UMC

PATIENT

ACCOUNT NUMBER

CONDITIONS OF ADMISSION, CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

1. The undersigned has been informed of the treatment considered necessary for the patient whose name appears above and hereby grants authorization for all treatment that may be considered advisable an necessary in the judgment of the physician. I understand that charges will be made for the use of the quick care center, x-rays, lab work, dressings, etc. by the hospital and charges for hospital physician services Services administered by private or consulting physicians will be billed by that physician.
2. MEDICAL AND SURGICAL CONSENT: The patient is under the control of his attending physicians and the hospital is not liable for any act or omission in following the instructions of said physicians, and th undersigned consents to any x-ray examination, laboratory procedures, including aids testing, anesthesia, medical or surgical treatment or hospital services rendered the patient under the general and speci instructions of the physicians. The undersigned recognizes that all doctors of medicine furnishing services to the patient, including the radiologist, pathologist, anesthetist and the like are independent contracto and are not employees or agents of the hospital.
3. RELEASE OF INFORMATION: The hospital may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to the hospital or to the patient or t a family member or employer of the patient for all or part of the hospital's charge, including but not limited to, hospital or medical service companies, insurance companies, workmen's compensation carriers welfare funds, or the patient's employer. The undersigned does hereby authorize any person or corporation, including but not limited to, hospital or medical service companies, insurance companies, workmen compensation carriers, welfare funds, or the patient's and/or guarantors employer to disclose to the hospital any and all information the hospital may request.
4. **SCIENTIFIC MEDICAL PHOTOGRAPHY: The undersigned approves the taking of pictures of medical or surgical progress, and the use of same for scientific or research purposes.**
5. PERSONAL VALUABLES: It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables and the hospital shall not be liable for the loss or damage to any money jewelry, glasses, dentures, documents, furs, fur coats and fur garments or other articles of unusual value and small compass, unless placed therein, and shall not be liable for loss or damage to any other persona property, unless deposited with the hospital for safekeeping. In the event that I am unable to sign for the release of said valuables, I wish to designate _____ as my representative
6. FINANCIAL AGREEMENT: The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pa the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collection expense. All delinquent accounts bear interest of the legal rate.
7. ASSIGNMENT OF INSURANCE: I/We do hereby assign directly to University Medical Center of Southern Nevada all insurance benefits, including automobile and homeowners insurance, otherwise payab to me, but not to exceed the hospital's regular charges for this penod of hospitalization. I/We hereby authorize the Executive Director of University Medical Center of Southern Nevada to furnish from its record any information requested by the above-mentioned insurance companies in connection with the above assignments. I do hereby appoint the Credit Manager of the hospital as my true and lawful attorney t endorse for me any checks made payable to me for benefits or claims collected under the above assignments and to apply any credit balance to any other account I may owe said hospital. I understand tha I am financially responsible for charges not paid by this assignment.
8. **FINANCIAL GUARANTY: By signing this, I hereby accept full financial responsibility for the above-named patient's bill and all charges relating to the above-named patient. In the event that th Hospital does not collect from the patient, I hereby agree to pay said bill and be primarily liable for said bill, and further, agree that demand need not be made of said patient but may initially b made against me or said patient, or both, at the option of University Medical Center of Southern Nevada. I further agree to pay attorney's fees and costs incurred in collection of the account an interest at the legal rate.**
9. ASSIGNMENT: I/We hereby guarantee payment of all charges incurred for the above patient from date of admission until discharge, or removal, including physicians and anesthesiologists fees.

SAMI RECIPIENTS:
Federal and State statutes require all other sources must be utilized prior to billing the SAMI Program for Medical Services. Other resources include private or employer-provided health and accident insuranc coverage. SAMI recipients are to complete the following certification:
I certify, under penalty of fraud, that I do not have private or employer provided health and accident insurance for myself or my dependents.

For the purpose of obtaining credit, I (we) warrant that the above statements are true and complete. The Hospital is authorized to verify any information on this application. I (we) further understand that the Hospita will receive, from time to time, information from others, and will answer questions and requests from others seeking credit experience information about my (our) account. I (WE) ACKNOWLEDGE RECEIPT OF A EQUAL CREDIT OPPORTUNITY ACT NOTICE.
THE UNDERSIGNED, HAVING RECEIVED A COPY OF THE CONDITIONS OF ADMISSION, CERTIFIES THAT HE OR SHE HAS READ THESE CONDITIONS AND AGREES TO THEM. THE UNDERSIGNE FURTHER CERTIFIES THAT HE OR SHE IS THE PATIENT OR RESPONSIBLE PARTY AUTHORIZED BY THE PATIENT, AND EXECUTES THE SAME ON BEHALF OF THE PATIENT AND HIMSELF/HERSELF JOINTLY AND SEVERALLY, AND ACCEPTS THE ABOVE TERMS.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA IS A TEACHING INSTITUTION UNDER THE SUPERVISION OF ATTENDING PHYSICIANS. RESIDENTS, INTERNS, MEDICAL STUDENTS AND POST GRADUATE FELLOWS MAY PARTICIPATE IN THE CARE OF THE PATIENT AS A PART OF THE MEDICAL EDUCATION PROGRAM OF THE INSTITUTE.

10. RETENTION OF RECORDS: The Hospital will retain all financial details pertaining to the patient account for a period of two (2) years from the date of patient discharge. Patients will receive an itemized statemer of charges after their discharge that are to be retained by the patient for future use.
11. "Admissions will not be based on race, color, age, sex, national origin, handicapping conditions, or religion. The gathering of such information is for demographics purposes only after the decision to admit."

ent/Guardian Signature Kristie Chiles Date 1/21/93 Guarantor's Signature Kristie Chiles Date 1/21/93

Patient Unable to Sign ☐ Witness [signature] Date 1/21/93

GENERAL INSTRUCTIONS: (1) Doxycycline 100mg every 12 hrs for 10 Days (2) Sexual Rape Crises Counseling Letter (3) Return to ER if worse (4) See OB/GYN Clinic in 1-2 weeks for recheck.

I hereby acknowledge receipt of the above instructions. I understand that I have had emergency treatment only. I will arrange for follow-up care as instructed.

Witness initial [signature] Date 1-20-93 Patient signature Kristie Chiles

NOTE: THE EXAMINATION AND TREATMENT YOU HAVE RECEIVED IS EMERGENCY CARE AND IS NOT INTENDED TO BE A SUBSTITUTE FOR COMPLETE MEDICAL CARE. YOU MUST GO TO YOUR DOCTOR OR CLINIC FOR ANY FOLLOW-UP CARE. FOLLOW-UP CARE IS ADVISED! MEANWHILE YOU CAN FOLLOW THE INSTRUCTIONS BELOW AS INDICATED

( ) HEAD INJURY INSTRUCTIONS
Avoid strenuous physical activity for at least 24 hours after injury.
Apply ice bag for headache for 24 hours.
You may use aspirin or tylenol for pain/headache every 3-4 hours as needed.
Clear liquids for first 12 hours, then reduced amounts of food for next 12 hrs.
Awaken patient every two hours for the first 24 hours and check for:
- Unable to arouse patient or if confusion occurs.
- Persistent or projectile vomiting.
- Unequal pupil size, either smaller or larger.
- Severe unrelenting headache, especially associated with visual or hearing difficulties.
- Clear or bloody drainage from ears or nose.
- Seizures, fits or convulsions.
- Any trouble with balance or unusual behavior.

IF ANY OF THESE SIGNS ARE NOTED, CONTACT YOUR OWN DOCTOR OR RETURN TO THIS EMERGENCY ROOM.

( ) SPRAINS, FRACTURES, SEVERE BRUISES
Elevate the extremity at night as much as possible during the day for the first 72 hrs.
Apply an ice pack for the first 24-48 hours with a towel between ice/skin.
After 48 hours, apply heat to the area for least 20-30 minutes 4 times/day,
if you have a fracture.
If an elastic bandage has been applied rewrap it if too tight or extremity is numb, discolored or increasingly painful.
If no pain medicine was given, you can take aspirin or tylenol every 3-4 hours.
If you have a plaster cast or splint, keep it dry at all times and do not allow any pressure on it for 48 hours. If you have crutches, use as instructed.
Limit use or activity of extremity for at least 24-48 hours, longer if necessary.

( ) WOUND CARE-cuts, burns, abrasions, etc.
Keep the wound and dressing clean and dry. Do not shower or bathe the involved area for 48 hours.
Change the dressing after 48 hours or if the dressing becomes wet or soiled.
If you have been given antibiotics take them all as directed
If pain, redness, swelling, pus or red streaks appear or fever develops, see doctor or return to the emergency department immediately.
Sutures should be removed in approximately _____ days.
Return to your doctor or the emergency department as instructed for an infection check in _____ days.
Tetanus immunization given _____ (for your record).

NOTE: IF YOUR CONDITION WORSENS BEFORE YOU ARE ABLE TO OBTAIN FURTHER MEDICAL ATTENTION, PLEASE RETURN TO THE EMERGENCY ROOM.	RASH	UTI	NOSEBLEED	HEPATITIS	STOMACH
		FLU	PID	FEVER	ANIMAL BITE

930121-r327 JF

STEP 1

CONSENT FOR TREATMENT, COLLECTION OF EVIDENCE, RELEASE OF INFORMATION

I, (victim/patient) Kristie Childs, request and authorize the attending physician and associates to perform all the necessary examinations for my physical well-being and any legal procedures. These may include, but are not limited to, general physical and pelvic examination; collection of specimens and materials, including photographs, for use as legal evidence; prophylactic treatment for venereal disease; and laboratory tests deemed necessary by the physician. The purpose and nature of these examinations and tests have been explained to me, and I understand that certain medications administered to me may not be totally effective in the prevention of disease.

I understand that I am to contact the County Health Department at the appropriate times for follow-up tests as described in the Follow-Up Instructions.

I further authorize University Medical Center Records Department to supply copies of ALL medical reports, including laboratory results, to the law enforcement agency, the Office of the District Attorney, the Emergency Room personnel, the County Health Department having jurisdiction, and to Community Action Against Rape.

PATIENT: [signature] (SIGNATURE) KRISTIE CHILDS (PRINT)

WITNESS: [signature] (SIGNATURE) Carole V Peterson (PRINT)

DATE: 1-21-93 TIME: r905

PARENT OR GUARDIAN: (IF APPLICABLE) _____ (SIGNATURE) _____ (PRINT)

RELATIONSHIP: MOTHER ☐ FATHER ☐ OTHER: _____ (DESCRIBE)

NOTE

IF AN AGENCY IS INVESTIGATING A REPORT OF ABUSE OR NEGLECT OF A CHILD, THE REPRESENTATIVE OF THE AGENCY MAY AUTHORIZE IN LIEU OF A PARENT OR GUARDIAN.

REFERRAL AGENCY: _____

REPRESENTATIVE: _____ (SIGNATURE) _____ (PRINT)

RE-1LVMP 10/91

930121-0327 JF

STEP 2 MEDICAL HISTORY AND ASSAULT INFORMATION

PATIENT'S NAME: [illegible] Kristie DATE OF BIRTH: 10-25-72 SEX: M ☐ F ☑

ADDRESS: [redacted]

DATE OF ASSAULT: [redacted] TIME OF ASSAULT: [redacted] NUMBER OF OFFENDERS: 1

DATE OF EXAMINATION: 1-21-93 TIME OF EXAMINATION: 1930 SEX OF OFFENDER(S) M ☑ F ☐

OFFENDER KNOWN TO PATIENT? FRIEND ☐ NEIGHBOR ☐ RELATIVE ☐ UNKNOWN ☑ OTHER ☐

BROUGHT IN BY: Metro POLICE REPORT BEING MADE? YES ☑ NO ☐

MEDICAL HISTORY: CURRENT MEDICAL PROBLEMS: [illegible]

CURRENT MEDICATION(S): [illegible]

ALLERGIES: [illegible]

B/P: 133/108 PULSE: 89 TEMPERATURE: 99 RESPIRATION: 30

Emotional demeanor of patient, i.e., crying, angry, agitated, lethargic, frightened, shocked, depressed, etc.?
[illegible]

Description of patient's outward appearance, i.e., clothes torn, shoe(s) missing, etc.:
[illegible]

Between the assault and now, has the patient: CHECK ALL THOSE WHICH APPLY

Bathed/Showered ☑	Inserted Tampon ☐ (If yes, collect tampon)	Defecated ☐	Brushed Teeth ☐	Drunk ☑
Changed Clothes ☑		Urinated ☑	Used Mouthwash ☐	Vomited ☐
Douched ☐			Eaten ☐	Smoked ☐

CHECK ALL WHICH APPLY AT TIME OF ASSAULT:

	YES	NO	UNSURE
WAS PATIENT'S VAGINA PENETRATED BY:			
Penis	☑	☐	☐
Finger	☐	☑	☐
Tongue	☑	☐	☐
If other, describe:			
WAS PATIENT'S MOUTH PENETRATED BY:			
Penis	☐	☑	☐
WAS SUSPECT'S MOUTH ON PATIENT'S:			
Vagina/Penis	☐	☑	☐
Anus	☐	☑	☐
USED DURING ASSAULT:			
Condom	☑	☐	☐
Diaphragm	☐	☑	☐
Contraceptive Foam	☐	☑	☐
Lubricant	☐	☑	☐
Other Spermacide	☐	☑	☐
WAS PATIENT BITTEN:	☐	☑	☐
If yes, describe: (LOCATION)			
WAS PATIENT LICKED/KISSED:	☑	☐	☐
If yes, describe [illegible] (LOCATION)			
DID PATIENT BITE SUSPECT:	☐	☑	☐
DID PATIENT SCRATCH SUSPECT:	☐	☑	☐
DID PATIENT PASS OUT:	☐	☑	☐

	YES	NO	UNSURE
WAS PATIENT'S RECTUM PENETRATED BY:			
Penis	☐	☑	☐
Finger	☐	☑	☐
Tongue	☐	☑	☐
If other, describe:			
MASTURBATION OF:			
Patient	☐	☑	☐
Suspect	☐	☑	☐
If other, describe:			
DID EJACULATION OCCUR:			
In/on patient's body	☐	☐	☑
If yes, describe: (LOCATION)			
MENSTRUATION:	☐	☑	☐
CONSENTING INTERCOURSE WITHIN LAST 72 HOURS:	☐	☐	☐
If yes, date: [illegible] and approximate time: [illegible] am pm			
WAS CONDOM USED:	☐	☑	☐
DOES PATIENT HAVE COMMUNICABLE DISEASE AT RISK TO LAB PERSONNEL:	☑	☐	☐
If yes, describe: [illegible]			

INFORMATION COLLECTED BY:

[signature] (SIGNATURE)

[illegible] (PRINT)

DATE: 1-21-93

(EXHIBIT "A")

RE-1LVMP 10/91

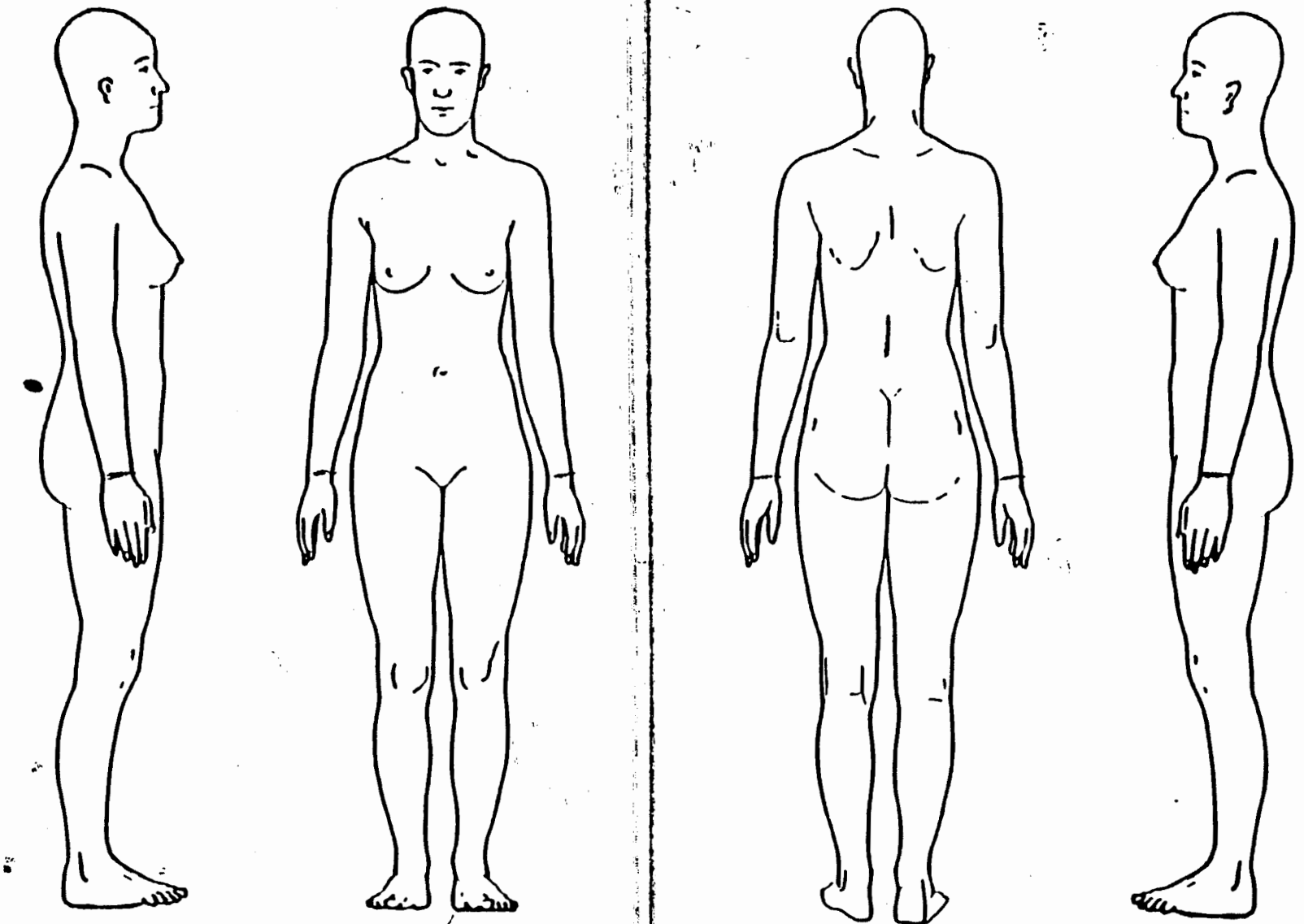
WHITE AND PINK COPY

YELLOW COPY

STEP 10A

ANATOMICAL DRAWINGS

Using the appropriate drawing(s), describe all bruises, scratches, lacerations, bitemarks, etc. Indicate approximate age of all injuries.



Were photographs taken? YES ☒ NO ☐

Examined By: Barton W. Butterbaugh, MD (SIGNATURE)

BARTON W. BUTTERBAUGH, MD (PRINT)

Date: Jan 21, 1993

RE-1LVMP 10/91

WHITE AND PINK COPIES—PLACE IN ENVELOPE ON KIT BOX

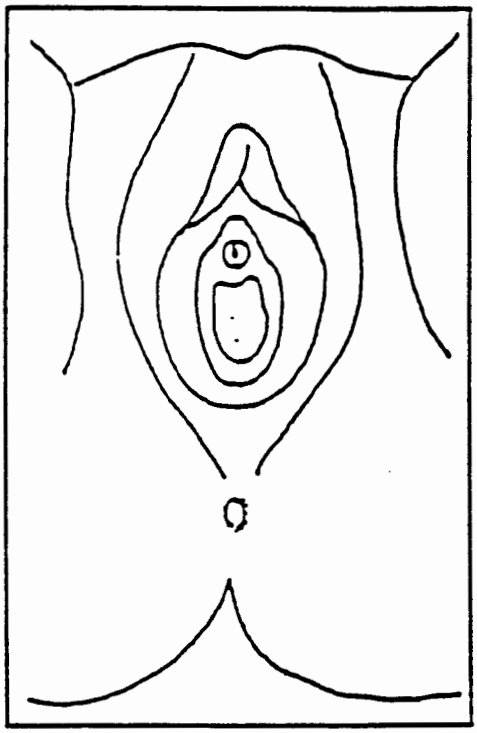
YELLOW COPY—RETAIN FOR PATIENT'S CHART

930121-0327

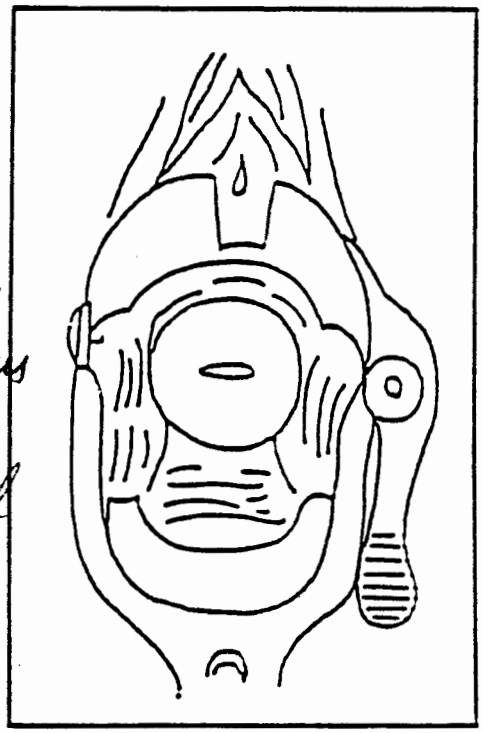
930121-027

STEP 10B

PELVIC EXAMINATION



No pooling of Secretions or Fluid in Vaginal apex



PELVIC EXAMINATION — Note and describe all signs of trauma, use water-lubricated speculum only.

VULVA: ~~A~~ / No evidence of abrasions / lacerations

INTROITUS: ~~A~~ / No evidence of contusions / abrasions

VAGINA: ~~A~~ Intact Vaginal mucosa; pink, moist ~~appearance~~ & Lesions

CERVIX: ~~A~~ appearance & lesions; OS Cervix Closed; ~~NORMAL~~

UTERUS: ~~A~~ Size

ADNEXA: ~~A~~ Ovaries palpated & Cysts/masses

HYMEN: Not intact

RECTUM: Intact; No Lacerations / abrasions / Contusions

ANUS: ~~A~~; No evidence of trauma

MALE GENITALIA EXAMINATION — Note and describe all signs of trauma, i.e., bruises, petechiae, discharges, sphincter tone. Also note any traces of lubricants or rectal soiling.

PENIS: N/A

SCROTUM:

MEATUS:

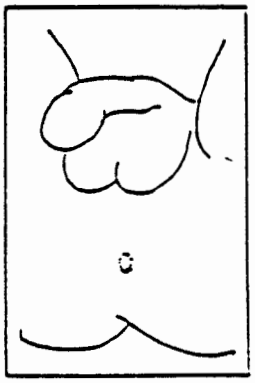
GLANS:

TESTICLES:

PERINEUM:

RECTUM:

ANUS:



EXAMINED BY: Barton W. Butterbaugh MD (SIGNATURE) BARTON W. BUTTERBAUGH, M.D. (PRINT) DATE: JAN 21, 1993

RE-1LVMP 10/91

MED REC NO. 159-008 EMERGENCY ... ACCOUNT NO.

PATIENT NAME (LAST, MIDDLE, FIRST)	SEX	BIRTHDATE	AGE	RACE	ADMIT DATE	TIME
CHILES, KRISTIE K	F	12/25/72	20Y	W	1/21/93	0:07:46

PATIENT ADDRESS STREET	CITY	STATE	ZIP CODE	NEXT OF KIN
PO BOX 26513	LAS VEGAS	NV	89126	

SOCIAL SECURITY	DATE LAST ADMITTED TO UMCSN	UNDER WHAT NAME	HOME PHONE	WORK PHONE
530-64-8632			648-2654	

I WOULD LIKE MY PERSONAL DOCTOR CALLED NAME

I REQUEST THE E.R. DR. TO ATTEND: Yes

NURSES NOTES: ADMITTING COMP. POSS. SEXUAL ASSAULT

BROUGHT BY NAME: SELF WALKED SB

TEMP	PULSE	RESP.	BP
99	89	20	133/89

ALLERGIES Penicillin

HISTORY & PHYSICAL:

CC: Possible sexual assault.

HPI: Twenty year old Caucasian female states that she was asleep in her apartment in the early morning of January 21, 1993 when she was suddenly awakened with an unknown black male on top of her in bed. The patient stated she pleaded with the assailant to not rape her in her bedroom and he complied, taking her into the living room whereupon he raped her. The patient stated that there was only vaginal penetration x 2. The patient admitted that the assailant performed cunnilingus and kissed her breasts. The patient states that prior to being brought from the bedroom to the living room her wrists were bound and her eyes were taped shut. After the second vaginal penetration, the patient was ordered by assailant to take a shower. She was brought to the bathroom where the door was closed and she was ordered by assailant to take a shower. Assailant allegedly watched her bathe. The patient stated that she knew it was not the best case scenario for her to bathe in relation to gathering evidence but she had no choice as the assailant forced her to bath. The patient denies LOC or any other trauma at this time. The patient denies any past medical history with the exception of herpes genitalis which she says she acquired prior to this alleged assault. The patient denies medications and states she is allergic to Penicillin. The patient's LMP was one week ago.

EKG & LAB ORDERS		X-RAY ORDERS	OTHER
EKG	BLOOD GASES	CHEST	
THM STRIP	CBC DIFF	C-SPINE	
CATH UA	PANEL 6	3 WAY ABD	
URINALYSIS	ETOH	CT HEAD c	
URINE C&S	PT/PTT	CT HEAD s	
BHCG ✓	CARDIAC ENZ.		
QUANT BHCG	NUTRITION PANEL		
WET PREP ✓	AMYLASE	HIV ✓	
GC ✓	LIPASE	VDRL ✓	
CHLAMYDIA ✓	TRAUMA PANEL	Hepatitis Screen ✓	
TYPE & RH			V71.5
HOLD CLOT			
TYPE & CROSS			
UNITS			

X-RAY INTERP.

EKG INTERP.

CLINICAL DATA

TREATMENT AND MED. ORDERS

1. ~~Heplock IV~~ Igram C. Laboratorits
2. 100mg Doxycycline PO
3. Rape Crisis Team to assist/counsel Pt
4. Discharge after all results & Lab Results on Chart
5. Pt may sit in Waiting Room

DISCHARGE PLAN

TIME : READY TO DISCHARGE

SUTURE REMOVAL DAYS

DIAGNOSIS: Suspected Sexual Assault

RX: Doxycycline 100mg PO BID X10 Days (DR)

TIME RESPONDED (TIME)

PHYSICIAN CALLED:

DISPOSITION: HOME: HOSPITAL POLICE OTHER:

DOCTOR'S SIGNATURE Dayton W. Brumbaugh MD

UMC
UNIVERSITY MEDICAL CENTER

EMERGENCY DEPARTMENT CONTINUATION FLOW SHEET

PATIENT IDENTIFICATION

Patient's name Chiles, Kristie

159008

NURSE / PHYSICIAN DOCUMENTATION

THIS FORM MUST BE ATTACHED TO THE EMERGENCY ROOM ADMISSION RECORD.

LAST NAME | FIRST NAME | SEX | ROOM

DATE/TIME

INTAKE

TIME	SOLUTION/AMT	SIZE/SITE	RATE	AMT. INF	IN

TIME	TEMP	PULSE	RESP	BP

EXAM: The patient is alert, awake, oriented x 4. Appears in mild emotional distress, secondary to above. HEENT head is normocephalic, atraumatic. EYES PERRL-EOMI. Sclerae and conjunctiva are within normal limits OU. Nares are patent bilaterally. Normal facial symmetry. No facial abrasions or contusions. Tympanic membranes are intact bilaterally, gray/white with sharp light reflexes. Normal dry external auditory canal's bilaterally. Oropharynx is clear without lesions or exudates. Tonsils are enlarged 3+/4 bilaterally. Posterior pharyngeal walls without exudates. NECK is supple without masses or adenopathy or tracheal shift. Carotid pulses are 4/4. The patient demonstrates full, active range of motion of the C-spine. CHEST is clear to A&P without rales, rhonchi or wheezes. CHEST WALL is non-tender to palpation anteriorly, laterally and posteriorly. No evidence of cutaneous abrasions of the chest or back. HEART RRR without murmurs, rubs, gallops. ABDOMEN is soft, non-distended, non-tender with normal active bowel sounds in all four quadrants. No palpable masses or organosplenomegaly. EXTREMITIES are intact, symmetrical bilaterally in the upper and lower regions. There are circumferential abrasions around the wrists bilaterally. PELVIC exam normal external genitalia, Tanner Class V. No evidence of contusions, abrasions or lacerations. Intravaginal exam reveals normal pink, rugated, moist, non-exudate laden vaginal mucosa. No hematoma, contusions or lacerations. Cervix appears to be within

DOCTOR'S ORDERS:	NURSE TIME	TREATMENT:	NURSE TIME

DOCTOR'S SIGNATURE | NURSE'S SIGNATURE

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UNIVERSITY MEDICAL CENTER

EMERGENCY DEPARTMENT CONTINUATION FLOW SHEET

PATIENT IDENTIFICATION

Patient's name Chiles Kristee

159008

NURSE / PHYSICIAN DOCUMENTATION

THIS FORM MUST BE ATTACHED TO THE EMERGENCY ROOM ADMISSION RECORD.

LAST NAME | FIRST NAME | SEX | ROOM

DATE/TIME

INTAKE

TIME	SOLUTION/AMT	SIZE/SITE	RATE	AMT. INF

TIME	TEMP	PULSE	RESP	BP

normal limits and nulliparous in appearance. Os cervix is closed. External cervical mucosa appears to be intact without abrasions, contusions of lacerations. No cervical motion tenderness. Bimanual examination reveals normal adnexa bilaterally without palpable cysts or masses. Uterus is normal in size and is non-tender. Anal/rectal examination reveals no evidence of trauma, lacerations, hematomas or contusions. Hemoccult test is negative. Gluteal area fails to show hematomas, lacerations, contusions or abrasions.

ASSESSMENT: SUSPECTED SEXUAL ASSAULT.

BUTTERBAUGH/sh

DOCTOR'S ORDERS:	NURSE TIME	TREATMENT:	NURSE TIME

DOCTOR'S SIGNATURE

NURSE'S SIGNATURE

Sexual Assault room 1-35m

TRIAGE INFORMATION SHEET

NAME CHILES KRISTIE AGE ____ DATE 1-21-93

BIRTHDATE 1-25-72 ALLERGIES _____

MEDICATIONS _____

LMP _____ LAST T.T. _____

CHIEF MEDICAL COMPLAINT Sexual assault

REFERRED BY Metro

WERE YOU IN ANOTHER HOSPITAL'S E.R. OR ADMITTED TO ANOTHER HOSPITAL WITHIN THE LAST 48 HOURS? YES ☐ NO ☑

IF YES, WHICH HOSPITAL?

BOULDER CITY	☐	COMMUNITY OF NLV	☐	MONTEVISTA	☐
CARE UNIT	☐	DESERT SPRINGS	☐	ST. ROSE deLIMA	☐
CHARTER	☐	HUMANA SUNRISE	☐	VALLEY	☐
				WOMENS	☐

OTHER _____

WAS YOUR TRANSFER DUE TO: SERVICES NOT AVAILABLE ☐ ABILITY TO PAY ☐

WHO ORDERED THE TRANSFER AT THE FACILITY? NURSE VIA ADMINISTRATION ☐

PHYSICIAN ☐

WAS TRANSFERRING HOSPITAL ON DIVERT? YES ☐ NO ☐

HOW WERE YOU TRANSPORTED? AMBULANCE ☐ PRIVATE CAR ☑ OTHER ☐

BRIEF MEDICAL HISTORY _____

PRIVATE PHYSICIAN _____ NOTIFIED YES ☐ NO ☐

VITAL SIGNS _____ TEMP _____ PULSE _____ RESP _____ BP _____

PREVIOUS VISIT WITHIN ONE WEEK _____ DATE OF VISIT _____

SIIS _____

INSURANCE TYPE _____

I.D. _____

REFERRED TO: QUICK CARE _____ HPN URGENT CARE _____ OPC _____

OPERATION LIFE _____ CAST CLINIC _____

MSRN

TRIAGE NURSE SIGNATURE

PLACE PINK COPY IN E.R. SUPERVISOR'S BOX

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PATIENT IDENTIFICATION: CHILES KRISTIE 20

EMERGENCY DEPARTMENT FLOW SHEET

TRIAGE ASSESSMENT: Alleged Sexual Assault

Rescued to Metro 2

ALLERGIES: Penicillin
CURRENT MEDICATIONS: None
TRIAGE SIGNATURE: [illegible]
WEIGHT
DATE: 1-21-93

NURSING DOCUMENTATION

TIME

Rape Crisis
830 Detectives in & pt.
0915 A+O x4. Frightened Crying. Forms signed.
0945 Dr in for exam Cultures obtained & sent, ~~Detectives~~ Detectives back talking w pt.

TIME	TEMP	PULSE	RESP	BP	PROCEDURE	TIME	SITE	BY
805	99	89	20	133/89	133 Tylenol 0900 Cultures 0945			

TIME	P	P	P

MEDICATIONS ADMINISTERED

TIME	MED/DOSE	ROUTE/SITE		INITIAL

FLUID INTAKE

TIME	SOLUTION/AMT	SIZE/SITE	RATE	AMT. INF.	INITIAL

TOTAL INTAKE _____

OUTPUT

TIME	URINE/FOLEY	EMESIS/NG	OTHER	

TOTAL OUTPUT _____

NURSES SIGNATURE	INITIAL	NURSES SIGNATURE	INITIAL
	/		/
	/		/

ADMITTING M.D.

RESTRAINT FORM COMPLETED ☐ YES ☐ NO ☐ N/A TIME

CLOTHING LIST BY: REPORT TO

TRANSFERRED TO TIME RELATIVE/POLICE CALLED

DISPOSITION — TIME 1020

DISCHARGE | EXPIRED | STABLE | CRITICAL | AMA

AMBULATORY | WHEELCHAIR | STRETCHER | ADMIT

STEP 13

SEXUAL ASSAULT FOLLOW-UP INSTRUCTIONS

PLEASE READ THIS FORM CAREFULLY AND COMPLETELY AND KEEP IT IN A SAFE PLACE. VALUABLE INFORMATION ABOUT YOUR HEALTH IS INCLUDED.

Your health is important to us. For that reason, today we ran tests for sexually transmitted diseases — syphilis, gonorrhea, and chlamydia - as well as tests for pregnancy and hepatitis. These are only PRELIMINARY TESTS (baseline tests) which will identify pre-existing conditions, and will not give meaningful information unless used with follow-up tests results.

We have arranged for the Clark County Health District to do the follow-up tests for you. They will receive information from the preliminary tests so they can give you the best possible care.

IT IS YOUR RESPONSIBILITY TO HAVE TESTS DONE. It is ENTIRELY UP TO YOU. Should you fail to take these tests and contract a venereal disease or are pregnant and do not receive this assistance, the results could be harmful to you. PLEASE KEEP THESE INSTRUCTIONS. They will explain when you should report for the tests.

It is also important for you to fill out an affidavit requesting compensation which can be done through the Rape Crisis Center office, Las Vegas Metropolitan Police Department's Sexual Assault Unit, or the Victim Witness Office of the District Attorney's Office. For information, call 385-2153. If approved, these funds will pay for your testing. Otherwise, you will be responsible for paying for the tests.

It is necessary for you to have follow-up tests on two (2) different occasions. YOU WILL ONLY BE CONTACTED BY THE HEALTH DISTRICT IF A TEST SHOWS POSITIVE RESULTS. The hospital, Rape Crisis and the police will not have this information immediately so please do not contact them for results. If you are not contacted, you can assume the test results are negative. If the results are positive, treatment and counseling will be provided. If you have symptoms prior to your testing date, please contact the Health District's V.D. clinic immediately at 383-1365.

The Health Department's Venereal Disease clinic is located at 625 Shadow Lane, Las Vegas. The entrance to the clinic is on the south side of the main building and the door is marked VD Clinic. All information is kept confidential. (If you are prosecuting the case, results will be provided to the Rape Crisis Center, law enforcement and the District Attorney's Office.) When you arrive, go to the window and inform them you are there. They will know what tests are needed at that time. You will be given a number.

Please be patient. Oftentimes there is a wait and your number may not be called in order. This is because different people require different assistance.

The Venereal Disease Clinic is open Monday through Friday from 8 a.m. to 3:30 p.m.

Seven (7) days from the date of today's examination or the next clinic working day after this 7 days, (date of bottom of this sheet) you should go to the Clinic. You will be tested for gonorrhea and chlamydia again. AIDS testing counseling will be available upon request.

Forty-five (45) days from the date of today's examination or the next clinic working day, you should return to the clinic. You will be tested for syphilis, hepatitis, and pregnancy again.

We hope you will take advantage of this additional service. We are concerned about your health and have made it possible for you to receive medical care, but only YOU can take advantage of this service and care for your health.

I have read the above and understand it is my responsibility to have the follow-up tests done. Should I fail to do so, I will not hold the hospital or other medical facility, the Health Department, the Police Department, or Community Action Against Rape responsible. I authorize Clark County Health District to release information about any findings to Community Action Against Rape, the appropriate law enforcement agency, and the office of the District Attorney.

1-21-93	X Kristie Childs	
DATE	PATIENT'S SIGNATURE	WITNESS SIGNATURE

IF AN AGENCY IS INVESTIGATING A REPORT OF ABUSE OR NEGLECT OF A CHILD, THE REPRESENTATIVE OF THE AGENCY MAY AUTHORIZE IN LIEU OF A PARENT OR GUARDIAN.

AGENCY REPRESENTATIVE SIGNATURE	REFERRAL AGENCY

RE-1LVMP 10/91

WHITE COPY
PLACE IN ENVELOPE ON KIT BOX

YELLOW COPY
RETAIN FOR PATIENT'S CHART

PINK COPY
HAND TO PATIENT

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Includes Public Law 93-282)

Date: 1/21/93

I hereby authorize **UNIVERSITY MEDICAL CENTER of SOUTHERN NEVADA** to disclose any pertinent information regarding the case of:

Patient's Name: _____

Age / Date of Birth: _____

This information **may be released** to any public agency, hospital, physician, attorney, insurance company, adjuster, etc. for the purpose of third party reimbursement.

This authorization **will remain in effect** until **UNIVERSITY MEDICAL CENTER's** claim to reimbursement for services rendered is satisfied in full.

Kristie Chiles

Patient / Legal Guardian

Witness

NOTE TO RECIPIENT OF INFORMATION:
This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Unless the records of your program are also subject to the Federal Law, **Federal regulations prohibit you** from making any further disclosure of this information without specific written authorization of the person to whom it pertains, or as otherwise permitted by such regulations. **A general authorization for the release of medical or other information is not sufficient for this purpose.**

ADM-103-1089

UNIVERSITY MEDICAL CENTER

1800 W. Charleston Blvd. • Las Vegas, Nevada 89102 • (702) 383-2000

1C CURRENT STATUS REPORT 10:01:14 21 JAN 1993

****

PATIENT NAME MR# PT ID# SEX AGE DOCTOR 99999

CHILES, KRISTIE K 3300159008 0022299838 F 20Y MISC. DR.

ACCN: 03029734

CONTACT:

LOCATION: EMER

TEST * STAT *		NORMALS	UNITS
	(01/21)		
RUM PREGNANCY, STAT	(09:30)		
Pregnancy, serum	NEGATIVE	NEGATIVE	

ACCN NO : 00029724 20Y F REPORTED BY : EMER,
PATIENT : KRISTIE K CHILES UNIVERSITY MEDICAL CENTER
LOCATION : ~~EMER~~
MED REC # : 3300159008 MISC. DR.
PATIENT ID : 0022299830
DATE/TIME DRAWN : 01/21/1993 0930 HOURS
DATE REPORTED : 01/25/1993 EMER 00059

PROF 355 HEP COMPREHENSIVE		NORMALS	UNITS
HBs Ag	NEGATIVE	NEGATIVE	
Anti-HBs	NEGATIVE	NEGATIVE	
Anti-HBc	NEGATIVE	NEGATIVE	
Anti-HAV	NEGATIVE	NEGATIVE	
Anti-HCV	NEGATIVE	NEGATIVE	
ALT (SGPT)	9	3-45	IU/L

This patient has none of the markers for hepatitis A, B or C.

(R111AA/M:911010)(AC96:N)

[illegible]

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DEPARTMENT OF PATHOLOGY
R.R. BELLIVEAU, M.D., Director of Laboratories

PATIENT CHILES, KRISTIE K
REFERRED BY EMER
MISC. DR.
99999

AGE/SEX 12/25/72 F
COLLECTED 01/21/1993 10:20
RECEIVED 01/21/1993 20:08
ACCESSION NO. 03029766
MED. RECORD NO. 3300159008

TEST	RESULTS	FLG	REFERENCE RANGE	UNITS	LOW	NORMAL	HIGH
CHLAMYDIA ANTIGEN (01) (VAGINA)	RESULT: NO CHLAMYDIA DETECTED						

[01] Test performed by: APL
4230 S. BURNHAM
SUITE 250
LAS VEGAS, NV 89119

01/21/93 10:52 THAYER MARTIN FOR GC (VAGINA)
* PRELIMINARY RESULTS *

NEGATIVE

WO

Results To Follow:
#T425-03 THAYER MARTIN FOR GC [03]

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DEPARTMENT OF PATHOLOGY
R.R. BELLIVEAU, M.D., Director of Laboratories

PATIENT CHILES, KRISTIE K
REFERRED BY EMER
MISC. DR.
99999

AGE/SEX 12/25/72 F
COLLECTED 01/21/1993 09:30
RECEIVED 01/21/1993 09:38
ACCESSION NO. 03029734
MED. RECORD NO. 3300159008

TEST	RESULTS	FLG	REFERENCE RANGE	UNITS	LOW	NORMAL	HIGH
SERUM PREGNANCY, STAT	NEGATIVE		NEGATIVE				
ALT (SGPT) (01)	6		3-45	IU/L		X	

[01] Test performed by: APL
4230 S. BURNHAM
SUITE 250
LAS VEGAS, NV 89119

Results To Follow:
#755-03 RPR [03]
#1463-03 HIV ANTIBODY (ELISA) [03]
#X355 HEPATITIS COMPREHENSIVE

PRINTED DATE/TIME: 01/22/1993 01:56

UNIVERSITY MEDICAL CENTER
DEPARTMENT OF PATHOLOGY
R.R. BELLIVEAU, M.D., Director of Laboratories

PATIENT CHILES, KRISTIE K
REFERRED BY EMER
MISC. DR.
99999

AGE/SEX 12/25/72 F
ACCESSION NO. 03029766
COLLECTED 01/21/1993 10:20
MED. RECORD NO. 3300159008
RECEIVED 01/21/1993 20:08

TEST	RESULTS	FLG	REFERENCE RANGE	UNITS	LOW	NORMAL	HIGH
WO							
WET PREP (VAGINA)	Collected 01/21/93 10:20						
NO TRICHOMONAS VAGINALIS OBSERVED							
Results To Follow:							
* 470	CHLAMYDIA ANTIGEN						
#T425-03	THAYER MARTIN FOR GC [03]						

PRINTED DATE/TIME: 01/22/1993 01:56

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DEPARTMENT OF PATHOLOGY
R.R. BELLIVEAU, M.D., Director of Laboratories

PATIENT CHILES, KRISTIE K
REFERRED BY EMER
MISC. DR.
99999

AGE/SEX 12/25/72 F
COLLECTED 01/21/1993 09:30
RECEIVED 01/21/1993 09:38
ACCESSION NO. 03029734
MED. RECORD NO. 3300159008

TEST	RESULTS	FLG	REFERENCE RANGE	UNITS	LOW	NORMAL	HIGH
HEPATITIS COMPREHENSI (01)							
HBs Ag	NEGATIVE		NEGATIVE				
Anti-HBs	NEGATIVE		NEGATIVE				
Anti-HBc	NEGATIVE		NEGATIVE				
Anti-HAV	NEGATIVE		NEGATIVE				
Anti-HCV	NEGATIVE		NEGATIVE				
Anti-HBs (SRU)	0		0-2			X	
ALT (SGPT)	6		3-45	IU/L		X	

This patient has none of the markers for hepatitis A, B or C.

(H111AA/N:911010)(AC46:N)

[01] Test performed by: APL
4230 S. BURNHAM
SUITE 250
LAS VEGAS, NV 89119

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UNIVERSITY MEDICAL CENTER

UNIVERSITY MEDICAL CENTER
DEPARTMENT OF PATHOLOGY
R.R. BELLIVEAU, M.D., Director of Laboratories

PATIENT CHILES, KRISTIE K

REFERRED BY EMER
MISC. DR.

99999

AGE/SEX 12/25/72 F
COLLECTED 01/21/1993 10:20
RECEIVED 01/21/1993 20:08

ACCESSION NO. 03029766
MED. RECORD NO. 3300159008

TEST	RESULTS	FLG	REFERENCE RANGE	UNITS	LOW	NORMAL	HIGH
01/21/93 10:52 THAYER MARTIN FOR GC (VAGINA)							
* FINAL RESULTS *							
NO NEISSERIA GONORRHOEAE ISOLATED							
WO							

PRINTED DATE/TIME: 01/24/1993 02:20