ATTORNEY SAMPLE DOWNLOAD

Critical Timeline™
Medical Intelligence Company
Organize. Understand. Decide.

ANALYTICAL MEDICAL CHRONOLOGY REPORT

Attorney and Professional Review Sample

Source-Cited Timeline of the Medical Record

Turn complex records into a clear, source-cited chronology counsel can review quickly and use confidently.

What attorneys see in this sample

- Chronological organization of care and events
- Source-cited key entries and timing points
- Identification of missing records and obvious gaps
- Attorney-ready formatting for efficient review

Fictitious sample • demonstration only

This sample is provided only to demonstrate report layout, organization, writing style, and the quality of the deliverable. It does not contain real patient information, legal advice, or medical advice.

Cover Information

Field	Sample Entry
Prepared for	Anderson & Cole Trial Counsel (fictional sample client)
Matter / Client	J.R. v. Bayview Regional Medical Center - SAMPLE
Patient	J.R. - fictional 62-year-old male
Date(s) of care reviewed	03/14/2025 - 03/16/2025
Facility / providers	Bayview Regional Medical Center and Bayview EMS - fictional entities
Report date	05/26/2026
Prepared by	Dwayne Adams, RN / Critical Timeline?
Report type	Analytical Medical Chronology Report
Status	Sample final
Version	SAMPLE v1.0

1. Purpose and Scope

Critical Timeline? was asked to organize the available fictional medical records related to the care provided on 03/14/2025 through 03/16/2025 into a clear, source-cited analytical medical chronology.

- Primary purpose: organize what happened, when it happened, who documented it, and where it appears in the record.
- Scope of records: ED arrival, ED course, ICU transfer, operative intervention, and discharge summary excerpts.
- Use case: attorney review, patient/family clarity, record organization, deposition preparation, or mediation packet.
- Known limitations: no EMS run sheet, no order audit trail, incomplete MAR detail, no sepsis protocol, no provider communication logs.

2. Audience-Specific Disclaimer

Audience	Use This Language
Attorney / law firm	Confidential work product prepared at the request of counsel. This report organizes medical-record events and source references for attorney review. It is not intended as legal advice, expert testimony, standard-of-care opinion, or causation opinion unless separately agreed in writing.
Patient / family	This report is a nurse-led organization of the medical record for informational purposes only. It does not provide legal advice, medical diagnosis, treatment recommendations, lawsuit valuation, statute-of-limitations calculation, or a determination of negligence or malpractice.

3. Records Reviewed

Every record reviewed in this sample is fictional. Source IDs demonstrate how a real report would remain traceable to Bates or PDF page numbers.

Source ID	Record / Document	Date Range	Bates / PDF Pages	Notes
ED-001	Emergency Department record	03/14-03/15/25	SAMPLE-0001-0059	Tracking, triage, provider note
NURS-001	ED nursing notes/flowsheets	03/14-03/15/25	SAMPLE-0060-0112	Vitals, reassessments, notifications
LAB-001	Laboratory results	03/14-03/15/25	SAMPLE-0113-0135	CBC, CMP, lactate, cultures
IMG-001	Radiology reports	03/14/25	SAMPLE-0136-0148	CT abdomen/pelvis report
MAR-001	Medication administration record	03/14-03/15/25	SAMPLE-0149-0168	Fluids, medications, antibiotics
ICU-001	ICU transfer note	03/15/25	SAMPLE-0169-0183	Transfer and hemodynamic status
OR-001	Operative report	03/15/25	SAMPLE-0184-0199	Exploratory surgery
DC-001	Hospital discharge summary	03/16-03/23/25	SAMPLE-0200-0218	Hospital course/disposition

4. Records Not Provided / Pending

This section identifies record gaps that may limit the completeness of the chronology. It does not interpret why records are missing.

Missing / Pending Record	Why It May Matter to the Timeline	Priority	Requested / Pending
EMS run sheet	May establish pre-arrival condition, symptoms, vital signs, and time of first documented concerns.	High	Pending
Provider order history / audit trail	May clarify when labs, imaging, medications, consults, and transfers were ordered.	High	Pending
Complete medication administration detail	Needed to compare order time to administration time.	High	Partial only
Sepsis protocol/policy	May help counsel/expert review timeline expectations if upgraded to clinical review.	Moderate/High	Not provided
Provider communication logs	May clarify notification, consult, and transfer timing.	Moderate/High	Pending

5. Chronology Summary

The available fictional records cover care from 03/14/2025 at 18:12 through 03/16/2025 discharge-summary excerpts. The chronology is organized by date and time and cites the source record for each entry. The major phases of the record include arrival/intake, assessment, diagnostics, interventions, reassessments, communications, disposition, and follow-up.

Timeline Segment	Date / Time Range	Brief Factual Summary	Source Range
Arrival / intake	03/14/25 18:12-18:24	EMS arrival, triage, presenting symptoms, initial vitals.	ED-001
Initial assessment	18:21-20:00	Triage, nursing notes, provider evaluation, family statement.	ED-001; NURS-001
Diagnostics	18:58-23:05	Labs, lactate, cultures, CT order/completion/result.	LAB-001; IMG-001
Treatment / interventions	21:12-08:30	IV fluids, antibiotics, consults, ICU transfer, surgery.	MAR-001; ICU-001; OR-001
Disposition / outcome	03/15-03/23/25	ICU care, surgery, discharge to rehabilitation per summary.	DC-001

6. Key Event Index

A quick map to the most important time points in the chronology. This section remains factual and avoids legal or clinical conclusions.

Key Event	Date / Time	Source	Chronology Row
First documented symptom / complaint	03/14/25 18:12	ED-001, SAMPLE-0004	1
First abnormal vital sign / finding	18:21	ED-001, SAMPLE-0007	2
First provider evaluation	18:42	ED-001, SAMPLE-0015	4
First diagnostic order	18:58	ED-001/LAB-001	5
Lactate resulted	20:04	LAB-001, SAMPLE-0118	8
CT result available	23:05	IMG-001, SAMPLE-0142	13
Deterioration documented	03/15/25 03:10	NURS-001, SAMPLE-0098	15
ICU transfer accepted	04:15	ICU-001, SAMPLE-0172	16
Exploratory surgery	08:30	OR-001, SAMPLE-0186	17

SAMPLE - FICTITIOUS DEMONSTRATION REPORT

7. Master Analytical Medical Chronology

Primary deliverable. Entries are factual, concise, and source-cited. The analytical note identifies objective timing, sequence, missing data, or cross-record inconsistency. It does not add legal conclusions or standard-of-care opinions.

Row	Date / Time	Event Category	Event / Record Summary	Source Citation	Analytical Note
1	03/14/25 18:12	Arrival / intake	Patient arrived by EMS for fever, weakness, confusion, and abdominal pain.	ED-001, SAMPLE-0004	Start of ED timeline. EMS source not provided.
2	18:21	Assessment	Triage vitals: T 39.0 C, HR 124, BP 96/58, RR 24, SpO2 94% RA.	ED-001, SAMPLE-0007	First abnormal vital sign cluster located.
3	18:24	Triage	ESI 3 documented. No sepsis screen result located in provided triage note.	ED-001, SAMPLE-0008	Source contains triage level; screen result not located.
4	18:42	Provider evaluation	Provider note lists abdominal pain, fever, weakness, confusion reported by family.	ED-001, SAMPLE-0015	First provider evaluation located.
5	18:58	Orders	Orders documented for CBC, CMP, lactate, cultures, IV fluids, and CT abdomen/pelvis.	ED-001/LAB-001, SAMPLE-0021;0116	Order audit trail not provided.
6	19:05	Nursing note	Patient resting; reports 8/10 abdominal pain; family states patient is not acting like himself.	NURS-001, SAMPLE-0074	Next reassessment entry located at 20:00.
7	20:00	Reassessment	Repeat vitals documented: HR 128, BP 94/54, RR 26, T 38.9 C.	NURS-001, SAMPLE-0084	Gap from 19:05 to 20:00 based on provided records.
8	20:04	Diagnostics	Lactate resulted at 3.2 mmol/L; WBC 18.6 K/uL.	LAB-001, SAMPLE-0118	Abnormal lab result timestamp located.
9	20:10	Diagnostics	CT abdomen/pelvis ordered with stat priority.	IMG-001, SAMPLE-0136	CT order time located.
10	20:20	Provider note	Provider note documents concern for intra-abdominal infection and plan for IV antibiotics.	ED-001, SAMPLE-0031	Antibiotic order time not confirmed in audit trail.
11	21:12	Treatment	1 L normal saline bolus documented as started.	MAR-001, SAMPLE-0151	Fluid administration timestamp located.
12	21:47	Medication	Piperacillin/tazobactam documented as administered.	MAR-001, SAMPLE-0155	Administration time located; order time unclear.
13	22:18	Diagnostics	CT abdomen/pelvis completed.	IMG-001, SAMPLE-0139	Approximately 2 hours 8 minutes after CT order.
14	23:05	Diagnostics	CT report available: acute diverticulitis with localized perforation and small free air.	IMG-001, SAMPLE-0142	Report availability time located.
15	23:22	Communication	Surgery consult note initiated; plan for admission and serial exams.	ED-001, SAMPLE-0044	Consult note time located.
16	03/15/25 03:10	Reassessment / communication	Nursing note: BP 82/46, HR 136, more lethargic; provider notified.	NURS-001, SAMPLE-0098	Provider notification noted, exact contact method not provided.
17	04:15	Disposition / escalation	ICU transfer accepted; vasopressor	ICU-001, SAMPLE-0172	ICU acceptance time located.

SAMPLE - FICTITIOUS DEMONSTRATION REPORT

Row	Date / Time	Event Category	Event / Record Summary	Source Citation	Analytical Note
18	08:30	Procedure / outcome	Exploratory surgery performed; perforated sigmoid diverticulitis with peritonitis documented.	OR-001, SAMPLE-0186	Operative endpoint located.
19	03/16/25	Hospital course	Discharge summary notes septic shock, surgery, ICU stay, and rehab discharge plan.	DC-001, SAMPLE-0205	Summary source located; daily progress notes not included.

8. Timeline Gap / Clarification Log

Gap / Unclear Period	Known Start	Known End	Records Reviewed	What Is Missing / Unclear	Follow-Up Needed
EMS condition before ED arrival	Unknown	18:12	ED-001	EMS vitals, field impression, and treatments not located.	Request EMS run sheet.
Reassessment interval	19:05	20:00	NURS-001	No reassessment entry located in provided records.	Request complete flowsheets/audit trail.
Antibiotic order-to-admin interval	20:20 note	21:47 admin	ED-001; MAR-001	Exact antibiotic order time not confirmed.	Request order audit trail/pharmacy records.
Provider notification after deterioration	03:10	04:15	NURS-001; ICU-001	Notification documented but contact time/method unclear.	Request communication logs/provider notes.

9. Source Index

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ED-001	Emergency Department Record	03/14-03/15/25	SAMPLE-0001-0059	Tracking, triage, provider entries
NURS-001	ED Nursing Notes/Flowsheets	03/14-03/15/25	SAMPLE-0060-0112	Vitals, reassessments, notification notes
LAB-001	Laboratory Results	03/14-03/15/25	SAMPLE-0113-0135	Lab orders and results
IMG-001	Imaging Reports	03/14/25	SAMPLE-0136-0148	CT report and timestamps
MAR-001	Medication Administration Record	03/14-03/15/25	SAMPLE-0149-0168	Medication administration times
ICU-001	ICU Transfer Note	03/15/25	SAMPLE-0169-0183	Transfer and hemodynamic status
OR-001	Operative Report	03/15/25	SAMPLE-0184-0199	Operative findings
DC-001	Hospital Discharge Summary	03/16-03/23/25	SAMPLE-0200-0218	Hospital course and discharge disposition

10. Limitations and Disclaimer

This Analytical Medical Chronology Report is based only on fictional records created for demonstration. Additional records may add, clarify, or change the sequence of events documented in a real report.

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Upgrade path

If clinical interpretation is needed, upgrade this chronology to a Critical Timeline Review. That separate report may include clinical red flags, documentation-gap analysis, questions for further expert review, suggested expert specialties, a negligence-element support matrix, and a discovery-date tracker for attorney review.