MEDICAL CHRONOLOGY - INSTRUCTIONS TO FOLLOW

General Instructions:

Brief Summary/Flow of Events:
In the beginning of the chronology, a Brief Summary/Flow of Events outlining the significant medical events is provided which will give a general picture of the focus points in the case

Patient History:
Details related to the patient's past history (medical, surgical, social and family history) present in the medical records

Detailed Medical Chronology:
Information captured "as it is" in the medical records without alteration of the meaning. Type of information capture (all details/zoom-out model and relevant details/zoom-in model) is as per the demands of the case which will be elaborated under the 'Specific Instructions'

Reviewer's Comments:
*Comments on contradicting information and misinterpretations in the medical records, illegible handwritten notes, missing records, clarifications needed etc. are given in italics and red font color and will appear as * Reviewer's Comment*

Illegible Dates: *Illegible and missing dates are presented as "00/00/0000"(mm/dd/yyyy format)*

Illegible Notes: *Illegible handwritten notes are left as a blank space "_____" with a note as "Illegible Notes" in the heading of the particular consultation/report.*

Specific Instructions:

- *The medical chronology focuses in detail on patient's clinical presentation to X-Hospital for Intrauterine pregnancy at term via epidural anesthesia. Spinal cord injury during delivery .Diagnosed with Sciatica in the left lower extremity, Syrinx of the thoracolumbar spine in the left side of the spinal cord of unknown etiology.*
- *If the provider name is illegible, the snapshot of the same is captured.*
- *Significant lab reports have been captured within the chronology*
- *Repetitive details have been avoided*
- *Other related records have not been included. It can be elaborated upon request.*
- *Case specific information have been highlighted with yellow color.*

Brief Summary/Flow of Events

A- Hospital

08/02/YYYY-08/04/YYYY- : Intrauterine pregnancy at term, epidural anesthesia, pushing and vacuum assistance delivered a viable7 pounds 12 ounces male fetus over an intact perineum. Discharged to home via wheel chair in stable condition

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B-Imaging

09/11/YYYY, 11/19/YYYY- MRI of Lumbar spine and MRI of thoracic spine respectively. Syrinx in the distal thoracic cord extending from the T11 level to the conus.
Reviewer's Comment: The referring physician Marjorie xxxx consultation is missing.

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X- center

10/31/YYYY-02/25/YYYY-correspondence- Sciatica in the left lower extremity. Syrinx of the thoracolumbar spine in the left side of the spinal cord of unknown etiology. Spinal cord injury during delivery.

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D- Spine and brain Institute

02/18/YYYY, 03/26/YYYY-S1 radiculopathy has improved. The lower motor neuron pathology was more widespread than the L5 and S1 nerve roots

Missing Medical Records

What Records are Needed	Hospital/ Medical Provider	Date/Time Period	Why we need the records?	Hint/Clue that records are missing
Dr. Majorie xxxx consultation	A- Hospital	08/04/YYYY-09/11/YYYY	Consultation after delivery when patient first developed symptoms	23
Spinal Tap procedure report	A- Hospital	08/02/YYYY-08/04/YYYY	No records of this procedure in the Hospital records	1-2
Follow up visits	X- Hospital	02/26/YYYY-03/25/YYYY	To review the progress of the patient	15-16

Patient History

Past Medical History: The patient has no significant past medical history. (pg1)

Surgical History: She has had no surgical procedures of any kind. (pg1)

Family History: Positive for heart disease in her maternal grandfather as well as diabetes and hypertension. Her maternal grandmother has a history of breast cancer, diabetes, heart disease, and high blood pressure.(pg1)

Social History: smokes a pack of tobacco daily. She does not use excessive caffeine or alcohol. (pg 202) Former smoker quit smoking 10 months ago (pg 135)) Quit during her pregnancy and restarted after delivery

Allergy: No Allergies

Detailed Chronology

Date	Provider	Occurrence	PDF Reference
02/04/YYYY-07/22/YYYY	A- Hospital Multiple physicians	**Flow Sheet:** Patient was a Gravida (G) 1 Term (T) 0 Para (P) 0 Abortion (A) 0 Living Children (L) 0 who had regular OB GYN visits during her prenatal period. Good Fetal Movement was noted. 05/14/YYYY- Patient complains of sore throat, drainage solid mucus, zygotec not helping, called in Z pack. Patient's mother called back late saying "patient unable to breath for 2 months and can't eat due to sore throat, advised to bring in or take to ER. She couldn't take her today well, take her tomorrow. Patient has never complained of any significant symptoms before today. 05/15/YYYY- Patient advised mucinocef, saline nasal spray, and Z pack. Lungs, clear throat erythema with exudates in posterior oropharynx. 07/22/YYYY she was weighing 132 lbs. Fetus of gestation age of 37.3, patient having few contractions and cervix of 1.	121-122,22
03/09/YYYY-03/29/YYYY	Z-Diagnostics Incorporated	**Labs:** Obstetric Panel MCV 99.4 High range 82.0-100.0fL Antibody Screen, Hepatitis, Rubella, Vitamin D, HIV, Penta Screen, Genetics Screen Summary Hemoglobin 11.2 Low range:11.5-15.3g/dL Hematocrit 33.9 Low range:34.0-45.0	125-129,124
06/27/YYYY	A- Hospital X- Anesthesia Services	**Labor Analgesia Consent** Possible complications of epidural anesthesia for labor: 1.Infection – requiring surgical exploration and drainage 2.Spinal headache 3.Catheter breakage 4.Intravascular Injection of local aesthetic during bolus Injections causing seizure or cardiac arrest	73-76

Date	Provider	Occurrence	PDF Reference
		5.Paralysis Except for the spinal headache the other possible complications are extremely rare	
06/27/YYYY	A-Hospital	**Anesthetic Assessment and plan:** **Diagnosis:** Intrauterine pregnancy **Proposed Operation:** Labor Analgesia Beta Blocker: Not indicated Platelets:217 **Current Medications**: Prenatal vitamins **Major Regional Anesthesia:** Spinal/Epidural **Physical exam**: Mean airway pressure-1, lungs clear **Heart**- Regular Rate and Rhythm (RRR) Anesthetic Assessment and plan ASA class- 2 Patient was seen and examined Procedure Of anesthesia explained. The Anesthesia: care-team Of MD and CRNA explained. Questions were allowed and discussed. Anesthesia Plan Discussed with CRNA. Major regional anesthesia: Spinal/epidural	71
07/24/YYYY	A-Hospital Melinda xxxx DO	**Physician Orders** Admit to labor, delivery at 2300 hrs 08/01/YYYY Initiate Antenatal orders Pitocin induction of labor per protocol **Reviewer's Comments: The consultation report pertaining to this visit is unavailable for review*	28
08/01/YYYY	A-Hospital Melinda xxxx DO	**Physician Orders** Change admit to 1300hrs on 08/02/YYYY Talk to Dr. xxxx Patient may have labor analgesia when in active labor. Place indwelling Foley catheter after spinal/epidural	28-29
08/02/YYYY-08/05/YYYY	A-Hospital Jessica xxxx, Nurse Staff	**Nursing assessment:** Arrival Date/Time: 08/02/YYYY 1310hrs Arrival mode: Ambulatory Admit reason: Pregnancy related Comment: Induction of labor Obstetrician: Melinda xxxx D.O. Date of last menstrual period: 11/02/YYYY	132-136

Date	Provider	Occurrence	PDF Reference
		<table><tr><td>Estimated date of confinement</td><td>08/09/YYYY</td></tr><tr><td>Gravida</td><td>1</td></tr><tr><td>RH</td><td>Positive</td></tr><tr><td>Rubella</td><td>Immune</td></tr><tr><td>Membranes</td><td>Intact</td></tr><tr><td>Anesthesia preference</td><td>Epidural spinal</td></tr><tr><td>Contraction frequency</td><td>Irregular</td></tr><tr><td>Previous anesthesia</td><td>No</td></tr><tr><td>Assist with Activities of Daily Living (ADL)</td><td>No assist needed</td></tr></table>	
08/02/YYYY	A-Hospital Melinda xxxx DO	**Admission record:** **History and Physical:** **Diagnosis**: Intrauterine pregnancy at term. **History Of Present Illness**: The patient is a 17-year-old patient, admitted at term for induction of labor. Pregnancy has been uncomplicated. **Medications**: Prenatal vitamins. **Review Of Systems**: Essentially negative other than the current pregnancy. Abdomen: Soft and gravid. Uterus is non tender. Size consistent with dates. **Physical Examination:** **Vital Signs:** Stable. Heart tones are in 150s. **Abdomen:** Soft and gravid. Uterus is nontender. Size consistent with dates. **Pelvic:** Cervical exam shows cervix is 2 cm dilated. **Extremities:** Free of cyanosis, clubbing or edema. **Assessment:** Intrauterine pregnancy at term. **Plan:** Induction of labor. We anticipate a vaginal delivery.	22,36
08/02/YYYY	A- Hospital	**Nursing Daily Assessment:** **Amy xxxx NS** **1544 hrs**(142pg): Preprocedure timeout for Epidural performed, Patient to shortness of Breath(SOB) **1554 hrs**(142pg)::Epidural catheter placed at this time **1556 hrs**(142pg):Test dose given, patient layed down after catheter taped **1625 hrs**(143pg):Cervix soft, dilation-1, Effacement=80% Station-3, bloody show-absent.	141-150, 186-187

Date	Provider	Occurrence	PDF Reference
		Jessica xxxx NS **1942 hrs** (146pg):Dr. Melinda xxxx at bedside. Cervical exam: Dilation=2, Effacement-80%, artificial membrane rupture, amniotic fluid-moderate, clear **Paula xxxx NS** **2000 hrs** (146pg): sedation score=1=awake/alert. Respirations -18, Pulse-76, NIBP-112/84, epidural site-dry, warm, site dressing-dry and intact. Semi fowlers position **2130 hrs**(148pg): Respirations-16, Pulse-90, NIBP-117/75 **2200 hrs**(148pg):Respirations-18, pulse-98, NIBP-122/87, Relaxed, cooperative, respond to labor,dilation-3,Effacement-90% **2230 hrs**(149pg):Respirations-18,pulse-76,NIBP-129/60 **2345 hrs** (150pg): Anxious uncomfortable, respond to labor, crying, dilation-4, effacement-90%, station-1, small bloody show. Xxxx CRNA notified of patient status.	
08/03/YYYY	A-Hospital	**Nursing Daily Assessment:** **1015 hrs** (173pg)**:** Pain rating-8, medicated with stadol 2mg per order from Dr. Melinda xxxx at delivery. Infant vacuum extraction, male, spontaneous, 3 umbilical vessel, estimated gestational age 39weeks1day **1020 hrs** (174pg)**:** Pericare given and ice pack to perineum. Down from stirrups at this time. IV contact to infuse easily into healthy site. **1030 hrs** (174pg)**:** Sedation Score-Epidural out, catheter intact, patient tolerated without pain. **1045 hrs** (175pg): Ice pack changed, peri pads changed and pericare given. Patient tolerated well. **1145 hrs** (176pg)**:** Patient complained of perineal pain, very edematous, ice pack reapplied. **1200 hr** (177pg) **s:** Patient voided on blue pad at this time, unable to move left leg from epidural. Hot pack to low back pain. New ice packs and pads e-applied to perineum. Lenins and gown changed. Patient tolerated well. **1215 hrs**(178pg): Pain rating-4,perineal pain, very edematous, **1715 hrs** (179pg)**:** Perineal pain throbbing, edema present, warm pack to low back pain at this time. Pain intervention=heat, medication request for patient. **1800 hrs**(179pg)**:**Pain rating-4	173-181

Date	Provider	Occurrence	PDF Reference
		Paula xxxx Nurse staff **1945 hrs** (179pg)**: Neuro:** WDL **CVS, Resp, MSK, and GI, urinary, psychosocial:** Within Defined Limits (WDL). Peri area is very edematous. Awake, family at bedside. No apparent distress. No complaints. Resting quietly. Patient has not been Out Of Bed (OOB) yet. Plan Of Care (POC) discussed patient. Will call when she feels the need to void. Call light within reach. **2100 hrs** (180pg)**:** Awake. Family at bedside. No apparent distress. No complaints. Resting quietly. **2200 hrs** (181pg)**:** BRP, up with assist x 1. **2230 hrs** (181pg)**:** Bed pad, gown, linen changed. Peri care. Shower. Patient tolerated well.	