



FOCUS
TIMELINE, LLC
ATTORNEY-READY MEDICAL CHRONOLOGIES

MEDICAL CHRONOLOGY

HENDERSON v. VALUE HEALTH

Date Range

08/12/2020-10/24/2020

Prepared for

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Prepared by Focus

Timeline LLC

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READER

THIS IS A FICTIONAL SAMPLE CASE CREATED FOR DEMONSTRATION PURPOSES ONLY. ALL
NAMES, DATES, AND CLINICAL DETAILS ARE NOT ASSOCIATED WITH ANY REAL INDIVIDUAL

How to Use This Medical Chronology

Purpose: This chronology product summarizes and organizes information contained within the records provided and is intended to facilitate efficient case review and document navigation. No medical opinions, causation opinions, legal conclusions, or expert witness services are provided.

- Snapshot = High-level overview of the clinical course and key events
- Master List = Consolidated index of encounters with source record navigation
- Chronology = Chronological summary of encounters with source record navigation
- Missing Records = Referenced records but not provided in raw documents
- Terms/Abbreviations = Quick-reference glossary
- Hyperlinks = First page number in range hyperlinked to source records
- Bookmarks = Quick product section navigation
- Fully searchable (OCR) = Instant keyword navigation

SAMPLE-FICTIONAL INFORMATION ONLY

SNAPSHOT

HENDERSON v. VALUE HEALTH

Clinical Overview

Records begin with the patient establishing primary care after approximately 20 years without regular medical follow-up, at which time a heavy smoking history, and chronic respiratory symptoms were documented, along with a new diagnosis of COPD. Records then continue document progressive respiratory complaints including repeated visits for shortness of breath, wheezing, hypoxia and COPD exacerbation symptoms.

Care included primary care and urgent care evaluations, emergency department treatment, inpatient hospitalizations, oxygen therapy, pulmonary referrals, antibiotics, steroids, and respiratory support interventions.

Records continue to document multiple episodes of declined follow-up care, AMA discharge events, and incomplete treatment encounters prior to later deterioration.

Subsequent records document Covid-19 infection with worsening respiratory distress, multi-focal pneumonia, sepsis, acute renal failure, ICU admission, ventilator support, cardiac arrest, and transition to comfort-focused care.

Final records document withdrawal of ventilator support and patient death on 10/26/2020.

SAMPLE-FICTIONAL INFORMATION ONLY

Master List—Index of Medical Records

HENDERSON v. VALUE HEALTH

Provider/Facility	Visit/Record Type	Date Range	Page Range
Value Health Primary Care	Primary Care	08/12/2020 09/08/2020 10/14/2020 10/19/2020	16-25 36-45 78-84 97-99
Value Health Urgent Care	Urgent Care	08/15/2020 09/09/2020	26-35 46-55
Value Health Memorial Emergency Department	Emergency Room	09/09/2020 10/17/2020 10/19/2020	56-68 85-96 100-105
Value Health Memorial Hospital	Hospital Admission	09/09/2020-09/12/2020 10/19/2020-10/24/2020	69-77 106-153

The first page number in each page range is hyperlinked to the corresponding source record

SAMPLE-FICTIONAL INFORMATION ONLY

Medical Chronology

HENDERSON v. VALUE HEALTH

08/12/2020—Value Health Primary Care

Reason for Visit: To establish care (no consistent medical care for the past 20 years documented per patient). SOB on exertion, persistent cough, heavy smoking history documented.

Documented Findings: Vital Signs: BP 179/111, HR 125, RR 20, SpO₂ 92%. Exam: mild SOB with exertion, diffuse wheezing and rhonchi. Imaging-CXR: hyperinflation of lungs with flattening of the diaphragm, no acute infiltrates.

Interventions: Decadron and DuoNeb given in clinic. Prescriptions for albuterol inhaler, Symbicort, prednisone and Norvasc.

Outcome / Follow-up: COPD exacerbation, Hypertension, improved with treatment in clinic. Discharged home, pulmonologist referral placed, follow-up this clinic 1 week. Patient later declined to schedule pulmonology and clinic follow-up appointments, stating “ I do not need to follow-up, I feel better”, per administrative note.

Source: pp. 16-25

08/15/2020—Value Health Urgent Care

Reason for visit: Right knee pain, swelling, no known injury.

Documented Findings: Exam: Afebrile. Right knee with swelling, warmth, tender to touch, and limited ROM due to pain. No erythema or drainage. Imaging-Right knee x-ray: Degenerative changes, soft tissue swelling, small joint effusion, no fracture.

Interventions: Toradol IM given in clinic, ace wrap applied, and crutches given. Prescription for Mobic given.

Outcome / Follow-up: Arthritis flare right knee. Compression, rest, elevate and ice recommended. Discharged home with orthopedic referral scheduled for 09/01/2020 per administrative note.

Source: pp. 26-35

09/08/2020—Value Health Primary Care

Reason for visit: SOB, Cough, wheezing.

Documented Findings: Vital Signs: HR 116, SpO₂ 90%. Exam: Alert, mild distress with SOB on exertion. Lungs with diffuse wheezing and rhonchi.

Interventions: EMS called, patient declined transport to ER. AMA forms signed. DuoNeb, Decadron, Nasal O₂ given in clinic. Prescriptions for Doxycycline, prednisone.

SAMPLE-FICTIONAL INFORMATION ONLY

Outcome / Follow-up: COPD exacerbation, SOB, hypoxia. Pulmonologist referral placed, follow-up emphasized. Follow-up primary care in 2 days. Go to the ER if worsening. Patient declined to schedule pulmonology appointment per administrative note.

Source: pp. 36-45

09/09/2020—Value Health Urgent Care

Reason for Visit: SOB, cough, chest tightness.

Documented Findings: Vital Signs: BP 189/110, HR 128, RR 28, SpO₂ 87%, Temp 99.2. Exam: Alert, pale, SOB with moderate distress. Diffuse wheezing, rales, rhonchi and accessory muscle use. EKG: sinus tachycardia, rate 122, No obvious ST elevation.

Interventions: EMS called, oxygen administered, DuoNeb given, saline lock started.

Outcome / Follow-up: Respiratory distress, hypoxia, and chest tightness. Transported by EMS to the emergency room.

Source: pp. 46-55

09/09/2020—Bell Worth County EMS

Reason for call: SOB, cough, chest tightness. Transported from Value Health Urgent Care

Documented Findings: Vital Signs: BP 221/112, HR 132, RR 26, SpO₂ 92% on NRB, Temp 98.9. Exam: Pale, alert, SOB with moderate distress with talking or exertion. Diffuse wheezing, rales, rhonchi and accessory muscle use. EKG: sinus tachycardia, rate 122, No obvious ST elevation.

Interventions: EMS called, oxygen administered, DuoNeb given, saline lock started.

Outcome / Follow-up: Respiratory distress, hypoxia, and chest tightness. Transported by EMS to the emergency room.

Source: pp. 154

09/09/2020—Value Health Memorial Emergency Department

Reason for Visit: Arrival by EMS, respiratory distress, hypoxia, chest tightness.

Documented Findings: Vital Signs: BP 176/100, HR 140, RR 28, SpO₂ 91% on NRB, Temp 100.2. Exam: Drowsy, anxious, agitated, pale, diaphoretic. Tachypnea, accessory muscle use with diffuse rales, rhonchi and wheezing in lungs. Labs: WBC 16,000. Hgb 8.9, NA 126, K 3.4, Troponins x 3 stable per notes, Lactic acid 3.0, Procalcitonin 0.25, Blood cultures pending. Imaging-CXR: Infiltrate left lower lobe. EKG: Sinus tachycardia, rate 136, no STEMI.

Interventions: BiPAP, DuoNeb, and Decadron. Normal saline bolus, Rocephin, Azithromycin, and labetalol.

SAMPLE-FICTIONAL INFORMATION ONLY

Outcome / Follow-up: COPD exacerbation, pneumonia, hypoxia, hypertension, chest tightness. Admitted to inpatient medicine services.

Source: pp. 56-68

09/09/2020-09/12/2020—Value Health Memorial Hospital (Admission)

Reason for Admission: Admitted from the ER for pneumonia, COPD exacerbation, hypoxia, hypertension, and chest tightness. Stable, on BiPAP.

Hospital Course:

09/09/2020—Day 1: Day of Admission

Documented Findings: Exam: Alert, oriented, mild distress on exertion, mild rhonchi in lungs. Documented stable condition per note.

Interventions: BiPAP discontinued, placed on O₂ 6 liters. Continue current treatment plan.

Outcome / Follow-up: Continue inpatient admission.

Source: pp. 69-71

09/10/2020—Day 2:

Documented Findings: Vital Signs: SpO₂ 96% on 3 liters O₂ by NC. Exam: Mild rhonchi in lungs. Talking without difficulty. Mild overall improvement in condition per notes.

Interventions: O₂ lowered over night to 3 liters by nasal cannula.

Source: pp. 72-73

09/11/2020—Day 3:

Documented Findings: Exam: Stable, lung sounds clear. Imaging-CXR: Improving left lower lobe infiltrate.

Interventions: Oxygen lowered to 1 liter by nasal cannula. Continues on antibiotics. Incentive spirometer use. Pulmonology consult ordered.

Outcome / Follow-up: Tentative discharge in 3-4 days.

Source: pp. 74-75

09/12/2020—Day 4:

Documented Findings: Condition documented as stable. Signed out AMA because not allowed to go smoke per nursing notes. Labs: Blood cultures, no growth. Imaging-CXR: Improving left lower lobe infiltrate.

Interventions: Prescriptions for Cefdinir and Azithromycin given. Continue home medications. Pulmonology follow-up visit 09/23/2020, and primary care visit 09/28/2020.

Outcome / Follow-up: COPD, Pneumonia with hypoxia, clinically improved. Left AMA.

Source: pp. 76-77

10/14/2020—Value Health Primary Care

Reason for Visit: Arrives alone by private car. SOB on exertion, feels worse since leaving hospital AMA. Asking for home oxygen.

Documented Findings: Vital Signs: Temp 100.4, BP 161/89, Pulse 102, RR 20, SpO₂ 92% at rest, →88% with exertion. Exam: Alert, oriented, non-toxic, mild distress/SOB with exertion. Labs: Covid POC positive. CXR: Near complete resolution of previous pneumonia.

Interventions: 911 called, patient declined transport to ER, signed AMA forms. Decadron, DuoNeb given in clinic. Order placed for home oxygen.

Outcome / Follow-up: Covid-19, hypoxia. Follow-up visit at primary care 2 days. Advised to go to the ER if worsening.

Source: pp. 78-84

10/17/2020—Value Health Memorial Emergency Department

Reason for Visit: Arrives by private car with spouse. Covid-19, worsening SOB and chest tightness.

Documented Findings: Vital Signs: Temp 101.8, BP 181/109, HR 121, RR 24, SpO₂ 87% on room air → 94% on 3 L O₂ applied in triage. Exam: Alert, mild distress, tachypneic on exertion with expiratory wheezing and rhonchi. Labs: WBC 22,000, hgb 8.0, NA 128, K 3.5, and creatinine 2.2. Lactic acid 4, Procalcitonin 3. Blood cultures pending. CXR: Multi-focal pneumonia bilaterally. EKG: Sinus tachycardia, rate of 123, No STEMI.

Interventions: Nursing notes indicate patient to be roomed from triage ASAP per provider order. Labs, EKG, imaging completed from lobby.

Outcome / Follow-up: Covid-19, hypoxia, pneumonia. Per record, patient called from waiting area and not found. According to documented notes, patient left the ED lobby prior to completion of treatment, without notifying staff.

Source: pp. 85-96

10/19/2020—Value Health Primary Care

Reason for Visit: Arrives by private car with wife. Severe SOB, Covid-19 positive. Left the ER 10/17/202 before completion of care.

SAMPLE-FICTIONAL INFORMATION ONLY

Documented Findings: Vital Signs: Temp 103.0, BP 89/52, HR 160, RR 30, SpO₂ 82% RA → 89% on 4 L O₂. Exam: Pale, Tachypneic, Diaphoretic, drowsy, disoriented. EKG sinus tachycardia rate of 162, no ST elevation.

Interventions: EMS called, pt placed on oxygen by NRB.

Outcome / Follow-up: SOB, Covid-19, severe hypoxia. Transferred to the emergency department.

Source: pp. 97-99

10/19/2020—Value Health Memorial Emergency Department

Reason for Visit: Arrives by EMS, intubated, severe hypoxia, Covid-19.

Documented Findings: Vital Signs: Temp 102.8, BP 90/60, HR 164, SpO₂ 92% on ventilator. Exam: Pale, unresponsive, weak, rapid peripheral pulses. Lungs with rales, rhonchi and wheezing diffusely. Labs: WBC 30,000, Hgb 6.8, NA 124, K 3.0, Creatinine 3.6, ALT 600, AST 423. Lactic acid 6, Procalcitonin 4, and blood cultures pending. Imaging-CXR: Diffuse bilateral multifocal pneumonia, worse on comparison from 10/17/2020, EKG sinus tachycardia rate 162, no STEMI.

Interventions: Placed on ventilator, central line placement. Normal saline bolus, Rocephin, Vancomycin, Vasopressin, Propofol drip started.

Outcome / Follow-up: SOB, COPD, severe hypoxia, Covid-19 pneumonia, sepsis, and renal failure. Admitted to ICU by critical care team. Per record family desire full code status at this time.

Source: pp. 100-105

10/19/2020-10/24/2020—Value Health Memorial Hospital (Admission)

Reason for Admission: Admitted from the ER to ICU for Respiratory failure, Covid-19, pneumonia, sepsis, and acute renal failure.

Hospital Course:

10/19/2020—Day 1: Day of Admission

Documented Findings: Vital Signs: Temp 100.4, BP 88/60, pulse 126, RR 18, SpO₂ 92% on ventilator. Exam: Unresponsive and pale, with diffuse wheezing, rales, and rhonchi.

Interventions: Added Remdesivir and Acyclovir. Continue treatment initiated in ED. Consult for infectious disease placed.

Outcome / Follow-up: Continue inpatient ICU admission.

Source: pp. 106-109

10/20/2020—Day 2:

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Documented Findings: Remains on ventilator, unresponsive.

Interventions: Per infectious disease consult recommendations, continue current treatment plan and await blood culture results.

Source: pp. 110-111

10/21/2020—Day 3:

Documented Findings: Event: Cardiac arrest at 02:00 with ventricular fibrillation on monitor. Code blue alert.

Interventions: ACLS measures taken. Pulses returned after 14 minutes. Stable on ventilator. Amiodarone drip started. Current treatment plan continued. Family aware and full code status remains.

Source: pp. 112-115

10/22/2020—Day 4:

Documented Findings: Vital Signs: Temp 97.0, BP 78/49, HR 70, RR 18 and SpO₂ 90% on ventilator. Exam: Declining condition documented per notes. Labs: WBC 30,000, Hgb 5, NA 128, K 3.7, Creatinine 5.4, BUN 40, AST 400, ALT 485, Alkaline Phosphate 390. Blood cultures positive for Streptococcus pneumonia.

Interventions: Vancomycin stopped and Rocephin continued per infectious disease. Blood transfusion given. Nephrology and Palliative care consults placed. EEG ordered.

Source: pp. 116-118

10/23/2020—Day 5:

Documented Findings: Per notes, no meaningful change in patient status. Nephrology and Palliative care consults completed and no change in recommendations. Family counseled on declining condition.

Interventions: Continue supportive care. DNR paperwork initiated at family request.

Source: pp. 119-123

10/24/2020—Day 6:

Documented Findings: Urine output has decreased per nursing documentation. K 5.5, Creatinine 6.0, BUN 46, BP 65/38, HR 105, SpO₂ 90% on Ventilator. EEG. No meaningful cortical activity, and poor neurological prognosis. Family counseled at bedside

Interventions: Lokelma given. Continue supportive care.

Source: pp. 124-126

10/25/2020—Day 7:

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Documented Findings: Persistent renal and respiratory failure. No meaningful change in critical condition documented.

Interventions: Family counseled. Care transitioned to supportive/comfort focused care. Under Palliative care services.

Source: pp. 127-135

10/26/2020—Day 8:

Documented Findings: Condition continued to decline; family elected to withdraw ventilator support, patient extubated and expired shortly thereafter; family present at bedside.

Outcome / Follow-up: Patient expired, time of death 14:04.

Source: pp. 136-153

REFERENCED RECORDS NOT PROVIDED

HENDERSON v. VALUE HEALTH

The following items reflect records referenced, expected, or implied within materials reviewed but not included in the records provided.

Referenced Records Not Provided

- Orthopedic follow up visit note from urgent care, referenced 08/15/2020
- AMA form referenced 09/08/2020
- Admission History and physical inpatient admission note from Value Health Memorial Hospital admission referenced on 09/09/2020
- Radiology note on the chest X-ray referenced on 09/12/2020
- Pulmonology visit referenced on 09/12/2020 Day 4
- Primary care visit note referenced on 09/12/2020 Day 4
- AMA form referenced on 10/14/2020 Primary Care note
- Critical care team note referenced on 10/19/2020 Emergency Department note
- Infectious disease note referenced on 10/20/2020 Day 2

This section reflects documentation availability only and does not address appropriateness of care.

Dates on this page hyperlinked to Medical Chronology section for reference.

COMMON MEDICAL TERMS AND ABBREVIATIONS

Quick Reference

TERMS/ ABBREVIATIONS		TERMS/ ABBREVIATIONS	
A&O x 3	Alert and Oriented	AMA	Against Medical Advice
AMS	Altered Mental Status	BID	Twice Daily
BMI	Body Mass Index	BMP	Basic Metabolic Panel
BP	Blood Pressure	BUN	Blood Urea Nitrogen
CAD	Coronary Artery Disease	CBC	Complete Blood Count
CHF	Congestive Heart Failure	CMP	Comprehensive Metabolic Panel
COPD	Chronic Obstructive Pulmonary Disease	CP	Chest Pain
CT	Computed Tomography	CVA	Stroke
Disc	Intervertebral Disc	DM	Diabetes Mellitus
DNR	Do Not Resuscitate	DOE	Dyspnea on Exertion
DVT	Deep Vein Thrombosis	Dx	Diagnosis
ECG/EKG	Electrocardiogram	ED	Emergency Department
ER	Emergency Room	ETOH	Alcohol

TERMS/ ABBREVIATIONS		TERMS/ ABBREVIATIONS	
FH	Family History	Fx	Fracture
GERD	Gastroesophageal Reflux Disease	GI	Gastrointestinal
GU	Genitourinary	H&P	History and Physical
HPI	History of Present Illness	HR	Heart Rate
HTN	Hypertension (high blood pressure)	Hx	History
ICU	Intensive Care Unit	IV	Intravenous
LOC	Loss of Consciousness	MRI	Magnetic Resonance Imaging
NAD	No Acute Distress	NKDA	No Known Drug Allergy
NPO	Nothing by Mouth	OR	Operating Room
PE	Physical Examination	PMH	Past Medical History
PRN	As Needed	PSH	Past Surgical History
PT	Physical Therapy	PTA	Prior to Arrival
QID	Four Times Daily	ROS	Review of Symptoms
RR	Respiratory Rate	Rx	Prescription of Treatment Plan
SH	Social History	SpO₂	Oxygen Saturation

TERMS/ ABBREVIATIONS		TERMS/ ABBREVIATIONS	
TIA	Transient Ischemic Attack	TID	Three Times Daily
Tx	Treatment	URI	Upper Respiratory Infection
VSS	Vital Signs Stable	WBC	White Blood Cell Count
WNL	Within Normal Limits	XR	X-Ray

Common abbreviations/terms encountered in routine clinical documentation. Not exhaustive.

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Pg.16: 8/12/2020 Value Health Primary care

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Pg. 26: 8/15/2020 Value Health Urgent Care

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Pg. 36: 09/08/2020 Value Health Primary care

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Pg. 46: 09/09/2020 Value Health Urgent Care

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Pg. 56: 09/09/2020 Value Health Memorial Emergency Department

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Pg. 69: 09/09/2020 Value Health Memorial Hospital

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Pg. 72: 09/10/2020 Value Health Memorial Hospital

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Pg. 74: 09/11/2020 Value Health Memorial Hospital

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Pg. 78: 10/14/2020 Value Health Primary care

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Pg. 85: 10/17/2020 Value Health Memorial Emergency Department

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Pg. 97: 10/19/2020 Value Health Primary care

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Pg. 100: 10/19/2020 Value Health Memorial Emergency Department

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Pg. 106: 10/19/2020 Value Health Memorial Hospital

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