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JAN 02 2013
STEVEN M. LARIMORE
CLERK U. S. DIST. CT.
S. D. of FLA. – MIAMI

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

LEMANE DEON WILLIAMS,
Plaintiff,

v. **Case No.:** 11-24638-CIV-LENARD/WHITE

DETECTIVE FERIA,
Defendant,
_____/

PLAINTIFF'S SUPPLEMENTAL DISCOVERY EVIDENCE

COMES NOW, the Plaintiff, Lemane Deon Williams, pro se, pursuant to Rule 7 of the Federal Rules of Civil Procedure request this Honorable Court to supplement plaintiffs discovery evidence. In support thereof alleges the following:

1. On December 20, 2012, the plaintiff received additional evidence that will support his claim that's pending before this Honorable Court. (See attached: Exhibit A, Page 1-14).

CONCLUSION

WHEREFORE, in the interest of justice the plaintiff pray that this Honorable Court grant this motion and allow this attached supplemental discovery evidence to be a part of the record.

Respectfully Submitted,
/s/ Lemane Williams
Lemane Deon Williams DC# M05282

CERTIFICATE OF SERVICE

I HEREBY CERTIFY, that a true and correct copy of this request for production documents has been furnished by U.S. Mail to the office of Lauren E. Morse Miami – Dade County Attorneys office 111 N.W. 1st Street Suite 2810 Miami, Florida 33128 this 28 day of DECEMBER 2012.

Respectfully Submitted
/s/ Lemane Williams
Lemane Deon Williams DC# M05282
Gulf C.I. – Annex
699 Ike Steele Road
Wewahitchka, Fl 32465

MAIL ROOM
DEC 28 2012
FOR MAILING
INMATE'S INITIALS

"EXHIBIT A"

PUBLIC HEALTH TRUST
CORRECTIONS HEALTH SERVICES

MEMORANDUM

TO: Shift Commanders

FROM: Adell Hackett, ANM
Associate Nurse Manager
Metro West Detention Center

DATE: 8/24/10

SUBJECT: **Procedure Preparation**
Re: WILLIAMS, Lemane
Jail: 100011196

This inmate is scheduled for a procedure Tuesday, Aug. 24th, 2010. He must have nothing by mouth beginning at midnight (11:59 hr.) Monday, Aug 23rd, 2010.

Please bring him to North Clinic at your convenience prior to midnight on Monday, Aug. 23rd, 2010. He will leave to the hospital from the clinic.

Thank you.

:procedurepreparation
RS/hr
cc: Capt.
Charge Nurse
file

EXHIBIT A

PUBLIC HEALTH TRUST
CORRECTIONS HEALTH SERVIC

Jail #: 100011196
CIN: 613080
Hospital #: 1404406

Name: WILLIAMS, Lemane Race: Sex: M Age: Cell Block: MW2D1

Date and time prisoner was taken: Tue 8/24/10 at 06:00 Hospital: JMH Board of Health:

Reason for sending prisoner: AMSU/DTC1

MEDICAL REPORT
Brief Resume

Date and time returned to jail Examining Physician

mw2

EXHIBIT A

Corrections
Health Services
Jackson Health System

Nursing Evaluation Tool:

General Sick Call

Facility:
Patient Name: Williams (Last) Lemarne (First) MI
Inmate Number: 10-11196
Date of Birth: 12 / 12 / 77 (MM DD YYYY)
Date of Report: 9 / 25 / 10 (MM DD YYYY)
Time Seen: 0800 AM / PM Circle One

Subjective: Chief Complaint(s): Difficulty up/down — request LBP extension
Onset: 8.25.10.
Brief History: (Continue on back if necessary)
cast to RUE x 1 mt

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: ____ P: ____ RR: 20 B/P: ____ / ____
Examination Findings: (Continue on back if necessary) Cast intact RUE

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):
☐ Referral NOT REQUIRED
☒ Referral REQUIRED due to the following: (Check all that apply)
☐ Recurrent Complaint (More than 2 visits for the same complaint)
☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given

Plan: Check All That Apply:
☒ Instructions to return if condition worsens.
☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☒ NO (If NO then schedule patient for appropriate follow-up visits)
☐ Other: (Describe)

OTC Medications given ☒ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Date for referral: ___ / ___ / ___ (MM DD YYYY)
Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (If emergent who was contacted?) Time

x Nurses Signature Name: F.L. Harris R.N. (Printed)

EXHIBIT A

03/26/09 14:1 3055851908 PATU PAGE 01/0

Jackson HEALTH SYSTEM

Time Received: _____

DISCHARGE PRESCRIPTION FORM

ATTACHMENT - A

2D 1
1100.11196
(013VD

☐ Jackson Memorial Hospital
1611 NW 12th Avenue
Miami, FL 33135
(305) 585 – 1111

☐ Jackson North Medical Center
160 NW 170 Street
North Miami, FL 33169
(305) 651 – 1100

Patient Information
Name: WILLIAMS, LEMANE MR#: 1404406
Address: _____
City: _____ State: _____
DOB: _____ Gender: ☐ Male ☐ Female

Patient Location
Floor: DTC Room#: #23
Bed: ☐ A ☐ B Other: _____

Number of Prescriptions: _____ Nurse/Floor Contact: _____ Ext: _____
Floor Fax #: _____

☐ Check if patient needs snap-on caps
☐ Check if patient needs directions in Spanish

Pharmacy Feedback:

Please Pay Cashier _____

Jackson HEALTH SYSTEM
Jackson Memorial Hospital
1611 N.W. 12th Avenue
Miami, Florida 33136-1096
305-585-1111

Rx for pediatric patients < 14 yo must include age & weight or BSA
Age: _____ Weight: _____ (kg) or BSA _____ (m^2)

	DRUG	DOSE / STRENGTH	Dose in mg/kg or mg/BSA	Qty.	Refills
1 ℞	Tylenol #3	300/30		#60 (Sixty)	0 1 2 / 3 4 5 / 6 7 8 / 9 10 11
Sig:	ii tabs PO Q 4° PRN pain		Indication:		
2 ℞			Dose in mg/kg or mg/BSA		0 1 2 / 3 4 5 / 6 7 8 / 9 10 11
Sig:			Indication:		

☐ NKA Allergies: _____

Prescriber's Signature: _____
Print Last Name: Commiran Phone/Beeper #: _____
DEA # AJ0194922 PHT DR.# 4801
FL LICENSE # 12738 (Required) Date: 8/24/10

Imprint/Write Patient's Name, Address and Medical Record #
WILLIAMS, LEMANE 1404406
DOB:12/12/1978 Sex: M Age:31 /Y SRVC:O
PHY: Owens Patrick W PLN: D07-
Fin: 40004743977 Admission: 08/24/2010
FC: D

☐ Sunday

EPF090828.352

Technician/ Driver Delivered: _____

Any questions regarding prescription order, please call (305) 585-6439.

Pharmacy Fax # 305-585-0088

"EXHIBIT A"

Schedule Inquiry - JMH Person - Custom

Task Edit View Help

Name: WILLIAMS, LEMANE | DOB: 12/12/78 | Age: 31 Years | Gender: Male

MRN: 1404406 (7074115) | Home Phone: (786) 263-5101 | Location: | Research: | Race: Black

Mother's Maiden Name: | Primary Care at: None Outside ... | Case Review Date: | Ins Plan 1: Corrections Health Services - D07

Copay: 0.00 | Auth Req?: Yes | Ins Plan 2:

Person | Resource

Inquiry: JMH Person - Custom

Person: WILLIAMS, LEMANE

Start date: 09/21/10 Start time: 0000

Find | Clear | Close

Begin Date	MRN	State	Appt Type	RESOURCE	Person Name	FIN	Type	Ph
10/04/2010 09:00	1404406	Confirmed	ORTHO-REHAB-FOLL-UP	HAND CLINIC	WILLIAMS, LEMANE	40004910601	Pre-Registratio	(78

appt. noted @ Metro West.

613080/10-11196

For Help, press F1

1 Item | P19 | HROSAS | Tuesday, September 21, 2010 | 14:07

EXHIBIT A

PRN MEDICATIONS ORDERS

DRUG NAME, SRENGTH, DOSE	INDICATION FOR USE	ORDER DATE	STOP DATE	INITIALS
Tylenol 650 mg P-O		2/9/10	2/15/10	LS
1 bid PRN x 7 days				

DATE	TIME	SITE/ROUTE	MEDICATION	COMPLAINT	INITIALS	RESULTS	INITIALS

DOCUMENTATION OF MEDICATION EXCEPTIONS (N CODE)

DATE	TIME	DOCUMENTATION BY NURSE	INITIALS
2/11/10	10:15	Recall @ MWDC clinic →	[illegible]

INDIVIDUAL PRESCRIPTION MEDICATION RETURNED TO PHARMACY

DATE	MEDICATION NAME & STRENGHT	AMOUNT REMAINING	REASON FOR RETURN	SIGNATURE	SIGNATURE CH. NURSE

INMATE NAME: Williams Lemmie CIN NUMBER: LOCATION:

"EXHIBIT A"

The date of your surgery/procedure is: _____

Please report to: _____ At:

Jackson Main ____ A.M./P.M. Jackson South ____ A.M/P.M Jackson North ____ A.M./P.M

ALL PATIENTS:

- ☐ Do not eat or drink anything after midnight the night before your surgery/procedure this includes water, coffee, chewing gum, or hard candy.
- ☐ Bring a picture identification and insurance card.
- ☐ Leave money/valuables such as watches, jewelry, credit cards, and laptops at home. REMOVE BODY PIERCINGS SUCH AS UMBILICAL RINGS AND TONGUE STUDS.
- ☐ Remove hairpins, hair ornaments, makeup, lipstick and nail polish. PLEASE DO NOT WEAR LOTIONS, CREAMS, DEODORANTS.
- ☐ If you have sleep apnea and use a machine, please bring it with you to the hospital.
- ☐ If you are going home the same day as your procedure, arrange for your family/designee to take you home.
- ☐ If you are going home the same day as your procedure wear comfortable, loose clothing.
- ☐ All your personal belongings will be given to your family/designee.
- ☐ Please bring copy of your Living Will (Advanced Directives).

CHILDREN:

- ☐ A parent, legal guardian or authorized representative must accompany all children. Please bring proof as legal guardian or authorized representative.
- ☐ If your child is going home the day of the surgery plan to stay with your child during the hospital stay.
- ☐ Special fasting instructions given.

SPECIAL INSTRUCTIONS:

- ☐ Bowel preparation instructions/prescriptions given per physician's orders.
- ☐ Surgical instructions given per physician's orders.
- ☐ Follow Chlorhexidine Shower Instructions.
- ☐ OTHER: _____

DO NOT SHAVE AT HOME FOR YOUR SURGICAL PROCEDURE. IT MAY RESULT IN CANCELLATION.

IF YOU GET A COLD OR OTHER ILLNESS BEFORE YOUR SURGERY/PROCEDURE OR ARE UNABLE TO COME AS SCHEDULED, CALL YOUR DOCTOR/ SERVICE AT: 305 285 4503

MEDICATIONS:

- ☐ Take the following medications the morning of your surgery procedure with a small sip of water: Rosuvastatin Mesylate
- ☐ DO NOT take the following medications the morning of surgery: _____
- ☐ DO NOT take aspirin or aspirin products for 5 days or anti-coagulants 5 for ____ days before your surgery/procedure unless your doctor instructs you otherwise.

ARNP/RN Print name/Employee ID#

ARNP/RN Signature/Title/Date

Metoprolol

Patient/Authorized representative signature

786 863 4935-6

Patient telephone number

PLEASE GIVE US THE BEST NUMBER TO REACH YOU IN THE EVENT THAT ANY OF THESE INSTRUCTIONS SHOULD CHANGE.

WILLIAMS, LEMANE 1404406
DOB: 12/12/1978 Sex: M Age: 31 /Y SRVC: O
PHY: Owens Patrick W PLN: L79-
Fin: 40004743977 Admission: 08/24/2010
FC: U

EXHIBIT A"

Corrections PUBLIC HEALTH TRUST
HEALTH SERVICES
Jackson Health System

ATE NAME: Williams Lemane DATE OF BIRTH: 12/12/78 (32)

HER'S NAME: Janet Williams AGE: 31 SEX: ☒ MALE ☐ FEMALE

RACE: B SOCIAL SECURITY #: [redacted] 766 BKNG #: 10-111196

EMERGENCY CONTACT: Janet Williams (mother)

ADDRESS: Miami, FL PHONE: (786) 217-4608

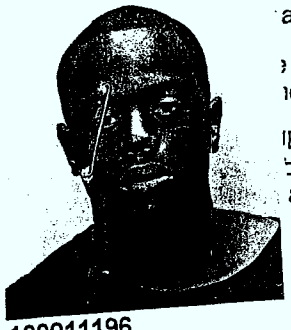
Minnie Williams (Grandma) (305) 969-9588

AUTHORIZATION FOR TREATMENT

Jim. H # 1404406

1. I hereby consent to and authorize the PUBLIC HEALTH TRUST, Corrections Health Services, its staff and physicians to conduct examinations and treatments which in their judgement become necessary or advisable in the diagnosis or treatment

he staff and administration of this Program to institute any emergency procedures which they deem necessary. I and/or referral to another facility if the emergency warrants such transfer and/or referral.



100011196
LEMANE WILLIAMS

e practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been ne result of treatment.

IBLIC HEALTH TRUST, Corrections Health Services, this Program, the medical staff, nurses and employees bility whatsoever from this course of treatment. I further understand that this release shall be binding upon me, administrator or assignees.

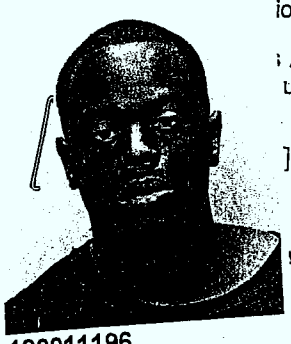
nate medical records and information contained herein are maintained in my best interest. I further understand sferred to another correctional facility within the Corrections Health Services Program, this information will be ensure continuity of inmate care.

mplete social, psychiatric and medical information as requested by Corrections Health Services.

Authorization for Treatment shall be binding for treatment rendered to myself at any of the correctional facili-ion of those facilities served by Corrections Health Services.

Authorization for Treatment shall remain in effect until my release from the Metropolitan Dade County until I formally rescind this authorization in writing.

] HAVE HAD READ TO ME BY _____



100011196
LEMANE WILLIAMS

NISH ☐ CREOLE ☐ _____ THIS AUTHORIZATION
FULLY UNDERSTAND THE CONTENTS OF THIS FORM.

DATE: 1/7/10 TIME: 10:00 AM/PM INMATE SIGNATURE: Lemane Williams

☐ See Refusal of Treatment

I CERTIFY THAT I HAVE FULLY EXPLAINED THIS AUTHORIZATION FOR TREATMENT TO THE ABOVE-NAMED INMATE.

☒ CHS STAFF / ☐ TRANSLATOR SIGNATURE: _____

SIGNATURE, TITLE _____

EXHIBIT A

201

DATE/ TIME	NURSE INITIAL	
		Discharge Date: _____ Attending Physician: _____
		Discharge To: _____ Procedure Performed: _____
		Diagnosis: _____ Phone Number: _____
		FOR THE NEXT 24 HOURS PLEASE OBSERVE THE FOLLOWING GENERAL INSTRUCTIONS:
		■ Do not drive or operate machinery or make important decisions
		■ Do not drink alcoholic beverages
		■ Rest and limit activities
		Follow up care: ☒ Clinic ☐ Private Physician
		Medication to take at home:
		Diet:
		Physical activity:
		☐ Resume normal activity
		☐ Return to work/school
		☒ No sports/heavy lifting
		☐ Special instructions
		☐ Bathing: ☐ Tub ☐ Shower ☐ Sponge bath
		Wound/Incision care:
		☐ Change dressing as needed
		☐ Remove dressing after ____Hours ____days
		☒ Keep dressing clean/dry
		☐ Catheter/drain/tube care
		☐ Special instructions
		If any of the following emergencies occur, come to JHM EMERGENCY ROOM or go to the nearest
		Emergency Room facility.
		■ Excessive pain not relieved by medication
		■ Temperature over 101.5°F or above for 24 hours
		■ Excessive bleeding/drainage
		■ Excessive redness/swelling around wound area

Physician Signature/Number: _____ Date/Time: _____ Service: _____

Nurse's Signature: _____ Date/Time: _____

Interpreter's Signature: _____ Date/Time: _____

Patient/Authorized Representative Signature: _____ Date/Time: _____

My signature indicates that I have received the instructions and that I understand them.

Jackson HEALTH SYSTEM — PUBLIC HEALTH TRUST — MIAMI, FLORIDA 33136-1096

WILLIAMS, LEMANE
Fin: 40004743977
1404406
ADM:08/24/2010
DOB:12/12/1978

PHYSICIAN'S ORDER/DISCHARGE INSTRUCTIONS
C-290 FM Rev. 07/2000 Page 1 of 1

-9-

PO0010

"EXHIBIT A"

file

CONSULTATION / REFERRAL FORM

Date of referral: 6/9/10 Time of referral: 1107 (military time)

Referring to (service): Ortho Hand clinic ☐ consult ☐ co-management ☐ referral

Referred from (service): MDTC Area / location:

Provider referring patient: (print) A. Mazon MD / DO / ARNP / PA. ID # 20030

Telephone: 786-263-4935 Beeper: Email address:

Reason for referral: 31 yr. old CB pain (R) 3rd finger 3-4 months because he fell & handcuffed & landed (R) hand. X-ray shows Displaced intra-articular Fractures 3rd middle & distal phalanges done 4/13/10

Past medical and surgical history: denies

List current medications or ☐ See attached list: Naproxen

Allergies: NKA

Authorization number: ICD 9 code: 829.0 CPT code:

Consultation Date: Time: (military time)

Findings and recommendations: Provide history and physical.

7/6/10 Faxed to Angela Boreland, DCN @ 305-585-2457

HECTOR ROSAS/CLERK TYPIST
METRO WEST DETENTION CENTER/CHS CLINIC
13850 NW 41 STREET MIAMI, FL 33178
TEL: 786-263-4935/ FAX: 786-263-5057

RECEIVED JUN 1 2010 INSTITUTED

Approved 6/22/10

Required follow up:

Consulting Provider Contact Phone Number: *Consulting Provider Signature & I.D. Number*

PATIENT IMPRINT

Jackson HEALTH SYSTEM — PUBLIC HEALTH TRUST — MIAMI, FLORIDA 33136-1096

LTD: 2/9/10
DOB: 12/12/78

Williams, Lemane
10-11196
cu 613080

CONSULTATION REPORT

C-260 Rev. 09/2005 1 of 1 CT0010 -10-

EXHIBIT A

Result type:	GR Hand Right 2 Views
Result date:	13 April 2010 11:19 EDT
Result status:	Auth (Verified)
Result title:	GR Hand Right 2 Views
Verified by:	Pevsner, N. Henry on 14 April 2010 20:43 EDT
Encounter info:	40004309004, JMH, Client, - 04/13/10

* Final Report *

Reason For Exam
pain&swelling(r)index finger, injury 2mth ago

Report
Right Hand Three Views – 04/13/10

Clinical indication: Pain and swelling of the right index finger. Injury 2 months ago.

No prior study is available for comparison.

Findings: There is a rounded radiopacity projecting along the radial soft tissues of the 3rd proximal phalanx, likely representing a BB. There is an oblique, subacute, intra-articular fracture of the distal 2nd phalanx. In addition, there is an oblique, subacute, intra-articular fracture of the 2nd middle phalanx. There is mild radial subluxation at the 2nd proximal interphalangeal joint. The remainder of the joint spaces is preserved. Bony mineralization is within normal limits.

Impression:

1. Foreign body along the radial soft tissues of the proximal 3rd digit, likely representing a BB.

2. Subacute intra-articular fractures of the 2nd middle and distal phalanges.

J#160991/svc

Signature Line

6/9/10

GR Hand Right 2 Views EXHIBIT A WILLIAMS, LEMANE - 1404406

* Final Report *

FINAL REPORT
Attending Physician: Pevsner, N. Henry

Transcribed by & Date/Time: Canales , Sylvia V 04/13/2010 20:23
I reviewed the films and the Radiology resident's findings and agree with the final report-Resident: Letzing, Michael
Electronically Signed By: Pevsner, N. Henry Signature Date/Time: 04/14/2010 20:43

Completed Action List:
* Order by Novitch, Edward H. on 12 April 2010 09:01 EDT
* Perform by DIAZ, JORGE J on 13 April 2010 11:19 EDT
* VERIFY by Pevsner, N. Henry on 14 April 2010 20:43 EDT

Printed by: Luzod, Athena
Printed on: 06/09/10 11:05 EDT

EXHIBIT "A"

Corrections HEALTH SERVICES Jackson Health System

01 3080

MEDICATION ADMINISTRATION

RECONCILED AND ACTIVE: DATE / INT; DATE / INT; DATE / INT; DATE / INT

IN ACTIVE: DATE / INT

ALLERGIES: NKA

MONTH / YEAR: 8/10

Order	Admin Time	1–27	28	29	30	31
ORDER DATE: 8/28/10 INT: Am; STOP DATE: 8-30-10 TIME: 78	8A	→		Nm		C
MEDICATION STRENGTH, DOSE, ROUTE & FREQUENCY: Tylenol 650 mg p.o. BID x 3 days	8P	→	Am	Nm		C
ORDER DATE / INT; STOP DATE / TIME						
MEDICATION STRENGTH, DOSE, ROUTE & FREQUENCY						
ORDER DATE / INT; STOP DATE / TIME						
MEDICATION STRENGTH, DOSE, ROUTE & FREQUENCY -13-						
ORDER DATE / INT; STOP DATE / TIME						
MEDICATION STRENGTH, DOSE, ROUTE & FREQUENCY						
ORDER DATE / INT; STOP DATE / TIME						
MEDICATION STRENGTH, DOSE, ROUTE & FREQUENCY: PRN						

CODES
G= Starter dose given in clinic
N=Dose not administered (Explain)
O=Out of cell, dose not administered
S=Self-administered dose

Init	Print Name & Title	Init	Print Name & Title
NJ	N. Sing R	RD	R. D. [illegible]

Name: Williams, Lemore
Race: B.
Mother:
SS#: [redacted]-7606
Sex: M
DOB: 12-12-28
Jail#: 10-11194
Location: 2D1

EXHIBIT A

Corrections

HEALTH SERVICES
Jackson Health System

PUBLIC HEALTH TRUST

INMATE REQUEST FOR HEALTH SERVICES
PEDIDO DE SERVICIOS DE SALUD POR PARTE DEL PRESO
REKLAMASYON PRINZONYE YO POU SERVIS SANTE YO

Name - Nombre - Non Lemane Williams		
Date - Fecha - Dat 6-8-10	Facility Institution - Instalaciones de la Institicion - Lokal Enstitisyon Metro West	
Jail # - Carcel # - Prizon # 10-11196		
Race - Raza - Ras B/M	Sex - Sexo Saks Male	Cell # - Celda # - Salil # 3 D 2
Date of Birth - Fecha de Nacimiento - Dat de Nesans 12-12-77		
Mother's Name - Nombre de su Madre - Non Manman-ou Ms. Janet Williams		

Cin#613080

EXPLAIN YOUR PROBLEM OR COMPLAINT
EXPLIQUE SU PROBLEMA O QUEJA
EXPLIKE PROBLEM-W OSWA KONPLENT KE QU GENYEN

(R) mid finger

My finger has been broken for 3 months X-rays has already been taken. Im in extreme pain. Im asking to see a doctor please.

I am aware that there is a fee for sick-call. Charges will be made to my commissary account.
Estoy conciente de que hay un costo por llamar a la enfermeria. Los cargos scran hechos a mi cuenta de la comisaria.
Mwen okouran keg en yon fre pou le ke-w rele ou malad. Sa key o chaje yo yap depos-l nan kont komisyon-w.

Lemane Williams 6/9/10
Inmate Signature / Firma del Preso / Siyati Prizonye-an

Circle Charges:

Doctor / Medico / Doktè	ARNP / Enfermera Practicante / Enfimyè Practient	PA / Asistente Medico / Asistan Doktè	Dentist..... $5.00 Dentista..... $5.00 Dantis..... $5.00	Nurse / Enfermera / Enfimyè	Dental Assistant..... $3.00 Asistente Dental..... $3.00 Asistan Dantis..... $3.00

**** STAFF SECTION / SECCION DEL PERSONAL / ESTAFF SEKSYON ****

Disposition: Stable

Triage Nurse: Dunbar RN (Print Full Name) Date: 06/08/10 Time: 1530

S: "My X-ray say my right finger is broken"

O: S/P right index finger injury. Seen clinic some swelling in very days. Pt's been go to throughing treated new medication when seen clinic

A: Alteration comfort pain - right index finger "Questionable referral" pain management

P: MD referral
06/08/10
Date

Dunbar RN
Health Service Signature

White copy: Medical record Pink copy: Inmate receipt for services

PROVIDED TO GULF CI
MAIL ROOM
JAN 09 2013
FOR MAILING_____
INMATE'S INITIALS_____

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

FILED by _____ D.C.
JAN 17 2013
STEVEN M. LARIMORE
CLERK U. S. DIST. CT.
S. D. of FLA. – MIAMI

LEMANE DEON WILLIAMS,
Plaintiff,

v.

CIVIL ACTION No.: 11-24638-CIV-LENARD
MAGISTRATE JUDGE: P.A. White

OFFICER ANTHONY FERIA,
Defendant,
_____/

MOTION TO REQUEST PERMISSION TO SUPPLEMENT PLAINTIFF'S PRETRIAL STATEMENT / GENERAL STATEMENT

COMES NOW, the plaintiff, Lemane Williams, pro se, pursuant to Rule 7 of the *Fed. R. Civ. P.* request this Honorable Court to grant him permission to supplement his pretrial statement and in support therefore alleges following:

1) On November 27, 2012, plaintiff filed his pretrial statement to the court.

2) On December 20, 2012 the plaintiff received his medical records that establishes (contrary to defendant claim that no records existed) additional relevant evidence of a sworn statement used against the plaintiff that he was never submitted into Jackson Memorial Hospital.

3) Plaintiff was unable to present this in his pretrial statement which can be established by date receipts.

WHEREFORE, in the interest of justice the plaintiff pray that this Honorable Court grant him permission to supplement his pretrial statement.

Respectfully Submitted,
/s/ Lemane Williams

CERTIFICATE OF SERVICE

I HEREBY CERTIFY, that a copy hereof has been furnished by placing it in the hands of a Gulf Correctional Official for mailing to: Lauren E. Morse Miami – Dade County Attorney's Office 111 N.W. 1st Street Suite 2810 Miami, Florida 33128 this 9 day of JANUARY, 2013.

/s/ Lemane Williams
Lemane Deon Williams DC# M05282
Gulf C.I. – Annex
699 Ike Steele Rd.
Wewahitchka, Fl 32465

PROVIDED TO GULF CI
MAIL ROOM
JAN 0 4 2013
FOR MAILING
INMATE'S INITIALS

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

FILED by D.C.
JAN 17 2013
STEVEN M. LARIMORE
CLERK U. S. DIST. CT.
S. D. of FLA. – MIAMI

LEMANE DEON WILLIAMS,
Plaintiff,

v.

Case No.: 11-24~~368~~638-CIV-LENARD
Magistrate Judge: P.A. White

DETECTIVE ANTHONY FERIA,
Defendant,
_____/

MOTION SUPPLEMENTING PRELIMINARY STATEMENT GENERAL STATEMENT

Plaintiff, Lemane Williams, pro se pursuant to Rule 7 *Fed. R. Civ. P.* supplements his pretrial statement / general statement filed on November 27, 2012, and in support thereof alleges the following:

1) As previously stated above, plaintiff filed his pretrial statements to the court (Exhibit – A).

2) On December 20, 2012 the plaintiff received his medical records that establishes (contrary to defendant's claim that no record's existed) additional relevant evidence of a sworn statement used against plaintiff that he was never

submitted into Jackson Memorial Hospital. (Exhibit – B cited as exhibit A in plaintiff's supplemental discovery evidence filed on December 28, 2012.

3) Plaintiff was unable to present this in his pretrial statement which can be established by date receipts (See Exhibit A &B).

4) This supplement in which the document will show that the corrections officer **Ruben Okera** #4143 falsely claimed that the plaintiff was not received at Jackson Memorial Hospital. (See document 24-5 entered on 9/14/2012 also using the wrong case number 08-20554-CIV-KING/WHITE).

WHEREFORE, plaintiff supplement's the attached documents as exhibits pursuant to Rule 7 *Fed. R. Civ. P.* as part of his pretrial statement.

Respectfully Submitted,
/s/ Lemone Williams

CERTIFICATE OF SERVICE

I HEREBY CERTIFY, that a copy hereof has been furnished by placing it in the hands of a Gulf Correctional Official for mailing to: Lauren E. Morse Miami – Dade County Attorney's Office 111 N.W. 1st Street Suite 2810 Miami, Florida 33128 this 9 day of JANUARY, 2013.

/s/ Lemane Williams

Lemane Deon Williams DC# M05282
Gulf C.I. – Annex
699 Ike Steele Rd.
Wewahitchka, Fl 32465

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
CASE NO. 08-20554-CIV-KING/WHITE

LEMANE WILLIAMS,

Plaintiff,

v.

Detective Feria

Defendant.
_____/

DECLARATION OF LT. RUBEN OKERA

Pursuant to 28 U.S.C. § 1746, Ruben Okera declares under penalty of perjury as follows:

1. My name is Ruben Okera. I am a lieutenant with Miami-Dade County Department of Corrections and Rehabilitation ("MDCR") and have been employed by MDCR since 1989. I am currently assigned to Ward D.

2. In 2010, arrestees in need of medical attention were transported to Ward D prior to admission to a MDCR facility.

3. As the lieutenant responsible for the operation of Ward D I am familiar with a MDCR record known as Jackson Memorial Hospital Prisoner Admission and Release Sheet (Hospital Service Unit) (the "Sign-In Sheet"). MDCR officers assigned to Ward D record on the Sign-In Sheet the names of all prisoners and arrestees admitted to, and released from, Ward D as well as the date, time and other related information.

4. I have reviewed the Sign-In Sheet for February 8, 2010 and February 9, 2010. (A copy of the Sign-In Sheet is attached hereto as Exhibit 1).

ATTACHMENT / EXHIBIT 1

5. My review of the Sign-In Sheet revealed that Lemane Williams was not admitted to Ward D on either date.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 13th day of September, 2012

Lt. Ruben Okera 4143
Ruben Okera

PROVIDED TO GULF CI
MAIL ROOM
NOV 27 2012
FOR MAILING
INMATE'S INITIALS

A)

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

LEMANE DEON WILLIAMS,
Plaintiff

Civil Action No: 11-24638-CIV-LENARD
Magistrate Judge: P.A. WHITE

v.

OFFICER ANTHONY FERIA,
Defendant

_____/

PRETRIAL STATEMENT / GENERAL STATEMENT

This case is about police brutality with the use of excessive force. On January 2010, Officer Anthony Feria (Badge 2637) Miami – Dade Police arrested me for various charges. After he placed me in handcuffs he transported me to the police station. He kept asking me for the "gun", then he commenced to start beating me up. He pushed me while I was in handcuff restraints behind my back. When I fell the officer began punching me in my face and body. I suffered a broken hand / index finger, chipped teeth, several abrasions and bruises. I was then taken to the County Jail, but the jail refused to receive me due to my visible injuries (please see included copy of booking photo). I was then transported to Jackson Memorial Hospital, Ward "D" to undergo treatment for my injuries which

(Exhibit - A)

included surgery to my hand where a steel plate was inserted in my right index finger. I have lost complete range of motion on my right index finger (unable to bend). This is a permanent injury.

(A) I'll be using my medical and dental records and statements from witnesses who observed plaintiff apprehension and those whom observed plaintiffs condition after the apprehension.

(B) Medical and dental records. Statements from observers of the arrest metro west medical condition, county jail dentition center records as to the condition of plaintiff when brought in on arrest

(C) NON-INMATE witnesses plaintiff intends to call:

Tamika Shavette Williams
15620 S.W. 103 Ct.
Miami, Fl 33157

William Osby
15620 S.W. 103 Ct.
Miami, Fl 33157

William L. Morgan
3545 N.W. 205th Street
Miami, Fl 33056

(D) INMATE WITNESS plaintiff intends to call

Desmond Rizby
South Florida Reception Center
1400 N.W. 41st Street
Doral, Fl 33178

Charles E. Dunmore DC# 939650
Gulf Correctional Institution – Annex
699 Ike Steele Road
Wewahitchka, Fl 32465

William Morgan
3545 N.W. 205th Street
Miami Gardens, Fl 33056

TESTIMONY

My wife Tamiks Shavette William and stepson William Osby. Is going to say is when I was arrested and I was not injured at the time of my arrest. And when she came to the jail to see me I was in a cast because my hand was broken. And rod in my index finger. When I got to metro west detention center Mr. William and Mr. Desmond can testify as to my condition and why I was unable to use my hand. Mr. Dunmore can testify as to months later the condition of my hand an not being able to write or properly hold eating utensils. For Mr. Dumore at the time of his incarceration at metro west. Did all my writing to various departments such as medical request L.R.A. request which is legal request research letters to public defender lawyer. Etc.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY, that a true and correct copy of this request for production documents has been furnished by U.S. Mail to the office of Lauren E. Morse Miami – Dade County Attorneys Office 111 N.W. 1st street suite 2810 Miami, Florida 33128 this 27 day of NOVEMBER 2012.

Respectfully Submitted
/s/ Lemane Williams
Lemane Deon Williams DC# M05282
Gulf C.I. – Annex
699 Ike Steele Rd.
Wewahitchka, Fl 32465

PROVIDED TO GULF CI
MAIL ROOM
DEC 28 2012
FOR MAILING
INMATE'S INITIALS

PUBLIC HEALTH TRUST
CORRECTIONS HEALTH SERVICES

MEMORANDUM

B)

TO: Shift Commanders

FROM: Adell Hackett, ANM
Associate Nurse Manager
Metro West Detention Center

DATE: 8/24/10

SUBJECT: **Procedure Preparation**
Re: WILLIAMS, Lemane
Jail: 100011196

This inmate is scheduled for a procedure Tuesday, Aug. 24th, 2010. He must have nothing by mouth beginning at midnight (11:59 hr.) Monday, Aug 23rd, 2010.

Please bring him to North Clinic at your convenience prior to midnight on Monday, Aug. 23rd, 2010. He will leave to the hospital from the clinic.

Thank you.

:procedurepreparation
RS/hr
cc: Capt.
Charge Nurse
file

(Exhibit -B)

PUBLIC HEALTH TRUST
CORRECTIONS HEALTH SERVIC_

Jail #: 100011196
CIN: 613080
Hospital #: 1404406

Name: WILLIAMS, Lemane Race: ____ Sex: M Age: ____ Cell Block: MW2D1

Date and time prisoner was taken: Tue 8/24/10 at 06:00 Hospital: JMH Board of Health: ____

Reason for sending prisoner: AMSU/DTC1

MEDICAL REPORT
Brief Resume

Date and time returned to jail ____ Examining Physician ____

mw2

Corrections Health Services
Jackson Health System

Nursing Evaluation Tool:

General Sick Call

Facility:
Patient Name: Williams (Last) Lemanne (First) MI
Inmate Number: 10-11196
Date of Birth: 12 / 12 / 77 (MM DD YYYY)
Date of Report: 9 / 25 / 10 (MM DD YYYY)
Time Seen: 0800 AM / PM Circle One

Subjective: Chief Complaint(s): Difficulty up/down — Request LBP extention
Onset: 8.25.10.
Brief History: (Continue on back if necessary)
cast to RUE x 1 mt

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: ____ P: ____ RR: 20 B/P: ____ / ____
Examination Findings: (Continue on back if necessary) Cast intact RUE

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):
☐ Referral NOT REQUIRED
☒ Referral REQUIRED due to the following: (Check all that apply)
☐ Recurrent Complaint (More than 2 visits for the same complaint)
☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given

Plan: Check All That Apply:
☒ Instructions to return if condition worsens.
☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☒ NO (If NO then schedule patient for appropriate follow-up visits)
☐ Other: (Describe)

OTC Medications given ☒ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Date for referral: ___/___/___ (MM DD YYYY)

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (If emergent who was contacted?) Time

x Harris (Nurses Signature) Name: F.E. Harris R. (Printed)

03/26/... 09 14:1' 305851908 PATU ... PAGE 01/0

Jackson HEALTH SYSTEM

Time Received: _____

DISCHARGE PRESCRIPTION FORM

ATTACHMENT - A

2D 1
1100.11196
6013VD

☐ Jackson Memorial Hospital
1611 NW 12th Avenue
Miami, FL 33135
(305) 585 – 1111

☐ Jackson North Medical Center
160 NW 170 Street
North Miami, FL 33169
(305) 651 – 1100

Patient Information
Name: WILLIAMS, LEMANE MR#: 1404406
Address: _____
City: _____ State: _____
DOB: _____ Gender: ☐ Male ☐ Female

Patient Location
Floor: DTC Room#: #23
Bed: ☐ A ☐ B Other: _____

Number of Prescriptions: _____ Nurse/Floor Contact: _____ Ext: _____
Floor Fax #: _____

☐ Check if patient needs snap-on caps
☐ Check if patient needs directions in Spanish

Pharmacy Feedback: Please Pay Cashier _____

Jackson HEALTH SYSTEM
Jackson Memorial Hospital
1611 N.W. 12th Avenue
Miami, Florida 33136-1096
305-585-1111

Rx for pediatric patients < 14 yo must include age & weight or BSA
Age: _____ Weight: _____ (kg) or BSA _____ (m^2)

DRUG	DOSE / STRENGTH	Dose in mg/kg or mg/BSA	Qty.	Refills
1 Rx Tylenol #3	300/30		#60 Sixty	0 1 2 / 3 4 5 / 6 7 8 / 9 10 11
Sig: ii tabs PO Q 4° PRN pain		Indication:		
2 Rx		Dose in mg/kg or mg/BSA		0 1 2 / 3 4 5 / 6 7 8 / 9 10 11
Sig:		Indication:		

☐ NKA Allergies: _____

Prescriber's Signature: _____
Print Last Name: Commiron Phone/Beeper #: _____
DEA # AO1949922 PHT DR.# 43801
FL LICENSE # 12738 (Required) Date: 8/24/10

Imprint/Write Patient's Name, Address and Medical Record #
WILLIAMS, LEMANE 1404406
DOB:12/12/1978 Sex: M Age:31 /Y SRVC:O
PHY: Owens Patrick W PLN: D07-
Fin: 40004743977 Admission: 08/24/2010
FC: D

☐ Sunday

EPF090828.352

Technician/ Driver Delivered: _____

Any questions regarding prescription order, please call (305) 585-6439.

Pharmacy Fax # 305-585-0088

Schedule Inquiry - JMH Person - Custom

Task Edit View Help

Name: WILLIAMS, LEMANE DOB: 12/12/78 Age: 31 Years Gender: Male

MRN: 1404406;(7074115) Home Phone: (786) 263-5101 Location: Research: Race: Black

Mother's Maiden Name: Primary Care at: None Outside ... Case Review Date: Ins Plan 1: Corrections Health Services - D07

Copay: 0.00 Auth Req?: Yes Ins Plan 2:

Person | Resource

Inquiry: JMH Person - Custom

Person: WILLIAMS, LEMANE

Start date: 09/21/10 Start time: 0000

Find Clear Close

Begin Date	MRN	State	Appt Type	RESOURCE	Person Name	FIN	Type	Ph
10/04/2010 09:00	1404406	Confirmed	ORTHO-REHAB-FOLL-UP	HAND CLINIC	WILLIAMS, LEMANE	40004910601	Pre-Registratio	(78

appt. noted @ Metro West.

613080/10-11196

r Help, press F1

1 Item P19 HROSAS Tuesday, September 21, 2010 14:07

BSR N. 11 MEDICATIONS ORDERS

DRUG NAME, SRENGTH, DOSE	INDICATION FOR USE	ORDER DATE	STOP DATE	INITIALS
Tylenol 650 mg P.O		2/9/10	2/15/10	LJ
1 bid PRN x 7 days				

DATE	TIME	SITE/ROUTE	MEDICATION	COMPLAINT	INITIALS	RESULTS	INITIALS

DOCUMENTATION OF MEDICATION EXCEPTIONS (N CODE)

DATE	TIME	DOCUMENTATION BY NURSE	INITIALS
2/11/10	10:15 a	Recall @ MWDC Clinic →	[illegible]

INDIVIDUAL PRESCRIPTION MEDICATION RETURNED TO PHARMACY

DATE	MEDICATION NAME & STRENGHT	AMOUNT REMAINING	REASON FOR RETURN	SIGNATURE	SIGNATURE CH. NURSE

INMATE NAME: Williams Lemmel CIN NUMBER: LOCATION:

The date of your surgery/procedure is: _____

Please report to: _____ At:

Jackson Main _____ A.M./P.M. Jackson South _____ A.M/P.M Jackson North _____ A.M./P.M

ALL PATIENTS:

- ☐ Do not eat or drink anything after midnight the night before your surgery/procedure this includes water, coffee, chewing gum, or hard candy.
- ☐ Bring a picture identification and insurance card.
- ☐ Leave money/valuables such as watches, jewelry, credit cards, and laptops at home. REMOVE BODY PIERCINGS SUCH AS UMBILICAL RINGS AND TONGUE STUDS.
- ☐ Remove hairpins, hair ornaments, makeup, lipstick and nail polish. PLEASE DO NOT WEAR LOTIONS, CREAMS, DEODORANTS.
- ☐ If you have sleep apnea and use a machine, please bring it with you to the hospital.
- ☐ If you are going home the same day as your procedure, arrange for your family/designee to take you home.
- ☐ If you are going home the same day as your procedure wear comfortable, loose clothing.
- ☐ All your personal belongings will be given to your family/designee.
- ☐ Please bring copy of your Living Will (Advanced Directives).

CHILDREN:

- ☐ A parent, legal guardian or authorized representative must accompany all children. Please bring proof as legal guardian or authorized representative.
- ☐ If your child is going home the day of the surgery plan to stay with your child during the hospital stay.
- ☐ Special fasting instructions given.

SPECIAL INSTRUCTIONS:

- ☐ Bowel preparation instructions/prescriptions given per physician's orders.
- ☐ Surgical instructions given per physician's orders.
- ☐ Follow Chlorhexidine Shower Instructions.
- ☐ OTHER: _____

DO NOT SHAVE AT HOME FOR YOUR SURGICAL PROCEDURE. IT MAY RESULT IN CANCELLATION.

IF YOU GET A COLD OR OTHER ILLNESS BEFORE YOUR SURGERY/PROCEDURE OR ARE UNABLE TO COME AS SCHEDULED, CALL YOUR DOCTOR/ SERVICE AT: 786 285 4503

MEDICATIONS:

- ☐ Take the following medications the morning of your surgery procedure with a small sip of water: Prednisone Mouthwash
- ☐ DO NOT take the following medications the morning of surgery: _____
- ☐ DO NOT take aspirin or aspirin products for 5 days or anti-coagulants 5 for ____ days before your surgery/procedure unless your doctor instructs you otherwise.

ARNP/RN Print name/Employee ID#

Maria Fernandez

ARNP/RN Signature/Title/Date

Mtorrent

Patient/Authorized representative signature

786 963 4935-6

Patient telephone number

PLEASE GIVE US THE BEST NUMBER TO REACH YOU IN THE EVENT THAT ANY OF THESE INSTRUCTIONS SHOULD CHANGE.

WILLIAMS, LEMANE 1404406
DOB: 12/12/1978 Sex: M Age: 31 /Y SRVC: O
PHY: Owens Patrick W PLN: L79-
Fin: 40004743977 Admission: 08/24/2010
FC: U

Corrections PUBLIC HEALTH TRUST
HEALTH SERVICES
Jackson Health System

ATE NAME: Williams Lemane DATE OF BIRTH: 12/12/78 (32)

HER'S NAME: Janet Williams AGE: 32 SEX: ☒ MALE ☐ FEMALE

RACE: B SOCIAL SECURITY #: [redacted] 7666 BKNG #: ID-111196

EMERGENCY CONTACT: Janet Williams (mother)

ADDRESS: Miami, FA PHONE: (786) 217-4608

Minnie Williams (Cousin) (305) 969-9588

AUTHORIZATION FOR TREATMENT

Jim. H # 1404406

1. I hereby consent to and authorize the PUBLIC HEALTH TRUST, Corrections Health Services, its staff and physicians to conduct examinations and treatments which in their judgement become necessary or advisable in the diagnosis or treatment

he staff and administration of this Program to institute any emergency procedures which they deem necessary. I and/or referral to another facility if the emergency warrants such transfer and/or referral.

practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been ne result of treatment.

IBLIC HEALTH TRUST, Corrections Health Services, this Program, the medical staff, nurses and employees bility whatsoever from this course of treatment. I further understand that this release shall be binding upon me, administrator or assignees.

nate medical records and information contained herein are maintained in my best interest. I further understand sferred to another correctional facility within the Corrections Health Services Program, this information will be ensure continuity of inmate care.

100011196
LEMANE WILLIAMS

mplete social, psychiatric and medical information as requested by Corrections Health Services.

Authorization for Treatment shall be binding for treatment rendered to myself at any of the correctional facili- ion of those facilities served by Corrections Health Services.

Authorization for Treatment shall remain in effect until my release from the Metropolitan Dade County until I formally rescind this authorization in writing.

] HAVE HAD READ TO ME BY _____

NISH ☐ CREOLE ☐ _____ THIS AUTHORIZATION

FULLY UNDERSTAND THE CONTENTS OF THIS FORM.

100011196
LEMANE WILLIAMS

DATE: 01/07/10 TIME: 10:00 AM/PM INMATE SIGNATURE: Lemane Williams

☐ See Refusal of Treatment

I CERTIFY THAT I HAVE FULLY EXPLAINED THIS AUTHORIZATION FOR TREATMENT TO THE ABOVE-NAMED INMATE.

☒ CHS STAFF / ☐ TRANSLATOR SIGNATURE: _____

SIGNATURE, TITLE _____

201

DATE/ TIME	NURSE INITIAL	
		Discharge Date: _____ Attending Physician: _____
		Discharge To: _____ Procedure Performed: _____
		Diagnosis: _____ Phone Number: _____
		FOR THE NEXT 24 HOURS PLEASE OBSERVE THE FOLLOWING GENERAL INSTRUCTIONS:
		■ Do not drive or operate machinery or make important decisions
		■ Do not drink alcoholic beverages
		■ Rest and limit activities
		Follow up care: ☐ Clinic ☐ Private Physician
		Medication to take at home:
		Diet:
		Physical activity:
		☐ Resume normal activity
		☐ Return to work/school
		☐ No sports/heavy lifting
		☐ Special instructions
		☐ Bathing: ☐ Tub ☐ Shower ☐ Sponge bath
		Wound/Incision care:
		☐ Change dressing as needed
		☐ Remove dressing after ____Hours ____days
		☐ Keep dressing clean/dry
		☐ Catheter/drain/tube care
		☐ Special instructions
		If any of the following emergencies occur, come to JHM EMERGENCY ROOM or go to the nearest
		Emergency Room facility.
		■ Excessive pain not relieved by medication
		■ Temperature over 101.5°F or above for 24 hours
		■ Excessive bleeding/drainage
		■ Excessive redness/swelling around wound area

Physician Signature/Number: _____ Date/Time: _____ Service: _____

Nurse's Signature: _____ Date/Time: _____

Interpreter's Signature: _____ Date/Time: _____

Patient/Authorized Representative Signature: _____ Date/Time: _____

My signature indicates that I have received the instructions and that I under[illegible] them.

Jackson HEALTH SYSTEM — PUBLIC HEALTH TRUST — MIAMI, FLORIDA 33136-1096

WILLIAMS, LEMANE
Fin: 40004743977
1404406
ADM:08/24/2010
DOB:12/12/1978

PHYSICIAN'S ORDER/DISCHARGE INSTRUCTIONS
C-290 EM Rev. 07/2000 Page 1 of 1

PO0010

file

CONSULTATION / REFERRAL FORM

Date of referral: 6/9/10 Time of referral: 1100 (military time)

Referring to (service): Ortho Hand clinic ☐ consult ☐ co-management ☐ referral

Referred from (service): MOTR Area / location:

Provider referring patient: (print) Dr. Lizano MD / DO / ARNP / PA. ID # 20030

Telephone: 786-263-4935 Beeper: Email address:

Reason for referral: (3) yr. old C/O pain (R) 3rd finger 3-4 months occurred the pt. x-handcuffed & locked (R) hand. X-ray shows Displaced with - articular Fracture 3rd Middle & Reserve Phalanges done 4/13/10

Past medical and surgical history: Denies

List current medications or ☐ See attached list: None

Allergies: NKA

Authorization number: ICD 9 code: 829.0 CPT code:

Consultation Date: Time: (military time)

Findings and recommendations: Provide history and physical.

7/6/10 Faxed to Angela Boreland, RN @ 305-585-2457

Dr. [illegible]

HECTOR ROSAS/CLERK TYPIST
METRO WEST DETENTION CENTER/CHS CLINIC
13850 NW 41 STREET MIAMI, FL 33178
TEL: 786-263-4935/ FAX: 786-263-5057

RECEIVED JUN 1 2010 PROCESSED

Approved [illegible] 6/22/10

Required follow up:

Consulting Provider Contact Phone Number: *Consulting Provider Signature & I.D. Number*

PATIENT IMPRINT [illegible]

Jackson HEALTH SYSTEM — PUBLIC HEALTH TRUST — MIAMI, FLORIDA 33136-1096

LTD: 2/9/10
DOB: 12/12/78

Williams, Lemane
10-11196
ca 613080

CONSULTATION REPORT

C-260 Rev. 09/2005 1 of 1 CT0010

Result type:	GR Hand Right 2 Views
Result date:	13 April 2010 11:19 EDT
Result status:	Auth (Verified)
Result title:	GR Hand Right 2 Views
Verified by:	Pevsner, N. Henry on 14 April 2010 20:43 EDT
Encounter info:	40004309004, JMH, Client, - 04/13/10

* Final Report *

Reason For Exam
pain&swelling(r)index finger, injury 2mth ago

Report
Right Hand Three Views – 04/13/10

Clinical indication: Pain and swelling of the right index finger. Injury 2 months ago.

No prior study is available for comparison.

Findings: There is a rounded radiopacity projecting along the radial soft tissues of the 3rd proximal phalanx, likely representing a BB. There is an oblique, subacute, intra-articular fracture of the distal 2nd phalanx. In addition, there is an oblique, subacute, intra-articular fracture of the 2nd middle phalanx. There is mild radial subluxation at the 2nd proximal interphalangeal joint. The remainder of the joint spaces is preserved. Bony mineralization is within normal limits.

Impression:

1. Foreign body along the radial soft tissues of the proximal 3rd digit, likely representing a BB.

2. Subacute intra-articular fractures of the 2nd middle and distal phalanges.

J#160991/svc

Signature Line

6/9/10

* Final Report *

FINAL REPORT
Attending Physician: Pevsner, N. Henry

Transcribed by & Date/Time: Canales , Sylvia V 04/13/2010 20:23
I reviewed the films and the Radiology resident's findings and agree with the final report-Resident: Letzing, Michael
Electronically Signed By: Pevsner, N. Henry Signature Date/Time: 04/14/2010 20:43

Completed Action List:
* Order by Novitch, Edward H. on 12 April 2010 09:01 EDT
* Perform by DIAZ, JORGE J on 13 April 2010 11:19 EDT
* VERIFY by Pevsner, N. Henry on 14 April 2010 20:43 EDT

Corrections Health Services

MEDICATION ADMINISTRATION

01 0080

RECONCILED AND ACTIVE			IN ACTIVE
DATE / INT	DATE / INT	DATE / INT	DATE / INT

ALLERGIES: NKA

MONTH / YEAR: 8/10

ORDER DATE	STOP DATE	MEDICATION STRENGTH, DOSE, ROUTE & FREQUENCY
8/28/10 Am (INT)	8-30-10 7PM (TIME)	Tylenol 650 mg po. BID x 3 days
		PRN

ADMIN TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8A																															
8P																															

CODES
G= Starter dose given in clinic
N=Dose not administered (Explain)
O=Out of cell,dose not administered
S=Self-administered dose

Init	Print Name & Title	Init	Print Name & Title

Name: Williams, Lemane
Sex: M
Race: B
DOB: 12-12-28
Mother
Jail#: 10-11196
SS#: [redacted]-7606
Location: 2D1

Corrections
HEALTH SERVICES
Jackson Health System

PUBLIC HEALTH TRUST

INMATE REQUEST FOR HEALTH SERVICES
PEDIDO DE SERVICIOS DE SALUD POR PARTE DEL PRESO
REKLAMASYON PRINZONYE YO POU SERVIS SANTE YO

Name - Nombre - Non: Lemark Williams		
Date - Fecha - Dat: 6-8-10	Facility Institution - Instalaciones de la Institicion - Lokal Enstitisyon: Metro West	
Jail # - Carcel # - Prizon #: 10-11196		
Race - Raza - Ras: B/M	Sex - Sexo Saks: Male	Cell # - Celda # - Salil #: 3 D 2
Date of Birth - Fecha de Nacimiento - Dat de Nesans: 12-12-77		
Mother's Name - Nombre de su Madre - Non Manman-ou: Ms. Janet Williams		

Cin#613080

(R) pain finger

EXPLAIN YOUR PROBLEM OR COMPLAINT
EXPLIQUE SU PROBLEMA O QUEJA
EXPLIKE PROBLEM-W OSWA KONPLENT KE QU GENYEN

My finger has been broken for 3 months & now has already been taken. Im in extreme pain. Im asking to see a doctor please.

I am aware that there is a fee for sick-call. Charges will be made to my commissary account.
Estoy conciente de que hay un costo por llamar a la enfermeria. Los cargos scran hechos a mi cuenta de la comisaria.
Mwen okouran keg en yon fre pou le ke-w rele ou malad. Sa key o chaje yo yap depos-l nan kont komisyon-w.

Lemark williams 06/9/10
Inmate Signature / Firma del Preso / Siyati Prizonye-an

Circle Charges:

Doctor	/ ARNP	/ PA	/ Dentist.....	$5.00	Nurse	/ Dental Assistant.....	$3.00
Medico	/ Enfermera Practicante	/ Asistente Medico	/ Dentista.....	$5.00	Enfermera	/ Asistente Dental.....	$3.00
Doktè	/ Enfimyè Practient	/ Asistan Doktè	/ Dantis.....	$5.00	Enfimyè	/ Asistan Dantis.....	$3.00

**** STAFF SECTION / SECCION DEL PERSONAL / ESTAFF SEKSYON ****

Disposition: State

Triage Nurse: Dunbar RN (Print Full Name) Date: 06/08/10 Time: 1:55a

S: "My X-ray say my right finger is broken"

O: S/P right index finger injury. Seen clinic some weeks ago. C/O "Doesn't feel right" treated with medication when seen at Ruth Clinic.

A: Alteration comfort - right index finger "Injury related" pain medication

P: MD referral

06/08/10
Date

Dunbar RN
Health Service Signature

White copy: Medical record

United States District Court
Southern District of Florida

Case Number: 11CV24368-JAL.

SUPPLEMENTAL ATTACHMENT(S)

Please refer to the supplemental paper "court file" in the division where the Judge is chambered. These attachments must not be placed in the "chron file".

☐ **NOT SCANNED**

- ☐ Due to Poor Quality
- ☐ Bound Extradition Papers
- ☐ Photographs
- ☐ Surety Bond (Original or Letter of Understanding)
- ☐ CD or DVD (Court Order or Trial Purposes only)
- ☐ Other: _____

☑ **SCANNED**

- ☑ But Poor Quality Exhibits.
- ☐ Habeas Cases (State Court Record/Transcript)

Date: 1/17/2013