

Wilson Part 8
Leather

↓ G2C0136.A1

1993

10 JAN 1993 31

1. CASE NO. 921229CCN0543		2. INVESTIGATOR'S ID 9 0 0 3		3. OFFICE CODE 8 3 0		EPIDEMIOLOGIC INVESTIGATION REPORT	
4. DATE OF ACCIDENT YR MO DAY 9 2 1 2 2 7		5. DATE INVESTIGATION INITIATED YR MO DAY 9 2 1 2 2 9					
6. SYNOPSIS OF ACCIDENT OR COMPLAINT This investigation was conducted in response to a consumer's complaint that a 17 Y.O. female experienced severe respiratory distress after being exposed to the fumes from an aerosol fabric protection product being used to treat a new leather jacket on 12/27/92. The victim was hospitalized overnight and treated for the symptoms of chemical pneumonia.							
7. LOCATION (Home, school, etc.) Home		8. CITY Oconto Falls		9. STATE WI			
10A. FIRST PRODUCT Fabric protection treatment product		10B. SECOND PRODUCT aerosol container leather jacket		11A. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS Wilson's Suede and Leather, Inc., Minneapolis, MN. Wilson's Leather Protector(5 oz.)			
12. AGE OF VICTIM 0 1 7		13. SEX (Use numerical code) MALE -1 FEMALE -2 UNKNOWN -3 2		14. DISPOSITION treated and transferred for hospitalization 3		15. INJURY DIAGNOSIS chemical pneumonia 7 1	
16. BODY PART all parts		17. RESPONDENT(S) (Mother, Friend) victim		18. TYPE INVESTIGATION ON SITE 1 TELEPHONE 2 OTHER 3 1		19. TIME SPENT Tr: 0.0 0 5 0	
20. ATTACHMENTS multiple		21. CASE SOURCE State Health Dept.		22. REVIEWED BY 8 1 3 0 9 3 0 1 12			
23. PERMISSION TO DISCLOSE NAMES (NON-EMERGENCY CASES ONLY)		CSPC MAY DISCLOSE MY NAME <input type="checkbox"/>		CSPC MAY NOT DISCLOSE MY NAME <input checked="" type="checkbox"/>			
24. NARRATIVE (See instructions on Other Side) See attached narrative.				25. REGIONAL OFFICE DIRECTOR REVIEW DATE			

6/10/93
 X
 25C
 X
 This has not requested before

G2C0136.A1

(USE OTHER SIDE AND ADDITIONAL SHEETS IF NECESSARY)

921229CCN0543

SUMMARY:

This investigation was conducted in response to a report that a 17 year old female experienced severe respiratory distress after being exposed to the fumes from an aerosol fabric protection product that she was using to treat a new leather jacket on 12/27/92. The victim was hospitalized overnight and treated for the symptoms of chemical pneumonia.

PRE-INCIDENT:

On Sunday, 12/27/92 at approximately 12:30 P.M. the complainant and her boyfriend each purchased a new waist-length brown suede leather jacket from the "Wilson's Suede and Leather Products," retail store located at A-1009 Port Plaza Mall in Green Bay, WI 54301.

As the complainant was purchasing her coat, the store clerk suggested that it would be important to treat the new jackets with a fabric protection product to avoid damage from dirt or moisture. The clerk suggested that the complainant and her boyfriend purchase "Wilson's Leather Protector," an aerosol product sold at the store in 5 ounce cans. The aerosol protector is sold in a two can package, described as a "Leather Care Starter Kit."

The complainant and her boyfriend agreed to purchase four cans of the above described product. They were told by the clerk that they should spray 1/2 the contents of a 5 ounce can on each jacket, then wait 30 minutes and spray another 1/2 can on each coat again.

(Each coat then has been treated with an entire 5 ounce can.) The clerk further suggested that each coat be treated again every 2 months by spraying an additional 1/2 can onto each coat, and, if the coats were subjected to rain or dirt, to spray them again immediately after such exposure.

The complainant paid \$19.96 for four 5 ounce containers of the Wilson's Leather Protector product.

The store clerk, whose name is unknown, is described as having short brown hair, and being 20-25 years of age. This clerk provided no further instructions to the complainant and her boyfriend as to how the product should be applied to the coats, and he did not suggest that the product's fumes might be hazardous.

INCIDENT:

Later that same day, 12/27/92 at approximately 3:00 P.M., the 17 year old female complainant and 21 year old boyfriend hung each coat on a hanger and suspended the hanger from a clothesline in the attached and enclosed front porch of the family's farm house. The 17 year old complainant did the actual spraying of the fabric protector product, though her boyfriend was present in the porch for part of the time. The complainant sprayed 1/2 the contents of a 5 ounce can onto each jacket as she had been directed, and estimated that this activity took her less than 5 minutes. Both complainants then left the porch where the spraying had taken place until 30 minutes had elapsed at which time the 17 year old female then re-entered the porch and sprayed 1/2 the contents of a second can of the fabric protector onto each coat. She estimated this activity again took her approximately 5 minutes. The complainant's boyfriend was not present during this second application.

Photographs depicting the complainant's reenactment of the manner in which she used the fabric protection product are attached to the end of this report as exhibit "A".

The complainant stated that before using the fabric protector product, she did read the instruction labels on the can, and noted the warning "Vapor's May Be Harmful." She felt that the unheated, enclosed porch was large enough a space to allow the vapors to dissipate, and she left one of the porch's, crank-out style windows open approximately 6 inches to assist in further ventilating the fumes. The porch area is 26 feet long by 6 feet wide by 7 feet high. The porch has two pedestrian doors that provide excess to the main living areas of the house; both doors were kept closed, except to enter and exit the porch during the spraying periods.

Approximately 20 minutes after treating the coats for the second time, the 17 year old complainant noticed that she could not take deep breaths, and felt like she could not catch her breath. It hurt her to breath, and she experienced a burning sensation in her lungs. The complainant also began coughing uncontrollably, and felt slightly dizzy. The complainant's boyfriend suffered no ill symptoms.

POST INCIDENT:

The complainant's condition continued to deteriorate, and she was later transported to nearby Community Memorial Hospital in Oconto Falls, Wisconsin for emergency treatment. She was diagnosed as suffering from chemical pneumonia, and was admitted to the hospital for treatment. Chest x-rays showed clouding in her lungs, and she received chemical and oxygen therapy. The complainant was released from the hospital late the following day, 12/28/92.

As the female complainant is a juvenile living apart from her parents, she was asked to obtain a parent's signature on the "Authorization for Release of Name" and "Authorization for Medical Records Disclosure" forms, and then return the completed forms to the CPSC Milwaukee Resident Post. When these authorizations are received, the medical records will be obtained and forwarded as an addendum to this report.

SAMPLES COLLECTED:

The complainant still had two full 5 ounce cans of the "Wilson's Leather Protector" product remaining. These containers were purchased from the complainant as a CPCS sample, sample no. R-830-4408, and were later forwarded to HSHL for further analysis.

A copy of the sample collection receipt issued to the consumer is attached to the end of this report as exhibit "B". A copy of the sample collection report is attached as exhibit "C".

APPLICABLE STANDARDS:

The hazardous substances labeling requirements detailed in 16 CFR 1500 may apply to this product; the adequacy of the present warning labeling could not be evaluated as the product's actual content ingredients are not known at this time.

PRODUCT IDENTIFICATION:

Product: "Wilson's Leather Protector" fabric protection treatment; 5 ounce aerosol container, described as black in color with red and white lettering. SKU no. 18996003. Date coding ink printing on the bottom of the container is apparently smudged and incomplete states "C1 2".

Manufacturer: Wilson's Suede and Leather, Inc.
Minneapolis, Minnesota.

ATTACHMENTS:

- Exhibit "A" Photographs depicting the complainant's reenactment of her use of the product in question.
- "B" Copy of the sample collection receipt issued to the complainant on 12/29/92.
- "C" Copy of sample collection report number R-830-4408.
- "D" Copy of the original consumer complaint.

U.S. CONSUMER PRODUCT SAFETY COMMISSION

1. AREA *Exhibit "B"*
CPSC ID# 921229 CCN 0543
12/29/92

2. NAME OF INDIVIDUAL <i>GARIBOLDI</i>	3. TITLE OF INDIVIDUAL <i>Self</i>	4. DATE <i>12/29/92</i>
5. FIRM NAME <i>[Redacted]</i>	6. SAMPLE NUMBER <i>[Redacted]</i>	
7. NUMBER OF SAMPLES <i>[Redacted]</i>	8. CITY AND STATE (Include Zip Code) <i>OSHTO TALLS W I 59154</i>	

9. SAMPLES COLLECTED (Describe fully - List lot, serial, model numbers and other positive identification)

The following samples were collected by the Consumer Product Safety Commission pursuant to Section 27(f) of the Consumer Product Safety Act (15 U.S.C. 2078(f), and/or Section 11(b) of the Federal Hazardous Substances Act (15 U.S.C. 1270(b) and/or Sections 5(c) and (d) of the Flammable Fabrics Act (15 U.S.C. 1194(c) and (d) and/or Section 704(c) of the Federal Food Drug and Cosmetic Act (21 U.S.C. 374(c)) (Authority for sample collections made in connection with the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.)), and receipt for said samples is hereby acknowledged. Sections cited are quoted on the reverse side of this form.

1. 1/1 [Redacted]

2. 502 CANS OF WILSON'S LEATHER PROTECTOR

1/1 [Redacted]

[Redacted]

10. AMOUNT RECEIVED <i>[Redacted]</i>	11. SAMPLES WERE <input checked="" type="checkbox"/> PURCHASED <input type="checkbox"/> BORROWED (To be returned)	12. COLLECTOR a. NAME (Print or type) <i>Dennis P. Blasius</i> b. SIGNATURE <i>[Signature]</i>
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U. S. CONSUMER PRODUCT S *Exhibit "C"*

12/29/92

SAMPLE COLLECTIC

IQ # 921229CCN0543

1. Flag		2. Date Collected 12/29/92		3. Sample type or number <input checked="" type="checkbox"/> Physical R-830-4408 <input type="checkbox"/> Documentary	
4a. Product name fabric treatment product		4b. Model Wilson's 5oz.		4c. NEISS 0952	
				5. Assignment ref. 921229CCN0543	
6. Complete for import samples				7. MIS 32672	
a. Port of Entry				8. Hours: a. Activity 2.0 b. Travel 0.0	
b. Entry # & date					
c. Country of Origin				9a. Home RO FOCR	
d. HSUSA code				9b. Collecting RO FOCR	
e. Customs Contact					
10. Sample Cost \$ 10.00 (C)		11. Invoice value of lot retail value approx. \$10.00		12. Size of lot two available from consumer	
13. Manufacturer/Importer Wilson's Suede and Leather Inc. Minneapolis, MN.		14. Shipper/Foreign Mfr. Wilson's Suede & Leather Port Plaza Mall A-1009 Port Plaza Mall Green Bay, WI. 54301		15. Dealer/Import Broker Oconto Falls, WI. 54154	
ID #		ID #		ID #	
16. Supporting documents attached:					
a. Invoice # & date: N/A		b. Date Shipped:			
c. Shipping record # & date:					
d. Affidavit signer's name, title & date:					
17. Product Identification:					
Sample consists of two 5 ounce aerosol can of "Wilson's Leather Protector." Can is black in color with red and white lettering, SKU #18996003. Date coding stamp on container bottom states 01292. Front labeling describes product as "making suede and leather stain and water resistant, keeps dirt on the surface for easy wipe-off;" container further lists various warning and usage instructions.					
18. Reason for collection & analysis needed: FHSA <input checked="" type="checkbox"/> CPSA <input type="checkbox"/> FFA <input type="checkbox"/> PPPA <input type="checkbox"/> RSA <input type="checkbox"/>					
F/U to IDI# 921229CCN0543. 17 year old female suffered respiratory distress after using the product); content and labeling analysis.					
19. Summary of Field Screening: None					
20. Sample Size, Method of Collection:					
Sample consists of two unused can as described in #17 above. Two cans - packaged together in a black cardboard display container. Sample was obtained from consumer at her residence on 12/29/92; it remained in my possession and in the locked CPSC office until shipment to the Sample Custodian on 12/31/92. Sample					
21. Identification on sample "R-830-4408 DRB 12/29/92"			22. Identification on seal "R-830-4408 Dennis R. Blasius 12/31/92"		
23a. Sample delivered to Sample Custodian via P.P. MKE		23b. Date 12/31/92		24. Orig. report/records sent to FOCR	
25. Laboratory/Office: ESEL <input type="checkbox"/> HSHL <input checked="" type="checkbox"/> GERM <input type="checkbox"/> CECA <input type="checkbox"/> OTHER <input type="checkbox"/>					
26. Remarks was shipped in a cardboard box which was sealed and identified as under #22 above; sample itself was tagged and identified as described in #21 above. Sample was mailed via P.P.MKE to the Sample Custodian on 12/31/92, to be forwarded to HSHL for further analysis. Sample collection receipt, copy of original assignment attached.					
27. Related Samples R-830-4407					
28a. Collector's name, title & employee # Dennis R. Blasius, Investigator, #9003			28b. Collector's signature & date <i>Dennis R. Blasius</i> 12/31/92		
29a. Reviewer's name, title & employee #			29b. Reviewer's signature & date		

Distribution: Orig Lab Fiscal Data Hdqcr Other

Exhibit "D"

12/29/92

FOI # 921229CCN0543

CONSUMER PRODUCT INCIDENT REPORT

1. NAME OF RESPONDENT [REDACTED]		2. TELEPHONE NO. (Home) (Work) [REDACTED]	
3. STREET ADDRESS [REDACTED]		4. CITY STATE ZIP CODE Oconto Falls, WI. 54154	
5. DESCRIBE ACCIDENT SITUATION OR HAZARD, INCLUDING DATA ON INJURIES. (Use second page if necessary.) Respondent's girlfriend was applying an aerosol leather protector treatment to her newly purchased leather jacket; victim began experiencing severe respiratory distress after several minutes exposure to the product's fumes. Victim was immediately transported to a nearby hospital for treatment, and remains hospitalized to date.			
6. DATE OF INCIDENT(S) 12/27/92	7. IF INJURY OR NEAR MISS, OBTAIN AGE SEX female AND DESCRIBE INJURY respiratory distress	8. IF VICTIM DIFFERENT FROM RESPONDENT, PROVIDE NAME RELATIONSHIP girlfriend	
9. DESCRIPTION OF PRODUCT Aerosol spray leather protector		10. BRAND NAME Wilson's Leather Protector	
11. MANUFACTURER/DISTRIBUTOR NAME, ADDRESS & PHONE Wilson Leather Company Minneapolis, MN.		12. MODEL, SERIAL NO.'S 5oz. can	
		13. DEALER'S NAME, ADDRESS & PHONE Wilson's Leather Products Port Plaza Shopping Center Greenbay, WI.	
14. WAS THE PRODUCT DAMAGED, REPAIRED OR MODIFIED? YES NO <input checked="" type="checkbox"/> IF YES, BEFORE OR AFTER THE INCIDENT? Describe		15. PRODUCT PURCHASED NEW <input checked="" type="checkbox"/> USED DATE PURCHASED 12/27/92 AGE one day	
		16. DOES PRODUCT HAVE WARNING LABELS? IF SO, NOTE:	
17. HAVE YOU CONTACTED THE MANUFACTURER? YES NO <input checked="" type="checkbox"/> IF NOT, DO YOU PLAN TO CONTACT THEM? YES <input checked="" type="checkbox"/> NO OTHER	18. IS THE PRODUCT STILL AVAILABLE? YES <input checked="" type="checkbox"/> NO IF NOT, ITS DISPOSITION	19. MAY WE USE YOUR NAME WITH THIS REPORT? YES <input checked="" type="checkbox"/> NO	
FOR ADMINISTRATION USE			
20. DATE RECEIVED 12/28/92	21. RECEIVED BY (Name & Office) Dennis R. Blasius, MKE-RP	22. DOCUMENT NO. 02 C 0136	
23. FOLLOW-UP ACTION Conduct FOI 921229CCN0543		24. PRODUCT CODE(S) 0952	
25. DISTRIBUTION cc: EPVS; cc: CERMA, Judd; cc: EF		26. ENDORSEER'S NAME & TITLE [Signature]	



Exhibit "A"
IDI# 921229CCN0543

Photos of the enclosed porch area where this incident occurred.

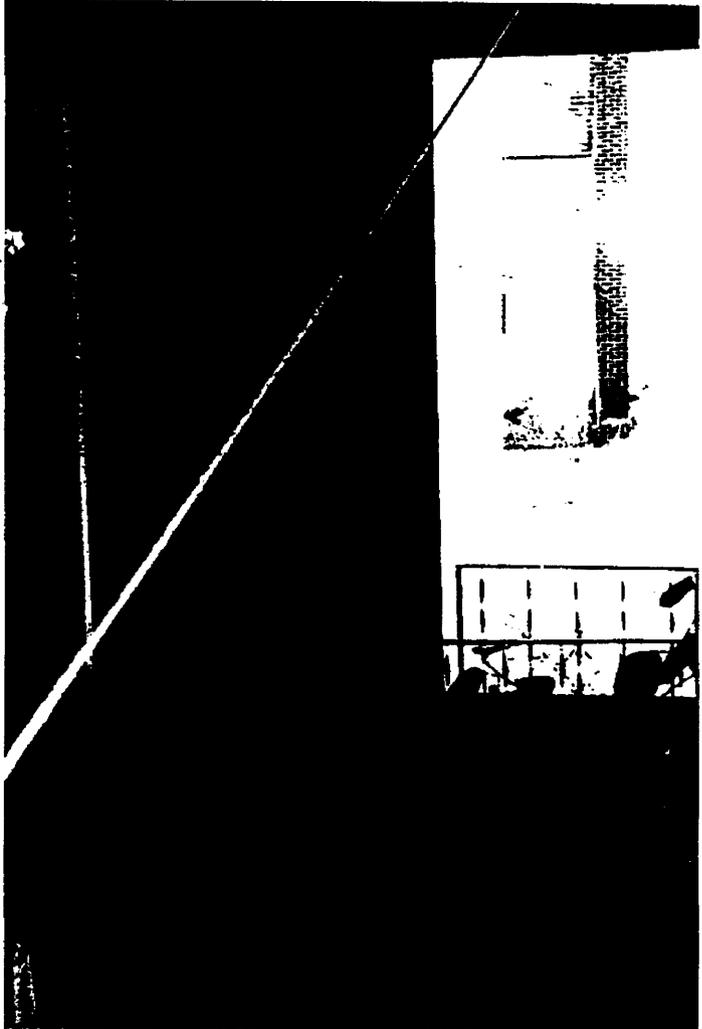




Exhibit "A"
IDI# 921229CCN0543

Photos of victim re-enacting
the manner in which she used
the product.





Exhibit "A"
IDI# 921229CCN0543

Photos of the open window providing some outside ventilation (left), and a front view of the suspect product as purchased by the consumer.

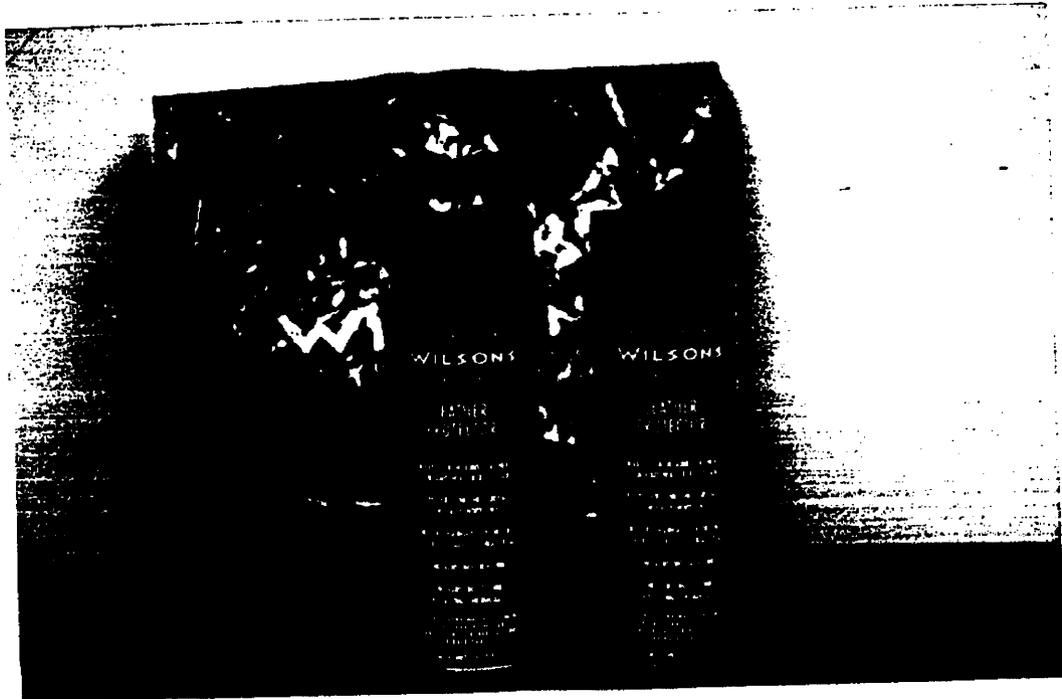


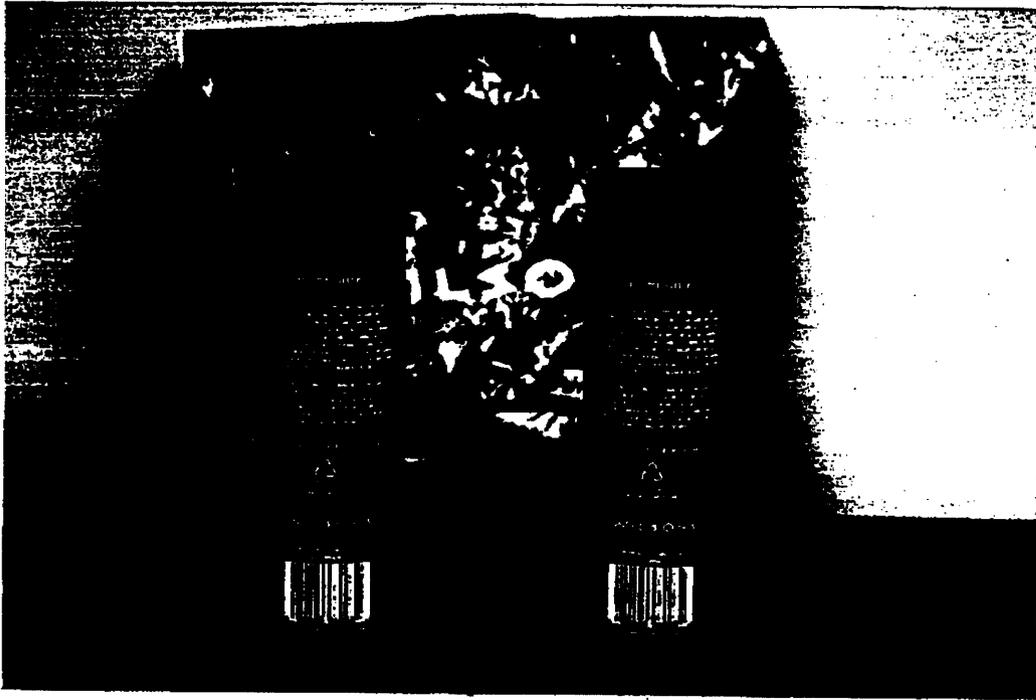
Exhibit "A"
IDI# 921229CCN0543



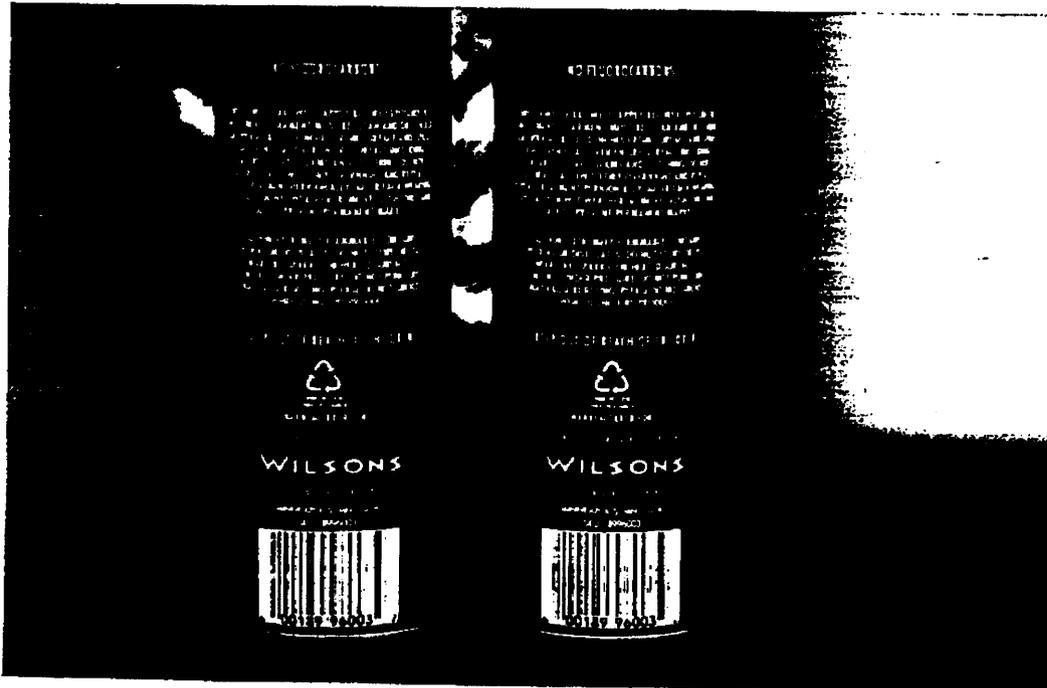
Date coding marking on bottom of containers (C1292.)

NEGATIVES

Exhibit "A"
IDI# 921229CCN0543



Photos of the labeling on the back panel of the aerosol container.



G2C0137

13 JAN 1993 J1

1. CASE NO. 921229CCN0544		2. INVESTIGATOR'S ID 9 0 0 3		3. OFFICE CODE 8 3 0		EPIDEMIOLOGIC INVESTIGATION REPORT
4. DATE OF ACCIDENT YR MO DAY 9 2 1 2 2 7		5. DATE INVESTIGATION INITIATED YR MO DAY 9 2 1 2 2 9				
6. SYNOPSIS OF ACCIDENT OR COMPLAINT This investigation was initiated in response to a report that two sisters, ages 10 and 19, experienced severe respiratory distress after being exposed to the fumes from an aerosol fabric protection product they were treating a new leather jacket with in their basement. Both victims were treated and released at a local hospital emergency room.						
7. LOCATION (Home, school, etc.) home			8. CITY 1 0 Gillett		9. STATE WI WI	
10A. FIRST PRODUCT fabric treatment product: 0 9 5 2			11A. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS Wilson's Suede and Leather, Inc.; Minneapolis, MN. Wilson's Leather Protector(5 oz.)			
10B. SECOND PRODUCT Aerosol Contaminant TTS3			11B. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS Same as above.			
12. AGE OF VICTIM 0 1 9		13. SEX (Use numerical code) MALE -1 FEMALE -2 UNKNOWN -3 2		14. DISPOSITION treated at E.R. and released 1		15. INJURY DIAGNOSIS chemical pneumonia 7 1
16. BODY PART all parts 8 5		17. RESPONDENT(S) (Mother, Friend) victim 1		18. TYPE INVESTIGATION ON SITE 1 TELEPHONE 2 OTHER 3 1		19. TIME SPENT Tr: 8.0 0 7 0
20. ATTACHMENTS multiple 9		21. CASE SOURCE State Health Dept. 0 2		22. REVIEWED BY YR MO DAY 8 1 3 0 9 2 0 1 0 8		
23. PERMISSION TO DISCLOSE NAMES (NON-BUSINESS CASES ONLY) CPSC MAY DISCLOSE MY NAME <input type="checkbox"/> CPSC MAY NOT DISCLOSE MY NAME <input checked="" type="checkbox"/>						
24. NARRATIVE (See Instructions on Other Side) See attached narrative.				25. REGIONAL OFFICE DIRECTOR REVIEW DATE		
6/10/93pc X 25c X G2C0137						

(USE OTHER SIDE AND ADDITIONAL SHEETS IF NECESSARY)

921229CCN0544

SUMMARY:

This investigation was conducted in response to a report that two sister, ages ten and nineteen, experienced severe respiratory distress after treating a new leather coat with an aerosol fabric protection product. Both victims were treated at a local hospital emergency room and released.

PRE-INCIDENT:

On Sunday 12/27/92, at approximately 3:30 p.m. the nineteen year old female complainant purchased a new black leather waist length jacket from the "Wilson's Suede and Leather Products" retail store located at A-1009 Port Plaza Mall, located in Green Bay, Wis. 54301, phone # 414-432-3121.

The complainant was assisted in making this purchase by a female clerk named Darla, last name unknown, who is believed to be a store manager. The store manager suggested to the complainant that it would be important to treat the new jacket with a fabric protection product to avoid damage to the coat from dirt or moisture. The clerk suggested that the complainant purchase "Wilson's Leather Protector", which is an aerosol product sold at the store in 5 oz. aerosol cans. This aerosol fabric protector is sold in a two can cardboard display packaged, described as a "Leather Care Starter Set". The two container set retails for approximately \$10.00.

The complainant agreed to purchased the fabric protector product. She was told by the manager that the entire contents of a five ounce can of the product should be sprayed on the coat before it was worn, and that the coat should be retreated every six months afterwards by spraying an additional one-half container of the five ounce size can onto the coat. The clerk provided no further direction as to how the fabric protector should be applied, and provided no cautionary warning that the product's fumes might be hazardous.

INCIDENT:

Later that same day, 12/27/92, at approximately 6:30 p.m., the nineteen year old complainant sprayed the entire content of a five ounce aerosol can of Wilson's Leather Protector onto her new jacket. This jacket was treated in the basement area of the family's twostory single family residence. The basement is unfinished, though a portion of the basement area is used by the complainant's ten year old sister as a playroom. The area where the coat was treated is described as being approximately 16ft. long x 14ft. wide x 8ft. high, and is adjacent to the home's gas forced air furnace. There are several windows in the basement of the home, however none of the windows were opened during the time period that this incident occurred.

The spraying of the jacket took approximately five to ten minutes. The complainant stated that she read the instruction and warning labeling on the aerosol can before starting to use the product. She noted that the labeling stated that "Vapors may be harmful", and "Please do not smoke while using this product". The complainant felt that the open basement area was large enough to preclude her from having any problems with the product's fumes, so she sprayed the can's entire five ounce contents on the coat in one application. She did not find the fumes particularly offensive or overpowering, and noticed no adverse physical effects while using the product. Photographs attached to the end of this report as exhibit "A" depict the complainant reenacting the manner in which she sprayed the coat.

The complainant's ten year old sister was playing approximately twelve feet from where the coat was being treated. At one point the ten year old was asked by the complainant to assist in holding the jacket open during the spraying procedure; the ten year old did so for approximately one minute. A photograph of this procedure, reenacted by the sisters, is also contained in Exhibit "A".

Approximately fifteen to twenty minutes after finishing the leather protector treatment of the jacket, the ten year old daughter complained to her mother that she was having difficulty breathing. The ten year old complained that she had a burning sensation in her lungs if she took a deep breath, and that "it feels like somebody is sitting on my chest". The ten year old laid down on the living room couch to rest, at which time the nineteen year old complainant came downstairs from her bedroom also complaining to her mother that she felt like she could not breath. The nineteen year old could only take short, shallow breathes, and she began coughing uncontrollably, feeling like she needed to vomited. The nineteen year old also complained of the same burning sensation in her lungs.

POST-INCIDENT:

The girl's mother suspected that the victims were having some reaction to the fabric protector; she immediately called the local poison control center but was told that the "Wilson's Leather Protector" product was not listed in their files, and that she should immediately take both girls to a local hospital for emergency treatment of their symptoms. The victims' mother drove the girls to the near by Oconto Falls Community Memorial Hospital, 855 S. Main Street, Oconto Falls, Wi. 54154, where they both received emergency treatment from Dr. Wallace. Both girls were giving oxygen tests, chest x-rays, and were found to be suffering from symptoms usually associated with chemical pneumonia. The symptoms begin to subside, and the two victims were released from the hospital approximately two hours after admittance. As of the

date of this investigator's interviews with the victims, 12/29/92, both victims complained only of a lingering cough and no further symptoms.

Attached the end to this report as Exhibits "B-E", are "Authorization for Release of Name" and "Authorization for Medical Records Disclosure" forms sign by the victims. The victims did not wish their identities revealed, except as necessary to interact with other investigative government agencies.

SAMPLES COLLECTED:

Of the two five ounce cans of "Wilson's Leather Protector" fabric protection product purchased by the consumer, they had one full unused container remaining. The other used container had been given to a local Television Station. The remaining container was collected by this investigator as a CPSC sample, sample number R-8304407, and forwarded to HSHL for further analysis.

A copy of the sample collection receipt issued to the consumer is attached as Exhibit "F". A copy of the sample collection receipt is attached as Exhibit "G".

APPLICABLE STANDARDS:

The hazardous substances labeling requirements detailed in 16CFR1500 may apply to this product; the adequacy of the present warning labeling could not be evaluated, as the product's actual content ingredients are not known at this time.

PRODUCT IDENTIFICATION:

Product: "Wilson's Leather Protector" fabric protection treatment; five ounce aerosol container, container -described as being black with red and white lettering. SKU number 18996003. Date coding ink print on bottom of container is apparently incomplete, states "C1--2".

MANUFACTURER: Wilson's Suede and Leather, Inc., Minneapolis, Mn.

ATTACHMENTS:

Exhibit A - Photographs of the product use reenactment as well as photographs of the product container itself.

Exhibit B - Authorization for release of name forms signed by

Michelle Rodefer.

Exhibit C - Authorization for release of name form signed by the parent of Lindsey Rodefer, a Juvenile.

Exhibit D - Authorization for Medical Records disclosure form signed by Michelle Rodefer.

Exhibit E - Authorization for Medical Records disclosure form signed by the mother of Lindsey Rodefer.

Exhibit F - Copy of the Sample Collection Receipt issued to Linda Rodefer for the sample of "Wilson's Leather Protector" obtained as a sample.

Exhibit G - Copy of the Sample Report, sample number R-830-4407.

Exhibit H - Copy of the original Consumer Product Incident Report, dated 12/28/92.

Medical Records pertaining to both victim's hospital treatment were requested on 1/4/93, and that information will be forwarded as a addendum to this report when it is received by the Milwaukee Resident Post.

Exhibit "D"

12/29/92

IOI # 921229CCN0544

U.S. CONSUMER PRODUCT SAFETY COMMISSION

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO WHOM IT MAY CONCERN:

You are hereby authorized to furnish the United States Consumer Product Safety Commission all information and copies of any and all records you may have pertaining to (my case)

(the case of

[Redacted Name]

Name

Relationship to you

including, but not limited to, medical history, physical reports, laboratory reports and pathological slides, and X-ray reports and films.

12-29-92

(Date)

[Redacted Signature]

(Signature)

[Redacted Witness]

(Witness)

U.S. CONSUMER PRODUCT

Exhibit "E"

12/29/92

IOI# 921229CCN0544

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO WHOM IT MAY CONCERN:

You are hereby authorized to furnish the United States Consumer Product Safety Commission

all information and copies of any and all records you may have pertaining to (my case)

(the case

[Redacted Name]

my daughter Relationship to you

including, but not limited to, medical history, physical reports, laboratory reports and pathological slides, and X-ray reports and films.

12-29-92
(Date)

[Redacted Signature]
(Signature)

[Redacted Witness]
(Witness)

U.S. CONSUMER PRODUCT SAFETY COMMISSION

Exhibit "F" 12/29/92

1. AREA
 CPSC -
 310 W. WISCONSIN AVE.
 MILWAUKEE, WI 53203

2. NAME OF INDIVIDUAL

3. TITLE OF INDIVIDUAL
 Self

4. DATE
 12/29/92

5. ITEM NAME

6. SAMPLE NUMBER

7. NUMBER AND STREET

8. CITY AND STATE (Include Zip Code)
 GILLET, WI 54124

9. SAMPLES RECEIVED (Describe fully, list lot, serial, model numbers and other positive identification)
 The following samples were collected by the Consumer Product Safety Commission pursuant to Section 27(f) of the Consumer Product Safety Act (15 U.S.C. 2075(f)) and/or Section 11(b) of the Federal Hazardous Substances Act (15 U.S.C. 1270(b)) and/or Sections 5(c) and (d) of the Flammable Fabrics Act (15 U.S.C. 1194(c) and (d)) and/or Section 704(e) of the Federal Food Drug and Cosmetic Act (21 U.S.C. 374(e)) [Authority for sample collections made in connection with the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.)] and receipt for said samples is hereby acknowledged. Sections cited are quoted on the reverse side of this form.

1 - ONE 532 CAN OF WILSON'S LEATHER PROTECTOR
 and this product to # 00189-76-203

10. SAMPLES

11. SAMPLES WERE

12. COLLECTOR

a. AMOUNT RECEIVED FOR SAMPLE

PURCHASED
 BORROWED (To be returned)

a. NAME (Print or type)
 DENNIS R. BLASIUS

b. SIGNATURE (Person from whom sample received)
 Linda Rodefer

b. SIGNATURE
 Dennis R. Blasius

U. S. CONSUMER PRODUCT
SAMPLE COLLECTI

Exhib. / "G"

12/29/92

FOI# 921229CCN 0544

1. Flag	2. Date Collected 12/29/92	3. Sample type & number <input checked="" type="checkbox"/> Physical R-830-4407 <input type="checkbox"/> Documentary
4a. Product name fabric treatment product	4b. Model Wilson's 5oz.	4c. NEISS 0952
5. Assignment ref. 921229CCN0544		
6. Complete for import samples	7. MIS 32672	8. Hours: a. Activity 2.0 b. Travel 0.0
a. Port of Entry		9a. Home RO
b. Entry # & date		9b. Collecting RO
c. Country of Origin		
d. HSUSA code		
e. Customs Contact		
10. Sample Cost \$0.	11. Invoice value of lot retail value approx. \$5.00	12. Size of lot one available from consumer
13. Manufacturer/Importer Wilson's Suede and Leather Inc. Minneapolis, MN.	14. Shipper/Foreign Mfr. Wilson's Suede & Leather Port Plaza Mall A-1009 Port Plaza Mall Green Bay, WI. 54301	15. Distributor [REDACTED] Gillett, WI. 54124
ID #	ID#	ID#
16. Supporting documents attached:		
a. Invoice # & date: N/A	b. Date Shipped:	
c. Shipping record # & date:		
d. Affidavit signer's name, title & date:		
17. Product Identification: Sample consists of one 5 ounce aerosol can of "Wilson's Leather Protector." Can is black in color with red and white lettering, SKU #18996003. Date coding stamp on container bottom states "Cl 2." Front labeling describes product as "making suede and leather stain and water resistant, keeps dirt on the surface for easy wipe-off;" container further lists various warning and usage instructions.		
18. Reason for collection & analysis needed: FHSA <input checked="" type="checkbox"/> CPSA <input type="checkbox"/> FFA <input type="checkbox"/> PPPA <input type="checkbox"/> RSA <input type="checkbox"/> F/U to ID# 921229CCN0544 (10 Y.O. and 19 Y.O. suffered respiratory distress after using the product); content and labeling analysis.		
19. Summary of Field Screening: None		
20. Sample Size, Method of Collection: Sample consists of one unused can as described in #17 above. This can was one of a two can set packaged together in a black cardboard display container. Sample was obtained from consumer at her residence on 12/29/92; it remained in my possession and in the locked CPSC office until shipment to the Sample Custodian on 12/31/92. Sample		
21. Identification on sample "R-830-4407 DRB 12/29/92"	22. Identification on seal "R-830-4407 Dennis R. Blasius 12/31/92"	
23a. Sample delivered to Sample Custodian via P.P. MKE	23b. Date 12/31/92	24. Orig. report/records sent to FOCR
25. Laboratory/Office: ESEL <input type="checkbox"/> HSHL <input checked="" type="checkbox"/> CERM <input type="checkbox"/> CECA <input type="checkbox"/> OTHER <input type="checkbox"/>		
26. Remarks was shipped in a cardboard box which was sealed and identified as under #22 above; sample itself was tagged and identified as described in #21 above. Sample was mailed via P.P.MKE to the Sample Custodian on 12/31/92, to be forwarded to HSHL for further analysis. Sample collection receipt, copy of original assignment attached.		
27. Related Samples R-830-4408		
28a. Collector's name, title & employee # Dennis R. Blasius, Investigator, #9003	28b. Collector's signature & date <i>Dennis R. Blasius</i> 12/31/92	
29a. Reviewer's name, title & employee #	29b. Reviewer's signature & date	

Distribution: Orig Lab Fiscal Data Hdqtr Other

CONSUMER PRODUCT INC

Exhibit "H"

12/29/92

TOI #921229CCNO544

1. NAME OF RESPONDENT [REDACTED]		2. TELEPHONE NO. (Home) (Work) [REDACTED]	
3. STREET ADDRESS [REDACTED]		4. CITY STATE ZIP CODE Gillett, WI. 54124	
5. DESCRIBE ACCIDENT SITUATION OR HAZARD, INCLUDING DATA ON INJURIES. (Use second page if necessary.) Respondent's two daughters, ages 19 and 10, were in the basement of their home treating a new leather coat with an aerosol leather protector product. After several minutes of exposure to the product's fumes both individuals began experiencing severe respiratory distress, including difficulty breathing, coughing, and tightness in their chests. Both victims were transported to a local hospital, where they were treated and released.			
6. DATE OF INCIDENT(S) 12/27/92	7. IF INJURY OR NEAR MISS, OBTAIN AGE <u>19</u> SEX <u>Female</u> AND DESCRIBE INJURY <u>respiratory distress</u>	8. IF VICTIM DIFFERENT FROM RESPONDENT, PROVIDE NAME _____ RELATIONSHIP <u>daughters</u>	
9. DESCRIPTION OF PRODUCT <u>aerosol spray leather protector</u>		10. BRAND NAME <u>Wilson's Leather Protector</u>	
11. MANUFACTURER/CONTRIBUTOR NAME, ADDRESS & PHONE <u>Wilson's Leather Company Minneapolis, MN.</u>		12. MODEL, SERIAL NO.'S <u>5oz. and 7oz. cans</u>	
		13. DEALER'S NAME, ADDRESS & PHONE <u>Wilson's Leather Products Port Plaza Shopping Center Greenbay, WI.</u>	
14. WAS THE PRODUCT DAMAGED, REPAIRED OR MODIFIED? YES _____ NO <u>X</u> IF YES, BEFORE OR AFTER THE INCIDENT? Describe _____		15. PRODUCT PURCHASED <u>NEW X</u> <u>USED</u> DATE PURCHASED <u>12/27/92</u> AGE <u>one day</u>	
		16. DOES PRODUCT HAVE WARNING LABEL? IF SO, NOTE: _____	
17. HAVE YOU CONTACTED THE MANUFACTURER? YES <u>X</u> NO _____ IF NOT, DO YOU PLAN TO CONTACT THEM? YES _____ NO _____ OTHER _____		18. IS THE PRODUCT STILL AVAILABLE? YES <u>X</u> NO _____ IF NOT, ITS DISPOSITION _____	
19. MAY WE USE YOUR NAME WITH THIS REPORT? YES <u>X</u> NO _____			
FOR ADMINISTRATION USE			
20. DATE RECEIVED 12/28/92	21. RECEIVED BY (Name & Office) Dennis R. Blasius, MKE-BP		22. DOCUMENT NO. 62 C. 0137
23. FOLLOW-UP ACTION <u>Conduct ITII 921889CCNO544</u>			24. PRODUCT CODE(S) <u>0952</u>
25. DISTRIBUTION <u>O: EPDS; cc (ERM, Jacobson); cc: EP</u>		26. ENDORSER'S NAME & TITLE <u>[Signature] DPSE</u>	

Exhibit "C"

12/29/92

FOI# 921229CCN0544

U.S. CONSUMER PRODUCT SAFETY COMMISSION

AUTHORIZATION FOR RELEASE OF NAME

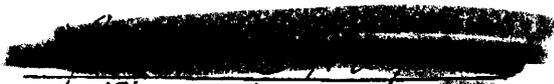
Thank you for assisting us in collecting information on a potential product safety problem. The Consumer Product Safety Commission depends on concerned people to share product safety information with us. We maintain a record of this information, and use it to assist us in identifying and resolving product safety problems.

We routinely forward this information to manufacturers and private labelers to inform them of the involvement of their product in an accident situation. We also give the information to others requesting information about specific products. Manufacturers need the individual's name so that they can obtain additional information on the product or accident situation.

Would you please indicate on the bottom of this page whether you will allow us to disclose your name. If you request that your name remain confidential, we will of course, honor that request. After you have indicated your preference, please sign your name and date the document on the lines provided.

You are hereby authorized to disclose my name and address with the information collected on this case.

My identity is to remain confidential.


(Signature)

12-29-92
(Date)

(for 1070)

Exhibit "B"

12/29/92

FOI # 92/229 CCN0544

U.S. CONSUMER PRODUCT SAFETY COMMISSION

AUTHORIZATION FOR RELEASE OF NAME

Thank you for assisting us in collecting information on a potential product safety problem. The Consumer Product Safety Commission depends on concerned people to share product safety information with us. We maintain a record of this information, and use it to assist us in identifying and resolving product safety problems.

We routinely forward this information to manufacturers and private labelers to inform them of the involvement of their product in an accident situation. We also give the information to others requesting information about specific products. Manufacturers need the individual's name so that they can obtain additional information on the product or accident situation.

Would you please indicate on the bottom of this page whether you will allow us to disclose your name. If you request that your name remain confidential, we will of course, honor that request. After you have indicated your preference, please sign your name and date the document on the lines provided.

You are hereby authorized to disclose my name and address with the information collected on this case.

My identity is to remain confidential.


12-29-92
(Date)

Exhibit "A"

IDI# 921229CCN0544

Additional photos of the instruction and warning labeling on the product container.

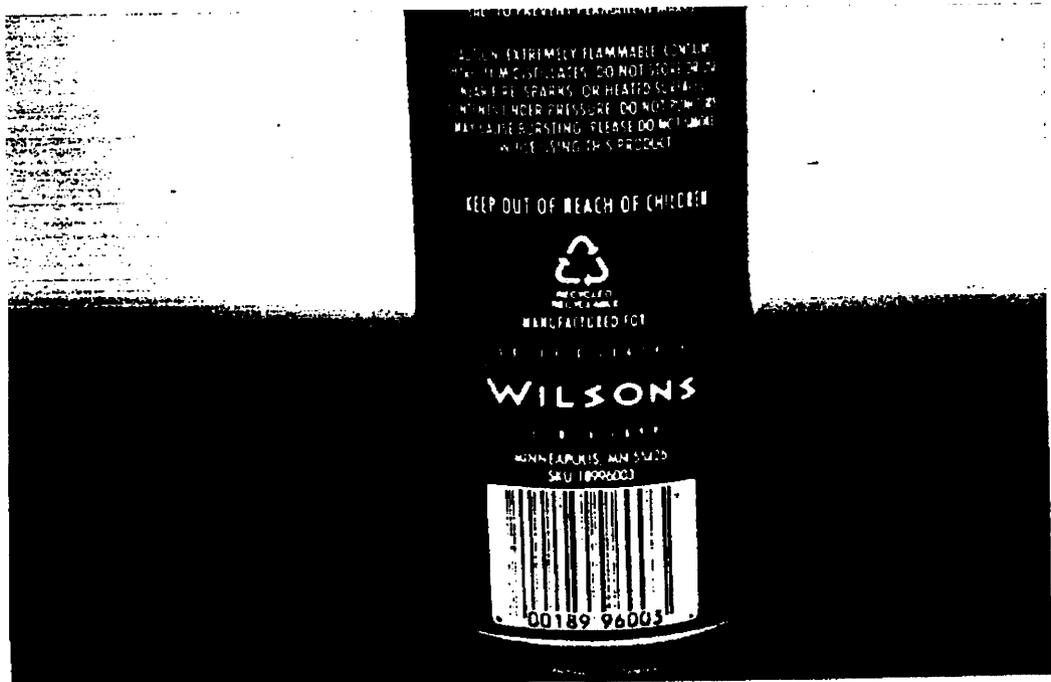
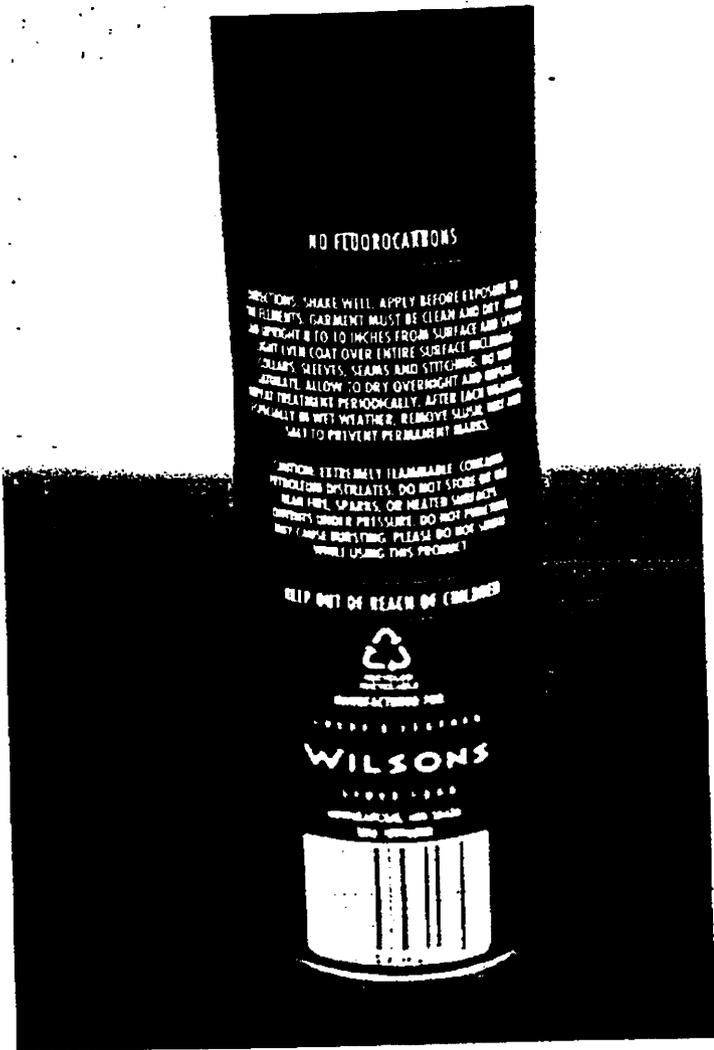


Exhibit "A"

IDI# 921229CCN0544

Photos of the suspect product.

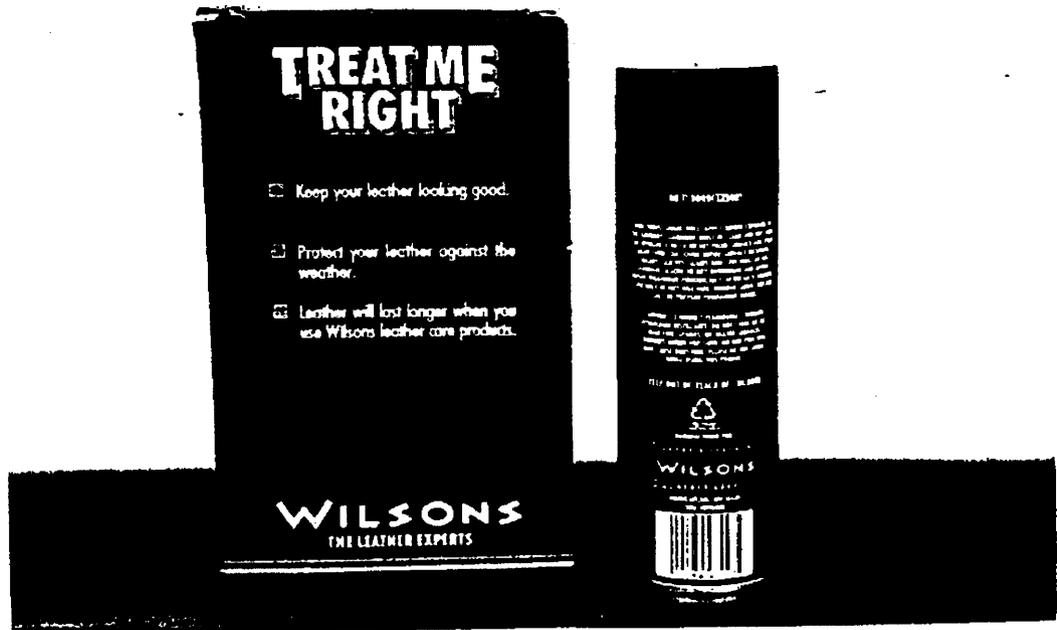


Exhibit "A"

IDI# 921229CCN0544

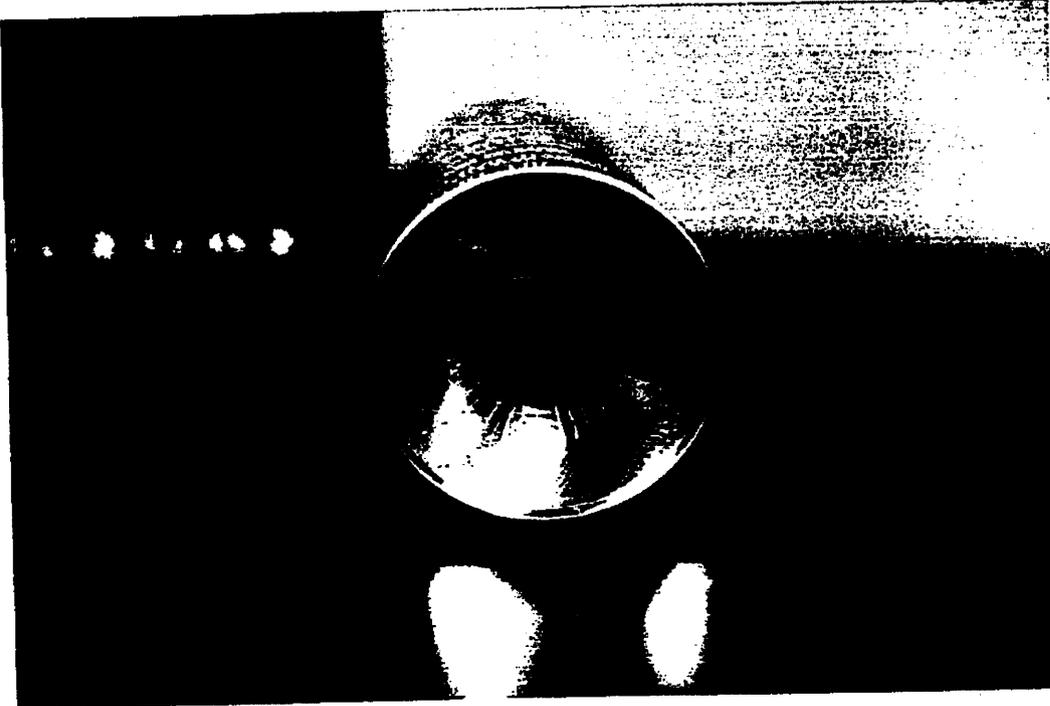


Photos of complainant re-enacting her use of the suspect product.



Exhibit "A"

IDI# 921229CCN0544



Date coding information on the bottom of the container; states "C1..2"

NEGATIVES

Exhibit "A"

IDI# 921229CCN0544



Above: Complainant and her sister re-enacting their use of the fabric protector product.
Below: Photo of the product in question, as purchased by the consumer.



MAR 4 1993

31

G310081

EPIDEMIOLOGIC INVESTIGATION REPORT

1. CASE NO. 930111CCN0667		2. INVESTIGATOR'S ID 8 1 1 1		3. OFFICE CODE 8 3 0	
4. DATE OF ACCIDENT YR MO DAY 9 2 1 2 2 5		5. DATE INVESTIGATION INITIATED YR MO DAY 9 3 0 1 2 8			
6. SYNOPSIS OF ACCIDENT OR COMPLAINT On 12-25-92 at approximately 0830 hours, a 43 year old male and his 17 year old son suffered chemical pneumonia after entering a room in which a leather protector had been applied to a coat. Both were treated and released at a local emergency room.					
7. LOCATION (Home, school, etc.) Home (Niece's bedroom)		8. CITY Raleigh		9. STATE Tennessee T N	
10A. FIRST PRODUCT Leather protector		11A. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS Wilson's Leather Protector, 5 oz. Wilson's, Minneapolis, Mn. 55426			
10B. SECOND PRODUCT n/a		11B. TRADE/BRAND NAME, MODEL NUMBER, MANUFACTURER & ADDRESS n/a			
12. AGE OF VICTIM 0 4 3		13. SEX (Use numerical code) MALE -1 FEMALE -2 UNKNOWN -3 1		14. DISPOSITION T & R 1	
15. INJURY DIAGNOSIS Chemical pneumonia (vapor inhalation)		6 8			
16. BODY PART All		17. RESPONDENT(S) (Mother, Friend) Victim		18. TYPE INVESTIGATION ON SITE 1 TELEPHONE 2 OTHER 3 1	
19. TIME SPENT 1 2 0		20. ATTACHMENTS Multi		21. CASE SOURCE Newspaper	
22. REVIEWED BY 8007		YR MO DAY 9 3 0 2 2 8			
23. PERMISSION TO DISCLOSE NAMES (NON-HESS CASES ONLY) CPSC MAY DISCLOSE MY NAME <input checked="" type="checkbox"/> CPSC MAY NOT DISCLOSE MY NAME <input type="checkbox"/>					
24. NARRATIVE (See Instructions on Other Side)				25. REGIONAL OFFICE DIRECTOR REVIEW DATE	
Narrative begins on page 2.					
<p>APPROVED FOR USE 6/10/93</p> <p>X - [Signature]</p> <p>X - [Signature]</p> <p>G310081</p>					

(USE OTHER SIDE AND ADDITIONAL SHEETS IF NECESSARY)

U.S. CONSUMER PRODUCT SAFETY COMMISSION

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

TO WHOM IT MAY CONCERN:

You are hereby authorized to furnish the United States Consumer Product Safety Commission
all information and copies of any and all records you may have pertaining to (my case)

(the case of Donald Adams (self), Carey Adams (son)
Name

Relationship to you

including, but not limited to, medical history, physical reports, laboratory reports and
pathological slides, and X-ray reports and films.

1/30/93
(Date)

Donald Leon Adams
(Signature)

Janice L. Mitchell
(Witness)

930111CCN0667

Pre-Accident

The victim, a 43 year old male, lives with his wife and 17 year old son in a one-story single family dwelling located in a blue-collar working class suburban community near Memphis, Tennessee.

The victim, a letter carrier with the U.S. Postal Service, said prior to this incident, he had not missed a day from work due to sickness in over 10 years. He said he has been in excellent health, and was not on any medication prior to this incident. He said he smokes cigarettes, averaging close to two packs per day, and has done so for some time.

He explained that the day of the incident was Christmas Day. He, his wife, and son went to his sister's home for Christmas breakfast, as their custom had been for several years. He said they arrived there at approximately 0730 hours. After greeting family and friends who were there, he said he went into one of the bedrooms, which had been designated as the "smoking area" to smoke a cigarette. Time was approximately 0745 hours. He then returned to the living room and kitchen area and ate breakfast. The family then began opening gifts.

The victim said his niece received a new waist length leather coat for Christmas from her boyfriend, who was there. The coat was in a garment bag. When she opened the garment bag, the first thing that fell out was a can of leather protector spray which came with the coat. He said she showed the coat to everyone, then took it to her bedroom (which was the room designated as the smoking area).

Unknown to the others, the niece's boyfriend proceeded to spray the leather coat with the 5 oz. leather protector spray in the niece's bedroom, as it hung on the outside of the closet door.

The victim said he went back to the designated smoking area and smoked another cigarette around 0830 hours.

Accident:

The victim said he noticed a peculiar smell in the room when he went to smoke a second cigarette, but assumed it was caused by stale cigarette smoke. After leaving the room, he said he felt a pain in his chest, and began coughing violently.

Post-Accident:

The victim said he and his family left his sister's house around 0900 hours. His wife said by the time they arrived home, both her husband and her son felt so ill, they immediately went to bed. She said they were complaining of shortness of breath,

930111CCN0667

coughing, chest pain, fever, and chills. She said she telephoned her sister-in-law and found out her niece and nephew were also experiencing similar symptoms. After talking about what was occurring, they both realized the only unusual occurrence was that the niece's boyfriend had sprayed her new leather coat in the same room that had been designated as the "smoking area."

The wife said she decided to telephone the poison control center for advice. She was told to take her husband and son to a local hospital emergency room for treatment.

She said they arrived at the hospital around 1245 hours. Their temperatures were at 102 degrees F. Both her husband and son were examined by physicians and diagnosed as experiencing chemical pneumonia. They were treated, prescribed medication, and released.

The victim said he continued feeling very ill until he began taking the medication. He remained at home recovering for three (3) days. He said his son was home recovering for 4 days, although he continued to cough for the next 10-14 days.

The victim said while he was being treated by the hospital emergency room staff, at least two physicians and one nurse questioned him on whether he had intentionally inhaled a chemical for drug abuse purposes. He said such questions were insulting and contributed to the discomfort he was experiencing.

The victim's wife said several of the family members became ill after being in the designated smoking room on Christmas Day, however, not all of them sought medical treatment. She said she subsequently contacted the local newspaper and reported her family's reaction to the leather protector spray, and found out that individuals nationwide had sustained similar illnesses.

The victim's niece who owned the leather coat was visited and she stated she also became ill and was treated at the local hospital emergency room. She said her boyfriend, however, did not become ill.

She said he purchased the leather coat and spray leather protector from a store in the Oakcourt Mall in Memphis, Tn. She said since the incident, he has subsequently purchased a second container of leather protector for her coat, however, it was a different size (7 oz.) and contained different label statements. She provided the original container for my examination and permitted me to photograph it, however, refused to permit CPSC to collect it as a sample due to possible litigation.

The room designated as the smoking area in which the spray protector was used was examined and noted to consist of approximately an 11'x12' area containing furnishings such as a waterbed, two dressers, and a storage bin (a diagram was drawn and is attached). The victim's niece stated the leather coat was hanging on the outer frame of the closet at the time the leather protector spray was applied, and left at the same location to dry. She said the room temperature was set at 73 degrees F. The window for the room was closed. There was no ventilation.

930111CCN0667

Product Information:

Product

Leather protector, product in black metal spray can, 5 oz. size, labeled in part: "**WILSONS LEATHER PROTECTOR**
CAUTION: VAPOR MAY BE HARMFUL. CONTENTS UNDER PRESSURE. READ CAREFULLY OTHER CAUTION ON BACK PANEL. NET WT. 5 OZ.**WILSONS MINNEAPOLIS, MN 55426**".

Manufacturer/Distributor

Wilson
Minneapolis, Ms. 55426

Product Code

"292" stamped on bottom of can

Standards Information:

Product is subject to 16 CFR Part 1500 under the Federal Hazardous Substances Act.

Attachments:

1. Photographs
2. Authorization to Release Name
3. Medical Records Disclosure
4. Medical Records
5. Poison Control Records
6. Diagram of room
7. Assignment

METHODIST

MEDICAL RECORDS

930111000667

ITEM NO. 187
FMC 10/80

attachment 4

PATIENT NAME: ER23798234
 ADAMS DONALD L #3 WMM 1620533-001
 REFERRING PHYSICIAN: 000000 NO REFER. DR.
 PERSONAL PHYSICIAN: NONE
 EMER. PM. CHG. [initials] M & S SUPPLIES: [initials] PHYSICIAN FEE: [initials]
 OTHER CHARGES: [initials] AMOUNT PAID: [initials]

IF ACCIDENT INDUSTRIAL DATE: [] TIME: [] LOCATION: []
 POLICE NOTIFIED (TIME): [] AM: [] PM: [] FAMILY NOTIFIED: []
 MERG. DR. [] HOUSE STAFF [] ADMITTING PHYSICIAN (INITIAL LAST): []
 DR. M. CARR

DATE IN: 2-25-92 TIME: 12:45
 DATE OUT: 2-25-92 TIME: 7:30
 BROUGHT BY: PRIVATE VEHICLE
 PATIENT PHONE: []
 VITAL SIGNS: []

HISTORY & PHYSICAL
 CHIEF COMPLAINT: DIFF BREATHING/INHALED CHEMICALS
 43yo M presented with difficulty breathing - 1/2 hr @ home 2 other family members present. Sudden onset of heavy coughing & wheezing several times since then. Had had chest pain cough. Necktie pulled. Cough - 2-25-92
 B/P 125/80 T 101 P 116
 1415 B/P 168 T 101 P 112

CBC: WBC 15.1
 HGB: []
 DIFF: []
 NA: [] K: []
 CL: [] CO₂: []
 BLN: [] GLU: []
 UA: []

DISCHARGE IMPRESSION: Pneumonia
 Orders: ABC, 1247-04K → RLC upful
 ASG's
 English
 No-Tuss

ARRIVAL TO ROOM #7: 2 family members - smoking left in car. 12:45
 43yo white male pt admitted to room #7 @ 9:00: diff breathing + coughs + 1/2 hr. - denies being sick - no history of lung disease. pt drew small 1pk/day. 2 tylenol po for temp 130.5 (12:45)

SENDING PHYSICIAN COMMUNICATION: []
 HOME OFFICE EXCHANGE PAGED AT AM CONSULT PM I.M.D. CALLED HOME OFFICE EXCHANGE PAGED AT

POSITION AND INSTRUCTION TO PATIENT: 1) Bedrest 2) Meds as directed 3) Return for any problems to Dr. Vengren
 SEND COPY OF CHART WITH PATIENT: []

TURN OR SEE DR. IMMEDIATELY IF WORSENS, OR IF NO BETTER IN [] HOURS. [] GOOD [] SATISFACTORY [] SERIOUS [] CRITICAL
 PHYSICIAN SIGNATURE: [] HOUSE STAFF PHYSICIAN'S SIGNATURE: [] TIME RC PHYSICIAN'S SIGNATURE: []

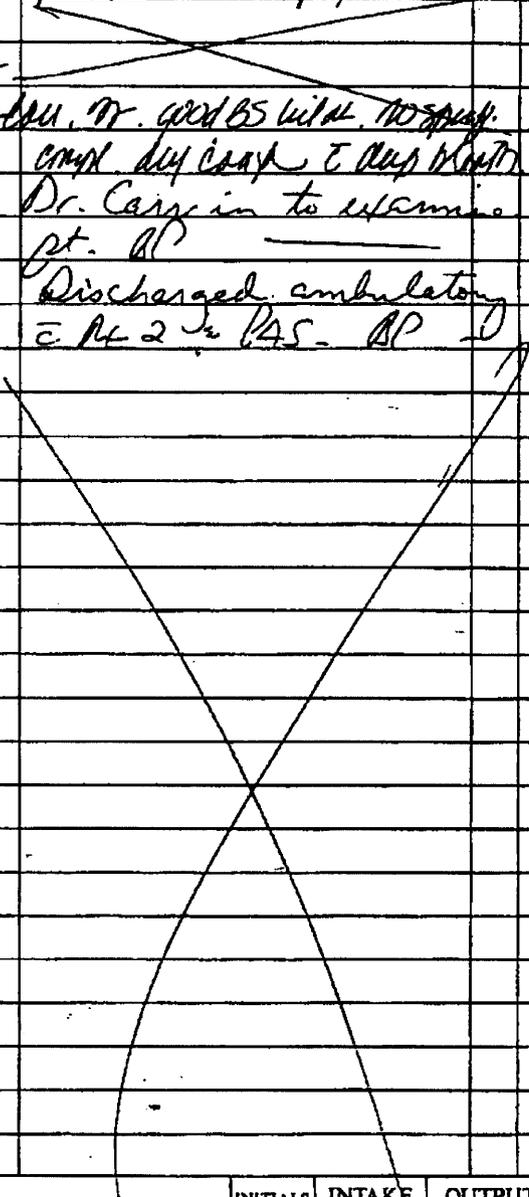
ER 23798234 01620533-001
ADAMS, DONALD L 2 043
DR. D NONE 001723
1780 WARNER AVE
MEMPHIS TN 38103

METHODIST
THE METHODIST HEALTH SYSTEMS

We Know What A Miracle You Are.

EMERGENCY DEPARTMENT ROOM NUMBER 7

TIME	BP	H T	-3 P	R	MEDICATIONS, TREATMENTS EQUIPMENT, & LABORATORY	OBSERVATIONS	I	O
1310						Dr. Call, wants to hold on pt Tympan & CW CBC / eye. Mr		
					Lab work drawn by LIT no result. Mr.			
1410	109/68	101	112	24	med ciprofloxacin per order Mr. Dr. good BS with no resp. CXR done	exam. by camp & Resp Mr. Dr.		
1420						Dr. Carr in to examine pt. AP		
1430						Discharged ambulatory E H 2 to PAS - AP		



SIGNATURE	INITIALS	SIGNATURE	INITIALS	INTAKE	OUTPUT
<i>[Signature]</i>	<i>[Initials]</i>	<i>[Signature]</i>	<i>[Initials]</i>		

LABORATORY REPORT

Know What A Miracle You Are

UNIT NUMBER

WARD

TIME

DATE

PAGE

1620533

SEEN 17:30 12/25/92

1

PATIENT NAME

PATIENT NO.

ROOM NO.

AGE

SEX

DOCTOR'S NAME

ADAMS, DONALD L

1620533

43Y

M

MONK, DR

DATE	TIME	TEST NAME	ABNORMAL	RESULTS	MISC	UNITS
12/25/92	17:10	ARTERIAL BLOOD GAS				
		ARTERIAL PH		7.35		PH UNITS
		ARTERIAL PCO2		35-45		MMHG
		ARTERIAL PO2	76	85-95		MMHG
		ART O2 SATURATION		94-98		%
		ART BASE DEFICIT		0-2.5		MMOL/L
		ARTERIAL HCO3	22	23-28		MMOL/L
		AIR PUNCTURE SITE				112
		TIME PRESSURE HMO				MINUTES
		ALLEN TEST PERFORMED				
12/25/92	13:10	COMPLETE BLOOD CNT & DIF				
		WBC	15.1	5.0-10.0		THOUS/CM3
		RBC		4.60-6.70		MILL/CM3
		HEMOCRITIN		14.0-18.0		CM/DE
		HEMATOCRIT		42.0-52.0		%
		MCV BLOOD		80.0-100.0		FU
		MCH BLOOD	32.0	27.0-31.0		PG
		MHC BLOOD		32.0-36.0		%
		PLATELET COUNT		150-400		THOUS/CM3
		RDW		11.5-14.5		%
		MPV	7.0	7.4-10.4		FL
		DIFFERENTIAL				
		SLIDE NO.				
		SEG NEUTROPHIL		50-70		%
		LYMPHOCYTE	14	20-40		%
		BAND NEUTROPHIL	10	0-5		%
		MONOCYTES		1-6		%
		EOSINOPHILS		1-5		%
		CELL MORPHOLOGY				
				ESSENTIALLY NORMAL		

qr

PATIENT NAME

PATIENT NO.

ROOM NO.

AGE

SEX

DOCTOR'S NAME

930111CCN0667
attachment 4

X-RAY PROFESSIONAL SERVICES BY:
MEMPHIS RADIOLOGICAL PROFESSIONAL CORP.

DEPARTMENT OF RADIOLOGY

C S N

23798234 01620533 16-72-75 North Radiology ER ✓

ADAMS, DONALD L.

Age 43 WM

ER PHYSICIAN

12-25-92 CHEST PA AND LATERAL: Heart size is normal.
Minimal chronic appearing densities are noted in the right
upper lobe. No active infiltrate is seen.

Roy Kulp M.D./cv ✓
Printed: 12/26/92 10:38

METHODIST
THE METHODIST HOSPITALS OF MEMPHIS

We Know What A Miracle You Are

ER 23798234
ADAMS, DONALD L
DR. D NONE
1780 WARNER AVE
MEMPHIS TN
H -3

0162-533-001
2 043
001723
12/25/92
E-354422-8

PATIENT AFTERCARE SHEET

METHODIST
We Know What A Muscle You Are

PATIENT AFTERCARE SHEET

The treatment you received in the Emergency Dept is an emergency treatment only. It is your responsibility to see your physician for follow-up and continuing care. You must make your appointments and necessary arrangements yourself and take this form with you to your doctor.

GENERAL INSTRUCTIONS:

- No weight bearing.
- Elevate affected extremity as much as possible for _____ days.
- Ice pack to affected area intermittently for _____ days.
- Watch for excessive swelling, numbness, or bluish coloration of fingers or toes.
- You have been referred to Dr. _____ for follow-up care. Make an appointment to see your physician in _____ days.
- An x-ray was performed and a preliminary interpretation was made. The final report will be made by the Radiologist. If any significant changes are made, you will be notified at the telephone number you listed.
- Rewrap ace bandage if too tight or loose. Rewrap at least once daily.
- The prescription you received contains a substance that may make you drowsy. Do not drive or drink alcohol while taking this medication.
- The prescription you received contains a substance that tends to upset your stomach. Do not take medication on an empty stomach.
- A laboratory test requiring several days for completion was performed. The results will be forwarded to your doctor.
- You may be excused from work or school for _____ (not to exceed 24 hours). For time beyond this period, approval must be obtained from your private physician or company physician.
- You may return to work or school today.

INSTRUCTIONS FOR CARE FOR SUTURES:

- (1) Make an appointment to see your doctor on _____
- (2) Keep stitches clean & dry.
- (3) Watch for infection. See your doctor if redness, swelling, or drainage develops.
- (4) If you return to ER for suture removal, you must bring this form and come between the hours of 6:00 a.m. and 11:00 a.m.

INSTRUCTIONS FOR CARE FOLLOWING HEAD INJURY:

- (1) Eat lightly for twenty-four hours. No sedatives or alcoholic drinks.
- (2) Awake patient every two (2) hours for the next twelve (12) hours.
- (3) If any of the following symptoms occur, contact your doctor immediately. If you are unable to reach your physician, return to the Emergency Department for assistance.
 - A. Inability to arouse or awaken patient.
 - B. Inability to move arms and legs equally.
 - C. Vomiting, convulsions, mental confusion, restlessness, double vision, blurred vision, drainage of blood or clear liquid from nose or ears.
 - D. Severe headache unrelieved by medication.

2 Prescriptions received

1 Medication received in ER

DISCHARGE IMPRESSION Pneumonia

OTHER INSTRUCTIONS:

Meds as directed. Bedrest x 24 hrs. Return for any problems. See Dr. Vergasa Monday.

If you are not much improved in _____ hours or, if you become worse at any time, contact your physician right away. If unable to reach your physician, return to the emergency department.

I understand these instructions and accept them:

X Donald L Adams

INSTRUCTED Car

Dr. B. Petre

Nurse

Date 12/25/92

MEDICAL RECORDS

PART I GENERAL CONDITIONS OF EMERGENCY MEDICAL TREATMENT - CONSENT TO TREATMENT

Each patient in the hospital is admitted under the care of his/her attending physician or dentist. Physicians and dentists of the medical staff are not employees of the hospital.

- A. **MEDICAL AND SURGICAL CONSENT:** The undersigned consents to any examination (X-ray or otherwise) including but not limited to laboratory procedures, medications, infusions, transfusions of blood and blood products, anesthesia, surgical procedures or treatments (including the placement of prostheses within a patient's body), photograph and/or other services rendered the patient by members of the medical staff, their representatives and/or associates, and hospital employees, under the instructions of the physician or dentist. The undersigned also consents to observations of surgical, diagnostic, or other procedures by medical personnel in training or by other appropriate persons permitted by the attending physician or dentist and allowed by hospital or departmental policy.
- B. **TISSUE DISPOSAL:** Should my hospital stay involve the removal of any tissue or parts of my body, including fetus or afterbirth, they may be retained or disposed of by the hospital.
- C. **PERSONAL VALUABLES:** It is understood that the hospital maintains a safe for money and valuables, and that the hospital will not be responsible for loss or damage to any money or property of the patient or others unless delivered to or deposited with the hospital for safekeeping and a written safekeeping receipt issued by the hospital therefor.
- D. **MEDICAL INFORMATION RECEIVED:** The patient, if in a condition to receive it, and if not, the undersigned representative of the patient, acknowledges that he/she has been informed concerning the need for hospital services, the purpose of the patient entering the hospital, and the planned examinations, procedures, and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained.

PART II. RELEASE OF INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL AGREEMENT

- A. **RELEASE OF INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS:** The hospital, my physician or physicians, or Memphis Radiologists, P.C. may disclose all or any part of the record of the patient to any person or organization which is or may be liable for or responsible for payment of all or part of the hospital's charges, including, but not limited to, insurance companies, medical or hospital service companies, workmen's compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on behalf of the patient directly to the said physicians, radiologists, and hospitals and any of their appropriate agents or divisors.
- B. **FINANCIAL AGREEMENT:** The undersigned SEVERALLY agree, whether signing as a patient or otherwise, that in consideration of the services rendered to patient, payment of the account is guaranteed by the undersigned in accordance with the regular rates and terms of the hospital, being payable to the hospital in Memphis, Tennessee. While any insurance or other protection related to the hospital account may be hereby assigned to and payable directly to the hospital, the undersigned clearly understands that the obligation to pay the hospital bill is primarily on the patient and the undersigned, and while insurance received by the hospital will be applied to the patient's account, any part of the account not so paid by insurance is nevertheless owing and payable. In case of default of payment, and if this account should be placed in the hands of a Collector or an Attorney for collection, all collection fees, attorney fees, (which shall equal one-third of any balance due), cost and other expenses will be paid by the undersigned. Notice of dishonor, demand and protest is waived. I further agree that due to the high cost of billing and refunding small amounts, the hospital will not bill or refund underpayments or overpayments of less than two dollars (\$2.00) on final balances, except on a request of the responsible party.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ THE FOREGOING, HAS RECEIVED A COPY HEREOF, IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT, AND THE FOREGOING CONDITIONS OF ADMISSION ARE ACCEPTED.

If patient is unable to execute above form (because of some disability, such as being a minor, non compos mentis, unconscious, or other disability which inhibits or precludes that patient's ability to legally sign) explain the patient's disability (tell chief complaint and diagnosis):

Patient's Signature (or Representative) for Consent to Treatment and Release of Information: Donald Lee Adams DATE 12-25-92 TIME _____
 Responsible Policyholder(s)'s Signature for Insurance Assignment: Donald Lee Adams DATE _____ TIME _____
 Financially Responsible Individual: Donald Lee Adams DATE 12/25 TIME _____
 I have read and/or explained the above information and all parts of this form outlining all stated conditions to the patient for the patient's representative and the patient's responsible party appears to fully understand these conditions as stated. Sheri Nelson

CAT.	UNIT NUMBER	ADM/SERVICE DATE	T/A PER	T/A RECD	PHYSICIAN NAME AND NUMBER	ADMIT/REG. TIME	ACCOUNT NUMBER	2-6			
ER	1620533-001	12/25/92	P		1723 NONE DR	12:47	23798234				
PATIENT NAME		NICKNAME		MC/SSN #		DATE OF BIRTH	AGE	MS	RS	GEO CODE	CL IN
ADAMS		DONALD		L		12/05/1949	43	M	WM	1	SL
RELIGION		CHURCH		HOME PHONE							
0 OTHER		NO PREF		901-353-3332							
PATIENT ADDRESS - LINE 1					PATIENT ADDRESS - LINE 2					LENGTH OF SERVICE	
1780 WARNER AVE					MEMPHIS TN 381271335					00	
EMPLOYER					EMPLOYER'S ADDRESS					LENGTH OF SERVICE	
US POSTAL SERVICE					UNK MEMPHIS - TN 00000					00	
OCCUPATION					EMPLOYER'S PHONE	PREV. ADM. DATE	PREVIOUS ADMISSION NAME				
LETTER CARRIER					999-999-9999	00/00/00	23798234				
PERSON TO NOTIFY IN EMERGENCY/NEAREST RELATIVE					PHONE NUMBER	RELATIONSHIP	ADDRESS				
ADAMS DORACE					901-357-4619	FATHER	00000				
COMMENTS:											
RESPONSIBLE PARTY					MC/SSN #	RELATIONSHIP	RP UNIT #	OWN/RENT	PHONE NUMBER		
ADAMS DONALD L					410-86-1396	SELF	1620533		901-353-3332		
ADDRESS - LINE 1					YEARS	ADDRESS - LINE 2	RP ACCT. NUMBER	PHONE NUMBER (BUS)			
1780 WARNER AVE						MEMPHIS TN 38127	E-354422-8	999-999-99			
OCCUPATION					EMPLOYER'S NAME		LENGTH OF SERVICE				
US POSTAL SERVICE					UNK MEMPHIS TN 00000		00				
NATL ASSOC OF LETTER CARR NATL ASSOC OF LETTER CARR ADAMS DONALD											
INSURANCE CARRIER		EFFECTIVE DATE		GROUP POLICYHOLDER		SUBSCRIBER		PHONE NUMBER (BUS)			
00/00/00		00/00/00		410-86-1396		P.O. BOX 9668		SCOTTSDALE AZ		8525	
INSURANCE CARRIER		EFFECTIVE DATE		GROUP POLICYHOLDER		SUBSCRIBER		PHONE NUMBER (BUS)			
00/00/00		00/00/00		410-86-1396		P.O. BOX 9668		SCOTTSDALE AZ		8525	

PLEASE DO NOT STAPLE IN THIS AREA

SEND TO PATIENT***** 0500
PLEASE FORWARD THIS CLAIM TO YOUR INDIVIDUAL INSURANCE CARRIER***THANK YOU*

930111CCN0667
attachment 4

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA ACTP# 0040781 ARC534 P CO 02 HEALTH INSURANCE CLAIM FORM 5078A

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (SSN)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **ADAMS DONALD L**

3. PATIENT'S BIRTH DATE (MM DD YY) **12 05 49** SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) **ADAMS DONALD**

5. PATIENT'S ADDRESS (No., Street) **1780 WARNER DR**

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street) **1780 WARNER DR**

CITY **MEMPHIS** STATE **TN**

8. PATIENT STATUS: Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO: Employed Full-Time Student Part-Time Student

11. INSURED'S POLICY GROUP OR FECA NUMBER **322**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: **SIGNATURE ON FILE** DATE **12/28/92**

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: **SIGNATURE ON FILE**

14. DATE OF CURRENT: **12 25 92** ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: **Methodist North Dr. Carr Room Emergency**

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. **466 0**

2. _____

3. _____

4. _____

A		B		C		D		E		F		G		H		I		J		K	
From	To	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSTY Family Plan		EMG		COB		RESERVED FOR LOCAL USE			
12 28 92		3	1	99203		1		92 00		1											
12 28 92		3	4	71020		1		58 00		1											
12 28 92		3	5	36415		1		5 00		1											
12 28 92		A	5	80019		1		32 00		1											
12 28 92		3	5	85024		1		25 00		1											

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

25. FEDERAL TAX I.D. NUMBER **621468260** SSN EIN X

26. PATIENT'S ACCOUNT NO. **01843119C**

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO *paid receipt enclosed*

28. TOTAL CHARGE \$ **212 00**

29. AMOUNT PAID \$ **212 00**

30. BALANCE DUE \$ **0 00**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) **SAMUEL T. VERZOSA, M.D. 00000**

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office) **BARTLETT-RALEIGH INTERNAL MED 5134 STAGE RD SUITE 300 MEMPHIS, TN 38134**

33. PHYSICIAN'S SIGNATURE & PHONE # **571 391 0200** ADDRESS, ZIP CODE **MEMPHIS, TN 38134**

SIGNED **1/11/93** DATE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICES

PATIENT/ADMISSION

METHODIST

930111000667

ITEM NO. 1003
FMC 10/90

attachment 4

Do These What A Minute You Are

PATIENT NAME ER23798234 AGE 43 RS MS UNIT NUMBER 1620333-001 REFERRING PHYSICIAN 000000 ER23798234
DAMS DONALD L. WMM NO REFER. DR. E-354422-1

PERSONAL PHYSICIAN EMERL. RM. CHG. M & S SUPPLIES PHYSICIAN FEE OTHER CHARGES AMOUNT PAID

ONE POLICE NOTIFIED DATE IN AM FAMILY NOTIFIED PM
ACCIDENT: POLICE NOTIFIED TIME:

ERG. DR. HOUSE STAFF ADMITTING PHYSICIAN (INITIAL LAST) DATE OUT

R M CARR BROUGHT BY PRIVATE VEHICLE AMB. NO. INS 1 EG INS 2 P INS 3

ALLERGIES PATIENT PHONE DIFF BREATHING/INHALED CHEMICALS

Table with 4 columns and multiple rows, mostly obscured by noise.

Table with 2 columns (CBC, WBC, HBG, HC, DIFF, NA, K, CL, CO2, BUN, GLU, UA) and multiple rows, mostly obscured by noise.

Table with 2 columns and multiple rows, mostly obscured by noise.

DISPOSITION AND INSTRUCTION TO PATIENT I SEND COPY OF CHART WITH PATIENT I DONE

RETURN OR SEE DR. IMMEDIATELY IF WORSENS, OR IF NO BETTER IN _____ HOURS. GOOD SATISFACTORY SERIOUS CRITICAL ROOM #
URGE'S SIGNATURE (HOUSE STAFF PHYSICIAN'S SIGNATURE) (MERC PHYSICIAN'S SIGNATURE) (ATTENDING PHYSICIAN'S SIGNATURE)

12/28/92
CAREY ADAMS

93011CCND667
attachment 4

5782042

HC/USA 285858
BARTLETT / RALEIGH
INTERNAL MEDICINE PC
MPHS TN

PURCHASER SIGN HERE

Shere C. Adams

Cardholder acknowledges receipt of goods and/or services at the amount of the Total shown hereon and agrees to perform the obligations set forth in the Cardholder's agreement with the issuer.

CUSTOMER COPY

IMPORTANT: RETAIN THIS COPY FOR YOUR RECORDS

QUAN.	CLASS	DESCRIPTION	PRICE	AMOUNT
		Donald Adams # 4078		212.00
		Carey Adams #4064		187.00
			SUB TOTAL	
			TAX	
			TOTAL	399.00

SAFEPAY® U.S. Pat. 4,403,700

DATE: 12/28/92 AUTHORIZATION: 008784
REFERENCE NO: 0060



SALES SLIP

Receipt

Date 12/28 1992

No. 478880

RECEIVED FROM

R Adams

\$399.00

FOR RENT

FOR

Office charges

DOLLARS

FROM

Credit card

TO

STV

4078
4064

ACCOUNT	# 4078
PAYMENT	# 4064
BALANCE DUE	

- cash
- check
- money order

BY *Cmassey*

Copy of receipt from
Bartlett-Raleigh Internal Med
Samuel T. Verzosa, M.D.
901 371-0200

Their Health Insurance Claim Form shows that they
Accept Assignment.

We paid their bills, and we request
reimbursement to us.

Shere Adams

NALC Health Benefit Plan

20547 Waverly Court, Ashburn, Virginia 22093
(703) 729-4677

AIM FORM FOR UNASSIGNED BILLS

(Benefits will be paid to member)

STATEMENT OF MEMBER

Complete in full and use separate form for each patient and each calendar year

CHECK BOX IF CHANGE OF ADDRESS

1. MEMBER INFORMATION	2. PATIENT INFORMATION
SOCIAL SECURITY NUMBER 410-86-1396	PATIENT CODE A
EMPLOYMENT STATUS: ACTIVE <input checked="" type="checkbox"/> ANNUITANT <input type="checkbox"/> SURVIVOR ANNUITANT <input type="checkbox"/>	NAME Donald L Adams
NAME Donald L Adams	DATE OF BIRTH 12-05-49
ADDRESS 1780 Warner Dr	RELATIONSHIP TO MEMBER Self
CITY Memphis STATE TN ZIP 38127	MARITAL STATUS MARRIED <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/>
TELEPHONE (DAYTIME) 901-353-3332	

Are charges related to or covered by: YES NO If yes, give:

3. Workers' Compensation Date of accident, diagnosis and compensation claim # **1/1**

4. Accidental Injury Date, place and diagnosis **12/25/92 Exposure to Wilson's Leather Protector, had difficulty breathing 102° chills, cough**
At Sister's house Linda Harnell diagnosis Pneumonitis
 Is claim covered by no-fault auto insurance? YES NO Third party liability (subrogation)? YES NO
 If yes, insurance company's name and address **Wilson's Claim Management, 400 S. Hwy 169, Minneapolis, Mn. 55428** *Spoke w/ Nancy Gjer 612 541-356 Collect*

5. Medicare Medicare Identification Number _____
 Effective date: Part A _____ Part B _____

6. Other group medical / dental coverage If yes, is insurance issued through active employment? YES NO
 Is this an HMO policy? YES NO
 Name of person to whom issued _____ Relationship to patient _____
 Name of organization or employer through which obtained _____
 HOSPITAL OR MEDICAL INSURANCE: Name and address of other insurance company _____
 Effective date _____ Cancellation date _____
 Policy # _____ Self Only Family *U.S. Consumer Product Safety Com 1-800-638-2772 on Wilson's Leather Protector*

DENTAL INSURANCE: Name and address of other insurance company _____
 Effective date _____ Cancellation date _____
 Policy # _____ Self Only Family

I authorize any holder of medical or other related information to release to NALC Health Benefit Plan any information in regard to myself or my family necessary for processing this or any related claim.

Donald L Adams 1-18-93 *Donald L Adams* 1-18-93
Member's signature Date Patient's signature (parent, if minor) Date

I certify that the above information is correct, that the enclosed expenses were incurred for the named patient, and that I am a member in good standing of NALC.

Donald L Adams 1-18-93
Member's signature Date

WARNING: Any intentional false statement or willful misrepresentation relative to this claim is a violation of the law punishable by a fine, imprisonment or both. (18 U.S.C. Section 1341 and Title 5 U.S.C.)

CONTROL NUMBER	SHEET	REF NUMBER
----------------	-------	------------

- NORTH

METHODIST
THE METHODIST HOSPITALS

3960 NEW
MEMPHIS

COVINGTON P 4056
TN 38128-0000

930111CCN0667
attachment 4

INSURANCE PENDING:

|||||
DONALD L ADAMS
1780 WARNER AVE
MEMPHIS TN 38127-1335

NATL ASSOC OF LETTER CARR

AMOUNT
ENCLOSED

MAKE CHECKS PAYABLE AND MAIL TO:
METHODIST HOSPITAL
P.O. BOX 1000, DEPT. 97
MEMPHIS TN 38148-0097

ACCOUNT NO.	PATIENT NAME	ADMISSION DATE	DISCHARGE DATE	STATEMENT DATE	AMOUNT DUE	DUE DATE
ER23798234	DONALD L ADAMS	12/25/92	12/25/92	12/29/92	251.50	01/23/93

▲ PLEASE DETACH UPPER PORTION AND RETURN WITH PAYMENT ▲ PAGE 1 OF 1

THIS IS A STATEMENT OF YOUR ACCOUNT. RETAIN THIS PORTION FOR YOUR RECORDS.
CHARGES OR PAYMENTS RECEIVED AFTER THE STATEMENT DATE WILL APPEAR ON YOUR NEXT STATEMENT.

ACCOUNT NO.	PATIENT NAME	ADMISSION DATE	DISCHARGE DATE	STATEMENT DATE	AMOUNT DUE	DUE DATE
ER23798234	DONALD L ADAMS	12/25/92	12/25/92	12/29/92	251.50	01/23/93

DATE	HOSPITAL CODE	DESCRIPTION	AMOUNT
12/25/92	000089	CHEST PA & LATERAL	65.50
12/25/92	000682	HEMOGRAM	51.00
12/25/92	000783	BLOOD GAS/ART	80.00
12/25/92	013567	EMERGENCY RM LEVEL II	46.00
12/25/92	027883	VENIPUNCTURE	4.50
12/25/92	027883	VENIPUNCTURE	4.50

IF YOU HAVE ANY QUESTIONS, PLEASE CALL
PATIENT ACCOUNTING @ 726-8375 (MON-FRI 9:00AM - 4:00PM)
OR VISIT US AT 1211 UNION AVE, SUITE 500. PLEASE KEEP THIS
STATEMENT FOR YOUR RECORDS. INSURANCES, IF SHOWN ABOVE,
HAVE BEEN BILLED. YOUR AMOUNT DUE AND DUE DATE ARE ALSO
SHOWN ABOVE. THANK YOU FOR ALLOWING US TO SERVE YOU.

TOTAL	251.50
ESTIMATED INSURANCE (SEE REVERSE)	.00
PLEASE PAY THIS AMOUNT	251.50

METHODIST



METHODIST

MEDICAL RECORDS

9301110070667
attachment 4

ITEM NO. 16
FMC 10/9

PATIENT NAME: ER23798245

PERSONAL PHYSICIAN: ADAMS DONALD C 17 WMB 471187-002 REFERRING PHYSICIAN: 000000 NO REFER. DR. ACCOUNT NUMBER: ER-334422

EMER. IRR. CHG. 40 M & S SUPPLIES PHYSICIAN FEE 80 OTHER CHARGES AMOUNT PAID

DATE TIME LOCATION POLICE NOTIFIED TIME AM FAMILY NOTIFIED DATE IN DATE OUT

DR. M. CARR HOUSE STAFF ADMITTING PHYSICIAN (INITIAL LAST) 12-25-92 12-25-92

ALLERGIES: IKDA BROUGHT BY: PRIVATE VEHICLE AMB. NO. INCL. EG INS. 2 INS.

CHIEF COMPLAINT: DIFF BREATHING/INHALED CHEMICAL PATIENT PHONE VITAL SIGNS

HISTORY & PHYSICAL: 1730 patient - cough - difficulty breathing. R has been in an enclosed space since leaving from bus. Has fallen & is on floor ill - intubated.

Need oxygen high? think a heavy - cough - deep breathing. CxR - infiltrate.

CBC: WBC 18.6
HGB
DIFF
NA K
CL CO2
BLIN GLU
UA

PHYSICIAN IMPRESSION: Bronchitis - early pneumonia? CXR, CBC/CP

DATE OF LAST TETANUS: N/A
CURRENT MEDICATIONS: see pg 2 N/A

NOTES: see pg 2 N/A - 2 Parker

ARM BAND ON SIDERAILS UP

ADMISSION: HOME OFFICE EXCHANGE PAGED AT AM CONSULT PM M.D. CALLED HOME OFFICE EXCHANGE PAGED AT

SEE DR. IMMEDIATELY IF WORSENS, OR IF NO BETTER IN _____ HOURS. CONDITION ON DISCHARGE / TRANSFER: ROOM

(HOUSE STAFF PHYSICIAN'S SIGNATURE) [MFCB]

ER 23798245 00471187-002
ADAMS, DONALD C 2 017
DR. ST VERZOSA 001942
1780 WARNER AVE
MEMPHIS TN 12/25/92



We Know What A Miracle You Are

EMERGENCY DEPARTMENT ROOM NUMBER 5

TIME	BP	H	T	P	R	MEDICATIONS, TREATMENTS, EQUIPMENT, & LABORATORY	OBSERVATIONS	I	O
1300	130/10	102	116		24	Allergies - ϕ meds - Eskalith CR 450 bid PMT Smokes - 1ppd	17 y w/m amb to ER E ϕ difficulty breathing dizziness, cough, general malaise \bar{F} being? exposed to leather protectant. Pt states was smoking in @ small room where @ leather coat had just been treated \bar{c} protectant. On arrival pt \bar{c} chills, on attempt to take deep inspiration coughs. Bilateral air exchange essentially normal \bar{c} (P)		
1315						Labwork drawn per LLT			
1340							To \bar{c} from X-ray ambulatory BP		
1355							Pt. moved to ER #5 so he can lie down. BP		
1415		102				Tylenol \bar{c} PO			
1435							Discharged amb \bar{c} parents Mother given PAS, Rx \bar{c} verbalized understanding of instructions by mother \bar{c}		

SIGNATURE	INITIALS	SIGNATURE	INITIALS	INTAKE	OUTPUT
Debra Foster RN	DF	Beverly Peterson RN	BP		

930111CCN0667
attachment 4

X-RAY PROFESSIONAL SERVICES BY:
MEMPHIS RADIOLOGICAL PROFESSIONAL CORP

MENT OF RADIOLOGY

C S N

23798245 00471187 16-72-74 North Radiology ER ✓

ADAMS, DONALD C.

Age 17 WM

Sam T. Verzosa M.D.

12-25-92 CHEST, TWO VIEWS: Heart size is normal. There are prominent interstitial markings noted throughout both lung fields present, and the possibility of an interstitial pneumonitis cannot be excluded from this examination. No discrete focal infiltrate is seen.

Roy Kulp M.D./cv **K**
Printed: 12/26/92 09:46

cc: Sam T. Verzosa M.D.
FAX # 3719317

METHODIST
THE METHODIST HOSPITALS OF MEMPHIS

We Know What A Miracle You Are.

STATEMENT MEMPHIS RADIOLOGICAL PROFESSIONAL CORPORATION Tax ID No. 62-0659736

FOR: 1211 Union Ave., Suite 359 P.O. Box 42047 Memphis, TN 38174-2047 Tel. (901) 726-1623

ACCOUNT NUMBER	PATIENT NAME	FACILITY WHERE SERVICES RENDERED	DATE	DESCRIPTION	AMOUNT
12790245	CHRISTIAN & LATERNA	REHABILITATION	12/29/92	PLEASE LOCATE YOUR ACCOUNT NUMBER ON THE LEFT BORDER OF THE STATEMENT BEFORE CALLING.	31.00
01/14/93					31.00
If you have remitted within the last 10 days, please disregard this statement.					
STATEMENT DATE	DIAGNOSIS CODE	LOCATION	TOTAL CHARGES	AMOUNT PAID	BALANCE DUE
01/14/93	196.01	99	31.00	0.00	31.00

ACCOUNT NUMBER	AMOUNT DUE
12790245	31.00
Detach & Return with Payment	
PATIENT NAME	01/14/93
<p>PHYSICIANS</p> <p>HOLLIS H. HALFORD, JR. WILLIAM E. LONG JOHN M. DOBSON JERRY W. GRISE ION C. JENKINS ROBERT L. DOCKROFT ROBERT E. LASTER, JR. EDWARD H. MARRY, JR. JAMES W. BOALS ROY KLEP, JR. ALVIN L. WEBER, III DAVIS D. MOSER BRIEVE R. SHELTON</p> <p>RADIOLOGISTS FOR: METHUEN CENTRAL HOSPITAL METHUEN NORTH HOSPITAL METHUEN SOUTH HOSPITAL GERMANTOWN COMMUNITY HOSPITAL METHUEN EAST EASTWOOD HOSPITAL</p>	
<p>REMIT PAYMENT TO: MEMPHIS RADIOLOGICAL, P.C. RESPONSIBLE PARTY INFORMATION</p> <p>23758245 DONALD L. ADAMS, JR. 1780 PARKWAY AT 2 MEMPHIS TN 38103-1336</p>	

PATIENT AFTERCARE SHEET

METHODIST

We Know What A Minute You Are

PATIENT AFTERCARE SHEET

The treatment you received in the Emergency Dept. is an emergency treatment only. It is your responsibility to see your physician for follow-up and continuing care. You must make any appointments and necessary arrangements yourself and take this form with you to your doctor.

ER 23798245
ADAMS, DONALD C
DR. ST VERZOSA
1780 WARNER AVE
MEMPHIS, TN
GENERAL INSTRUCTIONS:
00471187-002
2 017
001942
12/25/92
E-354423-A

- ___ No weight bearing.
- ___ Elevate affected extremity as much as possible for ___ days.
- ___ Ice pack to affected area intermittently for ___ days.
- ___ Watch for excessive swelling, numbness, or bluish coloration of fingers or toes.
- ___ You have been referred to Dr. _____ for follow-up care. Make an appointment to see your physician in ___ days.
- ___ An x-ray was performed and a preliminary interpretation was made. The final report will be made by the Radiologist. If any significant changes are made, you will be notified at the telephone number you listed.
- ___ Rewrap ace bandage if too tight or loose. Rewrap at least once daily.
- ___ The prescription you received contains a substance that may make you drowsy. Do not drive or drink alcohol while taking this medication.
- ___ The prescription you received contains a substance that tends to upset your stomach. Do not take medication on an empty stomach.
- ___ A laboratory test requiring several days for completion was performed. The results will be forwarded to your doctor.
- ___ You may be excused from work or school for ___ (not to exceed 24 hours). For time beyond this period, approval must be obtained from your private physician or company physician.
- ___ You may return to work or school today.

INSTRUCTIONS FOR CARE FOR SUTURES:

- ___ (1) Make an appointment to see your doctor on _____
- ___ (2) Keep stitches clean & dry.
- ___ (3) Watch for infection. See your doctor if redness, swelling, or drainage develops.
- ___ (4) If you return to ER for suture removal, you must bring this form and come between the hours of 6:00 a.m. and 11:00 a.m.

INSTRUCTIONS FOR CARE FOLLOWING HEAD INJURY:

- ___ (1) Eat lightly for twenty-four hours. No sedatives or alcoholic drinks.
- ___ (2) Awake patient every two (2) hours for the next twelve (12) hours.
- ___ (3) If any of the following symptoms occur, contact your doctor immediately. If you are unable to reach your physician, return to the Emergency Department for assistance.
 - A. Inability to arouse or awaken patient.
 - B. Inability to move arms and legs equally.
 - C. Vomiting, convulsions, mental confusion, restlessness, double vision, blurred vision, drainage of blood or clear liquid from nose or ears.
 - D. Severe headache unrelieved by medication.

② Prescriptions received _____ Medication received in ER _____

DISCHARGE IMPRESSION Bronchitis /

OTHER INSTRUCTIONS: Tylenol q 4° for temp / meds as directed
Return if you get worse / Follow-up with Dr.
Verzosa Monday am

___ If you are not much improved in ___ hours or, if you become worse at any time, contact your physician right away. If unable to reach your physician, return to the emergency department.

I understand these instructions and accept them: Donald Adams

PLEASE DO NOT STAPLE IN THIS AREA

930111CCN0667
attachment 4

SEND TO PATIENT***** 0500
PLEASE FORWARD THIS CLAIM TO
YOUR INDIVIDUAL INSURANCE
CARRIER**THANK YOU*

PICA ACP# 0040641 ARC534 P CO HEALTH INSURANCE CLAIM FORM 5064A

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)	
8. PATIENT STATUS		CITY	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		STATE	
10. IS PATIENT'S CONDITION RELATED TO:		CITY	
11. INSURED'S POLICY GROUP OR FECA NUMBER		STATE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		ZIP CODE	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		TELEPHONE (INCLUDE AREA CODE)	
14. DATE OF CURRENT ILLNESS		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		17a. I.D. NUMBER OF REFERRING PHYSICIAN	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
20. OUTSIDE LAB?		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	
22. MEDICARE RESUBMISSION CODE		22. MEDICARE RESUBMISSION CODE	
23. PRIOR AUTHORIZATION NUMBER		23. PRIOR AUTHORIZATION NUMBER	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE
SIGNED: _____ DATE: _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE
SIGNED: _____

14. DATE OF CURRENT ILLNESS	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB?	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
22. MEDICARE RESUBMISSION CODE	22. MEDICARE RESUBMISSION CODE	23. PRIOR AUTHORIZATION NUMBER

A		B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE		Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES	DIAGNOSIS CODE	S CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
12	28	92	3	1 99203	1	92 00	1				
12	28	92	3	4 71020	1	58 00	1				
12	28	92	3	5 36415	1	5 00	1				
12	28	92	A	5 80019	1	32 00	1				

5. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
621468260		01842517C	NO	\$ 187 00	\$ 187 00	\$ 0 00
SIGNATURE OF PHYSICIAN OR SUPPLIER		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED		33. PHYSICIAN'S ADDRESS, ZIP CODE		
SAMUEL T. VERZOSA, M.D.		00000		BARTLETT-RALEIGH INTERNAL MED 5134 STAGE RD SUITE 300 MEMPHIS, TN 38134		

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

NALC Health Benefit Plan

20547 Waverly Court, Ashburn, Virginia 22093
(703) 729-4677

CLAIM FORM FOR UNASSIGNED BILLS

(Benefits will be paid to member)

STATEMENT OF MEMBER

Complete in full and use separate form for each patient and each calendar year

CHECK BOX IF CHANGE OF ADDRESS

1. MEMBER INFORMATION		2. PATIENT INFORMATION	
SOCIAL SECURITY NUMBER 4 1 0 - 8 6 - 1 3 9 6		PATIENT CODE <input checked="" type="checkbox"/> C	
EMPLOYMENT STATUS: ACTIVE <input checked="" type="checkbox"/> ANNUITANT <input type="checkbox"/> SURVIVOR ANNUITANT <input type="checkbox"/>			
NAME Donald L. Adams		NAME Donald Carey Adams	
ADDRESS 1780 Warner Dr.		DATE OF BIRTH 08-14-75	
CITY Memphis STATE TN ZIP 38127		RELATIONSHIP TO MEMBER Son	
TELEPHONE (DAYTIME) 901 353-3332		MARITAL STATUS MARRIED <input type="checkbox"/> SINGLE <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	

Are charges related to or covered by: YES NO If yes, give:

3. Workers' Compensation Date of accident, diagnosis and compensation claim # 1/1

4. Accidental Injury Date, place and diagnosis 12/25/92 Exposure to Wilson's Leather Protector. Had difficulty breathing, 102° fever, chills, coughing.
Is claim covered by no-fault auto insurance? YES NO Third party liability (subrogation)? YES NO
If yes, insurance company's name and address Wilson's Claim Management
400 S. Hwy 169, Minneapolis, MN 55428 / Spoke with Nancy Gjerd

5. Medicare Medicare Identification Number 612
Effective date: Part A 1/1/1 Part B 1/1/1
541-3561
Collected

6. Other group medical / dental coverage If yes, is insurance issued through active employment? YES NO
is this an HMO policy? YES NO
Name of person to whom issued _____ Relationship to patient _____
Name of organization or employer through which obtained _____
HOSPITAL OR MEDICAL INSURANCE: Name and address of other insurance company U.S. Consumer Product Safety C
1-800-638-2772
Effective date _____ Cancellation date 1/1/1
Policy # _____ Self Only Family
Tap # 162
on Wilson's Leather Protector

DENTAL INSURANCE: Name and address of other insurance company _____
Effective date _____ Cancellation date _____
Policy # _____ Self Only Family

I authorize any holder of medical or other related information to release to NALC Health Benefit Plan any information in regard to myself or my family necessary for processing this or any related claim.

Donald L Adams 1-18-93 Jane C. Adams 1-18-93
Member's signature Date Patient's signature (parent, if minor) Date

I certify that the above information is correct, that the enclosed expenses were incurred for the named patient, and that I am a member in good standing of NALC.

Donald L Adams 1-18-93
Member's signature Date

WARNING: Any intentional false statement or willful misrepresentation relative to this claim is a violation of the law punishable by a fine, imprisonment or both. (18 U.S.C. Section 1341 and Title 5 U.S.C.)

CONTROL NUMBER	DATE	REF. NUMBER

CLAIM FORM FOR UNASSIGNED BILLS

930111CCN0667
attachment 4

NOTE: When filing claims for doctor, laboratory, x-ray, durable medical equipment, etc. expenses, attach fully itemized bills. Be sure the diagnosis, date and description of service, patient's name and charge for each service is indicated on all bills. Enter total at bottom.
The Plan will accept any claim form which provides the same information.
If another insurance company is primary on this claim, their explanation of payment form must be included for each bill submitted.

PRESCRIPTION DRUGS AND MEDICINES

Use ONLY for prescription drugs and medicines. List each prescription on a separate line and complete each column. ATTACH DRUG BILLS SHOWING INFORMATION LISTED BELOW.

DATE OF PURCHASE	RX NUMBER	NAME OF DRUG	PRESCRIBING PHYSICIAN	DIAGNOSIS (ILLNESS TREATED)	CHARGES
12-25-92		Methodist North Hosp. E.R.	Carr	13567 Bronchitis/early pneumonia	\$ 46.00
S				Hemogram 682	51.00
				Blood Gas/Act 783	80.00
				Venipuncture 27883	4.50
				Venipuncture 27883	4.50
			Mchs. Radiological Prac Corps		Chest PA-lateral 89 786.01
12-28-92			Samuel T Verzosa	99203 office visit 71020 chest x-ray 36415 venipuncture 80019 SMAC	92.00 58.00 5.00 32.00
12-25-92	C523133	Erythromycin	Carr	Bronchitis/early pneumonia	8.39
12-25-92	C523134	Notus Liquid	Carr	" " " "	12.09

Assessment accepted
/ Paid by

Walgreens The Pharmacy America Trusts
2926 COVINGTON PIK. PH. 382-9237
MEMPHIS TN
PATIENT: DONALD C ADAMS
1780 WARNER DR
MEMPHIS TN 381-3332
RX NO. C523133 DR. CARR
MEDICATION: ERYTHROMYCIN 250MG TABS
ABBOTT-ROSS*00074-6346-53
QTY: 40 REFILL CALLRPH TMO/HRR
DATE: 12/25/92 \$ 9.39 EUA

Walgreens The Pharmacy America Trusts
2926 COVINGTON PIK. PH. 382-9237
MEMPHIS TN
PATIENT: DONALD C ADAMS
1780 WARNER DR
MEMPHIS TN 381-3332
RX NO. C523134 DR. CARR
MEDICATION: NOTUS LIQUID
S-U 45988-0621-16
QTY: 15 REFILL CALLRPH TMO/HRR
DATE: 12/25/92 \$ 12.09 BANA

TOTAL DRUGS \$ 20 48
TOTAL ALL OTHER CHARGES \$ 469 50
TOTAL \$ 489 98

METHODIST
THE METHODIST HOSPITALS

We Know What A Miracle You Are

METHODIST NORTH

3960 NEW COVINGTON PIKE
MEMPHIS TN 38128

930111CCN0667
attachment 4

DONALD L ADAMS
1780 WARNER AVE
MEMPHIS TN 38127-1335

INSURANCE PENDING:
NATIONAL ASSOC LETTER CAR

METHODIST NORTH
MAIL TO: MAKE CHECKS P.O. BOX 1000, DEPT. 97
PAYABLE AND MEMPHIS TN 38148 - 0097

AMOUNT
ENCLOSED

ACCOUNT NO.	PATIENT NAME	ADMISSION DATE	DISCHARGE DATE	STATEMENT DATE	AMOUNT DUE	DUE DATE
ER23798245	DONALD C ADAMS	12/25/92	12/25/92	01/06/93	0.00	

▲ PLEASE DETACH UPPER PORTION AND RETURN WITH PAYMENT ▲

METHODIST NORTH

PAGE 1 OF 1

THIS IS A STATEMENT OF YOUR ACCOUNT. RETAIN THIS PORTION FOR YOUR RECORDS.
CHARGES OR PAYMENTS RECEIVED AFTER THE STATEMENT DATE WILL APPEAR ON YOUR NEXT STATEMENT.

ACCOUNT NO.	PATIENT NAME	ADMISSION DATE	DISCHARGE DATE	STATEMENT DATE	AMOUNT DUE	DUE DATE
ER23798245	DONALD C ADAMS	12/25/92	12/25/92	01/06/93	0.00	

DATE	HOSPITAL CODE	DESCRIPTION	AMOUNT
122592	13567	EMERGENCY RM LEVEL II	46.00
122592	682	HEMOGRAM	51.00
122592	783	BLOOD GAS/ART	80.00
122592	27883	VENIPUNCTURE	4.50
122592	27883	VENIPUNCTURE	4.50
122592	89	CHEST PA & LATERAL	65.50
122992	6168	NATIONAL ASSOC LETTER CAR	0.00

FOR INFORMATION REGARDING YOUR ACCOUNT, PLEASE CALL
PATIENT ACCOUNTING @ 726-8375 (MON-FRI 9:00AM-4:00PM).

TOTAL	251.50
ESTIMATED INSURANCE (SEE REVERSE)	251.50
PLEASE PAY THIS AMOUNT	0.00

METHODIST
THE METHODIST HOSPITALS

MEDICAL RECORDS

PART I GENERAL CONDITIONS OF EMERGENCY MEDICAL TREATMENT - CONSENT TO TREATMENT

Each patient in the hospital is admitted under the care of his/her attending physician or dentist. Physicians and dentists of the medical staff are not employees of the hospital.

- A. **MEDICAL AND SURGICAL CONSENT:** The undersigned consents to any examination (X-ray or otherwise) including but not limited to laboratory procedures, medications, infusions, transfusions of blood and blood products, anesthesia, surgical procedures or treatments (including the placement of prostheses within a patient's body), photograph and/or other services rendered by members of the medical staff, their representatives and/or associates, and hospital employees, under the instructions of the physician or dentist. The undersigned also consents to observations of surgical, diagnostic, or other procedures by medical personnel in training or by other appropriate persons permitted by the attending physician or dentist and allowed by hospital or departmental policy.
- B. **TISSUE DISPOSAL:** Should my hospital stay involve the removal of any tissue or parts of my body, including fetus or afterbirth, they may be retained or disposed of by the hospital.
- C. **PERSONAL VALUABLES:** It is understood that the hospital maintains a safe for money and valuables, and that the hospital will not be responsible for loss or damage to any money or property of the patient or others unless delivered to or deposited with the hospital for safekeeping and a written safekeeping receipt issued by the hospital therefor.
- D. **MEDICAL INFORMATION RECEIVED:** The patient, if in a condition to receive it, and if not, the undersigned representative of the patient, acknowledges that he/she has been informed concerning the need for hospital services, the purpose of the patient entering the hospital, and the planned examinations, procedures, and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained.

PART II. RELEASE OF INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL AGREEMENT

A. **RELEASE OF INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS:** The hospital, my physician or physicians, or Memphis Radiologists, P.C. may disclose all or any part of the record of the patient to any person or organization which is or may be liable for or responsible for payment of all or part of the hospital's charges, including, but not limited to, insurance companies, medical or hospital service companies, workmen's compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on behalf of the patient directly to the said physicians, radiologists, and hospitals and of their appropriate agents or divisions.

B. **FINANCIAL AGREEMENT:** The undersigned SEVERALLY agrees, whether signing as a patient or otherwise, that in consideration of the services rendered to patient, payment of the account is guaranteed by the undersigned in accordance with the regular rates and terms of the hospital, being payable to the hospital in Memphis, Tennessee. While any insurance or other protection related to the hospital account may be hereby assigned to and payable directly to the hospital, the undersigned clearly understands that the obligation to pay the hospital bill is primarily on the patient and the undersigned, and while insurance received by the hospital will be applied to the patient's account, any part of the account not so paid by insurance is nevertheless owing and payable, in case of default of payment, and if this account should be placed in the hands of a Collector or an Attorney for collection, all collection fees, attorney fees, (which shall equal one-third of any balances due), cost and other expenses will be paid by the undersigned. Notice of dishonor, demand and protest is waived. I further agree that due to the high cost of billing and refunding small amounts, the hospital will not bill or refund underpayments or overpayments of less than two dollars (\$2.00) on final balances, except on a request of the responsible party.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ THE FOREGOING, HAS RECEIVED A COPY HEREOF, IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT, AND THE FOREGOING CONDITIONS OF ADMISSION ARE ACCEPTED.

If patient is unable to execute above form (because of some disability, such as being a minor, non compos mentis, unconscious, or other disability which inhibits or precludes that patient's ability to legally sign) explain the patient's disability (full chief complaint and diagnosis):

Patient's Signature (or Representative) for Consent to Treatment and Release of Information: X Donald Lee Adams

Responsible Policyholder's Signature for Insurance Assignment: (1) X Donald Lee Adams

All Financially Responsible Individuals: (2) X Donald Lee Adams

I have read and/or explained the above information and all parts of this form outlining all stated conditions to the patient or the patient's responsible party and the patient/responsible party appears to fully understand these conditions as stated.

UNIT NUMBER 471187-002		ADM/SERVICE DATE 12/25/92	T/A PER P	PHYSICIAN NAME AND NUMBER 1942 VERZOSA		ADMIT/REG. TIME T 12:51	ACCOUNT NUMBER 3-A 23798245			
PATIENT NAME AMS DONALD CAREY		MC/SSN # 000-00-0000		DATE OF BIRTH 08/14/1975		AGE 17	MS S	RS M	GEO CODE 1	CLEN INITIA SJK
HOME ADDRESS - LINE 1 30 WARNER AVE		CITY MEMPHIS		STATE TN		HOME PHONE 381271335				
EMPLOYER'S ADDRESS UNK		EMPLOYER'S PHONE 999-999-9999		PREV. ADM. DATE 00/00/00		PREVIOUS ADMISSION NAME 23798245		LENGTH OF SERVICE 00		
PERSON TO NOTIFY IN EMERGENCY/NEAREST RELATIVE DORACE		PHONE NUMBER 901-357-4619		RELATIONSHIP GRANDFATH		ADDRESS 00000				
VISIBLE PARTY MS DONALD		MC/SSN # 410-86-1396		RELATIONSHIP FATHER		RP UNIT # 1620533	PHONE NUMBER 901-353-333			
HOME ADDRESS - LINE 1 30 WARNER AVE		CITY MEMPHIS		STATE TN		ZIP 38127		PHONE NUMBER (BUSINESS) 999-999-999		
EMPLOYER'S NAME ASSOC. OF LETTER CARR		ADDRESS NATL. ASSOC. OF LETTER CAR		CITY MEMPHIS		STATE TN		ZIP 00000		
GROUP NUMBER 004708		POLICY NUMBER 410-86-1396		ADDRESS/STREET P.O. BOX 9668		CITY SCOTTSDALE		STATE AZ		
SUBSCRIBER 0/00		GROUP POLICY HOLDER 0/00		ADDRESS/STREET ADAMS		CITY SCOTTSDALE		STATE AZ		
SUBSCRIBER 0/00		GROUP POLICY HOLDER 0/00		ADDRESS/STREET ADAMS		CITY SCOTTSDALE		STATE AZ		

AAPCC COOPERATIVE POISON CENTER REPORT

930111CCN0667
attachment 5

14621801

DATE: 12-25-98 TIME: 11:58

See # 14621802

CALL TYPE (T) (one only)	Victim (V) (one only)	Exposure Type (E) (one only)	REASON (R) (one only)			
			Accidental	Intentional	Adverse Reaction	Unknown
1. Exposure 2. Drug Information 3. Poison Information 4. Medical/Other	1. Human 2. Animal	1. Acute 2. Chronic 3. Unknown	1. General 2. Occupational 3. Environmental 4. Misuse 5. Unknown	6. Suicidal 7. Misuse 8. Abuse 9. Unknown	10. Drug 11. Food 12. Other	13. Unknown Reason

PATIENT DATA
 Name: Donald Adams
 Telephone no.: ()
 Address: _____
 Zip: _____
 Age: 43 mo. yr. Weight: 170 lbs. kg.
 Sex: Male Female Unknown

CALLER DATA
 Name: Irene Adams MD RN
 RPh OHP
 Relationship to patient: Self Father Mother Other wife
 Telephone no.: (901) 353-3332
 Address: _____ Memphis
 Zip: _____ County: _____

Pertinent Medical History: Healthy No chronic meds No known allergies
 Check here if patient is pregnant Medical history unknown
 *MD name & no.: _____

Site of Caller Residence Site of Exposure
 Workplace
 Health Care Facility
 School
 Other
 Unknown

SUBSTANCE DATA
 Substance: Leather Protector
 Amount: inhaled fumes
 Ingredients: Petroleum Distillates per Label Manufacturer: Wilson
794-6567
308-9095
 Time of/Since exposure: 1^o PTC
 Route of Exposure: Ingestion Inhalation/Nasal Ocular Dermal Bite/Sting Parenteral Unknown Other

HISTORY, ASSESSMENT, SYMPTOMS & CALCULATIONS
 History (witnessed? amount verified? other products/victims?) No other products suspected
to Room Caller's son & husband were in room that coat was sprayed & above pdt. They went in p spraying was over. The room also was used for smoking cigarettes. She is unsure how long they were in the room. Possibly exposed for 10-15". Has sus below desires fxt ingt.
 Subjective complaints/objective findings No symptoms at this time
Coughing, gagging
ough if breathes real deep, cold (chills)
 Assessment (symptoms expected? rationale?)
 Initial assessment (choose one)
 Asymptomatic
 Symptomatic, related ↑ risk of
 Symptomatic, unrelated
Due to symptomatology 3^o
p exposure → Refer to HCF..

Code:

MANAGEMENT PLAN, FOLLOW-UP NOTES AND OUTCOME: (Time & date each entry)

DATE/TIME

Treatment suggested: HCF

Symptoms to monitor:

coughing, choking, tachypnea, dyspnea, CNS excitation/depression, N/V/D, Abd pain.

Follow-up schedule: 2-4

1:45 Caller's sister calls: desires to know which HCF/ER SISTER went to. TOLD SISTER decision was left to Ms. Adams. Rec. least HCF/ER. SRH

58 Ans. Machine SRH

3 Ans. Machine SRH

10 Spoke to Kerry. states feel a little bit better, but not the much better. Then spoke to Irene. went to Methodist North. Both husband & son received CXR. & given Scripts for No-Tuss PRN & Erythro. Husband had pneumonia & son had bronchitis. Assigned bed Res & H/c to MD (specialist on Monday). SRH

192 34 Spoke to Donald. States chest hurts a little bit but is feeling much better. Kerry today is more active & feels better today. r/c Monday. SRH P MOS appt.

192 3 Going to MD @ 3pm & 3 Ans Machine &

STAFF/RESOURCES USED:

- Medical director _____
- Other consultant _____
- Texts _____
- Other _____

Poisindex®

ED BY: SRH / PM

FORM

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION
VIA TELEPHONE

TO: Peter A. Chyka, Pharm.D.
Executive Director
Southern Poison Center, Inc.
848 Adams Avenue
Memphis, TN 38103

You are hereby authorized to release to the US Consumer Product
Safety Commission, Tennessee Agent: Janice Mitchell to
investigate incident.

the case data that involved the following person: Kerry Adams
Donald Adams
12/25 Irene Adams

My relationship to the above person is checked below

- Mother
- Self
- Father
- Other, please describe wife of Donald Adams
-mother of Kerry Adams
- Legal guardian

Verbal authorization given by telephone on the following date:

Signed Lynette X 304
Date 1/21/93 1030

For Poison Center Use
Date received _____
Case no. _____

14621802

AAPCC COOPERATIVE POISON CENTER REPORT 930111CCN0667 attachment 5

DATE: 12-25-72 TIME: 11:58

CALL TYPE (T) (one only)	Victim (V) (one only)	Exposure Type (E) (one only)	REASON (R) (one only)			
			Accidental	Intentional	Adverse Reaction	Unknown
1. Exposure 2. Drug Information 3. Poison Information 4. Medical/Other	1. Human 2. Animal	1. Acute 2. Chronic 3. Unknown	1. General 2. Occupational 3. Environmental 4. Misuse 5. Unknown	5. Suicidal 7. Misuse 8. Abuse 9. Unknown	10. Drug 11. Food 12. Other	13. Unknown Reason

See # 14621801

PATIENT DATA

Name: Kerry Adams

Telephone no.: 1 1

Address: _____

Age: 17 mo. yr. Weight: 180 lbs. kg.

Sex: Male Female Unknown

CALLER DATA

Name: Trene Adams MD RN RPH OHP

Relationship to patient: Self Father Mother Other

Telephone no.: (901) 353-3332

Address: _____ Memphis

Zip: _____ County: _____

Pertinent Medical History: Healthy No chronic meds No known allergies

Respiratory Problems - Breathing Machine
Med's: Lithium

Check here if patient is pregnant Medical history unknown

MD name & no.:

SUBSTANCE DATA

Substance: Leather Protector
Route: inhaled fumes

Ingredients: Petroleum Distillates Manufacturer: 744-6567
308-904

Time of/Since exposure: 1^o PTC

Route of Exposure: Ingestion Inhalation/Nasal Ocular Dermal Bite/Sting Parenteral Unknown Other

HISTORY, ASSESSMENT, SYMPTOMS & CALCULATIONS

History (witnessed? amount verified? other products/victims?) No other products suspected

See # 14621802

Subjective complaints/objective findings No symptoms at this time

Coughing, gagging
can only take shallow breaths, lungs feel real cold

Assessment (symptoms expected? rationale?)
Initial assessment (choose one)

- Asymptomatic
- Symptomatic, related
- Symptomatic, unrelated
- Symptomatic, unknown if related

↑ risk of aspiration pneumonia

Due to symptoms 3^o p exposure
Refer to HCF for evaluation.

Treatment
Facility:

Code:

MANAGEMENT PLAN, FOLLOW-UP NOTES AND OUTCOME: (Time & date each entry)

DATE/TIME

Treatment suggested: HCF

Symptoms to monitor:

Coughing, Choking, tachypnea, dyspnea, CNS excitation/
depression, N/V/D, Abd pain

Follow-up schedule: 2-4^o

:45 Caller's sister calls SPC; desires to know which HCF/ER
sister went to. Told sister decision was left to us. Adam:
Rec Newcastle HCF/ER. SPT

:58 Ans. Machine. SPT

:53 Ans. Machine. SPT

:40 Spoke Kerry States feel a little bit better, but not
that much better. Then spoke Irene. Went to
Methodist North. Both Husband & son went to ER.
Were CXR'd & given scripts of NoTuss PRN &
Erythromycin. Husband had pneumonitis; son was
dx'd bronchitis. Assigned bed rest & F/u w MD
on Monday. SPT

192
:34 Spoke Donald. States chest hurts a little bit but is
feeling much better. Kerry today is more active &
feels better today. F/u Monday after MD's appt. SR

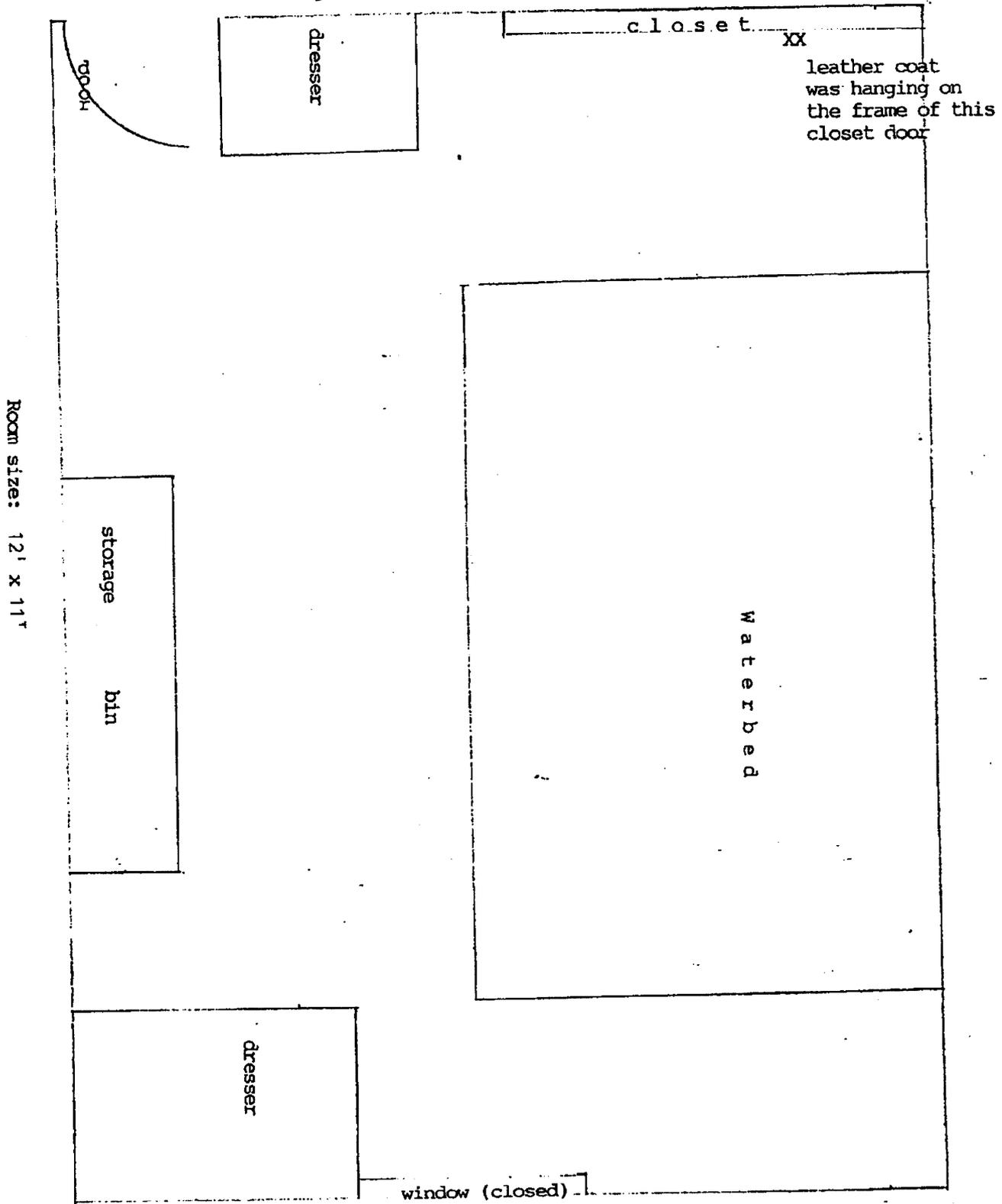
31 Going to MD @ 3pm

33 Ans Machine

INSULTANTS/RESOURCES USED:

- Medical director _____
- Other consultant _____
- Texts _____
- Other _____
- Poisindex®

Diagram of Bedroom (where leather protector was sprayed)



Room size: 12' x 11'

Not to scale

MAGNOLIA
CLIPPING SERVICE
JACKSON, MS (601) 956-4271
TUSCALOOSA, AL (205) 768-8610

COMMERCIAL APPEAL
Memphis, Tennessee
DAILY

G31 0081

IOI 930111CCN0667

DEC-30-92

Exposure to spray ⁵⁰⁶leaves 27 people ill

By Jon Hamilton
The Commercial Appeal

Several members of a Memphis-area family were among dozens of people nationwide who fell ill over the holidays after exposure to a spray-on leather protector, poison control officials said Tuesday.

Irene Adams, 41, of Frayser said her husband, her son and a niece were treated in the emergency room at Methodist Hospital North on Christmas Day after spending time in a room where a leather coat had been sprayed with the product. "They couldn't breathe when they came out of the room," she said.

On Monday, Wilsons Suede and Leather Co. in St. Louis Park, Minn., recalled 270,000 cans of leather protector spray from 600 stores it operates, including several in Memphis.

The Southern Poison Control Center in Memphis has confirmed three local reports of exposure to the spray, said Dr. Peter Chyka, executive director of the center. Through Sunday there were 27 confirmed reports of illness linked to the spray, he said, adding that the number is likely to rise as more poison

centers submit information.

No consumer has died.

Poison control centers in at least six states have received hundreds of calls since Christmas from people reporting coughing, nausea, shortness of breath and other flu-like symptoms after exposure to the product. Wilsons said the problem seems to be a petroleum-based substance in new five-ounce cans of its leather protectant.

Chyka said the spray irritates the lining of the lungs, causing the symptoms.

Carey Adams, 17, said he realized something was wrong about 25 minutes after he left a room in which the product had been used to waterproof a leather coat given as a Christmas gift.

"My lungs started hurting," he said. "It kept getting worse and worse." Adams said his father and others who had been in the room also began coughing. He and his father are better, he said, though they still cough and are congested.

Chyka said people who think they have been exposed to the spray or have questions should call the center at 528-6408. Wilsons is encouraging consumers who purchased the spray to return it for a full refund.

U.S. CONSUMER PRODUCT SAFETY COMMISSION

AUTHORIZATION FOR RELEASE OF NAME

Thank you for assisting us in collecting information on a potential product safety problem. The Consumer Product Safety Commission depends on concerned people to share product safety information with us. We maintain a record of this information, and use it to assist us in identifying and resolving product safety problems.

We routinely forward this information to manufacturers and private labelers to inform them of the involvement of their product in an accident situation. We also give the information to others requesting information about specific products. Manufacturers need the individual's name so that they can obtain additional information on the product or accident situation.

Would you please indicate on the bottom of this page whether you will allow us to disclose your name. If you request that your name remain confidential, we will of course, honor that request. After you have indicated your preference, please sign your name and date the document on the lines provided.

You are hereby authorized to disclose my name and address with the information collected on this case.

My identity is to remain confidential.

Donald Leon Adams
(Signature)

1-30-93
(Date)

930111CCN0667
attachment #1

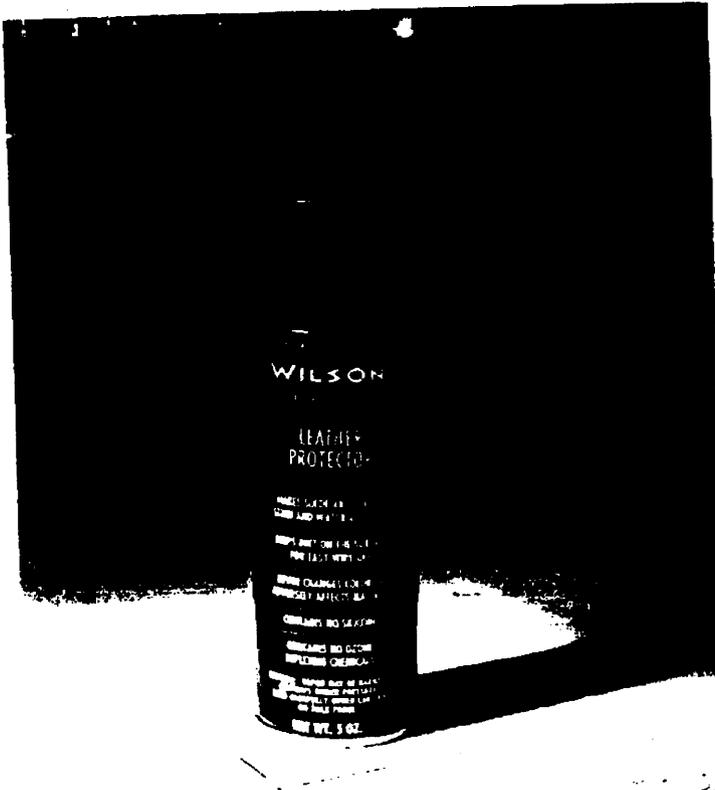


Photo #1: This photo shows the front panel of the 5 oz. leather protector which was used to spray a leather coat on Christmas morning, the day of the incident.

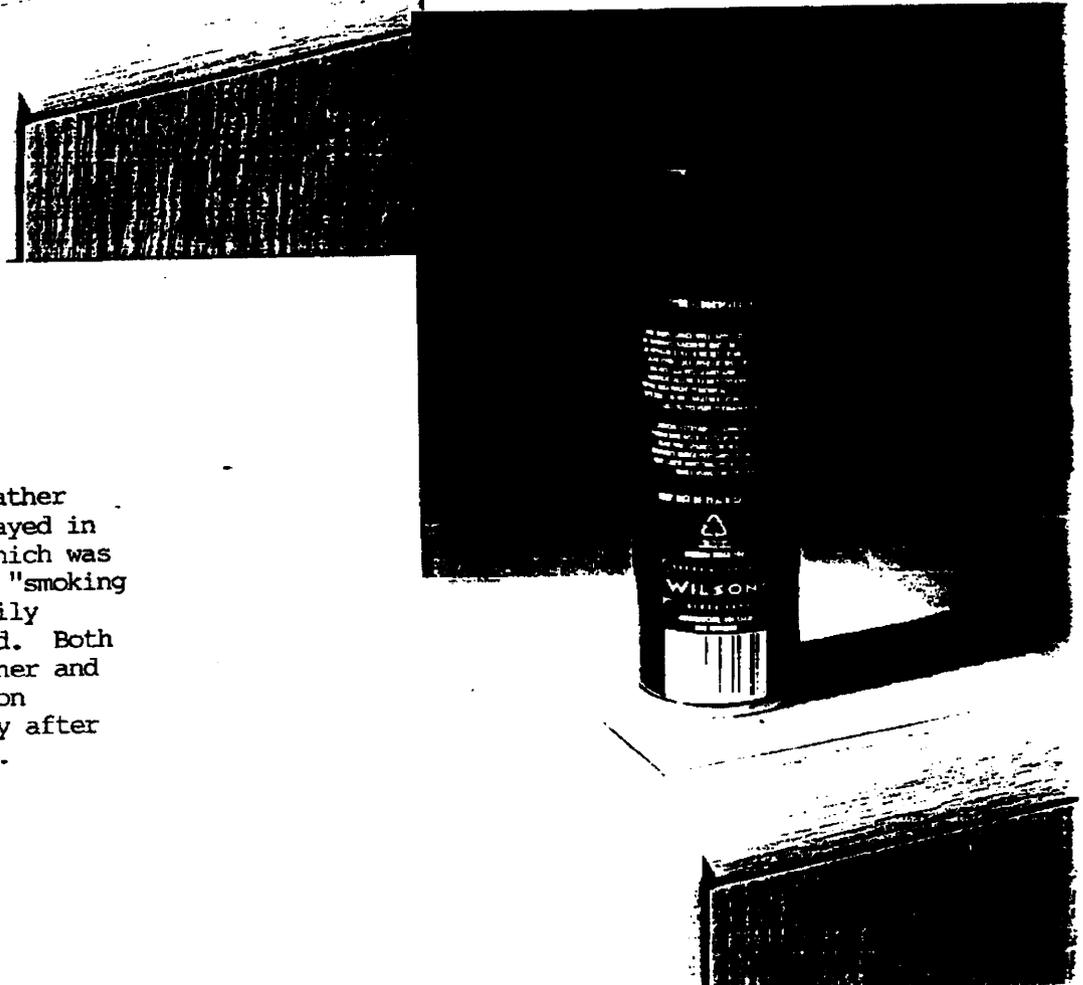


Photo #2: The leather protector was sprayed in a small bedroom which was being used as the "smoking room" for the family members who smoked. Both a 43 year old father and his 17 year old son became ill shortly after entering the room.

930111CCN0667
attachment #1

Photo #3: This photo shows the markings on the bottom of the 5 oz.
spray can which states "292."

