



STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESEN	TATIVIT	ECIMEN ID NO.	
A. Employer Name, Address, J.D. No.	B. MRO Name, Address, Pi	none and Fay No	· · · · · · · · · · · · · · · · · · ·
ACCT: BJC CMCT. REF1	er millo (yame) Addices, ()	ionis alia i ax ivo.	C
STIX #			
city of Ferguson - PD			
	×		6,0
Hochwood 37 Ferguson No 63135			.*
	r Taran		
Donor Name	: -		
G. Donor F.D. No Name	MADE POIL	200	-
D. Reason for Test:	☐ Reasonable Suspicion/Ca	use 🖫 Post Ac	Cident
☐ Return to Duty ☐ Follow-up	Other (specify)	<del></del>	
E-Drug Tests to be Performed: ( ) P700 (0505F) 60	PZ05 (5DSP) ( )	and the second second second second second	
() P710 (100GP) () P711 (90GP)	F 7 (7 th C 1817 (3 th )	2708 (B-DS	(P)
F. Collection Site Name and Address: ODM. MOSL		<u> </u>	
Name: SOMMOBL/BUARDIAN MEDE ALLE HEALT	- A	7743 i	
Address:	Collector Phone No	ITXTI,	
City, St, Zip:		Year Nat	
14	Collector Fax No.	FX::	*::
STEP 2: COMPLETED BY COLLECTOR			
Read specimen temperature within 4 minutes. Is temperature	Specimen Collection (CHECK A		
between 90° and 100° F? ☐ Yes ☐ No, enter remark		aliva	Observed (Enter Remark)
REMARKS:	☐ Urine Single	□ Blood	(Circe Hemark)
STEP 3: Collector affixes container seal(s) to container(s). Collector dates	s seal(s). Donor initials seal(s)	Donor completes S	Teo 4
STEP 4: COMPLETED BY DONOR			LET.4
I consent to have my specimen collected by the named collector, analyzed including data as	nalysis, by Clinical Beference Laborator	v. Inc. its employees are	Into analiana
("CRL"); and the results of that analysis made available to the above name Company/Employee	er and/or their designee. I certify that I p	rovided my specimen to t	he collector: that I have not
adulterated it in any manner, that each specimen container used was sealed with a tamper-el affixed to each specimen container is correct.	vident seal in my presence; and that the	e information provided on	this form and on the label
		1	
Date of Collection			. 1
8/9/20/9	X	Charles and the second	
Mo. Day Year □ □aytime иполе поле поле поле поле поле поле поле	No.	Signature of Donor	
Date of Birth	i e ajt		
Mo. Day Year Evening Phone I	SPEC	DIMEN ID NO.	
		11.27	
STEP 5: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND C			
I certify that the specimen given to me by the donor identified in the certification section in step  Time and Date of Collection	o 4 of this form was collected, labeled, s	sealed and released to the	Delivery Service noted.
Time and Date of Gollection	POPEONE CONTRINGO	OV DECE 4 OFF #6	
X	SPECIMEN CONTAINER(	S) RELEASED IO:	
81 91 201	ע ע □ UPS		
(PRINT) Collector's Name (First, MI, Last). Mo. Day Year	Courier	Other	<u></u>
RECEIVED AT LAB	S	PECIMEN CONTAIN	ER(S) RELEASED TO:
Signature of Accessioner			1,0,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1
$L = L_{00}$	Container Seal Intact		
(PRINT) Accessioner's Name (First, MI, Last)  Mo. Day Year	☐ Yes ☐ No, enter remarks below		
STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY	SPECIMEN		<del></del>
My determination/verification is:			<del></del>
	Test because:	ч	
			* * * * * * * * * * * * * * * * * * * *
REMARKS	Iterated 🛘 Substituted	*	
		er er er	
Signature of Medical Review Officer (PRI	NT) Medical Review Officer's Name (First, M	II. Last)	//20
STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPE	CIMEN	i, Lasty	Date (Mo./Day/Yr.)
- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	wanted V		
My determination/verification for the split specimen (if tested) is:			
☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON			
<b>X</b>			

## Aconol lesung Form

(The instructions for completing this form are on the back of Copy 3)

STEP 1; TO BE COMPLETED BY ALCOHOL TECHNICIAN				Affix or Print Screening Results Here Affix with Tamper Evident Tape		
	(Print) (First, M.I., La		<u> </u>			
<ul><li>B: SSN or Employee ID N</li><li>C: Employer Name</li></ul>		= Feroi	es oh	RBT IV# 016		
Street City, ST ZIP	Ha chu	rah et		DATE 08-09-1		
DER Name and Telephone No.	Fergus 8	w pro	63/35	AS IU# 04391		
D' Reason for the Test:	DEK Name andom □ Reasonable Susp ♣Pos		none Number	000 AUTO 15:90		
D. Reason for the Test. Lik	andom   Reasonable Susp   Pos	r-Accident   Return to Duty	Li Pollow-up   Pre-employment			
STEP 2: TO BE COMPL	ETED BY EMPLOYEE	· · · · · · · · · · · · · · · · · · ·		Affix or Print Confirmation Results Here Affix with Tamper Evident Tape		
I certify that I am about to s form is true and correct.	submit to alcohol testing and 7	d that the identifying i	nformation provided on the	Tamper Isvaesu Iupe		
Signature of Employee		Date	8 / 9 / / / Month Day Year			
STEP 3: TO BE COMPL	ETED BY ALCOHOL TI	ECHNICIAN				
confirmation test, each tech	individual and that I am qu	own form). I certify th	nat I have conducted alcohol			
TECHNICIAN: ZBAT		DIA MARCATUS 14	5-Minute Wait: □ Yes <del>□ No</del> -			
_	BREATH DEVICE* write in the sp					
Test# Testing Device Name	Device Serial # OR Lot # &	Exp Date Activation T	ime Reading Time Result			
CONFIRMATION TEST	Result <u>MUST</u> be affixed to ea	ch copy of this form or p	rinted directly onto the form.			
REMARKS:			Affix or Print Additional Results Here Affix with Tamper Evident Tape			
		,				
GUARDIAN MI						
Alcohol Technician's Com		Company Street Ad ST. LOUIS, MO 6	3146			
(PRINT) Alcohol Technicia	m's Name (First, M.L., Last)	) Company City, Stat	e, Zip Phone Number			
Signature of Alcohol Techr	ician	Date	Month Day Year			
STEP 4: TO BE COMPL	ETED BY EMPLOYEE I	F TEST RESULT IS	0.02 OR HIGHER			
	ed to the alcohol test, the re- ust not drive, perform safety or greater.		•			
Signature of Employee		D-4-	/ /			

## NORTHWEST HEALTHCARE a part of Christian Hospital

1225 Graham Road Florissant, MO 63031

Patient: WILSON, DARREN Sex/Age: M 28

Address: Date/Time: 08/09/2014 15

R Naprosyn 500mg; Twenty (20); Take one by mouth twice daily as needed for pain, with food

Collaborating physician:

NO REF

Substitution Permitted

Dispense As Written

Signed by:

- Collaborating Physician:

Historia Volumentalia

DEA Number:

NPI Number:

## THIS IS YOUR PRESCRIPTION.

DO NOT LOSE IT.

Take it to a pharmacy as soon as possible so that you may begin taking your medicine.

EMERGENCY CARE DEPARTMENT





Patient: WILSON, DARREN D

MR#: Acct #: DOB:

Northwest Healthcare a part of Christian Hospital 1225 Graham Road Florissant, MO 63031

General Emergency Department Discharge Instructions

The exam and treatment you received in the Emergency Department were for an urgent problem and are not intended as complete care. It is important that you follow up with a doctor, nurse practitioner, or physician's assistant for ongoing care. If your symptoms become worse or you do not improve as expected and you are unable to reach your usual health care provider, you should return to the Emergency Department. We are available 24 hours a day.

You were treated in the Emergency Department by:

What to do:

Follow the instructions on the additional sheets you were given:

Please call as soon as possible to make an appointment for follow-up care:

Discharge from ED: The patient is discharged to home . Patient's condition is satisfactory . Discharge occurred after medical screening and evaluation. . The patient is to follow-up with Contact your supervisor at work on the next business day for information on where to get further treatment of your medical problem. If your supevisor has not been contacted by 11AM, have him/her call BJC Occupational Medicine at . in the next 1-2 day(s) as needed . Purpose of referral: for re-evaluation and further treatment

Take this sheet with you when you go to your follow-up visit.

• If you have any problem arranging the follow-up visit, contact the Emergency Department immediately.

• Take all medications as directed.

Your diagnosis is Contusion of mandibular joint area (ED) Assault by other bodily force (ED)

Diagnosis Instructions: Facial Contusion

**Facial Contusion** 

You have been diagnosed with a facial contusion.

Date/Time: 8/9/20143:36 PM Page 1





Patient: WILSON, DARREN D

MR#: Acct #: DOB:

Contusion is the medical term for a bruise. A facial contusion can be caused by a fall or by being struck in the face.

The skin, muscles and other soft tissues of the face may become swollen and painful. You may have other injuries, like cuts or scrapes. The bones under your face might be bruised.

The doctor does not believe you have injured essential organs, like your eyes, brain or spine.

Apply ice to the face to help with pain and swelling. Place some ice cubes in a re-sealable plastic bag (like Ziploc). Add some water. Seal the bag. Put a thin washcloth between the bag and the skin. Apply the ice bag for at least 20 minutes. Do this at least 4 times per day. It's okay to apply ice longer or more often. NEVER APPLY ICE DIRECTLY TO THE SKIN. Always keep a washcloth between the ice pack and your body. Swelling may increase overnight when your head is down and gravity causes fluids to pool in your face. This should improve within a few hours after you are awake with your head up. Try sleeping with extra pillows to keep your head high.

Use Acetaminophen (Tylenol) or Ibuprofen (Advil or Motrin) to decrease pain and inflammation. The physician will decide if you need a prescription medication.

If your nose bleeds, pinch it closed for 15 minutes. If that does not stop the bleeding, then return here or to the closest Emergency Department.

If you have a cut that requires stitches, then you will receive additional wound care instructions.

One concern after a facial injury is the possibility of other injuries to the head or neck. The doctor has determined that you do not have any other serious injuries and that it is safe for you to go home. If you develop symptoms of a head or neck injury, return immediately to the nearest Emergency Department.

YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:

- Your headaches are severe or become worse.
- You vomit repeatedly.
- You are lethargic or difficult to awaken or you feel confused or seem intoxicated (drunk).
- You have trouble with coordination or balance, feel dizzy, pass out, or have difficulty speaking or slurred speech.
- Your vision changes or your pupils are unequal in size.

Date/Time: 8/9/20143:36 PM Page 2





Patient: WILSON, DARREN D MR#: Acct #: DOB: Medication Reconciliation: THIS IS A LIST OF THE MEDICATIONS THAT YOU WERE ON: Patient not currently taking any medications. THESE ARE THE MEDICATIONS YOU WERE GIVEN IN THE EMERGENCY ROOM: NAPROSYN ORAL 500mas PO THESE ARE THE PRESCRIPTIONS THAT YOU WERE GIVEN TODAY: New: Naprosyn 500mg; Twenty (20); Take one by mouth twice daily as needed for pain, with food New: ; Collaborating physician: \* \* If side effects develop, such as a rash, difficulty breathing, or a severe upset stomach, stop the medication and call your doctor or the Emergency Department. I, WILSON, DARREN D, understand the instructions and will arrange for follow-up care. <PTSig> Patient Signature <RepSig> Representative Signature <StaffSig> Staff Signature

Date/Time: 8/9/20143:36 PM





Patient: WILSON, DARREN D MR#:

MR#: Acct #: DOB:

<Attach:Nutritional Screening>

Date/Time: 8/9/20143:36 PM