

ILLUSTRATIVE ATTORNEY REPORT SAMPLE

DEMAND-READY PACKAGE

Deliverable 3 of 3: Record Gap List | Provider requests and unresolved evidence

MATTER

Sepsis Demonstration / SEP-DEMO-002

PATIENT / CLAIMANT

Patient A, age 72 — fictional

PREPARED FOR

Prospective Attorney Clients

REPORT DATE

October 1, 2026



1. Matter Identification and Record Review Scope

This completed fictional record-gap report identifies the additional materials needed to clarify Patient A's September 3–6, 2026 course at Northbridge Regional Hospital. It accompanies the Medical Chronology and Narrative Summary for SEP-DEMO-002 and uses the same source set, RS-DEMO-002, version 1.0. Baseline records reviewed date from June 2 and August 20; the reported acute illness began September 2. Report date and record cutoff: October 1, 2026.

The highest-priority gaps concern result availability, provider notification, medication administration and the transition to intensive care. These gaps could materially change the interpretation of the documented sequence. Baseline, policy and certified outcome records are also needed to complete the account. Each request below identifies a fictional custodian, date range, specific materials, existing source reference and the question the production could resolve.

This standalone companion uses a practical provider-request structure developed for this sample. It does not claim a separately approved Lexcura report-standard number. It distinguishes materials missing from the supplied set from records known not to exist; no provider has been contacted and no actual request has been sent.

All people, providers, clinical events, source identifiers, and page references in this sample are fictional. Source labels demonstrate report traceability; no underlying medical-record packet exists. This expanded demonstration case is separate from the earlier screening sample. No actual clinical review, specialty approval, or QA release is represented.

2. Materials Received and Completeness Assessment

Source range	Provider and coverage	Materials and limitations
PC001–012	Juniper Primary Care June 2 and August 20, 2026	Baseline history, medications, renal laboratory results and function; earlier longitudinal chart not supplied.
EMS001–008	Cedar County EMS September 3, 2026	Dispatch extract and transport narrative; monitor download and full dispatch audio absent.
ED001–032	Northbridge Regional Hospital September 3, 2026	Triage, nursing observations, physician note, deterioration and transfer entries; communication metadata incomplete.
LAB001–010	Northbridge laboratory September 3–6, 2026	Selected serial chemistry, lactate and culture reports; notification history absent.
MAR001–016	Northbridge pharmacy and nursing September 3–6, 2026	Selected medication and fluid administration entries; complete infusion and edit histories absent.
RAD001–004	Northbridge radiology September 3–4, 2026	Chest radiograph reports and selected metadata; original images and report acknowledgment unavailable.
ICU001–040	Northbridge intensive care September 3–6, 2026	Admission, daily progress, respiratory support, family discussion and death summary; some flowsheets absent.

Source range	Provider and coverage	Materials and limitations
POL001-006	Northbridge policy office Version not established	Sepsis escalation and critical-result excerpts; approval and effective-date pages absent.

The demonstration inventory totals 128 fictional pages. The coverage dates describe the sample inventory; they do not certify a complete production from any provider. Missing materials are not included in that count. Bracketed references identify hypothetical pages within this inventory.

The supplied set supports a provisional factual sequence across the full defined episode but is not a certified complete chart. The presence of a discharge or death summary does not establish that all nursing flowsheets, medication events, consults, communications or underlying electronic records are present. No material is marked complete solely because one report mentions it.

Status conventions

Open — not supplied: requested category is absent from the defined inventory. Open — partial: some related material is supplied but does not answer the stated question. Conditional: request the item if it exists and obtain a written response if it does not. “Not located” is a statement about this review, not an assertion that care was omitted. Priority reflects its effect on reconstructing the case, not a legal deadline.

3. Priority Record Request Register

ID / priority	Provider or custodian	Records and present status
G01 High	Northbridge Health Information Management, with EHR application custodian	ED audit and communication history Status: Partial Question: 09:00 notification and 10:15 assessment / 11:10 entry sequence
G02 High	Northbridge laboratory and microbiology records custodian	Result lifecycle, critical calls and final cultures Status: Partial Question: 08:20 lactate availability; definitive microbiology
G03 High	Northbridge pharmacy and nursing records custodians	Orders, eMAR, infusion delivery and reassessment Status: Partial Question: 10:30 order → 11:45 administration; actual fluid delivery
G04 High	Northbridge ICU, respiratory therapy and bed management records custodians	Consultation, transfer, flowsheets and goals-of-care orders Status: Partial Question: 14:20 request → 16:15 ICU transfer; complete terminal sequence
G05 Targeted	Northbridge radiology and consulting-service records custodians	Imaging originals and renal / infectious-disease consultation records Status: Partial Question: Report receipt, interpretation context and treatment reasoning

ID / priority	Provider or custodian	Records and present status
G06 Supporting	Juniper Primary Care and Cedar County EMS records custodians	Longitudinal baseline, referrals and complete transport records Status: Partial Question: Baseline reserve; symptom onset; prehospital treatment and handoff
G07 Supporting	Northbridge policy / document-control custodian	Policies and effective-version records Status: Partial Question: Which local escalation and communication procedures applied
G08 Supporting	Authorized death-record custodian; Northbridge pathology if applicable	Certified death record and any postmortem report Status: Conditional Question: Certified outcome and any additional source-of-illness evidence

All custodian and provider names are fictional. Counsel should verify real custodians, authorization requirements and appropriate request channels before using this format for a real matter. No mailing address, telephone number, service contact or provider identity has been invented for operational use.

4. Detailed Provider Requests and Clinical Relevance

G01 — Northbridge Regional Hospital electronic and communication records

Requested period. September 3, 2026, 06:30–18:00 for encounter events; all later creations, edits and amendments relating to those events through the October 1 cutoff.

Request recipient. Health Information Management should coordinate with the EHR application custodian and the custodians of the clinician messaging and notification systems. A conventional PDF chart may not contain the requested metadata.

Specific materials to request. Provide the complete ED chart, original and amended physician and nursing entries, creation and signature timestamps, event-time fields, author and role identifiers, relevant audit history, correction history, provider assignment history, notification tasks, secure-message or pager records retained for the encounter, and any linked acknowledgment or response entries. Include system field definitions and the time-zone convention. Limit the production to this patient and relevant encounter.

Existing record basis. The supplied nursing record states provider notified at 09:00. A physician note entered at 11:10 describes assessment at 10:15. The current set does not show the notification recipient or the full sequence of note creation and amendments. [ED010–018]

Why the records matter. The production may establish which clinician received the concern, when it was acknowledged, what response was recorded, and whether additional contemporaneous assessments exist. It may support or narrow a response concern; it cannot be assumed to prove one in advance.

Completion criteria. Accept a searchable chart with a native or structured metadata export where available, plus a data dictionary. Closure requires reconciling the 09:00 notification, identifying the available note versions and distinguishing event, creation and signature times. If the communication system has no retained record, obtain a custodian response stating the system searched and the reason the information is unavailable.

G02 — Northbridge laboratory and microbiology records

Requested period. September 3–6, 2026; include results finalized or corrected after September 6 for specimens collected during the admission, through October 1.

Request recipient. Laboratory information-system records custodian and microbiology records custodian, coordinated through the hospital's authorized records process.

Specific materials to request. Provide all relevant specimen collection, accession, receipt, analysis, verification, release and correction timestamps; full serial chemistry and lactate results; critical-result call logs; recipient and read-back fields; transmission failures or amended results; final blood-culture organism identification and susceptibility reports; and any final respiratory or other cultures from the admission if obtained. Identify accession numbers connecting preliminary and final results.

Existing record basis. The sample lists lactate 4.8 mmol/L at 08:20 and 6.1 mmol/L at 12:30 on September 3 without a full notification history. Preliminary gram-positive cocci are reported September 4, but a final report is absent. [LAB002, LAB006, LAB009]

Why the records matter. This request separates the biological trend from the information-delivery sequence. It also tests whether final microbiology supports, changes or leaves uncertain the treating team's presumed infectious source and antimicrobial rationale. A result timestamp alone does not establish clinician knowledge.

Completion criteria. Closure requires a lifecycle trace for both lactate results and a final disposition for each preliminary culture, including a written statement if a final report was not generated or cannot be located. If the laboratory export cannot establish clinician acknowledgment, retain that part as unresolved and cross-reference G01.

G03 — Northbridge pharmacy, medication and infusion records

Requested period. September 3–6, 2026, with particular focus on 07:45–16:15 on September 3; include later corrections to those administration events through October 1.

Request recipient. Pharmacy records custodian, nursing documentation custodian and infusion-system custodian where a separate system was used.

Specific materials to request. Provide original medication and fluid orders, revisions and discontinuations; pharmacy receipt, verification and dispensing timestamps; delivery records where retained; complete eMAR with barcode events, late entries, refusals, holds and omitted-dose reasons; IV access and infiltration records; bolus start and stop times; actual infused-volume entries; pump history if retained; intake and output; serial vital signs; and reassessment documentation linked to fluids and vasoactive therapy.

Existing record basis. The supplied extract shows bolus starts at 08:35 and 10:40, antibiotic orders at 10:30, antibiotic administration at 11:45 and norepinephrine initiation at 15:45. Complete delivery and reassessment histories are absent. [MAR001–010]

Why the records matter. These records could resolve the order-to-administration interval, identify treatment constraints, and establish actual fluid delivery. They are also needed to assess documented reasoning in a patient with heart failure and kidney disease. Ordered volume should not be treated as delivered volume. [PC005–012]

Completion criteria. Closure requires reconciled medication-event times and a defensible accounting of documented fluid delivery, with duplicate entries distinguished from separate administrations. If pump data are

unavailable, identify the best retained source and the residual uncertainty. Do not close merely because the same MAR PDF is produced again.

G04 — Northbridge ICU, consultation and care-transition records

Requested period. September 3, 2026, 13:00 through death September 6 at 12:42; include later documentation relating to this period through October 1.

Request recipient. ICU records custodian, bed management / transfer-center custodian, rapid-response records custodian and respiratory therapy records custodian.

Specific materials to request. Provide consultation request and response records; clinician acceptance and bedside-assessment times; bed request, assignment and transfer events; rapid-response documentation; ICU nursing flowsheets; hourly intake and output; vasopressor titration records; respiratory therapy and ventilator records; intubation documentation; family meeting records; code-status and comfort-care orders with their histories; withdrawal-of-support documentation; and full death-pronouncement and discharge / death summaries.

Existing record basis. The current set shows a 14:20 consultation request, 15:30 rapid response, 15:45 vasopressor start and 16:15 ICU transfer. It also documents continued intensive care September 5 and a separate comfort-care decision September 6. [ED027-032; MAR009-010; ICU029-040]

Why the records matter. The production should clarify whether consultation or higher-acuity management occurred before physical transfer and what happened during the transition interval. It should also preserve the distinct sequence of family discussions, treatment decisions, orders and implementation near the end of life.

Completion criteria. Closure requires a reconciled transition timeline and a complete available goals-of-care sequence. A transfer timestamp alone does not answer when critical-care involvement began. A family meeting note alone does not establish every corresponding order. Where a category was not retained, request a specific custodian explanation.

G05 — Northbridge radiology and consulting services

Requested period. September 3–6, 2026; include final reports and addenda relating to admission studies and consultations through October 1.

Request recipient. Radiology / PACS custodian and the medical-record custodians for renal and infectious-disease consultations, whether facility-held or separately maintained.

Specific materials to request. Provide final chest radiograph reports and addenda; acquisition, interpretation, finalization and distribution metadata; any critical-finding communications; original DICOM studies for authorized specialist review; and comparison studies actually used. Provide the complete renal consultation referenced September 4, subsequent renal notes and orders, and any infectious-disease consultation or antimicrobial-stewardship notes supporting the treatment revision. If no such consultation occurred, request confirmation rather than inventing a missing encounter.

Existing record basis. The supplied imaging reports describe a right basilar opacity and later bilateral interstitial opacities. The ICU note references renal consultation, and another entry records antimicrobial revision. Separate consulting reports are absent. [RAD001-004; ICU015-022; MAR012-014]

Why the records matter. The imaging metadata may clarify when the report reached the care team. Specialist records may explain the renal trajectory, treatment choices and alternative causes of the respiratory findings. Original images require appropriately authorized specialist interpretation; this report does not reinterpret them.

Completion criteria. Closure requires receipt or a specific absence response for each referenced consultation, final imaging reports with addenda, and a clear status for original images. Distinguish a study that was never obtained from a study obtained but not produced. Keep receipt of images separate from completion of any specialist interpretation.

G06 — Juniper Primary Care and Cedar County EMS

Requested period. Primary care: September 3, 2025 through September 3, 2026. EMS: the September 3, 2026 dispatch and transport, including relevant later corrections through October 1.

Request recipient. Juniper Primary Care records custodian and Cedar County EMS / dispatch records custodian. Request actual referral-provider identities from the primary-care chart before directing additional requests.

Specific materials to request. For primary care, provide the longitudinal chart, laboratory trends, reconciled medication lists, heart-failure and kidney-disease history, functional assessments, relevant referral reports and any telephone contact about the acute illness. For EMS, provide the complete electronic patient-care report, dispatch chronology, retained call audio, monitor data, medication and fluid records, amendments, and receiving-facility handoff documentation.

Existing record basis. The present baseline consists of two visits; EMS materials are extracts. Chronic disease is documented, but the longer trajectory and full prehospital treatment and handoff are not established. [PC001-012; EMS001-008]

Why the records matter. This production may clarify preexisting reserve, actual assistance needs, symptom history and treatment before triage. It may prevent attribution of a preexisting limitation to the acute admission. It may also reconcile the 07:38 EMS arrival with the 07:45 triage entry without assuming a care gap.

Completion criteria. Close the baseline request only after the specified period is produced or its omissions are identified. If specialty providers appear in referrals, record their verified identities and issue targeted supplemental requests. Close the EMS request only after the written report and available underlying timing / monitor sources are reconciled.

G07 — Northbridge policy and document control

Requested period. Policies in effect September 3–6, 2026, including approval, implementation and supersession records needed to identify the applicable versions.

Request recipient. Policy / document-control custodian through the authorized hospital records or legal-response process.

Specific materials to request. Provide complete versions of the sepsis recognition and escalation policy, critical-result communication procedure, nursing notification / chain-of-command procedure, ICU consultation and transfer process, and relevant medication administration or reassessment procedures cited in the chart. Include effective dates, approvals, amendments and retirement dates. Request only encounter-relevant policy categories.

Existing record basis. The sample contains six pages of policy excerpts without the complete approval and effective-date information. [POL001-006]

Why the records matter. The purpose is to establish which local process documents actually applied. An excerpt cannot be assumed current. Receipt of a policy does not independently establish a breach, regulatory violation or the applicable professional standard of care.

Completion criteria. Closure requires version verification, complete text and effective-date support. If a requested policy did not exist, ask for a written response identifying any alternative procedure used. Do not substitute a current policy for the September 2026 version without identifying the difference.

G08 — Certified death and any postmortem records

Requested period. Death on September 6, 2026; subsequent certification, amendment or postmortem reporting through October 1.

Request recipient. Authorized vital-records custodian for the applicable jurisdiction, to be identified in a real matter. Northbridge pathology or the responsible medical examiner / coroner only if the chart identifies involvement.

Specific materials to request. Obtain the certified death certificate and any amendments. Determine whether a postmortem examination, pathology report or medical-examiner / coroner investigation exists; if so, request the final report and relevant addenda through the proper authorization process. If none occurred, record that response rather than leaving a presumed missing report indefinitely open.

Existing record basis. The hospital death summary and pronouncement are included, but a certified death certificate and postmortem record are not. [ICU039-040]

Why the records matter. The certified record may corroborate or qualify the terminal diagnosis. A postmortem report, if one exists, could supply additional findings about the infectious source or competing disease. Neither should be presumed to exist or to resolve whether an earlier intervention would have changed the outcome.

Completion criteria. Closure requires the certified record or a documented availability limitation and a definite status for any postmortem examination. Separate the administrative cause-of-death statement from a patient-specific clinical causation assessment.

5. Unresolved Timing and Cross-Report Impact

Question	Affected report passages	What a complete response could change
Was the lactate known at 08:20?	Chronology Sections 5 and 7; Narrative Section 4; Demand Support Section 7.	May change the usable start point for any knowledge-to-response interval. G01 / G02.
What followed the 09:00 notification?	Chronology Sections 5-7; Narrative Sections 4 and 6.	May identify an earlier assessment, response or unresolved communication step. G01.
What treatment was actually delivered?	Chronology Section 5; Narrative Sections 4-6.	May change fluid accounting and interpretation of medication timing. G03.

Question	Affected report passages	What a complete response could change
When did critical-care involvement begin?	Chronology Section 6; Narrative Section 4; Demand Support Section 7.	May show involvement before physical ICU transfer. G04.
What was the final infectious evidence?	Narrative Section 4; Demand Support Sections 2, 6 and 8.	May qualify the presumed source or treatment rationale. G02 / G05.
What did baseline and outcome records establish?	Chronology Sections 4 and 6; Narrative Sections 3–5.	May refine functional comparison, comorbidity context and certified outcome. G06 / G08.

6. Request Sequencing and Completion Status

First request G01–G04, because the current reconstruction depends most heavily on communication, result timing, delivered treatment and the ICU transition. G05–G08 can proceed alongside those requests to complete specialist context, baseline, policy and outcome documentation. This sequence does not assign legal deadlines or replace counsel's preservation decisions.

Current status: all eight requests remain open within this demonstration. No request has been sent, no provider response has been received, and no receipt date or person responsible for follow-up is represented as an actual completed action. Conditional categories remain conditional until existence is confirmed.

For a real production, log the request ID, verified custodian, date range, request date, response date, files received and remaining omissions. Compare the response with the itemized request, not merely its page count. Preserve the original filename and record-set identifier. Deduplicate identical copies while retaining amendments and different versions that bear on the disputed sequence.

When a response is incomplete, name the exact missing field or category in the follow-up. For example, a repeat laboratory PDF does not close a request for verification and acknowledgment history. A reply that no responsive record was found should identify the custodian's search scope and, where provided, the reason for unavailability. The report should continue to state any remaining limitation.

7. Effect of Additional Records on Report Conclusions

Additional evidence may strengthen, narrow or remove an apparent documentation concern. Earlier provider acknowledgment, assessment or treatment may alter the response timeline. Conversely, a complete record confirming no documented response may support more focused clinical review. Neither result automatically proves a breach or establishes that the outcome was preventable.

New source material should be assigned to a new record-set version. The chronology should be revised where dates, events or qualifiers change, and the narrative and demand-support passages should be updated consistently. Previously delivered versions should remain preserved. References to requests G01–G08 should show which questions were answered and which remain unresolved.

8. Limitations and Source Reference Appendix

This report identifies missing or incomplete information within the defined fictional source set. It is not a representation that all possible providers or records have been discovered. The clinician names, specialty practices, jurisdiction and actual records custodians would require verification in a real case. No undocumented provider encounter has been treated as an established fact.

A record gap is not a finding that care did not occur. Electronic metadata may be incomplete or require explanation from the relevant custodian. This report does not establish retention duties, preservation obligations, discoverability, legal liability or causation. Counsel determines the appropriate legal mechanism for obtaining records.

Source reference appendix

G01 is anchored to ED010-018. G02 is anchored to LAB002, LAB006 and LAB009. G03 is anchored to MAR001-016 and PC005-012. G04 is anchored to ED027-032 and ICU029-040. G05 is anchored to RAD001-004 and ICU015-022. G06 is anchored to PC001-012 and EMS001-008. G07 is anchored to POL001-006. G08 is anchored to ICU039-040. These anchors explain why each request appears; they are not evidence that the requested missing record has been reviewed.

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