



FAX

Attn: Irwin Army Hospital
600 Caisson Hill Rd
Ft Riley KS 66442
Fax Number: 630-570-5779
Fax Date: 12/1/2020

From: Fatma A Radhi
Dept. MANHATTAN NEUROLOGY

Main HIM Fax: (785) 354-5413

CONFIDENTIAL

PLEASE NOTE: The information contained in this message and any accompanying document is privileged and confidential, intended solely for the use of the recipient(s) designated above. If you are not the intended recipient or an employee or agent responsible for delivering it to the intended recipient, you are hereby on notice that you are in possession of confidential and privileged information. Any dissemination, distribution or copying of this communication is strictly prohibited. Please notify the sender immediately by telephone of your inadvertent receipt and to receive instructions for returning the document to the sender.

Amieva, Yessenia (MRN 10243212)

Encounter Date: 11/30/2020

Yessenia Amieva11/30/2020 8:00 AM Initial consult
MRN: 10243212Department: Manhattan
Neurology
CSN: 1849367687Description: Female DOB:
5/19/1998
Provider: Radhi, Fatma A,
MD**Referring Provider**

Army Hospital Irwin

Reason for Visit**Seizures** has had only one, got it after a covid test, got light headed**Vitals**

Most recent update: 11/30/2020 8:16 AM

BP	Pulse	Wt
115/75 (BP Location: Left arm, Patient Position: Sitting, Cuff Size: Regular Adult)	72	171 lb 9.6 oz (77.8 kg)

Diagnoses

	Codes	Comments
Convulsions, unspecified convulsion type (HCC) - Primary	R56.9	

Allergies as of 11/30/2020Reviewed by Radhi, Fatma A, MD on
11/30/2020

No Known Allergies

Progress Notes**Radhi, Fatma A, MD at 11/30/2020 8:00 AM**

Status: Signed

COTTON O'NEIL NEUROLOGY - MANHATTAN1133 College Ave Bldg E
Manhattan KS 66502
785-537-2651**Patient: Yessenia Amieva****MRN: 10243212****DOB: 5/19/1998****PCP: Irwin, Army Hospital****Age: 22 y.o.****Referring: Irwin, Army Hospital****Sex: female****11/30/2020****NEUROLOGY NEW PATIENT VISIT****Subjective****Reason for Visit: Syncope and collapse****HPI**

Yessenia is a 22 years old female referred to our clinic for self-reported seizure event

On the end of August patient was going through the drive-through Covid 19 testing which is needed as a routine check. She did have the nasal swab and immediately felt lightheaded after that her husband said she was gasping for air and her whole body shook for few seconds then she tried to speak but nothing came up for Amieva, Yessenia (MRN 10243212) Printed by Radhi, Fatma A, MD [FRADHI] at 12/1/20 4:24 PM

Amieva, Yessenia (MRN 10243212)

Encounter Date: 11/30/2020

Progress Notes (continued)**Radhi, Fatma A, MD at 11/30/2020 8:00 AM (continued)**

few seconds then she woke up and in the first few seconds she was confused and did not know where she was but after that she was back completely to normal. Patient went to the emergency room after that and had MRI of the brain that we reviewed today which was normal. She also had EKG that showed normal sinus rhythm she also had normal CBC and CMP as per the referral documents

Patient previously had fainting events on 2 occasion 1 time when she was giving blood and another time when she received shots. Patient is concerned because her maternal grandfather had brain aneurysm

No history of brain concussion or childhood seizure disorder

Past Medical History

The patient has no past medical history on file.

No past surgical history on file.

Medication

No outpatient medications have been marked as taking for the 11/30/20 encounter (Initial consult) with Radhi, Fatma A, MD.

Allergies

No Known Allergies

Family History

The family history includes No Known Problems in her father and mother; Other in her maternal grandfather.

Social History

The patient reports that she has never smoked. She has never used smokeless tobacco. She reports that she does not drink alcohol or use drugs.

Patient's medications, allergies, past medical, surgical, social and family histories were reviewed and updated as appropriate.

ROS:**Review of Systems**

All other systems reviewed and are negative.

Objective**Visit Vitals**

BP 115/75 (BP Location: Left arm,
Patient Position: Sitting, Cuff
Size: Regular Adult)
Pulse 72
Wt 171 lb 9.6 oz (77.8 kg)

Amieva, Yessenia (MRN 10243212)

Encounter Date: 11/30/2020

Progress Notes (continued)**Radhi, Fatma A, MD at 11/30/2020 8:00 AM (continued)****Neurological Exam**

Well-developed and nourished lady looks in her stated age in no acute distress has normal mental status and speech and good fund of knowledge

Optic disc clear bilateral

Cranial Nerves:

II - PERRLA, VFFTc

III, IV, VI - EOMI without elicitation of pain/diplopia, physiologic end-gaze nystagmus.

V, VII - subtle right facial weakness

VIII - Hearing intact to voice; no primary or provoked nystagmus.

IX and X - Palate elevates symmetrically/uvula midline.

XI - SCM/Trap 5/5 bilaterally.

XII - Tongue midline on protrusion and AROM intact.

Motor:

Normal tone and bulk, no atrophy, no drift or fix.

Sensory :

Intact to pinprick bilaterally

Cerebellar: Normal coordination on finger nose test bilaterally**Gait:** normal

Upper:	Del	Tri	Bl	WE	WF	FE	FF	HI
Right	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5
Left	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5

Lower:	Hip F	Knee E		Knee F		ADF	APF	EHL
Right	5/5	5/5		5/5		5/5	5/5	5/5
Left	5/5	5/5		5/5		5/5	5/5	5/5

Reflexes:	Bic	BR	Tri	Pat	Ach	Plantar
Right	1	0	0	2		
Left	1	0	0	2		

Recent Labs

No lab results queried.

Assessment / Plan**Assessment****1. Convulsions, unspecified convolution type (HCC)**

Episode of syncopal convolution after nasal swab with previous episode of vasovagal syncope. We suspect Amieva, Yessenia (MRN 10243212) Printed by Radhi, Fatma A, MD [FRADHI] at 12/1/20 4:24 PM

Amieva, Yessenia (MRN 10243212)

Encounter Date: 11/30/2020

Progress Notes (continued)**Radhi, Fatma A, MD at 11/30/2020 8:00 AM (continued)**

patient has vasovagal syncope with syncopal convolution rather than epileptic convolution. So far work-up and neuro exam is unremarkable. Would like to obtain EEG to look for epileptiform activity but our clinical suspicion for seizure disorder is very low

Plan**Orders Placed This Encounter****Procedures**

- EEG awake or drowsy routine

#1 sleep deprived EEG

2. Follow-up as needed if there is any new neurologic events

No follow-ups on file.

Fatma A Radhi, MD*Electronically Signed*

11/30/2020 8:46 AM

Orders

Future Labs/Procedures	Expected by	Expires
EEG awake or drowsy routine [NEU15 Custom]	12/1/2020	11/30/2021

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AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.

AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.

PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.

ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.

DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.

This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial) <i>Amieva, Yessenica</i>	2. DATE OF BIRTH (YYYYMMDD) <i>19980519</i>	3. SOCIAL SECURITY NUMBER <i>595-75-1668</i>	
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD) <i>20201008 - 20201013</i>	5. TYPE OF TREATMENT (X one)		
	<input type="checkbox"/> OUTPATIENT	<input type="checkbox"/> INPATIENT	<input type="checkbox"/> BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE Irwin Army Community Hospital (Name of Facility/TRICARE Health Plan)		TO RELEASE MY PATIENT INFORMATION TO:		
a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS (Street, City, State and ZIP Code)			
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)			
7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable)				
<input type="checkbox"/> PERSONAL USE	<input type="checkbox"/> CONTINUED MEDICAL CARE	<input type="checkbox"/> SCHOOL	<input type="checkbox"/> OTHER (Specify) _____	
<input type="checkbox"/> INSURANCE	<input type="checkbox"/> RETIREMENT/SEPARATION	<input type="checkbox"/> LEGAL		

8. INFORMATION TO BE RELEASED

Please circle: MAIL or **PICK UP**

Please indicate what is needing to be placed on a disc: *MEI - Brain*

Disc QTY: /

9. AUTHORIZATION START DATE (YYYYMMDD) <i>20201013</i>	10. AUTHORIZATION EXPIRATION	11. ACTION COMPLETED
	<input type="checkbox"/> DATE (YYYYMMDD)	<input type="checkbox"/> ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:

- a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
- b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR § 164.524.
- d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE <i>[Signature]</i>	12. RELATIONSHIP TO PATIENT (If applicable)	13. DATE (YYYYMMDD) <i>20201013</i>
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SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

14. X IF APPLICABLE: <input type="checkbox"/> AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
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17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER: <i>786-348-8898</i>
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RECEIVED
OCT 13 2020

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CONTACT LENS PRESCRIPTION
VALID FOR ONE YEAR

(MEDICAL TREATMENT FACILITY)
Farrelly Optometry Clinic
8072 Normandy Dr
Ft. Riley KS 66442

NAME: Yessenia Amieva DATE: 10/13/2020

	Brand	BC	DIAM	Power
O.D.	Biofinity	8.6	14.0	-3.50
O.S.	Biofinity	8.6	14.0	-3.25

Rx

SPECIAL INSTRUCTIONS

DW only / 2 week repl

Cooper Vision

Russell

(Signature)

Russell W. Hart OD
KS 1396-3 (785) 240-5516

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

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ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.

DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.

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SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial) <i>Amieva, Yessenia</i>	2. DATE OF BIRTH (YYYYMMDD) <i>19980519</i>	3. SOCIAL SECURITY NUMBER <i>595-75-11068</i>
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD) <i>20201013 - 20201013</i>	5. TYPE OF TREATMENT (X one) <input checked="" type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input type="checkbox"/> BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE Farrelly Health Clinic, Optometry (Name of Facility/TRICARE Health Plan)		TO RELEASE MY PATIENT INFORMATION TO:	
a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION SELF	b. ADDRESS (Street, City, State and ZIP Code) <i>112 Silo Place, Manhattan KS 66502</i>		
c. TELEPHONE (Include Area Code) <i>786-316-8898</i>	d. FAX (Include Area Code)		

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable)

<input checked="" type="checkbox"/> PERSONAL USE	<input type="checkbox"/> CONTINUED MEDICAL CARE	<input type="checkbox"/> SCHOOL	<input type="checkbox"/> OTHER (Specify) LEGAL
<input type="checkbox"/> INSURANCE	<input type="checkbox"/> RETIREMENT/SEPARATION		

8. INFORMATION TO BE RELEASED

Prescription for optical devices written by: *Dr. Hart. Russell* on *20201013*

9. AUTHORIZATION START DATE (YYYYMMDD) <i>20201013</i>	10. AUTHORIZATION EXPIRATION <input type="checkbox"/> DATE (YYYYMMDD)	<input checked="" type="checkbox"/> ACTION COMPLETED
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SECTION III - RELEASE AUTHORIZATION

I understand that:

- I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
- If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
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I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE <i>[Signature]</i>	12. RELATIONSHIP TO PATIENT (If applicable) <i>SELF</i>	13. DATE (YYYYMMDD) <i>20201013</i>
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SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

14. X IF APPLICABLE: <input type="checkbox"/> AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
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17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE
received by Haley A Tucker

SPONSOR NAME: 20/*11068*
SPONSOR RANK:
FMP/SPONSOR SSN:
BRANCH OF SERVICE:
PHONE NUMBER:



DEPARTMENT OF THE ARMY
IRWIN ARMY COMMUNITY HOSPITAL
650 HUEBNER ROAD
FORT RILEY KANSAS 66442-4030

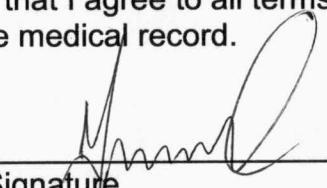
MCMI-ZAA-CS

MEMORANDUM FOR RECORD, Release of Information Policy

SUBJECT: Patient/guardian acceptance of medical records copy request policy at Irwin Army Community Hospital

1. You are entitled to one free copy of your medical records. You may request updates of any record(s) from the date annotated on the DD2870 stored in the medical record.
2. In accordance with AR 40-66, you may request a copy of your medical records for your personal use.
3. The copies will be processed within thirty (30) working days from the signature and date in block 13.
4. Entry of all blocks from 1 thru 13 must be completed accurately and legibly.
 - a. If records are being released to someone else other than the patient, the recipient's information must be completed in blocks 6a and 6b. Upon pick-up, recipient will be asked to provide their identification.
 - b. Block 8 specifying what is being requested must be completed.
 - c. The copy of records will be downloaded to a CD as a PDF.
5. There are two options for receiving the medical records.
 - a. Mail: Copy of records will be mailed to address in 6b. We will contact phone number listed in 6c to verify the address. A voicemail may be left stating records is mailed to address provided. The copy will be sent using standard priority and may take 7-10 business days to arrive.
 - b. Pick-up: You will be contacted when the copy is ready for pick-up.
6. If additional copies are requested, \$18.97 check payment will be due at pick-up.
7. By signing below, I am stating that I agree to all terms. Signed memo will be stored with corresponding DD2870 in the medical record.

Yessenia Amieila
Printed Name


Signature

28201013
Date

Separator Page - This page has been left blank intentionally.

Personal Data - Privacy Act of 1974 (PL93-579)

EMERGENCY CARE & TREATMENT - IRWIN ARMY COMMUNITY HO | LOG NUMBER: 200829-00003

Arrival Date/Time: 08/29/20 04:55 | 3rd Party Payer: NO
Trans to Hospital: PRIVATELY OWNED VEHICLE | Time Seen:
History Obtained From: PATIENT | Category:

Addr: CANDLEWOOD SUITES , FORT RILEY KS 66442 | Phone: 7863168898
Chief Complaint: Seizure | Sex: FEMALE Age: 22

Is patient pregnant or breastfeeding? Yes/No

If pt is pregnant...

does the current complaint significantly affect the pregnancy? YES/NO

Injury Form Completed: Yes/No

Advanced Directive: Yes/No Handout given: Yes/No

3rd Party Insurance Form: Yes/No

MEDICATION RECONCILIATION
Current Outpatient Medications: Ref Last Currently
Filled Taking Not Taking

List OTC meds, herbal, natural products or vitamins:

ALLERGIES

NKA

SEE DISCHARGE MEDICATIONS IN CHCS

AMIEVA, YESSENIA A11 20/595-75-1668
19 May 1998 FEMALE W: H: 7863168898
Loc: EMERGENCY MEDICAL CLINIC
Spon: AMIEVA, YESSENIA

Bank: SECOND Lieutenant

D:

Unit: 0001 FA HHB DIVISION AR RR:

SF558

Note Type: ED Discharge Sheet *
Note Time: 0642 29 Aug 2020
Last Stored: 0643 29 Aug 2020
Stored By: Hager, Kenneth RN

Rev. 2017.11.27.2250 (R36)

Emergency Department Discharge Sheet

TRICARE Regional Appointment Lines
1-888-874-9378 Tricare

Contact info for 48hrs: 786-316-8898

Most Recent

Temperature(F) **98.6 (at 0632** HR **72 (at 0632 29** Resp. Rate **14** BP **119 / 62**
29 Aug 2020) **Aug 2020)**

** Normal VS Ranges **

Age Range	Nm1 Temp(F)	Nm1 Temp(C)	Nm1 HR	Nm1 RR	Pulse Ox	Nm1 SBP	Nm1 DBP	Nm1 Pain
PreTerm<30wks	97.7-100.4	36.5-38.0	80-160	20-100	NA	NA	NA	0
PreTerm 30-37wks	97.7-100.4	36.5-38.0	80-160	20-100	NA	NA	NA	0
Full Term 37+1d - 1mo	97.7-100.4	36.5-38.0	80-160	30-60	NA	50-70	29-45	0
1+1d mo - 6 mo	97.7-100.4	36.5-38.0	80-160	24-38	>95%	60-118	50-70	0
6+1d mo - 2 yrs	97.7-100.4	36.5-38.0	80-150	20-35	>95%	66-126	41-91	0
2+1d yrs - 3 yrs	97.7-100.4	36.5-38.0	80-140	22-30	>95%	74-124	39-89	0
3+1d yrs - 5 yrs	97.7-100.4	36.5-38.0	60-110	20-24	>95%	79-119	45-85	0
5+1d yrs - 9 yrs	97.7-100.4	36.5-38.0	60-110	16-25	>95%	80-120	50-80	0
9+1d yrs - 12 yrs	97.7-100.4	36.5-38.0	60-110	16-22	>95%	92-132	53-83	0
12+1d yrs and older	97.7-100.4	36.5-38.0	50-110	12-18	>95%	100-140	60-90	0

Diagnosis:

Vital Signs Reviewed_

Dx 1: vasovagal syncope episode

Dx 2: URINARY TRACT INFECTION UTI (ICD9: 599.0, ICD10: N39.0)

Condition On Release: **Stable**

Patient Instructions

Patient Aftercare/Discharge Instructions/AAEM Patient Education Brochures Provided:

DI 1: *vasovagal episode/syncope*

DI 2: *UTI*

Discharge Instructions:

drink plenty of fluids, rest, call and see your doctor for close followup. Your labs, urine and EKG were essentially normal in the ED

Follow up with Primary Care Provider as directed.

Primary Care Manager: **MASON, DALLAS TRISTAN**

Primary Care Team: AMHS02EFHC2

To schedule an appointment with your Primary Care Provider, TRICARE beneficiaries in CONUS should visit the TRICARE website (www.tricareonline.com) to book online or call their local TRICARE Appointment Line (see above).

Department of Defense Reserve or Guard members treated in the Emergency Department:
Please report your care status to your supporting medical unit as soon as possible.

MRN: 20-595-75-1668	Hosp # 200829-000
AMIEVA, YESSENIA	
Rank: SECOND LIEUT	Status: ???
DOB: 19May1998	Age: 22
Irwin Army Community Hospital	
Admit Date: 29Aug2020	
DODID: 1548801377	
CliniComp, Int'l.	

Please be advised that all radiology studies will have a formal review and final read in 1-2 days. Please follow-up with your physician to review the final report.

New Medications

Name

1 SULFAMETHOXAZOLE/TRIMETHOPR
TM 1800(160MG TAB)

Current Outpatient Medications List Upon Discharge

Continue the outpatient medications you have been taking except as noted below.

Medication	Generic Name	Not currently taking	SIG	D/C Medication Comment
------------	--------------	----------------------	-----	------------------------

Birth Control

Medication Review

Completed

Pharmacy Data Transaction Service (PDTs) Medications List

CHCS PDTs Drug Name	Not currently taking	SIG	D/C Medication Comment
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Medication Review Completed

If you find other medications you have not informed the ED about during your current visit today, please contact your primary care provider.

Staff Physician/Provider: Skinner, Adam D.O.

Two copies of this form were printed, the signed copy was placed in the patient's record. **Prescribed meds received in the ED.**

Yes No
(Circle one & initial)

Return to the emergency department if you are not improving, symptoms worsen, or any concerns.

Patient / Significant Other communicates knowledge of and understands all of the above.

Signature X

Time: 0651 Date: 29 Aug 2020

TIME SEEN BY PROVIDER: **0457**

MRN: 20-595-75-1668 Hosp # 200829-000
AMIEVA, YESSENIA
Rank: SECOND LIEUT Status: ???
DOB: 19May1998 Age: 22
Irwin Army Community Hospital
Admit Date: 29Aug2020
DODID: 1548801377
ClinicComp, Int'l.

Full Disclosure

ED|RM 5

999999999 29-Aug-2020 05:31:29

HR 56 PVC 0 ST I 0.5

SPO2 99% **RATE 54/min NBP 90 / 51 (65)05:03 RR - II 17



amieva, yessenia

ID: 154880137

29-Aug-2020 5:14:14

22years
Female Caucasian

Vent. rate 57 bpm
PR interval 156 ms
QRS duration 92 ms
QT/QTc 404/393 ms
P-R-T axes 62 53 23

Sinus bradycardia
Otherwise normal ECG

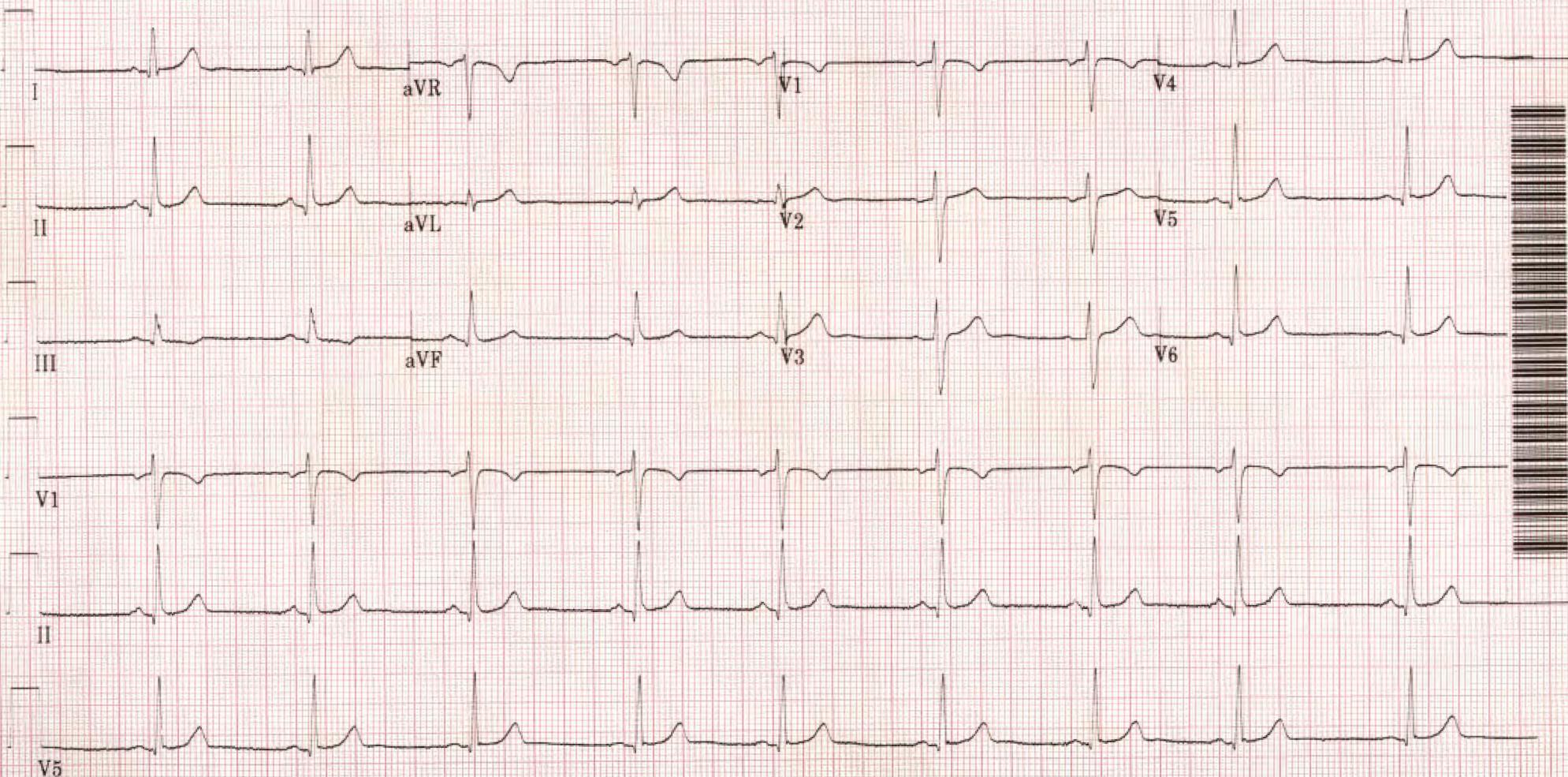
AMIEVA, YESSENIA

1548801377 Sex: F Age: 22Y
DOB: 19 May 1998
PatCat: A11 Marital: Z
SponRank: 2LT MEPRS:
Rel: LAPPT: Clinic:
IACH

Technician: AMJ
Test ind: Seizure

Referred by: Dr Skinner

Unconfirmed



150 Hz 25.0 mm/s 10.0 mm/mV

4 by 2.5s + 3 rhythm lds

MAC55 010A.1

12SL™ v241 HD

Printed in U.S.A.

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IACH ED Rapid Triage Form

Do not delay bed placement to complete standing orders**

Patient Name	Age:	Male	<input checked="" type="checkbox"/> Female	Preferred Name
Chief Complaint: <i>conscious to covid swab</i>		Mobility: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Litter <input type="checkbox"/> WC <input type="checkbox"/> Carried		
Subj:		Appearance: <input type="checkbox"/> Unremarkable <input type="checkbox"/> Distress		
Obj:		Respiratory: <input type="checkbox"/> Even & Unlabored <input type="checkbox"/> Distress Neuro: <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Disorient. <input type="checkbox"/> Altered		
Rapid Triage Decision		Obj. Continuation:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Influenza Symptoms
Immediate Bed Criteria Met	<input type="checkbox"/> Yes <input type="checkbox"/> Appt. Ok	<input type="checkbox"/> Routine <input type="checkbox"/> Expedite	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Contact w/ +COVID Pt
<input type="checkbox"/> No <input type="checkbox"/> Minor Care	ESI Level : 1 2 3 4 5	Temp: <i>97.1</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Travel outside FR in last 14 days
		Date: <i>29 APR 20</i> Time: <i>15452</i>	Triage Nurse Print/Stamp & Signature:	

Standing Order Set		CHCS Initial When Ordered*	Essentris Initial When Ordered*

Waiting Area Patient Re-Assesement		Vitals	Impression & Notes
Time:	HR RR Temp	BP SpO2 Glucose	
Time:	HR RR Temp	BP SpO2 Glucose	<i>out</i>
Time:	HR RR Temp	BP SpO2 Glucose	

Referral	Vitals	Disposition
Time:	HR RR Temp	
Staff Stamp/Print & Sign:	BP SpO2 Glucose	Clinic: Handoff to *: *(Required for Walk-In)

Provider Stamp/Print & Sign:

AMIEVA, YESSENIA
1548801377 Sex: F Age: 22Y
DOB: 19 May 1998
PatCat: A11 Marital: Z
SponRank: 2LT MEPRS:
Ref: Clinic:
LAPPT: IACH

COLUMBIA - SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past	Month
Ask questions that are bolded and underlined	YES	NO
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		X
2) Suicide Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide. "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. <u>Have you actually had any thoughts of killing yourself?</u>		X
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place, or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it.... and I would never go through with it." <u>Have you been thinking about how you might kill yourself?</u>		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to " <i>I have the thoughts but I definitely will not do anything about them.</i> " <u>Have you had these thoughts and had some intention of acting on them?</u>		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>		
6) Suicide Behavior Question: <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. <u>If YES, ask: How long ago did you do any of these?</u> <input type="checkbox"/> Over a year ago? <input type="checkbox"/> Between three months and a year ago? <input type="checkbox"/> Within the last three months?		X

Response Protocol to C-SSRS Screening (Linked to last item marked "YES")

Item 1 Behavioral Health Referral at Discharge.

Item 2 Behavioral Health Referral at Discharge.

Item 3 Behavioral Health Consult (Psychiatric Nurse / Social Worker) and consider Patient Safety Precautions.

Item 4 Immediate Notification of Physician and / or Behavioral Health and Safety precautions.

Item 5 Immediate Notification of Physician and / or Behavioral Health and Safety precautions.

Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse / Social Worker) and consider Patient Safety precautions.

- Disposition:**
- Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions.
 - Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions.
 - Behavioral Health Referral at Discharge

AMIEVA, YESSENIA
 1548801377 Sex: F Age: 22Y
DOB: 19 May 1998
 PatCat: A11 Marital :Z
 SponRank: 2LT MEPRS:
 Ref: LAPPT: Clinic:
 IACH

Separator Page - This page has been left blank intentionally.

RWBAHC MEDICAL RECORD SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General

REPORT TITLE:

Acknowledgment of Military Health System Notice of Privacy Practice (N.O.P.P.)

OTSG APPROVED (Date)

10/19/2017

Military Health System NOTICE OF PRIVACY PRACTICES
Effective October 1, 2013

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule (45 CFR 164.528) establishes requirements regarding an individual's right to an accounting of disclosures of their protected health information (PHI).

Individual Right. An individual has a right to receive an accounting of disclosures of PHI made by a covered entity in the six years, or less if specified by the individual, prior to the date of the request.

The signature below only acknowledges receipt of the Military Health System Notice of Privacy Practices, effective date 1 October, 2013.

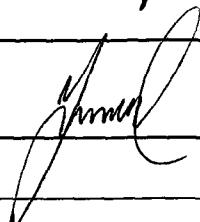
Patient/Patient Representative (Print)

Amieva, Yessenia

Date

10MAR20

Patient/Patient Representative (Signature)



Relationship to Patient

Self Patient/Representative declined to sign

Date

RWBAHC Staff (Print)

RWBAHC Staff (Signature)

This Notice of Privacy Practices is required by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. If you have any questions about this notice, please contact the RWBAHC HIPAA Privacy Officer at (520) 533-1856 or the RWBAHC Information desk at 520-533-5159/5150.

PATIENT'S IDENTIFICATION(For typed or written entries give Name,- last, first, middle; DOB, DOD ID)

 HISTORY/PHYSICAL FLOW CHART OTHER EXAMINATION OR
 EVALUATION OTHER (Specify) DIAGNOSTIC STUDIESAdministrative:
Notice of Privacy
Practices TREATMENTPatient Name: Amieva, YesseniaPatient DOB: 19 MAY 1998Patient SSN or DOD ID: 595-75-1668

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

This form is not an authorization or consent to use or disclose your health information.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):

10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Chapter 55, Medical and Dental Care; 42 U.S.C. Chapter 32, Third Party Liability for Hospital and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); DoDI 6055.05, Occupational and Environmental Health (OEH); and E.O. 9397 (SSN), as amended.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED:

Information may be collected from you to provide and document your medical care; determine your eligibility for benefits and entitlements; adjudicate claims; determine whether a third party is responsible for the cost of Military Health System (MHS) provided healthcare and recover that cost; evaluate your fitness for duty and medical concerns which may have resulted from an occupational or environmental hazard; evaluate the MHS and its programs; and perform administrative tasks related to MHS operations and personnel readiness.

3. ROUTINE USES:

Information in your records may be disclosed to:

- Private physicians and Federal agencies, including the Department of Veterans Affairs, Health and Human Services, and Homeland Security (with regard to members of the Coast Guard), in connection with your medical care;
- Government agencies to determine your eligibility for benefits and entitlements;
- Government and nongovernment third parties to recover the cost of MHS provided care;
- Public health authorities to document and review occupational and environmental exposure data; and
- Government and nongovernment organizations to perform DoD-approved research.

Information in your records may be used for other lawful reasons which may include teaching, compiling statistical data, and evaluating the care rendered. Use and disclosure of your records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at:
<http://dpcl.dod.mil/privacy/SORNsIndex/BlanketRoutineUses.aspx>.

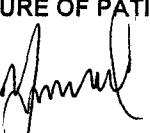
Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION:

Voluntary. If you choose not to provide the requested information, comprehensive health care services may not be possible, you may experience administrative delays, and you may be rejected for service or an assignment. However, care will not be denied.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by MHS health care treatment personnel or for medical/dental treatment purposes and is intended to become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

5. SIGNATURE OF PATIENT OR SPONSOR 	6. SOCIAL SECURITY NUMBER OR DOD IDENTIFICATION NUMBER OF MEMBER OR SPONSOR 595-75-1668	7. DATE (YYYYMMDD) 20200310
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