KAISER PERMANENTE®

Myhanh Le, Ph.D.
California License #PSY16527
Department of Medicine and Family Practice
Behavioral Medicine Service

The Permanente Medical Group, Inc.
260 International Circle, Medical 2B
San Jose, CA 95119-1197
Voice Mail: (408) 972-3208
Appointments: (408) 972-6442, Option 2
www.kaiserpermanente.org

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P. Alexandra Tran, M.D.
Department of Medicine and Family Practice

The Permanente Medical Group, Inc.
260 International Circle, Medical 2A
San Jose, CA 95119-1197
Appts/Advice: (408) 362-4791
Spanish: (408) 362-4744
www.kaiserpermanente.org

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Donna Wueste, L.C.S.W.
Licensed Clinical Social Worker
Department of Psychiatry

The Permanente Medical Group, Inc.
5755 Cottle Road, Building 4
San Jose, CA 95123-3698
(408) 972-3262
Psychiatry: (408) 972-3095
Fax: (408) 972-3242
www.kponline.org

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At the bottom of this page are reminders for some preventive services based on Kaiser Permanente's current electronic records. If you have on-going health problems or are at high risk for certain diseases, you may need more frequent preventive services and should consult your physician. If an appointment is necessary, please schedule it.

11244330 DEFARIA OLGA A

APPT TIME : 02:30 PM FAC/DEPT: STR/PSY
APPT WITH : D A WUESTE LCSW
REG DATE : 10/10/02 02:18 PM STRNPB

PURCHASER : 000082297/0000

EXCEPTION :

REG FEE : $5.00

AMT PAID : $5.00

ADVANCE DIRECTIVE : PLEASE REVIEW
|
MED/PED PHY: TRANAP STR OTHER PCP:
*** NO APPOINTMENTS FOUND ***

PREVENTIVE	SERVICES	LAST	DUE
Review	PAP TEST		
Review	BREAST EXAM		
Current	TETANUS		2/09/21
Current	PNEUMO VACCINE		2/09/36
Current	CHOLESTEROL SCREEN		NA
Current	INFLUENZA VACCINE		NA
Current	MAMMOGRAPHY		NA

Return appointment: _____ days _____ weeks _____ months

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11244330 DEFARIA OLGA A

APPT TIME : 08:45 AM FAC/DEPT: STR/MED
APPT WITH : P A TRAN M.D.
REG DATE : 10/03/02 08:18 AM STRLOS

PURCHASER : 000082297/0000

EXCEPTION :

REG FEE : $5.00

AMT PAID : $5.00

ADVANCE DIRECTIVE : PLEASE REVIEW
|
MED/PED PHY: TRANAP STR OTHER PCP:

10/03/02 08:45A TRANAP 1 MED STR

PREVENTIVE	SERVICES	CAN	MOV	LAST	DUE
Review	PAP TEST				
Review	BREAST EXAM				
Current	TETANUS				2/09/
Current	PNEUMO VACCINE				2/09/
Current	CHOLESTEROL SCREEN				NA
Current	INFLUENZA VACCINE				NA
Current	MAMMOGRAPHY				NA

Return appointment: _____ days _____ weeks 3 months

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11244330 DEFARIA OLGA A

APPT TIME : 11:00 AM FAC/DEPT: STR/PSY
APPT WITH : ADULT CRISIS GROUP
REG DATE : 10/11/02 11:37 AM STRLIM

PURCHASER : 000082297/0000

EXCEPTION :

REG FEE : $5.00

AMT PAID : $5.00

ADVANCE DIRECTIVE : PLEASE REVIEW

MED/PED PHY: TRANAP STR OTHER PCP:
*** NO APPOINTMENTS FOUND ***

PREVENTIVE	SERVICES	LAST	DUE
Review	PAP TEST		
Review	BREAST EXAM		
Current	TETANUS		2/09/21
Current	PNEUMO VACCINE		2/09/36
Current	CHOLESTEROL SCREEN		NA
Current	INFLUENZA VACCINE		NA
Current	MAMMOGRAPHY		NA

eturn appointment: _____ days _____ weeks _____ months

10 (REV 6.00)

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11244330 DEFARIA OLGA A

APPT TIME : 09:00 AM FAC/DEPT: STR/PSY
APPT WITH : PSY-INTENSIVE OUTPT PROG ADULT
REG DATE : 10/14/02 10:12 AM STRPSY

PURCHASER : 000082297/0000

EXCEPTION :

ADVANCE DIRECTIVE : PLEASE REVIEW

MED/PED PHY: TRANAP STR OTHER PCP:
*** NO APPOINTMENTS FOUND ***

PREVENTIVE	SERVICES	LAST	DUE
Review	PAP TEST		
Review	BREAST EXAM		
Current	TETANUS		2/09/2
Current	PNEUMO VACCINE		2/09/3
Current	CHOLESTEROL SCREEN		NA
Current	INFLUENZA VACCINE		NA
Current	MAMMOGRAPHY		NA

Return appointment: _____ days _____ weeks _____ months

10 (REV 6.00)

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11244330 DEFARIA OLGA A

APPT TIME :
APPT WITH : PSY-INTENSIVE OUTPT PROG ADULT FAC/DEPT: STR/PSY
REG DATE : 10/17/02 09:09 AM STRNPB

PURCHASER : 000082297/0000

EXCEPTION :

ADVANCE DIRECTIVE : PLEASE REVIEW

MED/PED PHY: TRANAP STR OTHER PCP:
*** NO APPOINTMENTS FOUND ***

PREVENTIVE	SERVICES	LAST	DUE
Review	PAP TEST		
Review	BREAST EXAM		
Current	TETANUS		2/09/21
Current	PNEUMO VACCINE		2/09/36
Current	CHOLESTEROL SCREEN		NA
Current	INFLUENZA VACCINE		NA
Current	MAMMOGRAPHY		NA

Return appointment: _____ days _____ weeks _____ months

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11244330 DEFARIA OLGA A

APPT TIME : 09:00 AM FAC/DEPT: STR/PSY
APPT WITH : PSY-INTENSIVE OUTPT PROG ADULT
REG DATE : 10/15/02 09:20 AM STRYMB

PURCHASER : 000082297/0000

EXCEPTION :

ADVANCE DIRECTIVE : PLEASE REVIEW

MED/PED PHY: TRANAP STR OTHER PCP:
*** NO APPOINTMENTS FOUND ***

PREVENTIVE	SERVICES	LAST	DUE
Review	PAP TEST		
Review	BREAST EXAM		2/09/6
Current	TETANUS		2/09/3
Current	PNEUMO VACCINE		NA
Current	CHOLESTEROL SCREEN		NA
Current	INFLUENZA VACCINE		NA
Current	MAMMOGRAPHY		

Return appointment: _____ days _____ weeks _____ months

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11244330 DEFARIA OLGA A

APPT TIME : 09:00 AM FAC/DEPT: STR/PSY
APPT WITH : PSY-INTENSIVE OUTPT PROG ADULT
REG DATE : 10/18/02 09:17 AM STRJAL

PURCHASER : 000082297/0000

EXCEPTION :

ADVANCE DIRECTIVE : PLEASE REVIEW

MED/PED PHY: TRANAP STR OTHER PCP:
*** NO APPOINTMENTS FOUND ***

PREVENTIVE	SERVICES	LAST	DUE
Review	PAP TEST		
Review	BREAST EXAM		
Current	TETANUS		2/09/2
Current	PNEUMO VACCINE		2/09/2
Current	CHOLESTEROL SCREEN		NA
Current	INFLUENZA VACCINE		NA
Current	MAMMOGRAPHY		NA

Return appointment: _____ days _____ weeks _____ months

KAISER PERMANENTE®

'aiser Foundation Hospitals
.he Permanente Medical Group, Inc.

Location: STR

De Faria, Olga
11 24 4330

IMPRINT AREA

REQUEST FOR ACCESS TO OR COPIES OF MEDICAL RECORDS

1. This request is made pursuant to California statute, Health and Safety Code sections 123100-123149. Under these sections I understand that the health care provider (hospital or medical group) is entitled to "payment of reasonable clerical costs incurred in locating and making the records available" before access to the records is permitted. If copies are requested, I acknowledge that the law requires me to pay reasonable clerical costs and permits copying fees of 25¢ per page (50¢ per page if copies from microfilm records). For copies of X-rays or tracings, fees are based upon actual costs incurred.

2. I understand that the provider has 5 working days, **after this request and payment of clerical costs**, in which to produce the requested medical records for examination. If I have requested copies, the provider has 15 days, **after receiving this request and payment of clerical costs and copying fees**, during which to assemble the records and make the copies.

3. I understand that the health care provider is authorized by law to determine if a summary is to be prepared in response to this request instead of providing original records for examination or copying. If the health care provider decides to furnish a summary instead of allowing access to the original record, it will be available within 10 days of this request and payment of the appropriate fee, or within 30 days if the record is of extraordinary length or if I was discharged from a health care facility within the last 10 days. The fee will be based upon actual time spent by our personnel in preparing the summary.

4. I further understand that records of mental health care, or alcohol or drug abuse treatment may not be disclosed to me directly if the health care provider determines that to do so would present a risk of significant adverse or detrimental consequences. I understand I then may designate a physician, licensed psychologist or clinical social worker to review the record on my behalf.

5. I understand that if I am a parent making a request regarding records of a minor, I will not be shown entries for health care to which, by law, the minor may consent without parental involvement.

6. I understand that if I am a minor, I will be given access only to those portions of my record describing health care for which I may consent, under applicable law, without involvement of parents.

7. The undersigned patient or patient's legal representative, hereby requests access to the Medical Records of: OLGA DEFARIA (AKA OLGA MOFFAT, OLGA FEDORY AKA) ☒ Adult ☐ Minor

8. The record being requested is: ☒ Medical Office (Outpatient) ☒ Hospital (Inpatient) ☒ Mental Health

   Other _____

   for the period SEPT 2002 to OCT 2002 or

   for the particular injury, illness or episode described as: _____

9. The physician I usually see is: _____

10. I am requesting: ☐ access to the record indicated above
    ☒ copies made of the record indicated above

    for the purpose of: COURT TRIAL (OPTIONAL) RUSH need before 12/16/02

12-9-02
DATE OF REQUEST

Amount $ 15.00
DEPOSIT RECEIVED
pd cash

IDENTIFICATION OF REQUESTER (DRIVER'S LICENSE, CREDIT CARD)

Requester: ☐ Reviewed Record ☐ Received Copies ☐ Received Summary ☐ Other _____

_____
DATE

Amount $ _____
AMOUNT PAID

PATIENT'S SIGNATURE
[signature]

PATIENT'S REPRESENTATIVE SIGNATURE
[signature]

RELATIONSHIP TO PATIENT (PARENT, GUARDIAN OR CONSERVATOR)
HUSBAND

DAYTIME PHONE #
408-363-0562

3 KAISER PERMANENTE® 58

EMERGENCY DEPARTMENT PHYSICIAN RECORD

DATE 9/1/02	PMD: Unempaneled
ROOM NO.	☐ MSE REVIEWED ☐ CIPS REVIEWED ☐ VITAL SIGNS ☐ MEDICATIONS ☐ ALLERGIES
ROOM TIME	VITAL SIGNS: TIME TAKEN: BP 141/82 HR 102 RR 16
PROVIDER EXAM TIME	T 98 SAO₂ ____ RA/O₂ ____ L/min Wt. ____ Kg Last dT. ____
DISCHARGE TIME	MEDICATIONS: ☐ None
OLD CHART ORDERED X YES ☐ NO 1936	ALLERGIES: ☐ NKDA

OLGA A FEDORIAKA
62297 11244330 IMPRINT AREA 02 71 363-09 F

☐ INDUSTRIAL

History obtained from: ☐ Old chart reviewed ☑ Patient ☐ Family ☐ Interpreter ☐ Other: ____

Unable to obtain complete hx due to: ____

CHIEF COMPLAINT: Abd pain

HPI CODING: ☐ Levels 1-3: *1-3 elements* ☐ Level 4,5: *4 or more elements or status of 3 multiple chronic conditions*

Location: 31 ♀ c/o Abd pain, mid umbilical, RLQ
Quality: x 2 days + ⊕ Temp 100.3 today
Severity: ⊖ chills ⊕ N/V occasionally ~ several months
Duration: ⊖ BM ~ last
Timing/Context: ⊖ pain ē ambulation. ⊖ URI symptoms.
Modifying Factors: ⊕ intermittent diarrhea/constipation
Associated Signs:

INSTRUCTIONS (PMH, FAM HX, SOC HX, and ROS sections): Slash = Not Present, Circle = Present

PMH: ☑ No serious illness **PMH, FAM HX, SOC HX CODING:** ☐ **Level 4:** 1 out of 3 (PMH, Fam Hx or Soc Hx) ☐ **Level 5:** 2 out of 3 (PMH, Fam Hx and/or Soc Hx)

Immune Status: Anemia HIV Chemo Steroids Splenectomy Leukemia CA

Cardiac HX: A-fib CHF CAD CABG MI PTCA Cardiac cath Pacemaker **Cardiac RF:** Smoker HTN DM Fam. HX CAD Hypercholesterolemia

Pulmonary HX: Asthma COPD Steroids

GI Disease: PUD GERD Liver/Biliary/Pancreatic disease IBD GI Bleed Diverticuli "Irritable Bowel Syndrome" c/ months

Renal Disease: Renal insuff Dialysis Renal transplant Urolithiasis

GYN HX: G ___ P ___ TAB ___ SAB ___ LMP ______ HX STD HX IUD HX Ectopic Preg. Tubal Ligation HX Endometriosis C-Section

Surgical HX: ~~Appy.~~ ~~Cholecyst~~ SBO AAA Hysterectomy Hernia

Neuro HX: CVA TIA Seizures HA Dementia Alzheimers Parkinsons **Psych HX:** Anxiety Depression

FAMILY HX: None Diabetes Hypertension Heart disease CA Other: ____

SOCIAL HX: Tobacco ___ ETOH ___ Drugs ___ Lives alone/w ______ S M D W Domestic violence Homeless Care facility: ____

Occupation: ______ Other: ______

REVIEW OF SYSTEMS: ☐ All other systems negative

ROS CODING: ☐ Level 1: *0 sys* ☐ Level 2-3: *pp* ☑ Level 4: *2-9 sys* ☐ Level 5: *10+ sys*

CONST: (Fever) ~~Chills~~ ~~Wt. loss~~ ~~Weakness~~ ~~Fatigue~~ ~~Diaphoresis~~
EYES: Acuity change Photophobia Pain Diplopia
ENMT: Hearing loss Earache Nasal drainage Sore throat Hoarseness
RESP: ~~SOB~~ ~~Cough~~ Sputum Wheezing Stridor Hemoptysis Pleuritic Pain DOE
CV: Chest Pain Palpitations PND Orthopnea DOE
GI: ~~Nausea~~ (Vomiting) ~~Diarrhea~~ ~~Pain~~ ~~Melena~~ Hematochezia Constipation Gallstones Anorexia
GU/GYN: ~~Dysuria~~ ~~Urgency~~ ~~Frequency~~ ~~Nocturia~~ Hematuria ~~Bleeding~~ Discharge ~~Cramping~~
ROS Other:

MUSC: Bone or joint pain Back/Neck problems ~~Trauma~~ Arthritis
NEURO: Syncope Focal weakness ~~HA~~ Seizure Dizziness Decreased LOC Dementia Numbness
PSYCH: Prior psych hx Depression Anxiety Memory Suicidal
INTEG: ~~Skin lesions~~ ~~Rash~~ Bruising
HEME/LYMPH: Bruising Adenopathy Anemia Edema
ENDO: ~~Polyuria~~ ~~Polydipsia~~ Heat/cold intolerance
ALLERGIC/IMMUNO: Urticaria Hayfever

E.D. M.D. SIGNATURE: [signature]

HYSICAL EXAMINATION/INSTRUCTIONS FOR PE: ✓ = Normal exam finding, ⬭ = Area for description of abnormal or relevant finding

OLGA A FEDORIAKA
MR #: 11244330 02 71

E CODING: ☐ HCFA req. elements ☐ Level 1: 1-5 elements in 1+ sys ☐ Level 2-3: 6 elements in 1+ sys ☑ Level 4: 2+ elements from 6 sys or 12+ elements from 2+ sys ☐ Level 5: 2+ elements from 9 sys

ONST: ☑ Vitals (See MSE) ☑ WDWN ☑ Well hydrated ☑ No resp. distress ☐ Appears well — does not appear ill

es: ☐ PERRL, Irises nl ☐ Lids, Conjunctiva / Cornea / Ant. chamber nl ☐ Discs & fundi nl ☐ EOMI

: ☐ Hearing grossly intact ☐ Ext. Ears, Nose nl ☐ Nasal mucosa nl ☐ TMs, Canal nl ☐ Lips, Teeth, Gums nl ☑ Oropharynx nl

ck: ☐ Supple/No masses / No C-spine tenderness / FROM w/o pain ☐ Thyroid nl

sp: ☑ Resp effort nl ☑ Palpation nl ☐ Percussion nl
☑ Clear to auscultation ☑ B/S equal ☐ No pleural rub

est: <Breasts> ☐ Inspection ☐ Palpation nl

: ☑ Regular rhythm ☑ No murmur, rub or gallop ☐ No carotid bruits ☐ No abdominal bruits ☐ Palpation nl ☐ No JVD ☐ Capillary refill nl
<Pulses> ☐ Femoral nl ☐ Dorsalis pedis nl ☐ No peripheral edema ☐ Post tibial nl ☐ All equal bilaterally

<ABD> ☐ Nondistended/BS nl / Soft/No masses or tenderness / No guarding or rebound / No palpable pulsatile mass ☑ Liver, Spleen nl ☑ No hernia
<Rectal> ☐ Tone nl/No masses or tenderness ☐ Stool hemocult neg. ☐ Quality control done

: <Male GU> ☐ Prostate nl ☐ Penis nl ☐ Scrotal contents nl/Testicular position and size nl/No tenderness or masses
<Female GU> ☐ Ext. genitalia nl ☐ Cervix nl/Os closed/No CMT ☐ Urethra nl ☐ Uterus nl ☐ No vaginal discharge
☐ No adnexal tenderness or mass ☐ Rectovaginal confirmatory
<Urinary> ☐ No bladder distension or tenderness ☐ No CVAT

: <Back> ☐ No vertebral tenderness ☐ FROM w/o pain <Pelvis> ☐ Stable, nontender
<Ext.> ☐ RUE nl ☐ LUE nl ☐ RLE nl ☐ LLE nl ☐ Inspection/Palpation: No Cyanosis/No Edema/No calf swelling/tenderness
☐ Gait & station nl ☐ Digits, Nails nl ☐ Neg. straight leg raise

uro: ☐ CN II-XII intact ☐ Sensation nl ☐ DTRs / Babinski nl ☐ Motor ☐ Speech nl ☐ Follows commands

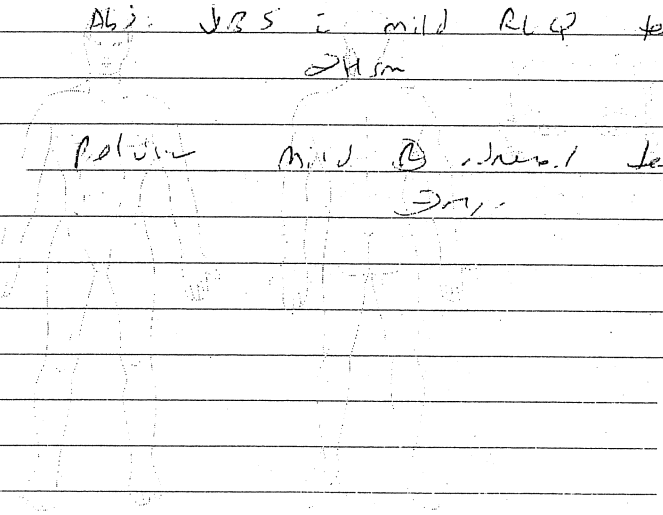
ych: ☑ A&Ox3 ☐ Judgement/insight nl ☐ Mood/affect nl ☐ Memory nl ☐ No suicidal ideation

n: ☑ No rash/No lesions ☑ Palpation nl

mph Nodes: Adenopathy: ☑ No cervical ☐ No axillary ☐ No inguinal ☐ Other:

Abd: ↓BS c mild RLQ tender ø rlg ø CVAT
ø HSM

Pelvis mild (B) adnexal tender ø rlg ø c-
ø m.



Visual acuity		
OD		
OS		

CONSULTANT Time Called:

DISCHARGE DIAGNOSIS:
Nonspecific Abdominal Pain
Pelvic

SPOSITION: ☑ Home ☐ Admit: Rm.#_____ Transfer to _____
☐ Deceased ☐ LWBS ☐ AMA ☐ Notified CME/_____

CONDITION UPON LEAVING E.D.:
☐ Improved ☑ Stable ☐ Guarded ☐ Critical

COMPLETE FOR INDUSTRIAL PATIENTS ONLY

1. Date of injury: ___/___/___ 2. Date last worked: ___/___/___
3. Are your findings and diagnosis consistent with history of injury or onset of illness?
☐ Yes ☐ No If "No," explain: _____
4. Is there any other current condition that will impede or delay patient's recovery?
☐ Yes ☐ No If "Yes," explain: _____
5. If occupational illness, specify etiologic agent and duration of exposure: _____
6. Were chemical or toxic compounds involved? ☐ Yes ☐ No
7. ☐ Return to work without restriction on ___/___/___ (date)
Remain off work until ___/___/___ (date)
☐ Modified duty as of ___/___/___ until ___/___/___ (dates)

Copy / V-mail / Fax sent to Dr. _____
☐ Referral / Follow-up request to _____
Discharge medications Rx

☐ Chart was dictated / computerized
☐ CHART COMPLETE:

KAISER PERMANENTE®

DATE: ______
TIME ARRIVED: ______
MSE TIME: 1928/1932

Team Assigned ______

MEDICAL SCREENING EXAMINATION 363-0562

OLGA A FEDORYAKA
11244330 02 71

Age: 31 ☐ Male ☒ Female **PCP:** ______

Mode of Arrival: ☒ Walked ☐ Ambulance ☐ PD ☐ Carried ☐ Wheelchair ☐ Gurney

Arrived From: ☒ Home ☐ Clinic ☐ Other ED ☐ Workplace ☐ Other Hospital ☐ SNF/ECF ☐ Jail ☐ Other: ______

Chief Complaint: fever, ABD Pain 1914

History of Present Illness: as above

Duration of Symptoms: Friday

Distress: ☐ None ☒ Mild ☐ Moderate ☐ Severe

Health History: ☒ Denies ☐ Asthma/COPD ☐ Smoking ☐ Diabetes ☐ Hypertension ☐ Seizures ☐ Cardiac ☐ CVA ☐ Psych.

D.V./ Abuse: ☐ Y ☐ N ☐ UNK ☐ Other: ______

Informant: ☒ Self ☐ Parent ☐ Paramedic ☐ Other: ______

Language: ☒ English ☐ Other/Translator: ______

☐ Industrial ☐ Needs Chart

MSE PRIORITY: 1 (2) 3 4

☐ Clinical presentation does not suggest an Emergency Medical condition exists per Standardized Procedure

02 Sat ______ % on ______ **Wt:** ______ KG/LBS
Temp 98% Resp 16 P 102 Bp 124/82 ( )
P 120 Bp 126/78 ( )

Medications: ☐ None Pepcid ASA @ 1730.

Allergies: ☒ NKA

Last Tetanus: ☒ N/A

Cardiac S1
Pulse: ☒ Regular ☐ Irreg
☐ Chest Pain (0-10) ______
☐ Chest Pressure
☐ Chest Tightness
☐ Other: ______

Respiratory ☒ Even and Unlabored
☐ CTA ☐ Dyspneic/SOB
☐ Cough ☐ Productive
☐ Wheezing ☐ PF ______
☐ Crackles ☐ Rhonchi
☐ Retracting ☐ Nasal Flaring
☐ Orthopneic
☐ Other: ______

Skin Signs ☒ Warm and Dry
☐ Hot ☐ Flushed
☐ Warm ☐ Pale
☐ Cool ☐ Dusky
☐ Cold ☐ Diaphoretic
☐ Hives ☐ Rash
☐ Other: ______
Mucous membranes: ☒ Moist ☐ Dry
☐ Other: ______

Pain Scale 0-10 5/10
Location: Umbilical.
Radiating: ☒ N ☐ Y ______
☐ Stabbing ☐ Burning
☐ Throbbing ☒ Sharp ☐ Dull
☐ Cramping ☐ Guarding
☐ Constant ☐ Intermittent
☐ Other: ______

GI ☐ Pt.Denies Symptoms
☐ Nausea ☐ Vomiting x ______
☐ Constipation ☐ Diarrhea x ______
☒ Other: last BM 1wk ago

GU ☐ Pt.Denies Symptoms
☐ Dysuria ☐ Hematuria
☐ Frequency/Urgency ☐ Retention
LMP: 4 wks
☐ Discharge ☐ Vaginal Bleeding
P/Hr: ______ ☐ Other: ______

Musc/Skel. ☒ MAE ☐ CMS intact
Deformity: ______
☐ Other: ______

Psych. ☒ Calm and Cooperative
☐ Risk to self/others
☐ Altered Thought Process
☐ ETOH/substance abuse
☐ Other: ______

Neuro
☒ Alert/age appropriate ☐ Disoriented

Loss of Consciousness
☐ No ☐ Yes, duration ______
Pupil Size (R) ____ mm (L) ____ mm

Glascow Coma Scale
Eye 4 Verbal 5

Eye		Verbal	
Spontaneously	4	Oriented	5
To Speech	3	Confused	4
To Pain	2	Inappropriate	3
None	1	Incomprehensible	2
		None	1

Motor 6

Obeys Command	6	Abnormal Flexion	3
Localized Pain	5	Abnormal Extension	2
Flexion Withdrawal	4	Flaccid	1

Weight Bearing
☒ Full ☐ Partial ☐ None ☐ Unsteady

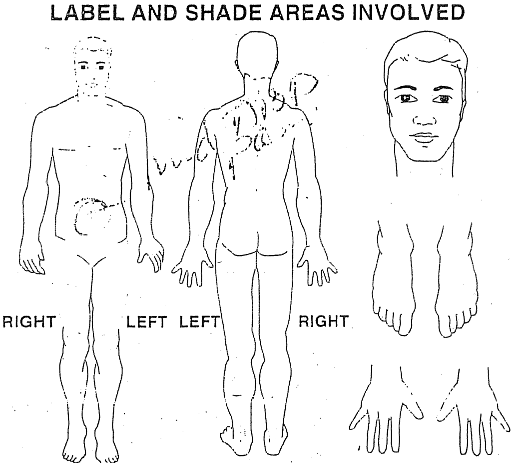
Bilateral Grasps
Right: ☐ Strong ☐ Weak ☐ Absent
Left: ☐ Strong ☐ Weak ☐ Absent

Field Care
☐ C-spine ☐ Backboard
☐ Splint ☐ IV
☐ O2
☐ Meds ______
☐ Rhythm ______
☐ Other: ______

Nurse Action @ MSE
☐ Dressing ☐ Splint
☐ Ice ☐ Sling
☐ NPO Instructions Given
☐ Resp. Precautions Initiated
☐ Security Standby
☐ FSBS ______ ☐ EKG

☐ Chest Pain Protocol (optional)
☐ UA per protocol (optional) ~~[illegible]~~
☐ UPT per protocol (optional)
☐ Ottawa protocol (optional)
☐ X-Ray per protocol (optional)
☐ Other: ______
Visual Acuity:
OS: ______ OD: ______ OU: ______

INJURY/LACERATION
LABEL AND SHADE AREAS INVOLVED



A = Abrasions
B = Burns
E = Ecchymosis
FB = Foreign Body
H = Hematoma
L = Laceration
P = Pain
PW = Punct. Wound
R = Reddened
S = Swelling
+ = Pulse Present
-- = Pulse Absent
↓ = ↓ ROM
Ø = Ø ROM

Notes: c/o guarding - tenderness, c/o rebound(-)
the pain is almost same
pt had similar episodes
Flagyl & px.

Disposition from MSE: ☐ LWBS ☐ Clinic: ______ Time ______
☒ E.D. Waiting Room ☐ E.D. Rm.# ______
Provider: ______
RN/MD SIGNATURE [signature]

CB 9'

KAISER PERMANENTE®

MEDICAL SCREENING EXAMINATION NURSE'S NOTES

OLGA A FEDORYAKA
11244330 02 71 F
IMPRINT AREA

Page 1 of ___ EXAM ROOM ___

TIME ___

Visual Acuity: OS: ___ OD: ___ OU: ___

O2 ___ l/min. ☐ cannula ☐ mask ☐ safety

Cardiac Rhythm ___

INITIAL	SIGNATURE	INITIAL	SIGNATURE
MO	MOwacarh		
DCC	DCa		

TIME	BP	P	R	T	PAIN	GCS	Pulse Ox	PROGRESS NOTES
2005	119/75	94	20		9/10	4 5 6		pt ambulated s̄ prob - denies
								abd pain ↑ this time. Sd
								into gown — MO
2145								Dr. Saavedra ↑ B/S for
2225	117/75	69	20					pelvic exam c̄ myself present
								pt c̄ minor discomfort c̄
								exam - GC/Chl. cx to lab in
								2155 To US via Gurney — DCC
					8/10			2215 Return from U/S. A!Ox4
								PWD C/o 8/10 abd pain. Dr
								Saavedra aware — DCC
							2230	Medicated for 8/10 pain.
								Dr Saavedra @ B/S — DCC
2300	108/68	83	20		4/10			A!Ox3 PWD NAD — DCC

START TIME	#	AMT	TYPE	GAUGE	SITE	RN IN	Amt Absorb

PARENTERAL FLUIDS

TIME	MEDICATIONS	DOSE	ROUTE	SITE	RN INIT
2230	Toradol	60mg	IM		DCC
	DT 0.5 cc		IM		
	Lot #	Exp. Date			

INTAKE TIME	TYPE	AMOUNT	OUTPUT TIME	TYPE	AMOUNT
TOTAL			TOTAL		

DISCHARGE DISPOSITION

Time: 2300

☑ Ambulate ☐ W/C ☐ Gurney ☐ EMS ☐ Gurney Van

☐ Carried ☑ Home ☐ SNF/ECF ☐ TX ___ ☐ Admitted Rm.# ___

☐ Pt/SO verbalizes understanding of D/C Instructions DCC (initials)

Patient belongings: ☐ with patient ☐ with family member

☐ Other: ___

Disposition Assessment: D/C'd home

KAISER PERMANENTE®

EMERGENCY DEPARTMENT PHYSICIAN ORDERS

OLGA A FEDORIAKA
11244330 02 71

TIME NOTED	INITIAL	CIRCLE INITIAL ORDERS
		Old Charts: outpatient inpatient
		O_2 ______ L/min ______ via ______
		O_2 SAT on RA or ______ L
		IV Solution ______ Rate ______
		Saline Lock
		Postural VS ☐ ☐ ☐
		EKG Rate ______ Rhythm: ☐ NSR ______
		ST/T abnls: ☐ None ______
		Ectopy: ☐ None ______
		☐ No change compared to ___/___ EKG
		Other Findings ______
2020	SG	Panel 1 (Basic Panel) [illegible]
		Panel 2 (Biliary/Abd Pain)
		Panel 3 (Chest Pain/MI)
		Panel 4 (Bleeder)
		Panel 5 (Thrombolytic)
		Panel 6 (AB/Ectopic)
		Panel 7 (Lumbar Puncture)
		Fever Panel
		CXR PA/Lat

DATE: ______

TIME ORDERED	TIME DONE	NURSE INITIAL	ADDITIONAL ORDERS
2014	2020	SG	UA, UPT
2040	2050	SG	RLQ ultrasound [illegible] r/o cyst vs appendicitis
2100		DLL	pelvic setup
			[illegible]
2210		DLL	[illegible] IM
2220			D/C Home [illegible]

TIME | PROGRESS NOTE / MEDICAL DECISION-MAKING

UA [illegible]
[illegible]
[illegible]
UPT ⊖

12.3 > 13 / 38 < 284 [illegible]

139 | 100 | 11 / 4.3 | 124 | 0.7 < 97

[illegible] [illegible] [illegible]
[illegible]
[illegible]

☐ Discharge from ED with instructions

Critical Care Time: ______ minutes

STAFF SIGNATURE [signature] INITIAL

ED MD SIGNATURE [signature]

INITIAL ORDER TIME

STAFF SIGNATURE INITIAL ED MD SIGNATURE

07724-22 (REV. 2-01) DISTRIBUTION: WHITE – MEDICAL RECORD • CANARY – BUSINESS OFFICE • WHITE – ED

EMERGENCY SERVICES PATIENT INSTRUCTION/DISCHARGE

VISIT VERIFICATION

☐ INDUSTRIAL ☐ NON-INDUSTRIAL

☐ Was seen at this office on _____

☐ Has been given telephone advice on _____

☐ Has been ill and unable to work from _____ through _____

☐ States has been ill and unable to work from _____ through _____

☐ Diagnosis _____

☐ Can return to full duties with NO RESTRICTIONS on _____

OR

☐ Can participate in a modified work program starting _____ and continuing to _____

(Please note: if modified work is not available, this patient is then unable to work for this time period.)

☐ RESTRICTIONS: _____ Hours per day _____ Hours per week

BASED ON AN 8-HOUR DAY EMPLOYEE CAN:

Stand/walk	_____ hours at a time	_____ total hours	☐ no restrictions
Sit	_____ hours at a time	_____ total hours	☐ no restrictions
Drive	_____ hours at a time	_____ total hours	☐ no restrictions

LIFT/CARRY: (Occasionally = up to 1/3 workday. Frequently = up to 2/3 workday)

0-10 lbs	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
11-25 lbs	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
26-40 lbs	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions

EMPLOYEE IS ABLE TO:

Bend	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
Squat	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
Kneel	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
Climb	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
Reach above shoulders	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
Perform repetitive hand motions	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions

ASSISTIVE DEVICES? (i.e., cast, brace, crutches) _____

RESTRICTIONS: (Interpersonal relations, stress, hearing or vision) _____

OTHER: _____

TREATMENT STATUS: _____

☐ Medication effects which could impair performance: _____

☐ Physical therapy required. Frequency: _____

☐ Re-evaluation on: _____

I hereby authorize the Kaiser Permanente Medical Care Program to verify to my employer/school, upon request, the information contained on this form.

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON

RELATIONSHIP TO PATIENT

☐ ANT ☐ DAV ☐ FLD ☐ FRE ☐ FRS ☐ GIL ☐ HAY ☐ MAR ☐ MIL ☐ NAP ☐ NOV ☐ OAK ☐ PET ☐ PLS ☐ RCO ☐ RWC ☐ RCH ☐ ROS ☐ SAC ☐ SFF

☐ SFO ☐ SJO ☐ SBF ☐ SCL ☐ SRO ☐ STR ☐ SSC ☐ STO ☐ SUN ☐ VAL ☐ WCR

SIGNATURE AND TITLE	NAME (PRINT)	LOCATION	DATE

DISCHARGE INSTRUCTIONS

☐ Make appointment to be seen _____ days/weeks with _____

☐ You have been referred to your primary physician for an urgent recheck in 24-48 hours. The appointment office will call you between 7 - 9 a.m. the morning of your appointment.

Return if symptoms worsen.

☐ Call your physician in _____ days for follow-up on your condition.

If you are unable to obtain the recommended follow-up treatment, return to the Emergency Department.

Dx: _____

PHYSICIAN SIGNATURE	DATE	TIME

☐ Wound sheet ☐ Vaginal bleeding ☐ Chest pain/angina sheet

☐ Eye sheet ☐ Spains/strains sheet ☐ UTI sheet

☐ Head sheet ☐ Back/neck strain sheet ☐ G.I. sheet

☐ Other _____

I acknowledge receiving and understanding these instructions:

PATIENT'S SIGNATURE	DATE	TIME

PLEASE BRING THIS SLIP WITH YOU ON RETURN VISIT.

PLEASE PRINT, TYPE, OR STAMP NAME

THE PERMANENTE MEDICAL GROUP, INC.
250 INTERNATIONAL CIRCLE, SAN JOSE, CALIFORNIA 95119-1197 • (408) 972-7777

NAME	ADDRESS, CITY	DATE

SPECIFY MAJOR **DRUG ALLERGIES** TO BE ENTERED INTO PHARMACY SYSTEM AND CIPS

Rx PLEASE ✓ BOX(ES) THAT APPLY(IES): ☐ IND ☐ TPL ☐ LABEL IN SPANISH ☐ LARGE FONT	Qty	Refill
1 Unless checked, authorization is given to include this Rx in all approved refill programs. ☐ SIG:		
2 Unless checked, authorization is given to include this Rx in all approved refill programs. ☐ SIG:		
3 Unless checked, authorization is given to include this Rx in all approved refill programs. ☐ SIG:		

_____ M.D. ☐ COVERING M.D./D.O. ☐ N.P./P.A.

CAL. LIC. # DEA # RESOURCE #

☐ NUMBER OF ITEMS PRESCRIBED UNLESS CHECKED ☐ DISPENSE NEAREST STANDARD SIZE

IMPRINT CARD

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COMMUNITY MEDICAL CENTER

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CB

KAISER PERMANENTE

Hospital POCT
250 Hospital Parkway
San Jose, CA 95119

Dr. Philip Engleman, MD, Director

OLGA A FEDORYAKA
02/09/71 F
11244330
82297

IMPRINT AREA

Ordering Provider: SAAVEDRA

Date and Time Stamped

Emergency Room: CB

URINE DIPSTICK –URINALYSIS:

	PT. RESULT (Circle the result)	REFERENCE RANGE
LEUKO	Neg. Trace Small Mod Large	NEGATIVE
NITRITE	Negative Positive	NEGATIVE
UROBILI	0.2 1 2 4 8	≤ 2.0
PROTEIN	Neg. Trace 30+ 100+ 300+ ≥2000	NEGATIVE
pH	5.0 6.5 6.0 6.5 7.0 7.5 8.0 8.5	4.5 - 8.0
BLOOD	Neg. Tr. Mod. Hemo Tr. Small Mod. Large	NEGATIVE
Sp. GRAV	1.0 +: 00 05 10 15 20 25 30	1.005-1.030
KETONES	Neg. Trace Small Mod Large	NEGATIVE
BILIRUBIN	Neg. Small Mod Large	NEGATIVE
GLUCOSE	Neg. 100 250 500 1000 ≥2000	NEGATIVE

LOT #: 205C EXP DATE: 2003/11

TESTER'S NAME: SG 2022

HEMOCCULT:

REFERENCE RANGE
Negative

PATIENT RESULT: _____
CONTROL RESULT: _____

LOT #: _____
EXP DATE: _____
TESTER'S NAME:

URINE PREGNANCY:

PATIENT RESULT: REF. RANGE: Negative

☐ Patient Bar Appears ☑ Control Bar Appears
☐ Patient Bar Weak

LOT #: 262386 EXP DATE: 2003/10

TESTER'S NAME: SG 2022

GASTROCCULT:

Lot #:
EXP DATE:
REFERENCE RANGE: NEGATIVE

PATIENT RESULT: _____ pH: _____
CONTROL RESULT: _____ pH: _____
Tester's Name:

GLUCOSE METER:

	Time:	Time:	Time:	Time:
Initials				
Patient Result:				

REF. RANGE:
65-110 mg/dl (fasting)
60-159 mg/dl (random)

KAISER PERMANENTE®

EMERGENCY DEPARTMENT PATIENT CONSENT
DEPARTAMENTO DE EMERGENCIA
CONSENTIMIENTO DEL PACIENTE

IMPRINT AREA / ÁREA DE IMPRESIÓN

OLGA A FEDORYAKA
1124430 02 71 F

VALUABLES CHECKED / OBJETOS DE VALOR PARA GUARDAR
☐ YES / SÍ ☐ NO

MARITAL STATUS / ESTADO CIVIL
☐ SINGLE / SOLTERO ☐ MARRIED / CASADO ☐ WIDOWED / VIUDO ☐ DIVORCED / DIVORCIADO

WHO BROUGHT PATIENT IN? / ¿QUIÉN TRAJO AL PACIENTE?

NEAREST RELATIVE OR FRIEND / PARIENTE MÁS CERCANO O AMIGO
Andrea Defazio

ADDRESS (NO., STREET) OF NEAREST RELATIVE OR FRIEND / DIRECCIÓN (NO., CALLE) DEL PARIENTE MÁS CERCANO

PHONE / TELÉFONO
363-0562

CITY / CIUDAD

STATE / ESTADO

DO YOU WISH TO STATE A RELIGION? / ¿DESEA DECLARAR SU RELIGIÓN?
☐ NO
☐ YES / SÍ: _____

RECEPTIONIST/STAFF SIGNATURE / FIRMA DE LA RECEPCIONISTA

DATE: _____ (FECHA)

SSN NON-MEMBER: _____ (Nº DEL SEGURO SOCIAL DEL NO MIEMBRO)

PATIENT'S HOME MAILING ADDRESS (MUST HAVE PROOF, PLEASE CHECK BELOW) / DOMICILIO DEL PACIENTE (DEBE TENER COMPROBANTE, VERIFIQUE A CONTINUACIÓN)

CITY / CIUDAD

STATE / ESTADO

ZIP / CÓDIGO POSTAL

☐ CA DRIVER'S LICENSE #: (Nº DE LICENCIA DE MANEJAR DE CALIFORNIA)

☐ OTHER: (OTRO)

DAYTIME TEL NO. / TELÉFONO EN EL DÍA ( )

HOME TEL NO. / TELÉFONO EN CASA ( ) -

GUARANTOR'S EMPLOYER / EMPLEADOR DEL GARANTE

BUSINESS PHONE / TELÉFONO EN EL TRABAJO

GUARANTOR'S EMPLOYER' S ADDRESS / DIRECCIÓN DEL EMPLEADOR DEL GARANTE

CITY, STATE, ZIP CODE / CIUDAD, ESTADO, CÓDIGO POSTAL

Patient Consent:

ED Treatment Release: I consent to an examination, treatment, and other procedures that may be performed by emergency department physicians, nurses, and other staff to care for my current medical problem. I understand that I may undergo laboratory tests, X-ray exams, injections, and removal of tissue as part of my visit.

Patient Valuables/Property: I am aware that the hospital has a safe for valuables and secure storage for other personal belongings. I understand that the emergency department physicians, nurses, staff, and hospital are not responsible for the loss of valuables and personal belongings that I have chosen to keep in my possession during my stay in the Emergency Department.

Assignment of Benefits: PATIENT COVERED BY ANOTHER HEALTH PLAN.

I am assigning benefits to Kaiser Permanente for the services provided. I also authorize release of information concerning all claims pertinent to this treatment and permit a copy of this authorization to be used in lieu of the original. This authorization will be valid for this visit to the Emergency Department.

Medicare Patients: Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf.

"I have read and understand the information concerning consent to treatment, securing my valuables and personal property, release of information to another health plan, and release of information and payment request for Medicare patients."

Consentimiento del paciente:

Permiso para tratamiento en el Departamento de emergencia: Doy mi consentimiento para un examen, tratamiento y otros procedimientos que puedan ser realizados por los médicos, las enfermeras y otros personal del departamento de emergencia para mi problema médico actual. Entiendo que, como parte de mi visita, es posible que me hagan pruebas de laboratorio, me tomen radiografías, den inyecciones y me extirpen tejidos.

Objetos de valor y posesiones del paciente: Sé que el hospital tiene una caja fuerte para guardar artículos de valor y un lugar seguro para otros artículos personales. Entiendo que los médicos, las enfermeras, el personal del Departamento de emergencia, así como el hospital, no son responsables por la pérdida de artículos de valor ni de objetos personales que haya decidido retener conmigo durante mi estadía en el Departamento de emergencia.

Asignación de beneficios: PACIENTE CUBIERTO POR OTRO PLAN DE SALUD.

Asigno mis beneficios a Kaiser Permanente por los servicios prestados. También autorizo la entrega de información relativa a todas las reclamaciones pertinentes a este tratamiento y permito que se utilice una copia de esta autorización en lugar del original. Esta autorización será válida para esta visita al Departamento de emergencia.

Pacientes con Medicare: Certificación, Autorización para Divulgar Información y Solicitud de Pago del Paciente. Certifico que la información dada por mí al solicitar pago bajo el Título XVIII de la Ley del Seguro Social es correcta. Autorizo a cualquier entidad que tenga información médica u otra información sobre mi persona para que la divulgue a la Dirección del Seguro Social y/o al programa Medicare, o a sus intermediarios o portadores, toda información necesaria para esta u otra reclamación de Medicare relacionada. Solicito que el pago de los beneficios autorizados se realice en mi nombre.

"He leído y entiendo la información relativa al consentimiento para tratamiento, a poner mis objetos de valor y artículos personales en un lugar seguro, a la entrega de información a otro plan de salud y a la entrega de información y la solicitud de pago para los pacientes con Medicare".

Patient/Guardian Signature. _____
(Firma del paciente o tutor)

KAISER PERMANENTE

CONFIDENTIAL
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SPECIAL RELEASE

Myhanh Le, Ph.D.
Behavioral Medicine Dept.

SEP 11 2002

260 International Cr.
San Jose, CA 95119

Olga Defaria
1124330

BEHAVIORAL MEDICINE CONSULTATION/ASSESSMENT

Referred by _____ PCP (if different) _____

Reason for referral ☐ Depression ☐ Stress ☐ Anxiety ☐ Fam/Marital prob. ☐ Coping with illness ☐ Sleep problem
☐ Job stress ☐ Pain ☐ ETOH/Substance abuse ☐ Noncompliance ☐ Grief ☐ Other _____

☐ Initial appt. ☐ Same-day appt. ☐ TAV
☐ F/U appt: Pt reports doing BETTER/WORSE/SAME. Compliance with treatment plan: FULL/PARTIAL/NONE
Language _____ Interpreter offered declined provided by _____

ID/PP/CONCERNS (include relevant precipitants, medical, psychol., or predisposing hx., progress since last visit)
31 yo F Russian Ukraine - been here 4 mos after married 2 mos. Left US 1st - had no prepared for S life in Ukraine - Depression, binge eating + vomiting 6-7 x/day - Period - when is menses when she's back in U.S. Reported marital probs w/ lack of support fr. spouse - doesn't know how to drive; not working - frequent arguments. Reported many symptoms of depression sxs - low energy, tiredness, crying easily, irritable

STRESSORS

PERTINENT PSYCH HX worrying too much, anxious - still vomits 2 x/day

PERTINENT MED HX Having stomach probs - feels like fear is not digesting

PERTINENT MEDS Paxil 20mg - for 1 wk ; Klonopin, Zoloft

FUNCTIONAL STATUS Work/School/Home/Interpersonal ☐ WNL ☒ Impaired _____

Nutrition poor appetite Exercise ⊖ Social support _____

COPING Worst 1 2 3 4 5 6 7 8 9 10 Best / per pt. report Need work both

cons formerly ! She had TAV in

MENTAL STATUS Attitude, behavior, mood, affect, speech, thought content/processing, memory, judgment, insight Psych 9/11
☐ WNL ☐ WNL except for _____

☐ Suicidal ideation/plan/intent ☐ Homicidal ideation/plan/intent ☐ Past hx of suicide attempts (means: _____)

HABITS ETOH 1-1½ qday Street drugs ⊖ Nicotine ⊖ Caffeine ⊖

DIAGNOSTIC IMPRESSION x-5x/wk
Eating D/O
Depression and anxiety features.

Discussed Treatment Options (Y) N Risks/benefits of treatment discussed (Y) N Obtained informed consent (Y) N

INTERVENTION/PLAN
- Start walking 3x/wk
- Eat small, frequent meals.
- Can provide book for report. I will also refer her to psych - will call Peggy Wallace who spoke w/ pt before

DISPOSITION ☐ TAV _____ (Best # _____) ☐ RTC _____ weeks/months
☐ RTC PRN ☐ BM group _____ ☒ Referred to psychiatry dept for Rx
☐ Chem. dep. _____ ☐ Health ed. _____ ☐ Other _____

SIGNATURE _____, Ph.D. DATE 9/11/02

0)902

KAISER PERMANENTE®

Phuong Tran, M.D.
Medicine/Family Practice [redacted]

OCT 0 3 2002

PROGRESS NOTES – INTERNAL MEDICINE

PLEASE IMPRINT OR PRINT

TELEPHONE	PROVIDER
DATE/TIME	PCP

DATE OF SERVICE	LOCATION	STATION
[redacted] NAME	FIRST NAME	INITIAL
BIRTH DATE MO. OLGA YEAR	HEALTH INSURANCE CLAIM NUMBER FEDORYAKA	
MEDICAL RECORD NUMBER 11244330	02 71	CHECK DIGIT
COVERAGE	GROUP NUMBER	ACCOUNT NUMBER / SUB GROUP

Allergies: 11/9/71 Age: 31 ☒ NKDA Weight: 127

Height: ______ Vitals: BP ______ Temp 98.4 Pulse 76 Resp ______

O_2 Sat: ______ Visual acuity: OS ______ OU ______ OD ______

PEFR ______ M.A. signature: [illegible] C/C: Flu Abdominal problem

HISTORY

1. **Chief Complaint / History of Present Illness:** *(Location, Quality, Timing, Severity, Duration, Context, Modifying Factors, Associated signs/symptoms) (1-3 Focused/Expanded, 4+ Detailed/Comprehensive)* **OR Status of 3 Chronic / Inactive Conditions** *(3+ Detailed/Comprehensive)*

[illegible]
– Hx [illegible]
– Ros; [illegible]

4. **Medications:**
☐ Agree with CIPS
☐ See visit ______
☐ Refer to chart chronic med list

☐ CIPS Reviewed Interval changes and additions noted

2. **Review of Systems – Check for negative or normal – Circle Abnormals**

☐ Constitutional ☐ Resp ☐ C/V ☐ GI ☐ Neurology ☐ Psych
☐ Eyes ☐ Skin ☐ G/U ☐ Endocrine ☐ Domestic violence
☐ Ears, nose, mouth, throat ☐ Heme/lymph ☐ All other systems neg
☐ Allergy/immunology ☐ Musculoskeletal ☐ See HPI

Comments / Elaboration:
ROS: 1 prob pertinent, 2-9 extended, 10+ complete

3. **Past, Family, Social History:** Marital status, employment, alcohol, tobacco, family.
☐ SESS/CIPS Reviewed ☐ SESS updated ☐ See HPI
Interpreter Used? ☐ Yes ☐ No Language: ______

EXAM

(Checking the box indicates that the exam was performed and within normal limits – **circle abnormals.**)
Exclude items in brackets from element count.

Pertinent Findings

Constitutional
Appearance: ☑ NAD ☐ Well developed ☐ Ill-appearing ☐ Cachectic

1. **Eyes**
☐ Conjunctivas / lids ☐ Pupils / irises (reaction, size & symmetry)
☐ Ophthal exam disks/post segments [☐ Visual fields]

2. **ENMT (Ear, Nose, Mouth & Throat)**
☐ Hearing ☐ Lips, teeth and gums ☐ Otoscopic exam EACs, tympanic membranes
☐ Oropharynx [☐ TMJ]
☐ Nasal mucosa / septum / turbinates ☐ External ears, nose

3. **Neck** ☐ Masses, appearance, symmetry ☐ Thyroid

4. **Respiratory** • Lungs • Chest
☑ Respiratory effort ☐ Percussion
☑ Auscultation/breath sounds ☐ Palpation

5. **Cardiovascular**
☐ PMI [☐ JVP] ☐ Pedal pulses
☑ Auscultation of heart ☐ Abdominal aorta ☐ Extremity edema / VV
☑ Carotid arteries ☐ Femoral arteries

[illegible]

6. **Breasts**

SOPC)U

TIENT NAME	DATE	MR#	PHYSICIAN

hecking the box indicates that the exam was performed and within normal limits – **circle abnormals**.)
ıde items in brackets from element count.

	Pertinent Findings
. **Gastrointestinal** ☐ Abdominal exam (tenderness/masses) [☐ Guaiac] ☐ Anus/perineum (sphincter tone, masses, hemorrhoids) [☐ Bowel sounds] ☐ Hernia ☐ Liver/spleen ☐ Obtain stool sample (if indicated) [☐ Deferred] [☐ Pt. refused]	
. **Genitourinary** Male: ☐ Scrotum [☐ Testes] ☐ Penis [☐ Epididymis] ☐ Digital rectal of prostate ☐ Pt. refused Female: ☐ External genitalia ☐ Urethra ☐ Uterus ☐ Bladder ☐ Adnexa/parametria ☐ Cervix	
Lymphatic System Palpation of lymph nodes in two or more areas: ☐ Neck ☐ Axillae ☐ Groin ☐ Other:	
. **Musculoskeletal** ☐ Inspection/palpation of digits and nails ☐ Gait and station ☐ Neuro/vascular intact ☐ Exam of joints/bones/muscles *(1 or more areas)* ☐ Head and neck ☐ Palpation ☐ ROM ☐ Stability ☐ Strength/tone ☐ Spine/ribs/pelvis ☐ Palpation ☐ ROM ☐ Stability ☐ Strength/tone ☐ Rt. Upper Ext. ☐ Palpation ☐ ROM ☐ Stability ☐ Strength/tone ☐ Lft. Upper Ext. ☐ Palpation ☐ ROM ☐ Stability ☐ Strength/tone ☐ Rt. Lower Ext. ☐ Palpation ☐ ROM ☐ Stability ☐ Strength/tone ☐ Lft. Lower Ext. ☐ Palpation ☐ ROM ☐ Stability ☐ Strength/tone	☐ Erythema ☐ Effusion ☐ Tender ☐ FROM ☐ Deformity ☐ Warmth
. **Skin** ☐ Inspect skin and subcutaneous tissue ☐ Palpation [☐ Good turgor] [☐ No rash]	
. **Neurologic** ☑ Cranial nerves ☐ Sensation ☑ Deep tendon reflexes [☐ Motor] [☐ Cerebellar]	
Psychiatric ☑ Mood/affect (depressed, anxious) ☐ Recent/remote memory ☑ Orientation: time, place, person ☐ Judgement and insight	Appropriate affect

rob-foc (1-5 bullets), Exp Prob-Foc (6-12 bullets), Detailed (2+ bullets from 6 area/sys or 12+ bullets from 2+ area/sys), omprehensive (perform all elements and document 2+ bullets from 9+ area/sys)

ASSESSMENT AND PLAN

A/ [illegible]
[illegible]

P/ – [illegible] 20 → 10 [illegible]
– Monitor for adverse effects [illegible]
– [illegible]
– [illegible]

☐ **Ed materials given/discussed**
Data reviewed/ordered (labs, x-rays, tests):
☐ Mammo
☐ F-sig
☐ Lipids
☐ CBC
☐ Lytes
☐ Lft
☐ HGBa1c
☐ Fructose
☐ FBS
Referral to:
☐ PT
☐ BMS
☐ CHE
☐ CC M:
New Meds:

TC: prn ______ weeks/months tav ______ weeks/months ADMITTED OTHER:

pent approximately ______ (%) / (minutes) in counseling and/or coordination of care during this encounter, which included discussion of the following:

tal visit time: ______

OMPLETED BY [signature] M.D./D.O./N.P./P.A. DATE [illegible]

KAISER PERMANENTE®

URGENT CARE CLINIC
PHYSICIAN RECORD

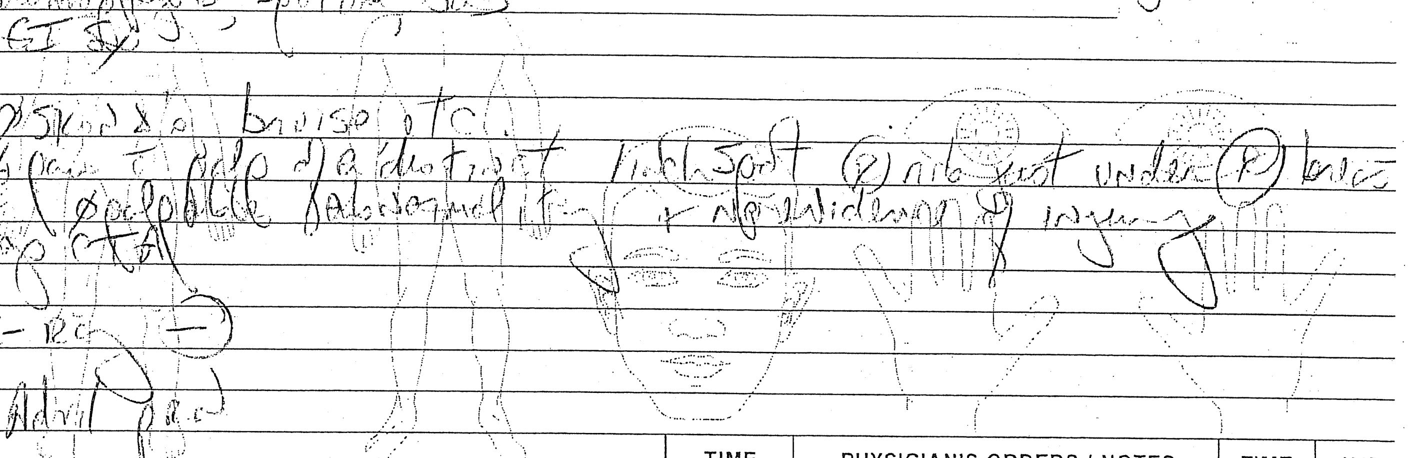
Olga [illegible] Alfaro
MR# 11244333
DOB 2-9-71
408 363 0562
IMPRINT AREA

DATE 10/14/02	PMD:
ROOM NO. 9	MSE REVIEWED CIPS REVIEWED ☐ Vital Signs ☐ Medications ☐ Allergies
ROOM TIME 1640	VITAL SIGNS: TIME TAKEN: BP 123/72 HR 101 RR 18
PROVIDER EXAM TIME	T 97.9 SAO2 ____ RA/O2 98% RA L/min Weight ____ Kg
DISCHARGE TIME	MEDICATIONS: ☒ None
OLD CHART ORDERED ☐ YES ☐ NO	ALLERGIES: ☒ NKDA

☐ EMS ____ AMBULANCE REQUEST PASSES PRUDENT LAYPERSON TEST ☐ YES ☐ NO ☐ INDUSTRIAL

CHIEF COMPLAINT: pain (R) rib; injury @ Oakridge mall × 6 days hand & breath ☐ INTERPRETER

HPI and PHYSICAL EXAMINATION:



31 yo f [illegible] (R) ribs just under breast 6 d ago
c/o persistent pain – hurts worse to cough, laugh, move
no [illegible], [illegible] SOB
no GI sx

O/ [illegible] bruise, [illegible]
c/o pain [illegible] tender spot (R) rib just under (R) breast
[illegible] + [illegible] injury
[illegible]

X-RC (–)

P/ Advil [illegible]

COMPLETE FOR INDUSTRIAL PATIENTS ONLY

1. Date of injury: ___/___/___ 2. Date last worked: ___/___/___
3. Are your findings and diagnosis consistent with history of injury or onset of illness?
   ☐ Yes ☐ No If "No," explain: ____
4. Is there any other current condition that will impede or delay patient's recovery?
   ☐ Yes ☐ No If "Yes," explain: ____
5. If occupational illness, specify etiologic agent and duration of exposure: ____
6. Were chemical or toxic compounds involved? ☐ Yes ☐ No
7. Work status: ☐ Full duty as of ____ (date)
   ☐ Modified duty as of ____ (date) ☐ Off work until ____ (date)

TIME	PHYSICIAN'S ORDERS / NOTES	TIME	INT.
	NOTIFY San Jose D.C.	1646	
	02-287-0807 Birch 3544		

NURSE SIGNATURE

Time 1800 Signature [illegible]

☐ Copy / V-mail / fax to Dr. ____
☐ Referral / Follow-up request to ____
☐ Discharge medications ____

CONSULTANT Time Called:

1. ____

DISPOSITION: ☒ Home ☐ Admit: Rm.# ____ ☐ Transfer to ____
☐ Deceased ☐ LWBS ☐ AMA ☐ Notified CMR/ ____

CONDITION ON DISCHARGE: ☐ Improved ☒ Stable ☐ Guarded ☐ Critical

DISCHARGE DIAGNOSIS:
Chest wall pain

☒ CHART WAS DICTATED / COMPUTERIZED
☒ CHART complete:

COMORBID CONDITIONS:
(Circle) CA CAD CHF COPD CVA DM ESRD HTN

U.C.C. PROVIDER SIGNATURE [signature]

KAISER PERMANENTE®
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

DEFARIA OLGA K
DOB 02/08/71 F
PLEASE IMPRINT OR PRINT

DATE OF SERVICE	LOCATION	STATION

LAST NAME	FIRST NAME	INITIAL

BIRTH DATE MO. DAY YEAR	HEALTH INSURANCE CLAIM NUMBER

MEDICAL RECORD NUMBER	CHECK DIGIT

SEX	COVERAGE	GROUP NUMBER	ACCOUNT NUMBER	SUB GROUP

PATIENT TREATMENT PERMIT AND RELEASE AGREEMENTS

Please read and sign the following necessary permits, releases and agreements so that we may proceed with the care and treatment ordere by your physician.

1. **MEDICAL AND SURGICAL TREATMENT PERMIT:** Permission is hereby given for any medical treatment including any X-ray examinations and injections as may be deemed advisable or necessary by the attending physicians and/ or his associates, assistants of his choice, including medical students and physician residents, and personnel assigned by the Hospital.

2. **RELEASE OF INFORMATION:** The hospital is authorized to furnish from patient's record requested information or excerpts to any insurer of patient. In accordance with California state law, the hospital is authorized to release patient's name, sex, city of residence, and a statement of general condition to persons who inquire, including representatives of the media unless otherwise requested. Callers will not be told of any admission to the hospital for treatment of alcohol or drug abuse, or for psychiatric care. Pursuant to the federal medical device requirements, I authorize release of my social security number for the purposes of filing a report to the manufacturer, if I am provided a device specified by the regulations. (21 C.F.R. Section 821.20)

3. **FINANCIAL AGREEMENT:** In consideration of hospital and medical services rendered to the patient, the undersigned, whether she/he signs as patient, parent, spouse or personal representative of patient, agrees to pay any and all non-covered charges for such services upon presentation of a statement of charges. Should the account be referred for collection, the undersigned hereby agrees to pay reasonable collection costs, including attorney's fees, together with interest at the legal rate.

4. **ASSIGNMENT OF BENEFITS:** PATIENTS COVERED BY ANOTHER HEALTH PLAN.
I am assigning benefits to KFHP for the service provided. I also authorize release of information concerning all claims pertinent to this treatment and permit a copy of this authorization to be used in lieu of the original.

   This authorization will be valid for up to one (1) year from the date of signature.

5. **MEDICARE PATIENTS:** Patient's Certification, Authorization to Release Information, and Payment Request.
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/ or the Medicare program or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefit be made on my behalf. I have received the information "An Important Message from Medicare."

THE UNDERSIGNED CERTIFIES THAT SHE/HE HAS READ AND UNDERSTOOD THE FOREGOING, HAS RECEIVED A COPY THEREOF, ACCEPTS AND AGREES TO ABIDE BY ITS TERMS.

DATE 10/14/02	HOUR	SIGNATURE OF PATIENT
WITNESS		SIGNATURE OF PATIENT'S PARENT OR REPRESENTATIVE
REASON PATIENT DID NOT SIGN RELEASE		RELATIONSHIP TO PATIENT

IF MEDICARE PATIENT **is unable to sign:** In order to process a Medicare Claim, the signature below, on behalf of the patient, pertains ONLY to the Patient's Certification, Authorization to Release Information and Payment Request, specified as Paragraph 5, above.

DATE	HOUR	SIGNATURE OF ADMITTING DESIGNEE	TITLE

KAISER® PERMANENTE

PATIENT PROGRESS RECORD

PATIENT'S NAME (LAST, FIRST, MIDDLE)

ADDRESS (NO., STREET)

CITY

BIRTHDATE | PHONE | CODE | GROUP

M.R. # Olga Defaria 1124430

Myhanh Le, Ph.D.

OCT 0 J 2002

~~Behavioral Medicine~~

TAV. Pt called - Said she was caught shop lifting yesterday for more than $2000 worth of clothes + jewelry - was arrested + released - Said she was feeling suicidal yesterday - afraid how her husband would react - She also called to inform me that her husband would call me ~~to~~ regarding her health - She gave verbal permission. Also r'cd her psych appt 10/1/02 - thinking that it would cost a lot more to be seen in psych - I assured her that it wasn't the case + encouraged her to call psych back - She agreed to do that, to also be safe to self.

M. Le, PhD

- Received msg fr. her spouse - LM for him at work on 10/10/02 to call back -

10/10/02 - Pt was seen in psych.

M. Le, PhD

FILE IN CHART

STR NUTRITION SERVICES Consult Form

created by Alex Tran on **09/04/2002**

Requested By:

Person requesting consult (if different from sender): Alex Tran	
Send Copy of Request to:	
Provider Mnemonic: **TRANAP**	Requestor's Department: MED
Provider ID: 13531	Requestor's Phone Number: 84406006
Facility: STR	Title: MD

Requested For:

Patient's MR Number:	11244330* *(format - 8 digits)*
Patient's Last Name:	Defaria*
Patient's First Name:	Olga*
Patient's Gender:	○ M ● F
Patient's Age:	31
Patient's Phone Number: (optional)	

Request Details:

Reason for Referral: (please click on the arrow to the right of the field to select a reason for referral)
EATING DISORDER*

CRES Reason Description: EATING DISORDER CRES Reason Code: **009**

History/Other Comments: 7+ years bulimia. Please counsel regarding good nutritional fundamentals. Thank you.

Urgency of consult:
○ Elective ● Urgent (Call the on-call physician if needed)

Patient Insists: ○ Yes ● No

Type of Injury (if applicable): ○ Industrial ● Non-Industrial
*

For Receiving Departments only:

Triage Disposition: DTC N60. PLEASE CALL.

Other Comments:

Edit History: 5-09/05/2002 06:38 PM-Debra Potosky; 4-09/04/2002 06:12 PM-Alex Tran; 3-09/04/2002 06:09 PM-Alex Tran; 2-09/04/2002 06:09 PM-Alex Tran; 1-09/04/2002 06:09 PM-Alex Tran

Provider's Findings:

CRES ✓
Received _____ /Init
Booked _____ /Init
Type appt _____

Cardiac
1st letter sent 9/9/09 /Init
No response _____ /Init
2nd letter sent 10-16 /Init
File _____

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Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

PLEASE IMPRINT OR PRINT

DATE OF SERVICE | LOCATION | STATION

LAST NAME | FIRST NAME | M.I.

BIRTH DATE MO. DAY YEAR | HEALTH INSURANCE CLAIM NUMBER

MEDICAL RECORD NUMBER | CHECK DIGIT

SEX | COVERAGE | GROUP NUMBER | ACCOUNT NUMBER | SUB GROUP

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT TREATMENT INFORMATION

MEDICAL, PSYCHIATRIC, DRUG/ALCOHOL, AND/OR BLOOD TEST

I hereby authorize Kaiser Santa Teresa
NAME OF SENDING PERSON, AGENCY, OR INSTITUTION

ADDRESS

CITY STATE ZIP

to release to ANDREW DEFARIA
NAME OF RECEIVING PERSON, AGENCY, OR INSTITUTION

6187 ELLERBROOK WAY
ADDRESS

SAN JOSE CA 95123
CITY STATE ZIP

records and information pertaining to

OLGA DEFARIA (OLGA MOFFAT) 1124330 2/9/1971
NAME OF PATIENT (LIST OTHER NAMES USED) MEDICAL RECORD NUMBER DATE OF BIRTH

6187 ELLERBROOK WAY (OLGA FEDORYAKA) SAN JOSE, CA 95123 408 363 0562
ADDRESS TELEPHONE NUMBER

DURATION: This authorization shall become effective immediately and shall remain in effect until 12/2/2003 or for one year from the date of signature. This consent is also subject to revocation by the undersigned at any time between now and the release of information by the sending person, agency, or institution.

RESTRICTIONS: I understand that the requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

PATIENT COPY: Please take a copy of this form after signing. ☐ Yes, I have taken my signed copy of this form.

☒ **MEDICAL INFORMATION:**
This authorization is limited to the following medical records and type of information: STOMACH PROBLEMS

The requester may use the medical records and type of information authorized only for the following purposes: COURT TRIAL

Date: 12/05/2002 Signature: [signature]

If signed by other than patient, indicate relationship:

☒ **PSYCHIATRIC INFORMATION:**
This authorization is limited to the following medical records and types of information: ALL RECORDS

The requester may use the medical records and type of information authorized only for the following purposes: COURT TRIAL

Date: 12/05/2002 Signature: [signature]

If signed by other than patient, indicate relationship:

☐ **DRUG/ALCOHOL INFORMATION:**
This authorization is limited to the following medical records and type of information:

The requester may use the medical records and type of information authorized only for the following purposes:

Date: Signature:

If signed by other than patient, indicate relationship:

☐ **RESULTS OF A BLOOD TEST TO DETECT THE PRESENCE OF HIV:**
This authorization is limited to the release of HIV test results. The requester may use this information only for the following purposes

Signature:

KAISER PERMANENTE®

Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

Location: STR

De Faria, Olga
1124 4330

REQUEST FOR ACCESS TO OR COPIES OF MEDICAL RECORDS

IMPRINT AREA

1. This request is made pursuant to California statute, Health and Safety Code sections 123100-123149. Under these sections I understand that the health care provider (hospital or medical group) is entitled to "payment of reasonable clerical costs incurred in locating and making the records available" before access to the records is permitted. If copies are requested, I acknowledge that the law requires me to pay reasonable clerical costs and permits copying fees of 25¢ per page (50¢ per page if copies from microfilm records). For copies of X-rays or tracings, fees are based upon actual costs incurred.
2. I understand that the provider has 5 working days, **after this request and payment of clerical costs**, in which to produce the requested medical records for examination. If I have requested copies, the provider has 15 days, **after receiving this request and payment of clerical costs and copying fees**, during which to assemble the records and make the copies.
3. I understand that the health care provider is authorized by law to determine if a summary is to be prepared in response to this request instead of providing original records for examination or copying. If the health care provider decides to furnish a summary instead of allowing access to the original record, it will be available within 10 days of this request and payment of the appropriate fee, or within 30 days if the record is of extraordinary length or if I was discharged from a health care facility within the last 10 days. The fee will be based upon actual time spent by our personnel in preparing the summary.
4. I further understand that records of mental health care, or alcohol or drug abuse treatment may not be disclosed to me directly if the health care provider determines that to do so would present a risk of significant adverse or detrimental consequences. I understand I then may designate a physician, licensed psychologist or clinical social worker to review the record on my behalf.
5. I understand that if I am a parent making a request regarding records of a minor, I will not be shown entries for health care to which, by law, the minor may consent without parental involvement.
6. I understand that if I am a minor, I will be given access only to those portions of my record describing health care for which I may consent, under applicable law, without involvement of parents.
7. The undersigned patient or patient's legal representative, hereby requests access to the Medical Records of: OLGA DEFARIA (AKA OLGA ~~MOFFAT~~, OLGA FESOR (AKA) ☒ Adult ☐ Minor
8. The record being requested is: ☒ Medical Office (Outpatient) ☒ Hospital (Inpatient) ☒ Mental Health
   Other _____
   for the period SEPT 2002 to OCT 2002 or
   for the particular injury, illness or episode described as: _____
9. The physician I usually see is: _____
10. I am requesting: ☐ access to the record indicated above
    ☒ copies made of the record indicated above
    for the purpose of: COURT TRIAL (OPTIONAL) RUSH need before 12/16/02

12-9-02
DATE OF REQUEST

Amount $ 15.00
DEPOSIT RECEIVED
pd cash

IDENTIFICATION OF REQUESTER (DRIVER'S LICENSE, CREDIT CARD)

Requester: ☐ Reviewed Record ☐ Received Copies
☐ Received Summary ☐ Other _____

Amount $

PATIENT'S SIGNATURE

PATIENT'S REPRESENTATIVE SIGNATURE

RELATIONSHIP TO PATIENT (PARENT, GUARDIAN OR CONSERVATOR)
HUSBAND

DAYTIME PHONE #

KAISER PERMANENTE

Department of Psychiatry
Santa Teresa

IOP Discharge Summary

Name Olga Dofaria MR# 11244330 Date 11-13-02

Admission Date 10/14/02 Discharge Date _____

The patient's discharge plans are:

- ☐ return visit with _____ in outpatient clinic
- ☐ medication visit on _____ with Pt. is currently in jail
- ☐ Post IOP Group
- ☐ referral to CDRP/CDS with CC to program
- ☐ continue in treatment with an outside therapist _____
- ☐ outside treatment with _____
- ☐ IOP Case Management by _____
- ☐ residential treatment program _____
- ☐ refused to participate in discharge planning (please comment below)
- ☐ refused further participation in IOP (please comment below)
- ☐ failed to return phone calls from staff
- ☐ other _____

Current medications Prozac 20mg qd

Additional comments Pt did not return to program. Husband reported domestic violence situation leading to Pt's incarceration. Unable to reach Pt.

Discharge diagnosis:

Axis I 296.32 MDD recurrent, moderate ??

Axis II (R/o Adult antisocial behaviors)

Axis III _____

Signature P. Heberlein PhD

IOP Disc: 5/98

Intensive Outpatient Program / Chemical Dependency Services

Defaria, Olga
Patient Name

11244330
Medical Record Number

is being referred to the CDS group within adult IOP.

IOP Clinician Signature Dana Wiesty, LCSW, 10/14/02
Date

Drinks 2-3 glasses of wine or mixed drinks daily — every other day. At times, pts. she has a problem controlling etoh intake.

CDS / IOP FEEDBACK

The above patient was seen and evaluated in IOP/CDS group _____.
Dates

It is recommended that:

- ☐ patient continue in IOP / CDS group.
- ☐ patient continue only in IOP group
- ☐ CDS Clinician will set up CDS intake
- ☐ other

CDS Clinician Signature _____ / _____
Date

KAISER PERMANENTE®

Northern California

Address 6187 Ellerbrook Way.
S.J. 95123
Phone 363-0562
Age 31

Defaria, Olga
11244330
IMPRINT AREA

INTENSIVE OUTPATIENT PROGRAM
INTAKE/DIAGNOSTIC SUMMARY

Date: 10/14/02

Identifying Data and Chief Complaint: (age, marital/relationship status, ethnicity, gender, occupation, referral source) 31 y.o. Ukraine-born ♀, married for 2nd time to an American husband. After first divorced, spent 6 years back home in Ukraine trying to get back to the U.S. Married x4 mo to current husband who has a ten y.o. dghr. who he cares for 2x/wk. Pt. currently unemployed and does not drive.

Referred by Shannon Michelson, ACSW from Crisis Grp

History of Present Problem: (symptoms, onset, duration, precipitating factors)
Severe depression, thoughts of suicide, hopelessness, helplessness, guilt, anxiety, fear, ∂° abusive husband, recent shoplifting arrest, marital problems, stepparenting problems.

States she has been depressed x6 yrs since divorce + return to Ukraine. 2 suicide attempts/gestures while in Russia - took pills, tried to "choke myself."

Fearful of husband, who drinks almost nightly and becomes abusive. Husband has pushed + pulled her to kick her out of the house and left bruises. (H) threatens to divorce her + sent her back to Russia, then recants and says he wants to work on the marriage.

H/O bulimia x 6 yrs - throwing up daily b/c overeats and feels too full. 5'7", 136 #. gained weight recently.

Psychosocial History: (childhood development, education, school, relationships, employment, legal)
Born in Ukraine, youngest of six girls. 1st husband was an American architect. He married her + they lived in Arizona, (H) travelled a lot and she was all alone, not speaking English, unemployed. (H) divorced her + she got a job + apt. in Arizona + was very happy. (H) convinced her to leave Arizona + go see him to Hong Kong, then did not get her VISA + she had to rtn. to Russia. Met current (H) when she was interpreter for dating firm. Mother critical

mptoms: See Personal Data Sheet

	Current	Past		Current	Past		Current	Past
aches								
ness			Restlessness			Hear voices others don't hear		
nach/bowel trouble	✓		Decreased need for sleep			See things others don't see		
th problems	✓		Mood swings			Strange experiences		
			Excess energy &/or feeling wired			Feel people plot against you		
nors or tics			Confusion			Constant suspicion/distrust		
g and/or alcohol cravings			Elated/euphoric mood			Unusual thoughts		
ng problems	✓		Excessive spending			Violent agressive behavior		
e eating	✓		Racing/overflow of thoughts			Thoughts of physically harming someone		
p problems	✓		Irritable			Physical abuse		
ght loss			Impulsive behavior shoplifting ✓			Sexual abuse		
ght gain	✓		Grandiose thoughts/plans			Sexual problems		
s of appetite			Anger or explosiveness			Relationship problems	✓	
ing apart from others	✓		Panic attacks			Financial problems		
energy	✓		Anxiety	✓		Work problems		
ing worthless	✓		Fears	✓		Conflict in family	✓	step dad
nory problems	✓		Nightmares					
ughts of suicide		✓	Fears of losing self control					
nning suicide			Recurring unwanted thoughts/ behaviors					
ing depressed	✓		Always worried	✓				
ng a lot			Concentration problems	✓				
ble to have a good time	✓							

ditional Symptoms: _____

ental Status Exam:

	WNL	Impaired/Comments
pearance/Behavior	✓	
gnition	✓	
ight	✓	
dgment	✓	
ention/Concentration	✓	
mory	✓	
entation x 3	✓	
nd of Knowledge	✓	
pulse Control		shoplifting, purging

eech		Pressured ☐	Slow ☑	Mute ☐		
od/Affect		Anxious ☑	Restricted ☐	Expansive ☐		
		Depressed ☑	Flat ☑	Angry ☐		
		Euphoric ☐	Blunted ☐	Tearful ☐		
ought Process	✓	Disorganized ☐	Loose Associations ☐			
ought Content	✓	Delusions ☐	Hallucinations ☐			

omments: _____

KAISER PERMANENTE®

Northern California

Defaria, Olga
11244330

IMPRINT AREA

INTENSIVE OUTPATIENT PROGRAM
INTAKE/DIAGNOSTIC SUMMARY

Date: 10/14/02

Alerts:

Does this patient have a history:	Current: Yes	Current: No	Current: Unknown	Past: Yes	Past: No	Past: Unknown
a) assault to persons			✓			
b) threat to persons		✓				
c) damaging property		✓				
d) involuntary holds (5150)		✓				
e) suicide threats	✓			✓		
f) suicide attempts				✓ x2 gestures		
g) self injurious behavior			✓			✓
h) treatment noncompliance		✓				
i) psychosis		✓				

Risk Statement: (If applicable) thoughts of suicide, contracts no harm

Alcohol and Drugs: See Personal Data Sheet (use patterns, treatments, DUIs, IV drugs, prescription drugs, tobacco, caffeine) drinks 2-3 glasses of wine or mixed drink every other day - at time felt she has difficulty controlling how much she drinks.

Past/Present Medical History: See Personal Data Sheet (illnesses, surgery/accidents/head injury/seizures)

Illness/Injury	Year	Comments
stomach problems		
amenorrhea	x5yrs	in Russia, was very thin

1. Current Medications: See Personal Data Sheet

Paxil, Zantac

2. Medications Tried:

rgies: ☒ None Known ☐ Yes

r Psychiatric History: (outpatient, inpatient, including psychiatric medications)
'96 Depression - during & after divorce
96-2000 Depression, 2 suicide gestures (pills, choking)
0/10/02 Admit ψ intake after shoplifting arrest.

OR LABS, CONSULTATIONS: ☐ Yes ☐ No ☒ Kaiser: See CIPS
er: ☐ Yes ☐ No Name(s): ☐ Requested

nily Psychiatric History: See Personal Data Sheet (psychiatric, substance abuse, suicides, medication responses)

Who	Maternal/Paternal	Psychiatric Illness	Alcohol & Drugs	Suicide Attempts	Psychiatric Medications
unknown					

mments:

ancial/Housing History:
lives w Husband, who "doesn't give me any money... I feel I have to beg him."
Wants to get a job & learn to drive

rengths: (family support, intelligence, motivation for treatment)
motivated for treatment
wants to get a job

eaknesses: (severity of impairment, noncompliance)
abusive husband
shoplifting charge
limited support

KAISER PERMANENTE®

Northern California

Defaria, Olga
11244330

IMPRINT AREA

INTENSIVE OUTPATIENT PROGRAM
INTAKE/DIAGNOSTIC SUMMARY

Date: 10/14/02

DIAGNOSES:

AXIS I. 296.3 MDD, r
Bulimia
R/O Alcohol Abuse

AXIS II. dependant features

AXIS III. stomach problems

AXIS IV. *(optional) Separating change, abusive husband unemployed, step parenting problems

AXIS V. *(optional) [GAF] 100 90 80 70 60 (50) 40 30 20 10 5 0

Formulation/Treatment Plan: (individual/marital/family/CD/medication/IOP/groups)
(Include goals, estimated timeframe, requests for previous treatment, information, labs)

↓ suicidal ideation
↓ vomiting
Stabilize mood

Attend IOP 5 days/wk x2-4 wks
CDS assessment

may refer Codependency Class after D/C IOP

Primary Care Provider Contacted: ☐ Yes ☒ No If no, reason: previously done

Follow-up Appointment: IOP 5 days/wk x 2-4 wks
may be absent 10/15/02 (H to airport), 10/16/02 dental work

PRACTITIONER'S NAME, SIGNATURE AND DEGREE	DATE
Dawn Wuesta, LCSW	10/14/02

IOP Referral

tient name: Olga Bedard MR#: 11244330
ge: ___ Sex: F Marital Status: ___ Telephone #: ___
n Disability? ___ Yes ✓ No
If yes, type of disability and expiration date: ___

ecklist — *Must all be "Yes" to be eligible*
tient has enough self-control and is **willing** to participate in a daily group-based program ✓ Yes ___ No
tient is not an imminent danger to self or others
("Yes" indicates patient is not imminently dangerous) ✓ Yes ___ No
(If "no", please consider evaluation for 5150 hospitalization.)
tient has been scheduled for IOP through Char or Paul, and has been booked on the computer ✓ Yes ___ No
IOP scheduled intake date: 10/14/02

story of psych. hospitalizations? ___ Yes (?) ___ No said she tried choking self in Ukraine
ate and location of most recent hospitalization: possibly Ukraine

agnoses: I: MDD 296.3 Eating Disorder NOS, Acute Stress R/O EtOH abuse
II: V71.09
III: stomach problem GAF: 45-50

hat current symptoms/circumstances are precipitating referral to IOP now? Include relevant ychosocial and environmental factors. severe depression, marital problems, eating disorder (purging) coping with ETOH. Recent shoplifting arrest + marital problem (husband is reportedly abusive + controlling)
urrent medications and target symptoms. Mention any problems with compliance.
Paxil 10mg - was on 20mg SI. Hx of suicide attempt by gestore had sexual side effect + went down to 10 choking here
story of current or past chemical dependence (include rx drug abuse)? ✓ Yes ___ No
yes, please describe:
Reports husband drinks a lot + she started drinking 3 glasses of wine at night to cope with stress + depression
iefly describe treatment goals you expect IOP to achieve within the 1-4 week IOP treatment model.
- Help pt learn adaptive coping skills to deal with current stressor
- Med eval to stabelize mood
- Attend dual Dx group to help pt deal with substance abuse issues + refer to Eating Disorder group

te: Admission to IOP will be determined by IOP staff. Upon discharge from IOP, patients may be urned to their therapist of record, if individual therapy is part of their follow-up treatment plan.
refer to therapist, Eating Disorder group, Next door

Shannon Mickelsen — 10/11/02
ferring clinician (include telephone extension) Date

Referral – revised 6/27/02

PATIENT	PROVIDER	CATEGORY	VIEW	FR DATE	TO DATE
11244330		LAB	RESULTS	09 / 01 / 02	12 / 12 / 02

Personal Physician : PHUONG A TRAN,M.D. STR
DEFARIA,OLGA 31/F Laboratory Results

-- Procedure -- ------- Results ------- (Reference Range) ----------
LOG#: 63G002008814 COL: 09/01/02 21:47 EMERG STR REQ: B SAAVEDRA,M.D.
** REGIONAL LAB **

Genprobe-GC/CH
SOURCE: CERVIX
---------- FINAL REPORT ----------
NEGATIVE FOR N.GONORRHOEAE BY DNA PROBE
NEGATIVE FOR CHLAMYDIA BY DNA PROBE

LOG#: 630224400557 COL: 09/01/02 21:43 EMERG STR REQ: B SAAVEDRA,M.D.
** SANTA TERESA MEDICAL CENTER **

Urinalysis

Color	YELLOW		
Culture?	NOT IND		
Microscopic?	NOT IND		
Appearance	CLEAR		
pH	6.5	(4.5 -	8.0)
Sp. Gravity	1.020	(1.010-30 -	)

LOG#: 630224400557 COL: 09/01/02 21:43 EMERG STR REQ: B SAAVEDRA,M.D. CONT
** SANTA TERESA MEDICAL CENTER **

Glucose	NEGATIVE	(NEGATIVE -	)
Blood	NEGATIVE	(NEGATIVE -	)
Nitrites	NEGATIVE	(NEGATIVE -	)
Ketones	NEGATIVE	(NEGATIVE -	)
Leuk Esterase	NEGATIVE	(NEGATIVE -	)
Protein	NEGATIVE	(NEGATIVE -	)
Bilirubin	NEGATIVE	(NEGATIVE -	)
Urobilinogen	0.2EU/dL	(=<2.0 -	)
Urine Source	CLEAN		

LOG#: 630224400528 COL: 09/01/02 21:42 EMERG STR REQ: B SAAVEDRA,M.D.
** SANTA TERESA MEDICAL CENTER **

CHEM7

BUN	11	mg/dL	(7 -	17)
Chloride	102	mEq/L	(98 -	107)

LOG#: 630224400528 COL: 09/01/02 21:42 EMERG STR REQ: B SAAVEDRA,M.D. CONT
** SANTA TERESA MEDICAL CENTER **

CO2	29	mEq/L	(22 -	30)
Creatinine	0.7	mg/dL	(0.6 -	1.2)
Glucose Random	93	mg/dL	(60 -	159)
Potassium	4.3	mEq/L	(3.5 -	5.3)
Sodium	139	mEq/L	(137 -	145)
Anion Gap	8	mEq/L		

LOG#: 630224400529 COL: 09/01/02 21:42 EMERG STR REQ: B SAAVEDRA,M.D.
** SANTA TERESA MEDICAL CENTER **

@CBC

WBC x 10¬3	12.3	K/uL	(3.5 -	12.5)
RBC x 10¬6	4.15	M/uL	(3.60 -	5.10)
Hemoglobin	13.1	g/dL	(11.0 -	15.0)
Hematocrit	38.3	%	(34.0 -	46.0)
MCV	92	fL	(80 -	100)

LOG#: 630224400529 COL: 09/01/02 21:42 EMERG STR REQ: B SAAVEDRA,M.D. CONT
** SANTA TERESA MEDICAL CENTER **

RDW	13.5	%	(11.9 -	14.3)
Plt x10¬3	289	K/uL	(140 -	450)
Manual Diff?	MD REQ			

@MDIF

Bands		2	%	(0 -	5)
Seg Neutrophils	H	86	%	(50 -	70)
Lymphocytes	L	7	%	(20 -	50)
Monocytes		2	%	(1 -	11)
Eosinophils		2	%	(1 -	5)
Basophils		1	%	(0 -	1)
Diff Method		MAN DIFF			
RBC Morphology		NORMAL			
PLT Estimate		ADEQUATE			

********** End of Report **********

file in Chart

STR NUTRITION SERVICES Consult Form

created by Alex Tran on **09/04/2002**

Requested By:

Person requesting consult (if different from sender): Alex Tran	
Send Copy of Request to:	
Provider Mnemonic: **TRANAP**	Requestor's Department: MED
Provider ID: 13531	Requestor's Phone Number: 84406006
Facility: STR	Title: MD

Requested For:

Patient's MR Number:	11244330* *(format - 8 digits)*
Patient's Last Name:	Defaria*
Patient's First Name:	Olga*
Patient's Gender:	○ M ● F
Patient's Age:	31
Patient's Phone Number: (optional)	

Request Details:

Reason for Referral: (please click on the arrow to the right of the field to select a reason for referral)
EATING DISORDER*

CRES Reason Description: EATING DISORDER CRES Reason Code: **009**

History/Other Comments: 7+ years bulimia. Please counsel regarding good nutritional fundamentals. Thank you.

Urgency of consult:
○ Elective ● Urgent (Call the on-call physician if needed)

Patient Insists: ○ Yes ● No	Type of Injury (if applicable): ○ Industrial ● Non-Industrial *

For Receiving Departments only:

Triage Disposition: DTC N60. PLEASE CALL.

Other Comments: called and sent 1st letter 9/9/02

Edit History: 6-09/09/2002 10:52 AM-Pat Botar; 5-09/05/2002 06:38 PM-Debra Potosky; 4-09/04/2002 06:12 PM-Alex Tran; 3-09/04/2002 06:09 PM-Alex Tran; 2-09/04/2002 06:09 PM-Alex Tran; 1-09/04/2002 06:09 PM-Alex Tran

Provider's Findings:

1 St letter + Card 9/9

11/20/02 Called

Need 2nd letter + card

Pt. is in Jail and will be dep

Kaiser Santa Teresa
Intensive Outpatient Program (IOP)
GUIDELINES FOR PATIENTS

Program Definition

IOP is designed to address current problems and symptoms, and to stabilize patients who have just been released from a psychiatric hospitalization or who are at risk of being hospitalized. It is a time-limited program of up to four weeks depending on individual needs and circumstances. An important component of the program is the development of an individualized treatment plan, including short-term goals that can be addressed in IOP groups, as well as treatment following IOP. ***Adherence to treatment recommendations is vital to your well-being and required for continued participation in the program***

Explanation of Benefits

IOP is part of your inpatient psychiatric benefit. However, this is a limited benefit, unlike medical hospitalizations. This means that three days of IOP are equivalent to one inpatient psychiatric hospital day. In other words, one IOP visit equals 1/3 of a psychiatric hospital day.

Program Guidelines

- Attending all IOP groups a minimum of three days per week. As you get closer to your discharge date attendance in IOP may be decreased to facilitate your transition out of IOP and into other treatment programs.
- On the days you attend IOP it is expected that you will arrive on time and attend the entire morning program. If you are going to be absent or late, please notify staff at (408) 972-3095.
- If you do not attend IOP for two or more weeks you will need to be re-evaluated by IOP staff before returning to the program. **You will need to call (408) 972-3095 and schedule an intake for re-evaluation.**
- All information about others discussed in group therapy is confidential and not to be discussed or shared with anyone else. No tape recording is allowed.
- It is important that everyone participate in IOP groups in a non-disruptive and respectful manner. Audible pagers, cell phones or similar devices are disruptive to the group and not allowed.
- No eating during groups.
- Wear appropriate, unrevealing clothing.
- Dating among group members is inappropriate and not allowed.
- Time off from work and associated paperwork is contingent upon your participation in the Program.
- Please maintain a fragrance free environment.
- Drug and alcohol use interferes with your treatment. If a patient is under the influence of drugs and/or alcohol, he/she can not participate in this program that day. Chemical dependency/abuse treatment is available in I.O.P. Tox screens are routinely utilized to check for drug use.
- No weapons of any kind will be allowed.
- I agree not to harm self or others while a patient in IOP. If I feel I cannot maintain this agreement I will contact professional services (for example, call 972-3095 at Kaiser).
- I will not drive a vehicle unless I am capable of doing so in a safe manner.

In order to fully benefit from the program, following the guidelines are important. Failure to follow these guidelines may result in our inability to help you in IOP.

I have read and agree to follow the above guidelines.

O A Peter — 10/14/02

Patient Signature — *Date*

KAISER® PERMANENTE

PATIENT PROGRESS RECORD

PLEASE IMPRINT OR PRINT

DATE OF SERVICE	LOCATION	STATION

LAST NAME	FIRST NAME	INITIAL
Defaria,	Olga	

PATIENT'S NAME (LAST, FIRST, MIDDLE)

ADDRESS

CITY

BIRTHDATE MO.	DAY	YEAR	HEALTH INSURANCE CLAIM NUMBER

MEDICAL RECORD NUMBER	CHECK DIGIT
11244330	

BIRTH DATE	PHONE	CODE	GROUP	SEX	COVERAGE	GROUP NUMBER	ACCOUNT NUMBER	SUB GROUP

DATE	TIME	
10-25-02	IOP 1:10p	Pt did not show for IOP. Left a message at home machine asking her to call. [signature] PhD JOHNSON
		R. Hebeler MD
11/25/01	IOP	Pt reportedly unable to return to program at this time. Will D/C in coming week if no further contact from Pt. No FTKA letter needs to be sent; Pt. does not need to be called again. ——— R. Hebeler MD

NAME: Defaria, Olga MR# 11244330

IOP GROUP NOTE: General group (circled), CBT, DBT, Discharge Planning, Mindfulness (circle one)

Mood/Affect: "ok"

Suicidal Ideation: ☐ yes ☒ no Homicidal Ideation: ☐ yes ☒ no

Comments/Plan

Alcohol/Drug Use ☐ yes ☒ no

Comments/plan:

Medication compliant: ✓ yes ______ no

Comments:

Hours of sleep: 6

Group participation, goals, treatment plan, etc: Olga spoke about the argument she had w/ husband yesterday & this morning. She did return home yesterday. She was able to acknowledge her passive-aggressive behavior w/ her husband & discuss more appropriate assertive behavior. Olga expressed concerned that this would be difficult for her but she would try.

GAF: 50 Signature: [signature] PhD JOHNSON Date: 10-18-02

[signature]

IOP GROUP NOTE: General group, CBT, DBT, Discharge Planning, Mindfulness (circle one)

Mood/Affect:

Suicidal Ideation: ☐ yes ☐ no Homicidal Ideation: ☐ yes ☐ no

Comments/plan:

Alcohol/Drug Use ☐ yes ☐ no

Comments/plan:

Medication compliant: ______ yes ______ no

Comments:

Hours of sleep: ______ Mental Status same as above for same day group ☐

Group participation, goals, treatment plan, etc: Pt absent. Left VM that IOP starts at 10:00 tomorrow.

GAF: N/A Signature: [signature] Date: 10/23/02

KAISER® PERMANENTE

PATIENT PROGRESS RECORD

PATIENT'S NAME (LAST, FIRST, MIDDLE)

ADDRESS

CITY

BIRTH DATE	PHONE	CODE	GROUP

PLEASE IMPRINT OR PRINT

DATE OF SERVICE	LOCATION	STATION

LAST NAME	FIRST NAME	INITIAL
Defaria	Olga	

BIRTHDATE MO.	DAY	YEAR	HEALTH INSURANCE CLAIM NUMBER

MEDICAL RECORD NUMBER	CHECK DIGIT
11244330	

SEX	COVERAGE	GROUP NUMBER	ACCOUNT NUMBER	SUB GROUP

DATE	TIME	
10/17/02	IOP	Husband showed up concerned about pt as she left the house last, did not come home & was making suicidal statements. Told husband we could not discuss his wife w/him as we do not have a release of information. He chose to wait for her. Informed pt & she would not talk to him after group. Contacted security. Pt was willing to talk to husband w/ security standby. Pt reported afterwards that husband left & she does not think she can go home. Pt met w/Char Howard, LCSW & was given shelter resources. Pt denied SI & agreed to call for help if needed. [signature], PhD
		Paul Helsen PhD

NAME: Defaria, Olga MR# 1124330

IOP GROUP NOTE: General group, CBT, DBT, Discharge Planning, Mindfulness (circle one)

Mood/Affect: "disappointed, angry, depressed"

Suicidal Ideation: ☐ yes ☒ no Homicidal Ideation: ☐ yes ☒ no

Comments/Plan last night SI, denies current SI, agreed to call professional services if becomes suicidal

Alcohol/Drug Use ☒ yes ☐ no

Comments/plan: last night

Medication compliant: ✓ yes _____ no

Comments:

Hours of sleep: unknown

Group participation, goals, treatment plan, etc: Olga shared about an argument she had w/her husband last night & applied it to the cognitive model. She said she didn't come home last night because she wanted to "shock him" & make him sorry since he told her to leave. Had thoughts of suicide & stole coffee pot to "cut my veins" & "punish him." Was able to apply to cognitive model & consider other alternatives.

GAF: 50 Signature: [signature] Date: 10-7-02

~~**IOP GROUP NOTE:** General group, CBT, DBT, Discharge Planning, Mindfulness (circle one)~~

Mood/Affect:

Suicidal Ideation: ☐ yes ☐ no Homicidal Ideation: ☐ yes ☐ no

Comments/plan:

Alcohol/Drug Use ☐ yes ☐ no

Comments/plan:

Medication compliant: _____ yes _____ no

Comments:

Hours of sleep: _____ Mental Status same as above for same day group ☐

Group participation, goals, treatment plan, etc:

GAF: Signature: Date:

NAME: Olga Defaria **MR#** 11244330

IOP GROUP NOTE: General group, CBT, DBT, Discharge Planning, Mindfulness (circle one) [CBT circled]

Mood/Affect: sad-tearful

Suicidal Ideation: ☐ yes ☐ no [no marked] Homicidal Ideation: ☐ yes ☐ no [no marked]

Comments/Plan

Alcohol/Drug Use ☐ yes ☐ no [no marked]

Comments/plan:

Medication compliant: ✓ yes ____ no just started meds

Comments:

Hours of sleep: 7

Group participation, goals, treatment plan, etc: Pt. appears to have multiple long-term problems. It was difficult for her to check-in. When asked to identify her problem she went back to her 1st marriage in 1996 which resulted in a divorce - now pt. has "been lied to again" by 2nd (H) who has left her in 2000. Pt. went on to talk about her (m) - needed to be redirected. [illegible] suspects multiple personality problems c this pt. She is quite bright & articulate, but many troubles

GAF: 55 Signature: Betsy Litteman, MFT Date: 10/15/03

IOP GROUP NOTE: General group, CBT, DBT, Discharge Planning, Mindfulness (circle one)

Mood/Affect:

Suicidal Ideation: ☐ yes ☐ no Homicidal Ideation: ☐ yes ☐ no

Comments/plan:

Alcohol/Drug Use ☐ yes ☐ no

Comments/plan:

Medication compliant: ____ yes ____ no

Comments:

Hours of sleep: ____ Mental Status same as above for same day group ☐

Group participation, goals, treatment plan, etc: Absent from program today. Called pt. but no answer.

GAF: N/A Signature: [illegible] Bondy [illegible] MD Date: [illegible]

KAISER® PERMANENTE

PATIENT PROGRESS RECORD

PLEASE IMPRINT OR PRINT

PATIENT'S NAME (LAST, FIRST, MIDDLE)	DATE OF SERVICE	LOCATION	STATION
Defaria Olga			

ADDRESS	LAST NAME	FIRST NAME	INITIAL

CITY	BIRTHDATE MO. DAY YEAR	HEALTH INSURANCE CLAIM NUMBER

BIRTH DATE	PHONE	CODE	GROUP	MEDICAL RECORD NUMBER	CHECK DIGIT
				11244330	

SEX	COVERAGE	GROUP NUMBER	ACCOUNT NUMBER	SUB GROUP

DATE	TIME	
10-14-02		Nursing notes

31 y.o. twice married WF referred to IOP for ↑ depression daily vomiting, & court date for shop lifting (x2)

Pt. is an Ukranian. Married to an American architect, got divorced and had to go back to Ukrane x 6 yrs. before married to current husband, a computer consultant who has a hx. of abusing her physically & verbally.

(+) Pt. vomits daily after eating, still gaining wt. pt. 5'6" – 126 lbs. Hx. of anoraxia & bulimia while was in Russia.

(+) side effects from paxil 20 mg -- too sedated and ↓ sexual drive.

medications evaluated and adjusted by Dr. Banerjee. starting:

Prozac 20 mg qd.

(D/C paxil)

will continue to monitor pt. while attending IOP.

M Jones RNC

KAISER® PERMANENTE

PATIENT PROGRESS RECORD

PLEASE IMPRINT OR PRINT

DATE OF SERVICE	LOCATION	STATION

PATIENT'S NAME (LAST, FIRST, MIDDLE)
DeLaria, Olga

LAST NAME	FIRST NAME	INITIAL

ADDRESS

CITY

BIRTHDATE MO.	DAY	YEAR	HEALTH INSURANCE CLAIM NUMBER

MEDICAL RECORD NUMBER: 11244330 — CHECK DIGIT:

BIRTH DATE	PHONE	CODE	GROUP

SEX	COVERAGE	GROUP NUMBER	ACCOUNT NUMBER	SUB GROUP

DATE	TIME	
Crisis Group		
6/11		pt comes to crisis group. pt has multiple stressor and symptom. stressor include a abusive husband, recent shoplifting charge, fear ab being sent back to Russia and lack ab support. pt reports severe depression, hopelessness dis/difficulty enjoying activities. pt also purging to deal with stress + has concerns about her appearance pt reports she has started to drink to deal with depression pt taking a low dose ab paxil 10 mg pt said she had

PATIENT PROGRESS RECORD

DATE	TIME	
		sexual side effect from Paxil. Given pt's current stressor + severe symptoms ACSW discussed pt attending IOP. pt appeared motivated so ACSW scheduled her to start on Monday 10/14. pt reports some SI but made a verbal contract to not harm herself or to contact on-call if symptom became worse. ACSW encouraged pt to avoid ETOH which ACSW told pt would d depression. pt agreed to try. pt is not voldable at this time Annabel Ray, ACSW 10/11 02

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NORTHERN CALIFORNIA REGION

KAISER PERMANENTE
Different from the ground up.

Date 10/10/02

Defarie 0/8a

11244330

ADULT INTAKE/DIAGNOSTIC SUMMARY

Identifying Data

Age: 31 **M** (F) **Ethnicity (Optional)** Ukraine born

Marital Status: S (M) D Sep W Other x4 mo to 2nd American Husband

Occupation: homemaker **Referral Source:** self

Presenting Problem: [Onset, Duration, Precipitating Factors] eats but throws up involuntarily
Depression x 6 years, vomiting daily, thoughts of suicide 2° arrest for shoplifting 2 days ago, verbal and physical abuse by Husband, fear of being deported back to the Ukraine. Was married in 93 to American architect who brought her back from Ukraine to U.S. He left her alone, without transportation, friends or language abilities while he traveled. She under a lot of stress. They divorced when he left her after 1.5 years. She got job + friends, apartment in Arizona when he begged her to move back to him in Hong Kong. After 4 mo, he

Symptoms: said he was unable to get her a VISA to U.S. So she went back to Ukraine where she tried for 6 years to get back to U.S. Mother very critical + unsupportive, was very depressed, may have had panic attacks, tried to choke herself + take pills in suicide attempt. Was working as an interpreter when met (H) current who was on a tour to meet a Russian bride. He brought her to U.S. + married her. Under a lot of stress, he (H) gets very angry to her, yells at her, has given her bruises pushing and pulling her, threatens to kick her out + send her back to Russia.

ADULT INTAKE/DIAGNOSTIC SUMMARY 10/10/02

Relevant Psychosocial History: [e.g., developmental issues, education, relationships, employment, legal] 1244330

Born in Ukraine, youngest of six girls. Defacia Olga was happy in Arizona after divorce, wanted to stay in U.S. Currently unemployed, doesn't drive. Husband controlling + abusive. He upset b/c her throws up 5-6 x/day. (A) has 10 g.o. dgtr. Pt has some friends

Past Psychiatric History: ☐ None ☑ Outpatient ☐ Inpatient

'96- Depression during divorce

'96-2002- Depression, a couple of suicide gesture(?) choking self pills

Past Medications:

Paxil - 9/4/02 from PCP, Dr. Tran

Zantac DW

Substance Use/Abuse: (Substance, amount, frequency, last used) ☐ WNL/Denies Abuse

drinks 2 glasses of wine every other day

no drugs

☐ **Treatment:**

Significant Medical History: ☐ None also see P.D.S.

stomach problems- folic acid, burning sensation, food gets "sour", doesn't digest properly

did not have period for 5 years in Ukraine - was very thin

Current Medications: ☐ None

Paxil

Zantac Ranitidine

Psychiatry Medications: ☐ None

Paxil

Medications

Allergies/Side Effects ☑ No ☐ Yes

ADULT INTAKE/DIAGNOSTIC SUMMARY

Date 10/10/02
Lefarria, Olga
11244330

Family Psychiatric/Substance Abuse History

unable to review

Mental Status:

Appearance	☑WNL	☐Disheveled ☐Other
Orientation	☑WNL	☐Impaired
Memory	☑WNL	☐Impaired: ☐ST ☐LT
Concentration	☑WNL	☐Impaired
Psychomotor Pace	☐WNL	☑Slowed ☐Rapid ☐Other
Mood	☐WNL	☑Anxious ☑Depressed ☐Angry ☐Other
Affect	☐WNL	☑Blunted/restricted ☐Labile
Perception	☑WNL	☐Delusions ☐Other
Thought Process/Content	☑WNL	☐Loose Assns ☐Hallucinations (Aud/Vis) ☐Blocking ☐Other
Insight	☐Good	☑Fair ☐Poor
Judgment	☐Good	☐Intact ☐Impaired

Risk Assessment:

	Yes	No		Yes	No
Suicidal Ideation	✓		No Harm Contract	✓	
Suicidal Plan pills	✓		Threatening/Assaultive		✓
Suicidal Intent		✓	Impulse Control Problem	? shoplifting	
Homicidal Ideation		✓	Weapons/Firearms		✓
Homicidal Plan		✓	Tarasoff Warning		✓
Homicidal Intent		✓	5150		✓

Risk Statement: (if yes on any of above)

Contracts no harm, advised of 911, Next Door, 24 hr on-call line

ADULT INTAKE/DIAGNOSTIC SUMMARY

Defaria 10/10/02
Olga 1124330

Strengths:

- ☑ Intelligent
- ☐ Family support
- ☑ Motivated
- ☐ Other _____

Weaknesses:

- ☑ Severity of Impairment
- ☐ Noncompliance
- ☐ Isolated
- ☐ Chronicity
- ☐ Borderline Intelligence
- ☐ Other domestic violence

DIAGNOSTIC IMPRESSIONS:

AXIS I. 296.3 MDD, r
Eating Disorder, NOS
R/O Anorexia, Bulimia
Acute Stress

AXIS II. deferred

AXIS III. Stomach Pain

AXIS IV. *(optional)
domestic violence
shoplifting charge
deportation fears

AXIS V. (GAF) 50

ADULT INTAKE/DIAGNOSTIC SUMMARY

Date 10/10
Defaria Olga
11244330

TREATMENT PLAN/RECOMMENDATIONS:

☑ PDS Reviewed

Goals:

Continue to assess for depression, eating disorder, anxiety, ↓ suicidal ideation
Stabilize mood
Stop involuntary vomiting

Targeted GAF: 70

PLAN:

☑ **Group or Class Referral** Crisis Group tomorrow 10/11/02

☐ **Individual Treatment** prn after Crisis Grp

Follow-up Appointment Shannon Michelson, ACSW or D. Wuesle, LCSW
Date / With

☑ **Refer for Med Eval (circle one):** Urgent Routine prn if necessary
Date / With

☐ **Other:** Pt. had to leave for court hearing. Booked for Crisis Grp. May refer Bulimia Grp, Dep. Group. Encouraged 911, Next Door, 24 hr on-call prn.

Primary care provider contacted:

☑ Yes ☐ No **Reason:** ☐ No PCP ☐ Patient doesn't consent

☐ Referred for PCP

Signature /with Licensure: Donna Wuesle, LCSW **Date:** 10/10/02

FTLA letter sent 10/1/02

Phuong Tran, MD

KAISER PERMANENTE

Receptionist: Juliet

Santa Teresa Psychiatry Adult Unit
Telephone Evaluation Form

Date: 9/4 **Time:** 11:50 **Coverage:** yes **Fee:** $ 5

Last Name First Initial	MR #	Age/DOB	Sex
Defaria Olga	11244330	31	F
Address	**Home Phone**	**Work Phone**	
6181 Ellenbrook Way.	363-0562	" "	

TAV with: Vanclave TAV date: Fri 9/6 Time: 10:30

Pt can be reached (time frame): 10:30 - 11:30 At what phone? 363-0562

Problem/Reason for Calling Now
- Husband angry & short-tempered. They argue a lot.
- Hx of anorexia - used to purge also. Is again.
- Either binge & purges or starves self. Gets sick if eats. Went to PCP yesterday & got got Rx for antidepressants & stomach meds.

Symptoms

Mood worries a lot	Appetite ↑↓ binge/purge or restricts	Suicidal Thoughts? Y [X] N [ ] Plans? Y [ ] N [X] Intent? Y [ ] N [X]	occasional - gets frustrated by husb. would OD
Sleep difficulty sleeping at times.	Affect soft-spoken	Homicidal Thought? Y [ ] N [X] Plans? Y [ ] N [X] Intent? Y [ ] N [X]	
Interest/Enjoyment ↓	Ability to Function ↓ not able to work in U.S. yet	Hx. of Suicidal/Homicidal Behavior? NO	
Concentration ↓	Insight WNL	Means available for S or H? yes	
Memory OK	Impulsive/euphoric behavior NO	Other sx	

Add'l Sx, Hx of the problem, other comments
- Just here 4 mo. from Ukraine. (met husb. in Ukraine)
- Has one friend here (Russian)
- Fears talking to husband. He has hit her & threw her out of house in past. She fears contacting police - may be sent back to Russia.

Telephone Evaluation Form Page 2

Past Psych History: Here? NO Who? — When? —

Previous Therapy/Psychiatrist? NO

Previous meds? NO Helpful? —

Previous Psych Hosp? NO 9/11/02 M. Le Depression Eating Disorder

Current Medical Issues: Stomach pains
Bulimia – 10/3/02 A.D. Tran

Current Medications
Psych: Paxil & stomach meds (yesterday)
9/4/02 Paxil 40 mg .5 QD
Non-Psych: Zantac
10/3/02 Paxil 20 mg .5 QD
Ranitidine ∅ All

Drug/Alcohol Current? 1-2 drinks/wk.

History of D/A problems: ∅

Family D/A or partner D/A problem: husb. alcoholic

Risk Assessment: Danger to self or others? no

No Harm Agreement (if applicable): Contracted for safety

Dx. Impression: Anorexia Nervosa – Binge/eat purge type

Impulse Control Disorder

Gave pt. # for Next Door shelter & suggested she call for info. GAF: 50

Plan: Pt. has 9/11/02 appt w/Dr. Le in Behav. Med. Pt. does not feel will hurt herself & has started on antidep.

Disposition:

CIT Overload

Signed: Peggy Van Clue ACSW Date: 9/6/02

9.12.02 Intake appt set for 10.1.02 at 12:30 pm [illegible] – [illegible]
10.1.02 FTKA intake appt. Please send letter of concern and file this request [illegible]

[illegible] 2:30 (2:00) [illegible] request

KAISER® PERMANENTE

PATIENT PROGRESS RECORD

PLEASE IMPRINT OR PRINT

PATIENT'S NAME (LAST, FIRST, MIDDLE)	DATE OF SERVICE	LOCATION	STATION
Defaria, Olga			

ADDRESS	LAST NAME	FIRST NAME	INITIAL
	Defaria,	Olga	

CITY	BIRTHDATE MO. DAY YEAR	HEALTH INSURANCE CLAIM NUMBER

BIRTH DATE	PHONE	CODE	GROUP	MEDICAL RECORD NUMBER	CHECK DIGIT
				112 44 330	

SEX	COVERAGE	GROUP NUMBER	ACCOUNT NUMBER	SUB GROUP

DATE	TIME	
10/9/02	5:00 p.m.	Pt called saying she missed regular NAI4 appt because she didn't want her husband to know. Since then, she was picked up for shoplifting today and her husband is very angry with her telling her she has ruined everything and may get sent back to Soviet Union after court proceedings. She is feeling thoughts of suicide, but no immediate plan/intent. Contracted for safety. Has 972-3095 and is aware can go to ER if serious suicidal thoughts arise. Pt was given UAI6 appt. with Donna Wueste for 2:30 Oct 10, 2002.
		UAI6 DONNA WUESTE 10/10/02 2:30 (2:00 CHECK IN TIME)
		Lorena Sfranchi, LMFT CIT