FAX COVER SHEET

TO	
COMPANY	
FAX NUMBER	61386790579
FROM	Medical Fax
DATE	2024/07/16 9:42:24 GMT+10
RE	Referral

COVER MESSAGE

Hello
Please find attached a referral for Max Corey from Dr Edward Carson.
Thanking you very much.
Kind Regards.

Jane McInnes
Medical Receptionist
Health Service Reception
Wathaurong Aboriginal Co-Operative
Lot 62 Morgan St, North Geelong
Vic 3215
Ph: (03) 5277 2038

-----Original Message-----
From: Scans <Scans@wathaurong.org.au>
Sent: Tuesday, July 16, 2024 10:18 AM
To: Jane McInnes <Jane.McInnes@wathaurong.org.au>
Subject: Send data from MFP13914163 16/07/2024 10:18

Scanned from MFP13914163
User Name: jane.mcinnes
Date:16/07/202410:18
Pages:44
Resolution:300x300 DPI
---

country. I pay my respects to Elders past, present and all Aboriginal people on Country who have contributed to the diverse Aboriginal cultural society we have today and in to the future.
[WathaurongAboriginalCooperativeLtd.]<http://www.wathaurong.org.au/>

15/07/2024

A/Prof Christopher Neil,
58A Whitehorse Road,
Deepdene 3103
ph: 1300 870 772 / fax: (03) 8679 0579

re: Mr Max Corey
2/9, Armalite Court,
Corio 3214
ph no: / mob no: 0483 842 006
DOB: 22/08/1994 Medicare no: 4348327476

Dear Christopher,

Thank you for seeing Max for an opinion of his diagnosis of Pericarditis secondary to his Pfizer COVID-19 immunisation in 2021.

Max has been experiencing a number of health issues over the past three years, including intermittent chest pains, lower back pain and sensory changes in his legs. These have significantly impacted his quality of life, and his prospects with finding employment.

He is currently on Suboxone for opioid replacement therapy, as his only medication. He is using marijuana every day. He is at home with his partner and is father of his 13 year old son.

Max is currently trying to receive compensation for what he believes to be medical issues that occurred specifically from his COVID-19 immunisation.

Max received his first Pfizer COVID-19 immunisation on 18/10/2021. Two days later on the 20/10/2021 he presented to University Hospital Geelong Emergency Department with left sided central chest pain which was worse on inspiration. As per ED discahrge summary (20/10/21) examination was unremarkable and ECG showed "no changes consistent with pericarditis". Bloods including FBE, UEC and troponin were normal, and he was discharged hom.
He then represented to ED the next day (21/10/21) and was seen by the same Emergency Physician, due to ongoing pain. A repeat ECG showed no changes, and he was discahrged home.

On the 24/11/22 he had a TTE which showed no evidence of chronic inflammation or constriction.

He presented to ED on 06/03/2022 for coughing up black phlegm and ongoing chest pain. Examination and ECG were normal, and he was discahrged home.

He represented to ED on 26/05/22 with sharp intermittent chest pain, associated nausea and diaphoresis ten days after testing positive to COVID-19 infection. The notes on this discahrge summary state a history of "pericarditis, with current insistence of the same?!". ECG was again normal and he was discahrged home.

On 24/03/23 he presented again to ED with chest pain radiating into the back, right arm pain and worse with movement and breathing. ECG showed saddled shaped ST elevation on anterior-lateral leads and t wave inversion in lead III. Troponin was negative and it was decided this was "most likely" pericarditis and he was treated with Colchecine and ibuprofen.

Other ED presentations between these times include
- 13/01/22: Presented with difficulty breathing. Thought to be secondary to anxiety and discharged home.
- 14/01/22: Presented with throat discomfort. Discahrged home.
- 17/01/22: Presented with swollen left testicle. Discharged home.
- 30/05/22: Right and left leg numbness. No clear diagnosis and discharged home.
- 02/07/22: Presented with left eye pain and blurred vision. Admission to short stay, but discahrge home.
- 04/07/22: Represent for left eye pain and blurred vision. Admitted under Neurology and diagnosed with migraine.
- 23/07/22: Right retroorbital headache. Diascharged home.
- 12/10/22: Quinsey. Required admission under ENT
- 14/10/22: Represent for pain and difficulty swallowing post Quinsey operation.

Please find a copy of recent bloods, his TTE and discahrge summaries from Barwon Health. Apologies it is a lot of paper, but I feel this will give you the best understanding to Max with this information.

Medical History:

acute pericarditis	Geelong ED Jan 2021, Normal RFTs Cailes May 2022

	methamphetamine drug abuse	On suboxone replacement program
	anxiety with depression	
	marijuana addiction	
	past IVDU	
	Asthma	
10/2021	Pericarditis	
2022	Migraine	
2022	Quinsy	

Allergies:

Codeine	Abdominal pain, Severe
Codeine Phosphate	

Medications:
Suboxone - opioid replacement therapy

Yours Sincerely,

Dr Edward Carson
BSc, MD, FRACGP
Prov No: 5396459J

WATHAURONG ABORIGINAL CO-OPERATIVE LTD
ABN 26 564 626 453
LOT 62, MORGAN STREET, NORTH GEELONG 3215 * PO Box 402, NORTH GEELONG 3215
PH: (03) 5277 0044 **FAX: (03) 5278 4123** **EMAIL: admin@wathaurong.org.au**

Investigations:

COREY, MAX JAIMI
2/9 ARMALITE CT, CORIO. 3214
Phone: 0483842006
Birthdate: 22/08/1994 **Sex:** M **Medicare Number:** 43483274761
Your Reference: **Lab Reference:** 23-79576657-MBI-0
Laboratory: AUSTRALIAN CLINICAL LABS
Addressee: DR BRIGETTE AGOSTINELLI **Referred by:** DR BELINDA HIBBLE
Copy to:
RECORDS BARWON UNI. HOSP
EVIEWER DOWNLOAD BARWON UNI. HOSP
DR BRIGETTE AGOSTINELLI

Name of Test: MULTIPLE BIOCHEM ANALYSIS
Requested: 31/05/2023 **Collected:** 31/05/2023 **Reported:** 31/05/2023 10:54

CLINICAL NOTES: tonsillitis quinsy

GENERAL CHEMISTRY **SPECIMEN: SERUM**

	Date: 28/05/23	Time: 03:20	Request: 79571832	Date: 29/05/23	Time: 21:50	Request: 79576373	Date: 31/05/23	Time: 09:20	Request: 79576657			
Sodium		139			139			144		(135 - 145)	mmol/L
Potassium		4.1			4.1			4.0		(3.5 - 5.2)	mmol/L
Chloride		108			105			108		(95 - 110)	mmol/L
Bicarbonate		22			25			22		(22 - 32)	mmol/L
Urea		3.7			4.6			4.2		(3.5 - 8.0)	mmol/L
Creatinine		70			70		*	**54**		(60 - 110)	umol/L
eGFR		> 90			> 90			> 90		(> 59)	mL/min/1.73m2
T.Protein					78					(60 - 82)	g/L
Albumin					41					(35 - 50)	g/L
Globulin					37					(23 - 39)	g/L
ALP					85					(30 - 120)	U/L
Bilirubin					7					(< 25)	umol/L
GGT					20					(< 51)	U/L
AST					20					(< 41)	U/L
ALT					21					(< 51)	U/L

79576657 Specialist management noted.
Haemolysed +

HAE-R CRP-C FBE-R ECU-C

All tests on this request have now been completed
COREY, MAX JAIMI

WATHAURONG ABORIGINAL CO-OPERATIVE LTD
ABN 26 564 626 453
LOT 62, MORGAN STREET, NORTH GEELONG 3215 * PO Box 402, NORTH GEELONG 3215
PH: (03) 5277 0044 **FAX: (03) 5278 4123** **EMAIL: admin@wathaurong.org.au**

2/9 ARMALITE CT, CORIO. 3214
Phone: 0483842006
Birthdate: 22/08/1994 **Sex:** M **Medicare Number:** 43483274761
Your Reference: **Lab Reference:** 23-79576657-CRP-0
Laboratory: AUSTRALIAN CLINICAL LABS
Addressee: DR BRIGETTE AGOSTINELLI **Referred by:** DR BELINDA HIBBLE
Copy to:
RECORDS BARWON UNI. HOSP
EVIEWER DOWNLOAD BARWON UNI. HOSP
DR BRIGETTE AGOSTINELLI

Name of Test: C-REACTIVE PROTEIN
Requested: 31/05/2023 **Collected:** 31/05/2023 **Reported:** 31/05/2023 10:53

CLINICAL NOTES: tonsillitis quinsy

BIOCHEMISTRY

C REACTIVE PROTEIN (CRP) **SPECIMEN: SERUM**

Date	Time	Lab No.		CRP	Units	Ref. Range
12/10/22	11:20	69010587	*	**38.8**		
14/10/22	12:00	69426722	*	**17.6**		
19/01/23	23:25	74761554	*	**4.5**		
24/03/23	18:05	76762795		2.8		
03/04/23	16:10	77991330		< 0.7		
28/05/23	03:20	79571832	**	**67.7**		
29/05/23	21:50	79576373	*	**37.4**		
31/05/23	09:20	79576657	*	**25.0**	mg/L	(< 3.0)

In the setting of infection, CRP levels >100 mg/L are supportive of bacterial rather than viral aetiology.

Note results from this CRP assay should not be used for cardiac risk assessment. Please request the high sensitivity assay (hsCRP) instead.

HAE-R CRP-C FBE-R ECU-W

This request has other tests in progress at the time of reporting
COREY, MAX JAIMI
2/9 ARMALITE CT, CORIO. 3214
Phone: 0483842006
Birthdate: 22/08/1994 **Sex:** M **Medicare Number:** 43483274761
Your Reference: **Lab Reference:** 23-79576657-HAE-0
Laboratory: AUSTRALIAN CLINICAL LABS
Addressee: DR BRIGETTE AGOSTINELLI **Referred by:** DR BELINDA HIBBLE
Copy to:
RECORDS BARWON UNI. HOSP
EVIEWER DOWNLOAD BARWON UNI. HOSP

WATHAURONG ABORIGINAL CO-OPERATIVE LTD
ABN 26 564 626 453
LOT 62, MORGAN STREET, NORTH GEELONG 3215 * PO Box 402, NORTH GEELONG 3215
PH: (03) 5277 0044 **FAX: (03) 5278 4123** **EMAIL: admin@wathaurong.org.au**

DR BRIGETTE AGOSTINELLI

Name of Test: HAEMATOLOGY GENERAL
Requested: 31/05/2023 **Collected:** 31/05/2023 **Reported:** 31/05/2023 10:24

CLINICAL NOTES: tonsillitis quinsy

HAEMATOLOGY **SPECIMEN: WHOLE BLOOD**

Date:		28/05/23		29/05/23		**31/05/23**	(#Refers to current result only)
Coll. Time:		03:20		21:50		09:20	
Lab Number:		79571832		79576373		#79576657	
HAEMOGLOBIN		147		149		146	(125 - 175) g/L
RBC		5.03		5.03		4.94	(4.50 - 6.50)x10 ^12 /L
HCT		0.43		0.43		0.41	(0.40 - 0.55)
MCV		86		85		84	(80 - 99) fL
MCH		29.2		29.6		29.6	(27.0 - 34.0)pg
MCHC		340		348		352	(310 - 360) g/L
RDW		12.8		12.5		12.3	(11.0 - 15.0)%
WCC	*	**13.8**	*	**11.6**	**	**16.7**	(4.0 - 11.0) x10 ^9 /L
Neutrophils	*	**10.3**	*	**8.1**	*	**12.5**	(2.0 - 8.0) x10 ^9 /L
Lymphocytes		1.9		2.1		2.7	(1.0 - 4.0) x10 ^9 /L
Monocytes	*	**1.5**	*	**1.4**	*	**1.3**	(< 1.1) x10 ^9 /L
Eosinophils		0.0		0.0		0.2	(< 0.7) x10 ^9 /L
Basophils		0.0		0.0		0.0	(< 0.3) x10 ^9 /L
PLATELETS		289		372		408	(150 - 450) x10 ^9 /L

#79576657 : There is a mild neutrophilia. There is a mild monocytosis.

HAE-C CRP-W FBE-C ECU-W

This request has other tests in progress at the time of reporting

WATHAURONG ABORIGINAL CO-OPERATIVE LTD
ABN 26 564 626 453
LOT 62, MORGAN STREET, NORTH GEELONG 3215 * PO Box 402, NORTH GEELONG 3215
PH: (03) 5277 0044 FAX: (03) 5278 4123 EMAIL: admin@wathaurong.org.au

COREY, MAX JAIMI
2/9 ARMALITE CT, CORIO. 3214
Phone: 0483842006
Birthdate: 22/08/1994 **Sex:** M **Medicare Number:** 43483274761
Your Reference: **Lab Reference:** 23-76762795-HAE-0
Laboratory: AUSTRALIAN CLINICAL LABS
Addressee: WATHAURONG HEALTH SE **Referred by:** DR BELINDA HIBBLE
Copy to:
RECORDS BARWON UNI. HOSP
EVIEWER DOWNLOAD BARWON UNI. HOSP
WATHAURONG HEALTH SE

Name of Test: HAEMATOLOGY GENERAL
Requested: 24/03/2023 **Collected:** 24/03/2023 **Reported:** 24/03/2023 18:36

CLINICAL NOTES:

HAEMATOLOGY **SPECIMEN: WHOLE BLOOD**

Date:	**24/03/23**		19/01/23		14/10/22		(#Refers to current result only)	
Coll. Time:	18:05		23:25		12:00			
Lab Number:	#76762795		74761554		69426722			
HAEMOGLOBIN	153		129		132	(125 - 175)	g/L	
RBC	5.22	*	**4.44**		4.53	(4.50 - 6.50)	x10 ^12 /L	
HCT	0.45	*	**0.38**		0.40	(0.40 - 0.55)		
MCV	87		85		89	(80 - 99)	fL	
MCH	29.3		29.1		29.1	(27.0 - 34.0)	pg	
MCHC	337		342		327	(310 - 360)	g/L	
RDW	12.7		12.9		13.0	(11.0 - 15.0)	%	
WCC	* **12.2**	*	**12.7**	***	**20.1**	(4.0 - 11.0)	x10 ^9 /L	
Neutrophils	* **8.5**	*	**8.4**	*	**13.9**	(2.0 - 8.0)	x10 ^9 /L	
Lymphocytes	2.7		3.2	*	**4.2**	(1.0 - 4.0)	x10 ^9 /L	
Monocytes	0.9		0.9	*	**1.8**	(< 1.1)	x10 ^9 /L	
Eosinophils	0.1		0.3		0.2	(< 0.7)	x10 ^9 /L	
Basophils	0.0		0.0		0.0	(< 0.3)	x10 ^9 /L	
PLATELETS	356		299		418	(150 - 450)	x10 ^9 /L	

#76762795 : There is a mild neutrophilia.

HAE-C CRP-W TIH-W FBE-C ECU-W

This request has other tests in progress at the time of reporting

COREY, MAX JAIMI
2/9 ARMALITE CT, CORIO. 3214
Phone: 0483842006
Birthdate: 22/08/1994 **Sex:** M **Medicare Number:** 43483274761
Your Reference: **Lab Reference:** 23-76762795-CRP-0
Laboratory: AUSTRALIAN CLINICAL LABS
Addressee: WATHAURONG HEALTH SE **Referred by:** DR BELINDA HIBBLE
Copy to:
RECORDS BARWON UNI. HOSP
EVIEWER DOWNLOAD BARWON UNI. HOSP
WATHAURONG HEALTH SE

Name of Test: C-REACTIVE PROTEIN
Requested: 24/03/2023 **Collected:** 24/03/2023 **Reported:** 24/03/2023 19:10

CLINICAL NOTES:

BIOCHEMISTRY

C REACTIVE PROTEIN (CRP) **SPECIMEN: SERUM**

Date	Time	Lab No.		CRP	Units	Ref. Range
24/03/23	18:05	76762795		2.8	mg/L	(< 3.0)
19/01/23	23:25	74761554	*	**4.5**		
14/10/22	12:00	69426722	*	**17.6**		
12/10/22	11:20	69010587	*	**38.8**		
06/10/22	23:20	69424799	**	**53.1**		
02/09/22	14:45	66954421	*	**5.1**		
04/07/22	18:45	66817453	*	**4.3**		
02/07/22	03:20	66786167	*	**5.3**		

In the setting of infection, CRP levels >100 mg/L are supportive of bacterial rather than viral aetiology.

Note results from this CRP assay should not be used for cardiac risk assessment. Please request the high sensitivity assay (hsCRP) instead.

HAE-R CRP-C TIH-W FBE-R ECU-W

This request has other tests in progress at the time of reporting

COREY, MAX JAIMI
2/9 ARMALITE CT, CORIO. 3214
Phone: 0483842006
Birthdate: 22/08/1994 **Sex:** M **Medicare Number:** 43483274761
Your Reference: **Lab Reference:** 23-76762795-MBI-0
Laboratory: AUSTRALIAN CLINICAL LABS
Addressee: WATHAURONG HEALTH SE **Referred by:** DR BELINDA HIBBLE
Copy to:
RECORDS BARWON UNI. HOSP
EVIEWER DOWNLOAD BARWON UNI. HOSP
WATHAURONG HEALTH SE

Name of Test: MULTIPLE BIOCHEM ANALYSIS
Requested: 24/03/2023 **Collected:** 24/03/2023 **Reported:** 24/03/2023 19:12

CLINICAL NOTES:

GENERAL CHEMISTRY **SPECIMEN: SERUM**

	24/03/23	19/01/23	14/10/22			
Date:						
Coll. Time:	18:05	23:25	12:00			
Lab Number:	76762795	74761554	69426722			
Sodium	141	140	143	(135 - 145)		mmol/L
Potassium	4.6	4.1	5.2	(3.5 - 5.2)		mmol/L
Chloride	104	106	106	(95 - 110)		mmol/L
Bicarbonate	29	27	29	(22 - 32)		mmol/L
Urea	4.1	4.9	6.3	(3.5 - 8.0)		mmol/L
Creatinine	68	72	65	(60 - 110)		umol/L
eGFR	> 90	> 90	> 90	(> 59)		mL/min/1.73m2
T.Protein		72	77	(60 - 82)		g/L
Albumin		43	40	(35 - 50)		g/L
Globulin		29	37	(23 - 39)		g/L
ALP		94	104	(30 - 120)		U/L
Bilirubin		3	4	(< 25)		umol/L
GGT		17	30	(< 51)		U/L
AST		31	**43**	(< 41)	*	U/L
ALT		25	37	(< 51)		U/L

$GLCOMM

76762795 Specialist management noted.

HAE-R CRP-C TIH-W FBE-R ECU-C

This request has other tests in progress at the time of reporting

COREY, MAX JAIMI
2/9 ARMALITE CT, CORIO. 3214
Phone: 0483842006
Birthdate: 22/08/1994 **Sex:** M **Medicare Number:** 43483274761
Your Reference: **Lab Reference:** 23-76762795-TIH-0
Laboratory: AUSTRALIAN CLINICAL LABS
Addressee: WATHAURONG HEALTH SE **Referred by:** DR BELINDA HIBBLE
Copy to:
RECORDS BARWON UNI. HOSP
EVIEWER DOWNLOAD BARWON UNI. HOSP
WATHAURONG HEALTH SE

Name of Test: TROPONIN I TNIH
Requested: 24/03/2023 **Collected:** 24/03/2023 **Reported:** 24/03/2023 19:12

CLINICAL NOTES:

BIOCHEMISTRY

CARDIAC MARKERS - TROPONIN I **SPECIMEN:SERUM/PLASMA/BLOOD**

Date:	**24/03/23**	19/01/23
Coll Time:	18:05	23:25
Lab Number:	76762795	74761554
hsTNI (CEN)	< 3	4 (< 58) ng/L

76762795 Normal troponin I result with the high sensitivity assay indicates it is unlikely that there is significant myocardial damage. Note that troponin levels may take several hours after an episode of chest pain to become raised.

Troponin I is analysed using a high sensitivity method on a Siemens Atellica system (SI units ng/L apply).
Note: gender and method specific Reference Intervals apply.

HAE-R CRP-C TIH-C FBE-R ECU-C

All tests on this request have now been completed

Wyndham Private Medical Centre
1st Flr, 242 Hoppers Lane, Werribee, Vic 3030
Ph: (03) 9908 2999
Fax: (03) 8742 7788

TRANSTHORACIC ECHOCARDIOGRAM

Patient: COREY, MAX **Date of birth:** 22/08/1995 Age: 27
Address:
Gender: M **File no:** 40823
Height: 182 cm **Weight:** 100 kg
BSA: 2.27 m² **Exam Date:** 24/11/2022 14:27
Copies to:
Indications:

LV Dimension			*LV/LA Volumes*			*LA/RA Area*			*Aorta*		
IVSd:	1.00	cm	EF Biplane:		%	LA Area:	24	cm²	LVOT Diam:	2.4	cm
LVPWd:	0.9	cm	LVIDV:		ml	RA Area:		cm²	Aortic Root:	2.9	cm
LVIDd:	5.1	cm	LVESV:		ml				Aorta STJ:		cm
LVIDs:	3.2	cm	LA Vol:		ml				Asc Aorta:	2.8	cm
			LA VI:		ml/m²				Arch:		cm
Aortic Valve			*Mitral Valve*			*Pulmonary Vein*			*Pulm/Tricuspid Valve*		
LVOT Vmax:	1.12	m/s	E vel:	0.90	m/s	Pulm s:		m/s	PV Vmax	1.48	m/s
AV Vmax:	1.58	m/s	Decel time:	124	ms	Pulm d:		m/s	TR Vmax	2.35	m/s
AV max grad:	10	mmHg	A vel:	0.65	m/s	S/D ratio			TR max grad:	22	mmHg
AV mean grad:		mmHg	E' sept:		m/s	Pulm A:		m/s	Est RAP:		mmHg
AVA:	3.1	cm²	E/E'			A dur:		ms	PV regurg:		
Regurg:			Regurg:						TV regurg:		

FINDINGS

Left Ventricle Normal left ventricular size and wall thickness. Normal LV ejection fraction (LVEF 65%) with no regional wall motion abnormalities. Normal diastolic filling pattern.

Right Ventricle Normal right ventricular size and contraction (TAPSE = mm, RVS' = cm/s).

Left Atrium Mild left atrial dilatation (may be normal for BSA).

Right Atrium Normal sized right atrium.

Aortic Valve Trileaflet aortic valve with unrestricted opening and no regurgitation.

Mitral Valve Normal mitral valve with trivial regurgitation.

Tricuspid Valve Normal tricuspid valve with trivial regurgitation.

Pulm Art Pressure Normal estimated pulmonary artery systolic pressure.

Pulmonary Valve Unremarkable pulmonary valve.

Pericardium No pericardial effusion. No evidence of chronic pericardial inflammation/constriction.

Aorta Normal size aortic root and proximal ascending aorta.

CONCLUSIONS

Normal biventricular size & systolic function.
Mild /High normal left atrial dimensions. Normal right atrial dimensions.
No significant valvular dysfunction.

No pericardial effusion. No evidence of chronic inflammation/constriction.

Comment: Clinical history unclear re: "Myocarditis after 1st dose of Pfizer MRNA vaccine". Immune response typically occurs with 2nd vaccine unless there is previous exposure to COVID-19 antigen. Suggest clinical correlation, review of previous ECG, biomarker's and cardiology review.

Reporting Cardiologist: Dr Arevinda Selvarajah **Technologist:**

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 Age: 27 years
Sex: Male

Barwon Health
272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4215 0112

Doctor Documentation

Document Type: Discharge Summary
Service Date/Time: 21/10/2021 21:11 AEDT
Result Status: Auth (Verified)
Perform Information: Perera,Anoushka SrDr (21/10/2021 21:11 AEDT)
Sign Information: Perera,Anoushka SrDr (21/10/2021 21:11 AEDT)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 23 SWIFT WAY, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 21/10/2021 19:49

Date Discharge Letter Completed: 21/10/2021 21:11:10
Print & Post
Name:
Address:
Phone: Fax:

Admission to SSU
No admission orders to SSU found for this patient

History
Re-presents with chest pain.
Seen by me yesterday with chest pain post Pfizer vaccine one week ago.
Had ECG and troponin which were normal.
States he has had pain since then.
Has taken one dose of paracetamol.
No other new symptoms such as SOB, cough, sore throat, fever.
Still able to do usual activities.
No PE risk factors.

ECG done again - no changes from yesterday.

Blood tests not clinically indicated.

Happy for patient to go home.
Can use simple analgesia and follow up with LMO as needed.
Patient requesting medical certificate for tomorrow as he works as a concretor.
Med certificate given for the 22nd Oct.

Referrals and Follow up
No qualifying data available.

Author
Name: Perera, Anoushka SrDr
Provider Number: 2418265J
Position: BWH ED Doctor

Principal Diagnosis
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
No current medications have been documented for this patient

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

Print Date & Time: 21/10/2021 21:11 AEDT

Barwon Health

URN: 744224
DOB: 22/08/1994 **Age:** 27 years
Sex: Male

272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4215 0112

Doctor Documentation

Document Type:	Discharge Summary
Service Date/Time:	20/10/2021 13:17 AEDT
Result Status:	Auth (Verified)
Perform Information:	Perera,Anoushka SrDr (20/10/2021 13:17 AEDT)
Sign Information:	Perera,Anoushka SrDr (20/10/2021 13:17 AEDT)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 23 SWIFT WAY, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 20/10/2021 10:58

Date Discharge Letter Completed: 20/10/2021 13:17:04
Print & Post
Name:
Address:
Phone: Fax:

Principal Diagnosis
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
No current medications have been documented for this patient

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

ED Progress Note

20/10/21 13:15:00
Progress Notes
Blood results seen - FBE, UEC normal. Troponin negative.
Patient states that pain has lessened with simple analgesia.

Happy for discharge home.
Can use simple analgesia as required while at home.
Patient will be able to have second dose of Pfizer when due.

Author
Name: Perera, Anoushka SrDr
Provider Number: 2418255J
Position: BWH ED Doctor

ED Initial Assessment

20/10/21 12:38:00
Presenting Complaint
L) sided CP onset 0600hrs, intermittent in nature, worse with deep inspiration on occassions. 1st pfizer 2/7 ago. n# N/V/D. Nil C19 sx/exposure. afebrile. Pmhx methadone, lyrica
History
Presents with chest pain since this morning in the setting of having had first Pfizer vaccination on Monday.

Usually fit and well.
Is currently on Methadone and Suboxone.
Has previously been in prison and while there, became addicted to Buprenorphine. Went onto Methadone program to come off this and is now on Suboxone program to come off the

Doctor Documentation

Methadone.
Managed by LMO.
Has a sensitivity to codeine - gets abdominal cramps if he takes it.

Had first Pfizer vaccine on Monday.
Felt okay initially but yesterday started to feel a bit unwell - achy and lethargic.
This morning noted chest pain.
No analgesia taken.

No fever, runny nose, sore throat, SOB.
No prior DVT/PE and no family history of same.

Examination
Not unwell looking.
Afebrile.
RR 16, Sa02 97% on room air, chest clear with equal air entry bilaterally.
HR 73, BP 120/80, dual heart sounds with nil added.
Calves not swollen or tender.

Impression & Plan
Impression:
Chest pain post Pfizer vaccine.

Plan:
ECG seen - no changes consistent with myo/pericarditis.
Bloods sent including troponin.
If normal will be able to go home and will be able to have second Pfizer dose.
Author
Name: Perera, Anoushka SrDr
Provider Number: 2418255J
Position: BWH ED Doctor

Admission to SSU
No admission orders to SSU found for this patient

Referrals and Followup
No qualifying data available.

Author
Name: Perera, Anoushka SrDr
Provider Number: 2418255J
Position: BWH ED Doctor

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 **Age:** 27 years
Sex: Male

Emergency Department
272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4215 0112

Doctor Documentation

Document Type:	Discharge Summary
Service Date/Time:	06/03/2022 00:11 AEDT
Result Status:	Auth (Verified)
Perform Information:	Stewart,Clare (06/03/2022 00:11 AEDT)
Sign Information:	Stewart,Clare (06/03/2022 00:11 AEDT)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 23 SWIFT WAY, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 05/03/2022 19:12

Date Discharge Letter Completed: 06/03/2022 00:11:33
Print & Post
Name:
Address:
Phone: Fax:

Principal Diagnosis
Cough
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
Home Medication List: Colchicine
Nurofen (05/03/22 20:28:00)

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

ED Initial Assessment

06/03/22 00:02:00
Presenting Complaint
Coughing up green + black phlegm. Ongoing L) sided CP, not worse with inpiration, intermittent past 1/52. Pt describes rattle in chest. SOB past 1/12. subjective fevers. -ve RAT 1/7 Pmhx - Pericarditis
History
27M presents with difficulty breathing, coughing + chest pain

HOPC:
- Reports has not been well since pericarditis dx + Pfizer vaccine in Sept 2021
- Increasing difficulty breathing, describes as a tightening around his throat upon inspiration, worsening over past 3-4/52, associated with"clicking"sensation in his throat upon swallowing
- Able to swallow, eating + drinking as usual
- Associated with cough + "ratty" breathing, productive, describes as green/yellow, intermittently grey/black
- Reports regular smoker, reports cutting back, smoked 8 "cones" today, down from a maxiumum of 80 cones 2-3/12 ago, states black sputum is often associated with increased smoking
- Reports intermittent L) sided chest pain, which has been present since his pericarditis dx, reports has been getting less severe over past few weeks, occasional R) sided sharp chest pain at night
- Reports frequent ear pain + a"bubbly"sensation at the back of his head, denies headaches, denies visual/hearing changes
- Reports frequently sweaty at home, nil fevers recorded

- Denies changes to L) sided chest pain, nil radiation
- Denies palpitations
- Denies abdo pain
- Denies nausea/vomiting

PMHx:

Patient: COREY, MAX JAIMI MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

Pericarditis
Anxiety
Opioid dependent - weaning suboxone

Meds:
Colchicine
Ibuprofen
Mirtazepine
Pantoprazole

Allergies:
Codeine - nausea

SHx:
Lives at home with partner + 10yo son
Past IVDU - states has been clean for 5 years

Examination
Pt appears comfortable lying in bed
Speaking in full sentences
Nil stridor
Nil increased WOB
HSDNM
Chest clear
Abdo SNT
Calves SNT

Ix:
FBE - NAD, WCC 10.0
CRP NAD
UEC NAD
Qiagen COVID negative

ECG NAD
- Has had multiple admissions to ED, serial ECGs NAD

Recent Observations
Diastolic Blood Pressure: 61 mmHg (05/03/22 22:09:00)
Peripheral Pulse Rate: 60 bpm (05/03/22 22:09:00)
Respiratory Rate: 16 br/min (05/03/22 22:09:00)
SpO2: 98 % (05/03/22 22:09:00)
Systolic Blood Pressure: 132 mmHg (05/03/22 22:09:00)
Temperature Tympanic: 36.4 DegC (05/03/22 22:09:00)
Glasgow Coma Score (GCS): 15 (05/03/22 22:09:00)

Impression & Plan
Imp: DDx: ?globus pharyngis ?vocal cord nodule ?euthymic goiter ?anxiety
- Haemodynamically stable + nil evidence of airway obstruction
- Tolerating oral intake in ED

Discussed with ED FACEM Dr Michael Sheridan
Pt R/v'd by ED Reg Dr Chris Carman

Plan, as agreed by Dr Carmen + Dr Sheridan:
1. D/c home
2. Reassurance provided +++
- Discussed recent CT chest showed nil cause for pts sx, nil pneumonia
3. Advised to continue to cut down on smoking
4. Advised to continue on ventolin recently commenced - reassured that may initially make cough worse
5. F/U with GP in 2-3/7 re symptom monitering, consideration of ENT referral as ?globus pharyngis vs. ?vocal cord nodule, consideration of thyroid US ?euthymic goiter
6. Educated re red flags + when to represent e.g. SOB causing difficulty speaking/swallowing, worsening chest pain, patient concern

Author

Patient: COREY, MAX JAIMI MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

Name: Stewart, Clare
Provider Number:
Position: BWH ED Doctor

Admission to SSU
No admission orders to SSU found for this patient

Referrals and Followup
No qualifying data available.

Author
Name: Stewart, Clare
Provider Number:
Position: BWH ED Doctor

Print Date & Time: 06/03/2022 00:11 AEDT

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 **Age:** 28 years
Sex: M

Emergency Department
272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4215 0112

Doctor Documentation

Document Type:	Discharge Summary
Service Date/Time:	24/03/2023 23:13 AEDT
Result Status:	Auth (Verified)
Perform Information:	Gurung,Sunita (24/03/2023 23:13 AEDT)
Sign Information:	Gurung,Sunita (24/03/2023 23:13 AEDT)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: M
Home address: 2/9 ARMALITE CT, Locked Bag 7, CORIO 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 24/03/2023 15:07
Date Discharge Letter Completed: 24/03/2023 23:13:08
Print & Post
Name:
Address:
Phone: Fax:

Principal Diagnosis
Chest pain, NEC
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
No current medications have been documented for this patient

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

ED Progress Note

24/03/23 19:50:48
Progress Notes
- Patient stable and comfortable
- chest xray NAD
- Troponin neg
- UEC/CRP WNL
-WBC 12.2

D/W ED Consultant J. Furyk

- given troponin neg, chest pain better, PERC 0- ruled out cardiac/PE- patient concern about fluid in lungs - advised the Chest X-ray is normal
- most likely dx pericarditis
- D/C on NSAIDS only VS NSAIDS+ Colchicine- patient prefer the second options
- script for Colchicine given for a month and repeats at GP follow up , advised to take with Ibuprofen
- if symptoms reoccur or worsen, return to ED
- GP follow up in a week
- patient happy about the plan

Author
Name: Gurung, Sunita
Provider Number:
Position: BWH ED Doctor

****

ED Progress Note

24/03/23 19:50:48
*colchicine 500mcg, twice daily for 3 months + Ibuprofen

Print Date & Time: 24/03/2023 23:13 AEDT

Patient: COREY, MAX JAIM MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

ED Initial Assessment

24/03/23 17:51:46

Presenting Complaint
2/7 CP radiating into back, right arm pain, worse on movement and breathing, productive sputum for 2/12. THC and cigarettes +++. denies NV, loose stools yesterday, nil thc today hx pericarditis

History
28Y/M presented with right chest pain 2/7

HOPI
- gradual onset, right sided chest pain for 2 days, around lunch time
- radiating between scapula
- sharp in nature, last few sec
- relief on sitting up and still
- aggravating on movement/ movements of his right limbs and breathing, lying flat
- not associated with fever/ flu like symptoms , SOB, Sweating, N/V, palpitation

- cough on/off for few months - blackish sputum, sometimes fresh blood stains- no recent hemoptysis
- chain smoker- hasn't smoked since yesterday
- normal bowel/ bladder

- denied recent trauma / surgery to chest

Past history:
-Post Covid- 19 vaccine pericarditis- admitted for 2 days- colchicine was given
- patient advised had few issues after COVID vaccine/ COVID infection beside pericarditis: right leg feels heavy and tingling now and then- few investigations ? Nerve studies done- no obvious cause found. feeling of click on the throat while swallowing but no painful swallowing
- history of oral abscess- roof of mouth - last year
- previous history of ICE use, methadone abuse- been to jail - been clean for years
- denied other heart problems, blood clot or bleeding history

Medications
- Suboxone (buprenorphine 8mg/Naloxone 2mg) since 4 years- non-compliant since 2 months

Examination
O/E

-alert, no respiratory distress,
- nil pallor, nil pedal edema
-vitals stable : No tachycardiac/tachypnoea, afebrile

Recent Observations
Diastolic Blood Pressure: 100 mmHg (24/03/23 17:46:00)
Peripheral Pulse Rate: 63 bpm (24/03/23 17:46:00)
Respiratory Rate: 16 br/min (24/03/23 17:46:00)
SpO2: 99 % (24/03/23 17:46:00)
Systolic Blood Pressure: 155 mmHg (24/03/23 17:46:00)
Temperature Tympanic: 36.1 DegC (24/03/23 17:46:00)
Glasgow Coma Score (GCS): 15 (24/03/23 17:46:00)

- Throat: clear
- chest clear, nil ribs tenderness, nil spinal or scapular tenderness
Heart S1S2, murmurs couldn't appreciate

Impression & Plan
Rt pleuritic pain, worsen on lying and relief on sitting
ECG showed some saddle shaped ST elevations on anterior- lateral leads, I inversion in lead III

? Pericarditis
? Pneumonia
? PE, less likely (PERC 0)

Print Date & Time: 24/03/2023 23:13 AEDT

Patient: COREY, MAX JAIMI MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

? ACS

Plan:
- pain killer given - paracetamol
- initial BSL 1.6 so a cup of apple juice, sandwich, a cup of coffee given- denied dizzy, SOB
- FBE, UEC, CRP

D/W ED Consultant J. Furyk with thanks
- ASSU
- add NSAIDS , If not better might consider colchicine
- chest x-ray , troponin
- Qlagen

Progress Notes
- repeat BSL after E+D- 5.9, Ketones 0.1
- chest pain has improved

Author
Name: Gurung, Sunita
Provider Number:
Position: BWH ED Doctor

Admission to SSU
Bed Request SSU - Ordered
– 24/03/2023 17:52:00, ASSU, Cardiac Monitoring, Furyk, Jeremy SrDr

Referrals and Followup
No qualifying data available.

Author
Name: Gurung, Sunita
Provider Number:
Position: BWH ED Doctor

Print Date & Time: 24/03/2023 23:13 AEDT

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 **Age:** 27 years
Sex: Male

Emergency Department
272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4216 0112

Doctor Documentation

Document Type:	Discharge Summary
Service Date/Time:	26/05/2022 23:18 AEST
Result Status:	Auth (Verified)
Perform Information:	Abusheba,Abdussalam HMO (26/05/2022 23:18 AEST)
Sign Information:	Abusheba,Abdussalam HMO (26/05/2022 23:18 AEST)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 23 SWIFT WAY, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 26/05/2022 17:55
Date Discharge Letter Completed: 26/05/2022 23:18:05
Print & Post
Name:
Address:
Phone: Fax:

Principal Diagnosis
Chest pain, NEC
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
No current medications have been documented for this patient

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

ED Progress Note

26/05/22 23:16:24
Progress Notes
-nil clinical concern after reviewing his previous records
-d/c
-he left before final review and advice
Author
Name: Abusheba, Abdussalam HMO
Provider Number:
Position: BWH ED Doctor

ED Initial Assessment

26/05/22 20:34:35
Presenting Complaint
CP - intermittent - sharp - worse on palpation/movement - assoc nausea/diaphoresis - excerbation of chronic cough - Covid + 2/52 - ongoing symptoms since. worse this PM - 12L NSR w/ nil ischaemic changes.
History
27 y old Man with chronic non-specific left para-sternal chest pain since last Oct 2021 after first dose of covid-vaccine
-multiple attendances
-10 days into his covid
-a lot of frustration
-h/o pericarditis, with current insistence of same?!
-normal bloods and CT chest twices
-there is no clinical signs of PE/pneumothorax/ACS/thoracic A dissection/oesophageal rupture/pneumonia/pericarditis
-no physical signs
-So2 Sat 99, PR is 75,
-no h/o DVT/PE, <50 of age, no h/o recent surgery/immobilisation/ no hormonal therapy?!/ (PERC/Well's are therefore 0)
-ECG normal

Print Date & Time: 26/05/2022 23:18 AEST

Patient: COREY, MAX JAIMI MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

Examination
unremarkable
Impression & Plan
non-specific chronic chest pain, probably anxiety related
Cd/c
-GP counsellin
Author
Name: Abusheba, Abdussalam HMO
Provider Number:
Position: BWH ED Doctor

Admission to SSU
No admission orders to SSU found for this patient

Referrals and Followup
No qualifying data available.

Author
Name: Abusheba, Abdussalam HMO
Provider Number:
Position: BWH ED Doctor

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 **Age:** 27 years
Sex: Male

Urgent Care Centre
Barwon Health North
155 Princess Highway
Norlane VIC, 3214
Phone 03 4215 8000

Doctor Documentation

Document Type:	Discharge Summary
Service Date/Time:	13/01/2022 18:44 AEDT
Result Status:	Auth (Verified)
Perform Information:	Stanhope,Bernadette NP (13/01/2022 18:45 AEDT)
Sign Information:	Stanhope,Bernadette NP (13/01/2022 18:45 AEDT)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 23 SWIFT WAY, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 13/01/2022 17:47

Date Discharge Letter Completed: 13/01/2022 18:45:04
Print & Post
Name:
Address:
Phone: Fax:

Principal Diagnosis
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
No current medications have been documented for this patient

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

UCC Initial Assessment

13/01/22 16:34:00

Presenting Complaint
Difficulty breathing, tracheal discomfort, tachypnoeic, emotional. Clear air entry on auscultation. L) CP earlier today, resolved. Hx Pericarditis post vaccination. Social issues. COVID neg on 6/01/22

History
Male 27 years presents with discomfort in larynx
had pericarditis with Pfizer and was treated with ibuprofen and colchicine
presents tonight stating that he has clicking noises when he breaths in
states he had some chest pain earlier but denies chest pain now
states he has a really sore throat but pointing to outside of neck
states he is socially isolated and violent
seeking medication for anxiety
covid test negative 6/1
allergy to codeine

Examination
well alert and orientated
anxious

Recent Observations
Diastolic Blood Pressure: 79 mmHg (13/01/22 18:15:00)
Peripheral Pulse Rate: 84 bpm (13/01/22 18:15:00)
Respiratory Rate: 20 br/min (13/01/22 18:15:00)
SpO2: 100 % (13/01/22 18:15:00)
Systolic Blood Pressure: 144 mmHg (13/01/22 18:15:00)
Temperature Tympanic: 36.4 DegC (13/01/22 18:15:00)
Glasgow Coma Score (GCS): 15 (13/01/22 18:15:00)
eyes clear
resps - nil increase in wob , nil adventitious sounds on auscultation, nil tachypnoea
ECG - SR

Print Date & Time: 13/01/2022 18:45 AEDT

Patient: COREY, MAX JAIMI MR **DOB: 22/08/1994** **URN: 744224**

Doctor Documentation

Impression & Plan
? anxiety related - cannot rule out laryngeal cause
covid 19 tested
to ED for review suggested
DC

Author
Name: Stanhope, Bernadette NP
Provider Number: 4675634T
Position: BWH ED Nurse Practitioner

Admission to SSU
No admission orders to SSU found for this patient

Referrals and Followup
No qualifying data available.

Author
Name: Stanhope, Bernadette NP
Provider Number: 4675634T
Position: BWH ED Nurse Practitioner

Print Date & Time: 13/01/2022 18:45 AEDT

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 **Age:** 27 years
Sex: Male

Emergency Department
272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4215 0112

Doctor Documentation

Document Type:	Discharge Summary
Service Date/Time:	14/01/2022 09:28 AEDT
Result Status:	Auth (Verified)
Perform Information:	Carrigan,Jaimee INTERN (14/01/2022 09:28 AEDT)
Sign Information:	Carrigan,Jaimee INTERN (14/01/2022 09:28 AEDT)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 23 SWIFT WAY, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 13/01/2022 21:00

Date Discharge Letter Completed: 14/01/2022 09:28:24
Print & Post
Name:
Address:
Phone: Fax:

Principal Diagnosis
Dysphagia
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
No current medications have been documented for this patient

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

ED Initial Assessment

14/01/22 09:27:00
Presenting Complaint
Throat"clicking"onset 3/24 ago, discomfort in throat, nil airway compromise. COVID swabbed at BHN, nil other COVID Sx. Px: Pericarditis 10/7 ago. Nil distress at triage.

History
27M presents with throat discomfort

HoPC:
throat discomfort this evening, last 3/24
sensation / audible 'clicking'in throat on breathing and swallowing
associated feeling of dysphagia, feels as though there is lump in his throat
also causing sensation of dyspnoea
denies cough / coryza /
no ear concerns
no headache / focal neurology
feeling extremely anxious as result of symptoms tonight, states he is"absolutely freaking out"
reports significant exacerbation of anxiety following recent pericarditis Dx, particularly surrounding his health
wonders if he might have throat CA
also wonders about thyroid issues (mother has same)

PMHx:
1. pericarditis (Dx early Jan)
2. anxiety

Meds:
colchicine
ibuprofen
mirtazepine

Patient: COREY, MAX JAIMI MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

Allregies:
codeine

SHx:
home with partner / son
recently unemployed secondary to pericarditis Dx
smoker, recently cut back secondary to pericarditis Dx
regular EtOH, 1-2 std drinks a few times a week
regular cannabis, 3 cones per day, has recently cut back / previously much more (100/day)
denies other drugs, however reports previously used ICE - nil 4 yrs

Examination
HR 99, BP 144/80, RR 18, SpO2 99%, afebrile
well looking young man
appears anxious ++, pacing

A: own, no stridor
B: speaking in full sentences (speech quite pressured), chest clear, SpO2 100% on RA

tonsils appear normal
no palpable thyroid enlargement / nodule, no palpable cervical nodes, no other masses
no exophthalmus, tremor, etc

Ix:
Bloods NAD - WCC 11.7, CRP 3.4, TSH normal

Impression & Plan
Imp:
? Globus pharyngis
? Vocal cord nodule
? Anxiety
No evidence of airway obstruction warranting imaging / further Ix in ED tonight
Reassurance offered +w
I wonder if nicotine withdrawal could be worsening Max's anxiety, offered nicotine patch however
he has declined this

D/W Snr ED Reg Amy Wark

Plan:
1. home
2. GP follow-up if symptoms persisting / to address ongoing anxiety concerns
3. aware to look out for voice changes / stridor /

Author
Name: Carrigan, Jaimee HMO
Provider Number: 5757902K
Position: BWH ED Doctor

Admission to SSU
No admission orders to SSU found for this patient

Referrals and Followup
No qualifying data available.

Author
Name: Carrigan, Jaimee HMO
Provider Number: 5757902K
Position: BWH ED Doctor

 Print Date & Time: 14/01/2022 09:28 AEDT

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 **Age:** 27 years
Sex: Male

Emergency Department
272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4215 0112

Doctor Documentation

Document Type:	Discharge Summary
Service Date/Time:	17/01/2022 02:29 AEDT
Result Status:	Auth (Verified)
Perform Information:	Geffen,Rebecca (17/01/2022 02:29 AEDT)
Sign Information:	Geffen,Rebecca (17/01/2022 02:29 AEDT)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 23 SWIFT WAY, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 16/01/2022 22:19

Date Discharge Letter Completed: 17/01/2022 02:29:11
Print & Post
Name:
Address:
Phone: Fax:

Principal Diagnosis
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
No current medications have been documented for this patient

Allergies
codeine (Abdominal pain)

ED/ICC Procedures
No Procedures found during this visit

ED Initial Assessment

17/01/22 00:51:00
Presenting Complaint
pt states'everything is wrong with me'. reports sore/swollen left testicle for 1/52-has seen GP for this, reporting cough/SOB-has had negative covid result, nil WOB. current pericarditis. tonight states'everything is way worse'.
History
27 M presented with left testicular pain and clicking sensation in throat
- reports has had testicular pain since start of the week. exacerbated by cough. described as dull pain with intermittent sharp pain shooting from groin into testes.
- saw GP and had STI screen for gonorrhoea / chlamydia which was negative. Also had negative MSU.
- Had IM abx injection and has also been taking PO abx past 4 days. unsure what.
- Today noticed swelling left testicle. Pain not changed but swelling new.
- nil trauma / previous surgeries to area
- nil urinary syx
- reports been feeling slightly sweaty and hot but nil documented fevers
- nil nausea / vomiting
- slightly constipated and testicular pain worsened by opening bowels

- also c/o mucous stuck base of throat and feels like can't get full breath of air in. describing globus sensation.
- reports clicking in throat when swallows
- nil post-nasal drip
- nil acid reflux / waterbrash
- long standing phlegm production - clear phlegm with black flecks. nil change recently.
- Nil cough / SOB
- GP started on course amoxicillin today

PMH
- pericarditis (Dx early Jan)

Patient: COREY, MAX JAIMI MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

- anxiety

DHx
- colchicine
- ibuprofen
- PPI
- mirtazapine
- started amox today
- completing course abx for presumed STI (d4 today)

Allergies - codeine

SH
- home with partner / son
- recently unemployed secondary to pericardills Dx. was concreter.
- smoker
- 1-2 drinks few times a weekbut not for past week when unwell
- regular cannabis, 3 cones per day, has recently cut back / previously much more (100/day)
- denies other drugs, however reports previously used ICE - nil 4 yrs
- suboxone program. collects weekly

Examination
Nil stridor / airway compromise
Nil cervical lymphadenopathy
cool peripheries
CRT <2s
HS I+II+0
Chest clear with equal air entry bilaterally
Abdo - Bowel sounds present and normal, abdo SNT
Scrotal exam- both sides: nil hydrocele/ varicocele. Nil palpable mass. Mild reported tenderness to palpate left testes. Nil epididymal tenderness. Nil cough reflex for hernia bilaterally
Calves SNT

Impression & Plan
Imp - testicular pain ?cause

Plan
- for home with GP f/up (has appt booked tomorrow).
- o/p US. Max aware to chase results from GP

Author
Name: Geffen, Rebecca
Provider Number:
Position: BWH ED Doctor

****

ED Initial Assessment

17/01/22 00:51:00
Discussed with Reg Henderson -for home

Author
Name: Geffen, Rebecca
Provider Number:
Position: BWH ED Doctor

Print Date & Time: 17/01/2022 02:29 AEDT

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 **Age:** 27 years
Sex: Male

Emergency Department
272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4215 0112

Doctor Documentation

Document Type:	Discharge Summary
Service Date/Time:	30/05/2022 06:09 AEST
Result Status:	Auth (Verified)
Perform Information:	Lee,Jeremy (30/05/2022 06:10 AEST)
Sign Information:	Lee,Jeremy (30/05/2022 06:10 AEST)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 23 SWIFT WAY, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 30/05/2022 01:20
Date Discharge Letter Completed: 30/05/2022 06:09:58
Print & Post
Name:
Address:
Phone: Fax:

Principal Diagnosis
Paraesthesia of skin
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
No current medications have been documented for this patient

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

ED Initial Assessment

30/05/22 03:53:03
Presenting Complaint
R and L leg numbness and tingling intermittently on b/g abdo cramping for multiple months.
Unable to sleep. Also c/o bubbling feeling in brain. Recent COVID- cough.
History
Self presents to ED this evening with long standing intermittent lower limb numbness
Hx of same for past 1-2/12, initially affecting right lower limb
Over past week, has experienced intermittent left lower limb numbness
Symptoms typically worse at night time
Unable to sleep tonight as a result
Presented to ED for further assessment

ALso reporting intermittent"bubbling"in head
No assoc motor deficit
No visual changes or slurring
Saw GP 1/52 prior with same
CT L spine organised and performed 3/7 prior at lake imaging
- Report not yet available on system
Well otherwise with no fevers, shakes or chills
No trauma
No cough, cold, coryzal symptoms
Long hx of THC use

PHx:
Anxiety
Depression

Meds:
Mirtazapine
Suboxone
NSAIDS

SHx:

Print Date & Time: 30/05/2022 06:10 AEST

Patient: COREY, MAX JAIMI MR **DOB: 22/08/1994** **URN: 744224**

Doctor Documentation

THC use
- 2-3g daily
Smoker 10 ciggs/day
Occasional ETOH

Examination
Seen in assessment cubicle
Self ambulated in
No gait changes
Patient unable to lay flat for examination
- Feeling too uncomfortable when laying flat (noted, was lying flat on WR couch)
- As such, formal neurological examination unable to be performed

Neurologically grossly intact with good control of all 4 limbs
Declined remaining formal examination

Impression & Plan
Imp:
Non specific symptoms of intermittent lower limb paraesthesia
- No motor deficits or features clinically concerning for CVA
- Less likely demyelination type syndrome (given intermittent nature of symptoms), unlikely MS
- No other clear focal infective features
- ?Sciatia (likely already being investigated by GP with recent CT)
- ?THC related symptoms

Plan:
Discharge home
Encouraged GP follow up to chase CT report and to consider MRI if needed
Diazepam 5mg given as requested here in ED
Return to ED if worsening or new neurological symptoms, or if further concerns

Author
Name: Lee, Jeremy
Provider Number: 5377577F
Position: BWH ED Doctor

Admission to SSU
No admission orders to SSU found for this patient

Referrals and Followup
No qualifying data available.

Author
Name: Lee, Jeremy
Provider Number: 5377577F
Position: BWH ED Doctor

Print Date & Time: 30/05/2022 06:10 AEST

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 **Age:** 27 years
Sex: Male

Emergency Department
272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4215 0112

Doctor Documentation

Document Type:	Discharge Summary
Service Date/Time:	02/07/2022 17:12 AEST
Result Status:	Auth (Verified)
Perform Information:	Campbell,Fraser (02/07/2022 17:13 AEST)
Sign Information:	Campbell,Fraser (02/07/2022 17:13 AEST)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 23 SWIFT WAY, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 01/07/2022 19:57
Date Discharge Letter Completed: 02/07/2022 17:12:52
Print & Post
Name: KNIGHCO01MCMC01 -KNIGHT, COLIN
Address:
Phone: Fax:

Principal Diagnosis
Blurred vision
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
Home Medication List: Colchicine
Nurofen (02/07/22 04:57:00)

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

SSU Progress Note/Ward Round

02/07/22 17:11:39
History
LL symptoms impression fromeuro was meralgia parasthesia
pregebalin increased to 75/150mg daily
Author
Name: Campbell, Fraser
Provider Number:
Position: BWH ED Doctor

****

SSU Progress Note/Ward Round

02/07/22 17:06:22
History
still some ongoing floaters with largactil.
d/w neurology reg option given to patient admission vs urgent OP MRI and follow up neuro clinic
opted for OP follow up
MRI requested.
Neuro follow up

was also reviewed by opthalmolgy reg re review in 4 week in clinic
Author
Name: Campbell, Fraser
Provider Number:
Position: BWH ED Doctor

****

SSU Progress Note/Ward Round

Print Date & Time: 02/07/2022 17:13 AEST

Patient: COREY, MAX JAIMI MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

02/07/22 09:04:50
History
WR Richards/Campbell
examination
complains of siplopia on left and right horizolontal gaze
normal eye movement
no RAPD
normal CN
power 5/5 upper limbs
power 5/5 lower limbs
down going plantars
mild hyperreflexia
no clonus normal tone

on mitrazapine pantaprazole pregabalin
Author
Name: Campbell, Fraser
Provider Number:
Position: BWH ED Doctor
ED Progress Note

02/07/22 08:50:44
History
SSU WR Richards/Campbell

Feels dizzy black dots both eyes when closing eyes. first noticed when walking through 2 days ago shopping centre blurred vision both eyes. Sudden onset. Still described'squiggly lines'and black dots both eyes moves around. Nil previous episodes like this.
Denies headache
some nausea nil vomiting
some dizziness lightheaded on moving head

Bilateral leg burning can occur one at a time sometimes both.
patient very concerned that he might have MS

nil known rhx medical conditions
Impression & Plan
?ocular migraine
neuro review.
CTB
aspirin +metoclopramide
Author
Name: Campbell, Fraser
Provider Number:
Position: BWH ED Doctor

ED Initial Assessment

02/07/22 02:34:02
Eye pressure R (14) and L (13)
ECG done

****

ED Initial Assessment

02/07/22 02:34:02
Presenting Complaint

Patient: COREY, MAX JAIMI MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

-more on the left than the right
- no concerns with vision (he is able to walk from ED WR to SSU) no bumping
- no double vision
- no concern with colour vision (? MS)
- he was able to read his emails on his phone

c/o of headache b/l not sudden headache currenlty feeling much better

c/o of nausea no vomiting and head spinning half a turn. no drowziness no weakness in the hand or feet

previous h/o of marujuina consumption 2 weeks ago regular intake 1 gm

smoker +
Diet - no dietary restriction
prev h/o of colchine for pericarditis
post covid 6 weeks back
CT spine at lake imaging done showing L5- S1 minor disc buldge (could be related to the right leg pain)

Examination
O/E
Recent Observations
Diastolic Blood Pressure: 86 mmHg (02/07/22 02:31:00)
Peripheral Pulse Rate: 80 bpm (02/07/22 02:31:00)
Respiratory Rate: 17 br/min (02/07/22 02:31:00)
SpO2: 100 % (02/07/22 02:31:00)
Systolic Blood Pressure: 145 mmHg (02/07/22 02:31:00)
Temperature Tympanic: 36.8 DegC (02/07/22 02:31:00)
Glasgow Coma Score (GCS): 15 (02/07/22 02:31:00)

Eye exam
R and L
VA- 6/6 (R and L)
Visual filed - normal in the R and L
accomdation - Normal in R and L
cover and uncover test - normal no diplopia
saying he can see wriggly lines
CNS - NFND

Impression & Plan
bloods
assess
opthal review outpatient vs inpatient tomorrow mane

Author
Name: Serrao, Samantha
Provider Number:
Position: BWH ED Doctor

****

ED Initial Assessment

02/07/22 02:34:02
no nystagmus or double vision
HINTS exam - nad

Admission to SSU
Bed Request SSU - Completed
– 02/07/2022 02:12:00, ASSU, Standard, Serrao, Samantha

Patient: COREY, MAX JAIMI MR **DOB: 22/08/1994** **URN: 744224**

Doctor Documentation

Referrals and Followup
Outpatient Clinic Referral - Ordered
-- 02/07/2022 13:56:00, Specialty/Service: Ophthalmology, Reason for Referral: spots and floaters seen by opthalmolgy reg nil visualised but advised follow up clinic 4 weeks for rpt dilated exam, Urgent

Author
Name: Campbell, Fraser
Provider Number:
Position: BWH ED Doctor

Print Date & Time: 02/07/2022 17:08 AEST

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 **Age:** 27 years
Sex: Male

Emergency Department
272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4215 0112

Doctor Documentation

Document Type: Discharge Summary
Service Date/Time: 04/07/2022 22:04 AEST
Result Status: Auth (Verified)
Perform Information: McRae,Christopher REG (04/07/2022 22:04 AEST)
Sign Information: McRae,Christopher REG (04/07/2022 22:04 AEST)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 23 SWIFT WAY, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 04/07/2022 14:29
Date Discharge Letter Completed: 04/07/2022 22:04:15
Print & Post
Name:
Address:
Phone: Fax:

Principal Diagnosis
Headache, migraine
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
No current medications have been documented for this patient

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

ED Initial Assessment

04/07/22 15:49:08
Presenting Complaint
represents with L) eye pain and blurred vision. waiting O/P MRI brain. reports worsening eyesight and increasing pain behind eye.
History
27y/o M Px worsening eye Sx since D/C 2/7 ago from SSU with Dx migraine w/eye Sx. Had floaters & bright light, some headache & nausea. Also seen by opthal reg, no ocular cause for floaters but dilated eye exam noted pigmented lesions in R eye with plan for f'up r/v in 4/52. CTB normal, has OP MRIB booked for next Monday.

Since d/c home:
Black floaters & bright light have increased. Black floaters L>R, worsen with bright environment, less when it's dark.
Also blurring of vision & new right eye pain. Pain feels sharp ache & pulsating eye ball 5-6/10 severity
Light sensitivity
No headache currently, only last night
Nausea but no vomiting
No neck pain/stiffness but pain turning head to the R side & upwards only, not downwards of L side.
Minor tearing of R eye but no discharge & no redness

No fever
No muscle aches/pain apart from LL Dx meralgia paraesthetica with numbness & pain down bilat leg (on Lyrica)
No Hx migraine in past but headaches pulsating
No trauma Hx or potential FB in eye. Nil grittiness

Reported the largactil did not help with his Sx previously, still had the floaters on d/c

MedHx:
Pericarditis post covid19 vax, Rxed 3/12 colchicine. Still uses it PRN
Opioid use/abuse, on OSTP

Print Date & Time: 04/07/2022 22:04 AEST

Patient: COREY, MAX JAIMI MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

Meds:
Lyrica 75mg BD (have not started increasing nocte dose to 150mg as yet)
Suboxone SL 16mg D
Mirtazapine 15mg nocte
Colchicine PRN

SHx:
Home with mom
Used to work concreter, not anymore
Occ cigarete smoke
Marijuana 2g daily, 3g on weekend
Occ ETOH

Examination
Pupils 4mm, reactive bilaterally + consensual
VA R 6/9 L 6/12 (was 6/6 before)
+ve red reflex
Full eye ROM, nil nystagmus. Pain on R lateral gaze
Nil proptosis
Nil conjunctivitis, nil tearing
Normal sensory face to touch bilat
Normal muscle mastication, nil trismus. Nil sensitivity over temple
Normal visual fields

Nil meningism.

Impression & Plan
R eye pain ?cause ?recurrence ocular migraine

D/W ED Consultant, suggest speaking to neuro
Can trial re-treatment as per prvs w/largactil

Progress Notes
D/W Neuro reg C. Butcher

Suggest trial aspirin 900mg & largactil 12.5mg in 1L over 1/24
Will review pt w/thanks & admission for inpt MRIB
Request to notify/ discuss with opthal re: pt's representation --> they will r/v pt tomorrow as inpatient if admitted or OP if he gets discharged. Request to notify if pt is discharged home instead

Author
Name: Ibrahim, Nur
Provider Number:
Position: BWH ED Doctor

Admission to SSU
No admission orders to SSU found for this patient

Referrals and Followup
No qualifying data available.

Author
Name: McRae, Christopher REG
Provider Number: 4748204H
Position: BWH ED Doctor

Print Date & Time: 04/07/2022 22:04 AEST

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 **Age:** 27 years
Sex: Male

Emergency Department
272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4215 0112

Doctor Documentation

Document Type: Discharge Summary
Service Date/Time: 23/07/2022 23:32 AEST
Result Status: Auth (Verified)
Perform Information: Thomas,Nicole HMO (23/07/2022 23:36 AEST)
Sign Information: Thomas,Nicole HMO (23/07/2022 23:36 AEST)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 23 SWIFT WAY, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 23/07/2022 16:02
Date Discharge Letter Completed: 23/07/2022 23:32:40
Print & Post
Name:
Address:
Phone: Fax:

Principal Diagnosis
Headache / Facial pain
Additional Diagnoses

Past Medical History/Alerts List
Chronic
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
No current medications have been documented for this patient

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

ED Progress Note * Preliminary *

23/07/22 21:17:24
Medical Update

27y M
R retroorbital headache with visual floaters

Ophthalmology an Neurology input
- impression cluster headache
- currently having ophthalmology review

Trialled high flow O2 and Sumatriptan as per Neurology
- definite improvement in symptoms
- visual symptoms/floaters now gone
- R retroorbital pain reduced from 10/10 to 4/10

Discussed with Neurology Reg Michael
- happy he does not need to be reviewed by them and that there is no organic pathology (based on previous admissions/imaging)
- suggested discharge home on increasing dose Verapamil and GP review for ECG changes
- for OPD follow-up in Neurology clinic

ED Initial Assessment

23/07/22 16:54:34
ED Initial Assessment

27y M
R eye pain and floaters?
Has presented here with same over past month

HPC:
Presents with ongoing visual floaters and R eye pain (representation with same)
- commenced ~3/52 ago

Print Date & Time: 23/07/2022 23:36 AEST

Patient: COREY, MAX JAIMI MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

- presented here and seen by both Neuro and Ophthalmology
Impression ?ocular migraine

Admitted early July under Neurology ?ocular migraine
Trialled aspirin and largactil, nil effect as per patient
Neurology impression meralgia parasthesia - increased pregabalin dose
Ophthalmology normal eye examination, plan for MRI Brain and OPD clinic review 4/52 (pending)
Some multiple hyperdense lesions on MRI brain ?migraine

R eye pain (retroorbitally)
- constant, worse on eye movement
Visual blurring intermittently
Visual floaters bilaterally

Nil fevers
Denies headache
Some nausea, nil vomits
Nil coryzal symptoms
Bilateral lower limb paraesthesia ?meralgia paraesthesia
- trialling pregabalin but nil improvement as per patient
Nil upper or lower limb weakness
Able to mobilse within department

Largely normal bloods
Normal CT Brain

PMHx:
Pericarditis post COVID vax
Nil other medical conditions

Meds:
Lyrica 75mg BD (have not started increasing nocte dose to 150mg as yet)
Suboxone SL 16mg OD
Mirtazapine 15mg nocte

NKA

Social Hx:
Living with partner and son
Marijuana use daily

O/E:
Awake, alert, interactive
Mobilised into department ok

Recent Observations
Peripheral Pulse Rate: 89 bpm (23/07/22 16:03:00)
Respiratory Rate: 16 br/min (23/07/22 16:03:00)
SpO2: 98 % (23/07/22 16:03:00)
Glasgow Coma Score (GCS): 15 (23/07/22 16:03:00)

Visual acuity
R 6/6-1 L 6/6

PEARL
Nil RPAD

Slit lamp examination NAD
Fluoroscein staining NAD

Print Date & Time: 23/07/2022 23:36 AEST

Patient: COREY, MAX JAIMI MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

Tonometer eye pressures
R 22 L 27

Imp:
R retro-orbital pain and visual floaters ?cause
DDx optic neuritic /ocular migraine / cluster headache

Plan:
1. Analagesia PRN
2. Opthalmology review
   - reviewing currently, also suggested Neurology input
3. Neurology review
   - have asked for management of ?cluster headache (high flow O2, sumatriptan) and reassess
4. Reassess post above

Admission to SSU
No admission orders to SSU found for this patient

Impression & Plan
Cluster headache
Offered admission for further analagesia but declined
Discharged home with plan for increasing Verapamil dose as preventative measure for cluster headache
Needs close monitoring with GP for Verapamil dosing
Safety netted re when to return to ED for review

Follow Up Recommendations
GP review
- needs close monitoring (ECG) and apprporiate uptitration of Verapamil as per eTG guidelines
OPD Neurology Clinic review (referred, awaited)
Safety netted re when to return to ED for review

Referrals and Followup

Date and Time	Location	Type
25/JUL/22 08:45		iPM Appointment

No qualifying data available.

Author
Name: Thomas, Nicole HMO
Provider Number: BH253681
Position: BWH ED Doctor

Print Date & Time: 23/07/2022 23:36 AEST

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 **Age:** 28 years
Sex: Male

Emergency Department
272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4215 0112

Doctor Documentation

Document Type: Discharge Summary
Service Date/Time: 12/10/2022 17:38 AEDT
Result Status: Auth (Verified)
Perform Information: Angel,Cara REG (12/10/2022 17:38 AEDT)
Sign Information: Angel,Cara REG (12/10/2022 17:38 AEDT)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 18B THRUSH ST, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 12/10/2022 08:27
Date Discharge Letter Completed: 12/10/2022 17:38:54
Print & Post
Name:
Address:
Phone: Fax:

Principal Diagnosis
Quinsy / Peritonsillar abscess
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
No current medications have been documented for this patient

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

ED Progress Note

12/10/22 13:21:07
Progress Notes
Reviewed and admitted by ENT registrar
- Quinsy drained
Author
Name: Angel, Cara REG
Provider Number: 5073211J
Position: BWH ED Doctor

ED Initial Assessment

12/10/22 11:41:49
Presenting Complaint
2/7 days of worsening throat pain, increased redness to mouth, difficulty swallowing due to pain,fevers, general body aches, dec PO intake, nil Vom/diarrhoea. recent tonsillitis finished PO abx 1/7 ago. Pale, dry MM.
History
28 year old male presents with 2 day history of worsening sore throat, unable to tolerate oral intake, fevers, myalgias
- Background of Glandular fever, has been on oral antibiotics for tonsillitis last dose yesterday
- Reports difficulty opening mouth
- Has missed this morning suboxone dose

Past History
- Pericarditis post COVID vacine

Allergies: codeine

Medications:
- Suboxone 16mg daily
- Colchicine
- Pregabalin

Print Date & Time: 12/10/2022 17:39 AEDT

Patient: COREY, MAX JAIMI MR **DOB:** 22/08/1994 **URN:** 744224

Doctor Documentation

Examination
GA: pale, sweaty, speaking in short sentences, appears unwell
A - reduced mouth opening / left sided swelling back of throat / normal neck movements with pain
B - RR 20 O2sats 99RA / air entry to bases bilaterally
C - HR 71 BP 136/79 / dual HS nil added
D - GCS 15 / pupils equal and reactive
E - afebrile

Abdo - soft / non-tender

Impression & Plan
Impression:
- Peritonsillar abscess left side / septic

Plan:
- Reviewed by FACEM (D Eddey) initially with IVC / bloods / medications charted
- Moved to resus
- For IV antibiotics (benzylpenicillin / metronidazole)
- Dexamethasone
- Analgesia
- IV fluids
- Referred to ENT registrar oncall phone, currently scrubbed, nurse to speak to registrar and will call back

Author
Name: Angel, Cara REG
Provider Number: 5073211J
Position: BWH ED Doctor

Admission to SSU
No admission orders to SSU found for this patient

Referrals and Followup

Date and Time	Location	Type
13/OCT/22 14:00		iPM Appointment

No qualifying data available.

Author
Name: Angel, Cara REG
Provider Number: 5073211J
Position: BWH ED Doctor

Print Date & Time: 12/10/2022 17:39 AEDT

Barwon Health

Patient: COREY, MAX JAIMI MR
URN: 744224
DOB: 22/08/1994 **Age:** 28 years
Sex: Male

Emergency Department
272 Ryrie Street
Geelong
University Hospital Geelong
Phone 03 4215 0112

Doctor Documentation

Document Type: Discharge Summary
Service Date/Time: 14/10/2022 20:39 AEDT
Result Status: Auth (Verified)
Perform Information: Jamieson,Ruairidh NP (14/10/2022 20:39 AEDT)
Sign Information: Jamieson,Ruairidh NP (14/10/2022 20:39 AEDT)

Admission Information

COREY, MAX JAIMI MR
URN: 744224 DOB: 22/08/1994 Sex: Male
Home address: 18B THRUSH ST, Locked Bag 7, NORLANE 3214, Australia
Home Phone: 5220 82222 Mobile Phone: x
Unit: Emergency
Admitted: 14/10/2022 11:24
Date Discharge Letter Completed: 14/10/2022 20:39:32
Print & Post
Name:
Address:
Phone: Fax:

Principal Diagnosis
Quinsy / Peritonsillar abscess
Additional Diagnoses

Past Medical History/Alerts List
Ongoing
No qualifying data
Historical
No qualifying data

Past Procedure History

Medications
No current medications have been documented for this patient

Allergies
codeine (Abdominal pain)

ED/UCC Procedures
No Procedures found during this visit

ED Initial Assessment

14/10/22 12:44:45
Presenting Complaint
Oral roof of mouth abscess drained Wed- DC Thurs. Increased swelling pain & difficulty swallowing AB's/analgesia. OE: L tonsillar swelling, nil uvula swelling. Erytheama to roof of mouth. Subjective fevers. A- patent, swallowing secretions/nil drooling.
History
See recent ED notes
(inpatient notes currently unavailable on BOSS)
I&D quinsy and admitted under ENT 2/7 ago. D/C yesterday.
Represents with increasing pain and difficulty swallowing / L throat swelling
No rigors.
Tolerating oral fluids

Examination
Recent Observations
Peripheral Pulse Rate: 64 bpm (14/10/22 11:25:00)
Respiratory Rate: 16 br/min (14/10/22 11:25:00)
SpO2: 99 % (14/10/22 11:25:00)
Temperature Tympanic: 36.1 DegC (14/10/22 11:25:00)
Glasgow Coma Score (GCS): 15 (14/10/22 11:25:00)

Able to swallow
No trismus
No voice changes
Marked L peritonsillar swelling with uvula deviation.
No FOM / neck swelling.
Impression & Plan
D/W ENT reg (Olivia) - knows patient - little pus on I&D / needle aspirate
- requesting CT neck to quantify and locate anatomically collection if present
- B.Penicillin 2.4gms 4/24.
- admit
Author
Name: Smith, Darren NP

Print Date & Time: 14/10/2022 20:39 AEDT

Patient: COREY, MAX JAIMI MR **DOB: 22/08/1994** **URN: 744224**

Doctor Documentation

Provider Number: 4427814H
Position: BWH ED Nurse Practitioner

Admission to SSU
No admission orders to SSU found for this patient

Referrals and Followup
No qualifying data available.

Author
Name: Jamieson, Ruaridh NP
Provider Number: BH248975
Position: BWH ED Nurse Practitioner

Print Date & Time: 14/10/2022 20:39 AEDT