State of New Jersey

MONMOUTH MEDICAL CENTER
CHRISTOPHER A. FABIAN, M.D.
AN AFFILIATE OF THE SAINT BARNABAS
HEALTH CARE SYSTEM
300 SECOND AVENUE
LONG BRANCH, NJ 07740-6395

(732) 923-6935 TEL.
(732) 923-7246 FAX
BATCH # MDI-20110712-PS0412507-03

DEA # BF 0795940
LIC. # 25MA04721200
NPI # 1649328923

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE ☐ 003959
AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT Robert Jaworski [redacted]
ADDRESS
DATE 5/27/13

Aspirin 81 mg
i tab PO daily
30

SUBSTITUTION PERMISSIBLE ✓ DO NOT SUBSTITUTE
DO NOT REFILL ✓ SIGNATURE OF PRESCRIBER
REFILL TIMES

Use separate form for each controlled substance prescription

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY ARE CRIMES PUNISHABLE BY LAW

State of New Jersey
PRESCRIPTION BLANK

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BATCH # MDI-20130521-PS0412507-05

DEA # BF 0795940
LIC. # 25MA04721200
NPI # 1649328923

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE ☐ 001961
AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

Robert Jaworski 2/12/62
DATE 8/26/13

Lipitor 20 mg
i tab PO qhs # 30
Metformin 500 mg
i tab PO bid before meals
60

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DEA # BF 0795940
LIC. # 25MA04721200
NPI # 1649328923

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE ☐ 000750
AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

Robert Jaworski 2/12/62
8/26/13

Lithium Carbonate 300 mg
ii tabs PO bid # 120
Geodon 40 mg
ii tabs PO w/ breakfast
iii tabs PO w/ dinner
150

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BARNABAS HEALTH
Monmouth Medical Center

0885461397 0001315639
Janowski, Robert
DOB: [redacted] Age: 51 M
Geller, Matthew A PSTI
Admitted: 8/28/2013

BEHAVIORAL HEALTH SERVICES

Discharge Care Plan and Brief Referral Summary **Discharge Date:** 9/27/13

Discharge diagnosis (include medical diagnosis if applicable) : Schizoaffective Disorder

Reason for hospital admission: ☑ Risk of injury to self/others ☐ Inability to care for self ☐ Other:

MEDICATIONS: (See Medication Discharge Report)

Justification form completed if patient is on two or more antipsychotic medications? ☑ N/A ☐ YES ☐ NO

PLAN FOR ANTIPSYCHOTIC MEDICATION CROSS TAPER OR TAPER TO MONOTHERAPY ☑ N/A

Antipsychotic medication name	Taper Plan

(Li 0.9 9/27/13)

Blood serum level for: (name of drug/serum level) NA last done on: NA
Next depot injection of NA Dosage: NA due on NA

Patient's condition on discharge: ☑ Medically & physically stable, BP 137/88 PR 65 RR 18 T 97°

☑ **Pt. has achieved maximum benefits from in-patient hospital stay and is not an imminent danger to self or others**

Recommendations for Therapy to Next Level of Care

☑ Individual ☐ Family ☑ Group ☐ Alcohol./Drug Treatment ☑ Medication monitoring ☐ Other

Living Arrangements: ☑ Home ☐ Nursing home /group home ☐ Shelter ☐ Other:

MD / MLP Signature [signature] Date: 9/27/13 Time: 9 Am

AFTER CARE APPOINTMENTS :

Psychiatrist / APN	Address/Telephone Number	Date / Time	Comment
Intake at CPC - Partial care Program	[redacted] Aberdeen, NJ 07747	Thursday October 3 9AM	Bring all MMC dischage paperwork
Medical:	[redacted]		

Support Groups : ☐ AA: 1-800-322-5525 ☐ NA: 1-800-992-0401 ☑ NJ Support Groups: 1-800-367-6274

Referral to Case Management made: ☐ YES ☑ NO

Special instructions: ☑ **Call MMC Crisis Hotline for return or worsening symptoms: (732) 923-6999**

All personal belongings have been returned ☒ Yes ☐ NA ☐ No, provide reason :

Receipt for cash /valuables have been returned ☒ Yes ☐ NA ☐ No, provide reason :

RN Signature [signature] Date: 9/27/13 Time: 18:30

Social Worker Signature [signature] LCSW Date: 9.27.13 Time: 18:30

Discharge recommendations stated above and discharge medications have been explained to me:
☒ YES ☐ NO

Patient Signature X Robert Janowski Date: 9/27/13

Parent/Guardian Signature (if minor): Date:

Discharge Care Plan , Brief Referral Summary and Medication Discharge Report sent to all aftercare providers on	Date/Time	Signature

BEH-090 DC form 03/21/13

MEDICATION DISCHARGE REPORT

Report Date:09/27/13 07:37 | Barnabas Health | **Monmouth Medical Center**

*** THIS FORM CANNOT BE USED AS A PRESCRIPTION *** | Resident/Physician/LIP MUST CIRCLE yes/no

Written Prescription Must Be Given | Cross out medication and initial each on marked as 'NO'

Patient:	JANOWSKI, ROBERT	DOB:	[redacted]	Age:	51 Years
Location:	AP1	Gender:	Male		
Room/Bed:	1102 /A	Ht:	173.00 cm	Wt:	97.70 kg
MRN#:	[redacted]	FIN#:	0885461397		
Admitting MD:	Geller MD, Matthew A	Admit DT:	08/28/13		

Continue	Medications / Instructions Given				
YES NO	**diphenhydrAMINE**	50 mg	Every 6 Hours	IntraMUSCULAR	Extrapyramidal symptoms (EPS)
YES NO	**benztropine**	1 mg	Every 8 Hours	Oral	Extrapyramidal symptoms (EPS)
YES NO	**magnesium hydroxide**	30 mL	At Bedtime	Oral	Constipation
YES NO	**Al hydroxide/Mg hydroxide/simethicone (Maalox/Mylanta)**	30 mL	Every 4 hours	Oral	Indigestion
YES NO	**acetaminophen**	650 mg	Every 6 Hours	Oral	Pain–Mild 1–3
YES NO	**haloperidol**	5 mg	Every 4 hours	Oral	Psychosis with Agitation
YES NO	**haloperidol**	5 mg	Every 4 hours	IntraMUSCULAR	Psychosis with Agitation
YES NO	**traZODone**	50 mg	At Bedtime	Oral	Insomnia
YES NO	**ziprasidone (Geodon)**	80 mg	With Breakfast	Oral	Schizophrenia
YES NO	**ziprasidone (Geodon)**	120 mg	With Dinner	Oral	Schizophrenia
YES NO	**metFORMIN**	500 mg	Twice a day (before meals)	Oral	DM
YES NO	**lithium**	600 mg	2 times a day	Oral	Schizophrenia
YES NO	**atorvastatin (Lipitor)**	20 mg	At Bedtime	Oral	hyperlipidemia
YES NO	**aspirin**	81 mg	Daily	Oral	cardiac

Patient:	JANOWSKI, ROBERT	DOB:	[redacted]	Age:	51 Years
Location:	AP1	Gender:	Male		
Room/Bed:	1102 /A	Ht:	173.00 cm	Wt:	97.70 kg
MRN#:	[redacted]	FIN#:	0885461397		
Admitting MD:	Geller MD, Matthew A	Admit DT:	08/28/13		

Continue	Medications / Instructions Given

This list does not include medications which have been ordered on a 'one-time' basis, such as Coumadin'

PNEUMOCOCCAL VACCIN Evaluate all patients > 65 years old for administration of PNEUMOCOCCAL VACCINE

In addition, please complete vaccine form

FLU VACCINE: **Evaluate all patients > 50 years old for administration of FLU VACCINE (Oct 1 – Mar 31 only)**

In addition, please complete vaccine form

Additional Medications: ____________________

Medical Equipment Used at Home? ✓ NO ________ YES

CPAP ________ BiPAP ________ Other ________

Patient's admission reconciliation form has been reviewed by Physician / LIP.

PHYSICIAN/LIP SIGNATURE: [signature] BEEPER/ID#: 2111 DATE: 9/27/13 TIME: 8 pm

RN SIGNATURE: [signature] DATE: 9/27/13 TIME: 18:30

If you smoke, **STOP!** Call QUITLINE at 1–866–657–8677 or contact NJ Quitnet at www.nj.quitnet.com for help

I have received and understand the instructions and handout information: X Robert Janowski

(PATIENT/CAREGIVER SIGNATURE)

ONE COPY FOR PATIENT, ONE COPY FOR MEDICAL RECORD CHART