CLINICAL SHEET

MPR NT/LABEL

INCLUDE W/EVERY NOTE DATE / / MO DAY YR	SERVICE	
08-18-06	RN	c/c "felt awful for the last three days." Returns today for
		Protocol No. NDP-1003 FV 02 study visit with Dr. Wilson.
		• Skin pale, diaphoretic, very warm to touch
		• Productive courgh, expectorating large amount yellow-green
		mucus. c/o chest pain in right lower "ribs with each breath."
		• Sputum specimen obtained.
		• c/o severe "poinding" headache for last 24 hours.
		• c/o "eyes sensitive to light"
		• c/o nausea and poor appetite for last five days, denies
		vomiting or diarrhea.
		• No apparent skin rash and denies skin rash while on study
		drug.
		VITAL SIGNS: BP 142/86; Pulse 104 ; Respirations 36.
		Weight 74.8kg.
		CHEST: crackle and wheezing noted in RLL. It appears that
		there has been no response to therapy. Patient brought in study
		drug and 2 out of seven capsules remain.
		PHYSICAL EXAM: performed and documented in medical
		record. pO2 88%. Admit to Clinical Decision Unit for
		Observation.
		ORDERS: Chest x-ray - PA / lateral; C & S Sputum; Lab work;
		Blood Draw; Routine Serum Chemistry; SGOT; SGPT;
		Creatinine; BUN; H & H; WBC, RBC, platelet
		Blood Draw should be prepared and packaged as required by
		protocol and shipped to Redi Lab. 08-18-06 J. James RN