Case Nos. 19-35017 and 19-35019

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO,
Plaintiff-Appellee,
v.
IDAHO DEPARTMENT OF CORRECTIONS, ET AL.,
Defendants-Appellants.

On Appeal from Orders of the United States District Court
For the District of Idaho
(No. 1:17-cv-00151-BLW)

EXCERPTS OF RECORD
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Dated: March 6, 2019

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Correctional Medical Services

NAME EDMO, MASON #94691
D.O.B [redacted] T

IDOC

SSN:

EDR 7-3-21

ALLERGIES & SENSITIVITIES

NKDA

PROBLEM LIST

	Date	1/13/10
1	4/30/12	RDU PE
2		~~Depression / Anxiety~~ Mood D/O NOS, ETOH Dep.
3		⊕ hx MTW – 4 meds x 4+ yrs — Karen Barrett MS, PA-C
4	8/24/12	GID-ccc — Cathy Whinnery, M.D.
5	3/10/14	MDD; GID, Alcohol Use D/O — Jane Seys PNP
6		GDD
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ID-MED-007 *(Rev. 01/06)*

Idaho Department of Correction

MEDICAL HISTORY QUESTIONNAIRE

Please fill in the requested information and return to the medical department

NAME: Mason Meeks NUMBER: ______ DATE: 1/7/10

DATE OF BIRTH: [redacted] AGE: 22 RACE: A.I.

HEIGHT: 5'8" WEIGHT: 260 HAIR COLOR: BLK EYE COLOR: BLK

1. Please list any medication to which you are allergic or which you are unable to take for any reason

2. Please list any medication either prescription or over the counter that you are taking on a regular basis

3. Please list all of your surgeries (tonsillectomy, appendectomy, etc)

Year	Surgery	Reason	Surgeon

4. Please list any serious illnesses that you have had in the past or have now (diabetes, blood pressure trouble, etc.)

Year of Onset	Illness	Condition at Present

PREVENTIVE HEALTH CARE INFORMATION

Date of most recent chest x-ray 11/09 EKG 7/09 PAP Test

Were they all normal? Yes No Explain

Date of most recent tetanus immunization 12/3/09

Date of most recent dental examination 2007

Have you ever had mumps? Yes (NO)

Have you ever had rubella? Yes (NO) or date of rubella vaccine

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY (Father, Mother, Brother, Sister, Grandparent) EVER HAD:

Cancer ____ Tuberculosis ____ Diabetes ✓ Epilepsy ____ Heart Disease ____

PERSONAL HISTORY

Marital Status: Single ✓ (or) Married ____ (or) Separated ____ (or) Divorced ____ (or) Widowed ____

Have you been married more than once? Yes (No)

Ages of children from this marriage, if any

Ages of children from previous marriage, if any

Education (highest degree or grade achieved) 11th

10110 Idaho Med 013 Medical History Questionnaire

HAVE YOU HAD OR DO YOU HAVE NOW: *(check each item)*

	YES	NO
Frequent or severe headaches		✓
Dizziness or fainting spells		✓
Chronic or frequent colds		✓
Eye trouble (except glasses)		✓
Hay fever or asthma		✓
Heart trouble		✓
High or low blood pressure		✓
Stomach or liver trouble		✓
Kidney stone or blood in urine		✓
Sugar or albumin in urine		✓
Epilepsy or seizures		✓
Drug or narcotic habit		✓
Hernia		✓
Recurrent back pain		✓
Bone joint or other deformity		✓
Allergies		✓
Glaucoma		✓
Stroke		✓
Coronary heart disease		✓
Emphysema		✓
Cancer		✓
Leukemia		✓
Arthritis or rheumatism		✓

	YES	NO
Skin disease		✓
Hemorrhoids or rectal bleeding		✓
Thyroid trouble		✓
Tuberculosis		✓
Polio		✓
Diabetes		✓
Venereal Disease		✓
Jaundice or hepatitis		✓
Gall bladder trouble	✓	
Nervous disorder		✓
Broken bones		✓
Hearing loss		✓
Trick or locked knee		✓
Admission to hospital		✓
Kidney problems		✓
Gout		✓
Mental retardation		✓
Mental illness		✓
Muscular dystrophy		✓
Bleeding tendency		✓
Blood disorder		✓
Dental problems	✓	✓
	✓	

RISK ASSESSMENT

1. Exposure:

Mark those to which you have frequently been exposed

____ Chemicals, Cleaning fluids, Oils

____ Loud noise

____ Asbestos or cement dust

____ X-rays or radioactive material

2. Alcohol:

Do you drink wine, beer or whiskey

How often? weekends

How much? 18 - day

Last time? 11/24/09

3. Tobacco:

NO Do you use?

How much? ____

4. Drugs

NO Do you use drugs?

What kind? ____

How often? ____

Last time? ____

REMARKS: State briefly what you think your physical condition is at the present time

I feel I am in pretty good physical condition.

ARE YOU RIGHT-HANDED ____ ( ) LEFT-HANDED ____ OCCUPATION ____ ( ) ____

CORRECTIONAL MEDICAL SERVICES
HISTORY AND SCREENING

Institution

INMATE NAME: MEEKS, MASON #94691 D.O.B. [redacted] R	ID#	RACE:	DOB:

	(circle one)	
1. Do you have a medical problem such as bleeding or injuries that requires immediate medical attention?	Yes	No (circled)
2. Have you fainted or had a head injury within past six months?	Yes	No (circled)
3. Has a doctor seen you in the past six months?	Yes (circled)	No
4. Do you wear glasses or contact lenses?	Yes (circled)	No (crossed out)
5. Do you have prosthesis, splint, crutches, cast or brace that you need while here?	Yes	No (circled)
6. Do you drink wine, beer or whiskey? How often? Wkd How much? 18 Last time? Nov 24th	Yes (circled)	No
7. Do you use drugs? Type ___ How often ___ Last time ___	Yes	No (circled)
8. Do you drink alcohol or use drugs regularly and have never stopped?	Yes	No (circled)
9. Have you had withdrawal problems, seizures or blackouts from alcohol or drugs?	Yes (circled)	No
10. Are you currently detoxing? If yes, from what substance?	Yes	No (circled)
11. Do you have any medical problems we should know about?	Yes (circled)	No
12. Have you been in this facility before?	Yes	No (circled)

FEMALE INMATES ONLY: (crossed out)

13. Are you pregnant? LMP	Yes	No
14. Do you use birth control? Type	Yes	No
15. Have you recently had a baby, miscarriage or abortion?	Yes	No

Hepatitis C Information and Instructions for follow-up Given ☒ Yes ☐ No

COMMENTS: (Explain "Yes" Responses Questions 1-15 only)

11. Bad gallbladder

VITAL SIGNS:

T 99.1 P 76 R 18 BP 143/93 HT 5'8" WT 277

FSBS ________ If level > 200, repeat within 48 hours. Above 300 call MD

DISPOSITION:

Referrals	Placement
☐ None Indicated	☐ General Population
☐ Emergency Room	☐ Detoxification Setting
☐ Physician	☐ Infirmary
☐ Sick Call	☐ Other

CURRENT MEDICAL CONDITIONS: (circle terms that apply)

Unconscious	Skin Infection
Disoriented	Skin Rash
Intoxicated	Skin Lesions
Restricted Mobility	Jaundice
Obvious Pain	Needle Marks
Bruises	Tattoos/body piercing
Fever	Swollen Glands
Nausea	Active Cough
Uses Tobacco	Vaginal/Penile Discharge
	Dental Problems

MEDICAL HISTORY:

Arthritis	Frequent Diarrhea
Diabetes	Genital Sores
Seizure Disorder	V.D.
Asthma	Hepatitis
Special Diet	HIV+
Heart Condition	Blood products before 1992
Hypertension	Tuberculosis
Stomach Ulcer	Persistent Sore Throat
Cancer	Dental Problems
Sickle Cell Anemia	Surgeries
Emphysema	Chest Pain
Dialysis	Jaundice
Herpes	Chicken Pox

TB HISTORY: (Circle symptoms if present)

Ever treated with TB Drugs?	☐ Yes	☒ No
Previous PPD test?	☒ Yes	☐ No
Previous Positive Reaction?	☐ Yes	☒ No

When ________

Where ________

Chronic Cough/Blood	Fever
Recent Weight Loss	Night Sweats
Recent Appetite Loss	Fatigue

Does pt describe current suicidal thoughts or indications? ☐ Yes ☒ No

MEDICATIONS:
(Current Medications, Last Dose, Compliant?)

ALLERGIES:

Medication Allergies: ☐ Yes ☒ No

Type: ________

Other Allergies: ☐ Yes ☒ No

Type: ________

I acknowledge that I have answered all questions truthfully and have been told the way to obtain health services and consent to routine care provided by facility healthcare professionals.

Inmate Signature: [signature] Mason Meeks

Screened by: [signature] Date: 1-7-10 Time: 2300

Reviewed by: Mike Takagi, PA Date: JAN 1 8 2010 Time: 1015

ADOC AL-7710P-CMS Prison Medical History and Screening

PHYSICAL ASSESSMENT

Institution: ____________

INMATE NAME:	VITAL SIGNS:
TYPE OF ASSESSMENT: INITIAL ☑ OTHER ☐	HT 5'4" WT 277 BP 111/64 PULSE 76 RESP 18 TEMP 97.1
FAMILY HISTORY: (F/FATHER, M/MOTHER, B/BROTHER, S/SISTER)	**VISION: (SNELLEN CHART)**
☐ ASTHMA ☐ CANCER ☐ DIABETES ☐ EPILEPSY/SEIZURES ☐ HEART DISEASE ☐ HYPERTENSION ☐ KIDNEY DISEASE ☐ SICKLE CELL ☐ TB ☐ MENTAL ILLNESS ☐ OTHER ____	Rt: 20/30 with glasses ____ Lt: 20/40 with glasses ____

PHYSICAL ASSESSMENT:

Please ✓: Normal (WNL) None Noted (NN) Abnormal (Make a comment)	WNL	NN	Abnormal/Comment
SKIN: Color, Condition, Turgor, Recent Injury	✓		
HEAD: Hair, Scalp (pediculi)	✓		
NECK: Veins, Mobility	✓		
EARS: Appearance, Canals	✓		
NOSE: Obstruction, Drainage	✓		
MOUTH: Throat, Tongue, Tonsils	✓		
eye	✓		PERLA, EOMS conj-clear
CHEST: Configuration, Auscultation, Respirations, Cough/Sputum	✓		
BREASTS: Palpation, Nipples, Symmetry	✓		
HEART: Auscultation, Radial pulse, Apical pulse, Rhythm	✓		
ABDOMEN: Shape, Bowel Sounds, Palpation, Hernia	✓ ✓ ✓ ✓		(-) Murphy's ⊘ (R) upper Abd pain
SPINE:	✓		
NEUROLOGICAL: Reflexes	✓		
EXTREMITIES: Pulses, Edema, Joints	✓		

FEMALES: (marked N/A)

Date of last mammogram: ____
Done where: ____

Results: ____
PELVIC EXAM:
Pap Smear Obtained YES ☐ NO ☐
Gonorrhea Culture Obtained YES ☐ NO ☐
Stool for Occult Blood + - Not Obtained ☐
Hemorrhoids YES ☐ NO ☐
Warts YES ☐ NO ☐
Lesions YES ☐ NO ☐
Discharge YES ☐ NO ☐

MALES:

GENITO/URINARY:
Warts YES ☐ NO ☑
Lesions YES ☐ NO ☑
Discharge YES ☐ NO ☐
(RECTAL EXAM if age 40 yrs. or older) (marked N/A)
Prostate:
Stool for Occult Blood + - Not Obtained ☐
Hemorrhoids YES ☐ NO ☐

ORAL SCREENING:

Pain/Discomfort YES ☐ NO ☑
Condition of teeth: poor fair good
Condition of gums: poor healthy
False teeth: partial plate upper lower
Oral Hygiene instructions given: ✓

IMMUNIZATION STATUS:

Date of last Tetanus: unk Other: ____

PPD STATUS:

___ Previous Positive
___ Implanted /Read/Documented in Medical Record
✓ Implanted/Results Pending
___ Needs Implant/Implant Ordered

PPD FOLLOW UP:

✓ None Indicated
✓ Needs Interpretation
___ Follow Up Indicated/Ordered

Indications for blood borne pathogen testing? ☐ Yes ☐ No

Test ordered: ☐ HCV ☑ HIV ☐ HBV

REFERRAL:

Assessed by: Mike Takagi, PA [signature]

Date: JAN 13 2010 **Time:** 1020

Physician Review: ____

Date: ____ **Time:** ____

AL-7710P-CMS
Prison Medical History and Screening

HAVE YOU HAD OR DO YOU HAVE NOW: *(check each item)*

	YES	NO
Frequent or severe headaches	✓	
Dizziness or fainting spells	✓	
Chronic or frequent colds		✓
Eye trouble (except glasses)	✓	
Hay fever or asthma		✓
Heart trouble		✓
High or low blood pressure	✓	
Stomach or liver trouble		✓
Kidney stone or blood in urine		✓
Sugar or albumin in urine		✓
Epilepsy or seizures		✓
Drug or narcotic habit		✓
Hernia		✓
Recurrent back pain		✓
Bone joint or other deformity		✓
Allergies		✓
Glaucoma		✓
Stroke		✓
Coronary heart disease		✓
Emphysema		✓
Cancer		✓
Leukemia		✓
Arthritis or rheumatism		✓

	YES	NO
Skin disease		✓
Hemorrhoids or rectal bleeding		✓
Thyroid trouble		✓
Tuberculosis		✓
Polio		✓
Diabetes		✓
Venereal Disease		✓
Jaundice or hepatitis		✓
Gall bladder trouble		✓
Nervous disorder		✓
Broken bones		✓
Hearing loss		✓
Trick or locked knee		✓
Admission to hospital		✓
Kidney problems		✓
Gout		✓
Mental retardation		✓
Mental illness	✓	
Muscular dystrophy		✓
Bleeding tendency		✓
Blood disorder		✓
Dental problems	✓	

RISK ASSESSMENT

1. **Exposure:**
   Mark those to which you have frequently been exposed
   ______Chemicals, Cleaning fluids, Oils
   ______Loud noise
   ______Asbestos or cement dust
   ______X-rays or radioactive material

2. **Alcohol:**
   ✓ Do you drink wine, beer or whiskey?
   How often? weekends
   How much? 1 case +
   Last time? 06-28-11

3. **Tobacco:**
   ______Do you use?
   How much?______

4. **Drugs:**
   ______Do you use drugs?
   What kind?______
   How often?______
   Last time?______

REMARKS: State briefly what you think your physical condition is at the present time.

I believe my current condition is okey.

ARE YOU: RIGHT-HANDED ✓ LEFT-HANDED____ OCCUPATION: N/A

YOUR SIGNATURE: [signature]

CP0101ID-Idaho Med-001 Medical History Questionnaire, created 06/09

Idaho Department of Correction

MEDICAL HISTORY QUESTIONNAIRE

Please fill in the requested information and return to the medical department

NAME: Mason Edmo NUMBER: 94691 DATE: 4-26-12
DATE OF BIRTH: [redacted] AGE: 24 RACE: A.I
HEIGHT: 5'8" WEIGHT: 250 HAIR COLOR: BLK EYE COLOR: Brwn

1. Please list any medication to which you are allergic or which you are unable to take for any reason:

   none

2. Please list any medication, either prescription or over the counter that you are taking on a regular basis:

   Ibuprofen, Zoloft, Visteril, Gabapentin, Preforan forte

3. Please list all of your surgeries (tonsillectomy, appendectomy, etc):

Year	Surgery	Reason	Surgeon
2010	Gallbladder		P.M.C

4. Please list any serious illnesses that you have had in the past or have now (diabetes, blood pressure trouble, etc.)

Year of Onset	Illness	Condition at Present
2006	High blood Pressure	Level

PREVENTIVE HEALTH CARE INFORMATION

1. Date of most recent chest x-ray: ______ EKG: ______ PAP Test: ______
   Were they all normal? Yes____ No____ Explain: ______
2. Date of most recent tetanus immunization: ______
3. Date of most recent dental examination: ______
4. Have you ever had mumps? Yes____ No____
5. Have you ever had rubella? Yes____ No____ or date of rubella vaccine______

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY (Father, Mother, Brother, Sister, Grandparent) EVER HAD:

Cancer______ Tuberculosis______ Diabetes______ Epilepsy______ Heart Disease______

PERSONAL HISTORY

1. Marital Status: Single ✓ Yr. Married______ Yr. Separated______ Yr. Divorced______ Yr. Widowed______
   Have you been married more than once? Yes____ No ✓
   Ages of children from this marriage, if any: Ø
   Ages of children from previous marriage, if any: Ø
2. Education (highest degree or grade achieved): 13

CP0101ID-Idaho Med-001 Medical History Questionnaire, created 06/09

CMS

CORRECTIONAL MEDICAL SERVICES
[PR]ISON MEDICAL HISTORY AND SCREENING

Institution ISC I

EDMO, MASON #94691
D.O.B [redacted] T

	ID#	RACE:	DOB:

	(circle one)		CURRENT MEDICAL CONDITIONS: (circle terms that apply)	
0. Do you have a medical problem such as bleeding or injuries that requires immediate medical attention?	Yes	No (circled)	Unconscious	Skin Infection
0. Have you fainted or had a head injury within past six months?	Yes	No (circled)	Disoriented	Skin Rash
0. Has a doctor seen you in the past six months?	Yes (crossed out)	No (circled)	Intoxicated	Skin Lesions
0. Do you wear glasses or contact lenses?	Yes (circled)	No	Restricted Mobility	Jaundice
0. Do you have prosthesis, splint, crutches, cast or brace that you need while here?	Yes	No (circled)	Obvious Pain	Needle Marks
0. Do you drink wine, beer or whiskey? How often? weekends How much? > 1 case Last time? June 2011	Yes (circled)	No	Bruises	Tattoos/body piercing
6. Do you use drugs? Type ___ How often ___ Last time ___	Yes	No (circled)	Fever	Swollen Glands
6. Do you drink alcohol or use drugs regularly and have never stopped?	Yes	No (circled)	Nausea	Active Cough
6. Have you had withdrawal problems, seizures or blackouts from alcohol or drugs?	Yes	No (circled)	Uses Tobacco	Vaginal/Penile Discharge
6. Are you currently detoxing? If yes, from what substance? ___	Yes	No (circled)		Dental Problems
6. Do you have any medical problems we should know about? thoracic muscle spasm	Yes (circled)	No		
6. Have you been in this facility before?	Yes (circled)	No		

MEDICAL HISTORY:

Arthritis	Frequent Diarrhea
Diabetes	Genital Sores
Seizure Disorder	V.D.
Asthma	Hepatitis
Special Diet	HIV+
Heart Condition	Blood products before 1992
Hypertension	Tuberculosis
Stomach Ulcer	Persistent Sore Throat
Cancer	Dental Problems
Sickle Cell Anemia	Surgeries
Emphysema	Chest Pain
Dialysis	Jaundice

FEMALE INMATES ONLY: (crossed out)

18. Are you pregnant? LMP	Yes	No
18. Do you use birth control? Type	Yes	No
18. Have you recently had a baby, miscarriage or abortion?	Yes	No

TB HISTORY: (Circle symptoms if present)

Ever treated with TB Drugs?	☐ Yes	☒ No
Previous PPD test?	☒ Yes	☐ No
Previous Positive Reaction?	☐ Yes	☒ No

When ___
Where ___

Chronic Cough/Blood	Fever
Recent Weight Loss	Night Sweats
Recent Appetite Loss	Fatigue

Hepatitis C Information and Instructions for follow-up Given
☐ Yes ☐ No

COMMENTS: (Explain "Yes" Responses Questions 1-15 only)

MEDICATIONS:
(Current Medications, Last Dose, Compliant?)

2010ft
Neurontin
Parafonforte
IBU

VITAL SIGNS:
T 96.1 P 110 R 16 BP 132/88 HT 5'9 WT 250

DISPOSITION:

Referrals	Placement
☐ None Indicated	☐ General Population
☐ Emergency Room	☐ Detoxification Setting
☐ Physician	☐ Infirmary
☐ Sick Call	☐ Other ___

ALLERGIES:

Medication Allergies: ☐ Yes ☒ No
Type: ___
Other Allergies: ☐ Yes ☒ No
Type: ___

I acknowledge that I have answered all questions truthfully and have been told the way to obtain health services and consent to routine care provided by facility healthcare professionals.

Inmate Signature: [signature]
Screened by: Brooke Olson, LPN [signature] **Date:** 4/28/12 **Time:** 1100
Reviewed by: Ben Bish N.P.-C [signature] **Date:** 4/30/12 **Time:** 1035

CP7710P-Prison Medical History and Screening- Revised 08/2004, reviewed 11/2009

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EDMO, MASON #94691
D.O.B [redacted] T

PHYSICAL ASSESSMENT Institution: ISCI

INMATE

TYPE

VITAL SIGNS:

HT___ WT___ BP___
PULSE___ RESP___ TEMP___ see front

FAMILY HISTORY: (F/FATHER, M/MOTHER, B/BROTHER, S/SISTER)

☐ ASTHMA ☐ CANCER ☒ DIABETES ☐ EPILEPSY/SEIZURES ☐ HEART DISEASE ☒ HYPERTENSION ☐ KIDNEY DISEASE GM - DM
☐ SICKLE CELL ☐ TB ☐ MENTAL ILLNESS M, GF, GM - HTN
☐ OTHER

VISION: (SNELLEN CHART)

Rt: 20/30 with glasses___
Lt: 20/30 with glasses___

PHYSICAL ASSESSMENT:

Please ☑ :
Normal (WNL)
None Noted (NN)
Abnormal (Make a comment)

		WNL	NN	☐ Abnormal/Comment
SKIN:	Color	☑	☐	☐
	Condition	☑	☐	☐
	Turgor	☑	☐	☐
	Recent Injury	☑	☐	☐
HEAD:	Hair	☑	☐	☐
	Scalp (pediculi)			
NECK:	Veins	☑	☐	☐
	Mobility	☑	☐	☐
EARS:	Appearance	☑	☐	☐
	Canals	☑	☐	☐
NOSE:	Obstruction	☑	☐	☐
	Drainage	☑	☐	☐
MOUTH:	Throat	☑	☐	☐
	Tongue			
	Tonsils	☑	☐	☐
CHEST:	Configuration	☑	☐	☐
	Auscultation	☑	☐	☐
	Respirations	☑	☐	☐
	Cough/Sputum	☑	☐	☐
BREASTs:	Palpation	☑	☐	☐
	Nipples	☑	☐	☐
	Symmetry	☑	☐	☐
HEART:	Auscultation	☑	☐	☐
	Radial pulse	☑	☐	☐
	Apical pulse	☑	☐	☐
	Rhythm	☑	☐	☐
ABDOMEN:	Shape	☑	☐	☐ Obese
	Bowel Sounds	☑	☐	☐
	Palpation	☑	☐	☐
	Hernia	☑	☐	☐
SPINE:		☑	☐	☐
NEUROLOGICAL:	Reflexes	☑	☐	☐
EXTREMITIES:	Pulses	☑	☐	☐
	Edema	☑	☐	☐
	Zone	☑	☐	☐

FEMALES:

Date of last mammogram: ___
Done where: ___

Results: ___

PELVIC EXAM:
Pap Smear Obtained YES ☐ NO ☐
Gonorrhea Culture Obtained YES ☐ NO ☐
Stool for Occult Blood + - Not Obtained ☐
Hemorrhoids YES ☐ NO ☐
Warts YES ☐ NO ☐
Lesions YES ☐ NO ☐
Discharge YES ☐ NO ☐

MALES:

GENITO/URINARY:
Warts YES ☐ NO ☑
Lesions YES ☐ NO ☑
Discharge YES ☐ NO ☑
(RECTAL EXAM if age 40 yrs. or older)
Prostate: NA
Stool for Occult Blood + - Not Obtained ☐
Hemorrhoids YES ☐ NO ☐

ORAL SCREENING:

Pain/Discomfort: YES ☐ NO ☑
Condition of teeth: (poor) fair good
Condition of gums: (poor) healthy
False teeth: partial plate upper lower
Oral Hygiene Instructions given: ___

IMMUNIZATION STATUS:

Date of last Tetanus: 2010 ? Other: ___

PPD STATUS:

___ Previous Positive
___ Implanted /Read/Documented in Medical Record
X Implanted/Results Pending
___ Needs Implant/Implant Ordered

PPD FOLLOW UP:

___ None Indicated
X Needs Interpretation
___ Follow Up Indicated/Ordered

Indications for blood borne pathogen testing? ☐ Yes ☐ No

Test ordered: ☐ HCV ☐ HIV ☐ HBV

REFERRAL:

Assessed by: ___

Date: ___ Time: ___

Physician Review: [signature] Ben Bish N.P.-C

Date: 4/10/12 Time: 1035

CP7710P-Prison Medical History and Screening- Revised 08/2004, reviewed 11/2009
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Dr. Craig
Chief Psychologist

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☑ Inmate Initiated Visit		Visit	$______
OTC (med)	x______	Med(s)	$______
Rx (med)	x______	Total	$______

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI Unit 7 - Cell 31A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: ______

Nature of Complaint/Problem: I am a transexual male. I am/would like to start Hormone therapy & talk to Dr. Craig Thank You.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

Subjective: As above

Objective: BP none required R______ T______ Wt______

Assessment: A+O x 3

HSR TRIAGE
Referred to:
☑ Nurse S.C. ☑ Mental Health
☐ Provider ☐ Dental
☐ CCC ☐ Optometric
Diane Rainier, LPN
Signature [signature] Date/Time 6/4/12 0711

Plan: forward Mental Health

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols

Pt. is scheduled 8/28/12. Received HSR 8/23/12. Stacy McGrew, LPN

Refer to: ☐ PA/ NP/ Physician ☐ Nurse/ CMS ☐ Mental Health ☐ Dental ☐ Optometry

Signature: Diane Rainier, LPN Title: ______ Date: 6/4/12 Time: 1412

ID_MED_7166 *(Rev. 02/2009)*

6/19

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		
☑ Inmate Initiated Visit		
	OTC (med)	x______
	Rx (med)	x______

Accounting Dept. Use Only	
Visit	$______
Med(s)	$______
Total	$______

Print Name: Mason Edmo Initials: MME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI - U10 51C

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 6-8-12

Nature of Complaint/Problem: I would like to be seen by mental health Lamictil that I take is giving me high mood swings

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

Subjective: As above

Objective: BP non-urgent T ______ Wt ______

Assessment: Ø voices
Ø threat self/others
Ø suicidal
A O x 3

Seen by Dr. [illegible] 6-25-12

HSR TRI[AGE]
Referred to:
☐ Nurse S.C. ☑ Mental Health
☐ Provider ☐ Dental
☐ CCC ☐ Optometric
Diane Rainier LPN 6-8-12 0712
Signature Date/Time

Plan: forward Mental Health

❑ Inmate Education Sheet Given

❑ Use of Nursing Protocols

Refer to: ❑ PA/ NP/ Physician ❑ Nurse/ CMS ❑ Mental Health ❑ Dental ❑ Optometry

Diane Rainier, LPN
Signature: [signature] Title: ______ Date: 6-8-12 Time: 1356

ID_MED_7166 (Rev. 02/2009)

522425

HEALTH SERVICES REQUEST
CO-PAY FORM

Dr. Ellison

Medical Dept. Use Only		Accounting Dept. Use Only	
☑ Inmate Initiated Visit		Visit	$____
OTC (med)	x____	Med(s)	$____
Rx (med)	x____	Total	$____

Print Name: Mason D. Edmo Initials: M. E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 10C-51A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 6-13-12

Nature of Complaint/Problem: I would like to speak to Dr. Ellison about Hormone Therapy. Thank you.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

Subjective: As above

Objective: BP none required R ____ T ____ Wt ____

Assessment: A O x 4 ⊖ threat self/others ⊖ voices ⊖ suicidal thought

HSR TRIAGE
Referred to:
Nurse S.C.
Provider
☑ Mental Health
☐ Dental
☐ Optometric

Plan: forward Mental Health

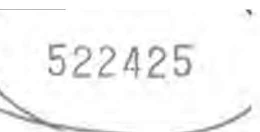
Diane Reinier, LPN 6-13-12 0715
Date/Time

referred to Dr. Craig 6-13-12

❑ Inmate Education Sheet Given

❑ Use of Nursing Protocols

Refer to: ☐ PA/ NP/ Physician ☐ Nurse/ CMS ☐ Mental Health ☐ Dental ☐ Optometry



HEALTH SERVICES REQUEST
CO-PAY FORM

Dr. Ellison

Medical Dept. Use Only		Accounting Dept. Use Only	
☑ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason D. Edmo Initials: M.E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 10C-51A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: M Mason Edmo Date: 6-13-12

Nature of Complaint/Problem: I would like to speak to Dr. Ellison about Hormone Therapy. Thank You.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

Subjective: As above

Clinical staff Received 6/14

Objective: BP none required R ____ T ____ Wt ____

Assessment: A+O x 4 ⊖ threat self/others ⊖ voices ⊖ suicidal thoughts

HSR TRIAGE
Referred to:
Nurse S.C.
Provider
TC
☑ Mental Health
☐ Dental
☐ Optometric

Plan: forward Mental Health

Diane Rainier, LPN 6-13-12 0715
Date/Time

Scheduled sexual Trans - move from Unit 08 to Unit 07 - Seen by Dr. [illegible] 6/25/12

❑ Inmate Education Sheet Given

❑ Use of Nursing Protocols

Refer to: ❑ PA/ NP/ Physician ❑ Nurse/ CMS ❑ Mental Health ❑ Dental ❑ Optometry

Signature: Diane Rainier, LPN Title: ____ Date: 6-13-12 Time: 1015

ID_MED_7166 *(Rev. 02/2009)*

523646

Dental

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
❑ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

4Tasy ISCI

Print Name: Mason Edmo Initials: M.E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI-U7c-28B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 6-17-12

Nature of Complaint/Problem: I would like to see a Dentist. My top teeth are in bad shape, Very Bad shape and bleed alot when I brush them.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA

Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

RECEIVED JUN 19 2012
Shayla Massengill, D.A.

Subjective:

Objective: BP ________ P ________ R ________ T ________ Wt ________

Assessment:

HSR TRIAGE
Referred to:
☐ Nurse S.C.
☐ Provider
☐ CCC
☐ Mental Health
☒ Dental
☐ Optometric
DeeAnn Kopczynski, LPN 6-17-12
Signature Date/Time

Plan: Pano
Pt. need FMX
Schedule

❑ Inmate Education Sheet Given

❑ Use of Nursing Protocols

Refer to: ❑ PA/ NP/ Physician ❑ Nurse/ CMS ❑ Mental Health ❑ Dental ❑ Optometry

Signature: [signature] *Shayla Massengill, D.A.* Title: ________ Date: 6.25.12 Time: 1030

ID_MED_7166 *(Rev. 02/2009)*

523645

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
❑ Inmate Initiated Visit		Visit	$______
OTC (med)	x______	Med(s)	$______
Rx (med)	x______	Total	$______

Print Name: Mason Edmo Initials: M.E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI - U7 - 20B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 6-17-12

Nature of Complaint/Problem: I need to see a clinician / fisher for my meds that I am on HSR this is my 3rd HSR! they are making me more depressed

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA

Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

Subjective:

referred to LOG 6-20-12

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

HSR TRIAGE
Referred to:
☐ Nurse S.C.
☐ Provider
☐ CCC
☒ Mental Health
☐ Dental
☐ Optometric
DeeAnn Kopczynski, LPN
Signature Date/Time

Plan:

❑ Inmate Education Sheet Given

❑ Use of Nursing Protocols

Refer to: ❑ PA/ NP/ Physician ❑ Nurse/ CMS ❑ Mental Health ❑ Dental ❑ Optometry

Signature: ______ Title: ______ Date: ______ Time: ______

ID_MED_7166 *(Rev. 02/2009)*

ISCI

525943

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		
❑ Inmate Initiated Visit		
	OTC (med)	x X
	Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI Unit 15A 32A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 7-8-12

Nature of Complaint/Problem: need to see the optometrist for eye glasses

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Date: 1/29 Time: 0800
Seen by Optometrist
☑ Yes ☐ No Glasses Ordered
Sign [signature]

HSR TRIAGE
Referred to:
☐ Nurse S.C.
☐ Provider
☐ CCC
☐ Mental Health
☐ Dental
☑ Optometric
7-9-12
Date
[signature]
Signature
Devin Jensen, LPN

Plan:

❑ Inmate Education Sheet Given

❑ Use of Nursing Protocols

Refer to: ❑ PA/ NP/ Physician ❑ Nurse/ CMS ❑ Mental Health ❑ Dental ❑ Optometry

Signature: ______ Title: ______ Date: ______ Time: ______

ID_MED_7166 *(Rev. 02/2009)*

589496

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x 1
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo Initials: M.E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI Unit 16 (Cell Restriction) B 34A

I consent to be treated by health staff for the condition described below. I understand my requesting health service may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 7-13-12

Nature of Complaint/Problem: I have a documented/preexisting back/shoulder muscle spasm causing severe neck/shoulder pain.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

[signature] 7/31/12
Edward Savala, MD

Assessment:

Plan:

☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: ______ Title: ______ Date: ______ Time: ______

CP7166ID
Revision 09/2012

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534917

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
❑ Inmate Initiated Visit	
OTC (med)	x________
Rx (med)	x________

Accounting Dept. Use Only	
Visit	$__________
Med(s)	$__________
Total	$__________

Print Name: mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI - 16A 63A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 8-9-12

Nature of Complaint/Problem: I need to get my chronic meds for GID (Hormones) I already did my GID eval.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

Subjective: NA

Objective: BP NA P NA R NA T NA Wt NA

Assessment: NA

Plan: Left s̄ being seen.
pt. must resubmit

❑ Inmate Education Sheet Given

❑ Use of Nursing Protocols

Refer to: ❑ PA/ NP/ Physician ❑ Nurse/ CMS ❑ Mental Health ☒ Dental ❑ Optometry

Signature: CRigdon Title: LPN Date: 8/9/12 Time: 1145

ID_MED_7166 (Rev. 02/2009) Cherri Rigdon LPN

ER 1210

534916

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
❑ Inmate Initiated Visit	
OTC (med)	x________
Rx (med)	x________

Accounting Dept. Use Only	
Visit	$__________
Med(s)	$__________
Total	$__________

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A-63A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 8-9-12

Nature of Complaint/Problem: I need to follow up on my dental. Im supposed to get dentures

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

Subjective: NA

Objective: BP NA P NA R NA T NA Wt NA

Assessment: NA

Plan: left [illegible] being seen. Pt. must resubmit.

❑ Inmate Education Sheet Given

❑ Use of Nursing Protocols

Refer to: ❑ PA/ NP/ Physician ☒ Nurse/ CMS ❑ Mental Health ☒ Dental ❑ Optometry

Signature: CRigdon Title: LPN Date: 8/9/12 Time: 1144

ID_MED_7166 (Rev. 02/2009) Cherri Rigdon LPN

539214

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	Accounting Dept. Use Only
☒ Inmate Initiated Visit	Visit $______
OTC (med) x______	Med(s) $______
Rx (med) x______	Total $______

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 8-28-12

Nature of Complaint/Problem: I am supposed to get dentures but I have not heard from dental since July.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

RECEIVED SEP 04 2012
Shayla Massengill, D.A.

Subjective: Not Applicable

Objective: BP ______ P ______ R ______ T ______ Wt ______

8-28-12

Assessment: Forward to Dental

10·2·12
XO#2,3,4,5 SOS
Plan: Shayla Massengill, D.A. 944

9·17·12
Pt. wants teeth out & dentures made. will schedule for starting extractions
Shayla Massengill, D.A. 1509

❑ Inmate Education Sheet Given

❑ Use of Nursing Protocols

Refer to: ❑ PA/ NP/ Physician ❑ Nurse/ CMS ❑ Mental Health ☒ Dental ❑ Optometry

Signature: [signature] Title: LPN Date: 8-28-12 Time: 1344

ID_MED_7166 *(Rev. 02/2009)* Devin Jensen, LPN

522062

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
❑ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [REDACTED] Housing Location: ISCI 16A-05A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 9-19-12

Nature of Complaint/Problem: I need to get my estrogen. I am G.I.D and recieved all other meds except estrogen. Dr. Whinnery said she prescribed it but I have not recieved it for 2 wks

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA

Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

Subjective: SEE Above

Objective: BP ____ P ____ R ____ T ____ Wt ____ — Not Applicable —

723

Assessment: Forward to CC

Plan: medication sent 9/21/12. Stacy McGrew, LPN

❑ Inmate Education Sheet Given

❑ Use of Nursing Protocols

Refer to: ☑ PA/ NP/ Physician ❑ Nurse/ CMS ❑ Mental Health ❑ Dental ❑ Optometry

Signature: [signature] Devin Jensen, LPN Title: LPN Date: 9-19-12 Time: 800

ID_MED_7166 *(Rev. 02/2009)*

541325

HEALTH SERVICES REQUEST
CO-PAY FORM *Chronic Health*

Medical Dept. Use Only		Accounting Dept. Use Only	
❑ Inmate Initiated Visit		Visit	$________
OTC (med)	x________	Med(s)	$________
Rx (med)	x________	Total	$________

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI Unit 16

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 10-26-12

Nature of Complaint/Problem: need to be sized (breasts) so that I may order a bra. I am GID. I need a memo so I can order off commissary.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

Subjective: — SEE Above —

Objective: BP 145/85 P 86 R 18 T 98.9 Wt 246 97% RA

Assessment: Forward to CC Per Tina Williams

Plan: Pt. is scheduled. [signature] Stacy McGrew, LPN

N/A ❑ Inmate Education Sheet Given
❑ Use of Nursing Protocols

Refer to: ❑ PA/ NP/ Physician ❑ Nurse/ CMS ❑ Mental Health ❑ Dental ❑ Optometry

Signature: [signature] Title: LPN Date: 10-26-12 Time: 1530

ID_MED_7166 *(Rev. 02/2009)* Devin Jensen, LPN

535739

HEALTH SERVICES REQUEST
CO-PAY FORM

SECOND H.S.R. FOR G.I.D

Medical Dept. Use Only		Accounting Dept. Use Only	
❑ Inmate Initiated Visit		Visit	$________
OTC (med)	x________	Med(s)	$________
Rx (med)	x________	Total	$________

Print Name: Mason Edmo Initials: M.E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: I.S.C.I Unit 16

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 11-22-12

Nature of Complaint/Problem: I need to see Dr. Whinnery for my estrogen dosage / memo for ordering labs. This is my 2nd HSR in medical.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

Subjective: SEE Above

Objective: BP ________ P ________ R ________ T ________ Wt ________ — Not Applicable —

Assessment: Forward CC for evaluation 7/10

Plan: scheduled in CCC ≈ 12/4/12 CRalston

n/a ❑ Inmate Education Sheet Given

❑ Use of Nursing Protocols

Caitlin Ralston, R.N.

Refer to: ❑ PA/ NP/ Physician ❑ Nurse/ CMS ❑ Mental Health ❑ Dental ❑ Optometry

Signature: [signature] Title: LPN Date: 11-23-12 Time: 1510

ID_MED_7166 *(Rev. 02/2009)* Devin Jensen, LPN

MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo, Mason **IDOC#:** 94691

HU: ~~16-B4~~ 16B34 **DATE:** 11/27/12

We have taken the following actions in response to your medical request / communication dated ______________

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ____________________
	You are scheduled to see the ☐ **NP/PA** ☐ **PHYSICIAN** ☐ **DIETICIAN** ☐ **CLINICIAN** ☐ **DIRECTOR OF NURSING** ☐ **CMS SUPERVISOR** ☐ **HS ADMINISTRATOR** ☐ **SPECIALIST**
	You missed your appointment for ______________________ **on** ____________________ ☐ **SUBMIT A NEW HEALTH SERVICE REQUEST** ☐ **YOU ARE RESCHEDULED**
	Medications have arrived for you. Pick them up during pill call on ____________________
	You are scheduled. Watch the call-out. ***DO NOT SUBMIT DUPLICATE KITES.***
	You are scheduled for ☐ **LAB TESTS** ☐ **X-RAYS** ☐ **MINOR SURGERY** ☐ **OUTPATIENT CLINIC** ☐ **DENTAL** ☐ **OPTOMETRY** ☐ **CHRONIC CARE CLINIC**
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
X	**Other:** your Estrace was Changed to Estrotab

Signature L Brown LPN

ID-MED-7177 *(Rev. 08/05)*

559353

HEALTH SERVICES REQUEST
CO-PAY FORM

NO SHOW 11/20/12 9AM

**Second H.S.R for Optical

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: M.E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: I.S.C.I Unit 16B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: Nov. 29. 2012

Nature of Complaint/Problem: I have a eyeglass prescription out of prison and need to be seen by the Optometrist for glasses here.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: SEE Above

Objective: BP ______ P ______ R ______ T ______ Wt ______ – Not Applicable –

OPTO

Assessment: Forward Optometry

NO SHOW 11/20 9AM

Plan:

☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☒ Optometry

Signature: [signature] Title: LPN Date: 11-29-12 Time: 1520

Devin Jensen, LPN

CP7166ID
Revision 09/2012

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558477

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo Initials: M.E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI unit 16

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 12-14-12

Nature of Complaint/Problem: I need to have the rest of my teeth extracted & dentures.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: SEE Above

RECEIVED DEC 17 2012
Shayla Massengill, D.A.

Objective: BP ____ P ____ R — Not Applicable — T ____ Wt ____

1.9.13
XO #30 #31 #32

Assessment: SE

Forward to Dental

Shayla Massengill, D.A.
1000

Plan:

N/A ☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☒ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 12-14-12 Time: 1522

Devin Jensen, LPN

CP7166ID
Revision 09/2012

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541610

H.S.R #3

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
N/A ☐ Inmate Initiated Visit	
OTC (med)	x________
Rx (med)	x________

Accounting Dept. Use Only	
Visit	$__________
Med(s)	$__________
Total	$__________

Print Name: Mason Edmo Initials: M.E Inmate ID: 94691

Date of Birth: [redacted] Housing Location: I.S.C.I Unit 16

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 12-31-12

Nature of Complaint/Problem: I need the rest of my teeth extracted and I need dentures, we've started but didn't finish.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
Do Not Write Below This Line

HEALTH CARE DOCUMENTATION

RECEIVED JAN 02 2013
Shayla Massengill, D.A.

Subjective: - SEE Above -

Duplicate HSR

Objective: BP ________ P ________ R ________ T ________ Wt ________ — Not Applicable —

Assessment: Forward to Dental

Plan:

N/A ☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols

Refer to: ☐ PA/ NP/ Physician ☐ Nurse/ CMS ☐ Mental Health ☑ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 12-31-12 Time: 1524

ID_MED_7166 *(Rev. 02/2009)* Devin Jensen, LPN

MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 16 DATE: 1/8/2013

We have taken the following actions in response to your medical request / communication dated ____________

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ____________
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ DIETICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ CMS SUPERVISOR ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for opto on 11/20 ☒ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ____________
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other:

Signature E. Aldape #2372

ID-MED-7177 *(Rev. 08/05)*

558971

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☒ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 1-25-13

Nature of Complaint/Problem: need to extract R. bottom teeth.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

RECEIVED JAN 28 2013 Shayla Massengill, D.A.

Subjective: — SEE Above —

Objective: BP ____ P ____ R ____ T ____ Wt ____ ← Not Applicable

Assessment: Forward to Dental

2.12.13 XO

Plan:

Shayla Massengill, D.A. 1140

N/A ☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☒ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 1-25-13 Time: 1453

Devin Jensen, LPN

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: M.E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI Unit 16 B tier

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 3-2-13

Nature of Complaint/Problem: Need to see Dr. Whinnery about GID medications I am on – not feeling well.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan: Forward to CCC ongoing issue

HSR TRIAGE
Referred to:
☑ Nurse S.C.
☐ Provider
☑ CCC
☐ Mental Health
☐ Dental
☐ Optometric
Signature [signature] Date/Time
Stacy McGrew, LPN

Pt. scheduled 3/14/13 [initials]

☑ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 3/2/13 Time: 0920

Veronica Ferro, LPN

CP7166ID
Revision 09/2012

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557104

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
N/C ☒ Inmate Initiated Visit	
OTC (med)	x_______
Rx (med)	x_______

Accounting Dept. Use Only	
Visit	$_______
Med(s)	$_______
Total	$_______

Print Name: Mason Edmo Initials: M. E Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI unit 16

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 3-8-13

Nature of Complaint/Problem: need to extract teeth for dentures.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

RECEIVED MAR 11 2013
Shayla Massengill, D.A.

4.2.13 Seen by dental
Shayla Massengill, D.A.
PM

Subjective: – SEE Above –

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan: Forward to Dental

☒ Inmate Education Sheet Given

N/A ☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☒ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 3-8-13 Time: 808

Devin Jensen, LPN

CP7166ID
Revision 09/2012

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557170

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
N/A Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 4-1-13

Nature of Complaint/Problem: need to see dentist for

wis extraction.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

RECEIVED APR 0 2 2013
Shayla Massengill, D.A.

Subjective: - SEE Above -

4.2.13
XO remaining ↑

Objective: BP ______ P ______ R n/a ______ T ______ Wt ______

Assessment: Forward to Dental

Shayla Massengill, D.A. 0957

Plan:

N/A ☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☑ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 4-1-13 Time: 1440

Devin Jensen, LPN

CP7166ID
Revision 09/2012

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577678

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☐ ~~Inmate~~ Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B34A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 4-12-13

Nature of Complaint/Problem: need to see dental for partial's to be made.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: SEE Above –

RECEIVED APR 15 2013
Shayla Massengill, D.A.

Objective: BP ____ P ____ R N/A ____ T ____ Wt ____

Assessment:

Plan: Forward to Dental 4.25.13 w/c alginates

Shayla Massengill, D.A. 1449

N/A ☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 4-12-13 Time: 734

Devin Jensen, LPN

CP7166ID
Revision 09/2012

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577944

HEALTH SERVICES REQUEST
CO-PAY FORM

(2nd H.SR)

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI - 16

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 4-23-13

Nature of Complaint/Problem: need to see dental for dentures

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

RECEIVED APR 24 2013
Shayla Massengill. D.A.
Duplicate

Subjective: SEE Above -

Objective: BP ______ P ______ R N/A T ______ Wt ______

Assessment:

Forward to Dental

Plan:

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☒ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 4-23-13 Time: 223

Devin Jensen, LPN

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B-34A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 5-13-13

Nature of Complaint/Problem: Need a appt. w/ Dr. Whinnery, having concerns with my GID medications.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: – SEE Above –

Objective: BP ____ P ____ R n/a T ____ Wt ____ 5/27/13

Assessment:

Forward to Chronic Care

Plan:

Seen in chronic care 5/29/13

NA ☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 5-13-13 Time: 721

Devin Jensen, LPN

CP716610
Revision 09/2012

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590101

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☒ Inmate Initiated Visit	N/C	Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B 34A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 5-29-13

Nature of Complaint/Problem: Need to see dental for top partials.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: – SEE Above –

RECEIVED JUN 03 2013
Shayla Massengill, D.A.

Objective: BP ______ P ______ R N/A T ______ Wt ______

Assessment: Forward to Dental

6.3.13 Pt. already has process started. No HSR's needed. Scheduled when each step returns from lab. SM Shayla Massengill, D.A. 0646

Plan:

☐ Inmate Education Sheet Given N/A

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☒ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 5-29-13 Time: 1520

Devin Jensen, LPN

CP7166ID
Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Mason Elmo IDOC#: 94691

HU: 16B-34A DATE: 6-10-13

We have taken the following actions in response to your medical request / communication dated 6-10-13

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ DIETICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ CMS SUPERVISOR ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for Sick Call on 6-10-13 ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED Athletes Foot
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other: Must stay in medical for eval.

Signature [signature] LPN

Devin Jensen, LPN

ID-MED-7177 *(Rev. 08/05)*

589940

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	Accounting Dept. Use Only
☐ Inmate Initiated Visit	Visit $
OTC (med) x	Med(s) $
Rx (med) x NO CHARGE	Total $

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B-34A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 6-10-13

Nature of Complaint/Problem: Have athletes foot on right side, need oitment.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: -SEE Above-

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment: Left medical c̄ out being seen

Plan:

☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☒ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 6-10-13 Time: 1623

Devin Jensen, LPN

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601032

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		
☐ Inmate Initiated Visit		
OTC (med)	x	
Rx (med)	x	

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo Initials: CM·E Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B 34A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 7-31-13

Nature of Complaint/Problem: I need to see Dr. Whinnery for my GID meds. I would like to be on spironolactone & proscar

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan: Forward to CC

We are currently not using those meds together – we can discuss at his next scheduled appt unless he needs to come in to discuss sooner
C 8/1/13
C. Whinnery, M.D.

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 7/31 Time: 1230

TC chart records

CP7166ID
Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edwin Mason IDOC#: 94191

HU: 16 DATE: 8/2/13

We have taken the following actions in response to your medical request / communication dated ____________

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ____________
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ DIETICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ CMS SUPERVISOR ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ____________ on ____________ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ____________
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
✓	Other: You submitted a Health Service Request form

to change your meds. The two meds you requested are currently not being used together. If you would like to discuss with Dr. Whinnery please resubmit HSR and appoint will be made.

Signature ____________

ID-MED-7177 (Rev. 08/03)

589255

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x________
Rx (med)	x________

Accounting Dept. Use Only	
Visit	$________
Med(s)	$________
Total	$________

Print Name: Mason Edmo Initials: M.E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: Unit 8-B49

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 8-9-13

Nature of Complaint/Problem: Need to see Dr. Whinnery, would like to continue spironolactone with Proscar (Chronic Care)

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: SEE ABOVE

Objective: BP 117/77 P 79 R 16 T 98.1 Wt 203 SaO2 96% RA

Assessment:

Plan: SCHEDULE c̄ CC

[initials]

TRIAGE
Rec'd 8-10-13
Date Seen 8-10-13
Referred to CC
Initials RS

☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 8-10-13 Time: 0920

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599197

HEALTH SERVICES REQUEST
CO-PAY FORM

AUG 19

Julie Gonzales, LPN

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-O, A-2, 224A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 8-20-13

Nature of Complaint/Problem: need to see dental about partials ISCI had made for me, I never got because I moved to ICI-O.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Received 8/22/13

Plan:

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☑ Dental ☐ Optometry

Signature: [signature] Michael Miller, DDS Title: DDS Date: 9/4/13 Time: 0800

TRIAGED

AUG 19 2013

INITIALS [initials]

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MEDICAL INFORMATION RESPONSE

INMATE NAME: Edmo, Mason

IDOC#: 94691

HU: A2 DATE: 8/29/13 KITE#:

FOR YOUR INFORMATION:

Mr. Edmo -

Per Policy 108.06.03.001 Offender Right to Review Medical Records - 05.05.00 - An Offender does not have the Right to Review his Medical file (Idaho Code, Title 9 Chapter 3, Public Records Act 9-342(31)(e).

Policy 401.06.03.001 Medical Records Confidentiality Medical Records or Copies thereof will only be Released to the following individuals & only under the following Specific Circumstances. By Court order, By Written Request by the inmates designated Attorney upon Attorneys Letterhead with attached Signed Consent of Release of information. Records will not be Released to inmate legal Representatives. By written Request of an inmate designated Physician upon that physician's letterhead with attached Signed Consent of Release of information.

Your $10.00 Check has been Sent back to Inmate Banking.

thank you -

Signature: Kim Powers/CMS Supervisor

617049

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic Care

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-O B2/A1A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 9-27-13

Nature of Complaint/Problem: Need to see physician to higher estrogen dosage and to check testosterone levels.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ________ P ________ R ________ T ________ Wt ________

Assessment:

Plan:

Scheduled
Seen 10/4

SEP 28
TM
TRIAGED
SEP
INITIALS TM

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: ____________ Title: ________ Date: ________ Time: ______

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617055

HEALTH SERVICES REQUEST
CO-PAY FORM

Julie Gonzales, LPN

Mental Health

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo Initials: CME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-D (B2 A1A)

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 10-03-13

Nature of Complaint/Problem: Need to see mental health for changing of meds - current meds give me constant headache.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ________ P ________ R ________ T ________ Wt ________

Assessment:

Plan: See Dr Montgomery - note 10-8-13

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☑ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: RN Date: 10-8-13 Time: 02w

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MEDICAL INFORMATION RESPONSE

INMATE NAME: Mason Edmo

IDOC#: 94691

HU: B-2 DATE: 10/04/2013 KITE#: 617055

FOR YOUR INFORMATION: _Mr. Edmo, I have scheduled you to see Dr. Montgomery at his next available appointment, 10/08/2013 at 0700. You can discuss your medication concerns and questions at this time.___________

Signature: ___*Fran Palazzo, RN BSN*

600145

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic Care
Mariah Cunningham, CMS

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x______
Rx (med)	x______

Accounting Dept. Use Only	
Visit	$______
Med(s)	$______
Total	$______

Print Name: A. Mam Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: 1C1-B C1 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 10-10-13

Nature of Complaint/Problem: I am considered "Chronic Care" may I please get a flue shot Asap.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Scheduled 10/11/13

Assessment:

Plan:

☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

TRIAGED

Signature: ______ Title: ______ Date: ______ Time: ______

INITIALS: [initials]

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599546

HEALTH SERVICES REQUEST
CO-PAY FORM

Mariah Cunningham, CMS

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: A. Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-D C1 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 10-10-13

Nature of Complaint/Problem: Would like to be checked for Diabetes. Both sides of family have Diabetes including all grandparents and two siblings.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ________ P ________ R ________ T ________ Wt ________

Assessment:

Plan:

10/11

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: Rory York, ARNP Date: 10/11/13 Time: 1100

IMAGED

INITIALS [initials]

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617702

HEALTH SERVICES REQUEST
CO-PAY FORM

Julie Gonzales, LPN

Medical Dept. Use Only		Accounting Dept. Use Only	
☑ Inmate Initiated Visit		Visit	$
OTC (med)	x 1	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: IC-O C1 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: Oct. 30 2013

Nature of Complaint/Problem: I have a redness on my face by my nose. It's irritated and burns.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan:

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Rory York, ARNP

Signature: [signature] Title: ______ Date: 11/1/13 Time: 0925

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617736

HEALTH SERVICES REQUEST
CO-PAY FORM

Julie Gonzales, LPN

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x 1

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: 1C1-0 C1 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 11-12-13

Nature of Complaint/Problem: Have a constant headache - ongoing for a week and a half.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan:

11/13

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Rory York, ARNP

Signature: [signature] Title: ______ Date: 11/13/13 Time: 0940

NOV 1 3 2013

INITIALS JY

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617853

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: A. Mason Edmo Initials: AMEo Inmate ID: 94691

Date of Birth: [redacted] Housing Location: 1C-D; C1 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Mason Edmo Date: Nov. 16.13

Nature of Complaint/Problem: need medication highered or changed to decrease facial hair. I am diagnosed as G.I.D

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Refer to York — by Dr Young TY

Assessment:

Seen by 12/17/13 KP

Plan:

11/18 TY

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: Rory York, ARNP Date: 11/18/13 Time: 0940

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600174

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x________
Rx (med)	x________

Accounting Dept. Use Only	
Visit	$________
Med(s)	$________
Total	$________

Print Name: Adlasm Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-O C1 AU1B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adlasm Edmo Date: 11-19-13

Nature of Complaint/Problem: I would like to have a S.T.D/H.IV test done.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: Tests Neg 1/9/10

Objective: BP ________ P ________ R ________ T ________ Wt ________

HIV + RPR

Assessment:

Plan:

11/20

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: Rory York, ARNP Date: 11/20/13 Time: 0955

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599703

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x________
Rx (med)	x________

Accounting Dept. Use Only	
Visit	$________
Med(s)	$________
Total	$________

Print Name: A. Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICIO C1 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A Mason Edmo Date: Dec. 08. 2013

Nature of Complaint/Problem: for a month, there is a hard pebble like on both of my breasts under my nipple. when squeezd, a clear discharg happens.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

RECEIVED DEC 08 TM By

Objective: BP ________ P ________ R ________ T ________ Wt ________

TRIAGED

Assessment:

DEC 08 2013

Plan: Req Done 12/11

INITIALS TM

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] PAC Title: PA-C Date: 12/11/13 Time: 0949

Anthony F. Bushell PA-C

CP7166ID
Revision 09/2012

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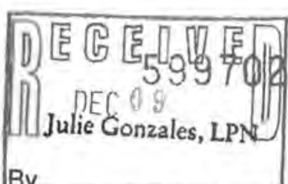
HEALTH SERVICES REQUEST
CO-PAY FORM



Chronic Care

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-O C1 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A. Mason Edmo Date: 12-09-13

Nature of Complaint/Problem: need medical memo for updated "Bra memo" & memo for panties. Clinician Gebhart said this is med. issue.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Done 12/11/13 KP

Assessment:

Plan:

Review 12/11

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

TRIAGED

Signature: ______ Title: ______ Date: ______ Time: ______ DEC 09 2013

INITIALS JG

CP7166ID
Revision 09/2012

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628607

HEALTH SERVICES REQUEST
CO-PAY FORM

* Chronic Care *

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-O C1 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 12-22-13

Nature of Complaint/Problem: May I have my medication as a K.O.P. (These meds were KOP's at I.S.C.I)

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

RECEIVED DEC 23 By Mariah Cunningham, CMS

Objective: BP ____ P ____ R ____ T ____ Wt ____

Assessment:

Plan: make ASA and ca++ KOP Review 12/23

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] PAC Title: ____ Date: 12/23/13 Time: 838 TRIAGED

Anthony Bushnell, PA-C

DEC 23 2013

INITIALS [initials]

CP7166ID
Revision 09/2012

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628618

CORIZON
Promote a culture of safety

HEALTH SERVICES REQUEST
CO-PAY FORM

RECEIVED
JAN 03
CM Hymbeaspoulos, CMS
By

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x 2
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: A. Masin Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-0 C1 A013

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 01-02-14

Nature of Complaint/Problem: Stuffy & Runny nose, headache, sore throat, & diarrhea.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ________ P ________ R ________ T ________ Wt ________

Assessment:

Plan:

☐ Inmate Education Sheet Given 1/3

☐ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: PA-C Date: 1/3/14 Time: 0949

Anthony Bushnell, PA-C

TRIAGED
JAN 03 2014
INITIALS [initials]

CP7166ID

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628619

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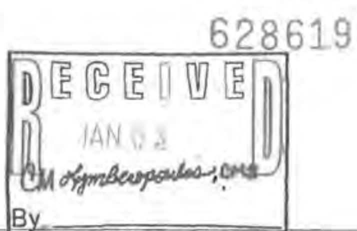
HEALTH SERVICES REQUEST
CO-PAY FORM



Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x________
Rx (med)	x________

Accounting Dept. Use Only	
Visit	$________
Med(s)	$________
Total	$________

Print Name: A Mason Edmo Initials: AmEE Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-O C1 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree M. Edmo Date: 01-02-14

Nature of Complaint/Problem: need another pair of prescription eye glasses.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ________ P ________ R ________ T ________

Not Due until Jan 2015

Assessment:

Plan:

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☑ Optometry

Signature: ________ Title: ________ Date: ________ Time: ________

TRIAGED
JAN 03 2014
INITIALS

CP7166ID
Revision 09/2012

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628260

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x______
Rx (med)	x______

Accounting Dept. Use Only	
Visit	$______
Med(s)	$______
Total	$______

Print Name: A. EdmO Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: B2, 1C1-O, A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 01-13-14

Nature of Complaint/Problem: need to see mental health for incr... [illegible] (IN PERSON)

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

RECEIVED JAN [illegible] By Mariah Cunningham, CMS

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan:
See Dr Montgomery's notes 1-21-14

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☑ Mental Health ☐ Dental ☐ Optometry

noted 1-21-14

TRIAGED

JAN 14 2014

Signature: [signature] Title: RN Date: 1-21-14 Time: 0700

INITIALS ML

CP7166ID
Revision 09/2012

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628261

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	Accounting Dept. Use Only
☐ Inmate Initiated Visit	Visit $______
OTC (med) x______	Med(s) $______
Rx (med) x______	Total $______

Print Name: A. Edmo Initials: A.M.E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-O B2-A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 01-13-14

Nature of Complaint/Problem: need increase in Eostrogen and blood/hormones and testesterone check. last check in sep. 2013

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

RECEIVED JAN 14 By Mariah Cunningham, CMA

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Bloodwork is drawn @ lomo

Assessment:

Plan:

1/16

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: PA-C Date: 1/16/14 Time: 0911

Anthony Bushnell, PA-C

TRIAGED JAN 14 2014 INITIALS MC

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MEDICAL INFORMATION RESPONSE

INMATE NAME: Mason Edmo

IDOC#: 94691

HU: C-1 DATE: 1/16/2014 KITE#: 628260

FOR YOUR INFORMATION: _Mr. Edmo, I have scheduled you an appointment with Dr. Montgomery at his next available appointment time: 1/21/2014 at 0700. You can discuss your medications with him at that time.

Signature: ___*Fran Palazzo, RN BSN*

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: A. Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-O B2 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A Edmo Date: 02-08-14

Nature of Complaint/Problem: Need to see G.I.D specialist for appropriate, necessary medical care ASAP!

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

RECEIVED FEB 09 Mariah Cunningham, CMS By

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Emailed request to Health Director 2/10/14 [signature]

Plan:

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: ______ Title: ______ Date: ______ Time: ______

TRIAGED FEB 09 2014 INITIALS [initials]

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Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x________
Rx (med)	x________

Accounting Dept. Use Only	
Visit	$________
Med(s)	$________
Total	$________

Print Name: A. Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-O B2 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A. Edmo Date: 02-08-14

Nature of Complaint/Problem: Need ~~[illegible]~~ Sex reassignment Surgery ~~[illegible]~~ ASAP.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

RECEIVED FEB 0 9 Mariah Cunningham, CMS By ______

Subjective:

Objective: BP ________ P ________ R ________ T ________ Wt ________

Assessment:

Emailed request to Health Director 2/10/14 J Herre HSA

Plan:

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

TRIAGED FEB 09 2014 INITIALS MC

Signature: ____________ Title: ________ Date: ________ Time: ______

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Promote a culture of safety

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		
] Inmate Initiated Visit		
OTC (med)	x	
Rx (med)	x	

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree M. Edmo Initials: AMEp Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICIO B2 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A. Edmo Date: 02-11-14

Nature of Complaint/Problem: need to see GID evaluator for Gender Reassignment surgery. ASAP.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

RECEIVED FEB 12 Mariah Cunningham, CMS By

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan: Dr Montgomery notified – On list to see him 2/13/14 [signature]

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

TRIAGED FEB 12 2014 INITIALS [initials]

Signature: ______ Title: ______ Date: ______ Time: ______

CP7166ID
Revision 09/2012

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646198

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x______
Rx (med)	x______

Accounting Dept. Use Only	
Visit	$______
Med(s)	$______
Total	$______

Print Name: Adree M. Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICIO B2 10113

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A. Edmo Date: 02-11-14

Nature of Complaint/Problem: need to speak with Dr. Craig for Gender Reassignment surgery.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

RECEIVED
FEB 1 2
Mariah Cunningham, CMS
By______

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

On schedule to see Dr Montgomery 2/13/14 [signature]

Plan:

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

TRIAGED
FEB 1 2 2014
INITIALS MC

Signature: ______ Title: ______ Date: ______ Time: ______

CP7166(I)
Revision 09/2012

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618326

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x Ø	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI Unit 8-20

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Mason Edmo Date: 2-26-14

Nature of Complaint/Problem: need to see Dr Whinney about GID meds. increase

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: Sent to providers clinc. 3/6/14

Objective: BP ___ P ___ R ___ T ___ Wt ___ Seen by Dr. Whinney

Assessment: Jennifer Prudhomme, LPN 3/6/14

Plan:

☐ Inmate Education Sheet Given

☒ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Revard, CMS Title: CMS Date: 2/26/14 Time: 0900

CP7166ID
Revision 09/2012

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652622

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic Care

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x ∅
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Masm Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A 05B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: MEdmo Date: 3-01-14

Nature of Complaint/Problem: need to have estrogen/testosterone blood levels checked; Checked last in Sept. 2013.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: **SEEN IN SICK CALL**

Objective: BP ______ P ______ R ______ **DATE** 03/01/14 **TIME** 0900

Assessment:
☐ Referred to a Provider
☐ OPC
☒ CC
☐ Dental
☐ Opto
☐ Other

Plan:

☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: Don Hoxsey, CMS Date: ______ Time: ______

CP7166ID
Revision 09/2011

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652621

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic care

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x Ø	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: MEp Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A 05B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: M Edmo Date: 2-01-14

Nature of Complaint/Problem: Would like GID meds KOP as before.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: **SEEN IN SICK CALL**

Objective: BP **DATE** 02/08/14 **TIME** 0930 Wt

Assessment:
- ☐ Referred to a Provider
- ☐ Dental
- ☐ OPC
- ☐ Opto
- ☑ CC
- ☐ Other

Plan:

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Don Hoxsey, CMS Title: Date: Time:

CP7166ID
Revision 09/2012

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641448

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic Care

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x________
Rx (med)	x________

Accounting Dept. Use Only	
Visit	$________
Med(s)	$________
Total	$________

Print Name: M. Edmo Initials: MGE Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI; 8 cell #2

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A M Edmo Date: 3-12-14

Nature of Complaint/Problem: I've been on GID meds for about 18 mos. Facial Hair has not decreased - Need Laser hair removal / Electrolysis ASAP.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: per M.D. Young procedure for hair removal is not medically nessesary.

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan:

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: Jared Hevard, CMS Title: CMS Date: 3/13/14 Time: 0900

CP7166ID
Rev 09/2012

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652317

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☑ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A-05B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: M. Edmo Date: Mar. 29. 2014

Nature of Complaint/Problem: I lost my only pair of glasses during transport of my property from ICIO to ISCI

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

TRIAGED MAR 29 2014 0907

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan: pt lost glasses. stated he contacted property s̄ success. ∅ nets used. refer to opto. WS for opto 5/13

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: K Larsen Title: LPN Date: 3/29/14 Time: 0907

Kelly Larsen, LPN

CP7166ID
Revision 09/2012

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652371

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☑ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Masum Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A-05B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: M. Edmo Date: Mar. 29. 2014

Nature of Complaint/Problem: Need to see mental health after increase of zoloft / change mental health meds!

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: see above

Seen 4-9-14 by Whitworth R.N. TRIAGED MAR 29 2014 0907

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan: ∅ nets used. pt denies thoughts of suicide or self harm refer to MH

☑ Inmate Education ~~Sheet~~ Given verbal

☑ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☑ Mental Health ☐ Dental ☐ Optometry

Signature: KLarsen Title: LPN Date: 3/29/14 Time: 0908

Kelly Larsen, LPN

CP7166ID
Revision 09/2012

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652357

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic Care

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x Ø	Med(s)	$
Rx (med)	x	Total	$

Mason Edmo NKA

Print Name: Adree Edmo Initials: A.E Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A-05B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 4-14-14 0208

Nature of Complaint/Problem: Spironolactone makes me sick; stomach cramps & Nausea. Need to change to something else.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ______ P ______ R ______ T ______ Wt ______
na

D/C'd per Whinnery
Jennifer Prudhomme, LPN
4/17/14 Dispo Sent

Assessment:
na

Plan: Forward to CCC

☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician (CDP) ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: RN Date: 4.14.14 Time: 1432

CP728810
Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 16 A5 DATE: 4/18/14

We have taken the following actions in response to your medical request / communication dated ______

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ DIETICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ CMS SUPERVISOR ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
✓	Other: Dr. Whinnery D/C your spirolactone since it is

making you sick. You should still have Proscar and can continue with that.

Signature Jennifer Prudhomme LPN

ID-MED-7177 *(Rev. 08/05)*

655454

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x 0	Med(s)	$
Rx (med)	x	Total	$

Print Name: Marcelino NKA Adree Edmo Initials: AE Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 1610 BB

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

TRIAGED APR 22 2014

Inmate Signature: A. Edmo Date:

Nature of Complaint/Problem: I want to be checked for hyperkalemia

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: pt says he doesn't know what hyperkalemia is – has no symptoms other than c/o tired

Objective: BP ______ P ______ R ______ T ______ Wt ______
Ø diaphoresis noted, pt upright –

Assessment:

Plan: forward

dispo sent per Dr Whinnery 4/24/14
Heather Nader, RN

☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician (CCC) ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: RN Date: 42214 Time: 1443
Gen Brewer, RN

CP7166ID
Revision 09/2012

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655455

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic Care

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x Ø	Med(s)	$
Rx (med)	x	Total	$

Print Name: Marm Edmo NKA Adree Edmo Initials: AE Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A 05B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

TRIAGED APR 22 2014 Initials: 28

Inmate Signature: A. Edmo Date: 04-22-14

Nature of Complaint/Problem: I want to switch from Spironolactone to goserelin, buserelin or triptorelin. Spironolactone makes me tired and sick.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ____ P ____ R ____ T ____ Wt ____

na

Assessment: na

Plan: Forward

dispo sent per Dr. Whinnery 4/24/14 Heather Nader, RN

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician (CCC) ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: GB Title: RN Date: 4.22.14 Time: 1408

Gen Brewer, RN

CP7166ID
Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 16 DATE: 4/24/14

We have taken the following actions in response to your medical request / communication dated ______

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ DIETICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ CMS SUPERVISOR ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
X	Other: "It's ok to stop the Spironolactone if it makes you tired and sick and

continue with the proscar. You have labs ordered for May that will test your potassium. We can go over results and your meds at your regular chronic care visit" per Dr. Whinnery

Signature [signature] Heather Nade

ID-MED-7177 *(Rev. 08/05)*

651261

HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED
Chronic Care MAY 17 2014 1012

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x 0
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo NKA Adree Edmo Initials: [illegible] Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI LCA-05B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: May 16 2014

Nature of Complaint/Problem: Need blood tests done, haven't had estrogen, testosterone levels checked since Sept. 2013.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: Pt Req Labs

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan: Fwd to CCC for Scheduling

DISPO Sent Pt has labs coming soon. 5/23/14 [signature] Jennifer Prudhomme, LPN JP 5/20/14

☑ Inmate Education ~~Sheet~~ Verbal Given
☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician CCC ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: L.A. Nisley Title: LPN Date: 5-17-14 Time: 1012

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651260

TRIAGED

MAY 17 2014

Chronic Care

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x ~~0~~
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Maximedmo NKA Edmo Adree Initials: AE Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A-05B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A. Edmo Date: May 16 2014

Nature of Complaint/Problem: Need increase in estrogen and increase in proscar.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See Above

Objective: BP ______ P ______ R ______ T ______ Wt ______

Dispo Sent pt has app appoint coming soon Jennifer Prudhomme, LPN 5/20/14

Assessment: Fwd to CCC for Scheduling

Plan:

☑ Inmate Education ~~Sheet~~ Verbal Given CCC

☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: L.A. Nisley Title: LPN Date: 5-17-14 Time: 1012

CP7166ID
Revision 09/2012

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651262

CORIZON
Promote a culture of safety

no show x3 cml

HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED
MAY 17 2014 10:12

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x Ø
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo A.K.A. Adree Edmo Initials: A.E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A-05B.

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A. Edmo Date: May 16. 2014

Nature of Complaint/Problem: Need new eye glasses, I lost only pair of glasses on transport to ISCI, can't see well.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See Above

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment: Fwd to Optometry for Scheduling

Plan:

☑ Inmate Education ~~Sheet~~ Verbal Given

☑ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☑ Optometry

Signature: L.A. Nisbey Title: LPN Date: 5-17-14 Time: 1012

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660216

HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED
MAY 17 2014 LW 1020

Medical Dept. Use Only		**Accounting Dept. Use Only**	
☒ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: 94691 (MVE) Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A05B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: May 17. 2014

Nature of Complaint/Problem: need blood Sugar monitoring for diabetes; both sides of family have diabetes.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: pt had Blood Sugar Glucose of 106 1.5HR after Eating @ 10:20am 5/17/14

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment: Fwd to OPC for Scheduling Consult

William Poulson NP-C [signature] 5/29/14 1100

Plan:

☑ Inmate Education Sheet Given
☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician (OPC) ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] L.A. Nisley Title: LPN Date: 5-17-14 Time: 10:20

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo, Mason IDOC#: 94691

HU: 16 A-5 DATE: 5/20/14

We have taken the following actions in response to your medical request / communication dated ______

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ DIETICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ CMS SUPERVISOR ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
✓	Other: labs have been ordered for you-they should

be coming up soon. Your chronic care visit is coming up soon after that & we can go over results & discuss meds.

C. Whinnery, M.D.

Signature [signature]

ID-MED-7177 *(Rev. 08/05)*

MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 16 DATE: 6/5/14

We have taken the following actions in response to your medical request / communication dated 3/29/14

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ DIETICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ CMS SUPERVISOR ☐ HS ADMINISTRATOR ☐ SPECIALIST
X	You missed your appointment for opto on 5/13/14 ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other:

ID-MED-7177 *(Rev. 08/05)*

Signature KMurray, RN

Kim Murray, R.N.

659506

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic Care

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Adree Edmo Initials: AE Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI/ unit 8/ B37A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 06-22-14

Nature of Complaint/Problem: Need to see provider for med. change, blood results, and GID issues.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan:

pt at scheduled early July S 6/24/14

Cathy Whinnery, M.D.

☐ Inmate Education Sheet Given

☒ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: Jared Revard CMS Title: CMS Date: 6/23/14 Time: 1200

?7166ID
Revision 09/2012

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634959

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x glasses

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Edmo Initials: AE Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI unit 8 - B-tier #37

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 06-26-14

Nature of Complaint/Problem: Need to see optometrist for eyeglasses; Lost Last pair during transport from ICI-O to ISCI (Feb. 2014)

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: Glasses. Reorderd 7/29/14

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan:

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☒ Optometry

Signature: Jared Blevard, CMS Title: as Date: 6/26/14 Time: 0845

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Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo **IDOC#:** 94691

HU: 8 **DATE:** 7/29/14

We have taken the following actions in response to your medical request / communication dated 6/26/14

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ____
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ DIETICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ CMS SUPERVISOR ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ____ on ____ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ____
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
✓	Other: glasses reordered Watch callout approx 3 weeks.

Signature K. Murray, RN
Kim Murray, R.N.

ID-MED-7177 *(Rev. 08/05)*

677402

HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED
AUG 1 0 2014 10:20

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Masun Edmo Initials: Ame Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 116A02A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 081014

Nature of Complaint/Problem: need to renew GID meds.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: Req: Estrace Calcium Asprin Spirolactone

Renewal Request: Exp approx 8.7.14

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

AUG 1 1 2014
Christian Gelok, NP

Plan: **Forwarded for Provider Review**: CDP

☑ Inmate Education ~~Sheet~~ Given Verbal
☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry
CDP

Signature: [signature] Ashley Nisbey, LPN Title: Date: 8-10-14 Time: 10:20

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HEALTH SERVICES REQUEST
CO-PAY FORM

677401

TRIAGED
AUG 10 2014 10:20 AN

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x 4
Rx (med)	x 1

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A02A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 08-10-14

Nature of Complaint/Problem: My butt is bleeding; have red spotting on toilet paper for about 1 week now

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: Pt States has had Hx of Hemorrhoids prior to incarceration

Objective: BP 128/81 P 73 R 20 T 97.7 Wt 212# Actual

Assessment: T Last BM: 8.9.14 Afternoon Normal, Hard @ night Evening; 8.8.14 night Hard

Cream
Softners
Suppositories
Tucks
AEdmo

Forwarded To: OPC

See Attached Nursing Protocol Document

Plan: Try OTC medications c̄ ↑ Fluids & Fiber Keep area clean & Dry
RTC if symptoms worsen or persists x A Edmo

☑ Inmate Education Verbal Given
☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician OPC ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Ashley Nisbey, LPN Title: Date: 8.10.14 Time: 10:20

Christian Gelok, NP 1100
AUG 22 2014

CP7166ID
Revision 09/2012

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677403

TRIAGED

AUG 10 2014 10:20

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☑ Inmate Initiated Visit		Visit	$
OTC (med)	x 1	Med(s)	$
Rx (med)	x 2	Total	$

Print Name: Adree Mason Edme Initials: Ame Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A 02A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A Edme Date: 08-10-14

Nature of Complaint/Problem: I have a sporadic muscle spasm in my Lwr back causing me great pain (migraine headaches) can't sleep!

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: Pt Req F/U for Treatment Review with Provider

1 analgesic balm issued
1 Painoff issued
X A Edme

Objective: BP ______ P ______ R ______ T ______ Wt ______

Forward for Scheduling

Assessment:

Plan: **Forwarded To:** OPC

R. Poulson NP 8/21/14 1600

Verbal
☑ Inmate Education Sheet Given
☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician (OPC) ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Ashley Nisbey, LPN Title: ______ Date: 8.10.14 Time: 10:20

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Revision 09/2012

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677406

HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED
AUG 10 2014 10:20

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Anee Mason Camo Initials: dmc Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISC 1 16102A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A dme Date: 08/10/14

Nature of Complaint/Problem: chapped itching skin on arms & legs and inner thighs - itchy real bad.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

William Poulson AUG 20 2014

Subjective: Pt states itching for @ 3mos

Familial Hx Psoriasis Paternal Father / Sibling Sister

Objective: BP ______ P ______ R ______ T ______ Wt ______

Forwarded To: OPC

Assessment:

Plan: Will try OTC until OPC appt. 1 ASD 1 HCCR18
RTC if Symptoms Worsen or Persist c OTC meds > 1wk

☑ Inmate Education Verbal Sheet Given

☑ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: Ashley Nisbey, LPN Date: 8.10.14 Time: 10:20

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676417

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x 1
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: A. Mason Edmo Initials: AMCE Inmate ID: 94691
Date of Birth: [redacted] Housing Location: ISCI 16A02B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: Aug. 28. 2014.

Nature of Complaint/Problem: Have severe dry skin. Talked w/ N.P. Poulsen on 08-26-14 he said I would have to pay for A&E ointment on sick call.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ________ P ________ R ________ T ________ Wt ________

Assessment:

Plan:

☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: ____________ Title: ________ Date: ________ Time: ______

CP7166ID
Revision 09/2012

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665692

HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED SEP 20 2014

TRIAGED ~~SEP 19 2014~~ 925

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Edmo/Mason Edmo Initials: AMG Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B-30B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 09-20-14

Nature of Complaint/Problem: I had seen NP Poulson last month about eczema issues and he had not prescribed anything or given me anything for my dry skin, my skin has been very very dry and very itchy where I itch and cause my skin to bleed!!

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: Pt Req A & D Rx for Eczema on legs bilaterally. Pt states not successful c̄ Hydrocortisone cream but OTC A & D from Sick Call was successful

Objective: BP ______ P ______ R ______ T ______ Wt ______ X [signature]

Assessment: No Sx/Sym of infection. No visible Broken Skin Bilaterally on legs. Evidence of Dry Patches s̄ Redness s̄ Swelling s̄ Active Bleeding Drainage or Blistering

Plan:

Forwarded To: OPC

☑ Inmate Education ~~Sheet~~ Verbal Given

☑ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature], LPN **Ashley Nisbey, LPN** Date: 9-20-2014 Time: 0930

William Poulson NP-C
OCT 02 2014
BC

CP7166ID
Revision 09/2012

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000030

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x______
Rx (med)	x 1

Accounting Dept. Use Only	
Visit	$______
Med(s)	$______
Total	$______

Print Name: Adree Edmo/Mason Edmo Initials: AMEd Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B-30B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 09-20-14

Nature of Complaint/Problem: My lower back and upper right shoulder still causes pain, I have a sporradic muscle spasm, causes incense muscle strain, migraines and naseau. Seen NP Poulson and he gave me 3 days of Paraton Forte, Back still hurts!

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file   Yellow – DOC   Pink-Accounting   Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: Pt states has tried Analgesic Rb, APAP & IBuProfen with little to no success. States IBuprofen upset Stomach. x [signature]

Christian Gelok, NP OCT 01 2014 1420

Objective: BP ______ P ______ R ______ T ______ Wt ______

Forwarded To: OPC

Assessment:

Plan:

Forward for Scheduling

☑ Inmate Education ~~Sheet~~ Verbal Given
☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician (OPC) ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: AN, LPN Title: Ashley Nisbey, LPN Date: 9.20.14 Time: 0925

ID
09/2012

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Promote a culture of safety

HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED SEP 20 2014   665691   TRIAGED ~~SEP 20 2014~~ 0915 [illegible]

Chronic Care

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x______
Rx (med)	x______

Accounting Dept. Use Only	
Visit	$______
Med(s)	$______
Total	$______

Print Name: Adree Edmo / [redacted] Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B-30B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 09-20-14

Nature of Complaint/Problem: Dr. Whinnery has prescribed me 3mg of estradiol to maintain gender dysphoria - this is not maintaining my gender dysphoria levels at all - need increase in Estradiol or been seen by a GID evaluator - ASAP!

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file   Yellow – DOC   Pink-Accounting   Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See Above

Can discuss again at CDP visit scheduled for 10/1/14 9/22/14

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Forwarded To: CDP

Plan:

Cathy Whinnery, M.D.

☑ Inmate Education ~~Sheet~~ Verbal Given

☑ Use of Nursing Protocols Refer to; ☑ PA/NP/Physician (CDP) ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature], LPN   Ashley Nisbey, LPN Title: ______ Date: 9-20-14 Time: 0915

09/2012

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642093
TRIAGED SEP 20 2014
~~TRIAGED SEP 19 2014~~ 0915 AN

HEALTH SERVICES REQUEST CO-PAY FORM

Chronic Care

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x__________
Rx (med)	x__________

Accounting Dept. Use Only	
Visit	$__________
Med(s)	$__________
Total	$__________

Print Name: Adree Edmo/Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B 30B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 09-20-14

Nature of Complaint/Problem: need memo for purchasing female underwear on commissary and ability to have panties which help me "tuck" my disgusting penis!

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ____ P ____ R ____ T ____ Wt ____

Assessment:

Can let Edmo know - Not allowed per IDOC. Thanks 9/22/14 20:25
Cathy Whinnery, M.D.

Forwarded To: CDP

Plan:

☑ Inmate Education ~~Sheet~~ Verbal Given

☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician (CDP) ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: AN, LPN **Ashley Nisbey, LPN** Date: 9.20.14 Time: 0915

7166ID
Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo, Adree Mason IDOC#: 94691

HU: 16B 30B DATE: 9/23/14

We have taken the following actions in response to your medical request / communication dated 9/20/14

X	Your request has been denied. Memo's for purchasing female underwear is not allowed per IDOC.
	Medication / Prescription has been ordered for you. Come to pill call on ______
X	You are scheduled to see the ☒ NP/PA ☒ PHYSICIAN ☐ DIETICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ CMS SUPERVISOR ☐ HS ADMINISTRATOR ☐ SPECIALIST 10/1/14 to discuss Estradial.
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other:

Signature [signature], RN

ID-MED-7177 *(Rev. 08/05)*

716470

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x 1

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree M. Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B-35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: NOV. 06.2014

Nature of Complaint/Problem: - Still having back spasms/pain (8 of 10 scale) - PT. had not helped at all - Parafon forte alleviated tension briefly, this has been the only meds that have worked so far.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: Parafon Forte expired - denies reinjury - Physical therapy made worse -

Objective: BP na P R T Wt

Assessment: na

William [illegible]son NP-C NOV 17 2014

Plan: **Forward for Scheduling**

☐ Inmate Education Sheet Given OEC

☐ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: Gen Brewer, RN Title: RN Date: 11.6.14 Time: 1009

CP7166ID
Revision 09/2012

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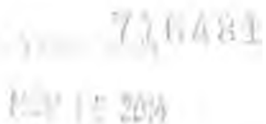

re a culture of safety

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic Care

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Masuin Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 11-15-14

Nature of Complaint/Problem: I need to see Dr. Whinnery for ordering a medical memo so that I can have panties. I've told Dr. Whinn before, that since I've been on estrogen my testicles have shrunk, and are very sensitive. Panties help apply pressure and keep them in one place - Men's do not.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: Memo Request

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Forwarded To: Chronic Care

Plan:

☒ Inmate Education Verbal Given
☒ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: ANisbey, LPN Ashley Nisbey, LPN Date: 11.15.14 Time: 1300

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Revision 09/2012

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716480

HEALTH SERVICES REQUEST
CO-PAY FORM

* follow-up *

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x 0
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Marion Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 11-15-14

Nature of Complaint/Problem: I am having continued migraine headaches from lower middle back pain, and lower left back spasms which shoots sharp pains up into my left shoulder, seen by N.P. Gluck who ordered (P.T.) - no help, made symptoms worse. Submitted a HSR on 11-06-14

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: Pt States Req to see Provider RE BK Pain Mgmt /PT Followup

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Forwarded To: OPC

Seen 11/17/14 in OPC for this. Jan Dale, LPN

Plan: Referred to OPC

☑ Inmate Education ~~Sheet~~ Verbal Given

☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry (OPC)

Signature: AN, LPN Ashley Nisbey, LPN Date: 11-15-14 Time: 1300

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Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo Mason IDOC#: 94691

HU: 16 DATE: 11-17-14

We have taken the following actions in response to your medical request / communication dated HSR 716481

✓	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
✓	Other: IDOC does not allow for panties. JS

Signature Julie Savell, LPN

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 16 DATE: 11/17/14

We have taken the following actions in response to your medical request / communication dated ______

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff. I am ordering a low dose of
	A requisition is being processed for your request. Elavil which we discussed today.
	We are researching your problem and will keep you advised. Behavioral health will review
	Lab results show no significant abnormalities. and evaluate if you may be
	X-ray results show no significant abnormalities. able to increase dose if
	Other: needed.

Signature [signature] William Poulson NP-C NOV 17 2014

CP7177ID
Issued 7/2005, Revised 7/2014

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718663

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic Care

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Arlee Edmo AKA Masin Edmo   Initials: AME   Inmate ID: 94691

Date of Birth: [redacted]   Housing Location: ISC 16B35B

DEC 22 2014 0907 MS

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature]   Date: 12-22-14

Nature of Complaint/Problem: Per Dr. Craig concern form Reply (12-14-14) and IDOC A.R.O. I am allowed to have a medical memo for panties. I've had alot of tenderness of my testicles because of estrogen, my testicles have shrunk tremendously, and the men's underwear does not provide any comfort or support, I need alot of support and pressure.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file   Yellow – DOC   Pink-Accounting   Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ______ P ______ R ______ T ______ Wt ______

na

Assessment: na

Julie Savell, LPN

Addressed by Whinnery on HSR on 12-30 — Intake/Initial

Plan: **Forward for Scheduling**

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician (CDP) ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature]   Title: Rn   Date: 12-22-14   Time: 1300

Gen Brewer, RN

CP7166ID
Revision 09/2012

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718664

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☒ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Adree Edmo AKA Mason Edmo Initials: AMLE Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B 35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A Edmo Date: 12-22-14

Nature of Complaint/Problem: My lower back is still causing alot of pain. 12 wks of physical therapy has helped my muscles, But its not my muscles, as I've continually said, it feels inside, like nerve sharp pains, I'm still having migraines & constant headache.

TRIAGED 2014 0907 mg

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment: See Attached Nursing Protocol Document

Plan: **Forward for Scheduling**

Christian Gelok, NP
CG 0930
JAN 05 2015

☒ Inmate Education ~~Sheet~~ Given Verbal OPC

☒ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: RN Date: 12-22-14 Time: 0943

Michael Grace, RN

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x________
Rx (med)	x________

Accounting Dept. Use Only	
Visit	$________
Med(s)	$________
Total	$________

Print Name: Adree Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 01-04-15

Nature of Complaint/Problem: Renew meds: Proscar, Estradiol, Spironolactone, Aspirin, Calcium Carb

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

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HEALTH CARE DOCUMENTATION

Subjective: —See Above—

Objective: BP ________ P ________ R ________ T ________ Wt ________

Assessment:

Plan: Fwd to CDP for Review & Scheduling

Julie Sallell, LPN — Seen by ... 1-8-15

☑ Inmate Education ~~Sheet~~ Verbal Given

☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician (EDR) ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: Ashley Nisbey, LPN Date: 1-4-15 Time: 1600

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Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x 2
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Edmo Initials: AMG Inmate ID: 94691

Date of Birth: [redacted] Housing Location: 18C/16B35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 01-04-15

Nature of Complaint/Problem: Skin very dry, scratching skin causing bleeding on legs & thighs

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ______ P ______ R ______ T ______ Wt 212 NO SHOW OPC Date 1/12 Dan Drake, LPN

See attached NET

Assessment:

Fwd to Opc : F/U possible Eczema/Dry Skin

Plan:

☐ Inmate Education ~~Sheet Given~~ Verbal

☒ Use of Nursing Protocols Refer to: ☒ OPC PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: ANisb Ashley Nisbey, LPN Title: Date: 1-4-15 Time: 1600

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Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 16 DATE: 1/12/15 HSR 726864

We have taken the following actions in response to your medical request / communication dated 1/4/15

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ____
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
X	You missed your appointment for ____ on ____ ☑ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED RE = Dry skin
	Medications have arrived for you. Pick them up during pill call on ____
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other:

Signature [signature] Jan Drake, LPN

CP7177ID
Issued 7/2005, Revised 7/2014

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732815

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic Care

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ~~18A 1LA B3~~ 18C1 08 Alcir

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 02-07-15

Nature of Complaint/Problem: In Dec 2014 Dr. Whinnery had indicated to me that she would be ordering me "Modified Supporting under wear" but has yet to get to me?

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Julie Sayell, LPN
Addressed 2/13

Plan: Forward to chronic Care

☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Clyde Young, LPN Title: [illegible] Date: 2-11-15 Time: 0900

166ID
ion 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Cdmo, M(Adree) **IDOC#:** 94691

HU: 16B **DATE:** 2-9-15

We have taken the following actions in response to your medical request / communication dated Concern to Whinnery re: underwear

RECEIVED FEB 0 9 2015

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ DIETICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ CMS SUPERVISOR ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
X	Other: You may take HSR to your sick call requesting ordered Jock Strap w/ Abd. pads. Supplies will be

dispensed either that day, or following day. Concern has been forwarded to Dr Whinnery for a response. She is out of the office this week so please be patient. Supplies order was placed by Dr Whinnery on 1-8-15

Signature SMallet LPN Shelli Mallet, LPN, Ombudsman

ID-MED-7177 *(Rev. 08/05)*

Promote a culture of safety

HEALTH SERVICES REQUEST
CO-PAY FORM

731379
TRIAGED
FEB 23 2015
0807 mb

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x 4
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: A Sedmo Initials: AMG Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI D7B13B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 02-23-15

Nature of Complaint/Problem: Heachaches, Dry itchy throat, runny nose, Body aches - blurry vision.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ____ P ____ R ____ T ____ Wt ____

Assessment: See Attached Nursing Protocol Document

Plan: RTC if symptoms persist > 14 days taking meds given

☑ Inmate Education ~~Sheet~~ Verbal Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: RN Date: 2-23-15 Time: 0848

Michael Grace, RN

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

734125

TRIAGED APR 04 2015

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

1 of 4

Print Name: Adree Chasm Gelmo Initials: Ajmee Inmate ID: 94691

Date of Birth: [redacted] Housing Location: 13C / 09A 09B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 04-04-15

Nature of Complaint/Problem: Have fibromyalgia in back and causing headaches/migraines and nausea again, can't sleep at all

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment: Pt Left & did not RTC @ 1200 or 1300 for Nursing assessment. —AN

Plan: — MRD Sent —

☑ Inmate Education Verbal Given

☑ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Ashley Nisby, LPN

Signature: AN, LPN Ashley Nisby, LPN Date: APR - 4 Time: 1400

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

734123

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x glasses –

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

3 of 4

Print Name: Adree Masmadmo Initials: AMG Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 09A 09B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 04-04-15

Nature of Complaint/Problem: Lost eyeglasses; need new pair, see SOP 320 Section 4.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

U8 4/21/15

Subjective: Req OptoVisit

APR 04 2015

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment: Fwd Opto

Plan: Ordered 4/28/15

☐ Inmate Education ~~Sheet~~ Verbal Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☑ Optometry

Signature: [signature], LPN Title: Ashley Nicky LPN Date: APR - 4 Time: 1400

CP716610
Revision 09/2012

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734126

HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED APR 04 2015

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x_______
Rx (med)	x_______

Accounting Dept. Use Only	
Visit	$_______
Med(s)	$_______
Total	$_______

2of4

Print Name: Adree Mason Edmo   Initials: AmE   Inmate ID: 94691

Date of Birth: [redacted]   Housing Location: ISCI 09A 091B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo   Date: 04-04-15

Nature of Complaint/Problem: History of hemmorhoids - butt is bleeding - need wipes and suppositories to help.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file   Yellow – DOC   Pink-Accounting   Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See Above

TRIAGED APR 04 2015

Objective: BP ________ P ________ R ________ T ________ Wt ________

Assessment: Pt Left for Recall and did not RTC at 1200 or 1300 for Nursing Assessment

Plan: – MRD Sent –

☑ Inmate Education ~~Sheet~~ Verbal Given

☑ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: 4/4/15 LPN   Ashley Nisby, LPN   Date: APR - 4   Time: 1400

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Revision 00/2013

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HEALTH SERVICES REQUEST
CO-PAY FORM

734124

Chronic Care

Medical Dept. Use Only	
~~☐ Inmate Initiated Visit~~ Supplies	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

4 of 4

Print Name: Cidree Maxim Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 09A 09B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 04-04-15

Nature of Complaint/Problem: need another jock strap & ABD pads - Have only one jock strap and out of ABD pads.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

TRIAGED APR 04 2015

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment: Pt to RTC this week to P/U supplies

Plan: Supplies issued week of 4/10/15

☑ Inmate Education ~~Sheet~~ Verbal Given

☑ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature], LPN Ashley Nisby, LPN Date: APR - 4 Time: 1400

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Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo, M. IDOC#: 94691

HU: 09A09B DATE: 4/5/15 HSR# 734126, 734125, 734123

We have taken the following actions in response to your medical request / communication dated 4/4/15

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ________
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
* AN	You missed your ~~appointment~~ Assessment for HSR: 734125, 734126, 734124, 734123 on 4/4/15 ☒ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED You Left before being assessed or p/u Supplies & did not RTC @ 1200 as agreed.
	Medications have arrived for you. Pick them up during pill call on ________
* AN	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.* Opto HSR# 734123
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other:

Signature [signature], LPN Ashley Nisby, LPN

CP7177ID
Issued 7/2005, Revised 7/2014

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750761

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x Supplies
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: A. Masonedmo Initials: [illegible] Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISC1 08-04

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 05-02-15

Nature of Complaint/Problem: need ABD pads for month of may- have order in chart.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: SEE ABOVE

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment: Pt to be issued 1x pad daily while in Segregation

Plan:

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: RN Date: 5/3/15 Time: 1400

CP7166ID
Revision 09/2012

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TRIAGED
AUG 08 2015
779740
1011

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo AKA Adree Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 15A48B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 08-08-15

Nature of Complaint/Problem: need to change meds. Effexor needs to be highered or changed.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: "Don't like the way it makes me feel" "hangover when wears off" denies thoughts of s/hi/self harm

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan: Forward MH

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☑ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Jue Savell LPN Title: LPN Date: 8-8-15 Time: 1011

8/11/15
NS 98

Received in Mental Health
DATE: 8-10-15 9B
sch 8/11/15

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Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 15 DATE: 8-11-15

We have taken the following actions in response to your medical request / communication dated ______________

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______________
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
X	You missed your appointment for mental health on 8.11.15 ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☑ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______________
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other:

Signature gb

Gen Brewer, RN

CP7177ID
Issued 7/2005, Revised 7/2014

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HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED 0908
AUG 30 2015
770386

Chronic Care

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B67B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 08-30-15

Nature of Complaint/Problem: HRT meds need changed. Progestin needed to my HRT, or higher estrogen or patch.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Christian Gelok, NP
AUG 31 2015

Subjective: See above

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan: Ø not used - pt has next CDP appt scheduled 9/21/15

Forwarded To: CDP

☑ Inmate Education ~~Sheet~~ verbal Given

☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: KLarsen Title: LPN Date: 8/30/15 Time: 0920

Kelly Larsen, LPN

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

0908 770385

Chronic Care

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Mason Edmo Initials: CAME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B67B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 08-30-15

Nature of Complaint/Problem: Need blood tests for estrogen & testosterone. Last labs 03/2015.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: see above

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan: pts last labs in March 2015 labs scheduled for 3rd week in Sept. **Forwarded To:** CDP c̄ CDP appt as well.

☑ Inmate Education ~~Sheet~~ verbal Given

☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: K Larsen Title: LPN Date: 8/30/15 Time: 0920

Kelly Larsen, LPN

CP7166ID
Revision 09/2012

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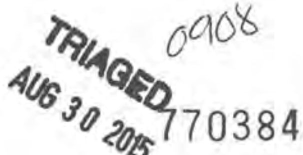
HEALTH SERVICES REQUEST
CO-PAY FORM



770384

Chronic Care

Medical Dept. Use Only		Accounting Dept. Use Only	
☑ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Adree Mason Edmo Initials: CAME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B67B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 08-30-15.

Nature of Complaint/Problem: Jock straps issued to me are no longer providing support. Testicles are more sensitive now. Need better support & more pressure.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Christian Gelok, NP
AUG 31 2015

Subjective: see above

Objective: BP ________ P ________ R ________ T ________ Wt ________

Assessment:

Plan: pt issued jock strap in April in COP appt. pts next appt. 9/21/15

Forwarded To: COP

☑ Inmate Education ~~Sheet~~ verbal Given

☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: K Larsen Title: LPN Date: 8/30/15 Time: 0920

Kelly Larsen, LPN

CP7166ID
Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 16 DATE: 8/31/15

We have taken the following actions in response to your medical request / communication dated ______

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
X	Other: Spironolactone is @ max dose level.

Signature [signature]

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Issued 7/2005, Revised 7/2014

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 16 DATE: 9/4/15

We have taken the following actions in response to your medical request / communication dated ______

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
/	Other: Normal female testosterone ranges from 230-189 in healthy 30 yo, non-smoker, moderate exercise. Your testosterone level is well below these values!

Signature [signature] Clark NPC 9/4/15 1020

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Issued 7/2005, Revised 7/2014

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo, M IDOC#: 94691

HU: 15 DATE: 9/16/15

We have taken the following actions in response to your medical request / communication dated ______________

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______________
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______________ on ______________ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______________
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
/	Other: Testosterone: 153 Estrogen: 97.8

Signature [signature] 9/16/15 1600

CP7177ID
Issued 7/2005, Revised 7/2014

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HEALTH SERVICES REQUEST
CO-PAY FORM

784730

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x______
Rx (med)	x______

Accounting Dept. Use Only	
Visit	$______
Med(s)	$______
Total	$______

Print Name: Edmo, Mason Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: Unit 16

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: medical response call (KL) Date: 9/29/15

Nature of Complaint/Problem: laceration to scrotum

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan: refer to nets / provider contacted

☑ Inmate Education Sheet Given
☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☑ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: K Larsen Title: LPN Date: 9/29/15 Time: 1830

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED
OCT 15 2015 770547
0730

Chronic Care

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x______
Rx (med)	x______

Accounting Dept. Use Only	
Visit	$______
Med(s)	$______
Total	$______

Print Name: Adree Mason Edmo Initials: AMG Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A 016B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 10-15-15

Nature of Complaint/Problem: I need a memo to possess, wear and order female panties. This helps to alleviate some of my gender dysphoria.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP NA P ______ R ______ T ______ 1050

Assessment: Chart review - Pt is G.I.D. IDOC underware provided

Plan:

Forwarded for Provider Review

☑ Inmate Education ~~Sheet~~ Given Verbal

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: Michael Grace Title: RN Date: 10-15-15 Time: 0731

Michael Grace, RN

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED
OCT 15 2015
0730 mg

770549

Chronic Care

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x______
Rx (med)	x______

Accounting Dept. Use Only	
Visit	$______
Med(s)	$______
Total	$______

Print Name: Adree Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A 06B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 10-15-15

Nature of Complaint/Problem: I need effexor increased, and proscar renewed, effexor increased because of extreme gender dysphoria.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP NA P ______ R ______ T ______ Wt ______

Assessment: Pt denies SI / HI

Educated about MH clinic M-F 8-9 @ Ed build

Plan: Forward for Scheduling

☑ Inmate Education ~~Sheet~~ Verbal Given
☑ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☒ Mental Health ☐ Dental ☐ Optometry

Signature: Michael Grace Title: RN Date: 10-15-15 Time: 0731
Michael Grace, RN

Received in Mental Health
DATE: 10.19.15
due 11/18 – moved to 11-16

CP7166ID
Revision 09/2012

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CORIZON
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HEALTH SERVICES REQUEST
CO-PAY FORM

0909 784404

TRIAGED
OCT 25 2015

Medical Dept. Use Only		Accounting Dept. Use Only	
☑ Inmate Initiated Visit		Visit	$______
OTC (med)	x______	Med(s)	$______
Rx (med)	x______	Total	$______

Chronic Care

Print Name: Adree Masun Edmo Initials: AMEY Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A006B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A Edmo Date: 10-25-15

Nature of Complaint/Problem: Having facial hair makes my depression extremely worse. I need electrolysis ASAP (WPATH "SOC")

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ______ P ______ R ______ T ______ Wt ______

Assessment:

Plan: ∅ nrts used

☑ Inmate Education ~~Sheet~~ verbal Given
☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: K Larsen Title: LPN Date: 0910 Time: 10/25/15

10.28.15 1544 email sent Dr R. Craig – gf

Kelly Larsen, LPN

Received in Mental Health
DATE: 10.26.15 gb
due 11/18

CP7166ID
Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 16 DATE: NOV 2, 2015

\# 770549
784404

We have taken the following actions in response to your medical request / communication dated 10/15 and 10/25

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ____
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ____ on ____ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ____
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
X	Other: Per the provider you can discuss your requests at your next scheduled visit - gB

Signature gB Gen Brewer, RN

CP7177ID
Issued 7/2008, Revised 7/2014

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HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED
NOV 22 2015
784687
Clyde Young, LPN
0730

Chronic care

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Edmo aka Mason Edmo Initials: GAME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 8C-74A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 11/22/2015

Nature of Complaint/Problem: My hormone levels are not where I believe they should be. They are too low. I feel tired, weak & my mind feels foggy. I believe I should be seen by an endocrinologist about appropriate hormone levels. Not a Nurse Practictioner

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP 120/75 P 102 R 20 T 98.0 Wt 199

Assessment: Tired, weak and alot of headaches

Plan: Refer to provider for f/u

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: CYoung Clyde Young, LPN Title: Sr Nurse Date: 11/22/15 Time: 0900

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED
NOV 22 2015
784637
Clyde Young, LPN
0730

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Adree Edmo / Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 8C-74A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 11/22/2015

Nature of Complaint/Problem: My GID meds. still have not been given to me on a consistent basis. This is causing me to have hightened depression, anxiety, and extreme gender dysphoria. Specifically Proscar + Spironolactone.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP 120/75 P 102 R 20 T 980 Wt 199

Assessment: Spironolactone was a BID order, was on the MAR correctly but H.S. dose was being missed.

Plan: corrected on MAR so he would get it correctly now.

☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: CYoung Clyde Young, LPN Title: Sg Nurse Date: 11/22/15 Time: 0900

CP7166ID
Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo Mason IDOC#: 94691

HU: 16 DATE: 12-7-15

We have taken the following actions in response to your medical request / communication dated ____________

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ____________
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
✓	You missed your appointment for HSR 784687 and CDP Appt on 12-7-15 ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☑ YOU ARE RESCHEDULED approx now to 14 days watch call out
	Medications have arrived for you. Pick them up during pill call on ____________
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other:

Signature [signature] Julie Savell, LPN

CP7177ID
Issued 7/2005, Revised 7/2014

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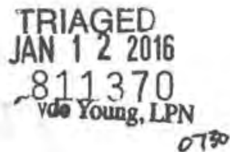
HEALTH SERVICES REQUEST
CO-PAY FORM



TRIAGED
JAN 1 2 2016
811370
Clyde Young, LPN
0730

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Cmasm edmo aka Adree Edmo Initials: ADME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 08A15A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 01/12/16

Nature of Complaint/Problem: I would like to be put on Remron to help sleep because my mind won't stop. Dr Elioson had offered to put me on Remron. I would like to start Remron now.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP 122/72 P 78 R 20 T 98.2 Wt 200lbs

Assessment: having trouble falling asleep and then having trouble staying asleep

Plan: Refer to MH OTC provider

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Clyde Young, LPN Title: Sr Nurse Date: 1/12/16 Time: 0930

Received in Mental Health
DATE: 1-14-16 gB
last seen 1-19 due 2-11 4-16

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED
FEB 02 2016 809272
OTC.6
Chronic Care

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [REDACTED] Housing Location: ISCI 16B35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: M. Edmo Date: 02/02/16

Nature of Complaint/Problem: I need my bra memo renewed for 2016, specifically allowing me to purchase IDOC commissary approved bras, as well as permission to have them in my possession. My breasts are still growing + need support.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

refilled memo written

Subjective: See above

[stamp: ...ian Clelok, NP — FEB 02 2016]

Objective: BP N/A P ______ R ______ T ______ Wt ______

Assessment: Chart Review

Plan:

☐ Inmate Education Sheet Given
☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: Alyssa Turpin Title: ______ Date: FEB 0 2 2016 Time: 1400

Alyssa Turpin, LPN

CP7166ID
Revision 09/2013

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Promote a culture of safety

HEALTH SERVICES REQUEST
CO-PAY FORM

845912
TRIAGED
MAY 2 1 2016

Chronic Care 1004

Medical Dept. Use Only		
☐ Inmate Initiated Visit		
OTC (med)	x	
Rx (med)	x	

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Edmo Initials: A/E Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 05/21/16

Nature of Complaint/Problem: I am provided a jockstrap - I need a new one plus ABD pads for additional support because the men's underwear provide no support - I need a (small) size jockstrap!!

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP N/A P ______ R ______ T ______ Wt ______

Assessment:

Plan: **Forwarded To:** CDP

5/25/16 Jock strap not medically indicated for GD. Bra only indicated. David Agler, MD

☐ Inmate Education Sheet Given

☒ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

CDP

Signature: [signature] Title: RN Date: 5/21/16 Time: 1010

Leslie Carlson, RN

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGE 845911
MAY 21 2016
1004
Chronic Care

Medical Dept. Use Only		
☐ Inmate Initiated Visit		
OTC (med)	x	
Rx (med)	x	

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Edmo Initials: AE Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B 35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 05/21/16

Nature of Complaint/Problem: I am becoming more depressed and anxious because I need a medical memo for panties. My psychological need for panties is greater than the blanket denial rule and denial because I am in a man's prison - I need PANTIES!!

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: see above

Objective: BP N/A P ______ R ______ T ______ Wt ______

Assessment:

Plan: **Forwarded To:** CDP

☐ Inmate Education Sheet Given
☒ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry
CDP

Signature: Leslie Carlson Title: RN Date: 5/21/16 Time: 1020

Leslie Carlson, RN

Received in Mental Health
DATE: 5/23/16 PC

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

TRIAGED 845910
MAY 2 1 2016 1004
Chronic Care

Medical Dept. Use Only		
☐ Inmate Initiated Visit		
OTC (med)	x______	
Rx (med)	x______	

Accounting Dept. Use Only	
Visit	$______
Med(s)	$______
Total	$______

Print Name: Adree Edmo Initials: A/E. Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree Edmo Date: 05/21/16

Nature of Complaint/Problem: According to WPATH standards of care, medically necessary medical care for my GID/GID is for me to have women's commissary items to treat my GID such as all the women's hygiene, including makeup - please allow this.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line
Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP N/A P ______ R ______ T ______ Wt ______

Assessment:

Plan: **Forwarded To:** CDP

☐ Inmate Education Sheet Given
☑ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician CDP ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: Leslie Carlson Title: RN Date: 5/21/16 Time: 1020

Leslie Carlson, RN

Received in Mental Health
DATE: 5/23/16 PC

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Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo, Adree IDOC#: 94691

HU: Unit 16 DATE: 5/25/16

We have taken the following actions in response to your medical request / communication dated ______

✓	Your request has been denied. HSR #s 845910 & 845911
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other:

Signature PCash RN Patricia Cash, RN

CP7177ID
Issued 7/2005. Revised 7/2014

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo, Mason IDOC#: 94691

HU: 16 DATE: 6/16/16

We have taken the following actions in response to your medical request / communication dated ______

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
X	Other: I reviewed your meds and discussed your case w/ Dr. Agler and Dr. Yang. We believe it is best to keep your meds where they are at

currently. I'm going to recheck your T level once again. I know you wanted to go up on meds. Sorry.

Daniel Dietrich/Daniel Dellwo, PA-C

Signature ______ JUN 16 2016

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo Adree IDOC#: 94691

HU: Unit 16 DATE: 6/15/16

We have taken the following actions in response to your medical request / communication dated ______________

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ____________
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ____________ on ____________ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ____________
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other: Dr Eliason does not make the decision what unit you are in.

Signature P Cash RN Patricia Cash, RN

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Issued 7/2005, Revised 7/2014

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo, Mason IDOC#: 94691

HU: 16 DATE: 6-24-16

We have taken the following actions in response to your medical request / communication dated 6-23-16

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ____________
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ____________ on ____________ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ____________
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
✓	Other: Per providers panties is not medically indicated.

Signature [signature] RN

CP7177ID
Issued 7/2005, Revised 7/2014

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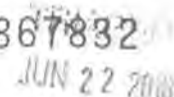

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic Care 0815 NB

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A Edmo Date: 06/25/16

Nature of Complaint/Problem: I need a medical memo so that I may possess, wear, and purchase panties from commissary and/or through laundry. Panties help me tuck my disgusting penis and keeps it from out of sight. I must have a medical memo before I can request or purchase panties.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP NA P ______ R ______ T ______ Wt ______

Assessment: NA

Plan: **Forwarded To:** EC

☒ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☒ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: RN Date: 6-23-16 Time: 0815

CP7166ID

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654595

TRIAGED

HEALTH SERVICES REQUEST
CO-PAY FORM

Chronic Care. 0700 WH

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x______
Rx (med)	x______

Accounting Dept. Use Only	
Visit	$______
Med(s)	$______
Total	$______

Print Name: Adree Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISC I 16B35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: AEdmo Date: 07/07/16

Nature of Complaint/Problem: I need a jockstrap for testicle support and ABD pads (I have a physicians Order for ABD pads).

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See Above-

Objective: BP NA P ______ R ______ T ______ Wt ______

Assessment: NA

Plan: pt left before being seen

MRD Sent

☒ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: 7.7.16 Time: 0700

CP7166ID
Revision 09/2012

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654526

HEALTH SERVICES REQUEST
CO-PAY FORM

THIA[illegible]
JUL 07 2016
0700 NH

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: CAdree Edmo Initials: CAme Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16B35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A CAme Date: 07/07/16

Nature of Complaint/Problem: I need HIV and all sexual related testing. It's been 5yrs. Since last testing.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See Above.

Objective: BP NA P R T Wt

Schedule per Bushnell PA

Assessment: NA

Seen DB

Plan: Forwarded for Provider Review

Daniel Barry, PA-C
JUL 19 2016

☑ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: RN Date: JUL 07 2016 Time: 0700

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654596

JUL 07 2016

HEALTH SERVICES REQUEST CO-PAY FORM

Chronic Care 0700 WH

Medical Dept. Use Only		Accounting Dept. Use Only	
☒ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Adree Edmo Initials: AmE Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 110B35B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A. Edmo Date: 07/07/16

Nature of Complaint/Problem: I need my Spironolactone highered to 150mg BID and re-newed, Spiro exp. 07/06/16.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See Above

Objective: BP NA P ____ R ____ T ____ Wt ____

Assessment: NA

Addressed by Dan Berry 7/6/16 [initials] 7/7/16

Plan: Forwarded for Provider Review

Anthony Bushnell, PA-C

☑ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: LPN Date: JUL 07 2[...] Time: 0700

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Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 16 DATE: 7.7.16

We have taken the following actions in response to your medical request / communication dated 7.7.16

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
X	You missed your appointment for Sickcall on 7.7.16 ☒ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED HSR# 654595
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other:

Signature [signature], LPN

CP7177ID
Issued 7/2005, Revised 7/2014

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885921

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		**Accounting Dept. Use Only**	
☑ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Adree M. Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16 Holding Cell

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A Edmo needed Date: 09/01/16

Nature of Complaint/Problem: STD testing due to sexual assault on 08/21/16.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: -SEE Above-

Objective: BP ______ P ______ R ______ T ______ Wt ______

TRIAGED SEP 02 2016

Assessment: Talked c̄ C/O Moppen and security in 16 Bubble, they confirmed that this has been reported

Plan: Forward to OPC

☑ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☑ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: Devin Jensen, LPN Title: LPN Date: SEP 02 2016 Time: 800

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Revision 09/2012

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868182

CORIZON
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HEALTH SERVICES REQUEST
CO-PAY FORM

MH

0800
9/13/16
TRIAGED
mental Health

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Mason Edmo Initials: ME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 16A 22A (cell restricted)

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: AEdmo Date: 09/12/16

Nature of Complaint/Problem: I want to be placed back onto Remron 7.5mg. my anxiety is high and my mind won't stop racing.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See Above

Objective: BP NA P R T Wt

Assessment: Denies thoughts of suicide or self harm @ this time

Plan: refer TO MH

☑ Inmate Education Sheet Given verbal

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☑ Mental Health ☐ Dental ☐ Optometry

Signature: TCase Title: LPN Date: 9/13/16 Time: 0830

Tammy Case, LPN

Received in Mental Health
DATE: 9/15/16 PC

last seen 7/28
scheduled 10/20
Jane Sup

clinician - email sent 9/19/16

CP7166ID
Revision 09/2012

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U16 cell restriction

MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo, Mason **IDOC#:** 94691

HU: 16 **DATE:** 9/19/16

We have taken the following actions in response to your medical request / communication dated ______________

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ____________
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ____________ on ____________ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ____________
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
✓	Other: Per our new protocol, you will soon be seeing Dr. Alviso, a provider focusing on gender dysphoria.

Signature [signature] David Agler, MD

CP7177ID
Issued 7/2005, Revised 7/2014

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo, Mason IDOC#: 94691

HU: Unit 16 DATE: 9/19/16

We have taken the following actions in response to your medical request / communication dated ______

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other: HSR # 868182 Please talk to the clinician first and have them email me. Thank you.

Signature PCash RN Patricia Cash, RN

CP7177ID
Issued 7/2005. Revised 7/2014

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HEALTH SERVICES REQUEST
CO-PAY FORM

878816
TRIAGED
OCT 05 2016
0806

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x 1

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 15A50A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 10/05/16

Nature of Complaint/Problem: I need a eye exam; glasses. I've not had an eye exam in 3 yrs, c/o broke eyeglasses in last property roll-up.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: see above

Objective: BP ____ P Ø R ____ T ____ Wt ____

Assessment:

Forwarded To: OPTO

Date: 10/25/16 Time: 0820
Seen by Optometrist Glasses Ordered
☒ Yes ☐ No
Sign: K Larsen
Kelly Larsen, LPN

Plan:

☒ Inmate Education ~~Sheet~~ verbal Given

☒ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☒ Optometry

Signature: [signature] Title: RN Date: OCT 0 5 2016 Time: 0806

McKenzie Jimenez, RN

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

878815
TRIAGED
OCT 05 2016 0805
Chronic Care

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x_______
Rx (med)	x_______

Accounting Dept. Use Only	
Visit	$_______
Med(s)	$_______
Total	$_______

Print Name: Adree Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 15A 58A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Adree M. Edmo Date: 10/05/16

Nature of Complaint/Problem: I need a med. size jockstrap; I have a current physician's order.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: see above

NO SHOW OPC
Date OCT 14 2016 Sign
Jan Drake, LPN

Objective: BP ______ P ∅ R ______ T ______ Wt ______

Assessment: chart review: jock strap/support ordered: 4/06/15 x 180 days expired: 10/3/15

Plan:

☒ Inmate Education ~~Sheet~~ verbal Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: RN Date: OCT 0 5 2016 Time: 0805

McKenzie Jimenez, RN

CP7166ID
Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 5 DATE: 10/14/16

We have taken the following actions in response to your medical request / communication dated 10/5/16

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
X	You missed your appointment for OPC on 10/14/16 ☒ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED RE Athletic supporter
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
	Other:

Jan Drake, LPN
Signature [signature]

CP7177ID
Issued 7/2005. Revised 7/2014

Promote a culture of safety

HEALTH SERVICES REQUEST
CO-PAY FORM

878894
TRIAGED
OCT 24 2016

Chronic Care 0807

Medical Dept. Use Only	
☒ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Edmo   Initials: AME   Inmate ID: 94691

Date of Birth: [redacted]   Housing Location: ISCI ISA58B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature]   Date: 10/24/2016

Nature of Complaint/Problem: I need a med size jockstrap - I have a current order in my file. * this is my 3rd HSR *

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file   Yellow – DOC   Pink-Accounting   Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Daniel Dellwo, PA-C
NOV 02 2016

Objective: BP ______ P ∅ R ______ T ______ Wt ______

Assessment: **Renewal Request:** ~~duplicate HSR, pt already being evaluated~~ ~~No discuss issue~~ no show

Plan:

Forwarded To: OPC

- pt needs to be rescheduled from no show on 10/14/16

☒ Inmate Education ~~Sheet~~ Given (verbal)

☒ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician (OPC) ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature]   Title: RN   Date: OCT 24 2016   Time: 0807

McKenzie Jimenez, RN

CP7166ID
Revision 09/2012

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878893
TRIAGED
OCT 24 2016
0807

HEALTH SERVICES REQUEST CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Adree Edino Initials: AmEe Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI ~~888~~ ISA58B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 10/24/2016

Nature of Complaint/Problem: I have hemmorhoids and need some cream & witch's Hazes sanitory wipes!

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ______ P Ø R ______ T ______ Wt ______

Assessment:

Renewal Request: no current orders; pt must be assessed • MRD sent •

Plan:

☒ Inmate Education ~~Sheet~~ verbal Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: RN Date: OCT 24 2016 Time: 0807

McKenzie Jimenez, RN

CP7166ID
Revision 09/2012

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MEDICAL REQUEST DISPOSITION / RESPONSE

INMATE NAME: Edmo IDOC#: 94691

HU: 15 DATE: 10-25-16

We have taken the following actions in response to your medical request / communication dated 10-24-16

	Your request has been denied.
	Medication / Prescription has been ordered for you. Come to pill call on ______
	You are scheduled to see the ☐ NP/PA ☐ PHYSICIAN ☐ CLINICIAN ☐ DIRECTOR OF NURSING ☐ HS ADMINISTRATOR ☐ SPECIALIST
	You missed your appointment for ______ on ______ ☐ SUBMIT A NEW HEALTH SERVICE REQUEST ☐ YOU ARE RESCHEDULED
	Medications have arrived for you. Pick them up during pill call on ______
	You are scheduled. Watch the call-out. *DO NOT SUBMIT DUPLICATE KITES.*
	You are scheduled for ☐ LAB TESTS ☐ X-RAYS ☐ MINOR SURGERY ☐ OUTPATIENT CLINIC ☐ DENTAL ☐ OPTOMETRY ☐ CHRONIC CARE CLINIC
	Your request has been forwarded to the psychology staff.
	A requisition is being processed for your request.
	We are researching your problem and will keep you advised.
	Lab results show no significant abnormalities.
	X-ray results show no significant abnormalities.
X	Other: you must first be seen and assessed @ sick call before new orders for hemorrhoids can be written. Thank you!

Signature [signature] RN

CP7177ID
Issued 7/2005, Revised 7/2014

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908931

TRIAGED 1/12/17 0900

HEALTH SERVICES REQUEST
CO-PAY FORM

MH

Mental Health

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Edmo Initials: Ame Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI-08-42

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: Edmo Date: 01/12/2017

Nature of Complaint/Problem: I seen Dr. Stoddard on 01/04/17, and he offered to put me on ~~[illegible]~~ Remeron; I want to be put on those meds. ASAP

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See Above

Objective: BP N/A P R T Wt

Assessment: Denies thoughts of Suicide or self harm @ this time
Effexor XR - current med

Plan: Refer to MH

☑ Inmate Education Sheet Given Verbal

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☑ Mental Health ☐ Dental ☐ Optometry

Signature: Tcase Title: Tammy Case, LPN Date: 1/12/17 Time: 0950

Received in Mental Health
DATE: 1/17/17 PC

seen 1/3/17
due 3/22
Stoddart

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

915205
TRIAGED
1/18/17
0900

OPC

Medical Dept. Use Only	
☑ Inmate Initiated Visit	
OTC (med)	x
Rx (med)	x

Accounting Dept. Use Only	
Visit	$
Med(s)	$
Total	$

Print Name: Adree Edmo Initials: AMME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI B6P42A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: [signature] Date: 01/18/2017

Nature of Complaint/Problem: I have 2 Large lumps on the R/L sides of my Lower back next to my spine that are sore.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP ______ P ______ R ______ T ______ Wt ______

noted Refr to NP

Assessment:

Plan:

Seen in OPC 2/1/17 Tipper Povar, NP-C

☑ Inmate Education ~~Sheet Given~~ Verbal

☑ Use of Nursing Protocols Refer to: ☑ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: Tammy Case, LPN Date: 1/18/17 Time: 1000

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Revision 09/2012

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HEALTH SERVICES REQUEST CO-PAY FORM

TRIAGED 933968
APR 04 2017
DY 0809

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Adree Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 09C 71A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A Edmo Date: 04/04/2017

Nature of Complaint/Problem: need additional pair of glasses: IDOC damaged 1st pair in property Roll up on 01/09/2017.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ___ P ___ R Ø T ___ Wt ___

Assessment:

...warded To: Opto

Plan:

☒ Inmate Education Sheet Given verbal

☒ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☒ Optometry

Signature: [signature] Title: LPN Date: 4/4/17 Time: 0809

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x_______
Rx (med)	x_______

Accounting Dept. Use Only	
Visit	$_______
Med(s)	$_______
Total	$_______

Print Name: Adree Edmo Initials: AMEE Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 09C77A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A. Edmo Date: 04/04/2017

Nature of Complaint/Problem: need to be fitted for new top dentures and bottom partial and/or current top denture fixed, front tooth broke & gone, and bottom partial lost.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ______ P ______ R Ø T ______ Wt ______

Assessment:

Forwarded To: Dental

Plan:

☒ Inmate Education verbal Given

☒ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☒ Dental ☐ Optometry

Signature: [signature] Title: RN Date: APR 4 2017 Time: 0910

McKenzie Jimenez, RN

CP7166ID
Revision 09/2012

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HEALTH SERVICES REQUEST CO-PAY FORM

924779
TRIAGED
APR 04 2017
DY 0809

Medical Dept. Use Only	
☐ Inmate Initiated Visit	
OTC (med)	x______
Rx (med)	x______

Accounting Dept. Use Only	
Visit	$______
Med(s)	$______
Total	$______

Print Name: Adree Edmo Initials: AMEE Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI UGC 77A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A Edmo Date: 04/04/2017

Nature of Complaint/Problem: need medical for bra re-newed. I am a GD offender.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: see above

Objective: BP ______ P ______ R Ø T ______ Wt ______

Assessment: bra memo ordered: 2/2/16 - 2/2/17

Plan:

☒ Inmate Education ~~Sheet~~ verbal Given

☐ Use of Nursing Protocols ~~Refer~~ to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: [signature] Title: RN Date: APR 04 2017 Time: 0809

McKenzie Jimenez, RN

CP7166ID
Revision 09/2012

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923788

DY Triaged 0907 4/9/17

HEALTH SERVICES REQUEST CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$
OTC (med)	x	Med(s)	$
Rx (med)	x	Total	$

Print Name: Adree Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ISCI 09C T7A

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A Edmo Date: 04/09/2017

Nature of Complaint/Problem: I need a HIV, Hep A, B, C test. Was sexually active in Jan. 2017 Very Concerned.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

Subjective: See above

Objective: BP ____ P Ø R ____ T ____ Wt ____

Assessment:

Forwarded To: OPC

Plan:

☒ Inmate Education Sheet Given verbal

☒ Use of Nursing Protocols Refer to: ☒ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: Dom [signature] Title: LPN Date: 4/9/17 Time: 0907

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Revision 09/2012

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Nursing Encounter Tool
Abrasions and Lacerations

HSR*

Facility Name ISCI/SICK CALL	Location Seen Unit 15	Date seen 10/29/87	Time Seen O AM ⊘ PM 1830
Patient's Name Last Edmo	First Mason	MI	ID Number 94691	Birth date [redacted]

Medication Allergies ⊘ N O Y If Yes List:
Chronic Care Clinic(s) O N ⊘ Y GID
Last seen in Sick Call: __/__/__ ☐ N/A
☐ Seizures __/__/__ ☐ Asthma __/__/__ ☐ CAD __/__/__ ☐ Dyslipidemia __/__/__
☐ DM __/__/__ ☐ COPD __/__/__ ☐ HTN __/__/__ ☐ Other __/__/__

SUBJECTIVE

Chief complaint with onset: medical emergency called to unit d/t pt cutting himself. pt
History of chief complaint: was attempting to remove scrotum c̄ razor blade
Location of injury: Ⓡ posterior side of scrotum Date of injury: 9/29/15
Describe laceration to Ⓡ posterior side of scrotum
Injury sustained in altercation with custody staff or other inmate: ⊘ N O Y: (May require custody staff notification.)
Exchange of body fluids ⊘ N O Y: Describe
Loss of sensation or movement ⊘ N O Y: Describe
Other injuries reported ⊘ N O Y: Describe

New medications or change in last 30 days ⊘ N O Y: List: pt GID
Past medical history: ☐ Diabetes ☐ PVD / impaired circulation ☐ Anticoagulation meds ☐ MRSA ☐ HIV ☐ HCV
Tetanus booster > 5 years: O N O Y ⊘ Unknown

OBJECTIVE

Response AVPU (Choose one) ⊘ Awake O Responds to Voice O Responds to Pain O Unresponsive

General appearance: Acute distress O N ⊘ Y: Describe pt shaken up, covered in blood, medical Ferro c̄ Hoffman

Vital Signs: T 97.9 P 109 RR 18 BP 133/85 Wt. 200 reported Pulse Ox 98 RA %
Skin: Cool ⊘ N O Y O Clammy ⊘ N O Y Pale ⊘ N O Y
Wound location: Ⓡ posterior side of scrotum Approximate wound size: 1.5cm
Approximate depth of wound: ⊘ Superficial ~~⊘ Other~~
Active bleeding: O N ⊘ Y: Describe bleeding controlled c̄ pressure
⊘ Bleeding controlled O Bleeding uncontrolled
Wound Description. ☐ Abrasion ☐ Avulsion ☑ Laceration ☐ Puncture
O Uncomplicated - Clean without foreign body or signs of infection
O Uncomplicated - Superficial debris, dirt, or crusting requiring wound cleansing
⊘ Complicated: Describe area irrigated c̄ 1500cc NS, steri-strips applied, dressing placed.
Embedded foreign material: ⊘ N O Y: Describe

Signs of infection: ⊘ N O Y: Describe

Additional examination: pt reported that he "hates it." referring to his penis/scrotum. "When I saw how much blood, [illegible]" pt placed on suicide watch in Unit 16.

K Larsen	Kelly Larsen, LPN	LPN
Nurse's Signature	Print/Stamp Name	Title

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Promote a culture of safety

Nursing Encounter Tool
Abrasions and Lacerations

Patient's Name	Last Edmo	First Mason	MI	ID Number 94691

☑ **Emergent intervention not required.**
Notify practitioner after EMS activation due to
Describe: ____

Practitioner notified: ____ Time: ____ ○ AM ○ PM

○ **Emergent intervention required due to:**
EMS process activated Time: ____ ○ AM ○ PM
EMS Arrival Time: ____ ○ AM ○ PM
EMS Transport Time: ____ ○ AM ○ PM
☐ Other: ____

○ **Urgent intervention not required.**
Practitioner contact required due to: (check all that apply)
☐ Vital signs: ____
☐ Diabetes or impaired circulation
☐ Unimproved or worsening symptoms
☐ Last tetanus booster unknown or >5 years (non-superficial)
☐ Avulsion ☐ Uncontrolled bleeding
☐ Loss of sensation/movement
☐ Exchange of body fluids ☐ Signs of infection
☐ Embedded foreign material
☐ Eye/mouth/ perineum,/joint involvement
☑ Other: tetanus shot unknown

○ Seen by Practitioner ☑ Contacted practitioner
Name: J. Mitchell PA

Time: ____ ○ AM ○ PM

☑ **Urgent intervention required due to:**
☑ See physician orders

Disposition:
☐ Same day practitioner visit/consult
☐ Monitor: ____
☐ Admit to: ____
☑ Other: pt placed on Suicide watch in 16
☐ Sick call follow up ○ Practitioner ○ Nurse
☐ Transport via: ____ to ____

Time: ____ ○ AM ○ PM

○ **Routine intervention**

Disposition:
Medical referral required for: (check all that apply)
☐ Recurrent complaint(2 x 72 hours) without urgent findings
☐ Medication Review
☐ Other: ____

○ Practitioner referral completed
○ Chart designated for practitioner review
○ No Medical Referral Required

Interventions: (check all that apply)
☐ Bleeding stopped with pressure
☐ Wound cleansed with mild antiseptic/soap & water
☐ Foreign materials removed
☐ Topical ointment applied
☐ Sutureless product used
☐ Dressing applied ____ /issued # ____
OTC medication given per guidelines ○ N ○ Y
☐ Medication: ____ ☐ KOP
☐ Other: ____

Contact a practitioner or nursing supervisor if you have any concerns about the status of the patient.

Patient Education	Follow Up / Follow Through
☑ Patient educated to contact medical if symptoms develop or worsen ☑ ~~Written~~ Information (verbal) provided ☑ The patient demonstrates an understanding of self-care, symptoms to report and when to return for follow-up care.	Nurse follow up scheduled ○ N ○ Y Custody notified of special needs ○ N ○ Y

K Larsen	Kelly Larsen, LPN	LPN
Nurse's Signature	Print/Stamp Name	Title

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CORIZON

Nursing Encounter Tool
Back Pain

ISR # 718664

Facility Name: ISCI/SICK CALL | Location Seen | Date seen 12/22/2014 | Time Seen 0943 ☒ AM ○ PM

Patient's Name: Last Edmo | First Adree | MI | ID Number 94691 | Birth date [redacted]

Medication Allergies ☒ N ○ Y If Yes List:

Chronic Care Clinic(s) ○ N ○ Y | Last seen in Sick Call: __/__/__ ☐ N/A

☐ Seizures __/__/__ ☐ Asthma __/__/__ ☐ CAD __/__/__ ☐ Dyslipidemia __/__/__

☐ DM __/__/__ ☐ COPD __/__/__ ☐ HTN __/__/__ ☐ Other __/__/__

SUBJECTIVE

Chief complaint with onset: back pain kicked in back (2010) Did physical therapy 6 weeks discharged 2 weeks ago told to come back if not successful

History of chief complaint: Hx 3-4 yrs (2011)

Recent injury ☒ N ○ Y: Describe ___ Is now 7/10 At worst 8-9/10

Location: ___ Radiation ○ N ☒ Y: Describe comes up on left shoulder

Associated symptoms:
☐ Urinary incontinence ☐ Fecal incontinence ☐ Nausea/vomiting ☐ Painful urination
☐ Blood in urine ☐ Abdominal pain ☐ Fever ☐ Other:
☐ Numbness: ○ Chronic ○ Acute ☐ Weakness: ○ Chronic ○ Acute ☒ None

New medications or change in last 30 days ☒ N ○ Y: List: Amatriptaline (not working)

Past medical history: ☐ IV Drug use
☐ Diabetes ☐ Renal disease ☐ Past back surgeries ☐ Recent infections: pt denies

OBJECTIVE

General appearance: Acute distress ☒ N ○ Y: Describe calm, cooperative, alert & oriented

Vital Signs: T 97.5 P 69 RR 12 BP 136/76 Wt. 200 Pulse Ox 97 % ☒ Room air ○ O2 LPM

Skin: Cool ☒ N ○ Y Clammy ☒ N ○ Y Pale ☒ N ○ Y

Conjunctiva pale ☒ N ○ Y Sclera icteric ☒ N ○ Y

Tender to touch ☒ N ○ Y (mark on figure to right)

Hand grip equal and strong ☒ Y ○ N: Describe

Straight leg raise equal and strong: ☒ Y ○ N: Describe

Posture erect: ☒ Y ○ N: Describe

Gait symmetrical: ☒ Y ○ N: Describe

FSBG ___ (if diabetes) N/A

uHCG ○ (+) ○ (-) ○ N/A: ☐ Total hysterectomy (uterus and both ovaries) or ☐ Post-menopausal

Dipstick U/A ○ Normal ○ Abnormal (see labs) ☒ Not done : Explain: hx

☒ Additional examination: No s/s infection

Nurse's Signature	Print/Stamp Name	Title
[signature]	Michael Grace, RN	RN

NA6225

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CORIZON

Nursing Encounter Tool

Back Pain

Patient's Name	Last Edmo	First Adrae	MI	ID Number 94691

☒ Emergent intervention not required.

Notify practitioner after EMS activation due to

Describe: ______________________

○ Emergent intervention required due to:

EMS process activated Time:_____ ○ AM ○ PM

EMS Arrival Time:_____ ○ AM ○ PM

EMS Transport Time:_____ ○ AM ○ PM

Consider: ☐ O_2 ☐ AED ☐ CPR

☐ Other: ______________________

Practitioner notified: ______________________ Time:_____ ○ AM ○ PM

☒ Urgent intervention not required

Practitioner contact required due to: (check all that apply)

☐ Vital signs: ______________________

☐ Recent infection

☐ Unimproved or worsening symptoms

☐ Urinary symptoms ☐ Radiation

☐ Abdominal pain ☐ Back pain with fever

☐ Incontinence ☐ Positive straight leg raise

☐ Numbness/weakness (acute)

☐ Other: ______________________

○ Seen by practitioner ○ Contacted practitioner.

Name: ______________________

Time:_____ ○ AM ○ PM

○ Urgent intervention required due to:

☐ See physician orders

Disposition:

☐ Same day practitioner visit/consult

☐ Monitor: ______________________

☐ Admit to: ______________________

☐ Other:

☐ Sick call follow up ○ Practitioner ○ Nurse

☐ Transport via: ______________ to ______________

Time:_____ ○ AM ○ PM

☒ Routine intervention

Disposition:

Medical referral required for: (check all that apply)

☐ Recurrent complaint(2 x 72 hours) without urgent findings

☐ Medication review

☐ Other: ______________________

☒ Practitioner referral completed

○ Chart designated for practitioner review

○ No Medical Referral Required

Interventions: (check all that apply)

☐ Cold compress – acute injury

☐ Warm compress

OTC medication given per guidelines ☒ N ○ Y

☐ Medication: pt declined ☐ KOP

☐ Other: ______________________

States tylenol & Ibn doesn't help (declined meds)

Contact a practitioner or nursing supervisor if you have any concerns about the status of the patient.

Patient Education	Follow Up / Follow Through
☒ Patient educated to contact medical if symptoms develop or worsen	Nurse follow up scheduled ○ N ○ Y
☒ Written information provided Verbal	Custody notified of special needs ○ N
☒ The patient demonstrates an understanding of self care, symptoms to report and when to return for follow-up care	

[signature]	Michael Grace, RN	RN
Nurse's Signature	Print/Stamp Name	Title

CORIZON

Nursing Encounter Tool
Skin / Nail Problems

ISC 726864

Facility Name ISCI/SICK CALL	Location Seen	Date seen 1 / 4 / 15	Time Seen ☒ AM ☐ PM
Patient's Name Last Edwo	First	MI	ID Number 94691	Birth date [redacted]

Medication Allergies ☒ N ○ Y If Yes List: Denies

Chronic Care Clinic(s) ☒ N ☐ Y GID

Last seen in Sick Call: __/__/__ ☐ N/A

☐ Seizures __/__/__ ☐ Asthma __/__/__ ☐ CAD __/__/__ ☐ Dyslipidemia __/__/__

☐ DM __/__/__ ☐ COPD __/__/__ ☐ HTN __/__/__ ☐ Other __/__/__

SUBJECTIVE

Chief complaint with onset: Dry Patches & Itching on Skin

History of chief complaint: 1+ wk

Associated symptoms: ☐ Fever ☒ Itching ☐ Burning ☐ Tingling ☐ Malaise Pain ☒ N ○ Y: Is now ___/10 At worst ___/10

☐ None ☐ Other:

Recent exposure to allergens/irritants ☒ N ○ Y Describe Denies

What makes it better? Lotion A&D cream What makes it worse?

Prior occurrence ○ N ☒ Y: Describe: Prior treatment ○ N ☒ Y: Describe: HC CR 1% Lotion A&D

Recent vaccination ☒ N ○ Y: Describe: Denies

New medications or change in last 30 days ○ N ○ Y: List: Pt Denies Recent A's to Rx meds

Past medical history: ☐ Diabetes ☐ Oral steroid use ☐ HIV Frequency of showering: QDay

☐ Other:

General appearance: A Calm Alert Oriented

Last meal 0730 Breakfast

Vital Signs: T 98.0 P 85 RR 20 BP 135/80 FSBG 104 (If diabetes) Wt. 212# Pulse Ox 97 RA %

Skin: Cool ☒ N ○ Y Clammy ☒ N ○ Y Pale ☒ N ○ Y Nail involvement ☒ N ○ Y:

Location / Describe: (L) Thigh 1 scratch "Pt states he scratched due to itching"

Appearance: ☐ Acne ☐ Weeping ☐ Blisters ☐ Redness ☐ Purulence

☐ Hives ☐ Inflammation ☐ Scaling ☐ Swelling ☐ Dandruff

Skin growth ☒ N ○ Y: Visible Dry Patches Thigh & lower legs Bilat

Diameter Elevation

Exam/assessment done
Witness Thomas Hall, LPN

Consistent color ☒ Y ○ N Describe:

Irregular borders ☒ N ○ Y: Describe

☒ Additional examination: No S/Sx Infection (L) Red 1 scratch on thigh Dry Patches Bilat lower leg

[signature], LPN	Ashley Nisbet	
Nurse's Signature	Print/Stamp Name	Title

6213

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Nursing Encounter Tool
Skin/Nail Problems

HSR# 726864

Patient's Name	Last Edmo	First	MI	ID Number 94691

☑ Emergent intervention not required. ○ Emergent Intervention Required due to:

Notify practitioner after EMS activation due to
Describe: ______

EMS process activated Time:____ ○ AM ○ PM
EMS arrival Time:____ ○ AM ○ PM
EMS Transport Time:____ ○ AM ○ PM

☐ Other: ______

○ Practitioner notified: Time: ○ AM ○ PM

☑ Urgent intervention not required. ○ Urgent Intervention Required due to:

Practitioner contact required due to: (check all that apply)
☐ Vital signs: ______
☐ New medication
☐ Unimproved or worsening symptoms
☐ Hives
☐ Signs of infection
☐ Other: ______

○ Seen by practitioner ○ Contacted practitioner

Name: ______

Time:____ ○ AM ○ PM

☐ See physician orders
Disposition:
☐ Same day practitioner visit/consult
☐ Monitor: ______
☐ Admit to: ______
☐ Other: ______
☐ Sick call follow up ○ Practitioner ○ Nurse
☐ Transport via: ______ to ______
Time:____ ○ AM ○ PM

☑ Routine intervention

Disposition:
Medical referral required for: (check all that apply)
☐ Recurrent complaint(2 x 72 hours) without urgent findings
☐ Medication review
☐ Other: ______
☑ Practitioner referral completed OPC
○ Chart designated for practitioner review
○ No Medical Referral Required

Interventions: (check all that apply)
OTC medication given per guidelines ○ N ☑ Y
☐ Medication: Bacitracin c̄ HcCRl% on Itching Areas ☑ KOP
A&D on Dry
☐ Other: ______

RTC if Redness Warmth Swelling or Rash Develops

Contact a practitioner or nursing supervisor if you have any concerns about the status of the patient.

Patient Education	Follow Up / Follow Through
☑ Patient educated to contact medical if symptoms develop or worsen ☑ ~~Written~~ information provided Verbal ☑ The patient demonstrates an understanding of self-care, symptoms to report and when to return for follow-up care	Nurse follow up scheduled ☑ N ○ Y Custody notified of special needs ☑ N ○ Y

Nurse Signature: [signature], LPN | Ashley Nisbey, LPN | Date:

Nursing Encounter Tool
Upper Respiratory Symptoms

ISR # 731379

Facility Name ISCI/SICK CALL	Location Seen	Date seen 2/23/15	Time Seen 0830 AM
Patient's Name Last Edmo	First A	MI	ID Number 94691	Birth date [redacted]
Medication Allergies N If Yes List: denies			
Chronic Care Clinic(s) O N O Y			Last seen in Sick Call: ___/___/___ ☐ N/A
☐ Seizures ___/___/___	☐ Asthma ___/___/___	☐ CAD ___/___/___	☐ Dyslipidemia ___/___/___
☐ DM ___/___/___	☐ COPD ___/___/___	☐ HTN ___/___/___	☐ Other ___ ___/___/___

SUBJECTIVE

Chief complaint with onset: cold symptoms

History of chief complaint: 3 days

Last documented TB test date: 10 2014 **result:** negative

Associated symptoms: ☒ Nasal congestion ☒ Sore throat ☐ Unable to swallow ☒ Earache ☒ Headache

Shortness of breath O N O Y ☒ Cough: Productive ☒ N O Y: ___

Fever ☒ N O Y Weight Loss ☒ N O Y Night Sweats ☒ N O Y Hemoptysis (coughing blood) ☒ N O Y

If yes to hemoptysis or any 2 (fever, weight loss, night sweats) place face mask or respiratory isolation

☐ Other: ___
☐ None

New medications or change in last 30 days ☒ N O Y: List: Just taking ASA

Past medical history:
☐ Seasonal allergies ☐ COPD ☐ ACE inhibitor use ☐ Smoking
☐ Cardiac/CHF ☐ HIV ☐ Asthma ☐ Other: denies

OBJECTIVE

General appearance: Acute distress ☒ N O Y: Describe calm, cooperative, alert & oriented

Vital Signs: T 97.5 P 85 RR 12 BP 125/76 Wt. 207 Pulse Ox 96 % ☒ Room air O O_2 LPM ___

Skin: Cool ☒ N O Y Clammy ☒ N O Y Pale ☒ N O Y

Eyes: ☒ Clear O Watery O Red-injected Drainage ☒ N O Y: Describe ___
Conjunctiva pale ☒ N O Y Sclera icteric ☒ N O Y

Ears: Drainage Left ☒ N O Y: ___ Right ☒ N O Y: ___
Otoscope available O N ☒ Y Tympanic membrane seen
Left O N ☒ Y: Describe ___ Right O N ☒ Y: Describe ___

Nose: Congestion O N ☒ Y Drainage O N ☒ Y: Describe clear, runny snot

Throat: O Unremarkable ☒ Remarkable for:: ☒ Redness ☐ Enlarged tonsils ☐ Swelling ☐ Exudates
slight / irritation

Neck: Enlarged lymph nodes ☒ N O Y: Describe ___

Supple ☒ Y O N: Describe ___

Lung sounds: Right: ☒ Clear ☐ Wheezing ☐ Diminished Lung sounds: Left: ☒ Clear ☐ Wheezing ☐ Diminished

☐ Additional examination: ___

[signature]	Michael Grace, RN	RN
Nurse's Signature	Print/Stamp Name	Title

NA6228
Issued 1/15/2013

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CORIZON

Nursing Encounter Tool
Upper Respiratory Symptoms

Patient's Name	Last Edmo	First	MI	ID Number 94691

Ø **Emergent intervention not required.**
Notify practitioner after EMS activation due to
Describe: ____

○ **Emergent intervention required due to:**
EMS process activated Time:____ ○ AM ○ PM
EMS Arrival Time:____ ○ AM ○ PM
EMS Transport Time:____ ○ AM ○ PM
Consider: ☐ O_2
☐ Other:____

Practitioner notified:____ Time:____ ○ AM ○ PM

Ø **Urgent intervention not required.**
Practitioner contact required due to: (check all that apply)
☐ Vital signs:____
☐ Immunocompromised
☐ Chronic lung disease
☐ Unimproved or worsening symptoms
☐ Positive TB screen ☐ Purulent drainage or exudates
☐ Unable to swallow ☐ Shortness of breath
☐ Wheezing or diminished lung sounds
☐ Foreign object in ear
☐ Other:____
○ Seen by practitioner ○ Contacted practitioner
Name:____
Time:____ ○ AM ○ PM

○ **Urgent intervention required due to:**
☐ **See physician orders**
Disposition:
☐ Same day practitioner visit/consult
☐ Isolation / rule out TB
☐ Monitor:____
☐ Admit to:____
☐ Other:____
☐ Sick call follow up: ○ Practitioner ○ Nurse
☐ Transport via: ____ to____
Time:____ ○ AM ○ PM

Ø **Routine Intervention**

Disposition:
Medical referral required for: (check all that apply)
☐ Recurrent complaint(2 x 72 hours) without urgent findings
☐ Medication review
☐ Other:____
○ Practitioner referral completed
○ Chart designated for practitioner [illegible]
Ø No Medical Referral Required

Interventions: (check all that apply)
☐ warm compress
☑ Advise rest and increase oral fluid intake
☑ Warm salt water gargles PRN
OTC medication given per guidelines ○ N Ø Y
☑ Medication: tussin x ii, APAP x ii, chlorphen x i, nasal spray x i ☑ KOP
☑ Other: RTC if symptoms persist > 14 days

Contact a practitioner or nursing supervisor if you have any concerns about the status of the patient.

Patient Education	Follow Up / Follow Through
✓ Patient educated to contact medical if symptoms develop or worsen ~~Written~~ information provided Verbal The patient demonstrates an understanding of self-care, symptoms to report and when to return for follow-up care.	Nurse follow up scheduled Ø N ○ Y Custody notified of special needs Ø N ○ Y

[signature]	Michael Grace, RN	RN
Nurse's Signature	Print/Stamp Name	Title

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Nursing Encounter Tool
Mental Health Complaint

Demographic/Vital Signs

Facility Name: ISCI/SICK CALL unit 8			Date Seen: 11-22-15		Time Seen: 0900
Patient Name: Last Edmo		First Mason	MI	ID # 94691	DOB: [redacted] Age: 28
Vital Signs: *Call Practitioner	*T>100 T: 98.0	*P>100 P: 102 R: 20	*SBP<100 BP: 120/75	Pulse Ox: 98 % ☒ RA ☐ O2: /lpm	Wt: 199 ☐ Actual ☒ Reported
Allergies:					
Chronic care clinic: ☐ Y ☐ N What Clinic(s):					

Subjective

Chief Complaint: ↑ Depression

Onset Date: about a week

Have you had this problem before: ☒ Y ☐ N

Describe: on Anti-depressants for this problems

Associated Factors:
- ☐ Suicidal thoughts (initiate suicide watch)
- ☐ Aggressive behavior
- ☐ Homicidal thoughts
- ☐ Difficulty with mood- patient stated c/o with mood
- ☐ Difficulty with thoughts
- ☒ Difficulty sleeping
- ☐ Auditory hallucinations
- ☐ Visual hallucinations
- ☐ Difficulty with memory
- ☐ Other: Weak, headaches

Precipitating Factors:
- ☐ Recent court hearing
- ☐ Bad news
- ☐ Parole denial
- ☐ Death in the family
- ☐ Recent conduct report

Current Medications:
- ☐ Psychotropics

Specify: ____

- ☐ Taking regularly
- ☐ New medication within past 30 days?

What Medication? ____

Pertinent Medical Conditions:
- ☒ Prior mental health treatment

Describe: on mental health meds currently

Objective

☐ Injury: Describe: ____

Location: ____

Oriented to:
- ☒ Person
- ☒ Place
- ☒ Time

Behaviors:
- ☐ Combative
- ☐ Withdrawn
- ☐ Aggressive
- ☐ Anxious

Describe: ____

Activity:
- ☐ Hyperactive
- ☐ Hypoactive
- ☐ Pacing
- ☐ Making eye contact
- ☐ Rapid speech

Mood:
- ☐ Unremarkable
- ☒ Depressed
- ☐ Irritable
- ☐ Euphoric
- ☐ Labile
- ☐ Flat affect
- ☐ Other: ____

Psychomotor:
☐ Dyskinesia ☐ Tremors ☐ Rigid

Tests:
☐ Fingerstick result ____ (Diabetics)

Thought Process:
- ☒ Logical
- ☐ Goal directed
- ☐ Rapid, pressured
- ☐ Discouraged

Thought Content:
- ☒ Normal
- ☐ Unremarkable
- ☐ Paranoid
- ☐ Delusional
- ☐ Auditory hallucinations
- ☐ Command auditory hallucinations

Memory:
- ☐ Recent
- ☐ Remote
- ☐ Recall 3/3 (give them 3 words to remember and in 5 minutes go back and ask them ro repeat those 3 words)
- ☐ Concentration

Suicidal Ideation:
- ☐ Thoughts
- ☐ Intent
- ☐ Means
- ☐ Plan

Comments:

Nurse Signature	Print/stamp
[signature]	Clyde Young, LPN

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Nursing Encounter Tool
Mental Health Complaint

Patient	Last Edmo	First Mason	ID Number 94691

☐ Emergent Intervention

Practitioner notified: ____________ Time: ________

If CPR or AED is initiated use Emergency Response Form

EMS process activated Time: ________
EMS arrival Time: ________
EMS transport Time: ________
Facility transported to: ____________
☐ Other: ____________

COMMENTS:

☐ Urgent Intervention-Contact Practitioner

Practitioner contact required due to: (check all that apply)

☐ Abnormal vital signs (*Rule of 100s*)T>100, P>100, SBP<100
☐ Delusional
☐ Altered mental status
☐ Auditory or visual hallucinations
☐ Rigid or tremors
☐ Current suicidal ideation (initiate suicide watch) *

*Must contact Mental Health

☐ Abnormal fingerstick, Diabetic <70 or>240
☐ Other: ____________

Reviewed with practitioner: ☐ MAR ☐Medical record
☐ Seen by practitioner Name: ____________ Time: ________
☐ Contacted practitioner Name: ____________ Time: ________
☐ Contacted in Mental Health Name: ____________ Time: ________

Practitioner Orders Received ☐ Y ☐ N
☐ Read back practitioners orders

Disposition ☐ Return to unit ☐ Monitor/Observation ☐ Admit to infirmary ☐ Other

COMMENTS/ORDERS:

☒ Nursing Intervention

CONTINUITY OF CARE

☐ Nurse follow up scheduled
☒ Referral to Mental Health
☐ Referral to practitioner for current presenting complaint
☐ Referral to practitioner for multiple visits for same complaint
☐ Referred to practitioner for evaluation of enrollment in CCC
☐ Custody notified of special needs
☐ No further follow up needed at this time

MEDICATION

☐ O_2 @ ____ LPM via ____________
☐ KOP
☐ Medication administered
☐ Medication noted on MAR

PATIENT EDUCATION

☒ Patient educated to contact medical if symptoms develop or worsen
☐ Written information provided ☒ Verbal information given
☒ The patient demonstrates an understanding of self-care, symptoms to report and when to return for follow-up care

COMMENTS:

[signature]	Clyde Young, LPN	11/22/15 0900
Nurse signature	Print/stamp	Date/time

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Nursing Encounter Tool
Sleep Disturbance

4 SR # 811370

Facility Name ISCI/SICK CALL	Location Seen unit 8	Date seen 1 / 12 / 16	Time Seen 0930 ● AM ○ PM
Patient's Name Last Edmo	First Mason	MI	ID Number 94691	Birth date [redacted]

Medication Allergies ○ N ○ Y If Yes List:

Chronic Care Clinic(s) ○ N ○ Y — Last seen in Sick Call: __/__/__ ☐ N/A

☐ Seizures __/__/__	☐ Asthma __/__/__	☐ CAD __/__/__	☐ Dyslipidemia __/__/__
☐ DM __/__/__	☐ COPD __/__/__	☐ HTN __/__/__	☐ Other __/__/__

SUBJECTIVE

Chief complaint with onset: can't sleep.

History of chief complaint: Has been having trouble for a while now. Dr. Eliason offered Remeron and now he would like it.

How long does it take to fall asleep: 4
How long do you stay asleep: 2 hours
Do you nap during the day ○ N ● Y
Do you snore or have difficulty breathing at night ● N ○ Y
Do you wake up sweating or coughing ● N ○ Y
Do you snack at night ● N ○ Y
How often do you drink coffee or soft drinks:
Recent pattern of weight gain ● N ○ Y or loss ● N ○ Y
Recent change in daily schedule or activity level ○ N ● Y
Are you awakened by pain ● N ○ Y
Recently received bad news ● N ○ Y:

Associated symptoms: Racing thoughts. Can't turn off his thoughts.

Medications: ☐ Heart: ☐ Allergy: ☐ Decongestants:
☐ Steroids: ☐ Mental Health: ☐ Pain:
☐ None ☐ Other:

New medications or change in last 30 days ○ N ○ Y List:

Past medical history:
☐ Chronic pain ☐ CVD ☐ CPAP ☐ Pulmonary ☐ CHF
☐ Diabetes ☐ Nocturia ☐ Mental health treatment ☐ Seizure
☐ Other

OBJECTIVE

General appearance: Acute distress ● N ○ Y : Describe

Orientation to: Person ● Y ○ N Place ● Y ○ N Time ● Y ○ N Lack of concentration ● N ○ Y

Vital Signs: T 98.2 P 78 RR 20 BP 122 / 72 Pulse Ox 97 % Wt 200 lbs ○ Actual ● Reported

Skin: Cool ● N ○ Y Clammy ● N ○ Y Pale ● N ○ Y
Eyes: Conjunctiva pale ● N ○ Y Sclera icteric ● N ○ Y Dark circles ● N ○ Y
Edema ● N ○ Y: ☐ Face ☐ Hands ☐ Lower extremities
Respirations: ● Unremarkable ○ Labored Stridor ○ N ○ Y
Lung sounds: Right: ☑ Clear ☐ Wheezing ☐ Diminished Lung sounds: Left: ☑ Clear ☐ Wheezing ☐ Diminished

uHCG ○ (+) ○ (-) ○ N/A ☐ Total hysterectomy (uterus and both ovaries) or ☐ Post-menopausal

☐ Additional examination:

C Young [signature]	Clyde Young, LPN	Sig Nurse
Nurse's Signature	Print/Stamp Name	Title

NA6246
Issued 1/15/2013

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Nursing Encounter Tool
Sleep Disturbance

Patient's Name	Last Edms	First Mason	MI	ID Number 94691

○ Emergent intervention not required.

Notify practitioner after EMS activation due to
Describe: ______

○ Emergent intervention required due to:

EMS process activated Time:____ ○ AM ○ PM
EMS Arrival Time:____ ○ AM ○ PM
EMS Transport Time:____ ○ AM ○ PM
Consider: ☐ O_2
☐ Other:____

Practitioner notified:____ Time:____ ○ AM ○ PM

○ Urgent intervention not required.

Practitioner contact required due to: (check all that apply)
☐ Vital signs:____
☐ History of CHF
☐ History of CVD
☐ Difficulty breathing at night
☐ Chronic pain
☐ Unimproved or worsening symptoms
☐ Other:____
○ Seen by practitioner ○ Contacted practitioner

Name: ____

Time:____ ○ AM ○ PM

○ Urgent intervention required due to:

☐ See physician orders

Disposition:
☐ Same day practitioner visit/consult
☐ Monitor:____
☐ Admit to:____
☐ Other:____
☐ Sick call follow up ○ Practitioner ○ Nurse
☐ Transport via: ____ to____

Time:____ ○ AM ○ PM

☑ Routine intervention

Disposition:
Medical referral required for: (check all that apply)
☐ Documented patter of weight gain/loss
☐ Unresolved or worsening symptoms
☐ Awakened by pain
☐ Medication review
☐ Other:____
☑ Practitioner referral completed
○ Chart designated for practitioner review
○ No Medical Referral Required
○ Mental health referral completed for: (check all that apply)
☐ Current or previous MH treatment (or patient request)
☐ Other:____

Interventions: (check all that apply)

OTC medications not indicated.

☐ Other:____

Contact a practitioner or nursing supervisor if you have any concerns about the status of the patient.

Patient Education	Follow Up / Follow Through
☑ Patient educated to contact medical if symptoms develop or worsen ☑ ~~Written~~ information provided Verbal ☑ The patient demonstrates an understanding of self-care, symptoms to report and when to return for follow-up care.	Nurse follow up scheduled ● N ○ Y Custody notified of special needs ● N ○ Y

	Clyde Young, LPN	Sg Nurse
Nurse's Signature	Print/Stamp Name	Title

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Nursing Encounter Tool
PREA

Demographic/Vital Signs

Facility Name: | Location Seen: | Date Seen: 9-2-16 | Time Seen: 1100

Patient Name: Last Edms | First Adree | MI | ID # 94691 | DOB: [redacted] | Age: 28

Vital Signs: *Call Practitioner | *T>100 T: 97.7 | *P>100 P: 106 | R: 18 | *SBP<100 BP: 109/76 | Pulse Ox: 96 % ☑RA ☐ O2: /lpm | Wt: 185 ☐ Actual ☐ Reported

Allergies: NKDA

Chronic care clinic: ☑Y ☐ N   What Clinic(s): GD

Subjective

Chief Complaint: Sexual

Date of incident: 8-21-16   Time: 930 Am

Description of incident: Forced oral Sex on

Is perpetrator known ☑Y ☐ N

Was custody notified ☑Y ☐ N

Who? C/O Adney   When? 8-31-16

Associated Factors:

Pain Where: mental Pain

Pain Scale: —/10

Open areas Where: none

Drainage Describe: None

Have you changed clothes since the incident ☑Y ☐ N

Have you bathed since the incident ☑Y ☑N Error

Have you douched since the incident ☐ Y ☑N

Have you urinated since the incident ☑Y ☐ N

Have you defecated since the incident ☐ Y ☑N

Have you ingested food/drink since incident ☑Y ☑ N

Have you combed your hair since incident ☑Y ☐ N

Current Medications:

☐ Anticoagulants ☐ Antipsychotics ☐ Antibiotics ☑ Hormones ☐ Birth control

Pertinent Medical Conditions:

☐ HIV
☐ Hepatitis B
☐ Hepatitis C
☐ Psychiatric illness
☐ Pregnancy

Describe:

Forced oral Sex on an inmate

Objective

DO NOT TREAT ANY INJURIES THAT AREN'T LIFE-THREATENING. THEY MAY BE USED FOR FORENSIC EVIDENCE COLLECTION OR PHOTOS.

General appearance

Acute Distress ☑Y ☐ N

Chaperone present during exam? ☐ Y ☑N

Name of chaperone

Response	Description	Points assigned	Score
Eye Opening Response	Opens eyes spontaneously	4	4
	Opens eyes in response to voice	3	
	Opens eyes in response to painful stimuli	2	
	Does not open eyes	1	
Verbal Response	Oriented	5	5
	Confused, disoriented	4	
	Utters inappropriate words	3	
	Incomprehensible sounds	2	
	Makes no sound	1	
Motor Response	Obeys commands	6	6
	Localizes painful stimuli	5	
	Flexion/withdrawal from painful stimuli	4	
	Abnormal flexion to painful stimuli (decorticate response)	3	
	Extension to painful stimuli (decelerate response)	2	
	Makes no movement	1	
		TOTAL SCORE	15

Orientation:

☑ Person ☑ Place ☑ Time

☐ Confused ☐ Lethargic ☑ Agitated

☐ Teary/crying ☐ Non-verbal

Physical assault:

Body site involved

☐ Oral cavity
Describe: N/A

☐ Anal
Describe: N/A

☐ Genital
Describe: Not effected

☐ Other
Describe:

Comments:

Nurse signature | Print/stamp: Devin Jensen, LPN

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Nursing Encounter Tool
PREA

Patient	Last: Edins	First: Adler	ID Number: 94691

☐ Emergent Intervention

Practitioner notified: ______ Time: ______
Place bloody hands in paper bag, not in plastic or latex gloves
(To protect possible evidence. Plastic/latex causes sweating)
If CPR or AED is initiated use Emergency Response Form

EMS process activated Time: ______
EMS arrival Time: ______
EMS transport Time: ______
Facility transported to: ______
☐ Other: ______

COMMENTS:

☐ Urgent Intervention (Call practitioner)

Practitioner contact required due to: (check all that apply)

REFERRAL IS ALWAYS REQUIRED***
☐ Call practitioner for all PREA
☐ Mental health referral completed

☐ Other: ______

Reviewed with provider: ☐ MAR ☐ Medical Record
☐ Seen by practitioner Name: ______ Time: ______
☐ Contacted practitioner Name: ______ Time: ______

Practitioner Orders Received ☐ Y ☐ N
☐ Read back practitioners orders
Disposition ☐ Return to Unit ☐ Monitor/Observation ☐ Admit to Infirmary
Transfer to ______ via ______ time: ______

COMMENTS:

☐ Nursing Intervention

CONTINUITY OF CARE

☑ Nurse follow up scheduled
☐ Referred to practitioner for evaluation of enrollment in CCC
☐ Custody notified of special needs
☐ No further follow up needed at this time

MEDICATION

☐ O_2 @ ______ LPM via ______
☐ OTC medication per site guideline
List: ______
☐ KOP
☐ Medication administered
☐ Medication noted on MAR

Forward to OPC for STD Testing

☑ Patient educated to contact medical if symptoms develop or worsen
☐ Written information provided ☑ Verbal information given
☐ The patient demonstrates an understanding of self-care, symptoms to report and when to return for follow-up care

COMMENTS No Anal penetration Forced oral only

[signature]	Devin Jensen, LPN	SEP 0 2 2016
Nurse signature	Print/stamp	Date/time

NA7855
Issued 8/2015

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CORIZON

Promote a culture of safety

Nursing Encounter Tool
Abrasions and Lacerations

HSR*

ISCI/SICK CALL

Facility Name | Location Seen U15 | Date seen 12/31/16 | Time Seen ○ AM ⊗ PM 1715

Patient's Name Last Edmo | First Adree | MI | ID Number 94691 | Birth date [redacted]

Medication Allergies ⊗ N ○ Y If Yes List

Chronic Care Clinic(s) ○ N ⊗ | Last seen in Sick Call: __/__/__ ⊗ N/A

☐ Seizures __/__/__ ☐ Asthma __/__/__ ☐ CAD __/__/__ ☐ Dyslipidemia __/__/__

☐ DM __/__/__ ☐ COPD __/__/__ ☐ HTN __/__/__ ☐ Other __/__/__

SUBJECTIVE

Chief complaint with onset: Laceration to Scrotum / exposed testicle

History of chief complaint: NA

Location of injury: Scrotum   Date of injury: 12/31/16

Describe

Injury sustained in altercation with custody staff or other inmate: ⊗ N ○ Y: (May require custody staff notification.)

Exchange of body fluids ⊗ N ○ Y: Describe

Loss of sensation or movement ⊗ N ○ Y: Describe

Other injuries reported ⊗ N ○ Y: Describe

New medications or change in last 30 days ○ N ⊗ Y: List: ↑ spironolactone,

Past medical history: ☐ Diabetes ☐ PVD / impaired circulation ☐ Anticoagulation meds ☐ MRSA ☐ HIV ☐ H

Tetanus booster > 5 years: ○ N ○ Y ⊗ Unknown

OBJECTIVE

Response: AVPU (Choose one) ⊗ Awake ○ Responds to Voice ○ Responds to Pain ○ Unresponsive

General appearance: Acute distress ⊗ N ○ Y: Describe 8/10 pain reported

Vital Signs: T 97.7 P 104 RR 16 BP 124/87 Wt. 175 Pulse Ox 97 % RA

Skin: Cool ⊗ N ○ Y ○ Clammy ⊗ N ○ Y Pale ⊗ N ○ Y

Wound location: Scrotum   Approximate wound size:

Approximate depth of wound: ○ Superficial ⊗ Other: exposed testicle

Active bleeding: ⊗ N ○ Y: Describe

⊗ Bleeding controlled ○ Bleeding uncontrolled

Wound Description: ☐ Abrasion ☒ ~~Avulsion~~ NA ☐ Laceration ☐ Puncture

○ Uncomplicated - Clean without foreign body or signs of infection

⊗ Uncomplicated - Superficial debris, dirt, or crusting requiring wound cleansing

○ Complicated: Describe

• Pt GID States they no longer want their testicles.

Embedded foreign material: ○ N ○ Y: Describe Unknown

Signs of Infection: ⊗ N ○ Y: Describe A&O x3, PERRLA, testicle pink in color ∅ Signs of infection or circulation loss. EMS notified ∅ Signs of blood loss, bleeding controlled.

Additional examination:

[signature]   Nicholas Hoffman, LPN

Nurse's Signature | Print/Stamp Name | Title

NA6200
Issued 1/15/2013

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Page 1

Nursing Encounter Tool
Abrasions and Lacerations

Patient's Name	Last Elmo	First Adree	MI	ID Number 94691

☒ **Emergent intervention not required.** ○ **Emergent intervention required due to:**

Notify practitioner after EMS activation due to
Describe: ______

EMS process activated Time:____ ○ AM ○ PM
EMS Arrival Time:____ ○ AM ○ PM
EMS Transport Time:____ ○ AM ○ PM

☐ Other: ______

Practitioner notified: ______ Time: ____ ○ AM ○ PM

○ **Urgent intervention not required.** ☒ **Urgent intervention required due to:**

Practitioner contact required due to: (check all that apply)

- ☐ Vital signs: ____
- ☐ Diabetes or impaired circulation
- ☐ Unimproved or worsening symptoms
- ☐ Last tetanus booster unknown or >5 years (non-superficial)
- ☒ Avulsion ☐ Uncontrolled bleeding
- ☐ Loss of sensation/movement
- ☐ Exchange of body fluids ☐ Signs of infection
- ☐ Embedded foreign material
- ☐ Eye/mouth/ perineum /joint involvement
- ☐ Other: ______

○ Seen by Practitioner ☒ Contacted practitioner
Name: Daniel Dellino PA-C
Time: 1730 ○ AM ☒ PM

☐ See physician orders

Disposition:

- ☐ Same day practitioner visit/consult
- ☐ Monitor: ______
- ☐ Admit to: ______
- ☐ Other: ______
- ☐ Sick call follow up ○ Practitioner ○ Nurse
- ☐ Transport via: Ambulance to St. A/S
Time: 1800 ○ AM ☒ PM per dellino

○ **Routine intervention**

Disposition:
Medical referral required for : (check all that apply)

- ☐ Recurrent complaint(2 x 72 hours) without urgent findings
- ☐ Medication Review
- ☐ Other: ______

○ Practitioner referral completed
○ Chart designated for practitioner review
○ No Medical Referral Required

Interventions: (check all that apply)

- ☐ Bleeding stopped with pressure
- ☐ Wound cleansed with mild antiseptic/soap & water
- ☐ Foreign materials removed
- ☐ Topical ointment applied
- ☐ Sutureless product used
- ☐ Dressing applied ______ /issued # ____
- OTC medication given per guidelines ○ N ○ Y
- ☐ Medication: ______ ☐ KOP
- ☐ Other: ______

Contact a practitioner or nursing supervisor if you have any concerns about the status of the patient.

Patient Education	Follow Up / Follow Through
☒ Patient educated to contact medical if symptoms develop or worsen ☒ Written information provided ☒ The patient demonstrates an understanding of self-care, symptoms to report and when to return for follow-up care.	Nurse follow up scheduled ☒ N ○ Y Custody notified of special needs ☒ N ○ Y

[signature]	Nicholas Hoffman LPN	
Nurse's Signature	Print/Stamp Name	Title

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Nursing Encounter Tool
Return from Off-Site

Facility Name: ISCI	Location Seen: Infirmary		Date Seen: 12·31·16			Time Seen: 2240
Patient Name: Last EDMO		First MASON	MI	ID # 94691		DOB: [redacted] Age: 29
Vital Signs: *Call Practitioner	*T>100 T: 985	*P>100 P: 95	R: 16	*SBP<100 BP: 128/86	Pulse Ox: 98 % ☒RA ☐ O2: /lpm	Wt: 175 ☐ Actual ☒ Reported
Allergies: NKDA						
Chronic care clinic: ☒Y ☐N	What Clinic(s): gender care -					

Return from

Time of return: 2240.

☐ Off site appointment
☒ Emergency visit
☐ Outpatient surgery
☐ Hospital admission
☐ Other: ______

Documentation with patient

☒ Discharge summary
☐ Discharge orders
☐ Other: ______

Treatment procedure expected:
assess & Rx of Rt testicular injury

Treatment procedure received:
same :

Current symptoms:
some pain
See MAR

Current Medications: (Mark all that apply)
☐ Antibiotics: ______ Last dose given: ______
☐ Diabetes Last med: ______ Time: ______
Last food intake ______ Time: ______
See MAR
☐ New medication within the past 30 days
What medications: ______

Past Medical History: see medical records.
☐ Other chronic condition ______

General appearance
Acute Distress ☐ Y ☒ N

Oriented to:
☒ Person ☒ Place ☒ Time

Eyes
☐ Pale ☐ Red ☒ PERRL ☐ Unequal/Abnormal ☐ Watery

Mouth
☐ Oral mucosa ☒ Moist ☐ Dry

Respiratory
☒ Normal
☐ Labored ☐ Stridor ☐ Accessory muscle use
☐ SOB ☐ Cough

Lung sounds
R Lung ☒ Clear ☐ Wheezing ☐ Diminished ☐ Wet
L Lung ☒ Clear ☐ Wheezing ☐ Diminished ☐ Wet

Skin
☐ Warm ☐ Dry ☐ Pale ☐ Cold ☐ Clammy

Wounds/incisions

Describe: Rt testicular c̄ penrose & drsg

Tests
☐ Fingerstick result: Ø (Diabetics)

Comments: to room #2 per H-care for medical OBS

Eileen Mitchell, RN — Nurse signature | Eileen Mitchell, RN — Print/stamp

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Nursing Encounter Tool
Musculoskeletal
(Back Pain, Musculoskeletal, Fracture) HSR#: 915205

Demographics/Vital Signs

Facility Name:	ISCI/SICK CALL Location Seen:		Date Seen: 1/18/17	Time Seen: 1000
Patient Name: Last EDMO		First M	MI ID# 915205	DOB: Age:
Vital Signs: *Call Practitioner	*T>100 T:97.6 *P>100 P:96 R/18	*SBP<100 BP:110/75	Pulse Ox: 98% ☑RA ☐ O₂: /lpm	Wt: 178 ☑Actual ☐ Reported
Allergies: NKDA				
Chronic care clinic: ☑Y ☐N	What Clinic(s): GID			

Chief Complaint: ↑ lump (L) side spine Lower Back
Onset Date: Noticed 3 days Ago

☐ Trauma
Describe injury:
☐ Difficulty breathing
☑ Pain ☐ Chronic ☑ Acute
☑ Dull ☑ Sharp ☐ Achy ☐ Burning
☑ Pain scale is now 4 /10 at worst 6 /10
What makes it better: nothing
What makes it worse: laying on back ; push on it
☐ Radiation
Describe:

Associated Factors:
☐ Urinary incontinence ☐ Painful urination
☐ Fecal incontinence ☐ Tingling
☐ Nausea/vomiting ☐ Abdominal pain ☐ Fever
☐ Numbness: ☐ Chronic ☐ Acute Describe:
☐ Weakness: ☐ Chronic ☐ Acute Describe:
☐ Weight change ☐ Gain: ☐ Loss:
☐ Impaired mobility ☐ Impaired ADL's

Current Medications: (mark all that apply)
☐ Steroids ☐ NSAIDS ☐ Anticoagulants
☑ New medication in the past 30 days?
What medication: Augmentin 1-4

Pertinent Medical Conditions:
☐ Arthritis
☐ Cancer
☐ Osteoporosis
☐ Kidney disease/stones
☐ Back surgery
☐ Working lifting heavy objects
Explain:
☐ Recent weight lifting lbs.
☐ Other:

Tetanus Booster >5 years ☐ Y ☐ N ☑ Unknown
Ever had a Tdap ☐ Y ☐ N ☑ Unknown

Skin
☐ Warm ☑ Dry ☐ Pale
☐ Red ☐ Cold ☐ Clammy ☐ Scratching ☐ Bruising

Abdomen
☑ Normal
☐ Pulsatile mass in abdomen
☐ Lumps ☐ Redness

Extremities
☑ Pedal pulse: ✓ R ✓ L ☐ Radial pulse: R L
☑ Handgrips equal and strong
☐ Handgrips unequal and weak
Describe:
☑ Tender to touch
Describe: Tender when touched
☑ Straight leg raise equal and strong
☐ Straight leg raise unequal and weak
Describe:
☑ Posture erect
☐ Posture not erect
Describe:
☑ Gait symmetrical
☐ Gait not symmetrical
Describe:
☑ Able to walk heel to toe
☐ Able to squat and rise

Tests
☐ Fingerstick result NA (diabetics)
☐ Dipstick U/A ☐ Normal ☐ Abnormal (see lab slip)
(Back pain or excessive exercise)

Comments:
Pt pinches to move feels "woozy" Difficult to palpate lumps, [illegible] while sitting. Reported that [illegible] more when lying down.

Nurse signature: [signature]	Print/stamp: Tammy Case, LPN

6225b
Issued 1/2013

Revised 8/2015

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Nursing Encou[illegible] Tool
Musculoske[illegible]
(Back Pain, Musculoskeletal, Fracture)

Patient	Last: Edmo	First: Adrec Mason	ID Number: 94691

Practitioner notified: ______________ Time: ______________

If CPR or AED is initiated use Emergency Response Form

EMS process activated Time: ______________
EMS arrival Time: ______________
EMS transport Time: ______________
Facility transported to: ______________
☐ Other:

COMMENTS:

Practitioner contact required due to: (check all that apply)

- ☐ Abnormal vital signs (*Rule of 100s*)T>100, P>100, SBP<100
- ☐ Abnormal abdominal exam
- ☐ Positive straight leg raise
- ☐ Numbness/weakness (acute)
- ☐ Decreased ROM
- ☐ Obvious deformity
- ☐ Uncontrolled bleeding
- ☐ Absence of pedal or radial pulse
- ☐ Abnormal fingerstick, Diabetic <70 or >240
- ☐ Abnormal dipstick UA
- ☐ Other: ______________

Reviewed with practitioner: ☐ MAR ☐ Medical record
☐ Seen by practitioner Name: ______________ Time: ______________
☐ Contacted practitioner Name: ______________ Time: ______________
☐ Read back practitioners orders

Practitioner Orders Received ☐ Y ☐ N

Disposition ☐ Return to unit ☐ Monitor/Observation ☐ Admit to infirmary ☐ Other:

COMMENTS/ORDERS:

Nursing Intervention

CONTINUITY OF CARE

- ☐ Nurse follow up scheduled
- ☑ Referral to practitioner for current presenting complaint
- ☐ Custody notified of special needs
- ☐ No further follow up needed at this time

MEDICATION

- ☐ O_2 @ ______ LPM via ______________
- ☐ OTC medication per site guideline
  List: Acetaminophen, Ibuprofen
- ☐ KOP
- ☐ Medication administered
- ☐ Medication noted on MAR

PATIENT EDUCATION

- ☑ Patient educated to contact medical if symptoms develop or worsen
- ☑ Education given ☐ Written information provided ☑ Verbal education given
- ☐ The patient demonstrates an understanding of self-care, symptoms to report and when to return for follow-up care

COMMENTS:

[signature]	Tammy Case, LPN	1/18/17 1000
Nurse Signature	Print/stamp	Date/time

Correctional Medical Services
Inter Disciplinary Progress Notes

Patient Name: MEEKS, MASON #94691
D.O.B. [redacted] R

ID#: Institution:

Date	Time	Notes	Signature
1/8/10			[signature]
JAN 13 2010		* hx of gall bladder disorder (unknown) Dx @ portNeuf - Benign exam Ø recent Sx - get records S: RDU HEALTH EVAL O: REVIEW OF MEDICAL RECORDS A: CLEARANCE OR WORK P: PATIENT CHART SCREENED AND PATIENT FIT TO WORK: ✓ ST. ANTHONY CAMP GIVENS HALL CREW- ✓ OVERNIGHT CAMPS ROAD CREW DAILY ✓ C.W.C.'S FOOD SERVICES [initials] IMPS Mike Takagi, PA [initials]	
-8-10	150°	[stamp illegible] [signature] 1015	
0600	FEB 09 2010	CHART REVIEW - NICI	[signature] RN

CMS 7113 - Inter Disciplinary Progress Notes – Rev 08/2008

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PROBLEM ORIENTED RECORD

CHM Correctional Healthcare Management

NAME Edmo, Mason
DOB
Hospital #
MR#

DATE/TIME	SUBJECTIVE/OBJECTIVE	ASSESSMENT/PLAN
2/27/11		if it worked or not
	Works in kitchen – misses doses occasionally – feels very depressed when he misses even 1 dose	Is presently appealing sentence. Constant headache from tension. "Super anxious" when she thinks about legal issues
	– increased anxiety – suicidal when doses are missed – has a plan at this time – doesn't care	Refer to NP for med eval – ★
	Sentenced to prison – 6 yrs fixed (sexual battery) registered sex offender. Insufficient funds – original charge. Causes great concern	Joyce E. Carson LCPC
	Relationship issues – b/f left him while he was on ride June, 2010 – June 2011 –	12/23/11 After my eval & MH eval I recommend ↑ Geodon to 100 mg qd. Vistaril 50 TID
	3 suicide attempts ★ – OD alcohol poisoning – OD pills (amitriptyline) sister's meds ★ – cut arms ★ hospitalized medically – BHS – 4 days – followed-up c̄ Ft. Hall Mental health	K Ball NP
	(tried Celexa – was also withdrawing from ... he's not sure	

ER 1372

PROBLEM ORIENTED RECORD

CHM
Correctional **Healthcare** Management

NAME Mason Meeks
DOB [redacted]
Hospital #
MR#

DATE/TIME	SUBJECTIVE/OBJECTIVE	ASSESSMENT/PLAN
10/5/11 0900	S: c/o (R) knee pain O: VS BP 140/84 P 105 temp 97.7 resp 14 249 lbs Had problem x 1 month Ø trauma, Ø injury Ø illness O. WDWN, NAD (R) knee – Ø swollen Ø bruising Ø LOM – full ROM AP/LAT, varus, valgus stressing negative ... negative.	A. Knee pain / injury IBP 800 T TID K Bauer DO
2/24/11	Refer to Dandruff POR msl/pm	
1-10-12 1333	S: c/o shoulder / back pain 7/10 O: BP 120/75 / P 71 ↑ back pain – primarily soft tissue thoracic region T2-5. with lifting of using back – sharp pain (L) upper back. Grips = ; strength = upper & lower reflexes 2+/4. Non spinal process tenderness.	A/P thoracic muscle spasm strain – chronic Parafon Forte 500 mg T po bid, monitor on stomach upset Cont. Tolnaftate as directed. Linda Cassell FNP-C
1/17/12 0920	S: c/o athlete's foot (R) c pain O: red crack between 2nd 3rd digit. peeling skin	a: risk for infection r/t broken skin p: miconazole to area BID x 10d f/u as needed malpm K Bauer DO
1/18/12 1800	S: c/o cold O: nasal congestion sounding	a: acute illness p: CTM 4mg T BID x 5d f/u c medical if unresolving msl/pm 3/23/12 K Babb DO

PROBLEM ORIENTED RECORD

CHM
Correctional Healthcare Management

NAME Edmo Mason

DOB [redacted]

Hospital #

MR# 1.18.12.

DATE/TIME	SUBJECTIVE/OBJECTIVE	ASSESSMENT/PLAN
1.18.12 0930	He is on muscle relaxer that he says helps — unable to take IBP because of stomach pain — will start tylenol 500 ii BID	KBrown NP
		LPN 01/18/12 2300
1/21/12 1045	S: Go back pain. O. BP 141/85 P 81. Chronic Back pain: Has been on parafon forte which he says helps now it feels like he needs to pop his Back. No wounds or Injury back: no muscle spasm from C-L spine. no pain over spinous process. (Just feels like it needs to pop!) States his anxiety is what starts his Back pain but is on Vistaril & he says he thinks that works	A. Back pain. P. continue muscle relaxer + tylenol. Stop Ctm's. Can no longer be an inmate worker — KBrown NP

PROBLEM ORIENTED RECORD

CHM
Correctional Healthcare Management

NAME Edmo, Mason
DOB [redacted]
Hospital #
MR#

DATE/TIME	SUBJECTIVE/OBJECTIVE	Chronic ASSESSMENT/PLAN
2/13/12 0955	S: f/u back pain & headaches O: BP 136/83 P 79 W 248 Back still hurts despite parafon forte, tylenol, Vistaril although he walks with normal gait sets comfortably c hip & knees @ 90° angle. Dropped down in the chair in exam room just plopped — Ø pain Back: mild spinous muscle spasm Ø spinous process pain — free ROM w/o catch.	A. Acute back pain P ~~[illegible]~~ ~~300 [illegible]~~ Gabapentin 100 mg TID (done [illegible]) K Balla MD
2/27/12	S: f/u tingling back of head/feet (R) arm dizzy ↑ fatigue O: BP 137/82 P 79 Wt 250 Pain is in the thoracic pain which gets him up for numbness & tingling in the hands. He is to go in for ~~arthritis~~ arthritis. Thinks he has been in a number of accidents. Ø LOC/DI [illegible] IMAD Thoracic spine: Ø pain over bony prominence, mild paraspinous muscle spasm — Ø numbness today but describes as whole hand believe when it occurs	A. Thoracic muscle strain — chronic P ↑ Gabapentin to 300 TID (done mgs) K Balla MD
3.20.12	May have a double matt K Balla DO	[illegible] called logged and reported

ER 1375

PROBLEM ORIENTED RECORD

CHM
Correctional Healthcare Management

NAME Edmo, Mason
DOB
Hospital #
MR#

DATE/TIME	SUBJECTIVE/OBJECTIVE	ASSESSMENT/PLAN
3/22/12	Wants higher dose of Zoloft - thoughts of suicide a couple of weeks ago Usually occurs after talking to family - Ex-boyfriend issues are involved Very tense - gabapentin helps (mood stabilizer) Feels worse in a.m. A Refer to NP for med eval for increased depression c suicidal ideation Joyce E. Carson LCPC	
3/26/12	After my eval & MH eval - I recommend Gabapentin to 600 TID Zoloft to 150 mg qd R Baker MD noted 3/27/12	

PROBLEM ORIENTED RECORD

NAME Edmo, Mason

DOB [redacted]

Hospital #

MR#

DATE/TIME	SUBJECTIVE/OBJECTIVE	ASSESSMENT/PLAN
/20/12	S. c/o cold seen @ med pass O. red nares sniffling slight running out of nares	a. acute illness p. CTM 4mg ii BID x 7d f/u c medical if not resolving 3/26/12 KBabb DO
/26/12 048	S: c/o muscle spasms O. BP 123/72, P 67 We have discussed these problems in the past, He also has an allergic Rhinitis which he says is better c Ctm's	A. allergic Rhinitis P. Ctm ii TID PRN x 1 mo KBabb DO see Joyce's visit KBabb DO
/18/12	S. c/o ears plugged; blood on Q tip O. BP 123/76 P. 67 WT 258 He stuck a Q tip in his ear & came out c a Red substance which he thought was blood O WDWN [illegible] HEENT – tm's grey only small amt Red cerumen Ⓛ ear nares pink & moist pharynx pink & moist	A. worried well visit completely nl ears P. Ø Q tips in ears or will have a real problem KBabb DO noted MS

CMS Correctional Medical Services

Correctional Medical Services
Inter Disciplinary Progress Notes

Patient Name: EDMO, MASON #94691
D.O.B [redacted] T

ID#:
Institution:

Date	Time	Notes	Signature
4/30/12	1035	RDU PE	
		S: RDU HEALTH EVAL	
		O: REVIEW OF MEDICAL RECORDS — (+) hx HTN – 4 meds x 4 yrs.	
		A: CLEARANCE ... — d'd ETOH & lost ~ 40 lbs.	
		P: PATIENT CHART SCREENED AND PATIENT FIT TO WORK: — BP on intake 133/88	
		X ST. ANTHONY CAMP	
		GIVENS HALL CREW-	
		X OVERNIGHT CAMPS	
		ROAD CREW DAILY	
		X C.W.C.'S	
		FOOD SERVICES	
		X IMITS	
		Food Service Clearance Completed X	
		[signature] NP-C Ben Bish N.P.-C	
5/1/12		blood drawn	Galyna Thurston, Phlebotomist GT
5-17-12	1600	Received chart B Fackrell RN	Becky Fackrell, R.N.
11912	0900	Weekly Health + Wellness Check Complete pt has no Complaints	Kevin Kaae, LPN. [signature]
26-12	0650	Chart has been reviewed and scaned out for transport, NCCHC has been filled out, pt sent w/ proper medications [signature]	Vickie Griggs, RMA, CPhT. Registered Medical Assistant
9-6-12			G. Thurston

CMS 7113 –Inter Disciplinary Progress Notes – Rev. 3/2008
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Correctional Medical Services
Inter Disciplinary Progress Notes

Patient Name: Edmo, Mason ID#: 94691 Institution: ISCI

Date	Time	Notes	Signature
-4-13	1000	R.N. review Signature Williams HSA Met c̄ Offender to address concerns of ill fitting bra. Offender reports he needs a size 42B. Will attempt to locate this size through the female prisons locally. Offender demonstrates effective communication was established by ⊕ questions & answers through-out. Tina Williams, R.N., HSA Williams RN HSA	
		SEEN IN SICK CALL DATE 3/2/13 TIME 0920 Veronica Ferro, LPN ☐ Referred to a Provider ☐ Dental ☐ OPC ☐ Opto ☑ CC ☐ Other	
1/29/13	1520	Pt in to chronic care clinic for HSR584834 pt has concerns and would like to speak to Dr Whinnery Wt 240 VS 98.5, 125/80, 60, 16, 98% RA — Jennifer Prudhomme, LPN	
Wt 3/26/13 223		Currently Estradiol 1mg, ASA 81, OsCal 500, Spironolactone 50 bid. Has been working on wt loss (Cont)	

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Correctional Medical Services
Inter Disciplinary Progress Notes

Patient Name: Edmo Mason ID#: 94691 Institution: 1801

Date	Time	Notes	Signature
5/24/13	(cont)	States he's getting breast development	
		Thinks he's tired from spironolactone - wants to	
		try a diff androgen suppressant. Discussed	
		finasteride.	
		Requests ↑ Estradiol	
		O: NAD. lungs clr. Ht Rrr Abd soft/active BS	
		nontender. No edema	
		Still coarse dark facial hair	
		A: GID	
		P: ↑ estradiol 2 mg /d	
		taper off spironolactone	
		start finasteride 5mg /d	
		Has labs June & will follow up prn	
		[signature] C. Whinnery, ...	
6-4-13			Certified Medical Assistant G. Thurston

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Promote a culture of safety

Progress Note

Name: Edmo, Mason (Last / First / MI)

Date of Birth [redacted] ID #: 94691

Date	Time	Description	Signature/Title
7/31/13	835	pt into opc for muscle spasms	[signature], LPN
DATE:	S:	Pt says he has pre-existing back & shoulder pain	
WT: 210		muscle spasm causing severe neck & shoulder pain.	
BP: 123/78		Discomfort has been a problem when pt feels	
P: 64		stressed because of personal. Taken aspirin & IBU	
T: 97.3		which helps a little.	
O: 98%			
KOP:		O: Pt is alert and answers questions clearly and appears	
584496		to understand treatment plan & is in agreement c it.	
R18		A: muscle tension - neck & shoulder	
		P: Parafon forte 500 mg tabs; i tab PO tid PRN	
		muscle tension	
		[signature] Edward Savala, MD	
8-10-13	0720	Seen in sick call referral entered to discuss meds c doctor	[signature], LPN
8-10-13	0720	SEE 589255 HSR FOR ABOVE	[signature], LPN
8/13/13 0800		CHART REVIEWED @ ICI-O GFD [illegible] [illegible] c meds	
		Labs OK [signature] Rory York, ARNP	
9/13/13	0520	LAB SEP 13 2013 DRAWN	[signature] Julie Gonzales, LPN
9/23/13 1110		[illegible] [illegible]	
		[illegible] [illegible]	
		[illegible]	
		P [illegible] [illegible] [illegible] [signature] Rory York, ARNP	

COMPLETE BOTH SIDES BEFORE USING ANOTHER SHEET

CS1104

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ICIO MEDICAL PROGRESS NOTES

DATE: 4 october 2013
TIME: 1210
PATIENT: Edmo, Mason #94691

VITALS

- **WEIGHT: 220.5**
- **HEIGHT: 68**
- **BMI: 33**
- **BP: 137/77**
- **TEMP: 98.3**
- **HR: 76**
- **RESP: 16**
- **O2 SAT: 100%**

SUBJECTIVE: here for evaluation. Has gid. He requests increase of his estrogen. States that the plan was to increase the dose from boise. He has been here for approx 5 weeks. Has been on 5mg proscar, and on 2mg of estrogen, and 25mg spironolactone twice a day. His estrogen level is in the target range, but the testosterone level is above target.

His eventual goal is reassignment surgery. He realizes that this can't be done in the prison system.

OBJECTIVE: healthy patient, no distress. Ent benign. Lungs clear, cardiac regular, normal heart tones. Abdomen benign.

ASSESSMENT: gid, estrogen at target. Testosterone above target

PLAN: increase the spironolactone to 50mg twice a day
Monitor blood pressure.

PHILLIP H PETERSEN, M.D.

Progress Note

Name: EDMO, MASON (Last / First / MI)

Date of Birth: [redacted] ID #: 94691

Date	Time	Description	Signature/Title
10/11/13		HSR 599546 wants [illegible] for [illegible]	
	1100	O. [illegible] PSEB 104	
224	68	A. [illegible] BS	Rory York, ARNP
[illegible]	33	P. [illegible]	[signature]
11/1/13		HSR 617702 - [illegible] on face	
0915		O. [illegible] mild [illegible]	
223	68	[illegible]	
[illegible]	33	A. [illegible]	
98.3		P. Hydrocort 1% [illegible] X30 days	
100	16	[illegible] use of soap [illegible] to face	
96	117/72		[signature] Rory York, ARNP
11/13/13		HSR 617736 c/o [illegible]	
0915		O. [illegible] front + Back of Head	
219	68	[illegible]	
[illegible]	32	A. [illegible]	
115/76		P. [illegible] PO Q6h #24 / [illegible] 3mo.	
97	75		Rory York, ARNP [signature]
16	98.0		
11/20/13		HSR 600114 wants [illegible]	
0950		[illegible] in 2012	
109/67		PT Ed. [illegible]	
80 98.5	18		Rory York, ARNP [signature]
217	68 / 96		
[illegible]	32		

COMPLETE BOTH SIDES BEFORE USING ANOTHER SHEET

CS1104

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Name: Edmo, Mason IDOC# 94691 DOB: [redacted] ICIO 12/16/13

HPI:

This is a 26 year old Native American GID patient who comes in today with the chief complaint of bilateral breast pain at the nipple. She is requesting a medical memo for bras and panties also Estrogen therapy for GID which the testosterone level right now is low. She is requesting that her Estrogen be increased due to facial hair. On review of systems and vital signs, please refer to chart and sheets. Physical exam today, bilateral breasts show mild firmness and tenderness over the nipple level bilaterally approx ½ cm in size bilaterally without tenderness.

A & P:

1) GID-Will discuss with the state for bras and panties to see what their requirements are and what the state requires us to do to receive those or not receive them.
2) Endocrine-At this time we will not change the Estrogen dose for symptoms. Will continue to follow labs.
3) Endocrine/GID-Breast tenderness and mass will discuss with Endocrine at ~~Tershery~~ TERITAN Care Center and I will follow up with that in the next 2 weeks with PA Breshell. — common w/ Hormones

\ DONE

[signature]

Murray F. Young, MD, Regional Medical Director

12/20/13

Date

Progress Note

Name: Edmo (Last) Mason (First)

Date of Birth: [redacted] ID #: 94C091

Date	Time	Description	Signature/Title
12/7/13	1400	Seen in chronic care today, refer to flow sheet	Sharon Brown, RN S Brown
12/11/13	0938	(S) Ref HSR: 599703 c/o "hard lumps" under both breasts c a clear discharge when	
BP	133/85	squeezing. Pain started about a month ago	
P	79	p being on estrogen for ≈ 16 months ago.	
R	16	(O) Breast exam s palpable masses in breasts or	
T	98.3	axillary nodes. Breasts more symetrically.	
Wt	217	⊗ nipple discharge	
Ht	68	(A) Gynecomastia	
BMI	33	(P) Pt education provided on gynecomastia	
SpO2	99%	and breast enlargement c estrogen.	
		Anthony G Bushell PA-C 12/11/13	
		Anthony G Bushell PA-C 0240	
12/16/13	1200	PT SEEN IN CLINIC FOR CCD - SEE CCD Dr Murray Young, RMD	
12-23-13	1510	Received call from Rena Supt @ IPOC asking that a MEMO for possession of a bra for this I/M. Told her I would need to discuss c Dr Young RMD before I could issue MEMO per discussion last week. Dr Young not available, left message @ Regional Office for C. Smith RDON. Received call from Ryan Valley, Regional Director to do MEMO, have written order for same. MEMO for possession of IPOC issued bra written & given to unit + I/M. RTC prn	Fran Palazzo [signature]

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Progress Note

ame: Edmo Mason
ate of Birth: [redacted] | ID #: 94691

Date	Time	Description	Signature/Title
1/3/14	0948	① Ref HSR 628618; 26 yo ♂ c/o stuffy/runny	
Bp	115/73	nose, HA, sore throat and diarrhea. Has	
P	76	been going on for 3 days. cough is	
R	18	nonproductive, ⊕ subjective fever, is	
T	98.1	getting worse. S/s worse at night	
Wt	218	② HEENT: eyes PERRLA c̄ conjunctival injection	
Ht	68	ears: Tm translucent c̄ good cone of light	
Bmi	33	nose: mucosa erythematous and boggy, ⊖	
SpO2	98%	tenderness to sinus percussion.	
		OP: linear erythema s̄ tonsillar edema or	
		exudate, ⊖ lymphedema	
		Lungs: clear + ⊜ bilat to bases	
		A/P Rhinitis: ① increase H_2O intake.	
		② CTM 4mg TPO TID x 8 days OOS	
		③ saline nose, 2 squirts each nostril daily	
		for 7 days.	
		1/3/14 [signature] PA-C	
		0958 Anthony Bushnell, PA-C	
1/16/14	0905	Ref HSR: 628261 Pt requesting	
Bp	121/72	an Δ in estrogen. Tests are	
P	66	done Q 6 months last done in	
R	16	9/2013. Estrogen was therapeutic and	
T	98.3	testosterone is low. Advised	
SpO2	100%	Pt that we are not going to Δ his	
Ht	68	dosage today. Pt request referral	
Wt	222	to see Dr. Young. granted.	
BMI	33.75	[signature] PA-C 1/16/14	
		Anthony Bushnell, PA-C 0910	

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Progress Note

Name: Edmo, Mason (Last / First / MI)
Date of Birth: [redacted] ID #: 94691

Date	Time	Description	Signature/Title
7/14/14	1420	S) Pt brought in to be informed that sexual reassignment surgery will not be done in IDOC unless deemed medically necessary by GID evaluator.	
		O) Pt recieved information well and would like to know who the GID evaluators are.	
		A/P) GID	
		1) refer to GID evaluator.	
[illegible]-12-14	0830	S: seg. placement, suicide watch, medical notified chart reveiwed	
		O: vitals taken, security and mental health notified	
		A: routine health maintenance	
		P: cleared for seg. placement	
		E: seg. handouts left with companion watch —	[signature] LPN Marcus Samson, LPN
4/12/14	0900	Phoned Dr Montgomery in regards to seg placement and written threat to "self castrate". Will place pt. on next psych clinic. —	[signature]
7-19-14	1930	Seen by Mental Health Clinician for intake.	[signature] Michael Malone, LPN
~~[illegible]~~	~~1340~~		
[illegible]4	1340	Pt. refuses to strip out for unit 8. [illegible] & mental health screening cannot be completed until pt stripped out. [illegible] mental health clinician to [illegible] talk to pt. — [signature]	

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Progress Note

Name:	Last: Edmo	First: Mason	MI:
Date of Birth:	[redacted]	ID #:	94691

Date	Time	Description	Signature/Title
3/24/14	1430	mental health screening completed for housing in Unit 8 Segregation. pt spoke c̄ clinician Menlove before speaking c̄ medical. pt denies thoughts of suicide or self harm at this time. Chart cleared for housing in Unit 8.	Kelly Larsen, LPN K Larsen LPN
3/2/14	1820	mental health screening completed for housing in unit 8. pt denies thoughts of suicide or self harm. chart reviewed. Cleared for housing in segregation.	K Larsen LPN Kelly Larsen, LPN
3/4/14	1350	Pt chart reviewed for housing in unit 8. Pt cleared from suicide watch in unit 16 by clinician Ruth. Mental health screening completed for housing in unit 8. Pt denies suicidal ideations or thoughts of self harm. Pt cleared for housing in Unit 8. J Prudhomme	Jennifer Prudhomme, LPN
3/6/14	0900	Pt into CDP for CDP follow up and HSR. VS and wt on CDP sheet	Heather Nader, RN [signature]
3-23-14			[signature]
5/29/14	940	pt into ccc for diabetes concerns	Jan Drake, LPN
DATE: WT: 218 BP: 129/75 P: 101 T: 96.9 O: 99% RA ISR:		S: [illegible] pt in estrogen (+) Fam. hx [illegible] Mother, Father, Sister. Pt denies fatigue, urinary frequency, blurry vision, joint pain	
		O: Review of Fasting BG: wnl. She is obese + of Native American heritage	
1/160 R16		A: ↑ risk for DM / pre-diabetes	
R15		P: A1C today Review @ CDP visit ~20 minute education today on risk reduction, A1C testing, HRT	William Poulson NP-C

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Progress Note

Name: Edmo (Last) Mason (First) MI

Date of Birth: [redacted] ID #: 94691

Date	Time	Description	Signature/Title
6/20/14	1340	Pt. m/H assessment cleared by Clinician Venegss into 4-8 ISCI. Pt. medically cleared into unit. CNS [signature]	REARD
6/20/14	1400	Pt. placed into 4-8 due to assault during which pt. received a minor laceration to the (R) pinky knuckle, Pt denied medical treatment at this time. Education given on how to contact medical for assistance and sick call purpose CNS [signature] REARD, J	
8.12.14 @ 0917		LAB DRAW @0915 from (R) AC	[signature] Desiree Luna, LPN
AUG 22 2014		ccpt into opc for hemorrhoids	[signature] Jan Drake, LPN
		HPI: Pt notes hx hemorrhoids in past c occasional	
DATE: WT: 217		irritation & light blood on tissue post BM. He	
BP: 118/72		notes straining to have BM & painful BM Hx. He	
P: 72		admits to anal intercourse during recent	
T: 97.9		exacerbation of hemorrhoidal symptoms. Denies	
O2: 99% RA		frank blood per rectum. Pt is also GID.	
HT: 6'07	140	O: Deferred to discussion.	
R15		A: Hemorrhoids exacerbation	
		P: Disuaded from intercourse in prison facility, and/or during hemorrhoidal exacerbation. Tucks pads provided, Hemorrhoidal suppositories provided. Instructed to only use these items c symptoms & they should not be over used nor will be supplied indefinitely. Fiber & PO GD x DOD + ↑ H2O intake	[signature] Christian Gelok, NP

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Correctional Medical Services
Inter Disciplinary Progress Notes

Patient Name: Edmo, Mason ID#: 94691 Institution:

Date	Time	Notes	Signature
AUG 5 2 2014	910	pt into opc for back spasms causing	
DATE:		migraines ———	Jan Drake, LPN
WT: 217			
BP: 118/78		S: c/o L/ level (L) paraspinal muscle spasm	
P: 64		and associated (L) upper back + levator	
T: 97.6		scapulae region pain + HA. Complex	
O: 97% R		of rx waning/waxing over last few weeks.	
MSR#: 077403		Taking ASA c̄ some relief. Had "migraine"	
214		previously. HA now begins occipital ache becoming	
		bi frontal ache	
		O: Pleasant, obese NAD. Gait + station wnl	
		Ambulates + arises table easily. There is some	
		palpable muscle tension (L) paraspinal region of concern.	
		Reactive trigger point levator scapulae palpation c̄	
		c/o occipital radiation. LE reflexes + bulk	
		wnl / symmetric	
		A: ① Lumbago / ② musculoskeletal neck pain ③ HA	
		P: Discussed + handouts + demonstration of HEP for	
		Lumbago + Cervical [illegible]. Advise ↑ activity / exercise /	
		wt loss. Rx Naproxen 500 mg ½-1 tab PO BID PRN x 30 days	
		[illegible] 500mg PO QHS x 3 nights to help spasm	
		subside. F/U Sx if not improving next 2-3 weeks.	B. Poulson NP

CMS 7113 –Inter Disciplinary Progress Notes – Rev 08/2008
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Progress Note

Name:	Last: Edmo	First: Mason	MI
Date of Birth:	[redacted]	ID #: 94691	

Date	Time	Description	Signature/Title
AUG 2 6 2014		pt into opc for dry, itchy skin	Jan Drake, LPN
DATE: 807			
WT: 217		S: Arm, les, thigh skin complaint has resolved.	
BP: 122/72		Has vert Red dry cracking skin between toes b/lat	
P: 77		O: Interdigital maceration and fissuring & scale	
T: 97.9		b/lat. No cellulitis or concerning lesions.	
O: 97 RA			
HSR#:		A: Tinea Pedis	
677406		P: Miconazole 2% Cream AAA BID x 3 weeks	
R13		then PRN x 30 days	
		Keep dry, Δ socks frequently.	
		William Poulson NP-C	
		AUG 2 6 2014	
			Certified Medical Assistant G. [illegible]
9-23-14		LAB DRAW	
OCT 0 1 2014		pt into opc for back spasms	Jan Drake, LPN
731		HPI: Notes muscle soreness and spasm @ (L)	
DATE:		shoulder & midback. Notes little physical activity.	
WT: 211		Notes ↑HA tendency correlated. Feels that all	
BP: 123/75		symptoms likely associated c stress of incarceration,	
P: 85		GID status. Denies systemic symptoms or	
T: 97.7		difficulty c ADL's. Denies trauma &/or surgery	
O: 99% RA			
665690		O: VSS, NAD Patient displays full ROM during	
R14		evaluation while trying to point to pain	
		location @ left scapular regions, superior &	
		inferior spinatus as well as left trapezius.	
		Palpable fasciculations @ (L) trap.	
		A: Spasm of muscle	
		P: PT x 4 treatments. Naproxen 250mg PO	
		BID x 180 Days. Continue c behavioral	
		health counseling	Christian Golok, NP

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Progress Note

	Last	First	MI
Name:	Edmo	Mason	
Date of Birth:	[redacted]	ID #: 94691	

Date	Time	Description	Signature/Title
OCT 02 2014		pt into opc for eczema ———	Drake, LPN
9/16		(S) 27 y/o male c̄ c/o dry, itching,	
DATE: WT: 211		bleeding skin caused by eczema. Showers 1-2x/Day	
BP: 120/69		(O) PMH - GID.	
P: 70		VSS, NAD, pt. pleasant & cooperative.	
T: 97.9		Three areas of focus:	
O2: 97% RA HSR:		(1) skin on face: where the nostrils	
6656692		meet the cheek, erythema present in	
R 15		(B) patches ≈ 2.5 cm x 2.5 cm	
		circular. Ø warmth, bleeding or	
		exudate.	
		(2) abdomen - Ø warmth, erythema,	
		or exudate/bleeding, or lesions.	
HSR 66 92		(3) Posterior (R) thigh - mid-thigh	
66		on lateral side - Ø erythema/warmth/	
66		bleeding/exudate, or lesions seen.	
		(A) Dry skin - Face	
		(P) Pt. admits to showering 1-2x/Day	
		which removes the needed oils from	
		skin. Ø eczema noted. Therefore	
		pt. to trial a bathing schedule	
		of every other Day to improve	
		dry skin. F/u PRN for ↑	
		erythema, bleeding, exudates, warmth.	
		Lastly, pt. to avoid vigorous scrubbing	
		or scratching affected areas. M. Jordan SNP	
		Pt Seen in conjunction c̄ SNP. Agree c̄ assessment & POC.	
		Nasolabial fold very mildly irritated - no redness or eczema	
		& no indication for emollients. Not indicated or necessary	
		OCT 02 2014	

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Progress Note

	Last	First	MI
Name:	Edmo	Mason	
Date of Birth:	[redacted]	ID #: 94691	

Date	Time	Description	Signature/Title
10/4/14	S	"Back muscle spasm = migraines & HA's ~ 4 years - recently ~ 1 month ago. ↑'s c stress."	
	O	SPS 6/10, 8/10, 4/10 sharp pains from middle of my back to (R) shoulder/scapula	
		Worse - pushing it, lay down	
		Better - ?	
		C+S ⊖ B+B ⊖ SLR ⊖ H+T ⊖	
		Wt loss ~ 3-4# 2 months	
		Posture - mild FHP, (R) lat shift	
		AROM - WFL - c/o end range pain	
		Strength - WFL Gait - WNL	
		Neuro - NOT (C) UE	
		Spinal compression - ⊖ Distrxn - ⊖	
		Rx - eval, therex, HEP - return vertical demo core control	
	A	SPS 6/10 p̄ Rx - ↑ AROM	Peter Faletto, PT
	P	cont, ↑ ex's [signature] Faletto PT	
10/9/14	S	"Doing alright - feeling anxious"	
	O	SPS - 7/10, 7/10, 5/10 sharp pain into shldr	
		CC - muscle tension	
		Px - a/a - ∅ vibration 2° illness p̄ last Tx	
		Palpation - ∅ tension/spasm palpable	
		Manual Therapy - PRRT to Lr lumbar "strain"	
		Forms maneuver, core control	
	A	SPS 5/10 p̄ Rx	Peter Faletto, PT
	P	cont	[signature]

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Progress Note

Name:	Last: Edno	First: mason	MI:
Date of Birth:	[redacted]	ID #:	41691

Date	Time	Description	Signature/Title
10/14/16	S	"Doing all right - shoulders tense"	
	O	SPS - 8/10, 8/10, 9/10 sharp pains to (R) shoulder	
		CC - tension, (R) shoulder	
		Rx - club vibe	
		- PRRT (R) shoulder, Lev Scapulae, trap, rhomboids	
		- club vibe reset/flush	
		- core control	
	A	SPS 5/10 ō Rx	
	P	D/C in 1-3 weeks if progress.	
		[signature]	

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Progress Note

Name:	Edmo (Last), Mason (First)	MI
Date of Birth:	[redacted]	ID #: 94691

Date	Time	Description	Signature/Title
		11/10/14	
		Patient Edmo has been on female hormones since 9/22/12 and is planning to live life as a female.	
		C. Whinnery MD	
		C. Whinnery, M.D.	
		Copy to chart – original to patient per Dr. Whinnery 11-11-14	
		[signature] Shell [illegible], LPN, Ombudsman	

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Progress Note

Name: Edmo (Last) (First) (MI)
Date of Birth:
ID #: 94469

Date	Time	Description	Signature/Title
NOV 17 2014	1025	pt into opc for back spasm	Jan Drake, LPN
DATE:		S: c/o of ~ 2 years of recurring on/off	
WT: 206		middle back pain/muscle tension/spasm	
BP: 118/73		that increasing with emotional stress. Also	
P: 63		worsens c physical activity. PT was not	
T: 97.8		helpful. Naprosyn of effect – has "allergic cond"	
O: 100	RA	– does not tolerate. No limitation of ADL's	
FBS#:			
716470		O: Pleasant, NAD overweight gender dysphoria	
R14		pt. UE strength & flexibility wnl.	
		Walks on toes, heels. LE strength/flexibility	
		wnl, Reflexes all wnl LE/UE.	
		No palpable spasm/tension in area of	
		concern which is from ~ T9 – L3 region	
		paraspinally. c/o tenderness to palpation	
		through this region	
		A: Persistent back pain	
		P: Pattern + history resemble functional fibromyalgia	
		type pain. May benefit from low dose	
		TCA. Trial Elavil 10 QHS – dose limited	
		by concomitant Zoloft. D/C NSAIDs.	
		We have a new PT who offers more conventional	
		therapies – we will try 3x PT sessions as well	
		William Poulson NP-C NOV 17 2014	

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Progress Note

	Last	First	MI
Name:	Edmo	Mason	
Date of Birth:	[redacted]	ID #: 94691	

Date	Time	Description	Signature/Title
11/19/14		S. Pain @ night and am (worse) 8/10 burns, aches feels cramped. Movement durning the day tension and burn starts to ↓. Worse pain walking. onset 3 years ago was kicked in the back. pn 7/10 - sharp, ache	
		O. Pain TTP @ Ⓡ deep paraspinal and QL over T_{11} T_{12} ribs. compression c̄ breathing ⊖, lumbar ext prone 15x seated T/s ext 5x, supine iso hip v c̄ TA quad. alt UE/LE 10x, mod plank, upper T/s ext prone 5"HAS	
		A: muscular tenderness, has ↑ Ⓡ Rot @ L/s compared to Ⓛ fair core strength	
		P: cont c̄ manual tx and strengthening	Ellen Westberg PT
11/26/14		S. more tender to touch still more sore with movement. He will walk 1 mile and have ↑ sharp pains. sneezing ↑ sharp pains.	
		O: treatment STM to Ⓡ QL, paraspinals T/A mob T_{10}/T_{11}, T_{11}/T_{12}. Instruction in HEP and maintaining upright posture.	
		A: cont to move spinal segments to improve mobility and working breathing intercostal muscle structures to improve rib mobility	
		P: Reassess next visit.	Ellen Westberg PT

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Progress Note

	Last	First	MI
Name:	Edmo	Mason	
Date of Birth:	[redacted]	ID #: 94691	

Date	Time	Description	Signature/Title
12/3/14		S. No Δ. doesn't feel muscular pt stated. Full ext ↑ pn. O. P/A ↑ Rad pn @ lower T/s and upper L/s TA contraction c̄ leg kick, march, unsupported Bridging. Instruction in maintaining neutral spine to limit impingement pain. quadruped arching of L/s is ok but sag ↑ sharp pain. A: Pain seems to be related to full extension position whether loaded or unloaded. P: cont c̄ core strengthening and body mechanic education	Ellen Westberg PT
12/10/14		S. No Δ. "Therapy is not helping" O. TA stab instruction TA c̄ leg press, Bridge, Iso hip √ hold c̄ TA quadruped, LTR Isometric, mod. plank instruction HEP Pt (I) demo of above therex. A: full ext and RR ↑ pn. Instructed pt to pay attention to posture that ↑ S/S. Pt will work to develop core strength x1 mo to see if improvement occurs. P: D/C to HEP	Ellen Westberg PT

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Progress Note

	Last	First	MI
Name:	Edmo	Mason	
Date of Birth:	[redacted]	ID #: 94691	

Date	Time	Description	Signature/Title
JAN 05 2015 915		S: pt into opc for BP/HA	Jan Drake, LPN
DATE:		HPI: 2+ years of low back pain noted worse ō movement	
WT: 211		of almost any type. She notes pain is constant but	
BP: 125/74		will get worse at times @ which point he gets a	
P: 76		head ache. She describes the HA as a typical migraine	
T: 97.9		for her. She indicates vaguely to middle back &	
O: 98% RA		lower back as origin. She notes diagnosis "fibromyalgia".	
718664		She attempted tx ō Flexeril but noted side effects &	
R13		psych MD DC'd. She attempted PT but had little	
		to no improvement. She denies any loss of ROM or	
		progressive paresthesia.	
		O: VSS, NAD. CN 2-12 grossly intact. Indicates mid	
		back T12-L1 region as location of discomfort. Easily	
		demonstrates ROM exercises including full 90° flexion	
		25° L/R lateral bending 20° extension. Demonstrates	
		standing on one leg, tip toes & heels s̄ complications	
		A: Mid back pain s̄ functional involvement, somatic	
		syndrome.	
		P: Cont working on physical exercise. The few	
		motions I asked the patient today to complete	
		were clearly tiring her. She notes several exercise	
		programs she has attempted to adopt but failed.	
		Her over weight status & limited physical activity	
		are likely obscuring organic diagnoses. May consider	
		alternative tx if no improvement in 4-6 months	
		or radiographic eval if clinically warranted	Christian Gelok, NP
			JAN 05 2015
1/12/15	1440	pt failed to show for opc appt.	
		Sent MRD to resubmit HSR PRN	Jan Drake, LPN

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Progress Note

Name:	Edmo, Mason	
Date of Birth:		ID #:

Date	Time	Description	Signature/Title
MAR 2 4 2015		LAB DRAW	[signature]
3-30-15		Recent Records Copied for SSA. RJ.	Ruthie Jablonski, MR
8.11.15	1447	Pt scheduled mental health today. Pt no show. See [illegible]	Gen Brewer, RN [signature] RN
8/31/15	0900	wt 210 VS: 129/83, P 107, R12, T 97°, SpO2 96% [illegible] Pt. up to CDR for HSR's # 770385, 770386 & 770384	Shauna Kitto, RN [signature]
		HPI: Multiple HSR's submitted all associated c GID request. Labs were ordered for Sept but yet to be conducted. Will assure they are scheduled. Discussed use of Jock strap for testicular support & reviewed current IDOC & Corizon treatment standard as use of athletic supporter. Also reviewed medications and current levels of estrogen are within range for menstruating female, testosterone well suppressed.	
		O: VSS, NAD. Labs reviewed & MAR reviewed.	
		A: GID	
		P: Athletic supporter standard policy treatment [illegible] Last estrogen & testosterone levels therapeutic for GID tx will redraw Testosterone & Estrogen & schedule in 2 wks to review [illegible] @ [illegible] else will send med to inform.	
SEP 0 ? 2015		LAB DRAW	[signature]
10-2-15	1110	f/u Nurse visit R/T self injurious Behavior. Steri-strips still intact, warm/dry area Ø S/S of infection. edu S/S of infection-IM verbal [illegible] understanding	Kasidee Barney, [illegible] [signature]

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Leslie Carlson RN/DON

CS1104 10/5/15 LAB DRAW

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Progress Note

Name:	Edmo, Mason		
Date of Birth:	[redacted]	ID #:	94691

Date	Time	Description	Signature/Title
10-8-	1412	wt 205 vs BP 122/81 HR 83 T 97.7 RR 14 SPO2 [illegible]	[signature]
		in CDP for f/u labs	[illegible]
		Repeat Total Estrogen level 137.4 pg/ml	
		Estradiol 36.4	
		Pt happy to continue single dosing medications	
		Note that Total E is decreased about 4 fold	
		which is somewhat concerning for lab error – recent Δ in	
		lab work. Level is just barely in low range	
		for a mid-cycle menstruating female.	
		Given this as well as the patient's heavier	
		weight as well as her dissatisfaction with	
		feminization, I discussed + agree to	
		↑ Estradiol with the explicit intent to	
		monitor level + ↓ if supraphysiologic. Risks/Benefits	
		of estrogen therapy are again discussed including	
		thrombosis/PE / ↓ bone density / ↑ CV risk and	
		she is eager to proceed.	
		O: Exam deferred – see labs	
		A: Gender dysphoria	
		P: ↑ Estradiol to 4mg PO QD x 90 days	
		F/U c Site MP next CPP visit. Requests to see	
		"A GD evaluator"	
		[signature] William Poulson, NP 1550	
		OCT 08 2015	
11/15/15	1845	mental health screening completed for housing in Unit 8. pt denies	
		thoughts of suicide or self harm at this time. Will continue to	
		monitor. Chart reviewed. Cleared for housing in Unit 8. K Larsen	
		Kelly Larsen, LPN	
MAR 09 2016		LAB DRAW	
MAY 02 2016			[signature]

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Progress Note

	Last	First	MI
Name:	Edna Mason		
Date of Birth:	[redacted]	ID #: 94691	

Date	Time	Description	Signature/Title
	JUN 2 1 2016	LAB [illegible]	GT

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Progress Note

Name: Edmo, mason		ID #: 94691
Date of Birth: [redacted]		

Date	Time	Description	Signature/Title
7/13/16	1245	Medical + MH Screens completed for Housing in US Seg, Cleared. Denies thoughts of Suicide or Self harm	Tammy Case, LPN TCase
JUL 19 2016		pt to stop for Lab tests request	Jan Drake, LPN
915		(S) Pt here to request STI screening. Denies fever, ~~chills~~ chills, lesions, discharge, fatigue. Has not been sexually active in over 8 months. Has not been screened for STIs since 2010. Pt declined GU exam.	
Date:			
WT: 190			
BP: 117/86			
P: 113		(O) WDWN male, NAD. Alert, responsive and cooperative.	
T: 97.3		PE deferred for discussion / chart review.	
O: 97%/RA		(A) STI screening request, asymptomatic.	
HSR#: 0545240		(P) Urine GC/chlamydia first void	
		HIV, RPR, Hep B and C. No need for CBC, CMP as 5/2/16 panel WNL	
		F/U PRN	
		DBarry Daniel Barry, PA-C 0940 JUL 19 2016	
	JUL 2? 2016		GT
8/4/16	1143	Lab for GC/CT come back not preformed will order repeat. Hep panel shows Hep B surface AB indicating hx of immunization.	
		[signature] PAC 8/4/16 1145	Anthony Bushnell, PA-C
8/8/16		Pt given cup for UA GC/Chlamydia	[signature]

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Progress Note

Name: Edmo, Mason (Last / First / MI)
Date of Birth: [redacted] | ID #: 94691

Date	Time	Description	Signature/Title
9/5/16	1200	Medical + MH Screens completed for U8 Seg placement, Cleared. Denies thoughts of Suicide or Self harm @ this time	Tammy Case, LPN
9.8.16	0800	Patient seen in CDP, see chronic disease follow up notes. Staff Present with provider during visit.	Amanda Beck, RN; Jan Drake, LPN
SEP 13 2016 955		pt into opc for Reab Test for STD	
Date: WT: 180 BP: 129/88 P: 110 T: 97.3 O2: 100% RA HSR#: 685021 RIH		S) Pt reports sexual assault on 8/21/16 security is aware. Had (-) G/C urine collected 8/10/16. Denies any symptoms of STD. O) VS to (L) in NAD, skin warm and dry, in good spirits. A/P) s/p sexual assault HIV, RPR, 1st void G/C, F/u ō labs back. [signature] PAC	Anthony Bushnell, PA-C 0915 SEP 13 2016 GT
SEP 13 2016		LAB DRAWN Pt. given cup for UA	GT
9/19/16	1400	Per our new protocol, GD pts will be sent to Dr. Alvino, a provider focusing on GD. Message sent to pt.	David Agler, MD

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Progress Note

Name: Last: Edmo First: MI:
Date of Birth: ID #: 94691

Date	Time	Description	Signature/Title
SEP 26 2016		pt into opc for lab results	Jan Drake LPN
8/6		(S) Pt here to review lab results. Denies any symptoms.	
Date:		(O) Negative HIV and RPR. Urine GC/chlamydia ordered 9/13/16	
WT: 180		was not performed	
BP: 115/72		(A) Concern for STI	
P: 115		(P) Urine GC/chlamydia - repeat ~~lab~~ since lab did not receive	
T: 96.6		F/U PRN	
O2: 98% RA		Daniel Barry, PA-C	
HSR#:		0910 SEP 26 2016	
R16			
SEP 2? 2016		Pt. give a cup	
OCT 14 2016			
1039		No Show for opc appt MRD sent	Jan Drake, LPN
		Date: 10/25/16 Time: 0820 HSR# 878816	
		Seen by Optometrist	
		☒ Yes ☐ No Glasses Ordered	
		Sign: K Larsen Kelly Larsen, LPN	Jan Drake, LPN
NOV 02 2016		pt into opc for jock strap request	
830			
Date:		(S) PT here for Jock strap	
WT: 180		because it helps w/ sports and	
BP: 10?/68		G.D. ∅ new or different Sx's	
P: 104			
T: 97.3		(O) Aox3 NAD	
O2: 97%, RA			
HSR#:		(A) G.D. Daniel Dellwo, PA-C	
R16		(P) OK for Jock Strap NOV 02 2016 0920	

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Progress Note

Name: Edmo, Mason

Date of Birth: [redacted] ID #: 94691

Date	Time	Description	Signature/Title
11/29/16	0800	Patient seen in CDP See notes	[signature]
		See CDP Notes for Non-Compliance on Oleductone	
		Daniel [illegible] NOV 2 9 2016 1600	
	DEC 1 2 2016		[signature]
12/14/16	0900	Pt to CDP to visit c̄ Dr. Aluso	
		wt: 181 VS: 128/80, 120-HR, 98% RA, 98.1° T, 18-RR	MBeck, RN

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Progress Note

Last	First	MI
Name: Mason Edmo		

Date of Birth: DOB [redacted] ID #:

Date	Time	Description	Signature/Title
12/14/16		Preferred name Adree	
	12:15	Preferred pronoun: her/she	
Physical Δ		Transgender hx	
- B cup		- knew she was different since she was 5,	
- softer hair		- called herself gay, but knew it was different	
- fat		- Teenager - always wore her sister's clothes	
distribution		makeup	
to thighs		- Puberty was rough - did not like her	
		deep voice, male sex organs	
Mental		- became more depressed, did not like the	
- felt hurt		fact she had penis	
hormone		- Transitioned full time / living as a female when	
helped		she was 17-18.	
her anxiety		- HRT Sept 2012	
and		FHx	
managing		⊖ DVT ⊕ DM - mother ⊖ CVD	
her emotions		⊖ Clotting d/o ⊕ breast, prostate CA	
		ROS	
		⊖ HA, ⊖ blurry vision, ⊖ cough, ⊖ colds, ⊖ CP,	
Labs		⊖ SOB, ⊖ Abdominal pain, ⊖ leg swelling	
K 4.3			
AST 18		PE VSS	
ALT 15		Gen: awake, alert NIAD	
Chol 160		HEENT: NCAT, EOMI, TM intact bilaterally	
TG 78		Mouth: MMM, ⊕ dentures	
HDL 41		Lungs CTAB, no wheeze, no crackles	
Rest 229		Cardiac RRR $S_1 S_2$ heard	
fm 63		Abdomen: soft, NT, ND	
		Extremities no leg swelling	

Prolactin 4.2

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Progress Note

Name: Last: Edmo First: Mason MI:

Date of Birth: [redacted] ID #: 94691

Date	Time	Description	Signature/Title
1/1/17	1415	IM Given ii T4's x once Now order from provider Dellwo (Verbal Order Read Back) (See MAR)	Tina Lee, RN
1/1/17	1715	IM resting quietly in bed. VSS. A+Ox3 +HRRR, Lungs CTA Bilat. B.S. x4 IM denies S/I + H/I (suicide ideations, homosidual ideations) + urges to self harm. Clinician (on-call) in to see IM today. (R) testicle sutures clean + dry, ∅ S/S infection. Penrose drain patent, small amount (scant) Serosang drainage on 4x4s) Pt educated on letting nursing staff know if 4x4's become saturated. Provider Dellwo instructed patient that he may shower in 24°. New orders for Augmentin ABx po + T4's for pain. Tina Lee, RN	Tina Lee, RN
1/1/17	1720	Shift infirmary nursing assessment complete. See nursing assessment tool.	Tina Lee RN
01.02.17	0000	Slept on + off this eve. Satis pain mgmt c meds ordered. Patient Edmo is changing the scrotal dsg. Minimal amt of drainage. Penrose intact. Up in the room. V.S.S. Eileen Mitchell RN. Eileen Mitchell, RN	
1/2/17	0943	Shift infirmary nursing assessment complete. See nursing assessment tool. Denies questions/concerns. 1000 mL H_2O & ice @ bedside. Will continue to monitor.	Amanda Benton, RN, DON ABenton RN

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Progress Note

Name: Edmo, Adree Mason
Date of Birth: [redacted]
ID #: 94691

Date	Time	Description	Signature/Title
01.03	0000	This patient told me that the cutting behavior has subsided at this time. no c/o questions or concerns. Eileen Mitchell RN	Eileen Mitchell, RN
1/3/16	1930	HS meds given pt c̄ Nd voiced c/o no longer pt DCed from care still in unit	G. Capshaw, RN
1/4/16	0015	Resp even and non labor lying quietly in bed	G. Capshaw, RN
01.05.17	0600	97°. 108. 16 106/75. States pain relief. no new c/o discomfort. In good spirits. Eileen Mitchell RN	Eileen Mitchell, RN
JAN 10 2017	1155	Pt scheduled ~~for follow up on~~ OPC appt DATE: 1/13/17 pt is in unit 8 security state unable to come to opc apt	Jan Drake, LPN
JAN 13 2017		pt into opc for OSS f/u 12/31 + infirmary discharge f/u	Jan Drake, LPN
Date: T 80 (S) Wt: BP: 134/91 P: 109 T: 97.3 O₂: 100/RA HSR#:		Pt in for f/u s/p ER trip & infirmary stay 2° to trying to remove testicles. Pt states everything has healed, stitches are gone & denies any s/s of infection, denies pain. (O) VSS, NAD. PE deferred for discussion. (A/P) s/p OSS & infirmary. 1) RTC PRN	1/17/17
JAN 17 2017	8:16		Galyan Thurston, Phlebotomist

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Progress Note

Name:	Last: Edmo	First: Mason	MI
Date of Birth:	[redacted]	ID #:	94691

Date	Time	Description	Signature/Title
1/9/17	1000	MH + Medical Screens completed for U8 Seg Placement, cleared. Denies thoughts of suicide or self harm @ this time. — Tammy Case, LPN	T Case LPN
FEB 01 2017		pt into opc for Lumb by spine	Jan Drake, LPN
9/15		(S) Pt presents c 2 bumps, 1 on each side of lower lumbar spine. states he noticed the lump ≈ 2 weeks ago. They don't affect [illegible] or [illegible] but are sore when he lays down & interfere c sleep.	
Date: WT: 178 BP: 116/76 P: 104 T: 97.3 O: 98% RA HSR#: 915205 R 16		(O) VSS NAD. CV RRR, lungs CTA. Lower back – 1 nodule/knot on lower left back & 1 on right. Hip. fixed Ø erythema, Ø edema	
		(A/P) bumps in back – Muscle knots – will give [illegible]. If not resolved, consider lymphadenopathy, lipomas, or other etiology. – RTC if symptoms persist or worsen	Tripper Power NP-C
2-16-17	1000	Pt to CDP See CDP notes	
		Wt: BP: HR: RR: SpO2: T:	R. [illegible] LPN

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CORRECTIONAL MEDICAL SERVICES, INC.
PHYSICIANS' ORDERS

Name_ EDMO, MASON #94691 D.O.B [redacted] T | _______ D.O.B. _______

Locatio | _______ Allergies _______

Check box as order is noted:	(Date & Time)
Noted by: Jared ... CMS Date: 4/26 Time: 2015	1) Miconazole 2% apply affected area BID x 7D 1 tube given V/O per N.P. Takagi per CMS Revard M.D. Signature Ben Bish N.P.-C Date/Time 4/30/12 1035
Noted by: BO 5/4/12 Brooke Olson, LPN Date: Time: 1930	1) start Lamictal 25 mg PO Q AM x 14 days, then increase to 50 mg PO Q AM. 2) MH F/U in 1 month Karen Barrett MS, PA-C M.D. Signature K. Barrett Date/Time 5/4/2012 1415
Noted by: BO 5/5/12 Brooke Olson LPN Date: Time: 0950	parafon forte 500 mg i PO BID x 7 days Neurontin 600 mg i PO TID x 7 days Vistaril 50 mg i PO TID x 21 days APAP 500 mg i PO BID x 7 days Zoloft 100 mg i PO QDAY x 21 days V/O Valley 5/5/12 0930 M.D. Signature Ben Bish N.P.-C Date/Time 5/7/12 0800
Noted by: E Eastman Eva Eastman, R.N. Date: 5/7/12 Time: 1005	Parafon Forte 500 mg i po BID x ~~180 days~~ 90 days Neurontin 600 mg po TID x 180 days M.D. Signature Ben Bish N.P.-C Date/Time 5/7/12 0800

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PHYSICIANS' ORDERS

Name: [illegible] Mason D.O.B. [redacted]

Location: ISCI ID# 94691 Allergies: NKDA

Check box as order is noted:		(Date & Time)
Noted by: [signature] LPN	1)	D/C Vistaril
Date: 5/7/12	2)	D/C Zoloft
Time: 0915		Karen Barrett MS, PA-C
		M.D. Signature [signature] Date/Time 5/7/12 1300

Check box as order is noted:		(Date & Time)
Noted by: [signature]		D/c Lamictal
Date: 6-25-12		Zoloft 100 mg HS ~~x 120~~ ~~days~~ ~~120 days~~
Time: [illegible]		x 1 wk then ↑ to 150 mg HS x 120 days
[illegible]worth, R.N., B.S.N.		RTC 2 mo
		M.D. Signature [signature] Eliason, M.D. Date/Time 6/25/12 1240

Check box as order is noted:		(Date & Time) 7-17-12 1600
Noted by: B Fackrell RN		Zoloft 150 mg PO QHS x 30 days
Date: 7-17-12		Parafon forte 500 mg BID x 90 days
Time: 1600		Neurontin 600 mg TID x 90 days
		VO/Matt Valley PAC / B Fackrell RN — Becky Fackrell, R.N.
		M.D. Signature [signature] Dawson, MD Date/Time 7/18/12 1830

Check box as order is noted:		(Date & Time)
Noted by: [signature]	✓	Schedule MH eval w/in 1 mo
J. Murray, R.N.		Schedule medical provider re: need for current meds long term
Date:		
Time: 1040		April Dawson, M.D.
JUL 19 2012		M.D. Signature [signature] MD Date/Time 7/18/12 1830

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CORRECTIONAL MEDICAL SERVICES, Inc. **PHYSICIANS' ORDERS**

Name EDMO, MASON D.O.B. [redacted]

Location IMSI ID# 94691 Allergies NKDA

Check box as order is noted:	(Date & Time)
Noted by: Dollie Wallace, LPN	1 Chlorzoxazone 500mg i PO x 30 days
	2 Gabapentin 600mg i PO x 30 days
	3 Sertraline 50mg iii PO x 30 days
Date: 8-2-12	
Time: 1540	
	William Poulson, NP-C
	M.D. Signature Date/Time 8/2/12 1300

Check box as order is noted:	(Date & Time)
Noted by:	
Date:	
Time:	
	M.D. Signature Date/Time

Check box as order is noted:	(Date & Time)
Noted by:	
Date:	
Time:	
	M.D. Signature Date/Time

Check box as order is noted:	(Date & Time)
Noted by:	
Date:	
Time:	
	M.D. Signature Date/Time

CORRECTIONAL MEDICAL SERVICES, INC.
PHYSICIANS' ORDERS

Name Edmo, Mason D.O.B. [redacted]
Location ISCI ID# 94691 Allergies NKDA

Check box as order is noted:		(Date & Time)
Noted by: Noted 8-15-12		Zoloft 50mg po QHS x 120 dy
Date: 8-15-12		
Time: 900 L. Whitworth R.N., B.S.N.	✓	
		M.D. Signature Dr. Eliason, M.D. Date/Time 8/15/12 0850

Check box as order is noted:		(Date & Time)
Noted by: noted 8-22-12		Change
		Zoloft to 150 mg po QHS X 120D
Date: 8-22	✓	
Time: 0850 Whitworth, R.N., B.S.N.		
		M.D. Signature Dr. Eliason, M.D. Date/Time 8/22/12 0830

Check box as order is noted:		(Date & Time)
Noted by: M.D.	Total ✓	Testosterone level, TSH, LH, FSH, Prolactin, estradiol. Lab req
	✓	Estrace 0.5mg po bid x 90 days NF
	✓	Spironolactone 25 mg po b.i.d x 180 days
Date: 8-30-12	✓	Oscal D 500mg po daily x 180 days
Time: 1800 RN	✓	EC ASA 81mg po daily with food x 180 days
	✓	Recheck 6CC 90 days 11-27-12
		M.D. Signature Cathy Whinnery, M.D. Date/Time 8/30/12 16:00

Check box as order is noted:		(Date & Time)
Noted by:	✓	Labs 3rd wk of Nov 2012: Testosterone level lab req
Date:		
Time:		
		Cathy Whinnery, M.D.
		M.D. Signature Date/Time 8/30/12 17:00

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PHYSICIANS' ORDERS

Name Emma, Mason D.O.B. [redacted]

Location JSCI ID# 94691 Allergies NKDA

Check box as order is noted:	(Date & Time)
Noted by: 9-19-12 0805 L. Whitworth, R.N., B.S.N. Date: Time:	Zoloft 150 g HS X120 day RTC 3 mo 12-12-12 M.D. Signature Dr. Eliason, M.D. Date/Time 9/19/12 0745
Noted by: 10-31-12 Date: Time:	Ibuprofen 400 mg #30 i/ii q8 p.o. prn pain M.D. Signature Date/Time 10-31-12
Noted by: Stacie McGrew, LPN Date: 11/13/12 Time: 1337	May buy bras from commissary. memo completed M.D. Signature Cathy Whinnery, M.D. Date/Time 11/13/12 13:00
Noted by: L. Brown LPN Date: 11-27-12 Time: 1500	Δ Estrace to Estrotab 0.625 mg PO daily x180days (due to Estrace back ordered) c.c pharmacy Please notify pt of the change - dispensing done M.D. Signature Cathy Whinnery, M.D. Date/Time 11/27/12 13:30

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PHYSICIANS' ORDERS

Name Edmo, Mason D.O.B. [redacted]

Location ISCI ID# 94691 Allergies NKDA

Check box as order is noted:	(Date & Time)
Noted by: Caitlin Ralston, R.N. Date: 12/3/12 Time: 1230	May buy a bra from commissary. C.C. to medrec. EC ASA 81mg po daily with food x180 days. Oscal D 500 po daily with food x 180 days. Spironolactone 25mg po bid x 180 days. Cathy Whinnery, M.D. M.D. Signature ___ Date/Time 12/3/12 11:00
Noted by: Lori Whitworth, R.N. Date: 12-12-12 Time: 1500	Zoloft 150 mg HS x120 dy. RTC 3 wks 3-6-13. Dr. Eliason, M.D. M.D. Signature ___ Date/Time 12/12/12 0950
Noted by: Lori Whitworth, R.N. Date: 1-16-13 Time: 1400	D/C Zoloft. Start Prozac 20mg AM x120 dy. Pharm. RTC 3 mo 4-10-13. Dr. Eliason, M.D. M.D. Signature ___ Date/Time 1/16/13 0920
Noted by: given to pt 2-12-13 Time: ___	2-12-13 Ibuprofen 600mg #30 i q 6 p.o. prn pain. given. Mark ___ DDS. M.D. Signature ___ Date/Time 2-12-13

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PHYSICIANS' ORDERS

Name EDMO, MASON D.O.B. [redacted]

Location ISCI ID# 94691 Allergies NKDA

Check box as order is noted:	(Date & Time)
Noted by: Prudhomme	Increase spironolactone to 50 mg po bid x 180 days
Date: 3/26/13	Estradiol 1 mg po daily x 90 days NF
Time:	D/C Estratest when estradiol available.
	EC ASA 81 mg po daily with food x 180 days
	Oscal D 500 mg po daily with food x 180 days
	Recheck with 90 days 6/20/13
	M.D. Signature Date/Time
Noted by: Jennifer Prudhomme, LPN	Lab 2nd wk June 2013: fasting lipid panel,
Date:	CMP, prolactin level 6/10/13 done 6-4-13
Time:	C. Whinnery, M.D.
	M.D. Signature Date/Time 3/26/13 10:15
Noted by: Stacey McGraw, LPN	4-2-13 Norco 5/325 mg
	36 (thirty-six) tabs
Date: 4/2/13	ii tid x six days
Time: 1026	MARK CUSHING, DDS MEDICAL DEPARTMENT
	M.D. Signature M Cushing Date/Time 4-2-13
Noted by: Whitworth, R.N.	Prozac 20 mg AM x 120 days - Pharmacy
Date: 4-10-13	RTC 3 wo 6-26-13
Time: 1000	
	M.D. Signature Dr. Eliason, M.D. Date/Time 4/10/13 0830

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CORRECTIONAL MEDICAL SERVICES, INC.
PHYSICIANS' ORDERS

Name: Edmo, Masa D.O.B. [redacted]

Location: ISCI ID# 94691 Allergies: NKDA

Check box as order is noted:	(Date & Time)
Noted by: Jennifer Prudhomme, LPN; Date: 5/30/13; Time: 1120	Increase Estradiol to 2mg po daily x90days NF Decrease spironolactone to 25mg po bid x 7 days then D/C Proscar 5mg po daily x 90 days NF Add total testosterone to labs ordered 2nd wk June C. Whinnery, M.D. M.D. Signature: [signature] Date/Time: 5/29/13 16:00
Noted by: Whitworth R.N. B.S.N.; Date: 6/26/13; Time:	Prozac 30mg AM x120 days 7 plan RTC 3w 9.18.13 M.D. Signature: [signature] Scott Eliason, MD Date/Time: 6/26/13 1100
Noted by: Jennifer Prudhomme, LPN; Date: 7/1/13; Time: 1530	EC ASA 81 mg po daily x180 days Oscal D 500mg 1 po daily x180 days Estradiol 2mg po daily x 90 days NF. This order to start 8/29/13 Proscar 5mg po daily x 90 days - this order to start 8/29/13 C. Whinnery, M.D. M.D. Signature: [signature] Date/Time: 7/1/13 14:00 MEDICAL RECORD ORDER REVIEW COMPLETED NAME: DATE:
Noted by: [signature]; Date: 7/31/13; Time: 1142	Parafon Forte 500 mg tabs, 1 tab PO tid PRN muscle tension Pharm MEDICAL RECORD ORDER REVIEW COMPLETED NAME: KB DATE: 7/31/13 M.D. Signature: [signature] Edward Savala, MD Date/Time: 7/31/13 0940

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CORRECTIONAL MEDICAL SERVICES, INC.
PHYSICIANS' ORDERS

Name: Edmo, Mason D.O.B. [redacted]

Location: ~~ISCI~~ ICIO ID# 94691 Allergies: NKDA

Check box as order is noted:	(Date & Time)
Noted by: D Kaufmann RN Date: 8-13-13 Time: 0850 Diane Kaufmann, RN	Prozac 30mg PO q AM x 30days Sched C Ø! Os Cal D 500mg T PO daily x 90dy Estradiol 2mg PO daily x 90days NF M.D. Signature ______ Date/Time ______
Noted by: D Kaufmann RN Date: 8-13-13 Time: 0850 Diane Kaufmann, RN	NF Proscar 5mg PO daily x 90days DC Porfomforte. Spironolactone 25mg PO bid x 90days ASA 81mg T PO daily x 90days Rory York, ARNP M.D. Signature [signature] Date/Time 8/13/13 0800
Noted by: Date: Time:	(Date & Time) M.D. Signature ______ Date/Time ______
Noted by: Date: Time:	(Date & Time) M.D. Signature ______ Date/Time ______

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CORIZON

Physician Order Sheet

Patient:	Mason Edmo	IDOC:	94691	DOB:	[redacted]
		Allergies:	NKDA		

Noted by: D Kaufmann RN Date: 9-12-13 Time: 1000 Diane Kaufmann, RN	=> Increase to Prozac 40mg PO QAM x 120 days => RTC in four weeks Richard A. Montgomery, M.D. [signature] 9/12/13 9:54:54 AM

Noted by: [signature] Date: 9/13/13 Time: Fran Palazzo RN, BSN	See Dr Peterson notes estrogen ↑. M.D. Signature [signature] Rory York, ARNP Date/ Time 9/13/13 1100

Noted by: Kim Powers CMS Date: 10/4/13 Time: 1600 Kim Powers, CMS	10/4/2013 ↑ Spironolactone + 50mg twice per day x 90d M.D. Signature [signature] Phillip Petersen, MD Date/ Time 10/4/2013

Noted by: Date: Time:	M.D. Signature______ Date/ Time______

CORIZON

Physician Order Sheet

Patient:	Mason Edmo	IDOC:	94691	DOB:	[redacted]
		Allergies:	NKDA		

Noted by:	Orders
Noted by: F Palazzo RN Date: 10-8-13 Time: 1012 **Fran Palazzo RN, BSN**	=> D/C Prozac => Start Zoloft 50mg PO QD x 5 days and then increase to 100mg PO QD x 120 days => RTC in four weeks Richard A. Montgomery, M.D. [signature] 10/8/13 8:19:51 AM
Noted by: [signature] LPN Date: 11-01-13 Time: 1000 **Marcus Samson, LPN**	Hydrocort 1% cr. BID [illegible] OOS X 30 days Rory York, ARNP M.D. Signature [signature] Date/ Time 11/1/13 0830
Noted by: S Brown RN Date: 11/3/13 Time: 1345 **Sharon Brown, RN**	11/3/13 1345 1) ASA 81 mg PO Q AM x 90 days 2) Calcium carb 1250 mg / Vit D 1250 mg PO QD x 90 days 3) estrace 2mg PO QD x 90 days 4) proscar 5mg PO QD x 90 days VO: R. York NP / S Brown RN Sharon Brown, RN Rory York, ARNP M.D. Signature [signature] Date/ Time 11/4/13 0800
Noted by: Date: Time:	M.D. Signature Date/ Time

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PHYSICIANS' ORDERS

Name Edmo, Mason D.O.B. [redacted]

Location 1C-D ID# 94691 Allergies NKDA

Check box as order is noted:	(Date & Time)
Noted by: [signature] LPN Date: 11-13-13 Time: 1000 Marcus Samson, LPN	[handwritten order] 003 Rory York, ARNP M.D. Signature [signature] Date/Time 11/13/13 0945
Noted by: [signature] RN Date: 11-18-13 Time: 0? Fran Palazzo RN, BSN	Refer to Dr Peterson [illegible] [illegible] Rory York, ARNP M.D. Signature [signature] Date/Time 11/18/13 0940
Noted by: [signature] Sharon Brown, RN Date: 12/23/13 Time: 0938	(Date & Time) 12/23/13 0837 ① Make ASA and Ca++ [illegible] KOP Rory York, ARNP [signature] 12/30/13 0800 Anthony Bushnell, PA-C M.D. Signature [signature] PA-C Date/Time 12/23/13 0837
Noted by: [signature] Sharon Brown, RN Date: 12/24/13 Time: 1440	(Date & Time) 12/24/13 1437 ① Spironolactone 50 mg PO BID x 120 days Rory York, ARNP [signature] 12/30/13 0800 Anthony Bushnell, PA-C M.D. Signature [signature] Date/Time 12/24/13 1437

CMS 7193 Physicians Orders Rev 03/04, Reviewed 08/08

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PHYSICIANS' ORDERS

Name Edmo, Mason D.O.B. [redacted]

Location 1C1-O ID# 94691 Allergies NKDA

Check box as order is noted:		(Date & Time) 1/3/14 0958
Noted by: [signature] 1-3-14	①	CTM 4mg PO TID x 8 days OOS
	②	Nasal saline, 2 squirts each nostril daily x 7 days OOS
Date: 1-3-14		
Time: 1825		Anthony Bushnell, PA-C
/ Fran Palazzo RN, BSN		M.D. Signature [signature] PA-C Date/Time 1/3/14 0958
Check box as order is noted:		(Date & Time) 1/16/14 0910
Noted by: Kim Powers CMS	①	Schedule c Dr. Young. 4/21
Date: 4/21/14		
Time: 0905		Anthony Bushnell, PA-C
Kim Powers, CMS		M.D. Signature [signature] PA-C Date/Time 1/16/14 0910
Check box as order is noted:		(Date & Time)
Noted by:		
Date:		
Time:		
		M.D. Signature Date/Time
Check box as order is noted:		(Date & Time)
Noted by:		
Date:		
Time:		
		M.D. Signature Date/Time

CMS 7193 Physicians Orders Rev 03/04, Reviewed 08/08

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Physician Order Sheet

Patient:	Mason "Adree" Edmo	IDOC:	94691	DOB:	[redacted]
		Allergies:	NKDA		

Noted by: J. Palazzo RN
Date: 1-21-14
Time: 937
Fran Palazzo RN, BSN

=> Increase to Zoloft 150mg PO QD x 120 days
=> KITE to see clinician
=> RTC in four weeks

Richard A. Montgomery, M.D. RAM 1/21/14 10:11:54 AM

Noted by: SBrown
Sharon Brown, RN
Date: 1/28/14
Time: 1152

1/28/14 1150
1. ASA 81 mg PO QD x 120 days
2. calcium carb 1250 mg / Vit D 1250 mg PO QD x 120 days
3. estrace 2 mg PO QD x 120 days
4. proscar 5 mg PO QD x 120 days
VO: T. Bushnell PA-C / SBrown Sharon Brown, RN
Anthony Bushnell, PA-C

M.D. Signature Anthony T. Bushnell PA-C Date/ Time 1/28/14 1331

Noted by: J. Palazzo RN
Date: 2/11/14
Time: 1167
Fran Palazzo RN, BSN

Refer to GID evaluator

Anthony Bushnell, PA-C

M.D. Signature Anthony T. Bushnell PA-C Date/ Time 2/11/14 1425

Noted by:

Date:

Time:

M.D. Signature Date/ Time

CORIZON | **Physician Order Sheet**

Patient:	Mason "Adree" Edmo	IDOC:	94691	DOB:	[redacted]
		Allergies:	NKDA		

Noted by: [signature] Date: 2/14/14 Time: 55 Fran Palazzo RN, BSN	=> RTC in three weeks Richard A. Montgomery, M.D. [signature] 2/13/14 8:53:15 AM
Noted by: [signature] Rachael Malone, LPN Date: 2-19-14 Time: 2130	~~Bridge order x 30 days Per Whinnery~~ ~~ASA 81 QD PO x30~~ ~~Oscal D 1250 mg x30~~ ~~Zoloft 100 mg QD x30~~ Error RMalone ~~Aldactone 50 mg Bid PO x30~~ ~~Estrace 2mg PO Qday x30~~ ~~Proscar 5mg PO Qday x30~~ M.D. Signature Date/ Time
Noted by: [signature] Jennifer Prudhomme LPN Date: 3/6/14 Time: 14:58	ASA 81 mg po daily with food x 210 days OsCal D 500mg 1 po daily x 210 days Increase Estradiol to 3mg po daily x 90 days Proscar 5mg po daily x 90 days - this order to start 4/5/14 Spironolactone 50 mg po bid x 210 days Labs: Fasting last wk May 2014: Diagnostic profile III, TSH, M.D. Signature Date/ Time
Noted by: Date: Time:	~~estradiol level~~, total serum estrogen level, testosterone level (total), prolactin Cathy Whinnery, M.D. M.D. Signature [signature] Date/ Time 3/6/14 Noon

[handwritten margin notations: pharm; labs/dated 5-23-14]

All orders will be generic unless specified by provider

Practitioner's Orders

Patient Name: Mason "Adree" Edmo **DOB:** [redacted] **ID#** 94691 **Housing Unit:** **Allergies:** NKDA **Noted By:** [signature] Whitworth R.N./B.S.N. **Date:** 3-10-14 **Time:** 1130	**Verbal / Telephone Orders** ☒ No ☐ Yes **Per:** ↑ Zoloft 100 mg po AM x 120 days RTC: 6 WKS 4-21-14 Jane Seys PNP **Provider Signature** [signature] **Date & Time:** 3/10/14 7:18 AM
Patient Name: [illegible] Mason **DOB:** [redacted] **ID#** 94691 **Housing Unit:** **Allergies:** NKA **Noted By:** [signature] R.N./B.S.N. Whitworth **Date:** [illegible] **Time:** 1500	**Verbal / Telephone Orders** ☐ No ☐ Yes **Per:** Δ Zoloft to 150 AM X 120 d RTC 3 mo 7-2-14 Scott Eliason, MD **Provider Signature** [signature] **Date & Time:** 4/9/14 0830
Patient Name: **DOB:** **ID#** **Housing Unit:** **Allergies:** **Noted By:** Jennifer [illegible], LPN **Date:** 4/17/14 **Time:** 1712	**Verbal / Telephone Orders** ☐ No ☐ Yes **Per:** Please send disposition that if the spironolactone makes him sick he can stop it - (I will D/C it). He already has the Proscar (finasteride) and can continue with that. D/C Spironolactone (causing nausea & stomach cramps) **Provider Signature** C. Whinnery, M.D. **Date & Time:** 4/17/14 1913
Patient Name: **DOB:** **ID#** **Housing Unit:** **Allergies:** **Noted By:** **Date:** **Time:**	**Verbal / Telephone Orders** ☐ No ☐ Yes **Per:** Can send another disposition - "it's ok. to stop the spironolactone if it makes you tired and sick and continue with the proscar. You have labs ordered for May that will test your potassium. We can go over results **Provider Signature** **Date & Time:**
Patient Name: **DOB:** **ID#** **Housing Unit:** **Allergies:** **Noted By:** Heather Nader, RN **Date:** 4/17/14 **Time:** 0817	**Verbal / Telephone Orders** ☐ No ☐ Yes **Per:** and your meds at your regular chronic care visit." C. Whinnery, M.D. **Provider Signature** [signature] **Date & Time:** 4/23/14 09:00

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Practitioner's Orders

Patient Information	Orders
Patient Name: Mason Edmo DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: [signature] Blake, LPN Date: 5/29/14 Time: 1134	Verbal / Telephone Orders ◯ No ◯ Yes Per: ① A1C screening today Lab William Poulson NP-C Provider Signature [signature] Date & Time: 5/29/14 1800
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: [signature] LPN Date: 6/5/14 Time: 1451	Verbal / Telephone Orders ◯ No ◯ Yes Per: Estradiol 3mg PO QD } x 90 days phone Proscar 5mg PO QD Provider Signature [signature] William Poulson NP-C Date & Time: 6/5/14 1400
Patient Name: Edmo Mason DOB: [redacted] ID# 94691 Housing Unit: Paulina Roberson, LPN Allergies: Noted By: [signature] Date: 7/3/14 Time: 1528	Verbal / Telephone Orders ◯ No ◯ Yes Per: EC ASA 81mg po daily x 210 days take with food Os Cal D 500mg 1 po daily x 210 days Estradiol 3mg po daily x 90 days - this order to start 8/2/14 Spironolactone 25mg po bid x 14 days followed by 50mg po bid x 30 days Provider Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Paulina Roberson, LPN [signature] Date: 7/3/14 Time: 1528	Verbal / Telephone Orders ◯ No ◯ Yes Per: followed by 100mg po bid x 90 days D/C Proscar when spironolactone started Lab 2nd wk August 2014: Chem 7 lab Lab last wk Sept 2014: Total testosterone level, Chem 7, total serum estrogen Provider Signature [signature] C. Whinnery MD Date & Time: 7/3/14 Noon
Patient Name: Edmo Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: Noted By: Julie Savell, LPN [signature] LPN Date: 7-16-14 Time: 1040	Verbal / Telephone Orders ◯ No ◯ Yes Per: ↓ Zoloft to 100 mg AM x 120 d RTC 3 wk Provider Signature [signature] Scott Eliason, MD Date & Time: 7/16/14 1040

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Practitioner's Orders

Patient Information	Orders
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Jan Drake, LPN Date: AUG 22 2014 Time: 1210	Verbal / Telephone Orders ○ No ○ Yes Per: Tucks pad (provided) given Hemmorhoid suppositories (provided) given Fiber tablet + PO QD x 180D Pharm ↑ H_2O intake ✓ Provider Signature Christian Gelok, NP 1100 Date & Time: AUG 22 2014
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Jan Drake, LPN Date: AUG 25 2014 Time: 1031	Verbal / Telephone Orders ○ No ○ Yes Per: 1) Naprosyn 500 mg ½-1 tab PO ATD x pharm 30 days (#30 tabs max/#30 dispensed) 2) Percogesic Forte 500 mg PO QHS x 3 days, pharm **MAY START WHEN ORDER ARRIVES** Provider Signature B. Poulson NP Date & Time: 8/25/14 1000
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Jan Drake, LPN Date: 8/26/14 Time: 937	Verbal / Telephone Orders ○ No ○ Yes Per: 1) Miconazole 2% cream AAA x 3 weeks BID, then daily PRN x 30 days pharm **MAY START WHEN ORDER ARRIVES** Provider Signature William Poulson NP-C Date & Time: AUG 26 2014
Patient Name: Edmo Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: Noted By: Julie [illegible] LPN Date: 9/7/14 Time: 0915	Verbal / Telephone Orders ○ No ○ Yes Per: ↑ Zoloft to 150 mg AM x 120 d RSE [illegible] 12-10 Provider Signature Scott Eliason [illegible] Date & Time: 9/7/14
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Jan Drake, LPN Date: 10/1/14 Time: 1437	Verbal / Telephone Orders ○ No ○ Yes Per: -PT (L) shoulder muscle spasm (L) shoulder x 4 treatments - Lyndsey Naproxen 350 mg PO BID x 180 Days KOP pharm Provider Signature Christian Gelok, NP 1400 Date & Time: OCT 01 2014

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Practitioner's Orders

Patient Name: Edmo, Mason **DOB:** [redacted] **ID#** 94691 **Housing Unit:** **Allergies:** NKDA NKDA **Noted By:** Shauna Kitto, RN **Date:** 10/8/14 **Time:** 1400	**Verbal / Telephone Orders** No Yes **Per:** NF Estradiol 3mg po daily x 90 days starting 10/31/14 NF Proscar 5mg po daily x 90 days Decrease spironolactone to 50mg po BID once the Proscar starts x 210 days Lab last wk December: CMP-14, A1C, TSH, total testosterone, prolactin level, total estrogen level. pharm / CMC **Provider Signature** **Date & Time:**
Patient Name: **DOB:** **ID#** **Housing Unit:** **Allergies:** Shauna Kitto, RN **Noted By:** [signature] RN **Date:** 10/8/14 **Time:** 1400	**Verbal / Telephone Orders** No Yes **Per:** C. Whinnery, M.D. **Provider Signature** [signature] **Date & Time:** 10/8/14 13:00
Patient Name: **DOB:** **ID#** **Housing Unit:** **Allergies:** **Noted By:** Jan Drake, LPN **Date:** 11/17/14 **Time:** 1135	**Verbal / Telephone Orders** No Yes **Per:** 1) D/C Naprosyn pharm 2) Elavil 10mg PO QHS x 90 days for pain - MH please review if pt suitable for long term TCA - Fibromyalgia type pain pharm 3) PT consult x 3 Lyndsey **Provider Signature** [signature] William Poulson NP-C **Date & Time:** NOV 17 2014
Patient Name: **DOB:** **ID#** **Housing Unit:** **Allergies:** **Noted By:** DEC 08 2014 [signature] **Date:** **Time:** 1134 Jan Drake, LPN	**Verbal / Telephone Orders** No Yes **Per:** 1) D/C Elavil - non-adherence. pharm **Provider Signature** [signature] William Poulson NP-C **Date & Time:** DEC 08 2014
Patient Name: **DOB:** **ID#** **Housing Unit:** **Allergies:** **Noted By:** **Date:** **Time:**	**Verbal / Telephone Orders** No Yes **Per:** **Provider Signature** **Date & Time:**

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Practitioner's Orders

Patient Name: Edmo Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Julie Savell, LPN Date: 12-10-14 Time: 0845	Verbal / Telephone Orders No Yes Per: Zoloft 150 mg AM x120 days RTC 3 mo 3-4 Provider Signature: Scott Eliason, MD Date & Time: 12/10/14
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders No Yes Per: Increase spironolactone to 100mg po bid x210 days ~~Spironolactone 50mg po BID~~ x120 Aspirin 81mg po qd x210 days Oscal-D 500 po qd NF Estradiol 3mg po qd x90 d this order to start 1/29/15 NF Proscar 5mg po daily x 90 days Provider Signature: Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Julie Savell, LPN Date: 1-8-15 Time: 2238	Verbal / Telephone Orders No Yes Per: Lab last wk March 2015: total testosterone, estrogen done C. Whinnery, M.D. 13:00 Provider Signature: C. Whinnery Date & Time: 1/8/15
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Julie Savell, LPN Date: 1-9-15 Time: 1001	Verbal / Telephone Orders No Yes Per: Jock strap (size medium) with ABD pad supply for scrotal support C. Whinnery MD 18:00 Provider Signature: Date & Time: 1/8/15
Patient Name: Edmo Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKA Noted By: Gen Brewer, RN	Verbal / Telephone Orders No Yes Per: Zoloft 150 mg PO Q HS x120 days RTC 3 month. 4.22.15 Scott Eliason, MD Provider Signature: Date & Time: 1/28/15

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Practitioner's Orders

Patient Information	Orders
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Shelli Mallet, LPN, Ombudsman Date: 2-9-15 Time: 1615	Verbal / Telephone Orders No Yes Per: Abd. pads for scrotal support (per ~~1-8-15 order~~), please allow 30 per month. Daniel Dellwo PA-C Provider Signature Date & Time: 2/9/15 1616
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Julie Sattell, LPN Date: 2-13-15 Time: 0854	Verbal / Telephone Orders No Yes Per: Please be sure pt has what was ordered 1/8/15 - Thank you done Cathy Whinnery, M.D. Provider Signature Date & Time: 2/12/15 18:15
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Julie Sattell, LPN Date: 2-13-15 Time: 1227	Verbal / Telephone Orders No Yes Per: may have jock strap and ABD pads. ABD pads 30 per month x 1 yr Gerlach-NPG 1000 Provider Signature 2/18/15 Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Jan Drake, LPN Date: FEB 19 2015 Time: 1355	Verbal / Telephone Orders No Yes Per: DC Fiber tab pt refusal pharm Christian Gelok, NP FEB 19 2015 1130 Provider Signature Date & Time:
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Gen Brewer, RN Date: 3-2-15 Time: 0017	Verbal / Telephone Orders No Yes Per: Stop Zoloft Start Effexor 37.5 mg PO QAM x 7 days then Effexor 75 mg PO QAM x 120 days RTC 6 weeks 3-24-15 Jeremy Stoddart, MD Provider Signature Date & Time: 3/2/15

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Practitioner's Orders

Patient Information	Orders
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: [signature] Date: 4-7-15 Time: 1111	Verbal / Telephone Orders No Yes Per: Estrace 3mg po qd x 90d Proscar 5mg po qd x 90d Size medium jock support + 30 ABD pads per month x 180 days William Poulson, NP Provider Signature APR 0 _ 2015 Date & Time:
Patient Name: Edmo DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Gen Brewer, RN Date: 4 30 15 Time: 0720	Verbal / Telephone Orders X No Yes Per: Effexor 75 mg po AM x 120 days RTC 3 mos Jane Seys PNP Provider Signature [signature] Date & Time: 4/30/15 7:10 AM
Patient Name: DOB: ID# Housing Unit: Allergies: Shauna Kitto, RN Noted By: [signature] Date: 6/26/15 Time: 1000	Verbal / Telephone Orders No Yes Per: ASA 81 mg i PO QD x 210 Days Calcium Carb 1250mg/Vit D 1250mg PO i QD x 210 Days ~~Estrace 1mg iii PO QD x 210 Days~~ ~~Proscar 5 mg i PO QD x 210 Days~~ Spironolactone 100mg i PO QD x 210 Days Provider Signature [signature] 6/26/15 Date & Time: 0845
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Shauna Kitto, RN Date: 6/26/15 Time: 1000	Verbal / Telephone Orders No Yes Per: Estrogen level, testosterone total & prolactin 3rd wk Sept. Estrace 1mg iii PO QD x 90 days } NF today Proscar 5mg i PO QD x 90 days JUN 26 2015 Provider Signature Date & Time:
Patient Name: Edmo DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Gen Brewer, RN Date: 7.21.15 Time: 1008	Verbal / Telephone Orders No Yes Per: Δ Effexor to Effexor XR 150 mg PO QAM x 120 days RTC 6 weeks Jeremy Stoddart, MD Provider Signature [signature] Date & Time: 7/21/15 0945

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Practitioner's Orders

Patient Information	Orders
Patient Name: Edmo DOB: [redacted] ID# 9469… Housing Unit: Allergies: NKDA Noted By: Gen Brewer, RN Date: 8-26-15 Time: 1110	Verbal / Telephone Orders No Yes Per: Effexor XR 150 mg p.o. QAM x 120 days RTC 3 months Provider Signature Scott Eliason, MD Date & Time: 8-26-15 1100
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Shauna Key, RN Date: 9/3/15 Time:	Verbal / Telephone Orders No Yes Per: Draw Estrogen level, Testosterone level total LAB Send MRB that spironolactone is at max dose level. ~~Schedule in 2 wks to review labs~~ CDP eval 9/21/15 Ok! Provider Signature Christian Gelok, NP Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Julie Savell, LPN Date: 9-4-15 Time: 1451	Verbal / Telephone Orders No Yes Per: Please draw labs as above. drawn 9-2-15 Provider Signature Christian Gelok, NP Date & Time:
Patient Name: Edmo DOB: [redacted] ID# 94691 Housing Unit: Allergies: Julie Savell Noted By: Date: 9-24-15 Time: 1445	Verbal / Telephone Orders No Yes Per: ① Single dose Estradiol ō ns tabs: take three tabs po daily @ AM Pill call x 90 days ② Total + Fractionated estrogens in 10 days (10-14 days) ③ f/u 2 days ō labs Provider Signature William Poulson NP Date & Time: 9/24/15 1100
Patient Name: DOB: ID# Housing Unit: Allergies: Kelly Larsen, LPN Date: 9/29/15 Time: 2048	Verbal / Telephone Orders No Yes ✓ Per: J. Mitchell PA ① Tetanus shot - given ② nurse f/u on Thurs. 10/1/15 - med. response VORB: J. Mitchell PA / K. Larsen Provider Signature Date & Time:

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Practitioner's Orders

Patient Information	Orders
Patient Name: Edmo, Mason R DOB: [redacted] ID# 94691 Housing Unit: Allergies: Noted By: Amanda Benton, RN Date: 10/9/15 Time: 0800	Verbal / Telephone Orders No Yes Per: ↑ Estradiol to 4 mg PO QD x 90 days Continue to single dose med in a.m. Next CDP visit with MD William Poulson, NP Provider Signature OCT 08 2015 Date & Time:
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: Noted By: Amanda Benton, RN Date: 11/5/15 Time: 1330	Verbal / Telephone Orders No X Yes Per: Proscar 5mg i po QD x 90d · NF V.O.D. Barry / Smalley LPN Daniel Barry, PA-C Provider Signature Date & Time NOV 05 2015 1330
Patient Name: Edmo DOB: 10.29.87 ID# 94691 Housing Unit: Allergies: NKDA Noted By: Gen Brewer, RN Date: 11-19-15 Time: 1005	Verbal / Telephone Orders X No Yes Per: Effexor XR 150 mg po Am x 120 days RTC: 3 mos. Jane Seys PNP Provider Signature Date & Time: 11/19/15 7:51 AM
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Amanda Benton, RN Date: 12/23/15 Time: 1109	Verbal / Telephone Orders No Yes Per: ↑ Aldactone to 125 mg PO BID x 120 days Continue Estradiol 4 mg PO QD x 90 ASA 81 mg PO QD Oscal D 500 i PO QHS } x 365 days Proscar 5 mg PO QD x 90 days Next visit c MP Provider Signature William Poulson Date & Time: 12/21/15
Patient Name: DOB: ID# Housing Unit: Amanda Benton, RN Allergies: Noted By: Date: 12/23/15 Time: 1109	Verbal / Telephone Orders No Yes Per: 3rd week March: Total Testosterone, Estradiol (E2) level. Do not notify pt of date of lab draw in advance please. William Poulson, NP Provider Signature DEC 23 2015 Date & Time: 1100

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Practitioner's Orders

Patient Information	Orders
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Patricia Cash, RN Date: 1/27/16 Time: 1025	Verbal / Telephone Orders No Yes Per: Start Remeron 7.5 mg HS X120d Effexor XR 150 mg AM RTC 3m Practitioner Signature Scott Eliason, MD Date & Time: 1/27/16 0800
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Patricia Cash, RN Date: 2/17/16 Time: 1155	Verbal / Telephone Orders No Yes ✓ Per: D/C Remeron VO Dr Eliason / PCashRN Practitioner Signature Jane Seys PNP 2/18/16, 11 AM Date & Time: 2/17/16 1000
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Michael Grace, RN Date: 3/16/16 Time: 1121	Verbal / Telephone Orders No Yes Per: ① Please change all pills to pill call only now ② Labs 2 months: free + total testosterone, estradiol, CBC, CMP, prolactin, TSH, T4 ③ F/u 3 months re: GDP ④ Proscar 5 mg i PO q day x 90 days (start 3.28.16) ⑤ Estrace 4 mg i PO q AM x 90 days (start 4.7.16) Practitioner Signature David Agler, MD Date & Time: 3/16/16 1035
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: [signature] Penn Date: 4/5/16 Time: 1405	Verbal / Telephone Orders No Yes Per: aldactone 125 mg PO BID x 90 days Practitioner Signature David Agler, MD Date & Time: 4/5/16 1405
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Patricia Cash, RN Date: 4/20/16 Time: 1325	Verbal / Telephone Orders No Yes Per: Effexor XR 150 mg AM X120d RTC 3w Practitioner Signature Scott Eliason, MD Date & Time: 4/20/16 1000

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Practitioner's Orders

Patient Information	Orders
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Michael Grace, RN Date: 5/5/16 Time: 0806	Verbal / Telephone Orders No Yes Per: Estrace 4 mg i PO q AM x 90 days (NF) Provider Signature David Agler, MD Date & Time: 5/5/16 0800
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Julie Savelli Date: 6-16-16 Time: 1400	Verbal / Telephone Orders No Yes Per: Total Testosterone, Estradiol, Prolactin Lab Daniel Dellwo, PA-C Provider Signature JUN 16 2016 Date & Time: 1100
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Julie Savelli, LPN Date: 6-27-16 Time: 1015	Verbal / Telephone Orders No Yes Per: Proscar 5mg po qd x 90 days Provider Signature David Agler, MD Date & Time: 6/27/16 0925
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Julie Savelli LPN Date: 7-6-16 Time: 1420	Verbal / Telephone Orders No Yes Per: Spironolactone 12.5mg po BID x 90d Daniel Barry, PA-C Provider Signature D Barry Date & Time: JUL 06 2016 1430
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: S. Mallette Date: 7-8 Ombudsman Time: 0900	Verbal / Telephone Orders No Yes Per: Schedule to be seen in OPC in 1-2 weeks Ref HSR 654526 -OPC Anthony Bushnell, PA-C Provider Signature Date & Time: 7/7/16 1649

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All orders will be generic unless specified by provider

Practitioner's Orders

Patient	Verbal / Telephone Orders
Patient Name: Edmo, Mason DOB: [redacted] ID# 14691 Housing Unit: Allergies: Noted By: Michael Grace, RN Date: 7/19/16 Time: 1200	Verbal / Telephone Orders No Yes Per: Urine GC/chlamydia first void HIV, RPR, ~~HSV~~, Hep B and C lab done Daniel Barry, PA-C Provider Signature D Barry Date & Time: 0930 JUL 19 2016
Patient Name: Edmo, Mason DOB: [redacted] ID# 14691 Housing Unit: Allergies: Noted By: Patricia Cash, RN Date: 7/28/16 Time: 0855	Verbal / Telephone Orders X No Yes Per: ↑ Effexor XR 225 mg po AM x 120 days RTC: 3 mos. Jane Seys PNP Provider Signature Jane Seys Date & Time: 7/28/16 8:39 AM
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Sayeu, LPN Date: 8-1-16 Time: 1416	Verbal / Telephone Orders No Yes Per: Estradiol 4mg po qd x 90d pharm Daniel Dellwo, PA-C Provider Signature Date & Time: 1400 AUG 01 2016
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Amanda Beck, RN Date: 8/4/16 Time: 1549	Verbal / Telephone Orders No Yes Per: Urine GC/CT first void lab done Anthony Bushnell, PA-C Provider Signature [signature] PAC Date & Time: 8/4/16 1145
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Jan Drake, LPN Date: AUG 29 2016 Time: 1200	Verbal / Telephone Orders No Yes Per: Proscar 5mg, T tab Q AM x 90days pharm Matthew Sweetser, MD Provider Signature [signature] Date & Time: 8/26/16 4pm

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Practitioner's Orders

Patient Information	Orders
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: Noted By: Date: Time: noted	Verbal / Telephone Orders No Yes Per: ① Estradiol 6 mg PO QD x 90 days - pill call pharm ② Labs 6 months: CBC, CMP, testosterone, estrogen, prolactin — Labs ③ F/u 3 months w: CDP ✓ Provider Signature: David Agler, MD Date & Time: 9/8/16 0900
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Julie Savell, LPN Date: 9-8-16 Time: 1930	Verbal / Telephone Orders No Yes Per: ④ Proscar 5 mg PO QD x 90 days — pharm ⑤ aldactone 125 mg PO BID x 1 year Provider Signature: David Agler, MD Date & Time: 9/8/16 0900
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Jan Drake, LPN Date: SEP 13 2016 Time: 1058	Verbal / Telephone Orders No Yes Per: HIV, RPR, Lab — done 1st void G/C Lab — done F/u p̄ labs back, OPC Provider Signature: Anthony Bushnell, PA-C Date & Time: SEP 13 2016 0812
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: MBeck, RN — Amanda Beck, RN Date: 9/19/16 Time: 1441	Verbal / Telephone Orders No Yes Per: Consult c̄ Dr. Aliso @ Wellness Center Provider Signature: David Agler, MD Date & Time: 9/19/16 1400
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Jan Drake, LPN Date: SEP 26 2016 Time: 1033	Verbal / Telephone Orders No Yes Per: Repeat urine GC/chlamydia - test was not performed (must be first void) — Lab Provider Signature: Daniel Barry, PA-C Date & Time: SEP 26 2016 0812

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Practitioner's Orders

Patient Information	Orders
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies:	Verbal / Telephone Orders No Yes Per: ① Schedule w/ provider to discuss HSR 878815 ✓
Noted By: Jan Drake, LPN Date: OCT 05 2016 Time: 1500	Diana Dise, PA-C Practitioner Signature Date & Time: 10-5-16 1215
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA	Verbal / Telephone Orders ☒ No Yes Per: Effexor XR 300mg po AM x 90 days Refer to clinician for groups or 1:1 d/t depression RTC: 3 mos'
Noted By: Patricia Cash, RN Date: 10/20/16 Time: 0858	Jane Seys PNP Practitioner Signature Date & Time 10/20/16 8:23Am
Patient Name: DOB: ID# Housing Unit: Allergies:	Verbal / Telephone Orders No Yes Per:
Noted By: Date: Time:	Practitioner Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies:	Verbal / Telephone Orders No Yes Per:
Noted By: Date: Time:	Practitioner Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies:	Verbal / Telephone Orders No Yes Per:
Noted By: Date: Time:	Practitioner Signature Date & Time:

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Practitioner's Orders

Patient Name: Edmo, Mason	Verbal / Telephone Orders ◯ No ◯ Yes Per:
DOB: [redacted] ID# 94691	OK for Jockstrap (Given in Clinic)
Housing Unit:	
Allergies:	
Noted By: Jan Drake, APN	Daniel Dietwo, PA-C
Date: NOV 02 2016 Time: 928	Practitioner Signature NOV 02 2016 Date & Time: 0920
Patient Name:	Verbal / Telephone Orders ◯ No ◯ Yes Per:
DOB: ID#	
Housing Unit:	
Allergies:	
Noted By:	
Date: Time:	Practitioner Signature Date & Time:
Patient Name:	Verbal / Telephone Orders ◯ No ◯ Yes Per:
DOB: ID#	
Housing Unit:	
Allergies:	
Noted By:	
Date: Time:	Practitioner Signature Date & Time:
Patient Name:	Verbal / Telephone Orders ◯ No ◯ Yes Per:
DOB: ID#	
Housing Unit:	
Allergies:	
Noted By:	
Date: Time:	Practitioner Signature Date & Time:
Patient Name:	Verbal / Telephone Orders ◯ No ◯ Yes Per:
DOB: ID#	
Housing Unit:	
Allergies:	
Noted By:	
Date: Time:	Practitioner Signature Date & Time:

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Practitioner's Orders

Patient Name: Edmo, mason **DOB:** [redacted] **ID#** 94691 **Housing Unit:** **Allergies:** Amanda Benton, RN, DON **Noted By:** [signature] RN **Date:** 11/21/16 **Time:** 1253	**Verbal / Telephone Orders** No Yes Per: Labs: CMP, Lipid panel, prolactin level, lab Free & total testosterone level (draw before 0900) Anthony Bushnell, PA-C 1245 Practitioner Signature [signature] Date & Time: NOV 21 2016
Patient Name: **DOB:** **ID#** **Housing Unit:** **Allergies:** **Noted By:** [signature] **Date:** **Time:**	**Verbal / Telephone Orders** No Yes Per: Estrace 6mg PO QD x90 days start 12/8/16 Proscar 5mg PO QD x 90 days Vitamin D ~ Oscal D 500 ~ PO QHS x 12 months pharm Daniel Gallero, PA-C Practitioner Signature NOV 29 2016 Date & Time: 1030
Patient Name: **DOB:** **ID#** **Housing Unit:** **Allergies:** [signature] **Noted By:** **Date:** 11-29-16 **Time:** 1505	**Verbal / Telephone Orders** No Yes Per: Estrogen Level, Lab done 12/12 Daniel Gallero, PA-C Practitioner Signature NOV 29 2016 Date & Time: 9005
Patient Name: **DOB:** **ID#** **Housing Unit:** **Allergies:** **Noted By:** MBeck, RN **Date:** 12/19/16 **Time:** 1512	**Verbal / Telephone Orders** No Yes Per: Medroxyprogesterone 10mg PO QD x 90days pharm Spironolactone 150 mg PO BID x 1 year Estradiol 3mg PO BID crush x 90 days Prolactin level in 1 month lab done 1/11/17 Anthony Bushnell, PA-C 1226 Practitioner Signature [signature] Date & Time: DEC 19 2016
Patient Name: **DOB:** **ID#** **Housing Unit:** **Allergies:** **Noted By:** MBeck, RN 12/20/16 **Time:** 1555	**Verbal / Telephone Orders** No Yes Per: Estrace 3mg PO BID crush x 90 days Practitioner Signature Tripper Povar, NP-C Date & Time 12/20/16 1553

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Practitioner's Orders

Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: Natasha Giove, LPN Noted By: N. Giove, LPN Date: 12-31-16 Time: 1845	Verbal / Telephone Orders No ✓Yes Per: Dellwo V.O.R.B @ 1740 12-31-16 ① send to ER via ambulance ✓ N. Giove, LPN / Daniel Dellwo, PA-C Provider Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders No Yes Per: Provider Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders No Yes Per: Provider Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders No Yes Per: Provider Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders No Yes Per: Provider Signature Date & Time:

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Practitioner's Orders

Patient	Orders
Patient Name: Edmo DOB: [redacted] ID# 94691 Housing Unit: Allergies: Noted By: Tina Lee, RN Date: 1/2/17 Time: 1400	Verbal / Telephone Orders No X Yes Per: Dellwo T4 II po prn x 1 Now (Given 1130) 96 Eileen Mitchell, RN 01-01-17 2000 Provider Signature Daniel Dellwo PA-C JAN 02 2017 Date & Time: 1400 24° chart ✓
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Amanda Banton, RN, DON Date: 1/2/17 Time: 1440	Verbal / Telephone Orders No Yes Per: Pull drain 1/3/16 (unless its producing much more fluid than previous days) INF ~~Provider order~~ to QA D/C from infirmary after drain pulled in AM ✓ Provider Signature Daniel Dellwo PA-C JAN 02 2017 Date & Time: 1400
Patient Name: Edmo DOB: [redacted] ID# 94691 Housing Unit: Allergies: Noted By: Gen Brewer, RN Date: 1.3.17 Time: 1227	Verbal / Telephone Orders No Yes Per: Effexor XR 300mg PO QAM x120d RTC 3 months Jeremy Stoddart, MD Provider Signature Date & Time: 1/3/17 1100
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders No Yes Per: Provider Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders No Yes Per: Provider Signature Date & Time:

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Practitioner's Orders

Patient Name: Edma, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Patricia Cash, RN Date: 1/26/17 Time: 1304	Verbal / Telephone Orders ☒ No ☐ Yes Per: Effexor XR 300 mg po AM } x 120 days Remeron 15 mg po HS RTC: 8wks. I know this is above normal dose of Effexor Jane Seys PNP Practitioner Signature Jane Seys Date & Time: 1/26/17 12:26 PM
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: FEB 01 2017 Date: Time: 1055 Jan Drake, LPN	Verbal / Telephone Orders ☐ No ☐ Yes Per: Pharm IBU 600 mg PO TID x10 days Practitioner Signature Tripper Povar, NP-C Date & Time: 2/1/17 0836
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders ☐ No ☐ Yes Per: Practitioner Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders ☐ No ☐ Yes Per: Practitioner Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders ☐ No ☐ Yes Per: Practitioner Signature Date & Time:

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Practitioner's Orders

Patient Information	Orders
Patient Name: Edmo, M DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Amanda Benton, RN [signature] Date: 2/14/17 Time: 1519	Verbal / Telephone Orders ☐ No ☐ Yes Per: Estrace 3mg SL BID x 90 days May use oral tab off label as SL per specialist Practitioner Signature [signature] MValley PA-C Date & Time: 2/14/17 1512
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders ☐ No ☐ Yes Per: ~~Medroxyprogesterone 10mg ÷ po QAM x 50 days NON-Form~~ mistaken entry Practitioner Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders ☐ No ☐ Yes Per: Practitioner Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders ☐ No ☐ Yes Per: Practitioner Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders ☐ No ☐ Yes Per: Practitioner Signature Date & Time:

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Practitioner's Orders

Patient Information	Orders
Patient Name: Edmo, Mason DOB: [redacted] ID# 94691 Housing Unit: Allergies: NKDA Noted By: Patricia Cash, RN PCash RN Date: 2/14/17 Time: 1324	Verbal / Telephone Orders ☐ No ☐ Yes Per: Stop Remeron per refusal Jeremy Stoddart, MD Practitioner Signature [signature] Date & Time: 2/14/17 1100
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: MBeck, RN Date: 2/16/17 Time: 1116	Verbal / Telephone Orders ☐ No ☐ Yes Per: pharm ① Finasteride 5 mg po @ day x 90 days - NF done ② CDP w/ provider 90 days [stamp, illegible], PA-C Practitioner Signature [signature] Date & Time: 2-16-17 [illegible]
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders ☐ No ☐ Yes Per: Practitioner Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders ☐ No ☐ Yes Per: Practitioner Signature Date & Time:
Patient Name: DOB: ID# Housing Unit: Allergies: Noted By: Date: Time:	Verbal / Telephone Orders ☐ No ☐ Yes Per: Practitioner Signature Date & Time:

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BIOREFERENCE LABORATORIES

481 EDWARD H. ROSS DR. ELMWOOD PARK, NJ 07407
1-800-229-LABS

DOCTOR
CMS IDAHO
13400 PLEASANT VALLEY RD
KUNA, ID 83634
(208) 424-3726 (ID302-9)

DOB: [redacted]

-FINAL- Original Report 01/11/2010

NAME	PATIENT I.D. / ROOM NO.	DOCTOR / GROUP
MEEKS, MASON	94691	DR. TAKAGI

LAB I.D. NO.	DATE COLLECTED	DATE RECEIVED	DATE OF REPORT	AGE	SEX
105904744	01/08/2010 18:00	01/09/2010 12:32	01/11/2010 14:52	22Y	M

Test Description	Result	Abnormal	Reference Range	
* CHEMISTRY *				
Total Protein	7.3		5.9-8.4	gm/dl
Albumin	4.3		3.2-5.2	gm/dl
Globulin	3.0		1.7-3.7	gm/dL
A/G Ratio	1.4		1.1-2.9	
Glucose	90		70-99	mg/dL
Sodium	143		133-145	mmol/L
Potassium	3.6		3.3-5.3	mmol/L
Chloride	105		96-108	mmol/L
CO2	21		21-29	mmol/L
BUN	10		7-25	mg/dl
Creatinine	1.0		0.6-1.3	mg/dl
e-GFR	93		> 60 mL/min/1.73m2	
BUN/Creat Ratio	10		10-28	
Calcium	9.7		8.4-10.4	mg/dl
Uric Acid		8.3 HI	2.4-7.0	mg/dl
Iron	129		30-160	mcg/dl
Bilirubin, Total		1.3 HI	0.1-1.0	mg/dl
LDH	162		94-250	u/l
Alk Phos	67		39-120	u/l
AST (SGOT)	31		< 37	u/l
Phosphorous	4.2		2.6-4.5	mg/dl
ALT (SGPT)		57 HI	< 40	u/L
G-GTP	30		7-51	u/L

****

GFR (Glomerular Filtration Rate) calculation utilizes the MDRD formula (Modification of Diet in Renal Disease Study Group) and assumes a normal adult body surface area of 1.73. If the patient is African American multiply result reported by 1.21. (Ref. National Kidney Disease Educa. Program.)

***** Male/Female reference range: >60 mL/min/1.73 m2 *****

Note: A calculated GFR of <60 mL suggests chronic kidney disease, but only if found consistently over at least 3 months. A calculated result of <15 mL is consistent with renal failure.

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JAN 13 2010 1320

Mike Takagi, PA

James Weisbarger, M.D.
Laboratory Director

BIOREFERENCE LABORATORIES

481 EDWARD H. ROSS DR. ELMWOOD PARK, NJ 07407
1-800-229-LABS

DOCTOR: CMS IDAHO
13400 PLEASANT VALLEY RD
KUNA, ID 83634
(208) 424-3726 (ID302-9)

DOB: [redacted]

-FINAL- Original Report 01/11/2010

NAME	PATIENT I.D. / ROOM NO.	DOCTOR / GROUP
MEEKS, MASON	94691	DR. TAKAGI

LAB I.D. NO.	DATE COLLECTED	DATE RECEIVED	DATE OF REPORT	AGE	SEX
105904744	01/08/2010 18:00	01/09/2010 12:32	01/11/2010 14:52	22Y	M

Test Description	Result	Abnormal	Reference Range	
CARDIOVASCULAR/LIPIDS				
Cholesterol	142		< 200	mg/dl
Triglycerides	77		< 151	mg/dl
HEMATOLOGY				
WBC	8.42		3.40-11.80	x10(3)/uL
RBC	5.08		4.20-5.90	x10(6)/uL
HGB	16.1		12.3-17.0	gm/dL
HCT	48.0		39.3-52.5	%
MCV	94.5		80.0-100.0	fL
MCH	31.7		25.0-34.1	pg
MCHC	33.5		29.0-35.0	gm/dL
RDW	13.0		10.9-16.9	%
POLYS	50.2		36.0-78.0	%
POLYS, ABS. COUNT	4.22		1.22-9.20	x10(3)/uL
LYMPHS	36.2		12.0-48.0	%
LYMPHS, ABS. COUNT	3.05		0.41-5.66	x10(3)/uL
MONOS	12.0		0.0-13.0	%
MONOS, ABS. COUNT	1.01		0.17-1.42	x10(3)/uL
EOS	1.3		0.0-8.0	%
EOS, ABS. COUNT	0.11		0.03-0.94	x10(3)/uL
BASOS	0.2		0.0-2.0	%
BASOS, ABS. COUNT	0.02		0.00-0.24	x10(3)/uL
IMMATURE GRANULOCYTES	0.1		0.0-0.5	%
PLATELET COUNT	263		144-400	x10(3)/uL
MPV	9.5		8.2-11.9	fL
MISCELLANEOUS				
RPR	NON-REACT		NON-REACTIVE	
HIV 1/O/2 ANTIBODY	Non-Reactive		Non-Reactive	

NOTE: Patients nonreactive for HIV antibody MAY BE infected but have not yet seroconverted. If a nonreactive result seems inconsistent with the clinical setting, RESUBMIT a new specimen for retest in 1-3 months.

ASSAY INFORMATION: Assay for the Detection of Antibodies to Human Immunodeficiency Virus Type 1, including Group O (HIV-1 + "O") and/or Type 2 (HIV-2).
Method: Chemiluminescence (Siemens Healthcare Diagnostics) effective 3/16/09.

Continued on Next Page

[signature]
James Weisberger, M.D.
Laboratory Director

BIOREFERENCE LABORATORIES

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1-800-229-LABS

DOCTOR			
CMS IDAHO 13400 PLEASANT VALLEY RD KUNA, ID 83634 (208) 424-3726 (ID302-9)	DOB: [redacted] -FINAL- Original Report 01/11/2010		

NAME	PATIENT I.D. / ROOM NO.	DOCTOR / GROUP
MEEKS, MASON	94691	DR. TAKAGI

LAB I.D. NO.	DATE COLLECTED	DATE RECEIVED	DATE OF REPORT	AGE	SEX
105904744	01/08/2010 18:00	01/09/2010 12:32	01/11/2010 14:52	22Y	M

Test Description	Result	Abnormal	Reference Range

****
NOTICE: IF the result of the RPR is reported as reactive with a titer of up to 1:8 please note that this level of reactivity can be caused by other, non-specific constituents and may not be related to syphilis. Confirmation of positive RPRs can only be made via performance of the T. Pallidum confirmation test.

Final Report

James Weisberger, M.D.
Laboratory Director

BIOREFERENCE LABORATORIES

481 EDWARD H. ROSS DR. ELMWOOD PARK, NJ 07407
1-800-229-LABS

DOCTOR
CMS IDAHO
13400 PLEASANT VALLEY RD
KUNA, ID 83634
(208) 424-3726 (ID302-9)

DOB: [redacted]

-FINAL- Original Report 02/01/2010

NAME	PATIENT I.D. / ROOM NO.	DOCTOR / GROUP
MEEKS, MASON	94691	TAKAGI

LAB I.D. NO.	DATE COLLECTED	DATE RECEIVED	DATE OF REPORT	AGE	SEX
106093743	01/29/2010 06:00	01/30/2010 17:51	02/01/2010 10:16	22Y	M

Test Description	Result	Abnormal	Reference Range

Comment :
FASTING

----------------------------* MISCELLANEOUS *----------------------------

HEPATITIS A AB/TOTAL	Negative		NEGATIVE
HBcAB	Negative		NEGATIVE
HBsAb		Positive	NEGATIVE
HBsAg	Negative		NEGATIVE
HEPATITIS C Ab.	Negative		NEGATIVE

****

NOTE: A positive HBsAb result indicates exposure to Hepatitis B virus due to active infection or inoculation. Hepatitis B antibodies which are 12 IU/mL or greater are considered adequate for immunity to infection (use test # 1606, HBsAb Quant). Hepatitis core antibody may be elevated after recovery from an active infection of Hepatitis B.

****

NOTE: Results for Hepatitis C Virus Antibody (test# 0812),when reported as positive indicates the presence of significant antibody levels (defined as a signal to cutoff ratio [s/co] of greater than 8.0). Sera with a high s/co ratio will confirm positive in >95% of cases, however <5% of results reported as positive may be false-positives. Additional serologic testing is available for patients whose anti-HCV result is inconsistent with clinical findings. Results that are considered borderline will be automatically reflexed for RIBA (immunoblot) analysis and reported accordingly. Results reported as indeterminate by RIBA indicate the presence of only one of the required protein bands or is reactive with multiple bands including control protein indicative of reactivity with irrelevant recombinant sequences.

Final Report

7655
2-1-10

James Weisberger, M.D.
Laboratory Director

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
BISH ID451 - ISCI INTAKR (6340A) 13500 PLEASANT VALLEY RD, KUNA, ID 83634 Acct #: (ID451) 00 P: 208-424-3726	EDMO, MASON DOB: [redacted] Age: 24 Yrs Sex: M Medical Record: Inmate ID: 94691 Address: , ID P:	Specimen ID: 107898751 Date Of Report: 05/03/2012 00:12 Date Collected: 05/01/2012 Date Received: 05/02/2012 12:37

Notes: PATIENT FASTING

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

Creatinine	**0.73 LO**	Bilirubin, Total	**1.1 HI**

Test	Result	Abnormal	Reference	Units	Previous Result	Date
-------* CHEMISTRY *--------						
Total Protein	7.5		5.9-8.4	g/dL		
Albumin	4.7		3.5-5.2	g/dL		
Globulin	2.8		1.7-3.7	g/dL		
A/G Ratio	1.7		1.1-2.9			
Glucose	92		70-99	mg/dL		
Sodium	137		133-145	mmol/L		
Potassium	3.9		3.3-5.3	mmol/L		
Chloride	100		96-108	mmol/L		
CO2	26		22-29	mmol/L		
BUN	13		6-20	mg/dL		
Creatinine		**0.73 LO**	0.90-1.30	mg/dL		
NOTE: The creatinine reference ranges have changed effective 11/7/11.						
e-GFR	132		>60	mL/min		
e-GFR, African American	160		>60	mL/min		
BUN/Creat Ratio	17.8		10.0-28.0			
Calcium	9.3		8.6-10.2	mg/dL		
Bilirubin, Total		**1.1 HI**	0.1-1.0	mg/dL		
Alk Phos	68		40-129	U/L		
AST	18		<40	U/L		
ALT	33		<41	U/L		
------* HEMATOLOGY *--------						
WBC	6.14		3.40-11.80	x10(3)/uL		
RBC	5.08		4.20-5.90	x10(6)/uL		
HGB	15.5		12.3-17.0	gm/dL		

5/7/12 Ben Bish N.P.-C

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
BISH ID451 - ISCI INTAKR (6340A) 13500 PLEASANT VALLEY RD, KUNA, ID 83634 Acct #: (ID451) 00 P: 208-424-3726	EDMO, MASON DOB: [redacted] Age: 24 Yrs Sex: M Medical Record: Inmate ID: 94691 Address: , ID P:	Specimen ID: 107898751 Date Of Report: 05/03/2012 00:12 Date Collected: 05/01/2012 Date Received: 05/02/2012 12:37

CLINICAL REPORT

Test	Result	Abnormal	Reference	Units	Previous Result	Date
HCT	47.9		39.3-52.5	%		
MCV	94.3		80.0-100.0	fL		
MCH	30.5		25.0-34.1	pg		
MCHC	32.4		29.0-35.0	gm/dL		
RDW	14.6		10.9-16.9	%		
POLYS	43.4		36.0-78.0	%		
LYMPHS	46.3		12.0-48.0	%		
MONOS	8.3		0.0-13.0	%		
EOS	1.5		0.0-8.0	%		
BASOS	0.3		0.0-2.0	%		
IMMATURE GRANULOCYTES	0.2		0.0-1.6	%		
Platelet Count	255		144-400	x10(3)/uL		
MPV	9.5		8.2-11.9	fL		
-----* MISCELLANEOUS *------						
RPR	Non-Reactive		Non-Reactive			
HIV 1/2 ANTIBODY	Negative		Negative			

NOTE: Patients negative for HIV antibody MAY BE infected but have not yet seroconverted. If a negative result seems inconsistent with the clinical setting, RESUBMIT a new specimen for retest in 1-3 months.
ASSAY INFORMATION: Assay for the Detection of Antibodies to Human Immunodeficiency Virus Type 1,(HIV-1) and/or Type 2 (HIV-2).
Method: Chemiluminescence (Ortho Clinical Diagnostics)

Ben Bish N.P.-C 5/7/12 BJB

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
WHIMMERY CORCMS IDAHO 13500 PLEASANT VALLEY RD KUNA, ID 83634 Acct #: (ID302-1) FX P: (208) 424-3726	EDMO, MASON DOB: [redacted] Age: 24 Y Sex: M Surgical #: ID: 94691 Address: ID P:	Specimen ID: 109958967 Date Of Report: 09/07/2012 Date Collected: 09/06/2012 Time Collected: 00:00 Date Received: 09/07/2012 Time Received: 14:27

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

HDL CHOL., DIRECT 27 LO
PROLACTIN, SERUM 20.6 HI

PATIENT FASTING

CARDIOVASCULAR/LIPIDS

Test	Result	Abnormal	Reference	Units	Previous Result	Date
Cholesterol	135		<200	mg/dL		
Triglycerides	145		<150	mg/dL		
HDL CHOL., DIRECT		27 LO	>40	mg/dL		
HDL as % of Cholesterol	20		>14	%		
Evaluation: AVERAGE RISK						
Chol/HDL Ratio	5.0		<7.4			
Evaluation: AVERAGE RISK						
LDL/HDL Ratio	2.93		<3.56			
LDL Cholesterol	79		<100	mg/dL		
VLDL, CALCULATED	29		7-32	mg/dL		

MISCELLANEOUS

Test	Result	Abnormal	Reference	Units	Previous Result	Date
TSH	1.890		0.270-4.200	uIU/mL		
TESTOSTERONE, TOT.,S.	398.8		249.0-836.0	ng/dL		
LH	5.1		1.7-8.6	mIU/mL		
FSH	2.3		1.5-12.4	mIU/mL		
PROLACTIN, SERUM		20.6 HI	4.0-15.2	ng/mL		
ESTRADIOL	26.38		7.63-42.60	pg/mL		

Final Report

Ben Bish N.P.-C 9/10/12 BB

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
WHINNERY CORCMS IDAHO 13500 PLEASANT VALLEY RD KUNA, ID 83634 Acct #: (ID302-1) FX P: (208) 424-3726	EDMO, MASON DOB: [redacted] Age: 25 Y Sex: M Surgical #: ID: 94691 Address: ID P:	Specimen ID: 105210164 Date Of Report: 06/05/2013 Date Collected: 06/04/2013 Time Collected: 00:00 Date Received: 06/05/2013 Time Received: 13:46

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

Bilirubin, Total 1.2 HI
HDL CHOL., DIRECT 35 LO

PATIENT FASTING

CHEMISTRY

Test	Result	Abnormal	Reference	Units	Previous Result	Date
Total Protein	7.0		5.9-8.4	g/dL		
Albumin	4.7		3.5-5.2	g/dL		
Globulin	2.3		1.7-3.7	g/dL		
A/G Ratio	2.0		1.1-2.9			
Glucose	93		70-99	mg/dL		
Sodium	139		133-145	mmol/L		
Potassium	3.8		3.3-5.3	mmol/L		
Chloride	102		96-108	mmol/L		
CO2	24		22-29	mmol/L		
BUN	11		6-20	mg/dL		
Creatinine	0.90		0.90-1.30	mg/dL		
e-GFR	103		>60	mL/min		
e-GFR, African American	125		>60	mL/min		
BUN/Creat Ratio	12.2		10.0-28.0			
Calcium	9.4		8.6-10.2	mg/dL		
Uric Acid	6.1		3.4-8.5	mg/dL		
Iron	120		45-160	ug/dL		
Bilirubin, Total		1.2 HI	0.1-1.0	mg/dL		
LD	160		135-225	U/L		
Alk Phos	63		40-156	U/L		
AST	8		<40	U/L		
Phosphorus	4.1		2.7-4.5	mg/dL		
ALT	10		<41	U/L		
GGTP	12		10-71	U/L		

CARDIOVASCULAR/LIPIDS

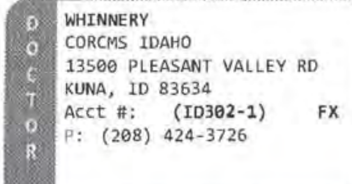
Test	Result	Abnormal	Reference	Units	Previous Result	Date
Cholesterol	155		<200	mg/dL	135	09/07/2012
Triglycerides	109		<150	mg/dL	145	09/07/2012
HDL CHOL., DIRECT		35 LO	>40	mg/dL	27 LO	09/07/2012
HDL as % of Cholesterol Evaluation: AVERAGE RISK	23		>14	%	20	09/07/2012
Chol/HDL Ratio Evaluation: AVERAGE RISK	4.4		<7.4		5.0	09/07/2012
LDL/HDL Ratio	2.80		<3.56		2.93	09/07/2012
LDL Cholesterol	98		<100	mg/dL	79	09/07/2012
VLDL, CALCULATED	22		7-32	mg/dL	29	09/07/2012

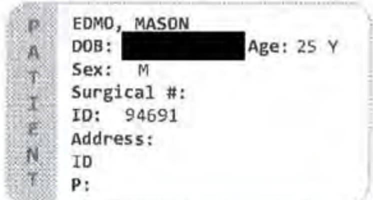
William Poulson NP-C 6-10-17 1700 [signature]

BioReference Laboratories, Inc.
481 Edward H. Ross Drive | Elmwood Park, NJ 07407 | (800) 229-5227

James Weisberger, M.D.
Laboratory Director

FINAL REPORT


DOCTOR
WHINNERY
CORCMS IDAHO
13500 PLEASANT VALLEY RD
KUNA, ID 83634
Acct #: (ID302-1) FX
P: (208) 424-3726


PATIENT
EDMO, MASON
DOB: [redacted] Age: 25 Y
Sex: M
Surgical #:
ID: 94691
Address:
ID
P:

SAMPLE
Specimen ID: 105210164
Date Of Report: 06/05/2013
Date Collected: 06/04/2013
Time Collected: 00:00
Date Received: 06/05/2013
Time Received: 13:46

CLINICAL REPORT

MISCELLANEOUS

Test	Result	Abnormal	Reference	Units	Previous Result	Date
TESTOSTERONE, TOT.,S.	480.0		249.0-836.0	ng/dL	398.8	09/07/2012
PROLACTIN, SERUM	14.6		4.0-15.2	ng/mL	20.6 HI	09/07/2012

Final Report

BioReference
LABORATORIES

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
YORK ID300 - IDAHO CORR. INST-OROFINO 381 WEST HOSPITAL DRIVE, OROFINO, ID 83544 Acct #: (ID300) MO P: 208-476-7926	EDMO, MASON DOB: [redacted] Age: 25 Y Sex: M U/FL: Bed: Rm: Inmate ID: 94691 Address: , , ID P:	Specimen ID: 106918350 Date Of Report: 09/18/2013 00:59 Date Collected: 09/13/2013 05:20 Date Received: 09/14/2013 09:15

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

Creatinine	0.85 LO	Bilirubin, Total	1.3 HI	LD	131 LO
LYMPHS	48.1 HI				
TESTOSTERONE, FREE, SERUM	7.99 LO				

Test	Result	Abnormal	Reference	Units	Previous Result	Date
-------* CHEMISTRY *--------						
Total Protein	6.7		5.9-8.4	g/dL	7.0	06/05/2013
Albumin	4.6		3.5-5.2	g/dL	4.7	06/05/2013
Globulin	2.1		1.7-3.7	g/dL	2.3	06/05/2013
A/G Ratio	2.2		1.1-2.9		2.0	06/05/2013
Glucose	90		70-99	mg/dL	93	06/05/2013
Sodium	140		133-145	mmol/L	139	06/05/2013
Potassium	3.8		3.3-5.3	mmol/L	3.8	06/05/2013
Chloride	101		96-108	mmol/L	102	06/05/2013
CO2	23		22-29	mmol/L	24	06/05/2013
BUN	14		6-20	mg/dL	11	06/05/2013
Creatinine		0.85 LO	0.90-1.30	mg/dL	0.90	06/05/2013
e-GFR	110		>60	mL/min	103	06/05/2013
e-GFR, African American	133		>60	mL/min	125	06/05/2013
BUN/Creat Ratio	16.5		10.0-28.0		12.2	06/05/2013
Calcium	9.7		8.6-10.2	mg/dL	9.4	06/05/2013
Uric Acid	5.8		3.4-8.5	mg/dL	6.1	06/05/2013
Iron	119		45-160	ug/dL	120	06/05/2013
Bilirubin, Total		1.3 HI	0.1-1.0	mg/dL	1.2 HI	06/05/2013
LD		131 LO	135-225	U/L	160	06/05/2013
Alk Phos	61		40-156	U/L	63	06/05/2013
AST	10		<40	U/L	8	06/05/2013
PHOSPHORUS	3.8		2.7-4.5	mg/dL	4.1	06/05/2013
ALT	10		<41	U/L	10	06/05/2013
GGTP	11		10-71	U/L	12	06/05/2013
-* CARDIOVASCULAR/LIPIDS *--						
Cholesterol	145		<200	mg/dL	155	06/05/2013
Triglycerides	87		<150	mg/dL	109	06/05/2013
HDL CHOL., DIRECT	45		>40		35 LO	06/05/2013
HDL as % of Cholesterol	31		>14	%	23	06/05/2013
Evaluation: BELOW AVERAGE RISK						
Chol/HDL Ratio	3.2		<7.4		4.4	06/05/2013

9/27/13

FINAL REPORT

DOCTOR YORK ID300 - IDAHO CORR. INST-OROFINO 381 WEST HOSPITAL DRIVE, OROFINO, ID 83544 Acct #: (ID300) MO P: 208-476-7926	**PATIENT** EDMO, MASON DOB: [redacted] Age: 25 Y Sex: M U/FL: Bed: Rm: Inmate ID: 94691 Address: , , ID P:	**SAMPLE** Specimen ID: 106918350 Date Of Report: 09/18/2013 00:59 Date Collected: 09/13/2013 05:20 Date Received: 09/14/2013 09:15

CLINICAL REPORT

Test	Result	Abnormal	Reference	Units	Previous Result	Date
Evaluation: BELOW AVERAGE RISK						
LDL/HDL Ratio	1.84		<3.56		2.80	06/05/2013
LDL Cholesterol	83		<100	mg/dL	98	06/05/2013
VLDL, CALCULATED	17		7-32	mg/dL	22	06/05/2013
------* HEMATOLOGY *---------						
WBC	5.90		3.40-11.80	x10(3)/uL	6.14	05/02/2012
RBC	4.63		4.20-5.90	x10(6)/uL	5.08	05/02/2012
HGB	14.8		12.3-17.0	gm/dL	15.5	05/02/2012
HCT	45.3		39.3-52.5	%	47.9	05/02/2012
MCV	97.8		80.0-100.0	fL	94.3	05/02/2012
MCH	32.0		25.0-34.1	pg	30.5	05/02/2012
MCHC	32.7		29.0-35.0	gm/dL	32.4	05/02/2012
RDW	12.8		10.9-16.9	%	14.6	05/02/2012
POLYS	39.5		36.0-78.0	%	43.4	05/02/2012
POLYS, ABS. COUNT	2.33		1.22-9.20	x10(3)/uL		
LYMPHS		48.1 HI	12.0-48.0	%	46.3	05/02/2012
LYMPHS, ABS. COUNT	2.84		0.41-5.66	x10(3)/uL		
MONOS	9.7		0.0-13.0	%	8.3	05/02/2012
MONOS, ABS. COUNT	0.57		0.17-1.42	x10(3)/uL		
EOS	2.2		0.0-8.0	%	1.5	05/02/2012
EOS, ABS. COUNT	0.13		0.03-0.94	x10(3)/uL		
BASOS	0.5		0.0-2.0	%	0.3	05/02/2012
BASOS, ABS. COUNT	0.03		0.00-0.24	x10(3)/uL		
IMMATURE GRANULOCYTES	0.0		0.0-1.6	%	0.2	05/02/2012
Platelet Count	228		144-400	x10(3)/uL	255	05/02/2012
MPV	9.6		8.2-11.9	fL	9.5	05/02/2012
-----* MISCELLANEOUS *------						
TESTOSTERONE, TOT.,S.	390.9		249.0-836.0	ng/dL	480.0	06/05/2013
TESTOSTERONE, FREE, SERUM		7.99 LO	8.80-27.00	pg/mL		
NOTE: New reference range for Free Testosterone effective 4/11/13.						
ESTROGENS,TOT.SER. (3)	241			pg/mL		

REFERENCE RANGE for Total Estrogens (E1 plus E2):

Female cycle	
1 - 10 days	61 - 394 pg/mL
11- 20 days	122 - 437 pg/mL
21- 30 days	156 - 350 pg/mL
Prepubertal	Less than 40 pg/mL
Postmenopausal	Less than 40 pg/mL
Adult Male	Less than 200 pg/mL

9/27/13

BioReference LABORATORIES

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
YORK ID300 - IDAHO CORR. INST-OROFINO 381 WEST HOSPITAL DRIVE, OROFINO, ID 83544 Acct #: (ID300) MO P: 208-476-7926	EDMO, MASON DOB: [redacted] Age: 25 Y Sex: M U/FL: Bed: Rm: Inmate ID: 94691 Address: , , ID P:	Specimen ID: 106918350 Date Of Report: 09/18/2013 00:59 Date Collected: 09/13/2013 05:20 Date Received: 09/14/2013 09:15

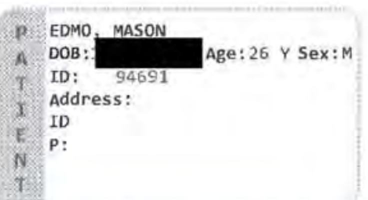
CLINICAL REPORT

Test	Result	Abnormal	Reference	Units	Previous Result	Date

hMG treatment (therapeutic range): 400-800 pg/mL
For specific assessment of Estrogen levels, request Estrone (test code #3154) and Estradiol (test code #3155).
(3)
Performed by: Specialty Laboratories, Inc.
27027 Tourney Road
Valencia, CA 91355-5386

9/22/13
[signature]

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
WHINNERY, CATHERINE CORCMS IDAHO 13500 PLEASANT VALLEY RD Kuna, ID 83634 Acct #: (ID302-1) FX P: (208) 424-3726	 EDMO, MASON DOB: [redacted] Age:26 Y Sex:M ID: 94691 Address: ID P:	Specimen ID: 101553922 Date Of Report: 05/30/2014 Date Collected: 05/23/2014 Time Collected: 00:00 Date Received: 05/24/2014 Time Received: 12:14

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

Creatinine	0.86 LO	Phosphorus	5.8 HI
LDL Cholesterol	108 HI		
LYMPHS	49.5 HI		
PROLACTIN, SERUM	17.7 HI		

PATIENT FASTING

CHEMISTRY

Test	Result	Abnormal	Reference	Units	Previous Result	Date
Total Protein	7.0		5.9-8.4	g/dL	7.0	06/05/2013
Albumin	4.7		3.5-5.2	g/dL	4.7	06/05/2013
Globulin	2.3		1.7-3.7	g/dL	2.3	06/05/2013
A/G Ratio	2.0		1.1-2.9		2.0	06/05/2013
Glucose	81		70-99	mg/dL	93	06/05/2013
Sodium	139		133-145	mmol/L	139	06/05/2013
Potassium	4.6		3.3-5.3	mmol/L	3.8	06/05/2013
Chloride	99		96-108	mmol/L	102	06/05/2013
CO2	22		22-29	mmol/L	24	06/05/2013
BUN	10		6-20	mg/dL	11	06/05/2013
Creatinine		0.86 LO	0.90-1.30	mg/dL	0.90	06/05/2013
e-GFR	107		>60	mL/min	103	06/05/2013
e-GFR, African American	129		>60	mL/min	125	06/05/2013
BUN/Creat Ratio	11.6		10.0-28.0		12.2	06/05/2013
Calcium	9.8		8.6-10.4	mg/dL	9.4	06/05/2013
Uric Acid	5.0		3.4-8.5	mg/dL	6.1	06/05/2013
Iron	110		45-160	ug/dL	120	06/05/2013
Bilirubin, Total	0.8		0.2-1.0	mg/dL	1.2 HI	06/05/2013
LD	163		135-225	U/L	160	06/05/2013
Alk Phos	62		40-156	U/L	63	06/05/2013
AST	14		<40	U/L	8	06/05/2013
Phosphorus		5.8 HI	2.7-4.5	mg/dL	4.1	06/05/2013
ALT	11		<41	U/L	10	06/05/2013
GGTP	12		10-71	U/L	12	06/05/2013

CARDIOVASCULAR/LIPIDS

Test	Result	Abnormal	Reference	Units	Previous Result	Date
Cholesterol	180		<200	mg/dL	155	06/05/2013
Triglycerides	134		<150	mg/dL	109	06/05/2013
HDL CHOL., DIRECT	45		>40	mg/dL	35 LO	06/05/2013
HDL as % of Cholesterol Evaluation: AVERAGE RISK	25		>14	%	23	06/05/2013
Chol/HDL Ratio Evaluation: BELOW AVERAGE RISK	4.0		<7.4		4.4	06/05/2013
LDL/HDL Ratio	2.40		<3.56		2.80	06/05/2013
LDL Cholesterol		108 HI	<100	mg/dL	98	06/05/2013

6/2/14 1300 [signature]

William Poulson NP-C

BioReference Laboratories, Inc.
481 Edward H. Ross Dr | Elmwood Park, NJ 07407 | (800) 229-5227

James Weisberger, M.D.
Laboratory Director

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
WHINNERY, CATHERINE CORCMS IDAHO 13500 PLEASANT VALLEY RD Kuna, ID 83634 Acct #: (ID302-1) FX P: (208) 424-3726	EDMO, MASON DOB: [redacted] Age:26 Y Sex:M ID: 94691 Address: ID P:	Specimen ID: 101553922 Date Of Report: 05/30/2014 Date Collected: 05/23/2014 Time Collected: 00:00 Date Received: 05/24/2014 Time Received: 12:14

CLINICAL REPORT

Test	Result	Abnormal	Reference	Units	Previous Result	Date
VLDL, CALCULATED	27		7-32	mg/dL	22	06/05/2013

HEMATOLOGY

Test	Result	Abnormal	Reference	Units	Previous Result	Date
WBC	5.80		3.40-11.80	x10(3)/uL		
RBC	4.75		4.20-5.90	x10(6)/uL		
HGB	14.7		12.3-17.0	gm/dL		
HCT	43.4		39.3-52.5	%		
MCV	91.4		80.0-100.0	fL		
MCH	30.9		25.0-34.1	pg		
MCHC	33.9		29.0-35.0	gm/dL		
RDW	13.4		10.9-16.9	%		
POLYS	37.6		36.0-78.0	%		
POLYS, ABS. COUNT	2.18		1.22-9.20	x10(3)/uL		
LYMPHS		49.5 HI	12.0-48.0	%		
LYMPHS, ABS. COUNT	2.87		0.41-5.66	x10(3)/uL		
MONOS	7.4		0.0-13.0	%		
MONOS, ABS. COUNT	0.43		0.17-1.42	x10(3)/uL		
EOS	4.8		0.0-8.0	%		
EOS, ABS. COUNT	0.28		0.03-0.94	x10(3)/uL		
BASOS	0.5		0.0-2.0	%		
BASOS, ABS. COUNT	0.03		0.00-0.24	x10(3)/uL		
IMMATURE GRANULOCYTES	0.2		0.0-1.6	%		
PLATELET COUNT	228		144-400	x10(3)/uL		
MPV	8.8		8.2-11.9	fL		

MISCELLANEOUS

Test	Result	Abnormal	Reference	Units	Previous Result	Date
TSH	3.050		0.270-4.200	uIU/mL		
TESTOSTERONE, TOT.,S.	820.9		249.0-836.0	ng/dL	480.0	06/05/2013
TESTOSTERONE, FREE, SERUM	9.60		8.80-27.00	pg/mL		
PROLACTIN, SERUM		17.7 HI	4.0-15.2	ng/mL	14.6	06/05/2013
ESTROGENS,TOT.SER.(3)	313			pg/mL		

REFERENCE RANGE for Total Estrogens (E1 plus E2):

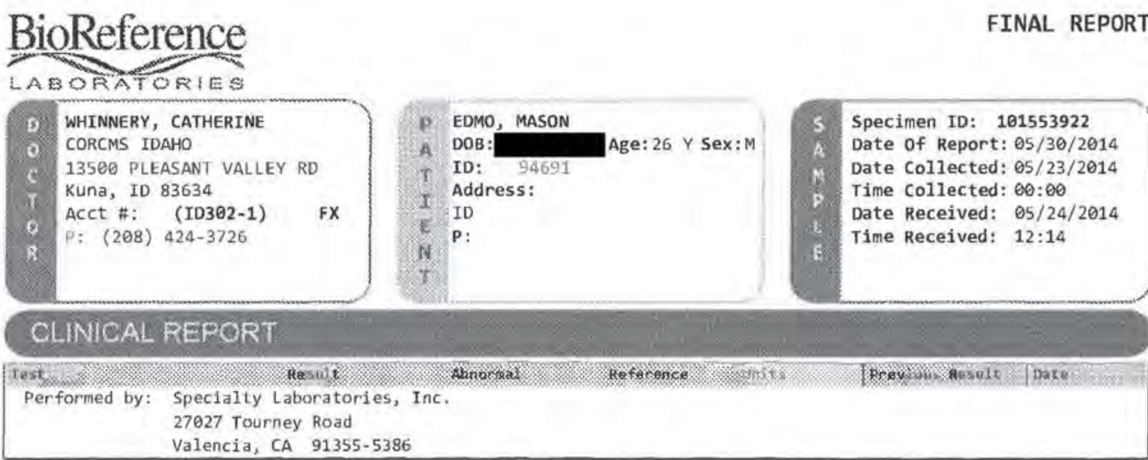
Female cycle
- 1 - 10 days 61 - 394 pg/mL
- 11- 20 days 122 - 437 pg/mL
- 21- 30 days 156 - 350 pg/mL

Prepubertal Less than 40 pg/mL
Postmenopausal Less than 40 pg/mL
Adult Male Less than 200 pg/mL
hMG treatment (therapeutic range): 400-800 pg/mL

For specific assessment of Estrogen levels, request Estrone (test code #3154) and Estradiol (test code #3155).

(3)

William Poulson NP-C



BioReference LABORATORIES

FINAL REPORT

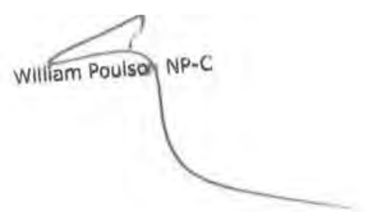
DOCTOR	PATIENT	SAMPLE
WHINNERY, CATHERINE	EDMO, MASON	Specimen ID: 101553922
CORCMS IDAHO	DOB: [redacted] Age: 26 Y Sex: M	Date Of Report: 05/30/2014
13500 PLEASANT VALLEY RD	ID: 94691	Date Collected: 05/23/2014
Kuna, ID 83634	Address:	Time Collected: 00:00
Acct #: (ID302-1) FX	ID	Date Received: 05/24/2014
P: (208) 424-3726	P:	Time Received: 12:14

CLINICAL REPORT

Test	Result	Abnormal	Reference	Units	Previous Result	Date

Performed by: Specialty Laboratories, Inc.
27027 Tourney Road
Valencia, CA 91355-5386

Final Report



BioReference LABORATORIES

FINAL REPORT

DOCTOR
POULSON, WILLIAM
CORCMS IDAHO
13500 PLEASANT VALLEY RD
Kuna, ID 83634
Acct #: (ID302-1) FX
P: (208) 424-3726

PATIENT
EDMD, MASON
DOB: [redacted] Age: 26 Y Sex: M
ID: 94691
Address:
ID
P:

SAMPLE
Specimen ID: 101639985
Date Of Report: 05/30/2014
Date Collected: 05/29/2014
Time Collected: 00:00
Date Received: 05/30/2014
Time Received: 13:01

CLINICAL REPORT

PATIENT FASTING

MISCELLANEOUS

Test	Result	Abnormal	Reference	Units	Previous Result	Date
Hemoglobin A1c	5.4		<5.7	%		

GLYCOHEMOGLOBIN A1C AND eAG REFERENCE RANGES

A1C(%)	DIABETES CATEGORY*
<5.7	Normal (non-diabetic)
5.7-6.4	Increased risk of diabetes
=>6.5	Consistent with diabetes

A1C(%)	eAG(ESTIMATED AVERAGE PLASMA GLUCOSE)(mg/dL)
6	126
7	154
8	183
9	212
10	240
11	269
12	298

*recommended ranges-American Diabetes Association(2010)

NOTE: Rare hemoglobin variants and thalassemia major may affect glycemic results.

Test	Result	Abnormal	Reference	Units	Previous Result	Date
SCREENING HgB A1C	5.4		<5.7	%		

GLYCOHEMOGLOBIN A1C AND eAG REFERENCE RANGES

A1C(%)	DIABETES CATEGORY*
<5.7	Normal (non-diabetic)
5.7-6.4	Increased risk of diabetes
=>6.5	Consistent with diabetes

A1C(%)	eAG(ESTIMATED AVERAGE PLASMA GLUCOSE)(mg/dL)
6	126
7	154
8	183
9	212
10	240
11	269
12	298

*recommended ranges-American Diabetes Association(2010)

NOTE: Rare hemoglobin variants and thalassemia major may affect glycemic results.

Final Report

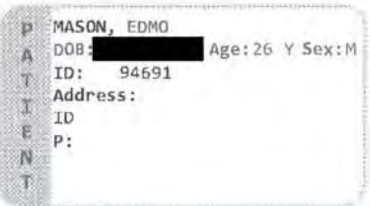
6/2/14 BUD

William Pouls...

BioReference LABORATORIES

FINAL REPORT

DOCTOR
WHINNERY, CATHERINE
CORCMS IDAHO
13500 PLEASANT VALLEY RD
Kuna, ID 83634
Acct #: (ID302-1) FX
P: (208) 424-3726


PATIENT
MASON, EDMO
DOB: [redacted] Age: 26 Y Sex: M
ID: 94691
Address:
ID
P:

SAMPLE
Specimen ID: 102963769
Date Of Report: 08/13/2014
Date Collected: 08/12/2014
Time Collected: 09:15
Date Received: 08/13/2014
Time Received: 14:14

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

Glucose	66 LO	Creatinine	0.80 LO

CHEMISTRY

Test	Result	Abnormal	Reference	Units	Previous Result	Date
Total Protein	6.9		5.9-8.4	g/dL		
Albumin	4.5		3.5-5.2	g/dL		
Globulin	2.4		1.7-3.7	g/dL		
A/G Ratio	1.9		1.1-2.9			
Glucose		66 LO	70-99	mg/dL		
Sodium	140		133-145	mmol/L		
Potassium	4.4		3.3-5.3	mmol/L		
Chloride	100		96-108	mmol/L		
CO2	24		22-29	mmol/L		
BUN	12		6-20	mg/dL		
Creatinine		0.80 LO	0.90-1.30	mg/dL		
e-GFR	117		>60	mL/min		
e-GFR, African American	142		>60	mL/min		
BUN/Creat Ratio	15.0		10.0-28.0			
Calcium	9.7		8.6-10.4	mg/dL		
Bilirubin, Total	0.7		0.2-1.0	mg/dL		
Alk Phos	60		40-156	U/L		
AST	13		<40	U/L		
ALT	7		<41	U/L		

Final Report

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
WHINNERY, CATHERINE ID302 - IDAHO STATE CORR.INST. 13500 PLEASANT VALLEY RD, KUNA, ID 83634 Acct #: (ID302) FX P: 208-424-3726	EDMO, MASON DOB: [redacted] Age: 26 Y Sex: M U/FL: Bed: Rm: Inmate ID: 94691 Address: , , ID P:	Specimen ID: 103729811 Date Of Report: 09/30/2014 10:40 Date Collected: 09/24/2014 Date Received: 09/25/2014 16:34

Notes: PATIENT FASTING

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

Creatinine 0.85 LO

Test	Result	Abnormal	Reference	Units	Previous Result	Date
------* CHEMISTRY *------						
Glucose	80		70-99	mg/dL	81	05/23/2014
Sodium	140		133-145	mmol/L	139	05/23/2014
Potassium	4.2		3.3-5.3	mmol/L	4.6	05/23/2014
Chloride	101		96-108	mmol/L	99	05/23/2014
CO2	22		22-29	mmol/L	22	05/23/2014
BUN	14		6-20	mg/dL	10	05/23/2014
Creatinine		0.85 LO	0.90-1.30	mg/dL	0.86 LO	05/23/2014
e-GFR	109		>60	mL/min	107	05/23/2014
e-GFR, African American	132		>60	mL/min	129	05/23/2014
BUN/Creat Ratio	16.5		10.0-28.0		11.6	05/23/2014
Calcium	9.1		8.6-10.4	mg/dL	9.8	05/23/2014
----* MISCELLANEOUS *-----						
TESTOSTERONE, TOT.,S.	467.9		249.0-836.0	ng/dL	820.9	05/23/2014
ESTROGENS,TOT.SER. (3)	366			pg/mL	313	05/23/2014

REFERENCE RANGE for Total Estrogens (E1 plus E2):
Female cycle
1 - 10 days 61 - 394 pg/mL
11- 20 days 122 - 437 pg/mL
21- 30 days 156 - 350 pg/mL
Prepubertal Less than 40 pg/mL
Postmenopausal Less than 40 pg/mL
Adult Male Less than 200 pg/mL
hMG treatment (therapeutic range): 400-800 pg/mL
For specific assessment of Estrogen levels, request Estrone (test code #3154) and Estradiol (test code #3155). T ESTROGEN 366 HIGH FOR MALE QN5 TO RPT FOR CONFIRMATION
(3)
Performed by: Quest Diagnostics Nichols Institute of Valencia
27027 Tourney Road
Valencia, CA 91355-5386

10/8/14
E. WHINNERY, M.D.

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
WHINNERY, CATHERINE CORCMS IDAHO 13500 PLEASANT VALLEY RD Kuna, ID 83634 Acct #: (ID302-1) FX P: (208) 424-3726	EDMO, MASON DOB: [redacted] Age:27 Y Sex:M ID: 94691 Address: ID P:	Specimen ID: 105277859 Date Of Report: 12/28/2014 Date Collected: 12/22/2014 Time Collected: 00:00 Date Received: 12/23/2014 Time Received: 15:17

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report)

Creatinine 0.76 LO
SEX HORM.BIND.GLOB. 83 HI

PATIENT FASTING

CHEMISTRY

Test	Result	Abnormal	Reference	Units	Previous Result	Date
Total Protein	6.2		5.9-8.4	g/dL	7.0	05/24/2014
Albumin	3.8		3.5-5.2	g/dL	4.7	05/24/2014
Globulin	2.4		1.7-3.7	g/dL	2.3	05/24/2014
A/G Ratio	1.6		1.1-2.9		2.0	05/24/2014
Glucose	86		70-99	mg/dL	80	09/25/2014
Sodium	138		133-145	mmol/L	140	09/25/2014
Potassium	4.0		3.3-5.3	mmol/L	4.2	09/25/2014
Chloride	105		96-108	mmol/L	101	09/25/2014
CO2	25		22-29	mmol/L	22	09/25/2014
BUN	9		6-20	mg/dL	14	09/25/2014
Creatinine		0.76 LO	0.90-1.30	mg/dL	0.85 LO	09/25/2014
e-GFR	123		>60	mL/min	109	09/25/2014
e-GFR, African American	149		>60	mL/min	132	09/25/2014
BUN/Creat Ratio	11.8		10.0-28.0		16.5	09/25/2014
Calcium	9.1		8.6-10.4	mg/dL	9.1	09/25/2014
Bilirubin, Total	0.3		0.2-1.0	mg/dL	0.8	05/24/2014
Alk Phos	52		40-156	U/L	62	05/24/2014
AST	17		<40	U/L	14	05/24/2014
ALT	12		<41	U/L	11	05/24/2014

MISCELLANEOUS

Test	Result	Abnormal	Reference	Units	Previous Result	Date
TSH	2.560		0.178-4.530	uIU/mL	3.050	05/24/2014
NOTE: New reference range for TSH effective 8/5/2014.						
TESTOSTERONE, TOT.,S.	304.8		249.0-836.0	ng/dL	467.9	09/25/2014
SEX HORM.BIND.GLOB.		83 HI	10-57	nmol/L		
FREE TESTOSTERONE	31.97		30.00-150.00	pg/mL		
Note: New MALE Reference Range for Free Testosterone effective 7/11/2014.						
PROLACTIN, SERUM	13.8		4.0-15.2	ng/mL	17.7 HI	05/24/2014
ESTROGENS,TOT.SER.(3)	405			pg/mL	366	09/25/2014

REFERENCE RANGE for Total Estrogens (E1 plus E2):

Female cycle
1 - 10 days 61 - 394 pg/mL
11- 20 days 122 - 437 pg/mL
21- 30 days 156 - 350 pg/mL
Prepubertal Less than 40 pg/mL
Postmenopausal Less than 40 pg/mL

Discuss at CDP visit

Cathy Whinnery, M.D.
12/30/14

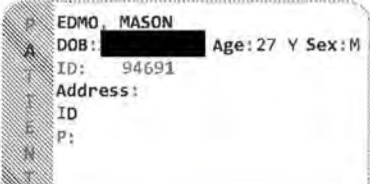
BioReference Laboratories, Inc.
481 Edward H. Ross Dr | Elmwood Park, NJ 07407 | (800) 229-5227

James Weisberger, M.D.
Laboratory Director

BioReference LABORATORIES

FINAL REPORT

DOCTOR	SAMPLE
WHINNERY, CATHERINE	Specimen ID: 105277859
CORCMS IDAHO	Date Of Report: 12/28/2014
13500 PLEASANT VALLEY RD	Date Collected: 12/22/2014
Kuna, ID 83634	Time Collected: 00:00
Acct #: (ID302-1) FX	Date Received: 12/23/2014
P: (208) 424-3726	Time Received: 15:17



CLINICAL REPORT

Test	Result	Abnormal	Reference	Units	Previous Result	Date

Adult Male Less than 200 pg/mL
hMG treatment (therapeutic range): 400-800 pg/mL
For specific assessment of Estrogen levels, request Estrone (test code #3154) and Estradiol (test code #3155).

Test	Result	Abnormal	Reference	Units	Previous Result	Date
Hemoglobin A1c	5.2		<5.7	%		

GLYCOHEMOGLOBIN A1C AND eAG REFERENCE RANGES

A1C(%)	DIABETES CATEGORY*
<5.7	Normal (non-diabetic)
5.7-6.4	Increased risk of diabetes
=>6.5	Consistent with diabetes

A1C(%)	eAG(ESTIMATED AVERAGE PLASMA GLUCOSE)(mg/dL)
6	126
7	154
8	183
9	212
10	240
11	269
12	298

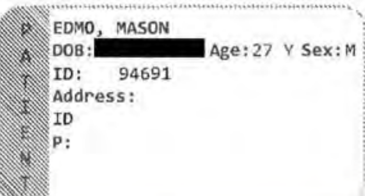
*recommended ranges-American Diabetes Association(2010)

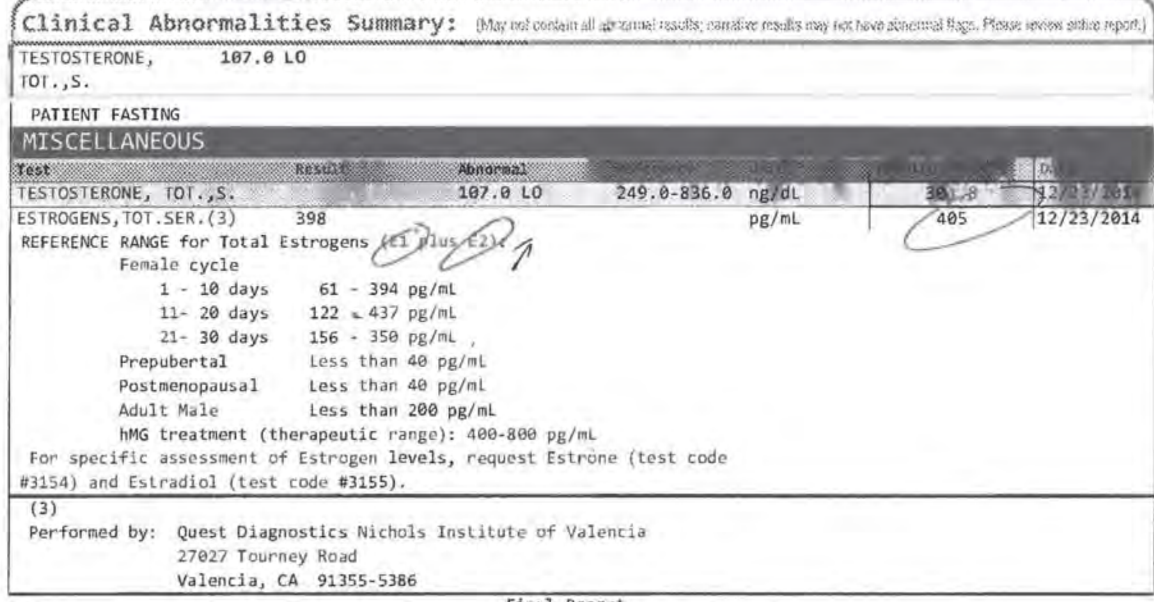
NOTE: Rare hemoglobin variants and thalassemia major may affect glycemic results.

(3)
Performed by: Quest Diagnostics Nichols Institute of Valencia
27027 Tourney Road
Valencia, CA 91355-5386

Final Report

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
IDAHO STATE CORR.INST. CORCMS IDAHO 13500 PLEASANT VALLEY RD Kuna, ID 83634 Acct #: (ID302-1) FX P: (208) 424-3726	 EDMO, MASON DOB: [redacted] Age:27 Y Sex:M ID: 94691 Address: ID P:	Specimen ID: 106836439 Date Of Report: 03/30/2015 Date Collected: 03/24/2015 Time Collected: 00:00 Date Received: 03/25/2015 Time Received: 13:00



CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

TESTOSTERONE, TOT.,S. 107.0 LO

PATIENT FASTING

MISCELLANEOUS

Test	Result	Abnormal	[illegible]	[illegible]	[illegible]	Date
TESTOSTERONE, TOT.,S.		107.0 LO	249.0-836.0	ng/dL	[illegible]	12/23/2014
ESTROGENS,TOT.SER.(3)	398			pg/mL	405	12/23/2014

REFERENCE RANGE for Total Estrogens (E1 plus E2):

Female cycle

1 - 10 days	61 - 394 pg/mL
11- 20 days	122 - 437 pg/mL
21- 30 days	156 - 350 pg/mL
Prepubertal	Less than 40 pg/mL
Postmenopausal	Less than 40 pg/mL
Adult Male	Less than 200 pg/mL

hMG treatment (therapeutic range): 400-800 pg/mL

For specific assessment of Estrogen levels, request Estrone (test code #3154) and Estradiol (test code #3155).

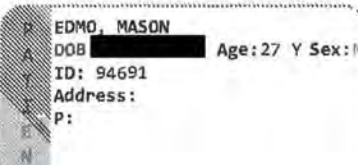
(3)
Performed by: Quest Diagnostics Nichols Institute of Valencia
27027 Tourney Road
Valencia, CA 91355-5386

Final Report

William Poulson, NP
MAR 31 2015
1600

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
IDAHO STATE CORR.INST. CORCMS IDAHO 13500 PLEASANT VALLEY RD Kuna, ID 83634 Acct #: (ID302-1) FX P: (208) 424-3726	EDMO, MASON DOB [redacted] Age:27 Y Sex:M ID: 94691 Address: P:	Specimen ID: 970260744 Date Of Report: 09/05/2015 Date Collected: 09/02/2015 Time Collected: Date Received: 09/03/2015 Time Received: 00:41 North America Mountain Time



Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

ESTROGENS, FRACT. SEE BELOW
(30)

PATIENT FASTING

MISCELLANEOUS

Test	Result	Abnormal	Reference	Units	Previous Result	Date
TESTOSTERONE, TOT.,S.	153.0		129.0-767.0	ng/dL	107.0 LO	03/25/2015
PROLACTIN, SERUM	13.7		2.1-17.7	ng/mL	13.8	12/23/2014
ESTROGENS, FRACT.(30)		SEE BELOW				
Estradiol by TMS	29.3		10.0-42.0	pg/mL		

--REFERENCE INTERVAL: Estradiol by TMS
--Access complete set of age- and/or gender-specific reference
--intervals for this test in the ARUP Laboratory Test Directory
--(aruplab.com).
--Test developed and characteristics determined by ARUP
--Laboratories. See Compliance Statement B: aruplab.com/CS

Test	Result	Abnormal	Reference	Units
Estrone by TMS	68.5	H	9.0-36.0	pg/mL

--REFERENCE INTERVAL: Estrone by TMS
--Access complete set of age- and/or gender-specific reference
--intervals for this test in the ARUP Laboratory Test Directory
--(aruplab.com).
--Test developed and characteristics determined by ARUP
--Laboratories. See Compliance Statement B: aruplab.com/CS

Test	Result	Abnormal	Reference	Units
Estrogens Total Calc.	97.8	H	19.0-69.0	pg/mL

--REFERENCE INTERVAL: Estrogens Total Calculation
--Access complete set of age- and/or gender-specific reference
--intervals for this test in the ARUP Laboratory Test Directory
--(aruplab.com).

(30)
Performed by: ARUP
500 Chipeta Way
Salt Lake City, UT 84108

Final Report

Christine Golden
CG 1100
SEP 08 2015

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
IDAHO STATE CORR.INST. ID302 - IDAHO STATE CORR.INST. 13500 PLEASANT VALLEY RD, KUNA, ID 83634 Acct #: (ID302) FX P: (208)424-3726	EDMO, MASON DOB: [redacted] Age: 27 Y Sex: M U/FL: Bed: Rm: Inmate ID: 94691 Address: , , P:	Specimen ID: 970260744 Date Of Report: 09/05/2015 17:18 Date Collected: 09/02/2015 00:00 Date Received: 09/03/2015 00:41 *North America Mountain Time*

Notes: PATIENT FASTING

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

ESTROGENS, FRACT. (30) SEE BELOW *

-----* MISCELLANEOUS *------

Test	Result	Abnormal	Reference	Units	Previous Result	Date
TESTOSTERONE, TOT.,S.	153.0		129.0-767.0	ng/dL	*107.0 LO*	03/24/2015
PROLACTIN, SERUM	13.7		2.1-17.7	ng/mL	*13.8*	12/22/2014
ESTROGENS, FRACT. (30)		SEE BELOW *				

```
Estradiol by TMS          29.3                          10.0-42.0       pg/mL
--REFERENCE INTERVAL: Estradiol by TMS
--Access complete set of age- and/or gender-specific reference
--intervals for this test in the ARUP Laboratory Test Directory
--(aruplab.com).
--Test developed and characteristics determined by ARUP
--Laboratories. See Compliance Statement B: aruplab.com/CS
Estrone by TMS            68.5        H                 9.0-36.0        pg/mL
--REFERENCE INTERVAL: Estrone by TMS
--Access complete set of age- and/or gender-specific reference
--intervals for this test in the ARUP Laboratory Test Directory
--(aruplab.com).
--Test developed and characteristics determined by ARUP
--Laboratories. See Compliance Statement B: aruplab.com/CS
Estrogens Total Calc.     97.8        H                 19.0-69.0       pg/mL
--REFERENCE INTERVAL: Estrogens Total Calculation
--Access complete set of age- and/or gender-specific reference
--intervals for this test in the ARUP Laboratory Test Directory
--(aruplab.com).
(30)
Performed by:    ARUP
                 500 Chipeta Way
                 Salt Lake City, UT  84108
```

[signature] 9/16/15 1600

BioReference LABORATORIES

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
POULSON, WILLIAM ID302 - IDAHO STATE CORR.INST. 13500 PLEASANT VALLEY RD, KUNA, ID 83634 Acct #: (ID302) FX P: (208)424-3726	EDMO, MASON DOB: [redacted] Age: 27 Y Sex: M U/FL: Bed: Rm: Inmate ID: 94691 Address: , , ID P:	Specimen ID: 970291278 Date Of Report: 10/08/2015 08:55 Date Collected: 10/05/2015 10:00 Date Received: 10/06/2015 00:34 *North America Mountain Time*

Notes: NON FASTING

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

ESTROGENS, FRACT. (30) SEE BELOW *

-----* MISCELLANEOUS *------

Test	Result	Abnormal	Reference	Units	Previous Result	Date
ESTROGENS, FRACT. (30)		SEE BELOW *			SEE BELOW *	09/01/2015

Test	Result	Abnormal	Reference	Units
Estradiol by TMS	36.4		10.0-42.0	pg/mL
Estrone by TMS	101.0	H	9.0-36.0	pg/mL
Estrogens Total Calc.	137.4	H	19.0-69.0	pg/mL

Estradiol by TMS 36.4 10.0-42.0 pg/mL
--REFERENCE INTERVAL: Estradiol by TMS
--Access complete set of age- and/or gender-specific reference
--intervals for this test in the ARUP Laboratory Test Directory
--(aruplab.com).
--Test developed and characteristics determined by ARUP
--Laboratories. See Compliance Statement B: aruplab.com/CS
Estrone by TMS 101.0 H 9.0-36.0 pg/mL
--REFERENCE INTERVAL: Estrone by TMS
--Access complete set of age- and/or gender-specific reference
--intervals for this test in the ARUP Laboratory Test Directory
--(aruplab.com).
--Test developed and characteristics determined by ARUP
--Laboratories. See Compliance Statement B: aruplab.com/CS
Estrogens Total Calc. 137.4 H 19.0-69.0 pg/mL
--REFERENCE INTERVAL: Estrogens Total Calculation
--Access complete set of age- and/or gender-specific reference
--intervals for this test in the ARUP Laboratory Test Directory
--(aruplab.com).
(30)
Performed by: ARUP
500 Chipeta Way
Salt Lake City, UT 84108

William Poulson, NP
OCT 08 2015

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
POULSON, WILLIAM ID302 - IDAHO STATE CORR.INST. 13500 PLEASANT VALLEY RD, KUNA, ID 83634 Acct #: (ID302) FX P: (208)424-3726	EDMO, MASON DOB: [redacted] Age: 28 Y Sex: M U/FL: Bed: Rm: Inmate ID: 94691 Address: , , ID P:	Specimen ID: 970441581 Date Of Report: 03/10/2016 22:06 Date Collected: 03/09/2016 09:23 Date Received: 03/10/2016 00:29 *North America Mountain Time*

Notes: NON FASTING

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

TESTOSTERONE, TOT.,S.	SEX HORM.BIND.GLOB.	115 HI	ESTRADIOL	57.00 HI

Test	Result	Abnormal	Reference	Units	Previous Result	Date
-------* CHEMISTRY *--------						
Albumin	4.2		3.2-4.8	g/dL	3.8	12/22/2014
-----* MISCELLANEOUS *------						
TESTOSTERONE, TOT.,S.		<20.0 LO	129.0-767.0	ng/dL	153.0	09/01/2015
SEX HORM.BIND.GLOB.		115 HI	10-57	nmol/L	83 HI	12/22/2014
FREE TESTOSTERONE	Can't Calc		30.00-150.00	pg/mL	31.97	12/22/2014
ESTRADIOL		57.00 HI	<39.90	pg/mL	26.38	09/06/2012

NOTE: The result for ESTRADIOL was confirmed by repeat analysis.

Can't Calc: One or more components was outside the measurable range. We are unable to calculate.

3/16/16
David Agler, MD

Fax Server

FINAL REPORT

DOCTOR	PATIENT	SAMPLE
AG E DAVID CO.C. S IDAHO 13500 PLEASANT VALLEY RD Kuna, ID 83634 Acct #: (ID302-1) FX P: (208) 424-3726	EDMO, MASON DOB: [redacted] Age:28 Y Sex:M ID: 94691 Address: ID P:	Specimen ID: 970498150 Date Of Report: 05/04/2016 Date Collected: 05/02/2016 Time Collected: 09:38 Date Received: 05/03/2016 Time Received: 00:48 North America Mountain Time

CLINICAL REPORT

Clinical Abnormalities Summary: (May not contain all abnormal results; narrative results may not have abnormal flags. Please review entire report.)

Triglycerides	152 HI		
SEX HORM.BIND.GLOB. *NJ1	103 HI	ESTRADIOL	41.84 HI

PATIENT FASTING

CHEMISTRY

Test	Result	Abnormal	Reference	Units	Previous Result	Date
Total Protein	7.3		5.7-8.2	g/dL		
Albumin	4.5		3.2-4.8	g/dL	4.2	03/10/2016
Globulin	2.8		1.7-3.7	g/dL		
A/G Ratio	1.6		1.1-2.9			
Glucose	75		70-99	mg/dL		
Sodium	142		132-146	mmol/L		
Potassium	4.1		3.5-5.5	mmol/L		
Chloride	105		99-109	mmol/L		
CO2	27		20-31	mmol/L		
BUN	10		9-23	mg/dL		
Creatinine	0.79		0.70-1.30	mg/dL		
e-GFR	122		>or=60	mL/min		
e-GFR, African American	141		>or=60	mL/min		
BUN/Creat Ratio	12.7		10.0-28.0			
Calcium	9.5		8.3-10.6	mg/dL		
Uric Acid	4.5		3.7-9.2	mg/dL		
Iron	124		65-175	ug/dL		
Bilirubin, Total	0.7		0.3-1.2	mg/dL		
LD	151		120-246	U/L		
Alk Phos	64		40-156	U/L		
AST	19		<34	U/L		
Phosphorus	3.6		2.4-5.1	mg/dL		
ALT	16		10-49	U/L		
GGTP	11		<73	U/L		

CARDIOVASCULAR/LIPIDS

Test	Result	Abnormal	Reference	Units	Previous Result	Date
Cho[illegible]	174		<200	mg/dL		
Triglycerides		152 HI	<150	mg/dL		

HEMATOLOGY

Test	Result	Abnormal	Reference	Units	Previous Result	Date
WBC	5.00		[illegible]-11.[illegible]	x10[illegible]/uL		
RBC	4.54		4.20-5.90	x10(6)/uL		
HGB	14.4		12.3-17.0	gm/dL		
HCT	42.9		39.3-52.5	%		
MCV	94.5		80.0-100.0	fL		

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