

Additional information and comments to whistleblower investigation OSC File #DI-13-4218

Page 20 of report: Melissa Birdhead should be added to the list of names that agree that clinic was in violation of Board of Nursing.

Page 21 and page 53 of report: Additional illness or "cascade effect" due to mischarting (Allegation 2) is hard to prove when immunization record shows current. I would summarize this as record shows MMR was given prior to administration and soldier leaves clinic prior to getting vaccine. Potentially, that same soldier could return to barracks and now be susceptible for measles when his MEDPROS shows him as medically ready.

Page 21 and page 53 of report: Allegation #3 was unsubstantiated. I do not agree with the findings of this portion of the investigation and feel this area of the investigation was poorly conducted. Reason: Mid August 2013 nursing staff was instructed to "transfer" all notes even when the PA never cares for or seen the patient. When you "transfer" a note the only signature is the PA. August 2013 Nursing staff asked to "co-sign" which would allow nurse and privileged provider to sign notes. I agree with "co-signature" of notes. "Co-signature" is not violating coding rules. When notes were "transferred" and the PA was not involved in care provided violates coding rules. (see AR 40-6 section 3-4).

AR 40-6, 3-4, a: "No healthcare practitioner is permitted to complete the documentation for a medical record on a patient unfamiliar to him/her." 3-4c: "signatures. All entries must be signed or electronically authenticated." Again, August 2013 was not reviewed in this investigation. Charts pulled in October for review were set up and brought to the main hospital by Barbara Story RN when HIPAA investigation was concluded. I was a witness to Ms Story setting up each chart prior to the "audit". This portion of the investigation should not have involved Occupational Health staff assistance. My greatest request would be Mid August 2013 be reviewed for this violation. An employee was terminated due to not wanting to participate in "up coding" process. I have attached 2 sworn statements (attachment 1a and 1b) written by staff in the efforts to terminate Ms Macko and Ms Birdhead for not wanting to participate in the "transfer" of notes. Termination of any employee for not assisting in "up-coding", which is not lawful, warrants a review of the notes closed from 12-15 August 2013. Charts reviewed in January 2014 when 2 RN's had lost computer privileges due to HIPAA violation and October when MS Story set chart up prior to going to hospital with patients charts. (Also see attachment 2)

Page 21 of report: HIPAA complaint from 3 employees were filed April 2013. May 2013, in unit meeting with COL Hiatt, all staff was made aware that a co-worker filed HIPAA against another co-worker in the clinic (12 staff in clinic total at this time). In May 2013 meeting levels of violation reviewed and penalties reviewed. June 2013 violators of HIPAA questioned

then Oct 2013 was finalized. Violator had months to prepare statement of violation prior to questioning. Mr Santiago (HIPAA officer) stated, "the only person that told the truth was Ms Lueken". If he knew Ms Story lied that should have been mentioned. Ms Birdhead was a transfer from another Army hospital and didn't require physical exam or medical record review. All viewing of record was inappropriate viewing of medical record since employee was not seen in clinic prior to start of employment (which is when violations occurred).

page 23 of report states, "Dr Mills to place nurses under the direct supervision of PA's ran contradictory to CPAC guidance and Union requirements and had to be reversed". This statement in the investigation clarifies nurses don't work directly under PA's as their supervisor. Again, "co-signatures" was not the issue it was "transfer" of notes when the only signature was the PA. Only a small select patients see the nurse and PA the same day.

page 26 of report: Ms Nesslage's statement "not for RVU's". See evaluation for clinic nurses. I have attached mine from Ms Nesslage and it clearly states one of my goals is to "transfer" my notes to her to maximize RVU's. (see attached document 2)

Page 26 of report: Again, "transfer" of notes vs. "counter signature" needs clarified when it comes to coding. Again, I agree with co-signatures not violating coding rules. Again, Mid August 2013 should have been reviewed to verify this claim of violation.

Page 29 of report: Ms Morrill's statement states, "Ms Story stated" this may be an accidental typo that may need edited.

Page 29 of report: Ms Lueken's statement states, "she claims she is asked to add information to the record on "depression, anxiety, suicidal thoughts, medication, or HTN"." Agreed these are in the RN's scope of practice. The concern was that Ms Lueken and Ms Birdhead was being asked to add this documentation prior to PA "co-signing" notes (during time when co-signing was being done). Issue was this conversation did not always occur with patient and we were told to add it to our note or the PA would not co-sign our note.

Page 38 of report: Per Ms Feyer' statement "that privileged providers are not supposed to code a visit unless they see the patient." "Provider has a conversation with/sees the patient" These statements support need for co-signatures and not a "transfer" of notes. Occupational Health staff new coding process initiated in August was inappropriate. Email from coder attached. (see attachment #3) Attached in meeting minutes from LTC Newsom's meeting which continued to address and clarify nurses signed, co-sign, and transfer of notes. LTC Newsom was working on fixing the process in the clinic. (attachment 4)

Page 41 of report: The Audit focused on encounters 1 January 2014. Again, mid August 2013 should have been reviewed. January 2014 LTC Newsom was the supervisor of the clinic while

Dr Mills was placed on leave. LTC Newsom informed all Occupational Health Clinic staff that "transfer" of notes when PA doesn't see the patient is "not legal". January 2014 we co-signed notes with PA's and nursing staff in clinic agreed to this form of closing out notes.

(attachment 4) Investigation audit was conducted after the clinic had the first investigation due to Ms Macko's termination and all staff cautious and knew they were being watched. The information gathered was not good data as to previous practice which warranted the allegation.

Page 44 of report: When immunization are pre-documented it not only includes vaccine and site it includes lot #. If a vaccine recall is warranted due to side effects all patients that get vaccine with specific lot numbers should be reviewed for same concern. Lot numbers were not verified when pre-charted.

Page 48 of report: Is a witness that people left and pre-documentation was not changed.

Page 50 of report: It was not just pre-documenting but documentation of Td changed to Tdap. Multiple immunization tabs show Td and T-dap given on same date. Multiple examples from patients charts were provided to investigator omitting PHI. (attached is 5a 1&2 which are one patient but separate area of record and 5 b 1 &2 is also 2 sections of another patients chart).

Page 58 of report under Corrective Actions: Ms Story violated 3 co-workers medical records. Punishment was no computer access for a set time. Nursing staff that was violated was forced to pick up her patient load along with Ms. Lueken's. Again, chart audit was conducted January 2014 when primary violator of charting rules had no access and Ms Lueken regained her access that month. Only 2 RN's had access to chart in AHLTA in January 2014. Again, January 2014 was not good data to collect for this investigation since charting privileges of 2 RN staff were suspended when audit occurred. Most RN notes reviewed would have been from whistleblower.

Page 60 of report: Practice of PA taking over note (transfer) and signing for patients is what Ms Macko was terminated for. This process was changed and staff was informed this was "not legal" by LTC Newsom. If LTC Newsom was available in August 2013 the employee would not have been terminated.

Attachment
1a



REPLY TO
ATTENTION OF:

DEPARTMENT OF THE ARMY
CARL R. DARNALL ARMY MEDICAL CENTER
36000 DARNALL ROAD
FORT HOOD, TEXAS 76711-4752

MCXI-DPM-OH

14 August 2013

MEMORANDUM FOR RECORD

SUBJECT: Ref observed behavior of Ms Christine Willey Mack and Ms Melissa Birdhead on 13 Aug 2013

1. I, Barbara Story am writing this MFR on the observed insubordinate behavior by Ms Christine Wiley Macko and Ms Melissa Birdhead. All RN's in the Occupational Health clinic were instructed in writing by Ms Byrd, Administrative Officer, Preventive Medicine at 13:22 and verbally by Dr Douglas Mills, Chief Occupational Health clinic at 13:30 to stop signing off their AHLTA encounter and transfer to a provider for signature. Dr Mills also put this out in writing at 14:02. See attached.

Ms Christine Willey Macko and Ms Melissa Birdhead refused to obey this order and signed off their appointment encounter at 14:00, 14:20 and 14:40.

2. POC for this memorandum is the undersigned at (254)-286-7233.

A handwritten signature in cursive script, reading "B Story", is positioned above the typed name.

Barbara Story
Registered Nurse
Occupational Health Clinic

ATTACHMENT

1B



REPLY TO
ATTENTION OF:

DEPARTMENT OF THE ARMY
CARL R. DARNALL ARMY MEDICAL CENTER
36000 DARNALL LOOP
FORT HOOD, TEXAS 76711-1742

MCXI-DPM-OH

14 August 2013

MEMORANDUM FOR RECORD

SUBJECT: Ref observed behavior of Christine Willey Macko on 13 August 2013.

1. On 13 August 2013, I Paula Morrill observed insubordinate behavior. I am writing this MFR on the observed behavior of Christine Willey Macko.
2. On 13 August 2013, the Occupational Health nurses were sent an email with instructions for transferring our encounters to a provider for signature. I was standing in the hallway and heard Christine Willey Macko insisting that she should be able to sign her own encounter. She was talking extremely loud to Dr. Mills. She told Dr. Mills that she was not taking instruction from an administrator or him, that she would only take orders from a Board Certified Physician or someone higher up. After which time, Dr. Mills said, "ma'am, you can go talk to whoever you want".
3. POC for this memorandum is the undersigned at (254)-286-7219.

A handwritten signature in black ink that reads "Paula Morrill, RN".

Paula Morrill
Registered Nurse
Occupational Health Clinic

ATTACHMENT

2

NIOR SYSTEM CIVILIAN EVALUATION REPORT SUPPORT FORM

For use of this form, see AR 690-400; the proponent agency is ASA(M&RA).

PART I - RATEE IDENTIFICATION

a. NAME OF RATEE (Last, First, Middle Initial) Birdhead, Melissa E	b. PAY PLAN, SERIES/GRADE GS 0610 10	c. ORGANIZATION/INSTALLATION CRDAMC Ft Hood, TX 76544
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PART II - RATING CHAIN - YOUR RATING CHAIN FOR THE EVALUATION PERIOD IS:

RATER	NAME Kimberly A. Nesslage	POSITION Physician Assistant, Occupational Health Clinic
INTERMEDIATE RATER (Optional)	NAME	POSITION
SENIOR RATER	NAME Dr. Douglas J. Mills	POSITION Chief, Occupational Health Clinic

PART III - VERIFICATION OF FACE-TO-FACE DISCUSSION

The following face-to-face discussions of duties, responsibilities, performance objectives, standards, and accomplishments for the rating period 20130517 to 20131031 took place:

	DATES	RATEE INITIALS	RATER INITIALS	INTERMEDIATE RATER INITIALS	SENIOR RATER INITIALS (If used)	DATE
INITIAL	20130614	-	KN			
MIDPOINT						

PART IV - RATEE (Complete a, b, c below for this rating period)

a. STATE YOUR SIGNIFICANT DUTIES AND RESPONSIBILITIES. DUTY TITLE IS: **OCCUPATIONAL HEALTH NURSE**

Assist in the coordination and implementation of the Occupational Health Program for Fort Hood. Provides a wide range of nursing and health care services, counseling, education and training to the military and civilian workforce related to their occupational and work environments, to include employee illness and injury. Performs health assessment for pre-placement, deployment, retirement, and annual job-related medical surveillance evaluations. Recognizes physical and emotional problems that could compromise the health and safety of the worker or co-worker. Conducts pulmonary function tests (spirometer), vision screening, respirator clearance evaluations and nursing assessments to clear or restrict duty as appropriate. Performs pregnancy surveillance, worksite evaluations, ergonomic surveys and blood borne pathogen exposure follow-up. Orders appropriate medical test specific to work place exposures. Helps ensure organizational compliance with State, Federal, Army, and OSHA regulations.

b. INDICATE YOUR MAJOR PERFORMANCE OBJECTIVES/INDIVIDUAL PERFORMANCE STANDARDS

- Annual medical surveillance, pre-employment and pre-deployment employee's assessment will be consistent with environment and functional requirements of the job and clients physical and mental health.
E=>95% S=75-94% N=<75%
- Medical/lab test are appropriate for each employee's specific hazard/exposure.
E=>95% S=75-94% N=<75%
- AHLTA encounters will include procedures ordered/performed and transferred to the PA or MD to collect maximum RVU productivity of the clinic.
E=>95% S=75-94% N=<75%
- Maintain required CEU's and competencies for this field of nursing.
E=>95% S=75-94% N=<75%
- Actively participates in worksite/ergonomic visits.
E=>95% S=75-94% N=<75%
- Will represent the clinic and Dept of Preventive Medicine at various assigned meetings.
E=>95% S=75-94% N=<75%
- Actively supports the safety program through participation in safety training, identification and mitigation of hazards, and compliance with established safety, hazard materials, and personal protective equipment requirements.
E=>95% S=75-94% N=<75%

Attachment

3

Birdhead, Melissa E CIV USARMY MEDCOM (US)

From: Reefer, Yolanda E CIV USARMY MEDCOM CRDAMC (US)
Sent: Thursday, October 17, 2013 2:25 PM
To: Moultry, Donna F CIV USARMY MEDCOM CRDAMC (US); Nesslage, Kimberly A CIV USARMY MEDCOM CRDAMC (US); Mills, Douglas J CIV (US); Story, Barbara R CIV (US); Morrill, Paula S CIV (US); Birdhead, Melissa E CIV USARMY MEDCOM (US); Lueken, Kristie L CIV (US)
Cc: Feyer, Laurel L CIV USARMY MEDCOM CRDAMC (US); Andrade, Barbara CIV (US)
Subject: E&M Documentation (UNCLASSIFIED)

Classification: UNCLASSIFIED

Caveats: NONE

Good Afternoon,

Please see DoD guidelines below in reference to documentation for E&M,

3.1.1.1. Documentation of Key Components The reason for the encounter, called the chief complaint, should always be noted in the encounter documentation. This requirement can be met by printing out the reason entered by the appointment clerk in the computer system. If the chief complaint is not what the appointment clerk entered, (e.g., patient told clerk the appointment was for abdominal pain, but when the patient met the provider, the patient expressed concerns about a sexually transmitted disease), the correct chief complaint must be documented. All parts of the history (review of systems (ROS), past-family-social history (PFSH) and the chief complaint may be documented by other staff members, medical students or the patient. In the case of history of present illness (HPI), staff documentation may only be counted towards E&M leveling if the provider's documentation demonstrates he reviewed and expanded on the staff documentation. This could be accomplished in the electronic medical record by having the provider "edit" the nurse's S/O section and add additional information in the HPI. Only those parts of the examination, and assessment/plan that are actually documented by the privileged provider may be used in calculating the level of the encounter. Any documentation, from provider, staff member, medical students or patient, may be used to calculate the level of the encounter for the ROS and PFSH.

To certify that the provider reviewed the information documented by others, there must be an expanded notation supplementing or confirming the review. Merely documenting "Reviewed and agree" is not sufficient documentation to demonstrate that the physician truly took ownership of the history.

3.1.4. Non-Privileged Providers (Nurses and Technicians) Non-privileged providers are normally restricted to using E&M code 99211 to document face-to-face encounters in which no procedure is performed (e.g., education by a technician or offering a service or supply item that does not have a specific code).

The following clinic services are not considered code-able events:

- * TB test reading
- * Patient who presents for an order for pregnancy test only
- * Blood pressure checks per patient request
- * Patient who presents to pick up a prescription refill
- * Pulse oximetry

If you have any questions please do not hesitate to contact me.

Thank You

Yolanda Reefer
Medical Records Technician-Coder
Carl R. Darnall Army Medical Center
Fort Hood, Texas, 76544
254-286-7280 (office)
254-553-2740 (fax)

"Serving to Heal... Honored to Serve"

CONFIDENTIALITY NOTICE

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Classification: UNCLASSIFIED
Caveats: NONE

Attachment
4

OCCUPATIONAL HEALTH CLINIC

Bldg. 36001, Room 111, CRDAMC, Fort Hood, TX

Meeting Minutes:

Subject: Six Sigma – Process Improvement Meeting

Date: January 16, 2014

In attendance:

Administrative Staff:

1. LTC R. Jason Newsom, MD, Clinic Chief, Department Deputy Chief
2. Maidā P. Johnson, MBA, Clinic Administrator
3. Robin Bredwell, MSA
4. Melissa Zednick, MSA, Medical Records

Clinical Staff:

1. Douglas Mills, MD, Department Medical Director
2. Donna Moultry, PA-C
3. Kimberly Nesslage, PA-C
4. Kristie Lueken, RN, BSN
5. Barbara Story, RN
6. Melissa Birdhead, RN
7. Debra Bordelon, OHT, LVN

Topic 1: Leave Annotation on DMHRSi and Timecard – still unresolved

Topic 2: Required PPE for CAF – completed

Topic 3: Signing AHLTA Notes – still under discussion

<u>(RN) Sign</u>	<u>Sig/Co-sign</u>	<u>Transfer</u>
<ol style="list-style-type: none">1. Pregnancy Class2. GS or AD in process annual NOT req or shot procedure	<ol style="list-style-type: none">1. Immunizations *PPD needs double check2. GS or AD in-process or annual <u>WITH</u> procedures	<ol style="list-style-type: none">1. LAR Annual2. Police/SG Annual3. Firefighter4. Pre-employment same day5. MD or PA consult

Please note: Nurse Code: 99211

*Protocols may require future adjustments (especially PFTs)

HEALTH RECORD

IMMUNIZATION RECORD

All entries in ink to be made in block letters

VACCINATION AGAINST SMALLPOX (Number of previous vaccination scars)

	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1					
2					
3					

TYPHOID VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

TETANUS-DIPHTHERIA TOXOIDS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1	28 Jun 04	Tdap 0.5ml	TRANSCRIBED FROM OFFICIAL RECORDS	4			
2				5			
3				6			

CHOLERA V

	DATE	PHYSICIAN'S NAME		DATE	PH
1			4		
2			5		
3			6		

PATIENT'S IDENTIFICATION (Mechanically Inscribed, Type or Print):

5a(1)

-This patient was seen mid Nov 2003
-Note T-dap in Bold pen above, again no Tdap in 2004

VACCINE ADMINISTRATION RECORD

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

By printing and placing in the medical record, providers are verifying that the vaccines annotated were administered and current CDC published Vaccine Information Sheets (VIS) or Important Information Sheet was given to the parent, legal guardian or patient. This form complies with all federal record keeping requirements of the National Childhood Vaccine Injury Act of 1986 as amended 14 December 1993. Parent, guardian, or patient signature is not required unless state law mandates a guardian signature and proof of informed consent. Local VIS's may be developed for vaccines not covered by CDC Publications. This document complies with article 80 of the WHO international health regulations and can be used in place of the PHS 731 when traveling outside the United States.

Vaccine	Series	Date	Manufacturer	Lot Number	Dose/Site	Exemption	Administering Tech
Hep B - Adult	1	14 Sep 1989	Transcribed	TRANSCRIBE D	/Unknown	None	
VIS Version(s): N/A							
Hep B - Adult	2	31 Oct 1989	Transcribed	TRANSCRIBE D	/Unknown	None	
VIS Version(s): N/A							
Hep B - Adult	3	26 Nov 1990	Transcribed	TRANSCRIBE D	/Unknown	None	
VIS Version(s): N/A							
Hep B - Adult	3	9 Jul 2003	Transcribed	EXEMPT	/Unknown	Pos Titer	
VIS Version(s): N/A							
Influenza	1	1 Dec 2006	Transcribed	TRANSCRIBE D	/Unknown	None	
VIS Version(s): N/A							
Influenza	1	8 Oct 2013	Other	UH890AA	.5 mL/Right Arm	None	ISTRE JENNIFER
VIS Version(s): 7/26/2013							
Influenza Split Virus	1	1 Sep 2009	Other	U3176AA	.5 mL/Left Arm	None	CRAWFORD ANDREA M
VIS Version(s): 07/24/08							
Influenza Split Virus	1	23 Sep 2011	Medimmune, Inc.	ut432aa	.5 mL/Left Arm	None	J VALENTINE-SMITH J
VIS Version(s): 08/10/10							
Influenza Split Virus	1	24 Sep 2012	CSL Biotherapies, Inc.	p58907	.5 mL/Left Arm	None	ZIEGLER PAUL
VIS Version(s): 7/2/2012							
IPPD	1	1 Dec 2006	Transcribed	TRANSCRIBE D	.1 mL/Left Arm	Neg/0mm	BALTRUN CINDY W
VIS Version(s): N/A							
PPD	2	1 May 2009	Other	C3036AA	.1 mL/Left Arm	Neg/0mm	J VALENTINE-SMITH J
VIS Version(s): N/A							
IPPD	0	19 Sep 2011	Sanofi Pasteur	C3375AB	.1 mL/Left Arm	Neg/0mm	J VALENTINE-SMITH J
VIS Version(s): N/A							
MMR	1	6 Jun 2005	Transcribed	EXEMPT	/Unknown	Pos Titer	
VIS Version(s): N/A							
Tdap	1	28 Jun 2004	Transcribed	TRANSCRIBE D	/Unknown	None	
VIS Version(s): N/A							
Varicella	1	25 Jun 2005	Transcribed	TRANSCRIBE D	/Unknown	None	
VIS Version(s): N/A							

LAST ITEM

DO NOT MAKE ENTRIES BELOW THIS BLOCK

5a (#2)

HEALTH RECORD

IMMUNIZATION RECORD

All entries in ink to be made in block letters

VACCINATION AGAINST SMALLPOX (Number of previous vaccination scars)

	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1					
2					
3					

TYPHOID VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			OCCEP... HEALTH CLINIC
2	1/10/97	1.0 ml	ATM	5			OCCEP... HEALTH CLINIC
3				6			

TETANUS-DIPHTHERIA TOXOIDS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1	1997	.5cc	per history	4			
2	9/10/97	0.5 ml	SANDY SUDDRETH, RN OCCUPATIONAL HEALTH CLINIC	5			
3				6			

CHOLERA VACCINE

	DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME
1			4		
2			5		
3			6		

Patient #2
Attachment 5b-1

- Again T-dap written in when it was a TD (see 5b-2)

Treatment Facility: Darnall AMC
Patient Status: Outpatient

Date: 09 Feb 2007 1000 CST
Clinic: OCCUPATIONAL HEALTH

Appt Type: WELL
Provider: SUDDRETH, SANDY K

Reason for Appointment: annual cdc naf

AutoCites Refreshed by SUDDRETH, SANDY K @ 09 Feb 2007 1005 CST

Screening Written by SUDDRETH, SANDY K @ 09 Feb 2007 1005 CST

Allergen information verified by SUDDRETH, SANDY K @ 09 Feb 2007 1005 CST

Reason(s) For Visit (Chief Complaint): visit for: occupational health / fitness exam V70.5 (New) ;

5b-2
Note of patient
when Td was
given.
-PHI protected
BUT was seen 12/19/13

Vitals

Vitals Written by SUDDRETH, SANDY K @ 09 Feb 2007 1005 CST

BP: 135/91, HR: 78, RR: 16, HT: 5' 9", WT: 188.6 lbs, BMI: 27.85, BSA: 2.015 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 5/10 Moderate, Pain Scale Comments: Sciatica right side

SO Note Written by SUDDRETH, SANDY K @ 09 Feb 2007 1021 CST

History of present illness

* Encounter Background Information: In to Occupational Health Clinic for periodic job related medical surveillance and review of immunizations IAW MEDCEN Reg 40-6

Past medical/surgical history

Reported History:

No recent change in medical history or in ability to perform job duties. Had a Migraine headache this morning and her B/P is slightly elevated. States it was elevated during her Coumadin Appt this morning also. Instructed pt to F/U with her PCM in regard to HTN

Previous therapy

History of review of immunization history —needs PPD # 1, and Td

Subjective

Working as a Technical Information specialist @ CRDAMC Library. Verbalized understanding and importance of using correct PPE

Physical findings

General appearance:

* Alert * Oriented to time, place, and person * Well developed * Well nourished * Healthy appearing

A/P Written by SUDDRETH, SANDY K @ 09 Feb 2007 1025 CST

1. visit for: occupational health / fitness exam (OCCUPATIONAL EXAMINATION)

Procedure(s):
-Immunization Administration One Vaccine x 1
-Skin Test Anergy Tuberculin Intradermal x 1
-Immunization Administration Each Additional Vaccine x 1
-Td Vaccine x 1

Patient Instruction(s):
-Wash Hands Regularly
-Standard Precautions Wash Hands With Antiseptic Agent

Disposition Written by SUDDRETH, SANDY K @ 09 Feb 2007 1025 CST

Released w/o Limitations

Follow up: as needed in 72 hour(s) in the OCCUPATIONAL HEALTH clinic or sooner if there are problems. - Comments: PPD # 1 reading

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. 30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.