



Special Commission of Inquiry into the Ruby Princess

EXHIBIT 81

Case Summaries: Lynette and Donald Jones

CASE SUMMARY

Ruby Princess - R007 (Mar 8, 2020 - May 1, 2020) - Mar 18, 2020 17:47 UTC+12:00

PATIENT ID	NAME	DATE OF BIRTH	GENDER	CABIN
[REDACTED]	JONES, DONALD	[REDACTED]	M	[REDACTED]

Communicable Disease

DISEASE	SYMPTOMS STARTED	LAST SYMPTOMS	CABIN	NO. IN CABIN	REPORTED DATE
Acute Respiratory Disease	Mar 17, 2020 18:15 UTC+12:00	Mar 18, 2020 18:15 UTC+12:00	[REDACTED]	2	Mar 18, 2020 18:15 UTC+12:00

TEMPERATURE
36.8 C 98.2 F O

SYMPTOMS
Cough

OTHER SYMPTOMS
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DETAILS

Received Current Seasonal Flu Vaccination: No
Close Contact of ARD Case: Yes
CXR: Not Done
Viral Culture: Not Done

Received Tamiflu: Yes
Pneumonia: No
Influenza Test: Flu A+B Negative
Legionella Urine Antigen: Not Done

SYSTEM DECISION

USER DECISION

ARI

ARI

MASTER LOG ADDITIONAL COMMENTS ⓘ

REPORTABLE LOG COMMENTS ⓘ

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ISOLATION STARTED	ANTICIPATED ISOLATION RELEASE	RELEASED
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ADMIN
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Triage

DATE	PERFORMED BY	VISIT REASON
Mar 18, 2020 17:56 UTC+12:00	Loh, Wen Ling RN	Illness

PRIORITY

NON-URGENT

CHIEF COMPLAINTS

Patient attends clinic for cough and sore throat.

NOTES

c/o sore throat and cough for 2 days
close contact with wife who diagnosed as ILI
denies travel history

Vitals

DATE	PERFORMED BY
Mar 18, 2020 17:57 UTC+12:00	LOH, WEN LING RN

VITAL SIGNS

TEMPERATURE	BLOOD PRESSURE	MAP
36.8 C 98.2 F O	140/88 RA sit	105
HEART RATE	SPO2	RESPIRATORY RATE
76 bpm reg Radial	95 SpO2 Finger Room air	18 breaths/min
A.V.P.U	PAIN SCORE	CAPILLARY REFILL
A	0	1 seconds Peripheral
COMMENTS		
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Allergy

No Known Allergies.

Medical History

DATE ONSET	DATE OF RESOLUTION	DOCUMENTED BY
--	--	Loh, Wen Ling RN

CONDITION

I10 - Essential (primary) hypertension Chronic Illness

NOTES

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DATE ONSET	DATE OF RESOLUTION	DOCUMENTED BY
--	--	Loh, Wen Ling RN

CONDITION

I71 - Aortic aneurysm and dissection Chronic Illness

NOTES

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Social History

SMOKING

Smoking History No

ALCOHOL

Alcohol History Yes

HPI

DATE	PERFORMED BY
Mar 18, 2020 18:17 UTC+12:00	Dalvie, Zaeem MD

ILI CLOSE CONTACT

Guest's wife has been isolated for ILI.

He has come down for prophylaxis.

He denies any fever, myalgia or lethargy.

He reports a 2 day history of a cough productive of clear sputum - which is already resolving.

No pleuritic chest pain or dyspnoea.

No other symptoms or concerns.

No travel outside of Australia prior to the start of the cruise.

No contact with a suspected or confirmed case of COVID-19.

Physical Examination

DATE	PERFORMED BY
Mar 18, 2020 18:15 UTC+12:00	Dalvie, Zaeem MD

GENERAL

Well developed, well nourished, alert and cooperative, and appears to be in no acute distress. Mental status: Awake and Alert. Orientated. Cooperative. General: Pallor: Absent. Central Cyanosis: Absent.

EARS, NOSE, MOUTH AND THROAT

Throat: Posterior oropharynx: Posterior oropharynx has no erythema, exudate, lesions, or cobblestoning.

CARDIOVASCULAR

Auscultation: S1 and S2 normal, no murmur or gallop.

RESPIRATORY

Inspection: Respiratory rate and pattern: Normal. Stridor: None. Auscultation of the lungs: Clear to auscultation.

Physician Orders

STATUS	TASK	USER	DATE
Completed	INFLUENZA A&B TEST	Dalvie, Zaeem MD	Mar 18, 2020 18:13 UTC+12:00

LAB RESULTS

Influenza virus A Ag	neg
Influenza virus B Ag	neg

FINDINGS	COMMENTS
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Current Medications

[REDACTED]

New Medications

OSELTAMIVIR PHOSPHATE CAPSULE 75MG PO
1 Capsule once daily starting Mar 18, 2020 18:13 UTC+12:00 for 5 day(s)

Diagnosis

DIAGNOSED DATE Mar 18, 2020	PERFORMED BY Dalvie, Zaeem MD
TYPE Final	DIAGNOSIS Z20 - Contact with and exposure to communicable diseases
NOTES --	

DIAGNOSED DATE Mar 18, 2020	PERFORMED BY Dalvie, Zaeem MD
TYPE Additional	DIAGNOSIS R05 - Cough
NOTES --	


Note

DATE Mar 18, 2020 18:17 UTC+12:00	PERFORMED BY Dalvie, Zaeem MD
NOTES On the following questions, patient responded with: IN THE PAST 14 DAYS, HAVE YOU OR ANY PERSON IN YOUR TRAVEL PARTY: 1. Travelled from, or through China, Hong Kong, Macau, South Korea, Iran, Italy or a location currently subject to lockdown (quarantine) measures by government health authorities (including transiting through an airport in these locations)? NO 2. Had contact with a suspected or confirmed case of coronavirus (COVID-19), or a person under monitoring for coronavirus? NO 3. Have you travelled from, or through any of the locations listed below (including transiting through an airport in these locations)? Taiwan, Indonesia, Thailand, Vietnam, Japan, Singapore NO	

Disposition

MEDICAL DEPARTMENT DECIDED TO Discharge from our care, follow up if required	PERFORMED BY Dalvie, Zaeem MD	DATE Mar 18, 2020 17:42 UTC+12:00
COMMENTS Follow up PRN		
DISCHARGE DOCUMENTS		
Instructions		
Prescriptions		

PATIENT SIGNATURE



JONES, DONALD
Mar 18, 2020 18:20 UTC+12:00



24305 Town Center Drive
 Santa Clarita, California 91355
 Corporate: +1-661-753-0000
 Fax: +1-661-259-3108
 Internet: www.princess.com

MEDICAL RECORDS CONSENT AND EXPENSE PAYMENT AGREEMENT

PASSENGER/PATIENT ONBOARD OR SHORESIDE TREATMENT

Ruby Princess

Patient Family Name:	JONES	Patient First name:	DONALD
Stateroom Number:	████	Patient Date of Birth:	████
Email Address:		Cell Phone:*	
Mailing Address:			

*** If my cell phone is provided, I authorize Princess Cruise Lines, Ltd. ("Princess") to call me with any questions regarding any amounts owing under this Agreement.**

PAYMENT AND ASSIGNMENT

PAYMENT. I agree to pay any and all expenses incurred on my behalf or on behalf of the patient (regardless of whether the patient is my family member, traveling companion, or my minor child), which are related to the medical care received onboard and/or at a shoreside facility ("Medical Expenses"). Medical expenses include, but are not limited to, medical or dental services and fees, hospitalization costs, transportation costs, shoreside lodging, shoreside meals, medical evacuation, prescription medication and port agency assistance fees related to the medical care. I agree my obligation to pay for Medical Expenses (including the payment of shoreside service provider(s) directly, if required) is not voided if I or the patient (in the case where the patient is my family member, traveling companion, or my minor child) has medical insurance, supplemental health insurance, or Princess Vacation Protection (PVP) Cancellation and Passenger Protection Program travel protection, or independent travel insurance. I agree that Princess Cruise Lines, Ltd. ("Princess") is not obligated to advance any payment(s) to cover Medical Expenses and that if Princess does so, it is performed as a courtesy and I agree to reimburse Princess as described in this Agreement. In the event I am or the patient is (in the case where the patient is my family member, traveling companion, or my minor child) medically disembarked on an emergency basis and shipboard Medical Staff is unable to provide me with a copy of my shipboard medical bill prior to disembarkation, I authorize ship's Medical Staff to charge any onboard medical bill to my credit card on file and understand I will receive a copy of this medical bill from the shoreside Health Services Department. In the event I am or the patient is (in the case where the patient is my family member, traveling companion, or my minor child) medically disembarked on an emergency basis, I understand that neither myself nor the patient will be entitled to any cruise fare refund as a result of early disembarkation. This does not preclude myself and/or the patient (in the case where the patient is my family member, traveling companion, or my minor child) from filing any claims under any insurance policy that may have been purchased.

ASSIGNMENT OF INSURANCE BENEFITS. On behalf of myself or the patient (in the case where the patient is my family member, traveling companion, or my minor child), I assign all applicable medical insurance or travel protection ("Provider") benefits for Medical Expenses and agree to reimburse Princess for any non-covered Medical Expenses within (30) days of the date invoiced by Princess. I authorize any Provider to reimburse Princess directly for all monies advanced as payment for Medical Expenses incurred. I authorize Princess to submit any reimbursement claims directly to any Provider covering the Medical Expenses.

MEDICAL RECORDS CONSENT

CONSENT TO DISCLOSE HEALTH INFORMATION. I authorize Princess to contact any Medical Provider and to receive directly copies of any and all medical or other records related to Medical Services or billing provided to me or the patient (in the case where the patient is my family member, traveling companion, or my minor child). I also authorize Princess to release any information regarding Medical Care, which can include without limitation, medical history, symptoms, treatment, examination, results or diagnosis to any Medical Provider. I also hereby authorize Princess to provide any necessary information to my traveling companion(s) and/or next of kin of my condition, and agree that Princess will have no obligation to do so.

On behalf of myself or the patient (in the case where the patient is my family member, traveling companion, or my minor child), I hereby expressly consent to the disclosure of medical and other records described above to any or all of the following for the purposes specified:

- The Princess Health Services Department in the United States;
- Selected persons within the Princess Legal and Finance Departments who have need of these records for business or legal purposes related to my medical care;
- Any medical assistance company or medical provider for the purpose of assisting with or continuing medical care, should it be necessary for me or the patient (in the case where the patient is my family member, traveling companion, or my minor child) to be medically landed from the vessel;

- Any other medical professional that the Princess Health Services Department feels it appropriate to consult for the purpose of assisting in medical care;
- A third party contractor (including, without limitation, any legal or financial adviser and any debt collection service provider) for recovery of costs incurred by Princess in relation to the medical care; and
- Health care professionals to review the quality of care through the process of clinical audit.

I also authorize my travel insurance provider to provide any necessary information to Princess in relation to assisting me with care and repatriation if required.

It has been explained to me that if I do not consent to any of the above, I may refuse my consent by deleting the relevant section(s). However, I acknowledge that if I withhold my consent for the transfer of medical records to any of the above, this may prejudice my treatment or that of the patient (in the case where the patient is my family member, traveling companion, or my minor child) and any issues associated therewith.

LEGAL NOTICES

COLLECTION EXPENSES. I agree to pay on demand all the losses, costs, and expenses (including, without limitation, attorneys' fees and disbursements) which incur in connection with enforcement or attempted enforcement of this Agreement, or the protection or preservation of your rights under this Agreement, whether by judicial proceedings or otherwise. Such costs and expenses include, without limitation, those incurred in connection with any workout or refinancing, or any bankruptcy, insolvency, liquidation or similar proceedings.

WAIVER OF DEFENSES. I hereby waive any rights I may otherwise have under the legal defenses of diligence, demand, presentment, protest or further notice of any kind. Time is of the essence for the performance of each and every obligation under this Agreement.

LEGAL RESPONSIBILITY AND LIABILITY. All health and medical services onboard are provided solely for the convenience and benefit of patients who may be charged for such services. You accept and use medicines and medical services at your sole risk and expense without liability or responsibility of Princess whatsoever, and agree to indemnify Princess for all medical or evacuation costs or expenses incurred on your behalf. Doctors, nurses, and other medical staff members work directly for you as their patient. Therefore the course of medical treatment will be determined exclusively by the shipboard medical staff and you.

REJOINING VESSEL FOLLOWING SHORESIDE TREATMENT OR MEDICAL DISEMBARKATION. Medical clearance from a shoreside provider for a patient to resume a cruise, is not a guarantee that the patient will be allowed to do so. The shipboard doctor will make the final determination, based not only on diagnostic results and/or response to treatment but also on factors including but not limited to the likelihood of recurrence or worsening of your condition, length of cruise, ship's itinerary, and available clinical resources onboard. Princess will always take a conservative approach when it comes to the health and safety of our guests.

GOVERNING LAW. THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH MARITIME LAW AS APPLIED IN CALIFORNIA AND CALIFORNIA LAW TO THE EXTENT IT DOES NOT CONFLICT WITH MARITIME LAW, WITHOUT GIVING EFFECT TO ITS CONFLICTS OF LAW PRINCIPLES.

NOTICE: ANY HOLDER OF THIS CONSUMER CREDIT CONTRACT IS SUBJECT TO ALL CLAIMS AND DEFENSES WHICH THE DEBTOR COULD ASSERT AGAINST THE SELLER OF GOODS OR SERVICES OBTAINED PURSUANT HERETO OR WITH THE PROCEEDS HEREOF. RECOVERY HEREUNDER BY THE DEBTOR SHALL NOT EXCEED AMOUNTS PAID BY THE DEBTOR HEREUNDER.

BY SIGNING BELOW, I AGREE TO ALL THE TERMS AND CONDITIONS SET FORTH ABOVE

Patient's Signature



Patient JONES, DONALD
Mar 18, 2020 17:48 UTC+12:00

Guardian / Family Member / Traveling Signature

Mar 18, 2020 17:48 UTC+12:00



PRINCESS CRUISES

COMPLETE THE FOLLOWING SECTION FOR MEDICAL
CENTER ADMISSIONS.

SHORESIDE REFERRALS AND DISEMBARKATIONS
ONLY

24305 Town Center Drive
Santa Clarita, California 91355
Corporate: +1-661-753-0000
Fax: +1-661-259-3108
Internet: www.princess.com

THE FOLLOWING INFORMATION MUST BE PROVIDED FOR THE PATIENT

1. Is the patient covered by any other Group Medical Benefit Plan, Group Payment Plan, Medicare or Government Plan?

No ☐ Yes ☐

* If Yes, please provide the name of the Plan Sponsor, Policy Number and Claim Office Address of Primary Medical Carrier:

Name: _____ Policy No: _____ Address: _____

2. Does the patient have supplemental insurance, such as a Medicare supplement plan? No ☐ Yes ☐

*If Yes, please provide the name of Plan Sponsor, Policy Number and Claim Office Address of Supplemental Insurance Carrier:

Name: _____ Policy No: _____ Address: _____

3. Did the patient purchase Princess Vacation Protection (PVP) Cancellation and Passenger Protection Program or was it purchased on his/her behalf?

No ☐ Yes ☐

4. Is the patient insured through any other independent travel insurance plan? No ☐ Yes ☐

* If Yes, please provide the name of the Plan, Policy Number and Phone Number of Insurance Plan Carrier:

Name: _____ Policy No: _____ Address: _____

TRAVELING COMPANION

If I am signing as a Traveling Companion below, I agree that if I accompany the patient ashore, I will be responsible to pay for any and all personal costs resulting from this disembarkation at the time the costs are incurred. If Princess advances any of my expenses to accompany the patient, I will reimburse Princess for those advances and authorize Princess to charge my stateroom account and/or credit card for such advances.

Traveling Companion Signature

Mar 18, 2020 17:48 UTC+12:00

PATIENT REGISTRATION FORM

Please complete this form to assist the medical team provide you with better care.
Your personal health information will be protected in accordance with applicable privacy requirements.

Family Name:	JONES	Stateroom Number:	
First Name:	DONALD ROBERT	Date Of Birth:	
		(e.g. 01-Sep-1964)	
Home City:	WOLLONGONG	Date:	14/3/2021
Country of Residence:	AUSTRALIA	Time:	1745hrs

Past Medical History		Please check any previous health conditions, with the applicable dates.	
<input type="checkbox"/> Heart Attack <i>No</i>	<input type="checkbox"/> Irregular Heart Rate <i>No</i>	<input type="checkbox"/> Seizures <i>No</i>	<input type="checkbox"/> Arthritis <i>No</i>
<input type="checkbox"/> Angina <i>No</i>	<input type="checkbox"/> Asthma or COPD <i>No</i>	<input type="checkbox"/> Blackouts <i>No</i>	<input type="checkbox"/> Mobility problems <i>No</i>
<input type="checkbox"/> Heart Failure <i>No</i>	<input type="checkbox"/> Emphysema <i>No</i>	<input type="checkbox"/> Stroke / TIA <i>No</i>	<input type="checkbox"/> Urinary infection <i>No</i>
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pneumonia <i>No</i>	<input type="checkbox"/> Stomach Ulcer / Acid reflux <i>No</i>	<input type="checkbox"/> Enlarged prostate <i>No</i>
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Bleeding problems <i>No</i>	<input type="checkbox"/> Diabetes <i>No</i>	<input type="checkbox"/> Cancer <i>No</i>

Please list previous MEDICAL PROBLEMS with dates.	
Please list previous SURGERIES with dates.	NIL.
Please list all the MEDICATIONS you are taking and their dosages and frequency.	
Please list any ALLERGIES to medications or other items.	NO

Do you Smoke?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	If yes, for how many years?	How many per day?
Do you drink Alcohol?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	If yes, approximately how many units per week?	4
Would you like a copy of your medical record for a nominal fee to assist with insurance claims?			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

140/88

952 76

PLEASE TURN OVER

36.8°C

What is your main complaint?
When did it start?

Flu symptoms
cough, sore throat x 2h

Do you have any of the following symptoms? Mark the corresponding box to indicate Yes or No:

General:	Yes	No	Ears, nose, eyes & throat:	Yes	No	Abdominal:	Yes	No
Change in appetite	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Tiredness	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Weight gain	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Fever / chills	<input type="checkbox"/>	<input type="checkbox"/>	Ears blocked / hearing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Indigestion or heartburn	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Swollen glands	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Runny / blocked nose	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Nausea	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Respiratory & Cardio:	Yes	No	Sneezing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cough (dry)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Pain or swelling in face	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stomach/abdominal pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cough (with sputum)	<input type="checkbox"/>	<input type="checkbox"/>	Painful eyes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Abdominal swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cough (with blood)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Red eyes	<input type="checkbox"/>	<input type="checkbox"/>	Pain/difficulty swallowing	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Itchy or discharging eyes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Eyes / skin yellow	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Change in voice	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Change in bowel habit	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Short of breath with activity or exercise	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Toothache, jaw pain or swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Loose bowel motions or diarrhea	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Short of breath at night	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Visual changes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Constipation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chest pain on breathing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Neurological:	Yes	No	Fecal incontinence	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chest pain with activity or exercise	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Tingling or numbness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Rectal bleeding, or blood in feces (black feces)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chest pain at rest	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Headache	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Genital / Urinary:	Yes	No
Palpitations or abnormal heart beat	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Tremor or abnormal movements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Burning or pain with urination	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Ankle or leg swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Urination frequency	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Musculoskeletal:	Yes	No	Fits / Seizures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Nightly urination	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Black-outs / fainting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Muscle pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Problems with balance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Urinary incontinence	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Weakness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Poor stream	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Joint swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental Health:	Yes	No	Genital discharge or pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Joint or bone pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Disorientated / confused	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Menstrual / OBGYN issue	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Back or neck pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Anxious or distressed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Erectile Dysfunction	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Skin:	Yes	No	Elevated mood (manic)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Endocrine:	Yes	No
Lumps or bumps	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Low mood or depressed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Abnormal behavior	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Neck swelling	<input type="checkbox"/>	<input type="checkbox"/>
Itchy Skin	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Memory concerns	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Sweating / hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers, abscess or sores	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Increased thirst	<input type="checkbox"/>	<input type="checkbox"/>
Change in a pigmented lesion or moles	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Seeing, hearing or imagining things	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Breast mass, pain / discharge	<input type="checkbox"/>	<input type="checkbox"/>

By my signature below, I certify that the medical information provided is correct and acknowledge that I have read and understood all details stated in this form.

Patient First & Last Names: DONALD ROBERT JONES

Date of Birth: [REDACTED]
(e.g. 01-Sep-1964)

Patient / Guardian Signature: [Signature]

Date: 18/3/2021

Name of person completing form
(if not the patient): _____

Relationship to patient: _____

Signature: _____

Date: _____

CASE SUMMARY

Ruby Princess - R007 (Mar 8, 2020 - May 1, 2020) - Mar 18, 2020 15:44 UTC+12:00

PATIENT ID	NAME	DATE OF BIRTH	GENDER	CABIN
[REDACTED]	JONES, LYNETTE	[REDACTED]	F	[REDACTED]

Communicable Disease

DISEASE	SYMPTOMS STARTED	LAST SYMPTOMS	CABIN	NO. IN CABIN	REPORTED DATE
Acute Respiratory Disease	Mar 16, 2020 16:28 UTC+12:00	Mar 18, 2020 16:28 UTC+12:00	[REDACTED]	--	Mar 18, 2020 16:28 UTC+12:00

TEMPERATURE
37.9 C 100.2 F O

SYMPTOMS
Reported Feverishness
Cough

OTHER SYMPTOMS
--

DETAILS
Received Current Seasonal Flu Vaccination: No
Close Contact of ARD Case: Yes
CXR: Not Done
Viral Culture: Not Done

Received Tamiflu: Yes
Pneumonia: No
Influenza Test: Flu A Positive
Legionella Urine Antigen: Not Done

SYSTEM DECISION

ILI

USER DECISION

ILI

MASTER LOG ADDITIONAL COMMENTS ⓘ

--

REPORTABLE LOG COMMENTS ⓘ

--

USER	DATE	LAST SYMPTOMS	TEMPERATURE
Davidson, Andy Wayne PARA	Mar 19, 2020 10:43 UTC+11:00	Mar 18, 2020 16:28 UTC+11:00	--

SYMPTOMS
--

OTHER SYMPTOMS
none

SYSTEM DECISION

ILI

USER DECISION

ILI

Master Log Additional Comments ⓘ --

Reportable Log Comments ⓘ Separate disembarkation

ISOLATION STARTED	ANTICIPATED ISOLATION RELEASE	RELEASED
Mar 18, 2020 16:28 UTC+11:00	Mar 19, 2020 16:28 UTC+11:00	Mar 19, 2020 10:43 UTC+11:00

ADMIN
--

Triage

DATE	PERFORMED BY	VISIT REASON
Mar 18, 2020 15:53 UTC+12:00	Loh, Wen Ling RN	Illness

PRIORITY

NON-URGENT

CHIEF COMPLAINTS

Patient attends clinic for cough

NOTES

c/o cough since yesterday evening
denies travel history

Vitals

DATE

Mar 18, 2020 15:53 UTC+12:00

PERFORMED BY

LOH, WEN LING RN

VITAL SIGNS

TEMPERATURE

37.9 C 100.2 F O

BLOOD PRESSURE

153/83 RA sit

MAP

106

HEART RATE

88 bpm reg Radial

SPO2

97 SpO2 Finger Room air

RESPIRATORY RATE

18 breaths/min

A.V.P.U

A

PAIN SCORE

0

CAPILLARY REFILL

1 seconds Peripheral

COMMENTS

--

Allergy

No Known Allergies.

Medical History

DATE ONSET

--

DATE OF RESOLUTION

--

DOCUMENTED BY

Loh, Wen Ling RN

CONDITION

NOTES

--

DATE ONSET

--

DATE OF RESOLUTION

--

DOCUMENTED BY

Loh, Wen Ling RN

CONDITION

NOTES

--

Surgical History

DATE [REDACTED]	LOCATION --	DOCUMENTED BY Loh, Wen Ling RN
SURGERY [REDACTED]		
NOTES --		

DATE [REDACTED]	LOCATION --	DOCUMENTED BY Loh, Wen Ling RN
SURGERY [REDACTED]		
NOTES --		

Social History

SMOKING	
Smoking History	No
ALCOHOL	
Alcohol History	No

HPI

DATE Mar 18, 2020 16:25 UTC+12:00	PERFORMED BY Von Watzdorf, Ilse MD
RESPIRATORY SYMPTOMS 78yr old female	
cough (minimally productive, nil pleurisy) 3/7 fever/ myalgia/ malaise	
flu vaccination had	

DATE Mar 18, 2020 16:25 UTC+12:00	PERFORMED BY Von Watzdorf, Ilse MD
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TRAVEL HISTORY

IN THE PAST 14 DAYS, HAVE YOU OR ANY PERSON IN YOUR TRAVEL PARTY:

1. Travelled from, or through China, Hong Kong, Macau, South Korea, Iran, Italy or a location currently subject to lockdown (quarantine) measures by government health authorities (including transiting through an airport in these locations)? NO
2. Had contact with a suspected or confirmed case of coronavirus (COVID-19), or a person under monitoring for coronavirus? NO
3. Have you travelled from, or through any of the locations listed below (including transiting through an airport in these locations)? Taiwan, Indonesia, Thailand, Vietnam, Japan, Singapore NO

Physical Examination

DATE	PERFORMED BY
Mar 18, 2020 16:25 UTC+12:00	Von Watzdorf, Ilse MD

GENERAL

Well developed, well nourished, alert and cooperative, and appears to be in no acute distress.

CARDIOVASCULAR

Auscultation: S1 and S2 normal, no murmur or gallop.

RESPIRATORY

Regular rate and depth of breathing; non-labored without retractions or accessory muscle use. Thorax symmetrical. Anterior and posterior lung fields resonant to percussion and clear on auscultation without crepitations, wheezes, rales or diminished breath sounds bilaterally.

Physician Orders

STATUS	TASK	USER	DATE
Completed	INFLUENZA A&B TEST	Von Watzdorf, Ilse MD	Mar 18, 2020 16:29 UTC+12:00

LAB RESULTS

Influenza virus A Ag	pos
Influenza virus B Ag	neg

FINDINGS	COMMENTS
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Current Medications**New Medications**

AMYLMETACRESOL + DICHLOROBENZYL LOZENGES PO

1 Lozenge every six(6) hours starting Mar 18, 2020 16:29 UTC+12:00 for 1 day(s)

OSELTAMIVIR PHOSPHATE CAPSULE 75MG PO

1 Capsule every twelve(12) hours starting Mar 18, 2020 16:29 UTC+12:00 for 5 day(s)

Diagnosis

DIAGNOSED DATE Mar 18, 2020	PERFORMED BY Von Watzdorf, Ilse MD
TYPE Final	DIAGNOSIS J10 - Influenza due to identified seasonal influenza virus
NOTES --	

Note

DATE Mar 18, 2020 16:26 UTC+12:00	PERFORMED BY Von Watzdorf, Ilse MD
NOTES Patient with Influenza A, denies kidney dysfunction Treatment, isolated, travel partner prophylaxis Phone 911 if any emergency concerns	

Disposition


MEDICAL DEPARTMENT DECIDED TO Discharge from clinic, follow up required	PERFORMED BY Loh, Wen Ling RN	DATE Mar 18, 2020 16:44 UTC+12:00
COMMENTS Medication dispensed and explained To isolate and follow up as per ILI protocol To dial 911 for emergency concerns		

DISCHARGE DOCUMENTS

Instructions

Prescriptions

PATIENT SIGNATURE



JONES, LYNETTE
Mar 18, 2020 16:45 UTC+12:00



24305 Town Center Drive
 Santa Clarita, California 91355
 Corporate: +1-661-753-0000
 Fax: +1-661-259-3108
 Internet: www.princess.com

MEDICAL RECORDS CONSENT AND EXPENSE PAYMENT AGREEMENT

PASSENGER/PATIENT ONBOARD OR SHORESIDE TREATMENT

Ruby Princess

Patient Family Name:	JONES	Patient First name:	LYNETTE
Stateroom Number:	████	Patient Date of Birth:	██████
Email Address:		Cell Phone:*	
Mailing Address:			

* If my cell phone is provided, I authorize Princess Cruise Lines, Ltd. ("Princess") to call me with any questions regarding any amounts owing under this Agreement.

PAYMENT AND ASSIGNMENT

PAYMENT. I agree to pay any and all expenses incurred on my behalf or on behalf of the patient (regardless of whether the patient is my family member, traveling companion, or my minor child), which are related to the medical care received onboard and/or at a shoreside facility ("Medical Expenses"). Medical expenses include, but are not limited to, medical or dental services and fees, hospitalization costs, transportation costs, shoreside lodging, shoreside meals, medical evacuation, prescription medication and port agency assistance fees related to the medical care. I agree my obligation to pay for Medical Expenses (including the payment of shoreside service provider(s) directly, if required) is not voided if I or the patient (in the case where the patient is my family member, traveling companion, or my minor child) has medical insurance, supplemental health insurance, or Princess Vacation Protection (PVP) Cancellation and Passenger Protection Program travel protection, or independent travel insurance. I agree that Princess Cruise Lines, Ltd. ("Princess") is not obligated to advance any payment(s) to cover Medical Expenses and that if Princess does so, it is performed as a courtesy and I agree to reimburse Princess as described in this Agreement. In the event I am or the patient is (in the case where the patient is my family member, traveling companion, or my minor child) medically disembarked on an emergency basis and shipboard Medical Staff is unable to provide me with a copy of my shipboard medical bill prior to disembarkation, I authorize ship's Medical Staff to charge any onboard medical bill to my credit card on file and understand I will receive a copy of this medical bill from the shoreside Health Services Department. In the event I am or the patient is (in the case where the patient is my family member, traveling companion, or my minor child) medically disembarked on an emergency basis, I understand that neither myself nor the patient will be entitled to any cruise fare refund as a result of early disembarkation. This does not preclude myself and/or the patient (in the case where the patient is my family member, traveling companion, or my minor child) from filing any claims under any insurance policy that may have been purchased.

ASSIGNMENT OF INSURANCE BENEFITS. On behalf of myself or the patient (in the case where the patient is my family member, traveling companion, or my minor child), I assign all applicable medical insurance or travel protection ("Provider") benefits for Medical Expenses and agree to reimburse Princess for any non-covered Medical Expenses within (30) days of the date invoiced by Princess. I authorize any Provider to reimburse Princess directly for all monies advanced as payment for Medical Expenses incurred. I authorize Princess to submit any reimbursement claims directly to any Provider covering the Medical Expenses.

MEDICAL RECORDS CONSENT

CONSENT TO DISCLOSE HEALTH INFORMATION. I authorize Princess to contact any Medical Provider and to receive directly copies of any and all medical or other records related to Medical Services or billing provided to me or the patient (in the case where the patient is my family member, traveling companion, or my minor child). I also authorize Princess to release any information regarding Medical Care, which can include without limitation, medical history, symptoms, treatment, examination, results or diagnosis to any Medical Provider. I also hereby authorize Princess to provide any necessary information to my traveling companion(s) and/or next of kin of my condition, and agree that Princess will have no obligation to do so.

On behalf of myself or the patient (in the case where the patient is my family member, traveling companion, or my minor child), I hereby expressly consent to the disclosure of medical and other records described above to any or all of the following for the purposes specified:

- The Princess Health Services Department in the United States;
- Selected persons within the Princess Legal and Finance Departments who have need of these records for business or legal purposes related to my medical care;
- Any medical assistance company or medical provider for the purpose of assisting with or continuing medical care, should it be necessary for me or the patient (in the case where the patient is my family member, traveling companion, or my minor child) to be medically landed from the vessel;

- Any other medical professional that the Princess Health Services Department feels it appropriate to consult for the purpose of assisting in medical care;
- A third party contractor (including, without limitation, any legal or financial adviser and any debt collection service provider) for recovery of costs incurred by Princess in relation to the medical care; and
- Health care professionals to review the quality of care through the process of clinical audit.

I also authorize my travel insurance provider to provide any necessary information to Princess in relation to assisting me with care and repatriation if required.

It has been explained to me that if I do not consent to any of the above, I may refuse my consent by deleting the relevant section(s). However, I acknowledge that if I withhold my consent for the transfer of medical records to any of the above, this may prejudice my treatment or that of the patient (in the case where the patient is my family member, traveling companion, or my minor child) and any issues associated therewith.

LEGAL NOTICES

COLLECTION EXPENSES. I agree to pay on demand all the losses, costs, and expenses (including, without limitation, attorneys' fees and disbursements) which incur in connection with enforcement or attempted enforcement of this Agreement, or the protection or preservation of your rights under this Agreement, whether by judicial proceedings or otherwise. Such costs and expenses include, without limitation, those incurred in connection with any workout or refinancing, or any bankruptcy, insolvency, liquidation or similar proceedings.

WAIVER OF DEFENSES. I hereby waive any rights I may otherwise have under the legal defenses of diligence, demand, presentment, protest or further notice of any kind. Time is of the essence for the performance of each and every obligation under this Agreement.

LEGAL RESPONSIBILITY AND LIABILITY. All health and medical services onboard are provided solely for the convenience and benefit of patients who may be charged for such services. You accept and use medicines and medical services at your sole risk and expense without liability or responsibility of Princess whatsoever, and agree to indemnify Princess for all medical or evacuation costs or expenses incurred on your behalf. Doctors, nurses, and other medical staff members work directly for you as their patient. Therefore the course of medical treatment will be determined exclusively by the shipboard medical staff and you.

REJOINING VESSEL FOLLOWING SHORESIDE TREATMENT OR MEDICAL DISEMBARKATION. Medical clearance from a shoreside provider for a patient to resume a cruise, is not a guarantee that the patient will be allowed to do so. The shipboard doctor will make the final determination, based not only on diagnostic results and/or response to treatment but also on factors including but not limited to the likelihood of recurrence or worsening of your condition, length of cruise, ship's itinerary, and available clinical resources onboard. Princess will always take a conservative approach when it comes to the health and safety of our guests.

GOVERNING LAW. THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH MARITIME LAW AS APPLIED IN CALIFORNIA AND CALIFORNIA LAW TO THE EXTENT IT DOES NOT CONFLICT WITH MARITIME LAW, WITHOUT GIVING EFFECT TO ITS CONFLICTS OF LAW PRINCIPLES.

NOTICE: ANY HOLDER OF THIS CONSUMER CREDIT CONTRACT IS SUBJECT TO ALL CLAIMS AND DEFENSES WHICH THE DEBTOR COULD ASSERT AGAINST THE SELLER OF GOODS OR SERVICES OBTAINED PURSUANT HERETO OR WITH THE PROCEEDS HEREOF. RECOVERY HEREUNDER BY THE DEBTOR SHALL NOT EXCEED AMOUNTS PAID BY THE DEBTOR HEREUNDER.

BY SIGNING BELOW, I AGREE TO ALL THE TERMS AND CONDITIONS SET FORTH ABOVE

Patient's Signature



Guardian / Family Member / Traveling Signature

Patient JONES, LYNETTE
Mar 18, 2020 15:45 UTC+12:00

Mar 18, 2020 15:45 UTC+12:00



PRINCESS CRUISES

COMPLETE THE FOLLOWING SECTION FOR MEDICAL
CENTER ADMISSIONS.

SHORESIDE REFERRALS AND DISEMBARKATIONS
ONLY

24305 Town Center Drive
Santa Clarita, California 91355
Corporate: +1-661-753-0000
Fax: +1-661-259-3108
Internet: www.princess.com

THE FOLLOWING INFORMATION MUST BE PROVIDED FOR THE PATIENT

1. Is the patient covered by any other Group Medical Benefit Plan, Group Payment Plan, Medicare or Government Plan?

No ☐ Yes ☐

* If Yes, please provide the name of the Plan Sponsor, Policy Number and Claim Office Address of Primary Medical Carrier:

Name: _____ Policy No: _____ Address: _____

2. Does the patient have supplemental insurance, such as a Medicare supplement plan? No ☐ Yes ☐

*If Yes, please provide the name of Plan Sponsor, Policy Number and Claim Office Address of Supplemental Insurance Carrier:

Name: _____ Policy No: _____ Address: _____

3. Did the patient purchase Princess Vacation Protection (PVP) Cancellation and Passenger Protection Program or was it purchased on his/her behalf?

No ☐ Yes ☐

4. Is the patient insured through any other independent travel insurance plan? No ☐ Yes ☐

* If Yes, please provide the name of the Plan, Policy Number and Phone Number of Insurance Plan Carrier:

Name: _____ Policy No: _____ Address: _____

TRAVELING COMPANION

If I am signing as a Traveling Companion below, I agree that if I accompany the patient ashore, I will be responsible to pay for any and all personal costs resulting from this disembarkation at the time the costs are incurred. If Princess advances any of my expenses to accompany the patient, I will reimburse Princess for those advances and authorize Princess to charge my stateroom account and/or credit card for such advances.

Traveling Companion Signature

Mar 18, 2020 15:45 UTC+12:00

PATIENT REGISTRATION FORM

Please complete this form to assist the medical team provide you with better care.

Your personal health information will be protected in accordance with applicable privacy requirements.

Family Name:	JONES	Stateroom Number:	[REDACTED]
First Name:	LYNETTE	Date Of Birth:	[REDACTED] (e.g. 01-Sep-1964)

Home City:	MOLLENGOW	Date:	17/3/20
Country of Residence:	AUSTRALIA	Time:	3:20

Past Medical History		Please check any previous health conditions, with the applicable dates.	
<input type="checkbox"/> Heart Attack <i>No</i>	<input type="checkbox"/> Irregular Heart Rate <i>No</i>	<input type="checkbox"/> Seizures <i>No</i>	<input checked="" type="checkbox"/> Arthritis <i>YES</i>
<input type="checkbox"/> Angina <i>No</i>	<input type="checkbox"/> Asthma or COPD <i>No</i>	<input type="checkbox"/> Blackouts <i>No</i>	<input type="checkbox"/> Mobility problems <i>No</i>
<input type="checkbox"/> Heart Failure <i>No</i>	<input type="checkbox"/> Emphysema <i>No</i>	<input type="checkbox"/> Stroke / TIA <i>No</i>	<input type="checkbox"/> Urinary infection <i>No</i>
<input type="checkbox"/> High Blood Pressure <i>No</i>	<input type="checkbox"/> Pneumonia <i>No</i>	<input checked="" type="checkbox"/> Stomach Ulcer / Acid reflux <i>YES</i>	<input type="checkbox"/> Enlarged prostate <i>No</i>
<input type="checkbox"/> High Cholesterol <i>No</i>	<input type="checkbox"/> Bleeding problems <i>No</i>	<input type="checkbox"/> Diabetes <i>No</i>	<input type="checkbox"/> Cancer <i>No</i>

Please list previous MEDICAL PROBLEMS with dates.	NONE
Please list previous SURGERIES with dates.	[REDACTED]
Please list all the MEDICATIONS you are taking and their dosages and frequency.	[REDACTED]
Please list any ALLERGIES to medications or other items.	NONE

Do you Smoke?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	If yes, for how many years?	How many per day?
Do you drink Alcohol?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	If yes, approximately how many units per week?	
Would you like a copy of your medical record for a nominal fee to assist with insurance claims?			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

153/83

PLEASE TURN OVER

97% 88 37.9°C

What is your main complaint? When did it start?	MONDAY EVENING. COUGH SINCE ↑
--	----------------------------------

Do you have any of the following symptoms? Mark the corresponding box to indicate Yes or No:

General:	Yes	No	Ears, nose, eyes & throat:	Yes	No	Abdominal:	Yes	No
Change in appetite	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Tiredness	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Weight gain	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Fever / chills	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Ears blocked / hearing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Indigestion or heartburn	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Swollen glands	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Runny / blocked nose	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Nausea	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Respiratory & Cardio:	Yes	No	Sneezing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cough (dry)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pain or swelling in face	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stomach/abdominal pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cough (with sputum)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Painful eyes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Abdominal swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cough (with blood)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Red eyes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pain/difficulty swallowing	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Itchy or discharging eyes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Eyes / skin yellow	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Change in voice	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Change in bowel habit	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Short of breath with activity or exercise	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Toothache, jaw pain or swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Loose bowel motions or diarrhea	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Short of breath at night	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Visual changes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Constipation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chest pain on breathing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Neurological:	Yes	No	Fecal incontinence	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chest pain with activity or exercise	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Tingling or numbness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Rectal bleeding, or blood in feces (black feces)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chest pain at rest	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Headache	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Genital / Urinary:	Yes	No
Palpitations or abnormal heart beat	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Tremor or abnormal movements	<input type="checkbox"/>	<input type="checkbox"/>	Burning or pain with urination	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Ankle or leg swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Urination frequency	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Musculoskeletal:	Yes	No	Fits / Seizures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Nightly urination	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Black-outs / fainting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Problems with balance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Urinary incontinence	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Weakness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Poor stream	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Joint swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental Health:	Yes	No	Genital discharge or pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Joint or bone pain	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Disorientated / confused	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Menstrual / OBGYN issue	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Back or neck pain	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Anxious or distressed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Erectile Dysfunction	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Skin:	Yes	No	Elevated mood (manic)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Endocrine:	Yes	No
Lumps or bumps	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Low mood or depressed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heat or cold intolerance	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Rashes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Abnormal behavior	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Neck swelling	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Itchy Skin	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Memory concerns	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Sweating / hot flashes	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Ulcers, abscess or sores	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Increased thirst	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Change in a pigmented lesion or moles	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Seeing, hearing or imagining things	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Breast mass, pain / discharge	<input type="checkbox"/>	<input checked="" type="checkbox"/>

By my signature below, I certify that the medical information provided is correct and acknowledge that I have read and understood all details stated in this form.

Patient First & Last Names: LYNETTE JONES

Date of Birth: [REDACTED]
(e.g. 01-Sep-1964)

Patient / Guardian Signature: [Signature]

Date: 17/3/2020

Name of person completing form
(if not the patient): _____

Relationship to patient: _____

Signature: _____

Date: _____