CHILDREN'S HOSPITAL OF PITTSBURGH

INPATIENT SUMMARY

ATTENDING PHYSICIAN MICHAEL WOLLMAN, M.D.

KNUPP, LOGAN
UN 80-72-99
BD

ADMISSION: 12-16-97
DISCHARGE: 12-21-97

HISTORY OF PRESENT ILLNESS
Logan is an 11-month-old with medulloblastoma which was diagnosed at 8 months of age. He had presented for routine chemotherapy, CCG protocol #9921, regimen B.

PHYSICAL EXAMINATION
Well nourished appearing child with obvious strabismus and craniotomy scars on the back of the head, otherwise essentially normal exam.

LABORATORY DATA
Normal electrolytes. White blood count of 14.8 with 66% neutrophils. Hemoglobin 10.5, hematocrit 31.5, platelets 396. ALT 20, AST 30, total bilirubin 0.3. Cholesterol 106, alkaline phosphatase 185, LDH 267.

HOSPITAL COURSE
The patient received routine induction chemotherapy of ifosfamide, VP-16 and carboplatin. He was continued on his prophylactic Bactrim M-W-F. He tolerated the chemotherapy well, eating well and sleeping well. He had no fevers or neutropenia while in the hospital. I&O's remained fairly balanced.

The patient was discharged to home with plans for counts five days after discharge. The plan was for chemotherapy three weeks later.

DISCHARGE INSTRUCTIONS
Biweekly for counts at Dr. Wollman's office.

DISCHARGE MEDICATIONS
1. Bactrim half po b.i.d. M-W-F.
2. Neupogen per protocol.
3. Phenergan prn.

DISCHARGE DIAGNOSIS
1. MEDULLOBLASTOMA.

Dictated by:

HEATHER AWAD, M.D.

MICHAEL WOLLMAN, M.D.

D: 1-29-98
T: 1-30-98
21235/vts

CHILDREN'S HOSPITAL OF PITTSBURGH

INPATIENT SUMMARY

KNUPP, LOGAN C
UN 80-72-99
BD 01/24/1997

ATTENDING PHYSICIAN MICHAEL WOLLMAN, M.D.

ADMISSION 12/03/97
DISCHARGE 12/08/97

BRIEF HISTORY

This is the sixth Children's Hospital admission for this 10-month-old male with medulloblastoma whose last chemotherapy was 11/30/97. He presented with a fever of 101.6. He was asymptomatic, but his brother had croup three days prior.

PHYSICAL EXAMINATION

General	Well-appearing toddler.
Vital Signs	Temperature 37.5 in the emergency room.
HEENT	Notable for strabismus and a 1 cm laceration on the upper mucosal surface of his lip, which had some minimal white exudate.

The remainder of the physical examination was unremarkable.

HOSPITAL COURSE

Initial count showed an absolute neutrophil count 8, hemoglobin 9.4, platelets 48. Logan spiked a temperature to 38 axillary on hospital day #2. From there, he defervesced on the cefotaxime, and his lip laceration healed. He required one blood transfusion and two platelet transfusions during the course, to keep his hemoglobin greater than 8 and his platelets greater than 40. On discharge day, his ANC was 72, hemoglobin 10.8, platelets were 22, for which he received a transfusion prior to discharge.

DISPOSITION

The patient is to be discharged home with follow-up for Vincristine tomorrow with Dr Wollman on 12/9/97.

DISCHARGE MEDICATIONS

1. Bactrim 1/2 tab twice a day, Monday, Wednesday, and Friday.
2. DCSF 0.21 cc subcu daily.

DISCHARGE DIAGNOSES

MEDULLOBLASTOMA
FEVER
NEUTROPENIA

Dictated by

H Awad MD

HEATHER AWAD, M.D.

Pwfill

MICHAEL WOLLMAN, M.D.

Pat Hon M.D

D 12/08/97
T 12/09/97 10:23 A
ems

cc MICHAEL WOLLMAN, M.D.

ORIGINAL

CHILDREN'S HOSPITAL OF PITTSBURGH

INPATIENT SUMMARY

KNUPP, LOGAN
UN 80-72-99
BD 1-24-97

ATTENDING PHYSICIAN LELAND ALBRIGHT, M.D.

ADMISSION: 10-3-97
DISCHARGE: 10-19-97

CONSULTATIONS
Neurosurgery Service, Ophthalmology Service, Anesthesia Service.

HISTORY OF PRESENT ILLNESS
This is an eight-month-old white male who was in his normal state of good health until two months ago when the mother noticed that the patient had become more wobbly when sitting up and crawling. The patient had also experienced strabismus since birth in the left eye. About one week prior to admission, the patient began to develop progressively emesis and was seen by his pediatrician, Dr. Romero, who ordered an MRI of the brain. The MRI was performed this evening and showed a posterior fossa mass. The mother stated that the patient reaches for objects, says three words, crawls, and pulls self up on his own. There is no history of seizures or reflux in the family. The rest of the past medical history is noncontributory.

PHYSICAL EXAMINATION
Vital signs — Temperature 36.5°, pulse 135, respirations 32, blood pressure 94/52, and weight 10 kg.
Neurologic — Normal examination.

The remainder of the examination was completely normal.

HOSPITAL COURSE
The patient was admitted to the Neurosurgery Service for stabilization and resection of the posterior fossa mass. The patient was placed on Decadron, Zofran, and Pepcid at the time of admission.

The posterior fossa resection was performed without incident. The patient was transferred to the PICU for stabilization. A repeat MRI was performed which showed good resection and the patient was stabilized without further incident.

On 10-14-97, the patient was transferred to the regular floor for chemotherapy.

Pathology performed on the resection specimen was consistent with a posterior fossa tumor of either medulloblastoma or ependymoma origin.

The patient was scheduled and received the first day of chemotherapy which included carboplatin, ifosfamide, and VP-16 which was tolerated without incident.

DISPOSITION
The patient was released on 10-19-97 to home upon completion of chemotherapy with no further symptomatology.

DISCHARGE MEDICATIONS
1. Bactrim RS 5 cc po b.i.d. Monday, Wednesday, Friday.
2. Neupogen injections 0.2 cc subcutaneous q day.
3. Phenergan 1/2 tsp q 4-6 hours prn nausea, vomiting.

DISCHARGE INSTRUCTIONS
1. Instructed to return to the clinic on the following Tuesday.
2. Call if experiencing any further fever, fatigue, or decreased oral intake.

Dictated by:

THOMAS PORTER, M.D.

[redacted], M.D.

Orlando

D: 11-20-97
T: 11-21-97
42562/vts

CHILDREN'S HOSPITAL OF PITTSBURGH

INPATIENT SUMMARY

ATTENDING PHYSICIAN MICHAEL WOLLMAN, M.D.

KNUPP, LOGAN
UN 80-72-99
BD 1-24-97

ADMISSION: 1-6-98
DISCHARGE: 1-11-98

ADMISSION DIAGNOSIS
MEDULLOBLASTOMA.

HISTORY OF PRESENT ILLNESS
Logan is an almost 1-year-old male with a diagnosis of an undifferentiated CNS malignancy found on 10-97, after symptoms including unsteadiness with sitting and crawling along with morning emesis. Imaging was performed which revealed an enhancing mass filling the fourth ventricle which caused obstruction with secondary hydrocephalus. Logan underwent posterior fossa craniotomy and final pathology was consistent with medulloblastoma. He was lasted admitted on 11-25-97. He has had no complications. No fever. No URI symptoms. No nausea, vomiting or diarrhea. Good po intake. Good activity level.

PAST MEDICAL HISTORY
As above.

PAST SURGICAL HISTORY
MediPort placed 10-97.

MEDICATIONS
Bactrim 5 cc po b.i.d. q M-W-F.

ALLERGIES
Tagamet.

IMMUNIZATIONS
Up-to-date.

PHYSICAL EXAMINATION

General	Logan was described as playful.
Vital signs	Afebrile, vital signs stable.
HEENT	Anterior fontanelle were soft and flat. Left eye remarkable for esotropia. Pupils equal, round and reactive to light. Pharynx was clear.
Lungs	Clear to auscultation bilaterally.
Cardiovascular	Regular rate and rhythm without murmur.
Abdomen	Soft, nontender, no hepatosplenomegaly.
Extremities	Warm and well perfused.
Skin	Negative rash.
Neurologic	DTRs 2+ throughout. Good tone.

LABORATORY DATA
WBC 4.3, hemoglobin and hematocrit 9.9 and 29.6 respectively, 197,000 platelets. Differential - 45 polys, 18 lymphs, 30 monos.

HOSPITAL COURSE
Logan was admitted for chemotherapy including etoposide, carboplatin, ifosfamide. During this hospitalization, Ophthalmology Service was consulted. Dr. Davis saw Logan. Recommendation was to patch the right eye approximately half of the waking hours and to follow-up as an outpatient in 4-6 hours. Physical therapy also saw Logan during this hospitalization. On 1-10-98, Logan had lab work performed which showed a white blood cell count of 1.8 with differential of 74 segs, 3 basophils, 7 lymphs, 16 monos. H&H were 8.7 and 24.6 with 295 platelets.

On 1-11-98, he was discharged to home after completing his chemotherapy.

DISCHARGE MEDICATIONS
1. Bactrim 5 cc po b.i.d. q M-W-F.
2. Neupogen 60 mcg subcu q d until notified to stop.

continued...

CHILDREN'S HOSPITAL OF PITTSBURGH

INPATIENT SUMMARY

ATTENDING PHYSICIAN SALVATORE ORLANDO, M.D.

KNUPP, LOGAN
UN 80-72-99
BD 1-24-97

ADMISSION: 10-6-98
DISCHARGE: 10-9-98

DISCHARGE DIAGNOSES

1. UNDIFFERENTIATED BRAIN TUMOR.
2. STAPHYLOCOCCUS EPIDERMIDIS BACTEREMIA.

HISTORY OF PRESENT ILLNESS

This is a 1¼-year-old male with undifferentiated brain/spinal tumor diagnosed in 10-97 after presenting with vomiting, eye crossing, and unsteady sitting. Today, the patient was evaluated at Children's Hospital of Pittsburgh for routine MRI with contrast. Preliminary report was okay, and the patient was discharged home after de-accessing his port. At home, the patient was sleeping and then started to have heaving and gasping breaths with chills. The patient returned to the Emergency Room where temperature was 38.8°. Trembling and shaking resolved and he was given Tylenol and a dose of Rocephin after blood cultures were obtained and discharged to home. Once he arrived home, the patient was acting himself, ate a large meal, and good po intake remained. However, at night the patient was noted to be gasping, drawing up his knees, and temperature to 102° axillary. The patient returned to the Emergency Room and was sent to the floor.

PHYSICAL EXAMINATION

Vital signs	Temperature 38.9°, pulse 164, respirations 32, blood pressure 100/46, weight 13.4 kg.
General	The patient was awake and alert, coloring on dad's lap.
HEENT	Within normal limits.
Neck	Supple.
Respiratory	Chest clear to auscultation.
Cardiovascular	Heart regular.
Abdomen	Soft, nontender, nondistended.
Extremities	Warm and well perfused. MediPort with slight ecchymosis (patient was accessed times two today.)

LABORATORY DATA

Admission laboratory data - White count 13.4, hemoglobin 9.5, platelet 182 with 80 polys, 12 bands, ANC of 12,328.

HOSPITAL COURSE

After blood cultures were obtained, the patient was started on ceftazidime. On hospital day #2, the blood culture from 10-6-98 grew gram-positive cocci and the patient was started on vancomycin.

The patient remained alert and awake during hospital course. Cultures came back showing coag-negative Staph which was sensitive to vancomycin. During his hospital stay, the patient was noted to have sores on his tongue and the patient was started on acyclovir.

The patient was discharged to home after remaining afebrile times 24 hours.

DISCHARGE MEDICATIONS

1. Vancomycin 250 mg IV q 12 hours.
2. Benadryl 12.5 mg po before vancomycin.
3. Tylenol 220 mg po before vancomycin.
4. Acyclovir 1 tsp. po five times a day x 10 days.

DISPOSITION

The patient is to call Hematology/Oncology Clinic for fevers or any increased symptoms.

continued...

CHILDREN'S HOSPITAL OF PITTSBURGH

INPATIENT SUMMARY

ATTENDING PHYSICIANS DRS. COREY/WOLLMAN

KNUPP, LOGAN
UN 80-72-99
BD

ADMISSION: 11-4-97
DISCHARGE: 11-9-97

HISTORY OF PRESENT ILLNESS

Logan is an 8 1/2-month-old white male diagnosed in 10-97 with a posterior fossa tumor of primitive nature but unknown pathological diagnosis. He was admitted today for his second round of chemotherapy. Logan was diagnosed with a posterior fossa in 10-97 at 8 months of age, after a history of some unsteadiness with sitting and crawling as well as some early morning emesis. MRI of the head at that time revealed a posterior fossa mass. Logan was then referred to Children's Hospital of Pittsburgh Neurosurgery Service and is now status post resection. At the time of diagnosis, there was evidence of subarachnoid spread of the tumor to the ventral pons on medulla with also findings suspicious for spread to the sylvian fissures bilaterally. On 10-2-97, the patient underwent a posterior fossa craniotomy and placement of an EVD drain. He was not known to have any postoperative neurologic deficits. According to parents on admission, he had been doing very well since his last discharge. He had good p.o. intake and started to be more active and babbling. The patient had a MediPort placed on 10-8-97 and had begun chemotherapy by the CCG protocol #9921 regimen B with plans made to receive five induction courses of etoposide, carboplatin, ifosfamide, and Neupogen. On the day of admission, he presented to receive vincristine, VP-16, carboplatin, and ifosfamide as per course #2 out of 5.

PHYSICAL EXAMINATION

Vital signs	Temperature 36.1°. Pulse 100. Respiratory rate 20. Blood pressure 92/58. Weight 11 kg.
HEENT	Well-healed scar on posterior occiput. No erythema or drainage. Right eye was patched. Left eye revealed pupil equal, round, and reactive to light. Extraocular muscles intact. The rest of the HEENT exam was unremarkable. No mouth ulcers or lesions. He appeared well hydrated.
Neurologic	DTRs were 2+ bilaterally. Strength was 5/5 bilaterally. Reaching for objects without tremor. Patient was not observed sitting or crawling at that time.
Skin	No rashes.
Heart	Clear.
Lungs	Clear. The resent of the physical exam was unremarkable.

LABORATORY DATA

Admission labs included a white count of 8.2, hemoglobin 8.3, hematocrit 24.9, and platelet count 460,000 with an absolute neutrophil count of 4200. Differential included 52% polys, 27% lymphs, and 2% monos. Electrolytes revealed a sodium of 140, potassium 4.5, chloride 107, CO2 24, and creatinine 0.6. ALT was 17, AST 24, alkaline phosphatase 134, LDH 261, and bilirubin 0.2.

HOSPITAL COURSE

The patient was admitted and started on chemotherapy as per protocol. He received vincristine, VP-16, carboplatin, and ifosfamide which he tolerated well. On hospital day #1, he had some emesis which was controlled by increasing his Kytril two twice a day; otherwise, Logan did remarkably well throughout his hospital stay. Electrolytes remained stable. White count and hemoglobin also remained stable. On 11-7-97, his white count was 7.2, hemoglobin 8.0, hematocrit 23.8, and platelets 661,000. Differential revealed 55% polys, 32% monos, and 1% band. Electrolytes revealed a sodium of 138, potassium 4.6, chloride 108, BUN 5, and creatinine 0.2.

Throughout his hospital stay, Logan took excellent p.o. and was alert, active, and interactive with his parents. Logan continued to do well and tolerated the chemo without incident. The day prior to admission his white count was 2.0, hemoglobin 9.2, and hematocrit 27.7 with differential of 77% polys, 4% bands, and 18% lymphs. ANC was 1620.

continued...

CHILDREN'S HOSPITAL OF PITTSBURGH

INPATIENT SUMMARY

KNUPP, LOGAN
UN 80-72-99
BD 1-24-97

ATTENDING PHYSICIAN MICHAEL WOLLMAN, M.D.

ADMISSION: 11-25-97
DISCHARGE: 11-30-97

DISCHARGE DIAGNOSES
1. UNDIFFERENTIATED CNS MALIGNANT TUMOR.
2. STATUS POST CHEMOTHERAPY.

HISTORY OF PRESENT ILLNESS
Logan is a 10-month-old male with undifferentiated CNS malignant tumor diagnosed in 10-97 who presents for his third round of chemotherapy with Vincristine, ifosfamide, and carboplatin today. His initial MRI had revealed a fourth ventricular mass and hydrocephalus with spread of the tumor to the ventral pons and medulla. Logan underwent a posterior fossa craniotomy and EVD placement on 10-3-97. The final pathology is consistent with medulloblastoma. He has been in good health since his last chemotherapy.

PHYSICAL EXAMINATION

Vital signs	Stable.
General	The patient was sleep but in no acute distress.
HEENT	Significant for esotropia of the left eye. Moist mucous membranes.
Lungs	Clear to auscultation bilaterally.
Cardiovascular	Regular rate and rhythm. No murmurs.
Abdomen	Soft, nontender, nondistended. No hepatosplenomegaly.
Neurologic	2+ DTR's. He had mildly decreased tone throughout. No focal deficits.

The remainder of his physical examination was unremarkable.

HOSPITAL COURSE
The patient's baseline lab work revealed hemoglobin 8.2, hematocrit of 24, white blood cell count of 9.1, and platelets of 41 on admission. Twelve-hour urine creatinine clearance was obtained and was within normal limits. Therefore, chemotherapy was begun. The patient tolerated chemotherapy without complications. During the hospitalization, he had an MRI of the spine which was reported as being much improved. The patient also had an audiology evaluation which revealed normal cochlea function and an audio evoked brain stem response was ordered. During the hospitalization, the patient's hemoglobin dropped to 7.9 and he required a 100 cc packed red blood transfusion which brought him hemoglobin back up to 11.3. The patient also did not have many bowel movements and therefore Senokot syrup was begun. There was some irritability after an LP was done and Tylenol was given with relief of these symptoms. The LP was done to evaluate spinal fluid for cytology which revealed 2 red blood cells, 3 white blood cells, glucose of 67, protein of 30. The final cytology was unavailable at the time of discharge. The patient was taking good po, tolerated the chemotherapy well, and was stable for discharge home on 11-30-97.

DISCHARGE INSTRUCTIONS
The patient is to have counts checked on 12-2-97 and to receive Vincristine as an outpatient at that time. The patient is also to have counts checked at home every Friday by home nursing.

DISCHARGE MEDICATIONS
1. Bactrim 5 ml po b.i.d. q Monday, Wednesday, Friday.
2. Neupogen 60 mcg subcu q day.

Dictated by:

D: 12-19-97
T: 12-19-97
2639/vts
cc: Dr. Gloria Romero
120 Lytton Avenue
Pittsburgh, PA 15213

ALEXANDER MARCUS, M.D.

MICHAEL WOLLMAN, M.D.

CHILDRENS HOSPITAL OF LOS ANGELES
LOS ANGELES, CALIFORNIA

DISCHARGE SUMMARY

PATIENT NAME	UNIT NUMBER
MANNING, Paul	37 40 23
DATE ADMITTED 7-14-69	FLOOR Infants West
DATE DISCHARGED 7-21-69	PRIVATE PHYSICIAN

HISTORY: This 48-hour-old White male was born to a 20-year-old G II, P II female. His birth weight was 8 lb. 10 1/2 oz. He was noted to be tachypneic at six hours of age by the mother. The child was seen by Dr. Baker at 36 hours of age who felt the child to be in considerable respiratory distress. X-ray taken at a local hospital was negative. The patient was also noted to be jaundiced and was transferred to CHLA.

PHYSICAL: Vital signs: temp 36.8°, respiratory rate 120, apical pulse 140, blood pressure flush 70 in the upper extremities. Weight 8 lb. 8 oz. Head circumference 35 cm. Physical exam was within normal limits except for examination of the chest which revealed tachypnea with mild subcostal retractions. Examination of the heart showed S-1 was of normal intensity, S-2 was increased in intensity and no splitting was heard.

LAB DATA: Within normal limits with exception of total bilirubin of 14.8 with direct of 1.1 and indirect of 13.7. Hemoglobin 21.2, hematocrit 66. Chest x-ray revealed increased vascular markings. On 7-18 total bilirubin was 10.2, direct 0.9 and indirect 9.3. Hemoglobin on 7-18 was 20.3, hematocrit 60. Hemoglobin on 7-21 was 20.8 and hematocrit 66. Repeated x-rays showed increased pulmonary vasculature and normal sized cardiac silhouette.

COURSE: On admission workup included EKG, chest x-ray. Because of severe tachypnea, cardiac consultation was obtained and two diagnostic possibilities were discussed - (1) polycythemia of the newborn and (2) congenital heart disease. In preparation for cardiac catheterization, it was found that an ABO incompatibility did exist between mother and child. However, the child's condition improved and on the second and third day of hospitalization tachypnea decreased to a respiratory rate of 50. The child was watched carefully. Appetite increased and jaundice decreased. On the sixth hospital day, the child's tachypnea increased once again. Cardiac catheterization was decided upon at this time but was refused by the parents. The child was signed out AMA by his parents.

DISPOSITION: The child was discharged to be followed in Cardiac Clinic in three weeks.

DIAGNOSIS:
1) Tachypnea, etiology unknown, possible congenital heart disease.
2) Hemolytic disease of the newborn, i.e. ABO incompatibility.

Dict: 7-21-69
Trans: 7-23-69/lmb

ROCHELLE SHAPIRO, M. D.

RShapiro
RS/mb

INFANT
103

374023
MANNING, PAUL C-33-B
7-14-69 677-0717
MR&MRS PAUL MANNING JR

LEAVING HOSPITAL AGAINST

ADVICE

CHILDRENS HOSPITAL OF LOS ANGELES

DATE July 21, 1969

This is to certify that Manning, Paul

a patient in the above-named hospital, is leaving the hospital against the advice of the attending physician and the hospital administration. I acknowledge that I have been informed of the risk involved and hereby release the attending physician, and the hospital, from all responsibility and any ill effects which may result from this action.

Gail L. Manning
(MOTHER)

Paul B. Manning Jr.
(FATHER)

OR _____
(LEGAL GUARDIAN)

R Shapiro M D
(Witness)

_____
(Witness)

AIM. - 20

CHILDRENS HOSPITAL OF LOS ANGELES
4614 Sunset Boulevard, Los Angeles 27, California

AGREEMENTS AND CONSENTS FOR PATIENT

MANNING, PAUL INF ICU 374023
(Name of Patient)

1. I hereby consent to any and all medical and surgical treatment prescribed by the physicians and surgeons of the Childrens Hospital for the above named patient.

   This consent includes HEART CATHETERIZATION AND/OR ANGIOCARDIOGRAM

2. I hereby grant authority to perform any and all medical examinations; surgical procedures and administration of anesthetics; diagnostic procedures; vaccinations and immunizations against diseases; and nursing procedures; which may now or during the course of the patient's care at the Childrens Hospital, be deemed advisable or necessary.
3. I hereby agree to the removal of the above named child to the Los Angeles County General Hospital if he or she develops a contagious disease.
4. Should medical care at Childrens Hospital be discontinued, contrary to the advice of the physician or physicians attending the patient, I relieve the Hospital and physicians attending my child, of all responsibility for any untoward results which may follow.
5. I hereby authorize the hospital to furnish to my insurance carrier(s) requested information from the above named child's medical records.
6. I agree that this consent shall cover medical care furnished by the Childrens Hospital Society in any of its facilities, including the Out-patient Department and the Convalescent Home.

   I agree that this consent covers exchange of information to doctors and/or other agencies when such exchange of information will be of benefit to the patient.

(Witness)
Bernice Gunderson
(Witness)

7/17/69
(Date)

(Mother)

Paul R. Manning Jr
(Father)

or

(Legal Guardian)

PHOTOGRAPHIC RELEASE

Childrens Hospital Society of Los Angeles — 4614 Sunset Boulevard, Los Angeles 27

I hereby give consent for photographs and/or motion pictures of my child to be used for:

1. Professional education at Childrens Hospital — yes ✓ no
2. Childrens Hospital publicity — yes ✓ no
3. Southern California Community Chest or United Fund publicity — yes ✓ no

Remarks:

Bernice Gunderson
(Witness)

(Witness)

Paul R. Manning Jr.
(Parent or Guardian)

7/17/69
(Date)

FORM 8

REFERRAL FORM
CHILDRENS HOSPITAL OF LOS ANGELES

Initial (X) Renewal ( )

Date 7/22/69 CT 6010 CHLA # 37 40 23

Medi-Cal# _____

A.

1. From: Childrens Hospital of Los Angeles
   Address: P. O. Box 54700
   City: Los Angeles, Calif. Tel: 663-3341
   Dept: OPS Medical
   Name: (Miss) Louisa McClurkin, PHN
   Ext. 554
2. To: Inglewood Health Department
   Address: 101 S. Grevillea Ave.
   City Inglewood, Calif. 90301
3. Hosp.Adm.date _____ Disch: _____
   Clinic App't. Dr. Stanton - Cardiology

Patient MANNING, Paul
Sex M Birthdate 7/14/69
Address 705 So. Larch Apt. 6
City Inglewood Tel: 677-0717

Responsible relative Paul 24 - Gail 20

Other _____ Relationship _____
Address _____ Apt. _____
City _____ Zone _____
Telephone _____

B.

1. Medical Diagnosis and Prognosis (Other significant factors)
   ? Transposition Gr. Vessels
   CHD - B. Wt. 8 lb. 10 oz. ? Total anomalous venous return

2. Medical orders and instructions:

Please supervise newborn care and evaluate home situation.

Dr Stanton (Dr.)

Signature of Physician
Dr. Stanton/L. McClurkin, PHN

C.

Hospital Staff Reports -

Second baby. Father signed baby out against Medical Advice. Refused cardiac cath. - seemed hostile. Will have appointment in Cardiology Clinic.

Family not told of PHN visit.

Louisa McClurkin

Name and Title
L. McClurkin. PHN

PHN-1 6/69

D. Plans:

E. Report by Public Health Nurse and/or other workers in community agency.

1/22/69 TC fr Children Hosp. Phn ↓ HV visit.

1/23/69 HV. Mrs Manning was home with her children - but was taking a nap & req. Phn to set another day - appt made 1/24/69

1/24/69 HV. Mrs Mc Manning and their 2 children reside in 2 BR apparently furnished clean apt - but intend to move to Glendale soon - cheaper rent & they want a small house & its near to their Church. "Assembly of God" which seems to be a very important part in their life - she refused any "cutting" procedure & baby because baby was "touched by God" and seems to be better - they also rely a great deal on prayers - Mrs. Manning seems to feel the strength about this and encourages her husband to do so - seems to feel whatever is - is God's Will.

P.E. of baby - color appeared somewhat flushed - skin clear - no apparent rashes noted - sitting while baby was quiet or crying - is taking SMA 4oz q 4h - stools soft - also takes approx. 4 oz water daily - circumcision was effectively healing, nothing unusual. Respirations regular - mother had no problems with feeding - intends to follow through c X Ray appts at Children - but Clinic wants to keep baby under care of her long-time family physician Dr. Vincent & Associate. Mouth-to-mouth resuscitation procedure discussed - mother seemed interested and asked questions.

Mrs. M. was cooperative - discussed her feelings re religion & medical care of family - appreciated the visit but will retain her medical supervision by Dr. Vincent.

Agency LA County Harbor Gen. Hospital Center Name Mrs. E. Jordahl

Address 101 So Gaffey, Hospital Center Tel. No. 617-3161 Date 1/25/69