PATIENT NAME: SWENSON,MICHAEL E ADMIT DATE: 05/27/04

DIAGNOSIS: Obstructive sleep apnea.

SURGERY PERFORMED: On May 27, 2004 was tonsillectomy, uvulopalatopharyngoplasty, and septoplasty with turbinate reduction.

Please see history and physical exam.

HOSPITAL COURSE: The patient was admitted to hospital postoperatively. He had complications of postobstructive pulmonary edema. Dr. Chestnut from pulmonary followed him postoperatively. He was placed on telemetry. He required oxygen initially. He was initially reintubated postoperatively but then extubated later on May 27, 2004. He was treated with IV Decadron postoperatively. By May 29, 2004, he was much improved. He was breathing without difficulty, no dyspnea. Dr. Chestnut felt he was fine for discharge home per his standpoint. He is being discharged home on May 29, 2004, with prescriptions for tapering dose of prednisone, amoxicillin, Lortab elixir, and Percocet. He has a followup with Dr. Cruz next week.

KD/CAP/MZ
TDX: 12:26 PM
TTX: 2:54 AM
D: 05/29/2004
T: 05/30/2004
BY: 2808
J: 778549
XZ: 3244213

Kent G Davis, MD

PATIENT: SWENSON,MICHAEL E D704-1
DOB: 04/05/66 SVC DT: 05/27/04 05/29/04
ACCT: D18054668 MED REC#: D0006[illegible]7544 DIS IN DISCHARGE SUMMARY
CC REP: 0530-0008 DEACONESS MEDICAL CENTER
Dict: Kent G Davis, MD N SPOKANE, WASHINGTON
Attnd:
THIS REPORT IS CONFIDENTIAL AND NOT TO BE RELEASED WITHOUT PROPER AUTHORIZATION.

**PATIENT NAME: SWENSON,MICHAEL E** **ADMIT DATE: 05/27/04**

DATE OF CONSULTATION: 05/27/2004.

1: Negative pressure pulmonary edema.
   A. Status post tonsil upper pharyngeal septoplasty.
   B. Laryngospasm on extubation.
   C. Hypoxia of approximately 3 to 5 minutes duration.
   D. Reintubation.
   E. Status post CVR.
   F. History of obstructive sleep apnea.
2: Obstructive sleep apnea, status post surgical repair.

RECOMMENDATIONS: High-volume, high-flow positive pressure ventilation with concomitant Lasix. Dexamethazone for laryngeal swelling. Anticipate extubation later today with use of steroids. Judicious opoid use to prevent apnea in this patient with a possible decrease in ventilatory drive secondary to obstructive sleep apnea.

HPI: The patient underwent upper palatoplasty and septoplasty this morning and apparently experienced laryngospasm on extubation. The patient was noted to have agonal breathing, developed hypoxia and subsequently coded. CPR was initiated and the patient was hypoxic for approximately 3 to 5 minutes. The patient received atropine and epinephrine during the resuscitation events. The patient was then reintubated. His sats rapidly recovered. The patient was then transferred to the ICU.

PAST MEDICAL HISTORY: Obstructive sleep apnea, turbinate hypertrophy and deviated septum.

PAST SURGICAL HISTORY: Immediate status post septoplasty and turbinate reduction along with tonsillectomy and uvulopalatoplasty. Right temporal regional exploration and excision in 1988.

MEDICATIONS: None.

ALLERGIES: NKDA.

FAMILY HISTORY: None.

SOCIAL HISTORY: The patient is married. He is occupied as a realtor. Former smoker of approximately 3 years, last smoked approximately 18 years ago. Alcohol use is 1 drink per week.

REVIEW OF SYSTEMS: Not obtainable.

PHYSICAL EXAMINATION: VITAL SIGNS: Blood pressure 134/71, pulse 87, ventilatory support 14 and temperature 99.1. Saturations 99% and FIO2 of 80.

GENERAL: This is a large Caucasian male who is intubated and sedated.
HEENT: Sclerae anicteric. Gaze is conjugate. Pupils equal, round and

posterior tonsil pillar muscle was then also notched on either side of the base of the uvula. This releases the glossopharyngeal muscle from the distal soft palate, allowing the soft palate to be released from the tethering of the posterior oropharyngeal wall. Bleeding points were controlled with needle tip Bovie cautery. Two separate over sewing stitches with 3-0 Chromic were then placed in the tonsil fossae bilaterally. This helps reapproximate both the anterior and posterior tonsil pillars. Using a 3-0 Vicryl stitch, horizontal mattress sutures were then used to approximate the reflected uvula musculature to the submucosal tissue and muscle of the distal soft palate. Reapproximation of the nasal mucosa of the soft palate to the oral mucosa of the soft palate was then performed using simple interrupted Chromic stitches. Mucosal edges were also reapproximated at the base of the uvula laterally as well as the superior portion of the tonsil fossa using horizontal mattress 4-0 Chromic stitches. The oral cavity was then suctioned clear of irrigation and debris and an esophageal tube was placed to aspirate the esophageal and gastric contents. This concluded the case.

Upon extubation the patient underwent laryngospasm followed by post-obstructive pulmonary edema. The patient required re-intubation to establish an airway and also required administration of atropine and epinephrine. The patient's oxygenation level was re-established at 99%. There was frothing of fluid in the endotracheal tube, confirming post-obstructive pulmonary edema. At that point Dr. Chestnut was called in the intensive care unit, and the patient will be transferred directly to the intensive care unit for critical care management. The situation was also explained to the patient's wife.

MC/CAP/KS
TDX: 10:33 AM
TTX: 11:43 PM
D: 05/27/2004
T: 05/27/2004
BY: 1755
J: 775403
XZ: 3237337

Michael J Cruz, MD

cc: Timothy M Chestnut, MD
Dr. Goldberg - Sandpoint, ID

***Digitally authenticated 05/28/04 0919 Michael J Cruz, MD***

RUN TIME: 0315
RUN DATE: 05/30/04

EMPIRE HEALTH SERVICES
DEACONESS MEDICAL CENTER
800 West 5th Avenue, Spokane, WA 99210-0248
LABORATORY CUMULATIVE SUMMARY - DISCHARGE REPORT



* * * * * * * * * DISCHARGE SUMMARY - DO NOT DESTROY * * * * * * * * *

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Name:** | SWENSON,MICHAEL E | | **Age/Sex:** | 38/M | **Attend Dr:** | Cruz,Michael J | |
| **Acct#:** | D18054668 | **Unit#:** | D000667544 | **Status:** | DIS IN | **Location:** | DACU7 D704-1 |
| **Reg:** | 05/27/04 | **Disch:** | 05/29/04 | **DOB:** | 04/05/66 | | |

## HEMATOLOGY
### AUTOHEMATOLOGY - DIFFERENTIAL - MORPHOLOGY

| | Date 05/28 Time 0400 | Reference | Units |
|---|---|---|---|
| HGB | 16.5 | 13.5-17.5 | g/dL |
| HCT | 46.5 | 41-53 | % |
| RBC | 5.32 | 4.5-5.9 | mil/ul |
| MCV | 87.4 | 80-100 | fl |
| MCH | 31.0 | 26-34 | pg |
| MCHC | 35.5 | 31-37 | g/dl |
| RDW-SD | 41.0 | 35.1-46.3 | fL |
| PLT | 298 | 140-440 | th/uL |
| WBC | 17.9 H | 4.5-11.0 | th/uL |
| MPV | 11.2 | 9.4-12.5 | fL |
| PMNS | 80.0 | | % |
| BANDS | 15.0 | | % |
| LYMPHOCYTES | 1.0 | | % |
| MONOCYTES | 4.0 | | % |
| PLATELET EST | NORMAL | NORMAL | |
| ATYPICAL LYMPHS | OCC | | |
| TOTAL CELLS CNT | 100 | | |

## CHEMISTRY
### BLOOD GAS ANALYSIS, ARTERIAL

| | Date ---------05/27--------- Time 1430 | 1220 | 1042 | Reference | Units |
|---|---|---|---|---|---|
| PH, ART | 7.390 | 7.370 | 7.260L* | 7.35-7.45 | |
| PCO2, ART | 45 | 41 | 53H* | 35-45 | mm/Hg |
| PO2, ART | 127 H | 230 H | 331 H | 80-100 | mm/Hg |
| O2 SAT, ART | 98 | 99 | 99 | 95-99 | % |
| BE, ART | 0.9 | -2.1 L | -4.3 L | -2.0-2.0 | mEq/l |
| HCO3, ART | 26.0 | 23.0 | 23.5 | 22-26 | mEq/l |
| PATIENT TEMP | 100.4 | 99.1 | | | deg F |
| MODE | CPAP | AC | AC | | |
| FIO2 | 40 | 60 | 100 | | % |
| RR | | 14 | 14 | | |
| PATIENT RR | 23 | 14 | 14 | | |
| Vt | | 750 | 1000 | | ml |
| PEEP | | 6.0 | 6.0 | | cm/H2O |
| PRESS SUPPORT | 10 | | | | cm/H2O |
| CPAP | 7.0 | | | | cm/H2O |

Name Michael Swenson

CC:
What is main goal you wish to accomplish today? ↑ faith ↑ wellness

SUBJ:
What symptoms have improved?
1. nothing
2.
3.

What symptoms still bother you?
1. all + added (as
2. specified diary)
3.

Please describe any changes we need to know of: Boomer

Are there any specific questions you need answered?

**Please Do Not Write Below This Line**

OBJ-
BP- 140/62
P-
T-
HT- 72
WT- 262

| PE abnl | PE nl | ROS neg | ROS sxs |
|---|---|---|---|
| | GENL | | |
| | HEENT | | |
| | NECK | | |
| | RESP | | |
| | BREAST | LL 10/24/05 | |
| | CARD | | |
| | GI | | |
| | GU | JH | |
| | RECTAL | | |
| | EXTR | | |
| | NEURO | | |
| | SKIN | | |

FHX
Filed Y N
Pt to complete Y N
Reviewed
Changes? Y N

Filed: LAB + ordered
XRAY
med decis (CMPLX)
STRFWD LO MED HI

Time Spent 1130 → 1235 = 65 min / 45 min = Cowns

4/18/06 MICHAEL SWENSON

S: Has had clinical deterioration since last visit, debilitating fatigue and increased pain and achiness consistent with FMS. He has really been unable to work now for three months, becoming increasingly concerned regarding health status. He had a workup through an internist in Sandpoint, those results are filed separately. Michael worked previously as a lab tech, examined his peripheral smear on CBC and was concerned with possible Rouleaux formation and spherocytosis. His clinical deterioration really began following complications from septoplasty and T&A 5/04. He had significant bleeding, required emergency transfusion with 3 units of O- blood. Patient is O+, concerned about long-term negative effects from transfusion reaction. At the time, he suffered acute pulmonary edema immediately postop, followed by cardiac arrest X2. Both he and his wife agree that he has never been the same since then. He would like formal hematology consultation to review his history and evaluate his peripheral smear at the present time. Regarding his mild adrenal insufficiency, he has been using natural measures to help support the adrenal glands, not really sure this has been helpful. He has been addressing insulin resistance via dietary management, has succeeded in another 7 pounds of weight loss. However, is increasingly discouraged with deteriorating health, went off the diet recently, willing to resume once again. Continues with significant sleep disturbance, note sleep apnea. He asks about a new CPAP machine that is quieter and may be better tolerated, this would be an excellent idea to explore further, and I asked him to contact Dr. Chestnut in this regard. Regarding testosterone replacement, he utilized 100 mg daily, though somewhat sporadically, found that it increased his libido but no further improvement in energy, muscle strength, etc. He realizes he did not try the hormone long enough to really evaluate fully and is willing to resume on a more consistent basis. Regarding his sleep, Teitelbaum's herbal sleep formula has provided some definite benefit. He remains strongly adverse to conventional medication intervention, though would be willing to try Provigil to address excess daytime somnolence due to sleep apnea. His wife is concerned that he remains clinically depressed, but he is quite unwilling to consider medication intervention at present.

↓ More dict Over ↓

Dr Don Colbert

x 1 wk: HoloSync Audio

Name Michael

CC:

What is main goal you wish to accomplish today? Another Step to Wellness

Now: ~ 3-4/10

SUBJ:

What symptoms have improved?
1. Lost weight (?10# @ home)
2. ? nail fungus (ThreeLac)
3. ↓ Constipation

What symptoms still bother you?
1. Chronic Fatigue
2. Chronic pain (tight mm, esp at night)
3. Lack of Concentration (but ↓ "brain fog")

Please describe any changes we need to know of: Started taking Curcumin, Gymnema Sylvestre, bitter melon, Fenugreek, Chromium Picolate, Nutopalea, American Ginseng

Are there any specific questions you need answered? Need to reverse feeling of dying!

**Please Do Not Write Below This Line**

OBJ-
BP- 122/64
P-
T- 60
HT-
WT- 269 (266# here)

PE (abnl / nl / neg / sxs)

| | nl | neg |
|---|---|---|
| GENL | ✓ | |
| HEENT | | |
| NECK | | |
| RESP | | |
| BREAST | | 5/4/05 |
| CARD | | 10/24/05 |
| GI | | |
| GU | | |
| RECTAL | | |
| EXTR | | |
| NEURO | | |
| SKIN | | |

ROS

FHX

Filed (Y) N
Pt to complete Y N
Reviewed
Changes? Y (N)

Filed: LAB + ordered

XRAY
med decis (CMPLX)
STRFWD LO MED (HI)

Time Spent 10:45 → 1:00 = 1015 min / 60 min = Couns

2/14/06 MICHAEL SWENSON

S: Continues to have significant CFS symptomatologies. The improvement he described at last visit following initiation of ThreeLac unfortunately has not continued. He has been trying to follow a lower CHO diet, also added various nutrients to further support blood sugar metabolism. Has lost some weight, he believes 10 pounds at home, our scales confirm six pounds. He does believe his toenail fungus is beginning to improve on the ThreeLac. His constipation has also lessened. However, continues with significant fatigue, myalgias, and lack of concentration. He describes long-standing difficulties with focus, dating to childhood. His wife strongly suspects ADD/ADHD, though Michael tends to question that diagnosis. She also believes he has had long-standing underlying depression. Michael states that the depression is secondary to his health concerns, situational rather than endogenous. He is strongly averse to any pharmaceutical intervention, willing to pursue aggressive nutraceutical support in addressing his problems. His lab did confirm insulin resistance and hyperlipidemia, current dietary modulation is definitely appropriate. With his low testosterone, he is strongly interested in a trial of androgen replacement therapy. His secondary pituitary workup was WNL. He does have a mild adrenal insufficiency with slightly low a.m. cortisol, normal throughout the rest of the day. Also note borderline B12 and iron status, and further support is indicated. Regarding sleep apnea, suggested he make sure his CPAP is calibrated correctly, he still has significant sleep difficulties (some of which is due to challenges in wearing the CPAP device). I suggested repeat sleep consultation with a local specialist, which he might consider (though he really did not seem interested at this point). Of interest, he has been utilizing a sublingual B12 product and his levels are still suboptimal. He would be willing to utilize injection therapy to improve results. Would also like non-pharmaceutical support in sleep management, as well as addressing his myalgias. Finally, I did mention Provigil as a potentially useful adjunct. He is not willing to consider medication intervention at this point in time.

Name Michael Swenson

CC:

What is main goal you wish to accomplish today? Find out if symptoms partially due to hormonal changes + if treatment can help feel better

SUBJ:

What symptoms have improved?
1. joint pain (slight)
2. Foggy/dizzy head (slight)
3. Fatigue (slight)

What symptoms still bother you?
1. extreme fatigue/low energy
2. unclear thinking/dizziness
3. aches/pain in body muscle/joints (chronic)

Please describe any changes we need to know of: just started taking Three-Lac (probiotic treatment for candida) felt great after first day) not as well each following day - started with mangosteen juice

Are there any specific questions you need answered? Any info on candida eradication (or normal balance) any info on how often testing needed for hormone treatment - can we obtain a prescription for these supplements?

**Please Do Not Write Below This Line**

OBJ-
BP- 110/70
P-
T-
HT- 60
WT- 275

PE

| abnl | nl | |
|---|---|---|
| | ✓ | GENL |
| | | HEENT |
| | | NECK |
| | | RESP |
| | | BREAST |
| | | CARD |
| | | GI |
| | | GU |
| | | RECTAL |
| | | EXTR |
| | | NEURO |
| | | SKIN |

ROS

| neg | sxs | |
|---|---|---|
| | | GENL |
| | | HEENT |
| | | NECK |
| | | RESP |
| | | BREAST |
| | | CARD |
| | | GI |
| | | GU |
| | | RECTAL |
| | | EXTR |
| | | NEURO |
| | | SKIN |

SJF 10/24/05 Note

FHX

Filed (Y) N
Pt to complete Y N
Reviewed
Changes? Y (N)

Filed: LAB

XRAY
med decis (CMPLX)
STRFWD LO MED (HI)

Time Spent 11:50 → 1:00 = 70 min / 50 min = Level 5

12/15/05 MICHAEL SWENSON

S: My first visit with this 39-year-old white male, see prior note by SJF for full historical detail. He has had a challenging course of chronic fatigue for the last several years, as previously documented. There has been some improvement with management of sleep apnea, though overall status has been generally unsatisfactory, with poor quality of life, decreased concentration, difficulties with work, as well as leisure activities. He has a positive symptom review for hypogonadism, and his testosterone levels are definitely quite low for his age. He had some routine lab earlier this year with no major abnormalities, but he has not had an aggressive fatigue workup, nor has he had further evaluation of pituitary function. Of interest, he has recently begun two nutritional products that appear to be helpful, the first is a Mangosteen product. The most dramatic was when he started a probiotic called Three-Lac. He felt dramatically improved by the next day, with better energy, decreased fatigue, and arthralgias, and improved mental clarity. He has not been as well for the next several days, but is encouraged thus far. Wants further information on yeast evaluation and management, and any support that could help him regain his vitality.

P: Extremely long and involved consultation this date. Reviewed history in some detail. Counseled regarding lab results and interpretation, discussed further options in evaluation and management. We had a long discussion regarding the multiple factors that could be impacting his fatigue. Gave him some further literature on PCC, discussed EBV/mono and its relationship to CFS, and went into hormone metabolism in some detail. We will need further lab clarification, have him draw FSH, LH, prolactin, ACTH, cortisol, TSH, free T3, free T4, iron studies, PSA, and B12/folic acid. He will also obtain a lipid profile fasting through Bonner General Hospital. Will also check TAP to further evaluate adrenal axis. Once these results are obtained, consultation with CV to complete prostate exam and begin appropriate hormonal support, based on lab work. Will utilize compounded testosterone if pituitary evaluation is unremarkable, otherwise might consider HCG injections. We will then need to order follow-up blood levels, and I will plan to see him back in about two months for follow-up.

A: 1. CFS. 2. LOW TESTOSTERONE, ? PRIMARY VERSUS SECONDARY HYPOGONADISM. 3. PROBABLE PCC BY HISTORY.

WFC:kc
12/15/05

10/24/05 MICHAEL SWENSON

S: Michael is a 39-year-old realtor for Sandpoint Realty who comes in to our office with the chief complaint of chronic fatigue. He states in 2003, he developed chronic fatigue, feeling extremely exhausted and this was even before he had a study for sleep apnea, which was positive, and even with using a CPAP. It has helped increase his energy some. He did have recent laboratory work done with his PCP, which was positive for mono and Epstein-Barr virus. He states that in May 2004, he had a septoplasty and a T&A, which required him to have a blood transfusion, and the fatigue has been much worse since that time. He also has difficulty with concentrating and short-term memory, and has developed digestive problems two years ago, with intermittent diarrhea and constipation, which was the same the year that he also started noticing more difficulty with his memory and concentration. In 1988, he had a bullet removed from his head, but we did not go into further details concerning this. Other than having the CPAP to have him sleep, he takes a considerable amount of supplements through Dr. Andrew Lessman, which includes a form of HGH which is in a tablet form that dissolves in water and becomes carbonated, and thinks this may also have helped to slightly increase his energy so as well. He is very interested in knowing what his testosterone levels are. He does have a decreased libido and is wanting to know if there is any other supplements or prescription medications that may help to increase his energy. He states his major stresses this past year has been the death of his grandmother, moving his brother up from Colorado with him driving over 2200 miles on the round trip. Also being involved in a head-on collision three months ago, and having a setback in his energy after having septoplasty and a T&A in 2004. He rarely drinks alcohol, does not smoke. Does not sleep well, but tries to get six or seven hours of sleep per night, but rarely feels rested upon awakening in the morning. He does walking, occasionally cutting wood about three times per week, but for very short periods of time. He also has chronic back pain from an injury in 1996, of a herniated disk L4-5 and then re-injuring his back again in 1999, and he apparently is disabled through the State of Washington.

O: A very pleasant gentleman in no acute distress. PE on file.

P: After a long discussion on Michael's very complexed medical history, he will get baseline laboratory work to include a SP 123, DHEA, stool analysis G-1, ELISA for food sensitivities, TAP, a total and free testosterone, E2, and PSA. Also when he returns for a follow-up visit, he will also arrange to have a DMPS injection for a Doctor's Data six-hour urine collection for heavy metals. He will have this done in about four weeks when he follows up with Dr. Corell to review his laboratory work, and he will have nutritional consultation with Jari Serra as well. He is given the basic protocol of supplements. He will consider this, but will continue on with his current supplements that both him and his wife take for now.

A: 1. FATIGUE. 2. DECREASED LIBIDO. 3. SLEEP DISTURBANCE. 4. MFA. 5. DYSPEPSIA, PROBABLE IBS. 6. RECENT HISTORY OF A POSITIVE TEST FOR MONONUCLEOSIS IN MARCH 2005.

SJF:jh
SF 10/24/05

Bonner General Hospital
520 North Third Avenue
Sandpoint, Idaho 83864

CONFIDENTIAL REPORT
Fax: 208-265-1288
Phone: 208-265-1182

Patient Name: SWENSON,MICHEAL E DOB:04/05/1966

Ordering Dr:BURGSTAHLER, SCO Collect:04/10/06 15:33 mtk LAB#100-0146

| Test Name | Results | Init | Reference Range | Units |
|---|---|---|---|---|
| **HEMATOLOGY** | | | | |
| WBC | 6.8 | | 4.0-9.6 | X10*3/UL |
| RBC | 5.68 | ↑ | 4.06-5.80 | X10*6/UL |
| HGB | 16.9 | ↑ | 12.9-17.5 | g/dl |
| HCT | 50.7 | ↑ | 38.1-51.7 | % |
| MCV | 89.2 | | 84.4-98.2 | fl |
| MCH | 29.7 | | 28.2-33.2 | pg |
| MCHC | 33.3 | | 32.6-35.0 | g/dl |
| RDW | 11.4 | | 10.8-14.2 | % |
| PLATELET CT,AUTO | 286 | | 133-357 | X10*3/UL |
| MPV | 8.4 | | 6.8-10.8 | fl |
| NE% | 59.3 | | 43.6-79.0 | % |
| LY% | 30.5 | | 10.3-45.1 | % |
| MO% | 7.0 | | 3.5-13.1 | % |
| EO% | 1.0 | ↓ | 0.0-7.4 | % |
| BA% | 2.2 | ↑ | 0.0-2.6 | % |
| NE# | 4.0 | | 1.9-6.7 | X10*3/UL |
| SED RATE | 5 | | 0-10 | mm/HR |
| **MANUAL DIFFERENTIAL** | | | | |
| SEG NEUTROPHILS | 51 | | 40-80 | % |
| BAND NEUTROPHILS | 1 | | 0-9 | % |
| LYMPHOCYTES | 38 | ↑ | 15-45 | % |
| MONOCYTES | 5 | | 0-10 | % |
| EOSINOPHILS | 2 | | 0-4 | % |
| BASOPHILS | 1 | | 0-1 | % |
| ATYPICAL LYMPHS | 2 | ! | | |
| RBC MORPHOLOGY | | | normal | |
| NORMAL MORPHOLOGY | | | | |
| PLT ESTIMATE | | | Adequate | |
| PLATELETS APPEAR ADEQUATE | | | | |

can indicate possible lung disease! or bone marrow issues!

Specify please

?

*** See Next Page for Additional Results ***

Rpt Comment:

Admit DR:BURGSTAHLER, SCO Admitted: 04/10/06 15:29
Consult Dr: BURGSTAHLER, SCO ACT# OP11279117
Sex: M Age: 40Y Room: DIS DIS Pt Phone:(208)265-8762
Reported: 04/10/06 20:49

Bonner General Hospital
520 North Third Avenue
Sandpoint, Idaho 83864

CONFIDENTIAL REPORT
Fax: 208-265-1288
Phone: 208-265-1182

Patient Name: SWENSON,MICHEAL E DOB:04/05/1966

Ordering Dr:BURGSTAHLER, SCO Collect:04/10/06 15:33 mtk LAB#100-0146

| Test Name | Results | Init | Reference Range | Units |
|---|---|---|---|---|
| **CARDIAC MARKERS** | | | | |
| CK | 161 | | 24-204 | U/L |
| **THYROID TESTS** | | | | |
| TSH | 0.85 | | 0.40-5.00 | uIU/ml |
| **CHEMISTRY** | | | | |
| SODIUM | 139 | | 136-145 | mmol/L |
| POTASSIUM | 4.2 | | 3.5-5.1 | mmol/L |
| CHLORIDE | 103 | | 98-109 | mmol/L |
| CO2, TOTAL | 26 | | 21-29 | mmol/L |
| OSMOLALITY-CALCU | 280 | | 272-295 | mOsm/Kg |
| ANION GAP | 10 | ↑ | 3-11 | MMOL/L |
| GLUCOSE | 104 | ↑ | 70-110 | mg/dl |
| BUN | 19 | ↑ | 8-21 | mg/dl |
| CREATININE | 1.2 | | 0.9-1.5 | mg/dL |
| CALCIUM | 9.7 | | 8.5-10.5 | mg/dl |
| TOTAL PROTEIN | 7.0 | | 6.3-8.3 | g/dL |
| ALBUMIN | 4.7 | ↑ | 3.5-5.0 | g/dl |
| ALK PHOSPHATASE | 83 | | 45-122 | U/L |
| BILIRUBIN, TOTAL | 0.7 | | 0.2-1.3 | mg/dl |
| AST | 28 | | 10-34 | U/L |
| ALT | 56 | H ↑ | 10-44 | U/L |
| HBA1cRATIO (WB) | 5.4 | | 4.50-5.70 | % |

possible pituitary or hypothalamus issues → test with TRH injection to rule out pituitary issues

(suggest overactive thyroid) (low side) → risk factor for Alzheimer's!

borderline diabetes kidneys not working well

coupled with K abnormal (possible kidney issues)

indicate possible injury to cells - possible damage to bone/liver/or gallstones

number of abscesses possible

*** See Next Page for Additional Results ***

Rpt Comment:

Admit DR:BURGSTAHLER, SCO
Consult Dr: BURGSTAHLER, SCO
Sex: M Age: 40Y Room: DIS DIS
Reported: 04/10/06 20:49

Admitted: 04/10/06 15:29
ACT# OP11279117
Pt Phone:(208)265-8762



MR# 122671 SWENSON,MICHEAL E

Bonner General Hospital
520 North Third Avenue
Sandpoint, Idaho 83864

CONFIDENTIAL REPORT
Fax: 208-265-1288
Phone: 208-265-1182

Patient Name: SWENSON,MICHEAL E DOB:04/05/1966

Ordering Dr:BURGSTAHLER, SCO Collect:04/10/06 15:37 mtk LAB#100-0149

| Test Name | Results | Init | Reference Range | Units |
|---|---|---|---|---|
| REFERENCE LABORATORY | | | | |
| HAV AB, IGM | . | | | |
| | Rslt: Non Reactive | | RR:NR | Units: |
| HBc AB, IGM | . | | | |
| | Rslt: Non Reactive | | RR:NR | Units: |
| HCV AB SCREEN | . | | | |
| | Rslt: Non Reactive | | RR:NR | Units: |
| HEP B SURFACE AG | . | | | |
| | Rslt: Non Reactive | | RR:NR | Units: |
| | HBsAG Confirm by Neutralizatio | | DNR | |
| INTERPRETATION | . | | | |
| | Rslt: See Below | | RR: | Units: |
| | No serologic evidence of HAV, HBV or HCV infection. | | | |

Test Performed At:
Pathology Associates Medical Lab
Spokane, WA 99204

***** Inquiry Copy *****

Rpt Comment:

Admit DR:BURGSTAHLER, SCO
Consult Dr: BURGSTAHLER, SCO
Sex: M Age: 40Y Room: DIS DIS
Reported: 04/11/06 08:14

Admitted: 04/10/06 15:29
ACT# OP11279117
Pt Phone:(208)265-8762



MR# 122671 SWENSON,MICHEAL E

Bonner General Hospital
520 North Third Avenue
Sandpoint, Idaho 83864

CONFIDENTIAL REPORT
Fax: 208-265-1288
Phone: 208-265-1182

Patient Name: SWENSON,MICHEAL E DOB:04/05/1966

Ordering Dr:BURGSTAHLER, SCO Collect:04/10/06 15:33 mtk LAB#100-0146

| Test Name | Results | Init | Reference Range | Units |
|---|---|---|---|---|
| BLOOD BANK | | | | |
| BLOOD TYPE | O | | | |
| RH | Positive | | | |
| ANTIBODY SCREEN | Negative | ? | NEGATIVE | |
| DIRECT COOMBS | Negative | ? | NEGATIVE | |

Why have these been positive on past tests suddenly negative?!

***** Inquiry Copy *****

Rpt Comment:

Admit DR:BURGSTAHLER, SCO
Consult Dr: BURGSTAHLER, SCO
Sex: M Age: 40Y Room: DIS DIS
Reported: 04/10/06 20:49

Admitted: 04/10/06 15:29
ACT# OP11279117
Pt Phone:(208)265-8762



MR# 122671 SWENSON,MICHEAL E

INTERIM REPORT
PATHOLOGY ASSOCIATES MEDICAL LABORATORIES
110 N Cliff Ave.
Spokane, Washington 99204

NAME: SWENSON,MICHAEL AGE: 39Y SEX: M
ACCOUNT NUMBER: IA00069092
DOCTOR: HAW MD, TAREK
ACCOUNT'S PHONE: (208)667-2663
CLIENT: NORTH IDAHO CL FOR INTERNAL ME

M77740 COLL: 04/11/2005 17:10 REC: 04/11/2005 19:06 PHYS: HAW MD, TAREK
Req# : 663000222188

| | | | | | |
|---|---|---|---|---|---|
| **Comprehensive Metabolic Panel** | | | | | |
| Sodium | | 140 | [135-145] | mmol/L | [01] |
| Potassium | | 4.3 | [3.5-5.3] | mmol/L | [01] |
| Chloride | | 104 | [98-109] | mmol/L | [01] |
| CO2 | | 25 | [22-29] | mmol/L | [01] |
| Glucose | | 83 | | | [01] |
| | | 0 to 2 days premature | | 30 to 80 mg/dL | |
| | | 0 to 2 days full term | | 40 to 90 mg/dL | |
| | | 2 days to 1 month | | 60 to 105 mg/dL | |
| | | Adults | | 65 to 99 | |
| | | ADA diagnostic categories for nonpregnant adults: Impaired fasting glucose: 100 to 125 mg/dL. A fasting glucose result of 126 mg/dL or greater indicates diabetes if the abnormality is confirmed on a subsequent day. A random glucose result of greater than 200 mg/dL indicates diabetes if the abnormality is confirmed on a subsequent day. | | | [65-99) mg/dL |
| BUN | | 16 | [7-23] | mg/dL | [01] |
| Creatinine | | 1.2 | [0.7-1.5] | mg/dL | [01] |
| Calcium | | 9.8 | [8.5-10.5] | mg/dL | [01] |
| Protein, Total | | 7.4 | [6.3-8.0] | g/dL | [01] |
| Albumin | | 5.0 | [3.5-5.0] | g/dL | [01] |
| Bilirubin, Total | | 0.8 | [0.1-1.5] | mg/dL | [01] |
| Alkaline Phosphatase | | 91 | [38-110] | U/L | [01] |
| AST | | 39 | [5-40] | U/L | [01] |
| ALT | H | 83 | [5-50] | U/L | [01] |
| Anion Gap | | 11 | [5-16] | mmol/L | [01] |
| **CMP Calculations** | | | | | |
| BUN/Creatinine Ratio | | 13.3 | [7.0-24.0] | Ratio | [01] |
| Globulin | | 2.4 | [1.8-3.5] | g/dL | [01] |
| A/G Ratio | | 2.1 | [1.1-2.2] | Ratio | [01] |
| **HIV 1/HIV 2 Antibodies** | | | | | |
| HIV 1/HIV 2 Abs | | | [NR] | | [01] |
| | | Non Reactive | | | |
| | | The Non Reactive HIV 1/2 antibody | | | |

INTERIM REPORT
PATHOLOGY ASSOCIATES MEDICAL LABORATORIES
110 W Cliff Ave.
Spokane, Washington 99204

NAME: SWENSON,MICHAEL AGE: 39Y SEX: M
ACCOUNT NUMBER: IA00069092
DOCTOR: HAW MD, TAREK
ACCOUNT'S PHONE: (208)667-2663
CLIENT: NORTH IDAHO CL FOR INTERNAL ME

M77740 COLL: 04/11/2005 17:10 REC: 04/11/2005 19:06 PHYS: HAW MD, TAREK
Req# : 663000222188

| | | | |
|---|---|---|---|
| HIV 1/HIV 2 Antibodies (CONTINUED) | | | |
| | result indicates that antibodies to HIV 1/2 have not been detected in this specimen. This result does not preclude previous exposure or infection. | | |
| Hepatitis A, B, C | | | |
| HAV Ab, Total [IgG and IgM] | [NR] Non Reactive | | [01] |
| HBs Ag Screen | [NR] Non Reactive | | [01] |
| HBc Ab, Total [IgG and IgM] | [NR] Non Reactive | | [01] |
| Hepatitis C Antibody | [NR] Non Reactive | | [01] |
| Interpretation | No serologic evidence of current Hepatitis A or B virus infection. Absence of antibody suggests no past Hepatitis C infection. Since antibody development may be delayed up to 6 months after infection, retesting may be indicated. | | [01] |
| Mono Test | * Positive [NEG] | | [01] |
| RPR | [NR] Non Reactive | | [01] |

[01] = Pathology Associates Medical Lab, Spokane, WA 99204

W65867 COLL: 04/13/2005 00:00 REC: 04/13/2005 15:10 PHYS: HAW MD, TAREK
Req# : 663000223325

| | | |
|---|---|---|
| Urine Time and Volume | | |
| Collection Period/h | Unknown | h |
| Volume/mL | 875 | mL |
| Cortisol, Urinary Free 24 Hr | Pending | |

RUN TIME: 0146
RUN DATE: 12/26/03

# EMPIRE HEALTH SERVICES
## DEACONESS MEDICAL CENTER
800 West 5th Avenue, Spokane, WA 99210-0248
LABORATORY CUMULATIVE SUMMARY - DISCHARGE REPORT



* * * * * * * * * DISCHARGE SUMMARY - DO NOT DESTROY * * * * * * * * *

Name: SWENSON,MICHAEL E. Age/Sex: 37/M Attend Dr: Goldberg,Harold R
Acct#: D17777285 Unit#: D0000667544 Status: DIS IN Location: DACU7 D705-1
Reg: 12/25/03 Disch: 12/25/03 DOB: 04/05/66

### HEMATOLOGY
### AUTOHEMATOLOGY - DIFFERENTIAL - MORPHOLOGY

| | Date 12/25 Time 0131 | Reference | Units |
|---|---|---|---|
| HGB | 15.4 | 13.5-17.5 | g/dL |
| HCT | 43.0 | 41-53 | % |
| RBC | 4.87 | 4.5-5.9 | mil/ul |
| MCV | 86.5 | 80-100 | fl |
| MCH | 31.0 | 26-34 | pg |
| MCHC | 35.8 | 31-37 | g/dl |
| RDW-SD | 38.8 | 35.1-46.3 | fL |
| PLT | 249 | 140-440 | th/uL |
| WBC | 7.7 | 4.50-11.00 | th/uL |
| NEUT % (AUTO) | 48.2 | | % |
| LYMPH % (AUTO) | 44.7 | | % |
| MONO % (AUTO) | 5.3 | | % |
| EOS % (AUTO) | 1.3 | | % |
| BASO % (AUTO) | 0.5 | | % |
| NEUT AB (AUTO) | 3.7 | 1.8-7.7 | th/ul |
| LYMPH AB (AUTO) | 3.5 | 1.0-4.8 | th/ul |
| MONO AB (AUTO) | 0.4 | 0.1-0.9 | th/ul |
| EOS AB (AUTO) | 0.1 | 0-0.7 | th/ul |
| BASO AB (AUTO) | 0.0 | 0-0.2 | th/ul |
| MPV | 10.4 | 9.4-12.5 | fL |

### CHEMISTRY
### BLOOD CHEMISTRY

| Date Time | SODIUM 135-146 mmol/L | POTASSIUM 3.5-5.1 mmol/L | CHLORIDE 98-108 mmol/l | CO2 23-30 mmol/l | ANION GAP 7-17 |
|---|---|---|---|---|---|
| 12/25 0131 | 136 | 3.8 | 99 | 28 | 9 |

| Date Time | CREATININE 0.6-1.4 mg/dL | BUN 7-25 mg/dL | GLUCOSE 65-115 mg/dL | CALCIUM 8.4-10.2 mg/dL | CK, TOT 35-232 U/L |
|---|---|---|---|---|---|
| 12/25 0925 | | | | | 378 H |
| 12/25 0131 | 1.3 | 17 | 114 | 8.6 | 383 H |

WESTERN MONTANA CLINIC
515 WEST FRONT STREET
MISSOULA, MONTANA 59802
GENE MEAD, PH.D.

ACCESSION # : 298-0284
COLLECTION DATE/TIME/INITIALS: 10/25/07 16:23 beb
REQUESTING DOCTOR: DONOVAN, JANELLE

| Test Name | Results | Reference Range | Units |
|---|---|---|---|
| | MANUAL DIFFERENTIAL | | |
| NEUTROPHILS | 59.0 | 40-80 | % |
| BANDS | 1 | 0-10 | % |
| LYMPHS | 18 | 15-50 | % |
| MONOCYTES | 4 | 0-10 | % |
| EOSINOPHILS | 1 | 0-7 | % |
| BASOPHILS | 1 | 0-2 | % |
| **ATYPICAL LYMPHS** | **16 H** | **0-5** | % |
| METAMYELOCYTES | 0 | | % |
| MYELOCYTES | 0 | | % |
| PROMYELOCYTES | 0 | | % |
| BLASTS | 0 | | % |
| IMMATURE CELLS | 0 | | % |
| NUCLEATED RBC | 0 | | |
| DIFF CMT | SEE BELOW | | |

RBC NORM, PLAT NORM
ABOUT 50% ATYPICAL LYMPHS
1 ATYPICAL/IMMATURE MONO ALSO SEEN

***** Permanent Report *****

Rpt Comment:

ID: 252059 NAME : swenson,michael
DOB: 04/05/1966 ROOM: f6p2 SEX: M
REPORT DATE/TIME : 10/25/07 17:30
ADMITTING DOCTOR: DONOVAN, JANELLE

Bonner General Hospital
520 North Third Avenue
Sandpoint, Idaho 83864

CONFIDENTIAL REPORT
Fax: 208-265-1288
Phone: 208-265-1182

Patient Name: SWENSON,MICHEAL E DOB:04/05/1966

Ordering Dr:CORELL, WILLIAM Collect:12/21/05 14:29 wga LAB#355-0078

| Test Name | Results | Init | Reference Range | Units |
|---|---|---|---|---|
| **CHEMISTRY** | | | | |
| CHOLESTEROL | 204 H | | 155-200 | mg/dl |

A general assessment of hyperlipidemia can be established by comparing the following sex dependent risk factors:

| Risk Factor | MEN | | WOMEN | |
|---|---|---|---|---|
| | CHOL/HDL | LDL/HDL | CHOL/HDL | LDL/HDL |
| 1/2 Average | 3.43 | 1.00 | 3.27 | 1.47 |
| Average Risk | 4.97 | 3.55 | 4.44 | 3.22 |
| 2X Average | 9.55 | 6.25 | 7.05 | 5.03 |
| 3x Average | 23.39 | 7.99 | 11.04 | 6.14 |

| | | | | |
|---|---|---|---|---|
| HDL CHOLESTEROL | 43 | | 40-55 | mg/dL |
| LDL CHOL Direct | 134 H | | 0-100 | mg/dl |
| LDL/HDL RATIO | 3.12 | | 0.00-3.55 | |
| CHOL/HDL RATIO | 4.74 | | 0.00-4.97 | |
| TRIGLYCERIDES | 201 H | | 40-150 | mg/dl |

***** Permanent Report *****

Rpt Comment:

Admit DR:CORELL, WILLIAM Admitted: 12/21/05 14:25
Consult Dr: CORELL, WILLIAM ACT# OP11264732
Sex: M Age: 39Y Room: LAB LAB Pt Phone:(208)265-8762
Reported: 12/21/05 15:24 PAGE # 1
MR# 122671 SWENSON,MICHEAL E

Bonner General Hospital
520 North Third Avenue
Sandpoint, Idaho 83864

CONFIDENTIAL REPORT
Fax: 208-265-1288
Phone: 208-265-1182

Patient Name: SWENSON,MICHEAL E DOB:04/05/1966

Ordering Dr:BURGSTAHLER, SCO Collect:04/10/06 15:33 mtk LAB#100-0146

| Test Name | Results | Init | Reference Range | Units |
|---|---|---|---|---|
| **CARDIAC MARKERS** | | | | |
| CK | 161 | | 24-204 | U/L |
| **THYROID TESTS** | | | | |
| TSH | 0.85 | | 0.40-5.00 | uIU/ml |
| **CHEMISTRY** | | | | |
| SODIUM | 139 | | 136-145 | mmol/L |
| POTASSIUM | 4.2 | | 3.5-5.1 | mmol/L |
| CHLORIDE | 103 | | 98-109 | mmol/L |
| CO2, TOTAL | 26 | | 21-29 | mmol/L |
| OSMOLALITY-CALCU | 280 | | 272-295 | mOsm/Kg |
| ANION GAP | 10 | | 3-11 | MMOL/L |
| GLUCOSE | 104 | | 70-110 | mg/dl |
| BUN | 19 | | 8-21 | mg/dl |
| CREATININE | 1.2 | | 0.9-1.5 | mg/dL |
| CALCIUM | 9.7 | | 8.5-10.5 | mg/dl |
| TOTAL PROTEIN | 7.0 | | 6.3-8.3 | g/dL |
| ALBUMIN | 4.7 | | 3.5-5.0 | g/dl |
| ALK PHOSPHATASE | 83 | | 45-122 | U/L |
| BILIRUBIN, TOTAL | 0.7 | | 0.2-1.3 | mg/dl |
| AST | 28 | | 10-34 | U/L |
| ALT | 56 H | | 10-44 | U/L |

*** See Next Page for Additional Results ***

Rpt Comment:

Admit DR:BURGSTAHLER, SCO Admitted: 04/10/06 15:29
Consult Dr: BURGSTAHLER, SCO ACT# OP11279117
Sex: M Age: 40Y Room: LAB LAB Pt Phone:(208)265-8762
Reported: 04/10/06 18:18 
MR# 122671 SWENSON,MICHEAL E

Bonner General Hospital
520 North Third Avenue
Sandpoint, Idaho 83864

CONFIDENTIAL REPORT
Fax: 208-265-1288
Phone: 208-265-1182

Patient Name: SWENSON,MICHEAL E DOB:04/05/1966

Ordering Dr:BURGSTAHLER, SCO Collect:04/10/06 15:33 mtk LAB#100-0146

| Test Name | Results | Init | Reference Range | Units |
|---|---|---|---|---|
| **HEMATOLOGY** | | | | |
| WBC | 6.8 | | 4.0-9.6 | X10*3/UL |
| RBC | 5.68 | | 4.06-5.80 | X10*6/UL |
| HGB | 16.9 | | 12.9-17.5 | g/dl |
| HCT | 50.7 | | 38.1-51.7 | % |
| MCV | 89.2 | | 84.4-98.2 | fl |
| MCH | 29.7 | | 28.2-33.2 | pg |
| MCHC | 33.3 | | 32.6-35.0 | g/dl |
| RDW | 11.4 | | 10.8-14.2 | % |
| PLATELET CT,AUTO | 286 | | 133-357 | X10*3/UL |
| MPV | 8.4 | | 6.8-10.8 | fl |
| NE% | 59.3 | | 43.6-79.0 | % |
| LY% | 30.5 | | 10.3-45.1 | % |
| MO% | 7.0 | | 3.5-13.1 | % |
| EO% | 1.0 | | 0.0-7.4 | % |
| BA% | 2.2 | | 0.0-2.6 | % |
| NE# | 4.0 | | 1.9-6.7 | X10*3/UL |
| SED RATE | 5 | | 0-10 | mm/HR |
| **MANUAL DIFFERENTIAL** | | | | |
| SEG NEUTROPHILS | 51 | | 40-80 | % |
| BAND NEUTROPHILS | 1 | | 0-9 | % |
| LYMPHOCYTES | 38 | | 15-45 | % |
| MONOCYTES | 5 | | 0-10 | % |
| EOSINOPHILS | 2 | | 0-4 | % |
| BASOPHILS | 1 | | 0-1 | % |
| ATYPICAL LYMPHS | 2 | | | |
| RBC MORPHOLOGY | | | normal | |
| NORMAL MORPHOLOGY | | | | |
| PLT ESTIMATE | | | Adequate | |
| PLATELETS APPEAR ADEQUATE | | | | |

*** See Next Page for Additional Results ***

Rpt Comment:

Admit DR:BURGSTAHLER, SCO
Consult Dr: BURGSTAHLER, SCO
Sex: M Age: 40Y Room: LAB LAB
Reported: 04/10/06 18:18

Admitted: 04/10/06 15:29
ACT# OP11279117
Pt Phone:(208)265-8762



MR# 122671 SWENSON,MICHEAL E

Bonner General Hospital - Department of Radiology
520 North Third Street, P.O. Box 1448, Sandpoint, ID 83864-0877
Voice - (208) 265-1142  FAX - (208) 265-1051



| | |
|---|---|
| Patient: SWENSON, MICHEAL E | Exam: ABDOMEN CT |
| Sex: M Age: 040Y DOB: 04/05/1966 | Seq# 1 |
| MR#/Rad# 122671 | Exam Date: 4/12/06 |
| Pat# 11279246 | Admit by: SCOTT BURGSTAHLER, MD |
| Location: | Atnd Phys: SCOTT BURGSTAHLER, MD |
| Pat Phone# (208)265-8762 | Copy to: |

CLINICAL HISTORY:
Abdominal and bilateral flank pain times two months.

No comparisons.

TECHNIQUE:
Using spiral technique, axial images of the abdomen were obtained after administration of oral and intravenous contrast. The patient received 100 cc of Omnipaque 300 intravenously at 2 cc per second.

FINDINGS:
The lung bases are clear. There is a subtle 1.0 cm low density lesion posterior segment right lobe of the liver. No other focal liver lesions. The biliary tree is not dilated. There are several partially calcified stones seen in the dependent portion of the gallbladder. The pancreas and spleen appear normal. No adrenal masses. The abdominal aorta and periaortic tissues appear normal. The kidneys appear normal. No stones or hydronephrosis.

There are diverticula in the colon. I see no findings of diverticulitis. The sigmoid colon and the pelvis is not imaged on this exam. The appendix is partially seen and appears normal. No ascites or free air. I see no abdominal wall hernia.

There are degenerative changes in the lower lumbosacral spine.

(Continued)

IMPRESSION:

1. Cholelithiasis. No other findings of cholecystitis. The biliary tree is not dilated.
2. There is a 1.0 cm low density lesion posterior segment right lobe of the liver seen on initial imaging, delayed scanning was also performed. The lesion is not seen on the delayed images. No other focal liver lesions seen. This finding is unlikely to be clinically significant. This may be a hemangioma.
3. Diverticulosis. No findings of diverticulitis. The distal colon and the pelvis is not imaged on this exam.
4. Appendix is partially seen and appears normal.
5. Degenerative changes are seen in the lower lumbosacral spine.

MARK E. WEBER, MD 04/13/2006
rlw
Electronically Signed by MARK E. WEBER, MD (04/13/06 16:38)

Bonner General Hospital - Department of Radiology
520 North Third Street, P.O. Box 1448, Sandpoint, ID 83864-0877
Voice - (208) 265-1142  FAX - (208) 265-1051



Patient: SWENSON, MICHEAL E
Sex: M Age: 040Y DOB: 04/05/1966
MR#/Rad# 122671
Pat# 11279753
Pat Phone# (208)265-8762

Exam: BRAIN MRI
Seq# 1
Exam Date: 4-14-2006
Admit by: SCOTT BURGSTAHLER, MD
Atnd Phys: SCOTT BURGSTAHLER, MD

CLINICAL HISTORY:
Memory deficits. History of gun shot wound to head.

Comparison Head CT 9-28-04

TECHNIQUE:
Sagittal and axial T1 weighted, axial FLAIR, T2 weighted and coronary FLAIR images of the brain were obtained.

FINDINGS:
There is a defect in the frontoparietal calvarium. There is an area of underlying encephalomalacia and gliosis deep to the calvarial defect. Findings consistent with patient's history of gun shot wound.

Sulci otherwise appear normal. The ventricular system appears normal. No other focal parenchyma findings. No mass. No intracranial hemorrhage seen. No focal abnormality in the mid brain or brain stem. Posterior fossa structures appear normal. I see no abnormality in the temporal bones. Orbits appear within normal limits. There is normal flow void in vascular structures at the skull base. I see no significant findings in the sinuses.

IMPRESSION:
1. Focal calvarial defect is seen in the right frontoparietal region with underlying small area of encephalomalacia and scarring. Findings are consistent with patient's history of a gun shot wound.
2. Intracranial structures otherwise appear normal. No other significant findings. Details above.

MARK E. WEBER, MD 04/17/2006
jlb
Electronically Signed by MARK E. WEBER, MD (04/17/06 08:28)

Bonner General Hospital
520 North Third Avenue
Sandpoint, Idaho 83864

CONFIDENTIAL REPORT
Fax: 208-265-1288
Phone: 208-265-1182

Patient Name: SWENSON,MICHEAL E DOB:04/05/1966

Ordering Dr:DICKENS Collect:12/24/03 18:45 dms LAB#358-0093

| Test Name | Results | Init | Reference Range | Units |
|---|---|---|---|---|
| **CARDIAC MARKERS** | | | | |
| CK | 523 H | | 24-204 | U/L |
| TROPONIN T,quant | <0.01 | | 0.01-0.10 | ng/ml |
| MYOGLOBIN | 44 | | 16-76 | ng/ml |

***** Permanent Report *****

Rpt Comment:

Admit DR:DICKENS
Consult Dr: DICKENS
Sex: M Age: 37Y Room: ER7 er7
Reported: 12/24/03 20:15

Admitted: 12/24/03 18:35
ACT# ER11174548
Pt Phone:(208)265-8762



MR# 122671 SWENSON,MICHEAL E

Bonner General Hospital
520 North Third Avenue
Sandpoint, Idaho 83864

CONFIDENTIAL REPORT
Fax: 208-265-1288
Phone: 208-265-1182

Patient Name: SWENSON,MICHEAL E DOB:04/05/1966

Ordering Dr:DICKENS Collect:12/24/03 19:02 dms LAB#358-0092

| Test Name | Results | Init | Reference Range | Units |
|---|---|---|---|---|
| BLOOD GASES | | | | |
| Carboxy HGB | 2.4 H | | 0.0-1.5 | % |

***** Permanent Report *****

Rpt Comment:

Admit DR:DICKENS
Consult Dr: DICKENS
Sex: M Age: 37Y Room: ER7 er7
Reported: 12/24/03 19:23

Admitted: 12/24/03 18:35
ACT# ER11174548
Pt Phone:(208)265-8762



MR# 122671 SWENSON,MICHEAL E

Kootenai Medical Center
Date of Admission: 05/24/2006
Date of Discharge: 06/01/2006

The patient is a 40-year-old male in a first North Idaho Behavioral Health admission who is brought in from Sandpoint with a chief complaint of "I have Wilson's disease."

He was brought in by friends and family who promised he would get treatment for his Wilson's disease. He has had several evaluations from multiple physicians, which have all been negative. He has had some pain problems starting about a month ago. He took one dose of Cymbalta and became quite manic and paranoid, not sleeping and not bathing. Doing research on the internet, thinking there is a conspiracy from his getting proper laboratory evaluations or other evaluations. He was driving erratically. Taking pictures of people, documenting they were part of a conspiracy, etc.

His wife reports he had been assaultive to her and a brother. There had been 4 police incidents. He apparently denied making any threats, assaults. He is convinced, that he has a disorder that physicians are refusing to treat. He has difficulty sleeping. He apparently has no indication of Wilson's disease. He denied any intent to harm himself. He wished to leave the hospital because he was not able to get the treatment, supposedly for Wilson's disease.

PAST MEDICAL HISTORY: He has a history of a bad conduct discharge from the navy. Intermittent difficulties at times consistent with manic episodes. History of drug and alcohol use. He has had significant difficulty with the law. He has also had depressive symptoms. Chronic pain over his whole body. Feeling sad and down with increased sleep.

PSYCHOSOCIAL HISTORY: Please see the history of present illness.

MENTAL STATUS: He is a white man who appears his stated age. He is cooperative with normal speech rate and volume. No evidence of psychomotor agitation or retardation noted. He slept after receiving a dose of Seroquel. His recent and remote memory are intact. Concentration is thought to be good. Intelligence average. Insight limited. Judgment intact in regard to formal testing. There is paranoid and delusional material noted, though he denies suicidal or homicidal thoughts. He has a fixed, paranoid and delusional system regarding the CIA doctors, presence of Wilson's disease and people involved in his laboratory work, interpretations of previous MRIs. He denied voices or visions. He was started by Dr. Wait on Seroquel.

Over time, he was placed on administrative hold and was later on released. Doing reasonably well after his stay in the hospital. It was thought that it is not needed to go to the state hospital. He was continued on Seroquel 100 mg, and then eventually it was reduced to 50 mg. By the time of discharge he was on Seroquel 50 mg at night. He is to be followed at Region I Mental

Health or persons of choice.

PAST MEDICAL HISTORY: He stated he had been physically ill for 2 years with pain, fatigue, decreasing work activity. No work in the past 6 months. He had surgery for sleep apnea. He had pulmonary edema and laryngospasm after being extubated. He had a respiratory arrest. He has a previous history of a gunshot wound to his head. He initially was convinced that he had leukemia with hepatitis, and then he became absolutely convinced that he had Wilson's disease.

DIAGNOSTIC IMPRESSION:
AXIS I:
1. Bipolar disorder, manic with psychotic features.
2. Hypochondriasis.
3. Delusional disorder.

RECOMMENDATION: As above, please note laboratory results were negative for Wilson's disease with a normal ceruloplasmin. A CT scan of his head showed a focal calvarial defect in the right frontoparietal region, underlying areas of encephalomalacia and scarring consistent with a previous history of a gunshot wound to the head. It is hoped that the patient will follow up.

Jeff Stevens, M.D.

JS:ms

Job ID:681840 Doc ID:893786
D:06/29/2006 07:53:57 T:06/30/2006 13:42:38

North Idaho Behavioral Health
Date of Admission: 05/24/2006

PSYCHIATRIC EVALUATION

IDENTIFYING DATA: This is the first psychiatric admission for this 40-year-old, white male from Sandpoint.

CHIEF COMPLAINT: "I've got Wilson's disease."

HISTORY OF PRESENT ILLNESS: This patient presents partly on referral from a physician in Sandpoint but brought in by friends and family, according to the patient on a promise that he would be able to get treatment for his Wilson's disease.

The patient has had several evaluations from multiple physicians which have all been negative. He was having significant difficulty with pain approximately a month ago. He took approximately one dose of Cymbalta, per report of his wife, and then became quite manic from what she describes, very paranoid, not sleeping, has been increasingly not sleeping, not bathing. He has been researching the Internet, thinks there is conspiracy that is preventing him from getting proper laboratory evaluations or other evaluations. Reportedly he was driving erratically, taking pictures of people, documenting that they are part of a conspiracy. The patient notes doing this, though he denies driving erratically.

His wife reports in a discussion with me that he has been assaultive to her and to a brother. She states there have been four police incidents and "they have done nothing." The patient denies that he has made any threats or assaults, actually does this fairly calmly, though he is clearly convinced that he has a disorder that physicians are refusing to evaluate or treat.

The patient does report some difficulty with sleeping. He reports this is from the disease that he thinks he has. However, the history and physical does not indicate further evaluation for Wilson's disease or other disease. No indication on laboratories of other difficulties or on physical examination.

The patient denies having any intent to harm himself or others. He states that he wishes to leave the hospital since he is not able to get treatment for what he thinks he has and he would go home and begin to do further research. He denies that he is a danger, he states that when he is driving and taking pictures, he is doing it safely.

PAST PSYCHIATRIC HISTORY: The patient does have a history of a bad conduct discharge from the Navy. He has had intermittent difficulties at times with what appears to have been consistent with manic episodes, including this one. He had an episode of drug and alcohol use in 1988 in which he went without

sleep for several days and got into considerable difficulty with the law. He, in the interim, has difficulties with depressive symptoms, primarily chronic pain over his whole body, feeling sad and down with increased sleep. The patient has not received any treatment for this at any point. He has had not received treatment for the substance use problems, though he denies such currently. He does state that he has an occasional drink of alcohol. He minimizes it any further.

FAMILY HISTORY: Per the patient, noncontributory.

PSYCHOSOCIAL HISTORY: The patient is married x10 years. I did speak with his wife who is profoundly angry at the police, angry at the inability to get treatment, quite concerned about her husband, feels that he is a danger to her and to family members as well as to people driving. Apparently they have a friend, and this is confirmed through case management through a physician call that had been made, who stated that he was "tricked" coming into the hospital, based on the promise of treating what he feels is his disorder.

The patient is a realtor. He is a high school graduate, has some college, after some time in the service. No children.

MENTAL STATUS EXAMINATION: This is a white male who appears his stated age. He is cooperative with the interview. Speech is normal rate and volume. There is no psychomotor agitation or retardation currently noted. The patient apparently slept last night after receiving a dose of Seroquel. He is alert and oriented x3. Recent and remote memory intact. Concentration appears to be good. Intelligence is average. Insight is limited to absent. Judgment is intact to formal testing about objective situations though clearly not with regard to his own personal situation. Thought demonstrates the paranoid delusional material noted. Denies suicidal or homicidal thoughts. He is otherwise fairly logical, in general, though he redirects to a fairly fixed paranoid delusional system regarding the CIA, doctors and the presence of a disorder that he feels that he has, as well as the fact that people have altered laboratories or interpretations of previous MRIs and evaluations that have been done. Denies auditory or visual hallucinations. As stated, denies suicidal or homicidal thoughts. He states that he wishes to go home and pursue other options for treatment.

DISCUSSION OF STRENGTHS: The patient has access to care, overall intact physical health.

DISCUSSION OF DIAGNOSES: The patient, although currently appears to have only the symptoms of a paranoid delusional disorder, recent history of decreased sleep, decreased appetite, impulsive and reckless behavior at times, as well as a history of such in the past, and also the history of depressive episodes, suggests the presence of a psychotic bipolar disorder, possibly triggered by doses of Cymbalta that were taken though with previous history of episodes of mania, again triggered by substance use or at least associated with substance use.

PRESENT DIAGNOSES:

AXIS I: Bipolar disorder, manic, severe with psychotic features versus delusional disorder.

AXIS II: No diagnosis.

AXIS III: No acute diagnosis.

PLAN: The patient's wife is quite insistent about her concern for her safety although the patient reports a fairly reasonable plan about leaving here. She states that with his history, he is unable to take care of himself and feels immediately at risk by him based on statements he has made to himself and others. Therefore, we will place him on an administrative hold, will have the designated examiner evaluate this question of forced treatment. I have encouraged the designated examiner to also speak to the spouse about these issues. I informed the patient of his rights, he understood them clearly. Will discharge against medical advice should the patient be released by the designated examiner.

David B. Wait, M.D.

DBW:sh

Job ID:668751 Doc ID:879593
D:05/25/2006 10:18:52 T:05/25/2006 13:27:33

Patient SWENSON,MICHAEL E Account No. KM7658271
Age/Sex 40/M Unit No. KM00328110

28. :
Route/ Frequency/ Indication for Med/

Date 05/24/06 Time 1752 User Helbling,Selina A RN

Functional Impairment/ Factors Affecting Ability to Learn/ Living arrangement/
None None Lives with Family
Do you feel concerned for your safety at home? N
Nutritional Intake/ 3 Fair
Social Habits:
Smoke? N Chew? Amount/packs per day: Quit? How Long Ago:
Second Hand Smoke?
Do you drink Alcohol? Y How often: OCC How much: WINE
Recreational drugs in the past 12 months? N
Drug(s): Last used:
Information obtained from:
Patient? Y Family? Significant Other? Caregiver?
Comment:

Date 05/24/06 Time 1945 User Godbehere,Elizabeth CNA

Temp: 98.0 Temp Method: Oral
Pulse: 88 Pulse Rhythm:
Resp: 16 Resp Rhythm:
B/P: 160/108 BP Site: Left Arm
Capillary Refill: Seconds
O2 Sat: 98 on: RA Cardiac Monitor? + Orthostatics?
Pain Intensity: +
Location:
Pain Quality/
Comment:

Pulse: Lying BP: Lying
Pulse: Sitting BP: Sitting
Pulse: Standing BP: Standing
Orthostatic Comment:

Date 05/24/06 Time 2017 User Keller,Brenda K CM

** NIBH Triage Assessment **

Current Crisis: PT IS A 40-YEAR-YEAR OLD MALE BROUGHT TO THE HOSPITAL BY FRIENDS. PT APPEARS VERY "MANICY" AND TALKS NON-STOP ABOUT HIS BELIEF THAT HE HAS WILSON'S DISEASE WHICH IS ALL PART OF A GREATER CONSPIRACY INVOLVING THE GOVERNMENT AND THE PHARMACUTICAL COMPANIES TO KILL HIM FOR HIS MONEY AND ASSESTS. PT THINKS THE CYMBALTA HE WAS GIVEN 4 WEEKS AGO IS THE ANSWER TO HIS TREATMENT OF HIS WILSON'S DISEASE AND HIS WIFE WON'T GIVE IT TO HIM ANYMORE. PT IS VERY GRANDIOSE AND TALKS ABOUT HOW HE HAD SEVERAL "MULTI-MILLION DOLLAR DEALS IN THE WORKS" BEFORE HE GOT SICK AND HAD TO STOP WORKING. PT APPEARS TO HAVE DELLUSIONS OF GRANDEUR AND REFERS TO HIMSELF AS "A CHILD OF GOD" AND "A SPECIAL PERSON."

Other's Concerns:

PT IS HERE TWO FRIENDS. PT'S WIFE AND BROTHER ARE ALSO AT THE HOSPITAL, BUT HE DOEN'T KNOW THEY ARE HERE. PT'S WIFE AND BROTHER TELL ME THAT 4 WEEKS AGO PT TOOK CYMBALTA FOR THE FIRST TIME AND BECAME

**Patient** SWENSON,MICHAEL E **Account No.** KM7658271
**Age/Sex** 40/M **Unit No.** KM00328110

**Date** 05/24/06 **Time** 2053 **User** Vogel,Sherry L RN

**** Interventions ****

| **Time:** | **Int/** | **Comment:** |
|---|---|---|
| 2053 | Note | PT COOPERATIVE WITH LAB DRAW, EKG AND URINE SAMPLE. READY FOR ADMIT TO NIBH. |
| **Time:** | **Int/** | **Comment:** |
| **Time:** | **Int/** | **Comment:** |

## Orders

| Date | Time | Procedure | Ordering Provider |
|---|---|---|---|
| 05/24/06 | 2016 | SOCIAL SERVICES CONSULT | Crook,Albert A |
| 05/24/06 | 2029 | CBC, PLT & AUTO DIFF | Paschall,Paul F |
| 05/24/06 | 2029 | COMPREHENSIVE METABOLIC PANEL | Paschall,Paul F |
| 05/24/06 | 2029 | DRUG SCREEN, UR | Paschall,Paul F |
| 05/24/06 | 2029 | ETHANOL | Paschall,Paul F |
| 05/24/06 | 2029 | RPR | Paschall,Paul F |
| 05/24/06 | 2029 | THYROID STIM HORMONE | Paschall,Paul F |
| 05/24/06 | 2029 | URINALYSIS | Paschall,Paul F |
| 05/24/06 | 2031 | EKG/ECG | Paschall,Paul F |
| 05/24/06 | 2114 | REGULAR | Wait,David B |
| 05/24/06 | 2114 | SOCIAL SERVICES CONSULT | Wait,David B |
| 05/26/06 | 1531 | EKG INTERP 12 LEAD MELCHIORE | Wait,David B |
| 05/28/06 | 1346 | DAILY PROG CHARGE I/P ADULT | Wait,David B |
| 05/29/06 | 1150 | DAILY PROG CHARGE I/P ADULT | Wait,David B |
| 05/29/06 | 1321 | REGULAR | Wait,David B |
| 05/30/06 | 1320 | DAILY PROG CHARGE I/P ADULT | Stevens,Thomas Jeffrey |
| 05/30/06 | 2119 | CERULOPLASMIN | Stevens,Thomas Jeffrey |
| 05/31/06 | 1241 | DAILY PROG CHARGE I/P ADULT | Stevens,Thomas Jeffrey |
| 06/01/06 | 1254 | DAILY PROG CHARGE I/P ADULT | Stevens,Thomas Jeffrey |

## Lab Results

| Date | Time | Test | Result | Reference |
|---|---|---|---|---|
| 05/24/06 | 2029 | APPEARANCE, UR | CLEAR | |
| 05/24/06 | 2029 | BARBITURATE | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | BENZODIAZEPINES | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | BILIRUBIN, UR | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | COCAINE | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | COLOR, UR | YELLOW | |
| 05/24/06 | 2029 | DRUG SCREEN METHADONE | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | DRUG SCREEN METHAMPHET/AMPHET | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | DRUG SCREEN OPIATES | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | DRUG SCREEN PHENCYCLIDINE | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | GLUCOSE, UR, QLT | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | KETONES, UR | NEGATIVE | NEGATIVE |

**Patient** SWENSON,MICHAEL E **Account No.** KM7658271
**Age/Sex** 40/M **Unit No.** KM00328110

| | | | | |
|---|---|---|---|---|
| 05/24/06 | 2029 | LEUKOCYTE ESTERASE, UR | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | NITRITE, UR | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | OCCULT BLOOD, UR | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | PH, UR | 5.0 | 5.0-7.5 |
| 05/24/06 | 2029 | PROTEIN, UR, QLT | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | SPECIFIC GRAVITY, UR | 1.026 | |
| 05/24/06 | 2029 | THC SCREEN, UR | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | UROBILINOGEN, UR | 1.0 | <2.0 E.U./dL |
| 05/24/06 | 2035 | ALBUMIN/GLOBULIN RATIO | 1.4 | 1.0-2.7 ratio |
| 05/24/06 | 2035 | ALBUMIN | 4.7 | 3.5-5.0 g/dl |
| 05/24/06 | 2035 | ALKALINE PHOSPHATASE | 108 | 38-110 u/L |
| 05/24/06 | 2035 | ALT | 61 H | 5-50 u/L |
| 05/24/06 | 2035 | ANION GAP | 8 | 4-14 ratio |
| 05/24/06 | 2035 | AST | 23 | 5-40 u/L |
| 05/24/06 | 2035 | BASOPHILS, % AUTO | 0.5 | 0.0-2.0 % |
| 05/24/06 | 2035 | BASOPHILS, ABS AUTO | 0.0 | 0.0-0.1 K/uL |
| 05/24/06 | 2035 | BILIRUBIN, TOT | 0.8 | 0.1-1.5 mg/dl |
| 05/24/06 | 2035 | CALCIUM | 9.3 | 8.5-10.5 mg/dl |
| 05/24/06 | 2035 | CHLORIDE | 105 | 98-109 mm/L |
| 05/24/06 | 2035 | CO2 | 25 | 23-33 mm/L |
| 05/24/06 | 2035 | CREATININE | 0.8 | 0.7-1.5 mg/dl |
| 05/24/06 | 2035 | EOSINOPHILS, % AUTO | 1.4 | 0.0-7.0 % |
| 05/24/06 | 2035 | EOSINOPHILS, ABS AUTO | 0.1 | 0.0-0.5 K/uL |
| 05/24/06 | 2035 | ETHANOL | 0.00 | LT 0.01 % |
| 05/24/06 | 2035 | GLOBULIN | 3.3 | 1.8-3.5 g/dl |
| 05/24/06 | 2035 | GLUCOSE | 90 | 65-99 mg/dl |
| 05/24/06 | 2035 | HEMATOCRIT | 48.8 | 40.0-50.0 % |
| 05/24/06 | 2035 | HEMOGLOBIN | 16.9 H | 13.7-16.7 g/dL |
| 05/24/06 | 2035 | LYMPHOCYTES, % AUTO | 30.8 | 15.0-45.0 % |
| 05/24/06 | 2035 | LYMPHOCYTES, ABS AUTO | 3.0 | 1.0-3.4 K/uL |
| 05/24/06 | 2035 | MCH | 30.3 | 27.0-34.0 pg |
| 05/24/06 | 2035 | MCHC | 34.7 | 32.0-35.5 g/dL |
| 05/24/06 | 2035 | MCV | 87.6 | 80.0-100.0 fL |
| 05/24/06 | 2035 | MEAN PLATELET VOLUME | 8.4 | 7.4-10.4 fL |
| 05/24/06 | 2035 | MONOCYTES, % AUTO | 5.4 | 0.0-12.0 % |
| 05/24/06 | 2035 | MONOCYTES, ABS AUTO | 0.5 | 0.0-0.8 K/uL |
| 05/24/06 | 2035 | NEUTROPHILS, % AUTO | 61.9 | 40.0-80.0 % |
| 05/24/06 | 2035 | NEUTROPHILS, ABS AUTO | 6.1 | 2.0-7.3 K/uL |
| 05/24/06 | 2035 | PLATELET COUNT | 304 | 150-400 K/uL |
| 05/24/06 | 2035 | POTASSIUM | 4.1 | 3.5-5.0 mm/L |
| 05/24/06 | 2035 | PROTEIN, TOT | 8.0 | 6.3-8.0 g/dl |
| 05/24/06 | 2035 | RBC DISTRIBUTION WIDTH | 13.1 | 11.0-15.0 % |
| 05/24/06 | 2035 | RBC | 5.57 | 4.30-5.70 M/uL |
| 05/24/06 | 2035 | RPR | Non Reactive | NR |
| | | Test Performed by Pathology Associates Medical Lab, Spokane, WA 99204 | | |
| 05/24/06 | 2035 | SODIUM | 139 | 135-145 mm/L |
| 05/24/06 | 2035 | THYROID STIM HORMONE | 1.58 | 0.40-5.00 uIU/ml |
| 05/24/06 | 2035 | UREA NITROGEN | 13 | 7-23 mg/dl |
| 05/24/06 | 2035 | WBC | 9.8 | 4.0-11.0 K/uL |
| 05/31/06 | 0708 | CERULOPLASMIN | 28 | 21-53 mg/dL |
| | | Test Performed by Sacred Heart Medical Center, 101 W 8th, Spokane, WA 99204 | | |

North Idaho Behavioral Health, Coeur d'Alene, Idaho
PSYCHIATRIC UPDATE
SWENSON, MICHAEL
328110
05/26/06

Dr. Crook is assuming care during the weekend, Dr. Stevens to assume care subsequently on Tuesday. Please see my evaluation from yesterday with regard to immediate recommendations.

Today he states that he may be wrong about all of these doctors telling him that he has some psychiatric difficulties and has at least some interest in looking at mood stabilizers but wishes to consider the options. Will have nursing provide the patient with information on Depakote, Zyprexa, lithium and Seroquel, which could be initiated once a discussion with either Dr. Crook or Dr. Stevens occurs, depending on the time frame of his interest.

Awaiting evaluations from the designated examiners, anticipate a probable filing. If they do not file, the patient could be discharged against medical advice. Otherwise, would start mood stabilizers and await the results of court hearing.

DAVID B. WAIT, M.D.

05/26/06
05/26/06
sh

**Patient: SWENSON,MICHAEL E** **DOB: 04/05/66 KM7658271** **(Continued)**

## CHEMISTRY
### BLOOD CHEMISTRY

| | Date | Time | Reference | Units |
|---|---|---|---|---|
| | 05/24/2006 | 2035 | | |
| > SODIUM | 139 | | 135-145 | mm/L |
| > POTASSIUM | 4.1 | | 3.5-5.0 | mm/L |
| > CHLORIDE | 105 | | 98-109 | mm/L |
| > CO2 | 25 | | 23-33 | mm/L |
| > ANION GAP | 8 | | 4-14 | ratio |
| > CREATININE | 0.8 | | 0.7-1.5 | mg/dl |
| > BUN | 13 | | 7-23 | mg/dl |
| > GLUCOSE | 90 | | 65-99 | mg/dl |
| > CALCIUM | 9.3 | | 8.5-10.5 | mg/dl |
| > TOTAL PROTEIN | 8.0 | | 6.3-8.0 | g/dl |
| > ALBUMIN | 4.7 | | 3.5-5.0 | g/dl |
| > GLOBULIN | 3.3 | | 1.8-3.5 | g/dl |
| > ALB/GLOB RATIO | 1.4 | | 1.0-2.7 | ratio |
| > BILIRUBIN, TOT | 0.8 | | 0.1-1.5 | mg/dl |
| > ALT | 61 H | | 5-50 | u/L |
| > ALK PHOS | 108 | | 38-110 | u/L |
| > AST | 23 | | 5-40 | u/L |

## THYROID STUDIES

| | Date | Time | Reference | Units |
|---|---|---|---|---|
| | 05/24/2006 | 2035 | | |
| > sTSH | 1.58 | | 0.40-5.00 | uIU/ml |

## MISCELLANEOUS

| | Date | Time | Reference | Units |
|---|---|---|---|---|
| | 05/31/2006 | 0708 | | |
| > CERULOPLASMIN | 28(A) | | 21-53 | mg/dL |

(A) Test Performed by Sacred Heart Medical Center, 101 W 8th, Spokane, WA 99204

**Patient: SWENSON,MICHAEL E** DOB: 04/05/66 KM7658271 (Continued)

## IMMUNO-SEROLOGY INFECTIOUS

| | | | |
|---|---|---|---|
| Date | 05/24/2006 | | |
| Time | 2035 | Reference | Units |
| > RPR (B) | | NR | |

(B) Non Reactive
Test Performed by Pathology Associates Medical Lab, Spokane, WA 99204

## MEDICAL BLOOD ALCOHOL

| | | | |
|---|---|---|---|
| Date | 05/24/2006 | | |
| Time | 2035 | Reference | Units |
| > ETHANOL | 0.00 | LT 0.01 | % |

## TOXICOLOGY MISCELLANEOUS

| | | | |
|---|---|---|---|
| Date | 05/24/2006 | | |
| Time | 2029 | Reference | Units |
| > BARBITURATE | NEGATIVE | NEGATIVE | |
| > BENZODIAZEPINES | NEGATIVE | NEGATIVE | |
| > COCAINE | NEGATIVE | NEGATIVE | |
| > AMPHET - GROUP | NEGATIVE | NEGATIVE | |
| > METHADONE | NEGATIVE | NEGATIVE | |
| > OPIATES | NEGATIVE | NEGATIVE | |
| > PHENCYCLIDINE | NEGATIVE | NEGATIVE | |
| > THC SCR, UR | NEGATIVE(a) | NEGATIVE | |

NOTES: (a)
The test for Amphetamine is designed to report as Positive, urine samples containing Amphetamine, Methamphetamine and their metabolites at a cutoff concentration of 500 ng/mL.

Drug Screen Concentration Cutoffs:
Barb: 200 ng/mL; Benzo: 300 ng/mL; Cocaine: 300 ng/mL;
Amphet: 500 ng/mL; Methadone: 300 ng/mL;
Opiates: 300 ng/mL; PCP: 25 ng/mL; THC: 50 ng/mL

# Treatment Plan For Michael Swenson

**Diagnosis** 1 296.44 Bipolar I disorder, manic, severe w/ psychotic features

**Patient Expectations**

**Others Expectations**

**Strengths**

Family support,

**Barriers**

No access to healthcare, administrative hold

| Levels: | Level S | Level I | Level IIA | Level IIB | Level III |
|---|---|---|---|---|---|
| Start Dates: | | 5/26/06 | | | |
| Completion Dates: | | | | | |

| | Focus | Track I | Track I+ | Track II | CD |
|---|---|---|---|---|---|
| Start Dates: | 5/26/06 | | | | |
| Completion Dates: | | | | | |

NOT I have Wilson's Disease - Valproic Acid (Depakote) + Quetiapine (Seroquel) are contra-productive in a Wilson's patient & could result in death! I WILL NOT take either of these medications. I AM NOT bipolar or manic (Wilson's disease, hepatic involvement

**Signatures**

PATIENT Michael Swenson — DATE:

W. Madsen LCSW — SOCIAL WORK — DATE: 5/26/06

NURSE — DATE: 5/26/06

Daniel [illegible] CTRS — REC THERAPY — DATE: 5/26/06

CASE MANAGER — DATE: 5/26/06

OTHER — DATE:

PSYCHIATRIST — DATE: 5/26/06

ACCT KH7658271
SWENSON, MICHAEL E
40 / M DOB 04/05/1966
UNIT KH00328110
CROOK, ALBERT A WAIT, DAVID B

05/26/06

**Patient** SWENSON,MICHAEL E **Account No.** KM7658271
**Age/Sex** 40/M **Unit No.** KM00328110

**Date** 05/24/06 **Time** 2053 **User** Vogel,Sherry L RN

**** Interventions ****

| **Time:** | **Int/** | **Comment:** |
|---|---|---|
| 2053 | Note | PT COOPERATIVE WITH LAB DRAW, EKG AND URINE SAMPLE. READY FOR ADMIT TO NIBH. |
| **Time:** | **Int/** | **Comment:** |
| **Time:** | **Int/** | **Comment:** |

## Orders

| Date | Time | Procedure | Ordering Provider |
|---|---|---|---|
| 05/24/06 | 2016 | SOCIAL SERVICES CONSULT | Crook,Albert A |
| 05/24/06 | 2029 | CBC, PLT & AUTO DIFF | Paschall,Paul F |
| 05/24/06 | 2029 | COMPREHENSIVE METABOLIC PANEL | Paschall,Paul F |
| 05/24/06 | 2029 | DRUG SCREEN, UR | Paschall,Paul F |
| 05/24/06 | 2029 | ETHANOL | Paschall,Paul F |
| 05/24/06 | 2029 | RPR | Paschall,Paul F |
| 05/24/06 | 2029 | THYROID STIM HORMONE | Paschall,Paul F |
| 05/24/06 | 2029 | URINALYSIS | Paschall,Paul F |
| 05/24/06 | 2031 | EKG/ECG | Paschall,Paul F |
| 05/24/06 | 2114 | REGULAR | Wait,David B |
| 05/24/06 | 2114 | SOCIAL SERVICES CONSULT | Wait,David B |
| 05/26/06 | 1531 | EKG INTERP 12 LEAD MELCHIORE | Wait,David B |
| 05/28/06 | 1346 | DAILY PROG CHARGE I/P ADULT | Wait,David B |
| 05/29/06 | 1150 | DAILY PROG CHARGE I/P ADULT | Wait,David B |
| 05/29/06 | 1321 | REGULAR | Wait,David B |
| 05/30/06 | 1320 | DAILY PROG CHARGE I/P ADULT | Stevens,Thomas Jeffrey |
| 05/30/06 | 2119 | CERULOPLASMIN | Stevens,Thomas Jeffrey |
| 05/31/06 | 1241 | DAILY PROG CHARGE I/P ADULT | Stevens,Thomas Jeffrey |
| 06/01/06 | 1254 | DAILY PROG CHARGE I/P ADULT | Stevens,Thomas Jeffrey |

## Lab Results

| Date | Time | Test | Result | Reference |
|---|---|---|---|---|
| 05/24/06 | 2029 | APPEARANCE, UR | CLEAR | |
| 05/24/06 | 2029 | BARBITURATE | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | BENZODIAZEPINES | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | BILIRUBIN, UR | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | COCAINE | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | COLOR, UR | YELLOW | |
| 05/24/06 | 2029 | DRUG SCREEN METHADONE | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | DRUG SCREEN METHAMPHET/AMPHET | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | DRUG SCREEN OPIATES | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | DRUG SCREEN PHENCYCLIDINE | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | GLUCOSE, UR, QLT | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | KETONES, UR | NEGATIVE | NEGATIVE |

**Patient** SWENSON,MICHAEL E **Account No.** KM7658271
**Age/Sex** 40/M **Unit No.** KM00328110

| | | | | |
|---|---|---|---|---|
| 05/24/06 | 2029 | LEUKOCYTE ESTERASE, UR | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | NITRITE, UR | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | OCCULT BLOOD, UR | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | PH, UR | 5.0 | 5.0-7.5 |
| 05/24/06 | 2029 | PROTEIN, UR, QLT | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | SPECIFIC GRAVITY, UR | 1.026 | |
| 05/24/06 | 2029 | THC SCREEN, UR | NEGATIVE | NEGATIVE |
| 05/24/06 | 2029 | UROBILINOGEN, UR | 1.0 | <2.0 E.U./dL |
| 05/24/06 | 2035 | ALBUMIN/GLOBULIN RATIO | 1.4 | 1.0-2.7 ratio |
| 05/24/06 | 2035 | ALBUMIN | 4.7 | 3.5-5.0 g/dl |
| 05/24/06 | 2035 | ALKALINE PHOSPHATASE | 108 | 38-110 u/L |
| 05/24/06 | 2035 | ALT | 61 H | 5-50 u/L |
| 05/24/06 | 2035 | ANION GAP | 8 | 4-14 ratio |
| 05/24/06 | 2035 | AST | 23 | 5-40 u/L |
| 05/24/06 | 2035 | BASOPHILS, % AUTO | 0.5 | 0.0-2.0 % |
| 05/24/06 | 2035 | BASOPHILS, ABS AUTO | 0.0 | 0.0-0.1 K/uL |
| 05/24/06 | 2035 | BILIRUBIN, TOT | 0.8 | 0.1-1.5 mg/dl |
| 05/24/06 | 2035 | CALCIUM | 9.3 | 8.5-10.5 mg/dl |
| 05/24/06 | 2035 | CHLORIDE | 105 | 98-109 mm/L |
| 05/24/06 | 2035 | CO2 | 25 | 23-33 mm/L |
| 05/24/06 | 2035 | CREATININE | 0.8 | 0.7-1.5 mg/dl |
| 05/24/06 | 2035 | EOSINOPHILS, % AUTO | 1.4 | 0.0-7.0 % |
| 05/24/06 | 2035 | EOSINOPHILS, ABS AUTO | 0.1 | 0.0-0.5 K/uL |
| 05/24/06 | 2035 | ETHANOL | 0.00 | LT 0.01 % |
| 05/24/06 | 2035 | GLOBULIN | 3.3 | 1.8-3.5 g/dl |
| 05/24/06 | 2035 | GLUCOSE | 90 | 65-99 mg/dl |
| 05/24/06 | 2035 | HEMATOCRIT | 48.8 | 40.0-50.0 % |
| 05/24/06 | 2035 | HEMOGLOBIN | 16.9 H | 13.7-16.7 g/dL |
| 05/24/06 | 2035 | LYMPHOCYTES, % AUTO | 30.8 | 15.0-45.0 % |
| 05/24/06 | 2035 | LYMPHOCYTES, ABS AUTO | 3.0 | 1.0-3.4 K/uL |
| 05/24/06 | 2035 | MCH | 30.3 | 27.0-34.0 pg |
| 05/24/06 | 2035 | MCHC | 34.7 | 32.0-35.5 g/dL |
| 05/24/06 | 2035 | MCV | 87.6 | 80.0-100.0 fL |
| 05/24/06 | 2035 | MEAN PLATELET VOLUME | 8.4 | 7.4-10.4 fL |
| 05/24/06 | 2035 | MONOCYTES, % AUTO | 5.4 | 0.0-12.0 % |
| 05/24/06 | 2035 | MONOCYTES, ABS AUTO | 0.5 | 0.0-0.8 K/uL |
| 05/24/06 | 2035 | NEUTROPHILS, % AUTO | 61.9 | 40.0-80.0 % |
| 05/24/06 | 2035 | NEUTROPHILS, ABS AUTO | 6.1 | 2.0-7.3 K/uL |
| 05/24/06 | 2035 | PLATELET COUNT | 304 | 150-400 K/uL |
| 05/24/06 | 2035 | POTASSIUM | 4.1 | 3.5-5.0 mm/L |
| 05/24/06 | 2035 | PROTEIN, TOT | 8.0 | 6.3-8.0 g/dl |
| 05/24/06 | 2035 | RBC DISTRIBUTION WIDTH | 13.1 | 11.0-15.0 % |
| 05/24/06 | 2035 | RBC | 5.57 | 4.30-5.70 M/uL |
| 05/24/06 | 2035 | RPR | Non Reactive | NR |
| | | Test Performed by Pathology Associates Medical Lab, Spokane, WA 99204 | | |
| 05/24/06 | 2035 | SODIUM | 139 | 135-145 mm/L |
| 05/24/06 | 2035 | THYROID STIM HORMONE | 1.58 | 0.40-5.00 uIU/ml |
| 05/24/06 | 2035 | UREA NITROGEN | 13 | 7-23 mg/dl |
| 05/24/06 | 2035 | WBC | 9.8 | 4.0-11.0 K/uL |
| 05/31/06 | 0708 | CERULOPLASMIN | 28 | 21-53 mg/dL |
| | | Test Performed by Sacred Heart Medical Center, 101 W 8th, Spokane, WA 99204 | | |

**Patient:** SWENSON,MICHAEL E
**Account #:** KM7658271 **Unit #:** KM00328110

**Age/Sex:** 40 M **Attending:** Stevens,Thomas Jeffrey
**Location:** KM.BHE **Admitted:** 05/24/06 at 2002
**Room/Bed:** KM0526-01 **Status:** DIS IN

| | Date | Time | By | Nurse Type | |
|---|---|---|---|---|---|
| **Occurred:** | 05/24/06 | 2240 | SKL Lynch,Shirley K | RN | **Category** |
| **Recorded:** | 05/24/06 | 2253 | SKL Lynch,Shirley K | RN | Nurse Notes |

**Abnormal?** N **Confidential?** N

PT ADMITTED TO IPU WITH HX OF DEPRESSION WHICH HAS CHANGED TO SOMATIC DELUSIONS SINCE BEING PUT ON CYMBALTA APPROX. 4 WEEKS AGO. SEARCHED WITH NO CONTRABAND. PT IS FOCUSED ON HAVING WILSON'S DISEASE STATING THAT HE HAS 'CHARLIE HORSE" TYPE CRAMPS BILATERALLY IN HIS LEGS. C/O BACK INJURY WITH PAIN IN NECK AND BACK L-4 & L-5. STATES THAT HE HAS BEEN HAVING BLACK STOOLS FOR 2 MONTHS AND THAT DR. CORRELL DIAGNOSED HIM WITH CHRONIC FATIGUE. RATES HIS PAIN 7/10 ALONG WITH HAVING A HEADACHE. " WHEN I WAS ON CYMBALTA 60MG FOR 10 DAYS IT WAS THE BEST I'VE EVER FELT." WIFE TOOK PRESCRIPTION AWAY BECAUSE OF HIS BIZZARE BEHAVIORS. HASN'T SLEPT MUCH FOR 4 WEEKS AND ONLY 1HR IN THE LAST 24HOURS. DENIES SUICIDAL AND HOMOCIDAL IDEATION. DENIES A/V HALL'S EXCEPT THAT HE TALKS TO THE HOLY SPIRIT SINCE BING FILLED WITH THE SPIRIT IN SEPT '88. "IS THIS A WILSON'S TX CENTER?" PT AGREED TO BE ADMITTED TO BE TESTED FOR THIS DISEASE AND HE REFUSES TO TAKE ANY MED EXCEPT FOR CYMBALTA. HAS BEEN ON SEVERAL HERBAL MEDS AND DOESN'T WANT ANY COOPER,IRON, OR METALS IN HIS FOOD. UNFAMILIAR WITH UNIT AND ISOLATES IN ROOM.

| Note Type | Description |
|---|---|
| No Type | NONE |

| | Date | Time | By | Nurse Type | |
|---|---|---|---|---|---|
| **Occurred:** | 05/25/06 | 1311 | MJB Brooks,Mary J | RN | **Category** |
| **Recorded:** | 05/25/06 | 1351 | MJB Brooks,Mary J | RN | Nurse Notes |

**Abnormal?** N **Confidential?** N

PT IS PLEASANT THIS AM. HE CHOOSES TO RESPOND TO THE NAME JOE, RATHER THAN MICHAEL AND CORRECTS STAFF WHEN ADDRESSED. HE MET WITH DR WAIT AND IS ASKING TO LEAVE THE HOSPITAL, STATING THAT HE CAME HERE TO BE PUT ON CYMBALTA AND TO HAVE HIS WILSONS DISEASE TAKEN CARE OF. HE DOES NOT WISH TO REMAIN IN THE HOSPITAL HERE IF WE ARE NOT GOING TO TAKE CARE OF THOSE THINGS FOR HIM. DR WAIT SPOKE WITH MICHAELS WIFE VIA PHONE AND DUE TO HER EXPRESSION OF HER FEAR OF HER HUSBAND, PLACED MICHAEL ON ADMINISTRATIVE HOLD. THIS WAS EXPLAINED TO MICHAEL AND HE STATES WIFE IS LYING ABOUT HIM MAKING THREATS TOWARD HER, BUT HE IS COOPERATIVE WITH THE PROCESS. IN 1:1 HE GOES INTO GREAT DETAIL ABOUT HIS REASONING FOR THINKING HE HAS WILSONS DISEASE AND ALSO THAT HE BELIEVES THERE IS A PLOT AGAINST HIM TO TAKE EVERYTHING HE HAS WORKED FOR AND THIS INCLUDES PHARMACEUTICAL COMPANIES, HIS WIFE, LAW ENFORCEMENT AND PEOPLE WHO ARE FOLLOWING HIM IN THE COMMUNITY. HE HAS ISOLATED IN HIS ROOM THIS AFTERNOON, STATING THAT HE NEEDS THE QUIET. THE DESIGNATED EXAMINER IS HERE THIS AFTERNOON TO SEE PT AND IS CURRENTLY MEETING WITH PTS WIFE, HIS BROTHER AND A FRIEND PRIOR TO SEEING THE PATIENT.

**Patient:** SWENSON,MICHAEL E
**Account #:** KM7658271 **Unit #:** KM00328110

| | Date | Time | By | Nurse Type | (Continued) |
|---|---|---|---|---|---|
| **Occurred:** | 05/25/06 | 1311 | MJB Brooks,Mary J | RN | **Category** |
| **Recorded:** | 05/25/06 | 1351 | MJB Brooks,Mary J | RN | Nurse Notes |

| Note Type | Description |
|---|---|
| No Type | NONE |

| | Date | Time | By | Nurse Type | |
|---|---|---|---|---|---|
| **Occurred:** | 05/25/06 | 2233 | LKJ Johnston,Linnea K | RN | **Category** |
| **Recorded:** | 05/25/06 | 2315 | LKJ Johnston,Linnea K | RN | Nurse Notes |

**Abnormal?** N **Confidential?** N

PT SLEPT SOUNDLY UNTIL 1645. PT AWAKENED, ACCEPTED OFFER OF JUICE. IN 1:1, PT TALKED ABOUT HIS BELIEF THAT HE HAS WILSONS DISEASE; "I HAVE ALL THE MAJOR SYMPTOMS", AND THAT HE BELIEVES THAT THE REASON HE IS NOT BEING TESTED FOR THIS, IS THAT "THEY ARE TRYING TO KEEP THE INFORMATION FROM OTHERS WHO HAVE THIS."
WHILE HE STATES HE IS IN SEVERE PAIN ALL THE TIME, AND THAT HE HAS "A HEADACHE MORE SEVERE THAN WHAT MOST PEOPLE CAN TOLERATE", AND THAT HE HAS SEVERE TREMORS AND SPASMS ASSOCIATED WITH WILSONS DISEASE, THE PATIENT IS CALM, NON RESTLESS, AND HAS RELAXED FACIAL EXPRESSION.
HE ATE DINNER IN THE DAYROOM WITH PEERS, AND WATCHED TV WITH THEM UNTIL BEDTIME.
PT HAS NOT BEEN INTRUSIVE OR PRESSURED IN SPEECH THIS EVENING, BUT HE REMAINS GRANDIOSE IN HIS DELUSIONS.

PT WAS COOPERATIVE WITH THE BEDTIME ROUTINE OF LOCKING THE BATHROOM DOORS. HE WILL LET NIGHT STAFF KNOW WHEN HE IS A WAKE

| Note Type | Description |
|---|---|
| No Type | NONE |

| | Date | Time | By | Nurse Type | |
|---|---|---|---|---|---|
| **Occurred:** | 05/26/06 | 1442 | MJB Brooks,Mary J | RN | **Category** |
| **Recorded:** | 05/26/06 | 1457 | MJB Brooks,Mary J | RN | Nurse Notes |

**Abnormal?** N **Confidential?** N

PT HAS ISOLATED ALL DAY IN HIS ROOM. HE IS POLITE IN INTERACTION BUT REMAINS QUITE DELUSIONAL REGARDING HIS NEED FOR TREATMENT FOR WILSONS DISEASE. HE WAS GIVEN INFORMATION REGARDING MOOD STABILIZERS AT REQUEST OF DR WAIT AND HE HAS BEEN STUDYING THIS INFORMATION MOST OF THE DAY. ATTEMPT TO REVIEW TX PLAN WITH PT AND HE BACAME ANGRY, STATING THAT HIS DIAGNOSIS IS NOT BIPOLAR AND HE WILL NOT BE TAKING ANY OF THE MEDICATIONS ORDERED AS THEY ALL WOULD ADVERSELY AFFECT HIS WILSONS DISEASE, WHICH HE STATES HE HAS AND NO ONE WILL TREAT. HE DOES NOT RESPOND TO REALITY ORIENTATION OR REASSURRANCE BUT REMAINS POLITE AND WITH NO ACTING OUT.

| Note Type | Description |
|---|---|
| No Type | NONE |

**Patient:** SWENSON,MICHAEL E
**Account #:** KM7658271 **Unit #:** KM00328110

| | Date | Time | By | Nurse Type | (Continued) |
|---|---|---|---|---|---|
| **Occurred:** | 05/31/06 | 1014 | SDS Sanford,Ellen K | SS | **Category** |
| **Recorded:** | 05/31/06 | 1025 | SDS Sanford,Ellen K | SS | Social Services Notes |

SURPRISED THAT HIS INSURANCE DOES NOT HAVE BENEFITS. PT TALKED ABOUT HIS DISEASE AND THE FACT THAT HE IS BEING HELD AGAINST HIS WILL. TRIED TO GET PT TO REFOCUS ON DISCUSSION. PT STATES HE DOESN'T CARE ABOUT HIS BILL AND DOES NOT NEED ASSISTANCE WITH OTHER RESOURCES.

| Note Type | Description |
|---|---|
| No Type | NONE |

| | Date | Time | By | Nurse Type | |
|---|---|---|---|---|---|
| **Occurred:** | 05/31/06 | 1755 | SKL Lynch,Shirley K | RN | **Category** |
| **Recorded:** | 05/31/06 | 1801 | SKL Lynch,Shirley K | RN | Nurse Notes |

**Abnormal?** N **Confidential?** N

PT'S SPEECH IS SOMEWHAT RAPID. EXPRESSES SOME ANGER OVER BEING HERE STATING THAT HE WILL HAVE TO GET A DIVORCE OVER THIS BECAUSE HE HAS NO MONEY TO PAY $1400/DAY. "I'LL HAVE TO GIVE EVERTHING TO MY WIFE TO PROTECT OUR ASSETS BUT SHE HAS BEEN GOOD TO ME AND MAYBE THIS WILL PERSUADE HER TO NOT TESTIFY AGAINST ME IN THAT KANGROO COURT THAT IS COMING UP." PT FEELS THAT HE DOES NOT NEED TO BE HERE AND HAS ANGER TOWARD HIS WIFE FOR SAYING THINGS THAT HAS KEPT HIM HERE. HAS BEEN APPROPRIATE ON OPEN UNIT AND ATTENDING GROUPS.

| Note Type | Description |
|---|---|
| No Type | NONE |

| | Date | Time | By | Nurse Type | |
|---|---|---|---|---|---|
| **Occurred:** | 06/01/06 | 1100 | KEV Vieselmeyer,Kate E | RN | **Category** |
| **Recorded:** | 06/01/06 | 1334 | KEV Vieselmeyer,Kate E | RN | Nurse Notes |

**Abnormal?** N **Confidential?** N

PT STAYS IN ROOM MOST OF THE TIME. DID NOT GO OUTSIDE FOR FRESH AIR. AFFECT BRIGHT. HAD A LONG VISIT WITH DR. STEVEN AND PT VERY GRATEFUL TO HAVE THE DR. SPEND TIME WITH HIM. SEEN BY D.E., JILL AND WAS RELEASED. SHOWERED AND CLEAN CLOTHES ON. HYPERVERBAL BUT ABLE TO STAY ON THE SUBJECT. DID NOT MENTION WILSON'S DISEASE THIS AM TO NURSING STAFF. APPETITE GOOD. REMAINS ON LEVEL IIB.

| Note Type | Description |
|---|---|
| No Type | NONE |

| Intervention Description | Sts | Frequency | From |
|---|---|---|---|

| Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change |
|---|---|---|---|---|---|---|---|---|---|

Activity Date: 05/26/06 Time: 1330 (continued)

Activity Date: 05/26/06 Time: 1330 (continued)
Comment:

Activity Date: 05/26/06 Time: 1400

1501116 Behavioral Health Observation Check + A CP
- Document 05/26/06 1400 SDS 05/26/06 1405 SDS

=== OBSERVATION CHECKS ===

Observation Level/ 1 30 Minutes

Patient Status/ Psychotic
Isolative

Comment:

Activity Date: 05/26/06 Time: 1430

1501116 Behavioral Health Observation Check + A CP
- Document 05/26/06 1430 SK 05/26/06 1430 SK

=== OBSERVATION CHECKS ===

Observation Level/ 1 30 Minutes

Patient Status/ Psychotic
Isolative

Comment:

Activity Date: 05/26/06 Time: 1442

Patient Notes: Nurse Notes
- Create 05/26/06 1442 MJB 05/26/06 1457 MJB
Abnormal? N Confidential? N
PT HAS ISOLATED ALL DAY IN HIS ROOM. HE IS POLITE IN INTERACTION BUT REMAINS QUITE DELUSIONAL REGARDING HIS NEED FOR TREATMENT FOR WILSONS DISEASE. HE WAS GIVEN INFORMATION REGARDING MOOD STABILIZERS AT REQUEST OF DR WAIT AND HE HAS BEEN STUDYING THIS INFORMATION MOST OF THE DAY ATTEMPT TO REVIEW TX PLAN WITH PT AND HE BACAME ANGRY, STATING THAT HIS DIAGNOSIS IS NOT BIPOLAR AND HE WILL

| Intervention Description | Sts | Frequency | From |
|---|---|---|---|

| Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change |
|---|---|---|---|---|---|---|---|---|---|

Activity Date: 05/26/06 Time: 1442 (continued)

Patient Notes: Nurse Notes (continued)
NOT BE TAKING ANY OF THE MEDICATIONS ORDERED AS THEY ALL WOULD ADVERSELY AFFECT HIS WILSONS DISEASE. WHICH HE STATES HE HAS AND NO ONE WILL TREAT. HE DOES NOT RESPOND TO REALITY ORIENTATION OR REASSURRANCE BUT REMAINS POLITE AND WITH NO ACTING OUT.

Activity Date: 05/26/06 Time: 1458

1501118 Care Area Statement: BH Adult A CP
- Document 05/26/06 1458 MJB 05/26/06 1458 MJB
1501119 Behavioral Health Patient Care Record + A AS
- Document 05/26/06 1458 MJB 05/26/06 1503 MJB
=== PATIENT CARE RECORD ===

BEHAVIOR WNL/ N +

| | | | |
|---|---|---|---|
| Non-participative/Interactive? | Y + | Flashbacks? | N + |
| Incongruent behavior/appearance? | N + | Disorganized? | N + |
| Unfamiliar with unit and/or program? | Y + | Depressive symptoms? | Y + |
| Social isolation/refuses participation? | Y + | Destructive to property? | N + |
| Demanding/interuptive behavior? | N + | Destructive to self or others? | N + |
| Focuses primarily on somatic complaints? | Y + | Inappropriate sexual bx? | N + |
| Passive-dependant,resistant,aggressive? | N + | Manipulative/Covert behavior? | N + |
| Ideas/prejudices/behaviors focused on others? | N + | | |
| Anxious,Agitated,Hyperactive/Argumentative/Angry? | Y + | | |

Behavioral Description: SEE NOTE

Behavioral Int:

Behavioral Outcome:

ACTIVITIES WNL/ N +

| | | | |
|---|---|---|---|
| Reinforce attendance/participation? | Y + | Phone/visit monitoring? | N + |
| Phone/visitor/unit restriction? | N + | Seclusion/restraints? | N + |
| Crisis intervention/code? | N + | Searching? | N + |
| Intervene in social isolation/withdrawal? | Y + | | |

Activity Description: SEE NOTE

Activity Int:

Activity Outcomes:

COMMUNICATION WNL/ N +

| | |
|---|---|
| Information interaction 5-15 min? | Y + |
| Structured group meetings? | N + |
| Discharge/treatment planning & education? | N + |
| Destructive thoughts? | N + |
| Moderate confusion/disorientation? | N + |
| Significant social/cultural/religious interference w/care? | N + |

| Intervention Description | Sts | Frequency | From | Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

Activity Date: 05/29/06 Time: 1913 (continued)

Activity Date: 05/29/06 Time: 1913 (continued)
Consolability/
FLACC Total:

MEDICATIONS WNL/ Y +
Medication education? Resistive/Manipulative? Other?
Med Comment:

SAFETY:
Observation Routine? N Observational Level/ Level II - Act 15pts
Hospital Clothes? Y Potential for Violence/ Self/Others

Sedatives or narcotics? N Pt new to narcotics? N
Medications which alter judgement and reduce reflexes
Vision impairment? Communication Barrier?
Previous Fall? N Age 65 or older
Risk to Fall Points: Risk To Fall? N
Total Points => 40 = Risk to Fall
Sleep/Activity Cycles WNL? Y
SLEEP:
Appropriate # hours slept: Sleep Pattern/
Sleep Comment:

Document Notes? Y
Patient Notes: Nurse Notes
- Create 05/29/06 1913 KEV 05/29/06 1918 KEV
Abnormal? N Confidential? N
PT SITTING IN CHAIR READING HIS BIBLE ON INITIAL ROUNDS. SEEMED VERY EAGER TO TELL HIS STORY TO THIS STAFF. ADMITTED SEVERAL TIMES THAT HE IS NOT CRAZY THAT HE HAS A SOUND MIND. INSISTS ON TELLING STAFF THAT HE HAS WILSON'S DISEASE AND HE HAS DONE LOTS OF RESEARCH. WENT INTO GREAT DETAIL ABOUT THIS ILLNESS. STATES HE HAS HAD SO MUCH FATIGUE AND HE FEELS LIKE HIS BODY IS FALLING APART HIS WIFE AND FRIENDS VISITED. ATE WELL FOR DINNER. REFUSED TO DRINK V-8 AS HE THOUGHT IT LOOKED FUNNY. GIVEN FRESH CUP OF V-8 JUICE. REMAINS ON LEVEL IIA AND STAYS MOST OF THE TIME IN HIS ROOM.

Activity Date: 05/29/06 Time: 1919

7001102 Care Plan Evaluation + A CP
- Document 05/29/06 1919 KEV 05/29/06 1919 KEV
===== CARE PLAN EVALUATION =====

| Intervention Description | Sts | Frequency | From | Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

Activity Date: 05/29/06 Time: 1919 (continued)

Activity Date: 05/29/06 Time 1919 (continued)

| | PROBLEM | OUTCOME |
|---|---|---|
| Pb1 | STANDARD OF CARE: KMC Adult BH | Status/ Ongoing |
| Oc1: | Standard of Practice: Adult Psych Unit | |
| Int: | PER UNIT PROTOCOL | |
| Pb2: | Developmental Age: Middle Adult 36 - 65 | Status/ Ongoing |
| Oc2: | Age appropriate guideline | |
| Int: | PER UNIT PROTOCOL | |
| Pb3: | Problem: Alteration in Thought Process | Status/ Ongoing |
| Oc3: | Clear thought process | |
| Int: | SOMATIC DELUSIONS: ASSESS Q SHIFT AND PRN | |
| Pb4: | Problem: Potential for Violence | Status/ Ongoing |
| Oc4: | No violent behavior. No assaultive | |
| Int | ASSESS FOR THOUGHTS OF ANGER AND VIOLENCE | |
| Pb5: | | Status/ |
| Oc5: | | |
| Int: | | |
| Pb6: | | Status/ |
| Oc6: | | |
| Int: | | |
| Pb7: | | Status/ |
| Oc7. | | |
| Int: | | |
| Pb8: | | Status/ |
| Oc8: | | |
| Int: | | |
| Pb9: | | Status/ |
| Oc9: | | |
| Int: | | |
| P10: | | Status/ |
| O10. | | |
| Int | | |
| P11: | | Status/ |
| O11: | | |
| Int: | | |
| P12: | | Status/ |
| Oc12: | | |
| Int: | | |

| Intervention Description | Sts | Frequency | From |
|---|---|---|---|

| Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change |
|---|---|---|---|---|---|---|---|---|---|

Activity Date: 05/29/06 Time: 2147 (continued)

Activity Date: 05/29/06 Time: 2147 (continued)
Foley/external? Ostomy Care? Suprapubic?

Incisions/Dressings/Irrigation
Incision with or without dressing? Wound irrigation and packing?
Decubitus Stage 1 & 2? Gaping Wound? Burn Dressing?

Description:

Int:

Outcome:

Procedures:
Cast Care? D/C IV Lock? Enemas/douches?
Foot Soaks? Glucose monitoring? Hemacult?
Specimen Collection/testing? Stump Care? Ted hose/all wraps?
Bowel or Bladder Program? Prosthesis? ROM (active/passive)?
Suture and Staple removal? History and Physical Assist? EKG? CPR?

Procedure Description:

Intervention Description:

Outcome Description:

Precautions.
Fall? N Assault? N
Seizure? N
Contact? N Elopement? N Suicide? N
SELF CARE
Physical Care? N + Physical Care Moderate? + Physiologically unstable? +
Self Care Deficit? + Unwilling unable to care for self? +
Activity Description:

Self Care Int:

Self Care Outcome:

Chemical Withdrawl
One time per shift? + Two or more times per shift? +
Misc
2 >or= contact to achieve test completion? +
Two or more staff for safe effective care? N +
Sleep/Eating Disturbance? N +
Mobility Impairment? N +
Chemical Withdrawl Desc:

| Intervention Description | Sts | Frequency | From |
|---|---|---|---|

| Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change |
|---|---|---|---|---|---|---|---|---|---|

Activity Date: 05/29/06 Time: 2147 (continued)

Activity Date: 05/29/06 Time: 2147 (continued)

Chemical Withdrawl Int:

Chemical Withdrawl Outcome:

Activity Date: 05/29/06 Time: 2153

Client Notes: Nurse Notes
Create 05/29/06 2153 KEV 05/29/06 2156 KEV
Abnormal? N Confidential? N
DURING 1:1 WITH PT HE BECAME VERY FORCEFUL IN HIS SPEECH IN ORDER TO CONVINCE STAFF THAT HE HAS ALL THE SYMPTOMS OF WILSON'S DISEASE. PT HYPERVERBAL WITH PRESSURED SPEECH. EXHIBITED SOME ANGER AT WIFE AND FRIENDS AS HE FEELS THEY HAVE TRICKED HIM INTO COMING TO THIS UNIT. IS VERY HESITANT TO TAKE MEDS BECAUSE THEY ARE TOXIC TO HIM ESP. WITH THE DISEASE HE HAS. IS FEARFUL OF BEING SENT AWAY. WIFE, BROTHER, AND FRIEND VISITED TONIGHT BRIEFLY. IS ANGRY THAT NO ONE WILL DIAGNOSE HIM EVEN THOUGH HE HAS THE SYMPTOMS. REMAINS ON LEVEL II A. FEELS AS THOUGH THE DOCTORS DO NOT LISTEN TO HIM AND THEY IMMEDIATELY MAKE A DIAGNOSIS. STATES HE WANTS TO BE CALLED JOE FOR SECURITY REASONS.

Activity Date: 05/29/06 Time: 2200

1501116 Behavioral Health Observation Check + A CP
~ Document 05/29/06 2200 MRB 05/29/06 2224 MRB

=== OBSERVATION CHECKS ===

Observation Level/ 2A 30 Minutes

Patient Status/ Appears to sleep

Comment.
- Undo 05/29/06 2200 MRB 05/29/06 2226 MRB
~ Document 05/29/06 2200 MRB 05/29/06 2225 MRB

=== OBSERVATION CHECKS ===

Observation Level/ 2A 30 Minutes

Patient Status/ Isolative
In room

Intervention Description | Sts | Frequency | From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 05/31/06 Time: 0953 (continued)

Activity Date: 05/31/06 Time: 0953 (continued)

MEDICATIONS WNL/ Y +
Medication education? Resistive/Manipulative? Other?
Med Comment:

SAFETY:
Observation Routine? N Observational Level/ Level II - Act 15pts
Hospital Clothes? N Potential for Violence/ Self/Others

Sedatives or narcotics? N Pt new to narcotics? N
Medications which alter judgement and reduce reflexes:
Vision impairment? N Communication Barrier? N
Previous Fall? N Age 65 or older:
Risk to Fall Points: Risk To Fall? N
Total Points => 40 = Risk to Fall
Sleep/Activity Cycles WNL? Y
SLEEP:
Appropriate # hours slept: Sleep Pattern/
Sleep Comment:

Document Notes?

Activity Date: 05/31/06 Time: 1000

1501116 Behavioral Health Observation Check + A CP
- Document 05/31/06 1000 SK 05/31/06 1005 SK

=== OBSERVATION CHECKS ===

Observation Level/ 2B 30 Minutes

Patient Status/ Situational appropriate

Comment:

Intervention Description | Sts | Frequency | From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 05/31/06 Time: 1007

Patient Notes: Nurse Notes
Create 05/31/06 1007 SDS 05/31/06 1017 SDS
Abnormal? N Confidential? N
PT. DENIES SUICIDE IDEATION & PROMISES HE'LL COME TO STAFF IF FEELING LIKE HARMING HIMSELF OR ANYONE ELSE. STATES THAT HE NEEDS TO BE CALLED JOE FOR SECURITY REASONS. STATES THAT A CLIENT OF HIS SAW HIS 1ST NAME & THEN RECOGNIZED HIM. STATES HE ONLY TRUSTS GOD, & HE DOESN'T NEED TO BE HERE. REPORTS HE DOESN'T WANT TO WASTE ALOT OF TIME IN GROUPS & NEEDS TO HAVE HIS FREEDOM BACK. ENCOURAGED PT. TO ATTEND THE THREE GROUPS HE'S ASSIGNED TO TODAY, & LET HIM KNOW WHAT TIME THEY ARE. PTS. SPEECH PRESSURED. REMAINS PARANOID, BUT COOPERATIVE WITH STAFF.

Activity Date: 05/31/06 Time: 1014

Patient Notes: Social Services Notes
- Create 05/31/06 1014 05/31/06 1025
Abnormal? N Confidential? N
FINANCIAL SOCIAL SERVICES:REFERRED TO SEE PT AS HE HAS NO MENTAL HEALTH BENEFITS THRU HIS INSURANCE. PT STATES THAT HE IS SELF EMPLOYED AND IS NOT SURPRISED THAT HIS INSURANCE DOES NOT HAVE BENEFITS. PT TALKED ABOUT HIS DISEASE AND THE FACT THAT HE IS BEING HELD AGAINST HIS WILL. TRIED TO GET PT TO REFOCUS ON DISCUSSION. PT STATES HE DOESN'T CARE ABOUT HIS BILL AND DOES NOT NEED ASSISTANCE WITH OTHER RESOURCES.

Activity Date: 05/31/06 Time: 1030

1501116 Behavioral Health Observation Check + A CP
- Document 05/31/06 1030 KLM 05/31/06 1038 KLM

=== OBSERVATION CHECKS ===

Observation Level/ 2B 30 Minutes

Patient Status/ Situational appropriate

Comment:

Activity Date: 05/31/06 Time: 1100

1501116 Behavioral Health Observation Check + A CP
- Document 05/31/06 1100 KLM 05/31/06 1135 KLM

=== OBSERVATION CHECKS ===

| Intervention Description | Activity Type | Occurred Date | Occurred Time | Occurred by | Recorded Date | Recorded Time | Recorded by | Sts | Frequency | Comment | Documented Units | From Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Activity Date: 06/01/06 Time: 1707** | | | | | | | | | | | | |
| 1501119 Behavioral Health Patient Care Record + | | | | | | | | D | | | | AS |
| - Ed Status | | 06/01/06 | 1707 | his | 06/01/06 | 1707 | his | | | | | A => D |
| 1501231 Assessment: RN Review + | | | | | | | | D | | | | CP |
| - Ed Status | | 06/01/06 | 1707 | his | 06/01/06 | 1707 | his | | | | | A => D |
| 1501257 Shift Assessment: Behavioral Health + | | | | | | | | D | Q8H | | | CP |
| - Ed Status | | 06/01/06 | 1707 | his | 06/01/06 | 1707 | his | | | | | A => D |
| 2001113 Vital Signs + | | | | | | | | D | | | | CP |
| - Ed Status | | 06/01/06 | 1707 | his | 06/01/06 | 1707 | his | | | | | A => D |
| 2001117 Intake & Output + | | | | | | | | D | | | | CP |
| - Ed Status | | 06/01/06 | 1707 | his | 06/01/06 | 1707 | his | | | | | A => D |
| 6500103 Education: Patient/Family + | | | | | | | | D | | | | CP |
| - Ed Status | | 06/01/06 | 1707 | his | 06/01/06 | 1707 | his | | | | | A => D |
| 7001102 Care Plan Evaluation + | | | | | | | | D | | | | CP |
| - Ed Status | | 06/01/06 | 1707 | his | 06/01/06 | 1707 | his | | | | | A => D |
| 7501101 Physician Contact + | | | | | | | | D | | | | CP |
| - Ed Status | | 06/01/06 | 1707 | his | 06/01/06 | 1707 | his | | | | | A => D |
| 7501103 Family Visitor Contact + | | | | | | | | D | | | | CP |
| - Ed Status | | 06/01/06 | 1707 | his | 06/01/06 | 1707 | his | | | | | A => D |
| 8001108 Age Appropriate: Middle Adult 36-65 | | | | | | | | D | | | | CP |
| - Ed Status | | 06/01/06 | 1707 | his | 06/01/06 | 1707 | his | | | | | A => D |
| 8501001 Discharge Plan + | | | | | | | | D | | | | CP |
| - Ed Status | | 06/01/06 | 1707 | his | 06/01/06 | 1707 | his | | | | | A => D |
| 9000101 Add a Problem + | | | | | | | | D | | | | CP |
| - Ed Status | | 06/01/06 | 1707 | his | 06/01/06 | 1707 | his | | | | | A => D |

| Monogram Initials | | Name | Nurse Type |
|---|---|---|---|
| | EKS2 | Sanford,Ellen K | SS |
| BKK | BKK1 | Keller,Brenda K | CM |
| BSJ | BSJ | Jerome,Brian S | CM |
| CLP | CLP15 | Pierson,Christina L | MHS |
| CMV | CMV6 | Vlastelic,Crystal M | LPN |
| DJE | DJE5 | Egan,Daniel J | RECTH |
| DNF | DNF | Foldvik,Dianne Nancy | MHS |
| EB | EXB1 | Boyer,Elizabeth | RN |
| GRN | GRN1 | Nelson,Gary R | RN |
| JAD | JAD13 | Demetrak,Jean A | RN |
| JBO | JBO3 | Orsua,Jennifer B | RN |
| JLF | JLF12 | Frangione,Johnnie L | MHS |
| JRD | JRF7 | Dorn,Jennifer R | RN |
| KEV | KEV2 | Vieselmeyer,Kate E | RN |
| KLM | KLM31 | McCorkle,Kathy L | MHS |
| KMH | KMM55 | Hicks,Kristen M | CNA |
| LKJ | LKJ5 | Johnston,Linnea K | RN |
| LLN | LLN4 | Newton,Linda L. | RN |
| LMM | LMM20 | Moen,Lynn M | RN |
| MJB | MJB14 | Brooks,Mary J | RN |
| MRB | MRB9 | Burns,Mitzi R | MHS |
| MRS | MRS21 | Strope,Michelle R | RN |
| SDS | SLD15 | Scarth,Susan D | RN |
| SES | SES15 | Saunders,Sandra E | RN |

| Monogram Initials | | Name | Nurse Type |
|---|---|---|---|
| SK | SXK4 | Kemp,Suzanne | RN |
| SKL | SKL10 | Lynch,Shirley K | RN |
| TLC | TLC38 | Cannon-Keiser,Tiffan | TH |
| VLB | VLB8 | Butka,Vickie L | RN |
| WNM | WNM1 | Madsen,Wanda N | TH |
| his | | automatic by program | |