

Medical Records - CONFIDENTIAL

FROM: NM - RMCHCS
520 NM HWY 564, GALLUP, NM 87301-4873
Phone: (505) 863-2273
Fax: (505) 722-3594

TO:

Name: ADEKY, RONE

DOB: 10/02/1986

Date Range: to

This document contains the following records of the patient:

- Allergy List
- Care Plan Audit
- Encounters and Procedures
- Encounter Documents
- Denied Medications
- Facesheet
- Imaging Results
- Lab Results
- Lab Orders
- Letters
- Medical Record Documents
- Medication List
- Order Groups
- Other Orders
- Patient Photo ID
- Vaccination History

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Allergy List

None recorded.

Care Plan Audit**Care Management Events**

None recorded

Health Concerns

None recorded

Goals

None recorded

Patient Tasks

None recorded

Care Team Tasks

None recorded

Health Status

None recorded

Encounters and Procedures

Clinical Encounter Summaries

Encounter Date: 05/10/2017 (Amendment closed by SHOBHA JAGANNATH, NP on 05/10/2017 at 12:40pm)

Amendment closed by SHOBHA JAGANNATH, NP on 05/11/2017 at 7:47pm

Amendment closed by SHOBHA JAGANNATH, NP on 05/18/2017 at 6:35pm

Last amended by SHOBHA JAGANNATH, NP on 05/18/2017 at 6:48pm)

Patient

Name ADEKY, RONE (30yo, F) ID# 45280 **Appt. Date/Time** 05/10/2017 10:50AM
DOB 10/02/1986 **Service Dept.** URGENT CARE CENTER
Provider SHOBHA JAGANNATH, NP
Insurance Med Contracts: CHS-FEDERAL FIREFIGHTERS
 Insurance #: 10021986
 Prescription: ORX - Member is eligible. details

Chief Complaint

None recorded.

Vitals

Ht: 5 ft 6 in 05/10/2017 11:18 am	Wt: 198.4 lbs 05/10/2017 11:18 am	BMI: 32 05/10/2017 11:18 am
BP: 112/62 sitting L arm 05/10/2017 11:18 am	Pulse: 78 bpm regular 05/10/2017 11:18 am	RR: 18 05/10/2017 11:18 am
O2Sat: 92% Room Air at Rest 05/10/2017 11:18 am	T: 97.7 F° temporal artery 05/10/2017 11:19 am	Pain Scale: 0 05/10/2017 11:19 am

Allergies

Reviewed Allergies

Medications

None recorded.

Vaccines

Reviewed Vaccines

Vaccine Type	Date	Amt.	Route	Site	Lot #	Mfr.	Exp. Date	Date on VIS	VIS Given	Vaccinator
Diphtheria, Tetanus, Pertussis	Tdap	05/10/17	0.5 mL	Intramuscular	Left Deltoid	YG7AY	GlaxoSmithKline	03/23/19	02/24/15	05/10/17

Problems

Reviewed Problems

Family History

Reviewed Family History

Social History

Reviewed Social History

Surgical History

Reviewed Surgical History

GYN History

Reviewed GYN History

Obstetric History

Reviewed Obstetric History

Past Medical History

Reviewed Past Medical History

HPI

here for pre-employment physical exam

ROS

Patient reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no dry eyes, no vision change, and no irritation. She reports no difficulty hearing and no ear pain. She reports no frequent nosebleeds, no nose problems, and no sinus problems. She reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, and no teeth problems. She reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, no known heart murmur, and no leg swelling. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no nausea, no vomiting, no constipation, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, no heartburn, and no black or tarry stools (melena). She reports no incontinence, no difficulty urinating, no hematuria, and no increased frequency. She reports no muscle aches, no muscle weakness, no arthralgias/joint pain, no back pain, and no swelling in the extremities. She reports no abnormal mole, no jaundice, no rashes, and no laceration. She reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, and no tremor. She reports no depression, no sleep disturbances, feeling safe in a relationship, no alcohol abuse, no anxiety, no hallucinations, and no suicidal thoughts. She reports no fatigue. She reports no swollen glands, no bruising, and no excessive bleeding. She reports no runny nose, no sinus pressure, no itching, and no hives, and no frequent sneezing.

Physical Exam

Patient is a 30-year-old female.

Constitutional: General Appearance: healthy-appearing, well-nourished, and well-developed. Level of Distress: NAD. Ambulation: ambulating normally.

Psychiatric: Insight: good judgement. Mental Status: normal mood and affect and active and alert. Orientation: to time, place, and person. Memory: recent memory normal and remote memory normal.

Head: Head: normocephalic and atraumatic.

Eyes: Lids and Conjunctivae: no discharge or pallor and non-injected. Pupils: PERRLA. Corneas: grossly intact. EOM: EOMI. Lens: clear. Sclerae: non-icteric. Vision: peripheral vision grossly intact and acuity grossly intact.

ENMT: Ears: no lesions on external ear, EACs clear, TMs clear, and TM mobility normal. Hearing: no hearing loss. Nose: no lesions on external nose, septal deviation, sinus tenderness, or nasal discharge and nares patent and nasal passages clear. Lips, Teeth, and Gums: no mouth or lip ulcers or bleeding gums and normal dentition. Oropharynx: no erythema or exudates and moist mucous membranes and tonsils not enlarged.

Neck: Neck: supple, FROM, trachea midline, and no masses. Lymph Nodes: no cervical LAD, supraclavicular LAD, axillary LAD, or inguinal LAD. Thyroid: no enlargement or nodules and non-tender.

Lungs: Respiratory effort: no dyspnea. Percussion: no dullness, flatness, or hyperresonance. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal, good air movement, and CTA except as noted.

Cardiovascular: Apical Impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR. Neck vessels: no carotid bruits. Pulses including femoral / pedal: normal throughout.

Abdomen: Bowel Sounds: normal. Inspection and Palpation: no tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended. Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hernia: none palpable.

Musculoskeletal: Motor Strength and Tone: normal tone and motor strength. Joints, Bones, and Muscles: no contractures, malalignment, tenderness, or bony abnormalities and normal movement of all extremities. Extremities: no cyanosis, edema, varicosities, or palpable cord.

Neurologic: Gait and Station: normal gait and station. Cranial Nerves: grossly intact. Sensation: grossly intact and monofilament test intact. Reflexes: DTRs 2+ bilaterally throughout. Coordination and Cerebellum: finger-to-nose intact and no tremor.

Skin: Inspection and palpation: no rash, lesions, ulcer, induration, nodules, jaundice, or abnormal nevi and good turgor. Nails: normal.

Back: Thoracolumbar Appearance: normal curvature.

Assessment / Plan

1. History and physical examination, pre-employment

Z02.1: Encounter for pre-employment examination

Return to Office

None recorded.

Amendment Sign-Off

Encounter signed-off by SHOBHA JAGANNATH, NP, 05/18/2017.

Encounter performed and documented by SHOBHA JAGANNATH, NP

Encounter reviewed & signed by SHOBHA JAGANNATH, NP on 05/10/2017 at 12:21 PM

Amendment closed by SHOBHA JAGANNATH, NP on 05/10/2017 at 12:40 PM

Amendment closed by SHOBHA JAGANNATH, NP on 05/11/2017 at 07:47 PM

Amendment closed by SHOBHA JAGANNATH, NP on 05/18/2017 at 06:35 PM

Amendment closed by SHOBHA JAGANNATH, NP on 05/18/2017 at 06:48 PM

RMCHCS
OCCUPATIONAL
HEALTH DEPT

EasyOne™ DIAGNOSTIC 5.2
© ndd 2000-2008
SN 70799 RecNo 1239
05/10/07 11:56

Patient Information

Name RONE ADEKY
ID 10021986
Age 30
Height 5 ft 2 in
Weight 198 lbs,BMI 36.4
Gender FEMALE
Ethnic OTHER
Smoker NO
Asthma NO

Test Information

Test Date/Time 05/10/07 11:52
Post Time --
Test Mode DIAGNOSTIC
Interpretation NLHEP
Predicted Ref NHANES III * 1.00
Value Select BEST VALUE
Tech ID
Automated QC ON
BTPS (INEX) --/1.02

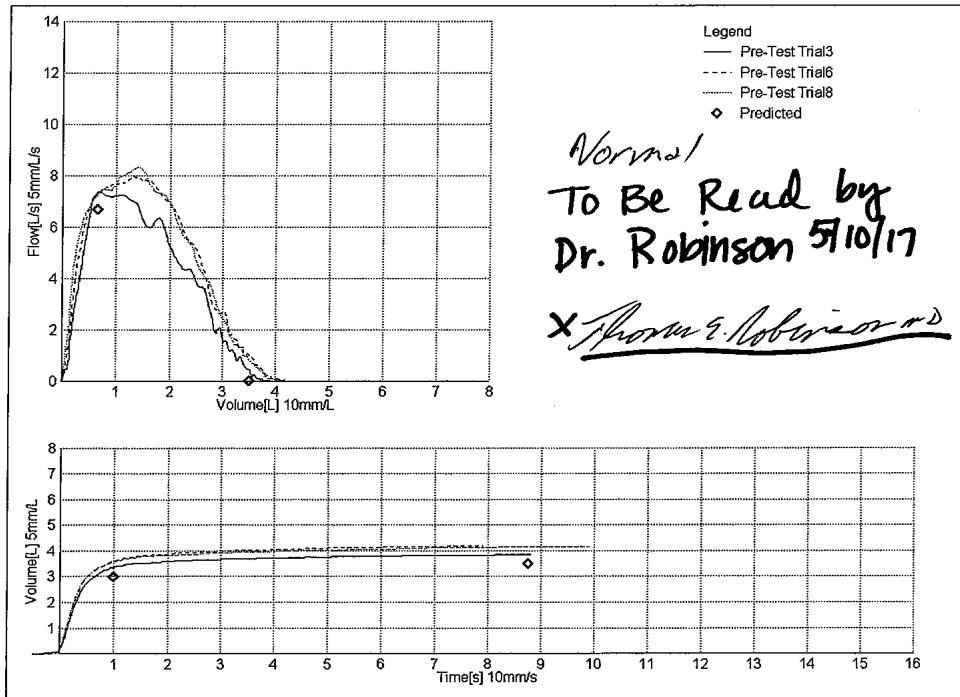
Test Results

Your FEV1 is 114% Predicted

Pre-Test

Parameter	Best	Trial3	Trial6#	Trial8#	Pred	%Pred
FVC[L]	3.88	3.88	4.20	4.20	3.51	110
FEV1[L]	3.39	3.39	3.63	3.60	2.98	114
FEV1/FVC[%]	87.5	87.5	86.3	85.8	84.4	104
PEF[L/min]	443.9	443.9	478.0	500.2	400.1	111
FEF25-75[L/s]	4.62	4.62	4.89	4.88	3.34	138
FET[s]	8.76	8.76	7.57	9.88	--	--

Pre-Test FEV1 Var=0.03L 0.9%, FVC Var=0.01L 0.1%; Session Quality D
Interpretation Normal, but the values shouldn't be used for comparisons with other tests
Caution: Only One Acceptable Maneuver - Interpret With Care.

Document History

Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/17/17 10:43am	Process document	ATHENA	UNPROCESSED		URGENT CARE CENTER STAFF	
05/17/17 10:43am	Classify document - Encounter Document - Procedure Documentation	BARCODE	CLOSED			

TIME: 10:00 am

DATE: 5/10/17

PATIENT REGISTRATION INFORMATION**OCCUPATIONAL HEALTH DEPT.****PATIENT INFORMATION**

Patient Name: Rone Adeky Birthdate 10/02/84 Age: 30
Patient Social Security #: 505-95-1058 Phone: 505 660-5250 SEX: M
Address: P.O. Box 14 City: Pine Hill State: NM ZIP: 87357
Email Address: rKayla@nmsu.edu Marital Status: Single Ethnicity/Race: Native American
Emergency Contact: Sarah Henion-Adeky Phone: 505-870-8776

COMPANY (BILLING) INFORMATION:

Company/Employer: CHS Wildland Firefighter Phone: _____
Billing Address: _____ City: _____ State: _____ ZIP: _____
Contact Person (DER/Safety Officer): _____ Phone: _____

SERVICES REQUESTED (PLEASE CHECK):**PHYSICALS**

DOT
 NON-DOT

DRUG SCREENS

DOT
 NON-DOT
 (SELF-PAY) DRUG SCREEN

OTHER TESTING

BREATH ALCOHOL

Notes:

Physical, TDAP, Vision, Audio, EKG, PFT, Blood work,
UA Dipstick.



COMPREHENSIVE HEALTH SERVICES, INC.

Exam Authorization:
2786111

8810 Astronaut Boulevard ° Suite 145 ° Cape Canaveral, FL 32920 ° Phone: (800) 638-8083

WLFF

This authorization is only valid for the date of exam.

The person below has an appointment on 5/10/2017 at Walkin. This form serves as your authorization to perform the following services. If this person does not show, please indicate below, and fax back to CHSi.

INVOICE INFORMATION

THE EXAMINEE IS NOT RESPONSIBLE FOR PAYMENT

Forward all invoices in accordance with instructions in your provider agreement. If you are performing services for CHSi through an agreement with a national provider, please send your invoice to them for payment processing. If you have any questions regarding invoicing CHSi for services rendered, contact our Quality Assurance Department at 1-866-532-1211.

Rehoboth McKinley Health Care Services 520 Highway 564 Gallup, NM 87301-5600	 N M - 1 0 6	<input type="checkbox"/> Did not attend the scheduled appt
Examinee Information: ADEKY, RONE Pinehill, NM 87357-0014	BIA/NM/LAA WLFF/BASE	<input type="checkbox"/> Rescheduled - Must have CHS authorization

DO NOT BILL THE EXAMINEE

Please forward all test results to 703-760-0890 as soon as the exam is completed.
Non-receipt of complete information will delay payment.

		Completed	*Not Performed
I001A	Tetanus-Diphtheria-Pertussis (Tdap) (If Medically Indicated)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
P002	Physical Exam(w/History Review & Acuity)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
P010	Purified Protein Derivative (PPD) (If Medically Indicated)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
P106	Vision - Peripheral Vision	<input checked="" type="checkbox"/>	<input type="checkbox"/>
P201D	Audiogram - Decibel Loss With Threshold	<input checked="" type="checkbox"/>	<input type="checkbox"/>
P301	Resting EKG - Tracing & Interpr Required	<input checked="" type="checkbox"/>	<input type="checkbox"/>
P303	Spirometry	<input checked="" type="checkbox"/>	<input type="checkbox"/>
P900	Blood Draw	<input checked="" type="checkbox"/>	<input type="checkbox"/>
P900UD	Urine Dipstick	<input type="checkbox"/>	<input type="checkbox"/>

* Not Performed - For any procedure not performed; please provide the reason



ADEKY, RONE

Exam Procedure	Procedure Name	Exam ID	Examinee Name
EQ103	WLFF/TC/SFF Health Questionnaire Form	2786111	ADEKY, RONE

- Complete the Health Questionnaire prior to your exam appointment.
- Bring supporting medical documentation (if applicable) to any YES responses.
- Bring contact lenses or eyeglasses (if applicable) for the eye exam portion of exam.
- If you wear glasses or contacts ensure facility tests your vision both with and without you wearing them.
- Please bring photo ID to exam appointment.

1 - TUBERCULOSIS (TB)

1. Have you ever had a skin test for TB? Yes No

When: 08/05/2016 (MM/DD/YYYY)

2. Have you ever had a positive TB skin test? Yes No
3. Have you ever been treated for active TB? (more than just a positive skin test) Yes No
4. Have you had symptoms of TB within the last 6 months like coughing up blood for 2-3 weeks, OR one or more of the following: chronic cough, chronic fatigue, fever >100, soaking night sweats, unexplained weight loss? Yes No

Please Explain ANY YES answers to TB questions: (include dates)

been tested**2 - MENTAL HEALTH**

1. Have you had any hospitalizations or rehabilitation for mental health issues? Yes No
2. Do you have anxiety, depression, panic disorder, or schizophrenia? Yes No
3. Do you have PTSD? Yes No
4. Do you have Claustrophobia or Fear of Heights? Yes No
5. Do you have any mental health conditions requiring prescription medication? Yes No

Please Explain ANY YES answers to Mental Health questions: (include dates)

3 - VISION

1. Do you wear corrective lenses? Yes No
2. Do you wear contacts? Yes No
- If yes: (select one) Soft Hard Tinted
3. Do you wear corrective lenses during firefighting? Yes No
4. If required, are you willing to carry a duplicate pair of corrective lenses or contact lenses while firefighting? Yes No
5. Have you had any eye surgeries? Yes No
6. Are you color blind or do you have optic neuritis? Yes No
7. Do you have night blindness, double vision or other vision issues? Yes No
8. Do you have or have you ever had either partial or complete loss of vision? Yes No
9. Do you have difficulty sensing distance or problems with depth perception? Yes No

Please Explain ANY YES answers to Vision questions:

N/A**4 - EARS, NOSE, AND THROAT**

- | | |
|--|---|
| 1. Do you have any type of ear disease or hearing loss? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 2. Do you get any ringing in the ear? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 3. Have you ever had any type of ear surgery? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 4. Do you use any protective hearing equipment when working around loud noises? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5. Are you in a hearing conservation program? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 6. Have you ever had an eardrum perforation? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 7. Do you have vertigo, dizziness, tinnitus (ringing in ears), or Meniere's disease? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 8. Do you have a cochlear implant? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 9. Do you have nosebleeds (recurrent or severe - requiring medical care)? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 10. Do you have Tumors or polyps? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 11. Do you have Allergic Rhinitis? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 12. Have you had ear/nose/throat surgery, other than minor or childhood? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 13. Do you have dental problems, gingivitis, or oral appliances? | <input type="radio"/> Yes <input checked="" type="radio"/> No |

Please Explain ANY YES answers to Ears, Nose, and Throat questions:

5 - SKIN

- | | |
|--|---|
| 1. Do you have skin cancer? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 2. Do you have albinism or other genetic conditions? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 3. Do you have eczema, psoriasis, contact dermatitis or allergic dermatitis? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 4. Do you have folliculitis or cystic acne? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5. Cysts or abscesses requiring surgery? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 6. Do you have urticaria, hives or scleroderma? | <input type="radio"/> Yes <input checked="" type="radio"/> No |

Please Explain ANY YES answers to Skin questions:

6 - LUNGS

Do you have or have you ever had any of the following:

- | | |
|---|---|
| 1. Shortness of breath, wheezing or persistent cough? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 2. Asthma, COPD, emphysema, or chronic bronchitis | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 3. Lung Cancer | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 4. Sarcoidosis | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5. Pulmonary embolism (clot in lungs) | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 6. Collapsed lung | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 7. Pulmonary hypertension | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 8. Lung Surgery | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 9. Loud snoring or pauses in breathing while asleep | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 10. Fall asleep easily during the day | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 11. Sleep disorder, sleep apnea, narcolepsy or ever advised to use CPAP | <input type="radio"/> Yes <input checked="" type="radio"/> No |

Please Explain ANY YES answers to Lung questions:

7 - HEART

Do you have or have you ever had any of the following:

- | | |
|---|---|
| 1. Heart attack or angina | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 2. Chest pain or tightness | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 3. Congestive heart failure | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 4. Cardiomyopathy | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5. Heart block | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 6. Pacemaker or ICD | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 7. Bypass or valve surgery | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 8. Angioplasty or stent | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 9. Murmur | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 10. Irregular heartbeat such as palpitations or arrhythmias | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 11. Abnormal electrocardiogram (ECG) | <input type="radio"/> Yes <input checked="" type="radio"/> No |

Please Explain ANY YES answers to Heart questions:

8 - HYPERTENSION (HIGH BLOOD PRESSURE)

- | | |
|--|---|
| 1. Have you ever been diagnosed with hypertension? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 2. Have you ever had hypertension requiring prescription medication? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 3. Have you ever required hospitalization due to hypertension? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 4. Do you have complications (kidneys, heart, brain, circulation, eyes)? | <input type="radio"/> Yes <input checked="" type="radio"/> No |

Please Explain ANY YES answers to Hypertension questions: (include dates)

9 - VASCULAR (CLOTS, CIRCULATION)

Do you have or have you ever had any of the following?

- | | |
|---|---|
| 1. Peripheral artery disease | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 2. Aneurysm | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 3. Varicose veins requiring stockings or surgery | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 4. Phlebitis, deep vein thrombosis, or clots in legs or lungs | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5. Taken a blood thinner (Coumadin or warfarin, heparin, Xarelto) | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 6. Raynaud's | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 7. Leg cramps in buttock, thigh, or calf | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 8. Vasculitis | <input type="radio"/> Yes <input checked="" type="radio"/> No |

Please Explain ANY YES answers to Vascular questions: (include dates)

10 - GASTROINTESTINAL (STOMACH, BOWELS)

Do you have or have you ever had any of the following?

- | | |
|--|---|
| 1. Crohn's disease, ileitis, ulcerative colitis, other colitis | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 2. Colostomy or ileostomy | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 3. Diverticulitis, chronic or recurrent | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 4. Irritable bowel syndrome | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5. Cholecystitis (gallbladder), chronic or recurrent | <input type="radio"/> Yes <input checked="" type="radio"/> No |

6. <input type="checkbox"/> Pancreatitis	<input type="radio"/> Yes <input checked="" type="radio"/> No
7. <input type="checkbox"/> Bleeding in the stomach or bowels	<input type="radio"/> Yes <input checked="" type="radio"/> No
8. <input type="checkbox"/> Blood in stool or vomited blood	<input type="radio"/> Yes <input checked="" type="radio"/> No
9. <input type="checkbox"/> Ulcers	<input type="radio"/> Yes <input checked="" type="radio"/> No
10. <input type="checkbox"/> Surgery (gastrointestinal)	<input type="radio"/> Yes <input checked="" type="radio"/> No
11. <input type="checkbox"/> Cancer (gastrointestinal)	<input type="radio"/> Yes <input checked="" type="radio"/> No
12. <input type="checkbox"/> Any dietary intolerance, special diet, or allergy?	<input type="radio"/> Yes <input checked="" type="radio"/> No

Please Explain ANY YES answers to Gastrointestinal questions: (include dates)

11 - LIVER

1. <input type="checkbox"/> Have you ever had hepatitis from any cause?	<input type="radio"/> Yes <input checked="" type="radio"/> No
2. <input type="checkbox"/> Do you have cirrhosis	<input type="radio"/> Yes <input checked="" type="radio"/> No
3. <input type="checkbox"/> Have you ever had jaundice (yellow skin) other than infancy?	<input type="radio"/> Yes <input checked="" type="radio"/> No

Please Explain ANY YES answers to Liver questions: (include dates)

12 - HERNIAS

Do you have or have you ever had any of the following?

1. <input type="checkbox"/> Inguinal (groin); surgery advised or have had surgery	<input type="radio"/> Yes <input checked="" type="radio"/> No
2. <input type="checkbox"/> Abdominal (ventral or umbilical); surgery advised or have had surgery	<input type="radio"/> Yes <input checked="" type="radio"/> No
3. <input type="checkbox"/> Femoral (thigh, inguinal or groin); surgery advised or have had surgery	<input type="radio"/> Yes <input checked="" type="radio"/> No

Please Explain ANY YES answers to Liver questions: (include dates)

13 - URINARY (KIDNEY, URETER, OR BLADDER)

Do you have or have you ever had any of the following?

1. <input type="checkbox"/> Renal (kidney) failure	<input type="radio"/> Yes <input checked="" type="radio"/> No
2. <input type="checkbox"/> Dialysis	<input type="radio"/> Yes <input checked="" type="radio"/> No
3. <input type="checkbox"/> Difficulty passing urine	<input type="radio"/> Yes <input checked="" type="radio"/> No
4. <input type="checkbox"/> Frequent urinating (more than once an hour)	<input type="radio"/> Yes <input checked="" type="radio"/> No
5. <input type="checkbox"/> Nocturia or need to urinate at night	<input type="radio"/> Yes <input checked="" type="radio"/> No
6. <input type="checkbox"/> Surgery or missing kidney	<input type="radio"/> Yes <input checked="" type="radio"/> No
7. <input type="checkbox"/> Recurrent urine infections	<input type="radio"/> Yes <input checked="" type="radio"/> No
8. <input type="checkbox"/> Kidney stones	<input type="radio"/> Yes <input checked="" type="radio"/> No
9. <input type="checkbox"/> Excess urine protein or Nephrotic Syndrome	<input type="radio"/> Yes <input checked="" type="radio"/> No

Please Explain ANY YES answers to Urinary questions: (include dates)

14 - EXTREMITIES (ARMS, LEGS)

Do you have or have you ever had any of the following?

1. <input type="checkbox"/> Amputation or prosthesis	<input type="radio"/> Yes <input checked="" type="radio"/> No
2. <input type="checkbox"/> Other orthopedic surgery	<input type="radio"/> Yes <input checked="" type="radio"/> No
3. <input type="checkbox"/> Deformity or chronic pain	<input type="radio"/> Yes <input checked="" type="radio"/> No

Please Explain ANY YES answers to deformity or chronic pain questions: (include dates)

15 - NECK OR SPINE

Do you have or have you ever had any of the following?

- | | |
|--|---|
| 1. Neck or spine surgery | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 2. Fractures | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 3. Chronic back or neck pain or loss of motion | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 4. Require assistive device with cane, crutches, walker, or wheelchair | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5. Herniated disc | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 6. Scoliosis | <input type="radio"/> Yes <input checked="" type="radio"/> No |

Please Explain ANY YES answers to Neck or Spine questions: (include dates)

16 - JOINTS OR ARTHRITIS

Do you have or have you ever had any of the following?

- | | |
|---|---|
| 1. Any kind of arthritis (rheumatoid, degenerative, gout, etc.) | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 2. Joint pain or swelling, loss of motion | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 3. Rotator cuff problems (shoulder) | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 4. Surgery or joint replacement | <input type="radio"/> Yes <input checked="" type="radio"/> No |

Please Explain ANY YES answers to Joint or Arthritis questions: (include dates)

17 - NEUROLOGICAL (BRAIN, NERVES)

Do you have or have you ever had any of the following?

- | | |
|--|---|
| 1. Seizures or epilepsy | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 2. Brain or skull surgery | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 3. Concussion or loss of consciousness from hitting head | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 4. Syncope or fainting | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 5. Bleeding in brain | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 6. Stroke or TIA | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 7. Problem with dizziness, balance or coordination | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 8. Numbness or tingling in hands or feet | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 9. Difficulty sensing hot or cold with hands or feet | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 10. Weakness in arms or legs | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 11. Peripheral neuropathy from any cause | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 12. Multiple sclerosis | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 13. Muscular dystrophy | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 14. Migraines | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| 15. Cancer (brain) | <input type="radio"/> Yes <input checked="" type="radio"/> No |

Please Explain ANY YES answers to Neurological (Brain, Nerves) questions: (include dates)

18 - ENDOCRINE (DIABETES, THYROID, ETC.)

Do you have or have you ever had any of the following?

1. Diabetes or elevated blood sugar Yes No
2. Thyroid gland disorder Yes No
3. Adrenal or pituitary gland disorder Yes No
4. Low blood sugar or hypoglycemia Yes No

Please Explain ANY YES answers to Endocrine questions: (include dates)

19 - HEMATOLOGIC OR BLOOD IMMUNE SYSTEM

Do you have or have you ever had any of the following?

1. Anemia Yes No
2. Leukemia Yes No
3. Low platelets Yes No
4. Bleeding disorder or coagulopathy, including hemophilia Yes No
5. Easy bruising Yes No
6. Sickle cell disease or trait, other hemoglobin variant Yes No
7. Enlarged spleen or splenectomy Yes No
8. Immune disorder or infection, including HIV Yes No
9. Myasthenia gravis Yes No
10. Lupus Yes No
11. Vaccine or immunization intolerance or allergy Yes No
12. Hereditary angioedema Yes No

Please Explain ANY YES answers to Hematologic questions: (include dates)

Select your gender then complete section "20 - FEMALES ONLY" or "21 - MALES ONLY"

Female Male

20 - FEMALES ONLY

Do you have or have you ever had any of the following?

1. Severe Menstrual Cramps or Heavy Bleeding Yes No
2. Chronic Pelvic or Abdominal Pain Yes No
3. Gynecological Surgery Yes No
4. Gynecological Cancer Yes No
5. Ectopic Pregnancy Yes No

Please Explain ANY YES answers: (include dates)

21 - MALES ONLY

Do you have or have you ever had any of the following?

1. Prostate disease or cancer Yes No

Please Explain ANY YES answers: (include dates)

22 - MEDICATIONS

1. Do you currently use an inhaler? Yes No

2. List all current medications and reason for taking. Please type 'None' if not applicable.

None

3. Do you take anabolic steroids or growth hormones?

Yes No

4. Over the counter, supplements, herbal medications

Yes No

5. Do you experience any side effects from any medication?

Yes No

23 - TOBACCO USE

1. Tobacco Use

Yes No

24 - ALCOHOL AND DRUG USE

1. Do you drink alcohol?

Yes No

If yes, what is the average number of drinks per week? 3

2. Have you had or do you have alcoholism, drug or alcohol dependency or abuse?

Yes No

3. Do you use illegal drugs?

Yes No

4. Are you currently using someone else's prescription medication?

Yes No

Please Explain ANY YES answers to any Alcohol or Drug questions: (include dates)

socially

25 - ALLERGY (MEDICATION, BEES, OTHER)

1. Allergy (medication, bees, other)

Yes No

26 - SURGERY OR HOSPITALIZATION

1. Any Surgery or Hospitalization?

Yes No

2. Any health changes since last medical evaluation or exam?

Yes No

3. Ever received a permanent disability rating?

Yes No

4. Do you have an active workers' compensation claim related to a work-related injury, illness, or exposure?

Yes No

5. Do you have current medical or physical work restrictions?

Yes No

I hereby certify that the above answers are complete and accurate to the best of my knowledge.



8810 Astronaut Blvd, Cape Canaveral, FL 32920

Wildland Firefighters, Tower Climbers, Structural Firefighters BASELINE Medical Examination Facility and Physician Instructions/Checklist

This applicant has been authorized for a Medical Exam with this affiliated Comprehensive Health Services clinic. Please conduct the appointment according to the instructions that follow below. Any test or procedure not authorized by CHSI will be the patient's responsibility for payment.

- Check candidate identification by picture ID.
- Have the candidate complete Medical Questionnaire Form, if they did not do this prior to coming for the appointment.
IF THE BOLDED QUESTIONS ARE ANSWERED THEN QUESTIONNAIRE HAS BEEN FILLED OUT PRIOR TO ARRIVAL....DO NOT MAKE EXAMINEE ANSWER SUBQUESTIONS.
- Have the candidate read and sign the "Notice of Privacy Practices" and "Authorization for Release of Medical Information" forms.
- Nurse to do vital signs – height, weight, BMI, pulse and blood pressure (**Repeat B/P if greater than 140/90**). Record on Page 1, the P002 (Examination) Form
- Perform Vision Acuity. Record results on Page 1, the P002 (Examination) Form (Note: examinees wearing glasses or contacts, both uncorrected and corrected screenings must be performed)
- Color vision **Examinee needs to recognize basic Red, Green, and Yellow.** Document on Page 1.
- Provider(MD, DO, NP, or PA) to perform Physical Exam and record results on Pages 1 - 12 of the P002 (Examination) Form
- Provider (MD, DO, NP, or PA) to review candidate's Medical History via the Health Questionnaire and note on **Examination form**, any information Provider wants to relay to medical reviewer.
 - All positive responses must be explained; include whether or not the examinee has had any complications and if he/she still experiences any problems from the condition. (Include Dates for all noted past surgeries, injuries and illnesses)
 - Complete and review all information.
- Administer PPD **ONLY** if Medically Indicated by a YES answer to HIGH RISK screening Questions on Page 4. If PPD is medically indicated, administer PPD, give Examinee a copy of page 5. Instruct examinee to provide CHS with PPD results within 72 hours.
- Perform EKG and attach the tracing – Record Results on Page 6.
- Administer Tetanus Booster if medically indicated (optional simply indicate if examinee declines) and record on Page 7
- Utilize Page 8 as work sheet for Vision Peripheral testing, if less than 85% vision in either eye, please repeat.
- Utilize Page 9 and 10 for Spirometry Testing and results & signature. Technician must conduct at least 3 trials. (**Provide the tracing printout**)
- Perform audiogram: Please **Indicate decibel** examinee heard for each frequency at the top of page 11. (Include printout if available)

Lab Specimen Collection:

- Collect Urine specimen and perform the Urine Dip Stick Test at clinic(not sent to LabCorp) – Record Results on Page 11
- Collect Blood (see Lab Requisition), Record Collection of Specimens and Fasting or NON-fasting status on Page 12
- Place blood specimen and test request forms in the Lab-Pak provided. **Contact LabCorp on day of collection for specimen pick up.** Failure to appropriately complete the requisitions may be cause for the tests to be rejected by the laboratory.

IF YOU DO NOT HAVE A RE-OCCURRING LABCORP PICK-UP AT YOUR FACILITY, PLEASE CALL (800) 833-3984 (OPTION 5) TO GET THE NUMBER OF A LABCORP COURIER IN YOUR AREA.

- If remote and only use FED EX for blood delivery, note the tracking number used on page 12.

Please Note: NO ADDITIONAL TESTS OR PROCEDURES ARE AUTHORIZED (Chest X-rays, Cardiac, etc.)

Fax: Please fax all results and completed forms to CHSI at **703-760-0890** on the same day of the examination.

Reminder: All laboratory specimens are to be forwarded to LabCorp the same day as the collection. Be certain to include the appropriately completed laboratory requisition forms.

Questions: If you have any additional questions please call Comprehensive Health Services, Inc. at **(888) 636-8619** press option 2 for the CHSI Wild Land Fire Fighter Representative.

PLEASE BE SURE TO COMPLETE EACH FORM IN ITS ENTIRETY

Updated 08/10/2016



8810 Astronaut Blvd • Cape Canaveral, FL 32920 • PH#: 800.638.8083 or 1-888-636-8619 • FAX 703-760-0890

www.chsmedical.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WE ARE REQUIRED BY LAW TO:

- Make sure medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

WHO IS REQUIRED TO ABIDE BY THIS NOTICE?

- Any healthcare professional authorized to enter information into your medical record.
- All employees, staff, and other healthcare personnel who make up the CHS workforce.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

- We may use medical information about you to provide you with medical treatment or services.
- We may disclose, with your signed permission, medical information about you necessary for your care at our facility and for examination results.
- We may also disclose, with your written permission, medical information about you to persons outside our facility who assist with decision making regarding your health issues.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT COMPREHENSIVE HEALTH SERVICES
AT 800-638-8083 or 888-636-8619 Option 2.

Rone K Adeky
Examinee Name (Please Print)

R-K-Adeky
Signature

5/10/17
Date



Comprehensive Health Services, Inc.
8810 Astronaut Blvd • Cape Canaveral, FL 32920 • PH# 800.638.8083 • FAX 703.261.1821
www.chsmmedical.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Examinee's Name Rone - K Adeky Date 5/10/17
Address P.O. Box 14 Pine Hill, NM 87357
Telephone 505-600-57650 Birth Date 10/02/186

1. I hereby authorize the assigned medical facility to release all medical information associated with this examination to Comprehensive Health Services, Inc.
2. I hereby authorize Comprehensive Health Services, Inc. to release all medical information associated with this examination to Department of Interior.

Company Name(s) and Address:

Comprehensive Health Services, Inc.
8810 Astronaut Blvd.
Cape Canaveral, FL 32920

Department of Interior
Wildland Firefighter Medical Standards
National Interagency Fire Center
3833 S. Development Ave. (Bldg. 106)
Boise, ID 83705

3. I understand this consent can be revoked at any time, except for any disclosure already made in good faith, in reliance on this consent.
4. The facility, its employees and officers, and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed Rone - K Adeky

5/10/17
Date of Signature



**COMPREHENSIVE
HEALTH SERVICES, INC.**

BASELINE Exam

Exam Procedure	Procedure Name	Exam Id	Examinee Name
P002	Physical Exam with History Review and Visual Acuity	278611	Adeky, Rone

TB QUESTIONNAIRE SCREENING

ANSWER THE FOLLOWING QUESTIONS AT EXAM		
Has the examinee ever had a skin test for TB?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, when? _____ / _____ month/year		
Has the examinee ever had a positive TB skin test? If Yes - Do Not Administer PPD	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If yes, did examinee take antibiotic (INH) for 3-6 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Has the examinee ever been treated for active TB? If Yes - Do Not Administer PPD	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
HIGH RISK SCREENING Questions - Administer PPD skin test ONLY if one of the answers Below is YES (answer all questions)		
Has the examinee had recent close or prolonged contact with someone with infectious TB disease?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the examinee a foreign-born person from or recent traveler to high-prevalence area as identified by Center for Disease Control?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Has the examinee had chest radiographs with fibrotic changes suggesting inactive or past TB?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the examinee have an HIV infection?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the examinee an organ transplant recipient?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the examinee have immunosuppression secondary to use of prednisone (equivalent of ≥ 15 mg/day for ≥ 1 month) or use other immunosuppressive medication such as TNF- α antagonists?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the examinee an injection drug user?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the examinee of a high-risk congregate setting (e.g., prison, long term care facility, hospital, homeless shelter)?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the examinee have any medical conditions associated with risk of progressing to TB disease if infected (e.g., diabetes mellitus, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, and end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight [10% or more below ideal for given population])?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Has the examinee had symptoms of TB within the last 6 months like coughing up blood for 2-3 weeks, OR one or more of the following: chronic cough, chronic fatigue, fever >100 , soaking night sweats, unexplained weight loss?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Administer TB skin test (PPD)

**ONLY if examinee answers YES to any of the HIGH Risk Screening Questions
AND the examinee has never had a positive skin test or has not been treated for active TB.**



**COMPREHENSIVE
HEALTH SERVICES, INC.**

BASELINE Exam

Exam Procedure	Procedure Name	Exam Id	Examinee Name
P002	Physical Exam with History Review and Visual Acuity	278611	Adeky, Rone

HEIGHT	5 (ft.)	5 (in.)	WEIGHT	194 (lbs.)	BMI	32	PULSE	78
Blood Pressure	112/102	(repeat if > 140/90)		/		<input type="checkbox"/> BP remains > 140/90		

VISION

DISTANT	UNCORRECTED	R20/100 L20/100 B20/100	CORRECTED	R20/20 L20/20 B20/20
NEAR:	UNCORRECTED	R20/20 L20/20 B20/20	CORRECTED	R20/20 L20/20 B20/20

(Note: Examinees wearing glasses or contacts, BOTH uncorrected & corrected screenings MUST be performed)

COLOR VISION: Recognizes Basic Colors (R,G,Y) Normal Abnormal

PLEASE REVIEW WITH EXAMINEE AND DOCUMENT ANY ABNORMAL FINDINGS IN THE FIELDS PROVIDED

EYES

1. Are there any eye abnormalities noted?

<input type="checkbox"/> Strabismus	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Scleral Icterus or Conjunctival Pallor	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Abnormal Fundi	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Unequal Pupils	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Conjunctival Pallor	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both

Document abnormal findings

MOUTH, EARS, OR NOSE/ OROPHARYNX

2. Are there any mouth, ears or nose abnormalities noted?

<input type="checkbox"/> Lesion (possible cancer)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Septal Perforation	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Gingivitis or Dental Disease	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> TM Perforation	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Cerumen Impaction	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Other			

Document abnormal findings

PULMONARY

3. Is there any SOB, dyspnea or coughing at rest abnormalities noted? (check all that apply) Yes No

<input type="checkbox"/> Wheezes	<input type="checkbox"/> Inspiratory crackles/rales, rhonchi, or coarse breath sounds	<input type="checkbox"/> Right- does not clear with cough	<input type="checkbox"/> Left- does not clear with cough
<input type="checkbox"/> Other (please specify)			

Document abnormal findings

CARDIOVASCULAR

4. Are there any cardiovascular abnormalities noted?

<input type="checkbox"/> Murmur - systolic or diastolic, grade, intensity, location	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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**COMPREHENSIVE
HEALTH SERVICES, INC.**

BASELINE Exam

Exam Procedure	Procedure Name	Exam Id	Examinee Name
PO02	Physical Exam with History Review and Visual Acuity	278011	Adeky, Rone

- Other abnormal sounds (rubs, etc.)
 Surgical scar(s) - thoracotomy, sternotomy, etc.
 Document abnormal findings

ABDOMEN

5. Are there any abdominal abnormalities noted?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Ascites		
<input type="checkbox"/> Enlarged spleen		
<input type="checkbox"/> Tenderness or mass		
<input type="checkbox"/> Bruit		
<input type="checkbox"/> Hernia (check all that apply)		
<input type="checkbox"/> Inguinal	<input type="checkbox"/> Ventral	<input type="checkbox"/> Umbilical
	<input type="checkbox"/> Not Reducible	<input type="checkbox"/> Tender
<input type="checkbox"/> Ostomy		
Document abnormal findings		

MALES

6. Are there any testicular abnormalities noted?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Document abnormal findings		

FEMALES

7. When was the last menstrual period	Date:(MM/DD/YYYY)	04/12/2017
Document abnormal findings		

EXTREMITIES

Are there any extremity abnormalities noted?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Cyanosis		
<input type="checkbox"/> Clubbing		
<input type="checkbox"/> Varicosities		
<input type="checkbox"/> Edema or swelling		
<input type="checkbox"/> Absent or diminished pulses		
<input type="checkbox"/> Deformities or atrophy		
Document abnormal findings		

*** EXTREMITIES - Abnormal range of motion (see table below for details)***

8. NEUROLOGICAL	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Are there any neurological abnormalities noted?		
<input type="checkbox"/> Sleeping or dozing off in waiting room		
<input type="checkbox"/> Sensory deficit		
<input type="checkbox"/> Motor deficit		
<input type="checkbox"/> Asymmetric or abnormal DTRs		
Document abnormal findings		



**COMPREHENSIVE
HEALTH SERVICES, INC.**

BASELINE Exam

Exam Procedure	Procedure Name	Exam Id	Examinee Name
P002	Physical Exam with History Review and Visual Acuity	218611	Adeky, Rone
<input type="checkbox"/> Gait or balance abnormality <input type="checkbox"/> Tremor <input type="checkbox"/> Other Document abnormal findings			
9. Spine/Neck and Back		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Are there any spine/neck or back abnormalities noted? <input type="checkbox"/> Surgical scar <input type="checkbox"/> Deformity of scoliosis <input type="checkbox"/> Difficulty changing positions <input type="checkbox"/> Assistive device - cane, crutches, walker, wheelchair, etc.			
SPINE/NECK AND BACK- Abnormal range of motion (see table below for details) Document abnormal findings			
10. SKIN		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Are there any skin abnormalities noted? <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Possible skin cancer <input type="checkbox"/> Other			
Document abnormal findings			
STRENGTH & RANGE OF MOTION Neck		<input type="checkbox"/> NORMAL	DETAILS IF ABNORMAL
Spine/Back		<input type="checkbox"/>	
Shoulders/Arms		<input type="checkbox"/>	
Elbow/Forearm		<input type="checkbox"/>	
Wrist/Hand		<input type="checkbox"/>	
Hip/Thigh		<input type="checkbox"/>	
Knee		<input type="checkbox"/>	
Feet/Ankle		<input type="checkbox"/>	



**COMPREHENSIVE
HEALTH SERVICES, INC.**

BASELINE Exam

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P010	Purified Protein Derivative (PPD) Medically Indicated Component	278411	Adeky, Rone

Facility Instructions: Only if Examinee answered YES to any HIGH Risk Screening Questions Administer TB Skin test (PPD). Examinee is not to return to clinic for a PPD read.

1. Administer PPD and give examinee copy of this form. (results will be read off site)
2. Instruct examinee to have read done within 48-72 hours, and fax completed form to CHSi at 703 760-0890.

<input type="checkbox"/> PPD applied <input type="checkbox"/> PPD contraindicated	Date applied: ____/____/____ Applied by: _____ Manufacturer: _____ mm of induration Lot No. _____ Exp. Date: ____/____/____	Date read: ____/____/____ Read by: _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <small>Note: For firefighters per NFPA, 5 mm increase previous reading occurring within last two years is considered positive.</small>
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Examinee Instructions:

1. Have PPD results read within 48-72 hours.
2. Results may be read by EMT, RN, LPN or self-read. **Do not return to the facility for PPD read.**
3. Return results page to CHSi at 1-703-261-1821 or WLFF@chsmedical.com
(Failure to return PPD results within 5 days will result in a NOT Qualified Status)

Interpreting a PPD test reaction

- Read between 48 and 72 hours after injection.
- If examinee shows up later than 72 hours and test is negative, PPD should be repeated in 1-3 weeks.
- Read the induration across the forearm, perpendicular to the long axis of the arm.

≥ 5 mm is positive if:
 ✓ Known or suspected HIV infection ✓ Close contact with infectious TB ✓ Use injectable drugs
 ✓ CXR suggestive of previous TB or recent TB infection within last 2 years

≥ 10 mm is positive if:
 ✓ Certain medical conditions, excluding HIV – drug abuse, diabetes, silicosis, prolonged treatment with steroids or other immunosuppressant, cancer, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndromes, low body weight ($\geq 10\%$ below ideal)
 ✓ Medically underserved populations ✓ Long term facility residents
 ✓ Children under 4 years of age ✓ Per NFPA: Fire rescue and EMS personnel
 ✓ Locally identified high prevalence groups (migrants, homeless, etc.)

≥ 15 mm is positive if no known risk factors for TB
 If a history of receiving BCG vaccine, a positive reaction is more likely due to TB infection vs. the vaccine if:
 ✓ The induration is large ✓ Received BCG a long time ago
 ✓ Recent contact with infectious TB ✓ Family history of TB
 ✓ Comes from area where TB is common ✓ CXR shows evidence of previous TB
 ✓ Per NFPA: 5 mm increase from previous reading occurring within last two years

COMPREHENSIVE
HEALTH SERVICES, INC.

BASELINE Exam

Exam Procedure	Procedure Name	Exam Id	Examinee Name
P301	Resting EKG – Tracing Required	278611	Adeky, Rone

Interpretation: Normal Abnormal (provide details below) Tracings attached



**COMPREHENSIVE
HEALTH SERVICES, INC.**

BASELINE Exam

Exam Procedure	Procedure Name	Exam Id	Examinee Name
I001 or I001A	Tetanus-Diphtheria (Td), or Tetanus-Diphtheria-Pertussis (Tdap) Immunization	278611	Adeky, Rone

Medically Indicated Component/Optional

Has the examinee received a Tetanus shot in the last 10 years?

- Yes (provide copy of immunization record if provided and not medically indicated) No (administer immunization)
- Examinee declines to receive Tetanus immunization (to be checked by facility if declined)

Vaccine	Type	Site	Vaccine		Vaccine Information Statement (VIS)		Vaccinator (Initials & Title)
			Lot#	Mfr	Date On VIS	Date Given	
<input type="checkbox"/> Tetanus, diphtheria (Td)	Inactivated Bacterial	IM	YG7AY	GlaxoSmithKline	03/23/19	05/10/17	FT CCMA
<input checked="" type="checkbox"/> Tetanus, diphtheria, acellular pertussis (Tdap)		IM					

Please attach any other records if received at the time of the appointment.

** If provided or presented a yellow immunization card, please update, copy and return to the examinee. Include copy with exam packet returned to CHSi. Immunization records are not required. This immunization is optional.



**COMPREHENSIVE
HEALTH SERVICES, INC.**

BASELINE Exam

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P106	Vision – Peripheral Vision	278611	Adeky, Rone

LATERAL VISUAL FIELDS BY CONFRONTATION (in degrees) – see instructions below.

Please circle best LATERAL (TEMPORAL) visual field for each eye.

NOTE: If less than 85° for either eye, please repeat.

RIGHT

LEFT

0° 10° 25° 40° 55° 70° 85° >90°

0° 10° 25° 40° 55° 70° 85° >90°

Repeated:

RIGHT

LEFT

0° 10° 25° 40° 55° 70° 85° >90°

0° 10° 25° 40° 55° 70° 85° >90°

Face examinee at eye level no more than arm's length apart.

1. To measure right eye temporal visual field:
 - a. Ask examinee to stare directly at examiner's nose and cover left eye.
 - b. Slowly move finger or small object from behind right ear in arc approaching right eye, asking examinee to indicate when seen; circle estimated degrees of arc for right eye using nose as zero point (0°).
2. Repeat step 1 for left eye with right eye covered to measure left eye temporal field.



**COMPREHENSIVE
HEALTH SERVICES, INC.**

BASELINE Exam

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P303	Spirometry (3 tracings)	878611	Adeky, Rone.

TO BE COMPLETED BY TECHNICIAN BEFORE SPIROMETRY IS PERFORMED:

1. How does examinee feel today? Well Sick
2. Does examinee have a history of any of the following:
- a) Heart attack within the past month Yes No
 - b) Chest or abdominal pain Yes No
 - c) Oral or facial pain that is aggravated by the spirometry mouthpiece Yes No
3. Has examinee:
- a) Had a severe respiratory illness or ear infection in the past three weeks? Yes No
 - b) Smoked cigarettes, pipes or cigars within the last hour? Yes No
 - c) Used any inhaled medications, such as an aerosolized bronchodilator within the last hour? Yes No
 - d) Had any eye, ear, chest or abdominal surgery in the past two months? Yes No
 - e) Eaten a heavy meal in the last hour? Yes No

SPIROMETER:

Daily calibration performed today? Yes No *If NO, last calibration date: _____/_____/_____

Machine make/model: Diagnostic/EasyOne Test performed by: (Please print) Lydia Grayhat
 Model: 2001



**COMPREHENSIVE
HEALTH SERVICES, INC.**

BASELINE Exam

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P303 (Cont'd)	Spirometry (3 tracings)	278611	Adelaij, Zone

SPIROMETRY:

Must complete at least 3 attempts. Attach all tracings with time/volume and flow/volume loops for each attempt. Please complete all information.

Examinee position: Standing (preferred) Sitting (if history of fainting or illness)

Examinee effort: Good Fair Poor

Ht: 5'05 in. Wt: 194 lbs Age: 30 Gender: Male Female

Race/Ethnicity: Caucasian African American Hispanic Asian Other

Two largest FEV1 and FVC efforts do not vary by more than 150 ml or 0.15 liter

Invalid test; does not meet ATS criteria for repeatability or acceptable flow curves.
(Please explain below why a valid test could not be completed at this time)

Test not performed at this time (Please explain below why test was not performed)



**COMPREHENSIVE
HEALTH SERVICES, INC.**

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P201D	Audiogram – Decibel Loss with Threshold	278611	Adeky, Rone

AUDIOGRAM RESULTS: Please note decibel tested at each frequency per ear

FREQUENCY (Hz)	500	1000	2000	3000	4000	6000	8000
Right Ear	00	05	00	05	20	10	25
Left Ear	00	00	00	00	10	10	05

All printouts attached, if not, please explain why?

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P900UD	Urine Dip		

Test Used: Multistix 10SG LOT#: 610089 Expiration Date: 04/30/2018

RESULTS:

URINALYSIS (DIPSTICK) 1.020 SP GRAVITY Negative PROTEIN Negative GLUCOSE Negative BLOOD

SHOBHA JAGANNATH

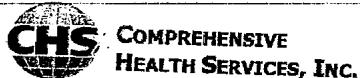
Medical Provider Name (Please print)

MD/DO PA NP

SJ Signature

05/10/17

Date



BASELINE Exam

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P900	Blood Draw	278411	Adeky, Rone.

Fasting is NOT required for this component
 (Please do not send examinee away. If non-fasting mark box below)

Fasting Non-fasting

Collector's Name: Felicia Tsoie CCMA (Please print)

Date of Collection: 05/10/17

Units Collected:

Tiger or Red top tube. Please spin for 20 minutes after letting sit for 30 minutes.
 LC319967 CMP12+P+7AC LabCorp Clinical Code -
 1ML - Serum (preferred) - Gel-barrier tube (send
 entire tube, filled)

Lavender-top (EDTA) tube. No spin needed however must invert a few times.
 LC5009 CBC With Differential/Platelet-
 LabCorp Clinical Code - 0.5 ML
 (send entire tube, filled)

Specimens sent to: (Labs must be sent the day of collection)

- LabCorp by LabCorp Courier
- LabCorp by FedEx via Air Bill Please provide tracking # _____

Note: Include copy of Lab requisition along with exam documents and fax to CHSi.



Rehoboth McKinley Christian Health Care Services

520 Highway 564 Gallup, NM 87301 P: (505)863-2273 F: (505)722-3594

Patient's Name: Rone Adeky Date: 5-10-17
 Date of Birth: 10-02-1986
 Company Name: CHS-Wildland Fire Fighter

OCCUPATIONAL HEALTH DEPARTMENT **(MANUAL AUDIOMETRY)**

??xx

IF NEEDED ONLY

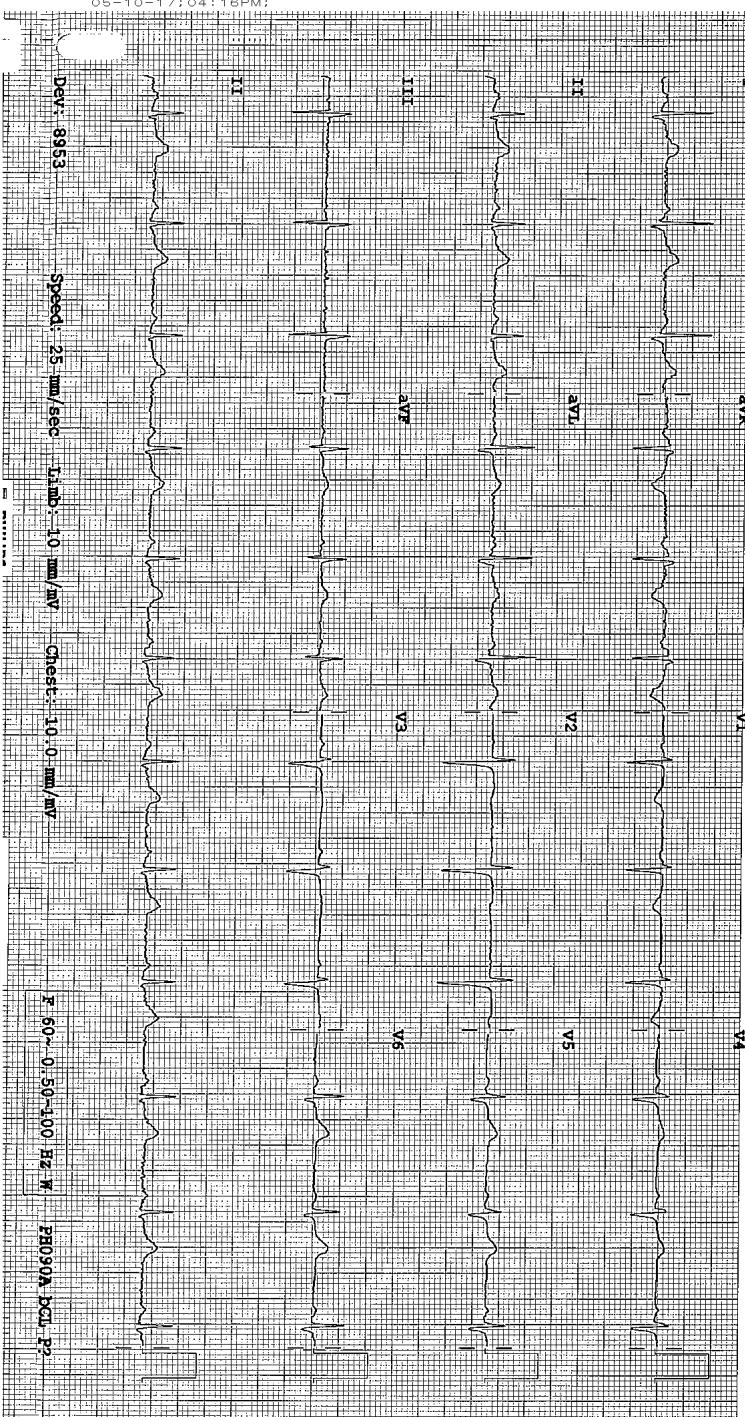
	LEFT/DB	RIGHT/DB
1KHZ	00	05
500HZ	00	00
1000HZ	00	05
2000HZ	00	00
3000HZ	00	05
4000HZ	10	20
6000HZ	10	10
8000HZ	05	25

RA300 AUDIOMETER
 TREMETRICS (C) 1996,
 1997, 1998
 DATE 05/10/17
 TIME 10:26
 TEST# 20 - 00147
 SUBJECT:
Rone Adeky
 SS#/ID# 010021986
 CURRENT AUDIogram
 DAILY BIOLOGICAL
 FREQ. L/DB R/DB
 1KHZ TEST 00 05
 500HZ 00 00
 1000HZ 00 05
 2000HZ 00 00
 3000HZ 00 05
 4000HZ 10 20
 6000HZ 10 10
 8000HZ 05 25

MODE PULSED
 SERIAL # 3684
 VERSION 1.17
 CAL. ANSI 1989 STD
 CAL. DATE 02/17
 EXAMINER SS#/ID#
 0000000088

RAJ
 X.....

SJ.
 5/10/17



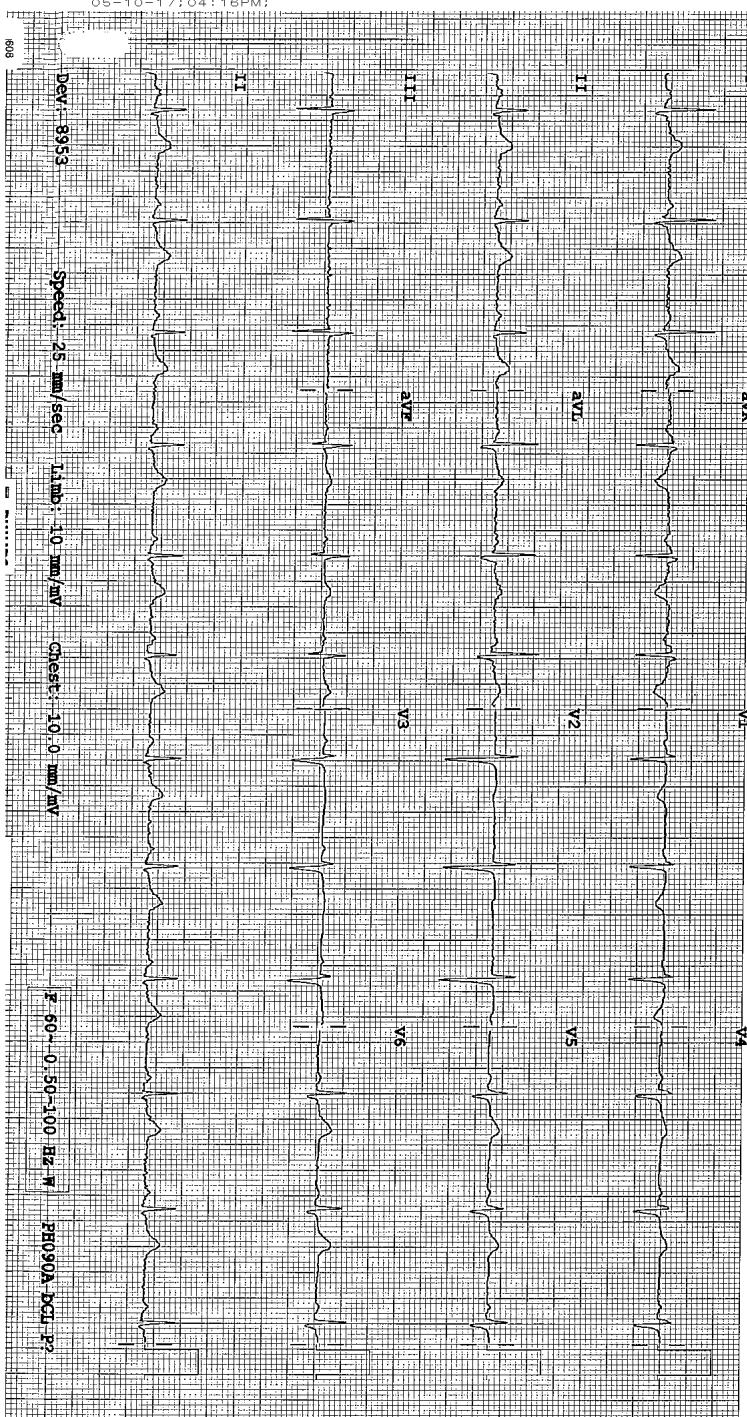
; 505+722+3594 # 27 / 32

R45280 5/10/2017 12:18:36 ADEKY, RONE
 30 Years Female
 Dx Z02.9 PHYSICAL EXAM, PHYSICAL EXAM, PHYSICAL EXAM
 Rate 70 SINUS RHYTHM.....
 RR 857 ..normal P axis, V-rate 50- 99
 PR 1.36
 QRS 94
 QT 412
 QTC 445
 --AXIS--
 P 15
 QRS 31
 T 29
 - NORMAL ECG -

Requested by: SREBHA JAGANNATH, >
 Unconfirmed Diagnosis

C.J
5/10/11

RMCHCS Hospital (863)
 Dept: (11)
 Room: 31
 Oper: LG/FT
 DOB 10-02-1986
 H number R45280



28 / 32
; 505+722+3594

R45280 5/10/2017 12:18:36 ADEKY, RONE
 30 Years Female PHYSICAL EXAM, PHYSICAL EXAM, PHYSICAL EXAM, PHYSICAL EXAM
 Dx Z02.9 PHYSICAL EXAM, PHYSICAL EXAM, PHYSICAL EXAM, PHYSICAL EXAM
 Rate 70 . SINUS RHYTHM.....normal p axis, v-rate 50- 99
 RR 857 PR 136 QRS 94 QT 412 QTC 445
 -AXIS--
 P 15 QRS 31 T 29
 - NORMAL ECG -
 Requested by: SHOBHA JAGANNATH, >
 Unconfirmed Diagnosis

S.T
δ\δ\δ\δ

RMCSCS Hospital (863)
 Dept: (11)
 Room: 31
 Oper: LG/FT
 DOB 10-02-1986
 H number E45280

RMCHCS
OCCUPATIONAL
HEALTH DEPT

EasyOne™ DIAGNOSTIC 5.2
© ndd 2000-2008
SN 70799 RecNo 1239
05/10/07 11:56

Patient Information

Name	RONE ADEKY
ID	10021986
Age	30
Height	5 ft 2 in
Weight	198 lbs BMI 36.4
Gender	FEMALE
Ethnic	OTHER
Smoker	NO
Asthma	NO

Test Information

Test Date/Time	05/10/07 11:52
Post Time	--
Test Mode	DIAGNOSTIC
Interpretation	NLHEP
Predicted Ref	NHANES III * 1.00
Value Select	BEST VALUE
Tech ID	
Automated QC	ON
BTSPS (INEX)	--/1.02

Test Results

Your FEV1 is 114% Predicted

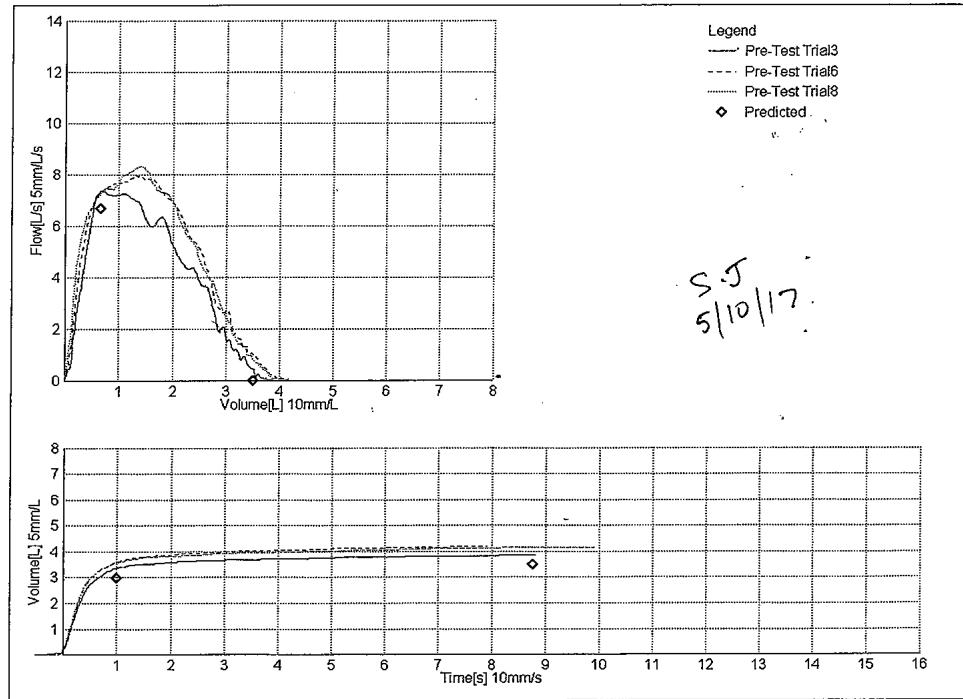
Pre-Test

Parameter	Best	Trial3	Trial6#	Trial8#	Pred	%Pred
FVC[L]	3.88	3.88	4.20	4.20	3.51	110
FEV1[L]	3.39	3.39	3.63	3.60	2.98	114
FEV1/FVC[%]	87.5	87.5	86.3	85.8	84.4	104
PEF[L/min]	443.9	443.9	478.0	500.2	400.1	111
FEF25-75[L/s]	4.62	4.62	4.89	4.88	3.34	138
FET[s]	8.76	8.76	7.57	9.88	--	--

Pre-Test FEV1 Var=0.03L 0.9%; FVC Var=0.01L 0.1%; Session Quality D

Interpretation Normal, but the values shouldn't be used for comparisons with other tests

Caution: Only One Acceptable Maneuver - Interpret With Care.





RONE ADEKY DOB: 10/02/1986

DATE: 05/10/2017

RMCHCS URGENT CARE

PROVIDER: SHOBHA JAGGANATH, NP

URINE DIPSTICK RESULTS

Siemens
Clinitek Status®
Serial Number: 64056

Patient Name: ADEKY RONE
Patient ID: 10.02.1986

S. JAG
Multistix® 10 SG
Test date 05-10-2017
Time 10:27AM
Operator LG
Test number 3845
Color Dark yellow
Clarity Clear

GLU Negative
BIL Negative
KET 15 mg/dL
SG 1.020
BLO Negative
PH 5.5
PRO Negative
URO 1.0 E.U./dL
NIT Negative
LEU Trace

S.J
5/10/17



New Mexico Immunization Record

Official Document

Registro de Inmunización

Documento Oficial

Name/Nombre: RONE K ADEKY

Date of Birth/Fecha de Nacimiento: 10/02/1986

Gender/Género: F

New Mexico WebIZ ID#: 835418

Date of Next Vaccination/Fecha de Próxima Vacuna: 6/7/2017

Present this record at each medical visit.
Presente este documento durante sus visitas médicas.

Immunization Provider:

COLLEGE CLINICS PEDIATRICS
2111 COLLEGE DR
GALLUP, NM 87301

505-863-1891

Allergies/Precautions/Contraindications

Alergias/Precauciones/Contraindicaciones:

Vaccine Reactions / Reacciones contra Vacunas:

Comments

Date	Note

Vaccines Refused

Date	Note

Vaccine/Vacuna	Date Given Dada en la Fecha MM/DD/YYYY	Age at Imm. Edad Cuando Inm.	Doctor or Clinic Doctor o Clínica
Influenza			
1 Influenza, P-Free	11/01/2010	24Y 0M 30D	IHS708
2			
3			

! Invalid Dose. Minimum age/interval not met.
Dose determined invalid by provider

Vaccine/Vacuna	Date Given Dada en la Fecha MM/DD/YYYY	Age at Imm. Edad Cuando Inm.	Doctor or Clinic Doctor o Clínica
DTaP / TD / Tdap			
1 Td , adsorbed	05/06/2003	16Y 7M 4D	DEFAULT
2 Tdap, Adsorbed	05/10/2017	30Y 7M 8D	PR
3			
4			
5			
Polio			
1			
2			
3			
4			
Hib			
1			
2			
3			
4			
Pneumococcal			
1			
2			
3			
4			
Rotavirus			
1			
2			
3			
Hep A			
1 Hep A, ped/adol, 2D	08/01/1997	10Y 9M 30D	DEFAULT
2 Hep A, ped/adol, 2D	12/02/1997	11Y 2M 0D	DEFAULT
3 Hep A, ped/adol, 2D	05/22/1998	11Y 7M 20D	DEFAULT
4			
Hep B			
1 Hep B, adol High Ris	08/01/1997	10Y 9M 30D	DEFAULT
2 Hep B, adol High Ris	12/02/1997	11Y 2M 0D	DEFAULT
3 Hep B, adol High Ris	05/22/1998	11Y 7M 20D	DEFAULT
4			
MMR			
1			
2			
Varicella (CPOX)			
1			
2			
Meningococcal			
1 MCV4P (Menactra)	11/01/2010	24Y 0M 30D	IHS708
2			
HPV			
1			
2			
3			
Other			
1			

Print Date 5/10/2017 11:40:42AM

Page 1 of 1

Document History

Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/10/17 04:29pm	Classify document - Encounter Document - Procedure Documentation	BARCODE	CLOSED			
08/24/17 05:17pm	Print	scruz47	CLOSED			Print initiated.
08/24/17 05:17pm	Print	scruz47	CLOSED			Print initiated.
08/24/17 05:18pm	Print	scruz47	CLOSED			Print initiated.
08/24/17 05:19pm	Print	scruz47	CLOSED			Print initiated.
08/24/17 05:19pm	Print	scruz47	CLOSED			Print initiated.

Denied Medications

None recorded.

Facesheet**Demographics**

Patient Name	ADEKY, RONE
Sex	F
DOB	10/02/1986
Address	PO BOX 14
City/State/Zip	PINEHILL, NM 87357
Home Phone	(505) 600-5650
Insurance	Med Contracts: CHS-WILD LAND FEDERAL FIREFIGHTERS Insurance #: 10021986

Height / Weight / BMI / BP

Height 66 in 05/10/2017
 Weight 198 lbs 6.4 oz 05/10/2017
 BMI 32 05/10/2017
 Blood Pressure 112 / 62 05/10/2017

Problems

None recorded.

Surgical & Procedure History

None recorded.

Medications

None recorded.

Vaccines

Vaccine	Type	Date	Amt.	Route	Site	NDC	Lot #	Mfr.	Exp. Date	VIS	VIS Given	Vaccinator
Diphtheria, Tetanus, Pertussis												
Tdap		05/10/17	0.5 mL	Intramuscular	Deltoid, Left	YG7AY	GlaxoSmithKline	03/23/19	Tdap 02/24/2015	05/10/17	Felicia Tsosie, INACTIVE	

Allergies / Adverse Reactions

None recorded.

Past Medical History

(none recorded)

Social History

None recorded.

Family History

None recorded.

GYN History

None recorded.

Patient History - Other

None recorded.

Past Pregnancies

None recorded.

Obstetric History

None recorded.

Screening

None recorded.

Imaging Results**AUDIOGRAM 05/10/2017 (#860903, 05/10/2017 10:26am)**

Result Note	RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING: CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083
-------------	---

Document History

Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/10/17 11:43am	New in-house result requires data entry	Igrayhat1	DATAENTRY		URGENT CARE CENTER STAFF	
05/10/17 11:54am	Data Entry Completed	ft sosie	REVIEW		sjagannath	
05/10/17 06:53pm	Notify Patient - Normal - By Provider	sjagannath	NOTIFY		sjagannath	pt. notified normal audiogram result
05/11/17 10:10am	Error Identified - Send back to REVIEW	sjagannath	REVIEW		sjagannath	
05/18/17 07:03pm	Delete	sjagannath	DELETED			
05/18/17 07:04pm	Reopen - Send to previous status/assigned	sjagannath	REVIEW		sjagannath	
05/19/17 07:30pm		sjagannath	REVIEW		sjagannath STAFF	
06/01/17 07:06pm	Close - No more actions - file away	ekee1	CLOSED			

Lab Results

VISUAL ACUITY* 05/10/2017 (#860898, final, 05/10/2017 11:45am)

Report	Result	Ref. Range	Units	▲	Status	Lab	Date
R Eye Uncorrected	20/160						
L Eye Uncorrected	20/160						
R Eye Corrected	20/20						
L Eye Corrected	20/20						
Result Note	RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING: CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083						

Document History

Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/10/17 11:43am	New in-house result requires data entry	Igrayhat1	DATAENTRY		URGENT CARE CENTER STAFF	
05/10/17 12:56pm		Igrayhat1	DATAENTRY		ft sosie	
05/10/17 03:11pm	Data Entry Completed	ft sosie	REVIEW		sjagannath	
05/11/17 10:11am	Notify Patient - Normal - By Provider	sjagannath	NOTIFY		sjagannath	pt. notified normal visual acuity test result
05/11/17 12:20pm	Patient Notified	sjagannath	CLOSED			pt. notified normal visual acuity test

URINALYSIS, DIPSTICK 05/10/2017 (#860896)

Report	Result	Ref. Range	Units	△	Status	Lab	Date
Color	DARK YELLOW						
Appearence	CLEAR						
Glucose	negative						
Bilirubin	negative						
Ketone	positive						
Specific Gravity	<1.030						
pH	5.5						
Protein	negative						
Urobilinogen	1.0						
Nitrite	negative						
Blood	negative						
Leukocyte	positive						
Result Note	RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING: CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083						

Document History

Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/10/17 11:43am	New in-house result requires data entry	Igrayhat1	DATAENTRY		URGENT CARE CENTER STAFF	
05/10/17 11:51am	Data Entry Completed	ftsocie	REVIEW		sjagannath	
05/13/17 07:12pm	Notify Patient - Abnormal - By Provider	sjagannath	NOTIFY		sjagannath	left a message on the phone to call back for lab test.
05/13/17 07:54pm	Patient Notified	sjagannath	CLOSED			pt. notified abnormal urine test and advised to follow up pcp . notified on 05-13-2017

Lab Orders

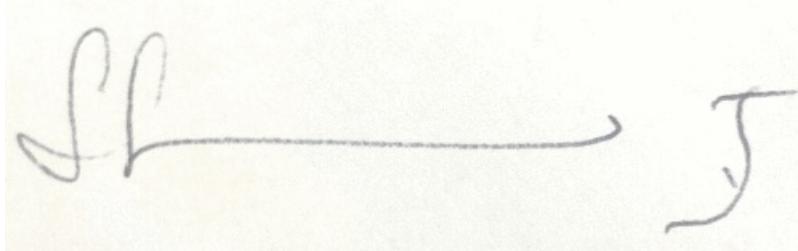
Lab Order

05/10/2017

Order To	Ordering Provider
REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES (RMCHCS LABS) 1909 RED ROCK DR GALLUP, NM 87301 Phone: (505) 863-7133 Fax: (505) 726-6714	SHOBHA JAGANNATH, NP URGENT CARE CENTER 520 NM HWY 564 GALLUP, NM 87301-4873 Phone: (505) 863-2273 Fax: (505) 722-3594

Order	
Orders included: 1	
Adult health examination ICD-10: Z00.00: Encounter for general adult medical examination without abnormal findings	
<ul style="list-style-type: none"> URINALYSIS, DIPSTICK BILL: Third Party 	
Patient Name	ADEKY, RONE
Sex - DOB - Age	F 10/02/1986 38yo
Address	PO BOX 14 PINEHILL, NM 87357
Phone	h: (505) 600-5650 w:
Primary Insurance	None recorded.
Secondary Insurance	None recorded.
Drawn by:	
Date/Time Drawn:	_____
Fasting?:	- None Needed - 8 HR - 12 HR
Other/Notes:	
CC:	

Electronically Signed by: SHOBHA JAGANNATH, NP



SHOBHA JAGANNATH, NP

Approved Date: 05/10/2017 11:44am

Document History

Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/10/17 11:43am	Create	Igrayhat1	REVIEW		sjagannath	
05/10/17 11:44am	Approve	Igrayhat1	PERFORM		URGENT CARE CENTER STAFF	Order Signed - Authorized by sjagannath
05/10/17 11:45am	Result Received	ATHENA	CLOSED			Result received as document 860896

Letters

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)



Urgent Care Center
520 NM HWY 564
GALLUP, NM 87301-4873
Phone: (505) 863-2273, Fax: (505) 722-3594

Date: 05/10/2017

Dear Rone Adeky,

The following is a summary of your visit today. If you have any questions, please contact our office.

Sincerely,

Electronically Signed by: SHOBHA JAGANNATH, NP

A handwritten signature in black ink, appearing to read "SJ".

Patient Care Summary for Rone Adeky

Most Recent Encounter

05/10/2017 Shobha Jagannath: 520 Nm Hwy 564, Gallup, NM 87301-4873, Ph. tel:+1-505-8632273

Reason for Visit

None recorded.

Assessment and Plan

The following list includes any diagnoses that were discussed at your visit.

1. History and physical examination, pre-employment

Discussion Note: None recorded.

Patient educational handouts: No information available.

Plan of Care

Reminders	Provider
Appointments	None recorded.
Lab	None recorded.
Referral	None recorded.
Procedures	None recorded.
Surgeries	None recorded.
Imaging	None recorded.

Current Medications

Your medical record indicates you are on the following medicine. If this list is not consistent with the medications you are currently taking, or if you are taking additional over-the-counter medicines, please inform your provider.

None recorded.

Medications Administered

None recorded.

Vitals

Height	Weight	BMI	Blood Pressure	Pulse	O2 Saturation	Temperature	Respiration Rate	Pain Scale Type	Pain Scale
5 ft 6 in	198.4 lbs	32	112/62	78 bpm regular	92% Room Air at Rest	97.7 F° temporal artery	18	Numeric	0

Lab Results

None recorded.

Allergies

Please review your allergy list for accuracy. Contact your provider if this list needs to be updated.

None recorded.

Problems

None recorded.

Procedures

Date	Name	Performed by
05/10/2017	Audiogram	Rehoboth McKinley Christian Health Care Services (Rmchcs Labs) 1909 Red Rock Dr Gallup, NM 87301 (505) 863-7133 (Work Place)

Vaccine List

Here is a copy of your most up-to-date vaccination list.

Vaccine Type

Tdap

05/10/2017 0.5 mL

Smoking Status

None recorded.

Past Encounters

05/10/2017

History and Physical Examination, Pre-employment

Shobha Jagannath, NP: 520 Nm Hwy 564, Gallup, NM 87301-4873, Ph. (505) 863-2273

Demographics

Sex:	Female	Ethnicity:	Not Hispanic or Latino
DOB:	10/02/1986	Race:	American Indian or Alaska Native
Preferred language:	English	Marital status:	Never Married

Contact: PO Box 14, Pinehill, NM 87357, Ph. tel:+1-505-6005650

Document History

Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/10/17 12:09pm	Create	sjagannath	REVIEW		sjagannath	
05/10/17 12:21pm	Approve - Notify by Portal	sjagannath	NOTIFY		PORTAL	
05/10/17 03:31pm	Notification Completed - By Portal	ATHENA	CLOSED			

Medical Record Documents

02/21/2011 08:15 5058637329

RMCH OCCUPT HLTH

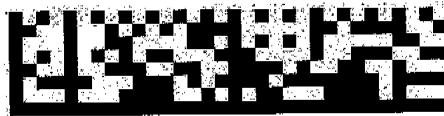
PAGE 01/09

Please place this one-time use coversheet at the BEGINNING of the document detailed below when faxing to athenahealth.

Document Information:

Patient Name	ADEKY, RONE
DOB	10/02/1986
Patient ID	45287
Document Class	Medical Record Document - Historical Medical Record
Fax to:	
First and Last Page Coversheets Printed:	05/25/2017
Information related to this document was added to athenaNet on	05/25/2017
The information was added by user	ekee1
# of pages (not including coversheet)	

FIRST PAGE



* 481428x11999

520 NM HWY 564
GALLUP, NM 87301-4873
Phone: (505) 863-2273, Fax: (505) 722-3594

This fax may contain legally privileged health information and is intended for the sole use of the intended recipient. You are hereby notified that the disclosure, or other unlawful use of this health information is prohibited.

If you received this fax in error visit www.athenahealth.com/NotMyFax to notify the sender and confirm that the information will be destroyed. If you do not have Internet access, please call 1-888-492-8436 to notify the sender and confirm that the information will be destroyed.
[ID:45287-A-11999]

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873**ADEKY, RONE (id #45280, dob: 10/02/1986)**520 NM HWY 564
GALLUP, NM 87301-4873
Phone: (505) 863-2273, Fax: (505) 722-3594

Date: 05/10/2017

Dear Rone Adeky,

The following is a summary of your visit today. If you have any questions, please contact our office.

Sincerely,

Electronically Signed by: SHOBHA JAGANNATH, NP



Patient Care Summary for Rone Adeky

Most Recent Encounter

05/10/2017 Shobha Jagannath: 520 Nm Hwy 564, Gallup, NM 87301-4873, Ph. tel:+1-505-8632273

Reason for Visit

None recorded.

Assessment and Plan

The following list includes any diagnoses that were discussed at your visit.

1. History and physical examination, pre-employment

Discussion Note: None recorded.

Patient educational handouts: No information available.

Plan of Care

Reminders	None recorded.
Appointments	None recorded.
Lab	None recorded.
Referral	None recorded.
Procedures	None recorded.
Surgeries	None recorded.
Imaging	None recorded.

02/21/2011 08:15 5058637329

RMCH OCCUPT HLTH

PAGE 03/09

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873**ADEKY, RONE (id #45280, dob: 10/02/1986)****Current Medications**

Your medical record indicates you are on the following medicine. If this list is not consistent with the medications you are currently taking, or if you are taking additional over-the-counter medicines, please inform your provider.

None recorded.

Medications Administered

None recorded.

Vitals

Height	Weight	BMI	Blood Pressure	Pulse	O2 Saturation	Temperature	Respiration Rate	Pain Scale Type	Pain Scale
5 ft 8 in	198.4 lbs	32	112/62	78 bpm regular	92% Room Air at Rest	97.7 F° temporal artery	18	Numeric	0

Lab Results

None recorded.

Allergies

Please review your allergy list for accuracy. Contact your provider if this list needs to be updated.

None recorded.

Problems

None recorded.

Procedures

Date 05/10/2017 Name Audiogram Performed by Rehoboth McKinley Christian Health Care Services (Rmchcs Labs)
1909 Red Rock Dr
Gallup, NM 87301
(505) 863-7133 (Work Place)

Vaccine List

Here is a copy of your most up-to-date vaccination list.

Vaccine Type

Tdap

05/10/2017 0.5 mL

Smoking Status

None recorded.

Past Encounters

05/10/2017

History and Physical Examination, Pre-employment
Shobha Jagannath, NP: 520 Nm Hwy 564, Gallup, NM 87301-4873, Ph. (505) 863-2273

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873**ADEKY, RONE (id #45280, dob: 10/02/1986)****Demographics**

Sex:	Female	Ethnicity:	Not Hispanic or Latino
DOB:	10/02/1986	Race:	American Indian or Alaska Native
Preferred language:	English	Marital status:	Never Married

Contact: PO Box 14, Pinehill, NM 87357, Ph. tel:+1-505-8005650

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

Document History

Date/Time	Action	Action By	Status	Secondary Status	Assigned To	Action Note
05/10/17 12:09pm	Create	sagannath	REVIEW		sagannath	
05/10/17 12:21pm	Approve - Notify by Portal	sagannath	NOTIFY		PORTAL	
05/10/17 03:31pm	Notification Completed - By Portal	ATHENA	CLOSED			

Order Groups

Order Group Summaries

Order Group on 05/10/2017 by JAGANNATH_SHOBA

Problems

Reviewed Problems

Medications

None recorded.

Allergies

Allergies not reviewed (last reviewed 05/10/2017)

Results / Interpretations

URINALYSIS, DIPSTICK

- Results:
 - Color: DARK YELLOW
 - Appearance: CLEAR
 - Glucose: negative
 - Bilirubin: negative
 - Ketone: positive
 - Specific Gravity: <1.030
 - pH: 5.5
 - Protein: negative
 - Urobilinogen: 1.0
 - Nitrite: negative
 - Blood: negative
 - Leukocyte: positive
- Result Note: RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING: CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083

VISUAL ACUITY

- Results:
 - R Eye Uncorrected: 20/160
 - L Eye Uncorrected: 20/160
 - R Eye Corrected: 20/20
 - L Eye Corrected: 20/20
- Result Note: RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING: CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083

Assessment / Plan**1. Adult health examination**

Z00.00: Encounter for general adult medical examination without abnormal findings

- URINALYSIS, DIPSTICK
- VISUAL ACUITY
- RHYTHM STRIP, EKG -

Note to Provider:

RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING:
CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083

- BOOSTRIX TDAP 2.5 LF UNIT-8 MCG-5 LF/0.5 ML INTRAMUSCULAR SUSPENSION - Tdap Site: Left Deltoid Qty: 0.5 mL Administered 05/10/2017 Perform Date: 05/10/2017

URINALYSIS, DIPSTICK

- Results:
 - Color: DARK YELLOW

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

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Return to Office

None recorded.

Other Orders

05/10/2017

From Provider	To Provider
SHOBHA JAGANNATH, NP RMCHCS URGENT CARE LLC 520 NM HWY 564 GALLUP, NM 87301-4873 Phone: (505) 863-2273 Fax: (505) 722-3594	REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES (RMCHCS LABS) 1909 RED ROCK DR GALLUP, NM 87301 Phone: (505) 863-7133 Fax: (505) 726-6714

Order Information

Order
Orders included: 1
Adult health examination ICD-10: Z00.00: Encounter for general adult medical examination without abnormal findings
• RHYTHM STRIP, EKG

Note to Provider:
RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING:
CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083

Patient Information

Patient Name	ADEKY, RONE
DOB	10/02/1986
Primary Insurance	None recorded.
Secondary Insurance	None recorded.

Electronically Signed by: SHOBHA JAGANNATH, NP

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

SHOBHA JAGANNATH, NP
Approved Date: 05/10/2017 7:44am

Document History

Date / Time	Action	Action By	Status	Priority	Assigned To	Action Notes
05/10/17 11:43am	Create	lgrayhat1	REVIEW		sjagannath	
05/10/17 11:44am	Approve	lgrayhat1	SUBMIT		URGENT CARE CENTER STAFF	Order Signed - Authorized by sjagannath
05/10/17 11:44am	Submit by Athena Fax	ATHENA	SUBMIT		ATHENAFAX	
05/10/17 11:45am	Submit by Athena Fax	lgrayhat1	SUBMIT		ATHENAFAX	
05/10/17 11:46am	Fax being sent	ATHENAFAX	SUBMITTED			
05/10/17 12:04pm	Fax delivery has been confirmed	ATHENAFAX	SUBMITTED			AthenaFax confirmed 1 page was sent to (505) 726-6714 on 05/10/2017 at 11:51:17 Eastern Time. The transmission took a total of 66 seconds.
05/17/17 03:19am	No response - Followup required	ATHENA	FOLLOWUP		URGENT CARE CENTER STAFF	
05/17/17 06:39pm	Close	lgrayhat1	CLOSED			

05/10/2017

From Provider	To Provider
SHOBHA JAGANNATH, NP RMCHCS URGENT CARE LLC 520 NM HWY 564 GALLUP, NM 87301-4873 Phone: (505) 863-2273 Fax: (505) 722-3594	REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES (RMCHCS LABS) 1909 RED ROCK DR GALLUP, NM 87301 Phone: (505) 663-7133 Fax: (505) 726-6714

Order Information

Order
Orders included: 1
Adult health examination ICD-10: Z00.00: Encounter for general adult medical examination without abnormal findings • VISUAL ACUITY

Patient Information

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

Patient Name	ADEKY, RONE
DOB	10/02/1986
Primary Insurance	None recorded.
Secondary Insurance	None recorded.

Electronically Signed by: SHOBHA JAGANNATH, NP



SHOBHA JAGANNATH, NP
Approved Date: 05/10/2017 11:44am

Document History

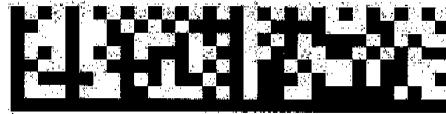
Date/Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/10/17 11:43am	Create	Igrayhat1	REVIEW		sjagannath	
05/10/17 11:44am	Approve	Igrayhat1	PERFORM		URGENT CARE CENTER STAFF	Order Signed - Authorized by sjagannath
05/10/17 11:45am	Result Received	ATHENA	CLOSED			Result received as document 860898

Please place this one-time use coversheet at the END of the document detailed below when faxing to athenahealth.

Document Information:

Patient Name	ADEKY, RONE
DOB	10/02/1986
Patient ID	45287
Document Class	Medical Record Document - Historical Medical Record
Fax to:	
First and Last Page Coversheets Printed:	05/25/2017
Information related to this document was added to athenaNet on	05/25/2017
The information was added by user	ekee1
# of pages (not including coversheet)	

LAST PAGE



* 481428y11999

520 NM HWY 564
GALLUP, NM 87301-4873
Phone: (505) 863-2273, Fax: (505) 722-3594

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Document History

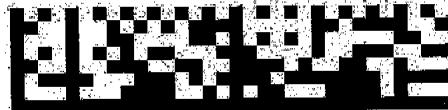
Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/25/17 06:40pm	Process document	ATHENA	UNPROCESSED		URGENT CARE CENTER STAFF	
05/25/17 06:40pm	Automatically classified by barcode - Classify and HOLD: only one barcode identified	BARCODE	HOLD		URGENT CARE CENTER STAFF	We are unable to locate a barcode on the last page of this document, so it has been classified based on the barcode found on the first page and put into HOLD. Please verify that the document has been classified correctly and includes the correct pages before sending it to REVIEW or CLOSED. If the document has extra pages at the end, please use the Process Document workflow to separate and process these pages.
05/29/17 12:01pm		ft sosie	HOLD		ekee1	
07/15/17 04:55pm	Close - No more actions necessary	ekee1	CLOSED			

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Document Information:

Patient Name	ADEKY, RONE
DOB	10/02/1986
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Fax to:	
First and Last Page Coversheets Printed:	05/25/2017
Information related to this document was added to athenaNet on	05/25/2017
The information was added by user	ekee1
# of pages (not including coversheet)	

FIRST PAGE



* 481428x11999

520 NM HWY 564
GALLUP, NM 87301-4873
Phone: (505) 863-2273, Fax: (505) 722-3594

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[ID:45287-A-11999]

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

05-10-17124 (16PM)

05-10-17224 (16PM) 80/ 82



RONE ADEKY DOB: 10/02/1986

DATE: 05/10/2017

RMCHCS URGENT CARE

PROVIDER: SHOBHA JAGGANATH, NP

URINE DIPSTICK RESULTS

Siemens
Clinitek Status

Serial Number: 64056

Patient Name: ADEKY RONE
Patient ID: 10/02/1986

B. JAG
Multistix 10 SG
Test date: 05-10-2017
Time: 10:27AM
Operator: LG
Test ID: 3845
Color: Dark yellow
Clarity: Clear

CLD Negative
BLD Negative
KET 15 mg/dL
SG: 1.020
BLD Negative
PH: 5.5
PRO Negative
URO 1.0 mg/dL
NIT Negative
LEU Trace

ADEKY, RONE (id #45280, dob: 10/02/1986)

02/21/2011 08:10 5058637329

RMCH OCCUPT HLTH

Page 52/125

PAGE 03/08

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

66-10-17; 04:16PMJ

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31 x 32

New Mexico Immunization Record Official Document																																																																																																																																																																			
Registro de Inmunización Documento Oficial																																																																																																																																																																			
<p>Name/Nombre: RONE K ADEKY</p> <p>Date of Birth/Fecha de Nacimiento: 10/02/1986</p> <p>Gender/Genero: F</p> <p>New Mexico WebIZ ID#: 835418</p> <p>Date of Next Vaccination/Fecha de Próxima Vacuna: 07/2017</p> <p>Present this record at each medical visit. Presente este documento durante sus visitas médicas.</p> <p>Immunization Provider: COLLEGE CLINICS PEDIATRICS 2111 COLLEGE DR. GALLUP, NM 87301 505-863-1691</p> <p>Allergies/Precuations/Contraindications: Alergias/Precuciones/Contraindicaciones:</p> <p>Vaccine Reactions / Reacciones contra Vacunas:</p> <p>Comments: Date Note</p> <p>Vaccines Refused:</p> <p>Date Note</p> <table border="1"> <thead> <tr> <th>Vaccine/Vacuna</th> <th>Date Given/ Fecha en la Ficha</th> <th>Age at time/ Edad cuando se dio</th> <th>Doctor or Clinic/ Doctor o Clínica</th> </tr> </thead> <tbody> <tr> <td>1 Influenza, P-Free</td> <td>11/01/2010</td> <td>34Y 0M 30D</td> <td>143708</td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>				Vaccine/Vacuna	Date Given/ Fecha en la Ficha	Age at time/ Edad cuando se dio	Doctor or Clinic/ Doctor o Clínica	1 Influenza, P-Free	11/01/2010	34Y 0M 30D	143708	2				3																																																																																																																																																			
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Document History

Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/10/17 04:29pm	Print Date 5/10/2017 11:40:42AM Classify document - Encounter Document - Procedure Documentation	BARCODE	CLOSED			Page 1 of 1

Imaging Results

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

AUDIOGRAM 05/10/2017 (#860903, 05/10/2017 10:26am)

Result Note	RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone (800) 638-8083
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Document History

Date/Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/10/17 11:43am	New in-house result requires data entry	lgrayhat1	DATAENTRY		URGENT CARE CENTER STAFF	
05/10/17 11:54am	Data Entry Completed	ftsosie	REVIEW		sjagannath	
05/10/17 05:53pm	Notify Patient - Normal - By Provider	sjagannath	NOTIFY		sjagannath	pt. notified normal audiomgram result
05/11/17 10:10am	Error Identified - Send back to REVIEW	sjagannath	REVIEW		sjagannath	
05/18/17 07:03pm	Delete	sjagannath	DELETED			
05/18/17 07:04pm	Reopen - Send to previous status/assigned	sjagannath	REVIEW		sjagannath	
05/19/17 07:30pm		sjagannath	REVIEW		sjagannath STAFF	

Lab Results

VISUAL ACUITY 05/10/2017 (#860898, final, 05/10/2017 11:45am)

Report	Results	Ref Range	Units	Avg	Status	Lab ID
R Eye Uncorrected	20/160					
L Eye Uncorrected	20/160					
R Eye Corrected	20/20					
L Eye Corrected	20/20					
Result Note	RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone (800) 638-8083					

Document History

Date/Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/10/17 11:43am	New in-house result requires data entry	lgrayhat1	DATAENTRY		URGENT CARE CENTER STAFF	
05/10/17 12:56pm		lgrayhat1	DATAENTRY		ftsosie	
05/10/17 03:11pm	Data Entry Completed	ftsosie	REVIEW		sjagannath	
05/11/17 07:11am	Notify Patient - Normal - By Provider	sjagannath	NOTIFY		sjagannath	pt. notified normal visual acuity test result
05/11/17 12:20pm	Patient Notified	sjagannath	CLOSED			pt. notified normal visual acuity test result

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

URINALYSIS, DIPSTICK 05/10/2017 (#860896)

Report	Result	Ref Range	Units	W	Status	Lab
Color	DARK YELLOW					
Appearance	CLEAR					
Glucose	negative					
Bilirubin	negative					
Ketone	positive					
Specific Gravity	<1.030					
pH	6.5					
Protein	negative					
Urobilinogen	1.0					
Nitrite	negative					
Blood	negative					
Leukocyte	positive					
Result Note	RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING CHS-FEDERAL FIREFIGHTERS [039577] 8810 ASTRONAUT BLVD, CAPE CANAVERAL, FL 32920-4239 phone (800) 638-8083					

Document History

Date/Time	Action	Entered By	Status	Entered By	Assigned To	Entered By
05/10/17 11:43am	New in-house result requires date entry	grayhall	DATA ENTRY		URGENT CARE CENTER STAFF	
05/10/17 11:51am	Data Entry Completed	itsosie	REVIEW		sjagannath	
05/13/17 07:12pm	Notify Patient - Abnormal - By Provider	sjagannath	NOTIFY		sjagannath	left a message on the phone to call back for lab test.
05/13/17 07:54pm	Patient Notified	sjagannath	CLOSED			pt. notified abnornal urine test and advised to follow up pcp. notified on 05-13-2017

Lab Orders

Lab Order

05/10/2017

Order To	Ordering Provider
REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES (RMCHCS LABS) 1909 RED ROCK DR GALLUP, NM 87301 Phone: (505) 863-7133 Fax: (505) 726-6714	SHOBHA JAGANNATH, NP URGENT CARE CENTER 520 NM HWY 564 GALLUP, NM 87301-4873 Phone: (505) 863-2273 Fax: (505) 722-3594

Order
Orders Included: 1
Adult health examination ICD-10: Z00.00: Encounter for general adult medical examination without abnormal findings

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

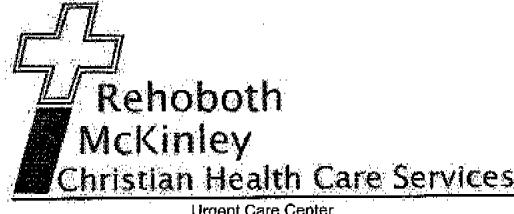
[e] URINALYSIS, DIPSTICK | BILL: Third Party

Patient Name	ADEKY, RONE
Sex - DOB - Age	F 10/02/1986 30yo
Address	PO BOX 14 PINEHILL, NM 87357
Phone	h: (505) 600-5650 w:
Primary Insurance	None recorded.
Secondary Insurance	None recorded.
Drawn by:	
Date/Time Drawn:	
Fasting?:	- None Needed - 8 HR - 12 HR
Other/Notes:	
CC:	

Electronically Signed by: SHOBHA JAGANNATH, NP

SHOBHA JAGANNATH, NP
Approved Date: 05/10/2017 11:44amDocument History

Date/Time	Action	Action By	Status	Priority	Assigned To	Comments	ACDID/Note
05/10/17 11:43am	Create	lgrayhat1	REVIEW		sjagannath		00000000000000000000000000000000
05/10/17 11:44am	Approve	lgrayhat1	PERFORM		URGENT CARE CENTER STAFF	Order Signed - Authorized by sjagannath	
05/10/17 11:45am	Result Received	ATHENA	CLOSED			Result received as document 860896	

Letters

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Document Information:

Patient Name	ADEKY, RONE
DOB	10/02/1986
Patient ID	45287
Document Class	Medical Record Document - Historical Medical Record
Fax to:	
First and Last Page Coversheets Printed:	05/25/2017
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The Information was added by user	ekee1
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520 NM HWY 564
GALLUP, NM 87301-4873
Phone: (505) 863-2273, Fax: (505) 722-3594

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Document History

Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
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05/25/17 06:38pm	Automatically classified by barcode - Classify and HOLD: only one barcode identified	BARCODE	HOLD		URGENT CARE CENTER STAFF	We are unable to locate a barcode on the last page of this document, so it has been classified based on the barcode found on the first page and put into HOLD. Please verify that the document has been classified correctly and includes the correct pages before sending it to REVIEW or CLOSED. If the document has extra pages at the end, please use the Process Document workflow to separate and process these pages.
05/29/17 12:01pm		ft sosie	HOLD		ekee1	
07/15/17 04:55pm	Close - No more actions necessary	ekee1	CLOSED			

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Document Information:

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Patient ID	45287
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Fax to:	
First and Last Page Coversheets Printed:	05/25/2017
Information related to this document was added to athenaNet on	05/25/2017
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RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

06-10-27X04 (Faxed)

505-722-45504 # 287 23



Rehoboth McKinley Christian Health Care Services

520 Highway 564 Gallup, NM 87301 P: (505)863-2273 F: (505)722-3594

Patient's Name: Rone Adeky Date: 5-10-17Date of Birth: 10-02-1986Company Name: CHS-Wildland Fire Fighter***OCCUPATIONAL HEALTH DEPARTMENT***

(MANUAL AUDIOMETRY)

IF NEEDED ONLY

	LEFT/DB	RIGHT/DB
1KHZ	00	05
500HZ	00	00
1000HZ	00	05
2000HZ	00	00
3000HZ	00	05
4000HZ	10	20
6000HZ	10	10
8000HZ	05	25

P2000

R4300 AUDIOMETER
TREMETRICS (C) 1996.
1997. 1998
DATE 05-10-17
TIME 10:26
TEST# 20 - 00147
SUBJECT:
J. K.
SSV1D4 010021986
CURRENT AUDIOTGRAM
DAILY BIOLOGICAL
FREQ. L/DB R/DB
1KHZ TEST 00 05
500HZ 00 00
1000HZ 00 05
2000HZ 00 00
3000HZ 00 05
4000HZ 10 20
6000HZ 10 10
8000HZ 05 25

MODE PULSED
SERIAL # 3664
VERSION 1.17
CAL. ANSI 1989 STD
CAL. DATE 02/17
EXAMINER SSV1D4
00000008
J. K.

SJ
5-10-17

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

00-104344-100

ADEKY, RONE (id #45280, dob: 10/02/1986)

02/21/2011 08:05 5058637329

RMCH OCCUPT HLTH

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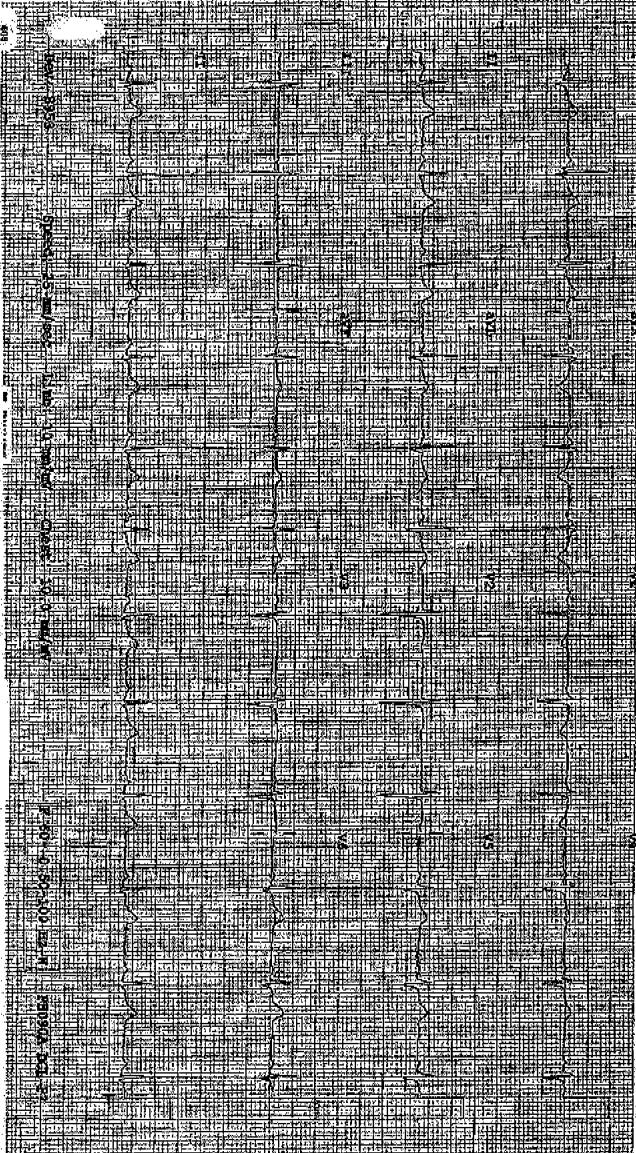
PAGE 04/08

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

06-10-17 (08:05PM)	
	
0509-7124-5694	# 281-82
36 years	36 years
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5/10/2011	12/18/98
SURGEON, PHYSICIAN, NURSE, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, NURSE, NURSE PRACTITIONER	NURSE, NURSE PRACTITIONER, PHYSICIAN, PHYSICIAN ASSISTANT, NURSE, NURSE PRACTITIONER
857	857
100	100
95	95
120	120
145	145
160	160
175	175
190	190
205	205
220	220
235	235
250	250
265	265
280	280
295	295
310	310
325	325
340	340
355	355
370	370
385	385
400	400
415	415
430	430
445	445
460	460
475	475
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744	

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

RMCHCS
OCCUPATIONAL
HEALTH DEPT
05-10-17104.118pmEspiOne® DIAGNOSTIC 5.2
© add 2000-2008
SN70798 RecNo 1239
05/10/07 1:58

Patient Information

Name: RONE ADEKY
 ID: 10021986
 Age: 30
 Height: 5ft. 2 in
 Weight: 198 lbs BM436.4
 Gender: FEMALE
 Ethnic: OTHER
 Smoker: NO
 Asthma: NO

Test Information

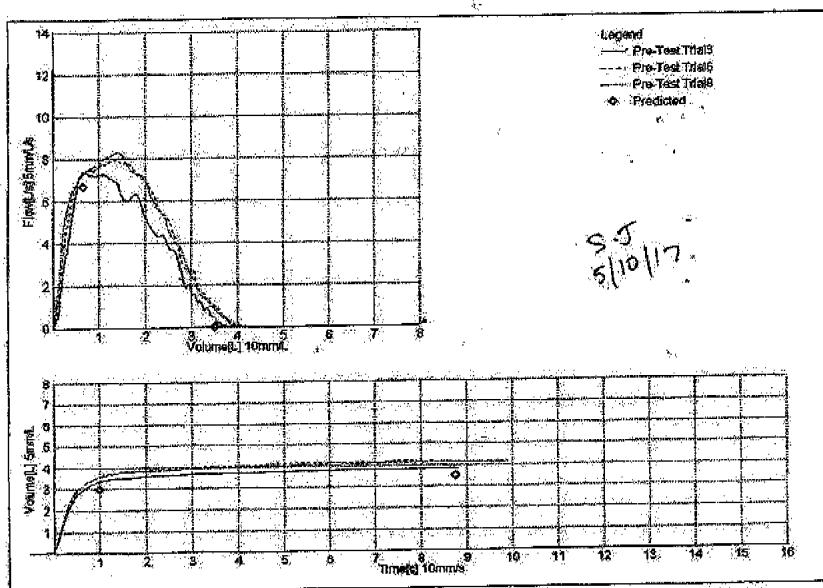
Test Date/Time: 05/10/07 1:52
 Post Test: →
 Test Mode: DIAGNOSTIC
 Interpretation: NL-HEP
 Predicted Ref: NHANES II* 1.00
 Value Selected: BEST VALUE
 Tech ID: ON
 Automated QC: BTPS (IN620)
 -/-1.02

Test Results

Your FEV1 is 114% Predicted

Parameter	Pre-Test	Best	Trial3	Trial6	Trial9	Pred	%Pred
FVC(L)	3.88	3.88	4.20	4.20	3.51	3.10	
FEV1(L)	3.39	3.39	3.68	3.68	2.98	1.14	
FEV1/FVC[%]	87.5	87.5	86.3	86.3	84.4	104	
PEF(L/min)	443.0	443.0	478.0	478.0	400.1	400.1	111
FEF25-75(L/s)	4.62	4.62	4.89	4.88	3.34	3.34	133
FET(s)	8.78	8.78	7.57	7.57	9.89	1.17	

Pre-Test: FEV1 Var=0.09L 0.0% FVC Var=0.01L 0.1% Session Quality D
 Interpretation: Normal, but the values shouldn't be used for comparisons with other tests.
 Caution: Only One Acceptable Maneuver - Interpret With Care.



ADEKY, RONE (id #45280, dob: 10/02/1986)

02/21/2011 08:05 5058637329

RMCH OCCUPT HLTH

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RMCHCS URGENT CARE LLC c 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

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Document Information:

Patient Name	ADEKY, RONE
DOB	10/02/1986
Patient ID	45287
Document Class	Medical Record Document - Historical Medical Record
Fax to:	
First and Last Page Coversheets Printed:	05/25/2017
Information related to this document was added to athenaNet on	05/25/2017
The information was added by user	ekee1
# of pages (not Including coversheet)	

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* 481428y11999

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GALLUP, NM 87301-4873
Phone: (505) 863-2273, Fax: (505) 722-3594

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Document History

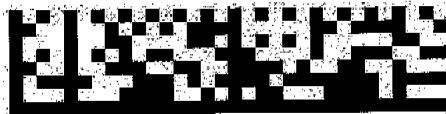
Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/25/17 06:33pm	Process document	ATHENA	UNPROCESSED		URGENT CARE CENTER STAFF	
05/25/17 06:33pm	Automatically classified by barcode - Classify and HOLD: only one barcode identified	BARCODE	HOLD		URGENT CARE CENTER STAFF	We are unable to locate a barcode on the last page of this document, so it has been classified based on the barcode found on the first page and put into HOLD. Please verify that the document has been classified correctly and includes the correct pages before sending it to REVIEW or CLOSED. If the document has extra pages at the end, please use the Process Document workflow to separate and process these pages.
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ADEKY, RONE (id #45280, dob: 10/02/1986)

COMPREHENSIVE
HEALTH SERVICES, INC.

505-732-4684 6-227-321

BASELINE Exam

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P303	Spirometry (3 tracings)	878611	Adeky, Rone

TO BE COMPLETED BY TECHNICIAN BEFORE SPIROMETRY IS PERFORMED:

1. How does examinee feel today? Well Sick
2. Does examinee have a history of any of the following:
- a) Heart attack within the past month Yes No
 - b) Chest or abdominal pain Yes No
 - c) Oral or facial pain that is aggravated by the spirometry mouthpiece Yes No
3. Has examinee:
- a) Had a severe respiratory illness or ear infection in the past three weeks? Yes No
 - b) Smoked cigarettes, pipes or cigars within the last hour? Yes No
 - c) Used any inhaled medications, such as an aerosolized bronchodilator within the last hour? Yes No
 - d) Had any eye, ear, chest or abdominal surgery in the past two months? Yes No
 - e) Eaten a heavy meal in the last hour? Yes No

SPIROMETER:

Daily calibration performed today? Yes No *If NO, last calibration date: _____Machine make/model: Diagnostic/EasyOne Test performed by: (Please print) Lydia Grayhat
Model: 2001

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ADEKY, RONE (id #45280, dob: 10/02/1986)

**BASELINE Exam**

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P303 (Cont'd)	Spirometry (3 tracings)	27841	Adeky, Rone

SPIROMETRY:

Must complete at least 3 attempts. Attach all tracings with time/volume and flow/volume loops for each attempt. Please complete all information.

Examinee position: Standing (preferred) Sitting (if history of fainting or illness)

Examinee effort: Good Fair Poor

Ht: 5'5 in. Wt: 194 lbs. Age: 30 Gender: Male Female

Race/Ethnicity: Caucasian African American Hispanic Asian Other

Two largest FEV1 and FVC efforts do not vary by more than 150 mL or 0.15 liter

Invalid test; does not meet ATS criteria for repeatability or acceptable flow curves.
(Please explain below why a valid test could not be completed at this time)

Test not performed at this time (Please explain below why test was not performed)

ADEKY, RONE (id #45280, dob: 10/02/1986)

02/21/2011 08:02 5058637329

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ADEKY, RONE (id #45280, dob: 10/02/1986)

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ADEKY, RONE (id #45280, dob: 10/02/1986)

COMPREHENSIVE
HEALTH SERVICES, INC.

Exam Procedure	Procedure Name	Exam ID	Examiner Name
P201D	Audiogram - Decibel Loss with Threshold	278611	Adeky, Rone

AUDIOGRAM RESULTS: Please note decibel tested at each frequency per ear.

FREQUENCY (Hz)	500	1000	2000	3000	4000	6000	8000
Right Ear	00	05	00	05	20	10	25
Left Ear	00	00	00	00	10	10	05

 All printouts attached. If not, please explain why?

--

Exam Procedure	Procedure Name	Exam ID	Examiner Name
P900UD	Urine Dip		

Test Used: Multistix 10SG LOT#: 610089 Expiration Date: 04/30/2018

RESULTS:

URINALYSIS (DIPSTICK) SP GRAVITY: 1.020 PROTEIN: Negative GLUCOSE: Negative BLOOD: Negative

SHOBHA JAGANNATH
Medical Provider Name (Please print)
 MD/DO PA NP

SHOBHA JAGANNATH
Signature

05/10/17
Date

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

COMPREHENSIVE
HEALTH SERVICES, INC.

BASELINE Exam

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P900	Blood Draw	Q78U11	Adeky, Rone

Fasting is NOT required for this component

(Please do not send examinee away. If non-fasting mark box below)

Fasting Non-fasting

Collector's Name: Felicia Tysie CCMA (Please print) Date of Collection: 05/10/17

Units Collected:

Tiger or Red top tube. Please spin for 20 minutes after letting sit for 30 minutes.

LC519967 CMP12+Lp+7AC LabCorp Clinical Code -

2ML - Serum (preferred) - Gel-Barrier tube (send entire tube, filled)

Lavender-top (EDTA) tube. No spin needed, however must invert a few times.
 LC5009 CBC With Differential/Platelet-
 LabCorp Clinical Code - 0.2 ML
 (send entire tube, filled)

Specimens sent to: (labs must be sent the day of collection)

 LabCorp by LabCorp Courier LabCorp by FedEx via Air Bill. Please provide tracking # _____

Note: include copy of Lab requisition along with exam documents and fax to CHSI.

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ADEKY, RONE (id #45280, dob: 10/02/1986)

COMPREHENSIVE
HEALTH SERVICES, INC.

BASELINE Exam

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P002	Physical Exam with History Review and Visual Acuity	278611	Adeky, Rone
<input type="checkbox"/> Gait or balance abnormality <input checked="" type="checkbox"/> Tremor <input type="checkbox"/> Other Document abnormal findings 9. Spine/Neck and Back Are there any spine/neck or back abnormalities noted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Surgical scar <input type="checkbox"/> Deformity of scoliosis <input type="checkbox"/> Difficulty changing positions <input type="checkbox"/> Assistive device - cane, crutches, walker, wheelchair, etc.			
SPINE/NECK AND BACK- Abnormal range of motion (see table below for details) Document abnormal findings 10. SKIN Are there any skin abnormalities noted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Possible skin cancer <input type="checkbox"/> Other Document abnormal findings			
STRENGTH & RANGE OF MOTION		NORMAL	DETAILS IF ABNORMAL
Neck		<input checked="" type="checkbox"/>	
Spine/Back		<input checked="" type="checkbox"/>	
Shoulders/Arms		<input checked="" type="checkbox"/>	
Elbow/Forearm		<input checked="" type="checkbox"/>	
Wrist/Hand		<input checked="" type="checkbox"/>	
Hip/Thigh		<input checked="" type="checkbox"/>	
Knee		<input checked="" type="checkbox"/>	
Feet/Ankle		<input checked="" type="checkbox"/>	

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ADEKY, RONE (id #45280, dob: 10/02/1986)

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COMPREHENSIVE
HEALTH SERVICES, INC.

BASELINE Exam

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P010	Purified Protein Derivative (PPD) Medically Indicated Component	278011	Adeky, Rone

Examinee Instructions: Only if Examinee answered YES to any HIGH Risk Screening Questions Administer TB Skin test.
(PPD): Examinee is not to return to clinic for a PPD read.

1. Administer PPD and give examinee copy of this form. (results will be read off site).
2. Instruct examinee to have read done within 48-72 hours, and fax completed form to CHSI at 703-760-0890.

<input type="checkbox"/> PPD applied <input type="checkbox"/> PPD contraindicated	Date applied: _____	Date read: _____
	Applied by: _____	Read by: _____
	Manufacturer: _____	mm of induration: _____
	Lot No.: _____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Exp. Date: _____	Note: For firefighters per NPPA, 5 mm increase previous reading occurring within last two years is considered positive.

Examinee Instructions:

1. Have PPD results read within 48-72 hours.
2. Results may be read by EMT, RN, LPN or self-read. Do not return to the facility for PPD read.
3. Return results page to CHSI at 1-703-261-1821 or WLEFD@chsmmedical.com
 (Failure to return PPD results within 5 days will result in a NOT Qualified status)

Interpreting a PPD test reaction

- * Read between 48 and 72 hours after injection.
 - If examinee shows up later than 72 hours and test is negative, PPD should be repeated in 1-3 weeks.
 - * Read the induration across the forearm, perpendicular to the long axis of the arm.
- ≥ 5 mm is positive if:**
- ✓ Known or suspected HIV infection ✓ Close contact with infectious TB ✓ Use injectable drugs
 - ✓ CXR suggestive of previous TB or recent TB infection within last 2 years
- ≥ 10 mm is positive if:**
- ✓ Certain medical conditions, excluding HIV – drug abuse, diabetes, cirrhosis, prolonged treatment with steroids or other immunosuppressant, cancer, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndromes, low body weight (> 10% below ideal)
 - ✓ Medically underserved populations ✓ Long term facility residents
 - ✓ Children under 4 years of age ✓ Per NPPA: Fire rescue and EMS personnel
 - ✓ Locally identified high prevalence groups (migrants, homeless, etc.)
- ≥ 15 mm is positive if no known risk factors for TB**
 If a history of receiving BCG vaccine, a positive reaction is more likely due to TB infection vs. the vaccine if:
- ✓ The induration is large ✓ Received BCG a long time ago
 - ✓ Recent contact with infectious TB ✓ Family history of TB
 - ✓ Comes from area where TB is common ✓ CXR shows evidence of previous TB
 - ✓ Per NPPA: 5 mm increase from previous reading occurring within last two years

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ADEKY, RONE (id #45280, dob: 10/02/1986)

06-10-19100-110362 4508472249694 # 18 / 32

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BASELINE Exam

Exam Procedure	Procedure Name	Exam Id	Examinee Name
P301	Resting EKG - Tracing Required	2784611	Adeky, Rone

Interpretation: Normal Abnormal (provide details below) Tracings attached

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BASELINE Exam

Exam Procedure	Procedure Name	Exam Id	Examiner Name
TD or TDa	Tetanus-Diphtheria (Td), or Tetanus-Diphtheria-Pertussis (Tdap) Immunization	2184611	Adeky, Rone

Medically Indicated Component/Optional:

Has the examinee received a Tetanus shot in the last 10 years?

- Yes (provide copy of immunization record if provided) No (administer immunization and not medically indicated).

- Examinee declines to receive Tetanus immunization (to be checked by facility if declined).

Vaccine	Type	Site	Vaccine		Vaccine Information Statement (VIS)		Vaccinator (Initials & Title)
			Lot#	Mfr	Date On VIS	Date Given	
<input type="checkbox"/> Tetanus, diphtheria (Td)	Inactivated Bacterial	IM	Y97AY	GlaxoSmithKline	03/23/16	05/01/17	FT CCMA
<input checked="" type="checkbox"/> Tetanus, diphtheria, acellular pertussis (Tdap)		IM					

Please attach any other records if received at the time of the appointment.

** If provided or presented a yellow Immunization card, please update, copy and return to the examinee. Include copy with exam packet returned to CHS. Immunization records are not required. This immunization is optional.

ADEKY, RONE (id #45280, dob: 10/02/1986)

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05-10-17124 (16PM) 505472249894 217 32

COMPREHENSIVE
HEALTH SERVICES, INC.

BASELINE EXAM

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P106	Vision - Peripheral Vision	278411	Adeky, Rone

LATERAL VISUAL FIELDS BY CONFRONTATION (in degrees) – see instructions below.

Please circle best LATERAL (TEMPORAL) visual field for each eye.

NOTE: If less than 65° for either eye, please repeat.RIGHT

0° 10° 25° 40° 55° 70° 85° >90°

LEFT

0° 10° 25° 40° 55° 70° 85° >90°

Repeated:

RIGHT

0° 10° 25° 40° 55° 70° 85° >90°

LEFT

0° 10° 25° 40° 55° 70° 85° >90°

Face examinee at eye level no more than arm's length apart:

1. To measure right eye temporal visual field:
 - a. Ask examinee to stare directly at examiner's nose and cover left eye.
 - b. Slowly move finger or small object from behind right ear in arc approaching right eye, asking examinee to indicate when seen; circle estimated degrees of arc for right eye using nose as zero point (0°).
2. Repeat step 1 for left eye with right eye covered to measure left eye temporal field.

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ADEKY, RONE (id #45280, dob: 10/02/1986)

06-10-17 (04-115761)

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127 82



Comprehensive
Health Services

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www.chsmedical.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WE ARE REQUIRED BY LAW TO:

- Make sure medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

WHO IS REQUIRED TO ABIDE BY THIS NOTICE?

- Any healthcare professional authorized to enter information into your medical record.
- All employees, staff, and other healthcare personnel who make up the CHS workforce.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

- We may use medical information about you to provide you with medical treatment or services.
- We may disclose, with your signed permission, medical information about you necessary for your care at our facility and for examination results.
- We may also disclose, with your written permission, medical information about you to persons outside our facility who assist with decision making regarding your health issues.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT COMPREHENSIVE HEALTH SERVICES
AT 800-638-8083 or 888-636-8619 Option 2.

Rone R Adeky

Examinee Name (Please Print)

A handwritten signature in black ink, appearing to read "Rone R Adeky".

5/10/17

Date

ADEKY, RONE (id #45280, dob: 10/02/1986)

02/21/2011 07:55 5058637329

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ADEKY, RONE (id #45280, dob: 10/02/1986)

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www.chimedical.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Examinee's Name Rone K Adeky Date 5/10/17

Address P.O. Box 47 Pine Hill NM 87347

Telephone 505-600-5650 Birth Date 10/02/186

1. I hereby authorize the assigned medical facility to release all medical information associated with this examination to Comprehensive Health Services, Inc.
2. I hereby authorize Comprehensive Health Services, Inc. to release all medical information associated with this examination to Department of Interior.

Company Name(s) and Address:

Comprehensive Health Services, Inc.
8810 Astronaut Blvd.
Cape Canaveral, FL 32920

Department of Interior
Wildland Firefighter Medical Standards
National Interagency Fire Center
3833 S. Development Ave. (Bldg. 106)
Boise, ID 83705

3. I understand this consent can be revoked at any time, except for any disclosure already made in good faith, in reliance on this consent.
4. The facility, its employees and officers, and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed Rone K Adeky

5/10/17

Date of Signature

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ADEKY, RONE (id #45280, dob: 10/02/1986)

COMPREHENSIVE
HEALTH SERVICES, INC.

BASELINE Exam

Exam Procedure	Procedure Name	Exam ID	Examinee Name
P002	Physical Exam with History Review and Visual Acuity	218611	Adeky, Rone

TB QUESTIONNAIRE SCREENING

ANSWER THE FOLLOWING QUESTIONS AT EXAM

Has the examinee ever had a skin test for TB?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If yes, when? / 3 month/year	
Has the examinee ever had a positive TB skin test? If Yes - Do Not Administer PPD	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes, did examinee take antibiotic (INH) for 3-6 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Has the examinee ever been treated for active TB? If Yes - Do Not Administer PPD	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
HIGH RISK SCREENING Questions - Administer PPD skin test ONLY if one of the answers below is YES (answer all questions)	
Has the examinee had recent close or prolonged contact with someone with infectious TB disease?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the examinee a foreign-born person from or recent traveler to high-prevalence areas as identified by Center for Disease Control?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Has the examinee had chest radiographs with fibrotic changes suggesting inactive or past TB?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Does the examinee have an HIV infection?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the examinee an organ transplant recipient?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Does the examinee have immunosuppression secondary to use of prednisone (equivalent of ≥15 mg/day for ≥1 month) or use other immunosuppressive medication such as TNF-α antagonists?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the examinee an injection drug user?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the examinee of a high-risk congregate setting (e.g., prison, long term care facility, hospital, homeless shelter)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Does the examinee have any medical conditions associated with risk of progressing to TB disease if infected (e.g., diabetes mellitus, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, and end-stage renal disease; intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight [10% or more below ideal for given population])?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Has the examinee had symptoms of TB within the last 6 months like coughing up blood for 2-3 weeks, OR one or more of the following: chronic cough, chronic fatigue, fever >100, soaking night sweats, unexplained weight loss?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Administer TB skin test (PPD)

ONLY if examinee answers YES to any of the HIGH Risk Screening Questions AND the examinee has never had a positive skin test or has not been treated for active TB.

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)



BASELINE Exam

Exam Procedure	Procedure Name	Exam Id	Examinee Name
P002	Physical Exam with History Review and Visual Acuity	27861	Adeky, Rone

HEIGHT	5' 0" (in.)	WEIGHT	104 (lbs.)	BMI	32	PULSE	78
Blood Pressure	120/70 (repeat if > 140/90)						<input type="checkbox"/> BP remains > 140/90

VISION							
DISTANT	UNCORRECTED	R20/100 L20/100	C20/100	CORRECTED	R20/20 L20/20	S20/20	
NEAR:	UNCORRECTED	R20/20 L20/20	S20/20	CORRECTED	R20/20 L20/20	S20/20	

(Note: Examinees wearing glasses or contacts, BOTH uncorrected & corrected screenings MUST be performed)

COLOR VISION: Recognizes Basic Colors (R.G.Y) Normal Abnormal

PLEASE REVIEW WITH EXAMINEE AND DOCUMENT ANY ABNORMAL FINDINGS IN THE FIELDS PROVIDED

EYES

1. Are there any eye abnormalities noted?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> Strabismus	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Scleral (choris or Conjunctival Pallor	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Abnormal Fundi	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Unequal Pupils	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Conjunctival Pallor	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
Document abnormal findings	

MOUTH, EARS, OR NOSE/ OROPHARYNX

2. Are there any mouth, ears or nose abnormalities noted?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> Lesion (possible cancer)	
<input type="checkbox"/> Septal Perforation	
<input type="checkbox"/> Gingivitis or Dental Disease	
<input type="checkbox"/> TM Perforation	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Cerumen Impaction	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Other	
Document abnormal findings	

PULMONARY

3. Is there any SOB, dyspnea or coughing at rest abnormalities noted? (check all that apply)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> Wheezes	<input type="checkbox"/> Inspiratory crackles/rales, rhonchi, or coarse breath sounds
<input type="checkbox"/> Right- does not clear with cough	<input type="checkbox"/> Left- does not clear with cough
<input type="checkbox"/> Other (please specify)	
Document abnormal findings	

CARDIOVASCULAR

4. Are there any cardiovascular abnormalities noted?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> Murmur- systolic or diastolic, grade, intensity, location	

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ADEKY, RONE (id #45280, dob: 10/02/1986)



BASELINE Exam

Exam Procedure	Procedure Name	Exam Id	Examiner Name
P002	Physical Exam with History Review and Visual Acuity	Z78411	Adeky, Rone

 Other abnormal sounds (rubs, etc.) Surgical scar(s) - Thoracotomy, sternotomy, etc.

Document abnormal findings

ABDOMEN

5. Are there any abdominal abnormalities noted?

 Yes No Ascites Enlarged spleen Tenderness or mass Bruit Hernia (check all that apply) Inguinal Ventral Umbilical Not Reducible Tender Ostomy

Document abnormal findings

MALES

6. Are there any testicular abnormalities noted?

 Yes No

Document abnormal findings

FEMALES

7. When was the last menstrual period

Date:(MM/DD/YYYY) 03/12/2012

Document abnormal findings

EXTREMITIES

Are there any extremity abnormalities noted?

 Yes No Cyanosis Clubbing Varicosities Edema or swelling Absent or diminished pulses Deformities or atrophy

*** EXTREMITIES - Abnormal/range of motion (See table below for details)***

Document abnormal findings

8. NEUROLOGICAL

 Yes No

Are there any neurological abnormalities noted?

 Sleeping or dozing off in waiting room Sensory deficit Motor deficit Asymmetric or abnormal DTRs

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ADEKY, RONE (id #45280, dob: 10/02/1986)

06-16-17184 (Revised)

1505-72240564

A 8X 32

Do you have or have you ever had any of the following?

1. Diabetes or elevated blood sugar Yes No
2. Thyroid gland disorder Yes No
3. Adrenal or pituitary gland disorder Yes No
4. Low blood sugar or hypoglycemia Yes No

Please Explain ANY YES answers to Endocrine questions: (include dates).

19 - HEMATOLOGIC OR BLOOD IMMUNE SYSTEM**Do you have or have you ever had any of the following?**

1. Anemia Yes No
2. Leukemia Yes No
3. Low platelets Yes No
4. Bleeding disorder or coagulopathy, including hemophilia Yes No
5. Easy bruising Yes No
6. Sickle cell disease or trait, other hemoglobin variant Yes No
7. Enlarged spleen or splenectomy Yes No
8. Immune disorder or infection, including HIV Yes No
9. Myasthenia gravis Yes No
10. Lupus Yes No
11. Vaccine or Immunization intolerance or allergy Yes No
12. Hereditary engorgedema Yes No

Please Explain ANY YES answers to Hematologic questions: (include dates).

Select your gender then complete section "20 - FEMALES ONLY" or "21 - MALES ONLY".

Female Male **20 - FEMALES ONLY****Do you have or have you ever had any of the following?**

1. Severe Menstrual Cramps or Heavy Bleeding Yes No
2. Chronic Pelvic or Abdominal Pain Yes No
3. Gynecological Surgery Yes No
4. Gynecological Cancer Yes No
5. Ectopic Pregnancy Yes No

Please Explain ANY YES answers: (include dates).

21 - MALES ONLY**Do you have or have you ever had any of the following?**

1. Prostate disease or cancer Yes No

Please Explain ANY YES answers: (include dates).

22 - MEDICATIONS

1. Do you currently use an inhaler? Yes No

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#5058637324-9804

107 32

2. List all current medications and reason for taking. Please type 'None' if not applicable.

 None Yes No

3. Do you take anabolic steroids or growth hormones?

 Yes No

4. Over the counter, supplements, herbal medications?

 Yes No

5. Do you experience any side effects from any medication?

 Yes No**23 - TOBACCO USE**

1. Tobacco Use

 Yes No**24 - ALCOHOL AND DRUG USE**

1. Do you drink alcohol?

 Yes No

If yes, what is the average number of drinks per week? 3

2. Have you had or do you have alcoholism, drug or alcohol dependency or abuse?

 Yes No

3. Do you use illegal drugs?

 Yes No

4. Are you currently using someone else's prescription medication?

 Yes No

Please Explain ANY YES answers to any Alcohol or Drug questions. (Include dates)

societly.

25 - ALLERGY (MEDICATION, BEES, OTHER)

1. Allergy (medication, bees, other)

 Yes No**26 - SURGERY OR HOSPITALIZATION**

1. Any Surgery or Hospitalization?

 Yes No

2. Any health changes since last medical evaluation or exam?

 Yes No

3. Ever received a permanent disability rating?

 Yes No

4. Do you have an active workers compensation claim related to a work-related injury, illness, or exposure?

 Yes No

5. Do you have current medical or physical work restrictions?

 Yes No

I hereby certify that the above answers are complete and accurate to the best of my knowledge.

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8810 Astronaut Blvd., Cape Canaveral, FL 32920

Wildland Firefighters, Tower Climbers, Structural Firefighters **BASELINE** Medical Examination Facility and Physician Instructions/Checklist

This applicant has been authorized for a Medical Exam with this affiliated Comprehensive Health Services clinic. Please conduct the appointment according to the instructions that follow below. Any test or procedure not authorized by CHS will be the patient's responsibility for payment.

- Check candidate identification by picture ID.

- Have the candidate complete Medical Questionnaire Form, if they did not do this prior to coming for the appointment.
IF THE BOLDED QUESTIONS ARE ANSWERED THEN QUESTIONNAIRE HAS BEEN FILLED OUT PRIOR TO ARRIVAL...DO NOT MAKE EXAMINEE ANSWER SUBSEQUENT.

- Have the candidate read and sign the "Notice of Privacy Practices" and "Authorization for Release of Medical Information" forms.

- Nurse to do vital signs – height, weight, BMI, pulse and blood pressure (Repeat B/P if greater than 140/90). Record on Page 1, the P002 (Examination) Form.

- Perform Vision Acuity. Record results on Page 1, the P002 (Examination) Form. (Note: examinee wearing glasses or contacts, both uncorrected and corrected screenings must be performed).

- Color vision Examinee needs to recognize basic Red, Green, and Yellow. Document on Page 1.

- Provider(MD, DO, NP, or PA) to perform Physical Exam and record results on Pages 1 - 12 of the P002 (Examination) Form.

- Provider (MD, DO, NP, or PA) to review candidate's Medical History via the Health Questionnaire and note on Examination form, any information Provider wants to relay to medical reviewer.

- * All positive responses must be explained; include whether or not the examinee has had any complications and if he/she still experiences any problems from the condition. (Include Dates for all noted past surgeries, Injuries and Illnesses).

- * Complete and review all information.

- Administer PPD ONLY if Medically indicated by a YES answer to HIGH RISK screening Questions on Page 4. If PPD is medically indicated, administer PPD, give examinee a copy of page 5. Instruct examinee to provide CHS with PPD results within 72 hours.

- Perform EKG and attach the tracing – Record Results on Page 6.

- Administer Tetanus Booster if medically indicated (optional simply indicate if examinee declines) and record on Page 7.

- Utilize Page 8 as work sheet for Vision Peripheral testing. If less than 85% vision in either eye, please repeat.

- Utilize Page 9 and 10 for Spirometry Testing and results & signature. Technician must conduct at least 3 trials. (Provide the tracing printout)

- Perform audiogram: Please indicate decibel examinee heard for each frequency at the top of page 11. (Include printout if available)

Lab Specimen Collection:

- Collect Urine specimen and perform the Urine Dip Stick Test at clinic/not sent to LabCorp) – Record Results on Page 11.
- Collect Blood (see Lab Requisition), Record Collection of Specimens and Fasting or NON-fasting status on Page 12.
- Place blood specimen and test request forms in the Lab-Pak provided. Contact LabCorp on day of collection for specimen pick up. Failure to appropriately complete the requisitions may be cause for the tests to be rejected by the laboratory.

IF YOU DO NOT HAVE A RE-OCCURRING LABCORP PICK-UP AT YOUR FACILITY, PLEASE CALL (800) 833-9984 (OPTION 5) TO GET THE NUMBER OF A LABCORP COLLECTOR IN YOUR AREA.

- If remote and only use FedEx for blood delivery, note the tracking number used on page 12.

Please Note: NO ADDITIONAL TESTS OR PROCEDURES ARE AUTHORIZED (Chest X-rays, Cardiac, etc.)

Fax: Please fax all results and completed forms to CHS at 703-761-0850 on the same day of the examination.

Reminder: All laboratory specimens are to be forwarded to LabCorp the same day as the collection. Be certain to include the appropriately completed laboratory requisition forms.

Questions: If you have any additional questions please call Comprehensive Health Services, Inc. at (888) 636-4619 press option 2 for the CHS Wild Land Fire Fighter Representative.

PLEASE BE SURE TO COMPLETE EACH FORM IN ITS ENTIRETY

Updated 06/10/2015

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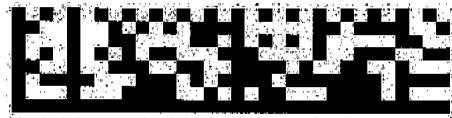
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06-10-17134119861

1806+72243594 4 6/ 82

Do you have or have you ever had any of the following:

- Yes No

Please Explain ANY YES answers to Heart questions:

8 - HYPERTENSION (HIGH BLOOD PRESSURE)

- Yes No
- Yes No
- Yes No
- Yes No

Please Explain ANY YES answers to Hypertension questions: (include dates)

9 - VASCULAR (CLOTS, CIRCULATION)

Do you have or have you ever had any of the following?

- Yes No

Please Explain ANY YES answers to Vascular questions: (include dates)

10 - GASTROINTESTINAL (STOMACH, BOWELS)

Do you have or have you ever had any of the following?

- Yes No

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08-10-17 04:16PM

ID 5058637329/246594 Date 7/7/08

6. **Pancrictitis** Yes No
 7. Bleeding in the stomach or bowels Yes No
 8. Blood in stool or vomited blood Yes No
 9. Ulcers Yes No
 10. Surgery (gastrointestinal) Yes No
 11. Cancer (gastrointestinal) Yes No
 12. Any dietary intolerance, special diet, or allergy? Yes No

Please Explain ANY YES answers to Gastrointestinal questions: (include dates)

11 - LIVER

1. Have you ever had hepatitis from any cause? Yes No
 2. Do you have cirrhosis? Yes No
 3. Have you ever had jaundice (yellow skin) other than infancy? Yes No

Please Explain ANY YES answers to Liver questions: (include dates)

12 - HERNIAS

Do you have or have you ever had any of the following?

1. Inguinal (groin); surgery advised or have had surgery Yes No
 2. Abdominal (ventral or umbilical); surgery advised or have had surgery Yes No
 3. Femoral (thigh, inguinal or groin); surgery advised or have had surgery Yes No

Please Explain ANY YES answers to Liver questions: (include dates)

13 - URINARY (KIDNEY, URETER, OR BLADDER)

Do you have or have you ever had any of the following?

1. Renal (kidney) failure Yes No
 2. Dialysis Yes No
 3. Difficulty passing urine Yes No
 4. Frequent urinating (more than once an hour) Yes No
 5. Nocturia or need to urinate at night Yes No
 6. Surgery on missing kidney Yes No
 7. Recurrent urine infections Yes No
 8. Kidney stones Yes No
 9. Excess urine protein or Nephrotic Syndrome Yes No

Please Explain ANY YES answers to Urinary questions: (include dates)

14 - EXTREMITIES (ARMS, LEGS)

Do you have or have you ever had any of the following?

1. Amputation or prosthesis Yes No
 2. Other orthopedic surgery Yes No
 3. Deformity or chronic pain Yes No

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Please Explain ANY YES answers to deformity or chronic pain questions: (include dates)

15 - NECK OR SPINE

Do you have or have you ever had any of the following?

1. Neck or spine surgery Yes No
2. Fractures Yes No
3. Chronic back or neck pain or loss of motion Yes No
4. Require assistive device with cane, crutches, walker, or wheelchair Yes No
5. Herniated disc Yes No
6. Scoliosis Yes No

Please Explain ANY YES answers to Neck or Spine questions: (include dates)

16 - JOINTS OR ARTHRITIS

Do you have or have you ever had any of the following?

1. Any kind of arthritis (rheumatoid, degenerative, gout, etc.) Yes No
2. Joint pain or swelling, loss of motion Yes No
3. Rotator cuff problems (shoulder) Yes No
4. Surgery or joint replacement Yes No

Please Explain ANY YES answers to Joint or Arthritis questions: (include dates)

17 - NEUROLOGICAL (BRAIN, NERVES)

Do you have or have you ever had any of the following?

1. Seizures or epilepsy Yes No
2. Brain or skull surgery Yes No
3. Concussion or loss of consciousness from hitting head Yes No
4. Syncope or fainting Yes No
5. Bleeding in brain Yes No
6. Stroke or TIA Yes No
7. Problem with dizziness, balance or coordination Yes No
8. Numbness or tingling in hands or feet Yes No
9. Difficulty sensing hot or cold with hands or feet Yes No
10. Weakness in arms or legs Yes No
11. Peripheral neuropathy from any cause Yes No
12. Multiple sclerosis Yes No
13. Muscular dystrophy Yes No
14. Migraines Yes No
15. Cancer (brain) Yes No

Please Explain ANY YES answers to Neurological (Brain, Nerves) questions: (include dates)

18 - ENDOCRINE (DIABETES, THYROID, ETC.)

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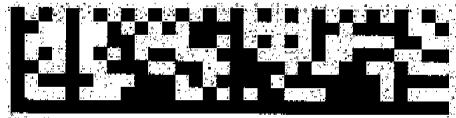
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RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

OS-194-172041-189M1

4506-722-9664

27 82

TIME: 10:00 amDATE: 5/10/17**PATIENT REGISTRATION INFORMATION****OCCUPATIONAL HEALTH DEPT.****PATIENT INFORMATION**

Patient Name: Rone Adeky Birthdate: 10/02/86 Age: 30
Patient Social Security #: 505-26-0578 Phone: 505-260-5252 SEX: M
Address: P.O. Box 14 City: Pine Hill State: NM ZIP: 87347
Email Address: 1Kayla@msn.com Marital Status: Single Ethnicity/Race: Native American
Emergency Contact: 3march heroic Adeky Phone: 505-270-8776

COMPANY (BILLING) INFORMATION:

Company/Employer: OTS Wildland Fire Fighter Phone: _____
Billing Address: _____ City: _____ State: _____ ZIP: _____
Contact Person (DER/Safety Officer): _____ Phone: _____

SERVICES REQUESTED (PLEASE CHECK):**PHYSICALS**

DOT
 NON-DOT

DRUG SCREENS

DOT
 NON-DOT
 (SELF-PAY) DRUG SCREEN

OTHER TESTING

BREATH ALCOHOL

Notes:

Physical, TDAP, Vision, Audio, EKG, PFT, Blood work,
UA Dipstick.

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

ID: 50586373294 * 3/2/2011



COMPREHENSIVE HEALTH SERVICES, INC.

Exam Authorization:
2786111

6810 Astronaut Boulevard • Suite 145 • Cape Canaveral, FL 32920 • Phone: (800) 838-8083

WLER

This authorization is only valid for the date of exam.

The person below has an appointment on 3/10/2011 at Watkin. This form serves as your authorization to perform the following services. If this person does not show, please indicate below, and fax back to CHS.

INVOICE INFORMATION

THE EXAMINEE IS NOT RESPONSIBLE FOR PAYMENT

Forward all invoices in accordance with instructions in your provider agreement. If you are performing services for CHS through an agreement with a national provider, please send your invoice to them for payment processing. If you have any questions regarding invoicing CHS for services rendered, contact our Quality Assurance Department at 1-866-532-1211.

Rehaboth McKinley Health Care Services		
820 Highway 564		NM - 106
Gallup, NM 87301-5600		Phone: 505-863-2272 Fax: 505-863-7329
Examinee Information:	ADEKY, RONE	BIAN/LAA
	Pinehill, NM 87387-0014	WLFF/BSAE

- Did not attend the scheduled aptt.
 Rescheduled - Must have CHS authorization

DO NOT BILL THE EXAMINEE

Please forward all test results to 703-760-0890 as soon as the exam is completed.
Non-receipt of complete information will delay payment.

	Completed	Not Performed
I001A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
P002	<input checked="" type="checkbox"/>	<input type="checkbox"/>
P010	<input type="checkbox"/>	<input checked="" type="checkbox"/>
P109	<input checked="" type="checkbox"/>	<input type="checkbox"/>
P201D	<input checked="" type="checkbox"/>	<input type="checkbox"/>
P301	<input checked="" type="checkbox"/>	<input type="checkbox"/>
P303	<input checked="" type="checkbox"/>	<input type="checkbox"/>
P900	<input checked="" type="checkbox"/>	<input type="checkbox"/>
P900UD	<input type="checkbox"/>	<input type="checkbox"/>

* Not Performed - For any procedure not performed, please provide the reason



ADEKY, RONE

E 2 7 8 6 1 1 1 E

D 6 8 2 1 0

ADEKY, RONE (id #45280, dob: 10/02/1986)

02/21/2011 07:46 5058637329

RMCH OCCUPT HLTH

Page 109/125

PAGE 04/08

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

05-19-17 04:15PM

4509472243694 42 22

Exam Procedure	Procedure Name	Exam ID	Examinee Name
EQ103	WLFF/TCS/PF Health Questionnaire Form	2796111	ADEKY, RONE

- Complete the Health Questionnaire prior to your exam appointment.
- Bring supporting medical documentation (if applicable) to any YES responses.
- Bring contact lenses or eyeglasses (if applicable) for the eye exam portion of exam.
- If you wear glasses or contacts ensure readily tests your vision both with and without them.
- Please bring photo ID to exam appointment.

1 - TUBERCULOSIS (TB)

1. Have you ever had a skin test for TB? Yes No
When: 08/05/2016 (MM/DD/YYYY)
2. Have you ever had a positive TB skin test? Yes No
3. Have you ever been treated for active TB? (more than just a positive skin test) Yes No
4. Have you had symptoms of TB within the last 6 months like coughing up blood for 2-3 weeks; OR one or more of the following: chronic cough, chronic fatigue, fever >100, soaking night sweats, unexplained weight loss?

Please Explain ANY YES answers to TB questions: (include dates).

been tested

2 - MENTAL HEALTH

1. Have you had any hospitalizations or rehabilitation for mental health issues? Yes No
2. Do you have anxiety, depression, panic disorder, or schizophrenia? Yes No
3. Do you have PTSD? Yes No
4. Do you have Claustrophobia or Fear of Heights? Yes No
5. Do you have any mental health conditions requiring prescription medication?

Please Explain ANY YES answers to Mental Health questions: (include dates).

3 - VISION

1. Do you wear corrective lenses? Yes No
2. Do you wear contacts? Yes No
If yes: (select one) Soft Hard Tinted
3. Do you wear corrective lenses during firefighting? Yes No
4. If required, are you willing to carry a duplicate pair of corrective lenses or contact lenses while firefighting? Yes No
5. Have you had any eye surgeries? Yes No
6. Are you color blind or do you have optic neuritis? Yes No
7. Do you have night blindness, double vision or other vision issues? Yes No
8. Do you have or have you ever had either partial or complete loss of vision? Yes No
9. Do you have difficulty seeing distance or problems with depth perception? Yes No

Please Explain ANY YES answers to Vision questions:

N/A

4 - EARS, NOSE, AND THROAT

ADEKY, RONE (id #45280, dob: 10/02/1986)

02/21/2011 07:46 5058637329

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PAGE 06/08

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ADEKY, RONE (id #45280, dob: 10/02/1986)

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

06-10-121041.16661

JU5G5192249884 * 87 82

1. Do you have any type of ear disease or hearing loss? Yes No
2. Do you get any ringing in the ear? Yes No
3. Have you ever had any type of ear surgery? Yes No
4. Do you use any protective hearing equipment when working around loud noises? Yes No
5. Are you in a hearing conservation program? Yes No
6. Have you ever had an eardrum perforation? Yes No
7. Do you have vertigo, dizziness, tinnitus (ringing in ears), or Meniere's Disease? Yes No
8. Do you have a cochlear implant? Yes No
9. Do you have nosebleeds (recurrent or severe - requiring medical care)? Yes No
10. Do you have Tumors or polyps? Yes No
11. Do you have Allergic Rhinitis? Yes No
12. Have you had ear/nose/throat surgery, other than minor or childhood? Yes No
13. Do you have dental problems, gingivitis, or oral appliances? Yes No

Please Explain ANY YES answers to Ears, Nose, and Throat questions:

5 - SKIN

1. Do you have skin cancer? Yes No
2. Do you have albinism or other genetic conditions? Yes No
3. Do you have eczema, psoriasis, contact dermatitis or allergic dermatitis? Yes No
4. Do you have folliculitis or cystic acne? Yes No
5. Cysts or abscesses requiring surgery? Yes No
6. Do you have urticaria, hives or scleroderma? Yes No

Please Explain ANY YES answers to Skin questions:

6 - LUNGS

Do you have or have you ever had any of the following:

1. Shortness of breath, wheezing or persistent cough? Yes No
2. Asthma; COPD, emphysema, or chronic bronchitis? Yes No
3. Lung Cancer Yes No
4. Sarcoidosis Yes No
5. Pulmonary embolism (clot in lungs) Yes No
6. Collapsed lung Yes No
7. Pulmonary hypertension Yes No
8. Lung Surgery Yes No
9. Loud snoring or pauses in breathing while asleep Yes No
10. Fall asleep easily during the day Yes No
11. Sleep disorder, sleep apnea, narcolepsy or ever advised to use CPAP? Yes No

Please Explain ANY YES answers to Lung questions:

7 - HEART

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DOB	10/02/1986
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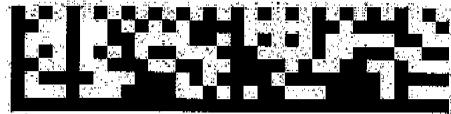
Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/25/17 06:13pm	Process document	ATHENA	UNPROCESSED		URGENT CARE CENTER STAFF	
05/25/17 06:13pm	Automatically classified by barcode - Classify and HOLD: only one barcode identified	BARCODE	HOLD		URGENT CARE CENTER STAFF	We are unable to locate a barcode on the last page of this document, so it has been classified based on the barcode found on the first page and put into HOLD. Please verify that the document has been classified correctly and includes the correct pages before sending it to REVIEW or CLOSED. If the document has extra pages at the end, please use the Process Document workflow to separate and process these pages.
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07/15/17 05:02pm	Close - No more actions necessary	ekee1	CLOSED			

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ADEKY, RONE (id #45280, dob: 10/02/1986)

Medical Records - CONFIDENTIAL

From: NM - RMCHCS
To: URGENT CARE CLINIC CHART
Name: ADEKY, RONE
DOB: 10/02/1986

Date Range: 01/01/2017 to 05/25/2017

This document contains the following records of the patient:

- Encounters and Procedures
- Encounter Documents
- Imaging Results
- Lab Results
- Lab Orders
- Letters
- Order Groups
- Other Orders

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ADEKY, RONE (id #45280, dob: 10/02/1986)

Encounters and Procedures

Clinical Encounter Summaries

Encounter Date: 05/10/2017 (Amendment closed by SHOBHA JAGANNATH, NP on 05/10/2017 at 12:40pm)

Amendment closed by SHOBHA JAGANNATH, NP on 05/11/2017 at 7:37pm

Amendment closed by SHOBHA JAGANNATH, NP on 05/18/2017 at 6:35pm

Last amended by SHOBHA JAGANNATH, NP on 05/18/2017 at 6:48pm)

Patient

Name ADEKY, RONE (30yo, F) ID# 45280 Appt. Date/Time 05/10/2017 10:50AM
 DOB 10/02/1986 Service Dept. URGENT CARE CENTER
 Provider SHOBHA JAGANNATH, NP
 Insurance Med Contracts: CHS-FEDERAL FIREFIGHTERS
 Insurance #: 10021986
 Prescription: ORX - Member is eligible, details

Chief Complaint

None recorded.

Vitals

Ht: 5 ft 6 in 05/10/2017 11:18 am	Wt: 198.4 lbs 05/10/2017 11:18 am	BMI: 32 05/10/2017 11:18 am
BP: 112/62 sitting L arm 05/10/2017 11:18 am	Pulse: 78 bpm regular 05/10/2017 11:18 am	RR: 18 05/10/2017 11:18 am
O2Sat: 92% Room Air at Rest 05/10/2017 11:18 am	T: 97.7 F° temporal artery 05/10/2017 11:19 am	Pain Scale: 0 05/10/2017 11:19 am

Allergies

Reviewed Allergies

Medications

None recorded.

Vaccines

Reviewed Vaccines

Vaccine	Type	Date Rec'd	Antibody	Dose	Site	Location	Manufacturer	Expiry Date	Expiry Date	Refillable	Refill Date	Refill Expiry	Refill Expiry Date
Diphtheria, Tetanus, Pertussis													
Tdap		05/10/17	0.5 mL	Intramuscular	Left Deltoid	YG7AY	GlaxoSmithKline	03/23/19	02/24/15	05/10/17	Felicia Tsosia, Med Assistant		

Problems

Reviewed Problems

Family History

Reviewed Family History

Social History

Reviewed Social History

Surgical History

Reviewed Surgical History

GYN History

Reviewed GYN History

Obstetric History

Reviewed Obstetric History

Past Medical History

Reviewed Past Medical History

HPI

here for pre-employment physical exam

RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)**ROS**

Patient reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no dry eyes, no vision change, and no irritation. She reports no difficulty hearing and no ear pain. She reports no frequent nosebleeds, no nose problems, and no sinus problems. She reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, and no teeth problems. She reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, no known heart murmur, and no leg swelling. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no nausea, no vomiting, no constipation, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, no heartburn, and no black or tarry stools (melena). She reports no incontinence, no difficulty urinating, no hematuria, and no increased frequency. She reports no muscle aches, no muscle weakness, no arthralgias/joint pain, no back pain, and no swelling in the extremities. She reports no abnormal mole, no jaundice, no rashes, and no laceration. She reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, and no tremor. She reports no depression, no sleep disturbances, feeling safe in a relationship, no alcohol abuse, no anxiety, no hallucinations, and no suicidal thoughts. She reports no fatigue. She reports no swollen glands, no bruising, and no excessive bleeding. She reports no runny nose, no sinus pressure, no itching, no hives, and no frequent sneezing.

Physical Exam

Patient is a 30-year-old female.

Constitutional: General Appearance: healthy-appearing, well-nourished, and well-developed. Level of Distress: NAD. Ambulation: ambulating normally.

Psychiatric: Insight: good judgement. Mental Status: normal mood and affect and active and alert. Orientation: to time, place, and person. Memory: recent memory normal and remote memory normal.

Head: Head: normocephalic and atraumatic.

Eyes: Lids and Conjunctivae: no discharge or pallor and non-injected. Pupils: PERRLA. Corneas: grossly intact. EOM: EOMI. Lens: clear. Sclerae: non-icteric. Vision: peripheral vision grossly intact and acuity grossly intact.

ENMT: Ears: no lesions on external ear, EACs clear, TMs clear, and TM mobility normal. Hearing: no hearing loss. Nose: no lesions on external nose, septal deviation, sinus tenderness, or nasal discharge and nares patent and nasal passages clear. Lips, Teeth, and Gums: no mouth or lip ulcers or bleeding gums and normal dentition. Oropharynx: no erythema or exudates and moist mucous membranes and tonsils not enlarged.

Neck: Neck: supple, FROM, trachea midline, and no masses. Lymph Nodes: no cervical LAD, supraclavicular LAD, axillary LAD, or Inguinal LAD. Thyroid: no enlargement or nodules and non-tender.

Lungs: Respiratory effort: no dyspnea. Percussion: no dullness, flatness, or hyperresonance. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal, good air movement, and CTA except as noted.

Cardiovascular: Apical Impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR. Neck vessels: no carotid bruits. Pulses including femoral / pedal: normal throughout.

Abdomen: Bowel Sounds: normal. Inspection and Palpation: no tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended. Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hernia: none palpable.

Musculoskeletal: Motor Strength and Tone: normal tone and motor strength. Joints, Bones, and Muscles: no contractures, malalignment, tenderness, or bony abnormalities and normal movement of all extremities. Extremities: no cyanosis, edema, varicosities, or palpable cord.

Neurologic: Gait and Station: normal gait and station. Cranial Nerves: grossly intact. Sensation: grossly intact and monofilament test intact. Reflexes: DTRs 2+ bilaterally throughout. Coordination and Cerebellum: finger-to-nose intact and no tremor.

Skin: Inspection and palpation: no rash, lesions, ulcer, induration, nodules, jaundice, or abnormal nevi and good turgor. Nails: normal.

Back: Thoracolumbar Appearance: normal curvature.

Assessment / Plan

1. History and physical examination, pre-employment
Z02.1: Encounter for pre-employment examination

Return to Office

None recorded.

Amendment Sign-Off

Encounter signed-off by SHOBHA JAGANNATH, NP, 05/18/2017.

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

Encounter performed and documented by SHOBHA JAGANNATH, NP
Encounter reviewed & signed by SHOBHA JAGANNATH, NP on 05/10/2017 at 12:21pm
Amendment closed by SHOBHA JAGANNATH, NP on 05/10/2017 at 12:40pm
Amendment closed by SHOBHA JAGANNATH, NP on 05/11/2017 at 7:47pm
Amendment closed by SHOBHA JAGANNATH, NP on 05/18/2017 at 6:35pm
Amendment closed by SHOBHA JAGANNATH, NP on 05/18/2017 at 6:48pm

RMCHCS URGENT CARE LLC • 520 NM HWY 564, GALLUP NM 87301-4873

ADEKY, RONE (id #45280, dob: 10/02/1986)

06-174-172 (10-13-04M)

U5064722+9584 # 2/ 3

RMCHCS
OCCUPATIONAL
HEALTH DEPTEasyOne™ DIAGNOSTIC 5.2
© ndi 2000-2008
SN 707SS RadNo 1239
05/10/07 11:39

Patient Information

Name: RONE ADEKY
 ID: 10621986
 Age: 30
 Height: 6 ft. 2 in.
 Weight: 188 lbs. BMI 36.4
 Gender: FEMALE
 Ethnic: OTHER
 Smoker: NO
 Asthma: NO

Test Information

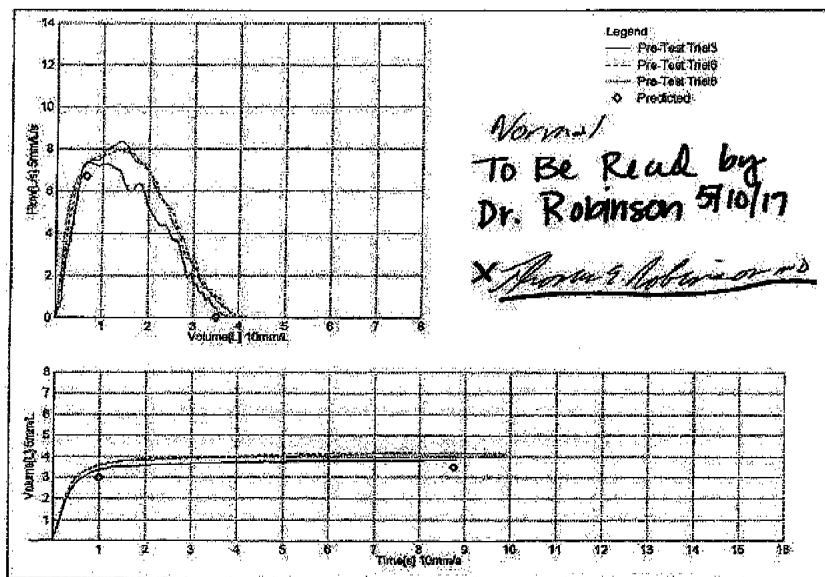
Test Date/Time: 05/10/07 11:52
 Post-Time: -
 Test Mode: DIAGNOSTIC
 Interpretation: NLHEP
 Predicted Ref: NHANES II* 4.00
 Value Select: BEST VALUE
 Tech ID: Automated (OC)
 Automation ID: BTPS (WEX)
 ON
 -1.02

Test Results

Your FEV1 is 114% Predicted.

Parameter	Pre-Test	Bst	Thres	Thresh	TestRef	Pred	%Pred
FVC(L)	3.89	3.89	4.20	4.20	3.51	110	
FEV1(L)	3.39	3.39	3.63	3.60	2.68	114	
FEV1/FVC(%)	87.5	97.5	86.3	85.8	84.4	104	
PEF(L/s)	443.9	443.9	476.0	476.0	400.1	111	
FEF25-75(L/s)	4.82	4.82	4.96	4.96	3.34	138	
FET(s)	0.76	0.76	0.77	0.76	-	-	

Pre-Test: FEV1 Var=0.03L 0.9% FVC Var=0.01L 0.1% Session Quality D
 Interpretation: Normal, but the values shouldn't be used for competitions with others less than 10 years old.
 Caution: Only One Acceptable Maneuver - Interpret With Care.



RMCHCS URGENT CARE LLC - 520 NM HWY 564, GALLUP NM 87301-4873**ADEKY, RONE (id #45280, dob: 10/02/1986)****Document History**

Date/Time	Action	Entered By	Status	Priority	Assigned To	Action Notes
05/17/17 10:43am	Process document	ATHENA	UNPROCESSED	LOW	URGENT CARE CENTER STAFF	
05/17/17 10:43am	Classify document- Encounter Document- Procedure Documentation	BARCODE	CLOSED	LOW		

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First and Last Page Coversheets Printed:	05/25/2017
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05/25/17 06:08pm	Process document	ATHENA	UNPROCESSED		URGENT CARE CENTER STAFF	
05/25/17 06:08pm	Automatically classified by barcode - Classify and HOLD: only one barcode identified	BARCODE	HOLD		URGENT CARE CENTER STAFF	We are unable to locate a barcode on the last page of this document, so it has been classified based on the barcode found on the first page and put into HOLD. Please verify that the document has been classified correctly and includes the correct pages before sending it to REVIEW or CLOSED. If the document has extra pages at the end, please use the Process Document workflow to separate and process these pages.
05/29/17 11:58am		ft sosie	HOLD		ekee1	
07/15/17 05:03pm	Close - No more actions necessary	ekee1	CLOSED			

Medication List

None recorded.

Order Groups

Order Group Summaries

Order Group on 05/10/2017 by JAGANNATH_SHOBA

Problems

Reviewed Problems

Medications

None recorded.

Allergies

Allergies not reviewed (last reviewed 05/10/2017)

Results / Interpretations

URINALYSIS, DIPSTICK

- Results:
 - Color: DARK YELLOW
 - Appearance: CLEAR
 - Glucose: negative
 - Bilirubin: negative
 - Ketone: positive
 - Specific Gravity: <1.030
 - pH: 5.5
 - Protein: negative
 - Urobilinogen: 1.0
 - Nitrite: negative
 - Blood: negative
 - Leukocyte: positive
- Result Note: RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING: CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083

VISUAL ACUITY*

- Results:
 - R Eye Uncorrected: 20/160
 - L Eye Uncorrected: 20/160
 - R Eye Corrected: 20/20
 - L Eye Corrected: 20/20
- Result Note: RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING: CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083

Assessment / Plan

1. Adult health examination

Z00.00: Encounter for general adult medical examination without abnormal findings

• URINALYSIS, DIPSTICK

• VISUAL ACUITY*

• RHYTHM STRIP, EKG* -

Note to Provider:

RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING:
CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083

• BOOSTRIX TDAP 2.5 LF UNIT-8 MCG-5 LF/0.5 ML INTRAMUSCULAR SUSPENSION - Tdap Site: Deltoid, Left Qty: (0.5) mL Administered on 05/10/2017 Perform Date: 05/10/2017

URINALYSIS, DIPSTICK

- Results:
 - Color: DARK YELLOW
 - Appearance: CLEAR
 - Glucose: negative
 - Bilirubin: negative
 - Ketone: positive
 - Specific Gravity: <1.030
 - pH: 5.5
 - Protein: negative
 - Urobilinogen: 1.0
 - Nitrite: negative
 - Blood: negative
 - Leukocyte: positive
- Result Note: RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING: CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083

VISUAL ACUITY*

- Results:
 - R Eye Uncorrected: 20/160
 - L Eye Uncorrected: 20/160
 - R Eye Corrected: 20/20
 - L Eye Corrected: 20/20
- Result Note: RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING: CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083

Return to Office

Patient will return to the office as needed.

Other Orders

From Provider	To Provider
SHOBHA JAGANNATH, NP RMCHCS URGENT CARE LLC 520 NM HWY 564 GALLUP, NM 87301-4873 Phone: (505) 863-2273 Fax: (505) 722-3594	REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES (RMCHCS LABS) 1909 RED ROCK DR GALLUP, NM 87301 Phone: (505) 863-7133 Fax: (505) 726-6714

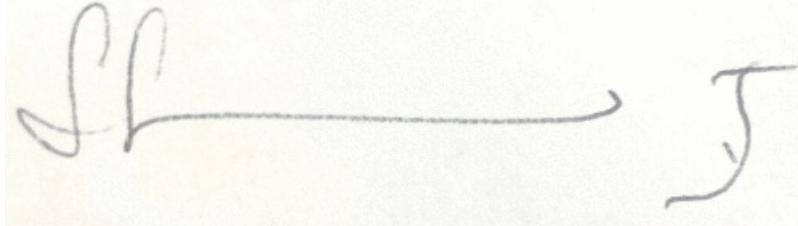
Order Information

Order
Orders included: 1
Adult health examination
ICD-10: Z00.00: Encounter for general adult medical examination without abnormal findings
• RHYTHM STRIP, EKG*
Note to Provider: RMCHCS URGENT CARE/OCCUPATIONAL HEALTH DEPT IS BILLING: CHS-FEDERAL FIREFIGHTERS [339577] 8810 ASTRONAUT BLVD , CAPE CANAVERAL, FL 32920-4239 phone:(800) 638-8083

Patient Information

Patient Name	ADEKY, RONE
DOB	10/02/1986
Primary Insurance	None recorded.
Secondary Insurance	None recorded.

Electronically Signed by: SHOBHA JAGANNATH, NP



SHOBHA JAGANNATH, NP
Approved Date: 05/10/2017 7:44am

Document History

Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/10/17 11:43am	Create	Igrayhat1	REVIEW		sjagannath	
05/10/17 11:44am	Approve	Igrayhat1	SUBMIT		URGENT CARE CENTER STAFF	Order Signed - Authorized by sjagannath
05/10/17 11:44am	Submit by Athena Fax	ATHENA	SUBMIT		ATHENAFAX	
05/10/17 11:45am	Submit by Athena Fax	Igrayhat1	SUBMIT		ATHENAFAX	
05/10/17 11:46am	Fax being sent	ATHENAFAX	SUBMITTED			
05/10/17 12:04pm	Fax delivery has been confirmed	ATHENAFAX	SUBMITTED			Athenafax confirmed 1 page was sent to (505) 726-6714 on 05/10/2017 13:51:17 Eastern Time. The transmission took a total of 66 seconds.
05/17/17 03:15am	No response - Followup required	ATHENA	FOLLOWUP		URGENT CARE CENTER STAFF	
05/17/17 06:39pm	Close	Igrayhat1	CLOSED			

From Provider	To Provider
SHOBHA JAGANNATH, NP RMCHCS URGENT CARE LLC 520 NM HWY 564 GALLUP, NM 87301-4873 Phone: (505) 863-2273 Fax: (505) 722-3594	URGENT CARE CENTER 520 NM HWY 564 GALLUP, NM 87301-4873 Phone: (505) 863-2273 Fax: (505) 722-3594

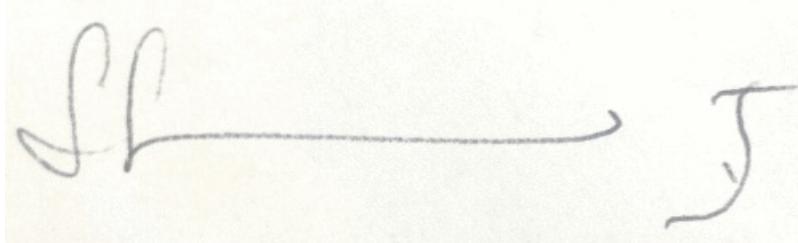
Order Information

Order
Orders included: 1
Adult health examination
ICD-10: Z00.00: Encounter for general adult medical examination without abnormal findings
• VISUAL ACUITY*

Patient Information

Patient Name	ADEKY, RONE
DOB	10/02/1986
Primary Insurance	None recorded.
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Electronically Signed by: SHOBHA JAGANNATH, NP



SHOBHA JAGANNATH, NP
Approved Date: 05/10/2017 11:44am

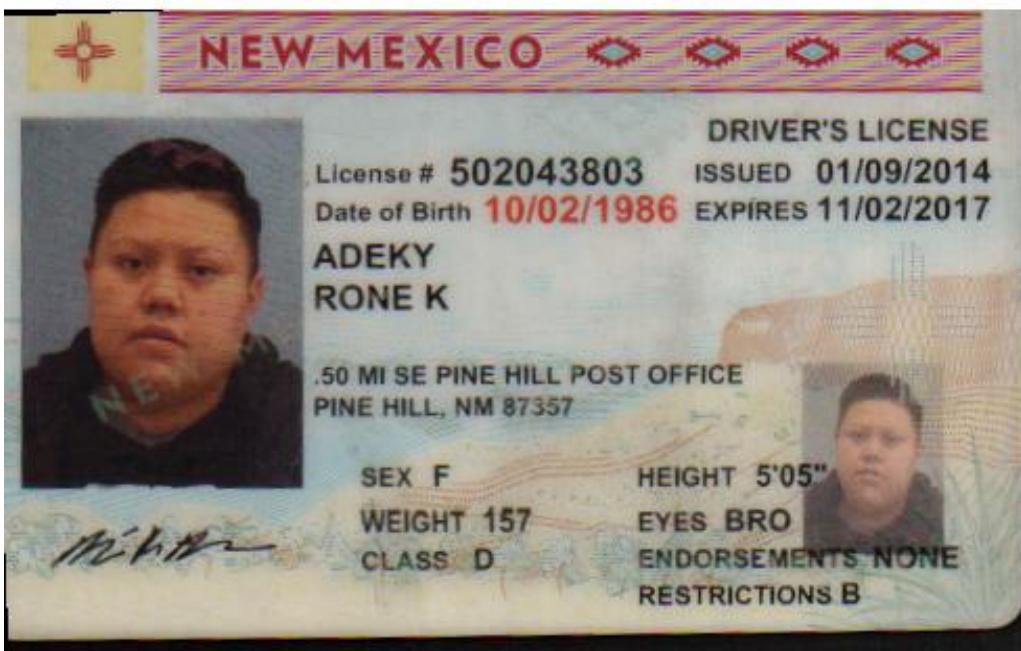
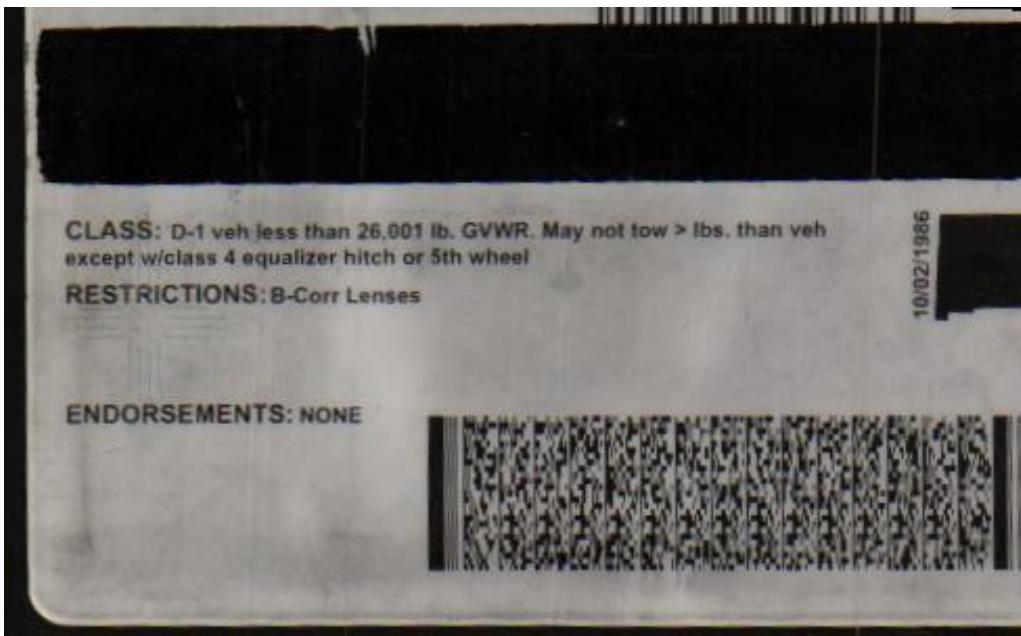
Document History

Date / Time	Action	Action By	Status	Priority	Assigned To	Action Note
05/10/17 11:43am	Create	Igrayhat1	REVIEW		sjagannath	
05/10/17 11:44am	Approve	Igrayhat1	PERFORM		URGENT CARE CENTER STAFF	Order Signed - Authorized by sjagannath
05/10/17 11:45am	Result Received	ATHENA	CLOSED			Result received as document 860898

Patient Photo ID

Upload Date

05-10-2017



Vaccination History

Vaccine	Type	Date	Amt.	Route	Site	NDC	Lot #	Mfr.	Exp. Date	Vis	Vis Given	Vaccinator
Diphtheria, Tetanus, Pertussis	Tdap	05/10/17	0.5 mL	Intramuscular	Deltoid, Left	YG7AY	GlaxoSmithKline	03/23/19	Tdap 02/24/2015	05/10/17	Felicia Tsosie, INACTIVE	