________ ... as directed.
- ______ Sedation given; **Do not drive, drink alcohol, climb stairs unassisted, sign important documents, or engage in any potentially hazardous activity for 24 hours after sedation**

NOTIFY THE PAIN CENTER IF:

Bleeding or Discoloration	Excessive Swelling	Fever Noted
Uncontrolled Pain	Inability To Urinate	Nausea/Vomiting
Unusual changes in color or temperature of skin	Weakness/numbness persists or increases after 8-10 hours	Difficulty in Breathing or Swallowing

If you have any questions or problems, please call our office at (985) 809-1997. After business hours call (985) 819-6817. If you have an emergency, go to Lakeview Regional Medical Center Emergency Department or to the nearest Emergency Department

PRE-PROCEDURE / RETURN INSTRUCTIONS

☐ M.D. Evaluation (Office) ☒ Nurse Practitioner

RETURN TO THE CENTER: In 13 weeks For MD Eval ~~Botox~~ 155u Procedure

NEXT APPOINTMENT: Day Mon Date 2/29 Time 815 Referral (BSPG

SKIN CLEANSING:
- ______ Bath/Shower with antibacterial soap such as Chlorhexidine/Hibiclens night before and morning of procedure.

DIET:
- ______ Regular diet
- ______ Nothing to eat or drink after midnight (including any gum, mints, cough drops, candy, chewing tobacco)
- ______ May have clear liquids (1/2 cup only) of either water, apple juice, up to six hour prior to procedure time if scheduled after 1:00 pm

MEDICATIONS:
- ______ As usual with sip of water only. Do not take any medication that causes you to be nauseated if taken on an empty stomach.
- ______ Do Not take diabetic medication unless otherwise instructed.
- ______ Do Not take anticoagulants; (such as aspirin, NSAIDS, Coumadin, Plavix, etc.) for ______ days prior to procedure.

BELONGINGS: Please leave valuables, including jewelry at home. We cannot be held responsible for valuables brought with you. Dress Comfortably.

TRANSPORTATION:
I must have a ride home, with a responsible adult, available at the time of discharge in order for procedure to be done ______ Yes ______ No
I understand the instructions and have been given a copy: [signature] Date ______ Time ______
Patient / Representative Signature
Nurse ___________

Revised 3/15

2/19/16 Premier Pain Center Appt

Attached to front of first pg of "FEB 19 2016" Premier Pain Center Dr. Conn appt sheet.

Top left hand corner. Not my handwriting.

First appointment at/with Dr. Conn.

Written up 9/16/17. For printing/sorting medical records in ascending date order.

INFORMATION FOR
HEALTH CARE PROFESSIONALS

AMERICAN HEADACHE SOCIETY

Medication Overuse Headache

Stephen D. Silberstein, MD
Neurology, Thomas Jefferson University, Philadelphia, PA

Medication overuse headache (MOH) is a secondary cause of chronic daily headache (CDH) due to the overuse of acute headache medication. All acute treaments can produce MOH with the possible exceptions of DHE and the neuroleptics MOH was previously called rebound headache drug-induced headache, and medication-misuse headache MOH headaches are experienced 15 or more days a month for at least 3 months and have developed or markedly worsened during medication overuse.[1] (Table 1) Overuse is defined in terms of treaiment days per month and depends on the drug. Ergotamine-, triptan- or opioid-overuse headache requires intake on 10 or more days a month on a regular basis for 3 or more months, while simple analgesics (or any combination of different acute drugs) require 15 or more days. This translates into 2 to 3 treatment days every week. Evidence suggests that this occurs sooner with triptan than with ergotamine overuse. [2]

Medication overuse is often motivated by a patient's desire to treat his headaches or a fear of future headaches.[3] Medication overuse can make headaches refractory to preventive medication [3] Although stopping the acute medication may result in withdrawal symptoms and a period of increased headache, subsequent headache improvement usually, but not always, occurs.[3]

Patients with MOH can be difficult to treat. Patients should be started on preventive medication (to decrease reliance on acute medication), with the explicit understanding that the drugs may not always become fully effective until medication overuse has been eliminated.[3] Some patients need to have their headache cycle terminated. Outpatient detoxification options, including outpatient infusion in an ambulatory infusion unit, are available. If outpatient treatment proves difficult or is dangerous hospitalization may be required.

Patients can have severe exacerbations of their migraine during detoxification. Patients often need additional treatment (***headache terminators)*** to break the cycle of CDH and/or help with the exacerbation that occurs when overused medications are discontinued. Withdrawal symptoms include severely exacerbated headaches accompanied by nausea, vomiting, agitation, restlessness, sleep disorder, and (rarely) seizures. Barbiturates, opioids, and benzodiazepines, unless replaced with long-acting derivatives, must be tapered to avoid a serious withdrawal syndrome.[3]

Terminaters include repetitive intravenous dihydroergotamine (DHE) which is often coadministered with metoclopramide, which helps control nausea and is an effective antimigraine drug in its own right. The neuroleptics (chlorpromazine, droperidol, haloperidol, and prochlorperazine) are used

intravenously, intramuscularly, and by suppository, as terminators for nausea, vomiting, and pain Intravenous ketorolac is a helpful adjunctive treatment. Clinical experience and open label trials suggest that corticosteroids are also effective.

One concern with using neuroleptics is a prolonged QTc interval on EKG. Patients who receive daily repetitive intravenous droperidol should have an EKG before their first dose of the medication and daily thereafter. A QTc that is above 450 msec is considered a 'grey zone' (the drug should be stopped or the dose reduced) and a QTc above 500 msec is a 'red zone' (an absolute contraindication). Bradycardia, abnormal EKG, and a change in the QTc of more than 60 msec are the other risk factors for torsades de pointes associated with prolonged QT syndrome.

REFERENCES

1. Headache Classification Committee. The International Classification of Headache Disorders, 2nd Edition. *Cepnalalgia* 2004;24:1-160.

2. Headache Classification Committee. New appendix criteria open for a broader concept of chronic migraine. *Cephalalgia* 2006:26:742-746

3. Silberstein SD Lipton RB, Saper JR Chronic daily headache including transformed migraine, chronic tension-type headache, and medication overuse headache In: Silberstein SD, Lipton RB, Dodick DW, eds. Wolff's Headache and Other Head Pain. Eighth ed. New York: Oxford University Press, 2007:315-378.

TABLE 1. ICHD-2 Criteria for Headache Attributed to Medication Overuse[1]

A. Headache present on >15 days/month

B. Regular overuse for > 3 months of one or more acute/symptomatic treatment drugs as defined under sub forms of 8.2.

   1. Ergotamine, triptans, opioids, or combination analgesic medications on ≥10 days/month on a regular basis for >3 months

   2. Simple analgesics or any combination of ergotamine, triptans, analgesics opioids on ≥ 15 days/month on a regular basis for > 3 months without overuse of any single class alone

C. Headache has developed or markedly worsened during medication overuse

Migraine Headache (cont.)

Headaches Quiz

Migraines Slideshow

Migraine Triggers

Table of Contents

Migraine medications

The treatment of an acute migraine headache may vary from over-the-counter medicines (OTC), like acetaminophen (Tylenol and others) or ibuprofen (Advil, Motrin, etc.) to prescription medications.

Triptans

Triptans (sumatriptan, rizatriptan, eletriptan, zolmitriptan, naratriptan, almotriptan, and frovatriptan), may be extremely effective in treating migraines and may be prescribed to help the patient treat their migraine at home.

Not every patient can take these medications, and there are specific limitations regarding how often these medications can be used.

Other medication regimens may also be used to control migraine headache.

Some medications are appropriate for home use and others require a visit to the health-care professional's office or emergency department.

Narcotics

Narcotic pain medications are not necessarily appropriate for the treatment of migraine headaches and are associated with the phenomenon of rebound headache, where the headache returns – sometimes more intensely – when the narcotics wear off. In all cases of migraine, the use of acute pain therapies must be watched closely so that a patient does not develop medication overuse headache.

Other medications

If an individual experiences frequent headaches, or if the headaches routinely last for several days, then preventive medications may be indicated. These may be prescribed on a daily basis in an effort to decrease the frequency, severity, and duration of migraine headaches. There are many different medications which have been shown to be effective in this role, including:

blood pressure medications, for example, propranolol (Inderal), nadolol (Corgard), verapamil (Clan, Covera, Isoptin, Verelan), and flunarizine),

anti-seizure medications, for example, divalproex sodium (Depakote and others), topiramate (Topamax), and gabapentin (Neurontin, Gralise),

antidepressant medications (amitriptyline and venlafaxine) and

other supplements (magnesium, butterbur, and riboflavin).

The specific medication which is selected for a patient is dependent on many other factors, including age, sex, blood pressure, and other pre-existing medical conditions.

Some patients who experience more than 15 headache days every month might benefit from Botox injections.

Continue Reading

Table of Contents

Name: Jeffrey Bodin | DOB: 5/22/1997 | MRN: 2592229 | PCP: Sherri Casey, MD

My Vitals

Table

Name	Weight	Blood Pressure	BMI
9/2/2010	81 lb 9.1 oz		
6/26/2013	116 lb 11.2 oz	109/66	18.27
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12/5/2013	112 lb 7 oz	124/66	17.61
1/3/2014	109 lb	119/75	17.07
1/10/2014	112 lb	123/73	17.54
2/21/2014	114 lb	143/78	17.85
4/24/2014	110 lb	123/68	17.06
7/2/2014	108 lb	123/73	16.75
9/9/2014	107 lb	122/74	16.52
10/9/2014	107 lb	128/76	16.75
10/29/2014	107 lb	114/76	16.5
12/23/2014	105 lb	130/85	16.44
1/27/2015	105 lb		16.44
3/2/2015	107 lb	121/78	16.75
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7/7/2015	105 lb	134/73	16.44
7/14/2015	104 lb 14.4 oz	129/79	16.43
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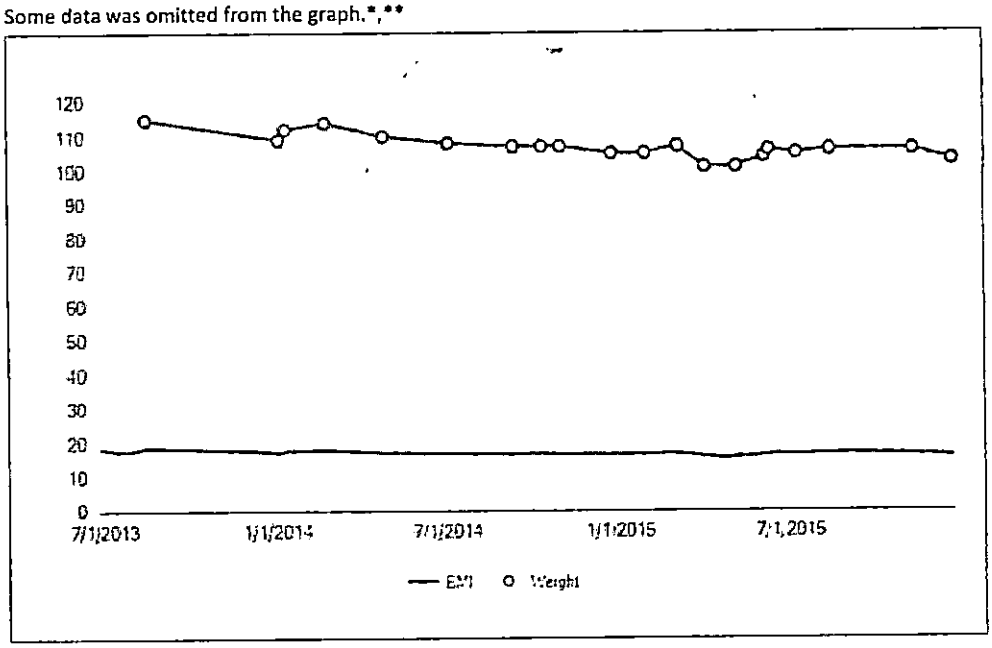
9/2/2015	106 lb 14.8 oz	135/79	16.74
11/9/2015	106 lb	123/87	16.35
12/21/2015	103 lb	131/88	15.88

Name: Jeffrey Bodin | DOB: 5/22/1997 | MRN: 2592229 | PCP: Sherri Casey, MD

My Vitals

Graph

Some data was omitted from the graph.*,**



*The following series cannot be graphed.

- Blood Pressure

**Non-numeric points were omitted from the following series.

- Weight

Lakeview Regional Medical Center
Emergency Department: (985) 809-1997

[redacted] Dr. Conn (after hrs): (985) 819-6817

7015 Hwy 190 E. Service Road
Covington LA 70433

Re-Writeup on 9/16/17

This was on back of "Participation Form For Freshman Retreat @ Camp Abbey Retreat Center Tuesday, March 1st and Wednesday, March 2nd, 2016". I did not have paper on my person, but I did have this when I went in w/ father, Mark Bolton, on 2/29/16 for Dr. Conn's appointment.
I wrote her address down as I expressed to Dr. Conn that I needed it to ensure I could call proper place w/info to Calm my mother back/withhold my medication again.
As stated as such by Dr. Conn herself that 2/29/16 appointment. As advice to me. Pretty sure I wrote it in sharpie etc.

Participation Form for Freshmen Retreat @ Camp Abbey Retreat Center
Tuesday, March 1st and Wednesday, March 2nd, 2016

My son & I request that my son Jeffrey Bodin participate in the Freshmen retreat as a facilitator and small group leader on (Tuesday, March 1st) OR Wednesday, March 2nd, 2016 (CIRCLE ONE) at the Camp Abbey Retreat Center. We understand he will arrive at school at 7:30 to assist in welcoming and organizing the 9th graders into groups. Bus transportation will be provided to and from the retreat center.

He will miss classes during Periods (DEFG (Tuesday)) OR ABCD (Wednesday) and will get written approval from the teachers for missing those classes. Lunch will be provided by the retreat staff (pizza). He will be dismissed at 3:00 when the retreat ends.

In order to insure as smooth and as seamless an event as possible, we will require that all participants attend training on **Wednesday, February 24th from 6:00 – 8:00 PM. This is a commitment for the training and the full day of school.**

Questions? jeaneens@stpauls.com j.ramon@stpauls.com

Thanks.

Mrs. Schmitt and Mr. Ramon
Lasallian Youth Leaders Moderators

Jeffrey Bodin — 2/23/16
Participant's signature — date

[signature] — 2/23/16
Parent's signature — date

Emergency numbers: 985-237-8363
Mom's cell number 985-264-5277 Dad's cell number ~~985-264~~

Teachers are requested to sign below acknowledging that the Lasallian Youth Leader is in good standing in your class and has permission to participate, knowing he is responsible for all work missed and to return to the next class meeting prepared. Thanks for allowing him to represent our school in this special campus ministry event.

(Tuesday, March 1 - DEFG) OR Wednesday, March 2nd - ABCD

	Subject	Teacher's Signature
Period D	Free Period	
Period E	Physics Honors	
Period F	Religion IV	
Period G	Free Period	

Dean of Students permission _____
Coach Sears

Please return this permission slip to Mrs. Schmitt by Friday, February 26th

Premier Pain Center

(985) 809-1997

ACCT#- 8456 DR- AC LOC- OF
BODIN, JEFFREY T DOB: 05/22/1997
CHRT#- (985)845-0969
FC- B INS(BLU/ /) H/S- N

MAR 14 2016

POST PROCEDURE INSTRUCTIONS

M.D. Conn

Type of Procedure:
- ☐ Nerve Root Injection
- ☐ Medial Branch Block
- ☐ Other: _____
- ☐ Radiofrequency
- ☐ Sacroiliac Joint Injection

ACTIVITY:
- _____ Regular Activity
- _____ Avoid Strenuous Activity Today
- _____ No Driving for 24 Hours
- _____ Other

Medication received during stay:
- ☐ Robinul ☐ Pepcid ☐ Reglan ☐ Toradol
- ☐ Propofol ☐ Valium ☐ Versed ☐ Other _____
- ☐ Marcaine, Omnipaque, Kenalog or Celestone - injected per physician

DIET:
- _____ Regular diet
- _____ Avoid hot liquids until normal sensation in throat returns
- _____ Other _____

MEDICATIONS:
- _____ Resume all previous medications
- _____ Do not use Aspirin for 3 days after procedure
- _____ Prescription for _____ given to be taken as directed.
- _____ Sedation given; **Do not drive, drink alcohol, climb stairs unassisted, sign important documents, or engage in any potentially hazardous activity for 24 hours after sedation**

NOTIFY THE PAIN CENTER IF:

Bleeding or Discoloration	Excessive Swelling	Fever Noted
Uncontrolled Pain	Inability To Urinate	Nausea/Vomiting
Unusual changes in color or temperature of skin	Weakness/numbness persists or increases after 8-10 hours	Difficulty in Breathing or Swallowing

If you have any questions or problems, please call our office at (985) 809-1997. After business hours call (985) 819-6817. If you have an emergency, go to Lakeview Regional Medical Center Emergency Department or to the nearest Emergency Department

PRE-PROCEDURE / RETURN INSTRUCTIONS

☒ M.D. Evaluation (Office) ☐ Nurse Practitioner

RETURN TO THE CENTER: In 2 weeks For 8:15 MD Eval Procedure

NEXT APPOINTMENT: Day Mon Date 3/28 Time ~~8:30~~ Referral _____

SKIN CLEANSING:
- _____ Bath/Shower with antibacterial soap such as Chlorhexidrine/Hibiclens night before and morning of procedure.

DIET:
- _____ Regular diet
- _____ Nothing to eat or drink after midnight (including any gum, mints, cough drops, candy, chewing tobacco)
- _____ May have clear liquids (1/2 cup only) of either water, apple juice, up to six hour prior to procedure time if scheduled after 1:00 pm

MEDICATIONS:
- _____ As usual with sip of water only. Do not take any medication that causes you to be nauseated if taken on an empty stomach.
- _____ Do Not take diabetic medication unless otherwise instructed.
- _____ Do Not take anticoagulants; (such as aspirin, NSAIDS, Coumadin, Plavix, etc.) for _____ days prior to procedure.

BELONGINGS: Please leave valuables, including jewelry at home. We cannot be held responsible for valuables brought with you. Dress Comfortably.

TRANSPORTATION:
I must have a ride home, with a responsible adult, available at the time of discharge in order for procedure to be done _____ Yes _____ No

I understand the instructions and have been given a copy: [signature] Date 3/14/16

Patient / Representative Signature

Nurse [signature]

Revised 3/15

ACCT#- 8456 DR- AC LOC- OF
DOB: 05/22/1997
BODIN, JEFFREY T
CHRT#- (985)845-0969
FC- B INS(BLU/ /) H/S- N

Premier Pain Center
(985) 809-1997

POST PROCEDURE INSTRUCTIONS

MAR 28 2016

M.D. Conn

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- ☐ Nerve Root Injection
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Medication received during stay:
☐ Robinul ☐ Pepcid ☐ Reglan ☐ Toradol
☐ Propofol ☐ Valium ☐ Versed ☐ Other ______
☐ Marcaine, Omnipaque, Kenalog or Celestone - injected per physician

(1) ↓ Fioricet to one @ night
(2) Weaning of Fioricet not associated with Fatigue complaints

DIET:
- ______ Regular diet
- ______ Avoid hot liquids until normal sensation in throat returns
- ______ Other ______

MEDICATIONS:
- ______ Resume all previous medications
- ______ Do not use Aspirin for 3 days after procedure
- ______ Prescription for ______ given to be taken as directed.
- ______ Sedation given; **Do not drive, drink alcohol, climb stairs unassisted, sign important documents, or engage in any potentially hazardous activity for 24 hours after sedation**

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PRE-PROCEDURE / RETURN INSTRUCTIONS

☑ M.D. Evaluation (Office) ☐ Nurse Practitioner

RETURN TO THE CENTER: In 2 weeks For ______ Procedure

NEXT APPOINTMENT: Day Mon Date 4/11 Time 8:15 Referral ______

SKIN CLEANSING:
______ Bath/Shower with antibacterial soap such as Chlorhexidrine/Hibiclens night before and morning of procedure.

DIET:
- ______ Regular diet
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BELONGINGS: Please leave valuables, including jewelry at home. We cannot be held responsible for valuables brought with you. Dress Comfortably.

TRANSPORTATION:
I must have a ride home, with a responsible adult, available at the time of discharge in order for procedure to be done ______ Yes ______ No
I understand the instructions and have been given a copy: [signature] Date 3/28/16 Time ______
Patient / Representative Signature
Nurse [signature]

Revised 3/15

Premier

C. Ann Conn, M.D.

mmcunnis@alparr.com

7015 Hwy 190 E Service Rd, Ste 101 Covington, LA 70433
985.809.1997
985.809.1664
drannconn.com

Premier

Allan T. Parr, M.D.

alparr@alparr.com

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985.809.1664
premierpaincenter.com

Premier

Lisa Jaubert, M.D.

7015 Hwy 190 E Service Rd, Ste 101 Covington, LA 70433
985.809.1997
985.809.1664
premierpaincenter.com

COMMUNITY ASSISTANCE PROGRAM
Prescription Drug Discount Card

I: 820193690
x Bin: 610709
x Grp: USAH216
x Pcn: 7777
armacist help desk: 844-728-3791
s card is available to the general public regardless of age or income.
e uses free discount drug cards every & ever.
is card does not expire. This is not insurance.

Rx

Re-Write up on 9/16/17

Business Cards collected over 1st two appointments w/Dr. Conn.

Taken in lobby and right inside door to clinic area. Had different cards depending on whether you were entering or leaving/exiting in lobby/ in the past the gatekeepers of society.

Dr. Conn herself gave me her business card. Don't remember if I ever saw it anywhere else besides her person. Front left medical coat pocket.

Similar to another doctor I know. As they told me long ago, "Always keep your identity close to your heart."
Within the context of a conversation on medical records, etc.

As only ghosts don't have their name on the forward facing address.

Note: This was how I knew Dr. Conn was the real deal.

Print This Page | Close This Window

Name: Jeffrey Bodin | DOB: 5/22/1997 | MRN: 2592229 | PCP: Sherri Casey, MD

My Vitals

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9/2/2015	106 lb 14.8 oz	135/79	16.74
11/9/2015	106 lb	123/87	16.35
12/21/2015	103 lb	131/88	15.88

February 15, 2016

I, Jeffrey Bodin, give permission for all my doctor's listed below to speak and discuss my care with Dr. William L. Terral.

Dr. Lysenko	neurologist	504-842-4910
Dr. Africk	neurologist	504-842-3900
Dr. Richard Guillot	allergist	985-892-3122
Dr. Jaime Morales	oncologist	504-899-9511
Dr. Foy	dentist	985-845-8042

If there are any questions, please feel free to contact me at 985-264-1080.

Sincerely,

Jeffrey Bodin

Dr. Pouw	985-882-7077	endocrinologist
Dr. Adema	985-727-2077	optometrist
Dr. Balcone	985-892-3376	dermatologist
Dr. Bludell	985-845-8101	psychiatrist
Dr Obyrne	985-624-5573	opthamologist
Dr. Sedrich	985-280-6770	rheumatologist
Dr. C. Ann Conn	985-809-1997	neurologist
Dr. Rick Casey	985-892-9143	Pulmonologist
Dr. Sherri Casey	985-893-2580	Pediatrician
Dr. Karlin Aaron M.	985-809-5800	Pediatric Sports Medicine
physical therapy - Paul Jones therapy		985-792-5997

1 hr - black

3 wks

- do ~~[illegible]~~ morning

A

• Migraine

[Amitriptyline]

• Trileptal - antidepressant

Drugs : all abortive

• Cambia (powder)
• Migranal (nasal spray)
• Zelrix (patch)
• Stadol (opioid nasal spray)

136/81 98bpm

1st Surgery - March 26, 2008
2nd Surgery - April 23, 2008
Apendectomy - May 13th, 2008

Others

Coach Barwick 985-373-4060
Coach Terryl 985-502-6286

I J.B give permission
for all my Doctors listed
below to speak & discuss my
care with DR. Wm L. TERRY

~~List~~ DRS

If there are any questions
please feel free to contact
me @ (985) ---/- ..
264-1080

Sincerely,

Jeff

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)		DOB
ADDRESS	SSN	
CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE THE PHI:	ENTITY RECEIVING THE PHI:
	NAME CHILDREN'S MEDICAL CENTER
	ADDRESS 71107 HIGHWAY 21, SUITE 1
	CITY: COVINGTON; STATE: LOUISIANA; ZIP: 70433
	ATTENTION: MEDICAL RECORDS 985-893-2580 Fax 985-871-9418

This authorization will expire on the following date or event:

Date: Event:

Purpose of this Disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
☐ All PHI in the record		
☐ Progress Notes		
☐ Laboratory Tests		
☐ X-Ray Tests / Reports		
☐ History and Physical Examination		
☐ Discharge Summary		
☐ Consultation Reports		
☐ Itemized Billing Statement		
☐ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

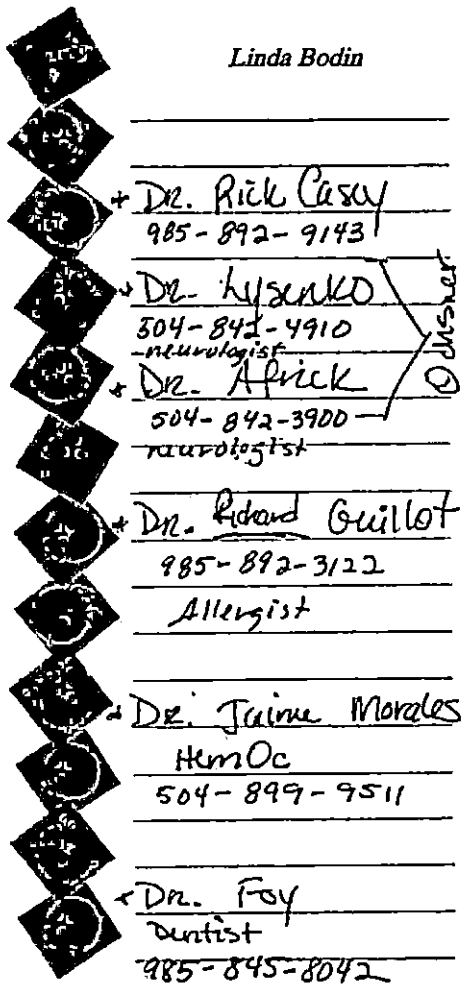
[ ] AIDS or HIV test results
[ ] Alcohol, drug or substance abuse treatment
[ ] Psychiatric or mental care / treatment
[ ] Other (specify):

I understand that:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign it.

Signature of Patient:	Date:
Signature of Patient's Representative (if necessary):	Date:
Personal Representative's Relationship to Patient:	

Re Writtenup on 9/16/17
Page 1 of 2



Linda Bodin

Dr. Rick Casey
985-892-9143

Dr. Hysenko
504-841-4910
neurologist

Dr. Africk
504-842-3900
neurologist

Dusher

Dr. Richard Guillot
985-892-3122
Allergist

Dr. Jaime Morales
HemOc
504-899-9511

Dr. Foy
Dentist
985-845-8042

9/16/17

Originally attached to upper left hand corner of back of AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
One addressed to

Children's Medical Center
71107 Highway 21, Suite 1
Covington, LA 70433
Attention:
Medical Records
985-893-2580 Fax 985-871-9418

This document is my mothers handwritten sheet to "help" me.

She wrote it out and gave to me when I asked for a list of my doctor's contact information. Name's, Phone #'s, address's etc. She gave me this permission authorization form, already ready w/Dr. Tural's info typed on it/printed on it. Almost like they had previously, recently, gotten a copy of the (PHI) form from them. She wrote her "helpful" how to write a I give permission letter in her handwriting on back. Brought into my room while I was doing something at my desk. Came in without permission. Proceeded to demand to help right then/there. Did not take no for an answer.

Re-Written up on 9/16/17 Pg 2 of 2

Almost positive I was printing out, w/school laptop, my medical records, sorting them.

Did not want her too see. Therefore, locked my door which she unlocked and came in. Why I was why she was so mad. At start of her "helpful conversation."

Around date of 2/23/16 see attached "Participation Form for Freshmen Retreat @ Camp Abbey Retreat Center Tuesday, March 1st and Wednesday, March 2nd, 2016." B/c got mom's signature really late, had not been able to do much b/studies compile medical records b/w 2/19/16 appt w/Dr. Conn and the date of her signature on 2/23/16.

This was when my mother took my medicine, Butalbital/Adderall by force. Threatened/Attempted to murder myself and my sister. By her admission and actions. See other previously recorded/then destroyed/then re-recorded records of this event.

Date of 2/26/16 as noted on bottom of Permission slip Please return this permission slip to Mrs. Schmitt by Friday, February 26th." Note. Was unable to meet deadline b/c was not in attendance that wk d/c of above mother's actions.

Could not get signatures of teachers + coach seen in time. Even though that wk was only wk that I planned ahead of time/could get signatures in time. See St. Paul's School Spring/winter Schedule. For 2/23/16 - 2/26/16

Lakeview Regional Medical Center
Emergency Department: (985) 809-1887

Dr. Conn (ortho): (985) 819-6817

7015 Hwy 190 E. Service Road
Covington LA 70433

Re-writing on 9/16/17

This was on back of "Participation Form For Freshman Retreat @ Camp Abbey Retreat Center Tuesday, March 1st and Wednesday, March 2nd, 2016". I did not have paper on my person, but I did have this when I went in w/ father Mark Bolton, on 2/29/16. for Dr. Conn's appointment.
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As stated as such by Dr. Conn herself that 2/29/16 appointment. As advice to me. Pretty sure I wrote it in staple for.

Participation Form for Freshmen Retreat @ Camp Abbey Retreat Center
Tuesday, March 1st and Wednesday, March 2nd, 2016

My son & I request that my son Jeffrey Bodin participate in the Freshmen retreat as a facilitator and small group leader on **Tuesday, March 1st OR Wednesday, March 2nd, 2016 (CIRCLE ONE)** at the Camp Abbey Retreat Center. We understand he will arrive at school at 7:30 to assist in welcoming and organizing the 9th graders into groups. Bus transportation will be provided to and from the retreat center.

He will miss classes during Periods **DEFG (Tuesday) OR ABCD (Wednesday)** and will get written approval from the teachers for missing those classes. Lunch will be provided by the retreat staff (pizza). He will be dismissed at 3:00 when the retreat ends.

In order to insure as smooth and as seamless an event as possible, we will require that all participants attend training on **Wednesday, February 24th from 6:00 – 8:00 PM. This is a commitment for the training and the full day of school.**

Questions? jeaneens@stpauls.com j.ramon@stpauls.com

Thanks.

Mrs. Schmitt and Mr. Ramon
Lasallian Youth Leader Moderators

Participant's signature _____ date 2/23/16

Parent's signature _____ date 2/23/16

Emergency numbers: 985-237-8363
Mom's cell number 985-264-5277 Dad's cell number ~~985-264~~

Teachers are requested to sign below acknowledging that the Lasallian Youth Leader is in good standing in your class and has permission to participate, knowing he is responsible for all work missed and to return to the next class meeting prepared. Thanks for allowing him to represent our school in this special campus ministry event.

Tuesday, March 1 - DEFG OR Wednesday, March 2nd - ABCD

	Subject	Teacher's Signature
Period D	Free Period	
Period E	Physics Honors	
Period F	Religion IV	
Period G	Free Period	

Dean of Students permission _____
Coach Sears

Please return this permission slip to Mrs. Schmitt by Friday, February 26th

Procedures
MD Anderson Sleep Center
PO Box 301439, Unit 1284
Houston, TX 77030
Phone: 713-792-2352

Multiple Sleep Latency Test Report

I. PATIENT PROFILE

Patient Name: Bodin, Jeffrey
Medical Record Number: 744652
Age: 19 (years)
Sex: Male
Height: 168 cm Weight: 50.0 Kg

BMI: 17.7 kg/m2
Study Date: 8/5/2016
Referring Physician: Dave Balachandran M.D., M.D.
Epworth Sleepiness Score (ESS): 14.0

II. DIAGNOSIS

Hypersomnia
347.00 Narcolepsy, Unspecified

III. PROCEDURE

The patient underwent a MSLT (multiple sleep latency test) according to the guidelines established by the American Academy of Sleep Medicine*. The patient was allowed to nap starting at two hours post awakening from the baseline study and subsequently at 2 hour intervals. During the baseline polysomnogram the sleep efficiency was 77/5%. There was no evidence of clinically significant sleep disordered breathing, nocturnal hypoxemia or movement disorders. The MSLT immediately followed the baseline study.

A total of four naps were performed. The patient slept during four of the four naps. The mean sleep latency (MSLT score) was 5.9 minutes. There were four sleep onset REM periods (SOREM) noted.

The diagnosis of narcolepsy requires 2 SOREMs, and an MSLT score of less than 8 minutes (mean sleep latency). An MSLT score of less than 10 minutes with less than 2 SOREMs can be seen in idiopathic (CNS) hypersomnia, upper airway resistance syndrome, periodic limb movement disorder and sleep apnea.

IV. CONCLUSION

The clinical history is suggestive of hypersomnia, and the MSLT is consistent with narcolepsy.

V. RECOMMENDATIONS

Stimulant therapy is recommended for daytime sleepiness.

Possible pharmacologic therapies include fluoxetine, venlafaxine, sodium oxybate, clomipramine, viloxazine, imipramine.

Additionally, HLA testing for DQ antigens (DQB1*0602 and DQA1*0102), which are associated with narcolepsy, and HLA-Cw2, which is associated with familial idiopathic hypersomnia, may provide further information.
Strategically timed naps should be incorporated in the patient's daily schedule.

The patient will be seen for a post-evaluation consultation with sleep clinic to discuss our findings and to explain the available treatment options.

If there are any questions regarding our examination, please feel free to contact our office for further elaboration or interpretation of our findings. Details concerning specific test scores and the results of sleep studies are available upon request.

Sincerely,
Diwakar Balachandran, MD
UT M. D. Anderson Sleep Center

* The International Classification of Sleep Disorders: Diagnostic and Coding Manual. Diagnostic Classification Steering Committee, Thorpy MJ, Chairman. Rochester, Minnesota: American Sleep Disorders Association, 2005

Berry RB, Brooks R, Gamaldo CE, Harding SM, Marcus CL and Vaughn BV for the American Academy of Sleep Medicine. The AASM Manual for the Scoring of Sleep and Associated Events: Rules, Terminology and Technical Specifications, Version 2.0. www.aasmnet.org, Darien, Illinois: American Academy of Sleep Medicine, 2012

Littner MR et al. Practice Parameters for Clinical Use of the Multiple Sleep Latency Test and the Maintenance of Wakefulness Test- AASM Practice Paramenters. Sleep 2005: 28(1) 113-121

Electronically signed by Dave Balachandran, MD at 8/15/2016 1:17 PM

Procedure visit on 8/5/2016

INSERT THIS END FIRST

Claimant Name: **Jeffrey T Bodin**
Document Description: **Medical Evidence Of Record**
Undated: **N**
Sensitive: **N**

RQID:00000000000000000219586670 SITE:Y32 DR:S
SSN:436958926 DOCTYPE:0001 RF:D CS:4dc9

MENTAL HEALTH MEDICAL SOURCE STATEMENT

Name and Title of Provider: Nicole León LPC
Patient's Name: Mr. Jeffrey Bodin
Patient's SSN:

Please answer the following questions regarding your patient's impairments:

1. Nature, frequency, and length of contact: 60 min by LWX
2. Diagnosis: Psychological factors affecting other medical conditions
   · Parent-Child relational Problem
   · unspecified depressive Disorder
3. Is your patient a malingerer? ☐ Yes ☒ No
4. How often are your patient's symptoms severe enough to interfere with concentration and attention?
   ☐ Never ☐ Seldom ☐ Often ☐ Frequently ☒ Constantly
5. Have your patient's impairments lasted or can be expected to last at least 12 months? ☒ Yes ☐ No
6. Please identify the level of limitation that your client has in the following areas **in a work setting**, using the following definitions:
   - **Not Impaired** means the patient can function independently and appropriately on a sustained basis
   - **Moderately Impaired** means that the ability to function on a sustained basis is fair
   - **Markedly Impaired** means that the ability to function on a sustained basis is seriously limited
   - **Extremely Impaired** means that the patient cannot function independently, appropriately, effectively, and on a sustained basis in the area

	Not Impaired	Moderately Impaired	Markedly Impaired	Extremely Impaired
Remember locations and work-like procedures			✓	
Understand and remember short or simple instructions			✓	
Understand and remember detailed instructions				✓
Carry out very short and simple instructions			✓	
Carry out detailed instructions				✓
Maintain attention / concentration for extended periods				✓
Perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances				✓
Sustain an ordinary routine without special supervision			✓	
Work in coordination with and proximity with others without being distracted by them			✓	
Make simple work-related decisions				✓
Complete a normal workday and workweek without interruptions from psychologically based symptoms				✓
Perform at a consistent pace without an unreasonable number and length of rest periods				✓
Interact appropriately with the general public			✓	
Ask simple questions or request assistance			✓	
Accept instructions and respond appropriately to criticism from supervisors				✓

Get along with coworkers or peers without distracting them or exhibiting behavioral extremes			✓	
Maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness			✓	
Respond appropriately to changes in the work setting				✓
Be aware of hazards and take appropriate precautions				✓
Travel in unfamiliar places or use public transportation				✓
Set realistic goals or make plans independently of others			✓	

7. Approximately how many days per month your patient is likely to be absent from work as a result of his or her impairment or treatment?

☐ Never
☐ One to two days per month
☐ About three days per month
☑ Four or more days per month

8. Would your patient sometimes need to take unscheduled breaks during an 8-hour work day? ☐ Yes ☐ No

If yes, 1) how often do you think this will happen? at current level c/b recent hospitalization to stay outside
2) how long, on average, will your patient have to take a break? more than 2-3 hrs

9. Does your patient have panic attacks? ☐ Yes ☑ No

If yes, 1) how often is the patient having panic attacks? _____
2) Do the attacks result ininability to function independently outside of home? ☐ Yes ☐ No
3) Would the frequency or severity of the attacks worsen if he/she was working? ☐ Yes ☐ No

10. Does the patient suffer recurrent and intrusive recollections of a traumatic experience? ☑ Yes ☐ No

11. Has your patient's condition lasted or can it be expected to last at least 12 months? ☑ Yes ☐ No

1. In your opinion, would any of this patient's symptoms or conditions interfere with his/her ability to perform work for eight-hours per day? If so, please explain:

Yes

Date: 4/3/18

Signature: [signature] for LPC

Printed/typed name: Nicole Leon, LPC

Address: 4000 Bienville ST

New Orleans 70119

LAW OFFICE
OF
JAMES S. CONNER
2237 FLORIDA STREET, SUITE D
MANDEVILLE, LA 70448

JAMES S. CONNER – Attorney
EVA D. CONNER – Attorney
TELEPHONE: (985) 626-1002
FACSIMILE: (985) 624-8103

TIFFANY CONNER
BRIAN HENLY
KIERSTEN PRITCHETT
Non-Attorney Representatives

April 26, 2018

Children's Medical Center
71107 LA-21
Covington, LA 70433

RE: **Jeffrey Bodin**

To Whom It May Concern:

Please be advised that I represent the above named client in a claim for **Social Security Disability Benefits**. I have enclosed a Medical Authorization form signed by my client.

Please send me **any** medical records you may have in connection with my client **specifically, those dated from 07/27/2017 to 04/25/2018.**

If records are available electronically, please send them in electronic format to connerdisability@gmail.com. Please note that under the HITECH Act, if records are available electronically, they MUST be provided in an electronic format. You may not bill for paper copies unless the records are **only** available via paper. If electronic copies are available under the HITECH Act, you may not charge more than your labor costs (a flat fee of not more than $6.50 may be requested in lieu of calculating labor costs). *See* 45 CFR 164.524.

Please note that under the HITECH Act, records **MUST** be received within 30 days of this request. Violations of the HITECH Act's requirements are subject to a penalty of $250,000.

If electronic copies are not available, please advise me in advance of any charge in excess of $20.00 for said records. Please note that Act 1241 of the Louisiana Legislature applies in this case and regulates what can be charged for medical records by healthcare providers in Social Security Disability and/or SSI cases.

Thank you for your cooperation in this matter.

Sincerely,

Eva Conner

Eva Conner

EDC/AK
Enclosure

5/3/18 c10x1 ROI

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
THE LAW OFFICES OF JAMES S. CONNER

I hereby authorize Children's Medical Center to disclose the following protected health information (PHI) from the medical records of the patient listed to:

Requestor Name: Law Office of James S. Conner
Requestor Address: 2237 Florida Street, Suite D
Mandeville, LA 70448

Patient Name: Mr. Jeffrey Bodin

Patient DOB: 5/22/1997

Patient SS# 436-95-8926

✓ Entire Chart	___ History & Physical	___ Discharge Summary	___ Consult
___ Operative Report(s)	___ Progress Notes	___ Admit Summary	___ Nurses Notes
___ ER Report(s)	___ Lab	___ X-ray/MRI/CT/Bone Scan	___ Abstract/Pertinent
✓ Other Specified	From: 7-27-17		
	To: 4-25-18		

The above information is disclosed for the purpose of obtaining Social Security Disability Benefits.

- A PHOTOCOPY OF THIS AUTHORIZATION MAY SERVE AS AN ORIGINAL.
- I understand that I have the right to revoke this authorization at any time and must do so in writing to the above facility, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- I understand that I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I have the right to receive a copy of this form after I sign it.
- This authorization shall expire one year from the date on which it was signed or upon the issuing of a favorable Decision for Social Security Disability benefits.

The following information will be released when included in the above information unless you indicated otherwise:

___ AIDS or HIV test results
___ Psychiatric or Mental Care treatment
___ Alcohol, Drug or Substance Abuse treatment
___ other (please specify)_____.

I have read the above and authorize the disclosed of this protected health information as stated.

Jeffrey Bodin
Signature of Patient/Legal Representative

4/25/18
Date

If signed by legal representative, relationship to patient _____

Signature of Witness

4/25/18
Date

Updated 03/2015

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Mr. Jeffrey Bodin	436-95-8926
Wage Earner (If Different)	Social Security Number

Part I CLAIMANT'S APPOINTMENT OF REPRESENTATIVE

I appoint this person, Eva Conner - 2237-D Florida St Mandeville LA 70448
Law Ofc James Conner
(Name and Address)
to act as my representative in connection with my claim(s) or asserted right(s) under:

☒ Title II (RSDI) ☒ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☒ I appoint, or I now have, more than one representative. My main representative is
Eva Conner
(Name of Principal Representative)

Signature (Claimant)	Address
Jeffrey Bodin	528 Beau Chene Dr. Mandeville, LA 70471
Telephone Number (with Area Code)	Fax Number (with Area Code) / Date
(985)520-4713	4/25/18

Part II REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I, Eva Conner, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☒ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☒ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☒ No

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address
Eva Conner	2237 Florida Street, Suite D, Mandeville, LA 70448
Telephone Number (with Area Code)	Fax Number (with Area Code) / Date
(985)626-1002	(985)624-8103 / 4/25/18

Part III FEE ARRANGEMENT

(Select an option, sign and date this section.)

☒ I am charging a fee and requesting direct payment of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.*

☐ I am charging a fee but waiving direct payment of the fee from withheld past-due benefits --I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ I am waiving fees and expenses from the claimant and any auxiliary beneficiaries --By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ I am waiving fees from any source --I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date
Eva Conner	4/25/18

Date: 10/5/17 Acct# 22110 Ins Elig Ck: 10/4/17

In With: Kelly (Nurse)

Patient's Name: Jeffrey Boden DOB: 5/22/97 Phone: 264-5277

Medications: Adderall 20mg tid / Singulair

Allergies: NKDA

HPI:

Chief Complaint: here to recheck meds

Constitutional (fever) (wt loss): Adderall 20mg tid - Wants to go to 30mg tid

HEENT

CV

Respiratory

GI

GU

MS

Skin/Breast

Neuro (HA)

Psych

Endo/Heme/Lymph

Allergic/Immunologic

SHx, FHx, PMHx, Work

LABS Today:

☐ Except as documented above all systems are negative.

PE:	BP:	Ht:	Wt: 104.8lb	HC:	P:	RR:	BMI:	Temp:

8 shoe

☑ NORMAL

- ☑ Constitutional
- ☐ HEENT
- ☐ CV
- ☐ Respiratory
- ☐ Chest
- ☐ GI
- ☐ GU
- ☐ Lymphatic
- ☐ MS
- ☐ Skin
- ☐ Neuro
- ☐ Psych

1 10mg tid No. 90 (x 7d)

refill

In: Out: Signature:

Plan/Treatment:

X Pt does not want any medical information on him. Feels (Parents) are not looking out for his best interest.

5/3/18 clot/ROI | James Conner

Date: 9/28/17 Acct# 22110 Ins Elig Ck: _____

In With: Ded - in waiting Rm

Patient's Name: Jeffrey Bodin DOB: 5/22/97 Phone: 264-5277

Medications:	Allergies:	HPI:
Adderall 20 mg tid	NKDA	

Chief Complaint: here for followup

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

SHx, FHx, PMHx, Work

LABS Today:

☐ Except as documented above all systems are negative.

PE: BP: Ht: Wt: 104.8 lb HC: P: RR: BMI: Temp:

☑ NORMAL

- ☐ Constitutional
- ☐ HEENT
- ☐ CV
- ☐ Respiratory
- ☐ Chest
- ☐ GI
- ☐ GU
- ☐ Lymphatic
- ☐ MS
- ☐ Skin
- ☐ Neuro
- ☐ Psych

In: Out: Signature:

Plan/Treatment:

Date: 9/19/17 Acct# 22110 Ins Elig Ck:

In With:

Patient's Name: Jeffrey Bodin DOB: 5/22/97 Phone:

Medications:	Allergies:	HPI:
Adderall	NKDA	

Chief Complaint: discuss meds - returned Rx written on 9/19/17 Adderall 30mg i po tid

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

SHx, FHx, PMHx, Work

LABS Today:

☐ Except as documented above all systems are negative.

PE:	BP:	Ht:	Wt:	HC:	P:	RR:	BMI:	Temp:

☑ NORMAL
☐ Constitutional
☐ HEENT
☐ CV
☐ Respiratory
☐ Chest
☐ GI
☐ GU
☐ Lymphatic
☐ MS
☐ Skin
☐ Neuro
☐ Psych

reduce Adderall to 20 mg t.i.d. #45 (2 wks)

In: Out: Signature: [signature]

Plan/Treatment:

Date: 9/14/17

Acct# 22110 Mom called mom [illegible] No Show 9/13/17 #707

In With: self

Patient's Name: Jeffrey Boden DOB: 5/22/97 Phone: 264-5277 Mom

Medications: Adderall

Allergies: NKDA

HPI:

Chief Complaint: ① follow up on meds Adderall 30mg i po tid

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

② constipated - bloated, plenty of gas, burping - constantly

③ & diarrhea

SHx, FHx, PMHx, Work

LABS Today:

☐ Except as documented above all systems are negative.

PE:	BP:	Ht:	Wt:	HC:	P:	RR:	BMI:	Temp:
			103.6lb (shoes)					

☑ NORMAL
☐ Constitutional
☐ HEENT
☐ CV
☐ Respiratory
☐ Chest
☐ GI
☐ GU
☐ Lymphatic
☐ MS
☐ Skin
☐ Neuro
☐ Psych

May d/c Adderall unless a plan is proposed / n progressing

In: Out: Signature: [signature]

Plan/Treatment:

last Rx given?? 9/7

Date: 8/29/17 Acct# 92112 Ins Elig Ck: _____

In With: self

Patient's Name: Jeffrey Boden DOB: 5/22/97 Phone: 264-1080 b/c
264-5277 Mom

Medications:	Allergies:	HPI:
Adderall 30mg tid	NKDA	

Chief Complaint: follow up & recheck meds Adderall 30mg 1 tid

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

SHx, FHx, PMHx, Work: lives w Parents

LABS Today:

☐ Except as documented above all systems are negative.

PE: BP: 102/68 Ht: Wt: 101.6 lb HC: P: RR: BMI: Temp:
& shoes

☑ NORMAL

☐ Constitutional
☐ HEENT
☐ CV
☐ Respiratory
☐ Chest
☐ GI
☐ GU
☐ Lymphatic
☐ MS
☐ Skin
☐ Neuro
☐ Psych

In: Out: Signature:

Plan/Treatment:

Date: 8-25-17 Acct#_____ Ins Elig Ck: 8/24/17

In With: _____

Patient's Name: DOB: Phone:

Medications:	Allergies:	HPI:

Chief Complaint: Parents only Discuss Problems

Constitutional (fever) (wt loss)
HEENT
CV
Respiratory
GI
GU
MS
Skin/Breast
Neuro (HA)
Psych
Endo/Heme/Lymph
Allergic/Immunologic

SHx, FHx, PMHx, Work

LABS Today:

☐ Except as documented above all systems are negative.

PE: BP: Ht: Wt: HC: P: RR: BMI: Temp:

☑ NORMAL

☐ Constitutional
☐ HEENT
☐ CV
☐ Respiratory
☐ Chest
☐ GI
☐ GU
☐ Lymphatic
☐ MS
☐ Skin
☐ Neuro
☐ Psych

In: Out: Signature:

Plan/Treatment:

MedSouth Record Management
P.O. Box 1630
Mandeville, LA 70470-1630

Pre-Bill Invoice

Phone: 985-951-7100
Fax : 985-951-7101

Request ID	LA356050320183
Date	05/03/2018
Site ID	LA356
Invoice Amount	$0.00
Processed By	LCJ

RECEIVED
MAY 29 2018
BY:

thank you!

Bill To:
JAMES S CONNER
2237 FLORIDA STREET SUITE D
MANDEVILLE, LA 70448

Ship To:
JAMES S CONNER
2237 FLORIDA STREET SUITE D
MANDEVILLE, LA 70448

Your request for medical records has been received by NORTHSHORE INTERVENTIONAL PAIN MANAGEMENT. MedSouth Record Management, LLC is contracted with NORTHSHORE INTERVENTIONAL PAIN MANAGEMENT to provide you with the enclosed medical record copies of the referenced patient below. These copies were generated from the original medical record, intended exclusively for the requested purpose and cannot be reproduced or redistributed for other purposes without the written informed consent of the patient.

If you have any questions regarding the contents and/or this invoice please call our customer service center at 985.951.7100.

Medical Facility:
NORTHSHORE INTERVENTIONAL PAIN MANAG
7015 HIGHWAY 190 EAST SERVICE ROAD, SUI
COVINGTON, LA 70433

Patient Name (Last, First):	
BODIN, JEFFREY	
Medical Record Number:	
Reference Number(s):	

Page Count	**43**
Processing Fee	$0.00
Document Charge	$20.00
Certification Charge	$0.00
Notary Charge	$0.00
Other Charges	$0.00
Late Charges	$0.00
Subtotal	**$20.00**
Shipping/Handling	$2.66
Balance Due	**$0.00**

Your request was processed. Please remit payment of this invoice amount to the address listed below. Once payment is received, your request will be completed. I have any questions, please call our customer service center at 985-951-7100.

Please note: Cancelled requests will incur a processing fee.

Please remit check payable to:

MedSouth Record Management, LLC
Federal Tax I.D. #: 72-1481471

Mailing address:

P.O. Box 1630
Mandeville, LA 70470-1630

Physical address for express mailing:

#5 Sanctuary Boulevard, Suite 102
Mandeville, LA 70471

To ensure proper credit, please return a copy of this invoice with payment, or write the Request ID number on your check. To make a credit card payment, please contact our Corporate Office at 985.951.7100.

MedSouth
Record Management

Cover Page

THE FOLLOWING DOCUMENTS ARE RELATIVE TO:

Site Number:	LA356	MCT:	BR
Patient: (Last Name, First Initial)	Bodin, Jeffrey	DOB:	5-22-97
Reference Number:	LA356-05032018-3 (old invoice number)		
Status of Request:	Processed	Page Count	

☑ Billable ☐ Non-Billable

	Records Scanned
	No record for dates specified
	No record of patient

Pre-Billed	✓	Page Count	43
Pending			

	Awaiting Authorization
	Awaiting HIPAA Authorization

	PHI		Right to Revoke
	Discloser Identity		Conditioning
	Recipient of PHI		Re-Disclosure
	Purpose		Signed & Dated
	Expiration Date		Patient Rep.

	Awaiting original subpoena
	Patient ID information is incorrect
	Patient signature does not match signature on file
	Awaiting Affidavit
	Patient is deceased, awaiting death certificate
	Patient is deceased, awaiting proper patient representative information
	Awaiting special circumstance authorization
	Other (explain):

COMMENTS

Law Office
James Conner

Abst.

1-1-2015 TO 4-25-18

MR = 43

The following items are included:

(✓) Request Document
(✓) Patient Authorization
( ) Blank Certification Letter
(✓) Patient Information Sheet
No PT Sheet
( ) Other: _____

MedSouth
☑ Processed
☐ Pending
MAY 03 2018
By: _____

LAW OFFICE
OF
JAMES S. CONNER
2237 FLORIDA STREET, SUITE D
MANDEVILLE, LA 70448

JAMES S. CONNER – Attorney
EVA D. CONNER – Attorney
TELEPHONE: (985) 626-1002
FACSIMILE: (985) 624-8103

TIFFANY CONNER
BRIAN HENLY
KIERSTEN PRITCHETT
Non-Attorney Representatives

April 26, 2018

Premier Pain Center
7015 Highway 190 E Svc Rd #101
Covington, LA 70433

RE: **Jeffrey Bodin**

To Whom It May Concern:

Please be advised that I represent the above named client in a claim for **Social Security Disability Benefits**. I have enclosed a Medical Authorization form signed by my client.

Please send me **any** medical records you may have in connection with my client **specifically, those dated from 01/01/2015 to 04/25/2018.**

If records are available electronically, please send them in electronic format to connerdisability@gmail.com. Please note that under the HITECH Act, if records are available electronically, they MUST be provided in an electronic format. You may not bill for paper copies unless the records are **only** available via paper. If electronic copies are available under the HITECH Act, you may not charge more than your labor costs (a flat fee of not more than $6.50 may be requested in lieu of calculating labor costs). *See* 45 CFR 164.524.

Please note that under the HITECH Act, records **MUST** be received within 30 days of this request. Violations of the HITECH Act's requirements are subject to a penalty of $250,000.

If electronic copies are not available, please advise me in advance of any charge in excess of $20.00 for said records. Please note that Act 1241 of the Louisiana Legislature applies in this case and regulates what can be charged for medical records by healthcare providers in Social Security Disability and/or SSI cases.

Thank you for your cooperation in this matter.

Sincerely,

Eva Conner

Eva Conner

EDC/AK
Enclosure

MedSouth
☑ Processed
☐ Pending
MAY 03 2018
By:

PREMIER PAIN CENTER AND SUMMIT SURGERY CENTER

ACCT#- 8456 DR- AC LOC- OF
DOB: 05/22/1997
BODIN, JEFFREY T
CHRT#- (985) 845-0969
FC- B INS(BLU/ /) H/S- N

SUMMIT/PREMIER

PCP/SPECIALIST Dr Casey. Dr. Blundell

PHARMACY/NUMBER

ALLERGIES
Keppra - hallucinations
Elavil - Sz

MEDICATION	DOSE	ROUTE (CIRCLE ROUTE)	FREQUENCY	FEB 19 2016	2/29/16	3/14/16	3/28/16	4/11/16					
Relpax	40 mg	(PO circled) IM Inhalation IV Topical SQ SL Nasal	PRN HA	A	C	C	Not started	Not started					
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											

A = ADD C = CONTINUE D/C = DISCONTINUE Δ = CHANGE T= TAKEOVER

UNAPPROVED ABBREVIATIONS: QD, QID, QOD, IU, U, MGSO4, MS, MSO4, CC, UG, AS, AD, AU, OS, OD, OU.

DO NOT WRITE A ZERO BY ITSELF AFTER A DECIMAL POINT: EXAMPLE 2.0. DO NOT USE LEADING DECIMAL POINTS EXAMPLE .25, CORRECT 0.25

PAIN MANAGEMENT CONTINUOUS INFORMATION SHEET revised 3/28/2011 — please complete/highlight:

Date	Procedure	Response to treatment	Referred to	Medications	VAS Pre/Post	Nurse Initials
FEB 18 2016	Initial Eval			Relpax	6	NM
2/29/16	MD Eval @ SPG			Ø	3-4	AM
3/14/16	MD Eval			@ SPG	3-4	AO
3/28/16	MD Eval				4	AO
	Talked to Dr Casey discussed anxiety		recommend Epilepsy Monitoring unit D.O.			
4/11/16	MD Eval			Ø	4	NM
5/18/16	Talk to Dr Terrell about case			Ok		

Allergies/Reaction:
Keppra - hallucinations
Elavil - sz

Anticoagulants:

Med Hx: melanoma
__Diabetes __CAD __CHF
__HTN __Asthma: __denies __COPD
__Needle Phobia X Anxiety
__Depression __Seizures: __denies
__Hepatitis __Hypothyroidism
__age over 70 __GERD __smoker
__Pacemaker __Defib __stimulator
__closed angle glaucoma/hold Robinul
__Other: Narcolepsy

Pre-op Meds: _Pepcid 2 0mg
__ Reglan 10 mg
Valium____mg
Benadryl ____mg

Special Instructions:
__Turn off SCS if applicable
__No IV/BP ___arm

Height: 5'7"
Weight: 103 lbs

UPT or Refusal / TAH / Menopausal
EMERGENCY CONTACT

ACCT#- 8456 DR- AC LOC- OF
BODIN, JEFFREY T DOB: 05/22/1997
CHRT#-
FC- B INS(BLU/ /) H/S- N
(985)845-0969

PREMIER PAIN CENTER AND SUMMIT SURGERY CENTER

ACCT#- 8456 DR- AC LOC- OF
DOB: 05/22/1997
BODIN, JEFFREY T
(985)845-0969
CHRT#-
FC- B INS(BLU/ /) H/S- N

REFERRING/PCP

CIRCLE ROUTE

MEDICATION	DOSE	ROUTE	FREQUENCY	FEB 19 2016	2/29/16	3/14/16	3/28/16	4/11/16					
Fioricet	50/325/40	(PO) IM Inhalation IV Topical SQ SL Nasal	ii BID	C	C	ii Am [illegible]	ii BID C	1 QDay					
Adderall XR	20 mg	(PO) IM Inhalation IV Topical SQ SL Nasal	ii BID	C	C	C	C	C					
Adderall	20 mg	(PO) IM Inhalation IV Topical SQ SL Nasal	ii QDay	C	C	C	C	C					
Zyrtec	10mg	(PO) IM Inhalation IV Topical SQ SL Nasal	Q day	C	C	C	C	C					
Singulair	10mg	(PO) IM Inhalation IV Topical SQ SL Nasal	Q day	C	C	C	C	C					
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											
		PO IM Inhalation IV Topical SQ SL Nasal											

A = ADD C = CONTINUE D/C = DISCONTINUE Δ = CHANGE T= TAKEOVER

UNAPPROVED ABBREVIATIONS: QD, QID,QOD, IU,U, MGSO4, MS, MSO4, CC, UG, AS, AD,AU, OS,OD, OU.

DO NOT WRITE A ZERO BY ITSELF AFTER A DECIMAL POINT: EXAMPLE 2.0. DO NOT USE LEADING DECIMAL POINTS EXAMPLE .25, CORRECT 0.25

Premier Pain Center

7015 Hwy 190 East Service Road
Suite 101
Covington, LA 70433

OFFICE VISIT

PATIENT NAME : Jeffrey T Bodin
PATIENT ID : 8456
DATE OF BIRTH : 5/22/1997 **AGE :** 18 **SEX :** Male

ATTENDED BY : C. Ann Conn M.D.
REFERRED BY : ,
EXAM DATE : 04/11/2016

CHIEF COMPLAINT:
Headache.

PRESENT ILLNESS:
Quality: Patient describes the quality of the pain as: aching and throbbing.
Severity: Moderate.
Work Status: Student.
Signs and Symptoms: Patient returns to the Pain Management Center today complaining of a headache he describes as "all-over." He sleeps well at night and remains active. His headache increased the day of the last procedure, a bilateral sphenopalatine ganglion block performed on 3-14-16.
Effects of Medications prescribed by Premier: He has not started Relpax. He is taking one Fioricet each day and feels "the headaches are worse with Fioricet wean." Discussed spell at home partially witnessed by Dr. Casey.
VAS: Moderate.

COMBI:
1.Global Impression of Change.
"With respect to your headache pain, how are you feeling *now* compared to before you received treatment?" or an equivalent
Answer: no answer.
2.Numeric Rating Scale of Pain Intensity.
"Please rate your pain by indicating the number that best describes your average pain in the last 24 hours on a 0 (no pain) to 10 (pain as bad as you can imagine) scale."
Answer: 4
3. The Patient Specified Functional Outcome Scale- Activities of Daily Living.
"What are four things in life that you can't do, or have difficulty doing, because of your pain, and which most dearly you would want restored? These should be simple, realistic, daily life improvements that other people can see most of the time."
Not on medications. Procedure not helpful.
4. Pain, Enjoyment, General Activity (PEG)
4.1 "What number best describes your pain, on average, over the past week?"
Answer: 6
4.2 "What number best describes how, during the past week, the pain has interfered with your enjoyment of life?"
Answer: 6
4.3 "What number best describes how, during the past week, the pain has interfered with your general activity?"
Answer: 6
5. Other Health Care
"What other treatments are you receiving for your pain?"
Answer: no answer.
6. Return to Work
"Are you working?"
Answer: Student.

MEDICATIONS:
Fioricet 50/325/40 mg 2 po bid
Adderall XR 20 mg 2 po bid
Adderall 20 mg 2 po qd
Zyrtec 10 mg 1 po qd
Singulair 10 mg 1 po qd
Relpax 40 mg 1 po prn headache (not started)

ALLERGIES:
Keppra - hallucinations
Elavil - seizure

MEDICAL HISTORY:

Significant for cancer (Stage III malign... melanoma 2008 left ankle; Interferon, removal of left groin lymph nodes), seizure syndrome, narcolepsy (CPAP).

HOSPITALIZATION AND SURGERY:
Appendectomy, T & A, 2 cancer - left ankle and left groin.

FAMILY HISTORY:
Significant for cancer (grandmother), cardiac disease (grandfather), arthritis (great grandmother), and diabetes (great grandmother). He denies migraines.

SOCIAL HISTORY:
Marital Status: Single
Military Service: Not noted.
Use of "Street/Non-prescription" drugs: Not noted.
Alcohol Use: Denies.
Tobacco Use: Denies.
Level of Education: Not noted.
Sexual History: Not noted.
Work Status: Student

SYSTEMS REVIEW:

CONSTITUTIONAL: Denies fever. Denies unexplained weight change. Denies flu like symptoms. Denies recent trips outside of US.

ENMT: Denies headaches. Denies vision changes. Denies hearing loss. Denies ringing in ears. Denies dizziness. Denies runny nose. Denies hoarseness. Denies oral tissue lesions.

CARDIOVASCULAR: Denies Chest Pain. Denies heart attack. Denies falling out episodes. Denies CHF past six months.

RESPIRATORY: Denies wheezing. Denies SOB. Denies asthma. Denies environmental allergies. Denies smoking.

GASTROINTESTINAL: Denies difficulty swallowing. Denies indigestion. Denies abdominal pain. Denies nausea. Denies vomiting. Denies diarrhea. Denies constipation. Denies Jaundice. Denies change in bowel function. Denies Rectal bleeding. Denies inability to control bowel movements.

GENITOURINARY: Denies painful urination. Denies frequent urination. Denies blood in urine. Denies unable to control urination. Denies nocturia.

MUSCULOSKELETAL: Denies joint swelling. Denies restriction. Denies muscle pain. Denies joint pain.

INTEGUMENTARY: Denies rashes. Denies lesions. Denies change to hair and nails. Denies open skin sores.

NEUROLOGICAL: Denies seizures. Denies fainting spells. Denies paralysis. Denies tremor. Denies weakness.

PSYCHIATRIC: Denies depression. Denies suicide attempts. Denies anxiety disorders. Denies fear of needles.

ENDOCRINE: Denies diabetes. Denies thyroid disorders.

HEMATOLOGIC: Denies anemia. Denies abnormal bleeding. Denies excessive bruising. Denies swollen glands. Denies previous blood transfusions. Denies pitting edema.

PHYSICAL EXAMINATION:

BP: 130/99 mmHg Pulse: 98 Resp: 16

CONSTITUTIONAL: GENERAL APPEARANCE: Clean, well nourished, oriented.

EYES: EXAMINATION OF PUPILS AND IRISES: Pupils round, normal light reactive. INSPECTION OF CONJUNCTIVAE AND LIDS: Clear without icterus; lids are normal.

ENMT: EXTERNAL INSPECTION OF EARS AND NOSE: No scars, lesions, deformities or masses. INSPECTION OF NASAL MUCOSA, SEPTUM AND TURBINATES: Mucosa and turbinates pink and moist without ulceration, exudate or bleeding. Septum is midline and symmetrical. INSPECTION OF LIPS AND GUMS: Lips, gums, tongue, buccal mucosa and palate are pink and moist without cyanosis or fissures. OROPHARYNX: Oral mucosa, salivary glands, hard and soft palates, tongue are pink and moist with no injection.

NECK: Supple, no masses, trachea is midline and freely moveable. THYROID: No enlargement, tenderness or masses noted.

RESPIRATORY: ASSESSMENT OF RESPIRATORY EFFORT: Chest moving equally on both sides. No retraction or stridor. AUSCULTATION OF LUNGS: Breath sounds are well heard. No wheezing, rhonchi, crackles, rales or rubs noted posteriorly or anteriorly.

CARDIOVASCULAR: AUSCULTATION OF HEART: Regular rate and rhythm without murmur, normal S1 S2, negative rubs, clicks or gallops. CAROTID ARTERIES: Pulses normal, no bruits noted. FEMORAL ARTERIES: Pulses normal, no bruits noted. PEDAL PULSES: Pulses normal.

GASTROINTESTINAL: ABDOMEN: Soft, without tenderness or masses.

Patient Name: Jeffrey T Bodin Patient ID: 8456 DOB: 5/22/199? Exam Date: 04/11/2016

LYMPHATICS: AXILLAE: No masses or tenderness noted. NECK: No masses or tenderness noted, no thyroid enlargement. GROIN: No masses or tenderness noted. PALPATION OF LYMPH NODES:.

MUSCULOSKELETAL: GAIT AND STATION: No difficulty walking or standing. INSPECTION AND/OR PALPATION OF DIGITS AND NAILS: No clubbing, cyanosis, or inflammation.

HEAD AND NECK:. INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SPINE, RIBS AND PELVIS: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT UPPER EXTREMITY: INSPECTION AND/OR PALPATION:. Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture,. Negative Patrick's Test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses, or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SKIN: SKIN AND SUBCUTANEOUS TISSUE: No rashes, lesions, ulcers or bruising noted. PALPATION OF SKIN AND SUBCUTANEOUS TISSUE: No indurations, nodules or tightening noted.

NEUROLOGIC: MOOD AND AFFECT: Appropriate affect; appears anxious at time of exam. ORIENTATION: Oriented to time, place and person. RECENT AND REMOTE MEMORY: Memory intact for long and short term. ATTENTION SPAN AND CONCENTRATION: Average attention and concentration. LANGUAGE: Speaks without aids, voice is strong, articulate, speech is spontaneous. FUND OF KNOWLEDGE: Average awareness of current events and history. MOTOR EXAMINATION: Normal strength in upper and lower extremities including quadricep, ankle, great toe dorsiflexion, and plantar flexion.Tone in upper and lower extremities normal. Muscle bulk within normal limits. No abnormal movements noticed. SENSATION: Light touch within normal limits. DEEP TENDON REFLEXES UPPER AND LOWER EXTREMITIES, INCLUDING ANKLE AND KNEE REFLEXES: 2+ symmetric throughout, plantar responses downgoing.

CRANIAL NERVES: I. Not tested. II. Visual acuity and fields WNL III, IV, VI. Extraocular movements intact, pupils equal, round and reactive to light OU, no nystagmus present, conjugate gaze. V. Facial sensation equal bilaterally, muscles of mastication normal. Allodynia bilaterally. VII. Face symmetric, no evidence of palsy noted. VIII. Hearing normal to the whispered voice, equilibrium normal. IX, X. Palate movement symmetric. XI. Sternocleidomastoid and trapezius muscles normal strength. XII. Tongue movement symmetric, position midline without fasciculations.

IMPRESSIONS:
CHRONIC DAILY HEADACHE
Medication overuse headache
ANXIETY DISORDER
ALLERGIC RHINITIS
SLEEP DISORDER

PLAN:
1. Return to the Pain Management Clinic on 6-06-16 for MD evaluation.
2. Continue current medications.
3. Discontinue Fioricet.
4. Recommended Epilepsy Monitor unit; Dr. O. at LSU.
5. Bilateral greater occipital nerve block at next visit.

dc 4-13-16

Signature: _____
C. Ann Conn M.D.

Premier Pain Center

7015 Hwy 190 East Service Road
Suite 101
Covington, LA 70433

OFFICE VISIT

PATIENT NAME : Jeffrey T Bodin
PATIENT ID : 8456
DATE OF BIRTH : 5/22/1997 **AGE :** 18 **SEX :** Male

ATTENDED BY : C. Ann Conn M.D.
REFERRED BY : ,
EXAM DATE : 03/28/2016

PRESENT ILLNESS:
Quality: Patient describes the quality of the pain as: achy, throbbing, and shooting.
Severity: Moderate.
Work Status: Student; yes.
Signs and Symptoms: Patient returns to the Pain Management Center today complaining of a headache he describes as "all-over, in no specific spot." His headaches increase with weather changes. He states, "I wasn't able to go to school at all last week. I have severe exhaustion from decreasing Butalbital," and "My headaches have been more of a 4 since I've been coming off my medication." He states he has "hallucinating kind of effects," speaking of aura with migraine. He sleeps okay at night. He remains active. He has had no pain relief from the bilateral sphenopalatine ganglion block of 3-14-16, and reports it increased his headache that day.
Effects of Medications prescribed by Premier: He has not tried Relpax, stating, "I have not had an aura yet." He is down to 2 Fioricet daily.
VAS: 4/10

COMBI:
1.Global Impression of Change.
"With respect to your headache pain, how are you feeling now compared to before you received treatment?" or an equivalent.
Answer: The length and frequency is worse. The severity is the same.
2.Numeric Rating Scale of Pain Intensity.
"Please rate your pain by indicating the number that best describes your average pain in the last 24 hours on a 0 (no pain) to 10 (pain as bad as you can imagine) scale."
Answer: 6
3. The Patient Specified Functional Outcome Scale- Activities of Daily Living.
"What are four things in life that you can't do, or have difficulty doing, because of your pain, and which most dearly you would want restored? These should be simple, realistic, daily life improvements that other people can see most of the time."
"Everything" - not restored.
4. Pain, Enjoyment, General Activity (PEG)
4.1 "What number best describes your pain, on average, over the past week?"
Answer: 6
4.2 "What number best describes how, during the past week, the pain has interfered with your enjoyment of life?"
Answer: 10
4.3 "What number best describes how, during the past week, the pain has interfered with your general activity?"
Answer: 10
5. Other Health Care
"What other treatments are you receiving for your pain?"
Answer: Relpax.
6. Return to Work
"Are you working?"
Answer: Student.Effects of Medications prescribed by Premier:

MEDICATIONS:
Fioricet 50/325/40 mg 2 po bid
Adderall XR 20 mg 2 po bid
Adderall 20 mg 2 po qd
Zyrtec 10 mg 1 po qd
Singulair 10 mg 1 po qd
Relpax 40 mg 1 po prn headache (not started)

ALLERGIES:
Keppra - hallucinations
Elavil - seizure

MEDICAL HISTORY:

Significant for cancer (Stage III malignant melanoma 2008 left ankle; Interferon, removal of left groin lymph nodes), seizure syndrome, narcolepsy (CPAP).

HOSPITALIZATION AND SURGERY:
Appendectomy, T & A, 2 cancer - left ankle and left groin.

FAMILY HISTORY:
Significant for cancer (grandmother), cardiac disease (grandfather), arthritis (great grandmother), and diabetes (great grandmother). He denies migraines.

SOCIAL HISTORY:
Marital Status: Single
Military Service: Not noted.
Use of "Street/Non-prescription" drugs: Not noted.
Alcohol Use: Denies.
Tobacco Use: Denies.
Level of Education: Not noted.
Sexual History: Not noted.
Work Status: Student.

SYSTEMS REVIEW:

CONSTITUTIONAL: Denies fever. Denies unexplained weight change. Denies flu like symptoms. Denies recent trips outside of US.

ENMT: Admits to headaches, Denies vision changes, Denies hearing loss. Denies ringing in ears. Denies dizziness. Denies runny nose. Denies hoarseness. Denies oral tissue lesions.

CARDIOVASCULAR: Denies Chest Pain. Denies heart attack. Denies falling out episodes. Denies CHF past six months.

RESPIRATORY: Denies wheezing. Denies SOB. Denies asthma. Denies environmental allergies. Denies smoking.

GASTROINTESTINAL: Admits to nausea, Denies difficulty swallowing. Denies indigestion. Denies abdominal pain. Denies vomiting. Denies diarrhea. Denies constipation. Denies Jaundice. Denies change in bowel function. Denies Rectal bleeding. Denies inability to control bowel movements.

GENITOURINARY: Denies painful urination. Denies frequent urination. Denies blood in urine. Denies unable to control urination. Denies nocturia.

MUSCULOSKELETAL: Admits to joint pain, Denies joint swelling. Denies restriction. Denies muscle pain.

INTEGUMENTARY: Denies rashes. Denies lesions. Denies change to hair and nails. Denies open skin sores.

NEUROLOGICAL: Denies seizures. Denies fainting spells. Denies paralysis. Denies tremor. Denies weakness.

PSYCHIATRIC: Denies depression. Denies suicide attempts. Denies anxiety disorders. Denies fear of needles.

ENDOCRINE: Denies diabetes. Denies thyroid disorders.

HEMATOLOGIC: Denies anemia. Denies abnormal bleeding. Denies excessive bruising. Denies swollen glands. Denies previous blood transfusions. Denies pitting edema.

PHYSICAL EXAMINATION:

BP: 110/99 mmHg Pulse: 94 Resp: 16

CONSTITUTIONAL: GENERAL APPEARANCE: Clean, well nourished, oriented.

EYES: EXAMINATION OF PUPILS AND IRISES: Pupils round, normal light reactive. INSPECTION OF CONJUNCTIVAE AND LIDS: Clear without icterus; lids are normal. Glasses.

ENMT: EXTERNAL INSPECTION OF EARS AND NOSE: No scars, lesions, deformities or masses. INSPECTION OF NASAL MUCOSA, SEPTUM AND TURBINATES: Mucosa and turbinates pink and moist without ulceration, exudate or bleeding. Septum is midline and symmetrical. INSPECTION OF LIPS AND GUMS: Lips, gums, tongue, buccal mucosa and palate are pink and moist without cyanosis or fissures. OROPHARYNX: Oral mucosa, salivary glands, hard and soft palates, tongue are pink and moist with no injection. Hoarse.

NECK: Supple, no masses, trachea is midline and freely moveable. THYROID: No enlargement, tenderness or masses noted.

RESPIRATORY: ASSESSMENT OF RESPIRATORY EFFORT: Chest moving equally on both sides. No retraction or stridor. AUSCULTATION OF LUNGS: Breath sounds are well heard. No wheezing, rhonchi, crackles, rales or rubs noted posteriorly or anteriorly.

CARDIOVASCULAR : AUSCULTATION OF HEART: Regular rate and rhythm without murmur, normal S1 S2, negative rubs, clicks or gallops. CAROTID ARTERIES: Pulses normal, no bruits noted . FEMORAL ARTERIES: Pulses normal, no bruits noted. PEDAL PULSES: Pulses normal.

GASTROINTESTINAL: ABDOMEN: Soft, without tenderness or masses.

LYMPHATICS: AXILLAE: No masses or tenderness noted. NECK: No masses or tenderness noted, no thyroid enlargement. GROIN: No masses or tenderness noted. PALPATION OF LYMPH NODES: .

MUSCULOSKELETAL: GAIT AND STATION: No difficulty walking or standing: INSPECTION AND/OR PALPATION OF DIGITS AND NAILS: No clubbing, cyanosis, or inflammation.

HEAD AND NECK: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SPINE, RIBS AND PELVIS: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's Test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses, or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SKIN: SKIN AND SUBCUTANEOUS TISSUE: No rashes, lesions, ulcers or bruising noted. PALPATION OF SKIN AND SUBCUTANEOUS TISSUE: No indurations, nodules or tightening noted.

NEUROLOGIC: MOOD AND AFFECT: Appropriate affect; appears anxious at time of exam. ORIENTATION: Oriented to time, place and person. RECENT AND REMOTE MEMORY: Memory intact for long and short term. ATTENTION SPAN AND CONCENTRATION: Average attention and concentration. LANGUAGE: Speaks without aids, voice is strong, articulate, speech is spontaneous. FUND OF KNOWLEDGE: Average awareness of current events and history. MOTOR EXAMINATION: Normal strength in upper and lower extremities including quadricep, ankle, great toe dorsiflexion, and plantar flexion. Tone in upper and lower extremities normal. Muscle bulk within normal limits. No abnormal movements noticed. SENSATION: Light touch within normal limits. DEEP TENDON REFLEXES UPPER AND LOWER EXTREMITIES, INCLUDING ANKLE AND KNEE REFLEXES: 2+ symmetric throughout, plantar responses downgoing.

CRANIAL NERVES: I. Not tested. II. Visual acuity and fields WNL. III, IV, VI. Extraocular movements intact, pupils equal, round and reactive to light OU, no nystagmus present, conjugate gaze. V. Facial sensation equal bilaterally, muscles of mastication normal. Allodynia bilaterally. VII. Face symmetric, no evidence of palsy noted. VIII. Hearing normal to the whispered voice, equilibrium normal. IX, X. Palate movement symmetric. XI. Sternocleidomastoid and trapezius muscles normal strength. XII. Tongue movement symmetric, position midline without fasciculations.

IMPRESSIONS:
CHRONIC DAILY HEADACHE
Medication overuse headache
Anxiety disorder
ALLERGIC RHINITIS
SLEEP DISORDER

PLAN:
1. Return to the Pain Management Clinic on 4-11-16 for MD evaluation.
2. Continue current medications.
3. Decrease Floricet to 1 po qd.
4. Educated on aura with Relpax use.
5. Decreased Butalbital; not associated with fatigue.

dc 3-28-16

Signature: _____
C. Ann Conn M.D.

Premier Pain Center

7015 Hwy 190 East Service Road
Suite 101
Covington, LA 70433

OFFICE VISIT

PATIENT NAME : Jeffrey T Bodin
PATIENT ID : 8456
DATE OF BIRTH : 5/22/1997 **AGE** : 16 **SEX** : Male

ATTENDED BY : C. Ann Conn M.D.
REFERRED BY : ,
EXAM DATE : 03/14/2016

CHIEF COMPLAINT:
Headache.

PRESENT ILLNESS:
Quality: Patient describes the quality of the pain as: pressing and throbbing.
Severity: Mild to moderate.
Work Status: Student.
Signs and Symptoms: Patient returns to the Pain Management Center today complaining of a headache "all-over" equally. He sleeps "fine" at night. His activity is moderate. He has had a small amount of pain relief from the bilateral sphenopalatine ganglion block of 2-29-16.
Effects of Medications prescribed by Premier: He has not used Relpax yet. He states,"I have not had a migraine with aura yet." He decreased Fioricet to 2 qam and 1 qhs.
VAS: 3-4/10

MEDICATIONS:
Fioricet 50/325/40 mg 2 po bid
Adderall XR 20 mg 2 po bid
Adderall 20 mg 2 po qd
Zyrtec 10 mg 1 po qd
Singulair 10 mg 1 po qd
Relpax 40 mg 1 po prn headache (not started)

ALLERGIES:
Keppra - hallucinations
Elavil - seizure
Keppra
Elavil

MEDICAL HISTORY:
Significant for cancer (Stage III malignant melanoma 2008 left ankle; Interferon, removal of left groin lymph nodes), seizure syndrome, narcolepsy (CPAP).

HOSPITALIZATION AND SURGERY:
Appendectomy, T & A, 2 cancer - left ankle and left groin.

FAMILY HISTORY:
Significant for cancer (grandmother), cardiac disease (grandfather), arthritis (great grandmother), and diabetes (great grandmother). He denies migraines.

SOCIAL HISTORY:
Marital Status: Single
Military Service: Not noted.
Use of "Street/Non-prescription" drugs: Not noted.
Alcohol Use: Denies.
Tobacco Use: Denies.
Level of Education: Not noted.
Sexual History: Not noted.
Work Status: Student.

SYSTEMS REVIEW:

CONSTITUTIONAL: Denies fever. Denies unexplained weight change. Denies flu like symptoms. Denies recent trips outside of US.

ENMT: Admits to headaches, Denies vision changes, Denies hearing loss. Denies ringing in ears. Denies dizziness. Denies runny nose. Denies hoarseness. Denies oral tissue lesions.

CARDIOVASCULAR: Denies Chest Pain. Denies heart attack. Denies falling out episodes. Denies CHF past six months.

RESPIRATORY: Denies wheezing. Denies SOB. Denies asthma. Denies environmental allergies. Denies smoking.

GASTROINTESTINAL: Admits to nausea, Denies difficulty swallowing. Denies indigestion. Denies abdominal pain. Denies vomiting. Denies diarrhea. Denies constipation. Denies Jaundice. Denies change in bowel function. Denies Rectal bleeding. Denies inability to control bowel movements.

GENITOURINARY: Denies painful urination. Denies frequent urination. Denies blood in urine. Denies unable to control urination. Denies nocturia.

MUSCULOSKELETAL: Admits to joint pain, Denies joint swelling. Denies restriction. Denies muscle pain.

INTEGUMENTARY: Denies rashes. Denies lesions. Denies change to hair and nails. Denies open skin sores.

NEUROLOGICAL: Admits to seizures, Admits to tremor, Denies fainting spells. Denies paralysis. Denies weakness.

PSYCHIATRIC: Denies depression. Denies suicide attempts. Denies anxiety disorders. Denies fear of needles.

ENDOCRINE: Denies diabetes. Denies thyroid disorders.

HEMATOLOGIC: Denies anemia. Denies abnormal bleeding. Denies excessive bruising. Denies swollen glands. Denies previous blood transfusions. Denies pitting edema.

PHYSICAL EXAMINATION:

BP: 121/86 mmHg Pulse: 96 Resp: 18

EYES: INSPECTION OF CONJUNCTIVAE AND LIDS:.

CRANIAL NERVES: I. Not tested. II. Visual acuity and fields WNL III, IV, VI. Extraocular movements intact, pupils equal, round and reactive to light OU, no nystagmus present, conjugate gaze. V. Facial sensation equal bilaterally, muscles of mastication normal. Allodynia bilaterally. VII. Face symmetric, no evidence of palsy noted. VIII. Hearing normal to the whispered voice, equilibrium normal. IX, X. Palate movement symmetric. XI. Sternocleidomastoid and trapezius muscles normal strength. XII. Tongue movement symmetric, position midline without fasciculations.

IMPRESSIONS:

CHRONIC DAILY HEADACHE
Medication overuse headache
Anxiety disorder
Allergic rhinitis
Sleep disorder.

PLAN:

1. Return to the Pain Management Clinic on 3-28-16 for MD evaluation.
2. Bilateral sphenopalatine ganglion block today.
3. Botox pending.

ENCOUNTER NOTES :

DESCRIPTION OF PROCEDURE: Treatment plan was discussed with the patient. After detailed procedural explanation was rendered to the patient, and the appropriate Risks and Benefits Ratio Profile was explained and described clearly, the patient signed the Procedural Informed Consent document, which outlined consent to the procedure discussed.

The patient was then taken to the procedural room, and placed on the procedural table in a supine position, with a pillow supporting the shoulders, and allowing the back of the head to rest on the procedural table, which facilitated gentle neck extension. Careful attention was directed towards the skin's surface from the tragus of the ear toward the lateral nasal passageway. Cleansing occurred repeatedly until the alcohol wipes revealed no makeup or lotion or other oils on the surface of the skin in the cutaneous V2 distribution. Both nostrils were then visually examined to quickly re-evaluate internal nasal anatomy, with particular emphasis towards detecting evidence of recent epistaxis, purulent nasal drainage, and/or visible nasal sinus anatomy abnormalities or nares obstruction.
A clean cotton-tipped applicator was then immersed with a generous portion of 2% lidocaine jelly and placed into each separate nostril advancing towards the internal nasal meatus. This procedure was then repeated on the contra lateral nostril. A sheath was advanced until contact with the posterior nasal pharynx. The sheath was then withdrawn several millimeters. A pigtail catheter was inserted and advanced towards the posterior elements of the right nasal-sinus passageway.. A syringe containing 0.25% Bupivicaine was attached to the extension. This was immediately followed by a pressurized delivery of 1.5 cc of 0.25% Bupivicaine down the right side wall of the nasal passageway over the middle turbinate and into the right spheno-palatine fossa, which saturated the parasympathetic SPG fibers, and allowed the gravitational egress of the lidocaine into the ipsi-lateral vidian canal, which produced right lateral pterygopalatine fossa filling, saturating the right maxillary branch of the trigeminal ganglion, and complete anesthetic (Bupivicaine) delivery to the sympathetic fibers of the right pterygopalitine ganglion.

Patient Name: Jeffrey T Bodin Bent ID: 8456 DOB: 5/22/19 Exam Date: 03/14/2016

After the right-sided block was complete, the left nasal passageway was prepped for the left-sided procedure. The patient's head was rechecked for proper supine positioning, maximum head extension, and chin lift. Careful attention was directed towards the conformational manifestation of the catheter prior to beginning the blockade of the left-sided structures. The same technique was performed on the left.

The patient remained on the procedural room table in a supine position for 8 minutes to allow gravitational assisted delivery and absorption of the lidocaine into the targeted structures. After the 8 minute absorption duration, the patient was discharged and instructed to call the office for any post-procedure complications.
dc 3-28-16

Signature: _____
C. Ann Conn M.D.

Premier Pain Center

7015 Hwy 190 East Service Road
Suite 101
Covington, LA 70433

OFFICE VISIT

PATIENT NAME : Jeffrey T Bodin
PATIENT ID : 8456
DATE OF BIRTH : 5/22/1997 **AGE :** 18 **SEX :** Male

ATTENDED BY : C. Ann Conn M.D.
REFERRED BY : ,
EXAM DATE : 02/29/2016

CHIEF COMPLAINT:
Head pain.

PRESENT ILLNESS:
Quality: Patient describes the quality of the pain as: burning, throbbing, and aching.
Severity: Mild to moderate.
Work Status: Student.
Signs and Symptoms: Patient returns to the Pain Management Center today complaining of all-over head pain. He states, "I'm not in that much pain today." He states he has been having "mini-seizures." He states he had a seizure on Friday, February 19, at 5:45 a.m. He states, "I wake up with no energy." His other took his medication away on February 1 and February 2. The patient had a fight with his mother in the waiting room and refused her attending the appointment.
VAS: 3-4/10

Effects of medications prescribed by NIPM: Patient is tolerating medications.
COMBI: (Patient has not started any medications or had any procedures.)

MEDICATIONS:
Fioricet 50/325/40 mg 2 po bid
Adderall XR 20 mg 2 po bid
Adderall 20 mg 2 po qd
Zyrtec 10 mg 1 po qd
Singulair 10 mg 1 po qd
Relpax 40 mg 1 po prn headache

ALLERGIES:
Keppra
Elavil

MEDICAL HISTORY:
Significant for cancer (Stage III malignant melanoma 2008 left ankle; Interferon, removal of left groin lymph nodes), seizure syndrome, narcolepsy (CPAP).

HOSPITALIZATION AND SURGERY:
Appendectomy, T & A, 2 cancer - left ankle and left groin.

FAMILY HISTORY:
Significant for cancer (grandmother), cardiac disease (grandfather), arthritis (great grandmother), and diabetes (great grandmother). He denies migraines.

SOCIAL HISTORY:
Marital Status: Single
Military Service: Not noted.
Use of "Street/Non-prescription" drugs: Not noted.
Alcohol Use: Denies.
Tobacco Use: Denies.
Level of Education: Not noted.
Sexual History: Not noted.
Work Status: Student.

SYSTEMS REVIEW:
CONSTITUTIONAL: Denies fever. Denies unexplained weight change. Denies flu like symptoms. Denies recent trips outside of US.

ENMT: Admits to headaches, Denies vision changes, Denies hearing loss. Denies ringing in ears. Denies dizziness. Denies runny nose. Denies hoarseness. Denies oral tissue lesions.

CARDIOVASCULAR: Denies Chest Pain. Denies heart attack. Denies falling out episodes. Denies CHF past six months.

RESPIRATORY: Denies wheezing. Denies SOB. Denies asthma. Denies environmental allergies. Denies smoking.

GASTROINTESTINAL: Denies difficulty swallowing. Denies indigestion. Denies abdominal pain. Denies nausea. Denies vomiting. Denies diarrhea. Denies constipation. Denies Jaundice. Denies change in bowel function. Denies Rectal bleeding. Denies inability to control bowel movements.

GENITOURINARY: Denies painful urination. Denies frequent urination. Denies blood in urine. Denies unable to control urination. Denies nocturia.

MUSCULOSKELETAL: Denies joint swelling. Denies restriction. Denies muscle pain. Denies joint pain.

INTEGUMENTARY: Denies rashes. Denies lesions. Denies change to hair and nails. Denies open skin sores.

NEUROLOGICAL: Admits to seizures, Denies fainting spells. Denies paralysis. Denies tremor. Denies weakness.

PSYCHIATRIC: Denies depression. Denies suicide attempts. Denies anxiety disorders. Denies fear of needles.

ENDOCRINE: Denies diabetes. Denies thyroid disorders.

HEMATOLOGIC: Denies anemia. Denies abnormal bleeding. Denies excessive bruising. Denies swollen glands. Denies previous blood transfusions. Denies pitting edema.

PHYSICAL EXAMINATION:

BP: 124/106 mmHg Pulse: 103 Resp: 16

CONSTITUTIONAL: GENERAL APPEARANCE: Clean, well nourished, oriented.

EYES: EXAMINATION OF PUPILS AND IRISES: Pupils round, normal light reactive. INSPECTION OF CONJUNCTIVAE AND LIDS: Clear without icterus; lids are normal.

ENMT: EXTERNAL INSPECTION OF EARS AND NOSE: No scars, lesions, deformities or masses. INSPECTION OF NASAL MUCOSA, SEPTUM AND TURBINATES: Mucosa and turbinates pink and moist without ulceration, exudate or bleeding. Septum is midline and symmetrical. INSPECTION OF LIPS AND GUMS: Lips, gums, tongue, buccal mucosa and palate are pink and moist without cyanosis or fissures. OROPHARYNX: Oral mucosa, salivary glands, hard and soft palates, tongue are pink and moist with no injection.

NECK: Supple, no masses, trachea is midline and freely moveable. THYROID: No enlargement, tenderness or masses noted.

RESPIRATORY: ASSESSMENT OF RESPIRATORY EFFORT: Chest moving equally on both sides. No retraction or stridor. AUSCULTATION OF LUNGS: Breath sounds are well heard. No wheezing, rhonchi, crackles, rales or rubs noted posteriorly or anteriorly.

CARDIOVASCULAR: AUSCULTATION OF HEART: Regular rate and rhythm without murmur, normal S1 S2, negative rubs, clicks or gallops. CAROTID ARTERIES: Pulses normal, no bruits noted . FEMORAL ARTERIES: Pulses normal, no bruits noted. PEDAL PULSES: Pulses normal.

GASTROINTESTINAL: ABDOMEN: Soft, without tenderness or masses.

LYMPHATICS: AXILLAE: No masses or tenderness noted. NECK: No masses or tenderness noted, no thyroid enlargement. GROIN: No masses or tenderness noted. PALPATION OF LYMPH NODES:.

MUSCULOSKELETAL: GAIT AND STATION: No difficulty walking or standing. INSPECTION AND/OR PALPATION OF DIGITS AND NAILS: No clubbing, cyanosis, or inflammation.

HEAD AND NECK: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SPINE, RIBS AND PELVIS: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's Test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses, or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SKIN: SKIN AND SUBCUTANEOUS TISSUE: No rashes, lesions, ulcers or bruising noted. PALPATION OF SKIN AND SUBCUTANEOUS TISSUE: No indurations, nodules or tightening noted.

NEUROLOGIC: MOOD AND AFFECT: Appropriate affect; appears anxious at time of exam. ORIENTATION: Oriented to time, place and person. RECENT AND REMOTE MEMORY: Memory intact for long and short term. ATTENTION SPAN AND CONCENTRATION: Average attention and concentration. LANGUAGE: Speaks without aids, voice is strong, articulate, speech is spontaneous. FUND OF KNOWLEDGE: Average awareness of current events and history. MOTOR EXAMINATION: Normal strength in upper and lower extremities including quadricep, ankle, great toe dorsiflexion, and plantar flexion. Tone in upper and lower extremities normal. Muscle bulk within normal limits. No abnormal movements noticed. SENSATION: Light touch within normal limits. DEEP TENDON REFLEXES UPPER AND LOWER EXTREMITIES, INCLUDING ANKLE AND KNEE REFLEXES: 2+ symmetric throughout, plantar responses downgoing.

CRANIAL NERVES: I. Not tested. II. Visual acuity and fields WNL III, IV, VI. Extraocular movements intact, pupils equal, round and reactive to light OU, no nystagmus present, conjugate gaze. V. Facial sensation equal bilaterally, muscles of mastication normal. Allodynia bilaterally. VII. Face symmetric, no evidence of palsy noted. VIII. Hearing normal to the whispered voice, equilibrium normal. IX, X. Palate movement symmetric. XI. Sternocleidomastoid and trapezius muscles normal strength. XII. Tongue movement symmetric, position midline without fasciculations.

IMPRESSIONS:
Chronic daily headache
Medication overuse headache
Anxiety disorder

PLAN:
1. Return to the Pain Management Clinic on 3-14-16 for MD evaluation.
2. Continue current medications.
3. Epilepsy monitoring unit revealed seizure activity twice.
4. Appointment with Dr. Afrik March 28, 2016.
5. Wean Fioricet to 1 pill every two weeks.
6. Botox ordered.
7. Bilateral sphenopalatine ganglion block today.
8. Take Relpax with auras.

ENCOUNTER NOTES :
DESCRIPTION OF PROCEDURE: Treatment plan was discussed with the patient. After detailed procedural explanation was rendered to the patient, and the appropriate Risks and Benefits Ratio Profile was explained and described clearly, the patient signed the Procedural Informed Consent document, which outlined consent to the procedure discussed.

The patient was then taken to the procedural room, and placed on the procedural table in a supine position, with a pillow supporting the shoulders, and allowing the back of the head to rest on the procedural table, which facilitated gentle neck extension. Careful attention was directed towards the skin's surface from the tragus of the ear toward the lateral nasal passageway. Cleansing occurred repeatedly until the alcohol wipes revealed no makeup or lotion or other oils on the surface of the skin in the cutaneous V2 distribution. Both nostrils were then visually examined to quickly re-evaluate internal nasal anatomy, with particular emphasis towards detecting evidence of recent epistaxis, purulent nasal drainage, and/or visible nasal sinus anatomy abnormalities or nares obstruction.
A clean cotton-tipped applicator was then immersed with a generous portion of 2% lidocaine jelly and placed into each separate nostril advancing towards the internal nasal meatus. This procedure was then repeated on the contra lateral nostril. A sheath was advanced until contact with the posterior nasal pharynx. The sheath was then withdrawn several millimeters. A pigtail catheter was inserted and advanced towards the posterior elements of the right nasal-sinus passageway. A syringe containing 0.25% Bupivicaine was attached to the extension. This was immediately followed by a pressurized delivery of 1.5 cc of 0.25% Bupivicaine down the right side wall of the nasal passageway over the middle turbinate and into the right spheno-palatine fossa, which saturated the parasympathetic SPG fibers, and allowed the gravitational egress of the lidocaine into the ipsi-lateral vidian canal, which produced right lateral pterygopalatine fossa filling, saturating the right maxillary branch of the trigeminal ganglion, and complete anesthetic (Bupivicaine) delivery to the sympathetic fibers of the right pterygopalitine ganglion.

Patient Name: Jeffrey T Bodin Patient ID: 8458 DOB: 5/22/1969 Exam Date: 02/29/2016

After the right-sided block was complete, the left nasal passageway was prepped for the left-sided procedure. The patient's head was rechecked for proper supine positioning, maximum head extension, and chin lift. Careful attention was directed towards the conformational manifestation of the catheter prior to beginning the blockade of the left-sided structures. The same technique was performed on the left.
dc 3-04-16

The patient remained on the procedural room table in a supine position for 8 minutes to allow gravitational assisted delivery and absorption of the lidocaine into the targeted structures. After the 8 minute absorption duration, the patient was discharged and instructed to call the office for any post-procedure complications.

Signature: _____
C. Ann Conn M.D.

Premier Pain Center

7015 Hwy 190 East Service Road
Suite 101
Covington, LA 70433

OFFICE VISIT

PATIENT NAME : Jeffrey T Bodin
PATIENT ID : 8456
DATE OF BIRTH : 5/22/1997 **AGE** : 19 **SEX** : Male

ATTENDED BY : C. Ann Conn M.D.
REFERRED BY : ,
EXAM DATE : 06/06/2016

CHIEF COMPLAINT:

Headache.

PRESENT ILLNESS:

LOCATION: The location of the patient's pain is in the head.
SEVERITY: Moderate.
SIGNS AND SYMPTOMS: The patient returns to the Pain Management Center complaining of a holochephalic headache that he describes as "all over." He has difficulty initiating sleep at night. He remains active. He has had no pain relief from the bilateral sphenopalatine ganglion block of 3-04-14. He discontinued Fioricet. His mother is in attendance today and, with patient's permission, is discussing his medical condition.
Conservative Treatments:
Physical Therapy completed for 6 weeks? No.
NSAIDS tried for 6 weeks? Yes.
If yes, was it helpful or not? No.

WORKING STATUS: Student. Not working.
EFFECTS OF MEDICATIONS PRESCRIBED BY PREMIER: None.
VAS: 4/10

COMBI:
1.Global Impression of Change.
"With respect to your headache pain, how are you feeling now compared to before you received treatment?" or an equivalent.
Answer: Minimally worse.
2.Numeric Rating Scale of Pain Intensity.
"Please rate your pain by indicating the number that best describes your average pain in the last 24 hours on a 0 (no pain) to 10 (pain as bad as you can imagine) scale."
Answer: 5
3. The Patient Specified Functional Outcome Scale- Activities of Daily Living.
"What are four things in life that you can't do, or have difficulty doing, because of your pain, and which most dearly you would want restored? These should be simple, realistic, daily life improvements that other people can see most of the time."
1. Go to a Saints game - not restored.
2. Go to church - - not restored.
3. Reading - not restored.
4. School work - not restored.
4. Pain, Enjoyment, General Activity (PEG)
4.1 "What number best describes your pain, on average, over the past week?"
Answer: 5
4.2 "What number best describes how, during the past week, the pain has interfered with your enjoyment of life?"
Answer: 6
4.3 "What number best describes how, during the past week, the pain has interfered with your general activity?"
Answer: 6
5. Other Health Care
"What other treatments are you receiving for your pain?"
Answer: No answer.
6. Return to Work
"Are you working?"
Answer: No answer.

MEDICATIONS:

Fioricet 50/325/40 mg 2 po bid
Adderall XR 20 mg 2 po bid
Adderall 20 mg 2 po qd
Zyrtec 10 mg 1 po qd
Singulair 10 mg 1 po qd
Relpax 40 mg 1 po prn headache (not started)

ALLERGIES:
Keppra - hallucinations
Elavil - seizure

MEDICAL HISTORY:
Significant for cancer (Stage III malignant melanoma 2008 left ankle; Interferon, removal of left groin lymph nodes), seizure syndrome, narcolepsy (CPAP).

HOSPITALIZATION AND SURGERY:
Appendectomy, T & A, 2 cancer - left ankle and left groin.

FAMILY HISTORY:
Significant for cancer (grandmother), cardiac disease (grandfather), arthritis (great grandmother), and diabetes (great grandmother). He denies migraines.

SOCIAL HISTORY:
Marital Status: Single
Military Service: Not noted.
Use of "Street/Non-prescription" drugs: Not noted.
Alcohol Use: Denies.
Tobacco Use: Denies.
Level of Education: Not noted.
Sexual History: Not noted.
Work Status: Student.

SYSTEMS REVIEW:

CONSTITUTIONAL: Denies fever. Denies unexplained weight change. Denies flu like symptoms. Denies recent trips outside of US.

ENMT: Denies headaches. Denies vision changes, Denies hearing loss. Denies ringing in ears. Denies dizziness. Denies runny nose. Denies hoarsness. Denies oral tissue lesions.

CARDIOVASCULAR: Denies Chest Pain. Denies heart attack. Denies falling out episodes. Denies CHF past six months.

RESPIRATORY: Denies wheezing. Denies SOB. Denies asthma. Denies environmental allergies. Denies smoking.

GASTROINTESTINAL: Denies difficulty swallowing. Denies indigestion. Denies abdominal pain. Denies nausea. Denies vomiting. Denies diarrhea. Denies constipation. Denies Jaundice. Denies change in bowel function. Denies Rectal bleeding. Denies inability to control bowel movements.

GENITOURINARY: Denies painful urination. Denies frequent urination. Denies blood in urine. Denies unable to control urination. Denies nocturia.

MUSCULOSKELETAL: Denies joint swelling. Denies restriction. Denies muscle pain. Denies joint pain.

INTEGUMENTARY: Denies rashes. Denies lesions. Denies change to hair and nails. Denies open skin sores.

NEUROLOGICAL: Denies seizures. Denies fainting spells. Denies paralysis. Denies tremor. Denies weakness.

PSYCHIATRIC: Denies depression. Denies suicide attempts. Denies anxiety disorders. Denies fear of needles.

ENDOCRINE: Denies diabetes. Denies thyroid disorders.

HEMATOLOGIC: Denies anemia. Denies abnormal bleeding. Denies excessive bruising. Denies swollen glands. Denies previous blood transfusions. Denies pitting edema.

PHYSICAL EXAMINATION:

BP: 134/94 mmHg Pulse: 92 Resp: 16

CONSTITUTIONAL: GENERAL APPEARANCE: Clean, well nourished, oriented.

EYES: EXAMINATION OF PUPILS AND IRISES: Pupils round, normal light reactive. INSPECTION OF CONJUNCTIVAE AND LIDS: Clear without icterus; lids are normal.

ENMT: EXTERNAL INSPECTION OF EARS AND NOSE: No scars, lesions, deformities or masses. INSPECTION OF NASAL MUCOSA, SEPTUM AND TURBINATES: Mucosa and turbinates pink and moist without ulceration, exudate or bleeding. Septum is midline and symmetrical. INSPECTION OF LIPS AND GUMS: Lips, gums, tongue, buccal mucosa and palate are pink and moist without cyanosis or fissures. OROPHARYNX: Oral mucosa, salivary glands, hard and soft palates, tongue are pink and moist with no injection.

NECK: Supple, no masses, trachea is midline and freely moveable. THYROID: No enlargement, tenderness or masses noted.

RESPIRATORY: ASSESSMENT OF RESPIRATORY EFFORT: Chest moving equally on both sides. No retraction or stridor. AUSCULTATION OF LUNGS: Breath sounds are well heard. No wheezing, rhonchi, crackles, rales or rubs noted posteriorly or anteriorly.

CARDIOVASCULAR : AUSCULTATION OF HEART: Regular rate and rhythm without murmur, normal S1 S2, negative rubs, clicks or gallops. CAROTID ARTERIES: Pulses normal, no bruits noted . FEMORAL ARTERIES: Pulses normal, no bruits noted. PEDAL PULSES: Pulses normal.

GASTROINTESTINAL: ABDOMEN: Soft, without tenderness or masses.

LYMPHATICS: AXILLAE: No masses or tenderness noted. NECK: No masses or tenderness noted, no thyroid enlargement. GROIN: No masses or tenderness noted. PALPATION OF LYMPH NODES: No masses or tenderness noted.

MUSCULOSKELETAL: GAIT AND STATION: No difficulty walking or standing. INSPECTION AND/OR PALPATION OF DIGITS AND NAILS: No clubbing, cyanosis, or inflammation.

HEAD AND NECK: INSPECTION AND/OR PALPATION: No pain to palpation over the greater occipital nerves, RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SPINE, RIBS AND PELVIS: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's Test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses, or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SKIN: SKIN AND SUBCUTANEOUS TISSUE: No rashes, lesions, ulcers or bruising noted. PALPATION OF SKIN AND SUBCUTANEOUS TISSUE: No indurations, nodules or tightening noted.

NEUROLOGIC: MOOD AND AFFECT: Appropriate affect; does not appear depressed, anxious or agitated at time of exam. ORIENTATION: Oriented to time, place and person. RECENT AND REMOTE MEMORY: Memory intact for long and short term. ATTENTION SPAN AND CONCENTRATION: Average attention and concentration. LANGUAGE: Speaks without aids, voice is strong, articulate, speech is spontaneous. FUND OF KNOWLEDGE: Average awareness of current events and history. MOTOR EXAMINATION: Normal strength in upper and lower extremities including quadricep, ankle, great toe dorsiflexion, and plantar flexion.Tone in upper and lower extremities normal. Muscle bulk within normal limits. No abnormal movements noticed. SENSATION: Light touch within normal limits. DEEP TENDON REFLEXES UPPER AND LOWER EXTREMITIES, INCLUDING ANKLE AND KNEE REFLEXES: 2+ symmetric throughout, plantar responses downgoing.

CRANIAL NERVES: I. Not tested. II. Visual acuity and fields WNL III, IV, VI. Extraocular movements intact, pupils equal, round and reactive to light OU, no nystagmus present, conjugate gaze. V. Facial sensation equal bilaterally, muscles of mastication normal. VII. Face symmetric, no evidence of palsy noted. VIII. Hearing normal to the whispered voice, equilibrium normal. IX, X. Palate movement symmetric. XI. Sternocleidomastoid and trapezius muscles normal strength. XII. Tongue movement symmetric, position midline without fasciculations.

IMPRESSIONS:

CHRONIC DAILY HEADACHE
MEDICATION OVERUSE HEADACHE
Anxiety disorder
Allergic rhinitis
SLEEP DISORDER
MIGRAINE WITH AURA

PLAN:

Patient Name: Jeffrey T Bodin Patient ID: 8456 DOB: 5/22/1997 Exam Date: 06/06/2016

1. Return to the Pain Management Center on 8-15-16 for MD evaluation.
2. Continue current medications.
3. Continue in care with Dr. Terrell; agree with wean of Adderall.
4. Relpax 40 mg + 2 Aleve prn headache (Limit to 9 x per month).
5. Sleep Study pending in future.
6. Reqeusting Botox therapy.
7. Bilateral greater occipital nerve block discussed.
8. Patient does not want to start Botox or have a bilateral greater occipital nerve block.
9. Relpax before Sleep Study.

dc 6-07-16

Signature: _____

C. Ann Conn M.D.

Premier Pain Center

7015 Hwy 190 East Service Road
Suite 101
Covington, LA 70433

OFFICE VISIT

PATIENT NAME : Jeffrey T Bodin
PATIENT ID : 8456
DATE OF BIRTH : 5/22/1997 AGE : 18 SEX : Male

ATTENDED BY : C. Ann Conn M.D.
REFERRED BY : ,
EXAM DATE : 04/11/2016

CHIEF COMPLAINT:

Headache.

PRESENT ILLNESS:

Quality: Patient describes the quality of the pain as: aching and throbbing.
Severity: Moderate.
Work Status: Student.
Signs and Symptoms: Patient returns to the Pain Management Center today complaining of a headache he describes as "all-over." He sleeps well at night and remains active. His headache increased the day of the last procedure, a bilateral sphenopalatine ganglion block performed on 3-14-16.
Effects of Medications prescribed by Premier: He has not started Relpax. He is taking one Fioricet each day and feels "the headaches are worse with Fioricet wean." Discussed spell at home partially witnessed by Dr. Casey.
VAS: Moderate.

COMBI:
1.Global Impression of Change.
"With respect to your headache pain, how are you feeling now compared to before you received treatment?" or an equivalent.
Answer: no answer.
2.Numeric Rating Scale of Pain Intensity.
"Please rate your pain by indicating the number that best describes your average pain in the last 24 hours on a 0 (no pain) to 10 (pain as bad as you can imagine) scale."
Answer: 4
3. The Patient Specified Functional Outcome Scale- Activities of Daily Living.
"What are four things in life that you can't do, or have difficulty doing, because of your pain, and which most dearly you would want restored? These should be simple, realistic, daily life improvements that other people can see most of the time."
Not on medications. Procedure not helpful.
4. Pain, Enjoyment, General Activity (PEG)
4.1 "What number best describes your pain, on average, over the past week?"
Answer: 6
4.2 "What number best describes how, during the past week, the pain has interfered with your enjoyment of life?"
Answer: 6
4.3 "What number best describes how, during the past week, the pain has interfered with your general activity?"
Answer: 6
5. Other Health Care
"What other treatments are you receiving for your pain?"
Answer: no answer.
6. Return to Work
"Are you working?"
Answer: Student.

MEDICATIONS:

Fioricet 50/325/40 mg 2 po bid
Adderall XR 20 mg 2 po bid
Adderall 20 mg 2 po qd
Zyrtec 10 mg 1 po qd
Singulair 10 mg 1 po qd
Relpax 40 mg 1 po prn headache (not started)

ALLERGIES:

Keppra - hallucinations
Elavil - seizure

MEDICAL HISTORY:

Significant for cancer (Stage III malignant melanoma 2008 left ankle; Interferon, removal of left groin lymph nodes), seizure syndrome, narcolepsy (CPAP).

HOSPITALIZATION AND SURGERY:

Appendectomy, T & A, 2 cancer - left ankle and left groin.

FAMILY HISTORY:

Significant for cancer (grandmother), cardiac disease (grandfather), arthritis (great grandmother), and diabetes (great grandmother). He denies migraines.

SOCIAL HISTORY:

Marital Status: Single
Military Service: Not noted.
Use of "Street/Non-prescription" drugs: Not noted.
Alcohol Use: Denies.
Tobacco Use: Denies.
Level of Education: Not noted.
Sexual History: Not noted.
Work Status: Student.

SYSTEMS REVIEW:

CONSTITUTIONAL: Denies fever. Denies unexplained weight change. Denies flu like symptoms. Denies recent trips outside of US.

ENMT: Denies headaches. Denies vision changes, Denies hearing loss. Denies ringing in ears. Denies dizziness. Denies runny nose. Denies hoarsness. Denies oral tissue lesions.

CARDIOVASCULAR: Denies Chest Pain. Denies heart attack. Denies falling out episodes. Denies CHF past six months.

RESPIRATORY: Denies wheezing. Denies SOB. Denies asthma. Denies environmental allergies. Denies smoking.

GASTROINTESTINAL: Denies difficulty swallowing. Denies indigestion. Denies abdominal pain. Denies nausea. Denies vomiting. Denies diarrhea. Denies constipation. Denies Jaundice. Denies change in bowel function. Denies Rectal bleeding. Denies inability to control bowel movements.

GENITOURINARY: Denies painful urination. Denies frequent urination. Denies blood in urine. Denies unable to control urination. Denies nocturia.

MUSCULOSKELETAL: Denies joint swelling. Denies restriction. Denies muscle pain. Denies joint pain.

INTEGUMENTARY: Denies rashes. Denies lesions. Denies change to hair and nails. Denies open skin sores.

NEUROLOGICAL: Denies seizures. Denies fainting spells. Denies paralysis. Denies tremor. Denies weakness.

PSYCHIATRIC: Denies depression. Denies suicide attempts. Denies anxiety disorders. Denies fear of needles.

ENDOCRINE: Denies diabetes. Denies thyroid disorders.

HEMATOLOGIC: Denies anemia. Denies abnormal bleeding. Denies excessive bruising. Denies swollen glands. Denies previous blood transfusions. Denies pitting edema.

PHYSICAL EXAMINATION:

BP: 130/99 mmHg Pulse: 96 Resp: 16

CONSTITUTIONAL: GENERAL APPEARANCE: Clean, well nourished, oriented.

EYES: EXAMINATION OF PUPILS AND IRISES: Pupils round, normal light reactive. INSPECTION OF CONJUNCTIVAE AND LIDS: Clear without icterus; lids are normal.

ENMT: EXTERNAL INSPECTION OF EARS AND NOSE: No scars, lesions, deformities or masses. INSPECTION OF NASAL MUCOSA, SEPTUM AND TURBINATES: Mucosa and turbinates pink and moist without ulceration, exudate or bleeding. Septum is midline and symmetrical. INSPECTION OF LIPS AND GUMS: Lips, gums, tongue, buccal mucosa and palate are pink and moist without cyanosis or fissures. OROPHARYNX: Oral mucosa, salivary glands, hard and soft palates, tongue are pink and moist with no injection.

NECK: Supple, no masses, trachea is midline and freely moveable. THYROID: No enlargement, tenderness or masses noted.

RESPIRATORY: ASSESSMENT OF RESPIRATORY EFFORT: Chest moving equally on both sides. No retraction or stridor. AUSCULTATION OF LUNGS: Breath sounds are well heard. No wheezing, rhonchi, crackles, rales or rubs noted posteriorly or anteriorly.

CARDIOVASCULAR : AUSCULTATION OF HEART: Regular rate and rhythm without murmur, normal S1 S2, negative rubs, clicks or gallops. CAROTID ARTERIES: Pulses normal, no bruits noted . FEMORAL ARTERIES: Pulses normal, no bruits noted. PEDAL PULSES: Pulses normal.

GASTROINTESTINAL: ABDOMEN: Soft, without tenderness or masses.

LYMPHATICS: AXILLAE: No masses or tenderness noted. NECK: No masses or tenderness noted, no thyroid enlargement. GROIN: No masses or tenderness noted. PALPATION OF LYMPH NODES:.

MUSCULOSKELETAL: GAIT AND STATION: No difficulty walking or standing. INSPECTION AND/OR PALPATION OF DIGITS AND NAILS: No clubbing, cyanosis, or inflammation.

HEAD AND NECK: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SPINE, RIBS AND PELVIS: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's Test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses, or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SKIN: SKIN AND SUBCUTANEOUS TISSUE: No rashes, lesions, ulcers or bruising noted. PALPATION OF SKIN AND SUBCUTANEOUS TISSUE: No indurations, nodules or tightening noted.

NEUROLOGIC: MOOD AND AFFECT: Appropriate affect; appears anxious at time of exam. ORIENTATION: Oriented to time, place and person. RECENT AND REMOTE MEMORY: Memory intact for long and short term. ATTENTION SPAN AND CONCENTRATION: Average attention and concentration. LANGUAGE: Speaks without aids, voice is strong, articulate, speech is spontaneous. FUND OF KNOWLEDGE: Average awareness of current events and history. MOTOR EXAMINATION: Normal strength in upper and lower extremities including quadricep, ankle, great toe dorsiflexion, and plantar flexion.Tone in upper and lower extremities normal. Muscle bulk within normal limits. No abnormal movements noticed. SENSATION: Light touch within normal limits. DEEP TENDON REFLEXES UPPER AND LOWER EXTREMITIES, INCLUDING ANKLE AND KNEE REFLEXES: 2+ symmetric throughout, plantar responses downgoing.

CRANIAL NERVES: I. Not tested. II. Visual acuity and fields WNL III, IV, VI. Extraocular movements intact, pupils equal, round and reactive to light OU, no nystagmus present, conjugate gaze. V. Facial sensation equal bilaterally, muscles of mastication normal. Allodynia bilaterally. VII. Face symmetric, no evidence of palsy noted. VIII. Hearing normal to the whispered voice, equilibrium normal. IX, X. Palate movement symmetric. XI. Sternocleidomastoid and trapezius muscles normal strength. XII. Tongue movement symmetric, position midline without fasciculations.

IMPRESSIONS:

CHRONIC DAILY HEADACHE
Medication overuse headache
ANXIETY DISORDER
ALLERGIC RHINITIS
SLEEP DISORDER

PLAN:

1. Return to the Pain Management Clinic on 6-06-16 for MD evaluation.
2. Continue current medications.
3. Discontinue Fioricet.
4. Recommended Epilepsy Monitor unit; Dr. O. at LSU.
5. Bilateral greater occipital nerve block at next visit.

dc 4-13-16

Signature: _____

C. Ann Conn M.D.

Premier Pain Center

7015 Hwy 190 East Service Road
Suite 101
Covington, LA 70433

OFFICE VISIT

PATIENT NAME : Jeffrey T Bodin
PATIENT ID : 8456
DATE OF BIRTH : 5/22/1997 **AGE** : 18 **SEX** : Male

ATTENDED BY : C. Ann Conn M.D.
REFERRED BY : ,
EXAM DATE : 03/28/2016

PRESENT ILLNESS:
Quality: Patient describes the quality of the pain as: achy, throbbing, and shooting.
Severity: Moderate.
Work Status: Student; yes.
Signs and Symptoms: Patient returns to the Pain Management Center today complaining of a headache he describes as "all-over, in no specific spot." His headaches increase with weather changes. He states, "I wasn't able to go to school at all last week. I have severe exhaustion from decreasing Butalbital," and "My headaches have been more of a 4 since I've been coming off my medication." He states he has "hallucinating kind of effects," speaking of aura with migraine. He sleeps okay at night. He remains active. He has had no pain relief from the bilateral sphenopalatine ganglion block of 3-14-16, and reports it increased his headache that day.
Effects of Medications prescribed by Premier: He has not tried Relpax, stating, "I have not had an aura yet." He is down to 2 Fioricet daily.
VAS: 4/10

COMBI:
1.Global Impression of Change.
"With respect to your headache pain, how are you feeling now compared to before you received treatment?" or an equivalent.
Answer: The length and frequency is worse. The severity is the same.
2.Numeric Rating Scale of Pain Intensity.
"Please rate your pain by indicating the number that best describes your average pain in the last 24 hours on a 0 (no pain) to 10 (pain as bad as you can imagine) scale."
Answer: 6
3. The Patient Specified Functional Outcome Scale- Activities of Daily Living.
"What are four things in life that you can't do, or have difficulty doing, because of your pain, and which most dearly you would want restored? These should be simple, realistic, daily life improvements that other people can see most of the time."
"Everything" - not restored.
4. Pain, Enjoyment, General Activity (PEG)
4.1 "What number best describes your pain, on average, over the past week?"
Answer: 6
4.2 "What number best describes how, during the past week, the pain has interfered with your enjoyment of life?"
Answer: 10
4.3 "What number best describes how, during the past week, the pain has interfered with your general activity?"
Answer: 10
5. Other Health Care
"What other treatments are you receiving for your pain?"
Answer: Relpax.
6. Return to Work
"Are you working?"
Answer: Student.Effects of Medications prescribed by Premier:

MEDICATIONS:
Fioricet 50/325/40 mg 2 po bid
Adderall XR 20 mg 2 po bid
Adderall 20 mg 2 po qd
Zyrtec 10 mg 1 po qd
Singulair 10 mg 1 po qd
Relpax 40 mg 1 po prn headache (not started)

ALLERGIES:
Keppra - hallucinations
Elavil - seizure

MEDICAL HISTORY:

Significant for cancer (Stage III malignant melanoma 2008 left ankle; Interferon, removal of left groin lymph nodes), seizure syndrome, narcolepsy (CPAP).

HOSPITALIZATION AND SURGERY:

Appendectomy, T & A, 2 cancer - left ankle and left groin.

FAMILY HISTORY:

Significant for cancer (grandmother), cardiac disease (grandfather), arthritis (great grandmother), and diabetes (great grandmother). He denies migraines.

SOCIAL HISTORY:

Marital Status: Single
Military Service: Not noted.
Use of "Street/Non-prescription" drugs: Not noted.
Alcohol Use: Denies.
Tobacco Use: Denies.
Level of Education: Not noted.
Sexual History: Not noted.
Work Status: Student.

SYSTEMS REVIEW:

CONSTITUTIONAL: Denies fever. Denies unexplained weight change. Denies flu like symptoms. Denies recent trips outside of US.

ENMT: Admits to headaches, Denies vision changes, Denies hearing loss. Denies ringing in ears. Denies dizziness. Denies runny nose. Denies hoarsness. Denies oral tissue lesions.

CARDIOVASCULAR: Denies Chest Pain. Denies heart attack. Denies falling out episodes. Denies CHF past six months.

RESPIRATORY: Denies wheezing. Denies SOB. Denies asthma. Denies environmental allergies. Denies smoking.

GASTROINTESTINAL: Admits to nausea, Denies difficulty swallowing. Denies indigestion. Denies abdominal pain. Denies vomiting. Denies diarrhea. Denies constipation. Denies Jaundice. Denies change in bowel function. Denies Rectal bleeding. Denies inability to control bowel movements.

GENITOURINARY: Denies painful urination. Denies frequent urination. Denies blood in urine. Denies unable to control urination. Denies nocturia.

MUSCULOSKELETAL: Admits to joint pain, Denies joint swelling. Denies restriction. Denies muscle pain.

INTEGUMENTARY: Denies rashes. Denies lesions. Denies change to hair and nails. Denies open skin sores.

NEUROLOGICAL: Denies seizures. Denies fainting spells. Denies paralysis. Denies tremor. Denies weakness.

PSYCHIATRIC: Denies depression. Denies suicide attempts. Denies anxiety disorders. Denies fear of needles.

ENDOCRINE: Denies diabetes. Denies thyroid disorders.

HEMATOLOGIC: Denies anemia. Denies abnormal bleeding. Denies excessive bruising. Denies swollen glands. Denies previous blood transfusions. Denies pitting edema.

PHYSICAL EXAMINATION:

BP: 110/99 mmHg Pulse: 94 Resp: 16

CONSTITUTIONAL: GENERAL APPEARANCE: Clean, well nourished, oriented.

EYES: EXAMINATION OF PUPILS AND IRISES: Pupils round, normal light reactive. INSPECTION OF CONJUNCTIVAE AND LIDS: Clear without icterus; lids are normal. Glasses.

ENMT: EXTERNAL INSPECTION OF EARS AND NOSE: No scars, lesions, deformities or masses. INSPECTION OF NASAL MUCOSA, SEPTUM AND TURBINATES: Mucosa and turbinates pink and moist without ulceration, exudate or bleeding. Septum is midline and symmetrical. INSPECTION OF LIPS AND GUMS: Lips, gums, tongue, buccal mucosa and palate are pink and moist without cyanosis or fissures. OROPHARYNX: Oral mucosa, salivary glands, hard and soft palates, tongue are pink and moist with no injection. Hoarse.

NECK: Supple, no masses, trachea is midline and freely moveable. THYROID: No enlargement, tenderness or masses noted.

RESPIRATORY: ASSESSMENT OF RESPIRATORY EFFORT: Chest moving equally on both sides. No retraction or stridor. AUSCULTATION OF LUNGS: Breath sounds are well heard. No wheezing, rhonchi, crackles, rales or rubs noted posteriorly or anteriorly.

CARDIOVASCULAR : AUSCULTATION OF HEART: Regular rate and rhythm without murmur, normal S1 S2, negative rubs, clicks or gallops. CAROTID ARTERIES: Pulses normal, no bruits noted . FEMORAL ARTERIES: Pulses normal, no bruits noted. PEDAL PULSES: Pulses normal.

GASTROINTESTINAL: ABDOMEN: Soft, without tenderness or masses.

LYMPHATICS: AXILLAE: No masses or tenderness noted. NECK: No masses or tenderness noted, no thyroid enlargement. GROIN: No masses or tenderness noted. PALPATION OF LYMPH NODES:

MUSCULOSKELETAL: GAIT AND STATION: No difficulty walking or standing. INSPECTION AND/OR PALPATION OF DIGITS AND NAILS: No clubbing, cyanosis, or inflammation.

HEAD AND NECK: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SPINE, RIBS AND PELVIS: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's Test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses, or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SKIN: SKIN AND SUBCUTANEOUS TISSUE: No rashes, lesions, ulcers or bruising noted. PALPATION OF SKIN AND SUBCUTANEOUS TISSUE: No indurations, nodules or tightening noted.

NEUROLOGIC: MOOD AND AFFECT: Appropriate affect; appears anxious at time of exam. ORIENTATION: Oriented to time, place and person. RECENT AND REMOTE MEMORY: Memory intact for long and short term. ATTENTION SPAN AND CONCENTRATION: Average attention and concentration. LANGUAGE: Speaks without aids, voice is strong, articulate, speech is spontaneous. FUND OF KNOWLEDGE: Average awareness of current events and history. MOTOR EXAMINATION: Normal strength in upper and lower extremities including quadricep, ankle, great toe dorsiflexion, and plantar flexion.Tone in upper and lower extremities normal. Muscle bulk within normal limits. No abnormal movements noticed. SENSATION: Light touch within normal limits. DEEP TENDON REFLEXES UPPER AND LOWER EXTREMITIES, INCLUDING ANKLE AND KNEE REFLEXES: 2+ symmetric throughout, plantar responses downgoing.

CRANIAL NERVES: I. Not tested. II. Visual acuity and fields WNL III, IV, VI. Extraocular movements intact, pupils equal, round and reactive to light OU, no nystagmus present, conjugate gaze. V. Facial sensation equal bilaterally, muscles of mastication normal. Allodynia bilaterally. VII. Face symmetric, no evidence of palsy noted. VIII. Hearing normal to the whispered voice, equilibrium normal. IX, X. Palate movement symmetric. XI. Sternocleidomastoid and trapezius muscles normal strength. XII. Tongue movement symmetric, position midline without fasciculations.

IMPRESSIONS:

CHRONIC DAILY HEADACHE
Medication overuse headache
Anxiety disorder
ALLERGIC RHINITIS
SLEEP DISORDER

PLAN:

1. Return to the Pain Management Clinic on 4-11-16 for MD evaluation.
2. Continue current medications.
3. Decrease Fioricet to 1 po qd.
4. Educated on aura with Relpax use.
5. Decreased Butalbital; not associated with fatigue.

dc 3-28-16

Signature: _____

C. Ann Conn M.D.

Patient Name: Jeffrey T Bodin Patient ID: 8456 DOB: 5/22/1997 Exam Date: 03/28/2016

Premier Pain Center

7015 Hwy 190 East Service Road
Suite 101
Covington, LA 70433

OFFICE VISIT

PATIENT NAME : Jeffrey T Bodin
PATIENT ID : 8456
DATE OF BIRTH : 5/22/1997 **AGE** : 18 **SEX** : Male

ATTENDED BY : C. Ann Conn M.D.
REFERRED BY : ,
EXAM DATE : 03/14/2016

CHIEF COMPLAINT:

Headache.

PRESENT ILLNESS:

Quality: Patient describes the quality of the pain as: pressing and throbbing.
Severity: Mild to moderate.
Work Status: Student.
Signs and Symptoms: Patient returns to the Pain Management Center today complaining of a headache "all-over" equally. He sleeps "fine" at night. His activity is moderate. He has had a small amount of pain relief from the bilateral sphenopalatine ganglion block of 2-29-16.
Effects of Medications prescribed by Premier: He has not used Relpax yet. He states, "I have not had a migraine with aura yet." He decreased Fioricet to 2 qam and 1 qhs.
VAS: 3-4/10

MEDICATIONS:

Fioricet 50/325/40 mg 2 po bid
Adderall XR 20 mg 2 po bid
Adderall 20 mg 2 po qd
Zyrtec 10 mg 1 po qd
Singulair 10 mg 1 po qd
Relpax 40 mg 1 po prn headache (not started)

ALLERGIES:

Keppra - hallucinations
Elavil - seizure
Keppra
Elavil

MEDICAL HISTORY:

Significant for cancer (Stage III malignant melanoma 2008 left ankle; Interferon, removal of left groin lymph nodes), seizure syndrome, narcolepsy (CPAP).

HOSPITALIZATION AND SURGERY:

Appendectomy, T & A, 2 cancer - left ankle and left groin.

FAMILY HISTORY:

Significant for cancer (grandmother), cardiac disease (grandfather), arthritis (great grandmother), and diabetes (great grandmother). He denies migraines.

SOCIAL HISTORY:

Marital Status: Single
Military Service: Not noted.
Use of "Street/Non-prescription" drugs: Not noted.
Alcohol Use: Denies.
Tobacco Use: Denies.
Level of Education: Not noted.
Sexual History: Not noted.
Work Status: Student.

SYSTEMS REVIEW:

CONSTITUTIONAL: Denies fever. Denies unexplained weight change. Denies flu like symptoms. Denies recent trips outside of US.

ENMT: Admits to headaches, Denies vision changes, Denies hearing loss. Denies ringing in ears. Denies dizziness. Denies runny nose. Denies hoarsness. Denies oral tissue lesions.

CARDIOVASCULAR: Denies Chest Pain. Denies heart attack. Denies falling out episodes. Denies CHF past six months.

RESPIRATORY: Denies wheezing. Denies SOB. Denies asthma. Denies environmental allergies. Denies smoking.

GASTROINTESTINAL: Admits to nausea, Denies difficulty swallowing. Denies indigestion. Denies abdominal pain. Denies vomiting. Denies diarrhea. Denies constipation. Denies Jaundice. Denies change in bowel function. Denies Rectal bleeding. Denies inability to control bowel movements.

GENITOURINARY: Denies painful urination. Denies frequent urination. Denies blood in urine. Denies unable to control urination. Denies nocturia.

MUSCULOSKELETAL: Admits to joint pain, Denies joint swelling. Denies restriction. Denies muscle pain.

INTEGUMENTARY: Denies rashes. Denies lesions. Denies change to hair and nails. Denies open skin sores.

NEUROLOGICAL: Admits to seizures, Admits to tremor, Denies fainting spells. Denies paralysis. Denies weakness.

PSYCHIATRIC: Denies depression. Denies suicide attempts. Denies anxiety disorders. Denies fear of needles.

ENDOCRINE: Denies diabetes. Denies thyroid disorders.

HEMATOLOGIC: Denies anemia. Denies abnormal bleeding. Denies excessive bruising. Denies swollen glands. Denies previous blood transfusions. Denies pitting edema.

PHYSICAL EXAMINATION:

BP: 121/86 mmHg Pulse: 96 Resp: 18

CONSTITUTIONAL: GENERAL APPEARANCE: Clean, well nourished, oriented.

EYES: INSPECTION OF CONJUNCTIVAE AND LIDS:, EXAMINATION OF PUPILS AND IRISES: Pupils round, normal light reactive. glasses.

ENMT: EXTERNAL INSPECTION OF EARS AND NOSE: No scars, lesions, deformities or masses. INSPECTION OF NASAL MUCOSA, SEPTUM AND TURBINATES: Mucosa and turbinates pink and moist without ulceration, exudate or bleeding. Septum is midline and symmetrical. INSPECTION OF LIPS AND GUMS: Lips, gums, tongue, buccal mucosa and palate are pink and moist without cyanosis or fissures. OROPHARYNX: Oral mucosa, salivary glands, hard and soft palates, tongue are pink and moist with no injection. Hoarse.

NECK: Supple, no masses, trachea is midline and freely moveable. THYROID: No enlargement, tenderness or masses noted.

RESPIRATORY: ASSESSMENT OF RESPIRATORY EFFORT: Chest moving equally on both sides. No retraction or stridor. AUSCULTATION OF LUNGS: Breath sounds are well heard. No wheezing, rhonchi, crackles, rales or rubs noted posteriorly or anteriorly.

CARDIOVASCULAR : AUSCULTATION OF HEART: Regular rate and rhythm without murmur, normal S1 S2, negative rubs, clicks or gallops. CAROTID ARTERIES: Pulses normal, no bruits noted . FEMORAL ARTERIES: Pulses normal, no bruits noted. PEDAL PULSES: Pulses normal.

GASTROINTESTINAL: ABDOMEN: Soft, without tenderness or masses.

LYMPHATICS: AXILLAE: No masses or tenderness noted. NECK: No masses or tenderness noted, no thyroid enlargement. GROIN: No masses or tenderness noted. PALPATION OF LYMPH NODES:.

MUSCULOSKELETAL: GAIT AND STATION: No difficulty walking or standing. INSPECTION AND/OR PALPATION OF DIGITS AND NAILS: No clubbing, cyanosis, or inflammation.

HEAD AND NECK: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SPINE, RIBS AND PELVIS: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's Test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses, or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SKIN: SKIN AND SUBCUTANEOUS TISSUE: No rashes, lesions, ulcers or bruising noted. PALPATION OF SKIN AND SUBCUTANEOUS TISSUE: No indurations, nodules or tightening noted.

NEUROLOGIC: MOOD AND AFFECT: Appropriate affect; appears anxious at time of exam. ORIENTATION: Oriented to time, place and person. RECENT AND REMOTE MEMORY: Memory intact for long and short term. ATTENTION SPAN AND CONCENTRATION: Average attention and concentration. LANGUAGE: Speaks without aids, voice is strong, articulate, speech is spontaneous. FUND OF KNOWLEDGE: Average awareness of current events and history. MOTOR EXAMINATION: Normal strength in upper and lower extremities including quadricep, ankle, great toe dorsiflexion, and plantar flexion.Tone in upper and lower extremities normal. Muscle bulk within normal limits. No abnormal movements noticed. SENSATION: Light touch within normal limits. DEEP TENDON REFLEXES UPPER AND LOWER EXTREMITIES, INCLUDING ANKLE AND KNEE REFLEXES: 2+ symmetric throughout, plantar responses downgoing.

CRANIAL NERVES: I. Not tested. II. Visual acuity and fields WNL III, IV, VI. Extraocular movements intact, pupils equal, round and reactive to light OU, no nystagmus present, conjugate gaze. V. Facial sensation equal bilaterally, muscles of mastication normal. Allodynia bilaterally. VII. Face symmetric, no evidence of palsy noted. VIII. Hearing normal to the whispered voice, equilibrium normal. IX, X. Palate movement symmetric. XI. Sternocleidomastoid and trapezius muscles normal strength. XII. Tongue movement symmetric, position midline without fasciculations.

IMPRESSIONS:

CHRONIC DAILY HEADACHE
Medication overuse headache
Anxiety disorder
Allergic rhinitis
Sleep disorder.

PLAN:

1. Return to the Pain Management Clinic on 3-28-16 for MD evaluation.
2. Bilateral sphenopalatine ganglion block today.
3. Botox pending.

ENCOUNTER NOTES :

DESCRIPTION OF PROCEDURE: Treatment plan was discussed with the patient. After detailed procedural explanation was rendered to the patient, and the appropriate Risks and Benefits Ratio Profile was explained and described clearly, the patient signed the Procedural Informed Consent document, which outlined consent to the procedure discussed.

The patient was then taken to the procedural room, and placed on the procedural table in a supine position, with a pillow supporting the shoulders, and allowing the back of the head to rest on the procedural table, which facilitated gentle neck extension. Careful attention was directed towards the skin's surface from the tragus of the ear toward the lateral nasal passageway. Cleansing occurred repeatedly until the alcohol wipes revealed no makeup or lotion or other oils on the surface of the skin in the cutaneous V2 distribution. Both nostrils were then visually examined to quickly re-evaluate internal nasal anatomy, with particular emphasis towards detecting evidence of recent epistaxis, purulent nasal drainage, and/or visible nasal sinus anatomy abnormalities or nares obstruction.
A clean cotton-tipped applicator was then immersed with a generous portion of 2% lidocaine jelly and placed into each separate nostril advancing towards the internal nasal meatus. This procedure was then repeated on the contra lateral nostril. A sheath was advanced until contact with the posterior nasal pharynx. The sheath was then withdrawn several millimeters. A pigtail catheter was inserted and advanced towards the posterior elements of the right nasal-sinus passageway. A syringe containing 0.25% Bupivicaine was attached to the extension. This was immediately followed by a pressurized delivery of 1.5 cc of 0.25% Bupivicaine down the right side wall of the nasal passageway over the middle turbinate and into the right spheno-palatine fossa, which saturated the parasympathetic SPG fibers, and allowed the gravitational egress of the lidocaine into the ipsi-lateral vidian canal, which produced right lateral pterygopalatine fossa filling, saturating the right maxillary branch of the trigeminal ganglion, and complete anesthetic (Bupivicaine) delivery to the sympathetic fibers of the right pterygopalitine ganglion.
After the right-sided block was complete, the left nasal passageway was prepped for the left-sided procedure. The patient's head was rechecked for proper supine positioning, maximum head extension, and chin lift. Careful attention was directed towards the conformational manifestation of the catheter prior to beginning the blockade of the left-sided structures. The same technique was performed on the left.

The patient remained on the procedural room table in a supine position for 8 minutes to allow gravitational assisted delivery and absorption of the lidocaine into the targeted structures. After the 8 minute absorption duration, the patient was discharged and instructed to call the office for any post-procedure complications.
dc 3-28-16

Signature: _____

C. Ann Conn M.D.

Premier Pain Center

7015 Hwy 190 East Service Road
Suite 101
Covington, LA 70433

OFFICE VISIT

PATIENT NAME : Jeffrey T Bodin
PATIENT ID : 8456
DATE OF BIRTH : 5/22/1997 **AGE** : 18 **SEX** : Male

ATTENDED BY : C. Ann Conn M.D.
REFERRED BY : ,
EXAM DATE : 02/29/2016

CHIEF COMPLAINT:

Head pain.

PRESENT ILLNESS:

Quality: Patient describes the quality of the pain as: burning, throbbing, and aching.
Severity: Mild to moderate.
Work Status: Student.
Signs and Symptoms: Patient returns to the Pain Management Center today complaining of all-over head pain. He states, "I'm not in that much pain today." He states he has been having "mini-seizures." He states he had a seizure on Friday, February 19, at 5:45 a.m. He states, "I wake up with no energy." His other took his medication away on February 1 and February 2. The patient had a fight with his mother in the waiting room and refused her attending the appointment.
VAS: 3-4/10

Effects of medications prescribed by NIPM: Patient is tolerating medications.
COMBI: (Patient has not started any medications or had any procedures.)

MEDICATIONS:

Fioricet 50/325/40 mg 2 po bid
Adderall XR 20 mg 2 po bid
Adderall 20 mg 2 po qd
Zyrtec 10 mg 1 po qd
Singulair 10 mg 1 po qd
Relpax 40 mg 1 po prn headache

ALLERGIES:

Keppra
Elavil

MEDICAL HISTORY:

Significant for cancer (Stage III malignant melanoma 2008 left ankle; Interferon, removal of left groin lymph nodes), seizure syndrome, narcolepsy (CPAP).

HOSPITALIZATION AND SURGERY:

Appendectomy, T & A, 2 cancer - left ankle and left groin.

FAMILY HISTORY:

Significant for cancer (grandmother), cardiac disease (grandfather), arthritis (great grandmother), and diabetes (great grandmother). He denies migraines.

SOCIAL HISTORY:

Marital Status: Single
Military Service: Not noted.
Use of "Street/Non-prescription" drugs: Not noted.
Alcohol Use: Denies.
Tobacco Use: Denies.
Level of Education: Not noted.
Sexual History: Not noted.
Work Status: Student.

SYSTEMS REVIEW:

CONSTITUTIONAL: Denies fever. Denies unexplained weight change. Denies flu like symptoms. Denies recent trips outside of US.

ENMT: Admits to headaches, Denies vision changes, Denies hearing loss. Denies ringing in ears. Denies dizziness. Denies runny nose. Denies hoarsness. Denies oral tissue lesions.

CARDIOVASCULAR: Denies Chest Pain. Denies heart attack. Denies falling out episodes. Denies CHF past six months.

RESPIRATORY: Denies wheezing. Denies SOB. Denies asthma. Denies environmental allergies. Denies smoking.

GASTROINTESTINAL: Denies difficulty swallowing. Denies indigestion. Denies abdominal pain. Denies nausea. Denies vomiting. Denies diarrhea. Denies constipation. Denies Jaundice. Denies change in bowel function. Denies Rectal bleeding. Denies inability to control bowel movements.

GENITOURINARY: Denies painful urination. Denies frequent urination. Denies blood in urine. Denies unable to control urination. Denies nocturia.

MUSCULOSKELETAL: Denies joint swelling. Denies restriction. Denies muscle pain. Denies joint pain.

INTEGUMENTARY: Denies rashes. Denies lesions. Denies change to hair and nails. Denies open skin sores.

NEUROLOGICAL: Admits to seizures, Denies fainting spells. Denies paralysis. Denies tremor. Denies weakness.

PSYCHIATRIC: Denies depression. Denies suicide attempts. Denies anxiety disorders. Denies fear of needles.

ENDOCRINE: Denies diabetes. Denies thyroid disorders.

HEMATOLOGIC: Denies anemia. Denies abnormal bleeding. Denies excessive bruising. Denies swollen glands. Denies previous blood transfusions. Denies pitting edema.

PHYSICAL EXAMINATION:

BP: 124/106 mmHg Pulse: 103 Resp: 16

CONSTITUTIONAL: GENERAL APPEARANCE: Clean, well nourished, oriented.

EYES: EXAMINATION OF PUPILS AND IRISES: Pupils round, normal light reactive. INSPECTION OF CONJUNCTIVAE AND LIDS: Clear without icterus; lids are normal.

ENMT: EXTERNAL INSPECTION OF EARS AND NOSE: No scars, lesions, deformities or masses. INSPECTION OF NASAL MUCOSA, SEPTUM AND TURBINATES: Mucosa and turbinates pink and moist without ulceration, exudate or bleeding. Septum is midline and symmetrical. INSPECTION OF LIPS AND GUMS: Lips, gums, tongue, buccal mucosa and palate are pink and moist without cyanosis or fissures. OROPHARYNX: Oral mucosa, salivary glands, hard and soft palates, tongue are pink and moist with no injection.

NECK: Supple, no masses, trachea is midline and freely moveable. THYROID: No enlargement, tenderness or masses noted.

RESPIRATORY: ASSESSMENT OF RESPIRATORY EFFORT: Chest moving equally on both sides. No retraction or stridor. AUSCULTATION OF LUNGS: Breath sounds are well heard. No wheezing, rhonchi, crackles, rales or rubs noted posteriorly or anteriorly.

CARDIOVASCULAR : AUSCULTATION OF HEART: Regular rate and rhythm without murmur, normal S1 S2, negative rubs, clicks or gallops. CAROTID ARTERIES: Pulses normal, no bruits noted . FEMORAL ARTERIES: Pulses normal, no bruits noted. PEDAL PULSES: Pulses normal.

GASTROINTESTINAL: ABDOMEN: Soft, without tenderness or masses.

LYMPHATICS: AXILLAE: No masses or tenderness noted. NECK: No masses or tenderness noted, no thyroid enlargement. GROIN: No masses or tenderness noted. PALPATION OF LYMPH NODES:.

MUSCULOSKELETAL: GAIT AND STATION: No difficulty walking or standing. INSPECTION AND/OR PALPATION OF DIGITS AND NAILS: No clubbing, cyanosis, or inflammation.

HEAD AND NECK: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SPINE, RIBS AND PELVIS: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's Test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses, or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SKIN: SKIN AND SUBCUTANEOUS TISSUE: No rashes, lesions, ulcers or bruising noted. PALPATION OF SKIN AND SUBCUTANEOUS TISSUE: No indurations, nodules or tightening noted.

NEUROLOGIC: MOOD AND AFFECT: Appropriate affect; appears anxious at time of exam. ORIENTATION: Oriented to time, place and person. RECENT AND REMOTE MEMORY: Memory intact for long and short term. ATTENTION SPAN AND CONCENTRATION: Average attention and concentration. LANGUAGE: Speaks without aids, voice is strong, articulate, speech is spontaneous. FUND OF KNOWLEDGE: Average awareness of current events and history. MOTOR EXAMINATION: Normal strength in upper and lower extremities including quadricep, ankle, great toe dorsiflexion, and plantar flexion.Tone in upper and lower extremities normal. Muscle bulk within normal limits. No abnormal movements noticed. SENSATION: Light touch within normal limits. DEEP TENDON REFLEXES UPPER AND LOWER EXTREMITIES, INCLUDING ANKLE AND KNEE REFLEXES: 2+ symmetric throughout, plantar responses downgoing.

CRANIAL NERVES: I. Not tested. II. Visual acuity and fields WNL III, IV, VI. Extraocular movements intact, pupils equal, round and reactive to light OU, no nystagmus present, conjugate gaze. V. Facial sensation equal bilaterally, muscles of mastication normal. Allodynia bilaterally. VII. Face symmetric, no evidence of palsy noted. VIII. Hearing normal to the whispered voice, equilibrium normal. IX, X. Palate movement symmetric. XI. Sternocleidomastoid and trapezius muscles normal strength. XII. Tongue movement symmetric, position midline without fasciculations.

IMPRESSIONS:

Chronic daily headache
Medication overuse headache
Anxiety disorder

PLAN:

1. Return to the Pain Management Clinic on 3-14-16 for MD evaluation.
2. Continue current medications.
3. Epilepsy monitoring unit revealed seizure activity twice.
4. Appointment with Dr. Afrik March 28, 2016.
5. Wean Fioricet to 1 pill every two weeks.
6. Botox ordered.
7. Bilateral sphenopalatine ganglion block today.
8. Take Relpax with auras.

ENCOUNTER NOTES :

DESCRIPTION OF PROCEDURE: Treatment plan was discussed with the patient. After detailed procedural explanation was rendered to the patient, and the appropriate Risks and Benefits Ratio Profile was explained and described clearly, the patient signed the Procedural Informed Consent document, which outlined consent to the procedure discussed.

The patient was then taken to the procedural room, and placed on the procedural table in a supine position, with a pillow supporting the shoulders, and allowing the back of the head to rest on the procedural table, which facilitated gentle neck extension. Careful attention was directed towards the skin's surface from the tragus of the ear toward the lateral nasal passageway. Cleansing occurred repeatedly until the alcohol wipes revealed no makeup or lotion or other oils on the surface of the skin in the cutaneous V2 distribution. Both nostrils were then visually examined to quickly re-evaluate internal nasal anatomy, with particular emphasis towards detecting evidence of recent epistaxis, purulent nasal drainage, and/or visible nasal sinus anatomy abnormalities or nares obstruction.
A clean cotton-tipped applicator was then immersed with a generous portion of 2% lidocaine jelly and placed into each separate nostril advancing towards the internal nasal meatus. This procedure was then repeated on the contra lateral nostril. A sheath was advanced until contact with the posterior nasal pharynx. The sheath was then withdrawn several millimeters. A pigtail catheter was inserted and advanced towards the posterior elements of the right nasal-sinus passageway. A syringe containing 0.25% Bupivicaine was attached to the extension. This was immediately followed by a pressurized delivery of 1.5 cc of 0.25% Bupivicaine down the right side wall of the nasal passageway over the middle turbinate and into the right spheno-palatine fossa, which saturated the parasympathetic SPG fibers, and allowed the gravitational egress of the lidocaine into the ipsi-lateral vidian canal, which produced right lateral pterygopalatine fossa filling, saturating the right maxillary branch of the trigeminal ganglion, and complete anesthetic (Bupivicaine) delivery to the sympathetic fibers of the right pterygopalitine ganglion.

After the right-sided block was complete, the left nasal passageway was prepped for the left-sided procedure. The patient's head was rechecked for proper supine positioning, maximum head extension, and chin lift. Careful attention was directed towards the conformational manifestation of the catheter prior to beginning the blockade of the left-sided structures. The same technique was performed on the left.
dc 3-04-16

The patient remained on the procedural room table in a supine position for 8 minutes to allow gravitational assisted delivery and absorption of the lidocaine into the targeted structures. After the 8 minute absorption duration, the patient was discharged and instructed to call the office for any post-procedure complications.

Signature: _____
C. Ann Conn M.D.

Premier Pain Center

7015 Hwy 190 East Service Road
Suite 101
Covington, LA 70433

INITIAL EVALUATION

PATIENT NAME : Jeffrey T Bodin
PATIENT ID : 8456
DATE OF BIRTH : 5/22/1997 **AGE** : 18 **SEX** : Male

ATTENDED BY : C. Ann Conn M.D.
REFERRED BY : ,
EXAM DATE : 02/19/2016

CHIEF COMPLAINT:

Headache.

PRESENT ILLNESS:

This 18 year old right handed white male complains of a headache. He denies neck pain. He has a history of melanoma in June of 2008 of the left ankle and left groin, and was treated with Interferon. He has a history of GTC seizure on medication, thought to be medication-induced. His headache was at its worst in 2008. He is in the care of Dr. Africk (Pediatric Neurology). Six hours function per day. He had an ophthalmology exam less than one year ago that was within normal limits. He has tried Provigil and Nuvigil.

LOCATION: The location of the patient's pain is in the head.
QUALITY: The patient describes the quality of the pain as pulsing, throbbing, flashing, sharp, blinding, nagging, radiating, and tiring.
SEVERITY: Moderate.

MEDICATIONS:

Fioricet 50/325/40 mg 2 po bid
Adderall XR 20 mg 2 po bid
Adderall 20 mg 2 po qd
Zyrtec 10 mg 1 po qd
Singulair 10 mg 1 po qd
Relpax 40 mg 1 po prn headache

ALLERGIES:

Keppra
Elavil

MEDICAL HISTORY:

Significant for cancer (Stage III malignant melanoma 2008 left ankle; Interferon, removal of left groin lymph nodes), seizure syndrome, narcolepsy (CPAP).

HOSPITALIZATION AND SURGERY:

Appendectomy, T & A, 2 cancer - left ankle and left groin.

FAMILY HISTORY:

Significant for cancer (grandmother), cardiac disease (grandfather), arthritis (great grandmother), and diabetes (great grandmother). He denies migraines.

SOCIAL HISTORY:

Marital Status: Single
Military Service: Not noted.
Use of "Street/Non-prescription" drugs: Not noted.
Alcohol Use: Denies.
Tobacco Use: Denies.
Level of Education: Not noted.
Sexual History: Not noted.
Work Status: Student.

SYSTEMS REVIEW:

CONSTITUTIONAL: Denies fever. Denies unexplained weight change. Denies flu like symptoms. Denies recent trips outside of US.

ENMT: Denies headaches. Denies vision changes, Denies hearing loss. Denies ringing in ears. Denies dizziness. Denies runny nose. Denies hoarsness. Denies oral tissue lesions.

CARDIOVASCULAR: Denies Chest Pain. Denies heart attack. Denies falling out episodes. Denies CHF past six months.

RESPIRATORY: Denies wheezing. Denies SOB. Denies asthma. Denies environmental allergies. Denies smoking.

GASTROINTESTINAL: Denies difficulty swallowing. Denies indigestion. Denies abdominal pain. Denies nausea. Denies vomiting. Denies diarrhea. Denies constipation. Denies Jaundice. Denies change in bowel function. Denies Rectal bleeding. Denies inability to control bowel movements.

GENITOURINARY: Denies painful urination. Denies frequent urination. Denies blood in urine. Denies unable to control urination. Denies nocturia.

MUSCULOSKELETAL: Denies joint swelling. Denies restriction. Denies muscle pain. Denies joint pain.

INTEGUMENTARY: Denies rashes. Denies lesions. Denies change to hair and nails. Denies open skin sores.

NEUROLOGICAL: Denies seizures. Denies fainting spells. Denies paralysis. Denies tremor. Denies weakness.

PSYCHIATRIC: Denies depression. Denies suicide attempts. Denies anxiety disorders. Denies fear of needles.

ENDOCRINE: Denies diabetes. Denies thyroid disorders.

HEMATOLOGIC: Denies anemia. Denies abnormal bleeding. Denies excessive bruising. Denies swollen glands. Denies previous blood transfusions. Denies pitting edema.

PHYSICAL EXAMINATION:

BP: 136/81 mmHg Pulse: 98 Resp: 16

CONSTITUTIONAL: GENERAL APPEARANCE: Clean, well nourished, oriented. Mother in attendance.

EYES: INSPECTION OF CONJUNCTIVAE AND LIDS: Clear without icterus; lids are normal. EXAMINATION OF PUPILS AND IRISES: Pupils round, normal light reactive. Glasses. Photophobia.

ENMT: EXTERNAL INSPECTION OF EARS AND NOSE: No scars, lesions, deformities or masses. INSPECTION OF NASAL MUCOSA, SEPTUM AND TURBINATES: Mucosa and turbinates pink and moist without ulceration, exudate or bleeding. Septum is midline and symmetrical. INSPECTION OF LIPS AND GUMS: Lips, gums, tongue, buccal mucosa and palate are pink and moist without cyanosis or fissures. OROPHARYNX: Oral mucosa, salivary glands, hard and soft palates, tongue are pink and moist with no injection.

NECK: Supple, no masses, trachea is midline and freely moveable. THYROID: No enlargement, tenderness or masses noted.

RESPIRATORY: ASSESSMENT OF RESPIRATORY EFFORT: Chest moving equally on both sides. No retraction or stridor. AUSCULTATION OF LUNGS: Breath sounds are well heard. No wheezing, rhonchi, crackles, rales or rubs noted posteriorly or anteriorly.

CARDIOVASCULAR : AUSCULTATION OF HEART: Tachycardia., CAROTID ARTERIES: Pulses normal, no bruits noted . FEMORAL ARTERIES: Pulses normal, no bruits noted. PEDAL PULSES: Pulses normal.

GASTROINTESTINAL: ABDOMEN: Soft, without tenderness or masses.

SKIN: SKIN AND SUBCUTANEOUS TISSUE: No rashes, lesions, ulcers or bruising noted. PALPATION OF SKIN AND SUBCUTANEOUS TISSUE: No indurations, nodules or tightening noted.

LYMPHATICS: AXILLAE: No masses or tenderness noted. NECK: No masses or tenderness noted, no thyroid enlargement. GROIN: No masses or tenderness noted. PALPATION OF LYMPH NODES:

MUSCULOSKELETAL: GAIT AND STATION: No difficulty walking or standing. INSPECTION AND/OR PALPATION OF DIGITS AND NAILS: No clubbing, cyanosis, or inflammation.

HEAD AND NECK: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

SPINE, RIBS AND PELVIS: INSPECTION AND/OR PALPATION: No pain to palpation over the cervical spine. Mild cervical and trapezius spasms., RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT UPPER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

RIGHT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's Test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STRENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

LEFT LOWER EXTREMITY: INSPECTION AND/OR PALPATION: Symmetrical without defects, tenderness, masses, or effusions. RANGE OF MOTION: Normal ROM without pain, crepitation or contracture. Negative Patrick's test. Negative straight leg raise. STABILITY: No dislocation, subluxation or laxity noted. MUSCLE STENGTH AND TONE: No spasticity, atrophy or abnormal movements noted.

NEUROLOGIC: MOOD AND AFFECT: Flat affect; appears anxious at time of exam. ORIENTATION: Oriented to time, place and person. RECENT AND REMOTE MEMORY: Memory intact for long and short term. ATTENTION SPAN AND CONCENTRATION: Average attention and concentration. LANGUAGE: Speaks without aids, voice is strong, articulate, speech is spontaneous. FUND OF KNOWLEDGE: Average awareness of current events and history. MOTOR EXAMINATION: Normal strength in upper and lower extremities including quadricep, ankle, great toe dorsiflexion, and plantar flexion.Tone in upper and lower extremities normal. Muscle bulk within normal limits. No abnormal movements noticed. SENSATION: Light touch within normal limits. DEEP TENDON REFLEXES UPPER AND LOWER EXTREMITIES, INCLUDING ANKLE AND KNEE REFLEXES: 2+ symmetric throughout, plantar responses downgoing. CEREBELLAR: Finger to nose movements and heel to shin movements without dysmetria. GAIT AND STATION: No difficulty walking or standing.

CRANIAL NERVES: I. Not tested. II. Visual acuity and fields WNL III, IV, VI. Extraocular movements intact, pupils equal, round and reactive to light OU, no nystagmus present, conjugate gaze. V. Facial sensation equal bilaterally, muscles of mastication normal. VII. Face symmetric, no evidence of palsy noted. VIII. Hearing normal to the whispered voice, equilibrium normal. IX, X. Palate movement symmetric. XI. Sternocleidomastoid and trapezius muscles normal strength. XII. Tongue movement symmetric, position midline without fasciculations.

IMPRESSIONS:

Chronic daily headache
Migraine with aura
Medication overuse headache
Chronic photophobia
Narcolepsy

PLAN:

1. Return to the Pain Management Center on 2-29-16 for MD evaluaiton and bilateral sphenopalatine ganglion block bilaterally.
2. Continue current medications.
3. Obtain notes from Dr. Casey.
4. American Academy of Neurology Medication Overuse Headache literature was given and education performed.
5. Continue in care with Dr. Africk and Dr. Lysenko (Ochsner, New Orleans).
6. Botox 155 units re-dose in three weeks.
7. Recommended wean of Fioricet.
8. Limit triptans to 9 x per month. Relpax 40 mg 1 po qd.
9. Obtain MRI of the brain report.
10. Recommended Home Exercise Program with stationary bike.

dc 2-24-16

Signature: _____
C. Ann Conn M.D.

AC 8456 DR- AC LOC- OF
DOB: 05/22/1997
BODIN, JEFFREY T
CHRT#- (985)845-0969
FC- B INS(BLU/ /) H/S- N

NURSING PAIN ASSESSMENT

DATE FEB 19 2016 NURSE Keli

BP 126/81 P 98 RR 16 VAS 6 HEIGHT 5'7" WEIGHT 103 lbs

ALLERGIES NKDA NKFA

AGE 19

PROSTHETICS (INCLUDES DENTURES) denies

SOCIAL HISTORY Single ∅ children Denies tobacco & ETOH.

EMOTIONAL STATUS Calm

REST & SLEEP PATTERNS Sleeping ok but always tired

ACTIVITY & EXERCISE moderate

OCCUPATIONAL HISTORY student

PATIENTS PERCEPTION OF CURRENT PAIN pulsing, throbbing, flashing, sharp blinding nagging, radiating, firing etc.

NURSING COMMENTS CC: pt c/o daily headaches; started p surgery for stage III melanoma; pain ↑ light sound vibration, exhaustion, anytime; HA's started during CA treatment; pt c/o neuropathy ⓑ feet & ⓑ hands; was on neurontin for neuropathy but did not like SE from it; pt reports MRI brain in past WNL; pt has been seeing DeLosReyes @ Oschner for HA's - who is giving Rx for Fioricet (which pt feels it helps) pt reports

PATIENTS GOAL multiple neurologic problems from Interferon tx. Pt reports Narcolepsy & on 120mg of Adderall per day.

865-302.0 4/07

Pt had sleep study 1yr ago Dx c̄ Apnea & Narcolepsy

Ref/PCP: Casey

FEB 18 2016 Attended by Mother

ACCT#- 8456 DR- AC LOC- OF
DOB: 05/22/1997
BODIN, JEFFREY T
CHRT#- (985)845-0969
PC- B INS(BLU/ /) H/S- N

General Appearance:
Eyes Glasses Photophobia
Ears, Nose, Mouth and Throat
Neck
Respiratory
Cardiovascular tachy
Gastrointestinal
Lymphatic
Skin

PTP:
Mild Sev. trap spasms

Musculoskeletal
1. **Head and Neck**
2. **Spine, Ribs and Pelvis**
3. **Right Upper Extremity**
4. **Left Upper Extremity**
5. **Right Lower Extremity**
6. **Left Lower Extremity**

Neurologic flat

Mood and Affect: Appropriate affect; does not appear depressed, anxious or agitated at time of exam
Orientation: Oriented to time, place and person
Recent and Remote Memory: Memory intact for long and short term
Attention Span and Concentration: Average attention and concentration
Language: Speaks without aids, voice is strong, articulate, speech is spontaneous
Fund of Knowledge: Average awareness of current events and history
Test of Following Cranial Nerves:

I. Not tested.
II. Visual acuity and fields WNL
III., IV., VI. Extraocular movements intact, pupils equal, round and reactive to light OU, no nystagmus present, conjugate gaze
V. Facial sensation equal bilaterally, muscles of mastication normal
VII. Face symmetric, no evident of palsy noted
VIII. Hearing normal to the whispered voice, equilibrium normal
IX., X. Palate movement symmetric
XI. Sternocleidomastoid and trapezius muscles normal strength
XII. Tongue movement symmetric, position midline without fasciculations

Motor Examination:
Strength in upper and lower extremities 5/5 throughout
Tone in upper and lower extremities normal
Muscle bulk within normal limits
No abnormal movements noticed

Sensation: Light touch within normal limits
Deep Tendon Reflexes Upper and Lower Extremities: 2+ symmetric throughout, plantar responses down going
Cerebellar: Finger to nose movements and heel to shin movements without dysmetria
Gait and Station: No difficulty walking or standing

Assessment:

FEB 19 2016

ACCT#- 8456 DR- AC LOC- OF
DOB: 05/22/1997
BODIN, JEFFREY T
CHRT#- (985)845-0969
FC- B INS(BLU/ /) H/S- N

18 yo [illegible] WM c̄
c/o HA [illegible] neck pain

h/o melanoma June 2008 Tx c̄ Interferon
(L) ankle; (L) groin
h/o GTC SZ on medication, thought to
be medication induced
HA since August 2008

cont 6

In care c̄ Dr Africk (Pediatric Neurology)
6 hours function per day
~~not~~ tried Provigil, Nuvigil) not that

optho less than 1 yr ago WNL

chronic photophobia

CDH migraine c̄ aura
Med narcolepsy

1. RTC 1 wk
2. Obtain notes from Dr Casey
3. AAN med
4. c/w Dr Africk, Dr Lysenko (Consult) Not
5. Botox 155 u ~~[illegible]~~ r ~~[illegible]~~ dose in 3 wk
6. ~~For~~ Rec wean Fioricet
7. (B) SPG block
8. triptans limit 9/month
9. obtain MRI brain report
10. Rec Home exercise program stationary bike

Refill [illegible] for

[signature]

Premier Pain Center
(985) 809-1997

ACCT#- 8456 DR- AC LOC- OP
DOB: 05/22/1997
BODIN, JEFFREY T
(985)845-0969
CHRT#-
FC- B INS(BLU/ /) H/S- N

POST PROCEDURE INSTRUCTIONS

FEB 19 2016

M.D. Conn

Type of Procedure:
- ☐ Nerve Root Injection
- ☐ Medial Branch Block
- ☐ Other:
- ☐ Radiofrequency
- ☐ Sacroiliac Joint Injection

ACTIVITY:
- _____ Regular Activity.
- _____ Avoid Strenuous Activity Today
- _____ No Driving for 24 Hours
- _____ Other

Recommend Stationary Bike (inside) Start 1 min at a time Slowly per week Add one min per week

Medication received during stay:
- ☐ Robinul ☐ Pepcid ☐ Reglan ☐ Toradol
- ☐ Propofol ☐ Valium ☐ Versed ☐ Other _____
- ☐ Marcaine, Omnipaque, Kenalog or Celestone - injected per physician

DIET:
- _____ Regular diet
- _____ Avoid hot liquids until normal sensation in tongue returns
- _____ Other

- Discontinue Flexeril slowly
- Sphenopalatine Ganglion blocks
- Relpax for Rescue (Limit to 9 per month)
- Do not use Running
- Rec. Boxer in 3 weeks

MEDICATIONS:
- _____ Resume all previous medications
- _____ Do not use Aspirin for 3 days after procedure
- _____ Prescription for _____ to be taken as directed.
- _____ Sedation given: **Do not drive, drink alcohol, climb stairs unassisted, sign important documents, or engage in any potentially hazardous activity for 24 hours after sedation**

NOTIFY THE PAIN CENTER IF:

Bleeding or Discoloration	Excessive Swelling	Fever Noted
Uncontrolled Pain	Inability To Urinate	Nausea/Vomiting
Unusual changes in color or temperature of skin	Weakness/numbness persists or increases after 8-10 hours	Difficulty in Breathing or Swallowing

If you have any questions or problems, please call our office at (985) 809-1997. After business hours call (985) 819-6817. If you have an emergency, go to Lakeview Regional Medical Center Emergency Department or to the nearest Emergency Department

PRE-PROCEDURE / RETURN INSTRUCTIONS

☐ M.D. Evaluation (Office) ☐ Nurse Practitioner

RETURN TO THE CENTER: In 13 weeks For MD Eval ~~Botox~~ Procedure

NEXT APPOINTMENT: Day Mon Date 2/29 Time 8:15 Referral (BSPG)

SKIN CLEANSING:
- _____ Bath/Shower with antibacterial soap such as Chlorhexidrine/Hibiclens night before and morning of procedure.

DIET:
- _____ Regular diet
- _____ Nothing to eat or drink after midnight (including any gum, mints, cough drops, candy, chewing tobacco)
- _____ May have clear liquids (1/2 cup only) of either water, apple juice, up to six hour prior to procedure time if scheduled after 1:00 pm

MEDICATIONS:
- _____ As usual with sip of water only. Do not take any medication that causes you to be nauseated if taken on an empty stomach.
- _____ Do Not take diabetic medication unless otherwise instructed.
- _____ Do Not take anticoagulants; (such as aspirin, NSAIDS, Coumadin, Plavix, etc.) for _____ days prior to procedure.

BELONGINGS: Please leave valuables, including jewelry at home. We cannot be held responsible for valuables brought with you. Dress Comfortably.

TRANSPORTATION:
I must have a ride home, with a responsible adult, available at the time of discharge in order for procedure to be done _____ Yes _____ No
I understand the instructions and have been given a copy: _____ Date _____ Time _____
Patient / Representative Signature

Revised 3/15

Nurse _____

INSERT THIS END FIRST

Please include this barcode cover sheet as the first page of each set of documents returned.

Fax the evidence to this fax number:

877-559-1922

RQID:00000000000000002292586 89 SITE:Y32 DR:S
SSN:436958926 DOCTYPE:5032 RF:D CS:e10b

Claimant: Jeffrey Bodin
SSN: 436-95-8926

Northlake Behavioral Health System
10/11/17 - 10/19/17

NORTHLAKE
BEHAVIORAL HEALTH SYSTEM

PHONE: 985-626-6335
FAX: 985-626-6616

FAX COVER SHEET

DATE: 6-14-2018

TO: Conner Law

FROM: NBHS Health Information Department

RE: Jeffrey Bodin

5/1/18 Sent previously to
Conneredsability@gmail.com

_____ pages including cover

LAW OFFICE
OF
JAMES S. CONNER
2237 FLORIDA STREET, SUITE D
MANDEVILLE, LA 70448

5-1-18
Sent Electronic Secure

JAMES S. CONNER – Attorney
EVA D. CONNER – Attorney
TELEPHONE: (985) 626-1002
FACSIMILE: (985) 624-8103

TIFFANY CONNER
BRIAN HENLY
KIERSTEN PRITCHETT
Non-Attorney Representatives

April 26, 2018

Northlake Behavioral Health System
Medical Records Department
23515 Hwy 190
Mandeville, LA 70448

RE: **Jeffrey Bodin**

To Whom It May Concern:

Please be advised that I represent the above named client in a claim for **Social Security Disability Benefits**. I have enclosed a Medical Authorization form signed by my client.

Please send me **any** medical records you may have in connection with my client **specifically, those dated from 01/01/2017 to 04/25/2018.**

If records are available electronically, please send them in electronic format to connerdisability@gmail.com. Please note that under the HITECH Act, if records are available electronically, they MUST be provided in an electronic format. You may not bill for paper copies unless the records are **only** available via paper. If electronic copies are available under the HITECH Act, you may not charge more than your labor costs (a flat fee of not more than $6.50 may be requested in lieu of calculating labor costs). *See* 45 CFR 164.524.

Please note that under the HITECH Act, records **MUST** be received within 30 days of this request. Violations of the HITECH Act's requirements are subject to a penalty of $250,000.

If electronic copies are not available, please advise me in advance of any charge in excess of $20.00 for said records. Please note that Act 1241 of the Louisiana Legislature applies in this case and regulates what can be charged for medical records by healthcare providers in Social Security Disability and/or SSI cases.

Thank you for your cooperation in this matter.

Sincerely,

Eva Conner

Eva Conner

EDC/AK
Enclosure

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
THE LAW OFFICES OF JAMES S. CONNER

I hereby authorize Northlake Behavioral Health to disclose the following protected health information (PHI) from the medical records of the patient listed to:

Requestor Name: Law Office of James S. Conner
Requestor Address: 2237 Florida Street, Suite D
Mandeville, LA 70448

Patient Name: Mr. Jeffrey Bodin

Patient DOB: 5/22/1997

Patient SS# 436-95-8926

✓ Entire Chart	___ History & Physical	___ Discharge Summary	___ Consult
___ Operative Report(s)	___ Progress Notes	___ Admit Summary	___ Nurses Notes
___ ER Report(s)	___ Lab	___ X-ray/MRI/CT/Bone Scan	___ Abstract/Pertinent
✓ Other Specified	From: 1-1-17		
	To: 4-25-18		

The above information is disclosed for the purpose of obtaining Social Security Disability Benefits.

- A PHOTOCOPY OF THIS AUTHORIZATION MAY SERVE AS AN ORIGINAL.
- I understand that I have the right to revoke this authorization at any time and must do so in writing to the above facility, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- I understand that I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I have the right to receive a copy of this form after I sign it.
- This authorization shall expire one year from the date on which it was signed or upon the issuing of a favorable Decision for Social Security Disability benefits.

The following information will be released when included in the above information unless you indicated otherwise:

___ AIDS or HIV test results
___ Psychiatric or Mental Care treatment
___ Alcohol, Drug or Substance Abuse treatment
___ other (please specify)_____.

I have read the above and authorize the disclosed of this protected health information as stated.

Jeffrey Bodin
Signature of Patient/Legal Representative

4/25/18
Date

If signed by legal representative, relationship to patient _____

Signature of Witness

4/25/18
Date

Updated 03/2015

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Mr. Jeffrey Bodin	436-95-8926
Wage Earner (If Different)	Social Security Number

Part I CLAIMANT'S APPOINTMENT OF REPRESENTATIVE

I appoint this person, Eva Conner - 2237-D Florida St Mandeville LA 70448 Law Ofc James Conner (Name and Address)
to act as my representative in connection with my claim(s) or asserted right(s) under:

☒ Title II (RSDI) ☒ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☒ I appoint, or I now have, more than one representative. My main representative is
Eva Conner (Name of Principal Representative)

Signature (Claimant)	Address
Jeffrey Bodin	528 Beau Chene Dr. Mandeville, LA 70471
Telephone Number (with Area Code) (985)520-4713	Fax Number (with Area Code) / Date 4/25/18

Part II REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I, Eva Conner, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☒ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☒ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☒ No

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address
Eva Conner	2237 Florida Street, Suite D, Mandeville, LA 70448
Telephone Number (with Area Code) (985)626-1002	Fax Number (with Area Code) (985)624-8103 / Date 4/25/18

Part III FEE ARRANGEMENT

(Select an option, sign and date this section.)

☒ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.*

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits --I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** --By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **I am waiving fees from any source** --I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date
Eva Conner	4/25/18

NORTHLAKE
BEHAVIORAL HEALTH SYSTEM

Date: 5-1-18

James S. Conner
2237 Florida Street #D
Mandeville LA 70448

Health Information Dept
23515 Highway 190
Mandeville, LA 70448
(985) 626-6335 (Voice)
(985) 626-6616 (Fax)

F: 985-624-8103

RE:

INVOICE – Tax ID #47-4572658

Please make check or money orders payable to: **Northlake Behavioral Health System**

Charge for retrieving/copy patient record:

Retrieval fee		~~25.00~~ 6.50
Per Page ($1.00 per pages 1-25)	pages	
Pages 26-350 (.50 per page)	pages	
Pages 350+ (.25 per page)	pages	
Shipping		

TOTAL AMOUNT $ 6.50

If you have questions concerning this invoice, please contact:
Health Information Services: (985) 626-6335

EXHIBIT NO. 14F
PAGE: 7 OF 30

5

Northlake Behavioral Health System

5313591

DATE: 10/20/2017
TIME: 8:01:21
RUN BY:STEPHENSS

NAME: BODIN, JEFFREY		MRN#: 00032982 / 001		BED: ESPLANADE 1/O10306/BED A
SSN: 436-95-8926	DOB: 05/22/1997	AGE: 20	SEX: MALE	RACE: WHITE / EUROPEAN AMERICAN
ADMIT DATE/TIME: 10/11/2017 9:00:00PM		DC DATE/TIME: 10/19/2017 2:31:00PM		Eth: NOT HISPANIC OR LATINO
10/19/2017 || Closed				
ADDRESS: 528 BEAU CHENE DR, MANDEVILLE, LA, 70471			LOS: 8	PARISH: ST. TAMMANY
ADDRESS: -				
RELIGION:	MARITAL:	PHONE: (985) 264-5277		PHONE:
EMPLOYMENT STATUS:		ADVANCE DIRECTIVE: N	ORGAN DONOR: N	
LEGAL STATUS: PEC		REFERRAL SOURCE: HOSP/ST TAMMANY PARISH HOSPITAL		
TREATING DOCTOR: JOSE RODRIGUEZ				
( ) DIAG: F29: UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBST...				
CUR/DC DIAG: F34.1: DYSTHYMIC DISORDER...				
PREVIOUS ADMITS: N	PREV. ADMIT DATE:			

EMERGENCY/GUARDIAN:

NAME: LINDA BODIN	ADDRESS: 528 BEAU CHENE DR, -, MANDEVILLE, LA, 70471				
TYPE: EMER	RELATION: MOTHER	DOB:	AGE:	PHONE: (985) 264-5277	SSN:
NAME:	ADDRESS:				
TYPE:	RELATION:	DOB:	AGE:	PHONE:	SSN:
NAME:	ADDRESS:				
	RELATION:	DOB:	AGE:	PHONE:	SSN:

INSURANCE:

1) INS NAME: BCBS PPO	INS ID#: XUP200597860	GRP#: 77307FF4
ADDRESS: P.O. BOX 98029, BATON ROUGE, LA, 70898		PHONE: (800) 424-4031
2) INS NAME:	INS ID#:	GRP#:
ADDRESS:		PHONE:
3) INS NAME:	INS ID#:	GRP#:
ADDRESS:		PHONE:
4) INS NAME:	INS ID#:	GRP#:
ADDRESS:		PHONE:

Northlake Behavioral Health System

I. Identifying Information:

NAME: Bodin, Jeffrey **NBHS#:** 32982-001 **DOB:** 05/22/1997
DATE OF ADMISSION: 10/11/2017 **DATE OF DISCHARGE:** 10/19/2017
SEX: Male **RACE:** Caucasian **AGE:** 20

Attending Physician: Jose Rodriguez, MD

II. Reason for Admission:

The patient is a 20-year-old white male with an unknown past medical history admitted on a PEC legal status. Per PEC, the patient was paranoid that his mother wanted to kill him. The patient is aggressive and violent towards father prior to admit. He also barricaded himself in the room. The patient has been treated in outpatient services for narcolepsy with Adderall. There has been recent adjustment to the medications and Dr. Turrell has seen trying to establish a baseline. The patient reported getting into an argument with mother. She was backing up against the wall. The patient's father believes related to this incident. He believes that mother tried to poison him in the past with bleach. "I can't deal with her." He believes that family trapped him in the kitchen. He reported that he barricaded himself in his room because he is concerned for his safety. The patient is impulsive and has excessive online spending. The patient is expansive about this and reported that he has been buying essential for daily living. He denies depressed mood and denies bipolar and denies schizophrenic history.

Procedures and Treatment:

1. Individual and group psychotherapy.
2. Psychopharmacological management.
3. Therapy conducted by the Social Work Department for the purpose of education and discharge planning.

III. Admit Diagnoses:

Primary: Unspecified mood disorder
Unspecified psychosis
Rule out adjustment disorder

Northlake Behavioral Health System

Rule out delusional disorder
Rule out substance-induced mood disorder
Substance-induced psychotic disorder secondary to Adderall

Secondary: Cluster A and B personality traits

Medical: The patient suffers narcolepsy without cataplexy
Allergies
Cluster headaches
History of melanoma
Lactose intolerance
Elevated AST, which was 85

IV. **Results of Labs, Medical Workups and All Hospital Consults:** See hospital charts

V. **Course:** The patient responded to individual and group psychotherapy, milieu therapy, and medication management. Medications were titrated as needed.

VI. **Complications of Treatment:** None

VII. **Final Diagnoses:**

Primary: Depression, unspecified
History of attention deficit hyperactivity disorder

Medical: History of narcolepsy
Migraines
Neuropathy

VIII. **Condition at Discharge:** At the time of discharge, the patient was alert and oriented to person, time, place, and situation. Denied any suicidal or homicidal ideation. Denied any auditory or visual hallucinations. Denied delusions. Judgment & Thoughts: Coherent and clear. Affect & Mood: Euthymic.

IX. **Discharge Plans:** At this time, the patient did not pose a risk to himself or others. The patient will continue on mirtazapine 50 mg one p.o. daily q.h.s. for

Northlake Behavioral Health System

depression. The patient is to follow up with Covington Behavioral Health in Mandeville, Louisiana.

Jose Rodriguez, MD
Staff Physician

10/23/17
Date

DT: 10/23/2017
VF: 53133591
SCR: AAA4

DOCTOR'S DISCHARGE SUMMARY

Pt. Name: Bodin, Jeffrey
NBHS: 32982-001
DOB: 05/22/1997
Admit Date: 10/11/2017
Doctor: Jose Rodriguez, MD

CURRENT: Height: 5' 7" Weight: 166 165 BMI: 16.6 BP: 95/67

ALLERGIES: (Incl. Drug & Food, Non-food, Non-drug allergies, food/drug reactions,) Lactose

AVOID OR DO NOT GIVE (REASON):

DATE: 10/19/17 TIME: 1130 DISCHARGE TIME: 1200

DISCHARGE TO: Home

PSYCHIATRIC DIAGNOSES: - Depression Unspecified
- H/o ADHD

MEDICAL DIAGNOSES: H/o Narcolepsy - Migraine. Neuropathy

Activities: Regular [X] Restricted [ ] Advanced Directive? Yes [ ] No [X] Attach

FOLLOW-UP: Medical PCP for medical problem

Behavioral Health: Y to follow up

MEDICATION MANAGEMENT: Applies only to patients on two (2) or more anti-psychotics: N/A

History of 3 or more Failed Trials of Monotherapy [ ] NO [ ] YES Specify meds:

If YES, Indicate the Number of Failed Trials Justification: (Select only one reason):

[ ] Recommend plan to taper to monotherapy. Name medications: [ ] Augmentation of Clozapine
(written in Doctors' Orders) Need for depot Symptom reduction Other augmentation Admitted on multiple antipsychotic medications

Discharge Medications to Include: dosage strength, drug route, dosage time(s), instructions, indication for use, taper instructions (if applicable) and/or other recommendations concerning medication for next provider.

[X] D/C all PRNS upon discharge [ ] Provide 7 day supply [X] Call in a 30 day supply to preferred Pharmacy.

The medications listed below have been reconciled with current meds and reviewed with the patient.

Medications and Indications: Mirtazapine 15 mg T po daily - QHS
(Depression)

Labs pending? Yes [ ] No [X] Which? Contact Health Records at 985-626-6615

FDA Approved Smoking Cessati[illegible] [X] No [ ] Yes:

SIGNATURES: [signature] Date: 10/19/17 Time: 1125

NORTHLAKE BEHAVIORAL HEALTH
Doctor's Discharge Order Sheet

NBHS-DDOS (11/16)

BODIN, JEFFREY 00032982-001
ADM:10/11/2017 DOB:05/22/1997
W/M SPLANADE 1 O10306
Rel. Unk DR:J RODRIGUEZ
NBHS ST. TAMMANY

PSYCHIATRIC EVALUATION

(Complete within 60 hrs. of admission)

Date: 10/12/17 Time: 100 pm

I. IDENTIFYING INFORMATION:

Name: Jeffrey Bodin Age: 20 Race/Sex: WM Marital Status: Single

Referral Source: outside hospital

Prior admits to NBHS:

II. LEGAL STATUS: ☐ FVA ☒ PEC ☐ CEC ☐ Judicial Commitment civil/criminal) ☐ Non-Contested

III. CHIEF COMPLAINT

☒ Reported by client:

☐ Reported by Support System:

IV. REASON FOR EVALUATION: ☒ Initial Psychiatric Evaluation ☐ Consultation ☐ Re-Evaluation Update
☐ Other:

V. HISTORY OF PRESENT ILLNESS:

20 y/o WM ē unknown pphx admitted on PEC legal status. Per PEC patient paranoid that his mother wants to kill him. Aggressive/violent towards father prior to admit. Also barricaded himself in room.

Was being treated outpt for Narcolepsy ē Adderall. There has been recent adjustments to the medication. Dr. Terrell has been trying to establish a baseline

Pt reported getting into argument ē mother. "She was backing me against the wall." Pt called the police related to this incident. Believes that mother tried to poison him in the past ē bleach. "I can't deal ē her." Believes that family traps him in the kitchen. Reported that he barricades himself in his room because he is concerned for his safety.

Concern for [illegible] [illegible] online spending. Pt defensive about this. Reported that he was buying "essentials for daily living."

Denies depressed mood. Denies [illegible] / SI/I hx.

2008: Improved [illegible] Headaches] → [illegible] treatment "Tetsuva" [illegible] → 2015 Narcolepsy Diagnosis

NORTHLAKE BEHAVIORAL HEALTH SYSTEM
Psychiatric Evaluation

140 | 101 | 13 < 81
3.9 | 29 | 0.76

15.6 / 235
4.7 / 44.1

NBHS-PE (Rev. 7/16)

BODIN, JEFFREY
ADM:10/11/2017
W/M
Rel. Unk
NBHS

00032982-001
DOB:05/22/1997
SPLANADE 1 O10306
DR:J RODRIGUEZ
ST. TAMMANY

ALT: (85) H
AST: 55

VI. PAST PSYCHIATRIC HISTORY: (prior treatment, pharmacotherapy history, and any failed trials of monotherapy)
(PCP) Covington
- Outpatient Dr. Terrell - Narcolepsy w/ Dr. Berg treated c Adderall
- Started on Adderall originally by Neurologist for Narcolepsy (2015)
- Was on multiple Stimulants in the past. Felt Adderall worked the best
- Family Counseling: Dr. Tom Nelson Clarkmore Family Psych
Oncologist: Childrens/LSU - melanoma. (treated c Immunotherapy Interferon)

VII. CURRENT MEDICATIONS
Recently d/c'd to Adderall 10mg po TID ; Dymista; Singulair; Allegra.

Adderall 30mg po TID → tapered to Adderall 20mg po TID → Adderall 10mg po TID

VIII. PAST MEDICAL HISTORY: (medical history/treatment, surgeries/injuries, head trauma, recent labs, Rx meds/responses)
(2015) Narcolepsy w/o cataplexy. (2008) cluster headaches, lactose intolerance,
(2008) Stage 3 Malignant melanoma. Allergies; Migraines, peripheral neuropathy. (2008)
2008: Cancer treatment HA Fatigue

Allergies: Lactose → Diarrhea

Surgical History: Appendectomy, tonsillectomy, Ear tube placement

IX. HISTORY OF SUBSTANCE ABUSE: (Substances, Ages of use, Frequency, Duration, Last Use, Rehab/Detox History)
Smoke: Denies.
Drink: Denies
Drugs: Denies
UDS(+) Amphetamines
ETOH <10 ASA <1 Acetaminophen <10

X. LEGAL HISTORY: (Current/pending and previous charges, incarcerations, etc.)
(Never)

XI. FAMILY HISTORY: (Include Substance Abuse, Mental Illness, Medical history, Legal History)
Mother: ??
Father: None reported by patient.

XII. PSYCHOSOCIAL/DEVELOPMENTAL/TRAUMA SCREEN (Physical & Social Development, Education, Living Circumstances, Family Dynamics, Peer Relationships, Finance, Employment, Physical/Sexual Abuse, Trauma History)
- Lives c parents in Mandeville
- One sister Age 18
- Graduated H.S.
- Unemployed
Applied Disability for Migraines, Narcolepsy

XIII. MENTAL STATUS EXAM

1. General Appearance: WM
2. Behavior & Psychomotor Activity: Suspicious, Defensive
3. Attitude: minimally cooperative
4. Speech: RAA
5. Mood: "Frustrated."
6. Affect: Guarded
7. Perceptual Disturbances: (Hallucinations, Illusions, Depersonalization):
   Paranoid (+)
8. Thought Process: (i.e. racing, rambling, loose associations, flight of ideas, circumstantiality, thought blocking, concrete)
   paranoid (+)
9. Thought Content: (delusions, thought broadcasting, thought insertion, thought withdrawal, ideas of reference)
   Delusions (+) persecutory.
10. Suicidal/Homicidal Ideations: (Include plan, previous attempts/sequelae)
    Ø SI Ø HI
11. Sensorium/Cognition: (Alertness, Orientation, Concentration)
    AxO3
12. Memory: (Include Recall, Recent, Remote & how Accessed)
    2/3 3
13. Intellectual Functioning: Average
14. Judgment: poor
15. Insight: poor
16. Impulse Control: Impulsive

XIV. DIAGNOSIS: Unspecified mood d/o Cluster A, & B personality traits,
unspecified psychosis

PSYCHIATRIC DIAGNOSIS: R/O Adjustment d/o
R/O Behavioral Dis
R/O SIMD SIED (2°/2 ADHD)

MEDICAL DIAGNOSIS: Narcolepsy w/o cataplexy, Migraines, Headaches (Cluster HA)
Hx of Melanoma, Lactose intolerance, Elevated ALT (ST)

PLAN:
- Admit Inpatient for acute Stabilization.
- Obtain collateral from parents.
- Family counselor Newton, Tom (Lakeview)
- D/C Adderall

XV. FORMULATION & JUSTIFICATION FOR HOSPITALIZATION:

Must have one of these: ☑ Danger to Self ☐ Danger to Others ☑ Gravely disabled
Must meet all of the following:
☑ 24 hour Monitoring Required
☑ Severity of illness precludes treatment in a less restrictive setting
☐ Treatment expected to improve client's condition
Explanation_____

XVI. STRENGTHS/ASSETS:

☐ Ability to express feelings	☐ Some Problem Solving skills	☐ Motivated for Treatment
☑ Ability to care for ADLs	☐ Verbally Skillful	☐ Assertive
☐ Good Support System	☐ Good Response to Past Treatment	☐ Capable of Independent Living

☐ Other: _____

XVII. TREATMENT PROBLEMS (Primary focus of treatment, reason for hospitalization, must be stabilized for discharge)
1. Psychosis
2. medication management
3. Delusions

XVIII. PRELIMINARY TREATMENT PLAN: (meds, precautions, assessments, interventions, special orders)
☐ Ongoing Evaluation for Diagnostic Confirmation
☐ Diagnostic tests (Labs, EKG, Radiology) to establish Baseline
☐ Initiate Precaution: ☐ Fall ☐ Seizure ☐ Withdrawal ☐ RAP ☐ RTU ☐ E.P. ☑ S.P. V.C or 1:1
☐ V.C. ☐ 1:1 Reason:_____ Other:_____
☐ Internal Medicine Consult for History and Physical
☑ Psychotropic Medications: _____

Diet: ☑ Regular ☐ Special (specify)_____ ☐ Nutritional Consult
Therapies/Tx: ☑ Individual/Psychiatrist ☐ Individual/Therapist ☑ Group Therapy ☐ H.O.P.E./Nsg. ☐ RT
☐ Family Session(s) ☐ Homebound School ☐ SSD#1 Classroom
Ancillary Consults: ☐ OT Evaluation ☐ Other: _____
☐ Outpatient Evaluation ☐ Placement Assistance Other: _____

XIX. PROGNOSIS: ☐ Good ☐ Fair ☑ Poor ☐ Guarded ☐ Undetermined ☐ Other: _____

XX. CRITERIA FOR DISCHARGE:
☑ Client is not Danger to Self or Others ☑ Client is no longer legally detainable or committed for treatment
☑ There is no longer a need for continuous skilled observations and treatment
☑ Client has achieved maximum inpatient benefits ☑ Client has completed aftercare plans

XXI. PRELIMINARY DISCHARGE PLAN: Estimated LOS: 5-7 days

☑ Meds ☐ Return home/family ☐ Return to school/job ☐ Placement ☑ Outpatient F/U ☑ Medical F/U ☐ PHP ☐ IOP

SIGNATURE: _____ Date: 10/12/17 Time: 2:00pm

NORTHLAKE BEHAVIORAL HEALTH SYSTEM
Psychiatric Evaluation

BODIN, JEFFREY
ADM:10/11/2017
W/M
Rel. Unk
NBHS

00032982-001
DOB:05/22/1997
SPLANADE 1 O10306
DR:J RODRIGUEZ
ST. TAMMANY

NBHS-PE (Rev. 7/16)

Progress Notes

Patient: Bodin, Jeffrey
Account Number: I65835
DOB: 05/22/1997 **Age:** 20 Y **Sex:** Male
Phone: 985-264-5277
Address: 528 Beau Chene Dr, Mandeville, LA-70471

Provider: Tuan Nguyen, MD
Date: 10/12/2017

Subjective:

Chief Complaints:
1. No physical complaints.

HPI:

-:
Admitted for Eval & Treat for... psychosis
Patient medical Hx...melanoma, neuropathy, headaches, hx seizures, misuse amphetamine
Current medical complaints..none
Admit labs, diagnostic testing normal, except...uds pos amphetamine.

ROS:

General/Constitutional:
Fever denies. Chills denies. Weight gain denies. Weight loss denies. Change in appetite denies.

ENT:
Ear pain denies. Blocked ear denies. Ringing in the ears denies. Sinus pain denies. Sore throat denies. Difficulty swallowing denies.

Endocrine:
Weakness denies.

Respiratory:
Cough denies. Sputum production denies. Chest pain denies. Pain with inspiration denies. SOB Denies.

Cardiovascular:
Chest pain with exertion denies. Dizziness denies. Orthopnea denies. Palpitations denies. Dyspnea on exertion denies.

Gastrointestinal:
Abdominal pain denies. Nausea denies. Vomiting denies. Diarrhea denies. Constipation denies. Blood in stool denies. Heartburn denies.

Genitourinary:
Abdominal pain/swelling denies. Frequent urination denies. Painful urination denies. Difficulty urinating denies. Blood in urine denies. Pain in lower back denies.

Musculoskeletal:
Muscle aches denies. Painful joints denies. Comments Full ROM. Joint stiffness denies.

Skin:
Itching denies. Hives denies. Rash denies. Skin lesion(s) denies. Discoloration denies.

Neurologic:
Severe Headache,Neck stiffness,nausea ,vomitting denies. Dizziness denies. Gait abnormality denies. Low back pain denies. Balance difficulty denies. Tingling/Numbness denies.

Psychiatric:
Anxiety denies. Delusions denies. Difficulty sleeping denies. Loss of appetite denies. Depressed mood denies. Stressors admits. Suicidal thoughts denies.

Medical History: Paranoid, ADHD, Altered Mental Status, Malignant melanoma ?.

Surgical History: Left ankle , Left leg to have lymph nods removed , Tonsilectomy , Adenoids , Appendectomy .

Hospitalization/Major Diagnostic Procedure: Denies Past Hospitalization.

Family History: Father: alive. Mother: alive. 1 sister(s) . .

Social History:

Tobacco Use: Tobacco Use Do you smoke - NO .

Drugs/Alcohol: Drug Use Are you a drug user? No. Alcohol Use Do you drink alcohol? No.

Medications: None

Allergies: Lactose.

Objective:

Vitals: BP 114/82 mm Hg, Temp 97.4 F, HR 85 /min, Oxygen sat % 98 %.

Examination:

Neurological:

CORTICAL FUNCTIONS: normal.

CRANIAL NERVES: no afferent pupil defect, No ptosis or nystagmus, Pinprick, light touch intact in all three divisons, I - Tested and normal., II - Pupils 4mms reacting briskly to 2 mms, III , IV, VI - EOM were full with normal pursuit and saccade, V - Motor V intact, VII - No asymmetry or weakness, VIII - Actuity intact to finger rub bilaterally, IX , X- Palate rose in midile., XI - Sternocleidomastoid, trapezius strength intact., XII - Tongue protruded midline w/o atrophy or fasciculations.

MOTOR STRENGTH: no cogwheeling, no drift.

SENSORY: normal bilateral lower extremities.

REFLEXES: bilaterally symmetrical.

PLANTARS: downgoing bilaterally.

CEREBELLAR SIGNS: absent.

TREMORS: absent.

COORDINATION: finger-to-nose and rapid alternating movements were intact, no ataxia.

GAIT AND STATION: within normal limits, Romberg was negative.

SPEECH: normal.

General Examination:

GENERAL APPEARANCE: In no acute distress.

HEAD: normocephalic, atraumatic.

EYES: pupils equal, round, reactive to light .

EARS: BOTH EARS, auditory canal clear, tympanic membrane intact, clear, light reflex present.

ORAL CAVITY: mucosa moist.

THROAT: clear.

NECK/THYROID: neck supple, full range of motion, no rigidity, no cervical lymphadenopathy.

SKIN: no suspicious lesions, warm and dry.

HEART: S1, S2 normal, regular rate and rhythm, no murmurs, rubs, gallops, no jugular venous distention.

LUNGS: clear to auscultation bilaterally, good air movement, no wheezes, rales, rhonchi.

ABDOMEN: soft, nontender, nondistended, bowel sounds present, no hepatosplenomegaly.

MUSCULOSKELETAL: normal.

EXTREMITIES: no clubbing, cyanosis, or edema.

NEUROLOGIC: cognitive exam grossly normal, alert and oriented, motor strength normal upper and lower extremities, cranial nerves 2-12 grossly intact, deep tendon reflexes 2+ symmetrical, gait normal..

PSYCH: cooperative with exam, good eye contact.

Psychiatry:

MOOD: SEE PSYCH NOTES.....

Assessment:

Assessment:

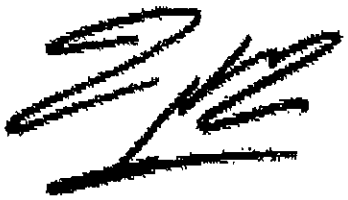
1. Adult general medical exam - Z00.00 (Primary)
2. Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations - F15.951

Plan:

1. Adult general medical exam

Notes: Defer mental health treatment to psychiatry.

Provider: Tuan Nguyen, MD
Patient: Bodin, Jeffrey **DOB:** 05/22/1997 **Date:** 10/12/2017



Electronically signed by Tuan Nguyen , MD on 10/12/2017 at 09:34 AM CDT
Sign off status: Pending

NBHS: PSYCHOSOCIAL

NAME/ID Jeffrey Bodin/32982 TYPE OF ADMIT: ☑ EVA ☑ PEC ☐ CEC ☐ Non-Contested
SOURCE: ☐ MEDICAL RECORDS ☐ PATIENT/CLIENT/RESIDENT ☐ FAMILY: ☐ OTHER:

SUPPORT SYSTEM/FAMILY
NAME: Mark Bodin Dad Contact # 985-845-0969

NAME: — Contact # —

POA/CURATOR: ✓ Contact # ✓

PRESENTING PROBLEM/ILLNESS
REASON FOR ADMISSION:
PER PATIENT/CLIENT/RESIDENT: Paranoia, believes his mother wants to kill him. Aggressive + violent towards father
PER FAMILY: Pt stated that his mother is delusional + does not have POA.

HISTORY OF PSYCHIATRIC/DEVELOPMENTAL/ADDICTIVE BEHAVIORS/TRAUMA EXPOSURE

PSYCHIATRIC ILLNESS-ORIGINAL ONSET:
HX OF INPATIENT ADMITS: 1ST Admit ✓ Last Admit ✓ TOTAL # ADMITS Ø
HX OF OUTPATIENT ADMITS: 1ST Admit ✓ Last Admit ✓ TOTAL # ADMITS Dr Blundell - Covington
HX OF SUIDICAL IDEATION/ATTEMPTS ☐ SUICIDAL IDEATION ☐ SUICIDE ATTEMPTS # ATTEMPTS Ø TYPES Ø
HX OF HOMICIDAL IDEATION/ATTEMPTS: ☐ HX VIOLENT BEHAVIOR ☐ HOMICIDAL IDEATION ☐ ATTEMPTS
HX OF PSYCHOSIS/DELUSIONS? Denies

Denies Denies Denies Denies Denies

DEVELOPMENTAL MILESTONES:
CURRENT COGNITIVE DEFICITS IDENTIFIED? Yes ____ No ✓
HEALTH ISSUES IDENTIFIED AT BIRTH? Yes ____ No ✓ Explain:

Milestones: Within Normal Limits? Yes ✓ NO ____ Unable to say ____
Check all areas of concern and document date of onset:

- Gross motor: using large groups of muscles to sit, stand, walk, run, etc., keeping balance, and changing positions.
- Fine motor: using hands to be able to eat, draw, dress, play, write, and do many other things.
- Language: speaking, using body language and gestures, communicating, and understanding what others say.
- Cognitive: Thinking skills: including learning, understanding, problem-solving, reasoning, and remembering.
- Social: interacting with others, having relationships with family, friends, and teachers, cooperating, and responding to the feelings of others.

SPECIAL SERVICES RECEIVED DURING LIFETIME: Normal to gifted "I was in Invall School"
OTHER LIFESPAN/DEVELOPMENTAL ISSUES: (INCLUDE MID-LIFE, SENIOR/ELDER, OTHER)
None reported

"My mom does not accept my disability. She took my medicine from me. She wakes me up alot" "She wasnt letting me sleep"

NBHS: PSYCHOSOCIAL

2

TRAUMA SCREENING: Complete the PTSD PCL and attach when the patient answers "YES" to any of the following:

1. Are you ever fearful/anxious and the fear/anxiety interferes with your daily living? YES (NO)
2. Do you experience nightmares or flashbacks? (YES) NO my mother
3. Do you avoid more and more things because they remind you of a bad time/event? YES (NO)
4. Do you use alcohol/drugs to forget things and make yourself feel better? YES (NO)

*****SUBSTANCE USE SCREEN: USE CRAFFT /SSI-SA (PA PART II) and attach******PTSD PCL (PRN)*****

CURRENT ONSET/FREQUENCY/DURATION OF SYMPTOMS Narcolepsy, Neuropathy, Headaches, [illegible] > Pt did not report any psych

CURRENT SMOKER? Yes (No)
Frequency last 30 days? ____ Per day
Do you want help to stop smoking? Yes No N/A
Patient given : TC Workbook Yes No Refused N/A

TX PROGRAM: (CURRENT/PAST, OUTPATIENT/LESSOR LOC) RESPONSE TO TX

1. Dr Terrell in Covington - PCP
2. Dr Blundell
3. ———

BEHAVIORAL HISTORY
"I has Narcolepsy"
CHILDHOOD/ADOLESCENT BEHAVIOR PROBLEMS: Denies
HX OF VIOLENT BEHAVIOR: Denies
CURRENT/RECENT SLEEPING PATTERN: "my mother forces me off of my stimulants."
CURRENT/RECENT APPETITE PATTERN: "Fine" "good"
CHANGES IN HYGIENE: No changes

PERSONAL/SOCIAL HISTORY

BIRTH ORDER Oldest
SIBLINGS LIVING: # OF SISTERS: 1 # OF BROTHERS: Ø SIBLINGS DECEASED: # OF SISTERS Ø # OF BROTHERS Ø
ISSUES/CONCERNS RELATED TO FAMILY UPBRINGING: Raised by Mom + Dad
MOTHER'S PREGNANCY: ☐ NORMAL ☐ ABNORMAL ☐ DEVLOPMENTAL ISSUES:
FAMILY HX OF PSYCH ILLNESS: MATERNAL: Denies PATERNAL: Denies
FAMILY HX OF ADDICTIVE BEHAVIORS: Denies ETHNIC/CULTURE FACTORS: None [illegible]
EDUCATION: High school EMPLOYMENT/LIFETIME "I'm Disabled"
OCCUPATION: Never
MILITARY HX/VA: Never LAST TIME HELD JOB? None LONGEST JOB HELD? ____
MARITAL STATUS/HX: S M S D NM LENGTH LONGEST RELATIONSHIP: Ø
CHILDREN/AGES Ø CURRENT RELATIONSHIP STATUS: Ø
DO YOU HAVE CONTACT/CONFLICT WITH YOUR CHILDREN: Y N Explain: never
RELIGIOUS/SPIRITUAL BELIEFS/VALUES/PREFERENCES: Protestant / [illegible] Where do you worship? None
What type of spiritual/religious support would you like to have while you are here? Bible
Does your faith help you get well and stay well? Can you explain? "to an extent. I feel good"
What can NBHS do to help you maintain your faith/spirituality while you are here? None

I quit going to church b/c of migraines.

"My mother [illegible] about income" I've been trying to get Disability.

BODIN, JEFFREY 00032982-001
ADM:10/11/2017 DOB:05/22/1997
W/M SPLANADE 1 O10306
Rel. Unk DR:J RODRIGUEZ
NBHS ST. TAMMANY

NBHS: PSYCHOSOCIAL

ACCESS TO WEAPONS: Do you have access to weapons (guns, knives, etc.) Yes____ No____ Which weapon?____

Do you have weapons at home? Yes ✓ No____ Which weapon? Antique rifle

Who will remove/secure the weapons prior to discharge?____ Date and Time of call____

PATIENT/CLIENT/RESIDENT SELF-ASSESSMENT

MY STRENGTHS ARE (include coping skills):
1 Perseverance
2 Positive

THINGS THAT CAN MAKE ME FEEL BETTER:
1 "I don't feel Down"
2

BARRIERS TO RECOVERY AND CONTINUED WELLNESS:
1. Finances - "I want to keep my fantasy"
2. My Mother's Behavior

SIGNIFICANT LOSSES/TRAUMATIC EVENTS: ~~None disputed~~ Skin Cancer

PHYSICAL/SEXUAL/EMOTIONAL ABUSE – EXPLOITATION: Physical & emotional by mom: "She yells @ me & that's physical"

LEGAL ISSUES (CURRENT & PAST): Denies

EVER ARRESTED? Denies

CURRENTLY ON PROBATION? Yes____ No ✓ PROBATION/PAROLE OFFICER? N/A

SERVED JAIL TIME? Denies

WARRANTS? Denies

PROBLEMS WITH SUPPORT SYSTEMS: "I don't right now"

CURRENT LIVING CIRCUMSTANCES/COMMUNITY RESOURCES

Mom, Dad, Sister

PLACE OF RESIDENCE: 528 Beau Chene Mandeville, La

MEDICATION ADMINISTRATION: Self

SOCIAL INVOLVEMENT: Alone LEISURE/REC. INTERESTS: Programming, engineering type stuff

TRANSPORTATION: None AMBULATORY ADLS: Independent

INCOME SOURCE/AMOUNT: Mom & Dad FOOD STAMPS/AMOUNT: Ø

RESOURCES TO SUPPORT DISCHARGE

☐ MEDICARE ☐ MEDICAID ☐ OBH ☐ INSURANCE MEDICATION BENEFITS: BCBS

☐ SITTERS ☐ HOME HEALTH:____ EXPECTED DESTINATION AT D/C: Home w/ family

PREVIOUS PRESCRIBER/PROVIDER: Dr Blundell

ACTIVITY/LEISURE ASSESSMENT

WHAT KIND OF THINGS STRESS YOU? Mother, not having a love feeling needed WHAT MAKES YOU HAPPY? Being Understood

LESIURE INTERESTS (NOW): Same (PAST): Spending time w/ friends

BARRIERS TO LEISURE ACTIVITIES: Finances, Mother being on there WHAT DO YOU WANT TO IMPROVE DURING YOUR TREATMENT STAY: To get SSI

Northlake Behavioral Health System
Psychosocial Assessment
NBHS-PA (5/2016)

BODIN, JEFFREY 00032982-001
ADM:10/11/2017 DOB:05/22/1997
W/M SPLANADE 1 O10306
Rel. Unk DR:J RODRIGUEZ
NBHS ST. TAMMANY

NBHS: PSYCHOSOCIAL

GOALS FOR TREATMENT

PER PATIENT/CLIENT/RESIDENT: "To be dependent & help out my family"

IMPRESSIONS AND RECOMMENDATIONS

MENTAL/EMOTIONAL STATUS AT TIME OF ASSESSMENT:

- ☐ ABUSIVE VERBALLY
- ☐ ABUSIVE PHYSICALLY
- ☐ AGITATED
- ☐ ANGRY @ SELF
- ☐ ANGRY @ OTHERS
- ☐ SLEEP DISTURBED
- ☐ HALLUCINATING
- ☐ APPETITE DISTURBED
- ☐ COMBATIVE
- ☐ CONFUSED
- ☐ CRYING
- ☐ IMPULSIVE
- ☐ IRRITABLE
- ☐ MANIC
- ☐ LETHARGIC
- ☐ ALERT/ORIENTED
- ☐ HOPELESS/HELPLESS
- ☐ WORTHLESS
- ☐ RESTLESS
- ☐ SAD
- ☐ SOMATIC
- ☑ UNREALISTIC FEARS
- ☐ UNCOOPERATIVE
- ☐ REPETITIVE QUESTIONS/ STATEMENTS/ MOVEMENTS
- ☑ PARANOIA
- ☐ DELUSIONAL
- ☐ ANXIOUS
- ☐ WANDERING
- ☐ YELLING/CALLING OUT LOUD
- ☐ DISORGANIZED SPEECH
- ☐ COMMUNICATION DEFICIT BARRIER
- ☐ WITHDRAWN
- ☐ OTHER:

CONCLUSIONS AND RECOMMENDATIONS

IS BEREAVEMENT PROCESS A SIGNIFICANT FACTOR IN NEED FOR TX: ☐ YES ☑ NO

FAMILY PARTICIPATION APPROPRIATE: ☑ YES ☐ NO. TO WHAT LEVEL: Collaborate

RECOMMENDED SERVICES

- ☐ ALL USUAL UNIT MODALITIES
- ☐ FAMILY TX
- ☐ ILLNESS EDUCATION: PATIENT/FAMLY
- ☐ IND/FAMILY THERAPY
- ☐ GROUP HOME
- ☐ PROTECTIVE SERVICES
- ☐ EMERGENCY RESPONSE SYSTEM
- ☐ PSYCHOLOGICAL TESTING
- ☐ OCCUPATIONAL TX
- ☑ FOLLOW-UP WITH PSYCHIATRY
- ☐ RESIDENTIAL TREATMENT
- ☐ HOME HEALTH
- ☐ TRANSPORTATION
- ☐ OTHER:
- ☐ INDIVIDUAL TX
- ☐ PHYSICAL TX
- ☐ PHP/IOP
- ☐ MENTAL HEALTH CLINIC
- ☐ LEGAL/FINANCIAL
- ☐ MEDICATION ASSISTANCE

D/C PLAN: Home of Parents & Dr Bennett

Substance Use Referral? (No) Refused Inpatient Outpatient

Smoking Cessation Referral? Yes (No) Refused

THERAPIST'S SIGNATURE: [signature] LCSW DATE: 10-13-17 TIME: 155P

PRTF Must complete the Trauma Screen (s) and Spiritual Assessment at the time this Psychosocial Assessment is completed! Attach the assessments to this form.

BODIN, JEFFREY 00032982-001
ADM:10/11/2017 DOB:05/22/1997
W/M SPLANADE 1 010306
Rel. Unk DR:J RODRIGUEZ
NBHS ST. TAMMANY

NORTHLAKE BEHAVIORAL HEALTH SYSTEM
23519 Hwy. 190
Mandeville, LA 70448
Phone: 985.626.6300 | Fax: 985.626.6685

TUBERCULIN (PPD) SCREENING QUESTIONNAIRE AND PPD FORM

☐ Pre-Employment ☐ Annual ☒ Patient ☐ Credential

Print Name: _____

Department: _____ Position: _____

BODIN, JEFFREY
ADM:10/11/2017
W/M
Rel. Unk
NBHS

00032982-001
DOB:05/22/1997
SPLANADE 1 O10306
DR:J RODRIGUEZ
ST. TAMMANY

1. Have you ever had the following symptoms during the past year for more than two weeks, NOT associated with a specific illness?

a. Chest Pain	☐ Yes	☒ No
b. Chills	☐ Yes	☒ No
c. Chronic cough (lasting greater then 3 weeks)	☐ Yes	☒ No
d. Coughing up phlegm or blood	☐ Yes	☒ No
e. Difficulty breathing or wheezing	☐ Yes	☒ No
f. Fatigue/Weakness	☐ Yes	☒ No
g. Fever, usually at night	☐ Yes	☒ No
h. Loss of appetite	☐ Yes	☒ No
i. Unexplained weight loss of more than 5 pounds	☐ Yes	☒ No
2. Have you ever had a *positive* TB skin test in the past? If so date: _____	☐ Yes	☒ No
3. Have you ever received treatment for TB (medication)? When? _____	☐ Yes	☒ No
4. Have you ever had a family member diagnosed with TB?	☐ Yes	☒ No
5. Have you ever received a BCG vaccine in the past?	☐ Yes	☒ No

pt refused

Signature: [signature] Date: 10/13/17

FAXED

DO NOT WRITE BELOW THIS LINE!

* Instructions: Initial Hire the nurse should complete Steps 1 & 2 * Annual the nurse should complete Step 1 only *

#1 HAVE READ IN "48 to 72 HRS." AFTER ADMINISTERED DATE

Administered date/time of PPD skin test _____ Administered by _____ Lot #_____

Site Planted: ☐ Left forearm ☐ Right forearm Exp:_____

Date/Time PPD site was read _____ Read by _____

Outcome-Induration: ☐Less than 5mm negative ☐5-9mm doubtful ☐More than 10mm positive

N/A

#2 HAVE READ IN "48 to 72 Hrs." AFTER ADMINISTERED DATE (NEW HIRES ONLY)

Administered date/time of PPD skin test _____ Administered by _____ Lot #_____

Site Planted: ☐ Left forearm ☐ Right forearm Exp:_____

Date/Time PPD site was read _____ Read by _____

Outcome-Induration: ☐Less than 5mm negative ☒ 5-9mm doubtful ☐ More than 10mm positive

FAXED
16585
10/14/17 w

BODIN, JEFFREY
ADM:10/11/2017
W/M
Rel. Unk
NBHS

00032982-001
DOB:05/22/1997
SPLANADE 1 O10306
DR:J RODRIGUEZ
ST. TAMMANY

NORTHLAKE
BEHAVIORAL HEALTH SYSTEM
23515 Hwy. 190
Mandeville, LA 70448
Phone: 985.626.6300 | Fax: 985.626.6685

TUBERCULIN (PPD) SCREENING QUESTIONNAIRE AND PPD FORM

BODIN, JEFFREY **00032982-001** ☑ Patient ☐ Credential ☐ Other _____
ADM:10/11/2017 **DOB:05/22/1997**
W/M **SPLANADE 1 O10306** _____
Rel. Unk **DR:J RODRIGUEZ** _____ Position: _____
NBHS **ST. TAMMANY**

1. Have you ever had the following symptoms during the past year for more than two weeks, NOT associated with a specific illness?

a. Chest Pain	☐ Yes	☐ No
b. Chills	☐ Yes	☐ No
c. Chronic cough (lasting greater then 3 weeks)	☐ Yes	☐ No
d. Coughing up phlegm or blood	☐ Yes	☐ No
e. Difficulty breathing or wheezing	☐ Yes	☐ No
f. Fatigue/Weakness	☐ Yes	☐ No
g. Fever, usually at night	☐ Yes	☐ No
h. Loss of appetite	☐ Yes	☐ No
i. Unexplained weight loss of more than 5 pounds	☐ Yes	☐ No
2. Have you ever had a ***positive*** TB skin test in the past? If so date:_____	☐ Yes	☐ No
3. Have you ever received treatment for TB (medication)? When? _____	☐ Yes	☐ No
4. Have you ever had a family member diagnosed with TB?	☐ Yes	☐ No
5. Have you ever received a BCG vaccine in the past?	☐ Yes	☐ No

pt refused

Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE!

FAXED 5/2/18

* Instructions: Initial Hire the nurse should complete Steps 1 & 2 * Annual the nurse should complete Step 1 only

#1 HAVE READ IN "48 to 72 HRS." AFTER ADMINISTERED DATE

Administered date/time of PPD skin test _____ Administered by _____ Lot #_____
Site Planted: ☐ Left forearm ☐ Right forearm Exp:_____
Date/Time PPD site was read _____ Read by _____
Outcome-Induration: ☐Less than 5mm negative ☐5-9mm doubtful ☐More than 10mm positive

N/A

#2 HAVE READ IN "48 to 72 Hrs." AFTER ADMINISTERED DATE (NEW HIRES ONLY)

Administered date/time of PPD skin test _____ Administered by _____ Lot #_____
Site Planted: ☐ Left forearm ☐ Right forearm Exp:_____
Date/Time PPD site was read _____ Read by _____
Outcome-Induration: ☐Less than 5mm negative ☐5-9mm doubtful ☐More than 10mm positive

OUR LADY OF THE LAKE
REGIONAL MEDICAL CENTER
5000 Hennessy Blvd
Baton Rouge, LA 70808

Medical Director: Anthony M. Harton M.D.

Patient Name:	Bodin, Jeffrey	Submitter Name:	Northlake Behavioral Health System- Esplanade I 23515 Hwy 190 Mandeville Louisiana 70448
FMOLHS MRN:	2065176	Submitter Phone:	985-626-6353
DOB:	5/22/1997	Submitter Fax:	985-626-6430
Age:	20 yrs	Submitter ID:	3428

See Values: COMPREHENSIVE METABOLIC PANEL (H), CBC w/ diff (L)

Pending Tests

Hemoglobin A1c

RPR (Final result)

Collected:	10/12/2017 0610	ID:	LA17285SR0047
Priority:	Routine	Type/Src:	Blood/Vein
Resulting Lab:	OUR LADY OF THE LAKE RMC	Authorized by:	Ricardo Rodriguez, MD
Received:	10/12/2017 1236	Verified On:	10/12/2017 1352

	Value	Range
RPR	Nonreactive	Nonreactive

COMPREHENSIVE METABOLIC PANEL (Final result)

Collected:	10/12/2017 0610	ID:	LA17285CA1288
Priority:	Routine	Type/Src:	Blood/Vein
Resulting Lab:	OUR LADY OF THE LAKE RMC	Authorized by:	Ricardo Rodriguez, MD
Received:	10/12/2017 1236	Verified On:	10/12/2017 1325

	Value	Range	
Sodium Level	141	136-145	mmol/L
Potassium Level	3.8	3.5-5.1	mmol/L
Chloride Level	105	100-109	mmol/L
CO2 Level	28	22-33	mmol/L
Glucose Level	74	70-100	mg/dL
Blood Urea Nitrogen Level	18	5-25	mg/dL
Creatinine Level	0.84	0.57-1.25	mg/dL
GFR-AA	141		mL/min/1.73mSq
GFR-NAA	116		mL/min/1.73mSq

Legend

L - Low H - High

10/12/17

Our Lady of the Lake Regional Medical Center

Bodin, Jeffrey
5/22/1997

	Value	Range
Calcium Level	8.8	8.8 10.6 mg/dL
Protein Total	6.6	6.0-8.3 g/dL
Albumin Level	4.0	3.5-5.0 g/dL
Bilirubin Total	0.2	0.2-1.2 mg/dL
Alkaline Phosphatase Level	86	40-150 IU/L
SGOT (AST)	51	10-58 IU/L
SGPT (ALT)	81 (H)	5-50 IU/L
Anion Gap	8	6-16 mmol/L

Comments:

MDRD Calculated GFR estimate resulted by system based on Creatinine Level. Adjusted for gender and age. Results calculated in ml/min/1.73mSquared. Reference Range: >= 60 ml/min/1.73mSquared.

Collection Questions

! Has the patient been fasting for 8 hours or more?	Unknown

LIPID PANEL (Final result)

Collected:	10/12/2017 0610	ID:	LA17286CA1288
Priority:	Routine	Type/Src:	Blood/Vein
Resulting Lab:	OUR LADY OF THE LAKE RMC	Authorized by:	Ricardo Rodriguez, MD
Received:	10/12/2017 1236	Verified On:	10/12/2017 1325

	Value	Range
Cholesterol	151	0-199 mg/dL
Triglycerides	97	0-149 mg/dL
HDL Cholesterol	53	>=40 mg/dL
Low Density Lipoprotein	79	0-129 mg/dL
Non-HDL Cholesterol (Calculated)	98	0-159 mg/dL

Comments:

TOTAL CHOLESTEROL

ADULT - Ages 18yr and up
Desirable: <200 mg/dL
Borderline High: 200-239 mg/dL
High: >= 240 mg/dL

TRIGLYCERIDES:

Adult - Ages 18yr and up
Normal: <150 mg/dL
Borderline High: 150-199 mg/dL
High: 200-499 mg/dL
Very High: >=500 mg/dL

HDL CHOLESTEROL

Legend

L - Low H - High

10/14/17

Our Lady of the Lake Regional Medical Center

Bodin, Jeffrey
5/22/1997

	Value	Range
ADULT - Ages 18yr and up Male: >= 40 mg/dL Female: >= 50 mg/dL		
LDL CHOLESTEROL		
ADULT - Ages 18 yr and up Optimal: <100 mg/dL Near Optimal: 100-129 mg/dL Borderline High: 130-159 mg/dL High: 160-189 mg/dL Very High: >= 190mg/dL		
NON HDL CHOLESTEROL		
ADULT - Ages 18yr and up Desirable: <130 mg/dL Above Desirable: 130-159 mg/dL Borderline High: 160-189 mg/dL High: 190-219 mg/dL Very High: >= 220 mg/dL		

Reference ranges for adults ages 18 and up are set by the National Lipid Association (NLA) and the National Cholesterol Education Program (NCEP).

Collection Questions

Has the patient been fasting for 8 hours or more?	Unknown

TSH (Final result)

Collected:	10/12/2017 0610	ID:	LA17285CA1288
Priority:	Routine	Type/Src:	Blood/Vein
Resulting Lab:	OUR LADY OF THE LAKE RMC	Authorized by:	Ricardo Rodriguez, MD
Received:	10/12/2017 1236	Verified On:	10/12/2017 1354

	Value	Range
TSH Ultrasensitive	2.064	0.350-4.940 uIU/mL

CBC with Auto Differential

CBC w/ diff (Final result)

Collected:	10/12/2017 0610	ID:	LA17285HM0763
Priority:	Routine	Type/Src:	Blood/Vein
Resulting Lab:	OUR LADY OF THE LAKE RMC	Authorized by:	Ricardo Rodriguez, MD
Received:	10/12/2017 1236	Verified On:	10/12/2017 1315

	Value	Range
WHITE BLOOD CELL COUNT	8.1	4.0-11.0 1000/ul
RED BLOOD CELL COUNT	4.97	4.50-5.60 mill/uL

Legend

L - Low H - High

10/14/17

Our Lady of the Lake Regional Medical Center

Bodin, Jeffrey
5/22/1997

	Value	Range
HEMOGLOBIN	15.1	14.0-18.0 gm/dl
HEMATOCRIT	45.7	42.0-52.0 %
MEAN CORPUSCULAR VOLUME	92	80-100 fl
MEAN CORPUSCULAR HEMOGLOBIN CONC	33.0	31.0-37.0 gm/dl
RED CELL DISTRIBUTION WIDTH	11.0 (L)	12.1-14.9 %
PLATELET COUNT	256	150-375 1000/ul
MEAN PLATELET VOLUME	7.9	6.5-12.0 fl
Neutrophils Abs	3.3	1.5-10.0 1000/ul
Lymphocytes Abs	4.0 (H)	1.3-2.9 1000/ul
Monocytes Abs	0.6	0.1-1.0 1000/ul
Eosinophils Abs	0.1	0.0-0.7 1000/ul
Basophils Abs	0.1	0.0-0.2 1000/ul
Neutrophils %	41 (L)	44-81 %
Lymphocytes %	50 (H)	21-47 %
Monocytes %	7	2-11 %
Eosinophils %	1	0-7 %
Basophils %	1	0-2 %

Resulting Labs

OUR LADY OF THE LAKE RMC, 5000 Hennessy Blvd., 225-765-8811
Baton Rouge LA 70808
Director: Dr. Anthony Harton

10/14/17

Legend

L - Low H - High

OUR LADY OF THE LAKE
REGIONAL MEDICAL CENTER
5000 Hennessy Blvd
Baton Rouge, LA 70808

Medical Director: Anthony M. Harton M.D.

Patient Name:	Bodin, Jeffrey	Submitter Name:	Northlake Behavioral Health System- Esplanade I 23515 Hwy 190 Mandeville Louisiana 70448
FMOLHS MRN:	2065176	Submitter Phone:	985-626-6353
DOB:	5/22/1997	Submitter Fax:	985-626-6430
Age:	20 yrs	Submitter ID:	3428

See Values: HGB URINE (A)

URINALYSIS OPT OUT OF C&S (Final result)

Collected:	10/12/2017 1252	ID:	LA17285HU0195
Priority:	Routine	Type/Src:	Urine Clean Catch/Urine
Resulting Lab:	OUR LADY OF THE LAKE RMC	Authorized by:	Lab Unidentified Provider
Received:	10/12/2017 1254	Verified On:	10/12/2017 1310

	Value	Range
COLOR	Light Yellow	Colorless, Light Yellow, Yellow, Dark Yellow, Straw, Amber
CLARITY	Clear	Clear
SPECIFIC GRAVITY UA	1.017	1.001 - 1.035
GLUCOSE UA	Negative	Negative mg/dL
PROTEIN UA	Negative	Negative mg/dL
BILIRUBIN URINE	Negative	Negative
UROBILINOGEN URINE	Negative	Negative E U /dL
PH UA	6	5 - 8
HGB URINE	Moderate (A)	Negative
KETONES UA	Negative	Negative mg/dL
NITRITE UA	Negative	Negative
LEUKOCYTE ESTERASE UA	Negative	Negative
MICROSCOPIC NEEDED?	Yes	
WBC UA	0-5	None, 0-5 /hpf
Blood UA	0-1	None Seen, 0-1, 1-5 /hpf
EPITHELIAL URINE	0-1	None Seen, 0-1, 2-3, 3-5
BACTERIA	None Seen	None Seen /hpf
URINE COLLECTION SOURCE	Urine Clean Catch	

Legend

A - Abnormal

10/14/17

OUR LADY OF THE LAKE
REGIONAL MEDICAL CENTER

5000 Hennessy Blvd
Baton Rouge, LA 70808

Medical Director: Anthony M. Harton M.D.

Patient Name:	Bodin, Jeffrey	Submitter Name:	Northlake Behavioral Health System- Esplanade I 23515 Hwy 190 Mandeville Louisiana 70448
FMOLHS MRN:	2065176	Submitter Phone:	985-626-6353
DOB:	5/22/1997	Submitter Fax:	985-626-6430
Age:	20 yrs	Submitter ID:	3428

Hemoglobin A1c (Final result)

Collected:	10/12/2017 0610	ID:	LA17285HS0149
Priority:	Routine	Type/Src:	Blood/Vein
Resulting Lab:	OUR LADY OF THE LAKE RMC	Authorized by:	Ricardo Rodriguez, MD
Received:	10/12/2017 1236	Verified On:	10/12/2017 1555

	Value	Range
HEMOGLOBIN A1C	4.8	<=6.5 %

Comments:

This assay method is useful in the diagnosis of diabetes mellitus, identification of patients at risk for developing diabetes, and monitoring of patients with diabetes mellitus. Reference range information and glycemic goals are based on recommendations from the ADA (American Diabetes Association).

Hgb A1C Value	Glycemic Goal
<8%	Less Stringent
<7%	General (Non-Pregnant Adults)
<6.5%	More Stringent
5.7% - 6.4%	Increased risk for diabetes

Resulting Labs

OUR LADY OF THE LAKE RMC, 5000 Hennessy Blvd., Baton Rouge LA 70808 225-765-8811
Director: Dr. Anthony Harton

10/13/17

INSERT THIS END FIRST

Please include this barcode cover sheet as the first page of each set of documents returned.

Fax the evidence to this fax number:

(877)559-1922

RQID:000000(000000000225487053 SITE:Y32 DR:S
SSN:436958926 DOCTYPE:5032 RF:D CS:e162

Claimant: Jeffrey T Bodin
SSN: 436-95-8926

Nicole Leon, LPC
10/31/17 - 5/14/18

FAX

Sinfonía
Family Services of Louisiana

TO:	FROM:
Ana Con[illegible]	Gi[illegible] Dillon
FAX NUMBER:	DATE:
985-624-8103	6-15-18
COMPANY: Law Office	TOTAL NO. OF PAGES: 67
SENDER'S PHONE NUMBER: 504-324-7922 office	SENDER'S FAX NUMBER: 504-324-8698
SUBJECT Jeffrey B.	

Urgent ☐ | For Review ☐ | Please Comment ☐ | Please Reply ☐ | Please Recycle ☐

NOTES/COMMENTS:

Medical Records Request For JB.

Thank you :)

CONFIDENTIAL

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Sinfonía Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:05/14/2018
Provider Name:Nicole Leon, LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client,

Objectives Addressed: I will identify 3 coping skills or protective skills to increase coping with unpredictability in my house

Discussion and Interventions: Met with client for individual session. Client continued to explore relationship with his parents. He identified ways they have shown care in the past.Explored relationship with father more. identified ways he is alike and different from father. Counselor reflected, displayed empathy and listened actively. Client continues to exhibit signs of fatigue but remains engaged in session.

Assessment

Dx Code	Dx Description	New/Continuing
Z62.820	Parent child relational problem	Continuing
F32.9	Unspecified depressive disorder	Continuing
F54	Psychological factors affecting other medical conditions	Continuing

Mood appears to be dysthymic Affect is flat

Client has no SI/HI Ideation.

Progress

Stable as evidenced by continued exploration of relationships

Plan

Continue services.

Electronically Signed By: Nicole Leon, LPC /s/ 05/23/2018 10:56 AM
Provider Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:05/07/2018
Provider Name:Nicole Leon, LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client,

Objectives Addressed: I will identify 3 coping skills or protective skills to increase coping with unpredictability in my house

Discussion and Interventions: Met with client for 1:1 session. Client seemed engaged. His affect remains lethargic. Discussed client's concerns about family coming to visit for his sister's graduation. Continued to explore client's relationships with his family members including sister, father, mother and extended family. Client explored and identified his role in the relationships, and demonstrated insight. Also continued to explore client's goals in those relationships Counselor asked open ended questions, reflected and validated.

Assessment

Dx Code	Dx Description	New/Continuing
Z62.820	Parent child relational problem	Continuing
F32.9	Unspecified depressive disorder	Continuing

Mood appears to be depressed Affect is lethargic, flat,

Client has no SI/HI Ideation.

Progress

Stable as evidenced by engagement in sessions

Plan

Continue services.

No homework given today.

Electronically Signed By: Nicole Leon, LPC /s/ 05/07/2018 02:50 PM
Provider Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:04/09/2018
Provider Name:Nicole Leon, LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client,

Objectives Addressed: I will identify 3 coping skills or protective skills to increase coping with unpredictability in my house

Discussion and Interventions: Client and counselor met for individual session. Client seemed engaged throughout session. Client displayed some difficulty completing thoughts and stated he was having a hard time fully explaining things but seemed to remain open and willing to engage in conversation. Continues to display signs of sleep deprivation and reports sleeping less than usual due to pain in arm. Client and counselor explored ways narcolepsy affects his physical and mental healthy. Client continues to discuss and explore his relationship with his parents and ways that affects his mental health. Counselor asked opened ended questions, displayed empathy, and validated. client identified and explored his frustration with his parents.

Assessment

Dx Code	Dx Description	New/Continuing
Z62.820	Parent child relational problem	Continuing
F54	Psychological factors affecting other medical conditions	Continuing
F32.9	Unspecified depressive disorder	Continuing

Clt presented with sx of Fatigue Mood appears to be depressed Affect is congruent

Client has no SI/HI Ideation.

Progress

Stable as evidenced by continued engagement in sessions

Plan

Continue services.

No homework given today.

Electronically Signed By: Nicole Leon, LPC /s/ 04/09/2018 01:04 PM
Provider Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:04/02/2018
Provider Name:Nicole Leon, LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client,

Objectives Addressed: I will identify 3 coping skills or protective skills to increase coping with unpredictability in my house

Discussion and Interventions: Client and counselor met for individual session. Client seemed engaged, aeb made more eye contact than previous sessions. Client continues to show signs of sleep deprivation and fatigue; remains able to engage with counselor. Client continues to explore his relationship with his parents and identifies ways that relationship affects his physical and mental health conditions. Client and counselor explored and discussed client's ability to work as it relates to mental health statement requested by his attorney. Client continues to discuss goals of medication treatment and concerns about his parents interference. Explored his relationship and level of trust with current and previous doctors. Counselor validated, reflected and displayed empathy.

Assessment

Dx Code	Dx Description	New/Continuing
F54	Psychological factors affecting other medical conditions	Continuing
Z62.820	Parent child relational problem	Continuing

Clt presented with sx of Fatigue Mood appears to be depressed Affect is congruent

Client has no SI/HI Ideation.

Progress

Stable as evidenced by continued engagement in sessions

Plan

Continue services.

No homework given today.

Electronically Signed By: Nicole Leon, LPC /s/
Provider

04/09/2018 12:52 PM
Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:03/26/2018
Provider Name:Nicole Leon, LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client,

Objectives Addressed: I will identify 3 coping skills or protective skills to increase coping with unpredictability in my house

Discussion and Interventions: Met with client for individual session. Client continues to seem fatigued but engaged. Client seemed slightly more engaged and alert in this session aeb yawning less and affect being less flat. Continued to discuss client's experience of and relationship with his parents. Continued to explore idea of not being able to change parents or other people. Explored client's dependence on parents and ways they have been barriers to his treatment in the past. Counselor reflected feelings to client throughout session. Counselor and client explored ways to prevent barriers to treatment moving forward. Client requested counselor speak to law office he is working with. Client signed release. Client also asked abouthis diagnosis. Counselor reported codes being treated including relationship distress with parents and psychological factors affecting medical conditions

Assessment

Dx Code	Dx Description	New/Continuing
Z62.820	Parent child relational problem	Continuing
F54	Psychological factors affecting other medical conditions	Continuing

Clt presented with sx of Fatigue Mood appears to be depressed Affect is flat

Client has no SI/HI Ideation.

Progress

Stable as evidenced by continued engagement in sessions

Plan

Continue services.

No homework given today.

Electronically Signed By: Nicole Leon, LPC /s/
Provider

03/26/2018 01:37 PM
Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:03/19/2018
Provider Name:Nicole Leon, LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client,

Objectives Addressed: I will identify 3 coping skills or protective skills to increase coping with unpredictability in my house

Discussion and Interventions: Client and counselor met for individual session. Client continues to present lethargic and sleep deprived. Affect flat. He presents withdrawn at first but seems to engage more as session progressed. Client and counselor continued to explore client's parents past behaviors and how they affect him. Counselor reflected feelings and client identified with some. Counselor modeled and client practiced future thinking. counselor and client explored the idea of whether his parents would ever change and what client's hopes and expectations of them are. Began discussing coping skills. Counselor validated and reflected through out session. Counselor asked open and closed ended questions to increase self awareness and insight.

Assessment

Dx Code	Dx Description	New/Continuing
F54	Psychological factors affecting other medical conditions	Continuing
Z62.820	Parent child relational problem	Continuing

Affect is flat

Client has no SI/HI ideation.

Progress

Steady progress as evidenced by continued engagement in sessions and exploration of thoughts and feelings.

Plan

Continue services.

No homework given today.

Electronically Signed By: Nicole Leon, LPC /s/
Provider

03/21/2018 02:45 PM
Date

Sinfonia Family Services of Louisiana

MRN #: 000000001984

Behavioral Health Service Plan

Name: Jeffrey Bodin **DOB:** 05/22/1997
CIS ID#: **StateID #:**

Program: Outpatient **Today's Date:** 3/12/2018

Individuals at Service Planning Meeting: self

Recovery Goal/Person-Family Vision: To cope with my parents

Reasons I want to participate in this program/activity:

Client/family say the following needs to have happened in order for them to feel ready to leave services:

Does client want anyone involved in treatment at this time? ○ Yes ◉ No

Person's Strengths

Type	Strength	Evidenced By
Individual	I am resiliant	self

Objectives and Interventions

Type of Goal	Need	Objective	Services	Freq	Current Measure	Desired Measure	Target Date	Met	Achieved Measure
	To learn how to protect and cope with parents and unpredictable behavior	I will identify 3 coping skills or protective skills to increase coping with unpredictability in my house	90836 - Individual Psychotherapy	1-5 times per month			09/12/2018		

Additional Services

Discharge Plan

☒ Yes, client has received a copy of this plan.

◉ Yes, client agrees with the types and levels of services in the ISP.

Client Name: Jeffrey Bodin
Client ID: AHCCCS ID:

☐ No, client disagrees with the types and/or levels of some or all of the services included in the plan. By checking this box, client will receive the services agreed to receive and may appeal the treatment team's decision to not include all types and/or levels of service that have been requested.

☐ Client has received a Notice of Action (PM Form 5.1.1 if disagreement concerns a Title XIX/XXI covered service)

☐ Client has received the Notice of Decision & Right to Appeal for Individual with a Serious Mental Illness (PM Form 5.5.1 if disagreement pertains to a Non-Title XIX/XXI covered service).

Review Date (Objective Target Date):03/12/2019

Service Plan Rights Acknowledgment for Persons who are Title XIX/XXI and/or SMI:
My service plan has been reviewed with me by my behavioral health provider. I know what services I will be getting and how often. All changes in the services have been explained to me. I have marked my agreement and/or disagreement with each service. I know that in most cases, any reductions, terminations, or suspensions (stopping for a set time frame) of current services will begin no earlier than 10 days from the date of the plan. I know that I can ask for this to be sooner.

If I do not agree with some or all of the services that have been authorized in this plan, I have noted that on my plan. I know if the service asked for was denied, reduced, suspended or terminated, that my behavioral health provider will give me a letter that tells me why the decision was made. That letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me how I can request continued services.

My behavioral health provider has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services changed. The letter will also tell me about my appeal rights.

I know that if I need more services or other services than what I am getting, I can call my behavioral health provider at ( ) - to talk about this. My behavioral health provider will call me back within 3 working days. Once I have talked with my behavioral health provider, s/he will give me a decision about that request within 14 days. If the behavioral health provider is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

The persons below participated in developing the treatment plan for JeffreyBodin, 05/22/1997 on the date of 3/12/2018.

JeffreyBodin, 05/22/1997 has been given a diagnosis of ECH96329-D43D-4209-8D67-FF4AFA8B8A5D. Persons with this diagnosis may have difficulty fully participating in a meaningful manner in educational, vocational, family or social activities. The treatment plan as it is described in the preceding pages has been recommended as Medically Necessary and will be implemented with the reasonable expectation of ameliorating the above difficulties or symptoms.

{SIGNATURE PAD}
Individual/Guardian Printed Name

03/12/2018 5:05 PM EDT
Date

Electronically Signed by: Nicole Leon, LPC
Staff Signature

03/12/2018 5:05 PM EDT
Date

***For Behavioral Health Professional Signatures see BHSrvplnAffidavit**

Client Name: Jeffrey Bodin
Client ID: AHCCCS ID:

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:03/12/2018
Provider Name:Nicole Leon, LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client,

Objectives Addressed: I will identify 3 coping skills or protective skills to increase coping with unpredictability in my house

Discussion and Interventions: Client and counselor met for individual session Client seemed lethargic but engaged. Client and counselor explored family dynamics and client's high school and social experiences. Continued to build rapport. Client identified feeling anxious about upcoming appointment with psychiatrist due to his mother "demanding" she attend. Counselor validated, reflected, and summarized with client. Counselor presented idea of identifying protecting and coping strategies for dealing with his mother who he reports is unpredictable. Counselor asked open ended questions and encouraged self exploration and self awareness.

Assessment

Dx Code	Dx Description	New/Continuing
Z62.820	Parent child relational problem	Continuing
F54	Psychological factors affecting other medical conditions	Continuing

Clt presented with sx of Fatigue Mood appears to be depressed Affect is congruent

Client has no SI/HI Ideation.

Progress

Slow progress as evidenced by continuing to build rapport and explore client's goals of treatment

Plan

Continue services.

No homework given today.

Electronically Signed By: Nicole Leon, LPC /s/
Provider

03/12/2018 05:15 PM
Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:03/05/2018
Provider Name:Nicole Leon, LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client,

Objectives Addressed: To learn at least one new coping skill withtin a 3 month period to help alleviate depression symptoms.; To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.

Discussion and Interventions: Met with client for individual session. Client appeared tired and lethargic but engaged. Client reports that things are "the same" and that he sleeps most of the time. He reports things are "better" at home as in his parents are "fixated" on other things other than him. Client and counselor continued to build rapport. Client shared about his nacolepsy, medical history, and childhood. Client's affect is very flat consistent with him reporting he is sleep deprived due to his narcoplsey. Client can identify long term goals but reports not having the proper dose of stimulant is a barrier to progress. Counselor reflected feelings, validated, and worked on building rapport. Goals of treatment seem vague, will continue to explore with client.

Assessment

Dx Code	Dx Description	New/Continuing
F54	Psychological factors affecting other medical conditions	Continuing
F32.9	Unspecified depressive disorder	Continuing

Clt presented with sx of Fatigue Barriers to progress are need for medication stabilization. Mood appears to be depressed Affect is flat

Client has no SI/HI Ideation.

Progress

continuing to Established rapport.

Plan

Continue services; develop treatment plan

Electronically Signed By: Nicole Leon, LPC /s/
Provider

03/05/2018 02:39 PM
Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:02/19/2018
Provider Name:Nicole Leon, LPC

09:05 AM to 10:00 AM Duration: 55 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client,

Objectives Addressed: To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.; To learn at least one new coping skill withtin a 3 month period to help alleviate depression symptoms.

Discussion and Interventions: Client met with new counselor to begin building rapport and establishing goals. Client reported to session on time. Client seemed tired and lethargic and stated that talking was difficult due to his narcolepsy. Client shared about medical and mental health history. He shared about his relationship with his parents and began discussing long term goals and short term obstacles. Counselor focused on strengths, displayed empathy, validated, and built rapport

Assessment

Dx Code	Dx Description	New/Continuing
F32.9	Unspecified depressive disorder	Continuing
Z62.820	Parent child relational problem	Continuing

Clt presented with sx of Fatigue Barriers to progress are Client reports his parents and his relationship with them are barriers to progress. Mood appears to be depressed Affect is blunted

Client has no SI/HI Ideation.

Progress

Initial session. Established rapport.

Plan

update treatment plan; Continue services.

No homework given today.

Electronically Signed By: Nicole Leon, LPC /s/
Provider

02/19/2018 02:38 PM
Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:01/15/2018
Provider Name:James Headrick LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client, Clinician,

Objectives Addressed: To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.; To learn at least one new coping skill withtin a 3 month period to help alleviate depression symptoms.

Discussion and Interventions: The client arrived on time and actively particiapted in his session. He presented with a depressed mood and flat affect. The client reported that he is hoping to get put back on his medication so that he might experience higher functioning. The client continue to resist bx modifications. The client was able to give some hx about his medical condition and and how it affected his educaiton (mostly in high school). He continues to blame his parents for his lack of ability to remain in college. The client demonstates low insight into his environment and support system. The client agreed to start seeing Nicole for therapy in one week.

Assessment

Dx Code	Dx Description	New/Continuing
F32.9	Unspecified depressive disorder	Continuing
F54	Psychological factors affecting other medical conditions	Continuing
G47.429	Narcolepsy secondary to another medical condition	Continuing
Z62.820	Parent child relational problem	Continuing

Mood appears to be depressed Affect is flat

Client has no SI/HI Ideation.

Progress

Slow progress as evidenced by the client's lack of insight and resistance to bx changes.

Plan

Continue services.

Electronically Signed By: James Headrick LPC /s/ 01/15/2018 10:51 AM
Provider Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:01/08/2018
Provider Name:James Headrick LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client, Clinician,

Objectives Addressed: To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.; To learn at least one new coping skill withtin a 3 month period to help alleviate depression symptoms.

Discussion and Interventions: The client arrived on time and actively participated in his session. He presented with a depressed mood and flat affect. The client reported that he is still having the same issues with his mother and does not see how things will get any better. He is convinced that until he gets his medication he will be forced to continue with his life as it currently is. The client struggles to assume any responsibility for his circumstances and continues to deflect any conversation concerning him making changes behaviorally. The client is able to acknowledge that he is "negative" in general but continues to engage in "all or nothing" thinking. The clinician helped the client process his resistance to bx tx. The clinician encouraged the client to challenge his perception of himself and his environment. The clinician also spoke with the client about transferring his case to Nicole in a couple of weeks. The clinician informed the client that the staff will talk about his progress and things he would l like to cover once he is seeing his new therapist. The staff will follow up with the client in one week.

Assessment

Dx Code	Dx Description	New/Continuing
F32.9	Unspecified depressive disorder	Continuing
F54	Psychological factors affecting other medical conditions	Continuing
G47.429	Narcolepsy secondary to another medical condition	Continuing
Z62.820	Parent child relational problem	Continuing

Mood appears to be depressed Affect is flat

Client has no SI/HI ideation.

Progress

Slow progress as evidenced by the client's medical condition and lack of insight

Plan

Continue services.

No homework given today.

Electronically Signed By: James Headrick LPC /s/ 01/08/2018 10:18 AM
Provider Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:12/29/2017
Provider Name:James Headrick LPC

12:00 PM to 01:00 PM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client, Clinician,

Objectives Addressed: To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.; To learn at least one new coping skill withtin a 3 month period to help alleviate depression symptoms.

Discussion and Interventions: The client arrived on time and actively participated in his session. He presented with a depressed mood and flat affect. The client reported that things were slightly better at home due to the holidays. He reported that his mother was tolerable this Christmas. The client also stated that he has an appointment with a new PCP and needed his medical records. The staff printed off copies of his assessment and tx plan. The clinician also offered to faxe over his records since his appointment was not until the end of January. The client agreed to bring his new doctor's contact information and to sign an ROI for his next session. The language the client uses to described himself and his medical/mental conditions offers insight into how he percieves himself. The client seems to see himself as the "identified patient" and his situation is basically as good as it can get. Whenever the clinician would bring this up, the client would state that he does not mean to come off that way and he believes things will be different once he gets prescribed Aderall. The clinician often attempted to challenge the client that medcations alone would be the defining difference in his life. The client stated that though he knew the medication was not the only thing that may help him, his language seems to indicate that he believes otherwise. The client stated that the medication is the only thing he feels has made any reasonable change in his condition. It would make sense that he would hold such a strong conviction that the medication is the catalyst for change. The staff will continue to encourage the client to challenge his negative thoughts and to devise a strategy on how he will change things behaviorally once he is back on his medicalton. The staff will follow up with the client in two weeks.

Assessment

Dx Code	Dx Description	New/Continuing
F32.9	Unspecified depressive disorder	Continuing

Mood appears to be depressed Affect is flat

Client has no SI/HI Ideation.

Progress

Slow progress as evidenced by the clien's resistance to change and feedback

Plan

Continue services.

No homework given today.

Electronically Signed By: James Headrick LPC /s/ 12/29/2017 01:20 PM
Provider Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:12/21/2017
Provider Name:James Headrick LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client, Clinician,

Objectives Addressed: To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.; To learn at least one new coping skill withtin a 3 month period to help alleviate depression symptoms.

Discussion and Interventions: The client arrived on time and actively particlapted in his session. He presented with a depressed/tired mood and flat affect. The client reported nothing has changed since his last session. He continues to engage in all or nothing thinking. The client seems to identify himself as sick and lives his life as the "sick one." The client becomes agitated or uncomfortable when pressed to think of himself outside of those terms. The client was able to state that he is not always "so negative". He reports that when he is on his medication (Aderall) he feels more positive. The clinician helped the client process how his self talk will affect his moods and behaviors. The client agreed to be more self aware of his inner dialogue and to try challenging his thoughts. Though the client is somewhat resistant to feedback, he does seem motivated to continue tx. The staff will follow up with the client in one week.

Assessment

Dx Code	Dx Description	New/Continuing
F32.9	Unspecified depressive disorder	Continuing
G47.429	Narcolepsy secondary to another medical condition	Continuing

Mood appears to be depressed Affect is appropriate to content

Progress

Slow progress as evidenced by the client's resistance to feedback and guarded presentation.

Plan

Continue services.

Electronically Signed By: James Headrick LPC /s/
Provider

12/21/2017 03:34 PM
Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:12/12/2017
Provider Name:James Headrick LPC

12:00 PM to 01:00 PM Duration: 60 min
Service Code: 90837HBHO11 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client, Clinician,

Objectives Addressed: To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.; To learn at least one new coping skill withtin a 3 month period to help alleviate depression symptoms.

Discussion and Interventions: The client arrived late and actively particiapted in his session. He presented with a depressed mood and flat affect. The client reported that nothing has changed since his last session and he is tired and sleeping all of the time. The clinician reviewed the plan with the client to have him seen by the neurologist regarding his possible Narcolepsy. The client is still focused on the toxic relationship with his mother. He stated that his plans are to get back on Aderall, then he will get disability benefits and move out of his parents house. The clinician challenged the client to consider what he will do once he has accomplished this. The client stated he would sleep and spend time "programming" his computer. The clnician continued to challenge the client to think about what he coud do, such as continue his eduation or work from home. The client was resistant and guarded toward this. He eventually admitted that his "education" is a sensitive subject for him because he would like to continue his education but does not believe that is possible due to his condition. This is the first time the client showed emotion and was able to articulate his sensitivity toward something. The clinician praised the client for talking about this emotionally sensitive subject. The client stated he did not like that, but was able to laugh about it at the end of the session. The client is becoming somewhat receptive to feedback and seems motivated to continue tx. The staff will follow up with the client in one week.

Assessment

Dx Code	Dx Description	New/Continuing
F32.9	Unspecified depressive disorder	Continuing
F54	Psychological factors affecting other medical conditions	Continuing

Mood appears to be depressed Affect is flat

Client has no SI/HI Ideation.

Progress

Slow progress as evidenced by the client's lack of insight into his bx.

Plan

Continue services.

Electronically Signed By: James Headrick LPC /s/ 12/12/2017 04:00 PM
Provider Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:12/05/2017
Provider Name:James Headrick LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client, Clinician,

Objectives Addressed: To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.

Discussion and Interventions: The client arrived on time and actively participated in his session. He presented with a depressed mood and flat affect. The client reported his condition has not changed and he still struggles with his relationship with his mother. The clinician processed with the client his transfer to the outpatient program and asked if he was okay seeing Nicole. The client agreed and stated he would like to stay with Sinfonia because he feels he is being heard and treated with respect. The client is still guarded in making changes, believing he can do nothing until he gets his "medication" (Aderall). The clinician helped the client process this and challenged him to consider small changes he might make to help his situation. The client agreed to consider this. The clinician remains guarded in some areas but is willing to explore possible trauma from his bout with cancer as a child. The client seems motivate to continue tx. The clinician will continue to see the client until next month when Nicole will be eligible to see him. The clinician will follow up with the client in one week.

Assessment

Dx Code	Dx Description	New/Continuing
F32.9	Unspecified depressive disorder	Continuing
F54	Psychological factors affecting other medical conditions	Continuing

Mood appears to be depressed Affect is appropriate to content

Client has no SI/HI Ideation.

Progress

Slow progress as evidenced by the client's lack of insight and low support.

Plan

Continue services.

Electronically Signed By: James Headrick LPC /s/ 12/11/2017 10:29 AM
Provider Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:11/27/2017
Provider Name:James Headrick LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client, Clinician,

Objectives Addressed: To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.; To learn at least one new coping skill withtin a 3 month period to help alleviate depression symptoms.

Discussion and Interventions: The client arrived on time and actively participating in his session. He presented with a depressed mood and flat affect. The client reported that his Thanksgiving was "okay" and no one had any arguments. The client was able to complete his Pathways to Care and Premorbid Adjustment scale. The client stated that the police were called and he was taken to the hospital b/c his mother said he was suicidal. The client denied having any suicidal ideation. The client continues to exhibit grandiose thinking and is suspected of suffering from NPD. The clinician will continue to assess for Personalit D/O. The client remains open to feedback and seems motivated to continue tx. The clinician will follow up with the client in one week.

Assessment

Dx Code	Dx Description	New/Continuing
F32.9	Unspecified depressive disorder	Continuing

Mood appears to be depressed Affect is flat

Client has no SI/HI Ideation.

Progress

Slow progress as evidenced by the clien't lack of insight and grandiose thinking.

Plan

Continue services.

No homework given today.

Electronically Signed By: James Headrick LPC /s/
Provider

11/27/2017 09:52 AM
Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:11/21/2017
Provider Name:James Headrick LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client, Clinician,

Objectives Addressed: To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.; To learn at least one new coping skill withtin a 3 month period to help alleviate depression symptoms.

Discussion and Interventions: The client arrived on time and acitvely particlpated in his session. He presented with a depressed mood and flat affect. The client's thought process was tangential. He displayed grandiose thinking regarding his education, his medical procedures and diagnosis. The client also displayed characteristics of NPD. The clinician would press the client on certain subjects to more specific, at which time the client would become visibly nervous and divert to another subject. The client is still convinced that his mother suffers from delusions. The clinician will continue to establish repoire with the client. The client seems motivated to continue tx. The staff will follow up with the client in one week.

Assessment

Dx Code	Dx Description	New/Continuing
F32.9	Unspecified depressive disorder	Continuing

Mood appears to be depressed Affect is flat

Client has no SI/HI Ideation.

Progress

Slow progress as evidenced by the client's lack of insight into his symptoms.

Plan

Continue services.

No homework given today.

Electronically Signed By: James Headrick LPC /s/
Provider

11/21/2017 10:47 AM
Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:11/16/2017
Provider Name:James Headrick LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client, Clinician,

Objectives Addressed: To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.; To learn at least one new coping skill withtin a 3 month period to help alleviate depression symptoms.

Discussion and Interventions: The client arrived on time and actively participated in his session. He presented with a depressed mood and flat affect. The client reported that his mother has been berating him and making him miserable. The client is hyper-focused on his mother and is unable to assume any responsibility for his actions. The clinician used mainly motivational interviewing to help establish repoire. The clincian was able to challenge the client on what it means for him to no longer be a minor. He stated that he did not know that his parents were no longer required to allow him to stay in their house or eat their food, etc. The client reported that once he begins to collect disability he wants to move out and live on his own. The clinician helped the client process what that might look like and if he would be able to do certain things based solely on his disability checks. The client continues to believe that his mother is out to make him miserable, while at the same time wanting him to not e sick. The client agreed to have a family session in the next couple of weeks. He also asked about possibly applying for Medicaid. The staff will make the necessary arrangements to help the client with this. The staff will follow up with the client in one week.

Assessment

Dx Code	Dx Description	New/Continuing
F32.9	Unspecified depressive disorder	Continuing

Mood appears to be depressed Affect is flat

Client has no SI/HI Ideation.

Progress

Slow progress as evidenced by the client's lack of insight into his symptoms

Plan

Continue services.

Electronically Signed By: James Headrick LPC /s/
Provider

11/16/2017 11:01 AM
Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Behavioral Health and Medical History Questionnaire

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Are you currently taking any medications (prescription, over the counter vitamins, homeopathic or naturopathic remedies, traditional or alternative medicine remedies, herbs)?

_ No X Yes, answer questions below.

Identify the medications that you are currently taking for medical or behavioral health concerns and the reason for taking the medications below:

Medication Name	Reason
mirtazapine	
singulair	

Are you allergic to any medications? X No _ Yes, which ones?

Do you have any other allergies? _ No X Yes

If yes, explain: lactose intolera t

Historical Vaccine Information:

DTap: unknown or not reported at this time
IPV: unknown or not reported at this time
HIB: unknown or not reported at this time
Hep B: unknown or not reported at this time
PVC13: unknown or not reported at this time
Rotavirus: unknown or not reported at this time
MMR: unknown or not reported at this time
Varicella: unknown or not reported at this time
Hep A: unknown or not reported at this time
Tdap: unknown or not reported at this time
Meningococcal: unknown or not reported at this time
HPV: unknown or not reported at this time

Flu: unknown or not reported at this time

Any history of head injury with concussion or loss of consciousness? X No _ Yes

Are you currently pregnant? 4 No 4 Yes 4 Unsure
Are you receiving prenatal care? _ No _ Yes
Child Birth within the last 5 years? _ No _ Yes X N/A
Total Number of Births (live and still):

Are there any medical problems that you are currently receiving treatment for?

_ No X Yes, answer questions below.

Describe below what current medical problems you have and what type of treatment you are currently receiving.

Medical Problem

Current Treatment

cluster headaches, peripheral nueropathy, Narcolepsy

Does your current medical condition(s) create problems in how you deal with life, including pain?
__ No X Yes

Do you use tobacco? X No _ Yes
Have you ever received out-patient (office-based) services, been hospitalized or received services in a residential facility for behavioral health concerns?

_ No X Yes, answer questions below

Describe below the type of treatment you received to address your behavioral health concerns and when you received this treatment.

Type of Treatment	When	Where
hospitalization	10/11/17	Northlake

What current or prior treatment/services, including medication, do you think have been the MOST helpful in addressing your behavioral health symptoms? Explain:

What current or prior treatment/services, including medication, do you think have been the LEAST helpful in addressing your behavioral health symptoms? Explain:

List previous physical health diagnosis, surgeries, and hospitalizations including dates and outcome of treatment received:

Narcolepsy, nueropathy,

Sinfonía Family Services of Louisiana

MRN #: 000000001984

Behavioral Health Service Plan

Name: Jeffrey Bodin **DOB:** 05/22/1997 **MRN:** 000000001984

Program: EPIC **Today's Date:** 11/9/2017

Axis I:	DSM -IV	ICD-10	DSM -V	Specifiers
	ECB96329-D43D-4209-8D67-FF4AFA8B8A5D	F32.9	Unspecified depressive disorder	

Axis II:Axis III: NONE

Significant recent losses as of 10/31/2017:

Axis V: NONE

Individuals at Service Planning Meeting: client, clinician

Recovery Goal: to get my parents to leave me alone

Client/family say the following needs to have happened in order for them to feel ready to leave services: parents will support his needs and give him his privacy

Person's Strengths

Type	Strength	Evidenced By
Individual	I am resiliant	self

Objectives and Interventions

Type of Goal	Need	Objective	Services	Freq	Current Measure	Desired Measure	Target Date	Met	Achieved Measure
	Depression	To learn at least one new coping skill within a 3 month period to help alleviate depression symptoms.	CBT+ for Depression, Navigate (EPIC), Psychiatric Services	1 hour/week with Clinician	Depression: sadness, isolation, fatigue, lack of	alleviation of symptoms.	02/10/2018		

					motivation				
	Anxiety	To learn at least one new coping skill within a 3 month period to help alleviate anxiety symptoms.	CBT+ for Anxiety, Psychiatric Services	1 hour/week with Clinician	Anxiety: stress, racing thoughts.	alleviation of symptoms.	02/10/2018		

Additional Services

Discharge Plan

Yes, client has received a copy of this plan: ☐
Client was offered a copy of this plan: ☒

◉ Yes, client participated in the development of this plan and agrees.

○ No, client participated in the development of this plan; however, client disagrees

Review Date (Objective Target Date): 11/09/2018

(SIGNATURE PAD) — 11/10/2017 08:11 AM
Patient Name — Date

(SIGNATURE PAD) — 11/10/2017 08:11 AM
Guardian Name — Date

Electronically Signed by: James Headrick LPC — 11/10/2017 08:11 AM
Provider Signature — Date

(SIGNATURE PAD) — 11/10/2017 08:11 AM
Signature — Date

(SIGNATURE PAD) — 11/10/2017 08:11 AM
Signature — Date

(SIGNATURE PAD) — 11/10/2017 08:11 AM
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(SIGNATURE PAD) — 11/10/2017 08:11 AM
Signature — Date

(SIGNATURE PAD) — 11/10/2017 08:11 AM
Signature — Date

Sinfonía Family Services of Louisiana

MRN #: 000000001984

Comprehensive Assessment

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997
Assessment Date: 11/09/2017

PCP/Physician	**Phone ( ) - FAX**
Legal Guardian	**Phone**
Emergency Contact	**Phone**

Sinfonía Family Services of Louisiana

MRN #: 000000001984

Behavioral Health and Medical History Questionnaire

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Are you currently taking any medications (prescription, over the counter vitamins, homeopathic or naturopathic remedies, traditional or alternative medicine remedies, herbs)?

_ No X Yes, answer questions below.

Identify the medications that you are currently taking for medical or behavioral health concerns and the reason for taking the medications below:

Medication Name	Reason
mirtazapine	

singulair

Are you allergic to any medications? X No _ Yes, which ones?

Do you have any other allergies? _ No X Yes

If yes, explain: lactose intolera t

Historical Vaccine Information:

DTap: unknown or not reported at this time
IPV: unknown or not reported at this time
HIB: unknown or not reported at this time
Hep B: unknown or not reported at this time
PVC13: unknown or not reported at this time
Rotavirus: unknown or not reported at this time
MMR: unknown or not reported at this time
Varicella: unknown or not reported at this time
Hep A: unknown or not reported at this time
Tdap: unknown or not reported at this time
Meningococcal: unknown or not reported at this time
HPV: unknown or not reported at this time
Flu: unknown or not reported at this time

Any history of head injury with concussion or loss of consciousness? X No _ Yes

Are you currently pregnant? 4 No 4 Yes 4 Unsure
Are you receiving prenatal care? _ No _ Yes
Child Birth within the last 5 years? _ No _ Yes X N/A
Total Number of Births (live and still):

Are there any medical problems that you are currently receiving treatment for?

_ No X Yes, answer questions below.

Describe below what current medical problems you have and what type of treatment you are currently receiving.

Medical Problem

Current Treatment

cluster headaches, peripheral nueropathy, Narcolepsy

Does your current medical condition(s) create problems in how you deal with life, including pain?
__ No X Yes

Do you use tobacco? X No _ Yes
Have you ever received out-patient (office-based) services, been hospitalized or received services in a residential facility for behavioral health concerns?

_ No X Yes, answer questions below

Describe below the type of treatment you received to address your behavioral health concerns and when you received this treatment.

Type of Treatment	When	Where
hospitalization	10/11/17	Northlake

What current or prior treatment/services, including medication, do you think have been the MOST helpful in addressing your behavioral health symptoms? Explain:

What current or prior treatment/services, including medication, do you think have been the LEAST helpful in addressing your behavioral health symptoms? Explain:

List previous physical health diagnosis, surgeries, and hospitalizations including dates and outcome of treatment received:

Narcolepsy, nueropathy,

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Presenting Issues

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

What are you seeking help for today? Why now?

Depression: sadness, isolation, fatigue, lack of motivation
Anxiety: stress, racing thoughts.
Grandiosity, possible paranoia.

How long have these issues been a concern (onset, intensity, duration, frequency)?

Client was diagnosed with cancer at the age of 10

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Family/Social History

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Living arrangements:

Do you need housing assistance: No

Household members and age:

Relation	Age	Month(s)/Day(s)	Name	DOB	Custody	Other Parent	Ethnicity	Sex
father	0		Mark					M
mother	0		Linda					F
sister	0		stephanie					F

Family history of mental illness and/or substance abuse (who and what relationship to client):

Summarize family history and child rearing practices:

Client reports that his family was "fine" growing up. He said his parents fought some, but that seems to be normal for them.

Does someone have custody/guardianship of client? No

Describe the relationships you are involved in and how you feel about these people (family, friends, significant others, community relationships, staff if placed out of home) In general, how do you get along with others?

I get along well with others, especially when I am on a stimulant

Which people are you most comfortable confiding in?
Do you think these people would be supportive and helpful to you at this time?
How do these people help?

None

What are the things that make you feel good about yourself and help make your life meaningful? (interests, skills, abilities, friends, family, values, religion/spirituality, work, school, culture/community)

Program comptuters, play games, read

Sexual Orientation: Heterosexual **Gender Expression:** Male

What do others consider to be your strengths? (including interests, talents, skills and abilities, knowledge/education, friends, family, values, religion/spirituality, your culture/community, work, school, etc.)

Person's Weakness(es)/Area(s) of Opportunity:

exercise. I don't exercise that much

Do you need assistance with self care and/or basic needs?

No

Sinfonía Family Services of Louisiana

MRN #: 000000001984

Abuse/Sexual Risk Behavior

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Do you feel safe in your current living situation? Yes

Do you feel safe outside of your home? Yes

Are you currently or have you ever been hurt, harmed, touched inappropriately, or abused by someone in any way? (Consider any physical, sexual, or emotional abuse) No

Is any member of your household/family currently being or has ever been harmed, abused, neglected, or victimized? (Consider any physical, sexual, or emotional abuse.) No

Summarize other relevant trauma history:

Had cancer as a 10 y/o child.

Do you engage in any sexual behaviors that you are concerned about, or that have raised concerns in your family or community (sexual acting out, inappropriate touching, exposure)? No

Have you ever been tested for HIV/STD/TB? No

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Developmental History

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Has the person ever been told that they have, or need assistance for, one of the following:

Intellectual Disability: No
Specific Learning Disabilities: No
Motor Skills Disorders: No
Communication Disorders: No
Autism Spectrum Disorder: No

Complete the following for all children and for adults with developmental disabilities:

During pregnancy did this person's mother:

Receive health care: No
Drink alcohol: No
Use tobacco: No
Use any illicit drugs: No
Use any medications: No
Have any medical or emotional problems: No
Give birth prematurely: Yes
Experience complications during labor/delivery: No

If yes to any of above, explain:

Premature birth. Mom had a c-section

Indicate below if the person ever experienced any of the following:

Could not gain weight: No
Wet the bed or soiled his/her clothes: No
Had difficulty with coordination: No
Had difficulty with speech: No
Had unusual sensitivity to touch: No
Had difficulty with social skills: No

Was evaluated for taking too much time to develop certain skills (e.g. communicating, reading, spelling, speech, language): No
Severe Illness: No

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Education/Vocation

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Highest grade completed: High School Diploma/GED

Current Literacy Level:proficient

Are you currently involved in school or a vocational training program? No

Special Ed:

Are you currently employed? No

If NO, are you currently looking for work? No

Any barriers to obtaining employment?

Primary Source of Income: Family/Relative

Do you receive disability income? No

What kind?

Are you receiving any financial support or assistance from state or federal entitlement programs (i.e. TANF, child support, food stamps)?
None

Do you gamble? No

Have you ever felt the need to bet more and more money? No

Has anyone ever expressed concern over how much you gamble? No

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Substance Use

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Complete the UNCOPE SCREENING for adults or the CRAFFT SCREENING for children:

SUBSTANCE RELATED DISORDERS- SCREENING FOR ADULTS

UNCOPE SCREENING (Age 18 and Above) (Hoffman, N.G. Retrieved from http://www.evinceassessment/UNCOPE_for_web.pdf)

1. **In the past year, have you ever drunk or used drugs more than you meant to? OR have you spent more time drinking or using than you intended to?**

2. **Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?**

3. **Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?**

4. **Has anyone objected to your drinking or drug use? OR has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use?**

5. **Have you ever found yourself preoccupied with wanting to use alcohol or drugs? OR have you found yourself thinking a lot about drinking or using?**

6. **Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?**

(Two or more positive responses indicate possible abuse or dependence. Four or more positive responses strongly indicate dependence.)

COMPLETE the Standard Assessment Substance Use Table, If TWO OR MORE responses are YES.

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Legal Issues

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Legal history and involvement (custody/guardianship, arrests, probation, court-ordered treatment):
No

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Mental Status

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Oriented: person, place, time, situation.
Appearance: clean.
Level of Consciousness: alert.
Eye Contact: good.
Concentration: good.
Motor Activity: normal.
Speech: normal.
Memory: immediate intact, short-term intact, long-term intact.
Affect: appropriate.
Mood: depressed.
Thought Process: logical.
Thought Content: grandiosity.
Hallucinations: none reported.
Judgment and Impulse Control: partial.
Insight: fair.

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Risk Assessment

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Have you ever thought about harming yourself or someone else? 0

Have you ever harmed/injured yourself or someone else intentionally? 0

Does the person demonstrate symptoms that suggest a risk for DTS, withdrawal, seizures, overdose or toxic use that may require immediate interventions? No

In terms of other potential risk factors, does the person appear:

Malnourished: No
Dehydrated: No
Dirty/malodorous: No
At risk of exposure to the elements: No

Considering the responses to the above risk factors in combination with all the other information you know about the person (e.g., gender, age, diagnosis, balancing factors, resiliency and supports), would you rate the level of risk for this person as:

Risk of Harm to Self: Low Risk
Risk of Harm to Others: Low Risk

Please explain your rating:

Client denies any past or current SI/HI

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Overall Impressions

Client Name: Jeffrey Bodin
Date of Birth: 05/22/1997

Overall Impressions: (Narrative)

The client is a 20 y/o Caucasian male who presented to this office as a referral from his parents. The client arrived on time and was appropriately dressed. He presented with an anxious mood and flat affect. The client reported that following presenting symptoms: Depression: sadness, isolation, fatigue, lack of motivation
Anxiety: stress, racing thoughts. The client reported that his relationship with his mother is strained. He stated that she tries to irritate him. He stated that he is convinced that she has "mental health issues." The client denied any psychotic symptoms, however, the client did present with grandiosity and possibly paranoia. The parents reported that the client is "very paranoid" and is convinced that his parents "are out to get him." He reported that his parents steal his mail and invade his personal life. The client was diagnosed with cancer at the age of 10. He described how at the age of 12 he was diagnosed with Peripheral Neuropathy and Narcolepsy. The client
reported that when he is on a stimulant, like Adderall, he is able to function and be sociable. He stated that his mother took him off of his medications and now he struggles not to sleep 12 + hours a day. The client denies any substance abuse or legal issues. He reported that he did graduate high school but he did not make good grades because he was unable to attend regularly or spend time studying because he was always too tired. The client is not employed and lives with his mother, father and sister. Staff will need to further evaluate to discover if client is appropriate for EPIC program.
Treatment Recommendations:

Need	Disposition	Recommendations	Preferences
Depression/Anxiety	Address	Individual therapy and medication management (possible EPIC program)	Medication managment

Diagnostic Impressions

Axis I:	DSM -IV	ICD-10	DSM -V	Specifiers
.	ECB96329-D43D-420 9-8D67-FF4AFA8B8A5 D	F32.9	Unspecified depressive disorder	

Axis II:Axis III: NONE
Significant recent losses as of 10/31/2017:
Axis V: NONE

Headrick LPC, James
Provider

11/09/2017
Date

***For Behavioral Health Professional Signatures see ComAsmtAffidavit**

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Initial and/or Change in Diagnosis

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Modified Date: 11/10/2017 08:03 AM
Modified By: James Headrick LPC

Mental Heath Diagnosis

Dx Code	Dx Description	Specifier
F32.9	Unspecified depressive disorder	

Significant recent losses as of 10/31/2017

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Evaluation and Diagnosis Note

Client:Jeffrey Bodin
Date of Birth:05/22/1997
Date of Service:11/09/2017
Provider Name:James Headrick LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90791 Units: 1

Met with client .

Discussed agency HIPAA Privacy Notice with client/guardian and obtained signature(s). Advanced Directives discussed with client/guardian and documentation provided.

Completed Comprehensive Assessment. Highlights are as follows: Client actively participated in his assessment and tx plan See Assessment for details.

Interim Service Plan completed.

Dx Code	Dx Description	New/Continuing
F32.9	Unspecified depressive disorder	Continuing

Electronically signed by: James Headrick LPC /s/ 11/10/2017 08:12 AM
Signature Date

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Initial and/or Change in Diagnosis

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Modified Date: 10/31/2017 10:59 AM
Modified By: Ashleigh Castro MS LPC

Mental Heath Diagnosis

Dx Code	Dx Description	Specifier
F32.9	Unspecified depressive disorder	

Significant recent losses as of 10/31/2017

Sinfonía
Family Services of Louisiana

MRN #: 000000001984

Progress Note

Client Name:Jeffrey Bodin
Date of Birth: 05/22/1997
Date of Service:10/31/2017
Provider Name:Ashleigh Castro MS LPC

09:00 AM to 10:00 AM Duration: 60 min
Service Code: 90837 Units: 1

Data

This session was held at office with the following person(s) in attendance: Client,

Objectives Addressed: Initial session - tx plan deferred

Discussion and Interventions: Therapist met with client for initial intake session in which therapist talked about EPIC-NOLA services. Client talked openly about how he does not have issues with mental health; however, he reports that his mother has disclosed to him that she has "paranoid schizophrenia". He talked about the challenges that he has with her and how he is adamant that she is not to have access to his medical records. Client was agreeable to consenting for services in order for psychiatrist to complete formal psyc eval to determine the best next step.

Assessment

Dx Code	Dx Description	New/Continuing
F32.9	Unspecified depressive disorder	New

Clt presented with sx of frustration Barriers to progress are possibly family interference. Mood appears to be congruent Affect is appropriate to content

Client has no SI/HI Ideation.

Progress

Initial session. Established rapport.

Plan

Return in 1 - 2 weeks.

No homework given today.

Electronically Signed By: Ashleigh Castro MS LPC /s/
Provider

10/31/2017 11:00 AM
Date

INSERT THIS END FIRST

Please include this barcode cover sheet as the first page of each set of documents returned.

Fax the evidence to this fax number:

(877)559-1922

RQID:0000006 0000000000225487053 SITE:Y32 DR:S
SSN:436958926 DOCTYPE:5032 RF:D CS:e162

Claimant: Jeffrey T Bodin
SSN: 436-95-8926

Ashley Weiss, DO, MPH
6/14/18
Sleep disorders RFC

§233.2 Form: Sleep Disorders Residual Functional Capacity Questionnaire

TO: Dr. Weiss

RE: Jeffrey Bodin

SSN: 436-95-8926

Please answer all the following questions concerning your patient's sleep disorders and other health problems. *Attach all relevant treatment notes, laboratory and test results that have not been provided previously to the Social Security Administration.*

1. Date began treatment: DX 2015 with me 10/2017 Frequency of tx: Month with Psychiatry Weekly with therapist

2. Diagnoses: Narcolepsy

3. Prognosis: Fair

4. Identify your patient's **symptoms and signs:** Hypnopompic phenomenon & sleep paralysis

☐ Cataplexy	☐ Sinus arrhythmia	☑ Hypnogogic phenomenon
☐ Insomnia	☐ Extreme bradycardia	☐ Ventricular tachycardia
☐ Atrial flutter	☐ Sleep paralysis	☑ Excessive daytime sleepiness
☐ Cognitive problems	☐ Automatic behavior	☐ Hypercapnia
☐ Hypoxia	☐ Pulmonary insufficiency	☐ Obesity

☐ Sleep apnea: A. ☐ obstructive B. ☐ central C. ☐ mixed

☑ Other: Narcolepsy

5. Does your patient exhibit **recurrent daytime sleep attacks**? ☐ Yes ☑ No sleepiness

If yes, He doesn't experience "attacks" but chronic

A. Can these attacks occur suddenly and in hazardous conditions (e.g., driving, while exposed to heights or moving machinery)? ☐ Yes ☑ No Pt doesn't drive

B. **How often** do these **attacks** typically occur: _____ per day or _____ per week or _____ per month

C. For **how long** does your patient typically sleep with each attack?_____

D. Identify situations that can precipitate attacks:
☐ Quiet ☐ Sleep disturbance ☐ Exertion ☐ Repetitive activity
☐ Side effects of medications ☐ Other _____

E. If your patient was working and has a sleep attack, would the attack likely disrupt the work of coworkers or supervisors in your patient's vicinity?
☐ Yes ☐ No

6. Identify positive clinical findings and test results (e.g., multiple sleep latency test, MSLT, MWT, REM testing, EEG, polysomnographic studies, etc.):
MSLT x2 → Narcolepsy dx
EEG

7. If your patient experiences symptoms that interfere with the **attention and concentration** needed to perform even simple work tasks, during a typical workday, please estimate the **frequency** of interference: ☐ rarely ☐ occasionally ☐ frequently ☑ constantly

For this and other questions on this form, "rarely" means 1% to 5% of an eight-hour working day; "occasionally" means 6% to 33% of an eight-hour working day; "frequently" means 34% to 66% of an eight-hour working day.

8. If your patient was placed in a competitive job, identify those aspects of **workplace stress** that your patient would be **unable to perform** or be exposed to:
☐ Public contact
☑ Routine, repetitive tasks at consistent pace
☑ Detailed or complicated tasks
☑ Strict deadlines
☐ Close interaction with coworkers/supervisors
☑ Fast paced tasks (e.g., production line)
☑ Exposure to work hazards (e.g., heights or moving machinery)
☐ Other:_____

9. Identify any **side effects** of medications that may have implications for working:
☐ Drowsiness/sedation ☐ Other: No side effects

10. Have your patient's impairments lasted or can they be expected to last at least twelve months? ☑ Yes ☐ No

11. As a result of your patient's impairment(s), estimate your patient's functional limitations assuming your patient was placed in a *competitive work situation* on an ongoing basis:

A. How many city blocks can the patient **walk** without rest or severe pain? ≈1

B. Please circle the hours and/or minutes that your patient can *continuously* **sit and stand** *at one time:*

1. **Sit:** 0 5 10 15 20 30 45 Minutes 1 2 More than 2 Hours
1 minute
What must your patient usually do after sitting this long? Fall asleep

☐ walk ☐ stand ☑ lie down ☐ other: _____

2. **Stand:** 0 5 10 20 30 45 Minutes 1 2 More than 2 Hours
What must your patient usually do after standing this long? ≈2 minutes

☐ walk ☑ sit ☑ lie down ☐ other: _____

C. Please indicate how long your patient can sit and stand/walk *total in an eight-hour work day* (with normal breaks)?

Sit	Stand/Walk	
☐	☑	Less than 2 hours
☐	☐	About 2 hours
☐	☐	About 4 hours
☐	☐	At least 6 hours

D. If your patient's symptom(s) would likely cause the need to take unscheduled **breaks** to rest during an average eight-hour workday,

1) **How many times** during an average workday do you expect this to happen?
0 1 2 3 4 5 6 7 8 9 10, more than 10

2) **How long** (on average) will your patient have to rest before returning to work? Less than 5, 5 10 20 30 45 Minutes; 1 2 more than 2 Hours

3) What symptom(s) cause a need for breaks?
☑ Daytime sleep attacks
☐ Chronic fatigue ☐ Adverse effects of medication
☐ Other: Chronic Sleepiness

E. How many pounds can the patient **lift and carry** in a competitive work situation?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.		☑	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☑	☐	☐	☐
50 lbs.	☑	☐	☐	☐

F. State the degree to which your patient should avoid the following:

ENVIRONMENTAL RESTRICTIONS:	NO RESTRICTION	AVOID CONCENTRATED OR EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Driving			✓
Heights			✓
Moving dangerous machinery			✓
Working alone without supervision			✓
Power tools			✓
Routine, repetitive tasks			✓

G. Please estimate, on average, how often your patient is likely to be **absent** from work as a result of the impairment(s) or treatment:

☐ Never/less than once a month
☐ About once or twice a month
☐ About three days a month
☐ About four days a month
☐ About five days a month
☑ More than five days a month

12. We understand your patient exhibits a sleep disorder, not a seizure disorder. However, Social Security describes a seizure disorder that it considers disabling as follows:

> 11.03 Epilepsy—Minor motor seizures (petit mal, psychomotor, or focal), occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment. With alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.

In your opinion, is your patient's sleep disorder in combination with any other impairments **at least as medically severe** as the condition described above? ☐ Yes ☑ No

If yes, please explain: _____

_____

13. Please describe any other limitations that would affect your patient's ability to work at a regular job on a sustained basis or any testing that would help to clarify the severity of your patient's impairment(s) or limitations:

_____

_____

_____

Date: 12/14/2018

Signed: _____

Print Name: Ashley Wiss

Address: 4000 Bienville St
Suite 6
New Orleans LA
70119

PHYSICAL MEDICAL SOURCE STATEMENT

Name and Title of Provider: Psychiatrist (Only MH 8)
Patient's Name: Mr. Jeffrey Bodin
Patient's SSN: 436-95-8926

Please answer the following questions regarding your patient's impairments:

1. Nature, frequency, and length of contact: Monthly for Med management
2. Diagnoses: Narcolepsy
3. Prognosis: FAIR
4. Symptoms: excessive daytime Sleep/fatigue
5. Clinical findings and objective signs of complaints: appears very sleepy/dark circles/very thin
6. Is your patient a malingerer? ☐ Yes ☒ ~~No~~
7. How often are your patient's symptoms/pain severe enough to interfere with concentration and attention? (occasional = up to 1/3 of day, frequent = 1/3 to 2/3 of day, constant = 2/3 of day or more)
   ☐ Never ☐ Occasionally ☐ Frequently ☒ ~~Constantly~~
8. Have your patient's impairments lasted or can be expected to last at least 12 months? ☒ ~~Yes~~ ☐ No
9. Approximately how many days per month your patient is likely to be absent from work as a result of his or her impairment or treatment?
   ☐ Never ☐ About three days per month
   ☐ One to two days per month ☒ ~~Four or more~~ days per month
10. Please estimate your patient's functional abilities if he/she were placed in a **competitive work situation:**
    (occasional = up to 1/3 of day, frequent = 1/3 to 2/3 of day, constant = 2/3 of day or more)
    a. How many city blocks can your patient walk without rest or severe pain? ≈1
    b. Standing at one time: ☒ ~~15 minutes~~ ☐ 30 minutes ☐ 1 hour ☐ 2 hours ☐ Other: _____
    c. Sitting at one time: ☐ 15 minutes ☒ ~~30 minutes~~ ☐ 1 hour ☐ 2 hours ☐ Other: _____
    d. Hours patient can work per day: ☒ ~~1 hour~~ ☐ 2 hours ☐ 4 hours ☐ Other: _____
    e. Lifting on an **occasional** basis: ☐ None ☒ ~~5lbs~~ ☐ 10lbs ☐ 20lbs ☐ Other: _____
    f. Lifting on a **frequent** basis: ☒ None ☐ 5lbs ☐ 10lbs ☐ 20lbs ☐ Other: _____
    g. Bending ☐ Never ☒ ~~Occasionally~~ ☐ Frequently ☐ Constantly
    h. Stooping ☐ Never ☒ ~~Occasionally~~ ☐ Frequently ☐ Constantly

i. Rotate neck ☐ Never ☐ Occasionally ☑ Frequently ☐ Constantly
j. Look up/down ☐ Never ☐ Occasionally ☑ Frequently ☐ Constantly

11. Would your patient sometimes need to take unscheduled breaks during an 8-hour work day? ☑ Yes ☐ No

If yes, 1) how often do you think this will happen? at least 1/HR daily
2) how long, on average, will your patient have to take a break? Rest/sleep
3) what will your patient need to do on these breaks? patient tends to fall asleep every 2 min.

12. Would your patient need a job that will permit shifting from sitting/standing/walking at will? ☐ Yes ☐ No N/A

13. With prolonged sitting, should your patient's leg(s) be elevated? ☐ Yes ☑ No

If yes, 1) how high should his/her legs be elevated? _____
2) what percentage of the time in an 8-hour day should they be elevated? _____

14. Does your patient have any limitations in reaching, handling, or fingering? ☐ Yes ☐ No

If yes, please explain: _____

15. Please describe any other limitations (e.g. psychological issues, obesity, vision or hearing problems, need to avoid temperature extremes or dust/gases/fumes) that would affect your patient's ability to work a full-time job on a sustained basis:

Psychological frustration
2/2 chronic/severe
sleep disorder

16. In your opinion, would any of this patient's symptoms or conditions interfere with his/her ability to perform work for eight-hours per day? If so, please explain:

Yes - he falls asleep
every 1-2 minutes.
even c treatment

Date: 6/14/18

Signature: [signature]

Printed/typed name: A. WEISS

Address: 4000 Bienville
Suite 6
New Orleans LA
70119

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
THE LAW OFFICES OF JAMES S. CONNER

I hereby authorize Ashley Weiss, DO, MPH to disclose the following protected health information (PHI) from the medical records of the patient listed to:

Requestor Name: Law Office of James S. Conner
Requestor Address: 2237 Florida Street, Suite D
Mandeville, LA 70448

Patient Name: Mr. Jeffrey Bodin

Patient DOB: 5/22/1997

Patient SS# 436-95-8926

✓ Entire Chart	___ History & Physical	___ Discharge Summary	___ Consult
___ Operative Report(s)	___ Progress Notes	___ Admit Summary	___ Nurses Notes
___ ER Report(s)	___ Lab	___ X-ray/MRI/CT/Bone Scan	___ Abstract/Pertinent
✓ Other Specified	From: 1-1-17		
	To: 6-14-18		

The above information is disclosed for the purpose of obtaining Social Security Disability Benefits.

- A PHOTOCOPY OF THIS AUTHORIZATION MAY SERVE AS AN ORIGINAL.
- I understand that I have the right to revoke this authorization at any time and must do so in writing to the above facility, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- I understand that I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I have the right to receive a copy of this form after I sign it.
- This authorization shall expire one year from the date on which it was signed or upon the issuing of a favorable Decision for Social Security Disability benefits.

The following information will be released when included in the above information unless you indicated otherwise:

___ AIDS or HIV test results
___ Psychiatric or Mental Care treatment
___ Alcohol, Drug or Substance Abuse treatment
___ other (please specify)_____.

I have read the above and authorize the disclosed of this protected health information as stated.

Jeffrey Bodin 6/14/18
Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient _____

[signature] 6/14/18
Signature of Witness Date

Updated 03/2015

Sinfonía Family Services of Louisiana **Psychiatric Progress Note**

MRN #: 000000001984

Encounter Date: 11/29/2017 **No billing for service**
Provider:
Patient Name: **Jeffrey Bodin** DOB: 05/22/1997 Age: 20 Years

Reason for Treatment:
Presenting issues/Chief Complaint: FEP evaluation
Depression: sadness, isolation, fatigue, lack of motivation
Anxiety: stress, racing thoughts.
Grandiosity, possible paranoia.

20 yo WM, referred for psychiatric evaluation for admission to EPIC-NOLA, CSC services for first-episode psychosis.
He presents alone.
20 Year-old M here for initial psychiatric evaluation for the Early Psychosis Intervention Clinic-NOLA (EPIC -NOLA). Referred from Convington Behavioral Health after his mom wanted him to go 'he is delusional'...she thought he was suicidal, 'I wasn't'. States his mom has been 'abusive'. Has multiple complaints about mom. He says the program was an addiction program, he was referred here and he is not sure why. He denies ANY sxs of psychosis, denies any prodromal psychotic sxs. Was at Northlake 1 week, dc on Oct 19.
Dx with Narcolepsy-'after cancer diagnosis'. Was on Adderall 30mg po TID this summer and felt he was more functional'was happy, motivated, social, eating well, sleeping at night. Had been on Adderall 40mg po TID last year. Was on 6 months this year, has been on it in the past. PCP was prescribing. But before this, his neurologist at Ochsner was prescribing, and mom refused to take him back there bc she does not like Adderall.
Denied having any sxs of depression. Denies ever feeling suicidal. Denies any attempts. Denies SIB. 'Ive only tried to survive and be happy'. He feels mom assumes he is depressed bc sleeps all the time. Dx with Narcolepsy at Ochsner and at M.D. Anderson. 2008 was dx with stage 3 melanoma. He feels his mom and dad have not reacted as he would have liked. Has many bad memories of his mom during his treatment. c/o not feeling like mom has enough food in house, that she can become violent, he has called police on her multiple times for her being scary-tells him she wants him to suffer; mother steals mail; controlling. Gets hysterical. Cops come and they separate them. Says mom demands to talk to docs, doesn't give him autonomy.
ROS: Denies past/present sxs psychosis, depression, anxiety, mania. Denies any PTSD sxs. Has preoccupation with medical issues. Denies any SI/no hx aggression.
Duration untreated psychosis estimate: n/a
SH: no learning issues, missed middle school a lot bc of cancer tx, feels he was passed along; high school was similar; ACT was 29 composite with Adderall after dx with Narcolepsy. Feels friendships decreased after cancer treatment (2/2 poor energy, etc); Senior year after treatment for Narcolepsy, felt increase in friendships, bc energy to do things (Slept 6-7 hours a day throughout school). +physical/emotional trauma; has never worked, graduated to HS; wants to move out; wants to have independent life; no real hobbies right now; no intimate relationship now. Has a 17 yo sister. 'Im not awake enough to know her well'. Don't interact with them much. Feels he was yelled at for having narcolepsy.

Psych Hx: See above/Narcolepsy; was at Northlake in October'was OPC by mom for SI'was accused of overdosing, he denies, relates it all to his mom's misperceptions; they referred him to Covington Behavioral Health; had seen a psychiatrist after cancer'was on Prozac, he didn't want to be on it; Dr Blendell at Madisonville; doesn't see him frequently but has seen him continuously for awhile
Family Psych Hx: Pt says mom says she is 'paranoid schizophrenic'. " I try to stay out of her life medically".
PMH: Hx Melanoma/Narcolepsy/Seizures 2/2 meds/ has 'low threshold for seizures'; endo work up in 2010 for growth hormone'gained 6 inches in height; had Achilles tendonitis/ was always behind on growth chart; was premature, unknown details; had genetic work up for cancer; butalbital for migraines at one time; last oncology appointment this summer
Surg Hx: March/April (lymphectomy L leg)/May 2008 (Cancer txs/Appendicitis); PIC line procedures; wisdom teeth out 2015
Allergies: NKDA

Review of Systems:
Initial Consultation

Ears, Nose, Throat:	Negative	
Constitutional:	Negative	
Cardiovascular:	Positive	Additional Detail: small
Endocrine:	Negative	
Gastrointestinal:	Negative	
Genitourinary:	Negative	
Hematological:	Negative	
Immunologic:	Negative	
Musculoskeletal:	Negative	
Respiratory:	Negative	
Skin/Breast:	Negative	
Eyes:	Negative	
Neurological:	Positive	Additional Detail: narcolepsy sxs
Psychiatric:	Positive	Additional Detail: see HPI

Histories:
Initial Consultation

Past Medical History
Past Medication:
Developmental History:
History of injury, illness, and seizures: See HPI
Meds Reported at Intake:

Medication	Reason
singulair	
mirtazapine	

Social History
See HPI

Medication Effectiveness and Side Effects: No meds currently Rx'd at this agency. n/a

Medical Data:

Vitals

Date	Time	BP	Ht Ft	Ht In	Ht Date	Wt Lb	Wt Context	Pulse	BMI
11/29/2017	1:19 PM	129/65	5.0	7.00		107.00		80	16.76

Allergies to Medications:
nkda

Substance Use:
No history of drug treatment reported.

Current Meds: No meds currently prescribed at this agency.

Axis I - DSM -IV		DSM -V	
F32.9	ECB96329-D43D-4209-8D67-FF4AFA8B8A5D	F32.9	Unspecified depressive disorder
G47.429	Narcolepsy secondary to another medical condition	G47.429	Narcolepsy secondary to another medical condition
Z62.820	Parent child relational problem	Z62.820	Parent child relational problem
F54	Psychological factors affecting other medical conditions	F54	Psychological factors affecting other medical conditions

Axis III: NONE
Axis III: NONE
Axis IV: Problems with/related to primary support group, access to health care services, family,
Axis V: NONE

Assessment:
Pt is 20 year-old WM here after referral for EPIC-NOLA. Presents with sxs c/w severe relationship disturbances, possible paranoia? But low on my differential as it being a psychotic process. Has complex medical history, and dx Narcolepsy, currently not treated. Most concerning sxs at this time are his complaints about being abused-emotionally, physically in past. Pt is not appropriate for this coordinated specialty care service for first-episode psychosis bc not psychotic. Needs expert in Narcolepsy. His story seems very logical, but has some mild depressive sxs which may be intermixed, but a lot is situational, perhaps adjustment related.
From a case formulation standpoint, biologically at psychosis risk bc mother possibly having illness (genetic), and also his own medical experiences. He apparently has documented sleep studies, all records, which will be reviewed. Psychologically, has not had typical developmental trajectory due to emotional abuse, and cancer, has severe problems with trust for mom, somatically preoccupied likely bc of these developmental issues . Socially. At this time, pt is functioning at a pretty low level, related to untreated medical issues, as well as lack of independence. Will help hom access medicaid transport to get him to Neuro appointments

Recommendations/Treatment Plan:
1.No medication at this point
2.Need to gather collateral from past and review medical records
3.Try and staff about psychosocial issues and help develop a plan
4.Will read up on APS and see if report should be made
5.RTC 6-8 wks or sooner if needed
6.ER or 911 for emergencies
7. Needs narcolepsy specialist

Treatment Plan:

MDM - Problem Points

Problem	Plan Desc	Problem Detail	NatureDesc
depressive sxs		New to Examiner	Stable
medical illness		New to Examiner	Worsened
psychosocial stressors		New to Examiner	Worsened

Problem	Chonic Acute	Workup	Notes
depressive sxs	Chronic	Additional Workup Planned	
medical illness	Chronic	Additional Workup Planned	
psychosocial stressors	Chronic	Additional Workup Planned	

Medical Decision Making (data points):

_X Obtained history from someone other than the patient OR made decision to obtain records

_X Reviewed evaluations/consultations from PCP or Specialist

_X Reviewed clinical lab tests

_X Reviewed and summarized records and obtained records and or had a discussion with another health care provider

Risk: High Risk

Date: 07/17/2018 01:29 PM

Sinfonía Family Services of Louisiana **Psychiatric Progress Note**

MRN #: 000000001984

Encounter Date: 01/03/2018 **No billing for service**
Provider:
Patient Name: **Jeffrey Bodin** DOB: 05/22/1997 Age: 20 Years

Reason for Treatment:
Presenting issues/Chief Complaint:
Original reason for referral (CC per mom) Depression: sadness, isolation, fatigue, lack of motivation
Anxiety: stress, racing thoughts.
Grandiosity, possible paranoia.

20 yo WM, referred for psychiatric evaluation for admission to EPIC-NOLA, CSC services for first-episode psychosis.
He presents alone. Here for first follow-up. Was concrned about mom wanting to come in to appointment. We discussed whats been going over the past month. He feels his 'narcolepsy' being untreated is still the main issue, leading to fatigue, low energy, low motivation. Denies feeling guilt, denies sxs related to depression, attributes everything to narcolepsy. Sleeping about 18 hours a day at least. Discussed boundaries of confidentiality.

Mom comes in per pt permission. She asks multiple questions about my diagnostic impressions, and frequently refers to his 'break' in October, where she describes him feeling unsafe around her, she does not know why, she describes 'bizarre spending' like buying a bunch of copy paper and envelopes. Describes all of this happening surrounding his decision to not go to college, how this was a huge shock for the family and 'his doctor and psychologist'. She feels his Adderall dose was too high, bc it made him have all of these bizarre behaviors (including perceiving things different than reality, i.e., that he thought she tried to break down his door with an ax)
It is important to note during this interview, they were augumentative the entire time. Argued about semantics concerning past cancer diagnosis. Required frequent redirection. Very maladaptive dynamic. His sory against hers typer of feel.
His father has apparently made it clear that he cannot be on Adderall while living in their house. Pt says he will be made 'homeless' if he gets 'adequate treatment for my narcolepsy.

Psychotherapy: Spent >60 min; family dynamics addressed, attempted to help them establish some communication boundaries. Minimal progress made except he identified to her that he feels hurt when she and dad yell at him, and feels scared.

PFSH updates: Still a lot of tension in the house
No mnew medical updates besides him making effort to look for neurologist

Pertinent info from initial eval: Referred from Convington Behavioral Health after his mom wanted him to go 'he is delusional'...she thought he was suicidal, 'I wasn't'. States his mom has been 'abusive'. Has multiple complaints about mom. He says the program was an addiction program, he was referred here and

he is not sure why. He denies ANY sxs of psychosis, denies any prodromal psychotic sxs. Was at Northlake 1 week, dc on Oct 19.
Dx with Narcolepsy-'after cancer diagnosis'. Was on Adderall 30mg po TID this summer and felt he was more functional'was happy, motivated, social, eating well, sleeping at night. Had been on Adderall 40mg po TID last year. Was on 6 months this year, has been on it in the past. PCP was prescribing. But before this, his neurologist at Ochsner was prescribing, and mom refused to take him back there bc she does not like Adderall.
Denied having any sxs of depression. Denies ever feeling suicidal. Denies any attempts. Denies SIB. 'Ive only tried to survive and be happy'. He feels mom assumes he is depressed bc sleeps all the time. Dx with Narcolepsy at Ochsner and at M.D. Anderson. 2008 was dx with stage 3 melanoma. He feels his mom and dad have not reacted as he would have liked. Has many bad memories of his mom during his treatment. c/o not feeling like mom has enough food in house, that she can become violent, he has called police on her multiple times for her being scary-tells him she wants him to suffer; mother steals mail; controlling. Gets hysterical. Cops come and they separate them. Says mom demands to talk to docs, doesn't give him autonomy.
ROS: Denies past/present sxs psychosis, depression, anxiety, mania. Denies any PTSD sxs. Has preoccupation with medical issues. Denies any SI/no hx aggression.
Duration untreated psychosis estimate: n/a
SH: no learning issues, missed middle school a lot bc of cancer tx, feels he was passed along; high school was similar; ACT was 29 composite with Adderall after dx with Narcolepsy. Feels friendships decreased after cancer treatment (2/2 poor energy, etc); Senior year after treatment for Narcolepsy, felt increase in friendships, bc energy to do things (Slept 6-7 hours a day throughout school). +physical/emotional trauma; has never worked, graduated to HS; wants to move out; wants to have independent life; no real hobbies right now; no intimate relationship now. Has a 17 yo sister. 'Im not awake enough to know her well'. Don't interact with them much. Feels he was yelled at for having narcolepsy.
Psych Hx: See above/Narcolepsy; was at Northlake in October'was OPC by mom for SI'was accused of overdosing, he denies, relates it all to his mom's misperceptions; they referred him to Covington Behavioral Health; had seen a psychiatrist after cancer'was on Prozac, he didn't want to be on it; Dr Blendell at Madisonville; doesn't see him frequently but has seen him continuously for awhile
Family Psych Hx: Pt says mom says she is 'paranoid schizophrenic'. " I try to stay out of her life medically".
PMH: Hx Melanoma/Narcolepsy/Seizures 2/2 meds/ has 'low threshold for seizures'; endo work up in 2010 for growth hormone'gained 6 inches in height; had Achilles tendonitis/ was always behind on growth chart; was premature, unknown details; had genetic work up for cancer; butalbital for migraines at one time; last oncology appointment this summer
Surg Hx: March/April (lymphectomy L leg)/May 2008 (Cancer txs/Appendicitis); PIC line procedures; wisdom teeth out 2015
Allergies: NKDA

Review of Systems:

Reviewed, WITH Changes		
Ears, Nose, Throat:	Negative	
Constitutional:	Negative	
Cardiovascular:	Positive	Additional Detail: small
Endocrine:	Negative	
Gastrointestinal:	Negative	
Genitourinary:	Negative	
Hematological:	Negative	
Immunologic:	Negative	
Musculoskeletal:	Negative	
Respiratory:	Negative	
Skin/Breast:	Negative	
Eyes:	Negative	

Neurological: Positive Additional Detail: narcolepsy sxs
Psychiatric: Positive Additional Detail: see HPI

Histories:
Reviewed with Changes

Past Medical History
Past Medication:
Developmental History:
History of injury, illness, and seizures: See HPI
Meds Reported at Intake:

Medication	Reason
singulair	
mirtazapine	

Social History
See HPI

Medication Effectiveness and Side Effects: No meds currently Rx'd at this agency. n/a

Medical Data:
Vitals

Date	Time	BP	Ht Ft	Ht In	Ht Date	Wt Lb	Wt Context	Pulse	BMI
01/03/2018	2:37 PM	128/59	5.0	7.00	11/29/2017	107.00		77	16.76

Allergies to Medications:
nkda

Substance Use:
No history of drug treatment reported.
Explained risks of use/abuse of substances while taking Rx meds.

Current Meds: No meds currently prescribed at this agency.

Axis I - DSM -IV		DSM -V	
F32.9	ECB96329-D43D-4209-8D67-FF4AFA8B8A5D	F32.9	Unspecified depressive disorder
G47.429	Narcolepsy secondary to another medical condition	G47.429	Narcolepsy secondary to another medical condition
Z62.820	Parent child relational problem	Z62.820	Parent child relational problem
F54	Psychological factors affecting other medical conditions	F54	Psychological factors affecting other medical conditions

Axis II: NONE
Axis III: NONE
Axis IV: Problems with/related to primary support group, access to health care services, family,

Axis V: NONE

Assessment: Pt is 20 year-old WM here for first follow up. Re-assessment is not consistent with medical intervention for a psychiatric issue-I think severe psychological issues at play, personality disorder high on differential. Possibly could benefit from Wellbutrin or something activiating, however in light of confirmed Narcolepsy diagnosis, this is my priority in helping to facilitate some improvement in his physical and emotional functioning. There are strong factors at play however between this dyad which are interferring with this proccess. Of course keeping more severe mental illness in the differential is necessary given mom's reports. At this time, clinically he shows a lot of regressed, immature behavior, defenses against feeling out of control as a child, and currently.
Recommending Family therapy
Will help facilitatet Neurologist
Continue individual therapy to address his own strengths/weaknesses, anxieties
No acute issues
Continue to consult with his therapist
6.ER or 911 for emergencies
RTC 4-8 weeks, consider discharge

Pertinent info from initial formulation:
Presents with sxs c/w severe relationship disturbances, possible paranoia? But low on my differential as it being a psychotic process. Has complex medical history, and dx Narcolepsy, currently not treated. Most concerning sxs at this time are his complaints about being abused-emotionally, physically in past. Pt is not appropriate for this coordinated specialty care service for first-episode psychosis bc not psychotic. Needs expert in Narcolepsy. His story seems very logical, but has some mild depressive sxs which may be intermixed, but a lot is situational, perhaps adjustment related.
From a case formulation standpoint, biologically at psychosis risk bc mother possibly having illness (genetic), and also his own medical experiences. He apparently has documented sleep studies, all records, which will be reviewed. Psychologically, has not had typical developmental trajectory due to emotional abuse, and cancer, has severe problems with trust for mom, somatically preoccupied likely bc of these developmental issues . Socially. At this time, pt is functioning at a pretty low level, related to untreated medical issues, as well as lack of independence. Will help hom access medicaid transport to get him to Neuro appointments

Treatment Plan:

MDM - Problem Points

Problem	Plan Desc	Problem Detail	NatureDesc
mood		Established to Examiner	Stable
narcolepsy		Established to Examiner	Stable
PCRP		Established to Examiner	Worsened

Problem	Chonic Acute	Workup	Notes
mood	Chronic	Additional Workup Planned	
narcolepsy	Chronic	Additional Workup Planned	
PCRP	Chronic	Additional Workup Planned	

Medical Decision Making (data points):

_X_ Obtained history from someone other than the patient OR made decision to obtain records

_X_ Reviewed and summarized records and obtained records and or had a discussion with another health care provider

Risk: High Risk

Date: 07/17/2018 01:30 PM

Sinfonía
Family Services of Louisiana

Progress Note
~~Initial Psychiatric Evaluation~~

DOB: ____

Client ID _____

Patient Name: Jeffrey Bodin Date: 2/15/18

HISTORY

CHIEF COMPLAINT/REASON FOR ENCOUNTER:
Narcolepsy, Mood f/u

HPI *(1-3 elements - Brief; 4+ elements – Extended)*
Pt here alone. Got RCP Rx for Adderall but needed Pt to never started. Reports still feeling sleepy has trouble c ADLs 2/2 sleepiness. ≈ 10 hours a day. Mood is low - he attrib
Elements: Location, Quality, Severity, Duration, Timing, Content, Modifying Factors, Associated Signs & Symptoms Narcolepsy.

PAST, FAMILY, SOCIAL HISTORY (PFSH) ___ Check if no change *(1 history area – Pertinent; 2-3 history areas – Complete)*
*still c family conflict, dependent on them apartment financially, considering school in July "OK" Looks thin. Anxious about future b/c feels he will not be able to fxn. ⊕ catastrophic ⊕ dysthymia. ⊕ anxiety in presence of family ⊕ hopelessness given his feeling of dysfunct

REVIEW OF SYSTEMS & ACTIVE MEDICAL PROBLEMS **NOTES IF POSITIVE**
(1 system - Problem Pertinent; 2-9 systems – Extended; 10 or more systems or some systems noted as "all others negative" - Complete)

1. Constitutional	pos ✓	neg ___	fatigue
2. Eyes	pos ___	neg ___	
3. Ears/Nose/Mouth/Throat	pos ___	neg ___	
4. Cardiovascular	pos ___	neg ___	
5. Respiratory	pos ___	neg ___	
6. Gastrointestinal	pos ___	neg ___	
7. Genitourinary	pos ___	neg ___	
8. Muscular	pos ___	neg ___	
9. Integumentary	pos ___	neg ___	
10. Neurological	pos ___	neg ___	
11. Endocrine	pos ___	neg ___	
12. Hemotologic/Lymphatic	pos ___	neg ___	
13. Allergies/Immune	pos ___	neg ___	

Past Psychiatric History: (outpatient psychiatric and counseling, psychiatric hospitalization, residential, including successes and issues with treatment)

Past Medical/Surgical History:
Narcolepsy

Past Family/Social History (PFSH):
1. Family Psychiatric/Medical History
2. Developmental History
3. Social History
4. Trauma History

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Family Services of Louisiana

Initial Psychiatric Evaluation

Client ID _____

Risk of Harm: ☐ High ☐ Moderate ☐ Low
Suicidal Ideation: ☐ Intent ☐ Plan ☐ Means ☐ None reported
Homicidal Ideation: ☐ Intent ☐ Plan ☐ Means ☐ None reported
Other risk behaviors:
Describe:

Substance Use/Addictive Behaviors: (past and present, type, route, prescription misuse, illicit, prior treatment, legal/financial issues related)

Medications:

Allergies:

Personal Strengths:

PSYCHIATRIC SPECIALTY EXAMINATION

(1-5 bullets- Problem Focused; at least 6 bullets Expanded Problem Focused; at least 9 bullets - Detailed; all bullets- Comprehensive Exam)

- Vital Signs (any 3 or more of the 7 listed): 115/76 P66 Patient personally examined: ✓ Yes __ No

Blood Pressure: (Sitting/Standing) 115/65 (Supine) 115/76

Temp_____ Pulse (Rate/Regularity) _____ Respiration _____ Height 5'4" Weight _____

- General Appearance and Manner: (e.g., development, nutrition, body habitus, deformities, attention to grooming)

Thin
decent grooming / looks tired

- Musculoskeletal: ~~Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) (note any atrophy or abnormal movements)~~

(and/or) ✓ Examination of gait and station WNL

- Speech: Check if normal: ~~rate~~ ~~volume~~ ~~articulation~~ ~~coherence~~ ~~spontaneity~~ (note abnormalities; e.g., perseveration, paucity of language) monotone at times

- Thought processes: Check if normal: ✓ associations __ processes __ abstraction __ computation

perseverative on some issues

- Description of associations (e.g., loose, tangential, circumstantial, intact):

intact

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Family Services of Louisiana

Initial Psychiatric Evaluation

Client ID ________

- Description of abnormal or psychotic thoughts (e.g., hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, obsessions): ØAVH

Suicidal ideation: __Present ✓ Absent Homicidal ideation: __Present ✓ Absent Violent ideation: __Present ✓ Absent

- Description of patient's judgment and insight: Judge - fair insight - fair
- Orientation: x3
- Memory (Recent/Remote):
- Attention/Concentration: intact / Redirectable
- Language:
- Fund of knowledge: __intact __inadequate
- Mood and affect: Mood - dysphoric Affect constricted
- Other Findings (e.g. cognitive screens, etc.): mostly cooperative, is able to tolerate my confronting his thinking style

MEDICAL DECISION MAKING

Diagnoses	Data
Axis I-V: ① Depressive D/O 2/2 GMC Rule outs: ② Illness Anxiety D/O Formulation ③ Narcolepsy	Medical Records/Labs/Diagnostic Tests Reviewed Narcolepsy records reviewed

Has had ⊕ response to adderall. Having access to care issues at this point I will go ahead (next pg) (PTO)

Problem/Condition	Treatment Plan
Problem/Condition: ✓ New ✓ Established Status: ___Improving ✓ Worsening Comorbidities: __~~Stable~~ ✓ Complications/side effects ✓ Independent management required ✓ Interference with management of primary condition(s)	Intervention/Psychotherapy Medication ① Adderall 10 BID #60 ② Wellbutrin XL 150 qam Labs/Radiology/Tests/Consultation Referral to facilitate Other Neurology

__Greater than 50% of time spent in counseling/coordination of care (document) Start therapy at Metairie next week

Next Appointment Timeframe: ☐ 1 week ☑ 1 month ☐ 3 mos ☐ 6 mos ☐ other:

12/6/2012 Am Psychiatric Assoc

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Family Services of Louisiana

Initial Psychiatric Evaluation

Client ID ________

PSYCHOTHERAPY Provided? ☑ Yes ☐ No Pt participate

Notes: (content, interventions, response to therapy, plan)
CBT strategies exploring sxs
Building foundation to explore all/nothing thinking
as it relates to present self

Start Time: 9:15 ~~90833~~	End Time: 9:15–10 ~~90836~~	E&M and/or CPT Code:

A Weiss — Physician Name (Print)
[signature] — Physician Signature
2/15/18 10:45 AM — Date and Time

and initiate Adderall 10 BID for Narcolepsy as bridge to Neuro appt. Also d/w him mood/anxiety c̄ its Rel'ship to medical issues. He is open to non sedating antidepressant. Will Start Wellbutrin XL 150mg qam. RBSE d/w pt. He is in agreement c̄ tx plan. Advised I would be ONLY provider of stimulant. No acute issue.
He downloaded HeadSpace – will do 10min mindfulness practice daily. Track sleep/wake time daily.
RTC 4wk or sooner if needed.

Need signature

Sinfonia
Family Services of Maine

INFORMED CONSENT TO RECEIVE MEDICATION

CLIENT NAME: Jeffrey Bodin Date of Birth: _____

I, _____, hereby authorize physician(s) and or licensed designee(s) of Sinfonia Family Services of Maine, Inc. to prescribe the following listed medication(s).

PO Medication:	Adderall	Dosage:	10 BID
PO Medication:	Wellbutrin XL	Dosage:	150 qam
PO Medication:		Dosage:	
PO Medication:		Dosage:	
PO Medication:		Dosage:	
PO Medication:		Dosage:	
PO Medication:		Dosage:	
PO Medication:		Dosage:	

As a part of the treatment of my psychiatric condition, I understand the information, which has been explained to me in simple, non-technical language by Dr. Weiss, or his/her agent, _____, and acknowledge that I have had the opportunity to discuss to my satisfaction the medications I have been prescribed and the proposed course and length of treatment. I also have been informed of the nature, purpose, and beneficial effects of the medication, reasonable, foreseeable risks or side effects, food drug interactions, potential interactions with over the counter medications, and possible alternative treatment methods. If applicable, no guarantee can be made that the above medications are safe during pregnancy. Taking these medications may cause fetal abnormalities, miscarriage, excretion in breast milk, or other unforeseen complications during pregnancy. The nature of my mental and physical condition has also been discussed with me and I have been offered the opportunity to review any questions I may have. I have been informed of the possible consequences of remaining untreated, including the occurrence, increase or re-occurrence of symptoms of mental illness, and the risks and possible complications of any alternatives presented. To guide in the explanation of side effects, I have specifically discussed with the physician or his/her agent the risk of potentially irreversible symptoms of tardive dyskinesia and the relevant side effects of the medication(s) being prescribed including any side effects which are known to frequently occur in most individuals, and any side effects to which I may be pre-disposed. I have been made aware to advise staff immediately if any adverse side effects occur. I do understand that I may request additional information from the dispensing pharmacy, or consult the Physicians' Desk Reference for further details about the medication(s) prescribed.

My patient rights have been reviewed and I do understand that I am under no obligation to take this (these) medication(s) and that I may decide to stop taking it (them) at any time without negative actions on the part of the staff. Should I decide to do so, I will notify the above named physician, agent or Sinfonia Family Services of Maine, Inc. staff promptly. I do understand and acknowledge that the physician may not be able to anticipate or explain all risks and potential complications of treatment and no guarantees have been made to me as to the results that may be obtained. Further, an undesirable result does not necessarily indicate an error in judgment, and I am willing to accept the risk involved.

DATE: _____ PATIENT'S SIGNATURE: _____

DATE: _____ PARENT/GUARDIAN SIGNATURE: _____

☐ Parent ☐ Guardian ☐ Guardian Advocate ☐ Healthcare Proxy ☐ Healthcare Surrogate

DATE: _____ WITNESS' SIGNATURE: _____

Original: May, 2015.

Sinfonía Family Services of Louisiana **Psychiatric Progress Note**

MRN #: 000000001984

Encounter Date: 03/14/2018 **No billing for service**
Provider:
Patient Name: **Jeffrey Bodin** DOB: 05/22/1997 Age: 20 Years

Reason for Treatment:
Presenting issues/Chief Complaint: Narcolepsy,
Original reason for referral (CC per mom) Depression: sadness, isolation, fatigue, lack of motivation
Anxiety: stress, racing thoughts.
Grandiosity, possible paranoia.

20 yo WM, referred for psychiatric evaluation for admission to EPIC-NOLA, CSC services for first-episode psychosis. Here for follow-up.
He presents alone.
Last visit I started Wellbutrin XL 150mg po qam. Also started Adderall 10mg po BID. Is taking every day.
He denies side effects. Denies worsening appetite. Denies worsened anxiety. Denies N/V.
Parents havent said anything about him being on medication. Has not had living situation threatened.
Denies any effect from the medication. Denies any increase in energy, still sleeping as much, not motivated, no improvement in concentration.
Sleeping about 15-18 hours a day. Still feels sleep deprived even when awake.
GOal when feeling better=have friends again. Enjoying his weekly therapy. Doesnt feel much has changed with interactions with patients.
Pts mom comes in (pt OK with it)
Mom comes in-wants to know details. I explained our treatment plan.

Psychotherapy: Spent 20 min with pt; motivational interviewing with some behavioral activation, to get him into routine; pt participates with some mild resistance

PFSH updates: Chronic severe dynamic tension in the house
No new medical updates
Still seeking neurology

Pertinent info from initial eval: Referred from Convington Behavioral Health after his mom wanted him to go 'he is delusional'...she thought he was suicidal, 'I wasn't'. States his mom has been 'abusive'. Has multiple complaints about mom. He says the program was an addiction program, he was referred here and he is not sure why. He denies ANY sxs of psychosis, denies any prodromal psychotic sxs. Was at Northlake 1 week, dc on Oct 19.
Dx with Narcolepsy-'after cancer diagnosis'. Was on Adderall 30mg po TID this summer and felt he was more functional'was happy, motivated, social, eating well, sleeping at night. Had been on Adderall 40mg po TID last year. Was on 6 months this year, has been on it in the past. PCP was prescribing. But before this, his neurologist at Ochsner was prescribing, and mom refused to take him back there bc she does not like Adderall.

Denied having any sxs of depression. Denies ever feeling suicidal. Denies any attempts. Denies SIB. 'Ive only tried to survive and be happy'. He feels mom assumes he is depressed bc sleeps all the time. Dx with Narcolepsy at Ochsner and at M.D. Anderson. 2008 was dx with stage 3 melanoma. He feels his mom and dad have not reacted as he would have liked. Has many bad memories of his mom during his treatment. c/o not feeling like mom has enough food in house, that she can become violent, he has called police on her multiple times for her being scary-tells him she wants him to suffer; mother steals mail; controlling. Gets hysterical. Cops come and they separate them. Says mom demands to talk to docs, doesn't give him autonomy.
ROS: Denies past/present sxs psychosis, depression, anxiety, mania. Denies any PTSD sxs. Has preoccupation with medical issues. Denies any SI/no hx aggression.
Duration untreated psychosis estimate: n/a
SH: no learning issues, missed middle school a lot bc of cancer tx, feels he was passed along; high school was similar; ACT was 29 composite with Adderall after dx with Narcolepsy. Feels friendships decreased after cancer treatment (2/2 poor energy, etc); Senior year after treatment for Narcolepsy, felt increase in friendships, bc energy to do things (Slept 6-7 hours a day throughout school). +physical/emotional trauma; has never worked, graduated to HS; wants to move out; wants to have independent life; no real hobbies right now; no intimate relationship now. Has a 17 yo sister. 'Im not awake enough to know her well'. Don't interact with them much. Feels he was yelled at for having narcolepsy.
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Surg Hx: March/April (lymphectomy L leg)/May 2008 (Cancer txs/Appendicitis); PIC line procedures; wisdom teeth out 2015
Allergies: NKDA

Depression: sadness, isolation, fatigue, lack of motivation
Anxiety: stress, racing thoughts.
Grandiosity, possible paranoia.

Review of Systems:
Reviewed, WITH Changes

Ears, Nose, Throat:	Negative	
Constitutional:	Negative	
Cardiovascular:	Positive	Additional Detail: small
Endocrine:	Negative	
Gastrointestinal:	Negative	
Genitourinary:	Negative	
Hematological:	Negative	
Immunologic:	Negative	
Musculoskeletal:	Negative	
Respiratory:	Negative	
Skin/Breast:	Negative	
Eyes:	Negative	
Neurological:	Positive	Additional Detail: narcolepsy sxs
Psychiatric:	Positive	Additional Detail: see HPI

Histories:
Reviewed with Changes

Past Medical History
Past Medication:
Developmental History:
History of injury, illness, and seizures: See HPI
Meds Reported at Intake:

Medication	Reason
singulair	
mirtazapine	

Social History
See HPI

Medication Effectiveness and Side Effects: No meds currently Rx'd at this agency. n/a

Medical Data:
Vitals

Date	Time	BP	Ht Ft	Ht In	Ht Date	Wt Lb	Wt Context	Pulse	BMI
03/14/2018	3:28 PM	119/91	5.0	7.50	11/29/2017	107.00		86	16.51

Allergies to Medications:
nkda

Substance Use:
No history of drug treatment reported.
Explained risks of use/abuse of substances while taking Rx meds.Client demonstrated understanding of the risks of their substance use when combined with their Rx meds.

Current Meds: No meds currently prescribed at this agency.

Axis I - DSM -IV		DSM -V	
F32.9	EC:B96329-D43D-4209-8D67-FF4AFA8B8A5D	F32.9	Unspecified depressive disorder
G47.429	Narcolepsy secondary to another medical condition	G47.429	Narcolepsy secondary to another medical condition
Z62.820	Parent child relational problem	Z62.820	Parent child relational problem
F54	Psychological factors affecting other medical conditions	F54	Psychological factors affecting other medical conditions

Axis III: NONE
Axis III: NONE
Axis IV: Problems with/related to primary support group, access to health care services, family,
Axis V: NONE

Assessment: Pt is 20 year-old WM here for follow up. Will increase stimulant to address narcolepsy, as well as Wellbutrin XL to address mood. Continue family dynamic issues. Need to get to narcolepsy specialistWill help facilitatet Neurologist (next appoinment in June)
Continue individual therapy to address his own strengths/weaknesses, anxieties
No acute issues
Continue to consult with his therapist
ER or 911 for emergencies
RTC 4-8 weeks, consider discharge

Pertinent info from initial formulation:
Presents with sxs c/w severe relationship disturbances, possible paranoia? But low on my differential as it being a psychotic process. Has complex medical history, and dx Narcolepsy, currently not treated. Most concerning sxs at this time are his complaints about being abused-emotionally, physically in past. Pt is not appropriate for this coordinated specialty care service for first-episode psychosis bc not psychotic. Needs expert in Narcolepsy. His story seems very logical, but has some mild depressive sxs which may be intermixed, but a lot is situational, perhaps adjustment related.
From a case formulation standpoint, biologically at psychosis risk bc mother possibly having illness (genetic), and also his own medical experiences. He apparently has documented sleep studies, all records, which will be reviewed. Psychologically, has not had typical developmental trajectory due to emotional abuse, and cancer, has severe problems with trust for mom, somatically preoccupied likely bc of these developmental issues . Socially. At this time, pt is functioning at a pretty low level, related to untreated medical issues, as well as lack of independence. Will help hom access medicaid transport to get him to Neuro appointments

Treatment Plan:

Medical Decision Making (data points):
_X Obtained history from someone other than the patient OR made decision to obtain records
_X Reviewed and summarized records and obtained records and or had a discussion with another health care provider
Risk: High Risk

Date: 07/17/2018 01:31 PM

Sinfonía Family Services of Louisiana **Psychiatric Progress Note**

MRN #: 000000001984

Encounter Date: 04/12/2018 **No billing for service**
Provider:
Patient Name: **Jeffrey Bodin** DOB: 05/22/1997 Age: 20 Years

Reason for Treatment:
Presenting issues/Chief Complaint:

Review of Systems:
Reviewed, WITH Changes

Ears, Nose, Throat:	Negative	
Constitutional:	Negative	
Cardiovascular:	Positive	Additional Detail: small
Endocrine:	Negative	
Gastrointestinal:	Negative	
Genitourinary:	Negative	
Hematological:	Negative	
Immunologic:	Negative	
Musculoskeletal:	Negative	
Respiratory:	Negative	
Skin/Breast:	Negative	
Eyes:	Negative	
Neurological:	Positive	Additional Detail: narcolepsy sxs
Psychiatric:	Positive	Additional Detail: see HPI

Histories:
Reviewed with Changes

Past Medical History
Past Medication:
Developmental History:
History of injury, illness, and seizures: See HPI
Meds Reported at Intake:

Medication	Reason
singulair	
mirtazapine	

Social History
See HPI

Medication Effectiveness and Side Effects: No meds currently Rx'd at this agency. n/a

Medical Data:

Vitals

Date	Time	BP	Ht Ft	Ht In	Ht Date	Wt Lb	Wt Context	Pulse	BMI
04/12/2018	12:34 PM	131/89	5.0	7.00	11/29/2017	107.00		93	16.76

Allergies to Medications:
nkda

Substance Use:
No history of drug treatment reported.

Current Meds: No meds currently prescribed at this agency.

Axis I - DSM -IV		DSM -V	
F32.9	ECB96329-D43D-4209-8D67-FF4AFA8B8A5D	F32.9	Unspecified depressive disorder
G47.429	Narcolepsy secondary to another medical condition	G47.429	Narcolepsy secondary to another medical condition
Z62.820	Parent child relational problem	Z62.820	Parent child relational problem
F54	Psychological factors affecting other medical conditions	F54	Psychological factors affecting other medical conditions

Axis III: NONE
Axis III: NONE
Axis IV: Problems with/related to primary support group, access to health care services, family,
Axis V: NONE

Assessment: Pt is 20 year-old WM here for follow up. Will increase stimulant to address narcolepsy, as well as Wellbutrin XL to address mood. Continue family dynamic issues. Need to get to narcolepsy specialistWill help faciliatet Neurologist (next appoinment in June)
Continue individual therapy to address his own strengths/weaknesses, anxieties
No acute issues
Continue to consult with his therapist
ER or 911 for emergencies
RTC 4-8 weeks, consider discharge

Pertinent info from initial formulation:
Presents with sxs c/w severe relationship disturbances, possible paranoia? But low on my differential as it being a psychotic process. Has complex medical history, and dx Narcolepsy, currently not treated. Most concerning sxs at this time are his complaints about being abused-emotionally, physically in past. Pt is not appropriate for this coordinated specialty care service for first-episode psychosis bc not psychotic. Needs expert in Narcolepsy. His story seems very logical, but has some mild depressive sxs which may be intermixed, but a lot is situational, perhaps adjustment related.
From a case formulation standpoint, biologically at psychosis risk bc mother possibly having illness (genetic), and also his own medical experiences. He apparently has documented sleep studies, all records, which will be reviewed. Psychologically, has not had typical developmental trajectory due to emotional abuse, and cancer, has severe problems with trust for mom, somatically preoccupied likely bc of these developmental issues . Socially. At this time, pt is functioning at a pretty low level, related to untreated

medical issues, as well as lack of independence. Will help hom access medicaid transport to get him to Neuro appointments

Treatment Plan:

Date: 06/21/2018 04:31 PM

MRO
1000 Madison Avenue
Suite 100
Norristown, PA 19403
Ph: (610) 994-7500 Opt. 1
Fx: (610) 962-8421

Medical Records Transmittal

Date: 7/25/2018
Request Number: 22502958
Page Count: 220

Your requested medical records are attached.

Patient Name: JEFFREY BODIN
Medical Facility: Children's Hospital of New Orleans

Requester: Eva Conner
Organization: James S. Conner

Your reference number:

Thank you,
MRO
MROcorp.com

LAW OFFICE
OF
JAMES S. CONNER
895 PARK AVENUE
MANDEVILLE, LA 70448

JAMES S. CONNER – Attorney
EVA D. CONNER – Attorney
TELEPHONE: (985) 626-1002

KIERSTEN PRITCHETT, EDPNA, ADR
BRIAN HENLY, EDPNA
FACSIMILE: (985) 624-8103

June 29, 2018

Children's Hospital
Medical Records Department
200 Henry Clay Ave.
New Orleans, LA 70118

RE: **Jeffrey Bodin**

To Whom It May Concern:

Please be advised that I represent the above named client in a claim for **Social Security Disability Benefits**. I have enclosed a Medical Authorization form signed by my client.

Please send me **any** medical records you may have in connection with my client **specifically, those dated from 10/06/2017 to 06/29/2018.**

If records are available electronically, please send them in electronic format to connerdisability@gmail.com. Please note that under the HITECH Act, if records are available electronically, they MUST be provided in an electronic format. You may not bill for paper copies unless the records are **only** available via paper. If electronic copies are available under the HITECH Act, you may not charge more than your labor costs (a flat fee of not more than $6.50 may be requested in lieu of calculating labor costs). *See* 45 CFR 164.524.

Please note that under the HITECH Act, records **MUST** be received within 30 days of this request. Violations of the HITECH Act's requirements are subject to a penalty of $250,000.

If electronic copies are not available, please advise me in advance of any charge in excess of $20.00 for said records. Please note that Act 1241 of the Louisiana Legislature applies in this case and regulates what can be charged for medical records by healthcare providers in Social Security Disability and/or SSI cases.

Thank you for your cooperation in this matter.

Sincerely,

Eva Conner

EDC/EDC
Enclosure

REQUEST FOR MEDICAL RECORDS PURSUANT TO HITECH ACT

Date: 6/29/2018

RE: **Mr. Jeffrey Bodin**
SSN: 436-95-8926
DOB: 5/22/1997
528 Beau Chene Dr.
Mandeville, LA 70471

Medical Records Technician:

I, Mr. Jeffrey Bodin, pursuant to the HITECH Act, 42 U.S.C.A § 17935 (e)(1), and its implementing regulations, 45 CFR 164.524 (c)(4)(i), am requesting, **in an electronic format only**, a copy of my medical records, as described below:

Name of Medical Provider/Hospital: Children's Hospital

Dates of Service Requested: 10/6/17 to 6/29/18

I hereby direct you to send these records to the following designated third party:

The Law Offices of James S. Conner, LLC
2237D Florida St.
Mandeville, LA 70448
Records can be sent via email to: conner-disability@gmail.com
If prepayment is required, please email or fax to: (985) 624-8103

Please note that a photocopy of this authorization may serve as an original.

I FURTHER AUTHORIZE YOU AND YOUR VENDOR, IF APPLICABLE, TO COMMUNICATE DIRECTLY WITH THE LAW OFFICES OF JAMES S. CONNER, LLC REGARDING ALL ISSUES RELATED TO THIS REQUEST INCLUDING AUTHORIZATION OF THE COST BASED CHARGES AND THE TIME FRAME FOR PROVIDING THE RECORDS TO THE OFFICE.

Sincerely yours,

Jeffrey Bodin

Mr. Jeffrey Bodin

If signed by representative of patient, relationship to patient: _____

EXHIBIT NO. 19F
PAGE: 4 OF 221

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Mr. Jeffrey Bodin	436-95-8926
Wage Earner (If Different)	Social Security Number

Part I CLAIMANT'S APPOINTMENT OF REPRESENTATIVE

I appoint this person, Eva Conner - 2237-D Florida St Mandeville LA 70448 Law Ofc James Conner (Name and Address)
to act as my representative in connection with my claim(s) or asserted right(s) under:

☒ Title II (RSDI) ☒ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☒ I appoint, or I now have, more than one representative. My main representative is
Eva Conner (Name of Principal Representative)

Signature (Claimant)	Address
Jeffrey Bodin	528 Beau Chene Dr. Mandeville, LA 70471
Telephone Number (with Area Code)	Fax Number (with Area Code) / Date
(985)520-4713	4/25/18

Part II REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I, Eva Conner, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☒ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☒ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☒ No

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address
Eva Conner	2237 Florida Street, Suite D, Mandeville, LA 70448
Telephone Number (with Area Code)	Fax Number (with Area Code) / Date
(985)626-1002	(985)624-8103 / 4/25/18

Part III FEE ARRANGEMENT

(Select an option, sign and date this section.)

☒ **I am charging a fee and requesting direct payment of the fee from withheld past-due benefits.** *(SSA must authorize the fee unless a regulatory exception applies.*

☐ **I am charging a fee but waiving direct payment of the fee from withheld past-due benefits** --I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** --By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **I am waiving fees from any source** --I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date
Eva Conner	4/25/18

Form SSA-1696-U4 (07-2014) ef (07-2014)
Use Prior Editions Until Exhausted

FILE COPY

MRO

JUL 02 2018

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Children's Hospital ATTN Medical Records	Eva Conner
FAX NUMBER: (844)240-6577	DATE: June 29, 2018
COMPANY:	TOTAL NO. OF PAGES INCL. COVER: 4
PHONE NUMBER:	

RE:
Mr. Jeffrey Bodin
SSN: 436-95-8926

URGENT FOR REVIEW PLEASE COMMENT PLEASE REPLY

NOTES/COMMENTS:

THE LAW OFFICES OF JAMES S. CONNER
895 PARK AVENUE
MANDEVILLE, LA 70448
PHONE: 985-626-1002 – FAX: 985-624-8103

FACSIMILE TRANSMITTAL SHEET

TO: MLO
Children's Hospital
ATTN Medical Records

FROM:
Eva Conner

FAX NUMBER:
~~(844)240-6577~~ 8610-962

DATE:
~~June 29, 2018~~ 7/16/18

COMPANY:
8421

TOTAL NO. OF PAGES INCL. COVER:
6

PHONE NUMBER:

RE:
Mr. Jeffrey Bodin
SSN: 436-95-8926

URGENT FOR REVIEW PLEASE COMMENT PLEASE REPLY

hearing 7/18 -

NOTES/COMMENTS:

Please find attached the new authorization, as per your request

THE LAW OFFICES OF JAMES S. CONNER
895 PARK AVENUE
MANDEVILLE, LA 70448
PHONE: 985-626-1002 – FAX: 985-624-8103

EXHIBIT NO. 19F
PAGE: 7 OF 221

MRO
1000 Madison Avenue, Suite 100
Norristown, PA 19403

MRO

Fax: (610) 962-8421
Phone: (610) 994-7500 Opt. 1

Request ID: 22502958
Tracking #: ILPHGH8EEPCAY

Eva Conner
James S. Conner
2237 Florida St
Ste D
Mandeville, LA 70448

Track your request at www.rollog.com.
Enter your Tracking # and Request ID.

Date: 7/12/2018
Phone:
Fax: 985-624-8103

Notice of an Issue Regarding Your Medical Record Information Request

MRO works with your healthcare provider to process requests for copies of medical records on their behalf. There is an issue with your medical record request (see below). In order to resolve this issue; please fax the information requested to MRO at (610) 962-8421. Upon receipt of the requested information, your request will be processed as quickly as possible.

Please note that you may be billed for a search/retrieval fee if you cancel your request.

Should you have any questions, please feel free to contact MRO directly regarding this request by dialing (610) 994-7500 Opt. 1 or by submitting an email to Requestinformation@mrocorp.com.
To help us better assist you, please be sure to include your Request ID in the subject line of your email.

MRO is processing your request in accordance with HIPAA regulations. Please notify the patient that the provision of treatment, payment, enrollment, or eligibility for benefits will not be conditioned on the elements of the authorization provided or your request for copies of the patient's records, unless permitted under 45 CFR 164.508(c)(2)(ii)(A)-(B).

Thank you,
MRO

Patient Name: JEFFREY BODIN

Your Request Date: 6/29/2018
Your Reference Number:
Date Received at Facility: 7/6/2018

Your request is being processed by MRO on behalf of the following facility:

Facility: **Children's Hospital of New Orleans**
200 Henry Clay
New Orleans, LA 70118

ISSUE LIST
Expiration Date/Event Missing The expiration date or event is not listed on the authorization. Please mail or fax an updated authorization to the address or fax number listed above.

ISSUE LIST
Revocation Statement Missing The authorization must state that the individual has a right to revoke, that the revocation must be in writing to the health care provider disclosing the records, and that the revocation will not apply to disclosures made in reliance upon the authorization before it is received by the health care provider. Privacy Rule, 45 C.F.R. § 164.508(c)(2).
Redisclosure Statement Missing The authorization must state that information disclosed pursuant to the authorization may be redisclosed by the recipient and no longer protected by the HIPAA Privacy Rule, 45 C.F.R. § 164.508(c)(2).
Authorization Required by Provider The provider requires an authorization signed by the patient for the disclosure of the records requested. Please mail or fax an authorization to the address or fax number listed above.

LAW OFFICE
OF
JAMES S. CONNER
895 PARK AVENUE
MANDEVILLE, LA 70448

JAMES S. CONNER – Attorney
EVA D. CONNER – Attorney
TELEPHONE: (985) 626-1002

KIERSTEN PRITCHETT, EDPNA, ADR
BRIAN HENLY, EDPNA
FACSIMILE: (985) 624-8103

June 29, 2018

Children's Hospital
Medical Records Department
200 Henry Clay Ave.
New Orleans, LA 70118

RE: **Jeffrey Bodin**

To Whom It May Concern:

Please be advised that I represent the above named client in a claim for **Social Security Disability Benefits**. I have enclosed a Medical Authorization form signed by my client.

Please send me **any** medical records you may have in connection with my client **specifically, those dated from 10/06/2017 to 06/29/2018.**

If records are available electronically, please send them in electronic format to connerdisability@gmail.com. Please note that under the HITECH Act, if records are available electronically, they MUST be provided in an electronic format. You may not bill for paper copies unless the records are **only** available via paper. If electronic copies are available under the HITECH Act, you may not charge more than your labor costs (a flat fee of not more than $6.50 may be requested in lieu of calculating labor costs). *See* 45 CFR 164.524.

Please note that under the HITECH Act, records **MUST** be received within 30 days of this request. Violations of the HITECH Act's requirements are subject to a penalty of $250,000.

If electronic copies are not available, please advise me in advance of any charge in excess of $20.00 for said records. Please note that Act 1241 of the Louisiana Legislature applies in this case and regulates what can be charged for medical records by healthcare providers in Social Security Disability and/or SSI cases.

Thank you for your cooperation in this matter.

Sincerely,

Eva Conner

EDC / EDC
Enclosure

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
THE LAW OFFICES OF JAMES S. CONNER

I hereby authorize Children's Hospital to disclose the following protected health information (PHI) from the medical records of the patient listed to:

Requestor Name: Law Office of James S. Conner
Requestor Address: 895 Park Ave
Mandeville, LA 70448

Patient Name: Mr. Jeffrey Bodin

Patient DOB: 5/22/1997

Patient SS# 436-95-8926

___ Entire Chart	___ History & Physical	✓ Discharge Summary	___ Consult
___ Operative Report(s)	___ Progress Notes	✓ Admit Summary	___ Nurses Notes
___ ER Report(s)	___ Lab	✓ X-ray/MRI/CT/Bone Scan	✓ Abstract/Pertinent
✓ Other Specified	From: 10-6-17		
	To: 6-29-18		

The above information is disclosed for the purpose of obtaining Social Security Disability Benefits.

- A PHOTOCOPY OF THIS AUTHORIZATION MAY SERVE AS AN ORIGINAL.
- I understand that I have the right to revoke this authorization at any time and must do so in writing to the above facility, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- I understand that I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I have the right to receive a copy of this form after I sign it.
- This authorization shall expire one year from the date on which it was signed or upon the issuing of a favorable Decision for Social Security Disability benefits.

The following information will be released when included in the above information unless you indicated otherwise:

___ AIDS or HIV test results
___ Psychiatric or Mental Care treatment
___ Alcohol, Drug or Substance Abuse treatment
___ other (please specify)_____

I have read the above and authorize the disclosed of this protected health information as stated.

Jeffrey Bodin _____ 6/29/18 _____
Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient _____

_____ 6/29/18 _____
Signature of Witness Date

Updated 03/2015

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Mr. Jeffrey Bodin	436-96-8926
Wage Earner (If Different)	Social Security Number

Part I CLAIMANT'S APPOINTMENT OF REPRESENTATIVE

I appoint this person, Eva Conner - 2237-D Florida St Mandeville LA 70448 Law Ofc James Conner (Name and Address)
to act as my representative in connection with my claim(s) or asserted right(s) under:

☒ Title II (RSDI) ☒ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☒ I appoint, or I now have, more than one representative. My main representative is Eva Conner (Name of Principal Representative)

Signature (Claimant)	Address
Jeffrey Bodin	528 Beau Chene Dr. Mandeville, LA 70471
Telephone Number (with Area Code) (985)520-4713	Fax Number (with Area Code) / Date 4/25/18

Part II REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I, Eva Conner, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☒ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☒ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☒ No

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address
Eva Conner	2237 Florida Street, Suite D, Mandeville, LA 70448
Telephone Number (with Area Code) (985)626-1002	Fax Number (with Area Code) (985)624-8103 / Date 4/25/18

Part III FEE ARRANGEMENT

(Select an option, sign and date this section.)

☒ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.*

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits --I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** --By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **I am waiving fees from any source** --I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date
Eva Conner	4/25/18

Form SSA-1696-U4 (07-2014) ef (07-2014)
Use Prior Editions Until Exhausted

FILE COPY

CC Payment Receipt

Transaction Status:	**Approved**
Transaction Date and Time:	**7/25/2018 4:52:04 PM**
Transaction Reference No.:	**1359723**
Approval Code:	**0001311451**
Order Number:	**22502958**
Charge Amount:	**$53.50**
Credit Card Number:	**XXXXXXXXXXXX5955**
Credit Card Holder:	**James S Conner Jr**

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/23/18

Allergies as of 5/23/2018

Not on File

Medical History

Medical as of 5/23/2018 **None**

Surgical as of 5/23/2018 **None**

Family as of 5/23/2018 **None**

Family Status as of 5/23/2018 **None**

Tobacco Use as of 5/23/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Assessed								Unknown	

Alcohol Use as of 5/23/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments

Drug Use as of 5/23/2018

Drug Use	Source	Types	Frequency	Comments

Sexual Activity as of 5/23/2018

Sexually Active	Source	Birth Control	Partners	Comments

Social ADL as of 5/23/2018 **None**

ADL Question	Response	Comments	Source

Social Doc as of 5/23/2018 **None**

Occupational as of 5/23/2018 **None**

Socioeconomic as of 5/23/2018

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				
Preferred Language	**Ethnicity**	**Race**		
English	Non-Hispanic	White or Caucasian		

Birth **None**

Current Immunizations — Never Reviewed

No immunizations on file.

Not reviewed this visit

Diagnoses

	Comments
Malignant melanoma, unspecified site	

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/23/18

Diagnoses (continued)

Orders and Results

All Orders and Results

No orders and results found

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Call Information

	Provider	Department	Center
5/23/2018 2:40 PM	Jodi Scallan	Chno Hemonc	CHNO ACC 1st

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/24/2018, D/C: 5/24/2018

Admission Information - Patient Record Only

Arrival Date/Time:		Admit Date/Time:	05/24/2018 1245	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	LCMC SERVICE AREA	Unit:	Children's Hospital Hematology and Oncology
Admit Provider:		Attending Provider:		Referring Provider:	Dana Marie Leblanc, MD

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
05/24/2018 1341	Home Or Self Care	None	None	Children's Hospital Hematology and Oncology

Patient Demographics

Name	Patient ID	SSN	Sex	Birth Date
Bodin, Jeffrey	1002548110	xxx-xx-8926	Male	05/22/97 (21 yrs)

Address	Phone	Email	Employer
528 BEAU CHENE DR MANDEVILLE LA 70471	985-272-8989 (H) 985-520-4713 (W) 985-272-8989 (M)	jeffreybodin713@gmail.com	

County	Race	Occupation	Emp Status
SAINT TAMMANY	White or Caucasian	-	-

Reg Status	PCP
Verified	Chno Zzzprovider, MD

HAR	Admission Date	Discharge Date	Admitting Provider
10071512	05/24/18	05/24/18	

Marital Status	Religion	Language
Single	Lutheran	English

Emergency Contact 1
Jeffrey Bodin (Other)
528 BEAU CHENE DR
MANDEVILLE LA 70471
985-272-8989 (H)

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
10071512 - BODIN,JEFFREY	AETNA BETTER HEALTH [3501]	None	10071507

LCMC HEALTH MEMBER HOSPITALS
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Scanned Information (continued)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
C43.9 [Principal]	Malignant melanoma of skin, unspecified				

CPT®/HCPCS Codes

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
05/24/18 1245	Hospital Outpatient	Outpatient	CHNO HEMONC		
05/24/18 1341	Discharge	Outpatient	CHNO HEMONC		

Allergies as of 5/24/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Latex	05/24/2018	Allergy	Rash	

Immunizations as of 05/24/18

None

Medical History

Medical as of 5/24/2018

Past Medical History	Date	Comments	Source
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seizure syndrome			Provider

Surgical as of 5/24/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	

Family as of 5/24/2018 **None**

Family Status as of 5/24/2018 **None**

Tobacco Use as of 5/24/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/24/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/24/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

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Scanned Information (continued)

Sexual Activity as of 5/24/2018	Sexually Active	Source Provider	Birth Control	Partners	Comments

Social ADL as of 5/24/2018	ADL Question	Response	Comments	Source
	None			

Social Doc as of 5/24/2018 **None**

Occupational as of 5/24/2018 **None**

Socioeconomic as of 5/24/2018	Marital Status	Spouse Name	Num of Children	Years Education	Source
	Single				
	Preferred Language	Ethnicity	Race		
	English	Non-Hispanic	White or Caucasian		

Birth **None**

Emergency Department Information

ED Arrival Information

Patient not seen in ED

Treatment Team

Not on file

Chief Complaint

Complaint	Comment	Last Edited By	Time	Relationship	ED Provider
Follow-up [110033]		Esther Barrios	5/24/2018 1:19 PM	None	No

Progress Notes - Inpatient Notes

Progress Notes by Dana Marie Leblanc, MD Version 1 of 1 at 5/24/2018 1:41 PM

Author: Dana Marie Leblanc, MD Service: Oncology Author Type: Physician
Filed: 6/18/2018 5:04 PM Date of Service: 5/24/2018 1:41 PM Status: Signed
Editor: Dana Marie Leblanc, MD (Physician)

CHNOLA PEDIATRIC HEMATOLOGY ONCOLOGY CLINIC NOTE

PATIENT: Jeffrey Bodin
MRN: 1002548110
DOB: 5/22/1997

Service: Pediatric Oncology

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Progress Notes - Inpatient Notes (continued)

Progress Notes by Dana Marie Leblanc, MD (continued) Version 1 of 1 at 5/24/2018 1:41 PM

Date of Service: 5/24/2018

IDENTIFICATION / CHIEF COMPLAINT: Jeffrey is a 21 y.o. male with history of stage III metastatic melanoma, with primary lesion to the left ankle and metastasis to the left inguinal nodes. He was treated with interferon and had been off of therapy since October of 2008. His primary oncologist was Dr. Herzog at MD Anderson, and subsequently followed by Dr. Morales at CHNOLA.
Jeffrey also has a history of seizure disorder following interferon therapy and has been followed by Neurology at Ochsner..

HPI: Jeffrey is here today by himself. He states that he has been doing "okay". He has been having some conflict with his apparent recently. He currently lives at home, is not attending school or working due to his disability. He states he is unable to participate normal activities due to his diagnosis of narcolepsy. He is currently using a lower dose of Adderall than was previously prescribed to manage his narcolepsy which has not been effective. He states that his parents have over the past year taking him off of their health insurance and he has since qualified for Medicaid. He states he has had some difficulty obtaining optimal medical care due to with Medicaid status. He has not seen a dermatologist since July of last year. He does now have a therapist that is helping to manage his narcolepsy. He does not have a primary care physician. He has an appointment with a neurologist in September. He has not had any seizures since February of 2016 and is currently not on seizure medications.
When questioned about his shoulder, he mentions that he fell asleep 1 to 2 months ago with his full body weight on his right arm. When he awoke, he was unable to appropriately move his right arm and was experiencing some pain. He states that he is now somewhat improved as he is currently able to put on his shirt without the help of his mother. He states he has been doing some exercises including pushups and lifting 10 lb weight as to try to improve his mobility of his shoulder. He denied significant pain currently. He did not seek medical care due to fear of incurring large medical bills.
He has not noticed any new skin lesions.

REVIEW OF SYSTEMS:
Review of Systems
Constitutional: Negative for chills, fever, malaise/fatigue and weight loss.
HENT: Negative for congestion, ear discharge, ear pain, nosebleeds, sinus pain and sore throat.
Eyes: Negative for blurred vision, double vision and photophobia.
Respiratory: Negative for cough, sputum production and shortness of breath.
Cardiovascular: Negative for chest pain and palpitations.
Gastrointestinal: Negative for abdominal pain, blood in stool, constipation, diarrhea, nausea and vomiting.
Genitourinary: Negative for dysuria, frequency and urgency.
Musculoskeletal: Positive for joint pain (right shoulder pain after sleeping on his arm in a chair) and neck pain. Negative for back pain and myalgias.
Skin: Negative for itching and rash.
Neurological: Negative for dizziness, tingling, tremors, sensory change, speech change, focal weakness and headaches.
Endo/Heme/Allergies: Does not bruise/bleed easily.
Psychiatric/Behavioral: Negative for depression. The patient is nervous/anxious. The patient does not have insomnia **(He carries a diagnosis of narcolepsy and states he is unable to stay awake for more than 4 hours at a time.)**.

LCMC HEALTH MEMBER HOSPITALS
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Progress Notes - Inpatient Notes (continued)

Progress Notes by Dana Marie Leblanc, MD (continued) Version 1 of 1 at 5/24/2018 1:41 PM

ALLERGIES:

Allergies

Allergen	Reactions
• Latex	Rash

PAST MEDICAL HISTORY:

Past Medical History:

Diagnosis	Date
• Clinical trial participant *Zyrem Rems Trial - pt states unsuccessful*	2016
• Migraine-cluster headache syndrome	
• Narcolepsy	02/15/2015
• Peripheral neuropathy	
• Seizure syndrome	

Past Surgical History:

Procedure	Laterality	Date
• WISDOM TOOTH EXTRACTION		2015

No family history on file.

MEDICATIONS:

Prior to Admission medications

Medication	Sig	Start Date	End Date	Taking?	Authorizing Provider
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry	1 spray by Nasal route daily			Yes	Historical Provider, MD
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet	Take 300 mg by mouth daily	5/7/18		Yes	Historical Provider, MD
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet	Take 20 mg by mouth 3 (three) times daily	5/13/18		Yes	Historical Provider, MD
montelukast (SINGULAIR) 10 mg tablet	Take 10 mg by mouth daily	5/7/18		Yes	Historical Provider, MD
naproxen sodium (ALEVE) 220 MG tablet	Take 1,000 mg by mouth 2 (two) times daily with meals			Yes	Historical Provider, MD

Medications reconciled with Medication List.

PHYSICAL EXAM:

Vitals:

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Progress Notes - Inpatient Notes (continued)

Progress Notes by Dana Marie Leblanc, MD (continued) Version 1 of 1 at 5/24/2018 1:41 PM

05/24/18 1319

BP:	(!) 131/85
Pulse:	95
Resp:	18
Temp:	97.6 °F (36.4 °C)
TempSrc:	Oral
Weight:	48.9 kg
Height:	1.697 m

Physical Exam
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished.
HENT:
Head: Normocephalic and atraumatic.
Eyes: Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple.
Cardiovascular: Normal rate and regular rhythm.
No murmur heard.
Pulmonary/Chest: Effort normal. No respiratory distress. He exhibits no tenderness.
Abdominal: Soft. He exhibits no distension. There is no tenderness.
Musculoskeletal: Deformity: **right acromion is prominent and right huleral head is displaced anteriorly**.
Neurological: He is alert and oriented to person, place, and time. No cranial nerve deficit.
Skin: Skin is warm.
Psychiatric:
Appears anxious

Radiology and Ancillary Studies:
CHEST AP AND LATERAL:

The lungs are symmetrically overinflated otherwise clear. Heart size and pulmonary vascularity are within normal limits. Aortic arch is left-sided. Pectus deformity of the chest is more pronounced since 1/5/2015. There is a presternal radiopaque screw projecting along/within the anterior chest wall. The right humeral head appears fractured and anteriorly dislocated. There are mild to moderate anterior wedge compression deformities of 2 midthoracic vertebral bodies which were not evident on prior exam dated 1/5/2015, and there is increased kyphoscoliosis.

IMPRESSION:
Underinflated otherwise clear lungs. Increased pectus deformity with a presternal radiopaque screw projecting along/within the anterior chest wall. Anterior fracture-dislocation of the right humeral head and anterior wedge compression deformities of two mid thoracic vertebral bodies with increased kyphoscoliosis, suspect pathologic fractures. Correlation with right shoulder radiographs and whole body nuclear medicine bone and/or PET/CT scan may be helpful for further characterization if clinically warranted.

Electronically Signed By: David Manning, M.D. 5/24/2018 2:28 PM CDT

Labs:
Hospital Outpatient Visit on 05/24/2018

Component	Date	Value	Ref Range	Status

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Children's Hospital
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Progress Notes - Inpatient Notes (continued)

Progress Notes by Dana Marie Leblanc, MD (continued) Version 1 of 1 at 5/24/2018 1:41 PM

• Sodium	05/24/2018	142	134 - 144 mmol/L	Final
• Potassium	05/24/2018	3.7	3.4 - 5.5 mmol/L	Final
• Chloride	05/24/2018	104	98 - 107 mmol/L	Final
• Carbon Dioxide	05/24/2018	29	20 - 31 mmol/L	Final
• Glucose	05/24/2018	68	65 - 110 mg/dL	Final
• BUN	05/24/2018	15.0	7.0 - 21.0 mg/dL	Final
• Creatinine	05/24/2018	0.80	0.20 - 1.40 mg/dL	Final
• Calcium	05/24/2018	9.8	8.5 - 10.4 mg/dL	Final
• Total Protein	05/24/2018	6.9	6.5 - 8.0 g/dL	Final
• Albumin	05/24/2018	4.5	3.0 - 4.8 g/dL	Final
• AST	05/24/2018	19	8 - 53 U/L	Final
• ALT	05/24/2018	26	7 - 56 U/L	Final
• Alkaline Phosphatase	05/24/2018	113	39 - 253 U/L	Final
• Bilirubin, Total	05/24/2018	0.3	0.3 - 1.3 mg/dL	Final
• EGFR, African American	05/24/2018	>105	>89 mL/min	Final
• EGFR, Non African American	05/24/2018	>105	>89 mL/min	Final
• WBC	05/24/2018	6.08	3.70 - 11.70 10^3/uL	Final
• RBC	05/24/2018	5.20	4.50 - 5.90 10^6/uL	Final
• Hemoglobin	05/24/2018	15.6	13.5 - 17.5 gm/dL	Final
• Hematocrit	05/24/2018	46.9*	35.0 - 46.0 %	Final
• MCV	05/24/2018	90.2	75.0 - 97.0 fL	Final
• MCH	05/24/2018	30.0	24.0 - 32.0 pg	Final
• MCHC	05/24/2018	33.3	31.0 - 35.0 g/dL	Final
• RDW	05/24/2018	11.9	11.5 - 15.4 %	Final
• RDW-SD	05/24/2018	39.3	35.1 - 46.3 fL	Final
• Platelet Count	05/24/2018	318	135 - 450 10^3/uL	Final
• MPV	05/24/2018	9.3	8.6 - 12.4 fL	Final
• nRBC Automated	05/24/2018	0.00	0 10^3/uL	Final
• nRBCs	05/24/2018	0	0 /100 WBC	Final
• Neutrophils Absolute - Instrument	05/24/2018	3.4	1.8 - 7.7 10^3/uL	Final
• Lymphocytes Absolute - Instrument	05/24/2018	2.1	1.2 - 5.2 10^3/uL	Final

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Progress Notes - Inpatient Notes (continued)

Progress Notes by Dana Marie Leblanc, MD (continued) Version 1 of 1 at 5/24/2018 1:41 PM

• Monocytes Absolute - Instrument	05/24/2018	0.5*	0.2 - 0.4 10^3/uL	Final
• Eosinophils Absolute - Instrument	05/24/2018	0.0	0.0 - 0.3 10^3/uL	Final
• Basophils Absolute - Instrument	05/24/2018	0.1*	0.0 - 0.0 10^3/uL	Final
• Neutrophils Percent - Instrument	05/24/2018	55.4	%	Final
• Lymphocytes Percent - Instrument	05/24/2018	34.0	%	Final
• Monocytes Percent - Instrument	05/24/2018	8.6	%	Final
• Eosinophils Percent - Instrument	05/24/2018	0.5	%	Final
• Basophils Percent - Instrument	05/24/2018	1.2	%	Final

IMPRESSION: Jeffrey is a 21 y.o. male history of stage III malignant melanoma of the left ankle with metastatic disease to the left inguinal nodes, status part post interferon therapy. Off therapy since October 2008.
History of seizure disorder status post seizure medications.
History of narcolepsy on stimulant medications (Adderall TID)
Two day with chonic right humeral head fracture and anterior dislocation

PLAN:
Lungs are clear of metastatic disease on chest x-ray today. However, needs referral to Orthopedics for evaluation of humeral head dislocation.
Referral made to Dermatology at UMC for comprehensive skin evaluation due to history of melanoma.
Encouraged Jeffrey to continue follow-up with Neurology and to establish care with a primary PCP. We discussed that Medicaid eligible care is always available through Children's Hospital or UMC.
Jeffrey is applying for disability benefits. He requested a letter stating the status of his melanoma. We will try to get this to him next week.

Dana Marie LeBlanc 5/24/2018 4:13 PM

I spent a total of 60 min attending to this pt. This includes time spent performing a compete history, physical exam, 14 point ROS, review of current medications, explanation of labs and surveillance tests to be done and referral to subspecialists, if necessary. More than 50% of my time was spent on educating, counseling, caretaker abut diagnosis, risks and treatment plan.

Electronically Signed by Dana Marie Leblanc, MD on 6/18/2018 5:04 PM

Patient Instructions - Inpatient Notes

Patient Instructions by Dana Marie Leblanc, MD Version 1 of 1 at 5/24/2018 4:21 PM

Author: Dana Marie Leblanc, MD Service: (none) Author Type: Physician
Filed: 5/24/2018 4:38 PM Date of Service: 5/24/2018 4:21 PM Status: Addendum
Editor: Dana Marie Leblanc, MD (Physician)
Related Notes: Original Note by Esther Barrios (Registered Nurse) filed at 5/24/2018 4:22 PM

Instructed on Return and Follow up Plan including any test times, NPO status and special instructions.

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
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Patient Instructions - Inpatient Notes (continued)

Patient Instructions by Dana Marie Leblanc, MD (continued) Version 1 of 1 at 5/24/2018 4:21 PM

Expressed understanding of: Medication(s) prescribed/administered, need to contact us for fever greater than 100.4 degrees, nausea, vomiting, diarrhea or any other change in status, complications or concerns. Instructed to carry a copy of all current medications to all appointments.

Appointment with Dr. Gonzales tomorrow, 5/25 at 12:45pm (ortho).

Electronically Signed by Dana Marie Leblanc, MD on 5/24/2018 4:38 PM

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All Orders and Results

LCMC HEALTH MEMBER HOSPITALS
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BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/24/2018, D/C: 5/24/2018

Lab - All Orders and Results

CBC with Differential

Status: **Completed**

Order placed as a reflex to CBC with Differential ordered on 05/23/18 at 1444
Ordering user: Jodi Scallan 05/23/18 1444 Ordering provider: Dana Marie Leblanc, MD
Final result (Abnormal)
Resulting lab: LCMC CH LAB

Components

	Value	Flag
WBC	6.08 10^3/uL	
RBC	5.20 10^6/uL	
Hemoglobin	15.6 gm/dL	
Hematocrit	46.9 %	H
MCV	90.2 fL	
MCH	30.0 pg	
MCHC	33.3 g/dL	
RDW	11.9 %	
RDW-SD	39.3 fL	
Platelet Count	318 10^3/uL	
MPV	9.3 fL	
nRBC Automated	0.00 10^3/uL	
nRBCs	0 /100 WBC	
Neutrophils Absolute - Instrument	3.4 10^3/uL	
Lymphocytes Absolute - Instrument	2.1 10^3/uL	
Monocytes Absolute - Instrument	0.5 10^3/uL	H
Eosinophils Absolute - Instrument	0.0 10^3/uL	
Basophils Absolute - Instrument	0.1 10^3/uL	H
Neutrophils Percent - Instrument	55.4 %	
Lymphocytes Percent - Instrument	34.0 %	
Monocytes Percent - Instrument	8.6 %	
Eosinophils Percent - Instrument	0.5 %	
Basophils Percent - Instrument	1.2 %	

CBC with Differential

Electronically signed by: **Jodi Scallan on 05/23/18 1444** Status: **Completed**
Ordering user: Jodi Scallan 05/23/18 1444 Ordering provider: Dana Marie Leblanc, MD
Final result
Resulting lab: LCMC HOSPITAL LABS
Narrative:
The following orders were created for panel order CBC with Differential.

Procedure	Abnormality	Status
CBC with Differential[98042854]	Abnormal	Final result

Please view results for these tests on the individual orders.

Comprehensive Metabolic Panel

Electronically signed by: **Jodi Scallan on 05/23/18 1444** Status: **Completed**

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Lab - All Orders and Results (continued)

Comprehensive Metabolic Panel (continued)

Ordering user: Jodi Scallan 05/23/18 1444 Ordering provider: Dana Marie Leblanc, MD

Final result (Normal)

Resulting lab: LCMC CH LAB

Components

	Value	Flag
Sodium	142 mmol/L	
Potassium	3.7 mmol/L	
Chloride	104 mmol/L	
Carbon Dioxide	29 mmol/L	
Glucose	68 mg/dL	
BUN	15.0 mg/dL	
Creatinine	0.80 mg/dL	
Calcium	9.8 mg/dL	
Total Protein	6.9 g/dL	
Albumin	4.5 g/dL	
AST	19 U/L	
ALT	26 U/L	
Alkaline Phosphatase	113 U/L	
Bilirubin, Total	0.3 mg/dL	
EGFR, African American	>105 mL/min	
EGFR, Non African American	>105 mL/min	

LCMC HEALTH MEMBER HOSPITALS
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Medications

Medication Admin Record

(No medication admins recorded for this encounter)

Medications the Patient Reported Taking

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry (Taking) 1 spray by Nasal route daily Nasal				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet (Taking) Take 300 mg by mouth daily Oral			5/7/2018	
Esther Barrios 5/24/2018 1:26 PM Esther Barrios 5/24/2018 1:25 PM Received from: External Pharmacy				
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet (Taking) Take 20 mg by mouth 3 (three) times daily Oral			5/13/2018	
Esther Barrios 5/24/2018 1:26 PM Esther Barrios 5/24/2018 1:25 PM Received from: External Pharmacy				
montelukast (SINGULAIR) 10 mg tablet (Taking) Take 10 mg by mouth daily Oral			5/7/2018	
Esther Barrios 5/24/2018 1:26 PM Esther Barrios 5/24/2018 1:25 PM Received from: External Pharmacy				
naproxen sodium (ALEVE) 220 MG tablet (Taking) Take 1,000 mg by mouth 2 (two) times daily with meals Oral				

Discharge Instructions

Discharge Instructions

Bodin, Jeffrey (MR # 1002548110)

None

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
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BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/24/2018, D/C: 5/24/2018

Discharge Instructions (continued)

Medication List

As of 5/24/2018 4:41 PM

ASK your doctor about these medications

ALEVE 220 MG tablet Generic drug: naproxen sodium	[ ]
buPROPion 300 MG 24 hr tablet Commonly known as: WELLBUTRIN XL	[ ]
dextroamphetamine-amphetamine 20 mg Tab per tablet Commonly known as: ADDERALL	[ ]
DYMISTA 137-50 mcg/spray Spry Generic drug: azelastine-fluticasone	[ ]
montelukast 10 mg tablet Commonly known as: SINGULAIR	[ ]

Flowsheets

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Flowsheets (all recorded)

Encounter Vitals - Thu May 24, 2018

	1319
Enc Vitals	
BP	**"NONE" 131/85** -EB
Pulse	95 -EB
Resp	18 -EB
Temp	97.6 °F (36.4 °C) -EB
Temp src	Oral -EB
Weight	48.9 kg -EB
Height	1.697 m -EB
Recorded by	[EB] EB 05/24/18 1320
Vital Signs	
BP Patient Position	Sitting -EB
Recorded by	[EB] EB 05/24/18 1320

Custom Formula Data - Thu May 24, 2018

	1319
Height and Weight	
BSA (Calculated - sq m)	1.52 sq meters -EB
Adjusted Body Weight	158.4 -EB
Recorded by	[EB] EB 05/24/18 1320
OTHER	
Shock Index (HR/SBP)	0.73 -EB
BMI (Calculated)	17 -EB
AIBW (Calculated) Female	56.26 kg -EB
IBW/kg (Calculated) Male	65.67 kg -EB
Low Range Vt 6cc/kg MALE	394.02 mL -EB
Adult Moderate Range Vt 8cc/kg MA	525.36 mL -EB
Adult High Range Vt 10cc/kg MALE	656.7 mL -EB
IBW/kg (Calculated) FEMALE	61.17 kg -EB

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Flowsheets (all recorded) (continued)

Custom Formula Data - Thu May 24, 2018 (continued)

	1319
Low Range Vt 6cc/kg FEMALE	367.02 mL -EB
Adult Moderate Range vt 8cc/kg FEMALE	489.36 mL -EB
Adult High Range Vt 10cc/kg FEMALE	611.7 mL -EB
FLOW1.6	2.43 CC/MIN -EB
FLOW1.8	2.74 CC/MIN -EB
FLOW2.0	3.04 CC/MIN -EB
FLOW2.2	3.34 CC/MIN -EB
FLOW2.4	3.65 CC/MIN -EB
FLOW2.8	4.26 CC/MIN -EB
FLOW3.0	4.56 CC/MIN -EB
Cerebral Perfusion flow	1.52 CC/MIN -EB
FLOW1.2	1.82 CC/MIN -EB
FLOW1.4	2.13 CC/MIN -EB
FLOW2.6	3.95 CC/MIN -EB
Percent Weight Change Since Birth	0 -EB
IBW/kg (Calculated)	65.67 -EB
Low Range Vt 6cc/kg	394.02 mL -EB
Adult Moderate Range Vt 8cc/kg	525.36 mL -EB
Adult High Range Vt 10cc/kg	656.7 mL -EB
Recorded by	[EB] EB 05/24/18 1320
Weight and Growth Recommendation	
AIBW (Calculated) Male	58.96 kg -EB
Recorded by	[EB] EB 05/24/18 1320
Relevant Labs and Vitals	
Temp (in Celsius)	36.4 -EB
Recorded by	[EB] EB 05/24/18 1320

Patient Education - Thu May 24, 2018

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/24/2018, D/C: 5/24/2018

Flowsheets (all recorded) (continued)

Patient Education - Thu May 24, 2018 (continued)

1701

Patient Education

Education Provided On:	Follow-up info given re ortho & derm appts -JG
Learner	Patient -JG
Barriers to Patient Learning	No Barriers Noted -JG
Readiness	Acceptance -JG
Method	Explanation;Hand out -JG
Response	Verbalizes Understanding -JG
Recorded by	[JG] JG 05/24/18 1702

Patient Identification - Thu May 24, 2018

1319

OTHER

Patient Identifier	Date of Birth;Name -EB
Recorded by	[EB] EB 05/24/18 1319

Patient Needs Assessment - Thu May 24, 2018

1336

Learning Needs Assessment

Readiness to learn	Accepting -EB
Barriers to Learning	None -EB
Learning Preferences	No preferences -EB
Preferred Language	English -EB
Recorded by	[EB] EB 05/24/18 1336

Screenings - Thu May 24, 2018

1336

Morse Fall Risk

History of Falling	0 -EB
Secondary Diagnosis	0 -EB
Ambulatory Aids	0 -EB
Intravenous Therapy/Infusion	0 -EB
Gait/Transferrin	0 -EB

LCMC HEALTH MEMBER HOSPITALS
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Flowsheets (all recorded) (continued)

Screenings - Thu May 24, 2018 (continued)

	1336
g	
Mental Status	0 -EB
Score	0 -EB
Recorded by	[EB] EB 05/24/18 1337

Pain Assessment - Thu May 24, 2018

	1338
Pain Screening	
Currently in Pain	No/denies -EB
Pain Assessment	0-10 -EB
Pain Score	Zero -EB
Recorded by	[EB] EB 05/24/18 1338

Patient Safety Initial Screen - Thu May 24, 2018

	1337
Suicide Risk Assessment	
Over the past 2 weeks, have you felt down, depressed, or hopeless?	No -EB
Over the past 2 weeks, have you had thoughts of harming/killing yourself?	No -EB
Recorded by	[EB] EB 05/24/18 1337

Pain Assessment - Thu May 24, 2018

	1338
OTHER	
Restart Pain Assessment Timer	Yes -EB
Recorded by	[EB] EB 05/24/18 1338

Vaccine Screen - Thu May 24, 2018

	1338
Pneumococcal Vaccine Screen - Year Round	
Have you ever had a pneumonia	Yes -EB

LCMC HEALTH MEMBER HOSPITALS
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Flowsheets (all recorded) (continued)

Vaccine Screen - Thu May 24, 2018 (continued)

1338

vaccination?	
Recorded by	[EB] EB 05/24/18 1338

Anthropometrics - Thu May 24, 2018

1319

Anthropometrics

Weight Change	0 -EB
Recorded by	[EB] EB 05/24/18 1320

Travel and Exposure Screening - Thu May 24, 2018

1336

Recent Travel Screening

Traveled outside the U.S. in the last month?	No -EB
Recorded by	[EB] EB 05/24/18 1336

Planned Travel Screening

Planned travel outside the U.S. in the next 12 months?	No -EB
Recorded by	[EB] EB 05/24/18 1336

Exposure Screening

Contact with someone with a communicable disease in the last month?	No -EB
Recorded by	[EB] EB 05/24/18 1336

Abuse Indicators - Thu May 24, 2018

1337

Screening

Safe in Home	Other (Comment) states he his having family problems and is currently seeing the psychiatrist regarding this matter. -EB
Recorded by	[EB] EB 05/24/18 1338

User Key (r) = Recorded By, (t) = Taken By, (c) = Cosigned By

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Flowsheets (all recorded) (continued)

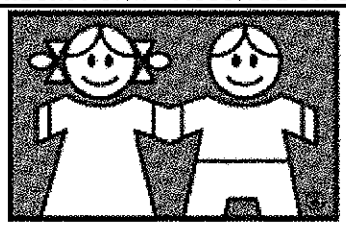
User Key (continued) (r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates	Provider Type	Discipline
EB	Esther Barrios	03/26/18 -	Registered Nurse	Nurse
JG	Jennifer Garvey	03/26/18 -	Registered Nurse	Nurse

Scanned Information

Encounter-Level E-Signatures:

Consent Form - Received on 5/24/2018



CHILDREN'S HOSPITAL

Financial Consent for Examination and Treatment

IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

This Consent for Examination and Treatment applies to referred to as "Provider" hereinafter.

1. Consent to Medical Treatment/Services and Surgical Procedures

I hereby authorize Provider, the provider(s) treating me, and whomever they may select as their assistants, to provide reasonable and necessary medical treatment to me, including but not limited to, emergency care, administration of approved drugs, nursing care, and radiology and pathology services. I understand it is the responsibility of my physician or surgeon to obtain my informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered under the general and special instructions of the physician. I understand that in many instances the physicians and surgeons furnishing services to me are independent contractors and are not employees or agents of Provider. If I am incapacitated and unable to provide my consent and authorization as discussed above, such consent and authorization may be given by any of those persons who are authorized to consent to surgical or medical treatment on my behalf pursuant to La. R. S. 40:1299.53.

2. Specimens

I authorize and consent to the preservation, examination, testing, retention, use, including, without limitation, the use for scientific, diagnostic, therapeutic or educational purposes, or disposal, by Provider, at its discretion, of any specimens, tissues, materials, or substances which may be removed during a diagnostic procedure, therapeutic intervention or medical treatment.

3. Photography

I consent to photographs, videotapes, digital or other images that may be recorded to document my care. I understand that these images may be used for treatment, health care operations, scientific, educational, research, patient identification, or security purposes. I understand that these images will

LCMC HEALTH MEMBER HOSPITALS
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Scanned Information (continued)

Encounter-Level E-Signatures: (continued)

be stored in a secure manner and will only be used for reasons other than those outlined above upon my written authorization, or as otherwise permitted by law.

4. **Telemedicine**

I consent to having some or all of my medical services provided by video or other interactive telecommunication technology as allowed by law. I understand that I may decline to receive medical services via telemedicine or withdraw from such care at any time.

5. **Education**

I have been informed and understand that Provider is a teaching institution and the procedures performed may require observation, cooperation and services of multiple health care providers. I authorize and understand that my care may be provided by student nurses, technicians, therapists, interns, residents, fellows and other providers and observers, which are supervised by qualified faculty and/or personnel, in accordance with policies of the Provider. I also consent to the presence of manufacturer's representative(s) during certain procedure(s) to observe and provide technical consultation to the physician(s) at the discretion and approval of the physician(s) and Provider.

6. **Drugs**

Unless my provider specifies otherwise, I agree and consent to Provider dispensing chemically identical or therapeutically comparable ("generic") drugs from a drug list approved by the Provider's Medical Staff, as part of its formulary system.

7. **Devices**

I consent to disposal of explanted medical device unless I specifically request it to be retained prior to procedure.

8. **No Guarantees**

I acknowledge that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any Medical Treatment/Services.

9. **Blood**

I understand that should any hospital or emergency medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including, without limitation, Hepatitis B and C as well as HIV/AIDS. I understand that I can decline HIV testing if it is for routine screening. I understand that state law requires Provider and/or physician to report certain infectious diseases including sexually transmitted diseases to the state Department of Health.

10. **Waiver of Liability for Loss of Personal Property**

Provider encourages patients and families NOT to store money and valuables at Provider facilities; these items should be left at home or with family members or other caregivers. Some Provider facilities have designated secure areas for the safekeeping of money and valuables (including but not limited to, money, jewelry, documents, fur garments, dentures, eyeglasses, hearing aids, prosthetics, or other personal property). Provider will not be liable for the loss of or damage to any personal property not formally deposited in a designated secure area.

10. **Assignment of Benefits**

I hereby assign and authorize, whether I sign as agent or as Patient, direct payment to Provider and/or

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
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Scanned Information (continued)

Encounter-Level E-Signatures: (continued)

to any hospital based physician of all insurance and health plan benefits, including, but not limited to, federal healthcare program benefits, otherwise payable to or on behalf of me for this hospitalization or for these outpatient services, including emergency services if rendered. It is understood by me that I am financially responsible to Provider for charges not covered by this assignment.

11. Authorization for Healthcare Related Calls, Texts, and E-mails

I authorize Provider, its employees, agents, representatives and/or designees to contact me using prerecorded/artificial voice messages and/or automatic dialing service at any telephone number (including a wireless telephone) that I disclose to Provider. This consent and authorization will apply to text messages sent to the wireless numbers I disclose to Provider as well as emails using any email address that I provide to Provider.

12. Authorization to Release Information

I hereby authorize Provider to obtain my medical information from other health care providers and suppliers as needed for my care and treatment. I authorize Provider to disclose, for review and/or copying, any of my medical information compiled during my admission as may be requested by my insurance company (private or governmental, i.e., Medicare or Medicaid), or other financially liable third party and/or their designated agent(s), for my benefit determinations, payment for services provided to me, and determination of the appropriateness of my admission or continued admission to, and length of stay at Provider location. EXCEPT AS I MAY SPECIFICALLY DIRECT OTHERWISE, I further authorize Provider to disclose my medical information to persons, participating in my care. As discussed above, I understand that some of these providers and suppliers may be independent of Provider. I understand that State and Federal regulations may also require Provider to report information about me for public health or safety purposes including, but not limited to, reporting to immunization registries.

I further understand that Provider belongs, directly or indirectly, to the Greater New Orleans Health Information Exchange (GNOHIE). GNOHIE allows other providers to see your health records including your health history, the medicines you take, test results, surgery reports, hospital discharge notes, and other health information. The sharing of this information saves time and helps providers give you better care. If you do not want GNOHIE to share your records, you can "opt out" of GNOHIE at any time by calling toll-free 1-855-446-6443 or by visiting the website at www.gnohie.org and clicking on "FAQs." Your records for treatment, payment, and operations will be shared until GNOHIE receives your "opt out" directive.

13. Financial Agreement

I hereby obligate myself to pay Provider for all care, services, and treatment I receive, according to Provider's regular rates and fee schedules. If I am covered by a health plan or insurance policy, I agree to provide current and accurate information prior to or at the time of admission/ registration. I certify that all information that I have provided or shared with the Provider is true and accurate and that I have complied with all insurance company requirements for referrals, pre-authorizations, and family coverage to avoid payment denial. I understand that if I have failed to comply with these requirements, I will be responsible for the bill. If I am eligible to receive benefits under a health care service plan with which Provider has contracted, I may be required to pay for some services pursuant to the plan's contract. If I prefer a private room during an inpatient stay, I understand that I may be responsible for its cost. If my health care plan determines Provider's services to me are not medically necessary, I authorize Provider to represent me in any review of the determination made by or on behalf of my health care plan. If non-insurance payments made on my account exceed the total amount due,

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Scanned Information (continued)

Encounter-Level E-Signatures: (continued)

including without limitation to any late charge, Provider is authorized to apply that excess to any pre-existing account for prior medical services furnished. In the event, my account becomes delinquent and is referred to an attorney or a collection agency, I will be expected to pay attorney fees, court costs, and collection expenses. I understand that I am responsible for any non-covered services, deductibles, and co-payments. All delinquent accounts shall bear interest at the maximum rate allowed by law. ***I understand that I will receive bills both from Provider and any independent physicians or other practitioners involved in my care.***

I understand that this General Consent for Examination and Treatment will remain in effect and apply to all treatment or services I receive unless I revoke it, in writing, except to the extent that Provider has already taken action in reliance therein. I also understand that I may be asked to provide informed consent for specific procedures, treatments, or services rendered by Provider, a physician, or other healthcare providers affiliated with Provider and that such informed consent will include, but is not limited to, the benefits and risks associated with a specific procedure, treatment, or service. Such informed consent will be presented to me in a separate document or electronic medium and will be made part of my medical record.

FINANCIAL RESPONSIBILITY BY PERSON OTHER THAN THE PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

I agree to accept financial responsibility for services rendered to the Patient and to unconditionally accept the terms of the Financial Agreement and Assignment of Benefits set forth above.

PATIENT CERTIFICATION

I have read, understood and fully agree to each of the above statements and have been provided the opportunity to ask questions regarding such statements. I sign below as my free and voluntary act. I also acknowledge that I have been offered information on the following subjects: Patient Rights and Responsibilities, Advance Directives, Notice of Privacy Practices, and Patient Billing. I also acknowledge that I have the right to receive a copy of this General Consent form upon my request.

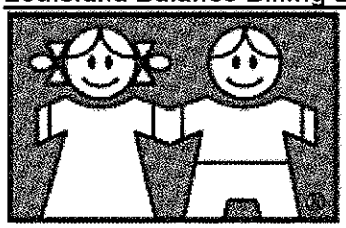
Signature of Responsible Party: 5/24/2018 2:02:46 PM 5/24/2018 2:02 PM

If other than Patient, indicate relationship:

Reason Patient is unable to sign (if applicable):

Hospital Representative: BLANCHARD, THELMA

Louisiana Balance Billing Disclosure Notice Act 306 - Received on 5/24/2018



CHILDREN'S HOSPITAL

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Encounter-Level E-Signatures: (continued)

Balance Billing Disclosure Notice

Patient Name:	BODIN,JEFFREY	Date Of Birth:	5/22/1997
Guarantor Name:	BODIN,JEFFREY	Relationship to Patient	Self
Payor Name:		Payor ID:	
Insured Name:		Provider:	

Pursuant to Louisiana Revised Statute 22:1880, Children's Hospital New Orleans is providing the above patient/guarantor with this notice and is disclosing that as of May 24, 2018 they

Yes, is a participating provider with the above listed payor

Professional services rendered by independent healthcare professionals are not part of the hospital, Ambulatory Surgery Centers (ASC), In-patient Hospice, Skilled Nursing Facilities (SNF), or Adult Residential Care Providers (ARCP) bill. These services will be billed to the patient separately. Please understand that physicians or other healthcare professionals may be called upon to provide care or services to you or on your behalf, but you may not actually see, or be examined by, all physicians or healthcare professionals participating in your care; for example, you may not see physicians providing radiology, pathology, and EKG interpretation. In many instances, there will be a separate charge for professional services rendered by physicians to you or on your behalf, and you will receive a bill for these professional services that is separate from the bill for hospital, ASC, In-patient Hospice, SNF, or ARCP services. These independent healthcare professionals may not participate in your health plan and you may be responsible for payment of all or part of the fees for the services provided by these physicians who have provided out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and non-covered services.

We encourage you to contact your health plan to determine whether the independent healthcare professionals are participating with your health plan. In order to obtain the most accurate and up-to-date information about in-network and out-of-network independent healthcare professionals, please contact the customer service number of your health plan or visit its website. Your health plan is the ***primary source*** of information on its provider network and benefits. To help you determine whether the independent healthcare professionals who provide services at this facility are participating with your health plan, we have provided you with a complete list of the names and contact information for each individual or group which includes the name and contact information for each individual or group.

We encourage you to request information from your health insurance issuer as to whether these physicians are contracted with your health insurance issuer and under what circumstance you may be responsible for payment of any amounts not paid your health insurance issuer.

In addition to receiving a hard copy listing of our physician list during the registration process, we maintain a listing of these physicians on our website, who have been granted medical staff privileges to provide medical services at our facility. This list is updated as needed and can be found at

LCMC HEALTH MEMBER HOSPITALS
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Scanned Information (continued)

Encounter-Level E-Signatures: (continued)

http://www.chnola.org/CHNOLABillPay
You are receiving services in a hospital-based outpatient facility where the facility provides the use of the facility, medical, or technical equipment, supplies, staff, and services. Depending on your health insurance benefit plan and the actual services furnished by the facility, you may receive a facility charge billed separately from the physician that covers the fees for the use of the facility, medical, or technical equipment, supplies, staff, and services.

Patient Signature: 5/24/2018 2:03:23 PM

Date: May 24, 2018

Hospital Representative: BLANCHARD, THELMA

Date: May 24, 2018

Interpreter Used? YesNoButtons
Information about the Interpreter (Name/Service/Company/Cyracom #/etc.): Not Applicable

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

Hospital account-Level Documents:

There are no hospital account-level documents.

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BODIN,JEFFREY
MRN: 1002548110
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Adm: 5/24/2018, D/C: 5/24/2018

Admission Information - Patient Record Only

Arrival Date/Time:		Admit Date/Time:	05/24/2018 1342	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	LCMC SERVICE AREA	Unit:	Children's Hospital Radiology
Admit Provider:		Attending Provider:	Dana Marie Leblanc, MD	Referring Provider:	Dana Marie Leblanc, MD

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
05/24/2018 2359	Home Or Self Care	None	None	Children's Hospital Radiology

Patient Demographics

Name	Patient ID	SSN	Sex	Birth Date
Bodin, Jeffrey	1002548110	xxx-xx-8926	Male	05/22/97 (21 yrs)

Address	Phone	Email	Employer
528 BEAU CHENE DR MANDEVILLE LA 70471	985-272-8989 (H) 985-520-4713 (W) 985-272-8989 (M)	jeffreybodin713@gmail.com	

County	Race	Occupation	Emp Status
SAINT TAMMANY	White or Caucasian	-	-

Reg Status	PCP
Verified	Chno Zzzprovider, MD

HAR	Admission Date	Discharge Date	Admitting Provider
10071512	05/24/18	05/24/18	

Marital Status	Religion	Language
Single	Lutheran	English

Emergency Contact 1

Jeffrey Bodin (Other)
528 BEAU CHENE DR
MANDEVILLE LA 70471
985-272-8989 (H)

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
10071512 - BODIN,JEFFREY	AETNA BETTER HEALTH [3501]	None	10071507

Final Diagnoses (ICD-10-CM)

touro UMC NOEH HOSPITAL
LCMC HEALTH MEMBER HOSPITALS
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Scanned Information (continued)

Final Diagnoses (ICD-10-CM) (continued)

Code	Description	POA	CC	HAC	Affects DRG
C43.9 [Principal]	Malignant melanoma of skin, unspecified				

CPT®/HCPCS Codes

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
05/24/18 1342	Hospital Outpatient	Outpatient	CHNO OP RADIOLOGY		
05/24/18 2359	Discharge	Outpatient	CHNO OP RADIOLOGY		

Allergies as of 5/24/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Latex	05/24/2018	Allergy	Rash	

Immunizations as of 05/24/18

None

Medical History

Medical as of 5/24/2018

Past Medical History	Date	Comments	Source
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seizure syndrome			Provider

Surgical as of 5/24/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	

Family as of 5/24/2018 **None**

Family Status as of 5/24/2018 **None**

Tobacco Use as of 5/24/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/24/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/24/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

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Scanned Information (continued)

Sexual Activity as of 5/24/2018	Sexually Active	Source	Birth Control	Partners	Comments
		Provider			

Social ADL as of 5/24/2018	ADL Question	Response	Comments	Source
	None			

Social Doc as of 5/24/2018 **None**

Occupational as of 5/24/2018 **None**

Socioeconomic as of 5/24/2018	Marital Status	Spouse Name	Num of Children	Years Education	Source
	Single				
	Preferred Language	Ethnicity	Race		
	English	Non-Hispanic	White or Caucasian		

Birth **None**

Emergency Department Information

ED Arrival Information

Patient not seen in ED

Treatment Team

Not on file

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All Orders and Results

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BODIN,JEFFREY
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Adm: 5/24/2018, D/C: 5/24/2018

Imaging - All Orders and Results

XR Chest Ap Pa Lateral 2 VW

Electronically signed by: **Jodi Scallan on 05/23/18 1444** Status: **Completed**
Ordering user: Jodi Scallan 05/23/18 1444 Ordering provider: Dana Marie Leblanc, MD
Final result

Performed: 05/24/18 1342 - 05/24/18 1353
Narrative:
CHEST AP AND LATERAL:

The lungs are symmetrically overinflated otherwise clear. Heart size and pulmonary vascularity are within normal limits. Aortic arch is left-sided. Pectus deformity of the chest is more pronounced since 1/5/2015. There is a presternal radiopaque screw projecting along/within the anterior chest wall. The right humeral head appears fractured and anteriorly dislocated. There are mild to moderate anterior wedge compression deformities of 2 midthoracic vertebral bodies which were not evident on prior exam dated 1/5/2015, and there is increased kyphoscoliosis.

Impression:
Underinflated otherwise clear lungs. Increased pectus deformity with a presternal radiopaque screw projecting along/within the anterior chest wall. Anterior fracture-dislocation of the right humeral head and anterior wedge compression deformities of two mid thoracic vertebral bodies with increased kyphoscoliosis, suspect pathologic fractures. Correlation with right shoulder radiographs and whole body nuclear medicine bone and/or PET/CT scan may be helpful for further characterization if clinically warranted.

Electronically Signed By: David Manning, M.D. 5/24/2018 2:28 PM CDT

Medications

Medication Admin Record

(No medication admins recorded for this encounter)

Discharge Instructions

Discharge Instructions Bodin, Jeffrey (MR # 1002548110)

None

Medication List

Notice

This visit has been closed. A record of the med list at the time of the visit is not available.

Flowsheets

LCMC HEALTH MEMBER HOSPITALS
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Adm: 5/24/2018, D/C: 5/24/2018

Scanned Information

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

Hospital account-Level Documents:

There are no hospital account-level documents.

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BODIN,JEFFREY
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DOB: 5/22/1997, Sex: M
Enc. Date: 05/24/18

Allergies as of 5/24/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 5/24/2018

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Migraine-cluster headache syndrome			Provider
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Peripheral neuropathy			Provider
Seizure syndrome			Provider

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Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	

Family as of 5/24/2018 **None**

Family Status as of 5/24/2018 **None**

Tobacco Use as of 5/24/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/24/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/24/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/24/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 5/24/2018

ADL Question	Response	Comments	Source
None			

Social Doc as of 5/24/2018 **None**

Occupational as of 5/24/2018 **None**

Socioeconomic as of 5/24/2018

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				

Preferred Language	Ethnicity	Race
English	Non-Hispanic	White or Caucasian

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Birth **None**

Current Immunizations — Never Reviewed

No immunizations on file.

Not reviewed this visit

Orders and Results

All Orders and Results

No orders and results found

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
montelukast (SINGULAIR) 10 mg tablet Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
naproxen sodium (ALEVE) 220 MG tablet Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral Class: Historical Med				

Call Information

	Provider	Department	Center
5/24/2018 1:19 PM	Dana Marie Leblanc, MD	Chno Hemonc	CHNO ACC 1st

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Admission Information - Patient Record Only

Arrival Date/Time:		Admit Date/Time:	05/25/2018 1122	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	LCMC SERVICE AREA	Unit:	Children's Hospital
Admit Provider:		Attending Provider:		Referring Provider:	Chno Zzzprovider, MD

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
05/25/2018 1304	Home Or Self Care	None	None	Children's Hospital

Patient Demographics

Name	Patient ID	SSN	Sex	Birth Date
Bodin, Jeffrey	1002548110	xxx-xx-8926	Male	05/22/97 (21 yrs)

Address	Phone	Email	Employer
528 BEAU CHENE DR MANDEVILLE LA 70471	985-272-8989 (H) 985-520-4713 (W) 985-272-8989 (M)	jeffreybodin713@gmail.com	

County	Race	Occupation	Emp Status
SAINT TAMMANY	White or Caucasian	-	-

Reg Status	PCP
Verified	Chno Zzzprovider, MD

HAR	Admission Date	Discharge Date	Admitting Provider
10072715	05/25/18	05/25/18	

Marital Status	Religion	Language
Single	Lutheran	English

Emergency Contact 1

Jeffrey Bodin (Other)
528 BEAU CHENE DR
MANDEVILLE LA 70471
985-272-8989 (H)

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
10072715 - BODIN,JEFFREY	AETNA BETTER HEALTH [3501]	None	None

CPT®/HCPCS Codes

Events

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Scanned Information (continued)

Events (continued)

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
05/25/18 1122	Hospital Outpatient	Outpatient	CHNO 2 CENTER		
05/25/18 1304	Discharge	Outpatient	CHNO 2 CENTER		

Allergies as of 5/25/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Latex	05/24/2018	Allergy	Rash	

Immunizations as of 05/25/18

None

Medical History

Medical as of 5/25/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seizure syndrome			Provider

Surgical as of 5/25/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			

Family as of 5/25/2018 **None**

Family Status as of 5/25/2018 **None**

Tobacco Use as of 5/25/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/25/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/25/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/25/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Scanned Information (continued)

Social ADL as of 5/25/2018	ADL Question **None**	Response	Comments		Source
Social Doc as of 5/25/2018	**None**				
Occupational as of 5/25/2018	**None**				
Socioeconomic as of 5/25/2018	Marital Status Single	Spouse Name	Num of Children	Years Education	Source
	Preferred Language English	Ethnicity Non-Hispanic	Race White or Caucasian		
Birth	**None**				

Emergency Department Information

ED Arrival Information

Patient not seen in ED

Treatment Team

Not on file

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

All Orders and Results

All Orders and Results

No orders and results found

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Medications

Medication Admin Record

(No medication admins recorded for this encounter)

Discharge Instructions

Discharge Instructions Bodin, Jeffrey (MR # 1002548110)

None

Medication List

Notice

This visit has been closed. A record of the med list at the time of the visit is not available.

Flowsheets

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Flowsheets (all recorded)

PAT Provider Name - Fri May 25, 2018

	Telephone Call from 5/25/2018 in Children's Hospital
OTHER	
PAT Provider	Judy Zeringue, RN -JZ
Recorded by	[JZ] JZ 05/25/18 1351

Pre-Admission Testing - Fri May 25, 2018

	1344
Pre-AdmissionTesting Checklist	
Patient can read and write?	Yes -JZ
History given by	Patient -JZ
NPO Status Reinforced	Yes NPO after 2:00/am -JZ
Recorded by	[JZ] JZ 05/25/18 1347
Patient Instructions	
Arrival Time Verified	1115 -JZ
Recorded by	[JZ] JZ 05/25/18 1347
Discharge Planning	
Living Arrangements	With Parent(s) sister -JZ
Recorded by	[JZ] JZ 05/25/18 1347

User Key (r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates	Provider Type	Discipline
JZ	Judy Zeringue	03/26/18 -	Registered Nurse	Nurse

Scanned Information

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

Hospital account-Level Documents:

There are no hospital account-level documents.

Allergies as of 5/25/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 5/25/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seizure syndrome			Provider

Surgical as of 5/25/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			

Family as of 5/25/2018 **None**

Family Status as of 5/25/2018 **None**

Tobacco Use as of 5/25/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/25/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/25/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/25/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 5/25/2018

ADL Question	Response	Comments	Source
None			

Social Doc as of 5/25/2018 **None**

Occupational as of 5/25/2018 **None**

Scanned Information (continued)

Socioeconomic as of 5/25/2018	Marital Status	Spouse Name	Num of Children	Years Education	Source
	Single				
	Preferred Language	Ethnicity	Race		
	English	Non-Hispanic	White or Caucasian		

Birth **None**

Most recent update: 5/25/2018 12:53 PM by Lynell Major

Vitals

Ht	Wt	BMI
1.72 m	51 kg	17.24 kg/m2

Medications the Patient Reported Taking

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry (Taking) Sig: 1 spray by Nasal route daily Class: Historical Med Route: Nasal				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet (Taking) Sig: Take 300 mg by mouth daily Class: Historical Med Route: Oral			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet (Taking) Sig: Take 20 mg by mouth 3 (three) times daily Class: Historical Med Route: Oral			5/13/2018	
montelukast (SINGULAIR) 10 mg tablet (Taking) Sig: Take 10 mg by mouth daily Class: Historical Med Route: Oral			5/7/2018	
naproxen sodium (ALEVE) 220 MG tablet (Taking) Sig: Take 1,000 mg by mouth 2 (two) times daily with meals Class: Historical Med Route: Oral				

Current Immunizations Never Reviewed

No immunizations on file.

Not reviewed this visit

Reason for Visit

Follow-up

Diagnoses

	Comments
Chronic dislocation of right shoulder	

Orders and Results

Orders and Results (continued)

All Orders and Results

No orders and results found

Progress Notes

Ryan James Dewitz, MD at 5/25/2018 12:45 PM

Author Type: Resident Status: Addendum

CHNOLA ORTHO CLINIC

Chief Complaint: Chronic right shoulder dislocation

HPI: 21-year-old male here today to establish as a new patient. He is here for evaluation of right shoulder. He has a history of narcolepsy and significant peripheral neuropathy related to history of chemotherapy for melanoma. He says about 2 months ago he sleeping up so we landed on his shoulder and his for about 6 hr. He woke up with shoulder pain which persisted. He says it improved over the course of weeks he still had movement of motion. He is seeking treatment today found to have right shoulder dislocation routine chest x-ray. He is also complaining of some neck pain which has present for about the last month and a half.

ROS: negative except as noted above

Past Medical History:

Diagnosis	Date
• Clinical trial participant *Zyrem Rems Trial - pt states unsuccessful*	2016
• Migraine-cluster headache syndrome	
• Narcolepsy	02/15/2015
• Peripheral neuropathy	
• Seizure syndrome	

Past Surgical History:

Procedure	Laterality	Date
• WISDOM TOOTH EXTRACTION		2015

Current Outpatient Prescriptions:
• azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry, 1 spray by Nasal route daily, Disp: , Rfl:
• buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet, Take 300 mg by mouth daily, Disp: , Rfl:
• dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet, Take 20 mg by mouth 3 (three) times daily, Disp: , Rfl:
• montelukast (SINGULAIR) 10 mg tablet, Take 10 mg by mouth daily, Disp: , Rfl:
• naproxen sodium (ALEVE) 220 MG tablet, Take 1,000 mg by mouth 2 (two) times daily with meals, Disp: , Rfl:

Allergies

Allergen	Reactions
• Latex	Rash

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Progress Notes (continued)

Ryan James Dewitz, MD at 5/25/2018 12:45 PM (continued)

Social History

Social History

- Marital status: Single
  Spouse name: N/A
- Number of children: N/A
- Years of education: N/A

Occupational History

- Not on file.

Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol use No
- Drug use: No
- Sexual activity: Not on file

Other Topics Concern

- Not on file

Social History Narrative

History reviewed. No pertinent family history.

Physical Examination:

Height 1.72 m, weight 51 kg.

GEN: NAD, pleasant
Neck: supple ROM
CV: RR by PP
Resp: Normal WOB on RA
Abd: soft
Psych: normal affect
Skin: no gross visible rash
Neuro: A&O

Neck: Full range of motion with flexion, extension lateral bending. There is some pain with these maneuvers. Motor and sensory function normal in the upper extremities for him.

Right upper extremity: Acromion very prominent. Palpable humeral head anterior aspect of the shoulder. Very limited range of motion. Sensation is intact in the axillary nerve distribution. He has some decreased sensation diffusely to the distal aspect of his upper extremity. Motor is intact. 2+ radial pulse

Progress Notes (continued)

Ryan James Dewitz, MD at 5/25/2018 12:45 PM (continued)

Imaging:
X-rays of the right shoulder demonstrates an anterior glenohumeral dislocation with what appears to be 3 part proximal humerus fracture with fracture lines through the anatomic neck as well as the greater tuberosity
X-rays of the neck show no obvious abnormality

A/P:
21-year-old male with chronic right shoulder dislocation and a history of narcolepsy as well as poly peripheral neuropathy previous chemotherapy

X-rays today demonstrate fracture dislocation. The plan on a trip to the operating room on Monday for open reduction internal fixation of his fracture with reduction of his glenohumeral joint. We discussed the risks and benefits of the surgery with the patient. We encouraged him to bring a family member is some to try for him is he will be discharged after surgery. We also gave him a card and encouraged him to call us with any questions. Office should call him later today with the details and instructions for Monday morning

Ryan Dewitz, MD
LSU Ortho PGY2

I have personally performed a face to face diagnostic evualation of this patient. I have reviewed and agree with care plan. My findings are in my signed addendum.
Patient with a chronic dislocation of the right shoulder in 2 part fracture discussed the risks and benefits of surgery both the location and open reduction internal fixation with possible loss of bone mass and also of roundness of the shoulder due to osteopenia with putting the shoulder back inalso understands the risk of need for future surgery

Electronically signed by Joseph Gonzales, MD on 5/28/2018 6:57 AM

H&P Notes

No notes of this type exist for this encounter.

Follow-up and Disposition History

05/25/2018 1329 - Ryan James Dewitz, MD

Disposition: Return if symptoms worsen or fail to improve.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry (Taking) Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet (Taking) Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet (Taking) Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Medications at Start of Encounter (continued)

	Disp	Refills	Start	End
montelukast (SINGULAIR) 10 mg tablet (Taking) Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
naproxen sodium (ALEVE) 220 MG tablet (Taking) Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral Class: Historical Med				

Call Information

	Provider	Department	Center
5/25/2018 12:45 PM	Joseph Gonzales, MD	Chno Orthopedics	CHNO Ambula

Reason for Call

Follow-up

Call Documentation

Ryan James Dewitz, MD at 5/25/2018 12:45 PM

Status: Addendum

CHNOLA ORTHO CLINIC

Chief Complaint: Chronic right shoulder dislocation

HPI: 21-year-old male here today to establish as a new patient. He is here for evaluation of right shoulder. He has a history of narcolepsy and significant peripheral neuropathy related to history of chemotherapy for melanoma. He says about 2 months ago he sleeping up so we landed on his shoulder and his for about 6 hr. He woke up with shoulder pain which persisted. He says it improved over the course of weeks he still had movement of motion. He is seeking treatment today found to have right shoulder dislocation routine chest x-ray. He is also complaining of some neck pain which has present for about the last month and a half.

ROS: negative except as noted above

Past Medical History:

Diagnosis	Date
• Clinical trial participant *Zyrem Rems Trial - pt states unsuccessful*	2016
• Migraine-cluster headache syndrome	
• Narcolepsy	02/15/2015
• Peripheral neuropathy	
• Seizure syndrome	

Past Surgical History:

Procedure	Laterality	Date
• WISDOM TOOTH EXTRACTION		2015

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Call Documentation (continued)

Ryan James Dewitz, MD at 5/25/2018 12:45 PM (continued)

Current Outpatient Prescriptions:
- azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry, 1 spray by Nasal route daily, Disp: , Rfl:
- buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet, Take 300 mg by mouth daily, Disp: , Rfl:
- dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet, Take 20 mg by mouth 3 (three) times daily, Disp: , Rfl:
- montelukast (SINGULAIR) 10 mg tablet, Take 10 mg by mouth daily, Disp: , Rfl:
- naproxen sodium (ALEVE) 220 MG tablet, Take 1,000 mg by mouth 2 (two) times daily with meals, Disp: , Rfl:

Allergies

Allergen	Reactions
• Latex	Rash

Social History

Social History

• Marital status:	Single
Spouse name:	N/A
• Number of children:	N/A
• Years of education:	N/A

Occupational History
- Not on file.

Social History Main Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used
• Alcohol use	No
• Drug use:	No
• Sexual activity:	Not on file

Other Topics	Concern
• Not on file	

Social History Narrative

History reviewed. No pertinent family history.

Physical Examination:

Height 1.72 m, weight 51 kg.

GEN: NAD, pleasant
Neck: supple ROM
CV: RR by PP

Call Documentation (continued)

Ryan James Dewitz, MD at 5/25/2018 12:45 PM (continued)

Resp: Normal WOB on RA
Abd: soft
Psych: normal affect
Skin: no gross visible rash
Neuro: A&O

Neck: Full range of motion with flexion, extension lateral bending. There is some pain with these maneuvers. Motor and sensory function normal in the upper extremities for him.

Right upper extremity: Acromion very prominent. Palpable humeral head anterior aspect of the shoulder. Very limited range of motion. Sensation is intact in the axillary nerve distribution. He has some decreased sensation diffusely to the distal aspect of his upper extremity. Motor is intact. 2+ radial pulse

Imaging:
X-rays of the right shoulder demonstrates an anterior glenohumeral dislocation with what appears to be 3 part proximal humerus fracture with fracture lines through the anatomic neck as well as the greater tuberosity
X-rays of the neck show no obvious abnormality

A/P:
21-year-old male with chronic right shoulder dislocation and a history of narcolepsy as well as poly peripheral neuropathy previous chemotherapy

X-rays today demonstrate fracture dislocation. The plan on a trip to the operating room on Monday for open reduction internal fixation of his fracture with reduction of his glenohumeral joint. We discussed the risks and benefits of the surgery with the patient. We encouraged him to bring a family member is some to try for him is he will be discharged after surgery. We also gave him a card and encouraged him to call us with any questions. Office should call him later today with the details and instructions for Monday morning

Ryan Dewitz, MD
LSU Ortho PGY2

I have personally performed a face to face diagnostic evualation of this patient. I have reviewed and agree with care plan. My findings are in my signed addendum.
Patient with a chronic dislocation of the right shoulder in 2 part fracture discussed the risks and benefits of surgery both the location and open reduction internal fixation with possible loss of bone mass and also of roundness of the shoulder due to osteopenia with putting the shoulder back inalso understands the risk of need for future surgery

Signed by Joseph Gonzales, MD on 5/28/2018 6:57 AM

Revision History

	Date/Time	User	Action
>	5/28/2018 6:57 AM	Joseph Gonzales, MD	Addend
	5/25/2018 1:29 PM	Ryan James Dewitz, MD	Sign

Scanned Information

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Admission Information - Patient Record Only

Arrival Date/Time:		Admit Date/Time:	05/25/2018 1305	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	LCMC SERVICE AREA	Unit:	Children's Hospital Radiology
Admit Provider:		Attending Provider:	Joseph Gonzales, MD	Referring Provider:	Joseph Gonzales, MD

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
05/25/2018 1307	Home Or Self Care	None	None	Children's Hospital Radiology

Patient Demographics

Name	Patient ID	SSN	Sex	Birth Date
Bodin, Jeffrey	1002548110	xxx-xx-8926	Male	05/22/97 (21 yrs)

Address	Phone	Email	Employer
528 BEAU CHENE DR MANDEVILLE LA 70471	985-272-8989 (H) 985-520-4713 (W) 985-272-8989 (M)	jeffreybodin713@gmail.com	

County	Race	Occupation	Emp Status
SAINT TAMMANY	White or Caucasian	-	-

Reg Status	PCP
Verified	Chno Zzzprovider, MD

HAR	Admission Date	Discharge Date	Admitting Provider
10072043	05/25/18	05/25/18	

Marital Status	Religion	Language
Single	Lutheran	English

Emergency Contact 1
Jeffrey Bodin (Other)
528 BEAU CHENE DR
MANDEVILLE LA 70471
985-272-8989 (H)

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
10072043 - BODIN,JEFFREY	AETNA BETTER HEALTH [3501]	None	None

Final Diagnoses (ICD-10-CM)

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Scanned Information (continued)

Final Diagnoses (ICD-10-CM) (continued)

Code	Description	POA	CC	HAC	Affects DRG
M24.411 [Principal]	Recurrent dislocation, right shoulder				

CPT®/HCPCS Codes

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
05/25/18 1305	Hospital Outpatient	Outpatient	CHNO OP RADIOLOGY		
05/25/18 1307	Discharge	Outpatient	CHNO OP RADIOLOGY		

Allergies as of 5/25/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Latex	05/24/2018	Allergy	Rash	

Immunizations as of 05/25/18

None

Medical History

Medical as of 5/25/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seizure syndrome			Provider

Surgical as of 5/25/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			

Family as of 5/25/2018 **None**

Family Status as of 5/25/2018 **None**

Tobacco Use as of 5/25/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Scanned Information (continued)

Alcohol Use as of 5/25/2018	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
	No	Provider			

Drug Use as of 5/25/2018	Drug Use	Source	Types	Frequency	Comments
	No	Provider			

Sexual Activity as of 5/25/2018	Sexually Active	Source	Birth Control	Partners	Comments
		Provider			

Social ADL as of 5/25/2018	ADL Question	Response	Comments	Source
	None			

Social Doc as of 5/25/2018 **None**

Occupational as of 5/25/2018 **None**

Socioeconomic as of 5/25/2018	Marital Status	Spouse Name	Num of Children	Years Education	Source
	Single				
	Preferred Language	Ethnicity	Race		
	English	Non-Hispanic	White or Caucasian		

Birth **None**

Emergency Department Information

ED Arrival Information

Patient not seen in ED

Treatment Team

Not on file

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

All Orders and Results

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Imaging - All Orders and Results

XR Shoulder 2+ VW Right (silent schedule)

Electronically signed by: **Ryan James Dewitz, MD on 05/25/18 1305** Status: **Completed**
Ordering user: Ryan James Dewitz, MD 05/25/18 1305 Ordering provider: Ryan James Dewitz, MD
Final result

Performed: 05/25/18 1305 - 05/25/18 1315

Narrative:
RIGHT SHOULDER VIEWS: There is fragmentation of the right humeral head with inferior and medial dislocation. There is mild osteopenia of the bony structures.

Impression:
RIGHT HUMERAL HEAD FRACTURE WITH INFERIOR MEDIAL DISLOCATION.

Electronically Signed By: Kenneth Ward, M.D. 5/25/2018 5:53 PM CDT

Medications

Medication Admin Record

(No medication admins recorded for this encounter)

Discharge Instructions

Discharge Instructions Bodin, Jeffrey (MR # 1002548110)

None

Medication List

Notice

This visit has been closed. A record of the med list at the time of the visit is not available.

Flowsheets

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Scanned Information

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

Hospital account-Level Documents:

There are no hospital account-level documents.

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Admission Information - Patient Record Only

Arrival Date/Time:		Admit Date/Time:	05/25/2018 1308	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	LCMC SERVICE AREA	Unit:	Children's Hospital Radiology
Admit Provider:		Attending Provider:	Joseph Gonzales, MD	Referring Provider:	Joseph Gonzales, MD

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
05/25/2018 2359	Home Or Self Care	None	None	Children's Hospital Radiology

Patient Demographics

Name	Patient ID	SSN	Sex	Birth Date
Bodin, Jeffrey	1002548110	xxx-xx-8926	Male	05/22/97 (21 yrs)

Address	Phone	Email	Employer
528 BEAU CHENE DR MANDEVILLE LA 70471	985-272-8989 (H) 985-520-4713 (W) 985-272-8989 (M)	jeffreybodin713@gmail.com	

County	Race	Occupation	Emp Status
SAINT TAMMANY	White or Caucasian	-	-

Reg Status	PCP
Verified	Chno Zzzprovider, MD

HAR	Admission Date	Discharge Date	Admitting Provider
10072043	05/25/18	05/25/18	

Marital Status	Religion	Language
Single	Lutheran	English

Emergency Contact 1

Jeffrey Bodin (Other)
528 BEAU CHENE DR
MANDEVILLE LA 70471
985-272-8989 (H)

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
10072043 - BODIN,JEFFREY	AETNA BETTER HEALTH [3501]	None	None

Final Diagnoses (ICD-10-CM)

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Scanned Information (continued)

Final Diagnoses (ICD-10-CM) (continued)

Code	Description	POA	CC	HAC	Affects DRG
M24.411 [Principal]	Recurrent dislocation, right shoulder				

CPT®/HCPCS Codes

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
05/25/18 1308	Hospital Outpatient	Outpatient	CHNO OP RADIOLOGY		
05/25/18 2359	Discharge	Outpatient	CHNO OP RADIOLOGY		

Allergies as of 5/25/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Latex	05/24/2018	Allergy	Rash	

Immunizations as of 05/25/18

None

Medical History

Medical as of 5/25/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seizure syndrome			Provider

Surgical as of 5/25/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			

Family as of 5/25/2018 **None**

Family Status as of 5/25/2018 **None**

Tobacco Use as of 5/25/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Scanned Information (continued)

Alcohol Use as of 5/25/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/25/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/25/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 5/25/2018

ADL Question	Response	Comments	Source
None			

Social Doc as of 5/25/2018 **None**

Occupational as of 5/25/2018 **None**

Socioeconomic as of 5/25/2018

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				

Preferred Language	Ethnicity	Race
English	Non-Hispanic	White or Caucasian

Birth **None**

Emergency Department Information

ED Arrival Information

Patient not seen in ED

Treatment Team

Not on file

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

All Orders and Results

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Imaging - All Orders and Results

XR Cervical Spine 2 or 3 VW (silent schedule)

Electronically signed by: **Ryan James Dewitz, MD on 05/25/18 1308** Status: **Completed**
Ordering user: Ryan James Dewitz, MD 05/25/18 1308 Ordering provider: Ryan James Dewitz, MD
Final result

Performed: 05/25/18 1309 - 05/25/18 1315
Narrative:
CERVICAL SPINE AP LAT:

Straightening of the cervical spine likely reflects patient positioning. No acute fracture or traumatic subluxation of the cervical spine is evident. The vertebral body and disc space heights are maintained. The precervical soft tissues are within normal limits.

Impression:
NO ACUTE FRACTURE OR TRAUMATIC SUBLUXATION OF THE CERVICAL SPINE.

Electronically Signed By: David Manning, M.D. 5/25/2018 5:31 PM CDT

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Medications

Medication Admin Record

(No medication admins recorded for this encounter)

Discharge Instructions

Discharge Instructions Bodin, Jeffrey (MR # 1002548110)

None

Medication List

Notice

This visit has been closed. A record of the med list at the time of the visit is not available.

Flowsheets

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/25/2018, D/C: 5/25/2018

Scanned Information

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

Hospital account-Level Documents:

There are no hospital account-level documents.

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/25/18

Allergies as of 5/25/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 5/25/2018

Past Medical History	Date	Comments	Source
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seizure syndrome			Provider

Surgical as of 5/25/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	

Family as of 5/25/2018 **None**

Family Status as of 5/25/2018 **None**

Tobacco Use as of 5/25/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/25/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/25/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/25/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 5/25/2018

ADL Question	Response	Comments	Source
None			

Social Doc as of 5/25/2018 **None**

Occupational as of 5/25/2018 **None**

Socioeconomic as of 5/25/2018

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				

Preferred Language	Ethnicity	Race
English	Non-Hispanic	White or Caucasian

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Birth **None**

Current Immunizations — Never Reviewed

No immunizations on file.

Not reviewed this visit

Orders and Results

All Orders and Results

No orders and results found

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet Sig - Route: Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days - Oral Class: Print	28 tablet	0	5/28/2018	6/4/2018
ketorolac (TORADOL) 10 mg tablet Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral Class: Print	12 tablet	0	5/28/2018	6/1/2018
montelukast (SINGULAIR) 10 mg tablet Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
naproxen sodium (ALEVE) 220 MG tablet Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral Class: Historical Med				
ketorolac (TORADOL) 10 mg tablet (Discontinued) Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral	12 tablet	0	5/28/2018	5/28/2018

Inpatient Medications

	Dose	Frequency	Start	End
dexmedetomidine (PRECEDEX) injection 15.3 mcg (Discontinued)	0.3 mcg/kg × 51 kg	Once PRN	5/28/2018	5/28/2018

Notes (continued)

Inpatient Medications (continued)

	Dose	Frequency	Start	End
Sig - Route: Inject 0.153 mLs (15.3 mcg total)into the vein once as needed (Post-operative delirium) - Intravenous Reason for Discontinue: **Patient Discharge**				
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet 1 tablet (Discontinued)	1 tablet	Every 6 Hours PRN	5/28/2018	5/28/2018
Sig - Route: Take 1 tabletby mouth every 6 (six) hours as needed for Pain Score 4 - 7 - Oral Reason for Discontinue: **Patient Discharge**				
ibuprofen (ADVIL,MOTRIN) tablet 600 mg (Discontinued)	600 mg	Every 8 Hours PRN	5/28/2018	5/28/2018
Sig - Route: Take 600 mgby mouth every 8 (eight) hours as needed for Pain Score 1 - 3 - Oral Reason for Discontinue: **Patient Discharge**				
midazolam (VERSED) 10 mg/5 mL (2 mg/mL) syrup 20 mg (Discontinued)	20 mg	Once	5/28/2018	5/28/2018
Sig - Route: Take 10 mLs (20 mg total)by mouth once - Oral Reason for Discontinue: **Patient Transfer**				

Call Information

	Provider	Department	Center
5/25/2018 12:48 PM	Joseph Gonzales, MD	Chno Orthopedics	CHNO Ambula

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

Allergies as of 5/25/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 5/25/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seizure syndrome			Provider

Surgical as of 5/25/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			

Family as of 5/25/2018 **None**

Family Status as of 5/25/2018 **None**

Tobacco Use as of 5/25/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/25/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/25/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/25/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 5/25/2018

ADL Question	Response	Comments	Source
None			

Social Doc as of 5/25/2018 **None**

Occupational as of 5/25/2018 **None**

Scanned Information (continued)

Socioeconomic as of 5/25/2018	Marital Status	Spouse Name	Num of Children	Years Education	Source
	Single				
	Preferred Language	Ethnicity	Race		
	English	Non-Hispanic	White or Caucasian		

Birth **None**

Current Immunizations — Never Reviewed

No immunizations on file.

Not reviewed this visit

Orders and Results

All Orders and Results

No orders and results found

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet	28 tablet	0	5/28/2018	6/4/2018
Sig - Route: Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days - Oral Class: Print				
ketorolac (TORADOL) 10 mg tablet	12 tablet	0	5/28/2018	6/1/2018
Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral Class: Print				
montelukast (SINGULAIR) 10 mg tablet Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
naproxen sodium (ALEVE) 220 MG tablet Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral Class: Historical Med				
ketorolac (TORADOL) 10 mg tablet (Discontinued)	12 tablet	0	5/28/2018	5/28/2018
Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral				

Notes (continued)

Medications at Start of Encounter (continued)

Inpatient Medications

	Dose	Frequency	Start	End
dexmedetomidine (PRECEDEX) injection 15.3 mcg (Discontinued)	0.3 mcg/kg × 51 kg	Once PRN	5/28/2018	5/28/2018
Sig - Route: Inject 0.153 mLs (15.3 mcg total)into the vein once as needed (Post-operative delirium) - Intravenous				
Reason for Discontinue: **Patient Discharge**				
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet 1 tablet (Discontinued)	1 tablet	Every 6 Hours PRN	5/28/2018	5/28/2018
Sig - Route: Take 1 tabletby mouth every 6 (six) hours as needed for Pain Score 4 - 7 - Oral				
Reason for Discontinue: **Patient Discharge**				
ibuprofen (ADVIL,MOTRIN) tablet 600 mg (Discontinued)	600 mg	Every 8 Hours PRN	5/28/2018	5/28/2018
Sig - Route: Take 600 mgby mouth every 8 (eight) hours as needed for Pain Score 1 - 3 - Oral				
Reason for Discontinue: **Patient Discharge**				
midazolam (VERSED) 10 mg/5 mL (2 mg/mL) syrup 20 mg (Discontinued)	20 mg	Once	5/28/2018	5/28/2018
Sig - Route: Take 10 mLs (20 mg total)by mouth once - Oral				
Reason for Discontinue: **Patient Transfer**				

Call Information

	Provider	Department	Center
5/25/2018 1:48 PM	CHNO PAT, NURSE	Chno 2 Center	CHNO Childre

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

Allergies as of 5/28/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 5/28/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Melanoma in situ of left lower leg			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seasonal allergies			Provider
Seizure syndrome			Provider

Surgical as of 5/28/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

Family as of 5/28/2018 **None**

Family Status as of 5/28/2018 **None**

Tobacco Use as of 5/28/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/28/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/28/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/28/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 5/28/2018

ADL Question	Response	Comments	Source
None			

Social Doc **None**

Scanned Information (continued)

as of 5/28/2018

Occupational ****None****
as of 5/28/2018

Socioeconomic **as of 5/28/2018**

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				
Preferred Language	**Ethnicity**	**Race**		
English	Non-Hispanic	White or Caucasian		

Birth ****None****

Current Immunizations Never Reviewed

No immunizations on file.

Not reviewed this visit

Orders and Results

All Orders and Results

No orders and results found

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet	28 tablet	0	5/28/2018	6/4/2018
Sig - Route: Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days - Oral Class: Print				
ketorolac (TORADOL) 10 mg tablet	12 tablet	0	5/28/2018	6/1/2018
Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral Class: Print				
montelukast (SINGULAIR) 10 mg tablet Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/27/18

Notes (continued)

Medications at Start of Encounter (continued)

	Disp	Refills	Start	End
naproxen sodium (ALEVE) 220 MG tablet Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral Class: Historical Med				
ketorolac (TORADOL) 10 mg tablet (Discontinued) Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral	12 tablet	0	5/28/2018	5/28/2018

Inpatient Medications

	Dose	Frequency	Start	End
dexmedetomidine (PRECEDEX) injection 15.3 mcg (Discontinued) Sig - Route: Inject 0.153 mLs (15.3 mcg total)into the vein once as needed (Post-operative delirium) - Intravenous Reason for Discontinue: **Patient Discharge**	0.3 mcg/kg × 51 kg	Once PRN	5/28/2018	5/28/2018
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet 1 tablet (Discontinued) Sig - Route: Take 1 tabletby mouth every 6 (six) hours as needed for Pain Score 4 - 7 - Oral Reason for Discontinue: **Patient Discharge**	1 tablet	Every 6 Hours PRN	5/28/2018	5/28/2018
ibuprofen (ADVIL,MOTRIN) tablet 600 mg (Discontinued) Sig - Route: Take 600 mgby mouth every 8 (eight) hours as needed for Pain Score 1 - 3 - Oral Reason for Discontinue: **Patient Discharge**	600 mg	Every 8 Hours PRN	5/28/2018	5/28/2018
midazolam (VERSED) 10 mg/5 mL (2 mg/mL) syrup 20 mg (Discontinued) Sig - Route: Take 10 mLs (20 mg total)by mouth once - Oral Reason for Discontinue: **Patient Transfer**	20 mg	Once	5/28/2018	5/28/2018

Call Information

Provider	Department	Center
5/27/2018 9:05 PM	Lorena Dumas Guntner, MD	Chno Surgery	CHNO Childre

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/28/2018, D/C: 5/28/2018

Admission Information - Patient Record Only

Arrival Date/Time:		Admit Date/Time:	05/28/2018 1120	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Ambulatory Surgery Center	Admit Category:	
Means of Arrival:		Primary Service:	Surgery	Secondary Service:	N/A
Transfer Source:		Service Area:	LCMC SERVICE AREA	Unit:	Children's Hospital
Admit Provider:	Joseph Gonzales, MD	Attending Provider:	Joseph Gonzales, MD	Referring Provider:	

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
05/28/2018 1815	Home Or Self Care	None	None	Children's Hospital

Patient Demographics

Name	Patient ID	SSN	Sex	Birth Date
Bodin, Jeffrey	1002548110	xxx-xx-8926	Male	05/22/97 (21 yrs)

Address	Phone	Email	Employer
528 BEAU CHENE DR MANDEVILLE LA 70471	985-272-8989 (H) 985-520-4713 (W) 985-272-8989 (M)	jeffreybodin713@gmail.com	

County	Race	Occupation	Emp Status
SAINT TAMMANY	White or Caucasian	-	-

Reg Status	PCP
Verified	Chno Zzzprovider, MD

HAR	Admission Date	Discharge Date	Admitting Provider
10073301	05/28/18	05/28/18	Joseph Gonzales, MD

Marital Status	Religion	Language
Single	Lutheran	English

Emergency Contact 1

Jeffrey Bodin (Other)
528 BEAU CHENE DR
MANDEVILLE LA 70471
985-272-8989 (H)

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
10073301 - BODIN,JEFFREY	AETNA BETTER HEALTH [3501]	None	None

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
M24.411	Recurrent dislocation, right shoulder				

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Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/28/2018, D/C: 5/28/2018

Scanned Information (continued)

Final Diagnoses (ICD-10-CM) (continued)

Code	Description	POA	CC	HAC	Affects DRG
[Principal]					

CPT®/HCPCS Codes

Code	Modifiers	Date	Qty	Performing Provider	APC	Exp Reimb	Px Event
23466 (CPT®)	RT	05/28/2018	1	Joseph Gonzales, MD	05114	5,215.17	

Description: Capsulorrhaphy glenohumrl jt multi-dirional ins; (-RT Right side of body)

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
05/28/18 1120	Admission	Hospital Outpatient Surgery	CHNO SURGERY	CHNO Surgery Pool/CHNO SURGERY	Surgery
05/28/18 1333	Surgery	Hospital Outpatient Surgery	CH MAIN OR	CH MAIN OR 10	Orthopedics
05/28/18 1815	Discharge	Hospital Outpatient Surgery	CHNO SURGERY	CHNO Surgery Pool/CHNO SURGERY	Surgery

Allergies as of 5/28/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
Latex	05/24/2018	Allergy	Rash	

Immunizations as of 05/28/18

None

Medical History

Medical as of 5/28/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Melanoma in situ of left lower leg			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seasonal allergies			Provider
Seizure syndrome			Provider

Surgical as of 5/28/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

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MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/28/2018, D/C: 5/28/2018

Scanned Information (continued)

Family ****None****
as of 5/28/2018

Family Status ****None****
as of 5/28/2018

Tobacco Use

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

as of 5/28/2018

Alcohol Use

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

as of 5/28/2018

Drug Use

Drug Use	Source	Types	Frequency	Comments
No	Provider			

as of 5/28/2018

Sexual Activity

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

as of 5/28/2018

Social ADL

ADL Question	Response	Comments	Source
****None****			

as of 5/28/2018

Social Doc ****None****
as of 5/28/2018

Occupational ****None****
as of 5/28/2018

Socioeconomic

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				

Preferred Language	Ethnicity	Race
English	Non-Hispanic	White or Caucasian

as of 5/28/2018

Birth ****None****

Emergency Department Information

ED Arrival Information

Patient not seen in ED

Treatment Team

Not on file

Discharge Summaries - Inpatient Notes

Discharge Summaries by Ryan James Dewitz, MD Version 1 of 1 at 5/28/2018 3:04 PM

Discharge Summaries - Inpatient Notes (continued)

Discharge Summaries by Ryan James Dewitz, MD (continued) Version 1 of 1 at 5/28/2018 3:04 PM

Author: Ryan James Dewitz, MD | Service: Orthopedics | Author Type: Resident
Filed: 5/28/2018 3:05 PM | Date of Service: 5/28/2018 3:04 PM | Status: Signed
Editor: Ryan James Dewitz, MD (Resident) | Cosigner: Joseph Gonzales, MD at 5/30/2018 10:01 AM

Physician Discharge Summary

Patient ID:
Jeffrey Bodin
1002548110
21 y.o.
5/22/1997

Admit date: 5/28/2018

Discharge date: same

Admitting Physician: Joseph Gonzales, MD

Discharge Physician: same

Admission Diagnoses: Dislocation of right shoulder joint, initial encounter [S43.004A]

Discharge Diagnoses: same

Admission Condition: good

Discharged Condition: good

Indication for Admission: reduction of dislocated glenohumeral joint

Hospital Course: Pt was admitted to same day surgery on 5/28/2018 for open reduction of chronic right glenohumeral dislocation. Pt underwent procedure, tolerated it well and without complication. Pt was brought to PACU and subsequently stepped down back to same day surgery. In same day, pt's pain was adequately controlled with PO pain medicine and pt met all criteria and was deemed stable for discharge. Pt was discharged to home with PO pain medicine, thorough wound care instructions, and appropriate L-ortho clinic follow up.

Consults: none

Significant Diagnostic Studies: post op xrays

Treatments: open reduction right shoulder

Discharge Exam:
RUE: sling/swath in place. Moving fingers

Disposition: Home

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Discharge Summaries - Inpatient Notes (continued)

Discharge Summaries by Ryan James Dewitz, MD (continued) Version 1 of 1 at 5/28/2018 3:04 PM

There are no hospital problems to display for this patient.

Patient Instructions:

Current Discharge Medication List

START taking these medications

	Details
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet	Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days *Qty:* 28 tablet, *Refills:* 0 *Associated Diagnoses:* Chronic dislocation of right shoulder

CONTINUE these medications which have NOT CHANGED

	Details
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry	1 spray by Nasal route daily
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet	Take 300 mg by mouth daily
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet	Take 20 mg by mouth 3 (three) times daily
montelukast (SINGULAIR) 10 mg tablet	Take 10 mg by mouth daily
naproxen sodium (ALEVE) 220 MG tablet	Take 1,000 mg by mouth 2 (two) times daily with meals

Activity: NWB RUE. Sling/swath at all times
Diet: regular diet
Wound Care: as directed

Discussed plan with patient and answered questions: Yes

Signed:
Ryan James Dewitz
5/28/2018
3:04 PM

Electronically Signed by Joseph Gonzales, MD on 5/30/2018 10:01 AM

H&P - Inpatient Notes

H&P by Ryan James Dewitz, MD Version 1 of 1 at 5/28/2018 11:46 AM

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H&P - Inpatient Notes (continued)

H&P by Ryan James Dewitz, MD (continued) Version 1 of 1 at 5/28/2018 11:46 AM

Author: Ryan James Dewitz, MD | Service: Orthopedics | Author Type: Resident
Filed: 5/28/2018 11:48 AM | Date of Service: 5/28/2018 11:46 AM | Status: Signed
Editor: Ryan James Dewitz, MD (Resident) | Cosigner: Joseph Gonzales, MD at 5/30/2018 10:01 AM

CHNOLA ORTHO H&P UPDATE

HPI: Patient is a 21M with R proximal humerus fracture dislocation. No recent illnesses. No nausea/vomiting. No constitutional signs. NPO since midnight.

ROS: Negative except as noted above

Past Medical History:

Diagnosis	Date
• Cancer *Dr. Leblanc*	
• Clinical trial participant *Zyrem Rems Trial - pt states unsuccessful*	2016
• Dislocated shoulder	
• Migraine-cluster headache syndrome	
• Narcolepsy	02/15/2015
• Peripheral neuropathy	
• Seizure syndrome	

Past Surgical History:

Procedure	Laterality	Date
• ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES		
• melanoma excision		
• TONSILLECTOMY		
• WISDOM TOOTH EXTRACTION		2015

No current facility-administered medications for this encounter.

Allergies

Allergen	Reactions
• Lactose	Nausea And Vomiting
• Latex	Rash

Social History

Social History	
• Marital status:	Single
Spouse name:	N/A
• Number of children:	N/A
• Years of education:	N/A

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H&P - Inpatient Notes (continued)

H&P by Ryan James Dewitz, MD (continued) Version 1 of 1 at 5/28/2018 11:46 AM

Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol use No
- Drug use: No
- Sexual activity: Not on file

Other Topics Concern

- Not on file

Social History Narrative

No family history on file.

PHYSICAL EXAM
There were no vitals taken for this visit.

GEN: NAD
Neck: supple ROM
CV: RR by PP
Resp: Normal WOB on RA
Abd: soft
Psych: normal affect
Skin: no gross visible rash
Neuro: A&O

R shoulder: Acromion very prominent. Palpable humeral head anterior aspect of the shoulder. Very limited range of motion. Sensation is intact in the axillary nerve distribution. He has some decreased sensation diffusely to the distal aspect of his upper extremity. Motor is intact. 2+ radial pulse

Imaging:
X-rays of the right shoulder demonstrates an anterior glenohumeral dislocation with what appears to be 3 part proximal humerus fracture with fracture lines through the anatomic neck as well as the greater tuberosity

Labs:
n/a

A/P:
21M with R proximal humerus fx/dx

-OR today for closed reduction, possible ORIF R proximal humerus

Ryan Dewitz, MD
LSU Ortho PGY2

Electronically Signed by Joseph Gonzales, MD on 5/30/2018 10:01 AM

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H&P - Inpatient Notes (continued)

Brief Op Note - Inpatient Notes

Brief Op Note by Ryan James Dewitz, MD Version 1 of 1 at 5/28/2018 2:59 PM

Author: Ryan James Dewitz, MD | Service: Orthopedics | Author Type: Resident
Filed: 5/28/2018 3:00 PM | Date of Service: 5/28/2018 2:59 PM | Status: Signed
Editor: Ryan James Dewitz, MD (Resident) | Cosigner: Joseph Gonzales, MD at 5/30/2018 10:01 AM

OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER Procedure Note

Jeffrey Bodin
1002548110

5/28/2018

Pre-op Diagnosis: Dislocation of right shoulder joint, initial encounter [S43.004A]
Dislocation of right shoulder joint, initial encounter [S43.004A]

Post-op Diagnosis: Same

Procedure(s):
OPEN REDUCTION CAPSULAR FIXATION OF RIGHT SHOULDER

Anesthesia: General

Surgeon(s) and Role:
* Joseph Gonzales, MD - Primary
* Ryan James Dewitz, MD - Resident: First Assistant
* Muayad Kadhim, MD - Resident: Teaching Assistant

Staff: Circulator: Melynda Catanese
Radiology Technologist: Kenneth Block
Scrub Person: Allison Alsaade; Glenysa Carbajal

Estimated Blood Loss: per anesthesia report

Drain: none

Total IV Fluids: per anesthesia report

Specimens: * No specimens in log *

Implants: * No implants in log *

Complications: none

Findings: consistent with preoperative diagnosis

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Brief Op Note - Inpatient Notes (continued)

Brief Op Note by Ryan James Dewitz, MD (continued) Version 1 of 1 at 5/28/2018 2:59 PM

Disposition: awakened from anesthesia, extubated and taken to the recovery room in a stable condition, having suffered no apparent untoward event.

Condition: doing well without problems

Technique: see operative report

Ryan Dewitz, MD
LSU Ortho PGY2

Electronically Signed by Joseph Gonzales, MD on 5/30/2018 10:01 AM

Op Note - Inpatient Notes

Op Note by Joseph Gonzales, MD Version 1 of 1 at 5/28/2018 4:23 PM

Author: Joseph Gonzales, MD | Service: Orthopedics | Author Type: Physician
Filed: 5/28/2018 4:28 PM | Date of Service: 5/28/2018 4:23 PM | Status: Signed
Editor: Joseph Gonzales, MD (Physician)

OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER Procedure Note

Jeffrey Bodin
1002548110

5/28/2018

Pre-op Diagnosis: Dislocation of right shoulder joint, initial encounter [S43.004A]
Dislocation of right shoulder joint, initial encounter [S43.004A]

Post-op Diagnosis: Same

Procedure(s):
OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER

Anesthesia: General

Surgeon(s) and Role:
* Joseph Gonzales, MD - Primary
* Ryan James Dewitz, MD - Resident: First Assistant
* Muayad Kadhim, MD - Resident: Teaching Assistant

Staff: Circulator: Melynda Catanese
Radiology Technologist: Kenneth Block
Scrub Person: Allison Alsaade; Glenysa Carbajal

Estimated Blood Loss: Minimal

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Op Note - Inpatient Notes (continued)

Op Note by Joseph Gonzales, MD (continued) Version 1 of 1 at 5/28/2018 4:23 PM

Drain: None

Total IV Fluids: see anesthesia mL

Specimens: * No specimens in log *

Implants: * No implants in log *

Complications: None

Findings: Chronically dislocated shoulder that was located once open under direct visualization

Disposition: awakened from anesthesia, extubated and taken to the recovery room in a stable condition, having suffered no apparent untoward event.

Condition: doing well without problems

Technique:

Justification

This is a young man who got a chest x-ray to his right upper extremity noted to have a chronic dislocation and presented to our clinic for evaluation we discussed risks and benefits he also had a fracture that appear to be healed that we may need to address during the reduction we explained the risks benefits of the procedure including but not limited to infection bleeding damage to blood vessels nerves need for future procedures risk of anesthesia they understood these risks signed consent willingly they also understood the risk possible need for fixation and possible future surgeries they signed the consent willingly in all questions were answered to satisfactory condition

Procedure

Patient was taken back to the operating room placed supine on the operative table placed under general anesthesia by anesthesia team the right upper extremity an attempted closed reduction was unable be maintained so the right upper extremity then prepped and draped usual sterile manner using a small deltopectoral approach skin was incised with a 15 blade scalpel dissection carried down to level of the cephalic vein cephalic vein was retracted to the side then the short head of the biceps was moved away subscap was applied exposed the fibers were cut in line down to the capsule capsule was exposed was capsule was open closed reduction was performed this turned be reduced so that time pants-over-vest closure of the redundant capsule and subscap was performed limiting external rotation once that was done the appear to be stable within a gentle range of motion so wounds were irrigated wounds were closed sterile dressings placed drapes were taken down patient woke from anesthesia transferred stretcher take coverage stable condition

Disposition patient remained hospital pain is well controlled discharged home in a sling and swath on Toradol with follow-up in 2 weeks

Electronically Signed by Joseph Gonzales, MD on 5/28/2018 4:28 PM

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BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/28/2018, D/C: 5/28/2018

Case Information
5/28/2018

Surgery Report

General Information

Date: 5/28/2018 | Time: 1500 | Status: Posted
Location: CH MAIN OR | Room: CH OR 10 | Service: Orthopedics
Patient class: Hospital Outpatient Surgery | Case classification: Elective

Panel Information With CPT Code

Panel 1

Surgeon	Role	Start Time	End Time	Procedure	Laterality	Anesthesia
Joseph Gonzales, MD	Primary			**OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER**	Right	General
Ryan James Dewitz, MD	Resident: First Assistant					
Muayad Kadhim, MD	Resident: Teaching Assistant					

Diagnosis Information

Diagnoses

Dislocation of right shoulder joint, initial encounter S43.004A

Op Notes

Op Note by Joseph Gonzales, MD at 5/28/2018 4:23 PM Version 1 of 1

Author: Joseph Gonzales, MD | Service: Orthopedics | Author Type: Physician
Filed: 5/28/2018 4:28 PM | Date of Service: 5/28/2018 4:23 PM | Status: Signed
Editor: Joseph Gonzales, MD (Physician)

OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER Procedure Note

Jeffrey Bodin
1002548110

5/28/2018

Pre-op Diagnosis: Dislocation of right shoulder joint, initial encounter [S43.004A]
Dislocation of right shoulder joint, initial encounter [S43.004A]

Post-op Diagnosis: Same

Procedure(s):

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New Orleans LA 70118-5798

Op Notes (continued)

Op Note by Joseph Gonzales, MD at 5/28/2018 4:23 PM (continued) Version 1 of 1

OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER

Anesthesia: General

Surgeon(s) and Role:
* Joseph Gonzales, MD - Primary
* Ryan James Dewitz, MD - Resident: First Assistant
* Muayad Kadhim, MD - Resident: Teaching Assistant

Staff: Circulator: Melynda Catanese
Radiology Technologist: Kenneth Block
Scrub Person: Allison Alsaade; Glenysa Carbajal

Estimated Blood Loss: Minimal

Drain: None

Total IV Fluids: see anesthesia mL

Specimens: * No specimens in log *

Implants: * No implants in log *

Complications: None

Findings: Chronically dislocated shoulder that was located once open under direct visualization

Disposition: awakened from anesthesia, extubated and taken to the recovery room in a stable condition, having suffered no apparent untoward event.

Condition: doing well without problems

Technique:

Justification

This is a young man who got a chest x-ray to his right upper extremity noted to have a chronic dislocation and presented to our clinic for evaluation we discussed risks and benefits he also had a fracture that appear to be healed that we may need to address during the reduction we explained the risks benefits of the procedure including but not limited to infection bleeding damage to blood vessels nerves need for future procedures risk of anesthesia they understood these risks signed consent willingly they also understood the risk possible need for fixation and possible future surgeries they signed the consent willingly in all questions were answered to satisfactory condition

Procedure

Patient was taken back to the operating room placed supine on the operative table placed under general anesthesia by anesthesia team the right upper extremity an attempted closed reduction was unable be

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Op Notes (continued)

Op Note by Joseph Gonzales, MD at 5/28/2018 4:23 PM (continued) Version 1 of 1

maintained so the right upper extremity then prepped and draped usual sterile manner using a small deltopectoral approach skin was incised with a 15 blade scalpel dissection carried down to level of the cephalic vein cephalic vein was retracted to the side then the short head of the biceps was moved away subscap was applied exposed the fibers were cut in line down to the capsule capsule was exposed was capsule was open closed reduction was performed this turned be reduced so that time pants-over-vest closure of the redundant capsule and subscap was performed limiting external rotation once that was done the appear to be stable within a gentle range of motion so wounds were irrigated wounds were closed sterile dressings placed drapes were taken down patient woke from anesthesia transferred stretcher take coverage stable condition

Disposition patient remained hospital pain is well controlled discharged home in a sling and swath on Toradol with follow-up in 2 weeks[JG1.1]

Revision History

User Key	Date/Time	User	Provider Type	Action
> JG1.1	5/28/2018 4:28 PM	Joseph Gonzales, MD	Physician	Sign

Brief Op Note by Ryan James Dewitz, MD at 5/28/2018 2:59 PM Version 1 of 1

Author: Ryan James Dewitz, MD
Filed: 5/28/2018 3:00 PM
Editor: Ryan James Dewitz, MD (Resident)
Service: Orthopedics
Date of Service: 5/28/2018 2:59 PM
Author Type: Resident
Status: Signed
Cosigner: Joseph Gonzales, MD at 5/30/2018 10:01 AM

OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER Procedure Note

Jeffrey Bodin
1002548110

5/28/2018

Pre-op Diagnosis: Dislocation of right shoulder joint, initial encounter [S43.004A]
Dislocation of right shoulder joint, initial encounter [S43.004A]

Post-op Diagnosis: Same

Procedure(s):
OPEN REDUCTION CAPSULAR FIXATION OF RIGHT SHOULDER

Anesthesia: General

Surgeon(s) and Role:
* Joseph Gonzales, MD - Primary
* Ryan James Dewitz, MD - Resident: First Assistant
* Muayad Kadhim, MD - Resident: Teaching Assistant

Staff: Circulator: Melynda Catanese
Radiology Technologist: Kenneth Block

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Op Notes (continued)

Brief Op Note by Ryan James Dewitz, MD at 5/28/2018 2:59 PM (continued) Version 1 of 1

Scrub Person: Allison Alsaade; Glenysa Carbajal

Estimated Blood Loss: per anesthesia report

Drain: none

Total IV Fluids: per anesthesia report

Specimens: * No specimens in log *

Implants: * No implants in log *

Complications: none

Findings: consistent with preoperative diagnosis

Disposition: awakened from anesthesia, extubated and taken to the recovery room in a stable condition, having suffered no apparent untoward event.

Condition: doing well without problems

Technique: see operative report

Ryan Dewitz, MD
LSU Ortho PGY2[RD1.1]

Revision History

User Key	Date/Time	User	Provider Type	Action
> RD1.1	5/28/2018 3:00 PM	Ryan James Dewitz, MD	Resident	Sign

Case Tracking Events

Event	Time In
In Facility	1120
Pre-procedure Arrival	
In Pre-Procedure	1135
Pre-Procedure Care Complete	1255
Anesthesia Start	1335
Anesthesia Ready	
Sent for Patient	
In Holding Room	1255
Holding Care Complete	1333
In Room	1333
Proc/Inc Start	1350
Proc/Inc Closing	1452
Proc/Inc Finish	1452

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BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/28/2018, D/C: 5/28/2018

Case Tracking Events (continued)

Event	Time In
Out of Room	1507
Cleanup Start	
Cleanup Complete	
In PACU	1508
Anesthesia Finish	1512
Ready for Discharge from PACU	1546
Out of PACU	1546
Return to PACU	
Out of PACU (2nd Time)	
In Phase II	1600
Ready for Discharge from Phase II	1745
Out of Phase II	1745
Return to Phase II	
Out of Phase II (2nd Time)	
Procedural Care Complete	1810

Event Tracking

Panel 1

Event	Start Time
Panel Start	
Panel End	

Procedure : OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER

Event	Start Time
Procedure Start	1350
Procedure End	1452

Verify History

Staff Name	Date	Time	Type
Courtnie Breaux	5/28/2018	1255	Pre-Op
Melynda Catanese	5/28/2018	1511	Intra-Op
Elise Michaelis	5/28/2018	1546	Phase I
Lisa Cruz	5/28/2018	1826	Phase II
Lynne Kennedy	5/29/2018	0740	AN Charge Trigger

OR Nursing Notes

No notes found.

Staff and Times
5/28/2018

Surgeons

		Role	Time In	Time Out
Joseph Gonzales, MD	Panel 1	Primary		
Muayad Kadhim, MD	Panel 1	Resident: Teaching Assistant		
Ryan James Dewitz, MD	Panel 1	Resident: First Assistant		

Staff

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/28/2018, D/C: 5/28/2018

Staff (continued)

	Type	Time In	Time Out
Melynda Catanese	Circulator	5/28/2018 1333	5/28/2018 1507
Allison Alsaade	Scrub Person	5/28/2018 1333	5/28/2018 1448
Kenneth Block	Radiology Technologist	5/28/2018 1357	5/28/2018 1448
Glenysa Carbajal	Scrub Person	5/28/2018 1445	5/28/2018 1507

Anesthesia Staff

	Type	Time In	Time Out
Donald Edward Smith, MD	Anesthesiologist		
Marie Denise Hollier, CRNA	CRNA		
Paula M Davis, RN	Student Nurse Anesthetist		

Pre-Incision Documentation
5/28/2018

Confirmed at Scheduling

None

Verification at Registration

None

Timeouts

Melynda Catanese at Mon May 28, 2018 1332

Timeout Details

Timeout type: Before Rolling To Room

Procedures

Panel 1: Right CLOSED MANIPULATION SHOULDER with Joseph Gonzales, MD
Panel 1: Right OPEN REDUCTION INTERNAL FIXATION HUMERUS with Joseph Gonzales, MD

Timeout Questions

Correct patient? Yes
Correct site? Yes
Correct side? Yes
Correct procedure? Yes
Site marked? Yes
H&P note completed? Yes
Consents verified? Yes
Radiology studies available? Yes
Relevant lab results available? Yes
Allergies reviewed? Yes
Are all required blood products & devices for the procedure available? Yes
Is documentation verified? Yes

Staff Present

Staff: Melynda Catanese

Verification History

Staff	Performed	Verified

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Timeouts (continued)

Melynda Catanese	Mon May 28, 2018 1332	Mon May 28, 2018 1357

Melynda Catanese at Mon May 28, 2018 1349

Timeout Details

Timeout type	Fire Safety

Procedures

Panel 1: Right CLOSED MANIPULATION SHOULDER with Joseph Gonzales, MD
Panel 1: Right OPEN REDUCTION INTERNAL FIXATION HUMERUS with Joseph Gonzales, MD

Staff Present

Surgeons	Joseph Gonzales, MD, Ryan James Dewitz, MD, Muayad Kadhim, MD
Anesthesia Staff	Marie Denise Hollier, CRNA, Paula M Davis, RN
Staff	Melynda Catanese, Allison Alsaade, Kenneth Block

Verification History

Staff	Performed	Verified
Melynda Catanese	Mon May 28, 2018 1349	Mon May 28, 2018 1442

Melynda Catanese at Mon May 28, 2018 1349

Timeout Details

Timeout type	Pre-incision

Procedures

Panel 1: Right CLOSED MANIPULATION SHOULDER with Joseph Gonzales, MD
Panel 1: Right OPEN REDUCTION INTERNAL FIXATION HUMERUS with Joseph Gonzales, MD

Timeout Questions

Correct patient? Yes
Correct site? Yes
Correct side? Yes
Correct position? Yes
Correct procedure? Yes
Site marked? Yes
Antibiotics ordered and given? Yes
Safety precautions reviewed? Yes
Have all team members been introduced? Yes
Has the surgeon reviewed the critical steps? Yes
Has the nursing team reviewed the sterility? Yes
Has the nursing staff reviewed the equipment for potential problems? Yes

Staff Present

Surgeons	Joseph Gonzales, MD, Ryan James Dewitz, MD, Muayad Kadhim, MD
Anesthesia Staff	Marie Denise Hollier, CRNA, Paula M Davis, RN
Staff	Melynda Catanese, Allison Alsaade, Kenneth Block

Verification History

Staff	Performed	Verified

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Timeouts (continued)

Melynda Catanese	Mon May 28, 2018 1349	Mon May 28, 2018 1443

Melynda Catanese at Mon May 28, 2018 1444

Timeout Details

Timeout type	Sign-out

Procedures

Panel 1: Right OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER with Joseph Gonzales, MD

Timeout Questions

Are counts correct? Yes
Have specimens been labeled? N/A
Have all new equipment problems been addressed? Yes
Have all recovery issues been reviewed? Yes

Staff Present

Surgeons	Joseph Gonzales, MD, Ryan James Dewitz, MD, Muayad Kadhim, MD
Anesthesia Staff	Marie Denise Hollier, CRNA, Paula M Davis, RN
Staff	Melynda Catanese, Allison Alsaade, Kenneth Block

Verification History

Staff	Performed	Verified
Melynda Catanese	Mon May 28, 2018 1444	Mon May 28, 2018 1444

Patient Preparation

Area	Laterality	Scrub	Paint	Hair Removal
Arm,Shoulder	Right	Chlorohexidine/Alcohol 70%		N/A

Skin Condition

Skin Site	Condition
Grounding	**Warm, Dry, Intact**
Operative	**Warm, Dry, Intact**
Overall	**Warm, Dry, Intact**

Positioning Information

Panel-1 Information

OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER (Right) - Position 1

Body:	**Supine** Sheet Draw, Strap Safety	Left Arm:	**Extended** Armboard	Right Arm:	**Extended** Armboard, Foam Eggcrate Pad
Head:	**Aligned** Pillow, Gel Pad Donut	Left Leg:	**Straight** Pillow, Foam Eggcrate Pad	Right Leg:	**Straight** Pillow, Foam Eggcrate Pad
Positioned by:	**Melynda Catanese** **Joseph Gonzales, MD**			Comments:	

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Positioning Information (continued)

Counts

Type	Which?	Correct?	X-Ray?	MD Notif?	Counted By	Verified By
Sponge	Initial				Allison Alsaade	Melynda Catanese
Needles/Sharps	Initial				Allison Alsaade	Melynda Catanese
Sponge	Final	Yes			Allison Alsaade	Melynda Catanese
Needles/Sharps	Final	Yes			Allison Alsaade	Melynda Catanese
Sponge	Closing	Yes			Allison Alsaade	Melynda Catanese
Needles/Sharps	Closing	Yes			Allison Alsaade	Melynda Catanese

Closing Documentation
5/28/2018

Post-op Skin Information

Skin Site	Condition
Grounding	**Warm, Dry, Intact**
Operative	**Warm, Dry, Intact**
Overall	**Warm, Dry, Intact**

Case Completion Information

Incision Site	Laterality	Dressings
Arm	Right	
Shoulder	Right	

Specimen Orders

Start		Ordered
Signed and Held	**Sickle Cell Screen per protocol** Once, Status: Canceled	Signed and Held

Equipment/Instruments/Supplies
5/28/2018

Electro Surgery Units

ESU Type	ESU	Blend Setting	Mode	Pad Loc	Laterality	Coag Set	Cut Set	Applied By
ESU	#27	MonoPolar	Monopolar	Outer Thigh	Right			

X-Rays

Device Type	Device	Image Type	Area	Laterality
C-Arm				

Other Equipment

Type	Equipment	Setting	Setting Low	Setting High	Applied By
Suction					

Instruments

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Instruments (continued)

Instrument Type	Instrument	Start	End
MINOR ORTHO SET			
blue			

Supplies

Panel 1 Combined Pick List

Manufacturer Number	Supply	Item Type	Used	Wasted	Reason Wstd	Inventory Loc	Is Lat ex?
45549	BANDAGE ADHESIVE COVER-ROLL POLYESTER POLYACRYLATE L2 YD X W6 IN STRETCHED NONWOVEN POROUS LATEX FREE DISPOSABLE	Bandage	1	0		LCMC SPECIAL ORDERS	
2108305000	BLADE SAW STAINLESS STEEL THK.9 MM MEDIUM WIDE L73 MM X W25 MM AGGRESSIVE TOOTH STERILE	Blade	1	0		LCMC SPECIAL ORDERS	
E2515H	CAUTERY PENCIL W/HOLSTER_E2515H	Electrode	1	0		LCMC SPECIAL ORDERS	
E7507	CAUTERY POLYHESIVE FOAM PAD _E7507	Electrode	1	0		LCMC SPECIAL ORDERS	
DYNJP2416	DRAPE 3/4 _DYNJP2416	Drape	1	0		LCMC SPECIAL ORDERS	
4955	DRAPE CASSETTE UNIVERSAL L40 IN X W24 IN XRAY ADHESIVE STRIP CLOSURE LATEX FREE DISPOSABLE	Drape	1	0		LCMC SPECIAL ORDERS	
DKC20068	DRESSING PETROLATUM XEROFORM GAUZE L9 IN X W5 IN NONADHERENT STERILE LATEX FREE	Dressing	1	0		LCMC SPECIAL ORDERS	
N104A	ELECTRODE ELECTROSURGICAL COLORADO TUNGSTEN NEEDLE L4 CM OD3/32 IN STRAIGHT SLEEVE MICRODISSECTION INSULATE STERILE DISPOSABLE	Electrode	1	0		LCMC SPECIAL ORDERS	
ESE1651	ELECTRODE ELECTROSURGICAL TUNGSTEN NEEDLE STANDARD L3 CM OD2.4 MM EXTEND INSULATION LATEX FREE MICROSURGICAL	Electrode	0	0		LCMC SPECIAL ORDERS	
E7510-25	ELECTRODE PATIENT RETURN VALLEYLAB REM POLYHESIVE II REM POLYHESIVE INFANT L9 FT CORD	Electrode	0	0		LCMC SPECIAL ORDERS	
2D73EB60	GLOVE SURGICAL PROTEXIS NEU-THERA POLYISOPRENE 6 L12 IN SMOOTH BEAD CUFF STERILE LATEX FREE BLUE THK7.9 MIL	Glove	0	0		LCMC SPECIAL ORDERS	
2D73EB65	GLOVE SURGICAL PROTEXIS NEU-THERA POLYISOPRENE 6.5 L12 IN SMOOTH BEAD CUFF STERILE LATEX FREE BLUE THK7.9 MIL	Glove	0	0		LCMC SPECIAL ORDERS	
2D73EB70	GLOVE SURGICAL PROTEXIS NEU-THERA POLYISOPRENE 7 L12 IN POWDER FREE	Glove	0	0		LCMC SPECIAL	

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	SMOOTH BEAD CUFF INTERLOCK STERILE LATEX FREE BLUE THK7.9 MIL				ORDERS
2D73EB75	GLOVE SURGICAL PROTEXIS NEU-THERA POLYISOPRENE 7.5 L12 IN POWDER FREE SMOOTH BEAD CUFF INTERLOCK STERILE LATEX FREE BLUE THK7.9 MIL	Glove	0	0	LCMC SPECIAL ORDERS
2D73EB80	GLOVE SURGICAL PROTEXIS NEU-THERA POLYISOPRENE 8 L12 IN SMOOTH BEAD CUFF STERILE LATEX FREE BLUE THK7.9 MIL	Glove	1	0	LCMC SPECIAL ORDERS
2D73EB85	GLOVE SURGICAL PROTEXIS NEU-THERA POLYISOPRENE 8.5 L12 IN SMOOTH BEAD CUFF STERILE LATEX FREE BLUE THK7.9 MIL	Glove	0	0	LCMC SPECIAL ORDERS
2D72PT65X	GLOVE SURGICAL PROTEXIS POLYISOPRENE 6 1/2 POWDER FREE BEAD CUFF INTERLOCK STERILE LATEX FREE	Glove	0	0	LCMC SPECIAL ORDERS
2D72PT75X	GLOVE SURGICAL PROTEXIS POLYISOPRENE 7 1/2 POWDER FREE BEAD CUFF INTERLOCK STERILE LATEX FREE	Glove	0	0	LCMC SPECIAL ORDERS
2D72PT70X	GLOVE SURGICAL PROTEXIS POLYISOPRENE 7 POWDER FREE BEAD CUFF INTERLOCK STERILE LATEX FREE	Glove	0	0	LCMC SPECIAL ORDERS
2D72PT85X	GLOVE SURGICAL PROTEXIS POLYISOPRENE 8 1/2 POWDER FREE BEAD CUFF INTERLOCK STERILE LATEX FREE	Glove	0	0	LCMC SPECIAL ORDERS
MSG1080	GLOVE SURGICAL SENSICARE ISOLEX ALOE 8 L12 IN POWDER FREE BEAD CUFF SMOOTH TEXTURE STERILE LATEX FREE WHITE THK9.8 MIL	Glove	0	0	LCMC SPECIAL ORDERS
MSG1060	GLOVE SURGICAL SENSICARE ISOLEX ALOE VERA 6 L12 IN POWDER FREE BEAD CUFF SMOOTH TEXTURE STERILE LATEX FREE WHITE THK10 MIL	Glove	0	0	LCMC SPECIAL ORDERS
MSG1085	GLOVE SURGICAL SENSICARE ISOLEX ALOE VERA 8.5 L12 IN POWDER FREE BEAD CUFF SMOOTH TEXTURE STERILE LATEX FREE WHITE THK10 MIL	Glove	4	0	LCMC SPECIAL ORDERS
DYNJP2307P	GOWN SURGICAL XL_DYNJP2307P	Gown	3	0	LCMC SPECIAL ORDERS
79-84230	IMMOBILIZER ORTHOPEDIC PROCARE FOAM UNIVERSAL OD54- IN SHOULDER SLING SWATHE CRISS CROSS STRAP CONTACT CLOSURE LATEX FREE	Immobilizer	1	0	LCMC SPECIAL ORDERS
DYNJ49192A	PACK SURGICAL CUSTOM MAJOR LCMC	Pack	1	0	LCMC SPECIAL ORDERS
DYNJP1005	PACK SURGICAL SET UP PACK	Pack	1	0	LCMC SPECIAL ORDERS
2F7124	SOLUTION IRRIGATION 0.9% NACL 1000 ML 2F7124	Solution	1	0	LCMC SPECIAL ORDERS
75-102	SOLUTION PREP 70% ISOPROPANOL 16 OZ	Solution	0	0	

MDS098001Z	SOLUTION WOUND 3% HYDROGEN PEROXIDE 16 OZ ANTISEPTIC DEBRIDE AGENT LATEX FREE	Solution	0	0	LCMC SPECIAL ORDERS	
MDS251518LF	SPONGE LAPAROTOMY COTTON L18 IN X W18 IN L7 IN 4 PLY RADIOPAQUE PYRONEMA FREE HIGH ABSORBENT STERILE LATEX FREE DISPOSABLE	Sponge	0	0	LCMC SPECIAL ORDERS	
J418H	SUTURE 0 VICRYL SH 27" BRAID_J418H	Suture	1	0	LCMC SPECIAL ORDERS	
J341H	SUTURE 1 VICRYL CT-1 27" VIOLET_J341H	Suture	1	0	LCMC SPECIAL ORDERS	
MCP427H	SUTURE ABSORBABLE MONOCRYL PLUS MULTIPASS 3-0 PS-2 L27 IN MONOFILAMENT UNDYED	Suture	1	0	LCMC SPECIAL ORDERS	Yes
J459H	SUTURE ABSORBABLE VICRYL 2-0 X-1 L27 IN BRAID COATED UNDYED	Suture	0	0	LCMC SPECIAL ORDERS	
J423H	SUTURE ABSORBABLE VICRYL 3-0 FS-2 L27 IN BRAID COATED UNDYED	Suture	0	0	LCMC SPECIAL ORDERS	
7345826	TAPE CASTING DELTA-LITE PLUS FIBERGLASS POLYURETHANE RESIN L4 YD X W3 IN SMOOTH SURFACE RIGID SUPPORT END LAY DOWN LOW TACK LATEX FREE GREEN	Tape	0	0	LCMC SPECIAL ORDERS	
28700-004	TOWEL SURGICAL ALLEGIANCE COTTON WOVEN L24 IN X W17 IN HIGH ABSORBENT DELINT PREWASH STERILE LATEX FREE DISPOSABLE BLUE	Towel	1	0	LCMC SPECIAL ORDERS	

Implants

None

Encounter-Level Documents:

There are no encounter-level documents.

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Anesthesia

Bodin, Jeffrey [1002548110] **Male** **21 y.o.** Current as of 05/28/18 1227

Height	Weight	BMI	NPO Status
1.72 m (05/28/18)	49.7 kg (05/28/18)	16.8 (05/28/18)	1900

Allergies	ASA Status
LACTOSE, LATEX	2

Anesthesia Type
general

Anesthesia Procedure Summary

Date	Anesthesia Start	Anesthesia Stop	Room / Location
05/28/18	1335	1512	CH MAIN OR 10 / CH MAIN OR

Procedure	Diagnosis	Surgeon	Responsible Staff
OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER (Right Arm)	Dislocation of right shoulder joint, initial encounter (Dislocation of right shoulder joint, initial encounter [S43.004A]; Dislocation of right shoulder joint, initial encounter [S43.004A])	Joseph Gonzales, MD	Donald Edward Smith, MD

Staff 05/28/18

Name	Role	Begin	End
Donald Edward Smith, MD	ANESTH	1335	1512
Marie Denise Hollier, CRNA	CRNA	1335	1512
Paula M Davis, RN	GSA	1335	1512

Events

Date	Time	Event
5/28/2018	1335	Anesthesia Start
	1335	Start Data Collection
	1335	Pre Induction Eval The patient was re-assessed just prior to induction/procedure start.
	1335	Induction
	1341	Intubation
	1502	Extubation Adequate spontaneous ventilation, TOF=4/4 with sustained tetanus, Patient Suctioned,Extubated with Positive Pressure, 100% oxygen applied by Face Mask, Positive ET CO2.
	1505	Stop Data Collection
	1512	Anesthesia Stop

Anesthesia History

Narcolepsy	Peripheral neuropathy
Migraine-cluster headache syndrome	Seizure syndrome

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Anesthesia (continued)

Anesthesia History (continued)

Clinical trial participant	Dislocated shoulder
Cancer	Seasonal allergies
Melanoma in situ of left lower leg	

Facility Administered Medications

No medications found

Surgical History

WISDOM TOOTH EXTRACTION	melanoma excision
TONSILLECTOMY	ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES
APPENDECTOMY	

Prescription Medications

Within last 14 days from 05/28/18

	Last Taken	Last Updated
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry	Taking	05/25/18 1248
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet	Taking	05/25/18 1248
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet	Taking	05/25/18 1248
montelukast (SINGULAIR) 10 mg tablet	Taking	05/25/18 1248
naproxen sodium (ALEVE) 220 MG tablet	Taking	05/25/18 1248

Substance History

Smoking Status: Never Smoker
Smokeless Tobacco Status: Never Used
Alcohol use: No
Drug use: No

Go to the Preprocedure Summary Report for this case.

Procedure Notes

Last edited 05/28/18 1355 by Marie Denise Hollier, CRNA

Airway Insertion

Patient Location is OR.

Staff:
Anesthesiologist: SMITH, DONALD EDWARD.

CRNA: HOLLIER, MARIE DENISE.

Performed with SRNAs.

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Anesthesia (continued)

Procedure Notes (continued)

PLACEMENT:
Airway indications Anesthesia.
Spontaneous vent: present
Sedation level: Anesthesia
Preoxygenated: yes
Patient position: Supine
MILS maintained throughout
Mask difficulty assessment: Easy mask

Final Airway Details

Final airway type: Endotracheal airwaySuccessful airway: Oral ETT
Cuffed: cuffed
Successful intubation technique: Direct laryngoscopy
Endotracheal tube insertion site: Oral
Blade: Miller
Blade size: #2
Placement verified by: auscultation, CO2 detection, chest rise and direct visualization
Breath Sounds: Equal
Cormack-Lehane Classification: grade I - full view of glottis
Inital cuff pressure (cm H2O): MOP
ETT to lips (cm): 21
Measured from: Lips
Lips/Dentition: Unchanged
Secured Method: Pink tape Secured Location: Left
Number of attempts at approach: 1

Preprocedure Note

Last edited 05/28/18 1227 by Tino Kuzma Vekic, CRNA

Anesthesia Evaluation

Review of Symptoms:

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Anesthesia (continued)

Preprocedure Note (continued)

Patient summary reviewed and Nursing notes reviewed
The patient is noted as not having history of anesthetic complications and family history of Anes complications.

Birth History: Neg birth History ROS.
Cardiovascular: Neg cardio ROS.
Hematologic: Hematologic/lymphatic negative.
Pulmonary: Neg pulmonary ROS.
Neurological: Severe narcolepsy- takes adderall
Muscle/Bone Problems: Right shoulder dislocation. Suffers from nerve problems 2nd to interferon infusions. Pt didn't know his shoulder was dislocated. Doesn't feel pain in that joint as well as other joints.
Miscellaneous: Positive for cancer (hx of melonoma 2010. in remission).

Physical Exam:

Identifiers: Name, DOB and MRN.

Airway Mallampati score: II. TM distance: >3 FB. Neck ROM: full.
Cardiovascular: Cardiovascular exam normal. Rhythm: regular Rate: normal.
Dental: No notable dental hx.

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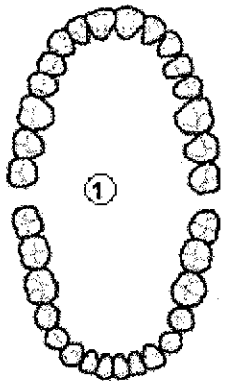
Anesthesia (continued)

Preprocedure Note (continued)



1: Permanent retainer on the bottom

Pulmonary:
Pulmonary exam normal.

Abdominal:

Other Findings:

Past Medical History:

Diagnosis	Date
• Cancer *Dr. Leblanc*	
• Clinical trial participant *Zyrem Rems Trial - pt states unsuccessful*	2016
• Dislocated shoulder	
• Melanoma in situ of left lower leg	
• Migraine-cluster headache syndrome	
• Narcolepsy	02/15/2015
• Peripheral neuropathy	
• Seasonal allergies	
• Seizure syndrome	

Past Surgical History:

Procedure	Laterality	Date
• ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES		
• APPENDECTOMY		
• melanoma excision		
• TONSILLECTOMY		
• WISDOM TOOTH EXTRACTION		2015

Anesthesia Plan
ASA Score: **2**

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Anesthesia (continued)

Preprocedure Note (continued)

Plan: **general**
CRNA/Resident and Attending have discussed this plan.
Informed Consent:
Discussed with: **patient**
Patient/representative **consented to** anesthesia plan.
NPO Status: **Confirmed**

All Postprocedure Notes

Last edited 05/28/18 1529 by Brandon Sanders Black, MD

Anesthesia Post Note

Patient: Jeffrey Bodin

Procedures(s) performed: *OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER*

Anesthesia type: General

Last Vitals:

Vitals:

	05/28/18 1520
BP:	(!) 149/95
Pulse:	79
Resp:	18
Temp:	
SpO2:	100%

Patient Location: PACU

Post assessment: tolerated well, no immediate complications

Post vital signs: post-procedure vital signs reviewed and stable

Temp: post-procedure temperature appropriate

Post pain: adequate control

Post Op Nausea/Vomiting: no PONV

Motor Function: gross motor function is at baseline for patient

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Anesthesia (continued)

All Postprocedure Notes (continued)

Level of Consciousness: awake

Procedure Information: hypotension not controlled and hypothermia not controlled
Complications: no anesthesia complication

Airway: room air

Postoperative Hydration: acceptable

Electronically signed by Brandon Sanders Black, MD at 5/28/2018 3:29 PM

Attestation Information

Staff Name	Date	Time	Type
Courtnie Breaux	05/28/18	1255	Pre-Op
Donald Edward Smith, MD	05/28/18	1335	Present at Induction
Melynda Catanese	05/28/18	1511	Intra-Op
Elise Michaelis	05/28/18	1546	Phase I
Lisa Cruz	05/28/18	1826	Phase II
Lynne Kennedy	05/29/18	0740	AN Charge Trigger

Medications

propofol (DIPRIVAN) injection 10 mg/mL (mg)	150 mg	Given	05/28/18 1338	Marie Denise Hollier, CRNA
	50 mg	Given	1340	Marie Denise Hollier, CRNA
fentaNYL (SUBLIMAZE) injection (mcg)	75 mcg	Given	05/28/18 1338	Marie Denise Hollier, CRNA
rocuronium (ZEMURON) 10 mg/mL injection (mg)	25 mg	Given	05/28/18 1338	Marie Denise Hollier, CRNA
	25 mg	Given	1412	Marie Denise Hollier, CRNA
ondansetron (PF) (ZOFRAN) injection (mg)	4 mg	Given	05/28/18 1440	Marie Denise Hollier, CRNA
sugammadex (BRIDION) injection (mg)	200 mg	Given	05/28/18 1455	Marie Denise Hollier, CRNA
lidocaine injection 2% (mg)	50 mg	Given	05/28/18 1338	Marie Denise Hollier, CRNA
ceFAZolin (ANCEF) 1 g injection (mg)	1,490 mg	Given	05/28/18 1416	Marie Denise Hollier, CRNA
ketorolac (TORADOL) injection (mg)	30 mg	Given	05/28/18 1442	Marie Denise Hollier, CRNA
lactated ringers infusion (mL)		New Bag	05/28/18 1338	Marie Denise Hollier, CRNA

Signoff Status

None

All Meds and Administrations

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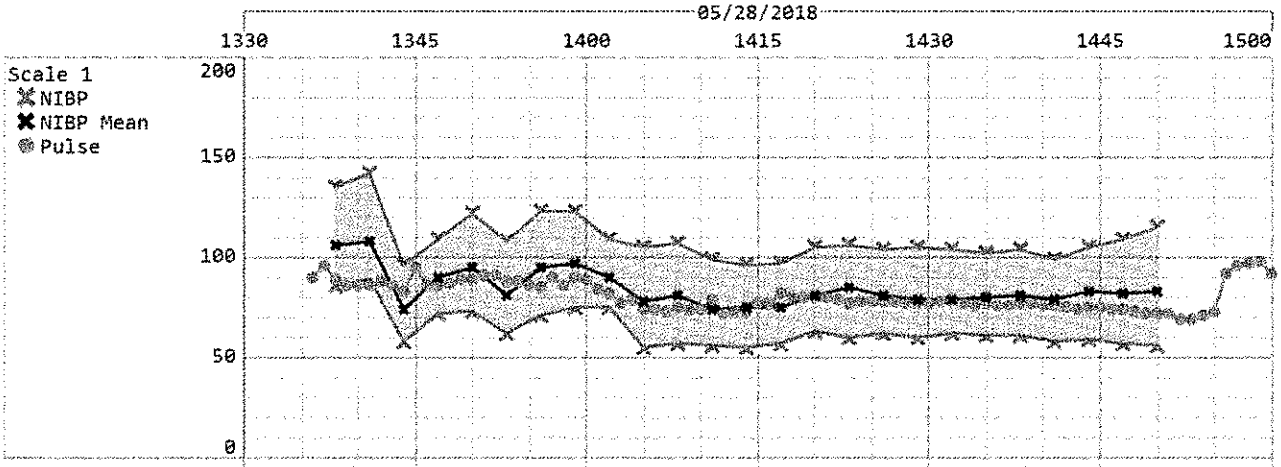
Anesthesia (continued)

All Meds and Administrations (continued)

(No medication admins scheduled or recorded for this encounter)



O2	(L/min)	[9.3]	[1]	[1]	[1]	[1]	[9.3]
N2O	(L/min)	[5.4]	[1.2]	[1.2]	[1.2]	[1.2]	[0]
N2O(I)	(%)	[35]	[45]	[51]	[52]	[51]	[4]
Air	(L/min)	[0]	[0]	[0]	[0]	[0]	[0]
Sevoflurane (I)	(%)	[0]	[1.5]	[2]	[2.1]	[1.6]	[0]
Sevoflurane (E)	(%)	[0]	[1.3]	[1.8]	[1.9]	[1.7]	[0.1]
propofol (DIP…	(mg)	[200]					
fentaNYL (SU…	(mcg)	75					
rocuronium (Z…	(mg)	25		25			
ondansetron (…	(mg)					4	
sugammadex (B…	(mg)						200
lidocaine inj…	(mg)	50					
ceFAZolin (AN…	(mg)				1490		
ketorolac (TO…	(mg)					30	
lactated ring…	(mL)	/					
FiO2 (%)	(%)	[63]	[51]	[44]	[43]	[45]	[89]
Vent Mode		[SV]	[VC]	[VC]	[VC]	[PSV]	[SV]
Resp		[2]	[15]	[12]	[14]	[5]	[16]
Vt Observed	(ml)	[47]	[484]	[441]	[437]	[350]	[30]
PIP Obser…	(cm H2O)		[12]	[10]	[10]	[12]	[12]
PEEP/CPAP…	(cm H2O)		[3]	[2]	[2]	[4]	[4]
Pressure …	(cm H2O)					[10]	[10]
Temp			[97.2]	[96.1]	[95.4]	[95.4]	[95.4]
EKG		[NSR]	NSR	NSR	NSR	NSR	NSR
SpO2	(%)	[99]	[98]	[98]	[98]	[98]	[97]
ETCO2	(mmHg)	[0]	[32]	[34]	[31]	[41]	[23]

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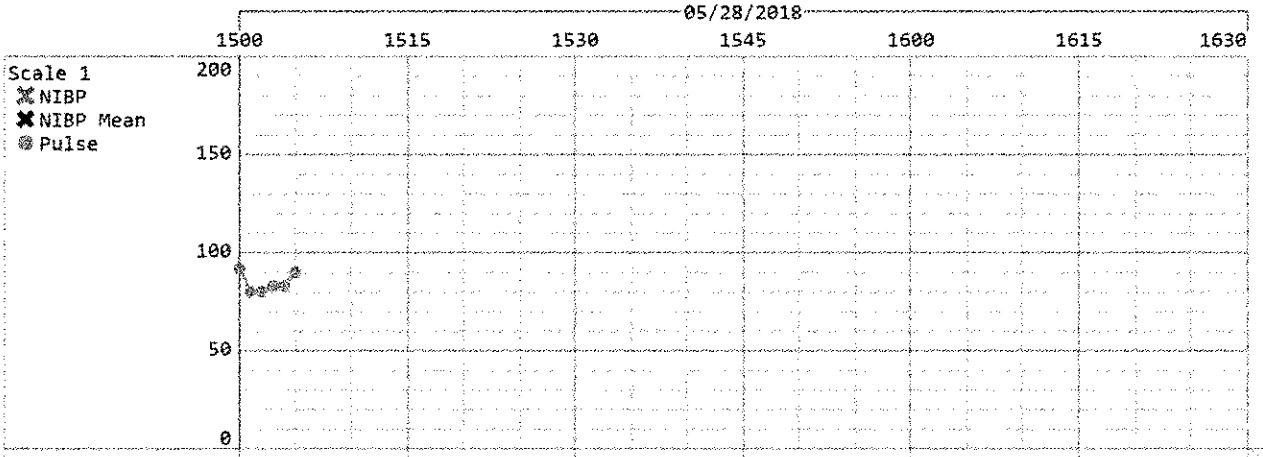
Anesthesia (continued)



O2	(L/min)	[9.2]	
N2O	(L/min)	[0]	
N2O(I)	(%)	[0]	
Air	(L/min)	[0]	
Sevoflurane (I)	(%)	[0]	
Sevoflurane (E)	(%)	[0]	
propofol (DIP…	(mg)		200 mg
fentaNYL (SU…	(mcg)		75 mcg
rocuronium (Z…	(mg)		50 mg
ondansetron (…	(mg)		4 mg
sugammadex (B…	(mg)		200 mg
lidocaine inj…	(mg)		50 mg
ceFAZolin (AN…	(mg)		1490 mg
ketorolac (TO…	(mg)		30 mg
lactated ring…	(mL)		
FiO2 (%)	(%)	[95]	
Vent Mode		[SV]	
Resp		[4]	
Vt Observed	(ml)		
PIP Obser…	(cm H2O)		
PEEP/CPAP…	(cm H20)		
Pressure …	(cm H2O)		
Temp			
EKG		NSR	
SpO2	(%)	[96]	
ETCO2	(mmHg)	[0]	

All Orders and Results

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Imaging - All Orders and Results

XR Shoulder 1 VW Right

Electronically signed by: **Ryan James Dewitz, MD on 05/28/18 1506** Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Ryan James Dewitz, MD 05/28/18 1506 Ordering provider: Ryan James Dewitz, MD
Final result

Performed: 05/28/18 1533 - 05/28/18 1546
Narrative:
RIGHT SHOULDER AP:

Impression:
There is a healing right humeral head fracture in near anatomical alignment based on this single AP view.

Electronically Signed By: Ewa Wasilewska, M.D. 5/28/2018 4:47 PM CDT

Fluoroscopy up to 1 Hour

Electronically signed by: **Joseph Gonzales, MD on 05/30/18 1000** Status: **Completed**
Mode: Ordering in Verbal with readback, cosign Required mode Communicated by: Melynda Catanese
This order may be acted on in another encounter.
Ordering user: Melynda Catanese 05/28/18 1355 Ordering provider: Joseph Gonzales, MD
Final result

Performed: 05/28/18 1345 - 05/28/18 1445
Narrative:
FLUOROSCOPY UP TO 1 HOUR:

Impression:

Fluoroscopic imaging and time was provided for intraoperative guidance without radiologist present and one image obtained.

Electronically Signed By: Christopher Arcement, M.D. 5/28/2018 3:09 PM CDT

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/28/2018, D/C: 5/28/2018

Medications

Medication Admin Record

HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet 1 tablet [98269712]

Status: Discontinued (Past End Date/Time), Reason: Patient Discharge

Ordering Provider: Ryan James Dewitz, MD
Ordered On: 05/28/18 1519
Dose (Remaining/Total): 1 tablet (-/-)
Route: Oral
Admin Instructions: Maximum dose of acetaminophen is 4000 mg from all sources in 24 hours.

Starts/Ends: 05/28/18 1519 - 05/28/18 2027
Frequency: Every 6 Hours PRN
Rate/Duration: - / -

Action Time	Action	Dose	Route	Other Information
05/28/18 1524	Given	1 tablet	Oral	Given by: Elise Michaelis

midazolam (VERSED) 10 mg/5 mL (2 mg/mL) syrup 20 mg [98042879]

Status: Discontinued (Past End Date/Time), Reason: Patient Transfer

Ordering Provider: Lorena Dumas Guntner, MD
Ordered On: 05/28/18 1200
Dose (Remaining/Total): 20 mg (1/1)
Route: Oral

Starts/Ends: 05/28/18 1215 - 05/28/18 1452
Frequency: Once
Rate/Duration: - / -

Action Time	Action / Reason	Dose	Route	Other Information
05/28/18 1251	Not Given Patient/family refused	20 mg	Oral	Given by: Joann Lee

Patient Education

Patient Education

Title: OR AFTER ANESTHESIA (Done)

Topic: Self Care (Done)

Point: Activities (Done)

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	Explanation	Verbalizes Understanding		EM 05/28/18 1545	Done

Point: Diet (Done)

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status

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Patient Education (continued)

Patient Education (continued)

Patient	Acceptance	Explanation	Verbalizes Understanding	EM 05/28/18 1545	Done

Point: When to Call the Doctor (Done)

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	Explanation	Verbalizes Understanding		EM 05/28/18 1545	Done

User Key

Initials	Effective Dates	Name	Provider Type	Discipline
EM	03/26/18 -	Elise Michaelis	Registered Nurse	Nurse

Discharge Instructions

Discharge Instructions Bodin, Jeffrey (MR # 1002548110)

None

Medication List

As of 5/28/2018 5:34 PM

START taking these medications

HYDROcodone-acetaminophen 5-325 mg per tablet [ ]
Commonly known as: NORCO
Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days

ketorolac 10 mg tablet [ ]
Commonly known as: TORADOL
Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days

CONTINUE taking these medications

ALEVE 220 MG tablet [ ]
Generic drug: naproxen sodium

buPROPion 300 MG 24 hr tablet [ ]
Commonly known as: WELLBUTRIN XL

dextroamphetamine-amphetamine 20 mg Tab per tablet [ ]
Commonly known as: ADDERALL

DYMISTA 137-50 mcg/spray Spry [ ]
Generic drug: azelastine-fluticasone

montelukast 10 mg tablet [ ]
Commonly known as: SINGULAIR

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Medication List (continued)

Where to Get Your Medications

Information about where to get these medications is not yet available

! Ask your nurse or doctor about these medications

- ☐ HYDROcodone-acetaminophen 5-325 mg per tablet
- ☐ ketorolac 10 mg tablet

Flowsheets

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Flowsheets (all recorded)

PACU - Thu May 31, 2018

Incision 05/28/18 Shoulder Right

Incision Properties	Date First Assessed: **05/28/18** MC Time First Assessed: **1425** MC Location: **Shoulder** MC Wound Orientation: **Right** MC Recorded by: [MC] -MC 05/28/18 1425

OR Incisions/Wounds - Thu May 31, 2018

Incision 05/28/18 Shoulder Right

Incision Properties	Date First Assessed: **05/28/18** MC Time First Assessed: **1425** MC Location: **Shoulder** MC Wound Orientation: **Right** MC Recorded by: [MC] -MC 05/28/18 1425

Call Complete - Thu May 31, 2018

1316

OTHER

Post-op Call Complete	Y -AC
Recorded by	[AC] AC 05/31/18 1316

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Flowsheets (all recorded)

Data - Mon May 28, 2018

	1524
OTHER	
Pain Assessment	0-10 -EM
Pain Score	Eight -EM
Recorded by	[EM] EM 05/28/18 1529
Pain Assessment	
Pain Type	Surgical pain -EM
Recorded by	[EM] EM 05/28/18 1529

Custom Formula Data - Mon May 28, 2018

	1700	1600	1540	1530	1520
Vitals Assessment					
Automatic Restart Vitals Timer			Yes -EM	Yes -EM	Yes -EM
Recorded by			[EM] EM 05/28/18 1546	[EM] EM 05/28/18 1543	[EM] EM 05/28/18 1528
OTHER					
Shock Index (HR/SBP)	0.54 -LC	0.49 -JW	0.46 -EM	0.53 -EM	0.53 -EM
Recorded by	[LC] LC 05/28/18 1806	[JW] JW 05/28/18 1631	[EM] EM 05/28/18 1546	[EM] EM 05/28/18 1543	[EM] EM 05/28/18 1528
Relevant Labs and Vitals					
Temp (in Celsius)	37.5 -LC	37.6 -JW			
Recorded by	[LC] LC 05/28/18 1806	[JW] JW 05/28/18 1631			

	1508	1152
Vitals Assessment		
Automatic Restart Vitals Timer		Yes -JL
Recorded by		[JL] JL 05/28/18 1154
OTHER		
Shock Index (HR/SBP)	0.56 -EM	0.73 -JL
AIBW (Calculated) Female		57.83 kg -JL
IBW/kg (Calculated) Male		67.75 kg -JL
Low Range Vt 6cc/kg MALE		406.5 mL -JL
Adult Moderate		542 mL -JL

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Flowsheets (all recorded) (continued)

Custom Formula Data - Mon May 28, 2018 (continued)

	1508	1152
Range Vt 8cc/kg MA		
Adult High Range Vt 10cc/kg MALE		677.5 mL -JL
IBW/kg (Calculated) FEMALE		63.25 kg -JL
Low Range Vt 6cc/kg FEMALE		379.5 mL -JL
Adult Moderate Range vt 8cc/kg FEMALE		506 mL -JL
Adult High Range Vt 10cc/kg FEMALE		632.5 mL -JL
FLOW1.6		2.46 CC/MIN -JL
FLOW1.8		2.77 CC/MIN -JL
FLOW2.0		3.08 CC/MIN -JL
FLOW2.2		3.39 CC/MIN -JL
FLOW2.4		3.7 CC/MIN -JL
FLOW2.8		4.31 CC/MIN -JL
FLOW3.0		4.62 CC/MIN -JL
Cerebral Perfusion flow		1.54 CC/MIN -JL
FLOW1.2		1.85 CC/MIN -JL
FLOW1.4		2.16 CC/MIN -JL
FLOW2.6		4 CC/MIN -JL
Percent Weight Change Since Birth		0 -JL
IBW/kg (Calculated)		67.75 -JL
Low Range Vt 6cc/kg		406.5 mL -JL
Adult Moderate Range Vt 8cc/kg		542 mL -JL
Adult High Range Vt 10cc/kg		677.5 mL -JL
Patient Denies Pain	Yes -EM	
Recorded by	[EM] EM 05/28/18 1512	[JL] JL 05/28/18 1154
Weight and Growth Recommendation		
AIBW (Calculated)		60.53 kg -JL

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Flowsheets (all recorded) (continued)

Custom Formula Data - Mon May 28, 2018 (continued)

	1508	1152
Male		
Recorded by		[JL] JL 05/28/18 1154
Relevant Labs and Vitals		
Temp (in Celsius)	36.4 -EM	36.7 -JL
Recorded by	[EM] EM 05/28/18 1512	[JL] JL 05/28/18 1154

Intra-op Care Plan - Mon May 28, 2018

	1355
Intra-op Care Plan	
Nursing Diagnosis	Risk for knowledge deficit/anxiety;Risk for pain;Risk for infection;Altered skin integrity;Risk for powerlessness;Risk for position injury -MC
Risk for knowledge deficit/anxiety	Yes -MC
Risk for infection	Yes -MC
Risk for position injury	Yes -MC
Altered Skin Integrity	Yes -MC
Risk for powerlessness	Yes -MC
Risk for pain	Yes -MC
Recorded by	[MC] MC 05/28/18 1355

OR Assessment Peds - Mon May 28, 2018

	1700	1600	1152
Charting Type			
Charting Type		Shift assessment -JW	--
Chart Reviewed		Y -JW	--
Recorded by		[JW] JW 05/28/18 1633	
Neurological			
Neuro (WDL)		WDL -JW	WDL -JL
Recorded by		[JW] JW 05/28/18 1633	[JL] JL 05/28/18 1156

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Flowsheets (all recorded) (continued)

OR Assessment Peds - Mon May 28, 2018 (continued)

	1700	1600	1152
HEENT			
HEENT (WDL)		WDL -JW	WDL -JL
Recorded by		[JW] JW 05/28/18 1633	[JL] JL 05/28/18 1156
Respiratory			
Respiratory (WDL)		WDL -JW	WDL -JL
Recorded by		[JW] JW 05/28/18 1633	[JL] JL 05/28/18 1156
Cardiac			
Cardiac (WDL)		WDL -JW	WDL -JL
Recorded by		[JW] JW 05/28/18 1633	[JL] JL 05/28/18 1156
Gastrointestinal			
Gastrointestinal (WDL)		WDL -JW	
Recorded by		[JW] JW 05/28/18 1633	
Peripheral Vascular			
Peripheral Vascular (WDL)		WDL -JW	WDL -JL
Recorded by		[JW] JW 05/28/18 1633	[JL] JL 05/28/18 1156
RUE Neurovascular Assessment			
RUE Capillary Refill	Less than/equal to 3 seconds -LC		
Color	Pink -LC		
Temperature	Warm -LC		
R Radial Pulse	+2 -LC		
Recorded by	[LC] LC 05/28/18 1808		
Integumentary			
Integumentary (WDL)		WDL -JW	WDL -JL
Recorded by		[JW] JW 05/28/18 1633	[JL] JL 05/28/18 1156
Musculoskeletal			
Musculoskeletal (WDL)		X -JW	WDL -JL
RUE		Limited movement;No Movement right arm in sling -JW2	
LUE		Full movement -JW	
RLE		Full movement -JW	
LLE		Full movement -JW	

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Flowsheets (all recorded) (continued)

OR Assessment Peds - Mon May 28, 2018 (continued)

1700	1600	1152
Recorded by	[JW] JW 05/28/18 1633 [JW2] JW 05/28/18 1635	[JL] JL 05/28/18 1156
Genitourinary		
Genitourinary (WDL)	WDL -JW	WDL -JL
Recorded by	[JW] JW 05/28/18 1633	[JL] JL 05/28/18 1156
Anus/Rectum		
Anus/Rectum (WDL)		WDL -JL
Recorded by		[JL] JL 05/28/18 1156
Psychosocial		
Psychosocial (WDL)	WDL -JW	WDL -JL
Recorded by	[JW] JW 05/28/18 1635	[JL] JL 05/28/18 1156
Humpty Dumpty Falls Assessment Scale		
Age	1 -JW	1 -JL
Gender	2 -JW	2 -JL
Diagnosis	1 -JW	1 -JL
Cognitive Impairments	1 -JW	1 -JL
Environmental Factors	2 -JW	2 -JL
Response to Surgery/Sedation/Anesthesia	3 -JW	1 -JL
Medication Usage	3 -JW	1 -JL
Humpty-Dumpty Fall Risk Score	13 -JW	9 -JL
Low Fall Risk Protocol Precautions have been implemented		Yes -JL
High Fall Risk Protocol Precautions have been implemented	Yes -JW	
Recorded by	[JW] JW 05/28/18 1635	[JL] JL 05/28/18 1156
Braden Q Scale		
Mobility		4 -JL
Activity		4 -JL

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Flowsheets (all recorded) (continued)

OR Assessment Peds - Mon May 28, 2018 (continued)

	1700	1600	1152
Moisture			4 -JL
Friction and Shear			4 -JL
Nutrition			3 -JL
Tissue Perfusion and Oxygenation			4 -JL
Recorded by			[JL] JL 05/28/18 1156

Aldrete - Mon May 28, 2018

	1529
Aldrete	
Activity	2 -EM
Respiration	2 -EM
Circulation	2 -EM
Consciousness	1 -EM
Color	2 -EM
Aldrete Score	9 -EM
Recorded by	[EM] EM 05/28/18 1529

NPO Status - Mon May 28, 2018

	1203
Liquids	
Date of last clear liquid consumption	05/28/18 -JL
Time of last clear liquid consumption	0917 -JL
Recorded by	[JL] JL 05/28/18 1204

Aldrete Score - Mon May 28, 2018

	1700	1600
Aldrete Score		
Respiration	2 -LC	2 -JW
Temperature	2 -LC	2 -JW
Circulation	2 -LC	2 -JW2
Consciousness	2 -LC	2 -JW2
Pain	2 -LC	2 -LC
Bleeding	2 -LC	2 -JW2
Intake & Output	2 -LC	2 -LC
Aldrete Score	14 -LC	14 -LC
Recorded by	[LC] LC 05/28/18 1812	[JW] JW 05/28/18 1620 [JW2] JW

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Flowsheets (all recorded) (continued)

Aldrete Score - Mon May 28, 2018 (continued)

	1700	1600
		05/28/18 1621 [LC] LC 05/28/18 1811

Vitals / Pain - Mon May 28, 2018

	1700	1645	1600
Vitals			
Temp	97.7 °F (36.5 °C) -LC		97.8 °F (36.6 °C) -JW
Temp src	Axillary -LC		Axillary -JW
Pulse	76 -LC		77 -JW
Heart Rate Source	Apical -LC		
Heart Sounds	Regular -LC		
Resp	18 -LC		18 -JW
BP	**"NONE" 140/99** -LC		**"NONE" 156/99** -JW
Recorded by	[LC] LC 05/28/18 1806		[JW] JW 05/28/18 1631
OTHER			
Pain Score	Three -LC	Five -JW	Six -JW
Recorded by	[LC] LC 05/28/18 1806	[JW] JW 05/28/18 1647	[JW] JW 05/28/18 1631
Pain Screening			
Scale Used	Verbal scale (0-10) -LC	Verbal scale (0-10) -JW	Verbal scale (0-10) -JW
Recorded by	[LC] LC 05/28/18 1806	[JW] JW 05/28/18 1647	[JW] JW 05/28/18 1631

Discharge Planning - Mon May 28, 2018

	1201
Discharge Planning	
Living Arrangements	With Foster Parent(s) -JL
Patient expects to be discharged to:	with mother -JL
Contact Person Relationship to Patient	Parent -JL
Parent/Guardian Phone Number	985-264-5277 -JL
Recorded by	[JL] JL 05/28/18 1201

PACU - Mon May 28, 2018

	1540	1530	1524	1520	1508
Vitals					

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Flowsheets (all recorded) (continued)

PACU - Mon May 28, 2018 (continued)

	1540	1530	1524	1520	1508
BP	**"NONE" 155/99** -EM	**"NONE" 146/95** -EM		**"NONE" 149/95** -EM	--
BP Location	Left arm -EM	Left arm -EM		Right leg -EM	--
Pulse	71 -EM2	77 -EM		79 -EM	--
Resp	18 -EM	18 -EM2		18 -EM	--
SpO2	100 % -EM2	100 % -EM		100 % -EM	
Recorded by	[EM] EM 05/28/18 1544 [EM2] EM 05/28/18 1546	[EM] EM 05/28/18 1543 [EM2] EM 05/28/18 1532		[EM] EM 05/28/18 1528	
Pain Assessment					
Pain Assessment	0-10 -EM	0-10 -EM	--	0-10 -EM	--
Pain Score	Five -EM	Five Pt states -EM2	--	Eight Pt states -EM	
Pain Type	Surgical pain -EM	Surgical pain -EM2	--	Surgical pain -EM	
Pain Location				Shoulder -EM	
Pain Orientation				Right -EM	
Recorded by	[EM] EM 05/28/18 1544	[EM] EM 05/28/18 1532 [EM2] EM 05/28/18 1543		[EM] EM 05/28/18 1528	
Oxygen Therapy					
Oxygen Therapy	None (Room air) -EM	None (Room air) -EM		None (Room air) -EM	--
Pulse Oximetry Type	Continuous -EM	Continuous -EM		Continuous -EM	--
Pulse Oximetry Site	Left thumb -EM	Left thumb -EM		Left thumb -EM	--
Recorded by	[EM] EM 05/28/18 1544	[EM] EM 05/28/18 1532		[EM] EM 05/28/18 1528	
Aldrete					
Activity	2 -EM	2 -EM		2 -EM	0 -EM
Respiration	2 -EM	2 -EM		2 -EM	2 -EM
Circulation	2 -EM	2 -EM		2 -EM	2 -EM
Consciousness	2 -EM	2 -EM		1 -EM	0 -EM
Color	2 -EM	2 -EM		2 -EM	2 -EM
Aldrete Score	10 -EM	10 -EM		9 -EM	6 -EM
Select Aldrete or Modified Aldrete	Aldrete -EM	Aldrete -EM		Aldrete -EM	Aldrete -EM
Recorded by	[EM] EM 05/28/18 1544	[EM] EM 05/28/18 1532		[EM] EM 05/28/18 1528	[EM] EM 05/28/18 1518
[REMOVED] Incision 05/28/18 Arm Right					
Incision Properties	Date First Assessed: **05/28/18** MC Time First Assessed: **1425** MC Location: **Arm** MC Wound Orientation: **Right** MC Final Assessment Date: **05/28/18** MC2, NO INCISION JUST SITE PREP Final Assessment Time: **1446** MC2 Recorded by: [MC] -MC 05/28/18 1425 [MC2] -MC 05/28/18 1446				
Incision 05/28/18 Shoulder Right					
Incision	Date First Assessed: **05/28/18** MC Time First Assessed: **1425** MC Location: **Shoulder** MC Wound				

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Flowsheets (all recorded) (continued)

PACU - Mon May 28, 2018 (continued)

	1540	1530	1524	1520	1508
Properties	Orientation: **Right** MC Recorded by: [MC] -MC 05/28/18 1425				
Dressing					Other (Comment) Coverall -EM
Dressing Status					Clean;Dry;Intact -EM
Drainage Description					Other (Comment) Shadowing noted to dressing, outlined with pen -EM
Drainage Amount					Scant Shadowing noted to dressing, outlined with pen -EM
Odor					None -EM
Recorded by					[EM] EM 05/28/18 1518
Safe Environment					
Arm Bands On					ID;Fall -EM
Bed Wheels Locked					Yes -EM
Side Rails/Bed Safety					2/2 -EM
NonSkid Footwear					On -EM
Recorded by					[EM] EM 05/28/18 1518
Respiratory					
Respiratory (WDL)					WDL -EM
Recorded by					[EM] EM 05/28/18 1518
Cardiac					
Cardiac (WDL)					WDL -EM
Recorded by					[EM] EM 05/28/18 1518
Musculoskeletal					
Musculoskeletal (WDL)					X -EM
RUE					Limited movement;Brace Brace applied per MD in OR -EM
LUE					Full movement -EM
RLE					Full movement -EM
LLE					Full movement -EM
Recorded by					[EM] EM

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Flowsheets (all recorded) (continued)

PACU - Mon May 28, 2018 (continued)

	1540	1530	1524	1520	1508
					05/28/18 1518
[REMOVED] Peripheral IV 05/28/18 Left Hand					
IV Properties	Placement Date: **05/28/18** MH Placement Time: **1349** MH Present on Admission: **Yes** MH Size (Gauge): **22 G** MH Orientation: **Left** MH Location: **Hand** MH Site Prep: **Chlorhexidine** MH Insertion attempts: **1** MH Securement Method: **Transparent tape** MH Patient Tolerance: **Tolerated well** MH Removal Date: **05/28/18** JW Removal Time: **1605** JW Catheter Tip Intact: **Yes** JW Removal Reason : **Per Protocol** JW, IV site asymptomatic bandiad applied to site Recorded by: [JW] -JW 05/28/18 1638 [MH] -MH 05/28/18 1350				
Site Assessment					Clean;Dry;Intact -EM
Line Status					Infusing -EM
Dressing Type					Transparent;Arm Board -EM
Dressing Status					Clean;Dry;Intact;Site visible -EM
Recorded by					[EM] EM 05/28/18 1518
Neurological					
Neuro (WDL)				WDL -EM	
Recorded by				[EM] EM 05/28/18 1528	
Skin Assessment					
Skin (WDL)					WDL -EM
Recorded by					[EM] EM 05/28/18 1518
Peripheral Vascular					
Peripheral Vascular (WDL)					WDL SCDs noted to bilateral lower extremities -EM
Recorded by					[EM] EM 05/28/18 1518
Intake					
P.O.			120 mL -EM		
I.V.	30 mL -EM				
Recorded by	[EM] EM 05/28/18 1546		[EM] EM 05/28/18 1544		

Pain Assessment - Mon May 28, 2018

	1700	1645	1600	1540	1530
OTHER					
Restart Pain Assessment Timer	Yes -LC	Yes -JW	Yes -JW	Yes -EM	Yes -EM
Recorded by	[LC] LC 05/28/18 1806	[JW] JW 05/28/18 1647	[JW] JW 05/28/18 1631	[EM] EM 05/28/18 1544	[EM] EM 05/28/18 1543

	1524	1520	1508
OTHER			
Restart Pain	Yes -EM	Yes -EM	Yes -EM

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Flowsheets (all recorded) (continued)

Pain Assessment - Mon May 28, 2018 (continued)

	1524	1520	1508
Assessment Timer			
Recorded by	[EM] EM 05/28/18 1529	[EM] EM 05/28/18 1528	[EM] EM 05/28/18 1512

Preop the patient? - Mon May 28, 2018

	1255	1240
Preop the patient?		
Preop the patient?	Done -CB	Yes -KG
Recorded by	[CB] CB 05/28/18 1255	[KG] KG 05/28/18 1240

Lines/Drains/Airways - Mon May 28, 2018

	1600
[REMOVED] Peripheral IV 05/28/18 Left Hand	
IV Properties	Placement Date: **05/28/18** MH Placement Time: **1349** MH Present on Admission: **Yes** MH Size (Gauge): **22 G** MH Orientation: **Left** MH Location: **Hand** MH Site Prep: **Chlorhexidine** MH Insertion attempts: **1** MH Securement Method: **Transparent tape** MH Patient Tolerance: **Tolerated well** MH Removal Date: **05/28/18** JW Removal Time: **1605** JW Catheter Tip Intact: **Yes** JW Removal Reason : **Per Protocol** JW, IV site asymptomatic bandiad applied to site Recorded by: [JW] -JW 05/28/18 1638 [MH] -MH 05/28/18 1350
Site Assessment	Clean;Dry;Intact -JW
Line Status	Saline locked -JW
Dressing Type	Transparent -JW
Dressing Status	Clean;Dry;Intact -JW
Recorded by	[JW] JW 05/28/18 1623

Anthropometrics - Mon May 28, 2018

	1152
Anthropometrics	
Weight Change	0 -JL
Recorded by	[JL] JL 05/28/18 1154

- Mon May 28, 2018

	1600	1508	1141
Arrived From			
Arrived From	PACU -JW	OR -EM	Home -JL
Mode of Transport	Stretcher -JW	Stretcher -EM	Ambulation -JL
Recorded by	[JW] JW 05/28/18 1620	[EM] EM 05/28/18 1511	[JL] JL 05/28/18 1141

PreOp Peds Checklist - Mon May 28, 2018

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/28/2018, D/C: 5/28/2018

Flowsheets (all recorded) (continued)

PreOp Peds Checklist - Mon May 28, 2018 (continued)

	1157
Patient Preparation	
Patient ID Verified	Armband;Verbal -JL
Correct Procedure?	Yes -JL
Correct Site?	Yes -JL
ID Band Applied	Yes -JL
Does patient refuse blood?	No -JL
Antibiotic Ordered?	N/A -JL
Site Marked	Yes -JL
Did Patient Void Prior to Procedure?	Yes -JL
Void Prior to Procedure (Time)	1157 -JL
Bowel Prep Compliant	N/A -JL
Bowel prep instructions given to patient?	N/A -JL
Does Patient take aspirin or other anticoagulants?	No -JL
Chlorhexidine bath/shower done?	Yes Patient reports CHG bath done last night and this morning. -JL
Procedure Teaching Done	Y -JL
Recorded by	[JL] JL 05/28/18 1159
NPO	
Date of last solid food consumption	05/27/18 -JL
Time of last solid food consumption	1900 -JL
Recorded by	[JL] JL 05/28/18 1159

Vital Signs - Mon May 28, 2018

	1700	1508
Vital Signs		
Temp	--	97.5 °F (36.4 °C)

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Flowsheets (all recorded) (continued)

Vital Signs - Mon May 28, 2018 (continued)

	1700	1508
		-EM
Temp src	--	Oral -EM
Pulse	--	77 -EM
Heart Rate Source	--	Monitor -EM
Resp	--	18 -EM
BP	--	**"NONE" 138/85** -EM
BP Patient Position		Supine -EM
BP Location		Right leg -EM
BP Method		Automatic -EM
Recorded by		[EM] EM 05/28/18 1512
Oxygen Therapy		
Oxygen Therapy		None (Room air) -EM
Pulse Oximetry Type		Continuous -EM
Pulse Oximetry Site		Left thumb -EM
Recorded by		[EM] EM 05/28/18 1512
Pain Assessment		
Pain Assessment	--	No/denies pain Pt asleep -EM
Pain Type	Surgical pain -LC	
Pain Location	Shoulder -LC	
Pain Orientation	Right -LC	
Recorded by	[LC] LC 05/28/18 1811	[EM] EM 05/28/18 1512

OR Incisions/Wounds - Mon May 28, 2018

	1700	1600	1445
[REMOVED] Incision 05/28/18 Arm Right			
Incision Properties	Date First Assessed: **05/28/18** MC Time First Assessed: **1425** MC Location: **Arm** MC Wound Orientation: **Right** MC Final Assessment Date: **05/28/18** MC2, NO INCISION JUST SITE PREP Final Assessment Time: **1446** MC2 Recorded by: [MC] -MC 05/28/18 1425 [MC2] -MC 05/28/18 1446		
Incision 05/28/18 Shoulder Right			
Incision Properties	Date First Assessed: **05/28/18** MC Time First Assessed: **1425** MC Location: **Shoulder** MC Wound Orientation: **Right** MC Recorded by: [MC] -MC 05/28/18 1425		
Incision Closure Type			Primary -MC
Closure			Sutures -MC
Dressing	Gauze covrall -LC	Other (Comment) coverall -JW	Xeroform;Gauze COVERALL -MC
Dressing Status	Clean;Dry;Intact -LC	Clean;Dry;Intact -JW	
Drainage	Serosanguineous -LC	Serosanguineous scant amount dried	

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BODIN,JEFFREY
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Adm: 5/28/2018, D/C: 5/28/2018

Flowsheets (all recorded) (continued)

OR Incisions/Wounds - Mon May 28, 2018 (continued)

	1700	1600	1445
Description		drainage noted marked by recovery room nu -JW	
Drainage Amount	Scant -LC	Scant -JW	
Odor	None -LC	None -JW	
Recorded by	[LC] LC 05/28/18 1805	[JW] JW 05/28/18 1625	[MC] MC 05/28/18 1446

Vitals / Assessment - Mon May 28, 2018

	1700	1152
Vital Signs		
Temp	--	98 °F (36.7 °C) -JL
Temp src	--	Oral -JL
Pulse	--	92 -JL
Heart Rate Source	--	Monitor -JL
Resp	--	20 -JL
BP	--	126/81 -JL
BP Patient Position		Sitting -JL
BP Location		Left arm -JL
BP Method		Automatic -JL
Currently in Pain		No/denies -JL
Recorded by		[JL] JL 05/28/18 1154
Pain Assessment		
Pain Assessment	0-10 -LC	
Recorded by	[LC] LC 05/28/18 1808	
Oxygen Therapy		
Oxygen Therapy		None (Room air) -JL
SpO2		100 % -JL
Recorded by		[JL] JL 05/28/18 1154
Height and Weight		
Height		1.72 m -JL
Height Method		Measured -JL
Weight		49.7 kg -JL
Weight Method		Standing Scale -JL
BSA (Calculated - sq m)		1.54 sq meters -JL
BMI (Calculated)		16.8 -JL
Adjusted Body Weight		162.7 -JL

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
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Flowsheets (all recorded) (continued)

Vitals / Assessment - Mon May 28, 2018 (continued)

	1700	1152
Recorded by		[JL] JL 05/28/18 1154
Charting Type		
Charting Type		Admission -JL
Chart Reviewed		Y -JL
Recorded by		[JL] JL 05/28/18 1154

Handoff - Mon May 28, 2018

	1645	1600	1508
Handoff			
SAFER Used?	Yes -JW	Yes -EM	Yes -MC
Handoff report received from:			M. Catanese, RN -MC
Handoff report given to:	L CruzRN -JW	J. Wild, RN -EM	PACU RN -MC
Opportunity for Questions	Yes -JW	Yes -EM	Yes -MC
Recorded by	[JW] JW 05/28/18 1646	[EM] EM 05/28/18 1615	[MC] MC 05/28/18 1510

PACU Nursing Care Plan - Mon May 28, 2018

	1529
PACU Assessment/Nursing Diagnosis: Potential for Ineffective Airway Maintenance	
Potential for Ineffective Airway Maintenance - Interventions	Assess lung sounds -EM
Evaluation of Goals Met	Goal met -EM
Recorded by	[EM] EM 05/28/18 1530
PACU Assessment/Nursing Diagnosis: Potential for Impaired Gas Exchange	
Potential for Impaired Gas Exchange - Interventions	Assess lung sounds -EM
Evaluation of Goals Met	Goal met -EM
Recorded by	[EM] EM 05/28/18 1530
PACU Assessment/Nursing Diagnosis: Potential for Hemorrhage	
Potential for Hemorrhage - Interventions	Assess op-site/dressings and output/measure drainage -EM
Evaluation of Goals Met	Goal met -EM

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Children's Hospital
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New Orleans LA 70118-5798

Flowsheets (all recorded) (continued)

PACU Nursing Care Plan - Mon May 28, 2018 (continued)

	1529
Recorded by	[EM] EM 05/28/18 1530
PACU Assessment/Nursing Diagnosis: Potential for Alteration in Comfort-Pain	
Potential for Alteration in Comfort: Pain - Interventions	Assess level of comfort/pain -EM
Evaluation of Goals Met	Goal met -EM
Recorded by	[EM] EM 05/28/18 1530
PACU Assessment/Nursing Diagnosis: Potential for Nausea & Vomiting	
Potential for Nausea and Vomiting - Interventions	Assess patient for complaints of nausea -EM
Evaluation of Goals Met	Goal met -EM
Recorded by	[EM] EM 05/28/18 1530
PACU Assessment/Nursing Diagnosis: Potential for Thermoregulatory-Hypo/Hyper	
Potential for Thermoregulatory-Hypo/Hyper - Interventions	Apply warm blankets/remove blankets -EM
Evaluation of Goals Met	Goal met -EM
Recorded by	[EM] EM 05/28/18 1530
PACU Assessment/Nursing Diagnosis: Potential for Injury Related to Sedation or Emergence Excitement	
Potential for Injury Related to Sedation or Emergence Excitement - Interventions	Siderails up;RN in constant bedside attendance -EM
Evaluation of Goals Met	Goal met -EM
Recorded by	[EM] EM 05/28/18 1530
PACU Assessment/Nursing Diagnosis: Potential for Knowledge Deficit Relative to Operative Procedure	
Potential for Knowledge Deficit Relative to Operative Procedure - Interventions	Post-op teaching related to 0-10 pain scale -EM
Evaluation of Goals Met	Goal met -EM
Recorded by	[EM] EM 05/28/18

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Flowsheets (all recorded) (continued)

PACU Nursing Care Plan - Mon May 28, 2018 (continued)

1529

1530

Pre-Procedure Nursing Care Plan - Mon May 28, 2018

1200

Pre-Procedure Care Plan Diagnosis: Anxiety Related to Impending Procedure and Anesthesia/Sedation

Does the patient have anxiety?	Yes -JL
Anxiety Care Plan Interventions	Identify self and address patient by name;Explain procedure (On patient's level) using age specific language;Answer questions and allow patient to verbalize anxieties;Provide support to patient and family members present -JL
Anxiety Care Plan Goal	Decrease anxiety -JL
Evaluation of Goals Met	Goal met -JL
Recorded by	[JL] JL 05/28/18

1201

Pre-Procedure Care Plan Diagnosis: Potential for Fluid Volume Deficit Related to NPO Status

Has the patient been NPO?	Yes -JL
Potential for Fluid Deficit Care Plan - Interventions	Monitor vital signs -JL
Fluid Deficit Care Plan Goal	Within normal limits -JL
Evaluation of Goals Met	Goal met -JL
Recorded by	[JL] JL 05/28/18

1201

Pre-Procedure Care Plan Diagnosis: Potential for Impaired Gas Exchange Related to Anesthesia/Sedation

Potential for Impaired Gas Exchange Care Plan Interventions	Assess respiratory status initially (Goal WNL);Assess NPO status (Goal NPO) -JL
Impaired Gas Exchange Care	Within normal limits -JL

Flowsheets (all recorded) (continued)

Pre-Procedure Nursing Care Plan - Mon May 28, 2018 (continued)

	1200
Plan Goal	
Evaluation of Goals Met	Goal met -JL
Recorded by	[JL] JL 05/28/18 1201

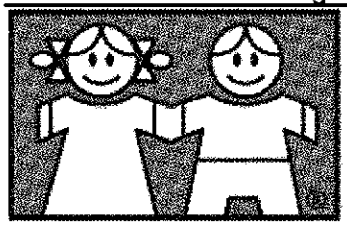
User Key (r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates	Provider Type	Discipline
MH	Marie Denise Hollier, CRNA	05/15/18 - 05/28/18	Nurse Anesthetist	
KG	Kristine Guillot	03/26/18 -	Registered Nurse	Nurse
MC	Melynda Catanese	03/26/18 -	Registered Nurse	Nurse
EM	Elise Michaelis	03/26/18 -	Registered Nurse	Nurse
AC	Angele Charlet	03/26/18 -	Registered Nurse	Nurse
CB	Courtnie Breaux	03/26/18 -	Registered Nurse	Nurse
JW	Jennifer Wild	03/26/18 -	Registered Nurse	Nurse
LC	Lisa Cruz	03/26/18 -	Registered Nurse	Nurse
JL	Joann Lee	03/26/18 -	Registered Nurse	Nurse

Scanned Information

Encounter-Level E-Signatures:

Louisiana Balance Billing Disclosure Notice Act 306 - Received on 5/28/2018



CHILDREN'S HOSPITAL

Balance Billing Disclosure Notice

Patient Name:	BODIN,JEFFREY	Date Of Birth:	5/22/1997
Guarantor Name:	BODIN,JEFFREY	Relationship to Patient	Self
Payor Name:	AETNA BETTER HEALTH	Payor ID:	5794038645696
Insured Name:	BODIN,JEFFREY	Provider:	GONZALES, JOSEPH

Pursuant to Louisiana Revised Statute 22:1880, Children's Hospital New Orleans is providing the above patient/guarantor with this notice and is disclosing that as of May 28, 2018 they

Yes, is a participating provider with the above listed payor

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
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Scanned Information (continued)

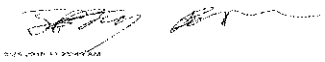
Encounter-Level E-Signatures: (continued)

Professional services rendered by independent healthcare professionals are not part of the hospital, Ambulatory Surgery Centers (ASC), In-patient Hospice, Skilled Nursing Facilities (SNF), or Adult Residential Care Providers (ARCP) bill. These services will be billed to the patient separately. Please understand that physicians or other healthcare professionals may be called upon to provide care or services to you or on your behalf, but you may not actually see, or be examined by, all physicians or healthcare professionals participating in your care; for example, you may not see physicians providing radiology, pathology, and EKG interpretation. In many instances, there will be a separate charge for professional services rendered by physicians to you or on your behalf, and you will receive a bill for these professional services that is separate from the bill for hospital, ASC, In-patient Hospice, SNF, or ARCP services. These independent healthcare professionals may not participate in your health plan and you may be responsible for payment of all or part of the fees for the services provided by these physicians who have provided out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and non-covered services.

We encourage you to contact your health plan to determine whether the independent healthcare professionals are participating with your health plan. In order to obtain the most accurate and up-to-date information about in-network and out-of-network independent healthcare professionals, please contact the customer service number of your health plan or visit its website. Your health plan is the ***primary source*** of information on its provider network and benefits. To help you determine whether the independent healthcare professionals who provide services at this facility are participating with your health plan, we have provided you with a complete list of the names and contact information for each individual or group which includes the name and contact information for each individual or group.

We encourage you to request information from your health insurance issuer as to whether these physicians are contracted with your health insurance issuer and under what circumstance you may be responsible for payment of any amounts not paid your health insurance issuer.

In addition to receiving a hard copy listing of our physician list during the registration process, we maintain a listing of these physicians on our website, who have been granted medical staff privileges to provide medical services at our facility. This list is updated as needed and can be found at http://www.chnola.org/CHNOLABillPay
You are receiving services in a hospital-based outpatient facility where the facility provides the use of the facility, medical, or technical equipment, supplies, staff, and services. Depending on your health insurance benefit plan and the actual services furnished by the facility, you may receive a facility charge billed separately from the physician that covers the fees for the use of the facility, medical, or technical equipment, supplies, staff, and services.

Patient Signature: 

Date: May 28, 2018

Hospital Representative: JOSEPH, BRITTANY

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Children's Hospital
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New Orleans LA 70118-5798

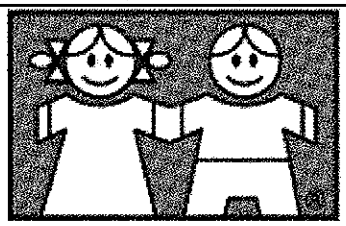
Scanned Information (continued)

Encounter-Level E-Signatures: (continued)

Date: May 28, 2018

Interpreter Used? YesNoButtons
Information about the Interpreter (Name/Service/Company/Cyracom #/etc.): Not Applicable

Consent Form - Received on 5/28/2018



CHILDREN'S HOSPITAL

Financial Consent for Examination and Treatment

IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

This Consent for Examination and Treatment applies to GONZALES, JOSEPH referred to as "Provider" hereinafter.

1. Consent to Medical Treatment/Services and Surgical Procedures

I hereby authorize Provider, the provider(s) treating me, and whomever they may select as their assistants, to provide reasonable and necessary medical treatment to me, including but not limited to, emergency care, administration of approved drugs, nursing care, and radiology and pathology services. I understand it is the responsibility of my physician or surgeon to obtain my informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered under the general and special instructions of the physician. I understand that in many instances the physicians and surgeons furnishing services to me are independent contractors and are not employees or agents of Provider. If I am incapacitated and unable to provide my consent and authorization as discussed above, such consent and authorization may be given by any of those persons who are authorized to consent to surgical or medical treatment on my behalf pursuant to La. R. S. 40:1299.53.

2. Specimens

I authorize and consent to the preservation, examination, testing, retention, use, including, without limitation, the use for scientific, diagnostic, therapeutic or educational purposes, or disposal, by Provider, at its discretion, of any specimens, tissues, materials, or substances which may be removed during a diagnostic procedure, therapeutic intervention or medical treatment.

3. Photography

I consent to photographs, videotapes, digital or other images that may be recorded to document my care. I understand that these images may be used for treatment, health care operations, scientific, educational, research, patient identification, or security purposes. I understand that these images will be stored in a secure manner and will only be used for reasons other than those outlined above upon my written authorization, or as otherwise permitted by law.

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Scanned Information (continued)

Encounter-Level E-Signatures: (continued)

4. **Telemedicine**

I consent to having some or all of my medical services provided by video or other interactive telecommunication technology as allowed by law. I understand that I may decline to receive medical services via telemedicine or withdraw from such care at any time.

5. **Education**

I have been informed and understand that Provider is a teaching institution and the procedures performed may require observation, cooperation and services of multiple health care providers. I authorize and understand that my care may be provided by student nurses, technicians, therapists, interns, residents, fellows and other providers and observers, which are supervised by qualified faculty and/or personnel, in accordance with policies of the Provider. I also consent to the presence of manufacturer's representative(s) during certain procedure(s) to observe and provide technical consultation to the physician(s) at the discretion and approval of the physician(s) and Provider.

6. **Drugs**

Unless my provider specifies otherwise, I agree and consent to Provider dispensing chemically identical or therapeutically comparable ("generic") drugs from a drug list approved by the Provider's Medical Staff, as part of its formulary system.

7. **Devices**

I consent to disposal of explanted medical device unless I specifically request it to be retained prior to procedure.

8. **No Guarantees**

I acknowledge that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any Medical Treatment/Services.

9. **Blood**

I understand that should any hospital or emergency medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including, without limitation, Hepatitis B and C as well as HIV/AIDS. I understand that I can decline HIV testing if it is for routine screening. I understand that state law requires Provider and/or physician to report certain infectious diseases including sexually transmitted diseases to the state Department of Health.

10. **Waiver of Liability for Loss of Personal Property**

Provider encourages patients and families NOT to store money and valuables at Provider facilities; these items should be left at home or with family members or other caregivers. Some Provider facilities have designated secure areas for the safekeeping of money and valuables (including but not limited to, money, jewelry, documents, fur garments, dentures, eyeglasses, hearing aids, prosthetics, or other personal property). Provider will not be liable for the loss of or damage to any personal property not formally deposited in a designated secure area.

10. **Assignment of Benefits**

I hereby assign and authorize, whether I sign as agent or as Patient, direct payment to Provider and/or to any hospital based physician of all insurance and health plan benefits, including, but not limited to, federal healthcare program benefits, otherwise payable to or on behalf of me for this hospitalization or for these outpatient services, including emergency services if rendered. It is understood by me that I am

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Encounter-Level E-Signatures: (continued)

financially responsible to Provider for charges not covered by this assignment.

11. Authorization for Healthcare Related Calls, Texts, and E-mails

I authorize Provider, its employees, agents, representatives and/or designees to contact me using prerecorded/artificial voice messages and/or automatic dialing service at any telephone number (including a wireless telephone) that I disclose to Provider. This consent and authorization will apply to text messages sent to the wireless numbers I disclose to Provider as well as emails using any email address that I provide to Provider.

12. Authorization to Release Information

I hereby authorize Provider to obtain my medical information from other health care providers and suppliers as needed for my care and treatment. I authorize Provider to disclose, for review and/or copying, any of my medical information compiled during my admission as may be requested by my insurance company (private or governmental, i.e., Medicare or Medicaid), or other financially liable third party and/or their designated agent(s), for my benefit determinations, payment for services provided to me, and determination of the appropriateness of my admission or continued admission to, and length of stay at Provider location. EXCEPT AS I MAY SPECIFICALLY DIRECT OTHERWISE, I further authorize Provider to disclose my medical information to persons, participating in my care. As discussed above, I understand that some of these providers and suppliers may be independent of Provider. I understand that State and Federal regulations may also require Provider to report information about me for public health or safety purposes including, but not limited to, reporting to immunization registries.

I further understand that Provider belongs, directly or indirectly, to the Greater New Orleans Health Information Exchange (GNOHIE). GNOHIE allows other providers to see your health records including your health history, the medicines you take, test results, surgery reports, hospital discharge notes, and other health information. The sharing of this information saves time and helps providers give you better care. If you do not want GNOHIE to share your records, you can "opt out" of GNOHIE at any time by calling toll-free 1-855-446-6443 or by visiting the website at www.gnohie.org and clicking on "FAQs." Your records for treatment, payment, and operations will be shared until GNOHIE receives your "opt out" directive.

13. Financial Agreement

I hereby obligate myself to pay Provider for all care, services, and treatment I receive, according to Provider's regular rates and fee schedules. If I am covered by a health plan or insurance policy, I agree to provide current and accurate information prior to or at the time of admission/ registration. I certify that all information that I have provided or shared with the Provider is true and accurate and that I have complied with all insurance company requirements for referrals, pre-authorizations, and family coverage to avoid payment denial. I understand that if I have failed to comply with these requirements, I will be responsible for the bill. If I am eligible to receive benefits under a health care service plan with which Provider has contracted, I may be required to pay for some services pursuant to the plan's contract. If I prefer a private room during an inpatient stay, I understand that I may be responsible for its cost. If my health care plan determines Provider's services to me are not medically necessary, I authorize Provider to represent me in any review of the determination made by or on behalf of my health care plan. If non-insurance payments made on my account exceed the total amount due, including without limitation to any late charge, Provider is authorized to apply that excess to any pre-existing account for prior medical services furnished. In the event, my account becomes delinquent and is referred to an attorney or a collection agency, I will be expected to pay attorney fees,

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Scanned Information (continued)

Encounter-Level E-Signatures: (continued)

court costs, and collection expenses. I understand that I am responsible for any non-covered services, deductibles, and co-payments. All delinquent accounts shall bear interest at the maximum rate allowed by law. ***I understand that I will receive bills both from Provider and any independent physicians or other practitioners involved in my care.***

I understand that this General Consent for Examination and Treatment will remain in effect and apply to all treatment or services I receive unless I revoke it, in writing, except to the extent that Provider has already taken action in reliance therein. I also understand that I may be asked to provide informed consent for specific procedures, treatments, or services rendered by Provider, a physician, or other healthcare providers affiliated with Provider and that such informed consent will include, but is not limited to, the benefits and risks associated with a specific procedure, treatment, or service. Such informed consent will be presented to me in a separate document or electronic medium and will be made part of my medical record.

FINANCIAL RESPONSIBILITY BY PERSON OTHER THAN THE PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

I agree to accept financial responsibility for services rendered to the Patient and to unconditionally accept the terms of the Financial Agreement and Assignment of Benefits set forth above.

PATIENT CERTIFICATION

I have read, understood and fully agree to each of the above statements and have been provided the opportunity to ask questions regarding such statements. I sign below as my free and voluntary act. I also acknowledge that I have been offered information on the following subjects: Patient Rights and Responsibilities, Advance Directives, Notice of Privacy Practices, and Patient Billing. I also acknowledge that I have the right to receive a copy of this General Consent form upon my request.

Signature of Responsible Party: 5/28/2018 11:25:11 AM 5/28/2018 11:25 AM

If other than Patient, indicate relationship:

Reason Patient is unable to sign (if applicable):

Hospital Representative: JOSEPH, BRITTANY

Encounter-Level Documents - 05/28/2018:

Surgical Consent (below)

Scanned Information (continued)

Encounter-Level Documents - 05/28/2018: (continued)

CHILDREN'S HOSPITAL

ANESTHESIA OPERATIVE PERMIT
PAGE 1 OF 2

BODIN,JEFFREY
CSN: 600062242600
DOB: 5/22/1997 (21 yrs) SEX: M
MRN: 1002548110
Adm Date: 5/28/2018

60006224
2600

PATIENT'S CONSENT TO SURGICAL ANESTHESIA AND ACKNOWLEDGMENT OF RECEIPT OF MEDICAL INFORMATION

READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: You have been told that you should consider medical treatment/surgery which would require surgical anesthesia. Louisiana law requires us to tell you (1) the nature of your condition, (2) the general nature of medical treatment/surgery, (3) the risks of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor, and (4) reasonable therapeutic alternatives and material risks associated with such alternatives.

You have the right , as a patient, to be informed about your condition, the recommended surgical, medical or diagnostic procedure and the use of surgical anesthesia so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible. Please read the form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

1. Patient's Name (if not documented above): ______________________

2. Treatment/Procedure: ADMINISTRATION OF SURGICAL ANESTHESIA ______________________
(Description, nature of the treatment/procedure)

3. Purpose/Types of Surgical Anesthesia:
The purpose of surgical anesthesia is to relieve pain during surgery through the use of various medications known as anesthetic agents. Along with the delivery of the anesthetic agent,life support measures are often undertaken in order to maintain the well-being of the patient. These measures might include the administration of blood or blood products; use of medications and equipment to support the heart,lungs, or other systems of the body; antibiotics (drugs used to prevent or treat infection); and chemicals to counteract disease states or correct imbalances.
Equipment and devices will be used to induce and maintain anesthesia and to prevent harm to the patient while he or she is anesthetized. Examples of equipment that would come into contact with the patient include breathing equipment such as masks and breathing tubes (inserted into the windpipe through the mouth or nose); monitoring devices, both topical devices (such as electrocardiogram (EKG) electrodes) and invasive devices (such as needles and monitoring lines placed in veins or arteries and temperature probes). Equipment is also used that does not come into direct contact with the patient but supports and maintains the patient such as anesthesia machines and ventilators.
General anesthesia is a method of surgical anesthesia in which the patient is "put to sleep" (rendered unconscious and insensitive to pain) through the use of anesthetic agents administered by inhalation (breathing an anesthetic gas through a mask) and/or by intravenous injection (using a needle to place the anesthetic agent into a vein and, thus, into the patient's bloodstream). The anesthetic agent, the route of administration, the dosage and the depth of general anesthesia are dependent on the nature of the surgery to be performed, the medical condition of the patient, and other considerations. It is hoped that a patient will remain asleep while under general anesthesia, but some patients will recall all or a portion of the surgery despite the fact that the anesthesia was administered appropriately. Endotracheal intubation (in which a tube is placed into the windpipe) and monitoring and support of various vital functions (such as respiratory and cardiovascular) are often necessary.
Regional anesthesia is a method of surgical anesthesia in which an anesthetic agent is used to block a group of sensory nerve fibers in order to make an area of the body insensitive to pain. Sometimes a tourniquet is used on an arm or leg and an anesthetic agent is injected into a vein of that arm or leg. The patient remains awake (although regional anesthesia may often be combined with a sedative to relax and calm the patient) during this type of anesthesia. Occasionally, for technical reasons, it is not possible to produce this type of anesthesia; and, in some cases, the surgical procedure outlasts the effects of this type of anesthesia. When this occurs another type of anesthesia, usually a general anesthetic, is substituted.
Local anesthesia involves the injection of an anesthetic agent into or near the area to be operated on to reduce or eliminate pain in that limited area of the body.
Topical anesthesia involves the application of an anesthetic agent in the form of a solution, gel or ointment to the skin, mucous membrane, or cornea to reduce or eliminate pain.
The type of anesthesia chosen in a given case will depend on the medical condition of the patient, the nature of the procedure to be performed, and the preferences of the patient and surgeon.

1. Patient's Condition:
Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in item number 2 is indicated and recommended:
____
____
____
____

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Operative Permit

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Scanned Information (continued)

Encounter-Level Documents - 05/28/2018: (continued)

ILDREN'S SPITAL

ANESTHESIA OPERATIVE PERMIT
PAGE 2 OF 2

BODIN,JEFFREY
CSN: 600062242600
DOB: 5/22/1997 (21 yrs) SEX: M
MRN: 1002548110
Adm Date: 5/28/2018
600062242600

Material Risks of Treatment/Procedure:

(a) All medical or surgical treatment involves risks. Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant but may not be listed below.
☐ See attachment for risks identified by the Louisiana Medical Disclosure Panel
☐ See attachment for risks identified by your doctor

(b) Additional risks (if any) particular to the patient because of a complicating medical condition are: ____

(c) Risks generally associated with any surgical treatment/procedure, including anesthesia, are: death, brain damage, disfiguring scars, quadriplegia (paralysis from neck down), paraplegia (paralysis from waist down), the loss or loss of function of any organ or limb, infection, bleeding and pain.

Reasonable therapeutic alternatives and the risks associated with such alternatives are: ____
NONE UNLESS OTHERWISE SPECIFIED

ACKNOWLEDGMENT AUTHORIZATION AND CONSENT

(a) No Guarantees: All information given me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternate procedures or as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either express or implied, as to the success or other results of the medical treatment or surgical procedure.

(b) Additional Information: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

(c) Particular Concerns: I have had an opportunity to disclose to and discuss with the physician providing such information those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

(d) Questions: I have had an opportunity to ask, and I have asked, any questions I may have about the information in this document and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner.

(e) Authorized Physician: The physician (or physician group) authorized to administer or perform the medical treatment, surgical procedures or other therapy described in item 2 is:

CHILDREN'S ANESTHESIOLOGY GROUP
(Name of authorized physician or group)

(f) Physician Certification: I hereby certify that I have provided and explained the information set forth herein, including any attachment, and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

DO NOT WRITE OUTSIDE BOX

Physician/Practitioner's Signature	Date	Time AM/PM
X [signature]	5/28/18	12:15 (PM circled)

CONSENT

nsent: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to ninister or perform the medical treatment or surgical procedure described in item 2 of this Consent Form, including any additional proces or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray or er radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby sent thereto.

have read and understand all information set forth in this document and all blanks were filled in prior to my signing. This authorization for consent to medical treatment or surgical procedure is and shall remain valid until revoked.

acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described em 2 of this consent form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

tient or Person Authorized to Consent	Relationship to Patient	
X [signature: Jeffrey Bodin]	Patient	
nature of Witness	Date MM/DD/YY	Time 00:00 am/pm
X [signature] RN	5/28/18	12:15 (PM circled)

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LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Encounter-Level Documents - 05/28/2018: (continued)

CHILDREN'S HOSPITAL

OPERATIVE PERMIT

BODIN,JEFFREY
CSN: 600062242600
DOB: 5/22/1997 (21 yrs) SEX: M
MRN: 1002548110
Adm Date: 5/28/2018

600062242600

ATTACHMENT TO PATIENT CONSENT TO MEDICAL TREATMENT OR SURGICAL PROCEDURE AND ACKNOWLEDGMENT OF RECEIPT OF MEDICAL INFORMATION

Risks Identified by Louisiana Medical Disclosure Panel

ANESTHESIA

Arterial Catheterization
1. Decrease in blood flow to area supplied by the artery
2. Nerve damage
3. Loss of or loss of function of the limb or portion of the limb supplied by the artery

Central Venous and Pulmonary Artery Catheterization
1. Hemorrhage (bleeding) into the lungs, the pericardium (sac which surrounds the heart), the chest cavity and elsewhere
2. Pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart)
3. Cardiac arrest (heart attack)
4. Stroke
5. Pneumothorax (lung collapse)
6. Infection
7. Cardiac arrhythmias (irregularities of the heart rhythm)
8. Shock (severe drop in blood pressure)
9. Damage to blood vessels
10. Damage to trachea (windpipe) and/or pharynx (throat)
11. Injury to vocal cords
12. Distal embolization (air, fat particles or blood clots which circulate in the bloodstream until becoming lodged in a vein or artery)
13. Damage to nerves, the lymph ducts, the heart and the lungs
14. Infusion of fluid into the chest cavity, lungs and pericardium

Transesophageal Echocardiography
1. Esophageal injury
2. Damage to teeth

Epidural, Spinal, Regional Anesthesia
1. Allergic, abnormal or hypersensitivity reaction to drugs or equipment may be fatal
2. Aspiration (inhalation) into the bronchi (airway) or lungs of stomach contents, stomach acids and foreign objects
3. Leakage of cerebrospinal fluid
4. Chipped or broken teeth
5. Convulsion (seizures)
6. Epidural blood clot or abscess (bleeding or infection in the space adjacent to the spinal cord which may damage the spinal cord)
7. Broken needles or catheters which may lead to complications and necessitate additional treatment
8. Production of an unintended high level of anesthesia which may necessitate need for artificial respirators and insertion of a breathing tube
9. Incomplete analgesia (pain or discomfort during the procedure)
10. Injury to the lips, tongue and inside of the mouth or airway injury
11. Laryngeal and vocal cord trauma or edema (injury to or swelling of the vocal cords)
12. Loss of bowel or bladder function or sexual function
13. Heart attack or other heart problems
14. Decreased blood pressure
15. Shock
16. Nerve damage ranging from loss of sensation to total paralysis
17. Back pain
18. Death
19. Brain damage
20. Severe headaches

General Anesthesia
1. Allergic, abnormal or hypersensitivity reaction to drugs or equipment, which may be fatal
2. Aspiration (inhalation) into the bronchi (airway) or lungs of stomach contents, stomach acids and foreign objects
3. Laryngeal and/or vocal cord trauma or edema (injury to or swelling of the vocal cords)
4. Heart attack or other heart problems
5. Death
6. Brain damage
7. Shock
8. Nerve damage ranging from loss of sensation to total paralysis
9. Chipped or broken teeth
10. Esophageal injury
11. Burns
12. Malignant hyperthermia (dangerously high fever which may result in death)
13. Injury to lips, tongue and inside of mouth or airway injury
14. Breathing difficulties
15. Eye injuries

Patient or Person Authorized to Consent Signature	Date	Time
X [signature]	5/28/18	12:50 PM

AHS/OP/MR108-6 | AHS 108-6 | (08/11) Revised | PDF

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Scanned Information (continued)

Encounter-Level Documents - 05/28/2018: (continued)

CHILDREN'S HOSPITAL
OPERATIVE PERMIT
PAGE 1 OF 2

BODIN,JEFFREY
CSN: 600062242600
DOB: 5/22/1997 (21 yrs) SEX: M
MRN: 1002548110
Adm Date: 5/28/2018
60006224
2600

PATIENT'S CONSENT TO MEDICAL TREATMENT OR SURGICAL PROCEDURE AND ACKNOWLEDGMENT OF RECEIPT OF MEDICAL INFORMATION

READ CAREFULLY BEFORE SIGNING

O THE PATIENT: You have been told that you should consider medical treatment/surgery. Louisiana law requires us to tell ou (1) the nature of your condition, (2) the general nature of the medical treatment/surgery, (3) the risks of the proposed eatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor, and (4) reasonable erapeutic alternatives and material risks associated with such alternatives.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diag- ostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the sks and hazards involved.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed l these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely possible. Please read the form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

Patient's Name (if not documented above): Jeffrey Bodin

Treatment/Procedure: Closed reduction right shoulder, possible open reduction internal fixation
(a) Description, nature of the treatment/procedure in layman's terms: right proximal humerus
Put shoulder back in place, possibly fix broken bone with plate and screws

Site location: ☒ Right ☐ Left ☐ Bilateral (Both) ☐ N/A
(b) Purpose: Promote healing

Patient's Condition:
Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in item number 2 is indicated and recommended:
Right proximal humerus fracture dislocation

Material Risks of Treatment/Procedure:
(a) All medical or surgical treatment involves risks. Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician/surgeon if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant but may not be listed below.

☒ See attachment for risks identified by the Louisiana Medical Disclosure Panel
☐ See attachment for risks identified by your doctor
(b) Additional risks (if any) particular to the patient because of a complicating medical condition are:
Malunion, nonunion, infection, axillary nerve dysfunction, need for more surgery, decreased limb/shoulder function
(c) Risks generally associated with any surgical treatment/procedure, including anesthesia are: death, brain damage, disfiguring scars, quadriplegia (paralysis from neck down), paraplegia (paralysis from waist down), the loss or loss of function of any organ or limb, infection, bleeding, and pain.

Reasonable therapeutic alternatives and the risks associated with such alternatives are:
NONE UNLESS OTHERWISE SPECIFIED

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CS0020

Scanned Information (continued)

Encounter-Level Documents - 05/28/2018: (continued)

OPERATIVE PERMIT
PAGE 2 OF 2

BODIN,JEFFREY
CSN: 600062242600
DOB: 5/22/1997 (21 yrs) SEX: M
MRN: 1002548110
Adm Date: 5/28/2018

60006224
2600

ACKNOWLEDGMENT
AUTHORIZATION AND CONSENT

a) No guarantees: All information given me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternate procedures or as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either express or implied, as to the success or other results of the medical treatment or surgical procedure.

b) Additional information: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

c) Particular concerns: I have had an opportunity to disclose to and discuss with the physician providing such information, those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

d) Questions: I have had an opportunity to ask, and I have asked, any questions I may have about the information in this document and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner.

e) Authorized physician: The physician (or physician group) authorized to administer or perform the medical treatment, surgical procedures or other therapy described in item 2 is:

(Name of authorized physician or group)
Gonzales

f) Physician certification: I hereby certify that I have provided and explained the information set forth herein, including any attachment, and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

Physician's Signature	Date MM/DD/YY	Time 00:00 am/pm
X Ryan Duoty	5/28/18	09:00 AM PM

DO NOT WRITE OUTSIDE BOX

CONSENT

ent: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of r choice, to administer or perform the medical treatment or surgical procedure described in item 2 of this Consent Form, ling any additional procedures or services as they may deem necessary or reasonable, including the administration of eneral or regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tis- moved during a diagnostic or surgical procedure, and I hereby consent thereto.

read and understand all information set forth in this document, including any attachment, and all blanks were filled in o my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid evoked.

owledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical dure described in item 2 of this consent form, including risks and alternatives, and acknowledge that my questions have answered to my satisfaction.

nt or Person Authorized to Consent	Relationship to Patient	
Jeffrey Bodin	Patient	
ture of Witness	Date MM/DD/YY	Time 00:00 am/pm
	5/28/18	09:00 AM PM

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Encounter-Level Documents - 05/28/2018: (continued)

OPERATIVE PERMIT
CHILDREN'S HOSPITAL 101 PAGE 1 OF 1 ADMISSION/CONSENTS SECTION

BODIN,JEFFREY
CSN: 600062242600
DOB: 5/22/1997 (21 yrs) SEX: M
MRN: 1002548110
Adm Date: 5/28/2018

60006224
2600

ATTACHMENT TO PATIENT CONSENT TO MEDICAL TREATMENT OR SURGICAL PROCEDURE AND ACKNOWLEDGMENT OF RECEIPT OF MEDICAL INFORMATION

Risks Identified by Louisiana Medical Disclosure Panel

ORTHOPAEDICS

Musculo-skeletal Procedures in the Extremities (formerly entitled "orthopaedic surgery on extremeties")

A surgical procedure upon, or even a closed manipulation of an extremity, entails risk to a greater or lesser degree, to all major systems of that limb, and can result in varying degrees of weakness, deformity, paralysis, pain, numbness, limitation of motion of the joints, and amputation. Furthermore, the goals of the procedure may not be obtained, and other therapy may be necessary.

Please have patient or person authorized to consent initial below.

Initials of patient or person authorized to consent JTB x

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LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Encounter-Level Documents - 05/28/2018: (continued)

After Visit Summary (below)

Scanned Information (continued)

Encounter-Level Documents - 05/28/2018: (continued)

Bodin, Jeffrey (MR # 1002548110)

CHILDREN'S HOSPITAL

BODIN,JEFFREY
CSN: 600062242600
DOB: 5/22/1997 (21 yrs) SEX: M
MRN: 1002548110
Adm Date: 5/28/2018

60006224
2600

Facility

Name	Address	Phone	Fax
Children's Hospital	200 Henry Clay Ave. New Orleans LA 70118-5720	504-896-9478	504-896-9814

Bodin, Jeffrey #1002548110 (CSN:600062242600) (21 y.o. M) (Adm: 05/28/18) **CHNOOR**

Attending providers for your hospitalization

Provider	Specialty	Primary office phone
Joseph Gonzales, MD	Pediatric Orthopedic Surgery	504-896-9569

Why you were hospitalized

Your primary diagnosis was: Not on File

Allergies as of 5/28/2018

	Reactions
Lactose	Nausea And Vomiting
Latex	Rash

Unresulted Tests

None

Medication List

TAKE these medications

	Morning	Noon	Evening	Bedtime	As Needed
ALEVE 220 MG tablet Take 1,000 mg by mouth 2 (two) times daily with meals Generic drug: naproxen sodium					
buPROPion 300 MG 24 hr tablet Take 300 mg by mouth daily Commonly known as: WELLBUTRIN XL					
dextroamphetamine-amphetamine 20 mg Tab per tablet Take 20 mg by mouth 3 (three) times daily Commonly known as: ADDERALL					
DYMISTA 137-50 mcg/spray Spry 1 spray by Nasal route daily Generic drug: azelastine-fluticasone					
HYDROcodone-acetaminophen 5-325 mg per tablet Last Dose Time: 5/28/2018 3:24 PM Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days Commonly known as: NORCO					

Bodin, Jeffrey Printed at 5/28/18 5:34 PM

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/28/2018, D/C: 5/28/2018

Scanned Information (continued)

Encounter-Level Documents - 05/28/2018: (continued)

Bodin, Jeffrey (MR # 1002548110)

Medication List (continued)

TAKE these medications (continued)

	Morning	Noon	Evening	Bedtime	As Needed
ketorolac 10 mg tablet Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days Commonly known as: TORADOL					
montelukast 10 mg tablet Take 10 mg by mouth daily Commonly known as: SINGULAIR					

These are the prescriptions given today (2 Prescriptions)

Walgreens Drug Store 05382 - MANDEVILLE, LA - 4330
HIGHWAY 22 AT SEC of Access Road & Hwy 22
4330 HIGHWAY 22, MANDEVILLE LA 70471-3317
Telephone: **985-674-2551**
Fax: **985-674-5334**
Hours:

Paper Script (2 of 2)

HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet
Sig: Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days
Start: 5/28/18
Quantity: 28 tablet Refills: 0

ketorolac (TORADOL) 10 mg tablet
Sig: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days
Start: 5/28/18
Quantity: 12 tablet Refills: 0

Nursing and Diet Instructions

Diet Regular	Complete by: As directed

Other Orders Instructions

Remove dressing in 72 hours	Complete by: As directed
Diet Regular	Complete by: As directed
Notify Physician - call for: Temperature > 101.5F Uncontrollable pain Uncontrollable nausea/vomiting Wound concerns (wound coming apart, persistent drainage, foul smelling odor, pus from wound, etc.)	Complete by: As directed
Weight bearing restrictions (specify) No weight bearing with right arm. Right arm to remain in sling and swath at all times	Complete by: As directed
Follow up from Inpatient Stay CHNO ORTHOPEDICS (Dr. Gonzales); F: Other (Specify Time Frame in	Complete by: Jun 11, 2018

Bodin, Jeffrey Printed at 5/28/18 5:34 PM

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 5/28/2018, D/C: 5/28/2018

Scanned Information (continued)

Encounter-Level Documents - 05/28/2018: (continued)

Bodin, Jeffrey (MR # 1002548110)

Other Orders Instructions (continued)

Comments) (two weeks post op)

Future Appointments

05/23/2019 1:30 PM CDT **(Arrive by 1:15 PM)** Hem Onc Established Patient with Dana Marie Leblanc, MD Children's Hospital Hematology and Oncology (CHNO ACC 1st Fl HemOnc)	200 Henry Clay Ave. New Orleans LA 70118-5720 504-896-9740

MyChart Sign-up Instructions

Patient is already MyChart active.

Patient/Parent/Responsible Party Signature:

Signature: _____ Date: 5/28/18

Print Name: _____

Bodin, Jeffrey Printed at 5/28/18 5:34 PM

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Encounter-Level Documents - 05/28/2018: (continued)

Case Management Attachment (below)

Scanned Information (continued)

Encounter-Level Documents - 05/28/2018: (continued)

CHILDREN'S HOSPITAL

LOUISIANA FAMILY CAREGIVER ACT

BODIN,JEFFREY
DOB: 5/22/1997 (21 yrs) SEX: M
MRN: 1002548110
Adm Date: 5/28/2018
PT SCANNING ONLY

Louisiana Family Caregiver Act

The Louisiana Family Caregiver Act requires all Louisiana licensed hospitals to provide its patients who are eighteen (18) years of age or older ("Patient(s)"), or if applicable, the Patient's legal representative, with an opportunity to designate at least one "caregiver" following a Patient's inpatient admission prior to the Patient's discharge. A "caregiver" is defined as an individual, 18 years of age or older, who, without compensation, will assist the Patient with the Patient's needs after discharge from the hospital in accordance with the Patient's discharge plan, which may include, but not be limited to: activities of daily living; carrying out post-discharge tasks, such as wound care; helping with administration of medications; and/or operating medical equipment. Designation of a caregiver does ***not*** obligate that individual to perform any post-hospital discharge tasks for the Patient. Designation of a caregiver will ***not*** interfere with the rights of a person legally authorized to make health care decisions for the Patient.

I, THE UNDERSIGNED PATIENT OR PATIENT'S LEGAL REPRESENTATIVE (INITIAL ONE):

INITIALS	
X JTB	**Decline at this time to designate a caregiver.**
X	**Designate the individual below to be the Patient's caregiver**

DO NOT WRITE OUTSIDE BOX

Caregiver Name: (Please Print)
Caregiver Address:
Relationship to Patient:
Caregiver Phone/Cell Phone Number:

I, the undersigned Patient or Patient's legal representative, understand that the designated caregiver may be changed at any time by notifying Children's Hospital in writing.

I also understand that the designated caregiver will be notified as soon as possible of the Patient's impending discharge from the hospital and that Children's Hospital will consult with the Patient or Patient's legal representative (as applicable) and the designated caregiver about the Patient's discharge plan.

Patient/Parent or Authorized Signature	Date MM/DD/YY	Time 00:00 AM/PM
X [signature]	5/28/18	12:05
Relationship / Source of Authority to Patient		
Witness's Signature	**Date MM/DD/YY**	**Time 00:00 AM/PM**
X [signature]	5/28/18	12:45

MR/MR5119 | MRR 5841 12/16 Revised | PDF | SS

LOUISIANA FAMILY CAREGIVER ACT
Louisiana Family Caregiver Act

CM0020

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Encounter-Level Documents - 05/28/2018: (continued)

Order-Level Documents:

There are no order-level documents.

Hospital account-Level Documents:

There are no hospital account-level documents.

touro UMC NOEH HOSPITAL
LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/28/18

Allergies as of 5/28/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 5/28/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Melanoma in situ of left lower leg			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seasonal allergies			Provider
Seizure syndrome			Provider

Surgical as of 5/28/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

Family as of 5/28/2018 **None**

Family Status as of 5/28/2018 **None**

Tobacco Use as of 5/28/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/28/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/28/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/28/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 5/28/2018

ADL Question	Response	Comments	Source
None			

Social Doc **None**

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/28/18

Scanned Information (continued)

as of 5/28/2018

Occupational ****None****
as of 5/28/2018

Socioeconomic
as of 5/28/2018

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				
Preferred Language	**Ethnicity**	**Race**		
English	Non-Hispanic	White or Caucasian		

Birth ****None****

Current Immunizations — Never Reviewed

No immunizations on file.

Not reviewed this visit

Orders and Results

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/28/18

Imaging - All Orders and Results

Fluoroscopy up to 1 Hour

Electronically signed by: **Joseph Gonzales, MD on 05/30/18 1000** Status: **Completed**
Mode: Ordering in Verbal with readback, cosign Required mode Communicated by: Melynda Catanese
Ordering user: Melynda Catanese 05/28/18 1355 Ordering provider: Joseph Gonzales, MD
Ordered during: Admission (Discharged) on 05/28/2018

Final result

Performed: 05/28/18 1345 - 05/28/18 1445
Narrative:
FLUOROSCOPY UP TO 1 HOUR:

Impression:

Fluoroscopic imaging and time was provided for intraoperative guidance without radiologist present and one image obtained.

Electronically Signed By: Christopher Arcement, M.D. 5/28/2018 3:09 PM CDT

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet	28 tablet	0	5/28/2018	6/4/2018
Sig - Route: Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days - Oral Class: Print				
ketorolac (TORADOL) 10 mg tablet	12 tablet	0	5/28/2018	6/1/2018
Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral Class: Print				
montelukast (SINGULAIR) 10 mg tablet Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Notes (continued)

Medications at Start of Encounter (continued)

	Disp	Refills	Start	End
naproxen sodium (ALEVE) 220 MG tablet Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral Class: Historical Med				
ketorolac (TORADOL) 10 mg tablet (Discontinued) Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral	12 tablet	0	5/28/2018	5/28/2018

Inpatient Medications

	Dose	Frequency	Start	End
ceFAZolin (ANCEF) injection (Discontinued) Sig: as needed Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
dexmedetomidine (PRECEDEX) injection 15.3 mcg (Discontinued) Sig - Route: Inject 0.153 mLs (15.3 mcg total)into the vein once as needed (Post-operative delirium) - Intravenous Reason for Discontinue: **Patient Discharge**	0.3 mcg/kg × 51 kg	Once PRN	5/28/2018	5/28/2018
fentaNYL (SUBLIMAZE) injection (Discontinued) Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet 1 tablet (Discontinued) Sig - Route: Take 1 tabletby mouth every 6 (six) hours as needed for Pain Score 4 - 7 - Oral Reason for Discontinue: **Patient Discharge**	1 tablet	Every 6 Hours PRN	5/28/2018	5/28/2018
ibuprofen (ADVIL,MOTRIN) tablet 600 mg (Discontinued) Sig - Route: Take 600 mgby mouth every 8 (eight) hours as needed for Pain Score 1 - 3 - Oral Reason for Discontinue: **Patient Discharge**	600 mg	Every 8 Hours PRN	5/28/2018	5/28/2018
ketorolac (TORADOL) injection (Discontinued) Sig: as needed Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
lactated Ringers infusion (Discontinued) Sig - Route: Injectinto the vein continuous prn - Intravenous Reason for Discontinue: **Anesthesia Stop**		Continuous PRN	5/28/2018	5/28/2018
lidocaine 20 mg/mL (2 %) injection (Discontinued) Sig: as needed Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
midazolam (VERSED) 10 mg/5 mL (2 mg/mL) syrup 20 mg (Discontinued) Sig - Route: Take 10 mLs (20 mg total)by mouth once - Oral Reason for Discontinue: **Patient Transfer**	20 mg	Once	5/28/2018	5/28/2018
ondansetron hcl (PF) (ZOFRAN) 4 mg/2 mL injection (Discontinued) Sig - Route: Injectinto the vein as needed for Nausea or Vomiting - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
propofol (DIPRIVAN) 10 mg/mL injection (Discontinued)		PRN	5/28/2018	5/28/2018

Notes (continued)

Inpatient Medications (continued)

	Dose	Frequency	Start	End
Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**				
rocuronium (ZEMURON) injection (Discontinued) Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
sugammadex (BRIDION) injection (Discontinued) Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018

Call Information

	Provider	Department	Center
5/28/2018 3:00 PM	LCMC CH XR CARM B	Chno Radiology	CHNO Childre

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/28/18

Allergies as of 5/28/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 5/28/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Melanoma in situ of left lower leg			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seasonal allergies			Provider
Seizure syndrome			Provider

Surgical as of 5/28/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

Family as of 5/28/2018 **None**

Family Status as of 5/28/2018 **None**

Tobacco Use as of 5/28/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/28/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/28/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/28/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 5/28/2018

ADL Question	Response	Comments	Source
None			

Social Doc **None**

Scanned Information (continued)

as of 5/28/2018

Occupational ****None****
as of 5/28/2018

Socioeconomic
as of 5/28/2018

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				
Preferred Language	**Ethnicity**	**Race**		
English	Non-Hispanic	White or Caucasian		

Birth ****None****

Current Immunizations — Never Reviewed

No immunizations on file.

Not reviewed this visit

Orders and Results

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Imaging - All Orders and Results

XR Shoulder 1 VW Right

Electronically signed by: **Ryan James Dewitz, MD on 05/28/18 1506** Status: **Completed**
Ordering user: Ryan James Dewitz, MD 05/28/18 1506 Ordering provider: Ryan James Dewitz, MD
Ordered during: Admission (Discharged) on 05/28/2018

Final result

Performed: 05/28/18 1533 - 05/28/18 1546

Narrative:
RIGHT SHOULDER AP:

Impression:
There is a healing right humeral head fracture in near anatomical alignment based on this single AP view.

Electronically Signed By: Ewa Wasilewska, M.D. 5/28/2018 4:47 PM CDT

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet	28 tablet	0	5/28/2018	6/4/2018
Sig - Route: Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days - Oral Class: Print				
ketorolac (TORADOL) 10 mg tablet	12 tablet	0	5/28/2018	6/1/2018
Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral Class: Print				
montelukast (SINGULAIR) 10 mg tablet Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
naproxen sodium (ALEVE) 220 MG tablet Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral Class: Historical Med				

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/28/18

Notes (continued)

Medications at Start of Encounter (continued)

	Disp	Refills	Start	End
ketorolac (TORADOL) 10 mg tablet (Discontinued)	12 tablet	0	5/28/2018	5/28/2018
Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral				

Inpatient Medications

	Dose	Frequency	Start	End
ceFAZolin (ANCEF) injection (Discontinued)		PRN	5/28/2018	5/28/2018
Sig: as needed				
Reason for Discontinue: **Anesthesia Stop**				
dexmedetomidine (PRECEDEX) injection 15.3 mcg (Discontinued)	0.3 mcg/kg × 51 kg	Once PRN	5/28/2018	5/28/2018
Sig - Route: Inject 0.153 mLs (15.3 mcg total)into the vein once as needed (Post-operative delirium) - Intravenous				
Reason for Discontinue: **Patient Discharge**				
fentaNYL (SUBLIMAZE) injection (Discontinued)		PRN	5/28/2018	5/28/2018
Sig - Route: Injectinto the vein as needed - Intravenous				
Reason for Discontinue: **Anesthesia Stop**				
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet 1 tablet (Discontinued)	1 tablet	Every 6 Hours PRN	5/28/2018	5/28/2018
Sig - Route: Take 1 tabletby mouth every 6 (six) hours as needed for Pain Score 4 - 7 - Oral				
Reason for Discontinue: **Patient Discharge**				
ibuprofen (ADVIL,MOTRIN) tablet 600 mg (Discontinued)	600 mg	Every 8 Hours PRN	5/28/2018	5/28/2018
Sig - Route: Take 600 mgby mouth every 8 (eight) hours as needed for Pain Score 1 - 3 - Oral				
Reason for Discontinue: **Patient Discharge**				
ketorolac (TORADOL) injection (Discontinued)		PRN	5/28/2018	5/28/2018
Sig: as needed				
Reason for Discontinue: **Anesthesia Stop**				
lactated Ringers infusion (Discontinued)		Continuous PRN	5/28/2018	5/28/2018
Sig - Route: Injectinto the vein continuous prn - Intravenous				
Reason for Discontinue: **Anesthesia Stop**				
lidocaine 20 mg/mL (2 %) injection (Discontinued)		PRN	5/28/2018	5/28/2018
Sig: as needed				
Reason for Discontinue: **Anesthesia Stop**				
midazolam (VERSED) 10 mg/5 mL (2 mg/mL) syrup 20 mg (Discontinued)	20 mg	Once	5/28/2018	5/28/2018
Sig - Route: Take 10 mLs (20 mg total)by mouth once - Oral				
Reason for Discontinue: **Patient Transfer**				
ondansetron hcl (PF) (ZOFRAN) 4 mg/2 mL injection (Discontinued)		PRN	5/28/2018	5/28/2018
Sig - Route: Injectinto the vein as needed for Nausea or Vomiting - Intravenous				
Reason for Discontinue: **Anesthesia Stop**				
propofol (DIPRIVAN) 10 mg/mL injection (Discontinued)		PRN	5/28/2018	5/28/2018
Sig - Route: Injectinto the vein as needed - Intravenous				
Reason for Discontinue: **Anesthesia Stop**				

Notes (continued)

Inpatient Medications (continued)

	Dose	Frequency	Start	End
rocuronium (ZEMURON) injection (Discontinued) Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
sugammadex (BRIDION) injection (Discontinued) Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018

Call Information

	Provider	Department	Center
5/28/2018 3:35 PM	LCMC CH XR IP PORT2	Chno Radiology	CHNO Childre

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Surg. Date: 05/28/18

Allergies as of 5/28/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 5/28/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Melanoma in situ of left lower leg			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seasonal allergies			Provider
Seizure syndrome			Provider

Surgical as of 5/28/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

Family as of 5/28/2018 **None**

Family Status as of 5/28/2018 **None**

Tobacco Use as of 5/28/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/28/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/28/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/28/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 5/28/2018

ADL Question	Response	Comments	Source
None			

Social Doc **None**

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Surg. Date: 05/28/18

Scanned Information (continued)

as of 5/28/2018

Occupational ****None****
as of 5/28/2018

Socioeconomic **as of 5/28/2018**

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				
Preferred Language	**Ethnicity**	**Race**		
English	Non-Hispanic	White or Caucasian		

Birth ****None****

Most recent update: 5/28/2018 6:06 PM by Lisa Cruz

Vitals

BP	Pulse	Temp	Resp	Ht	Wt
(!) 140/99	76	97.7 °F (36.5 °C) (Axillary)	18	1.72 m	49.7 kg

SpO2	BMI
100%	16.8 kg/m2

Current Immunizations

Never Reviewed

No immunizations on file.

Not reviewed this visit

Orders and Results

All Orders and Results

No orders and results found

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet Sig - Route: Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days - Oral	28 tablet	0	5/28/2018	6/4/2018

Notes (continued)

Medications at Start of Encounter (continued)

	Disp	Refills	Start	End
Class: Print				
ketorolac (TORADOL) 10 mg tablet	12 tablet	0	5/28/2018	6/1/2018
Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral				
Class: Print				
montelukast (SINGULAIR) 10 mg tablet			5/7/2018	
Sig - Route: Take 10 mg by mouth daily - Oral				
Class: Historical Med				
naproxen sodium (ALEVE) 220 MG tablet				
Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral				
Class: Historical Med				
ketorolac (TORADOL) 10 mg tablet (Discontinued)	12 tablet	0	5/28/2018	5/28/2018
Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral				

Call Information

	Department	Center
5/28/2018 9:05 AM	Chno Surgery	CHNO Childre

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/28/18

Allergies as of 5/28/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 5/28/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Melanoma in situ of left lower leg			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seasonal allergies			Provider
Seizure syndrome			Provider

Surgical as of 5/28/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

Family as of 5/28/2018 **None**

Family Status as of 5/28/2018 **None**

Tobacco Use as of 5/28/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/28/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/28/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/28/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 5/28/2018

ADL Question	Response	Comments	Source
None			

Social Doc **None**

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

as of 5/28/2018

Occupational ****None****
as of 5/28/2018

Socioeconomic
as of 5/28/2018

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				
Preferred Language	**Ethnicity**	**Race**		
English	Non-Hispanic	White or Caucasian		

Birth ****None****

Current Immunizations — Never Reviewed

No immunizations on file.

Not reviewed this visit

Orders and Results

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

PR Charge - All Orders and Results

Airway Insertion

Electronically signed by: **Marie Denise Hollier, CRNA on 05/28/18 1354** Status: **Completed**
Ordering user: Marie Denise Hollier, CRNA 05/28/18 1354 Ordering provider: Marie Denise Hollier, CRNA

Airway Insertion

Electronically signed by: **Marie Denise Hollier, CRNA on 05/28/18 1354** Status: **Completed**
Ordering user: Marie Denise Hollier, CRNA 05/28/18 1354 Ordering provider: Marie Denise Hollier, CRNA

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
montelukast (SINGULAIR) 10 mg tablet Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
naproxen sodium (ALEVE) 220 MG tablet Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral Class: Historical Med				

Inpatient Medications

	Dose	Frequency	Start	End
midazolam (VERSED) 10 mg/5 mL (2 mg/mL) syrup 20 mg (Discontinued) Sig - Route: Take 10 mLs (20 mg total)by mouth once - Oral Reason for Discontinue: **Patient Transfer**	20 mg	Once	5/28/2018	5/28/2018

Ordered Facility-Administered Medications

	Dose	Freq	Start	End
lactated Ringers infusion (Discontinued) Sig - Route: Injectinto the vein continuous prn - Intravenous Reason for Discontinue: **Anesthesia Stop**		Continuous PRN	5/28/2018	5/28/2018

Notes (continued)

Ordered Facility-Administered Medications (continued)

	Dose	Freq	Start	End
fentaNYL (SUBLIMAZE) injection (Discontinued) Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
propofol (DIPRIVAN) 10 mg/mL injection (Discontinued) Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
rocuronium (ZEMURON) injection (Discontinued) Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
lidocaine 20 mg/mL (2 %) injection (Discontinued) Sig: as needed Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
ceFAZolin (ANCEF) injection (Discontinued) Sig: as needed Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
ondansetron hcl (PF) (ZOFRAN) 4 mg/2 mL injection (Discontinued) Sig - Route: Injectinto the vein as needed for Nausea or Vomiting - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
ketorolac (TORADOL) injection (Discontinued) Sig: as needed Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
sugammadex (BRIDION) injection (Discontinued) Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018

Call Information

	Provider	Department	Center
5/28/2018 9:05 PM	Lorena Dumas Guntner, MD	Chno Surgery	CHNO Childre

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

Bodin, Jeffrey [1002548110] Male 21 y.o. Current as of 05/28/18 1227

Height	Weight	BMI	NPO Status
1.72 m (05/28/18)	49.7 kg (05/28/18)	16.8 (05/28/18)	1900

Allergies	ASA Status
LACTOSE, LATEX	2

Anesthesia Type
general

Anesthesia Procedure Summary

Date	Anesthesia Start	Anesthesia Stop	Room / Location
05/28/18	1335	1512	CH MAIN OR 10 / CH MAIN OR

Procedure	Diagnosis	Surgeon	Responsible Staff
OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER (Right Arm)	Dislocation of right shoulder joint, initial encounter	Joseph Gonzales, MD	Donald Edward Smith, MD

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/28/18

Scanned Information (continued)

Procedure	Diagnosis	Surgeon	Responsible Staff
	(Dislocation of right shoulder joint, initial encounter [S43.004A]; Dislocation of right shoulder joint, initial encounter [S43.004A])		

Staff

05/28/18

Name	Role	Begin	End
Donald Edward Smith, MD	ANESTH	1335	1512
Marie Denise Hollier, CRNA	CRNA	1335	1512
Paula M Davis, RN	GSA	1335	1512

Events

Date	Time	Event
5/28/2018	1335	Anesthesia Start
	1335	Start Data Collection
	1335	Pre Induction Eval The patient was re-assessed just prior to induction/procedure start.
	1335	Induction
	1341	Intubation
	1502	Extubation Adequate spontaneous ventilation, TOF=4/4 with sustained tetanus, Patient Suctioned,Extubated with Positive Pressure, 100% oxygen applied by Face Mask, Positive ET CO2.
	1505	Stop Data Collection
	1512	Anesthesia Stop

Anesthesia History

Narcolepsy	Peripheral neuropathy
Migraine-cluster headache syndrome	Seizure syndrome
Clinical trial participant	Dislocated shoulder
Cancer	Seasonal allergies
Melanoma in situ of left lower leg	

Facility Administered Medications

No medications found

Surgical History

WISDOM TOOTH EXTRACTION	melanoma excision
TONSILLECTOMY	ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES
APPENDECTOMY	

Prescription Medications

Within last 14 days from 05/28/18

	Last Taken	Last Updated
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry	Taking	05/25/18 1248
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet	Taking	05/25/18 1248
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet	Taking	05/25/18 1248
montelukast (SINGULAIR) 10 mg tablet	Taking	05/25/18 1248
naproxen sodium (ALEVE) 220 MG tablet	Taking	05/25/18 1248

Substance History

Smoking Status: Never Smoker
Smokeless Tobacco Status: Never Used
Alcohol use: No
Drug use: No

Go to the Preprocedure Summary Report for this case.

Procedure Notes

Last edited 05/28/18 1355 by Marie Denise Hollier, CRNA

Airway Insertion

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Procedure Notes (continued)

Patient Location is OR.

Staff:
Anesthesiologist: SMITH, DONALD EDWARD.

CRNA: HOLLIER, MARIE DENISE.

Performed with SRNAs.

PLACEMENT:
Airway indications Anesthesia.
Spontaneous vent: present
Sedation level: Anesthesia
Preoxygenated: yes
Patient position: Supine
MILS maintained throughout
Mask difficulty assessment: Easy mask

Final Airway Details

Final airway type: Endotracheal airwaySuccessful airway: Oral ETT
Cuffed: cuffed
Successful intubation technique: Direct laryngoscopy
Endotracheal tube insertion site: Oral
Blade: Miller
Blade size: #2
Placement verified by: auscultation, CO2 detection, chest rise and direct visualization
Breath Sounds: Equal
Cormack-Lehane Classification: grade I - full view of glottis
Inital cuff pressure (cm H2O): MOP
ETT to lips (cm): 21
Measured from: Lips
Lips/Dentition: Unchanged
Secured Method: Pink tape Secured Location: Left
Number of attempts at approach: 1

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Children's Hospital
200 Henry Clay Avenue
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Scanned Information (continued)

Procedure Notes (continued)

Preprocedure Note

Last edited 05/28/18 1227 by Tino Kuzma Vekic, CRNA

Anesthesia Evaluation

Review of Symptoms:

Patient summary reviewed and Nursing notes reviewed
The patient is noted as not having history of anesthetic complications and family history of Anes complications.

Birth History: Neg birth History ROS.
Cardiovascular: Neg cardio ROS.
Hematologic: Hematologic/lymphatic negative.
Pulmonary: Neg pulmonary ROS.
Neurological: Severe narcolepsy- takes adderall
Muscle/Bone Problems: Right shoulder dislocation. Suffers from nerve problems 2nd to interferon infusions. Pt didn't know his shoulder was dislocated. Doesn't feel pain in that joint as well as other joints.
Miscellaneous: Positive for cancer (hx of melonoma 2010. in remission).

Physical Exam:

Identifiers: Name, DOB and MRN.

Airway Mallampati score: II. TM distance: >3 FB. Neck ROM: full.
Cardiovascular: Cardiovascular exam normal. Rhythm: regular Rate: normal.

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200 Henry Clay Avenue
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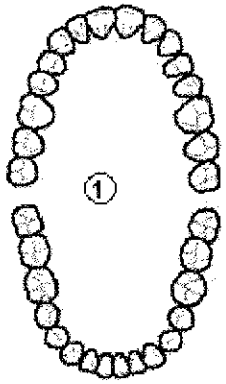
Scanned Information (continued)

Preprocedure Note (continued)

Dental:
No notable dental hx.



1: Permanent retainer on the bottom

Pulmonary:
Pulmonary exam normal.

Abdominal:

Other Findings:

Past Medical History:

Diagnosis	Date
• Cancer *Dr. Leblanc*	
• Clinical trial participant *Zyrem Rems Trial - pt states unsuccessful*	2016
• Dislocated shoulder	
• Melanoma in situ of left lower leg	
• Migraine-cluster headache syndrome	
• Narcolepsy	02/15/2015
• Peripheral neuropathy	
• Seasonal allergies	
• Seizure syndrome	

Past Surgical History:

Procedure	Laterality	Date
• ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES		
• APPENDECTOMY		
• melanoma excision		
• TONSILLECTOMY		
• WISDOM TOOTH EXTRACTION		2015

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Scanned Information (continued)

Preprocedure Note (continued)

Anesthesia Plan
ASA Score: **2**
Plan: **general**
CRNA/Resident and Attending have discussed this plan.
Informed Consent:
Discussed with: **patient**
Patient/representative **consented to** anesthesia plan.
NPO Status: **Confirmed**

All Postprocedure Notes

Last edited 05/28/18 1529 by Brandon Sanders Black, MD

Anesthesia Post Note

Patient: Jeffrey Bodin

Procedures(s) performed: *OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER*

Anesthesia type: General

Last Vitals:
Vitals:

	05/28/18 1520
BP:	(!) 149/95
Pulse:	79
Resp:	18
Temp:	
SpO2:	100%

Patient Location: PACU

Post assessment: tolerated well, no immediate complications

Post vital signs: post-procedure vital signs reviewed and stable

Temp: post-procedure temperature appropriate

Post pain: adequate control

Post Op Nausea/Vomiting: no PONV

Motor Function: gross motor function is at baseline for patient

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Scanned Information (continued)

All Postprocedure Notes (continued)

Level of Consciousness: awake

Procedure Information: hypotension not controlled and hypothermia not controlled
Complications: no anesthesia complication

Airway: room air

Postoperative Hydration: acceptable

Electronically signed by Brandon Sanders Black, MD at 5/28/2018 3:29 PM

Attestation Information

Staff Name	Date	Time	Type
Courtnie Breaux	05/28/18	1255	Pre-Op
Donald Edward Smith, MD	05/28/18	1335	Present at Induction
Melynda Catanese	05/28/18	1511	Intra-Op
Elise Michaelis	05/28/18	1546	Phase I
Lisa Cruz	05/28/18	1826	Phase II
Lynne Kennedy	05/29/18	0740	AN Charge Trigger

Medications

propofol (DIPRIVAN) injection 10 mg/mL (mg)	150 mg	Given	05/28/18	1338	Marie Denise Hollier, CRNA
	50 mg	Given		1340	Marie Denise Hollier, CRNA
fentaNYL (SUBLIMAZE) injection (mcg)	75 mcg	Given	05/28/18	1338	Marie Denise Hollier, CRNA
rocuronium (ZEMURON) 10 mg/mL injection (mg)	25 mg	Given	05/28/18	1338	Marie Denise Hollier, CRNA
	25 mg	Given		1412	Marie Denise Hollier, CRNA
ondansetron (PF) (ZOFRAN) injection (mg)	4 mg	Given	05/28/18	1440	Marie Denise Hollier, CRNA
sugammadex (BRIDION) injection (mg)	200 mg	Given	05/28/18	1455	Marie Denise Hollier, CRNA
lidocaine injection 2% (mg)	50 mg	Given	05/28/18	1338	Marie Denise Hollier, CRNA
ceFAZolin (ANCEF) 1 g injection (mg)	1,490 mg	Given	05/28/18	1416	Marie Denise Hollier, CRNA
ketorolac (TORADOL) injection (mg)	30 mg	Given	05/28/18	1442	Marie Denise Hollier, CRNA
lactated ringers infusion (mL)		New Bag	05/28/18	1338	Marie Denise Hollier, CRNA

Signoff Status

None

All Meds and Administrations

(No medication admins scheduled or recorded for this encounter)

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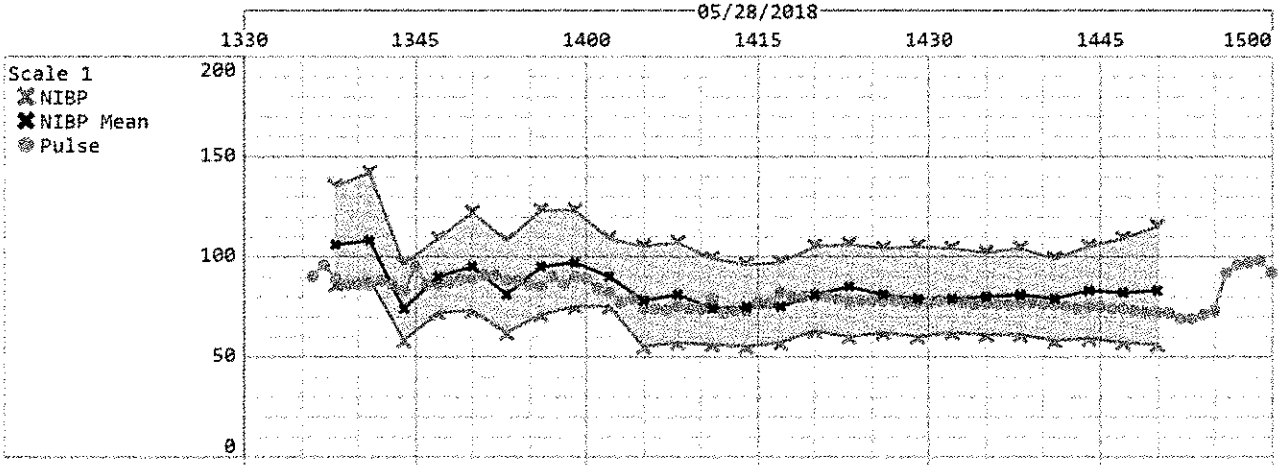
Enc. Date: 05/28/18

Scanned Information (continued)



O2	(L/min)	[9.3]	[1]	[1]	[1]	[1]	[9.3]
N2O	(L/min)	[5.4]	[1.2]	[1.2]	[1.2]	[1.2]	[0]
N2O(I)	(%)	[35]	[45]	[51]	[52]	[51]	[4]
Air	(L/min)	[0]	[0]	[0]	[0]	[0]	[0]
Sevoflurane (I)	(%)	[0]	[1.5]	[2]	[2.1]	[1.6]	[0]
Sevoflurane (E)	(%)	[0]	[1.3]	[1.8]	[1.9]	[1.7]	[0.1]
propofol (DIP…	(mg)	[200]					
fentaNYL (SU…	(mcg)	75					
rocuronium (Z…	(mg)	25		25			
ondansetron (…	(mg)					4	
sugammadex (B…	(mg)						200
lidocaine inj…	(mg)	50					
ceFAZolin (AN…	(mg)				1490		
ketorolac (TO…	(mg)					30	
lactated ring…	(mL)	/					
FiO2 (%)	(%)	[63]	[51]	[44]	[43]	[45]	[89]
Vent Mode		[SV]	[VC]	[VC]	[VC]	[PSV]	[SV]
Resp		[2]	[15]	[12]	[14]	[5]	[16]
Vt Observed	(ml)	[47]	[484]	[441]	[437]	[350]	[30]
PIP Obser…	(cm H2O)		[12]	[10]	[10]	[12]	[12]
PEEP/CPAP…	(cm H20)		[3]	[2]	[2]	[4]	[4]
Pressure …	(cm H2O)					[10]	[10]
Temp			[97.2]	[96.1]	[95.4]	[95.4]	[95.4]
EKG		[NSR]	NSR	NSR	NSR	NSR	NSR
SpO2	(%)	[99]	[98]	[98]	[98]	[98]	[97]
ETCO2	(mmHg)	[0]	[32]	[34]	[31]	[41]	[23]

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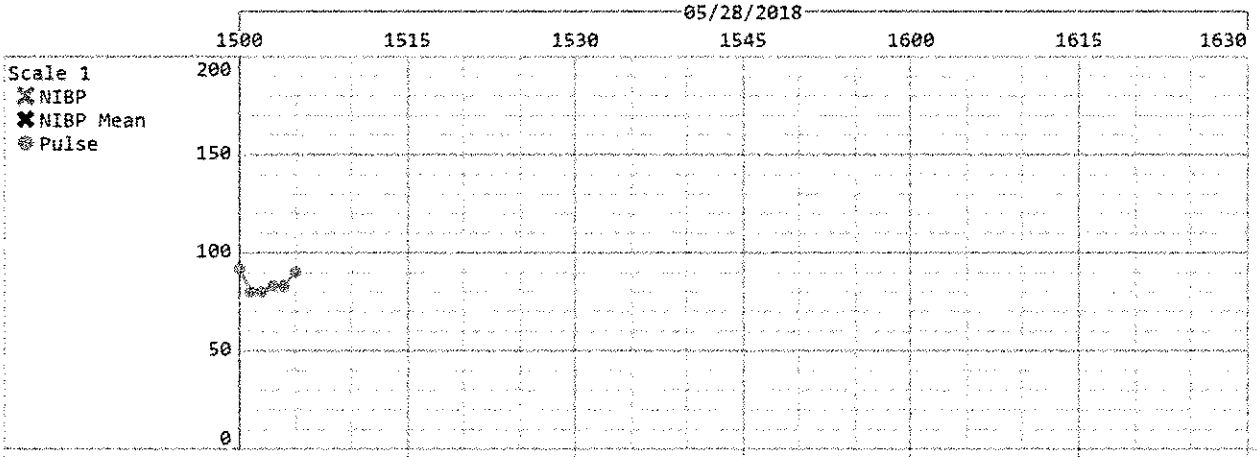
Scanned Information (continued)



O2 (L/min)	[9.2]	
N2O (L/min)	[0]	
N2O(I) (%)	[0]	
Air (L/min)	[0]	
Sevoflurane (I) (%)	[0]	
Sevoflurane (E) (%)	[0]	
propofol (DIP… (mg)		200 mg
fentaNYL (SU… (mcg)		75 mcg
rocuronium (Z… (mg)		50 mg
ondansetron (… (mg)		4 mg
sugammadex (B… (mg)		200 mg
lidocaine inj… (mg)		50 mg
ceFAZolin (AN… (mg)		1490 mg
ketorolac (TO… (mg)		30 mg
lactated ring… (mL)		
FiO2 (%) (%)	[95]	
Vent Mode	[SV]	
Resp	[4]	
Vt Observed (ml)		
PIP Obser… (cm H2O)		
PEEP/CPAP… (cm H20)		
Pressure … (cm H2O)		
Temp		
EKG	NSR	
SpO2 (%)	[96]	
ETCO2 (mmHg)	[0]	

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LCMC HEALTH MEMBER HOSPITALS
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BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/28/18

Allergies as of 5/28/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 5/28/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Melanoma in situ of left lower leg			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seasonal allergies			Provider
Seizure syndrome			Provider

Surgical as of 5/28/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

Family as of 5/28/2018 **None**

Family Status as of 5/28/2018 **None**

Tobacco Use as of 5/28/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/28/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/28/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/28/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 5/28/2018

ADL Question	Response	Comments	Source
None			

Social Doc **None**

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

as of 5/28/2018

Occupational ****None****
as of 5/28/2018

Socioeconomic	Marital Status	Spouse Name	Num of Children	Years Education	Source
as of 5/28/2018	Single				
	Preferred Language	Ethnicity	Race		
	English	Non-Hispanic	White or Caucasian		

Birth ****None****

Current Immunizations — Never Reviewed

No immunizations on file.

Not reviewed this visit

Orders and Results

All Orders and Results

No orders and results found

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet	28 tablet	0	5/28/2018	6/4/2018
Sig - Route: Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days - Oral Class: Print				
ketorolac (TORADOL) 10 mg tablet	12 tablet	0	5/28/2018	6/1/2018
Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral Class: Print				
montelukast (SINGULAIR) 10 mg tablet Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	

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BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/28/18

Notes (continued)

Medications at Start of Encounter (continued)

	Disp	Refills	Start	End
naproxen sodium (ALEVE) 220 MG tablet Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral Class: Historical Med				
ketorolac (TORADOL) 10 mg tablet (Discontinued) Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral	12 tablet	0	5/28/2018	5/28/2018

Inpatient Medications

	Dose	Frequency	Start	End
ceFAZolin (ANCEF) injection (Discontinued) Sig: as needed Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
dexmedetomidine (PRECEDEX) injection 15.3 mcg (Discontinued) Sig - Route: Inject 0.153 mLs (15.3 mcg total)into the vein once as needed (Post-operative delirium) - Intravenous Reason for Discontinue: **Patient Discharge**	0.3 mcg/kg × 51 kg	Once PRN	5/28/2018	5/28/2018
fentaNYL (SUBLIMAZE) injection (Discontinued) Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet 1 tablet (Discontinued) Sig - Route: Take 1 tabletby mouth every 6 (six) hours as needed for Pain Score 4 - 7 - Oral Reason for Discontinue: **Patient Discharge**	1 tablet	Every 6 Hours PRN	5/28/2018	5/28/2018
ibuprofen (ADVIL,MOTRIN) tablet 600 mg (Discontinued) Sig - Route: Take 600 mgby mouth every 8 (eight) hours as needed for Pain Score 1 - 3 - Oral Reason for Discontinue: **Patient Discharge**	600 mg	Every 8 Hours PRN	5/28/2018	5/28/2018
ketorolac (TORADOL) injection (Discontinued) Sig: as needed Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
lactated Ringers infusion (Discontinued) Sig - Route: Injectinto the vein continuous prn - Intravenous Reason for Discontinue: **Anesthesia Stop**		Continuous PRN	5/28/2018	5/28/2018
lidocaine 20 mg/mL (2 %) injection (Discontinued) Sig: as needed Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
midazolam (VERSED) 10 mg/5 mL (2 mg/mL) syrup 20 mg (Discontinued) Sig - Route: Take 10 mLs (20 mg total)by mouth once - Oral Reason for Discontinue: **Patient Transfer**	20 mg	Once	5/28/2018	5/28/2018
ondansetron hcl (PF) (ZOFRAN) 4 mg/2 mL injection (Discontinued) Sig - Route: Injectinto the vein as needed for Nausea or Vomiting - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
propofol (DIPRIVAN) 10 mg/mL injection (Discontinued)		PRN	5/28/2018	5/28/2018

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Notes (continued)

Inpatient Medications (continued)

	Dose	Frequency	Start	End
Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**				
rocuronium (ZEMURON) injection (Discontinued) Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018
sugammadex (BRIDION) injection (Discontinued) Sig - Route: Injectinto the vein as needed - Intravenous Reason for Discontinue: **Anesthesia Stop**		PRN	5/28/2018	5/28/2018

Call Information

	Provider	Department	Center
5/28/2018 11:52 AM	Joann Lee	Chno Surgery	CHNO Childre

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

touro UMC NOLH HOSPITAL
LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 05/29/18

Allergies as of 5/29/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 5/29/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Melanoma in situ of left lower leg			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seasonal allergies			Provider
Seizure syndrome			Provider

Surgical as of 5/29/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

Family as of 5/29/2018 **None**

Family Status as of 5/29/2018 **None**

Tobacco Use as of 5/29/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 5/29/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 5/29/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 5/29/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 5/29/2018

ADL Question	Response	Comments	Source
None			

Social Doc **None**

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DOB: 5/22/1997, Sex: M
Enc. Date: 05/29/18

Scanned Information (continued)

as of 5/29/2018

Occupational ****None****
as of 5/29/2018

Socioeconomic **as of 5/29/2018**

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				
Preferred Language	**Ethnicity**	**Race**		
English	Non-Hispanic	White or Caucasian		

Birth ****None****

Current Immunizations Never Reviewed

No immunizations on file.

Not reviewed this visit

Orders and Results

All Orders and Results

No orders and results found

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet Sig - Route: Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days - Oral Class: Print	28 tablet	0	5/28/2018	6/4/2018
ketorolac (TORADOL) 10 mg tablet Sig - Route: Take 1 tablet (10 mg total) by mouth every 8 (eight) hours for 4 days - Oral Class: Print	12 tablet	0	5/28/2018	6/1/2018
montelukast (SINGULAIR) 10 mg tablet Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	

Notes (continued)

Medications at Start of Encounter (continued)

	Disp	Refills	Start	End

naproxen sodium (ALEVE) 220 MG tablet
Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral
Class: Historical Med

Call Information

	Department	Center
5/29/2018 12:35 PM	Lcmc Central Sched	

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 06/05/18

Allergies as of 6/5/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 6/5/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Melanoma in situ of left lower leg			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seasonal allergies			Provider
Seizure syndrome			Provider

Surgical as of 6/5/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

Family as of 6/5/2018 **None**

Family Status as of 6/5/2018 **None**

Tobacco Use as of 6/5/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 6/5/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 6/5/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 6/5/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 6/5/2018

ADL Question	Response	Comments	Source
None			

Social Doc **None**

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 06/05/18

Scanned Information (continued)

as of 6/5/2018

Occupational ****None****
as of 6/5/2018

Socioeconomic **as of 6/5/2018**

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				
Preferred Language	**Ethnicity**	**Race**		
English	Non-Hispanic	White or Caucasian		

Birth ****None****

Current Immunizations

Never Reviewed

No immunizations on file.

Not reviewed this visit

Diagnoses

	Comments
Chronic dislocation of right shoulder	
Closed 2-part displaced fracture of surgical neck of right humerus with routine healing, subsequent encounter	

Orders and Results

All Orders and Results

No orders and results found

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet (Expired) Sig - Route: Take 1 tablet by mouth every 6 (six) hours as needed for Pain for up to 7 days - Oral Class: Print	28 tablet	0	5/28/2018	6/4/2018

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Notes (continued)

Medications at Start of Encounter (continued)

	Disp	Refills	Start	End
montelukast (SINGULAIR) 10 mg tablet			5/7/2018	
Sig - Route: Take 10 mg by mouth daily - Oral				
Class: Historical Med				
naproxen sodium (ALEVE) 220 MG tablet				
Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral				
Class: Historical Med				

Call Information

	Provider	Department	Center
6/5/2018 4:34 PM	Kathleen Kelleher	Chno Orthopedics	CHNO Ambula

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
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BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 06/12/18

Allergies as of 6/12/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 6/12/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Melanoma in situ of left lower leg			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seasonal allergies			Provider
Seizure syndrome			Provider

Surgical as of 6/12/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

Family as of 6/12/2018

Problem	Relation	Name	Age of Onset	Comments	Source
No Known Problems	Mother				Provider
No Known Problems	Father				Provider

Family Status as of 6/12/2018

Relation	Name	Status	Comments	Sex
Mother				F
Father				M

Tobacco Use as of 6/12/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 6/12/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 6/12/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 6/12/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 6/12/2018

ADL Question	Response	Comments	Source
None			

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Social Doc as of 6/12/2018 **None**

Occupational as of 6/12/2018 **None**

Socioeconomic as of 6/12/2018

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				
Preferred Language	**Ethnicity**	**Race**		
English	Non-Hispanic	White or Caucasian		

Birth **None**

Medications the Patient Reported Taking

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry (Taking) Sig: 1 spray by Nasal route daily Class: Historical Med Route: Nasal				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet (Taking) Sig: Take 300 mg by mouth daily Class: Historical Med Route: Oral			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet (Taking) Sig: Take 20 mg by mouth 3 (three) times daily Class: Historical Med Route: Oral			5/13/2018	
montelukast (SINGULAIR) 10 mg tablet (Taking) Sig: Take 10 mg by mouth daily Class: Historical Med Route: Oral			5/7/2018	
naproxen sodium (ALEVE) 220 MG tablet (Taking) Sig: Take 1,000 mg by mouth 2 (two) times daily with meals Class: Historical Med Route: Oral				

Current Immunizations — Never Reviewed

No immunizations on file.

Not reviewed this visit

Reason for Visit

Post-op Follow-up SHOULDER RIGHT

Diagnoses

	Comments
Chronic dislocation of right shoulder	

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Orders and Results

All Orders and Results

No orders and results found

Progress Notes

Katherine Gill, NP at 6/12/2018 7:45 AM

Author Type: Nurse Practitioner Status: Attested Cosigner: Joseph Gonzales, MD at 6/12/2018 2:20 PM

Attestation signed by Joseph Gonzales, MD at 6/12/2018 2:20 PM

I have personally performed a face to face diagnostic evaluation of this patient. I have reviewed and agree with care plan. My findings are in my signed addendum.
The patient is status-post surgery. Otherwise, the patient is doing well without issues or real complaints.

On physical examination, the incision is well healed, clean dry and intact. The patient is neurovascularly intact at that spot distally. The wounds are clean, dry and intact.

At this point, we will either begin gentle range of motion or therapy. This is up to the patient and the site of the injury. We will follow up with the patient to make sure he has resolution of the symptoms.

Patient here today for 2 week pos op follow up of right shoulder dislocation s/p OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER performed on 5/28/18. Denies numbness and tingling states he is still having pain however his pain medication gives him relief.

Objective: Right shoulder incision well healed, edges approximated no signs and symptoms of infection, limited ROM to right shoulder, good perfusion to all fingers 2+ radial pulse, neuro intact to light touch, fires radial ulna and median nerve function without difficulty.

Xray right shoulder: Right shoulder in place, healing well

Assessment/Plan: 21 yo M right shoulder dislocation s/p OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER. Work on gentle ROM over the next few weeks, ROM limitation was discussed with external rotation and extension of his arm where he cannot see it, we will see him back in 4 weeks for exam only.

Katherine Gill, FNP for Dr. Gonzales

Electronically signed by Joseph Gonzales, MD on 6/12/2018 2:20 PM

H&P Notes

No notes of this type exist for this encounter.

Follow-up and Disposition History

06/12/2018 0844 - Katherine Gill, NP

Disposition: Return in about 4 weeks (around 7/10/2018).

touro UMC NOEH HOSPITAL
LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 06/12/18

Follow-up and Disposition History (continued)

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry (Taking) Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet (Taking) Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet (Taking) Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
montelukast (SINGULAIR) 10 mg tablet (Taking) Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
naproxen sodium (ALEVE) 220 MG tablet (Taking) Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral Class: Historical Med				

Call Information

	Provider	Department	Center
6/12/2018 7:45 AM	Joseph Gonzales, MD	Chno Orthopedics	CHNO Ambula

Reason for Call

Post-op Follow-up	SHOULDER RIGHT

Call Documentation

Katherine Gill, NP at 6/12/2018 7:45 AM

Status: Attested
Cosigner: Joseph Gonzales, MD at 6/12/2018 2:20 PM

Attestation signed by Joseph Gonzales, MD at 6/12/2018 2:20 PM

I have personally performed a face to face diagnostic evaluation of this patient. I have reviewed and agree with care plan. My findings are in my signed addendum.
The patient is status-post surgery. Otherwise, the patient is doing well without issues or real complaints.

On physical examination, the incision is well healed, clean dry and intact. The patient is neurovascularly intact at that spot distally. The wounds are clean, dry and intact.

At this point, we will either begin gentle range of motion or therapy. This is up to the patient and the site of the injury. We will follow up with the patient to make sure he has resolution of the symptoms.

Patient here today for 2 week pos op follow up of right shoulder dislocation s/p OPEN REDUCTION

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Call Documentation (continued)

Katherine Gill, NP at 6/12/2018 7:45 AM (continued)

CAPSULAR FIXATION OF SHOULDER performed on 5/28/18. Denies numbness and tingling states he is still having pain however his pain medication gives him relief.

Objective: Right shoulder incision well healed, edges approximated no signs and symptoms of infection, limited ROM to right shoulder, good perfusion to all fingers 2+ radial pulse, neuro intact to light touch, fires radial ulna and median nerve function without difficulty.

Xray right shoulder: Right shoulder in place, healing well

Assessment/Plan: 21 yo M right shoulder dislocation s/p OPEN REDUCTION CAPSULAR FIXATION OF SHOULDER. Work on gentle ROM over the next few weeks, ROM limitation was discussed with external rotation and extension of his arm where he cannot see it, we will see him back in 4 weeks for exam only.

Katherine Gill, FNP for Dr. Gonzales

Signed by Joseph Gonzales, MD on 6/12/2018 2:20 PM

Scanned Information

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 6/12/2018, D/C: 6/12/2018

Admission Information - Patient Record Only

Arrival Date/Time:		Admit Date/Time:	06/12/2018 0745	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	LCMC SERVICE AREA	Unit:	Children's Hospital Radiology
Admit Provider:		Attending Provider:	Joseph Gonzales, MD	Referring Provider:	Joseph Gonzales, MD

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
06/12/2018 2359	Home Or Self Care	None	None	Children's Hospital Radiology

Patient Demographics

Name	Patient ID	SSN	Sex	Birth Date
Bodin, Jeffrey	1002548110	xxx-xx-8926	Male	05/22/97 (21 yrs)

Address	Phone	Email	Employer
528 BEAU CHENE DR MANDEVILLE LA 70471	985-272-8989 (H) 985-520-4713 (W) 985-272-8989 (M)	jeffreybodin713@gmail.com	

County	Race	Occupation	Emp Status
SAINT TAMMANY	White or Caucasian	-	-

Reg Status	PCP
Verified	Chno Zzzprovider, MD

HAR	Admission Date	Discharge Date	Admitting Provider
10075896	06/12/18	06/12/18	

Marital Status	Religion	Language
Single	Lutheran	English

Emergency Contact 1

Jeffrey Bodin (Other)
528 BEAU CHENE DR
MANDEVILLE LA 70471
985-272-8989 (H)

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
10075896 - BODIN,JEFFREY	AETNA BETTER HEALTH [3501]	None	None

Final Diagnoses (ICD-10-CM)

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 6/12/2018, D/C: 6/12/2018

Scanned Information (continued)

Final Diagnoses (ICD-10-CM) (continued)

Code	Description	POA	CC	HAC	Affects DRG
M24.411 [Principal]	Recurrent dislocation, right shoulder				
S42.221D	2-part displaced fracture of surgical neck of right humerus, subsequent encounter for fracture with routine healing				

CPT®/HCPCS Codes

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
06/12/18 0745	Hospital Outpatient	Outpatient	CHNO OP RADIOLOGY		
06/12/18 2359	Discharge	Outpatient	CHNO OP RADIOLOGY		

Allergies as of 6/12/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
Latex	05/24/2018	Allergy	Rash	

Immunizations as of 06/12/18

None

Medical History

Medical as of 6/12/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Melanoma in situ of left lower leg			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seasonal allergies			Provider
Seizure syndrome			Provider

Surgical as of 6/12/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

Family as of 6/12/2018

Problem	Relation	Name	Age of Onset	Comments	Source
No Known Problems	Mother				Provider
No Known Problems	Father				Provider

Family Status

Relation	Name	Status	Comments	Sex

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 6/12/2018, D/C: 6/12/2018

Scanned Information (continued)

as of 6/12/2018	Mother	F
	Father	M

Tobacco Use	Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
as of 6/12/2018	Never Smoker	Provider							Never Used	

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 6/12/2018	No	Provider			

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 6/12/2018	No	Provider			

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 6/12/2018		Provider			

Social ADL	ADL Question	Response	Comments	Source
as of 6/12/2018	**None**			

Social Doc **None**
as of 6/12/2018

Occupational **None**
as of 6/12/2018

Socioeconomic	Marital Status	Spouse Name	Num of Children	Years Education	Source
as of 6/12/2018	Single				
	Preferred Language	Ethnicity	Race		
	English	Non-Hispanic	White or Caucasian		

Birth **None**

Emergency Department Information

ED Arrival Information

Patient not seen in ED

Treatment Team

Not on file

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
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Adm: 6/12/2018, D/C: 6/12/2018

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 6/12/2018, D/C: 6/12/2018

All Orders and Results

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
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BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 6/12/2018, D/C: 6/12/2018

Imaging - All Orders and Results

XR Shoulder 2+ VW Right

Electronically signed by: **Joseph Gonzales, MD on 06/06/18 1507** Status: **Completed**
Mode: Ordering in Verbal with readback, cosign Required mode Communicated by: Kathleen Kelleher
Ordering user: Kathleen Kelleher 06/05/18 1637 Ordering provider: Joseph Gonzales, MD
Final result

Performed: 06/12/18 0810 - 06/12/18 0819
Narrative:
RIGHT SHOULDER 2 VIEWS:

Impression:
Again noted is fragmentation of the right humeral head with residual separation of an avulsion fragment along the lateral aspect of the right humeral head with residual lateral and inferior displacement. The glenohumeral relationship is maintained. There is a round metallic screw superimposed on the mediastinum, correlation with lateral view would be helpful to exclude an embedded foreign body.

Electronically Signed By: Ewa Wasilewska, M.D. 6/12/2018 12:36 PM CDT

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 6/12/2018, D/C: 6/12/2018

Medications

Medication Admin Record

(No medication admins recorded for this encounter)

Discharge Instructions

Discharge Instructions Bodin, Jeffrey (MR # 1002548110)

None

Medication List

Notice

This visit has been closed. A record of the med list at the time of the visit is not available.

Flowsheets

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Adm: 6/12/2018, D/C: 6/12/2018

Scanned Information

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

Hospital account-Level Documents:

There are no hospital account-level documents.

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
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BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 06/12/18

Allergies as of 6/12/2018

	Noted	Reaction Type	Reactions	Deletion Reason
Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
Latex	05/24/2018	Allergy	Rash	

Medical History

Medical as of 6/12/2018

Past Medical History	Date	Comments	Source
Cancer		Dr. Leblanc	Provider
Clinical trial participant	2016	Zyrem Rems Trial - pt states unsuccessful	Provider
Dislocated shoulder			Provider
Melanoma in situ of left lower leg			Provider
Migraine-cluster headache syndrome			Provider
Narcolepsy	02/15/2015		Provider
Peripheral neuropathy			Provider
Seasonal allergies			Provider
Seizure syndrome			Provider

Surgical as of 6/12/2018

Past Surgical History	Laterality	Date	Comments
WISDOM TOOTH EXTRACTION		2015	
melanoma excision [Other]			
TONSILLECTOMY			
ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

Family as of 6/12/2018

Problem	Relation	Name	Age of Onset	Comments	Source
No Known Problems	Mother				Provider
No Known Problems	Father				Provider

Family Status as of 6/12/2018

Relation	Name	Status	Comments	Sex
Mother				F
Father				M

Tobacco Use as of 6/12/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 6/12/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 6/12/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 6/12/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 6/12/2018

ADL Question	Response	Comments	Source
None			

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
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BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 06/12/18

Scanned Information (continued)

Social Doc as of 6/12/2018 **None**

Occupational as of 6/12/2018 **None**

Socioeconomic as of 6/12/2018

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				

Preferred Language	Ethnicity	Race
English	Non-Hispanic	White or Caucasian

Birth **None**

Current Immunizations

Never Reviewed

No immunizations on file.

Not reviewed this visit

Orders and Results

All Orders and Results

No orders and results found

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
montelukast (SINGULAIR) 10 mg tablet Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
naproxen sodium (ALEVE) 220 MG tablet Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral Class: Historical Med				

Call Information

Notes (continued)

Call Information (continued)

	Provider	Department	Center
6/12/2018 8:23 AM	Joseph Gonzales, MD	Chno Orthopedics	CHNO Ambula

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
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BODIN,JEFFREY
MRN: 1002548110
DOB: 5/22/1997, Sex: M
Enc. Date: 06/20/18

Allergies as of 6/20/2018

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Lactose	05/28/2018	Intolerance	Nausea And Vomiting	
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Medical History

Medical as of 6/20/2018

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Seasonal allergies			Provider
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Surgical as of 6/20/2018

Past Surgical History	Laterality	Date	Comments
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melanoma excision [Other]			
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ADENOIDECTOMY W/ MYRINGOTOMY AND TUBES			
APPENDECTOMY			

Family as of 6/20/2018

Problem	Relation	Name	Age of Onset	Comments	Source
No Known Problems	Mother				Provider
No Known Problems	Father				Provider

Family Status as of 6/20/2018

Relation	Name	Status	Comments	Sex
Mother				F
Father				M

Tobacco Use as of 6/20/2018

Smoking Status	Source	Types	Packs/Day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
Never Smoker	Provider							Never Used	

Alcohol Use as of 6/20/2018

Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
No	Provider			

Drug Use as of 6/20/2018

Drug Use	Source	Types	Frequency	Comments
No	Provider			

Sexual Activity as of 6/20/2018

Sexually Active	Source	Birth Control	Partners	Comments
	Provider			

Social ADL as of 6/20/2018

ADL Question	Response	Comments	Source
None			

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Social Doc as of 6/20/2018 **None**

Occupational as of 6/20/2018 **None**

Socioeconomic as of 6/20/2018

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				
Preferred Language	**Ethnicity**	**Race**		
English	Non-Hispanic	White or Caucasian		

Birth **None**

Current Immunizations

Never Reviewed

No immunizations on file.

Not reviewed this visit

Orders and Results

All Orders and Results

No orders and results found

Notes

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Medications at Start of Encounter

	Disp	Refills	Start	End
azelastine-fluticasone (DYMISTA) 137-50 mcg/spray Spry Sig - Route: 1 spray by Nasal route daily - Nasal Class: Historical Med				
buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet Sig - Route: Take 300 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab per tablet Sig - Route: Take 20 mg by mouth 3 (three) times daily - Oral Class: Historical Med			5/13/2018	
montelukast (SINGULAIR) 10 mg tablet Sig - Route: Take 10 mg by mouth daily - Oral Class: Historical Med			5/7/2018	
naproxen sodium (ALEVE) 220 MG tablet Sig - Route: Take 1,000 mg by mouth 2 (two) times daily with meals - Oral Class: Historical Med				

Call Information

Notes (continued)

Call Information (continued)

	Provider	Department	Center
6/20/2018 3:54 PM	Joseph Gonzales, MD	Chno Orthopedics	CHNO Ambula

Call Documentation

No notes of this type exist for this encounter.

Scanned Information

Encounter-Level Documents - 06/20/2018:

Physician Order (below)

Scanned Information (continued)

Encounter-Level Documents - 06/20/2018: (continued)

YOUR PERSONAL PRESCRIPTION INFORMATION

Your Walgreens Pharmacy Location
4330 Highway 22
Mandeville, LA 70471
(985)674-2551

IF YOU HAVE QUESTIONS ABOUT YOUR PRESCRIPTION, PLEASE CONTACT YOUR WALGREENS PHARMACIST OR CALL 1-800-WALGREENS

PATIENT JEFFREY BODIN
BIRTH DATE 05/22/97
MEDICATION D-AMPHETAMINE SALT COMBO 20MG TABS
QUANTITY 90
DIRECTIONS TAKE 1 TABLET BY MOUTH THREE TIMES DAILY(6AM, 12PM, 4PM)

DOCTOR A. WEISS, DO
PATIENT ALLERGIES

DRUG DESCRIPTION
PEACH
FRONT: b / 973
BACK: 20

INGREDIENT NAME: Dextroamphetamine and Amphetamine Tablets [illegible]

WARNING: This drug may be habit-forming; avoid long-term use. Use this drug as you were told by your doctor. Tell your doctor if you have a history of drug or alcohol abuse. Misuse of this drug may cause unsafe heart-related side effects or even sudden death. Tell your doctor if you have any heart disease.

COMMON USES: [illegible]

BEFORE USING THIS MEDICINE: WHAT DO I NEED TO TELL MY DOCTOR BEFORE I TAKE THIS DRUG? [illegible]

HOW TO USE THIS MEDICINE: HOW IS THIS DRUG BEST TAKEN? [illegible]

CAUTIONS: [illegible] Do not switch between this product and other products that have the same drugs in them without checking with the doctor. New or worse behavior and mood changes like change in thinking, anger, and hallucinations have happened with this drug. Tell your doctor if you or a family member have any mental or mood problems like low mood (depression) or bipolar illness, or if a family member has killed themselves. Call your doctor right away if you have hallucinations; change in the way you act; or signs of mood changes like low mood (depression), thoughts of killing yourself, nervousness, emotional ups and downs, thinking that is not normal, anxiety, or lack of [illegible]

POSSIBLE SIDE EFFECTS: WHAT ARE SOME SIDE EFFECTS THAT I NEED TO CALL MY DOCTOR ABOUT RIGHT AWAY? [illegible]

OVERDOSE: [illegible]

ADDITIONAL INFORMATION: [illegible] Give this list to your doctor. Talk with the doctor before starting any new drug, including prescription or OTC, natural products, or vitamins. This drug comes with an extra patient fact sheet called a Medication Guide. Read it with care. Read it again each time this drug is refilled. If you have any questions about this drug, please talk with the doctor, pharmacist, or other health care provider.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088

KEEP OUT OF REACH OF CHILDREN: STORE IN SAFETY CONTAINER OR SECURE AREA.

JEFFREY BODIN
RX # 2045860-05382 DATE: 05/13/18
D-AMPHETAMINE SALT COMBO 20MG TABS
QTY: 90 NO REFILLS
New NDC 00555-0973-02
$ 0.00
A. WEISS, DO
MFG TEVA
PLAN: ABHPA
GROUP# RX8834
CLAIM REF# 181333719729067996
Walgreens
PH: (985)674-2551
[redacted]

JEFFREY BODIN
RX # 2045860-05382 DATE: 05/13/18
D-AMPHETAMINE SALT COMBO 20MG TABS
QTY: 90 NO REFILLS
New NDC 00555-0973-02
$ 0.00
A. WEISS, DO
MFG TEVA
PLAN: ABHPA
GROUP# RX8834
CLAIM REF# 181333719729067996
Walgreens
PH: (985)674-2551
[redacted]

Pharmacy use only

SUN 11:44AM
New

D AMPHETAMINE SALT COMBO 20MG TABS
00555-0973-02
SAFE

QTY 90
10 DRAM

PEACH
FRONT: b / 973
BACK: 20

Med Guide

Scanned Information (continued)

Encounter-Level Documents - 06/20/2018: (continued)

YOUR PERSONAL PRESCRIPTION INFORMATION

Your Walgreens Pharmacy Location
4330 Highway 22
Mandeville, LA 70471
(985)674-2561

PATIENT	JEFFREY BODIN	DOCTOR	A. WEISS, DO
BIRTH DATE	05/22/97		
MEDICATION	BUPROPION XL 300MG TABLETS		
QUANTITY	30	PATIENT ALLERGIES	
DIRECTIONS	TAKE 1 TABLET BY MOUTH EVERY MORNING		

DRUG DESCRIPTION
WHITE
FRONT: 142

INGREDIENT NAME: Bupropion Extended-Release Tablets [illegible]

WARNING: [illegible]

COMMON USES: [illegible]

BEFORE USING THIS MEDICINE: WHAT DO I NEED TO TELL MY DOCTOR BEFORE I TAKE THIS DRUG? [illegible]

HOW TO USE THIS MEDICINE: HOW IS THIS DRUG BEST TAKEN? [illegible]

CAUTIONS: [illegible]

POSSIBLE SIDE EFFECTS: WHAT ARE SOME SIDE EFFECTS THAT I NEED TO CALL MY DOCTOR ABOUT RIGHT AWAY? [illegible]

OVERDOSE: [illegible]

ADDITIONAL INFORMATION: [illegible]

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

KEEP OUT OF REACH OF CHILDREN. STORE IN SAFETY CONTAINER OR SECURE AREA.

JEFFREY BODIN
RX # 2043645-05382 DATE: 05/08/18
BUPROPION XL 300MG TABLETS
QTY 30 2 REFILLS BEFORE 04/12/19
Copy NDC:45963-0142-05
$ 0.00
A. WEISS, DO
MFG ACTAVIS
PLAN: ABHPA
GROUP: RX8834
CLAIM REF# 18127207231521899
Walgreens PH:(985)674-2561 [redacted]

JEFFREY BODIN
RX # 2043645-05382 DATE: 05/08/18
BUPROPION XL 300MG TABLETS
QTY 30 2 REFILLS BEFORE 04/12/19
Copy NDC:45963-0142-05
$ 0.00
A. WEISS, DO
MFG ACTAVIS
PLAN: ABHPA
GROUP: RX8834
CLAIM REF# 18127207231521899
Walgreens PH:(985)674-2561 [redacted]

Pharmacy use only

MON 11:00AM
Copy

BUPROPION XL 300MG TABLETS
45963-0142-05
ALPHA

QTY 30
10 DRAM

WHITE
FRONT: 142

Med Guide

Scanned Information (continued)

Encounter-Level Documents - 06/20/2018: (continued)

YOUR PERSONAL PRESCRIPTION INFORMATION

Your Walgreens Pharmacy Location
4330 Highway 22
Mandeville, LA 70471
(985)674-2551

IF YOU HAVE QUESTIONS ABOUT YOUR PRESCRIPTION, PLEASE CONTACT YOUR WALGREENS PHARMACIST OR CALL 1-800-WALGREENS

PATIENT JEFFREY BODIN
BIRTH DATE 05/22/97
MEDICATION MONTELUKAST 10MG TABLETS
QUANTITY 30
DIRECTIONS TAKE 1 TABLET BY MOUTH EVERY DAY

DOCTOR J. CRUZ, MD

PATIENT ALLERGIES

DRUG DESCRIPTION
BEIGE
FRONT: I
BACK: 114

INGREDIENT NAME: Montelukast Tablets (MON te LOO kast)

COMMON USES: It is used to ease allergy signs. It is used to prevent exercise-induced breathing problems. It is used to treat or prevent asthma. It may be given to you for other reasons. Talk with the doctor. For asthma: Do not use this drug to treat an asthma attack. Use a rescue inhaler. Talk with your doctor.

BEFORE USING THIS MEDICINE: WHAT DO I NEED TO TELL MY DOCTOR BEFORE I TAKE THIS DRUG? TELL YOUR DOCTOR: If you have an allergy to montelukast or any other part of this drug. TELL YOUR DOCTOR: If you are allergic to any drugs like this one, any other drugs, foods, or other substances. Tell your doctor about the allergy and what signs you had, like rash; hives; itching; shortness of breath; wheezing; cough; swelling of face, lips, tongue, or throat; or any other signs. This drug may interact with other drugs or health problems. Tell your doctor and pharmacist about all of your drugs (prescription or OTC, natural products, vitamins) and health problems. You must check to make sure that it is safe for you to take this drug with all of your drugs and health problems. Do not start, stop, or change the dose of any drug without checking with your doctor.

HOW TO USE THIS MEDICINE: HOW IS THIS DRUG BEST TAKEN? Use this drug as ordered by your doctor. Read all information given to you. Follow all instructions closely. Take with or without food. Take even during sign-free periods. If working out or playing sports causes signs, use at least 2 hours before doing it. If this drug is for asthma, take in the evening. To gain the most benefit, do not miss doses. Take this drug at the same time of day. Keep taking this drug as you have been told by your doctor or other health care provider, even if you feel well. HOW DO I STORE AND/OR THROW OUT THIS DRUG? Store at room temperature. Protect from light. Store in a dry place. Do not store in a bathroom. Keep all drugs in a safe place. Keep all drugs out of the reach of children and pets. Throw away unused or expired drugs. Do not flush down a toilet or pour down a drain unless you are told to do so. Check with your pharmacist if you have questions about the best way to throw out drugs. There may be drug take-back programs in your area. WHAT DO I DO IF I MISS A DOSE? Skip the missed dose and go back to your normal time. Do not take 2 doses at the same time or extra doses.

CAUTIONS: Tell all of your health care providers that you take this drug. This includes your doctors, nurses, pharmacists, and dentists. Call your doctor right away if your normal dose does not work as well or if you need to use your inhaler more often. This drug is not helpful during an asthma attack. Do not use this drug to stop exercise induced breathing problems if you are already using it for asthma or allergy. If you have asthma and taking aspirin makes it worse, keep avoiding aspirin and NSAIDs while you take this drug. Tell your doctor if you are pregnant or plan on getting pregnant. You will need to talk about the benefits and risks of using this drug while you are pregnant. Tell your doctor if you are breast-feeding. You will need to talk about any risks to your baby.

POSSIBLE SIDE EFFECTS: WHAT ARE SOME SIDE EFFECTS THAT I NEED TO CALL MY DOCTOR ABOUT RIGHT AWAY? WARNING/CAUTION: Even though it may be rare, some people may have very bad and sometimes deadly side effects when taking a drug. Tell your doctor or get medical help right away if you have any of the following signs or symptoms that may be related to a very bad side effect: Signs of an allergic reaction, like rash; hives; itching; red, swollen, blistered, or peeling skin with or without fever; wheezing; tightness in the chest or throat; trouble breathing, swallowing, or talking; unusual hoarseness; or swelling of the mouth, face, lips, tongue, or throat. Signs of liver problems like dark urine, feeling tired, not hungry, upset stomach or stomach pain, light-colored stools, throwing up, or yellow skin or eyes. Signs of a pancreas problem (pancreatitis) like very bad stomach pain, very bad back pain, or very bad upset stomach or throwing up. Signs of low mood (depression), thoughts of killing yourself, nervousness, emotional ups and downs, thinking that is not normal, anxiety, or lack of interest in life. Hallucinations (seeing or hearing things that are not there). Change in how you act. Memory problems or loss. Feeling confused. Not able to focus. Bad dreams. Not able to sleep. Sleepwalking. Shakiness. Seizures. Trouble breathing that is new or worse. Fever. Flu-like signs. Sinus pain. Chest pain. A heartbeat that does not feel normal. Any unexplained bruising or bleeding. A burning, numbness, or tingling feeling that is not normal. Ear pain. A very bad skin reaction (Stevens-Johnson syndrome/toxic epidermal necrolysis) may happen. It can cause very bad health problems that may not go away, and sometimes death. Get medical help right away if you have signs like red, swollen, blistered, or peeling skin (with or without fever); red or irritated eyes; or sores in your mouth, throat, nose, or eyes. WHAT ARE SOME OTHER SIDE EFFECTS OF THIS DRUG? All drugs may cause side effects. However, many people have no side effects or only have minor side effects. Call your doctor or get medical help if any of these side effects or any other side effects bother you or do not go away: Cough. Loose stools (diarrhea). Headache. Sore throat. Belly pain. Stuffy nose. Runny nose. These are not all of the side effects that may occur. If you have questions about side effects, call your doctor. Call your doctor for medical advice about side effects. You may report side effects to the FDA at 1-800-FDA-1088. You may also report side effects at http://www.fda.gov/medwatch.

OVERDOSE: If you think there has been an overdose, call your poison control center or get medical care right away. Be ready to tell or show what was taken, how much, and when it happened.

ADDITIONAL INFORMATION: If your symptoms or health problems do not get better or if they become worse, call your doctor. Do not share your drugs with others and do not take anyone else's drugs. Keep a list of all your drugs (prescription, natural products, vitamins, OTC) with you. Give this list to your doctor. Talk with the doctor before starting any new drug, including prescription or OTC, natural products, or vitamins. Some drugs may have another patient information leaflet. Check with your pharmacist. If you have any questions about this drug, please talk with your doctor, nurse, pharmacist, or other health care provider.

Call your doctor for medical advice about side effects
You may report side effects to FDA at 1-800-FDA-1088

KEEP OUT OF REACH OF CHILDREN. STORE IN SAFETY CONTAINER OR SECURE AREA

JEFFREY BODIN
RX # 2014428-05382 DATE: 05-07-18
MONTELUKAST 10MG TABLETS
QTY 30 — 1 REFILL BEFORE 02-03-19
Refill — NDC: 31722-0726-30
$ 0.00
J. CRUZ, MD
MFG: CAMBER
GROUP: RX8834
CLAIM REF#: 18127206527814699
Walgreens PH: (985)674-2551 [redacted]

JEFFREY BODIN
RX # 2014428-05382 DATE: 05-07-18
MONTELUKAST 10MG TABLETS
QTY 30 — 1 REFILL BEFORE 02-03-19
Refill — NDC 31722-0726-30
$ 0.00
J. CRUZ, MD
MFG: CAMBER
GROUP: RX8834
CLAIM REF#: 18127206827814699
Walgreens PH: (985)674-2551 [redacted]

Pharmacy use only

MON 11:00AM
Refill

MONTELUKAST 10MG TABLETS
31722-0726-30
FAST RACK

QTY 30
10 DRAM

BEIGE
FRONT: I
BACK: 114

LCMC HEALTH MEMBER HOSPITALS
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118-5798

Scanned Information (continued)

Encounter-Level Documents - 06/20/2018: (continued)

- **5/25/2018** — **Google Calendar - Event details**

Prescription Medication for Shoulder/Neck April - May 2018
Note: Taking as needed for Dislocated Shoulder + Neck Pain
Aleve naproxen sodium tablets, 220 mg (NSAID)
Twice a day 12 hr intervals.
Walgreens Pain Relief Roll-On Liquid
4% Lidocaine HCl/Topical Anesthetic
2.5 FL Oz (73 ml)

Scanned Information (continued)

Encounter-Level Documents - 06/20/2018: (continued)

END OF REPORT