

RECEIVED

APR 19 2012

PA PUBLIC UTILITY COMMISSION  
SECRETARY'S BUREAU

2100 W 4th Street  
Chester, PA, 19013  
April 17, 2012

F-2011-2266250

Commonwealth of Pennsylvania  
Pennsylvania Public Utility Commission  
PO Box 3265,  
Harrisburg, Pa 17105-3265

To Whom It May Concern:

Enclosed are copies of my hospital admission & discharge records. I Deborah Bethany had Bi-lateral Knee replacements on the dates of my hearing with the Electric Company and the PUC. Also I was sent to Rehabilitation Facility at Taylor Hospital 175 E. Chester Pike Ridley Park, Pa 19078.

Thank you  
Deborah/Bethany  
(Exceptions)



ND0080

- CROZER
- DCMH
- COMMUNITY HOSPITAL
- SPRINGFIELD HOSPITAL
- TAYLOR HOSPITAL

BETHAY, DEBORAH J 58  
MR# 192422252 08/31/1953

adm: 03/21/12

**RECEIVED**



APR 19 2012

PT#: 10025984179

**PA PUBLIC UTILITY COMMISSION**  
Palmer **SECRETARY'S BUREAU**

**INTER DISCIPLINARY PATIENT EDUCATION RECORD**

**EDUCATION PROVIDED**

**LIVING WITH VASCULAR DISEASE**

- smoking cessation
- foot/skin care
- appropriate garments
- hygiene
- trouble signs

**LIVING WITH STROKE / TIA  
NEUROLOGIC DISEASE**

- safety techniques
- alternative communication
- trouble signs
- warning signs/symptoms of stroke
- activation of EMS systems
- personal risk factors:  
(circle items reviewed)  
hypertension, dyslipidemia, diabetes, heart disease, atrial fibrillation, prior stroke/TIA, obesity, other: \_\_\_\_\_
- medications: antiplatelets, antihypertensive, statins, anticoagulants, other: \_\_\_\_\_  
(circle medications reviewed)
- follow-up after discharge

**LIVING WITH HEART DISEASE**

- smoking cessation
- lowering cholesterol
- exercise tolerance
- prudent nutrition
- trouble signs

**POST CARDIAC CATHETERIZATION**

- groin care
- closure devices
- dressing changes
- nutrition
- activity
- trouble signs

**INTERVENTIONAL PROCEDURES**

- groin care
- closure devices
- dressing changes
- nutrition
- activity
- trouble signs

**LIVING WITH DIABETES**

- measuring blood glucose
- role of diet
- oral agents
- insulin administration
- sick day guidelines
- trouble signs

**LIVING WITH RENAL DISEASE**

- home peritoneal dialysis
- nutrition
- fluid management
- graft care
- trouble signs

**PROCEDURAL EDUCATION**

- general information
- pre-procedural restrictions
- post-procedural restrictions
- diet modification
- smoking cessation
- activity guidelines
- trouble signs

**WOUND CARE / SURGICAL SITE**

- dressing change
- special wound care products
- nutrition
- positioning
- S/S of infection
- surgical site care

**TUBE FEEDING**

- tube care
- administration techniques
- placement verification
- positioning
- equipment

**SUCCESSFUL RETURN DEMO**

- blood glucose monitoring
- insulin administration
- subcutaneous injection
- intramuscular injection
- crutch/crane walking
- tube feeding
- wound care
- dressing change
- trach care
- suctioning
- foley care/leg bag care

**LIVING WITH RESPIRATORY DISEASE**

- precipitating factors
- home oxygen use
- alternative breathing
- MDI with spacer
- relaxation techniques
- trouble signs
- smoking cessation
- use of nebulizer

**LIVING WITH MENTAL ILLNESS**

- precipitating factors
- importance of compliance
- coping techniques
- support group/resources
- trouble signs

**LIVING WITH AIDS**

- safe sex
- immunocompromised issues
- trouble signs

**LIVING WITH GI DISEASE**

- precipitating factors
- dietary modifications
- trouble signs

**OSTOMY CARE**

- changes in self image
- stoma care
- appliance application
- dietary modifications

**LIVING WITH CANCER**

- chemotherapy
- radiation therapy
- nutrition
- changes in self image
- support group/resources
- trouble signs

**TRACHEOSTOMY CARE**

- S/S of infection
- site care
- airway patency
- tube replacement
- alternative communication

**OTHER INSTRUCTION**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

INITIALS	SIGNATURE FULL NAME & TITLE	INITIALS	SIGNATURE FULL NAME & TITLE	INITIALS	SIGNATURE FULL NAME & TITLE

I HAVE RECEIVED A COPY OF MY RECORD OF EDUCATION, AND HEREBY ACKNOWLEDGE THAT I UNDERSTAND THE INSTRUCTIONS WHICH I HAVE BEEN GIVEN.  
DATE 4/11/12 PATIENT/RESPONSIBLE PARTY Deborah Bethay DISCHARGE RN Deborah Bethay RN

# TAYLOR

TAYLOR HOSPITAL

## Medication Schedule

Page 2 of 2

BETHAY, DEBORAH J 58  
 MR# 192422252 08/31/1953  
 adm: 03/21/12  
 BRUNNER, DOUGL



PT#: 10025984179

Medication name (Please Print):	How much do I take? (Dose)	How do I take this medication? (Route)	What time of day do I take this Medicine? (Frequency)				Why am I taking this medicine?
Smoker	One tblt	<input checked="" type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	Morning <input checked="" type="checkbox"/>	Noon <input type="checkbox"/>	Evening <input type="checkbox"/>	Bedtime <input type="checkbox"/>	<input type="checkbox"/> Other: <i>constip</i>
Metamucil	1 tsp	<input checked="" type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	Morning <input checked="" type="checkbox"/>	Noon <input type="checkbox"/>	Evening <input checked="" type="checkbox"/>	Bedtime <input type="checkbox"/>	<input type="checkbox"/> Other: ↓
Colace	1tblt	<input type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	Morning <input type="checkbox"/>	Noon <input type="checkbox"/>	Evening <input checked="" type="checkbox"/>	Bedtime <input type="checkbox"/>	<input type="checkbox"/> Other: ↓
Oxycontin	Eqy	<input checked="" type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	Morning <input type="checkbox"/>	Noon <input type="checkbox"/>	Evening <input checked="" type="checkbox"/>	Bedtime <input type="checkbox"/>	<input type="checkbox"/> Other: <i>pain</i>
Oxycodone	5mg orals every 4 as needed	<input type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	Morning <input type="checkbox"/>	Noon <input type="checkbox"/>	Evening <input type="checkbox"/>	Bedtime <input type="checkbox"/>	<input type="checkbox"/> Other: ↓
		<input type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	Morning <input type="checkbox"/>	Noon <input type="checkbox"/>	Evening <input type="checkbox"/>	Bedtime <input type="checkbox"/>	<input type="checkbox"/> Other:
		<input type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	Morning <input type="checkbox"/>	Noon <input type="checkbox"/>	Evening <input type="checkbox"/>	Bedtime <input type="checkbox"/>	<input type="checkbox"/> Other:
		<input type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	Morning <input type="checkbox"/>	Noon <input type="checkbox"/>	Evening <input type="checkbox"/>	Bedtime <input type="checkbox"/>	<input type="checkbox"/> Other:
		<input type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	Morning <input type="checkbox"/>	Noon <input type="checkbox"/>	Evening <input type="checkbox"/>	Bedtime <input type="checkbox"/>	<input type="checkbox"/> Other:
		<input type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	Morning <input type="checkbox"/>	Noon <input type="checkbox"/>	Evening <input type="checkbox"/>	Bedtime <input type="checkbox"/>	<input type="checkbox"/> Other:



Orthopaedic Associates Division

Evan K. Bash, M.D.  
Frank P. Giannattei, M.D.  
Charles D. Hummer, Jr., M.D.  
Charles D. Hummer, III, M.D.

Craig G. Kriza, D.P.M., J.D.  
Eric J. Lake, D.O.  
R. Bruce Lutz, M.D.

James T. McGlynn, M.D.  
Raymond M. Wolfe, M.D.  
David T. Yucha, M.D.  
James M. Zurbach, M.D.

Dear Patient: Deborah Bethsy

Date: \_\_\_\_\_

You are scheduled to have surgery at Crozer Chester Medical Center on 3-19-12 T-F

Your pre-operative appointment is scheduled for NO. If you need to reschedule this appointment please call 610-876-0347.

Your pre-admission testing appointment is scheduled for 3-28-12 1045 AM. If you need to re-schedule this appointment please call 610-447-6287.

Please contact your primary care physician to schedule an appointment three weeks prior to your surgery date to obtain medical clearance for your surgery. Return a copy of your medical clearance to our office as soon as possible but no later than 5 business days prior to your above surgery date. Please have the medical clearance faxed to the attention of Ferina Randolph at 610-876-2418.

Your insurance No requires referrals, obtain a referral for Crozer Chester Medical Center as well as the doctor performing the surgery.

Please begin taking an over-the-counter Iron supplement in preparation for your surgery. If you already take a multivitamin that contains Iron, you do not need to take any additional Iron supplement.

Crozer Chester Medical Center offers Joint Replacement Education Classes. Please contact them at 610-447-2262 to sign up for the next class.

Refrain from eating or drinking after midnight the night before your surgery.

In my role as Surgery Service Coordinator, I am your point of contact regarding your surgery. In the future, if you have any questions or concerns, please do not hesitate to contact me. If you need to reschedule your Pre-Admission Testing appointment or if you are referred to another physician for additional medical clearance, please let me know.

Regards,

- Ferina Randolph, Phone: 610-876-0347 ext: 3240, Email: frandolph@premierortho.com
- Nancy Borowski, Phone: 610-361-4186, Email: nborowski@premierortho.com
- Nicole Eufrazio, Phone: 610-872-4410, Email: neufrazio@premierortho.com

Crozer-Chester Medical Center / Suite 324, POB II / One Medical Center Boulevard / Upland, PA 19013 / Fax 610.876.3788  
Crozer Medical Plaza at Brinton Lake / 300 Evergreen Drive / Suite 200 / Glen Mills, PA 19342 / Fax 610.876.3480  
- Media / 200 E. State Street / Suite 108 / Media, PA 19063 / Fax 610.876.2670  
St. Francis Hospital / 701 N. Clayton St. MSB, Suite 600 / Wilmington, DE 19805 / Fax 302.656.2823  
610.876.0347 or 302.656.2643

# TAYLOR

## TAYLOR HOSPITAL

### Medication Schedule

Page 1 of 1

BETHAY, DEBORAH J 58

MR# 192422252 08/31/1953









































adm: 03/21/12

BRUNNER, DOUGL

DA:




PT#: 10025984179

Medication name (Please Print):	How much do I take? (Dose)	How do I take this medication? (Route)	What time of day do I take this Medicine? (Frequency)	Why am I taking this medicine?
Aspirin Description Given: Yes <input type="checkbox"/> No	325mg	<input checked="" type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	 Morning <input checked="" type="checkbox"/>  Noon <input type="checkbox"/>  Evening <input type="checkbox"/>  Bedtime <input type="checkbox"/> <input type="checkbox"/> Other:	
✓ Divalan Description Given: Yes <input type="checkbox"/> No	160mg	<input checked="" type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	 Morning <input checked="" type="checkbox"/>  Noon <input type="checkbox"/>  Evening <input type="checkbox"/>  Bedtime <input type="checkbox"/> <input type="checkbox"/> Other:	
✓ Norax Description Given: Yes <input type="checkbox"/> No	10mg	<input checked="" type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	 Morning <input checked="" type="checkbox"/>  Noon <input type="checkbox"/>  Evening <input type="checkbox"/>  Bedtime <input type="checkbox"/> <input type="checkbox"/> Other:	
✓ Prenvit Description Given: Yes <input type="checkbox"/> No	20mg	<input checked="" type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	 Morning <input checked="" type="checkbox"/>  Noon <input type="checkbox"/>  Evening <input type="checkbox"/>  Bedtime <input type="checkbox"/> <input type="checkbox"/> Other:	
<del>Protonix</del> Description Given: Yes <input type="checkbox"/> No	<del>40mg</del>	<del><input checked="" type="checkbox"/> By mouth <i>crax</i> <input type="checkbox"/> Needle <input type="checkbox"/> Other _____</del>	<del>  Morning <input checked="" type="checkbox"/>   Noon <input type="checkbox"/>   Evening <input type="checkbox"/>   Bedtime <input type="checkbox"/>  <input type="checkbox"/> Other:         </del>	
✓ Iron Description Given: Yes <input type="checkbox"/> No	325mg	<input checked="" type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	 Morning <input checked="" type="checkbox"/>  Noon <input type="checkbox"/>  Evening <input type="checkbox"/>  Bedtime <input type="checkbox"/> <input type="checkbox"/> Other:	
✓ Depressor Description Given: Yes <input type="checkbox"/> No	50mg	<input checked="" type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	 Morning <input checked="" type="checkbox"/>  Noon <input type="checkbox"/>  Evening <input type="checkbox"/>  Bedtime <input type="checkbox"/> <input type="checkbox"/> Other:	
✓ Tenex Description Given: Yes <input type="checkbox"/> No	2mg	<input checked="" type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	 Morning <input checked="" type="checkbox"/>  Noon <input type="checkbox"/>  Evening <input type="checkbox"/>  Bedtime <input type="checkbox"/> <input type="checkbox"/> Other:	
✓ Protonix Description Given: Yes <input type="checkbox"/> No	40mg	<input checked="" type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	 Morning <input checked="" type="checkbox"/>  Noon <input type="checkbox"/>  Evening <input type="checkbox"/>  Bedtime <input type="checkbox"/> <input type="checkbox"/> Other:	
✓ Carafate Description Given: Yes <input type="checkbox"/> No	1g	<input checked="" type="checkbox"/> By mouth <input type="checkbox"/> Needle <input type="checkbox"/> Other _____	 Morning <input checked="" type="checkbox"/>  Noon <input type="checkbox"/>  Evening <input type="checkbox"/>  Bedtime <input type="checkbox"/> <input type="checkbox"/> Other:	

TAYLOR  
• • • •  
TAYLOR HOSPITAL

Medication Information Sheet

PATIENT NAME: BETHAY, DEBORAH J 58  
MEDICAL: MR# 192422252 08/31/1953  
DATE OF BIRTH: adm: 03/21/12  
BRUNNER, DOUGL  
DATE OF BIRTH:   
PT#: 10025984179

Allergies: None Pharmacy Phone Number(s): \_\_\_\_\_  
Phone Number for Questions: \_\_\_\_\_

**STOP** taking the following medications:


For discharging nurse to complete:

Patient given information on all new medications and possible side effects.

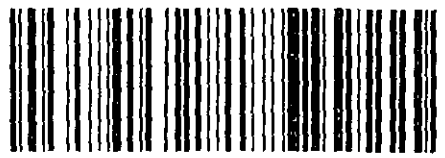
Medication schedule has been reviewed with patient and/or family and instructions read back by patient and/or family to show understanding.

Patient given all new medication prescriptions.

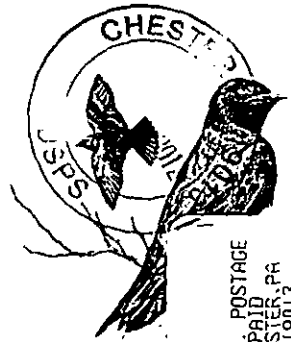
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient/Family Signature: Deborah Bethay Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Discharging Nurse Signature: Brenda Toronto RN Date: 4/1/12 Time: 1300  
Discharging Physician Signature: [Signature] Date: 4/1/12 Time: 600

Deborah Bethany  
2100 W 4th Street  
Chester, Pa 19013



7011 1570 0003 1094 5127

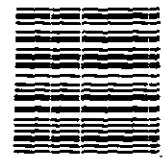


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Harrisburg, Pa



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