IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OKLAHOMA
TULSA DIVISION

UNITED STATES OF AMERICA	)	
	)	
v.	)	4:21-CR-00239-GKF-1
	)	
ALETA NECOLE THOMAS	)	

MOTION TO EXTEND SELF-SURRENDER DATE

COMES NOW Defendant, Aleta Thomas, pursuant to 18 U.S.C. § 3143(a)(1), who respectfully requests that this Court extend the date upon which she has been ordered to surrender to the Federal Bureau of Prisons ("BOP") for service of her sentence in said case (currently scheduled for July 20, 2022) due to her recent hospitalization at , for a period of not less than fourteen (14) days. In support of this motion, Ms. Thomas states the following:

I. Relevant Procedural History

On June 8, 2022, this Court sentenced Ms. Thomas, *inter alia*, to serve a term of imprisonment of thirty months, and ordered that Ms. Thomas voluntarily surrender to the Federal Bureau of Prisons' designated institution on July 20, 2022, before 2:00 p.m. J., ECF No. 113, at 2.

II. Factual Assertions

On July 19, 2022, Ms. Thomas was admitted to Ascension St. John Medical Center in Tulsa, Oklahoma for acute neurological deficits/suspected stroke, as indicated by the Consultation Report attached hereunto as Exhibit A. Ms. Thomas is currently undergoing additional testing at the hospital.

III. Memorandum of Law

This Court, by its releasing Ms. Thomas, pending execution of her sentence of imprisonment, necessarily has found by clear and convincing evidence that she is not likely to flee or pose a danger to the community, as contemplated in 18 U.S.C. § 3142(a)(1). Therefore, this Court's ordering Ms. Thomas to surrender voluntarily for the execution of her sentence, rather than its remanding her to the custody of the United States Marshals Service, was warranted. Ms. Thomas respectfully submits that those circumstances remain unchanged.

IV. Conclusion

Ms. Thomas, based on the foregoing assertions and argument, prays that this Court extend her surrender date pending release from her current hospitalization for a period of not less than fourteen (14) days.

Date: July 20, 2022

s/ Matthew Allen Chivari, Esq.
Matthew Allen Chivari, Esq.
Il. Bar # 6337524
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Attorney for Aleta Necole Thomas

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CERTIFICATE OF SERVICE

I certify that on July 20, 2022, I electronically filed the forgoing MOTION TO EXTEND SELF-SURRENDER DATE with the Clerk of the United States District Court for the Northern District of Oklahoma by way of the CM/ECF system, which automatically will serve this document on the attorneys of record for the parties in this case by electronic mail.

Date: July 20, 2022

s/ Matthew Allen Chivari, Esq.
Matthew Allen Chivari, Esq.
Il. Bar # 6337524
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Attorney for Aleta Necole Thomas

Exhibit A

Consultation Report

THOMAS, ALETA NICOLE - SJ01807254

Result type: Consultation Report
Result date: Tuesday, July 19 , 2022 10:50 CDT
Result status: Auth (Verified)
Result title: NEUROSTROKE Consultation Report
Performed by: Steichen PA, Mark A on Tuesday, July 19 , 2022 13:06 CDT
Verified by: Abdo DO, Christopher G on Tuesday, July 19 , 2022 20:24 CDT
Encounter info: SJ7102248818, ST JOHN MEDICAL, Observation, 07/19/22 -

Date of Consult
7/19/22

Consulting Physician
Christopher Abdo, DO
Neurology/Stroke

Referring Physician
James Hensel, DO
ASJMC ED

Chief Complaint
headache, vision change
generalized weakness

Reason for Consultation
stroke-like symptoms

History of Present Illness
Mrs. Thomas is a 43 year-old lady who has been having 5 days of shooting pain from the back of her head radiating toward her left eye. She reports the pain comes "like a spark" and has been associated with dark spots in her left eye. She says the pain lasts for about 10-15 seconds with it occurs. She went to see her PCP today because of recent pain behind her right knee and calf. She was sent to the ED for further evaluation and because she was told she would need a scan of her leg to make sure she did not have a blood clot. Because of headache and vision change, also complaint of generalized weakness, a code stroke alert was sent and a NECT head and CTA head/neck were obtained. These studies showed no acute findings. The patient was evaluated in ED room 9 with Dr. Abdo.

The patient reports feeling "heavy all over" currently. She reports a history of stroke in the past as well as TIA, however, she is unable to say how the stroke impacted her. She was previously evaluated at SJMC in 2017 for complaint of right-sided weakness and sensory changes. Stroke work-up including MRI brain (5/21/17 and 5/22/17) were negative at that time. She is not an IV tNK candidate due to symptoms present for 5 days and exam findings less suggestive of stroke. There is no LVO on vessel imaging therefore she is not a thrombectomy candidate.

Review of Systems
REVIEW OF SYSTEMS:
Constitutional symptoms: The patient denies any fever chills or night sweats
Eyes: The patient denies wearing glasses or having any **visual disturbances**
Ears nose and throat: The patient denies any hearing loss or ringing of the ears
Cardiovascular: The patient denies any chest pain or palpitations
Respiratory: The patient denies any hemoptysis or frequent cough
Gastrointestinal: The patient denies any loss of appetite, constipation, diarrhea

Problem List/Past Medical History
Ongoing
- Ear pain
- Knee injury - Minor
- Morbid obesity
- MVC (motor vehicle collision)

Lupus
Asthma

Procedure/Surgical History
- biopsy done left arm
- Cholecystectomy
- cyst on back of neck

Medications
Inpatient
No active inpatient medications
Home
albuterol 2.5 mg/3 mL (0.083%) inhalation solution, 2.5 mg= 3 mL, NEB, Q6 hr, PRN
albuterol 90 mcg/inh inhalation aerosol, 2 Puffs, INH, QID, PRN, with spacer
Cheratussin AC 10 mg-100 mg/5 mL oral syrup, 10 mL, PO, Q4 hr, **Not taking**
Combivent Respimat, 1 Puffs, INH, QID
hydroCHLOROthiazide 25 mg oral tablet, 25 mg= 1 Tab, PO, DAILY
hydroxychloroquine 200 mg oral tablet, 400 mg= 2 Tab, PO, DAILY
hydrOXYzine pamoate 50 mg oral capsule, 50 mg= 1 Cap, PO, QID, PRN
meloxicam 15 mg oral tablet, 15 mg= 1 Tab, PO, DAILY
oxyCODONE 10 mg oral tablet, 10 mg= 1 Tab, PO, TID, PRN
pantoprazole 40 mg oral delayed release tablet, 40 mg= 1 Tab, PO, DAILY
predniSONE 10 mg oral tablet, See Instructions, 6 tabs PO QD x 4 days, then take 5 tabs PO QD x 3 days, then 4 tabs PO QD x3 days, then take 3 tabs by mouth daily for 3 days, then take 2 tabs PO QD x 3 days, then take 1 tab PO QD x 3 days, then take 0.5mg tab PO QD then stop, **Not taking**
predniSONE 20 mg oral tablet, 60 mg= 3 Tab, PO, DAILY, **Not taking**

Printed by: Brooks, Micha
Printed on: 07/19/22 23:20 CDT

or bloody stools
Genitourinary: The patient denies any burning, hematuria or incontinence
Musculoskeletal: The patient denies any difficulty with walking or pain in the back, **right leg pain**
Integumentary: The patient denies any rash or itching of the skin
Neurological: The patient denies any dizziness, frequent **headaches**, seizures or numbness or tingling, **weakness**
Psychiatric: The patient denies any sleep disturbance, confusion or depression
Endocrine: The patient denies any excessive thirst, hunger. No complaint of intolerance to heat or cold
Hematology and lymphatics: The patient denies any excessive bruising or bleeding
Allergy and immunology: The patient denies any frequent infections or seasonal allergies
Positives in bold

Physical Exam

Vitals & Measurements
T: 36.1(Temporal Artery) **HR:** 46 **RR:** 12 **BP:** 132/82 **SpO2:** 99% **HT:** 165 cm **WT:** 61.5 Kg(Dosing) **BMI:** 22.6

GEN: Appears stated age. Well developed & nourished. No acute distress.
HEENT: Neck is supple without evidence of meningismus. No lesions of the tongue or soft palate. No scleral icterus.
CV: S1, S2. Normal rate & rhythm.
Resp: Clear to auscultation. Breathing room air.
GI: Bowel sounds present in four quadrants. No tenderness to palpation. No distension.
Integument: No rashes or lesions noted.
Extremities: Peripheral pulses are patent. No pitting edema noted.

NIH Stroke Scale

NIH Stroke Scale-LOC : 0 - Alert, keenly responsive
NIH Stroke Scale-LOC Questions : 0 - Answers both questions correctly
NIH Stroke Scale-LOC Commands : 0 - Performs both tasks correctly
NIH Stroke Scale-Best Gaze : 0 - Normal
NIH Stroke Scale-Visual : 0 - No visual loss
NIH Stroke Scale-Facial Palsy : 0 - Normal symmetrical movements
NIH Stroke Scale-Motor Left Arm : 0 - No drift
NIH Stroke Scale-Motor Right Arm : 0 - No drift
NIH Stroke Scale-Motor Left Leg : 1 - Drifts down before 5 seconds. Does not hit bed or other support.
NIH Stroke Scale-Motor Right Leg : 0 - No drift
NIH Stroke Scale-Limb Ataxia : 0 - Absent
NIH Stroke Scale-Sensory : 1 - Mild to moderate sensory loss. Patient feels pinprick is less sharp or is dull on the affected side. Patient is aware of being touched.
NIH Stroke Scale-Best Language : 0 - No aphasia.
NIH Stroke Scale-Dysarthria : 0 - Normal.
NIH Stroke Scale-Extinction : 0 - No abnormality.

NIH Stroke Scale Score Total : 2
Time: 1055

Additional pertinent findings: effort-dependent weakness LLE, decreased sensation to light touch in LLE>LUE

Reflexes:	R/L
Biceps	2/2
Triceps	2/2

Pulmicort Flexhaler 180 mcg/inh inhalation powder, 180 Mcg, INH, BID, **Not taking**
Symbicort 160 mcg-4.5 mcg/inh inhalation aerosol, 2 Puffs, INH, BID
Zofran ODT 4 mg oral tablet, disintegrating, 4 mg= 1 Tab, PO, Q8 hr, PRN, **Not taking**

Allergies

Reglan (Agitation..)
morphine
penicillin G benzathine

Social History

Right handed. Has 6 adopted kids and also helps care for her elderly grandmother. No tobacco, etoh or illicit drug use.

Family History

Her mother died from CAD in her mid-20s. Her father was shot and died in his mid 20s. No known history of stroke in her parents.

Lab Results

WBC: 6.2 10^9/L (07/19/22 10:41:00)
RBC: 4.26 10^12/L (07/19/22 10:41:00)
HGB: 12.1 g/dL (07/19/22 10:41:00)
HCT: 36.6 % (07/19/22 10:41:00)
MCV: 85.9 fL (07/19/22 10:41:00)
MCH: 28.4 PG (07/19/22 10:41:00)
MCHC: 33.1 g/dL (07/19/22 10:41:00)
PLT: 209 10^9/L (07/19/22 10:41:00)

PRO TIME: 14.5 seconds (07/19/22 10:41:00)
INR DETAIL: 1.1 (07/19/22 10:41:00)

GLUCOSE LEVEL: 91 mg/dL (07/19/22 10:41:00)
BUN: 14 mg/dL (07/19/22 10:41:00)
CREATININE: 0.69 mg/dL (07/19/22 10:41:00)
SODIUM: 134 mmol/L Low (07/19/22 10:41:00)
POTASSIUM: 3.9 mmol/L (07/19/22 10:41:00)
CHLORIDE: 109 mmol/L (07/19/22 10:41:00)
BICARB: 16 mmol/L Low (07/19/22 10:41:00)
ANION GAP: 9 mmol/L (07/19/22 10:41:00)
CALCIUM: 8.3 mg/dL Low (07/19/22 10:41:00)

AST: 24 units/L (07/19/22 10:41:00)
ALT: 21 units/L (07/19/22 10:41:00)
ALBUMIN: 3.6 g/dL Low (07/19/22 10:41:00)
ALK PHOS: 74 units/L (07/19/22 10:41:00)
PROT TOT: 6.5 g/dL (07/19/22 10:41:00)
BILI TOT: 0.3 mg/dL (07/19/22 10:41:00)
GFR CALC: >60 mL/min (07/19/22 10:41:00)
Estimated Creatinine Clearance: 94 mL/min (07/19/22 10:41:00)

CPK: 102 units/L (07/19/22 10:41:00)
TROPONIN: <0.010 ng/mL (07/19/22 10:41:00)

Brachioradialis	2/2
Patellar	2/2
Achilles	2/2
Plantar resp.	F/F

F:flexion, E:extension, Q:equivocal, M:Mute
Comments: none

Assessment/Plan
Problem list:
1. Cephalgia
2. Vision change
3. RLE pain
4. Left sided sensory disturbance/weakness

Stroke Evaluation summarized:
Head CT: no acute findings
CTA head/neck: no LVO or flow-limiting stenosis
EKG/Telemetry: sinus brady/NSR
Troponin: <0.010
SDS: negative
CT chest with contrast: no acute findings

MDM:
43 year-old with 5 days of shooting headache associated with left eye dark spots, generalized weakness and RLE pain. Variable degree of weakness on exam. Presentation and exam findings atypical for acute stroke. CT/CTA head/neck with no acute findings that would explain symptoms.

Seen with Dr. Abdo. His impressions/recommendations to follow. I spent 10 minutes on this patient encounter.

I examined the patient and reviewed lab work and imaging. Agree with the assessment, plan and notation as above by Neurology APP. I have spent 34 minutes on the care of this patient, including face to face evaluation, chart review, placing orders, and documentation.

43 yo female with called code stroke.

Pt reported left sided weakness to ED who called code stroke.
CTH/CTA showed no acute abnormalities.
Pt reports heaviness in all extremities.
Intermittent left sided shooting pain from occiput to eye.

No evidence of acute stroke at this time. Defer tPA.

On exam, give way weakness noted on the left. Reports leg weaker than arm.
Reports decreased sensation on left.
Toes downgoing.
Funduscopic examination unremarkable.
Reports stroke approximately 5 years ago. MRI from 2017 where patient presented with right sided weakness shows no acute abnormalities. No neuro consultation obtained during that visit.

Critical care time: 36 minutes performing critical care.

BRAIN PEP: 28 pg/mL (07/19/22 10:41:00)
BL DRG SC: Negative (07/19/22 10:41:00)
Barbiturates Screen: Negative (07/19/22 10:41:00)
TRICYCL SC: Negative (07/19/22 10:41:00)
BENZ SC: Negative (07/19/22 10:41:00)
SAL SC: Negative (07/19/22 10:41:00)
ACETAM SC: Negative (07/19/22 10:41:00)
ALCOHOL: <10 mg/dL (07/19/22 10:41:00)

Diagnostic Results
*** Final Report ***

Reason For Exam
Neuro Deficit, Acute, Stroke Suspected

CT Head RAPID
EXAM: CT Head RAPID

HISTORY: Neuro Deficit, Acute, Stroke Suspected.

COMPARISON: 2020 CT

TECHNIQUE: Utilizing automatic exposure control, standard noncontrast axial CT images were obtained of the head.

FINDINGS:
Hemorrhage: none

Mass effect: None

Ventricles and sulci: No hydrocephalus. Cavum of septum pellucidum incidentally noted.

Brain parenchyma: unremarkable

Globes and orbits: unremarkable

Paranasal sinuses, mastoid air cells, and middle ear cavities: Moderate left maxillary ethmoid sinus mucosal thickening/fluid opacification.

Calvarium: Intact

IMPRESSION:
1. **No acute intracranial hemorrhage or mass effect.**
2. Paranasal sinus disease.
3. Otherwise, as detailed above.

Signature Line
********** FINAL REPORT **********

Consultation Report

Critical care time spent did not include any separately billable procedure time The patient required critical care services due to the following conditions and threat of imminent deterioration or life threatening events related to these conditions:
- Acute ischemic stroke

Critical care time reflects my personal work performing the following specific actions a the patient bedside:
-

Additional activities performed during critical care time include: clinical examination, review of overnight events/labs/imaging, serial data review, ordering/interpreting/reviewing diagnostic studies/labs/tests, high complexity medical decision making, care coordination with family members about services and decisions made in critical events, communication and coordination with consulting services and other multidisciplinary team members for the patient. This time also includes time spent in documentation.

THOMAS, ALETA NICOLE - SJ01807254

Dictated: 07/19/2022 10:33 am Fischer MD, Ian T

Signed: 07/19/2022 10:34 am Fischer MD, Ian T

*** Final Report ***

Reason For Exam
Neuro Deficit, Acute, Stroke Suspected

CTA Head Neck RAPID
CT angiogram head and neck with contrast - 7/19/2022 10:25 AM

The exam was performed utilizing automated exposure control for dose reduction.

COMPARISON: CT brain 7/19/2022.

TECHNIQUE: Multiple contiguous axial imaging through the intracranial vasculature and cervical arterial vasculature was obtained from the skull base through the vertex during the dynamic arterial phase of intravenous contrast. Post processed MIP reformatted imaging in the sagittal and coronal planes obtained.

CTA dataset was post-processed using RAPID LVO detection to evaluate blood vessel density. RAPID automated results notification made to the stroke team.

HISTORY: Neuro Deficit, Acute, Stroke Suspected

FINDINGS:

CT ANGIOGRAM HEAD:
Dominant left vertebral artery. Right vertebral artery essentially terminates in the posterior inferior cerebellar artery on the right which is likely a normal variant for this patient. Fetal type bilateral posterior cerebral arteries. No aneurysm or convincing evidence for significant acquired flow-limiting stenosis throughout the posterior circulation.

No aneurysm or significant flow-limiting stenosis throughout the anterior circulation.

Partial opacification paranasal sinuses.

CT ANGIOGRAM NECK:
The vessels originating from the thoracic aortic

arch demonstrate normal anatomy. The origins of both vertebral arteries, common carotid arteries, left subclavian and innominate artery demonstrate no significant flow limiting stenosis.

There is a dominant left vertebral artery. There is no significant flow limiting stenosis demonstrated throughout the course of either vertebral artery.

There is no significant flow limiting stenosis demonstrated throughout the course of either common carotid artery or cervical internal carotid artery by NASCET criteria. Tortuous distal cervical internal carotid arteries.

Degenerative changes in the spine.

==========

IMPRESSION (HEAD):
1. **No aneurysm or convincing evidence for acquired flow-limiting stenosis throughout the intracranial arterial vasculature**.
2. Normal variant anatomy.

IMPRESSION (NECK):
1. No significant flow-limiting stenosis throughout the cervical arterial vasculature.

Signature Line
********** FINAL REPORT **********

Dictated: 07/19/2022 10:36 am Shaffer MD, Rodney G

Signed: 07/19/2022 10:42 am Shaffer MD, Rodney G

*** Final Report ***

Reason For Exam
chest pain / Shortness of breath;Shortness of breath

CT Chest w PE Protocol CTA

CT CHEST WITH CONTRAST- PE PROTOCOL

DATE: 7/19/2022 12:02 PM

Consultation Report

THOMAS, ALETA NICOLE - SJ01807254

7254

INDICATION: Shortness of breath

PROCEDURE: CT images of the chest was obtained following intravenous contrast injection. 3D/MIP reconstructions were submitted. Automatic exposure control was used for dose reduction. Dictation is based on receipt of 132 images.

COMPARISON: March 5, 2020

FINDINGS:

There is satisfactory opacification of pulmonary circulation. No convincing evidence of pulmonary embolism. No CT evidence of pulmonary hypertension or right heart strain. The heart and vascular structures are normal. Nonspecific body wall edema.

Lungs demonstrate no consolidation or mass. No pneumothorax or cavitary lesion. No pleural or pericardial effusion. The central airways are patent. No significant mediastinal, axillary, or hilar adenopathy.

The thyroid is not enlarged.

Limited images below diaphragm show gastric surgery.

No aggressive osseous lesion.

IMPRESSION:
1. No acute intrathoracic abnormality. Nonemergent findings described above.

Signature Line
********** FINAL REPORT **********

Dictated: 07/19/2022 12:27 pm Smith MD, Bryan Scott

Signed: 07/19/2022 12:30 pm Smith MD, Bryan Scott

Completed Action List:

* Perform by Steichen PA, Mark A on Tuesday, July 19 , 2022 13:06 CDT
* Modify by Steichen PA, Mark A on Tuesday, July 19 , 2022 13:06 CDT
* Modify by Steichen PA, Mark A on Tuesday, July 19 , 2022 13:13 CDT
* Modify by Steichen PA, Mark A on Tuesday, July 19 , 2022 13:16 CDT
* Modify by Steichen PA, Mark A on Tuesday, July 19 , 2022 13:21 CDT

Printed by: Brooks, Micha
Printed on: 07/19/22 23:20 CDT

Consultation Report

THOMAS, ALETA NICOLE - SJ01807254

* Modify by Steichen PA, Mark A on Tuesday, July 19 , 2022 13:27 CDT
* Modify by Steichen PA, Mark A on Tuesday, July 19 , 2022 13:29 CDT
* Modify by Steichen PA, Mark A on Tuesday, July 19 , 2022 13:31 CDT
* Sign by Steichen PA, Mark A on Tuesday, July 19 , 2022 13:31 CDT Requested by Steichen PA, Mark A on Tuesday, July 19 , 2022 13:06 CDT
* Modify by Steichen PA, Mark A on Tuesday, July 19 , 2022 14:27 CDT
* Sign by Steichen PA, Mark A on Tuesday, July 19 , 2022 14:27 CDT
* Modify by Steichen PA, Mark A on Tuesday, July 19 , 2022 14:28 CDT
* Sign by Steichen PA, Mark A on Tuesday, July 19 , 2022 14:28 CDT
* Modify by Abdo DO, Christopher G on Tuesday, July 19 , 2022 20:24 CDT
* Sign by Abdo DO, Christopher G on Tuesday, July 19 , 2022 20:24 CDT Requested by Steichen PA, Mark A on Tuesday, July 19 , 2022 14:28 CDT
* VERIFY by Abdo DO, Christopher G on Tuesday, July 19 , 2022 20:24 CDT