

PLEASE DO NOT STAPLE IN THIS AREA

SUZLON ROTOR CORP  
1711 S HWY 75  
PIPESTONE, MN 56164-

CARRIER

## HEALTH INSURANCE CLAIM FORM

PICA   

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input checked="" type="checkbox"/>				1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 504843630								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAQUA TOMMY L				3. PATIENT'S BIRTH DATE MM DD YY 02 10 1957		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME						
5. PATIENT'S ADDRESS (No., Street) 333 S SPRING AVE				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 333 S SPRING AVE						
CITY SIOUX FALLS		STATE SD		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>		CITY SIOUX FALLS		STATE SD				
ZIP CODE 57104-		TELEPHONE (Include Area Code) (605) 332-6730		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE 57104-		TELEPHONE (INCLUDE AREA CODE) (605) 332-6730				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER D01 02/01/08						
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY 02 10 1957						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME LABOR READY						
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME SUZLON ROTOR CORP						
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>						
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
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.						SIGNED SIGNATURE ON FILE DATE 02/11/2008						
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 02 01 2008				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 PETER LOOBY, MD				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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
1. 882.1						23. PRIOR AUTHORIZATION NUMBER						
2.						3.						
4.						5.						
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
02 01 2008 02 01 2008		21	07	00400		1	440 00	5	69	MIN	RESERVED FOR LOCAL USE	
00400 ANES: 20:40-21:49				(69 MIN)								
25. FEDERAL TAX I.D. NUMBER 460418791		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 305338		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 440.00		29. AMOUNT PAID \$		30. BALANCE DUE \$ 440.00
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.) DEAN DEWALD MD DATE 02112008				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) AVERA MCKENNAN HOSPITAL 800 E 21ST STREET SIOUX FALLS SD 57105				33. PHYSICIAN'S BILLING NAME, ADDRESS, ZIP CODE & PHONE ANESTHESIOLOGY ASSOCIATES, INC PO BOX 2756 SIOUX FALLS SD 57101-				
				PIN#				GRP#				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



**McKenna Hospital  
and University Health Center**

800 East 21<sup>st</sup> Street  
Sioux Falls, SD 57117-5045  
P#: 605-322-8000 F#: 605-322-8100

Patient: JAQUA, TOMMY L  
DOB: 02/10/1957 M/50  
Acct: MK0001385059 MR: MK00364826  
Adm: 02/01/08 Dsch: 02/02/08  
Loc: MK.2W Rm: 2.234 Status: DIS IN  
Attending: Looby, Peter A MD

**OPERATIVE REPORT**

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**DATE OF PROCEDURE**

February 1, 2008

**SURGEON**

Peter Looby, MD

**PREPROCEDURE DIAGNOSIS**

Laceration, left hand/wrist.

**POSTPROCEDURE DIAGNOSIS**

Laceration of the dorsum of the left hand, with laceration of the princeps pollicis artery.

**PROCEDURE**

Exploration, irrigation and debridement, wound closure, and ligation of princeps pollicis artery, left hand.

**ANESTHESIA**

General.

**ESTIMATED BLOOD LOSS**

Minimal.

**TOTAL TOURNIQUET TIME**

Unknown.

**SPECIMENS**

None.

**DRAINS**

None.

**IMPLANTS**

None.

Meditech report ID number: 0213-0091

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Loc: MK.2W Rm: 2.234 Status: DIS IN

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## OPERATIVE REPORT

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### COMPLICATIONS

None.

### INDICATIONS

A 50-year-old male with history and physical examination and diagnostic imaging studies all consistent with a soft tissue laceration to the radial aspect of the left hand and/or wrist with probable significant vascular injury. Patient is indicated for wound exploration, artery ligation, and wound closure.

### FINDINGS

Patient had an approximately 4- to 5-cm oblique laceration over the dorsal aspect of the 1st webspace of the left hand. The laceration extended down through the skin and subcutaneous tissues and had lacerated the princeps pollicis artery in its entirety. The extensor pollicis longus tendon was adjacent to the laceration but had no significant damage. The extensor digitorum tendon to the index finger was untouched.

### DESCRIPTION OF PROCEDURE

After signed informed consent was obtained, the patient was brought to the operating room and satisfactory general anesthesia was administered by anesthesiology. The patient's left upper extremity was prepped and draped in the usual sterile fashion. Limb exsanguinated with Esmarch bandage. Pneumatic tourniquet inflated to 250 mmHg. The laceration was explored with the findings as above. We extended the laceration both proximally and distally to aid exposure. Devitalized skin edges were sharply removed using a 15-blade. Any devitalized tissue was sharply excised, as was hematoma in the wound. Both ends of the princeps pollicis artery were then suture ligated with 3-0 silk suture on a small tapered needle. The wound was copiously irrigated with pulse lavage normal saline and the skin closed using interrupted 4-0 nylon. Sterile bulky dressing was applied and patient taken to the recovery room awake, alert, in stable condition.

Meditech report ID number: 0213-0091

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## OPERATIVE REPORT

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Peter A. Looby, MD  
Orthopedics  
Orthopedic Institute  
810 E. 23rd St.  
Sioux Falls, SD 57105-2100  
1.605.331.5890

cc:

D: 02/01/2008 21:53:12 PETER A LOOBY

T: 02/13/2008 07:03:28 div 1092028/422776

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Meditech report ID number: 0213-0091

AVERA MCKENNAN HOSPITAL		AVERA MCKENNAN HOSPITAL		3a PAT. CNTL #	MKAF0639	TYPE OF BILL
800 E 21ST ST		PO BOX 9191		b. MED. REC. #	MK00364826	0111
SIOUX FALLS SD 57105		MINNEAPOLIS MN 55480		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH
6053226400				460224743	021108	021308

8 PATIENT NAME	a	9 PATIENT ADDRESS	a	333 S SPRING AVE				
b	JAQUA, TOMMY L	b	SIOUX FALLS	c	SD	d	57104	e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	16 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
02101957	M	021108	15	2	1	15	01													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE CODE	DATE	37 OCCURRENCE CODE	DATE
04	021108												

38	JAQUA, TOMMY L	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	333 S SPRING AVE	a	02 00	b	80 2	c	81 0
	SIOUX FALLS, SD 57104	d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0111	ROOM BOARD PR MED/SURG	906.00		2	181200		1
0250	PHARMACY GENERAL			23	230484		2
0270	MED SURG SUPPLIES			13	27555		3
0272	MED/SRG STERILE SUPPLY			2	2320		4
0301	LAB CHEMISTRY			1	13800		5
0302	LAB IMMUNOLOGY			1	8300		6
0305	LAB HEMATOLOGY			1	11800		7
0999	PT CONV OTHER			2	114		8
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0001	PAGE 1 OF 1	CREATION DATE	021808	TOTALS	475573	0	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1568460772
SUZLON ROTOR CORP		Y	Y		475573	57	460224743
						OTHER	
						PRV ID	

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO
JAQUA TOMMY L	18	504843630		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	68
6824 Y3051 Y	

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73
6824		0603		603

74 PRINCIPAL PROCEDURE CODE	OTHER PROCEDURE CODE	DATE	75	76 ATTENDING	NPI	1003823170	QUAL	1GD25209
				LAST	Carlson	FIRST	Walter	
				77 OPERATING	NPI		QUAL	
				LAST		FIRST		

80 REMARKS	81 CC a	81 CC b	81 CC c	81 CC d	78 OTHER	NPI	QUAL	
SUZLON ROTOR CORP					LAST		FIRST	
1711 S HWY 75					79 OTHER	NPI	QUAL	
PIPESTONE MN 56164					LAST		FIRST	

1500

COMMERCIAL

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA									
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 504843630									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAQUA TOMMY L					3. PATIENT'S BIRTH DATE MM DD YY 02 10 1957 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) JAQUA TOMMY L									
5. PATIENT'S ADDRESS (No., Street) 333 S SPRING AVE					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 333 S SPRING AVE									
CITY SIOUX FALLS			STATE SD		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>					CITY SIOUX FALLS			STATE SD						
ZIP CODE 57104			TELEPHONE (Include Area Code) (605) 3326730		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE 57104			TELEPHONE (Include Area Code) (605) 3326730						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY 02 10 1957 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME COMMERCIAL									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
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. SIGNED SIGNATURE ON FILE DATE 01/01/2008										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					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 PROVIDER OR OTHER SOURCE WALTER O CARLSON MD					17a. IG D25209 17b. NPI 1003823170					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM 02 11 2008 TO									
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 0 00					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 882 0					23. PRIOR AUTHORIZATION NUMBER					24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #									
1 02112008 02112008 21 99254 1 273 00 1					TJ 460462277					NPI 1114993128									
2 02122008 02122008 21 99233 1 153 00 1					TJ 460462277					NPI 1114993128									
3 02132008 02132008 21 99232 1 108 00 1					TJ 460462277					NPI 1114993128									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER 460462277					26. PATIENT'S ACCOUNT NO. A8200EH2					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
29. AMOUNT PAID \$ 0 00					30. BALANCE DUE \$ 534 00					28. TOTAL CHARGE \$ 534 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.) MANUEL D ARBO MD 02/20/2008					32. SERVICE FACILITY LOCATION INFORMATION AVERA MCKENNAN HOSPITAL 800 E 21 STREET SIOUX FALLS SD 571051016 a. 1568460772					33. BILLING PROVIDER INFO & PH # (800) 5684311 INFECTIOUS DISEASE SPECIALIST PO BOX 5126 SIOUX FALLS SD 571175126 a. 1770538084 b. TJ460462277									

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PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



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P#: 605-322-8000 F#: 605-322-8100

Patient: JAQUA, TOMMY L

DOB: 02/10/1957 M/51

Acct: MK0001388257 MR: MK00364826

Adm: 02/11/08 Dsch:

Loc: MK.2W.ORT Rm: 2.252 Status: ADM IN

Attending: Carlson, Walter O MD

## CONSULT

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### DATE OF CONSULTATION

February 11, 2008

### CONSULTING PHYSICIAN

Manuel D. Arbo, MD, infectious disease

### IDENTIFICATION

I was asked by Dr. Walter Carlson, orthopedics, to see this 51-year-old man with left hand cellulitis.

### HISTORY OF PRESENT ILLNESS

This is a 51-year-old man who is healthy otherwise who presented on February 1, 2008, with an acute laceration in the dorsal aspect of the left hand. He required surgical repair. There was no damage to tendons or nerve structures. He had closure of the wound and was treated with cephalexin. He went home and took cephalexin until today. He had an appointment today to see Dr. Peter Looby, orthopedics, and when he was in clinic it was noted that he had significant erythema involving the hand and was admitted for that reason.

Patient denies recent fevers, chills or sweats. In general, he does not feel too well because the hand is sore, but no significant systemic complaints. He did not notice any drainage. He tells me that the dressing was left in place several days ago. He was instructed not to remove it.

Patient was admitted and started on intravenous Ancef, and I am asked to see him for advice on further antibiotic therapy.

### REVIEW OF SYSTEMS

CONSTITUTIONAL: Negative.

HEENT: Negative.

CARDIAC: Negative.

RESPIRATORY: Negative.

GASTROINTESTINAL: Negative.

GENITOURINARY: Negative.

MUSCULOSKELETAL: Negative.

Meditech report ID number: 0212-0146

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Attending: Carlson, Walter O MD

## CONSULT

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SKIN: Positive tenderness and some erythema in the dorsal aspect of the hand, but no drainage or any significant swelling.

NEUROLOGICAL: Negative.

PSYCHIATRIC: Negative.

ENDOCRINE: Negative.

HEMATOLOGIC/LYMPHATIC: Negative.

A complete review of systems was done and all remaining systems were negative.

### ALLERGIES

No known drug allergies.

### MEDICATIONS

Receiving Ancef, so far 1 dose of 1 g IV.

### PAST MEDICAL HISTORY

Laceration of soft tissues on February 1, 2008, status post surgery for repair.

### FAMILY HISTORY

Noncontributory.

### SOCIAL HISTORY

Not drinking, but he admits that he had a drinking problem up to about 2 years ago, and since then has not had any. Positive smoking history. Denies drugs.

### PHYSICAL EXAMINATION

VITAL SIGNS: Temperature 97.8. Pulse 62. Respiratory rate 16. Blood pressure 138/86. O2 saturation 91% on room air.

GENERAL: Well-developed adult male who is alert and oriented. Looks very comfortable, in no distress, and appears well.

HEENT: Head is normocephalic and atraumatic. Sinuses are nontender. PERRL.

EOMI. Conjunctivae have no lesions. No scleral icterus. External auditory canals have no drainage or abnormality. Mastoids are nontender. Oropharynx has

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## CONSULT

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no hemorrhage, petechiae or ulcers.

NECK: No thyromegaly, mass or rigidity.

LUNGS: Clear to auscultation with no dyspnea.

CARDIAC: Regular rate and rhythm. Normal S1 and S2. No murmurs, rubs or gallops.

CHEST: No abnormalities.

ABDOMEN: Soft and nontender. Bowel sounds are present. No hepatosplenomegaly, masses or bruits.

EXTREMITIES: The left upper extremity reveals erythema in the left hand in an area of about 4 x 3 cm surrounding a recent surgical incision. The wound is healing and there are no openings. There is no drainage. The erythema is mild and is not edematous. There is no satellite lymphadenopathy and there is no lymphatic streaking into the forearm. Patient is able to move all fingers and has normal sensation and capillary refill.

LYMPHATICS: No axillary, cervical or inguinal lymphadenopathy.

SKIN: No rashes, ulcers or ecchymoses.

NEUROLOGICAL: Alert and oriented with no gross focal neurological deficits.

PSYCHIATRIC: Mood and affect are appropriate.

## DIAGNOSTIC STUDIES

Laboratory: None available.

Imaging studies: None obtained.

## ASSESSMENT

This 51-year-old male is presenting with moderate degree of cellulitis in a surgical wound from 10 days ago. He has been on Keflex throughout this period, so that suggests that the infection is produced by some resistant organism. However, overall the hand looks pretty good and I do not think any serious infection will be anticipated here.

I will cover with intravenous antibiotics probably for some short period of time and hopefully switching to oral as soon as he shows good response.

Meditech report ID number: 0212-0146

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Attending: Carlson, Walter O MD

## CONSULT

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### RECOMMENDATIONS

1. Stop Keflex.
2. Begin Zosyn 3.375 g IV every 6 hours.
3. Obtain a CBC and a CRP.
4. Will follow up, and if there are any fevers will do blood cultures.

Thank you for allowing me to participate in the care of this patient. I will follow him up with you.

---

Manuel D. Arbo, MD  
Infectious Disease  
Infectious Disease Specialists, PC  
911 E. 20th St. Ste. #505  
Sioux Falls, SD 57105-1046  
1.605.322.7250

cc: Walter O. Carlson, MD, Attending Physician

D: 02/11/2008 18:32:13 MANUEL D ARBO

T: 02/12/2008 08:53:41 bas 1098131/422245

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Meditech report ID number: 0212-0146