Debra Lloyd
Proffer Exhibit G
Depp v. Heard
CL-2019-0002911

Patient: RW
DOB: 06/09/63

6/12/14 – 2300 - RN and MD met with patient to discuss plan and medication regime. At this time the plan is for RN to assess patient twice a day and to give him his medication every morning to self-administer throughout the day. If patient needs to travel without RN he can have two days of medication at a time. RN will be in close contact with patient's assistants to arrange daily meetings. RN will report status of patient to MD via telephone on a daily basis.

During initial meeting patient was pleasant and cooperative. Patient agreed to the plan and appears motivated to make positive changes in his life. Patient was able to identify some negative consequences of current medication usage and looks forward to living a healthier lifestyle. Plan is for RN to monitor patient and current medication regime while patient finishes his work commitment in Boston through mid July. Once patient completes work commitment he will begin a medical detox in LA.

6/13/14 – 1500 – Met with patient in his apartment. Patient continues to be pleasant and cooperative. He stated that he initially started taking opiates after some dental work and became dependant on them. Patient is fearful of coming off of opiates but knows it is what he needs to do. Patient also expressed some emotional trauma, which causes him depression and anxiety. Patient given positive reinforcement for reaching out for help at this time. Patient was given his daily medication. Each medication was discussed with patient and he expressed verbal understanding. When asked to turn over all medications that he had in his possession, assistant gave the following medications to RN:

Crestor 10mg #19
Lexapro 20mg #80
Lexapro 10mg #2
Klonopin 1mg #115
Valtrex 1G #15
Nexium 40mg #41
Hydrocodone 10-325mg #2
Oxycodone 30mg #53 and 2 halves
Dilauded 8mg #2.5

Patient also takes Cialis 10mg daily but chose to keep this in his possession.

Patient states that he currently takes Oxycodone 15mg BID and Oxycodone 30 mg at bedtime – Not Oxycodone 30 mg TID as originally reported. Patient also states that he takes Adderall 2.5 – 5mg BID prn, not Adderall 5mg BID as originally reported.

Patient will be given the following medications on a daily basis to self administer:

Azilect 1mg – 1 tab in am
Klonopin 1mg - 2 tabs in am
Oxycodone 30 mg – ½ tab BID, 1 tab at HS
Adderall 10 mg – ½ tab BID PRN
Lexapro 20 mg – 1 tab in am
Crestor 10 mg – 1 tab in am
Valtrex 1G – 1 tab in am
Nexium 40 mg – 1 tab in am (patient chose to take in am rather than pm)
PrevPac – ½ pack BID
Librium 300 mg – 1 capsule BID
Ambien 10 mg – 1 tab at HS

Patient instructed to leave any medication that he does not take in the pill container and give back to RN at the end of each day. Patient expressed appreciation to medical team for coming to Boston to help him. Patient or assistant will check in with RN later tonight to determine when will be a good time to check in this evening after patient finishes work. Report given to MD via text. Report included current status of patient and requested refills of Valtrex and Cialis.

1900 – Patient's assistant came to hotel to pick up 2 days worth of medication as patient will be driving straight to NY when finished filming at 0200. Patient will return to Boston Sunday night. Per assistant patient stated that he is "feeling great today". Assistant voiced concern that patient does not have an appetite and his nutritional intake is poor. Suggested Ensure TID. Assistant instructed to tell patient to please call at anytime with any questions or concerns while he is away. Report given to MD via text. Report included patient's status and what medications were given to patient's assistant to take to NY.

6/14/14 – Patient in NY. Per assistant he is doing well.

6/15/14 –1600 – Contacted patient's assistants to find out a good time this evening to check in with patient. I was informed patient would not be arriving back to Boston until late tonight and had a 0600 call time tomorrow morning. I offered to see patient last tonight or before 0600 call time tomorrow but it is preferred that I go to the set to see patient tomorrow. Patient does have morning and afternoon medication. Report given to MD via text.

6/16/14 – 0800 – Contacted patient's assistant to find out a good time to go to set to check in with patient. Assistant will call around noon to set a time.

1500 - Spoke to RN at MD's office. Crestor, Valtrex and Cialas will be mailed to hotel today.

2300 – Accompanied patient on set today from 1300 – 2200. Patient appeared focused and worked hard throughout the day. After filming patient and RN spent time talking back at the hotel. Patient states that his GERD feels better and he is experiencing less burning in his esophagus and throat. VS WNL BP 122/79 P 76. Patient stated that he is getting a better night's sleep but still wakes up a few times during the night and is able to fall right back to sleep. Patient stated he is having a hard time focusing in the morning and requested increasing his AM dose of Adderrall to 10mg. Report given to MD and Adderrall will be increased. Patient will also be started on Melatonin 20mg tonight. Patient continues to have a decreased appetite. Ensure TID was suggested again and patient is willing to try it. Patient continues to be pleasant and cooperative. Patient was given HS medications and one day of routine meds were left with patient's assistant for tomorrow. Plan was for patient to go straight to bed as he has an early call in the morning. Plan for tomorrow is for RN to go to set to assess patient sometime during the afternoon. Full report given to MD via telephone.

Medications changes today:

Adderall 5 mg AM discontinued
Adderall 10 mg AM ordered
Melatonin 20 mg HS ordered

6/17/14 – 1400 – Checked in with patient's assistant to see when I could check in with patient today. Plan is to meet up with patient this evening on location and attend concert with patient and staff. Ensure was picked up from pharmacy and will be given to assistant when convenient.

Medication delivered to hotel today:

Valtrex 1G # 90
Melatonin 20mg #60
Cialis 10 mg #30

2330 – Accompanied patient, fiancé, assistants and security to concert. Patient was preoccupied as he was performing with other musicians during the concert. Patient appeared in good spirits but I was unable to spend any one on one time with patient to assess him or speak to him about how he is feeling. Daily routine medications were given to assistant for patient to self-administer tomorrow. Assistant informed me that patient took Adderall 5mg in am today rather than Adderall 10mg, which he had previously requested. Assistant was asked to please have patient call MD tomorrow, as he would like to check in with him. Assistant was also asked to pass on RN and MD's numbers to fiancé as we would both like to speak with her and to obtain her input towards patients treatment needs. Tomorrow patient is off from his current film but has to do some voiceover commitments for a previous film. Plan is for RN to check in with assistant in the afternoon to see when a good time to assess patient would be. Assistant was also asked to find a good time when we could get some blood drawn for lab work that MD is requesting.

1420 – Status report given to MD via telephone. MD will be visiting patient June 22 – 24 and would like labs drawn prior to

his visit. Information relayed to patient's assistant and asked to suggest some possible lab draw times that would work over the next few days. Call made to RN to find out lab hours and her availability.

1700 – RN is available to draw labs on 6/20 between 1400 – 1600 and on 6/21 anytime before 1100. Quest Diagnostics closes at 5pm M-F and noon on Saturdays. Labs must be dropped off during business hours. Lab orders will be faxed to Quest Diagnostics fax # (617) 735-8874 by MD's office. The following labs will be drawn: CBC, Metabolic Panel, Serum H Pylori, PSA, Thyroid functions, Arthritis Panel and Glycohemoglobin.

2000 – Patient is back at hotel for the evening. Per assistant, patient is eating dinner and will be going to bed shortly. HS medications were left for patient to self-administer. Per security guard, patient appears more focused and in a good state of mind over the past few days. RN reminded assistant and security that I am supposed to be seeing the patient on a daily basis. Plan for tomorrow is for RN to go to the set, assess patient and spend time speaking with fiancé about her thoughts and goals for patient's treatment.

6/19/14 – 1230 - Report given to MD via telephone. The following are medication orders for today:

Discontinue – Lithium 300mg BID
Order – Lithium 300 TID

Waiting to hear from assistant as to what time RN will visit patient on set.

1700 – Reached out to assistant to see when RN should head over to the set. Informed that it would be better if patient were seen back at the hotel when he was finished filming this evening.

2330 – Met with patient in his apartment. Patient stated that he is exhausted from his work schedule but overall is feeling great. States his stomach no longer bothers him although he does have some esophageal discomfort throughout the day. Encouraged patient to cut down on the amount of redbull and coffee that he is drinking. Patient returned the pill containers that he has been given containing his daily meds. It is noted that patient did not take his HS medications on 6/14, 6/15, and 6/17 – MD informed and ordered Lithium BID to continue for 3 more days before increasing dosage. Patient educated on importance of taking prescribed medication on a continual basis and patient expressed verbal understanding. Patient stated that the Melatonin had a good affect and he slept soundly last night and woke up feeling energetic this morning. Patient spoke to MD via telephone and updated him on his status. Patient's routine medications for tomorrow were left with patient for self - administration. Patient took HS meds and was planning on going to bed immediately. Plan is for RN to visit patient on set tomorrow and for labs to be drawn at 1530.

Med Changes:

Discontinue: Lithium 300mg TID
Order: Lithium 300mg TID x 3 days.

6/20/14 – 1700 Went to set to see patient. States he did not sleep well last night but feels it was due to emotional stress. Patient states he has been drinking lots of water today and was

able to eat 50% of lunch. Labs were drawn and dropped off at the lab. Results will be faxed to MD's office when available. Patient plans on relaxing and staying in Boston for his next two days off. Plan is for RN to check in with assistant to set up a time to see patient tomorrow. Routine meds for Saturday were left with assistant to give to patient to self – administer.

6/21/14 – Patient is spending the day relaxing with his fiancé in his apartment. Routine medications for Sunday were given to patient's security guard to give to patient for self-administration. Texted patient to set up time to meet with MD tomorrow and did not get a response.

6/22/14 – 2100 – Met with patient and MD. Reviewed all medications, patient's status and plan for detox off opiates when he is finished filming. Patient is in agreement of current plan. Patient states he is sleeping better but feels mildly sedated throughout day and depressed for the past 3 days. Patient feels this is situational rather than related to any medications he is taking. Patient spoke about his difficult childhood and current mood swings. It was explained to patient that once his medications have reached therapeutic effect he should experience increased mood stability and he will be able to benefit more from therapy. Patient states his stomach issues have diminished and he does not have any medical complaints at this time. Patient was given his routine medications for Monday to self-administer.

Medication changes:

Discontinue: Lithium 300mg BID
Order: Lithium 900mg HS
Discontinue Adderall 5 mg in afternoon
Order: Adderall 10 mg in afternoon

6/23/14 – 1400 - Plan was for RN and MD to visit patient on set today. Patient's assistant informed us that the set was very chaotic and patient would like to meet with us tomorrow on his day off instead.

2210 – RN met with patient's security and assistant and was informed that patient and his fiancé will be leaving early morning to go to a Spa for Tuesday and Wednesday. Plan is for MD and RN to meet with patient and fiancé before they leave in the morning. Assistant given patient's routine meds for the next three days to self-administer while he is away.

2300 – Per MD we will only be meeting with patient's fiancé tomorrow.

6/24/14 – 1200 – RN and MD met with patient's fiancé to inform her of treatment plan for patient. Fiancé voiced concerns of patient's behavior while using drugs and alcohol. She is in agreement of treatment plan and supportive of patient's decision to detox after he finishes filming. Fiancé was educated on patient's current medication regime and feels comfortable with treatment he is receiving. She was encouraged to call RN or MD with any questions or concerns that might arise.

6/25/14 – Patient is away at for the day and will not be seen today.

6/26/14 – 1415 – RN went to set to assess patient. He stated he has been experiencing "jerking movements" in his hands and legs for the past two days and he feels lethargic throughout the day. MD informed and plan is to stop Lithium at this time and see if patient feels better and symptoms

subside. Patient informed of medication change and educated that he should feel better within 24 – 36 hrs and asked to report and changes to RN.

2115 – Patient's fiancé called. Medication changes were discussed with her and she was asked to remove Lithium from patient's medication box that she was in possession of. Fiancé expressed to RN that she feels patient's "jerky movements" and clenched jaw started when adderall dosage was increased. She was informed that this was a possibility but we should only make one change at a time so we could r/o what was causing side effects. Fiancé expressed understanding. MD informed of fiancé's concerns.

Medication Changes:

Lithium 600 mg at HS discontinued

6/27/14 – 1500 - Per assistant patient appears more alert today. RN will not see patient on set today but will assess him first thing tomorrow morning.

6/28/14 – 0930 – Met with patient in his apartment. Patient reports feeling more energetic since discontinuing Lithium. Patient stated others commented yesterday that appeared to be feeling better. Patient states he continues to have some jerky movements of his hands but it seems to be decreasing. Patient educated that side effects could last up to 36 hrs after last dose of medication. VS BP 111/69, P 61. Patient will be going to his island for the next 3 days. He was given MD's number to call on his way to airport to review lab results. Patient and his fiancé were given RN's and MD's email addresses as they stated this was the best way to communicate from the island. Patient was given 4 days worth of routine

medications and will self-administer. Patient informed that RN would like to see him on Tuesday to assess how he is feeling. Patient instructed to call, email or text if needed while he is away. Patient's status reported to MD via telephone.

6/29/14 - Patient away with fiancé and did not contact RN. RN spoke with patient's sister and updated her on status of treatment. Sister will speak with patient in the next few days and will update RN and MD on plan for detox when filming is finished.

6/30/14 – Patient continues to be away and has not contacted RN. Plan is for patient to return last this evening.

7/1/14 – 1100 - RN contacted patient's assistant and requested a time to visit patient on set to assess him. Assistant will contact RN after lunch to set up a time.

1730 – Visited patient on set. Plan was to give him a urine drug screen but it was not an appropriate time or place. Patient stated that he feels much better since stopping the Lithium. Stated he could feel when the medication was no longer in his system and no longer has any complaints of jerky movements in hands and legs, no longer feels lethargic during the day and no longer feels "cloudy". Patient states that he is sleeping well at night and feels his mood has improved over the last few days. Patient continues to have poor nutritional intake and does not like the Ensure. Patient is able to eat small portions at a time and is encouraged to try other protein shakes throughout the day. Patient was given daily routine meds for 7/2/14 and will self-administer. Status reported to MD via telephone.

7/2/14 – Patient has the day off from work and will be spending time with his fiancé and children. Daily routine medications for 7/3/14 given to assistant to give to patient for self – administration. Plan for tomorrow is for RN to visit patient on set.

7/3/14 – 2030 – RN visited set where patient was working from 1100 – 1900. RN spent time with patient's sister who stated she felt her brother was looking and feeling good. Plan of detoxing patient was discussed with his sister and she is going to try to solidify dates and location of detox. Patient was busy filming majority of day and took a 45 min nap during his lunch period. RN briefly spoke with patient and he stated that all is well and had no complaints or concerns at this time. Plan is for patient to travel to his island early tomorrow morning and return last Sunday night. MD notified that urine drug screen has not yet been administered and ordered it to be completed Monday. Routine medications for 7/4/14 – 7/7/14 given to patient's assistant. Assistant will give to patient to self-administer while away. Plan is for RN to visit patient on set on Monday but will be available via phone or email if needed before. Full report given to MD via email.

7/4/14 – Per patient's sister, patient left for island this morning. He was in good spirits and had no physical complaints. Sister will be flying home today and coming back on 7/7/14 to spend time with her brother and will try to firm up plan for detox.

7/5/17 - Patient away and did not contact RN.

7/6/14 - Patient away and did not contact RN. Per security staff patient will return around 11pm tonight and has a 6am call time tomorrow.

7/7/14 – 1115 – Waiting to hear from patient's assistant to find out a good time to visit patient on set today to assess him and do a urine drug screen.

1230 – Per assistant filming was cancelled today and patient will be spending the day with his fiancé and children. MD informed and ok'd urine drug screen to be done in the next day or two.

2130 – Saw patient in his apartment. Patient stated he is feeling great. Stated he feels restful after his time away on his island. Patient was relaxing with his fiancé for the evening. Routine meds for 7/08/14 left with patient to self-administer tomorrow. Plan is for RN to visit patient on the set tomorrow.

7/8/14 - 1300 - Per patient's assistant it will be a short day on the set today and it would be better for me to see patient tomorrow.

7/9/14 – 1930 – Spent the majority of the day on set with patient today. Urine drug screen completed and results given to MD. MD will discuss results with patient. Patient states that he is feeling great. States he feels he is getting REM sleep every night and wakes up feeling energetic. States he still has a limited appetite but eats "just enough". Plan for detox was discussed with patient's sister and MD. Plan continues to be for patient to finish his work commitment and detox in LA or on his island at the end of July. MD will come to visit patient on 7/14/14 to further discuss plan. Routine medications for 7/10/14 & 7/11/14 left with patient for self-administration.

7/10/14 – Medications delivered by MD's office:

Ambien 10mg #30
Oxycodone HCL 30mg #15
Adderall 10mg #60
Cialis 10mg #30
Azilect 1mg #30

7/11/14 – Patient working long hours on set today. RN met up with patient's fiancé and gave her his daily routine medications for the weekend (7/12 – 7/14) for self - administration. Patient will be filming through the night tonight and plans on sleeping all day Saturday and relaxing on Sunday. Plan is for MD to arrive on 7/14 and will discuss next step of treatment with patient.

7/12/13 – Spoke to patient's assistant and patient is feeling fine and will not need to be seen before the MD arrives on Monday. They will notify RN if anything changes.

7/13/14 – Checked in with patient's assistant and no changes at this time.

7/14/14 – MD arrived this afternoon. Plan is for MD and RN to spend time with patient tomorrow before he leaves for work. RN will check in with assistant in the morning to confirm meeting. Routine meds for 7/15/14 given to assistant to give to patient for self-admininstaration.

7/15/14 – 1100 – Per assistant patient is in a rush to get to work. Assistant will be in contact later this afternoon to set up a time for RN and MD to visit patient on set.

2300 – RN and MD met with patient. Results of drug test were discussed. The next step in treatment plan is for patient to finish filming and return to la in one week. RN will stay with patient and continue to monitor medications through approximately 8/1/14. At that time patient and RN will go to patients vacation home and will detox in a safe and quiet environment. MD will assess patient prior to detox and will visit patient and RN at his vacation home to assess and supervise detox. Patient is in agreement with plan. Patient was given his daily routine medications for 7/16 & 7/17 to self-administer.

7/17/14 – 1200 - Patient's assistant contacted RN to say that patient would be filming last tonight and has a night shoot tomorrow night. Assistant requested that RN meet up with patient's fiancé to give her patient's routine medications for the weekend.

2130 – Dropped patient's routine medications for 7/18 – 7/21/14 off to his fiancé. Patient will continue to self – administer his medications on a daily basis. Fiancé instructed to call RN if needed over the weekend. Plan is for RN to visit patient on set on Monday.

7/21/14 – 1140 -Patient will have a short day on the set today – it will be his last day filming. Plan is for RN to visit him in his apartment when he is finished working for the day.

2145 – RN visited patient in his apartment. He has mixed emotions about filming being finished. States he always gets a bid sad when a project is finished. Talked about future plans and he is looking forward to relaxing on the island in a week or so. Plan is for RN to fly home tomorrow – patient will fly back to LA tomorrow. RN and patient will meet back up in LA on

Thursday. Daily routine medications for 7/22 – 7/24 given to patient for self-administration.

7/24/14 – 1800 – RN and MD met with patient in his home. All medications were reviewed with patient and no changes will be made at this time. Patient is scheduled for an endoscopy, colonoscopy, lung scan and heart scan on 7/28/14. Preparations for tests were discussed with patient. Prep meds and instructions will be delivered to his home tomorrow. Patient expressed verbal understanding of preparations.

7/25/14 – Patient's assistant was given prep medications and instructions to deliver to patient today. Patient is aware of his dietary restrictions to start on Sunday morning and to start his prep medications at 6pm on 7/27/14. Patient instructed to call RN or MD if he has any questions or concerns.

7/27/14 – 2100 – RN spoke to assistant and all is set to meet patient at first test tomorrow at 7am.

7/28/14 – Patient met MD and RN and underwent a colonoscopy, endoscopy, lung scan and heart scan. Initial results came back as non-significant and were discussed with patient. When finals results come in, MD will discuss with patient. Patient was alert and orientated after the tests and was escorted home by his assistant.

Checked in with patient and his fiancé a few hrs after test. Fiance said patient felt fine and had slept majority of day. Patient's assistant given patients routine medications for 7/29 & 7/30. He will give to patient to self – administer.

New Meds Orders as of 7/28/14

Discontinue Crestor 10 mg QAM.

7/31/14 – RN was suppose to meet patient at his studio today but patient slept through recording session. RN met with patients assistant and gave him his rountine medications from 7/31 – 8/4/14. RN and MD will meet with patient on 8/4/14 to discuss detox plan for the island.

8/4/14 – RN and MD met with patient in his home. MD and patient spoke privately for about an hr. Per MD patient is nervous but continues to be in agreement to detox once we get to the island. Patient was given his routine meds for 8/5 - 8/7. Plan is to leave for the island in the next day or two.

8/7/14 – Trip to island has been postponed for one more day due to personal issues for the patient. Assistant requested that RN deliver one more day of routine medications to patient in his downtown home. Medications for 8/8/14 delivered to patients security guard to be given to patient for self-administration.

8/8/14 – Arrived on island today. Plan is for patient to continue to take routine meds through tomorrow at HS. At that time he will not take his Oxycodone and detox medications will be initiated.

8/9/14 – Patient expressed fears of never feeling normal without his drugs. Reassured him that this is a normal feeling and to just focus on one day at a time and see how he feels on a day-to-day basis. Patient encouraged to be open and honest with how he is feeling physically and emotionally throughout the detox process and assured we will keep his safe and

comfortable. Patient took his routine meds today. His HS dosage of Oxycodone was discontinued and replaced with phenobarb 64.8 mg and baclofen 20mg. Patient was also given his routine morning medications minus the discontinued Klonopin and Oxycodone. Patient was left Phenobarb 64.8mg and Baclofen 20mg in addition to morning meds. Patient will self-administer medications. Patient was left with written instructions of what meds he was taking. Patient was also left with an automatic BP cuff and shown how to use machine. Patient encouraged to check BP prior to administering meds and if he starts to feel any withdrawal s/s. Patient expressed verbal understanding and patient's fiancé demonstrated using the BP machine. Patient was instructed to call RN if he needs anything throughout the night. If patient does not need RN throughout the night he was instructed that RN needs to see him 1 hr after he takes his morning medications to assess how he is feeling. MD will arrive tomorrow evening.

New medications orders as of 8/9/14

Discontinue Oxycodone 30 mg – ½ tab BID, 1 tab at HS
Discontinue Klonopin 1mg - 2 tabs in am
Start Phenobarb 64.8mg q6-8 hr while awake
Start Baclofen 20 mg QID prn body aches

8/10/14 – 0130 – Patient's fiancé contacted RN and said patient feels like he needs more "help". Fiancé stated that patient had taken Pheno 64.8mg about 50 min ago. Patient stated his body felt "twitchy". Patient instructed to take Pheno 16. 2 mg along with his HS medications and try to go to sleep. Fiancé instructed to let RN know if patient is not asleep within an hr.

1000 – MD's flight has been cancelled. Arrangements are being made for him to arrive on the island 8/12/14.

1330 – Per patient's fiancé, patient fell asleep immediately after taking his HS meds and additional pheno and is currently still sleeping.

1615 – Patient awake and states he feels ok. States he is having some cravings but physically he feels better than expected. No s/s of withdrawal noted at this time and no complaints from patient. VS BP 117/ 78, P 72. Patient self-administered routine morning medications along with Pheno 64.8 mg and Baclofen 20mg. Patient will self administer afternoon and HS medications and call RN if needed. Patient and fiancé educated on all medications and instructed to check BP prior to administering any medications.

Detox orders for today:

Phenobarb 64.8 mg BID
Phenobarb 16.2 mg prn BID breakthrough withdrawal
Phenobarb 80 mg HS
Baclofen 20 mg TID
Neurontin 600 mg BID PRN anxiety / agitation
Clonodine 0.1 mg q6-8 hr prn withdrawal
Zofran 8mg q6h prn nausea
Imodium 2-4mg prn diarrhea, may repeat in 1 hr in needed
Vistaril 25mg prn qHS if still awake 1 hr after routine HS meds

1800 – Patient's status reported to MD via telephone. Additional orders given

Phenobarb 32.4 - 64.8 prn Q3h breakthrough withdrawal
D/C phenobarb

2020 – Patient's fiancé reported that patient took afternoon meds at 2000. BP 116/67, P 81.

2115 – Patients fiancé contacted RN to report patient is experiencing runny nose, chills, aches and watery eyes. RN assessed patient and gave prn phenobarb, clonodine and aleve. Contacted MD to bring Motrin when he comes on Tuesday. VS 117/82, P 74.

2210 – Patient states he had some relief with prn meds. VS 116/75, P 72. Patient instructed to take his HS meds between 0100 – 0200 so he can start to get on a regular sleep cycle. Patient and fiancé encouraged to call RN if needed during the night.

8/11/14 –

0220 - Patient's fiancé contacted RN. Stated she had given patient his HS meds along with Phenobarb 81 mg and Baclofen 20 mg at 0100. Stated patient is complaining of being in a lot of discomfort – muscle spasms, chills and pains. Instructed to give patient a prn phenobarb 32.4 mg and neurontin 300 mg and to let RN know if it has an affect on patient.

0335 – Patients fiancé contacted RN to inform that patient is still awake and continues to complain of discomfort. Instructed to give vistaril 25 mg.

0445 – Patients fiancé contacted RN to inform that patient is still awake and complaining of muscle spasms and pain. Instructed to have him take a hot shower and take Neurontin 600 mg.

0540 – Patient continues to be awake and complain of muscle spams and pain. RN assessed patient – he had restless legs, muscle twitches, complained of feeling like skin was crawling. BP 124/83 P 63. Magnesium 1 tab and Toradol 30 mg IM administered. Patient encouraged to take a warm shower and did so with assistance from his fiancé. After show patient felt better and restless legs had calmed down. Patient was able to sit still in bed.

0600 – Status reported to MD.

Increase pheno to 97.2mg Q4-6h

0615 – AM dose of Phenobarb 97.2 mg and Baclofen 20 mg given to patient. Patient was relaxing in bed and felt as thought he could finally go to sleep. RN instructed patient to call when he wakes up in the morning / afternoon. Encouraged him to wake and take his next dose of meds around noon.

8/12/14 –

1030 - Per fiancé, patient slept till 1000. Meds given at 1010. VS 117/83 P68. Patient states he feels much better this morning. Medications will be increased today. MD arriving this morning and will assess patient.

New Medicaiton orders:

Phenobarb 120 mg q4-6h

Per fiancé – patient took meds at 1534 VS 112/65

1715 – Patient's fiancé text called and reported patient was c/o headache, deep chills, restlessness and body aches. VS 114/69 P 65. Went to see patient. MD ordered

Motrin 800 mg QID,
Requip .5mg stat and at HS

Patient states he feels better after taking Motrin

2200 – Patient, Fiance, RN and MD had dinner together. Patient was in good spirits and expressed appreciation for RN and MD to treat him on the island. Patient continues to be fearful of who he will be off medications but continues to have a positive attitude toward detox process. Patient had no w/d complaints throughout dinner.

2250 – Patient's fiancé called to say that patient is "not feeling well" and his hands are "twitching bad" – Instructed to give him his HS meds and have him lie down. Fiance instructed to call RN if patient does not fall asleep within 30 min.

8/13/14

1230 – Patient slept through the night. Took his am meds at 1240. RN and MD assessed patient. Hand spasms noted. No meds changes at this time.

1340 – Patients fiancé text to say he wasn't feeling well. MD orders Pheno 64.8 mg, Neurontin 600 mg Stat. Patient and fiancé informed that today and tomorrow will be the most difficult days and to keep in close contact with us.

1630 – Fiancé text to say patients feels much better.

1700 - Fiance text to ask is MD could come to talk with patient privately – stating "something has come up". RN drove MD to meet with patient.

1830 –Patient feels he has a herpes outbreak and is upset that he might have given virus to fiancé. Valtrex increased.

Valtrex 1G TID x2 Day

1930 – Fiancé text to say that patient is emotional over possibility of giving fiancé virus. MD went to talk to him. Patient feeling much better after discussion.
2040 – Fiance text to say that patient was feeling "heeby geebies" – Intsructed to next dose of detox meds. (pheno 4, neurontin 2, baclofen)

2315 – HS meds given – no complaints at this time.

8/14/14

0030 – Fiancé tex to say that patient complaining of "cramp, bloating. Instruced to give Bentyl 20 mg. VS 116/56. Fiance instructed to call RN if patient still awake in 30 min.

******1120 – Fiancé text to say that patient feels much better. AM meds given at 1030, VS 117/76

1515 – Fiancé administered afternoon meds. VS 115/70. States patient is feeling great today.

1600 – MD spent time with patient.

2200 – HS meds given 99/66 - Clonodine held.

2350 – Text from fiancé that patient is "jonesing" – Instructed fiancé to give patient HS meds.

8/15/14 –

0130 – Text from fiancé that patient is "paranoid" and trying to fight with fiancé. States he is "angry" and "freaking out" – RN and MD went to assess patient.

0200 – Seroquel 25mg, Pheno 96.4mg, Toradol 45mg IM, given and patient escorted to bed.

8/16/14 –

1030 – Per patient's fiancé patient woke up and was feeling restless. AM meds were given and patient fell asleep.

1400 – RN and MD assessed patient and administered meds

1700 – RN and MD assessed patient and administered meds

2000 – RN and MD assessed patient and administered meds. Current med regime is keeping patient comfortable.

Med Changes:

Pheno 64.2 Q4H
d/c Clonodine 0.1mg
Neurontin 300 TID, 600 HS
d/c Requip 1 mg
Seroquel 12.5 TID, 25mg HS

2300 – Patient feel asleep at 2200 – Missed his HS medications.

8/17/14

0830 – Patient awake VS 132/82 P 82. RN and MD assessed patient. Patient is social but appears guarded. Discussed med changes with patient and he is on board to continue taper.

Phenobarb 64.2 TID
Seroquel 25mg BID, 50mg HS

1400 – Patient called to ask if we were tapering him today. Reminded him that he got the same dose this am but we are spreading the dose out. Patient stated he was ok to wait till dose.

1545 – Patients fiancé came to get MD and RN stating that patient was erratic and paranoid. RN and MD found patient sitting quietly on his porch. Patient was calm and stated he was frustrated with the process of detoxing. Stated he thought he should be feeling better by now. RN and MD sat with patient and listened to his express his frustrations with how he was feeling physically and emotionally. Patient reassured that what he is feeling is part of the process. Patient stated he wanted to speed the process up and it was agreed between patient and treatment team that we should go back to LA tomorrow and start the next stage of patient's treatment.

8/18/14 – 0100 – text from fiancé that patient is upset and irritable. MD and RN went to assess patient. He states he had a fight with fiancé and is questioning whether or not he can emotionally and physically handle detox. Complains of

agitation and nausea. RN and MD gave patient emotional support. MD ordered:

Seroquel 100mg - STAT
Phenergan 100 mg IM – STAT

Patient was escorted to bed. Plan is to leave the island tomorrow.

8/19/14 – 0900 – RN and MD went to check in on patient. Patient is still agreeing that it is best to leave the island but is unsure if he wants to continue detox when he arrives back to LA. MD sat with patient and discussed all the benefits of continuing treatment. AM meds administered. Plan is to leave the island at 1800.

1500 – Patient's fiancé administered afternoon dose of medications.

1830 – Upon leaving the island patient appears to be in good spirits. He states that the med combination that he is on making him comfortable and he agrees to continue treatment once back to LA.

2130 – Patient complains of body aches – evening dose of medications administered.

2335 – Arrived back in LA. Patient was social for ½ the flight home and then rested for the last ½ flight home. Upon arrival at LAX patient and fiancé head back to house downtown. Fiancé was given patient's HS meds and AM meds for 8/20/21. Plan is for RN to see patient in the morning.

8/20/14 – 0135 – Patient's fiancé text that patient took HS meds at this time. BP 122/78

New Med Orders:

Lamicatal 6.25mg QD

0915 – RN received text from patient's fiancé – patient self - administered medications at 0915 – BP 134/79. Fiancé states, "he feels great." Plan is for RN to see patient at 4pm.

1630 – RN saw patient in his downtown home. He was in good spirits and denied any w/d s/s at this time. States he is glad to be home and back on track. Patient educated on new medications and warned of possible side effects. Patient was off to see his daughter on her fist day of filming. Plan is for RN to move into a hotel close by and will see the patient on a daily basis and leave medications for one day at a time. Patient and Fiancé instructed to call RN if needed at any time.

2135 – Received text from Fiancé saying that he is "feeling it but doesn't want to go to bed yet". Fiancé instructed to give **Pheno 64.8mg** now and patient can take the rest of HS meds when he is ready to go to sleep. Patient also complains of body aches at this time. **Motrin 800 mg given**.

2315 – RN received text from fiancé stating "he's manic, full on flipping out, give up, not to call you guys". Instructed to give HS meds and additional **Seroquel 50 mg** and to call if RN needs to go assess patient.

8/20/14

0010 – RN received text from fiancé stating, "he seems calmer, not as crazed".

0820 – RN received text from fiancé stating, "we need help, he's at the border, refusing to take his meds." Fiancé informed RN would come right over.

1230 – RN and MD spend time talking with patient. Patient expressed frustration with the detox process and with not liking how the phenobarb was making him feel. Initially, he stated he was done with the process and no longer wanted MD and RN's services. After processing his feelings and realizing how far he had come and that part of his wanting to give up was due to tension between him and his fiancé. Patient, Fiancé, RN and MD came up with a plan for Fiancé to take a few days for herself and patient was willing to continue treatment but was going to refuse Phenobarbital from this point forward. **Patient took AM medications except Phenobarbital at 1020** RN and MD informed patient of the dangers of stopping medication abruptly and offered to shorten the taper but patient refused to take pheno all together. Patient requested Xanax for breakthrough anxiety while going off pheno abruptly. MD agreed to prescribe Xanax 0.5 #15 and patient could keep in his possession as long as RN could randomly count meds to see how many he had taken.

New Medication Orders

D/C Phenobarbital 64.2 TID
Xanax 0.5 mg – 1-2 tabs prn q4-6 h severe anxiety. May keep on person.

Current Med Orders:

Cialis 10gm QD
Valtrex 1G QD
Nexium 40mg QD
Lexapro 30mg QD
Neurontin 300 BID, 600mg HS
Neurontin 100 mg prn anxiety q4-6h
Adderall 10mg BID
Seroquel 25mg BID, 50mg HS
Ambien 10mg QHS
Melatonin 20mg QHS
Bently 20mg prn BID abdominal cramping
Motrin 800mg prn TID pain
Toradol 60mg IM prn Q8h pain
Immodium 2mg prn diarrhea
Xanax 0.5mg prn Q4-6h severe anxiety

Patient may self-administer all medications with the exception of Toradol IM.

1500 – Patient agreed to have RN stay with him throughout the day / evening to monitor how he would feel after stopping the Phenobarbital abruptly. Patient complains of increase anxiety but is not requesting prn medication. Stating he wants to sit with feelings and see if he can work through them. Patient given positive reinforcement for behaviors.

1610 – Afternoon meds administered. VS 137/98 P62. Patient c/o body aches – Toradol IM given

1930 – Patient continues to have a diminished appetite. Ate 25% of pasta dinner.

2105 – Patient starting to fall asleep on the couch. Administered HS meds.

8/21/14 – 0130 – Patient continues to sleep soundly on the couch.

0315 – Patient continues to sleep soundly on the couch.

0545 – Patient awake, reading on the couch. No complaints at this time.

0700 – AM meds administered. Patient states he is feeling less groggy since stopping the pheno and can feel his mind becoming clearer. Patient states he is determined to be sober and is glad that he has now stopped all detox medications.

0745 – Patient ate 25% of English muffin for breakfast. C/o body aches – Toradol IM given.

1340 – Patient continues to have a positive attitude towards sobriety. He has called a sober friend for support and feels it was helpful to speak with someone who understands what he is going through. Patient encouraged to reach out to other sober friends and set up some accountability for his sobriety. Patient's sister has come to spend the day / night with him. Patient was given meds for the remainder of the day and for tomorrow morning and instructed to check in with RN. RN will be close by at a hotel if needed.

2010 – Received text from patient that he has been chatting with his sister all evening and is really enjoying how he is feeling. Patient encouraged to call RN at anytime during the night if needed. If not, to call RN when he awakes in the am.

8/22/14 – 0730 – Received a text from patient's sister Christi that patient took his afternoon meds at 1600 and HS meds

around 0130 and was asleep by 0210. She stated that patient had an appetite and ate a sandwich late last night. Per sister patient took Xanax 0.5 mg around 1700. Per sister, patient continues to sleep at this time.

0930 – Received text from sister that patient is up and has taken his AM medications. Sister asked to tell patient that RN would be by in about an hour to see him.

1020 – Arrived at patient's house and he is in good spirits. Patient refused breakfast as he stated he still not does not have an appetite.

Report given to MD via telephone. New med orders:

D/C Lamicatal 6.25mg QD
Start Lamicatl 12.5 mg QD x 7days.

1400 – Patient c/o body aches and abdominal cramping. Torordol 60 mg IM and Bentyl 20 mg PO administered.

1520 – Patient c/o diarrhea. Given bottle of Imodium to self - administer as needed. Patient took Imodium 4 mg at this time. VS 141/78 P95.

2020 – Plan is for patient to spend the weekend at his children's house. Per MD okay to given patient his routine meds to self – administer throughout the weekend. Patient asked to touch base with RN throughout the weekend and reminded to stay on a regular sleep schedule. Plan is to see patient when he returns to his home Sunday evening.

8/23/14

1025 – Received a text from patient that "all is well".

1940 – Checked in with patient via text and got a response, "been very good, I am still a raw nerve and, of course, the receptors are buzzing with electricity." Per text patient plans on having dinner out with some friends tonight and will check in tomorrow.

8/24/14

1125 – Checked in with patient via text message. Plan is to see patient later this evening to see how he is doing and to give him his routine medications for tomorrow to self-administer.

1830 – Plan is to meet patient at his house around 2000.

1930 – Patient text to say that he was staying with his kids longer than expected and would let RN know when he was headed back to his house.

2130 – Patient text RN to say that he needed to increase his Valterx. Patient instructed to use the ointment given to him on Friday to self-administer. Patient stated it was at his house, not with him. Call to MD to report patient status.

New Medication Order:

d/c Valtrex 1G QD
Start Valtrex 1 G TID

8/25/14

1000 - Met patient at the house of his children and gave him Acyclovier Ointment. New Medication Order – Acyclovier Ointment 1% - Apply as needed up to 3x per day. Patient stated he was enjoying spending time with his children with a clear mind. He took his daughter shopping and the spa and took his son to a comedy show. Plan is for patient to visit his daughter on set today and then meet with RN, MD and fiancé at 1600. Patient given his routine meds for 8/25/14 and 8/26/14.

1900 – Meeting at MD's house was quite stressful for patient. Him and his fiancé are having a hard time communicating and understanding each other's point of view and feelings. A few times during the meeting patient wanted to give up process and talked about going out and relapsing. Per MD stat order – patient was given prn dosage of Neurontin 600mg and Seroquel 50mg to help with his anxiety. Patient was able to talk through his feelings and agreed to stay working with treatment team. Plan is for fiancé to start therapy tomorrow, patient will continue with current treatment plan through movie shoot and start individual therapy as soon as he is back in LA. By end of meeting patient and fiancé were emotionally stable and agreed to go home and have a relaxing night and not to continue discussion while alone with each other. Patient will call MD or RN if needed throughout the evening.

8/26/14

1300 – Visited patient in his home. He stated last night was peaceful and he fell asleep early on the couch and had a good nights sleep. Stated him and his fiancé had no further discussions about relationship and just enjoyed each others

company throughout the evening. Patient given routine meds for 8/27/14 for self-administration. Plan is for patient to go play music with his friend this evening; he will call RN if needed.

8/27/14 – 0900 – Received text from patient's sister that patient had been recording music with his friend till 0500 and did not go to sleep till 0700 and is currently still sleeping. Sister stated that patient and his fiancé has a disagreement last night and that patient was able to remain calm and handled situation appropriately.

1330 – Patient awake and self –administered routine morning medications. Patient expressing feeling about argument with fiancé and feels relationship is putting unwanted stress on him right now. Patient given positive reinforcement for recognizing triggers and some healthy coping mechanisms for stress were discussed. RN counted patient's Xanax and he has taken #9 tabs since prescription was filled on 8/20/14. Patient reminded that the Xanax was only to be used when his anxiety reach 8/10 and he should use alternative methods of stress relief before taking medication. Patient expressed verbal understanding.

1600 – Patient off to play music with friend and will self-administer routine afternoon medication.

2130 – Patient back home. Per patient he had a long conversation with fiancé and they both understand that right now is a time to work on themselves as individuals. Patient's fiancé now has a RN to help her anxiety and to monitor her while starting a new mood stabilizer medication. Patient feels this will take some stress of their relationship and in return

take some stress off of him. Patient is in good spirits. Plan is to leave for London this evening.

8/28/14 – 0230 -On plane flying to London. Patient self administered routine HS medications 1hr ago and fell asleep at 0210.
*Time change now 8 hrs ahead

1800 – Landed in London. Patient self-administered routine AM medications. Patient slept about 5 hrs on plane. Complains of body aches and neck tension. PRN Toradol 60 IM given with good effect.

2230 – Patient and fiancé are settling into hotel. Patient was given routine medications for 8/29/30 that he will self-administer. He is ordering dinner to eat in hotel. Plan is for RN to see patient at 1030 tomorrow morning before he leaves for work.

8/29/14 –

1100 – Patient is awake and preparing for his first day of work. He is pleasant and social. Patient self-administered AM medications and a prn Motrin 800 mg for body aches. Patient did not take his Seroquel 25mg this am as he wanted to see how he felt without it as he has some concerns of sedations while having to work. MD notified. Plan is for patient to touch base with RN this evening when he arrives back to hotel.

Med orders:

d/c Valterex 1G TID
Valtrex 1G BID

2330 – Per patient's security, patient had a good day at work and is now home preparing for bed.

8/30/14 –

1230 - Patient text RN at 1015 stating he had a HA. Patient assessed - Toradol IM 60mg administered LUOQ at 1030 with good effect. Patient stated he had a good day at work yesterday and could tell he was more creative now that he is no longer taking opiates. Patient stated he felt fatigued in the afternoon and requested in increase Adderall while he is filming over the next month. Patient reminded he might just be feeling jet lagged and to see how he feels over the next few days. Patient also complains about tension in his shoulders and neck. RN suggested getting a massage today. Patient self-administered routine AM medications at 1115.
Plan is for patient to read script for a while and possibly get a massage later this afternoon. Patient will check in later.
Patient status reported to MD via email.

New Medication Order

Aderall 10mg ½ - 1 tab daily prn lethargy

2130 – Patient text RN to say that he was going to dinner with his fiancé and was feeling pain and tension in his neck. Assessed patient and Motrin 800mg and Baclofen 20mg was given with good effect. Patient stated he had self-administered his afternoon meds around 1500. Patient instructed to call RN during the night if needed. If not needed to text when he wakes up so RN can check in.

8/31/14

1120 – Patient text to say that he was having neck and shoulder pain. RN assessed patient and administered Toradol 60mg IM ROUQ and Baclofen 20mg. Patient encouraged to do some stretching exercises and get a massage today. Patient's fiancé stated that she would make an appt for him. Patient stated he took his routine AM medications around 1000. Report emailed to MD. Plan is for RN to check in with patient around 1800.

2100 – Patient and Fiancé went out for the afternoon shopping. Patient ate 50% lunch of a salad. This evening patient, fiancé and both RN's went to the Tate museum. Patient was in great spirits and was focused on the museum and stated he really enjoyed himself. Patient self-administered routine medications at 1500. Patient continues to complain of body aches but does not request medication at this time. Plan is for patient to get a massage this evening and go to sleep early as he has to work early tomorrow morning.

9/1/14

0630 – Patient awake and self-administered routine AM medications at this time. Stated his body aches feel much better after his massage last night. Patient encouraged to drink plenty of water throughout the day today. Patient is alert and energetic and looking forward to his first day of work. Plan is for RN to visit patient on set this afternoon.

1845 – RN went to set to check in with patient. He complained of body aches and stated his body was tightening up throughout the day. Torodol 60mg IM ROUQ given and Baclofen 20mg given at 1530. Patient stated he self administered in routine afternoon meds at 1230 and stated he

was feeling lethargic. Adderall 5mg prn given at 1800. Patient will check in with RN upon arriving back at hotel this evening.

2210 – Patient back at hotel. Planning on going to bed shortly as he is exhausted. No complaints at this time.

9/2/14

New Orders:
D/C Lamictal 18mg QD
Start Lamictal 25 mg QD
d/c Valtrex 1G BID
Start Valtrex 1G QD

0730 – Patient had a hard time waking up this morning. RN noted that he did not take his HS medications last night but states he slept soundly. Patient stated he was exhausted and fell asleep and forgot to self-administer medications. Patient self-administered routine AM medications at 0645. Complained he was still experiencing body aches and had night sweats during the night. Toradol 60mg IM LUOQ and Baclfen 20mg prn given at 0725. Patient is off to work. RN will visit patient on set this afternoon.

1600 – Visited patient on set. States he is having some break through anxiety and is taking Xanax 1.5 mg prn for the past 3 days. Patient asked if Xanax .5 – 1mg could be added to routine morning medications. Patient educated on how Xanax is addictive and our goal is to have patient only use Xanax in emergency situations while we are increasing Lamictal throughout next couple of weeks. Will discuss options with MD. Patient stated was still experiencing body aches but did not require any prn medications. Plan is for patient to attend an awards ceremony tonight and will be picked up for work

tomorrow at 0730. RN will visit patient on set again tomorrow. Patient given all routine medications to self administer for 9/3/14

2150 – Spoke to MD. New medication orders:

D/C Seroquel 25mg QAM
Start Seroquel 50mg QAM

9/3/14 – 1730 Visited patient on set from 1400 – 1700. Patient was in good spirits but complained of continually feel lethargic due to his long work days. Patient told RN that he took an additional Adderall 10mg yesterday. He took medication from today's med box. RN refilled today's med box and explained to patient that he could not increase his medications on his own. Per MD – B12 will be delivered tomorrow and this will help with patient's energy. RN will discuss other options with MD tonight. Patient complained of continued body aches and Toradol 60mg IM LOUQ administered with good effect. Patient given routine medications for 9/4/14. Plan is for patient to work till 2200 tonight. RN will come to set again tomorrow to assess patient.

New Med Order:
Adderall 10mg – ½ - 1 tab prn lethargy QD during work days

9/4/14 - 1230 – Per assistant, RN unable to go to set due to transportation. Per assistant, patient ok with seeing RN at home, after work.

0030 – Patient home from work. Complained of body aches and muscle tension in neck 6/10 Toradol 60 mg IM LOUQ, baclofen 20mg administered with good effect.

Explained to patient that MD would like patient to only take an extra dose of adderall during the work week and rest when needed on the weekends. MD would also like patient to try not to take any Xanax over the weekend to give his body a break from the benzos. Patient reminded that Xanax is for emergency anxiety of 8/10. Patient verbally agreed. VS 121/74 P92. Patient self-administered HS meds at this time and is going straight to bed. Patient requested to RN come to work with him tomorrow. Plan is to meet at house at 11:30am.

9/5/14 – 1300 – Currently at set with patient. Stated he self-administered routine AM meds at 1100 along with a prn Xanax 0.5mg. Patient complains of mild neck / shoulder tension and pain. Patient shown some stretching exercises and practiced them with good effect. Patient encouraged to stretch every morning after his shower. Patient also encourage to get weekly massages to work out the tension in his shoulder and neck. Patient agreed to do so over the weekend.

1530 – Patient relaxing in trailer between shoots. B12 1cc administered ROUQ.

2140 – Patient back home from work. Fiancé expressed some concerns about his decreased appetite. Patient agreed he does not have an appetite but explained to fiancé that he is drinking protein shakes during the day. Patient agrees to work on some nutritional goals after the weekend. Patient plans on spending the weekend at home relaxing. He is given routine medications for 9/6 & 9/7 with instructions to call RN if needed at all during the weekend.

9/6/14 – 2125 – RN checked in with patient via text message and patient replied "all's well...Great day!!! Went to see play for about 11 minutes and split at intermission!!! Fucking

dreadful!!! Now going to get a bite to eat...Definitely different with the Adderall!!! Struggled to stay awake during the play...More pleasant with, for sure. But, I'm up for the experiment!!!" Status reported to MD via telephone.

9/7/14 – 1600 – RN went to see patient in his home. He stated he has a nice weekend with his fiancé and he is pleased with how they are communicating and with how they are getting along. He states he continues to feel clearer every day and is thrilled with his creativity at work. He expressed gratitude for his "clarity" and is very happy to have the "blue mini beast" off his back. Patient given positive reinforcement for all the positive changes that he has made in his life over the past month. Patient states that he was not able to go the weekend without taking any Xanax. States he took Xanax 1mg before going out yesterday evening. Again, patient reminded to limit the Xanax for severe, breakthrough anxiety. Patient verbally agreed. B12 100mg 1cc administered ROUQ. Patient given rountine medications for 9/8/14. Plan is for patient to relax and play music for the evening and then get a massage at 2100. RN will go to set tomorrow at 1300 to check in with patient.

9/8/14 – 1230 – RN received text from patient assistant that he is wrapped for the day and will be heading home soon. New plan is for RN to see patient at his home at 1500.

2030 – RN with patient from 1500 – 2010. Patient continues to be in good spirits and be motivated for "clarity". Patient stated that he was able to not take any Xanax yesterday. Complained of mild anxiety at 1630 and self-administered Inderal 40mg VS 127/77 p 80. Patient encouraged using the gym, pool and sauna in his home to work through some of his anxiety rather than reaching for medications. Patient agreed

and went to turn on sauna for later use. Patient and RN set up a plan to work on his nutritional goals starting this week. RN went over goals with chef. Plan is for chef to pack small portions of protein and veggies and for patient to have small portions throughout the day. Patient agreed to try replacing some of the red bulls he drinks with coconut water throughout the day. Patient eating dinner of fries and a burger when RN leaves. Patient has the day off from work tomorrow and will text RN in the morning to set up a time to visit tomorrow.

9/9/14

1500 – Went to see client in his home. He stated that he slept well last night and self administered routine AM meds at 1030. Patient stated that he feels he is still experiencing anxiety throughout the day and would like to try other medication options. Status reported to MD –Inderal LA 80mg PRN QD ordered. Inderal administered at 1330 VS 117/74 p79. Patient continues to complain of body aches 5/10 Motrin 800 mg, Baclofen 20mg administered at 1400 with good effect. Plan is for patient to get a massage at 1700. Patient stated he ate 75% of his dinner last night and has been drinking coconut water throughout the day today.

New Med Orders:
D/C Lamictal 25mg QD
Start Lamictal 37.5mg QD x7D
Inderal LA 80mg QD PRN anxiety

9/10/14

1300 – Per assistant, RN is unable to go to patient's work to see him due to transportation issues. Patient will be seen at his home when he is finished with work.

2120 – RN received call from patient's assistant stating the patient was requesting an extra dose of Adderall and had asked assistant to take it from tomorrow's meds. Assistant instructed to tell patient that he cold not do that and reminded assistant that patient is not allowed to self medicate and change his medications without speaking to MD and situations like this are why RN needs to see patient while he is at work.

2215 – Received text from patient that he is on his way home, stating that "he feels a little weird. Trying to rule out possibilities..... No biggie, though! Promise though. Might be lack of sleep, or a lack of food??? Patient informed RN would be at house to see him when he got home.

2330 – Met with patient. He complained of body aches and nausea. Phenergan 100ml IM RUOQ administered with good effect. Patient reminded the importance of eating small portions throughout the day. While RN was visiting patient, fiancé came in and tried to start at argument with him. Patient was able to stay calm and talk his fiancé down. Patient given positive reinforcement for his reaction. RN encourage patient to take his HS meds within the next 30 minutes and to get some rest. Patient was exhausted but in good spirits when RN left home. Plan is for RN to visit patient at work tomorrow.

9/11/14

2210 – Spent the day with patient at work. His appetite has mildly increased. For breakfast he ate 2 hard-boiled eggs, for lunch he had ½ tuna sandwich and had a protein shake for late afternoon snack. Patient stated he self-administered routine AM meds at 1100 and routine afternoon meds at 1710. At 1500 patient complained of neck and shoulder pain 7/10 –

Baclofen 20mg, Motrin 800 mg administered. AT 1720 - Patient continued to complain of neck and shoulder pain 6/10 – Toradol 60mg IM LOUQ administered with good effect as pain decreased to 2/10. Plan is for MD to arrive tomorrow morning and MD and RN will visit patient at work. Patient given all routine meds for 9/12/14 for self - administration.

9/12/14 – 1700 – RN and MD visited patient at work. Patient continues to be satisfied with his "clarity" progress and expresses appreciated for medical team. Patient expressed some concerns with fiancé's behavior and how it is adding stress to his life. Patient given positive reinforcement on how he is working through his emotions and redirected to continuing to work on himself as his fiancé is continuing to work with her treatment team. MD gave patient some communication techniques to use with his fiancé when confrontation situations arise. MD also suggested it was time for patient to begin working with a psychiatrists and patient agreed. Patient informed MD and RN that he will be traveling to France with his fiancé this weekend. MD and patient decided it would best for patient and fiancé to travel without treatment team so they could be alone and focus on one another for the weekend. RN gave patient all routine medications for 9/14, 9/14, 9/15 for self-administration. Per MD orders patient was given Xanax 1mg #5 and Adderall 10mg #5 as prn medications for his trip. Plan is for RN to check in with patient via text msgs throughout the weekend and will see him back at work on Monday.

9/13/14 – 2010 – RN checked in with patient via text msg. Patient returned text and stated he was doing well and was "sort of" catching up on sleep.

9/14/14 – Did not hear from patient today. Per his sister he is doing well and will return to London late tonight.

9/15/14 – 1900 – RN and MD went to visit patient at his work. Patient stated he had a nice weekend and that things were peaceful between him and his fiancé. Patient spoke about really enjoying being at his house in France for the first time in three years and being able to enjoy it with a clear mind. Patient continues to complain of neck pain and waking in the mornings with a headache. MD feels this is from tendinitis in the neck and will order cortisone IM to be delivered on 9/17/14. Patient given all routine medications for 9/16/17 for self-administration. Plan is for RN and MD to see patient tomorrow at his home as he had the day off from work.

9/16/14 – 1300 - MD met with patient briefly this morning. RN did not see patient but left his routine medications for 9/16/14 with his fiancé to give to patient for self-administration. Plan is for patient to spend day relaxing and playing music with a friend. RN and MD will see patient at 11 am tomorrow.

1850 – Patient text RN to see if the medication for his neck had arrived. Patient reminded that it should be here tomorrow morning and that RN and MD would see him around 11am for the injection.

D/C Lamictal 37.5mg
Start Lamical 50mg QD x14 D
Start Xanaflex 4mg QID prn neck pain / tension
Start Prednisone 20mg QD x2D

9/17/14 – 1100 – RN and MD arrive at patients home and he is still sleeping.

1150 – Patient awake. MD administers cortisone injections for tendinitis. Patient tolerates well. Patient informed of new order of prednisone and zanaflex. Plan if for patient to relax in the morning and then spend the afternoon with a friend playing music. Patient informed to contact RN or MD if feeling any side effects from injections. Patient given all routine medications for 9/18/14 for self-administration.

1505 – RN checked in with patient via text to see how his neck and head was feeling after injections. Patient replied, "all is well so far."

9/18/14 – RN and MD visited patient at work. Patient stated he slept well last night and woke up without a headache this morning. Patient states, "this is life changing". Patient encouraged taking a zanaflex for muscle tensions this afternoon rather than a xanax. Patient is willing to try. At 1400 patient requested a zanaflex prn - one hr later patient stated he felt better and was going to try to get through the day without taking any xanax. Plan is for patient to work till 2200 and then perform with a friend at his concert. Patient given routine medications for 9/19, 9/20 for self-administration. RN will visit patient at work tomorrow.

9/19/20

1400 – RN with patient on set today. Set is extremely warm and patient is feeling lethargic. Patient continues to take the prn dosage of adderall in the afternoon stating that he does not have enough energy to get through the day. Report given to MD and per MD - continue current adderall regime and see if patient will get more sleep after finace leaves for NY. If getting more sleep does not help, MD will increase Adderall dosage.

Patient states his neck continues to feel great and has not complaints at this time.

2035 – While performing a stunt at work, patient hurt his neck. Patient c/o neck pain and headache and is worried that stunt has ruined what the MD had just fixed with the cortisone injection. Call to MD and Stat order of Toradol 60mg IM - LUOQ, and Balofen 20 mg given. Patient states he is in pain but still wishes to go play music with his friend tonight. Patient instructed to call RN if pain increases or is he feels dizzy or nauseous throughout the night. Patient given routine medications for 9/20/14 for sel-administration.

9/20/14 –

1300 – RN received at text from patient's fiancé asking to come over and check on patient as he is in a lot of pain from injury at work yesterday. Upon arrival at house patient c/o of head and neck pain 7/10, dizziness, nausea VS 114/78, p84. Call to MD – per MD he would like patient to have a CT scan of head and neck to r/o any fractures or bleeding. Per MD order – Stat Toradol 60mg IM LOUQ, Baclofen 20mg, zofran 4mg SL given. Call to patient's sister to inform production company of patient's status. Production company is arranging a local MD to come and assess patient.

1500 – Local MD assessed patient and patient diagnosed with whiplash and mild concussion. MD ordered CT scan of head and neck to r/o fractures or bleeding. MD ordered – Tylenol 1G prn q4h as needed.

1630 – Patient taken to London Clinic for CT Scan. Scan was well tolerated – Per technician results reported to ordering MD and scan was negative.

1645 – Local MD called to confirm all tests were negative and told patient to take it easy for next 24 hrs.

1715 – Patient back at house relaxing with fiancé. States his pain has decreased to 3/10. Plan is for patient to stay in and relax tonight. Will call RN if pain increases or if he experiences any nausea, dizziness or blurred vision.

2330 – RN text patient to check in. States his neck pain and headache are at a 6/10. RN went to house and administered Toradol 60mg IM ROUQ. Patient given routine meds for 8/21 to self - administer. Patient informed to call RN if he expereiences any of the symptoms we have discussed.

9/21/14

1130 – Received text from patient that he woke up and cracked his neck and it was the "loudest crack ever" and he feels much better today. RN went to visit patient and gave him Toradol 60mg IM to help with any residual inflammation. Plan is for patient to relax during the day and to go play music with a friend tonight. Patient will call RN if needed. Patient given routine meds for 8/22/14 for self-administration. RN will visit patient on set tomorrow.

2330 – AT 2130 RN received text from patient asking if this RN and Erin, RN could come to house and he would explain when we got there. Upon arrival we were told that some personal photos of fiancé had been hacked and posted to internet. Patient's fiancé was extremely upset. Both RN's sat with patient and fiancé and talked about feelings and how to work together as a couple and get through this. Couple given positive reinforcement for how they were handling this

stressful situation. At 2315 – both patient and fiancé took HS medications and said they were going upstairs to go to bed.

9/22/14

0125– RN received text from patient stating that he had been in an argument with fiancé and she "had a nasty freakout" and he would like RN to come give him "some fuckin' knockout yum, yum. RN instructed patient to take prn Neurontin 300mg prn and Seroquel 50mg and that RN was on her way over.

0330 – Upon arriving at the home patient was sitting in kitchen with scraped and bloody knuckles on R hand. Patient stated he had punched white board in kitchen after fight. Patient stated he had been texting his friend explaining why he didn't show up to play music and fiancé got upset that he was not giving her enough support and the fight escalated from there. Call to MD at 0145 and instructed to given a Stat order of Ambien 10mg to help patient get to sleep as he has an early work day. After taking medication – patient refused to lie down as he didn't want fiancé to think he didn't care by falling asleep. Patient was able to talk through his feelings and realized that he had not caused this argument. At 0300 fiancé came downstairs (she had been talking with Erin, RN) and asked fiancé to come to back. RN asked fiancé and patient to not discuss argument anymore tonight as patient needed to get to sleep. They both agreed. RN let patient know she would stay at house to make sure things remained calm for the rest of the night.

0630 – Patient up for work. Stated he slept about an hr. Patient informed RN that he would be taking extra adderall throughout the day as he could not get through work without

it. Report given to MD via email. RN will visit patient at work in a few hrs.

1930 – Patient stated he took an additional Adderall 5mg with his routine morning medications and took and additional Adderall 10 mg in the afternoon. Report given to MD. MD is ok with patient taking additional Adderall at this time but does not want to increase his routine dosage until we see how he feels after fiancé leaves for NY tomorrow and patient will get more sleep. Patient and fiancé texted throughout the day and appear to be in a better place. Patient instructed to go to bed early tonight and to not stay up late discussing relationship.. RN is now living in house with patient and informed patient to text if he needs anything throughout the night.

9/23/14

0820 – Patient up and off to work. Stated he stayed up last but things with fiancé were peaceful. No complaints at this time. Patient given routine meds for the day and took AM meds at this time. RN will see patient at set later in the day.

1600 – Patient took and additional Adderall 5 mg at this time.

2210 – Patient home from work. Ate a healthy dinner and took HS meds at this time. Patient plans to sleep on the couch tonight so given pillow and a blanket. Patient is falling asleep when RN leaves him on couch.

9/24/14

1030 – Patient reported vomiting in the middle of the night and continues to c/o nausea. Phenergan 50mg IM LOUQ

administered. Pt self-administered am medications. Pt will be re assessed in 1 hr.

1130 – Patient states he feels better and nausea has subsided.

1630 – Pt c/o lethargy and body aches 6/10. Self-administered afteroon meds. Tylenol 1G, Baclofen 20mg, Toradol 60mg IM RUOQ administered with good effect.

1720 – Patient c/o nausea – Zofran 4mg administered with good effect.

1840 – Patient c/o lethargy and still has to be at work for a few hrs. Self-administered an Adderall 10 mg prn.

2245 – Patient ate 75% dinner of fish and vegetables. Now getting a massage. Plan is for patient to self-administer medications after massage and then go to bed.

9/25/14

1030 – Patient awake. Stated he slept well, in his bed rather than the couch. Self-administered routine meds plus an additional Adderall 5mg. Feels he might be getting a cold. B12 1000mg IM ROUQ administered. Patient ate 100% of scone and jam for breakfast.

1330 – Patient states he continues to feel lethargic and asks if he can take an additional Adderall 10mg. Patient encouraged to hold off until afternoon dosage is due and patient agrees. MD emailed to inform that patient continues to request additional Adderall even after getting a good nights rest.

1500 – Patient self administers routine afternoon medications. C/o body aches and neck tension 6/10 – Toradol 60mg IM LOUQ administred.

1540 – Patietn states Toradol did not help with neck tension and self-administers Xanax 0.5mg. MD responded to email regarding patients continued lethargy and would like to decrease some medications that could be causing lethargy before increasing Adderall.

Medicaiton Orders

D/C Neurontin 600 mg HS
Start Neurontin 300 mg HS

Patient had been taking prn Zanaflex 4mg at bedtime. Per MD hold Zanaflex in addition to decreasing neurontin. Patient informed of changes and understands need to try this but still feels he needs additional adderall throughout the day.

2355 – Patient home from work at 2230. Ate 100% of healthy dinner. Patient relaxed by playing music and watching TV. Self-administered HS medications at 2355. Patient will call fiancé and then go to bed.

9/26/14

1015 – Patient awake – stated he stayed up really late talking to fiancé on phone but slept soundly after falling asleep. Stated he continues to feel achy but did not request any prn medications. Patient self – administered routnine AM medications and left for work. RN will meet patient at work around 1300.

1300 – Patient informed RN that he took an Additional Adderall 10 mg 1 hr after arriving at work. Stated he needed the medication, as he could not wake up.

1930 – Patient requesting Xanaz 0.5 mg to get through last shot of the day. Patient encouraged to try to relax with some breathing exercises first and then if he still needs medication he can take it. Patient agrees and is able to get through day without Xanax and comments that he is taking less and feels good about this. Patient given positive reinforcement about working with RN and not fighting suggestions.

2130 – Patient home from work – takes an additional Adderall 10 mg stating that he has a friend coming over and needs to be awake to entertain friend. Patient encouraged not to take adderall this late at night but he takes medication any way stating "I can sleep on this shit". Plan is for patient to have dinner with his friend and try to get to bed at a reasonable hour as he has had a long week. Patient given routine meds for 9/27/14 for self-administration.

2355 – Patient still up with friend. RN says good night.

9/27/14

1130 – House is still quiet and patient is in bedroom sleeping. Per security, patient stayed up visiting with friend till 0500. Report given to MD.

New Med Orders
Start Nexium 20mg Q HS

1630 – Patient awake and self-administered routine AM meds at this time. Patient is currently talking business with his assistant.

1845 – Patient leaves for play. Plan is for patient to go to play and then out for dinner with friends. Patient instructed to text RN if needed at all during the noc.

1155 – Patient home from the play and complains of neck pain 7/10. Toradol 60MG IM administered LUOQ. Patient states he did not eat much at dinner and eats 3 pb&j sandwiches at this time. Plan is for patient to self-administer HS meds and go up to bed.

9/28

1110 – Patient awake. States he slept well. Self-administered AM meds at this time. C/O mild neck pain 3/10. No prn medications requested at this time. Patient refused breakfast.

1730 - Patient self administered afternoon meds. C/O neck pain 6/10 Motrin 800mg, Zanaflex 4mg administered. Patient ate 1 piece of pizza for lunch.

2230 – Patient watching tv in kitchen. Plan is for patient to take HS meds soon and go to bed.

9/29/14

0945 – According to security, patient slept in the kitchen chair till 0600 and then went up to bed. Patient awake now – he stated he fell asleep in chair till 0200 and then went upstairs but did not fall asleep till 0500. Stated his neck aches but does not request and prn medication at this time.

1500 – RN arrives on set. Patient has just received news that a friend was in an accident and is currently on life support. Patient informed RN that he had taken Xanax 1mg due to being upset about news. Patient able to process news with RN.

2010 – Patient finished with work. States he is feeling really sad and would like to take another Xanax. Patient asked to process his feelings for a while and see if he cannot medicate himself immediately. Patient agrees and talks about how he feels "more than most" and feels bad for his friend's family. Patient decides to listen to music for a distraction.

2145 – Patient tries to cancel dinner plans for tonight and friend gets upset. This is more than patient can handle in his current state of mind so he self-administers prn Xanax 1mg.

2230 – Patient calls MD and talks about friend's accident and prognosis. Patient handling his emotions appropriately.

2315 – Patient complains of nausea Phenergan 50mg IM administered ROUQ.

Paste email to kipper.

9/30

1145 - pt awake and showered. Ate 100% bowl of oatmeal. Self administered routine meds at this time. Pt fearful of catching virus going around set. B12 1000mg IM ROUq administered. Plan is for patient to leave for work shortly and rn will join him on set around 1500. Status reported to MD via email.

1610 - pt c/o nausea. Phenergan 50mg IM LOUQ

1820 - call to local md

1830 - prn addrell.

2200 prn phenerga

2300 - md house call - order tamiflu 75mg qx10d

2330 - pt ate double portion of pho noodles. Pt asked what time he would like to bed - no later than 0100.

10/1

0120- pt took HSeds 20 min ago. Refusing tongonto bed until talks to fiancé. Reminded of need for allep. C/o anxiety over friend and feeling distant from girlfriend. Seroquel 50mg prn taken.

0250. Off phone. C/0 and cramping. Bentyl. Off to bed.

1015 - pt awake since 0900. Self administered routine AM meds. States he slept but feels he had "weird dreams". Affect is flat today. Patient states he is feeling "melancholy" due to missing his fiancé and kids and about his friends accident. Patient processing feelings appropriately. Plan is for patient to have a phone introduction with new therapist this evening.

1530 - met patient at work. Patient to stated he was feeling anxious and

took a prn seroquel 25 mg. pt c/o nausea and is still fearful of getting the flu. Phenergan 50mg IM RUOQ. Pt self administered tamiflu 75mg.

2245- pt had initial phone meeting w therapists. Therapists had sent wrong phone number and patient was unable to call. Email sent to therapists and rescheduled for tomorrow night.

2315 - patient ate sushi for dinner and is heading downstairs to get a massage. Patient agreed to go directly to bed after massage.

10/2

1030 - patient awake and feeling rested. Stated he took his HD meds around 0100 and fell asleep.

1130 - patient's assistant called to say patient was nauseous on the ride to work. Instructed to take a Zofran 4mg for prn pill container.

1420 - patient states nausea has subsided but complains of abdominal cramping. Bentyl 20mg given with good effect.

1850 - patient complained of lethargy and nausea. Phenergan 50mg R Deltoid.

1155 - patient ate 100% of healthy dinner of chicken, potatoes and veggies. Patient will call therapists at 0015 for a brief initial phone session. Patient self administered HS medications at this time.

10/3

0130 - patient spent over an hr speaking with dr blaustien. He was open and raw when speaking the therapists. Plan is for them to have another therapy session next week - possibly Tuesday evening, depending on patients schedule. Patient in bed, preparing for sleep at this time.

0745 - patient awake, eating breakfast of porridge at this time. Patient states he had a dream that assistant woke him and he got up and prepared for work. When he went down to the kitchen he realized it was only 0330 and he had been dreaming. Patient slept in a kitchen chair until he was

awakened by assistant at 0715. Patient self administered am meds at this time.

1610- patient is sad today as his friend was taken off life support and passed. Patient is processing feeling appropriately and has not requested any prn medication. Patient eating ramen noodles for a late lunch.

2330 - patient home from work. At 2 sandwiches for dinner. Patient plans on self administering HS meds shortly and going to bed. Instructed to text RN if he needs anything throughout the night.

10/4

1130 - patient states he slept in the kitchen chair all night. Self administered Am meds at this time. Patient stated he ate some rice earlier as that is all he dared to eat due to fear of upset stomach. Patient informed that rn spoke to MD about ongoing stomach issues and that he must change his nutritional intake and cut back on red bull. Patient expressed understanding and stated he will cut back on red bull. Plan is to relax, get a massage and go to dinner with friends.

1230 - patient co neck pain. Zanaflex 4mg administered. Patient educated on the importance of sleeping in bed or at least on couch so his neck is not in an awkward position while sleeping.

1440 - patient sleeping in kitchen chair.

1830 - patient finished with massage. Stated his neck feels better but would like another massage tomorrow. Massage scheduled for 9pm.

2330 - patient back from dinner and stated he had a fun night. Patient administered HS meds and preparing to rest on the couch.

105/

1045 - patient awake. States he woke up in the middle of the night and felt like his foot was asleep. When he stepped down on ot he felt pain. Foot is swollen with a 1 inch cut. Ice applied. Patient self administered am meds and ate toast with peanut butter.

1630 - patient sleeping on coach.

1900 - patient awake. Watching tv. Will have massage at 2100.

1145- patient resting on couch - stated he self administered HS meds after massage and is still unable to sleep. Prn neurontin 300mg and seroquel 25mg administered. Patient continues to complain of pain in r foot. Motrin 800 mg administered and report given md. Patient resting on couch. Instructed to text RN if still awake in one hr.

10/6

1030 - patient awake. Stated he fell asleep immediately after taking the prn neurontin and seroquel and slept soundly throughout the evening. Patient ate 10% of breakfast. Continues to complain of r foot pain. Dorsal, lateral foot swollen w 1" laceration. Mortin 800mg given. Ice applied.

1615- Patient continues to complain of foot pain. Production office will send an orthopedists to assess patient this evening. Production RN wrapped r foot and ankle. Motrin 800mg and Tylenol 1G administered. Update left for md via voicemail.

1700 - Patient assessed my local orthopedists. He believes it is a sprained ankle but ordered x ray of r foot and ankle to r/o broken bones.

2130 - x ray of r foot and ankle completed. No broken bones noted. Results will be emailed to PMD in Los Angeles.

New orders: adderall 15mg tid.

10/7

0015 - patient ate 100% dinner of fish and veggies. Patient chose to eat dinner by himself stating he had to make some phone calls and was feeling sad missing his children. Patient self administered HS meds at 2355. Patient informed of adderall increase and felt comfortable with change. Patient prepared a bed on the couch. Ice applied to r dorsal foot and instructed patient to sleep with foot elevated. RN on set will wrap foot

when patient arrives at work tomorrow.

0945 - patient awake. States he slept well on the couch last night. Fiancé called him at 0500 but he slept through the call. Patient states his foot feels better today. Less swelling noted. Am meds self administered at this time. Patient will ice foot on way to work and RN on set will wrap foot when he arrives to set. This RN will check in with patient via text around 1300 today.

1310 - text patient to see how he is feeling today. Patient replied the increase in adderall is "a marked difference, much more effective". Plan is for rn to see patient when he arrives home from work. Patient is scheduled to speak with psychiatrists at 10pm tonight.

2345- patient had a 30 minute therapy session tonight. After session he conditioned to process feelings with RN for 1.5hrs. Patient ate 100% of healthy dinner. Patient plans on taking a sauna, self administering HS meds and sleeping on the couch. Security informed to check on patient in 20-30 minutes to make sure he is not asleep in sauna.

1045 - pt awake. C/o headache. Motin 800mg. 100% porridge

1530 - Tylenol 1 G.

1715 - f/u by orthopedists.

1930 - continues to c/o ha. Toradol LOUQ.

9/9

0300 - patient home from work. Will take HS meds and go to sleep on couch. States his head feels much better.

1500- patient continues to sleep on the couch.

1630 - patient awake, showered and watching tv. He self administered AM meds at this time. states he is happy to have the day off and relax and is happy he did not wake up with a headache today.

2100 - patient spent the day sleeping on and off and watching tv. His sister is coming over to watch a movie tonight. Rn instructed patient to text if he needs anything.

1400 - patient awake. States he took his HS meds around 0300 and slept from 0500-1330. Pt c/o headache and cold s/s. Toradol Im, b12 administered. Plan is for patient to go to photoshoot and return home around 1700.

2030 - patient home and showering. Patient will hang out house and have hair dyed tonight.

10/11

0230 - Hair dresser left. Patient stated he was going to administer HS medications and go to bed.

1030- patient sleeping soundly on couch.

1130 - patients fiancé has arrived home and he is awake. They are chatting in living room. Patient self administered meds at this time. Plan is for patient to attend a screening this afternoon.

1430 - patient leaving for screening. No complaints at this time.

1700 - patient home from screening. Complains of neck pain a d headache 7/10. Toradol 60mg, baclofen 30 administered. Patient hanging with friends at this time.

2300 - patient and fiancé in argument. Patient is calm but states he is upset and would like to be left alone at this time. Patient self administers HS meds and plans to sleep on couch.

10/12

0230 - patient awake in kitchen. Stated he waited for fiancé to fall asleep and could not sleep himself. Patient offered prn meds to help him sleep but

refused.

0500 - patient processed feelings appropriately and was going to bed at this time.

1300- patient continues to sleep.

1530 - patient awake and preparing for wardrobe fitting. AM self administered at this time.

2130 - patient and fiancé have decided to stay in tonight. Will order dinner in and watch tv.

10/13

0100 - patient self administered HS medications and going to bed.

0545 - patient refusing to get out of bed when assistant wakes him for work.

1210 - patient out of bed. Had been refusing to get up and go to work due to not feeling well. Complains of sore throat, congestion and body aches. B12 RUOQ and Toradol luoq. administered. Report given to la doctor and call to local doctor. Local md plans to come between 2-3 to assess patient.

1515- md assessed patient. Do: URI. Tx: Zithromax 3d, nasonex 3dv. Encouraged rest and increase fluid intake.

1930 - patient feeling a bit better this evening. Was able to visit friend and god children for a few hrs. Came home and ate 100% of healthy dinner.

2130 - patient self administered HS meds and going to bed at this time.

10/14

0630 - local md came to assess patient and cleared him to go back to work. Patient continues to complain of fatigue, sore throat and body aches but states he does feel better than yesterday and feels he is ok to work. Patient self administered AM medications and per MD order administered B12

1000mcg LOUQ. RN will vibist patient at work this afternoon.

1300 - RN checked in with patients sister and was informed he is tired but doing ok at work.

1630 - RN and MD arrived on set to assess patient. Patient appeared agitated and was short towards RN. Patient states he is ok at this time. Per patient's sister, he is upset with the director for making him do too may unnecessary takes when he is not feeling well.

1930 - patient finished filming and was extremely agitated leaving the set. Patient kicked in the door of his trailer and refused to speak to director. Patient was verbally aggressive to another person on the set so no apparent reason. Per MD patient is to take Xanax 2mg to reduce his agitation at this time.

2115 - RN and MD check on patient at his home. He appears calmer but still agitated about work. Per MD orders - seroquel 50mg administered. Plan is for patient to eat dinner, take HS meds and go to bed shortly.

10/15

0645 - patient awake and states he slept from 2200-0430. Patient continues to be agitated about work and is verbalizing having desires to escape with drugs. Patient given positive reinforcement for processing feelings and encouraged to call his so we friends for support regarding the feelings he is having. Patient has a 2245 appointment with psychiatrists. Patient self administered routine AM meds and Xanax 1mg.

0845 - MD informed of patients state of mind and continued agitated. He is on his was to assess patient.

1230 - patient had fallen asleep and is now wake talking with MD. It has been decided patient is under too much stress at it would be best for him to stay home and rest todAy. Per md order: seroquel 50mg, neurontin 900mg administered. Plan is for patient to stay home and rest today.

2330 - patient relaxed and played music throughout the afternoon. He fell asleep around 1900 and continues to sleep at this time.

New med orders:
Increase lamictal 75mg qAm
Neurontin 600mg q4-6hrs
Seroquel 37.5mg tid, 50mg HS

10/16

0920 - patient awake and self administered routine medications. Patient Informed of medications changes. Patient appears to be less agitated this morning and states he feels rested.

2100 - patient home from work. States he self administered routine meds at 1400 and 2015. Patient much calmer today. Md injected patient in bottom Occipital lobe with cortisone for tendinitis. Well tolerated. Patient plans on having dinner with fiancé, taking HS meds and going to bed shortly.

10/17 -

1000 - patient awake, stated he slept well. Self administered am meds and is off to work.

2100 - md given X-rays of foot and report from local surgeon. Md saw patient and states no relief from injection yesterday.

10/18

1130 - pt awake. Is 3 hrs late leaving for work. Stated he had a hard time waking up even though he went to bed at 0100. States he still has no relief from neck pain. Self administers am meds at this time.

1700 - per assistant patient has had a nice day at work and has remained calm and peaceful.

10/19

0130 - patient home from work and is in good spirits. Continues to complain of neck pain. MD administers cortisone injections. New med orders: prednisone 20mg Qd x2d. Patient self administers HS meds at this

time and will go to bed.

0730 - patient awake preparing for work. States he slept from 0200- 0700 and is excited to start his last day of shooting. Patient ate toast and coffee for breakfast and self administered routine AM meds and zanaflex 4mg for muscle tension in neck. Patient will leave for work after and sauna and shower and nurse will visit him on set later today.

1400 - Patient in good spirits and is enjoying last day if work. States he administered routine meds at 12:15.

1730- patient states he is feeling fatigued and complains of neck pain 7/10. Self administers routine medications and given Motrin 800mg, zanaflex 4mg. Rn will see patient when he gets home from work.

10/20

0130 - patient home from work. States he is physically and emotionally exhausted and looks forward to his time off and seeing his kids. He is waiting for chef to finish dinner and will eat, administer his HS meds and go to bed. Plan is for him to sleep in tomorrow and we will travel to savannah GA in the evening.

1530 - patient awake and self administers am medications. States he was up really late but feels rested. Patient eats 100% of porridge.

1630 - patient tells his sister and RN that him and his fiancé argued last night and he is upset with her and feels he must talk to her before boarding the plane. Patient is feeling anxious and self administers Xanax 1mg. Goes upstairs to talk to fiancé.

2200 - leaving for airport. Patient and fiancé traveling alone in separate car.

10/22

0100- patient self administers HS meds and heads to back of plane to sleep.

Now in Georgia -5 hrs

0300 - arrived at hotel. Patient requested additional melatonin to help get him asleep and to adjust to time change. Melatonin 20 mg administered. Patient asked to text rn when he awakens later today.

1530 - patient states he awakened at 1430 and self administered am meds. He requested an emergency session w psychiatrists to discuss feeling about arguments with fiancé and would like some tools to help him feel with his emotions. Appointment made for 1900.

2010 - patient spoke to psychiatrists for 50 min and was open and honest with his feelings. He feels better after conversation but also feels he is in a "no win situation" with fiancé. Patient will meet with psychiatrists in person next week. Plan is for patient and fiancé to go to dinner this evening. Patient is feeling exhausted and wants to stay home but does not want to upset fiancé. Patient encouraged to text rn if he needs anything throughout the night.

10/23

1520 - text patient to see if RN could stop by and check in. When RN arrived in the room patient was agitated and felt fiancé was using the term mania to explain his behavior and excuse herself from any fault during arguments. Patient was upset by this label. RN processes feelings with patient and he was able to see fiancé' negative behaviors. Patient looks forward to meetings with psychiatrists next week as he is stressed about current state of his relationship. Report given to MD. Patient given routine meds for 10/24 to self administer. Patient will text rn if needed throughout the evening.

10/24

1130 - RN text patient to check in. No response.

1615 - Per patients assistant, patient is awake.

1710 - RN stopped my patients's room to check in. Stated he slept well and had a peaceful night. Fiancé was not feeling well and he took care of her. Patient spoke to MD on phone as processed the stress he was currently going through. Patient given routine meds for 10/25 and encouraged to call

RN if needed during the night.

10/25

0930 - RN received text from client that he is awake. He had another rough morning with fiancé and would like to process. RN informed client she would be over in 10 min.

12:00 - patient able to process feelings appropriately and remained calm. Plan is for patient to keep the peace with fiancé in hopes that they can both speak to their individual therapists about the issues they are having after returning to la. Patient is scheduled to see his therapists 3x next week.

2100 - patients fiancé is having to work later than expected. Patient is debating whether or not to leave GA and this is causing patient stress and anxiety. Prn neurontin 900 mg and seroquel 100 mg administered.

2230- patient's fiancé is home from work. They talked privately for 30 min and have decided to travel home together. Patient is calm. Leaving for airport now.

10/26/14
0315 - patient dropped off at apartment. He is given all routine medications for 10/26/14 for self administration. Plan is for rn to visit patient to tomorrow.

10/26/14

1700 - patient is home spending time with his children. Stated he and fiance had a long talk and he feels a lot "lighter" after expressing his true feelings. Patient given routine medications for 10/27 and 10/28 for self administration.

10/27/14

1313- RN touched base with patient via text - he states everything is ok and he is spending time with fiancé and assistant.

10/28/14

1035 - rn received text from patient stating he had "dipped into today's meds" yesterday and needs them replaced. RN informed patient she would come over in an hr. MD informed.

1300- Arrived at patient's home at 1145. Patient was pleasant and calm. The following medications replaced: adderall 15 mg bid, neurontin 300mg bid, seroquel 25mg bid. MD informed. Patient and fiancé are talking about house remodel - will will check in again later in the evening.

2300 - RN attended screening with patient and other friends and family. Patient was proud of his work and in good spirits. Patient given routine meds for 10/29 for self administration. RN will visit patient tomorrow around noon.

10/29/14

New Med Order:

D/C Lamicatal 50mg QD
Start Lamicatl 75mg QD

1300- visited with patient for an hour. He is in good spirits and looking forward to relaxing, playing music with friends and spending time with his children for the next couple of days. RN explained to patient that she will be going home for 2 days and MD will be covering if patient needs anything and RN will be checking in via text. Patient left was for 10/30, 10/31 11/1 for self administration.

10/30

1500 - RN text patient to check in and did not get a response.

10/31

1505 - RN reached out to client via text to ask how he is doing. No response.

1600 - client responded via text and said he is "all good" and apologized

for not responding yesterday. Plan is for RN to see home tomorrow afternoon.

11/1

1700 - RN arrived at patient's home. Stated he has been hanging with his son and enjoying relaxing at the house. Patient returned med containers from last 3 days and it was noticed that patient did not take 10/30 evening or HS meds. Patient cannot recall why he did not take them. Reported to MD. Patient appears calm and pleasant. Routine Medications for 11/1 and 11/2 given to patient to self administer.

2300 - RN, patient, son, security, and assistant watched a movie together. Patient was present and social.

11/2

1500 - RN checked in with patient via text message. Patient complained of headache. Patient instructed to self administer Motrin 800mg, increase fluid intake and to eat a meal. Patient instructed to notify RN if headache persists.

1930 - Patient notified RN via text that he was feeling better. Plan is for RN to visit patient tomorrow evening.

11/3

1130 - RN arrived a patient's home at 1930. Patient stated he had not eaten all day. Assistant ordered burgers and patient ate 25%. Patient was focused on relationship with fiancé and is struggling with conflicted emotions. Patient encouraged to process these feelings with therapists tomorrow. Patient was hyper focused about relationship issues. MD and therapists notified about patients state of mind. Patient given routine meds for 11/3 and 11/4 and plan is for RN to see patient tomorrow around noon.

11/3

1210 - RN stopped by patient's home and he was asleep sitting up on the couch. Patient's nephew was at house and informed RN that patient was up

till 0830 this morning. Report given to MD and he is concerned with patient's sleep cycle. New medication orders given:

D/C previous seroqel orders
Start Seroquel 50mg QID

1700 – RN went back to patients house. He was chatting with a friend and is feeling stressed about his relationship. He feels she is not being truthful with him and he is not sure how to confront her about this when she arrives home. Patient encouraged to discuss his feeling and concerns with his therapists tomorrow. RN emailed therapists to let him know how patient was feeling. Patient's plan is to hang out with friend for the evening. Patient encouraged to take his HS meds at a reasonable hour and to try to go to bed early and get back on a healthy sleep cycle. Routine medications for 11/4 left with patient to self-administer.

11/4/14

0900 – Stopped by patient's house and he was asleep on the couch.

1400 – Received text message from patient's friend stating that patient did not take HS meds till 0500 this morning. MD informed via phone.

1515 – Went to patient's home to make sure patient made it to his therapy appointment. Patient was in good spirits but continues to be negative about his feeling towards relationship. Patient made it out the door to be on time for appointment. Patient given routine meds for 11/5 for self-administration.

11/5/14

2300 – Went over to patient's home to check in on him. He was ganging with friend and concerned that fiancé was not responding to his texts all day. This is making him angry and feeling like she is doing this on purpose to upset him. Patient encouraged to speak to her about why she did not return text msgs before assuming she is trying to upset him. Patient also encouraged to speak to therapists about his continuous negative feelings about his relationship. Patient's friend was going to spend the night with

him. Plan is for fiancé to return home tomorrow around 1400. Patient encouraged to get a good nights sleep so he will be in a good state of mind when fiancé returns. Patient given routine meds for 11/6 and 11/7 to self administer.

11/6/14 –

11/4

New med order

Seroquel 50mg TID
Seroquel 25mg 1800

0900 - stopped by patients home and he was asleep on the couch.

1400- received text msg from patient's friend that patient did not take HS meds till 0500 this morning.

1515 - went to patients home to make sure he made therapy appointment. Patient was in good spirits but continues to be negative about his feelings towards relationship. He made it out the door in time to be on time for appointment

11/10

Seroquel 50mg qid
Lamictal 100mg

11:45 - pt did not take HS meds last nights. Appears anxious. Patient went to get in shower when RN arrived. Plan is for patient to see therapists at 12:45 and then see MD at 2:00.

11/11

1230 - did not take HS meds last night.

11/14

RN will be out of town through 11/17 report given to Erin Boerum, RN, who will will cover. Patient given medications for 11/15 - 11/17 for self administration.

11/17

1400 - RN and MD went to patients house to assess him. Patient appeared anxious and depressed over relationship issues. Patient continues to be ambivalent about relationship status. Patient has not been sleeping. Seroquel HS increased to 150mg for tonight. Patient agrees to take only medications prescribed my MD and to work to get his sleep cycle normalized. Patient agreed to let RN know if he feels he cannot handle his emotions and requires more medication. Patient will resume seeing psychiatrists next week when he is not working.

2105 - per patients assistant, patient has left to go out to dinner with fiancé.

11/17

0845 - per patient's security, he spent the night with his fiancé downtown.

1300- received text from patient to meet him at 1600 back in Hollywood.

1930 - patient stated he had a nice night with fiancé and they are working things out. He said he got a good nights sleep and felt much better today. Report given to MD and MD would like to continue patient on Seroquel 150mg at HS x2 more nights. Patient will work in Lancaster for the next 3 days and was given routine meds for 11/18 & 11/19 for self administration. Patient will contact RN via phone of he needs anything. Patient will be back home during the nights.

11/18

1315 - received text from patient's assistant that he was on time for work this morn and "he is like a brand new man". He said reception is bad where they are filming so not to expect to hear much from anyone today.

11/19 – Per assistant patient continues to enjoy this shoot. He is upbeat and energetic.

11/20

1715 – Sent patient a text at 1515 asking how he was doing. At 1715 he responded that shoot is going well. He said that he spend the night with his children last night and enjoyed the time with them.

2100 – Met patient at his home. He was in good spirits and plans to spend the night with his children again tonight. He states him and his fiancé are continuing to talk things out and he is feeling good about their communication. Patient given routine meds for 11/21, 11/22 and 11/23 for self administration.

11/21

11/22 - checked in with patient's assistant. He continues to be enjoying work and is in good spirits. Patient has taken an extra dose of adderall 15mg for the past 3 days. MD notified and new meds orders given.

11/23

1330 - arrived at patients home downtown. When gathering patient's med boxes it was noticed patient has not taken his HS meds for the past 2 nights. Patient stated he had been exhausted from work and passed out. Patient educated on the importance of taking medications as prescribed. Patient states he has been sleeping well and is in a good place emotionally and things are going smoothly with fiancé. Patient informed of med changes and is in agreement with them. Patient given routine meds for 11/24 and 11/25 for self-administration. Patient given his therapy appointments for next 2 weeks.

New med orders

D/C adderall 15 mg tid
Start adderall 30mg bid

11/24

1700 – Text sent t patient to check in and did not get a response.

11/25 -

1300 - patient awake and in good spirits. Patient aware and apologetic for missing therapists appointment. Stated he was up till 0430 and could not wake up for appt. patient given meds for 11/25 - 1-/30 for self administration. Report given to Erin, RN who will be covering patient. Patient aware that this RN will be out of town but still available via phone. Plan is for RN and patient to check in via text through the weekend.

11/26 - RN text patient to Check in and did not get a response.

11/27 - RN text patient and did not get a response.

11/28 - RN text patient and did not get a response.

11/29

1520 - RN heard from nurse covering that patient has been experiencing nausea and vomiting a few times over the past few days. RN reached out to client and he responded that he has woken up from a dead sleep and vomited 2x. Reported to MD. MD will call patient to discuss some possible causes and treatments.

2300 - per MD he instructed patient to take Zofran 4mg SL prn nausea and to not eat past 9pm and to decrease his smoke inhalation.

11/30

1700 - RN went to visit with patient and his sat and sun med containers were in disarray. He had not taken all meds in certain days and other slots had pills in in that should not have. Patient was not able to tell RN exactly what he had taken yesterday or this morning. Patient explained that he had put the med containers in his bag and they had fallen out and he did not know what to take at what times. RN corrected the rest of patient's meds for Sunday and gave him meds for 12/1 and 12/2 for self administration. Patient educated on his med regime and instructed to call in the future if he ever gets confused with his medications. Per patient, the Zofran helped his nausea and he did not vomit last night. Patient was in good spirits and was going to visit his mother this evening. Patient and RN will touch base tomorrow.

12/1/14

12/2/14

1415 - Met with patient and MD to discuss patient's nausea and vomiting. MD instructed patient to to not eat 4 hrs prior to going to bed and to take a Zofran 4mg SL at HS. No other meds changes were made. Patient was in good spirits and feels he is getting a lot from his therapy sessions. Patient given routine meds for 12/4. Plan is for RN to visit patient at his home on 12/3 or 12/4.

12/3

0015 - received text msg from patient'a fiancé with a picture of Zofran asking if that was his Zofran. RN responsed yes and asked fiancé to remind him to let the tablet dissolve under his tongue rather than swallow.

1520 - RN sent text to patient asking how his nausea and / or vomiting was last night. Patient did not respond.

1745 - RN sent patient a text reminding him of therapy appt tomorrow at 10:30am.

12/4

1520 - RN received text from patient staying that his "meds were in horrific shape and all over the place". Patient asked RN to please come to office and help sort his medications. Upon arrival patient asked for a Xanax and stated he could not find his prn Xanax. Xanax 1mg given to patient. All previous med boxes were taken

away and RN made new med boxes for the next 3 days. Patient was also given a new prn medication box which locks. Patient was in good spirits and spoke about how much he was getting out of his therapy sessions. Patient requested 3 appointments for next week. RN requested appointments from therapists via email and gave md report via telephone. Patients sister was concerned that patients speech appeared slowed and slurred after he had taken Xanax - this was reported to MD.

New med orders

Zantac 150mg qhs

12/5

1915 - RN checked in with patient to see how his heartburn was this morning. Patient stated he did not have any but stated he also took 4 tums before going to bed. Patient instructed to only take his routine HS meds, which includes Tagament, so we can tell if it helps.

2050 - patient texted rn to say that some of his meds had gotten wet and were a confusing mess so he was going to "rob peter to pay Paul". RN told patient she would like to come over and see the meds and make sure he was taking the correct meds. Patient did not respond.

12/6

1200 - RN text patient to say she would like to come over and make sure his meds were correct. No response.

1930 - RN sent another text asking to come over and correct medications. No response.

12/7

1:45 - RN sent another text to patient at 11:30am stating that I need to see him today. Patient responded at 1345 that he was downtown and to come over.

1700 - arrived at patient's house at approximately 1445. Patient was in good spirits. He talked about how happy he is to "to not have the monkey on his back". He said he is happy to feel clear and to be back participating in life. He states that him and his fiancé are in a good spot and that he recognizes that he could not have gotten there if he was still using. Patient was given positive reinforcement for his actions and behaviors and for his continued work towards personal growth. Patient was given his appointment times for Dr Blaustein this week and was given his routine meds for 12/8, 12/9, 12/10 for self-administration. Plan is for rn and

patient to be in contact via text over the next 2 days and for RN to see patient again on 12/10.

12/8 - patient missed 1:45 therapy appt. patient text to sat he had a horrible fight with fiancé last night and was up all night. Stated they are working through things today.

12/9 –

1000- Reached out to Patient via text and did not get a response.

12/10 –

1115 - Reached out to patient via text and did not get a response.

1300 – Report given to MD via telephone. Following med orders given.

New meds
Wellbutrin 75 mg x7days

1/7/14

New Medication Order

D/C Wellbutrin 150 mg QD
Wellbutrin 300mg QD
Dexalant 60mg qHS

1700 - Patient continues to complain of heartburn and nausea in the during the night and early mornings. Dexalant 60mg to be initiated and will schedule an endoscopy for early next week. Patient given 1 weeks worth of routine meds to self administer. Patient asked to please respond to RN's text messages and to reach out if he needs anything. Patient verbally agreed.

1/8/14

Endoscopy scheduled for 1/13/15 @ 10:45am. Dr. Kipper, patient and

patient's assistant informed of appointment and pre-op instructions.

1/12/15 –

Per Dr. Blaustien, patient missed appointment today.

1500 – Patient requesting to cancel is endoscopy for tomorrow. States he feels his symptoms were brought on by stress and that he is feeling better now. MD informed, spoke to the patient and the test has been cancelled. RN requested to see patient tonight and he did not reposnd to request.

2100 – Patient informed test had been cancelled via text and asked if he still planned on making hypnotherapy appt and patient did not respond.

1/13/15 –

1800 - Patient did not respond to RN's text messages. Per assistant patient did make it to his hypnotherapy session.

2/1

2100 - text patient to remind him of procedure tomorrow morning and to not eat or drink past midnight tonight. No response.

2/3

0745 - patient refusing to wake up and go to endoscopy. MD informed and appointment cancelled.

1300 - text patient to see if he would like me to schedule appointment with therapists for tomorrow. No response.

2/4 -

1040 - text patient to follow up regarding setting up an appointment with his therapist. No response.

1330 - text patient to ask if he was ok since he had not responded to my last few text. No response.

1425 - according to patient's assistant and security, patient is ok.

2/5/ – Patient and fiancé travleling to island to get married. RN will join them in 24 hrs. Patient given his routine medications for the next week.

2/9/ – Patient will be returning the island today. RN spent very little time with him on the island.

2/10

Patient concerned about weight gain from Seroquel. Plan is to start to taper Seroquel and start Metformin 500mg bid. Patient given routine medications for the next week.

2/11 Patient and crew flying to Australia today to start filming of patient's next movie. Patient is in good spirits and excited about the project.

2/13/15 – Patient arrived at home in Australia. Is happy with his accommodations. Plan is for patient to rest during the day. He will start work tomorrow.

2/14 – Patient stated he did not sleep well last night due to jet lag. Patient encouraged to stay awake as much as he can today to try to get his sleep cycle on track.

2/16 – Today is patient's first day of filming. RN will not be going to set today but will see him tomorrow.

2/17 – Patient appears in good spirits but continues to not be able to sleep at night. Patient stated that he took his hs meds too late on 2/14 and forgot to take his hs meds on 2/15. RN and patient decided that RN should text patient every night at 2200 as a reminder to take his bedtime meds. Patient given his routine medications for the next week.

2205 – Med reminder text sent. Patient responded.

2/18 – RN went to set to visit with patient. He appeared to be in good spirits and is enjoying work. However, he continues to complain of not being able to sleep at night. Patient admitted to staying up and talking with fiancé on the phone till 0400 and 0500 am for the last couple of nights. Patient educated on sleep hygiene and told me he must take his meds, lie down and create a calming environment to sleep in. Patient encouraged to take a prn xanax for the next few nights if he is still awake after 1 hr of taking his hs meds.

2210 – Med reminder text. Patient responded.

2/19 New Med Order
Seroquel 25 bid, 50 hs

2/20 – 1100 – Went to patient's home to wake him for a spray tan appointment. Patient refused to wake up and after 3 hrs of trying appointment was rescheduled.

2100 – House manager text and said patient slept all day.

2200 – Text sent to patient asking if he would like his med reminder later since he had the day off tomorrow. No response.

2/21 –

1335 – Sent patient a text asking if he needed anything or wanted me to go visit him at the house. Patient responded that he planned on sleeping most of the day. Patient encouraged not to sleep the entire day so he would not mess up his sleep cycle.

2200 – Text msg sent for med reminder. No response.

2/22

1255 – Text msg sent to client checking in and asking how he slept and if he needed anything. No response.

1900 – According to house manager patient slept till around 1700 and then got a spray tan.

2311 – Text msg sent for med reminder. Patient responded.

2/27 Seroquel 25 tid.

3/7/15 –

1130 – MD received a text msg from client that he had been arguing with wife and that he had cut his finger. According to patient his assistant and security were on there way to pick him up.

New Med Order

Augmentin 875 mg BID x10D

1300 – Patient was having a hard time leaving the house so security suggested the MD and RN go to house to see patient. Upon arrival to house patient was sitting in car ready to leave. MD assessed patients finger and will spend more time with patient at the location he is being moved to.

1530 – MD cleaned and dressed wound to R middle finger. RN, MD, security and assistant will be taking patient to ER to have finger wound properly cleansed and treated. Patient given Toradol 60 mg IM ROUQ and Augmentin 875mg PO.

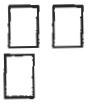
1130 – Patient and staff returned from ER at 2130. Patient was seen by ER MD and hand specialists. Wound was cleaned and dressed and patient was given a tetanus shot L deltoid and given IV antibiotics. Discharge instructions were for patient to see hand specialists tomorrow to discuss possible treatment options for finger. Upon arrival back to apartment patient discussed feeling of anger and sadness about relationship. Patient was encouraged to stay away from wife as the relationship is toxic. Patient expressed verbal understanding and why they needed to separate. MD offered patient Valium 10mg IM to help with his anxiety and anger but patient refused. RN and MD suggested that patient take his bedtime meds and go to sleep and patient refused. Patient was talking about wanting to

drink alcohol but did not obtain any.

3/8/15 –

0145 –

Patient has been on phone with his security guard that is staying with his wife at their rented house. Patient is discussing wanting to go home to LA tomorrow and rehashing night. Patient's personal security guard came to stay with patient. RN will be next door and instructed security to call during the night if needed.



3/20 - 1835 - pain 6/10, Toradol 60 mg IM ROuQ

MD orders

Toradol 60mg IM q6h pain
Valium 5mg IM q6h anxiety
Valium 10mg IM qhs
Continue all routine Meds

Monday 3:30 follow up
OT 4pm for splint.

2015 - patient stated pain level decreased to 4/10. Right arm placed in splint to decrease pulsating sensation in finger.

2115 - Mortrin 800 mg, Valium 5mg

3/21/15 - 0115 - patient in good spirits. Pain 6/10. Patient self administered routine HS medications. Toradol 60mg IM LUOQ, Valium 10mg RUOQ administered. Patient encouraged to be settled in bed within 30 min and instructed to sleep with arm elevated. Patient instructed to call RN during the night if he experienced any pain or right when he awakes in the morning. Patient verbally agreed.

0730 - report given to MD via telephone.
New Med Orders

D/C previous Toradol order
Toradol 60 mg q4h pain

1000 - Toradol 60mg IM ROUQ, Valium 5mg IM RUOQ. Pain 6/10. Patient slept from 0200 - 0930. In good spirits. Report given to MD via text. VS 149/94 P 70.

1105 - patient states pain continues to be 6/10. Motrin 800mg administered.

1200 - status of patient reported to MD via telephone.

1400 - patient states his pain continued to be a 6/10. Toradol 60mg LUOQ. Patient self administered routine noon Meds.

1530 - patient spoke to MD. No changes at this time. Valium 5 mg IM ROUQ administered.

1845 - Toradol 60mg IM LOUQ. Patient continues to state that pain in at 6/10 but that he is able to tolerate it. Patient is social and pleasant. Patient continues to smoke cigarettes. RN continues to educate on the importance of smoking cessation and the effects on the healing process. Patient states he will switch to a vapor cigarette tomorrow.

3/22/15

0105 - Toradol 60mg IM LUOQ, Valium 10mg RUOQ. Patient encouraged to take his routine HS medications at this time so he can get to sleep soon but he refused. Stated he will take them within 30 min. Patient instructed to call RN during the night if he awakens with any pain. If not, patient to call RN fist thing in the morning. Patient left with a Motrin 800 mg prn pain during the night.

1615 - patient stated he slept from 0400 - 1300. Vs 139/85 p 64. Pain 5/10. Toradol 60mg IM RUOQ, Valium 5mg LOUQ. Patient self administered routine afternoon Meds.

2015 - patient states that his pain has been better today and was a 3/10 after last Toradol injection. Currently 5/10. Toradol 60mg IM LOUQ, Valium 5mg RUOQ administered. Patient plans to have a quiet night watching tv with wife.

03/23

0120 - Toradol 60mg IM LOUQ, Valium 10mg IM RUOQ administered. Patient self administered Routine HS medications. Patient states his wife is trying to argue with him. Patient encouraged to go to bed as they both have important appointments tomorrow and reminded

him the importance of a healthy sleep pattern while he is healing. Patient encouraged to call RN during the night if needed. If not, RN will return to home at 11am.

0545 - call to loft

0820 - torod, val

1445 - torod, val

F/u Thursday afternoon and Tuesday afternoon. Skin graft bandage off week from Tuesday. Pin off in two weeks.

2000 - patient informed wife is coming to talk to him and he became extremely anxious. Toradol 60mg IM LUOQ and Valium 5 mg RUOQ administered.

3/24 -

0030 back at lofts. Patient and wife appear to be getting along and all is peaceful but them. Toradol 60mg IM RUOQ, Valium 10mg LUOQ. Patient stated he would self administer his routine Meds within 30 min and go to bed. Patient instructed to call Rn if needed during the night.

1445 - RN informed by patients security that he patient was awake and was leaving in 5 min to go to studio to record. RN went to asses patient. Stated pain was 4/5. Toradol 60 mg LOUQ, Valium 5 mg -RUOQ administered. Patient stated the Valium really helped him last night as it was a stressful evening with wife. He stated he is "ok" emotionally and plans to spend the afternoon with friends. Patient instructed to check in RN this afternoon to let her know where to meet him for afternoon Meds. Patient encouraged to do his finger exercises but refuses to take bandages off.

2145 -

3/25

0215 - Toradol 60mg IM, Valium 10mg IM, administered. Patient

resting in bed- self administered routine HS Meds.

1330 - patient states pain 4/10. Toradol 60mg IM LOUQ, Valium 5mg IM RUOQ. Patient self administered routine AM Meds. Patient informed Valium would be switched to PO and tapered down over the next 3 days. Patient in good spirits and stated he slept from 0230-1300. Patient encouraged to do his finger exercises but refuses to take bandages off.

New med order

Valium 5 mg TID X3 days.
Valium 5mg PRN q6h severe anxiety.

3/26

0145 - RN called to patients home. Upon arrival patient and wife were fighting in garage. When argument became heated patient removed himself from situation and had security drive him to another home. Patient and wife spoke on know for an hr and patient became anxious. Toradol 60 mg IM LOUQ and Valium 10mg LOUQ administered. Patient has decided to return home to speak to wife. Security will accompany patient.

1510 - arrived at patient house to take him to follow up appt. States pain 5/10. Toradol 60mf IM RUOQ. Patient is in good spirits s d states all is peaceful between him and wife. Patient, wife, security and RN off to follow up appt.

1930 - patient arrived home from follow up appt. Per surgeon finger healing appropriately. Bandage was changed and MD stressed importance of doing finger exercises daily to ensure finger does not lose movement. MD also stressed importance of not smoking and the effects in healing process. Next follow up is Tuesday. Patient states his finer was hurting due to wound care and movement. Toradol 60mg IM, RUOQ administered.

2330 - patient called to request pain medication. Toradol 60mg IM LOUQ administered. Patient encouraged to take his routines HS

medications and get a good night sleep. Patient to call RN when he wakes up. If after 1300, Erin, RN will be covering for the afternoon and will be at house to assess patient and his wife.

3/27 -

1300 - per security patient still asleep. Erin, RN will be on call for patient this afternoon.

2310 -met Erin, RN at patients home. He states his pain was 9/10 today. Patient unsure if he hit his finger last night during his sleep or during the day. Toradol 60mg IM administered. Patient self administered routine HS Meds. Patient did finger exercises. RN will return tomorrow at noon to assess patient but he is instructed to call if he needs anything prior to that. Patient left with a Toradol 10mg PO prn pain during the night.

3/28 -

1210 - patient states he slept from 0300 - 1100. States his pain level is 9/1 again today. Toradol 60 mg IM LOUQ administered. Patient did finger exercises. Splint was re applied and dressed. Patient's right arm placed in sling.

Per MD call in concerta 18mg #6. Take 3 tabs Qam.

D/C all routine Seroquel
Seroquel 50-100mg prn q4-5 hr anxiety or agitation.

1810-

2330 -

3/29

1000 - arrived at patients home and is is sleeping soundly on couch.

1250 - patient awake and states his pain is 9/10. Toradol 60mg IM LUOQ administered. Patient will be switched to Mobic 7.5mg Qd

starting tomorrow and Toradol will be discontinued. Patients states he slept from 0300-12:45 and feels rested.

1830 - checked in with patient to see how he was feeling. Stated he was in pain. Instructed Patient to take Toradol 10mg PO.

1920 - checked in with patient via text to see his Toradol helped his pain and patient states he had not taken it.

2015 - patient called to say he was going to studio to record and did not take Toradol PO as he wanted an injection. Patient met RN and hotel and Toradol 60 mg LUOQ administered. Patient requested and was given Valium 5mg PO. Patient unsure if he will spend the night in W Hollywood or Downtown. RN offered to go see patient at either place before he goes to bed. Patient not sure he will need that and requested to take a dose of Toradol and Valium with him. Patient given 2 tabs Toradol 10mg with instructions for HS and AM and 1 tab Valium 5 mg PO to take prn anxiety.

2210- reached out to patient via text to see if he wanted RN to come to west Hollywood. No response.

3/29

0115 - RN received a text from patients wife stating that she was concerned he was "fucked up". RN called security and patient's assistant who is with patient. Per assistant, patient has smoked marijuana tonight but there has been no evidence of any other drug or alcohol use. Wife informed of this.

0330 - per assistant patient will spend the night at his home in west Hollywood.

0535 - text from patients wife stating she just spoke to patient and he is awake and stating he cannot sleep and cannot find HS Meds. Call to patient and reminded him where Meds are. Patient responded and stated he is taking Meds at this time and going to sleep.

0935 - report given to Erin, RN. She will pick up new medications from

pharmacy and start concerta 36mg QD and mobic 7.5 mg QD prn pain.

2215 - patient reports increased pain in finger. States it's a 11/10. Call to MD and he orders to increase HS neurontin from 600mg to 1200 mg.

3/31

0130 - patient continues to c/o pain 10/10 which is causing anxiety and insomnia. Toradol 10mg PO and Xanax 1mg PO administered.

0220 - patient sleeping soundly on couch.

0900 - patient awake. States finger pain is 7/10. Patient self administered routine am Meds and mobic 7.5mg.

1415 - patient preparing to leave for follows up with surgeon. Plan is to remove bandages from skin graft today. Per MD give patient Toradol 60 mg IM and Valium 5mg PO 45 min prior to appointment. Medications administered. Patient stated mobic did not help relieve his pain this morning. Patient also states he is not feeling the concerta is working as well as the adderall did. Status reported to MD.

1615 - at follow up with surgeon bandage was removed from skin graft. Graft took 100% but there was an infection under bolster. Finger was drained, pin was removed and rocephin 1G was administered during appt. Patient will follow up with surge again on Thursday. Per surgeon patient might experience increased pain for 1-2 days. Surgeon ordered rocephin 1G IM for tomorrow and would like a WBC drawn. RN from PMD's office will come to patients home tomorrow to give antibiotic and draw labs. Report given to MD.

2320 - patient states finger pain is 8/10. Toradol 60mg IM RUOQ administered. Patient self admin routine HS Meds and is relaxing watching TV. Plan is for RN to come. Back at 1030 tomorrow to assess patient. Patient instructed to call RN if needed before that.

4/1 -

1030 - arrived at patient's home and he is sleeping soundly.

1145 - patient awake. States finger feels better than yesterday but pain is at 7/10. Toradol 60mg IM administered. Patient administered his routine am Meds.

1300 - RN from MD's office came to patients home for lab draw and to administer Rocephin 1G IM.

1815 - patient text RN to come over as he was in pain.
Finger 7/10 described as a burning sensation. Toradol 60mg IM RUOQ administered. Patient self administered routine afternoon Meds. Per surgeon, PO antibiotics held today due to rocephin injection. UDS done on patient and was only positive for medications prescribed by MD. Report given to MD via telephone.

4/2

0030 - patient's sister text RN to come to patient's house and administer pain medication. Finger pain 7/10 Toradol 60mg IM LOUQ administered. Patient states pain has been decreasing to 3/10 after injections.

4/4

1200 - woke patient to administer Toradol 60 mg IM LOUQ. Patient informed this RN will be leaving for a week and Erin, Rn will be covering till 4/11.

4/11

1310 - text to patient that this RN is back and would like to come assess patient and do his bandage change and help him with hand exercises.

1500 - Still no response from patient. MD and patient's assistant informed.

2105 - still have not heard back from patient. MD informed that RN had not seen patient and had not done dressing change or hand exercises. Patient's assistant informed that rn had not heard from patient today and

per assistant all was peaceful at apartment and no one had heard from patient.

4/12

1130 - text patient to set up a time to see him today for dressing change and hand exercises.

1300 - no response from patient. MD informed.

1700 - still no response from patient. Md and assistant informed.

2300 - still no response from patient. MD has cancelled patients 8am psychiatry appt for tomorrow since patient has not responded to anyone in medical team all weekend.

4/13

1300 - per Md RN is to meet patient at follow up appt with hand surgeon and hand therapy. Text sent to patient to let him know RN would be at appt.

1500 - Bandage changed and hand exercises done at appt with surgeon's office. Per RN at surgeon's office and occupational therapist, hand is healing well and finger has good range of motion. Exercises to be done 3-5 times per day. Patient is in good spirits and said he has not smoked marijuana in 3 days. States he feels majority of his issues with his wife have been from him using drugs and alcohol. Patient states he will no longer sneak / use and wants to enjoy clarity.

2130 - per assistant patient has been resting and watching tv all evening.

4/14 -

1400 - RN and MD arrived at patients home to have meeting to set treatment plan and boundaries while traveling in Australia.

Med changes

Discontinue Inderal LA 80mg
Discontinue metformin 500mg BID

Patient would like to continue working with medical team. Patient states he did not respond over the weekend as he has gotten rid of his phone. Plan is for RN to communicate with security on when she will visit patient daily. Patient informed RN will be over late morning tomorrow.

4-15

1035 – patient's assistant and security infringed RN will be at house around noon to see patient, assist him in hand exercises and change bandages.

1215 - arrived at patient's home. Assistant was in hallway and informed RN that patient was in a bad mood and told assistant he did not need anything from him today. RN was let in home by security and knocked on patient's bedroom door to let him know she was there. Patient screamed "what!". RN informed patient she was just letting him know she was there and would be down stairs. About 5 minutes later security came into house and informed RN that patient has told security to get everyone out of his home and he did not want any more unexpected guests. RN left property and informed MD of the events. Per MD drop tomorrow's Meds off with security and do not reach out to patient again - wait for patient to reach out to medical team.

2145 - patient text RN to apologize for his behavior earlier. Explained that was upset with his assistant and needed to be alone. Plan is for RN to visit patient tomorrow at noon to change bandage and assist in hand exercises.

4/16

0830 - Patient text RN that he cannot find his routine Meds for today. Patient informed RN will be there in 15 min to replenish medications.

1000. - RN found missing medications in patients bag. Patient states he did not take his HS medications last night as he could not find them and

did not sleep well. Patient reminded I am always close by and he needs to call when he cannot find medications. Patient self administered am medications. Bandaged changed and hand exercises done. Patient was left routine Meds for tomorrow. RN will check in with patient at 1300.

1300 - RN text patient to see if she can come over to do hand exercises again. Patient responded he is leaving to go spend afternoon / evening with daughter. RN will check in with patient around bedtime.

2300 - text to patient to see if he needed anything.

2345 - no respond from patient.

4/17

1100 - arrived at patients home. Patient awake on the couch and stated he slept well last night. Patient showered and self administered AM Meds. RN noted mild hand tremors in both bands. Reported to MD and instructed to decrease lithium to 900 mg daily. 300 mg TID.

1200 - leaving for follow up hand appt.

1500 - patient is cleared to fly on Sunday. During bandage change there was some drainage so patient is started back on antibiotics for 7 days. Patient and RN were emailed discharge instructions and patient given 6 splints for Australia. Patient is to have daily dressing changes and send pics every few days to surgeon.

4/18

1100 - arrived at patients home and he was awake, showered and in good spirits. Patient administered his routine AM Meds. Patient ste 100% of breakfast. Bandage changed and hand exercises done. Wound is healing appropriately. No drainage and no s/s of infection. Mild hand tremors continue bilaterally. MD informed. Erin, RN will be covering patient tomorrow. Report given via telephone.

4/19

1500 - Report received from Erin, RN via telephone.

2330 - Leaving for Australia. MD assessed hand tremors and would like to decrease Lithium to 600 mg starting tomorrow.

4/21 + 1 day Australia

1500 - client settled in at home in Australia. Bandage changed and hand exercises done. Patient will go back to work today and work throughout the night. Patient left routing Meds for today and tomorrow. Patient, security and assistant informed that if patient's bandages become dirty or wet while I work to please call RN as finger would need to be assessed and bandages changed.

4/22/15

1700 - met patient at work to assess finger and change dressing. When patient arrived at work he stated him and his wife had changed his dressing and done his exercises. Patient states finger looks and feels good. Patient asked to please have RN assess finger at next bandage change as pictures need to be taken and sent to surgeon. Patient was given supplies to be kept at work and at home for future bandage changes. Patient given routine Meds for tomorrow.

1900 - patient now states his finger has increased pain and is asking how we know if he had an infection. RN removed bandage to assess finger. No drainage noted. Fingers appear swollen. Patient states while filming yesterday his hand was tied to his side all day and he was unable to elevate for hours at a time. RN informed patient this could be the cause for increased pain and swelling. RN took a picture of wound and sent to surgeon along with patients concerns. Surgeon agrees swelling is due to hand being at patient's side while filming. Instructions included soaking finger daily and continue on antibiotics. Patient informed of surgeons reply. Patient given Toradol 10mg PO at this time.

2330 - RN leaving set for the day. Patient instructed to elevate hand as much as possible throughout work evening. Patient instructed to call RN as soon as he wakes tomorrow so she can come assess finger, soak and dress wound. Patient states he will be working throughout night and will

text when he awakes late in the day.

4/23

1500 - MD informed of patient status. MD and RN will go assess patient's finger when they hear patient is awake.

1715 - Still have not heard from patient. RN reached out to his assistant and was informed he worked till 0430 and is currently still sleeping. Assistant states patient has a dinner planned for wives birthday tonight and could potentially not want to see RN and MD.

1830 - Per MD we will not be seeing patient tonight.

4/27 - RN reached out to client via text and requested pics of finger. No response.

4/28 - RN reached out to patient and wife and requested pics of finger. No response.

4/29 - 1000 - patient sent pics of finger to RN. Fingers appears swollen. Pics forwarded to surgeon and PMD. RN to see patient at 1400 to assess finger. RN set up X-ray of finger tomorrow via help of production company. X-ray to be done at 1100. Results will be emailed to surgeon in LA.

1500 - PMD and Surgeon reviewed pics of fingers and feel patient should go back on antibiotics. This request was passed onto surgeon that patient will see tomorrow for X-ray. Wound was cleansed and dressed. Per MD patient should allow wound to get more air. Patient instructed to air wound 2-3x per day. Patient was given routine medications for 4 days as he is planning to go away for the weekend with wife. MD and surgeon informed that RN will not being seeing patient Friday - Monday.

4/30 - 1130 - patient had X-ray of finger. Local surgeon will email results to surgeon in LA. Local surgeon states bone in finger is still crushed. He states finger is red and swollen and patient should be back on antibiotics for 1 week.

Med order

Cipro 750 mg BID x7days.

1600 - antibiotics were picked up and were added to patient's routine med boxes. Patient and wife were sent a text to send daily pictures of finger while they were away. They were told MD instructions of continuing to soak finger, change bandages daily and do hand exercises at least 3x per day.

5/1 -

2100 - RN has not heard from patient and no pics of finger have been received.

5/2

1445 - RN has not heard from patient and no pics of finger have been received.

FINISH NOTES 5-3 – 5/13

5/15/15 –

1915 – Patient c/o headache and is requesting to see RN. Patient states he has been taking Mortin 800mg and Zanaflex 4mg q4-6 hrs for the pain for the past 2 days. Toradol 60mg IM LUOQ administered. MD emailed to update him on status of patients neck tension and HA. Patient instructed to continue doing acupuncture 2x per week and adding a massage 1-2x per week. Patient given 1week worth of routine medications to self administer.

5/16/15 – 2115 RN scheduled acupuncturist for 1900 tonight per

patients request. Acupuncturists waited for 2 hours at the house and then was asked to reschedule appointment for tomorrow. Rescheduled for 7pm tomorrow.

5/17/15 – 2115 – According to house manager patient received acupuncture with good effect.

5/18 –

1400 – Call to MD back home and patient's status was reported via telephone. MD will schedule a neurology appointment for patient on 5/29 to assess neck pain and HA.

1530 – RN sent text to assistant to see if we could schedule an xray of finger tomorrow at 12:30.

1600 – Xray is scheduled for 1430 tomorrow. Patient and assistant informed.

5/19/15 –

1300 – Text patient to let him know RN and security are on our way to pick him up for xray, no response.

1700 – Arrived at patients home at approximately 1430. Patient came downstairs at 1530 and stated he was cancelling xray as he had a friend coming to the house and did not have time to go to xray. Patient informed that xray was important and that we needed to find out if he still had an infection in the bone so we would know whether or not to stay on antibiotics. Patient stated he would do xray later in the week or back in LA early next week. MD informed. Patient's finger assessed. Wound has healed, finger is still swollen with no signs of skin infection. Patient able to make a fist and is using the finger now. Patient continues to wear silicon sleeve to help with forming the finger and wears splint to sleep and work for protection. Patient was given one week of routine meds to self administer. Patient was also given a heat pack for his neck and tennis balls to lie on to start to relieve some of the tension in his neck.

5/24/15

2100 – RN received a text message from patient's wife stating that patient was complaining of his finger burning. The text message included a picture of the finger. RN forwarded this information onto patient's primary MD, hand surgeon in Australia and hand surgeoin in LA. Surgeon in LA responded to keep patient on Cipro and Bactrim, soak in Epsom salt and he will see patient on 5/26. This information was passed onto patient and his wife. Patient's PMD is going to set up an appointment with an infectious disease MD while in LA to r/o osteomylitis. It has been recommended by Australian attorney that patient not to fly with any medication. Patient's assistant was given over the counter Melatonin, Tylenol and Neurontin to take on the plane if needed. RN will fly ahead to LA and prepare routine meds for patient for his week in LA.

5/25/15

2330 – RN gave 2 days worth of patients routine medication to security to give to paient. Patient has an xray at 11:30 tomoorw and will see the infectious disease MD and 14:45. RN will accompany patient to both appotments. RN text patient at 1630 and 2200 to make sure he received meds from security and to inform him of appoinments tomorrow. Patient did not respond. Email was sent to his wife of all appointments scheduled for this week.

5/26/15

1300 – Patient had an X-ray of right distal finger at surgeon's office and was seen by an infectious disease specialist. The finger appears to be healing but appears to still have an infection in the bone. The patient has been instructed to soak finger in warm water and Espom salt and will be started on a new antibiotic. Zyvox 600 mg BID x 2 weeks ordered. Medications will be ready on 5/29/15. Patient is to have another xray and a CBC w/ diff in 2 weeks. RN will inform RN traveling back to Australia with patient and will email MD in Australia tht has been working locally with patient. Patient given 2 days work of routine meds to self-administer.

5/29/15

1400 – Patient was scheduled to have a CT scan of head and see neurologists for c/o chronic headaches. Appt was scheduled for 0930. MD and RN were waiting for patient at CT scan when RN received a call from patient's assistant stating he was too tired and was cancelling appt. RN delivered new antibiotic to be started today and 1 day of routine medication to patient's security. RN handed off all medications to MD that will be delivered to RN traveling to Australia with client to cover case while this RN is off until 6/15/15. RN gave report to covering RN via telephone.

1500 – Patient's assistant called to see if it was possible to reschedule CT scan for this afternoon or tomorrow. RN called to see and was informed that machine was being serviced today and facility was closed tomorrow. Assistant notified. RN traveling with patient also notified and will reschedule in Australia if needed.

1830 – Patient's wife text to ask why antibiotic was not in patient's meds. Wife was informed that it was given to security, as patient did not show up at MD appt earlier today. RN checked with security and was told the he had given all meds to patient earlier today. Wife informed that patient was given antibiotic by security and that the rest of the antibiotics have been added to med containers. Wife did not respond.

6/15/15

1400 – RN arrived back in Australia and received report from RN covering case. Per report patient is doing well. He has finished antibiotics and finger shows no s/s of infection. Labs have been drawn and results are pending. Patient has cancelled MRI and head and neck and x-ray of R middle finger multiple times. RN will continue to set up appointments and encourage patient not to cancel. Per RN patient has routine meds through 6/16 and there have been no med changes.

6/16/15

2230 – RN visited patient on set today. Patient was in good spirits. His finger remains swollen but no redness noted. Patient states he had not been wearing silicon wrap at night. Patient reminded to do so and called Dr. Kalamaras to set up appt with PT to get more splints and silicon wraps for patient. Patient continues to c/o of neck pain and headaches. Patient continues to take prn toradol, baclofen or Motrin, Zanaflex. Patient reminded of the importance of getting MRI done. RN that was covering will be in contact with MD's to set up tests for this weekend. Patient was given 1 week worth of routine meds to self administer.

6/17/15

1100 – Dr. Kalamaras and PT Kate will see patient on set on Friday 6/19 to assess finger and supply patient with more splints and silicone wraps. Patient informed.

6/19/15

1900 – Patient was seen by Dr. Kalamaras and hand PT today. Patient was shown hand exercizes to increase range of motion and increase circulation and feeling to finger tip. Patient was fitted for more splints and given silicon wraps with instruction to wear the splints while at work and the wrap while sleeping. Dr. Kalamaras reviewed lab results with patient. Overall, labs showed the infection in finger has subsided. Patient's Cholesterol was elevated and Dr. Kipper was informed of this. Plan is for patient to do fasting labs when back in states prior to adding medication. Patient is anemic and was started on B12. MD feels this is due to diet and chef has been informed of this and will add more red meat to his diet. Patient was encouraged to do MRI over the weekend but requests for it to be done next week. Lab results will be forwarded to Dr. Kipper by Dr. Kalamaras. Patient in good spirits and has no complaints other than chronic headaches. Patient encouraged to call RN over the weekend if needed. RN offered to go stay with patient while wife is traveling. For now, assistant will stay in guest house and will be checking on patient and will inform RN if needed.

6/21/15

2200 – RN sent text to patient to check in and see how he was feeling. No response.

6/22/15

1530 – Received text from house manager that he had been asked to set up a chiropractor appt for patient. RN asked house manager to hold off in setting up appt till it was approved by MD. RN sent MD an email asking MD if he would approve / order a chiropractor appt for treatment of patients neck. MD does not approve any treatment of neck / back until patient has MRI done. House manager and assistant informed.

2100 – RN informed that patient will be filming far away tomorrow and RN will not have access to set. One week of routine meds was given to house manager to bring to patient for self-administration. RN will see patient on 6/24.

6/23/15

1500 – MRI has been set up for 6/25/15 at 1800. Dr. Kalamaras will meet us at appt to oversee. X-ray of R middle finger will be done prior to MRI. Dr. Kipper informed of appt.

6/24/15

1830 – RN visited patient on set from 1200 – 1800 today. Patient was in good spirits and stated his last headache was on Monday. Patient has been working long hours and states he has not been a lot but when he sleeps it is soundly. States he averages about 5 hours per night. Patient informed of his MRI appt tomorrow.

6/25/15 –

0830 – Call to Dr. Lindberg, neurologists to set up appt. If patient follows through with his MRI appointment, she can see him tomorrow afternoon.

0845 – Call to Stephen, patient's assistant to find out patient's work schedule tomorrow to set up appointment with neurologists. Assistant

said we could set it up when RN gets to set around 1400 today.

1600 – Neurologists appt set for Monday 6/29 at 1800. Email to MD, patients assistant and patient's sister to inform them of appt.

2100 – Patient completed MRI of neck and brain and x-ray and CT scan of R middle finger. Results will be emailed to hand surgeon. Labs were drawn to check on infection of R middle finger.

6/28/15

1700– RN received initial results from brain MRI – no obvious abnormalities noted. Final report will be done tomorrow. Patient informed of results.

6/29/15 –

1800 - Patient met with hand surgeon and neurologists. Labs were redrawn to check on infection and b12. All results were discussed and explained to patient by MD. Plan is for patient to receive a steroid injection in occipital lobe tomorrow at set for his headaches. The diagnosis for headaches was tension headaches.

6/30

1300 – RN arrived on set to visit patient. He was upset due to having an argument with his wife. Patient stated he had taken "about 4" Xanax 1 mg over the past 24 hours to deal with the stress he was feeling. Patient was able to express his emotions appropriately. Patient stated that he had not slept the night before due to argument with his wife.

1830 – Neurologists visited patient on set and administered steroid injections. She informed patient he could have some minor discomfort in the injections sights and would feel the effect of the medicine with a few days. Patient stated he already could feel some relief of the tension.

1920 – Patient had another argument with his wife. Patient was anxious and was asking for medication to help calm him down. Seroquel 50 mg administered.

2010 – Patient fell asleep within 20 minutes after taking Seroquel. He was unable to wake up and had to be carried to the car and then to bed when arriving at home. Respirations were even and unlabored.

2320 – Patient continues to sleep soundly. Respirations even and unlabored.

07/01

0830 – RN text assistant to see how patient was feeling this morning. RN informed that patient slept 12 hours and was just getting up for work now. RN asked assistant to let her know how he was doing emotionally today.

0930 – RN sent text to patient to check on him. He responded by saying he was grateful for the sleep he had gotten and that he would let the RN know how he was feeling later and how his stress level was from arguments with wife.

1235 – RN received text from patient's assistant that the arguments between patient and wife were continuing and RN should come to set to see patient. RN will be picked up at 1430.

2100 – Between shooting patient was able to express his feeling to RN. He explained that his wife makes him feel that he can never do anything right and that they cannot have a conversation without her blowing up. Patient was given positive reinforcement for expressing his feelings. Patient verbalized he knows it is best for them to "take a break" from each other when the fights start to escalate but how she will follow him from room to room when he tries to get away. Patients states he is going to try his best to keep things peaceful in his relationship and focus on finishing up the filming of his movie.