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BUREAU OF PROPERTY & CASUALTY FORMS & RATES

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
CLOSED CLAIM REPORTING FORM

9701148
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 94-21296-01-047

1. PRIMARY INSURER NAME: PHYSICIANS PROTECTIVE TRUST FUND INSURER CODE: | 4 | 4 | 0 | 5 | 0 (See Table A)

2. EXCESS INSURER NAME: N/A INSURER CODE: | | | | | (See Table A)

3a. HEALTH CARE PROVIDER: REINA, LUIS ANDRES
(Last Name, First and Middle Name or Hospital Name from Table D)

3b. IF HEALTH CARE PROVIDER (above) IS A PHYSICIAN, DENTIST OR PODIATRIST, ENTER DEPARTMENT OF PROFESSIONAL REGULATION LICENSE NUMBER: | 0 | 0 | 4 | 6 | 5 | 6 | 0 |

3c. INSURED'S NAME: LUIS A. REINA, MD

STREET ADDRESS: SUITE 515, 7100 WEST 20 AVENUE

CITY: HIALEAH STATE: | F | L | ZIP: | 3 | 3 | 0 | 1 | 6 | COUNTY CODE: | 0 | 1 | (See Table B

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	1001571	$ 250,000.00	$ 750,000.00
EXCESS INSURER:	N/A	$ 0.00	$ 0.00

5. IS THE INSURED PHYSICIAN A FOREIGN MEDICAL GRADUATE? X (01) Yes ___ (02) No (If yes, enter the Country in which primary medical education was received: SPAIN SP

6. PROFESSION OR BUSINESS: (Check One)

X (01) Physicians & Surgeons ___ (04) Dentist ___ (07) Crisis Stabilization Unit
___ (02) Hospitals ___ (05) Abortion Clinics ___ (08) Health Maintenance Organization
___ (03) Podiatrists ___ (06) Ambulatory Surgical Centers

7. SPECIALTY CODE: | 8 | 0 | 2 | 6 | 1 | (See Table C) (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classisification Codes.)

8. BOARD CERTIFICATION: (Check One)

X (01) In specialty coded in Item 7, above.
___ (02) In a different specialty.
___ (03) In the specialty in Item 7 and another. Enter the additional specialty code here: ___ (See Table C)
___ (04) Insured is not board certified.

9. PLACE WHERE INJURY OCCURRED: (Check One)

X (01) Hospital Inpatient Facility ___ (04) Nursing Home ___ (07) Other Outpatient Facility
___ (02) Emergency Room ___ (05) Physician's Office ___ (08) Other Location
___ (03) Hospital Outpatient Facility ___ (06) Patient's Home ___ (09) Other Hospital/Institution

10. IF PLACE OF INJURY (above) IS CHECKED AS ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY OCCURRED: ___

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11. NAME OF INSTITUTION: HIALEAH HOSPITAL INSTITUTION CODE: | 1 | 0 | 0 | 0 | 5 | 3 |
(See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check One)

X (01) Patient's Room	___ (05) Physical Therapy Dept.	___ (09) Radiology
___ (02) Operating Suite	___ (06) Nursery	___ (10) Emergency Room
___ (03) Recovery Room	___ (07) Critical Care Unit	___ (11) Other: _____
___ (04) Labor & Delivery Room	___ (08) Special Procedure Room	

13. DATE OF OCCURRENCE: 05/29/92

DATE REPORTED TO INSURER: 07/08/94

14. INJURED PERSON'S AGE: 60 Years (If less than one year, enter 00; if unknown, enter UNK.)

INJURED PERSO

14.1 INJURED PERS(

STREET

CITY: MIAMI STATE: | F | L | ZIP: | 3 | 3 | - | - | 3 |

5. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:
Consultation for numbness and weakness in left leg.

(LEAVE BLANK)
15.

6. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:
N/A

16.

7. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
Following aortoiliac enderectomy and subsequent surgery embolectomy, patient require mid thigh amputation of the left leg, allegedly as a result of improper assessment of postoperative status by Dr. Reina. Expert witnesses were divided regarding the appropriateness of Dr. Reina's care and the cause of the amputation.

17.

8. DESCRIBE THE OPERATION, DIAGNOSTIC OR TREATMENT PROCEDURE CAUSING THE INJURY. USE NOMENCLATURE AND/OR DESCRIPTIONS OF THE PROCEDURES USED. INCLUDE METHOD OF ANESTHESIA, OR NAME OF DRUG USED FOR TREATMENT, WITH DETAIL OF ADMINISTRATION:
N/A

18.

9. DESCRIBE THE PRINCIPAL INJURY GIVING RISE TO THE CLAIM. USE NOMENCLATURE AND/OR DESCRIPTIONS OF THE INJURY. INCLUDE TYPE OF ADVERSE EFFECT FROM DRUGS WHERE APPLICABLE:
Mid thigh amputation of left leg with multiple revisions and ongoing antibiotic therapy.

19.

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20. SEVERITY OF INJURY: (Check only one - rate most serious injury if several are involved.)

___ (01) Emotional only - Fright, no physical damage.

Temporary
___ (02) Insignificant--- Lacerations, contusions, minor scars, rash. No delay.
___ (03) Minor---------- Infections, missed fracture, fall in hospital. Recovery delayed.
___ (04) Major---------- Burns, surgical material left, drug side effect, brain damage. Recovery delayed.

Permanent
___ (05) Minor---------- Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
_X_ (06) Significant----- Deafness, loss of limb, loss of eye, loss of one kidney or lung.
___ (07) Major---------- Paraplegia, blindness, loss of two limbs, brain damage.
___ (08) Grave---------- Quadriplegia, severe brain damage, lifelong care or fatal prognosis.

___ (09) Death

21. DATE OF SUIT, IF ANY: 1/04/95

21.1 CIRCUIT COURT CASE NUMBER: 94-24031

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: | 0 | 1 | (SEE TABLE B)

22. LIST OTHER DEFENDANTS INVOLVED IN THIS CLAIM, THE INSURER'S NUMBER AND THE COMPANION CLAIM FILE ID NUMBER:

	DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE ID.
1)	Garcia-Rivera, Carlos	UNKNOWN	UNKNOWN
2)	Hialeah Hospital	04145	UNKNOWN
3)	Century Medical Plan, Inc.	04145	UNKNOWN
4)			
5)			

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check One)
_X_ (01) Yes ____ (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 4/09/97

25. FINAL METHOD OF CLAIM DISPOSITION:
_X_ (01) Settled by parties.
___ (02) Disposed of by a court.
___ (03) Disposed of by arbitration.

26. STAGE OF THE LEGAL SYSTEM AT WHICH SETTLEMENT WAS REACHED OR AWARD MADE: (Check One)
___ (01) Within the presuit period as set forth in Section 768.57, Florida Statute (usually within 90 days).
___ (02) After arbitration is initiated or prior to suit being filed.
___ (03) Within 90 days of suit being filed.
_X_ (04) More than 90 days after suit filed and prior to or during the course of mandatory settlement conference.
___ (05) During trial but before court verdict.
___ (06) After court verdict and prior to filing notice of appeal.
___ (07) After notice of appeal is filed or post-judgement relief or action is required for recovery.
___ (08) During appeal.
___ (09) After appeal.
___ (10) Claim or suit abandoned.

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27. COURT: (Check One)

X	(01) No court proceedings.	___	(07) Judgement for the defendant.
___	(02) Directed verdict for plaintiff.	___	(08) Judgement for the plaintiff after appeal.
___	(03) Directed verdict for defendant.	___	(09) Judgement for the defendant after appeal.
___	(04) Judgement notwithstanding the verdict for plaintiff.	___	(10) Other
___	(05) Judgement notwithstanding the verdict for defendant.	___	(11) Summary judgement for the plaintiff.
___	(06) Judgement for the plaintiff.	___	(12) Summary judgement for the defendant.

28. ARBITRATION: (Check one)

X	(01) Claim not subject to arbitration.	___	(03) Award for plaintiff.
___	(02) Claim subject to arbitration, but settlement reached in lieu of award.	___	(04) Award for defendant.

29. WAS THERE AN ITEMIZED VERDICT? (Check One)
___ (01) Yes X (02) No (If yes, please attach copy of settlement or verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: . . . . . $ 250,000.00

30.1 AMOUNT OF DEDUCTIBLE PAID BY THIS DEFENDANT: . . . . . $ 0.00

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: . . . . . $ 0.00

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL:. . . . . $ 27,677.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID:. . . . . $ 49,321.00

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: . . . . . 0 days

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: . . . . . 0 days

36. INJURED PERSON'S GROSS WEEKLY INCOME: . . . . . $ 0.00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE . . .	$ 0.00	$ 0.00	$ 0.00
B) ESTIMATED FUTURE . . .	$ 0.00	$ 0.00	$ 0.00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS:. . . . . $ 250,000.00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:

A) PRESENT VALUE OF PERIODIC PAYMENTS . . . . . $ 0.00

B) COST TO THE INSURER OF THE PAYMENTS . . . . . $ 0.00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF . . . . . $ 0.00

D) DID YOU PURCHASE AN ANNUITY? ___ (01) Yes X (02) No

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40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: N/A

41. TYPE OF NON-ECONOMIC DAMAGE LIMIT: (Check One)

X (01) No limit (neither party requests or agrees to voluntary binding arbitration).
___ (02) No limit (defendant refuses claimant's offer of voluntary binding arbitration).
___ (03) $250,000 Limit (both parties accept arbitration). (See Item 42 for exception.)
___ (04) $350,000 Limit (plaintiff rejects arbitration).
___ (05) Does not apply because occurrence happened before the 02-08-88 law.

42. IF (03) IS CHECKED IN ITEM 41 AND THE LIMIT ON NON-ECONOMICAL DAMAGES IS DIFFERENT THAN $250,000, THEN INDICATE THE MODIFIED LIMIT: . . . . . $ 0.00

43. COLLATERAL SOURCE INFORMATION:
ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM:

A. 0% Health
B. 0% Disability
C. 0% Worker's Compensation
D. 0% Automobile
E. 0% Medicare, Medicaid & Social Security
F. 0 % Other sources, specify:

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Insured met with experts and insurance company personnel.

CONTACT PERSON: Fred Scheriff, Miami Regional Claims Manager
TELEPHONE: (305) 442-4001
ADDRESS: Physicians Protective Trust Fund
2121 Ponce De Leon Boulevard, Suite 350
Coral Gables, Florida 33134