

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 1-13-10 Are you an AUM student? YES ☐ NO ☒

Name: ANITA C. ALL

Social Security Number: 316-52-3565 Birth Date: 1/29/49

Local Phone Number: 334-283-0022 Alternate Number: 334-414-5794

Local Address: 984 MUSKOGEE TRAIL Box Number: _____

City: TALLASSEE State: AL Zip Code: 36028

Permanent Address: SAME

City: _____ State: _____ Zip Code: _____

Please Circle Your Marital Status: Single ☐ Married ☒ Divorced ☐ Widowed ☐ Other _____

Sex: Male ☐ Female ☒ (Please Circle)

Primary Physician: Dr. P. Bayon City: Opelika Phone #: _____

Patient's Employer: Auburn University Work #: 334-244-3715

Parent's or Spouse's Name (Circle which): RICHARD Phone #: 54110

Parent's or Spouse's Employer: Retired Work #: _____

Emergency Contact: Richard All Relationship: Uncle Phone #: 334-414-5795

How did you hear about the Clinic? (Please Circle) Friend ☐ Faculty/Staff ☒ Orientation ☐ Other _____

INSURANCE INFORMATION

Do you have health insurance? YES ☒ NO ☐

If yes, please give your card to the receptionist in order for a copy to be made for your chart.

CONSENT FOR TREATMENT

I am requesting care for myself or my above named dependent and give my consent for treatment. I am responsible for all fees for services incurred at the Student Health Center (Nursing Care Center).

Signature X _____

Signature of patient or parent/guardian, if patient is a minor

Patient Bill of Rights

AUM Nursing Care Center (AUM NCC) exists primarily for the purpose of providing high quality care that meets or exceeds accepted standards for care. AUM NCC believes that each client is worthy of respect and understanding and has certain rights and responsibilities related to the care he/she receives. In accordance with this philosophy, AUM NCC wishes to advise you of the following rights and responsibilities and to assist you in understanding and exercising these rights.

As a client of AUM NCC, you have the right to:

1. Be treated with dignity, courtesy, and respect.
2. Obtain from caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. Know the identity of all caregivers involved in their care, as well as when those involved are students or trainees.
4. Know the immediate and long-term financial implications of treatment choices, insofar as they are known.
5. Make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and AUM NCC policy and to be informed of the medical consequences of the action. In case of refusal, the patient is entitled to other appropriate care and services or to be referred to another health care facility.
6. Receive competent, individualized quality services from AUM NCC regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, or any other category protected by law.
7. Expect confidentiality of all clinical records and access to your records on request. Information will not be released to anyone without your written consent or unless required by law.
8. Have family or guardian exercise these rights on your behalf if you are unable to do so yourself.
9. Voice grievances about care which is or is not provided, recommend policy/service changes, and make complaints without fear of reprisal or unreasonable interruption of care.

I also understand I have a responsibility to:

1. Provide accurate and complete information to AUM NCC regarding medical history and current condition and medications, and to promptly inform AUM NCC of any changes in this information.
2. Agree to accept all caregivers regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, being a qualified veteran of the Vietnam era, or any other category protected by law.
3. Participate in planning, evaluation and revising my plan of care to the degree that I am able to do so and to take responsibility for my actions and for the impact that those actions have on my health and recovery.
4. Adhere to the plan of care which I have participated in developing.
5. Treat AUM NCC staff with respect, courtesy, and consideration.

I have read and understand the above Patient Bill of Rights and agree to the contents thereof.

Patient Signature: _____

Date: _____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Avita All Date of Birth 1/29/49

General Consent for Treatment

I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Student Health Center. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

Avita All
Signature of Patient

9/1/15
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

AUM Student Health Services

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this 1 day of Sept 2015.

Print Patient Name

Avita Hill

Signature

Avita Hill

Relationship to Patient

Self



AUM Student Health Services
Medical Information Release Form
(HIPAA Release Form)

Name: Anita ALL Date of Birth: 1/18/91

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☒ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☒ my cell Number: 334-414-5794

If unable to reach me:

☒ you may leave a detailed message

☒ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) _____ between (time) _____

Signed: Anita ALL Date: 9/1/15



SERVICES CONSENT FORM

NAME: _____

DATE OF BIRTH: _____

I AM REQUESTING CARE FOR MYSELF OR MY ABOVE NAMED DEPENDENT AND
GIVE MY CONSENT FOR TREATMENT. I AM RESPONSIBLE FOR ALL BILLS
INCURRED AT THE NURSING CARE CENTER.

SIGNATURE: _____

DATE: _____

SIGNATURE: _____

DATE: _____

SIGNATURE: _____

DATE: _____

SIGNATURE: _____

DATE: _____

SIGNATURE: _____

DATE: _____

SIGNATURE: _____

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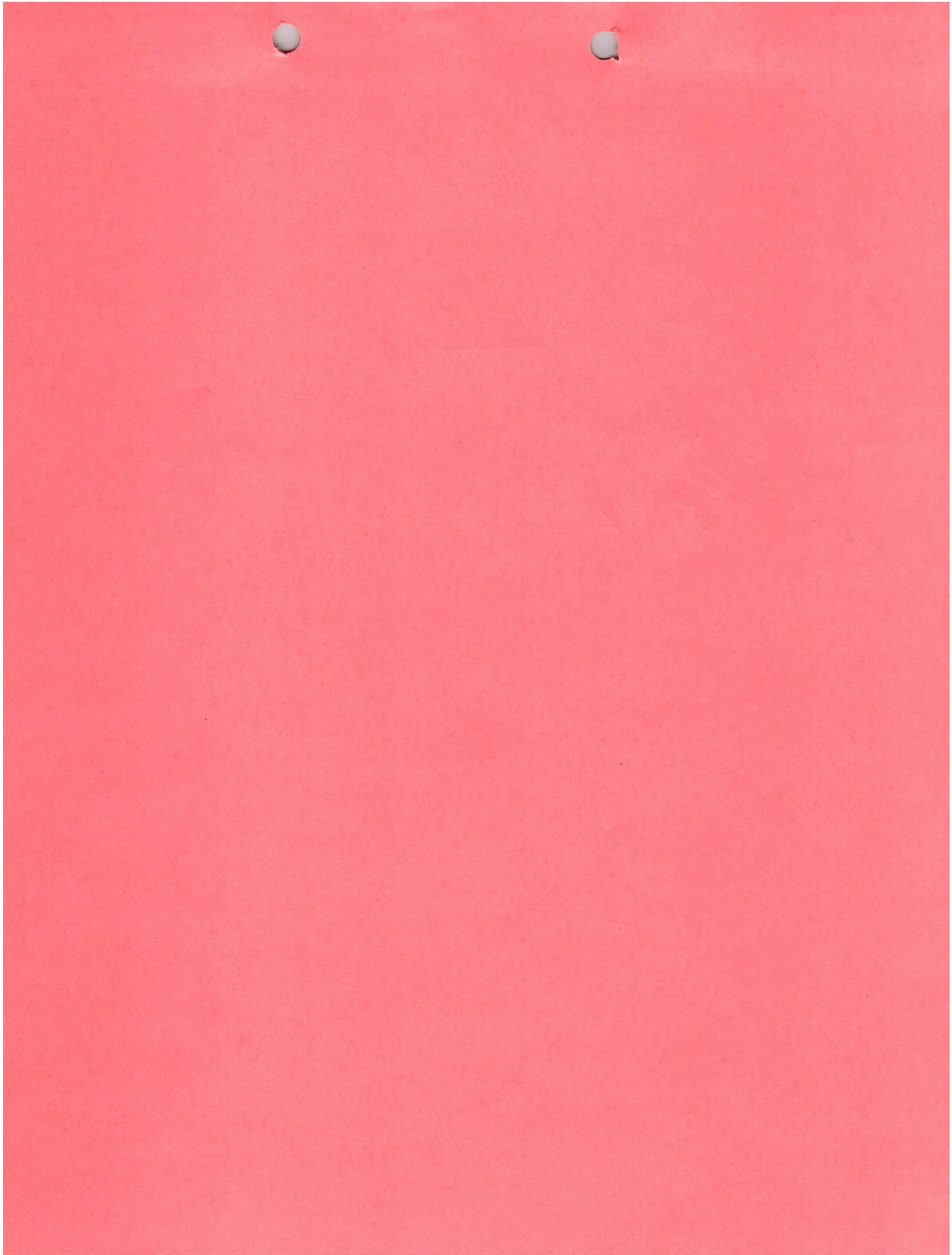
DATE: _____

SIGNATURE: _____

DATE: _____

SIGNATURE: _____

DATE: _____



AUM Student Health Services
Medical Information Release Form
(HIPAA Release Form)

Name: Anita A 12 Date of Birth: 10/13/14

Release of Information

☒ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☒ Spouse Richard

☐ Child(ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☒ my cell Number: 334-414-5794

If unable to reach me:

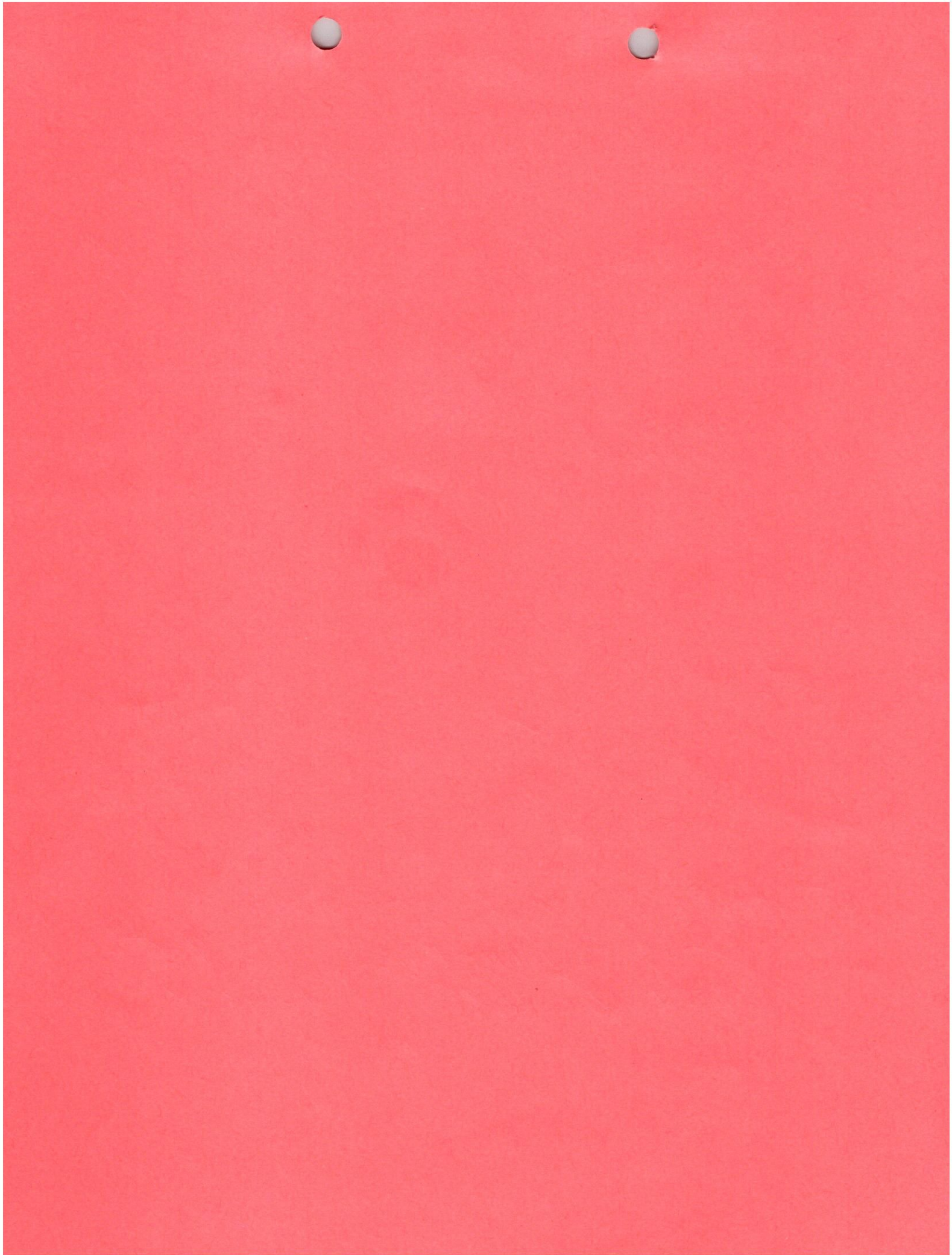
☒ you may leave a detailed message

☐ please leave a message asking me to return your call

☒ DICK AIL - text 334-414-5795

The best time to reach me is (day) MON-FRI between (time) 9-5

Signed: Anita A-12 Date: 10/13/14



AUM Student Health Services PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

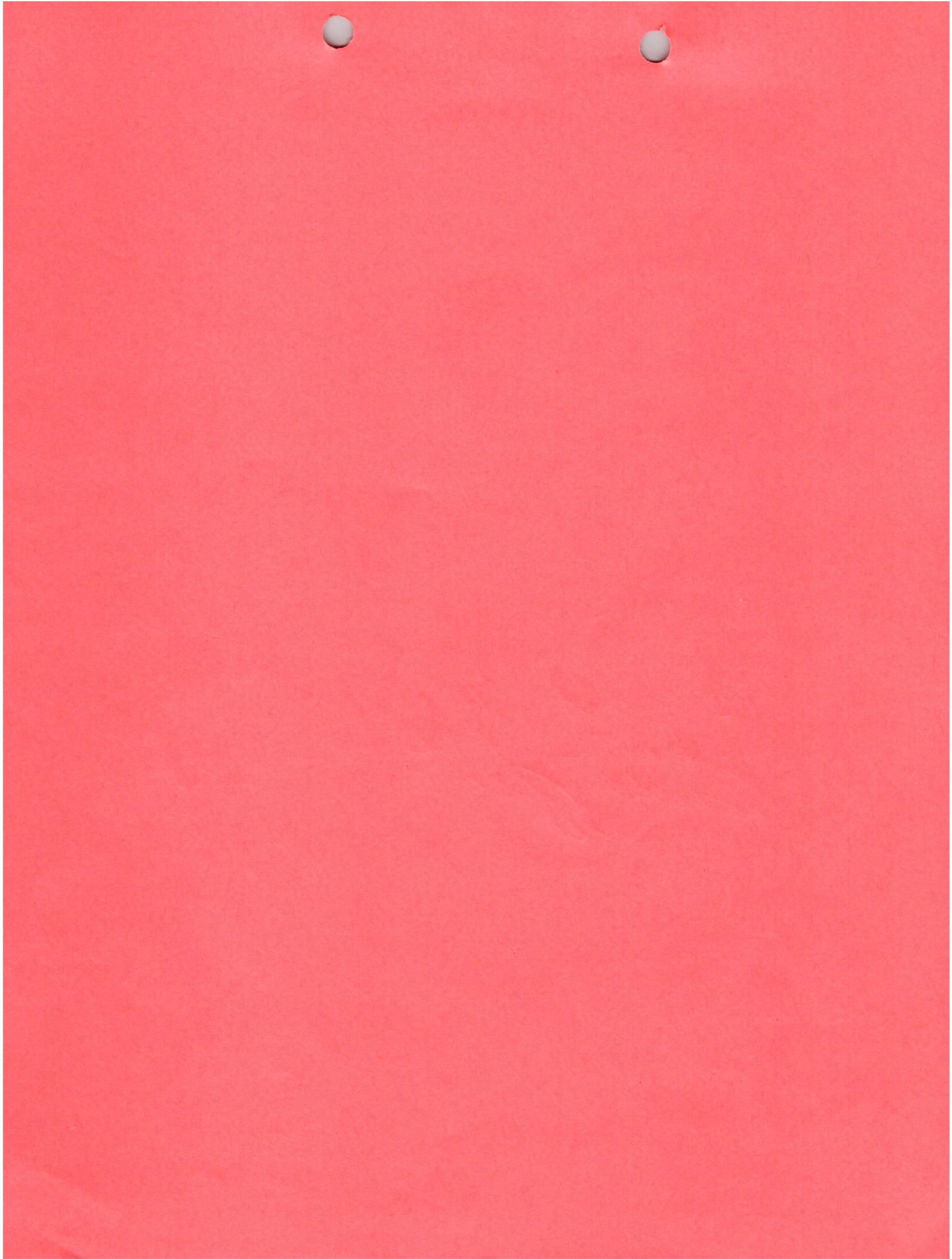
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this 13 day of Oct 2014.

Print Patient Name Anita ALG

Signature Anita ALG

Relationship to Patient Self



Orineta Day

3-30-15 TC

Trazadone 50mg $\frac{1}{2}$ at 11:00 go to H.S

pm sleep # 60 noisier x 2

Moved into Low-mast Terrace

(334) 991-2207. Lasterest, CRN

7-9-15 11:00

Trazadone 50mg $\frac{1}{2}$ at 11:00 p.m. H.S

pm sleep # 30 noisier

Moved into Low-mast Terrace

Lasterest, CRN

AUM NURSING CARE CENTER PROBLEM VISIT RECORD

DATE: _____ TIME: _____ PT. HISTORY REVIEWED / UPDATED: _____ / _____ / _____
 PATIENT NAME: _____ DOB: _____ AGE: _____
 PRESENT COMPLAINT: _____

MEDICATIONS:						LMP:
Temp	Pulse	Resp	B/P	HT	WT	Allergies

INITIAL VISIT	RETURN VISIT
Skin	
Sinuses	
Ears	
Eyes	
Nose	
Throat	
Neck/ Back	
Heart	
Lungs	
Abdomen	
GU/GI	
Extremities	

DIAGNOSIS: _____ _____ _____ _____	<u>TESTS</u>	<u>RESULTS</u>

PLAN:

CALL BACK:

PRACTITIONER SIGNATURE: _____ STAFF SIGNATURE: _____
 AUDIT DATE: _____ COMMENTS: _____
 PHYSICIAN SIGNATURE: _____

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE: 11/18/10 TIME: 1445 PT. HISTORY REVIEWED / UPDATED:

PATIENT NAME: Anita All DOB: AGE:

PRESENT COMPLAINT: Cultured out MRSA last January in nasal area. Has lesions now in nares. (+) dripping. & congested. NO known fever. NO HAs.

MEDICATIONS: HTN, Zocor, Exemalta, Lyrica

Temp	Pulse	Resp	B/P	HT	WT	LMP:	Allergies
98.3			104/78				Doxycycline, sulfa

INITIAL VISIT		RETURN VISIT
Skin	<u>Currently using Bactroban</u>	
Sinuses	<u>no swelling</u>	
Ears		
Eyes		
Nose	<u>(+) nares red. & obstruction</u>	
Throat	<u>no swelling noted</u>	
Neck/ Back		
Heart		
Lungs		
Abdomen		
GU/GI		
Extremities		

DIAGNOSIS: <u>H/O MRSA</u>	TESTS	RESULTS

PLAN: Cont. Bactroban for a total of 5 days (PRN)

CALL BACK:

PRACTITIONER SIGNATURE: [Signature] STAFF SIGNATURE: [Signature]

AUDIT DATE: COMMENTS:

Anita ALL

Allergies: Sulfa Drugs, Doxycycline
Propulsid

AM-MEDS

- | | |
|-----------------------------------|---------------------------|
| 1.) Calcium+D 1200mg | 10. Cymbalta 60mg
T AM |
| 2.) NABUMETONE 750mg | 12. LUVAZA
2 gm AM |
| 3.) Prilosec OTC i | |
| 4.) Lisinopril 20mg | |
| 5.) ERYTHROMYCIN 250mg | 13. ZOCOR 20mg
AM |
| 6.) PRILASEC 0.3mg | |
| 7.) HTEZ 25mg | 14. Felodipine |
| 8.) TOPRAI XL 50mg | 14. VITAMIN
90mg qd |
| 9.) CLINDAMYCIN TOPICAL | |
| 10.) LYRICA 25mg 75mg | |

1-12-10

90 Continued fatigued since
surgery approx 6 wks ago.

Concerned thyroid reversal may
be out of response.

A: Thyroid palpable, no masses

O: Fatigue ? origin

P: CBC, Thyroid profile

Continued, up

1-13-10

Continued of poor results.

advised to F/U regular M.D.

! Surgeon.

Continued up



Anita ALL

PRN MEDS:

- 1.) IMITREX Intectable
- 2.) HYDROXYAMINE 0.125 mg SL
- 3.) PROMETHAZINE 25 mg
- 4.) HYDROXYZINE HCL 25 mg
- 5.) TRAVOCET-N
- 6.) TRIAMCINOLONE ACETONIDE Cream 1%

Anita ALL

PM MEDS:

- 1.) Lyrica 75 mg
- 2.) Calcium + D 600 mg
- 3.) ERYTHROMYCIN 250 mg
- 4.) ~~FELCIPINE 2.5 mg~~
- 5.) ~~CITAPROPRAM HBR 20 mg~~
- 6.) Lisinopril 20 mg
- 7.) Ambien CR
- 8.) LOVAZA 2 gm PM
- 9.) ~~ESTRACE~~ FEMTAS

Anita ALL

ALLERGIES: Sulfur Drugs, Doxycycline
Proplisid

AM-MEDS

- 1.) Calcium + D 1200 mg
 - 2.) ~~NABUMETONE 750 mg~~
 - 3.) Prilosec OTC 1
 - 4.) Lisinopril 20 mg
10. Cymbalta 60 mg T AM
11. LOVAZA 2 gm AM



AUM NURSING CARE CENTER
ADOLESCENT/ADULT HEALTH HIST

Date _____

Name _____

Anita AL

1. What is the reason for your visit today? *Fatigue*
2. Is there anything about you and your health that we need to know? _____

- *3. List medicine, drugs, or food you are allergic to: *Aspirin, Sulfa Drugs, doxycycline*
- *4. List any medicines or drugs you take: _____

5. Have YOU or anyone in your family had any of the following: (circle)

heart disease

high blood pressure

stroke

diabetes/sugar

blood problem or disease

cancer

tuberculosis

birth defects

mental retardation

nerve or mental problems

asthma

died before age 50

other "family" disease

6. Have you ever been in the hospital? *YES* Why? *Surgery*
7. Have you ever had surgery? *YES* Why? *Arise, cervical hernia*
8. Have you ever had a serious accident? _____
9. Have you had serious or recent problems with:

ears or throat

NO YES

cough

NO YES

kidneys

NO YES

gallbladder

NO YES

allergies

NO YES

thyroid

NO YES

weight loss

NO YES

liver

NO YES

lung infections

NO YES

skin problems

NO YES

ulcers

NO YES

depression

NO YES

headaches

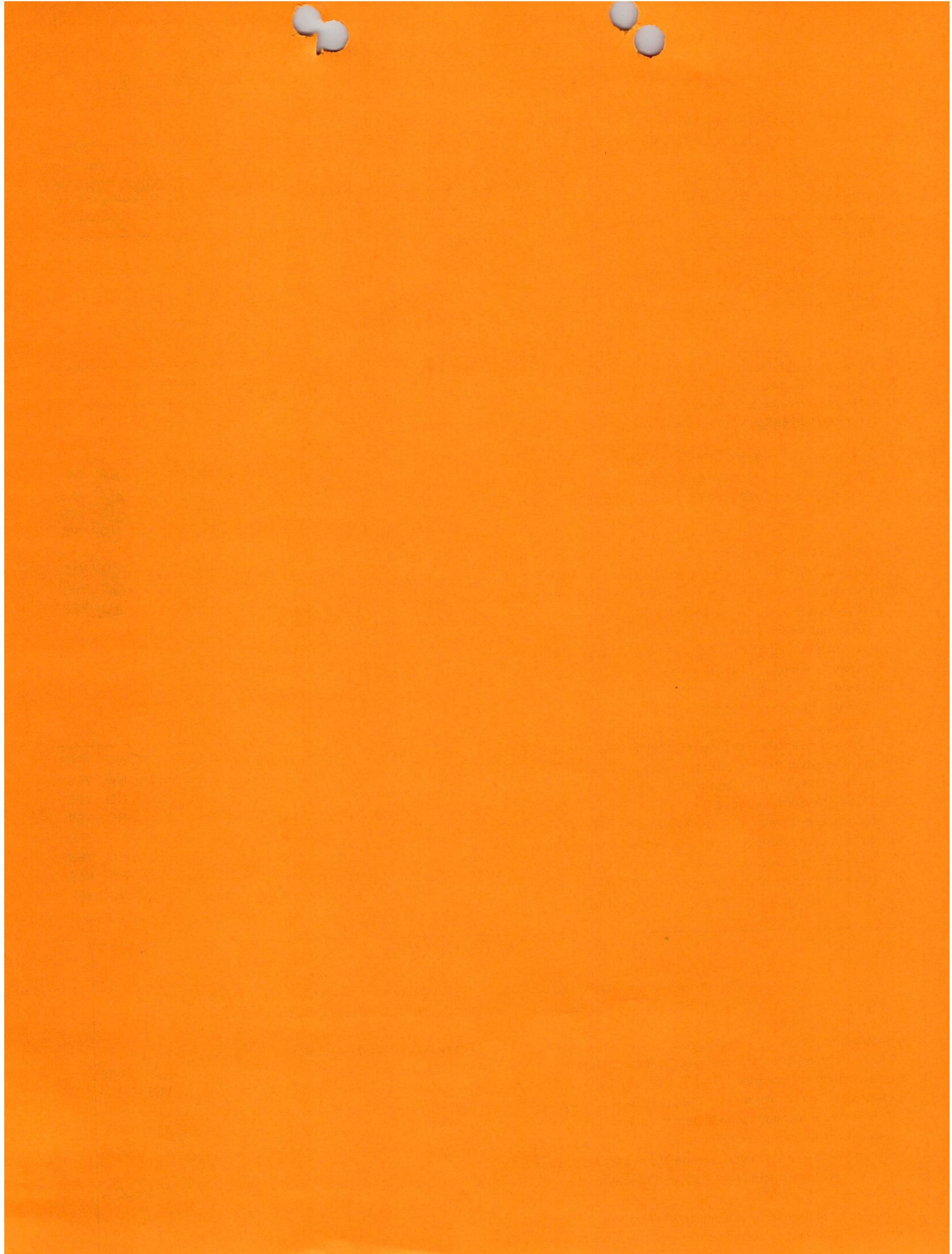
NO YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? NO YES
- *12. Have you ever smoked cigarettes or used smokeless tobacco? NO YES
- If yes, are you an: Ex-smoker? Smoking now? Do you smoke (less) (more) than a pack a day?
- How much smokeless tobacco do you use a day? _____
- *13. How often do you drink beer, wine, wine coolers, or liquor?
- Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week
- If you drink beer, wine, wine coolers, or liquor, do you have:
- (less) (more) than 5 drinks a day?

- *14. Have you ever used marijuana, cocaine, crack or other drugs? NO YES
- *15. Have you ever used I.V. drugs? NO YES
16. Have you ever had a blood transfusion? NO YES
17. Do you have any tattoos? NO YES
18. Have you ever been treated for a venereal disease? NO YES
19. Have you had more than one sex partner in the past 5 years? NO YES
20. Have you ever had sex with a member of your own sex? NO YES
21. Have you had or been around anyone with hepatitis? NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? *11* Date of your last period? *20 yr ago*
- How often do you have your periods? _____ Are they regular? _____
- How many days do they last? _____
- Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
- B. Do you have any problems with your breasts (lumps, discharge, or other)? NO YES
- Do you check them regularly? YES NO
- *C. How many times have you ever been pregnant? *1* How many children are living? *1*
- Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? NO YES
- Were any of your children premature? NO YES
- How old were you when your first child was born? *22*
- D. Have you ever used: (circle NO/YES) birth control pills? NO YES foam? NO YES; condoms? NO YES IUD? NO YES
- diaphragm? NO YES
- E. Did you have problems with any of these methods? NO YES
- F. Have you ever had an abnormal PAP smear? NO YES



AUM NURSING CARE CENTER MEDICATION RECORD

PATIENT NAME: <u>Anita All</u>	DATE: <u>10/23/12</u>
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ALLERGIES/ MEDICAL ALERT: <u>Doxycycline, Sulfa</u>	BIRTHDATE:
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PHARMACY:	PHONE:
-----------	--------

DATE	MEDICATION	DOSAGE	ROUTE	FREQ	COMMENTS	INITIALS
10/23/12	Sandostatin LAR	20 mg/aml	IM	q month	19C 1 1/2" (R) G-lot	AM
					PLEASE PEEL OFF OUTER LAYER AFTER PRODUCT SUSPENSION Diluent for suspension of Sandostatin LAR® Depot Each syringe contains: sodium CMC 12.5 mg mannitol 15.0 mg water for injection 2.5 mL STORAGE: Refrigerate at 2 °C- 8 °C (36 °F-46 °F). Rx only Manufactured for: Novartis Pharmaceuticals Corporation East Hanover, NJ 07936 85059001 EXP. FEB2015 LOT 342487	
11/19/12	Sandostatin LAR	20 mg/aml	IM	q month	19C 1 1/2" (R) G-lot	AM
					PLEASE PEEL OFF OUTER LAYER AFTER PRODUCT SUSPENSION Diluent for suspension of Sandostatin LAR® Depot Each syringe contains: sodium CMC 12.5 mg mannitol 15.0 mg water for injection 2.5 mL STORAGE: Refrigerate at 2 °C- 8 °C (36 °F-46 °F). Rx only Manufactured for: Novartis Pharmaceuticals Corporation East Hanover, NJ 07936 85059001 EXP. MAR2015 LOT 342775	
11/11/13	Sandostatin LAR	30 mg/aml	IM	q month	19C 1 1/2" (R) G-lot	AM
					PLEASE PEEL OFF OUTER LAYER AFTER PRODUCT SUSPENSION Diluent for suspension of Sandostatin® LAR Depot Each syringe contains: sodium CMC 12.5 mg mannitol 15.0 mg water for injection 2.5 mL STORAGE: Refrigerate at 2 °C- 8 °C (36 °F-46 °F). Rx only Manufactured for: Novartis Pharmaceuticals Corporation East Hanover, NJ 07936 1081374 EXP. JUN2015 LOT 343450	

INITIALS	SIGNATURE	INITIALS	SIGNATURE
AM	<u>[Signature]</u>		30 mg Sandostatin® LAR Depot (octreotide acetate for injectable suspension) Rx only Novartis Pharmaceuticals Corporation East Hanover, NJ 07936 NOVARTIS ©Novartis



**AUM Adult Child Screening and Immunization Documentation Form
2014-2015 Influenza Vaccination Program**

Patient Information:

Last Name: ALL First Name: Anita Date of Birth: 1-29-49 M/F (Circle) F
 Phone #: 334-414-5794 Local Address: 954 Mulholland Blvd Dallas TX 75208
 Emergency Contact: John Physician (Name/Number): Dr. D. Brown

Please Carefully Read and Answer the Following Questions: (circle your answer)

1	Do you currently feel sick or have a fever?	Yes	<u>No</u>
2	Are you taking any prescription medications to prevent or treat influenza? (Amantadine, Rimantidine, Tamiflu®, Relenza®) Have you taken any antivirals in the past 48 hours?	Yes	<u>No</u>
3	Have you ever had a serious reaction to the flu vaccine? Please describe:	Yes	<u>No</u>
4	Do you have an allergy to any of the following: eggs, latex, gentamicin, neomycin, formaldehyde? List any allergies:	Yes	<u>No</u>
5	Do you have a chronic health problem such as: heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorder?	<u>Yes</u>	No
6	Do you have an active neurological disease (a disease of the brain, nervous system, etc.)?	Yes	<u>No</u>
7	Do you have a history of Guillain-Barre Syndrome (GBS)?	Yes	No
8	Has your doctor ever told you that you have an immune system disorder? Are you currently taking long-term corticosteroids (prednisone, methylprednisolone, etc.); immunosuppressants; chemotherapy; biologic immune modulating medications such as Remicade®, Enbrel®, Humira®, etc? Do you have an inflammatory condition such as arthritis, asthma, psoriasis, inflammatory intestinal disease, etc.?	Yes	<u>No</u>
9	Do you have HIV, cancer, or have you received an organ transplant?	Yes	<u>No</u>
10	Do you live with, care for, or have close contact with anyone who is severely immunocompromised or someone who has to be in protective environment (such as transplant patients)?	Yes	<u>No</u>
11	Have you received any vaccines in the past 30 days or do you plan to receive any vaccines in the next 4 weeks?	Yes	<u>No</u>
12	For children 3-8 years of age: since 2010 have you received 2 doses of the influenza vaccine given in the same season?	Yes	No
13	Is there any chance that you are currently pregnant?	Yes	<u>No</u>
14	Please list all of the medications that you currently take (including supplements and over the counter medications) so the healthcare provider administering the vaccine can conduct a medication screening to ensure you are a candidate.		

"I have read (or have had explained to me) the information in the **2014-2015 Inactivated Influenza Vaccine Information Statement (VIS)**. I have also had an opportunity to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine, and I consent to receive the vaccine."

Signature: Anita E. [Signature] Date: 9-30-14

ASSESSMENT BY IMMUNIZATION CERTIFIED HEALTHCARE PROVIDER:

FOR CLINIC USE ONLY Provider-Initial when done: Patient was: ___ Observed x 15 minutes w/o reaction ___ instructed to use TYLENOL if needed, not ASA	Vaccine Information Statement (VIS) Provided: ___ Inactivated Influenza Vaccine 2014-2015 Interviewer's Signature: _____ Date: _____
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DOCUMENTATION OF VACCINE ADMINISTRATION

Administered By: <u>[Signature]</u> Date: <u>9/30/14</u>  Influenza Vaccine FLUARIX® QUADRIVALENT 2014/2015 Formula 0.5 mL Mfd. by GlaxoSmithKline Biologicals NDC 58160-901-41 	Inactivated Influenza: Manufacturer: GSK Lot# 7LE2S Dose: 0.5 ml Route: IM Site: <u>Left</u> Right Deltoid
--	--

Notes:

467899



** REPRINT **

ALL, ANITA
FUENTES
AUM NURSING CARE CENTER
7461 EAST DRIVE
MONTGOMERY, AL 36117

01/08/2010 01/08/2010 01/11/2010
2:00 PM 5:35 PM 6:00 AM

436099 K6963796

60 F UNKNOWN 9501 1

01/29/1949

Pt Ph:

MRN:

PT ID#:

REQ#:

CBC

WBC	11.20	4.0-11.7	THOU/CUMM
RBC	4.79	4.2-5.4	MILL/CUMM
HEMOGLOBIN	12.3 (L)	12.5-16.0	GMS
HEMATOCRIT	37.8	37.0-47.0	%
MCV	79.0	78-99	FL
MCH	25.6 (L)	27-31	PG
MCHC	32.5	32.0-36.0	G/DL
RDW	19.2 (H)	11.5-14.0	%
PLATELET COUNT	283	140-440	THOU/CUMM
NEUTROPHILS	57.6	40-75	%
LYMPHOCYTES	31.7	15-45	%
MONOCYTES	7.2	4.0-12.0	%
EOSINOPHILS	2.8	0-6	%
BASOPHILS	0.7	0-2	%
THYROID PROFILE 2			
T3 (% UPTAKE)	33.3	27-42	%
T4	9.0	4.5-12	MCG/DL
T7	3.0	1.0-3.8	INDEX
TSH	2.70	0.27-4.2	uIU/ML

*** FINAL REPORT ***

EXCEPT WHERE NOTED: TEST PERFORMED AT DOCTORS LABORATORY, VALDOSTA, GA
DIRECTOR: JACKSON L. GATES, M.D.

