Erin Falati
Proffer Exhibit H
Depp v. Heard
CL-2019-0002911

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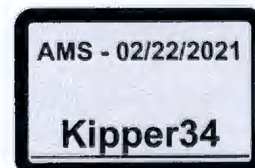
MAY 23 2022
JOHN T. FREY
Clerk of the Circuit Court
of Fairfax County, VA

8/27/14

RN has been hired to provide private nursing care for client Amber Heard. (Amber Heard will hereafter be referred to as "client" or "AH"). Amber's fiancé, Johhny Depp (hereafter referred to as "JD") is currently under the care of Dr. David Kipper and is attended to by private nurse Debbie. L., RN. This RN will attend to AH while traveling with her fiance to London, UK for his work. JD is a film actor and plans to be working in London for several months. Client AH is also an actress and model, but does not have any work planned for the duration of JD's work trip to London.

Client history:
AH is a 28 year old female. Current occupation is actress and model. She has been in a relationship with JD since 2012. AH and JD met in 2010 on a film set but did not start dating until 2012. Client reports a strong support system, with her sister Whitney living with her in Los Angeles, and "several best friends" that she socializes with frequently. Both parents are living and married, and live in Austin, Texas. Client states she moved from Austin, Texas to New York City when she was 17 to pursue a career in modeling. She moved to Los Angeles in her "early 20's" to continue her modeling career and to pursue an acting career. Client states she works on 1-3 films per year on average, and spends free time volunteering at The Art of Elysium. She has two pet dogs named Pistol and Boo that travel with her frequently. AH reports history of substance abuse, including an addiction to cocaine and liquor. Ct reports abstaining from cocaine "for a couple years" but was unable to report exact dates. Ct does not smoke cigarettes. She reports consuming 1-3 glasses red wine each day. She reports familial history of substance abuse; both mother and father have abused and become dependent on stimulants (methamphetamine), opiates, and alcohol. Her fiancé JD has history of polysubstance abuse and completed a medical detox in July 2014. He has abstained from all substances since the detoxification period. Client admits to history of anxiety, eating disorder, Attention Deficit Disorder, Bipolar disorder, codependence issues, and occasional insomnia. Client identifies as bi-sexual, and was married to female partner prior to current relationship with fiancé.

Per report from JD, Debbie, RN, Dr. Kipper, client AH has reportedly been experiencing increased anxiety and agitation recently, and has had several outbursts of anger and rage. Her mood has been labile. Both client and fiancé JD report an increase in verbal disagreements resulting from client's anxiety and emotional lability. Client expressed concern to husband and Dr. Kipper that she is nervous about being alone while husband is working (on movie set in London) and expressed she has difficulty dealing with feelings of insecurity and jealousy when not in presence of her husband. RN will serve as a companion for client, and will monitor current prescribed medication as well as the introduction and titration of mood stabilization medication. She is a current patient of Dr. Kipper and will remain under his care. Ct has begun bi-weekly individual therapy sessions with Dr. Cowan, and will continue therapy sessions via Skype while in London.



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RN met ct and her husband JD at their home in Los Angeles at 2130. Ct is smiling, laughing, eye contact good. Appears calm, comfortable, relaxed, mildly fatigued. Ct and RN start to build rapport. Ct consumes 2 glasses red wine. Current medications include Neurontin 100mg po TID, Neurontin 300mg po qhs, Provigil 200mg po bid, Melatonin 20mg po qhs. Ct will begin Latuda 20mg po qam on 8/28/14 for mood disorder. Ct pleasant with minimal interaction with RN during evening and while arriving on private jet. Plan is to fly to London through the night. Ct self-administered HS medications with the addition of Ambien 10mg at 0030 on 8/28/14. Retired to bed at 0115.

8/28/14
Landed in London at approximately 1800. Ct states she slept for duration of flight and "feels refreshed." No anxiety noted or reported by ct. Ct self-administered AM medication as scheduled upon landing. RN gave ct daily HS medications and was also provided with Ambien 10mg for sleep. Latuda was not initiated due to flight time and time change, as client and RN arrived in London during the evening. RN will begin Latuda administration tomorrow. Ct's appetite is good, fluid intake adequate. Ct's mood stable, no anxiety noted. RN and Debbie, RN staying in rooms directly across from clients AH and JD in hotel. RN reassured ct to notify her during the night for any needs. Ct expressed appreciation of having RN available on trip. Dr. Kipper notified of ct's status and reason for Latuda not being administered.

8/29/14
1045 Ct awake, OOB. Appears calm. Hygiene good. Ct maintains good eye contact, speech normal and logical. Ct consumes coffee and small amount of pastry. States she slept soundly through the night. Reports feeling "fine" but requests to decline Neurontin 100mg po QAM as routine medication as she feels it causes morning lethargy. RN will discuss with Dr. Kipper regarding ct's request. RN reviewed all medications, administration times, and side effects with ct. Ct verbalizes understanding. Ct was provided with pill box containing daily medication divided by administration time. Latuda 20mg initiated for AM dose. RN will fill weekly pill box and review with ct this evening. Ct is grooming self and plans to shop and sightsee today. No anxiety noted at this time.

1400 Dr. Kipper updated on ct's status via email. Per Dr. Kipper's request, RN will discuss need for steady state of medication (Neurontin) in ct's system to keep anxiety level minimal. RN will discuss possibility of reducing AM Neurontin dose to 50mg instead of 100mg, or possibly changing Neurontin dosing schedule to q6-8hrs. RN will also discuss ct's plans to continue communicating with therapist, Dr. Cowan.

2345 Client, RN, and Debbie, RN went to dinner together. Ct demonstrates good appetite. Drinks 2-3 glasses red wine. No water consumes as ct "prefers only bottled water." RN encouraged ct to adequately hydrate upon returning to hotel where bottled water is available. Ct agrees to do so and verbalizes understanding for necessity of adequate hydration especially due to dehydrating effects of wine and also medication regimen. RN also educates client that alcohol intake can effect

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prescribed medication, including new medication Latuda. Ct states she understands but continued to consume wine. Ct discussed individual and couples therapy with RN and states she "looks forward to it." 1:1 emotional support and positive reinforcement given. Ct verbalizes feelings of confusion as she feels fiancé would like her to decrease/eliminate acting career and stay at home. Ct wishes to continue working and expresses feelings of fulfillment from career. Ct will have individual therapy session with Dr. Cowan tomorrow at 1800, and RN encouraged her to discuss feelings with him. RN discussed Neurontin with ct per prior request. RN educated ct on necessity of steady blood level of medication for maximum effectiveness, along with ct's typical wake/sleep schedule. Plan was determined to administer Neurontin q 6-8hr. Ct will take Neurontin 100mg an hour after waking, then Neurontin 100mg 6-8 hr after first dose, then Neurontin 300mg at bedtime. Ct verbalizes understanding and is agreeable to this plan. RN offers to notify ct at administration times to assist in establishing medication schedule, but ct declines stating, "it's ok, I will remember." Dr. Kipper is made aware of Neurontin dosing administration change. Ct appeared to enjoy socializing with both nurses during evening. Ct's mood has remained stable throughout day. She responds well to positive reinforcement along with distraction and relaxation techniques. Ct verbalizes desire to increase exercise and to specifically start yoga. RN will continue to encourage ct to achieve this goal. RN offered to provide ct with three day's worth of medication in case she would like privacy during the weekend. Ct declined and took only the pill box for tomorrow. Ct states, "it's ok, you are nearby and I'd like to see you anyway." Ct has bedtime medication with her and has retired to room.

8/30/14

Ct slept soundly throughout night and woke at 1245 today. Ct alerted RN upon waking and self-administered Latuda 20mg and Provigil 200mg at 1300. RN encouraged ct to take Neurontin 100mg at 1400 and 1900 per plan agreed upon yesterday to take q6-8hr. Ct notified RN upon self-administering Neurontin 100mg at 1415. Ct self-administered Provigil 200mg at 1530, then required reminding to take second dose of Neurontin 100mg, which was self-administered at 2110. Ct states she plans to wake earlier tomorrow and will space Neurontin 100mg dosages more evenly. Ct has rested throughout day in her room. Ct requested and was given Motrin 800mg at 1800 for menstrual cramps as her cycle began today. States Motrin was mildly effective at 2000. RN provided ct with additional ibuprofen in case needed during the night and following morning, and educated ct on dosing instructions as well as possible side effects. RN suggested use of heating pad and/or massage for continued cramping and pain. Ct states she will alert RN if additional measures are needed. Ct appears well groomed, relaxed, well rested. Ct's affect appropriate, maintains good eye contact. Ct had phone session with Dr. Cowan today at 1800. Ct and fiancé went out to dinner. Ct left and returned in good spirits. Ct states that she has an appointment with Dr. Cowan on Monday, September 1. They will alternate phone and Skype sessions. Positive reinforcement given for ct's continued therapy sessions and for adherence to medication schedule.

8/31/14

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Ct notified RN at 0945 that she was awake and had self-administered Latuda 20mg and Provigil 200mg. RN will remind ct at appropriate times for Neurontin 100mg dosing today to assist in establishing pattern for ct. Ct appears in good spirits. States she slept from 0400 to 0800 but woke with energy. Ct states she is fatigued but believes interrupted sleep is related to jet lag. Mood calm, relaxed. Affect appropriate. C/o moderate menstrual cramping 5:10 and was given Motrin 800mg at 1230. Ct self-administered Neurontin 100mg at 1215 without prompting. Ct appears to tolerate Latuda well thus far. Ct denies SI, irritability, agitation. No signs or symptoms of NMS or TD noted. BP while sitting 92/50, pulse 64 and regular. Ct self-administered Neurontin 100mg at 1800 without prompting. Positive reinforcement given for establishing medication schedule. Ct given naproxen 250mg if needed for menstrual cramps as ibuprofen is not fully effective. Ct educated on medication and possible side effects. Ct ate 100% dinner and is adequately hydrated. Ct plans to use spa facilities and receive facial tonight to relax.

9/1/14

Ct woken by RN at 1215. States she took HS medication with addition of Ambien 5mg last night at 0100 and fell asleep at 0230. Ct slept soundly through the night. Ct mood, affect, eye contact appropriate. Ct denies TD or NMS symptoms. Manual BP left arm while sitting 88/60, pulse 78 and regular. Ct given Latuda 20mg and Provigil 200mg at 1230. Ct c/o menstrual cramps and was given ibuprofen 600mg at 1300 per her request. RN and ct have spent time together building rapport. Ct is opening up to RN regarding family history and relationships. Ct was informed via friend that some information on her cell phone may have been leaked due to hacking. Ct expressed concern but maintained stable and appropriate reaction. Positive support given for healthy coping skills. Ct appears happy, appetite good, able to hold attention for medication education. Ct is provided with pill boxes with appropriate medication for today and tomorrow. Ct expresses excitement regarding beginning online religious studies class tomorrow. Ct will have phone session with Dr. Cowan at 1700, then ct and RN will go to the spa together per ct's request.

1900 Ct informed RN she self-administered Neurontin 100mg at 1345, Provigil 200mg at 1445. Ct reminded to take Neurontin 100mg at 1830 and she did so immediately.

2350 RN and ct spent time in spa during evening. Ct's mood calm and stable despite dealing with phone hacking. Positive reinforcement given for healthy coping skills. Ct appears to have difficulty maintaining attention for continuous periods. Ct reports numbness x 20 minutes in both hands while receiving manicure and states same experience happened yesterday afternoon. RN to report to Dr. Kipper. Ct continues to build trusting relationship with RN. Ct self-administered HS medication at 2230 and retired to hotel room with fiancé.

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9/2/14

Ct in good spirits during morning despite sleeping only from 0300 to 0730. Ct took Provigil 200mg at 0800, Latuda 20mg at 0945, Neurontin 100mg at 1100. Ct self-admin Ambien 5mg at 0100 last night but then started painting. RN educated ct on onset, duration, and proper administration of Ambien, and encouraged ct to only take Ambien when needed and to be in bed ready for sleep when she administers it. Ct ate small fruit breakfast. States "I feel really good." RN and ct discuss ct's history and current relationship. Ct reports difficulty with jealousy issues and anxiety around fiance's fame and ability to interact with females often. 1:1 emotional support given. Ct is encouraged to continue activities to enhance well-being such as therapy, journaling, sleep hygiene. Ct agrees. Ct requests RN to continue stay in London as it is assisting her mood stabilization and comfort. RN agrees to do so and reassures ct that she will have access to RN as long as needed.

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9/2/14

Ct moved into new home in London. Mood cheerful and stable throughout day. RN notified Dr. Kipper of ct's insomnia. Orders received to increase HS Neurontin to 600mg and to be given two hours prior to bedtime. RN educated ct on medication change and also on necessity to use Ambien only as last resort. Ct verbalized understanding and expressed reassurance regarding Dr. Kipper's recommendation. Ct preparing for outing with fiancé and declines RN offer to remind her for Neurontin administration. Ct will notify RN of any needs.

9/3/14

Ct awake at 12:30pm. States she slept well but is "groggy." RN informed ct that she will decrease HS Neurontin to 400mg tonight per Dr. Kipper. Ct has maintained focus and attention during online class x 2 days. RN changed ct's pill boxes to reflect medication change for HS. Ct in good spirits throughout day. Self-admin Neurontin 100mg at 1430 and 1855. Ct denies taking Ambien last night. Positive reinforcement given for following treatment advice. Ct hygiene good, appetite good. Ct maintains adequate oral fluid intake. Ct and RN spent time together today; rapport established. RN reminds ct to take Neurontin 400mg two hours prior to bedtime. Ct verbalizes understanding. Ct states she will notify RN of any needs during night and will contact RN upon wakening.

9/4/14

Ct awake at 0900. Reports sleeping soundly from 0300 to 0900. Woke without difficulty this morning. Denies lethargy, fatigue, or "grogginess." Dr. Kipper notified of dosage reduction effectiveness. RN confirmed with ct that she will continue Neurontin 400mg two hours prior to bedtime, as dose was effective. Ct spent day participating in online college course, attending a meeting, and studying. Ct self-administered all medications at proper times without prompting. Ct, RN out for shopping with ct's assistant and Debbie, RN this evening per ct's request. Ct ate dinner with RN at 2100 at restaurant. Ct became frustrated with wait staff over miscommunication; ct calmly repeated herself to staff to resolve issue. Ct expressed frustration after conflict to RN. RN reflected change in coping mechanisms as ct's previous coping skills involved impulsive anger and yelling. Ct able to acknowledge ability to process conflict and expressed pride in healthy conflict resolution. Ct had small piece fish and salad at home at 2330. RN discussed eating small, frequent meals throughout the day with ct as she tends to have limited amount of food during daytime and consumes most of her daily calories 1-3 hours prior to bedtime. Ct is social, affect and mood appropriate. States minimal anxiety. Ct expresses appreciation of RN's presence and assistance, and reports that she "is feeling great" with her current medication regimen. Positive reinforcement given. Manual BP 96/50 left arm while sitting, P 78. RN has created chart of VS for ct so she is able to determine baseline VS. Ct expresses much interest in well-being. Ct plans to fly to

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NY Sept 7-8 for work; declined RN's offer to accompany her. RN will ensure ct has all medication and instructions prior to departure.

9/5/14

Ct awake at 0815. Administered Provigil 200mg and Latuda 20mg at 0820. Neurontin 100mg and Provigil 200mg self-admin at 1205 per ct. Positive reinforcement given for adhering to medication administration schedule. Ct attended work meeting and then request RN to go shopping. VS checked at 1400, BP 94/56 P 62. Ct appetite good. Ate 100% salad with falafel at lunch. Ct mood stable and appropriate. When asked how she feels about current medication regimen ct states, "it is working well for me, I feel great." Ct taking responsibility for self-admin medication at scheduled times. Ct reports fatigue today but does not nap. Tolerates 40 minutes light walking well. Ct ate 100 % dinner with RN. VS taken again at 2230 per ct request. BP 96/52, P 84. Ct reports that she was accepted for acting role in film to begin at undetermined date. Ct discussed concerns regarding fiancé's' weight loss in front of fiancé and both RNs, and implemented effective conflict resolution. Positive reinforcement given for healthy coping skills.

9/6/14

Ct awake at 1200, self-admin Latuda 20mg and Provigil 200mg. Ct states she will decline second dose of Provigil today to increase nighttime sleepiness. Ct reports sleeping soundly through the night. Ct and RN in touch via text throughout day. Ct spent day with fiancé and reports that she told fiancé about acting role and he was accepting of it. RN encouraged ct to notify her with any concerns and to notify RN upon waking tomorrow.

9/7/14

Ct states she slept from 0100 until 0630. C/o vivid dreams and nightmares. Ct appears anxious, withdrawn. States she felt increased agitation yesterday. Ct reports withdrawing and isolating when with fiancé yesterday, but able to recognize her behavior and communicate with fiancé. Positive reinforcement given for reflection and healthy coping skills. Ct is going to NY this morning by herself for work commitment and will return Tuesday Sept. 9. Ct reports anxiety related to travel, being alone, family issues, impending work. 1:1 emotional support provided. RN educated ct on effects of anxiety such as insomnia, vivid dreams, and agitation. RN taught ct deep breathing exercises and relaxation techniques. Ct provided with routine medications in addition to Inderal and Neurontin 100mg to take PRN for anxiety. RN will assist ct with anxiety via phone while ct is in NY, and will implement a physical exercise routine with ct upon return. Ct continues therapy sessions with Dr. Cowan every other day and states she is learning coping mechanisms and effective communication skills. RN notified Dr. Kipper of ct's increased anxiety.

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9/8/14

1300 Ct in NY for work. Reports sleeping from 0300 to 0745. Ct woke feeling anxious and questions RN if Latuda is causing insomnia. 1:1 emotional support given. RN educated ct on medication and provided reassurance. Ct is encouraged to continue therapy sessions with Dr. Cowan as she is experiencing several stressors currently. RN educated ct on effects of stress and anxiety on well-being and sleep patterns. Deep breathing and relaxation techniques reviewed with ct and implementation is encouraged. RN suggests creating plan with ct upon her return to have daily private time in which ct can discuss health and mental status, mood, sleep, questions, concerns, etc. with RN. Ct agrees to do so. Dr. Kipper updated on ct's increased anxiety and insomnia. Orders received to increase Neurontin to 100mg po tid and keep Neurontin 400mg po qhs. Ct educated on this change and is encouraged to begin immediately.

2200 Ct had phone session with Dr. Cowan this afternoon. Has been busy with work commitments throughout day. RN encouraged increased oral fluids and small meals throughout day. Dr. Kipper discussed ct's status with RN. Orders received to increase Neurontin to 200mg po TID and Neurontin 400mg po qhs. Ct made aware of medication change and will begin increased dosages on 9/10/14 AM as she does not have medication with her currently.

9/9/14

1100 Ct reports sleeping 2 hours due to late work schedule and early flight. RN encouraged ct to take Neurontin 100mg q4 hr today as she will travel from NY to London, and will experience a longer day. RN plans to meet with ct upon her return this evening to review new medication changes and assess mental and physical status.

2300 Ct returned this evening with friends and sister. Having dinner with fiancé. States she is fatigued but mood stable. RN will assess ct in the morning.

9/10/14

1600 Ct states she slept soundly from 0100 to 1130. Appears in good spirits, states she "feels so much better after sleeping." RN met ct and friends at house. Ct hygiene is good. Observed drinking adequate fluids. RN reviewed medication changes with ct. Ct is hesitant to take Neurontin 200mg TID as she fears sedation. Ct and RN agree for ct to take Neurontin 100mg TID and 400mg at HS and will reassess anxiety and medication effectiveness. RN and ct agree to have private session during afternoon to discuss ct's mental and physical status. Ct, RN, and ct's friends out on a walking tour for several hours during the afternoon. Ct takes medication as scheduled without prompting. Mood stable throughout day. Ct will have therapy session with Dr. Cowan at 1700.

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2330 Ct experienced increased anxiety and appeared more agitated during evening hours. Ct took additional Neurontin 100mg at 2100 for anxiety. BP 115/68, P 88. RN reviewed deep breathing exercises. Ct returned demonstration. RN discussed ct's stressors including friends present, work commitments, relationship. Healthy coping mechanisms reviewed. Ct observed consuming several glasses wine. Affect flat, appears withdrawn. Ct expresses anger toward fiancé's friend and associates blame for fiancé's substance abuse. 1:1 emotional support given. RN attempted to process feelings with ct but ct declined. RN encouraged ct to notify RN of any needs throughout night.

Sign Here

9/11/14

1900 RN met ct at house at 1300. Ct states she slept from 0200 until 0830. Ct appears fatigued. Ct took vitals upon waking as she felt anxious. BP 85/67, P 121 while supine. Oral fluids encouraged to correct dehydration. Ct self-admin Latuda 20mg and Provigil 200mg at 1015, then Neurontin 100mg at 1230. Ct requests and is given Vit B12 1cc IM left ventrogluteal at 1315. Ct, RN, and friends spent several hours shopping and sightseeing. Ct c/o intermittent nausea and fatigue throughout day. Declines offer to return home to rest. Ct observed eating variety of foods. Provigil 200mg taken at 1400, Neurontin 100mg taken at 1500. Upon return to house at 1800, ct c/o nausea, fatigue, feeling "dizzy" while sitting. BP 99/72, P 70 at 1820. Ct encouraged to rest this evening. Zofran 8mg given at 1820. Ginger tea provided. Dr. Kipper notified of ct's status. Orders received to increase Latuda to 40mg po qam and change Neurontin to 200mg po bid and 400mg po qhs.

2350 RN assessed ct throughout evening. States nausea minimal but continues to c/o fatigue. RN and ct had 1:1 discussion about ct's increased anxiety, agitation, insomnia, and life stressors. Ct receptive to support and expressed fear r/t fiance's possible relapse. RN encouraged ct to stay present and highlighted need to focus on ct's own well-being. Relaxation and distraction techniques reviewed. Ct expresses hesitation r/t increase in Latuda dose and change in Neurontin. RN provided medication education and explained how medication and cognitive/behavioral techniques are used to increase well-being. Ct verbalizes understanding and agrees to medication regimen. Positive support given for adhearance to medication regimen and for expressing feelings, concerns, questions to RN. Ct will continue with psychotherapy every other day and is utilizing learned coping skills to minimize anxiety.

9/12/14

1100 Ct notified RN of c/o drowsiness at 1015. States she took Provigil 200mg, Latuda 40mg at 0900 and Neurontin 100mg at 1015. Ct declines to take full dose of Neurontin d/t fatigue and drowsiness. RN encourages ct to take ordered dose of Neurontin within 1 hour. Ct is currently spending time with friends and will notify RN when she is available for assessment. Ct plans to have therapy session this afternoon and then go to France for the weekend with fiancé.

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2000 RN assessed ct throughout day. Ct continues to c/o fatigue. Hydrating adequately. Ct met with Dr. Kipper. Ct expressed gratitude to RN for 1:1 talk the night before. States she was able to process anger, fear, and anxiety in order to have therapeutic communication with fiancé. Positive reinforcement given for insight, processing, and utilizing healthy coping and communication skills. Ct asks RN for reminders of medication administration times as she feels more confident in utilizing medication to achieve mood stabilization. RN will do so. Ct left house with sister at 1945 and will be in France for the weekend with fiancé. All medication provided to ct upon departure.

9/13/14

Ct states she slept soundly last night x 10 hours. RN has reminded ct at medication administration times. Ct medication compliant today. RN has encouraged ct to notify of any questions or needs.

9/14/14

Ct remained in France most of day. Returned to house in London late tonight. Self-admin Latuda 40mg and Provigil 200mg at 1100, Neurontin 200mg at 1300, Neurontin 200mg at 1825, and Neurontin 400mg at 2315. Ct then self-admin melatonin 20mg at 0015. RN plans to meet with ct tomorrow. Ct has had limited interaction and communication with RN throughout weekend.

9/15/14

Ct had several appointments and meetings today; did not see RN. Ct continued therapy with Dr. Cowan this afternoon. States she had a relaxing weekend and "feels good besides the morning grogginess." Dr. Kipper notified and will meet with ct tomorrow to discuss fatigue and medication regimen. RN will assess ct tomorrow and encourages ct to notify of any needs throughout night.

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9/16/14

Ct met with Dr. Kipper to discuss c/o daytime lethargy and fatigue. Ct states she typically wakes with energy but begins to feel fatigued approx. 2 hours after waking. Orders received to change Neurontin to 200mg po TID. Ct is educated on medication change and is instructed to take Neurontin at 1400, 1830, and 2330. She is instructed to also take Melatonin 20mg with the last dose of Neurontin at 2330. Ct verbalizes understanding but requests RN assist her in remembering dosage times. RN agrees to do so and reminds ct throughout day of appropriate medication administration times. Ct responds to RN at delayed intervals.

9/17/14

Ct slept from 0100 to 1100. Appears in good spirits. Looks well rested. Ct tolerated decrease in HS Neurontin well. Ct c/o AM nausea following Latuda administration. Ct educated to take Latuda with food to decrease GI upset. Ct's nausea decreased following food intake. Ct plans to return to Los Angeles on Tuesday Sept. 23. She will then go to Savannah, Georgia for approx. one month for work. RN will accompany ct to Los Angeles and to Savannah. Ct expresses gratitude for RN's presence on work trip. Ct states she is experiencing anxiety r/t departure from fiancé and work commitments. 1:1 support provided. Ct encouraged to practice deep breathing and relaxation techniques as well as continue with therapy sessions. Coping mechanisms for anxiety reviewed with ct. RN reminds ct throughout day at appropriate medication administration times. Ct is unresponsive and/or responses at delayed intervals. RN will discuss communication with ct and will encourage ct to take more active role and increase responsibility of well-being and medication regimen.

9/18/14

Ct awake at 0600. States she fell asleep at 0200. States she is "wide awake and has lots of nervous energy." RN provides 1:1 support and encourages ct to rest more but if unable to use distraction techniques such as deep breathing, reading, drawing. Ct requests RN assist her with yoga today for stress relief. RN agrees to do so and offers to visit ct but ct is unresponsive via text. RN contacts ct at 1130 and offers to visit ct. Ct states she has been awake since 0600 but will attempt to nap. RN encourages ct to take first dose Neurontin 200mg at 1130. Dr. Kipper notified. Orders received to increase HS Neurontin to 300mg. Ct requests to take only 200mg at HS but does take 300mg at HS. Ct denies GI upset today after taking Latuda with food. Positive reinforcement given. Ct compliant with medication administration times today. Ct's mood stable throughout afternoon and evening hours.

9/19/14

Ct states she slept soundly last night. Took all morning medications as prescribed. Also took Inderal XR 40mg at 1300 in preparation for work audition. Tolerates well.

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Inderal 40mg tabs ordered to be ready for ct's audition and work commitments next week. Ct busy with work commitments throughout the day. RN reminds ct at Neurontin administration times. Ct replies to RN intermittently. RN plans to continue to assist ct in time management and communication. Ct states she is in "a good mood" today and spends evening going to comedy show and then to see fiance's music show. RN reminds ct to take all bedtime medications at 0015 and ct complies immediately. Plan is made for RN to have private discussion with ct tomorrow to assess ct's physical and mental status, as well as plan for ct's and RN's upcoming departure to Los Angeles and then to Savannah, Georgia for work.

9/20/14

Ct slept without interruption from 0200 to 1220. Ct appears well rested. Affect appropriate. Ct verbalizes anxiety r/t upcoming travel to Los Angeles and states that RN does not need to be present for more than one week with ct in Savannah, Georgia. RN discussed ct's feelings and concerns, and reassured ct that RN is available to ct as long as needed. RN and ct spent time 1:1 reviewing healthy coping skills and medication regimen. Ct states she wakes with energy each morning but experiences period of extreme fatigue approx. 2 hours after waking. Fatigue coincides with postprandial period. Dr. Kipper notified and diary is to be kept for exact medication administration times as well as onset and duration of fatigue.
Today is as follows:
1230: Latuda 40mg and Provigil 200mg
1445: c/o extreme fatigue, lethargy. Desires to rest but does not do so.
1450: Provigil 200mg and Neurontin 200mg
1530: lethargy diminished, ct states energy level normal
1915: Neurontin 200mg
2305: Neurontin 200mg and Melatonin 20mg

9/21/14

Ct asleep last night at 0030. Woke at 0300 with mild anxiety. Ct self-admin what she believed was Neurontin 100mg at 0300 but later suspects it was Inderal XR 40mg based on description of capsule. Ct returned to sleep at 0400 and slept soundly until 1045.

1050: Provigil 200mg
1210: Latuda 40mg
1230: c/o nausea
1310: denies nausea
1330: Neurontin 100mg

RN notified at 2100 that ct's cell phone had been hacked and nude photos posted online. Ct states she is experiencing high level of anxiety. RN went to ct's house. Ct crying, hyperverbal. 1:1 emotional support provided. Ct guided through relaxation techniques. Ct's fiancé offered emotional support. Ct able to calm self and agreed to

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journal thoughts as coping mechanism. Neurontin 200mg given at 2120, Neurontin 100mg prn given at 2200. Dr. Kipper notified, orders received to give ct Neurontin 400mg and Seroquel 25mg at bedtime and to give Neurontin 200mg q4hr throughout daytime. Ct declined full dose Seroquel but agreed to take partial dose. Neurontin 400mg, Melatonin 20mg, Seroquel 6.25mg given at 2320. Ct states she is going to bed. RN departed.

9/22/14

0100 RN notified that ct requires assistance. Upon arrival, ct noted to appear irritable, loud, angry. Ct screaming at times and appears agitated. Ct crying and states she got into verbal argument with fiancé after RN departure. Ct states she feels fiancé did not provide support to ct. Ct emotionally labile. 1:1 support given. RN assisted ct with deep breathing techniques, processing feelings and thoughts, and encouraged ct to relax in bed. Seroquel 18.75mg given at 0140, Vistaril 50mg given at 0230. Ct in bed attempting to sleep at 0330. Ct mood calm when attempting to sleep.

0500 Ct asleep in bed.

0600 Ct asleep in bed.

0800 Ct asleep in bed.

0930 Ct woke easily by RN. States she slept soundly from 0345 until 0930. Ct verbalizes embarrassment r/t emotional lability during previous night. Support given and ct's feelings processed. Ct is encouraged to increase fluid intake and eat small meals throughout day for energy. Ct also encouraged to have session with Dr. Cowan to discuss trauma associated with personal photos made public. Ct self-admin Provigil 20mg at 0950, ibuprofen 200mg for headache and Latuda 40mg at 1015. Reports lethargy 1150. Ct attends meetings throughout day. Self-admin Neurontin 200mg at 1200, 1600, 2000. Neurontin 400mg at Melatonin 20mg given at 2255. Ct mood stable and calm throughout day and evening. Discussing feelings and thoughts in therapeutic manner. Positive reinforcement given for healthy coping skills.

9/23/24

10/2/14

Ct in good spirits throughout day. Spent day with RN and assistant shopping, dining, touring city. Ct requests RN to continue working with her through next week to ensure her physical and mental stability when filming commences. RN agrees to do so. Ct compliant with medication regimen with prompts from RN. RN attempts to assist ct in gaining more responsibility for medication administration schedule.

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20797

Goal made to find application for cell phone with alarm reminders every 4 hours to prompt ct to self-admin Neurontin during daytime. States the Seroquel taken at HS is effective in sleep onset and duration.

10/3/14

Ct took Neurontin 200mg and Provigil 200mg at 1030. Denies negative side effects of administering both medications at same time. Ct states she will continue this administration schedule to reduce confusion and increase adherance to regimen. Ct self-admin Neurontin 200mg at 1630 after several prompts from RN. Ct affect flat, appears anxious. States experiencing moderate stress r/t work and upcoming trip to visit sister. Support provided, ct encouraged to maintain proper intake food and fluids. Ct provided with medication for the weekend. RN will continue to remind ct of medication administration times per ct request. Ct admin Neurontin 200mg at 2030 prior to departure after prompt from RN. Ct departed with sister for trip to Mississippi to visit family. Plans to return Sunday Oct. 5.

10/4/14

Ct notified RN of her arrival at sister's house at 0600. Ct slept until 1030 and self-admin Provigil 200mg. RN reminded ct to take Neurontin 200mg at 1130, 1530, and 1930. Ct reports forgetting afternoon dose and taking Neurontin 200mg at 1700 instead of 1530. RN advised ct to take following Neurontin dose at 2030. Ct did so. RN reminded ct to take Neurontin 400mg, Melatonin 20mg, Seroquel 12.5mg, and Latuda 40mg at 2305, ct did so. Ct continues to deny daytime lethargy since changing Latuda administration to HS, and is tolerating change well. Ct plans to drive to Savannah tomorrow morning as she will begin 4-5 days of work beginning Mon. Oct. 6.

10/5/14

Ct self-admin medications throughout day with minimal prompting. Ct returned from visiting sister in Mississippi. States she is fatigued but enjoyed seeing family. C/o 5:10 headache pain. Self-admin ibuprofen 400mg with good effect. C/o minimal vertigo, dizziness, feeling of fluid in bilateral ears. Abebrile. Denies nausea. Gait steady. Dr. Kipper notified and orders received to start Medrol dose pack 1 tab po qam with food x 6 days. Ct educated on medication but requests to delay start of medication in hopes symptoms will resolve. Dr. Kipper notified. RN will continue to monitor ct. RN reviewed medication with ct and ct's assistant in preparation for day of work tomorrow. Ct verbalized understanding and requests RN to remind her and assistant at appropriate medication times.

10/6/14

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PLAINTIFF'S TRIAL EXHIBIT 0046_14
20798

Ct awake at 0630. Self-admin Provigil 200mg at 0630, Neurontin 200mg at 0700. Ct will take Neurontin 200mg q4hr today while at work to decrease anxiety. RN encouraged ct to maintain adequate fluid and food intake. Ct agreed to do so.

Symptoms of ear..............

10/7/14

Ct c/o fluid in bilateral ears, vertigo. No gait disturbances, no nystagmus, no nausea. RN educated ct again on Medrol and effectiveness in decreasing inflammation and congestion. Ct agreed to take medication. Medication reviewed with ct as she will begin dose pack tomorrow morning. Ct mood stable throughout out day. RN visited ct on set and ct able to focus and work without decrease in attention. Appetite good, fluid intake adequate. Ct compliant with medication regimen throughout day with prompts from RN.

10/8/14

Ct states she slept 7.5 hours, felt sleep was deep and restorative. Ct's mood appropriate and stable. Discussed conflict with fiancé from previous night. Ct verbalized understanding of how miscommunication affected fiance's feelings. Positive reinforcement given for empathy and attempts at therapeutic communication. Ct, RN, sister, and assistant out for the day shopping. Ct prompted by RN to take medication at appropriate times. Medrol dose pack began today. Ct educated and verbalizes understanding of how to take medication and need to follow timing appropriately. Ct given B12 1cc IM right ventrogluteal at 1115. Tolerated well. No redness , pain, or swelling at injection site. Ct c/o vertigo and nausea 15 minutes prior to leaving for work. VS stable and WNL 104/62, P 80 at 1800, 98/58, P 82 at 1830. Ct well hydrated but seems increasingly focused on weight and food intake. RN educated ct and provided 1:1 support. Encouraged ct to maintain small, frequent, balanced meals.

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PLAINTIFF'S TRIAL EXHIBIT 0046_15
20799

11/6/14: RN visited ct at her home and provided her with one week of daily medication boxes. Ct appears anxious, withdrawn. Expresses fatigue and anxiety. States she has been arguing with fiancé since arriving home last night. Ct is supported by her sister at home. Ct planned several meetings throughout day. RN encouraged ct to adhere to adequate food and fluid intake, and to use distraction and relaxation techniques to assist in stress reduction.

11/10/14: Ct awake at 0800, c/o anxiety. Requests RN to replenish medication supply as she is now taking Neurontin 400mg po q6hr per Dr. Kipper. RN visited ct's home but ct away at the time. Extra PRN medication provided to ct along with one week's worth of daily med boxes to decrease confusion over administration times. Ct busy throughout day and continue to c/o anxiety. RN offered to visit ct during evening and ct accepted, but later declined. Ct concerned that anxiety will interfere with sleep. Dr. Kipper notified. Ct encouraged to take Seroquel 25mg at hs. Ct did so and agreed to notify RN of any needs throughout night.

11/11/14: Ct verbalizes anxiety r/t fears of abandonment, uncertainty of relationship status, and confusion about cause of argument with fiancé. Emotional support given. RN encouraged ct to use separation from fiancé as time for personal reflection and self-care. RN reminds ct to stay in present and set small, short-term goals to decrease anxiety. Ct had therapy session and states talk therapy decreased anxiety for short duration. She will continue to see therapist daily. Reinforcement given for healthy coping mechanism. RN offered to visit ct but ct declined. Ct is supported by sister and friends at home. RN will remain in close contact with ct to assess physical and mental status.

11/12/14: Ct notified RN of waking at 1000. Compliant with medication. C/o severe anxiety. RN offered to assess ct at home several times but ct declined. RN encouraged ct to consume fluids and food and practice deep breathing exercises taught on previous visit. Dr. Kipper notified of ct's anxiety and Seroquel 12.5mg po q4-6hr ordered. Ct educated on medication change. Ct self –admin Seroquel 6.25mg at 1640 and Seroquel 6.25 at 1800. Mild decrease in anxiety noted. Ct remained in touch with RN periodically throughout day. Ct had session with therapist and will continue to do so daily.

11/13/14: Ct continues to report moderate to severe anxiety. Ct also c/o anorexia, depressed mood, anhedonia. RN notified Dr. Kipper and Atenolol 12.5mg bid ordered (hold p<55). RN visited ct at home. Ct appeared distressed, crying frequently, irritable, fatigued. RN discussed ct's stressors and coping mechanisms, and encouraged and reviewed relaxation techniques with ct. RN educated ct on new medication atenolol. BP left arm 106/58, P 88 at 1940. Atenolol 12.5mg given at 1945. BP left arm 98/56, P 78 at 2050. Ct ate 75% dinner with encouragement. Upon RN's departure at 2130, ct appeared less anxious and agreed to continue contact with RN throughout evening.

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PLAINTIFF'S TRIAL EXHIBIT 0046_16

20800

11/14/14: Ct reports increase in sleep last evening. Ct had daily session with therapist and states she will continue to see therapist daily until crisis resolved. Positive reinforcement given for coping skills. RN visited ct at home. Ct appeared with depressed mood, flat affect. BP left arm 102/54, P 84 at 1230. Atenolol 12.5mg given at 1235. BP left arm 98/56, P 80 at 1300. Ct drinking adequate oral liquids. Food intake fair. Ct has friends staying with her for emotional support. Ct states she is attempting to use distraction by scheduling meetings throughout day. RN encouraged ct to rest when fatigued and implement relaxation techniques. Ct did not return RN's attempt at communication during evening hours.

11/15/14: RN made several attempts to contact ct but ct did not respond. Dr. Kipper notified.

11/16/14: Ct and RN spoke via phone. Voice monotone, affect flat. Ct thought process rational and logical. Ct states she has been self-admin prescribed medication as ordered. Reports increase in appetite and food intake x 2 days. Ct expressed confusion related to relationship with fiancé. Emotional support provided. Positive reinforcement given for ct utilizing healthy coping mechanisms of meditation, journaling, distraction techniques. Ct agrees to notify RN of any needs.

11/17/14: RN in touch with ct via text. Ct did not respond to inquiry by RN as to ct's emotional and physical status. RN requested ct to notify her of any needs throughout night.

11/20/14: Client continues to c/o anxiety but states it is tolerable. Ct continues to self-administer all prescribed medication with prompting from RN. Remains on Neurontin 400mg po q6hr for anxiety with good effect. Ct expresses desire to decrease dosage to 200mg q4hr starting tomorrow as anxiety level has decreased. Ct continues to interact with fiancé and implements healthy coping mechanisms and practices therapeutic communication.

11/21/14: Client in contact with RN throughout day via phone and text. Ct chose to decrease daytime Neurontin to 200mg po q 4hr for anxiety. Ct states decreased dosage is effective in managing anxiety. Dr. Kipper notified. Ct continues to implement learned relaxation techniques and attends therapy sessions three times per week.

11/22/14: Ct in good spirits. States sleep duration and quality have increased over past two nights. Ct reports good appetite. Adequate hydration maintained with oral liquids. Ct compliant with medication when reminded at administration times by

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AH_TPG_00016945

PLAINTIFF'S TRIAL EXHIBIT 0046_17

20801

RN. Ct reports "feeling happy" and states anxiety is minimal. Plans made for RN to assess client in person tomorrow.

11/23/14: RN visited ct at home. Ct reports sleeping 7-8 hours past three nights. Appears well-rested, well groomed. Mood stable, appropriate affect. Food and fluid intake adequate. RN reviewed all prescribed medication with ct and prepared daily pill boxes for ct. Ct reports Neurontin 200mg q 4hr and 400mg qhs along with meditation, relaxation and distraction techniques, and cognitive-behavioral therapy effective in minimizing anxiety level. Ct and fiancé have reconciled. Ct states feeling "really happy and content." RN encouraged ct to notify her of any needs.

11/24/14: Ct reports quality and quantity of sleep continue to increase nightly. Ct self-admin all AM medication at appropriate time. Ct did not have her medication during majority of the day. Ct notified RN at 1900 that she had not taken afternoon Neurontin 200mg dose. RN offered to bring medication to her but ct declined. Ct self-admin Neurontin 200mg upon arrival home at 2000 and took all prescribed HS medication with prompting. Ct reports feeling slight increase in anxiety during daytime. RN assisted ct with processing stressors and feelings. Plans made for ct and RN to attend yoga and medication class tomorrow for stress reduction.

11/25/14: Ct reports sleeping from 0300 until 1400. Reports feeling well rested. RN met ct for yoga class at her house during evening. Ct completed full class. Positive reinforcement given. Ct appears in good spirits with stable mood. Ct plans to spend next few days with friends and family for Thanksgiving holiday. RN encouraged ct to notify her of any needs.

11/26/14: Ct contact RN throughout day via text. C/o increased anxiety but states "it is manageable." Ct reports implementing healthy coping mechanisms of maintaining therapy appointments, exercising, spending time with friends, meditating. Positive reinforcement given. Ct agrees to notify RN if anxiety persists. RN continues to remind ct at medication times throughout day to assist in maintaining serum level. Ct asleep at 0230.

11/27/14:

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PLAINTIFF'S TRIAL EXHIBIT 0046_18
20802

12/1/14: RN visited ct at home. Ct appears rested, calm, in good spirits. Ct and RN participate in yoga class per ct's request. Positive reinforcement given for utilizing physical exercise and relaxation techniques as coping mechanism for anxiety. Ct requires reminders throughout day to take medication.

12/2/14: Ct reports increase in stress and anxiety. Afternoon dose Neurontin 200mg missed due to ct not having medication with her during day. RN offered to bring medication to ct; ct refused. RN encouraged ct to implement sleep hygiene to increase sleep quality and quantity. Ct did not confirm medication administration reminders by RN.

12/3/14:

12/4/14: Ct reports increased sleep quality and quantity. Ct regulating on earlier sleep/wake cycle and is satisfied with progress. Ct continues to self-admin prescribed medication with prompting from RN. Ct and RN remain in contact via text throughout day. Plans made for RN to visit ct during evening but ct rescheduled. RN notified ct to provide RN with dates/times so RN may schedule follow up appointment with Dr. Kipper in the next week. Ct states anxiety level remains low and attributes it to increased sleep, taking medication at regular intervals, and increased physical exercise. Positive reinforcement given.

12/5/14:

12/6/14: RN in contact with ct throughout day via text. Plans made for RN to visit ct, but ct cancelled. Ct compliant with medication with RN prompts. Ct expresses that prompts from RN at appropriate medication administration times very helpful. RN will continue to prompt ct.

12/7/14: RN visited ct at home. Ct appears in good sprits, sociable, mood and affect appropriate. Ct interacts well with RN, fiancé, friends. Compliant with medication with prompts from RN. Ct is provided with one week of prepared medication boxes. Medication education and review provided.

12/8/14: Ct reports moderate anxiety throughout day resulting from argument with fiancé after RN left yesterday. States she slept 3 hours last night. Ct is in contact with RN sporadically throughout day via text. RN offered to visit ct to assist in processing feelings but ct declined. Ct took all prescribed medication but delayed dosage time due to inattention to prompts from RN. Ct states she has increased Neurontin to 400mg for afternoon and evening dose to decrease anxiety. RN encouraged use of relaxation and distraction techniques. Ct reports taking

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additional Seroquel 12.5mg at hs to total 25mg in attempt to decrease sleep onset time. RN encouraged ct to notify of any needs or if she would like RN to visit.

12/9/14: RN visited ct at home. Ct reports good quality sleep totaling 8 hours last night. Ct appears relaxed, mood and affect appropriate. Demonstrates insight into triggers for stress, anxiety, and conflict escalation. Processes argument with fiancé from yesterday with RN, reflects upon feelings and motivations for behavior. Positive reinforcement for conflict resolution. Ct has been compliant with medication throughout day with prompts from RN. Ct is provided with additional PRN Neurontin and Seroquel. All prescribed medication reviewed with ct.

12/10/14:

12/11/14: Ct appears in good spirits, stable mood throughout day. In contact with RN via text and phone. Ct compliant with medication with RN reminders, and responds quickly to inquiries from RN. Ct states communication with fiancé remains "very good" and appears happy to continue psychotherapy. Ct examined by Dr. Kipper today. New orders to begin Wellbutrin 75mg qam.

12/12/14: Ct has remained in contact with RN via text throughout day. Ct dosing times for Neurontin extended to q6-7hrs instead of prescribed q4 hrs due to ct's inattention to reminders from RN. Ct states mood stable, able to concentrate and focus despite demanding schedule today.

12/31/14: RN attempted to visit ct but ct did not respond to requests. Medication left with security personnel. RN notified ct via text and gave instructions for medication.

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PLAINTIFF'S TRIAL EXHIBIT 0046_20

20804

1/1/15: Ct notified RN upon waking and self-administration of AM medication. Reports sleeping soundly through the night. Anxiety minimal. RN reminded ct throughout day of medication administration times. Ct compliant and confirmed self-administration of meds. RN offered to visit ct today. Ct declined.

1/2/15: RN in contact with ct throughout day via text. Ct mood appears stable, relaxed. Ct reports anxiety minimal and reports implementing daily physical exercise and relaxation techniques. Positive reinforcement given for effective use of coping skills. Plans made for RN to visit ct tomorrow. Ct compliant with medication.

1/3/15: Ct reports continued increase in sleep quality and quantity. Mood stable. Ct reports increase in anxiety r/t family stress. RN reviewed coping skills with ct. Ct declined RN visit due to wanting to spend day with fiancé at work. RN remained in contact with ct throughout day via text and phone calls. Medication taken at appropriate times.

1/4/15: Ct in contact with RN via text throughout day. Reports happy, stable mood. RN reminds ct of medication times via text. Ct confirms via text. RN encourages ct to notify her of any needs. Ct declines and states "all is good."

1/5/15: Ct is reminded at medication administration times during day by RN via text. Ct states she is in "a good mood" but is experiencing mild anxiety. Ct attempts to implement relaxation techniques with moderate effect. Ct requests RN to visit "soon". RN offers to visit immediately but ct declines, requesting RN visit tomorrow. Ct compliant with medication throughout day and requests increase Neurontin to 300mg q 4hr during day. RN encouraged ct to maintain current regimen and implement coping skills to assess effect. If continued anxiety, RN will discuss with Dr. Kipper.

1/6/15: Ct in contact with RN via text during day. Reports increase in anxiety r/t upcoming work engagement. RN reviews relaxation techniques with ct. Ct attended therapy session and reports feeling decrease in anxiety after. RN offered to visit ct to discuss stress and anxiety; ct declined. Ct has been encouraged to notify RN of any needs during night or of desire to speak to RN in person or via phone. Plan is made for RN to travel to London, UK with ct on 1/11/15 for two week work engagement.

1/10/15: RN contacted ct via text throughout day. Ct reports insomnia last night. Did not respond to RN's attempt to assess anxiety, stress, insomnia. RN called ct to discuss but ct did not answer and did not return call. Ct prepared for and attended

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PLAINTIFF'S TRIAL EXHIBIT 0046_21

20805

public appearance with fiancé. Confirmed administration of HS medications with RN's prompting.

1/11/15: Ct awake at 1000, notified RN of administering AM medication. RN sent reminders via text at medication administration times throughout day. Ct confirmed only for 1400 dose. Ct did not respond to any other texts from RN including offer from RN to visit her. Plan remains for RN to travel with ct to London on Wed. 1/14/15 for work rehearsal.

1/12/15: Ct awake and OOB at 0915. Self-admin all AM meds. Ct and RN in contact via phone throughout day. RN assesses ct's anxiety level. Ct experiencing mild/moderate anxiety. Relaxation techniques reviewed with ct. RN and ct to travel together on Wed. 1/14/15. Ct continues to verbalize indecision r/t Wellbutrin but continues to take it qhs as prescribed. No adverse s/sx.

2/10/15: Client states she will not need RN to accompany her on trip to London as assistant Savannah is going. Client states she will be able to take all prescribed medication without prompting. Dr. Kipper notified.

2/11/15: Client in touch with RN via UK cell phone that she has arrived in London. Client is in London for work (filming "The Danish Girl" and is accompanied by her assistant, Savannah. Client's husband is in Australia for work. Client reports redness, pain, swelling after attempting to pierce her earlobe by herself. Client states earlobe initially bled but has subsided. Ct requests information from RN regarding UK equivalent of antibacterial topical ointment (similar to Neosporin). RN researched and sent information of over-the-counter antibiotic ointment to client's assistant Savannah. Ct reports cyst remains on eyelid. RN educated ct on use of warm compress on eyelid to assist in drainage and to decrease swelling, and also provided instructions for using antibiotic ointment on earlobe. RN encouraged client to keep wound clean and dry and to monitor for change or increase in swelling, irritation, redness. Ct states she will do so.

2/17/15: Client reports wounded earlobe (from self-inflicted pierce) bleeds occasionally and feels warm to the touch when she tries to clean the wound. Dr. Kipper notified. RN educated client via text on proper hygiene of wound, causes of infection and allergic reactions, and educates client on implementing saline rinse of wound. Ct does not respond to RN.

2/18/15: RN in touch with client via text. Ct states she will return to Los Angeles on 2/21/15 "for a few days" and then will return to UK to continue working on film for 3-4 days. After that, client will travel to Australia to be with her husband who is currently there for work. RN offered to travel with client to UK and/or Australia as ct has requested RN's presence in the past to assist in decreasing her anxiety and abandonment and jealousy concerns when not with her husband. Ct declined and stated she "does not need it" {RN to travel} for trips to UK or Australia. Ct admits to RN that she has fired her assistant Kate. RN asks ct how she is feeling about the

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20806

termination but ct does not respond. Dr. Kipper notified of ct's status and requests to examine ct in office.

2/19/15: RN informs ct via text that Dr. Kipper would like to assess her in his office upon her return to Los Angeles to examine cyst on eyelid as well as do a general check-up. RN offered to coordinate care and schedule appointment for client. Client did not respond to RN.

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PLAINTIFF'S TRIAL EXHIBIT 0046_23

20807

3/7/15: Ct notifies RN via text of increasing anxiety. Reports emotional lability. RN encourages client to use distraction and coping skills taught in past. Ct reports self-admin additional Seroquel 12.5mg at 0430 due to insomnia. Ct able to sleep again at 0500 until 0930. RN encourages ct to remain in contact to assist in decreasing anxiety and increase emotional stabilizaton.

3/8/15: RN received report from Debbie, RN. Client will be returning to Los Angeles on 3/9/15 accompanied by house manager Ben. RN plans to meet client upon arrival. Ct is in touch with RN via text throughout day expressing feelings of moderate to severe anxiety. Ct compliant with medication including Xanax 0.5mg now dose at 2015 (PST) with prompting from RN. Deep breathing and relaxation techniques reviewed with ct. Ct states medication and breathing effective in reducing anxiety.

3/9/15: RN and ct in touch via text and phone calls after ct arrived at 1500. Ct expressed feeling "sad." Ct attended two hour psychotherapy session. Reports feeling "a little more sorted out" after session. RN met ct and her friends for dinner at 2200. Ct appears in good spirits; laughing, socializing. Appetite normal. Ct states she would like to discuss recent events between her and husband with RN in private tomorrow. Plans are made for RN to visit ct at her home tomorrow. Ct has been compliant with medication throughout day with prompting. RN encouraged ct to notify her of any needs throughout night.

3/10/15: Ct awake and OOB at 1200. Ct did not fall asleep last night until 0445 d/t socializing with friends at home. Reports feeling rested. RN met ct at home at 1600. Ct is well groomed, appetite appears normal, is hydrating adequately...

3/24/15:

3/25/15:
1900 Ct and RN in contact throughout day via text and phone conversations. Ct expresses uncertainty regarding relationship with fiancé. States she is concerned about ability to trust fiancé following argument on 3/23/15. RN assists ct in processing thoughts and feelings, and encourages ct to continue communication with therapist. RN also encourages ct to utilize coping mechanisms for stress and conflict resolution. Ct states symptoms of candidiasis are minimal following administration of Diflucan. RN educates ct on s/sx to report. Ct verbalizes understanding. RN offers to visit ct but ct declines, but requests RN to visit on 3/27/15 to assist her in travel preparation. RN agrees to do so. Ct will be traveling to London, UK followed by travel to Denmark and then to New York City beginning 3/27/15. Ct plans to return to Los Angeles on April 18. Per Dr. Kipper, ct will be accompanied abroad by mother and declines RN to accompany as well. Ct and Dr.

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PLAINTIFF'S TRIAL EXHIBIT 0046_24
20808

Kipper request RN to remain in contact with ct and available at all times while ct is traveling.

2300 Debbie L., RN notified RN that ct and her fiancé were having verbal argument at home. RN attempted to contact ct via phone call and text. Ct did not respond. RN sent messages to ct to contact RN to discuss mood and feelings, and encouraged ct to contact her throughout night if needed.

3/26/15: Several attempts made by RN to contact ct throughout night and morning. Ct did not answer phone and did not respond to texts. Ct contacts RN at 2000. Ct states she would like RN to visit home tomorrow to assist her in packing and preparing medication for upcoming trip. RN agrees and plans to visit ct in the morning when ct notifies RN. Ct does not respond to RN inquiry of mental status and mood following argument with fiancé on previous night. Ct plans to spend evening with family and agrees to notify RN immediately of any needs, changes in mood, and/or conflicts. Compliant with medication.

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AH_TPD_00016953

PLAINTIFF'S TRIAL EXHIBIT 0046_25

20809

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Client: Amber Heard Depp
RN: Erin Boerum

11/25/15: Client contacts RN via text and invites RN to Thanksgiving dinner at her home in downtown Los Angeles. RN accepts.

11/26/15: RN visited client and husband/client JD's home in downtown Los Angeles. Client appears well groomed, calm, in good spirits. Client socializes well with peers and RN and appears to be enjoying hosting her family and friends. Client and husband JD. JD appeared calm and coherent. Client AH notified RN that she will need refills on her routine and PRN medication as she has a few days of prefilled daily medication boxes remaining. RN will notify Dr. Kipper and refill medication as approved. RN encouraged client to notify her of any needs.

11/28/15: Client and RN are in contact via text. Client states both she and her husband JD will require refills of routine and PRN medication. Dr. Kipper notified and approved request for client AH. RN notified Debbie L., RN about JD's request for medication refill. Debbie, RN to follow up. RN contacted client via text that she would be delivering requested medication refill to her home. Client did not respond. RN left wrapped and sealed medication boxes (five days of routine medication, as well as following PRN: #14 Neurontin 100mg, #14 Ambien 10mg, #10 propranolol 20mg, # 15 Xanax 0.25mg, #6 Provigil 200mg) at concierge desk. RN notified ct of arrangement. Client notified RN via text during the evening that she had retrieved the medication.

12/2/15: RN in touch with client several times via text. Client AH and JD have requested refills on routine and PRN medication. All approved for refill by Dr. Kipper. RN received medication for both clients from the pharmacies and made daily medication boxes for both. RN notified client AH that mail order pharmacy Express Scripts needs updated financial information for payment on refill of Provigil. Ct asked RN to update information and provided RN new credit card number. RN ensured that all personal and financial information with Express Scripts up-to-date. RN attempted to coordinate time to deliver medication to ct but unable due to ct's schedule. RN contacted client JD's assistant Stephen and delivered medication for both clients to Stephen. RN notified ct that Stephen will

Client: Amber Heard Depp
RN: Erin Boerum

deliver her medication to her home this evening. Ct confirmed delivery upon receipt.

12/4/15: RN in contact with ct via text to remind her of Dr. Kipper's appointment to visit her and ct JD at home tomorrow, Saturday Dec. 5 at 11:00am. Ct acknowledges appointment. RN has made arrangements with assistant Stephen and security for Dr. Kipper's arrival.

12/10/15: Client in touch with RN via text. Ct states she will be out of town visiting private island in Bahamas with husband JD and family. Ct will be gone from Dec. 20-30.

12/12/15: RN contacted Dr. Kipper to notify him of ct's vacation. Dr. Kipper approved refill of medication to ensure ct has enough for trip. RN has contacted pharmacies to refill routine and PRN medication. RN attempted to contact ct regarding medication and to coordinate a suitable time for RN to deliver them to her. Ct did not respond. RN will continue to attempt to contact ct.

12/15/15: RN picked up medication from pharmacy for client and made daily med boxes for her. Attempts made to contact ct to coordinate time for delivery but ct has not responded.

12/16/15: Ct contacts RN via phone and states she had an argument with husband JD previous night. Ct states husband JD has left home and she is unaware of his location. Client reports getting into verbal disagreement with husband at their home in downtown LA. She states husband JD was inebriated. Ct states the disagreement escalated and states husband JD used his forehead to hit her head. Ct denies loss of consciousness. States she has headache and bruised eye. RN encouraged ct to notify Dr. Kipper and/or go to emergency room if she was injured or felt like she is in danger. Ct declined and stated friend Rocky is with her and that husband JD will not be able to reenter home.

12/17/15: (23:00) RN in contact with ct to notify her that she would be able to deliver medications to her home. RN waited at door for several minutes after knocking . Ct greeted RN at door looking disheveled. Hair appeared unbrushed. Ct appeared weepy and sad. Posture is slouched. Ct told RN about argument with husband. RN offered emotional support but reminded ct that RN could not stay as was on duty with another client and was only visiting in order to deliver medication. Per ct, she has not had contact with husband since altercation. Ct had visible bright red blood appearing at center of lower lip. When RN made client aware that she was actively bleeding on her lip, ct stated it was from the injury sustained in the

argument between her and her husband, and that it continues to bleed actively. Ct also states that her head is bruised and that she lost clumps of hair in altercation. RN briefly looked at ct's scalp but was unable to visualize the hematomas ct had described. RN encouraged ct to be seen by physician Dr. Kipper or go to emergency/Urgent care for thorough assessment. Ct states she will contact Dr.

Kipper tomorrow. Ct is supported by friends Rocky and iO, who will be staying in ct's home with her. RN reminds ct to hydrate with oral fluids and to limit/abstain from alcohol. Ct was consuming red wine with RN left but assured RN she would consume in moderation. RN left and will follow up with ct tomorrow and will notify Dr. Kipper.

12/18/15: Ct states she went to Dr. Kipper's office and was assessed by NP Monroe T. as Dr. Kipper was out of the office.

12/19/15: Ct states she is experiencing increased anxiety and insomnia. RN offers emotional support via text and also encourages ct to utilize relaxation techniques and deep breathing exercises to assist in decreasing anxiety. Ct states that attempts to use Xanax and propranolol have been ineffective in managing anxiety. Ct states that Provigil "is the only thing that has made me feel better" but that she immediately feels depressed and anxious when medication is not longer effective. Dr. Kipper notified, and ordered to increase Xanax to 0.5mg q4-6hr prn. Refill for Xanax and Ambien granted by Dr. Kipper. Ct continues to state that her anxiety is worsened by unknown status of relationship with her husband as he has not returned home or contacted her since their argument several days ago. RN encouraged ct to continue to hydrate, eat small meals, and utilize support of friends and to continue seeing therapist Dr. Cowan. RN reminded ct that RN is out of town until Dec. 29 and to contact Dr. Kipper's office directly for any needs while RN is away. Ct verbalizes understanding.

12/21/15: RN received phone call from ct and husband JD. RN was confused regarding what client and husband were asking, and client AH told RN they were going to hang up. Client AH later texted RN and stated that she and husband JD had reconciled, but then argued about their argument last week. Ct plans to visit private island in Bahamas with husband JD x 1 week.

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PLAINTIFF'S TRIAL EXHIBIT 0046_28

4/12/16: RN attended ct's movie premiere of "Adderall Diaries" per ct's request. Ct appeared in good spirits and stated she had taken prescribed Neurontin prior to arriving to premiere. Ct reports drinking 2 glasses red wine prior to arrival, and consumed 2 glasses red wine during film. RN accompanied ct to after party. Ct appeared social and in good spirits, and consumed 2-3 glasses red wine. Ct invited RN to attend Coachella music festival with her and several friends for her birthday. Ct and friend Rocky admitted that they would be using illicit and recreational drugs such as MDMA, mushrooms, and marijuana. RN declined offer, and reminded ct that RN cannot be in presence of illicit drugs. RN also reminded ct that she should not be using illicit drugs, and that her prescribed medication could be adversely affected by other herbs, medications, or drugs.

4/21/16: Client invited RN to dinner party at 2000 at her home in downtown Los Angeles to celebrate her birthday as client will be attending Coachella music festival on day of her birthday. RN arrived with client's UK assistant, Savannah at 2100. Ct was socializing with friends upon RN's arrival. RN apologized for tardiness. Ct appeared irritable and upset. Ct reports being angry with husband JD "because he is late." RN provided reassurance that JD would arrive and encouraged ct to distract by socializing with friends. Ct agreed to do so. Ct ate 70% dinner and consumed several glasses red wine. Ct appears to laugh and smile when talking to friends, but mood turns depressed and affect flat when she is alone or talking with friend Rockly. Ct states, "I can't believe he (JD) isn't here yet." RN attempted to assist ct with processing feelings, but ct declines stating, "he keeps saying he (JD) is on his way, but he still hasn't shown up." Ct's husband JD arrives at 2215. JD appears in good spirits and greets client's guests. During dinner, client and JD sitting next to each other and appear affectionate towards one another. RN socialized with JD x 45 minutes. JD appeared coherent, oriented, and sociable. Thought processes logical and clear. JD and RN spent time laughing and watching a PSA he and AH had made. RN discussed ct's birthday trip to Coachella with client. She states that she and her friends will leave tomorrow around noon and will return on Sunday. She states she wants JD to drive to Coachella with her for a birthday dinner there, and then he will return to Los Angeles. Upon this statement, JD states, "Yeah, she wants me to drive all the way there just to have dinner. That really makes sense." Ct and JD appeared to be cordial but irritated. Client AH told guests that she "was tired" and escorted guests to door to leave around 1230

4/22/16:
1130: Ct notified RN via text that she was awake. States "I had a long fucked up night." Ct also states that she was concerned that her marriage with husband JD was "over." Ct reports taking Xanax 0.5mg two tablets (1mg total) and Ambien 10mg during the night, and sleeping only from 0700-1130. RN provided emotional support as client and husband appeared to be affectionate and stable last night. RN educated client on Xanax and Ambien and reminded client that both medications will remain in her system for several hours, and encouraged client to fall back asleep. RN asked ct to notify her when she wakes again and reminded ct that she would assist ct in processing feelings. Ct did not respond.

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PLAINTIFF'S TRIAL EXHIBIT 0046_29

1415: RN asks ct if she was able to fall back asleep earlier via text. Client does not respond.

4/28/16: Ct tells RN via text that she returned from Coachella but has been working on a film all week.

4/29/16: Ct tells RN that she will be traveling to New York City tomorrow for the Met Gala.

4/30/16: Ct requests medication refills on all prescribed medication as she is traveling to NYC today. Ct reports "feeling sick" and requests vitamin injection, but quickly changes her mind. RN agrees to bring medication to client as RN has kept client's medication in possession (per ct's request).

4/30/16, 1345: RN learns that ct has left for the airport while RN was en route to her home in downtown Los Angeles. Client requests RN to give medication to house manager Kevin Murphy so he can ship them to her. RN drops all medication to client's sister Whitney for delivery to Kevin. Ct notified RN when she landed in NYC at 1925.

5/1/16: Client is in touch with RN via texts. Client reports "walking alone" and is insinuating that husband JD did not travel to NYC with her as planned. Emotional support provided.

5/5/16: Client reports that she will be returning to Los Angeles tomorrow, and states being in NYC has provided distraction from relationship issues. Client has not seen husband JD since 4/22/16.

5/11/16: RN visited ct at her home in downtown Los Angeles. Ct is provided with two weeks worth of prepared daily medication boxes for upcoming travel to NYC. Ct is visiting with assistant Savannah, and friends Rocky and Josh. Ct discussed her birthday trip to Coachella music festival (trip was 4/22/16-4/24/16). Ct admits to illicit drug use during the trip, and states she ingested mushrooms and MDMA simultaneously while also consuming alcohol, and states she vomited and was "high for at least 24 hours straight." RN reminded ct that illicit drug use will not be tolerated by medical staff and that any medications or drugs that are not prescribed can interfere and cause adverse effects with her prescribed medication. Ct laughed and also reported using illicit drugs (mushrooms and MDMA) on 5/9/16 at home with a high-profile male acquaintance. Ct reported that her husband was not aware of the male visitor, nor her illicit drug use.

5/26/16: Client texted RN requesting Ambien as she states she is suffering from insomnia d/t stress and anxiety. Client reports "having the hardest week of my life." Client states she cannot deal with the negative media publicity she has received

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surrounding the divorce she requested from her husband JD. Dr. Kipper notified. Ambien 10mg qhs prn #14 ordered. Per Dr. Kipper, ct is encouraged to make appointment with Dr. Kipper in office to be assessed. Ct did not respond.

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PLAINTIFF'S TRIAL EXHIBIT 0046_31

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