

EXHIBIT 2

TO

**DEFENDANTS' NOTICE OF FILING EXHIBITS
IN SUPPORT OF THEIR MOTION FOR
PARTIAL SUMMARY JUDGMENT**

Your Hospital Name

FILE

CHEST PAIN - MALE 1 of 2

Date in: 9/10/99 Pres Tm: 10:00

Pro-MED Navigator™

Name: JONES, JOHNNY J Age: 7 Yrs 0 Mos 0 Wks Sex: M MR#: PI#: 47375
 Chief Complaint: CHEST PAIN--ATRAUMATIC >35 YRS Triage Tm: 10:05
 Allergies: Penicillin T: 103.6
 Medicines: Aspirin R: 125
 History: Numerous Ear Infections R: 32
 Wt: 20.5 KG Ht: '42" Head: 25 LMP: N/A LDT: Under Five Imm. Status: True BP: 114/076
 PMD: Wagner, H ED Phys: Byrne, G Mode of Arrival: Ambulance SaO2: 100 %

TIME: ROOM: PREHOSPITAL ORDERS: No Yes

HPI SOURCE: Patient Family Member Friend EMS Nurse's Notes Reviewed
 ONSET/TIMING: Mins Hrs Days Gradual or Sudden / Intermittent or Continuous
 LOCATION OF INJURY / PAIN: L R Anterior Sternal Lateral Radiating to
 QUALITY: Similar to Previous CP Sharp Dull Throbbing Pressure Burning Squeezing
 Stabbing Tightness Other
 SEVERITY: Mild Moderate Severe 1 2 3 4 5 6 7 8 9 10
 CONTEXT: Occurred At Rest During Activity
 MODIFYING FACTORS: Aggravated By: Nothing Position Inspiration Activity
 Relieved By: Nothing Rest NTG
 ASSOC. SIGNS & SYMPTOMS: None Nausea Vomiting Sweats Fever SOB Cough Reflex
 CARDIAC RISK FACTORS: None Age Sex Tobacco HTN DM FH Elev. Chol. Obesity Cocaine Use

Unable to obtain additional information from patient. Reason:

ROS All Other Systems Reviewed And Negative (unless written or circled)
 CONST: Wt. Loss GI: PSYCH:
 EYES: GU: ENDO:
 ENT: MS: HEME/LYMPH:
 CV: Orthopnea PND SKIN: ALL/IMMUN:
 RESP: NEURO: Rheumatic Fever

PMH ADULT ILLNESS: None CAD HTN CVAs DM Asthma COPD Angina MI
 PREVIOUS STUDIES: None Stress Test Stress Thal Echocardiogram Cardiac Cath (Date: _____)
 RESULTS:
 SURGERY: CABG Angioplasty Stent
 IMMUNIZATIONS: UTD TET >5yrs ALLERGIES: NKDA PCN
 MEDICATIONS: See Nurse's Note

FH Negative
 SH OCCUPATION: HABITS: Tobacco Y N H/O ETOH Y N H/O Illicit Drugs Y N H/O

PE CONSTITUTIONAL: VITAL SIGNS: Normal Abnormal APPEARANCE Well Ill Poor Hygiene/Grooming
 PSYCHIATRIC: Appropriate Inappropriate Combative Anxious Sad
 SKIN: Normal Cyanotic Diaphoretic
 EYES: Normal
 ENT: Normal

PMED-000539



Your Hospital Name

FILE

CHEST PAIN - MALE 2 of 2

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Pres Trm: 10:00

Pro-MED Navigator™

Name: JONES, JOHNNY J Age: 7 Yrs 0 Mos 0 Wks Sex: M MR#: Pt#: 47375

PE

- CV: Normal
- PMI: Normal Laterally Displaced
- AUSCULTATION: Normal Tachycardic Bradycardic Irregular Rhythm
- MURMUR: None Systolic Diastolic
 - Grade 1 Barely audible, great difficulty
 - Grade 2 Just audible, without thrill
 - Grade 3 Intermediate
 - Grade 4 Intermediate with slight thrill
 - Grade 5 Loudest requiring stethoscope, palpable thrill
 - Grade 6 Heard with stethoscope, off chest, palpable thrill
- RUB: Absent Present
- GALLOPS: None S3 (Ventricular Gallop) S4 (Atrial Gallop) S3 & S4 (Summation Gallop)
- PULSE / BLOOD PRESSURE: Equal Bilaterally Unequal
- RESP: Normal Unequal Breath Sounds Crackles Wheezes
- GI: Normal Tender Organomegally Hepatojugular Reflux
- MS (includes neck & back): Normal Edema JVD
- NEURO: Normal Lethargic Obtunded

Medical Decision Making

- Discussed With Family Old Chart Requested FINDINGS:
- DDX: Stable Angina Unstable Angina MI PE Dissecting TAA Atypical CP - Etiology Unknown Pericarditis
- Pleurisy Pneumonia MVP Esophageal Spasm GERD COPD Exacerbation Costochondritis
- LABS: Labs Essentially Normal Unless Noted Below

- CBC: WBC Hg Hct Plts
- CHEMISTRIES: Na K Cl HCO3 BUN Cr Glu
- GLUCOSE STICK: (O Low O Elevated) PT / PTT: DIGOXIN:
- CARDIAC ENZYMES: CK CK-MB MB% Troponin Myoglobin
- ABG: pH PCO2 PO2 O2 sats ABG Interpretation:

- EKG INTERPRETATION: NSR No ST Abnormality
- Compared To EKG On ___/___/___; No Significant Change
- X-RAY: CXR: Normal Pneumonia CMG PTX Effusion Pulm. Edema
- ECHO: V/Q SCAN:
- Preliminary / Read By Radiologist

Treatment/Management

- See Procedure Note See Addendum Total Critical Care Time (> 30 mins)
- ADDITIONAL PROCEDURES (Done by Physician): Foley Insertion Vaso-Active Drips
- RE-EVALUATION Time: Improved Worsened No Change

TIME	INTERVENTION / RESULTS	VITALS	CP	RATING									
			Y N	1 2 3 4 5 6 7 8 9 10									
			Y N	1 2 3 4 5 6 7 8 9 10									
			Y N	1 2 3 4 5 6 7 8 9 10									

CONSULTATION DR. @ Returned @ ; DR. @ Returned @

To See @ ED Hospital Office Rec.

Impression(s)

Disposition

- AMA LWT DOA ED Death CONDITION @ D/C: Improved Stable No Change
- HOME: Alone With Family With Friend Ambulance
- PRESCRIPTIONS:
- DISCHARGE INSTRUCTIONS:
- FOLLOW-UP: PMD Cardiologist Tomorrow 1-2 Days 3-5 Days 7-10 Days PRN
- ADMIT: Observation Unit Floor Telemetry ICU OR Stable Unstable
- TRANSFER TO:
- ACCEPTING PHYSICIAN: DR. Called @ Accepted @
- PA/ARNP: PHYSICIAN'S SIGNATURE: PMED-000540

ED RECORD

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