FORT SMITH ER & HOSPITAL

Fax: 479-974-9404

Phone: 479-974-9403

FAX

To: Carisk Partners

Fax: 786-361-0981

Date: 04/17/2024 Pages:

From: Fort Smith ER & Hospital

Subject: Medical records

Message:

CONFIDENTIAL

Carisk PARTNERS

Name: Jeremiah Howerton
Claim #: FTL0138
DOB: 8/30/1978
Carisk is the payor

Attention: Medical Records

I am requesting medical records from Fort Smith Emergency for the date of service: 04/05/2024. Please fax them to (786) 361-0981 or email them to Daniela.Gordon@cariskpartners.com.

Thank you,

Daniela Gordon, BSW
Care Coordinator Assistant
Carisk Outcomes

Carisk PARTNERS Modern Healthcare Best Places to Work 2021 - 2022 BEST PLACES TO WORK Ethisphere 50

10685 N. Kendall Drive
Miami, FL 33176
Office: (305) 514-5373
Fax: (786) 361-0981
www.cariskpartners.com

Carisk™ OUTCOMES

CONSENT TO RELEASE INFORMATION

I UNDERSTAND THAT THIS IS A VOLUNTARY AUTHORIZATION AND I UNDERSTAND THAT HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION

I, Jeremiah Haverton, have been advised that Carisk Behavioral Health, Inc., a Florida corporation with its address at 10685 North Kendall Drive, Miami, Florida 33176 d/b/a Carisk Outcomes ("Carisk") has been requested by _____ to prepare a care coordination plan and an individual assessment regarding my ongoing course of treatment. In order for a care coordinator to properly perform this service, Carisk needs to interview me and inspect and/or review my medical records, injury and treatment course to date, as well as any personal health information, including mental illness, use of drugs, use of alcohol or diagnoses of AIDS/HIV, for the purpose of providing services to me in connection with my Workers' Compensation claim. I understand that the purpose of providing this service to me in connection with my Workers' Compensation claim is to establish care coordination plan. I understand that by signing this consent I authorize Carisk, its affiliate and subsidiary companies, authorized agents and contractors, as well as all care coordinators, access to my private, personal, and protected health information ("PHI"), inclusive of, but not limited to, the following:

All medical information including but not limited to: medical reports, records, notes (typed or handwritten), charts, any letters, physical therapy records, pain management records, laboratory reports, outpatient reports, X-Ray films and reports, pharmacy information and records and discharge summaries, Billing Information, Photographs of injuries, Operative Reports and Intraoperative imaging, X-Rays/Films (MRI's, CT-Scans and Reports), Drug/Alcohol information, Mental Health/Psychiatric Information, and Sexually Transmitted Diseases/HIV.

I hereby authorize disclosure of my PHI, to the extent necessary, and communications by Carisk on my behalf. The limits of confidentiality have been discussed with me and I understand them. By signing below, I confirm that I have read this Consent to Release Information and give my permission to disclose my health information as necessary. I understand that my health information may be transmitted by facsimile, electronic mail or regular mail. I further understand that my personal health information disclosed pursuant to this authorization may be re-disclosed by Carisk and no longer be protected from disclosure to others by state and/or federal law.

This authorization is subject to revocation by the undersigned at any time except to the extent that action has already been taken. This information has been disclosed to Carisk from records whose confidentiality is protected by various state laws. Any further disclosure of this information shall be in in accordance with all applicable laws. A photocopy, electronic signature or facsimile copy of this authorization is to be accepted with the same authority as the original.

J. Haverton
Claimant/Patient

8-19-22
Date

Jeremiah C. Haverton
Print Name

_____
Claim Number

8-30-78
Date of Birth

FINAL

Fort Smith ER & Hospital - Emergency Department
4701 Phoenix Avenue, Fort Smith, AR 72903
(479) 974-9403

Patient: Howerton, Jeremiah
DOB: 08/30/1978 45 year/M Wt: 235 lb(107 kg) Stated; Ht: 70 in(178 cm)
MRN: 9114 PROVIDER: Bradly S Holland, DO
Acct #: 9114-1 Printed: 04/06/2024 04:00
DOS: 04/05/2024 12:40

PHYSICIAN CHART

CHIEF COMPLAINT:
Ankle problem

HISTORY OF PRESENT ILLNESS:
This patient is a 45 year old male who presents with a chief complaint of Ankle problem. Provider assessment time was 04/05/2024 13:24. I reviewed the vital signs, the oxygen saturation result and the nursing/ treatment notes. I agree with the chief complaint selected for this patient's chart. Other History / Staff Note: 45-year-old male patient presents to the emergency department secondary to swelling in bilateral lower extremities. The right lower extremity is greater than the left. He has a history of a traumatic brain injury and due to hospitalizations and immobilization, he ended up with a DVT in the past. He was on Eliquis for a while but is no longer on it. He recently had to move out of his house and is currently living in his jeep. His seats do not lie back very far and he is sleeping with his legs bent at the knees. The swelling does get better when she is up moving around but because they are constantly dependent position, they have been swollen. He does have pain in bilateral legs with the swelling. He has not had any redness. He has chronic pain secondary to his previous traumatic brain injury and other injuries sustained at the same time. -[BH@04/05/2024 14:24].

CURRENT MEDICATIONS:
ABILIFY 20 MG TABLET Dose: Unknown Route: Unknown Last Taken: Unknown
AMLODIPINE BESYLATE 2.5 MG TAB Dose: Unknown Route: Unknown Last Taken: Unknown
ASPIRIN 81 MG CHEWABLE TABLET Dose: Unknown Route: Unknown Last Taken: Unknown
TRAZODONE 150 MG TABLET Dose: Unknown Route: Unknown Last Taken: Unknown
Patient's pharmacy: WALMART PHARMACY 10-0125 - 2425 SOUTH ZERO ST FORT SMITH, AR 72901, (479) 317-8711
Medication Reconciliation Completed and Signed by I. Sutton, RN @ 04/05/2024 12:48:56

ALLERGIES:
Penicillins causes Unknown.

MODE OF ARRIVAL:
The patient arrived by walk in. Patient arrived with an attendant.

ROS
CONSTITUTIONAL: Denies any constitutional symptoms.
RESPIRATORY: Denies any respiratory problems.
NEUROLOGICAL: Denies any neurological problems.
MUSCULOSKELETAL: Denies any musculoskeletal problems.
INTEGUMENTARY: Denies any skin problems.
ALLERGIC/IMMUNOLOGIC: Denies any allergic/immunologic problems.

PAST MEDICAL HISTORY (PHYS):
Medical: SYSTEMIC: History of high lipids. NEUROLOGICAL: History of transient ischemic attack. CARDIOVASCULAR: History of hypertension.
Surgical: The patient has a history of inguinal hernia repair and umbilical hernia repair.
Other: Other medical history: DVT RIGHT/LEFT LEG -[IS@04/05/2024 12:51].

FAMILY HISTORY (PHYS):
No significant Family History.

SOCIAL HISTORY (PHYS):
Habits: Tobacco use: Former smoker - [8517006]. Admits to drinking alcohol (ETOH) socially. No reported illegal drug use.

VITALS HISTORY:
04/05/2024 12:51 Weight:235 lb(107 kg) Stated; Height:70 in(178 cm) BMI:33.64

04/05/2024
12:51 BP: 160/108 Arm (Automatic) MAP: 125.33 mmHG, Temp: 98.3 °F Oral, HR: 92 Sitting Awake , RR: 16, O2 Sat: 97% , Pain: 9

INITIAL VITALS AT PRESENTATION:
04/05/2024 12:51 Weight:235 lb(107 kg) Stated; Height:70 in(178 cm) BMI:33.64

04/05/2024
12:51 BP: 160/108 Arm (Automatic) MAP: 125.33 mmHG, Temp: 98.3 °F Oral, HR: 92 Sitting Awake , RR: 16, O2 Sat: 97% , Pain: 9

PHYSICAL EXAMINATION
Constitutional: The patient was alert. The patient was not ill-appearing. The patient was in no distress.
Respiratory: The pulse oximeter reading was within a normal range.
Psychiatric: Affect was depressed and flat.
Other exam: Additional examination findings: Bilateral lower extremity edema from mid pretibial to the foot. No cords. No redness. Mild tenderness in the pretib region without posterior calf tenderness. -[BH@04/05/2024 14:40].

DIAGNOSTIC CONSIDERATIONS FOR ANKLE PROBLEM:
DIAGNOSTIC CONSIDERATIONS: Dependent edema
Congestive heart failure
DVT -[BH@04/05/2024 14:42].
(I have considered the above as the potential cause of the patient's condition. I have based my consideration on a limited patient encounter, and my considerations may not be all-inclusive. History, physical examination, and/or diagnostic studies, in combination with medical judgment, have been used in determining the final diagnosis)

ORDERS AND RESULTS:

ED Orders:

Placed Orders:

US Duplex Leg Venous Bilat - Mode of transport: WC; Indications: ;leg swelling, history of DVT; Placed at 04/05/2024 13:37, BH, DO; Completed at 04/05/2024 14:11, ML, Rad Tech; Reviewed at 04/05/2024 14:44, BH, DO; B. Holland at 04/05/2024 14:44 Interpretation WNL. ; per dictated report by Dr. Banerjee, No evidence of deep veln thrombosis -[BH@04/05/2024 14:44] Interpreted by radiologist. ; Image viewed by ED Provider.

SOCIAL DETERMINANTS:
ECONOMIC STABILITY: Income / Employment: The patient workman's comp -[BH@04/05/2024 14:43]. Housing: The patient is homeless. Transportation: The patient has no Transportation Issues. HEALTHCARE:The patient has full access to healthcare. EDUCATION: The patient has no literacy or language issues.

MDM:
Problems Addressed: The patient's care was impacted by the following chronic conditions: (Type): other: History of traumatic brain injury with chronic pain and altered mental status -[BH@04/05/2024 14:41].

Reviewed and Analyzed Data: Information regarding the patient was obtained from the caretaker. Caseworker/RN -[BH@04/05/2024 14:41]. Review of external records included none. Independent study was performed on ultrasound(s). For labs: See Notes in Results. For Ultrasound: See Notes in Results. Test interpretation discussed with external physician or other qualified healthcare provider: See Notes in Results.

Disposition Management: Patient care management was discussed with The patient management was not discussed with any outside entities. The patient and I, along with available family/guardian/friends, had a discussion in layman's terms which included SHARED DECISION MAKING. All parties indicated they understood the condition, diagnosis, treatment, and agreed with the plan. STRONG PRECAUTIONS were discussed, including study limitations, and the patientwas advised toreturn to the emergency department if any changes occur or concerns ariseregarding their condition. I have also informed thepatient/family that if needed they would beable to call the emergency department and discuss any concerns with nurses and or doctors. I have counseled the patient about ongoing non-emergent medical problems and have recommended close follow-up with their PMD. This includes incidental findings on labs and/or radiologic studies done in ED.

IMPRESSION:
DEPENDENT EDEMA BILATERAL LOWER EXTREMITIES

DISPOSITION (PHYS):
The disposition time decision was 04/05/2024 14:45.
Discharge.

Discharge: The patient was discharged to Home. The patient's condition upon discharge was good and stable. Education was provided to the patient in reference to the final impressions, prognosis and need for follow up.

Instructions given to the patient: A Blank Discharge Instruction.

DISPOSITION NOTES:
Smoking History (from Social History review) Former smoker - [8517006].

SIGN OFF:
B. Holland, DO
Chart electronically signed by B. Holland, DO @ 04/05/2024 14:49:23

IMPRESSION:
DEPENDENT EDEMA BILATERAL LOWER EXTREMITIES

Discharge Signature:

Emergency Department Record
Fort Smith ER & Hospital - Emergency Department
4701 Phoenix Avenue, Fort Smith, AR 72903
(479) 974-9403

PATIENT: Howerton, Jeremiah
DOB: 08/30/1978 Wt: 235 lb(107 kg) Stated; Ht: 70 in(178 cm)
MRN: 9114
Acct. No: 9114-1 Printed: 04/05/2024 14:47
DOS: 04/05/2024 12:40 Page 1 of 1

SUMMARY SIGNATURE SHEET

The signature below acknowledges the patient and/or Guardian has received these instructions, understands them, and has been given the time needed for clarification of all patient questions or concerns at the time of transfer or discharge from the Emergency Department:

✓ Discharge Instructions

_____ Excuses

_____ Prescriptions

_____ Electronic Prescriptions

✓ Medication Reconciliation Sheet

_____ Transition Report

Patient / Guardian Signature

Healthcare staff

5/4/24

Date/Time

Driver's Signature

RAD:

vRad Fax Appl3 4/5/2024 2:17:28 PM CDT PAGE 1/001 Fax Server

SYNERGY RADIOLOGY ASSOCIATES

FSED-Nutex Fort Smith ER & Hospital
Final Radiology Report

24/7/365 assistance Call: 713.358.0823 Online chat: https://access.vrad.com

Patient Name:	HOWERTON, JEREMIAH	**MRN:**	9114
DOB (Age):	8/30/1978 45	**Gender:**	M
Date of Exam:	04/05/2024	**Accession:**	7194
Referring Physician:	HOLLAND, BRADLY	**# of Images:**	42
Ordered As:	US DUPLEX LEG VENOUS BILAT		

PROCEDURE INFORMATION:
Exam: US Duplex Lower Extremity Veins, Bilateral
Exam date and time: 4/5/2024 1:38 PM
Age: 45 years old
Clinical indication: Pain; Swelling (edema) of limb; Lower extremity, bilateral; Leg, lower, Additional info: ; Leg swelling, history of dvt

TECHNIQUE:
Imaging protocol: Real-time duplex ultrasound of the bilateral extremities with 2-D gray scale, color Doppler flow and spectral waveform analysis including responses to compression and other maneuvers (when performed) with image documentation. Complete exam focused on the lower extremity veins.

COMPARISON:
No relevant prior studies available

FINDINGS:
Right deep veins: Unremarkable. The common femoral, femoral, proximal profunda femoral and popliteal veins are patent without thrombus. Normal Doppler waveforms. Normal compressibility and/or augmentation response

Left deep veins: Unremarkable. The common femoral, femoral, proximal profunda femoral and popliteal veins are patent without thrombus. Normal Doppler waveforms. Normal compressibility and/or augmentation response

Superficial veins: Greater saphenous veins at the saphenofemoral junctions are patent bilaterally without thrombus.

Soft tissues: Unremarkable. Few normal appearing reactive lymph nodes are seen in the right inguinal region

IMPRESSION:
No evidence of deep vein thrombosis.

Thank you for allowing us to participate in the care of your patient.

Dictated and Authenticated by: Banerjee, Amitabha, MD
04/05/2024 2:15 PM Central Time (US & Canada)

FINAL

Fort Smith ER & Hospital - Emergency Department
4701 Phoenix Avenue, Fort Smith, AR 72903
(479) 974-9403

Patient: Howerton, Jeremiah
DOB: 08/30/1978 45 year/M Wt: 235 lb(107 kg) Stated; Ht: 70 in(178 cm)
MRN: 9114 PROVIDER: Ian Sutton, RN
Acct #: 9114-1 Printed: 04/06/2024 04:00
DOS: 04/05/2024 12:40 Nursing Record - Page 1 of 5

NURSING CHART

CHIEF COMPLAINT:
Ankle problem

CURRENT MEDICATIONS:
ABILIFY 20 MG TABLET Dose: Unknown Route: Unknown Last Taken: Unknown
AMLODIPINE BESYLATE 2.5 MG TAB Dose: Unknown Route: Unknown Last Taken: Unknown
ASPIRIN 81 MG CHEWABLE TABLET Dose: Unknown Route: Unknown Last Taken: Unknown
TRAZODONE 150 MG TABLET Dose: Unknown Route: Unknown Last Taken: Unknown
Patient's pharmacy: WALMART PHARMACY 10-0125 - 2425 SOUTH ZERO ST FORT SMITH, AR 72901, (479) 317-8711
Medication Reconciliation Completed and Signed by I. Sutton, RN @ 04/05/2024 12:48:56

ALLERGIES:
Penicillins causes Unknown.

MODE OF ARRIVAL:
The patient arrived by walk in. Patient arrived with an attendant.

CURRENT VISIT:
Arrival time: 04/05/2024 12:40. 1. Triage time: 04/05/2024 12:46. Assessment time: 04/05/2024 12:46. Room #: ER 07. Time to room: 04/05/2024 12:46. This is not a return visit for the same problem. Patient had no recent surgery.

INITIAL VITALS AT PRESENTATION:
04/05/2024 12:51 Weight:235 lb(107 kg) Stated; Height:70 in(178 cm) BMI:33.64

04/05/2024
12:51 BP: 160/108 Arm (Automatic) MAP: 125.33 mmHG, Temp: 98.3 ºF Oral, HR: 92 Sitting Awake , RR: 16, O2 Sat: 97% , Pain: 9

PAST MEDICAL/SURGICAL HX:
Medical: SYSTEMIC: History of high lipids. NEUROLOGICAL: History of transient ischemic attack. CARDIOVASCULAR: History of hypertension.
Surgical: The patient has a history of inguinal hernia repair and umbilical hernia repair.
Other: Other medical history: DVT RIGHT/LEFT LEG -[IS@04/05/2024 12:51].

SOCIAL HISTORY:
Habits: Tobacco use: Former smoker - [8517006]. Admits to drinking alcohol (ETOH) socially. No reported illegal drug use.

TRIAGE DISPOSITION:
Room #: ER 07 and Time to room: 04/05/2024 12:46.

ASSESSMENT
Triage performed with Assessment

SOURCE:
The information was obtained from the patient.

GENERAL ASSESSMENT:

04/05/2024 12:46.

Constitutional: The patient was well-appearing. The patient was in no distress.

Psychosocial: Attentive and appropriate.

Speech: The patient's speech was coherent.

Skin: The skin was warm and dry. Skin color was normal. Skin turgor was normal. Skin Integrity: Intact.

Mental Status: The patient was oriented to person, place and time.

Deficits: The patient has no hearing deficit(s). The patient has no vision deficit(s). The patient has no sensory/motor deficits. The patient has no mental deficits.

FOCUSED ASSESSMENT:

Chief complaint: Ankle problem

Timing: The onset / occurrence was 1 day(s) ago.

Location: The symptoms are (in the) right and left ankle.

Severity: The severity of the pain was 9.

Other history/Staff note: Note: Companion (RN case manager) reports that patient is homeless and has been sleeping in his jeep. Reports that when she saw him this morning she was concerned with his bilateral ankle swelling and pain. Pt states that pain started yesterday and is worse on the right than the left. Hx includes bilateral DVT during recovery after wreck in 2021. -[IS@04/05/2024 12:54].

EXAMINATION:

Respiratory: Right lung negative for wheezes, rales and rhonchi. Right breath sounds were not diminished. Left lung negative for wheezes, rales and rhonchi. Left breath sounds were not diminished.

CV: The patient's heart rate was normal and the rhythm was regular.

GI: Bowel sounds were normal.

Musculoskeletal: Negative for RIGHT-sided ankle redness, swelling, ecchymosis, deformity and tenderness. Negative for LEFT-sided ankle redness, swelling, ecchymosis, deformity and tenderness.

ACUITY:

3 (Urgent).

VITALS HISTORY:

04/05/2024 12:51 Weight:235 lb(107 kg) Stated; Height:70 in(178 cm) BMI:33.64

04/05/2024

12:51 BP: 160/108 Arm (Automatic) MAP: 125.33 mmHG, Temp: 98.3 ºF Oral, HR: 92 Sitting Awake , RR: 16, O2 Sat: 97% , Pain: 9

ORDERS WITHOUT RESULTS:

ED Orders:

Placed Orders:

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TREATMENT NOTES:

4/5/2024

12:51 - VS: VITALS : Weight: 235 lb S Height: 70 in - Recorded by Ian Sutton, RN.

12:51 - VS: VITALS : BP: 160/108 Arm (Auto) MAP: 125.33 mmHG, Temp: 98.3 ºF Oral, HR: 92 Sitting Awake, RR: 16, O2 Sat: 97%, Pain: 9 - Recorded by Ian Sutton, RN.

14:11 - ORDER: Order Performed: US Duplex Leg Venous Bilat , Mode Of Transfer: WC , Indication: ;leg swelling, history of DVT - Recorded by Morgan Lesslie, Rad Tech.

IMPRESSION:
DEPENDENT EDEMA BILATERAL LOWER EXTREMITIES

DISPOSITION:
Discharged.
Discharge: The patient was discharged to Home. Tthe patient was in good condition. On a 0 to 10 pain scale, the patient's pain was 4/10. The patient was given education, information and/or training regarding follow-up care and medication(s). Verbal discharge instructions were given and Written discharge instructions were given to the patient. Understanding of the instructions was expressed. The patient left the facility ambulatory. Upon discharge, IV status was not applicable. The patient departed the facility on 04/05/2024 14:53. Disposition Signed by I. Sutton, RN @ 04/05/2024 14:53:29
Instructions given to the patient: A Blank Discharge Instruction.

SIGN OFF:
M. Lesslie, Rad Tech
I. Sutton, RN
Assessment unsigned by Ian Sutton, RN on 04/05/2024 12:55
Assessment signed by Ian Sutton, RN on 04/05/2024 12:54
Chart electronically signed by I. Sutton, RN @ 04/05/2024 14:54:00

Discharge Signature:

Emergency Department Record
Fort Smith ER & Hospital - Emergency Department
4701 Phoenix Avenue, Fort Smith, AR 72903
(479) 974-9403

PATIENT: Howerton, Jeremiah
DOB: 08/30/1978 Wt: 235 lb(107 kg) Stated; Ht: 70 in(178 cm)
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Patient / Guardian Signature

Healthcare staff

5 Apr 24
Date/Time

Driver's Signature

RAD:

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SYNERGY RADIOLOGY ASSOCIATES

FSED-Nutex Fort Smith ER & Hospital
Final Radiology Report

24/7/365 assistance Call: 713.368.0823 Online chat: https://access.vrad.com

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IMPRESSION:
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Dictated and Authenticated by: Banerjee, Amitabha, MD
04/05/2024 2:15 PM Central Time (US & Canada)