IN THE SUPREME COURT OF THE STATE OF NEVADA

BARRY JAMES RIVES, M.D.; and LAPAROSCOPIC SURGERY OF NEVADA, LLC, Appellants/Cross-Respondents, vs. TITINA FARRIS and PATRICK FARRIS, Respondents/Cross-Appellants.	Case No. 80271
BARRY JAMES RIVES, M.D.; and LAPAROSCOPIC SURGERY OF NEVADA, LLC, Appellants, vs. TITINA FARRIS and PATRICK FARRIS, Respondents.	Case No. 81052

APPELLANTS' APPENDIX
VOLUME 10

ROBERT L. EISENBERG (SBN 950)
LEMONS, GRUNDY & EISENBERG
6005 Plumas Street, Third Floor
Reno, NV 89519
775-786-6868
775-786-9716 fax
rle@lge.net

ATTORNEYS FOR APPELLANTS

CHRONOLOGICAL INDEX TO APPELLANTS' APPENDIX

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
1.	Complaint (Arbitration Exemption Claimed: Medical Malpractice)	7/1/16	1	1-8
	Exhibit 1: Affidavit of Vincent E. Pesiri, M.D.	7/1/16	1	9-12
	Exhibit 2: CV of Vincent E. Pesiri, M.D.		1	13-15
	Initial Appearance Fee Disclosure (NRS Chapter 19)	7/1/16	1	16-17
2.	Defendants Barry Rives, M.D.; Laparoscopic Surgery of Nevada, LLC Answer to Complaint *(Arbitration Exempt – Medical Malpractice)*	9/14/16	1	18-25
3.	Notice of Association of Counsel	7/15/19	1	26-28
4.	Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada LLC's Motion to Compel The Deposition of Gregg Ripplinger, M.D. and Extend the Close of Discovery (9th Request) on an Order Shortening Time	9/13/19	1	29-32
	Declaration of Chad C. Couchot, Esq.	9/13/19	1	33-35
	Declaration of Thomas J. Doyle, Esq.	9/13/19	1	36-37
	Memorandum of Points and Authorities	9/13/19	1	38-44
	Exhibit 1: Notice of Taking Deposition of Dr. Michael Hurwitz	2/6/19	1	45-49
	Exhibit 2: Amended Notice of Taking Deposition of Dr. Michael Hurwitz	7/16/19	1	50-54

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 4)	Second Amended Notice of Taking Deposition of Dr. Michael Hurwitz (Location Change Only)	7/25/19	1	55-58
	Exhibit 3: Third Amended Notice of Taking Deposition of Dr. Michael Hurwitz	9/11/19	1	59-63
	Exhibit 4: Subpoena – Civil re Dr. Gregg Ripplinger	7/18/19	1	64-67
	Notice of Taking Deposition of Dr. Gregg Ripplinger	7/18/19	1	68-70
	Exhibit 5: Amended Notice of Taking Deposition of Dr. Gregg Ripplinger	9/11/19	1	71-74
5.	Defendants Barry Rives, M.D.; Laparoscopic Surgery of Nevada LLC's NRCP 16.1(A)(3) Pretrial Disclosure	9/13/19	1	75-81
6.	Trial Subpoena – Civil Regular re Dr. Naomi Chaney	9/16/19	1	82-86
7.	Plaintiffs' Motion for Sanctions Under Rule 37 for Defendants' Intentional Concealment of Defendant Rives' History of Negligence and Litigation and Motion for Leave to Amend Complaint to Add Claim for Punitive Damages on Order Shortening Time	9/18/19	1	87-89
	Affidavit of Kimball Jones, Esq. in Support of Plaintiff's Motion and in Compliance with EDCR 2.34 and NRCP 37	9/18/19	1	90-91
	Memorandum of Points and Authorities	9/16/19	1	92-104
	Exhibit "1": Defendant Dr. Barry Rives' Response to Plaintiff Titina Farris' First Set of Interrogatories	4/17/17	1	105-122

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 7)	Exhibit "2": Deposition Transcript of Dr. Barry Rives, M.D. in the Farris Case	10/24/18	1	123-149
	Exhibit "3": Transcript of Video Deposition of Barry James Rives, M.D. in the Center Case	4/17/18	1	150-187
8.	Order Denying Stipulation Regarding Motions in Limine and Order Setting Hearing for September 26, 2019 at 10:00 AM, to Address Counsel Submitting Multiple Impermissible Documents that Are Not Complaint with the Rules/Order(s)	9/19/19	1	188-195
	Stipulation and Order Regarding Motions in Limine	9/18/19	1	196-198
9.	Plaintiffs' Motion to Strike Defendants' Rebuttal Witnesses Sarah Larsen, R.N., Bruce Adornato, M.D. and Scott Kush, M.D., and to Limit the Testimony of Lance Stone, D.O. and Kim Erlich, M.D., for Giving Improper "Rebuttal" Opinions, on Order Shortening Time	9/19/19	1	199-200
	Motion to Be Heard	9/18/19	1	201
	Affidavit of Kimball Jones, Esq. in Compliance with EDCR 2.34 and in Support of Plaintiff's Motion on Order Shortening Time	9/16/19	1	202-203
	Memorandum of Points and Authorities	9/16/19	1	204-220
	Exhibit "1": Defendants Barry J. Rives, M.D. and Laparoscopic Surgery of Nevada, LLC's Rebuttal Disclosure of Expert Witnesses and Reports	12/19/18	1	221-225

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 9)	Exhibit "2": Expert Report of Sarah Larsen, R.N., MSN, FNP, C.L.C.P. with Life Care Plan	12/19/18	2	226-257
	Exhibit "3": Life Expectancy Report of Ms. Titina Farris by Scott Kush, MD JD MHP	12/19/18	2	258-290
	Exhibit "4": Expert Report by Bruce T. Adornato, M.D.	12/18/18	2	291-309
	Exhibit "5": Expert Report by Lance R. Stone, DO	12/19/18	2	310-323
	Exhibit "6": Expert Report by Kim S. Erlich, M.D.	11/26/18	2	324-339
	Exhibit "7": Expert Report by Brian E. Juell, MD FACS	12/16/18	2	340-343
	Exhibit "8": Expert Report by Bart Carter, MD, FACS	12/19/18	2	344-346
10.	Court Minutes Vacating Plaintiffs' Motion to Strike	9/20/19	2	347
11.	Plaintiffs' Objection to Defendants' Second Amended Notice of Taking Deposition of Dr. Gregg Ripplinger	9/20/19	2	348-350
12.	Plaintiffs' Objections to Defendants' Pre-Trial Disclosure Statement Pursuant to NRCP 6.1(a)(3)(C)	9/20/19	2	351-354
13.	Plaintiffs' Objection to Defendants' Trial Subpoena of Naomi Chaney, M.D.	9/20/19	2	355-357
14.	Defendants Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC's Opposition to Plaintiffs' Motion for Sanctions Under Rule 37 for Defendants' Intentional Concealment of Defendant Rives' History of Negligence and Litigation and Motion for Leave to Amend Compliant to Add Claim for Punitive Damages on Order Shortening Time	9/24/19	2	358-380

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
15.	Declaration of Chad Couchot in Support of Opposition to Plaintiffs' Motion for Sanctions Under Rule 37 for Defendants' Intentional Concealment of Defendant Rives' History of Negligence and Litigation and Motion for Leave to Amend Complaint to Add Claim for Punitive Damages on Order Shortening Time	9/24/19	2	381-385
	Exhibit A: Defendant Dr. Barry Rives' Response to Plaintiff Vickie Center's First Set of Interrogatories	3/7/17	2	386-391
	Exhibit B: Defendant Dr. Barry Rives' Response to Plaintiff Titina Farris' First Set of Interrogatories	4/17/17	2	392-397
	Exhibit C: Partial Deposition Transcript of Barry Rives, M.D. in the Farris case	10/24/18	2	398-406
	Exhibit D: Partial Transcript of Video Deposition of Barry Rives, M.D. in the Center case	4/17/18	2	407-411
	Exhibit E: Defendant Dr. Barry Rives' Supplemental Response to Plaintiff Titina Farris' First Set of Interrogatories	9/13/19	2	412-418
	Exhibit F: Partial Transcript of Video Deposition of Yan-Borr Lin, M.D. in the Center case	5/9/18	2	419-425
	Exhibit G: Expert Report of Alex A. Balekian, MD MSHS in the *Rives v. Center* case	8/5/18	2	426-429
16.	Defendants Barry J. Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Objection to Plaintiffs' Ninth	9/25/19	2	430-433

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 16)	Supplement to Early Case Conference Disclosure of Witnesses and Documents			
17.	Court Minutes on Motion for Sanctions and Setting Matter for an Evidentiary Hearing	9/26/19	2	434
18.	Plaintiffs' Objection to Defendants' Fourth and Fifth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents	9/26/19	2	435-438
19.	Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Objection to Plaintiffs' Initial Pre-Trial Disclosures	9/26/19	2	439-445
20.	Plaintiffs' Motion to Strike Defendants' Fourth and Fifth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents on Order Shortening Time	9/27/19	2	446-447
	Notice of Hearing	9/26/19	2	448
	Affidavit of Kimball Jones, Esq. in Support of Plaintiff's Motion and in Compliance with EDCR 2.26	9/24/19	2	449
	Memorandum of Points and Authorities	9/25/19	2	450-455
	Exhibit "1": Defendants Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC's Fourth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents	9/12/19	2	456-470
	Exhibit "2": Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Fifth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents	9/23/19	3	471-495

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
21.	Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Pretrial Memorandum	9/30/19	3	496-514
22.	Plaintiffs' Pre-Trial Memorandum Pursuant to EDCR 2.67	9/30/19	3	515-530
23.	Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's First Supplemental NRCP 16.1(A)(3) Pretrial Disclosure	9/30/19	3	531-540
24.	Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Supplemental Objection to Plaintiffs' Initial Pre-Trial Disclosures	9/30/19	3	541-548
25.	Order Denying Defendants' Order Shortening Time Request on Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Motion to Extend the Close of Discovery (9th Request) and Order Setting Hearing at 8:30 AM to Address Counsel's Continued Submission of Impermissible Pleading/Proposed Orders Even After Receiving Notification and the Court Setting a Prior Hearing re Submitting Multiple Impermissible Documents that Are Not Compliant with the Rules/Order(s)	10/2/19	3	549-552
	Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Motion to Extend the Close of Discovery (9th Request) on an Order Shortening Time	9/20/19	3	553-558
	Declaration of Aimee Clark Newberry, Esq. in Support of Defendants' Motion on Order Shortening Time	9/20/19	3	559-562
	Declaration of Thomas J. Doyle, Esq.	9/20/19	3	563-595

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 25)	Memorandum of Points and Authorities	9/20/19	3	566-571
	Exhibit 1: Notice of Taking Deposition of Dr. Michael Hurwitz	2/6/19	3	572-579
	Exhibit 2: Amended Notice of Taking Deposition of Dr. Michael Hurwitz	7/16/19	3	580-584
	Second Amended Notice of Taking Deposition of Dr. Michael Hurwitz (Location Change Only)	7/25/19	3	585-590
26.	Defendants Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC's Opposition to Plaintiffs' Motion to Strike Defendants' Fourth and Fifth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents on Order Shortening Time	10/2/19	3	591-601
27.	Declaration of Chad Couchot in Support of Opposition to Plaintiffs' Motion to Strike Defendants' Fourth and Fifth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents on Order Shortening Time	10/2/19	3	602-605
	Exhibit A: Partial Transcript of Video Deposition of Brain Juell, M.D.	6/12/19	3	606-611
	Exhibit B: Partial Transcript of Examination Before Trial of the Non-Party Witness Justin A. Willer, M.D.	7/17/19	3	612-618
	Exhibit C: Partial Transcript of Video Deposition of Bruce Adornato, M.D.	7/23/19	3	619-626
	Exhibit D: Plaintiffs' Eighth Supplement to Early Case Conference Disclosure of Witnesses and Documents	7/24/19	3	627-640

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 27)	Exhibit E: Plaintiffs' Ninth Supplement to Early Case Conference Disclosure of Witnesses and Documents	9/11/19	3	641-655
	Exhibit F: Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Fourth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents	9/12/19	3	656-670
	Exhibit G: Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Fifth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents	9/23/19	3	671-695
	Exhibit H: Expert Report of Michael B. Hurwitz, M.D.	11/13/18	3	696-702
	Exhibit I: Expert Report of Alan J. Stein, M.D.	11/2018	3	703-708
	Exhibit J: Expert Report of Bart J. Carter, M.D., F.A.C.S.		3	709-717
	Exhibit K: Expert Report of Alex Barchuk, M.D.	3/20/18	4	718-750
	Exhibit L: Expert Report of Brian E Juell, MD FACS	12/16/18	4	751-755
28.	Declaration of Thomas J. Doyle in Support of Opposition to Plaintiffs' Motion to Strike Defendants' Fourth and Fifth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents on Order Shortening Time	10/2/19	4	756-758
29.	Reply in Support of Plaintiffs' Motion to Strike Defendants' Fourth and Fifth Supplement to NRCP 16.1 Disclosure Of Witnesses and Documents on Order Shortening Time	10/3/19	4	759-766
30.	Defendants' Proposed List of Exhibits	10/7/19	4	767-772

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
31.	Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Reply to Plaintiffs' Opposition to Motion to Compel the Deposition of Gregg Ripplinger, M.D. and Extend the Close of Discovery (9th Request) on an Order Shortening Time	10/10/19	4	773-776
32.	Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Trial Brief Regarding Their Request to Preclude Defendants' Expert Witnesses' Involvement as a Defendant in Medical Malpractice Actions	10/14/19	4	777-785
	Exhibit 1: Partial Transcript Video Deposition of Bart Carter, M.D.	6/13/19	4	786-790
	Exhibit 2: Partial Transcript of Video Deposition of Brian E. Juell, M.D.	6/12/19	4	791-796
33.	Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Trial Brief Regarding the Need to Limit Evidence of Past Medical Expenses to Actual Out-of-Pocket Expenses or the Amounts Reimbursed	10/14/19	4	797-804
	Exhibit 1: LexisNexis Articles		4	805-891
34.	Plaintiffs' Renewed Motion to Strike Defendants' Answer for Rule 37 Violations, Including Perjury and Discovery Violations on an Order Shortening Time	10/19/19	4	892-896
	Memorandum of Points and Authorities	10/19/19	4	897-909
	Exhibit "1": Recorder's Transcript of Pending Motions	10/7/19	5	910-992
	Exhibit "2": Verification of Barry Rives, M.D.	4/27/17	5	993-994

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
35.	Defendants' Trial Brief in Support of Their Position Regarding the Propriety of Dr. Rives' Responses to Plaintiffs' Counsel's Questions Eliciting Insurance Information	10/22/19	5	995-996
	Declaration of Thomas J. Doyle	10/22/19	5	997
	Memorandum of Points and Authorities	10/22/19	5	998-1004
	Exhibit 1: MGM Resorts Health and Welfare Benefit Plan (As Amended and Restated Effective January 1, 2012)		5	1005-1046
	Exhibit 2: LexisNexis Articles		5	1047-1080
36.	Defendants Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC's Opposition to Plaintiffs' Renewed Motion to Strike	10/22/19	5	1081-1086
	Exhibit A: Declaration of Amy B. Hanegan	10/18/19	5	1087-1089
	Exhibit B: Deposition Transcript of Michael B. Hurwitz, M.D., FACS	9/18/119	6	1090-1253
	Exhibit C: Recorder's Transcript of Pending Motions (Heard 10/7/19)	10/14/19	6	1254-1337
37.	Reply in Support of, and Supplement to, Plaintiffs' Renewed Motion to Strike Defendants' Answer for Rule 37 Violations, Including Perjury and Discovery Violations on an Order Shortening Time	10/22/19	7	1338-1339
	Declaration of Kimball Jones, Esq. in Support of Plaintiff's Reply and Declaration for an Order Shortening Time		7	1340
	Memorandum of Points and Authorities	10/22/19	7	1341-1355

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 37)	Exhibit "1": Plaintiffs' Seventh Supplement to Early Case Conference Disclosure of Witnesses and Documents	7/5/19	7	1356-1409
38.	Order on Plaintiffs' Motion to Strike Defendants' Fourth and Fifth Supplements to NRCP 16.1 Disclosures	10/23/19	7	1410-1412
39.	Plaintiffs' Trial Brief Regarding Improper Arguments Including "Medical Judgment," "Risk of Procedure" and "Assumption of Risk"	10/23/19	7	1413-1414
	Memorandum of Points and Authorities	10/23/19	7	1415-1419
40.	Plaintiffs' Trial Brief on Rebuttal Experts Must Only be Limited to Rebuttal Opinions Not Initial Opinions	10/24/19	7	1420
	Memorandum of Points and Authorities	10/24/19	7	1421-1428
	Exhibit "1": Defendants Barry J. Rives, M.D. and Laparoscopic Surgery of Nevada, LLC's Rebuttal Disclosure of Expert Witnesses and Reports	12/19/18	7	1429-1434
	Exhibit "2": Expert Report of Bruce T. Adornato, M.D.	12/18/18	7	1435-1438
41.	Plaintiffs' Trial Brief on Admissibility of Malpractice Lawsuits Against an Expert Witness	10/27/19	7	1439-1440
	Memorandum of Points and Authorities	10/26/19	7	1441-1448
	Exhibit "1": Transcript of Video Deposition of Brian E. Juell, M.D.	6/12/19	7	1449-1475

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
42.	Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Trial Brief on Rebuttal Experts Being Limited to Rebuttal Opinions Not Initial Opinions	10/28/19	7	1476-1477
	Declaration of Thomas J. Doyle, Esq.	10/28/19	7	1478
	Memorandum of Points and Authorities	10/28/19	7	1479-1486
	Exhibit 1: Expert Report of Justin Aaron Willer, MD, FAAN	10/22/18	7	1487-1497
	Exhibit 2: LexisNexis Articles		7	1498-1507
	Exhibit 3: Partial Transcript of Examination Before Trial of the Non-Party Witness Justin A. Willer, M.D.	7/17/19	7	1508-1512
43.	Plaintiffs' Trial Brief Regarding Disclosure Requirements for Non-Retained Experts	10/28/19	7	1513-1514
	Memorandum of Points and Authorities	10/28/19	7	1515-1521
44.	Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Trial Brief Regarding Propriety of Disclosure of Naomi Chaney, M.D. as a Non-Retained Expert Witness	10/29/19	7	1522-1523
	Declaration of Thomas J. Doyle, Esq.	10/29/19	7	1524
	Memorandum of Points and Authorities	10/29/19	7	1525-1529
	Exhibit 1: Partial Deposition Transcript of Naomi L. Chaney Chaney, M.D.	8/9/19	7	1530-1545
	Exhibit 2: Plaintiffs' Expert Witness Disclosure	11/15/18	7	1546-1552

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 44)	Exhibit 3: Plaintiffs' Second Supplemental Expert Witness Disclosure	7/12/19	7	1553-1573
	Exhibit 4: Expert Report of Justin Aaron Willer, MD, FAAN	10/22/18	7	1574-1584
	Exhibit 5: LexisNexis Articles		8	1585-1595
	Exhibit 6: Defendant Barry Rives M.D.'s and Laparoscopic Surgery of Nevada, LLC's First Supplement to NRCP 16.1 Disclosure of Witnesses and Documents	12/4/18	8	1596-1603
45.	Plaintiffs' Motion to Quash Trial Subpoena of Dr. Naomi Chaney on Order Shortening Time	10/29/19	8	1604-1605
	Notice of Motion on Order Shortening Time		8	1606
	Declaration of Kimball Jones, Esq. in Support of Plaintiff's Motion on Order Shortening Time		8	1607-1608
	Memorandum of Points and Authorities	10/29/19	8	1609-1626
	Exhibit "1": Trial Subpoena – Civil Regular re Dr. Naomi Chaney	10/24/19	8	1627-1632
	Exhibit "2": Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Fifth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents	9/23/19	8	1633-1645
	Exhibit "3": Defendants Barry J. Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Initial Disclosure of Expert Witnesses and Reports	11/15/18	8	1646-1650

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 45)	Exhibit "4": Deposition Transcript of Naomi L. Chaney, M.D.	5/9/19	8	1651-1669
46.	Plaintiffs' Trial Brief Regarding the Testimony of Dr. Barry Rives	10/29/19	8	1670-1671
	Memorandum of Points and Authorities	10/29/19	8	1672-1678
	Exhibit "1": Defendants Barry Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Fifth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents	9/23/19	8	1679-1691
	Exhibit "2": Deposition Transcript of Barry Rives, M.D.	10/24/18	8	1692-1718
47.	Plaintiffs' Objection to Defendants' Misleading Demonstratives (11-17)	10/29/19	8	1719-1720
	Memorandum of Points and Authorities	10/29/19	8	1721-1723
	Exhibit "1" Diagrams of Mrs. Farris' Pre- and Post-Operative Condition		8	1724-1734
48.	Plaintiffs' Trial Brief on Defendants Retained Rebuttal Experts' Testimony	10/29/19	8	1735-1736
	Memorandum of Points and Authorities	10/28/19	8	1737-1747
	Exhibit "1": Plaintiffs Objections to Defendants' Pre-Trial Disclosure Statement Pursuant to NRCP 16.1(a)(3)(C)	9/20/19	8	1748-1752
	Exhibit "2": Defendants Barry J. Rives, M.D. and Laparoscopic Surgery of Nevada, LLC's Rebuttal Disclosure of Expert Witnesses and Reports	12/19/18	8	1753-1758

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 48)	Exhibit "3": Deposition Transcript of Lance Stone, D.O.	7/29/19	8	1759-1772
	Exhibit "4": Plaintiff Titina Farris's Answers to Defendant's First Set of Interrogatories	12/29/16	8	1773-1785
	Exhibit "5": Expert Report of Lance R. Stone, DO	12/19/18	8	1786-1792
	Exhibit "6": Expert Report of Sarah Larsen, R.N., MSN, FNP, C.L.C.P.	12/19/18	8	1793-1817
	Exhibit "7": Expert Report of Erik Volk, M.A.	12/19/18	8	1818-1834
49.	Trial Subpoena – Civil Regular re Dr. Naomi Chaney	10/29/19	9	1835-1839
50.	Offer of Proof re Bruce Adornato, M.D.'s Testimony	11/1/19	9	1840-1842
	Exhibit A: Expert Report of Bruce T. Adornato, M.D.	12/18/18	9	1843-1846
	Exhibit B: Expert Report of Bruce T. Adornato, M.D.	9/20/19	9	1847-1849
	Exhibit C: Deposition Transcript of Bruce Adornato, M.D.	7/23/19	9	1850-1973
51.	Offer of Proof re Defendants' Exhibit C	11/1/19	9	1974-1976
	Exhibit C: Medical Records (Dr. Chaney) re Titina Farris		10	1977-2088
52.	Offer of Proof re Michael Hurwitz, M.D.	11/1/19	10	2089-2091
	Exhibit A: Partial Transcript of Video Deposition of Michael Hurwitz, M.D.	10/18/19	10	2092-2097
	Exhibit B: Transcript of Video Deposition of Michael B. Hurwitz, M.D., FACS	9/18/19	10 11	2098-2221 2222-2261

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
53.	Offer of Proof re Brian Juell, M.D.	11/1/19	11	2262-2264
	Exhibit A: Expert Report of Brian E. Juell, MD FACS	12/16/18	11	2265-2268
	Exhibit B: Expert Report of Brian E. Juell, MD FACS	9/9/19	11	2269-2271
	Exhibit C: Transcript of Video Transcript of Brian E. Juell, M.D.	6/12/19	11	2272-2314
54.	Offer of Proof re Sarah Larsen	11/1/19	11	2315-2317
	Exhibit A: CV of Sarah Larsen, RN, MSN, FNP, LNC, CLCP		11	2318-2322
	Exhibit B: Expert Report of Sarah Larsen, R.N.. MSN, FNP, LNC, C.L.C.P.	12/19/18	11	2323-2325
	Exhibit C: Life Care Plan for Titina Farris by Sarah Larsen, R.N., M.S.N., F.N.P., L.N.C., C.L.C.P	12/19/18	11	2326-2346
55.	Offer of Proof re Erik Volk	11/1/19	11	2347-2349
	Exhibit A: Expert Report of Erik Volk	12/19/18	11	2350-2375
	Exhibit B: Transcript of Video Deposition of Erik Volk	6/20/19	11	2376-2436
56.	Offer of Proof re Lance Stone, D.O.	11/1/19	11	2437-2439
	Exhibit A: CV of Lance R. Stone, DO		11	2440-2446
	Exhibit B: Expert Report of Lance R. Stone, DO	12/19/18	11	2447-2453
	Exhibit C: Life Care Plan for Titina Farris by Sarah Larsen, R.N., M.S.N., F.N.P., L.N.C., C.L.C.P	12/19/18	12	2454-2474
57.	Special Verdict Form	11/1/19	12	2475-2476

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
58.	Order to Show Cause {To Thomas J. Doyle, Esq.}	11/5/19	12	2477-2478
59.	Judgment on Verdict	11/14/19	12	2479-2482
60.	Notice of Entry of Judgment	11/19/19	12	2483-2488
61.	Plaintiffs' Motion for Fees and Costs	11/22/19	12	2489-2490
	Declaration of Kimball Jones, Esq. in Support of Motion for Attorneys' Fees and Costs	11/22/19	12	2491-2493
	Declaration of Jacob G. Leavitt Esq. in Support of Motion for Attorneys' Fees and Costs	11/22/19	12	2494-2495
	Declaration of George F. Hand in Support of Motion for Attorneys' Fees and Costs	11/22/19	12	2496-2497
	Memorandum of Points and Authorities	11/22/19	12	2498-2511
	Exhibit "1": Plaintiffs' Joint Unapportioned Offer of Judgment to Defendant Barry Rives, M.D. and Laparoscopic Surgery of Nevada, LLC	6/5/19	12	2512-2516
	Exhibit "2": Judgment on Verdict	11/14/19	12	2517-2521
	Exhibit "3": Notice of Entry of Order	4/3/19	12	2522-2536
	Exhibit "4": Declarations of Patrick Farris and Titina Farris		12	2537-2541
	Exhibit "5": Plaintiffs' Verified Memorandum of Costs and Disbursements	11/19/19	12	2542-2550
62.	Defendants Barry J. Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Opposition to Plaintiffs' Motion for Fees and Costs	12/2/19	12	2551-2552

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 62)	Declaration of Thomas J. Doyle, Esq.		12	2553-2557
	Declaration of Robert L. Eisenberg, Esq.		12	2558-2561
	Memorandum of Points and Authorities	12/2/19	12	2562-2577
	Exhibit 1: Defendants Barry J. Rives, M.D. and Laparoscopic Surgery of Nevada, LLC's Initial Disclosure of Expert Witnesses and Reports	11/15/18	12	2578-2611
	Exhibit 2: Defendants Barry J. Rives, M.D. and Laparoscopic Surgery of Nevada, LLC's Rebuttal Disclosure of Expert Witnesses and Reports	12/19/18	12 13	2612-2688 2689-2767
	Exhibit 3: Recorder's Transcript Transcript of Pending Motions (Heard 10/10/19)	10/14/19	13	2768-2776
	Exhibit 4: 2004 Statewide Ballot Questions		13	2777-2801
	Exhibit 5: Emails between Carri Perrault and Dr. Chaney re trial dates availability with Trial Subpoena and Plaintiffs' Objection to Defendants' Trial Subpoena on Naomi Chaney, M.D.	9/13/19 - 9/16/19	13	2802-2813
	Exhibit 6: Emails between Riesa Rice and Dr. Chaney re trial dates availability with Trial Subpoena	10/11/19 - 10/15/19	13	2814-2828
	Exhibit 7: Plaintiff Titina Farris's Answers to Defendant's First Set of Interrogatories	12/29/16	13	2829-2841
	Exhibit 8: Plaintiff's Medical Records		13	2842-2877

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
63.	Reply in Support of Plaintiffs' Motion for Fees and Costs	12/31/19	13	2878-2879
	Memorandum of Points and Authorities	12/31/19	13	2880-2893
	Exhibit "1": Plaintiffs' Joint Unapportioned Offer of Judgment to Defendant Barry Rives, M.D. and Defendant Laparoscopic Surgery of Nevada LLC	6/5/19	13	2894-2898
	Exhibit "2": Judgment on Verdict	11/14/19	13	2899-2903
	Exhibit "3": Defendants' Offer Pursuant to NRCP 68	9/20/19	13	2904-2907
64.	Supplemental and/or Amended Notice of Appeal	4/13/20	13	2908-2909
	Exhibit 1: Judgment on Verdict	11/14/19	13	2910-2914
	Exhibit 2: Order on Plaintiffs' Motion for Fees and Costs and Defendants' Motion to Re-Tax and Settle Plaintiffs' Costs	3/30/20	13	2915-2930
	TRANSCRIPTS			
65.	*Transcript of Proceedings Re*: Status Check	7/16/19	14	2931-2938
66.	*Transcript of Proceedings Re*: Mandatory In-Person Status Check per Court's Memo Dated August 30, 2019	9/5/19	14	2939-2959
67.	*Transcript of Proceedings Re*: Pretrial Conference	9/12/19	14	2960-2970
68.	*Transcript of Proceedings Re*: All Pending Motions	9/26/19	14	2971-3042
69.	*Transcript of Proceedings Re*: Pending Motions	10/7/19	14	3043-3124

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
70.	*Transcript of Proceedings Re*: Calendar Call	10/8/19	14	3125-3162
71.	*Transcript of Proceedings Re*: Pending Motions	10/10/19	15	3163-3301
72.	*Transcript of Proceedings Re*: Status Check: Judgment — Show Cause Hearing	11/7/19	15	3302-3363
73.	*Transcript of Proceedings Re*: Pending Motions	11/13/19	16	3364-3432
74.	*Transcript of Proceedings Re*: Pending Motions	11/14/19	16	3433-3569
75.	*Transcript of Proceedings Re*: Pending Motions	11/20/19	17	3570-3660
	TRIAL TRANSCRIPTS			
76.	*Jury Trial Transcript* — Day 1 (Monday)	10/14/19	17 18	3661-3819 3820-3909
77.	*Jury Trial Transcript* — Day 2 (Tuesday)	10/15/19	18	3910-4068
78.	*Jury Trial Transcript* — Day 3 (Wednesday)	10/16/19	19	4069-4284
79.	*Jury Trial Transcript* — Day 4 (Thursday)	10/17/19	20	4285-4331
93.	*Partial Transcript re*: Trial by Jury – Day 4 Testimony of Justin Willer, M.D. [Included in "Additional Documents" at the end of this Index]	10/17/19	30	6514-6618
80.	*Jury Trial Transcript* — Day 5 (Friday)	10/18/19	20	4332-4533
81.	*Jury Trial Transcript* — Day 6 (Monday)	10/21/19	21	4534-4769
82.	*Jury Trial Transcript* — Day 7 (Tuesday)	10/22/19	22	4770-4938

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
83.	*Jury Trial Transcript* — Day 8 (Wednesday)	10/23/19	23	4939-5121
84.	*Jury Trial Transcript* — Day 9 (Thursday)	10/24/19	24	5122-5293
85.	*Jury Trial Transcript* — Day 10 (Monday)	10/28/19	25 26	5294-5543 5544-5574
86.	*Jury Trial Transcript* — Day 11 (Tuesday)	10/29/19	26	5575-5794
87.	*Jury Trial Transcript* — Day 12 (Wednesday)	10/30/19	27 28	5795-6044 6045-6067
88.	*Jury Trial Transcript* — Day 13 (Thursday)	10/31/19	28 29	6068-6293 6294-6336
89.	*Jury Trial Transcript* — Day 14 (Friday)	11/1/19	29	6337-6493
	ADDITIONAL DOCUMENTS[1]			
91.	Defendants Barry Rives, M.D. and Laparoscopic Surgery of, LLC's Supplemental Opposition to Plaintiffs' Motion for Sanctions Under Rule 37 for Defendants' Intentional Concealment of Defendant Rives' History of Negligence and Litigation And Motion for Leave to Amend Complaint to Add Claim for Punitive Damages on Order Shortening Time	10/4/19	30	6494-6503
92.	Declaration of Thomas J. Doyle in Support of Supplemental Opposition to Plaintiffs' Motion for Sanctions Under Rule 37 for Defendants' Intentional Concealment of Defendant Rives' History of Negligence and litigation and Motion for Leave to Amend Complaint to Add Claim for Punitive Damages on Order Shortening Time	10/4/19	30	6504-6505

[1] These additional documents were added after the first 29 volumes of the appendix were complete and already numbered (6,493 pages).

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 92)	Exhibit A: Partial Deposition Transcript of Barry Rives, M.D.	10/24/18	30	6506-6513
93.	*Partial Transcript re*: Trial by Jury – Day 4 Testimony of Justin Willer, M.D. (Filed 11/20/19)	10/17/19	30	6514-6618
94.	Jury Instructions	11/1/19	30	6619-6664
95.	Notice of Appeal	12/18/19	30	6665-6666
	Exhibit 1: Judgment on Verdict	11/14/19	30	6667-6672
96.	Notice of Cross-Appeal	12/30/19	30	6673-6675
	Exhibit "1": Notice of Entry Judgment	11/19/19	30	6676-6682
97.	*Transcript of Proceedings Re*: Pending Motions	1/7/20	31	6683-6786
98.	*Transcript of Hearing Re*: Defendants Barry J. Rives, M.D.'s and Laparoscopic Surgery of Nevada, LLC's Motion to Re-Tax and Settle Plaintiffs' Costs	2/11/20	31	6787-6801
99.	Order on Plaintiffs' Motion for Fees and Costs and Defendants' Motion to Re-Tax and Settle Plaintiffs' Costs	3/30/20	31	6802-6815
100.	Notice of Entry Order on Plaintiffs' Motion for Fees and Costs and Defendants' Motion to Re-Tax and Settle Plaintiffs' Costs	3/31/20	31	6816-6819
	Exhibit "A": Order on Plaintiffs' Motion for Fees and Costs and Defendants' Motion to Re-Tax and Settle Plaintiffs' Costs	3/30/20	31	6820-6834
101.	Supplemental and/or Amended Notice of Appeal	4/13/20	31	6835-6836
	Exhibit 1: Judgment on Verdict	11/14/19	31	6837-6841

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
(Cont. 101)	Exhibit 2: Order on Plaintiffs' Motion for Fees and Costs and Defendants' Motion to Re-Tax and Settle Plaintiffs' Costs	3/30/20	31	6842-6857

EXHIBIT C

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS TINNAY (DOB: [redacted]) 1/17/2014 11:05:37 PM

CC	REFILLS SR
HPI	On last evaluation the patient was asked to get labs, and referred for a mammogram, colonoscopy, and opthamologist. The patient was started on Lantus and reports her blood glucose is within normal limitis. She has not been able to get her blood work done. She did not see the opthamologist.
ROS	10 system reviewed and performed by patient on the Phressia tablet.
PMH	Diabetes. Hypertenion Neuropathy.
SH	Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption. [Tobacco: Never smoker] married daughter 8 - patrick husband She has several dogs - she toy collie and a Yorkshire interior toy collie little yorki and chiweenie.
FH	Mother: pacer dx diabetes? Father: good Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.
Allergies	asprin (Updated by Naomi on 01/17/2014 03:37 PM)
Meds	1) Cymbalta 60 mg oral delayed release capsule, 1 po qd 2) gabapentin 300 mg oral capsule, 2 po bid 3) glucometer on plan 4) lancets and strips on plan, check tid prior meals 5) Lantus Solostar Pen 100 units/mL subcutaneous solution, 30 units sq q day 6) Lantus Solostar Pen needles, q day 7) lisinopril 5 mg oral tablet, one po bid 8) loratab 5/325 , one po bid 9) metFORMIN 1000 mg oral tablet, 1 PO BID 10) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) 11) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN 12) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d) 13) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X Month (30d) 14) triamcinolone 0.025% topical ointment, APPLY TO LESION 15) valsartan 160/hctz 12.5, one po q day
Vitals	Wt: 167.8 lb Ht/Ln: 62 in BMI: 30.7 BP: 132/78 Pulse: 72 RR: 12 Sat: 98
PE	GENERAL: WNWD NAD HEENT: WNL

Printed By: NAOMI CHANEY, MD 3/31/2018 11:55:40 AM

Ameritox Order [redacted] Page 1 of 2

LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.

A/P # Diabetes type 2 on insulin (250.00):
Hypertension (401.9):
Back pain (724.5):

Electronically Signed By: NAOMI CHANEY, MD
6/19/14 6:02 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 11:55:40 AM

Patient Referral

REFERRAL #: 884-D31Y

DATE: 06/19/14

PATIENT INFORMATION

NAME:	Titina Farris
DOB:	[redacted]
PAYER:	(MGM) Direct
MOBILE:	
HOME:	

REASON FOR REFERRAL

NEUROPATHY

ELIGIBILITY PERIOD

06/19/14 - 09/17/14

SENDING PROVIDER

NAME:	Naomi Chaney, MD
	[redacted]
ADDRESS:	[redacted] Las [redacted]
PHONE:	
FAX:	

RECEIVING PROVIDER

NAME:	Randall Yee, DO Orthopedic Surgery NPI: 1427040591
ADDRESS:	2551 W. Horizon Ridge Pkwy., #130, Henderson, NV
PHONE:	702-740-5327
FAX:	702-740-5328

c:\data\work\fax_3563.4 173_7023195901_071414013718P7 _0.htm

Fax Cover Sheet - Advanced Orthopedics & Sports Medicine

From: Advanced Orthopedics & Sports Medicine
9280 West Sunset Road
Suite 422
Las Vegas, NV 89148
Phone: (702) 740-5327
Fax: (702) 740-5328

Requestor: DEYP
Fax Number: 702-319-5901
Fax Destination: CHANEY, NAOMI M.D.
To the ATTENTION of: CHART COPY
Fax Priority: Immediate
Request Date: 07/14/2014 - 01:37:18 PM

REVIEWED
By Naomi L. Chaney, M.D. at 2:[illegible] Jul 14, 20[illegible]

c:\data\patients\062\786[illegible]786\\transcript0.htm

AOSM ADVANCED ORTHOPEDICS & SPORTS MEDICINE

X. Nick Liu, D.O.
Board Certified Orthopedic Surgeon
Fellowship Trained Sports Medicine
Timothy F. Trainor, M.D.
Board Certified Orthopedic Surgeon
Board Certified Orthopedic Sports Subspecialty Surgeon
Randall E. Yee, D.O.
Board Certified Orthopedic Surgeon
Fellowship Trained Sports Medicine

Jay Kelly M.D.
Board Certified Orthopedic Surgeon
Fellowship Trained Spine Surgeon
Thomas Kuruvilla D.P.M.
Board Certified Podiatry
Certified Wound Care & Hyperbaric Medicine
Matthew R.C. Otten, D.O.
Sports Medicine Fellowship Trained
Michael Trainor, D.O.
Board Certified Orthopedic Surgeon
Fellowship Trained Spine Surgeon

Sports Injuries • Fracture Care • Joint Replacement • Cartilage Replacement • Minimally Invasive Arthroscopic Surgery

ADVANCED ORTHOPEDICS & SPORTS MEDICINE

Sports Injuries • Fracture Care • Joint Replacement • Cartilage Replacement • Minimally Invasive Arthroscopic Surgery

REVIEWED
By Naomi C. Chaney, MD at 9:24 am, Jul 10, 2014

FARRIS, TITINA
[redacted]
DR. YEE/ Brittany Hough
07/02/2014
Left shoulder

Dear Dr. Naomi Chaney,

Titina is a patient who presents today for left shoulder and bilateral feet pain. She states her pain started little over a year ago, no known trauma or injury. She states her pain is getting worse daily. she states shoulder has pain maybe 3 times a week and sore if pressure is put on shoulder. He also states feet is daily pain and sometimes numbness and sharp pain.

Allergies and history were reviewed with the patient in the office.

On physical examination, regarding the right shoulder, patient has a negative Neer's, negative Hawkin's, and negative Speed's. There are no signs of instability. There is 5/5 strength. There is +2/4 DTR's. There is no visible scars. Skin in intact. Tenderness absent. Non tenderness palpation over the AC joint and over the gleneral humeral joint. Normal flexion and abduction over the normal limits. Patient has no erythema on the skin. Plus pulses are noted. DIstal neurovascular status is noted to be intact. Regarding the left shoulder, she has a positive Neer's, positive Hawkin's, and a positive Speed's. There is a negative O'Brien's. There is no signs of instability. There is tenderness to palpation over the supraspinatus tendon. There are no signs of dislocation There is +2/4 DTR's in these upper extremities. There is 5/5 strength. Plus pulses are noted. Distal neurovascular status is noted to be intact. Regarding the bilateral feet, there is pain noted.

IMPRESSION: Left shoulder impingement syndrome
Left AC DJD asymptomatic
History of diabetic neuropathy.
Bilateral foot pain

Ultrasound guidance showed: Static real-time views in longitudinal and transverse orientation were obtained on this patient. In transverse view the bicep tendon is hypoechoic and increased in size. It is well situated in the inter-tubercular groove, no evidence of medial or lateral subluxation. On long axis, the biceps is intact, but remains hypoechoic with a fusiform appearance as it proceeds distally. On external rotation, the subscapularis tendon appeared intact, not edematous, with no evidence of tenosynovitis nor tendinosis. The supraspinatus tendon is noted to have decreased thickened consistent with the tear. The infraspinatus and teres minor tendons were inflammed consistent with possible tear tendonitis. No cortical interruption or irregularity of the humeral head. The humeral hyaline cartilage was 0.8 mm in thickness below the supraspinatus. The rotator cuff interval did not demonstrate increased supraspinatus or subscapularis margin effusion. Dynamic imaging to evaluate for impingement demonstrated smooth, unobstructed movement of the supraspinatus beneath the acromion with patient flexion/ abduction. Bilateral acromo-clavicular joint images do not reveal sonographic criteria of ligament laxity or shoulder separation. Glenoid labrum and inferior gleno-humeral ligament interruption or tear were not demonstrated.

PLAN: We will see her back in this office in 4 weeks. She was placed on Duexis and Hydrocodone. She will follow up with Dr. Kuruvilla. She was injected with 80mg of Methylprednisolone into her left shoulder under sterile condition, using ultrasound guidance. Risk for injections were discussed. There is a possibility of skin color change, the possibility of infection and increase in blood sugar. The possibility of tendon or ligament damage and early arthritis.
She will call or return with questions.

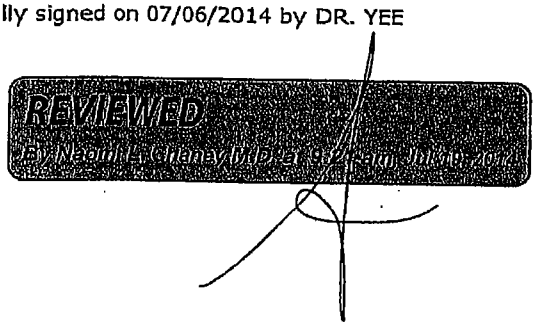
PLTF9134

c:\data\patients\062\786\786\\transcript0.htm

Brittany Hough, PA-C
RY/cp

Tel. (702) 740-5327 * Fax (702) 740-5328 * 8420 Warm Springs Rd., Ste. 100, Las Vegas, Nevada 89113
10001 S. Eastern Avenue, Suite 406, Henderson, Nevada 89052 * 601 Whitney Ranch Dr., Suite B-6, Henderson, Nevada 89014

Electronically signed on 07/06/2014 by DR. YEE



INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

[redacted] 01/23/2014 Wed 05:09 PM

CC refills

HPI Patient is here in interval follow-up. She requires refills on her medication. She is being evaluated currently by neurologist for her neuropathy. Additionally, she states that her blood glucose is well controlled generally 120. She has had her mammogram, Pap smear and bone density. She is scheduled for her colonoscopy.

ROS Patient denies any recent fever, chills, headache, change in weight without trying, vision or hearing problems. No cp, sob, doe, pnd, orthopnea, or peripheral edema.They note no lumps or swollen glands, no new rashes, changing moles, or change in bowel or bladder function. No melena or BRBPR. Mood has been good and overall doing well.

PMH Diabetes.
Hypertenion
Neuropathy.

SH Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie.

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Cymbalta 60 mg oral delayed release capsule, 1 po qd
2) gabapentin 300 mg oral capsule, 2 po bid
3) glucometer on plan
4) lancets and strips on plan, check tid prior meals
5) Lantus Solostar Pen 100 units/mL subcutaneous solution, 30 units sq q day
6) loratab 5/325, one po bid
7) metFORMIN 1000 mg oral tablet, 1 PO BID
8) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d)
9) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN
10) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
11) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
12) triamcinolone 0.025% topical ointment, APPLY TO LESION
13) valsartan 160/hctz 12.5, one po q day

Vitals Wt: 158 lb Ht/Ln: 62 in BMI: 29.0 BP: 132/70 Pulse: 82 RR: 12

PE GENERAL: WNWD NAD
HEENT: WNL

Printed By: NAOMI CHANEY, MD 3/31/2018 11:55:51 AM

[redacted] Page 1 of 2

LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.
EXTREMITIES: NO C/C/E. Normal Pulses.

A/P

DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION TYPE II OR UNSPECIFIED TYPE UNCONTROLLED (250.02): Obtain labs
POLYNEUROPATHY IN DIABETES (357.2): She is on Cymbalta, Neurontin and requires refills on her Norco. Risks and benefits discussed regarding these medications.

PRESCRIBE: Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN, # 60, RF: 0.
PRESCRIBE: Lantus Solostar Pen 100 units/mL subcutaneous solution, 30 units sq q day, # 3 months , RF: 1.
PRESCRIBE: Lantus Solostar Pen needles, q day, # 3 months , RF: 1.

Coded: Medium Complexity > 99213

Electronically Signed By: NAOMI CHANEY, MD
7/23/14 5:39 PM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

PAT ID	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008	F	TITINA FARRIS	Quest
DOB			
[redacted]			

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	NAOMI CHANEY, MD

LAB ID #	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
372	Specimen ID: 48589699 Type: Source: Condition:	08/21/2014 08:06:44	08/19/2014 10:44:00
		COLLECTION DATE/TIME	FASTING
		08/18/2014 15:07:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLG	STATUS	REPORTED BY
HEMOGLOBIN A1C					F	
-HEMOGLOBIN A1c	[redacted]	0.0-5.6	%T.Hgb	H	F	Quest

NOTES on 'HEMOGLOBIN A1c':
According to ADA guidelines, hemoglobin A1c <7.0% represents optimal control in non-pregnant diabetic patients. Different metrics may apply to specific patient populations. Standards of Medical Care in Diabetes-2013.
Diabetes Care. 2013;36:s11-s66

<5.7	Consistent with absence of diabetes
5.7-6.4	Consistent with increased risk of diabetes (prediabetes)
>or= 6.5	Consistent with diabetes

This assay result is consistent with diabetes mellitus.
Currently, no consensus exists for use of hemoglobin A1C for diagnosis of diabetes for children.

****
PATIENT COMMENTS:
Ordering Physician: CHANEY, NAOMI L

COMPREHENSIVE METABOLIC PANEL					F	
-Glucose, Fasting	[redacted]	65-99	mg/dL	H	F	Quest
-BUN	9	7-25	mg/dL	N	F	Quest
-Creatinine	0.68	0.50-1.05	mg/dL	N	F	Quest
-BUN/Creatinine Ratio	13.2	6.0-22.0	–	N	F	Quest
-Calcium	9.5	8.6-10.4	mg/dL	N	F	Quest
-Protein, Total	7.5	6.1-8.1	g/dL	N	F	Quest

[redacted] Abnormals

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

ID / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008 F	TITINA FARRIS	Quest
DOB		
[redacted]		
AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	NAOMI CHANEY, MD
LAB ID	SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
372	Specimen ID: 48589699 Type: Source: Condition:	08/21/2014 08:06:44 / 08/19/2014 10:44:00
		COLLECTION DATE/TIME / FASTING
		08/18/2014 15:07:00 / NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLG	Stat	Performed By
-Albumin	3.8	3.6-5.1	g/dL	N	F	Quest
-Globulin	3.7	1.9-3.7	g/dL	N	F	Quest
-A/G Ratio	1.0	1.0-2.5	–	N	F	Quest
-BILIRUBIN, TOTAL	0.2	0.2-1.2	mg/dL	N	F	Quest
-Alkaline Phosphatase	119	33-130	IU/L	N	F	Quest
-AST (SGOT)	13	10-35	IU/L	N	F	Quest
-ALT (SGPT)	13	6-29	IU/L	N	F	Quest
-Sodium	[redacted]	135-146	meq/L	L	F	Quest
-Potassium	4.2	3.5-5.3	meq/L	N	F	Quest
-Chloride	[redacted]	98-110	meq/L	L	F	Quest
-CO2	23	19-30	meq/L	N	F	Quest
-eGFR African American	117	>59	–	N	F	Quest
-eGFR Non-AFR. American	101	>59	–	N	F	Quest

NOTES on 'eGFR Non-AFR. American':
REPORT CALLED ON 08/19/14 AT 10:44AM BY CS/KAS910 TO: IRENEL A/FRONT DESK
The upper reference limit for Creatinine is approximately
13% higher for people identified as African-American.
Glucose reference range reflects a fasting state.
For non-fasting patients glucose reference range
is 65 - 139 mg/dL.

LIPID PANEL F

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

PATIENT DEMOGRAPHICS		RESULTS PROVIDED BY
10008 F	TITINA FARRIS	Quest
DOB		
[redacted]		
AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	NAOMI CHANEY, MD
LAB ID	SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
372	Specimen ID: 48589699 Type: Source: Condition:	08/21/2014 08:06:44 / 08/19/2014 10:44:00
		COLLECTION DATE / TIME / FASTING
		08/18/2014 15:07:00 / NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	ABN	STATUS	PERFORMED BY
-CHOLESTEROL	[redacted]	125-200	mg/dL	H	F	Quest
-TRIGLYCERIDES	[redacted]	0-150	mg/dL	H	F	Quest
-HDL CHOLESTEROL	[redacted]	46-199	mg/dL	L	F	Quest
-CHOL/HDLC RATIO	[redacted]	0.0-5.00	–	H	F	Quest
-LDL (Calculated)	[redacted]	0-130	mg/dL	A	F	Quest
-Non-HDL Cholesterol	191	–	mg/dL	N	F	Quest

NOTES on 'Non-HDL Cholesterol':
NOTE: A LDL RESULT OF ** INDICATES THAT TRIGLYCERIDES GREATER THAN 400 MG/DL RENDER LDL CALCULATIONS INVALID. A DIRECTLY MEASURED LDL MAY BE ORDERED SEPARATELY.
1. Initial classification by total blood cholesterol:
<200 mg/dL Desirable cholesterol level
200-239 mg/dL Borderline high cholesterol level
>239 mg/dL High cholesterol level

2. HDL cholesterol values less than 40 mg/dL are associated with increased risk of coronary heart disease (CHD).

3. Cholesterol/HDL ratio of greater than 4.5 is associated with increased risk of coronary heart disease.
4. Triglyceride elevation is an independent risk factor for coronary heart disease as well as a marker for several factors that may themselves raise coronary heart disease risk.
Target for non-HDL cholesterol is
30 mg/dL higher than LDL- Cholesterol target.

MICROALBUMIN,RANDOM URINE WITH CREATININE F

-MICROALB/CREAT RATIO	Pending	–	mg/g Cr	N	P	Quest

[redacted] AmazonCharts

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

ID# SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008 F	TITINA FARRIS	Quest
DOB		
[redacted]		
AGE	ACCESSION#	ORDERING PROVIDER
55	[redacted]	NAOMI CHANEY, MD
LAB ID	SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
372	Specimen ID: 48589699 Type: Source: Condition:	08/21/2014 08:06:44 / 08/19/2014 10:44:00
		COLLECTION DATE / TIME / FASTING
		08/18/2014 15:07:00 / NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	ABN	STATUS	PERFORMED BY
NOTES on 'MICROALB/CREAT RATIO': The ADA (Diabetes Care 26: S94-S98,2003) defines abnormalities in albumin excretion as follows: . Category / Result (mg/G creatinine) Normal / <30 Microalbuminuria / 30-299 Clinical albuminuria / >or= 300 . The ADA recommends that at least two of three specimens collected within a 3-6 month period be abnormal before considering a patient to be within a diagnostic category.						
**********						
PATIENT COMMENTS: Ordering Physician: CHANEY, NAOMI L						
-MICROALB/CREAT RATIO	Pending	-	mg/g Cr	N	P	Quest
NOTES on 'MICROALB/CREAT RATIO': The ADA (Diabetes Care 26: S94-S98,2003) defines abnormalities in albumin excretion as follows: . Category / Result (mg/G creatinine) Normal / <30 Microalbuminuria / 30-299 Clinical albuminuria / >or= 300 . The ADA recommends that at least two of three specimens collected within a 3-6 month period be abnormal before considering a patient to be within a diagnostic category.						
**********						
PATIENT COMMENTS: Ordering Physician: CHANEY, NAOMI L						
-MICROALBUMIN	<0.2	-	mg/dL	N	F	Quest
-Creat Random Ur (mg/dL)	37.5	20.0-320.0	mg/dL	N	F	Quest
NOTES on 'Creat Random Ur (mg/dL)': RESULT CONFIRMED BY REPEAT ANALYSIS						

NOTES Awaiting Charts

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

ID# / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY	
10008 F	TITINA FARRIS	Quest	
DOB			
[redacted]			
AGE	ACCESSION #	ORDERING PROVIDER	
55	[redacted]	NAOMI CHANEY, MD	
LAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
372	Specimen ID: 48589699 Type: Source: Condition:	08/21/2014 08:06:44	08/19/2014 10:44:00
		COLLECTION DATE / TIME	FASTING
		08/18/2014 15:07:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By

```
THE RATIO/EXCRETION WILL NOT CALCULATE BECAUSE THE URINE
RESULTS ARE BEYOND (ABOVE OR BELOW) THE REPORTABLE RANGE
OF THE INSTRUMENT.
The ADA (Diabetes Care 26: S94-S98,2003) defines
abnormalities in albumin excretion as follows:
.
Category                Result (mg/G creatinine)
Normal                  <30
Microalbuminuria        30-299
Clinical albuminuria    >or= 300
.
The ADA recommends that at least two of three specimens
collected within a 3-6 month period be abnormal before
considering a patient to be within a diagnostic category.
```

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
CLINICAL PDF REPORT 49684482-1					F	
-Clinical PDF Report 49684482-1	See Lab Report	–	–		F	Quest

**Signed Off by N. CHANEY, MD on 8/22/2014 3:24:17 PM.
**Comments: [Added by N. CHANEY, MD]

PLTF9150

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TINA (DOB: 10/23/1962) (ID: 10008) Aug 20, 2014 Wed 06:04 PM

CC	pain medication
HPI	Patient is here in interval follow-up. She has known type 2 diabetes insulin requiring with a long-standing history of noncompliance. She has peripheral neuropathy with a history of back pain. MRI of the lumbar spine was unrevealing for any pathology. She has tried to treat her pain syndrome with ibuprofen without improvement. The patient also requires Norco.
ROS	Patient denies any chest pain, shortness of breath, or dyspnea on exertion. No palpitations, presyncope, or syncope. No leg swelling or pain that is new for them. Patient denies any change in bowel or bladder function. No melena, hematochezia, or dysuria, frequency, or urgency. Patient denies dyspepsia or abdominal pain. Patient denies cough, coryza type symptoms, wheeze or shortness of breath
PMH	Diabetes. Hypertenion Neuropathy.
SH	Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption. [Tobacco: Never smoker] married daughter 8 - patrick husband She has several dogs - she toy collie and a Yorkshire interior toy collie little yorki and chiweenie.
FH	Mother: pacer dx diabetes? Father: good Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.
Allergies	asprin (Updated by Naomi on 01/17/2014 03:37 PM)
Meds	1) Cymbalta 60 mg oral delayed release capsule, 1 po qd 2) gabapentin 300 mg oral capsule, 2 po bid 3) glucometer on plan 4) lancets and strips on plan, check tid prior meals 5) Lantus Solostar Pen 100 units/mL subcutaneous solution, 30 units sq q day 6) Lantus Solostar Pen needles, q day 7) loratab 5/325, one po bid 8) metFORMIN 1000 mg oral tablet, 1 PO BID 9) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) 10) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN 11) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d) 12) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d) 13) triamcinolone 0.025% topical ointment, APPLY TO LESION 14) valsartan 160/hctz 12.5, one po q day

Printed By: NAOMI CHANEY, MD 3/31/2018 11:56:01 AM

Amazing Charts Page 1 of 2

[redacted]

Vitals	Wt: 164 lb Ht/Ln: 62 in BMI: 30.1 BP: 120/78 Pulse: 70 RR: 12
PE	GENERAL: WNWD NAD HEENT: WNL LUNGS: CTA HEART: RRR S1 S2 without murmers, thrills, rubs CHEST WALL: WNL ABDOMEN: WNL. Normal BS. EXTREMITIES: NO C/C/E. Normal Pulses.
A/P	# DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION TYPE II OR UNSPECIFIED TYPE UNCONTROLLED (250.02): Discussed with patient that she will be given a glucometer to help control her blood glucose a little better. # POLYNEUROPATHY IN DIABETES (357.2): # BACKACHE UNSPECIFIED (724.5): PRESCRIBE: Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN, # 60, RF: 0.

Coded: Medium Complexity > 99213

Electronically Signed By: NAOMI CHANEY, MD
8/23/14 10:46 AM

Printed By: NAOMI CHANEY, MD 3/31/2018 11:56:01 AM

[redacted]

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TINA (DOB: [redacted]) Sep 16 2014 Tue 05:08 PM

CC refill

HPI 51-year-old penal here in interval follow-up. She is a client with all recommendations in terms of mammogram, Pap and blood work. Historically she has been considered a poorly controlled diabetic and continues to engage in dietary indiscretion. However, there has been improvement.
She has a long-standing history of neuropathy and back pain with requirement of narcotics. She understands the need to utilize this medication judiciously. MRI of the lumbar spine was noncontributory in terms of pathology.
Since I seen her last she had surgery for her hernia and abdominal wall mass which is improving.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.

SH Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie.

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Cymbalta 60 mg oral delayed release capsule, 1 po qd
2) gabepentin 300 mg oral capsule, 2 po bid
3) glucometer on plan
4) lancets and strips on plan, check tid prior meals
5) Lantus Solostar Pen 100 units/mL subcutaneous solution, 30 units sq q day
6) Lantus Solostar Pen needles, q day
7) loratab 5/325, one po bid
8) metFORMIN 1000 mg oral tablet, 1 PO BID
9) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d)
10) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN
11) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
12) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
13) triamcinolone 0.025% topical ointment, APPLY TO LESION
14) valsartan 160/hctz 12.5, one po q day

Printed By: NAOMI CHANEY, MD 3/31/2018 11:56:09 AM

Page 1 of 2

[redacted] SEP 16 2014 TUE 06:08 PM

Vitals Wt: 167 lb Ht/Ln: 62 in BMI: 30.6 BP: 122/70 Pulse: 78 RR: 12

PE
GENERAL: WNWD NAD
HEENT: WNL
LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.
EXTREMITIES: NO C/C/E. Normal Pulses.

A/P
BACKACHE UNSPECIFIED (724.5):
DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION TYPE II OR UNSPECIFIED TYPE UNCONTROLLED (250.02): Glucometer.
POLYNEUROPATHY IN OTHER DISEASES CLASSIFIED ELSEWHERE (357.4):

PRESCRIBE: Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN, # 60, RF: 0.

Coded: Medium Complexity > 99213

Electronically Signed By: NAOMI CHANEY, MD
9/21/14 4:31 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 11:56:09 AM

[redacted]

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TINA (DOB: [redacted]) [redacted] 10/09/2014 11:02:27 PM

CC REFILLS

PMH
Diabetes.
Hypertenion
Neuropathy.

SH
Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie.

FH
Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies
asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Bydureon 2 mg subcutaneous injection, extended release, one im q week
2) Cymbalta 60 mg oral delayed release capsule, 1 po qd
3) gabapentin 300 mg oral capsule, 2 po bid
4) glucometer on plan
5) lancets and strips on plan, check tid prior meals
6) Lantus Solostar Pen 100 units/mL subcutaneous solution, 30 units sq q day
7) Lantus Solostar Pen needles, q day
8) loratab 5/325, one po bid
9) metFORMIN 1000 mg oral tablet, 1 PO BID
10) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d)
11) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN
12) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
13) Percocet 7.5/325 oral tablet, ONE PO BID PRN
14) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
15) triamcinolone 0.025% topical ointment, APPLY TO LESION
16) valsartan 160/hctz 12.5, one po q day

PE

A/P
Patient came in for instuction on the new glucometer and has opted to try the atkins diet in lieu of changing medication.
POLYNEUROPATHY IN OTHER DISEASES CLASSIFIED ELSEWHERE (357.4):
BACKACHE UNSPECIFIED (724.5):
DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION TYPE II OR UNSPECIFIED TYPE UNCONTROLLED (250.02):

Instructions printed and provided to patient:
Printed By: NAOMI CHANEY, MD 3/31/2018 11:56:22 AM

[redacted]

[redacted] 10/09/2014 1:02:27 PM

atkins diet-

PROVIDED: Patient Education (10/17/2014)

Coded: 99213

Electronically Signed By: NAOMI CHANEY, MD
10/9/14 2:42 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 11:56:22 AM

[redacted]

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

[redacted]

PMH
Diabetes.
Hypertenion
Neuropathy.

SH
Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie.

FH
Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies
asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Cymbalta 60 mg oral delayed release capsule, 1 po qd
2) gabapentin 300 mg oral capsule, 2 po bid
3) glucometer on plan
4) lancets and strips on plan, check tid prior meals
5) Lantus Solostar Pen 100 units/mL subcutaneous solution, 30 units sq q day
6) Lantus Solostar Pen needles, q day
7) loratab 5/325, one po bid
8) metFORMIN 1000 mg oral tablet, 1 PO BID
9) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d)
10) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN
11) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
12) Percocet 7.5/325 oral tablet, ONE PO BID PRN
13) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
14) triamcinolone 0.025% topical ointment, APPLY TO LESION
15) valsartan 160/hctz 12.5, one po q day

PE

A/P
Patient came in for instuction on the new glucometer and has opted to try the atkins diet in lieu of changing medication.

Instructions printed and provided to patient:

atkins diet-

PROVIDED: Patient Education (10/17/2014)

Printed By: NAOMI CHANEY, MD 3/31/2018 11:57:02 AM

[redacted]

[redacted]

Coded: Medium Complexity

Electronically Signed By: NAOMI CHANEY, MD
10/18/14 6:27 AM

Printed By: NAOMI CHANEY, MD 3/31/2018 11:57:02 AM

[redacted]

PLTF9176

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

HARRIS, TIFFANY (DOB: [redacted]) - FRI NOV 03 2017 10:05:51 PM

CC sick 5:30.

HPI Patient notes cough and cold symptoms including runny nose, dry cough, low-grade fever, and some discolored rhinorrhea. Notes feeling run down and has some sinus congestion. No frank shortness of breath or rigors.
Patient reports that she is monitoring her blood pressure as well as her diabetes.
She continues to have chronic pain and neuropathy requires refills on her medication

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.

SH Patient denies any tobacco use or recreational drug use. Occasional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, AS DIRECTED
2) Bydureon Pen 2 mg subcutaneous injection, extended release, one im q week
3) Cymbalta 60 mg oral delayed release capsule, 1 po q d
4) gabapentin 300 mg oral capsule, 2 po bid
5) glucometer on plan
6) lancets and strips and plan, check tid prior to meals
7) Lantus Solostar Pen 100 units/mL subcutaneous solution, 30 units sq q day
8) Lantus Solostar Pen needles, q day
9) loratab 5/325 , one po bid
10) metFORMIN 1000 mg oral tablet, 1 PO BID
11) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d)
12) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN
13) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
14) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X Month (30d)
15) Tamiflu 75 mg oral capsule, one po bid
16) triamcinolone 0.025% topical ointment, APPLY TO LESION
17) valsartan 160/hctz 12.5, one po q day

Vitals Wt: 169 lb Ht/Ln: 62 In BMI: 30.9 BP: 122/78 Pulse: 78 RR: 12 Sat: 98
Printed By: NAOMI CHANEY, MD 3/31/2018 11:57:09 AM

Ambulatory Charge [redacted]

[redacted] (0008) [redacted] Nov 06 2014 11:05:58 PM

PE
GENERAL: WNWD NAD
HEENT: WNL
LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.
EXTREMITIES: NO C/C/E. Normal Pulses.

A/P
CHRONIC PAIN SYNDROME (338.4):
DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION TYPE II OR UNSPECIFIED TYPE UNCONTROLLED (250.02):
UNSPECIFIED ESSENTIAL HYPERTENSION (401.9):
UPPER RESPIRATORY INFECTION (465.9):

Plan printed and provided to patient:
PRESCRIBE: Percocet 7.5/325 mg oral tablet, ONE PO BID PRN, # 60, RF: 0.
PRESCRIBE: Azithromycin 5 Day Dose Pack 250 mg oral tablet, AS DIRECTED, # 6, RF: 0.
PRESCRIBE: Tamiflu 75 mg oral capsule, one po bid, # 10, RF: 0.

Electronically Signed By: NAOMI CHANEY, MD
11/3/14 6:17 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 11:57:09 AM

[redacted]

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TUNA ([redacted] D: 10008) Dec 09, 2014 Tue 06:48 PM

CC	REFILLS
HPI	since I seen the patient last the patient reports that her upper respiratory infection has improved. She stopped her sugars as requested. However, she reports full compliance with all medications.
ROS	10 system reviewed and performed by patient on the Phressia tablet.
PMH	Diabetes. Hypertenion Neuropathy.
SH	Patient denies any tobacco use or recreational drug use. Occasional alcohol consumption. [Tobacco: Never smoker] married daughter 8 - patrick husband She has several dogs - she toy collie and a Yorkshire interior toy collie little yorki and chiweenie
FH	Mother: pacer dx diabetes? Father: good. Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.
Allergies	asprin (Updated by Naomi on 01/17/2014 03:37 PM)
Meds	1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, AS DIRECTED 2) Bydureon Pen 2 mg subcutaneous injection, extended release, one im q week 3) Cymbalta 60 mg oral delayed release capsule, 1 po q d 4) gabapentin 300 mg oral capsule, 2 po bid 5) glucometer on plan 6) lancets and strips and plan, check tid prior to meals 7) Lantus Solostar Pen 100 units/mL subcutaneous solution, 30 units sq q day 8) Lantus Solostar Pen needles, q day 9) loratab 5/325 , one po bid 10) metFORMIN 1000 mg oral tablet, 1 PO BID 11) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) 12) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN 13) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d) 14) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X Month (30d) 15) Tamiflu 75 mg oral capsule, one po bid 16) triamcinolone 0.025% topical ointment, APPLY TO LESION 17) valsartan 160/hctz 12.5, one po q day
Vitals	Wt: 164 lb Ht/Ln: 63 in BMI: 29.1 BP: 142/78 Pulse: 97 RR: 12 Sat: 98
PE	GENERAL: WNWD NAD

Printed By: NAOMI CHANEY, MD 3/31/2018 11:57:20 AM

HEENT: WNL
LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.
EXTREMITIES: NO C/C/E. Normal Pulses.

A/P

Hypertension (401.9):
Type II diabetes mellitus uncontrolled (250.02):
Chronic back pain (724.5):
Chronic pain syndrome (338.4):

Electronically Signed By: NAOMI CHANEY, MD
12/9/14 6:02 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 11:57:20 AM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS TUINA (DOB [redacted]) Jul 07, 2015 06:05:52 PM

CC fu 5:15 rj

HPI The patient is here in interval follow-up. She requires refills on her medication. The patient is not monitoring her blood glucose on a regular basis. I've asked the patient to please document her blood glucose and she can text me her numbers.
She reports full compliance with all medications.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.

SH Patient denies any tobacco use or recreational drug use. Occasional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Azithromycin 6 Day Dose Pack 250 mg oral tablet, AS DIRECTED
2) Bydureon Pen 2 mg subcutaneous injection, extended release, one im q week
3) Cymbalta 60 mg oral delayed release capsule, 1 po q d
4) gabapentin 300 mg oral capsule, 2 po bid
5) glucometer on plan
6) lancets and strips and plan, check tid prior to meals
7) Lantus Solostar Pen 100 units/mL subcutaneous solution, 30 units sq q day
8) Lantus Solostar Pen needles, q day
9) loratab 5/325 , one po bid
10) metFORMIN 1000 mg oral tablet, 1 PO BID
11) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d)
12) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN
13) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
14) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X Month (30d)
15) Tamiflu 75 mg oral capsule, one po bid
16) triamcinolone 0.025% topical ointment, APPLY TO LESION
17) valsartan 160/hctz 12.5, one po q day

Vitals Wt: 163.5 lb Ht/Ln: 63 in BMI: 29.0 BP: 142/80 Pulse: 98 RR: 12 Sat: 98

Printed By: NAOMI CHANEY, MD 3/31/2018 11:57:27 AM

Page 1 of 2

[redacted] Jan 05 2015 06:54 PM

PE
GENERAL: WNWD NAD
HEENT: WNL
LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.
EXTREMITIES: NO C/C/E. Normal Pulses.

A/P
Follow-up in outpatient clinic (V67.9):
Type II diabetes mellitus uncontrolled (250.02):
Chronic back pain (724.5):
Hypertensive disorder (401.9):
Chronic pain syndrome (338.4):

Electronically Signed By: NAOMI CHANEY, MD
1/5/15 6:17 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 11:57:27 AM

[redacted]

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

HARRIS, TINA (DOB: [redacted]) Feb 06, 2015 11:30:12 AM

CC REFILLS

HPI tha patient is here on interval follow-up. She requires refills On her pain medication. She has History of type II diabetes insulin required not well-controlled. Historically she is reluctant to see physicians and develop diabetic neuropathy as a consequence. she had a long-standing history of low back pain with the normal MRI. She has neuropathy which has been improved on Cymbalta. She has some tachycardia today without complaining of chest pain or chest pressure. She has been seen by a cardiologist during a hospital evaluation for chest pain; She underwent stress testing which was normal.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.

SH Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie.

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies aspirin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, as directed
2) Bydureon 2 mg subcutaneous injection, extended release, one im q week
3) Cymbalta 60 mg oral delayed release capsule, 1 po qd
4) gabapentin 300 mg oral capsule, 2 po bid
5) glucometer on plan
6) lancets and strips on plan, check tid prior meals
7) Lantus Solostar Pen 100 units/mL subcutaneous solution, 30 units sq q day
8) Lantus Solostar Pen needles, q day
9) loratab 5/325, one po bid
10) metFORMIN 1000 mg oral tablet, 1 PO BID
11) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d)
12) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN
13) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
14) Percocet 7.5/325 oral tablet, ONE PO BID PRN
15) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
16) Tamiflu 75 mg oral capsule, one po bid
17) triamcinolone 0.025% topical ointment, APPLY TO LESION

Printed By: NAOMI CHANEY, MD 3/31/2018 11:57:35 AM

PLTF9210

18) valsartan 160/hctz 12.5, one po q day

Vitals Wt: 163.2 lb Ht/Ln: 63 in BMI: 28.9 BP: 140/75 Pulse: 118 RR: 12 Sat: 98

PE
GENERAL: WNWD NAD
HEENT: WNL
LUNGS: CTA
HEART: Sinus Tachycardia. S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.
EXTREMITIES: NO C/C/E. Normal Pulses.

A/P
Tachycardia (785.0):
High blood pressure (401.9):
Back pain (724.5):
Type II diabetes mellitus uncontrolled (250.02):

Instructions printed and provided to patient:
PRESCRIBE: Percocet 7.5/325 oral tablet, ONE PO BID PRN, # 60, RF: 0.
PRESCRIBE: lisinopril 2.5 mg oral tablet, one po bid, # 180, RF: 1.
PRESCRIBE: carvedilol 3.125 mg oral tablet, 1 po bid, # 180, RF: 1.
Dr leavitt for back pain
PROVIDED: Patient Education (2/6/2015)

Coded: Medium Complexity > 99214 25, 93000

Electronically Signed By: NAOMI CHANEY, MD
2/8/15 1:42 PM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

ID#	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008	F	TITINA FARRIS	Quest
DOB			
[redacted]			
AGE		ACCESSION #	ORDERING PROVIDER
55		[redacted]	NAOMI CHANEY, MD
FASID		SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
4672		Specimen ID: 48715928	02/12/2015 13:30:18	02/10/2015 00:39:00
		Type:	COLLECTION DATE / TIME	FASTING
		Source:	02/06/2015 10:22:00	NOT SPECIFIED
		Condition:		

NAME	VALUE	NORMAL	UNITS	FLG	STAT	PERFORMED BY
COMPREHENSIVE METABOLIC PANEL					F	
-Glucose, Fasting	[redacted]	65-99	mg/dL	H	F	Quest
-BUN	10	7-25	mg/dL	N	F	Quest
-Creatinine	0.74	0.50-1.05	mg/dL	N	F	Quest
-BUN/Creatinine Ratio	13.5	6.0-22.0	–	N	F	Quest
-Calcium	[redacted]	8.6-10.4	mg/dL	H	F	Quest
-Protein, Total	7.7	6.1-8.1	g/dL	N	F	Quest
-Albumin	4.1	3.6-5.1	g/dL	N	F	Quest
-Globulin	3.6	1.9-3.7	g/dL	N	F	Quest
-A/G Ratio	1.1	1.0-2.5	–	N	F	Quest
-BILIRUBIN, TOTAL	0.3	0.2-1.2	mg/dL	N	F	Quest
-Alkaline Phosphatase	107	33-130	IU/L	N	F	Quest
-AST (SGOT)	14	10-35	IU/L	N	F	Quest
-ALT (SGPT)	17	6-29	IU/L	N	F	Quest
-Sodium	[redacted]	135-146	mEq/L	L	F	Quest
-Potassium	4.6	3.5-5.3	mEq/L	N	F	Quest

[redacted] Additional Tests

PLTF9213

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

ID# / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008 F	TITINA FARRIS	Quest
DOB		
[redacted]		
AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	NAOMI CHANEY, MD
PAT ID	SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
4672	Specimen ID: 48715928 Type: Source: Condition:	02/12/2015 13:30:18 / 02/10/2015 00:39:00
		COLLECTION DATE/TIME / FASTING
		02/06/2015 10:22:00 / NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLAG	SCIDS	PERFORMED BY
-Chloride	[redacted]	98-110	mEq/L	L	F	Quest
-CO2	23	19-30	mEq/L	N	F	Quest
-eGFR African American	108	>59	--	N	F	Quest
-eGFR Non-AFR. American	93	>59	--	N	F	Quest

NOTES on 'eGFR Non-AFR. American':
The upper reference limit for Creatinine is approximately
13% higher for people identified as African-American.
Glucose reference range reflects a fasting state.
For non-fasting patients glucose reference range
is 65 - 139 mg/dL.

LIPID PANEL F

-CHOLESTEROL	[redacted]	125-200	mg/dL	H	F	Quest
-TRIGLYCERIDES	[redacted]	0-150	mg/dL	HH	F	Quest
-HDL CHOLESTEROL	[redacted]	46-199	mg/dL	L	F	Quest
-CHOL/HDLC RATIO	[redacted]	0.0-5.00	--	H	F	Quest
-LDL (Calculated)	[redacted]	0-130	mg/dL	A	F	Quest
-Non-HDL Cholesterol	341	--	mg/dL	N	F	Quest

NOTES on 'Non-HDL Cholesterol':
ABNORMAL RESULT(S) CONFIRMED BY REPEAT ANALYSIS.
NOTE: A LDL RESULT OF ** INDICATES THAT TRIGLYCERIDES
GREATER THAN 400 MG/DL RENDER LDL CALCULATIONS INVALID. A
DIRECTLY MEASURED LDL MAY BE ORDERED SEPARATELY.

LDL-C levels > or = 190 mg/dL may indicate familial
hypercholesterolemia (FH). Clinical assessment and
measurement of blood lipid levels should be considered

[redacted] AmeriHealth

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

ID	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008	F	TITINA FARRIS	Quest

DOB
[redacted]

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	NAOMI CHANEY, MD

PAT ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
4672	Specimen ID: 48715928 Type: Source: Condition:	02/12/2015 13:30:18	02/10/2015 00:39:00

COLLECTION DATE/TIME	FASTING
02/06/2015 10:22:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLAG	Status	PERFORMED BY

for all first degree relatives of patients with an FH diagnosis.
J of Clinical Lipidology 5:s1-S8 2011.
1. Initial classification by total blood cholesterol:
<200 mg/dL Desirable cholesterol level
200-239 mg/dL Borderline high cholesterol level
>239 mg/dL High cholesterol level

2. HDL cholesterol values less than 40 mg/dL are associated with increased risk of coronary heart disease (CHD).

3. Cholesterol/HDL ratio of greater than 4.5 is associated with increased risk of coronary heart disease.
4. Triglyceride elevation is an independent risk factor for coronary heart disease as well as a marker for several factors that may themselves raise coronary heart disease risk.
Target for non-HDL cholesterol is
30 mg/dL higher than LDL- Cholesterol target.

CBC (H/H, RBC, INDICES, WBC, PLT) F

-WHITE BLOOD CELL COUNT	[redacted]	3.8-10.8	k/uL	H	F	Quest
-RBC	4.06	3.80-5.10	Million/uL	N	F	Quest
-HEMOGLOBIN	11.8	11.7-15.5	g/dL	N	F	Quest
-HEMATOCRIT	36.3	35.0-45.0	%	N	F	Quest
-MCV	89.5	80.0-100.0	fL	N	F	Quest
-MCH	29.1	27.0-33.0	pg	N	F	Quest
-MCHC	32.6	32.0-36.0	g/dL	N	F	Quest

PLTF9215

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

PAT ID	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008	F	TITINA FARRIS	Quest

DOB: [redacted]

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	NAOMI CHANEY, MD

LAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
4672	Specimen ID: 48715928 Type: Source: Condition:	02/12/2015 13:30:18	02/10/2015 00:39:00

COLLECTION DATE/TIME	FASTING
02/06/2015 10:22:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLAG	STATUS	PERFORMED BY
-RED CELL DISTRIBUTION	14.7	11.0-15.0	%	N	F	Quest
-PLATELET COUNT	[redacted]	140-400	k/uL	H	F	Quest
-MEAN PLATELET VOLUME	9.3	7.5-11.5	fL	N	F	Quest
URINALYSIS, COMPLETE WITH REFLEX TO CULTURE					F	
-COLOR	YELLOW	YELLOW	--	N	F	Quest
-APPEARANCE	CLEAR	CLEAR	--	N	F	Quest
-SPECIFIC GRAVITY	1.027	1.001-1.035	--	N	F	Quest
-PH	5.5	5.0-8.0	--	N	F	Quest
-PROTEIN	NEGATIVE	NEGATIVE	--	N	F	Quest
-GLUCOSE	[redacted]	NEGATIVE	--	A	F	Quest
-KETONES	NEGATIVE	NEGATIVE	--	N	F	Quest
-OCCULT BLOOD	NEGATIVE	NEGATIVE	--	N	F	Quest
-LEUKOCYTE ESTERASE	NEGATIVE	NEGATIVE	--	N	F	Quest
-BILIRUBIN	NEGATIVE	NEGATIVE	--	N	F	Quest
-NITRITE	NEGATIVE	NEGATIVE	--	N	F	Quest
-WBC	0-5	0-5	/HPF	N	F	Quest
-RBC	0-3	--	/HPF	N	F	Quest

PLTF9216

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

ID	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008	F	TITINA FARRIS	Quest

DOB
[redacted]

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	NAOMI CHANEY, MD

PAT ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
4672	Specimen ID: 48715928 Type: Source: Condition:	02/12/2015 13:30:18	02/10/2015 00:39:00

COLLECTION DATE/TIME	FASTING
02/06/2015 10:22:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLG	STAT	PERFORMED BY
-SQUAMOUS EPITHELIAL CELL	0-5	0-5	/HPF	N	F	Quest
-BACTERIA	NONE SEEN	NONE	/HPF	N	F	Quest

NOTES on 'BACTERIA':
When a urine microscopic exam is performed it is analyzed for the presence of WBC, RBC, bacteria, casts, and other formed elements. Only those elements seen are reported.

MICROALBUMIN,RANDOM URINE WITH CREATININE F

-MICROALBUMIN	0.4	–	mg/dL	N	F	Quest
-Creat Random Ur (mg/dL)	32.5	20.0-320.0	mg/dL	N	F	Quest
-MICROALB/CREAT RATIO	12.3	0.0-30.0	mg/g cr	N	F	Quest

NOTES on 'MICROALB/CREAT RATIO':
The ADA (Diabetes Care 26: S94-S98,2003) defines abnormalities in albumin excretion as follows:

Category	Result (mg/G creatinine)
Normal	<30
Microalbuminuria	30-299
Clinical albuminuria	>or= 300

The ADA recommends that at least two of three specimens collected within a 3-6 month period be abnormal before considering a patient to be within a diagnostic category.

HEMOGLOBIN A1C F

-HEMOGLOBIN A1c	[redacted]	0.0-5.6	%T.Hgb	H	F	Quest

NOTES on 'HEMOGLOBIN A1c':
According to ADA guidelines, hemoglobin A1c <7.0% represents optimal control in non-pregnant diabetic patients. Different

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

ID# / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008 F	TITINA FARRIS	Quest
DOB		
[redacted]		
AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	NAOMI CHANEY, MD
LAB ID	SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
4672	Specimen ID: 48715928 Type: Source: Condition:	02/12/2015 13:30:18 / 02/10/2015 00:39:00
		COLLECTION DATE/TIME / FASTING
		02/06/2015 10:22:00 / NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FED	STATUS	REFERENCE LAB

metrics may apply to specific patient populations. Standards of Medical Care in Diabetes-2013. Diabetes Care. 2013;36:s11-s66

<5.7 Consistent with absence of diabetes
5.7-6.4 Consistent with increased risk of diabetes (prediabetes)
>or= 6.5 Consistent with diabetes
This assay result is consistent with diabetes mellitus. Currently, no consensus exists for use of hemoglobin A1C for diagnosis of diabetes for children.

TSH F

-TSH	1.10	0.40-4.50	mIU/L	N	F	Quest

NOTES on 'TSH':
PREGNANCY REFERENCE RANGES:
First Trimester: 0.26-2.66 mIU/L
Second Trimester: 0.55-2.73 mIU/L
Third Trimester: 0.43-2.91 mIU/L
(TSH11P:050712)(AC92:N)

DELETED F

-Vitamin D,25-OH,Total	[redacted]	–	–	A	F	Quest

NOTES on 'Vitamin D,25-OH,Total':

TEST	RESULT		UNITS	REF RANGE
Vitamin D, 25-OH, Total	9	*	ng/mL	30-100

25-OHD3 indicates both endogenous production and supplementation. 25-OHD2 is an indicator of exogenous sources, such as diet or supplementation. Therapy is based on measurement of Total 25-OHD, with levels <20 ng/mL indicative of Vitamin D deficiency, while levels between 20 ng/mL and 30 ng/mL suggest insufficiency. Optimal levels are > or = 30 ng/mL.

Vitamin D, 25-OH, D3	9	ng/mL	Not established
Vitamin D, 25-OH, D2	< 4	ng/mL	Not established

(* = out of range)

COMMENT F

[redacted] Attending Chart

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

PAT ID	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008	F	TITINA FARRIS	Quest
DOB		[redacted]	
AGE		ACCESSION #	ORDERING PROVIDER
55		[redacted]	NAOMI CHANEY, MD
LAB ID		SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
4672		Specimen ID: 48715928 Type: Source: Condition:	02/12/2015 13:30:18 / 02/10/2015 00:39:00
			COLLECTION DATE / TIME / FASTING
			02/06/2015 10:22:00 / NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLAG	STATUS	PERFORMED BY
-COMMENT	SEE NOTE	–	–	N	F	Quest

NOTES on 'COMMENT':
One or more test(s) on this accession were ordered without a specific test code. In order to avoid testing delays, we have ordered our most basic test(s)/profile. The test results indicate test(s)/profile that we performed. If you desired either more or less testing, please immediately contact Client Services at 733-3700.

****
PATIENT COMMENTS:
Ordering Physician: CHANEY, NAOMI L

CLINICAL PDF REPORT 49684482-1 F

-Clinical PDF Report 49684482-1	See PDF Report	–	–		F	Quest

**Signed Off by N. CHANEY, MD on 2/15/2015 2:38:00 PM.
**Comments: [Added by N. CHANEY, MD]

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TINA (DOE [redacted] Mar 05 2015 01:03:04 PM

CC LABS

HPI The patient was asked to come in today for further evaluation secondary to her blood work. The blood work demonstrates abnormal control of her blood glucose. Her cholesterol is elevated as well as her triglycerides. Prolonged discussion with the patient of a hemoglobin A1c of 12.3. Discussion about referral to endocrinologist. Patient agrees to redouble her efforts. I've explained to the patient and cannot emphasize enough to need for improved control. I have asked the patient to please send me or her readings. She agrees.
She requires refills on medication we discussed new start of Crestor mandatory that we improve her cholesterol profile.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.

SH Patient denies any tobacco use or recreational drug use. Occasional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, AS DIRECTED
2) Bydureon Pen 2 mg subcutaneous injection, extended release, one im q week
3) carvedilol 3.125 mg oral tablet, 1 po bid
4) Cymbalta 60 mg oral delayed release capsule, 1 po q d
5) gabapentin 300 mg oral capsule, 2 po bid
6) glucometer on plan
7) lancets and strips and plan, check tid prior to meals
8) Lantus Solostar Pen 100 units/mL subcutaneous solution, 30 units sq q day
9) Lantus Solostar Pen needles, q day
10) lisinopril 2.5 mg oral tablet, one po bid
11) loratab 5/325 , one po bid
12) metFORMIN 1000 mg oral tablet, 1 PO BID
13) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d)
14) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN
15) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
16) Percocet 7.5/325 oral tablet, ONE PO BID PRN

Printed By: NAOMI CHANEY, MD 3/31/2018 11:57:47 AM

17) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X Month (30d)
18) Tamiflu 75 mg oral capsule, one po bid
19) triamcinolone 0.025% topical ointment, APPLY TO LESION
20) valsartan 160/hctz 12.5, one po q day

Vitals — Wt: 163 lb Ht/Ln: 63 in BMI: 28.9 BP: 141/76 Pulse: 100 RR: 12 Sat: 98

PE
GENERAL: WNWD NAD
HEENT: WNL
LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.
EXTREMITIES: NO C/C/E. Normal Pulses.

A/P
Paresthesia of skin (782.0):
Type II diabetes mellitus poorly controlled (250.02):
Hypertensive disorder (401.9):
Backache (724.5):
Chronic pain syndrome (338.4):

Plan printed and provided to patient:
PRESCRIBE: metFORMIN 1000 mg oral tablet, 1 PO BID, # 180, RF: 1.
PRESCRIBE: Lantus Solostar Pen 100 units/mL subcutaneous solution, 40 units sq q day, # 3 months , RF: 0.
PRESCRIBE: Crestor 10 mg oral tablet, Take 1 pill by mouth QHS (nightly) X 1 Month (30d), #90, RF: 1.
PRESCRIBE: Percocet 7.5/325 oral tablet, ONE PO BID PRN, # 60, RF: 0

PROVIDED: Patient Education (3/5/2015)

Electronically Signed By: NAOMI CHANEY, MD
3/5/15 3:32 PM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS TITINA [redacted] VADOC 2015FH10713CAM

CC Follow-up

HPI Patient is here in interval follow-up. She requires refills on her medications. Patient states that her blood glucose has improved and is not regularly sending me her numbers. I explained to the patient that I'm more than willing to participate in improving her diabetes.
She complains of shoulder pain.
She requires refills.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.

SH Patient denies any tobacco use or recreational drug use. Occasional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, AS DIRECTED
2) Bydureon Pen 2 mg subcutaneous injection, extended release, one im q week
3) carvedilol 3.125 mg oral tablet, 1 po bid
4) Crestor 10 mg oral tablet, Take 1 pill by mouth QHS (nightly) X 1 Month (30d)
5) Cymbalta 60 mg oral delayed release capsule, 1 po q d
6) gabapentin 300 mg oral capsule, 2 po bid
7) glucometer on plan
8) lancets and strips and plan, check tid prior to meals
9) Lantus Solostar Pen 100 units/mL subcutaneous solution, 40 units sq q day
10) Lantus Solostar Pen needles, q day
11) lisinopril 2.5 mg oral tablet, one po bid
12) loratab 5/325 , one po bid
13) metFORMIN 1000 mg oral tablet, 1 PO BID
14) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d)
15) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN
16) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
17) Percocet 7.5/325 oral tablet, ONE PO BID PRN
18) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X Month (30d)
19) Tamiflu 75 mg oral capsule, one po bid

Printed By: NAOMI CHANEY, MD 3/31/2018 11:57:54 AM

Annual Medicare [redacted] Page 1 of 2

20) triamcinolone 0.025% topical ointment, APPLY TO LESION
21) valsartan 160/hctz 12.5, one po q day

Vitals Wt. 163 lb Ht/Ln: 63 in BMI: 28.9 BP: 136/88 Pulse: 88 RR: 12 Sat: 98

PE
GENERAL: WNWD NAD
HEENT: WNL
LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.
EXTREMITIES: NO C/C/E. Normal Pulses.

A/P
Type II diabetes mellitus poorly controlled (250.02):
Polyneuropathy in diabetes (357.2):
Chronic pain syndrome (338.4):
Hypertensive disorder (401.9):

Electronically Signed By: NAOMI CHANEY, MD
4/3/15 10:34 AM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TINA (DOB: [redacted]) May 08, 2015 Tue 01:25 PM

CC FU AP

HPI Patient is here in interval follow-up. She requires refills and would like to have relief from the pain in her shoulder. I've explained to the patient that her diabetes has not been well controlled and she does require improved diabetic control and clearance from cardiology. She is reluctant. She reports that she is fully compliant with all medications.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.

SH Patient denies any tobacco use or recreational drug use. Occasional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, AS DIRECTED
2) Bydureon Pen 2 mg subcutaneous injection, extended release, one im q week
3) carvedilol 3.125 mg oral tablet, 1 po bid
4) Crestor 10 mg oral tablet, Take 1 pill by mouth QHS (nightly) X 1 Month (30d)
5) Cymbalta 60 mg oral delayed release capsule, 1 po q d
6) gabapentin 300 mg oral capsule, 2 po bid
7) glucometer on plan
8) lancets and strips and plan, check tid prior to meals
9) Lantus Solostar Pen 100 units/mL subcutaneous solution, 40 units sq q day
10) Lantus Solostar Pen needles, q day
11) lisinopril 2.5 mg oral tablet, one po bid
12) loratab 5/325 , one po bid
13) metFORMIN 1000 mg oral tablet, 1 PO BID
14) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d)
15) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN
16) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
17) Percocet 7.5/325 oral tablet, ONE PO BID PRN
18) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X Month (30d)
19) Tamiflu 75 mg oral capsule, one po bid
20) triamcinolone 0.025% topical ointment, APPLY TO LESION

Printed By: NAOMI CHANEY, MD 3/31/2018 11:58:05 AM

Authorized Chart [illegible] Page 1 of 2

21) valsartan 160/hctz 12.5, one po q day

Vitals Wt: 164 lb Ht/Ln: 63 in BMI: 29.1 BP: 138/82 Pulse: 90 RR: 12 Sat: 98

PE GENERAL: WNWD NAD
HEENT: WNL
LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.
EXTREMITIES: NO C/C/E.

A/P # Pre-operative examination, unspecified (V72.84):
Paresthesia of skin (782.0):
Backache (724.5):
Chronic pain syndrome (338.4):
Patient noncompliance - general (V15.81):
Type II diabetes mellitus uncontrolled (250.02):

Plan printed and provided to patient:
dr.yee ordered mri of the left shoulder.
dr. reeves and he ordered mri of the abdomen
prepare for surgery.
ORDERED/ADVISED: - VALENCIA, RAFAEL (CARDIOLOGY) (Preoperative clearance for shoulder) ICD Codes (V72.84)
ORDERED/ADVISED: - CXR - PA & Lat ICD Codes (V72.84)

ORDERED/ADVISED: - CBC with diff (automated) ICD Codes (V72.84)
- CMP (Complete Metabolic Panel) ICD Codes (V72.84)
- HemoglobinA1c ICD Codes (V72.84)
- PT/PTT ICD Codes (V72.84)
- Urinalysis with reflex to culture if abnormal ICD Codes (V72.84)

Electronically Signed By: NAOMI CHANEY, MD
5/5/15 5:02 PM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

ID #	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008	F	TITINA FARRIS	Quest
DOB			
[redacted]			
AGE		ACCESSION #	ORDERING PROVIDER
55		[redacted]	NAOMI CHANEY, MD
LAB ID #		SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
7037		Specimen ID: 48785513 Type: Source: Condition:	05/06/2015 16:11:23	05/06/2015 07:34:00
			COLLECTION DATE/TIME	FASTING
			05/05/2015 16:34:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	HEC	Status	Performed By
COMPREHENSIVE METABOLIC PANEL					F	
-Glucose, Fasting	[redacted]	65-99	mg/dL	H	F	Quest
-BUN	11	7-25	mg/dL	N	F	Quest
-Creatinine	0.82	0.50-1.05	mg/dL	N	F	Quest
-BUN/Creatinine Ratio	13.4	6.0-22.0	--	N	F	Quest
-Calcium	10.0	8.6-10.4	mg/dL	N	F	Quest
-Protein, Total	8.0	6.1-8.1	g/dL	N	F	Quest
-Albumin	4.5	3.6-5.1	g/dL	N	F	Quest
-Globulin	3.5	1.9-3.7	g/dL	N	F	Quest
-A/G Ratio	1.3	1.0-2.5	--	N	F	Quest
-BILIRUBIN, TOTAL	0.2	0.2-1.2	mg/dL	N	F	Quest
-Alkaline Phosphatase	103	33-130	IU/L	N	F	Quest
-AST (SGOT)	18	10-35	IU/L	N	F	Quest
-ALT (SGPT)	18	6-29	IU/L	N	F	Quest
-Sodium	[redacted]	135-146	mEq/L	L	F	Quest
-Potassium	4.6	3.5-5.3	mEq/L	N	F	Quest

Page 1 of 1 Amazing Charts

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

ID #	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008	F	TITINA FARRIS	Quest
DOB			
[redacted]			

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	NAOMI CHANEY, MD

LAB ID #	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
7037	Specimen ID: 48785513 Type: Source: Condition:	05/06/2015 16:11:23	05/06/2015 07:34:00
		COLLECTION DATE/TIME	FASTING?
		05/05/2015 16:34:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-Chloride	95	98-110	mEq/L	L	F	Quest
-CO2	25	19-30	mEq/L	N	F	Quest
-eGFR African American	95	>59	--	N	F	Quest
-eGFR Non-AFR. American	82	>59	--	N	F	Quest

NOTES on 'eGFR Non-AFR. American':
The upper reference limit for Creatinine is approximately
13% higher for people identified as African-American.
Glucose reference range reflects a fasting state.
For non-fasting patients glucose reference range
is 65 - 139 mg/dL.

PROTHROMBIN TIME WITH INR F

-PT	9.5	9.0-11.5	sec	N	F	Quest
-INR	0.9	0.9-1.1	--	N	F	Quest

NOTES on 'INR':
The recommended therapeutic INR for moderate-intensity
Warfarin therapy is 2.0 to 3.0, except for patients on
higher-intensity Warfarin therapy. In these latter
patients, the therapeutic INR range is 3.0 to 4.0.

PARTIAL THROMBOPLASTIN TIME, ACTIVATED F

-PTT	26	22-34	sec	N	F	Quest

NOTES on 'PTT':
This test has not been validated for monitoring
unfractionated heparin therapy. For testing that
is validated for this type of therapy, please refer
to Heparin, Unfractionated (Xa Inhibition) - TC 132092.

CBC (INCLUDES DIFFERENTIAL AND PLATELETS) F

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

ID	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
10008	F	TITINA FARRIS	Quest

DOB: [redacted]

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	NAOMI CHANEY, MD

PAT ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
7037	Specimen ID: 48785513 Type: Source: Condition:	05/06/2015 16:11:23	05/06/2015 07:34:00

COLLECTION DATE / TIME	FASTING
05/06/2015 16:34:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLAG	Status	PERFORMED BY
-WHITE BLOOD CELL COUNT	[redacted]	3.8-10.8	k/uL	H	F	Quest
-RBC	4.17	3.80-5.10	Million/uL	N	F	Quest
-HEMOGLOBIN	12.1	11.7-15.5	g/dL	N	F	Quest
-HEMATOCRIT	37.2	35.0-45.0	%	N	F	Quest
-MCV	89.2	80.0-100.0	fL	N	F	Quest
-MCH	29.0	27.0-33.0	pg	N	F	Quest
-MCHC	32.5	32.0-36.0	g/dL	N	F	Quest
-RED CELL DISTRIBUTION	13.9	11.0-15.0	%	N	F	Quest
-PLATELET COUNT	45[redacted]	140-400	k/uL	H	F	Quest
-MEAN PLATELET VOLUME	9.5	7.5-11.5	fL	N	F	Quest
-Absolute Neutrophils	12967[redacted]	1500-7800	/uL	H	F	Quest
-Absolute Lymphocytes	1833	850-3900	/uL	N	F	Quest
-Absolute Monocytes	493	200-950	/uL	N	F	Quest
-Absolute Eosinophils	92	15-550	/uL	N	F	Quest
-Absolute Basophils	15	0-200	/uL	N	F	Quest
-SEGMENTED NEUTROPHILS	84.2	--	%	N	F	Quest

[redacted] AmazingCharts

PLTF9252

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

LABORATORY REPORT

PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
TITINA FARRIS	Quest

ID#	SEX	DOB	AGE	ACCESSION #	PAT ID
10008	F	[redacted]	55	[redacted]	7037

ORDERING PROVIDER
NAOMI CHANEY, MD

SPECIMEN INFORMATION
Specimen ID: 48785513
Type:
Source:
Condition:

RECEIVED ON	REPORTED ON
05/06/2015 16:11:23	05/06/2015 07:34:00

COLLECTION DATE/TIME	FASTING
05/05/2015 16:34:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLG	STATUS	PERFORMED BY
-LYMPHOCYTES	11.9	--	%	N	F	Quest
-MONOCYTES	3.2	--	%	N	F	Quest
-EOSINOPHILS	0.6	--	%	N	F	Quest
-BASOPHILS	0.1	--	%	N	F	Quest
URINALYSIS, COMPLETE WITH REFLEX TO CULTURE					F	
-COLOR	YELLOW	YELLOW	--	N	F	Quest
-APPEARANCE	CLOUDY	CLEAR	--	A	F	Quest
-SPECIFIC GRAVITY	1.015	1.001-1.035	--	N	F	Quest
-PH	7.5	5.0-8.0	--	N	F	Quest
-GLUCOSE	[redacted]	NEGATIVE	--	A	F	Quest
-BILIRUBIN	NEGATIVE	NEGATIVE	--	N	F	Quest
-KETONES	NEGATIVE	NEGATIVE	--	N	F	Quest
-OCCULT BLOOD	NEGATIVE	NEGATIVE	--	N	F	Quest
-PROTEIN	NEGATIVE	NEGATIVE	--	N	F	Quest
-NITRITE	NEGATIVE	NEGATIVE	--	N	F	Quest
-LEUKOCYTE ESTERASE	NEGATIVE	NEGATIVE	--	N	F	Quest
-WBC	0-5	0-5	/HPF	N	F	Quest

c:\data\work\fax_45091_ _7023195901_051415035001PM_1 tm

Fax Cover Sheet - Advanced Orthopedics & Sports Medicine

From: Advanced Orthopedics & Sports Medicine
9280 West Sunset Road
Suite 422
Las Vegas, NV 89148
Phone: (702) 740-5327
Fax: (702) 740-5328

Requestor: MELLY
Fax Number: 702-319-6901
Fax Destination: CHANEY, NAOMI M.D.
To the ATTENTION of: CHART COPY
Fax Priority: Immediate
Request Date: 05/14/2015 - 03:50:01 PM

c:\data\patients\062\786\6. .\\transcript0-3.htm

AOSM ADVANCED ORTHOPEDICS & SPORTS MEDICINE

X. Nick Go, D.O.
Board Certified Orthopedic Surgeon
Fellowship Trained Sports Medicine

Timothy E. Trainor, M.D.
Board Certified Orthopedic Surgeon
Board Certified Orthopedic Sports Subspecialty Surgeon

Randall E. Yee, D.O.
Board Certified Orthopedic Surgeon
Fellowship Trained Sports Medicine

Jay Reidy, M.D.
Board Certified Orthopedic Surgeon
Fellowship Trained Spine Surgeon

Thomas Kuoviko, D.P.M.
Board Certified Podiatry
Certified Wound Care & Hyperbaric Medicine

Matthew H.C. Otten, D.O.
Sports Medicine Fellowship Trained

Michael Trainor, D.O.
Board Certified Orthopedic Surgeon
Fellowship Trained Spine Surgeon

Sports Injuries • Fracture Care • Joint Replacement • Cartilage Replacement • Minimally Invasive Arthroscopic Surgery

ADVANCED ORTHOPEDICS & SPORTS MEDICINE

Sports Injuries • Fracture Care • Joint Replacement • Cartilage Replacement • Minimally Invasive Arthroscopic Surgery

FARRIS, TITINA
[redacted]
Yee, Randall
05/05/2015
Left shoulder

Dear Dr. Naomi Chaney,

Titina is a patient who presents today for left shoulder pain. She states cortisone injection helped until about last week, would like another injection and some medication.
\
Allergies and history were reviewed with the patient in the office.

On physical examination, regarding the right shoulder, patient has a negative Neer's, negative Hawkin's, and negative Speed's. There are no signs of instability. There is 5/5 strength. There is +2/4 DTR's. There is no visible scars. Skin in intact. Tenderness absent. Non tenderness palpation over the AC joint and over the gleneral humeral joint. Normal flexion and abduction over the normal limits. Patient has no erythema on the skin. Plus pulses are noted. DIstal neurovascular status is noted to be intact. Regarding the left shoulder, she has a positive Neer's, positive Hawkin's, and a positive Speed's. There is a negative O'Brien's. There is no signs of instability. There is tenderness to palpation over the supraspinatus tendon. There are no signs of dislocation There is +2/4 DTR's in these upper extremities. There is 5/5 strength. Plus pulses are noted. Distal neurovascular status is noted to be intact. Regarding the bilateral feet, there is pain noted. Regarding the neckshe has a positive Lhermitte's and a positive Spurling's. She has decreased strength in the upper extremities. There is decreased DTR's in these bilateral upper extremities. Sensations seems to be intact. Plus pulses are noted. There is tenderness to palpation over the C-spine.

IMPRESSION: Left shoulder impingement syndrome
Left AC DJD, asymptomatic
History of diabetic neuropathy.
Bilateral foot pain
C spine radiculopathy

Ultrasound guidance showed: Static real-time views in longitudinal and transverse orientation were obtained on this patient. In transverse view the bicep tendon is hypoechoic and increased in size. It is well situated in the inter-tubercular groove, no evidence of medial or lateral subluxation. On long axis, the biceps is intact, but remains hypoechoic with a fusiform appearance as it proceeds distally. On external rotation, the subscapularis tendon appeared intact, not edematous, with no evidence of tenosynovitis nor tendinosis. The supraspinatus tendon is noted to have decreased thickened consistent with the tear. The infraspinatus and teres minor tendons were inflammed consistent with possible tear tendonitis. No cortical interruption or irregularity of the humeral head. The humeral hyaline cartilage was 0.8 mm in thickness below the supraspinatus. The rotator cuff interval did not demonstrate increased supraspinatus or subscapularis margin effusion. Dynamic imaging to evaluate for impingement demonstrated smooth, unobstructed movement of the supraspinatus beneath the acromion with patient flexion/ abduction. Bilateral acromio-clavicular joint images do not reveal sonographic criteria of ligament laxity or shoulder separation. Glenoid labrum and inferior gleno-humeral ligament interruption or tear were not demonstrated.

PLAN: We will see her back in this office in 2 weeks. She was placed on Hydrocodone. We will obtain an MRI of her left

c:\data\patients\062\786\6 ;\\transcript0-3.htm

shoulder. She was injected with 80mg of Methylprednisolone into her left shoulder under sterile condition, using ultrasound guidance. Risk for injections were discussed. There is a possibility of skin color change, the possibility of infection and increase in blood sugar. The possibility of tendon or ligament damage and early arthritis.
She will call or return with questions.

Randall Yee, D.O.
RY/cp

Tel. (702) 740-5327 * Fax (702) 740-5328 * 8420 Warm Springs Rd., Ste. 100, Las Vegas, Nevada 89113
10001 S. Eastern Avenue, Suite 405, Henderson, Nevada 89052 * 601 Whitney Ranch Dr., Suite B-6, Henderson, Nevada 89014

Electronically signed on 05/09/2015 by DR. YEE

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS,TINA (DOB:10/24/1962 ID:10008) - Jun 04 2015 THU 05:39 PM

CC cough, refills 530 ia

HPI Patient is here in interval follow-up for labs performed in preparation for surgery. I've explained to the patient that although her hemoglobin A1c is improved she continues to demonstrate poor control. I have advised the patient that she must see an endocrinologist. She states that she is in agreement. She also has an elevated white count and reports that she has a cough that is nonproductive. She also received a steroid injection which may cause elevation of white count.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.

SH Patient denies any tobacco use or recreational drug use. Occasional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, AS DIRECTED
2) Bydureon Pen 2 mg subcutaneous injection, extended release, one im q week
3) carvedilol 3.125 mg oral tablet, 1 po bid
4) Crestor 10 mg oral tablet, Take 1 pill by mouth QHS (nightly) X 1 Month (30d)
5) Cymbalta 60 mg oral delayed release capsule, 1 po q d
6) gabapentin 300 mg oral capsule, 2 po bid
7) glucometer on plan
8) lancets and strips and plan, check tid prior to meals
9) Lantus Solostar Pen 100 units/mL subcutaneous solution, 40 units sq q day
10) Lantus Solostar Pen needles, q day
11) lisinopril 2.5 mg oral tablet, one po bid
12) loratab 5/325 , one po bid
13) metFORMIN 1000 mg oral tablet, 1 PO BID
14) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d)
15) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN
16) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
17) Percocet 7.5/325 oral tablet, ONE PO BID PRN
18) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X Month (30d)
19) Tamiflu 75 mg oral capsule, one po bid

Printed By: NAOMI CHANEY, MD 3/31/2018 11:58:22 AM

Amazing Charts Page 1 of 2

20) triamcinolone 0.025% topical ointment, APPLY TO LESION
21) valsartan 160/hctz 12.5, one po q day

Vitals — Wt: 162 lb Ht/Ln: 63 in BMI: 28.7 BP: 130/80 Pulse: 102 RR: 12 Sat: 98

PE
GENERAL: WNWD NAD
HEENT: WNL
LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.
EXTREMITIES: NO C/C/E. Normal Pulses.

A/P
Type II diabetes mellitus poorly controlled (250.02):
On examination - pulse rate tachycardia (785.0):
Hypertension (401.9):
Backache (724.5):

Plan printed and provided to patient:
PRESCRIBE: Percocet 7.5/325 oral tablet, ONE PO BID PRN, # 60, RF: 0.
PRESCRIBE: lisinopril 5 mg oral tablet, one po bid, #180, RF: 1.

ORDERED/ADVISED: - PALAL BETSY (ENDOCRINOLOGIST) ICD Codes (250.02)

PROVIDED: Patient Education (6/4/2015)

Electronically Signed By: NAOMI CHANEY, MD
6/4/15 6:12 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 11:58:22 AM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TINA [redacted] Jun 30, 2015 Tue 12:59 PM

CC Refills

HPI Patient is here in interval follow-up. As we are moving into the holiday she is here early in requires refills on her pain medications. She has not contacted me with respect to her numbers but agrees that she will try again. She has been referred to the endocrinologist. She reports that she has been fully compliant with all her medications.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.

SH Patient denies any tobacco use or recreational drug use. Occasional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, AS DIRECTED
2) Bydureon Pen 2 mg subcutaneous injection, extended release, one im q week
3) carvedilol 12.5 mg oral tablet, 1 po bid
4) carvedilol 3.125 mg oral tablet, 1 po bid
5) Crestor 10 mg oral tablet, Take 1 pill by mouth QHS (nightly) X 1 Month (30d)
6) Cymbalta 60 mg oral delayed release capsule, 1 po q d
7) gabapentin 300 mg oral capsule, 2 po bid
8) glucometer on plan
9) lancets and strips and plan, check tid prior to meals
10) Lantus Solostar Pen 100 units/mL subcutaneous solution, 40 units sq q day
11) Lantus Solostar Pen needles, q day
12) lisinopril 2.5 mg oral tablet, one po bid
13) lisinopril 5 mg oral tablet, one po bid
14) loratab 5/325 , one po bid
15) metFORMIN 1000 mg oral tablet, 1 PO BID
16) Norco 5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d)
17) Norco 7.5 mg-325 mg oral tablet, Take 1 pill by mouth BID X 1 Month (30d) As Needed PAIN
18) Onglyza 5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 1 Month (30d)
19) Percocet 7.5/325 oral tablet, ONE PO BID PRN
20) pravastatin 10 mg oral tablet, Take 1 pill by mouth QD (Daily) X Month (30d)

Printed By: NAOMI CHANEY, MD 3/31/2018 11:58:30 AM

Amazing Charts [redacted] Page 1 of 2

PLTF9404

21) Tamiflu 75 mg oral capsule, one po bid
22) triamcinolone 0.025% topical ointment, APPLY TO LESION
23) valsartan 160/hctz 12.5, one po q day

Vitals — Wt: 163 lb Ht/Ln: 63 in BMI: 28.9 BP: 124/88 Pulse: 96 RR: 12 Sat: 98

PE
GENERAL: WNWD NAD
HEENT: WNL
LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.
EXTREMITIES: NO C/C/E. Normal Pulses.

A/P
Type II diabetes mellitus uncontrolled (250.02): She has been referred to Dr. Betsey Palal.
Chronic pain syndrome (338.4):
Hypertension (401.9):

Plan printed and provided to patient:
PRESCRIBE: Percocet 7.5/325 oral tablet, ONE PO BID PRN, # 60, RF: 0.

PROVIDED: Patient Education (6/30/2015)

Electronically Signed By: NAOMI CHANEY, MD
6/30/15 1:22 PM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

HARRIS, TIFFANY (DOB: [redacted]) Jun 09, 2016 (11:04 PM)

CC	600pm per doc ref ia
HPI	Patient states that the left foot is improving in sensation. She is no longer wearing the foot brace. She reports that her blood glucose is well controlled. She continues to participate heavily in physical therapy and acupuncture. She is motivated to have the colostomy reversal.
ROS	10 system reviewed and performed by patient on the Phressia tablet.
PMH	Diabetes. Hypertenion Neuropathy. Critical care neuropathy Diverting colonostomy
SH	Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption. [Tobacco: Never smoker] married daughter 8 - patrick husband She has several dogs - she toy collie and a Yorkshire interior toy collie little yorki and chiweenie.
FH	Mother: pacer dx diabetes? Father: good Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.
Allergies	asprin (Updated by Naomi on 01/17/2014 03:37 PM)
Meds	1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, as directed 2) Bydureon 2 mg subcutaneous injection, extended release, one im q week 3) carvedilol 12.5 mg oral tablet, 1 po bid 4) Crestor 5 mg oral tablet, one po qhs 5) Cymbalta 60 mg oral delayed release capsule, 1 po qd 6) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days 7) Folbee oral tablet, one po q day 8) glucometer 9) glucometer on plan 10) Horizant 600 mg oral tablet, extended release, one po q day 11) hydrochlorathiazide 25 mg, Take 1 pill by mouth QD (Daily) X 3 Months (90d) 12) ibuprofen 800 mg oral tablet, one po bid pm 13) ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal 14) lancets and strips, check qid prior to meal 15) lancets and strips true trak, check tid prior meals 16) Lantus Solostar Pen 100 units/mL subcutaneous solution, 45 units sq q day 17) Lantus Solostar Pen needles, q day 18) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days 19) lisinopril 2.5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 3 Months (90d) 20) metFORMIN 1000 mg oral tablet, 1 PO BID

Printed By: NAOMI CHANEY, MD 3/31/2018 12:01:08 PM

[redacted]

21) odanestron 4 mg, one po tid pm
22) pantoprazole 40 mg oral delayed release tablet, one po q day
23) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
24) Percocet 7.5/325 oral tablet, ONE PO BID PRN
25) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals — Wt: 157.2 lb Ht/Ln: 62 in BMI: 28.8 BP: 132/72 Pulse: 103 RR: 12 Sat: 98

PE — WAIST: 42.5 Well nourished and well developed in no acute distress. Affect is normal and appropriate. Mucosa pink and moist. Chest is CTA. Heart is RRR without murmers. Walks with front wheel walker.

A/P — # Footdrop | Foot drop, right foot (M21.371):
Neuropathy (G62.9): referral to neurologist and MRI of the lumbar spine.
Patient with multiple cardiovascuair risk factors. Clearance for surgery.

PRESCRIBE: Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed, # 90, RF: 0.
PRESCRIBE: ibuprofen 800 mg oral tablet, one po bid pm, # 60, RF: 0.
Plan printed and provided to patient:
ORDERED/ADVISED: - MRI - Lumbar Spine (no contrast) ICD Codes (M21.371, G62.9)

ORDERED/ADVISED: - Yu, Santos (Neurology) ICD Codes (M21.371, G62.9)

ORDERED/ADVISED: - Chandler, Keshav (Cardiology) ICD Codes (M21.371, G62.9)

PROVIDED: Patient Education (6/9/2016)

Electronically Signed By: NAOMI CHANEY, MD
6/9/16 8:47 PM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

[redacted] ALEX 1X 2016 MON 01:15 PM

CC REFILLS SR

HPI Patient had surgery without ill event. They are both excited about the outcome. She and her husband report no hiccups around surgery. Copy of the pathology report discussed and given to the patient. Her bowel movement are normal.
She continues to do physical therapy at home now.
She reports her blood glucose is largley normal.
She reports full compliance with medicaiton.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.
Critical care neuropathy
Diverting colonostomy

SH Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie.

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, as directed
2) Bydureon 2 mg subcutaneous injection, extended release, one im q week
3) carvedilol 12.5 mg oral tablet, 1 po bid
4) Crestor 5 mg oral tablet, one po qhs
5) Cymbalta 60 mg oral delayed release capsule, 1 po qd
6) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days
7) Folbee oral tablet, one po q day
8) glucometer
9) glucometer on plan
10) Horizant 600 mg oral tablet, extended release, one po q day
11) hydrochlorathiazide 25 mg, Take 1 pill by mouth QD (Daily) X 3 Months (90d)
12) ibuprofen 800 mg oral tablet, one po bid pm
13) ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal
14) lancets and strips, check qid prior to meal
15) lancets and strips true trak, check tid prior meals
16) Lantus Solostar Pen 100 units/mL subcutaneous solution, 45 units sq q day
17) Lantus Solostar Pen needles, q day

Printed By: NAOMI CHANEY, MD 3/31/2018 12:01:35 PM

[redacted]

[redacted] Aug 15, 2016 Mon 07:15 PM

18) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days
19) lisinopril 2.5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 3 Months (90d)
20) metFORMIN 1000 mg oral tablet, 1 PO BID
21) odanestron 4 mg, one po tid pm
22) pantoprazole 40 mg oral delayed release tablet, one po q day
23) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
24) Percocet 7.5/325 oral tablet, ONE PO BID PRN
25) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals — Wt: 152 lb Ht/Ln: 62 in BMI: 27.8 BP: 120/82 Pulse: 103 RR: 12 Sat: 98

PE — waist 38
Well nourished and well developed in no acute distress. Affect is normal and appropriate. Mucosa pink and moist. Chest is CTA. Heart is RRR without murmers. Abnormal gait.

A/P — # Hypertension (I10):on ace inhibitor.
Pain in back (M54.9):
Chronic back pain (R52):
Neuropathy (G62.9):
Breast screening, unspecified (Z12.39):
Diabetes mellitus (E11.9):Patient requires labs. She reports not fasting.

PRESCRIBE: Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed, # 90, RF: 0.
ORDERED/ADVISED: - Mammogram ICD Codes (Z12.39)

Electronically Signed By: NAOMI CHANEY, MD

8/15/16 7:14 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 12:01:35 PM

Medical Chart

PLTF9805

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

HARRIS, TINA (DOB: [redacted]) Oct 26, 2016 Wed 02:28 PM

CC REFILLS, FU IA

HPI Pronlonged discussed with the patient regarding the need for labs. The patient is not fasting but will have them done today. She states that her blood glucose is running higher. She reports that she has been less compliant with checking.
She continues to have pain in her extermities. She reports she is doing more rehabilitation.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.
Critical care neuropathy
Diverting colonostomy

SH Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie.

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, as directed
2) Bydureon 2 mg subcutaneous injection, extended release, one im q week
3) carvedilol 12.5 mg oral tablet, 1 po bid
4) Crestor 5 mg oral tablet, one po qhs
5) Cymbalta 60 mg oral delayed release capsule, 1 po qd
6) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days
7) Folbee oral tablet, one po q day
8) glucometer
9) glucometer on plan
10) Horizant 600 mg oral tablet, extended release, one po q day
11) hydrochlorathiazide 25 mg, Take 1 pill by mouth QD (Daily) X 3 Months (90d)
12) Ibuprofen 800 mg oral tablet, one po bid prn
13) ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal
14) lancets and strips, check qid prior to meal
15) lancets and strips true trak, check tid prior meals
16) Lantus Solostar Pen 100 units/mL subcutaneous solution, 45 units sq q day
17) Lantus Solostar Pen needles, q day
18) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days
19) lisinopril 2.5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 3 Months (90d)

Printed By: NAOMI CHANEY, MD 3/31/2018 12:01:58 PM

PLTF9822

20) metFORMIN 1000 mg oral tablet, 1 PO BID
21) odanestron 4 mg, one po tid pm
22) pantoprazole 40 mg oral delayed release tablet, one po q day
23) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
24) Percocet 7.5/325 oral tablet, ONE PO BID PRN
25) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals — Wt: 161 lb Ht/Ln: 62 in BMI: 29.4 BP: 138/76 Pulse: 99 RR: 12 Sat: 97

PE — Well nourished and well developed in no acute distress. Affect is normal and appropriate. Mucosa pink and moist. Chest is CTA. Heart is RRR without murmers. Abnormal gait

A/P — # Diabetes mellitus (E11.9):obtain labs today
Chronic back pain (R52):
Neuropathy (G62.9):Refill meds for chronic pain.
Hypertension (I10):

Plan printed and provided to patient:
PRESCRIBE: four pronged cane, # 1,
PRESCRIBE: Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed, # 90, RF: 0.
PRESCRIBE: metFORMIN 1000 mg oral tablet, one po bid, # 180, RF: 0.

ORDERED/ADVISED: - HGBA1C ICD Codes (R52, E11.9, G62.9)
- REGULAR - cbc, cmp urine analysis with reflex to culture and sensitivity, lipid , tsh, vitamin d ICD Codes (R52, E11.9, G62.9)
- URINE MICROALBUMIN ICD Codes (R52, E11.9, G62.9)

PROVIDED: Patient Education (10/26/2016)

Electronically Signed By: NAOMI CHANEY, MD
10/26/16 8:03 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 12:01:58 PM

INTERNAL MEDICINE OF SPRING \ :Y
5380 S RAINBOW BLVD STE 210
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID# SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955 F	TITINA FARRIS	Clinical Pathology Laboratories
DOB		
[redacted]		
AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD
LAB ID #	SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
4740	Specimen ID: UW987816 Type: Source: Condition:	11/02/2016 08:55:15 / 10/29/2016 10:04:14
		COLLECTION DATE/TIME / FASTING STATUS
		10/26/2016 16:45:00 / NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
INDICATED URINE CULTURE					F	
Reported On: 10/29/2016 10:04:14						
-CULTURE, URINE	SPECIMEN NUMBER: 16827515	--	--	A	F	Clinical Pathology Laboratories

NOTES on 'CULTURE, URINE':

CULTURE, URINE
SPECIMEN NUMBER: 16827515

SOURCE: URINE

REPORT STATUS: FINAL

ISOLATE NUMBER 1:
ORGANISM:
10/28/2016 >100,000 CFU/ML GRAM NEGATIVE BACILLI

IDENTIFICATION:
10/29/2016 KLEBSIELLA PNEUMONIAE

K. PNEUMONIAE

AMOXICILLIN/CA	SENSITIVE	<=8/4
AMPICILLIN	RESISTANT	>16
CEFAZOLIN	SENSITIVE	<=8
CEFTRIAXONE	SENSITIVE	<=8
CEFUROXIME	SENSITIVE	<=4
CIPROFLOXACIN	SENSITIVE	<=1
LEVOFLOXACIN	SENSITIVE	<=2
NITROFURANTOIN	RESISTANT	>64
PIP/TAZOBAC	SENSITIVE	<=16
TETRACYCLINE	SENSITIVE	<=4
TRIMETH/SULFA	SENSITIVE	<=2/38

NOTE: NUMBERS DISPLAYED REPRESENT MINIMUM INHIBITORY CONCENTRATION (MIC) WHICH IS EXPRESSED IN MCG/ML.

CBC W/AUTO DIFF WITH PLATELETS					F	
Reported On: 10/27/2016 00:28:44						
-WBC	12.2	4.0-11.0	K/UL	H	F	Clinical Pathology Laboratories
-RBC	4.05	3.80-5.10	M/UL		F	Clinical Pathology Laboratories
-HEMOGLOBIN	11.8	11.5-15.5	G/DL		F	Clinical Pathology

INTERNAL MEDICINE OF SPRING \ :Y
5380 S RAINBOW BLVD STE 218
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID# / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955 F	TITINA FARRIS	Clinical Pathology Laboratories
DOB		
[redacted]		
AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD
LAB ID	SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
4740	Specimen ID: UW987816 Type: Source: Condition:	11/02/2016 08:55:15 / 10/29/2016 10:04:14
		COLLECTION DATE/TIME / FASTING
		10/26/2016 16:45:00 / NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-HEMATOCRIT	36.5	34.0-45.0	%		F	Clinical Pathology Laboratories
-MCV	90.1	80.0-100.0	fL		F	Clinical Pathology Laboratories
-MCH	29.1	27.0-34.0	PG		F	Clinical Pathology Laboratories
-MCHC	32.3	32.0-35.5	G/DL		F	Clinical Pathology Laboratories
-RDW	13.6	11.0-15.0	%		F	Clinical Pathology Laboratories
-NEUTROPHILS	57	40.0-74.0	%		F	Clinical Pathology Laboratories
-LYMPHOCYTES	33	19.0-48.0	%		F	Clinical Pathology Laboratories
-MONOCYTES	7	4.0-13.0	%		F	Clinical Pathology Laboratories
-EOSINOPHILS	2	0.0-7.0	%		F	Clinical Pathology Laboratories
-BASOPHILS	0	0.0-2.0	%		F	Clinical Pathology Laboratories
-PLATELET COUNT	[redacted]	130-400	K/UL	H	F	Clinical Pathology Laboratories

NOTES on 'PLATELET COUNT':

TESTING PERFORMED AT CLINICAL PATHOLOGY LABORATORIES, INC.
6830 SPENCER STREET, SUITE 102 LAS VEGAS, NV 89119
CLIA NO. 29D1075255

URINALYSIS (CULTURE IF INDICATED) F
Reported On: 10/27/2016 03:31:20

-COLOR	[redacted]	YELLOW/STRAW	--		F	Clinical Pathology Laboratories
-APPEARANCE	CLEAR	CLEAR	--		F	Clinical Pathology Laboratories
-SPECIFIC GRAVITY	[redacted]	1.005-1.035	--	H	F	Clinical Pathology Laboratories

[redacted] Amazing Charts

INTERNAL MEDICINE OF SPRING ' EY
5380 S RAINBOW BLVD STE 210
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID#	SEX	PATIENT DEMOGRAPHICS
9955	F	TITINA FARRIS

DOB [redacted]

RESULTS PROVIDED BY
Clinical Pathology Laboratories

AGE	ACCESSION
55	[redacted]

ORDERING PROVIDER
Naomi Chaney, MD

LAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
4740	Specimen ID: UW987816 Type: Source: Condition:	11/02/2016 08:55:15	10/29/2016 10:04:14
		COLLECTION DATE/TIME	FASTING
		10/26/2016 16:45:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-LEUKOCYTE ESTERASE	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-NITRITE	POSITIVE	NEGATIVE	--	A	F	Clinical Pathology Laboratories
-pH	5.5	5.0-9.0	--		F	Clinical Pathology Laboratories
-PROTEIN	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-GLUCOSE	[redacted]	NEGATIVE	--	A	F	Clinical Pathology Laboratories
-KETONES	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-UROBILINOGEN	NORMAL	</=2.0	MG/DL		F	Clinical Pathology Laboratories
-BILIRUBIN	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-OCCULT BLOOD	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories

NOTES on 'OCCULT BLOOD':

TESTING PERFORMED AT CLINICAL PATHOLOGY LABORATORIES, INC.
6830 SPENCER STREET, SUITE 102 LAS VEGAS, NV 89119
CLIA NO. 29D1075255

-WHITE BLOOD CELLS	[redacted]	0-5	/HPF	A	F	Clinical Pathology Laboratories
-RED BLOOD CELLS	0	0-5	/HPF		F	Clinical Pathology Laboratories
-EPITHELIAL CELLS	0	0-10	/HPF		F	Clinical Pathology Laboratories
-BACTERIA	[redacted]	NEGATIVE	--	A	F	Clinical Pathology Laboratories

COMPREHENSIVE METABOLIC PANEL F
Reported On: 10/28/2016 02:27:10

-GLUCOSE	[redacted]	70-99	MG/DL	H	F	Clinical Pathology Laboratories

INTERNAL MEDICINE OF SPRING EY
5380 S RAINBOW BLVD STE 218
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID#	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories

DOB: [redacted]

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD

LAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
4740	Specimen ID: UW987816 Type: Source: Condition:	11/02/2016 08:55:15	10/29/2016 10:04:14

COLLECTION DATE/TIME	FASTING
10/26/2016 16:45:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-BUN	15	6-20	MG/DL		F	Clinical Pathology Laboratories
-CREATININE	0.82	0.60-1.30	MG/DL		F	Clinical Pathology Laboratories
-eGFR AFRICAN AMER.	94	>60	ML/MIN/1.73		F	Clinical Pathology Laboratories
-eGFR NON-AFRICAN AMER.	81	>60	ML/MIN/1.73		F	Clinical Pathology Laboratories
-CALC BUN/CREAT	18	6-28	RATIO		F	Clinical Pathology Laboratories
-SODIUM	135	133-146	MEQ/L		F	Clinical Pathology Laboratories
-POTASSIUM	4.5	3.5-5.3	MEQ/L		F	Clinical Pathology Laboratories
-CHLORIDE	[redacted]	97-110	MEQ/L	L	F	Clinical Pathology Laboratories
-CARBON DIOXIDE	26	18-29	MEQ/L		F	Clinical Pathology Laboratories
-CALCIUM	9.6	8.5-10.5	MG/DL		F	Clinical Pathology Laboratories
-PROTEIN, TOTAL	8.0	6.1-8.3	G/DL		F	Clinical Pathology Laboratories
-ALBUMIN	4.2	3.5-5.2	G/DL		F	Clinical Pathology Laboratories
-CALC GLOBULIN	[redacted]	1.9-3.7	G/DL	H	F	Clinical Pathology Laboratories
-CALC A/G RATIO	1.1	1.0-2.6	RATIO		F	Clinical Pathology Laboratories
-BILIRUBIN, TOTAL	0.2	<=1.2	MG/DL		F	Clinical Pathology Laboratories
-ALKALINE PHOSPHATASE	[redacted]	38-111	U/L	H	F	Clinical Pathology Laboratories
-AST	11	9-40	U/L		F	Clinical Pathology Laboratories
-ALT	15	5-40	U/L		F	Clinical Pathology

INTERNAL MEDICINE OF SPRING \ :Y
5380 S RAINBOW BLVD STE 218
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories
DOB		[redacted]	
AGE		ACCESSION	ORDERING PROVIDER
55		[redacted]	Naomi Chaney, MD
LAB ID		SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
4740		Specimen ID: UW987816 Type: Source: Condition:	11/02/2016 08:55:15 / 10/29/2016 10:04:14 COLLECTION DATE/TIME / FASTING 10/28/2016 16:45:00 / NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLAG	STATUS	PERFORMED BY
						Laboratories
LIPID PANEL **Reported On: 10/28/2016 02:27:10**					F	
-CHOLESTEROL	[redacted]	<200	MG/DL	H	F	Clinical Pathology Laboratories
-TRIGLYCERIDES	[redacted]	<150	MG/DL	H	F	Clinical Pathology Laboratories
-HDL CHOLESTEROL	[redacted]	>39	MG/DL	L	F	Clinical Pathology Laboratories
-CALC LDL CHOL	[redacted]	<100	MG/DL		F	Clinical Pathology Laboratories

NOTES on 'CALC LDL CHOL':
UNABLE TO CALCULATE A VALID LDL CHOLESTEROL WHEN THE TRIGLYCERIDE VALUE IS GREATER THAN 400 MG/DL.

HEMOGLOBIN A1C **Reported On: 10/28/2016 02:41:46**					F	
-HEMOGLOBIN A1c	[redacted]	4.0-5.6	%	H	F	Clinical Pathology Laboratories

NOTES on 'HEMOGLOBIN A1c':

AMERICAN DIABETES ASSOCIATION GUIDELINES FOR HGB A1C:
GLYCEMIC GOAL IN DIABETES . . . . . <7.0%
DIAGNOSIS OF DIABETES . . . . . >/=6.5%
CONFIRMED ON REPEAT ANALYSIS OR
WITH APPROPRIATE SYMPTOMS.

MICROALBUMIN/CREATININE, RANDOM AND RATIO **Reported On: 10/28/2016 02:27:33**					F	
-CREATININE, URINE, CONC.	81.9	NOT ESTAB	MG/DL		F	Clinical Pathology Laboratories

NOTES on 'CREATININE, URINE, CONC.':

Reference interval for random urine samples has not been established.

-MICROALBUMIN, RANDOM	1.5	<=1.8	MG/DL		F	Clinical Pathology Laboratories

NOTES on 'MICROALBUMIN, RANDOM':

NOTE: Random Microalbumin concentration can be affected by hydration status and dilution. Random Microalbumin/Creatinine Ratio is less sensitive to dilution and is recommended by ADA and NKF to assess for diabetic or chronic kidney disease.

INTERNAL MEDICINE OF SPRING V Y
5380 S RAINBOW BLVD STE 218
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID# / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955 F	TITINA FARRIS	Clinical Pathology Laboratories
DOB		
[redacted]		
AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD
LAB ID #	SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
4740	Specimen ID: UW987816 Type: Source: Condition:	11/02/2016 08:55:15 / 10/29/2016 10:04:14
		COLLECTION DATE / TIME / FASTING
		10/26/2016 16:45:00 / NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-CALC MICROALB/CREAT RND	18	<30	MG/G		F	Clinical Pathology Laboratories
TSH **Reported On: 10/28/2016 05:51:31**					F	
-TSH	1.9	0.5-4.7	UIU/ML		F	Clinical Pathology Laboratories
VITAMIN D, 25 OH **Reported On: 10/28/2016 03:42:25**					F	
-VITAMIN D, 25 OH	18	SEE BELOW	NG/ML	L	F	Clinical Pathology Laboratories

NOTES on 'VITAMIN D, 25 OH':

NOTE: 25-HYDROXYVITAMIN D ASSAY INCLUDES 25-HYDROXYVITAMIN D2
AND D3. METHODOLOGY IS CHEMILUMINESCENT IMMUNOASSAY.

***** INTERPRETIVE RANGES *****

PEDIATRIC (<17 YEARS)	NG/ML	20-100
ADULT:		
INSUFFICIENT	NG/ML	<20
SUBOPTIMAL	NG/ML	20-29
OPTIMAL	NG/ML	30-100

UNLESS OTHERWISE INDICATED, ALL TESTING PERFORMED AT
CLINICAL PATHOLOGY LABORATORIES, INC. 9200 WALL ST AUSTIN, TX 78754
LABORATORY DIRECTOR: MARK A. SILBERMAN, M.D.
CLIA NUMBER 45D0505003 CAP ACCREDITATION NO. 21525-01

**Signed Off by N. Chaney, MD on 11/4/2016 3:58:38 PM.
**Comments: [Added by N. Chaney, MD] / [Added by N. Chaney, MD]

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TINA (DOB: [redacted]) Nov 29, 2018 10:05:28 PM

CC REFILLS, BLADDER INFECTION IA

HPI Patient is here for refills and complaints of a urinary tract infections. The results of the patients labs were very concerning. The diabetes is clearly not controlled. The patient states that she will improve her glycemic control. She states she is very motivated but feels that she feel out of control secondary to the holidays.
The triglycerides are high enough that the patient could have spontaneous pancreatitis. She reports understanding.
She reports she no abdominal pain but some nausea. NO altered bowel movement.
She reports she has hot flashes that has worsened of late.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.
Critical care neuropathy
Diverting colonostomy

SH Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie.

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, as directed
2) Bydureon 2 mg subcutaneous injection, extended release, one im q week
3) carvedilol 12.5 mg oral tablet, 1 po bid
4) Crestor 5 mg oral tablet, one po qhs
5) Cymbalta 60 mg oral delayed release capsule, 1 po qd
6) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days
7) Folbee oral tablet, one po q day
8) four pronged cane
9) glucometer
10) glucometer on plan
11) Horizant 600 mg oral tablet, extended release, one po q day
12) hydrochlorathiazide 25 mg, Take 1 pill by mouth QD (Daily) X 3 Months (90d)
13) ibuprofen 800 mg oral tablet, one po bid pm
14) Ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal
15) lancets and strips, check qid prior to meal

Printed By: NAOMI CHANEY, MD 3/31/2018 12:02:08 PM

Farris, Tina (DOB: [redacted]) Page 2 of 2

16) lancets and strips true trak, check tid prior meals
17) Lantus Solostar Pen 100 units/mL subcutaneous solution, 45 units sq q day
18) Lantus Solostar Pen needles, q day
19) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days
20) lisinopril 2.5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 3 Months (90d)
21) metFORMIN 1000 mg oral tablet, one po bid
22) odanestron 4 mg, one po tid prn
23) pantoprazole 40 mg oral delayed release tablet, one po q day
24) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
25) Percocet 7.5/325 oral tablet, ONE PO BID PRN
26) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals — Wt: 165.4 lb Ht/Ln: 62 in BMI: 30.3 BP: 140/80 Pulse: 105 RR: 12 Sat: 95

PE — WNWD NAD. Affect and behavior are appropriate. Mucosa pink & moist. Positive bowel sounds. Abdomen is soft and non-tender without hepatosplenomegaly appreciated. No rebound or guarding. No CVA tenderness.
wc 41

A/P — # Hot flashes (N95.1):
Nausea (R11.0):
Dysuria (R30.0):
Type II diabetes mellitus uncontrolled (E11.65):
Serum triglycerides raised (R79.89):discussion of spontaneous pancreatitis.
Neuropathy (G62.9):

Plan printed and provided to patient:
PRESCRIBE: Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed, # 90, RF: 0.
PRESCRIBE: odanestron 4 mg, one po tid prn nausea, # 90, RF: 0.
PRESCRIBE: ciprofloxacin 500 mg oral tablet, one po bid for 3 days, # 6, RF: 0.

ORDERED/ADVISED: - Urinalysis ICD Codes (R30.0, N95.1, R11.0)

PROVIDED: Patient Education (11/29/2016)

Electronically Signed By: NAOMI CHANEY, MD
11/29/16 6:18 PM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS STITNA (DOB: [redacted]) Dec 28, 2016 Wed 06:15 PM

HPI The patient is here on interval follow up. We discussed her blood glucose readings which she states has improved and is confirmed. Evaluation of her foot with nonhealing shallow ulcer. The patient states that she has kept it clean. She understands all out concerns that were outlined in the past.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH
Diabetes.
Hypertenion
Neuropathy.
Critical care neuropathy
Diverting colonostomy

SH Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption.
[Tobacco: Never smoker]
married
daughter 8 - patrick husband
She has several dogs - she toy collie and a Yorkshire interior toy collie
little yorki and chiweenie.

FH
Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) Azithromycin 5 Day Dose Pack 250 mg oral tablet, as directed
2) Bydureon 2 mg subcutaneous injection, extended release, one im q week
3) carvedilol 12.5 mg oral tablet, 1 po bid
4) ciprofloxacin 500 mg oral tablet, one po bid for 3 days
5) Crestor 5 mg oral tablet, one po qhs
6) Cymbalta 60 mg oral delayed release capsule, 1 po qd
7) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days
8) Folbee oral tablet, one po q day
9) four prongad cane
10) glucometer
11) glucometer on plan
12) Horizant 600 mg oral tablet, extended release, one po q day
13) hydrochlorathiazide 25 mg, Take 1 pill by mouth QD (Daily) X 3 Months (90d)
14) ibuprofen 800 mg oral tablet, one po bid prn
15) ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal
16) lancets and strips, check qid prior to meal
17) lancets and strips true trak, check tid prior meals
18) Lantus Solostar Pen 100 units/mL subcutaneous solution, 45 units sq q day
19) Lantus Solostar Pen needles, q day
20) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days
21) lisinopril 2.5 mg oral tablet, Take 1 pill by mouth QD (Daily) X 3 Months (90d)
22) metFORMIN 1000 mg oral tablet, one po bid

Printed By: NAOMI CHANEY, MD 3/31/2018 12:02:14 PM

Amazing Charts [redacted] Page 2

23) odanestron 4 mg, one po tid prn nausea
24) pantoprazole 40 mg oral delayed release tablet, one po q day
25) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
26) Percocet 7.5/325 oral tablet, ONE PO BID PRN
27) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals — Wt: 158 lb Ht/Ln: 62 in BMI: 28.9 BP: 130/78 Pulse: 104 RR: 12 Sat: 97

PE — wc 40 Well nourished and well developed in no acute distress. Affect is normal and appropriate. Mucosa pink and moist. Chest is CTA. Heart is RRR without murmers. Foot with 3cm by 2cm shallow area without skin coverage. The area around the site is not erythematous. No exudate.

A/P — # Diabetic foot ulcer (E11.40):
Neuropathy (G62.9):
Chronic back pain (R52):
Type II diabetes mellitus uncontrolled (E11.65):

Plan printed and provided to patient:
PRESCRIBE: Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days, # 10, RF: 0.
PRESCRIBE: clindamycin 1% topical foam, clean area q day, # 50, RF: 1.
PRESCRIBE: Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed, # 90, RF: 0.

ORDERED/ADVISED: - Ultrasound (arterial ultrasound) ICD Codes (E11.40)
- MRI (left foot) ICD Codes (E11.40)

ORDERED/ADVISED: - CBC with diff (automated) ICD Codes (E11.40)
- c reactive protein ICD Codes (E11.40)
- ESR (Erythrocyte Sedimentation Rate) ICD Codes (E11.40)

ORDERED/ADVISED: - Message (wound specialist - dr.javed) ICD Codes (E11.40)

PROVIDED: Patient Education (12/28/2016)

Electronically Signed By: NAOMI CHANEY, MD
12/28/16 5:43 PM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

HARRIS, TINA (DOB: [redacted]) Apr 26, 2017 W8CH10:38 AM

HPI
Patient with diabetes that historically has not been well controlled.
She has not been able to get her labs done before this visit. Ive reminded the patient that this is necessary in order to manage her numbers well.
She reports no new episodes of abdominal pain.
She reports that her sugars are running in the high one hundreds.
She continues to have neuropathic pain. Ive explained this is in part related to the diabetes.
Patient reports understanding and the need to control her numbers.
She shows me changes related to her hands. Ive explained this is Dupuytrens contracture.

ROS
10 system reviewed and performed by patient on the Phressia tablet.

PMH
Diabetes.
Hypertenion
Neuropathy.
Critical care neuropathy
Diverting colonostomy
Dupuytren's contracture.

SH
Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption.
[Tobacco: Never smoker]
Denies alcohol.
Married.
Husband - Patrick.
2 daughters, 1 son.
Pets: several dogs.

FH
Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies
asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) carvedilol 12.5 mg oral tablet, 1 po bid
2) DULoxetine 60 mg oral delayed release capsule, one po q day
3) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days
4) four pronged cane
5) ibuprofen 800 mg oral tablet, one po bid prn
6) Ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal
7) kcl 10 meq, one po q day
8) Lantus Solostar Pen 100 units/mL subcutaneous solution, 85 units sq q day
9) Lasix 20 mg oral tablet, one po q day
10) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days
11) lisinopril 2.5 mg oral tablet, one po q day
12) metFORMIN 1000 mg oral tablet, one po bid
13) odanestron 4 mg, one po tid prn nausea
14) olopatadine 0.2% ophthalmic solution, one drip bid
15) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
16) predniSONE 10 mg oral tablet, 3 po times one then one po tid for 2 days then 1 po bid for

Printed By: NAOMI CHANEY, MD 3/31/2018 12:03:16 PM

Amezquita Charts [redacted] Page 1 of 2

PLTFF9914

2 days then 1 po q day for 2 days then stop
17) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals — Wt: 161 lb Ht/Ln: 64 in BMI: 27.6 BP: 142/80 Pulse: 99 RR: 12 Sat: 98

PE — Well nourished and well developed in no acute distress. Affect is normal and appropriate. Mucosa pink and moist. Chest is CTA. Heart is RRR without murmers. Gait is abnormal. Bilateral dupuytren's contracture.

A/P
Chronic back pain (R52):
Diabetes mellitus type 2 (E11.9):
Dyslipidemia (E78.5):
Hypertension (I10):
Neuropathy (G62.9):
Dupuytren's disease of palm (M72.0):Refer to Hand surgeon

Plan printed and provided to patient:
PRESCRIBE: Percoset 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed, 90, RF: 0.
ORDERED/ADVISED: - HGBA1C ICD Codes (R52, E11.9, E78.5, I10, G62.9)
- REGULAR - cbc, cmp urine analysis with reflex to culture and sensitivity, lipid , tsh, vitamin d ICD Codes (R52, E11.9, E78.5, I10, G62.9)
- URINE MICROALBUMIN ICD Codes (R52, E11.9, E78.5, I10, G62.9)

PROVIDED: Patient Education (4/26/2017)

Electronically Signed By: NAOMI CHANEY, MD
4/26/17 10:58 AM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TINA [redacted] MAY 25, 2017 10:10:51 PM

CC FU APPT/ PHYSICAL

HPI The patient is here on interval follow up. She has known history of diabetes without labs of long standing despite multiple requests for labs. Barrier to care includes transportation. The patient understands the necessity to monitor her blood glucose but is forthright in that she is sporadic. She has neuropathy, diabetes, hypertension, dupuytrens contracture. She is not current on screens and will do a pap on follow up.
She will do the blood work prior to next appointment.
She requires refills on her pain medication for neuropathy.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.
Critical care neuropathy
Diverting colonostomy
Dupuytrens's contracture.

SH Patient denies any tobacco use or recreational drug use.
[Tobacco: Never smoker]
Denies alcohol.
Married.
Husband - Patrick.
2 daughters, 1 son.
Pets: several dogs.

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) carvedilol 12.5 mg oral tablet, 1 po bid
2) DULoxetine 60 mg oral delayed release capsule, one po q day
3) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days
4) four pronged cane
5) ibuprofen 800 mg oral tablet, one po bid prn
6) ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal
7) kcl 10 meq, one po q day
8) Lantus Solostar Pen 100 units/mL subcutaneous solution, 85 units sq q day
9) Lasix 20 mg oral tablet, one po q day
10) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days
11) lisinopril 2.5 mg oral tablet, one po q day
12) metFORMIN 1000 mg oral tablet, one po bid
13) odanestron 4 mg, one po tid prn nausea
14) olopatadine 0.2% ophthalmic solution, one drip bid

Printed By: NAOMI CHANEY, MD 3/31/2018 12:03:26 PM

Visit Information Page 1 of 2

15) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
16) predniSONE 10 mg oral tablet, 3 po times one then one po tid for 2 days then 1 po bid for 2 days then 1 po q day for 2 days then stop
17) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals — Wt: 163 lb Ht/Ln: 64 in BMI: 28.0 BP: 141/80 Pulse: 78 RR: 12 Sat: 98

PE
GENERAL: WNWD NAD
HEENT: WNL
LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.
WC 40

A/P
Routine general medical examination at a health care facility (Z00.00):
Diabetes mellitus (E11.9):

Plan printed and provided to patient:
PRESCRIBE: Percoset 10/325 oral tablet, Take 1 pill by mouth TID X 1 Month (30d) As Needed, # 90, RF: 0.
ORDERED/ADVISED: - COTININE ICD Codes (E11.9, Z00.00)
- HGBA1C ICD Codes (E11.9, Z00.00)
- REGULAR - cbc, cmp urine analysis with reflex to culture and sensitivity, lipid , tsh, vitamin d ICD Codes (E11.9, Z00.00)
- URINE MICROALBUMIN ICD Codes (E11.9, Z00.00)

PROVIDED: Patient Education (5/25/2017)

Electronically Signed By: NAOMI CHANEY, MD
5/25/17 2:12 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 12:03:26 PM

INTERNAL MEDICINE OF SPRING EY
5380 S RAINBOW BLVD STE 2__
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

PAT ID	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories
DOB			
[redacted]			

AGE	ACCESSION	ORDERING PROVIDER	
55	[redacted]	Naomi Chaney, MD	
LAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
8770	Specimen ID: UZ458371 Type: Source: Condition:	07/05/2017 13:59:05	07/02/2017 15:51:12
		COLLECTION DATE/TIME	FASTING
		06/29/2017 15:25:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLAG	STATUS	PERFORMED BY
INDICATED URINE CULTURE **Reported On: 07/02/2017 15:51:12**					F	
-CULTURE, URINE	SPECIMEN NUMBER: 17502620	--	--	A	F	Clinical Pathology Laboratories

NOTES on 'CULTURE, URINE':

CULTURE, URINE
SPECIMEN NUMBER: 17502620

SOURCE: URINE

REPORT STATUS: FINAL

ISOLATE NUMBER 1:
ORGANISM:
07/01/2017 >100,000 CFU/ML GRAM NEGATIVE BACILLI

IDENTIFICATION:
07/02/2017 KLEBSIELLA PNEUMONIAE

K. PNEUMONIAE

AMOXICILLIN/CA	SENSITIVE	<=8/4
AMPICILLIN	RESISTANT	16
CEFAZOLIN	SENSITIVE	<=8
CEFTRIAXONE	SENSITIVE	<=8
CEFUROXIME	SENSITIVE	<=4
CIPROFLOXACIN	SENSITIVE	<=1
LEVOFLOXACIN	SENSITIVE	<=2
NITROFURANTOIN	SENSITIVE	<=32
PIP/TAZOBAC	SENSITIVE	<=16
TETRACYCLINE	SENSITIVE	<=4
TRIMETH/SULFA	SENSITIVE	<=2/38

NOTE: NUMBERS DISPLAYED REPRESENT MINIMUM INHIBITORY CONCENTRATION (MIC) WHICH IS EXPRESSED IN MCG/ML.

CBC W/AUTO DIFF WITH PLATELETS **Reported On: 06/30/2017 06:03:13**				F	
-WBC	10.0	4.0-11.0	K/UL	F	Clinical Pathology Laboratories
-RBC	4.17	3.80-5.10	M/UL	F	Clinical Pathology Laboratories
-HEMOGLOBIN	12.2	11.5-15.5	G/DL	F	Clinical Pathology

INTERNAL MEDICINE OF SPRING EY
5380 S RAINBOW BLVD STE
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID #	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories

DOB: [redacted]

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD

LAB ID #	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
8770	Specimen ID: UZ458371 Type: Source: Condition:	07/05/2017 13:59:05	07/02/2017 15:51:12
		COLLECTION DATE/TIME	FASTING
		06/29/2017 15:25:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLAG	STATUS	PERFORMED BY
-HEMATOCRIT	34.9	34.0-45.0	%		F	Laboratories Clinical Pathology Laboratories
-MCV	83.7	80.0-100.0	fL		F	Clinical Pathology Laboratories
-MCH	29.3	27.0-34.0	PG		F	Clinical Pathology Laboratories
-MCHC	35.0	32.0-35.5	G/DL		F	Clinical Pathology Laboratories
-RDW	13.3	11.0-15.0	%		F	Clinical Pathology Laboratories
-NEUTROPHILS	50.7	40.0-74.0	%		F	Clinical Pathology Laboratories
-LYMPHOCYTES	40.5	19.0-48.0	%		F	Clinical Pathology Laboratories
-MONOCYTES	6.0	4.0-13.0	%		F	Clinical Pathology Laboratories
-EOSINOPHILS	2.1	0.0-7.0	%		F	Clinical Pathology Laboratories
-BASOPHILS	0.7	0.0-2.0	%		F	Clinical Pathology Laboratories
-PLATELET COUNT	[redacted]	130-400	K/UL	H	F	Clinical Pathology Laboratories
TSH					F	
Reported On: 06/30/2017 08:22:02						
-TSH	1.260	0.400-4.100	UIU/ML		F	Clinical Pathology Laboratories
COMPREHENSIVE METABOLIC PANEL					F	
Reported On: 06/30/2017 07:50:46						
-GLUCOSE	[redacted]	70-99	MG/DL	H	F	Clinical Pathology Laboratories
-BUN	12	6-20	MG/DL		F	Clinical Pathology Laboratories
-CREATININE	0.79	0.60-1.30	MG/DL		F	Clinical Pathology

INTERNAL MEDICINE OF SPRING [illegible] EY
5380 S RAINBOW BLVD STE 2[illegible]
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID# / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955 F	TITINA FARRIS	Clinical Pathology Laboratories
DOB: [redacted]		
AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD
LAB ID	SPECIMEN INFORMATION	RECEIVED ON: 07/05/2017 13:59:05
8770	Specimen ID: UZ458371 Type: Source: Condition:	REPORTED ON: 07/02/2017 15:51:12
		COLLECTION DATE / TIME: 06/29/2017 15:25:00
		FASTING: NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-eGFR AFRICAN AMER.	98	>60	ML/MIN/1.73		F	Clinical Pathology Laboratories
-eGFR NON-AFRICAN AMER.	85	>60	ML/MIN/1.73		F	Clinical Pathology Laboratories
-CALC BUN/CREAT	15	6-28	RATIO		F	Clinical Pathology Laboratories
-SODIUM	[redacted]	133-146	MEQ/L	L	F	Clinical Pathology Laboratories
-POTASSIUM	4.6	3.5-5.4	MEQ/L		F	Clinical Pathology Laboratories
-CHLORIDE	[redacted]	95-107	MEQ/L	L	F	Clinical Pathology Laboratories
-CARBON DIOXIDE	23	19-31	MEQ/L		F	Clinical Pathology Laboratories
-CALCIUM	10.4	8.5-10.5	MG/DL		F	Clinical Pathology Laboratories
-PROTEIN, TOTAL	8.3	6.1-8.3	G/DL		F	Clinical Pathology Laboratories
-ALBUMIN	4.4	3.5-5.2	G/DL		F	Clinical Pathology Laboratories
-CALC GLOBULIN	[redacted]	1.9-3.7	G/DL	H	F	Clinical Pathology Laboratories
-CALC A/G RATIO	1.1	1.0-2.6	RATIO		F	Clinical Pathology Laboratories
-BILIRUBIN, TOTAL	0.3	<=1.2	MG/DL		F	Clinical Pathology Laboratories
-ALKALINE PHOSPHATASE	111	30-111	U/L		F	Clinical Pathology Laboratories
-AST	19	9-40	U/L		F	Clinical Pathology Laboratories
-ALT	23	5-40	U/L		F	Clinical Pathology Laboratories
HEMOGLOBIN A1C					F	

INTERNAL MEDICINE OF SPRING ' EY
5380 S RAINBOW BLVD STE 2..
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories
DOB			
[redacted]			

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD

LAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
8770	Specimen ID: UZ458371 Type: Source: Condition:	07/05/2017 13:59:05	07/02/2017 15:51:12
		COLLECTION DATE/TIME	FASTING
		06/29/2017 15:25:00	NOT SPECIFIED

NAME	VALUE	NORMALITY	UNITS	Flags	Status	Performed By
Reported On: 06/30/2017 07:33:08						
-HEMOGLOBIN A1c	193	4.0-5.6	%	H	F	Clinical Pathology Laboratories

NOTES on 'HEMOGLOBIN A1c':

AMERICAN DIABETES ASSOCIATION GUIDELINES FOR HGB A1C:
PREDIABETES/INCREASED RISK 5.7-6.4%
DIAGNOSIS OF DIABETES . . . . . >=6.5%
WITH CONFIRMATION OR APPROPRIATE SYMPTOMS

NOTE: ASSAY MAY BE AFFECTED BY HEMOGLOBINOPATHIES (SICKLE CELL ANEMIA, S-C DISEASE, OTHERS) OR ARTIFICIALLY LOWERED BY DECREASED RED CELL SURVIVAL (HEMOLYTIC ANEMIAS, BLOOD LOSS, ETC.). CONSIDER ALTERNATE TESTING OR LABORATORY CONSULTATION.

NICOTINE, SERUM/PLASMA, QUANT					F	
Reported On: 07/05/2017 13:54:37						
-COTININE	[redacted]	--	ng/mL		F	Clinical Pathology Laboratories
-3-OH-COTININE	[redacted]	--	ng/mL		F	Clinical Pathology Laboratories
-NICOTINE	[redacted]	--	ng/mL		F	Clinical Pathology Laboratories

NOTES on 'NICOTINE':
Consistent with abstinence from nicotine-containing products for at least 1 week.
INTERPRETIVE INFORMATION: Nicotine and Metabolites, Serum or Plasma,
Quantitative
Methodology: Quantitative Liquid Chromatography-Tandem Mass Spectrometry
Positive cutoff: 2 ng/mL
For medical purposes only; not valid for forensic use.
This test is designed to evaluate recent use of nicotine-containing products. Passive and active exposure cannot be discriminated definitively, although a cutoff of 10 ng/mL cotinine is frequently used for surgery qualification purposes. For smoking cessation programs or compliance testing, the absence of expected drug(s) and/or drug metabolite(s) may indicate non-compliance, inappropriate timing of specimen collection relative to drug administration, poor drug absorption, or limitations of testing. This test cannot distinguish between use of tobacco and purified nicotine products.
The concentration value must be greater than or equal to the cutoff to be reported as positive.
Test developed and characteristics determined by ARUP Laboratories.
See Compliance Statement B: aruplab.com/CS

INTERNAL MEDICINE OF SPRING [illegible] EY
5380 S RAINBOW BLVD STE 2[illegible]
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID# / AGE / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955 F	TITINA FARRIS	Clinical Pathology Laboratories
DOB: [redacted]		
AGE AT STAT	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD
LAB ID #	SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
8770	Specimen ID: UZ458371 Type: Source: Condition:	07/05/2017 13:59:05 / 07/02/2017 15:51:12 COLLECTION DATE/TIME / FASTING 06/29/2017 15:25:00 / NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
TESTING PERFORMED AT ASSOCIATED REGIONAL UNIVERSITY PATHOLOGISTS, INC 500 CHIPETA WAY SALT LAKE CITY, UTAH 84108 CAP NO. 40963-01 CLIA NO. 46D0523979						
URINALYSIS (CULTURE IF INDICATED) **Reported On: 06/30/2017 07:19:19**					F	
-COLOR	YELLOW	YELLOW-STRAW	--		F	Clinical Pathology Laboratories
-APPEARANCE	SLIGHTLY CLOUDY	CLEAR	--		F	Clinical Pathology Laboratories
-SPECIFIC GRAVITY	1.026	1.005-1.035	--		F	Clinical Pathology Laboratories
-LEUKOCYTE ESTERASE	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-NITRITE	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-pH	5.0	5.0-9.0	--		F	Clinical Pathology Laboratories
-PROTEIN	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-GLUCOSE	[redacted]	NEGATIVE	--	A	F	Clinical Pathology Laboratories
-KETONES	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-UROBILINOGEN	2.0	<=2.0	MG/DL		F	Clinical Pathology Laboratories
-BILIRUBIN	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-OCCULT BLOOD	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-WHITE BLOOD CELLS	10-15	0-5	/HPF	A	F	Clinical Pathology Laboratories
-RED BLOOD CELLS	0-5	0-5	/HPF		F	Clinical Pathology Laboratories
-EPITHELIAL CELLS	0	0-10	/HPF		F	Clinical Pathology Laboratories

INTERNAL MEDICINE OF SPRING EY
5380 S RAINBOW BLVD STE 2.
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID #	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories
DOB			
[redacted]			
AGE		ACCESSION #	ORDERING PROVIDER
55		[redacted]	Naomi Chaney, MD
LAB ID		SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
8770		Specimen ID: UZ458371 Type: Source: Condition:	07/05/2017 13:59:05	07/02/2017 15:51:12
			COLLECTION DATE/TIME	FASTING
			06/29/2017 15:25:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-BACTERIA	[redacted]	NEGATIVE	--	A	F	Clinical Pathology Laboratories
-OTHER	SEE BELOW	--	--	A	F	Clinical Pathology Laboratories

NOTES on 'OTHER':
FEW YEAST

MICROALBUMIN, RANDOM F
Reported On: 06/30/2017 08:01:45

-MICROALBUMIN, RANDOM	[redacted]	<=1.8	MG/DL	H	F	Clinical Pathology Laboratories

NOTES on 'MICROALBUMIN, RANDOM':

NOTE: Random Microalbumin concentration can be affected by hydration status and dilution. Random Microalbumin/Creatinine Ratio is less sensitive to dilution and is recommended by ADA and NKF to assess for diabetic or chronic kidney disease.

VITAMIN D, 25 OH F
Reported On: 06/30/2017 08:29:24

-VITAMIN D, 25 OH	[redacted]	SEE BELOW	NG/ML	L	F	Clinical Pathology Laboratories

NOTES on 'VITAMIN D, 25 OH':

NOTE: 25-HYDROXYVITAMIN D ASSAY INCLUDES 25-HYDROXYVITAMIN D2 AND D3. METHODOLOGY IS CHEMILUMINESCENT IMMUNOASSAY.

***** INTERPRETIVE RANGES *****

PEDIATRIC (<17 YEARS)	NG/ML	20-100
ADULT:		
INSUFFICIENT	NG/ML	<20
SUBOPTIMAL	NG/ML	20-29
OPTIMAL	NG/ML	30-100

LIPID PANEL F
Reported On: 06/30/2017 07:50:46

-CHOLESTEROL	[redacted]	<200	MG/DL	H	F	Clinical Pathology Laboratories
-TRIGLYCERIDES	[redacted]	<150	MG/DL	H	F	Clinical Pathology Laboratories
-HDL CHOLESTEROL	[redacted]	>39	MG/DL	L	F	Clinical Pathology Laboratories
-CALC LDL CHOL	NOTE	<100	MG/DL		F	Clinical Pathology

INTERNAL MEDICINE OF SPRING ' EY
5380 S RAINBOW BLVD STE 2_
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID#	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories
DOB		[redacted]	

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD

FAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
8770	Specimen ID: UZ458371 Type: Source: Condition:	07/05/2017 13:59:05	07/02/2017 15:51:12
		COLLECTION DATE/TIME	FASTING STATUS
		06/29/2017 15:25:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
						Laboratories

NOTES on 'CALC LDL CHOL':
UNABLE TO CALCULATE A VALID LDL CHOLESTEROL WHEN THE TRIGLYCERIDE
VALUE IS GREATER THAN 400 MG/DL.

-RISK RATIO LDL/HDL	[redacted]	<3.22	RATIO		F	Clinical Pathology Laboratories

NOTES on 'RISK RATIO LDL/HDL':
UNABLE TO CALCULATE

UNLESS OTHERWISE INDICATED, ALL TESTING PERFORMED AT
CLINICAL PATHOLOGY LABORATORIES, INC. 9200 WALL ST AUSTIN, TX 78754
LABORATORY DIRECTOR: MARK A. SILBERMAN, M.D.
CLIA NUMBER 45D0505003 CAP ACCREDITATION NO. 21525-01

**Signed Off by N. Chaney, MD on 8/6/2017 11:15:43 PM.

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TINA (DOB: [redacted]) Aug 02 2017 Wed 01:24 PM

CC FU 1 MONTH IA

HPI Patient is here on interval follow up to discuss the results of her labs and pap smear. The results were very concerning and this was conveyed to the patient. She has diabetes that is not controlled. She has lipid levels that place her at risk for spontaneous pancreatitis. We discussed this at length. She is under the care of the wound care specialist and understands that she wound care is compromised with elevated glucose. We talked about all these items at length.
The patient defers going to the endocrinologist or cardiologist at this time. She will redouble her efforts in terms of managing her blood glucose. She has my number and she is to text me her readings daily. She agrees to the plan.
She is also seeing the wellness coach.
Her urine is abnormal but she has no symptoms - will repeat urine in light of her history of c. difficile.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.
Critical care neuropathy
Diverting colonostomy

SH Patient denies any tobacco use or recreational drug use. Occassional alcohol consumption.
[Tobacco: Never smoker]
Denies alcohol.
Married.
Husband - Patrick.
2 daughters, 1 son.

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) ALPRAZolam 0.5 mg oral tablet, one po bid prn
2) busPIRone 15 mg oral tablet, one third tab po tid prn
3) carvedilol 12.5 mg oral tablet, 1 po bid
4) citalopram 10 mg oral tablet, one half tab po q day
5) DULoxetine 60 mg oral delayed release capsule, one po q day
6) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days
7) four pronged cane
8) Ibuprofen 800 mg oral tablet, one po bid prn
9) ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal
10) kcl 10 meq, one po q day
11) Lantus Solostar Pen 100 units/mL subcutaneous solution, 85 units sq q day

Printed By: NAOMI CHANEY, MD 3/31/2018 12:03:47 PM

Ambulatory Chart Page 1 of 2

12) Lasix 20 mg oral tablet, one po q day
13) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days
14) lisinopril 2.5 mg oral tablet, one po q day
15) metFORMIN 1000 mg oral tablet, one po bid
16) odanestron 4 mg, one po tid prn nausea
17) olopatadine 0.2% ophthalmic solution, one drip bid
18) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
19) predniSONE 10 mg oral tablet, 3 po times one then one po tid for 2 days then 1 po bid for 2 days then 1 po q day for 2 days then stop
20) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals — Wt: 163 lb Ht/Ln: 64 in BMI: 28.0 BP: 138/71 Pulse: 80 RR: 12 Sat: 98

PE — Well nourished and well developed in no acute distress. Affect is normal and appropriate. Mucosa is pink & moist. Pupils equal and round, extraoccular movements are intact. Extremities show no cyanosis or clubbing. Gait is normal.

A/P
Generalized chronic body pains (R52):
Diabetes mellitus type II (E11.9):
Neuropathy (G62.9):
Diabetic foot ulcer (E11.40):
Dyslipidemia (E78.5):
Abnormal urine (R82.90):

Plant printed and provided to patient:
PRESCRIBE: Crestor 5 mg oral tablet, one po q day, # 90, RF:1.
PRESCRIBE: Januvia 100 mg oral tablet, one po q day, 90, RF: 1.
PRESCRIBE: Percoset 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed, # 90 , RF: 0.
vitamin d 5000 iu a day for 6 months then decrease to 2000 iu a day
PROVIDED: Patient Education (8/2/2017)

Electronically Signed By: NAOMI CHANEY, MD
8/2/17 1:42 PM

PLTF9975

INTERNAL MEDICINE OF SPRING \ :Y
5380 S RAINBOW BLVD STE 2..
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID#	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories

DOB: [redacted]

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD

LAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
10501	Specimen ID: UZ755286 Type: Source: Condition:	10/05/2017 20:58:22	10/01/2017 12:45:58
		COLLECTION DATE/TIME	FASTING
		09/28/2017 17:28:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
INDICATED URINE CULTURE **Reported On: 10/01/2017 12:45:58**					F	
-CULTURE, URINE	SPECIMEN NUMBER: 17755708	--	--	A	F	Clinical Pathology Laboratories

NOTES on 'CULTURE, URINE':

CULTURE, URINE
SPECIMEN NUMBER: 17755708

SOURCE: URINE

REPORT STATUS: FINAL

ISOLATE NUMBER 1:
ORGANISM:
09/30/2017 >100,000 CFU/ML GRAM NEGATIVE BACILLI

IDENTIFICATION:
10/01/2017 KLEBSIELLA PNEUMONIAE

K. PNEUMONIAE

AMOXICILLIN/CA	SENSITIVE	<=8/4
AMPICILLIN	RESISTANT	>16
CEFAZOLIN	SENSITIVE	<=8
CEFTRIAXONE	SENSITIVE	<=8
CEFUROXIME	SENSITIVE	<=4
CIPROFLOXACIN	SENSITIVE	<=1
LEVOFLOXACIN	SENSITIVE	<=2
NITROFURANTOIN	SENSITIVE	<=32
PIP/TAZOBAC	SENSITIVE	<=16
TETRACYCLINE	SENSITIVE	<=4
TRIMETH/SULFA	SENSITIVE	<=2/38

NOTE: NUMBERS DISPLAYED REPRESENT MINIMUM INHIBITORY CONCENTRATION (MIC) WHICH IS EXPRESSED IN MCG/ML.

CBC W/AUTO DIFF WITH PLATELETS **Reported On: 09/29/2017 07:06:04**					F	
-WBC	[redacted]	4.0-11.0	K/UL	H	F	Clinical Pathology Laboratories
-RBC	[redacted]	3.80-5.10	M/UL	L	F	Clinical Pathology Laboratories
-HEMOGLOBIN	11.6	11.5-15.5	G/DL		F	Clinical Pathology

INTERNAL MEDICINE OF SPRING V Y
5380 S RAINBOW BLVD STE 2..
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

PAT ID#	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories
DOB		[redacted]	
AGE		ACCESSION #	ORDERING PROVIDER
55		[redacted]	Naomi Chaney, MD
LAB ID #		SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
10501		Specimen ID: UZ755286 Type: Source: Condition:	10/05/2017 20:58:22	10/01/2017 12:45:58
			COLLECTION DATE/TIME	FASTING
			09/28/2017 17:28:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-HEMATOCRIT	34.3	34.0-45.0	%		F	Clinical Pathology Laboratories
-MCV	90.7	80.0-100.0	fL		F	Clinical Pathology Laboratories
-MCH	30.7	27.0-34.0	PG		F	Clinical Pathology Laboratories
-MCHC	33.8	32.0-36.5	G/DL		F	Clinical Pathology Laboratories
-RDW	12.8	11.0-15.0	%		F	Clinical Pathology Laboratories
-NEUTROPHILS	58	40.0-74.0	%		F	Clinical Pathology Laboratories
-LYMPHOCYTES	31	19.0-48.0	%		F	Clinical Pathology Laboratories
-MONOCYTES	7	4.0-13.0	%		F	Clinical Pathology Laboratories
-EOSINOPHILS	3	0.0-7.0	%		F	Clinical Pathology Laboratories
-BASOPHILS	0	0.0-2.0	%		F	Clinical Pathology Laboratories
-PLATELET COUNT	412	130-400	K/UL	H	F	Clinical Pathology Laboratories

NOTES on 'PLATELET COUNT':

TESTING PERFORMED AT CLINICAL PATHOLOGY LABORATORIES, INC.
650 N. NELLIS BLVD LAS VEGAS, NV 89110
CLIA NO. 29D1075255

URINALYSIS (CULTURE IF INDICATED) F
Reported On: 09/29/2017 06:20:43

-COLOR	YELLOW	YELLOW-STRAW	--		F	Clinical Pathology Laboratories
-APPEARANCE	CLOUDY	CLEAR	--	A	F	Clinical Pathology Laboratories
-SPECIFIC GRAVITY	1.029	1.005-1.035	--		F	Clinical Pathology Laboratories

INTERNAL MEDICINE OF SPRING [illegible]EY
5380 S RAINBOW BLVD STE 2[illegible]
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID #	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories

DOB: [redacted]

AGE	ACCESSION	ORDERING PROVIDER	
55	[redacted]	Napmi Chaney, MD	
LAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
10501	Specimen ID: UZ755286 Type: Source: Condition:	10/05/2017 20:58:22	10/01/2017 12:45:58
		COLLECTION DATE/TIME	FASTING
		09/28/2017 17:28:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLAG	Status	Performed by
-LEUKOCYTE ESTERASE	TRACE [redacted]	NEGATIVE	--	A	F	Clinical Pathology Laboratories
-NITRITE	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-pH	5.5	5.0-9.0	--		F	Clinical Pathology Laboratories
-PROTEIN	[redacted]	NEGATIVE	--	A	F	Clinical Pathology Laboratories
-GLUCOSE	[redacted]	NEGATIVE	--	A	F	Clinical Pathology Laboratories
-KETONES	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-UROBILINOGEN	NORMAL [redacted]	<=2.0	MG/DL		F	Clinical Pathology Laboratories
-BILIRUBIN	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-OCCULT BLOOD	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories

NOTES on 'OCCULT BLOOD':

TESTING PERFORMED AT CLINICAL PATHOLOGY LABORATORIES, INC.
650 N. NELLIS BLVD LAS VEGAS, NV 89110
CLIA NO. 29D1075255

-WHITE BLOOD CELLS	10-15 [redacted]	0-5	/HPF	A	F	Clinical Pathology Laboratories
-RED BLOOD CELLS	03 [redacted]	0-5	/HPF		F	Clinical Pathology Laboratories
-EPITHELIAL CELLS	250 [redacted]	0-10	/HPF	A	F	Clinical Pathology Laboratories
-BACTERIA	3+ [redacted]	NEGATIVE	--	A	F	Clinical Pathology Laboratories
-OTHER	(NOTE) [redacted]	--	--		F	Clinical Pathology Laboratories

NOTES on 'OTHER':
YEAST PRESENT

HEMOGLOBIN A1C F

INTERNAL MEDICINE OF SPRING ' EY
5380 S RAINBOW BLVD STE 2..
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories
DOB		[redacted]	
AGE		ACCESSION	ORDERING PROVIDER
55		[redacted]	Naomi Chaney, MD
LAB ID		SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
10501		Specimen ID: UZ755286 Type: Source: Condition:	10/05/2017 20:58:22 / 10/01/2017 12:45:58 COLLECTION DATE/TIME / FASTING 09/28/2017 17:28:00 / NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLAG	Status	Performed By
Reported On: 09/30/2017 03:48:17						
-HEMOGLOBIN A1c	[redacted]	4.0-5.6	%	H	F	Clinical Pathology Laboratories

NOTES on 'HEMOGLOBIN A1c':

AMERICAN DIABETES ASSOCIATION GUIDELINES FOR HGB A1C:
PREDIABETES/INCREASED RISK 5.7-6.4%
DIAGNOSIS OF DIABETES . . . . . >=6.5%
WITH CONFIRMATION OR APPROPRIATE SYMPTOMS

NOTE: ASSAY MAY BE AFFECTED BY HEMOGLOBINOPATHIES (SICKLE CELL ANEMIA, S-C DISEASE, OTHERS) OR ARTIFICIALLY LOWERED BY DECREASED RED CELL SURVIVAL (HEMOLYTIC ANEMIAS, BLOOD LOSS, ETC.). CONSIDER ALTERNATE TESTING OR LABORATORY CONSULTATION.

LIPID PANEL					F	
Reported On: 09/30/2017 00:36:11						
-CHOLESTEROL	[redacted]	<200	MG/DL	H	F	Clinical Pathology Laboratories
-TRIGLYCERIDES	[redacted]	<150	MG/DL	H	F	Clinical Pathology Laboratories

NOTES on 'TRIGLYCERIDES':
*****SPECIMEN LIPEMIC
RESULTS RECHECKED AND VERIFIED

-HDL CHOLESTEROL	[redacted]	>39	MG/DL	L	F	Clinical Pathology Laboratories
-CALC LDL CHOL	[redacted]	<100	MG/DL		F	Clinical Pathology Laboratories

NOTES on 'CALC LDL CHOL':
UNABLE TO CALCULATE A VALID LDL CHOLESTEROL WHEN THE TRIGLYCERIDE VALUE IS GREATER THAN 400 MG/DL.

-RISK RATIO LDL/HDL	[redacted]	<3.22	RATIO		F	Clinical Pathology Laboratories

NOTES on 'RISK RATIO LDL/HDL':
UNABLE TO CALCULATE

TSH					F	
Reported On: 09/30/2017 02:37:54						
-TSH	1.550	0.400-4.100	UIU/ML		F	Clinical Pathology Laboratories
VITAMIN D, 25 OH					F	
Reported On: 09/30/2017 02:50:52						

INTERNAL MEDICINE OF SPRING EY
5380 S RAINBOW BLVD STE
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID# / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955 F	TITINA FARRIS	Clinical Pathology Laboratories
DOB / AGE		
[redacted]		
AGE AT TEST	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD
LAB ID	SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
10501	Specimen ID: UZ755286 Type: Source: Condition:	10/05/2017 20:58:22 / 10/01/2017 12:45:58
	COLLECTION DATE/TIME	FASTING
	09/28/2017 17:28:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-VITAMIN D, 25 OH	25	SEE BELOW	NG/ML	L	F	Clinical Pathology Laboratories

NOTES on 'VITAMIN D, 25 OH':

NOTE: 25-HYDROXYVITAMIN D ASSAY INCLUDES 25-HYDROXYVITAMIN D2 AND D3. METHODOLOGY IS CHEMILUMINESCENT IMMUNOASSAY.

***** INTERPRETIVE RANGES *****

PEDIATRIC (<17 YEARS)	NG/ML	20-100
ADULT:		
INSUFFICIENT	NG/ML	<20
SUBOPTIMAL	NG/ML	20-29
OPTIMAL	NG/ML	30-100

COMPREHENSIVE METABOLIC PANEL
Reported On: 09/30/2017 00:36:11

-GLUCOSE	255	70-99	MG/DL	H	F	Clinical Pathology Laboratories
-BUN	21	6-20	MG/DL	H	F	Clinical Pathology Laboratories
-CREATININE	0.80	0.60-1.30	MG/DL		F	Clinical Pathology Laboratories
-eGFR AFRICAN AMER.	97	>60	ML/MIN/1.73		F	Clinical Pathology Laboratories
-eGFR NON-AFRICAN AMER.	84	>60	ML/MIN/1.73		F	Clinical Pathology Laboratories
-CALC BUN/CREAT	26	6-28	RATIO		F	Clinical Pathology Laboratories
-SODIUM	136	133-146	MEQ/L		F	Clinical Pathology Laboratories
-POTASSIUM	4.7	3.5-5.4	MEQ/L		F	Clinical Pathology Laboratories
-CHLORIDE	97	95-107	MEQ/L		F	Clinical Pathology Laboratories
-CARBON DIOXIDE	24	19-31	MEQ/L		F	Clinical Pathology Laboratories
-CALCIUM	10.1	8.5-10.5	MG/DL		F	Clinical Pathology Laboratories

INTERNAL MEDICINE OF SPRING [illegible]Y
5380 S RAINBOW BLVD STE 2[illegible]
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

PAT ID#	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories

DOB: [redacted]

AGE AT ACC	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD

PAT ID #	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
10501	Specimen ID: UZ755286 Type: Source: Condition:	10/05/2017 20:58:22	10/01/2017 12:45:58

COLLECTION DATE/TIME	FASTING
09/28/2017 17:28:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	FLG	Status	Performed By
-PROTEIN, TOTAL	8.0	6.1-8.3	G/DL		F	Clinical Pathology Laboratories
-ALBUMIN	4.2	3.5-5.2	G/DL		F	Clinical Pathology Laboratories
-CALC GLOBULIN	[redacted]	1.9-3.7	G/DL	H	F	Clinical Pathology Laboratories
-CALC A/G RATIO	1.1	1.0-2.6	RATIO		F	Clinical Pathology Laboratories
-BILIRUBIN, TOTAL	0.2	<=1.2	MG/DL		F	Clinical Pathology Laboratories
-ALKALINE PHOSPHATASE	107	30-111	U/L		F	Clinical Pathology Laboratories
-AST	16	9-40	U/L		F	Clinical Pathology Laboratories
-ALT	18	5-40	U/L		F	Clinical Pathology Laboratories
NICOTINE, SERUM/PLASMA, QUANT **Reported On: 10/05/2017 13:55:11**					F	
-COTININE	[redacted]	--	ng/mL		F	Clinical Pathology Laboratories
-3-OH-COTININE	[redacted]	--	ng/mL		F	Clinical Pathology Laboratories
-NICOTINE	[redacted]	--	ng/mL		F	Clinical Pathology Laboratories

NOTES on 'NICOTINE':
Consistent with abstinence from nicotine-containing products for at least 1 week.
INTERPRETIVE INFORMATION: Nicotine and Metabolites, Serum or Plasma, Quantitative
Methodology: Quantitative Liquid Chromatography-Tandem Mass Spectrometry
Positive cutoff: 2 ng/mL
For medical purposes only; not valid for forensic use.
This test is designed to evaluate recent use of nicotine-containing products. Passive and active exposure cannot be discriminated definitively, although a cutoff of 10 ng/mL cotinine is frequently used for surgery qualification purposes. For smoking cessation programs or compliance testing, the absence of expected drug(s) and/or drug metabolite(s) may indicate non-compliance, inappropriate

INTERNAL MEDICINE OF SPRING LEY
5380 S RAINBOW BLVD STE
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

PID	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories
DOB			
[redacted]			

AGE	ACCESSION	ORDERING PROVIDER	
55	[redacted]	Naomi Chaney, MD	
LAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
10501	Specimen ID: UZ755286 Type: Source: Condition:	10/05/2017 20:58:22	10/01/2017 12:45:58
		COLLECTION DATE/TIME	FASTING
		09/28/2017 17:28:00	NOT SPECIFIED

NAME	VALUE	NORMAL VALUE	UNITS	Flag	Status	Performed By

timing of specimen collection relative to drug administration, poor drug absorption, or limitations of testing. This test cannot distinguish between use of tobacco and purified nicotine products. The concentration value must be greater than or equal to the cutoff to be reported as positive.
Test developed and characteristics determined by ARUP Laboratories.
See Compliance Statement B: aruplab.com/CS

TESTING PERFORMED AT ASSOCIATED REGIONAL UNIVERSITY PATHOLOGISTS, INC
500 CHIPETA WAY SALT LAKE CITY, UTAH 84108
CAP NO. 40963-01 CLIA NO. 46D0523979

UNLESS OTHERWISE INDICATED, ALL TESTING PERFORMED AT
CLINICAL PATHOLOGY LABORATORIES, INC. 9200 WALL ST AUSTIN, TX 78754
LABORATORY DIRECTOR: MARK A. SILBERMAN, M.D.
CLIA NUMBER 45D0505003 CAP ACCREDITATION NO. 21525-01

**Signed Off by N. Chaney, MD on 11/12/2017 9:23:31 AM.

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TINA (DoB: [redacted]) Nov 30, 2017 7th 06:21 PM

CC f/u 4weeks rpr

HPI The patient reports full compliance with medications related to diabetes, dyslipidemia and blood pressure. She is on an ACE inhibitor.
With discussed in the past that the patient would benefit from following up with subspecialists include cardiology, endocrinology and establishing care with pain management.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.
Critical care neuropathy
Diverting colonostomy
Dupuytren's contracture
Dyslipidemia

SH Patient denies any tobacco use or recreational drug use.
[Tobacco: Never smoker]
Denies alcohol.
Married.
Husband-Patrick.
2 daughters, 1 son.
Pets: several dogs

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) ALPRAZolam 0.5 mg oral tablet, one po bid pm
2) busPIRone 15 mg oral tablet, one third tab po tid pm
3) carvedilol 12.5 mg oral tablet, 1 po bid
4) citalopram 10 mg oral tablet, one half tab po q day
5) Crestor 10 mg oral tablet, one po q day
6) DULoxetine 60 mg oral delayed release capsule, one po q day
7) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days
8) four pronged cane
9) ibuprofen 800 mg oral tablet, one po bid pm
10) ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal
11) Jardiance 10 mg oral tablet, one po q day
12) kcl 10 meq, one po q day
13) Lantus Solostar Pen 100 units/mL subcutaneous solution, 85 units sq q day
14) Lasix 20 mg oral tablet, one po q day
15) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days
16) lisinopril 2.5 mg oral tablet, one po q day

Printed By: NAOMI CHANEY, MD 3/31/2018 12:04:25 PM

Andrea Chaney Page 1 of 2

17) metFORMIN 1000 mg oral tablet, one po bid
18) odanestron 4 mg, one po tid prn nausea
19) olopatadine 0.2% ophthalmic solution, one drip bid
20) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
21) predniSONE 10 mg oral tablet, 3 po times one then one po tid for 2 days then 1 po bid for 2 days then 1 po q day for 2 days then stop
22) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals: Wt: 165.2 lb Ht/Ln: 64 in BMI: 28.4 BP: 120/60 Pulse: 95 RR: 12 Sat: 98

PE: Well nourished and well developed in no acute distress. Affect is normal and appropriate. Mucosa pink and moist. Chest is CTA. Heart is RRR without murmers. Gait is abnormal .

A/P:
Dyslipidemia (E78.5):
Hypertension (I10):
Insulin treated type 2 diabetes mellitus (E11.9):
Chronic pain (R52):
Neuropathy (G62.9):

Plan printed and provided to patient:
PRESCRIBE: Lantus Solostar Pen 100 units/mL subcutaneous solution, 85 units a day, # 3, RF: 3.
PRESCRIBE: Jardiance 25 mg oral tablet, one po q day, # 30 , RF: 5.
PRESCRIBE: Januvia 100 mg oral tablet, one po q day, # 90 , RF: 1.
PRESCRIBE: Percocet 10/325 oral tablet, Take 1 pill by mouth TID X 1 Month (30d) As Needed, # 90 , RF: 0.
PRESCRIBE: accucheck smart view lancets and strips, three times a day, # 100 , RF: 3.

ORDERED/ADVISED: - HGBA1C ICD Codes (E78.5, I10, E11.9)
- REGULAR - cbc, cmp urine analysis with reflex to culture and sensitivity, lipid , tsh, vitamin d ICD Codes (E78.5, I10, E11.9)
- URINE MICROALBUMIN ICD Codes (E78.5, I10, E11.9)

Electronically Signed By: NAOMI CHANEY, MD
11/30/17 6:44 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 12:04:25 PM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

HARRIS, TIINA (DOB: [redacted]) Jan 05 2018 at 09:24 AM

CC refills kd

HPI The patient is here in interval follow-up to obtain refills on her medication. She did not take her blood pressure medications morning and that is why her blood pressure so high. Additionally, reports the pain in her feet are much worse.
She has been referred to Dr. Betsy Palal endocrinologyfor menagement of her diabetes. We will obtain labs today. Her last blood work was in September which was markedly concerning. Additionally, I have referred the patient forward to cardiology.
She reports intermittently she has become nauseous but denies chest pain or chest pressure shortness of breath or fatigue related to exertion.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.
Critical care neuropathy
Diverting colonostomy
Dupuytren's contracture
Dyslipidemia

SH Patient denies any tobacco use or recreational drug use.
[Tobacco: Never smoker]
denies alcohol.
Married.
Husband-Patrick.
2 daughters, 1 son.
Pets: several dogs.

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) accucheck smart view lancets and strips, three times a day
2) ALPRAZolam 0.5 mg oral tablet, one po bid prn
3) busPIRone 15 mg oral tablet, one third tab po tid prn
4) carvedilol 12.5 mg oral tablet, 1 po bid
5) citalopram 10 mg oral tablet, one half tab po q day
6) Crestor 10 mg oral tablet, one po q day
7) DULoxetine 60 mg oral delayed release capsule, one po q day
8) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days
9) four pronged cane
10) ibuprofen 800 mg oral tablet, one po bid prn
11) ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal
12) Januvia 100 mg oral tablet, one po q day

Printed By: NAOMI CHANEY, MD 3/31/2018 12:04:32 PM

Page 1 of 2

13) Jardiance 25 mg oral tablet, one po q day
14) kcl 10 meq, one po q day
15) Lantus Solostar Pen 100 units/mL subcutaneous solution, 85 units sq q day
16) Lasix 20 mg oral tablet, one po q day
17) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days
18) lisinopril 2.5 mg oral tablet, one po q day
19) metFORMIN 1000 mg oral tablet, one po bid
20) odanestron 4 mg, one po tid prn nausea
21) olopatadine 0.2% ophthalmic solution, one drip bid
22) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
23) predniSONE 10 mg oral tablet, 3 po times one then one po tid for 2 days then 1 po bid for 2 days then 1 po q day for 2 days then stop
24) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals — Wt: 157 lb Ht/Ln: 64 in BMI: 26.9 BP: 170/100 Pulse: 86 RR: 12

PE — Well nourished and well developed in no acute distress. Affect is normal and appropriate. Mucosa pink and moist. Chest is CTA. Heart is RRR without murmers. Gait is abnormal.

A/P
Insulin treated type 2 diabetes mellitus (E11.9):
Dyslipidemia (E78.5):
Neuropathy (G62.9):
Chronic pain (R52):
Hypertension (I10):

Plan printed and provided to patient:
PRESCRIBE: Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed, # 90 , RF: 0.
PRESCRIBE: odanestron 4 mg, one po tid prn nausea, # 90 , RF: 0.
ORDERED/ADVISED: - COTININE ICD Codes (E78.5, E11.9, G62.9)
- HGBA1C ICD Codes (E78.5, E11.9, G62.9)
- URINE MICROALBUMIN ICD Codes (E78.5, E11.9, G62.9)
- REGULAR - cbc, cmp urine analysis with reflex to culture and sensitivity, lipid , tsh, vitamin d ICD Codes (E78.5, E11.9, G62.9)

ORDERED/ADVISED: - CT CHEST LOW DOSE RADIATION (LUNG SCREENING) ICD Codes (E78.5, E11.9, G62.9, Z72.0)
- Steinberg Diagnostic Imaging - MAIN NUMBER - 702 732 6000 ICD Codes (E78.5, E11.9, G62.9, Z72.0)

Electronically Signed By: NAOMI CHANEY, MD
1/9/18 5:05 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 12:04:32 PM

INTERNAL MEDICINE OF SPRING EY
5380 S RAINBOW BLVD STE
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

DOB / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955 F	TITINA FARRIS	Clinical Pathology Laboratories
DOB: [redacted]		

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD

LAB ID #	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
11779	Specimen ID: U1706867 Type: Source: Condition:	01/15/2018 08:46:04	01/12/2018 11:53:16
		COLLECTION DATE/TIME	FASTING
		01/09/2018 11:49:00	NOT SPECIFIED

NAME	VALUE	NORMALS	UNITS	Flag	Status	Performed By
INDICATED URINE CULTURE **Reported On: 01/12/2018 11:53:16**					F	
-CULTURE, URINE	SPECIMEN NUMBER: 18024338	--	--	A	F	Clinical Pathology Laboratories

NOTES on 'CULTURE, URINE':

CULTURE, URINE
SPECIMEN NUMBER: 18024338

SOURCE: URINE

REPORT STATUS: FINAL

ISOLATE NUMBER 1:
ORGANISM:
01/11/2018 >100,000 CFU/ML GRAM NEGATIVE BACILLI

IDENTIFICATION:
01/12/2018 KLEBSIELLA PNEUMONIAE

K. PNEUMONIAE

AMOXICILLIN/CA	SENSITIVE	<=8/4
AMPICILLIN	RESISTANT	>16
CEFAZOLIN	SENSITIVE	<=8
CEFTRIAXONE	SENSITIVE	<=8
CEFUROXIME	SENSITIVE	<=4
CIPROFLOXACIN	RESISTANT	>4
LEVOFLOXACIN	RESISTANT	>4
NITROFURANTOIN	INTERMED	64
PIP/TAZOBAC	SENSITIVE	<=16
TETRACYCLINE	RESISTANT	>8
TRIMETH/SULFA	RESISTANT	>2/38

NOTE: NUMBERS DISPLAYED REPRESENT MINIMUM INHIBITORY CONCENTRATION (MIC) WHICH IS EXPRESSED IN MCG/ML.

CBC W/AUTO DIFF WITH PLATELETS **Reported On: 01/10/2018 07:15:19**					F	
-WBC	[redacted]	4.0-11.0	K/UL	H	F	Clinical Pathology Laboratories
-RBC	4.19	3.80-5.10	M/UL		F	Clinical Pathology Laboratories
-HEMOGLOBIN	12.2	11.5-15.5	G/DL		F	Clinical Pathology

INTERNAL MEDICINE OF SPRING LEY
5380 S RAINBOW BLVD STE [illegible]
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID / AGE / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955 F	TITINA FARRIS	Clinical Pathology Laboratories
DOB: [redacted]		
AGE: 55	ACCESSION #: [redacted]	ORDERING PROVIDER: Naomi Chaney, MD
LAB ID #: 11779	SPECIMEN INFORMATION: Specimen ID: U1706867 Type: Source: Condition:	RECEIVED ON: 01/15/2018 08:46:04
		REPORTED ON: 01/12/2018 11:53:16
		COLLECTION DATE/TIME: 01/09/2018 11:49:00
		FASTING: NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-HEMATOCRIT	35.9	34.0-46.0	%		F	Laboratories Clinical Pathology Laboratories
-MCV	85.7	80.0-100.0	fL		F	Clinical Pathology Laboratories
-MCH	29.1	27.0-34.0	PG		F	Clinical Pathology Laboratories
-MCHC	34.0	32.0-35.5	G/DL		F	Clinical Pathology Laboratories
-RDW	13.5	11.0-15.0	%		F	Clinical Pathology Laboratories
-NEUTROPHILS	60.8	40.0-74.0	%		F	Clinical Pathology Laboratories
-LYMPHOCYTES	28.2	19.0-48.0	%		F	Clinical Pathology Laboratories
-MONOCYTES	7.2	4.0-13.0	%		F	Clinical Pathology Laboratories
-EOSINOPHILS	3.2	0.0-7.0	%		F	Clinical Pathology Laboratories
-BASOPHILS	0.6	0.0-2.0	%		F	Clinical Pathology Laboratories
-PLATELET COUNT	[redacted]	130-400	K/UL	H	F	Clinical Pathology Laboratories
VITAMIN D, 25 OH					F	
Reported On: 01/10/2018 06:54:13						
-VITAMIN D, 25 OH	[redacted]	SEE BELOW	NG/ML	L	F	Clinical Pathology Laboratories

NOTES on 'VITAMIN D, 25 OH':

NOTE: 25-HYDROXYVITAMIN D ASSAY INCLUDES 25-HYDROXYVITAMIN D2 AND D3. METHODOLOGY IS CHEMILUMINESCENT IMMUNOASSAY.

***** INTERPRETIVE RANGES *****

PEDIATRIC (<17 YEARS)	NG/ML	20-100
ADULT:		
INSUFFICIENT	NG/ML	<20
SUBOPTIMAL	NG/ML	20-29
OPTIMAL	NG/ML	30-100

INTERNAL MEDICINE OF SPRING EY
5380 S RAINBOW BLVD STE
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID#	SEX:	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY:
9955	F	TITINA FARRIS	Clinical Pathology Laboratories
DOB			
[redacted]			
AGE		ACCESSION#	ORDERING PROVIDER
55		[redacted]	Naomi Chaney, MD
LAB ID		SPECIMEN INFORMATION	RECEIVED ON
11779		Specimen ID: U1706867 Type: Source: Condition:	01/15/2018 08:46:04
			REPORTED ON
			01/12/2018 11:53:16
			COLLECTION DATE/TIME
			01/09/2018 11:49:00
			FASTING
			NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
TSH					F	
Reported On: 01/10/2018 06:58:20						
-TSH	1.470	0.400-4.100	UIU/ML		F	Clinical Pathology Laboratories
COMPREHENSIVE METABOLIC PANEL					F	
Reported On: 01/10/2018 07:27:44						
-GLUCOSE	[redacted]	70-99	MG/DL	H	F	Clinical Pathology Laboratories
-BUN	13	6-20	MG/DL		F	Clinical Pathology Laboratories
-CREATININE	0.72	0.60-1.30	MG/DL		F	Clinical Pathology Laboratories
-eGFR AFRICAN AMER.	109	>60	ML/MIN/1.73		F	Clinical Pathology Laboratories
-eGFR NON-AFRICAN AMER.	94	>60	ML/MIN/1.73		F	Clinical Pathology Laboratories
-CALC BUN/CREAT	18	6-28	RATIO		F	Clinical Pathology Laboratories
-SODIUM	137	133-146	MEQ/L		F	Clinical Pathology Laboratories
-POTASSIUM	4.2	3.5-5.4	MEQ/L		F	Clinical Pathology Laboratories
-CHLORIDE	98	95-107	MEQ/L		F	Clinical Pathology Laboratories
-CARBON DIOXIDE	25	19-31	MEQ/L		F	Clinical Pathology Laboratories
-CALCIUM	10.0	8.5-10.5	MG/DL		F	Clinical Pathology Laboratories
-PROTEIN, TOTAL	8.3	6.1-8.3	G/DL		F	Clinical Pathology Laboratories
-ALBUMIN	4.2	3.5-5.2	G/DL		F	Clinical Pathology Laboratories
-CALC GLOBULIN	[redacted]	1.9-3.7	G/DL	H	F	Clinical Pathology Laboratories

INTERNAL MEDICINE OF SPRING EY
5380 S RAINBOW BLVD STE 2..
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID#	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories

DOB: [redacted]

AGE	ACCESSION#	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD

PAT ID#	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
11779	Specimen ID: U1706867 Type: Source: Condition:	01/15/2018 08:46:04	01/12/2018 11:53:16
		COLLECTION DATE/TIME	FASTING
		01/09/2018 11:49:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-CALC A/G RATIO	1.0	1.0-2.6	RATIO		F	Clinical Pathology Laboratories
-BILIRUBIN, TOTAL	0.2	<=1.2	MG/DL		F	Clinical Pathology Laboratories
-ALKALINE PHOSPHATASE	105	30-111	U/L		F	Clinical Pathology Laboratories
-AST	11	9-40	U/L		F	Clinical Pathology Laboratories
-ALT	13	5-40	U/L		F	Clinical Pathology Laboratories
HEMOGLOBIN A1C **Reported On: 01/10/2018 08:50:16**					F	
-HEMOGLOBIN A1c	[redacted]	4.2-5.6	%	H	F	Clinical Pathology Laboratories

NOTES on 'HEMOGLOBIN A1c':

AMERICAN DIABETES ASSOCIATION GUIDELINES FOR HGB A1C:
PREDIABETES/INCREASED RISK 5.7-6.4%
DIAGNOSIS OF DIABETES . . . . . >=6.5%
WITH CONFIRMATION OR APPROPRIATE SYMPTOMS

NOTE: ASSAY MAY BE AFFECTED BY HEMOGLOBINOPATHIES (SICKLE CELL ANEMIA, S-C DISEASE, OTHERS) OR ARTIFICIALLY LOWERED BY DECREASED RED CELL SURVIVAL (HEMOLYTIC ANEMIAS, BLOOD LOSS, ETC.). CONSIDER ALTERNATE TESTING OR LABORATORY CONSULTATION.

LIPID PANEL **Reported On: 01/10/2018 07:27:44**					F	
-CHOLESTEROL	[redacted]	<200	MG/DL	H	F	Clinical Pathology Laboratories
-TRIGLYCERIDES	[redacted]	<150	MG/DL	H	F	Clinical Pathology Laboratories
-HDL CHOLESTEROL	[redacted]	>39	MG/DL	L	F	Clinical Pathology Laboratories
-CALC LDL CHOL	[redacted]	<100	MG/DL		F	Clinical Pathology Laboratories

NOTES on 'CALC LDL CHOL':
UNABLE TO CALCULATE A VALID LDL CHOLESTEROL WHEN THE TRIGLYCERIDE VALUE IS GREATER THAN 400 MG/DL.

INTERNAL MEDICINE OF SPRING EY
5380 S RAINBOW BLVD STE 2
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID # / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955 F	TITINA FARRIS	Clinical Pathology Laboratories
DOB / AGE		
[redacted]		
AGE AT COLLECTION	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD
PAT ID #	SPECIMEN INFORMATION	RECEIVED ON / REPORTED ON
11779	Specimen ID: U1706867 Type: Source: Condition:	01/15/2018 08:46:04 01/12/2018 11:53:16
	COLLECTION DATE/TIME	FASTING STATUS
	01/09/2018 11:49:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-RISK RATIO LDL/HDL	(NOTE)	<3.22	RATIO		F	Clinical Pathology Laboratories
NOTES on 'RISK RATIO LDL/HDL': UNABLE TO CALCULATE						
URINALYSIS (CULTURE IF INDICATED) **Reported On: 01/10/2018 06:49:36**					F	
-COLOR	YELLOW	YELLOW-STRAW	--		F	Clinical Pathology Laboratories
-APPEARANCE	CLOUDY	CLEAR	--	A	F	Clinical Pathology Laboratories
-SPECIFIC GRAVITY	1.030	1.005-1.035	--		F	Clinical Pathology Laboratories
-LEUKOCYTE ESTERASE	[redacted]	NEGATIVE	--	A	F	Clinical Pathology Laboratories
-NITRITE	POSITIVE	NEGATIVE	--	A	F	Clinical Pathology Laboratories
-pH	5.0	5.0-9.0	--		F	Clinical Pathology Laboratories
-PROTEIN	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-GLUCOSE	[redacted]	NEGATIVE	--	A	F	Clinical Pathology Laboratories
-KETONES	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-UROBILINOGEN	[redacted]	<=2.0	MG/DL		F	Clinical Pathology Laboratories
-BILIRUBIN	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-OCCULT BLOOD	NEGATIVE	NEGATIVE	--		F	Clinical Pathology Laboratories
-WHITE BLOOD CELLS	[redacted]	0-5	/HPF	A	F	Clinical Pathology Laboratories
-RED BLOOD CELLS	[redacted]	0-5	/HPF		F	Clinical Pathology Laboratories
-EPITHELIAL CELLS	[redacted]	0-10	/HPF		F	Clinical Pathology

INTERNAL MEDICINE OF SPRING .EY
5380 S RAINBOW BLVD STE
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

PATIENT DEMOGRAPHICS		RESULTS PROVIDED BY	
9955 F	TITINA FARRIS	Clinical Pathology Laboratories	
DOB			
[redacted]			
AGE	ACCESSION #	ORDERING PROVIDER	
55	[redacted]	Naomi Chaney, MD	
LAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
11779	Specimen ID: U1706867 Type: Source: Condition:	01/15/2018 08:46:04	01/12/2018 11:53:16
		COLLECTION DATE/TIME	FASTING
		01/09/2018 11:49:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-BACTERIA	[redacted]	NEGATIVE	--	A	F	Laboratories Clinical Pathology Laboratories
-OTHER	[redacted]	-	--		F	Clinical Pathology Laboratories

NOTES on 'OTHER':
FEW YEAST

MICROALBUMIN, RANDOM
Reported On: 01/10/2018 07:22:07

F

-MICROALBUMIN, RANDOM	[redacted]	<=1.8	MG/DL	H	F	Clinical Pathology Laboratories

NOTES on 'MICROALBUMIN, RANDOM':

NOTE: Random Microalbumin concentration can be affected by hydration status and dilution. Random Microalbumin/Creatinine Ratio is less sensitive to dilution and is recommended by ADA and NKF to assess for diabetic or chronic kidney disease.

NICOTINE, SERUM/PLASMA, QUANT
Reported On: 01/13/2018 23:23:01

F

-COTININE	[redacted]	--	ng/mL		F	Clinical Pathology Laboratories
-3-OH-COTININE	[redacted]	--	ng/mL		F	Clinical Pathology Laboratories
-NICOTINE	[redacted]	--	ng/mL		F	Clinical Pathology Laboratories

NOTES on 'NICOTINE':
Consistent with abstinence from nicotine-containing products for at least 1 week.
INTERPRETIVE INFORMATION: Nicotine and Metabolites, Serum or Plasma, Quantitative
Methodology: Quantitative Liquid Chromatography-Tandem Mass Spectrometry
Positive cutoff: 2 ng/mL
For medical purposes only; not valid for forensic use.
This test is designed to evaluate recent use of nicotine-containing products.. Passive and active exposure cannot be discriminated definitively, although a cutoff of 10 ng/mL cotinine is frequently used for surgery qualification purposes. For smoking cessation programs or compliance testing, the absence of expected drug(s) and/or drug metabolite(s) may indicate non-compliance, inappropriate timing of specimen collection relative to drug administration, poor drug absorption, or limitations of testing. This test cannot

INTERNAL MEDICINE OF SPRING EY
5380 S RAINBOW BLVD STE
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

PAT.ID	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories
DOB			
[redacted]			

AGE	ACCESSION #	ORDERING PROVIDER	
55	[redacted]	Naomi Chaney, MD	
LAB ID #	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
11779	Specimen ID: U1706867 Type: Source: Condition:	01/15/2018 08:46:04	01/12/2018 11:53:16
		COLLECTION DATE/TIME	FASTING
		01/09/2018 11:49:00	NOT SPECIFIED

NAME	VALUE	NORMALS	UNITS	Flag	Status	Performed By

distinguish between use of tobacco and purified nicotine products.
The concentration value must be greater than or equal to the cutoff
to be reported as positive.
Test developed and characteristics determined by ARUP Laboratories.
See Compliance Statement B: aruplab.com/CS

TESTING PERFORMED AT ASSOCIATED REGIONAL UNIVERSITY PATHOLOGISTS, INC
500 CHIPETA WAY SALT LAKE CITY, UTAH 84108
CAP NO. 40963-01 CLIA NO. 46D0523979

UNLESS OTHERWISE INDICATED, ALL TESTING PERFORMED AT
CLINICAL PATHOLOGY LABORATORIES, INC. 9200 WALL ST AUSTIN, TX 78754
LABORATORY DIRECTOR: MARK A. SILBERMAN, M.D.
CLIA NUMBER 45D0505003 CAP ACCREDITATION NO. 21525-01

**Signed Off by N. Chaney, MD on 1/28/2018 11:42:26 AM.

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

HARRIS, TINA (DOB: 10/24/1962) (ID: 10008) Feb 06, 2016 Tue 03:23 PM

CC	fu 1 month la
HPI	Patient is here in interval follow-up to discuss the results of her blood work. It is markedly concerning of this was conveyed to the patient. Although her hemoglobin A1c has improved it is markedly elevated and is not consistent with the numbers the patient has been reporting to me. Her cholesterol is high triglycerides are high and she is at risk of spontaneous pancreatitis I've explained to the patient all parameters must be modified. Additionally several referrals have been sent forward I've asked the patient to please be compliant with recommendations. I've explained the neuropathy is worsened with diabetes not adequately controlled.
ROS	10 system reviewed and performed by patient on the Phressia tablet.
PMH	Diabetes. Hypertenion Neuropathy. Critical care neuropathy Diverting colonostomy Dupuytren's contracture Dyslipidemia
SH	Patient denies any tobacco use or recreational drug use. [Tobacco: Never smoker] denies alcohol. Married. Husband-Patrick. 2 daughters, 1 son. Pets: several dogs.
FH	Mother: pacer dx diabetes? Father: good Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.
Allergies	asprin (Updated by Naomi on 01/17/2014 03:37 PM)
Meds	1) accucheck smart view lancets and strips, three times a day 2) ALPRAZolam 0.5 mg oral tablet, one po bid prn 3) busPIRone 15 mg oral tablet, one third tab po tid prn 4) carvedilol 12.5 mg oral tablet, 1 po bid 5) citalopram 10 mg oral tablet, one half tab po q day 6) Crestor 10 mg oral tablet, one po q day 7) DULoxetine 60 mg oral delayed release capsule, one po q day 8) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days 9) four pronged cane 10) Ibuprofen 800 mg oral tablet, one po bid prn 11) Ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal 12) Januvia 100 mg oral tablet, one po q day 13) Jardiance 25 mg oral tablet, one po q day

Printed By: NAOMI CHANEY, MD 3/31/2018 12:04:40 PM

Tina Harris (Chart) Page 2

14) kcl 10 meq, one po q day
15) Lantus Solostar Pen 100 units/mL subcutaneous solution, 85 units sq q day
16) Lasix 20 mg oral tablet, one po q day
17) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days
18) lisinopril 2.5 mg oral tablet, one po q day
19) metFORMIN 1000 mg oral tablet, one po bid
20) odanestron 4 mg, one po tid prn nausea
21) olopatadine 0.2% ophthalmic solution, one drip bid
22) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
23) predniSONE 10 mg oral tablet, 3 po times one then one po tid for 2 days then 1 po bid for 2 days then 1 po q day for 2 days then stop
24) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals — Wt: 163 lb Ht/Ln: 64 in BMI: 28.0 BP: 124/78 Pulse: 84 RR: 12 Sat: 98

PE — Well nourished and well developed in no acute distress. Affect is normal and appropriate. Mucosa pink and moist. Chest is CTA. Heart is RRR without murmers. Gait is abnormal.

A/P

Chronic pain (R52):
Neuropathy (G62.9):
Serum triglycerides raised (R79.89):
Insulin treated type 2 diabetes mellitus (E11.9):

PRESCRIBE: Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed, # 90 , RF: 0. (R52, G62)

Electronically Signed By: NAOMI CHANEY, MD
2/6/18 5:19 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 12:04:40 PM

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TINA (DOB: [redacted]) Mar 07, 2018 Wed 01:18 PM

CC fit in cold & refills ia

HPI Patient notes cough and cold symptoms including runny nose, dry cough, low-grade fever, and some discolored rhinorrhea. Notes feeling run down and has some sinus congestion. No frank shortness of breath or rigors.
The patient reports that she requires refills on her medication as well.
She has known history of diabetes historically not well controlled and dyslipidemia not controlled

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH Diabetes.
Hypertenion
Neuropathy.
Critical care neuropathy
Diverting colonostomy
Dupuytren's contracture
Dyslipidemia

SH Patient denies any tobacco use or recreational drug use.
[Tobacco: Never smoker]
denies alcohol.
Married.
Husband-Patrick.
2 daughters, 1 son.
Pets: several dogs.

FH Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) accucheck smart view lancets and strips, three times a day
2) ALPRAZolam 0.5 mg oral tablet, one po bid prn
3) busPIRone 15 mg oral tablet, one third tab po tid prn
4) carvedilol 12.5 mg oral tablet, 1 po bid
5) citalopram 10 mg oral tablet, one half tab po q day
6) Crestor 10 mg oral tablet, one po q day
7) DULoxetine 60 mg oral delayed release capsule, one po q day
8) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days
9) four pronged cane
10) ibuprofen 800 mg oral tablet, one po bid prn
11) ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal
12) Januvia 100 mg oral tablet, one po q day
13) Jardiance 25 mg oral tablet, one po q day
14) kcl 10 meq, one po q day

Printed By: NAOMI CHANEY, MD 3/31/2018 12:04:47 PM

Page 1 of 2

15) Lantus Solostar Pen 100 units/mL subcutaneous solution, 85 units sq q day
16) Lasix 20 mg oral tablet, one po q day
17) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days
18) lisinopril 2.5 mg oral tablet, one po q day
19) metFORMIN 1000 mg oral tablet, one po bid
20) odanestron 4 mg, one po tid pm nausea
21) olopatadine 0.2% ophthalmic solution, one drip bid
22) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
23) predniSONE 10 mg oral tablet, 3 po times one then one po tid for 2 days then 1 po bid for 2 days then 1 po q day for 2 days then stop
24) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals — Wt: 163 lb Ht/Ln: 64 in BMI: 28.0 BP: 120/80 Pulse: 99 RR: 12 Sat: 98

PE
GENERAL: WNWD NAD
HEENT: WNL
LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.

A/P
Upper respiratory infection (J06.9):
Insulin treated type 2 diabetes mellitus (E11.9):
Hypertension (I10):

Plan printed and provided to patient:
PRESCRIBE: lancets and strips, check in am and pm prior to meals, # 100 , RF: 3. (e 55.9)
PRESCRIBE: Lantus Solostar pen 100 units/mL subcutaneous solution, 85 units a day, # 3, RF: 3.
PRESCRIBE: Januvia 100 mg oral tablet, one po q day, # 90 , RF: 1.
PRESCRIBE: Tessalon Perles 200 mg oral capsule, one po tid, # 90 , RF: 0(generic)
PRESCRIBE: montelukast 10 mg oral tablet, one po q day, # 30 , RF: 3.
PRESCRIBE: Azithromycin 5 Day Dose Pack 250 mg oral tablet, as directed, # 6 , RF: 0.
PRESCRIBE: predniSONE 10 mg oral tablet, one po tid for 2 days then one po bid for 2 days then one po q day for 2 days, # 12 , RF: 0

PROVIDED: Patient Education (3/7/2018)

Electronically Signed By: NAOMI CHANEY, MD
3/7/18 5:47 PM

Printed By: NAOMI CHANEY, MD 3/31/2018 12:04:47 PM

9280 West Sunset, Suite 306
Las Vegas, NV 89148
(702) 696-7256
FAX (702) 796-7256

Date: 3/8/18

To: Dr. Naomi Chaney Fax #: 7023195901

From: ☐ Samer Nakhle, MD, FACE ☐ Serena Klugh, MD ☒ Betsy Palal, MD

☐ Bijan Ahrari, MD ☐ Nicholas Vernetti, MD ☐ Omid Rad Pour, MD

☐ Antonio Flores Erazo, MD

Regarding: Farris, Tiana DOB: [redacted]

Thank you for the referral on the above listed patient. However, we were unable to see the patient for the following reason.

☐ The patient did not return our calls to schedule an appointment

☐ The phone number was out of service or we were unable to leave a message on voicemail

☐ The patient wanted an endocrinologist closer to their home and chose not to schedule an appointment

☐ The patient didn't understand the need for a referral to an endocrinologist and refused to set up an appointment

☐ The patient stated he/she had transportation problems and would call back. They have not contacted our office to schedule.

☒ The patient did schedule more than one appointment and failed to show or cancelled less than 24 hours prior to the appointment each time. Our policy for new patients is after two consecutive late cancellations/no shows no further appointments will be scheduled

Appt on 2/8/18 - cancelled > 24hrs.
Appt on 2/19/18 - cancelled Appt 3/5/18 - no show.

Please feel free to contact us if you have any questions regarding this matter. Choose Option 3 on the menu for scheduling. Again, thank you for the referral.

Iris

ATTENTION: Palm Medical Group has two locations. They are located in the medical buildings associated with Southern Hills Hospital, Suite 306, in the South West and Mountain View Hospital, Suite 415, in the North West. The phone number will be the same for both offices.

All providers will be available at BOTH locations.

INTERNAL MEDICINE OF SPRING VALLEY
5380 S RAINBOW BLVD STE 218
LAS VEGAS, NV 89118
Phone (702) 319-5900 Fax (702)319-5901

FARRIS, TINA (DOB: [redacted]) PA Mar 22 2018 [illegible] PM

CC fit in per doc la

HPI The patient was asked to come in with her husband for frank discussion regarding noncompliance with recommendations. I've explained again my concern as we received notification from the endocrinologist office regarding to reschedules and 1 no-show. As a consequence, they will not rescheduled the patient again. I discussed with the patient if there inability to go to other physicians include barrier finances then we will attempt to manage the diabetes together by having daily interaction on the glucose readings and titrated up with short acting. Additionally, the patient will need to be on cholesterol lowering medications as I explained that she is at high risk for pancreatitis and quite frankly death. We will need to move the patient forward to cardiology but in the meantime her goals are to lower her glucose readings. Weekly medications would be helpful but place the patient at risk for pancreatitis and therefore we must get the glucose down with insulin and other agents before we could switch her. They state that they will try.
Additionally, I explained to the patient the practice will longer right for chronic pain medications and she will have to establish with a pain management specialist.

ROS 10 system reviewed and performed by patient on the Phressia tablet.

PMH
Diabetes.
Hypertenion
Neuropathy.
Critical care neuropathy
Diverting colonostomy
Dupuytren's contracture
Dyslipidemia
Noncompliance
Barrier to care to include finances
Chronic diabetic ulcer - multiple referrals

SH
Patient denies any tobacco use or recreational drug use.
[Tobacco: Never smoker]
Denies alcohol.
Married.
Husband-Patrick.
2 daughters, 1 son.
Pets: several dogs.

FH
Mother: pacer dx diabetes?
Father: good
Siblings: brothers - had a brother cancer liver cancer , brother - diabetes, 3 sisters, 9 originally.

Allergies asprin (Updated by Naomi on 01/17/2014 03:37 PM)

Meds
1) accucheck smart view lancets and strips, three times a day
2) ALPRAZolam 0.5 mg oral tablet, one po bid prn
3) busPIRone 15 mg oral tablet, one third tab po tid prn

Printed By: NAOMI CHANEY, MD 3/31/2018 12:05:02 PM

Amended Chart [illegible] PAGE 1 of 2

PLTF10085

4) carvedilol 12.5 mg oral tablet, 1 po bid
5) citalopram 10 mg oral tablet, one half tab po q day
6) Crestor 10 mg oral tablet, one po q day
7) DULoxetine 60 mg oral delayed release capsule, one po q day
8) Flagyl 500 mg oral tablet, Take 1 pill by mouth TID X 10 Days
9) four pronged cane
10) ibuprofen 800 mg oral tablet, one po bid prn
11) ipratropium 42 mcg/inh (0.06%) nasal spray, Take 2 squirts bid intranasal
12) Januvia 100 mg oral tablet, one po q day
13) Jardiance 25 mg oral tablet, one po q day
14) kcl 10 meq, one po q day
15) Lantus Solostar Pen 100 units/mL subcutaneous solution, 85 units sq q day
16) Lasix 20 mg oral tablet, one po q day
17) Levaquin 500 mg oral tablet, Take 1 pill by mouth QD (Daily) X 10 Days
18) lisinopril 2.5 mg oral tablet, one po q day
19) metFORMIN 1000 mg oral tablet, one po bid
20) odanestron 4 mg, one po tid prn nausea
21) olopatadine 0.2% ophthalmic solution, one drip bid
22) Percocet 10/325 oral tablet, Take 1 pill by mouth TID X Month (30d) As Needed
23) predniSONE 10 mg oral tablet, 3 po times one then one po tid for 2 days then 1 po bid for 2 days then 1 po q day for 2 days then stop
24) vancomycin 125 mg oral capsule, Take 1 pill by mouth QID (4 times a day) X 10 Days

Vitals — Wt: 162.2 lb Ht/Ln: 62 in BMI: 29.7 BP: 120/82 Pulse: 78 RR: 12 Sat: 98

PE
GENERAL: WNWD NAD
HEENT: WNL
LUNGS: CTA
HEART: RRR S1 S2 without murmers, thrills, rubs
CHEST WALL: WNL
ABDOMEN: WNL. Normal BS.

A/P
Insulin treated type 2 diabetes mellitus (E11.9):
Hypertension (I10):
Dyslipidemia (E78.5):
Serum triglycerides raised (R79.89):

Plan printed and provided to patient:
PRESCRIBE: HumuLOG KwikPen 100 units/mL injectable solution, 12 units sq tid pm sliding scale, # 3, RF: 1.
PRESCRIBE: pravastatin 10 mg oral tablet one po qhs, # 90 , RF: 1. (3/30/2018 patient to start)
PRESCRIBE: Lopid 600 mg oral tablet, one po bid, # 60 , RF: 3.
we communicate daily
focus on your sugars in am and pm
lantus 45 units in am and pm
Sliding scale short acting insulin - check sugar before a meal - at table
100 - 150 - do nothing
151 - 200 2 units of short acting
201 - 250 4 units
251 - 300 6 units

drop the insulin - athrogenic

PROVIDED: Patient Education (3/22/2008)

Printed By: NAOMI CHANEY, MD 3/31/2018 12:05:02 PM

[redacted]

Electronically Signed By: NAOMI CHANEY, MD
3/27/18 8:06 AM

Printed By: NAOMI CHANEY, MD 3/31/2018 12:05:02 PM

[redacted]

PLTFI0087

INTERNAL MEDICINE OF SPRING LEY
5380 S RAINBOW BLVD STE [illegible]
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID# / SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955 F	TITINA FARRIS	Clinical Pathology Laboratories
DOB		
[redacted]		
AGE / DLW	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD
LAB ID / PLT	SPECIMEN INFORMATION	RECEIVED ON / DTE	REPORTED ON / DTE
12840	Specimen ID: U1712416 Type: Source: Condition:	03/26/2018 12:56:19	03/23/2018 23:52:51
		COLLECTION DATE/TIME	FASTING / UA
		03/22/2018 16:14:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
LIPID PANEL **Reported On: 03/23/2018 23:52:51**					F	
-CHOLESTEROL	456	<200	MG/DL	H	F	Clinical Pathology Laboratories
-TRIGLYCERIDES	1178	<150	MG/DL	H	F	Clinical Pathology Laboratories
NOTES on 'TRIGLYCERIDES': *****SPECIMEN LIPEMIC RESULTS RECHECKED AND VERIFIED						
-HDL CHOLESTEROL	26	>39	MG/DL	L	F	Clinical Pathology Laboratories
-CALC LDL CHOL	NOTE	<100	MG/DL		F	Clinical Pathology Laboratories
NOTES on 'CALC LDL CHOL': UNABLE TO CALCULATE A VALID LDL CHOLESTEROL WHEN THE TRIGLYCERIDE VALUE IS GREATER THAN 400 MG/DL.						
-RISK RATIO LDL/HDL	NOTE	<3.22	RATIO		F	Clinical Pathology Laboratories
NOTES on 'RISK RATIO LDL/HDL': UNABLE TO CALCULATE						
COMPREHENSIVE METABOLIC PANEL **Reported On: 03/23/2018 23:52:51**					F	
-GLUCOSE	169	70-99	MG/DL	H	F	Clinical Pathology Laboratories
-BUN	18	6-20	MG/DL		F	Clinical Pathology Laboratories
-CREATININE	0.86	0.60-1.30	MG/DL		F	Clinical Pathology Laboratories
-eGFR AFRICAN AMER.	88	>60	ML/MIN/1.73		F	Clinical Pathology Laboratories
-eGFR NON-AFRICAN AMER.	76	>60	ML/MIN/1.73		F	Clinical Pathology Laboratories
-CALC BUN/CREAT	21	6-25	RATIO		F	Clinical Pathology Laboratories
-SODIUM	136	135-146	MEQ/L		F	Clinical Pathology Laboratories
-POTASSIUM	4.0	3.5-5.4	MEQ/L		F	Clinical Pathology

INTERNAL MEDICINE OF SPRIN LLEY
5380 S RAINBOW BLVD STE 3
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID#	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories

DOB: [redacted]

AGE	ACCESSION #	ORDERING PROVIDER
55	[redacted]	Naomi Chaney, MD

LAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
12840	Specimen ID: U1712416 Type: Source: Condition;	03/25/2018 12:56:19	03/23/2018 23:52:51
		COLLECTION DATE/TIME	FASTING
		03/22/2018 16:14:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	Flag	Status	Performed By
-CHLORIDE	96	95-107	MEQ/L		F	Laboratories Clinical Patholog Laboratories
-CARBON DIOXIDE	25	19-31	MEQ/L		F	Clinical Patholog Laboratories
-CALCIUM	10.5	8.5-10.5	MG/DL		F	Clinical Patholog Laboratories
-PROTEIN, TOTAL	[redacted]	6.1-8.3	G/DL	H	F	Clinical Patholog Laboratories
-ALBUMIN	4.3	3.5-5.2	G/DL		F	Clinical Patholog Laboratories
-CALC GLOBULIN	[redacted]	1.9-3.7	G/DL	H	F	Clinical Patholog Laboratories
-CALC A/G RATIO	1.0	1.0-2.6	RATIO		F	Clinical Patholog Laboratories
-BILIRUBIN, TOTAL	0.2	<=1.2	MG/DL		F	Clinical Patholog Laboratories
-ALKALINE PHOSPHATASE	108	30-111	U/L		F	Clinical Patholog Laboratories
-AST	12	9-40	U/L		F	Clinical Patholog Laboratories
-ALT	13	5-40	U/L		F	Clinical Patholog Laboratories
HEMOGLOBIN A1C					F	
Reported On: 03/24/2018 03:11:39						
-HEMOGLOBIN A1c	[redacted]	4.2-5.6	%	H	F	Clinical Patholog Laboratories

NOTES on 'HEMOGLOBIN A1c':

AMERICAN DIABETES ASSOCIATION GUIDELINES FOR HGB A1C:
PREDIABETES/INCREASED RISK 5.7-6.4%
DIAGNOSIS OF DIABETES . . . . . >=6.5%
WITH CONFIRMATION OR APPROPRIATE SYMPTOMS

NOTE: ASSAY MAY BE AFFECTED BY HEMOGLOBINOPATHIES (SICKLE CELL ANEMIA, S-C DISEASE, OTHERS) OR ARTIFICIALLY LOWERED BY DECREASED RED CELL SURVIVAL (HEMOLYTIC ANEMIAS, BLOOD LOSS, ETC.). CONSIDER ALTERNATE TESTING OR LABORATORY CONSULTATION.

INTERNAL MEDICINE OF SPRIN[redacted]LEY
5380 S RAINBOW BLVD STE [redacted]
Las Vegas, NV 89118
Phone (702) 319-5900 Fax (702) 319-5901

LABORATORY REPORT

ID#	SEX	PATIENT DEMOGRAPHICS	RESULTS PROVIDED BY
9955	F	TITINA FARRIS	Clinical Pathology Laboratories
DOB		[redacted]	

AGE	ACCESSION#	ORDERING PROVIDER	
55	[redacted]	Naomi Chaney, MD	
LAB ID	SPECIMEN INFORMATION	RECEIVED ON	REPORTED ON
12840	Specimen ID: U1712416 Type: Source: Condition:	03/25/2018 12:56:19	03/23/2018 23:52:51
		COLLECTION DATE/TIME	FASTING
		03/22/2018 16:14:00	NOT SPECIFIED

NAME	VALUE	NORMAL	UNITS	LAST RESULT	STATUS	PERFORMED BY
NOTE:					F	
Reported On: 03/23/2018 06:05:06						
-NOTE:	(NOTE)	-	-		F	Clinical Pathology Laboratories

NOTES on 'NOTE:':

IN ACCORDANCE WITH FEDERAL GUIDELINES REQUIRING ALL VERBAL
REQUESTS FOR LABORATORY TESTS TO BE ACCOMPANIED BY WRITTEN
AUTHORIZATION WITHIN 30 DAYS OF THIS REQUEST, PLEASE SIGN BELOW
AND RETURN A COPY OF THIS REPORT BY FAX TO THE LABORATORY
SCANNING DEPARTMENT AT 512-873-5078.

PHYSICIAN'S SIGNATURE _____ DATE _____

UNLESS OTHERWISE INDICATED, ALL TESTING PERFORMED AT
CLINICAL PATHOLOGY LABORATORIES, INC. 9200 WALL ST AUSTIN, TX 78754
LABORATORY DIRECTOR: MARK A. SILBERMAN, M.D.
CLIA NUMBER 45D0505003 CAP ACCREDITATION NO. 21525-01

**This report has not been signed-off.

Electronically Filed
11/1/2019 11:01 AM
Steven D. Grierson
CLERK OF THE COURT

[PROF]
THOMAS J. DOYLE
Nevada Bar No. 1120
AIMEE CLARK NEWBERRY
Nevada Bar No. 11084
SCHUERING ZIMMERMAN & DOYLE, LLP
400 University Avenue
Sacramento, California 95825-6502
(916) 567-0400
Fax: 568-0400
Email: calendar@szs.com

KIM MANDELBAUM
Nevada Bar No. 318
MANDELBAUM ELLERTON & ASSOCIATES
2012 Hamilton Lane
Las Vegas, Nevada 89106
(702) 367-1234
Email: filing@memlaw.net

Attorneys for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **OFFER OF PROOF RE MICHAEL HURWITZ, M.D.**

Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC hereby submit the following offer of proof:

Attached are pages 180-182 from an unofficial transcription for October 18, 2019 showing the question asked, and Dr. Hurwitz' answer at pages 180:23-182:5. If Defendants had been allowed to open and publish the original deposition transcript they would have

Case Number: A-16-739464-C

been able to impeach him with his deposition testimony at page 5: 15-24 and page 7:4-14. Attached are the pages from the unofficial transcription and Dr. Hurwitz' complete deposition as exhibits A and B respectively.

Dated: November 1, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By */s/ Thomas J. Doyle*
THOMAS J. DOYLE
Nevada Bar No. 1120
400 University Avenue
Sacramento, CA 95825-6502
(916) 567-0400
Attorneys for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 1st day of November , 2019, service of a true and correct copy of the foregoing:

OFFER OF PROOF RE MICHAEL HURWITZ, M.D.

was served as indicated below:

☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);

☐ served on all parties electronically pursuant to mandatory NEFCR 4(b) , exhibits to follow by U.S. Mail;

Attorney	Representing	Phone/Fax/E-Mail
George F. Hand, Esq. HAND & SULLIVAN, LLC 3442 North Buffalo Drive Las Vegas, NV 89129	Plaintiffs	702/656-5814 Fax: 702/656-9820 hsadmin@handsullivan.com
Kimball Jones, Esq. Jacob G. Leavitt, Esq. BIGHORN LAW 716 S. Jones Boulevard Las Vegas, NV 89107	Plaintiffs	702/333-1111 Kimball@BighornLaw.com Jacob@BighornLaw.com

/s/ Riesa R. Rice
an employee of Schuering Zimmerman & Doyle, LLP
1737-10881

EXHIBIT A

TRANSCRIPT OF VIDEO-RECORDED
TESTIMONY IN THE MATTER OF
FARRIS V. RIVES, M.D., ET AL.
OCTOBER 18, 2019

Job No. 583184

clearly violative -- well, it's become narrative. It's nonresponsive. It's a new opinion not expressed at the time, in any report or deposition. It's irrelevant and it's 48.035. And there's no foundation.

THE COURT: Three additional words have been stated since the court's last ruling. The court have to overrule narrative because those three words would not make it narrative. The three additional words would not make it 48.035. Three additional words would not make it lacking foundation. The court would have to overrule that.

And the court would also have to overrule the additional objection with regards to [inaudible] and with regards to it being a new opinion since this juncture, those -- those additional three words since the court's last ruling, the court can't say that it is a new opinion, violative NRCP 16. Nobody's presented this court with the opinion so that the court could determine that.

MR. LEAVITT: Doctor, are you offering a new opinion at this time?

DR. HURWITZ: I don't think so. No.

MR. LEAVITT: Okay. So same question. What did you mean by your statement?

DR. HURWITZ: In the Center case, there was a

perforation. There was sepsis that was initially attributed to aspiration and it took 11 or 12 days to ultimately discover that there was an intraabdominal process that was causing the infection. And, um, that was just five months earlier. So the lessons of that case clearly weren't applied here.

And it's -- and so the -- the similarities are striking and, um, in both cases, for instance, there was significant harm, ultimately, to the lower extremities. It's -- there's a -- there's a -- a clear correlation. There's clearly a -- a -- a lesson that was not learned form the Center case that w- -- that had so many similarities. Yes. There were some differences to a- -- to be applied here. Uh, and for me, that -- having had that recent experience in -- e- -- even increases the negligence because you didn't learn anything.

So I -- I just don't -- I -- I -- it's surprising to me that something like that with -- with such similarities can -- can repeat itself in such short order where there's an intraabdominal process, uh, that's -- it's attributed to a pulmonary process, even though there's no evidence of a pulmonary process.

And then ultimately it turns out there's an intraabdominal process as the source. There's this --

this long delay in identifying this that leads to sepsis and a bad outcome. So that's -- so it -- it didn't change my opinion about the case. I already made an opinion. But it certainly increases the negligence in my opinion.

MR. DOYLE: And, Your Honor, I move to strike as irrelevant, 48.035, an opinion not expre- -- a new opinion not expressed at the time of the deposition or in any of the reports.

THE COURT: Counsel, can you please approach and can someone bring me a report?

MR. LEAVITT: I got it. I'll grab the report.

[audio break]

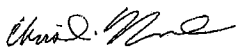
THE COURT: Having you sit there. We're going to send you out for, um, a brief few moments. Um, I hope it's only going to be a few moments. Marshal will let you know. [Inaudible] only be about 10 minutes.

So ladies and gentlemen, during this recess, you are admonished not to talk or converse among yourselves or with anyone else on any subject connected with this trial.

You may not read, watch or listen to any report or commentary of the trial or any person connected with the trial by any medium of information, including without limitation social media, texts, tweets,

I, Chris Naaden, a transcriber, hereby declare under penalty of perjury that to the best of my ability the above 235 pages contain a full, true and transcription of the tape-recording that I received regarding the event listed on the caption on page 1.

I further declare that I have no interest in the event of the action.



October 24, 2019

Chris Naaden

(Farris v. Rives, et al., 10-18-19)

EXHIBIT B

In the Matter Of:

Farris vs Rives, M.D., et al.

MICHAEL B. HURWITZ, M.D., FACS

September 18, 2019

Job Number: 573931

10A.App.2099

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS,
Plaintiffs,
vs.
BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al.,
Defendants.

Case No. A-16-739464-C
Dept. No. 31

DEPOSITION OF MICHAEL B. HURWITZ, M.D., FACS, a witness herein, noticed by Schuering Zimmerman & Doyle, LLP, taken at 510 Superior Avenue, Newport Beach, California, at 3:07 p.m. on Wednesday, September 18, 2019, before Delia M. Satterlee, CSR 9114.

Job Number 573931

APPEARANCES OF COUNSEL:

For Plaintiffs:

Bighorn Law

By Kimball Jones

716 South Jones Boulevard

Las Vegas, Nevada 89107

(702)800-5506

Kimball@bighornlaw.com

For Defendants:

Schuering Zimmerman & Doyle, LLP

By Thomas J. Doyle

400 University Avenue

Sacramento, California 95825

(916) 567-0400

tjd@szs.com

I N D E X

WITNESS: MICHAEL B. HURWITZ, M.D., FACS

EXAMINATION BY:	PAGE
MR. DOYLE	4, 117
MR. JONES	113

EXHIBITS

EXHIBIT	DESCRIPTION	PAGE
Exhibit A	Correspondence of the witness with Mr. George Hand, CV of the witness, document headed "Record of Expert Deposition and Trial Testimony" by the witness, and bill for services	7
Exhibit B	Letter dated June 26, 2019 from George F. Hand, Esq. to Michael B. Hurwitz, M.D., F.A.C.S. enclosing CD of diagnostic tests and St. Rose Dominican radiology reports	8
Exhibit C	Hospital records from St. Rose Dominican Hospital	8

MICHAEL B. HURWITZ, M.D., FACS,
a witness herein, having been sworn, testifies as
follows:

-EXAMINATION-

BY MR. DOYLE:

Q. Please tell us your full name.

A. Michael Hurwitz.

Q. Business address.

A. 510 Superior Avenue, Suite 200G, Newport Beach, California 92663.

Q. Have you given a deposition before?

A. I have.

Q. About how many times?

A. Probably ten times or so. I've got a complete list there (indicating).

Q. Are you generally familiar with the process?

A. Yes, I am.

Q. Can I dispense with the various does and don'ts you've probably heard a number of times?

A. Yes, you may.

Q. The only thing I would ask is: If I should pose a question and for whatever reason my question is not clear to you, will you let me know so I can restate

or rephrase it in some way?

A. Yes, I will.

Q. Okay. We have marked some things that you brought with you today. Is this your complete file in this case?

A. Yes, it is, with the exception of depositions that I reviewed electronically.

Q. Your rebuttal report, did that list some dep- -- Well, strike that.

Can you tell me which depositions you have reviewed?

A. I'd have to look at the rebuttal report. I've reviewed all of those that are listed on the rebuttal report.

Q. The only one listed on the rebuttal -- I'm sorry. In the expert report, we have the deposition of Dr. Rives. And in the rebuttal report, you said you reviewed expert reports by Dr. Carter and Dr. Jewell, but there's no mention of depositions.

A. Okay. So I hadn't reviewed the depositions at that point. I have since reviewed depositions on -- depositions of Carter and Jewell, Erlich, Stein, Rives. I reviewed also a deposition of Rives in the Center case.

Q. Any other depositions?

A. And I briefly looked at --
I'd have to -- I -- I'd need a memory check here.
I looked at --
MR. JONES: If you like, we can verify on our end if we've sent him over anything.
THE WITNESS: I was sent depositions. There was a deposition of the husband of -- of the plaintiff, and there were some others that were included that I -- I did not review. I haven't read the depositions of the neurologists.
MR. DOYLE:
Q. Have you been provided Mrs. Farris's deposition?
A. I don't know that I've seen that one.
Q. Dr. Chaney's deposition?
A. I don't believe so. Who is Dr. Chaney?
Q. Mrs. Farris's primary care physician.
A. No, I did not read it.
Q. When you say you've not reviewed the neurologists, are you talking about the neurology experts in this case?
A. I believe so.
Q. These various depositions that you told me about, did you take any notes when you read them?
A. No.

Q. Did you mark or highlight in any form or fashion the transcripts when you read them?

A. No.

Q. What was your understanding why you were given Dr. Rives's deposition in this other case?

A. The reason was to demonstrate his interpretation of the events leading up to the discovery of the gastric perforation as a pulmonary process.

Q. Well, did you find any striking or important similarity -- similarities or dissimilarities in that Center deposition?

A. To be fair, I didn't -- I didn't -- I had already reviewed everything else, and it didn't really change my opinion.

Q. Okay. We marked as Exhibit A --

(Exhibit A identified.)

MR. DOYLE:

Q. Just tell me generally what is in Exhibit A.

A. So you asked for all of my correspondence with Mr. Hand, and so I provided that, a series of e-mails, mostly -- almost entirely around, you know, reviewing the records and getting in contact with them. So there's nothing of significance in there.

I've also provided my CV, as you requested, and a list of the cases in which I've testified as a -- as an

expert and my depositions.

And I have also provided, I believe in here somewhere -- was my bill to -- was my -- my bill for services --

Q. Okay.

A. -- as an expert witness.

Q. Tell me what Exhibit B is, which has on top a correspondence to you dated June 26, 2019.

(Exhibit B identified.)

MR. DOYLE:

Q. This was a separate mailing from Mr. Hand with the CD, the imaging, and these are the interpretations of -- these are the radiol- -- radiologist's interpretations.

Had you seen the radiology reports for this case prior to receipt of Exhibit B?

A. Whatever is included in the hospital records I had seen, so a lot of this was duplicated.

Q. And when you say "in the hospital records," you were pointing to the binder we marked as Exhibit C?

A. Correct.

Q. Okay.

(Exhibit C identified.)

MR. DOYLE:

Q. Then I'm not going to mark these, but we have a

couple of CDs. One of them says "Farris St. Rose CD." And stapled to it is -- stapled to it is a description of the contents and a couple of imaging studies.

Did you look at this CD?

A. I did not.

Q. The other CD that has a handwritten note that says "Complete records if needed," did you look at those?

A. No. I believe that's a -- that's the same thing that's in the binder that you have as evidence on a disc.

Q. Have you -- your -- Have you looked at the -- any CT images yourself?

A. I briefly looked at them. It's been some time.

Q. How long ago?

A. Whenever I received that (indicating) -- Whenever I received this (indicating). So it would have been in the end of June or beginning of July.

Q. Is there yet another CD somewhere that has the imaging studies that you reviewed?

A. There is.

Q. Do you know where that is?

A. I think it's in my office. I can get that for you.

Q. Let's do that at a break.

And then we've marked as Exhibit C a three-ring binder. Tell me generally, what is Exhibit C?

A. Exhibit C is the hospital records from St. Rose Dominican Hospital.

Q. Okay. Did you review the entirety of these records?

A. As much as I could.

Q. When you reviewed the records, did you make any handwritten or typed notes?

A. No.

Q. Did you make any marks, notes or highlighting on the records themselves as you reviewed them?

A. No.

Q. The top of Exhibit C has what looks like a three-page letter from George Hand. It doesn't have a date. But is it your understanding this is a letter from Mr. Hand those first three pages?

A. It looks like it, yeah. Yes.

Q. Did this come with the binder?

A. Yes.

Q. And you looked at this before you started going through the records? It's right on top.

MR. JONES: Objection.

THE WITNESS: I don't know in --

MR. JONES: Speculation.

THE WITNESS: -- which order I looked at it.
MR. DOYLE:
Q. Well, in all likelihood, you looked at the cover letter first before going to the records?
MR. JONES: Objection; speculation --
THE WITNESS: To be --
MR. JONES: -- asked and answered.
THE WITNESS: To be honest, I have -- I don't think I did. I think I just opened the records.
(A discussion is held off the record.)
MR. DOYLE:
Q. Why do you think you skipped the cover letter that came with it?
A. Well, first of all, I don't even remember what's in the cover letter, so I don't recall the specifics of it. It looked like a summary of -- of the case, and I just don't recall when I looked at it.
Q. Okay. At some point in time you read the letter?
A. Yes.
Q. So with the exception of the CD that's in your office that you'll get for us at a break, we have in front of us your complete file for this case?
A. Yes.
Q. Have you discussed this case with any

colleagues?

A. No.

Q. Have you done any research specifically for this case on any particular topic?

A. No.

Q. Now, the term "colotomy," what does that mean?

A. That is a hole in the colon.

Q. And that could be anywhere along the length of the colon and its different parts?

A. Yes.

Q. If you have a hole in the small bowel, what is that called?

A. An enterotomy.

Q. And if you have one in the rectum, is there a term?

A. I'll -- I'll call it a proctotomy or a rectotomy or a colotomy.

Q. When performing surgery -- abdominal surgery on a patient who has had a surgical history and the presence of adhesions, what are the common causes of a colotomy in general?

MR. JONES: Objection; overbroad, vague, compound.

THE WITNESS: Colotomies can occur during the course of dissection of adhesions.

MR. DOYLE:

Q. How does that happen?

A. Well, there's a number of ways that can happen. It can be caused by putting traction on the bowel as you're dissecting it, tearing the bowel, essentially.

It can be caused by physically cutting into the bowel with a sharp implement.

It can -- They can be -- Colotomies can be caused by a thermal injury, so using a thermal device on the bowel can lead to a colotomy.

Colotomies can also be deliberate. We make colotomies when we are creating an anastomosis. So sometimes colotomies are deliberate for that purpose.

Q. The -- You mentioned that traction on the bowel can result in a tearing of the bowel in a colotomy. How does that work? What is the mechanics of that?

A. If one is tugging on the bowel or pulling on the intestine in some manner and the intestine is tethered, you can essentially rip the intestine.

Q. And how does a thermal colotomy occur?

A. Well, a thermal source in contact with a bowel can essentially burn the bowel. And just as with a sharp instrument, one can go all the way through the bowel with a heat source, such as cautery. One can also go partially through bowel with a heat source and lead to a partial-thickness thermal injury that can develop

later into a colotomy as the tissue dies.

Q. When we use the term "colotomy," are we referring to an injury that goes all the way through the bowel?

A. I think that when one mentions a -- when one says "colotomy," one is typically referring to a full-thickness injury. If you're talking about a partial-thickness injury, you might call that a partial-thickness injury or you might call it a partial-thickness colotomy, I suppose. More commonly, if you cut the outside of the bowel but not the inner layer of the bowel, you might call that a serosal injury.

Q. So when dissecting adhesions, you can sometimes have a partial-thickness injury to the bowel; for example, just the serosa.

A. Correct.

Q. And you can also have a full-thickness injury, which is commonly called a colotomy, where the injury goes all the way through the mucosa into the lumen of the bowel?

A. Correct.

Q. And I think you mentioned these can occur inadvertently or intentionally.

A. Correct.

Q. I assume -- You're a general surgeon.
A. Yes, I am.
Q. I assume you have encountered inadvertent colotomies over the years?
A. I have.
Q. The fact that a colotomy occurs during an abdominal procedure does not necessarily mean the care was below the standard of care. Fair statement?
A. Yes.
Q. How many times have you inadvertently caused a colotomy? Best estimate.
MR. JONES: Object to form.
THE WITNESS: I -- I would be making up an answer if I tried to answer that. I -- I've been in practice or in training since 1988, so that's a long time to try and estimate the number of colotomies I've seen. Over that period of time, perhaps several dozen.
MR. DOYLE:
Q. Less than 50, then?
A. Probably.
Q. In those instances where you yourself encountered an inadvertent colotomy, were there some that you repaired?
A. Well, hopefully they were all that I repaired.
Q. Well, sometimes you may see a colotomy and make

a decision that rather than repairing --

A. Oh.

Q. -- the hole itself, that you're going to fix the problem with a resection and an anastomosis; correct?

A. I would say that the vast majority of inadvertent bowel injuries have been in small bowel rather than in large bowel. And sometimes I've repaired those with suture, closing the hole. But there have been times when I've had to resect a section of bowel -- of the small intestine.

I would say that the vast majority have been in small bowel and not in colon. True colotomies are -- are reasonably infrequent, and I can't recall having to resect bowel because I put holes in it, but I'm sure that's happened at some point in my career.

Q. So as you sit here today, your thinking is that those colotomies that you have encountered over the years, typically you have repaired them rather than doing a resection and an anastomosis. Fair statement?

A. I think that's reasonable.

Q. And in your own experience when you have repaired colotomies, do you have a preference for sutures versus staples?

A. Well, my preference would be to close with

suture. Staples can be used; but especially during an open operation when you have the facility to close with suture, I prefer that.

Q. Why do you prefer a -- Well, let's -- let's focus for a moment -- Well, strike that.

Have you repaired colotomies with sutures laparoscopically?

A. I have.

MR. JONES: Objection; foundation.

MR. DOYLE:

Q. Have you ever repaired a colotomy laparoscopically using a stapler?

A. Probably.

Q. How many times would be your best estimate? Less than five?

A. None -- I can't recall any specific cases where I've had to do that. I'm sure I've done it at some point in the past.

Q. Are you familiar with the Endo GIA stapler?

A. I am.

Q. Do you use it?

A. Yes, I do.

Q. What do you use it for?

A. I've used it to divide the bowel endoscopically.

I've used it to remove an appendix.

I've used it to – during -- I've used it during the course of sigmoid colectomies, for example.

Q. In a typical month, how often will you use an endoscopic stapler?

A. Probably four or five times.

Q. I mean, do you have any standard-of-care criticism of Dr. Rives and his decision to use a stapler to close the colotomies in this case?

A. (No response.)

Q. Or is that surgeon's choice?

A. My concern about Dr. Rives' choice of using a stapler in this case isn't specific to him just using a stapler but using a stapler across an area of colon that he has separated from mesh using a thermal instrument. And my concern is that using the thermal instrument, the LigaSure bipolar device, to separate the transverse colon from the mesh to which it was densely adherent put that section of bowel at risk of tissue necrosis. And then stapling across the bowel in order to close it, I think he created a situation where he may have been stapling thermally injured bowel. And in that case, it's difficult to get a good purchase on -- on the colon.

My criticism is more in the use of the thermal

device for the dissection than it is in using a stapler.

Q. Do you use the LigaSure?

A. I have used the LigaSure, and I've also used the Harmonic scalpel, but I don't use it in approximation with bowel.

Q. Have you stopped using one and instead started using the other?

A. No. They both have their place. Sometimes it's a function of what's available to us.

Q. Does one carry a higher risk of thermal injury than the other?

A. Well, both carry a risk of thermal injury, and the manufacturer of each will tell you that the other has a higher risk of thermal injury. But they both have the potential for lateral thermal spread, for the spread of heat beyond that which is being cauterized. So I consider them both to be potentially dangerous when the device is against the serosa of the bowel.

Q. You did a fellowship in surgical oncology?

A. So when I was at Harbor-UCLA in 19- -- between 1994 and '95, I was a -- I was kind of a hybrid between a junior faculty and a -- essentially a breast oncology fellow. So it wasn't a formal fellowship, but I was helping to run the breast clinic. I was working with a mentor who was involved in the breast clinic. And I was

also an attending at Harbor during that same period of time as a -- as a clinical instructor.

Q. Well, on your CV, you say you did a fellowship in surgical oncology.

A. Well, that was the --

Q. Got to let me finish my question, please.

On your CV, you said you did a surgical oncology fellowship at Harbor-UCLA. Was that a formal or an informal program?

A. Well, it was formal in that I did receive a certificate and so forth, so yes.

Q. And then you also have, under "Fellowship," "Advanced Minimally Invasive Surgery."

Was that a formal MIS fellowship?

A. Yes, it was.

Q. For one -- For the two years at L.A. County-USC?

A. One year, '97 to '98.

Q. Is that where you encountered Dr. Katkhouda?

A. Yes, it is.

Q. Your CV has some publications including publications where you co-authored publications with Dr. Katkhouda. My question is; any of your publications on the CV have any pertinence or relevance to the issues in our case?

A. No.

Can I go off the record for a second?

MR. JONES: No.

MR. DOYLE: No. We need to keep going. At the break.

THE WITNESS: Okay.

MR. DOYLE:

Q. When a colotomy is repaired with sutures, does the literature indicate that there's a certain failure rate?

A. There is a certain failure rate, certainly.

Q. What is that failure rate for a colotomy repair with sutures?

A. You know, I don't have the -- the current literature number off the top of my head, but I would estimate it to be probably 10 percent, something of that nature.

Q. And then how about a colotomy repair with staples? What is the -- What does the literature have for the failure rate in that instance?

A. I would imagine it to be similar.

Q. And when we say "failure rate" and reference the literature, what we're talking about is the -- the repair is done; and then subsequent to the repair, something comes undone or comes apart and there is

leakage of bowel contents?

A. Correct.

Q. In general, why do you have an approximate 10 percent failure rate for a colotomy repair whether it's with sutures or staples? What physiologically happens afterwards?

A. Well, a number of things can affect the integrity of the tissue. I mentioned thermal injury as one. Tissue ischemia because of inadequate blood supply is another. That inadequate blood supply could be due to factors intrinsic to the patient or due to the patient's underlying, you know, health. Injuries, you know, failure of the -- of the suture repair due to other host factors like the presence of infection can lead to breakdown of a staple line or a breakdown of a sutured repair. Technical failure in performance of the suture closure or staple closure can lead to breakdown of the repair, to name a few.

Q. Okay. Any other common ones that come to mind?

A. Other health problems related to the patient: patients on steroids, for example, hypotensive patients, smokers, a number of reasons that staple ends can fail, sutures can fail.

Q. If a patient is obese, does that increase the risk of a colotomy repair failure?

A. In and of itself it shouldn't if it's done correctly. If -- If a patient's significantly obese, they might have other significant health concerns that could impact the repair. If somebody has diabetes, for example, that might impact their ability to heal. If -- If they've got vascular disease they may not have adequate blood supply to the area being sewn. So -- So indirectly, I suppose.

Q. You were provided with the records of Dr. Chaney, according to your expert report, Mrs. Farris's primary care physician.

Are those in the binder?

A. I do not believe so.

Q. Let me show you my copy of your -- and you can ignore my highlighting (indicating). But does your report list Dr. Chaney's office and billing records as records provided to you?

A. It does, and I believe I read them -- I reviewed these records early on.

Q. Where -- Where are they?

A. That's a good question. I don't know offhand.

Q. Well --

A. I must have them in a file.

Q. What other records on that list are not contained in Exhibit C?

MR. JONES: Objection; foundation.
MR. DOYLE: Well, if you want, I'll have him look at Exhibit C and look for Chaney's records, but I don't think they're in there.
THE WITNESS: Anything that's on this list wouldn't be in that binder, so I must have another file that I -- I did not bring in. So I'll be sure to get that to you.
MR. DOYLE:
Q. Would that be in your office with the CD?
A. No. That would be at home.
Q. This expert report, is this something you drafted or someone drafted for you?
A. I wrote it.
Q. Okay. From beginning to end?
A. As I recall.
Q. Are you aware that Ms. Farris was diagnosed with diabetes mellitus type II prior to July of 2015?
A. May I see my report?
Q. I've marked this up (indicating). Do you not have a...
A. I don't have a copy.
Q. Well -- Okay. You say here, "Titina Farris was an obese type II diabetic female."
A. So yes, I was aware of it.
Q. Were you aware that she was generally

noncompliant with the diabetes recommendations for treatment?

A. I may have been at the time that I wrote that report. I don't recall that specifically.

Q. Were you aware the prior to July of 2015, her blood sugars often were out of control?

MR. JONES: Objection; overbroad.

THE WITNESS: Again, I -- I may have been at the time that I wrote that. I don't recall that specifically.

MR. DOYLE:

Q. I mean, if we assume those facts to be true, would that be the kind of diabetic patient that would have an impaired ability to heal?

A. Yes, for sure.

Q. And I apologize if I asked you this question already, but in terms of using a stapler to repair a colotomy, have you ever done that?

A. Yes.

Q. How many times?

A. Somewhere less than 50, but I've done it.

Q. Okay. You told me that you've encountered somewhere less than 50 colotomies over your career. So each time?

A. You know, to be fair, I can't recall, over all

these years, how many times I've encountered colotomies in my own practice. If I'm doing a case as an open procedure, I would, as I said, close that with sutures.

In terms of laparoscopic cases where I would have -- where I would use a stapler and I encountered a colotomy, I can't recall a specific instance of that. But given that I've been doing this for a very long time, in all likelihood it's happened; I just can't recall a specific instance that I can call to mind.

Q. Do you remember in Dr. Rives's report referring to the blue load for the --

A. Mm-hmm.

Q. -- stapler?

A. Yes.

Q. Can you tell me what the blue load is?

A. So there is different color-coded cartridges that are used with these mechanical stapling devices, and the -- the color designates the staple height.

So the blue load is typically used for intestine, most specifically small intestine or large intestine.

The green load is used for thicker tissue, like stomach.

And the white load typically is a vascular cartridge used for small- -- for narrower staple lines.

So we -- So when we're using these Ethicon

products, those are the three colored staplers that we typically have to choose from.

Q. Would you assume that your failure rate for a colotomy repair using sutures would mirror what's described in the literature or be more or less?

MR. JONES: Objection; foundation.

THE WITNESS: I think in my personal experience, I have had far fewer than 10 percent of my closures leak. Now, I may have been off with my 10 percent estimate because I said I didn't consult the literature. That was off the top of my head. But I think in my -- my numbers have been small. I don't recall too many leaks in my career, so I may be lucky or I may just not have had many leaks.

MR. DOYLE:

Q. Do you recall in your career repairing a colotomy with a stapler, whether it's laparoscopic or open, and it goes on to have a leak?

A. Not specifically.

Q. In a typical week, how many days are you in the OR?

A. Typically three, and then I'm also on call some weekends, so sometimes as many as five or six.

Q. And in a typical week, you'll perform how many surgical procedures?

A. Anywhere from seven to 15 procedures.
Q. And what number or percentage of those typically are open versus laparoscopic?
A. I'd say they're probably 75 percent laparoscopic.
Q. When Dr. Rives performed his surgery on July 3, 2015, did you see in his operative report a description of creating inadvertently two colotomies?
A. Yes, I did.
Q. Do you have an opinion whether there were more than two inadvertent colotomies during that procedure?
A. Well, I know that the pathology report for the specimen resected by Dr. Hamilton showed three colotomies.
Q. You also noted in Dr. Hamilton's operative report, she described only seeing one colotomy; correct?
A. That's correct.
MR. JONES: Objection; foundation.
MR. DOYLE:
Q. And you would expect, if Dr. Hamilton saw three colotomies, that she would comment on that number.
MR. JONES: Objection; argumentative, foundation.
THE WITNESS: Having been in cases like that, I know that when Dr. Hamilton was in there, her goal was to get the damaged section of intestine out. So what we

looked for in those cases is a healthy proximal end to divide and a healthy distal end to divide to get out the bad section.

The goal in that situation is to look for the good tissue on either end, to remove the im- -- impaired section and get beyond all the areas of damage, not necessarily to catalog the injuries that are within that section. So the fact that she didn't account for all of those doesn't surprise me.

She also described very inflamed tissue, so that can obscure the -- that it can obscure the -- the appearance of the perforation when looking at it grossly in that circumstance.

MR. DOYLE:

Q. Did you consider the possibility that when Dr. Hamilton was manipulating the transverse colon, that she inadvertently created one or two colotomies in the section that she knew she was going to resect?

A. Well, she described -- she described during her operation that she had an area of deserosalization of -- of the colon. So she does describe that, but she does not describe a colotomy.

I think that had Dr. Hamilton knowingly gone into the bowel full thickness, she would have described it. And I say that only based upon her dictation technique.

She seems to leave, you know, little out of the dictation even to the point that she described tearing her glove on the -- on the Securestrap tack. So I think had she knowingly put a hole in the colon, she would have described it.

Q. Similarly, if she had seen three holes, she would have described three holes, not one. Fair statement?

A. Had -- Could she -- Had she been able to see them. But again, in this circumstance, we're looking for the healthy tissue down below and the healthy tissue up above and just to get that section out before more stuff spills out of it. So I think her focus would have been on getting that proximal and distal resection.

Q. Okay. Going back to the question I asked, did you consider the possibility that Dr. Hamilton, not intentionally but inadvertently, caused two colotomies when manipulating the transverse colon and resecting it?

MR. JONES: Objection; asked and answered, argumentative.

THE WITNESS: It's possible.

MR. DOYLE:

Q. Did you consider that possibility?

A. Yes.

Q. And you acknowledge that that's a possible

explanation for what the pathologist found?

MR. JONES: Objection; asked and answered.

THE WITNESS: It's possible.

MR. DOYLE:

Q. Now, did you consider the possibility that the pathologist's manipulation of the bowel segment prior to the gross examination caused what appeared to be a second and third hole?

A. I considered that, but I don't think that's -- that's likely.

Q. Why not?

A. Well, generally speaking, pathologists, in my experience, can tell the difference between something that occurred in live tissue versus something that happened in the specimen handling. So pathologists typically inspect specimens after it's -- after they've been fixed in formalin, so they can tell the difference between something that's occurred in -- in -- in -- in the moment in realtime and something that's occurred during the processing afterward.

Furthermore, pathology is -- you know, is, by its very nature, a forensic specialty, so pathologists tend to be careful in not damaging the evidence, if you will. So I -- I think it's unlikely that the hole was caused by the pathologist.

Q. You're familiar with the term "reasonable degree of medical probability" or "certainty"?

A. Yes.

Q. What is your understanding of that term?

A. That there's a 51 percent chance that -- that something occurred in such a way.

Q. Is it your opinion to a reasonable degree of medical probability or certainty that at the end of Dr. Rives's surgery on July 3rd, there was a third colotomy not repaired?

A. I think it's to a reasonable degree of certainty that there was a third injury. But what I can't tell you is whether that was a full-thickness injury or a partial-thickness injury. In other words, was this an injury that occurred that was not apparent to him at the time by virtue of using a thermal energy device.

Q. Well, a thermal injury can cause a through-and-through perforation at the time of the application of the instrument, or it may cause a partial injury that necroses and opens later; true?

A. True.

Q. Is it your opinion that there was some thermal injury to -- Strike that.

Is it your opinion to a reasonable degree of

medical probability that there was some thermal injury to the transverse colon at the point in time when Dr. Rives completed the procedure on July 3rd?

A. I think it's possible.

Q. Okay. I'm interested in -- Can you tell me to a reasonable degree of medical probability that at the end of Dr. Rives's surgery on July 3rd, there was a thermal injury, whether it was partial thickness or full thickness?

A. I think that -- I'll put it this way: I think that the injuries that occurred to the colon did not happen in a vacuum; it did not happen by themselves. They were a consequence of the manipulation of the bowel, however that occurred.

The use of thermal injury -- The use of thermal energy to dissect bowel from mesh is contraindicated because of the potential for a thermal injury such as this. I can't say with certainty that there was a thermal injury, but clearly there were three injuries to the colon that occurred during the course of the dissection, at Dr. Rives' hand. So I think it's reasonable to suspect that -- or to believe that he caused the injury. I can't tell you with a reasonable degree of certainty that it was specifically the thermal injury that caused that third hole.

Q. And according to Dr. Rives's operative report, there were two inadvertent colotomies; correct?

A. Correct.

Q. Both in the transverse colon.

A. Correct.

Q. Both of which he repaired.

A. Correct.

Q. Can you tell me to a reasonable degree of medical probability where in the transverse colon either one of those were located?

A. I'd have to go back to his operative report to look at that.

Q. Would you have expected them to be visible to him through the laparoscope?

A. Clearly the two were -- that he saw were visible to -- to him through the laparoscope.

I think it's possible laparoscopically to overlook injuries that occur, particularly in an area that you've been dissecting off of the abdominal wall or off of mesh.

The challenge with laparoscopy -- one challenge with laparoscopy is that you're looking at something in -- in two dimensions. You don't really have the ability to feel or touch it or to handle it as you would if you were doing an open surgery. So your ability to

inspect the colon is somewhat hampered. So it is certainly possible that he could have overlooked an injury because he was laparoscopic.

Q. Are you able to tell me to a reasonable degree of medical probability that there was a third full-thickness injury -- in other words, a through-and-through colotomy -- at the end of Dr. Rives's procedure on July 3rd?

A. No.

Q. Are you able to tell me to a reasonable degree of medical probability that there was a third but partial-thickness injury at the end of his surgery on July 3rd?

A. I think it -- there was one or the other, but I can't tell you which, and I can't speculate as to whether it was 51 percent in favor of a full or a partial. But -- But the conditions were set at that operation. If it wasn't a full-thickness injury at that time that was overlooked, then it was an injury that developed subsequently --

Q. Well, if --

A. -- in an area that was injured.

Q. If it wasn't a full-thickness injury at the end of the surgery on July 3rd, when did the hole open up, to a reasonable degree of medical probability?

A. Well, sometime over the ensuing days.
Q. What range of days?
A. Well, I would say that --
(Interruption in proceedings.)
THE WITNESS: I would say that range could be anywhere as -- as early as 24 hours to as late as 72, three or four days.
MR. DOYLE:
Q. So is it your opinion to a reasonable degree of medical probability that by July 8th, there was a full-thickness injury to the transverse colon?
A. Well, I think clearly by that time there was a full-thickness injury, whether it was at one of the two staple lines or whether it was at this third injury.
Q. Well, do you have an opinion to a reasonable degree of medical probability that one or both of the staple lines failed, leading to a full-thickness opening?
A. Well, we have the pathology report that shows that there was an opening at a staple line where there was a full-thickness injury.
Q. Are you able to discern which staple line that was, based on Dr. Rives's operative report?
A. No.
Q. And is it your opinion to a reasonable degree

of medical probability that the opening at one staple line described by the pathologist was present as of July 8th?

A. I think that to a reasonable degree of medical certainty, that at some point between the 3rd and -- I would characterize it a little more narrowly -- perhaps the 6th or 7th, sometime in that time frame, there was clearly an intra-abdominal source of sepsis, so I think we have to therefore conclude that there was a perforation in the bowel, whether it was at the third site that wasn't yet discovered or at one of the two colotomy sites that were stapled.

Q. So when you had the -- this full-thickness injury or perforation of the bowel open up sometime between July 3rd and July 6th, 7th, that time range, there would then be spillage of bowel contents.

A. There would be -- There would certainly be leakage of bacteria and possibly frank spillage of content.

Q. But when you said a few moments ago that -- that clearly -- Strike that.

When you said a few moments ago that by the 6th or 7th of July there was clearly an intra-abdominal source of sepsis, what you're saying is by that point in time, there's an opening in the bowel and there is spillage of

bacteria and bowel contents; true?

A. You know, not necessarily you can have a perforation in the bowel that can -- that can allow bacteria to escape into the peritoneal cavity that can lead to intra-abdominal sepsis and not have frank spillage of fluid or colon contents into the abdominal cavity.

For example, we can -- we see patients who are septic with perforations that have temporarily sealed themselves off with something, either omentum or the abdominal wall or some adjacent structure that can create intra-abdominal sepsis.

Q. How big was this hole by the 7th?

A. Well, I wasn't there. I can't tell you the answer to that. I can tell you --

Q. What's your estimate?

A. -- in looking at the pathology report -- you know, I'd have to look at it, but how big the hole was at the time that the specimen was resected. How big the hole was on the -- on the 7th I can't tell you. It's -- It's a little bit immaterial because it doesn't take a large hole to release bacteria from within the colon to outside the colon.

Q. Are you able to give me a reasonable estimate of the range of size of this through-and-through

perforation that you believe existed as of July 6th or 7th?

A. Well, it can be anything from, you know, the range of -- of, you know, a millimeter or two to a centimeter or more. Again, it's -- it's -- it's a little irrelevant because patients can become profoundly septic with tiny holes in the colon.

Q. And can a patient become -- Well, strike that.

You said a patient could become profoundly septic even with a tiny hole. That would occur because there is spillage of bacteria; correct?

A. Correct.

Q. And in some patients, not much bacteria can cause a lot of problems where some patients that same amount of bacteria would not cause the same cascade of problems. Fair statement?

A. Yes.

Q. Given your opinion that there was a through-and-through perforation by July 7th with a range perhaps of 1 to 2 milliliters to 1 centimeter or more in size, how do you explain the results of the July 9th CT scan?

A. (No response.)

Q. And let me ask you a foundational question.

You understand that CT scan was done with triple

contrast.

A. Yes.

Q. How do you explain the CT findings given your opinion about the presence of a hole at the time of that CT scan?

A. Well -- So a CT scan is a diagnostic tool. It's just one tool that we have at our disposal. And as with any diagnostic imaging, there's the potential for false positives and false negatives.

CT scans are limited by a number of things. One is that they're subject to interpretation. They're subject to the -- to the tolerances of the imaging capability, and they miss things. And it's certainly not inconceivable that the CT scan under-called the extent of infection.

In fact, frankly, in the presence of somebody who is septic, to rely on a CT scan to determine whether one should intervene surgically is foolish, and you have to take one imaging study and -- in the context of everything else that's going on. So the fact that the CT scan didn't show clear evidence of a perforation doesn't mean that that -- that there was no perforation. It's possible that the perforation could have temporarily sealed with omentum, for example, or the bowel could have stuck to something else like the

abdominal wall. So the fact that the CT is -- is -- you know, doesn't show the problem doesn't mean there's no problem.

Q. Okay. My question is this: To a reasonable degree of medical probability, can you tell me why the July 9th CT scan did not show any extravasation of oral contrast through this hole you have described?

MR. JONES: Objection; overbroad, vague, asked and answered.

THE WITNESS: Can I answer it again?

MR. DOYLE:

Q. Doctor, you provided me a general explanation of why a CT scan wouldn't show a hole. I'm interested in why this CT scan did not show this hole.

So my question is: Can you tell me to a reasonable degree of medical probability why the CT scan on July 9th there was no extravasation of oral contrast through the hole?

MR. JONES: Same objection that I just made.

THE WITNESS: Well, it's certainly likely that the hole had been -- occurred and sealed off by omentum or something else.

MR. DOYLE:

Q. And --

A. There's something preventing that contrast in

the colon lumen from leaking out through the hole.

Q. Did you consider the possibility that there was not yet a hole?

A. Well, one can consider that possibility, but it's illogical in the presence of evidence of intra-abdominal sepsis.

Q. At the time of Dr. Rives's surgery, given the two colotomies, you would expect there to be some minute amount of bacteria escaping from the transverse colon into the peritoneum; correct?

A. Yes.

Q. And that bacteria that has escaped from the transverse colon during the procedure on July 3 can cause an intra-abdominal infection.

A. Yes.

Q. Peritonitis.

A. Yes.

Q. And...

A. So given that that injury during surgery can cause peritonitis and given that Dr. Rives knew that he had caused at least two colotomies during the course of the operation, as I said in my previous documents, it's incumbent upon him to rule that out as a source of sepsis and do something about it.

Q. The two colotomies that Dr. Rives described

seeing and repairing, do you have an opinion to a reasonable degree of medical probability how those were caused? What was the mechanism?

A. They occurred during the course of dissecting the -- the colon from the mesh.

Q. Was it a -- tugging and pulling a sharp instrument or a through-and-through thermal injury?

A. Or some bottom combination of all three perhaps.

Q. And I'm asking you to a reasonable degree of medical probability whether you have an opinion how those two colotomies occurred. And if you don't, that's fine.

A. I can't say with certainty which technique specifically led to those specific holes.

Q. The rectal contra- -- Have you ever ordered a CT scan with rectal contrast?

A. I have.

Q. And the rectal contrast typically will pass how far up?

A. It depends. There is this -- It just depends. I mean, I -- I wouldn't necessarily expect it to get all the way to the transverse colon, but it depends on how much is used and how much pressure is put upon it.

Q. And you would expect the oral contrast to make

it to and through the transverse colon; correct?

A. It should if enough time is allowed from the time it's administered to the time the imaging is taken.

Q. When you looked at the actual images for the July 9th CT scan, did you look at the transverse colon to see if there was contrast within the lumen of the bowel?

A. There was contrast, and there was contrast beyond it.

Q. So there was contrast not only in the transverse colon but also in the descending colon as well.

A. Yes.

Q. And whether that was oral contrast, rectal contrast or some combination of the two, one would not know.

A. True.

Q. But we do know there was contrast all the way across the transverse colon down the left colon and through the rectum; correct?

A. Yes.

Q. Did you consider the possibility that the pressure caused by the rectal contrast caused a staple line to open?

A. That's possible, but it doesn't explain the

sepsis that was occurring prior to the study that was done.

Q. Okay. But the sepsis that was occurring prior to the study that was done can be explained by spillage of bacteria before the colotomies were repaired; true?

A. That is true --

Q. Okay. And --

A. -- yes.

MR. JONES: Hold on. Hold on. Let him finish his answer.

MR. DOYLE: Well, I got a plane to catch, and you guys -- you -- you showed up 30 minutes late, so I'd like to just --

MR. JONES: No, no.

MR. DOYLE: -- keep moving.

MR. JONES: He gets to finish his answer.

THE WITNESS: Okay. It's -- It's -- It's true. But if you've got a patient who's got abdominal sepsis, intra-abdominal sepsis, whether it's from a perforation that's actively spewing stuff out or it's from a perforation -- or it's from the colotomy at the time of surgery, it's still intra-abdominal sepsis. And the thing that should be done by a reasonable and prudent surgeon taking care of that patient is to reoperate.

So -- So we're splitting hairs a little bit as to

whether -- as to the source of it. Whether it's actively coming out or whether it came out at the time of surgery and then stopped coming out after the colotomy was closed with staples, it still occurred. And if the patient is exhibiting signs of sepsis -- and all indications are that the patient was exhibiting signs of sepsis that was intra-abdominal, not pulmonary or anything else -- then it's incumbent upon the surgeon to go back.

The worst thing that he could do -- The worst-case scenario is he goes back and takes a look and it turns out everything's fine. He's ruled out a – an intra-abdominal source. But he didn't do that.

So I -- I think it's, to a -- a significant extent, splitting hairs to determine exactly when the bacteria came out. The patient clearly was septic postop.

MR. DOYLE:

Q. But, Doctor, wouldn't you agree that if there's spillage of bacteria at the time of the colotomies, the colotomies are repaired, there's no more spillage of bacteria but that bacteria goes on to cause an intra-abdominal infection, that can lead to an abscess; true?

A. True.

Q. And an abscess often is treated by an

interventional radiologist with a drain rather than a general surgeon performing an open or a laparoscopic procedure; true?

A. If an abscess develops -- If -- If a -- If an abscess develops in an area that's essentially walled off, that's contained by something, by loops of intestine, for instance, or by bowel, and that -- that infection is well contained and well controlled and on CT scan you see an abscess that's discrete and that can be drained, certainly that's an indication for drainage.

In this case, that wasn't what was going on. That wasn't the case. There wasn't a drainable abscess. So one could say, "Well, there's not a drainable abscess because there's no infection," but that's not what's going on here. What's going on here is you've got a patient who's got intra-abdominal sepsis but isn't fortunate enough to have a drainable abscess. They've got peritonitis; they've got -- they've got sepsis; and it demands that the surgeon go back to surgery and wash the abdomen out.

Q. What are the peritoneal signs?

A. Well, peritoneal signs can be a rigid abdomen. They can be abdominal tenderness. They can be a distended abdomen. They can be absent bowel sounds. They can also be very difficult to determine in a

patient who is intubated and sedated and particularly a patient who had an encephalopathy who isn't really responding to normal cues. There's a lot of things that can obscure physical examination. So --

Q. I understand. I was just asking you what the signs are.

A. So I said those.

Q. Okay. Thank you.

You mentioned abdominal tenderness. But as a peritoneal sign, that's a specific type of tenderness called rebound tenderness; true?

A. True.

Q. And rebound tenderness is something different than generalized abdominal tenderness; true?

A. Well, rebound tenderness, um --

Q. Is that true or not?

MR. JONES: He can answer the question the way that he needs to answer the question.

THE WITNESS: Yes. But it's -- it's not a valuable sign in somebody who's unable to respond appropriately.

MR. DOYLE:

Q. Did I ask that question?

A. No, but I answered it.

Q. I understand. You know, I understand you want to be advocate here, but if you could just -- if you

could just answer my questions --

MR. JONES: Okay.

MR. DOYLE:

Q. -- then we can --

MR. JONES: We're not going to have any of this nonsense with you trying to instruct my witness on what he -- how he is to answer or not answer a question. So -- So he is able to answer it how he feels it is appropriate. And if your question -- the call of the question cannot be answered with a "yes" or "no," he can answer it the way he needs to.

MR. DOYLE:

Q. Can we continue?

A. Yes.

Q. All right. What role does a physician's judgment play in their treatment of a patient?

A. Well, a physician's judgment is important in treatment of a patient.

Q. Why is it important?

A. So we have to apply sound medical judgment to the decisions we make in the -- in the care of our patients. Sound medical judgment requires that you consider the pros and cons of -- of any given approach, that you consider the ramifications of -- of the actions you're taking, that you provide the patient with an

opportunity to consider those -- those risks and benefits of -- of both sides of a -- of -- of -- of an issue and come to the correct conclusion. They require that you apply the -- you know, your education and your training to help guide you in those decisions.

So part and parcel of surgical decision-making is understanding the risks and the benefits of -- of the approach that you're taking. If you are taking a conservative, nonoperative approach to a patient, for example, you have to consider what the potential deleterious effect of that nonoperative course may be and also what the deleterious effects could be of -- of surgical intervention.

And it's also incumbent upon the physician to have that discussion with the patient so they can make an informed decision. If the patient is incapacitated, then that falls to, you know, whoever has got, you know -- you know, whoever is, you know, in -- in charge of their care.

Q. So it sounds like judgment is an important component of a physician's care of a patient.

A. Yes.

Q. And one has to exercise their judgment when looking at the pros and cons of different alternative ways of approaching a patient; correct?

A. Yes.

Q. Can you and I agree that -- that in surgery, there are a number of situations where you might have two different general surgeons go about treating care -- treating a patient differently yet both be within the standard of care?

A. Yes, but I don't think this is one of those circumstances.

Q. I asked you a general question, Doctor.

Can you agree as a general matter that you can have situations where two general surgeons can be taking care of a given patient and both be within the standard of care even though they're taking of the patient differently?

A. Yes. That hypothetical exists.

Q. And that's part the art of medicine as well; correct?

A. Yes.

Q. And can a physician err in judgment?

A. Yes.

Q. Can a physician err in judgment and still be within the standard of care?

A. Yes.

Q. Can a physician err in judgment, be within the standard of care, yet unfortunately cause their patient

some injury?

A. Yes.

Q. Has that happened to you where you have looked back on your care of a patient and thought that you had erred in judgment but were within the standard of care yet unfortunately caused some injury?

A. Yes.

Q. Have you ever been a defendant in a malpractice case?

A. Yes.

Q. How many times?

A. I was -- I've been named in three cases. Two of those were -- never went anywhere. They were dismissed outright. And one went to arbitration. And in that -- And that case had very -- really no similarity to this, but -- so yes.

Q. Was there an arbitrator's award against you?

A. No. The arbitrator dismissed the case without judgment.

Q. The other side had an expert witness?

A. Yes.

Q. Who disagreed with your expert witness.

A. I -- I don't remember whether the other side had an expert witness. I -- I have to assume they did.

Q. And assuming the other side had an expert

witness, presumably that expert witness disagreed with your expert witness about whether your care was within the standard of care.

A. Yes.

Q. Yours said "Okay"; theirs said "Not okay."

A. Right.

Q. How does that happen?

A. You know, clearly -- How is it that you can get an expert to take any position?

Q. Sure.

A. Is that what you're asking --

Q. Sure.

A. -- how -- how can you get an expert to take any position?

I -- I think that you can look at things from different perspectives and through different lenses.

I happen to feel that in this case -- and -- and -- and I will say I have not done a lot of expert witness work, but I have done expert witness both on the defense side and on the plaintiff side. People have different perspectives on things. That doesn't mean both sides are right every time. And in this case, it is very clear to me that sound surgical judgment required that Dr. Rives recognize that this is an intra-abdominal source of sepsis that is not improving with antibiotic

therapy alone and that surgical intervention is required. And I, frankly, find it hard to see the perspective of the other side. So I feel that he did not exercise sound judgment in this case.

Q. Do you know Dr. Brian Jewell?

A. No, I do not.

Q. From reading the information provided to you, did it appear to you that he's a well-qualified general surgeon?

A. Yes.

Q. Do you know Dr. Bart Carter?

A. I do not.

Q. Based upon the information provided to you, would you agree that he's a well-qualified general surgeon?

A. Yes.

Q. Do you practice in a group here?

A. I do.

Q. How many general surgeons in the group?

A. 12.

Q. Are all board certified?

A. Yes.

Q. At Hoag Memorial, are there general surgeons on staff who are not board certified?

A. No.

Q. Do you know any -- Go ahead.

A. I was going to say that they're either board certified or board eligible. I believe that everybody is -- has -- everybody that's on staff has been in practice long enough to be certified.

Q. Do you know any general surgeons, perhaps socially or professionally, that are not board certified?

A. If they're not board certified, they don't talk about it. I -- I wouldn't know.

Q. You saw in this case that Dr. Rives is not board certified.

A. Yeah, I saw that.

Q. You were provided with the details of why.

A. Yes.

Q. And would you agree with me that as a general proposition, a general surgeon can still be well qualified, well trained and competent even though he or she is not board certified?

MR. JONES: Objection; overbroad, speculation.

THE WITNESS: I think that i- -- i- -- it's certainly possible that a good surgeon can be a good surgeon despite having failed board exams. I don't necessarily think that an ability to pass a board makes you a better surgeon. But -- I don't want to qualify

that. I don't -- I don't -- I -- I -- I can't point to data that would show a board-certified surgeon is better than a non-board-certified surgeon except that there's a reason that we have boards, and there's a reason that surgeons are required to pass boards in order to be board certified because -- because it's important to maintain that -- that knowledge base and to show that you've mastered the information.

MR. DOYLE:

Q. Do you have any information about how Dr. Rives has maintained his knowledge in general surgery?

A. No.

Q. Or minimally invasive surgery?

A. No.

Q. Any of the courses or lectures or -- or what he does to remain current?

A. No.

Q. Can we agree as a general matter that a general surgeon who is not board certified can practice within the standard of care?

A. Yes.

Q. That you have to look at the care, not the absence of board certification; correct?

A. Correct.

Q. Have you been practicing long enough where,

like me, you remember paper hospital charts?

A. Yes, fondly.

Q. As do I.

In the days of paper hospital charts, generally when multiple physicians would be following a patient -- for example, a patient in the ICU -- the physician would either write a note or dictate a note for that particular day's visit; correct?

A. Correct.

Q. And that note would go into the chart.

A. Yes.

Q. And if you wanted to look at a particular physician's thinking over, say, a one-week period of time, you could read their different progress notes and you could figure out the evolution of their thinking, typically.

A. Yes.

Q. Can't do that with electronic medical records, can you?

A. Well --

Q. Can you?

A. Yes, you can. I would -- I would disagree with that.

Q. All right. Well --

A. But it's challenging because you have to get

past a lot of filler. But ultimately, when reviewing charts, you go to the -- to the Assessment and Plan portion of the progress note, and -- and that's where we, you know, free text or free -- you know, free type in our -- our conclusions and what we plan to do going forward.

So I -- I would disagree with the notion that -- that you can't draw conclusions like you could from a paper chart. To the contrary, I think you can read them better. You can read -- You don't have to worry about doctors' handwriting. You just have to wade through a lot more filler that -- that doesn't contribute to the -- to the discussion.

Q. What system does Hoag use?

A. We use a system call Epic.

Q. What system does St. Rose-San Martin use?

A. I don't know.

Q. Was it your impression when you were reviewing these records that different physicians could choose different templates for creating progress notes?

A. It looked to be the case to me.

Q. And the same is true for Epic, isn't it?

A. More or less.

Q. So some physicians may choose to have certain information self-populated, and others choose not to

have that information self-populated.

A. Yes.

Q. A physician's progress note from a day earlier may or may not self-populate their next day's progress note, depending on the choices they've made.

A. Well, we certainly see an issue where sometimes physicians will cut and paste, copy forward and so forth, if that's what you're referring to.

Q. Well, yes. And did you see that in this case?

A. I can't think of a specific instance. I do recall seeing some things that look like it was the same thing going forward, not necessarily with Dr. Rives.

Q. Okay. But other physicians caring for Mrs. Farris?

A. Yes.

Q. You saw the same entry day after day even though that same entry was no longer germane.

A. I think so, yes.

Q. Okay. You mentioned something about having your billing records. Can you show me where the --

A. My billing records?

Q. Yeah. I thought you said something when we were going -- marking exhibits. You -- I thought you said your bills were here.

A. The -- I have the -- the invoice that I

submitted for the review of the case up to the point that I've submitted that bill.

Q. Can I see it?

A. It's old-fashioned handwritten.

Q. I like handwriting.

A. (Indicating.)

Q. You don't need to pull the clip off.

A. Here it is.

Q. I saw that earlier.

So this is something contained in Exhibit A, and it says at the top "Invoice Summary, Doctor"; correct?

A. Yes.

Q. And it's an invoice dated December 4, 2018?

A. Yes.

Q. Is this the first invoice that you created documenting the time you spent on this case?

A. Well, according to that, it says that's for additional time, but then I couldn't find the original invoice, which to me begs the question as to whether I ever sent one. So this is the only one I could find, so, um...

Q. Can you give me an estimate of the total amount of time that you have spent on this case as of December 4, 2018 when you prepared this invoice?

A. Well, how many hours is on there?

Q. On here is four hours.

A. So the initial -- So if that's my secondary invoice, I -- I probably submitted an invoice for about an hour to an hour and a half for my initial review of -- of the case and my discussion with Mr. Hand.

Q. Okay. And then the invoice that we have, then, for December 4, 2018, capturing your time after that, we have "Case review" and "discussion with Mr. Hand, 1.5." And then "Declaration prep November 13, 2018" we have "2.5"; correct?

A. Yes.

Q. And what is your fee, by the way, for reviewing records?

A. Well, the amount that I'm paid for reviewing records by National Medical Consultants is 375 an hour, but that's not the -- that's not the bill to the -- to the attorney.

Q. Is -- I forget. Is National Medical Consultants that company in New York that has provided the other experts in this case?

A. Yes.

Q. And how long have you been affiliated with them?

A. I think two or three years.

Q. Is that how Mr. Hand found you for this case?

A. Yes.

Q. And when the Complaint was filed, there was a different general surgeon who was his expert who prepared an affidavit, and --

A. Uh-huh.

Q. -- you were provided with that affidavit.

Do you recall it?

A. Yes.

Q. Do you know why that person is no longer involved?

MR. JONES: Objection; speculation, foundation.

MR. DOYLE:

Q. That's why I asked "do you know."

A. I do not.

Q. Have you had any conversations with that general surgeon?

A. No.

Q. Have you had any conversations with any of the attorneys about that other general surgeon?

A. No. I never asked.

Q. Okay. And then what is your fee for -- well, what do you get paid, and, if you know, what am I being charged for your deposition?

A. I -- I think you're being charged -- I'm not sure what you're being charged, to be honest with you.

I think it's a -- I think it's a thousand an hour.

Q. What are you getting?

A. Something less than that.

Q. How many cases have you received from NMC?

A. I'd have to look at the list there.

(Reviews document.)

Maybe -- Maybe 10 to 15, somewhere in that range. A lot of them don't really go anywhere or, you know, have any resolution. There are several that I've declined to participate in. So really it's just handful of cases that's listed there.

Q. Have you ever testified at a trial --

A. Yes.

Q. -- as a ex- --

Have you ever testified at trial as an expert witness?

A. Yes, I have.

Q. In what states?

A. California.

Q. How many times?

A. I testified -- I've testified at two trials and one arbitration.

Q. Plaintiff, defense, or combination?

A. Those were all defense.

Q. I'm looking at the "Record of Expert Deposition

and Trial Testimony" in Exhibit A. Is this all of your deposition and trial testimony or just back to a certain point?

A. That's back to, I believe, 2014. I may have had a couple of depositions prior to that, but I don't have any record of them, so I couldn't include them on the list.

Q. Any of these cases that are on this list in Exhibit A, do they have any issues similar to our case?

A. No.

Q. Oliver versus Blanco-Cuevas, the general surgeon in Las Vegas, do you remember what that case was about?

A. That was a patient who died of exsanguinating hemorrhage following a laparoscopic chol- -- a laparoscopic to open cholecystectomy.

Q. Have you worked with Mr. Hand on other cases?

A. There's one other case that I've worked on with him.

Q. And the new counsel, Bighorn Law --

Am I saying that right?

MR. JONES: Yeah, big.

MR. DOYLE: Yeah.

Q. These guys. Have you worked with the new associated counsel before?

A. No.

Q. The money that you earn as an expert witness, does that go to you? Does it go to some academic institution, some philanthropic organization? What happens to it?

A. It goes to me.

Q. And if you look at the percentage of time that you spend doing medical/legal work compared to your practice of medicine, what would those numbers be?

A. Maybe 5 percent of my time.

Q. Same question for earned income from medical/legal work versus other earned income.

A. 5 percent or less.

Q. And I apologize. You might have said this a moment ago. But when you went through Mrs. Farris's records from the St. Rose Hospital, you did see, in the progress notes, information that was self-populated; correct?

A. Well, certainly every progress note is loaded with labs and vitals and everything that -- all that is self-populated.

Q. But there was also information entered by physicians on prior days that was also carried forward into a subsequent day.

A. Probably. I -- I can't -- I can't think of a

specific example, but I believe there may be that.

Q. Do you recall seeing sometimes notes in just small letters and sometimes notes in all capital letters?

A. No, but I'd be happy to...

Q. Does that have any meaning to you, knowing what you know about electronic medical records, if you see someone's note that has small letters and then, at the end of the note, it's all capital letters?

A. Well, it would suggest either that it was cut and paste, you know, or copied forward or something of that nature.

Q. I want to ask you some questions about sepsis generally.

The definition of sepsis has changed and evolved over the years. Can we agree?

A. Yes.

Q. In -- Strike that.

Are you familiar with the Third International Consensus Definitions for Sepsis and Septic Shock that came out in 2016?

A. Not specifically.

Q. Are you aware of the American College of Surgeons' definitions for sepsis and septic shock?

A. I mean, I have a good understanding of what

sepsis and septic shock are. I don't know if I can, you know, quote the American College of Surgeons version, but...

Q. Would you agree with me that the defi- -- the commonly used definition of sepsis in 2015 was Systemic Inflammatory Response Syndrome plus an infection?

A. Yes. And the -- And Systemic Inflammatory Response Syndrome is -- is -- has sort of -- seems to have fallen out of favor a little bit in response to sepsis syndrome.

Q. Right. And it fell out of fa- -- started failing out of favor in 2016 when there were different consensus definitions; correct?

A. Yes.

Q. All right. But in 2015, the commonly used definition of sepsis did include Systemic Inflammatory Response Syndrome as part of the definition.

A. Oh. Okay.

Q. "Yes"?

A. I believe so.

Q. And Systemic Inflammatory Response Syndrome, short for that is SIRS, S-I-R-S?

A. Yes.

Q. So I'm just going to say SIRS.

A. Okay.

Q. Would you agree that one of the criteria for SIRS back in 2015 was a temperature greater than 38 degrees Celsius or less than 36 degrees Celsius?

MR. JONES: Objection; foundation.

THE WITNESS: I don't know the answer to that.

MR. DOYLE:

Q. Would you agree that one of the SIRS criteria in 2015 was a heart rate greater than 90?

MR. JONES: Objection; foundation.

THE WITNESS: I will take your word for that.

MR. DOYLE:

Q. Would you agree that one of the SIRS criteria in 2015 was a respiratory rate greater than 20?

MR. JONES: Objection; foundation.

THE WITNESS: I believe so.

MR. DOYLE:

Q. Would you agree that one of the SIRS criteria in 2015 was a white blood cell count greater than 12 or less than 4 or greater than 10 percent bands?

MR. JONES: Foundation.

THE WITNESS: I was not aware of that specifically.

MR. DOYLE:

Q. Were you aware that in 2015, the definition of severe sepsis was SIRS plus an infection plus organ dysfunction?

MR. JONES: Foundation.

THE WITNESS: I -- I -- I don't recall what the definition was in 2015 or 2016.

MR. DOYLE:

Q. Can we agree that amongst practicing physicians, the term "sepsis" can be bandied about sometimes loosely?

A. Yes.

MR. JONES: Objection; vague.

MR. DOYLE:

Q. Can we agree that when "SIRS" was being commonly used, that it too was bandied about sometimes loosely?

MR. JONES: Vague.

THE WITNESS: I -- I don't -- I -- I don't know that I can answer whether somebody was bandying that about loosely. I think -- I think that sepsis in 2015, as with sepsis in 2019, is apparent to clinicians taking care of patients and -- and we don't generally look up the consensus statement of our parent organization to determine whether our patients are septic.

MR. DOYLE:

Q. Well, but if you're going to be expert witness in a medical malpractice case, you want to use the terms precisely; true?

MR. JONES: Objection; vague, argumentative.

THE WITNESS: I think when you have a -- a patient who is -- who is tachycardic, has a increased respiratory rate, has a leukocytosis, respiratory failure and organ dysfunction, I think we can agree that that patient has signs of sepsis.

MR. DOYLE:

Q. And can you tell me what the current definition of "sepsis" is according to the American College of Surgeons, which you are a member of?

A. I am a member of the American College of Surgeons.

Sepsis is the -- and I can't tell you the exact verbiage of -- of the statement, but sepsis is the -- is the derangement in -- in a patient's health with derangement in metabolic processes, vital signs and other abnormalities in -- in response to a -- an infectious process that leads to a cascade of inflammatory events.

Q. Based on your review of Mrs. Farris's records and going back to 2015 when "SIRS" was still being used, did she meet the criteria for having SIRS on July 4th?

A. I'd have to look at -- go back to her -- I'd have to go back to that date to look at it.

Q. And if I asked you the same question for each

day up to the time of Dr. Hamilton's surgery, would your answer be the same?

A. Well, I -- she clearly exhibited signs of -- of -- of SIRS and sepsis. She had -- She had respiratory failure; she had tachycardic -- tachycardia; she had an increased respiratory rate. Ultimately she required intubation. She had a profound leukocytosis. She had at least low-grade fevers. All that was partially mitigated by the broad spectrum antibiotics that she was on. But I -- I think that -- that any reasonable physician would recognize that she had evidence of sepsis, whether you call it SIRS with infection or sepsis.

Q. Here's my question: Did she have SIRS as that definition was used in 2015 on July 8th?

A. I'm going to, uh...

MR. JONES: Object foundation.

THE WITNESS: I would have to look at all of her vitals and look at the definition and go line by line and tell you whether they met -- she met the SIRS criteria at that time. But she was clearly septic.

MR. DOYLE:

Q. Same question for July 9. Same answer?

A. I believe she did.

Q. Okay. If the definition of sepsis in 2015

included a patient having SIRS yet you can't tell me whether she met the criteria for SIRS on any particular day, how do you come to the conclusion that she met the definition of "sepsis" in 2015 on a particular day?

MR. JONES: Objection; compound, argumentative.

THE WITNESS: I think, first of all -- I think, first of all, it's irrelevant because you've got a patient who is clinically -- that -- who clinically has an ongoing infection, and that should be apparent to any surgeon, whether or not they're board certified.

I -- I would leave the definition and the parsing of -- of the definition to infectious disease or critical care experts, but I would say that -- that any reasonable and prudent surgeon is going to recognize that this patient has an infectious source of their acute and unrelenting illness. So I -- I don't understand the reliance upon the definition to determine that.

MR. DOYLE: Okay.

Q. But I get to be the lawyer; right?

A. Okay.

Q. Okay. Did Mrs. Farris's renal function improve between July 4 and July 15?

A. Yes.

Q. Did her left shift improve between July 4th and

July 15th?

A. There was a time when it did, yes.

Q. Did her blood pressure improve between July 4 and July 15?

A. Yes.

Q. Did her heart rate improve between those dates?

A. Yes.

Q. Did her temperature improve between those dates?

A. Before it got worse? Yes. She was -- There were times when she was not febrile.

Q. Between July 4th and July 15th, was she requiring less ventilatory support?

MR. JONES: Objection; vague, form.

THE WITNESS: I'd have to go back and look at that again. I don't know the answer to that.

MR. DOYLE:

Q. Between July 4th and July 15th, did her mental status improve?

MR. JONES: Objection; vague, form.

THE WITNESS: Her encephalopathy improved.

MR. DOYLE:

Q. That would be her mental status --

A. Yes.

Q. -- correct?

Between July 4 and July 15, the a-fib resolved; true?

MR. JONES: Objection --

THE WITNESS: Yes.

MR. DOYLE:

Q. Between --

MR. JONES: -- vague.

MR. DOYLE:

Q. -- July 4 and July 15, her blood glucoses came under control; correct?

A. Yes.

Q. Between July 4 and July 15, her abdominal pain improved?

MR. JONES: Objection; vague, speculation, form.

THE WITNESS: Yes, there were times that it did.

MR. DOYLE:

Q. Did you see that each physician who saw her each day -- or virtually each physician documented abdominal examination?

A. Yes.

Q. Did you ever see someone document any peritoneal signs?

A. Specifically using that term?

Q. Correct.

A. I don't recall.

Q. Have you ever had a patient or a patient's family become unhappy with you and your care?

A. Probably.

Q. Have you ever had a patient or a patient's family who you're taking care of the patient and the patient or the family asked for a second opinion from a different general surgeon?

A. Yes.

Q. Have you been in a situation yourself where the patient or the patient's family says, "Dr. Hurwitz, I'd rather you stop taking care of me. I want someone else to take care of me"?

A. I can't -- I can't -- I can think of one, yes.

Q. And in that situ- -- In your own experience, when a patient or the patient's family member asked you to step out of the case and let someone else take over, you did so?

A. Yes.

Q. When you -- When you were in a situation where you had a patient or a patient's family member say, "Hey, Dr. Hurwitz, I'd like to get a second set of eyes" or "get a second general surgery opinion on this case," you agreed?

A. Yes.

Q. And I assume that's happened to your partners

or colleagues here?

A. Yes.

Q. Something that happens from time to time, patients are unhappy with a particular individual?

A. Correct.

Q. The conversation that you had with counsel today, how long did you guys talk?

A. Maybe 30 minutes.

Q. Were you --

A. 20, 30 minutes.

Q. Were you provided with any records that had not already been provided to you?

A. No.

Q. Were you provided with any information orally that was information you were not already aware of?

A. No.

Q. What was the gist of the conversation today?

A. I can't tell you exactly. We just went over -- We went over the -- the case and -- and -- I can't specifically recall the exact nature of the discussion. We went over the -- my interpretation of the x-rays, for example.

Q. Did you have films up?

A. No.

Q. What did you -- Were there any x-ray -- Well,

strike that.

Did you discuss any of the plain films?

A. Yes.

Q. Which plain films did you discuss specifically?

A. The chest x-rays from the -- from the beginning of the case forward.

Q. And what was your conclusion, having looked at those -- Films or reports?

A. Reports. But I'd looked at the films previously.

Q. And what was your conclusion?

A. That there wasn't evidence to support the notion that this was sepsis secondary to an aspiration pneumonia or aspiration pneumonitis, that it wasn't a pulmonary source of -- of sepsis as the source of all this.

Q. Did you see, on July 4th, Dr. Rives's note about Ms. Farris drinking a SoBe beverage?

A. Yes.

Q. What's a SoBe beverage?

A. I think that's like an ice tea or something.

Q. She was NPO at that point in time; correct?

A. Yes.

Q. Nothing by mouth.

A. Correct.

Q. Not supposed to be drinking thin or thick fluids; correct?

A. Correct.

Q. Not supposed to be drinking a SoBe beverage; correct?

A. Correct.

Q. Because drinking such a beverage puts a patient at risk for aspiration.

MR. JONES: Objection; calls for speculation.

THE WITNESS: It does.

MR. DOYLE:

Q. And if a patient were to aspirate drinking such a beverage, that can cause an aspiration pneumonia or pneumonitis, generally speaking.

A. Particularly if that patient vomits as a consequence of drinking the beverage and -- and aspirates because of that.

Q. Have you ever heard the term "microaspirate"?

A. I suppose so.

Q. Can a patient microaspirate during intubation for general anesthesia?

A. Yes.

Q. If a patient is obese, are they at increased risk for microaspiration during intubation for general anesthesia?

A. I think if a patient is -- Particularly if a patient is morbidly obese or is being intubated having not been NPO prior to surgery for some period of time, aspiration is possible.

Q. What is your definition of "morbidly obese" in terms of a BMI?

A. 40.

Q. Do you recall what Ms. Farris's BMI was on admission?

A. I thought it was -- and correct me if I'm wrong. I thought it was around 31 maybe.

Q. When you reviewed Dr. Chaney's records, the primary care physician, I assume you noticed in Dr. Chaney's records her diagnosis of a peripheral neuropathy before July of 2015?

A. I recall that, yes.

Q. And peripheral neuropathy is a -- is a complication of diabetes.

A. Yes.

Q. And the risk of peripheral neuropathy increases if a patient is noncompliant with the treatment for diabetes.

A. That's my understanding, but I'm not a neurologist.

Q. As a general surgeon, do you have any reason to

disagree with Dr. Chaney's diagnosis of a peripheral neuropathy due to diabetes?

A. No.

Q. The ICU at Hoag, is it open or closed?

A. What do you mean?

Q. Is there a single intensivist group that has the contract or can any intensivist see a patient in the ICU at Hoag?

A. It's closed.

Q. Who has the contract?

A. There's a group of intensivists that cover the ICU.

Q. How often will you have one of your postop patients in the ICU?

A. Occasionally. You know, once or twice a month maybe.

Q. In those instances where you have a patient in Hoag's closed ICU, is the critical care medicine specialist typically the attending in the ICU?

A. In other words, do we sign out our care to that --

Q. No.

A. -- doctor? I don't know what you mean by that.

Q. Who's the captain of the ship when one of your postoperative patients requires an ICU admission?

A. Well, I'll generally -- I'll generally defer to the intensivist when it comes to ventilatory management and -- and drips and so forth.

Q. And other medical issues as well; correct?

MR. JONES: Objection; speculation, overbroad.

THE WITNESS: Typically if the -- the patient's got a surgical problem, I'll manage the surgical problem, if there's a wound issue for example. And other specialists are also involved in the care of critically ill patients, the pulmonologi- -- or not the pulmonologists necessarily but the nephrologists, cardiologists and so forth.

MR. DOYLE:

Q. You saw there was a nephrologist involved in Mrs. Farris's care?

A. Yes.

Q. Cardiologist?

A. Yes.

Q. Infectious disease specialist?

A. Yes.

Q. Critical care medicine?

A. Yes.

Q. In addition to Dr. Rives?

A. Yes.

Q. There was also a hospitalist that was seeing

her from time to time in the ICU.

A. Yes.

Q. Is it your understanding that at St. Rose back in 2015 -- and tell me if you don't know -- that the critical care medicine specialist would be the one typically writing the orders and arranging for the consults of a patient in the ICU?

A. I don't know.

Q. Here at Hoag when you have a patient of yours in the ICU and is being followed by one or more specialists in the ICU, do you communicate with those specialists?

A. Yes.

Q. Orally and by way of the hospital records?

A. By -- Orally by way of the hospital records and also by secured text and other means at our disposal.

Q. And so you're generally communicating with the specialists who are following your patients to see how your patient is doing.

A. Yes.

Q. And you always appreciate their insight and input.

A. Yes.

Q. And I assume over the years you've had a patient in the intensive care unit followed by the

critical care specialist or some other specialist, and that physician has come to you with a concern about something going on inside the abdomen.

A. I'm sure that's happened, yes.

Q. And you would, of course, appreciate their advice and input.

A. Yes.

Q. Have you had conversations with a critical care -- Well, strike that.

When you've had your postop patients in the ICU and they're being followed by one or more specialists, have you ever had discussions with those specialists about taking your patient back to surgery?

A. Yes.

Q. Bounce the idea off of them, see what they think?

A. Yes.

Q. You might be interested in what they think are the pros and cons of surgery from a medical or perhaps renal point of view?

A. Or whether the patient is stable enough for surgery, yes.

Q. I mean ultimately the decision whether a patient goes back to surgery is yours, but you certainly welcome advice and input from others.

A. That is true.

Q. Is there any particular piece of literature that you're going to be using or referring to at trial when you testify?

A. Not necessarily, no.

Q. I mean, as you sit here today, are you aware of any literature that you're going to be bringing to trial to support your opinions or refute the opinions that are different than yours?

A. No, I can't -- None that spring to mind, but I reserve the right to do so.

Q. In your opinion --

MR. JONES: Just one thing so you're aware: The same -- The same studies that Dr. Stein -- sorry -- that Dr. Stein talked about in his deposition, those were provided along with Dr. Stein's deposition, so he has those.

MR. DOYLE: Okay.

We okay to continue, or do you want to take a break? Let's take five minutes. I want to go through my notes and --

THE WITNESS: Okay.

MR. DOYLE: I mean, I'm hoping we'll finish by 6:00.

THE WITNESS: Okay.

(A recess is taken.)

MR. DOYLE: Let's go back on.

Q. Dr. Hurwitz, at the break did you get the CD you mentioned earlier that was in your office?

A. Yes, I did.

Q. And tell me what's written on it.

A. "Titina Farris, St. Rose-San Martin 2015 Admission Films."

Q. Did you review all of the images on this CD or just some?

A. Most of them. They're -- I -- I believe I reviewed all of them, yes.

Q. So it's your opinion, Doc- -- Strike that.

It's your opinion the standard of care required Dr. Rives to take Ms. Farris back to the operating room; correct?

A. Correct.

Q. At what point in time or what's the latest point in time he could do so and, in your opinion, still be within the standard of care?

A. Well, I would say that -- that beginning on the 5th when she went into -- when -- when she required intubation, from that point forward he had an obligation to take her to the operating room.

I think clearly it was evident within -- it was

evident by the -- within the next 48 to 72 hours that she was declining and showing evidence of intra-abdominal sepsis. I think it was incumbent upon him to do so. I would say even on -- up to the 9th. I think beyond that he's clearly delaying taking her back, and I think that beyond that -- that time frame, he's below the standard of care.

I think that -- that it's -- it's difficult when you look at something incrementally to say, "Okay. Well, now we've passed the point where it's standard of care." I don't know that there's a bright line. But there's clearly a time frame over the 48 to 72 hours from the time that she evidenced -- that she showed clear evidence of decline that he should have taken her back to the operating room.

Q. So -- Don't let me put words in your mouth. I know you wouldn't. I'm just trying to understand.

Are you saying that -- that say by the morning of July 9th, the standard of care mandated a return to the operating room by that point in time, and whether he took her back earlier would be a matter of debate or judgment?

MR. JONES: Objection; compound, misstates.

THE WITNESS: I think that he's -- that over that time frame, it is clearly evident that the patient is

showing clear evidence of intra-abdominal sepsis.

I think that it's reasonable to take a couple of days to see if her course improves with antibiotics. But I think it became evident, as her white blood cell count remained elevated and she showed other signs of sepsis, that she was not improving and any improvement that she was exhibiting was incremental and minimal and was not -- and was negligible in the -- in the scheme of things. And I think that by the time the patient was seen in second-opinion consultation by Dr. Ripplinger, who clearly expressed his concern, I think that it -- it was incumbent upon Dr. Rives to take her back.

Now, I would quibble a little with the morning of the 9th. Dr. Ripplinger saw her on the morning of the 9th. So had Dr. Ripplinger seen her, communicated his concerns with Dr. Rives, I -- I think at that point it was clear that the patient needed to go back. And -- And I think beyond that point, it -- he's clearly below the standard of care.

So the exact time when he crosses that line is difficult to say. But I'd say -- I would say that by the time that he's had that opportunity to have a second opinion -- and Dr. Ripplinger clearly was concerned about the status of this patient -- I think it was incumbent upon him to take her back.

I think that -- I -- I think that relying upon a CAT scan to make that determination was a mistake.

MR. DOYLE:

Q. So again, I -- just for purposes of trial, I need to understand what your opinion is going to be.

But if we assume hypothetically Dr. Rives had taken Mrs. Farris back to the operating room sometime on July 9th after Dr. Ripplinger had seen her, that would have been within the standard of care?

A. I -- I would -- I would think that that would be -- I think that would be reasonable.

Q. And within the standard of care.

A. Yes.

Q. Okay. And I assume over the years you've been involved in M&M meetings.

A. Yes.

Q. Grand rounds.

A. Yes.

Q. Peer review.

A. Yes.

Q. I assume you have participated in meetings where there have been frank discussions about a particular physician's care of a particular patient.

A. Yes.

Q. And in those frank discussions, well-qualified

and reasonable physicians might disagree about the care and the quality of care; correct?

A. Yes.

Q. And so, you know, what's important in our case is not a personal criticism or "I would have done something differently," but rather it's the standard of care. So what I'm hearing you say is -- is if Dr. Rives had performed surgery on --

(Interruption in proceedings.)

MR. DOYLE: I'll start over.

Q. If Dr. Rives had taken Mrs. Farris back to the operating room on July 9th after Dr. Ripplinger had seen her, that would have been reasonable and within the standard of care.

A. I think that -- Yes. I would --

Q. Okay.

A. I would grant you that.

Q. And taking her back on the 10th would be below standard of care.

A. Again, it's -- I would say "yes," that's true as well.

Q. Did the standard -- Okay.

A. Yes. I would agree with you on that -- in that case.

Q. So if he takes her back to surgery on the 10th,

that would be too late and below the standard of care.

A. I think it's pushing it. It's pushing it. It's -- It's pushing that standard. It -- It's -- There's not a clear line. There's not -- It's -- It's a -- It's very difficult to say, "Well, this is where the standard of care stops, and this is where below the standard of care begins." It's very clear that several days have gone by and the day -- and the -- and even -- even the 9th is pushing it; right? But I'm saying the 9th because at least then he gets a second opinion from Dr. Ripplinger.

So I would say if on the 9th he takes that advice, he discusses it with Dr. Ripplinger, he goes to surgery, I'd say it's kind of late to be doing this but at least you got the patient back to the operating room. You wait another day, you're just pushing it down the road even further. So I'll leave it at that.

Q. If Dr. Rives had taken her back to the operating room on July 9th, of course there would have been a second surgery; correct?

A. Yes.

Q. There would have been the care and medical expenses incurred with that surgery; correct?

A. Yes.

Q. And I noticed in your affidav- -- or in your

initial report, that you reviewed the hospital bills in this case; correct?

A. Yes.

Q. And you indicated they were reasonable, necessary or -- I don't remember.

A. Yeah.

Q. Okay. But taking her back on the 9th, there still would have been medical bills incurred for the surgery, the anesthesia and the hospital; correct?

A. Correct.

Q. And even taking her back to surgery on the 9th, she would have required some length of time in the hospital before she could be discharged home.

A. Yes.

Q. Can you tell me to a reasonable degree of medical probability -- Well, strike that.

If he had taken her back to surgery on the 9th, it's likely that in the postoperative period, she would have spent some time in the ICU; correct?

A. Correct.

Q. Because she was still on the ventilator.

A. Correct.

Q. Even with surgery on the 9th, they would have to keep her in the ICU, keep her on the ventilator for some period of time until they could wean her from the

ventilator; correct?

A. Correct.

Q. And treat her other medical problems that were still ongoing; correct?

A. Yes.

Q. Can you tell me to a reasonable degree of medical probability -- and if you can't, that's fine. But can you tell me to a reasonable degree of medical probability: With surgery on the 9th, at what point in time would she have been able to go home?

A. (No response.)

Q. And if it would be speculating, tell me that too.

A. It would be somewhat speculative. But give her a -- assuming she has surgery on the 9th -- on the 9th she would require a colostomy as she ended up getting several days later -- it certainly would have hastened her recovery, so perhaps she would have gone home a week later. But that is speculative.

Q. Okay. But even with surgery on the 9th, she was going to need the colostomy, and she was going to need the colostomy takedown later; correct?

A. I think she would have needed a colostomy whether she were operated on the 9th or whether she were operated on the 5th. So regardless of -- And again,

standard of care, you know, even giving him the benefit of the doubt of the 9th, even had he operated her on the -- on the 5th, she would have ended up with a colostomy. She would have had to have her infected synthetic mesh removed. So it would have been a -- a big operation. But it would have hastened her recovery, gotten her off of the ventilator sooner. She may have avoided having a tracheostomy, and she would have been out sooner.

Q. Well, typically if you have a patient on a ventilator, you don't want them on the ventilator for more than 10 or 14 days with an oral intubation; correct?

A. True.

Q. After 10 to 14 days, the risk of infection to the patient goes up enough where you need to do a tracheostomy and to have -- and breathe the patient through the trach tube.

A. In some cases unless it's evident that the patient's respiratory status is improving to the point where it appears that they'll be weaned.

Part of the reason she was in respiratory failure was because of this ongoing intra-abdominal sepsis and the compromise of her -- of her diaphragm to expand in order to ventilate adequately. And it's reasonable to

expect that her resp- -- her pulmonary status would have improved, her respiratory status would have improved with -- sooner with earlier operation. And the earlier that they had done that, the sooner she would have recovered.

Q. Can you tell me to a reasonable degree of medical probability that with surgery on July 9th, that Mrs. Farris would not have a foot drop today? Or would that be speculation on your part?

A. That's beyond the scope of my expertise.

Q. And a critical illness polyneuropathy, is that beyond your area of expertise?

A. Yes.

Q. Would it be beyond your area of -- Strike that.

Would it be beyond your area of expertise to tell me how her condition today would be different with surgery on the 9th rather than on the 17th?

A. I don't know what her condition is today, so I can't answer that.

Q. Okay. Dr. Ripplinger. Did Dr. Ripplinger recommend surgery in his note, or did he -- he mention surgery but then recommend a CT scan and perhaps surgery depending on what the CT scan showed?

A. That's correct.

Q. The latter?

A. The latter.

Q. Any criticism of that recommendation by Dr. Ripplinger?

A. Yes. I disagree with him. I --

Q. Okay.

A. I think that the patient clearly needed surgery. The patient needed surgery several days ago. I think that -- I -- I can't -- I -- I can't explain Dr. Ripplinger's opinion or his motives in couching it in those terms. I think that -- I have no issue with ordering a CT scan; but, as I said before, there is the potential for false negatives, and I certainly wouldn't base my opinion upon it. So I -- I disagree with Dr. Ripplinger. I think the patient should have gone into surgery.

Q. And when we look at Dr. Farooq, the infectious disease specialist, his or her -- I'm not sure if it's a man or a woman -- but his or her consultation on July 4th, you saw in the note the comment "This could represent fecal peritonitis"; correct?

A. Yes.

Q. And then did you see those exact same words in each subsequent note by Dr. Farooq?

A. Yes.

Q. Do you know whether that was something that was

simply carried forward, or was that an actual reflection of what she was thinking that day? He or she.

A. I don't know the answer to that.

Q. You mentioned in your report -- back to the medical bills for a moment -- "The medical expenses incurred were reasonable, necessary and customary for the treatment rendered to Titina Farris."

What research did you do, if any, to look at medical expenses in Las Vegas?

A. I did not research medical expenses in Las Vegas.

Q. Did you research medical expenses anywhere?

A. Well, I think given what I do, I have a -- a -- you know, there was nothing in those expenses that struck me as being un- -- aside from the fact that they were high, as being outrageous or outlandish or -- or in some way beyond what is expected in a hospital course of this duration.

Q. And in your own practice of medicine, how often are you called upon to review hospital bills?

A. Not often, but I know it -- I -- you know, I understand how things are billed and I, you know, have some general knowledge about that.

Q. When was the last time you reviewed an actual patient's actual hospital bill from Hoag?

A. Well, I've had patients bring me -- It's been awhile, but I've had patients bring me bills and point to things and complain about them. So I've seen what bills look like, and I know that bills are -- I know that bills, you know, are derived from a chargemaster, and that chargemaster may be wildly inflated and was ultimately negotiated to a much lower rate by the insurance company or -- or based upon the contract that the patient -- you know, the insurer has with the hospital. So, you know, I think these -- this was within what was within reason for a hospital to bill for a patient's care.

Q. But we can agree, nonetheless, that if Dr. Rives had provided appropriate care to Ms. Farris, she still would have incurred some percentage of those hospital bills.

A. Yes.

MR. JONES: I'm sorry. I'm just going to object to that last question as being vague.

MR. DOYLE:

Q. Take no offense. I ask everybody the same question: Have you ever had a problem or an issue of any sort with the California Medical Board?

A. No.

Q. Or any other board where you have had a

license?

A. No.

Q. Ever had a problem of any sort with hospital privileges anywhere?

A. No.

Q. Ever had a problem of any sort with a medical society or organization?

A. No.

Q. Have you thrown anything away?

A. What do you mean?

Q. That was provided to you, or have you tossed anything?

A. No.

Q. What was the cause of her anasarca?

A. Well, in all likely, that was a combination of factors that involved this sepsis syndrome, or SIRS as it was known back then, humoral factors that are released, on top of which patients receive a large volume of fluid intraoperatively. Patients are third-spacing fluid. They're -- as part of that fight or flight response. So there's a lot of reasons that patients can develop anasarca when critically ill.

Q. Did you discuss with any of plaintiffs' counsel what you perceive to be weaknesses in their case?

A. Not specifically weaknesses.

Q. Well, generally what are you --

A. Well --

Q. -- thinking?

A. -- I -- I think that the -- as -- as we discussed, things change incrementally over time. So it's day one, patient's exhibiting signs of sepsis. Is it okay not to go back to the operating room on day one? "Okay. Well, we'll give you day one." Day two, day three, day four, at what point are we beyond the standard of care? You can't keep your head in the sand forever.

So I think that the challenge is in determining at what point you're ignoring a problem. And I think I'm being very generous with saying July 9th, but there's clearly a progression of this patient's disease that is being ignored. So if -- I don't know if you would call it a weakness, but I think that that's a challenge.

Q. So -- I'm trying to wrap this up.

As of July 9, what was going on with her that says to you "Standard of care requires surgery"?

A. She's still septic.

Q. Okay. Just give me the laundry list.

A. She's still septic.

She still has a leukocytosis.

She's been on antibiotics for days and days.

She's still in respiratory failure.
She's not improving.
Most significantly I think is that Dr. Rives knew that he had created an injury to the bowel during the course of a laparoscopic hernia repair that would otherwise be an outpatient procedure, and now you've got a patient who's septic in the ICU.
He used a thermal source to dissect the bowel from the mesh.
Q. I'm going to get to the standard of care in a moment. I just want to get the list so we can finish up here.
A. Okay.
Q. So --
MR. JONES: Well --
MR. DOYLE:
Q. -- I'm looking --
No. Counsel --
MR. JONES: Well, he's --
MR. DOYLE: -- I just want to finish.
MR. JONES: -- he's answering the question. It's --
MR. DOYLE: I'm going to come --
MR. JONES: -- part of his answer.
MR. DOYLE: I'm going to come back to it.

MR. JONES: It's part of his answer.
MR. DOYLE: I'm promise I'm going to come back.
MR. JONES: Look, if you want to withdraw the last question, that's fine, and we can scratch it. But --
MR. DOYLE: Fine.
MR. JONES: -- otherwise you have to let him answer it.
MR. DOYLE: Fine. We'll just keep going.
Q. Go ahead, Doctor.
THE WITNESS: Can you read back to me what I said?
MR. DOYLE: Read the whole answer.
I'm just trying to finish up by 5:30 --
THE WITNESS: Okay.
MR. DOYLE: -- but we'll keep going.
Why don't you read the question too.
(The record is read by the reporter.)
THE WITNESS: So can I pick up from there?
MR. DOYLE: Sure.
THE WITNESS: So -- So he has every reason to expect that her illness, her ongoing and prolonged illness, is a result of something going on in the abdomen, and he's not doing what is necessary, which is take the patient to the operating room, period.
Q. I'm trying to get the data points --
A. I appreciate that.

Q. -- that -- that -- that -- that you believe the standard of care required him to consider and make that decision.

A. Yes.

Q. As of July 9th, you said she's still septic; correct?

A. Yes.

Q. She still has the leukocytosis, which is the increased white blood cell count; correct?

A. Yes.

Q. She's been on antibiotics for days; correct?

A. Yes.

Q. She has respiratory failure; correct?

A. Yes.

Q. He knew that he had caused two colotomies and had used thermal injury; correct?

A. Yes.

Q. And she's not improving; correct?

A. Correct.

Q. Any other data points that he should have been looking at and incorporating into his decisions?

A. She has a synthetic mesh in the abdomen that he placed in the presence of a bowel injury, knowing the significant likelihood that that synthetic mesh will get infected because it's been exposed to bowel contents

either macroscopically or microscopically. That mesh is at very high risk of -- of becoming infected.

Q. Any other data points?

A. She has intra-abdominal sepsis that's not improving with nonoperative management. It's time to go to the operating room.

Q. When you said she was not improving, was she improving in any ways?

A. She's -- She's making small incremental improvements in various limited aspects. And one can attribute that to the excellent critical care support she's getting. She's -- She's getting broad spectrum antibiotics from the infectious disease specialist. She's getting respiratory care. She's being hydrated. She's being maintained. So -- So she's see- -- she's showing little areas of -- of improvement, but it's window dressing, because ultimately those things aren't going to save her.

And anybody who's taking care of patients with intra-abdominal sepsis knows that ultimately you are going to have multisystem problems, and you're going to have organ system failure. And ultimately, if not addressed, these things will progress to death.

So -- So these areas of minor improvement that you can point to where the white blood cell count might drop

by a point or two are insignificant.

Q. And what are the other insignificant incremental improvements besides the WBC?

A. Well, you mentioned them earlier: decrease in the tachycardia or a -- a slight decrease in the fever curve. That's two examples.

Q. Okay. The term "defi-" -- I'm sorry.

The term "standard of care," what -- what -- what is that term or what is your definition?

A. The standard of care is what a reasonable and prudent physician would do under cir- -- in similar circumstances.

Q. So let me just -- I just want to get the list -- I think we've covered a lot of this in some form or fashion -- of what Dr. Rives did or didn't do that was below the standard of care, keeping in mind my earlier comments that I'm not interested in your personal criticisms or what you would have done differently, understanding that there can be various ways of going about taking care of a different patient.

But in terms of something that Dr. Rives did or didn't do that was below the standard of care, was there anything in 2014?

A. No.

Q. Was there anything that he did or didn't do in

the office on June 23, 2015 that was below the standard of care?

A. I don't believe so.

Q. On July 3, 2015, prior to the procedure, was there anything Dr. Rives did or didn't do that was below the standard of care?

A. No. I may take issue with something, but I would say that -- as you said, that there are areas to disagree that do not fall below the standard of care.

Q. Okay. So now it's surgery on July 3. I just -- If you can, just give me the list of what you believe he did or didn't do that was below the standard of care. I may or may not have any follow-up questions. Then I'm just going to march forward chronologically.

A. With regard to the surgery, I think where he fell below the standard of care was in using a thermal energy source -- in this case the LigaSure bipolar device -- to -- to dissect bowel from the underlying mesh to which it was densely adherent. And that created a -- a situation where he's -- he's -- he's -- he's -- his intraoperative technique is flawed in the use of that thermal energy.

The appropriate thing to do -- The standard of care would dictate that you do not use a thermal energy source against the bowel and that if you have any

concerns about the integrity of the bowel during the course of the operation, then the standard of care would dictate that you convert to an open operation, if necessary, to complete the procedure.

So that's it.

Q. Okay. I'm just trying to find out what he did or didn't do that was below the standard of care.

Are you telling me that his failure to convert to a laparotomy was below the standard of care?

A. I think that the -- the standard of care -- the intraoperative technique that fell below the standard of care was using the thermal energy source to dissect the bowel from the mesh.

Q. And in terms of the standard of care, is there anything else that he did or didn't do intraoperatively that was below the standard of care? Again setting aside personal criticisms or "I would have done it this way" or...

A. I understand. No. I would leave it at that.

Q. Then on July 3 after the surgery -- we'll get -- was there anything that day he did or did not do that was below the standard of care?

A. Not to my knowledge.

Q. Now, by July 4th she's in the ICU, and she's intubated, so let me just ask you -- rather than doing

day by day, let me ask you: Between July 4th and July 9th, which we've already talked about, is there anything else Dr. Rives did or didn't do that was below the standard of care in that time period other than not taking her back to the operating room?

A. I can't think of a specific -- a specific instance.

Q. And I assume...

A. Can I re- -- Can I readdress that?

I -- I would say he fell below the standard of care in failing to exercise sound medical judgment in the approach to this patient in determining whether to intervene surgically, "sound medical judgment" meaning considering fully the risks and benefits of his approach, the risk of nonoperative bene- -- management versus a risk of surgery, and the failure to consider all these -- these issues.

Q. And his failure to exercise sound medical judgment, as you have just described, was that below the standard of care?

A. Yes.

Q. And that failure to exercise sound medical judgment led to his not doing surgery by July 9.

A. Yes.

Q. And if we look at the time period then from

July 9 to July 17th when Dr. Hamilton operates, in terms of something Dr. Rives did or didn't do below the standard of care, would it be the same comments?

A. Yes.

Q. And then, of course, once Dr. Rives is off the case and Dr. Hamilton is on the case, he's no longer involved in her care; correct?

A. Correct.

Q. Then nothing he would have or could have or should have done.

A. Correct.

Q. So have you now given me each and every -- Strike that.

In these last few minutes -- and plus, of course, going through the deposition and your two reports -- have you now given me each and every standard-of-care opinion concerning Dr. Rives and his care of Ms. Farris?

A. Yes.

Q. And all the bases for those opinions?

A. I believe so.

Q. In your report you say "Failure to adequately repair iatrogenic bowel perforations during the July 3, 2015 operation." I mean, having given this case additional thought and study, would you withdraw that particular opinion?

A. Well, you over- -- he -- I think that -- that -- that clearly he failed to repair these completely; but again, I think that's a consequence of -- of his faulty intraoperative technique, and I think his o- -- intraoperative technique led to those damages. So it -- it's...

Q. Let me quote from your report. "Dr. Rives fell beneath the accepted standard of care as follows:"

Item Number 2 says "Failure to adequately repair iatrogenic bowel perforations" --

A. Mm-hmm.

Q. -- "during the July 3, 2015."

Sitting here at this moment in time, is that yet another standard-of-care opinion, or is -- or would we -- would we say at that point in time he adequately repaired the two colotomies, but your criticism is the use of the thermal device? And that was a long question, but...

A. I would say that my criticism is that he -- he used the thermal device to cause the injury.

I think that the -- at the -- as far as I can tell, at the time that he closed the injuries, he thought he had gotten a good closure. I think time showed that these -- these opened up. But I think his failure was in how he dissected the bowel, creating the injuries,

and the fact that he didn't go back to reoperate. So I would say that while his closure may have been temporarily adequate, it was these other factors that were below the standard of care.

Q. So in terms of the -- the actual technique that he used to close the two colotomies that he saw, the technique he used for both, while you might disagree, was appropriate and within the standard of care?

MR. JONES: Objection; misstates.

THE WITNESS: I think that he -- I -- I'm trying to be charitable, but I -- I think that he -- he did a lousy job. He had these injuries. He zipped across them with a stapler, and the patient ultimately be- -- became septic.

I would say that using a stapler is not below the standard of care, so I -- I'm not going to say that using a stapler on these injuries is below the standard of care. The standard of care was in not recognizing the injury when it occurred.

So I would say the -- the -- the standard-of-care breach is in using the thermal energy on the bowel, which is clearly a standard-of-care failure, and failing to recognize the perforation and the -- and the intra-abdominal sepsis timely. So those are the two standard-of-care failures.

MR. DOYLE:

Q. When you have inadvertently caused colotomies, did you do a lousy job?

A. I mean, not -- not every one of my operations has been perfect. I think that -- that there's always room for improvement. There's always a learning opportunity. So --

Q. But you characterized his creation of the two colotomies, as I understood you, as "a lousy job."

A. Well, I think --

MR. JONES: Objection; misstates.

THE WITNESS: Well, I think that his handling of the operation was poor, and I -- and -- but where I'm going to say that he fell below the standard of care is in using the thermal energy on the bowel, which is clearly a breach of the standard of care. But I will grant you that using a stapler to close a colotomy is an acceptable way to close a colotomy, so it's difficult to say that's below the standard of care.

MR. DOYLE: Okay.

Q. Then if we -- As a general matter, can there be a partial thickness thermal injury to bowel that is not visible at the time of surgery?

A. Yes.

Q. And can you have a non-visible

partial-thickness injury to bowel caused by thermal energy where then, after the surgery, there is decreased blood flow, necrosis of tissue, and then opening up of a perforation?

A. Yes.

Q. Okay. In some form or fashion today and in your two reports, have we covered all the topics and areas you understand you're going to be testifying about at the time of trial?

A. Yes.

Q. Then -- Oh. Has there been any discussion about illustrations or demonstrative exhibits for trial with counsel?

A. No.

Q. And can we agree that for some period of time after Dr. Hamilton's surgery, that Mrs. Farris remained critically ill?

A. Yes.

Q. And can we also agree that during those days after Dr. Hamilton's surgery, she too was concerned about whether there was still some intra-abdominal problem?

A. Yes.

Q. Okay. That's all I have. Thanks.

MR. JONES: I have just really a quick couple of

follow-ups.

-EXAMINATION-

BY MR. JONES:

Q. The answers that you've given, have those -- with respect to the record, have they taken for granted that Dr. Rives in his notes was candid and complete?

MR. DOYLE: Object to the question.

MR. JONES:

Q. Or did -- Or have you -- So, for example, when Dr. Rives in his record states that he saw two colotomies and that he was able to sew it all up and everything was kind of normal at that point, are you taking him at his word for that, or are you -- are you assuming he was being untruthful?

A. I'm taking him at his word.

Q. Okay. And so some of your opinions where you have not made a definitive determination as to whether or not a standard of care has been breached, that could potentially change if there was evidence that what has been represented is not exactly the truth. Is that fair?

A. Yes.

MR. DOYLE: Calls for speculation.

MR. JONES:

Q. And just as -- as -- for example, if there was fecal matter at the time of the operation that hadn't been identified that could have been identified, that would be something you'd take issue with. Would that be fair?

A. Well, he didn't -- he didn't describe any fecal matter contamination.

Q. So did you take it for granted, then, that he was indicating essentially there was none?

A. I can only -- I can only draw conclusions based upon what's entered in the -- in the operative report.

Q. Right. And so that's all I'm getting at.

If there were additional significant findings like that that were there, that wouldn't be something that you would say is okay; correct?

A. So if there were significant -- if there was evidence that something took place in the operating room that isn't in the operative report and had come to light later, then I would reserve my right to change my opinion.

Q. Fair enough.

And if there -- evidence came out, for example, that Dr. Rives didn't have necessarily a really good view or angle to be able to -- to safely staple, for example, that would be something that would cause you to

have a different opinion about the staples?

A. Well, the whole idea of stapling the bowel is to get a good purchase and to make sure you've closed it completely. Where you can err and where you can be below the standard of care is where -- if you don't get enough tissue in the -- in the staple. So if you're -- if you're just pulling up the edge of the mucosa and stapling it, you're not going to get a good closure. You have to make sure that you're getting a full-thickness closure.

I -- You know, I have no way of knowing whether he got a good closure or not other than hi- -- what -- his statement in the operative report. If it turns out that he just -- he didn't close the bowel well or didn't get good tissue apposition, then that's a -- a different issue. But I have no way of knowing. I'm not there. I'm not seeing how he's doing the staple lines.

The preferred way to do this if you've got a -- you know, an inflamed bowel that you've dissected away from -- you know, a torn-up bowel that you dissected away from the abdominal wall, if you can't see it clearly, you have to open. But can I say that -- I -- I don't know that he couldn't see it clearly because he didn't say that in his operative report.

Q. Okay. And if -- if he had misdiagnosed -- For

example, if he -- if he ruled out sepsis at a time that she did have sepsis and the evidence was there indicating sepsis, would that be below the standard of care?

A. Yes.

Q. Okay. Do you recall that happening at one point in the records?

A. Well, I think clearly he's -- he's misinterpreting her intra-abdominal sepsis as arising from a respiratory source. So I would say all that is below the standard of care. I didn't separate that from – I mean, in my mind, that's the same as not going to the operating room. I mean you're -- you're not diagnosing the problem; you're not going to the operating room.

But -- But if you want to break that down into discrete elements, his failure to diagnose intra-abdominal sepsis would be part one of the failure, the breach of standard of care, and breach two would be not going to the operating room to fix it.

Q. Okay. And then -- And then just as you gave him latitude where you said he probably should have gone into operation on the 5th but you gave him up to essentially the 9th, each -- each day and each opportunity had -- he had to perform after the 9th would

have, again, been a breach at that point as well; correct?

A. Yes.

MR. JONES: That's all.

-EXAMINATION-

BY MR. DOYLE:

Q. You're not going to testify at trial that Dr. Rives is a liar?

A. No.

Q. Or that he's been untruthful?

A. No.

Q. You were provided with his deposition; correct?

A. Yes.

Q. He certainly could have been asked questions about how he used the stapler and his -- his -- his closure of those two colotomies; correct?

A. Correct.

Q. Nobody asked him those questions.

A. No.

Q. Okay. So you have no idea.

A. Correct.

Q. Pure speculation on your part as to how he closed them.

A. And that's why I --
MR. JONES: Misstates.
THE WITNESS: That's why I made the statement that I did.
MR. DOYLE: Okay. Thanks.
THE REPORTER: And, Mr. Jones, you are requesting a copy?
MR. JONES: Yes. Thank you.
(The proceedings concluded at 5:53 p.m.)
***

STATE OF CALIFORNIA) ss

I, Delia M. Satterlee, CSR 9114, do hereby declare:

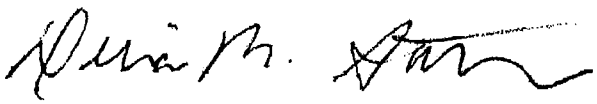
That, prior to being examined, the witness named in the foregoing deposition was by me duly sworn pursuant to Section 2093(b) and 2094 of the Code of Civil Procedure;

That said deposition was taken down by me in shorthand at the time and place therein named and thereafter reduced to text under my direction.

I further declare that I have no interest in the event of the action.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

WITNESS my hand this 1st day of October 2019.



Delia M. Satterlee, CSR 9114

ERRATA SHEET

I declare under penalty of perjury that I have read the foregoing _____ pages of my testimony, taken on _____ (date) at _____(city), _____(state), and that the same is a true record of the testimony given by me at the time and place herein above set forth, with the following exceptions:

Page	Line	Should read:	Reason for Change:
___	___	_____	_____
		_____	_____
___	___	_____	_____
		_____	_____
___	___	_____	_____
		_____	_____
___	___	_____	_____
		_____	_____
___	___	_____	_____
		_____	_____
___	___	_____	_____
		_____	_____

ERRATA SHEET

Page	Line	Should read:	Reason for Change:

Date: _____ _____

Signature of Witness

_____

Name Typed or Printed

HEALTH INFORMATION PRIVACY & SECURITY: CAUTIONARY NOTICE

Litigation Services is committed to compliance with applicable federal and state laws and regulations ("Privacy Laws") governing the protection and security of patient health information. Notice is hereby given to all parties that transcripts of depositions and legal proceedings, and transcript exhibits, may contain patient health information that is protected from unauthorized access, use and disclosure by Privacy Laws. Litigation Services requires that access, maintenance, use, and disclosure (including but not limited to electronic database maintenance and access, storage, distribution/ dissemination and communication) of transcripts/exhibits containing patient information be performed in compliance with Privacy Laws. No transcript or exhibit containing protected patient health information may be further disclosed except as permitted by Privacy Laws. Litigation Services expects that all parties, parties' attorneys, and their HIPAA Business Associates and Subcontractors will make every reasonable effort to protect and secure patient health information, and to comply with applicable Privacy Law mandates, including but not limited to restrictions on access, storage, use, and disclosure (sharing) of transcripts and transcript exhibits, and applying "minimum necessary" standards where appropriate. It is recommended that your office review its policies regarding sharing of transcripts and exhibits - including access, storage, use, and disclosure - for compliance with Privacy Laws.