SAN GABRIEL VALLEY MEDICAL CENTER
438 W LAS TUNAS DRIVE
SAN GABRIEL, CA 91778

---------NAME--------- NUMBER SEX AGE ADMIT DISC. XRAY# F/C TYPE
GAN HONG 30858401 F 50 2/17/19 826190 RO4 E/R
DATE OF BIRTH: 12/06/1968 M/R# 826190 PH#: 626-235-9275 RM ER14A

LOCATION: RADIOLOGY-DIAGN TRANSCRIBED: 02/17/19 20:58 mpa
US DPLX VENOUS LOW EXT (L) 93971 COMPLETED:02/17/19 20:53 cza 46839
{REASON FOR VASCULAR: SWOLLEN EXTREMITY

PHYSICIAN: WU KENNY K CHAN JENNI

RADIOLOGY REPORT

PROCEDURE: VENOUS DUPLEX OF THE LEFT LOWER EXTREMITY

COMPARISON: None.

INDICATIONS: SWOLLEN EXTREMITY

TECHNIQUE: Multiple grayscale, color Doppler and spectral waveform techniques were used to create images of the venous system in the left lower extremity.

FINDINGS:

The deep venous system of the left lower extremity is evaluated from the level of the common femoral vein to the proximal calf.
The proximal greater saphenous vein is also interrogated.
No filling defects are identified
There is normal compressibility and augmentation throughout
The peroneal vein is not identified in the calf. There is no clot in the popliteal vein.
There are no abnormal fluid collections to suggest abscess or hematoma

CONCLUSION:

1. No evidence venous thrombosis in the left lower extremity.

Dictated by: MIGUEL PALOS M.D. on 2/17/2019 at 20:55
Approved by: MIGUEL PALOS M.D. on 2/17/2019 at 20:57

SAN GABRIEL VALLEY
Medical Center, AHMC

San Gabriel Valley Medical Center
438 West Las Tunas Drive
San Gabriel CA 91776

EMERGENCY DEPARTMENT DISCHARGE INSTRUCTIONS & REFERRAL

Current Date: 021719 **Current Time:** 2107

Patient Name: GAN HONG **Account Number:** 30858401 **Medical Record Number:** 826190
Date of Birth: 12061968 **Gender:** F **Admitting Physician:** WU KENNY K

YOU HAVE RECEIVED THE FOLLOWING CHECKED DIAGNOSTIC STUDIES, WHICH YOU CAN BRING TO YOUR PRIMARY DOCTOR:

- ☐ LABORATORY EXAMS
- ☐ X-RAY EXAMS
- ☐ ELECTROCARDIOGRAM (EKG)
- ☐ ULTRASOUNDS
- ☐ CT SCAN

Your EKG and labs are given to you with this document. For other documents from your medical record, you may contact our Medical Records Department at (626) 570-6630.

You may be contacted by us if review of pending labs, X-rays, or EKG's reveals additional information.

PROVISIONAL DIAGNOSIS:
1. DERMATITIS
2.
3.
4.

ER PHYSCIAN AFTER CARE INSTRUCTIONS:

FOLLOW UP WITH YOUR PRIMARY CARE DOCTOR WITHIN 2-3 DAYS FOR A REFERAL TO VASCULAR SURGERY. TAKE ALL MEDICATIONS AS PERSCRIBED. RETURN TO THE ER FOR ANY WORSEINING SYMPTOMS.

☐ **Abdominal Pain**	☐ **Abrasion / Laceration**	☐ **Abscess**
☐ **Back Pain**	☐ **Bronchitis / Pneumonia**	☐ **Chest Pain**
☐ **Cold / Flu / Viral Syndrome**	☐ **Ear Infection**	☐ **Headache**
☐ **Head Trauma / Concussion**	☐ **Neck Pain**	☐ **Pharyngitis / Tonsilitis**
☐ **Splint Care**	☐ **Sprain / Strain / Bruises / Fracture**	☐ **Urinary Tract Infection / Bladder Infection**
☐ **Vaginal Bleeding**	☐ **Vomiting and Diarrhea**	

List of Medications:

New medication prescribed from Emergency Department:

Drug Name	Strength	Directions
TRIAMCINOLONE	0.1% CREAME	APPLY TWICE A DAY FOR 1 WEEK TO THE REDNESS

Notes:

☑ Additional Medication

New medication prescribed from Emergency Department:

Drug Name	Strength	Directions

keflex	500MG	TAKE ONE TAB TWICE A DAY FOR 1 WEEK.

Notes:

☐ Additional Medication

☐ Additional Medication

☐ Additional Medication

IF YOUR PROBLEM DOES NOT IMPROVE OR GETS WORSE, CONTACT YOUR PRIMARY PHYSICIAN OR THE REFERRAL HEALTH CARE RESOURCE IMMEDIATELY, OR RETURN TO THE EMERGENCY DEPARTMENT.

☐ Follow up with your primary physician, Dr. ____ in __ day(s).

☐ May return to work / school.

☐ No work / school for ____ day(s).

☐ No physical education for ____ day(s).

Comments:

1. If you receive or take narcotics or sedating medications, we recommend not to drive or operate heavy machinery for 12 hours after your last dose. If after 12 hours you feel dizzy or sleepy, extend this period to 24 hours.
2. Children must be secured in appropriate child passenger restraints (safety seat or booster seat) until they are at least 8 years old or a height of at least 4' 9."

I hereby acknowledge that I have received and understand the instructions above and that I will arrange for follow-up care as instructed.

Patient/Representative Signature

Date: 021719

Witness Signature

Date 021719