

2015

**State of Utah, Plaintiff/ Appellee, v. Rick Jimenez Defendant/
Appellant.**

Utah Court of Appeals

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Case No. 20140841-CA

IN THE
UTAH COURT OF APPEALS

STATE OF UTAH,
Plaintiff/Appellee,

v.

RICK JIMENEZ,
Defendant/Appellant.

Brief of Appellee

Appeal from a conviction for burglary, in the Third Judicial District, Salt Lake County, the Honorable Denise P. Lindberg presiding

NATHALIE S. SKIBINE
SCOTT A. WILSON
Salt Lake Legal Defender Assoc.
424 East 500 South, Suite 300
Salt Lake City, UT 84111

Counsel for Appellant

JEANNE B. INOUE (1618)
Assistant Attorney General
SEAN D. REYES (7969)
Utah Attorney General
160 East 300 South, 6th Floor
P.O. Box 140854
Salt Lake City, UT 84114-0854
Telephone: (801) 366-0180

PETER LEAVITT
Salt Lake District Attorney's Office

Counsel for Appellee

Oral Argument Not Requested

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Telephone: (801) 366-0180

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Salt Lake District Attorney's Office

Counsel for Appellee

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IN THE
UTAH COURT OF APPEALS

STATE OF UTAH,
Plaintiff/Appellee,

v.

RICK JIMENEZ,
Defendant/Appellant.

Brief of Appellee

STATEMENT OF JURISDICTION

Defendant appeals from a conviction for burglary, a second degree felony. This Court has jurisdiction under Utah Code Ann. §78A-4-103(2)(e) (West Supp. 2015).

INTRODUCTION

Defendant's DNA was found in blood left in the victim's home after someone burglarized the home, apparently entering through a window. Defendant insisted he had never been in the home. At trial, he asserted that he was so physically disabled that he could not have climbed up to and through the window. He offered a fantastical explanation, supported by only his own testimony, of how his blood might have been found in the victim's home. He also proffered medical records he claimed would

establish that he was too disabled to enter through a window. The trial court excluded the medical records under rule 403, Utah Rules of Evidence.

STATEMENT OF THE ISSUES

Did the trial court abuse its discretion when it excluded Defendant's medical records under evidence rule 403, where the records did not directly address his mobility; were 70 pages long, outdated, potentially confusing and misleading, and cumulative of Defendant's own testimony; and where Defendant proffered no expert to help the jury understand them? If so, did Defendant suffer any prejudice?

Standard of Review. An appellate court "reviews a trial court's decision to admit or exclude specific evidence for an abuse of discretion." *State v. Jones*, 2015 UT 19, ¶12, 345 P.3d 1195 (citation and internal quotation omitted). Even where error occurs, this Court will disregard it if "it does not affect the substantial rights of a party." Utah R. Crim. P. 30(a).

CONSTITUTIONAL PROVISIONS, STATUTES, AND RULES

Utah evidence rules 401, 402, and 403, and Utah criminal procedure rule 30 are relevant to this appeal and are reproduced in Addendum A.

STATEMENT OF THE CASE

A. Summary of facts.

When Nalani Namauu returned home after work on December 14, 2012, she discovered that someone had broken into her home and taken numerous valuables, including including an Ipod, a Garmin GPS, a cell phone, jewelry, Lortab tablets and other prescription drugs, and checks she had received when conducting a fundraiser for the Huntsman Cancer Hospital. R178:79, 84, 89; State's Exhibit 14. The point of entry appeared to be a back window. R178:79. Someone had placed a garbage can under the window. R178:97, 99. The plastic sheeting Namauu had secured to the inside of the window had been pushed away. R178:79.

Namauu called police. R178:78. An officer came out and took her statement. *Id.*

The next morning, Namauu noticed blood on a bed pillow and on a kitchen blender—blood that had not been there when she went to work the day before. R178:84, 88. She called police again to report her finding. R178:84. Crime lab personnel came that day and collected blood from a button on the blender. R178:95, 112-13. Due to a backlog at the State Crime Lab, testing was not completed until almost six months later, when staff created a DNA profile from the blood and compared it against a DNA

database for possible matches. R178:124-26. The result was a match for Defendant Rick Jimenez. *Id.*

Based on the match, officers secured a warrant to take a buccal sample from Defendant. R178:126. On June 24, 2013, officers served the warrant on Defendant and took a sample from his mouth. R178:130. While executing the warrant, the officers explained that they were investigating a burglary and that Defendant was a suspect. *Id.* One of the officers showed Defendant a picture of Namauu's home and asked Defendant if he recognized it or had been to it. R178:129. Defendant said it looked like his grandmother's home in Rose Park. *Id.* The officer explained that the home was in Glendale, that someone had broken into the home, and that the DNA in blood found in the home matched Defendant's DNA database profile. R178:130. Defendant told the officer that "he didn't understand how that could happen because he was never inside that house." *Id.*

Testing at the State Crime Lab confirmed that the blood DNA from the buccal swab matched the DNA in the blood sample from the blender. R178:130, 150. The probability of selecting a random person from the population whose DNA would match the DNA in the blender blood sample was about "1 in 16 sextillion in Caucasians, 1 in 1.9 septillion in blacks, and 1 in 2.36 sextillion in Southwestern Hispanics." R178:152.

Defendant's version at trial. At trial, Defendant took the stand and testified in his own defense that he was physically unable to climb onto a garbage can or through a window. R178:188, 192. He testified that he had six herniated disks, a crushed vertebrae in his neck, and a torn tendon in his left arm and right leg. R178:190. He also testified that he had been treated for sciatic pain for 14 years. R178:190-91.

And, for the first time, Defendant offered an explanation for why his blood might have been found in the victim's home.¹ According to Defendant, about a week before the burglary, he traveled from his home in Ogden to Salt Lake City with his friend Daniel Lemons. R178:189. They came down to help one of Lemons' friends and met Lemons' girlfriend, Crystal, at a motel. R178:189-90.

While Lemons visited with his girlfriend, Defendant walked around in front of the motel. R178:192. He saw a girl crying and asked her what was wrong. *Id.* She said that she needed her medication, Xanax. *Id.* So Defendant, Lemons, Lemons' girlfriend, and the girl drove to the home of one of the girl's friends, a Danny Burk. R178: 192. As it turned out, Defendant knew Danny Burk because he had grown up with him. *Id.*

¹ The State has attempted to reproduce Defendant's story. The disconnected summary reflects the disconnected testimony Defendant gave at trial.

When they arrived, Defendant asked Burk about the girl's medications, and Burk began yelling and saying to "get her out of my house." R178:194. But Burk's girlfriend came out and said that she could get the pills. *Id.*

Defendant asked the girlfriend to talk to the girl. *Id.* So the girlfriend ran across the street, went into a house, and a younger Polynesian girl came out. *Id.* Another girl was there with two dogs, saying "something about taking her dogs for a walk." R178: 195. The girl with the dogs told Defendant that "she" [the girl who needed the Xanax?] did not "have enough money." *Id.* So Defendant pitched in \$20 and Lemons pitched in \$3 more. *Id.*

Defendant claimed that at about that time, one of the dogs, a pit bull, jumped up on him, knocked him to the sidewalk, and caused his arm and hand to bleed. R178:195-96. Defendant asked the girl with the dogs whether she had a "rag or something." R178:196. She got a dishrag, he wiped himself off, and she said she would take care of the rag. *Id.* Defendant said he saw the girl with the dog and the Polynesian girl walk up the driveway that led to the victim's house. R178:208. Defendant and Lemons then returned to Ogden. *Id.*

But Defendant did not call Daniel Lemons, Daniel's girlfriend, Danny Burk, Danny's girlfriend, the girl with the dog, the Polynesian girl, or any other witness to testify at trial.

Asked at trial if he told the detective that he "never entered into this house," Defendant testified that he did. R178:200. Asked on cross-examination by the prosecutor whether the interviewing officer had said that he was investigating a burglary and had mentioned blood left in the victim's home, Defendant answered yes. R178:201-202. Asked whether the officer had told him that the DNA in the blood found in the burglarized home matched Defendant's, Defendant answered yes. R178:202-04. Asked whether he then told the officer anything about the alleged incident with the Polynesian girl and the girl with the dog, his being knocked to the ground, and his bleeding, Defendant answered no. R178:204. Rather, Defendant conceded that the first time he said anything about this alleged incident was in his trial testimony. R178:205.

B. Summary of proceedings.

Defendant was charged with one count of burglary, a second degree felony, and one count of theft, a third degree felony. After the State rested its case, but before Defendant put on his evidence, the prosecutor noted that Defendant intended to admit some medical records and moved to exclude

them. R178:165; *see* Defendant's Ex. 1 (proffered and included in the record on appeal, but not received at trial). Defendant proffered seventy pages of medical records detailing several visits to a doctor in 2011 and indicating he was last seen in January 2012. *See id.* The records set forth Defendant's self-reported past history with herniated intervertebral disks and his 2011 and 2012 diagnosis of "lumbago." Defendant's Ex. 1 at 10, 66. But the records did not include reports of MRI, X-ray, or other scans and did not address his mobility status. *See id.* 1-70. Many of the pages set forth his requests for prescriptions for Lortab and Ibuprofen, his failure to appear for appointments, and his need to see the doctor to permit further refills. *See id.* 1-7.

While Defendant had made the records available to the State during discovery, he had not provided the records to the court. R178:170. He had not redacted or otherwise limited the pages, nor had he provided any expert to guide the jury through the records and explain what they did and did not mean. R178:177. He had not called the examining doctor to explain what she personally had found during her examination of him. *See id.* Thus, no one could give an opinion, based on the records, of Defendant's ability to perform the physical activities that would be required to enter the home through the window. R178:178. The State argued that admitting the

records would be “inviting the jury to speculate” about that matter. R178:177-78.

The trial court ruled that the records were not relevant to show Defendant’s ability to enter through the window. *Id.* The court ruled alternatively that they were cumulative of Defendant’s own testimony and potentially confusing to the jury and therefore excludable under rule 403, Utah Rules of Evidence. R178:185-86.

SUMMARY OF ARGUMENT

The trial court did not abuse its discretion when it excluded Defendant’s medical records under rule 403, Utah Rules of Evidence. The trial court properly determined that the evidence had the potential to waste time, confuse the issues, and mislead the jury. While the medical records contain later requests for prescriptions, the last visit to the doctor that they document was on January 23, 2012—almost a year before the burglary. Thus, the records do not address Defendant’s physical state at the time of the offense. And the records from Defendant’s clinic visits do not include any reports of scans or assessments of mobility and do not discuss the extent of Defendant’s mobility. Rather, they provide only a general diagnosis of “lumbago.”

Moreover, the records were over seventy pages long, and Defendant had provided no expert to guide the jury through them and explain what they meant. Thus, the jury would have had to pour over them, trying to extract and understand information they were not qualified to assess. The length of the records and the medical terminology in them may, in fact, have lead the jury to speculate that Defendant's injuries were more severe than the records—accurately read and explained—showed. Further, the records showed that Defendant received pain medications, but did not document how effective the medications were, thus leaving the jurors to speculate about whether Defendant was medicated at the time of the burglary and, if so, how that would have affected his ability to enter the home. Finally, the records contained a good deal of unnecessary information about Defendant's long history of requesting more medication without "showing up" for doctor's visits.

But even if the trial court erred in excluding the records, Defendant cannot show prejudice. The evidence against Defendant was overwhelming. Defendant's blood was found in the victim's house after the burglary. Its DNA matched the Defendant's DNA profile in an existing database. Defendant presented an implausible story of how the DNA came to be in the burglarized home, and the jury rejected it. The medical records

were not relevant to the explanation, and admitting them therefore would not have changed the outcome.

ARGUMENT

DEFENDANT HAS NOT SHOWN THAT THE TRIAL COURT ABUSED ITS DISCRETION WHEN IT EXCLUDED THE MEDICAL RECORDS OR THAT EXCLUDING THEM WAS PREJUDICIAL

Defendant claims that the trial court abused its discretion in excluding his medical records and that, absent the error, there was a reasonable likelihood of a verdict more favorable to him. Br.Aplt. 7-19. Specifically, he argues that his medical records would have “corroborated his testimony that his physical condition would have made it impossible to climb on a garbage can and through a window.” *Id.* 6. But Defendant has not shown that. Nor has he shown that the trial court abused its discretion when it found that the records were cumulative of Defendant’s testimony and may have confused the issues and misled the jury. And even assuming *arguendo* that the trial court erred in excluding the records, Defendant cannot show that any error affected his substantial rights, because the evidence of his guilt was overwhelming.

A. The medical records.

The records Defendant proffered were created by University of Utah Health Care. *See* Defense Ex. 1 cover sheet. They include clinic notes of

office visits from June 13, 2011 to January 23, 2012, and associated prescription requests, phone calls, and correspondence.² *See id.*

Defendant first visited the clinic on June 13, 2011. *Id.* at 64. He came in complaining of back pain in his upper and lower back. *Id.* 65. He stated that the pain had begun about five days earlier. *Id.* He reported a past injury and said he had herniated disks and tendon pain.³ *Id.* 65-66. He said that he had tried ibuprofen and Lortab. *Id.* 65. The doctor ordered lab testing and prescribed those two drugs. *Id.* 52, 50.

Defendant visited the clinic again on June 15, July 6, July 29, August 5, September 26, and October 26, 2011. *Id.* 56, 48, 39, 37, 29, 24. His final visit was on January 23, 2012. *Id.* 10. Throughout the visits, the doctor diagnosed Defendant's back and leg problems as "generalized pain," "back pain" or "lumbago." *Id.* 67, 65, 60, 58, 50, 39, 32, 14. The medical records also include Defendant's report that he tore his tendons in 2004 and listed "tendon disorder" and herniated disks or crushed vertebrae as part of his past medical history. *Id.* 58, 44, 43.

² The documents are arranged in reverse chronological order, begin with Defendant's last contacts with the clinic, and end with his first contacts. *See* Defense Ex. 1. It is sometimes difficult to determine where one document ends and another begins. *See id.*

³ On July 20, 2011, Defendant visited a physical therapist. State's Ex. 2 at 43. Defendant reported to the therapist that his back pain began in 2004 after he lifted an engine at work. *Id.*

But the records include no X-rays or other scans, no reports on such scans, and no mobility assessments. *See id.* 1-70. Moreover, the entries after January 23, 2012 merely memorialize Defendant's requests for medication from the pharmacy, the refills given, and the doctor's repeated cautions that she could not prescribe pain medication unless Defendant appeared for office visits. *See id.* 7, 3, 1.

B. The trial court did not abuse its discretion when it excluded Defendant's medical records.

Because "'trial courts have wide discretion in determining relevance, probative value, and prejudice,'" this Court generally "'will not reverse the trial court's ruling on evidentiary issues unless it is manifest that the trial court so abused its discretion that there is a likelihood that injustice resulted.'" *State v. Valdez*, 2006 UT App 290, ¶ 7, 141 P.3d 614 (quoting *State v. Gomez*, 2002 UT 120, ¶12, 63 P.3d 72).

Evidence is relevant and presumptively admissible if "it has any tendency to make a fact more or less probable than it would be without the evidence" and "the fact is of consequence in determining the action." Utah R. Evid. 401; *see also State v. Richardson*, 2013 UT 50, ¶27, 308 P.3d 526. But the presumption of admissibility is rebuttable. A "court may exclude relevant evidence if its probative value is substantially outweighed by the danger of one or more of the following: unfair prejudice, confusing the

issues, misleading the jury, undue delay, wasting time, or needlessly presenting cumulative evidence.” Utah R. Evid. 403.

Defendant asserts that the proffered medical records were relevant to whether he could or could not have entered the window to burglarize Namaau’s home. Br.Aplt. 8. The trial court ruled that they were not. The trial court concluded that the records were not relevant because they were not current and because they were records of Defendant’s self-reported health problems, not of actual testing or other objective measures of Defendant’s mobility. R178:173-74.

But the court also ruled that even if the records were relevant to “corroborate” Defendant’s testimony about his inability to climb a garbage can and enter through the window, the records were cumulative of Defendant’s own trial testimony and presented the potential to confuse the

issues and mislead the jury. R178:175-86. Thus, the records were more prejudicial than probative.⁴ See Utah R. Evid. 403.

The trial court did not abuse its discretion in excluding the records under rule 403. First, as explained, the records were not current. Although Defendant had seen his doctor at least monthly between June and October, 2011, he saw her only once after that—in January 2012, eleven months before the burglary. Accordingly, the records did not address his mobility status eleven months later in December 2012. Thus, the probative value of any information they might have provided concerning Defendant's ability to climb through a window was reduced because the records were not current. See, e.g., *Commissioner v. Delgado*, 939 N.E.2d 802, *1 (Mass App. 2011) (medical records indicating that defendant suffered from back pain

⁴ Defendant also argues that the trial court erred for not admitting a redacted version of the records he had not yet prepared. Br.Aplt. 1, 16-17. Defendant suggested that he could admit only pages 11-13, 25-26, 30, 38, 40, 43-45, and 58-59. R178:171. While redacting the records might have shortened them, it would not have reduced potential for confusing the jury. Redacting the records would have stripped the entries from their context and may have made them even more confusing to the jury. Moreover, the trial court's denying Defendant's midtrial request to redact the records and admit the redacted records, was "well within its power to manage the trial process." *State v. Clopten*, 2015 UT 82, ¶15, 794 Utah Adv. Rep. 33. "The trial court, with its inherent powers as the authority in charge of the trial, has broad latitude to control and manage the proceedings and preserve the integrity of the trial process." *State v. Parsons*, 781 P.2d 1275, 1282 (Utah 1989).

and pain in his groin were “temporally remote and not relevant or probative of his ability to perpetrate his attack upon the victim” three months later); *State v. Whitmire*, 2009 WL 2486178, at *15 (Tenn. Crim. App. Aug. 13, 2009) (mental health records two years prior to offense too remote to provide any information regarding defendant’s mental condition at time of offense).

Second, the records did not include any X-rays or reports of other scans that might have provided an objective basis for evaluating Defendant’s mobility nor did they include any mobility assessments or other tests that might have suggested the likelihood or not of Defendant’s being able to climb through a window. *See* Defendant’s Ex. 1, 1-70; *see also Delgado*, 939 N.E.2d at 802, *1 (medical records showing defendant reported suffering from back and groin pain “contain no suggestion that the defendant’s pain rendered him physically unable to accomplish the acts alleged”); *People v. Ortiz*, 686 N.Y.S.2d 386, **386 (N.Y. App. Div. 1999) (medical records concerning the condition of defendant’s jaw contained no information relevant to his ability to speak at the time of his hospitalization, much less to his ability to speak at the time of the offense three weeks later); *People v. Green*, 2003 WL 22359566, *3 (Mich. App. Oct. 16, 2003) (“medical records would have only shown that defendant suffered a leg injury months

before the incident, not that he could not have chased the victim"). And while the medical records document the doctor's prescribing pain medications, they do not document the effect of the medications on his mobility. Moreover, the diagnosis set forth in the records was simply "lumbago," a general term for any lower back pain, but a term not necessarily familiar to lay persons.⁵ *See id.* at 1, 10.

At the same time, the records had the potential to unduly waste time, confuse the issues, and mislead the jury. First, the records were lengthy – seventy pages long. *See id.* at 70; *see also Everett v. Ejofodomi*, 76 Mass. App. 1131, *2 (2010) (likely confusion to jury "left to sift through voluminous unexplained medical records"). This was especially problematic because Defendant did not have any expert, much less the doctor who created the

⁵ Lumbago "is considered by health professionals to be an antiquated term that designates nothing more than lower back pain caused by any of a number of underlying conditions. The pain may be mild or severe, acute or chronic, confined to the lower back or radiating into the buttocks and upper thighs." Encyclopædia Britannica, Inc. (2015), *available at* <http://www.britannica.com/science/lumbago>. *See also* "Lumbago," *available at* <http://www.avogel.co.uk/health/muscles-joints/back-pain/lumbago> ("Lumbago is another term for lower back pain, a condition experienced by up to 80% of people in the industrialised [English spelling] Western world at some point in their lives."); "Understanding Low Back Pain (Lumbago), *available at* <http://www.spine-health.com/conditions/lower-back-pain/understanding-low-back-pain-lumbago> ("Lumbago is the general term referring to low back pain, and the two terms are often used interchangeably.").

records, to introduce them, sort through them, and explain what they contained. *See* R178:67; *see also* *Wheaton v. State*, 2003 WL 21513623, *2 (Tex. App. July 3, 2003) (unaccompanied “by any explanatory expert testimony,” admitting medical records “would have created an impermissible danger of misleading the jury and confusing the issues”); *Kayman v. Rasheed*, 31 N.E.3d 427, 438 (Ill. App. 2015) (medical records containing “terminology unfamiliar to a lay jury” likely confusing); *Bullington v. Bush*, 2009 WL 1347177, at *2 (Ky. App. May 15, 2009) (“medical records may have been confusing to the jury because at that juncture they had not been explained by a medical expert”). It was also especially problematic where Defendant’s records sometimes list diagnoses under “Past Medical History,” but do not always clarify whether those particular diagnoses were merely self-reported. *See* Defense Ex. 1 at 44, 30, 25. These circumstances increased the likelihood of confusing the jurors and wasting their time pouring over records that they were not qualified to understand. *Cf. Troyan v. Reyes*, 855 N.E.2d 967, 974 (Ill. App. 2006) (“Like all business records, medical records may be excluded if they are not relevant or are too complex for the jury to understand on its own.”). Indeed, the first nine or ten pages of the records—the pages jurors were most likely to attempt to read—document only Defendant’s requests for renewal of his pain medications, responses to

those requests, the need for Defendant to be seen again, and his history of “no shows” for appointments made. *Sid.* at 1-9.

Additionally, the records were potentially unfairly prejudicial. Because the jurors did not have the background to understand the records, admitting them presented the possibility of confusing the jurors and causing them to speculate about the extent of Defendant’s injuries. See *People v. Collins*, 6 N.Y.S.2d 169, 171 (N.Y. App. Div. 2015) (excluding medical records where records might cause jurors to speculate about effect of injuries on defendant’s behavior); *Reed v. State*, 59 S.W.3d 278, 283 (Tex. App. 2001) (lay jurors not expected to evaluate technical medical evidence and make informed decision regarding proof of any link between the evidence and the fact issue without assistance of an expert in technical or specialized field). The seventy pages of Defendant’s self-reported health problems and the medical terminology used to document them may have led the jury to believe the injuries were severe simply because the records were so long. And to the extent they contained any diagnosis, such as “lumbago,” Defendant had called no expert to explain what that meant. Defendant’s Ex. 1 at 10, 66.

Finally, the records were cumulative of Defendant’s own trial testimony. Defense counsel conceded that Defendant intended to take the

stand to testify to his medical issues and difficulty in moving. R178:166. The medical records he wanted to present to the jury focused on his self-reported past medical history and the general diagnosis of lumbago. See R178:171 (listing pages 11, 12, 13, 25, 26, 30, 36, 40, 43, 44, 45, 58, and 59 of medical records he would introduce into the record if the court would allow him to redact the proffered records). The entries were cumulative of the testimony Defendant intended to and did present regarding his medical history and back pain. See R178:190-92. Trial courts have discretion to exclude evidence where, as here, a defendant's own testimony adequately allows him to present the defense theory. See *Whitmire*, 2009 WL 2486178, at *15.

Thus, the trial court did not abuse its discretion when it excluded the medical records under rule 403.

C. Because the evidence of Defendant's guilt was overwhelming, Defendant cannot show that any error affected his substantial rights.

In any event, any error was harmless in light of the overwhelming evidence against Defendant. Error that "does not affect the substantial rights of a party shall be disregarded." Utah R. Crim. P. 30(a). "An erroneous decision to exclude evidence constitutes reversible error only if the error is harmful. *State v. McCullar*, 2014 UT App 215, ¶ 53, 335 P.3d 900,

cert. denied, 343 P.3d 708 (Utah 2015) (citation and quotation omitted). An “error is harmful if it is reasonably likely that the error affected the outcome of the proceedings.” *Id.* This Court will reverse only if convinced of “the likelihood of a different outcome ... sufficiently high to undermine confidence in the verdict.” *Id.* (quoting *State v. Knight*, 734 P.2d 913, 920 (Utah 1987)).

Here, Defendant’s medical records would not have made a different outcome likely. Defendant’s DNA was found on blood left in Namaau’s home after she left for work on the day of the burglary and before she returned home later that day. R178:87-88. DNA testing showed that DNA in the blood matched Defendant’s. R178:146-53. The chances of its coming from a randomly selected person were infinitesimally small. R178:152.

The jury rejected Defendant’s rambling, unconnected, and implausible explanation for the blood’s presence in the home—his story of driving to the neighborhood to help a girl get her medications, of running into a bull dog who knocked him to the ground, and of a young girl’s wiping away his blood and then heading toward the later-burglarized home with a bloody rag. Nothing suggests that any reasonable jury would have credited it. First, even though the investigating detective told Defendant about the burglary, about the blood, about Defendant’s DNA in the blood,

and about Defendant's being a suspect, Defendant did not tell this story to the detective. R178:204. Rather, he offered his explanation for the first time at trial. R192:205. Even then, he brought in no witness to corroborate any part of it—not the Polynesian girl or the girl with the dog, who Defendant allegedly saw approaching the victim's house and who might have carried a bloody rag with Defendant's DNA inside; not his friend Daniel, who allegedly could have at least corroborated the trips from Ogden to Salt Lake and then to Glenwood a week before the burglary; not Daniel's girlfriend, who allegedly accompanied them on the drive; and not Danny Burk, whose home was across the street from the victim's home and who allegedly could have testified that he saw Defendant in the neighborhood a week before the December 2012 burglary. Rather, Defendant offered only his own self-serving testimony.

Second, Defendant presented no evidence to contradict the victim's testimony that no blood was on the blender when she left her home on the morning of the burglary, which occurred several days after Defendant allegedly was in her neighborhood and several days after some little girl allegedly could have entered the victim's home, perhaps with a rag dripping blood.

As a result, Defendant's explanation for why his blood was on the blender button in the victim's home following the burglary, but not earlier the same day, was unconvincing. The excluded medical records would not have made Defendant's explanation any more persuasive.

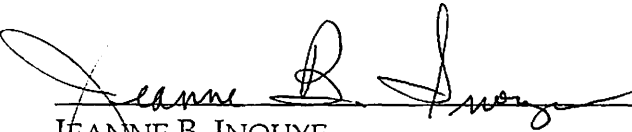
In sum, given the overwhelming evidence of guilt presented by the DNA evidence, and given Defendant's hopelessly implausible explanation for how his DNA might have been introduced into the victim's home a week before the burglary, there is no reasonable likelihood of a different result, even if the medical records had been presented.

CONCLUSION

The trial court did not abuse its discretion in excluding the medical records under rule 403, Utah Rules of Evidence. But even if the court did err, any error was harmless because the evidence against Defendant was overwhelming. For these reasons, the Court should affirm.

Respectfully submitted on November 18, 2015.

SEAN D. REYES
Utah Attorney General



JEANNE B. INOUE
Assistant Attorney General
Counsel for Appellee

CERTIFICATE OF SERVICE

I certify that on November 18, 2015, two copies of the Brief of Appellee were ☐ mailed ☒ hand-delivered to:

Nathalie S. Skibine
Scott A. Wilson
Salt Lake Legal Defender Assoc.
424 East 500 South, Suite 300
Salt Lake City, UT 84111

Also, in accordance with Utah Supreme Court Standing Order No. 8,
a courtesy brief on CD in searchable portable document format (pdf):

☒ was filed with the Court and served on appellant.

☐ will be filed and served within 14 days.

Lee Nakamura

Addenda

Addendum A

Utah Rules of Criminal Procedure

Rule 30. Errors and defects.

- (a) Any error, defect, irregularity or variance which does not affect the substantial rights of a party shall be disregarded.
- (b) Clerical mistakes in judgments, orders or other parts of the record and errors in the record arising from oversight or omission may be corrected by the court at any time and after such notice, if any, as the court may order.

Utah Rules of Evidence

Rule 401. Test for Relevant Evidence

Evidence is relevant if:

- (a) it has any tendency to make a fact more or less probable than it would be without the evidence; and
- (b) the fact is of consequence in determining the action.

2011 Advisory Committee Note. – The language of this rule has been amended as part of the restyling of the Evidence Rules to make them more easily understood and to make style and terminology consistent throughout the rules. These changes are intended to be stylistic only. There is no intent to change any result in any ruling on evidence admissibility. This rule is the federal rule, verbatim.

ADVISORY COMMITTEE NOTE

This rule is the federal rule, verbatim, and is comparable in substance to Rule 1(2), Utah Rules of Evidence (1971), but the former rule defined relevant evidence as that having a tendency to prove or disprove the existence of any "material fact." Avoiding the use of the term "material fact" accords with the application given to former Rule 1(2) by the Utah Supreme Court. *State v. Peterson*, 560 P.2d 1387 (Utah 1977).

Utah Rules of Evidence

Rule 402. General Admissibility of Relevant Evidence

Relevant evidence is admissible unless any of the following provides otherwise:

- the United States Constitution;
- the Utah Constitution;
- a statute; or
- rules applicable in courts of this state.

Irrelevant evidence is not admissible.

2011 Advisory Committee Note. – The language of this rule has been amended as part of the restyling of the Evidence Rules to make them more easily understood and to make style and terminology consistent throughout the rules. These changes are intended to be stylistic only. There is no intent to change any result in any ruling on evidence admissibility.

ADVISORY COMMITTEE NOTE

The text of this rule is Rule 402, Uniform Rules of Evidence (1974) except that prior to the word "statute" the words "Constitution of the United States" have been added.

Utah Rules of Evidence

Rule 403. Excluding Relevant Evidence for Prejudice, Confusion, Waste of Time, or Other Reasons

The court may exclude relevant evidence if its probative value is substantially outweighed by a danger of one or more of the following: unfair prejudice, confusing the issues, misleading the jury, undue delay, wasting time, or needlessly presenting cumulative evidence.

2011 Advisory Committee Note. – The language of this rule has been amended as part of the restyling of the Evidence Rules to make them more easily understood and to make style and terminology consistent throughout the rules. These changes are intended to be stylistic only. There is no intent to change any result in any ruling on evidence admissibility. This rule is the federal rule, verbatim.

ADVISORY COMMITTEE NOTE

This rule is the federal rule, verbatim, and is substantively comparable to Rule 45, Utah Rules of Evidence (1971) except that "surprise" is not included as a basis for exclusion of relevant evidence. The change in language is not one of substance, since "surprise" would be within the concept of "unfair prejudice" as contained in Rule 403. See also Advisory Committee Note to Federal Rule 403 indicating that a continuance in most instances would be a more appropriate method of dealing with "surprise." See also *Smith v. Estelle*, 445 F. Supp. 647 (N.D. Tex. 1977) (surprise use of psychiatric testimony in capital case ruled prejudicial and violation of due process). See the following Utah cases to the same effect. *Terry v. Zions Coop. Mercantile Inst.*, 605 P.2d 314 (Utah 1979); *State v. Johns*, 615 P.2d 1260 (Utah 1980); *Reiser v. Lohner*, 641 P.2d 93 (Utah 1982).

Addendum B



UNIVERSITY OF UTAH
HEALTH CARE

CERTIFICATION OF MEDICAL RECORDS

RE: Rick Jimenez

MRN: 20322546

As custodian of medical records, I hereby certify that to the best of our knowledge:

- The attached records are true and accurate copies of the medical records in our custody
- The attached records were prepared in the course of the hospital's regular business practices
- The attached records were kept as part of the hospital's regular business practices
- The attached records were made at or near the time of the matters contained therein and per the hospital's policies and procedures
- The attached records were made by, or from information transmitted by, a person with direct knowledge of the matters contained therein

This certification is made under penalty of law.

Signed on March 10, 2014


(Signature)

Judith Hagen

SCANNED



UNIVERSITY OF UTAH
HEALTH CARE

March 10, 2014

Salt Lake Legal Defender Assoc
424 East 500 South, Ste.200
Salt Lake City, Utah 84111

Dear Rick Jimenez,

Per your request, the enclosed report lists all disclosures of your patient information we have made to fulfill release requests including:

Clinic notes
Lab reports

If you have any questions, please contact our department during normal business hours at (801) 581-2704.

Sincerely,

Judith Hagen
Health Information Department

ENC: Patient Disclosure Report

University of Utah Hospitals and Clinics
Salt Lake City, UT

Patient: JIMENEZ, RICK
MRN: 20322546

Flowsheet Print Request
Date Range: 01/01/1990 00:00 - 03/10/2014 00:00

Printed by: Hagen, Judith L
Printed on: 03/10/2014 21:16

Event Date	Event	Result	Ref. Range	Status
06/15/2011 10:32	Amphetamine, Urine	Negative		
	Barbiturates, Urine	Negative		
	Benzodiazepines, Urine	Negative		
	Cocaine, Urine	Negative		
	Creatinine	217.6 mg/dL	(20.0 - 400.0)	
	DAS 9 Comments	See Note *		
	Marijuana, Urine	Negative		
	Methadone, Urine	Negative		
	Opiates, Urine	Negative		
	Phencyclidine, Urine	Negative		
	Propoxyphene, Urine	Negative		
07/06/2011 14:48	Amphetamine, Urine	Negative		
	Barbiturates, Urine	Negative		
	Benzodiazepines, Urine	Negative		
	Cocaine, Urine	Negative		
	Creatinine	79.5 mg/dL	(20.0 - 400.0)	
	DAS 9 Comments	See Note *		
	Marijuana, Urine	Negative		
	Methadone, Urine	Negative		
	Opiates, Urine	Positive *		
	Phencyclidine, Urine	Negative		
	Propoxyphene, Urine	Negative		
09/26/2011 10:38	Alcohol, Urine	Negative		
	Amphetamine, Urine	Negative		
	Barbiturates, Urine	Negative		
	Benzodiazepines, Urine	Negative		
	Cocaine, Urine	Negative		
	Creatinine	179.9 mg/dL	(20.0 - 400.0)	
	DAS 9A Comments	See Note *		
	Marijuana, Urine	Negative		
	Methadone, Urine	Negative		
	Opiates, Urine	Positive *		
	Phencyclidine, Urine	Negative		
	Propoxyphene, Urine	Negative		
09/26/2011 10:54	Helicobacter Pylori Ag, Stool	Negative	(Negative -)	
01/23/2012 10:36	Alcohol, Urine	Negative		
	Amphetamine, Urine	Negative		
	Barbiturates, Urine	Negative		
	Benzodiazepines, Urine	Negative		
	Cocaine, Urine	Negative		
	Creatinine	257.6 mg/dL	(20.0 - 400.0)	
	DAS 9A Comments	See Note *		
	DAS Confirm Opiates-Medicat	Positive *		
	Marijuana, Urine	Negative		
	Methadone, Urine	Negative		
	Opiates, Urine	Positive *		
	Phencyclidine, Urine	Negative		
	Propoxyphene, Urine	Negative		

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Reason for Call

Refill Request	Lortab
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Reason For Call History Recorded

Call Documentation

Margaret Solomon, MD, MD 11/9/2012 11:46 AM Signed
Pt has been sent letter to schedule visit for more refills.

Ian Lund 11/9/2012 11:00 AM Signed
7.5-500 mg #90; Last refill: 10/04/12

Patient last seen: 01/23/12
Appointment to be seen: no

See full documentation**Order**

(Order)

Pharmacy Contact

Telephone	Fax
801-213-9950	801-213-9965

Allergies as of 11/9/2012

Reviewed On: 1/23/2012 By: Pamela Melis

No Known Allergies

Diagnoses

Lumbago - Primary	724.2
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Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 11/9/12 at 11:46 AM

Routing History

Priority	Sent On	From	To	Message Type
	11/9/2012 11:00 AM	Ian Lund	Margaret Hope Solomon, MD	

Created by

Ian Lund on 11/09/2012 10:59 AM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Reason for Call

Refill Request	loratab,IBU
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Reason For Call History Recorded

Call Documentation

Jane Fischer 10/4/2012 10:52 AM Signed
Pt also req IBU 800mg #90 (rx last written 8.14.12 for #90 plus 2 refills, no refill info available);

Jane Fischer 10/4/2012 10:48 AM Signed
Pt req refill loratab 7.5/500mg #90;last visit 1.23.12;rx last written 8.14.12;notes at last refill indicate pt needs appt;please eval. thanks

See full documentation**Order**

(Order)

Order Summary

Medications

Hydrocodone-Acetaminophen 7.5-500 MG PO Tab Order #: 32197562**Ibuprofen 800 MG PO Tab Order #: 32197563****Pharmacy Contact**

Telephone

801-213-9950

Fax

801-213-9965

Allergies as of 10/4/2012

Reviewed On: 1/23/2012 By: Pamela Melis

No Known Allergies

Diagnoses**Lumbago - Primary**

724.2

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 10/4/12 at 11:36 AM

Routing History

Priority	Sent On	From	To	Message Type
	10/4/2012 10:48 AM	Jane Fischer	Margaret Hope Solomon, MD	

Created by

Jane Fischer on 10/04/2012 10:46 AM

Patient Information

Patient Name

Jimenez, Rick (20322546)

Sex

Male

DOB

7/4/1960

Encounter Information

Date & Time

9/21/2012 4:24 PM

Provider

Margaret Solomon, MD,
MD

Department

Rwc Im/Peds

Encounter #

190556111

Letter (Out)

9/21/2012 Letter (Out)

Rick Jimenez | MRN: 20322546

Progress Notes

No notes of this type exist for this encounter.

Letters

Letter Information

Margaret Hope Solomon on 9/21/2012Status
Sent**Patient Information**

Patient Name

Jimenez, Rick (20322546)

Sex

Male

DOB

7/4/1960

Contacts

	Type	Contact	Phone	User
09/21/2012 2:19 PM	Phone (Outgoing)	Jimenez, Rick (Self)		Margaret Hope Solomon, MD
09/21/2012 4:28 PM	Phone (Outgoing)	Jimenez, Rick (Self)		Jessica Sisneros

Reason for Call

Telephone-No Show

Call Documentation

Jessica Sisneros 9/21/2012 4:28 PM Signed
Letter sent

Margaret Solomon, MD, MD 9/21/2012 2:20 PM Signed
Please mail letter to pt re: no show earlier this week. He has no showed a total of 4 appointments with me and has not been seen since January. I will no longer be able to prescribe pain medications unless he is able to come to appts regularly.

See full documentation

Order**(Order)****Allergies as of 9/21/2012****Reviewed On: 1/23/2012 By: Pamela Melis**

No Known Allergies

Encounter Status

Electronically signed and closed by: Jessica Sisneros on 9/21/12 at 4:28 PM

Routing History

Priority	Sent On	From	To	Message Type
	9/21/2012 2:20 PM	Margaret Hope Solomon, MD	P CC RWC IM/PEDS MESSAGE POOL	

Created by

Margaret Hope Solomon, MD on 09/21/2012 02:19 PM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Reason for Call**Refill Request** Omeprazole, Ibuprofen, Hydrocodone/APAP

Reason For Call History Recorded

Call Documentation

Macheala Jacquez 8/14/2012 1:16 PM Signed
Last written: 7/9/12 for # 90 Hydrocodone/APAP

Last Filled: 6/13/11 for #90 Ibuprofen
60 Omeprazole

Last appt: 1/23/12

Next appt: none

Please review, approve or deny and close the encounter. Thanks.

See full documentation

Order**(Order)****Order Summary**

Medications
Hydrocodone-Acetaminophen 7.5-500 MG PO Tab Order #: 32197559
Ibuprofen 800 MG PO Tab Order #: 32197560
Omeprazole 20 MG PO CAPSULE DELAYED RELEASE Order #: 32197561

Pharmacy Contact

Telephone
801-213-9950

Fax
801-213-9965

Allergies as of 8/14/2012**Reviewed On: 1/23/2012 By: Pamela Melis**

No Known Allergies

Diagnoses

Lumbago	724.2
Reflux esophagitis	530.11

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 8/16/12 at 2:40 PM

Routing History

Priority	Sent On	From	To	Message Type
	8/14/2012 1:16 PM	Macheala Jacquez	Margaret Hope Solomon, MD	

Created by

Macheala Jacquez on 08/14/2012 01:11 PM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Reason for Call**Refill Request** Lortab

Reason For Call History Recorded

Call Documentation

Amy Love 7/9/2012 9:57 AM Signed
Last filled: 05/09/2012
Medication: Lortab 7.5-500 MG
Quantity: 90

Last appointment: 01/23/2012

Next Appointment: none

Please review, approve, or deny and close the encounter. Thanks

[See full documentation](#)**Order****(Order)****Order Summary**

Medications
Hydrocodone-Acetaminophen 7.5-500 MG PO Tab Order #: 28700406

Allergies as of 7/9/2012**Reviewed On: 1/23/2012 By: Pamela Melis**

No Known Allergies

Diagnoses

Lumbago - Primary	724.2
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Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 7/9/12 at 4:34 PM

Routing History

Priority	Sent On	From	To	Message Type
	7/9/2012 9:57	Amy Love	Margaret Hope Solomon, MD	

AM

Created by

Amy Love on 07/09/2012 09:56 AM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Reason for Call

Refill Request lortab

Reason For Call History Recorded

Call DocumentationMargaret Solomon, MD, MD 6/5/2012 5:50 PM Signed
DOPL reviewed, looks okay, needs f/u visitCarlee Bailey 6/5/2012 12:01 PM Signed
7.5/500 mg #90
Last fill 5/9

Last seen 1/23

Next appt none

Please review approve or deny, then close encounter.

Prescription will print at your local printer, please sign to send to the pharmacy.

[See full documentation](#)**Order**

(Order)

Order SummaryMedications
Hydrocodone-Acetaminophen 7.5-500 MG PO Tab Order #: 28700405**Pharmacy Contact**

Telephone	Fax
801-213-9950	801-213-9965

Allergies as of 6/5/2012

Reviewed On: 1/23/2012 By: Pamela Melis

No Known Allergies

Diagnoses

Lumbago - Primary 724.2

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 6/5/12 at 5:50 PM

Routing History

Priority	Sent On	From	To	Message Type
	6/5/2012 12:01 PM	Carlee Bailey	Margaret Hope Solomon, MD	

Created by

Carlee Bailey on 06/05/2012 12:00 PM

Patient Information

Patient Name	Sex	DOB
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Jimenez, Rick (20322546)

Male

7/4/1960

Reason for Call**Refill Request** lortab

Reason For Call History Recorded

Call Documentation**Carlee Bailey** 5/7/2012 4:02 PM Signed
Pt also requestingErythromycin-benzoyl peroxide #46.6
Last fill 7/27/11fluticasone 50 mcg #16 gm
Last fill 11/1/11**Carlee Bailey** 5/7/2012 1:13 PM Signed
7.5/500 mg #90
Last fill 4/6

Last seen 1/13

Next appt none

Please review approve or deny, then close encounter.

Prescription will print at your local printer, please sign to send to the pharmacy.

See full documentation**Order**

(Order)

Order Summary

Medications

Benzoyl Peroxide-Erythromycin EX Gel Order #: 28700403**Fluticasone Propionate (FLONASE) 50 MCG/ACT NA nasal spray** Order #: 28700404**Hydrocodone-Acetaminophen 7.5-500 MG PO Tab** Order #: 28700402**Pharmacy Contact**Telephone
801-213-9950Fax
801-213-9965**Allergies as of 5/7/2012****Reviewed On: 1/23/2012 By: Pamela Melis**

No Known Allergies

Diagnoses

Lumbago - Primary	724.2
Acne	706.1
Allergic rhinitis	477.9

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 5/7/12 at 4:48 PM

Routing History

Priority	Sent On	From	To	Message Type
	5/7/2012 1:13 PM	Carlee Bailey	Margaret Hope Solomon, MD	

Created by

Carlee Bailey on 05/07/2012 01:11 PM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Contacts

	Type	Contact	Phone	User
04/20/2012 9:04 AM	Phone (Incoming)	Jimenez, Rick (Self)	435-890-6884	Cindy Snow
04/20/2012 4:32 PM	Phone (Outgoing)	Jimenez, Rick (Self)		Felissadee Campbell

Reason for Call

Telephone-Patient Has Questions

Call Documentation**Felissadee Campbell** 4/20/2012 4:33 PM Signed

Called pt and let him know that you were not i office today burt will call Monday I let him know that if need to go to uC and that they are open over weekend

Margaret Solomon, MD, MD 4/20/2012 4:21 PM Signed

Please call and let him know I am not in the office today but I will call him Monday. If he feels he needs help urgently he can come to urgent care, but they cannot prescribe pain meds because he has a contract with me.

Felissadee Campbell 4/20/2012 9:46 AM Signed

Forward to provider to be advised

Cindy Snow 4/20/2012 9:08 AM Signed

Patient is calling and says that last time he was in to see Dr Solomon he was introduced to Dr Solomon's assistant and told her could call her anytime he needed anything.

He does not remember that person's name and lost the phone number.

He said he is still have really bad leg cramps and headaches.

He also said a friend of his just passed away and he is having problems with that.

Other info: please call him

Best number to reach patient : 435 890 6884

[See full documentation](#)**Order**

(Order)

Allergies as of 4/20/2012

Reviewed On: 1/23/2012 By: Pamela Melis

No Known Allergies

Encounter Status

Electronically signed and closed by: Felissadee Campbell on 4/20/12 at 4:33 PM

Routing History

Priority	Sent On	From	To	Message Type
	4/20/2012 4:21 PM	Margaret Hope Solomon, MD	P CC RWC IM/PEDS MESSAGE POOL	
	4/20/2012 9:46 AM	Felissadee Campbell	Margaret Hope Solomon, MD	

4/20/2012
9:08 AM

Cindy Snow

P CC RWC IM/PEDS
MESSAGE POOL**Created by**

Cindy Snow on 04/20/2012 09:04 AM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Reason for Call

Refill Request	Lortab/Ibuprofen
Reason For Call History Recorded	

Call Documentation

Margaret Solomon, MD, MD 4/5/2012 2:39 PM Signed
DOPL reviewed, looks appropriate

Ian Lund 4/5/2012 1:36 PM Signed
Lortab 7.5-500 mg #90; Last refill: 03/07/12
Ibuprofen 800 mg #90; Last refill: 08/19/11

Patient last seen: 01/23/12
Appointment to be seen: no

See full documentation

Order

(Order)

Order Summary

Medications
Hydrocodone-Acetaminophen 7.5-500 MG PO Tab Order #: 28700401
Ibuprofen 800 MG PO Tab Order #: 28700400

Allergies as of 4/5/2012

Reviewed On: 1/23/2012 By: Pamela Melis

No Known Allergies

Diagnoses

Lumbago - Primary	724.2
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Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 4/5/12 at 2:39 PM

Routing History

Priority	Sent On	From	To	Message Type
	4/5/2012 1:36 PM	Ian Lund	Margaret Hope Solomon, MD	

Created by

Ian Lund on 04/05/2012 01:35 PM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Reason for Call

Refill Request	Lortab
Reason For Call History Recorded	

Call Documentation

Kristen Veth 2/29/2012 12:27 PM Signed
Lortab 7.5-500 mg #90
Last written 2-6-12

Last seen 1-23-12

Next appt none

Please review approve or deny, then close encounter.

See full documentation

Order**(Order)****Order Summary**

Medications

Hydrocodone-Acetaminophen 7.5-500 MG PO Tab Order #: 28700399

Allergies as of 2/29/2012**Reviewed On: 1/23/2012 By: Pamela Melis**

No Known Allergies

Diagnoses

Lumbago - Primary

724.2

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 2/29/12 at 5:42 PM

Routing History

Priority	Sent On	From	To	Message Type
	2/29/2012 12:27 PM	Kristen Veth	Margaret Hope Solomon, MD	

Created by

Kristen Veth on 02/29/2012 12:25 PM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Reason for Call

Refill Request Lortab

Reason For Call History Recorded

Call Documentation

Carri L Palmer 2/6/2012 3:55 PM Signed
.Please evaluate refills. Thanks

Last date filled : 01-07-12 for # 90

Last appointment : 01-23-12

Next scheduled appointment : none

See full documentation

Order

(Order)

Order Summary

Medications

Hydrocodone-Acetaminophen 7.5-500 MG PO Tab Order #: 28700398**Pharmacy Contact**Telephone
801-213-9950Fax
801-213-9965**Allergies as of 2/6/2012****Reviewed On: 1/23/2012 By: Pamela Melis**

No Known Allergies

Diagnoses**Lumbago - Primary**

724.2

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 2/6/12 at 4:11 PM

Routing History

Priority	Sent On	From	To	Message Type
	2/6/2012 3:55 PM	Carri L Palmer	Margaret Hope Solomon, MD	

Created by

Carri L Palmer on 02/06/2012 03:54 PM

Office Visit**1/23/2012 Office Visit****Rick Jimenez | MRN: 20322546****Patient Information**

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Visit Information

Date & Time	Provider	Department	Encounter #
1/23/2012 9:40 AM	Margaret Solomon, MD, MD	Rwc Im/Peds	187740457

Referring Provider**Self Referring****Reason for Visit****Leg Pain-Other** muscle cramps**Vitals**

Vitals	Most Recent Value
BP	116/64 mmHg
Temp	97 °F (36.1 °C)
Temp src	TEMPORAL
Pulse	80
Resp	20
Height	5' 4.5" (1.638 m)
Weight	159 lb (72.122 kg)

Pain Information (Last Filed)

Score	Location	Comments	Edu?
0			

All Flowsheet Templates (all recorded)Encounter Vitals Flowsheet

Substances and Sexuality as of 1/23/2012

Smoking Status	Amount
Current Every Day Smoker	0 packs/day for 0 years
Smokeless Tobacco Status	
Unknown	
Tobacco Comment	
pt states that he is cutting down to 1-2 cigarettes per day now (09/26/11)	
Alcohol Use	Amount
No	N/A
Drug Use	Frequency
Not Asked	N/A
Sexually Active	Partners
Not Asked	N/A

BMI Data

Body Mass Index	Body Surface Area
26.88 kg/m ²	1.81 m ²

Allergies as of 1/23/2012**Reviewed On: 1/23/2012 By: Pamela Melis**

No Known Allergies

HPI**Leg Pain-Other**

Additional comments: muscle cramps

Visit Notes**PAMELA MELIS** Mon Jan 23, 2012 10:01 AM

The medical assistant for this encounter is Pam Melis.

Patient is being seen in clinic today for cramps in calves and thighs x about a year but worsening lately

Patient is an established patient. Vitals performed, history and allergies reviewed by Pamela Melis.
Reviewed and reconciled patient's medications.**Nursing Notes**

No notes of this type exist for this encounter.

Pharmacist Notes

No notes of this type exist for this encounter.

Progress Notes**Margaret Hope Solomon, MD at 1/23/2012 10:20 PM**

Status: Signed

Leg Pain (Not in a Joint)

History of Present Illness:

- Duration of symptoms: 1 year
- Frequency of symptoms: daily
- Which leg affected (R or L): both
- Location of pain on leg: calf and posterior thigh, R side is worse, mostly pain in muscles, not so much in joints
- Injury to leg?: no
- Intensity of pain (0-10/10): 10
- Pain worse after walking or exertion?: no
- Pain at rest?: yes
- Factors making pain worse: cold weather

- Factors relieving pain:
- Medications tried for symptoms: none

Targeted Review of Systems:

- Erythema (redness)?: no
- Edema (swelling)?: no
- Dyspnea (shortness of breath)?: no
- Chest pain?: no
- Wound/ulcer on leg or foot?: no
- Back pain?: yes
- Cold feet?: yes
- Hair loss on feet?: no
- Color change in feet?: no
- Numbness/tingling in feet or leg?: yes
- Muscle cramps?: yes

<S>

Patient is a 51 year old male who presents for follow up re pain.

-continues to have a lot of low back and leg pain. Sx reviewed as above. He is having a worse time in the cold weather.

-heartburn sx are stable, does have occasional dysphagia with solids but not worsening. He has run out of omeprazole. Tried to get egd done but it was not covered by limited insurance.

-he is currently living on his own. Previously had SSI, was told it would be reinstated but has not happened yet. Has Form 20 that needs to be completed.

-mood is okay, he tells me several anecdotes about seeing people killed in front of him which still bother him, but denies being depressed. Mom passed away several yrs ago and still finds himself thinking of her often.

Past Medical History**Diagnosis****Date**

- Herniated intervertebral disk
- Tendon disorder

Reports torn tendon in right leg

- Environmental allergies
- Chronic hypotension
- H/O: stroke

Family History**Problem****Relation****Age of Onset**

- Other

None

Past Surgical History**Procedure****Date**

- Past surgical history
- None*

Current Outpatient Prescriptions on File Prior to Visit**Medication****Sig****Dispense****Refill**

- Fluticasone Propionate (FLONASE) 50 MCG/ACT NA Suspension

2 sprays each nostril daily

1

2

• Hydrocodone-Acetaminophen 7.5-500 MG PO Tab	1 po tid prn back pain, to last 30 days	90	0
• Ibuprofen 800 MG PO Tab	1 po TID with food prn	90	2
• Azithromycin (ZITHROMAX) 250 MG OR Tab	Take two tabs PO day one then one tab qd for 3 days	5 tabs	0
• Erythromycin 5 MG/GM OP Ointment	Apply 1/4 inch ribbon to eyelids tid for 10 days, OS	3 gm	0
• Loratadine (CLARITIN) 10 MG OR Tab	1 tab po at night for allergies, prn	30	2
• Benzoyl Peroxide-Erythromycin 5-3 % EX Gel	apply to face nightly to treat acne	60 g	2
• Clarithromycin 500 MG OR Tab	1 po bid x 14 days	28	0
• Omeprazole 20 MG OR CAPSULE DELAYED RELEASE	1 tab po twice daily	60	5

<O>

Physical exam:

GENERAL: Patient is alert and interactive. Patient is in no apparent distress.

HEAD: atraumatic and normocephalic

EYES: normal bilaterally, conjunctiva non-erythematous and sclerae anicteric

NECK: full ROM, lymphadenopathy absent, supple and thyromegaly absent

CHEST: no retractions, symmetrical and non-tender

LUNGS: clear all lung fields, A-P Bilaterally

CARDIAC: regular rate and rhythm, normal S1 and S2 heart sounds and no murmus/gallops/rubs

ABDOMEN: nontender, non-distended, no masses, no hepatomegaly, normal bowel sounds and soft

EXTREMITIES: no clubbing, cyanosis, or edema. Pulses and perfusion are normal. Tender B calves but no redness, warmth. Low back diffusely tender.

NEURO: Alert and oriented. 2+ patellar DTRs, normal strength B lower extremities. No focal neurological deficits are noticed.

SKIN: Scarring facial acne.

<A/P>

724.2 Lumbago (primary encounter diagnosis)

Comment: refill meds, check Utox. Reviewed terms of pain contract.

Plan: Ibuprofen 800 MG PO Tab, DRUG SCREEN 9A PNL
URINE /CONF

530.11 Reflux esophagitis

Comment: refill omeprazole, sx stable, consider egd when insurance covers

Plan: Omeprazole 20 MG PO CAPSULE DELAYED RELEASE

477.9 Allergic rhinitis

Comment: refill meds

Plan: Fluticasone Propionate (FLONASE) 50 MCG/ACT NA
Suspension, Loratadine (CLARITIN) 10 MG PO Tab

706.1 Acne

Comment: can try topical, if not helping consider oral abx

Plan: Clindamycin Phos-Benzoyl Perox (BENZACLIN) 1-5
% EX Gel

He brings in old records today, need to comb through to see if there are imaging reports of spine mri and prior treatments.

Return to clinic if symptoms persist or worsen or for any other concerns.

After visit summary given to patient and information reviewed with patient.
Margaret Solomon, MD

Revision History



H&P Notes

No notes of this type exist for this encounter.

Current Immunizations

Never Reviewed

No immunizations on file.

SmartForms

Procedure Checklist
Aud Devices

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 1/23/12 at 10:20 PM

Diagnoses

Lumbago - Primary	724.2
Reflux esophagitis	530.11
Allergic rhinitis	477.9
Acne	706.1

Order

(Order)

The codes documented are preliminary and upon coder review with provider may be revised to meet compliance requirements.

Order Summary

ASSAY OF OPIATES [83925 CPT(R)] Order #: 28700397

DRUG SCREEN 9A PNL URINE /CONF [80101 Custom] Order #: 27333532

Medications

Clindamycin Phos-Benzoyl Perox (BENZACLIN) 1-5 % EX Gel Order #: 28700396

Fluticasone Propionate (FLONASE) 50 MCG/ACT NA Suspension Order #: 27333530

Ibuprofen 800 MG PO Tab Order #: 27333528

Loratadine (CLARITIN) 10 MG PO Tab Order #: 27333531

Omeprazole 20 MG PO CAPSULE DELAYED RELEASE Order #: 27333529

Level of Service

OFFICE/OUTPT VISIT,EST,LEVL IV
[99214]

Patient Instructions

None

Result Summary for DRUG SCREEN 9A PNL URINE /CONF

Result Information

Status

Provider Status

Final result (1/24/2012 12:20 AM) Reviewed

Entry Date

1/24/2012

Component Results

Component	Value	Flag	Range	Units	Status
Amphetamines, Urine	Negative				Final
Barbiturates, Urine	Negative				Final
Benzodiazepines, Urine	Negative				Final
Marijuana, Urine	Negative				Final
Cocaine, Urine	Negative				Final
Methadone, Urine	Negative				Final
Opiates, Urine	Positive				Final

Comment:

Confirmation testing is pending.

Unconfirmed positive may be useful for medical purposes, but does not meet forensic standards.

Phencyclidine, Urine	Negative				Final
Propoxyphene, Urine	Negative				Final
Alcohol, Urine	Negative				Final
Creatinine, Urine	257.6		20.0 - 400.0	mg/dL	Final
CDASU 9A Comments	See Note				Final

Comment:

INTERPRETIVE INFORMATION: Drug Panel 9A, Urn, Scrn w/Rflx to Conf

1. Drugs Covered and Cutoff Concentrations:

Drugs/Drug Classes	Screen	Confirmation
Marijuana	20 ng/mL	5 ng/mL
Cocaine	150 ng/mL	50 ng/mL
Opiates	300 ng/mL	5 ng/mL
Oxycodone.....	100 ng/mL	5 ng/mL
Phencyclidine	25 ng/mL	10 ng/mL
Amphetamines	300 ng/mL	200 ng/mL
MDMA (Ecstasy).....	500 ng/mL	200 ng/mL
Barbiturates	200 ng/mL	50 ng/mL
Benzodiazepines	200 ng/mL	20 ng/mL
Methadone	150 ng/mL	10 ng/mL
Propoxyphene	300 ng/mL	10 ng/mL
Alcohol	40 mg/dL	40 mg/dL

Oxycodone results will be reported with the opiates results. MDMA results will be reported with the amphetamines results.

2. For medical purposes only; not valid for forensic use.

3. 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, diluted/adulterated urine, or limitations of testing. The concentration at which the screening test can detect a drug or metabolite varies within a drug class. Specimens for which drugs or drug classes are detected by the screen are reflexed to a second, more specific technology (GC/MS and/or LC-MS/MS).

The concentration value must be greater than or equal to the cutoff to be reported as positive. Interpretive questions should be directed to the laboratory.

Lab and Collection

DRUG SCREEN 9A PNL URINE /CONF (Order #27333532) on 1/23/2012 - Lab and Collection Information

Result History

DRUG SCREEN 9A PNL URINE /CONF (Order #27333532) on 1/24/12 - Order Result History Report.

Result Summary for ASSAY OF OPIATES**Result Information**

Status	Provider Status
Final result (1/25/2012 2:43 PM)	Reviewed

Entry Date

1/25/2012

Component Results

Component

Drug Confirmation, Opiates, Urine

Positive

Comment:

Confirmed POSITIVE by LC-MS/MS for the following opiate(s):

Hydrocodone = 3226 ng/mL
Hydromorphone (free) = 120 ng/mL
Dihydrocodeine (qualitative only)

Methodology: LC-MS/MS

Drugs covered: 6-acetylmorphine (6-AM), morphine, codeine, dihydrocodeine, hydrocodone, hydromorphone, oxycodone, and oxymorphone.

The presence of more than one opiate in urine may reflect drug metabolism or use of multiple drugs. Low concentrations of an unexpected opiate in the presence of large concentrations of another opiate may also reflect impurities in the pharmaceutical preparation. The absence of expected opiates may indicate non-compliance or limitations of the testing. Interpretive questions should be directed to the laboratory.

Hydrocodone may arise from hydrocodone-containing drugs or by metabolism. When generated by metabolism of codeine, hydrocodone is usually less than 40% of the free codeine concentration. Hydrocodone is metabolized to hydromorphone and dihydrocodeine (hydrocodol).

Dihydrocodeine (hydrocodol) may arise from dihydrocodeine-containing drugs or by metabolism of hydrocodone.

Hydromorphone may arise from hydromorphone-containing drugs or by metabolism. When generated by metabolism of hydrocodone, free hydromorphone is usually less than 30% of the hydrocodone concentration. When generated by metabolism of morphine, free hydromorphone is usually less than 25% of the free

morphine concentration.

INTERPRETIVE INFORMATION: Drug Confirmation, Opiates, Urine

1. Drugs covered: codeine, dihydrocodeine, morphine, 6-acetylmorphine, hydrocodone, hydromorphone, oxycodone and oxymorphone.

2. Positive cutoff: 5 ng/mL.

3. For medical purposes only; not valid for forensic use.

4. 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, diluted/adulterated urine, or limitations of testing. The concentration value must be greater than or equal to the cutoff to be reported as positive. Interpretive questions should be directed to the laboratory.

Lab and Collection

ASSAY OF OPIATES (Order #28700397) on 1/23/2012 - Lab and Collection Information

Living Will

On File
No

Chart Review Routing History

No Routing History on File

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Contacts

	Type	Contact	Phone	User
01/03/2012 2:58 PM	Phone (Incoming)	Jimenez, Rick (Self)		Dawn Spor
01/03/2012 3:30 PM	Phone (Outgoing)	Jimenez, Rick (Self)		Jessica Sisneros

Reason for Call

Telephone-Patient Has Questions

Call Documentation

Pamela Melis 1/4/2012 8:31 AM Signed
Unable to reach pt, if he calls back please relay message from provider
Thanks!

Margaret Solomon, MD, MD 1/3/2012 6:18 PM Signed
Part of his medication agreement is to keep his scheduled appts. He was an hour late for last appt and missed today's appt. I will refill this time. This is his 7th no show at our clinic including missed PT visits. If he does not come on time to 1/23 appt I will no longer be able to see him and will not prescribe any further medications to him. Will route to Curtis Newman FYI.

Jessica Sisneros 1/3/2012 3:31 PM Signed
Forward to provider-please advise.

Dawn Spor 1/3/2012 3:09 PM Signed
*the pt stated he forgot he had an appt today but is needing this medication refilled until his

next appt 1.23.12

Patient called requesting the following prescription:

What medication do you need?: Lortab and Claritin

Have you used this prescription before?: Yes-refill only

What is the last date it was filled?: 11.30.11 and 9.21.11

What was the last date you were seen in the clinic: 9.26.11

Who is the Prescribing/Ordering Provider?: Solomon

Which University of Utah Pharmacy would you like this prescription to be sent to:

If an outside pharmacy, what is the name of the pharmacy:

Pharmacy Phone #:

Pharmacy Location (approx. Address):

Pharmacy fax #:

Best number to get a hold of you: PLEASE LEAVE A MESSAGE IN HIS CHARTS AND HE WILL CALL BACK

Call was taken in scheduling/messaging department because: caller already waited on hold for scheduling department.

See full documentation

Order**(Order)****Order Summary**

Medications

Hydrocodone-Acetaminophen 7.5-500 MG PO Tab Order #: 27333527

Reviewed On: 10/26/2011 By: Mark A McKay

Allergies as of 1/3/2012

No Known Allergies

Diagnoses

Lumbago - Primary

724.2

Encounter Status

Electronically signed and closed by: Auto Batch Job on 4/3/12 at 1:00 AM

Routing History

Priority	Sent On	From	To	Message Type
	1/3/2012 6:18 PM	Margaret Hope Solomon, MD	P CC RWC IM/PEDS MESSAGE POOL	
	1/3/2012 3:31	Jessica Sisneros	Margaret Hope Solomon, MD	

PM
1/3/2012 3:09 Dawn Spor
PM

P CC RWC IM/PEDS
MESSAGE POOL

Created by

Dawn Spor on 01/03/2012 02:58 PM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Encounter Information

Date & Time	Provider	Department	Encounter #
12/9/2011 9:01 AM	Margaret Solomon, MD, MD	Rwc Im/Peds	187538273

Letter (Out)

12/9/2011 Letter (Out) Rick Jimenez | MRN: 20322546

Progress Notes

No notes of this type exist for this encounter.

Letters**Letter Information**

<u>Margaret Hope Solomon on 12/9/2011</u>	Status
	Sent

Letter Information

<u>Margaret Hope Solomon on 12/12/2011</u>	Status
	Sent

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Encounter Information

Date & Time	Provider	Department	Encounter #
12/9/2011 8:56 AM	Margaret Solomon, MD, MD	Rwc Im/Peds	187538176

Letter (Out)

12/9/2011 Letter (Out) Rick Jimenez | MRN: 20322546

Progress Notes

No notes of this type exist for this encounter.

Letters**Letter Information**

<u>Margaret Hope Solomon on 12/9/2011</u>	Status
	Sent

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Reason for Call

Telephone-No Show

Call Documentation

Brooke Corbin 12/6/2011 3:04 PM Signed
Patient called regarding missed/noshowed appointment today.

Reason appointment was missed: no transportation

Did patient reschedule?: Yes

Other Info: N/A

See full documentation

Order

(Order)

Reviewed On: 10/26/2011 By: Mark A McKay

Allergies as of 12/6/2011

No Known Allergies

Encounter Status

Electronically signed and closed by: Pamela Melis on 12/6/11 at 3:10 PM

Routing History

Priority	Sent On	From	To	Message Type
	12/6/2011 3:04 PM	Brooke Corbin	P CC RWC IM/PEDS MESSAGE POOL	

Created by

Brooke Corbin on 12/06/2011 03:04 PM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Contacts

	Type	Contact	Phone	User
12/05/2011 12:51 PM	Phone (Incoming)	Jimenez, Rick (Self)	801-973-3800 (H)	David Kingsbury
12/05/2011 12:59 PM	Phone (Incoming)	Jimenez, Rick (Self)		Matthew Hood

Reason for Call

Telephone-Triage/Advice

Call Documentation

Margaret Solomon, MD, MD 12/5/2011 5:17 PM Signed

Tried to call residence where he was living, apparently he no longer lives there. LM for his caseworker to call us with a ph number if they have one.

Often a signed ROI is sent to medical records to get info? I am not sure which orders or records he needs. Will route this to Heather in med records. If Rick calls back please clarify exactly what orders he needs and what records.

Pamela Melis 12/5/2011 5:01 PM Signed

Do we need to put in a new referral for vocational rehab?

Forwarded to provider for review.

Please advise. Thanks!

Leeann Perez 12/5/2011 1:37 PM Signed

xxxxyz

Jimenez, Rick (MR # 20322546) Printed by Judith Hagen [U0524757] at 3/10/14 9:17 ... Page 21 of 70

Please review approve or deny, then close encounter.

Prescription will print at your local printer, please sign to send to the pharmacy.

See full documentation

Order

(Order)

Order Summary

Medications

Hydrocodone-Acetaminophen 7.5-500 MG PO Tab Order #: 27333526

Pharmacy Contact

Telephone
801-213-9950

Fax
801-213-9965

Reviewed On: **10/26/2011** By: **Mark A McKay**

Allergies as of 11/30/2011

No Known Allergies

Diagnoses

Lumbago - Primary

724.2

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 11/30/11 at 5:49 PM

Routing History

Priority	Sent On	From	To	Message Type
	11/30/2011 12:17 PM	Carlee Bailey	Margaret Hope Solomon, MD	

Created by

Carlee Bailey on 11/30/2011 12:15 PM

Patient Information

Patient Name
Jimenez, Rick (20322546)

Sex
Male

DOB
7/4/1960

Encounter Information

Date & Time
11/9/2011 10:01 AM

Provider
Margaret Solomon, MD,
MD

Department
Rwc Im/Peds

Encounter #
187256032

Letter (Out)

11/9/2011 Letter (Out)

Rick Jimenez | MRN: 20322546

Progress Notes

No notes of this type exist for this encounter.

Letters

Letter Information

Margaret Hope Solomon on 11/9/2011

Status
Sent

Patient Information

Patient Name
Jimenez, Rick (20322546)

Sex
Male

DOB
7/4/1960

Reason for Call

Refill Request

Ibuprofen

Reason For Call History Recorded

Call Documentation

Davis Scott Moore, Pharm D 11/1/2011 3:40 PM Signed
800 mg #90; Last refill: 9/22/11

Patient last seen: 9/26/11
Appointment to be seen: 11/8/11

See full documentation

Order**(Order)****Order Summary**

Medications
Ibuprofen 800 MG PO Tab Order #: 27333525

Pharmacy Contact

Telephone	Fax
801-213-9950	801-213-9965

Reviewed On: 10/26/2011 By: Mark A McKay

Allergies as of 11/1/2011

No Known Allergies

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 11/2/11 at 5:42 AM

Routing History

Priority	Sent On	From	To	Message Type
	11/1/2011 3:41 PM	Davis Scott Moore	Margaret Hope Solomon, MD	

Created by

Davis Scott Moore on 11/01/2011 03:39 PM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Reason for Call

Refill Request Lortab

Reason For Call History Recorded

Call Documentation

Carri L Palmer 10/31/2011 3:03 PM Signed
Please evaluate refills. Thanks

Last date filled : 09-30-11 for # 90

Last appointment : 09-26-11

Next scheduled appointment : 11-08-11

See full documentation

Order

(Order)

Order Summary

Medications

Hydrocodone-Acetaminophen 7.5-500 MG PO Tab Order #: 27333524**Pharmacy Contact**Telephone
801-213-9950Fax
801-213-9965Reviewed On: 10/26/2011 By: Mark A
McKay**Allergies as of 10/31/2011**

No Known Allergies

Diagnoses**Lumbago** - Primary

724.2

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 10/31/11 at 5:32 PM

Routing History

Priority	Sent On	From	To	Message Type
	10/31/2011 3:03 PM	Carri L Palmer	Margaret Hope Solomon, MD	

Created by

Carri L Palmer on 10/31/2011 03:02 PM

Office Visit**10/26/2011 Office Visit****Rick Jimenez | MRN: 20322546****Patient Information**

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Visit Information

Date & Time	Provider	Department	Encounter #
10/26/2011 10:40 AM	Mark McKay	Rwc Optometry	187109884

Referring Provider**Self Referring****Reason for Visit****Eyelid Swelling****Pain Information**

No pain information on file

Substances and Sexuality as of 10/26/2011

Smoking Status	Amount
Current Every Day Smoker	0 packs/day for 0 years
Smokeless Tobacco Status	
Unknown	
Tobacco Comment	
pt states that he is cutting down to 1-2 cigarettes per day now (09/26/11)	
Alcohol Use	Amount
No	N/A
Drug Use	Frequency
Not Asked	N/A
Sexually Active	Partners

Not Asked

N/A

Reviewed On: 10/26/2011 By: Mark A
McKay**Allergies as of 10/26/2011**

No Known Allergies

Visit Notes

NATALIE SMITH Wed Oct 26, 2011 11:55 AM

Patient presents with:
Eyelid Swelling**Nursing Notes**

No notes of this type exist for this encounter.

Pharmacist Notes

No notes of this type exist for this encounter.

Progress Notes

Mark A McKay at 10/26/2011 10:54 AM

Status: Signed

HISTORY OF PRESENT ILLNESS

Location: Upper left eyelid

Quality: swollen/itchy

Severity: moderate

Duration: 24 hrs

Timing: constant

Context: noted mosquito bite on lid

Modifying Factors: None

Associated Signs and Symptoms: slightly goopy

I reviewed and updated the following current today, 10/26/2011, for Rick Jimenez

Patient Active Problem List**Diagnoses**

- Reflux esophagitis
- Lumbago

Past Medical History**Diagnosis**

Date

- Herniated intervertebral disk
- Tendon disorder

Reports torn tendon in right leg

- Environmental allergies
- Chronic hypotension
- H/O: stroke

Family History**Problem**

Relation

Age of Onset

- Other
None

Past Surgical History**Procedure**

Date

- Past surgical history
None

Current Outpatient Prescriptions on File Prior to Visit

Medication	Sig	Dispense	Refill
• Ibuprofen 800 MG OR Tab	1 po TID with food prn	90	2
• Hydrocodone-Acetaminophen 7.5-500 MG OR Tab	1 po tid prn back pain, to last 30 days	90	0
• Fluticasone Propionate (FLONASE) 50 MCG/ACT NA Suspension	2 sprays each nostril daily	1	2
• Loratadine (CLARITIN) 10 MG OR Tab	1 tab po at night for allergies, prn	30	2
• Benzoyl Peroxide-Erythromycin 5-3 % EX Gel	apply to face nightly to treat acne	60 g	2
• Clarithromycin 500 MG OR Tab	1 po bid x 14 days	28	0
• Omeprazole 20 MG OR CAPSULE DELAYED RELEASE	1 tab po twice daily	60	5

No Known Allergies

Clinical findings are documented in the Ophthalmology Smartform.

H&P Notes

No notes of this type exist for this encounter.

Current Immunizations

Never Reviewed

No immunizations on file.

Base Ophthalmology Exam

Visual Acuity			Pupils		
	Right	Left		Right	Left
Dist sc	20/20	20/20 -1		PERRL	PERRL
Method: Snellen - Linear					
Extraocular Movement					
	Right	Left		Right	Left
	0 0 0	0 0 0		0 0 0	0 0 0
	0 0 0	0 0 0		0 0 0	0 0 0
	0 0 0	0 0 0		0 0 0	0 0 0

Edited by: Mark A McKay, OD

Main Ophthalmology Exam

External Exam		
	Right	Left
External	Normal	Normal
Slit Lamp Exam		
	Right	Left
Lids/Lashes	Normal	2+ Lid thickening, Hordeolum - Upper lid
Conjunctiva/Sclera	White and quiet	1+ Injection
Cornea	Clear	Clear
Anterior Chamber	Deep and quiet	Deep and quiet
Iris	Round and reactive	Round and reactive
Lens	Clear	Clear
Vitreous	Normal	Normal

Edited by: Mark A McKay, OD

SmartForms

Procedure Checklist
Aud Devices

Encounter Status

Electronically signed and closed by: Mark A McKay on 10/26/11 at 11:06 AM

Diagnoses

Hordeolum internum	373.12
Blepharitis	373.00

Order**(Order)**

The codes documented are preliminary and upon coder review with provider may be revised to meet compliance requirements.

Order Summary

Medications

Azithromycin (ZITHROMAX) 250 MG OR Tab Order #: 27333522

Erythromycin 5 MG/GM OP Ointment Order #: 27333523

Level of ServiceOFFICE/OUTPT VISIT,NEW,LEVL II
[99202]**Follow-up and Disposition**

Return if symptoms worsen or fail to improve, for if symptoms worsen or fail to improve..

Patient Instructions

Lid soaks and scrubs:

Use a warm, clean wet washcloth to soak eyelids then gently wipe away oily debris with the same cloth. Repeat this in both eyes twice a day

Living WillOn File
No**Chart Review Routing History**

No Routing History on File

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Reason for Call

Refill Request IBU

Reason For Call History Recorded

Call Documentation

Jane Fischer 10/25/2011 3:41 PM Signed

Pt req refill IBU 800mg #90;last visit 9.26.11;rx last fill 9.22.11;ok'd x 3mo per protocol.

thanksUniversity Health Care Refill Protocol:

Notes:

1. All refills require a minimum yearly patient visit to the appropriate provider; some refills require more frequent follow up. See specific recommendations below.
2. The number of refills allowed must comply with all state and federal regulations.
3. Unless specifically noted, the protocol includes only those medications listed.

Arthritis

Includes all NSAIDs, COX-II inhibitors, and anti-inflammatory doses of aspirin (see cardiology meds section for low-dose aspirin).

- Chem-12 q 12 months
- CBC q 12 months

See full documentation

Order**(Order)****Order Summary**

Medications

Ibuprofen 800 MG OR Tab Order #: 26045074**Pharmacy Contact**Telephone
801-213-9950Fax
801-213-9965**Reviewed On: 9/26/2011 By: Christopher Hill****Allergies as of 10/25/2011**

No Known Allergies

Encounter Status

Electronically signed and closed by: Jane Fischer on 10/25/11 at 3:42 PM

Created by

Jane Fischer on 10/25/2011 03:40 PM

Patient InformationPatient Name
Jimenez, Rick (20322546)Sex
MaleDOB
7/4/1960**Reason for Call****Refill Request** hydrocodone/apap

Reason For Call History Recorded

Call Documentation**Megan Lowe** 9/28/2011 3:12 PM Signed
Pt also requesting fluticasone nasal spray, last fill 9/9/11.**Megan Lowe** 9/28/2011 2:58 PM Signed
Last fill: 8/29/11 for # 90
Last appt: 9/26/11
Next appt: none

Please review, approve or deny and close the encounter. Thanks.

See full documentation**Order****(Order)****Order Summary**

Medications

Fluticasone Propionate (FLONASE) 50 MCG/ACT NA Suspension Order #: 26045073**Hydrocodone-Acetaminophen 7.5-500 MG OR Tab Order #: 26045072****Pharmacy Contact**Telephone
801-213-9950Fax
801-213-9965**Reviewed On: 9/26/2011 By: Christopher Hill****Allergies as of 9/28/2011**

No Known Allergies

Diagnoses**Lumbago**

724.2

Encounter Status

Electronically signed and closed by: Auto Batch Job on 10/13/11 at 12:30 AM

Routing History

Priority	Sent On	From	To	Message Type
	9/28/2011 2:58 PM	Megan Lowe	Margaret Hope Solomon, MD	

Created by

Megan Lowe on 09/28/2011 02:58 PM

Office Visit**9/26/2011 Office Visit****Rick Jimenez | MRN: 20322546****Patient Information**

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Visit Information

Date & Time	Provider	Department	Encounter #
9/26/2011 9:40 AM	Margaret Solomon, MD, MD	Rwc Im/Peds	186567576

Referring Provider**Self Referring****Reason for Visit****Follow Up Diagnostic Test Results****Disability Evaluation****Vitals**

Vitals	Most Recent Value
BP	128/84 mmHg
Temp	97.4 °F (36.3 °C)
Temp src	TEMPORAL
Pulse	68
Resp	20
Weight	167 lb 9.6 oz (76.023 kg)

Pain Information

No pain information on file

All Flowsheet Templates (all recorded)Encounter Vitals Flowsheet**Substances and Sexuality as of 9/26/2011**

Smoking Status	Amount
Current Every Day Smoker	0 packs/day for 0 years

Smokeless Tobacco Status
Unknown

Tobacco Comment
pt states that he is cutting down to 1-2 cigarettes per day now (09/26/11)

Alcohol Use	Amount
No	N/A

Drug Use	Frequency

Not Asked

N/A

Sexually Active

Partners

Not Asked

N/A

BMI Data

Body Mass Index
28.75 kg/m²

Body Surface Area
1.85 m²

Reviewed On: 9/26/2011 By: Christopher Hill

Allergies as of 9/26/2011

No Known Allergies

Visit Notes

JESSICA SISNEROS Mon Sep 26, 2011 10:29 AM

... durable medical equipment knee brace given and instructed correct use of equipment.

CHRISTOPHER HILL Mon Sep 26, 2011 9:49 AM

... Patient is an established patient. Vitals performed, history and allergies reviewed by Christopher Hill.
... Reviewed and reconciled patient's medications.

Nursing Notes

No notes of this type exist for this encounter.

Pharmacist Notes

No notes of this type exist for this encounter.

Progress Notes

Margaret Hope Solomon, MD at 9/26/2011 10:17 AM

Status: Signed

Pt is here for a follow up for medications and for an evaluation for disability forms.

<S>

Patient is a 51 year old male who presents for follow up visit.

-he reports persistent back pain. He had a fall in the shower because there are no rails at facility he is staying. Went to a few PT sessions but he reports missing these because his facility would not authorize a trip to clinic for therapy. He found therapy helpful when he was attending. Apparently his PT is also not covered by insurance. DOPL reviewed, filled rx for hydrocodone from a dentist 7/11 after signing pain contract with me. He admits to this but says it was because place he is staying would not let him fill rx from me?

-did not get colonoscopy due to insurance issues. He also was unable to get endoscopy because of these constraints. GERD sx slightly improved since he took rx for H pylori.

-will need WFS forms completed. He is able to do simple work (ie using hands), would need to be able to sit and take breaks for back pain. Does not have form with him today, they will send to me apparently.

Past Medical History

Diagnosis

Date

- Herniated intervertebral disk
- Tendon disorder

Reports torn tendon in right leg

- Environmental allergies
- Chronic hypotension
- H/O: stroke

No family history on file.

No past surgical history on file.

Current outpatient prescriptions ordered prior to encounter

Medication	Sig	Dispense	Refill
• Ibuprofen 800 MG OR Tab	1 po TID with food prn	90	0
• Loratadine (CLARITIN) 10 MG OR Tab	1 tab po at night for allergies, prn	30	2
• Hydrocodone-Acetaminophen 7.5-500 MG OR Tab	1 po tid prn back pain, to last 30 days	90	0
• Omeprazole 20 MG OR CAPSULE DELAYED RELEASE	1 tab po twice daily	60	5
• Fluticasone Propionate (FLONASE) 50 MCG/ACT NA Suspension	2 sprays each nostril daily	1	2
• Benzoyl Peroxide-Erythromycin 5-3 % EX Gel	apply to face nightly to treat acne	60 g	2
• Clarithromycin 500 MG OR Tab	1 po bid x 14 days	28	0

<O>

Physical exam:

GENERAL: Patient is alert and interactive. Patient is in no apparent distress.

HEAD: atraumatic and normocephalic

EYES: normal bilaterally, conjunctiva non-erythematous and sclerae anicteric

LUNGS: clear all lung fields, A-P Bilaterally

CARDIAC: regular rate and rhythm, normal S1 and S2 heart sounds and no murmur/gallops/rubs

BACK: diffuse low back tenderness, no deformities, ambulates with cane.

EXTREMITIES: no clubbing, cyanosis, or edema. Pulses and perfusion are normal.

NEURO: Alert and oriented. Antalgic gait. No focal neurological deficits are noticed.

SKIN: No lesions.

<A/P>

724.2 Lumbago (primary encounter diagnosis)

Comment: warned him of contract violation filling rx from another provider. He indicates understanding. Let him know if this happens again I will be unable to continue to rx pain meds for him. Will check U tox today. Would benefit from on going PT but he has limited health benefits which do not cover this

Plan: DRUG SCREEN 9A PNL URINE /CONF, SPECIMEN HANDLING, DR OFF->LAB, SPECIMEN HANDLING, DR OFF->LAB

530.11 Reflux esophagitis

Comment: stable sx, unable to get egd given insurance issues

Plan: SPECIMEN HANDLING, DR OFF->LAB, SPECIMEN HANDLING, DR OFF->LAB

041.86 Helicobacter pylori

Comment: check stool to document cure.

Plan: HELICOBACTER PYLORI STOOL, SPECIMEN HANDLING,DR
 OFF->LAB, HELICOBACTER PYLORI STOOL, SPECIMEN
 HANDLING,DR OFF->LAB

Return to clinic if symptoms persist or worsen or for any other concerns.

After visit summary given to patient and information reviewed with patient.

Margaret Solomon, MD

Revision History



H&P Notes

No notes of this type exist for this encounter.

Current Immunizations

Never Reviewed

No immunizations on file.

SmartForms

Procedure Checklist

Aud Devices

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 9/26/11 at 3:11 PM

Diagnoses

Lumbago - Primary	724.2
Reflux esophagitis	530.11
Helicobacter pylori	041.86

Order

(Order)

The codes documented are preliminary and upon coder review with provider may be revised to meet compliance requirements.

Order Summary

DRUG SCREEN 9A PNL URINE /CONF [80101 Custom] Order #: 26045067
 HELICOBACTER PYLORI STOOL [87338 EC AMB] Order #: 26045070
 SPECIMEN HANDLING,DR OFF->LAB [99000 CPT(R)] Order #: 26045069
 SPECIMEN HANDLING,DR OFF->LAB [99000 CPT(R)] Order #: 26045071

Future Labs/Procedures	Expected by	Expires
HELICOBACTER PYLORI STOOL [87338 EC AMB] Order #: 26045068	10/26/2011	10/26/2011

Other Orders

SPECIMEN HANDLING,DR OFF->LAB	Enter Results	Ordered On
SPECIMEN HANDLING,DR OFF->LAB	Enter Results	9/26/2011
		9/26/2011

Level of Service

OFFICE/OUTPT VISIT,EST,LEVL IV
 [99214]

Patient Instructions

None

Result Summary for DRUG SCREEN 9A PNL URINE /CONF

Result Information

Status
Final result (9/29/2011 2:35 PM)

Provider Status
Reviewed

Entry Date

9/29/2011

Component Results

Component	Value	Flag	Range	Units	Status
Amphetamines, Urine	Negative				Final
Barbiturates, Urine	Negative				Final
Benzodiazepines, Urine	Negative				Final
Marijuana, Urine	Negative				Final
Cocaine, Urine	Negative				Final
Methadone, Urine	Negative				Final
Phencyclidine, Urine	Negative				Final
Propoxyphene, Urine	Negative				Final
Alcohol, Urine	Negative				Final
Creatinine, Urine	179.9		20.0 - 400.0	mg/dL	Final
CDASU 9A Comments	See Note				Final

Comment:

TEST INFORMATION: Drug Panel 9A, Urn, Scrn w/Rflx to Conf

1. Drugs Covered and Cutoff Concentrations:

Drugs/Drug Classes	Screen	Confirmation
Marijuana	20 ng/mL	5 ng/mL
Cocaine	150 ng/mL	50 ng/mL
Opiates	300 ng/mL	5 ng/mL
Oxycodone.....	100 ng/mL	5 ng/mL
Phencyclidine	25 ng/mL	10 ng/mL
Amphetamines	300 ng/mL	200 ng/mL
MDMA (Ecstasy).....	500 ng/mL	200 ng/mL
Barbiturates	200 ng/mL	50 ng/mL
Benzodiazepines	200 ng/mL	20 ng/mL
Methadone	150 ng/mL	10 ng/mL
Propoxyphene	300 ng/mL	10 ng/mL
Alcohol	40 mg/dL	40 mg/dL

Oxycodone results will be reported with the opiates results. MDMA results will be reported with the amphetamines results.

2. For medical purposes only; not valid for forensic use.

3. 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, diluted/adulterated urine, or limitations of testing. The concentration at which the screening test can detect a drug or metabolite varies within a drug class. Specimens for which drugs or drug classes are detected by the screen are reflexed to a second, more specific technology (GC/MS and/or LC-MS/MS). The concentration value must be greater than or equal to the cutoff to be reported as positive. Interpretive questions should be directed to the laboratory.

Opiates, Urine Positive

Final

Comment:

Confirmed POSITIVE by LC-MS/MS for the following opiate(s):

Hydrocodone = 2322 ng/mL
Hydromorphone (free) = 108 ng/mL
Dihydrocodeine (qualitative only)

Methodology: LC-MS/MS

Drugs covered: 6-acetylmorphine (6-AM), morphine, codeine, dihydrocodeine, hydrocodone, hydromorphone, oxycodone, and oxymorphone.

The presence of more than one opiate in urine may reflect drug metabolism or use of multiple drugs. Low concentrations of an unexpected opiate in the presence of large concentrations of another opiate may also reflect impurities in the pharmaceutical preparation. The absence of expected opiates may indicate non-compliance or limitations of the testing. Interpretive questions should be directed to the laboratory.

Hydrocodone may arise from hydrocodone-containing drugs or by metabolism. When generated by metabolism of codeine, hydrocodone is usually less than 40% of the free codeine concentration. Hydrocodone is metabolized to hydromorphone and dihydrocodeine (hydrocodol).

Dihydrocodeine (hydrocodol) may arise from dihydrocodeine-containing drugs or by metabolism of hydrocodone.

Hydromorphone may arise from hydromorphone-containing drugs or by metabolism. When generated by metabolism of hydrocodone, free hydromorphone is usually less than 30% of the hydrocodone concentration. When generated by metabolism of morphine, free hydromorphone is usually less than 25% of the free morphine concentration.

Lab and Collection

DRUG SCREEN 9A PNL URINE /CONF (Order #26045067) on 9/26/2011 - Lab and Collection Information

Result History

DRUG SCREEN 9A PNL URINE /CONF (Order #26045067) on 9/29/11 - Order Result History Report.

Result Summary for HELICOBACTER PYLORI STOOL

Result Information

Status	Provider Status
Final result (9/27/2011 2:40 AM)	Reviewed

Entry Date

9/27/2011

Component Results

Component	Value	Flag	Range	Units	Status
Helicobacter pylori Ag, by EIA	Negative		Negative		Final

Lab and Collection

HELICOBACTER PYLORI STOOL (Order #26045070) on 9/26/2011 - Lab and Collection Information

Result History

HELICOBACTER PYLORI STOOL (Order #26045070) on 9/27/11 - Order Result History Report.

Living WillOn File
No**Letters****Letter Information****Margaret Hope Solomon on 9/26/2011**Status
Sent**Letter Information****Margaret Hope Solomon on 9/27/2011**Status
Sent**Chart Review Routing History**

No Routing History on File

Patient InformationPatient Name
Jimenez, Rick (20322546)Sex
MaleDOB
7/4/1960**Reason for Call****Refill Request**

Ibuprofen, Loratadine

Reason For Call History Recorded

Call Documentation**Douglas G Bunting, RPH, RPH** 9/21/2011 3:00 PM SignedPlease review this request, indicate appropriate refills, then close the encounter.
Thanks.

Last date filled : 8/19 for # 90 Ibuprofen and # 30 Loratadine, both from Dr. Flynn

Last appointment : 7/6

Next scheduled appointment : none

See full documentation**Order**

(Order)

Order Summary

Medications

Ibuprofen 800 MG OR Tab Order #: 26045065**Loratadine (CLARITIN) 10 MG OR Tab** Order #: 26045066**Pharmacy Contact**Telephone
801-213-9950Fax
801-213-9965Reviewed On: 7/6/2011 By: **Margaret Hope
Solomon, MD****Allergies as of 9/21/2011**

No Known Allergies

Encounter Status

Electronically signed and closed by: Douglas G Bunting, RPH on 9/27/11 at 5:12 PM

Routing History

Priority	Sent On	From	To	Message Type
	9/21/2011 3:00 PM	Douglas G Bunting, RPH	Margaret Hope Solomon, MD	

Created by

Douglas G Bunting, RPH on 09/21/2011 02:59 PM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Contacts

	Type	Contact	Phone	User
08/23/2011 9:20 AM	Phone (Outgoing)	Jimenez, Rick (Self)	801-973-3800 (H)	Kristin Clark

Reason for Call

Endo Scheduling egd/cln

Call Documentation**Kristin Clark** 8/23/2011 10:45 AM Signed

Rick Jimenez was contacted 8/23/2011 to confirm an appointment for a colonoscopy and EGD on August 30, 2011 at 1000 with Dr. Adler at the Redwood Endoscopy Center.

Nurse reviewed Miralax Prep preparation with the pt. Pt instructed to only drink clear liquids and the laxatives and not eat any solid food the entire day and night before the procedure. Pt instructed to remain NPO for at least two hours prior to their arrival time for the procedure. Pt to take B/P and/or heart medication with a small sip of water early a.m. the day of the procedure. Pt stated that he/she is not diabetic.

Pt reminded to stop taking aspirin, ibuprofen, coumadin, heparin, plavix, or any other blood thinners for at least 5 days before the procedure. Patient reminded to bring a current list of medications. Pt denied any other questions at this time regarding this preparation.

Pt informed that they will be unable to drive home after the procedure and a reliable ride will need to be arranged for that day. Pt encouraged to leave all valuables at home.

Pt directed to call the Pre Procedure Endoscopy Line with any other questions or problems at phone number 801-213-9765. Kristin Clark

Kristin Clark 8/23/2011 9:25 AM Signed

Rick Jimenez was called 8/23/2011 to confirm an appointment on August 30, 2011 at 1000 for a colonoscopy and EGD with Dr. Adler at the Redwood Endoscopy Center.

Pt was not home at this time. A msg was left to call the pre procedure confirmation line at 801-213-9765 to confirm the appointment. Kristin Clark

[See full documentation](#)**Order**

(Order)

Reviewed On: 7/6/2011 By: Margaret Hope Solomon, MD

Allergies as of 8/23/2011

No Known Allergies

Encounter Status

Electronically signed and closed by: Kristin Clark on 10/25/11 at 12:42 PM

Created by

Kristin Clark on 08/23/2011 09:20 AM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Visit Information

Date & Time	Provider	Department	Encounter #
8/12/2011 9:40 AM	Jared Esplin, PT	Rwc Physical Therapy	186315905

Insurance Information**Insurance Information**

Payor/Plan
(No coverage on file)

Appointment

Status
No Show [4]

Display Notes

RPV

Visit Coverage

Payor	Plan
AGENCY	AGENCY OTHER

Primary Coverage

Payor	Plan
AGENCY	AGENCY OTHER

Progress Notes

No notes of this type exist for this encounter.

All Notes

No notes found.

Letters**Letter Information**

<u>Jared Esplin on 8/12/2011</u>	Status Sent
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Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Progress Notes

No notes of this type exist for this encounter.

Encounter-Level Documents:

Scan on 8/8/2011 by Joanne Buck : DWS Evidence of Impairment 7/28/11

Encounter Status

Electronically signed and closed by: Joanne Buck on 8/8/11 at 2:09 PM

Office Visit

8/5/2011 Office Visit

Rick Jimenez | MRN: 20322546

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Visit Information

Date & Time 8/5/2011 10:40 AM	Provider Jared Esplin, PT	Department Rwc Physical Therapy	Encounter # 186249124
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Referring Provider**Margaret Hope Solomon, MD****Reason for Visit****Back Pain-Injury****Pain Information**

No pain information on file

Substances and Sexuality as of 7/6/2011

Smoking Status Current Every Day Smoker	Amount 0 packs/day for 0 years
Smokeless Tobacco Status Unknown	
Alcohol Use No	Amount N/A
Drug Use Not Asked	Frequency N/A
Sexually Active Not Asked	Partners N/A

Reviewed On: 7/6/2011 By: Margaret Hope Solomon, MD**Allergies as of 8/5/2011**

No Known Allergies

Nursing Notes

No notes of this type exist for this encounter.

Pharmacist Notes

No notes of this type exist for this encounter.

Progress Notes

Jared Esplin at 8/5/2011 11:01 AM

Status: Signed

S: Patient reports no new problems since last physical therapy visit. Patient reports no change of symptoms. Patient reports compliance with home exercise program and activity modifications.

O: Treatment time of 45 minutes with direct contact time of 45 minutes including therapeutic exercises 15 minutes, neuromuscular re-education 20 minutes and manual therapy techniques (as previous) 10 minutes. We progressed with no new exercises. All other exercises were performed as described last visit.

A: pt has no increased symptoms with exercises, fatigues easily, should progress with therapy.

P: We plan to continue to see the patient 1 time a week. We plan to focus on flexibility, proprioception.

Jared Esplin, P.T.

H&P Notes

No notes of this type exist for this encounter.

Current Immunizations

Never Reviewed

No immunizations on file.

SmartFormsProcedure Checklist
Aud Devices**Encounter Status**

Electronically signed and closed by: Jared Esplin on 8/5/11 at 11:41 AM

Diagnoses**Lumbago** - Primary 724.2**Order**

(Order)

The codes documented are preliminary and upon coder review with provider may be revised to meet compliance requirements.

Order Summary**MANUAL THER TECH,1+REGIONS,EA 15 MIN [97140 CPT(R)] Order #: 25608543**
NEUROMUSC REEDUCAT,1+ AREAS, EA 15 MIN [97112 CPT(R)] Order #: 26045064
THERAPEUTIC EXERCISES [97110 CPT(R)] Order #: 25608544**Other Orders**

<u>MANUAL THER TECH,1+REGIONS,EA 15 MIN</u>	<u>Enter Results</u>	Ordered On 8/5/2011
<u>THERAPEUTIC EXERCISES</u>	<u>Enter Results</u>	8/5/2011
<u>NEUROMUSC REEDUCAT,1+ AREAS, EA 15 MIN</u>	<u>Enter Results</u>	8/5/2011

Patient Instructions

None

Living WillOn File
No**Chart Review Routing History**

No Routing History on File

Office Visit

7/29/2011 Office Visit

Rick Jimenez | MRN: 20322546

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Visit Information

Date & Time	Provider	Department	Encounter #
7/29/2011 8:40 AM	Jared Esplin, PT	Rwc Physical Therapy	186241357

Referring Provider

Margaret Hope Solomon, MD

Reason for Visit

Back Pain-Injury

Pain Information

No pain information on file

Substances and Sexuality as of 7/6/2011

Smoking Status	Amount
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Current Every Day Smoker

0 packs/day for 0 years

Smokeless Tobacco Status
UnknownAlcohol Use
NoAmount
N/ADrug Use
Not AskedFrequency
N/ASexually Active
Not AskedPartners
N/AReviewed On: 7/6/2011 By: Margaret Hope
Solomon, MD**Allergies as of 7/29/2011**

No Known Allergies

Nursing Notes

No notes of this type exist for this encounter.

Pharmacist Notes

No notes of this type exist for this encounter.

Progress Notes

Jared Esplin at 7/29/2011 10:16 AM

Status: Signed

S: Patient reports no new problems since last physical therapy visit. Patient reports no change of symptoms. Patient reports compliance with home exercise program and activity modifications.

O: Treatment time of 40 minutes with direct contact time of 40 minutes including therapeutic exercises 10 minutes, neuromuscular re-education 20 minutes and manual therapy techniques (piriformis stretch, lumbar rotation) 10 minutes. All exercises were performed as described last visit.

A: pt fatigues with exercises, should progress well with therapy and HEP.

P: We plan to continue to see the patient 1 time a week. We plan to focus on flexibility, proprioception.

Jared Esplin, P.T.

Revision History

**H&P Notes**

No notes of this type exist for this encounter.

Current Immunizations

Never Reviewed

No immunizations on file.

SmartFormsProcedure ChecklistAud Devices**Encounter Status**

Electronically signed and closed by: Jared Esplin on 7/29/11 at 10:16 AM

Diagnoses**Lumbago** - Primary

724.2

Order

(Order)

The codes documented are preliminary and upon coder review with provider may be revised to meet compliance requirements.

Order Summary

MANUAL THER TECH,1+REGIONS,EA 15 MIN [97140 CPT(R)] Order #: 25608540
NEUROMUSC REEDUCAT,1+ AREAS, EA 15 MIN [97112 CPT(R)] Order #: 25608542
THERAPEUTIC EXERCISES [97110 CPT(R)] Order #: 25608541

Other Orders

MANUAL THER TECH,1+REGIONS,EA 15 MIN	Enter Results	Ordered On 7/29/2011
THERAPEUTIC EXERCISES	Enter Results	7/29/2011
NEUROMUSC REEDUCAT,1+ AREAS, EA 15 MIN	Enter Results	7/29/2011

Patient Instructions

None

Living Will

On File
No

Chart Review Routing History

No Routing History on File

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Visit Information

Date & Time	Provider	Department	Encounter #
7/28/2011 10:00 AM	Jared Esplin, PT	Rwc Physical Therapy	186228301

Insurance Information**Insurance Information**

Payor/Plan
(No coverage on file)

Appointment

Status
No Show [4]

Display Notes

rpv

Visit Coverage

Payor	Plan
AGENCY	AGENCY OTHER

Primary Coverage

Payor	Plan
AGENCY	AGENCY OTHER

Progress Notes

No notes of this type exist for this encounter.

All Notes

No notes found.

Letters**Letter Information****Jared Esplin on 7/28/2011**Status
Sent**Patient Information**

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Reason for Call**Refill Request** Hydrocod/APAP, Ibuprofen

Reason For Call History Recorded

Call Documentation

Douglas G Bunting, RPH, RPH 7/27/2011 11:59 AM Signed
Please review this request, indicate appropriate refills, then close the encounter.
Thanks.

Last date filled : 6/15 for # 90 Hydrocod/APAP, 6/13 for # 90 Ibuprofen

Last appointment : 7/6

Next scheduled appointment : none

See full documentation**Order**

(Order)

Order Summary

Medications
Hydrocodone-Acetaminophen 7.5-500 MG OR Tab Order #: 25608538
Ibuprofen 800 MG OR Tab Order #: 25608539

Pharmacy Contact

Telephone	Fax
801-213-9950	801-213-9965

Reviewed On: 7/6/2011 By: **Margaret Hope Solomon, MD****Allergies as of 7/27/2011**

No Known Allergies

Diagnoses**Lumbago** 724.2**Encounter Status**

Electronically signed and closed by: Auto Batch Job on 8/11/11 at 12:30 AM

Routing History

Priority	Sent On	From	To	Message Type
	7/27/2011 11:59 AM	Douglas G Bunting, RPH	Margaret Hope Solomon, MD	

Created by

Douglas G Bunting, RPH on 07/27/2011 11:58 AM

Office Visit

7/20/2011 Office Visit

Rick Jimenez | MRN: 20322546

Patient Information

Patient Name Jimenez, Rick (20322546)	Sex Male	DOB 7/4/1960
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Visit Information

Date & Time 7/20/2011 10:20 AM	Provider Jared Esplin, PT	Department Rwc Physical Therapy	Encounter # 186112936
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Referring Provider**Self Referring****Reason for Visit****Back Pain-Injury****Pain Information**

No pain information on file

Substances and Sexuality as of 7/6/2011

Smoking Status Current Every Day Smoker	Amount 0 packs/day for 0 years
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Smokeless Tobacco Status Unknown
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Alcohol Use No	Amount N/A
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Drug Use Not Asked	Frequency N/A
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Sexually Active Not Asked	Partners N/A
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Reviewed On: 7/6/2011 By: Margaret Hope Solomon, MD**Allergies as of 7/20/2011**

No Known Allergies

Nursing Notes

No notes of this type exist for this encounter.

Pharmacist Notes

No notes of this type exist for this encounter.

Progress Notes

Jared Esplin at 7/20/2011 10:56 AM

Status: Signed

The patient has been referred for Physical Therapy evaluation and treatment by Dr. Solomon.
Chief complaint: back pain.

INITIAL ONSET

Date of onset: 2004

Patient reports lifting an engine at work.

Initial symptoms included back pain.

Initial treatment consisted of PT, med, injections in 2004.

SINCE INITIAL ONSET

Patient reports that they have had an increase of symptoms.

Further treatment has included nothing recently.

CURRENT SYMPTOMS

Location: lumbar region, and upper thoracic.

Pain rating: 6/10 at initial evaluation
Duration: constant and has no change in a 24 hr. period.
Most comfortable sleeping position: supine.
Aggravating factors: unsure.
Alleviating factors: meds, heat, ice.

FUNCTIONAL STATUS AND ACTIVITY

Reported limits: difficulty with activity due to pain.
Patients Goals: decrease pain.

MEDICATIONS:

Current outpatient prescriptions: Hydrocodone-Acetaminophen 7.5-500 MG OR Tab, 1 po tid prn back pain, to last 30 days, Disp: 90, Rfl: 0; Benzoyl Peroxide-Erythromycin 5-3 % EX Gel, apply to face nightly to treat acne, Disp: 60 g, Rfl: 2; Amoxicillin 500 MG OR Cap, 2 po qam and 2 po qpm x 2 weeks, Disp: qs 2 weeks, Rfl: 0; Clarithromycin 500 MG OR Tab, 1 po bid x 14 days, Disp: 28, Rfl: 0
Omeprazole 20 MG OR CAPSULE DELAYED RELEASE, 1 tab po twice daily, Disp: 60, Rfl: 5; Ibuprofen 800 MG OR Tab, 1 po TID with food prn, Disp: 90, Rfl: 0; Loratadine (CLARITIN) 10 MG OR Tab, 1 tab po at night for allergies, prn, Disp: 30, Rfl: 2; Fluticasone Propionate (FLONASE) 50 MCG/ACT NA Suspension, 2 sprays each nostril daily, Disp: 1, Rfl: 2

SURGICAL HISTORY:

No past surgical history on file.

Past Medical History

Diagnosis	Date
• Herniated intervertebral disk	
• Tendon disorder	
<i>Reports torn tendon in right leg</i>	
• Environmental allergies	
• Chronic hypotension	
• H/O: stroke	

PERSONAL HISTORY

Occupation: none

COMMUNICATION, AFFECT, COGNITION, LEARNING STYLE

Patient communication: age appropriate. Patient is oriented to person, place and time.
Emotional/Behavioral response not impaired. Patients learning barriers are none.

SYSTEMS REVIEW

Cardiovascular: is not impaired with regards to heart rate, respiratory rate, blood pressure and edema per pt report.
Musculoskeletal: Height: 5'4" Weight: 166#
See Tests and Measures section for further details
Integumentary: has no disruptions, abnormal skin color or pliability
Neuromuscular: Gait is impaired with using cane due to pain.

EVALUATION

Diagnosis: lumbar HNP.
Impaired Joint mobility, motor function, muscle performance, R.O.M, and reflex integrity associated with spinal disorders.
Impairments:

1. 6/10 pn LB
2. decreased lumbar AROM
3. decreased hip flexibility
4. weak hip ABD

Prognosis: fair with chronicity, multiple HNP as per patient report as complicating pathology.

Goals:

1. Decrease pn to 4/10 max by 6 weeks.
2. Increase lumbar flexion to 70 degrees by 6 weeks.
3. Increase hip flexibility to WFL by 6 weeks.
4. Increase hip ABD strength to 5/5 by 6 weeks.

Functional outcomes:

1. Patient will be able to do all IADLs with 4/10 pn max by 6 weeks.

Plan of Care

Interventions: 1 time a week for 6-8 weeks. Treatment will/may include modalities, manual therapy techniques, therapeutic, neuromuscular and functional exercise. Patient education regarding home exercise instruction and activity modifications.

Education: The patient was informed of their examination findings, proposed treatment plan, procedures and expected outcomes.

Initial treatment: heat LB. The patient was instructed on home exercise program and demonstrated proper technique in clinic today and was given handout with written instructions and pictures of exercises (10 min). See attached letter.

Exercises for plan of care: Total gym for 5 minutes on level 7, thoracic extension 30 times, rows 2 sets of 20 with 3 kg, rotation stabilizations bilateral for 1 minute with 3 kg, bilateral standing abduction 2 sets of 20 with 2 pounds, ball bridges 2 sets of 20, crate lifting 2 sets for 1 minute with 20 pounds, planks prone and sides 30 seconds each.

Jared Esplin, PT

Revision History

H&P Notes

No notes of this type exist for this encounter.

Current Immunizations

Never Reviewed

No immunizations on file.

Lumbar Spine Exam

Palpation	Pain		Spasm	
Lumbar Spine:	Yes		No	
Paraspinals:	R: Yes	L: Yes	R: Yes	L: Yes
Sacroiliac:	R: Yes	L: Yes		
Iliolumbar:	R: Yes	L: Yes		
Sciatic Notch:	R: Yes	L: Yes		

Range of Motion

Pain

Range

Extension:	Yes	15
Flexion:	Yes	60

Motor/Strength	Right	Left
Adductors (L2):	4/5	5/5
Quadriceps (L3):	4/5	5/5
Ankle Dorsiflexors (L4):	5/5	5/5
Extensor Hallucis Longus (L5):	4/5	5/5
Plantar Flexors/Evertors (S1):	4/5	5/5

Reflexes	Right	Left
Patellar:	3/4	3/4
Achilles:	2/4	2/4

Straight Leg Raise	Right	Left
Straight Leg Raise:	Negative	Negative

Observations

tight piriformis and hamstring B, R>L.

increased pain with manual traction.

leg lengths equal supine.

lumbar rotation tight and painful B, limited by guarding.

hip ABD 5/5 strength L, 3/5 R.

unable to grade lumbar or thoracic P/A glide due to severe guarding.

SmartForms

- Procedure Checklist
- Aud Devices

Encounter Status

Electronically signed and closed by: Jared Esplin on 7/20/11 at 12:28 PM

Diagnoses

Lumbago - Primary 724.2

Order**(Order)**

The codes documented are preliminary and upon coder review with provider may be revised to meet compliance requirements.

Order Summary

HOT OR COLD PACKS THERAPY [97010 CPT(R)] Order #: 25608536

PHYS THERAPY EVALUATION [97001 CPT(R)] Order #: 25608535

THERAPEUTIC EXERCISES [97110 CPT(R)] Order #: 25608537

Other OrdersPHYS THERAPY EVALUATIONEnter ResultsOrdered On
7/20/2011HOT OR COLD PACKS THERAPYEnter Results

7/20/2011

THERAPEUTIC EXERCISESEnter Results

7/20/2011

Patient Instructions

None

Classic SmartForms

Classic SmartForms Filed During this Visit

LUMBAR SPINE EXAM**Living Will**

On File
No

LettersLetter InformationJared Esplin on 7/20/2011

Status
Sent

Chart Review Routing History

No Routing History on File

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Contacts

	Type	Contact	Phone	User
07/13/2011 8:49 AM	Phone (Incoming)	Jimenez, Rick (Self)	801-973-3800 (H)	Dawn Spor
07/13/2011 9:18 AM	Phone (Outgoing)	Jimenez, Rick (Self)	801-973-3800 (H)	Rebecca Hanshew
Not Available				

Reason for CallTelephone-Health Status**Call Documentation**

Rebecca Hanshew 7/13/2011 9:20 AM Signed
Tried to contact pt but could not get a hold of him. Will try later

Dawn Spor 7/13/2011 8:51 AM Signed
Patient called to report the following information:

What condition is being reported: Pt called and wanted to let the dr know that the reason he missed his PT appt yesterday was because his tooth broke again and he was at the dentist all day. He also is requesting to speak with the dr in regards to some of the medications they gave him. I transferred the pt to PT to reschedule his appt.

Please call and advise.
(801)973-3800

See full documentation**Order**

(Order)

Reviewed On: 7/6/2011 By: **Margaret Hope Solomon, MD**

Allergies as of 7/13/2011

No Known Allergies

Encounter Status

Electronically signed and closed by: Pamela Melis on 7/14/11 at 5:05 PM

Routing History

Priority	Sent On	From	To	Message Type
	7/14/2011 5:05 PM	Pamela Melis	P CC RWC IM/PEDS MESSAGE POOL	

7/13/2011 Rebecca Hanshew
9:20 AM
7/13/2011 Dawn Spor
8:51 AM

P CC RWC IM/PEDS
MESSAGE POOL
P CC RWC IM/PEDS
MESSAGE POOL

Created by

Dawn Spor on 07/13/2011 08:49 AM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Visit Information

Date & Time	Provider	Department	Encounter #
7/11/2011 2:00 PM	Jared Esplin, PT	Rwc Physical Therapy	186004966

Insurance Information**Insurance Information**

Payor/Plan
(No coverage on file)

Appointment

Status
No Show [4]

Display Notes

npv

Primary Coverage

Payor	Plan
AGENCY	AGENCY OTHER

Progress Notes

No notes of this type exist for this encounter.

All Notes

No notes found.

Letters**Letter Information**

	Status
<u>Jared Esplin on 7/11/2011</u>	Sent

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Progress Notes

No notes of this type exist for this encounter.

Encounter-Level Documents:

Document on 7/7/2011 by Joanne Buck : ROI - Patient handcarried

Encounter Status

Electronically signed and closed by: Joanne Buck on 7/7/11 at 11:52 AM

Office Visit

7/6/2011 Office Visit Rick Jimenez | MRN: 20322546

Patient Information

Patient Name	Sex	DOB
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Jimenez, Rick (20322546)

Male

7/4/1960

Visit Information

Date & Time	Provider	Department	Encounter #
7/6/2011 2:00 PM	Margaret Solomon, MD, MD	Rwc Im/Peds	185867619

Referring Provider

Self Referring

Reason for Visit

Pain-Generalized

Vitals

Vitals	Most Recent Value
BP	120/80 mmHg
Temp	97.1 °F (36.2 °C)
Temp src	TEMPORAL
Pulse	91
Resp	16
Weight	166 lb 8 oz (75.524 kg)

Pain Information (Last Filed)

Score	Location	Comments	Edu?
4	Generalized		

All Flowsheet Templates (all recorded)Encounter Vitals Flowsheet**Substances and Sexuality as of 7/6/2011**

Smoking Status	Amount
Current Every Day Smoker	0 packs/day for 0 years
Smokeless Tobacco Status	
Unknown	
Alcohol Use	Amount
No	N/A
Drug Use	Frequency
Not Asked	N/A
Sexually Active	Partners
Not Asked	N/A

BMI Data

Body Mass Index	Body Surface Area
28.56 kg/m ²	1.85 m ²

Reviewed On: 7/6/2011 By: Margaret Hope Solomon, MD

Allergies as of 7/6/2011

No Known Allergies

Visit Notes

LEEANN PEREZ Wed Jul 6, 2011 3:17 PM

Collected urine specimen for culture and sent to mini lab upstairs and signed in

LEEANN PEREZ Wed Jul 6, 2011 1:46 PM

Rick Jimenez is a 51 year old male

Patient is an established patient. Vitals performed, history and allergies reviewed by Leeann Perez.

Reviewed and reconciled patient's medications.

This pt is here for a follow up on his last visit, he thought it was for his colonoscopy, but apparently not.

Nursing Notes

No notes of this type exist for this encounter.

Pharmacist Notes

No notes of this type exist for this encounter.

Progress Notes

Margaret Hope Solomon, MD at 7/6/2011 2:34 PM

Status: Signed

The medical assistant and/or scribe for this encounter is Leeann Perez

S- Rick Jimenez is a 51 year old male presenting to address the following issue(s):

This pt is here for a follow up on his last visit, he thought it was for his colonoscopy, but apparently not

<S>

Patient is a 51 year old male who presents for follow up visit.

-he has been having GERD sx, omeprazole helps but sx come back afterwards.
Scheduled for EGD late August. Denies any hematemesis, emesis, blood in stools.

-back same, no new sx. He is scheduled to see PT for initial eval 7/11/11. He is living in half way house, has had some issues with them giving him his medication when he requests.

-he has skin lesions on his face which are painful. Present x 3 yrs. Intermittently itchy.
No prior h/o acne.

Ros:

No fevers, chills

No diarrhea, emesis, hematemesis or blood in stools.

Past Medical History

Diagnosis

Date

- Herniated intervertebral disk
- Tendon disorder

Reports torn tendon in right leg

- Environmental allergies
- Chronic hypotension
- H/O: stroke

No family history on file.

No past surgical history on file.

Current outpatient prescriptions ordered prior to encounter

Medication	Sig	Dispense	Refill
• Hydrocodone- Acetaminophen 7.5-500 MG OR Tab	1 po tid prn back pain	90	0
• Ibuprofen 800 MG OR Tab	1 po TID with food prn	90	0
• Omeprazole 20 MG OR	1 tab po twice daily	60	0

CAPSULE DELAYED
RELEASE

- Loratadine (CLARITIN) 10 MG OR Tab 1 tab po at night for allergies, prn 30 2
- Fluticasone Propionate (FLONASE) 50 MCG/ACT NA Suspension 2 sprays each nostril daily 1 2

<O>

Physical exam:

GENERAL: Patient is alert and interactive. Patient is in no apparent distress.

HEAD: atraumatic and normocephalic

EYES: conjunctiva non-erythematous and sclerae anicteric

CHEST: no retractions, symmetrical and non-tender

LUNGS: clear all lung fields, A-P Bilaterally

CARDIAC: regular rate and rhythm, normal S1 and S2 heart sounds and no murmus/gallops/rubs

NEURO: Ambulates with a cane

SKIN: Indurated lesions on cheeks B c/w scarring acne, no lesions in beard area.

<A/P>

530.11 Reflux esophagitis

Comment: given persistent sx on PPI will treat for H pylori, see below. EGD in late August.

724.2 Lumbago

Comment: check urine drug screen, refill pain meds. Counseled re risks of narcotic pain meds.

Plan: Hydrocodone-Acetaminophen 7.5-500 MG OR Tab,
DRUG OF ABUSE 9PNL,UA,W/CONFIRM

706.1 Acne

Comment: trial topical rx, also consider tinea barbae but lesions appear more c/w inflammatory acne, may need oral abx.

Plan: Benzoyl Peroxide-Erythromycin 5-3 % EX Gel

041.86 Helicobacter pylori

Comment: will treat for positive prior serum test and sx.

Plan: Amoxicillin 500 MG OR Cap, Clarithromycin 500
MG OR Tab, Omeprazole 20 MG OR CAPSULE DELAYED
RELEASE

F/u 1-2 months re above issues.

Return to clinic if symptoms persist or worsen or for any other concerns.

After visit summary given to patient and information reviewed with patient.

Margaret Solomon, MD

General Review of Systems

O-

The Physical Exam SmartForm was not used in this encounter.

A/P-

Revision History



H&P Notes

No notes of this type exist for this encounter.

Current Immunizations

Never Reviewed

No immunizations on file.

SmartForms

Procedure Checklist

Aud Devices

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon, MD on 7/9/11 at 6:11 AM

Diagnoses

Reflux esophagitis	530.11
Lumbago	724.2
Acne	706.1
Helicobacter pylori	041.86

Order

(Order)

The codes documented are preliminary and upon coder review with provider may be revised to meet compliance requirements.

Order Summary

DRUG OF ABUSE 9PNL,UA,W/CONFIRM [80101 Custom] Order #: 25311067
SPECIMEN HANDLING,DR OFF->LAB [99000 CPT(R)] Order #: 25608534

Medications

Amoxicillin 500 MG OR Cap Order #: 25311068
Benzoyl Peroxide-Erythromycin 5-3 % EX Gel Order #: 25311066
Clarithromycin 500 MG OR Tab Order #: 25311069
Hydrocodone-Acetaminophen 7.5-500 MG OR Tab Order #: 25311065
Omeprazole 20 MG OR CAPSULE DELAYED RELEASE Order #: 25311070

Other Orders

Ordered On

SPECIMEN HANDLING.DR OFF->LAB

Enter Results

7/6/2011

Level of ServiceOFFICE/OUTPT VISIT,EST,LEVL IV
[99214]**Patient Instructions**

Today we are giving you a prescription for a gel to apply to your face for skin issues.

We are also giving you 2 antibiotics to take twice per day for 2 weeks in addition to your omeprazole to treat stomach symptoms.

Result Summary for DRUG OF ABUSE 9PNL,UA,W/CONFIRM**Result Information**

Status	Provider Status
Final result (7/8/2011 1:16 PM)	Reviewed

Entry Date

7/8/2011

Component Results

Component	Value	Flag	Range	Units	Status
Amphetamines, Urine	Negative				Final
Barbiturates, Urine	Negative				Final
Benzodiazepines, Urine	Negative				Final
Marijuana, Urine	Negative				Final
Cocaine, Urine	Negative				Final
Methadone, Urine	Negative				Final
Phencyclidine, Urine	Negative				Final
Propoxyphene, Urine	Negative				Final
Creatinine, Urine	79.5		20.0 - 400.0	mg/dL	Final
CDASU 9 Comments	See Note				Final

Comment:

TEST INFORMATION: Drug Panel 9, Urn, Screen w/Rflx to Conf

1. Drugs Covered and Cutoff Concentrations:

Drugs/Drug Classes	Screen	Confirmation
Marijuana	20 ng/mL	5 ng/mL
Cocaine	150 ng/mL	50 ng/mL
Opiates	300 ng/mL	5 ng/mL
Oxycodone.....	100 ng/mL	5 ng/mL
Phencyclidine	25 ng/mL	10 ng/mL
Amphetamines	300 ng/mL	200 ng/mL
MDMA (Ecstasy).....	500 ng/mL	200 ng/mL
Barbiturates	200 ng/mL	50 ng/mL
Benzodiazepines	200 ng/mL	20 ng/mL
Methadone	150 ng/mL	10 ng/mL
Propoxyphene	300 ng/mL	10 ng/mL

Oxycodone results will be reported with the opiates results. MDMA results will be reported with the amphetamines results.

2. For medical purposes only; not valid for forensic use.

3. 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, diluted/adulterated urine, or limitations of testing. The concentration at which the screening test can detect a drug or metabolite varies within a drug class. Specimens for which drugs or drug classes are detected by the screen are reflexed to a second, more specific technology (GC/MS and/or LC-MS/MS). The concentration value must be greater than or equal to the cutoff to be reported as positive. Interpretive questions should be directed to the laboratory.

Opiates, Urine

Positive

Final

Comment:

Confirmed POSITIVE by LC-MS/MS for the following opiate(s):

Hydrocodone = 207 ng/mL
Hydromorphone (free) = 12 ng/mL
Dihydrocodeine (qualitative only)

Methodology: LC-MS/MS

Drugs covered: 6-acetylmorphine (6-AM), morphine, codeine, dihydrocodeine, hydrocodone, hydromorphone, oxycodone, and oxymorphone.

The presence of more than one opiate in urine may reflect drug metabolism or use of multiple drugs. Low concentrations of an unexpected opiate in the presence of large concentrations of another opiate may also reflect impurities in the pharmaceutical preparation. The absence of expected opiates may indicate non-compliance or limitations of the testing. Interpretive questions should be directed to the laboratory.

Hydrocodone may arise from hydrocodone-containing drugs or by metabolism. When generated by metabolism of codeine, hydrocodone is usually less than 40% of the free codeine concentration. Hydrocodone is metabolized to hydromorphone and dihydrocodeine (hydrocodol).

Dihydrocodeine (hydrocodol) may arise from dihydrocodeine-containing drugs or by metabolism of hydrocodone.

Hydromorphone may arise from hydromorphone-containing drugs or by metabolism. When generated by metabolism of hydrocodone, free hydromorphone is usually less than 30% of the hydrocodone concentration. When generated by metabolism of morphine, free hydromorphone is usually less than 25% of the free morphine concentration.

Lab and Collection

DRUG OF ABUSE 9PNL,UA,W/CONFIRM (Order #25311067) on 7/6/2011 - Lab and Collection Information

Result History

DRUG OF ABUSE 9PNL,UA,W/CONFIRM (Order #25311067) on 7/8/11 - Order Result History Report.

Living Will

On File

No

Chart Review Routing History

No Routing History on File

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Progress Notes

No notes of this type exist for this encounter.

Encounter-Level Documents:Scan on 6/28/2011 by Connie Fondren : Medication Agreement 6/14/11**Encounter Status**

Electronically signed and closed by: Connie Fondren on 6/28/11 at 11:28 AM

Outside Records**6/20/2011 Outside Records****Rick Jimenez | MRN: 20322546****Patient Information**

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Progress Notes

No notes of this type exist for this encounter.

Encounter-Level Documents:Document on 6/20/2011 by Joanne Buck : Records - Bureau of Prisons Health Services**Encounter Status**

Electronically signed and closed by: Joanne Buck on 6/20/11 at 1:40 PM

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Contacts

	Type	Contact	Phone	User
06/19/2011 6:31 AM	Phone (Outgoing)	Jimenez, Rick (Self)	801-973-3800 (H)	Margaret Hope Solomon
06/20/2011 4:11 PM	Phone (Outgoing)	Jimenez, Rick (Self)	801-973-3800 (H)	Leeann Perez
Not Available				

Reason for Call

Telephone Follow-Up

Call Documentation

Felissadee Campbell 6/21/2011 10:55 AM Signed
Sent pt a letter

Leeann Perez 6/20/2011 4:12 PM Signed
I tried calling the number that is in the system and it was apparently not the right one. It asked for the person by name and the recording says that there is no one by that name.....
Will try again Tuesday

Margaret Solomon, MD 6/19/2011 6:32 AM Signed
Please contact pt, give him information about scheduling physical therapy, let him know I want him to do physical therapy in addition to his medications. Also does not look like he has scheduled EGD

and colonoscopy, please give him GI scheduling number.

See full documentation

Order

(Order)

Allergies as of 6/19/2011

Reviewed On: 6/15/2011 By: Pamela Melis

No Known Allergies

Encounter Status

Electronically signed and closed by: Felissadee Campbell on 6/21/11 at 10:55 AM

LettersLetter Information**Margaret Hope Solomon on 6/21/2011**Status
Sent**Routing History**

Priority	Sent On	From	To	Message Type
	6/21/2011 10:55 AM	Felissadee Campbell	P CC RWC IM/PEDS MESSAGE POOL	
	6/21/2011 10:50 AM	Felissadee Campbell	P CC RWC IM/PEDS MESSAGE POOL	
	6/20/2011 4:12 PM	Leeann Perez	P CC RWC IM/PEDS MESSAGE POOL	
	6/19/2011 6:32 AM	Margaret Hope Solomon	P CC RWC IM/PEDS MESSAGE POOL	

Created by

Margaret Hope Solomon on 06/19/2011 06:31 AM

Outside Records**6/16/2011 Outside Records****Rick Jimenez | MRN: 20322546****Patient Information**

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Progress Notes

No notes of this type exist for this encounter.

Encounter-Level Documents:

Scan on 6/16/2011 by Connie Fondren : Federal Bureau of Prisons - Visit request

Encounter Status

Electronically signed and closed by: Connie Fondren on 6/16/11 at 2:29 PM

Office Visit**6/15/2011 Office Visit****Rick Jimenez | MRN: 20322546****Patient Information**

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Visit Information

Date & Time	Provider	Department	Encounter #
6/15/2011 9:20 AM	Margaret Solomon, MD	Rwc Im/Peds	185850815

Referring Provider

Margaret Hope Solomon

Reason for Visit

BACK PAIN-OTHER**Vitals**

Vitals	Most Recent Value
BP	120/82 mmHg
Temp	97.6 °F (36.4 °C)
Temp src	TEMPORAL
Pulse	76
Resp	16
Height	5' 4" (1.626 m)
Weight	172 lb (78.019 kg)

Pain Information (Last Filed)

Score	Location	Comments	Edu?
6	Back		

All Flowsheet Templates (all recorded)Encounter Vitals Flowsheet**Substances and Sexuality as of 6/15/2011**

Smoking Status	Amount
Current Every Day Smoker	0 packs/day for 0 years
Smokeless Tobacco Status	
Unknown	
Alcohol Use	Amount
No	N/A
Drug Use	Frequency
Not Asked	N/A
Sexually Active	Partners
Not Asked	N/A

BMI Data

Body Mass Index	Body Surface Area
29.50 kg/m ²	1.88 m ²

Allergies as of 6/15/2011

Reviewed On: 6/15/2011 By: Pamela Melis

No Known Allergies

Visit Notes

LEEANN PEREZ Wed Jun 15, 2011 10:28 AM
 ua taken to mini lab Maggie Lora M.A. (she was on her way to mini lab w/another pt's labs)

LEEANN PEREZ Wed Jun 15, 2011 10:26 AM
 Pt signed pain contract with provider.

PAMELA MELIS Wed Jun 15, 2011 9:44 AM
 The medical assistant for this encounter is Pam Melis.

Patient is being seen in clinic today for followup on back pain meds

Patient is an established patient. Vitals performed, history and allergies reviewed by Pamela Melis.
 Reviewed and reconciled patient's medications.

Nursing Notes

No notes of this type exist for this encounter.

Pharmacist Notes

No notes of this type exist for this encounter.

Progress Notes

Margaret Hope Solomon at 6/19/2011 6:33 AM

Status: Addendum

Back Pain:**History of Present Illness:**

- Duration of time back pain has been a problem: since 2004
- Intensity of pain (scale of 0-10): varies, 6-8
- Location of back pain: cervical, lumbar
- History of injury to the back? (how, when, where): yes, back in 2004, lifting an engine block crushed some vertebrae and tore some tendons
- Frequency of episodes of back pain (N/A if this is first episode): pretty constant
- Duration of each back pain episode (N/A if this is first episode): constant
- History of back surgery?: no
- Personal history of cancer?: no
- History of MRI scan of the back?: yes
- Medications tried for back pain?: ibuprofen, lortab,

Targeted Review of Systems:

- Does pain radiate to a leg?: yes
- Fever or chills?: no
- Unexplained weight loss?: no
- Change in bowel or bladder function?: no
- Dysuria (burning with urination): no
- Hematuria (blood in urine): no
- Muscle cramps?: yes
- Weakness in a leg?: no
- Numbness or tingling in foot/feet?: yes

<S>

Patient is a 50 year old male who presents for initial visit with me re back pain.

-recently released from Pennsylvania prison, in halfway house nearby now. Reports he was in prison for "being near guns" but denies h/o substance abuse.

-back pain as reviewed above. Pain is in lower back, also has neck pain and headaches. Intermittent cramps in feet. Pain radiates down R and L leg. Has done PT in past and it was helpful. Has had imaging, results not available.

-tells me he had a stroke after his back injury and had residual L sided weakness.

-h/o GERD, has some intermittent trouble swallowing. Does take Ibuprofen. He is unsure if he has had a prior EGD.

-allergies: gets nasal congestion, some eye watering.

Past Medical History**Diagnosis**

Date

- Herniated intervertebral disk
- Tendon disorder
 - Reports torn tendon in right leg*
- Environmental allergies
- Chronic hypotension
- H/O: stroke

No family history on file.

No past surgical history on file.

Current outpatient prescriptions ordered prior to encounter

Medication	Sig	Dispense	Refill
• Ibuprofen 800 MG OR Tab	1 po TID with food prn	90	0
• Omeprazole 20 MG OR CAPSULE DELAYED RELEASE	1 tab po twice daily	60	0
• Loratadine (CLARITIN) 10 MG OR Tab	1 tab po at night for allergies, prn	30	2
• Fluticasone Propionate (FLONASE) 50 MCG/ACT NA Suspension	2 sprays each nostril daily	1	2

<O>

Physical exam:

GENERAL: Patient is alert and interactive. Patient is in no apparent distress.

HEAD: atraumatic and normocephalic

EYES: normal bilaterally, PERRL, conjunctiva non-erythematous and sclerae anicteric

EARS: Rightnormal canal, no cerumen impaction, non-tender and TM light reflex normal
Leftnormal canal, no cerumen impaction, non-tender and TM light reflex normal

NOSE: normal, nares patent, mucosa nl, clear mucous

ORAL: clear/normal in appearance, tonsils non-enlarged, without exudate

NECK: full ROM, lymphadenopathy absent, supple and thyromegaly absent

CHEST: no retractions, symmetrical and non-tender

LUNGS: clear all lung fields, A-P Bilaterally

CARDIAC: regular rate and rhythm, normal S1 and S2 heart sounds and no murmus/gallops/rubs

EXTREMITIES: no clubbing, cyanosis, or edema. Pulses and perfusion are normal.

NEURO: Alert and oriented. Slightly diminished strength L > R upper extremity, normal patellar DTRs. Straight leg raise + B. No focal neurological deficits are noticed.

SKIN: normal, no lesions and pink, warm, dry

<A/P>

724.2 Lumbago (primary encounter diagnosis)

Comment: chronic low back pain, he has requested records of prior imaging, sx seem stable. Narcotic pain contract signed, Utox today, monthly visits for med refills. Will have him do physical therapy.

Plan: DRUG OF ABUSE 9PNL,UA,W/CONFIRM, CONSULT,
PHYSICAL THERAPY, Hydrocodone-Acetaminophen
7.5-500 MG OR Tab, COLLECTION VENOUS
BLOOD,VENIPUNCTURE, SPECIMEN HANDLING,DR
OFF->LAB

V76.51 Special screening for malignant neoplasms, colon

Comment: has not had screening colonoscopy.

Plan: COLONOSCOPY REFERRAL, COLLECTION VENOUS
BLOOD,VENIPUNCTURE, SPECIMEN HANDLING,DR
OFF->LAB

530.11 Reflux esophagitis

Comment: refer for egd, has rx for omeprazole. Serum H pylori was positive, will refer to egd to confirm.

Plan: EGD REFERRAL, COLLECTION VENOUS
BLOOD, VENIPUNCTURE, SPECIMEN HANDLING, DR
OFF->LAB

477.9 Allergic rhinitis, cause unspecified

Comment: using flonase and loratadine with good effect.

Plan: COLLECTION VENOUS BLOOD, VENIPUNCTURE, SPECIMEN
HANDLING, DR OFF->LAB

272.4 Hyperlipidemia LDL goal < 100

Comment: check lipids, given unclear h/o prior CVA target goal < 100.

Plan: LIPID PANEL, COLLECTION VENOUS
BLOOD, VENIPUNCTURE, SPECIMEN HANDLING, DR
OFF->LAB

436 Stroke syndrome

Comment: history unclear, will try to obtain records, consider adding daily ASA

Plan: COLLECTION VENOUS BLOOD, VENIPUNCTURE, SPECIMEN
HANDLING, DR OFF->LAB

Return to clinic if symptoms persist or worsen or for any other concerns.

After visit summary given to patient and information reviewed with patient.

F/u 1 month for med refills.

Margaret Solomon, MD

Revision History

**H&P Notes**

No notes of this type exist for this encounter.

Current Immunizations

Never Reviewed

No immunizations on file.

SmartForms

Procedure Checklist
Aud Devices

Encounter Status

Electronically signed and closed by: Margaret Hope Solomon on 6/19/11 at 6:30 AM

Diagnoses

Lumbago - Primary	724.2
Special screening for malignant neoplasms, colon	V76.51
Reflux esophagitis	530.11
Allergic rhinitis, cause unspecified	477.9
Hyperlipidemia LDL goal < 100	272.4
Stroke syndrome	436

Order

(Order)

The codes documented are preliminary and upon coder review with provider may be revised to

meet compliance requirements.

Order Summary

COLLECTION VENOUS BLOOD, VENIPUNCTURE [36415 CPT(R)] Order #: 25311063
 COLONOSCOPY REFERRAL [CN0131 EC AMB] Order #: 25284158
 CONSULT, PHYSICAL THERAPY [CN0020 Custom] Order #: 25311061
 DRUG OF ABUSE 9PNL, UA, W/CONFIRM [80101 Custom] Order #: 25284160
 EGD REFERRAL [CN0145 EC AMB] Order #: 25284159
 LIPID PANEL [80061 CPT(R)] Order #: 25311060
 SPECIMEN HANDLING, DR OFF->LAB [99000 CPT(R)] Order #: 25311064

Medications

Hydrocodone-Acetaminophen 7.5-500 MG OR Tab Order #: 25311062

Other Orders

		Ordered On
COLONOSCOPY REFERRAL	Edit Results (In process)	6/15/2011
EGD REFERRAL	Edit Results (In process)	6/15/2011
CONSULT, PHYSICAL THERAPY	Enter Results	6/15/2011
COLLECTION VENOUS BLOOD, VENIPUNCTURE	Enter Results	6/15/2011
SPECIMEN HANDLING, DR OFF->LAB	Enter Results	6/15/2011

Level of Service

OFFICE/OUTPT VISIT, EST, LEVEL IV
 [99214]

Patient Instructions

None

Result Summary for COLONOSCOPY REFERRAL

Result Information

Status	Provider Status
In process (6/27/2011)	Open

Entry Date

6/27/2011

Result Narrative

Mailed letter and colonoscopy instructions on 6.16.11
 Kaitlyn
 Called home number, GEO Group residential center, it gave
 options, got operator she said that she would give him a msg.
 /06.27.11 mpaskett

Result Summary for EGD REFERRAL

Result Information

Status	Provider Status
In process (6/27/2011)	Open

Entry Date

6/27/2011

Result Narrative

Mailed letter and EGD instructions on 6.16.11
 Kaitlyn
 Called home number, GEO Group residential center, it gave
 options, got operator she said that she would give him a msg.
 /06.27.11 mpaskett

Result Summary for DRUG OF ABUSE 9PNL,UA,W/CONFIRM**Result Information**

Status	Provider Status
Final result (6/16/2011 3:34 PM)	Reviewed

Entry Date

6/16/2011

Component Results

Component	Value	Flag	Range	Units	Status
Amphetamines, Urine	Negative				Final
Barbiturates, Urine	Negative				Final
Benzodiazepines, Urine	Negative				Final
Marijuana, Urine	Negative				Final
Cocaine, Urine	Negative				Final
Methadone, Urine	Negative				Final
Opiates, Urine	Negative				Final
Phencyclidine, Urine	Negative				Final
Propoxyphene, Urine	Negative				Final
Creatinine, Urine	217.6		20.0 - 400.0	mg/dL	Final
CDASU 9 Comments	See Note				Final

Comment:

TEST INFORMATION: Drug Panel 9, Urn, Screen w/Rflx to Conf

1. Drugs Covered and Cutoff Concentrations:

Drugs/Drug Classes	Screen	Confirmation
Marijuana	20 ng/mL	5 ng/mL
Cocaine	150 ng/mL	50 ng/mL
Opiates	300 ng/mL	5 ng/mL
Oxycodone.....	100 ng/mL	5 ng/mL
Phencyclidine	25 ng/mL	10 ng/mL
Amphetamines	300 ng/mL	200 ng/mL
MDMA (Ecstasy).....	500 ng/mL	200 ng/mL
Barbiturates	200 ng/mL	50 ng/mL
Benzodiazepines	200 ng/mL	20 ng/mL
Methadone	150 ng/mL	10 ng/mL
Propoxyphene	300 ng/mL	10 ng/mL

Oxycodone results will be reported with the opiates results. MDMA results will be reported with the amphetamines results.

2. For medical purposes only; not valid for forensic use.

3. 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, diluted/adulterated urine, or limitations of testing. The concentration at which the screening test can detect a drug or metabolite varies within a drug class. Specimens for which drugs or drug classes are detected by the screen are reflexed to a second, more specific technology (GC/MS and/or LC-MS/MS). The concentration value must be greater than or equal to the cutoff to be reported as positive. Interpretive

questions should be directed to the laboratory.

Lab and Collection

DRUG OF ABUSE 9PNL,UA,W/CONFIRM (Order #25284160) on 6/15/2011 - Lab and Collection Information

Result History

DRUG OF ABUSE 9PNL,UA,W/CONFIRM (Order #25284160) on 6/16/11 - Order Result History Report.

Result Summary for LIPID PANEL

Result Information

Status	Provider Status
Abnormal Final result (6/15/2011 12:05 PM)	Reviewed

Entry Date

6/15/2011

Component Results

Component	Value	Flag	Range	Units	Status
CHOLESTEROL,TOTAL	200	(H)	0 - 199	mg/dL	Final
TRIGLYCERIDE	145		0 - 150	mg/dL	Final
HDL Cholesterol	41		40 - 60	mg/dL	Final
LDL, CALCULATED	130	(H)	0 - 129	mg/dL	Final
Very Low Density Lipoprotein, Calc	29		0 - 30	mg/dL	Final
NON-HDL CHOL, CALCULATED	159			mg/dL	Final

Comment:

Non-HDL cholesterol is a secondary target of therapy in persons with high serum triglycerides (greater than 199 mg/dL). The goal for non-HDL cholesterol in persons with high triglycerides is 30 mg/dL higher than their LDL cholesterol goal.

CHOL/HDL RATIO	4.9	0.0 - 6.0	Final
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Lab and Collection

LIPID PANEL (Order #25311060) on 6/15/2011 - Lab and Collection Information

Result History

LIPID PANEL (Order #25311060) on 6/15/11 - Order Result History Report.

Living Will

On File
No

Letters

Letter Information

<u>Margaret Hope Solomon on 6/15/2011</u>	Status Sent
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Letter Information

<u>Margaret Hope Solomon on 6/16/2011</u>	Status Sent
---	----------------

Letter Information

<u>Margaret Hope Solomon on 6/16/2011</u>	Status Sent
---	----------------

Letter Information

<u>Margaret Hope Solomon on 8/8/2011</u>	Status Sent
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Chart Review Routing History

No Routing History on File

Office Visit

6/13/2011 Office Visit

Rick Jimenez | MRN: 20322546

Patient Information

Patient Name	Sex	DOB
Jimenez, Rick (20322546)	Male	7/4/1960

Visit Information

Date & Time	Provider	Department	Encounter #
6/13/2011 5:25 PM	Michael Flynn, MD	Rwc Urgent Care	185850498

Referring Provider

Self Referring

Reason for Visit

BACK PAIN-OTHER

Vitals

Vitals	Most Recent Value
BP	130/72 mmHg
Temp	97.4 °F (36.3 °C)
Temp src	TEMPORAL
Pulse	100
SpO2	97 %
Weight	172 lb (78.019 kg)

Pain Information (Last Filed)

Score	Location	Comments	Edu?
8	Back		

All Flowsheet Templates (all recorded)Encounter Vitals Flowsheet**Substances and Sexuality as of 6/13/2011**

Smoking Status	Amount
Current Every Day Smoker	0 packs/day for 0 years
Smokeless Tobacco Status	
Unknown	
Alcohol Use	Amount
No	N/A
Drug Use	Frequency
Not Asked	N/A
Sexually Active	Partners
Not Asked	N/A

Reviewed On: 6/13/2011 By: Nina Kapetanovic

Allergies as of 6/13/2011

No Known Allergies

Visit Notes

NINA KAPETANOVIC Mon Jun 13, 2011 5:40 PM

Patient is a new patient. Vitals performed, history and allergies reviewed by Nina Kapetanovic.
Reviewed and reconciled patient's medications.

Nursing Notes

No notes of this type exist for this encounter.

Pharmacist Notes

No notes of this type exist for this encounter.

Progress Notes

Michael Flynn at 6/13/2011 5:58 PM

Status: Signed

The medical assistant and/or scribe for this encounter is Nina Kapetanovic

S- Richard Jimenez is a 50 year old male presenting to address the following issue(s):

Pt here with upper and lower back pain. Reports he has herniated disks. States he usually takes IBU and Lortab for pain; ran out on Wednesday

Current meds: blood pressure meds, Ranitidine and IBU.

Back Pain:

History of Present Illness:

- Location: upper and lower back
- Duration of symptom(s): about 5 days
- Injury to the back? (how, when, where): Reports herniated disks
- Medications tried for back pain?: IBU, Lortab

Targeted Review of Systems:

- Area of pain?: upper and lower back
- Does pain radiate down?: yes, right side
- Numbness or tingling arms/feet?: yes, always present
- If non-injury: blood in urine or pain with urination? no

PFSH:

- Past history of back surgery? no

Has hx of GERD. Well controlled with medications.

'bleeding ulcer' a few years back. He doesn't remember how this was diagnosed.

'medication for low blood pressure'

Two different antacids he was given. Had a three times a day.

meds for migraines: Ibuprofen, helps with this.

Has taken naproxen, which works for a few months.

No dark tarry stools. No vomiting.

Lortab for back pain. 2 herniated disks/4 on bottom.

Was told the only thing to help would be to fuse spine.

Tendon injury in ankle/groin.

'in prison because he was in reach of guns'.

Gets bad allergies, and has a medication for that.

No lung/heart problems.

General Review of Systems

Past Medical History

Diagnosis

Date

- Herniated intervertebral disk
- Tendon disorder
Reports torn tendon in right leg
- Environmental allergies
- Chronic hypotension

History

Social History

- Marital Status: Single
- Spouse Name: N/A
- Number of Children: N/A
- Years of Education: N/A

Occupational History

- Not on file.

Social History Main Topics

- Smoking status: Current Everyday Smoker
- Smokeless tobacco: Not on file
- Alcohol Use: No
- Drug Use: Not on file
- Sexually Active: Not on file

Other Topics

Concern

- Not on file

Social History Narrative

- No narrative on file

O-

Filed Vitals:	
	06/13/11 1732
BP:	130/72
Pulse:	100
Temp:	97.4 °F (36.3 °C)
TempSrc:	Temporal
Weight:	172 lb (78.019 kg)
SpO2:	97%
PainSc:	Eight
PainLoc:	BACK

The Physical Exam SmartForm was not used in this encounter.

Comfortable, no distress

Chest clear

CV rrr

Tender posterior neck.

Tender lower back diffusely.

A/P-

346.90 Migraine NOS/not intrcbl

Comment: intermittent, No t changed. ibuprofen

Plan:

724.5 Back pain

Comment: Chronic, upper and lower. rec heat, antiinflam. Defer narcotic prescribing until hx is more clear

Plan: f/u pcp.

530.11 Reflux esophagitis

Comment: Pretty severe, though no signs of bleeding

Plan: COMPLETE CBC & AUTO DIFF WBC, METABOLIC

PANEL, COMPREHENSIVE

restatr ppi at bid, check h pylori. Follow up with any worsening of symptoms, failure of symptoms to resolve, or recurrence.

Revision History**H&P Notes**

No notes of this type exist for this encounter.

Current Immunizations

Never Reviewed

No immunizations on file.

SmartFormsProcedure ChecklistAud Devices**Encounter Status**

Electronically signed and closed by: Michael Flynn on 6/13/11 at 6:49 PM

Diagnoses

Migraine NOS/not intrcbl	346.90
Back pain	724.5
Reflux esophagitis	530.11

Order

(Order)

The codes documented are preliminary and upon coder review with provider may be revised to meet compliance requirements.

Order Summary

COMPLETE CBC & AUTO DIFF WBC [85025 CPT(R)] Order #: 25284152

IMMUNOASSAY, INFECTION AGENT, QUAL [86318 CPT(R)] Order #: 25284157

METABOLIC PANEL, COMPREHENSIVE [80053 CPT(R)] Order #: 25284153

Medications

Fluticasone Propionate (FLONASE) 50 MCG/ACT NA Suspension Order #: 25284156

Ibuprofen 800 MG OR Tab Order #: 25284151

Loratadine (CLARITIN) 10 MG OR Tab Order #: 25284155

Omeprazole 20 MG OR CAPSULE DELAYED RELEASE Order #: 25284154

Discontinued Medications

Omeprazole 20 MG OR CAPSULE DELAYED RELEASE Order #: 25284150

Level of ServiceOFFICE/OUTPT VISIT,NEW,LEVL III
[99203]**Patient Instructions**

None

Result Summary for COMPLETE CBC & AUTO DIFF WBC**Result Information**

Status	Provider Status
Abnormal Edited (6/13/2011 6:33 PM)	Reviewed

Entry Date

6/13/2011

Component Results

Component	Value	Flag	Range	Units	Status
White Blood Cell Count	8.9		3.9 - 11.6	x10 ³ /uL	Final
Red Blood Cell	4.20	(L)	4.4 - 6.18	x10 ⁶ /uL	Final
Hemoglobin	13.3		13.3 - 16.8	g/dL	Final
HCT	39		39 - 53	%	Final
Mean Corpuscular Volume	92.9		80 - 100	um ³	Final
Mean Corpuscular Hemoglobin	31.7		26 - 35	pg	Final
Mean Corpuscular HGB Concentration	34.1		31 - 36	%	Final
Red Cell Distribution Width	12.8		11.5 - 14.8	%	Final
Platelet	264		140 - 440	x10 ³ /uL	Final
Mean Platelet Volume	6.8	(L)	6.9 - 12.2	um ³	Final
Lymphocyte %	22.1		10 - 50	%	Final
Monocyte %	6.6		4 - 12.8	%	Final
Granulocyte %	63.8		42 - 72	%	Final
Lymphocyte #	2.0		1.1 - 4.3	x10 ³ /uL	Final
Monocyte #	0.6		0 - 0.8	x10 ³ /uL	Final
Granulocyte #	5.6		1.5 - 7.5	x10 ³ /uL	Final
Basophil #	0.3	(H)	0 - 0.2	x10 ³ /uL	Final
Eosinophil #	0.4	(H)	0 - 0.3	x10 ³ /uL	Final
Eosinophil %	4.1		0.5 - 11.0	%	Final
Basophil %	3.4		0 - 3.4	%	Final

Lab and Collection

COMPLETE CBC & AUTO DIFF WBC (Order #25284152) on 6/13/2011 - Lab and Collection Information

Result History

COMPLETE CBC & AUTO DIFF WBC (Order #25284152) on 6/13/11 - Order Result History Report.

Result Summary for METABOLIC PANEL,COMPREHENSIVE

Result Information

Status	Provider Status
Final result (6/13/2011 7:10 PM)	Reviewed

Entry Date

6/13/2011

Component Results

Component	Value	Flag	Range	Units	Status
SODIUM	140		136 - 144	mmol/L	Final
POTASSIUM	4.3		3.5 - 5.1	mmol/L	Final
Chloride, Serum or Plasma	106		102 - 112	mmol/L	Final
Glucose, Fasting	75		75 - 106	mg/dL	Final
BLOOD UREA NITROGEN	19.0		9 - 22	mg/dL	Final
CREATININE	1.5		0.8 - 1.5	mg/dL	Final
Calcium, Serum or Plasma	9.4		8.4 - 10.2	mg/dL	Final
TOTAL PROTEIN	7.1		6.2 - 7.8	g/dL	Final
ALBUMIN	4.4		3.5 - 4.6	g/dL	Final
Aspartate Aminotransferase	23		14 - 50	U/L	Final
Alkaline Phosphatase	120		38 - 126	U/L	Final
TOTAL BILIRUBIN	0.3		0.2 - 1.3	mg/dL	Final
Carbon Dioxide, Serum or Plasma	25		20 - 31	mmol/L	Final
Anion Gap	14		7 - 16	meq/L	Final
Alanine Aminotransferase	29		9 - 52	U/L	Final
EGFRE Calc	50			mL/min/1.73 m ²	Final

Comment:

Average GFR for 50-59 years: 93 mL/min/1.73 m

Chronic Kidney Disease: <60 mL/min/1.73 m

Kidney Failure: <15 mL/min/1.73 m

To estimate the glomerular filtration rate for African Americans, multiply the result provided by 1.21.

Estimated Glomerular Filtration Rate (eGFR) calculated by MDRD equation. The MDRD equation has been validated for adults older than 18 and younger than 70 years of age. The calculation is not applicable for persons with unstable serum creatinine and is inaccurate for persons with extreme body habitus.

Lab and CollectionMETABOLIC PANEL, COMPREHENSIVE (Order #25284153) on 6/13/2011 - Lab and Collection Information**Result History**METABOLIC PANEL, COMPREHENSIVE (Order #25284153) on 6/13/11 - Order Result History Report.**Result Summary for IMMUNOASSAY, INFECT AGENT, QUAL****Result Information**

Status	Provider Status
Abnormal Final result (6/13/2011 6:38 PM)	Reviewed

Entry Date

6/13/2011

Component Results

Component	Value	Flag	Range	Units	Status
H PYLORI AB, IGG	POSITIVE	(A)	NEGATIVE		Final

Lab and Collection

IMMUNOASSAY,INFECT AGENT,QUAL (Order #25284157) on 6/13/2011 - Lab and Collection Information

Result History

IMMUNOASSAY,INFECT AGENT,QUAL (Order #25284157) on 6/13/11 - Order Result History Report.

Living Will

On File

No

Chart Review Routing History

No Routing History on File

Addendum C

13-00604-1

THIRD JUDICIAL DISTRICT COURT
FOR SALT LAKE COUNTY, STATE OF UTAH

STATE OF UTAH,)	
)	
Plaintiff,)	
)	
VS.)	Case No. 131905941
)	
RICK JIMENEZ,)	
)	JURY TRIAL
Defendant.)	

BEFORE THE HONORABLE DENISE P. LINDBERG

SCOTT M. MATHESON COURTHOUSE
450 South State Street
Salt Lake City, Utah 84111

FILED DISTRICT COURT
Third Judicial District

JUNE 17, 2014

DEC 03 2014
SALT LAKE COUNTY
Deputy Clerk

FILED
UTAH APPELLATE COURTS
MAR 02 2015

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A P P E A R A N C E S

FOR THE STATE:

Peter Leavitt
SALT LAKE COUNTY DISTRICT ATTORNEY'S OFFICE
111 East Broadway, Suite 400
Salt Lake City, Utah 84111
Telephone: 801.363.7900

FOR THE DEFENSE:

Scott Wilson
SALT LAKE LEGAL DEFENDER ASSOCIATION
424 East 500 South Suite 300
Salt Lake City, Utah 84111
Telephone: 801.532.5444

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E X H I B I T s

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State's Exhibit Nos. 7 & 987
State's Exhibit No. 1491
State's Exhibit Nos. 5-6, 8, 10-11108
State's Exhibit No. 12135
State's Exhibit No. 13158

1 **MR. LEAVITT:** Your Honor, before the defense presents
2 its evidence, I do have a motion I would like to make outside
3 the presence of the jury.

4 **THE COURT:** All right.

5 **MR. LEAVITT:** Mr. Wilson had mentioned earlier that
6 he had intended to admit some medical records. I received
7 those in discovery from Mr. Wilson. They are the defendant's
8 medical records dating back to -- gol, I think 2007 or
9 something. Anyway, it's a large history of his medical
10 records. My objection at this point is for their admission on
11 the ground of relevance. I don't see how the defendant's
12 medical records from quite a long history of time -- the
13 closest to this that I see in here is -- it looks like April,
14 maybe of 2000 -- well, July of 2012. And again, my objection
15 is they're not relevant pursuant to Rule 401 under the
16 [inaudible], Your Honor.

17 **THE COURT:** Okay. And Mr. Wilson, your response?

18 **MR. WILSON:** Well, the response is that my client has
19 back problems and is disabled and among other maladies which he
20 has been treated for. And the manner of getting into this home
21 would be highly unlikely considering his disability. And he's
22 some on pain medication for his back problem and for other -- I
23 mean, see he's got the support for his carpal tunnel and one of
24 his wrists. He had a cane previously.

25 He has very difficult -- he has great difficulty in

1 moving and therefore this -- to climb up on a garage can, which
2 they're suggesting, and crawling through a window of some
3 height above is unlikely considering his medical condition.
4 And therefore the jury should be apprized of that in making
5 their deliberations as to whether he's the one who did the
6 burglary.

7 **THE COURT:** Didn't you indicate that your client is
8 going to be testifying?

9 **MR. WILSON:** He is.

10 **THE COURT:** So those -- I guess the question is: The
11 relevance of the specific monthly records when that
12 information -- to the extent that -- that it would have the
13 relevance to identify medical issues...

14 **MR. WILSON:** It's just to corroborate his testimony
15 that he has these medical issues and has difficulty in moving
16 and this scenario, pattern he's gotten into, this house, will
17 be highly unlikely as a result of those conditions.

18 **THE COURT:** State's response?

19 **MR. LEAVITT:** Most of that's argument, the high
20 unlikely part. The medical records aren't going to give an
21 opinion on whether or not he can do that or not. There may be
22 documentation of -- what I see is documentation of doctors
23 visits where the defendant is self reporting an injury.

24 **MR. WILSON:** That's correct.

25 **MR. LEAVITT:** I don't -- I don't necessarily -- there

1 is -- there is not X-rays or some type opinion by the doctor
2 about what he can or can't do. These are self-reporting
3 incidents of the defendant going to doctors, trying to get pain
4 medication. Don't think that that's relevant.

5 And I think that the only thing that makes it
6 relevant simply an argument by counsel that the records aren't
7 going to state that. It's an additional argument he's making
8 that -- that gets it even close to relevance. This is simply
9 just the defendant self-reporting to a doctor. No one is going
10 to come in and testify about what that injury means, what
11 exactly it was, how it was verified, if it was verified or what
12 he would be able to do as a result of the injury.

13 MR. WILSON: Well, that's something that state can
14 argue in their closing.

15 MR. LEAVITT: No, I'm not going to flip the burden.
16 I can't -- I can't argue that.

17 MR. WILSON: Yes, you can. You can say this has no
18 effect on him because it hasn't been shown that it shown him.
19 He is going to testify as to what effect it had that he has
20 gone into -- said his treatment that he's received drugs as the
21 record will so indicate and that it is -- he couldn't get
22 through that window; he couldn't get up on that garbage can.

23 And then it will be up to the jury as to whether to
24 believe him and this is to corroborate the fact that he has
25 received treatment for what he is going to explain to the jury

1 is his disability.

2 MR. LEAVITT: The treatment is giving pain pills,
3 that's it.

4 MR. WILSON: No, there is physical therapy and pain
5 pills.

6 THE COURT: What is -- well, I can't see any
7 relevance to anything, anything, that -- let me restate it.

8 The only potentially relevant piece of medical record
9 would be something dating from 2012. Nothing else would be --
10 would be relevant to show because if I'm hearing correctly, the
11 most recent -- the most latest self-report is in June or July
12 of 2012; is that correct?

13 MR. LEAVITT: Actually, the one in October -- wait,
14 sorry.

15 MR. WILSON: It's a long history of it.

16 MR. LEAVITT: Patient last seen January of 2012. He
17 was seen in January of 2012. Other records of him calling in
18 and asking for pain meds.

19 MR. WILSON: Is not -- this is an ongoing problem of
20 his. It has been in existence for a substantial amount of
21 time. It didn't end. He did go to jail as a result of another
22 charge that was dismissed, which is part of the reason that he
23 doesn't have any more documents going forward. It's long
24 standing problem, physical problem, that he's having.

25 And this shows the history of it and the drug that he

1 has obtained for several years, the physical therapy that he's
2 received as a result of it.

3 THE COURT: When he was last seen on January of
4 2012 --

5 MR. WILSON: January 23, 2012.

6 THE COURT: What was that for?

7 MR. LEAVITT: What was your question?

8 THE COURT: What -- what is -- what is the purpose of
9 the visit and were there any tests done? Was there any --

10 MR. LEAVITT: I'm not -- I'm not certain [inaudible].

11 MR. WILSON: No, there is just a -- I only want to
12 introduce a portion of it because some of -- some of it
13 mentions jail, prison. So it goes through a whole lot of
14 things as to his -- this is from Dr. Solomon, progress notes.

15 MR. LEAVITT: What page are you on?

16 MR. WILSON: History and present illness. Page 11.
17 Duration of symptoms, one year. Frequency of symptoms, daily.
18 Which leg effected, both.

19 You know, it goes to the whole -- I mean, I could
20 read every one of these. Numbness, tingling, in feet or leg,
21 yes. Muscle cramps, yes. Color change in feet, no. Hair loss
22 on feet, no. I mean, it's a whole --

23 THE COURT: Okay. Counsel, this was -- this is a
24 matter that should have been addressed as a motion in limine
25 with an opportunity to --

1 **MR. WILSON:** I've already provided it to you -- to
2 the State, Your Honor.

3 **THE COURT:** But you didn't bring it to me in advance
4 of today. We don't reacted records. You already indicated
5 that you want to read portions of it and leave other portions
6 out. It -- we're dealing with very old records. And so no.

7 You have -- you had the opportunity to bring this
8 matter in advance, you choose not to. I'm not going to sit
9 here and have incomplete records presented or incomplete
10 information or --

11 **MR. WILSON:** Well, then I will ask that they all be
12 introduced then.

13 **THE COURT:** -- selectively presented information.
14 And the -- anything that is relevant -- anything that you
15 include is -- at most would be cumulative of the testimony that
16 he's going to be presenting. So the motion is denied.

17 **MR. WILSON:** Well, I move to --

18 **MR. LEAVITT:** Actually, it was my motion to not have
19 the --

20 **THE COURT:** I'm sorry. The motion granted. The
21 State's motion is granted.

22 **MR. WILSON:** So I want to introduce them as an avow.

23 **THE COURT:** As an avow?

24 **MR. WILSON:** Yes, ma'am.

25 **THE COURT:** What is that?

1 **MR. WILSON:** So that the court of appeals can look at
2 these to determine if that is necessary, can look at these to
3 determine whether they should have been introduced. They are
4 certificated medical records. The only reason they are being
5 excluded is supposedly for relevance and the --

6 **THE COURT:** And the failure to present that in
7 advance --

8 **MR. WILSON:** Right.

9 **THE COURT:** -- when I specifically asked, always, do
10 we have motions in limine, do we need to brief those motions in
11 limine. I'm told -- I'm told no. We don't have that and we --
12 and then at the last minute it gets brought here with
13 unredacted records. No.

14 **MR. WILSON:** So I want to tell you what I was wanting
15 to introduce for the record. And then I am willing to
16 introduce all of them so that they can be looked at at a later
17 time. It's page 11, 12, 13, 25, 26, 30, 38, 40, 43, 44, 45, 58
18 and 59 of pages 1 through 70. I think it's 70.

19 **MR. LEAVITT:** Yeah, there is 70.

20 **MR. WILSON:** Okay.

21 **THE COURT:** Well, and I guess I need to ask this the
22 state: Why wasn't this brought then as a motion in limine?

23 **MR. LEAVITT:** It's simple relevance objection, Your
24 Honor. I could object at any point --

25 **THE COURT:** Well, you can object at any point.

1 **MR. LEAVITT:** -- that it's not relevant, it's simply
2 an objection under 401. I'm addressing beforehand so that in
3 Mr. Wilson's opening statement he doesn't make mention of
4 inadmissible evidence. I'm making that motion now. I could
5 object I think the objection would certainly be sustained.
6 It's certainly a relevance objection. But it's a simple rule,
7 Rule 401. And that -- that's why I'm making the objection now
8 so that he doesn't bring it up in his opening statement.

9 If I may have -- since we're talking about
10 appellate -- if I could just have the benefit of the record.

11 **THE COURT:** You may.

12 **MR. LEAVITT:** I have made my arguments as far as Rule
13 401. The court has ruled and -- in regard to that and also to
14 timeliness. I would also, just again for the record, preserve
15 the record, just make the objection.

16 But also, the records, since they are the majority of
17 the problem self-reporting, those are inadmissible hearsay.
18 They are offered by the defendant. They are self-serving
19 statements. They are not necessarily admissible.

20 There is multiple layers of hearsay in medical
21 documents. The medical documents -- the medical records
22 exception gets the doctor's statements in. However, the doctor
23 is writing statements from the defendant that he is
24 self-reporting to them. That is hearsay. And not admissible
25 under any exception to the rule. I would like to declare that

1 as well.

2 And also Rule 403 since there is a very minimum
3 probative value. The prejudicial effect substantially
4 outweighs -- I'm making a record since you mentioned appeals,
5 that's all.

6 MR. WILSON: And I already have an envelope for them,
7 Your Honor, so that they can be marked as Defense Exhibit No. 1
8 and for purposes of the record.

9 THE COURT: Okay. As to the argument by the
10 prosecution regarding inadmissibility, I disagree. I believe
11 that to the extent that -- that they are made for unreasonably
12 pertinent to a medical diagnosis or treatment and describe the
13 medical history, past or present symptoms or sensations, their
14 general cost, their inception, all of that is clearly covered
15 by the exception to the hearsay rule for medical records and
16 for statements made in the medical diagnosis of treatment.

17 I disagree with the prosecution that they are so --
18 that they are un-- well, I just disagree with the prosecution's
19 position that it will not come in as hearsay under Rule 8034.
20 That my more fundamental question is the relevance of 2007
21 medical records or 2008, 2009, 2010, 2011. I am also --
22 especially since it apparently -- at least it's been
23 represented to me, does not include actually testing; does not
24 include actual evidence of objective measures other than
25 self-report.

1 Certainly self-report would be -- I believe under the
2 exception of the hearsay rule for purposes of giving
3 information to a physician or a medical practitioner for
4 purposes of treatment. But there -- and to the extent that
5 there are -- that the argument is that they are corroborative,
6 they are also cumulative.

7 And to the extent that they are -- records that even
8 assuming relevance, would have been -- would include
9 selective -- would have only been selective coverage of or
10 presentation of information which, as the defense has put on,
11 by simply naming what pages he wishes to include, you know,
12 clearly evidence that that would be a selective presentation
13 and were brought to a court in a properly redacted form and
14 were not properly raised to the court for prior determination
15 of admissibility. All those are my grounds for denial.

16 MR. WILSON: I would gladly --

17 THE COURT: Okay.

18 MR. WILSON: -- try to introduce all 1 through 70 if
19 the Court --

20 THE COURT: At point I've ruled.

21 MR. WILSON: -- is concerned about taking some out of
22 context so to speak.

23 THE COURT: All right.

24 MR. WILSON: And I would like to have this marked as
25 Defense Exhibit 1 and introduced by way of avow.

1 **THE COURT:** There was one more grounds for objection
2 by the State.

3 **MR. LEAVITT:** Rule 403.

4 **THE COURT:** Rule 403, which I do not believe -- I do
5 not believe that -- I guess, the state has not articulated what
6 the undue prejudice is that it would receive as a result and
7 while rule -- and 403 is a rule of inclusion rather than a rule
8 of exclusion, it has to be the -- probative value has to be
9 substantially outweighed by its prejudicial effect in the event
10 before it would even be excluded on that grounds.

11 And the State has not articulated any prejudice to
12 itself by it. But in any event, I'm not -- I'm not persuaded
13 that the probative value would be substantially outweighed by
14 it's probativeness to the extent that there were any rely --
15 any relevant records included there. And I'm not -- I'm not
16 concluded that there are relevant records.

17 I'm indicated that if there was relevance I do not
18 see why records so far in time that do not demonstrate more
19 specific medical action to establish [inaudible] [inaudible] in
20 the scheme of things rather than to this case. So that's my
21 ruling.

22 It will take --

23 **MR. WILSON:** Your Honor, I need a few more minutes.

24 **THE COURT:** That's fine. You take -- we'll indicate
25 to the jury that we're going to be taking a break.