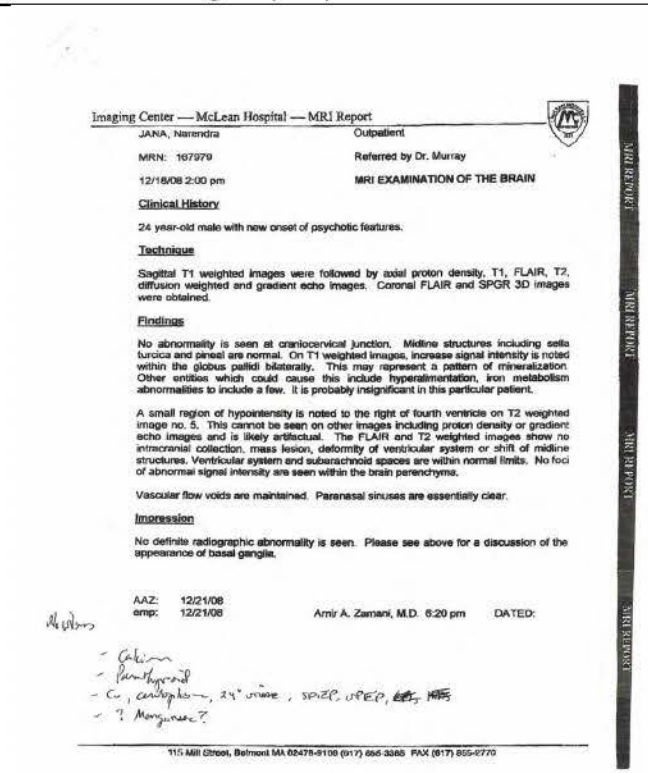
2009 August 20th, 2009 December

- **UMass Memorial Hospital Outpatient and Emergency Room– Worcester, MA**
  - **Negligence under emergency room toxicology →**

Dr. Debra Heitmann was the attending ER doctor (thought there are no medical reports or summaries for her) in the hospital.
UMass memorial emergency department - Denial of Treatment under Toxicology causing Neurodegeneration



Imaging Center — McLean Hospital — MRI Report

JANA, Narendra — Outpatient

MRN: 167979 — Referred by Dr. Murray

12/18/08 2:00 pm — MRI EXAMINATION OF THE BRAIN

Clinical History

24 year-old male with new onset of psychotic features.

Technique

Sagittal T1 weighted images were followed by axial proton density, T1, FLAIR, T2, diffusion weighted and gradient echo images. Coronal FLAIR and SPGR 3D images were obtained.

Findings

No abnormality is seen at craniocervical junction. Midline structures including sella turcica and pineal are normal. On T1 weighted images, increase signal intensity is noted within the globus pallidi bilaterally. This may represent a pattern of mineralization. Other entities which could cause this include hyperalimentation, iron metabolism abnormalities to include a few. It is probably insignificant in this particular patient.

A small region of hypointensity is noted to the right of fourth ventricle on T2 weighted image no. 5. This cannot be seen on other images including proton density or gradient echo images and is likely artifactual. The FLAIR and T2 weighted images show no intracranial collection, mass lesion, deformity of ventricular system or shift of midline structures. Ventricular system and subarachnoid spaces are within normal limits. No foci of abnormal signal intensity are seen within the brain parenchyma.

Vascular flow voids are maintained. Paranasal sinuses are essentially clear.

Impression

No definite radiographic abnormality is seen. Please see above for a discussion of the appearance of basal ganglia.

AAZ: 12/21/08
emp: 12/21/08 — Amir A. Zamani, M.D. 6:20 pm — DATED:

- Calcium
- Parathyroid
- Cu, ceruloplasm, 24° urine, SPEP, UPEP, [illegible]
- ? Manganese?

116 Mill Street, Belmont MA 02478-9100 (617) 855-3385 FAX (617) 855-2770

MRI REPORT MRI REPORT MRI REPORT MRI REPORT

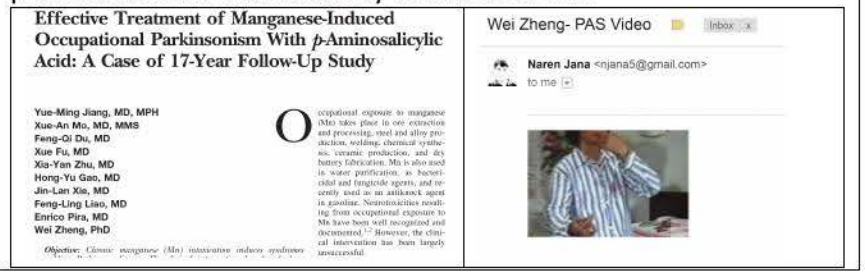
According to Dr. Evan Murray's note in the MRI report he understood that I had an Mn toxicity. He states "?Manganese?" as the last footnote in the article. He still refuses to treat the toxicity and appears to have directed other doctors to do the same.

The toxicity is well researched and has a number of unique properties, the first being that its persistent and though there is temporary relief from metal chelators like EDTA-Ca it doesn't stop that toxicity. It causes a mitochondrial syndrome that effects cellular respiration that causes recurrent lesions in brain and spine (multiple sclerosis).

There is a belief that its the underlying cause of the condition Multiple Sclerosis due to its similarity in causing progressive loss of functional mitochondria in brain support cells leading to inefficient myelination and eventual sclerosis. 14 to 20 % of people with multiple sclerosis have the same bilateral intensity in the basal ganglia similar to my MRI but the intensity is far less prominent them mine. By correlation these two conditions have the greatest overlap.

There is a research article by Dr. Wei Zheng of Purdue university that describes the ineffectiveness of EDTA-Ca chelators and denotes how the condition is similar to symptoms in multiple sclerosis (eg. Pseudobulbar effect):

There is also a video by Dr. Zheng that shows what the presentation of a Mn toxicity would look like:



Effective Treatment of Manganese-Induced Occupational Parkinsonism With *p*-Aminosalicylic Acid: A Case of 17-Year Follow-Up Study

Yue-Ming Jiang, MD, MPH
Xue-An Mo, MD, MMS
Feng-Qi Du, MD
Xue Fu, MD
Xia-Yan Zhu, MD
Hong-Yu Gao, MD
Jin-Lan Xie, MD
Feng-Ling Liao, MD
Enrico Pira, MD
Wei Zheng, PhD

Occupational exposure to manganese (Mn) takes place in ore extraction and processing, steel and alloy production, welding, chemical synthesis, ceramic production, and dry battery fabrication. Mn is also used in water purification, as bactericidal and fungicide agents, and recently used as an antiknock agent in gasoline. Neurotoxicities resulting from occupational exposure to Mn have been well recognized and documented.[1] However, the clinical intervention has been largely unsuccessful.

Objective: Chronic manganese (Mn) intoxication induces syndromes

Wei Zheng- PAS Video — Inbox x

Naren Jana <njana5@gmail.com>
to me

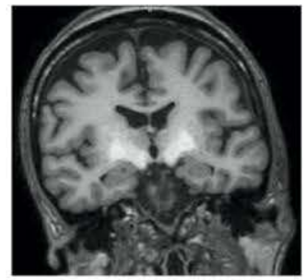
My MRI:

A medical journal example of manganese toxicity (with contrast).

Orphanet Journal of Rare Diseases BMC

PMC full text: Orphanet J Rare Dis. 2017; 12: 92.
Published online 2017 May 18. doi: 10.1186/s13023-017-0632-2

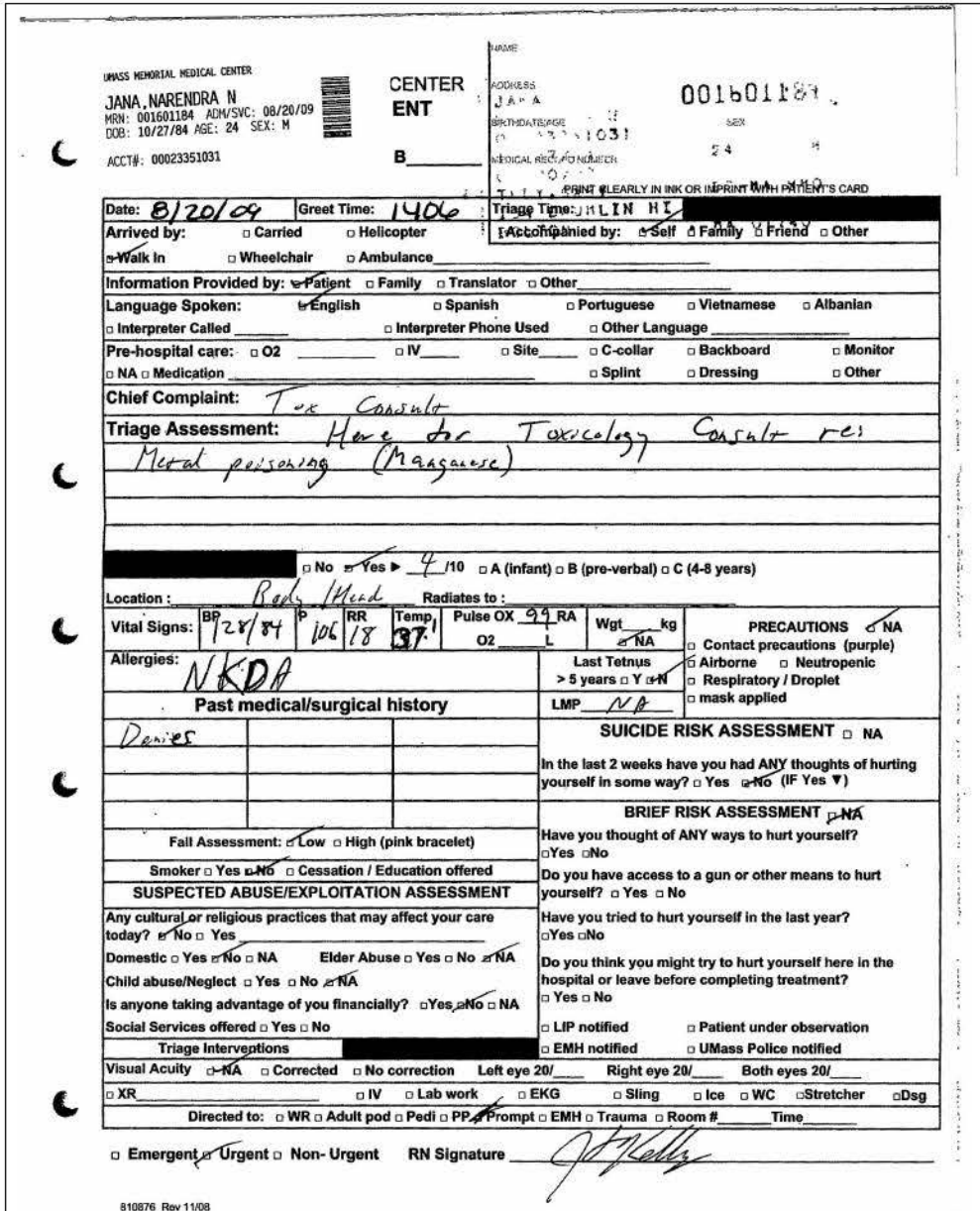
Fig. 3



BG-MnIL MRI image. T1 sequence Brain MRI showing hyperintensity signal in the basal ganglia as consequence of manganese deposition

Images in this article

Click on the image to see a larger version.



UMASS MEMORIAL MEDICAL CENTER

JANA, NARENDRA N
MRN: 001601184 ADM/SVC: 08/20/09
DOB: 10/27/84 AGE: 24 SEX: M

ACCT#: 00023351031

CENTER
ENT

B_____

NAME
ADDRESS
JANA
BIRTHDATE/AGE
MEDICAL RECORD NUMBER
00160118
SEX
24
PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD

Date: 8/20/09 Greet Time: 1406 Triage Time: [redacted]

Arrived by: ☐ Carried ☐ Helicopter
☒ Walk In ☐ Wheelchair ☐ Ambulance

Accompanied by: ☒ Self ☐ Family ☐ Friend ☐ Other

Information Provided by: ☒ Patient ☐ Family ☐ Translator ☐ Other

Language Spoken: ☒ English ☐ Spanish ☐ Portuguese ☐ Vietnamese ☐ Albanian
☐ Interpreter Called ☐ Interpreter Phone Used ☐ Other Language

Pre-hospital care: ☐ O2 ☐ IV ☐ Site ☐ C-collar ☐ Backboard ☐ Monitor
☐ NA ☐ Medication ☐ Splint ☐ Dressing ☐ Other

Chief Complaint: Tox Consult

Triage Assessment: Here for Toxicology Consult re: Metal poisoning (Manganese)

[redacted] ☐ No ☒ Yes ▶ 4 /10 ☐ A (infant) ☐ B (pre-verbal) ☐ C (4-8 years)

Location: Body/Head Radiates to:

Vital Signs:	BP	P	RR	Temp	Pulse OX	Wgt	PRECAUTIONS
	128/84	106	18	37.1	99 RA O2 ___ L	___ kg ☒ NA	☒ NA ☐ Contact precautions (purple) ☐ Airborne ☐ Neutropenic ☐ Respiratory / Droplet ☐ mask applied

Allergies: NKDA

Last Tetnus > 5 years ☐ Y ☒ N

LMP NA

Past medical/surgical history

Denies

SUICIDE RISK ASSESSMENT ☐ NA

In the last 2 weeks have you had ANY thoughts of hurting yourself in some way? ☐ Yes ☒ No (IF Yes ▼)

BRIEF RISK ASSESSMENT ☐ NA

Have you thought of ANY ways to hurt yourself? ☐Yes ☐No

Do you have access to a gun or other means to hurt yourself? ☐ Yes ☐ No

Have you tried to hurt yourself in the last year? ☐Yes ☐No

Do you think you might try to hurt yourself here in the hospital or leave before completing treatment? ☐ Yes ☐ No

Fall Assessment: ☒ Low ☐ High (pink bracelet)

Smoker ☐ Yes ☒ No ☐ Cessation / Education offered

SUSPECTED ABUSE/EXPLOITATION ASSESSMENT

Any cultural or religious practices that may affect your care today? ☒ No ☐ Yes

Domestic ☐ Yes ☒ No ☐ NA Elder Abuse ☐ Yes ☐ No ☒ NA

Child abuse/Neglect ☐ Yes ☐ No ☒ NA

Is anyone taking advantage of you financially? ☐Yes ☒ No ☐ NA

Social Services offered ☐ Yes ☐ No

☐ LIP notified ☐ Patient under observation

Triage Interventions [redacted] ☐ EMH notified ☐ UMass Police notified

Visual Acuity ☒ NA ☐ Corrected ☐ No correction Left eye 20/___ Right eye 20/___ Both eyes 20/___

☐ XR ☐ IV ☐ Lab work ☐ EKG ☐ Sling ☐ Ice ☐ WC ☐ Stretcher ☐ Dsg

Directed to: ☐ WR ☐ Adult pod ☐ Pedi ☐ PP ☒ Prompt ☐ EMH ☐ Trauma ☐ Room #_____ Time_____

☐ Emergent ☒ Urgent ☐ Non- Urgent RN Signature

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The toxicology consultation occurs on August 20th 2009 but there is no acknowledgement or treatment in the hospital in a outpatient consultation.

The toxicologist would have known that the toxicity is unresolvable due to how it distributes in our physiology. The emergency treatment then should have been dialysis with concomitant chelation to reduce the toxicity and limit neurological damage. EDTA (given in IV then) only has a temporary effect followed with anti inflammatory medication (Para Aminosalicylic Acid) that has a limited effect. This is why all future MRIs (that don't have erased series images and which aren't fraudulent) show the same toxicity.

PUPILS (MM)

N = NORMAL S = SLUGGISH F = FIXED

2mm 3mm 4mm 5mm 6mm 7mm 8mm

SECONDARY ASSESSMENT

Neuro / Mental Status ☐NA

☐ WNL
☐ Awake, alert ____

GCS	Arrival
Eye opening	
Verbal react	
Motor	
Total	

Pupils L____ R____ mm
Reaction L____ R____

Cardiac ☐NA

☐ WNL Chest pain ☐ Y ☐ N
☐ Monitor alarms on, NIBP, SpO2
Monitor Rhythm _____
☐ Regular ☐ Irregular

Oxygen @ _____L/NC
☐ NRB ☐ Mask @ _____%

Respiratory ☐NA

☐ WNL
☐ Dyspnea
☐ Retraction
☐ Nasal Flaring
☐ Shallow
☐ Deep
☐ Cough

Breath Sounds:

Crackles ☐R ☐L
Wheezes ☐R ☐L
Diminished ☐R ☐L
Absent ☐R ☐L

Abdomen ☐NA

☐ WNL ☐ Soft ☐ Distended
☐ Guarding ☐ Rigid

Tenderness

☐ RUQ ☐ LUQ
☐ RLQ ☐ LLQ

Other:_____

Bowel Sounds

☐ Absent

Last BM

GU ☐NA

☐ WNL ☐ Anuric ☐ Dysuria
☐ Hematuria ☐ Frequency ☐ Urgency
☐ Unable to void _____
☐ Incontinence ☐ Foley

OB/GYN ☐NA

☐ WNL EDC_____ FHT ____
GR____ Para____
☐ Vaginal bleeding
☐ Vaginal discharge

Musculoskeletal / Extremities / Skin ☐NA

Musculoskeletal ☐ WNL
Deformity: _____ ☐ Swelling
Extremities ☐ WNL
☐ Edema _____
Laceration_____ Abrasion_____
Skin ☐ WNL ☐ Warm ☐ Dry ☐ Moist
☐ Cool ☐ Pale ☐ Flushed ☐ Ecchymosis
☐ Pressure Ulcer location _____
☐ Puncture _____ ☐ Contusion

ENT ☐NA

Ears ☐ WNL
Pain ☐ R ☐ L
Drainage ☐ R ☐ L
Nose: _____
Throat ☐ Redness ☐ Exudate
Mucous Membranes
☐ Dry ☐ Moist

Behavior ☐NA

☐ Calm, cooperative
☐ Withdrawn/depressed
☐ Anxious
☐ Irritable/defensive
☐ Hostile/aggressive

Chronic Deficits ☐NA

☐ Legally Blind
☐ Hearing Aid
☐ Amputation/paralysis
☐ AV Shunt ☐ R ☐ L
☐ Mastectomy ☐ R ☐ L
☐ Walker ☐ Cane ☐ Brace
Other_____

Speech ☐NA

☐ Normal
☐ Slurred
☐ Aphasic

OTHER ☐NA

☐ Section 12
☐ Belongings removed
☐ Searched
☐ Constant observer
☐ Frequent checks

Location:_____ Radiates to:_____

☐ Sharp ☐ Dull ☐ Ache ☐ Pressure ☐ Cramp ☐ Constant ☐ Intermittent Pain scale ____/10

Signature RN Time

IV THERAPY

Time	Size	Site	RN	Time	Size	Site	RN

TIME OUT PERFORMED

Procedure_____ ☐ Correct patient ☐ Consent
☐ Correct procedure ☐ Correct site/side ☐ Correct position
☐ Allergies verified ☐ Confirmation of prophylactic antibiotic
☐ Availability of implants/special equipment Time_____
☐ Review of relevant studies and labs Initials_____

INTAKE

Time	Solution/Blood	PO	Time abs	Total
Total				

OUTPUT

Time	Urine	Feces	Drainage	Emesis	Total
Total					

Initial	Signature	Title

Initial	Signature	Title

☐ Belongings with patient / family ☐ Valuables checklist done ☐ Belongings in safe

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☐ Verbal report given to _____RN Time_____

☐ Report faxed to RN ▶ any additional questions please call _____RN in the Emergency Department

Time	BP	P	RR	T	Pox	FSBS	Time & IV med start		Pre-med pain	Medications Administered	Pain & Time	RN Initial

Nursing Documentation

Time	
	Tox Eval
	Only

CONDITION ☐ Same ☐ Improved ☐ Worse ☐ Expired ☐ Transferred_____ ☐ Transfer Form Completed

DISPOSITION TIME:_____ ☐ Admitted RM _____ ☐ Unit ☐ ED Obs ☐ CDU ☐ EMH ☐ AMA ☐ Elope ☐ LWBS ☐ Morgue

☐ Written instructions received/reviewed with patient/caregiver ☐ PT D/C Home
☐ Patient/caregiver verbalizes understanding of D/C instructions

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UMASS MEMORIAL MEDICAL CENTER

PHYSICIAN'S ORDERS
EMERGENCY DEPARTMENT
NURSING RECORD

NAME: JANA 00160114

ADDRESS:

BIRTHDATE/AGE: SEX:

MEDICAL RECORD NUMBER: LIN HI 49786417

PRINT CLEARLY IN INK OR STAMP WITH PATIENT CARD

Height inches ____ cm ____ Weight Kg: ____

ALLERGIES: ☐ NONE KNOWN

INDICATE CHOICE OF ORDER OPTIONS BY USING X IN CHECK BOXES

DATE	TIME	ALL OTHER ORDERS	DATE	TIME	MEDICATION ORDERS ONLY
		☐ CBC WITH DIFF ☐ FSBS			
		☐ BMP ☐ ABG ☐ BNP			
		☐ EKG #1 ☐ EKG #2			
		☐ CPK ☐ TROPONIN			
		☐ PT ☐ PTT			
		☐ LFT's ☐ AMYLASE ☐ LIPASE			
		☐ TYPE AND CROSS # UNITS____			
		☐ TRANSFUSE ____ UNITS			
		☐ BLOOD CULTURES X2			
		☐ INSERT FOLEY ☐ STRAIGHT CATH			
		☐ URINE DIP ☐ UA ☐ C+S			
		☐ UCG ☐ QUANTITATIVE HCG			
		☐ GC CHLAMYDIA			
		☐ DRUG OF ABUSE ☐ ETOH LEVEL			
		☐ PULSE OX ☐ TRENDING PULSE OX			
		RADIOLOGY			
		Clinical Indication:____			
		X-RAY: ☐ CXR ☐ PCXR			
		CAT SCAN			
		Clinical Indication____			
		☐ ABD/PELVIS with/without contrast			
		☐ KUB ☐ HEAD with/without contrast			
		☐ VASCULAR STUDY			
		Clinical Indication:____			
		☐ ULTRASOUND			
		Clinical indication:____			
		☐ SAFETY RESTRAINTS			
		☐ MAY TRANSPORT WITHOUT TELEMETRY			
		☐ ADMIT TO CDU/OBS @ ____			

Prohibited Abbreviations: U, qd, qod, IU, .1(write 0.1), MS, MS04, MgS04, ug, AS, AD, AU, OS, OD, OU, tiw

UMassMemorial
EMERGENCY DEPARTMENT PHYSICIAN RECORD

NAME: JANA NARENDRA N 001601184
ADDRESS: 3351031
10/27/84 24 M
BIRTHDATE/AGE: 0/09 SEX:
EC-MA HMO
MEDICAL RECORD NUMBER: LIN HI
BOLTON MA 01740
PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD **2**

Time: Hist: ☐ Patient ☐ EMS ☐ Other: ☐ Interpreter:

Medical Student Signature: ____ MS ____

HPI/CC:
Location:
Quality:
Severity:
Duration:
Timing:
Context:
Modifying Factors:
Associated:

tox consult only.

PMH: ☐ None ☐ Type I DM ☐ Type II DM ☐ Asthma ☐ COPD ☐ HIV ☐ PUD ☐ ESRD ☐ GI Bleed ☐ SZ ☐ Cancer ☐ Transplant ☐ CAD ☐ MI ☐ PTCA ☐ CABG ☐ HTN ☐ AFIB ☐ Chol ☐ CHF ☐ Psych ☐ CVA ☐ ESLD

MEDS: ☐ None ☐ Insulin ☐ Coumadin ☐ See List
ALLERGIES: ☐ NKDA ☐ See List

FAMILY: ☐ N/C ☐ CAD ☐ CVA ☐ DM ☐ HTN ☐ CHOL ☐ SZ ☐ Cancer ☐ Other:

SOCIAL: ☐ N/C - + Quit Smoking - + Smoker - + ETOH - + Drugs
LIVING SITUATION: ☐ with Family ☐ Alone ☐ Nursing Home ☐ Has Services ☐ Homeless ☐ Domestic Violence

ROS: CONS - + EYES - + ENT - + CVS - + RESP - + GI - + GU - + Neuro - + INTEG - + MS - + ENDO - + HEME - + Psych - + IMMUN - +
OCCUPATION:
PAST SURGICAL HISTORY: ☐ SBO ☐ Appendectomy ☐ Cholecystectomy ☐ Other
☐ Unable Due To:
☐ All Others Negative Unless Noted

PHYSICAL EXAM: Alert/Oriented X APPEARS: ☐ Well ☐ Mildly Ill ☐ Ill ☐ In Pain ☐ OTHER:
☐ VS: Reviewed PULSE OX: ____ RA LMP: ☐ Age Appropriate Behavior
BP P RR TEMP O2 ____ L Visual Acuity: Right Eye / Left Eye / Bilateral /
☐ TD UTD ☐ > 5 YR ☐ > 10 YR ☐ Pedi Immunization, UTD ☐ Exam Limited Due To:

HEAD: ☐ NCAT
EARS: NL ABNL — Canal (R), Canal (L), TM (R), TM (L), Pinnae (R), Pinnae (L)
EYES: NL ABNL — Fund/Disc (R), Fund/Disc (L), Perrl, EOMI, Conjunc (R), Conjunc (L)

NOSE/SINUS: N Y — Rhinorrhea, Hemorrhage, Discharge, Sinuses Tender
PHARYNX: N Y — Obstructed, Injected, Edema, ↑ Tonsils, Dry Mucosa
NECK: N Y — Rigid, Adenopathy, Tender, Thyromegaly, JVD, Stridor

LUNGS: R L — Clear, Rales, Wheezes, Rhonchi, BS ↓; N Y — Sym. Expansion, Retractions, Accessory Muscle Use
HEART: N Y — Palpable, Thrill; ☐ TACHY ☐ Brady ☐ Murmur: /VI ☐ RUB: ☐ Gallop:
PULSES: R L — Carotid, Brachial, Radial, Femoral, DP, PT
ABDOMEN: N Y — Hepatomegaly, Splenomegaly, Tender, Mass, Distended, Hernia, CVAT; Bowel Sounds ☐ NL ☐ ↑ ☐ ↓ ☐ Absent
RECTAL: ☐ NL ☐ ABNL HEME +
MUSCULOSKELETAL EXAM:
PELVIC / GENITOURINARY:
NEUROPSYCH: NL ABNL — CN II-XII, Gait, COORD., Sensory, Motor, Strength, Memory, Concent; Folstein Score: ____
DTR
SKIN: ☐ NL ☐ ABNL
☐ NO EDEMA/CYANOSIS/CLUBBING

DISTRIBUTION: WHITE — MEDICAL RECORD; YELLOW — PHYSICIAN BILLING; PINK — FOLLOW-UP/DEPT; WHITE — PCP
810875 Rev 04/30/09

CX: ☐ Blood ☐ Throat ☐ Urine ☐ Stool ☐ Wound ☐ CDIFF ☐ CSF ☐ Fluid:

S B L M E — Ca, Mag, Pho

☐ Rhythm Strip Interpretation ☐ EKG #1 ____ +/- Δ C/W ____ ☐ EKG #2 ____ +/- Δ C/W ____ ☐ No Comparison Available ☐ Interpreted BY EP

NAME: JANA NARENDRA N 001601184
ADDRESS: 3351031
10/27/84 24 M
BIRTHDATE/AGE: 06/20/09 SEX:
EC-MA HMO
MEDICAL RECORD NUMBER: LIN HI H9786341726
BOLTON MA 01740
PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD

RADIOLOGY: ☐ CXR ☐ ABD ☐ Other ☐ EXT
CT: ☐ Head ☐ ABD ☐ Chest
SPINE: ☐ C ☐ T ☐ LS
ED US INTERPRETED BY EP: ☐ RUQ ☐ Pelvic ☐ Vascular ☐ Fast ☐ Other
☐ INTERPRETED BY EP ☐ D/W RADIOLOGIST

#1 CK MB I TROP
#2 CK MB I TROP
☐ ABG FiO2
☐ D-DIMER ☐ BNP
U/A: WBC Nitrate RBC LE Bact
UCG
ETOH, ASA, APAP, DOA, APTT, PT, INR; LIP, AMY, LDH, ALT, AST, ALP, TBIL, Lactate

TIME — MANAGEMENT/INTERVENTION — RESPONSE:
1) ☐ MED ☐ Exam ☐ VS ☐ O2 ☐ SAT → ☐ IMP ☐ Same ☐ Worse
2) ☐ MED ☐ Exam ☐ VS ☐ O2 ☐ SAT → ☐ IMP ☐ Same ☐ Worse
CONSULTATIONS/PCP: 1) CALL/ANS
Discussion / Recommendation

☐ Intervention Team notified at: ____
☐ Reviewed Nurse's Notes
☐ Requested Old Records
☐ Reviewed Old Records
Please Summarize:

ED Progress:

ATTENDING NOTE: DR. TIME/DATE:
☐ Chart by Attending.
☐ Patient seen and examined personally by Attending: history, findings and plan of care reviewed with resident. I agree with resident's documented findings and plan of care. Key elements, clarifications, and/or exceptions are noted below by me:
☐ Patient seen and examined by resident in Attending's presence/with Attending: history, findings and plan of care reviewed with resident. I agree with resident's documented findings and plan of care. Key elements, clarifications, and/or exceptions are noted below by me:
☐ Chart by NP. Dr. ____ was immediately available to me during the care of this patient and was / was not actively involved during the course of treatment. Physician's active involvement included:
HPI
CONST: ☐ NL ☐ ABNL:
HEENT: ☐ NL ☐ ABNL:
Neck: ☐ NL ☐ ABNL:
Lungs: ☐ NL ☐ ABNL:
CVS: ☐ NL ☐ ABNL:
ABD/GI: ☐ NL ☐ ABNL:
GU/Pelvic: ☐ NL ☐ ABNL:
NEURO: ☐ NL ☐ ABNL:
Skin: ☐ NL ☐ ABNL:
LYMPH: ☐ NL ☐ ABNL:
PSYCH: ☐ NL ☐ ABNL:
EXT/BACK: ☐ NL ☐ ABNL:
Assessment/Plan:

1. AMI: Aspirin within 24hrs before/during ED stay ☐ Yes ☐ No; Reason:
2. Chest: 12 Lead EKG patient 40 years/older ☐ Yes ☐ No; Reason:
3. Syncope: 12 Lead EKG patient 60 years/older ☐ Yes ☐ No; Reason:
☐ See Procedure Form ☐ See Observation Note
☐ Smoking Cessation > 3 minute Counseling

MEDICAL DECISION MAKING DIFFERENTIAL DIAGNOSIS: 1) 2) 3) 4)
FINAL DIAGNOSIS: 1) 2) tox consult 3) 4)

CONDITION: ☐ Improved ☐ Guarded ☐ Same ☐ Expired __/__/__ Time: __:__
☐ ME Notified DR.
DISPOSITION: ☐ Home ☐ RX Given ☐ Transfer to: ☐ Admit ____ Time: ____ ☐ ED/OBS Start Time: ____
☐ EMH ☐ AMA ☐ Eloped ☐ Police ☐ PSYCH

RESIDENT(S) SIGNATURE: 1) MD/DO Time: Date:

CRITICAL CARE NOTE: The services I provided to the patient were to treat and/or prevent clinically significant deterioration that could result in: *(circle all that apply)*.
System Failure: RESP Renal Circulatory CNS Multi-Organ Metabolic
Overwhelming Infection Severe Shock Other:
Critical Care Time by Attending ____ mins (cumulative) Initials: ____
SEPARATE FROM BILLABLE PROCEDURES

ATTENDING(S) SIGNATURE: INFORMATION ABOVE REVIEWED WITH RESIDENT AND PATIENT
1) MD/DO Time: Date:
2) MD/DO Time: Date:
☐ MD COMPLETE ✓

MF

The second attempt at a consultation with toxicology happens in 2009 December at UMass Memorial in a emergency room setting:

UMASS MEMORIAL MEDICAL CENTER

EMERGENCY DEPARTMENT NURSING RECORD
Page 3 of 5

Date: ______________

Report faxed, please call ______________ and ask for ______________ RN

NAME JANA 001601164
ADDRESS KARENCRA N
BIRTHDATE AGE SEX M
MEDICAL RECORD NUMBER
MA 01740
PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD

Time	BP	Pulse	RR	Pulse OX	Rhythm	Temp	Time	PRE PAIN	Medications	RN initial	POST PAIN & TIME
0200	106/70	99	18	100							

FSBS	Time	Results	initials	Time	Results	initials	Time	Results	initials	Time	Results	initials	FSBS

Nursing Documentation

Time	
	Pt walked to rm accompanied by parents
	and police. mo at bedside
0210	urine sent for urine tox
0213	pt transported to EMH

Belongings/Valuables: ☐ None ☐ Belongings with patient ☐ Belongings with family ☐ Valuables Checklist
Departure Time: ☐ Admitted RM # ______ ☐ Transported with RN ☐ On monitor ☐ IV Infusing ☐ Respiratory with patient
Disposition: ☐ Home ☐ ED Obs/CDU ☒ EMH ☐ AMA ☐ Elope ☐ LWBS ☐ Morgue ☐ Transfer to: ______
☐ D/C Instructions reviewed with patient/caregiver ☐ Patient/caregiver verbalizes understanding of D/C instructions

Initials	Signature and Title	Printed Name

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There is no acknowledgement in the hospital of the clear presence of toxicology and there is no treatment.
But the hospital doctors and nurses were clearly aware of what was happening.

A urine toxicological screening was ordered but the results aren't materialized. It isn't required due to the presence of the finding in the MRI (the MRI feature automatically indicates the toxicity).

Its easy to demonstrate that many of these hospitals tried to hide the underlying medical pathology in toxicology. Since many tests for a specific toxicity (manganese) were attempted to be hidden it could be determined that they knew what they were mistreating under medical toxicology.

In order to limit obligation under medicine, the MRI series images are either erased or not recorded in a subsequent MRI series on 2010 February, 22nd (criminal fraud).
The mentality here is that "if we erase the features that show the toxicity in the MRI series then according to doctors in the US it doesn't exist", which is unrealistic and immature. The MRI done in 2/22/2010 is fraudulated for this reason, the MRI series has a number of T1 and T2 images missing making it a incomplete series.
How this fraud was perpetuated in later demonstrated when a MRI clinic erases 799 MRI images to try and hide the pathology.
The neurotoxicity is persistent for a decade and visible in all future MRI series images as a T1 intensity in the same area (globus pallidus) (15 or more brain MRIs show the same feature that causes progressive neurodegeneration), MRI with contrast agent makes it even more clear in some MRIs.