



AUBURN UNIVERSITY
AT MONTGOMERY

STUDENT HEALTH SERVICES

12/16

2434601737

P.O. Box 244023
Montgomery, AL 36124
Phone: 334-244-3281
Fax: 334-244-3396

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Information

Student Number: _____
Name: Devonna Gray Date of Birth: 3/25/61
Address: 5621 Calmar dr apt. C Phone Number: 318-364-4394
City: Montgomery State: AL Zip: 36116 Email: devonna1030@gmail.com

Please select one of the following:

- ☒ Release information FROM Auburn University at Montgomery Student Health Services to an AUM department/outside medical facility/person (Circle one)
☒ Release information from an AUM department/outside medical facility/person (Circle one) TO Auburn University at Montgomery Student Health Services

Outside Medical Facility/ AUM Department/Person

Name: RMCE ER Date of Birth: ____/____/____
Address: _____ Phone: _____ Fax: _____
City: _____ State: _____ Zip: _____ Email: _____

Please select one of the following:

☒ Fax Records

☐ Mail Records

☐ Hold Records for Patient Pickup

Type(s) of Records Requested:

- ☐ Immunizations ONLY: please specify (if all, put ALL) _____
☒ Radiology Report
☒ Lab Results
☒ General summary of treatment issues, progress, current functioning
☒ Other: please specify All notes from most recent ER visit.

This consent may be needed at any time by the patient/client, but ending the consent will not cancel any actions that have already taken as allowed by this form. Unless the client wishes to cancel this consent at an earlier time, it will automatically stop upon the date and/or condition indicated below.

Date: _____ Event/Consent: _____

It is understood that the duration of this consent will not be longer than necessary and reasonable to carry out the purpose for which it is given.

Devonna Gray
Patient Name or Authorized Representative (Please Print)

Devonna Gray
Patient's Signature or Authorized Representative

12/16/24
Date

16645
Last 4 of Patient's Social Security #

MB
Witness Signature (REQUIRED)

12/16/2024
Date

Emergency Room Report

GRAY, DEVONNA MARIA - E000610504

* Final Report *

Result type: Emergency Room Report
Result date: December 11, 2024 11:48 CST
Result status: Auth (Verified)
Result title: Chest Pain *ED
Performed by: Redwood, William T, MD on December 11, 2024 11:55 CST
Verified by: Redwood, William T, MD on December 11, 2024 17:33 CST
Encounter info: E2434601737, Baptist East, East Emergency Room, 12/11/2024 - 12/11/2024

* Final Report *

Chest Pain *ED

Patient: GRAY, DEVONNA MARIA MRN: E000610504 FIN: E2434601737
Age: 63 years Sex: Female DOB: 3/25/1961
Associated Diagnoses: Chest pain; Bradycardia; Adverse drug reaction
Author: Redwood, William T, MD

Basic Information

Time seen: Date and time 12/11/2024 11:30:00.

History source: Patient.

Arrival mode:

Automobile from Home or Work

History limitation: None.

Additional information: ED Chief Complaint

12/11/2024 11:15 CST ED Chief Complaint c/o chest pain and HTN since before Thanksgiving. pt taking clonidine. sent by PCP for bradycardia and HTN. feels dizzy after taking clonidine. .

History of Present Illness

The patient presents with chest pain. The onset was A couple of weeks ago. The course/duration of symptoms is constant. Location: chest. Radiating pain: none. The character of symptoms is heaviness. The degree at onset was moderate. The degree at maximum was moderate. The degree at present is minimal. The exacerbating factor is none. The relieving factor is none. Risk factors consist of hypertension and obesity. Prior episodes: none. Therapy today None. Associated symptoms: palpitations and dizziness. The patient is a 63 year old female with a medical history of HTN and obesity. She presents to the ED due to having chest pains for the past couple of weeks. She reports having a heaviness in her chest. earlier today the patient was at her Dr. office for her uncontrolled HTN and was given Clonidine. since taking the clonidine she has been feeling dizzy and having palpitations. Family also reports that the patient speech is abnormally slow..

Review of Systems

Constitutional symptoms: Negative except as documented in HPI.

Skin symptoms: Negative except as documented in HPI.

Eye symptoms: Negative except as documented in HPI.

ENMT symptoms: Negative except as documented in HPI.

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Respiratory symptoms: Negative except as documented in HPI.
Cardiovascular symptoms: Negative except as documented in HPI.
Gastrointestinal symptoms: Negative except as documented in HPI.
Genitourinary symptoms: Negative except as documented in HPI.
Musculoskeletal symptoms: Negative except as documented in HPI.
Neurologic symptoms: Negative except as documented in HPI.
Psychiatric symptoms: Negative except as documented in HPI.
Endocrine symptoms: Negative except as documented in HPI.
Hematologic/Lymphatic symptoms: Negative except as documented in HPI.
Allergy/immunologic symptoms: Negative except as documented in HPI.

Health Status**Allergies:**

No Known Medication Allergies

Medications:**Home Medications (15) Active**

Acidophilus oral capsule , PO, DAILY
budesonide 32 mcg/inh nasal spray 2 Spray, NASAL, DAILY
calcium (as calcium citrate) 250 mg oral tablet 250 mg = 1 Tab, PO, Twice Daily
Celebrate Multivitamin , Chewed, DAILY
Eliquis Starter Pack for Treatment of DVT and PE 5 mg oral tablet 5 mg = 1 Tab, PO, As Directed
ferrous sulfate (as elemental iron) 45 mg oral tablet, extended release 45 mg = 1 Tab, PO, DAILY
hydroCHLORothiazide , PO, DAILY
hydroCHLORothiazide 25 mg oral tablet 25 mg = 1 Tab, PO, DAILY
hydroCHLORothiazide 25 mg oral tablet 25 mg = 1 Tab, PO, Every Morning
magnesium (as citrate)-melatonin 71.5 mg-1 mg oral tablet 2 Tab, PO, DAILY
omeprazole , PO, DAILY
potassium acetate 2 mEq/mL intravenous solution
Tylenol 8 Hour 650 mg oral tablet, extended release 1,300 mg = 2 Tab, PO, Every 8 Hours
valACYclovir , PO
Vitamin B12

Past Medical/ Family/ Social History**Medical history:** Reviewed with patient and negative .**Surgical history:** Reviewed with patient and negative .**Family history:** Reviewed with patient and negative .**Social history:****Alcohol****Details:** Alcohol Use: No.**Substance Abuse****Details:** Drug Use: No.**Tobacco****Details:** Tobacco Use: Never (less than 100 in lifetime). Non-Smoking Literature: Non-smoker.

Additional Past History: Allergies, Home Medications, Past Medical History, Past Surgical History, Family History, and Social History were entered by nurse and/or scribe and reviewed during patient's visit and in chart by physician. .

Emergency Room Report

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Physical Examination**Vital Signs****Triage Vital Signs (First Results)**

Label	Result	Date/Time
Respiratory Rate	20 br/min	12/11/2024 11:15
Blood Pressure, Systolic (Monitored)	139 mmHg	12/11/2024 11:15
Blood Pressure, Diastolic (Monitored)	52 mmHg	12/11/2024 11:15
Temperature, Oral	98.4 DegF	12/11/2024 11:15
SpO2	96 %	12/11/2024 11:15
Heart Rate, Monitored	41 bpm <	12/11/2024 11:15

Oxygen saturation: 96 %.

O2 sat interpretation: normal.

General: Alert, no acute distress.**Skin:** Warm.**Head:** Normocephalic, atraumatic.**Neck:** Supple, trachea midline.**Eye:** Pupils are equal, round and reactive to light, extraocular movements are intact.**Cardiovascular:** Regular rate and rhythm.**Respiratory:** Lungs are clear to auscultation.**Chest wall:** No tenderness.**Musculoskeletal:** Normal ROM.**Gastrointestinal:** Soft, Nontender.**Neurological:** No focal neurological deficit observed, Level of consciousness: Slow.**Psychiatric:** Cooperative, appropriate mood and affect.**Medical Decision Making****Results review:****ED Lab Results**

Assay Result	Date/Time	
Hematology		
WBC	7.4 X10 ³ /uL	12/11/24 11:41
RBC5.29 X 10 ⁶ /uL	12/11/24 11:41	
Hemoglobin	10.7 gm/dl	12/11/24 11:41
Hematocrit	34.2 %	12/11/24 11:41
Immature Platelet Fraction		
IPF 3.5 %	12/11/24 11:52	
MCV	65 fL L	12/11/24 11:41
MCH	20 pg L	12/11/24 11:41
MCHC	31 gm/dl L	12/11/24 11:41
Platelet Count	286 X10 ³ /uL	12/11/24 11:41
RDW	18.7 % H	12/11/24 11:41
Automated Differential		
Neutro Auto	56 %	12/11/24 11:41
Lymph Auto	35 %	12/11/24 11:41

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Mono Auto	8 %	12/11/24 11:41
Eos Auto	1 %	12/11/24 11:41
Basophil Auto	1 %	12/11/24 11:41
Immature Gran Auto	0.4 %	12/11/24 11:41
Neutro Abs	4.1 X10-3/uL	12/11/24 11:41
Lymph Abs	2.6 X10-3/uL	12/11/24 11:41
Mono Abs	0.6 X10-3/uL	12/11/24 11:41
Eos Abs	0.1 X10-3/uL	12/11/24 11:41
Basophil Abs	0.0 X10-3/uL	12/11/24 11:41
Immature Gran Abs	0.0 X10-3/uL	12/11/24 11:41
NRBC	0.0 /100 WBC	12/11/24 11:41
NRBC Abs	0.0 X10-3/uL	12/11/24 11:41

Chemistry**Chemistry Tests**

Gluc	108 mg/dL H	12/11/24 12:10
BUN15 mg/dL	12/11/24 12:10	
Creat	0.90 mg/dL	12/11/24 12:10
eGFR CKD-EPI	72 mL/min/1.73m2 L	12/11/24 12:10
eCrCl	68 mL/min	12/11/24 12:10
Sodium Ivl	138 mmol/L	12/11/24 12:10
Potassium Ivl	3.7 mmol/L	12/11/24 12:10
Chloride	103 mmol/L	12/11/24 12:10
CO2	30 mmol/L	12/11/24 12:10
Anion Gap	9	12/11/24 12:10
Calcium	9.8 mg/dL	12/11/24 12:10
Total Protein	7.9 g/dL	12/11/24 12:10
Albumin	3.7 gm/dl	12/11/24 12:10
Alk Phos	100 unit/L	12/11/24 12:10
ALT38 unit/L	12/11/24 12:10	
AST	28 unit/L	12/11/24 12:10
Bili Total	0.6 mg/dL	12/11/24 12:10

Cardiac Panel

HS Troponin	6.28 ng/L	12/11/24 14:44
HS Troponin	6.86 ng/L	12/11/24 12:10

DEC 11 11:31

138 I 103 I 15 (**H 108**

3.7 I 30 I 0.90 (

DEC 11 11:31

) 10.7 (**286**

) 34.2 (

Emergency Room Report

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Radiology results: Radiology results (ST)**Radiology Reports (Last 24 Hours) - Range: 12/10/2024 07:00 - 12/11/2024 15:07**

Reports Found: 1

Chest Portable Exam Dt/Tm: 12/11/2024 11:50

IMPRESSION: No acute pulmonary disease. Workstation: EPACS-READ01-PC Job ID: 222454

, reviewed radiologist's report.

Reexamination/ Reevaluation

Time: 12/11/2024 15:07:00 .

Notes: Patient has been having several months now of intermittent vaguely described chest pain that occurs at rest and occasionally with exertion. She was being seen by her primary care physician today who noted that her blood pressure was elevated and gave her a dose of clonidine. She was also noted to be bradycardic at that time. She was bradycardic before the clonidine was given according to the patient and family members. On exam here the patient initially had a somewhat slurred speech and appeared sedate. Remainder of exam is unremarkable and over the course of her ED evaluation patient seem to increase and mental acuity and I suspect her symptoms were secondary to clonidine ingestion. She she stated that the symptoms of feeling sedated and sleepy began within minutes after taking the clonidine. She continues to have mild bradycardia with rate anywhere from 40-60 her blood pressure is good she denies any chest pain has no trouble breathing any chest good room air saturations. Troponin x 2 normal EKG shows a sinus bradycardia with occasional PAC. I feel based on workup she stable for discharge with outpatient cardiology follow-up, return precautions provided.

Impression and Plan**Diagnosis**

Chest pain (ICD10-CM R07.9, Discharge, Medical)

Bradycardia (ICD10-CM R00.1, Discharge, Medical)

Adverse drug reaction (ICD10-CM T50.905A, Discharge, Medical)

Plan**Condition:** Improved, Stable.**Disposition:** Medically cleared, Discharged: Time 12/11/2024 15:15:00, to home.**Certified medical emergency:** Yes.**Discharge vital signs review:****Vital Signs (Latest Results)**

Assay Result	Date/Time	
Temperature, Oral	98.4 DegF	12/11/24 11:19
Heart Rate, Monitored	52 bpm L	12/11/24 14:51
Respiratory Rate	16 br/min	12/11/24 14:51
Blood Pressure, Systolic (Monitored)	101 mmHg	12/11/24 14:51
Blood Pressure, Diastolic (Monitored)	44 mmHg L	12/11/24 14:51
SpO2 93 %	12/11/24 14:51	

Patient was given the following educational materials: Chest Pain (Nonspecific), Easy-to-Read, Bradycardia.**Follow up with:** Followup with Cardiology as arranged by your PCP. Return here as needed; LINDSEY BARTON.**Counseled:** Patient, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Patient indicated understanding of instructions.**Addendum**

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Reviewed
12/16/24
L. Barton, CLP

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Attestations: Scribe Entry: I Williams, Melanie L acting as scribe for and in the presence of, [Clinician's Name Redwood, William T, MD], Clinician Scribe: I === personally performed the services described in the documentation, reviewed and edited the documentation which was dictated to the scribe in my presence, and it accurately records my words and actions.

Signature Line

(Electronically Signed On 12.11.24 17:33 CST)

Redwood, William T, MD

Completed Action List:

- * Perform by Redwood, William T, MD on December 11, 2024 11:55 CST
- * Modify by Williams, Melanie L on December 11, 2024 15:08 CST
- * Modify by Williams, Melanie L on December 11, 2024 15:15 CST
- * Modify by Redwood, William T, MD on December 11, 2024 17:32 CST
- * Sign by Redwood, William T, MD on December 11, 2024 17:33 CST Requested by Williams, Melanie L on December 11, 2024 15:15 CST
- * VERIFY by Redwood, William T, MD on December 11, 2024 17:33 CST

GRAY, DEVONNA

ID:000610504

11-Dec-2024 11:24:06

Baptist Health - East-DEFLT ROUTINE RECORD

25-Mar-1961 (63 yr)

Female Black

Room:EED23
Loc:0

Heart rate	58	BPM
PR interval	176	ms
QRS duration	80	ms
QT/QTc	440/437	ms
P-R-T axes	66 49 38	

SINUS BRADYCARDIA WITH OCCASIONAL SUPRAVENTRICULAR PREMATURE COMPLEXES
LOW QRS VOLTAGE IN CHEST LEADS [QRS DEFLECTION < 1.0 MV IN CHEST LEADS]
ABNORMAL ECG

Confirmed by: KNAPP, M.D., DAVID (30) on 12/11/2024 9:53:18 PM

Technician:
Test Ind:

Confirmed By: DAVID KNAPP, M.D.

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