Medical Chronology/Summary

Confidential and privileged information

Usage guidelines/Instructions

Verbatim summary: All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

Case synopsis/Flow of events: For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

Injury report: Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

Comments: We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows: "***Comments***".

Indecipherable notes/date: Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes"*** in heading reference.

Patient's History: Pre-existing history of the patient has been included in the history section.

Snapshot inclusion: If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

De-Duplication: Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical chronology for XXXX has been summarized in detail from focusing on her pre-natal visits, labor and delivery assessments, post-partum visits, and delivery summary. The chronology also focuses in detail on Baby XXXX complaints of HIE, respiratory distress and depression, and management provided till the death of the baby on 02/19/YYYY.*

- *Records from 02/13/YYYY to 02/19/YYYY have been summarized in brief to show the damages and sufferings incurred by Baby XXXX*

- *Baby records are summarized in blue color font and records pertaining to mother are summarized in black color for ease of differentiation.*

Flow of events

ABC Center
02/12/YYYY-02/14/YYYY

G1P0 female with 38 w 4 d gestation with Fetal BPP of 2/10 - Presented with decreased fetal movement – Admitted and monitored – Administered multiple doses of Pitocin for induction – FHT monitored – Planned and underwent primary low transverse cesarean section – Single viable male baby delivered at 0644 hours – Post-op care provided and discharged home on 02/14/YYYY

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ABC Center
02/13/YYYY

Baby delivered at 0644 hours – Code called at 0645 hours – ETT placed at 0649 hours – Also UAC and UVC placed – Transferred to NICU in radiant warmer and neopuffed on 100% FiO2 at 0704 hours – APGAR scores were 1, 1, 1, and 2 - Transferred to St. Louis Children's Hospital via EMS for management of respiratory distress

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ABC Children's Hospital
02/13/YYYY-02/19/YYYY

Baby transferred via helicopter for ECMO evaluation – Admitted – Assessed with neonatal encephalopathy, respiratory failure, and hyponatremia – Intubated and mechanically ventilated – Kept NPO – Monitored periodically and started on empiric antibiotics – Condition continued to decline – Condition discussed with family – Parents decided for compassionate extubation – Extubated on 02/19/YYYY – Pronounced dead at 1740 hours on 02/19/YYYY by Erin O'Brien, M.D.

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ABC Health Services
03/14/YYYY:

Death Certificate: Cause of death was hypoxic ischemic encephalopathy.

Patient History

Past Medical History: Scoliosis *(**BATES Ref:** Ex 1 000558)*

Surgical History: Patient denies *(**BATES Ref:** Ex 1 000558)*

Family History: Not relevant *(**BATES Ref:** Ex 2 000008)*

Social History: Denies smoking, alcohol and drug use *(**BATES Ref:** Ex 2 000008- Ex 2 000009)*

Allergy: No known allergies *(**BATES Ref:** Ex 1 000558)*

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
02/24/YYYY - 02/28/YYYY	Provider/ Hospital	**Telephone Encounter:** **02/24/YYYY:** **At 1100 hours:** *XXXX* Patient states she is calling to give medical staff an update. **At 1337 hours:** *Teresa Jackson, Nursing Assistant* Returned call to patient. She is wanting to give an update on her period since the last time she had called. She had a yearly on 12/02/YYYY and c/o intermittent spotting since stopping her OCP. She was advised to monitor spotting and follow up in Feb/March if persist. She did have a period 12/13/YYYY and then did not have another period until 02/19/YYYY. She is currently only lightly bleeding but it did start as heavy and bright red. She does state she was under a lot of stress but does feel that her stress has improved some. She will continue to monitor cycle and advise if any concerns Advised patient Faith out of the office but would send this to her for review. Patient verbalizes understanding and is agreeable to plan of care. **02/28/YYYY:** **At 1616 hours:** *XXXX* Attempted to reach patient. LM on her personal VM stating FJ has reviewed her update, recommends continue to monitor. Advised to call back if further questions.	Ex 1 000620- Ex 1 000629
06/29/YYYY	Provider/ Hospital	**Telephone Encounter:** **At 0953 hours:** *XXXX, Nursing Assistant* Patient would like to establish OB care with Dr. Lehnert. Patient thinks her LMP 06/09/YYYY. 02/13/YYYY EDD. 7w 2d **At 1116 hours:** *XXXX* Returned call to patient. Appointment made for 07/13/YYYY at 1330 hours. Patient agreeable to plan, verbalized understanding, no further questions.	Ex 1 000610- Ex 1 000620
07/13/YYYY	Provider/ Hospital	@ 1416 hours: **Office Visit:** **Subjective:** Patient is a 29 YO G1P0 who is here for an OB initial visit. Patient's last menstrual period was 05/09/YYYY. Fetal movement is not yet present. **Her OB history is significant for:** Negative **Estimated date of delivery:** 02/13/YYYY Has irregular cycles **OB history:** **Gravida:** 1 **Review of systems:** Positive for nausea, emesis, and fatigue. RX Zofran	Ex 1 000550- Ex 1 000610

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Objective: **Vitals:** BP: 120/74, height: 5 feet 9 inches, weight: 72.1 kg, LMP: 05/09/YYYY, BMI: 23.48 **Physical examination:** **Pelvic:** Normal appearing vulva with no masses, tenderness or lesions, normal appearing vagina with normal color and discharge, no lesions, normal appearing cervix without discharge or lesions, closed. Uterus is 8 weeks size and shape; no adnexal masses or fullness, non-tender. **Assessment/plan:** 29 YO G1P0 for **NOB:** • PNLs ordered • Pap smear is current • Medications reviewed. • Continue taking PNV if able. Otherwise can take Folic acid 400-800mcg daily. • Reviewed questions related to diet and exercise in pregnancy. Recommended total weight gain for the pregnancy limited to 35lbs. • Genetic screening options reviewed. Patient desires to consider • Reviewed anticipated course of prenatal care. • Nurse at the orthopedic hospital • RTC in 4 weeks	
07/13/YYYY	Provider/ Hospital	**Labs:** **Normal:** WBC: 6.9, RBC: 4.51, hemoglobin: 13.5, hematocrit: 40.4 RPR: Non-reactive Hepatitis B surface antigen: Non-reactive Rubella immune status: 5.63 HIV – ½ AG and AB screen: Non-reactive	Ex 1 000559- Ex 1 000565
08/11/YYYY	Provider/ Hospital	**Follow-up Visit:** Patient is a G1P0 at 13 W 3 D here for an OB visit. Fetal movement is not yet present. **Assessment/plan:** • Supervision of normal first pregnancy, antepartum • 13 weeks gestation of pregnancy • Rh negative status during pregnancy in second trimester • Screening for genetic disease carrier status **Pregnancy at 13w3d** • Panorama ordered • RTC in 4 weeks	Ex 1 000534- Ex 1 000550
08/11/YYYY	Provider/ Hospital	**Labs:** **Non-invasive prenatal testing panel:** **Report summary:**	Ex 1 000542- Ex 1 000544

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Comment: Low risk	
08/31/YYYY	Provider/ Hospital	**Follow-up Visit:** Patient is a G1P0 at 16w2d here for an OB visit. Fetal movement is not yet present. **Assessment/plan:** **Supervision of normal first pregnancy, antepartum:** **Pregnancy at 16w2d:** • Miscarriage precautions discussed • NIPT reviewed. Male.	Ex 1 000521- Ex 1 000534
09/13/YYYY	Provider/ Hospital	**Correspondence** **From:** Patient **To:** ObGyn Nurses supporting *XXXX*, APRN-BC Good morning *XXXX* I realize it's normal for everyone to have different experiences during pregnancy, but my nausea isn't going away It's better than it was during the 1st trimester. Yesterday, I vomited 6Xs at work and had to go home. I couldn't keep anything down. At home it was a little better, I had a snack and some water; still felt really nauseous but v/as able to lay down and keep it down until the evening I was supposed to work today too, but had to call in. Crackers and water came back up, and just tried a few bites of pancake and sips of juice. I feel like this is fairly normal, but my husband is nervous. Is this okay? I haven't used the Zofran as much as I should. It makes me Very constipated and even more uncomfortable. **From:** XXXX, APRN-BC **To:** Patient Do you think you have a virus? I would take the Zofran **From:** Patient **To:** ObGyn Nurses supporting XXXX, APRN-BC Maybe so. It's gotten a lot better today, but to be honest, I haven't tried eating much. I'll use the Zofran if I need to. I used it on Saturday and it made me so constipated the rest of the day and Sunday. It's like a catch 22 for me. Thanks for getting back with me.	Ex 1 000514- Ex 1 000521
09/26/YYYY	Provider/ Hospital	**Orders:** **Order:** US OB follow-up per fetus **Diagnosis:** Antenatal screening for malformation using ultrasonics.	Ex 1 000507- Ex 1 000514
09/28/YYYY	Provider/ Hospital	**Orders:** **Order:** US OB 14+ weeks single gestation **Diagnosis:** • Encounter for antenatal screening for malformation using ultrasound • Encounter for antenatal screening for mother	Ex 1 000500- Ex 1 000507
09/29/YYYY	Provider/ Hospital	**Follow-up Visit:** Patient is a G1P0 at 20w3d here for an OB visit. Fetal movement is unsure.	Ex 1 000463- Ex 1 000476

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Objective: **Vitals:** BP: 112/62, weight: 74.4 kg, BMI: 24.22 **Assessment/plan:** **Supervision of normal first pregnancy,, antepartum:** **Pregnancy at 20w3d:** • Miscarriage/preterm labor precautions are discussed **Screening for fetal anomalies:** • Ultrasound for anatomy screen is pending	
09/29/YYYY	Provider/ Hospital	**Transabdominal Ultrasound examination:** **Indication:** • Encounter for antenatal screening for malformation using ultrasound • Encounter for antenatal screening of mother **EDD by prior assessment:** 02/23/YYYY **EDD by US:** 02/23/YYYY **GA by US:** 19w + 0d **General evaluation:** Cardiac activity present. FHR 130 BPM Fetal movements: Visualized. Presentation: Cephalic Placenta: Placental site: Posterior, fundal Umbilical cord: Cord vessels: 3 vessel cord. Insertion site: Velamentous insertion. Placental insertion not in proximity of the cervix so as to predispose to vasa previa. Amniotic fluid: Amount of AF: Subjectively normal **Fetal anatomy:** **The following structures appear normal:** Cranium. Cisterna magna. Cerebellum. Nose. Lips. Abdominal wall. Cord insertion. Stomach. Kidneys. Bladder. Spine. Arms. Right hand. Left hand. Legs. Right foot. Left foot. **The following structures could not be adequately visualized:** Midline falx. Cavum septi pellucidi. 4-chamber view. LVOT view. RVOT view. Fetal sex: Male **Maternal structures:**	Ex 1 000476- Ex 1 000500

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Uterus: Normal Right ovary: Normal Left ovary: Normal Cul de sac: Visualized. Imaging of the cul-de-sac is unremarkable. **Impression:** **Findings and comments:** Intrauterine pregnancy: This exam used to establish EDD Fetal abnormalities are not identified: Incomplete fetal anatomical survey Velamentous umbilical cord insertion: Velamentous umbilical cord insertion is an indication for weekly antepartum fetal surveillance beginning at 36 0/7 weeks gestation. Third trimester growth ultrasounds are warranted. Velamentous umbilical cord insertion may predispose to fetal intolerance to labor. **Follow-up:** Arranged.	
10/03/YYYY	Provider/ Hospital	**Correspondence** **From:** Patient **To:** ObGyn Nurses supporting XXXX, APRN-BC Good morning Faith. I realize it's important to get a flu shot this year, but does it matter when? I'm a Mercy co-worker so they want it done within the next months but I forgot to ask Dr. Lehnert at my last apt. Thanks so much! **From:** XXXX, APRN-BC **To:** Patient We definitely recommend the flu shot. Sometime in October is ideal.	Ex 1 000456- Ex 1 000463
10/26/YYYY	Provider/ Hospital	**Orders:** **Order:** US OB follow-up per Fetus **Diagnosis:** • Antenatal screening for malformation using ultrasonics. • Image test inconclusive **Indications:** Velamentous insertion of umbilical cord in third trimester	Ex 1 000449- Ex 1 000456
10/27/YYYY	Provider/ Hospital	**Follow-up Visit:** Patient is a G1P0 at 24w3d here for an OB visit. Fetal movement is normal. **Assessment/plan:** • Supervision of normal first pregnancy, antepartum • 24 weeks gestation of pregnancy • Rh negative status during pregnancy in second trimester • Velamentous insertion of umbilical cord in second trimester **Pregnancy at 24w3d** • Patient reports due date change per MFM – Will review this when ultrasound resulted – Velamentous cord insertion – Surv will need to be scheduled with MFM. • Labs at next visit • Will need rhogam	Ex 1 000403- Ex 1 000425

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		• Discussed process for breast pump • RTC in 4 weeks	
10/27/YYYY	Provider/ Hospital	**Transabdominal Ultrasound:** **Indication:** • Antenatal screening for malformation using ultrasonics • Image test inconclusive • Follow-up for ML falx, CSP, 4CH, LVOT, and RVOT **Diagnosis:** Encounter for antenatal screening for malformations **GA by US:** 22w + 6d **General evaluation:** Cardiac activity present FHR 148 BPM. Fetal movements: Visualized Presentation: Cephalic Placenta: Placental site: Posterior Umbilical cord Insertion site: Velamentous insertion **Fetal anatomy:** **The following structures appear normal:** Midline falx. Cavum septi pellucidi 4-chamber view LVOT view. RVOT view 3-vesselview. 3-vessel - trachea view. High short axis view. **Impression:** **Findings and comment:** • Fetal abnormalities are not identified • Gestational age is in agreement with established eating	Ex 1 000425- Ex 1 000441
10/27/YYYY - 10/28/YYYY	Provider/ Hospital	**Correspondence:** **10/27/YYYY:** **From:** XXXX **To:** Patient We are just reviewing your ultrasound and want to verify your due date. We have down from your initial OB appointment that the first day of your last period was 05/09/YYYY. Can you confirm if this is correct? **10/28/YYYY:** **From:** Patient **To:** XXXX Yes, that is correct. However, I had a few days of light bleeding starting on May 28th. I spoke to Faith, my NP, about it in the beginning and we figured it was implantation bleeding. Since ending my birth control in September of last year, my cycles have been sporadic. They evened out a bit more in March thru May, but I'm sure it's possible it was still a bit messed up. Hope that's not TMI. Thanks for your help!	Ex 1 000441- Ex 1 000449
11/22/YYYY	Provider/	**Labs:**	Ex 1 000411-

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
	Hospital	**Normal:** WBC: 7.1, RBC: 3.96, hemoglobin: 12.5, hematocrit: 36.9	Ex 1 000413
11/07/YYYY	Provider/ Hospital	**Telephone Encounter:** *XXXX* Patient states she is needing to speak to medical staff about her official due date for FMLA purposes. Please call patient back. *XXXX* Attempted to reach patient with no answer. Will send MyMercy message.	Ex 1 000386- Ex 1 000396
11/07/YYYY	Provider/ Hospital	**Correspondence to Patient:** Dr. Lehnert said your due date has been changed to February 23rd, YYYY. Please let us know if you have any questions.	Ex 1 000397- Ex 1 000403
11/22/YYYY	Provider/ Hospital	**Follow-up Visit:** Patient is a G1P0 at 26w5d here for an OB visit. Fetal movement is normal. **Assessment/Plan:** • Supervision of normal first pregnancy, antepartum • 26 weeks gestation of pregnancy • Rh negative status during pregnancy in second trimester **Pregnancy at 26w5d:** • Doing labs • FHT – Irregular today, sent to MFM for ultrasound (Late entry: No arrhythmia noted. Weekly FHT with Doppler recommended for a couple weeks.) • RTC in 4 weeks.	Ex 1 000359- Ex 1 000386
11/22/YYYY	Provider/ Hospital	**Transabdominal Ultrasound:** **Indication:** • Velamentous insertion of umbilical cord in third trimester • Encounter for ultrasound to check fetal growth **Diagnoses:** • Weeks of gestation • Encounter for other antenatal screening follow-up • Velamentous insertion of umbilical cord **GA by US:** 26w3d **EDD by US:** 02/25/YYYY **General evaluation:** Cardiac activity present FHR 143 BPM. Fetal movements: Visualized Presentation: Transverse Head: Maternal left Placenta: Posterior	Ex 1 000342- Ex 1 000379

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Amniotic fluid: MVP 4.0 cm AFI 11.6 cm Q1 17 cm: Q2 4.0 cm, Q3 3.4 cm, Q4 2 5 cm **Fetal anatomy:** The following structures appear normal: 4-chamber view. Stomach Kidneys. Bladder **Fetal sex:** Male **Impression:** **Findings and comments:** Estimated fetal weight is appropriate for gestational age No evidence of arrhythmia on today's assessment- Concern for arrhythmia in office. Discussed with office weekly fetal heart rate assessment by Doppler for the next couple of weeks to continue to screen for possible arrhythmia **Follow-up:** Discussed with office weekly fetal heart rate assessment by Doppler for the next couple of weeks to continue to screen for possible arrhythmia.	
11/22/YYYY - 11/28/YYYY	Provider/ Hospital	**Correspondence:** **11/22/YYYY:** *XXXX, APRN-BC* **To:** Patient We need to see you back in the office weekly for the next couple weeks to do fetal heart tones. Is there a day next week that works better for you? We are not in on Fridays. **11/23/YYYY:** *Patient* **To:** ObGyn Nurses supporting *XXXX*, APRN-BC Okay. Do you have anything available next Thursday after 3 PM? If not, I can talk to my boss and get some time off sooner than that. I work 12 hr shifts Monday thru Wednesday and picked up some one Thursday, but my boss is pretty good about letting me leave for a bit if needed. **11/28/YYYY:** *XXXX* I'm going to go ahead and put you on out schedule for Thursday, December 1st at 3 PM, but just come over here when you can. It's okay if you can't be here right at 3. Just head over here when you can, as long as if s sometime between 3 and 4, it will be fine.	Ex 1 000379- Ex 1 000386
12/01/YYYY	Provider/ Hospital	**Follow-up Visit:** Here for FHT. Doing well. FHT are normal today. Needs rhogam today. Antibody screen done RTC in 1 week	Ex 1 000328- Ex 1 000342
12/01/YYYY	Provider/	**Nursing Notes:**	Ex 1 000335

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
	Hospital	Rhogam given due to Rh negative at 28.0 weeks. Tolerated well. She left the office in stable condition. NOC 44206-300-01	
12/08/YYYY	Provider/ Hospital	**Follow-up Visit:** Patient is a G1P0 at 29w0d here for an OB visit. Fetal movement is normal. **Assessment/plan:** • Supervision of normal first pregnancy, antepartum • Rh negative status during pregnancy in third trimester • 29 weeks gestation of pregnancy • Velamentous insertion of umbilical cord in second trimester **Pregnancy at 29w0d** • Doing well • Passed GTT • Need growth scan and surv scheduled with MFM due to velamentous cord insertion • RTC in 2 weeks	Ex 1 000315- Ex 1 000328
12/14/YYYY	Provider/ Hospital	**Notes:** *XXXX, Nursing Assistant* Appointment made for consult with MFM growth and surveillance due to velamontous insertion of umbilical cord. Appointment scheduled 12/29/YYYY at 1:00. **Orders:** *XXXX.* **Order:** US OB follow-up per fetus **Diagnoses:** • Velamentous insertion of umbilical cord in second trimester • Scheduling instructions	Ex 1 000302- Ex 1 000309
12/14/YYYY	Provider/ Hospital	**Correspondence to Patient:** Faith asked that I got you set up for an appointment with MFM for surveillance. This has been scheduled on 12/29/YYYY at 1 00. If you need to change this appointment please call.	Ex 1 000309- Ex 1 000315
12/19/YYYY	Provider/ Hospital	**Orders:** **Order:** • US OB FU + NST • US OB limited + NST • US fetal biophysical PROF with NST **Diagnoses:** • Velamentous insertion of umbilical cord insertion in third trimester • High risk pregnancy (HRP), third trimester • Scheduling instructions	Ex 1 000287- Ex 1 000302
12/21/YYYY	Provider/ Hospital	**Correspondence:** **12/21/YYYY:** *Jamie Maples, CMA* **To:** Patient	Ex 1 000280- Ex 1 000287

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Due to the forecast tomorrow we are rescheduling. Are you able to come in on Tuesday 12/27/YYYY for this appointment? We have morning and afternoon openings You can reply to this message or call our office. **12/22/YYYY:** **To:** ObGyn Nurses supporting XXXX, APRN-BC Hello Jamie, my husband told me we went ahead and re-scheduled the appt for Tuesday at 1100 Is there any possibility I could have it on Thursday before or after my ultrasound?? I already have permission to leave work for Thursday's appt but don't think I would be able to get off on Tuesday. I work 12-hr shifts at the Orthopedic Hospital, so scheduling is always rough. Thanks for checking in to this for me! Sorry for the inconvenience. *XXXX* I scheduled you for Thursday at 2:15 with Dr. Lehnert. Just come on up once you are done with your Maternal Fetal Medicine appointment.	
12/29/YYYY	Provider/ Hospital	**Follow-up Visit:** ROB Doing well MFM earlier today and now weekly.	Ex 1 000239- Ex 1 000254
12/29/YYYY	Provider/ Hospital	**Transabdominal Ultrasound:** **Indication:** • Velamentous insertion of umbilical cord in third trimester • High risk pregnancy, third trimester **Diagnoses:** • Weeks of gestation • Supervision of other high risk pregnancies • Velamentous insertion of umbilical cord • Ultrasound, pregnant uterus, real time with image documentation, follow-up transabdominal approach per fetus • NST/fetal monitoring **GA by US:** 33w+0d **EDD by US:** 02/16/YYYY **General evaluation:** Cardiac activity present. FHR 139 BPM. Fetal movements: Visualized Presentation: cephalic Placenta: Placental site: Posterior Amniotic fluid: MVP 4.6 cm. AFI 14.2 cm. Q1 4.6 cm, Q2 2.4 cm, Q3 3.4 cm, Q4 3.9 cm **Fetal anatomy:** The following strictures appear normal:	Ex 1 000254- Ex 1 000273

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Nose Lips. Profile. 4-charnber view. Diaphragm Stomach Kidneys. Bladder. Fetal sex: Male **Non-stress test:** NST interpretation reactive, Variability: Moderate Baseline FHR 130 BPM Accelerations: Present Decelerations Not present **Impression:** **Findings and comments:** Estimated fetal weight is appropriate for gestational age Reassuring modified biophysical profile Fetal Cardiac Arrhythmia The findings are typical of fetal PACs or PVCs PACs and PVCs are generally benign. Neither PACs a PVCs have an independent association with structural cardiac abnormality. Not noted during her NST assessment. Continue weekly testing. Known velamentous cord insertion - superior insertion near fundus **Follow-up:** MFM visit performed.	
01/05/YYYY	Provider/ Hospital	**Follow-up Visit:** Patient is a G1P0 at 33w 0d here for an OB visit. Fetal movement is normal. **Assessment/plan:** • Supervision of normal first pregnanct, antepartum • Rh negative status during pregnancy in third trimester • 33 weeks gestation of pregnancy • Velamentous insertion of umbilical cord, antepartum **Pregnancy at 33w0d** • RTC in 2 weeks	Ex 1 000224- Ex 1 000239
01/05/YYYY	Provider/ Hospital	**Transabdominal Ultrasound:** **Indication:** • Velamentous insertion of umbilical cord in third trimester • High risk pregnancy, third trimester **Diagnoses:** • Weeks of gestation • Supervision of pregnancy with other poor reproductive or obstetric	Ex 1 000209- Ex 1 000224

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		history • Velamentous insertion of umbilical cord **General evaluation:** Cardiac activity present FHR 146 BPM Fetal movements: Visualized. Presentation: Cephalic Placenta: Posterior **Non-stress test:** NST interpretation: Reactive Variability: Moderate. Baseline FHR 130 BPM. Baseline variability: Moderate Accelerations: Present Decelerations: Not present **Amniotic fluid assessment:** Amount of AF: Normal amount MVP 4.8 cm. AFI 14 3 cm Q1 1.8 cm, Q2 3.7 cm, Q3 4.8 cm, Q4 4.0 cm **Impression:** **Findings and comments:** Reassuring modified biophysical profile.	
01/12/YYYY	Provider/ Hospital	**Transabdominal Ultrasound:** **Indication:** • Velamentous insertion of umbilical cord in third trimester • High risk pregnancy, third trimester **Diagnoses:** • Weeks of gestation • Supervision of other high risk pregnancies • Velamentous insertion of umbilical cord **Assigned GA:** 34w + 0d **Assigned EDD:** 02/23/YYYY **General evaluation:** Cardiac activity present FHR 140 BPM Fetal movements: Visualized. Presentation: Cephalic **Non-stress test:** NST interpretation: Reactive	Ex 1 000194- Ex 1 000209

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Variability: Moderate. Baseline FHR 130 BPM. Accelerations: Present Decelerations: Not present **Amniotic fluid assessment:** MVP 6.0 cm. AFI 12.8 cm Q1 6.0 cm, Q2 0.0 cm, Q3 3.7 cm, Q4 3.0 cm **Impression:** **Findings and comments:** Reassuring modified biophysical profile.	
01/19/YYYY	Provider/ Hospital	**Orders:** **Order:** US fetal biophysical profile with NST **Indication:** • Velamentous insertion of umbilical cord in third trimester • High risk pregnancy, third trimester	Ex 1 000187- Ex 1 000194
01/19/YYYY	Provider/ Hospital	**Transabdominal Ultrasound:** **Indication:** • Velamentous insertion of umbilical cord in third trimester • High risk pregnancy, third trimester **Diagnoses:** • Weeks of gestation • Supervision of pregnancy with other poor reproductive or obstetric history • Velamentous insertion of umbilical cord **Assigned GA:** 35w + 0d **Assigned EDD:** 02/23/YYYY **General evaluation:** Cardiac activity present FHR 131 BPM Fetal movements: Visualized. Presentation: Cephalic Placenta: Posterior **Non-stress test:** NST interpretation: Non-reactive Baseline Variability: Moderate. Baseline FHR 140 BPM. Accelerations: Present Decelerations: Absent **Amniotic fluid assessment:**	Ex 1 000169- Ex 1 000187

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Amount of AF: Subjectively normal MVP 4.5 cm. AFI 16.4 cm Q1 3.8 cm, Q2 4.5 cm, Q3 4.3 cm, Q4 3.7 cm **Biophysical profile:** 2: Fetal breathing movements 2: Gross body movements 2: Fetal tone 2: Amniotic fluid volume NST: non-reactive 8/10 Biophysical profile score **Impression:** **Findings and comments:** Reassuring biophysical profile: 8/10 (Non-reactive NST)	
01/19/YYYY	Provider/ Hospital	**Follow-up Visit:** Patient is a G1P0 at 35w0d here for an OB visit. Fetal movement is normal. **Assessment/plan:** • Supervision of normal first pregnancy, antepartum **Pregnancy at 35w0d** • Doing OK. She was emotional today. Baby failed NST, but BPP 8/10 • GBS at next visit • RTC in 1 weeks	Ex 1 000156- Ex 1 000169
01/26/YYYY	Provider/ Hospital	**Follow-up Visit:** Patient is a G1P0 at 36w0d here for an OB visit. Fetal movement is normal. **Assessment/plan:** • Supervision of normal first pregnancy, antepartum • Rh negative status during pregnancy in third trimester • 36 weeks gestation of pregnancy **Pregnancy at 36w0d** • Doing well • GBS done • RTC in 1 weeks	Ex 1 000133- Ex 1 000148
01/26/YYYY	Provider/ Hospital	**Orders:** **Order:** US fetal biophysical profile without NST **Diagnoses:** • Velamentous insertion of umbilical cord in third trimester • High risk pregnancy, third trimester	Ex 1 000148- Ex 1 000156
01/26/YYYY	Provider/ Hospital	**Transabdominal Ultrasound:** **Indication:** • Velamentous insertion of umbilical cord in third trimester • High risk pregnancy, third trimester	Ex 1 000111- Ex 1 000133

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Diagnoses: • Weeks of gestation • Supervision of pregnancy with other poor reproductive or obstetric history • Velamentous insertion of umbilical cord **Assigned GA:** 36w + 0d **Assigned EDD:** 02/23/YYYY **General evaluation:** Cardiac activity present FHR 161 BPM Fetal movements: Visualized. Presentation: Cephalic Placenta: Posterior, fundal Amount fluid: MVP 4.5 cm. AFI 11.7 cm Q1 2.2 cm, Q2 2.0 cm, Q3 3.0 cm, Q4 4.5 cm **Fetal anatomy:** 4-chamberview: Previously seen The following structures appear normal: Stomach. Kidneys. Bladder Fetal sex: mate **Biophysical profile:** 2: Fetal breathing movements 2: Gross body movements 2: Fetal tone 2: Amniotic fluid volume NST: non-reactive 8/10 Biophysical profile score **Non-stress test:** NST interpretation: Non-reactive Variability: Moderate Baseline FHR 140 BPM. Accelerations: Not Present Decelerations: Not present **Impression:** **Findings and comments:** Estimated fetal weight is appropriate for gestational age Reassuring biophysical profile: Biophysical profile 8/10 (Non-reactive NST)	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Velamentous umbilical cord insertion	
01/28/YYYY	Provider/ Hospital	**Labs:** **Collected date:** 01/26/YYYY at 1134 hours **Source:** Vaginal/rectal **Result:** **Group B streptococcus by PCR:** Not detected	Ex 1 000141
02/02/YYYY	Provider/ Hospital	**Follow-up Visit:** Patient is a G1P0 at 37w0d here for an OB visit. Fetal movement is normal. Fluid leaking: No Contractions: No **Objective:** **Vitals:** BP: 108/64, weight: 82.1 kg, LMP: 05/09/YYYY, BMI: 26.73 **Assessment/plan:** Supervision of normal first pregnancy, antepartum **Pregnancy at 37w0d:** • Labor precautions reviewed • L&D triage and on call contact process reviewed • Birth preferences discussed	Ex 1 000081- Ex 1 000095
02/02/YYYY	Provider/ Hospital	**Transabdominal Ultrasound:** **Indication:** • Velamentous insertion of umbilical cord in third trimester • High risk pregnancy, third trimester **Diagnoses:** • Weeks of gestation • Supervision of pregnancy with other poor reproductive or obstetric history • Velamentous insertion of umbilical cord **Assigned GA:** 37w + 0d **Assigned EDD:** 02/23/YYYY **General evaluation:** Cardiac activity present FHR 133 BPM Fetal movements: Visualized. Presentation: Cephalic **Non-stress test:** NST interpretation: Reactive Variability: Moderate Baseline FHR 130 BPM. Accelerations: Present	Ex 1 000095- Ex 1 000111

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Decelerations: Not present **Amount fluid assessment:** MVP 4.4 cm. AFI 14.9 cm Q1 4.1 cm, Q2 3.8 cm, Q3 4.4 cm, Q4 2.7 cm **Impression:** Reassuring modified biophysical profile.	
02/08/YYYY	Provider/ Hospital	**Correspondence:** **Contractions, rough few days:** *Patient* Good morning Mrs. XXXX. I called but no answer after 20mins; wondered if this would be faster. The last few days I haven't felt very good. Very nauseous Monday, took Zofran but still vomited several times. Yesterday afternoon at work, I was nauseous, very short of breath, cramping, getting dizzy, and overall feeling puny. Last night I had a bunch of contractions, though not all v/ere painful. They were about 7-10 mins apart and approximately 30sec. The baby wasn't moving a bunch, but when he did, it v/as big movements. Contractions didn't get closer together, so I went to bed. This morning I've had some contractions, mostly not painful. Drank some juice, laid on my side, and baby is moving fine. Just still really puny feeling. What should I do? *Patient* I forgot to add that I've been having a lot of rectal pressure when I stand. Not so much when I sit,....I know that's kinda TMI. *XXXX, APRN-BC* If you are contracting regularly and still feeling off I would go to triage for evaluation especially if you are having rectal pressure now.	Ex 1 000074- Ex 1 000081
02/08/YYYY	Provider/ Hospital	**Triage visit summary note:** G1P0 **Current provider:** XXXX **Estimated date of delivery:** 02/23/YYYY **Gestational age:** 37w6d **OB Chief Complaint:** Nausea and/or vomiting **Patient Stated Reason for Admission:** Nausea/vomiting since Monday, still not feeling well in general, some UC **Fetal Assessment:** FHR (A) FHR (A) Baseline: 135 Mode (A): External Variability (A): Moderate (6-25 BPM) Pattern (A): Accelerations Fetal Movement (A): Present **Contractions:** Uterine Resting Tone: Soft by palpation	Ex 2 000287- Ex 2 000322

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Status of Membranes: Intact, patient denies leaking **Labs drawn:** No **Ultrasound performed:** No **Visit Details and Discharge Plan of care:** Patient presented to unit c/o general malaise and not feeling well after having been vomiting on Monday and Tuesday. FHT reactive, uterine irritability noted. Report called to physician, ordered to discharge to home with education on when to return for further evaluation. Patient verbalized understanding and agreeable with POC. Patient discharged in stable condition AVS/Pertinent Medical Records sent with patient F/U with Dr. Darren Lehnert as scheduled.	
02/08/YYYY	Provider/ Hospital	**Procedure Report:** **Antepartum fetal heart rate tracing:** **Indication:** General malaise **Gestational age:** 37w6d **Total EFM time:** Greater than 20 mn=inutes **Physician interpretation:** **Non-stress test:** Baseline: 135 Variability: Moderate Accelerations: Present Decelerations: Absent TOCO: None Interpretation: Reactive	Ex 2 000294- Ex 2 000296
02/08/YYYY	Provider/ Hospital	**Urinalysis:** **Abnormal:** Leukocyte esterase: Trace	Ex 2 000299- Ex 2 000300
02/09/YYYY	Provider/ Hospital	**Follow-up Visit:** Patient is a G1P0 here for an OB visit. Fetal movement is normal. Fluid leaking: No Contractions: No **Objective:** **Vitals:** BP: 108/66, weight: 83 kg, LMP: 05/09/YYYY, BMI: 27.02 **Assessment/plan:** • Supervision of normal first pregnancy, antepartum • Velamentous insertion of umbilical cord, antepartum **Pregnancy at 38w0d** • Labor precautions reviewed • L&D triage and on call contact process reviewed	Ex 1 000044- Ex 1 000058

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		• Birth preferences discussed	
02/09/YYYY	Provider/ Hospital	**Transabdominal Ultrasound:** **Indication:** • Velamentous insertion of umbilical cord in third trimester • High risk pregnancy, third trimester **Diagnoses:** • Weeks of gestation • Supervision of pregnancy with other poor reproductive or obstetric history • Velamentous insertion of umbilical cord **Assigned GA:** 38w + 0d **Assigned EDD:** 02/23/YYYY **General evaluation:** Cardiac activity present FHR 148 BPM Fetal movements: Visualized. Presentation: Cephalic **Non-stress test:** NST interpretation: Reactive Variability: Moderate Baseline FHR 130 BPM. Accelerations: Present Decelerations: Not present **Amount fluid assessment:** MVP 4.1 cm. AFI 10.6 cm Q1 0.0 cm, Q2 3.6 cm, Q3 4.1 cm, Q4 3.0 cm **Impression:** Reassuring modified biophysical profile.	Ex 1 000058- Ex 1 000074
		ABC Center ***02/12/YYYY-02/14/YYYY***	
02/12/YYYY	Provider/ Hospital	**@ 2104 hours: Orders:** **Order:** Fetal heart tones by Doppler **Frequency:** Routine now then Q8H 02/12/YYYY at 2105 hours – Until specified	Ex 2 000125
02/12/YYYY	Provider/ Hospital	**@ 2115 hours: Urinalysis** **Abnormal:** Leukocyte esterase: Trace Bacteria: 1+ Epithelial cells: 6-10	Ex 2 000054- Ex 2 000055
02/12/YYYY	Provider/ Hospital	**@ 2135 hours: Flow sheet:** **L and D Admission screen:**	Ex 2 000156

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Triage screen: **OB chief complaint:** Decreased fetal movement **Patient stated reason for admission:** Haven't felt baby move since this morning **Onset of symptoms date:** 02/12/YYYY **Onset of symptoms time:** At 0630 hours **Prenatal care:** **Prenatal record reviewed:** Yes **Prenatal care:** Yes, prenatal record on chart **Followed by fetal care team:** Yes **Antenatal steroids:** No **Pregnancy complication detail:** Velamentous cord insertion **Preeclampsia assessment completed?** No	
02/12/YYYY	Provider/ Hospital	**@ 2138 hours: Flow Sheet:** **OB:** **Vaginal bleeding:** **Presence:** Not present	Ex 2 000164- Ex 2 000165
02/12/YYYY	Provider/ Hospital	**@ 2200 hours: Flow Sheet:** **Labor assessment:** **FMS:** **FMS reviewed?** Yes **FMS reviewed by:** Dr. Sammarco	Ex 2 000156- Ex 2 000157
02/12/YYYY	Provider/ Hospital	**@ 2200 hours: Physician Notification:** **Time called:** At 2200 hours **Name of physician notified:** Dr. Sammarco **Call result:** Orders received **Reason for call:** Orders for IV, fluids, labs and BPP. Physician reviewed strips.	Ex 2 000157
02/12/YYYY	Provider/ Hospital	**@ 2215 hours: Labs:** **High:** Monocyte absolute: 0.88, immature granulocytes absolute: 0.20 **Low:** RBC: 4.03, lymphocytes: 19 **Normal:** WBC: 10.2, hemoglobin: 12.7, hematocrit: 37.2	Ex 2 000056
02/12/YYYY	Provider/ Hospital	**@ 2230 hours: Flow Sheet:** **Labor assessment:** **FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction intensity by palpation:** No contractions **Uterine resting tone:** Soft by palpation	Ex 2 000156- Ex 2 000157
02/12/YYYY	Provider/	**@ 2234 hours: Flow Sheet:** **Labor assessment:**	Ex 2 000156- Ex 2 000157

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
	Hospital	**FMS:** **FMS reviewed?** Yes **FMS reviewed by:** Dr. Stanczyk	
02/12/YYYY	Provider/ Hospital	**@ 2234 hours: Physician notification:** **Time called:** At 2234 hours **Name of physician notified:** Dr. Stanczyk **Reason for call:** Request OB review strip. No further orders received at this time.	Ex 2 000157
02/12/YYYY	Provider/ Hospital	**@ 2250 hours: Flow Sheet:** **Labor assessment:** **FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer **Contraction intensity by palpation:** No contractions	Ex 2 000156- Ex 2 000157
02/12/YYYY	Provider/ Hospital	**@ 2251 hours: Flow Sheet:** **Labor assessment:** **FHR (A):** **FHR (A) baseline:** Off monitor for BPP	Ex 2 000156- Ex 2 000157
02/12/YYYY	Provider/ Hospital	**@ 2330 hours: Provider notification:** **Time called:** At 2330 hours **Name of physician notified:** Dr. Stanczyk **Call result:** Orders received **Reason for call:** Report BPP 2/8, cephalic, AFI 12.8, CBC WNL. Orders to admit to L&D for IOL. SVE in L&D to determine means of induction.	Ex 2 000158
02/12/YYYY	Provider/ Hospital	**@ 2337 hours: Transabdominal ultrasound:** **Indication:** Decreased fetal movement, non-reactive NST, fetal assessment/well being **OB history:** Gravida 1 **Assigned GA:** 38w + 3d **Assigned EDD:** 02/23/YYYY **General evaluation:** Cardiac activity present FHR 154 BPM. Fetal movements: Not visualized. Presentation: Cephalic Placenta: Placental site: posterior, right **Amniotic fluid assessment:** MVP 5.7 cm AFI 12.9 cm. Q1 4.2 cm. Q2 0.0 cm. Q3 3.0 cm. 04 5.7 cm	Ex 2 000063- Ex 2 000068

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Biophysical profile: 0: Fetal breathing movements 0: Gross body movements 0: Fetal tone 2: Amniotic fluid volume 2/8 Biophysical profile score **Impression:** **Findings and comment:** Abnormal biophysical profile. Biophysical profile score does not include NST. The findings are reported to L&D staff.	
02/12/YYYY	Provider/ Hospital	**@ 2348 hours: Orders:** **Order:** Admit to inpatient	Ex 2 000112
02/12/YYYY	Provider/ Hospital	**@ 2348 hours: Orders:** **Order:** Oxytocin in sodium chloride 0.9 % (Pitocin) 20 units in 1,000 mL infusion **Frequency:** 02/13/YYYY at 0019 hours – 1 occurrence **Administration instructions:** Titrate to uterine response	Ex 2 000117
02/12/YYYY	Provider/ Hospital	**@ 2348 hours: Orders:** **Order:** Oxytocin in sodium chloride 0.9 % (Pitocin) 20 units in 1,000 mL infusion **PRN reason:** Excessive bleeding in the immediate postpartum period **Frequency:** Routine continuous 02/13/YYYY at 0019 hours – 02/14/YYYY at 1243 hours **Administration instructions:** Excessive bleeding in the immediate postpartum period	Ex 2 000117
02/12/YYYY	Provider/ Hospital	**@ 2348 hours: Orders:** **Order:** Terbutaline (Brethine) injection 0.25 mg PRN reason: For tachysystole in the presence of category 2 or category 3 FHR tracing after consultation with provider. Frequency: Routine one time PRN 02/12/YYYY at 2348 hours – 1 occurrence.	Ex 2 000116
02/12/YYYY	Provider/ Hospital	**@ 2348 hours: Medication Administration Record:** **Medication:** Terbutaline (Brethine) injection 0.25 mg **Ordering provider:** Geoffery Stanczyk, M.D. on 02/12/YYYY at 2348 hours **Ordered dose:** 0.25 mg **Remaining/total:** 1/1 **Route:** Subcutaneous **Frequency:** One time PRN **Administration instructions:** May administer for tachysystole in the presence of category 2 or category 3 FHR tracing after consultation with provider. **Notes:** No administrations scheduled or recorded for this medication in the specified date/time range.	Ex 2 000111- Ex 2 000112
02/13/YYYY	Provider/ Hospital	**@ 0001 hours: Flow Sheet:** **Labor assessment:**	Ex 2 000157- Ex 2 000158

<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>BATES REF</th></tr>
<tr><td></td><td></td><td>Vaginal exam:
Method: Sterile vaginal exam per RN
Examiner: EJ, RN
Bloody show: Not present
Position – Cervical: Middle
Consistency – Cervical: Soft
Dilation – Cervical: 1
Effacement % - Cervical: 50
Fetal station: -3
Bishop score: 5
Presentation baby A: Vertex</td><td></td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 0011 hours: Provider notification:
Time called: At 0011 hours
Name of physician notified: Dr. Stanczyk
Call result: Orders received
Reason for call: Report SVE, request for Tums</td><td>Ex 2 000158</td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 0015 hours: Orders:
Order: Oxytocin (Pitocin) 30 units in 0.9% sodium chloride 500 mL infusion
Frequency: Routine titrate 02/13/YYYY at 0030 hours to 02/14/YYYY at 1243 houes
Indications comment: BPP 2/8

<table><tr><th>Question</th><th>Answer</th></tr><tr><td>Should this infusion be titrated?</td><td>Yes</td></tr><tr><td>Initial infusion dose</td><td>2 milli-units/min</td></tr><tr><td>Titration dose increment?</td><td>2 milli-units/min</td></tr><tr><td>Titration interval?</td><td>30 minutes</td></tr><tr><td>Goal?</td><td>Effective pattern of contractions every 2-3 minutes or 200-220 Montevideo units</td></tr><tr><td>Indication</td><td>Induction</td></tr><tr><td>Induction reason</td><td>Fetal other</td></tr></table>
Administration instructions:
Maximum dose = 20 milli-units/min

Any increase over 20 milli-units/min to be ordered by physician

Tachysystole with Category I/II FHR tracing: Reposition patient and reassess in 10 minutes. If tachysystole persists, decrease Oxytocin dose by half and reassess in 10 minutes. If tachysystole persists, discontinue Oxytocin infusion and notify provider and discuss whether to give Terbutaline 0.25 mg subcutaneous one time as ordered.

Category III FHR tracing with or without tachysystole: Discontinue Oxytocin infusion, reposition patient, and notify provider.</td><td>Ex 2 000116-
Ex 2 000117</td></tr>
</table>

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Restarting Oxytocin infusion: if infusion has been discontinued for 30 minutes or less, restart Oxytocin infusion at half the prior dose. If discontinued for more than 30 minutes, restart at the initial ordered dose Discontinue Oxytocin infusion and notify the provider: Urine output less than 30 mL/hr, sign of uterine rupture, or symptoms of water intoxication.	
02/13/YYYY	Provider/ Hospital	**@ 0030 hours: Flow Sheet:** **OB:** **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:** Coping **Non-verbal indicators of coping:** States coping; Maintaining composure; Able to relax between contractions **Maternal positioning:** Right side **FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Fetal movement (A):** Present **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction frequency (minutes):** 3-5 **Contraction duration (seconds):** 60-90 **Uterine resting tome:** Soft by palpation **Vaginal bleeding:** **Presence:** Not present	Ex 2 000164- Ex 2 000165
02/13/YYYY	Provider/ Hospital	**@ 0035 hours: Flow Sheet:** **Labor assessment:** **Oxytocin (Pitocin):** **Rate (ml/hr):** 2 ml/hr **Dose (milli-units/min):** 2 milli-units/min **Medication concentration:** 0.06 units/ml	Ex 2 000158
02/13/YYYY	Provider/ Hospital	**@ 0048 hours: Flow Sheet:** **OB chief complaint:** Induction of labor **Prenatal care:** **Prenatal record reviewed:** Yes, prenatal record on chart **Followed by fetal care team:** Yes **Antenatal steroids:** No **Prenatal test procedures:** None **Pregnancy complication detail:** None **Preeclampsia assessment completed?** Yes	Ex 2 000156

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Preeclampsia signs and symptoms: Denies **Patellar reflex:** Right: Average, normal **Clonus:** None **Edema:** Negative	
02/13/YYYY	Provider/ Hospital	**@ 0056 hours: Flow Sheet:** **Provider notification:** **Name of physician notified:** Dr. Stanczyk at bedside.	Ex 2 000168- Ex 2 000170
02/13/YYYY	Provider/ Hospital	**@ 0100 hours: OB History and Physical Update:** **History of present illness:** Patient is a 29 YO G1P0 female with 38w4d weeks gestation who is being admitted for fetal BPP of 2/10. Pt was seen in triage for contractions. Noted to have flat fetal strip BPP done and noted to have 2/10 given that she had velamentous cord insertion indication to proceed to delivery. Patient reports no complaints. Good fetal movement. **Pregnancy complicated by Active Problems:** Velamentous insertion of umbilical cord, antepartum Rh negative status during pregnancy in third trimester Supervision of normal first pregnancy, antepartum Fetal arrhythmia affecting pregnancy, antepartum **Overview:** Confirmed on 12/29 most consistent with intermittent PAC/PVC. Continue weekly antenatal testing Primary obstetrician/Ob provider is Dr. Darren Lehnert. **Current Facility-Administered Medications:** Oxytocin in sodium chloride 0.9 % (Pitocin) 20 units in 1,000 mL infusion, 500 mL/hr, IV, see admin instructions Oxytocin in sodium chloride 0.9 % (Pitocin) 20 units in 1,000 mL infusion, , IV, continuous PRN Methylergonovine maleate (Methergine) 0.2 mg/mL (1 mL) injection 0.2 mg, IM, every 2 hours PRN Carboprost tromethamine (Hemabate) 250 mcg/mL injection 1 mL, 250 mcg, IM, every 15 minutes PRN Misoprostol (Cytotec) tablet 800 mcg, Oral, one time PRN or Misoprostol (Cytotec) tablet 800 mcg, Buccal, one time PRN or Misoprostol (Cytotec) tablet 800 mcg, Rectal, one time PRN Tranexamic acid (Cyklokapron) 1,000 mg in sodium chloride (Iso-osmotic) 100 mL IVPB, 1,000 mg, IV, one time PRN (Completed) Calcium as carbonate (TUMS) 500 mg (200 mg elemental) chewable tablet 400 mg, 400 mg, Oral, one time only 400 mg at 02/13/YYYY at 0029 hours Oxytocin (Pitocin) 30 units in 0.9% sodium chloride 500 mL infusion, 0-20 milli-units/min, IV, titrate. Last Rate: 2 mL/hr, 2 milli-units/min at 02/13/YYYY at 0035 hours	Ex 2 000012- Ex 2 000016

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		(Completed) Lactated ringers bolus solution 1,000 mL, IV, one time only. Stopped at 02/12/YYYY at 2245 hours Lactated ringers infusion, IV, continuous. Last Rate: 125 mL/hr at 02/13/YYYY at 0032 hours, New Bag Lidocaine PF 1% (Xylocaine MPF) injection 0-10 mL, Infiltration, one time PRN Naloxone (Narcan) 0.4 mg/mL injection 0.1 mg, IV, see admin instructions Ondansetron (Zofran) 4 mg/2 mL injection 4 mg, IV, every 6 hours PRN Metoclopramide (Reglan) 5 mg/mL injection 10 mg, IV, every 6 hours PRN Terbutaline (Brethine) injection 0.25 mg, subcutaneous, one time PRN **Review of systems:** No fever, SOB, dysuria, or GI complaints **Physical examination:** Weight: 83.2 kg **Vitals:** RR: 18, temperature: 98F **General:** Alert, no distress, alert and oriented. **Abdomen:** Soft, no fundal tenderness **FHT:** Baseline: 150 BPM Variability: Minimal Accelerations: Absent Uterine contractions: Irregular, every 5 minutes Estimated fetal weight: 7 pounds, 8 ounces Presentations: Cephalic Cervix: Dilation: 1 cm Effacement: 50% Station: -3 Pelvic relationship: Adequate **Assessment:** 38w4d weeks gestation. **Active Problems:** Velamentous insertion of umbilical cord, antepartum Rh negative status during pregnancy in third trimester Supervision of normal first pregnancy, antepartum Fetal arrhythmia affecting pregnancy, antepartum **Overview:** Confirmed on 12/29 most consistent with intermittent PAC/PVC. Continue weekly antenatal testing **Plan:** **Augmentation:** IV Pitocin induction, and see orders.	
02/13/YYYY	Provider/	**@ 0100 hours: Flow Sheet:**	Ex 2 000168-

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
	Hospital	**OB:** **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:** Coping **Non-verbal indicators of coping:** States coping; Maintaining composure **Maternal positioning:** Semi-fowlers **FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Fetal movement (A):** Present **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction frequency (minutes):** 4-9 **Contraction duration (seconds):** 40-70 **Uterine resting tome:** Soft by palpation	Ex 2 000170
02/13/YYYY	Provider/ Hospital	**@ 0106 hours: Flow Sheet:** **Labor assessment:** **Oxytocin (Pitocin):** **Rate (ml/hr):** 4 ml/hr **Dose (milli-units/min):** 4 milli-units/min **Medication concentration:** 0.06 units/ml	Ex 2 000158
02/13/YYYY	Provider/ Hospital	**@ 0130 hours: Flow Sheet:** **OB:** **FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Fetal movement (A):** Present **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction frequency (minutes):** 2.5-9 **Contraction duration (seconds):** 60-100 **Uterine resting tome:** Soft by palpation	Ex 2 000168- Ex 2 000170
02/13/YYYY	Provider/ Hospital	**@ 0135 hours: Flow Sheet:** **Labor assessment:** **Oxytocin (Pitocin):** **Rate (ml/hr):** 6 ml/hr **Dose (milli-units/min):** 6 milli-units/min **Medication concentration:** 0.06 units/ml	Ex 2 000158
02/13/YYYY	Provider/ Hospital	**@ 0157 hours: Flow Sheet:** **Labor assessment:**	Ex 2 000158- Ex 2 000159

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Anesthesia/pain management type: Epidural – Anesthesia at bedside	
02/13/YYYY	Provider/ Hospital	**@ 0157 hours: Flow Sheet:** **Provider notification:** **Name of physician notified:** Dr. Cassanova at bedside.	Ex 2 000170- Ex 2 000171
02/13/YYYY	Provider/ Hospital	**@ 0200 hours: Flow Sheet:** **Labor assessment:** **Patient rounding:** **Rounding tasks:** Reassessment unchanged **Vitals:** RR: 18 Oxygen therapy O2 device: Room air **Oxytocin (Pitocin):** **Rate (ml/hr):** 6 ml/hr **Dose (milli-units/min):** 6 milli-units/min **Medication concentration:** 0.06 units/ml **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:** Coping **Non-verbal indicators of coping:** States coping; Maintaining composure; Able to relax between contractions **Maternal positioning:** Dangling at bedside **Patient observation:** Patient positioned for epidural	Ex 2 000158- Ex 2 000159
02/13/YYYY	Provider/ Hospital	**@ 0200 hours: Flow Sheet:** **FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction frequency (minutes):** Unable to determine **Oxytocin (Pitocin):** **Rate (ml/hr):** 6 ml/hr **Dose (milli-units/min):** 6 milli-units/min **Medication concentration:** 0.06 units/ml	Ex 2 000170- Ex 2 000171
02/13/YYYY	Provider/ Hospital	**@ 0205 hours: Flow sheet:** **Labor assessment:** **Oxytocin (Pitocin):** **Rate (ml/hr):** 8 ml/hr **Dose (milli-units/min):** 8 milli-units/min	Ex 2 000159

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Medication concentration: 0.06 units/ml	
02/13/YYYY	Provider/ Hospital	**@ 0205 hours: Flow Sheet:** **Labor assessment:** **FMS:** **FMS reviewed?** Yes **FMS reviewed by:** Dr. Johnson	Ex 2 000162- Ex 2 000163
02/13/YYYY	Provider/ Hospital	**@ 0206 hours: Flow sheet:** **Labor assessment:** **Anesthesia/pain management type:** Catheter placed by anesthesia	Ex 2 000159
02/13/YYYY	Provider/ Hospital	**@ 0208 hours: Flow sheet:** **Labor assessment:** **Anesthesia/pain management type:** Test dose given by anesthesia	Ex 2 000159
02/13/YYYY	Provider/ Hospital	**@ 0214 hours: Flow sheet:** **Labor assessment:** **Anesthesia/pain management type:** Loading and continuous infusion by anesthesia	Ex 2 000159
02/13/YYYY	Provider/ Hospital	**@ 0157-0215 hours: Anesthesia Procedure Notes:** **Epidural Block:** **Patient location during procedure:** OB **Start time:** 02/13/YYYY at 0157 hours **End time:** 02/13/YYYY at 0215 hours **Reason for block:** Primary analgesia **Staffing** **Performed By:** **Anesthesiologist:** Anthony Casanova, M.D. **Pre-anesthetic Checklist** **Completed:** Patient identified, IV checked, site marked, risks and benefits discussed, surgical consent, monitors and equipment checked, pre-op evaluation and timeout performed **Epidural** Hand hygiene performed prior to procedure Patient was prepped and draped in usual sterile fashion Time out performed Mask worn **Patient position:** Sitting **Prep:** ChloraPrep **Local Anesthetic:** Lidocaine 1% without Epinephrine **Patient monitoring:** Continuous pulse oximetry, heart rate and non-invasive blood pressure **Approach:** Right paramedian **Landmark Identification:** Palpation technique **Number of Attempts:** 1	Ex 2 000094- Ex 2 000095

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Epidural Needle **Identification Technique:** LOR saline **Needle Type:** Tuohy **Needle Gauge:** 18 G **Needle Length:** 3.5 in **Needle Insertion Depth (cm):** 7 **Location:** Lumbar (1-5) and L4-5 **Catheter** **Catheter Type:** End hole (Closed Tip) **Catheter Size:** 20 G **Skin Depth (cm):** 12 **Test dose:** Lidocaine 1.5% with Epinephrine 1-to-200,000 and negative **Test dose:** 3 **Events:** Easy and well tolerated and no block events **Secured with:** Tegaderm, Adhesive and Medipore Tape (Adhesive Spray) **Test Dose Time:** 02/13/YYYY at 0208 hours **Assessment** **Outcome:** A full evaluation is pending **Additional Notes** Negative TD of 3cc via catheter. After negative aspiration of catheter for heme or CSF, 10cc 0.25% PF Bupivacaine injected via catheter without complications. Pt tolerated procedure well. Connected to pump and started at 12cc/hr.	
02/13/YYYY	Provider/ Hospital	**@ 0226 hours: Anesthesia Pre-procedure Evaluation:** **Other findings:** 06:20 Fetal heart tone down, patient moving to OR for C/S with CLE. **Anesthesia plan:** **ASA final:** 2 – Emergent Epidural plan and risks discussed with patient. N/A induction NPO status N/A Anesthetic plan and risks discussed with patient. **Post-op pain control:** Plan to use epidural for post-op pain control. **Smoking compliance:** Patient did not smoke on day of surgery.	Ex 2 000091-Ex 2 000093

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
02/13/YYYY	Provider/ Hospital	**@ 0230 hours: Flow Sheet:** **FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Fetal movement (A):** Present **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction frequency (minutes):** 2.5-6 **Contraction duration (seconds):** 60-120 **Uterine resting tome:** Soft by palpation	Ex 2 000170- Ex 2 000171
02/13/YYYY	Provider/ Hospital	**@ 0300 hours: Flow sheet:** **Labor assessment:** **Oxytocin (Pitocin):** **Rate (ml/hr):** 8 ml/hr **Dose (milli-units/min):** 8 milli-units/min **Medication concentration:** 0.06 units/ml **Hygiene:** **Hygiene care:** Perineal care; Linen change	Ex 2 000159
02/13/YYYY	Provider/ Hospital	**@ 0300 hours: Flow Sheet:** **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:** Coping **Non-verbal indicators of coping:** States coping; Maintaining composure **Maternal positioning:** Right side **FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Fetal movement (A):** Present **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction frequency (minutes):** 2.5-3.5 **Contraction duration (seconds):** 90-120 **Uterine resting tome:** Soft by palpation **Oxytocin (Pitocin):** **Rate (ml/hr):** 8 ml/hr **Dose (milli-units/min):** 8 milli-units/min **Medication concentration:** 0.06 units/ml	Ex 2 000171- Ex 2 000173
02/13/YYYY	Provider/	**@ 0330 hours: Flow Sheet:**	Ex 2 000171-

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
	Hospital	**FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Fetal movement (A):** Present **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction frequency (minutes):** 3-3.5 **Contraction duration (seconds):** 70-100 **Uterine resting tome:** Soft by palpation	Ex 2 000173
02/13/YYYY	Provider/ Hospital	**@ 0332 hours: Flow sheet:** **Labor assessment:** **FHR (A):** **Prevent/Minimize Category II (indeterminate)/Category III (abnormal)** **Fetal Heart Rate Tracing Duration of Decelerations (mm:ss):** Maternal position changed – Left side – Peanut ball between knees.	Ex 2 000160
02/13/YYYY	Provider/ Hospital	**@ 0332 hours: Flow Sheet:** **Vaginal Exam:** **Method:** Sterile vaginal exam per RB **Examiner:** C Maringola **Bloody show:** Not present **Position – Cervical:** Middle **Consistency – cervical:** Soft **Dilation – cervical:** 2 **Effacement % - cervical:** 50 **Fetal station:** -3 **Bishop score:** 5 **Presentation baby A:** Vertex	Ex 2 000171- Ex 2 000173
02/**13**/YYYY	Provider/ Hospital	**@ 0340 hours: Flow Sheet:** **Labor assessment:** **FMS:** **FMS reviewed?** Yes **FMS reviewed by:** Dr. Stanczyk	Ex 2 000160
02/13/YYYY	Provider/ Hospital	**@ 0400 hours: Flow sheet:** **Labor assessment:** **Oxytocin (Pitocin):** **Rate (ml/hr):** 8 ml/hr **Dose (milli-units/min):** 8 milli-units/min **Medication concentration:** 0.06 units/ml **Hygiene:** **Hygiene care:** Perineal care; Linen change	Ex 2 000160
02/13/YYYY	Provider/ Hospital	**@ 0400 hours: Flow Sheet:** **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:**	Ex 2 000171- Ex 2 000173

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Coping **Non-verbal indicators of coping:** States coping; Maintaining composure; Able t relax between contractions **Maternal positioning:** Left side; peanut ball (comment for placement) **FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Pattern (A):** Late decelerations **Fetal movement (A):** Present **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction frequency (minutes):** 2-4 **Contraction duration (seconds):** 60-110 **Oxytocin (Pitocin):** **Rate (ml/hr):** 8 ml/hr **Dose (milli-units/min):** 8 milli-units/min **Medication concentration:** 0.06 units/ml	
02/13/YYYY	Provider/ Hospital	**@ 0410 hours: Flow Sheet:** **Labor assessment:** **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:** Coping **Non-verbal indicators of coping:** States coping; Maintaining composure; Able to relax between contractions **Maternal positioning:** Throne or frog-legged	Ex 2 000160
02/13/YYYY	Provider/ Hospital	**@ 0412 hours: Flow Sheet:** **FHR (A):** **FHR (A) baseline:** Patient was positioned forward vomiting	Ex 2 000171- Ex 2 000173
02/13/YYYY	Provider/ Hospital	**@ 0430 hours: Flow Sheet:** **FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Pattern (A):** Later decelerations **Prevent/Minimize Category II (indeterminate)/Category III (abnormal) Fetal Heart Rate Tracing Duration of Decelerations (mm:ss):** Maternal position changed **Fetal movement (A):** Present **Uterine activity assessment:**	Ex 2 000173- Ex 2 000175

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Method: TOCO (External tocodynamometer) **Contraction frequency (minutes):** 2-4 **Contraction duration (seconds):** 60-110 **Uterine resting tone:** Soft by palpation	
02/13/YYYY	Provider/ Hospital	**@ 0431 hours: Flow Sheet:** **Labor assessment:** **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:** Coping **Non-verbal indicators of coping:** States coping; Maintaining composure; Able to relax between contractions **Maternal positioning:** Right side	Ex 2 000160
02/13/YYYY	Provider/ Hospital	**@ 0500 hours: Flow Sheet:** **Labor assessment:** **FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Fetal movement (A):** Present **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction frequency (minutes):** 2-3.5 **Contraction duration (seconds):** 80-120 **Oxytocin (Pitocin):** **Rate (ml/hr):** 8 ml/hr **Dose (milli-units/min):** 8 milli-units/min **Medication concentration:** 0.06 units/ml **Vaginal exam:** **Consistency – Cervical:** Soft **Dilation – Cervical:** 2 **Effacement % - Cervical:** 50 **Fetal station:** -3 **Presentation baby A:** Vertex	Ex 2 000160- Ex 2 000161
02/13/YYYY	Provider/ Hospital	**@ 0500 hours: Flow Sheet:** **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:** Coping **Non-verbal indicators of coping:** States coping; Maintaining composure **Maternal positioning:** Right side	Ex 2 000173- Ex 2 000175

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
02/13/YYYY	Provider/ Hospital	**@ 0505 hours: Flow Sheet:** **Labor assessment:** **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:** Coping **Non-verbal indicators of coping:** States coping; Maintaining composure; Able to relax between contractions **Maternal positioning:** Left side **Oxytocin (Pitocin):** **Rate (ml/hr):** 10 ml/hr **Dose (milli-units/min):** 10 milli-units/min **Medication concentration:** 0.06 units/ml	Ex 2 000160- Ex 2 000161
02/13/YYYY	Provider/ Hospital	**@ 0505 hours: Flow Sheet:** **FHR (A):** **FHR (A) baseline:** Patient turned from right, to left, back to right	Ex 2 000173- Ex 2 000175
02/13/YYYY	Provider/ Hospital	**@ 0507 hours: Flow sheet:** **Labor assessment:** **FHR (A):** **Prevent/Minimize Category II (indeterminate)/Category III (abnormal) Fetal Heart Rate Tracing Duration of Decelerations (mm:ss):** Maternal position changed **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:** Coping **Non-verbal indicators of coping:** States coping; Maintaining composure	Ex 2 000160- Ex 2 000161
02/13/YYYY	Provider/ Hospital	**@ 0507 hours: Flow Sheet:** **Labor coping:** **Maternal positioning:** Right side	Ex 2 000173- Ex 2 000175
02/13/YYYY	Provider/ Hospital	**@ 0530 hours: Flow sheet:** **Labor assessment:** **Oxytocin (Pitocin):** **Rate (ml/hr):** 10 ml/hr **Dose (milli-units/min):** 10 milli-units/min **Medication concentration:** 0.06 units/ml	Ex 2 000160- Ex 2 000161
02/13/YYYY	Provider/ Hospital	**@ 0530 hours: Flow Sheet:** **FHR (A):** **FHR (A) baseline:** 155	Ex 2 000175- Ex 2 000176

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Mode (A): External **Variability (A):** Minimal (0-5 BPM) **Pattern (A):** Variable decelerations **Fetal movement (A):** Present **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction frequency (minutes):** 2-3.6 **Contraction duration (seconds):** 80-100 **Uterine resting tone:** Soft by palpation	
02/13/YYYY	Provider/ Hospital	**@ 0536 hours: Flow sheet:** **Labor assessment:** **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:** Coping **Non-verbal indicators of coping:** States coping; Maintaining composure **Maternal positioning:** Left side	Ex 2 000162
02/13/YYYY	Provider/ Hospital	**@ 0536 hours: Flow Sheet:** **FHR (A):** **Prevent/Minimize Category II (indeterminate)/Category III (abnormal) Fetal Heart Rate Tracing Duration of Decelerations (mm:ss):** Maternal position changed	Ex 2 000175- Ex 2 000176
02/13/YYYY	Provider/ Hospital	**@ 0538 hours: Flow sheet:** **Labor assessment:** **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:** Coping **Non-verbal indicators of coping:** States coping; Maintaining composure **Maternal positioning:** Right side	Ex 2 000162
02/13/YYYY	Provider/ Hospital	**@ 0538 hours: Flow Sheet:** **FHR (A):** **Prevent/Minimize Category II (indeterminate)/Category III (abnormal) Fetal Heart Rate Tracing Duration of Decelerations (mm:ss):** Maternal position changed	Ex 2 000175- Ex 2 000176
02/13/YYYY	Provider/ Hospital	**@ 0542 hours: Flow Sheet:** **Labor assessment:** **FMS:** **FMS reviewed?** Yes **FMS reviewed by:** Dr. Stanczyk	Ex 2 000162
02/13/YYYY	Provider/	**@ 0550 hours: Flow Sheet:**	Ex 2 000162

<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>BATES REF</th></tr>
<tr><td></td><td>Hospital</td><td>Labor assessment:

Oxytocin (Pitocin):
Rate (ml/hr): 5 ml/hr
Dose (milli-units/min): 5 milli-units/min
Medication concentration: 0.06 units/ml</td><td></td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 0552 hours: Flow Sheet:
FHR (A):
Prevent/Minimize Category II (indeterminate)/Category III (abnormal) Fetal Heart Rate Tracing Duration of Decelerations (mm:ss): Oxygen administration</td><td>Ex 2 000175-
Ex 2 000176</td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 0035-0558 hours: Medication Administration Record:
Medication: Oxytocin (Pitocin) 30 units in 0.9% sodium chloride 500 mL infusion
Ordering provider: Geoffery Stanczyk, M.D. on 02/13/YYYY at 0015 hours
Ordered dose: 0-20 milli-units/min
Frequency: Titrate
Route: IV
Ordered rate/ordered duration: 0.20ml/hr /__

Administration instructions:
Maximum dose = 20 milli-units/min

Any increase over 20 milli-units/min to be ordered by physician

Tachysystole with Category I/II FHR tracing: Reposition patient and reassess in 10 minutes. If tachysystole persists, decrease Oxytocin dose by half and reassess in 10 minutes. If tachysystole persists, discontinue Oxytocin infusion and notify provider and discuss whether to give Terbutaline 0.25 mg subcutaneous one time as ordered.

Category III FHR tracing with or without tachysystole: Discontinue Oxytocin infusion, reposition patient, and notify provider.

Restarting Oxytocin infusion: if infusion has been discontinued for 30 minutes or less, restart Oxytocin infusion at half the prior dose. If discontinued for more than 30 minutes, restart at the initial ordered dose

Discontinue Oxytocin infusion and notify the provider: Urine output less than 30 mL/hr, sign of uterine rupture, or symptoms of water intoxication.

<table><tr><th>Question</th><th>Answer</th></tr><tr><td>Should this infusion be titrated?</td><td>Yes</td></tr><tr><td>Initial infusion dose</td><td>2 milli-units/min</td></tr><tr><td>Titration dose increment?</td><td>2 milli-units/min</td></tr></table></td><td>Ex 2 000108-
Ex 2 000109</td></tr>
</table>

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF

Titration interval?	30 minutes
Goal?	Effective pattern of contractions every 2-3 minutes or 200-220 Montevideo units
Indication	Induction
Induction reason	Fetal other

Time	Action	Dose/rate	Route	Performed by
0035	New bag	2 milli-units/min 2 ml/hr	IV	Eva James, RN
0106	Rate change	4 milli-units/min 4 ml/hr	IV	Carrie Maringola, RN
0135	Rate change	6 milli-units/min 6 ml/hr	IV	Carrie Maringola, RN
0200	Rate verify	6 milli-units/min 6 ml/hr	IV	Carrie Maringola, RN
0205	Rate change	8 milli-units/min 8 ml/hr	IV	Carrie Maringola, RN
0300	Rate verify	8 milli-units/min 8 ml/hr	IV	Carrie Maringola, RN
0400	Rate verify	8 milli-units/min 8 ml/hr	IV	Carrie Maringola, RN
0500	Rate verify	8 milli-units/min 8 ml/hr	IV	Carrie Maringola, RN
0505	Rate change	10 milli-units/min 10 ml/hr	IV	Carrie Maringola, RN
0530	Rate verify	10 milli-units/min 10 ml/hr	IV	Carrie Maringola, RN
0550	Rate change	5 milli-units/min 5 ml/hr	IV	Carrie Maringola, RN
0558	Stopped	0 milli-units/min 0 ml/hr	IV	Carrie Maringola, RN

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
02/13/YYYY	Provider/ Hospital	**@ 0558 hours: Flow Sheet:** **Labor assessment:** **Oxytocin (Pitocin):** **Rate (ml/hr):** 0 ml/hr **Dose (milli-units/min):** 0 milli-units/min **Medication concentration:** 0.06 units/ml	Ex 2 000162
02/13/YYYY	Provider/ Hospital	**@ 0600 hours: Flow Sheet:** **Labor assessment:** **FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Pattern (A):** Variable decelerations; Late decelerations **Fetal movement (A):** Present **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction frequency (minutes):** 2.5-3.5 **Contraction duration:** 80-110 **Uterine resting tone:** Soft by palpation	Ex 2 000162- Ex 2 000163
02/13/YYYY	Provider/ Hospital	**@ 0600 hours: Flow Sheet:** **Labor coping:** **Is the patient coping with labor per the coping with labor algorithm V2:** Coping **Non-verbal indicators of coping:** States coping; Maintaining composure **Maternal positioning:** Right side	Ex 2 000176- Ex 2 000177
02/13/YYYY	Provider/ Hospital	**@ 0621 hours: Progress Notes:** Patient evaluated in the labor room. Fetal tracing reviewed. There has been absent variability with intermittent decelerations for the last several hours. Discussed with the patient and recommend proceed with CS at this time. The patient is counseled regarding recommendation for C-section for category 3 tracing. The risks, benefits and alternatives to C-section are reviewed with the patient in detail. Specific risks of C-section discussed include but are not limited to pain, bleeding, blood transfusion (and associated transfusion risks), injury to abdominal organs requiring repair or future surgery, and surgical site infection. The patient's questions are answered to the patient's satisfaction. The patient agrees to proceed with C-section at this time.	Ex 2 000025
02/13/YYYY	Provider/ Hospital	**@ 0626 hours: Flow Sheet:** **Labor assessment:** **Patient observation:** Patient transported to ORB	Ex 2 000162- Ex 2 000163
02/13/YYYY	Provider/	**@ 0630 hours: Flow Sheet:** **Labor assessment:**	Ex 2 000162- Ex 2 000163

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
	Hospital	**FHR (A):** **FHR (A) baseline:** 155 **Mode (A):** External **Variability (A):** Minimal (0-5 BPM) **Pattern (A):** Late decelerations **Fetal movement (A):** Present **Uterine activity assessment:** **Method:** TOCO (External tocodynamometer) **Contraction frequency (minutes):** 2-3.5 **Contraction duration:** 60-100 **Uterine resting tone:** Soft by palpation	
02/13/YYYY	Provider/ Hospital	**@ 0632 hours: Nursing Notes:** Labor progressing. Patient Stable. Fetal Well being monitored. VS WDL and pain management addressed.	Ex 2 000026
02/12/YYYY - 02/13/YYYY	Provider/ Hospital	**Fetal Monitoring Strips** From 02/12/YYYY at 2119 hours to 02/13/YYYY at 0630 hours.	Ex 2 000356- Ex 2 000414
02/13/YYYY	Provider/ Hospital	**Operative Report – Cesarean Section:** **Pre-operative Diagnosis:** • 38w4d IUP • Category 3 fetal tracing **Post -operative Diagnosis:** Same as pre-operative diagnosis **Indications:** See pre-op diagnosis above, H&P, and most recent progress note(s) **Procedure:** Primary Low Transverse Cesarean Section **Surgeon:** Chandria Johnson, M.D. **Anesthesia:** Spinal **Anesthesiologist:** Anthony Casanova, M.D. **CRNA:** Matthew Gaddis, CRNA; Shelby Little, CRNA **Operative Findings:** Viable male delivered without complication. **Gestational Age:** 38w4d **Date of Delivery:** 02/13/YYYY **Time of Delivery:** At 0644 hours **Newborn Sex:** Refer to Delivery Summary. **Delivery Type:** Refer to Delivery Summary. **Delayed Cord Clamping:** (Refer to Delivery Summary) **Newborn Weight:** Refer to Delivery Summary. **Apgar 1 Minute:** Refer to Delivery Summary. **Apgar 5 Minutes:** Refer to Delivery Summary. **Maternal Findings:** The uterine outline, tubes and ovaries appeared normal. **Estimated Blood Loss:** 600 mL **Drains:** Foley catheter **Specimens:** Cord blood sample was obtained. The placenta is sent to pathology. Cord pH collected. **Complications:** None	Ex 2 000017- Ex 2 000018

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Disposition: To post-op care on labor and delivery in stable condition **Delivery Summary:** Review the Delivery Report for details. **Procedure Details:** The patient is counseled on the proposed procedure and gives informed consent. The site of surgery was properly noted. The patient was taken to the Operating Room, identified as XXXX and the procedure verified as cesarean delivery. A Time Out was held and the above information confirmed. The patient received antibiotic prophylaxis in the form of Ancef prior to the skin incision. After informed consent, placement of Foley, SCDs, and appropriate anesthesia as listed above, the patient was prepped and draped in usual fashion. A Joel-Cohen incision was made and carried down through the subcutaneous tissue to the fascia in the midline. The fascial incision was made with the scalpel in the midline and extended transversely digitally. The rectus muscles were separated in the midline. The peritoneum was identified and entered bluntly at the superior aspect of the intramuscular space. The peritoneal incision was extended longitudinally with manual traction with careful visualization of the bladder. A low transverse uterine incision was made. The baby was delivered in a cephalic occiput anterior presentation through the hysterotomy. The cord was clamped and cut 10 seconds after birth. Delayed cord clamping not done because of need for neonate resuscitation. The baby was then handed off to the awaiting NICU team for resuscitation. Samples for cord blood were obtained for evaluation. Cord ph samples were collected. The placenta removal was spontaneous and appeared normal. The uterine outline, tubes and ovaries appeared normal. The uterine incision was closed with running unlocked sutures of 0 Biosyn in 2 layer(s). The abdomen is cleared of clots and debris. The uterine incision was reexamined and hemostasis was observed. The peritoneum was closed using 3-0 Caprosyn. The pyramidalis and rectus muscles were loosely closed over the dome of the bladder with Caprosyn. The fascia was then re-approximated with running sutures of 1 PDS. The adipose tissue was irrigated and hemostasis was confirmed. The subcutaneous tissue was approximated with 3-0 Caprosyn. The skin was approximated with 3-0 Biosyn subcuticular and Mepilex dressing is applied. Instrument, sponge, and needle counts were correct times two per nursing. The patient tolerated the procedure well and is prepared for transfer to recovery in stable condition.	
02/13/YYYY	Provider/ Hospital	**@ 0645 hours: Orders:** **Order:** Oxytocin in Sodium chloride 0.9 % (Pitocin) 20 units in 1,000 mL infusion **Frequency:** Routine intra-procedure continuous PRN 02/13/YYYY at 0645 to 02/13/YYYY at 0727 hours **Discontinued by:** Shelby Little, CRNA on 02/13/YYYY at 0727 hours	Ex 2 000098

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		ABC Center ***02/13/YYYY***	
02/13/YYYY	Provider/ Hospital	**@ 0659 hours: Arterial cord blood gas:** **High:** PCO2: 56, TCO2: 27 **Low:** pH: 7.27, PO2: 12, O2 saturation: 14	
02/13/YYYY	Provider/ Hospital	**@ 0702 hours: Venous cord blood gas:** **High:** PCO2: 47 **Low:** pH: 7.31, PO2: 24, base excess: -3, O2 saturation: 48	
02/13/YYYY	Provider/ Hospital	**Nursing Notes:** **At 0644 hours:** Born **At 0645 hours:** PPV @ 100%, chest compressions started, Code called **At 0647 hours:** NNP Ashley Chapman arrived with code team. **At 0648 hours:** Dr. Yen on phone **At 0649 hours:** ETT tube place with one attempt @ 9 cm @ gum, placement confirmed with CO2 detector, PPV @ 100 %. HR checked < 60. **At 0651hours:** Minute of life 6:46 - Epinephrine 3 mL given down ETT, compressions continued with PPV @ 100 % FiO2. **At 0652 hours:** Minute of life 8:07-Umbilical line set up, HR still <60 **At 0653 hours:** Minute of life 8:50- 2nd dose of epinephrine 3 mL given down ETT. **At 0654 hours:** Umbilical line place successfully in vein. **At 0657 hours:** Minute of life 12:45 HR -checked and < 60. IV Epinephrine given. Compressions continued with PPV @100%. NS bolus 38 mL given per UVC. **At 0700 hours:** Minute of life 15:20-HR checked and is < 60. IV Epinephrine given (2nd IV dose). Patient now has agonal gasp occasionally. Blood in ETT noticed. **At 0701 hours:** Minutes of life 16:20- HR rate checked, HR 114. Compressions stopped. PPV continued @ 100 %. Pulse oximeter reading for the first time @ 65%. **At 0702 hours:** Minute of 17:48- HR 144, Sats 69% using PPV @ 100% FiO2. **At 0703 hours:** Patient placed on neopuff @ 100% FiO2. **At 0704 hours:** Patient transferred to NICU in radiant warmer and neopuffed on 100% FiO2.	
02/13/YYYY	Provider/ Hospital	**@ 0707 hours: Admit History and Physical:** **Admit summary:** **Admission Type:** Following Delivery **Initial Admission Statement:** CS for absent variability, poor BPP, and deceleration. Coded at delivery (Intubation/compression/2 doses ETT Epi/2 doses IV Epi/NS bolus.) Admit for hypothermia protocol. **Hospitalization Summary** **Hospital Name:** Mercy Springfield **Service Type:** NICU **Maternal History**	Ex 3 000012- Ex 3 000023

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		RPR Serology: Non-Reactive **HIV:** Negative **Rubella:** Immune **GBS:** Negative **HBsAg:** Negative **Prenatal Care:** Yes **EDC OB:** 02/23/YYYY **Family History:** No relevant maternal or family history. **Complications - Pregnancy/Labor/Delivery:** Yes **Non-Reassuring Fetal Status Comment:** Absent variability **Other Comment:** Fetal arrhythmia (Intermittent PAC/PVC) Velamentous cord insertion Poor biophysical profile Variable FHR decelerations **Maternal Steroids:** No **Maternal Medications:** Yes Prenatal vitamins Pitocin Ancef Rhogam **Comment:** Given 12/01/YYYY **Pregnancy Comment:** Denies the use of drugs, alcohol, and tobacco. No recent infections. **Delivery** **Birth Hospital:** Mercy Springfield **Delivering OB:** Chandria Johnson, M.D. **DOB:** 02/13/YYYY at 0644 hours **Birth Type:** Single **Birth Order:** Single **Fluid at Delivery:** Clear **Presentation:** Vertex **Anesthesia:** Epidural **Delivery Type:** Cesarean Section **Reason for Attendance:** Non-Reassuring Fetal Status - during labor **ROM Prior to Delivery:** No Monitoring VS, NP/OP Suctioning, Supplemental O2, Warming/Drying **Delivery Procedures**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Cardiac Compressions **Start:** 02/13/YYYY **Stop:** 02/13/YYYY **Duration:** 1 **POS:** L&D Clinician: XXXX **Comment:** L&D **Delivery Room Resuscitation (PPV or Chest Comp)** **Start:** 02/13/YYYY **Stop:** 02/13/YYYY **Duration:** 1 **POS:** L&D Clinician: XXXX **Comment:** L&D **Endotracheal Intubation (ETT)** **Start:** 02/13/YYYY **Duration:** 1 **POS:** L&D Clinician: XXXX **Comment:** L&D **Epinephrine** **Start:** 02/13/YYYY **Stop:** 02/13/YYYY **Duration:** 1 **POS:** L&D Clinician: XXXX **Comment:** L&D - 2 doses via ETT, 2 doses via UVC **Positive Pressure Ventilation** **Start:** 02/13/YYYY **Stop:** 02/13/YYYY **Duration:** 1 **POS:** L&D Clinician: XXXX **Comment:** L&D **Umbilical Venous Catheter (UVC)** **Start:** 02/13/YYYY **Stop:** 02/13/YYYY **Duration:** 1 **POS:** L&D Clinician: XXX, XXX **Comment:** L&D - replaced upon arrival to the NICU **Volume Bolus** **Start:** 02/13/YYYY **Duration:** 1 **POS:** L&D **Clinician:** XXXX **Comment:** L&D **APGARS** **1 Minute:** 0 **Practitioner at Delivery:** XXXX **Additional Team Members at Delivery:** Multiple NICU RN + RT **Labor and Delivery Comment:** Urgent C/S for non-reassuring fetal status. NICU nurses present at delivery. Infant born at 0644. Stimulated with no response. Bag/mask ventilation initiated. HR <60. Chest compressions started and emergency buzzer activated. NNP and other NICU nursing/RT staff arrived at just under 3 minutes of life. Compressions and bag/mask ventilation underway. Infant immediately prepped for intubation.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Time 0649: ETT tube place with one attempt @ 9 cm @ gum, placement confirmed with CO2 detector, PPV @ 100 %. HR checked < 60. **Time 0651:** Minute of life 6:46 - Epinephrine 3 mL given down ETT, compressions continued with PPV @ 100 % FiO2. **Time 0652:** Minute of life 8:07 - Umbilical line set up, HR still <60 **Time 0653:** Minute of life 8:50 - 2nd dose of epinephrine 3 mL given down ETT. **Time 0654:** Umbilical line place successfully in vein. **Time 0657:** Minute of life 12:45 - HR checked and < 60. IV epinephrine given. Compressions continued with PPV @100%. NS bolus 38 mL given per UVC at minute of life 12:55. **Time 0700:** Minute of life 15:20 - HR checked and is < 60. IV Epinephrine given (2nd IV dose). First gasp noted at 15:28 minutes of life. Small amount of blood in ETT noted. **Time 0701:** Minute of life 16:20 - HR rate checked, HR 114. Compressions stopped. PPV continued @ 100 %. Pulse oximeter reading for the first time @ 65% at 16:45 minutes of life. **Time 0702:** Minute of life 17:48 - HR 144, Sats 69% using PPV @ 100% FiO2. **Time 0703:** Patient placed on neopuff @ 100% FiO2. **Time 0704:** Patient transferred to NICU in radiant warmer and neopuffed on 100% FiO2. **Admission Comment:** NPO. Insert UAC/DL UVC. CBC, blood culture, ABG with lactic acid, Neo2, Coag Panel drawn. Placed on vent. NS bolus given. Initiate therapeutic hypothermia protocol. **Physical Exam** **GEST OB:** 38 wks 4 d **DOL:** 0 GA: 38 wks 4 d PMA: 38 wks 4 d Sex: Male **BW (g):** 3520 (70) **Admit Weight (g):** 3520 **Temperature:** 94.7F **Place of Service:** NICU	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Intensive Cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring **General Exam:** Intermittent agonal respirations, dusky pink in color, no activity. **Head/Neck:** Anterior fontanel is soft and flat. No oral lesions. Pupils non-reactive. Right pupil larger than left. Gag reflex absent. **Chest:** Clear, equal breath sounds. Good aeration. **Heart:** Regular rate. Significant murmur. Perfusion decreased. **Abdomen:** Soft and flat. No heptosplenomegaly. Normal bowel sounds. **Genitalia:** Normal external genitalia are present. **Extremities:** No deformities noted. Normal range of motion for all extremities. Hips exam deferred. **Neurologic:** No spontaneous activity. Hypotonic. No seizure activity. **Skin:** Dusky pink. Bruising to sternum. **Procedures:** Cardiac Compressions **Clinician:** XXXX **Start:** 02/13/YYYY **Stop:** 02/13/YYYY **Duration:** 1 **POS:** L&D **Comments:** L&D **Delivery Room Resuscitation (PPV or Chest Comp)** **Clinician:** XXXX **Start:** 02/13/YYYY **Stop:** 02/13/YYYY **Duration:** 1 POS: L&D **Comments:** L&D **Endotracheal Intubation (ETT)** **Clinician:** XXXX **Start:** 02/13/YYYY **Duration:** 1 **POS:** L&D **Comments:** L&D **Epinephrine** **Clinician:** XXXX **Start:** 02/13/YYYY **Stop:** 02/13/YYYY **Duration:** 1 **POS:** L&D **Comments:** L&D - 2 doses via ETT, 2 doses via UVC **Positive Pressure Ventilation** **Clinician:** XXXX **Start:** 02/13/YYYY **Stop:** 02/13/YYYY **Duration:** 1 **POS:** L&D **Comments:** L&D **Umbilical Arterial Catheter (UAC)** **Clinician:** XXX, XXX **Start:** 02/13/YYYY **Duration:** 1 **POS:** NICU **Umbilical Venous Catheter (UVC)** **Clinician:** XXX, XXX **Start:** 02/13/YYYY **Duration:** 1 **POS:** NICU	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Comments: Double-Lumen **Umbilical Venous Catheter (UVC)** **Clinician:** XXX, XXX **Start:** 02/13/YYYY **Stop:** 02/13/YYYY **Duration:** 1 **POS:** L&D **Comments:** L&D - replaced upon arrival to the NICU **Volume Bolus** **Clinician:** XXXX **Start:** 02/13/YYYY **Duration:** 1 **POS:** L&D **Comments:** L&D **Medication** **Active Medications:** Ampicillin, Start Date: 02/13/YYYY, Duration: 1 Ceftazidime, Start Date: 02/13/YYYY, Duration: 1 Curosurf (Once), Start Date: 02/13/YYYY, End Date: 02/13/YYYY, Duration: 1 Erythromycin Eye Ointment (Once), Start Date: 02/13/YYYY, End Date: 02/13/YYYY, Duration: 1 Fentanyl, Start Date: 02/13/YYYY, Duration: 1 Inhaled Nitric Oxide, Start Date: 02/13/YYYY, Duration: 1 Comment: 20 ppm Normal saline (Once), Start Date: 02/13/YYYY, End Date: 02/13/YYYY, Duration: 1 Comment: Total of two boluses. Sodium Bicarbonate, Start Date: 02/13/YYYY, End Date: 02/13/YYYY, Duration: 1 Comment: 2 meq/ kg Vitamin K (Once), Start Date: 02/13/YYYY, End Date: 02/13/YYYY, Duration: 1 **Lab Culture** **Active Culture:** **Type:** Blood Date Done: 02/13/YYYY **Result:** Pending Status: Active **Respiratory Support:** **Type:** Oscillator Start Date: 02/13/YYYY Duration: 1 **FiO2:** 1 **Type:** Ventilator Start Date: 02/13/YYYY End Date: 02/13/YYYY Duration: 1 **FiO2:** 1 **Health Maintenance** **Newborn Screening** **Screening Date:** 02/15/YYYY Status: Ordered **Comments:** MO NBS **Screening Date:** 02/27/YYYY Status: Ordered	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Comments: MO NBS **Screening Date:** 03/13/YYYY Status: Ordered **Comments:** MO NBS **FEN** Daily Weight (g): 3520 Dry Weight (g): 3520 Weight Gain Over 7 Days (g): 0 **Today's Status** NPO Fluid: IVF hr/d: 24 Comments: Meds and flushes Fluid: 1/2 NaAce hr/d: 24 Comments: UAC and second lumen of UVC Fluid: TPN hr/d: 24 **Diagnoses** **Diagnosis:** Nutritional Support System: FEN/GI Start Date: 02/13/YYYY **History:** NPO. Initial glucose 134. UVC placed in the delivery room – removed upon arrived and exchanged with double lumen UVC. UAC placed. Starter TPN to run at FG 60. Admit NeoChemBiliPlus => Na 137, K 4.2, Cl 103, CO2 15, Ca 9.9, BUN 9, Cr 0.63, Gluc 151, TPro 5, Alk Phos 244, AST 163, ALT 130, Mag 2.4, Phos 8.7, GGT 102. **Plan:** NeoChem q AM. **Diagnosis:** Respiratory Depression - newborn (P28.9) **System:** Respiratory **Start Date:** 02/13/YYYY **History:** PPV at delivery. Intubated. On 100% FiO2. First agonal breath noted at 15 minutes and 28 seconds of life. To NICU for admission. Placed on Ventilator support on admission - initially on SIMV then changed to volume guarantee. Remains on 100% FiO2. Initial ABG <6.8/>125/64/bicarb incalculable/base excess incalculable/75. Curosurf given x1. Infant pressure limiting on high volume-guarantee settings => shifted to HFOV. **Plan:** Titrate Ventilator support as needed. Follow chest X-ray and blood gases as needed. Repeat Surfactant dosing if clinically indicated. **Diagnosis:** Cardiovascular System: Cardiovascular Start Date: 02/13/YYYY **History:** Required 2 doses of ETT Epi + 2 doses of IV Epi at delivery.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Decreased perfusion. Significant murmur noted. STAT ECHO ordered upon arrival to NICU => Normal study. **Plan:** Monitor. **Diagnosis:** Infectious Screen <= 28D (P00.2) System: Infectious Disease **Start Date:** 02/13/YYYY **History:** Maternal GBS negative. ROM at delivery. CBC and blood culture drawn on admit. Amp and Ceftazidime started. **Plan:** Monitor cultures. Continue antibiotic therapy. **Diagnosis:** Hypoxic-ischemic encephalopathy (severe) (P91.63) System: Neurology **Start Date:** 02/13/YYYY **Diagnosis:** Neurology System: Neurology **Start Date:** 02/13/YYYY **History:** Post-code. Pupils non-reactive. Right pupil greater than the left. No spontaneous activity. Hypotonic. Meets therapeutic hypothermia protocol (initial pH <6.8, lactic acid 11.2, initial base deficit incalculable, no seizures.) STAT HUS done => overall mild increased brain parenchymal echotexture, non specific. 4mm right caudothalamic germinal matrix hemorrhage. Continuous Video EEG ordered (video unavailable.) Neuro consult ordered. **Neuroimaging** **Date:** 02/13/YYYY **Type:** Cranial Ultrasound **Comment:** Overall mild increased brain parenchymal echotexture, non-specific. 4mm right caudothalamic germinal matrix hemorrhage. **Diagnosis:** Term Infant **System:** Gestation **Start Date:** 02/13/YYYY **History:** This is a 38 wks and 3520 grams term infant. AGA. **Diagnosis:** Hematology **System:** Hematology **Start Date:** 02/13/YYYY **History:** Admit CBC => WCC 17.9, Hct 44.6, Plt 233k, and no bands. ANC 8230. Admit Coag Panel => PT 14.7, INR 1.1, PTT 48.2, Fibrinogen 289 **Plan:** CBC q AM. Coag panel q AM. **Diagnosis:** At risk for Hyperbilirubinemia System: Hyperbilirubinemia **Start Date:** 02/13/YYYY **History:** Bili 1.2 on admit to NICU. Bruising to sternum from chest compressions. **Plan:** Monitor bilirubin levels. Initiate photo-therapy as indicated. **Diagnosis:** Metabolic Acidosis of newborn (P84) System: Metabolic **Start Date:** 02/13/YYYY	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		History: Poor BPP. Urgent C/S for non-reassuring fetal status. Coded at delivery. First gasp at 15 minutes 28 seconds of life. Required total of 4 doses of Epi at delivery + NS bolus. Cord gases 7.27/7.31. Infant's initial ABG on arrival to the NICU <6.8/>125/64/bicarb incalculable/base excess incalculable/75. NS bolus repeated. **Parent Communication** Verbal Parent Communication Ashley Chapman- 02/13/YYYY at 0952 hours Mother and father updated at the delivery regarding infant's critical status. Informed that the infant will FOB to NICU and updated further. Dr. Yen to mother's L&D room to update further. **Attestation** On this day of service, this patient required critical care services which included high complexity assessment and management necessary to support vital organ system function. **Authenticated by:** XXXX **Date/Time:** 02/13/YYYY at 0952 hours On this day of service, this patient required critical care services which included high complexity assessment and management necessary to support vital organ system function. The attending physician provided on-site coordination of the healthcare team inclusive of the advanced practitioner which included patient assessment, directing the patient's plan of care, and making decisions regarding the patient's management on this visit's date of service as reflected in the documentation above.	
02/13/YYYY	Provider/ Hospital	**@ 0723 hours: ABG:** **High:** PCO2: > 125, calcium ionized: 6.0 **Low:** pH: < 6.80, PO2: 64, O2 saturation: 75, sodium: 135	Ex 3 000040-Ex 3 000041
02/13/YYYY	Provider/ Hospital	**@ 0723 hours: Labs:** **High:** POC Lactic acid: 11.2	Ex 3 000041
02/13/YYYY	Provider/ Hospital	**@ 0726 hours: Labs:** **High:** POC glucose: 134	Ex 3 000042
02/13/YYYY	Provider/ Hospital	**@ 0740 hours: Labs:** **High:** NRBC: 11, RDW: 18.1, RDW-STDEV: 75.8, glucose: 151, AST: 163, ALT: 130, GGT: 102, magnesium: 2.4, phosphorus: 8.7, lymphocytes relative: 41, monocytes relative: 11, neutrophils absolute count: 8.23, lymphocytes absolute: 7.34, monocytes absolute: 1.97 **Low:** RBC: 3.94 **Normal:** WBC: 17.9, hemoglobin: 14.1, hematocrit: 44.6	Ex 3 000046, Ex 3 000048-Ex 3 000049
02/13/YYYY	Provider/ Hospital	**@ 0751 hours: ABG:** **High:** PCO2: 95, ionized calcium: 5.8 **Low:** pH: 6.85, PO2: 72, HCO3: 17, base excess: -17, O2 saturation: 90, sodium: 136, potassium: 3.3, TCO2: 20	Ex 3 000050-Ex 3 000051
02/13/YYYY	Provider/ Hospital	**@ 0751 hours: Labs:** **High:** POC lactic acid: 9.0	Ex 3 000051

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
02/13/YYYY	Provider/ Hospital	**@ 0753 hours: Labs:** **High:** POC glucose: 130	Ex 3 000052
02/13/YYYY	Provider/ Hospital	**@ 0800 hours: X-Ray of Chest:** **Ordering provider:** XXXX **Reason For Exam:** Difficulty Breathing. **Diagnosis:** See Reason for Exam. **Comparison:** None **Findings:** Endotracheal tube in good position. PH probe and OG tube in the gastric body. Normal cardiothymic silhouette. No airspace consolidation, pneumothorax or pleural fluid. The bowel gas pattern is unremarkable. A UA catheter terminates at the T11-T12 level. UV catheter tip at the right T11 level. No acute osseous abnormality.	Ex 3 000065- Ex 3 000066
02/13/YYYY	Provider/ Hospital	**@ 0804 hours: X-Ray of Chest:** **Ordering provider:** XXXX **Reason For Exam:** Line Placement. **Diagnosis:** See Reason for Exam. **Comparison:** Earlier same day 0741 hours. **Findings:** Cardiomediastinal silhouette is stable. Support lines and tubes remain in place in similar position. Umbilical arterial catheter has been advanced to the level of the mid thoracic aorta. Persistent decreased lung volumes with mild hazy interstitial infiltration. No airspace consolidate or effusion. No pneumothorax. Bowel gas pattern appears stable.	Ex 3 000067- Ex 3 000068
02/13/YYYY	Provider/ Hospital	**@ 0806 hours: Labs:** **High:** PTT: 48.2 **Normal:** Protime: 14.7, INR: 1.1	Ex 3 000053- Ex 3 000054
02/13/YYYY	Provider/ Hospital	**@ 0810 hours: Ultrasound of Head:** **Ordering provider:** XXXX **Comparison:** None **Findings:** No hydrocephalus or midline shift. Overall mild increased brain parenchymal echotexture, nonspecific. Findings suggesting a 4 mm right caudothalamic germinal matrix hemorrhage. No abnormal extra-axial fluid.	Ex 3 000069- Ex 3 000070
02/13/YYYY	Provider/ Hospital	**@ 0815 hours: Nursing Notes:** Called to an urgent CSEC due to a low BPP of 2. Patient delivered and immediately placed under radiant warmer. Patient's first APGAR score of 1. Patient stimulated for approximately 20 seconds. No response to stimulation. Patient given BVM @ 100% FiO2. Heart rate checked once PPV began. Pulse oximeter placed pre-ductal. Heart rate checked and was less than 60. Compressions/Code started at approximately 1.5 minutes of life.	Ex 3 000033
02/13/YYYY	Provider/ Hospital	**@ 0820 hours: Transthoracic Echocardiography:** **Ordering provider:** XXXX **Indications and History:** R/O CHD. S/P code	Ex 3 000002- Ex 3 000011, Ex 3 000075- Ex 3 000078

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Procedure information: No prior study is available for comparison. **Study status:** STAT. **Procedure:** A transthoracic echocardiogram was performed. Image quality was adequate. Scanning was performed from the parasternal, apical, subcostal, and suprasternal notch acoustic windows. **Study components:** M-mode, 2D, complete spectral Doppler, and color Doppler. **Location:** ICU/CCU **Cardiac Anatomy:** **Cardiac segment:** Normal. **Left ventricle:** The cavity size is normal. Systolic function is normal. **Right ventricle:** The cavity size is normal. Systolic function is normal. The estimated peak pressure is 31mm Hg to 43mm Hg. **Left atrium:** The atrium is normal in size. **Right atrium:** The atrium is normal in size. **Atrial septum:** No obvious PFO or ASD identified by 2D imaging and color Doppler. **Aortic valve:** The valve is trileaflet. The leaflets are normal thickness. There is no stenosis. There is no significant regurgitation. **Mitral valve:** Structurally normal valve. No evidence for prolapse. There is no evidence for stenosis. There is no significant regurgitation. **Tricuspid valve:** Structurally normal valve. There is no evidence for stenosis. There is no significant regurgitation. The peak diastolic gradient is 37mm Hg. **Pulmonic valve:** Well visualized. Velocity is within the normal range. There is no evidence for stenosis. There is no significant regurgitation. **Pericardium:** There is no pericardial effusion. **Aorta:** **Aortic root:** The root is normal-sized. **Aortic arch:** The vessel is normal without evidence of coarctation. **Systemic veins:** SVR is normal and to the RA. **Intracardiac mass thrombus:** No apparent intracavitary masses or thrombi detected. **Summary and Conclusion:** **Left ventricle:** The cavity size is normal. Systolic function is normal. **Right ventricle:** The cavity size is normal. Systolic function is normal. The estimated peak pressure is 31mm Hg to 43mm Hg. **Aortic arch:** The vessel is normal without evidence of coarctation. **Cardiac segments:** Normal. **Impressions:** • Normal study. • Estimated RV pressure 31-43 mm Hg. LVSF 32%, EF 64%	
02/13/YYYY	Provider/	**@ 0903 hours: Arterial Blood Gas:**	Ex 3 000055

<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>BATES REF</th></tr>
<tr><td></td><td>Hospital</td><td>High: PCO2: 75, glucose: 136, ionized calcium: 5.5
Low: pH: 6.98, PO2: 49, TCO2: 20, HCO3: 18, O2 saturation: 78, base excess: -14, sodium: 136</td><td></td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 0922 hours: X-Ray of Chest:
Ordering provider: XXXX
Comparison: 02/13/YYYY.

Findings: The endotracheal tube has pulled back to the T1 level. Mild retraction of a pH probe which extends just beyond the GE junction. The OG tube remains in the gastric body/fundus. A UA catheter terminates at T5-T6. A right UV catheter terminates at the right T7-T8 level. Normal cardiothymic silhouette. No airspace consolidation or pleural fluid. Unremarkable visualized bowel gas pattern. No acute osseous abnormality.</td><td>Ex 3 000071-
Ex 3 000072</td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 0929 hours: Medication Administration Record:
Medication: Oxytocin in sodium chloride 0.9 % (Pitocin) 20 units in 1,000 mL infusion
Starts/ends: 02/13/YYYY at 0019 to 02/13/YYYY at 0929 hours
Route: IV
Ordered rate/order duration: 500 ml/hr / __
Ordering provider: Geoffery Stanczyk, M.D. on 02/13/YYYY at 0019 hours
Administration instructions: Titrate to uterine response

<table><tr><th>Time</th><th>Action</th><th>Dose/rate</th><th>Route</th><th>Performed by</th></tr><tr><td>0929</td><td>New bag</td><td>125 ml/hr</td><td>IV</td><td>Heather Schroeder, RN</td></tr></table></td><td>Ex 2 000109-
Ex 2 000110</td></tr>
<tr><td>02/18/YYYY</td><td>Provider/ Hospital</td><td>@ 0933 hours: Blood culture report:
Collected date: 02/13/YYYY at 0740 hours
Result: No growth</td><td>Ex 3 000047</td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 0947 hours: Arterial Blood Gas:
High: PCO2: 74, glucose: 127, PCO2 temp correct: 62
Low: pH: 7.02, PO2: 61, TCO2: 21, HCO3: 19, O2 saturation: 88, base excess: -12, sodium: 132, potassium: 3.1, pH temp correct: 7.0, PO2 temp correct: 47</td><td>Ex 3 000056</td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 1009 hours: Progress Notes:
I was signed out for the weekend.
I was not aware that this patient was in labor and delivery until this morning.
I did visit with this patient after delivery.
I was just notified that the baby is being transferred to Barnes for further evaluation and treatment.
I will see her on a daily basis to try and assist with discharge planning.</td><td>Ex 2 000026</td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 1025 hours: Nursing Notes:
XXXX and Heather Schroeder, RN took report on pt prior to transport to ORB for C-Section. Report given at bedside 02/13/YYYY @ 0622 hours. Pt in ORB with nurses and CRNA at 0628 hours.</td><td>Ex 2 000026</td></tr>
</table>

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
02/13/YYYY	Provider/ Hospital	**@ 1028 hours: Nursing Notes:** **Stork FCMC C section report - Mother** **Prenatal Provider:** XXXX **Delivery Provider:** XXXX **Gravida/Para:** G1P0 **Gestational Age:** 38w4d **Date of Delivery:** 02/13/YYYY **Time of Delivery:** At 0644 hours **Type of Delivery:** C-Section, Low Transverse **C-Section Principal Indication:** Non-reassuring fetal status **C-Section Secondary Indication:** None **Primary or Repeat C-Section:** Primary **Labor Complications:** Fetal Intolerance (1) **Anesthesia:** Epidural (dosed for surgery by anesthesia) **Duramorph given:** Yes **Terbutaline given during labor:** No **Diagnosis of Chorioamnionitis:** No **Post Delivery Antibiotics:** No **Social Concerns:** No **Hotline Call Made:** No **Hotline Note Applied:** No **IV:** Yes **EBL:** 600 mL **Vitals:** BP: 122/69, pulse: 85, temperature: 98.8F, RR: 18, weight: 83.2 kg, LMP: 05/09/YYYY, SpO2: 100%, breastfeeding: Yes, BMI: 27.08 **02/13/YYYY at 0716 hours:** **Uterus** Uterus (WDL): WDL Fundal Height: 2 finger breadths below umbilicus Uterus Position: Midline Uterus Consistency: Firm w/o massage Lochia 1-3 Days Lochia 1-3 Days (WDL): WDL Color: Rubra Amount: Light (less than 10 cm on pad/hr) Odor: Similar to menstrual flow Episiotomy: NA or None Laceration: NA or None **Void:** Foley catheter dependent to gravity Plan to Breastmilk feed? (Asked prior to first feed): Yes (02/13/YYYY at 0054	Ex 2 000026- Ex 2 000033

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		hours) Data Validate disassociated Yes Mother Facility worksheet complete Yes **Additional Information:** RN Report: Holly McGee, RN RN Report: Andrea Suter, RN	
02/13/YYYY	Provider/ Hospital	**@ 1040 hours: Arterial Blood Gas:** **High:** PCO2: 76, PO2: 138, ionized calcium: 5.4 **Low:** pH: 7.05, HCO3: 21, base excess: -10, sodium: 132, potassium: 3.2	Ex 3 000058
02/13/YYYY	Provider/ Hospital	**@ 1047 hours: Arterial Blood Gas:** **High:** PCO2: 77, PO2: 148, O2 saturation: 99, PCO2 temp correct: 65, PO2 temp correct: 127 **Low:** pH: 7.08, base excess: -7, sodium: 135, potassium: 3.0, pH temp correct: 7.13	Ex 3 000059
02/13/YYYY	Provider/ Hospital	**@ 1140 hours: X-Ray of Chest:** **Ordering provider:** XXXX **Reason for exam:** Tube Placement. **Findings:** Comparison is made to the prior examination performed 02/13/YYYY. Endotracheal tube is been advanced and now ends midway between the clavicles and carina in good position approximately 1.1 cm above the carina. An esophageal temperature monitor ends in the distal third esophagus. An enteric tube ends in the region of the gastric fundus. An umbilical venous catheter ends in the right atrium. Umbilical arterial catheter ends at T6. The lung volumes are slightly diminished. The appearance of mild central peribronchial thickening may be accentuated by low lung volumes. There is a relative posterior bowel gas. There is no evidence of free air or pneumatosis. **Impression:** Endotracheal tube ending in good position between the clavicles and carina, as above. Otherwise, no significant interval change.	Ex 3 000073- Ex 3 000074
02/13/YYYY	Provider/ Hospital	**@ 1153 hours: EEG:** **Ordering provider:** XXXX **Referring Physician:** Dr. Yen **Clinical history (from EEG tech sheet):** 5-hour old male, postmenstrual age 38-4/7 weeks, with neonatal encephalopathy **Technical report:** A routine EEG was recorded at the Mercy Hospital in Springfield, MO, using the Nihon Kohden system with recording of digital EEG-video data using scalp electrodes, video, and audio data. An extended international 10-20 electrode placement was used. A variety of referential and	Ex 3 000082

<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>BATES REF</th></tr>
<tr><td></td><td></td><td>bipolar montages were used to analyze the data. All voltages reported were measured peak to peak in a longitudinal bipolar montage unless indicated otherwise. The duration of the study was 1:58:53. The study began at 09:54:45 and ended at 11:53:38 on 02/13/YYYY.

The EEG background activity was symmetric with decreased voltage, decreased reactivity, and decreased variability. No epileptiform abnormalities or clinical or electrographic seizures occurred during the recording. Single channel EKG revealed a normal heart rate without apparent arrhythmia.

Impression: This neonatal EEG is abnormal due to moderate to severe encephalopathy. No epileptiform abnormalities occurred.</td><td></td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 1205 hours: Arterial Blood Gas:
High: PCO2: 84, PO2: 121, TCO2: 28, PCO2 temp correct: 71
Low: pH: 7.08, base excess: -5, sodium: 135, potassium: 3.3, pH temp correct: 7.13</td><td>Ex 3 000060</td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 1255 hours: Arterial Blood Gas:
High: PCO2: 55, PO2: 329, O2 saturation: 99, PCO2 temp correct: 47, PO2 temp correct: 311
Low: pH: 7.25, base excess: -3, sodium: 133, potassium: 3.4, ionized calcium: 4.7, pH temp correct: 7.30</td><td>Ex 3 000061-
Ex 3 000062</td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 0727-1300 hours: Medication Administration Record:
Medication: Oxytocin in sodium chloride 0.9 % (Pitocin) 20 units in 1,000 mL infusion
Starts/ends: 02/13/YYYY at 0019 to 02/14/YYYY at 1243 hours
Route: IV
Ordered rate/order duration: 999 ml/hr /__
Ordering provider: Geoffery Stanczyk, M.D. on 02/13/YYYY at 0019 hours
Frequency: Continuous PRN
Administration instructions: Excessive bleeding in the immediate postpartum period

<table><tr><th>Time</th><th>Action</th><th>Dose/rate</th><th>Route</th><th>Performed by</th></tr><tr><td>0727</td><td>Restarted</td><td>999 ml/hr</td><td>IV</td><td>Holly McGee, RN</td></tr><tr><td>1300</td><td>Stopped</td><td>0 ml/hr</td><td>IV</td><td>Andrea Suter, RN</td></tr></table></td><td>Ex 2 000110</td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 1326 hours: Nursing Notes:
Emergent UVC line placement with orders per A. XXXX . 5fr UVC placed under sterile technique. Pushed to 5 free flow of blood obtained. Held UVC through resuscitation.</td><td>Ex 3 000037</td></tr>
<tr><td>02/13/YYYY</td><td>Provider/ Hospital</td><td>@ 1332 hours: Nursing Notes:
Refer to WDL for Time Out prior to line placement.</td><td>Ex 3 000038</td></tr>
</table>

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		The infant was/secured supine in a developmentally supportive position. The umbilicus and abdomen were prepped with Betadine and draped with sterile towels to cover infant. A 5 Fr umbilical line was placed in the umbilical artery and advanced to 17 cm. Free flow of blood was obtained. Radiologic confirmation of the catheter is in need of advancement by 4cm. The catheter was secured to the cord with 2.0 suture at 21 cm and to the abdomen with transparent dressing. A 5 Fr duel lumen line was placed in the umbilical vein and advanced to 9.5 cm. Free flow of blood was obtained. Radiologic confirmation of the catheter is in need of advancement by 1.5cm. The catheter was secured to the cord with 2.0 suture at 11 cm and to the abdomen with transparent dressing. The infant tolerated the procedure well. The central line checklist was followed.	
02/13/YYYY	Provider/ Hospital	**@ 1437 hours: ABG:** **High:** PO2: 418, O2 saturation: 99, pH: 7.47, PO2 correct: 397 **Low:** PCO2: 34, sodium: 130, potassium: 3.3, calcium ionized: 4.3, PCO2 correct: 29	Ex 2 000060
02/13/YYYY	Provider/ Hospital	**@ 1515 hours: Arterial Blood Gas:** **High:** PO2: 399, O2 saturation: 99, hematocrit: 52, PO2 temp correct: 380 **Low:** Sodium: 133, potassium: 3.3, ionized calcium: 4.5, PCO2 temp correct: 33	Ex 3 000062- Ex 3 000063
02/13/YYYY	Provider/ Hospital	**@ 1530 hours: Nursing Notes:** Patient was transferred to STL children's hospital. He was stabilized by their staff, placed in a transport isolette, and transported intubated on ventilatory support. He continued to be actively cooled by transport team. He was stable at the time of discharge. All necessary medical information and forms were given to the transport team.	Ex 3 000038
02/13/YYYY	Provider/ Hospital	**Transfer Summary:** **Reason For Transfer:** Pulmonary hypertension (newborn) **Transferring To:** ABC Childrens Hospital **Hospitalization Summary** **Hospital Name:** Mercy Springfield **Service Type:** NICU **Admit Date:** 02/13/YYYY **Admit Time:** At 0707 hours **Discharge Date:** 02/13/YYYY **Discharge Time:** At 1300 hours **Discharge Summary** **BW:** 3520 (gms) **Admit DOL:** 0 **Disposition:** Inter-facility transfer (between facilities) **Admit GA:** 38 wks 4 d **Admission Weight:** 3520 (gms)	Ex 3 000024- Ex 3 000033

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Discharge Weight: 3520 (gms) **Discharge Date:** 02/13/YYYY **Discharge Time:** 13:00 **Discharge CGA:** 38 wks 4 d **Admission Type:** Following Delivery **Birth Hospital:** Mercy Springfield **Discharge Comment:** Critical sedated, paralyzed infant requiring frequent adjustments, updates to parents at the bedside and transfer facility via phone (50+ minutes on the phone). Awaiting arrival of St. Louis Children's who is coming by air. Parents aware of infant's critical life threatening status. Cobra forms signed and gone over with the parents. Parents aware if infant survives concerns of long term neurodevelopmental deficits. Questions answered. Initial transport call at 10:05 AM with no answer and then able to get through to transport center at 10:07 AM. **APGARS** **1 Minute:** 1 **5 minute:** 1 **10 minute:** 1 **Discharge Physical Exam** **DOL:** 0 **Temperature:** 94.7F **Today's Weight (g):** 3520 **Birth Weight (g):** 3520 **Birth Gest:** 38 wks 4 d **Pos-Mens Age:** 38 wks 4 d **Date:** 02/13/YYYY **Place of Service:** NICU Intensive Cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring **Diagnoses** **Diagnosis:** Nutritional Support System: FEN/GI Start Date: 02/13/YYYY **History:** NPO. Initial glucose 134. UVC placed in the delivery room – removed upon arrived and exchanged with double lumen UVC. UAC placed. Starter TPN to run at FG 60. Admit NeoChemBiliPlus => Na 137, K 4.2, Cl 103, CO2 15, Ca 9.9, BUN 9, Cr 0.63, Gluc 151, TPro 5, Alk Phos 244, AST 163, ALT 130, Mag 2.4, Phos 8.7, GGT 102. **Plan:** NPO FG 60 on starter TPN. UVC double lumen with 1/2 Na acet with Heparin running through second lumen and UAC with 1/2 Na acet with Heparin	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Diagnosis: Respiratory Depression - newborn (P28.9) **System:** Respiratory **Start Date:** 02/13/YYYY **Diagnosis:** Respiratory Failure - onset <= 28d age (P28.5) **System:** Respiratory **Start Date:** 02/13/YYYY **History:** PPV at delivery. Intubated. On 100% FiO2. First agonal breath noted at 15 minutes and 28 seconds of life. To NICU for admission. Placed on Ventilator support on admission - initially on SIMV then changed to volume guarantee. Remains on 100% FiO2. Initial ABG <6.8/>125/64/bicarb incalculable/base excess incalculable/75. Curosurf given x1. Infant pressure limiting on high volume-guarantee settings => shifted to HFOV. **Assessment:** Infant with OI index of 36.7 and nitric oxide started. OI then 40.4 (approx 15 minutes after starting nitric) and then 15 on subsequent gas. **Plan:** Titrate HFOV support as needed. Follow chest X-ray and blood gases as needed. Repeat Surfactant dosing if clinically indicated. **Diagnosis:** Cardiovascular System: Cardiovascular Start Date: 02/13/YYYY **History:** Required 2 doses of ETT Epi + 2 doses of IV Epi at delivery. Decreased perfusion. Significant murmur noted. STAT ECHO ordered upon arrival to NICU => Normal study. – Estimated RV pressure 31-43 mm Hg. LVSF 32%, EF 64%. **Plan:** Monitor. **Diagnosis:** Infectious Screen <= 28D (P00.2) System: Infectious Disease **Start Date:** 02/13/YYYY **History:** Maternal GBS negative. ROM at delivery. CBC and blood culture drawn on admit. Amp and Ceftazidime started. **Plan:** Monitor cultures. Continue antibiotic therapy. **Diagnosis:** Hypoxic-ischemic encephalopathy (severe) (P91.63) System: Neurology **Start Date:** 02/13/YYYY **Diagnosis:** Neurology System: Neurology **Start Date:** 02/13/YYYY **History:** Post-code. Pupils non-reactive. Right pupil greater than the left. No spontaneous activity. Hypotonic. Meets therapeutic hypothermia protocol (initial pH <6.8, lactic acid 11.2, initial base deficit incalculable, no seizures.) STAT HUS done => overall mild increased brain parenchymal echotexture, non specific. 4mm right caudothalamic germinal matrix hemorrhage. Continuous Video EEG ordered (video unavailable.) Dr. Hauer states low voltage No epileptiform at this point Neuro consult ordered. **Neuroimaging**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Date: 02/13/YYYY **Type:** Cranial Ultrasound **Comment:** Overall mild increased brain parenchymal echotexture, non-specific. 4mm right caudothalamic germinal matrix hemorrhage. **Diagnosis:** Term Infant **System:** Gestation **Start Date:** 02/13/YYYY **History:** This is a 38 wks and 3520 grams term infant. AGA. **Diagnosis:** Hematology **System:** Hematology **Start Date:** 02/13/YYYY **History:** Admit CBC => WCC 17.9, Hct 44.6, Plt 233k, and no bands. ANC 8230. Admit Coag Panel => PT 14.7, INR 1.1, PTT 48.2, Fibrinogen 289 Infant A+DAT negative **Plan:** CBC q AM. Coag panel q AM. **Diagnosis:** At risk for Hyperbilirubinemia System: Hyperbilirubinemia **Start Date:** 02/13/YYYY **History:** Bili 1.2 on admit to NICU. Bruising to sternum from chest compressions. **Plan:** Monitor bilirubin levels. Initiate photo-therapy as indicated. **Diagnosis:** Metabolic Acidosis of newborn (P84) System: Metabolic **Start Date:** 02/13/YYYY **History:** Poor BPP. Urgent C/S for non-reassuring fetal status. Coded at delivery. First gasp at 15 minutes 28 seconds of life. Required total of 4 doses of Epi at delivery + NS bolus. Cord gases 7.27/7.31. Infant's initial ABG on arrival to the NICU <6.8/>125/64/bicarb incalculable/base excess incalculable/75. NS bolus repeated. Received one 2 meq/kg Na bicarbonate. **Parent Communication** Verbal Parent Communication Ashley Chapman- 02/13/YYYY at 1158 hours Parents updated multiple times and aware of infant's life threatening status and if survives high risk of neurodevelopmental impairment. Aware of risks of transport but the need for transfer for possible ECMO if infant worsens. Questions answered. *Others remain same as of history and physical report.*	
02/13/YYYY	Provider/ Hospital	**@ 1626 hours: Labs:** **Rh immune globulin evaluation:** **RHIG eligibility:** Patient is RhIg candidate, see fetal screen result **Fetal screen:** Negative; 1 vial Rh immune Globulin recommended.	Ex 2 000061- Ex 2 000062
02/13/YYYY	Provider/ Hospital	**EMS/Ambulance Report:** **Response info:** **Location:** Mercy Hospital – Springfield **Call type:** ALS 2 **Response priority:** Urgent **Referring M.D.:** Amy Yen	Ex 4 001081- Ex 4 001102

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Chief complaint: **Respiratory** – Respiratory distress **Other:** **Note:** APGARS at birth 1/1/1/2 with arrhythmias noted prior to birth. No spontaneous movement. Fixed non-equal pupils. **Disposition:** **Destination:** ABC Children's Hospital **Destination reason:** Regional Specialty Center **Outcome:** Treated, transported by EMS **Level of care:** Critical Care **Times:** **Received:** At 1014 hours **Dispatch:** At 1043 hours **En route:** At 1113 hours **At scene:** At 1236 hours **At patient side:** At 1243 hours **Transport:** At 1537 hours **At destination:** At 1701 hours **In service:** At 1714 hours **Weight:** 8 lb (3.50 kg) **History:** **Note:** TPN, Fentanyl drip, starting a paralytic birth **At 1303 hours: Assessment:** **Airway:** Patent **Circulation:** Capillary refill - < 3 seconds **Neurological:** Normal baseline for patient **Breathing:** Assisted with ventilation **Mental status:** Normal baseline for patient. **Impression:** **Primary impression:** Respiratory distress syndrome - Acute **Narrative:** Term baby born via C/S this AM for absent variability and decels. Some arrythmia activity prior to birth. Baby coded with APGARS of 1/1/1/2. Got 1 x ETT epi and x2 IV epi. Has a UAC and a double lumen UVC. 3-5 ETT. Surf given. ECHO normal. HUS normal. NS bolus x2. Being cooled currently. Was on conventional vent now on oscillator. Nitric Added. MAP 19. Hz 12, AMP 30, 100%FiO2. Fentanyl gtt, TPN, and paralytic. Pupils are fixed with RT sometimes larger than left. No spontaneous movements. Gas was 6.8/122/24; cord gasses were good; cooled from 15% heat right away.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		AMP 32 on oscillator at 1215 No spontaneous movement even prior to every intervention; pupils unreactive: right side 3mm left 5mm During transfer to our equipment: Our oscillator had a malfunction with the screen not showing and we tried anything we could by swapping batteries and gong oft and on again but no luck elected to change to AC 24/8 rate of 45; Heparin running at 0.5 ml/hr in the UVC and 1 ml/hr in the UAC, Heparin is 5 u/ml. Patient is on Vecuronium 1 mcg/kg/hr and Fentanyl at 1 mcg/kg/hr. started TPN running at 6.6 ml/hr. UAC and UVC in place. Patient with arterial blod pressure. Patient given Amp and Cefta at OSH; patient tolerated transfer to conventional vent on AC and nitric and Gest age 38 Mother's age. GP status, serologies: serologies negative and G1P1 **Pregnancy complications:** **Why presented to hospital:** Labor **L&D complications:** Decels and absent variability. Pt C/S due to these issues in utero. **Mode of delivery and anesthesia** tROM and delivery time **Resuscitation given?** Intervention, two high dose ETT tube epi; UVC/UAC Vit K and Ilotycin given? Delivery until TT? On nitric and cooling blanket with oscillator vent **Assessment:** Pt with bilateral clear lungs and heart rate regular, pt is chemically sedated with Vec upon our arrival with Fentanyl drip as well, pt with no spontaneous movement since delivery and right eye and left eye variable in size with fixed pupils. Gas improved but overventilated to 7 45 pH but good oxygenation ABX timing? Started in AM after birth around 0800 Events during transport? Looked like arrythmias but changed to different primary lead and likely due to vibration as pattern had pulses that did not match the arrythmia OB, Referring, and primary Breast or bottle? Breast feeding	
		ABC Children's Hospital 02/13/YYYY-02/19/YYYY	
02/13/YYYY	Provider/ Hospital	**NICU Fellow Transport Note:** **Referring Hospital:** Mercy Springfield **Referring Physician:** Dr. Yen **Mode of Transport:** Helicopter **Reason for Transfer:** ECMO Evaluation	Ex 4 000273- Ex 4 000274

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Brief History: Patient is a 38w4d with good prenatal care who presented in labor and was found to have a fetal tracing with absent variability and a BPP of 2/8 prompting emergent C/S. ROM at time of delivery, serologies all negative including GBS. At delivery, infant was gray and apneic with HR <60 that did not respond to PPV. Chest compressions were initiated on he was intubated on NICU arrival at MOL3, HR remained <60. He received a total of 2 doses of ETT epinephrine and 2 doses of UVC Epinephrine; first HR >60 was at MOL7. He was transferred to the NICU. Notably, cord gases were normal but initial patient gas <1 hour of life had pH <6.9 pCO2 >100 and base deficit <-20. Infant had no spontaneous activity, hypotonia, and absent primitive reflexes, thus initiating therapeutic hypothermia at 0800. Spot EEG without seizures. He was sedated with Fentanyl and muscle relaxed with Vecuronium. Blood cultures drawn and Ampicillin and Ceftazidime started. His hypoxemia worsened prompting surfactant without improvement. Also transitioned to HFOV for hypercarbia. An echo was performed with normal anatomy and estimated RVP 40; normal biventricular function. iNO started empirically with gradual response, dropping OI from 40 to 20. SLCH was consulted for transport for ECMO evaluation. **Transport Ventilator Mode:** CrossVent Conventional **Special Equipment:** iNO and Tecotherm **Transport Course:** We attempted to transition to the Phasitron oscillator however, the ventilator malfuctioned and was unable to be repaired. We then attempted to transition directly from HFOV to the Crossvent conventional but there was no flow from the vent until we identified a missing piece that should have been occluding a port was missing. After this trouble shooting, we transitioned to CMV settings with a MAP of ~15 (down from 18) and tolerated this from an oxygenation standpoint, he was over-ventilated as well. He was titrated down to settings of PC 17 over PEEP 8 and RR 45 iT 0.4. Pulse ox reading en route was unreliable (mostly in high 80s, infant pink) and as such we did not wean FiO2. He continued to be relatively tachycardic en route (HR 130s while cooling) and received Fentanyl bolus x2 with no effect. His transport was otherwise uneventful. I updated Mikayla on arrival to the unit. **Signout given to:** NICU **Parents updated:** Yes **Parents contact information:** XXXXnet, Rick Beckham	
02/13/YYYY	Provider/ Hospital	**@ 1730 hours: X-Ray of Chest and Abdomen:** **History:** Newborn boy of former 38 weeks gestational age with endotracheal tube and umbilical lines.	Ex 4 000564- Ex 4 000566

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Comparison: None available **Impression:** The umbilical arterial catheter terminates at the level of T6. The umbilical venous catheter terminates in the right atrium, recommend retraction. Enteric tube terminates in the gastric body. Endotracheal tube terminates in the midthoracic trachea. A temperature probe is seen overlying the pelvis. Cardiothymic silhouette is normal. Granular opacities are seen throughout both lungs, which may represent transient tachypnea of the newborn. There is no pleural effusion or pneumothorax. A small amount of gas is seen in nondilated right lower quadrant loops of bowel. There is a paucity of bowel gas throughout the abdomen.	
02/13/YYYY	Provider/ Hospital	**@ 1822 hours: Ultrasound Intracranial:** **History:** Newborn boy of former 38 weeks gestational age with concern for hypoxic ischemic encephalopathy. **Comparison:** None. **Findings:** Echogenicities in the caudothalamic groove, right greater than left, may represent choroid plexus rather than hemorrhage. There is no definite subependymal hemorrhage. There is no intraventricular or intraparenchymal hemorrhage. There is no ventricular dilatation. The periventricular parenchyma is normal. Images through the mastoid fontanelle demonstrate no additional abnormalities. The resistive indices of the right middle cerebral artery and left middle cerebral artery are 0.38 and 0.40 respectively, which is abnormally low (normal is greater than 0.6). **Impression:** • Abnormally low bilateral resistive indices in the middle cerebral arteries. Low resistive indices in the anterior cerebral artery are associated with greater risk for brain injury (reference Snyder et al). • Echogenicities in the caudothalamic grooves, right greater than left, are favored to represent choroid plexus rather than subependymal hemorrhage. Recommend follow-up ultrasound in 24 to 48 hours for further evaluation. **Addendum:** This addendum is being placed on the report for a non-time dependent finding on a patient who is admitted to the hospital (2C). There is a small right grade 1 germinal matrix hemorrhage. These findings were communicated to Arin Phillips, RN by Jonathan Wood, M.D. at 1038 on 02/14/YYYY. XXXX. and Tekes, A., YYYY. Head ultrasound resistive indices are associated	Ex 4 000568- Ex 4 000573

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		with brain injury on diffusion tensor imaging magnetic resonance imaging in neonates with hypoxic-ischemic encephalopathy. Journal of computer assisted tomography, 44(5), p.687.	
02/13/YYYY	Provider/ Hospital	**@ 2048 hours: Neonatology History and Physical:** **Subjective:** Patient is a Gestational Age: 38w4d infant born to XXXX a 29 YO primigravid mother whose pregnancy was complicated by: • Fetal arrhythmia (intermittent PAC/PVC) • Velamentous cord insertion • Non-reassuring fetal status. **Maternal serologies:** Blood type A negative/RPR non-reactive/ HIV negative/ Rubella immune/ GBS negative/ Hepatitis B surface antigen negative **L&D Steroids:** None **Antibiotics Received During Labor:** **Notable maternal medications:** Prenatal vitamins **Membranes:** **Rupture Date:** 02/13/YYYY **Rupture Time:** At delivery **Fluid Color:** Clear **Newborn data:** **Delivery date:** 02/13/YYYY at 0644 hours **Birth history:** **Birth:** Length: 53.3 cm (20.98") Weight: 3.52 kg (7 lb 12.2 oz) HC: 35 cm **APGAR:** One: 1 Five: 1 Ten: 1 Delivery method: C-section, low transverse Gestation age: 38 4/7 weeks Hospital name: Mercy Hospital, Springfield, MO Hospital location: Springfield, MO **Delivery narrative:** **Delivery Resuscitation:** Infant was delivered via C-section for non-reassuring fetal status. The infant did not have spontaneous cry upon delivery and was warmed, dried, and stimulated. Vertex presentation. Infant initiated on bag-mask ventilation shortly after birth, initial heart rate <60. Chest compressions initiated	Ex 4 000119- Ex 4 000127

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		and code called. Infant intubated at ~5 min of life, and bag-mask ventilation continued with 100% FiO2. Received 2 doses of ETT Epinephrine. Umbilical venous catheter placed and infant received 2 doses of IV Epinephrine as well as normal saline bolus. First gasp noted at 15 minutes of life, small amount of blood noted in ETT. Heart rate >100 by 16 minutes of life and compressions discontinued. Heart rate and saturations increased, infant transferred to NICU. Cord gases: 7.27/56/12/26/-1 and 7.31/47/24/24/-3. APGARS 1, 1, 1, 1, 2 at 1, 5, 10, 15 and 20 minutes. In Mercy NICU, infant had initial patient gas of 6./>125/64/incalculable base deficit, subsequent gases with improving ventilation and pH (7.08/77/148/25/-7 prior to transport). Lactate 11.2--> 9.0. INR 1.1. Infant with abnormal neurologic exam (hypotonic, pupils nonreactive, right pupil greater than left) and initiated on therapeutic hypothermia. Had intermittent EEG without seizures noted. Sedated with fentanyl and muscle relaxed with Vecuronium. Blood cultures drawn and infant received Ampicillin and Ceftazidime. Single lumen UVC replaced with double lumen UVC. Started on TPN. Infant received Na bicarbonate. Head ultrasound with mild increased brain parenchymal echotexture, nonspecific and 4mm right caudothalamic germinal matrix hemorrhage. EEG with no seizures, but low voltage per report. AST 163/ALT. Infant had worsening hypoxemia and received surfactant without reported improvement. Transitioned from conventional to HFOV for hypercarbia. Echocardiogram revealed normal cardiac structure and biventricular function, but with estimated RVP 40. Initiated on iNO with gradual improvement in saturations. SLCH consulted for ECMO evaluation. Infant transported by SLCH NICU (please see transport note from Dr. Jack Wren) on conventional ventilator 28/8, received Fentanyl boluses during transport. Maintained on 100% FiO2 and inhaled nitric oxide. **Delayed Cord Clamping:** Not performed Vitamin K Given: Yes Erythromycin Eye ointment (Ilotycin) Given: Yes Infant was transferred to the SLCH NICU for further evaluation and management. **Objective:** **Measurements:** **Admission measurement:** Height: 53.3 cm Weight: 3610 g Head circumference: 35 cm 77 %ile (Z= 0.73) based on Fenton (Boys, 22-50 Weeks) weight-for-age data	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		using vitals from 02/13/YYYY. Length 53.3cm (93rd percentile) OFC: 35cm (69th percentile) **Arrival vitals:** **@ 1712 hours:** Pulse: 135, RR: 45, FiO2: 100% **@ 1715 hours:** Temperature: 32.8C, BP: 77/56, SpO2: 99% **Physical Exam:** **General appearance:** Exam consistent with estimated gestational age, AGA, muscle relaxed **Skin:** Pink, no rash **Head:** Anterior fontanelle soft, open, flat, no molding **Eyes:** normally spaced, open spontaneously **Red Reflex:** Present, pupils 4mm, did not change with light **Ears/Nose/Throat/Palate:** No ear pits or tags, nares appear patent, lip intact, difficulty assessing palate because of presence of ETT **Respiratory:** Clear to auscultation bilaterally, no retractions, moderate aeration bilaterally **Cardiovascular:** Regular rate and rhythm, no murmurs, femoral pulses 2+ bilaterally, normal capillary refill **Abdomen:** Round, soft, non-tender, non-distended **Genitalia:** Male - normal phallus, bilateral descended testes, normal genitalia for gestational age and uncircumcised **Anus:** Appears patent **Spine:** Difficulty assessing back due to presence of cooling blanket **Extremities:** No clavicular crepitus **Neurologic:** Muscle relaxed **Assessment/Plan:** **Assessment:** Patient is a former **Gestational Age:** 38w4d infant, now 0 days infant with the following problems **Problem List Reviewed by Jennifer Wambach, M.D.:** Yes **Active Hospital Problems:** • Neonatal encephalopathy • Respiratory failure • Encounter for central line care • Encounter for observation of infant for suspected infection • Hyponatremia **Plan:** **Thermoregulation:** He is on an open table. Monitor thermoregulatory status secondary to need for respiratory monitoring and sepsis evaluation. **Respiratory:** Infant is intubated and mechanically ventilated. He has respiratory failure secondary to pulmonary hypertension and neonatal encephalopathy. Chest	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		radiograph on admission demonstrated mild granular opacities of bilateral lung fields. Continue to monitor respiratory status with clinical exams and continuous pulse oximetry. Will adjust support as indicated. **Apnea/Bradycardia/Desat:** Monitor for acute, life-threatening apnea and/or bradycardia. Remain on continuous cardiopulmonary monitoring. Infant has not had any episodes of apnea/bradycardia/desaturation. **CV:** He is currently hemodynamically stable. Monitor for hemodynamic instability related to risk for sepsis. He will remain on continuous cardiopulmonary monitoring. Monitor HR, BP, and output closely and support cardiac output as needed. History of fetal PACs and PVCs- will remain on continuous cardiorespiratory monitoring. **FEN/GI:** Infant is currently NPO. Discussed the benefits of providing human milk for infants and mother desires to provide human milk and has consented to donor milk. Infant is on: Dextrose-containing IV fluids at 60 ml/kg/day. Electrolytes notable for mild hyponatremia, will continue to follow serial levels. Monitor growth trajectory, blood glucose, and electrolytes as indicated. Will monitor fluid balance to help optimize intake. **Endo:** Glucoses have been 70-120s since admission. **ID:** Early Onset Sepsis Risk Assessment: Membranes were ruptured at time of delivery. Maternal GBS negative, and antibiotics not indicated. Infant's clinical presentation is categorized as Clinical Illness. Blood culture pending. Infant is receiving Ampicillin and Ceftazidime- will determine length of antibiotic therapy based on clinical course and culture results. Monitor for signs and symptoms of infection. **Heme:** Maternal blood type is A negative. Infant is A positive, Coombs negative. Initial hemoglobin was 17.4, normal platelets. Monitor for anemia and clinically significant hyperbilirubinemia as indicated. **Neurologic:** He has a history and/or exam concerning for neonatal encephalopathy and is receiving neuroprotective hypothermia. Head ultrasound with abnormally low bilateral resistive indices in the middle cerebral arteries, which indicates that the patient is at greater risk for brain injury (reference Snyder et al). Echogenicities in the caudothalamic grooves, right greater than left, are favored to represent choroid plexus rather than subependymal hemorrhage. Recommend follow-up ultrasound in 24 to 48 hours for further evaluation. Neurology service consulted and appreciate recommendations. Infant is receiving continuous EEG, no seizures reported per Neurology. Will likely receive brain MRI at 4 and 10 days. Will receive PT, OT services as tolerated. Infant receiving Fentanyl, Dexmedetomidine, and Vecuronium, transitioned to morphine and Dexmedetomidine after admission. Vecuronium discontinued 02/13/YYYY evening as infant tolerating weans to respiratory support.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		ROP: Eye exam not indicated. **Vascular Access:** Umbilical arterial line and umbilical venous line (double lumen) **Social:** Continue to update family and provide support. Dad updated at bedside by NICU team 02/13/YYYY. Mother updated by phone after infant arrived in SLCH NICU. Screening for In Utero Drug Exposure: No history of exposure. Infant drug screening not indicated. This patient's mother is not on file.	
02/13/YYYY	Provider/ Hospital	**@ 2245 hours: Progress Notes** Visited with patient on 5B Her pain is well controlled Right now we are planning on discharge on postoperative day 1 tomorrow so that she can go to St. Louis to be with her newborn at Barnes.	Ex 2 000037
02/13/YYYY	Provider/ Hospital	**Neonatal Neurology Consultation Report:** *XXXX .* *XXXX D.* **Requesting Physician:** XXXX **Consulting Attending:** XXXX **Date of Birth (DOB):** 02/13/YYYY **Date of admission:** 02/13/YYYY **Reason for Consultation:** Neonatal encephalopathy **Subjective** **History of present illness:** Patient is a 12 hours old former Gestational Age: 38w4d (corrects to 38w 4d) male with neonatal encephalopathy meeting criteria for therapeutic hypothermia transferred from Springfield Mercy. Patient was born via urgent C-section at 0644 hours due to absent variability on fetal tracing. APGARS were 1, 1, 1, 2. Heart rate was less than 60 and did not respond with PPV. Chest compressions were initiated and he was intubated at minute of life 3. Heart rate remained less than 60 and he received total 2 doses of ETT Epinephrine and 2 UVC Epinephrine doses. Admitted of life 7 heart rate rose above 60. Initial cord gases were repeatedly normal, but initial patient gas at less than 1 hour life revealed pH 6.9 and base deficit -20. Infant's initial NEAT score is unknown, but patient met criteria for therapeutic hypothermia which was initiated at just over 1 hour of life (0800.) Blood cultures were drawn and empiric Ampicillin and Ceftazidime were started. He was eventually transitioned to the HFOV worsening hypercarbia and was started on iNO. ECHO was reportedly reassuring. Patient was transferred to SLCH on Vecuronium and Fentanyl.	Ex 4 000276- Ex 4 000282

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		HUS on admission with Abnormally low bilateral resistive indices in the middle cerebral Arteries (L 0.40, R 0.38). Echogenicities in the caudothalamic grooves, right greater than left, are favored to represent choroid plexus rather than subependymal hemorrhage. Pregnancy was reportedly uncomplicated. Maternal serologies were all negative including GBS. **Principal Problem:** HIE (hypoxic-ischemic encephalopathy) **Review of Systems:** All other systems negative except as per HPI. **At 1815 hours: Vitals:** Pulse: 136, RR: 45, temperature: 33.5C **Weight percentile:** 77 %ile (Z= 0.73) based on Fenton (Boys, 22-50 Weeks) weight-for-age data using vitals from 02/13/YYYY. **OFC percentile:** No head circumference on file for this encounter. No intake/output data recorded. **I/O this shift:** **In:** 8.5 (Other:8.5) **Out:** 44.3 (Urine:40.1; Blood:4.2) **General Physical Exam** **General:** Intubated and sedated in isolette, cooling blanket in place. **Head:** Anterior fontanelle difficult to appreciate due to EEG leads. **Lungs:** Mechanically ventilated **Heart:** Regular rate and rhythm **Abdomen:** Soft, non-distended, **Extremities:** Normal digits and extremities, no edema **Neurologic Exam - (Neuromuscular blockaid stopped three hours prior to exam - Sedated with Precedex 0.3 mcg/kg/hr and Morphine 20mcg/kg/hr)** **Mental status:** Intubated and sedated, recently weaned off paralytic **Cranial nerves:** Pupils 4mm bilaterally with minimal reactivity to light **Motor:** Flaccid. No spontaneous movement or response to noxious stimuli. **Reflexes:** No clonus with ankle jerk. **Lab/Radiology/Diagnostic Review:** **The following images and reports were personally reviewed:** ***12/13 (Must be "02/13/YYYY")*** **HUS:** Abnormally low bilateral resistive indices in the middle cerebral arteries. Echogenicities in the caudothalamic grooves, right greater than left, are favored to represent choroid plexus rather than subependymal hemorrhage. **The following EEG reports were personally reviewed:**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		12/13 (Must be "02/13/YYYY") **- present:** Pending **The following labs were personally reviewed:** ***12/13 (Must be "02/13/YYYY")***: AST 200, ALT 149, lactate 2.8, CBC WNL, INR 1.0, PTT 44 **Assessment/Plan** **Assessment:** Patient is a former Gestational Age: 38w4d now 0 days (corrects to 38w 4d) male with neonatal encephalopathy meeting criteria for therapeutic hypothermia. Cooling was initiated shortly after the first HOL at 0800 on 02/13/YYYY. Delivery was complicated by urgent C-section given absent variability and fetal tracing, APGARS of 1, 1, 1, 2 requiring intubation with eventual transition to HFOV with iNO. Initial HR < 60 requiring several doses of Epinephrine and chest compressions. Initial blood gas within the 1st hour of life showed pH 6.0 and BE -20. HUS on admission with Abnormally low bilateral resistive indices in the middle cerebral Arteries (L 0.40, R 0.38) and echogenicities in the caudothalamic grooves, right greater than left, favored to represent choroid plexus rather than subependymal hemorrhage. Please obtain follow up HUS in 24 hours. Etiologies for encephalopathy include hypoxemia, vascular, infectious, metabolic, and genetic. Will plan to initiate EEG per protocol and trend neurologic exam. **Plan:** • cvEEG • Repeat HUS on 02/15/YYYY • Infectious workup per primary team; we agree with LP and CSF infectious studies given unclear cause/contributing factors of neonatal encephalopathy. • OFC 2x/week • MRI brain neonatal protocol on DOL4 and DOL10 (not on scanner 3) • HUS PRN for rapid increase in OFC, signs/symptoms suggestive of increased intracranial pressure, or concerns for acute intracranial process • PT/OT/ST when medically able • Will need early intervention services after discharge • NICU Neurology consult team will continue to follow. Please contact us with any questions or concerns. **Addendum:** The patient had subclinical seizure on 02/14/YYYY at 1150 hours and loaded with Phenobarbital 20 mg/kg. We will continue to monitor his exam and EEG.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Repeat exam in the morning: **Mental status:** Intubated and sedated, no eye opening to stimulus **Cranial nerves:** Pupils 4mm bilaterally, no reactivity OS, OD is minimal reactivity **Motor:** Flaccid. No spontaneous movement or response to noxious stimuli. **Attestation:** *XXXX* I have seen and examined the patient on 02/14/YYYY. I agree with the findings and plan of care as documented in the resident's/fellow's note.	
02/14/YYYY	Provider/ Hospital	**@ 0444 hours: Cesarean Section Post-Operative Progress Note:** **Subjective:** **Postpartum Day 1:** S/P Cesarean Delivery The patient feels well. Pain is well controlled with current medications. The patient is ambulating well. The patient is currently breastfeeding. The patient is tolerating a normal diet. Flatus has been passed. Lochia is normal. **General:** Alert, in no distress **Uterine Fundus:** Normal size, well involuted, firm, non-tender **Incision:** Healing well, no significant drainage, no dehiscence, no significant erythema **DVT Evaluation:** No evidence of DVT seen on physical exam. **Assessment:** Status post cesarean section. Doing well post-operatively. **Plan:** • Continue current postoperative care. • Discharge home today; D/C instructions discussed. • F/U in 6 weeks.	Ex 2 000037- Ex 2 000040
02/13/YYYY - 02/14/YYYY	Provider/ Hospital	**X-Ray of Chest and Abdomen:** **History:** One-day-old born and 38 weeks gestational age with an endotracheal tube and umbilical lines. Evaluate UVC placement. Evaluate lung fields and bowel gas pattern. **Comparison:** Chest radiograph 02/13/YYYY **Findings:** **Study 1:** (02/13/YYYY at 2224 hours) Umbilical arterial catheter terminates at the level of T7. The umbilical venous catheter terminates in the right atrium. The enteric tube terminates in the gastric body. Endotracheal tube terminates in the midthoracic trachea. A temperature rectal probe is seen. The cardiothymic silhouette is normal. The lungs appear clear. No pleural effusion or pneumothorax. A small amount of gas is seen in the nondilated right lower quadrant and lower central abdomen with overall paucity of bowel gas.	Ex 4 000574- Ex 4 000581

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Study 2: (02/14/YYYY at 0506 hours) Unchanged findings compared to Study 1. **Impression:** • Umbilical arterial catheter terminates at the level of T7. Umbilical venous catheter terminates in the right atrium. • Endotracheal tube terminates in the midthoracic trachea. • Clear lungs. • Small amount of gas in the nondilated right lower quadrant and lower central abdomen with overall paucity of bowel gas. The radiology attending physician has personally reviewed this study, and had reviewed and/or edited this written report and agrees with it.	
02/14/YYYY	Provider/ Hospital	**@ 0652 hours: Pediatric Transthoracic Echocardiography:** **Summary:** • Normal segmental anatomy (S, D, S). • Moderate to severe decreased systolic function of left ventricle. • Moderate to severe decreased systolic function of right ventricle. • Qualitatively under filled ventricles. • Low Doppler velocities suggestive of low cardiac output (aortic 0.3 m/sec). • A moderate atrial level shunt is seen with mostly right-to-left shunt. • Mild tricuspid valve regurgitation is seen. • Mild mitral regurgitation is seen. • A tiny patent ductus arteriosus is seen with left to right shunt.	Ex 4 000554- Ex 4 000558
02/14/YYYY	Provider/ Hospital	**@ 0700 hours: Daily EEG – Video study (NICU) Report:** **History:** Patient is a 27 hours old male undergoing EEG-video study for neonatal hypothermia protocol. He does not have a history of seizures and does not have a history of prior neurological conditions. **Gestational Age:** 38w 5d **Study start date:** 02/13/YYYY **Study start time:** At 1844 hours **Daily end date:** 02/14/YYYY **Daily end time:** At 0700 hours The study period was not interrupted. **Daily neuroactive medication changes:** None. **Montage modifications:** Not modified	Ex 4 000296- Ex 4 000298

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Background EEG: The EEG background was excessively discontinuous, asynchronous, and without evidence of state change or cycling. The EEG background consisted of occasional bursts of 40-100 microvolt delta and theta activity with superimposed 9-12 Hz faster frequency activity. The bursts of activity were asynchronous. The interburst intervals consisted of 20-60 second periods of suppression of the background to below 10uV. There was no persistent asymmetry. Electrographic reactivity was not appreciated. No interictal epileptiform abnormalities were noted. The single channel ECG showed heart rate ranging between 110 and 140 beats per minute. **Seizures:** None. **Reported spells:** None. **Daily Interpretation:** This portion of the EEG-video study is abnormal due to excessive discontinuity, low voltage of EEG background, lack of normal grapho-elements expected for age and lack of cycling and reactivity. This is consistent with moderate to severe encephalopathy from any cause. Results were communicated directly to the neonatal neurology team daily and as needed throughout the study period.	
02/14/YYYY	Provider/ Hospital	**@ 0709 hours: Nursing Notes:** Pain relieved with current medication. Tolerating diet, voiding without difficulty. Pumping and storing breast milk to take to INA	Ex 2 000048
02/14/YYYY	Provider/ Hospital	**Obstetrical Discharge Form:** **Primary OB Clinician:** Dr. XXXX **EDC::Estimated Date of Delivery:** 02/23/YYYY **Gestational Age:** 38w4d **Antepartum complications and discharge diagnosis:** • Velamentous insertion of umbilical cord, antepartum • Rh negative status during pregnancy in third trimester • Supervision of normal first pregnancy, antepartum • Fetal arrhythmia affecting pregnancy, antepartum **Overview:** Confirmed on 12/29 most consistent with intermittent PAC/PVC. Continue weekly antenatal testing Cesarean delivery delivered **Hospital Course:** See H&P, progress notes, lab results, and imaging reports for	Ex 2 000019- Ex 2 000022

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		complete details of the current hospital course. **Delivered By:** Dr. Chandria Johnson **Delivery Type:** C-Section non-labor **Tubal Ligation:** N/A **Anesthesia:** Epidural **Medications prior to admission:** • Prenatal vitamin – Iron Fumarate – Folic acid 27 mg – 0.8 mg tablet. Take 1 tablet by mouth daily • Fluoxetine (Prozac) 20 mg capsule. Take 60 mg by mouth daily • Ondansetron (Zofran ODT) 4 mg tablet, rapid dissolve. Take 1 tablet (4 mg) by mouth every 8 hours as needed for nausea/emesis. Dissolve tablet on top of tongue, then swallow with saliva. • Paroxetine HCl (Paxil oral). Take by mouth **DC medications:** • Oxycodone 5 mg tablet • Fluoxetine 20 mg capsule • Paxil oral • Prenatal vitamin – Iron Fumarate – Folic acid 27 mg – 0.8 mg tablet **Stop taking these medications:** • Ondansetron 4 mg tablet, rapid dissolve **Admit date:** 02/12/YYYY **Discharge date:** 02/14/YYYY **Plan:** D/C Instructions, postpartum follow up, and patient's questions answered. Reviewed D/C Medications. Prescriptions provided: Yes Follow-up appointment with Dr. Darren Lehnert in 6 weeks. Pt is being dismissed on POD 1 so she can be with her newborn son at Barnes.	
02/14/YYYY	Provider/ Hospital	**@ 1118 hours: Neonatology Daily Progress Notes:** **Subjective:** **Interval history:** I have examined and reviewed patient's course over the past 24 hours. Remains on conventional ventilation. Weaned FiO2 to 60%. Receiving iNO. Adequate ventilation and oxygenation. No urine output overnight, but started to have some urine in the morning. MBP stable, not receiving vasopressors. Started on Ca gluconate infusion and low dose epi today for decreased function per cardiology report. **Objective**	Ex 4 000299-Ex 4 000305

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		02/13/YYYY at 1715 hours: Weight: 3.61 kg (7 lb 15.3 oz) **Physical Exam:** **General:** Tolerated exam **HEENT:** Anterior fontanelle open, soft, and flat **Cardiovascular:** Heart regular in rate and rhythm, no murmur; capillary refill <2 seconds **Respiratory:** Chest rise symmetric bilaterally with clear, equal breath sounds **GI/GU:** Abdomen soft, nontender, nondistended **Musculoskeletal:** No spontaneous movements **Neurological:** Hypotonic and flaccid, no spontaneous movements, does not open eyes. Pupils fixed and dilated. **Skin:** Without rash or jaundice **Assessment:** Patient is a former Gestational age: 38w4d infant, now 1 days old with problem list that has included: **Active hospital problems:** • Hypokalemia • Hyperglycemia • Biventricular failure • Neonatal encephalopathy • Respiratory failure • Encounter for central line care • Encounter for observation of infant for suspected infection • Hyponatremia **Plan:** **Thermoregulation:** Off, Radiant warmer. Monitor thermoregulatory status secondary to need for therapeutic hypothermia and adjust as indicated. **Respiratory:** Infant is intubated and mechanically ventilated. **Conventional Ventilator:** SIMV PRVC Vt (Set, mL): (S) 19 mL PEEP/CPAP/EPAP (cm H2O): 7 cm H2O Resp Rate (Set): 35 FiO2 (%) Avg: 68.9 % Min: 60 % Max: 70 % Insp Time (sec): 0.4 sec Continue to wean FiO2 as tolerated. Stable at 60% while weaning iNO. Continue to monitor pre- and post- ductal SpO2. Continue gases Q4hrs. Continue to monitor respiratory status with clinical exams and continuous pulse oximetry. Will adjust support as indicated. **Apnea/Bradycardia/Desat:** Monitor for acute, life-threatening apnea and/or bradycardia. Remain on continuous cardiopulmonary monitoring. Infant has not had any episodes of apnea/bradycardia/desaturation.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		CV: He is currently hemodynamically stable. Monitor for hemodynamic instability related to decreased cardiac function and risk for sepsis. He will remain on continuous cardiopulmonary monitoring. Monitor HR, BP, and output closely and support cardiac output as needed. Echo on 02/14/YYYY showed moderate to severe decreased biventricular function, mild mitral regurgitation, mild tricuspid regurgitation and PDA left to right shunt. He was started on 02/14/YYYY on low dose epi and Ca gluconate infusion. **FEN/GI:** Mother desires to provide human milk. Infant is on: Dextrose/electrolyte-containing IV fluids at 50 ml/kg/day. Infant will be advanced to: Total fluid goal of 60 ml/kg/day. Monitor urine output and advance TF as tolerated. Titrate GIR as tolerated. CMP with mildly elevated AST/ALT. He will remain NPO. Will advance per protocol. Monitor growth trajectory, blood glucose, and electrolytes as indicated. Will monitor fluid balance to help optimize intake. **ID:** Blood culture is no growth to date. Sepsis screening labs were reassuring. Infant is on empiric Ampicillin and Ceftazidime. Consider LP when rewarming. Monitor for signs and symptoms of infection. Placental pathology was not sent. **Heme:** Maternal blood type is: This patient's mother is not on file. Infant ABO: 02/13/YYYY: ABO/Rh Neonate A Positive (Ref range:). H/H stable. Coagulation profile normal. Screening for Hyperbilirubinemia: **Interventions:** None - Monitor for clinically significant jaundice **Neurologic:** • He has a history and/or exam concerning for neonatal encephalopathy and is receiving neuroprotective hypothermia. Vecuronium discontinued 02/13/YYYY evening as infant tolerating weans to respiratory support. Discontinued Morphine on 02/14/YYYY. Remains on Precedex. • Head ultrasound with abnormally low bilateral resistive indices in the middle cerebral arteries, which indicates that the patient is at greater risk for brain injury. Echogenicities in the caudothalamic grooves, right greater than left, are favored to represent choroid plexus rather than subependymal hemorrhage. Recommend follow-up ultrasound in 24 to 48 hours for further evaluation. • Neurology service consulted and appreciate recommendations. • Infant is receiving continuous EEG, seizure reported on 02/14/YYYY. Received one dose of Phenobarbital.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		• Will perform brain MRI at 4 and 10 days. • Will receive PT, OT services as tolerated. **Vascular Access:** Umbilical arterial line and umbilical venous line **Social:** Continue to update family and provide support. Screening for In Utero Drug Exposure: No history of exposure. Infant drug screening not indicated. **YYYY-YYYY Annual Synagis Prophylaxis:** Not indicated. Plan to discuss RSV, influenza, and COVID prophylaxis as appropriate. **Newborn Discharge Checklist:** **Discharge Teaching Complete:** In Progress **Primary Care Physician:** Sara Lyn Caffey, M.D. **Additional Appointments:** No future appointments. **Immunizations:** There is no immunization history for the selected administration types on file for this patient.	
02/15/YYYY	Provider/ Hospital	**@ 0700 hours: Daily EEG – Video study (NICU) Report:** **History:** Patient is a 2 days old male undergoing EEG-video study for neonatal hypothermia protocol. He does not have a history of seizures and does not have a history of prior neurological conditions. **Study Part 2** **Daily start date:** 02/14/YYYY **Daily start time:** At 0700 hours **Daily end date:** 02/15/YYYY **Daily end time:** At 0700 hours The study period was not interrupted. **Daily neuroactive medication changes:** Phenobarbital was administered at 1213 hours. **Montage modifications:** Not modified. **Background EEG** The EEG background was excessively discontinuous, asynchronous, and without evidence of state change or cycling. The EEG background consisted of occasional bursts of 40-100 microvolt delta and theta activity with superimposed 9-12 Hz faster frequency activity. The bursts of activity were asynchronous. The interburst intervals consisted of 20-60 second periods of suppression of the background to below 10uV. There was no persistent asymmetry. Electrographic reactivity was not appreciated. No interictal epileptiform abnormalities were	Ex 4 000316- Ex 4 000318

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		noted. The single channel ECG showed heart rate ranging between 110 and 135 beats per minute. **Seizures:** Four brief electrographic only seizures occurred during this portion of the study between 08:52 and 11:34 independently at the F3/C3/Fz or F4/C4/Fz electrodes. Electrographically, the ictal pattern consisted of 20-40 microvolt rhythmic 1-2 Hz delta frequency activity with superimposed 15-20 Hz faster frequency activity which evolved to include 40-60 microvolt 0.5-1 Hz sharp waves for approximately 1 minute before ending abruptly. Runs of rhythmic discharges having a similar morphology but without clear evolution were additionally present in the same distribution without clinical correlation. Phenobarbital was administered at 12:13 which resulted in resolution of further seizure activity. **Reported spells:** One clinical spell was documented with a depression of the patient event button on 02/14/YYYY at 16:30 for "drop of blood pressure to MAP of 30" that was without an ictal electrographic correlate. **Daily Interpretation:** **This portion of the EEG-video study is abnormal due to:** • Presence of four electrographic seizures arising independently from right and left frontal/central electrodes and resolution after phenobarbital administration. Last seizure at 11:34 on 02/14/YYYY. • Excessive discontinuity, low voltage of EEG background, lack of normal grapho-elements expected for age and lack of cycling and reactivity. This is consistent with moderate to severe encephalopathy from any cause. Results were communicated directly to the neonatal neurology team daily and as needed throughout the study period.	
02/15/YYYY	Provider/ Hospital	**@ 0752 hours: Neonatal Neurology Consultation Service Progress Notes:** *XXXX*. **Subjective:** **Summary:** Patient is a former Gestational Age: 38w4d now 2 days (corrects to 38w 6d) male with neonatal encephalopathy meeting criteria for therapeutic hypothermia transferred from Springfield Mercy on 02/13/YYYY PM. **Interval History:** • Cooling protocol, completed 48 hr this morning • No acute events overnight • Intubated and sedated with Precedex • Started on Epinephrine on 02/14/YYYY **Brief Summary of HPI:**	Ex 4 000282-Ex 4 000286

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Patient was born via urgent C-section at 0644 hours on 02/13/YYYY due to absent variability on fetal tracing. APGARS were 1, 1, 1, 2. Heart rate was less than 60 and did not respond with PPV. Chest compressions were initiated and he was intubated at minute of life 3. Heart rate remained less than 60 and he received total 2 doses of ETT Epinephrine and 2 UVC Epinephrine doses. Admitted of life 7 heart rate rose above 60. Initial cord gases were repeatedly normal, but initial patient gas at less than 1 hour life revealed pH 6.9 and base deficit -20. Infant's initial NEAT score is unknown, but patient met criteria for therapeutic hypothermia which was initiated at just over 1 hour of life (0800.) Blood cultures were drawn and empiric Ampicillin and Ceftazidime were started. He was eventually transitioned to the HFOV worsening hypercarbia and was started on iNO. ECHO was reportedly reassuring. **Objective:** **At 0700 hours: Vitals:** Pulse: 126, RR: 33, temperature: 33.5C **Weight reading from last 1 encounters:** 3.61 kg (7 lb 15.3 oz) (77%, Z = 0.73) Growth percentiles are based on Fenton (Boys, 22-50 Weeks) data. **Weight percentile:** 77 %ile (Z= 0.73) based on Fenton (Boys, 22-50 Weeks) weight-for-age data using vitals from 02/13/YYYY. **HC Readings from Last 3 Encounters:** No data found for HC **OFC percentile:** No head circumference on file for this encounter. **I/O last 2 completed shifts:** **In:** 223.1 (I.V.:196.6; IV Piggyback:26.5) **Out:** 215.8 (Urine:214; Blood:1.8) No intake/output data recorded. **General Physical Exam:** **General:** Resting comfortably in isolette **Head:** Anterior fontanelle open, soft, and flat **Lungs:** Mechanically ventilated, triggers breaths **Heart:** Regular rate and rhythm on monitor **Abdomen:** Soft, non-distended and no organomegaly **Neurologic Exam** **Mental status:** No eye opening **Cranial nerves:** Pupils anisocoric, R>L, OD non reactive, OS sluggishly reactive. **Sensory-Motor:** No spontaneous activity, does not move extremities with noxious stimuli	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Lab/Radiology/Diagnostic Review: **The following images and reports were personally reviewed:** **02/13/YYYY HUS:** Abnormally low bilateral resistive indices in the middle cerebral arteries. Low resistive indices in the anterior cerebral artery are associated with greater risk for brain injury. There is a small right grade 1 germinal matrix hemorrhage. **The following EEG reports were personally reviewed:** **cEEG 02/13/YYYY-02/14/YYYY AM:** This portion of the EEG-video study is abnormal due to excessive discontinuity, low voltage of EEG background, lack of normal grapho-elements expected for age and lack of cycling and reactivity. This is consistent with moderate to severe encephalopathy from any cause. **Assessment/Plan:** **Assessment:** Patient is a former Gestational Age: 38w4d now 2 days (corrects to 38w6d) male with severe neonatal encephalopathy meeting criteria for therapeutic hypothermia. Cooling was initiated shortly after the first HOL at 0800 on 02/13/YYYY. Delivery was complicated by urgent C-section given absent variability and fetal tracing, APGARS of 1, 1, 1, 2 requiring intubation with eventual transition to HFOV with iNO. Initial HR < 60 requiring several doses of Epinephrine and chest compressions. Initial blood gas within the 1st hour of life showed pH 6.0 and BE -20. HUS on admission with abnormally low bilateral resistive indices in the middle cerebral Arteries (L 0.40, R 0.38) and echogenicities in the caudothalamic grooves, right greater than left, favored to represent choroid plexus rather than subependymal hemorrhage. Please obtain follow up HUS in 24 hours. cEEG showed excessive discontinuity, suppressed background, with lack of cycling and reactivity. The patient had electrographical seizure on 02/14/YYYY for which treated with Phenobabital. Given he has been seizure free almost 24 hours, we recommend discontinue vEEG and follow clinically. Etiologies for encephalopathy include hypoxemic injury, vascular, infectious, metabolic, and genetic. **Plan:** • We will continue VEEG given high risk for recurrent seizures in the context of limited neurological examination. • Repeat HUS on 02/15/YYYY • Infectious workup per primary team; we agree with LP and CSF infectious studies given unclear cause/contributing factors of neonatal encephalopathy. • OFC 2x/week • MRI brain neonatal protocol on DOL4 (02/17/YYYY) and DOL10 (not	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		on scanner 3) • HUS PRN for rapid increase in OFC, signs/symptoms suggestive of increased intracranial pressure, or concerns for acute intracranial process • PT/OT/ST when medically able • Will need early intervention services after discharge • NICU Neurology team will continue to follow. Please contact us via the Neurology NICU pager with any questions or concerns. **Attestation:** *XXXX* I have seen and examined the patient on 02/15/YYYY. I agree with the findings and plan of care as documented in the resident's/fellow's note. I reviewed the EEG findings with mom and dad at the bedside. I expressed to them my concerns regarding his severely depressed EEG background and presence of seizures in the setting of persistent severe encephalopathy. I indicated my concern that these are signs consistent with global cerebral dysfunction likely representative of global cerebral injury. These findings regrettably place Wyatt at risk for chronic and global neurodevelopmental impairment. We will continue to support patient, parents and primary team with regards to his neurological care.	
02/15/YYYY	Provider/ Hospital	**@ 1103 hours: Initial Nutrition Assessment:** **Nutrition evaluation:** Patient is a 2 days old male. Admit Dx: HIE (hypoxic-ischemic encephalopathy). Admitted on 02/13/YYYY, current LOS is 2 days. **Birth History** **Birth:** Length: 53.3 cm Weight: 3.52 kg HC: 35 cm **APGAR:** One: 1 Five: 1 Ten: 1 **Delivery method:** C-section, low transverse Gestation age: 38 4/7 weeks Hospital name: Mercy Hospital, Spring field, MO Hospital location: Springfield, MO **Diagnosis:** • Neonatal encephalopathy • Respiratory failure • Encounter for central line care • Encounter for observation of infant for suspected infection • Hyponatremia	Ex 4 000305- Ex 4 000308

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Impression: Mother desires to breastfeed and Mother has consented to donor breastmilk. Currently NPO undergoing therapeutic hypothermia, on D12.5% fluids at 60 mLs/kg. Mom is pumping and giving oral care. **Aspen/Pediatric Malnutrition** Not applicable at the moment, will start assessing when: Infants born 37 weeks+ are 29 days old or greater Preterm infants are 44 weeks and older corrected gestation **Plan/Recommendations:** • NPO through rewarming. Consider trophic feeds (20 ml/kg/d or 8 mLq3h of EBM or DBM during cooling once evidence of return of bowel function (as defined by presence of clinical improvement and normal bowel sounds). Consider TPN on DOL# 2 with 3 gm/kg/d protein and 1gm/kg/d SMOF lipid if electrolytes and urine output are stable and severity of encephalopathy predicts poor feeding tolerance after therapeutic hypothermia. TPN duration determined by enteral feeding tolerance at 100ml/kg/d. • Oral care per guideline • Enteral feeding goal of EBM/DBM @ 150 mls/kg (66 mlsq3) and 100 kcals/kg • Vitamin D supplementation once at full feeds, 400 IUs • Donor milk as a bridge- Review/stop after 96 hours • Daily weights • Will monitor intake, growth and make necessary changes on medical rounds	
02/15/YYYY	Provider/ Hospital	**@ 1139 hours. Neonatology Daily Progress Notes:** **Subjective:** **Interval history:** I have examined and reviewed patient's course over the past 24 hours. Remains on conventional ventilation. Weaned FiO2 to 60%. Receiving iNO but weaning appropriately. No urine output overnight, improved overnight with a total of 2.5 ml/kg/hr for the last 24 hours. TF increased to 70 ml/kg/day. MBP stable, not receiving vasopressors. Started on Ca gluconate infusion and low dose epi on 02/14/YYYY for decreased function per echo report. **Plan:** **Respiratory:** Infant is intubated and mechanically ventilated. **Conventional Ventilator:** SIMV PRVC Vt (Set, mL): (S) 16 mL PEEP/CPAP/EPAP (cm H2O): 7 cm H2O Resp Rate (Set): 30 FiO2 (%) Avg: 59.8 % Min: 58 % Max: 60 %	Ex 4 000308- Ex 4 000316

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Insp Time (sec): 0.4 sec Continue to wean FiO2 as tolerated, decrease floor to 50% while weaning iNO. Continue to monitor pre-and-post ductal SpO2. Continue gases Q8H Continue to monitor respiratory status with clinical exams and continuous pulse oximetry. Will adjust support as indicated. **CV:** Repeat echo on 02/16/YYYY **FEN/GI:** Mother desires to provide human milk. Infant will be advanced to: Total fluid goal of 70 ml/kg/day. Monitor urine output and advance TF as tolerated. Hyponatremia improving with improved diuresis. Hypokalemia on 02/14/YYYY-02/15/YYYY, will replete with 1 meq/kg on 02/15/YYYY. Titrate GIR as tolerated. Hyperglycemia on 02/14/YYYY-02/15/YYYY. Adjust GI as indicated. CMP with mildly elevated AST/ALT. He will remain NPO. Will advance per protocol. Monitor growth trajectory, blood glucose, and electrolytes as indicated. Will monitor fluid balance to help optimize intake. *Others remain same.*	
02/15/YYYY	Provider/ Hospital	**Pathology report:** **Collected date:** 02/13/YYYY at 0801 hours **Specimen:** A1- Proximal and distal umbilical cord A2-Fetal membranes and peripheral placenta A3-A4- Full thickness cross section from central placenta **Result:** Third trimester placenta, cesarean section Mature placenta (620 g) with weight greater than 90th percentile for gestational age Umbilical cord with three vessels, marginal/velamentous insertion, and mild acute inflammation (early funisitis) Amniotic membranes with rare pigment laden macrophages consistent with meconium and no significant inflammation	Ex 2 000052- Ex 2 000053
02/16/YYYY	Provider/ Hospital	**@ 0700 hours: Daily EEG – Video Study (NICU) Report:** **Daily start date:** 02/15/YYYY **Daily start time:** At 0700 hours **Daily end date:** 02/16/YYYY **Daily end time:** At 0700 hours	Ex 4 000324- Ex 4 000326

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		The study period was not interrupted. **Daily neuroactive medication changes:** Phenobarbital was administered at 2210 hours. **Seizures:** At least three 10-14 second electrographic only seizures occurred during this portion of the study. Electrographically, the ictal pattern consisted of 5-15 microvolt 0.5-1 Hz rhythmic, sharply contoured activity maximal at the Pz electrode with a surface negative voltage field to Cz and P4. Runs of rhythmic discharges having a similar morphology but without clear evolution were additionally present in the same distribution for up to 5 seconds in duration without clinical correlation. Phenobarbital was administered at 2210 which resulted in a decrease in the frequency and duration of this activity. **Reported spells:** None. **Daily Interpretation:** **This portion of the EEG-video study is abnormal due to:** • Presence of at least three, very subtle, low-voltage electrographic seizures at midline and right parietal electrodes. • Excessive discontinuity, low voltage of EEG background, lack of normal grapho-elements expected for age and lack of cycling and reactivity. This is consistent with moderate to severe encephalopathy from any cause. Results were communicated directly to the neonatal neurology team daily and as needed throughout the study period.	
02/16/YYYY	Provider/ Hospital	**@ 0723 hours: Pediatric Transthoracic Echocardiography:** **Summary:** • Mild tricuspid regurgitation, estimated RV pressure 32mmHg + RA pressure • Small PFO with bidirectional flow • Mild mitral regurgitation • Qualitatively normal RV size and systolic function • Normal LV size and systolic function	Ex 4 000560-Ex 4 000563
02/16/YYYY	Provider/ Hospital	**@ 1027 hours: Neonatology Daily Progress Notes:** **Subjective:** **Interval history:** I have examined and reviewed patient's course over the past 24 hours. • Remains on conventional ventilation. Weaned FiO2 to 40%. Off iNO. Adequate ventilation and oxygenation. Initiating occasional breaths. • UOP stable overnight. TF increased to 90 ml/kg/day today. • MBP stable, not receiving vasopressors. Discontinued epi on 02/16/YYYY.	Ex 4 000319-Ex 4 000324

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Objective: **02/16/YYYY at 0000 hours:** Weight: 3.69 kg **Plan:** **Thermoregulation:** Cooling device, Radiant warmer, Off. Monitor thermoregulatory status secondary to need for therapeutic hypothermia and rewarming and adjust as indicated. **Respiratory:** Infant is intubated and mechanically ventilated. **Conventional Ventilator:** SIMV PRVC Vt (Set, mL): 16 mL PEEP/CPAP/EPAP (cm H2O): 7 cm H2O Resp Rate (Set): 30 FiO2 (%) Avg: 49.6 % Min: 46 % Max: 50 % Insp Time (sec): 0.4 sec Continue to wean FiO2 as tolerated, wean as tolerated. Off INO. Continue to monitor pre- and post- ductal SpO2. Continue gases Q12H Continue to monitor respiratory status with clinical exams and continuous pulse oximetry. Will adjust support as indicated. **CV:** Repeat echo on 02/16/YYYY showed improvement of biventricular function with mild TR. Low dose epi discontinued on 02/16/YYYY **FEN/GI:** Mother desires to provide human milk. Infant will be advanced to: Total fluid goal of 90 ml/kg/day. Hypokalemia resolved. He didn't pass BM. will administer glycerin and start trophic feeds. Will advance per protocol. **Neurologic:** • Infant receiving continuous EEG, seizure reported on 02/16/YYYY overnight. Received one dose of Phenobarbital overnight on 02/16/YYYY *Others remain same.*	
02/16/YYYY	Provider/ Hospital	**@ 1418 hours: Neonatal Neurology Consultation Service Progress Notes:** *XXXX D.* **Subjective:** **Summary:** Patient is a former Gestational Age: 38w4d now 3 days (corrects to 39w 0d) male with neonatal encephalopathy meeting criteria for therapeutic hypothermia transferred from Springfield Mercy on 02/13/YYYY PM. **Interval history:** • EEG with concern for right parietal sz vs BIRDS -> given PHB 20mg/kg	Ex 4 000286-Ex 4 000290

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		load at 2200. Level this AM at 36. • Continues on cooling protocol • Intubated on conventional vent • Sedated with Precedex • Requiring pressor support with Epinephrine and calcium. • Continues on empiric Amp and Ceftaz. Considering LP after rewarming. • NPO • 02/16/YYYY - lactated 2.1 **Brief summary of HPI:** Patient was born via urgent C-section at 0644 hours on 02/13/YYYY due to absent variability on fetal tracing. APGARS were 1, 1, 1, 2. Heart rate was less than 60 and did not respond with PPV. Chest compressions were initiated and he was intubated at minute of life 3. Heart rate remained less than 60 and he received total 2 doses of ETT Epinephrine and 2 UVC Epinephrine doses. Admitted of life 7 heart rate rose above 60. Initial cord gases were repeatedly normal, but initial patient gas at less than 1 hour life revealed pH 6.9 and base deficit -20. Infant's initial NEAT score is unknown, but patient met criteria for therapeutic hypothermia which was initiated at just over 1 hour of life (0800.) Blood cultures were drawn and empiric Ampicillin and Ceftazidime were started. He was eventually transitioned to the HFOV worsening hypercarbia and was started on iNO. ECHO was reportedly reassuring. **Objective:** **At 0700 hours: Vitals:** Pulse: 120, RR: 30 **Weight readings from last 1 encounters:** **02/16/YYYY:** 3.69 kg (8 lb 2.2 oz) (76%, z = 0.71) Growth percentiles are based on Fenton (Boys, 22-50 Weeks) data. **Weight percentile:** 76 %ile (Z= 0.71) based on Fenton (Boys, 22-50 Weeks) weight-for-age data using vitals from 02/16/YYYY. **HC Readings from Last 3 Encounters:** No data found for HC **OFC percentile:** No head circumference on file for this encounter. **I/O last 2 completed shifts:** **In:** 280.4 (I.V.:241.6; IV Piggyback:38.8) **Out:** 126.5 (Urine:126.5) No intake/output data recorded. **General Physical Exam:** **General:** Resting in isolette intubated, sedated, and cooled	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Head: Anterior fontanelle open, soft, and flat **Lungs:** Mechanically ventilated , triggers breaths **Heart:** Regular rate and rhythm on monitor **Abdomen:** Soft, non-distended and no organomegaly **Neurologic Exam** **Mental status:** No spontaneous movements, no spontaneous eye opening. **Cranial nerves:** Pupils 3/4 mm bilaterally and minimally reactive to light. **Sensory-Motor:** No spontaneous activity, does not move extremities with noxious stimuli **Lab/Radiology/Diagnostic Review:** **The following images and reports were personally reviewed:** **02/13/YYYY HUS:** Abnormally low bilateral resistive indices in the middle cerebral arteries. Low resistive indices in the anterior cerebral artery are associated with greater risk for brain injury. There is a small right grade 1 germinal matrix hemorrhage. **The following EEG reports were personally reviewed:** **cEEG 02/13/YYYY-02/14/YYYY AM:** This portion of the EEG-video study is abnormal due to excessive discontinuity, low voltage of EEG background, lack of normal grapho-elements expected for age and lack of cycling and reactivity. This is consistent with moderate to severe encephalopathy from any cause. **Assessment/Plan** **Assessment:** Patient is a former Gestational Age: 38w4d now 3 days (corrects to 39w 0d) male with severe neonatal encephalopathy meeting criteria for therapeutic hypothermia. Cooling was initiated shortly after the first HOL at 0800 on 02/13/YYYY. Delivery was complicated by urgent C-section given absent variability and fetal tracing, APGARS of 1, 1, 1, 2 requiring intubation with eventual transition to HFOV with iNO. Initial HR < 60 requiring several doses of Epinephrine and chest compressions. Initial blood gas within the 1st hour of life showed pH 6.0 and BE -20. HUS on admission with abnormally low bilateral resistive indices in the middle cerebral Arteries (L 0.40, R 0.38) and echogenicities in the caudothalamic grooves, right greater than left, favored to represent choroid plexus rather than subependymal hemorrhage. cEEG showed excessive discontinuity, and suppressed background, with lack of cycling and reactivity. The patient had several episodes of electrographic seizure on treated with intermittent abortive doses of Phenobarbital. Last seizure was 02/16/YYYY at 0300. Etiologies for encephalopathy include hypoxemic injury, vascular, infectious, metabolic, and genetic.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Plan: • We will continue VEEG through rewarming period • Repeat HUS on 02/15/202 • Infectious workup per primary team; we agree with LP and CSF infectious studies given unclear cause/contributing factors of neonatal encephalopathy. • OFC 2x/week • MRI brain neonatal protocol on DOL4 (02/17/YYYY) and DOL10 (not on scanner 3) • HUS PRN for rapid increase in OFC, signs/symptoms suggestive of increased intracranial pressure, or concerns for acute intracranial process • PT/OT/ST when medically able • Will need early intervention services after discharge • NICU Neurology team will continue to follow. Please contact us via the Neurology NICU pager with any questions or concerns. **Attestation:** *XXXX* I have seen and examined the patient on 02/16/YYYY. I agree with the findings and plan of care as documented in the resident's/fellow's note. We reviewed updated EEG findings with parents. We will treat recurrent seizures with additional Phenobarbital if needed. Anticipate coming down VEEG for MRI brain study tomorrow morning. We will discuss need for placing EEG back on based on review of the VEEG overnight, discussion with parents and primary team.	
02/17/YYYY	Provider/ Hospital	**@ 0034 hours: Procedure Report:** **Lumbar puncture:** **Immediately prior to the procedure a time out was called:** A verbal verification by the procedure participants confirmed correct patient identity, correct site/side marked and visible (if applicable); agreement on procedure to be done; and correct patient positioning **Indications:** Evaluation for infection **Patient preparation:** Full body drape **Skin preparation:** Skin prepped with Povidone-Iodine **Lumbar space:** L4-L5 interspace **Patient's position:** Left lateral decubitus **Needle gauge:** 22 **Needle type:** Spinal needle - Quincke tip **Number of attempts:** 1 **Fluid appearance:** Blood-tinged **Tubes of fluid:** 1 **Total volume (ml):** 1	Ex 4 000354- Ex 4 000355

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Post-procedure: Site cleaned and adhesive bandage applied **Patient tolerance:** Patient tolerated the procedure well with no immediate complications **Post Procedure Debrief:** **All guidewires, needles, sponges or other items are accounted for:** Yes **Any special post procedure monitoring, testing or other considerations:** NA **All specimens identified, labeled and matched to patient identification:** Yes **Responsible party for transporting specimen(s) to lab determined:** Yes	
02/17/YYYY	Provider/ Hospital	**@ 0557 hours: X-Ray of Chest and Abdomen:** **History:** 4-day-old born at 38 weeks gestational age with neonatal encephalopathy. Evaluate umbilical venous catheter. **Comparison:** 02/14/YYYY **Findings:** Endotracheal terminates at the upper to mid thoracic trachea. Enteric tube tip projects over the stomach. Umbilical venous catheter tip has been slightly retracted with the tip overlies inferior cavoatrial junction. Interval removal of the temperature rectal probe and umbilical arterial catheter. New right lower lobe opacity, likely atelectasis. The cardiac silhouette is within normal limits. There is no pleural effusion or pneumothorax. Small amount of bowel gas with scattered nondilated air-filled bowel loops. Bowel gas is mildly increased since prior exam. There is no pneumatosis or portal venous gas. **Impression:** • Umbilical venous catheter tip overlies inferior cavoatrial junction. • New right basilar atelectasis.	Ex 4 000583- Ex 4 000586
02/17/YYYY	Provider/ Hospital	**@ 0712 hours: Daily EEG – Video study (NICU) Report:** **Study Part 4** **Daily start date:** 02/16/YYYY **Daily start time:** At 0700 hours **Daily end date:** 02/17/YYYY **Daily end time:** At 0712 hours The study period was not interrupted. **Daily neuroactive medication changes:** Phenobarbital was administered at 2224 hours. **Montage modifications:** Not modified. **Seizures:** At least two 10-20 second electrographic only seizures occurred during	Ex 4 000331- Ex 4 000333

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		this portion of the study. Electrographically, the ictal pattern consisted of 10-15 microvolt 0.5-2 Hz rhythmic, sharply contoured activity maximal at the F3/C3 electrodes with subtle evolution. Runs of rhythmic discharges having a similar morphology but without clear evolution were additionally present in the same distribution for up to 5 seconds in duration without clinical correlation. **Reported spells:** None. **Daily Interpretation:** This portion of the EEG-video study is abnormal due to: • Presence of at least two, low-voltage electrographic seizures at left central-frontal electrodes. • Excessive discontinuity, low voltage of EEG background, lack of normal grapho-elements expected for age and lack of cycling and reactivity. This is consistent with moderate to severe encephalopathy from any cause. Results were communicated directly to the neonatal neurology team daily and as needed throughout the study period.	
02/17/YYYY	Provider/ Hospital	**@ 0814 hours: Neonatal Neurology Consultation Service Progress Notes:** *XXXX* . **Subjective:** **Summary:** Patient is a former Gestational Age: 38w4d now 4 days (corrects to 39w 1d) male with neonatal encephalopathy meeting criteria for therapeutic hypothermia transferred from Springfield Mercy on 02/13/YYYY PM. **Interval History:** • Rewarmed overnight • Intubated on conventional vent, sedated with Precedex • EEG showed excessive discontinuity, low voltage background, lack of normal grapho-elements expected for age and lack of cycling and reactivity, at least two, low-voltage electrographic seizures at left central frontal electrodes. • Continues on empiric Amp and Ceftaz. Considering LP after rewarming • MRI brain performed this morning, see below for details. **Objective:** **At 0700 hours: Vitals:** BP: 73/42, pulse: 163, RR: 44, temperature: 37.1C **Wt Readings from Last 1 Encounters:** 02/17/YYYY 3.85 kg (8 lb 7.8 oz) (83 %, Z= 0.97) Growth percentiles are based on Fenton (Boys, 22-50 Weeks) data. **Weight percentile:** 83 %ile (Z= 0.97) based on Fenton (Boys, 22-50 Weeks)	Ex 4 000290-Ex 4 000295

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		weight-for-age data using vitals from 02/17/YYYY. **HC Readings from Last 3 Encounters:** No data found for HC **OFC percentile:** No head circumference on file for this encounter. **I/O last 2 completed shifts:** **In:** 364.5 (I.V.:304.5; NG/GT:45; IV Piggyback:15) **Out:** 207.7 (Urine:206.7; Blood:1) **I/O this shift:** **In:** 13.3 (I.V.:13.3) **Out:** 12.9 (Urine:12.9) **General Physical Exam:** **General:** Resting in isolette intubated, sedated s/p rewarming. **Neurologic Exam** **Mental status:** No spontaneous movements, no spontaneous eye opening. **Cranial nerves:** Deferred **Sensory-Motor:** No spontaneous activity **Lab/Radiology/Diagnostic Review:** **The following images and reports were personally reviewed:** **02/13/YYYY HUS:** Abnormally low bilateral resistive indices in the middle cerebral arteries. Low resistive indices in the anterior cerebral artery are associated with greater risk for brain injury. There is a small right grade 1 germinal matrix hemorrhage. **The following EEG reports were personally reviewed:** **cEEG 02/13/YYYY-02/14/YYYY AM:** This portion of the EEG-video study is abnormal due to excessive discontinuity, low voltage of EEG background, lack of normal grapho-elements expected for age and lack of cycling and reactivity. This is consistent with moderate to severe encephalopathy from any cause. **MRI brain 02/17/YYYY:** Extensive restricted effusion involving the bilateral precentral and postcentral gyri, bilateral frontal centrum semiovale, corpus callosum, insula and subinsular white matter, basal ganglia, and deep white matter tracts, as well as the bilateral hippocampal structures, and bilateral cerebellar peduncles consistent with global hypoxic ischemic event. There is associated intrinsic T1 hyperintensity corresponding to the dorsal aspect of the bilateral globus pallidus, bilateral hippocampi, thalami, bilateral superior colliculi, central midbrain involving the decussating fibers, medulla, bilateral dentate nuclei in the cerebellum, and proximal cervical spine. **Assessment/Plan** **Assessment:**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Patient is a former Gestational Age: 38w4d now 4 days (corrects to 39w1d) male with severe neonatal encephalopathy meeting criteria for therapeutic hypothermia. Cooling was initiated shortly after the first HOL at 0800 on 02/13/YYYY and ended on 02/16/YYYY. Delivery was complicated by urgent C-section given absent variability and fetal tracing, APGARS of 1, 1, 1, 2 requiring intubation with eventual transition to HFOV with iNO. Initial HR < 60 requiring several doses of epinephrine and chest compressions. Initial blood gas within the 1st hour of life showed pH 6.0 and BE -20. HUS on admission with abnormally low bilateral resistive indices in the middle cerebral Arteries (L 0.40, R 0.38). cEEG showed excessive discontinuity, and suppressed background, with lack of cycling and reactivity. The patient had several episodes of electrographic seizure (no clinical correlate) and treated with intermittent abortive doses of Phenobarbital. Last seizure on 02/16/YYYY PM. We will discontinue cEEG today and follow clinically. On exam the patient has severe encephalopathy with no spontaneous movements. Etiologies for encephalopathy include hypoxemic injury, vascular, infectious, metabolic, and genetic. We have reviewed brain images with family and discussed about neurological outcomes. Given the severity of injury, there is a high concern for neurodevelopmental impairment. We will communicate with family and primary team, and continue to provide support and care. **Plan:** • Discontinue vEEG • Consider seizure treatment for clinical seizure • NICU Neurology team will continue to follow. Please contact us via the Neurology NICU pager with any questions or concerns. • We will continue to support patient, family and primary team with regards to his neurological care and related counseling. **Attestation:** *Rafael Dalindo, M.D., PhD* I have seen and examined the patient on 02/17/YYYY. I agree with the findings and plan of care as documented in the resident's/fellow's note. **Counseling note:** This morning I met with mom and dad in conjunction with the primary to review the EEG findings from overnight and reviewed his MRI brain performed this morning. Prior to discussing these findings with parents, I reviewed the findings with Neuroradiology. MRI of the brain demonstrates severe and diffuse areas of ischemia involving both cerebral hemispheres, deep gray matter, brainstem and cerebellum as noted above. I started my counseling by reviewing the neurological intervention of his seizures from last night. Seizures were	

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		infrequent, non-clinical and responsive to phenobarbital. I then reviewed the T1 cerebral sequences of patient's brain and orient them to the various anatomical structures. I then reviewed with them the diffusion sequences indicating that this modality of imaging allows us to examine areas of ischemia-associated brain injury. I proceeded to review the DWI sequences demonstrating obvious diffuse cerebral involvement as above. I explained that regrettably these findings coupled with his known examination and neurological course predict Wyatt will be at severe risk for chronic and extensive neurological and developmental impairment that includes need for support with all activities of daily living including ambulation/transport and feeding. Given his poor respiratory drive, it is possible that he will not be able to achieve the ability to breathe on his own. He also remains at high risk for chronic long standing seizures. I expressed our commitment in assisting Wyatt and parents in supporting his neurological care to the extent that they wish. Parents expressed understanding of the above explanation. Parents wish for now to treat any clinical seizures and hold placing back EEG. I spent 30 minutes in the counseling and coordination of care.	
02/17/YYYY	Provider/ Hospital	**@ 0828 hours: MRI of Brain and SPEC without Contrast:** **History:** Hypoxic ischemic encephalopathy [HIE]. 38w4d now 4 days (corrects to 39w 1d) male with neonatal encephalopathy. **Comparison:** Intracranial ultrasound 02/13/2013 **Findings:** Extensive restricted effusion involving the bilateral precentral and postcentral gyri, bilateral frontal centrum semiovale, corpus callosum, insula and subinsular white matter, basal ganglia, and deep white matter tracts, as well as the bilateral hippocampal structures, and bilateral cerebellar peduncles consistent with global hypoxic ischemic event. There is associated intrinsic T1 hyperintensity corresponding to the dorsal aspect of the bilateral globus pallidus, bilateral hippocampi, thalami, bilateral superior colliculi, central midbrain involving the decussating fibers, medulla, bilateral dentate nuclei in the cerebellum, and proximal cervical spine. The susceptibility weighted sequences reveal no evidence of acute or chronic hemorrhage. On the eddy current corrected spectroscopy sequences, there is inversion of Hunter's angle with elevation of the choline and creatinine peaks compared to the NAA peak and prominent lactate peaks in all voxels. Bilateral scalp hematomas, likely sequela of recent birth. The superior sagittal sinus demonstrates normal venous flow. The corpus callosum is normal in shape. The posterior fossa is unremarkable. The pituitary and sella are normal. The ventricles are normal in size and position without evidence of	Ex 4 000589-Ex 4 000594

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		hydrocephalus. The paranasal sinuses are normal. The visualized portions of the mastoids are unremarkable. The orbits appear normal. Normal flow voids are demonstrated in the carotid arteries and basilar artery. **Impression:** Findings suggesting hypoxic ischemic injury with a central pattern. No evidence of intracranial hemorrhage at this time. The radiology attending physician has personally reviewed this study, and had reviewed and/or edited this written report and agrees with it.	
02/17/YYYY	Provider/ Hospital	**@ 1007 hours: Neonatology Daily Progress Notes:** **Subjective:** **Interval history:** I have examined and reviewed patient's course over the past 24 hours. • Remains on conventional ventilation. Weaned FiO2 to 40%. Off iNO. Adequate ventilation and oxygenation. Initiating occasional breaths. Babygram in the morning showed increased interstitial opacities in the RLL, correlating with exam, representing atelectasis/collapse. • UOP stable overnight. TF increased to 100 ml/kg/day today. He passed a BM and started on trophic feeds. • MBP stable, not receiving vasopressors. **Objective:** **02/17/YYYY at 0200 hours: Weight:** 3.85 kg Weight change: 0.16 kg **Plan:** **Thermoregulation:** Radiant warmer, On. Monitor thermoregulatory status, S/P therapeutic hypothermia and rewarming. Adjust as indicated. **Respiratory:** Infant is intubated and mechanically ventilated. **Conventional Ventilator:** SIMV PRVC Vt (Set, mL): 16 mL PEEP/CPAP/EPAP (cm H2O): 7 cm H2O Resp Rate (Set): 30 FiO2 (%) Avg: 40.1 % Min: 35 % Max: 42 % Insp Time (sec): 0.4 sec Continue to wean FiO2 as tolerated. Off INO. Continue gases Q12H Continue to monitor respiratory status with clinical exams and continuous pulse oximetry. Will adjust support as indicated. **FEN/GI:** Mother desires to provide human milk. Infant will be advanced to: Total fluid goal of 100 ml/kg/day. Titrate GIR as tolerated. Hyperglycemia on 02/14/YYYY-02/15/YYYY,	Ex 4 000326- Ex 4 000331

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		resolved. **Neurologic:** • Infant is receiving continuous EEG, multiple seizures in the first 4 days of life, last on 02/16/YYYY night, given a dose of Phenobarbital. EEG 02/16/YYYY-02/17/YYYY showed excessively discontinuous and asynchronous background without evidence of state change or cycling, consistent with moderate to severe encephalopathy. • Brain MRI at 4 and 10 days. Awaiting brain MRI results done on 02/17/YYYY. Plan for a neurology/neonatology/family meeting on 02/17/YYYY. *Others remain same.*	
02/17/YYYY	Provider/ Hospital	**@ 1957 hours: Neonatology Progress Notes:** **Patient update:** I met with parents and maternal grandmother today along with XXXX and XXXX Patient's parents, grandparents, and aunt/uncle have spent the day holding patient after his brain MRI this morning and discussions with the primary team and neurology. During our discussion, both parents expressed that they wished to compassionately extubate patient on Sunday evening. We discussed that any family members can be present at that time. We also touched on the fact that it is difficult to predict what will happen following extubation, but that patient could breathe spontaneously for hours to even days. Dad again expressed his interest in organ donation, and I shared that representatives from MidAmerica Transplant will be visiting this evening to meet with them. I then asked if for some reason patient's heart were to stop or he ETT were to become dislodged prior to Sunday, would they like patient to receive resuscitation. They both confirmed that they would not like chest compressions, life-sustaining medications, or re-intubation if that were to happen. They will be staying within minutes of the hospital and I informed them that we would call immediately. After discussion with the on-call attending Patrick Sloan, I have entered the DNR/DNI order.	Ex 4 000339
02/18/YYYY	Provider/ Hospital	**@ 0149 hours: Ultrasound Renal Complete with Complete Renal Doppler:** **History:** 5-day-old term infant with hypoxic ischemic encephalopathy. Evaluation for kidney donation. **Comparison:** None. **Findings:** Real-time and spectral Doppler images of the kidneys were obtained. The right kidney measures 5.9 cm in length, and the left kidney measures 5.4 cm in length. Renal cortical echogenicity is normal. There is mild upper pole caliectasis in the right kidney. Otherwise, no hydronephrosis, masses, or stones are seen. The urinary bladder is relatively distended but appears normal .	Ex 4 000596- Ex 4 000599

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Color Doppler and spectral waveform analysis of both renal arteries and veins was performed. The vessels are patent with no thrombus seen. Resistive indices in the parenchymal arteries range from 0.5 to 0.59. **Impression:** Mild focal upper pole caliectasis in the right kidney, likely due to full bladder, otherwise normal renal sonogram with Doppler. The radiology attending physician has personally reviewed this study, and had reviewed and/or edited this written report and agrees with it.	
02/18/YYYY	Provider/ Hospital	**@ 0927 hours: Neonatology Daily Progress Notes:** **Subjective:** **Interval history:** I have examined and reviewed patient's course over the past 24 hours. • Remains on conventional ventilation. FiO2 30-40%. • UOP stable overnight. TF increased to 130 ml/kg/day today. He passed 5x BM and tolerated feeds. • MBP stable, not receiving vasopressors **Objective:** **02/18/YYYY at 0000 hours:** Weight: 3.97 kg Weight change: 0.12 kg **Plan:** **Thermoregulation:** Servo, On, Radiant warmer, sleeper, hat, swaddled. Monitor thermoregulatory status, s/p therapeutic hypothermia and rewarming. Adjust as indicated. **Respiratory:** Infant is intubated and mechanically ventilated. **Conventional Ventilator:** SIMV PRVC Vt (Set, mL): 16 mL PEEP/CPAP/EPAP (cm H2O): 7 cm H2O Resp Rate (Set): 30 FiO2 (%) Avg: 38.5 % Min: 28 % Max: 45 % Insp Time (sec): 0.4 sec Continue to wean FiO2 as tolerated. Off INO. Continue gases Q24H Continue to monitor respiratory status with clinical exams and continuous pulse oximetry. Will adjust support as indicated. **FEN/GI:** • CMP with mildly elevated AST/ALT. Draw CMP Q6hrs for pre-organ donation protocol. • Monitor growth trajectory, blood glucose, and electrolytes as indicated. Will monitor fluid balance to help optimize intake. **ID:**	Ex 4 000340-Ex 4 000345

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		• Urine culture sent on 02/18/YYYY **Neurologic:** • Brain MRI on DOL 4 showed extensive hypoxic ischemic injury with a central pattern (extensive restricted diffusion involving the bilateral precentral and postcentral gyri, bilateral frontal centrum semiovale, corpus callosum, insula and subinsular white matter, basal ganglia, and deep white matter tracts, as well as the bilateral hippocampal structures, and bilateral cerebellar peduncles consistent with global hypoxic ischemic event). • A family meeting was held on 02/17/YYYY to discuss the implication of the brain MRI and its significance for patient's neurodevelopmental outcomes. Parents decided to redirect care and decided on organ donation which we will respect and accomplish their wishes. *Others remain same.*	
02/19/YYYY	Provider/ Hospital	**@ 0956 hours: Neonatology Daily Progress Note:** **Subjective:** **Interval history:** I have examined and reviewed patient's course over the past 24 hours. • Remains on conventional ventilation. FiO2 range 25%-40% for the last 24 hrs. CBG in the morning showed mild worsening in ventilation. TV adjusted and rate increased. • UOP stable overnight (~5 ml/kg/hr), Cr stable on serial checks. TF at 130-140 ml/kg/day. He passed 4 x BM and tolerated feeds. • MBP stable to increased intermittently, not receiving vasopressors. **Objective:** **02/19/YYYY at 0000 hours:** Weight: 3.89 kg Weight change: -0.08 kg **Physical examination:** **Neurological:** Pupils fixed and dilated, couldn't examine today fue to eye swelling. **Plan:** **Thermoregulation:** Servo, On, Radiant warmer, Hat, Onesie. Monitor thermoregulatory status, s/p therapeutic hypothermia and rewarming. Adjust as indicated. **Respiratory:** Infant is intubated and mechanically ventilated. **Conventional Ventilator:** SIMV PRVC Vt (Set, mL): 18 mL PEEP/CPAP/EPAP (cm H2O): 7 cm H2O Resp Rate (Set): 30 FiO2 (%) Avg: 26.9 % Min: 24 % Max: 35 %	Ex 4 000345- Ex 4 000350

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Insp Time (sec): 0.4 sec Continue to wean FiO2 as tolerated. Off INO. Continue gases Q24H Continue to monitor respiratory status with clinical exams and continuous pulse oximetry. Will adjust support as indicated. **ID:** • Pre-organ donation protocol: Urine culture sent on 02/18/YYYY and 02/19/YYYY. Blood culture on 02/19/YYYY *Others remain same.*	
02/19/YYYY	Provider/ Hospital	**Neonatology Brief Death Note:** **Information:** **Date of Death:** 02/19/YYYY **Time of Death:** At 1740 hours **Preliminary Cause of Death:** Cardiorespiratory failure secondary to severe hypoxic ischemic encephalopathy **Events Leading to Death:** Patient was delivered in the setting of non-reassuring fetal status and subsequently suffered from severe hypoxic ischemic encephalopathy. Transferred to SLCH NICU for ECMO evaluation in the setting of HIE. Hypoxemia improved however his neurologic exam remained severely abnormal; no reactivity, minimal to respiratory drive, and MRI findings consistent with severe and diffuse areas of ischemia. Given his grim prognosis, parents lovingly decided to compassionately extubate him on the evening of 02/19/YYYY. **Findings at Time of Death:** No respiratory effort, ashen color, absent heart rate **Pronouncing Provider:** Erin O'Brien, M.D. **Expiration Summary to be Dictated by:** Tyler King, D.O. **Death Certificate to be completed by:** Erin O'Brien, M.D. **Notifications:** **Providers Notified:** Neurology Medical Examiner for the City of St. Louis contacted as required if patient under 18 and/or sustained trauma, gunshot wounds, motor vehicle collision, near drowning, or at my discretion. Yes. Reassigned to a Medical Examiner in a different county? No. **Investigator Name:** Pam Perkins **Case#:** 23-0405 **Medical Examiner Office Notified by:** Erin O'Brien, M.D.	Ex 4 000274- Ex 4 000276

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Post-Mortem Testing: **Autopsy offered:** Yes. Autopsy was declined by Family/Legal representative parents **Special Post-Mortem Testing:** NA **Anatomical Gift Information:** Mid-America Transplant Service (MTS) was called. **Candidate for tissue donation?** Yes. Eligible for heart valve donation. Discussed eligibility with parents prior to terminal extubation with Mid America Transplant Services. **Patient is 16 years of age or older?** No **Chaplain has been contacted to approach the family for consent?** N\A **Family/Legal Representative consent obtained (Form CN 1054-complete and signed)?** Yes **Special requests or limitations?** NA **MD Review:** I have reviewed and confirmed that all expiration tasks are completed. **Death Certificate Information:** Will complete death certificate via MoEVR website once assigned.	
02/19/YYYY	Provider/ Hospital	**Neonatology Inpatient Death Summary:** **Brief overview:** **Admitting Provider:** XXXX **Primary Care Physician at Discharge:** XXXX **Admission Date:** 02/13/YYYY **Discharge Date:** 02/19/YYYY **Admission Location:** St Louis Childrens Hospital **Hospital Problems/Diagnoses:** **Active Problems:** Neonatal encephalopathy Respiratory failure Encounter for central line care Encounter for observation of infant for suspected infection Hyponatremia Hypokalemia Hyperglycemia	Ex 4 000127- Ex 4 000131

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	BATES REF
		Biventricular failure **Details of hospital stay:** **Presenting problem/history of present illness:** Patient was a 38+4 male born at Mercy Springfield on 02/13/YYYY via C-section for non-reassuring fetal status. Maternal history remarkable for fetal arrhythmia (intermittent PAC/PVC) and velamentous cord insertion. Newborn resuscitation including intubation, chest compressions, Epinephrine x 2 and saline bolus x 1. Following delivery he was encephalopathic with significant metabolic acidosis on his admission blood gas and therapeutic hypothermia was initiated. Prior to transfer his course was complicated by worsening hypoxia and hypercarbia with escalation of care including sedation, muscle relaxation, 100% FiO2, nitric oxide and increased ventilatory support. He was transferred to SLCH for his continued care. **Hospital course:** Patient was a former Gestational Age: 38w4d infant, now born to a 29 year old mother by the name of XXXXnett. **Maternal History:** **Maternal Labs:** **Blood type:** A **Rhesus factor:** Negative **Rubella immunity:** Immune **Hep B Surface Antigen:** Non-detected **VDRL/RPR:** Nonreactive **HIV status:** Nonreactive **Group B Strep status:** Negative **Maternal Intrapartum History:** **L&D Steroids:** None **Antibiotics Received During Labor:** N/A **Maternal Temperature:** This patient's mother is not on file. **Notable maternal medications:** Rhogam **Membranes:** **Length of Time Membranes Ruptured:** ROM at delivery **Fluid Color:** **Pertinent pregnancy complications include:** • Velamentous cord insertion • Fetal arrhythmia (intermittent PAC/PVC) **Delivery Resuscitation Summary:** The infant was born on 02/13/YYYY at 0644 hours via emergent C-section for non-reassuring fetal status and absent variability. The infant did not have spontaneous cry upon delivery and was warmed, dried, and stimulated. HR <60,	

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		bag/mask ventilation initiated without improvement. Received chest compressions for 16 minutes, intubated at 5 MOL, 100% FiO2, 2 doses of ETT epi, 2 doses IV epi, NS bolus. First agonal breath noted at 15 minutes of life. APGARS 1/1/1/1/2. Delayed cord clamping: Delay in seconds: Not performed **Vitamin K Given:** Yes **Erythromycin Eye ointment (Ilotycin) Given:** Yes Infant was transferred to NICU for further evaluation and management. Received surf x1 in NICU at OSH. Placed on HFOV, iNO initiated. Transfer initiated to SLCH NICU for potential ECMO evaluation and escalation of care. **Birth measurements:** **Birth history:** **Birth:** Length: 53.3 cm (20.98") Weight: 3.52 kg (7 lb 12.2 oz) HC: 35 cm **APGAR:** One: 1 Five: 1 Ten: 1 **Delivery method:** C-section, low transverse **Gestation age:** 38 4/7 weeks **Hospital name:** ABC Center **Hospital location:** **Hospital Course by Systems:** **Respiratory:** Patient was mechanically ventilated throughout the entire admission and additionally required nitric oxide and increased oxygenation for pulmonary hypertension that improved. **CV:** He required calcium gluconate and low dose Epinephrine gtts for biventricular dysfunction that improved and were later discontinued. **GI/FEN:** He was started on IV fluids and slowly transitioned to enteral feeds on DOL 3. Increased total fluids as tolerated. **ID:** He was empirically started on antibiotics for early onset sepsis and meningitis. He was continued on antibiotics during his entire admission. His sepsis screening was reassuring. An LP was performed but was a bloody tap and was pre-treated, thus findings were non-contributory.	

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		Heme: Baby's blood type: A+. He did not require phototherapy. **Neuro:** Patient received therapeutic hypothermia for severe neonatal encephalopathy. His course was complicated by multiple seizures verified by EEG requiring multiple doses of phenobarbital. He was sedated with Precedex, Fentanyl and Morphine. Did receive muscle relaxation briefly. Head Ultrasound on 02/13/YYYY showed abnormally low bilateral resistive indices in the middle cerebral arteries, which is associated with greater risk of brain injury. Echogenicities in the caudothalamic grooves, right greater than left, are favored to represent choroid plexus rather than subependymal hemorrhage. Brain MRI on DOL 4 showed extensive hypoxic ischemic injury with a central pattern (extensive restricted diffusion involving the bilateral precentral and postcentral gyri, bilateral frontal centrum semiovale, corpus callosum, insula and subinsular white matter, basal ganglia, and deep white matter tracts, as well as the bilateral hippocampal structures, and bilateral cerebellar peduncles consistent with global hypoxic ischemic event). After discussing these radiographic findings with the family with the neurology team, parents lovingly decided to pursue redirection of care in the garden. Family members were able to spend time with him prior to his redirection. Family requested evaluation by the transplant team in hopes that he may be a candidate for organ donation. A recipient for kidney transplant was identified, however was not deemed eligible on the day of compassionate extubation. **Vascular access:** UAC (02/13/YYYY-02/16/YYYY), UVC (02/13/YYYY-02/19/YYYY) **Social:** Mom is XXXX, dad is XXX. **Consulting services:** Neurology **Discharge diagnoses:** • Hypokalemia • Hyperglycemia • Biventricular failure • Neonatal encephalopathy • Respiratory failure • Encounter for central line care • Encounter for observation of infant for suspected infection • Hyponatremia **Time of death:** Patient was pronounced by Dr. Erin O'Brien on 02/19/YYYY at 1740 hours.	

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02/19/YYYY	Provider/ Hospital	**Memorandum of Death:** **Patient name:** XXXX **Pronouncing physician:** XXXX **Race:** Caucasian/white **Age:** 6 days **Floor:** SLC – CHC **Expired date:** 02/19/YYYY at 1740 hours **Family notified?** Yes **State:** MO **Date:** 02/19/YYYY at 1950 hours **Expiration technician notified:** Mulenda Mukadi Chaplain, patient placement, MTS **Is case reportable to the medical examiner?** Yes. On 02/19/YYYY at 1800 hours **Investigator:** Pam **Did medical examiner pick up the remains?** No **Did medical examiner release the remains?** Yes **Who is signing the death certificate?** Physician. Erin O'Brien, M.D. **Autopsy?** No. **Declined autopsy:** Family on 02/19/YYYY at 2000 hours **Outcome of request for organ and tissue donation:** Tissue **Expiration technician:** Mulenda Mukadi 02/19/YYYY at 2030 hours **Funeral home: Local:** MTS **Isolation or communicable disease?** No **Is the body radioactive?** No **Name of person at Funeral Home or Medical Examiner's office notified:** MTS McKenzie **Complete and released?** Yes. 02/19/YYYY at 2213 hours **Restraints on or within 24 hours of death:** No	Ex 4 000269
03/14/YYYY	Provider/ Hospital	**Death Certificate:** **Date of birth:** 02/13/YYYY **Place of death:** **If death occurred in a hospital:** Inpatient **Facility name:** ABC Children's Hospital **Method of disposition:** Burial **Date of disposition:** 02/23/YYYY **Place of disposition:** Greenlawn Memorial Gardens **Signature of funeral service licensee or other person acting as such:** James Brent Barnes **Actual or presumed time of death:** At 1740 hours **Was medical examiner/coroner contacted?** Yes	Ex 4 000271

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		Cause of death: **Immediate cause:** Hypoxic ischemic encephalopathy **Approximate interval:** Onset to death: 02/13/YYYY to 02/19/YYYY **Was autopsy performed?** No **Manner of death:** Natural **Certifier:** **Certifying physician** – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated **Person completing cause of death:** Erin O'Brien, M.D.	

Related records:

Patient's information, patient history, admission record, assessment, lactation assessment, plan of care, progress notes, labs, surgical case record, medication sheet, orders, medication sheet, flow sheet, consent, authorization, patient education, coding sheet, others, correspondence, fetal monitoring strips

BATES Ref: *Ex 1 000001-Ex 1 000044, Ex 1 000273-Ex 1 000280, Ex 2 000001- Ex 2 000011, Ex 2 000023-Ex 2 000063, Ex 2 000023-Ex 2 000069- Ex 2 000023-Ex 2 000286, Ex 2 000323-Ex 2 000415*

Reviewer's Comment: *All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence they are not elaborated.*

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Patient's information, patient history, admission record, assessment, lactation assessment, plan of care, progress notes, labs, surgical case record, medication sheet, orders, medication sheet, flow sheet, consent, authorization, patient education, coding sheet, others, correspondence, fetal monitoring strips

BATES REF: *Ex 3 000001, Ex 3 000033-Ex 3 000177, Ex 4 000001-Ex 4 000119, Ex 4 000131-Ex 4 000274, Ex 4 000296-Ex 4 001080, Ex 4 001103-Ex 4 001119*

Reviewer's Comment: *All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence they are not elaborated.*