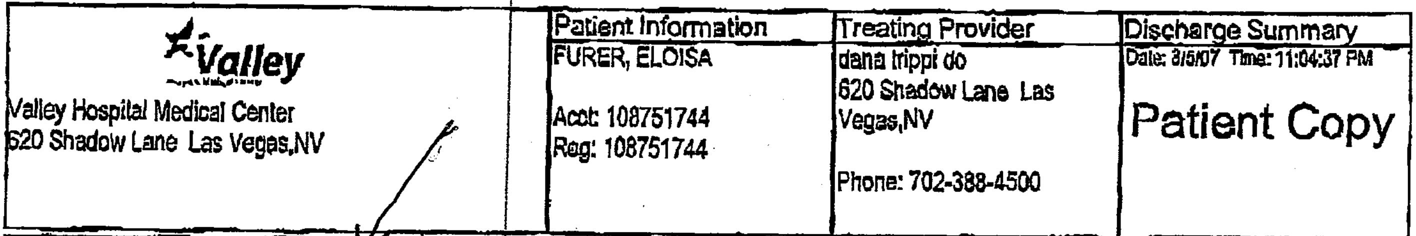


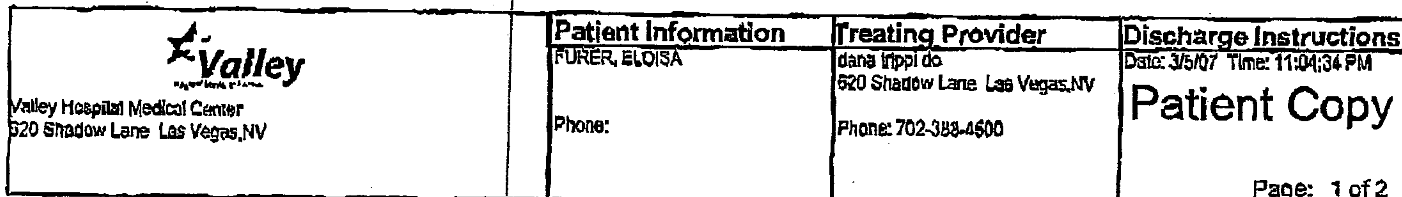
Valley	Patient Information	Treating Provider	Discharge Summary
Valley Hospital Medical Center 620 Shadow Lane Las Vegas,NV	FURER, ELOISA Acct: 108751744 Reg: 108751744	dana trippi do 620 Shadow Lane Las Vegas,NV Phone: 702-388-4500	Date: 3/5/07 Time: 11:04:37 PM Patient Copy

1) Your Discharge Instructions	2) Your Prescriptions:
TRANSIENT ISCHEMIC ATTACK (TIA) #Document: 421 (English) CEREBROVASCULAR ACCIDENT (STROKE) #Document: 65 (English) AMA FORM #Document: 681 (English)	

3) You should Follow Up with:

Follow Up Physician:	Follow Up Information
Camilo B Tabora , 3301 W Charleston Blvd Las Vegas NV 89102 Phone: 968-0100 Fax: 968-0104	On 03/5/2007 this patient was treated in the Emergency Department of Valley Hospital Medical Center at 620 Shadow Lane Las Vegas,NV for Refer to Discharge list above. The patient was asked to follow up 2 Days.

Based on your visit to Valley Hospital Medical Center, you may safely continue your home medications with the additional medications prescribed in box #2 above, if any. Please contact your prescribing physician if you have any questions about your home medications. If certain home medications require discontinuation it will be listed under follow up information in box #3.



Valley Hospital Medical Center 620 Shadow Lane Las Vegas,NV	Patient Information	Treating Provider	Discharge Instructions
	FURER, ELOISA	dana trippi do 620 Shadow Lane Las Vegas,NV	Date: 3/5/07 Time: 11:04:34 PM
	Phone:	Phone: 702-388-4600	Patient Copy
			Page: 1 of 2

Patient Discharge Instructions

Document: 421 Last Update: 05/08/2002

TRANSIENT ISCHEMIC ATTACK (TIA verses CVA)

The spell you had today is called a T.I.A. and is caused by a temporary decrease of blood flow to part of your brain. T.I.A. usually occurs in persons with hardening of the arteries. A tiny piece of clot breaks off of the lining of the carotid artery (main artery in your neck) and travels up to the brain. This temporarily blocks flow in a smaller blood vessel to one part of the brain. Symptoms are caused by the lack of oxygen in the part of the brain where the blockage occurs. After a short while, the small piece of clot dissolves, blood flows again and symptoms disappear. TIA causes temporary symptoms like a stroke, lasting less than 24 hours. Once you have had a T.I.A. you are at risk for having a full stroke! Therefore, be sure to follow up with your doctor for further evaluation and treatment.

Follow These Instructions Carefully:

1. If all of your symptoms have resolved, there is nothing special that you need to do today. Rest at home and avoid exertion for the rest of the day.
2. Unless you cannot tolerate aspirin or your doctor tells you otherwise, you should take one adult aspirin tablet a day for the rest of your life. Aspirin "thins the blood" and lowers the risk of forming new clots. This reduces your risk of having another T.I.A or stroke.

How To Reduce The Possibility For A Stroke:

1. Monitor your blood pressure and take any prescribed medicine for blood pressure exactly as directed.
2. **If you smoke, you must stop.**
3. If you are overweight, talk to your doctor about starting an effective weight loss program.
4. Aspirin is a simple but important part of preventing stroke. Discuss this with your doctor.

Follow up: Call your doctor for an appointment in the next few days for another evaluation. Additional tests may be needed.

Return to this facility immediately or contact your doctor if you begin to have any of the following:

- Any of your T.I.A. symptoms return.
- Difficulty with speech, vision, weakness or numbness on one side of your body.
- Severe headache, fainting spell, dizziness or seizure.
- Chest pain or shortness of breath.

Patient Discharge Instructions

Document: 85 Last Update: 04/16/2002

CEREBROVASCULAR ACCIDENT (STROKE)

You have had a stroke or CVA. A stroke means you have a brain injury from blocked circulation or bleeding. The symptoms depend on the area of brain that is affected. They can include problems with speech and vision, paralysis, loss of balance, vertigo, numbness, headache, or fainting. Symptoms of a stroke may progress or fluctuate over the first 1-2 days. If your symptoms have been continuously present for over 3 hours, treatment with drugs to dissolve the blood clots in the brain circulation is not helpful.

A stroke or CVA may occur when a tiny piece of clot breaks off of the lining of the carotid artery (main artery in your neck) and travels up to the brain, blocking blood flow. The other common cause for stroke is a gradual narrowing of the arteries in the brain due to arteriosclerosis ("hardening of the arteries") until a complete blockage occurs.

The main goals in treating a CVA include measures to prevent secondary complications, and treatment to reduce the risk of future strokes. Tests that help confirm the diagnosis of a CVA include CT and MRI scans, ultrasound examinations, and x-rays of the brain circulation. Recovery depends on the location and size of the damaged area, and whether other nerve tissue can take over the job.

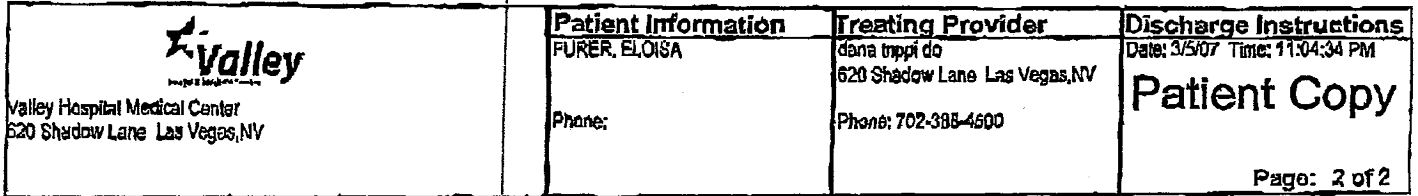
If control of the bladder has been lost, an internal or condom catheter may be used. If swallowing is difficult, tube feedings may be necessary. Surgery to remove blood clots or to open up blocked arteries may be necessary in some patients. Once you have had a stroke, you are at risk for having another!

Follow These Instructions Carefully:

1. Rest at home and avoid exertion for the next few days.
2. Unless you cannot tolerate aspirin or your doctor tells you otherwise, you should take one adult aspirin tablet a day for the rest of your life. Aspirin "thins the blood" and lowers the risk of forming new clots and having another stroke.

How To Reduce The Risk Of Another Stroke:

(3)



Valley Hospital Medical Center, 620 Shadow Lane Las Vegas,NV	Patient Information	Treating Provider	Discharge Instructions
	FURER, ELOISA	dana tippi do 620 Shadow Lane Las Vegas,NV	Date: 3/5/07 Time: 11:04:34 PM
	Phone:	Phone: 702-388-4600	Patient Copy
			Page: 2 of 2

1. Monitor your blood pressure and take any prescribed medicine for blood pressure exactly as directed.
2. If you smoke, you must stop.
3. If you are overweight, talk to your doctor about starting an effective weight loss program.

Follow up: Call your doctor for an appointment in the next few days for repeat exam. Additional tests may be needed. Call your doctor or the Stroke Association (1-888-478-7653) if you or your family has any questions about your condition or treatment.

Return to this facility immediately or contact your doctor if you begin to have any of the following:

- Marked worsening in paralysis, numbness, speech, or alertness.
- New difficulty with speech, vision, weakness or numbness on one side of your body.
- Severe headache, fainting spell, dizziness, seizure or blurred vision.
- Chest pain or shortness of breath.
- Repeated vomiting.
- Any falls.

Discharge Instructions Special Notes

Discharge Instructions Special Notes

Emergency care received is not intended to be definitive medical care and treatment. I acknowledge that I have been instructed to contact a follow up physician and/or my primary care physician for continued medical evaluation, care, and treatment. Diagnostic studies completed in the Emergency Department have been evaluated by the emergency doctor and may require follow up. My signature authorizes this hospital to release all or any part of my medical record (including, if applicable, information pertaining to AIDS and/or HIV testing, mental health records, and drug and/or alcohol treatment) to the referred physician. Medications prescribed (list in Box 2, under your prescription), should be taken as directed and reported to your physician for review.

AVIECO

Patient Information

Patient Name: FURER, ELOISA
DOB: 9/5/1941
Age: 65
Marital Status: U

Patient ID: 59633
SSN: 549352191
Sex: F
Patient Alerts:

Patient Phone: (702)2288553
Address: 9812 WINTER PALACE DR LAS VEGAS, NEVADA 89145
County Code:

Referring MD

Name: YU, SANTOS MD
ldress: 100 N. GREEN VALLEY PKWY #225 HENDERSON

Phone: (702) 247-9994 EXT.
Beeper: ()

Fax: (702)651-9995
Email:

Exam Information

ate Time: 3/20/2007 1:30:00 PM
cam Type: MRA HEAD W/O CONTRAST
History:

Location: MOUNTAIN VISTA
Special Instructions - Prep:
Underlying Diagnosis: DIZZINESS, SYNCOPE

Accession Number: 106866
Procedure Code: 70544
Modality: MR

Insurance Information

Company Name: **SECURE HORIZONS
Policy Holders Name: FURER, ELOISA B
Insurance ID: 761984501

Group:
Authorization:
Insurance Phone: ()

Effective Date:
Expiration Date:

EBFurer

Account Billing

106 34

Today's Payment: 106 34 paid VISA
Billing Notes:

yment of Office Fees Required at Time of Service - Thank You

evada Physicains Imaging has filed this claim for you in accordance with Medicare regulations.

e above information is complete and correct. I hereby authorize release of information necessary to file a claim with my surance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. All prfessional rvices rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event collection proceedings due to a lack of payment on my part, I agree to pay any and all collection fees that may be added to my count in order to recover monies due the doctor.

gnature and Date: X EBF

CC Camillo Tabora

HOPE HOME HEALTH, LLC
1401 So. Arville, Ste. G
Las Vegas, NV 89102
Telephone: (702) 258-4673 ♡ Fax: (702) 259-3119

INVOICE

Ms. Eloisa Furer
9812 Winter Palace Drive
Las Vegas, NV 89145

Nursing services for Intravenous insertion and fluid therapy (August 15 – Evaluation) (August 16 - 2 Visits)	**$150.00**	**3**	**$450.00**
Please pay either by cash or check at the end of the service.			

Thank you,

Remy Caballero

Remy Caballero, RN
Administrator

Pd Check #272 B7A -

P.O. BOX 3902 • 625 SHADOW LANE • LAS VEGAS, NEVADA 89127 • 702-759-1050 • FAX 702-38[illegible]

Clark County HEALTH DISTRICT

CLARK COUNTY EMERGENCY MEDICAL SERVICES

☐ **American Medical Response**
1200 S. Martin Luther King Blvd.
Las Vegas, NV 89102
(702) 386-9985

☐ **Boulder City Fire Department**
1101 Elm Street
Boulder City, NV 89005
(702) 293-9228

☐ **Clark County Fire Department**
575 E. Flamingo Road
Las Vegas, NV 89119
(702) 455-7311

☐ **Henderson Fire Department**
223 Lead Street
Henderson, NV 89015
(702) 565-2016

☐ **Las Vegas Fire & Rescue**
500 N. Casino Center Blvd.
Las Vegas, NV 89101
(702) 383-2888

☐ **North Las Vegas Fire Department**
2626 East Carey Ave.
North Las Vegas, NV 89030
(702) 633-1104

☐ **Southwest Ambulance**
4640 South Arville, Suite G
Las Vegas, NV 89103
(702) 650-9900

☐ **Mesquite Fire & Rescue**
10 East Mesquite Blvd.
Mesquite, NV 89027
(702) 346-5231

RELEASE OF MEDICAL ASSISTANCE

- I (or my guardian) have been informed of the reason I should go to the hospital for further emergency care.
- I (or my guardian) have been informed that only an initial evaluation has been rendered to me and have been advised that I seek the advice of a physician as soon as possible.
- I (or my guardian) have been informed of the potential consequences and/or complications that may result in my (or my guardian's) refusal to go the hospital for further emergency care.
- I (or my guardian), the undersigned, have been advised that emergency medical care on my/the patient's behalf is necessary, and that refusal of recommended care and transport to a hospital facility may result in death, or imperil my/the patient's health by increasing the opportunity for consequences or complications. Nevertheless, and understanding all of the above, I (or my guardian), refuse to accept emergency medical care or transport to a hospital facility, assume all risks and consequences resulting from my (or my guardian's) decision, and release Clark County provider agencies, and all personnel directly or indirectly involved in my care, from any and all liability resulting from my (or my guardian's) refusal. I have had the opportunity to ask all of the questions I feel necessary to provide this informed refusal.
- The reason for this refusal is as follows: (to be completed by patient/guardian) Because I do not want to again stay in the Emergency Room for 18 Hours

Patient's Name: ELOISA B. FURER DOB: [illegible]

Patient's Address: 9812 WINTER PALACE DR

Patient's Phone Number:

Signature (Patient/Guardian): [signature]

Witness: [signature]

Witness: RYAN [illegible]

Date: 8/15/06 Time: 0201 Incident #: 6176509

Refused to Sign (Patient/Guardian):

Telemetry Physician: N/A Hospital: N/A

I have received a copy of my patient rights: ☐ Yes ☒ No Initials: [initials]

120 BS 58 HR 84/50 BP

[illegible] AMA

Patient Name: Eloisa B. Furer
Clinical Impression

Examination Date: 11/7/06
Page Two

	WITHIN NORMAL LIMITS:	ABNORMALITIES:
1. NECK:		
• Thyroid:	☐	☒ enlarged, inhomogeneous- rule out goiter; recommend checking thyroid hormone levels
• Carotid calcified plaque at origin: Right:	☐	☒ large calcified plaque right subclavian artery
Left:	☒	☐
2. HEART:		
• Normal chambers/pericardium	☒	☐
• Aorta:	☐	☒ calcified plaque ascending aorta
• Aortic valve calcification?	☒ No	Mitral valve calcification? ☒ No

Rate of Plaque Burden Progression:

	Cardiac Plaque:	Aorto-iliac Plaque:
Previous exam tracking score (as evaluated today):	15.2	426.4
Current exam tracking score:	25.6	1261.1
Approximate annualized average increase of:	12%	increase of: 27%

	WITHIN NORMAL LIMITS:	ABNORMALITIES:
3. LUNGS/MEDIASTINUM:	☐	☒ Emphysematous changes: scattered

☒ Other: two non-calcified nodules: right upper lobe 2-3mm; lingula 1.3mm; recommend lung CT follow-up in 3-6 months

	WITHIN NORMAL LIMITS:	ABNORMALITIES:
4. BREASTS: *	☐	☒ Fibrocystic changes ☐ Implants intact

* (This test does not replace an annual mammogram)

	WITHIN NORMAL LIMITS:	ABNORMALITIES:
5. ABDOMEN:		
• Liver:	☐	☒ 1.7cm (was 1.2cm in 4/02) and 1.4cm (was 2.5cm in 4/02) cysts in the right lobe
• Gallbladder:	☒	☐
• Left kidney:	☒	☐
• Right kidney:	☒	☐
• Pancreas:	☒	☐
• Adrenals:	☒	☐
• Spleen:	☒	☐
• Colon Diverticulosis:	☐ NO	☒ YES
• Viscera:	☒	☐

☐ Other:

Patient Name: Eloisa B. Furer **Examination Date: 11/7/06**
Clinical Impression **Page Three**

6. **PELVIS:**	WITHIN NORMAL LIMITS:		ABNORMALITIES:
• Prostate:	☒ N/A	☐	☐ ________
• Uterus:	☐ N/A	☒	☐ tilted
• Ovaries:	☐ N/A	☐	☒ not seen
• Bladder:		☒	☐ ________

Aorto-iliac calcification:
☐ None ☐ Mild ☒ Moderate ☐ Severe

Femoral vessel calcification:
☒ None ☐ Mild ☐ Moderate ☐ Severe

7. **SPINE:**

	WNL	*	CCS	DB	DDD	DJD	DN	LCS	FJA	NNF	VP
L1-2:						moderate	mild				
L2-3:				mild posterior	mild	mild					
L3-4:			x	moderate posterior	moderate	moderate		bilateral			
L4-5:			x	moderate posterior	moderate	moderate	moderate	bilateral			
L5-S1:				moderate anterior and mild posterior	mild to moderate	mild	mild		right		

WNL = within normal limits
* = see below
CCS = central canal stenosis
DB = disc bulge
DDD = degenerative disc disease
DJD = degenerative joint disease
DN = disc narrowing
LCS = lateral canal stenosis
FJA. = facet joint arthropathy
NNF = narrowed neural foramen
VP = vacuum phenomenon

Dextroscoliosis: ☒ No ☐ Yes
Levoscoliosis: ☐ No ☒ Yes: mild; lumbar spine L4-5
Hypertrophied ligamentum flavum: ☒ No ☐ Yes

☒ Other: severe osteoporosis

Other Findings:
☐ Atherosclerotic disease (mild/moderate/severe) of:
☐ Other:

Counseling Coordination Activities:
☐ Pathophysiology of Coronary Artery Disease
☐ Pathophysiology of Disc Disease
☐ Plaque Regression Education
☐ Functional Testing

Under Medical Bills

Green Valley Drugs

1433 North Boulder Highway • Henderson, NV 89015
702-564-2079 • 702-564-8273

☒ NEW ☐ EXISTING

DATE: 8-15-06

Patient S.S. #

TRANSACTION TYPE
☒ DELIVERY
☐ PICK UP
☐ EXCHANGE

CUSTOMER INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL): Furer, Eloisa			PHONE: (702) 821-5144	
ADDRESS: 9812 Winter ~~Pine~~ Dr LV, NV 89145				MARITAL STATUS
BIRTH DATE / /	SEX	HEIGHT PALACE	WEIGHT	DATE OF INJURY / /	RELATIONSHIP TO INSURED
PRIMARY INSURANCE	POLICY #	PHONE ( )	GROUP #	
SECONDARY INSURANCE	POLICY #	PHONE ( )	GROUP #	
RESPONSIBLE PARTY	ADDRESS	SS #	PHONE ( )	
EMERGENCY CONTACT	RELATIONSHIP	PHONE ( )	ADDRESS	
NURSING	ALLERGIES			

ITEM	R S	DESCRIPTION	RENTAL #	D P	QTY.	BILLED AMT	EXT AMT
		D5 1/2 NS, 1000ML		D	2		
		NS w/10meq KCL, 1000ML		D	1		
		MICS INFUSION SUPPLIES					
		IV POLE	RENTAL		1		

DELIVERY INSTRUCTIONS

SUBTOTAL ➤
TAX ➤
TOTAL CHARGE ➤ 285.00

COMMENTS:

COLLECT

The above information has been given to Green Valley Drugs to provide it with information necessary to bill Medicare, Medicaid or other sources for services provided. I certify that this information is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or their intermediaries or the billing agent of Green Valley Drugs, any information for this or any related health claim. I agree to permit a copy of this authorization to be used in place of an original. I authorize Green Valley Drugs to release records for the purpose of obtaining payment or medical treatment. Such records may be released to any agency or individual to receive such information. I understand I have the right to refuse to release Green Valley Drugs records and that signing this consent constitutes a waiver of the right for a period of 2 years. I request that payment of authorized benefits be made on my behalf to Green Valley Drugs. I HAVE READ AND UNDERSTAND THE PROVISIONS ON THE FRONT AND BACK OF THIS FORM. I UNDERSTAND THAT MY SIGNATURE BELOW SHALL BE EVIDENCE OF MY AGREEMENT TO THE PROVISIONS ON THE FRONT AND BACK OF THIS FORM. CONSENT FOR TREATMENT: I hereby authorize Green Valley Drugs staff to deliver/teach/administer/perform that which has been prescribed by my physician.

☐ (Initials) **I understand that if my claim is denied from Medicare, Medicaid or insurance due to same or similar equipment already dispensed, I will be fully responsible for payment. I acknowledge that I have received a copy of the CMS Medicare DMEPOS.**

☐ (Initials) **I acknowledge that I have received from Green Valley Drugs Home Health the Privacy Notice policies in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

Patient Signature or Authorized Individual

Date Aug 15 06

Form completed by (GVD Staff)

If other than patient (Print Name)

Relationship

Delivery person Date Time

White - Office Yellow - Billing Pink - Patient