OBH-1 (PEC)
Rev. 05/2017

Complete Prior to Admission

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH – OFFICE OF BEHAVIORAL HEALTH
PHYSICIAN'S EMERGENCY CERTIFICATE

For observation, diagnosis, and treatment at a treatment facility for a period not to exceed 15 days, or 28 days, for substance abuse (Title 28:52.4). See Louisiana Revised Statutes, Title 28, Sections 53 and 63. These directives must be fulfilled in order for this certificate to be valid.

NAME OF EXAMINING PHYSICIAN: Dr. Farquhar	EXAMINATION DATE: 07-31-2023	EXAMINATION TIME: 1610
ADDRESS OF EXAMINING PHYSICIAN: 2600 Greenwood Rd Shreveport LA 71103		

HEMINGWAY, STANLEY 04/14/1993 30Y M W10084126183 00000000171050S

NAME OF PATIENT: Stanley Hemingway			
ADDRESS OF PATIENT: 7101 Venecia Dr. Bossier City, LA 71111			
RACE: AA	SEX: ☑ M ☐ F	DATE OF BIRTH: 04-14-1993	BIRTHPLACE: LA
MARITIAL STATUS: ☑ S ☐ M ☐ D ☐ W ☐ SEP	MILITARY STATUS: ☐ VETERAN ☑ NON-VETERAN		RELIGION: Unk
NAME OF NEAREST RELATIVE, FRIEND, OR GUARDIAN: Troy Ikner.			RELATIONSHIP: Friend
ADDRESS: 9110 Windwood Ave Shreveport LA 71106			PHONE NUMBER: 318 987-1981

CHECK:
☐ Mental Illness or Substance Abuse (15 Day) ☐ Substance Abuse (28 Day) ☐ 1st ☐ 2nd Order For Protective Custody Date: _____

FINDINGS OF EXAMINATION

HISTORY OF PRESENT ILLNESS (REASONS FOR ADMISSION, INCLUDING BEHAVIOR, ACTS, THREATS, ETC.)
Hx of Depression OD on Narco

PHYSICAL FINDINGS (MEDICAL HISTORY, CURRENT MEDICATIONS, ETC.)
Normal Exam

MENTAL CONDITION (ORIENTATION, MOOD, THOUGHT CONTENT, AFFECT, ANY HALLUCINATIONS OR DELUSIONS)
Depressed

PREVIOUS PSYCHIATRIC TREATMENT	DATE OF TREATMENT	PLACE, IF KNOWN
☐ INPATIENT ☐ OUTPATIENT	Unknown	Unknown

IS PATIENT CURRENTLY: ☑ SUICIDAL ☐ HOMICIDAL ☐ VIOLENT

I am of the opinion that the above person named is in need of immediate psychiatric treatment in a treatment facility because he/she is seriously mentally ill or suffering from substance abuse so that he/she is (check where appropriate in both 1 & 2):
1. ☑ Dangerous to self ☐ Dangerous to others ☐ Gravely disabled
2. ☐ Unwilling ☐ Unable to seek voluntary admission

SIGNATURE OF EXAMINING PHYSICIAN	LA MEDICAL LICENSE NUMBER	DATE SIGNED	TIME SIGNED
FARQUHAR	BF 44704 03	7/31/23	6:45 PM

Completion of above certificate shall constitute legal authority to transport patient to the following facility:

1. _____

2. _____

To be transported by: _____ Relationship to patient: _____

ORIGINAL TO HOSPITAL – ONE COPY TO EXAMINING PHYSICIAN

[redacted]

WK Medical Center
2600 Greenwood Road
Shreveport, LA 71103

Emergency Department Note
Signed

Patient: HEMINGWAY,STANLEY
DOB: 04/14/1993
Age/Sex: 30 / M
Loc: ER
Attending Dr:

MR#: D000404470
Acct:W10084126183
ED ADM Date: 07/31/23
ED DIS Date:

cc: ~

HPI - Overdose

General

Chief Complaint: Overdose
Time Seen by Provider: 07/31/23 16:26
Source: patient, EMS and RN notes reviewed
Mode of arrival: EMS
Limitations: no limitations

History of Present Illness

HPI Narrative:
30 y/o male presenting to the ED w/ c/o overdose. Pt is coming from home, intentional overdose. Pt took 5-6 Norco.
MD complaint: intentional overdose
Intent: suicide attempt
How Overdose Was Discovered: called 911
Associated symptoms: depression

Related Data

Home Medications

Medication	Instructions	Recorded	Confirmed
No Known Home Medications		07/31/23	07/31/23

ROS

Status of ROS

10 or more systems reviewed and unremarkable except in HPI and below

Psych

Reports: suicidal ideation and depression

PFSH

PFSH

Social History

Smoking Status: Never smoker
How often do you have a drink containing alcohol?: Never
AUDIT-C Alcohol total score: 0
Non-Prescribed Substance Use: Marijuana (Any Form)
Does Your Home Environment Cause You Fear, Pain, or Injury: Denies
Have You Recently Felt Abused, Taken Advantage of, or Neglected?: Denies

Exam

Const
Attestation: Documenting provider has reviewed patient's vital signs
General appearance: cooperative and comfortable
Orientation/consciousness: awake, oriented to person, oriented to place and oriented to time
HENMT
Head and scalp: normal to inspection, normocephalic and atraumatic
Face/Sinus: normal facial exam and Normal nares present;
No sinuses nontender
Ear: external ears normal and TM's normal bilaterally
Mouth: Normal oral and palatal mucosa present, posterior oropharynx normal and tonsils normal
Eye
General: appearance normal, both eyes and all related structures, normal light reflex and Equal, round and reactive pupils present
Anatomy: conjunctivae normal and sclerae normal
Direct Ophthalmoscopy: normal light reflex
Neck & C-Spine
General: normal visual inspection and trachea midline;
No JVD
Thyroid: Thyroid normal
Cervical spine: cervical ROM normal;
No Cervical spine tenderness and No Paracervical muscle tenderness
Lymph
Lymphatic: No lymphadenopathy
Chest
Chest: normal inspection of the chest
Respiratory
Effort & inspection: normal and able to speak in complete sentences
Auscultation: clear to auscultation bilaterally;
no crackles, no rales, no rhonchi and no wheezes
Percussion: percussion normal
Cardio
Rate/Rhythm: regular rate and regular rhythm
Heart sounds: S1 normal heart sound present and S2 normal heart sound present;
no click, no gallops, no murmurs and no rubs
GI
Inspection: normal to inspection
Auscultation: normoactive bowel sounds
Palpation: Soft to palpation;
non-tender, No Hepatosplenomegaly present and no rebound tenderness present
Percussion: normal to percussion
GU
Bladder/kidney exam: No CVA tenderness
Back & Pelvis
General back: No tenderness
Thoracic spine/upper back: normal to inspection and thoracic ROM normal;
No thoracic spinal tenderness
Lumbar spine/lower back: normal to inspection;
No lumbar spinal tenderness

Extremity/Vascular
General: normal exam except as noted
Peripheral pulses: Peripheral pulses 2+ throughout
Neuro
Glasgow Coma Scale: document GCS findings Eye Opening: 4 - Spontaneous - open with blinking at baseline Verbal Response: 5 - Oriented Glasgow coma scale motor response: 6 - Obeys commands for movement Glasgow coma scale total score: 15
Sensorium/orientation: awake, alert, oriented to person, oriented to place and oriented to time
Cranial Nerves: Cranial nerves II - XII intact
Speech: speech normal
Gait: Normal gait present
Motor Exam: 5/5 motor strength present throughout
Psych
Appearance: grossly normal
Attitude: calm
Speech: normal speech
Thought content: Suicidality present;
No Homicidality present
Memory/cognition: memory grossly intact
Insight: Good insight present (Psych)
Judgement: Good judgement present (Psych)
Skin
General skin exam: turgor normal
Lesions: No lesion noted
Rashes: No rashes noted
Hair: normal
Nails: normal

Course
Vital Signs
Vital signs:

Vital Signs

Temp	Pulse	Resp	BP	Pulse Ox
98.6 F	96	18	139/75	99
07/31/23 16:28	07/31/23 16:28	07/31/23 16:28	07/31/23 16:28	07/31/23 16:28

Temperature:(F or C)	98.6 F	07/31/23 16:28
Pulse Rate	88	07/31/23 17:43
Respirations	16	07/31/23 17:43
Blood Pressure	135/76	07/31/23 17:43
O2 Saturation	98	07/31/23 17:43

MDM - Overdose

MDM Narrative

Medical decision making narrative:
I JOSEPH FARQUHAR PERSONALLY PERFORMED THE SERVICES DESCRIBED IN THIS DOCUMENTATION AS SCRIBED IN MY PRESENCE IT IS BOTH ACCURATE AND COMPLETE History and physical exam will be addressing the chief complaint differential diagnosis will be mention escalation care will be mention consult management will be mention review imaging study with the radiologist was performed independent interpretation all laboratory vast were performed additional historian was the patient review of external non ED record recordings was noncontributory diagnostic test considered but not performed were 9 prescription medications considered but not given her 9 chronic conditions involving healthcare 9 social determine so healthcare noncontributory summary will be mentioned patient comes in here overdosed on Tylenol intentionally trying to hurt so

Differential Diagnosis

Differential diagnosis: cocaine intoxication, suicide attempt by multiple drug overdose, poisoning by opiate or related narcotic, drug overdose, acetaminophen overdose and accidental drug ingestion

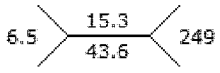
Medical Records

Attestation: I reviewed the patient's medical records.

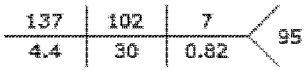
Lab Data

Attestation: I reviewed the patient's lab results.
Lab results narrative:
H&H
Is 15 and 43 BUN is 7 creatinine is 0.82

07/31/23 16:55



07/31/23 16:55



Labs:

Lab Results

	07/31/23 16:55	07/31/23 17:42	Range/Units
WBC	6.5		(3.1-9.7) 10E3/uL
RBC	5.05		(4.08-5.70) 10E6/uL
Hgb	15.3		(13.1-16.8) g/dL
Hct	43.6		(38.2-48.4) %
MCV	86.3		(81.4-98.5) fL
MCH	30.2		(27.1-34.2) pg
MCHC	35.0		(31.7-35.2) g/dL
RDW	13.0		(12.3-16.3) %
Plt Count	249		(130-351) 10E3/uL
MPV	8.1		(6.6-10.2) fL
Neut % (Auto)	61.4		(40.6-75.3) %
Lymph % (Auto)	27.9		(16.1-45.7) %

Mono % (Auto)	8.4		(3.7-12.2) %
Eos % (Auto)	1.8		(0.0-6.3) %
Baso % (Auto)	0.5		(0.1-1.3) %
Neut # (Auto)	4.0		(0.9-7.4) 10E3/uL
Lymph # (Auto)	1.8		(0.9-3.3) 10E3/uL
Mono # (Auto)	0.5		(0.2-0.9) 10E3/uL
Eos # (Auto)	0.1		(0.0-0.5) 10E3/uL
Baso # (Auto)	0.0		(0.0-0.1) 10E3/uL
Sodium	137		(137-145) mmol/L
Potassium	4.4		(3.5-5.1) mmol/L
Chloride	102		(98-107) mmol/L
Carbon Dioxide	30		(21-32) mmol/L
Anion Gap	5.0		(5.0-15.0) mmol/L
BUN	7		(7-20) mg/dL
Creatinine	0.82		(0.66-1.25) mg/dL
Est GFR (CKD-EPI)	121.2		(>60) SeeBelow
Glucose	95		(70-109) mg/dL
Calcium	10.1		(8.4-10.2) mg/dL
Total Bilirubin	0.6		(0.2-1.3) mg/dL
Direct Bilirubin	0.1		(0.0-0.4) mg/dL
AST	28		(3-45) U/L
ALT	32		(0-50) U/L
Alkaline Phosphatase	41		(38-126) U/L
Total Protein	8.1		(6.3-8.2) g/dL
Albumin	4.5		(3.5-5.0) g/dL
Urine Color		Yellow	(Yellow)
Urine Clarity		Clear	(Clear)
Urine pH		7.0	(5.0-8.0)
Ur Specific Gravity		1.016	(1.000-1.035)
Urine Protein		Negative	(Negative)
Urine Ketones		Negative	(Negative)
Urine Occult Blood		Negative	(Negative)
Urine Nitrite		Negative	(Negative)
Urine Bilirubin		Negative	(Negative)
Urine Urobilinogen		0.2	(0.2) E.U./dL
Urine Leukocytes		Negative	(Negative)
Urine Glucose		Negative	(Negative)
Salicylates	< 1.0		(<20.0) mg/dL
Urine Opiates Screen		Negative	(< 300 ng/mL)
Urine Methadone Screen		Negative	(< 300 ng/mL)
Acetaminophen	< 10.0 L		(10.0-30.0) ug/mL
Ur Barbiturates Screen		Negative	(< 200 ng/mL)
Ur Phencyclidine Scrn		Negative	(< 25 ng/mL)
Ur Amphetamines Screen		Negative	(< 500 ng/mL)
U Benzodiazepines Scrn		Negative	(< 200 ng/mL)
Urine Cocaine Screen		Negative	(< 300 ng/mL)
U Marijuana (THC) Screen		Positive H	(< 50 ng/mL)
Ur Drug Screen Comment		See comments	
Ethyl Alcohol	< 10		(< 10) mg/dL

Imaging Data
Attestation imaging: I personally reviewed and interpreted this imaging study as follows:
My impression:
Chest x-ray is clear

EKG Interpretations

EKG
EKG 1:
- Rate: 88
- PR Interval: Normal
- QRS Interval: Normal
- QT Interval: Normal
- Rhythm: Normal Sinus Rhythm
- QRS Axis: Normal
- Axis: Normal axis
- Q Wave: Absent

Attestations

Scribe
I, KELSEY S WARE, am scribing for and in the presence of Farquhar Jr, Joseph Alexander,M.D..
07/31/23, 1810, by KELSEY S WARE

Provider
I, Farquhar Jr, Joseph Alexander,M.D., personally performed the services described in this documentation, as scribed in my presence, and it is both accurate and complete.
07/31/23, 1850 by Farquhar Jr, Joseph Alexander,M.D.

NP/PA
I performed the substantive portion of the visit. I reviewed the NP/PA's documentation and agree with the NP/PA's assessment and plan of care. I had face to face time with the patient.
07/31/23, 1850 by Farquhar Jr, Joseph Alexander,M.D.

Discharge Plan

Discharge
Service Date/Time: 07/31/23 16:25

ED Provider: Farquhar,Joseph Alexander JR

Patient Disposition: Psychiatric Hospital or Unit

Receiving Facility: PHYSICIANS BEHAVIORAL HOSPITAL

Clinical Impression:
Suicidal thoughts, Drug overdose

Stand Alone Forms: Discharge Handout Stoplight

Discharge Medications:
No Action
No Known Home Medications

Dictated By: Farquhar Jr, Joseph A., M.D.
Signed By: <Electronically signed by Joseph A. Farquhar Jr, M.D.> 08/05/23 1504

DD/DT: 07/31/23 1808
TD/TT: 07/31/23 1808 Transcriptionist: KSW